



BOARD OF DIRECTORS (IN PUBLIC)

Meeting to be held on Tuesday, 12 September 2023 at 13.45 – 16.45 in Lecture Theatre
1, Education Centre

AGENDA

NO	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
Preliminary Business				
1.	Welcome and Apologies for Absence	Information	Chair	
2.	Declarations of Interest	Information	Chair	
3.	Patient Story	Information	Patient and Public Involvement Lead	13.45
4.	Minutes of the Last Meeting – 15 th June 2023	Approval	Chair	14.05
5.	Matters Arising and Action Log	Approval	Chair	
6.	Chief Executive's Report	Information	Chief Executive	14.10
Strategic				
7.	Response to the Verdict in the trial of Lucy Letby	Assurance	Chief Executive	14.25
8.	Healthier Together ICS Green Plan	Approval	Chief Financial Officer	14.40
9.	Pharmacy Technical Services Outline Business Case	Approval	Chief Medical Officer	14.50
Quality and Performance				
10.	Quality and Outcomes Chair's Report	Assurance	Chair of the Quality and Outcomes Committee	15.05
11.	Performance Report	Assurance	Chief Operating Officer; Chief Nurse and Midwife; Chief People Officer; Chief Medical Officer	15.10
BREAK 15.25 – 15.35				
12.	Annual Infection Prevention Control Report	Assurance	Director of Infection Prevention and Control	15.35
Research and Innovation				
13.	NIHR CRN Annual Plan and Annual Report (hosted body report)	Approval	Chief Medical Officer	15.45
Financial Performance				
14.	Finance, Digital & Estates Committee Chair's Report	Assurance	Chair of the Finance and Digital Committee	15.50

NO	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
15.	Trust Finance Report	Assurance	Chief Financial Officer	15.55
People Management				
16.	People Committee Chair's Report	Assurance	Chair of the People Committee	16.05
Governance				
18.	Audit Committee Chair's Report	Assurance	Chair of the Audit Committee	16.10
19.	Framework of quality assurance for responsible officers and revalidation	Approval	Director of Corporate Governance	16.15
20.	Register of Seals	Information	Director of Corporate Governance	16.25
21.	Governors' Log of Communications	Information	Director of Corporate Governance	
Concluding Business				
22.	Any Other Urgent Business	Information	Chair	
23.	Date of Next Meeting: Tuesday, 14 November 2023	Information	Chair	

Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Report Title	What Matters to Me – a Patient Story
Report Author	Tony Watkin, Experience of Care and Inclusion Team
Executive Lead	Deirdre Fowler, Chief Nurse and Midwife

1. Purpose

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

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

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

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

Weston General Hospital is continuing to develop into a thriving hospital at the heart of the community. In addition to routine and ongoing service development at the hospital there is a focus on three areas. The hospital will:

- become a centre of surgical excellence.
- become a centre of excellence for older people's care.
- help more people go home quickly after going to hospital in an emergency.

Underpinning this is a focus on experience of care, concentrating on the fundamentals of nursing care. This is complemented by several ward-based improvement initiatives including, for example: the introduction of well-being walks with staff and patients to improve and continue rehabilitation and, an enhanced recovery initiative which pro-actively involves patients in achieving their targets.

In this patient story we will meet Lindsey, a patient who underwent surgery for bowel cancer at Weston General Hospital. What follows (in italics) is an account of Lindsey's personal experience of care at University Hospitals Bristol & Weston NHS Foundation Trust.

The account offers both a reflection of the impact of the care received and a summary of areas for on-going improvement commensurate with the direction of travel at the hospital.

These are Lindsey's own words:

"I had a blood test in February, to investigate my extreme fatigue, and was found to be anaemic. Your Cancer Pathway kicked in efficiently and a colonoscopy identified bowel cancer. No spread was seen from the scan. I had a right hemi-colectomy at Weston on the 25th of April. The care of Mr Krishna and team has been outstanding; however, the nursing care was not. I was put at significant risk and did not receive the level of care and compassion that I would expect.

To set the context, I recognise what safe high-quality care is, as a previous Chief Nurse in the Trust, Senior NHSE SW Director of Nursing and Quality, and a Senior Lecturer at University of the West of England until 2022.

This was my first surgical experience. I had complex thoughts and feelings, including the 'normal' fears of someone with a cancer diagnosis. I was distraught as a single parent of a daughter whose father had recently died and was about to complete her university studies. I had been part of NHSE work addressing safe medical staffing at Weston, I had supervised the turnaround following a poor CQC report regarding care and compassion. The merger and anecdotal feedback reassured me on these aspects, and the medical staff assured me that a safe medical staffing framework was in place. My main fear on admission was that low staffing levels might compromise the nursing care. It was compromised but my experience was of a ward which was well staffed.

So, what happened? I was admitted to the ward at teatime and had a comfortable post-operative night. This meant that this is the only period when I cannot be 100% sure of all events. I recall observations being done before lights out and again in the morning, but not in between. This surprised me having been in surgery for 6 hours. I was found to be hypotensive in the morning leading to a MEWS¹ call to the medical team.

That morning was the start of a truly distressing 24 hrs, feeling unsafe and vulnerable. There were a myriad of issues: offered high fibre breakfast when on fluids only; consistently poor Infection Prevention & Control practice [IPC]; delays in pain relief; no checking of identity for controlled drugs; and a lack of care and compassion. None of the nurses appeared to know or understand anything about me other than what operation I had had.

Then came a very difficult night. Whilst the ward was well staffed there clearly was an issue with a very unwell patient. Our 6-bed area had a dedicated support worker, but she spent much of the night feet up, on her mobile phone, possibly sleeping. She did not appear to escalate any issues to the registered nurses. For me it was the first time my bowels opened, not a comfortable experience. She ignored another patient in pain and who was vomiting. I settled at 2 am but was unable to go to sleep, as I felt I needed to self-mange my infusion. She made hourly records, documenting that I was sleeping comfortably. This was untrue.

¹ MEWS – Modified Early Warning Score to identify patients at risk of deterioration.

You might ask why, with my experience, I not raise my concerns? But I just didn't feel able to as I was vulnerable, felt disempowered and feared being identified as a 'difficult patient'. I did not at any time tell the nurses of my previous role and experience.

For the rest of my admission issues relating to safety, care and compassion continued but to a lesser degree. There were 2 support workers and a student nurse who were very good. Unsurprisingly, I tested positive to COVID two days after discharge and felt this was contracted from the patient in 'isolation' in the side room, as I had observed the consistently poor IPC. This meant that at my most vulnerable I spent a week in isolation at home, my daughter and friends unable to support me.

In summary, my concerns related to:

- Patient Safety – patients placed at significant risk due to unsafe IPC practice, medicines management, infusion management etc.
- Lack of care & compassion from nursing staff, ironically demonstrated positively by medical staff.
- Lack of knowledge of the patients and little application of evidence-based practice.
- Care was task orientated with little application of person-centred care or a holistic approach.

I am reassured that the Trust, having learnt of my concerns, has been receptive, listened and has not been defensive. I feel proud that this is part of my legacy. I know that the problems I have experienced are not endemic, however lessons must be learnt.

What I would like to see from this is that you:

- Do not re-invent the wheel to address this with new initiatives or projects. You have the staff, knowledge and tools to act.
- Invest in your nursing leaders. Leadership and supervision is key to assuring high quality nursing.
- Monitor the data for assurance not reassurance. When a process achieves 95% reliability, don't assume it will stay that way. Use real time data collection and don't revert to 'clinical audits'."

The Division has provided this update:

Since hearing of Lindsey's experience staff have been working collaboratively with teams in the Trust to improve their skills, knowledge, and practice. The PEF² team have been essential at leading this change by organising training for the ward staff with intravenous medications, cannula care and administration via volumetric devices. Sessions have included:

- Demonstrating checking the pumps, identifying key parts, troubleshooting and reporting when damaged

² Practice Development Education Facilitator

- Discussing preparation of IV antibiotics, 5 R's of medication administration, 5 moments of hand hygiene
- Explaining the rationale for the use of combi stopper / syringe bungs when infusion is on hold or pause
- Implementing in practice the updated flushing guidance by NIVAS 2021³
- Identifying the correct waste container for vials, ampoules, giving sets, and bags of fluids

The Infection Prevention and Control Team (IPC) have been supporting with facilitating audits and spot checks on the ward. An IPC colleague visited the ward to observe practice and gave recommendations for improvement to the ward sister.

- Staff have been sent on upskilling days and will continue to have these sessions throughout the next few months.
- New blue ANTT⁴ trays ordered and in use.
- Additional auditing of devices such as cannulas and catheters; matron and ward sister to spot check weekly to maintain achieved standards and to feed back to the ward staff.

IPC colleagues have been working on a cannula improvement plan to improve the care and management of cannulas. This includes:

- An updated policy.
- E-learning for the cannula module

Senior nursing presence on the ward:

- Matron is visible, reviewing standards and challenging any poor practice. Ward sister has been working to improve the team working skills between members of staff and has worked night shifts and completed unannounced visits to observe practice at night.
- Behaviour and conduct policies have been recirculated to the staff for awareness of their responsibilities and the professional standards.
- Orientation of bank and agency workers, and focussed support given to those temporary workers.

3. Strategic Alignment

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

4. Risks and Opportunities

None.

5. Recommendation

This report is for Information

- This report is for **INFORMATION**

³ National Infusion and Vascular Access

⁴ Aseptic non-touch tray

<ul style="list-style-type: none">• The Board is asked to NOTE the report
6. History of the paper Please include details of where paper has <u>previously</u> been received.
N/A



BOARD OF DIRECTORS (IN PUBLIC)

Minutes of the Meeting held on Thursday 15th June 2023 at
13.45 – 16.45 in City Hall, Bristol

Present

Board Members

Name	Job Title/Position
Jayne Mee	Chair
Eugine Yafele	Chief Executive
Arabel Bailey	Associate Non-Executive Director
Sue Balcombe	Non-Executive Director
Paula Clarke	Executive Managing Director, Weston General Hospital
Neil Darvill	Chief Digital Information Officer
Deirdre Fowler	Chief Nurse and Midwife
Bernard Galton	Non-Executive Director
Marc Griffiths	Non-Executive Director
Jane Norman	Non-Executive Director
Roy Shubhabrata	Non-Executive Director
Martin Sykes	Non-Executive Director

In Attendance

Rachel Hughes	Divisional Director of Nursing
Emily Judd	Corporate Governance Manager (minutes)
Philip Kiely	Deputy Chief Operating Officer
Alex Nestor	Deputy Chief People Officer
Eric Sanders	Director of Corporate Governance
Jeremy Spearing	Acting Chief Financial Officer
Mandie Townsend	Deputy Medical Director
Tony Watkin	Patient and Public Involvement Lead (for Item 3: Patient Story)
Ingrid	Parent of patient (for Item 3: Patient Story)

Apologies

Jane Farrell	Chief Operating Officer
Stuart Walker	Chief Medical Officer
Neil Kemsley	Chief Financial Officer
Emma Wood	Chief People Officer

The Chair opened the Meeting at 13.45

Minute Ref.	Item	Actions
01/06/23	Item 1 - Welcome and Apologies for Absence	
	Jayne Mee, Chair, welcomed members of the Board to the meeting. Jayne informed the Board that the meeting would be recorded and published on the Trust's YouTube account for public access following the meeting.	
	Apologies of absence had been received from:	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • Neil Kemsley, Chief Financial Officer; Jeremy Spearing, Acting Chief Financial Officer deputised. • Emma Wood, Chief People Officer; Alex Nestor, Deputy Chief People Officer deputised. • Jane Farrell, Chief Operating Officer; Philip Kiely, Deputy Chief Operating Officer deputised. • Stuart Walker, Chief Medical Officer; Mandie Townsend, Deputy Medical Director deputised. <p>Eugine Yafele, Chief Executive, noted the larger number of apologies received for the meeting had been due to a change to meeting dates and would not be a usual occurrence.</p> <p>Jayne Mee welcomed Neil Darvill, the Trust's new Joint Chief Digital Information Officer who was now in post to oversee digital services at the Trust and at North Bristol NHS Trust (NBT).</p>	
02/06/23	Item 2 - Declarations of Interest	
	There were no new declarations of interest relevant to the meeting to note.	
03/06/23	Item 3 - Patient Story	
	<p>Rachel Hughes, Divisional Director of Nursing introduced Ingrid who was the parent of a patient at the Trust's children's hospital and who described their experience of a last-minute cancellation of neurosurgery which occurred due to limited nursing available in the Neonatal Intensive Care Unit (NICU).</p> <p>Ingrid told the story of the family's journey relating to their daughter's care. The Board heard about the complicated health plans that had been put in place at her daughter's school, and the urgency around getting their daughter to the hospital for her operation, which had required extensive planning for the entire family. Ingrid explained the emotions felt by the entire family during the period in January 2023, including the stress around organising the logistics for the family around the scheduled operation which had included her children missing school days. On the operation day, her daughter had been nil by mouth overnight, had seen the anaesthetist and surgical team on their rounds, and the consent form with the daunting list of possible surgical complications was checked. However, at this point the family was informed that even though theatre staff and the operating theatre were available, the operation needed to be cancelled because there was a lack of specialist paediatric intensive care nurses to safely cover the intensive care unit that evening for the after-care.</p> <p>Ingrid recalled the clinical team desperately calling agencies to find last-minute staff to cover the shift, but they failed. Ingrid could not bear the apologies from staff and managers who she knew were under immense pressure and who were left feeling upset and frustrated by their situation. Ingrid recalled hearing about burnt-out staff, car parking limitations and charges, and a new clean air zone that had added to the costs and burdens of working at the Trust.</p> <p>Ingrid said their story celebrated the generous kindness, commitment and expertise of NHS staff and reflected the immense strain on the system, as this example was one of many that would happen this year. Ingrid</p>	

Minute Ref.	Item	Actions
	<p>believed that putting in additional resources would support the staff who were at risk of moral injury. Ingrid finished her story by noting that her daughter did have the surgery eventually and had recovered well.</p> <p>Sue Balcombe, Non-executive Director thanked Ingrid and noted how remarkable it was for Ingrid to take into consideration the staff, above everything else she had experienced. Sue asked why the team did not know the day before that the after-care would not be available and whether there was anything the Trust could do to change the system. Rachel Hughes explained that the teams had planned to cover 18 beds in intensive care and that all staff that could, had worked that day, as well as calling all specialist agencies. Rachel recalled that at the time, the region was in high escalation and medical emergencies took priority over elective care. Ingrid added how she thought the decision-making being made because of insufficient resources was unfair and added long-term pressures on clinical and administrative staff.</p> <p>The Board talked about how it was prioritising staff wellbeing. Ingrid talked about how the Trust could attract and retain staff by supporting staff with subsidised car parking and clean air zone charges.</p> <p>Eugene Yafele, Chief Executive said he felt and related to the emotions from the story and echoed Ingrid's comments around staff value and wellbeing. Eugene said the Board was actively working on its staff care and wanted to make a difference to staff in providing additional care and support. Eugene was delighted that the surgery went well, which was not the case for all the Trust's families, and this would support the organisation's aim to get that right.</p> <p>Jayne Mee, Chair thanked Ingrid for her courage in sharing her story and hoped Ingrid's daughter continued to be well and was enjoying life following her surgery.</p> <p>Members of the Board received the Patient Story for information.</p>	
04/06/23	Item 4 - Minutes of the Last Meeting	
	<p>The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 18th April 2023.</p> <p>Members of the Board approved the above minutes as a true and accurate record.</p>	
05/06/23	Item 5 - Matters Arising and Action Log	
	<p>Board Members received and reviewed the action log. Updates on completed actions were noted, and others were discussed as follows:</p> <p><u>06/04/23 Trust Secretariat to circulate the National 3 Year Delivery Plan for Maternity and Neonatal Services to Non-Executive Directors.</u></p> <p>The National 3 Year Delivery Plan for Maternity and Neonatal Services had been circulated to Non-Executive Directors.</p> <p>Action Closed</p>	

Minute Ref.	Item	Actions
	<p><u>07/04/23 Chief Operating Officer, Chief Medical Officer, Chief Nurse and Midwife, to present the Quality Objectives to a future Quality and Outcomes Committee.</u></p> <p>Quality Objectives were presented to the Quality and Outcomes Committee in May 2023. Action Closed</p> <p><u>Matters Arising:</u></p> <ul style="list-style-type: none"> • Cleft Service Review: Mandie Townsend, Deputy Medical Director explained that further clarification had been provided to the Board to outline the processes undertaken with the cleft review, starting with the first scoring system set at a local and national level, and how it was mapped to the National Reporting and Learning System (NRLS) after the Care Quality Group. A timeline and the results of the review had been provided for the two groups for completeness and it was noted the outcome plan for the cleft service has not changed because of this. The main purpose of the report was to highlight the differences between the two mechanisms. The Board raised no questions. <p>Members of the Board noted the updates against the action log and the Matters Arising.</p>	
06/06/23	Item 6 - Chief Executive's Report	
	<p>Eugene Yafele, Chief Executive, provided a verbal update on the following key issues:</p> <ul style="list-style-type: none"> • Industrial Action: At the time of the meeting, the hospital was in day two of industrial action for Junior Doctors in training. It was noted that due to good planning, the hospitals were working at safe staffing levels and managing the risks well. The Trust was planning again for a further round of industrial action by Junior Doctor members of the British Medical Association from 14-17 June inclusive, and further industrial action was expected for Consultants. • Nursing and midwifery consultation: An investigation from the Nursing and Midwifery Council (NMC) was announced that was investigating potentially fraudulent activity for certification at a test centre in Ibadan, Nigeria. The Trust had employed 33 Nigerian nurses with two in our pipeline yet only one nurse had been affected which the Trust would support. • Integrated Care System (ICS) Update: A further draft of the ICS strategy had been produced about the care and services for our people. The strategy was with system partners for review and the Trust had taken part in an extraordinary session to provide feedback and would take on actions on behalf of the system. The Divisions had been working on their plans to deliver some of the system plans and good progress was being made. • Health and Safety Executive (HSE) inspection update: HSE inspectors returned to Weston General Hospital to review progress against two improvement notices. The improvement notice relating to how Weston hospital investigates incidents had been closed. The second improvement notice was not signed-off following concern that theatres were not able to demonstrate complete awareness of safety procedures and it was noted that this could be something that was prevalent to the whole estate. 	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • Performance: The Trust continued to incrementally improve, sustaining the zero tolerance for waiting times greater than 104 weeks and making good progress on 78-week wait elimination. • Elective recovery: The Trust received further guidance from NHS England regarding elective care 2023/24 priorities. The publication acknowledged the improvement that had been made at a national level in reducing long Referral To Treatment (RTT) and cancer waiting times over the last year and recognised the challenges in complexity in delivering elective recovery over the year ahead. • National tiering: The National Director of Elective Recovery for NHS England wrote to acknowledge the exceptional progress that had been made in recent months across both elective and cancer waiting times. This led to the review of the Trusts' position in terms of regulatory oversight, and confirmation that the Trust would be de-escalated from the Tiering Programme completely. • 2022/23 Financial Position: The Trust ended the 2022/23 financial year with a £22k net income and expenditure surplus. <p>Arabel Bailey, Associate Non-Executive Director commended the work to tackle Tier 4 agency use, through the introduction of a new “Break Glass” bank rate which clearly had a great impact with approximately half of all Tier 4 agency shifts being removed so far.</p> <p>Jayne Mee, Chair commended the teams on behalf of the Board for the achievement of being removed from the national tiering programme which she commented was fantastic. Jayne noted that the Trust had been asked to share learning with other Trusts.</p> <p>Bernard Galton, Non-Executive Director noted the fantastic achievement in reaching a £22k net income and expenditure surplus for 2022/23.</p> <p>Members of the Board received the Chief Executive’s report for information.</p>	
07/06/23	Item 7 - UHBW Strategic Priorities – 2023/24 delivery plan	
	<p>Paula Clarke, Executive Managing Director, Weston General Hospital presented the UHBW Strategic Priorities for 2023/24 to the Board and highlighted the following:</p> <ul style="list-style-type: none"> • The Trust’s strategic priorities for 2023/24 were devised to focus on the areas where it believes it can make the greatest improvement and “turn the dial” on achieving the Trust’s True North strategic goals. These priorities were developed through the Trust’s new Patient First approach which was about putting the patient at the heart of everything the Trust does by doing less, therefore doing well. • To reach this position a rigorous data gathering exercise was carried out to ensure the actions were evidence-based and addressed the core contributors to improvement. The data would continue to be refined and used more effectively to identify the key objectives to drive improvement and transformation, creating a golden thread from strategic ambitions to what the Trust’s people focus on. 	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • Engagement with Divisions was critical in delivering the plan, with a process for collectively agreeing where each Division can make the greatest impact towards the priorities. Progress would then be tracked through Key Performance Indicators and monthly divisional strategy deployment reviews with Executives. • Delivery of the 2023/24 strategic priorities assurance would be provided to the Board primarily via the Board Committees meetings. <p>Jayne Mee commented that the Board had received an update earlier that day where members fully supported Patient First and the governance behind it. Jayne noted that it may take some time for the organisation to shift to the new way of working but was looking forward to seeing the results.</p> <p>Roy Shubhabrata, Non-Executive Director, asked what support was available for Divisions to deliver their plans. Paula Clarke said corporate support was fully available and the data would be able to identify those teams were doing well and equally those where more support was required. The shift to a coaching approach was part of the Patient First for leaders training.</p> <p>Arabel Bailey, Associate Non-Executive Director welcomed the fact that all the meeting papers for this meeting were effectively aligned to the strategic priorities of Patient First.</p> <p>The Board approved the strategic priorities for 2023/24 and supported the proposal for a new quarterly report to be brought to future meetings to monitor progress. Jayne Mee thanked the teams for their work on the new framework.</p> <p>Members of the Board approved the UHBW Strategic Priorities for 2023/24.</p>	
08/06/23	Item 8 - Board Assurance Framework: Strategic Risk Register	
	<p>Eric Sanders, Director of Corporate Governance, presented the Strategic Risk Register to the Board which set out the latest position against the strategic risks for the organisation and how the risks were being mitigated. Eric noted that the risk registers would be developed to align to the new strategic priorities for the organisation.</p> <p>In response to a query from Neil Darvill, Joint Chief Digital Information Officer, Eric confirmed there was an entry relating to cyber security on the risk register, but that it had not to date been escalated to the level of a corporate or strategic risk. Eric said that he would work with Neil to ensure the entry was reviewed to ensure it was accurate and achievable.</p> <p>With the Patient Story in mind, Jayne Mee noted that one of the top three risks related to the Trust's workforce and wellbeing, and assured the Board that this was a priority for the organisation. Jane Norman, Non-Executive Director, queried whether the moral injury of the workforce had been captured within the risk registers and it was agreed that this should be checked.</p> <p>Action: Eric Sanders to confirm whether the moral injury of the workforce has been captured within the risk registers.</p>	<p>Director of Corporate Governance</p>

Minute Ref.	Item	Actions
	Members of the Board approved the Strategic Risk Register position.	
09/06/23	Item 9 - Review of PHSO Complaints	
	<p>Deirdre Fowler, Chief Nurse and Midwife, presented the Review of Parliamentary and Health Service Ombudsman (PHSO) complaints report to the Board. Since April 2020, the PHSO had carried out either preliminary or detailed investigations of 26 complaints within the Trust, of which:</p> <ul style="list-style-type: none"> • None had been fully upheld; • Four had been partly upheld; • 21 had been recorded as not upheld or 'no further action'. <p>Deirdre explained that the report covered the four complaints that had been partly upheld, with the issues highlighted relating to communications, which aligned to a new breakthrough objective of Patient First. Deirdre highlighted how the data reflected the robustness of the complaints processes, policies and standard operating procedures in place at the Trust, and noted the percentage of cases upheld was lower for the Trust than for comparable acute trusts nationally.</p> <p>In response to a query from Sue Balcombe, Non-Executive Director, Deirdre said there was still work to be done in respect of learning and culture which the Board could support. Deirdre added that initiatives to improve learning would be reported to the Quality and Outcomes Committee for Board oversight.</p> <p>Bernard Galton, Non-Executive Director, asked whether the Integrated Care System had requested oversight of complaints across the partners within the region. Deirdre said there were assurance groups within the system, but agreed that this was a good point and she would raise this at a future system learning group.</p> <p>Martin Sykes, Non-Executive Director, asked whether the complaints team routinely offered face to face meetings with patients and families. Deirdre said that over the last year there was more of a personalised approach being used, which would form part of the learning and culture that was so important.</p> <p>Members of the Board received the Review of PHSO Complaints for assurance.</p>	
10/06/23	Item 10 - Quality and Outcomes Chair's Report	
	<p>Marc Griffiths, Non-Executive Director, who had chaired May's meeting, presented the meeting highlights to the Board. The following items were highlighted:</p> <ul style="list-style-type: none"> • The Committee had received the Quarterly Infection Control Report which focused on theatres, and a recent Care Quality Commission (CQC) monitoring visit. • The strategic emerging risks and issues discussed at the meeting included an update on industrial action from Junior Doctors and how the risks arising from this would be mitigated. 	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • The Committee noted that the Trust declared compliance with the standards for Clinical Negligence Scheme for Trusts (CNST) and Saving Babies Lives audits. • The potential for an upcoming CQC inspection of maternity services was also discussed and it was confirmed that work was already underway in respect of this. <p>Jayne Mee, Chair, assured the Board that there would be an estates discussion in private around theatres in July.</p> <p>Members of the Board received the Quality and Outcomes Chair's Report for assurance.</p>	
11/06/23	Item 11 – Performance Report	
	<p>Philip Kiely, Deputy Chief Operating Officer, introduced the Performance Report to provide an update on the key performance metrics for 2022/23 and the Trust's 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.</p> <p>Philip highlighted the following timely care key performance points:</p> <ul style="list-style-type: none"> • To build on the picture created earlier in the meeting by the Chief Executive, there had been improvement in waiting times in the Emergency Department and compared to last year, the department was operating at a 10% improvement this year. It was noted that the "Every Minute Matters" campaign had supported this improvement, along with the efforts made to reduce the patients that had No Criteria to Reside (NC2R), which was 130 patients at the time of the meeting. • There had been a month-to-month improvement in ambulance handovers and an operations hub for clinical oversight and operational flow assessment would be opened in Bristol for senior decision makers to focus on rapid decisions and the streaming of patients. If this was a success, the initiative would be rolled out to services at Weston General Hospital. Another initiative was the "Perfect Week" which would aim to observe ambulance handovers to seek improvements in Bristol, Weston and North Bristol. • Progress had been made in elective care backlogs, however the industrial action had raised the level of challenge on addressing longer waiting patients on Referral to Treatment (RTT) and cancer pathways. The teams were mitigating the impact by pausing booking of lists that were at a higher likelihood of being cancelled to avoid the distress for patients, families and administrative staff. This had in turn impacted on the reported level of cancellations. • There had been a deterioration in diagnostics performance during April relating to workforce matters, however it recovered in May. • The mobile scanning capacity had started earlier in the week at Weston General Hospital. • Endoscopy adult services had vastly improved since March against the performance standard to investigate patients within 6 weeks. <p>In response to a query from Jane Norman, Non-Executive Director, Philip Kiely said the diagnostic capacity was currently being upheld with collaborative working taking place across the organisation.</p>	

Minute Ref.	Item	Actions
	<p>Roy Shubhabrata, Non-Executive Director, asked about the variation in data for specialties. Deirdre Fowler, Chief Nurse and Midwife said there was variety and the Trust was actively working with specialities to improve the discharge process. Deirdre noted there were some areas where the discharge processes were efficient and patients were being transferred on the day, but that there was further work to do in other parts of the Trust.</p> <p>Arabel Bailey, Associate Non-Executive Director, queried the data for fractured neck of femur in December 2022. Philip explained that this had related to resource at Weston General Hospital and a new consultant in geriatrics was being recruited.</p> <p>Deirdre Fowler, Chief Nurse and Midwife highlighted the following quality and safety points:</p> <ul style="list-style-type: none"> • There had been further regional and national challenges relating to C.difficile and Methicillin-resistant Staphylococcus aureus (MRSA) infections. It was anticipated that improvements to this performance was on the horizon. • In April there had been twelve hospital attributable C.difficile cases against a target of no more than seven per month. In-depth investigations had been carried out for each case and contributory factors toward C.difficile cases included poor prescribing practice of antibiotics, and compromised cleaning standards which needed targeting in educational training. For MRSA, contributory factors included vascular access. A detailed plan for the recommendations on what the Trust needed to do was included with the main report. <p>Jayne Mee, Chair, summarised that education and training needed to be the main focus to improve the picture and noted that performance would continue to be monitored by the Quality and Outcomes Committee. Deirdre Fowler agreed that education and training was a focus, but added there were changes to the infrastructure and digital solutions that would help with this improvement, such as electronic prescribing for antibiotic stewardship.</p> <p>Martin Sykes, Non-Executive Director, asked who was accountable for the prescribing process and noted there was a failure somewhere in the system. Deirdre Fowler said everyone had a responsibility to identify poor practice by utilising the checkpoints and reviews within the process. The Board noted how beneficial electronic prescribing was in supporting good practice.</p> <p>In response to a query from Jane Norman, Deirdre Fowler confirmed that electronic prescribing fell within the training for Junior Doctors at induction stage. Jayne Mee noted this would be a good opportunity to review the training clinical staff received at induction around antibiotic and electronic prescribing and Marc Griffiths, Non-Executive Director, confirmed that it was included in the education for independent prescribers.</p> <p>Mandie Townsend, Deputy Medical Director noted the following updates:</p>	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • The Summary Hospital Mortality Indicator was in a similar position and the teams were identifying themes on review. • Teams were still working hard to improve venous thromboembolism (VTE) compliance and it was noted that electronic prescribing would boost this performance. A job advert for a VTE Lead was going live this week to support the education of staff. <p>Alex Nestor, Deputy Chief People Officer, noted the following People key points:</p> <ul style="list-style-type: none"> • Overall, the year-end position was positive. • The vacancy turnover rate was positive and had reduced. • Turnover and the recruitment retention strategy remained a key focus for the team. • An update on Health and Wellbeing was provided to the People Committee which noted the investment by the Board of voluntary services and how it had positively impacted on this service. <p>In response to a query from Arabel Bailey, Associate Non-Executive Director, Alex said the exit process had been utilised well with key themes for leavers of the Trust including career development and flexible working. Alex noted how important conversations would be to support staff wanting to move across the organisation.</p> <p>Marc Griffiths, Non-Executive Director noted the reduction in agency usage of 31.2 full time equivalents to 1.7% which he said was a phenomenal position and a testament to the hard work being done across the Trust. Marc went on to positively note the Allied Health Professionals (AHP) leavers rate had reduced and Alex confirmed that the retention group had been looking to see how they could support AHPs.</p> <p>Roy Shubhabrata, Non-Executive Director, queried the poor performance for appraisal compliance. Alex said this remained a key focus and noted how the target was ambitious.</p> <p>Members of the Board received the Performance Report for assurance.</p>	
12/06/23	Item 12 - UHBW Annual Quality Account	
	<p>Deirdre Fowler, Chief Nurse and Midwife presented the final UHBW Annual Quality Account for 2022/23 to the Board for approval before formally proof-read by the Trust's Communication Team ahead of publication. Key points to highlight included:</p> <ul style="list-style-type: none"> • The Quality and Outcomes Committee and the Bristol Health Scrutiny Committee had reviewed the Quality Account. • Five corporate quality objectives had been selected for 2022/23 and existing objectives relating to delivering the NHS Patient Safety Strategy, Discharge and Waiting Well would be carried forward. • Two of the Trust's quality objectives for 2023/24 related directly to Patient First strategic priorities. 	

Minute Ref.	Item	Actions
	<p>Arabel Bailey, Associate Non-Executive Director noted a detailed comment in the report from the Bristol Health Scrutiny Committee relating to the Trust looking to develop its liaison with schools in terms of work experience opportunities for young people, and was keen to understand whether this pipeline would continue. Alex Nestor, Deputy Chief People Officer explained that work experience had only recently stepped up again since the pandemic and a large cohort had just been at the Trust and across the system. Deirdre added that the new Volunteer Strategy for the Trust had reduced the age limit for becoming a volunteer to 16.</p> <p>Sue Balcombe, Non-Executive Director said the document was well formatted, making it straightforward to find the quality objectives, and passed on her thanks to the team involved for putting it together.</p> <p>Members of the Board received the UHBW Annual Quality Account for approval.</p>	
13/06/23	Item 13 – Maternity Survey Results	
	<p>The Board receive the Maternity Survey Results for information.</p> <p>In response to a query from Arabel Bailey, Associate Non-Executive Director, Deirdre Fowler, Chief Nurse and Midwife, said the action plan had not been included in the Board papers. Deirdre assured the Board the survey had been to the Quality and Outcomes Committee where it had been noted that the maternity unit was improving from looking at scores from the Friends and Family Test.</p> <p>Members of the Board received the Maternity Survey Results for information.</p>	
14/06/23	Item 14 - Six Monthly Safe Staffing Report	
	<p>Deirdre Fowler, Chief Nurse and Midwife presented the Six-Monthly Safe Staffing Report to the Board and highlighted the following items to the Board:</p> <ul style="list-style-type: none"> • The purpose of the paper 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. • The fill rate had been consistently in the mid to high 80's for registered nurses and was starting to return to the pre-covid levels of being above 90%. It was noted that this was really being felt on the wards. • All in-patient area fill rates were based on funded beds and did not take into account escalation areas and boarding beds. • Fragile areas included the Childrens Intensive Care Department (PICU), the children's emergency department, and the theatre workforce. • It had been positive to see the Registered Nurse turnover rate decreasing, which was primarily down to international nursing colleagues. Work was underway to develop the band 3 and 4 workforce to further support this area. • The Trust had now completed 3 cycles of the Safer Nursing Care Tool (SNCT) assessments with increasingly reliable results. Key areas that indicated an uplift of nursing were in the Weston 	

Minute Ref.	Item	Actions
	<p>Emergency Department, Childrens Intensive Care Department and the Childrens Emergency Department and the Board was asked for support to progress the establishment in these areas. Jeremy Spearing, Acting Chief Financial Officer, added that no allowance had been allocated in the plan for this and that resource reallocation needed to be explored initially before a discussion with the Southwest region commissioners.</p> <p>Deirdre said agency staff were being utilised for the Children’s Hospital to mitigate the risk, but noted this did not provide a long-term solution to the risk.</p> <p>The Board discussed the proposal and asked that due diligence be undertaken. It was agreed that an update should be received at the Board in September.</p> <p>Action: due diligence to return to the Board in September to support the proposal from the Safer Nursing Care Tool (SNCT) assessment.</p> <p>Members of the Board received the Six-Monthly Safe Staffing Report for assurance.</p>	<p>Chief Nurse and Midwife / Acting Chief Financial Officer</p>
15/06/23	Item 15 - Research and Innovation Report	
	<p>Mandie Townsend, Deputy Chief Medical Officer, introduced the Research and Innovation Report to the Board on behalf of the Research team, and highlighted the following items:</p> <ul style="list-style-type: none"> • Post pandemic, Research Recovery and Reset remained a high priority. • The department supporting research across the Trust had been renamed as Research and Development rather than Research and Innovation to provide clarity for service users, against the implementation of the Patient First Programme. • The new Commercial Research Manager was working across both UHBW and North Bristol Trust to support commercial contract studies. • Workforce issues were being felt across the research teams. • There had been a successful launch of the new National Institute for Health and Care Research (NIHR) Bristol Biomedical Research Centre <p>Roy Shubhabrata, Non-Executive Director, suggested it would be useful to see where the strategy position would be at the end of 2024.</p> <p>Jayne said this would be helpful to understand what had driven the monthly commercial income figures and whether it related to vaccinations.</p> <p>Action: Mandie Townsend to confirm what had driven the monthly commercial income figures in figure D of the report and whether it related to vaccinations.</p> <p>In response to a query from Marc Griffiths, Non-Executive Director, about the change away from Research and Innovation to Research and Development, Paula Clarke, Executive Managing Director Weston</p>	<p>Deputy Medical Officer</p>

Minute Ref.	Item	Actions
	<p>General Hospital, explained there was a difference around pure research and commercial development and wider engagement with innovation. Paula added one of our strategic priorities agreed earlier today is “innovate and improve” which aims to engage all of our people and avoid the sense that innovative practice is only for those undertaking research. A new clinical lead for improvement has also just been appointed to support this broader focus on Innovation within our strategy.</p> <p>Marc asked how relationships were forming with Bristol Health Partners’ Academic Science Centre and how it was mapping into what Allied Health Professionals did at the Trust. Mandie said she would discuss this in detail with Marc following the meeting.</p> <p>Members of the Board received the Research and Innovation Report for assurance.</p>	
16/06/23	Item 16 - Finance & Digital Committee Chair's Report	
	<p>Martin Sykes, Non-Executive Director introduced the Finance & Digital Committee Chair's Report and highlighted the following items:</p> <ul style="list-style-type: none"> • The Committee reviewed the year-end accounts and the month 1 position. • The Terms of Reference had been reviewed to include it receiving assurance around estates. • Electronic prescribing would be reviewed at future committee meetings. <p>Members of the Board received the Finance & Digital Committee Chair's Report for assurance.</p>	
17/06/23	Item 17 - Trust Finance Report	
	<p>Jeremy Spearing, Acting Chief Financial Officer introduced the Trust Finance Report and highlighted the following items.</p> <ul style="list-style-type: none"> • The report circulated to the Board was for the financial performance in Month 1, April 2023. • The month 1 net income and expenditure position was a net deficit of £3.9m against a planned deficit of £2.3m. This had been driven by higher than planned operating expenditure from additional activity related non pay costs and a shortfall in savings delivery. • Elective activity delivery was ahead of plan in April at 105% of plan for day cases and 104% of planned for inpatients. • The Trust’s cash position increased to £136.5m in April. • The Trust delivered capital investment of £3.2m in April, which was broadly in line with the plan. <p>Bernard Galton, Non-Executive Director, queried how the savings forecast for 2023/24 which was set at the end of the financial year was already at a shortfall position in Month 1. Jeremy explained that services would be supported to identify 75% of their recurrent savings target by the end of June which accounted for a third of the gap. Plans that had been identified accounted for another third, and the last third was based on system transformation savings. Jeremy said it was an early assessment and it would be good to see where the savings were in June as it was expected to improve.</p>	

Minute Ref.	Item	Actions
	<p>In response to a query from Arabel Bailey, Associate Non-Executive Director, Jeremy confirmed that the 105% of the plan related to the plan that was profiled for April and was volume based, whereas the 104% was value based. Jeremy noted that average length of stay had helped the financial position in April.</p> <p>Members of the Board received the Trust Finance Report for assurance.</p>	
18/06/23	Item 18 - Digital Update – verbal update	
	<p>Neil Darvill, Joint Chief Digital Information Officer, thanked the Board for such a warm welcome to his first Trust Board in Public. Neil Darvill explained that he could see some of the digital programmes triangulating well with Patient First. Neil noted that a key priority going forward would be to assess the digital risks to the organisation to ensure risks were appropriately quantified. A longer-term piece of work would see a review against industry standards which would align to North Bristol NHS Trust (NBT) to ensure best practice across the region. An interim digital strategy would be developed to cover the period between now and 2025 to continue the work to deliver key digital programmes, before moving towards a joint digital strategy with NBT.</p> <p>Members of the Board received a Digital update for discussion.</p>	
19/06/23	Item 19 - Freedom to Speak Up Annual Report	
	<p>Eric Sanders, Director of Corporate Governance, introduced the Freedom to Speak Up Annual Report and highlighted the following items:</p> <ul style="list-style-type: none"> • Arabel Bailey would become the Non-Executive Director Champion for Freedom to Speak Up shortly. • Eric thanked Kate Hanlon, Stephanie Stocks and the FTSU Champions for their work to promote Freedom to Speak Up across the organisation. • The Trust had supported 109 cases throughout the last year with the majority receiving a positive outcome. • Concerns around the recruitment process had been tackled and a fall in complaints relating to this had been seen. • The National Guardian Office highlighted during a visit to the Trust that staff weren't always given a voice in organisations which some of the Trust's staff survey data had reflected. This showed there was further work to do to encourage staff voices and raise confidence that the Trust would do something about issues raised. • There was further work required for the way in which managers responded to the individuals who were raising the concerns, and some needed to think differently about dealing with things in the moment and having compassion for staff raising concerns. <p>Deirdre Fowler, Chief Nurse and Midwife agreed that managers could change how they were responding to issues by dealing with concerns in the moment to avoid any element of surprise further down the line.</p> <p>Alex Nestor, Deputy Chief People Officer thanked Kate Hanlon and the team for working so well with HR services. Alex agreed that supporting a culture of change was essential and along with the Respecting Everyone</p>	

Minute Ref.	Item	Actions
	<p>Policy, there would be a toolkit and training available to support managers in reaching this ambition. Alex confirmed that 600 managers had started the new leadership training programme which focused on supporting teams.</p> <p>Marc Griffiths, Non-Executive Director noted how powerful the report was and asked whether the sub-regional network of guardians had met to share best practice across the region. Eric confirmed the network had met and the first piece of work related to agency staff knowing how to access the service. Marc suggested the group could be opened out to education partners within the region.</p> <p>Marc added the importance of getting the culture right and referred to a section within the report where it stated that staff who had raised concerns and had not seen demonstrable action were being labelled as troublemakers or agitators.</p> <p>Paula Clarke, Executive Managing Director Weston General Hospital, noted there were signs of positivity within the report, however said it was challenging reading which highlighted the need for behavioural change, and noted how the Board could support its managers to support their staff. Paula flagged the approach being taken at Weston General Hospital to co-design the cultural change by listening to lived experiences and engaging staff in taking actions, noting this was a journey not a quick fix. Eric added that psychology staff members had talked to the Board about how listening to staff was a vital tool in achieving a new culture.</p> <p>Eugene Yafele, Chief Executive said there was uncomfortable reading within the report and noted the importance of managers being present and accessible for staff. Eugene said leaders needed to change their thinking and a governance process might not support this. Eugene said there was a golden opportunity for the organisation to try something new and push to achieve improvements in this area.</p> <p>Jayne Mee, Chair suggested that the Board included a discussion around culture change at its next Board Development Day. Jayne said she would like all people in the organisation to take self-ownership for solving issues, listening and talking to work challenges through. Jayne noted that the Board needed to support leaders with the right tools to develop the culture and to do things differently.</p> <p>Arabel Bailey, as the Non-Executive Champion for Freedom To Speak Up, said she was excited about the role which was a good opportunity to see things that were discussed by the Board and actioned across the organisation. Arabel was particularly interested in finding out how far removed the Board was from the lived experiences of staff.</p> <p>Members of the Board received the Freedom to Speak Up Annual Report for assurance.</p>	
20/06/23	Item 20- People Committee Chair's Report	
	Bernard Galton, Non-Executive Director, introduced the People Committee Chair's Report and highlighted the following items from its meeting in May 2023:	

Minute Ref.	Item	Actions
	<ul style="list-style-type: none"> • The Committee had received a new risk report covering strategic and workforce corporate risks which it was hoped would address some of the cultural issues that were more challenging to link to a process. • The bi-annual report for wellbeing and Equality Diversity and Inclusion was discussed, with a focus on how the team could interpret meaningful data by listening to staff. The Director of Communications would be joining the next meeting to discuss the best communications mechanisms available for staff to use. • Improvements to the Trust's appraisal compliance was discussed by the Committee. • The Equality Diversity and Inclusion report included broader protected characteristics data which was positive. • A detailed workforce plan would be presented to a future meeting. <p>Members of the Board received the People Committee Chair's Report assurance.</p>	
21/06/23	Item 21 - Audit Committee Chair's Report	
	<p>Jane Norman, Non-Executive Director, introduced the Audit Committee Chair's Report and highlighted the following items from the last meetings that took place in April 2023 and June 2023:</p> <ul style="list-style-type: none"> • April 2023: The Committee reviewed the risk registers and received the internal audit interim reports where a discussion took place on whether more could be done to ensure that high risk and overdue actions were being addressed efficiently. • June 2023: The Committee received the Trust's draft annual accounts and annual report for 2022/23 for review, and had recommended them to the Board for approval. <p>In response to a query from Martin Sykes, Non-Executive Director, Eric Sanders, Director of Corporate Governance, confirmed that a report from the Information Governance Team would be presented to the Finance and Digital Committee to specifically retain oversight on clinical data quality governance systems relating to cyber security.</p> <p>Members of the Board received the Audit Committee Chair's Report for assurance.</p>	
22/06/23	Item 22 - NHS Self-Certification	
	<p>Eric Sanders, Director of Corporate Governance, explained that approval of the self-certifications against the Provider Licence conditions was an annual process. The Board was asked to note that this year the licence had been modified following a statutory consultation to bring it up to date to reflect current statutory and policy requirements, specifically about Trusts communicating their system's strategy to its workforce. The communication plan would be launched once the joint plan had been developed.</p> <p>In response to a query from Annabel Bailey, Associate Non-Executive Director, Eric confirmed that this year there was no expectation to complete the Trusts Working in Systems for digital transformation and expected this to be more detailed next year.</p>	

Minute Ref.	Item	Actions
	Members of the Board approved the Trust's provider licence self-certifications.	
23/06/23	Item 23 - Revised Terms of Reference	
	<p>Eric Sanders, Director of Corporate Governance, advised the Board that following a review of the responsibilities of the Board committees, it had been agreed to move responsibility for estates and facilities from the Audit Committee to the Finance and Digital Committee. This reflected the realignment of Executive Director responsibilities, with estates and facilities now being the responsibility of the Chief Financial Officer. The Finance and Digital Committee would be renamed the Finance, Digital and Estates Committee to reflect this.</p> <p>Members of the Board approved the Revised Terms of References for the Finance, Digital and Estates Committee and the Audit Committee.</p>	
24/06/23	Item 24 - Register of Seals	
	<p>Eric Sanders, Director of Corporate Governance, said there had been seven sealings since the last report, including the purchase of the dental hospital building.</p> <p>Members of the Board received the Register of Seals for information.</p>	
25/06/23	Item 25 - Governors' Log of Communications	
	<p>Eric Sanders, Director of Corporate Governance, said the report had been provided for information and would be discussed in detail at the next Council of Governors meeting at the end of June.</p> <p>Jayne Mee, Chair, noted that questions arising from a recent Non-Executive Directors and Governor engagement session would be added to the governor's log.</p> <p>Members of the Board received the Governors' Log of Communications for information.</p>	
26/06/23	Item 26 - Any Other Urgent Business	
	There were no further items of urgent business to discuss, and the Chair thanked everyone for attending and closed the meeting.	
27/06/23	Item 27 – Date of Next Meeting: Tuesday 12 September 2023	



**Public Trust Board of Directors Meeting on Tuesday, 12 September 2023
Action Log**

Outstanding actions from the meeting held in June 2023					
No.	Minute reference	Detail of action required	Executive Lead	Due Date	Action Update
1.	08/06/23	Eric Sanders to confirm whether the moral injury of the workforce has been captured within the risk registers.	Director of Corporate Governance	September 2023	<u>September Update:</u> The risk registers have been reviewed and although there is a corporate risk related to workplace stress (ID: 793), there is no specific mention of a risk of moral injury in any risk. The risk team will follow this up with HR and frontline teams to ensure that this risk is assessed.
2.	14/06/23	Due diligence to return to the Board in September to support the proposal from the Safer Nursing Care Tool (SNCT) assessment.	Chief Nurse and Midwife / Chief Financial Officer	September 2023	<u>September Update:</u> A solution has been achieved for CED winter 2023 and conversations are ongoing regarding the recurrent solution for PICU.
3.	15/06/23	Mandie Townsend to confirm what had driven the monthly commercial income figures in figure D of the report and whether it related to vaccinations.	Deputy Medical Officer	September 2023	<u>September Update:</u> There was a surge of commercial trials income in 21/22 due to the COVID vaccine trials. These were the first few commercial covid vaccine trials available and we were recruiting high numbers of participants. The drop off in 22/23 reflects those studies closing and new vaccine trials having smaller target numbers for recruitment. Our 22/23 income is still higher than in pre-COVID times as we have continued to deliver vaccine trials in adults, which we weren't routinely doing previously.
Closed actions from the meeting held in June 2023					

No. Public Board	Minute reference	Detail of action required	Action for	Due Date	Action Update 5. Matters Arising and Action Log
1.	06/04/23	Trust Secretariat to circulate the National 3 Year Delivery Plan for Maternity and Neonatal Services to Non-Executive Directors.	Trust Secretariat	June 2023	Action Closed <u>June Update:</u> The National 3 Year Delivery Plan for Maternity and Neonatal Services to Non-Executive Directors was circulated.
2.	07/04/23	Chief Operating Officer, Chief Medical Officer, Chief Nurse and Midwife, to present the Quality Objectives to a future Quality and Outcomes Committee.	Chief Operating Officer, Chief Medical Officer, Chief Nurse and Midwife,	June 2023	Action Closed <u>June Update:</u> Quality Objectives were presented to the Quality and Outcomes Committee in May 2023.

Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Report Title	Chief Executive Report
Report Author	Executive Directors
Executive Lead	Eugene Yafele, Chief Executive

1. Purpose
To provide an update on key strategic and operational issues affecting the Trust, system and the wider NHS.
2. Key points to note <i>(Including any previous decisions taken)</i>
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: <ul style="list-style-type: none"> • National Topics of Interest • Integrated Care System Update • Strategy • Operational Delivery
3. Strategic Alignment
This report highlights work that aligns with the Trust's strategic priorities.
4. Risks and Opportunities
The risks associated with this report include: <ul style="list-style-type: none"> • The potential impact of strikes on the availability of services and quality of care delivery.
5. Recommendation
This report is for Information
The Board is asked to note the report.
6. History of the paper
Please include details of where paper has <u>previously</u> been received.
N/A

Chief Executive's Report

Background

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

National Topics of Interest

Industrial Action

Since the last written report of 15 June 2023, the Trust has overseen the following Industrial Action:

- Junior Drs: 13–18 July and 11 - 15 August
- Radiographers: 25 – 27 July
- Consultants: 24 - 25 August

The British Medical Association (BMA) have further announced that Consultants will go on strike on 19 and 20 September, and 2-4 October. Junior Doctors will strike on 20-22 September, and 2-4 October.

The BMA have successfully re-balloted Junior Doctors for further strike action and now have a mandate to continue through February 2024. However, the RCN failed to meet the thresholds for continued industrial action and have announced that they will not re-ballot again in relation to the 2023/24 pay award.

The impact on our patients, and delays in their treatment, remain a concern but we are assured that we have provided safe care for our In-Patients during periods of action. There are delays in Out-Patient appointments and elective operations as a consequence of the strikes, but the Operational teams continue to programme our recovery agenda. We recognise that this adds stress to our patients and their families. Equally our staff are feeling increasingly tired covering gaps and catching up with cancelled services. We continue to work with NHSE, NHS Providers and NHS Employers to encourage a national solution to the remaining disputes.

The legislative framework guiding Industrial Action has changed over the summer and we continue to adapt our planning to ensure we are compliant. Following a judicial review into the removal of the provision that prevented employers from using agency staff to cover strikes the Trade Unions were successful in their claim. The quashing order which rewrites the Regulations came into effect on the 10 August 2023 and the Trust ensured that no agents were employed to cover gaps created by action taken by BMA members in August. The use of agency staff in these circumstances is now an offence and a criminal one, with accountability resting on individual Directors.

And finally, a new law passed on 20 July 2023 relating to minimum service levels during strike action. The Strikes (Minimum Service Level) Act 2023 has received Royal Assent and came into force on the day it was passed, but will have no immediate impact on strike action as the Act itself does not set minimum service levels. Instead, it gives the Secretary of State the power to make regulations that set MSLs in respect of services that fall within health, education, fire and rescue, transport, border security and nuclear decommissioning.

Long Term Workforce Plan (LTWP)

The LTWP has been published and provides a commitment to grow our NHS workforce.

The plan is divided into sections entitled 'train,' 'retain' and 'reform'. Many of the ambitions and programmes in the plan are familiar to the Trust and form part of the People Strategy and Patient First ambitions and projects, but the plan to diversify training placements, grow trainees and reform how education is delivered is welcomed.

It is anticipated that in the first year much of the plan will be delivered and negotiated by NHSE with Higher Education Institutes and bodies such as the Nursing Midwifery Council and Deanery. As details regarding implementation become known the People Committee will be appraised.

It is not expected that the LTWP will result in any funding for this financial year, but we continue to attend briefings to understand if funding might be available for year 2 of our 5 year nurse supply and 'grow our own' plan.

A review of the LTWP and the role of the ICS is being considered at a workshop later this month as it is clear that commissioning and funding of programmes will be overseen by ICS's in future years. Fortunately, we already coordinate placements, apprenticeships and some training programmes collaboratively but the role of the Learning and Leadership Academy will be key to delivery.

HSE inspection update

The HSE inspector returned to Weston in July to review progress against the remaining improvement notices relating to the use of Sharps in Theatres. The Inspector was pleased with progress and closed the notice. No further action will be taken and the improvements made in Weston will now be embedded across all UHBW sites.

Integrated Care System (ICS) Update

Community Diagnostic Centre in Weston

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) has worked with local partners to increase capacity for diagnostic tests available for patients in Bristol, North Somerset and South Gloucester.

Weston-Super-Mare has been chosen as a location for one of the new state-of-the-art community diagnostic centres (CDC) opening in 2024. The CDC at Weston will provide MRI and CT scans, ultrasounds, blood and lung tests. Endoscopy will be provided by our colleagues at North Bristol Trust at another CDC site at Cribbs Causeway.

InHealth has been chosen by NHS England as the preferred bidder for the project and will be responsible for staffing and ownership of the building. Plans include working collaboratively across NHS and InHealth professionals, both on and off site. The array of scans and tests at the CDCs will help with the diagnosis and treatment of people with a range of conditions, from cancer to joint problems, increasing the number of local and accessible diagnostic tests for patients in Weston and North Somerset and helping reduce waiting times.

Mobile diagnostic units are currently running at Weston-Super-Mare's Locality Health Centre (UHBW) and at Southmead and Cossham North Bristol Trust (NBT) hospitals to

provide additional endoscopy and imaging capacity for patients until the fixed centres open.

ICB system update – corporate services

Work progresses to consider how best to create a single shared service centre for recruitment, international recruitment and the bank. North London Partners will be assisting the working groups to share their expertise and digital automation having collaborated with 11 Trusts to create a single recruitment function. The recruitment teams have mapped current and future state Agenda for Change recruitment, have a developed joint vision and are standardising processes and data dashboards.

The collaborative work underway to establish a more integrated Learning and Leadership Academy (LLA) continues and it is expected a business case outlining models for collaboration and joint delivery across all areas of education will be written by February 2024. The base line data exploring what each provider is delivering with what staff and at what cost has been provided for analysis. Reviewing this in the context of the LTWP and the requirement for ICS oversight of training programmes and funding will be important in designing a future proofed LLA.

ICS Strategy

The ICS Strategy has now been published and can be accessed on the Healthier Together Website. It focuses on five opportunities over the coming years to help us realise the better health and wellbeing and improved services our local population deserve. The five opportunities are: Tackling inequalities; Strengthening building blocks; Prevention and early intervention; Healthy behaviours; Strategic prioritisation of key conditions. Commitments made by the ICS via the strategy include: investing in the first 1001 days of life, early identification and support for people experiencing anxiety and depression, supporting people to be a healthy weight, reducing harm from tobacco, reducing harm from drugs and alcohol, improving presentation, detection and treatment of cancer, tackling cardiovascular disease, better supporting people with painful conditions and supporting older people towards the end of life.

To support delivery the ICS Strategy, four health and care improvement groups have been established with representation from across the system. UHBW is a key member of these cross-system groups who will work together to agree and deliver the ICS Strategic Objectives and Joint Forward Plan, instruct and oversee transformational and continuous improvement activity and provide ICS Oversight, ensuring that ICS partners are working together effectively, collaboratively and symbiotically, are enabling resource co-ordination and management and managing risk.

Strategy and Culture

UHBW Clinical Strategy

UHBW has commenced the development of new clinical strategy for our organisation. This will refresh work completed in 2019, which is predominantly contained within the Divisions and within our Trust Strategy “Embracing Change, Proud To Care”. It will build important links with more recent strategies that have been developed across our system,

such as the Healthy Weston Strategic Business Case, within our collaboration with North Bristol Trust, and the new ICS Strategy. The baselining work will be complete in August 2023 and engagement with stakeholders and UHBW's clinical teams will be undertaken through the autumn. The UHBW Clinical Strategy will be complete in Spring 2024.

Operational Delivery

Delivering operational resilience across the NHS this winter

On 27 July 2023, NHS England wrote to ICBs and NHS trusts to set out the national approach to 2023/24 winter planning, and the key steps that must be taken together across all parts of the system to meet the challenges ahead.

The letter referenced the national UEC Recovery Plan, which was published in January 2023 following an incredibly challenging winter. It acknowledged that operational challenges have continued and offered thanks for efforts that have contributed to significant improvements in performance.

This progress and the plan set out for winter preparedness are key steps in achieving two key ambitions for UEC recovery:

- 76% of ED patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

Whilst NHS England acknowledged the progress that has been made, trusts have also been invited to meet two stretch targets this winter and, in doing so, to qualify for part of a new capital allocation for 2024/25:

- Achieving an average of 80% ED 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

Finally, the letter set out four areas of focus for systems to prepare for winter, including:

- Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place.
- Completing operational and surge planning to prepare for different winter scenarios.
- ICBs should ensure effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.
- Supporting our workforce to deliver over winter.

Protecting and expanding elective capacity

On 4 August 2023, NHS England wrote to acute trusts on 4th August, thanking colleagues for the progress that has been made against elective and

cancer recovery and acknowledging the operational challenges faced, including ongoing industrial action.

However, it was acknowledged that the NHS had further work to do around outpatients in supporting elective recovery. In order to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis, acute trusts are asked to undertake three key actions:

- Revisit the plan on outpatient follow-up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for an outpatient appointment after 31 October 2023.
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

As part of the above priorities, NHS England are asking each provider to ensure that this work is discussed and challenged appropriately at Board, undertake a board self-certification process and have it signed off by trust Chairs and Chief Executives by 30 September 2023.

Cancer waiting time standards

Following the clinically-led review of NHS access standards, changes to cancer waiting times standards have been agreed between NHS England and the Department of Health and Social Care. These changes were communicated to Trusts on the 17 August 2023 and will come into effect from Sunday 1 October 2023.

Developed by clinical experts and supported by leading cancer charities, these changes include the removal of the two-week wait standard in favour of a focus on the Faster Diagnosis Standard, and the rationalisation of those standards into three core measures for the NHS:

- The 28-day Faster Diagnosis Standard (75%)
- One headline 62-day referral to treatment standard (85%)
- One headline 31-day decision to treat to treatment standard (96%).

Most of the performance standards are pledges in the handbook to the NHS constitution, which DHSC has confirmed will be updated and published prior to the 1 October implementation date.

The Trust's Board Performance Report will be updated to reflect these changes from 1 October 2023.

Transfer of care hubs

The mobilisation of the Transfer of Care Hubs in BRI and Weston continues to progress well, working as an integrated team with colleagues from the local authorities, Sirona and voluntary sector.

The recruitment process is progressing with most new staff due to have started in post by the end of September.

The leadership teams have started working on some of the transformation opportunities which are afforded by the co-location and onsite presence in the Hubs. This includes redesigning discharge teams to focus in the three key areas of emergency departments and the assessment units, supporting patients with complex discharge planning requirements, and supporting patients with longer lengths of stay.

A pilot will commence on 4 September 2023, testing a new way to put together discharge options for patients using the whole discharge multi-disciplinary team expertise. Initial work indicates that it will be possible to support more people to return home from hospital using this approach.

Sexual Assault Referral Centre (SARC): Development and delivery of a non-recent child sexual abuse (CSA) pathway across Avon & Somerset, Gloucestershire and Wiltshire

UHBW provides a Sexual Assault Referral Centre (SARC) and Sexual Offences Examiner (SOE) regional service. The service, known as The Bridge, offers medical care, emotional and psychological support as well as practical support to adults and children that have been raped or sexually assaulted. The service has recently been awarded additional funding by commissioners to develop a pathway for non-recent cases of child sexual abuse. This will give the service an opportunity to ensure consistency and high quality provision for all children and young people who have experienced sexual abuse at any time in their lives.

Recommendation

The Board is asked to note the report.

Eugine Yafele
Chief Executive



Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Report Title	Response to the Verdict in the trial of Lucy Letby
Report Author	Eric Sanders, Director of Corporate Governance
Executive Lead	Eric Sanders, Director of Corporate Governance

1. Purpose
To present the Trust's response to the letter received from NHS England on 18 August 2023 relating to the verdict in the trial of Lucy Letby and the specified actions contained within.
2. Key points to note <i>(Including any previous decisions taken)</i>
<ul style="list-style-type: none"> • The Trust has a range of mechanisms in place to support staff and patients to have a voice. • There are a range of reports which are regularly presented to the Board and its Committees which share this feedback. It is recommended that the Board seek further assurance as to the impact and embeddedness of the actions agreed following consideration of the feedback. • Further work is required to ensure that all staff understand the different routes to speak up, and to ensure they have confidence that the Trust will listen and act promptly. In addition, continued work is required to understand and address the cultural barriers in existence across the Trust which stop some staff speaking up. • The Trust has a robust approach to ensuring that all Directors are Fit and Proper Persons (FPP) and we comply with the regulations. The new guidance relating to FPP will now be reviewed and our processes updated. All Directors meet the regulatory requirements relating to Fit and Proper Persons.
3. Strategic Alignment
The two key issues within the letter relate to the Trust listening to the views of staff and patients, and the regulatory requirement that Board members are Fit and Proper. These fit with our strategic ambition of being a well-governed Trust.
4. Risks and Opportunities
<p>There is a risk that the Trust does not effectively listen to and hear the voice of staff and/or patients resulting in missed opportunities to improve. Related to this, is a risk that due to the number and variety of routes to speak up, then feedback is not collated, and the complete picture of a service or an individual's performance is not known and acted upon.</p> <p>There is a risk that the Trust appoints and continues to employ individuals who are not Fit and Proper to operate as a Board director.</p>

5. Recommendation
This report is for Assurance The Board is asked to consider and challenge the contents of the report and identify if there are further areas where they would like further assurance.
6. History of the paper Please include details of where paper has <u>previously</u> been received.
N/A

1. Purpose

- 1.1. To present the Trust's response to the letter received from NHS England on 18 August 2023 relating to the verdict in the trial of Lucy Letby and the specified actions contained within.

2. Background

- 2.1. Following the verdict into the trial of Lucy Letby, NHS England wrote to all Trusts setting out their expectations related to supporting staff and patients to speak up and to remind Trusts of the requirements around ensuring Board Directors are Fit and Proper Persons.
- 2.2. The letter from NHS England is attached in Appendix 1.
- 2.3. The Trust has considered the mechanisms for ensuring that staff and patient's voices can be heard, and how this feedback is reported to the Board or, to one of its committees. This forms part of the five-point requirement that has been outlined in the letter. Further details are shared below. Board members will note that the five requirements focus on staff speaking up, but we have taken the opportunity to describe how the Trust captures patient feedback as this is a valuable source of evidence about how services and individual clinicians are operating. We recognise that creating a culture where listening is active and feedback is given, requires consistency of leadership behaviours alongside robust systems and processes. We will continue to embed this expectation in our communications and individual interactions.

3. Response to Speaking Up Requirements

- 3.1. Prior to responding to the five points outlined in the letter, the Board should be aware of the various routes for speaking up and how these are reported to the Board and its committees. The following table summarises the routes and reporting. Some of the reports are formal reports and others are conversations where there are opportunities for discussion and for sharing issues and concerns.

Routes for Speaking Up	Reporting
FTSU (includes whistleblowing) Line managers Unions Wellbeing Advocates FTSU Champions EDI Advocates Staff networks HR processes Direct to the NED/CEO/Exec (or via listening events) Governors Safeguarding team Legal team Patient Safety team Medical Examiner/Coroner Child death reviews Police PSIRF including incident reporting	FTSU annual and quarterly reporting Learning from Deaths quarterly and annual reporting Equality, Diversity and Inclusion reports Meeting with staff network chairs Governor meetings Safeguarding annual report Inquest and claims group reports Quarterly patient experience and complaints reports Meetings with CQC Staff surveys – annual and pulse surveys Staff and patient stories to Board Employee Relations case reporting (under banner of Just and Learning Culture) Essential training (including LMC) compliance Patient Safety Incident Investigation reports to QOC QOC Quarterly legal reports to QOC

Routes for Speaking Up	Reporting
Patient feedback – complaints, PALS, surveys Via colleges/professional bodies Regulators including to CQC and NHSE Ward accreditation and clinical visits Counter Fraud HR Services Trust Chaplains Doctors wellbeing support Employee Assistance Programme Educators e.g. Practice Education Facilitators and supervisors Violence Reduction Officers	

3.2. The recruitment process for staff also includes robust checks to ensure staff meet the required qualifications, experience, and values of the Trust. Where there is a requirement to have a professional registration, this is also checked at appointment.

3.3. Below is a short summary of how the Trust meets the five requirements as outlined in the letter in Appendix 1:

1. All staff have easy access to information on how to speak up

There are posters, cards and leaflets on display and distributed around the Trust which describe what speaking up is and how to contact the FTSU Guardians or champions. The same information is also visible on the landing page of the intranet. Regular communications about speaking up are included in the all-staff newsletter or shared with the 80-strong FTSU staff champion network.

The FTSU Guardians are present at corporate induction and meet different teams and departments on an ad hoc basis and conduct regular walkrounds. Mandatory essential speak up training for all staff, which highlights the role of the FTSU Guardian and prompts staff to seek out the local policy and Guardian, was introduced in February 2021 and compliance in June 2023 was 81% across the Trust.

The Trust's Leadership and Management training encourages a culture where staff can speak up and Listening Up training provides advice and guidance on how to create the right environment where staff can come forward with issues.

2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme

Details of the national Speaking Up Support Scheme were shared by the Speaking Up support scheme team with the FTSU Guardian on 22 May and publicised by the National Guardian's Office. The FTSU Guardian shared the details with three individuals who fit the eligibility criteria, all of whom have been through a speak up process which remains unresolved after several years. Details of the scheme are included in the Trust's FTSU policy.

3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up

Alongside contact from the FTSU Guardian with teams/services where members of staff do not have regular online access to speak up information, work unsociable hours or may have cultural barriers (e.g. face to face meetings with the portering teams, sterile services, newly recruited international nurses), the 80 staff speaking up champions located across all hospital sites, support the FTSU Guardian and encourage staff to raise concerns at the earliest reasonable opportunity. The network is diverse in terms of age, gender, ethnicity, seniority, and location of champion. Most champions have now completed the NGO champion training programme, which is delivered in house on a regular basis.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

FTSU reports go to Board/People Committee on a quarterly basis. The outcome of an internal audit of the process for raising a concern via the Freedom to Speak Up route, published in October 2022, was satisfactory. Recommendations around tackling barriers to speaking up and sharing learning will be taken into the refresh of the FTSU strategy planned to be completed by March 2024.

5. Boards are regularly reporting, reviewing and acting upon available data

As outlined above there are a range of reports that are presented to the Board or Committees which contain feedback from staff and patients, and wider information about the quality of services. These reports are reviewed on a regular basis and where required recommendations and actions are identified.

3.4 In considering the above, the Board should note that more work is required to ensure that all staff understand the different routes to speak up, and to address the cultural barriers that are in place across the Trust. Further work is also required to ensure that when staff speak up, that managers listen and either act or explain why not. Where action is required, the timeliness of investigation/response needs to be improved in some cases, as this directly impacts on the confidence of staff to speak up.

3.5 Finally, it is recommended that the Board should continually review the impact and embeddedness of actions agreed having considered the feedback received.

4 Assurance relating to Fit and Proper Person Compliance

4.1 The Trust has a Fit and Proper Persons (Directors) Policy in place, which was last reviewed in Autumn of 2022. Directors must satisfy all the requirements set out in the CQC's Regulation 5(3) and be declared fit and proper persons.

Individuals must be:

- Of good character.

- Have the necessary qualifications, competence, skills and experience for the relevant office or position/work for which they are employed.
- Have the appropriate level of physical and mental fitness.
- Have not been responsible for or privy to any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity.
- Not be deemed unfit under the Regulation provisions.

4.2 The following fit and proper person checks are undertaken when directors are appointed:

- A search to check if any provider for whom the individual has worked has had Registration suspended/cancelled due to failings in care in the last 5 years (or longer if available).
- The involvement of the individual or any providers in previous CQC inspections and investigate further if inspection rating is 'requires improvement', or 'inadequate'.
- Homicide investigations for mental health trusts (if employed previously by mental health trust).
- Review of Parliamentary and Health Service Ombudsman reports relating to providers to identify whether these give rise to further lines of enquiry regarding the individual.
- Financial checks (including CCJs, register of insolvent companies, disqualified directors register, individual insolvency register and bankruptcy register) carried out by Experian.
- DBS checks in line with NHS Employment Check Standards.
- Registered Professional Checks.
- Proof of identity (including recent photograph) and proof of address.
- Confirmation of right to work in the UK in line with NHS Employment Check Standards.
- A full employment history, together with a satisfactory written explanation of any gaps in employment in line with NHS Employment Check Standards.
- At least two references - one of which must be most recent employer, in line with NHS Employment Check Standards.
- Academic and professional qualifications check in line with NHS Employment Check Standards.

4.3 The DBS and Experian financial checks are currently refreshed every three years after appointment. A new Fit and Proper Person Test ("FPPT") Framework has this month been published by NHSE which will require Trusts to undertake more comprehensive reviews on an annual basis with Chair sign off and capture the FPPT data on ESR so that this can follow a director should they move to a different Trust. A new template for references will also be issued in due course.

4.4 Where concerns are raised about a director, then the approach as defined by the CQC is implemented to investigate and consider if there is any change to where a director meets the requirements. A decision is taken, based on the concern(s) raised, whether an independent person/organisation, is required to comprehensively investigate concerns. The decision on how to proceed rests with the Chair.

4.5 All Directors are currently considered to be Fit and Proper Persons.

5 Summary

5.1 The Trust has a range of mechanisms that allow for the voice of staff and patients to be heard. These mechanisms recognise that a single approach does not necessarily work for all groups of staff and that a diversity of approaches may illicit greater engagement.

5.2 There is a risk that having such a variety of approaches means that triangulation of feedback is more challenging and that a truly holistic view of a service, or an individual's performance can be hard to capture. Additionally, it relies on our leaders and managers to be open to receiving and acting on feedback they receive. This forms part of the leadership and management training that is now mandatory.

5.3 Finally, the Trust has robust mechanism for checking that Board members are Fit and Proper Persons on appointment, and there are mechanisms to review compliance annually, with a more in-depth review every three years. Where concerns about a director are raised, then the Trust follows the process as described by the CQC to investigate and respond to concerns. The Trust will now consider how best to implement the new requirements around ensuring compliance with the Fit and Proper Persons requirements and a further update will be provided in due course.

6 Recommendations

6.1 The Board is asked to consider and challenge the contents of the report and identify if there are further areas where they would like further assurance.

Meeting of the Trust Board of Directors in Public on Tuesday 12 September 2023

Report Title	Integrated Care System Green Plan 2022-2025
Report Author	Samuel Willitts, Head Of Sustainability for the ICS
Executive Lead	Neil Kemsley, Chief Financial Officer

1. Purpose	
To approve the BNSSG Integrated Care System Green Plan 2022-2025.	
2. Key points to note <i>(Including any previous decisions taken)</i>	
<p>This report satisfies the NHS England guidance for all Trust to have a “Green Plan”. Previously UHBW had the “Sustainable Development Strategy 2020 – 2025”. It is proposed that this is superseded with the attached joint BNSSG ICS Green Plan.</p> <p>The joint ICS Green Plan sets out ambitions for environmental and social sustainability, most notably our plans for net zero greenhouse gas emissions by 2030. These ambitions were previously agreed by the board when the Trust declared a climate emergency in 2018. This new plan expands on previous ambitions to now also covers topics such as air pollution, social value in procurement and biodiversity net gain.</p>	
3. Strategic Alignment	
There is national legislation on greenhouse gas emissions which commits the public sector to achieve net zero by 2050. NHS England has also committed to achieve net zero by 2040. The joint ICS Green Plan covers a broad range of areas but is most associated to the Ture North Strategic Priority of “Making the Most of Our Resources”.	
4. Risks and Opportunities	
There is a risk that if the Trust fails to decarbonise over time, we will be noncompliant to net zero legislation. This carries a reputational risk and a financial risk due to mechanisms for emissions taxation which are already ~£200k annually and are expected to reach £9m a year by the 2030s should we fail to lower our emissions over the next decade.	
5. Recommendation	
This report is for Approval	
Board is asked to approve the ambition, intent, and proposals for delivery of the joint ICS Green Plan.	
6. History of the paper	
Please include details of where paper has <u>previously</u> been received.	
ICS Green Plan Steering Group	February 2023



Healthier Together Integrated Care System

Bristol North, Somerset, and South
Gloucestershire

Green Plan

2022 – 2025

Version 1.2 draft

1.0 Approved by Healthier Together Executive Group DATE



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Foreword

As an Integrated Care System we are committed to meeting the health and care needs of our communities today and into the future. We have a duty to ensure we continue to deliver exceptional health and care in a responsible way that embraces our role as anchor organisations in Bristol, North Somerset, and South Gloucestershire.

We are committed to delivering the ambitious plans set out in this Green Plan, providing high standards of quality health and care whilst addressing the environmental impact this creates. We want to do more than just minimise any negative impact of our activities; this plan shows how, through developing sustainably, we can make a significant positive contribution to the local economy, society and environment.

Climate change has been declared as ‘the greatest threat to global health’ (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. Failure to act quickly will heighten existing national health and care challenges, place further financial strain on the NHS and care sector, and worsen health inequalities within the UK and internationally.

In recognition of the urgency of the threat that climate and ecological breakdown poses to public health, we are setting out extremely ambitious goals. We wish to be leaders in fast tracking plans to achieve carbon neutrality – improving the health of our population in the process. This strategy commits us to a net zero carbon target of 2030, improving air quality and biodiversity, reducing our use of single use plastics, and creating a wider change movement amongst local communities and businesses. These targets are challenging but show our commitment to working with partners to deliver our vision.



Shane Devlin

Chief Executive, Healthier Together Integrated Care System

Executive Summary

Climate change is one of ‘the greatest threats to global health’ (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. As an ICS we have put sustainability at the core of our aims and objectives. This plan sets out the commitments we have made to deliver 3 key outcomes for our population:



Improve the environment: We will improve the overall environmental impact and sustainability of our 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: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030

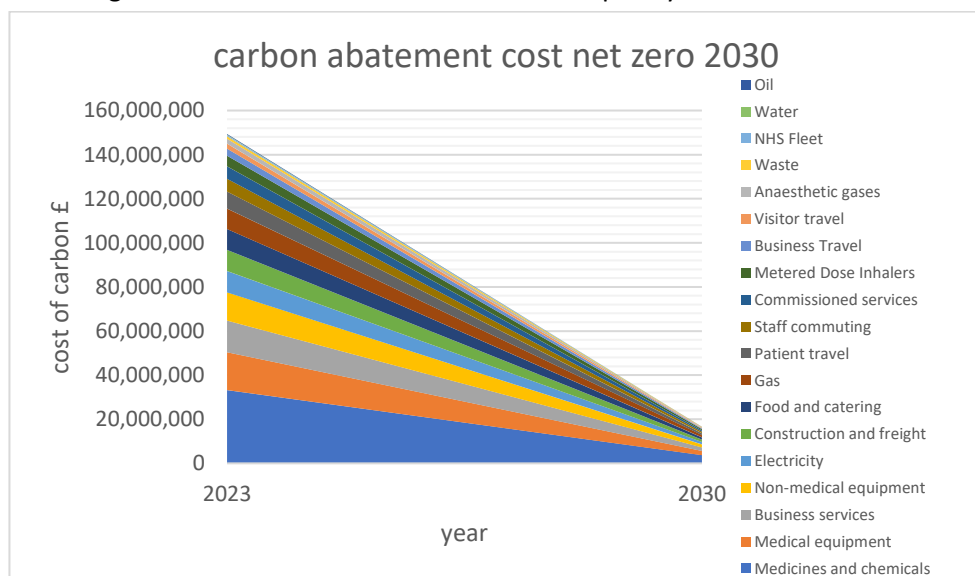


Fig1. Carbon abatement cost for ICS carbon footprint



Generate a BNSSG-wide movement: Our 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 our communities.

We will do this by:

- 1. Holding our shared ambition** - building on the success of our organisational level work, we have set out this clear shared ambition that all partners align to
- 2. Establish the enabling conditions for change** – putting the green agenda at the heart of our ICS – how we business plan, allocate resources, and develop our governance
- 3. Coordinating highest impact projects across partner organisations** – we have set out ambitious pledges, commitments, and deliverables across the highest impact areas
- 4. Creating assurance of delivery of actions** – through the clarity of our ambitions, executive leadership, defined outcomes measures and clear accountability.

We want to ensure that we harness the power of our staff, citizens, community and voluntary organisations and local business networks in the delivery of this plan.

1. Status of this plan

This plan was developed at pace during the Covid-19 pandemic with less organisational and public engagement than we would have liked. Since the initial plan was approved in March 2022 we have engaged widely with stakeholders to develop this revised version.

This ICS plan covers three main areas:

- i. **Our shared ambition:** Our broad ambitions, linked to our ICS Outcomes Framework and the specific needs of our population
- ii. **Our collaborative intent:** Those priorities that will benefit from cross-organisational action. It is likely these will initially be focused on health partners but will be extended to cover the shared benefits of working across health & social care and beyond
- iii. **Assurance and delivery:** A framework for assurance, support and accountability of our organisational plans and specific deliverables against priority required over the next 3-years:
 - a. Initial focus on University Hospitals Bristol & Weston NHS Foundation Trust, North Bristol NHS Trust, Avon & Wiltshire Mental Health Partnership NHS Trust, Sirona Care & Health CIC and Primary Care
 - b. Plans for extending scope and our shared agenda with local authorities and wider partners

Consultation and engagement

Wider engagement and assurance of the actions set out in this plan has been undertaken through 2022. This process has involved system groups representation, wider partners and external review Bristol Advisory Committee on Climate Change. The results of that consultation have been included in this revised version. It is anticipated that a final public version will be approved by the ICS Executive and published in early 2023.

Links to other strategies / core documents

Our ICS Green Plan sets out broad ranging ambitions and actions that will change almost every aspect of how we operate. As such, it is seen as a central pillar of our ICS development, embedded within our core aims and objectives. The implications will crosscut many of our existing and future strategies, including:

- ICS Strategy Framework
- ICS Memorandum of Understanding
- Provider Green Plans (UHBW, NBT, AWP, Sirona)
- ICS Population Health Approaches
- ICS Quality Improvement & Oversight Framework
- ICS Financial Framework
- ICS Performance Management & Improvement Framework
- ICS Communications & Engagement Framework
- Bristol & Weston Purchasing Consortium Procurement Strategy
- Integrating NHS Pharmacy and Medicines Optimisation (IPMO) implementation plan 21-24
- Joint Green Infrastructure Strategy
- WENP Nature and Health Strategy

Note: Some of these documents will be redrafted as the ICS strategy develops

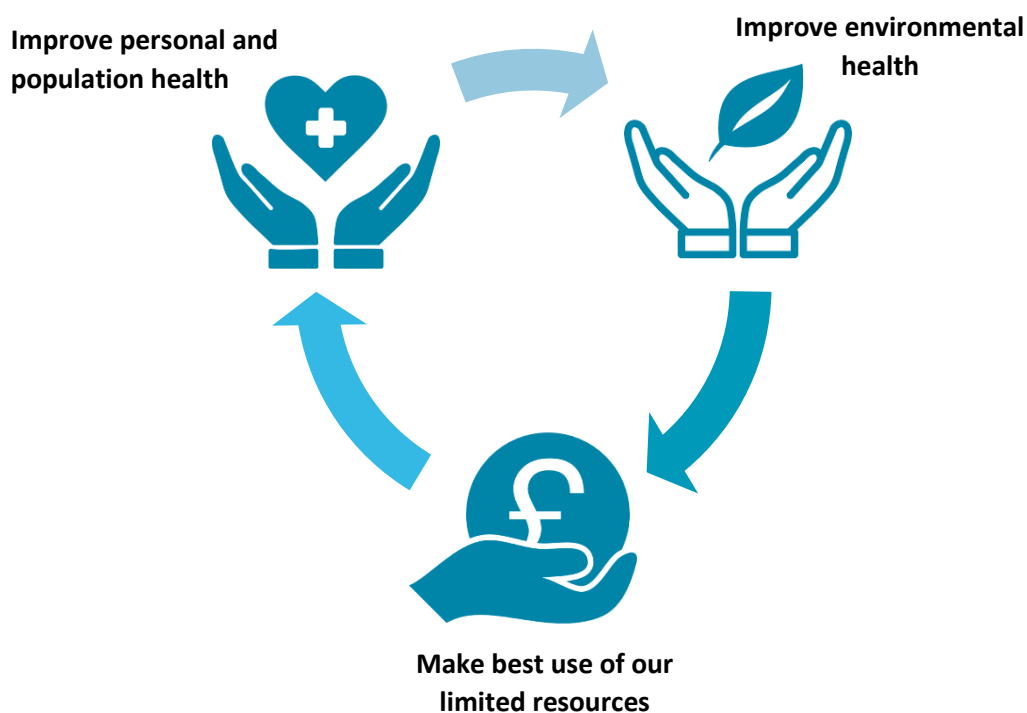
2. About Greener NHS Agenda & Climate Change

Climate change has been declared as ‘the greatest threat to global health’ (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. Failure to act quickly will heighten existing national health challenges, place further financial strain on the NHS, and worsen health inequalities within the UK and internationally.

In delivering services for the public, the NHS and Local Authorities also generate carbon emissions and air pollution that are harmful to health. We have a moral duty to our population to minimise these impacts and to adapt our services to the unavoidable impacts of climate change.

We recognise that meeting our sustainability goals is not something we will focus on once we have met our core aims and objectives; **operating sustainably is at the core of how we will meet our ICS aims and objectives**

In developing our ICS we aim to deliver a truly sustainable health and care system that will bring multiple mutually reinforcing benefits:



- **Improve personal and population health:** improved physical & mental wellbeing of our citizens, more resilient communities, improved health outcomes & reduced demand on our services
- **Improve environmental health:** create a cleaner, safer, more ecologically sound environment locally and globally, including restoring the environment and biodiversity as much as possible
- **Make best use of our limited resources:** use our resources at maximum efficiency by getting it right first time to make our services more cost effective and eliminate waste

Examples of mutual benefits

Access to nature-rich green space: There is a wealth of evidence linking nature-rich green space and engagement with nature with improved health and wellbeing. This includes accelerated patient recovery, improved social cohesion and improved mental health. If every household in England were provided with good access to quality green space, it could save an estimated £2.1 billion in health care costsⁱ. BNSSG is in a strong position to develop this way of working having been awarded one of just seven national test and learn sites for Green Social Prescribing.



Active travel: Across BNSSG, 5% of deaths are attributable to air pollutionⁱⁱ. Green transport options, such as improved bicycle infrastructure and facilities can yield a high benefit-cost ratio in the long term for both health and the environment. For example, in the Netherlands where about 27% of all trips are made by bicycle, cycling prevents about 6,500 deaths each yearⁱⁱⁱ. Increased physical activity will lead to fewer strokes and heart conditions and improved mental health.



Improve our buildings: Between 2013 and 2018, there were an estimated 160,000 excess winter deaths in the UK. Of these, each year around 9,700 people died due to a cold home – the same as the number of people who die from breast or prostate cancer each year. The fact that UK homes are amongst the least energy efficient in Europe suggests that these deaths are preventable. By improving energy efficiency in homes, we can reduce preventable deaths associated with living in a cold home as well as reducing unnecessary fuel consumption^{iv}

Financial efficiency: Sustainable health & care is high-quality, cost-effective care: Procuring for whole life costs; stripping out waste; high-quality services Getting It Right First Time; accounting for whole population benefits of service design, creating a resilient supply chain with security of supply

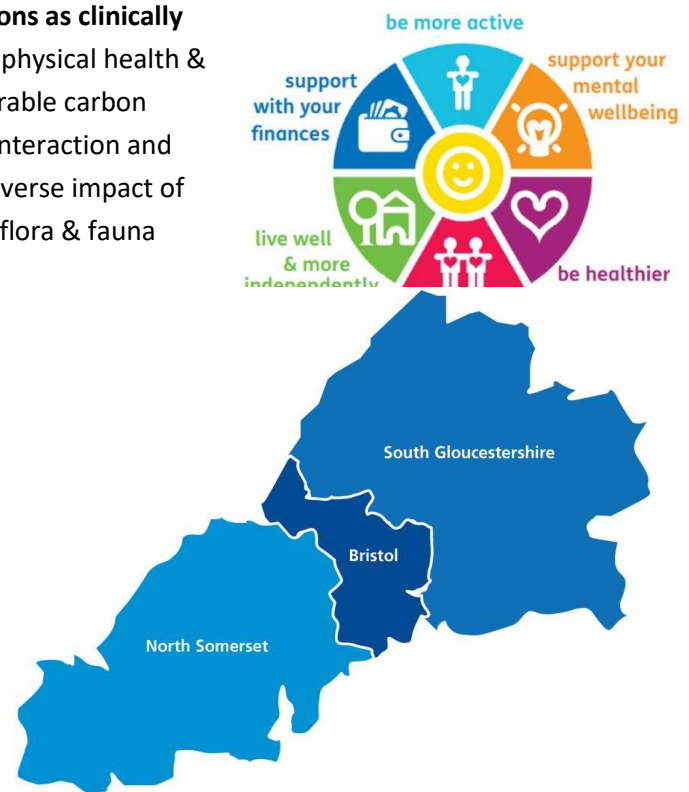
Green procurement: decarbonise supply chain; reduce whole life costs by adopting the principles of a circular economy; address carbon & air pollution impact of transport of goods. Accounting for the value of ecosystem services on air pollution, flooding, heat waves and the health cost savings they provide.

Supporting social value through procurement: Regional collaboration ensuring the collective £1bn purchasing power of local anchor institutions supports social value by creating opportunities for micro, small and medium size businesses, social enterprises and voluntary / community organisations

Social prescribing alternative to certain medications as clinically appropriate: increase physical activity, improving physical health & reducing demand on services; reduce the considerable carbon impact of medicine manufacture; increase social interaction and connection, spreading the benefits; reduce the adverse impact of medicines on the local water supply & associated flora & fauna

3. About our ICS

The Healthier Together Integrated Care System has been established to realise our shared ambitions to improve the health and wellbeing of the people of Bristol, North Somerset, and South Gloucestershire. The Partnership was established in 2016 to work together across the NHS, local government and social care. In 2019 we agreed a five-year plan to deliver significant improvements in the health and wellbeing of our population, to improve the quality of our services and people's experience of care and to make BNSSG the best place to work for our staff.



We were formally designated as an Integrated Care System in December 2020. The Integrated Care Board was established in July 2022. An Integrated Care Strategy is being developed for the population of BNSSG, covering health and social care and addressing the wider determinants of health and wellbeing. This strategy will focus on improving outcomes, reducing inequalities, and addressing the consequences of the pandemic for our local communities. Fundamental to this is our commitment to sustainability.

Healthier Together Integrated Care Partnership (ICP)

Bristol, North Somerset and South Gloucestershire Integrated Care Partnership is a statutory committee of the Integrated Care System. Members:

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)
- 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)

GP Federation:

- One Care (BNSSG) C.I.C. (One Care)

Local Authorities:

- Bristol City Council (BCC)
- North Somerset Council (NSC)
- South Gloucestershire Council (SGC)

Contribution to and commitment to this Green Plan

All Healthier Together Partners have endorsed the vision and aims set out in this plan. However, due to the evolving nature of the ICS the level of engagement in the development of the plan, and the involvement in the delivery of actions varies across partners. This is summarised as follows:

Organisation	Organisational Green Plan (or equivalent) with exec leadership	Commitment to core vision & aims	Involvement in plan development	Delivery
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)	No	Yes	Core	Core delivery of plan
Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)	Yes	Yes	Core	Core delivery of plan
North Bristol NHS Trust (NBT)	Yes	Yes	Core	Core delivery of plan
Sirona care and health (Sirona)	Yes	Yes	Core	Core delivery of plan
University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)	Yes	Yes	Core	Core delivery of plan
Primary Care One Care (BNSSG) C.I.C.	Yes	Yes	Core	Core delivery of plan
Commissioning Support Unit	Yes	Yes	High level engagement	Wider partnering opportunities
Southwestern Ambulance Service NHS Foundation Trust (SWASFT)	Yes	Yes		Wider partnering opportunities
Bristol City Council (BCC)	Yes	Yes	High level engagement	Wider partnering opportunities
North Somerset Council (NSC)	Yes	Yes	High level engagement	Wider partnering opportunities
South Gloucestershire Council (SGC)	Yes	Yes	High level engagement	Wider partnering opportunities

Wider partners

As anchor institutions we recognise our role in leading with our local communities. As such, successfully meeting our sustainability ambitions will require us to work closely with a number of leading local institutions. These include:

- Our landlords & property partners, including NHS Property Services
- Southwest Commissioning Support Unit
- West of England Combined Authority
- Academic partners including the West AHSN, Bristol Health Partners, University of Bristol and University of the West of England
- Bristol Advisory Committee on Climate Change


- NHS Blood & Transport
- Independent Sector Treatment Centres and private hospitals
- Voluntary sector bodies
- Healthier with Nature and West of England Nature Partnership
- Citizen leaders
- Key supply chain partners

Our ICS organisations acting as anchor Institutions

The term anchor institutions 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 communities¹.


What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:



- Purchasing more locally and for social benefit**
In England alone, the NHS spends £27bn every year on goods and services.
- Using buildings and spaces to support communities**
The NHS occupies 8,253 sites across England on 6,500 hectares of land.
- Working more closely with local partners**
The NHS can learn from others, spread good ideas and model civic responsibility.
- Widening access to quality work**
The NHS is the UK's biggest employer, with 1.6 million staff.
- Reducing its environmental impact**
The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

 The Health Foundation

References available at www.health.org.uk/anchor-institutions
© 2019 The Health Foundation.

As an ICS we recognise the power we have as anchor institutions and commit to using this to positively contribute to our local area. This green plan gives us an opportunity to demonstrate what this means in practice, as set out in our vision and outcomes measures.

¹ The NHS as an anchor institution, The Health Foundation, [The NHS as an anchor institution \(health.org.uk\)](http://www.health.org.uk)

4. Our Population

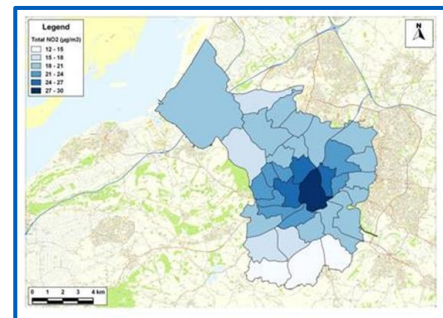
We serve a population of approximately one million people within distinct communities: a vibrant city with huge economic resources but also pockets of deprivation, seaside towns and villages and rural areas. People’s life chances and prospects of enjoying good health vary dramatically depending on where they are born and where they live. Our children are disproportionately affected, with nearly 40% of children in Bristol falling within the most deprived quintile. We need to deliver health and wellbeing services that meet the needs of each of these diverse communities.

Specific Sustainability Aspects of Our Population

There are some specific aspects of our demographics and geography that we will look to address through our green plan, including:

Air pollution

Across BNSSG, 5% of deaths are attributable to air pollution, which rises to 8.5% for Bristol residents^v. Air pollution particularly affects the most vulnerable in society: children and older people, those with heart and lung conditions and those living in the most deprived, inner-city areas. It is recognised as a contributing factor in the onset of heart disease and cancer.



Population-weighted total nitrogen dioxide concentrations, Bristol, 2013.

Our health behaviours – obesity & activity levels

Being overweight or obese increases the risk of death from a number of conditions including cancer, heart disease and stroke and is associated with increased risk of poor physical, mental and social health. Whilst prevalence of obesity in BNSSG is lower than South West and England averages, a large proportion of our population are affected. Around 1 in 5 reception age children in BNSSG are overweight or obese and this rises to almost 1 in 3 by the age of 11^{vi}.

Risk Factors attributed to Disability	Bristol	South Gloucestershire	North Somerset
High body-mass index	1	1	1
Tobacco	2	2	3
High fasting plasma glucose	3	3	2
Alcohol use	4	4	5
Drug use	5	8	7
Dietary risks	6	5	4
Occupational risks	7	6	6
Malnutrition	8	7	9
High blood pressure	9	9	8
Low bone mineral density	10	10	10

Risk factors for Years Lived with Disability rate per 100,000 population by local authority 2019

Activity levels amongst adults in BNSSG are relatively high (61.1% of adults in BNSSG are considered active), particularly when compared with the England population as a whole, but there are substantial levels of inactivity. Approximately 1 in 4 (25%) of the adult population in BNSSG do less than 30 minutes of moderate intensity physical activity per week. In England, on average, 28.7% of the adult population are inactive. Promoting active travel as part of our sustainability ambitions will help to support healthy behaviours^{vii}.

Access to healthy food:

70% of BNSSG households purchase fresh and affordable food close to home on a weekly basis. This figure drops to 30% for those with serious long-term conditions and 45% in Worle, Weston and Villages. It rises to 75% in North Bristol and Woodspring. Our food and nutrition actions set out in this plan aim to increase awareness of nutritious and environmentally sound food choices^{viii}.

Healthy life expectancy

Healthy life expectancy (the number of years expected to be lived in self-reported good or very good health) is associated with a strong deprivation gradient within BNSSG

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

Summary

With wider determinants impacting health outcomes by up to 40%^{ix}, we know that we can only gain real traction in significantly improving the health of our population by working together and particularly capitalise upon the full range of interactions our Local Authorities have with the public.

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

5. Our Green Plan Vision

Our sustainability vision is set out as one of our 7 ICS strategic aims.

ICS Strategic Aim 6: We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 2030; improving the quality of the natural environment; driving efficiency of resource use.

We will focus on delivering 3 key outcomes for our population:



Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution, creating a cleaner, safer, more ecologically sound environment locally and globally, including restoring the environment and biodiversity as much as possible



Net zero carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030



Generate a BNSSG-wide movement: Our 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

Our pledges:

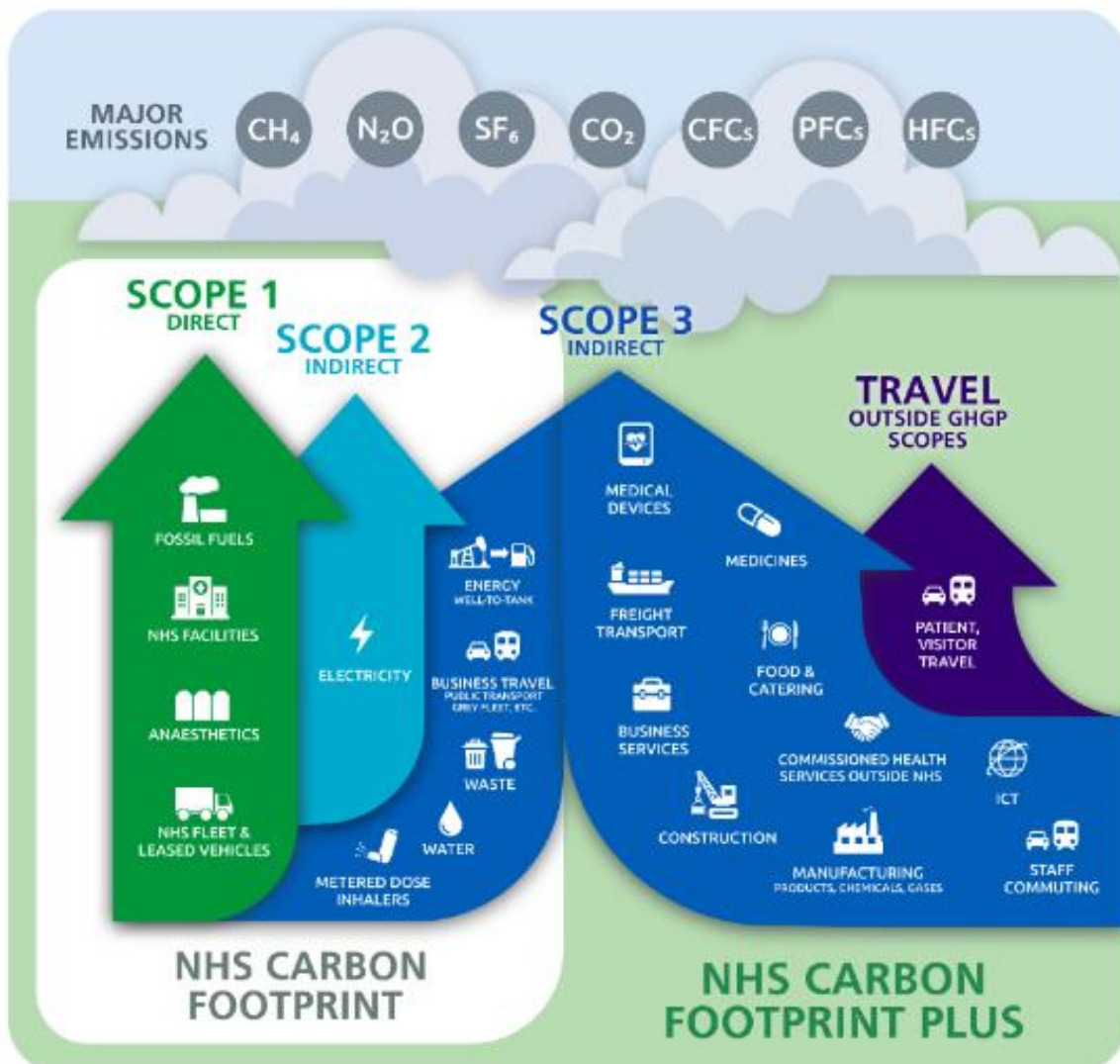
- We will ensure all new capital developments are net zero unless there are significant exceptions. This will be considered a pass/fail decision point in our capital prioritisation matrix
- We will maximise our system building capacity, facilitated by investments in digital infrastructure, before any partner organisation builds new non-clinical buildings
- We will lease or purchase only ultra-low emission vehicles unless a sustainable equivalent is not available in the market
- All new buildings and refurbishments must meet the NHS Net Zero Carbon Building Standard
- We will invest in increasing biodiversity and supporting local sustainable food production, enabling access to nature rich green spaces that provide opportunities for nature connection across our services
- We will expect all new models of care to demonstrate a carbon reduction and/or a wider sustainable benefit to support population health
- We will aim for all new procurements or renewals to be with suppliers that demonstrated a clear commitment and plan to achieve net zero carbon and social value. We will evaluate and monitor suppliers on their delivery against those commitments
- We will actively seek opportunities to create social value through our spending to appoint micro, small and medium size businesses, social enterprises and voluntary / community organisations

6. Our Carbon Footprint – Scope Definitions

The NHS categorises scope 1 & 2, and a specific sub-set of scope 3 emissions as the NHS Carbon Footprint. The remainder of the scope 3 emissions are classed as the NHS Carbon Footprint Plus.

Throughout this plan, and in our ICS commitments, we are referring to the total carbon emissions generated directly and indirectly by our services – i.e., scopes 1, 2 & 3.

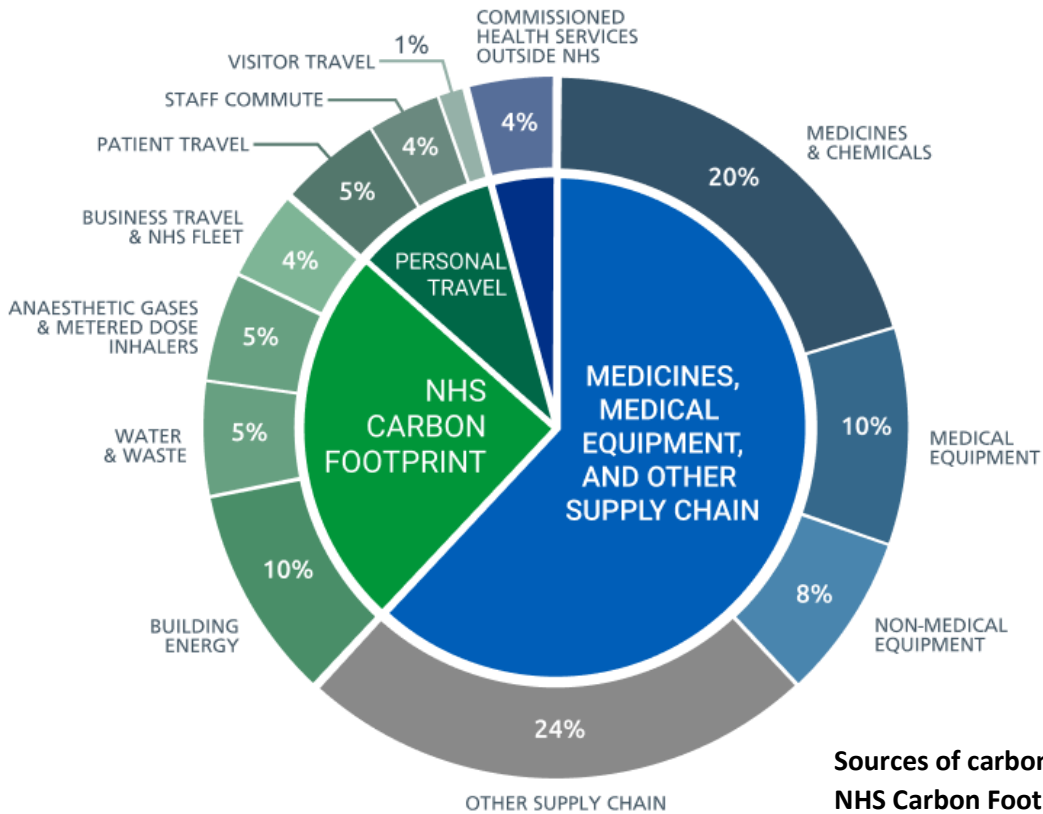
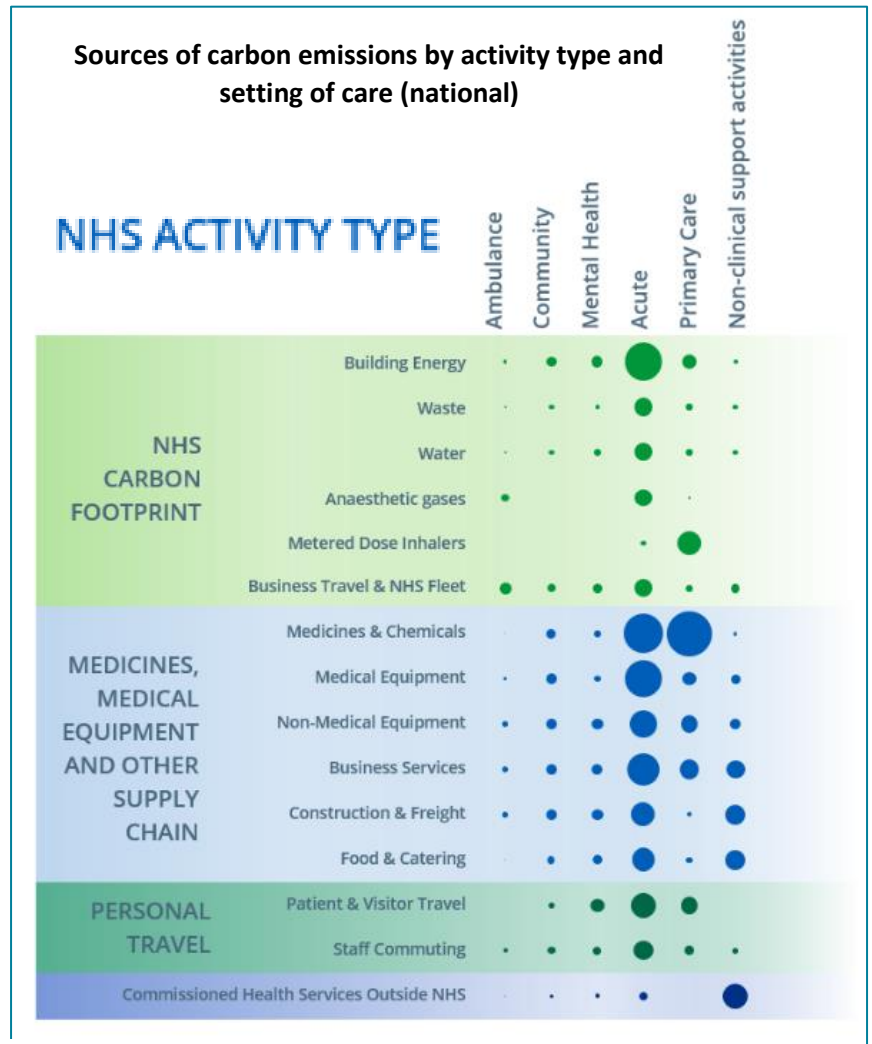
Scope	Description	Examples
Scope 1: Direct Emissions	Direct emissions from sources that are owned or controlled by the NHS	<ul style="list-style-type: none"> • Direct fuel/energy use e.g. natural gas • Fuel used from institution owned vehicles • Anaesthetic Gases
Scope 2: Electricity Indirect Emissions	Emissions from the generation of purchased electricity consumed by the NHS	<ul style="list-style-type: none"> • Purchased electricity
Scope 3: Other Indirect Emissions	Emissions that are a consequence of the activities of the NHS, but occur from sources not owned or controlled by the NHS	<ul style="list-style-type: none"> • Construction, water, waste, land-based travel, commuting (both staff and students) • Food and catering • Procurement & supply chain



What makes up our carbon footprint (based on national top-down figures):

Most of our carbon footprint is associated with the acute sector, with building energy, waste & water being the largest element of the NHS Carbon Footprint

Medicines & chemicals, NHS purchasing, and other supply chain are the largest element of the NHS Carbon Footprint Plus. We commit to actively influencing our supply chain and associated manufacturers to achieve net zero.



Sources of carbon emissions by proportion of NHS Carbon Footprint Plus (national)

7. How we will measure our progress


To assure ourselves and our citizens that we are on track to deliver our headline ambitions we will establish a number of key metrics. For some aspects of our sustainability ambitions there are not currently suitable measures. For these we will work to develop measures and use proxy measures in the meantime.


Our approach to measuring our progress is:


- To have an ICS-wide dashboard by March 2023
- Develop costed delivery plan by March 2024 to measure ourselves against
- Ensure wherever possible we measure outcomes (i.e., what will be different for our population), rather than processes
- To review our dashboard at least annual at organisational and ICS board level

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
To establish a system-wide dashboard																				
Develop costed delivery plan to measure ourselves against																				
Ensure that we measure outcomes (i.e., what will be different for our population), rather than processes																				
Review our dashboard at least annually at organisational and ICS board level																				

Headline Measures:

Target areas	Measures	Target
 Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution		
Travel & Transport: Reduce particulate, CO ₂ & NOX impacts of travel (ultra-low emission vehicles, active travel)	Air quality around our main hospital sites & mean annual background concentration of PM 2.5 and PM 10 particulates	Within legal limits of the 2008 ambient air quality directive by 2025.
	Fraction of mortality attributable to air pollution	Improve across a medium-term rolling average
	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends non-F2F from 22/23
	% Of patients that travel to care contact by sustainable methods	50% by March 2025
	% Of staff that travel to work by sustainable methods	50% by March 2025
	% Of fleet vehicles that are ULEV (or EURO 6 standard where ULEV not available)	100% by March 2024
	% Of fleet vehicles that are ZEV	50% March 2025, 75% March 2027, 100% by March 2027
Waste & water: Reduce waste & water across all estates	Total water consumption of our services (vol)	Reduce compared to previous year
	% Waste to landfill	0% zero waste to landfill from our estates by 2025
	Clinical waste ratio: 20% high temp incineration, 20% alternative treatment, 60% offensive waste by weight	Ratio achieved by March 2025
	Recycling weight	60% of all waste reused or recycled by March 2026, 80% by 2028, 100% by 2030
Plastics: Reduce single use plastics	Total volume / number of single use plastic products replaced with reusable alternative	Volume/number reduced through clinically led replacement with reusable alternative
Biodiversity: Protect and enhance biodiversity across our estates	Area (m ²) of our sites improved/managed for biodiversity and staff wellbeing	30% of sites greenspace protected for wildlife by 2025
	New trees planted across our footprint by 2025	10000 trees planted by 2025, 20000 by 2030
	Biodiversity value of our sites	All new development and relevant refurbishments achieve 10% net gain in biodiversity by 2026

Target areas	Measures	Target
 Net Zero Carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030		
Total all scopes carbon	Carbon footprint for our activates scope 1, 2 & 3	Net zero by 2030
	Total financial cost to the system if we were to off-set our carbon emissions (all scopes)	Reduction year on year towards minimal offset by 2030 [£378/tCO2e]
Estate: Decarbonise estates	Carbon footprint from estate (exc. energy) - i.e., waste, water, other	80% by 2028, Net zero by 2030
	% New build capital projects achieving NHS Net Zero Carbon Building Standard	100% from 22/23 (unless significant exceptions)
	% Refurbishment capital projects contributing to NHS Net Zero Carbon Building Standard	100% from 22/23 (unless significant exceptions)
	Utilisation of our estate: carbon use per care episode to [not yet measurable]	Reduce year on year
	Use of Sustainable Design Guide / net zero building standard for all new buildings/refurbs	100%
Energy: Decarbonise energy	Carbon footprint from all building energy	80% by 2028, Net zero by 2030
	Percentage of imported electricity from truly renewable sources (showing additionality)	100% by March 2028
Supply chain: Decarbonise supply chain	Total carbon footprint of supply chain	Net zero by 2030
	New or renewed contracts with suppliers to have a plan to take their operations to net zero by 2030	All new procurement over £5m to ensure carbon reductions plans in place from April 2023. Robust plan to be in place to target all appropriate category spend by March 2024
Medicines: Target the significant carbon impact of medicines and associated supply chain	Total carbon footprint of medicines & chemicals	Net zero by 2030 (trajectory TBD)
	Carbon footprint associated with anaesthetic gases	Desflurane decommissioned by 2024, all net zero by 2030
	Carbon footprint associated with metered dose inhalers	Net zero by 2030 (trajectory TBD)
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 23/24 (except where no viable supplier available)
Care models: Low carbon models of care – do less (preventative & up-stream care), do local (digitally enabled, local care models), do most efficiently (GIRFT,	Reduction in patient miles travelled / CO ₂ as a result of outpatient transformation	30% reduction on 19/20 levels
	Reduction in patient miles travelled / CO ₂ as a result of other sustainable models of care	TBD
	Reduction of carbon associated with new models of care	TBD using Healthy Weston Phase 2 as test
	% Of patients that travel to hospital by sustainable methods	50% by March 2025
	Reduction in carbon achieved through green social prescribing [measure to be defined]	TBD
	Utilisation of our estate: carbon use per care episode to [not yet measurable]	Reduce year on year

Target areas	Measures	Target
low carbon alternatives etc)	% Of large-scale service changes that can demonstrate a positive impact on key environmental measures (e.g. through a Sustainability Impact Assessment)	100% by 23/24
	Generate a BNSSG-wide movement: Our 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	
Staff: Training, engagement & personal action	Number of staff reporting increased awareness of C&E emergency and report having made practical changes (in workplace and outside) Conduct annual staff sustainability survey	Increase from baseline established in year 1
	Number of active users on sustainable staff engagement scheme / app	10% of staff by 2025
	Number of people who have received training in sustainability / carbon literacy	e-learning completed by 20% of staff by 2025
	Number of Green Champions – staff who are dedicated to reducing our environmental impact and given the time and resources to do so.	Increase year on year
ICS culture & process: Embed sustainability within all our core decisions	% Of large-scale business cases that can demonstrate a positive impact on the environment	100% by 23/24 (scale and mechanism TBD in 22/23)
	ICS value and financial framework has sustainability as a central component	100% of business cases pricing in environmental costs and benefits in the value equation by March 2024
	% Organisations with a staff engagement programme e.g. RCGP endorsed Green Impact	100% by 23/24
Lead change with our citizens: use touch points for raising awareness; behaviour change	Number of citizens who have reported an increased awareness & changed behaviour as a result of contact with an ICS organisation or our messaging	TBD
	Number of people with improved self-reported health due to connecting with nature	TBD by the Green Social Prescribing work
	Percentage of BNSSG adults walking for travel at least three days per week	
	Percentage of BNSSG adults cycling for travel at least three days per week	
	% Of service users who report ICS organisations as leading the way in sustainable provision of services	TBD – citizen panel or local authority survey
	Number of citizen communication campaigns / number of citizens reached by campaigns (e.g. front door messaging, appointment letters, transport options)	TBD – to increase year on year, use academically-validated approaches to use health interventions to create a step change in personal sustainability behaviour
Acting as anchor institutions to influence local business & economy:	Demonstrable positive impact on local business economy	% of spend with micro, small and medium size businesses, social enterprises and voluntary / community organisations
	Value of external reuse of durable goods by value (e.g. reuse of office furniture)	Increase year on year
	Number of citizens who have benefited from ICS projects such as community heat project	Increase year on year

Target areas	Measures	Target
Create a step change that directly benefits our citizens	Number of citizens we have helped to access key areas of support such as warm homes / sustainability grants	Increase year on year

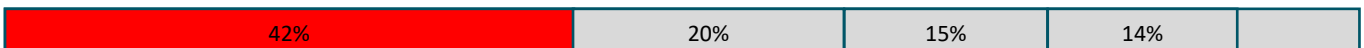
8. Our ICS ambitions, commitments and actions

The following pages set out the ambitions, commitments and actions that we have made across key thematic areas.

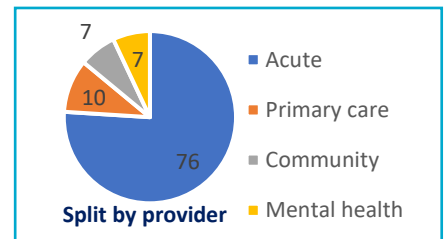
Explanation of page layout

Contribution to carbon footprint: The coloured bar at the top of the next four pages shows the approximate percentage of all-scope carbon emissions attributable to that area of our operations. We will ensure we target our actions at the highest impact areas. Due to incomplete local data these estimates are based on the national figures². The example shown below is for supply chain & procurement.

Contribution to NHS Carbon Footprint Plus



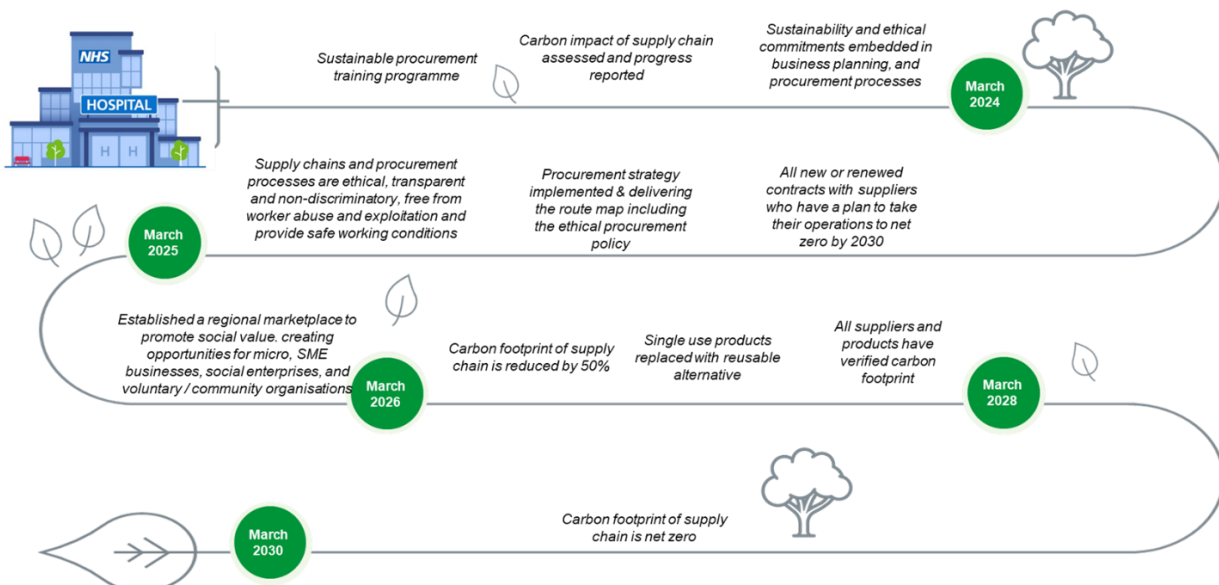
Split by provider: The chart on the top right of the next four pages shows the approximate split of the carbon emissions for that area of our operations across provider type. This is also drawn from national data. It is important we know the relative contribution of each organisation as it allows us to focus on the actions within each organisation that will deliver the biggest benefit. The example shown to the right is for supply chain & procurement.



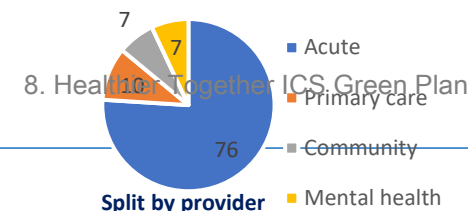
Contribution to our headline metrics: Most actions will contribute to several headline metrics. In the following pages we have highlighted the metrics that will be most significantly impacted by actions in that aspect of our operations.

Roadmap : A summary timeline of key targets

Procurement – We will drive towards a net zero procurement and supply chain by 2030. We will have an ethical approach at the centre of our procurement decisions



² Delivering a ‘Net Zero’ National Health Service, [delivering-a-net-zero-national-health-service.pdf](https://www.england.nhs.uk/delivering-a-net-zero-national-health-service.pdf) (england.nhs.uk)



Headline ambition for our ICS

We will drive towards a net zero procurement and supply chain by 2030. We will have an ethical approach at the centre of our procurement decisions, recognising that our need to procure to deliver our health service should never be at the detriment of others and we will work to ensure that is the case. We will:

- Driving the supply chain to net zero
- Using our spend as a positive influence in our community
- Promoting a fair, diverse, and inclusive supply chain

Additional opportunities through acting as anchor instructions

We are committed to delivering social value from our £424M annual expenditure. Our duty under the Social Value Act 2012 is to consider the economic, social and environmental benefits that can be delivered when making procurement decisions. In short, how can we deliver wider public benefits for communities beyond the service being commissioned. Wherever practical, we will create opportunities to contract with local businesses, voluntary groups, charities and social enterprises.

Key actions:

- Implement and embed new procurement strategy & deliver the NBT route map (NBT, UHBW, AWP & Sirona), including the ethical procurement policy
- Establish mechanism to measure the carbon footprint of our supply chain
- Establish key delivery metrics to achieve net zero by 2030 and develop a mechanism for reporting and recording progress made against our sustainability objectives in our contracts – scope 3 and social value.
- Establish mechanisms, tools and processes to ensure sustainability is inputted into procurement lifecycle at key points (this would include whole life costing, evaluation criteria and setting a carbon cost).
- Embed procurement commitments within business planning processes, including amending the TORs of the non-pay group to include both a carbon and monetary assessment
- Establish process for evaluating, recording and monitoring social value commitments.
- Work in partnership with other anchor institutions (local authorities and universities) to establish a regional marketplace to promote social value.
- Actively creating opportunities for micro, small and medium size businesses, social enterprises, and voluntary / community organisations
- Category level risk identification and management. Working with category teams to manage these risks and realise the opportunities.
- Develop and start to deliver a market engagement plan.
- Sustainable procurement training programme for BWPC staff.
- Case studies on three high risk contracts to demonstrate what can be achieved.
- Clinically led targeted work on single use plastics: share and rapidly adopt learning

Key ICS Pledges & Commitments

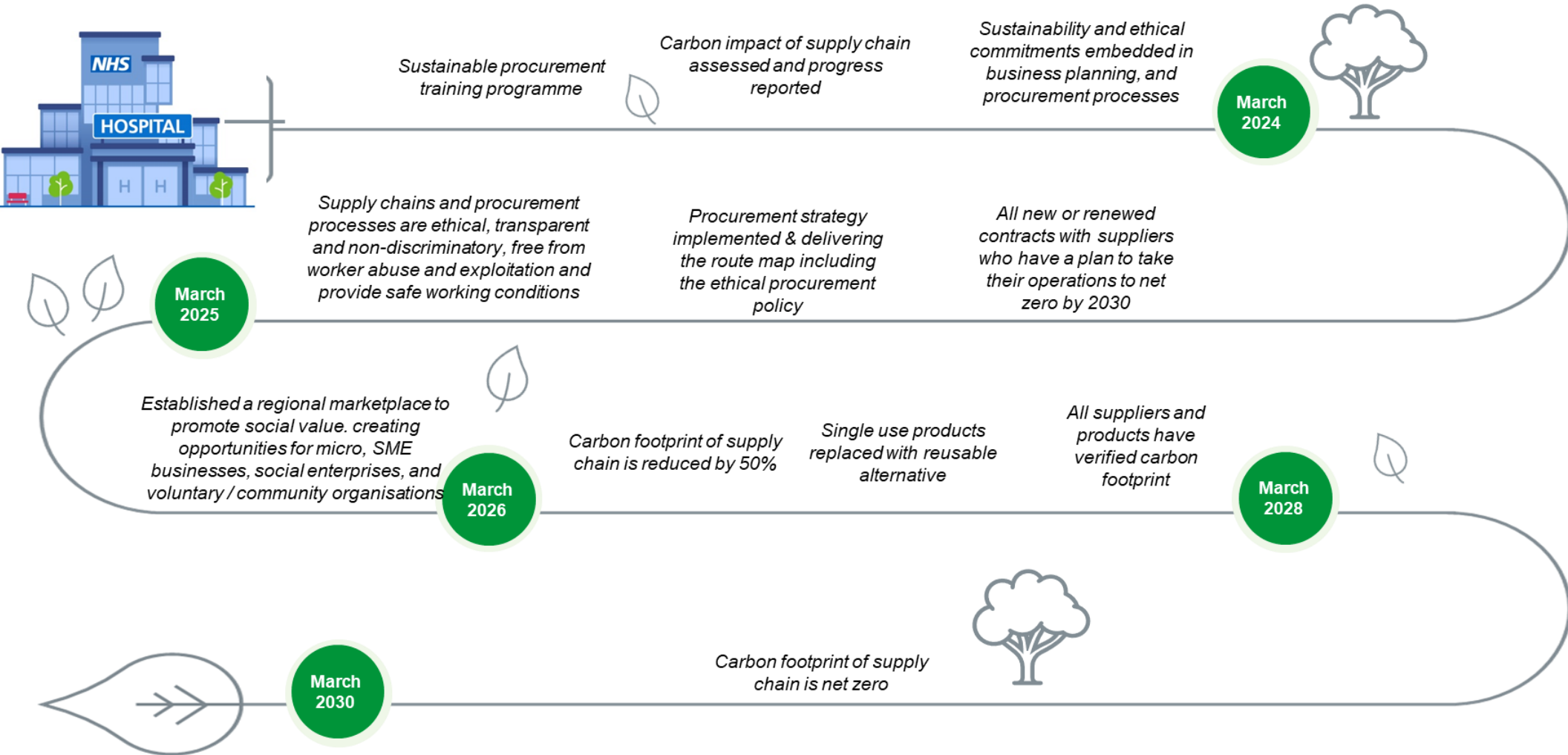
As a system recognise the positive impact that can be leveraged from a collaborative approach to procurement, to ensure social, responsible, and environmental commitments are included in all decision making.

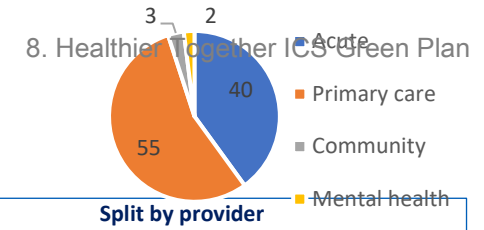
- We will challenge the market to make a significant reduction in carbon for every (re)procurement, including showing how they are on target to meet the 2030 net zero each time we renew a procurement. For all suppliers with a spend greater than £5m we will require them to publish a carbon reduction plan from April 2023.
- We will require all suppliers to publish a carbon reduction plan from March 2024
- Where market conditions allow we will ensure our procurement processes drive resource efficiency and support our suppliers to move to a circular economy. Including adjusting our procurement, finance and decision-making processes to incorporate different business models e.g. leasing options rather than buy outright, focusing on take-back schemes and producer responsibility for waste, purchasing closed loop products etc.
- Ensure our supply chains and procurement processes are ethical, transparent and non-discriminatory, free from worker abuse and exploitation and provide safe working conditions.
- We will commit to assessing our supply chains ethical practises and compliance in consideration of our contribution towards the SDGs.
- We will review our suppliers for compliance with relevant minimum labour standards and (where applicable) with the Modern Slavery Act 2015.

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Total volume / number of single use plastic products replaced with reusable alternative	Volume/number reduced through clinically led replacement with reusable alternative
	Reduce packaging waste	TBD
Target carbon	Total carbon footprint of supply chain	50% by March 2028, Net zero by 2030
	New or renewed contracts with suppliers to have a plan to take their operations to net zero by 2030	All new procurement over £5m to ensure carbon reductions plans in place from April 2023. Robust plan to be in place to target all appropriate category spend by March 2024
Lead change with our citizens	Demonstrable positive impact on local business economy	% Of spend with micro, small and medium size businesses, social enterprises and voluntary / community organisations
	% of staff trained in sustainable procurement	100% of procurement staff trained by March 2024

Procurement – We will drive towards a net zero procurement and supply chain by 2030. We will have an ethical approach at the centre of our procurement decisions





Headline ambition for our ICS

We will reduce the impact of our medicine & medical devices on the environment towards net zero by:

- Reducing overuse of medicines and medicines waste
- Switching to lower impact alternatives wherever possible or green social prescribing initiatives -Every patient prescribed anti-depressants to be offered a nature based intervention
- Driving changes in the manufacture of medicines through our procurement approach

Key actions:

- Embed green plan ambitions within medicines optimisation strategy
- Ensure delivery of anaesthetic gases & metered dose inhaler (MDI) projects
- Appoint a primary care clinical lead to accelerate delivery of the MDI project, other green priorities, and support polypharmacy review programme / switch to social prescribing / recommend digital tools that could enable culture change
- Embed green impact within formulary decision making process and establish a clear decision-making protocol for trade-offs (e.g., carbon v cost v patient experience v clinical benefit). This will also support guideline development.
- Work with Commercial Medicines Unit (CMU), NHSE Commercial and Regional Pharmacy Procurement Specialist to ensure our green procurement commitments are featured
- Promote wider culture change through our regular communications
- Anaesthetic gases 1. Decommission all nitrous oxide manifold systems. 2. Eliminate the use of desflurane in line with NHSE 2024 mandate. 3. Install capture on volatile agents that can't be eliminated. 4. Install destruction technology for nitrous oxide use that can't be eliminated
- Identify pipeline of future lower carbon medicine switches and commit to these through annual business planning rounds
- Consider how carbon impact can be visible at point of care as part of shared decision-making conversations
- Maximise the benefits of our Green Social Prescribing project in line with the WENP Nature and Health Strategy; embedding the value of nature-based health interventions into strategies and policies and providing investment for their sustainable provision
- Drive more effective waste management by ensuring contracted services evidence recycling of packaging and driving for teracycle option for plastic blisters
- Recognise environmental challenges relating to medicines and minimise impact where possible

Key ICS Pledges & Commitments

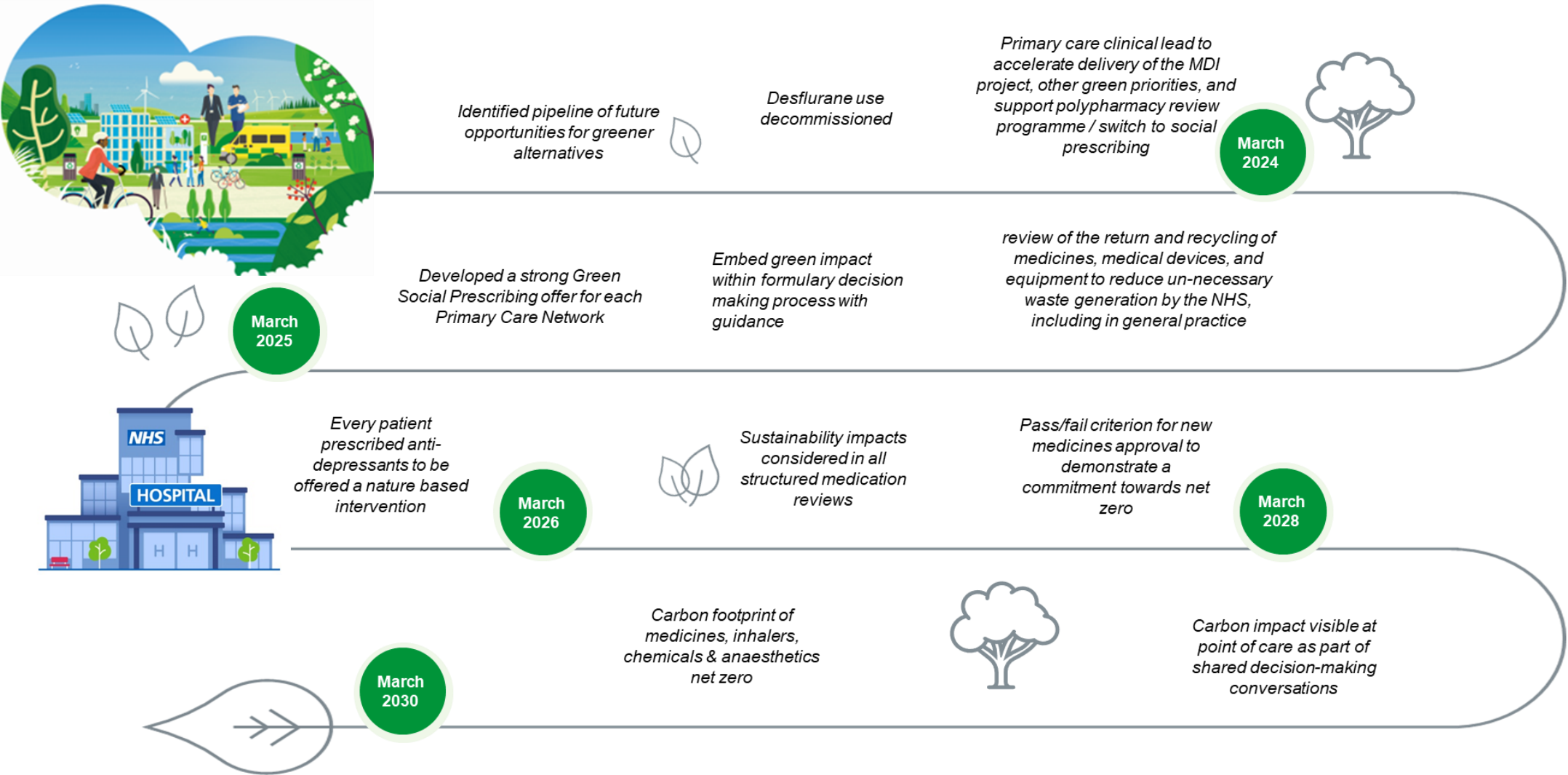
To have an iterative approach to targeting the highest opportunity medicine change each year. Approach to include:

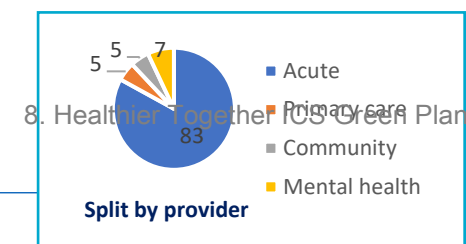
- Aligning our sustainability commitments to the 'delivering best value' strand of our Medicines Optimisation Strategy
- A review of the return and recycling of medicines, medical devices, and equipment to reduce un-necessary waste generation by the NHS, including in general practice
- Reduce medicines waste
- Consider switching highest carbon impact medicines e.g., anaesthetic gasses and inhalers to low carbon alternatives
- Identifying pipeline of future opportunities for greener alternatives
- Develop a strong Green Social Prescribing offer for each Primary Care Network
- Considering environmental impacts within structured medication reviews
- Influencing the procurement and supply chain
- Aligning medicine changes to Sustainable Models of Care
- Considering a pass/fail criterion for new medicines approval to demonstrate a commitment towards net zero, unless no viable alternative is available
- Demonstrating where the most environmentally sustainable solution is also the optimal

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Reduce anti-depressant prescriptions (and in our environment via a Green Social Prescribing pilot	Reduction by 25% for a target cohort of patients
Target carbon	Total carbon footprint of medicines & chemicals	Net zero by 2030 (trajectory TBD)
	Carbon footprint associated with anaesthetic gases	Net zero by 2030 (trajectory TBD)
	Carbon footprint associated with metered dose inhalers	Net zero by 2030 (trajectory TBD)
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 23/24 (except where no viable supplier available)

Medicines – reduce the impact of our medicine & medical devices on the environment towards net zero





Headline ambition for our ICS

We will be net zero as a health system by 2030. To achieve this, we will:

- **Upgrade & renew buildings and infrastructure**
 - Develop and implement a sustainable design guide for use by system partners
 - Have a strategic system-wide investment programme to decarbonise our estate
 - Work with our landlords where we are not property owners, negotiating improvements in building performance at lease renewal and rent reviews. Consider divestment where landlords are unable to meet this
- **Optimise the way we use our buildings and grounds:**
 - Embed energy and water efficient technologies and practices throughout our estate and services to deliver year-on-year reductions in consumption of water & energy
 - Use the benefit of working as a system to make most environmentally sensible use of our joint estate (e.g., sharing buildings, joint back-office functions, and shared working hubs). Look to reduce total estate footprint through new ways of working
 - Increase the proportion of our clinical buildings used for delivery of clinical service & increase overall building utilisation, thus reducing carbon output per care episode
 - Increase staff and patient access to NHS estates green settings for improved health and wellbeing
 - Minimise our use of fluorinated gases, reduce losses and move to lower green house gas types
 - Implement the Clean Air Hospital Framework and apply principles across the system
- **Change our energy source**
 - Derive 100% of our energy from renewable sources – supporting development of new renewable (NHS windfarm) and source more sustainable oils for generators

Key actions:

- Amend business planning, financial approval and capital prioritisation processes to reflect our ambitions
- Each organisation will undertake an assessment of how far existing organisation plans take us to net zero, collated into an ICS plan
- Establish view of non-owned estates, the routes & timescales for actions (e.g. lease review) & take a system view of investment vs benefit
- Establish corporate service review and use this to drive new ways of working such as hot-desking & working from home (reduced carbon, reduced estate need)
- Establish a system-wide strategy for clinical & non-clinical waste
- Sharing sustainable design guides
- Supporting system partners with business cases to attract grant funding
- Engage with City Leap on energy efficiency and district heat network opportunities

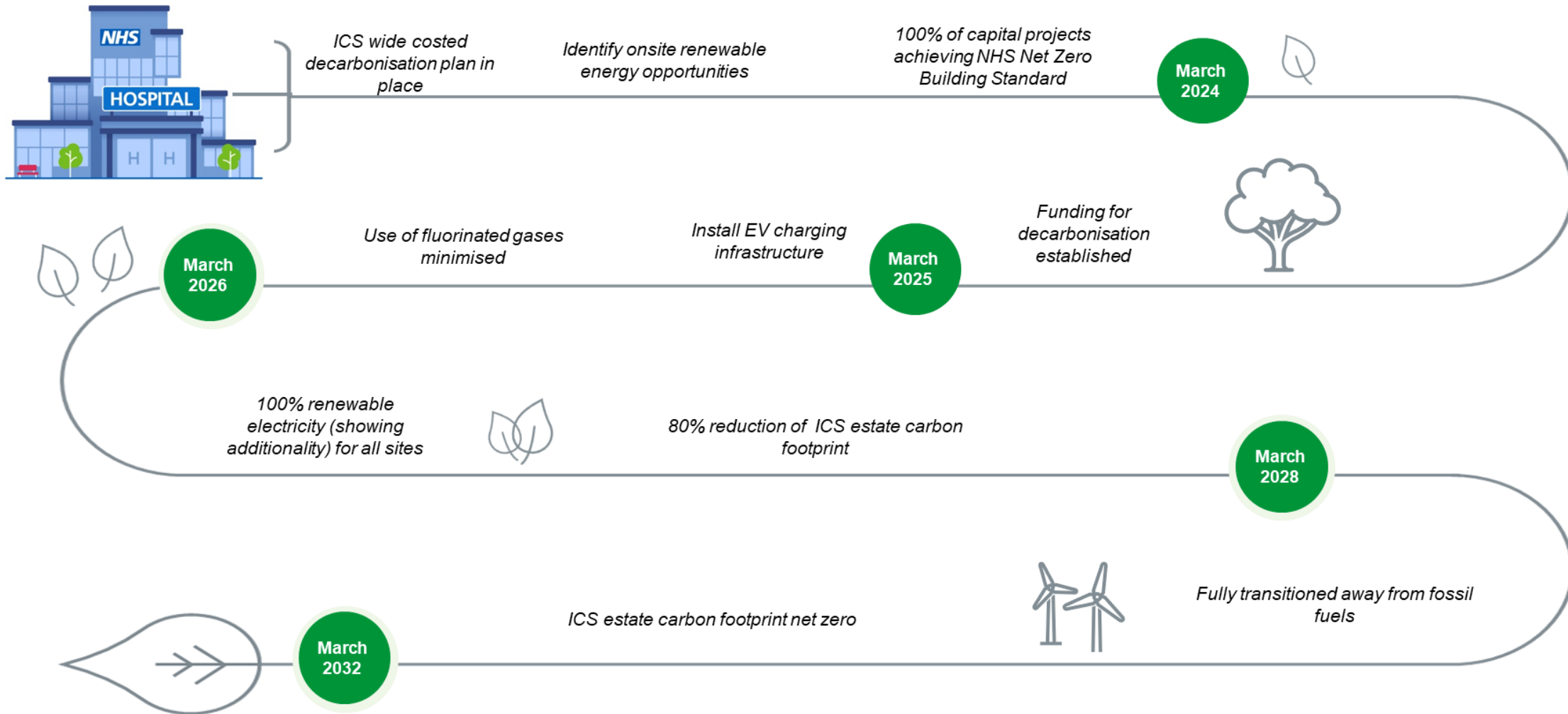
Key ICS Pledges & Commitments

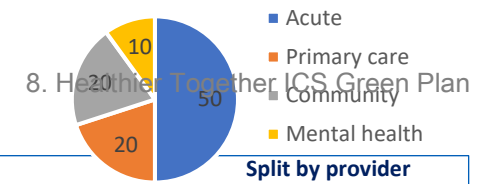
- Each of our tier 1 partners agrees to becoming net zero for estates and facilities by 2030
- We will ensure all new capital developments are net zero unless there are significant exceptions. This will be considered a pass/fail decision point in our capital prioritisation matrix
- We will exhaust our system building capacity, facilitated by investments in digital infrastructure, before any partner organisation builds new non-clinical buildings
- All new buildings and refurbishments must meet the NHS Net Zero Carbon Building Standard
- We will ensure that replacement services & infrastructure will meet net zero carbon requirements (e.g. no new gas boilers)
- We will increase the total amount of green & blue spaces across our total footprint
- We will use our capital allocations & primary care improvement grants and levies to enable developments in infrastructure which prioritise net zero.
- We will positively support investment in decarbonisation. The phasing and prioritisation for this will be considered at system level (i.e. greatest relative impact)
- We will adopt the principles of circular economy to minimise waste and maximise local reuse

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Total water consumption	Reduce consumption year on year
	Total volume of single use plastic products	
	Area (m2) of our sites improved/managed for biodiversity and staff wellbeing	30% of sites greenspace protected for wildlife by 2028
Target carbon	Carbon footprint from estate (exc. energy) - i.e. waste, water, other	80% by 2028, Net zero by 2030
	Carbon footprint from all building energy	80% by 2028, Net zero by 2030
Lead change with our citizens	% Of service users who see ICS organisations as leading the way in sustainable provision of services	TBC

Estates —Reduce scope 1 & 2 greenhouse gas emissions from direct operations using best available technology and offset remaining to achieve net zero by 2030





Headline ambition for our ICS

Transport emissions play a role in poor air quality impacting on our population health, contributing to 300 deaths per year in Bristol. Physical activity through active travel can play a key role in improving health and wellbeing. We will drive towards net zero carbon and significant reduction in damaging air pollution from the travel & transport associated with our activities.

Key actions:

Headline measures:

- Identify targeted action to address air pollution on our key sites – e.g., standard signage to turn off engines
- Develop a common set of key metrics – e.g., deaths attributable to air pollution, active travel, staff miles, patient journey types, business mileage

Staff & business travel

- Commission system-wide review of fleet vehicles to purchase only ULEVs or Euro 6
- System wide review of travel expenses policy: consider making the expenses rates for using sustainable travel for work options (this will include EV's) higher than the rates for using a private motor car. Promote active travel: All staff to have access to personal travel plans that can be used to identify travel to work options or travel for work options
- Staff loan / salary sacrifice schemes for ULEVs (currently only for B4 up), and active travel options (cycle schemes)
- Ensure that all car parking policies are in line with HTM 07-03 where parking is only provided for those that need it e.g., disabled, night staff, staff that work when unsocial hours when public transport options are limited, and rates discourage the use of the private motor vehicle to get to work
- Promote and facilitate working from home / most accessible office hob.
- Participate in the TravelWest Travel to Work survey to collect baseline staff travel data
- Implement the Clean Air Hospital Framework and apply principles across the system

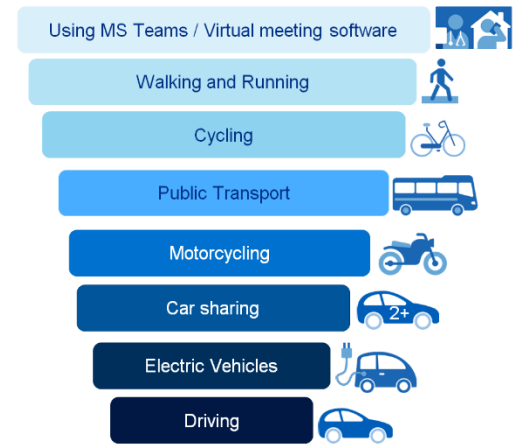
Service user travel

- Work with public transport providers to provide a fit for purpose public transport service for the area
- Consider free public transport tickets for those patients already eligible for free parking
- Review active travel corridors/routes with WECA – all sites should have safe / dedicated low-traffic routes
- System wide events and communications plan to promote active and sustainable travel benefits to drive behaviour change
- Green social prescribing of active travel for rehabilitation

Key ICS Pledges & Commitments

We will act collectively to change travel behaviours & decarbonise our fleet:

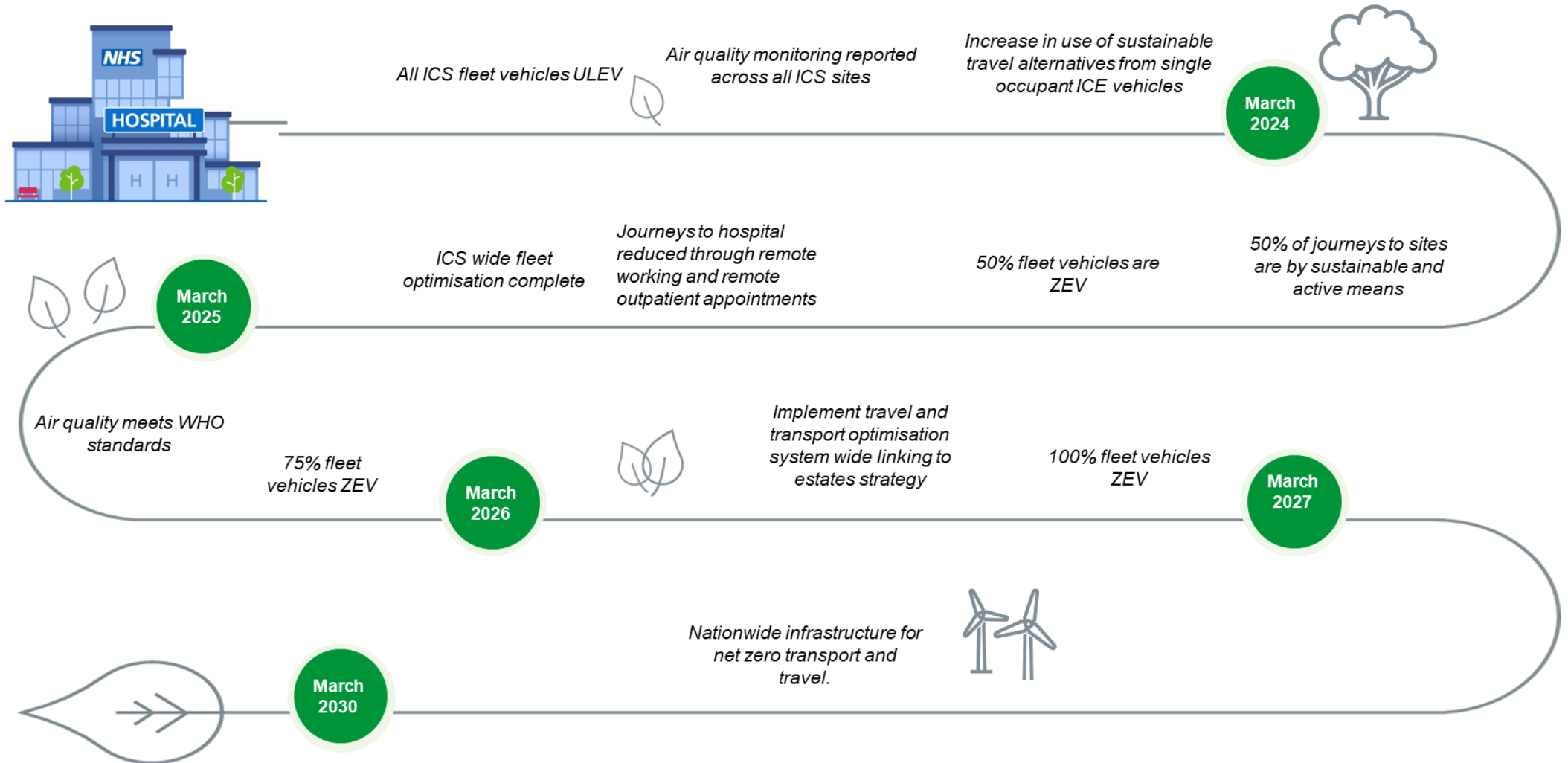
- We will lease or purchase only ultra-low emission vehicles unless a sustainable equivalent is not available in the market
- We will ensure new models of care provide care digitally or closer to home wherever possible
- We will develop an ICS approach to lease vehicles and salary sacrifice aligned to our sustainability goals
- We will align our travel expenses policies to support our goals (e.g., mileage expenses for active travel that are comparable to vehicle mileage)
- Ensure that new ways of working, supported by our policies, reduce the need for travel
- Promote active travel (running, walking, cycling etc) for staff and patients, including as part of green social prescribing initiatives.
- Implement a hierarchy of vehicle use: remove travel (work from home), minimise travel with care closer to home, promote active travel, public transport, shared modes, private ultra-low emission vehicles, private fossil fuel as last resort



Contribution to our headline metrics

Outcome	Metrics
Improve our environment	Air quality around hospital sites & mean annual background concentration of PM 2.5 & PM 10 particulates
	Fraction of mortality attributable to air pollution
	% Of patients that travel to care by sustainable methods
	% Of staff that travel to work by sustainable methods
	% Of new vehicle purchases / contracts that are ULEV (or EURO 6 standard where ULEV not available)
Carbon	Carbon footprint for our activities scope 1, 2 & 3
Lead change with our citizens	No. of citizens who have reported an increased awareness & changed behaviour as a result of contact with an ICS organisation or our messaging
	% of adults walking for travel at least 3 days per week
	% of adults cycling for travel at least 3 days per week

Travel, Transport and air quality – Improving air quality and active travel for better population health. Transport travel activity delivering net zero carbon by 2030.



Headline ambition for BNSSG

We will drive towards achieving net zero carbon by 2030. A significant reduction in damage to our climate and local air pollution is due to waste management logistics and activities. This will include moving towards a circular economy, changing how we procure our services and enable a step change in our staff and patient behaviours by:

- implementing a waste hierarchy approach towards achieving zero waste by 2030
- promoting the health and wellbeing benefits of sustainable waste management
- Promoting compliance with sustainable waste management showing the benefits and the positive impact on healthcare
- implementing engagement and educational activities related to sustainable waste management

Key ICS Pledges & Commitments

We will act collectively to change Sustainable Waste Management behaviours and we will:

- Develop sustainable waste management education for all staff and to engage public - changing the perception of waste to valuable commodity, retaining the value of our used goods so they are not wasted
- Align sustainable waste management contracts across the system
- By 2025 Implement the NHS Estates and Facilities clinical waste management strategy to include:
 1. 20% High Treatment Incineration
 2. 20% Alternative Treatment
 3. 60% Percent Offensive Waste
- Ensure no waste is disposed to landfill by 2025
- Roll out an accessible system for reuse of equipment and furniture across the health and care system
- Increase recycling year on year
- Target work on reduction of plastics and moving to a circular economy



Key actions

Headline measures:

- Develop the ICS Sustainable Waste Management Work Stream and support the implementation of organisation level sustainable waste management
- Identify targeted action to address air pollution on our key sites – e.g., reduction in waste collections and reducing incinerated waste
- Develop a common set of key metrics – e.g. ERIC returns & carbon impacts of waste
- Review current waste management contractual obligations to enable moving to more sustainable solutions

Policy

- System-wide review of sustainable waste management policy and procedure
- Implement the health technical memorandum 07-01
- Plan for sustainable waste management education delivery across the system to include carbon literacy
- Launch sustainable waste management engagement programme to include annual displays & roadshow of case studies; staff, patient, public and local authority engagement events; discretionary funding & design competitions to accelerate new ideas
- Investigate and plan for regular sustainable waste management audits to support behavioural changes
- Implement the Clean Air Hospital Framework and apply principles across the system

Service

- Work with waste management suppliers to provide fit for purpose and sustainable services
- Identify sustainable waste management data gaps and areas to work with supply chain eg packaging
- Consider regular plastics audits to understand waste composition and carbon impacts
- Use our sites as recycling centres for hard to recycle items we give to patients e.g. blister packs, inhalers, walking aids.
- Promote working together with the supply chain to include manufacturers, suppliers, users, and local authorities.

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	% Waste to landfill	Zero waste to landfill by 2025
	NHS clinical waste strategy	%20 HTI - %20 AT- %60 OW
	Sustainable Waste management education	Increase compulsory sustainable waste management training
	% Waste reused or recycled	Increase % reused or recycled 60% 2026, 80% 2028, 100% 2030
Target carbon	% Waste collections	Reductions year on year
	Carbon footprint from waste treatment services	Net zero by 2030
	Carbon footprint from all wastes	Net zero by 2030
Lead change with our citizens	% Of service users who see ICS organisations as leading the way in sustainable waste management	3 sustainable waste management engagement programme events per year

Waste – reduce the impact of our waste management on the environment towards net zero implementing a waste hierarchy, moving to a circular economy and changing how we procure and deliver our services



Sustainable waste management contracts in place

Establish system wide sustainable waste management Group

Staff engagement strategy and education plan set and implemented across the system

Implemented HTM 07-01

Establish a waste Carbon footprint measure across the system

March 2024



Suppliers engagement strategy plan set across the system

March 2025

Establish a common system wide practice system for reuse of equipment and furniture

Implemented NHSE clinical waste strategy in healthcare settings to achieve:

20% High Temp Incineration
20% Alternative Treatment,
60% offensive waste

Zero waste to landfill



System wide waste reduction procurement opportunities identified

Community Engagement Plans set out across the system

System wide sites are recycling centres for hard to recycle items we give to patients e.g. blister packs, inhalers, walking aids diabetic pens

60% of ALL waste is reused or recycled

March 2026

80% of ALL waste is reused or recycled



System wide waste management effectiveness review

March 2030

Reduced air pollution from waste transport and incineration

100% of ALL waste is reused or recycled

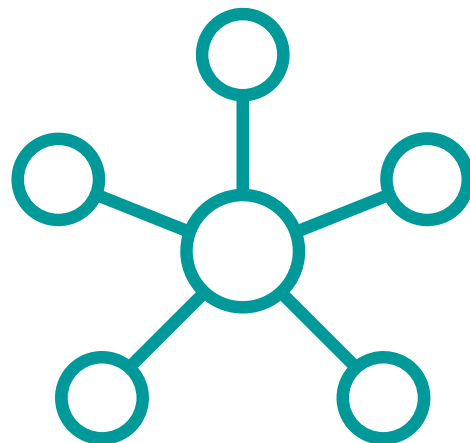
March 2028



Last updated April 2022

Headline ambition for our ICS

Our digital vision is to become an exemplar of a digitally advanced ICS. We recognise that this will play a key part in meeting our environmental ambitions. This includes through digitalised clinical systems, smart facilitates management monitoring systems, and facilitating agile working across our footprint.



Digital infrastructure can also contribute to environmental damage through carbon use as well as the use of rare materials. We commit to maximising the positive environmental benefits of our digital enablers, while minimising their impact on the environment.

Key actions:

- Ensure the environmental benefits of existing capabilities are being maximised (Electronic Patient Records, virtual appointments, digital prescribing)
- Work with the CSU to identify the highest impact interventions & pathways for transformation
- Development of fully integrated BNSSG wide community first digital capability that is specifically designed to support our ambition for integrated community first care as the default setting for care.
- Through our digital workforce objective, creating the network infrastructure that will allow seamless working across the BNSSG estate and considering that significant levels of care already happen in the persons home
- Create a BNSSG Digital Infrastructure Alliance joining up key systems that drive cost & resource saving by removing duplication and creating shared services
- Ensure through our contracting and procurement that we are moving to lower carbon impact provision of digital infrastructure and hardware, including the impact of outsourced or subcontracted services
- Embed uptake of digital solutions within services through Digital Changemakers to ensure sustainability and other benefits are realised.

Key ICS Pledges & Commitments

We will drive towards a net zero digital provision by 2030 by:

- Providing digital capabilities that support clinical models of care that are non-face-to-face or digital by default wherever clinically appropriate
- Achieving a minimum of 30% outpatient care non-face-to-face and increasing our proportion of primary care appointments delivered digitally
- Enable much more effective sharing of clinical information across the ICS, reducing the need for additional patient contacts & travel. We will move information, not people
- Support a community first model of care via an Integrated Delivery Unit
- Enable a personalised & proactive care experience for the service user, thereby reducing the need for more resource-intensive reactive care
- Maximising the use of digital technologies in our facilities management (e.g., smart metering, building management systems, automation)
- Through our procurement strategies, align to the requirements set out in the government sustainable IT strategy, as well ensuring suppliers entering new or renewed contracts with us have a plan to take their operations to net zero by 2030. This includes our commitments to transparency of supply chain, data storage, data centres and power use /cooling
- Joining up our infrastructure to reduce cost and resource use

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends delivered non-F2F from 23/24
Target carbon	Utilisation of our estate: carbon use per care episode to	Reduce year on year
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 23/24 (except where no viable supplier available)
	Reduction of carbon associated with new models of care	TBD using Healthy Weston Phase 2 as test
Lead change with our citizens	Demonstrable positive impact on local business economy	TBD – e.g.; increase in % of contracts to local businesses
	Value of external reuse of durable goods by value (e.g. reuse of IT / office furniture)	Increase year on year

15. Sustainable models of care

Headline ambition for our ICS

We will ensure that we are at the leading edge of sustainable models of care. We will embed carbon reduction principles throughout our care delivery recognising that the way we deliver care and the way we operate sustainably are inextricably linked. National estimates are that preventative medicine, reduced health inequalities & lower carbon models of care can contribute to a 15% overall reduction in the NHS Carbon Footprint Plus. The goals of our model of care are to:



Help people stay well and independent in their community and promote community resilience, for example, by investing in voluntary and community sector partners, such as those providing nature-based interventions



Provide early help and support that is integrated, personalised and wherever possible proactive, avoiding the need for intensive support or hospitalisation



Where hospital is unavoidable and becomes the only way to meet the needs of the person, stays are kept to a minimum and community support is integrated, personalised and pre-emptive



People have a system of support to get them back home as quickly and easily as possible. We help people once home to get back to being as well and independent as possible, including accommodations for any new ways of staying well

Key actions:

- Establish an ICS-wide network of sustainability experts who can support service redesign
- Use Healthy Weston Phase 2 service redesign as a test case for how to make sustainability principles central to large scale service change
- Create a set of standardised tools, such as Sustainability Impact Assessments that support the initiate & delivery of service change
- Use the service redesign gateways to ensure sustainable models of care are part of the service model. Ensure that all service changes & business cases can demonstrate positive environmental impacts through their SIA.
- Establish sustainability agenda into priorities for QI programmes and academic research (e.g. AHSN)
- Continue to deliver the highest impact interventions, including anaesthetic gases & metered dose inhalers as well as digital models of care & telemedicine
- Identify & communicate the benefits of sustainable models of care delivered during COVID-19 to discourage reversion to original state – promote what is already done
- Identifying the next wave of opportunities / highest environmental impact pathways. Share case studies on service models that have reduced carbon impacts
- Launch broader engagement around sustainable models of care including annual displays & roadshow of examples; staff & patient engagement events; discretionary funding & design competitions to accelerate new ideas
- Through shared decision-making conversations, involve service users more fully in treatment choices and options for minimising environmental impacts
- Use Right Care and other tools to reduce unwarranted variation in care and associated resource waste

Key ICS Pledges & Commitments

8. Healthier Together ICS Green Plan

By supporting people to stay healthy and well we will reduce overall demands on healthcare services, and thereby their associated environmental impact, by:

- Delivering our prevention agenda
- Reducing health inequalities that lead to inefficient allocation of healthcare resources
- Promote sustainable approaches to wider determinants of health such as access to nature-rich green spaces and active travel.

We will reduce the carbon impact of the services we deliver by:

- Providing services from places and in ways which minimise the need for unnecessary travel
- Getting it right first time – reducing unwarranted variations in care, delivering the right care, to the right person in the right place.
- Delivering lowest impact, clinically appropriate care
- Ensuring that sustainability and environmental impacts are key considerations in system design principles & integrated care plans
- Ensuring that patients are engaged and well-informed about the carbon impacts (including as part of shared decision making around choice of care pathway)

We will facilitate change at all levels by:

- Ensuring that sustainability principles are central to service design and redesign, not an afterthought
- Enabling a culture where considering the environmental impact of services becomes the norm (education, tools to decide trade-offs, the information to support the right decisions - e.g. GIS -

Contribution to our headline metrics

Outcome	Metrics	Target
Improve our environment	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends non-F2F
Target carbon	Utilisation of our estate: carbon use per care episode to	Reduce year on year
Lead change with our citizens	% Of business cases with a sustainable impact assessment (that has influenced the design of the business case)	100% by 23/24

Headline ambition for our ICS

We will demonstrate our commitment to delivery of our sustainability agenda through a clear approach to leadership and people development at all levels of our organisations to increase sustainability, wellbeing and resilience in our staff and communities

Key actions:

System leadership:

- Establish the executive-led ICS Green Plan Steering Group
- Organisational development of Board level engagement and training
- Integrate personal and environmental sustainability with connection to wellbeing
- We will develop our “Developing leadership and leaders Principles” to include a focus on holistic sustainability

Wider actions:

- Use our environmental credentials to establish our organisations as employers of choice. ICS job description template should include sustainable vision, and standard interview questions to incorporate sustainability focussed questions.
- Formalise sustainability advocates / link roles in each division & department and systemwide.
- Encourage the development of Green Staff Networks / Sustainability advocates across the system.
- Take a proactive approach to engaging underrepresented staff groups with sustainability activities.
- Build awareness with carbon literacy training, starting at Execs. Consider realistic levels of training appropriate to roles. Include:
 - E-learning for all staff - Introduction to sustainable healthcare
 - Informal lunch and learn - open to whole ICS
 - Bespoke training - Institute of Environmental Management training - for accredited qualification (e.g. finance, procurement).
- Ensure healthcare practitioners have access to training in nature connection & practice at a range of levels to embed this across the health and care system
- Develop as an element of all apprenticeships for future

Staff engagement:

- Expand the UHBW - NBT Greener Together staff engagement to the wider ICS
- Grow the Greener Practice Group to establish a fully represented primary care sustainability network, linked into our ICS Green Plan Steering Group
- Connect in with One Care/Primary Care e.g. system level newsletter or through Primary Care Networks

Key ICS Pledges & Commitments

We will have clear leadership of our Green Plan delivery including:

- An executive lead in each organisation
- Establishment of an ICS Green Plan Steering Group
- Development and delivery of the ICS Green Plan strategy including nature-based healthcare
- Establish a compelling vision and narrative to embed green agenda into BAU

We will equip our workforce with the skills and capabilities required to meet our ambitions:

- Ambition to establish and energise a social movement
- Use of sustainability ambitions and record of delivery to position us as an employer of choice
- Appropriate training and awareness building at all levels
- All health and care organisations commit to support staff to undertake e-learning – Introduction to sustainable healthcare
- Use all development opportunities to help people to feel, think and, therefore, behave differently. This includes ensuring all leadership development includes support and challenge for environmentally sustainable mindsets
- Build connection to wellbeing agenda -staff wellbeing will be central to sustainability initiatives
- Improve sustainability staff benefit schemes to support recruitment and retention

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends delivered non-F2F from 22/23
Target carbon	Utilisation of our estate: carbon use per care episode	Reduce year on year
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 22/23 (except where no viable supplier available)
	Reduction of carbon associated with new models of care	TBD using Healthy Weston Phase 2 as test
Lead change with our citizens	Demonstrable positive impact on local business economy	TBD – e.g.; increase in % of contracts to local businesses
	Value of external reuse of durable goods by value (e.g. reuse of IT / office furniture)	Increase year on year

Headline ambition for our ICS

We will make a positive contribution to the environment and our local citizens through the food we provide.

Key actions for:

- Link with local authorities and other partners to consider a single Food and Drink Strategy including avoidance of food waste. Work already underway with the NHS Healthy Weight Declaration pilot
- Follow the Bristol One City Plan - going for gold process for sustainable food city. Generate a wider health and social change message of a sustainable, nutritional diet.
- Estates’ director support to promote importance of nutritional and food, including the role in influencing wider staff and service user behaviours. Trusts supporting going for Gold
- Through joint procurement strategy increase the use local suppliers, Fairtrade, red tractor, MSC food items; encourage more plant-based meals; and increase patient education
- Review vending machines to ensure supplier compliant with CQUINS
- Implement approaches to measure and reduce food waste. Change to measurement of weight of waste. Change food waste system away from macerators. Introduce on-site composting where possible
- Implement plans to change the menu at least twice a year by 2025 to maximise the use of seasonal ingredients.
- Review and adapt menus to offer healthier lower carbon options for patients, staff and visitors.
- Achieving Rainforest Alliance Certification for coffee beans across footprint
- Support access to fresh food including setting up a weekly food/veg stall for staff and visitors
- Aim to achieve Food for life awards (at least Bronze and Silver) and ensuring catering meets the Eat well guidance.
- Deliver Bristol Good Food 2030 framework action plan
- Promote staff engagement in healthy food & the environment e.g. through staff restaurant roof top herb garden and staff allotment – supplies food to staff kitchen.

Key ICS Pledges & Commitments

We will minimise the impact of our food use by:

- Buying Better: procuring local, seasonal, sustainable food wherever possible
- Reducing food waste
- Promoting urban growing and engagement with the natural environment
- Promoting sustainable and healthy food choices and access for staff and service users
- Supporting community action and food equality.
- Replace single use takeaway containers and cutlery with reusable items

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	% Waste to landfill	Zero waste to landfill by 2025
	% Waste recycled	Increase year on year
	Total volume of single use plastic products	
Target carbon	Total carbon footprint of supply chain	Net zero by 2030 (trajectory TBD)
Lead change with our citizens	% Of service users who see ICS organisations as leading the way in sustainable provision of services	TBC
	Number of citizens who have reported an increased awareness & changed behaviour as a result of contact with an ICS	TBD



Headline ambition for our ICS

We will identify our shared climate change risks as a system and implement an action plan to mitigate these risks and adapt our services, activities, and infrastructure to build resilience against climate change impacts.

Key ICS Pledges & Commitments

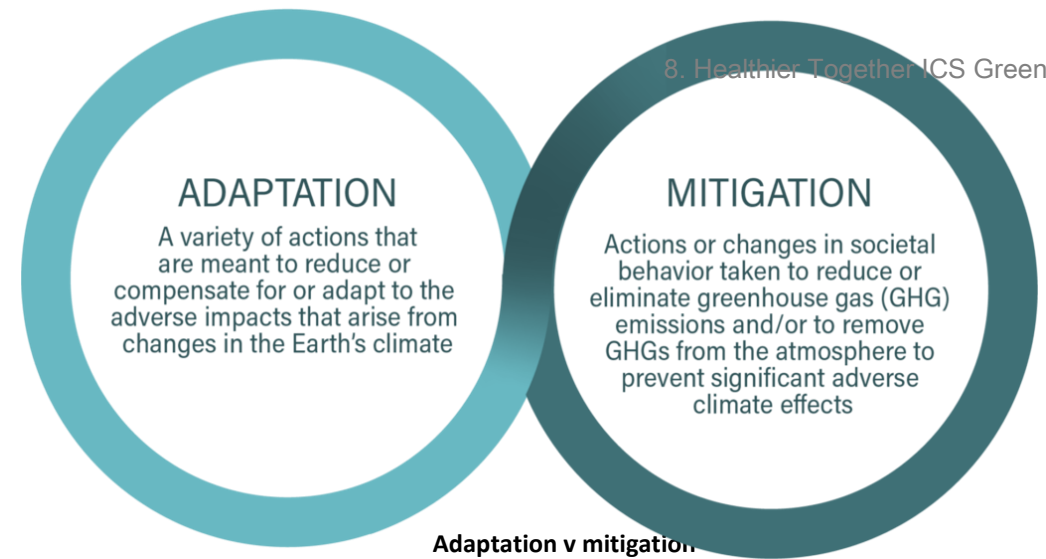
We will ensure all our organisations are prepared to deal with the effects of climate change, particularly extreme weather events, and continue to invest in adaptation and mitigation measures:

- Assess the shared risks and impacts of climate change for the system and adapt services, processes and infrastructure to mitigate the negative effects of past and future climate-altering actions.
- Reduce the impact on public health from climate change.
- Ensure our infrastructure, services, procurement, local communities, and colleagues are prepared for and resilient against the impacts of climate change.
- Support delivery of Bristol Fuel Poverty Action Plan and engage fully in actions to end cold homes as a cause of ill-health and prevent discharge from hospital into cold homes.

Contribution to our headline metrics

These metrics are specific to the adaptation work and do not currently feature in our headline metrics. We will assess which of these to include within our green plan monitoring.

- Number of overheating incidents in a year (maximum daily temperature exceeds 26 degrees)
- Number of flooding occurrences.
- Business Continuity Plans that contain climate change risks, impacts and adaptation measures.
- Number of patient admissions for asthma / other respiratory diseases.
- Number of supply chain disruptions (items not available or shortages and delays in delivery).



Key actions for:

- Recommend identification of an adaptation lead for each partner and encourage implementation of the ICS adaptation plan
- Understand organisation baselines of how much work the EPRR team are doing around climate adaptation
- Identify key shared risks from the adaptation plan and agree as a system our approach to those risks - which ones we need to collaborate on
- Link the climate adaptation plan to scenario testing by the emergency planning committees and existing network of people through local authorities
- Ultimately, develop an ICS level change and adaptation plan. Consider whether this should be held entirely by the emergency planning groups.
- Forward planning by Estates and Facilities teams to ensure they know how to respond and when adverse weather events are expected to occur. Bristol One City & Partners – Adaptation Strategy.
- Green and blue space joint-funding opportunities with Bristol organisations to mitigate the Urban Heat Island effect and to remove increased volume of air pollutants.
- Working with BCC to utilise the Heat Vulnerability Index tool to identify vulnerable communities and areas.

Headline ambition for our ICS

We will fulfil our duty to conserve and enhance biodiversity of our sites and across the region by working closely with our partners. We will promote and utilise our green and blue spaces to support the health and wellbeing of our staff, patients and local communities.

Key actions:

- ICS partners to open up and promote their green spaces for use by other partners, particularly those with limited free space.
- Develop business case for a network of nature recovery rangers that work across ICS partner sites to conserve and enhance biodiversity. Develop volunteer network to support activity.
- Partner with Health & Wellbeing teams to utilise green spaces, staff allotments and green gyms to improve staff, patient and community health and wellbeing.
- All new building developments and relevant refurbishments will develop comprehensive plans to achieve biodiversity net gain and mitigate adverse impacts on biodiversity, enhance existing biodiversity, adopt biophilic design and include a robust grounds maintenance regime.
- Undertake ecological surveys across our sites; pollinator surveys, butterfly surveys, newt surveys, bird identification that inform ecological action plans. Involve staff and service users in ecological surveys to provide opportunity for nature connection through citizen science
- Develop baseline biodiversity measures and targets in consultations with Avon Wildlife Trust and Natural England.
- Adopt and implement the guidance detailed in the Healthier Together Green Infrastructure Planning Guide, Green Pockets Planning Guide and Meadow Management Guide.
- Become pesticide free by 2025 across our sites
- Create designated areas for grassland management and pond creation - Participating in No Mow May each year and ongoing management for nature
- Each partner organisation will register with NHS Forest and will partner with external organisations and groups across the region to designate areas for tree planting.
- Estate masterplans will incorporate green corridors that align with city plans and link sites with community green spaces taking into consideration wildlife highways.
- Implement the Clean Air Hospital Framework install living roofs and walls at appropriate sites, particularly where air quality is poor
- Apply for grants to undertake ICS-wide projects that will conserve and enhance biodiversity and support external organisations bids to develop land for the use of green social prescribing.

Key ICS Pledges & Commitments

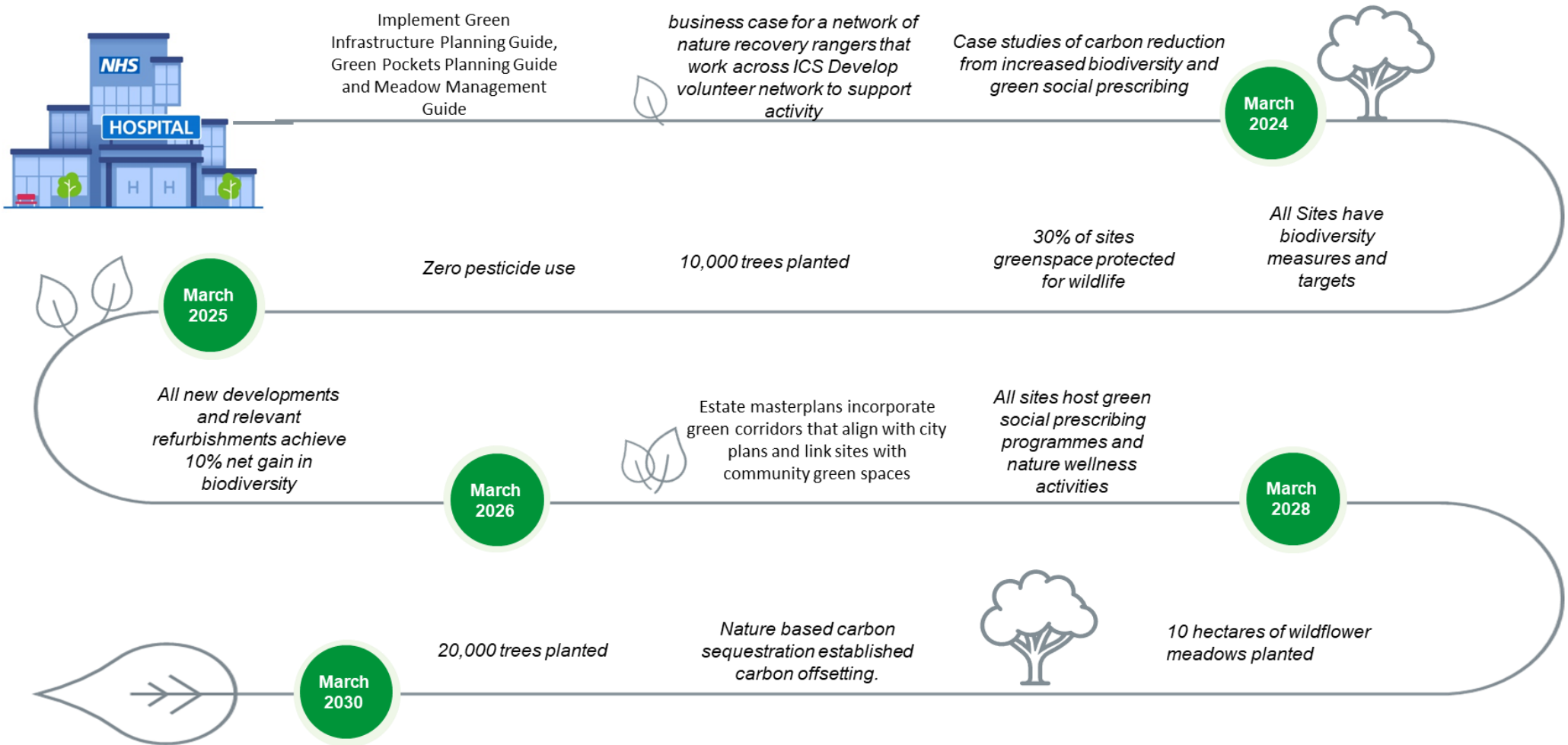
We will improve the biodiversity across all of our sites and improve the health and wellbeing of our population by:

- Establishing our sites as an open and accessible network of green spaces and facilities that can be utilised by staff, patients, visitors and volunteers from all ICS partners.
- Prohibiting the use of harmful chemicals and methods in our ground’s maintenance regimes.
- Conserve existing and establish new habitats for local wildlife ,
- Promote the use of our green spaces and facilities to staff, patients and the community as areas to improve health and wellbeing and to educate on biodiversity conservation.
- Mandating all new developments and relevant refurbishments achieve 10% net gain in the biodiversity associated with the development area. including new green and blue infrastructure living walls and roofs
- Host green social prescribing programmes and nature wellness activities on our sites.

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Area (m ²) of sites improved for biodiversity and health and wellbeing	Increase year on year
	New trees planted across our footprint by 2025	10,000 trees planted by 2025
	Biodiversity values of our sites	Achieve 30% protected for wildlife by 2025 for sites with green space
	Pesticide free by 2025	Zero pesticide use by 2025
Target carbon	Use of Sustainable Design Guide for all new buildings / refurb	100% of projects use guide
	Reduction in carbon achieved through increased biodiversity and green social prescribing	2 case studies in 2023/24
Lead change with our citizens	% of service changes that have a SIA demonstrating positive impact	100% by 2023/24
	Number of citizens who have reported an increased awareness & changed behaviour	TBD
	Number of citizen communication	TBD

Biodiversity – Conserve and enhance biodiversity of our sites and across the region, promote and utilise our green and blue spaces to support the health and wellbeing of our staff, patients and local communities.



20. Governance and Delivery

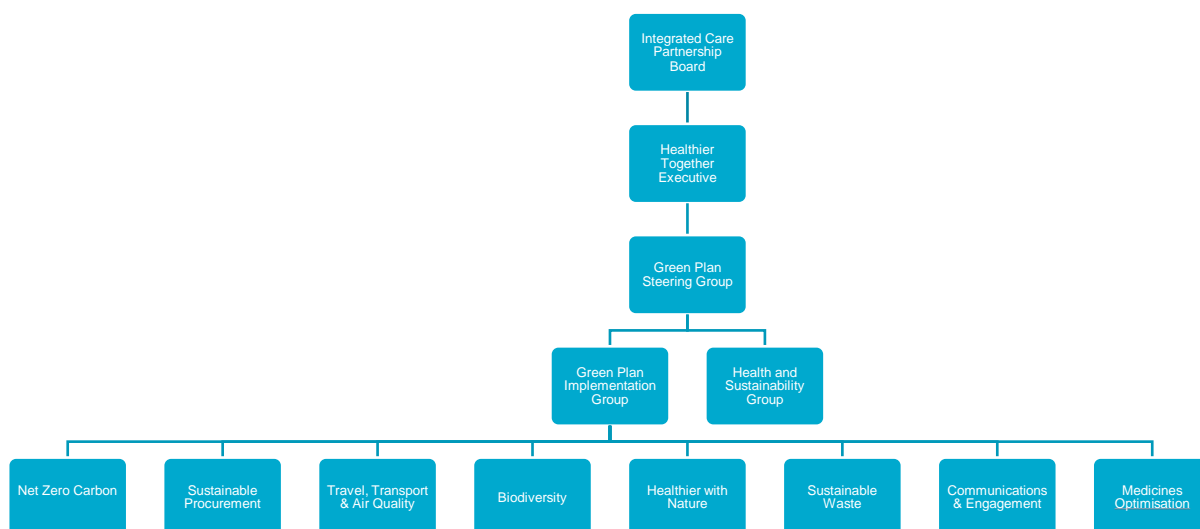
To ensure achievement of our ICS Green Plan we have developed a governance structure and supporting delivery infrastructure. Whilst much of the work of delivering change will be devolved to our core operations and strategic change programmes, the wide-ranging and large-scale nature of the ambition requires a formal governance structure.

We have established an executive-led **ICS Green Plan Steering Group** that reports directly into our ICS Executive Board. This is responsible for:

1. **Holding our shared ambition** - building on the success of our organisational level work, we will hold a singular clear ambition as an ICS that all partners align to
2. **Establish the enabling conditions for change** – putting the green agenda at the heart of our ICS – how we business plan, allocation of resources, development of frameworks and governance
3. **Coordinating collaborative projects across partner organisations**, including advising the Executive Board on priorities and trade-offs - At an ICS level we will put our collective resources and energy behind a small number of impactful changes
4. **Provide assurance of delivery of actions** devolved to other steering groups and organisations - Recognising that the green agenda is everyone’s business we will build on the success of organisational plans, putting in place monitoring and support frameworks to maximise the impact across the system, target highest impact interventions, hold collective risks, and hold groups to account for delivery of key actions

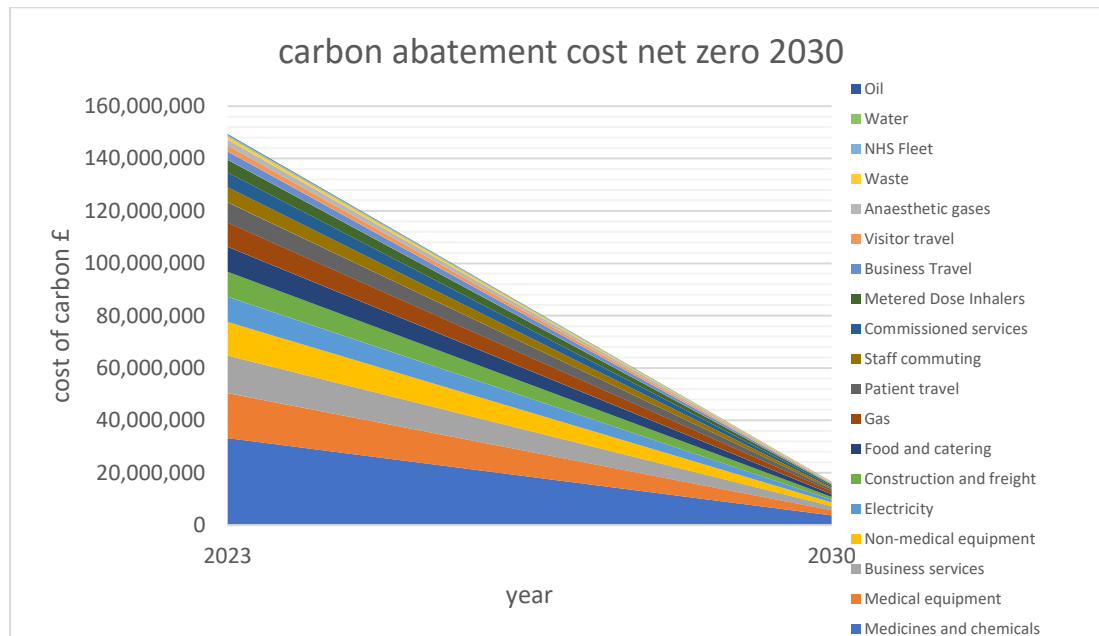
The **Green Plan Implementation Group** has been established to monitor progress with implementation by the Green Plan workstreams. The workstreams were initially set up as a working across the acute trusts but now include representation from other ICS organisations. A costed delivery plan for Green Plan actions across all workstreams will be developed in 2023/24.

The **Sustainability and Health Group** enables wider representation from across the system including Primary care, local authorities, SWAST and Sirona to provide input and coordination for cross cutting areas such as climate change adaptation.



Changes to key ICS processes and decision making

Meeting our sustainability objectives will require changes to almost all our prioritisation and decision making. The ICS Green Plan Steering Group has started to embed our sustainability ambitions within our core governance and decision-making processes. This includes developing a carbon price following [Treasury Greenbook supplementary guidance](#) currently £378/tCO₂e to be applied in business cases and procurement.



Key changes are:

Capital prioritisation:

- Principle: ensure that any new capital allocations (estates, digital, major medical) are actively driving towards our environmental outcomes
- How: amend our prioritisation matrices and decision-making processes to reflect this. For example, the estates capital prioritisation is now includes net zero carbon and sustainability as a pass/fail criterion for business cases. Introduce a carbon price into business planning and procurement processes. Commit 10% of system capital for a decarbonisation fund that all organisations can bid against. Green Plan Steering Group to determine best value use of funding.

Revenue allocation:

- Principle: allocation of resources within the ICS should clearly evidence how it meets our 7 system goals, one of which is our environmental commitments set out in this plan
- How:
 - ICS Outcomes Framework, including our green plan outcomes, will increasingly be used to allocate resources across programme areas
 - Transformation & major change: transformation programmes need to demonstrate how they meet our ICS Outcomes; all programmes will need a sustainability impact assessment that demonstrates a positive impact on our environmental outcomes. We will use the development of Healthy Weston Phase 2 business case as a test case for how to incorporate sustainability into large scale change
 - Business planning: we will use annual business planning to drive our collective sustainability ambitions

- ICS Value Improvement Framework: used to: allocate resources efficiently across our system so that we achieve the overall best possible outcomes; Identify and improve the outcomes and experience that matter to people; Commission and deliver effective services that avoiding overuse of low value interventions (unwanted or not cost-effective) and underuse of high value interventions (deemed cost-effective but not taken up by those who would benefit)

Service Change:

- Principle: we will use key service changes as an opportunity to meet our sustainability ambitions
- How:
 - Identify biggest wins: Our benchmark work will consider how to measure carbon 'heavy' opportunities. This will need to link with a system approach for measuring green credentials for Benchmarking analysis i.e., is there a 'green version' of model hospital
 - As part of good practice for transformation initiation and gateway controls, we will consider sustainability opportunities
 - Setting a carbon price [Treasury Greenbook supplementary guidance](#) currently £378/tCO₂e to be applied in business cases and procurement
 - Quality improvement: integration of a '**Sustainability Impact Assessment**' into our Programme Methodology that works alongside current QIA/EIA formats.

Annual operational planning: We will embed our sustainability outcomes as one of our key success measures for departmental and organisational planning – e.g., targeting procurement product switches & associated carbon reductions

21. Finance and resourcing

There will need to be significant financial and staff resource investment to deliver against the ambitions of this plan. We also recognise that there will also be considerable financial and non-financial value from operating more sustainably.

The ICS capital prioritisation agreed that a proportion of capital should be allocated to carbon reduction schemes as this is a key national priority and also provides more opportunities to leverage additional system funds. It was agreed to undertake surveys across ICS sites in 23/24 utilising non-recurrent revenue funding and then to commit 10% of system capital in 24/25 and future years for the Green Plan Steering Group to assess what schemes will bring the best value for money for the system to achieve the greatest benefits.

We do not have a complete picture of the likely capital and revenue implications, nor of the source of funds to meet this. The revenue requirements for 2023/24 to develop the detailed costed actions to deliver the Green Plan and start on that delivery are outlined below. This will provide a clear evidence base for the financial implications of this plan. We will account for the full financial & non-financial implications of both action and inaction.

Indications of the likely cost implications are:

- Capital investments to decarbonise estates
- Capital & revenue investments to adapt to the unavoidable impacts of climate change

- Potential additional non-pay costs associated with switching to low carbon products
- Pay costs associated with developing the expertise and resource to deliver our plans
- Increasing costs of carbon taxation
- Off-set-set payments for any carbon it is not possible to remove from our operations

Indications of likely benefits from meeting our ambitions:

- Reduced whole life costs of procurement
- Reduced spend on waste
- Reduce heating and power costs through building efficiency
- Reduced healthcare delivery costs due to more efficient models of care
- Social value procurement generating local economic value, reducing inequalities and the associated health burdens
- Reduced mortality and morbidity associated with air pollution and associated costs
- Reduced mortality and morbidity associated with inactivity and associated costs
- Increased value from green capital

Sources of funds will include:

- National funds e.g., Public Sector Decarbonisation Fund
- Greener NHS funding
- System capital allocations
- Transformation funding
- Primary care improvement grants
- Procurement savings – savings for reinvestment, CIP savings, cost avoidance savings
- Charitable funding

How we will assess value

As an ICS we will need to make prioritisation decisions and trade-offs over the coming years, balancing our commitment to the goals of this plan against our responsibilities to deliver safe and effective care. We will seek to make decisions in a clear and transparent way. Our ICS Value Framework provides guidance on how we can frame decision making and allocation of resource.

We define value as:

Meeting the goals of Population Health (including improving the environment); improving physical and mental health outcomes, promoting wellbeing, and reducing health inequalities, for the whole population and not just those who present to services through a focus on achieving the outcomes that matter to people and making best use of our common resources (including our environmental resources).

The outcomes that are important to people (including environmental & social benefits)
The costs to deliver them (including any social & environmental costs)

We will develop additional tools to enable us to make the most effective decisions for our population. These include:

- A refreshed capital prioritisation matrix, aligned to our net-zero ambitions with top sliced capital funding ring fenced for allocation by the Green Plan Steering Group
- A procurement assessment approach aligned to our net-zero and social value ambitions
- A sustainability impact assessment that aligns to the whole system value of care models

Resource investment planned for 2023/24

The first year of our plan 22/23 has shown there are already significant investments in progress within our partner organisations, which have started to set the foundations for delivery. Revenue investment across the ICS, subject to executive sign-off, includes:

Area of Impact Impact	Sub - Area of Impact Impact	2022/23		2023/24					Notes
		Cost £k	Funding source	Cost £k	Less Funded £k	Confirmed funding source	Outstanding Funding required £k	Potential funding source	
Decarbonisation of estates - 15% of carbon footprint	Decarbonising Primary - energy surveys of primary and community estate	50	ICB Primary care	115	-65	Onecare estates programme manager	50	ICB Primary care	
	Feasibility studies for decarbonising for estates 100k 1st year AWP £30K for Fountains way detailed, 26 sites to RIBA stage 2 £130K, UHBW £35K+? NBT ??	183	Salix Low Carbon Skills fund UHBW, NBT, AWP and trusts funded	100	0		100	Acutes and AWP feasibility funding, Salix feasibility funding	1st year funding only. Enabler for external funding
Procurement - 42% of carbon footprint	existing UHBW band 6, additional 2 band 6 sustainable procurement project managers	48	UHBW sustainable procurement manager	144	-48	UHBW sustainable procurement manager	96	Incorporate in BWPC fees	
Travel and transport - 14% of carbon footprint	vehicle changes, fleet review Transport optimisation - Project management and GIS mapping resource	45	SW greener NHS Sirona GIS mapping funding, WECA ebikes, UHBW air quality monitoring	96	0		96	invest to save, EU funding for air quality	

	fleet consolidation, staff & patient travel - consultancy support			78	-30	WECA travel hub	48		
Medicines optimisation - 20% of carbon footprint	Project manager medicines waste			48	-48	Onecare funded by medicines management	0		identified opportunity to expand
	Inhaler switching project - training for nurses, pharmacist time	5	SW greener NHS funding UHBW inhaler project	58	0		58		
Biodiversity	Nature recovery ranger band 6 support officer band 3 master planning and Offsetting opportunity assessment	37	Southmead Hospital Charity funded Band 5 post	75	0		75	Acutes biodiversity support, potential Centre for Sustainable Healthcare	
	mapping ICS greenspace 20k, Ecological surveys 20K, NHS forest consultancy 8K	20	UHBW funded biodiversity action plans	48	0		48		Could be 1 year project post
Healthier with Nature	Green Social Prescribing Core resourcing 2 posts	250	NHSE- Test and learn site funding	250	-125	Community mental health ICS funds AWP 125K 1st 6mths	125		
	Training plus tasters for staff 10k, Network events for hospitals and primary care 2k, Development of resources website 5k, Grant programme voluntary sector partners 10k match funding	650	Match funding wide range of sources	27	0		27	ICB, Public Health, Grant funding	Attract match funding
Waste decarbonisation	consultancy for decarbonising waste costed plan	50	Ecoquip+ EU funding	20	0		20		

Engagement awareness - Net zero training	ICB and ICP board training - ICS staff wide training	5	SW Greener NHS		0		0	SW Greener NHS funding	Staff wide training would be further cost
TOTAL		1343		1059	-316		743		

22. Risks

Risk	Mitigations
<p>Engagement – risk that the plan will fail to become adopted and embedded across the breadth of our activities due to the pace of the development of the plan and lack of wider engagement</p>	<ul style="list-style-type: none"> • Delivery of communications & engagement strategy • Senior approval by ICS Executive and Partnership Board • Role of ICS Steering Group to oversee alignment
<p>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</p>	<ul style="list-style-type: none"> • 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 • 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
<p>Reputational – Risk that our reputation is impacted if we are unable to meet the outcomes set out in this plan</p>	<ul style="list-style-type: none"> • 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)
<p>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)</p>	<ul style="list-style-type: none"> • Early and robust engagement with supply chains • Use collective pressure through regional and national bodies
<p>Competing priorities – risk that the pressures of the covid-19 pandemic, elective recovery, and establishment of new models of care impact on delivery and relative priority of this plan</p>	<ul style="list-style-type: none"> • 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.

23. Communications & engagement

One of our 3 priority outcomes is to:



Generate a BNSSG-wide movement: Our 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

What we already know

Because of the pace at which we have developed this initial plan, and the context of the Covid-19 pandemic, we have done relatively little engagement with either staff or citizens whilst developing this plan. However, there are some things we already know from our existing engagement work:

1. **Staff want us to improve the environment and for us to have a wider positive impact on the community.** This is exemplified in many of our key partners having publicly declaring a climate emergency, as well as in placing our role as anchor institutions central to our organisational strategies
2. **Many of our citizens see improvement of the environment as a top priority.**

How we will engage with this plan:

We will continue to develop further insights, ensuring that our ambitions are aligned to those of our staff and citizens. Key actions will include:

Staff engagement:

- Engagement with key operational and leadership groups
- Focus groups and roadshows with staff groups
- ICS wide staff engagement scheme
- Festival of engagement –presented in different areas of our organisations to gather comment, questions and ideas.

Citizen engagement

- We will develop a joined-up engagement strategy across all our partners to share our collective ambitions and hear our citizens' priorities and requirements.
- GP surgeries are key institutions in the local community with real opportunity to influence citizen behaviours

How we will use our position as anchor institutions

We will use this plan, and the actions that we undertake as a result, as an opportunity to create the widest possible engagement with the climate and ecological emergency. We aim to generate a culture change across our citizens, leading to further environmental benefits. Key actions will include:

1. Promoting the work we are doing to establish BNSSG as a leading sustainability region
2. Creating opportunities for citizen awareness raising – e.g. with information in hospital atriums, GP surgeries, patient letters
3. Promoting lifestyle changes that benefit both personal and planetary health – e.g. increased use of green spaces, active travel
4. Supporting our citizens to access financial and other support towards more environmentally friendly actions – e.g. warm homes grants, vehicle grants for those living in the emissions zones

5. Providing locally sourced, low-carbon nutrition in our facilities and using this as an opportunity to provide education and information for citizen lifestyle change
6. Working with academic partners to understand how we can most effectively influence behaviour change through our interactions

24. How we are working with key partners

1. Academic Partners
2. Local Authorities & public health
3. Other Health and Care Partners

23.1 Academic Partners

BNSSG has the benefit of leading academic institutions within our geography, including West AHSN, Bristol Health Partners, University of Bristol and University of the West of England. These partners will support in the delivery of our sustainability ambitions in several ways:

- i. Assessment of plans – any unintended adverse consequences
- ii. Linking inequalities, outcomes and health planning
- iii. Service user behaviour change at key life events
- iv. NIHR – will do a call around Local Authority health priorities

Support the development & rigour of our plan

We have leaders in climate change and health, including the Cabot Inst for Environment which brings together 600 academics focusing on an inter-disciplinary approach to the environment. These experts can be drawn upon to:

- Assess the ambitions and deliverability of our plans
- Help identify and understand any unintended adverse consequences (e.g., indoor air quality for making buildings super-efficient)
- Looking at mitigation and adaptation as a whole - the things that give mutual wins and minimise harm. Partnering with public health will be important for this
- Thinking as a region how we become net zero - e.g. green space 'offsets'
- Target actions that will help address inequalities by considering who will benefit from interventions such as better air quality. Draw on experts from our academic partners working on climate justice.
- Understand how academic work can inform our priorities - such as cognitive psychology research about behaviour change, climate change and awareness.

23.2 Local Authorities:

Our local authority partners also have bold sustainability ambitions. We have continued to build on our engagement with our local authority partners to further align our actions. The early areas for collaboration include:

- i. Procurement and creating a city-region green innovation driver
- ii. Community heat and power – city leap


- iii. Citizen engagement and messaging
- iv. Proactive climate adaptation planning



















23.3 Other Health and Care Partners:

We will increasingly need to work with wider health and care partners to align delivery of our ambitions. These include:

- Southwest Ambulance Service
- Private and independent sector treatment providers
- Care providers
- Community and voluntary organisations

We have a collective responsibility as anchor institutions to work together drive the solutions to the climate & ecological emergency. There are some key elements where we will need to work together

Key:  – immediate involvement  – expected adoption within 2-years  – possible future involvement

	Acute & MH providers	Community	Primary care	Local Authorities	Academic institutions	What may this look like
Patient, staff & public engagement						<ul style="list-style-type: none"> Joined up public messaging between health & LAs (e.g., signposting to energy advice), building on existing successes such as Warm Home Advice for people leaving hospital. Building on the Bristol One City approach to broad communications with the public / stakeholders, recognising the role of GP practices as hubs of community Commissioning academic institutions to advise on behaviour change & nudge theory; how key life events, such as having a baby, can be hooks for environmental and health behaviour change. Internal literacy training - opportunity for developing joint toolkits
Estate strategies						<ul style="list-style-type: none"> Strategic review of estate decarbonisation potential cross health & LA, which can link to the green capital, community assets and accommodation strategies Phased disposal of estate that is not viable for net zero Joined up adaptation plans (e.g. cooling centres), and extend the Bristol mapping projects to wider region. Challenge estate requirement through new ways of working across entire footprint (shared back office, mobile working, hot desking) Draw on expertise in UWE & UoB climate action plans and the Bristol advisory group on climate change.
Energy strategy						<ul style="list-style-type: none"> Review of non-gas energy options across public institutions at regional scale (e.g., strategic heat networks, wind turbines). City Leap at Bristol city scale. Could include electric vehicles and rooftop renewables. Possibility to extend beyond Bristol. Connecting to the heat network may be simplest solution for GP practices / health centres following improvement of the building fabric Consider novel contract forms for energy Smart technology across shared grids to distribute load across 24/7 variations.
Clinical waste						<ul style="list-style-type: none"> System-wide strategy for clinical waste. Resource Futures for the circular economy SevernNet – Industrial business network to support circular economy

Public Board	Acute & MH providers	Community	Primary care	Local Authorities	Academic institutions	What may this look like
Supply chain & procurement	✓	✓	✓	✓	✓	<ul style="list-style-type: none"> Implement and embed new procurement strategy in UHBW, NBT, Sirona & AWP. Align to local authority sustainable procurement strategy– be good to share. Opportunity for joint messaging to market, promoting a circular economy, aligning to economic policy (WECA). Provide a clear drive to business that the collective purchasing power of our top local institutions will be directed to social and environmental value. Targeted projects on single use plastics
Travel & Transport	✓	✓	✓	✓		<ul style="list-style-type: none"> Commission system-wide review of fleet vehicles. Drawing on experience from local authorities (e.g., waste vehicle depots for North Somerset and gritting lorries converted to use recycled veg oil leading to a 90% drop in carbon emissions. Bristol Waste vehicles are electric & hydrogen, and bus policy moving towards electric System review of key policies (active travel, lease vehicles, expenses) - draw on best practice nationally to drive change & identify priorities for intervention System visibility of key metrics - e.g. active travel, staff miles, patient journey types. Joined up messaging and infrastructure investment in active travel (e.g. North Somerset bike lease to WGH staff during pandemic). Joined up transport needs assessments. BCC are producing an active travel strategy including pilots. Also Travel West, Sustrans. All to link to the positive health impacts Action for air pollution to be identified. Anti-idling campaigns. Ambulance conveyance and associated travel, plus patient transport
Adaptation	✓	✓	✓			<ul style="list-style-type: none"> Stress-testing plans across H&SC providers and consider collateral impacts (e.g. inability to discharge patients into housing stock that cannot cope with extreme heat). Heatmapping project
Natural Capital Assessments	✓	✓	✓	✓		<ul style="list-style-type: none"> Ensure that all estates are assessed for natural capital value (e.g. as heat sequestration, ecological anchors, contributors to mental health & wellbeing). NS Green Infrastructure Policy – doing a lot of tree planting and rewilding. Link up land etc Consider broader factors in decision making (e.g. Cornwall’s decision making wheel⁴) BCC ecological strategy – pollution, pesticides, green spaces, procurement. Currently very little carbon sequestration in the city
Public health interventions	✓	✓	✓	✓		<ul style="list-style-type: none"> Prioritising those activities that have greatest mutual benefit (e.g. addressing vulnerable housing stock that may result in higher frailty / respiratory morbidity). Most social housing in Bristol is still council owned Need to develop a strategy with private landlords, retirement and care homes, which may require joined up working. Consider training NHS staff in post-discharge assessment of safe/warm homes. Scope to drive other public health interventions including – approaches to urban planning, green/blue infrastructure, and obesity/physical activity

⁴ [Cornwall Council: decision-making wheel \(local.gov.uk\)](https://www.local.gov.uk)

26. Impact of COVID-19

During the COVID-19 pandemic major strides were made nationally to develop the sustainability ambition for the NHS. As we reconfigured health and care services to meet the needs of our communities over the course of the pandemic, we've experienced both sustainability opportunities and challenges.

The COVID-19 pandemic exposed and exacerbated health inequalities, with disproportionate effects on disadvantaged communities. The effects of climate change will similarly affect and disrupt our communities if action is not taken to reduce our carbon emissions and adapt to an already changing climate.

Demands on both frontline and support services staff have been extraordinary. We have worked flexibly, collaboratively and at pace, all of which will be needed for a modern, sustainable healthcare service; however, the ability of staff to consider and reduce the environmental impact of the services they deliver has been affected.

COVID-19 has shown that important changes can be made quickly in a crisis. Climate change is a crisis which needs to be addressed as a priority and with as much speed as the response to the pandemic. In developing this plan, we have tried to learn from and embed those changes that we want to continue. We also need to mitigate to continue the work to reduce the adverse impacts of changes.

Key negative impacts on our sustainability

- Slowed down some aspects of our sustainability project work
- Additional waste and single use products for PPE
- Recycling schemes, such as PVC mask recycling with Recomed and theatre plastics with Scrapstore, were put on hold.
- Reduced our overall efficiency per care episode due to reduced activity levels
- Increased use of private transport
- Externalising our carbon emissions due to working from home – in autumn and winter, emissions from people's homes are likely to be higher than if people were at work.

Key positive impacts on our sustainability

- Massive acceleration of non-face-to-face appointments resulting in less patient travel
- New ways of working, such as home working and virtual meetings have significantly reduced staff travel and made some aspects of work more efficient and more enjoyable for staff
- Decreased gas and electricity consumption across some of our estates
- Reduction in some waste streams (infectious, contaminated) due to reduced theatre activity from COVID disruption
- Improved local air quality in some locations due to annual reduction in NO₂, which is likely linked to reduced travel during the pandemic

27. Conclusion

Following wide consultation with stakeholders this revised Green Plan sets out the key objectives, pledges and actions for us to become a more sustainable health and care system. The actions in this Green Plan for the health and wellbeing of our environment will support the wider system outcomes improving the health and wellbeing our communities, population and staff and help secure the sustainability of our services.

The addition of roadmaps for key areas provide a clear summary of the targets and their timelines.

Over the past year we have established governance which will ensure delivery of the plan is monitored and supported. Crucially we must continue to ensure that the Green Plan approaches to tackling the climate and ecological emergencies are embedded in the way the Integrated Care System operates to ensure the benefits are realised.

The detailed actions and costs of delivering our targets will be further developed over 2023/24 so we have a clear understanding of the resources required.

We will regularly review this Green Plan and further develop our partnerships with organisations across our region to work together to deliver our targets.

28. Glossary

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.

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 carbon neutral 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. This is also called net zero carbon emissions or net zero carbon, because 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.

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

Value based health and care: Meeting the goals of Population Health; improving physical and mental health outcomes, promoting wellbeing, and reducing health inequalities, for the whole population and not just those who present to services. Delivered through a focus on achieving the outcomes that matter to people and making best use of our common resources.

29. Approval and sign off process

Core plan development team:

- Tricia Down, Associate Director Strategic Estate Development and Sustainable Health, NBT
- Megan Murphy, acting Sustainability Manager, NBT
- Sam Willitts, Head of Sustainability, NHS BNSSG ICS
- Luke Champion, Energy and Sustainability Manager, AWP
- Kelly Scott, Energy & Sustainability Lead, Sirona Care and Health
- Ned Maynard, acting Head of Sustainability, UHBW

Executive support:

The following are executive leads for sustainability in their respective organisations. They have endorsed the overarching aims and proposed delivery approach.

- Glyn Howells, SRO and Chief Financial Officer, NBT
- Sarah Truelove, Deputy Chief Executive and Chief Finance Officer, NHS BNSSG ICB
- Neil Kemsley, Chief Finance Officer, UHBW
- Simon Truelove, Chief Financial Officer, AWP
- Clive Bassett, Sirona Care and Health

Approval:

Formal approval: Healthier Together Executive Group DATE

Appendices

Appendix 1: Case studies

CASE STUDY

GSP – Nordic Walking

Green Care Models



Problem

Low levels of connection with nature amongst populations experiencing inequalities in mental health outcomes.



Solution Overview

Grants to increase the range of nature and health interventions targeting health inequality populations alongside strengthened referral pathways both from the health system but also the community

Project Background

The BNSSG Green Social Prescribing Programme Learning (now rebranding as Healthier with Nature) has funded a range of projects across BNSSG that both help people connect with nature to improve their health but also work to protect the natural environment.

One of these programmes is a series of Nordic Walking courses taking place in Inner City East Bristol. Nordic Walking is an established intervention that delivers both improved mental and physical health. It builds physical fitness, improves posture and develops supportive peer relationships.

Nordic Walking and the related health benefits have tended to be largely enjoyed by populations who have better health outcomes. The funded project looked to address this by introducing sessions in Easton, Bristol in partnership with two GP surgeries. Sessions are run in partnership between a walking organisation, a local community development worker and two local GP surgeries.

Taster sessions raised awareness and helped recruit walk leaders from the local community and then link workers and GP refer people to a series of 6-week courses.

Process for Improvements

We had clear outcomes in mind.

1. More connection with nature from priority populations (to improve their health outcomes)
2. To embed nature and health interventions in the health system

We then secured some resource for NHS England and other sources to achieve this broad aim but then trusted a range of stakeholders to find the best ways to deliver on the two aims outlined above.

After an engagement process and round of community grants that followed, we are now funding over 40 projects across BNSSG which if they meet their targets will improve the mental health of around 4000 people. Many of these projects also protect and natural environment.

Outcomes

The Nordic Walking Project we are highlighting in this case study will support around 100 people in the Easton area of Bristol to reduce self-reported anxiety and improve self-reported happiness. However, we are also working with partners to measure impact on waiting lists, number of health appointments and possibly prescription of medication.

These outcomes are reported collectively for all the projects and will provide a strong overall data set. This is backed up by individual case studies.

Project Top Tips

Trust communities to find and then deliver their own solutions

Identify and support green champions within both the community and statutory bodies

Create spaces where stakeholders can come together and create partnerships and joint working

Work with existing structures such as PCNs, ICPs, Local authorities or VCSE anchor organisation that already hold local relationships

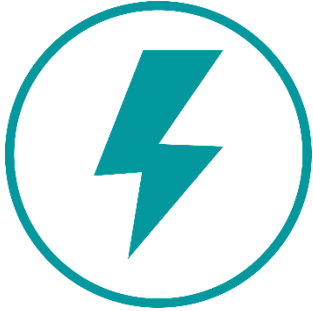
Celebrate and share good news case studies it keeps partners engaged.

Contact: Steve Spiers
Green Social Prescribing
Manager
BNSSG CCG
steve.spiers@nhs.net
07825 647 783

CASE STUDY

Chiller Optimisation

Energy Efficiency



Problem

900kW chiller using large amounts of energy, with no strong correlation with external temperature. Chiller and chiller pumps also suffering from early failures and large maintenance costs.



Solution Overview

Review of BMS control strategy resulted in several initiatives to reduce the time the chiller and associated pumps were running saving energy, cost, carbon and increasing the expected life of the equipment.

Contact: Matt Gitsham
Carbon and Energy Manager
North Bristol NHS Trust
Matthew.Gitsham@nbt.nhs.uk
07825 647 783

Project Background

The Learning and Resource Building's chiller was installed in 2010 when the building was built. The chiller is a 900kW Carrier unit supplying a primary circuit at 6°C with a nominal return of 12°C.

The chiller should have been operating 7am-7pm and should not switch on until the ambient temperature exceeded 10°C. We demonstrated that in fact the chiller was running 24/7 with no regard for the ambient temperature.

We also demonstrated that the two sets of secondary pumps were not being switched off when the systems they served did not require chilled water, particularly the pumps serving the AHUs. These pumps were running 8,760 hours per year, despite analysis showing they were only likely to be required 2,000 hours per year.

Further, we noted that the pumps were all running far too fast leading to a vastly reduced difference between the flow and return temperatures, damaging chiller efficiency and wasting pump energy.

Process for Improvements

Working alongside NBT's BMS contractor, our Carbon and Energy Manager assessed the various issues affecting the chiller and using metered energy data put forward a business case for making improvements.

The BMS contractor was able to determine the timeclock and external ambient interlock issues were due to mistakes in the code and they resolved them quickly. They also added new code that switched off the secondary pumps when there was no requirement for them to run.

Changes to pump speed were achieved by adjusting the BMS controls already in place. Future work will involve optimising the temperature set point of the chiller, raising it when the cooling load is low.

Outcomes

Energy metering data demonstrates the electricity cost associated with the chiller and chiller pumps has more than halved since these changes were implemented. In the first year this has saved the trust over £35,000 on an initial outlay of £400 and nearly 70,000kg of CO₂. We also expect to have significantly decreased the wear and tear on the chiller and pumps, reducing their annual maintenance costs and increasing their overall life.

Project Top Tips

Confirm the timeclock settings match the requirement of the building.

Confirm the timeclock is working correctly by checking logs of water temperature.

Confirm the ambient interlock is working correctly by comparing the outside temperature to water temperature logs.

Confirm pumps switch off when the equipment they serve (such as AHUs) do not require cooling (or heating).

Assess whether pump speeds are correct by comparing flow and return temperature if they are very similar consider reducing pump speed.

ⁱ [Natural England: An estimate of the economic and health value and cost effectiveness of the expanded WHI scheme 2009](#)

ⁱⁱ BNSSG 5-Year Plan

ⁱⁱⁱ [Dutch Cycling: Quantifying the Health and Related Economic Benefits \(nih.gov\)](#)

^{iv} NICE Guidance NG6: [Excess winter deaths and illness and the health risks associated](#) with cold homes

^v BNSSG 5-Year Plan

^{vi} 2017/18; PHOF, PHE NCMP and Child Obesity Profile

^{vii} BNSSG 5-Year Plan

^{viii} Healthier Together Citizen Panel Survey, conducted 2020

^{ix} BNSSG 5-Year Plan

Meeting of the Trust Board of Directors in Public on Tuesday 12 September 2023

Report Title	Pharmacy Technical Services Outline Business Case
Report Author	Michael Compton c/o Akeso co. LTD
Executive Lead	Stuart Walker, Chief Medical Officer

1. Purpose

The outline business case paper details the requirement to transform pharmacy technical services across the BNSSG ICS and presents the preferred option which has been derived from a full options appraisal undertaken by a specialist external consultancy firm (Akeso). The intention is to develop the outline business case into a full business case to bid for capital funding from NHSE with a Capital Departmental Expenditure Limit (CDEL) uplift for the BNSSG ICS.

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

In 2020, Lord Carter of Coles conducted a review of NHS Pharmacy Aseptic Services in England, which recognised nationally that aseptic services are experiencing significant challenges based on increasing growth in demand, a lack of capacity to meet the demand and aging aseptic units requiring investment to maintain.

These challenges are also reflected locally at University Hospital Bristol and Weston (UHBW), and North Bristol NHS Trust (NBT) where the rising demand in aseptic services has been highlighted along with the aging estate:

- NBT is approaching maximum production output with limited ability to expand their current site of operations.
- UHBW Bristol has multiple aging aseptic sites that are approaching maximum capacity with significant reinvestment required in the coming years. The additional requirements because of Annex 1 of the Good Manufacturing Practice (GMP) regulations are expected to accelerate and increase the cost of necessary reinvestment required.

This outline business case is predicated on the requirement for capital funding from outside of the BNSSG ICS CDEL. This funding would be made available for applications as part of the national NHSE Infusions and Special Medicines Programme following on from Lord Carter of Coles' Transforming Aseptic Care in England Report.

This paper represents an application for a portion of the £275m national funding from NHSE. Following successful allocation of £75m to phase 1 pathfinder initiatives, this project would be funded through the remaining allocation £200m, which is expected to be made available in FY 2025/26.

UHBW and NBT have come together to initiate a project to assess the opportunities available to transform their pharmacy aseptic and technical services at an ICS level.

The project team have assessed a variety of options to develop Pharmacy Aseptic and Technical Services (PATs) in the ICS and have worked closely with all service leads across the two trusts to ensure operational and regulatory requirements are fully understood in the development of a future service option.

UHBW and NBT are seeking to establish and operate a new, fully MHRA licensed off-site aseptics and technical services hub, supported by existing on-site spokes at both

Trusts to deliver the required capacity – Option 4c of the Outline Business Case Options Appraisal.

The proposal capitalises on existing MHRA licensing, and provides futureproofing of pharmacy technical services in terms of growth, service developments (e.g. NHS@Home) and technical advances in medicine (e.g. Genomics).

The transformation aims to deliver service efficiencies, and ultimately enhance patient safety, patient care, and the patient experience through fulfilling the unmet need and releasing nursing time to care, consistent with the recommendations in the Transforming NHS Pharmacy Aseptic Services in England Report, Lord Carter 2020.

The proposed operating model will also aim to provide services to NHS organisations within other integrated care systems across the country, helping to bridge the demand gap between external suppliers and NHS requirements, as well as creating commercial opportunities in collaboration with the existing market.

This business case has been developed in line with the HMT Blue Book Guidance in accordance with the five case methodology.

3. Strategic Alignment

The case aligns with the Trust strategy ***‘Embracing Change, Proud to Care: Our 2025 Strategy’*** through enabling significant update to the old hospital estate, and going some of the way to addressing one of the areas for improvement identified within the strategy:

‘Although we have made major improvements to our hospital estate, the physical capacity and environment in some of our buildings is still inadequate and there is more work to do.’

Implementation of the preferred option would enable us to ***‘continue to develop our estate and provide a modern, nurturing environment for staff and patients’***, as well as realise the ambitions related to our specialist and regional services:

‘1. Consolidate and grow our specialist portfolio. We offer specialist services in all our hospitals and we have assessed that our core areas of excellence are where we expect demand to continue to rise, from both demographic growth, our reputation and national service designations. We are planning to target growth primarily in the following services:

- ***Haematology and oncology services including the introduction of new immune effector cell treatments and increased clinical research trials through a further development of the Bristol Haematology and Oncology Centre’***

Implementation of the preferred option aligns with the ambition within the strategy to ***‘Invest in our hospital estate and a healing environment creating the physical capacity required to support our specialist and tertiary care demand, upgrade our core infrastructure’*** and ***‘ensure that adequate estate options are available for future clinical or non-clinical developments.’***

The recommendations in the report also align to all elements in the UHBW Trust vision:

‘grow our specialist hospital services and our position as a leading provider in south west England and beyond’

‘work more closely with our health and care partners to provide more joined up local healthcare services and support the improvement of the health and wellbeing of our communities’

‘become a beacon for outstanding education and research and our culture of innovation.’

The paper recommends developing a hub and spoke model for the provision of pharmacy technical services, to manufacture products for multiple integrated care systems across the country, futureproofing the service regarding capacity and growth. It lays the foundations for innovative technologies in terms of both automation and new medicines.

Development of the paper has been collaborative between key stakeholders in the acute hospitals within the BNSSG ICS. The recommendations have been derived from qualitative and quantitative information provided by pharmacy technical service leads, with shared decision making at the core in order to deliver care to our patients in a more joined up approach across the ICS. Furthermore, key stakeholders from national teams have been engaged in the project to ensure a substantiated approach to aligning the recommendations with national strategy.

The concept of the project aligns to the BNSSG Strategic Framework for Integrated Care through enhancing productivity and value for money in the acute sector by leveraging economies of scale, and by following an innovative and asset-based approach. If realised, the space to be brave and innovative relating to emerging fields such as genomics and new medicines will be created, further reflecting system level and national priorities.

4. Risks and Opportunities

Risks

Risk of requiring significant local financial resource would be presented in not proceeding with the case.

-Service delivery through the current technical services estates is not sustainable in the long term, and would require renovation and maintenance in line with legislation to ensure adherence to the regulations of the MHRA and new standards such as Annex 1 of GMP. This would place a substantial financial burden on the Trusts/ICS, along with a risk of down time where refurbishment/ renovation is required, impacting integrated care systems beyond BNSSG for whom UHBW are a current supplier.

-There would be an increasing over-reliance on the commercial sector/ third party suppliers in line with demand growth, meaning potential unavoidable cost pressures and decreased resilience in an already fragile supply chain.

-Opportunities for innovation may be restricted due to finite capacity and limited room for growth.

Key delivery risks:

The requirement to re-evaluate options for delivery of pharmacy technical services in the region would be necessary if national funding was not allocated to the project. Considerable efforts have been made to liaise with NHSE colleagues and align to expectations; these efforts will continue to further minimise this risk.

The necessary workforce may not be available to support the preferred model. This would be mitigated through exploration of new approaches to skill mix, early initiation of recruitment and phased waves to reduce recruitment burden and impact of risk. Creating training pipelines for delivery of the required workforce.

Delays to the project’s transitional timelines may cause a reduction in aseptic services across the ICS which cannot be covered elsewhere, particularly regarding radiopharmacy services where UHBW are the key supplier in the SW region. Services and facilities would transition on

a scaling basis and where necessary, would dual-run facilities to cover any potential down-time of services in order to mitigate the risk.

A fully detailed Risk Log can be found in the Management Case of this Outline Business Case with impact and severity scoring.

Opportunities

Supporting development of the case into a full business case would mean the Trust and ICS would have the opportunity to develop an exemplar pharmacy manufacturing unit, improving and futureproofing service delivery in terms of capacity, growth and innovation. The unit would service other integrated care systems in the country, fulfilling unmet needs in the market and creating commercial viability and income to re-invest into further growth and innovation. The supply of ready to administer (RTA) products would also see nursing time released, which could be redirected towards caring for our patients.

Furthermore, the stature of the facility could positively impact the reputation of UHBW, and increase the appeal of UHBW as an employer, attracting more talent into the organisation and region.

5. Recommendation

This report is for **Approval**

The Board is asked to approve the development of this outline business case into a full business case to present to NHSE in order to bid for national funding and regional CDEL uplift for the transformation of pharmacy aseptic and technical services in line with the preferred option.

6. History of the paper

Please include details of where paper has previously been received.

UHBW Diagnostics and Therapies Divisional Board	26 th April 2023
UHBW Clinical Strategy Delivery Group	15 th May 2023
NBT Core Clinical Services Divisional Group	16 th May 2023
UHBW Strategic Estates Development Programme Board	18 th May 2023
UHBW Capital Programme Steering Group	23 rd May 2023
NBT Business Case Review Group	5 th July 2023
UHBW Finance, Estates and Digital Committee	25 th July 2023
UHBW Executive Committee	7 th August 2023



UHBW & NBT Pharmacy Aseptic and Technical Services Short Form Business Case Template £5m - £25m Schemes

SECTION 1: SCHEME OVERVIEW

SCHEME DETAILS

PROJECT DESCRIPTION	Region:	South West
	STP / ICS Name:	Bristol, North Somerset, and South Gloucestershire
	Lead Organisation for the Scheme:	University Hospital Bristol and Weston NHS Foundation Trust (UHBW), North Bristol NHS Trust (NBT)
	Title of the Scheme:	Pharmacy Aseptic and Technical Services
	One Line Description of the Scheme:	UHBW and NBT are seeking national capital funding to establish a pharmacy technical services hub model to increase production and capacity of these services to better meet current and future patient requirements and support national supply constraints.
	Specific Sites for Investment:	<ul style="list-style-type: none"> ▪ UHBW – Bristol Hospital Sites ▪ NBT – Southmead Hospital Site ▪ UHBW - Weston General Hospital (WGH) Site
Other Organisations Impacted by this Scheme:	<ul style="list-style-type: none"> ▪ BNSSG ICB ▪ NHS Hospitals in the South West Region ▪ Wider NHS Organisations serving as potential customers to the proposed scheme 	

<p>BRIEF SCHEME OVERVIEW</p> <p>Summarise the key dimensions of the scheme in terms of the outputs that will be enabled in service terms as a consequence of the investment.</p>	<p>This business case is predicated on the assumption of capital funding from outside of the BNSSG ICS CDEL from nationally available funding as part of the national NHSE Infusions and Special Medicines Programme following on from Lord Carter of Coles' Transforming Aseptic Care in England Report.</p> <p>This represents an application to a portion of the £275m national funding from NHSE. Following successful allocation £75m to phase 1 pathfinder initiatives, this project be funded through the remaining allocation £200m. As with the phase 1 pathfinder initiative, this business case will also be reliant on an uplift of CDEL limits. While this has not been agreed to or approved yet, NHSE stakeholders have indicated that this will be allowed.</p> <p>University Hospital Bristol and Weston (UHBW), combined with North Bristol NHS Trust (NBT) have come together to initiate a project to assess the opportunities available to transform their pharmacy aseptic and technical services. The project identified in 2019 but was delayed due to COVID-19 and was re-initiated in the middle of 2022 once the pandemic pressures had subsided. Given the proportional split of current production volume output and overall scale of operations, UHBW will act as a lead organisation as part of this project. Both organisations have considered this appropriate in the context of current working operations, expected future demand profiles and the intended working operations of the preferred option.</p>
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	<p>Since then, the project team have assessed a variety of options to develop Pharmacy Aseptic and Technical Services (PATS) in the region and have worked closely with all department leads across the two trusts to ensure operational and regulatory requirements are fully understood in the development of a future service options.</p> <p>To ensure PATS across Bristol, North Somerset and South Gloucestershire ICS continue to address growing demand, UHBW and NBT are seeking to establish and operate a new, fully MHRA licensed off-site regional aseptics and technical services hub, supported by existing on site spokes at both Trusts to deliver the required capacity (infrastructure, equipment and crucially, the skilled workforce) and capability (including improved batch production capacity) to develop an NHS-leading pharmacy aseptics and technical service, resilient to future demand and pressures.</p> <p>The transformation aims to deliver service efficiencies, and ultimately enhance patient safety, patient care, and the patient experience through meeting the unmet need and releasing nursing time to care, consistent with the recommendations in the Transforming NHS Pharmacy Aseptic Services in England Report, Lord Carter 2020</p> <p>The proposed operating model will also aim to provide services to other NHS providers, helping to bridge the demand gap between external suppliers and NHS requirements.</p> <p>This business case has been developed in line with the HMT Blue Book Guidance in accordance with the five case methodology.</p>
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LEAD ORGANISATION DETAILS

SENIOR RESPONSIBLE OFFICER (SRO) DETAILS	Title	Medical Director and Deputy Chief Executive Officer
	Name	Professor Stuart Walker
	Organisation	University Hospital Bristol and Weston NHS Foundation Trust
	Office tel.	0117 3423640
	Mobile tel.	
	e-mail	Stuart.walker@uhbw.nhs.uk

APPENDICES CHECKLIST

APPENDIX	COMPLETED / ATTACHED (Y/N)
Appendix 1 – Additional Programme Detail	Y
Appendix 2 – Schedule of Works	TBC
Appendix 3 – OB Forms	TBC
Appendix 4 – Key Estates Information	TBC

SECTION 2: PROGRAMME SPECIFIC INFORMATION REQUESTS

PROGRAMME TO REQUEST SPECIFIC REQUIREMENTS FROM PROVIDERS

PROPOSED BENEFITS AS A RESULT OF CAPITAL INJECTION

Please provide a description of the anticipated benefit of the scheme on:

- production and supply of ready to administer aseptic infusions.
- anticipated patient safety benefits
- resilience against increases in demand
- release in WTE nursing capacity
- Contribution to the NHS Net Zero aspirations

- **Production & Supply of ready-to-administer aseptic infusions:** Based on the key benefits of, batch scale production, releasing nursing time to care and meeting future growth in demand, it was decided that the initial product scope for the off-site hub would focus on products ranging from chemotherapy, immunotherapy, central intravenous additive services (CIVAS), parenteral nutrition and radiopharmacy aseptic products, as well as pre-packs and non-sterile products. The product portfolio will remain under review to ensure the benefits continue to be realised and the overall demand for aseptic products is considered. However, for the purposes of this business case, we have not included costs or benefits related to pre-packs or non-sterile manufactured items. For the purposes of this business case, all numbers presented allow for separation of radiopharmacy from the other in scope aseptic products as defined by NHSE (which we have considered as chemotherapy, immunotherapy, parenteral nutrition and CIVAS). While the authors recognise that the allocated NHSE funding pot is not currently intended for radiopharmacy, there is recognition of the sense that it makes to include radiopharmacy. This is for several reasons.
 - In the context of pharmacy aseptic and technical services, it is important to note that radiopharmacy does not act in total isolation, independent of other service areas.
 - One of the stated goals within the critical success factors working session, during the development of this business case, was to improve internal collaboration capabilities and provide a greater level of contingency in terms of both staffing and facilities. Similarly, in the context of ICSs and the business case requirements of improving external collaboration, we have recognised that we can best support this by improving internal PATS collaborative ability. By providing a single facility from which all core operations will work, this will help to support this aim.
 - Radiopharmacy, along with NHSE in-scope aseptic areas, aligns closely with the NHS Long Term goals regarding improved cancer diagnosis and treatment.
 - The current UHBW radiopharmacy facility supplies to multiple external organisations, including NBT. Given this, and the fact that these services have limited external regional resilience, it makes logical sense to improve this service line in looking to build resilience and improve patient outcomes.
 - Radiopharmacy services is included in the context of the wider South West aseptic services strategic approach.
 - Lastly, in the context of the preferred option (involving a new hub off site), and the current UHBW radiopharmacy site conditions, it makes financial and strategic sense to include these services.
- **Production & Supply of ready-to-administer aseptic infusions (continued):** If needed, the structure of the model design allows for separation of the radiopharmacy elements. Total output for the Off-site hub and the local hospital satellite services will increase from approximately 46.5k doses per annum to 339k doses per annum across UHBW and NBT, with radiopharmacy excluded. Conversely, total dose output rises from 58.5k to 381k dose per annum when radiopharmacy is included. C.25% of the total need of high-cost products (c. 14k dose units, with the majority being chemotherapy products) are purchased from third-party commercial suppliers which are also facing capacity constraint with extended lead times (from 3 to 40+ days). Establishment of the new hub, however, will increase in-house capacity to levels which will remove the high dependency on the third-party sector and significant cost elements. For example, the Weston General Hospital site, which has no pharmacy aseptic production capacity, had an outsourcing cost of £4.9m for 2021/2022 alone. When considered in the context of demand growth, this will represent significant cost avoidance and medication budget efficiency resulting in better use of public resources. One of the stated goals of NHSE's Infusions and Special Medicines

Programme is to scale aseptic volume production from 4 million doses per annum to 40 million doses per annum. The proposed volumetric production scale increases will support this ambition.

Baseline Volume (2021/22)				
Medication Category	Made	Purchased	Total Volume	Relative Contribution
Chemotherapy	26,326	13,449	39,775	55%
CIVAs	8,037	-	8,037	11%
Immunotherapy	4,144	16	4,160	6%
PN	8,062	-	8,062	11%
Radiopharmacy	11,892	-	11,892	11%
Total	58,461	13,465	71,926	100%

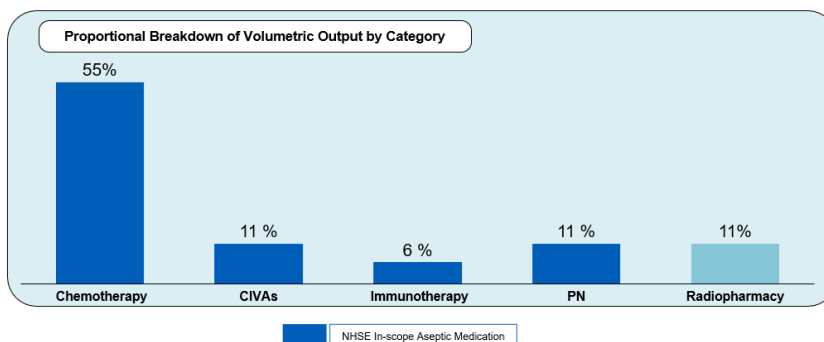


Figure 1: Proportional Breakdown of Baseline Volume

- Anticipated patient safety benefits:** NHS sources have estimated that in 2006, there were approximately 800 patient safety reports per month (nationally) relating to injectable medications. As off 2021, this had risen to a national average of 3750 reports per month, representing a nearly 5-fold increase. While we cannot comment on the causal nature of this increase, the increase in demand for these products will be a significant contributing factor. With the stated goals of the NHS Long Term plan and the expected associated demand in aseptic products, investment in this area is a must. Decreased prescribing and administration errors, by further adoption of standardised or dose banded administration and increase in supply of ready to administer products, as well as reducing infection risk associated with licensed manufacturing. Indeed, this has been stated as a key goal of the NHSE Infusions and Special Medicines Programme. Large scale batch manufacture in a licensed hub will facilitate the movement of 'could-do' and 'should-do' product lines into pharmacy aseptic units which will result in a more optimal skill-mix for preparation and reduce the risks associated with preparation in clinical areas, particularly regarding contamination risk and errors resulting from disruption. A decrease in missed doses is also anticipated due to the availability of ready to administer products. The retention of production capacity in small on-site facilities will further ensure that short shelf life, clinical trials or urgent request items are still available when required. In arriving at the preferred option, retaining on site production capability was recognised by all clinical leads and stakeholders as essential in maintaining the highest standards of patient care.
- Increased ability to contribute toward inpatient reductions:** As outpatient parenteral antibiotic therapy (OPAT) schemes and comparable prioritised care in the community schemes (such as virtual wards) develop, it is envisioned that through effective utilisation and management of the offsite hub facility, it will be possible to contribute to these ambitions. This will have direct care benefits for patients but will also help to manage demand profiles for acute NHS facilities. Furthermore, it should reduce the number and risk of hospital acquired infections (compounding bed pressure reduction benefits) and should support antimicrobial stewardship goals. Already, there is a growing body of evidence of the benefits of utilisation of OPAT services for patients who are otherwise well enough to avoid hospital admissions or facilitate early discharge. Since November 2021 to February 2023 over 4000 bed days have been saved. A Bristol Area OPAT review from 2022 has listed that one of the key decisions for multi-disciplinary teams (MDTs) in reviewing patient eligibility for OPAT services is the direct capacity available. Furthermore, the same retrospective review highlighted the diversity in patients eligible for this service. By ensuring broad access and

improving patient access, this new facility should act to support reduction of health inequalities.

- **Resilience against increases in demand:** The project will deliver improved resilience particularly with respect to availability of workforce and continuity of supply and output as the products are prepared in-house. In line with the Health Building Note (HBN) 00-07 Planning for a resilient healthcare estate, multiple factors have been identified that can negatively impact facility and system resilience that represent current risks to existing facilities. These include facility downtime because of fire or flood, problems related to transport infrastructure that impact delivery availability, security and staffing wellbeing risks, loss of critical support in the wider supply chain (especially in the context of third-party reliance). The new hub model will therefore ensure improved resilience as demand mapping has first ensured that internal demand is satisfied even in the context of increasing demand. Similarly, to the above, the proposed model reduces the reliance on third-party providers who are already struggling to meet NHS demand at current levels. Increasing capacity in the market provides a safety net for BNSSG and the South West to support their demand and capacity planning across the network. As the hub will be a fully licensed facility it will be positioned to be able to support and act as contingency for other SW NHS Trusts who may require aseptic products.
- **Release in WTE nursing capacity:** Baseline product volume of high use and stable CIVAS products currently produced at ward level by nurses was provided by UHBW sources. Following the Lord Carter of Coles method (of 12.5 minutes per dose and 1950 hours per WTE), a maximum potential of 31 WTE nursing time to care release per annum was calculated. Based on the modelling conducted by the project team, up to 130,000 nursing hours per annum (approximately 66 whole time equivalents (WTEs)) could be released back to patient care activities by removing some of the requirement for nurses to make the injectable medicines on the wards. This has only been considered from a UHBW and NBT (direct) nursing time to care standpoint, but it is also expected that indirect nursing time could be released through supply of products to other NHS partners.
- **Release in hospital beds:** At a national level, availability of ready to use medicines could free up to 1 million bed days a year. This benefit has not been quantified at a regional level due to its complexities, but it is anticipated that this benefit will be realised across the organisations through the preparation of Outpatient Parenteral Antimicrobial Therapy (OPAT) products, and through reductions in adverse incidents and time to first dose. Although the national project is still in the initial stages, the project team have every confidence that this project will release these benefits across BNSSG and surrounding region.
- **Support the four ICS strategic priorities outlined in the BNSSG Strategic Framework V3:** Through investment and funding in this area, positive contributions can be made to all priorities -

 - Improve outcomes in population health and healthcare – as noted, aseptic ready to administer medication plays an integral role in a variety of patient care pathways and outcomes. Through effective investment, there should be a reduction in treatment delays (through a reduction in reliance in third party providers and associated delays), patient safety incidents (through improved facilities and standardisation of care) and overall patient experience and outcomes. Associated wider benefits such as reduction in bed days etc, should also benefit patients not directly treated by aseptic means.
 - Tackle inequalities in outcomes, experience, and access – through enhanced network demand resilience, external supply capability and overall product output flexibility, this will greatly improve the reactivity of services to patients and enhance access for patients. For example, incidence and mortality rates from respiratory disease and associated infections are significantly higher from disadvantaged groups and individuals from areas of social deprivation. There is already evidence of positive outcomes from respiratory infections treated through OPAT care in the BNSSG area. Enhanced support for such services through

	<p>improved aseptic contributions will therefore help to reduce health inequalities.</p> <ul style="list-style-type: none"> ○ Enhance productivity and value for money – through utilisation of a new hub facility, the direct productivity and value for money benefits will be twofold. Firstly, there will be a direct financial saving through a reduction in reliance on third-party vendors. Secondly, there will be greater leverage of economies of scale in the production of aseptic products through workforce efficiencies. More broadly, there will be productivity gains through the release of nursing time to care and value for money benefits by support of NHS-to-NHS product supply. ○ Help the NHS support broader social and economic development – The preferred option will require a significant investment into a new facility. In bringing this facility online, there will be a requirement to recruit relatively large numbers of staff. These jobs will be specialist positions in a niche area of science and healthcare resulting in numerous employment benefits derived from direct (taxation) and indirect (local spending investment) benefits to the local area. Furthermore, there will be a requirement for non-technical roles such as specialist cleaners and transport couriers, further supporting the employment benefits. More broadly, through healthcare improvements and reductions in health inequalities, this will have economic benefits through improved productivity and reduction on public sector service demand (most notably related to healthcare provision). <ul style="list-style-type: none"> ▪ Contribution to the NHS Net Zero Aspirations: The design and implementation of the Preferred Option (Option 4c, see Economic Case) will be in accordance with the NBT's Green Plan and UHBW's, outlining the commitment to improving sustainability throughout the organisations with support for the NHS in the pursuit of becoming the world's first net zero health service. The NHS Green Plan is focused on nine core areas, aligned to the key drivers for change and key sources of carbon emissions, within the NHS. ▪ Increase Investigational Medicinal Products (IMPs) capacity: The current IMP license as held by UHBW is deemed to be broadly underutilised. Accordingly, one of the aims of the new facility will be to enhance the ability to utilise this license facility. This is intended to generate direct financial benefits, and will further support UHBW and NBT reputationally by enhancing their clinical research profile.
<p>TYPE OF SCHEME</p> <p>Please detail the intended output that this scheme intends to deliver. I.e. reconfiguration of an existing site / addition to an existing site, enhancement to existing facilities, etc</p>	<p>The Preferred Option (Option 4c, see Economic Case) will involve establishing a single off-site facility for pharmacy aseptic and technical services. Products produced at the new hub will be distributed to UHBW sites and NBT with excess production capacity prioritised for demand growth, followed by commercial income and release of local nursing time. Local sites (excluding Weston General Hospital will maintain a small satellite facility that will be utilised for extremely short shelf-life, clinical trials, and urgent aseptic preparation requests.</p> <p>This prioritisation has been deemed necessary to ensure stability in the network by ensuring internal patient needs are met first. Excess production will be flexible depending commercial income by supplying products to surrounding Trusts within and beyond the ICS while ensuring the flexibility to address short term internal demand spikes. The project envisions that as the likes of community diagnostic hubs and NHS@Home virtual wards (including OPAT) services mature and develop, there will be greater opportunity for alignment with such strategies to support patient care in the community, and reductions of inpatient services and reduce pressure on acute NHS resources.</p>
<p>CAPACITY CREATED</p> <p>Please set out the additional capacity created by the scheme.</p> <p>Provide figures in the table below.</p>	<p>Product Capacity: The scheme can generate increased capacity in production of Chemotherapy, Immunotherapy, CIVAs, Parenteral Nutrition and Radiopharmacy products, as well as to pre-pack activity and non-sterile products from 46.5k doses per annum to 339k (excluding radiopharmacy, pre-pack and other non-aseptic activities). Capacity will also be available to meet the national or regional level requirements for a limited number of strategic high volume activity batch produced lines. This represents an approximate seven-fold increase in doses per annum across UHBW and NBT.</p> <p>As noted, when radiopharmacy is included the baseline number of 58.5k doses per annum rises to 381k, representing a six and half fold increase. These volumetric</p>

output increases have been conservatively estimated during this preliminary phase. As design elements are refined, it is possible that these estimates will increase further. This increased capacity is expected to meet growth and deliver the unmet need, releasing nursing time to care.

Product volume and scope will continue to be assessed by the project group as the project continues and periodic assessments of the baseline will be made to ensure the project delivers the required benefits.

Nursing Capacity: The scheme will also generate additional capacity in the form of freeing up nursing staff allowing this time to be utilised for patient-facing activities. Based on the detailed and conservative modelling conducted by the project team a up to, of 130,000 nursing hours per annum (approximately 66 whole time equivalents (WTEs)) can be released.

CAPACITY PROFILE – Additional capacity delivered as a result of this investment.

EXPECTED INCREMENTAL CAPACITY																
	Equipment in place	Production capacity *	Fully trained and operational staff *	Estimated Hospital Beds Released & Released Nursing Time to Care												
Y1 H1	Kick off procurement process and define delivery schedule for Isolators and ports	N/A	<p>Preliminary modelling indicates that senior production, QA, QC, and training staff will need to be in post and fully operational during Y1.</p> <p>Consideration for low levels of over recruitment in to UHBW (as lead organisation) operational staff to be assessed by workforce workstream to grow experience workforce in preparation for mid-level positions in both production and QA/QC. At this stage, it will be essential to ensure that over recruitment is at an adequate level that will provide sufficient capacity needed to carry the additional workload associated with validating a new facility.</p> <p>Clinical Leadership Fellows to assist with establishing a recruitment “blueprint” to identify strategy and timelines for recruitment of operational staff, to include training timelines.</p>	N/A												
Y1 H2	Equipment, including isolators and ports to be delivered to hub in staged process as determined in schedule above. Installation and validation to commence on a rolling basis with go live in Q4 following MHRA inspection.	<p>Workforce modelling indicates potential output achievable for go live of Q3 of Y1. However, in looking to achieve this, significant investment into staffing will be required to ensure that they can meet validation and training requirements in line with anticipated go live times.</p> <table border="1"> <tr> <td>Chemotherapy</td> <td>116k</td> </tr> <tr> <td>CIVAS</td> <td>44k</td> </tr> <tr> <td>Immunotherapy</td> <td>16k</td> </tr> <tr> <td>PN</td> <td>36k</td> </tr> <tr> <td>Radiopharmacy</td> <td>26k</td> </tr> <tr> <td>Total</td> <td>238k</td> </tr> </table>	Chemotherapy	116k	CIVAS	44k	Immunotherapy	16k	PN	36k	Radiopharmacy	26k	Total	238k	<p>Once an achievable go-live date is identified, workforce blueprint will be utilised to establish recruitment focus and training team will be in place to implement this strategy.</p> <p>Over the course of Y1 a phased increase to the existing workforce will be implemented to facilitate a safe transition from the existing facility to the new hub. This will increase exponentially towards Q3-4 in anticipation of go live.</p> <p>During Y1, strong focus on recruitment, in line with the blueprint will be undertaken with the aim to increase the workforce up to a minimum of 60-65% of total required workforce. Given the training and validation activities required before staff can contribute to production activities, it has been</p>	<p>Bed release not calculated at this point.</p> <p>Limited excess production capacity mean that initial nursing time released will not be released until Y2. However, depending on management strategy at the time or product demand profile, it may be possible to start releasing WTE nursing time to care during this year.</p>
Chemotherapy	116k															
CIVAS	44k															
Immunotherapy	16k															
PN	36k															
Radiopharmacy	26k															
Total	238k															

			deemed necessary to begin this recruitment drive in Y1.													
Y2 H1	Transfer existing equipment to hub and complete outstanding validation, subject to staffing capacity activities to facilitate 100% output	Phase increase in output modelled in line with workforce planning. All operational isolators in use at project capacity over incremental steps. <table border="1"> <tr><td>Chemotherapy</td><td>139k</td></tr> <tr><td>CIVAS</td><td>53k</td></tr> <tr><td>Immunotherapy</td><td>20k</td></tr> <tr><td>PN</td><td>43k</td></tr> <tr><td>Radiopharmacy</td><td>32k</td></tr> <tr><td>Total</td><td>286k</td></tr> </table>	Chemotherapy	139k	CIVAS	53k	Immunotherapy	20k	PN	43k	Radiopharmacy	32k	Total	286k	Continued efforts will be made regarding the staffing recruitment drive. A target minimum of 70% of the required staff is expected during this phase. Should this target not be achieved or there are significant validation and training disruptions, considerations regarding the revision of the workforce blueprint and go-live date will be completed.	Bed release not calculated at this point. Initial nursing time to care released will be 10k hours, equivalent to 5 WTE. Initial estimates have not taken full OPAT demand into account, so it may be possible to release further time depending on the refinement and maturity of these.
Chemotherapy	139k															
CIVAS	53k															
Immunotherapy	20k															
PN	43k															
Radiopharmacy	32k															
Total	286k															
Transitional Year Impact Y3	All equipment should have full operational capacity. Limiting factor will be staffing recruitment. Subsequent calculations have been based on conservative estimates, but possible that 28/29 benefits will be realised in this year.	<table border="1"> <tr><td>Chemotherapy</td><td>162k</td></tr> <tr><td>CIVAS</td><td>62k</td></tr> <tr><td>Immunotherapy</td><td>23k</td></tr> <tr><td>PN</td><td>50k</td></tr> <tr><td>Radiopharmacy</td><td>37k</td></tr> <tr><td>Total</td><td>333k</td></tr> </table>	Chemotherapy	162k	CIVAS	62k	Immunotherapy	23k	PN	50k	Radiopharmacy	37k	Total	333k	During Y3, further workforce recruitment efforts will be made to ensure that this does not significantly impact production capacity. Modelled estimates have assumed that the project will achieve 70-85% of total required workforce.	Bed release not calculated at this point. Nursing time released in this year has been estimated at 21k hours, equivalent to 11 WTE.
Chemotherapy	162k															
CIVAS	62k															
Immunotherapy	23k															
PN	50k															
Radiopharmacy	37k															
Total	333k															
Recurrent Full Year Impact Y4	N/A	<table border="1"> <tr><td>Chemotherapy</td><td>185k</td></tr> <tr><td>CIVAS</td><td>71k</td></tr> <tr><td>Immunotherapy</td><td>26k</td></tr> <tr><td>PN</td><td>57k</td></tr> <tr><td>Radiopharmacy</td><td>42k</td></tr> <tr><td>Total</td><td>381k</td></tr> </table>	Chemotherapy	185k	CIVAS	71k	Immunotherapy	26k	PN	57k	Radiopharmacy	42k	Total	381k	Workforce to be taken to 100% if not already achieved prior. Focus on retention and maintaining pipeline for recruitment. Ongoing work will be required to ensure safe staffing levels are maintained throughout by the hub	Bed release not calculated at this point. Peak of 31k Nursing Time to Care Hours released (equivalent to 16 WTE). This benefit has been modelled as diminishing over a 4-year period before staying on a long-term average of 22k hours (11 WTE) owing to demand peaks. The diminishing levels of benefit seen here are in line with the assumption that production capacity will be prioritised to address in house demand growth meaning that excess production capacity volume will diminish over time.
Chemotherapy	185k															
CIVAS	71k															
Immunotherapy	26k															
PN	57k															
Radiopharmacy	42k															
Total	381k															

SECTION 3: PROJECT DELIVERY OVERVIEW

DELIVERABILITY ASSESSMENT

DELIVERY AND TIMETABLE

Please set out the anticipated commercial and procurement route, and provide a simple timeline with key milestones for the procurement and delivery of the scheme

To achieve the objectives in establishing a new off-site pharmacy technical services hub, particular goods and services that need to be procured include:

- Professional services
- Refurbishment and associated works
- Equipment
- Systems

The UHBW and NBT programme have considered potential routes to markets and frameworks, including NHS Supply chain framework and Procure23, but assessment of procurement routes and implementation of the process is to be conducted as upcoming programme activities. Based on success criteria for the project, UHBW and NBT will evaluate the available procurement routes to identify which procurement offers closest fit to project-specific requirements and drivers.

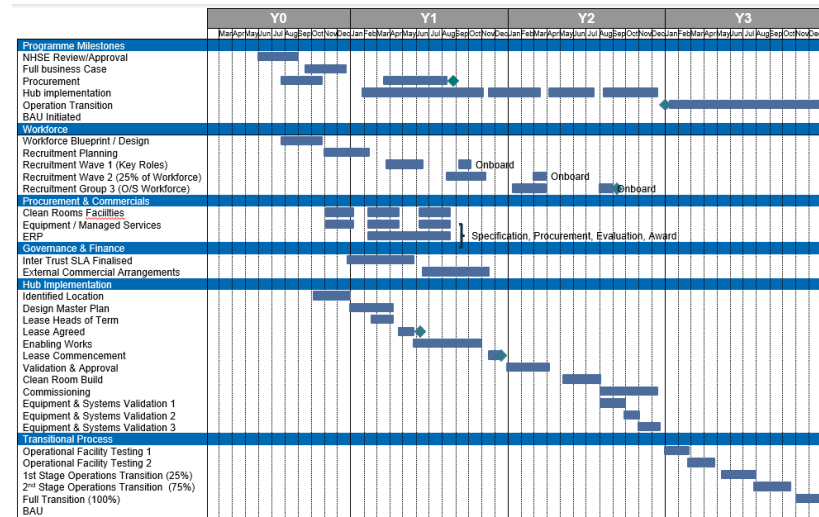


Figure 2: Outline Implementation Timeline

RISKS TO DELIVERY

Please set out the potential risks to delivery and mitigating actions to address these.

A Risk Log is in place for the UHBW and NBT project team and is maintained by the Project Manager. Risks are to be continually monitored and managed by the Project Team, with escalation to the group's Executive Boards when appropriate and will continue to do so throughout the project lifecycle.

Key risks have been classified into four types: financial, transformational change, operations, and workforce. Example risks across these types and supporting mitigation strategies have been captured below:

Financial:

- Necessary capital funding may not be available to support construction of a new pharmacy aseptic and technical services hub. This has been mitigated through review of financial case to align with the national capital funding allocation. Pending approval of NHSE on Business Case, it will also be possible to amend and refine (as needed) given that the capital funding is not expected until 2025 / 26. Considerable efforts have been made to liaise and align with NHSE colleague expectations; these efforts will continue to further minimise this risk. While it is recognised that radiopharmacy is excluded from the current national funding pot, the required capital has been calculated in a method which allows for simple exclusion of these funding elements.
- Significant lead times for procurement of equipment due to high numbers of specialist equipment required. Mitigated by initiation of procurement process at earliest opportunity and scope potential to take delivery of equipment in a staggered process. Additionally, the project team has worked closely with key workstream leads across all aseptic disciplines to understand the key equipment requirements from the outset. As the design matures, personnel will establish relationships with key suppliers to understand lead times and availability of products so that any purchasing requirements can be handled with these lead times in mind.

Transformational Change:

- Timelines and availability of space do not allow for an initial fully automated technology solution where possible; this will be mitigated by design of the hub unit to incorporate ability to replace equipment in future to introduce automated technology if available and supported by the MHRA.
- Delays to the projects transitional timelines may cause a reduction in aseptic services across the region which cannot be covered elsewhere, particularly regarding radiopharmacy services as UHBW are the key supplier in the region. The project will transition services and facilities on a scaling basis and where necessary, will dual-run facilities to cover any potential down-time of services.

Operations:

- Delay to project implementation awaiting MHRA site inspections, especially in the context of the MHRA itself facing staffing challenges, and therefore delaying commissioning. Mitigated through regular liaison with MHRA at regular intervals throughout project and work closely with them to avoid potential delays. The project team have considerable experience in dealing with the MHRA, so effective leveraging of this experience will further help to mitigate this risk.

Workforce:

- The necessary workforce may not be available to support the preferred model or delayed recruitment due to availability. Mitigated through exploration of new approaches to skill mix, early initiation of recruitment and through phased waves to reduce burden of recruitment requirement and impact of risk. This will be further mitigated through consideration of inhouse training and development programmes to augment staffing recruitment drives should significant external recruitment challenges be met. Benefits calculations have factored in gradual phase increases of staffing levels to mitigate this risk and provide a level of achievability reassurance.
- Potential concerns for wellbeing of workforce due to unfavourable shift patterns. The new facility will support staff by providing on-site parking and facilitating public transport, ensuring that the workforce feel comfortable travelling to and from the off-site location. Furthermore, the People Plan will be adhered to, to further mitigate staff welfare related risks.

A fully detailed Risk Log can be found in the Management Case of this Business Case with impact and severity scoring.

Score	Impact	Likelihood
1	None	Rare
2	Low	Unlikely
3	Moderate	Possible
4	Severe	Likely
5	Catastrophic	Certain

Each risk has been allocated an 'impact' score. Each risk has been allocated a 'likelihood' score for each option. Risk rating scores have been individually calculated by multiplying impact and likelihood. These scores have been aggregated to show the total for each option.

Risk Title and Impact Score	Option 4c Major Off-Site Hub	Mitigation Strategy
National funding unavailable (5)	Possible (3)	Business Plan Drafting to align with national strategy.
Procurement related delays (4)	Possible (3)	Planning at the earliest outset to prevent likelihood of delays.
Inability to recruit required staff in relation to preferred option (4)	Possible (3)	Collaboration with workforce strategy team to inform recruitment.
Negative impact on workforce wellbeing owing preferred option working patterns (3)	Possible (3)	Appropriate planning to reduce likelihood and impact.
Patient Care Risk (5)	Unlikely (2)	Full operational mapping to mitigate operational risk and match demand
Reputational Risks (4)	Unlikely (2)	Alignment with national strategy in business case.
Failure to translate design (4)	Possible (3)	Collaboration with estates and facilities and design specialists.
Incorrect cost estimates (3)	Possible (3)	Procurement strategy to maximise competitive advantage and VFM
Contractor default (4)	Unlikely (2)	Procurement strategy to minimise this risk.
Failure to meet performance standards (4)	Unlikely (2)	Collaboration with respective clinical leads.
Incorrect estimated cost of providing clinical services (2)	Possible (3)	Pessimistic cost modelling; iterative reviews.
Changes in the volume of demand for patient services (2)	Possible (3)	Pessimistic output modelling; flexible design capabilities
Estimated income from income generating schemes is incorrect (2)	Possible (3)	Pessimistic output modelling; flexible design capabilities; SCMD demand mapping.
Incorrect time estimates (3)	Possible (3)	Procurement strategy to minimise this risk.
Incorrect cost and time estimates for decanting from existing buildings (2)	Possible (3)	Procurement strategy to minimise this risk.
Regulatory licenses / accreditations cannot be achieved option (5)	Unlikely (2)	Collaboration with respective clinical leads and regulatory stakeholders.
Changes in national agenda shift focus for pharmacy technical services (4)	Unlikely (2)	Collaboration with NHSE colleagues
Model does not sufficiently allow for future changes in infrastructure (3)	Unlikely (2)	Pessimistic output modelling; flexible design capabilities
Local configurations are varied and complex driving additional complexity and cost (3)	Possible (3)	Early collaboration with design specialists.
TOTAL	169	

Figure 3: Risk Log Summary of Preferred option with mitigation strategies

PLANNING ASSUMPTIONS

Please set out the current planning position, and the steps that will be taken to ensure appropriate planning permission is in place.

It is not envisaged that there will be any significant procurement-related commercial or legal issues arising for the design, refurbishment, or associated works of any potential new facility. Once the new hub site has been identified, the need for landlord permission or planning permission to complete the required construction will be assessed, but there is no reason to expect that planning permission or Building Research Establishment Environmental Assessment Method (BREEAM) assessment will be required for the hub.

The project does not anticipate any acquisitions or wider impact on other clinical service designs and provisions.

PROVIDER CAPACITY AND CAPABILITY

Please provide a brief overview of the experience of the SRO and Exec Team accountable for the project.

Across the two Trusts, there are several experienced and knowledgeable personnel with assigned roles within the programme delivery. Key personnel of note include:

Professor Stuart Walker. Medical Director and Deputy Chief Executive Officer - Project Senior Responsible Officer
(To be added)

Jon Standing. UHBW Director of Pharmacy
Jon Standing has 26 years of Hospital Pharmacy service and has built up a significant degree of experience having worked in all key areas. He has been a Chief Pharmacist for nearly 10 years, initially in at Yeovil District Hospital and more recently in a University Hospitals Bristol and Weston NHS FT since October 2017. This has given him experience of the varied spectrums of Acute Trusts and an appreciation of the different challenges set before each.

He currently sits on a wide range of groups, committees and boards (listed below) that has given him a broad understanding of the current areas of focus and strategic NHS delivery;
-National Pharmacy Supply Group
-Specialised Pharmacy Service National Medicines Board

- Medicines Optimisation Clinical Reference Group
- National High-Cost Medicines Steering Group
- SW Regional Medicines Optimisation Committee
- SW Regional Pharmacy Workforce Strategy Group
- SW Regional Pharmacy Education and Training Group
- Chair Regional Pharmacy Procurement Group
- Regional Clinical Senate Assembly member
- Chair UHBW Medicines Advisory Group
- Chair UHBW Medicines Governance Group
- UHBW Antimicrobial Steering Group
- UHBW Advanced Therapy Molecular Products Group
- UHBW Clinical Quality Group
- UHBW Intrathecal Medicines Group
- UHBW Medical Gas Group

Matthew Kaye. NBT Director of Pharmacy

Matt has 22 years of NHS hospital pharmacy experience including 18 months in his current role as Director of Pharmacy for NBT.

Prior to this role, he was the Chief Pharmacist at Northern Devon Healthcare NHS Trust for 6 years. As part of this role, he had 2 secondments into operational management during the pandemic. These secondments included involvement in the North Devon District Hospital (NDDH) "Our Future Hospital" programme as NDDH was one of 40 hospitals included in the Government's New Hospital Programme (NHP) and was confirmed as a priority for investment in 2020, plus involvement in building a new majors unit for the Emergency Department to develop COVID-19 and non-COVID-19 pathways.

In addition to this experience, Matt is the Chair of the SW Pharmacy Aseptic Group and hosts the Regional QA Service in NBT. Matt is a member of the SW Genomics Steering Group with UHBW and NBT acting as leads for the SW Genomics Medicines Service Alliance (GMSA). Matt is also the SW GMSA Chief Pharmacist (which lies as part of his role as NBT Director of Pharmacy)

Helen Kingston. UHBW Associate Director of Pharmacy – Adult Cancer and Aseptic Services

Helen has been working in NHS Hospital Pharmacy for more than 25 years, with over 20 years been spent working in aseptic technical services. Helen has been employed in the Parenteral Services Unit at UHBW since November 2001 initially as the Lead Clinical Trials and Aseptic Services Pharmacist and then the Senior Aseptic Lead for Chemotherapy.

Helen was promoted to the position as the Associate Director of Pharmacy - Adult Cancer and Aseptic Services back in September 2021. In this position she is the named Accountable Pharmacist for PSU. Helen has extensive knowledge and experience of working and managing an aseptic unit that supplies Chemotherapy and Parenteral Nutrition under section 10 exemption.

Helen has also been involved in several in house improvement projects with UHBW. Most notably, she is currently involved in the UHBW Intrathecal Group, MHRA Inspections Oversight Group and the Weekend Working Group.

Sean Fradgley. UHBW Associate Director of Pharmacy – QA/QC

Sean's qualifications include a BSc(Hons) in Pharmaceutical Sciences (Aston University, 1987), registration as a professional pharmacist (RPharmS/GPhC, since 1988) and a PhD in breast cancer/medicinal chemistry (Cardiff University, 1992). Subsequently, his career has included 9 years in academic research followed by 25 years in NHS hospital pharmacy as a Quality Assurance specialist. He has been in his present post as UHBW Associate Director of Pharmacy, Quality Assurance since October 2018. Within UHBW, he is Chair of the Pharmacy Technical Services/Stores quality review meetings and the UHBW Medical Gas Group, in addition to attending a variety of other local and regional meetings. During his career, he has been directly involved in the design and commissioning of three new pharmaceutical aseptic cleanroom facilities (University Hospitals of North Midlands/PFI, North Bristol NHS Trust/PFI - temporary and permanent).

Kevin Griffiths. UHBW Associate Director of Pharmacy – Production

Kevin has been qualified as a pharmacist for 29 years, the last 26 of which have been spent working as a Technical Services pharmacist in the NHS. He has been in post at UHBW as Associate Director of Pharmacy – Production for the last 4 years. Prior to that he spent 20 years working at the Royal Free Hospital in London during which time he was named as Production Manager on the MIA(IMP) licence, was deputy to the Head of Production and spent a short period

of time acting up as the Head of Production. He also spent 2 years working at Kings College Hospital in London as a Senior Aseptic Services Pharmacist.

Kevin has held several positions on national NHS Technical Services groups and committees, including 4 years as a London representative on the NHS Pharmaceutical Aseptic Services Group (PASG) during which time he led a project to review and update the high-risk injectable drugs list on behalf of PASG.

He is the Lead Station Writer and Assessor for the Health Education England (HEE) National School of Healthcare Science (NSHCS) Scientist Training Programme (STP) for Clinical Pharmaceutical Scientists (CPS), a position held since the start of 2015. He is a member of the NHS Pharmaceutical Production Committee and acts as the NPPC representative to the NHS Technical Specialist Education and Training (TSET) group.

Whilst working at the Royal Free he was the Technical Lead for the successful preparation of a business case for over £2million to carry out a major refurbishment of the Production department and then contributed to the technical assessment of the tender bids to carry out the building works.

Kathy Beard. UHBW Cancer Lead Pharmacist (Weston General Hospital)

Kathy has worked in cancer services for over 15 years. She has held her current post for 3 years. Kathy has worked as aseptic services pharmacist from about 2003 to 2016 when the Weston pharmacy prepared cytotoxic chemotherapy products and total parenteral nutrition for its patients until the unit closed. Since then, Kathy has managed and overseen all outsourcing of aseptic operations and accompanying clinical oversight.

Annika Boloz. UHBW Associate Director of Pharmacy - Radiopharmacy

Annika is a Pharmacist and Clinical Scientist. Since joining the NHS as a hospital pharmacist, Annika completed MSc Clinical Pharmaceutical Science, then PGDip Pharmaceutical Quality and Regulation and is in her final weeks of completing Masters in Business Administration, MBA. Annika is currently undertaking Qualified Person training, aiming to be a named QP on the MIA (IMP) license at UHBW in early 2024.

Annika completed her Scientist Training Programme (STP) in Manchester University Hospitals NHS Foundation Trust, subsequently held roles as Production Manager and Quality Lead. During pandemic Annika was deployed to Nightingale Hospital to work as the Pharmacy CIVAS Lead, and then was involved in setting up the COVID vaccination centre at UHBW.

Annika actively engages in staff development

- National, presenting at conferences (BNMS, UKRG)
- National, Station writer, Assessor at the National School of Healthcare Science
- National, Specialty Writer for Pharmaceutical Science STP Curriculum Review, where Annika introduced leadership training into revised STP curriculum for Clinical Scientist Trainees
- National, co-wrote a UKRG Guidance for Radiopharmacies during the Covid-19 Pandemic
- National, Royal Pharmaceutical Society Mentor
- Associate Lecturer at the UCL, UWE and University of Bath
- UHBW Training Officer for Clinical Pharmaceutical Science trainees

Annika sits on a wide range of groups/committees

- National Infusions & Special Medicines Workforce Working Group
- National NHS England Radiopharmacy Review
- National UK Radiopharmacy Group Committee
- National Quality Assurance Committee
- Regional Short-life Cytotoxic Residue Group
- UHBW Advanced Therapy Molecular Products Group
- UHBW MHRA Inspections Oversight Group

Kate North. NBT Principal Pharmacist - Technical Services and Haematology

Kate North has 11 years of post-qualification pharmacy experience. She has previously worked for Cardiff and Vale University Hospital Board, Royal Surrey County Hospital before specialising in oncology, haematology and aseptic services with Guys and St Thomas' NHS Trust. She has held her current post with NBT for 4 years which includes Accountable Pharmacist role.

In addition to leading the Technical Services and Haematology services with NBT, she is the chair of the NBT Technical Services and Quality Assurance Pharmaceutical Quality System Group, a member

of the NBT Chemotherapy Multi-professional Team Group and a member of the NBT Nutrition Steering Group.

Matthew Smith. NBT Lead Pharmacy Technician - Aseptic Services

Matt has been qualified for over 30 years, with 27 in Technical Services. While working in Reading 1998-2001, he supported the commissioning of new isolators.

Matt has worked at NBT for 22 years, with most time spent as Senior or Lead Technician in Aseptics. Additionally, Matt was named on the MS License for Frenchay Hospital. Following a failure of facility, he facilitated a period of design and installation while having also managed a temporary facility and commissioning of the new department.

In 2010 Southmead and Frenchay merged departments (with Frenchay surrendering their License). Again, Matt supported the design qualification of the new Brunel facility including the installation, qualification, and commissioning of the temporary unit during the building of the current unit.

Matt is currently responsible for maintaining the MHRA and NHSE expectations regarding the facility and work closely with the estates department to ensure that the unit meets their HTM03 planned maintenance schedule without compromising ISO14644 GMP.

Akeso and Co

UHBW and NBT have also commissioned Akeso & Co, an experienced Healthcare and Life Science Consulting firm, to support in the Business Case development and Healthcare planning.

SECTION 4: FINANCIAL OVERVIEW

These Tables can be provided in Excel Form. If a proposal involves multiple Providers, these Tables will need to be completed for each individual Provider.

FUNDING SOURCES

PLEASE SET OUT ALL FUNDING SOURCES FOR THE PROJECT	DHSC CDEL cover £	£24.6 million (inclusive of radiopharmacy) £20.2 million (exclusive of radiopharmacy)
	Other e.g. ICB (please specify) £	£0.0 million (inclusive and exclusive of radio pharmacy)
	Total £	£24.6 million (inclusive of radiopharmacy) £20.2 million (exclusive of radiopharmacy)

CAPITAL EXPENDITURE PROFILE (inclusive of radiopharmacy, Optimism Bias, Planning Contingency and VAT)

FUNDING SOURCE	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/ 2030 - 2047/48 £'000	TOTAL £'000
DHSC CDEL cover funded capital expenditure	0	(2,412)	(22,093)	0	0	0	0	(24,549)
Other (<i>specify</i>)	0	0	0	0	0	0	0	0
Total	0	(2,454)	(22,093)	0	0	0	0	(24,549)

CAPITAL EXPENDITURE PROFILE (exclusive of radiopharmacy, inclusive of Optimism Bias, Planning Contingency and VAT)

FUNDING SOURCE	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/ 2030 - 2047/48 £'000	TOTAL £'000
DHSC CDEL cover funded capital expenditure	0	(2,019)	(18,172)	0	0	0	0	(20,192)
Other (<i>specify</i>)	0	0	0	0	0	0	0	0
Total	0	(2,019)	(18,172)	0	0	0	0	(20,192)

BREAKDOWN OF SCHEME CAPITAL COST (inclusive of radiopharmacy)								
FUNDING SOURCE	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/ 2030 - 2047/48 £'000	TOTAL £'000
Works Costs	0	(394)	(3547)	0	0	0	0	(3,941)
Fees	0	(140)	(1259)	0	0	0	0	(1,399)
Non-Works Costs	0	(1006)	(9058)	0	0	0	0	(10,064)
Equipment Costs	0	(239)	(2,146)	0	0	0	0	(2,385)
Optimism bias	0	(89)	(801)	0	0	0	0	(889)
Planning contingency	0	(89)	(801)	0	0	0	0	(889)
Inflation Adjustment	0	(89)	(801)	0	0	0	0	(889)
VAT	0	(356)	(3682)	0	0	0	0	(4,091)
Total	0	(2,455)	(22,094)	0	0	0	0	(24,549)

Please provide a narrative on the basis of the costs e.g. tendered costs, PUBSEC indices, cost advisor reports. Please **STATE** the following:

1) PUBSEC Indices used:	Previous project estimates validated by independent clinical and clean room advisors.
2) Basis of the costs: HPCG / benchmark rates from cost advisor / tendered costs / schedules of rates / previously tendered rates.	Previously tendered rates with inflationary uplifts applied.
3) Cost advisor Review of the VfM / procurement process.	N/A

BREAKDOWN OF SCHEME CAPITAL COST (exclusive of radiopharmacy)								
FUNDING SOURCE	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/ 2030 - 2047/48 £'000	TOTAL £'000
Works Costs	0	(337)	(3,036)	0	0	0	0	(3,373)
Fees	0	(120)	(1,077)	0	0	0	0	(1,197)
Non-Works Costs	0	(796)	(7,164)	0	0	0	0	(7,960)
Equipment Costs	0	(210)	(1,892)	0	0	0	0	(2,102)
Optimism bias	0	(73)	(658)	0	0	0	0	(732)
Planning contingency	0	(73)	(658)	0	0	0	0	(732)
Inflation Adjustment	0	(73)	(658)	0	0	0	0	(732)
VAT	0	(337)	(3,028)	0	0	0	0	(3,365)
Total	0	(2,096)	(18,072)	0	0	0	0	(20,192)
Please provide a narrative on the basis of the costs e.g. tendered costs, PUBSEC indices, cost advisor reports. Please STATE the following:								
1) PUBSEC Indices used:				Previous project estimates validated by independent clinical and clean room advisors.				
2) Basis of the costs: HPCG / benchmark rates from cost advisor / tendered costs / schedules of rates / previously tendered rates.				Previously tendered rates with inflationary uplifts applied.				
3) Cost advisor Review of the VfM / procurement process.				N/A				

Total	Option 2 - Do Minimum				Option 4c				Differential			
Public Board	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25
Balance Sheet Summary	FY 22/23	FY 23/24	FY 27/28	FY 47/48	FY 22/23	FY 23/24	FY 27/28	FY 47/48	FY 22/23	FY 23/24	FY 27/28	FY 47/48
Opening Balance	0	0	0	0	0	0	23,855,760	16,925,210	0	0	23,855,760	16,925,210
Capital Investment	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation	0	0	0	0	0	0	(346,528)	(346,528)	0	0	(346,528)	(346,528)
TOTAL ASSETS EMPLOYED	0	0	0	0	0	0	23,509,233	16,578,682	0	0	23,509,233	16,578,682
	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25
MCFlow Summary	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0	0	0	0	0	0	0	0	0
Operating Income	0	0	19,106,784	589,428,865	0	0	17,645,241	447,748,451	0	0	(1,461,543)	(141,680,414)
Operating Expenditure	0	0	(19,106,784)	(589,428,865)	0	0	(17,645,241)	(447,748,451)	0	0	1,461,543	141,680,414
C/F Before Financing	0	0	0	0	0	0	0	0	0	0	0	0
Financing (PDC Funding)	0	0	0	0	0	0	0	0	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0	0	0	0	0	0	0	0	0
	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25
I&E Summary	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	19,106,784	589,428,865	0	0	17,645,241	447,748,451	0	0	(1,461,543)	(141,680,414)
Commercial Income	0	0	1,303,719	34,208,181	0	0	2,346,693	61,574,725	0	0	1,042,975	27,366,544
Cost Avoidance	0	0	0	0	0	0	0	0	0	0	0	0
Baseline Trust Funding	0	0	17,803,065	555,220,685	0	0	15,298,547	386,173,726	0	0	(2,504,518)	(169,046,959)
Expenses												
Pay	0	0	(3,933,888)	(103,221,004)	0	0	(5,424,913)	(140,910,799)	0	0	(1,491,026)	(37,689,795)
Non-Pay: Clinical Services	0	0	(14,933,229)	(479,919,248)	0	0	(10,965,302)	(279,901,055)	0	0	3,967,927	200,018,193
Non-Pay: Other	0	0	(239,667)	(6,288,613)	0	0	(592,350)	(15,203,651)	0	0	(352,683)	(8,915,038)
TOTAL COSTS	0	0	(19,106,784)	(589,428,865)	0	0	(16,982,565)	(436,015,505)	0	0	2,124,219	153,413,360
EBITDA	0	0	(580,397)	(15,228,993)	0	0	(20,976)	(3,181,588)	0	0	559,421	12,047,406
Interest	0	0	0	0	0	0	(69,766)	(936,425)	0	0	(69,766)	(936,425)
Depreciation	0	0	0	0	0	0	(346,528)	(7,623,606)	0	0	(346,528)	(7,623,606)
PDC & Finance Charges	0	0	0	0	0	0	(246,382)	(3,172,916)	0	0	(246,382)	(3,172,916)
SUB-TOTAL	0	0	0	0	0	0	(662,675)	(11,732,946)	0	0	(662,675)	(11,732,946)
NET SURPLUS/(DEFICIT)	0	0	0	0	0	0	0	0	0	0	0	0
CUMULATIVE	0	0	0	0	0	0	0	0	0	0	0	0

Figure 4: Combined Financial Position Summary (inclusive of radio pharmacy)

UHBW	Option 2 - DO Minimum				Option 4c				Differential			
	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25
Balance Sheet Summary	FY 22/23	FY 23/24	FY 27/28	FY 47/48	FY 22/23	FY 23/24	FY 27/28	FY 47/48	FY 22/23	FY 23/24	FY 27/28	FY 47/48
Opening Balance	0	0	0	0	0	0	23,855,760	16,925,210	0	0	23,855,760	16,925,210
Capital Investment	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation	0	0	0	0	0	0	(346,528)	(346,528)	0	0	(346,528)	(346,528)
TOTAL ASSETS EMPLOYED	0	0	0	0	0	0	23,509,233	16,578,682	0	0	23,509,233	16,578,682

MCFlow Summary	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0	0	0	0	0	0	0	0	0
Operating Income	0	0	18,526,387	574,199,872	0	0	16,961,590	432,833,917	0	0	(1,564,798)	(141,365,955)
Operating Expenditure	0	0	(18,526,387)	(574,199,872)	0	0	(16,961,590)	(432,833,917)	0	0	1,564,798	141,365,955
C/F Before Financing	0	0	0	0	0	0	0	0	0	0	0	0
Financing (PDC Funding)	0	0	0	0	0	0	0	0	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0	0	0	0	0	0	0	0	0

I&E Summary	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	18,526,387	574,199,872	0	0	16,961,590	432,833,917	0	0	(1,564,798)	(141,365,955)
Commercial Income	0	0	1,303,719	34,208,181	0	0	2,229,359	58,495,989	0	0	925,640	24,287,808
Cost Avoidance	0	0	0	0	0	0	0	0	0	0	0	0
Baseline Trust Funding	0	0	17,222,669	539,991,692	0	0	14,732,231	374,337,928	0	0	(2,490,438)	(165,653,763)
Expenses												
Pay	0	0	(3,462,771)	(90,859,405)	0	0	(4,869,984)	(128,804,451)	0	0	(1,407,213)	(37,945,046)
Non-Pay: Clinical Services	0	0	(14,843,367)	(477,561,365)	0	0	(10,859,453)	(277,591,859)	0	0	3,983,914	199,969,506
Non-Pay: Other	0	0	(220,249)	(5,779,103)	0	0	(569,478)	(14,704,661)	0	0	(349,228)	(8,925,558)
TOTAL COSTS	0	0	(18,526,387)	(574,199,872)	0	0	(16,298,914)	(421,100,971)	0	0	2,227,473	153,098,901
EBITDA	0	0	0	0	0	0	662,675	11,732,946	0	0	662,675	11,732,946
Interest	0	0	0	0	0	0	(69,766)	(936,425)	0	0	(69,766)	(936,425)
Depreciation	0	0	0	0	0	0	(346,528)	(7,623,606)	0	0	(346,528)	(7,623,606)
PDC & Finance Charges	0	0	0	0	0	0	(246,382)	(3,172,916)	0	0	(246,382)	(3,172,916)
SUB-TOTAL	0	0	0	0	0	0	(662,675)	(11,732,946)	0	0	(662,675)	(11,732,946)
NET SURPLUS/(DEFICIT)	0	0	0	0	0	0	0	0	0	0	0	0
CUMULATIVE	0	0	0	0	0	0	0	0	0	0	0	0

Figure 5: UHBW Financial Position Summary (inclusive of radio pharmacy)

NBT	Option 2 - DO Minimum			
	Y0	Y1	Y5	Y25
Balance Sheet Summary	FY 22/23	FY 23/24	FY 27/28	Total
Opening Balance	0	0	0	0
Capital Investment	0	0	0	0
Depreciation	0	0	0	0
TOTAL ASSETS EMPLOYED	0	0	0	0

Option 4c	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Total
Opening Balance	0	0	0	0
Capital Investment	0	0	0	0
Depreciation	0	0	0	0
TOTAL ASSETS EMPLOYED	0	0	0	0

Differential	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Total
Opening Balance	0	0	0	0
Capital Investment	0	0	0	0
Depreciation	0	0	0	0
TOTAL ASSETS EMPLOYED	0	0	0	0

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	580,397	15,228,993
Operating Expenditure	0	0	(580,397)	(15,228,993)
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0

Option 4c	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	683,651	14,914,534
Operating Expenditure	0	0	(683,651)	(14,914,534)
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0

Differential	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	103,254	(314,459)
Operating Expenditure	0	0	(103,254)	314,459
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	580,397	15,228,993
Commercial Income	0	0	0	0
Cost Avoidance	0	0	0	0
Baseline Trust Funding	0	0	580,397	15,228,993
Expenses				
Pay	0	0	(471,117)	(12,361,599)
Non-Pay: Clinical Services	0	0	(89,862)	(2,357,884)
Non-Pay: Other	0	0	(19,418)	(509,510)
TOTAL COSTS	0	0	(580,397)	(15,228,993)
EBITDA	0	0	(580,397)	(15,228,993)
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Option 4c	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	683,651	14,914,534
Commercial Income	0	0	117,335	3,078,736
Cost Avoidance	0	0	0	0
Baseline Trust Funding	0	0	566,316	11,835,798
Expenses				
Pay	0	0	(554,930)	(12,106,348)
Non-Pay: Clinical Services	0	0	(105,849)	(2,309,196)
Non-Pay: Other	0	0	(22,873)	(498,989)
TOTAL COSTS	0	0	(683,651)	(14,914,534)
EBITDA	0	0	(683,651)	(14,914,534)
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Differential	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	103,254	(314,459)
Commercial Income	0	0	117,335	3,078,736
Cost Avoidance	0	0	0	0
Baseline Trust Funding	0	0	(14,080)	(3,393,196)
Expenses				
Pay	0	0	(83,813)	255,251
Non-Pay: Clinical Services	0	0	(15,987)	48,687
Non-Pay: Other	0	0	(3,455)	10,521
TOTAL COSTS	0	0	(103,254)	314,459
EBITDA	0	0	(103,254)	314,459
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Figure 6: NBT Financial Position Summary (inclusive of radio pharmacy)

Total	Option 2 - DO Minimum			
	Y0	Y1	Y5	Y25
Balance Sheet Summary	FY 22/23	FY 23/24	FY 27/28	FY 47/48
Opening Balance	0	0	0	0
Capital Investment	0	0	0	0
Depreciation	0	0	0	0
TOTAL ASSETS EMPLOYED	0	0	0	0

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	17,974,812	557,226,007
Operating Expenditure	0	0	(17,974,812)	(557,226,007)
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	17,974,812	557,226,007
Commercial Income Potential	0	0	291,823	7,657,116
CRB (Cost Avoidance)	0	0	0	0
Baseline Trust Funding	0	0	17,682,989	549,568,891
Expenses				
Pay	0	0	(3,465,731)	(90,937,065)
Non-Pay: Clinical Services	0	0	(14,382,711)	(462,973,132)
Non-Pay: Other	0	0	(126,370)	(3,315,811)
TOTAL COSTS	0	0	(17,974,812)	(557,226,007)
EBITDA	0	0	0	0
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Option 4c			
Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	FY 47/48
0	0	19,598,463	13,667,254
0	0	0	0
0	0	(296,560)	(296,560)
0	0	19,301,902	13,370,693

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	15,425,530	391,077,677
Operating Expenditure	0	0	(15,425,530)	(391,077,677)
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	16,028,178	401,576,321
Commercial Income Potential	0	0	535,261	14,044,682
CRB (Cost Avoidance)	0	0	0	0
Baseline Trust Funding	0	0	15,492,917	387,531,639
Expenses				
Pay	0	0	(4,596,424)	(119,585,076)
Non-Pay: Clinical Services	0	0	(9,955,860)	(254,029,965)
Non-Pay: Other	0	0	(270,598)	(6,963,992)
TOTAL COSTS	0	0	(14,822,881)	(380,579,033)
EBITDA	0	0	602,648	10,498,644
Interest	0	0	(59,706)	(801,398)
Depreciation	0	0	(296,560)	(6,524,330)
PDC & Finance Charges	0	0	(246,382)	(3,172,916)
SUB-TOTAL	0	0	(602,648)	(10,498,644)
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Differential			
Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	FY 47/48
0	0	19,598,463	13,667,254
0	0	0	0
0	0	(296,560)	(296,560)
0	0	19,301,902	13,370,693

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	(3,274,778)	(184,319,611)
Operating Expenditure	0	0	3,877,426	194,818,255
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	(46,651,397)	(46,651,397)

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	(2,549,282)	(166,148,330)
Commercial Income Potential	0	0	243,439	6,387,566
CRB (Cost Avoidance)	0	0	0	0
Baseline Trust Funding	0	0	(2,792,720)	(172,535,897)
Expenses				
Pay	0	0	(1,130,693)	(28,648,012)
Non-Pay: Clinical Services	0	0	4,426,851	208,943,167
Non-Pay: Other	0	0	(144,228)	(3,648,181)
TOTAL COSTS	0	0	3,151,930	176,646,974
EBITDA	0	0	602,648	10,498,644
Interest	0	0	(59,706)	(801,398)
Depreciation	0	0	(296,560)	(6,524,330)
PDC & Finance Charges	0	0	(246,382)	(3,172,916)
SUB-TOTAL	0	0	(602,648)	(10,498,644)
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Figure 7: Combined Financial Position Summary (exclusive of radio pharmacy)

UHBW	Option 2 - DO Minimum			
	Y0	Y1	Y5	Y25
Balance Sheet Summary	FY 22/23	FY 23/24	FY 27/28	FY 47/48
Opening Balance	0	0	0	0
Capital Investment	0	0	0	0
Depreciation	0	0	0	0
TOTAL ASSETS EMPLOYED	0	0	0	0

Option 4c			
Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	FY 47/48
0	0	19,598,463	13,667,254
0	0	0	0
0	0	(296,560)	(296,560)
0	0	19,301,902	13,370,693

Differential			
Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	FY 47/48
0	0	19,598,463	13,667,254
0	0	0	0
0	0	(296,560)	(296,560)
0	0	19,301,902	13,370,693

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	17,394,415	541,997,014
Operating Expenditure	0	0	(17,394,415)	(541,997,014)
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0

Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	Y25 Total
0	0	0	0
0	0	14,700,034	372,180,900
0	0	(14,700,034)	(372,180,900)
0	0	0	0
0	0	0	0
0	0	0	0

Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	Y25 Total
0	0	0	0
0	0	(2,694,381)	(169,816,114)
0	0	3,297,030	180,314,758
0	0	0	0
0	0	0	0
0	0	602,648	10,498,644

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	17,394,415	541,997,014
Commercial Income Potential	0	0	291,823	7,657,116
CRB (Cost Avoidance)	0	0	0	0
Baseline Trust Funding	0	0	17,102,592	534,339,898
Expenses				
Pay	0	0	(2,994,614)	(78,575,465)
Non-Pay: Clinical Services	0	0	(14,292,849)	(460,615,248)
Non-Pay: Other	0	0	(106,952)	(2,806,301)
TOTAL COSTS	0	0	(17,394,415)	(541,997,014)
EBITDA	0	0	0	0
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	Y25 Total
0	0	14,700,034	372,180,900
0	0	508,997	13,355,542
0	0	0	0
0	0	14,191,037	358,825,358
0	0	0	0
0	0	(4,007,528)	(104,246,283)
0	0	(9,843,533)	(251,104,203)
0	0	(246,325)	(6,331,770)
0	0	(14,097,385)	(361,682,256)
0	0	602,648	10,498,644
0	0	(59,706)	(801,398)
0	0	(296,560)	(6,524,330)
0	0	(246,382)	(3,172,916)
0	0	(602,648)	(10,498,644)
0	0	0	0
0	0	0	0

Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	Y25 Total
0	0	(2,694,381)	(169,816,114)
0	0	217,174	5,698,426
0	0	0	0
0	0	(2,911,556)	(175,514,540)
0	0	0	0
0	0	(1,012,914)	(25,670,818)
0	0	4,449,317	209,511,045
0	0	(139,373)	(3,525,470)
0	0	3,297,030	180,314,758
0	0	602,648	10,498,644
0	0	(59,706)	(801,398)
0	0	(296,560)	(6,524,330)
0	0	(246,382)	(3,172,916)
0	0	(602,648)	(10,498,644)
0	0	0	0
0	0	0	0

Figure 8: UHBW Financial Position Summary (exclusive of radio pharmacy)

NBT	Option 2 - DO Minimum			
	Y0	Y1	Y5	Y25
Balance Sheet Summary	FY 22/23	FY 23/24	FY 27/28	FY 47/48
Opening Balance	0	0	0	0
Capital Investment	0	0	0	0
Depreciation	0	0	0	0
TOTAL ASSETS EMPLOYED	0	0	0	0

Option 4c			
Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	FY 47/48
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0

Differential			
Y0	Y1	Y5	Y25
FY 22/23	FY 23/24	FY 27/28	FY 47/48
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	580,397	15,228,993
Operating Expenditure	0	0	(580,397)	(15,228,993)
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
NET CASH (OUT) / IN	0	0	0	0

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	725,496	18,896,777
Operating Expenditure	0	0	(725,496)	(18,896,777)
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
0	0	0	0	0

MCFlow Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Starting Position	0	0	0	0
Operating Income	0	0	(580,397)	(14,503,497)
Operating Expenditure	0	0	580,397	14,503,497
C/F Before Financing	0	0	0	0
Financing (PDC Funding)	0	0	0	0
0	0	0	0	0

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	580,397	15,228,993
Commercial Income Potential	0	0	0	0
CRB (Cost Avoidance)	0	0	0	0
Baseline Trust Funding	0	0	580,397	15,228,993
Expenses				
Pay	0	0	(471,117)	(12,361,599)
Non-Pay: Clinical Services	0	0	(89,862)	(2,357,884)
Non-Pay: Other	0	0	(19,418)	(509,510)
TOTAL COSTS	0	0	(580,397)	(15,228,993)
EBITDA	0	0	(580,397)	(15,228,993)
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	725,496	18,896,777
Commercial Income Potential	0	0	26,264	689,140
CRB (Cost Avoidance)	0	0	0	0
Baseline Trust Funding	0	0	699,232	18,207,636
Expenses				
Pay	0	0	(588,896)	(15,338,793)
Non-Pay: Clinical Services	0	0	(112,328)	(2,925,761)
Non-Pay: Other	0	0	(24,273)	(632,222)
TOTAL COSTS	0	0	(725,496)	(18,896,777)
EBITDA	0	0	(725,496)	(18,896,777)
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

I&E Summary	Y0	Y1	Y5	Y25
	FY 22/23	FY 23/24	FY 27/28	Y25 Total
TOTAL INCOME	0	0	145,099	3,667,783
Commercial Income Potential	0	0	26,264	689,140
CRB (Cost Avoidance)	0	0	0	0
Baseline Trust Funding	0	0	118,835	2,978,643
Expenses				
Pay	0	0	(117,779)	(2,977,194)
Non-Pay: Clinical Services	0	0	(22,466)	(567,878)
Non-Pay: Other	0	0	(4,855)	(122,712)
TOTAL COSTS	0	0	(145,099)	(3,667,783)
EBITDA	0	0	(145,099)	(3,667,783)
Interest	0	0	0	0
Depreciation	0	0	0	0
PDC & Finance Charges	0	0	0	0
SUB-TOTAL	0	0	0	0
NET SURPLUS/(DEFICIT)	0	0	0	0
CUMULATIVE	0	0	0	0

Figure 9: NBT Financial Position Summary (exclusive of radio pharmacy)

UHBW	Current Position (based on current position)				Option 4c Differential Impact				Updated Total			
I&E Summary £000s	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Income from Patient Care Activities	1,021,126	1,041,548	1,127,405	32,706,957	0	0	14,732	374,338	1,021,126	1,041,548	1,142,137	33,081,295
Other Operating Income	116,076	118,397	128,157	3,717,942	0	0	2,229	58,496	0	0	0	0
Total Operating Income	1,137,201	1,159,945	1,255,562	1,280,673	0	0	16,962	432,834	1,021,126	1,041,548	1,142,137	33,081,295
Pay Costs	(692,991)	(706,851)	(765,119)	(22,196,725)	0	0	(4,870)	(128,804)	(692,991)	(706,851)	(769,989)	(22,325,529)
Non Pay Costs	(395,064)	(402,965)	(436,182)	(12,654,014)	0	0	(11,429)	(292,297)	(395,064)	(402,965)	(447,611)	(12,946,311)
Depreciation	(38,284)	(39,050)	(42,269)	(1,226,248)	0	0	(347)	(7,624)	(38,284)	(39,050)	(42,615)	(1,233,872)
Impairment	(16,876)	(17,214)	(18,632)	(540,543)	0	0	0	0	(16,876)	(17,214)	(18,632)	(540,543)
Total Operating Expense	(1,143,215)	(1,166,080)	(1,262,202)	(36,617,530)	0	0	(16,645)	(428,725)	(1,143,215)	(1,166,080)	(1,278,848)	(37,046,255)
Total operating surplus/(deficit)	(6,014)	(6,134)	(6,640)	(192,632)	0	0	0	0	(6,014)	(6,134)	(6,640)	(192,632)
PDC dividend charge	(12,863)	(13,120)	(14,202)	(412,006)	0	0	(246)	(3,173)	(12,863)	(13,120)	(14,448)	(415,179)
Other net financing costs	(754)	(769)	(832)	(24,151)	0	0	(70)	(936)	(754)	(769)	(902)	(25,087)
Impact on I&E surplus/(deficit)	(19,631)	(20,024)	(21,674)	(628,788)	0	0	0	0	(19,631)	(20,024)	(21,990)	(632,897)
Less: I&E impairments	16,876	17,214	18,632	540,543	0	0	0	0	16,876	17,214	18,632	540,543
Less: Other technical items	2,776	2,832	3,065	88,916	0	0	0	0	2,776	2,832	3,065	88,916
Impact on I&E surplus/(deficit) - Adjusted Financial Performance	21	21	22	671	0	0	0	0	21	21	22	671

Figure 10: UHBW Whole Trust Financial Position Impact of Option 4c implementation (inclusive of radio pharmacy)

UHBW	Current Position (based on current position)				Option 4c Differential Impact				Updated Total			
I&E Summary - £000s	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total	FY 22/23	FY 23/24	FY 27/28	Y25 Total
Income from Patient Care Activities	1,021,126	1,041,548	1,127,405	32,706,957	0	0	14,191	358,825	1,021,126	1,041,548	1,141,596	33,065,782
Other Operating Income	116,076	118,397	128,157	3,717,942	0	0	509	13,356	0	0	0	0
Total Operating Income	1,137,201	1,159,945	1,255,562	36,424,899	0	0	14,700	372,181	1,021,126	1,041,548	1,141,596	33,065,782
Pay Costs	(692,991)	(706,851)	(765,119)	(22,196,725)	0	0	(4,008)	(104,246)	(692,991)	(706,851)	(769,126)	(22,300,971)
Non Pay Costs	(395,064)	(402,965)	(436,182)	(12,654,014)	0	0	(10,090)	(257,436)	(395,064)	(402,965)	(446,272)	(12,911,450)
Depreciation	(38,284)	(39,050)	(42,269)	(1,226,248)	0	0	(297)	(6,524)	(38,284)	(39,050)	(42,565)	(1,232,772)
Impairment	(16,876)	(17,214)	(18,632)	(540,543)	0	0	0	0	(16,876)	(17,214)	(18,632)	(540,543)
Total Operating Expense	(1,143,215)	(1,166,080)	(1,262,202)	(36,617,530)	0	0	(14,394)	(368,207)	(1,143,215)	(1,166,080)	(1,276,596)	(36,985,737)
Total operating surplus/(deficit)	(6,014)	(6,134)	(6,640)	(192,632)	0	0	0	0	(6,014)	(6,134)	(6,640)	(192,632)
PDC dividend charge	(12,863)	(13,120)	(14,202)	(412,006)	0	0	(246)	(3,173)	(12,863)	(13,120)	(14,448)	(415,179)
Other net financing costs	(754)	(769)	(832)	(24,151)	0	0	(60)	(801)	(754)	(769)	(892)	(24,952)
Impact on I&E surplus/(deficit)	(19,631)	(20,024)	(21,674)	(628,788)	0	0	0	0	(19,631)	(20,024)	(21,980)	(632,762)
Less: I&E impairments	16,876	17,214	18,632	540,543	0	0	0	0	16,876	17,214	18,632	540,543
Less: Other technical items	2,776	2,832	3,065	88,916	0	0	0	0	2,776	2,832	3,065	88,916
Impact on I&E surplus/(deficit) - Adjusted Financial Performance	21	21	23	671	0	0	0	0	21	21	23	671

Figure 11: UHBW Whole Trust Financial Position Impact of Option 4c implementation (inclusive of radio pharmacy)

SECTION 5: FIVE CASE MODEL PROJECT DETAIL

STRATEGIC CASE

a) Please set out the strategic rationale and case for change.

Please cite Lord Carter's 2020 review and recommendations along with local need

Aseptic preparation can broadly be defined as the reconstitution of an injectable medication or any other aseptic manipulation when undertaken within NHS aseptic facilities to produce a labelled ready-to-administer presentation of a medicine, in accordance with a prescription provided by a practitioner, for a specific patient. It is linked to, but distinct from dispensing which is the supply of a finished product to a specific patient, or to the person responsible for its administration, in accordance with a prescription.

NHS hospital pharmacy aseptic services provide sterile, controlled environments in which highly qualified staff prepare or manufacture injectable medicines for intravenous (IV) antibiotics, chemotherapy, and immunotherapy treatments (such as monoclonal antibodies), as well as parenteral nutrition and cutting-edge medicines for cell therapy and clinical trials. Aseptically produced injectable medicines have an annual cost of £3.8 billion representing 3.1% of the total annual budget of NHS England. While perhaps representing a low-profile aspect of the treatment landscape within the NHS, their importance crucial in terms of treatment outcomes.

Given that the types of products align closely with treatment goals as outlined in the NHS Long Term Plan, there is clear indication that demand for these pharmacy aseptic and technical services will continue to grow.

In 2020, Lord Carter of Coles conducted a review of NHS Pharmacy Aseptic Services in England, which recognised nationally that aseptic services are experiencing significant challenges based on increasing growth in demand, a lack of capacity to meet the demand and aging aseptic units requiring investment to maintain.

On a local level, similar challenges are experienced by the UHBW and NBT where the rising demand in aseptic services can be highlighted by the following:

- Combined product volume growth between FY19/20 – FY22/23 shows a y-o-y growth of 6.85%. At this rate, overall demand doubles after approximately 11 years. This is in line with the national average growth rate of 6% as outlined by NHSE's Infusions and Special Medicines Programme.
- Following shift away from aseptically prepared products where possible to minimise COVID-19 related disruption, there has been significant rebound demand. This is seen most clearly in product growth rate as outlined below.
- UHBW-WGH Cancer Satellite has had non-operational aseptic facilities since 2015, with entire reliance on third-party suppliers. In the context of demand growth, this is not sustainable from a patient care, supply risk or financial standpoint. For example, their 2021/2022 spend on third-party medication supply was c.£4.9m, greater than the entire staffing budget UHBW and NBT pharmacy technical services staffing budget for the same period.
- NBT is approaching maximum production output with limited ability to expand their current site of operations.
- UHBW-Bristol sites are approaching maximum capacity with significant reinvestment required in the coming years. The additional requirement because of Annex 1 of the GMP regulations are expected to accelerate and increase the cost of necessary reinvestment required.

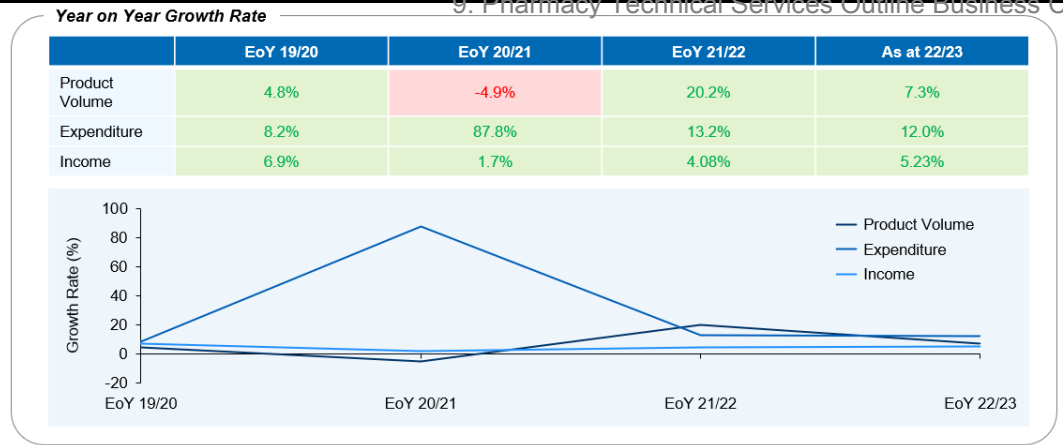


Figure 12: Product volume, expenditure, and income growth rates. Please note, owing to the relatively minor differential influence of Radiopharmacy, these values have been retained within figure 4. Please note the expenditure increase seen in EoY 20/21 is largely derived from supply chain disruption and resulting price increases seen in the initial phases of the COVID-19 Pandemic outbreak.

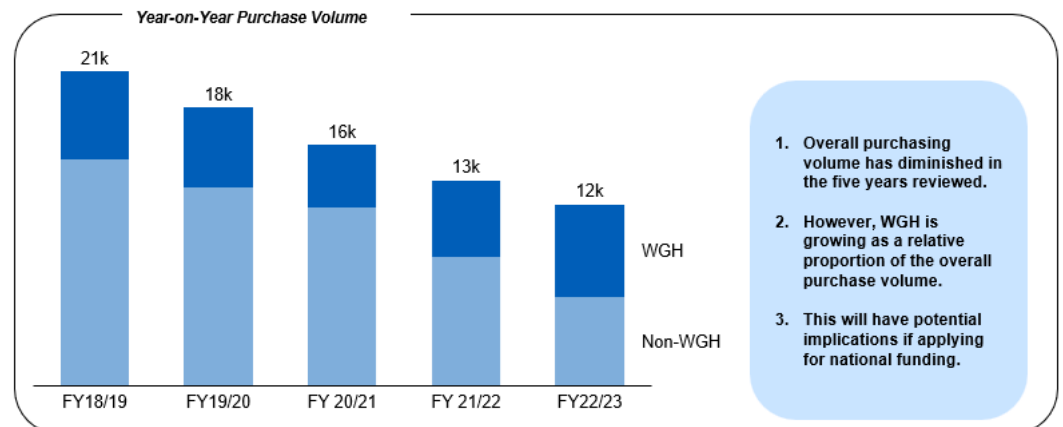


Figure 13: Diminishing, but unsustainable purchase volume. Please note, there is no purchased radiopharmacy volume within these totals.

There is limited available pharmacy technical services capacity across UHBW and NBT to be able to meet these demands sustainably and resiliently and therefore these organisations are faced with the need to invest in new local facilities.



With a lack of transformation, UHBW and NBT have identified significant implications such as increased waiting times for patients to receive specialist services, particular cancer and increase in patient safety incidents due to the increasing demand for ward-based preparation of injectable medicines (as aseptic units are saturated) combined with the increasing complexity of nursing shortages. Furthermore, it is expected to pose a significant reputational and safety risk should they not act to update and modernise their PATS. In the context of the NHS’ Long-Term Plan, it is recognised that without significant transformation, there will be limited to no ability to support aims such as improving cancer diagnosis rates and treatment outcomes.

The findings of Lord Carter’s review, supported by a series of recommendations, were documented in a report which set out the Case for Change for transformation of these services. The report highlighted that the creation of a network of collaborative regional hub aseptic facilities responsible for preparing large scale volumes of injectable medicines, supported by local Trust-level spoke facilities services will help to deliver the following outcomes:

1. Improved patient experience by enabling care closer to home.

	<ol style="list-style-type: none"> 2. Increased patient safety by reducing errors in the manipulation and administration of these medicines. 3. Free up the time of 4,000 nursing staff for patient care. 4. Increase productivity from the medicines budget. 5. Increase the resilience of the sector. <p>This has led to the Infusions and Specials Medicines workstream within NHSE to press for the development of hub and spoke facilities to modernise practise while scaling up to meet anticipated demand growth. Recommendations of this work are varied and numerous. They include the desire to:</p> <ul style="list-style-type: none"> ▪ Create a network of collaborative regional aseptic hub facilities to scale up production capacity while supporting existing relations with commercial providers. ▪ Agree standard dose bandings for chemotherapy, parenteral nutrition, and antimicrobial products. ▪ Develop an NHS manufacturing network and transform NHS medicines manufacturing into a strategic asset that meets otherwise unmet need of patients. ▪ Assess the potential for new role and skill mixes in aseptic services, while also developing a new pharmacy technical services workforce to enable greater patient facing activities. <p>Already pathfinder projects such as those seen at West Yorkshire Association of Acute Trusts (WYAAT), Manchester University NHS Foundation Trust (through the Greater Manchester Health and Social Care Partnership) and University Hospital Southampton NHS Foundation Trust (through the Hampshire and Isle of White ICS) have evidenced the potential benefit of national investment into aseptic services. By extrapolating the potential benefits as outlined within the Lord Carter of Coles report, there is significant evidence of these benefits extending to UHBW and NBT, and beyond. For example, it is expected that through investment into this aseptic service area, this will help both UHBW and NBT to support the BNSSG strategic aims of improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience, and access, enhancing productivity and value for money, and helping the NHS support broader social and economic development.</p> <p>By extension, the intended benefits of the new hub facility should extend to support Lord Carter's efficiency goals as outlined in the Operational Productivity and Performance in English NHS Acute Hospitals Report. For example, through centralisation of current ward based CIVAS preparation, this will not only release nurse time, but reduce unwarranted variation in medication preparation practice. This will therefore provide direct and indirect efficiency benefits. Through enhanced collaboration and a greater shift from external to internal supply reliance, this will also have procurement benefits, most notably by reducing the amount paid per medication, reducing staff time spent sourcing medication and reducing the number and duration of patient treatment delays relating to medication delays. Again, this should help to aid efficiency of operations within the hospital, for example, by enabling quicker treatment and discharge pathways to be realised. These will all have further benefits relating to the sustainability and risk factors of the current service.</p>
<p>b) Please explain how this scheme will contribute to the delivery of the programme aims.</p>	<p>In line with the national operating model which identifies the establishment of centralised, regional hubs supported by Trust-located spokes as the gold-standard service transformation, UHBW and NBT are looking to implement a collaborative, region-wide programme that will:</p> <ul style="list-style-type: none"> ▪ Improve the productivity from the medicines budget by reducing the cost and reliance on third-party vendors. This will not only have direct financial benefits given the productivity and efficiency savings but is expected to improve patient experience outcomes and result in significant time savings owing to the relative unsustainability of the private aseptic commercial sector. ▪ Improve safety aspects through improved standardisation of practice at a single hub facility. ▪ Establish the pharmacy capacity and capability to produce central intravenous additives (CIVAs) products that release nursing time to care. CIVAS are injectable medicines made in a ready-to-administer format, saving nursing drug preparation time on wards. ▪ Establish production capacity and capability that not only delivers for NBT and UHBW demand but caters to support beyond the ICS to regional strategy (and beyond). This will support the wider aim of enhancing system resilience which has been recognised as a significant risk in the context of current demand.

	<ul style="list-style-type: none"> ▪ Establish the capacity to deliver high quality cancer treatment to a steadily increasing proportion of patients diagnosed at Stages 1 and 2 in line with the NHS Long Term Plan ambition. <p>This short-form business case seeks the approval of national capital funding which will allow implementation of this regional hub model and will investigate aspects needed to deliver the long-term vision, for further integration and collaboration to appropriately future proof pharmacy aseptic and technical services in this region.</p>
<p>c) Provide confirmation of stakeholders e.g. support from clinicians, provider collaborative, commissioners and STP / ICS accountable officers (formal letters of support to be appended to this business case template).</p>	<p>The UHBW and NBT Pharmacy Aseptic and Technical Services Options Appraisal Project has been guided and advised by the respective clinical leads throughout development, in addition to the NBT and UHBW Chief Pharmacists and project manager in collaboration with Akeso and Company, a London based management consultancy firm with experience in pharmacy transformation projects. Wider support has been sought from NHS England and NHS Improvement collaborative. Additionally, the project has been considered by the Non-Executive and Financial Directors at UHBW. Both parties have indicated initial support, although formal sign off and approval will be sought at a later stage.</p> <p>Modelled benefits figures have been validated with clinical leads through a series of workshop sessions in addition to individual calls and correspondence. Further validation has been conducted with;</p> <p>NHSE SW Specialised Commissioning Pharmacists SW Regional Chief Pharmacist SW Deputy Regional QA Pharmacist NHSE Infusions & Special Medicines Specialist Pharmacy Advisor BNSSG ICB Deputy Director Medicines Optimisation and ICS Lead Pharmacist</p> <p>BNSSG have been informed regarding the project and indicated high level support. The project is an agreed ICS Medicines Optimisation workstream reporting into the Acute Care Collaborative Group, and part of the Integrated Pharmacy Medicines Optimisation (IPMO) plan/strategy for BNSSG. The preferred option has considered the four strategic priorities as outlined in the BNSSG Strategic Framework v3. These aims are to</p> <ul style="list-style-type: none"> • improve outcomes in population health and healthcare; • tackle inequalities in outcomes, experience, and access; • enhance productivity and value for money; and • help the NHS support broader social and economic development. <p>While, formal approval has not been requested and will be sought at a later stage, ICS colleagues have acknowledged how this scheme if effectively executed will contribute to the above list strategic aims.</p> <p>Regional collaboration has also been considered in terms of the long-term preferred option. While this has not formed one of the formal decision criteria, the preferred option selected with consideration for this potential.</p>
<p>d) Please outline the investment objectives for the project.</p>	<p>Investment in designing and implementing an off-site pharmacy aseptic and technical services hub, with retention on site bespoke production, aims to meet the following series of objectives:</p> <ul style="list-style-type: none"> ▪ Improve patient experience by reducing time to first dose and enabling greater care in the community potential as wider services such as OPAT. ▪ Increase patient safety by reducing medication preparation errors through improved standardisation of preparation practice and a reduction of ward level preparation activity. ▪ Leverage economies of scale concerning equipment and workforce, to greatly improve overall volumetric output relative to investment spent. Current combined per annum dose volume output is 58.4k doses per annum. Modelled activity has listed an estimate of 381k, representing a 550% increase. ▪ Deliver facilities to support unmet and additional needs for Research and Development/Clinical Trials. ▪ Generate additional production capacity to satisfy current demand. At present, approximately 25% of current demand is outsourced representing a significant cost burden.

	<p>Following effective implementation of the preferred option, this will drop to 0% (excluding strategic medication lines chosen for continued outsourcing).</p> <ul style="list-style-type: none"> ▪ Generate additional production capacity to satisfy future demand, with consideration of local, regional, and national strategic lines while also enhancing NHS-to-NHS supply capability. ▪ Satisfy the two above listed aims while also generating additional production capacity to deliver, 'excess', production capacity. <ul style="list-style-type: none"> ○ Excess capacity will be allocated to 'commercial income' with the intention of supplying to parties outside of the UHBW and NBT. ○ Release nursing time to care both within the UHBW and NBT and beyond through centralised production at the new facility. ▪ Act as a focal point to reduce unwarranted variation for in-scope products. ▪ Enhance pharmacy technical services resilience, by reducing reliance on private sector vendors and enhancing spend efficiency. <p>Enhance collaborative working, first between NBT and UHBW, but with the potential to expand to pan ICS or pan regional collaboration.</p>
<p>e) Please confirm fit with estate strategy.</p>	<p>The project has support from and is in line with both current UHBW and NBT Estates Strategy. While formal approval from ICS Capital and Infrastructure Board has not been sought at this stage, ICS colleagues have been sighted on the project and formal support is not expected to be a problem.</p> <p>UHBW and NBT have both recognised that neither site would be suitable for an onsite facility, which substantially limits the feasibility of option 3c before considering the economic and value for money aspects. NBT as part of a new PFI build has little to no space for expansion of current facilities. While two potential UHBW on-site options have been considered, neither were deemed suitable from a timescale or feasibility standpoint.</p> <p>The first, Marlborough Hill project would have required significant redesign of current plans which would have required significant internal stakeholder buy in and would have not aligned with planned timelines. The second option would have involved repurposing of an existing building on the UHBW main site. However, it was recognised that this site would have been highly competitive with limited realistic prospect of being able to utilise this space. Furthermore, the ambiguity regarding the actual amount of space available would mean that there would be limited potential to expand for the future, and indeed cast uncertainty regarding the proposed scope of operations.</p> <p>No objection has been raised to the prospect of an offsite facility, although no site has been identified at this stage. To reduce capital requirements of the project, it was decided that it would be more prudent that a leasing strategy was more suitable. While cost and risk elements were raised in relation to pursuing a long-term risk, these were deemed acceptable in the context of the project and alternative options.</p>
ECONOMIC CASE	
<p>a) Please submit a VFM template with this business case template.</p>	<p>CIA Model Template used to support the economic appraisal, including value for money (VfM) analysis, is linked below:</p> <p>Inclusive of radiopharmacy</p> <p> BWPC_CIA_Model_v radio.xlsx</p> <p>Exclusive of radiopharmacy</p> <p> BWPC_CIA_Model_v noradio.xlsx</p>

b) Please provide an incremental VFM analysis that shows the VFM ratio (Net Present Social Value) for Business As Usual and the preferred option and provide an explanatory narrative on the VFM analysis.

Preferred Option Summary

Option	Variation	'Do Nothing' Option 1	'Do Minimum' Option 2	Preferred Option Option 4c
Total Incremental Costs	Exclusive of Radiopharmacy	£297.2m	£327.4m	£302.3m
	Inclusive of Radiopharmacy	£327.6m	£346.4m	£340.5m
Total Incremental Benefits	Exclusive of Radiopharmacy	£34.5m	£102.7m	£606.1m
	Inclusive of Radiopharmacy	£41.5m	£144.5m	£712.7m
Risk-adjusted Net Present Social Value (NPSV)	Exclusive of Radiopharmacy	£262.8m	£224.6m	£303.8m
	Inclusive of Radiopharmacy	£285.7m	£201.9m	£372.3m
Benefit-Cost Ratio	Exclusive of Radiopharmacy	<u>0.12</u>	<u>0.31</u>	<u>2.00</u>
	Inclusive of Radiopharmacy	<u>0.13</u>	<u>0.42</u>	<u>2.09</u>

Figure 14: VFM summary inclusive and exclusive of radiopharmacy

The Preferred Option, Option 4c, offers the highest Value for Money due to the ratio of cost vs output / benefit. This option will involve the lease and refurbishment of an off-site fully licensed hub. Following discussion with the clinical leads from both NBT and UHBW, it was recognised that some degree on site production would have to be retained for acute or products prescribed at short notice. Accordingly, the NBT site would continue to operate to produce bespoke, urgently required, short-shelf life or non-standardised products in line with current operations. However, greater collaboration and utilisation of the hub facility once operational is intended for large volume, standardised products that would be suitable for outsourcing to batch production. The Weston General Hospital Cancer Site would shift its reliance to the new hub facility (except for outsourcing retention for strategically chosen lines, which are yet to be decided). UHBW Bristol site will retain onsite operations in their current Parenteral Services Unit (PSU) as this is expected to match the required bespoke capacity needs while requiring minimal additional investment.

The high-cost elements seen in both do nothing and do minimum derive from the expectation that as demand grows in the context of diminishing or flatlined production capacity, third-party vendor reliance increases. Accordingly, while revenue cost elements such as staffing costs will reduce, this is greatly offset by the expectation of much higher costs because of third-party purchase costs. It should also be noted that the risk elements of these options have not been fully explored, but clinical leads agree that there would be significant supply risks if increasing any reliance on third-party vendors, in addition to the financial risks.

Sensitivity Analysis

Sensitivity analyses were conducted in relation to the nearest VFM option (option 3c which represented a near mirror facility on site). This sensitivity analysis was considered from two perspectives. Firstly, by how much option 3c's production capacity need to increase to shift the preferred option allocation. This rationale was derived from the fact that with increased production capacity, this will increase the benefits generated (relative to modelled costs) thus improving the benefit cost ratio.

Inclusive of radio pharmacy, option 3c must produce an additional 16% dose volume (on top of base assumptions) to match the VFM of option 4c. Exclusive of radio pharmacy, this volumetric increase required to match option 4c's VFM is raised to an additional 18%.

Secondly, sensitivity analysis was considered from the perspective of option 4c costs, i.e., by how much must revenue costs increase to reduce the VFM to below that of option 3c. Again, for both iterations of option 4c (i.e., with and without radiopharmacy), revenue costs must increase

by approximately 18% to reduce option 4c's VfM to below that of option 3c. An increase of 20% to both 3c's volumetric output and 4c's revenue costs are shown in figure 16.

Option	Variation	Option 3c	Option 4c
Total Incremental Costs	Exclusive of Radiopharmacy	-£298.8m	-£302.3m
	Inclusive of Radiopharmacy	-£330.8m	-£340.5m
Total Incremental Benefits	Exclusive of Radiopharmacy	£524.7m	£606.1m
	Inclusive of Radiopharmacy	£618.8m	£712.7m
Risk-adjusted Net Present Social Value (NPSV)	Exclusive of Radiopharmacy	£225.9m	£303.8m
	Inclusive of Radiopharmacy	£288.0m	£372.3m
Benefit-Cost Ratio	Exclusive of Radiopharmacy	<u>1.76</u>	<u>2.00</u>
	Inclusive of Radiopharmacy	<u>1.87</u>	<u>2.09</u>

Figure 15: VfM comparison of option 3c and 4c. Option 3c represents the closest comparison to the preferred option both from an operational and VfM standpoint.

Option	Variation	Option 3c – Additional Volumetric Capacity	Option 4c - Additional Revenue Costs
Total Incremental Costs	Exclusive of Radiopharmacy	-£298.8m	-£358.2m
	Inclusive of Radiopharmacy	-£340.6m	-£403.1m
Total Incremental Benefits	Exclusive of Radiopharmacy	£622.5m	£606.1m
	Inclusive of Radiopharmacy	£730.3m	£712.7m
Risk-adjusted Net Present Social Value (NPSV)	Exclusive of Radiopharmacy	£323.7m	£247.9m
	Inclusive of Radiopharmacy	£389.6m	£309.7m
Benefit-Cost Ratio	Exclusive of Radiopharmacy	<u>2.08</u>	<u>1.69</u>
	Inclusive of Radiopharmacy	<u>2.14</u>	<u>1.77</u>

Figure 16: Sensitivity Analysis of the option 3c and 4c with a volumetric and revenue cost increase of 20% respectively.

In addition to the sensitivity analysis considerations, from a qualitative standpoint, significant doubts were raised regarding the feasibility of implementing option 3c. Given these and the significant changes to operation changes required to make 3c the VfM option, it was agreed that option 4c should proceed as the preferred option.

- c) Provide a narrative on:
- The options considered to achieve the scheme's objectives, including business as usual.
 - The process through which the long list of options was narrowed down to the preferred option.
 - The main costs, benefits and risks for the Business as Usual and preferred option.
 - The appraisal period for the scheme.

The Options Considered

An initial list of four options were provided as the minimum appraisal requirement as part of the Tender Specification. Different permutations of the onsite and offsite facility options were developed following initial discussions and data gathering site visits and calls with respective clinical leads, bringing the total longlist to 8 options. These were assessed and considered in the context of the Critical Success Factors (CSFs) which were discussed during our longlist workshop which took place on 05/12/22.

While a total of ten (CSFs) exceeded the recommended maximum of seven as outlined in the HMT Green Book, it was deemed necessary in the context of the UHBW and NBT project board and wider national aims and guidelines regarding aseptic medication production. The ten CSFs include five defined by Green Book and five defined by UHBW and NBT Strategic Workshop.

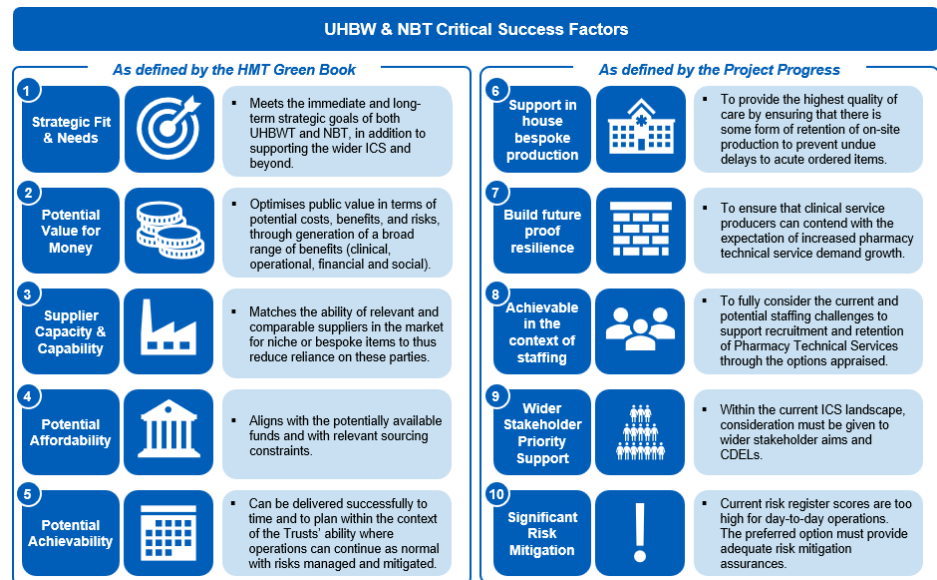


Figure 17: Critical Success Factors as outlined by the HMT Green Book and Project workshop.

The qualitative assessment against the ten CSF's allowed the list to be shortlisted to the following five options, which through more detailed modelling and costing assessment identified Option 4c as the Preferred Option.



AC_UHBTNBT_Workshop1_v4.pdf

- **Option 1 - Business As-Usual (Do Nothing):** This option would involve no refurbishment, reconfiguration or new build works and current state of services would continue As-Is, therefore requiring no capital investment. Accordingly, this option would see diminishing output as equipment falls into disrepair and ceases to function. From a modelling standpoint, volumetric output was matched to diminish proportionally to essential equipment failure in line with listed or expected shelf lives from baseline data provided by clinical leads. In this way, increasing reliance shifts to third-party vendors resulting in significant revenue cost increases with diminishing benefits. While never truly expected to represent a viable long-term solution, this option was carried forward to the short list to evidence the need to act. This option was discounted as it delivered no benefit or value to the Trusts or local health economy and services will continue to operate in an uncoordinated manner through not-fit-for purpose facilities, increasing risk to patient outcomes and safety and anticipated decrease in product output.
- **Option 2 - Do Minimum:** Allocation of capital towards upgrading current Trust-level facilities through major refurbishment and reconfiguration of all in-scope pharmacy technical services. In comparison to Option 1, this would help drive a small increase in output production, however, the option was discounted as it does not represent value for money

from an investment standpoint. Additionally, it does not address the long-term sustainability and demand challenges expected from NHS pharmacy technical services.

- **Option 3c – On-site Hub for Technical Services:** Utilisation of capital to establish a single facility for technical services on-site at UHBW. Products produced at the new hub will be utilised at UHBW (including WGH) and distributed to NBT. Excess production capacity will be prioritised for demand growth, followed by commercial income and nursing time released. This option was discounted due to additional complications and uncertainty around a viable location for the new hub within the Trust’s facilities. Furthermore, during the qualitative assessment following discussions with clinical leads, several potential flaws were recognised. Retrofitting to existing sites would likely be more costly relative to a new site, there would be increased complication and internal governance checks, staffing recruitment would be complicated (relative to options 4a and 4c) based on staff feedback and internal research and there would limit ability to work in an agile or flexible manner to meet evolving demand profiles.

- **Option 4a – Off-Site Hub without WGH Reliance:** Utilisation of capital to establish a single off-site facility for technical services. Products produced at the new hub will be distributed to UHBW and NBT, however WGH will continue to rely on third-party vendors. Excess production at the new hub will be prioritised for commercial output. Despite demonstrating the highest overall monetisable benefits, this option was discounted as the expected growth in expense associated with third-party costs outpace assumed commercial potential. While acknowledging the need to support external demand, it was recognised that the need to prioritise internal demand profiles would have to come first to maintain a financially sustainable and reliable service.

- **Option 4c – Off-Site Hub with WGH Reliance:** Utilisation of capital to establish a single off-site facility for technical services. Products produced at the new hub will be distributed to UHBW (including WGH and NBT with excess production capacity prioritised for demand growth, followed by commercial income and nursing time released. This option demonstrated the greatest net present social value and benefit cost ratio. Furthermore, it was deemed the preferred option from a qualitative perspective for several reasons. This option owing to the volumetric output potential would support the most thorough future proofed option. While the logistic cost elements have not been fully defined and costed at this stage, it was acknowledged from discussion with experts and based on previous experience that this would not drive a cost element significant enough to diminish the cost benefit ratio below that of 4a (which had the second best from the five options considered).

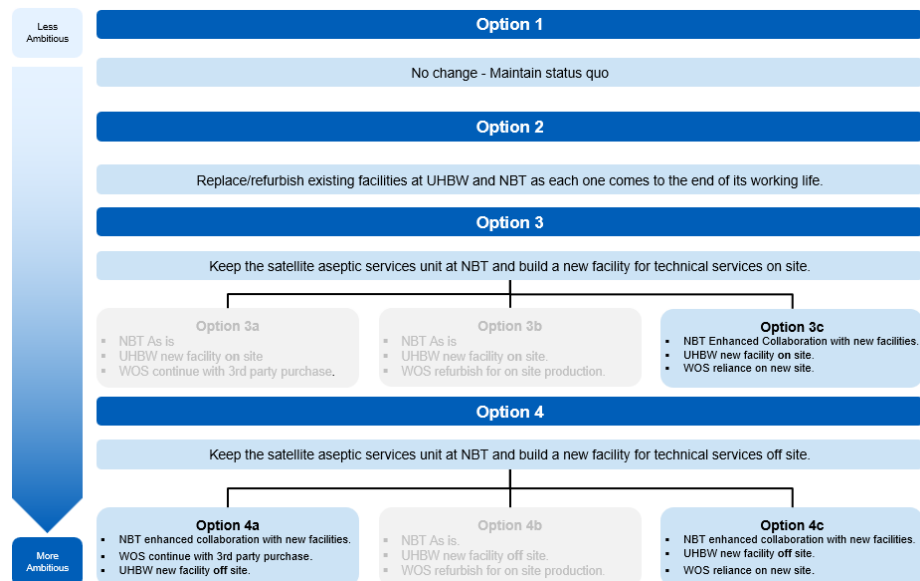


Figure 18: Options Summary confirmation of shortlist following shortlisting workshop

Costs, benefits, and risks for the BAU and Preferred Option

The quantified benefits of focus were cash-releasing benefits in the form of cost avoidance from a reduction in reliance on purchasing from third-party sources. Medication was categorised with average cost data applied to each medication category (derived from baseline data provided). Y-o-Y growth rates were applied to each category to develop overall demand profiles. These growth rates were applied for 10-year period followed by flatline period afterward owing to the relative unknown of the market after 10 years and the assumption of significant clinical innovation. Baseline production capacity volume data was used to evidence prospect third-party reliance, which when coupled with baseline cost information, showed ongoing cost profile.

Baseline Volume (2021/22)				
	Made	Purchased	Total Volume	Relative Contribution
Chemotherapy	26,326	13,449	39,775	17%
CIVAs	8,037	-	8,037	3%
Immunotherapy	4,144	16	4,160	2%
PN	8,062	-	8,062	3%
Radiopharmacy	11,892	-	11,892	5%
TTO	127,791	-	127,791	55%
Other Non-Aseptic	33,125	-	33,125	14%
Total	219,377	13,465	232,842	100%

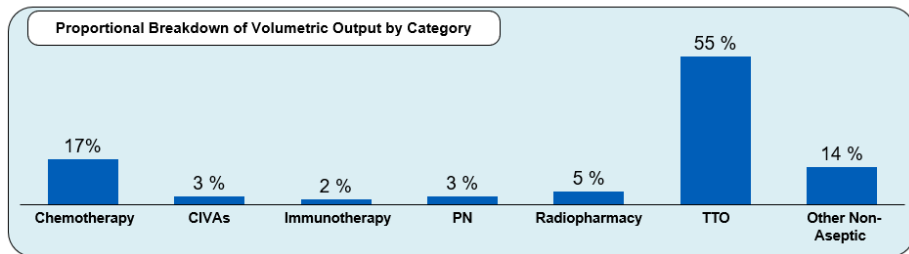


Figure 19: Overall Baseline Volume Production Proportions

While to pre-packs and other non-aseptic was included in the categorisation, the associated capital and revenue costs as well as benefits were not considered in terms of the final options appraisal and subsequent VfM calculations.

Rather, this was included in baseline activity review to ensure that by investing in the expansion of aseptic pharmacy technical services, these wider services would not be compromised.

Baseline Volume (2021/22)				
Medication Category	Made	Purchased	Total Volume	Relative Contribution
Chemotherapy	26,326	13,449	39,775	55%
CIVAs	8,037	-	8,037	11%
Immunotherapy	4,144	16	4,160	6%
PN	8,062	-	8,062	11%
Radiopharmacy	11,892	-	11,892	11%
Total	58,461	13,465	71,926	100%

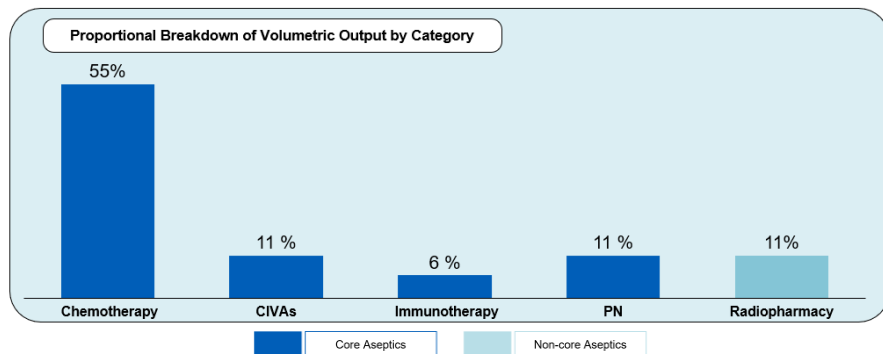


Figure 20: Proportional Breakdown of Baseline Volume

Cash releasing benefits focused on the cost avoidance element of no longer requiring purchases from third-party providers. This benefit accounted for the largest single proportion of benefits. Benefit rationale assumed that production capacity would be first prioritised for internal (UHBW and NBT) demand. Excess production capacity was then allocated to either direct CIVAS ward production to release nursing time to care (derived from baseline data provided) or commercial income where production capacity is used to meet demand from third-party NHS partners. In this way, it is expected that nursing time to care will be released directed or indirectly (for example if providing standardised, long shelf life CIVAS products to other trusts thus reducing their requirement for nurse led ward level CIVAS preparation).

Costs:

Option	Variation	'Do Nothing' Option 1	'Do Minimum' Option 2	Preferred Option - Option 4c
Opportunity Costs	Exclusive of Radiopharmacy	£0	£0	£0
	Inclusive of Radiopharmacy	£0	£0	£0
Total Lifecycle Capital Costs + Optimism Bias Uplift	Exclusive of Radiopharmacy	-£9.8k	-£7.7m	-£22.7m
	Inclusive of Radiopharmacy	-£9.8k	-£7.7m	-£27.2m
Revenue Costs	Exclusive of Radiopharmacy	-£297.2m	-£318.1m	-£279.3m
	Inclusive of Radiopharmacy	-£327.2m	-£337.1m	-£313.1m
Transitional Costs	Exclusive of Radiopharmacy	£0	£0	£0
	Inclusive of Radiopharmacy	£0	£0	£0
Externality Costs	Exclusive of Radiopharmacy	£0	£0	£0
	Inclusive of Radiopharmacy	£0	£0	£0
Net Contribution Costs	Exclusive of Radiopharmacy	£0	£0	£0
	Inclusive of Radiopharmacy	£0	£0	£0
Risks	Exclusive of Radiopharmacy	£0	-£1.6m	-£278k
	Inclusive of Radiopharmacy	£0	-£1.6m	-£278k
Total Costs	Inclusive of Radiopharmacy	<u>-£297.2m</u>	<u>-£327.4m</u>	<u>-£302.1m</u>
	Exclusive of Radiopharmacy	<u>-£327.2m</u>	<u>-£346.4m</u>	<u>-£340.2m</u>

Figure 21: Summary of Costs inclusive and exclusive of Radiopharmacy.

Please note risk for the purposes of the Comprehensive Investment Appraisal (CIA), the risks associate with the 'do nothing' option have not been quantified. While this option if pursued will pose the significant financial risks, these will be related to the costs and stability of third-party vendor product supply. For the purposes of the CIA, quantified risks have focused on the costs associated with investment into either a new facility or to bring the current operational facilities up to standard. While the costs calculated shown against option 1, do nothing, are lowest, this has not been considered as a realistic or viable option owing to the assumed unreliability of relying entirely on third-party vendors. Furthermore, this option delivers no long-term benefits meaning that it produces the lowest benefit cost ratio.

Preferred Option Selection | Quantified Benefits Summary

Benefits have been calculated with focus on three main categories of benefits. While further benefits can be further incorporated to refine the model, these have been deemed as the most relevant in the first instance.

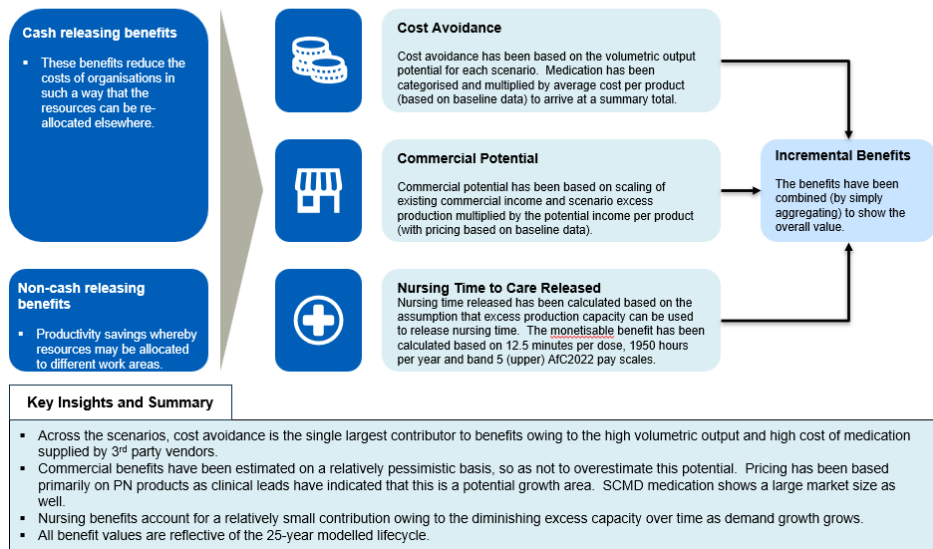


Figure 22: Quantified Benefits Methodology Summary

Benefits:

Option	Variation	'Do Nothing' Option 0	'Do Minimum' Option 1	Preferred Option Option 4c
Cash releasing (cost avoidance)	Exclusive of Radiopharmacy	£33.0m	£98.4m	£563.2m
	Inclusive of Radiopharmacy	£36.9m	£124.8m	£642.2
Non-cash releasing (i.e. nursing time released)	Exclusive of Radiopharmacy	£0	£0	£36.9m
	Inclusive of Radiopharmacy	£0	£0	£6.3m
Cash Releasing (Commercial Income Potential)	Exclusive of Radiopharmacy	£1.4m	£4.4m	£7.5m
	Inclusive of Radiopharmacy	£4.6m	£19.7m	£33.6m
Total Benefits	Exclusive of Radiopharmacy	<u>£34.5m</u>	<u>£102.8m</u>	<u>£606.1m</u>
	Inclusive of Radiopharmacy	<u>£41.5m</u>	<u>£144.5m</u>	<u>£712.8m</u>

Figure 23: Quantitative Benefits of the preferred option inclusive and exclusive of Radiopharmacy

Other Benefits of preferred option 4c:

- Greatest workforce efficiencies.
- Multitude of rooms as specified in the service design will allow for production variation to meet the any demand fluctuations within the network.

- Greatest ability to support wider network.
- Greatest ability to consider future requirements and subsequent refurbishment.
- More effective utilisation of MHRA licenses and greatest potential expansion of clinical trial manufacturing (of IMPs).
- Enhanced ability to support advanced therapy medicinal products (ATMP) and advanced therapy investigational medicinal products (ATIMPs) together with Class 2 Biological handling.
- Improved resilience for UHBW and the wider region and NHS.
- Greatest flexibility to expand production output to meet future demand variations.
- Greatest ability to support OPAT and virtual ward and theoretically improve bed days released.

Please note, these 'other' benefits have not been quantified as part of the economic appraisal through the comprehensive investment appraisal model process. These benefits were deemed to not have sufficient baseline data to consider quantification through extrapolation of each into a workable benefit calculation for considering with each option.

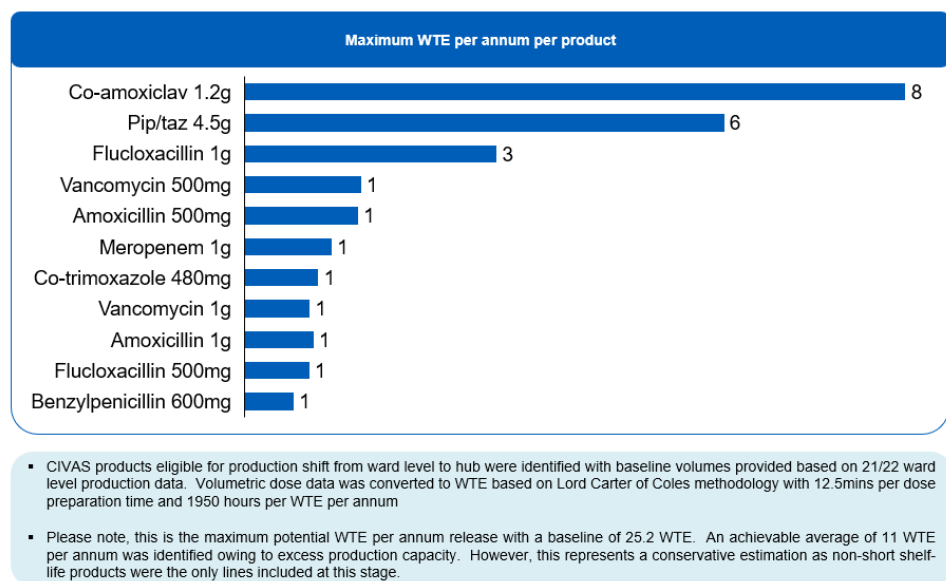


Figure 24: Maximum Nursing Time to Care WTE Release Potential

Risks:

Option	'Do Nothing' Option 0	'Do Minimum' Option 1	Preferred Option Option 4c
Identified Risks of each Option	<ul style="list-style-type: none"> ▪ Operating Risk ▪ Revenue Risk ▪ Regulatory Risk ▪ Performance Risk ▪ Technology Risk ▪ Control Risk 	<ul style="list-style-type: none"> ▪ Operating Risk ▪ Revenue Risk ▪ Regulatory Risk ▪ Performance Risk ▪ Technology Risk ▪ Control Risk 	<ul style="list-style-type: none"> ▪ Design Risk ▪ Construction Risk ▪ Performance Risk ▪ Operating Risk ▪ Revenue Risk ▪ Termination Risk ▪ Technology Risk ▪ Control Risk ▪ Residual Value Risk

(See CIA model for sub-category risks)

Figure 25: Risk Quantification and summary for preferred option vs do nothing and do minimum.

Appraisal Period:

- The Economic Appraisal has been conducted in accordance with the Treasury Green Book, utilising the DHSC's Comprehensive Investment Appraisal (CIA) Model.
- This reflects the differential costs, benefits, and risks in the different options, appraised against the baseline "Business as Usual" Option.
- The appraisal was conducted over the entire project projected lifecycle of 25 years beginning Year 0 2022/23 and finishing as Year 25 in 2047/48
- UHBW and NBT provided baseline data for analysis in October – December 2022. This was utilised as part of the shortlisting workshops which formed the basis options appraised. The economic appraisal was conducted in December 2022 and January 2023 with a final review with clinical leads and senior stakeholders completed in February 2023.

d) Confirm inflation, VAT, depreciation, CDEL cover are excluded from the economic analysis.

As per DHSC methodology and instructions, inflation, VAT, CDEL, depreciation and PDC have all been excluded from the economic analysis.

COMMERCIAL CASE

a) Please set out the commercial and procurement route, e.g., P22.

To achieve the objectives of the collaboration aseptic project, particular goods and services that need to be procured include:

- Professional services
- Refurbishment and associated works
- Equipment
- Systems
- Logistics

To procure the preferred provider across these functions, the following initial list of procurement routes have been considered:

1. Find-a-Tender (national tender process – replacement to the Official Journal of the European Union since departure from the EU). These could take the form of either an open procedure or a restricted procedure.
Note: there are other routes available, that have not been detailed here as would not be suitable e.g., Competitive Dialogue.
2. Clean Room or Similar Framework Routes: There are no comprehensive national framework routes available for cleanroom design, build and validation. However, the North of England Commercial Procurement Collaborative have a localised pharmacy clean room services framework in place. This covers three specific lots; Pharmacy Clean Room Garments, Provision of mops including processing and pharmacy specific clean room consumables. Suitability of this approach has not been considered, but it is assumed that similar categorisation approach could be mirrored in the development of tender

	<p>specification for UHBW and NBT. Depending on external stakeholder buy in, this could be extended to include the ICS or SW region.</p> <p>3. Construction Frameworks: A construction framework would need to fully verify the credentials of participants to be confident that an appointed provider would have the capability to deliver the complex project. There are numerous construction frameworks available to the project such as the:</p> <ul style="list-style-type: none"> ▪ North of England Commercial Procurement Collaborative – Estates Consultancy ▪ Fusion 21 ▪ NHS ProCure23 Framework (P23) <p>At the next stage of project progression, the UHBW and NBT collaborative in line with the Procurement and Commercial workstream will decide upon the best procurement route which will generate outcomes that deliver best value to the project and UHBW and NBT collaborative. The procurement routes will be assessed based on alignment and fit with project-specific requirements, drivers, and success criteria for the project.</p> <p>When the optimum procurement route for the new regional hub model development has been determined, the procurement framework will align with the following to select the preferred principal partner who will then provide a suitable design to ensure best procurement is secured for cost, time, and quality assurance across the collaborative.</p> <ul style="list-style-type: none"> ▪ Payment Mechanisms ▪ Value for Money ▪ Actual Cost ▪ Incentivisation & Gainshare ▪ Delay Damages
<p>b) Set out the basis of the negotiated position, including the final price for the works.</p>	<p>Professional services Professional services will be acquired in line with the delivery timetable outlined above. Core professional services such as architectural contracting etc will be managed by the procurement and commercial workstream. Wider professional services such as facilities maintenance will also be managed by the workforce workstream. As the exact specification of the facility becomes defined more clearly as the project design matures, exact pricing can be considered regarding the wider professional services. Regardless of overall need, value for money, experience and quality aspects will be considered as the most important aspects.</p> <p>Refurbishment and Fit Out This will be undertaken through a procurement process as outlined above. Outline costs have been established in the business case work up to ensure costs listed have merit, however, further refinement will be added during the procurement process.</p> <p>Construction and associated works will utilise Procure23 and will be led by the Procurement & Commercial workstream, with input from clinical leads to ensure that facilities are suitable, fit for purpose and have the correct level of flexibility to allow for subsequent improvements or expansions as technological improvements or regulatory requirements allow or dictate.</p> <p>Equipment This work will be led by the Procurement & Commercial workstream with detailed input from the hub implementation workstream. The equipment procurement will make use of relevant frameworks where possible with tenders undertaken where necessary.</p> <p>Logistics With the preferred option for an offsite facility, and the longer-term aim to increase commercial income through increased collaboration with NHS parties within the ICS and beyond, there will be further logistics and supply chain management requirement.</p> <p>While price has not been defined at this stage, consideration of storage requirements during transport will influence pricing aspects. This in turn will largely be defined by demand profile including destinations and product mix. Again, as the project matures toward implementation a clearer idea of logistics requirements will be defined which will inform pricing structure. It is expected that NHS Supply Chain will manage this aspect.</p> <p>Systems</p>

	<p>During 2023, a “detailed “design” workstream will establish a subgroup to undertake market scanning for potential systems required to operate a large aseptic hub. Multiple potential suppliers, all available on existing frameworks, will be engaged regarding the requirements of the hub and associated systems. Whilst work is still underway to establish whether a new full Enterprise Resource Planning (ERP) system is required, the costings used in the business case are based on extensive work with previous providers. Other system requirements are based on updates to current systems in place within the production units at UHBW and NBT and therefore minimum input is required to implement updates and expansion as necessary.</p> <p>The use of single tender waivers is appropriate where costs exceed the threshold for competitive tendering or quotation will be applied where appropriate and costings of these systems are well understood.</p> <p>Once the procurement for the works have been conducted and contracted for, the final price for the works can be confirmed.</p> <p>Social Value Underpinning all elements of the procurement strands and strategy will be the need to consider social value in all contracts awarded and partnerships developed. In considering social value benefits, factors such local employment effects, skill improvements for young people, staff welfare factors and sustainable procurement aspects will be assessed. While no social value measurement methodology has been defined yet as part of the procurement and commercial strategy, the National TOMs Framework 2019 for social value measurement should act as a sufficient guide in this matter.</p>
<p>c) Confirm status of any legal documentation or processes required for the scheme to be delivered in full and what (if anything) remains to be agreed.</p>	<p>In accordance with section 12ZB of the Health and Care 2022, all elements of the project will fully comply with all required procurement legislation as well as the SFIs of both UHBW and NBT in terms of the new funding requirements.</p> <p>Furthermore, the following employment legislation has been identified as applicable to the project and will be adhered to:</p> <ul style="list-style-type: none"> ▪ Employment Rights Act 1996 ▪ National Minimum Wage Act 1998 ▪ Employment Relations Act 1999 ▪ The Maternity and Parental Leave etc. Regulations 1999 ▪ Part-Time Workers (Prevention of Less Favourable Treatment) Regulations 2000 ▪ Transfer of Undertakings (Protection of Employment) Regulations 2006 ▪ The Equality Act 2010 ▪ Agency Workers Regulations 2010 <p>Full regulatory requirements have been considered in the context of the MHRA Orange Book. Additionally, the project has been considered in the context of MHRA requirements including Annex 1 of GMP in relation to the manufacture of sterile products.</p> <p>Lastly, in addition to regulatory requirements, the new facility will aim to adhere to NHS best practice requirements such as those outlined in the NHS Agency Rules June 2019.</p>
<p>d) We assume that Modern Methods of Construction (MMC) will be used for new builds. Please provide details of how MMC will be utilised.</p>	<p>The preferred option will identify lease of a facility in place of construction of a new regional hub, refurbishment requirements will be incorporated in the lease terms and conditions and third-party leases will not be considered.</p> <p>Thus, this project does not anticipate the preferred option requiring construct of a new build and fall under a new build scheme remit and will therefore not require a Building Research Establishment's Environmental Assessment Method (BREEAM) assessment or planning permission. However, a BREEAM assessment will be conducted should NHSE deem it necessary. Furthermore, confirmation of both procurement and design will be followed with the completion of the Health Building Note (HBN) on the extension of the aseptic service and facilities (with any deviations explained).</p> <p>Health Technology Memoranda (HTM) reflect a standardised set of documents that offer comprehensive guidance regarding the design, installation and operation of specialised buildings and engineering technology used in the delivery of healthcare. These have been considered at the outset to ensure that best practice has been considered and align with their stated goals of improved patient outcomes relating to safety, effectiveness, and patient experience.</p>

	<p>As the design phase matures further, these will be further considered to ensure compliance with building requirements and alignment with best practice considerations. While no pre-defined hierarchy of HTMs has been confirmed in relation to the HTMs, early consideration has been focused on HTM 00 Policies and principles of healthcare engineering especially regarding the construction management governance arrangements, utilities consideration, infection prevention and control, electrical services and ventilation and cooling considerations. HTM 03 Specialised ventilation for healthcare premises has also been considered and will continue to be relied upon given the requirement for air handling units, particle monitoring and limits as part of clean room, and aseptic production requirements. Furthermore, HTM07-02 Making energy work in healthcare has also been considered in line with broader NHS sustainability goals.</p> <p>Similarly, health building notes (HBN) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. While the preferred option will not involve construction of a new facility, the relevant principles can still be considered to ensure best practice is achieved. Again, while no confirmed HBN hierarchy has been defined, core consideration has initially focused on HBN00 General design guidance for healthcare buildings especially regarding the policy and regulatory overview elements such as CQC or MHRA requirements, NHS Constitution consideration which sets out the rights to which patient, public and staff are entitled to, health and safety considerations, and the code of practice regarding the practice in infection prevention and control Strategic and master planning elements as outlined in HBN 00 have also been considered. Given that improving resilience has been outlined as one of the key aims of the project, HBN 00-07 Planning for a resilient healthcare estate has also been considered. Key elements of focus from this guidance has centred around robustness of facility design, especially in relation to varying product demand profiles, and aspects that can impact facility robustness. These include, but are not limited to, unavailability of premises due to fire or flood etc, transport infrastructure challenges, major IT or electronic disruption, loss of access to key resources, loss of critical support services or loss of access to key resources. In considering these aspects, it was accepted by clinical leads that UHBW clinical facilities are currently dealing with many of these aspects that can negatively impact facility resilience. Given that the pharmacy aseptic and technical services will require aseptic clean room working conditions, HBN00-09 Infection control in the built environment will also be considered. Lastly, as this is ultimately a pharmacy project, HBN 14-01 Pharmacy and radiopharmacy facilities have been (and will continue to be) considered. General design principles have such as facility location, aseptic and storage requirements, radiation protection, security and general infection control have been considered. As the design phase matures, the detailed information regarding aseptic preparation facilities, including the requirement of changing rooms, inner and outer support rooms, and clean room requirement as well as the flow of overall design.</p>
e) Confirm contribution to carbon reduction plan (if applicable).	<p>The design and implementation of the Preferred Option (Option 4c, see Economic Case) will be in accordance with the Green Plan 2022, outlining the commitment to improving sustainability throughout the organisation with support for the NHS in the pursuit of becoming the world's first net zero health service. The Green Plan is focused on nine core areas, aligned to the key drivers for change and key sources of carbon emissions, within the NHS.</p> <p>Both NBT and UHBW have published individual documents detailing their commitment to the carbon reduction and sustainable development. Full details can be found in UHBW's Sustainable Development Strategy (SDS) 2020-2025 and NBT's Green Plan 2020-2021. Project leads have already considered the need to align the project with this documentation in relation to sustainability elements including carbon reduction strategies. This will range from scope 1, 2 and 3 emissions. While reporting elements are yet to be defined, UHBW's SDS provides clear aims and potential metrics and reporting mechanisms that could be adapted as part of the project. Wider literature sources are available to further support the development of a carbon evaluation calculation methodology. These include the Magenta Book detailing ventral government guidance on evaluation and the carbon valuation literature as developed by the department for Emergency Security and Net Zero and Department for Business, Energy, and Industrial Strategy.</p>

FINANCIAL CASE

a) Please provide narrative to support the detail provided in Section 4 (above).

As noted in the introduction, this business case will rely on the assumption of capital funding from outside of the BNSSG ICS CDEL from nationally available funding as part of the national NHSE Infusions and Special Medicines Programme following on from Lord Carter of Coles' Transforming Aseptic Care in England Report.

The scope of this Business Case is to deliver a full scale aseptics hub with capacity to meet current demand, including supply to Weston General Hospital Cancer Satellite, absorb future growth, of multiple medication categories as well as address the significant unmet need, releasing nursing time to care by producing ready-to-administer CIVAS products for use on wards and support product supply to other NHS partners both within and beyond the scope of the BNSSG ICS.

Capital Expenditure Profile

Two iterations of the capital expenditure profile have been presented. The first is inclusive of radiopharmacy and the second exclusive. The key difference in pricing is derived from the expectation that with the exclusion of radio pharmacy, there will be a reduction in floor space and associated equipment which drive the cost differences. While the exact breakdown of capital expenditure has yet to be finalised, it is expected that most of the funding will be spent during the 2025/26 financial year in line with expected NHSE funding release. An initial outlay of 10% has been suggested for the 2024/25 financial year to enable some of the preliminary works etc to be completed and enable smooth transition into full completion in 2025/26. This 10% would be comprised of preliminary planning costs and associated professional fees. Once again, it must be noted that the breakdown of fees presented is for illustrative purposes and may be subject to further change as the design phase matures.

Breakdown of Scheme Capital Costs

Similarly, two iterations of the breakdown of scheme capital costs have been presented, again to enable differentiation of the costs inclusive and exclusive of radio pharmacy. The work costs, fees, non-work costs, equipment costs have all been derived and extrapolated from baseline data provided and third-party experts. Conservative estimates have been applied to reduce the risk of underestimation of costs. Additionally, optimism bias, planning contingency and inflationary adjustments have been included at 5% each, again to reduce the risk of underestimation of costs. These represents approximately £2.6m inclusive of radiopharmacy and £2.2m exclusive of radiopharmacy. VAT has been applied to all elements at the standard 20%.

There are two versions of three tables (i.e., six tables total from figure 4 – 9). Figure 4 shows the combined financial summary of both UHBW and NBT, with figure 5 and 6 detailing UHBW and NBT independently, with all figures reflecting radio pharmacy inclusion. Conversely, figures 7 – 9 show the same detail but exclusive of radio pharmacy activity, or other financial involvement.

Financial Position Summary

Balance Sheet Summary

The balance sheets presented are indicative of the assets employed after completion of the project. No 'additional' assets will be employed under the do minimum scenario, hence this has not been zeroed. Depreciation has been applied on a flat line basis as per UHBW's (the lead organisation) instructions in accordance with IRFS 16 rules over a 23-year basis (excluding 2 base years until FY 25/26) when the facility will be operational with leasing charges incurred. The asset values represented in years Y25 show the value the assets employed after the life of the project with the diminished value driven by the annual depreciation.

MCFlow Summary

Master cash flow statements have been presented inclusive and exclusive of radiopharmacy. Cashflow will operate on a net neutral basis. However, in both figure 5 and 8 the UHBW operating income is significantly lower in option 4c (inclusive and exclusive) of radiopharmacy. This assumes that through operation of the new hub facility, the increased capacity created will lead an increase in volume available for commercial activity. Based on this rationale, this should reduce the baseline funding from trust input needed to operate pharmacy aseptic and technical services.

	<p>I&E Summary</p> <p>Income and expenditure have been developed based on baseline data provided. Commercial income has is driven by current activity, which in turn is derived mainly from PSU activity relating to parenteral nutrition product supply radio pharmacy and UHBW's production facility. While full market scoping and investigations have not been discussed, preliminary review of activity with discussion of current local facility landscape indicate this will be a significant potential revenue driver. This amount diminishes within option 4c as there is a greater potential for commercial income. Inflation at 2% per annum has been applied to all costs and the commercial income potential.</p> <p>Baseline funding is the amount that each respective trust must provide to enable services to continue to operate year on year. The diminished value seen in both iterations of option 4c is reflective of the assumption that as the facility becomes operational, and commercial income potential increases, trusts must commit a reduced level of baseline funding to maintain an operational pharmacy aseptic and technical service.</p> <p>Pay data is derived from 2021/22 baseline pay figures. Minor amendments have been made to accounting data provided by clinical leads to reflect a more accurate cost of operating the facility (i.e., to reduce potential double counting for staff members with current PATS and Non-PATS roles). All assumptions have been confirmed with respective clinical leads and financial representatives. As seen in all sets of tables, there is an increase in staffing costs in option 4c reflecting the additional staff required to operate the service. Inclusive of radiopharmacy, this is reflected in an additional £38m over the course of 25 years. Exclusive of radiopharmacy this is reflected in an additional £26m over the course of 25 years.</p> <p>Non-Pay clinical services are largely driven by third party expenditure costs. As seen in the differential tables, option 4c offers significant cost savings in this element which in turn reduces the amount of trust commitment funding required for the service to operate and reduced the overall total income required for the service to operate.</p> <p>Interest has been applied at the Treasury standard of 0.95%. Public dividend capital (PDC) charges have been assumed at 3.5% of net relevant assets. With the leasing charge derived from assumed floor space requirements, this ranges from approximately £346k to £296k per annum (inclusive and exclusive of radio pharmacy).</p> <p>These charges have been applied to UHBW's financial position alone as it is acting as the lead financial organisation and so will retain responsibility for the management of these elements. As there is no public capital applicable to the do minimum option, these charges are entirely derived from the assumption of the progression of the leasing of the new facility in line with cost estimates. Leasing has been selected as more appropriate from an ongoing financial management standpoint.</p> <p>UHBW Whole Trust Impact</p> <p>The impact of the project on UHBW is represented in figures 10 and 11 (inclusive and exclusive of radio pharmacy respectively). Regardless of radio pharmacy involvement, the overall operating expense in net neutral on the basis that the PATS operating costs will also be. While option 4c does add significant staffing costs to UHBW's position, these costs are greatly offset by the commercial income potential as evidenced in figures 5 and 8.</p>
<p>b) Please explain any incremental revenue consequences of the investment and how they can be mitigated.</p>	<p>For the purposes of the business case, revenue elements have been structured in three categories, pay revenue, clinical services (including drug cost) and miscellaneous cost elements.</p> <p>Increases seen in pay and miscellaneous costs have been greatly offset by the expected savings seen against clinical services costs. This savings element is derived from the expectation that through greater volumetric production capacity, the hub facility will be able to meet current demand levels and absorb subsequent growth. Accordingly, there will be no need to be entirely reliant on third-party vendors for medication supply. Regardless of the financial element, it has also been noted that third-party production capacity has been shown to be currently struggling to meet demand levels. Therefore, it does not make financial or risk management strategic sense to expect this to be a viable supply source.</p> <p>While additional staffing revenue costs will be incurred through increased staffing numbers to maximise the output potential, the reduction in third-party reliance and associated costs means that this is a much more efficient means of managing pharmacy technical services financially.</p>

	<p>In this way, the successful operation of the preferred option through implementation of a new hub facility will mitigate incremental revenue consequences by reducing the overall long-term revenue burden through a reduction in third-party spend expenditure. As outlined in all sets of the total financial position summaries, successful implementation of the preferred option will lead to a significant drop in non-pay clinical service costs which are primarily driven by costs associated with increased costs of purchasing medication from third party commercial providers.</p>
<p>c) Are there any cash flow issues, such as fees, enabling works, that require early funding?</p>	<p>The cashflow from operations are expected to be net zero. This is on the basis that capital funding is drawn down in a profile to match to investments and that income is received from partner organisations to support revenue costs.</p> <p>Accordingly, we do not expect any cash flow issues that require early funding. As noted in the financial tables, the long-term cash flow requirements are significantly lower in option 4c compared to those in the do nothing or do minimum options. While there are initial cost pressures seen in the first five years as recruitment drives raise the level of staffing (and associated pay costs), this is quickly recouped by the anticipated savings from the avoidance of third-party cost elements.</p>
<p>d) Confirm that the project can be managed within existing funding envelopes.</p>	<p>Following NHSE approval of Business Case, national capital funding of £20.2million or £24.6million (i.e., funding pot allocation inclusive or exclusive of radio pharmacy) will be allocated to the project which covers the proposed service works.</p> <p>While there may be some revisions in cost elements as the design phase matures, conservative cost estimates have been applied to minimise the risk of optimism bias. As such, we can confirm that the project will be managed within the funding envelope stated.</p> <p>The project will be managed in pre-defined management stages with cost tolerances established and approved by the board for each stage.</p> <p>If an exception is forecast, this will be reported to the board and corrective action taken to ensure the delivery of the project within the funding envelopes.</p>
<p>e) Confirm and demonstrate that the recurrent revenue cost of the scheme is affordable.</p>	<p>As noted, the comparable 'do nothing' and 'do minimum' result in significantly higher longer revenue costs with the expectation that increased reliance on third party vendors will incur significant revenue increases. Due to the cost associated with "do-nothing", the incremental revenue cost is minimised and accepted as a system cost pressure as detailed above.</p> <p>To date, opportunities for income generation have not been explored fully beyond basic extrapolation of current commercial income. As such, we expect the commercial income listed to be a representation of the floor minimum, meaning this could offer an additional source of affordability for the project.</p> <p>Consideration of options to include income generation will be overseen by the project board.</p> <p>Additionally, the financial benefits associated with support of and collaboration with OPAT services have not been calculated. While these elements are still relatively immature, it was deemed that it would not have been appropriate to calculate financial values as any assumptions made would be abstract and potentially too far removed from working practice. However, given that these schemes, when properly supported, have the potential to have a substantial positive impact on bed release (which represents one of the most considerable pressures facing the acute NHS care settings at present), this could result in significant financial benefits further aiding the affordability of this scheme.</p>
<p>f) Confirm the trust has assessed and is able to fund lifecycle costs to keep the facility at condition B.</p>	<p>Lifecycle costs have been included in the initial CIA model which has been used to populate the VfM model. We have calculated that the expected lifecycle capital required to replace and maintain necessary equipment as per stated shelf lives provided by clinical leads within the baseline data. This has been estimated in line with expected minimum shelf lives, while considering optimism bias and risk elements. We therefore expect that the lifecycle capital costs stated may be an overestimate. Furthermore, we have considered the broader revenue cost elements as part of the costings.</p> <p>All project parties have been sighted to these cost elements and are comfortable with the minimum requirements to maintain the facility to condition B (sound, operationally safe and exhibiting only minor deterioration).</p>

MANAGEMENT CASE	
a) Confirm the arrangements for the management and delivery of the scheme.	<p>The new facility will operate to the highest achievable standards. This will be guided by literature sources such as the NHS' Assurance of aseptic preparation of medicines (https://www.england.nhs.uk/long-read/assurance-of-aseptic-preparation-of-medicines/), the Royal Pharmaceutical Society's Quality Assurance of Aseptic Preparation Services: Standards (https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Quality%20Assurance%20of%20Aseptic%20Preparation%20Services%20%28QAAPS%29/rps---qaaps-standards-document.pdf) and compliance with the current MHRA Good Manufacturing Practice and Good Distribution Practice (https://www.gov.uk/guidance/good-manufacturing-practice-and-good-distribution-practice) and in conjunction with leadership from the project team as outlined in the provider capacity and capability section.</p> <p>A robust 3-tiered governance structure will be established and deployed to manage, oversee, and enable the delivery of the implementation of the aseptic service transformation:</p> <ul style="list-style-type: none"> ▪ Tier 1- Programme Executive: Responsible for approving any transformational and / or strategic change and is the final point of escalation. <ul style="list-style-type: none"> ○ Professor Stuart Walker, Medical Director and Deputy Chief Executive Officer, and Project SRO. ○ Neil Kemsley UHBW Director of Finance and Information. ○ UHBW Director of Pharmacy ○ Strategy Officers ○ NHSE Colleagues ○ Debbie Campbell – ICB Deputy Director of Medicines Optimisation ○ ICS Chief Pharmacist ▪ Tier 2 - Project Board and Clinical Reference Groups: The board are responsible for overseeing the project planning and delivery and oversight of adherence to the principles set out in the MoU. The Board monitors progress through the monthly Board meeting, and update teleconferences, as needed. The CRG will be responsible for product catalogue changes from a product perspective and horizon scanning. <ul style="list-style-type: none"> ○ ICB Deputy Director of Medicines Optimisation ○ UHBW Director of Pharmacy ○ NBT Director of Pharmacy ○ UHBW Associate Director of Pharmacy – Production ○ UHBW Associate Director of Pharmacy – Adult Cancer and Aseptic Services ○ UHBW Associate Director of Pharmacy - Radiopharmacy ○ UHBW Associate Director of Pharmacy – QA/QC ▪ Tier 3 - Hub Leadership Team: Management of service delivery and ensuring quality is in line with licensing. <ul style="list-style-type: none"> ○ UHBW Associate Director of Pharmacy – Adult Cancer and Aseptic Services ○ NBT Principal Pharmacist - Technical Services and Haematology ○ NBT Lead Pharmacy Technician - Aseptic Services ○ UHBW Associate Director of Pharmacy – QA/QC ○ UHBW Associate Director of Pharmacy – Pharmacy Production ○ UHBW Associate Director of Pharmacy - Radiopharmacy

	<p>Clear responsibility across the three-tiered structure have been identified within each of the following critical workstreams:</p> <ul style="list-style-type: none"> ▪ Contracting and charging ▪ Catalogue Management ▪ Allocation Management ▪ Managing Capital Funding ▪ Business Continuity ▪ Service Key Performance Indicators and Metrics ▪ Term and Exit Provisions ▪ Procurement and Commercial ▪ Workforce ▪ Audit and Risk <p>As part of the project management process, key areas for leadership will be identified from respective subject matter leads. The management strategy of the new facility will endeavour to support individual accountability while also facilitating an open and transparent working environment that does not promote blame culture but enables mistakes to be openly discussed and learned from.</p> <p>For contracts to deliver successfully, on time and on budget, they must be actively managed from inception to conclusion. A proactive contract management plan will also be implemented to ensure successful contract delivery and better achievement of value for money. This will be managed by the procurement and commercial workstream but in conjunction with the audit and risk workstream to ensure that risks are appropriately quantified, and all stakeholders are aware of the potential impacts of poorly managed contracts. Through effective management of this element, this will further support achievement of financial benefits, for example through regular review of medication and pricing structures.</p>
<p>b) Confirm the key risks to delivery and measures to mitigate and manage these risks.</p>	<p>A Risk Log is in place for the collaboration, maintained by the Project Manager. Risks will be continually monitored and managed by the Project Team, with escalation to the Project Board and the Executive when appropriate and will continue to do so throughout the project lifecycle.</p> <p>The key risks to date have been classified into four types: financial, transformational change, operations, and workforce. Example risks across these types and supporting mitigation strategies have been captured below:</p> <p>Financial:</p> <ul style="list-style-type: none"> ▪ Necessary capital funding may not be available to support construction of a new hub to provide increased production of aseptically prepared medicines via a hub and spoke model. Mitigated through review of financial case to align with the national capital funding allocation. Pending approval of NHSE on Business Case. ▪ Incorrect cost or time estimates leading to increased costs (either directly or indirectly). Continual refinement of cost and timeline elements to ensure accuracy will mitigate this risk. With the required capital not expected for release until FY 2025/2026, effective utilisation of this lead time will further strengthen this mitigation strategy. ▪ Significant lead times for procurement of equipment due to high numbers of specialist equipment required. Mitigated by initiation of procurement process at earliest opportunity and scope potential to take delivery of equipment in a staggered process. <p>Transformational Change:</p> <ul style="list-style-type: none"> ▪ Missed opportunity to implement fully automated technology due to market position and feasibility at point of unit build. Flexibility regarding future demand and service provision has been continually highlighted as a necessity within the project, which has in part driven the decision toward a preferred option that will enable flexibility. This will therefore enable mitigation of this risk by design of the hub unit to incorporate ability to replace equipment in future to introduce automated technology if available and supported by the MHRA. <p>Operations:</p>

- Delay to project implementation awaiting MHRA site inspections and therefore delaying commissioning. Mitigated through regular liaison with MHRA at regular intervals throughout project and work closely with them to avoid potential delays and effective utilisation of project team's MHRA experience.

Workforce:

- The necessary workforce may not be available to support the preferred model or delayed recruitment due to availability. Mitigated through exploration of new approaches to skill mix, early initiation of recruitment and through phased waves to reduce burden of recruitment requirement and impact of risk. This can be further mitigated through enhanced in-house training opportunities should significant recruitment challenges be encountered. Training of non-pharmacy staff where possible will also act to further mitigate this risk. Benefits calculations have further mitigated this risk through conservative recruitment estimates that have reduced the modelled benefits realisation. In turn this should ensure that the benefits presented are in line with the minimum expected for realisation.

Risk Title and Impact Score	Option 4c Major Off-Site Hub	Mitigation Strategy
National funding unavailable (5)	Possible (3)	Business Plan Drafting to align with national strategy.
Procurement related delays (4)	Possible (3)	Planning at the earliest outset to prevent likelihood of delays.
Inability to recruit required staff in relation to preferred option (4)	Possible (3)	Collaboration with workforce strategy team to inform recruitment.
Negative impact on workforce wellbeing owing preferred option working patterns (3)	Possible (3)	Appropriate planning to reduce likelihood and impact.
Patient Care Risk (5)	Unlikely (2)	Full operational mapping to mitigate operational risk and match demand
Reputational Risks (4)	Unlikely (2)	Alignment with national strategy in business case.
Failure to translate design (4)	Possible (3)	Collaboration with estates and facilities and design specialists.
Incorrect cost estimates (3)	Possible (3)	Procurement strategy to maximise competitive advantage and VIM
Contractor default (4)	Unlikely (2)	Procurement strategy to minimise this risk.
Failure to meet performance standards (4)	Unlikely (2)	Collaboration with respective clinical leads.
Incorrect estimated cost of providing clinical services (2)	Possible (3)	Pessimistic cost modelling; iterative reviews.
Changes in the volume of demand for patient services (2)	Possible (3)	Pessimistic output modelling; flexible design capabilities
Estimated income from income generating schemes is incorrect (2)	Possible (3)	Pessimistic output modelling; flexible design capabilities; SCMD demand mapping.
Incorrect time estimates (3)	Possible (3)	Procurement strategy to minimise this risk.
Incorrect cost and time estimates for decanting from existing buildings (2)	Possible (3)	Procurement strategy to minimise this risk.
Regulatory licenses / accreditations cannot be achieved option (5)	Unlikely (2)	Collaboration with respective clinical leads and regulatory stakeholders.
Changes in national agenda shift focus for pharmacy technical services (4)	Unlikely (2)	Collaboration with NHSE colleagues
Model does not sufficiently allow for future changes in infrastructure (3)	Unlikely (2)	Pessimistic output modelling; flexible design capabilities
Local configurations are varied and complex driving additional complexity and cost (3)	Possible (3)	Early collaboration with design specialists.
TOTAL	169	

Figure 26: Risk Log Summary of Preferred option with mitigation strategies

c) Set out the benefits realisation strategy and how the Trust intend to monitor and report on benefits.

To measure and track benefits realisation, benefits to monitor have been grouped into the following with examples provided for each:

Direct & Financial Benefits

- Release nursing time to care.
 - **Realisation Strategy** – This benefit will be realised as the offsite hub facility becomes operational and approaches maximum capacity output. In doing so, it is expected that the excess production capacity will become available to reallocate ward level production to the hub facility.
 - **Calculation Method** – Released nursing time to care will be calculated through the hub CIVAS production output. In line with Lord Carter of Coles methodology, this benefit will assume 12.5mins per dose and 1950 hours per WTE. Monetisable benefits will be extrapolated from the Agenda for Change (updated yearly).
 - **Reporting method** – Production output will be tracked monthly. While yet to be finalised, this benefit will be reported monthly in line with the drafted Governance arrangements.
- third-party cost avoidance Financial Release

- **Realisation Strategy** – This benefit will be realised through total volumetric output which will in turn link to a reduction in reliance and need from third-party vendors.
- **Calculation Method** – This will be considered through categorisation of volumetric output which will be multiplied against average cost data to calculate estimates of cost levels avoided.
- **Reporting method** – Production output will be tracked on a monthly basis. While yet to be finalised, this benefit is expected to be reported monthly in line with the drafted Governance arrangements.
- Bulk procurement efficiency savings
 - **Realisation Strategy** – With expansion of collaboration services, there will be increased potential to combine procurement elements to leverage economies of scale benefits more effectively. This benefit will therefore be realised as the new facility becomes operational allowing bulk procurement.
 - **Calculation Method** – This benefit will be monitored by the Procurement and Commercial Workstream. Savings targets and potentials will be identified by subject area leads within this workstream, with exact method of calculating savings calculated as the facility becomes operational.
 - **Reporting method** – Corresponding benefits will be reported in a format and frequency as defined by the Procurement and Commercial Workstream, but this is expected to be monthly.

Indirect & Non-financial Benefits

- Improved production safety and product quality
 - **Realisation Strategy** – Improved production safety and product quality should be realised naturally through improved governance benefits. Standardised practice through development and implementation of SOPs and other training guidelines will support realisation of this strategy.
 - **Calculation Method** – No calculation method has been defined for this aspect. However, quarterly, bi-annual, or annual audits for medication safety incidents would seemingly be a suitable method in combination with ongoing error, safety or near miss logs would be prudent.
 - **Reporting method** – Ongoing incident reports will be reported internally. Depending on the frequency, nature and risk of errors or safety incidents, these may be reported on an ad-hoc basis with corrective and preventative actions reported in conjunction.
- Improved product availability of raw materials
 - **Realisation Strategy** – Through combined procurement and bulk purchasing arrangements, it should be possible for the commercial and procurement workstreams to implement a realisation strategy effectively.
 - **Calculation Method** – This benefit will be monitored by the Procurement and Commercial Workstream. Savings targets and potentials will be identified by subject area leads within this workstream, with exact method of calculating savings defined on a case by case basis and as the facility becomes operational.

- **Reporting method** – Raw material shortages and frequency may be tracked and reported internally. Depending on the nature, risk, and frequency on any unavailable products, this will be reported on an ad-hoc basis with suggested alternative sourcing strategies.
- Reduced impact of unplanned downtime of equipment / unit
 - **Realisation Strategy** – This benefit will be realised through operations of the new hub facility as it approaches maximum capacity. In ensuring limited downtime, the Service Key Performance Indicators and Metrics Workstream will work to ensure that all equipment is adequately maintained to minimise the risk of any 'knock on' unplanned equipment downtime as a result of unforeseen maintenance or replacement. Furthermore, this benefit should be realised through effective planning and management of demand profiles (both internally and externally) to ensure effective and efficient utilisation of all equipment.
 - **Calculation Method** – Monitoring of planned and unplanned equipment downtime with corresponding reasons or explanation will serve as a suitable calculation method.
 - **Reporting method** – This could potentially serve as a bi-annual audit metric. Unless otherwise specified by the project board, this frequency should be suitable to ensure that this benefit is realised.
- Regulatory and Operation Risk Improvements
 - **Realisation Strategy** – Ongoing review of the relevant risk registers, with recalculation of risks following pre and post the hub becoming operational.
 - **Calculation Method** – Exact method of calculation will be defined by the audit and risk workstream, but it is expected that risks will be scored on an impact x likelihood basis to provide a raw risk score. The TAME framework will further be used to define risk management strategies.
 - **Reporting method** – A risk summary will be reported monthly as part of the appendices. High scoring or risks in need of discussion will be highlighted to the project board on an ad-hoc basis (as defined by the project boards risk appetite score).

Soft Benefits (areas of opportunity)

Soft Benefits represent areas of further potential exploration for the project board to define their feasibility, realisation strategy, calculation, and reporting methods. These include:

- Enforced standardisation.
- Workforce, training, and retention.

A benefits register template has been provided to outline how benefits may be tracked. Again, as the project progresses toward maturity and implementation, this register may need to be refined and update. However, it should serve as an adequate starting point.



BenefitsRegisterv2.

<p>d) Set out the expectations for Post-Project Evaluation, and the expected timescales for the review of delivery.</p>	<p>The Project Board once established will meet on a regular monthly basis to provide continuous monitoring of the project. As part of a recurring item on the Project Board meeting agenda, post-project evaluation (PPE) will be regularly conducted, reviewed, and is set as a priority for all board members to provide feedback on the project throughout the stages of implementation.</p> <p>This practice will continue post go-live of the aseptic hub, and its partners will undertake PPE, in line with Green Book, NHS England / Improvement, and procurement framework requirements. PPE will enable the following to be reviewed, tracked, and monitored:</p> <ul style="list-style-type: none"> ▪ Business Case Development Review: Following the completion of both business cases, reviews will be completed between the project delivery team and working group to ensure successful completion of the necessary activities and all lessons learned have been captured. ▪ Implementation Review: Following successful implementation and delivery of the new aseptic facility, an implementation review will be conducted, to assess the specific aspects of implementation and lessons learned for any future implementation programme. ▪ Benefits Tracking: The project's SRO will retain overall responsibility for ensuring benefits' realisation and the PPE will ensure that the project's planned benefits and aims are realised and will measure the extent to which they are realised. ▪ Risk Management: The project's SRO will retain overall responsibility for managing risks and issues which develop over the course of the project and will ensure these are tracked and mitigated successfully in line with PPE requirements. <p>The project board will define a dedicated PMO function allocated to this project and will commit to ensuring PPE and the activities outlined are completed.</p>
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Appendix 1 – Additional Programme Detail

APPENDIX 1: ADDITIONAL PROGRAMME DETAIL	
The approx. population size of your ICS that your hub will cover?	Approximately 1 million
How many hospitals and ICS areas will you be supplying?	Two trusts (multiple sites including the Weston General Hospital) and BNSSG ICS initially with aims to supply to wider parties.
The number of spoke units the hub will support?	<p>Three</p> <ul style="list-style-type: none"> - UHBW - Weston General Hospital will shift its reliance from third-party producers entirely to the new hub facility (unless strategically chosen medication lines retained for third-party outsourcing). - North Bristol Trust to continue on-site bespoke production, but with greater reliance on the new hub facility. - UHBW – Bristol Hospitals (7 sites) to continue on-site bespoke production on site but will shift majority of production operations to the new hub facility.
The range of products, e.g. PN, chemo etc. you will produce?	Core products will consist of parenteral nutrition, chemotherapy, immunotherapy, ATMP/genomic therapy and CIVAS products.
What are your plans for production of standardised products?	<p>The hub would be designed to be able to output a limited number of specifically commissioned high volume activity lines of standardised products as directed by NHSE.</p> <p>All the output from the hub will be standardised in its nature and made under license to allow onward supply to other NHS organisations. Products will be produced in dose bands as recommended by NHSE where this is available; any newer medications produced that do not yet have a national consensus will be manufactured according to an agreed specification as defined by the project board after consultation with other key stakeholders.</p> <p>All CIVAS products will also be standardised, agreed by the overarching clinical reference group which will work closely with National Infusions & Special Medicines Groups and system level antimicrobial stewardship groups. Any changes or amendments to the range of products will require consideration and agreement by the group. Clinical leads will liaise with colleagues in the British Society of Anti-microbial chemotherapy and use connections with other key groups to ensure that the presentations reflect the latest best practice.</p>
What is your workforce plan to support the projected production capacity of the facilities?	<p>Workforce Considerations</p> <p>There is a well understood risk to the existing workforce in establishing a new large workforce for the hub. To mitigate this, the hub would be fully licensed and the use of a novel workforce is being promoted, such as expanded roles SMT apprenticeship graduates and for science graduates to reduce reliance on registered pharmacy staff.</p> <p>Already, project staff have liaised with the staffing working groups to consider the factors that could improve the effectiveness of staff recruitment and retention.</p> <p>Work Planned</p> <p>Consolidation of the learning and themes established is underway and meetings for 2023 have been planned. The workforce group will now look to define the required outputs and implement the required task and finish groups to deliver these.</p>
What are your plans for use of automation, digital and other technology?	<p>Technology considerations have primarily focused on ensuring that the facility is fit from a regulatory standpoint, especially in the context of the upcoming GMP Annex 1 considerations which will be mandatory from August 2023.</p> <p>Market scanning has been undertaken with the adoption of full automation deemed non-viable within the time frames of the project due to regulatory restrictions and technology efficiency. However, as the clean room designs are refined, considerations of future ways of working including integration of new technologies and automations suites with minimal disruption to over</p>

Anticipated operational hours to deliver the projected capacity?	Workforce modelling has been completed based on operational hours of 7am-7pm, Monday-Friday. This model maximises the standard working hours for NHS agenda for change and therefore ensures the best value for money with respect to workforce costs. This also allows for future expansion of capacity by extending the operating hours to include weekends and bank holidays. Any changes to the operating model will be undertaken through consultation and overseen by the board.
Contingency plans to mitigate risk of major site failure?	Extensive work has been done to consider contingency plans in the event of site failure. The first major decision was the retention of onsite minor production facilities to reduce entire reliance on the new hub facility thus mitigating this site failure risk.

Appendix 2 – Schedule of Works (to be attached by Trust)

Appendix 3 – OB Forms (to be attached by Trust)

Appendix 4 – Key Estates Information [to be evaluated and adjusted for each individual programme]

KEY ESTATE METRICS	
Total Area of Building m ²	TBC
New build clinical GIA m ² and % of total GIA	N/A
New build non-clinical GIA m ² and % of total GIA	N/A
Refurbishment clinical GIA m ² and % of total GIA	TBC
Refurbishment non-clinical GIA m ² and % of total GIA	TBC
No. of beds and type	N/A
PFI Estate Implications <ul style="list-style-type: none"> - Is the build on an existing PFI Estate? - Does the build interface with any PFI Estate? - Are there any other implications with the PFI Contract that need to be considered? 	N/A
MMC (Modern Methods of Construction) Status. Percentage to be achieved and brief overview	N/A
Summary of any significant derogations and assurance (derogations template is available)	N/A
£ Reduction in BLM	N/A
Any temporary accommodation required – provide details	TBD
Is a land purchase required – provide details	No.
Is this an owned or leased facility – provide details if leased	Lease (TBC) – Intention to negotiate break clauses for year 10, 15, 20 as part of overall 25 year lease.
Stage of design development and trust approval (please attach design drawings)	TBC
Estimated average lifecycle costs £/m ² over asset life	TBC



Meeting of the Trust Board of Directors in Public on Tuesday 12 September 2023

Reporting Committee	Quality and Outcomes Committee
Chaired By	Sue Balcombe, Non-Executive Director
Executive Lead	Deirdre Fowler, Chief Nurse and Midwife

For Information

Industrial action continues to have an impact on performance. The committee was assured that planning for such events was continuing to be managed effectively however the wellbeing of staff is being affected.

There is a sustained improvement in patient flow with better performance in 4-hour ED waits, ambulance handover times. No Criteria to Reside and Timely Discharge. The committee will receive a detailed overview of the range of actions taken to support this at a future meeting.

The committee received the Quarter One progress against the Quality Objectives and noted two new objectives around Patient Experience and Managing Sepsis.

The Quarter Four complaints report showed the ongoing challenge with managing the backlog of complaints within the target timelines even though there were fewer complaints especially regarding outpatient appointments and admissions.

The committee was really pleased to see the sustained improvement in Safer Staffing fill rate which was 98% for June. Vacancies and turnover remain stable with a good reduction in the use of agency staff.

The Quarter One Legal Report highlighted the ongoing backlog in inquests with many becoming more complex and requiring increased levels of preparation and collaborative working.

For Board Awareness, Action or Response

The committee received a paper summarising the review of services to support the transition from Children to Adults services for patients within the Trust. NICE Quality Standards set out clear practice guidance and whilst there are many services providing an excellent standard of care there are currently gaps in the Transition Lead post and appropriate support to ensure that this function is consistent and compliant. This has been escalated.

Saving Babies Lives has issued Care Bundle 3 with implications for scan capacity amongst other things. The requirements are currently being costed prior to a funding decision.

The committee received the HSMR Learning from Deaths Deep Dive which was a very detailed report exploring the possible cause of the raised HSMR since January 2022 - which has now fallen back to within expected levels. The report outlined the



strong association between operational pressures and the increase in HSMR and gave assurance regarding action taken including palliative care coding.

Concerns regarding the system management of patient with paediatric mental needs is ongoing and has been escalated within the system and to CQC.

Key Decisions and Actions

Transition From Childrens to Adults Services funding gap escalated.

Additional Chair Comments

The committee received an excellent presentation outlining the excellent work being undertaken by the Diagnostic Service in the face of a huge growth in referrals, a skills shortage and a significant increase in costs. Innovative solutions include the use of AI to detect and diagnose, the development of Community Diagnostic Centres and the development of new roles.

Date of next meeting:

26th September 2023

Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Report Title	Performance Report
Report Author	David Markwick, Director of Performance Philip Kiely/Lucy Parsons, Deputy Chief Operating Officers James Rabbitts, Head of Performance Reporting Anne Reader, Associate Director of Quality and Patient Safety Julie Crawford, Head of Quality and Patient Safety Alex Nestor, Deputy Chief People Officer Kate Herrick, Head of Finance
Executive Lead	Overview and Access – Jane Farrell, Chief Operating Officer Quality – Deirdre Fowler, Chief Nurse and Midwife/Stuart Walker, Chief Medical Officer Workforce – Emma Wood, Chief People Officer Finance – Neil Kemsley, Chief Financial Officer

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

Performance Report

Reporting Month: July 2023

INTRODUCTION

This report provides a monthly update of the key performance metrics within the NHS Oversight Framework for 2023/24 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.

PRIORITY	CORPORATE OBJECTIVE	Page
Quality and Safety	Ensure our patients have access to timely and effective care, with a risk based approach to preventing patient harm in our urgent and elective pathways	14
Our People	Deliver our workforce plans to develop new roles to retain and attract talent. Invest in high quality learning and development to retain colleagues and students. Ensure colleagues are safe and healthy by prioritising wellbeing and that everyone has a voice which counts, and are treated with respect regardless of their personal characteristics.	22
Timely Care	Reduce ambulance handover delays and waiting time in emergency departments Reduce delays for elective admissions and cancer treatment Improve hospital flow with a focus on timely discharging.	27
Financial Performance	Year To Date Income & Expenditure Position. Recurrent savings delivery and delivery of elective activity recovery. Strategic Risks.	48

Reporting Month: July 2023

EXECUTIVE SUMMARY

Quality and Safety

There have been six hospital onset hospital acquired cases and two community onset hospital acquired cases of C difficile reported in July. The Year to Date Total (YTD) in 2023/24 is 41 cases in the combined total of HOHA and COHA cases. Cleaning standards are generally compliant in FR2 areas but in the very high risk areas (FR1) full compliance has not been achieved consistently. This is actively scrutinised by the Operational Infection Control Group with Divisions, and the Facilities team. Each Division has a schedule of monthly 'walk arounds' with an Infection Prevention and Control (IPC) nurse and the matron for the Division. The monthly clinical ward audits will from August include a section for the ward manager to review the sluice and commodes formally and report this as part of their quality schedule for the ward.

The MRSA limit set for 2023/24 is zero. In July there have been two cases of MRSA bacteremia. Year to Date (YTD) in 2023/24 we have reported five cases in total. The Infection Prevention and Control team are working with procurement to agree a peripheral venous catheter (PVC) insertion pack to be used Trust wide, with its implementation to include enhanced training across the organisation about Aseptic Non Touch Technique (ANTT) practice.

Recent VTE risk assessment compliance remains relatively stable at 84% (excluding Weston due to data feed issues). Diagnostics and Therapies Division continues to be 100% compliant. With the exception of Surgery division, which saw a slight reduction of 0.4%, all other divisions reported improved compliance, with Women's and Children's division increasing by 3.8% to 90.8%.

In July, there were 16 patients eligible for the Best Practice Tariff (BPT) at Bristol. For the 36hr time to surgery standard, 9/16 patients (56%) achieved the standard. Orthopaedics have experienced difficulty accessing theatres to ensure consistent #NOF theatre and challenges with theatre and anaesthetic staffing which is impacting on overall theatre capacity. This predominantly effects our ability to utilise extra theatres for trauma in the event of cancellations. For the 72 hr. time to Ortho-Geri assessment, 16/16 patients (100%) achieved the standard.

In July, there were 26 patients eligible for BPT at Weston. 17/26, 65%, had surgery within 36hrs of admission. No patients 0/26 0% had an Ortho-geriatrician assessment within 72hrs of admission. Ortho-geriatrician post remains vacant.

Reporting Month: July 2023

EXECUTIVE SUMMARY

Our People

In summary, the Performance data for July 2023 shows the following:

The vacancy position has been adjusted in line with the ledger, and in July this decreased from 6.3% in the previous month to 6.2%. The Registered Nursing & Midwifery (N&M) vacancy rate is 10.6% and there continues to be a healthy pipeline of Internationally Educated Nurses (IENs) joining the Trust over the next nine months.

Turnover for the 12-month period reduced to 13.2%, compared to 13.8% (adjusted figure) for the previous month. Six divisions saw a reduction whilst two divisions saw increases in turnover in comparison to the previous month.

The largest divisional reduction was seen within Weston General Hospital, where turnover reduced by 1.4 percentage points to 11.0% compared with 12.4% the previous month.

Sickness absence has increased from 4.2% to 4.5% There were increases within all divisions apart from Women's and Children's. The largest divisional increase was seen within Facilities and Estates, increasing by 0.96 percentage points to 7.22%, compared to 6.27% in the previous month.

Overall appraisal compliance increased to 76.0% from 75.4% in June and there is a programme of work to improve the quality of appraisals conversations and a revised KPI of 81% for the new financial year for divisions to meet.

Mandatory training levels have increased to 89.4%, close to the 90% target.

Agency usage reduced to 1.6% from 1.7%, whilst Bank usage saw a slight increase from 6.2% to 6.6%.

EXECUTIVE SUMMARY

Timely Care

During July, industrial action has continued to challenge performance in some areas whilst improvement has been noted against a range of performance measures.

At the end of July 2023, 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.

The Trust had made significant progress in reducing the number of patients waiting over 78 weeks, bringing the number down from 877 in December 2022 to 166 in March 2023. Progress was also made during this period in narrowing the range of specialties that have care backlogs over 78 weeks.

The recent periods of industrial action have made progress towards elimination of these care backlogs more challenging, with the number of patients reported to be waiting over 78 weeks rising to 248 in May and subsequently falling to 215 in June and further reducing to 203 by the end of July. Whilst the number of patients waiting over 78 weeks is forecast to rise in August, the Trust is anticipating a sustained reduction from September and continues to work towards an elimination of patients waiting over 78 weeks in Q3 2023/24.

At the end of July 2023, the number of patients waiting longer than 65 weeks increased to 1,933 against an operating plan trajectory of no more than 1,670 patients. Industrial action has contributed towards a deterioration from June when 1,765 patients were waiting longer than 65 weeks against the trajectory of 1,870. As part of the 2023/24 Annual Planning Process, divisions have developed plans to move towards the national ambition of no patient waiting longer than 65 weeks by end of March 2024. This is now the focus of NHSE nationally, hence the recent letter received from NHSE (*Protecting and expanding elective capacity*) noted later in the report.

During 2022/23, the Trust made sustained progress in reducing the number of patients on a cancer pathway waiting over 62 days. The number of patients waiting over 62 days was reduced from a peak of 416 patients in August 2022 to 178 patients in March 2023. This reflected a recovery to below the 62-day baseline set for the Trust by NHS England.

The recent industrial action has made progress towards further reducing the number of patients waiting over 62 days more challenging, with the number of patients reported to be waiting over this threshold increasing to 238 in May and subsequently falling to 179 in June 2023. Performance has deteriorated in July, with 233 patients reported as waiting 62 days or more. Whilst performance is anticipated to deteriorate into August because of the loss of treatment capacity resulting from the industrial action, work will continue to mitigate against any impact and towards the new target of 150 by March 2024.

EXECUTIVE SUMMARY

Timely Care (continued)

Improvement has been made against the diagnostic six week wait standard. At the end of July, 78.0% of patients waiting for a diagnostic test had been waiting less than six weeks, with progress noted across a range of diagnostic modalities. This is ahead of the operational planning forecast and reflects an ongoing improvement against this standard. This is the best performance against this standard since March 2020 and the Trust continues to work towards the ambition that 85% of patients will be waiting six weeks or less for their diagnostic test by March 2024.

The Proactive Hospital Programme continues to run a range of initiatives focussing on ambulance handover, ED crowding and inpatient flow and discharge. During July, 75.3% of attendances spent less than 4 hours in an emergency department (ED), from arrival to discharge or admission. Performance against this standard continues to improve each month this year and is ahead of the operational planning trajectory of 63% with July being the highest performing month since March 2021. The Trust is on-track to achieving the March 2024 target of 76% of patients waiting less than 4 hours in ED.

The number of patients spending 12 hours or more in ED also improved significantly again in July 2023. The national ambition is that no more than 2% of patients spend 12 hours or more (total time) in ED and July saw the performance improve to 0.9%, the best reported position in the last four years. The Trust continue to progress actions to eliminate 12 hour waits altogether.

The proportion of ambulance handovers in excess of 15 minutes has been improving over the last eight months, with July reporting a much-improved position of 48.6% (62% in June). A similarly improved position was noted for ambulance handovers in excess of 30 minutes, with July reporting 17.1% compared to 27.3% in June and 45% in May. It is anticipated that further improvements will be seen as the various initiatives are deployed more widely over the coming months at the BRI and Weston.

During July, the average daily number of patients in hospital with no criteria to reside (NCTR) was 135. This maintains ongoing improvement and is the best reported performance since May 2021. The range of schemes implemented continues to have a positive impact on this standard.

The Transfer of Care Hub is currently being recruited to (c77% posts have been offered) and the Trust are working through the expected bed benefits from the fully established model.

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EXECUTIVE SUMMARY

Timely Care (continued)

NHS England wrote to acute trusts on 4th August, thanking colleagues for the progress that has been made against elective and cancer recovery and acknowledging the operational challenges faced, including ongoing industrial action. The [Protecting and expanding elective capacity](#) letter highlights the important role that outpatient services play in achieving elective recovery and asks each trust to provide assurance against a range of associated areas. The letter references three key actions that trusts are being asked to respond to:

- Revisit the plan on outpatient follow-up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for an outpatient appointment after 31 October 2023.
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied

Work is already in train to respond to the expectations outlined in the letter. In addition, to support the requirement the Trust have been asked to complete a self-certification on behalf do the Board by 30th September. In addition, in May the Trust received a notification of elective care priorities which included a checklist which has been completed and will be shared with Quality and Outcomes Committee in September.

The Trust also received a letter on 27th July relating to the delivery of operational resilience across the NHS this winter ([Delivering operational resilience across the NHS this winter](#)). The letter was addressed to all NHS Trusts, ICB and Primary Care Networks, setting out the key steps that must be taken together to meet the challenges ahead. The letter recognises the progress that has been made during a challenging period and reiterates the two key ambitions for urgent and emergency care recovery, namely:

- 76% of ED patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

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EXECUTIVE SUMMARY

Timely Care (continued)

Whilst NHS England have acknowledged the progress that has been made, trusts have also been invited to meet two stretch targets this winter and, in doing so, to qualify for part of a new capital allocation for 2024/25:

- Achieving an average of 80% ED 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

Work is progressing to complete the requirement in terms of winter preparedness.

NHS England (NHSE) and the Department of Health and Social Care (DHSC) wrote to NHS trusts and ICBs on the 17th August describing the changes to cancer waiting times standards that have been agreed between NHSE and DHSC. The changes will come into effect from 1 October 2023 ([Changes to cancer waiting times standards](#)).

The changes announced include the removal of the two-week wait standard in favour of a focus on the Faster Diagnosis Standard, and the rationalisation of current standards into three core measures for the NHS:

- The 28-day Faster Diagnosis Standard (2023/24: 75%)
- One headline 62-day referral to treatment standard (2023/24: 85%)
- One headline 31-day decision to treat to treatment standard (2023/24: 96%)

Most of the performance standards are pledges in the handbook to the NHS constitution, which DHSC has confirmed will be updated and published prior to the 1 October implementation date.

The Trust's Board Performance Report will be updated to reflect these changes from 1 October 2023.

Reporting Month: July 2023

EXECUTIVE SUMMARY (continued)

Financial Position

At the end of July there is a net I&E deficit of £9,446k against a deficit plan(excluding technical items) of £5,818k. Total operating income is £11,162k favourable to plan due to higher than planned income from activities of £9.828k and higher than planned other operating income of £1,334k. Operating expenses are £16,514k adverse to plan due to higher pay and non-pay expenditure. Depreciation is broadly in line with plan. Technical and financing items are £1,631k favourable to plan mainly due to interest receivable.

The key issues underlying the financial position are recurrent savings delivery below plan – Trust-led CIP delivery is £5,769k or 92% of plan of which recurrent savings are £2,493k, 40% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full will result in the Trust failing to meet the financial plan. Delivery of elective activity recovery below plan – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m which may result in the Trust not achieving its financial plan. Corporate mitigations not delivered in full – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan. Failure to deliver the financial plan – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of statutory duty and will result in regulatory intervention.

SUMMARY SCORECARD – FINANCIAL YEAR 2023/24

DOMAINS: “Quality and Safety”, “Our People”

			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Infection Control: C.Diff Cases (Hospital Attributable)	Risks: 800 and 4651	Actual	12	8	13	8	-	-	-	-	-	-	-	-
		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	1	0	2	2	-	-	-	-	-	-	-	-
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Fracture NOF: Theatre Within 36 Hours		Actual	53.6%	44.4%	48.3%	61.9%	-	-	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Fracture NOF: Geriatrician Review Within 72 Hours		Actual	42.9%	47.6%	40.0%	38.1%	-	-	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
VTE Risk Assessment	Risk: 720	Actual	82.0%	82.8%	82.6%	84.0%	-	-	-	-	-	-	-	-
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Workforce: Agency Usage	Risk: 674	Actual	1.7%	1.7%	1.7%	1.6%	-	-	-	-	-	-	-	-
		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	14.3%	14.1%	13.8%	13.2%	-	-	-	-	-	-	-	-
		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	4.1%	4.1%	4.2%	4.5%	-	-	-	-	-	-	-	-
		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	4.2%	6.1%	6.3%	6.2%	-	-	-	-	-	-	-	-
		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-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Summary Hospital Level Mortality Indicator (SHMI)		Actual	100.4	98.0	98.9	97.5	-	-	-	-	-	-	-	-
		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

SUMMARY SCORECARD – FINANCIAL YEAR 2023/24

DOMAIN: “Timely Care”

			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Referral To Treatment 78+ Weeks	Risk: 801	Actual	182	248	215	203	-	-	-	-	-	-	-	-
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Referral To Treatment 65+ Weeks	Risk: 801	Actual	1,549	1,599	1,765	1,933	-	-	-	-	-	-	-	-
		Trajectory	1,950	1,910	1,870	1,670	1,470	1,260	1,050	840	630	420	210	0
Cancer 62+ Days	Risk: 801	Actual	218	238	179	233	-	-	-	-	-	-	-	-
		Trajectory	180	178	176	174	172	170	168	166	166	164	162	160
Cancer Treated Within 62 Days	Risk: 801	Actual	68.2%	66.7%	66.0%	-	-	-	-	-	-	-	-	-
		Trajectory	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Diagnostics: Percentage Waiting Under 6 Weeks	Risk: 801	Actual	71.8%	73.5%	76.8%	78.0%	-	-	-	-	-	-	-	-
		Trajectory	72.9%	73.4%	74.7%	75.6%	76.8%	77.8%	79.1%	79.9%	80.4%	81.2%	82.3%	83.3%
Diagnostics: Number Waiting 26+ Weeks	Risk: 801	Actual	358	294	191	188	-	-	-	-	-	-	-	-
		Trajectory	411	357	281	188	102	9	0	0	0	0	0	0
Emergency Department: Percentage Spending Under 4 Hours	Risks: 910 and 4700	Actual	70.7%	67.5%	72.1%	75.3%	-	-	-	-	-	-	-	-
		Trajectory	61%	61%	62%	63%	64%	65%	67%	68%	70%	72%	73%	76%
Emergency Department: Percentage Spending Over 12 Hours	Risks: 910 and 4700	Actual	4.7%	5.0%	3.1%	0.9%	-	-	-	-	-	-	-	-
		Trajectory	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Emergency Department: Handovers Over 15 Minutes	Risks: 910 and 4700	Actual	72.0%	74.9%	62.0%	48.6%	-	-	-	-	-	-	-	-
		Trajectory	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Emergency Department: Handovers Over 30 Minutes	Risks: 910 and 4700	Actual	37.0%	45.0%	27.3%	17.1%	-	-	-	-	-	-	-	-
		Trajectory	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
Every Minute Matters: Timely Discharges (12 Noon)	Risk: 423	Actual	21.2%	22.4%	22.7%	22.5%	-	-	-	-	-	-	-	-
		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	22.3%	22.1%	21.9%	26.2%	-	-	-	-	-	-	-	-
		Trajectory												
Every Minute Matters: No Criteria To Reside Average Beds Occupied	Risk: 423	Actual	159	143	139	135	-	-	-	-	-	-	-	-
		Trajectory												

Final Quarter 1 Position

CORPORATE RISKS

ID	Corporate Risks, Projected Mitigation	22/23		2023/24				2024/25				2025/26				26/27
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
801	NHS System Oversight Framework	20	20	20			8									
2244	Long waits for Outpatient follow-up appointments	20	20	20	12	12		4								
910	Patients in ED do not receive timely and effective care	20	16	16				6								
972	Fire Safety Regulations	16	16	16	16	16										4
1035	Cancelled operations, breached performance targets cancelled	16	16	16		4										
2264	Delays in commencing induction of labour	16	16	16	16	16	4									
588	Patient deterioration is not identified and responded to	15	15	15	15	15		5								
856	Emotional and mental health needs of children and YP	15	15	15	15	15		8!								
5477	Nurse staffing levels	15	15	15	12	12	6									
1595	Mental health patients in Adult ED for prolonged periods	20	12	12				8!								
422	Patients and staff experience V&A	12	12	12			6									
674	Agency use - national pricing caps	12	12	12				4								
793	Staff experience work-related stress	12	12	12	12	9!										
1598	Patients suffer harm or injury from preventable falls	12	12	12	12	12		9!								
2639	Staff compliance with appraisal requirements	12	12	12	9	9	6									
2695	Robust governance processes	9	9	12	12	12	6									
5520	Health inequalities exacerbated for patients on waiting list	12	12	12												
6502	Industrial action impact on patient safety	10	20	9	5											
921	Staff compliance with their Essential Training	9	9	9	6											
2614	Patients being cared for in extra capacity locations	10	10	8	6	4										
720	VTE prevention and management	8	8	8			4									
291	Critical IT equipment fails	8	8	8*												

← History →

← Prediction →

*denotes that the risk has achieved its target

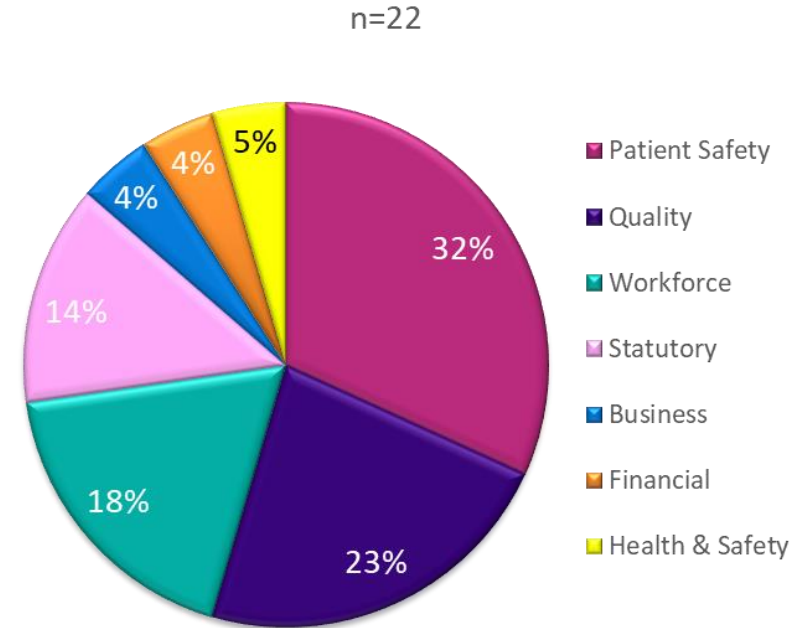
! denotes that the target assessment is above tolerance

CORPORATE RISKS

Corporate Risks by Domain and Risk Level



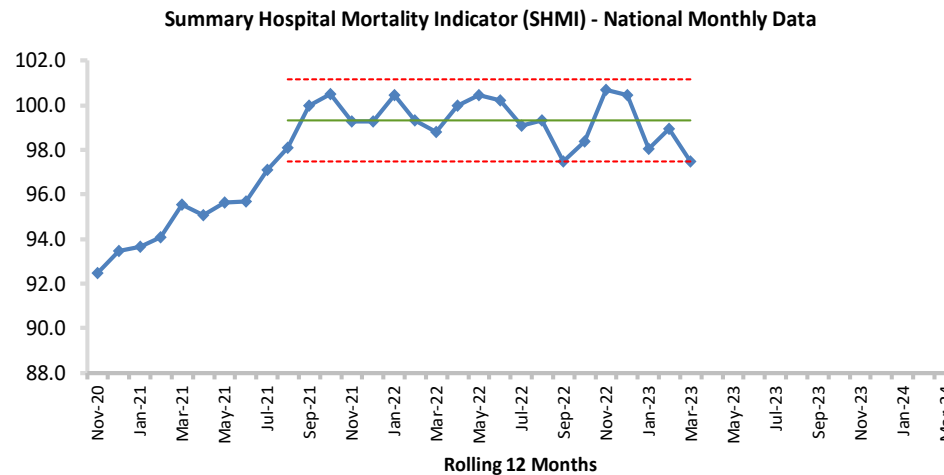
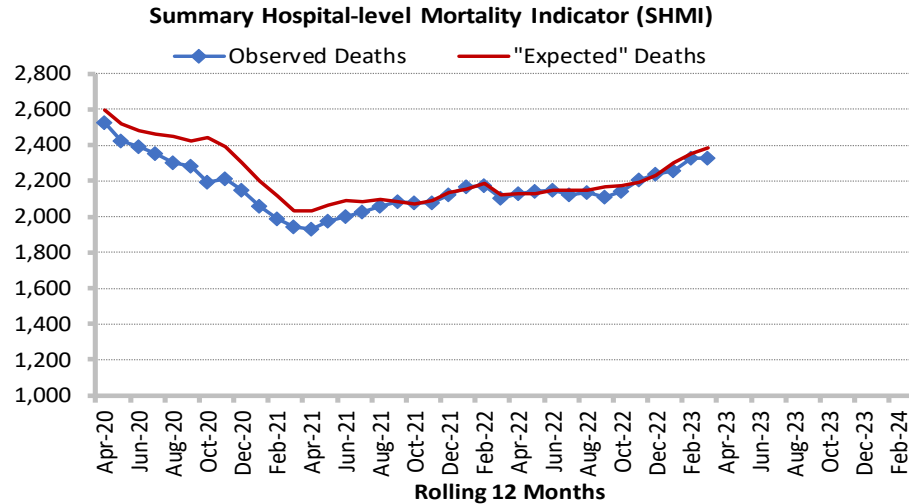
Corporate Risks by Domain



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 2022 to March 2023 was 97.5 and in NHS Digital's "as expected" category. This is below the overall national peer group of English NHS trusts of 100.	
National Data:	UHBW's total is slightly below the overall national peer group of English NHS trusts of 100.	
Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required and investigating any identified alerts.	

Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
Apr-22	2,130	2,130	100.0
May-22	2,140	2,130	100.5
Jun-22	2,150	2,145	100.2
Jul-22	2,125	2,145	99.1
Aug-22	2,135	2,150	99.3
Sep-22	2,110	2,165	97.5
Oct-22	2,140	2,175	98.4
Nov-22	2,205	2,190	100.7
Dec-22	2,240	2,230	100.4
Jan-23	2,255	2,300	98.0
Feb-23	2,325	2,350	98.9
Mar-23	2,325	2,385	97.5

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



Reporting Month: July 2023

STANDARD		QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA
Background:	<p>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:</p> <ol style="list-style-type: none"> 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. <p>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.</p>	
Performance:	<p>There have been six Trust HOHA and two COHA C.Difficile cases reported in July 2023. The reported Year To Date (YTD) in 2023/24 is 27 Hospital Onset cases and 41 Hospital Attributable cases. There were two trust-apportioned MRSA cases in July 2023. Therefore five trust apportioned cases in 2023/24 YTD.</p>	
National Data:	<p>See next page.</p>	
Actions:	<p>C.Difficile</p> <p>There are numerous potential causes of Clostridium difficile infection and the most important ones are antibiotic prescribing and appropriate standards of cleanliness including commodes and toilet areas. Cleaning standards are generally compliant in low risk (FR2) areas but in the high risk areas (FR1) full compliance has not been achieved consistently. This is actively scrutinised by the Operational Infection Control Group with Divisions, and the Facilities team.</p> <p>Actions taken:</p> <ul style="list-style-type: none"> • With the transition to the Patient Safety Incident Response Framework in UHBW will retain C.difficile reviews as an important focus, but in an improved and more responsive format. • The Infection Prevention and Control team (IPC) will continue regular sluice auditing. • Each Division has a schedule of monthly 'walk arounds' with an IPC nurse and the matron for the Division to review and consider IPC related practice. • The monthly clinical ward audits from August will include a section for the ward manager to review the sluice and commodes formally and report this as part of their quality schedule for the ward. <p>MRSA</p> <ul style="list-style-type: none"> • Progress with vascular access improvement work continues. 	

...continued over page

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

- Actions (continued):**
- The Infection Prevention and control team are working with procurement to agree a Peripheral Venous Catheter (PVC) insertion pack to be used Trust wide, with its implementation to include enhanced training across the organisation about Aseptic non-touch technique (ANTT) practice.
 - First stage of improvement work is underway with adult Emergency Department's with lead senior doctor involvements to review practice with a Quality Improvement (QI) approach.
 - Numerous policy and guidance documents around Central venous catheters (CVC) and Peripheral venous catheters (PVC) care have been reviewed, updated and are in the process of cascade to clinical teams.

Risks:
800: Risk that Trust operations are negatively impacted by (COVID-19) pandemic
4651: Risk that Covid -19 is transmitted between patients and staff within the Trust

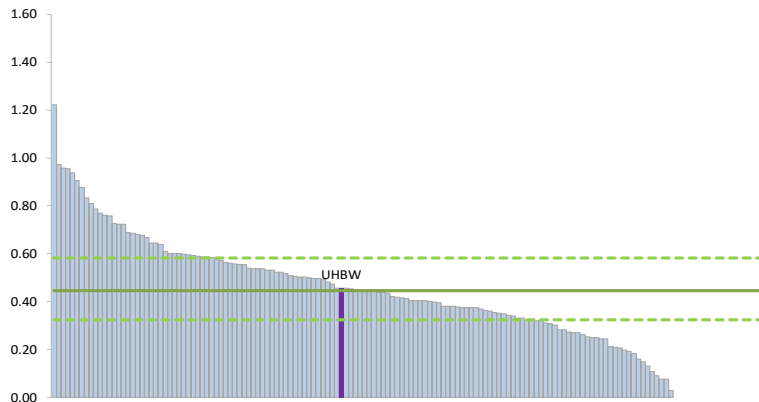
C.Difficile

	Jul-23		2023/2024		2022/2023	
	HOHA	COHA	HOHA	COHA	HOHA	COHA
Medicine	2	0	9	3	23	4
Specialised Services	2	0	4	5	8	3
Surgery	0	0	2	0	11	1
Weston	1	1	10	3	27	7
Women's and Children's	1	1	2	1	8	3
Other	0	0	0	2	1	4
UHBW TOTAL	6	2	27	14	78	22

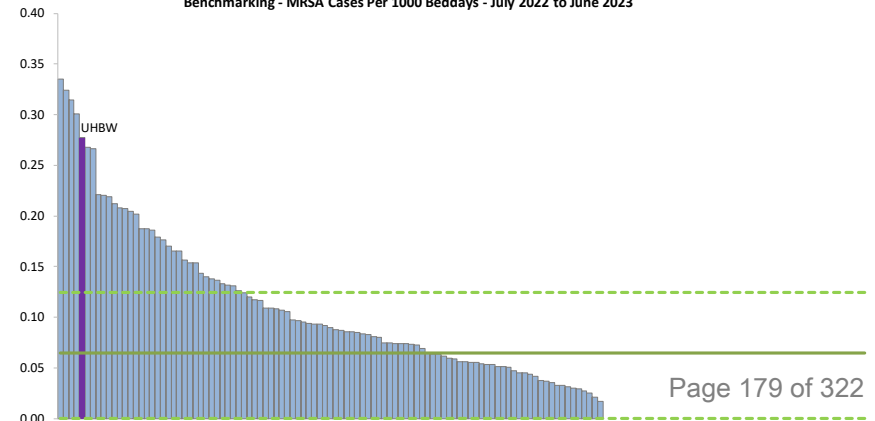
MRSA

	Jul-23	2023/2024	2022/2023
Medicine	1	1	1
Specialised Services	0	0	1
Surgery	0	1	2
Weston	1	2	1
Women's and Children's	0	1	2
Other	0	0	0
UHBW TOTAL	2	5	7

Benchmarking - C.Diff Rate Per 1000 Beddays - July 2022 to June 2023

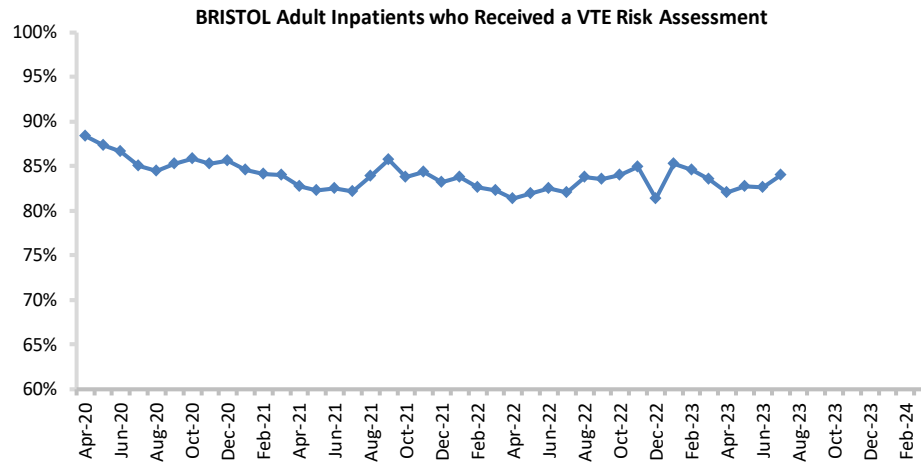


Benchmarking - MRSA Cases Per 1000 Beddays - July 2022 to June 2023



Reporting Month: July 2023

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:	Recent VTE risk assessment compliance remains relatively stable at 84% (excluding Weston due to data feed issues). Diagnostics and Therapies division continues to be 100% compliant. With the exception of Surgery division, which saw a slight reduction of 0.4%, all other divisions reported improved compliance, with Women's and Children's division increasing by 3.8% to 90.8%.	
Actions:	<ul style="list-style-type: none"> The successful appointment of a new VTE lead (due to commence October 2023) will provide clinical expertise and prioritisation needed in order to make a step change in progress of the VTE workstream, medicines medical, pharmacy, patient safety and clinical digital and digital colleagues are progressing incorporating the electronic VTE risk assessment into Careflow Medicines Management system. The VTE data metric requires review once the new VTE lead is in post to agree a consistent approach for cohorts and exclusions for VTE risk assessment compliance in line with national guidance to enable accurate Board and ward data feeds (including assurance that areas that complete paper-based RAs are compliant). Initial scoping for this is being undertaken by the Patient Safety Improvement Team. Actions pending VTE Lead commencing in role. 	
Risks:	Corporate Risk 720: Risk that VTE risk assessments are not completed	



Reporting Month: July 2023

STANDARD QUALITY AND SAFETY: VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT

	SubDivision	Number Risk		Percentage Risk
		Assessed	Total Patients	Assessed
Diagnostics and Therapies	Audiology Adult	1	1	100.0%
	Radiology	29	29	100.0%
Diagnostics and Therapies Total		30	30	100.0%
Medicine	Medicine	2,239	2,927	76.5%
Medicine Total		2,239	2,927	76.5%
Specialised Services	BHOC	2,271	2,356	96.4%
	Cardiac	331	468	70.7%
Specialised Services Total		2,602	2,824	92.1%
Surgery	Anaesthetics	25	25	100.0%
	Dental Services	109	122	89.3%
	ENT & Thoracics	268	387	69.3%
	GI Surgery	864	1,120	77.1%
	Ophthalmology	301	309	97.4%
	Trauma & Orthopaedics	114	182	62.6%
Surgery Total		1,681	2,145	78.4%
Women's and Children's	Children's Services	22	35	62.9%
	Women's Services	1,386	1,515	91.5%
Women's and Children's Total		1,408	1,550	90.8%
Grand Total		7,960	9,476	84.0%

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:	<p>In July, there were 42 patients eligible for Best Practice Tariff (BPT) across UHBW (16 in Bristol and 26 in Weston).</p> <ul style="list-style-type: none"> For the 36 hour standard, 61.9% achieved the standard (26 out of 42 patients). For the 72 hour standard, 38.1% achieved the standard (16 out of 42 patients).
Actions:	<p>Underlying Issues (Bristol):</p> <ul style="list-style-type: none"> Difficulty accessing theatres to ensure consistent #NOF theatre – also challenges with theatre and anaesthetic staffing which is impacting on overall theatre capacity. This predominantly effects our ability to utilise extra theatres for trauma in the event of cancellations. Difficulty starting on time in theatre and also some anecdotal reports that theatre efficiency is being lost at the end of the day due to staffing pressures and a reticence to start cases in case they overrun. Lack of beds in the right area to have patients seen quickly. This is exacerbated by outliers in the Trauma & Orthopaedic (T&O) wards which cause our own T&O patients to outlie into other surgical beds. <p>Underlying Issues (Weston):</p> <ul style="list-style-type: none"> Reasons for missing time to surgery: 9 patients. 6 of the 9 missed due to increased trauma demand/lack of space in theatre. 3 of the 9 missed due to unavoidable medical/drug issues that needed resolving before surgery. Ortho-geriatrician post remains vacant. <p>Actions (Bristol):</p> <ul style="list-style-type: none"> Theatre capacity being actively monitored and prioritised on a weekly basis across all specialties. Any last minute cancellation from another specialty is usually then backfilled by trauma surgeons. Poor results discussed in T&O Governance & Silver trauma steering group meeting so ideas for improvement could be discussed. Restart of “Automatic Send” so each theatre should be sending for their first patient without any delay. Trauma Standard Operating Procedure (SOP) signed off to allow the allocation of a “Golden Patient”, enabling a prompt start. Actively re-patriating patients to Weston Hospital to avoid breaches. <p>Actions (Weston):</p> <ul style="list-style-type: none"> Extra theatre space is sometimes available via the shared Emergency (CEPOD) lists or cancelling elective orthopaedic surgery. The Ortho-geriatrician post remains vacant and unchanged. Lack of an Ortho-geriatrician and limited access to medical team support will cause surgical delays for patients who need medical optimisation. This post has been out to advert and closed with no shortlistable candidates.
Risks:	<p>924: Risk that there is a delay in hip fracture patients accessing surgery within 36 hours of admission.</p> <p>1834: Risk of failure to achieve best practice tariff and good quality care for patients with #NOF</p>

Reporting Month: July 2023

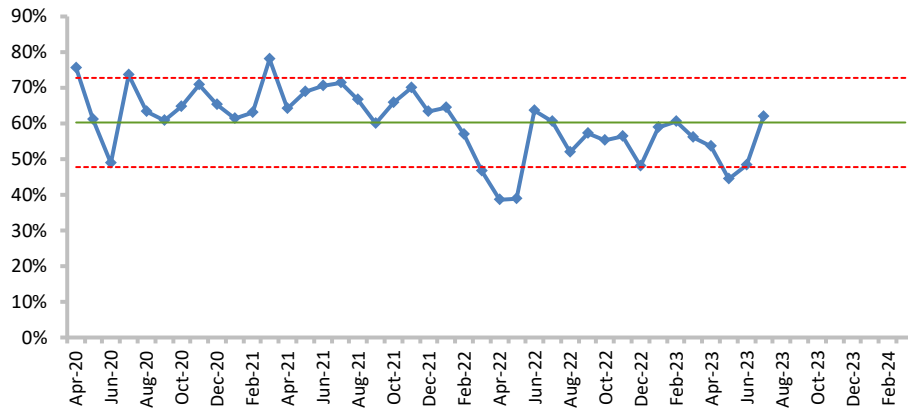
STANDARD

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

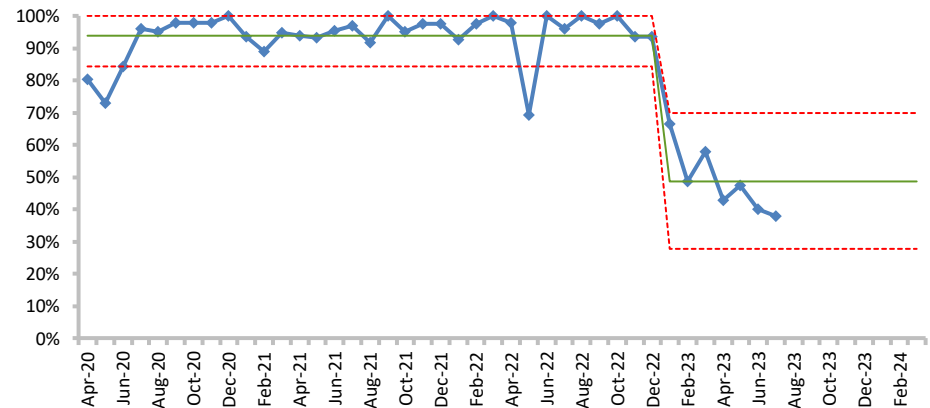
Jul-23

	Total Patients	36 Hours		72 Hours	
		Seen In Target	Percentage	Seen In Target	Percentage
Bristol	16	9	56%	16	100%
Weston	26	17	65%	0	0%
TOTAL	42	26	61.9%	16	38.1%

Fracture Neck of Femur Patients Treated Within 36 Hours

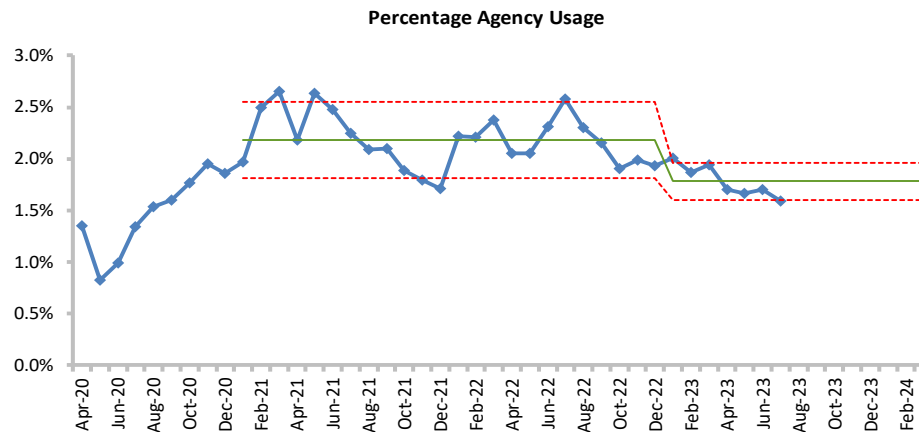


Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours



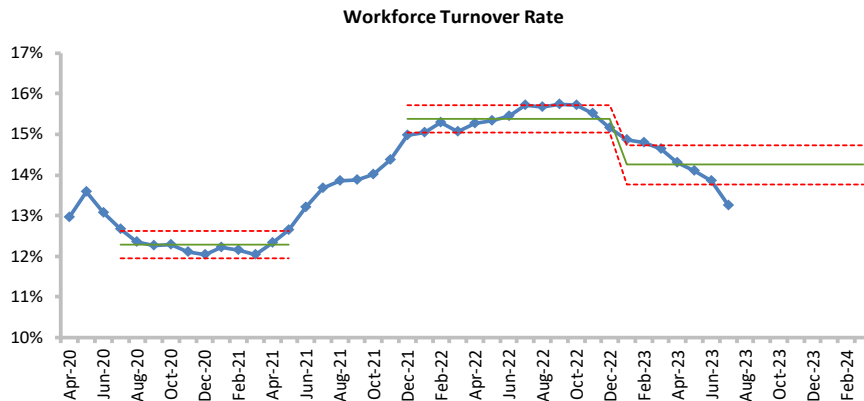
Reporting Month: July 2023

STANDARD	OUR PEOPLE: WORKFORCE AGENCY USAGE
<p>Performance:</p>	<p>Agency usage increased by 12.8 Full Time Equivalents (FTE) to 1.6%. There were increases within two divisions. The largest divisional increase was seen in Surgery, where usage increased to 29.2 FTE from 21.9 FTE in the previous month. There were reductions within four divisions. The largest divisional reduction was seen within Medicine, where usage reduced to 90.0 FTE from 101.7 FTE in the previous month.</p>
<p>Actions:</p>	<ul style="list-style-type: none"> • There were 73 new starters across the Bank in July consisting of the following: 12 Administrators, 4 Cleaning and Catering Assistants, 1 Dental Nursing Assistant, 35 Healthcare Support Workers including 5 re-appointments, 2 Porters, 10 Nurses including 2 re-appointments, 5 re-appointed Midwives, 2 Retail Cafe Assistants, 1 re-appointed Genetic Counsellor and 1 Therapy Technician. • System work continues at ICB level to drive the supply of lower cost framework nursing agency supply. • Strict controls are also in place internally to control agency usage and review through a Patient First approach led by the Deputy Chief Nurse. • 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. • The Trust continues to offer paid travel time for clinical staff as an incentive for staff to pick up bank shifts at Weston to reduce agency reliance. • The Trust continues to offer school hour and twilight shifts in a small number of clinical areas within the division of Medicine as a pilot to reduce the number of unfilled shifts, this is in place for both registered and unregistered nursing workers.
<p>Risks:</p>	<p>Corporate Risk 674: Risk that use of agencies who are non-compliant with national pricing caps does not reduce</p>



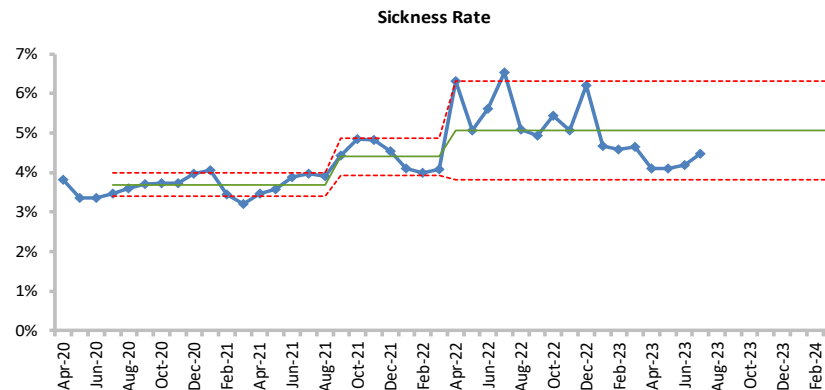
STANDARD OUR PEOPLE: WORKFORCE STAFF TURNOVER

<p>Performance:</p>	<p>Turnover for the 12-month period reduced to 13.2% compared to 13.8% (updated figures) for the previous month. Six divisions saw a reduction whilst two divisions saw increases in turnover in comparison to the previous month. The largest divisional reduction was seen within Weston General Hospital, where turnover reduced by 1.4 percentage points to 11.0% compared with 12.4% the previous month. The largest divisional increase was seen within Facilities and Estates, where turnover increased by 0.1 percentage points to 14.4% compared with 14.3% the previous month. Eight staff groups saw a reduction and one remained unchanged in comparison to the previous month. The largest staff group reduction was seen within Healthcare Scientists, where turnover reduced by 2.4 percentage points to 11.2% compared with 13.5% the previous month.</p>
<p>Actions:</p>	<ul style="list-style-type: none"> Quarterly Pulse Survey: The Quarter 2 Pulse Survey ran from 3rd to 30th July, the additional questions in the survey were a focus on reviewing the Trust appraisal check in form. The feedback will be utilised to update the form which will be relaunched in August 2023. Staff Survey 2023: Data preparation is in place in preparation for Staff Survey 2023 which will launch in October 2023. Recognition: Long service badges recognising colleagues reaching a career milestone between May 23 – Jan 24 was delivered to HRBPs at the end of July for divisionally distribution A revision of the reasonable adjustment process is in place, enabling colleagues to escalate quickly and effectively, resolving any barriers. A review of the retire and return policy and process is underway. Respecting Everyone will launch in November enabling colleagues to raise and resolve grievances or issues with bullying and harassment. Flexible pension options increased.
<p>Risk:</p>	<p>Strategic Risk 2694: Risk that Trust is unable to retain members of the substantive workforce</p>



Reporting Month: July 2023

STANDARD	OUR PEOPLE: WORKFORCE STAFF SICKNESS
<p>Performance:</p>	<p>Sickness absence increased to 4.5% compared with 4.2% the previous month, based on updated figures for both months. This figure is now combined with Covid Related absence.</p> <p>There was a reduction within one divisions, Women’s and Children’s, where sickness reduced by 0.15 percentage points to 4.14%, compared to 4.29% in the previous month.</p> <p>There were increases within all other divisions. The largest divisional increase was seen within Facilities and Estates, increasing by 0.96 percentage points to 7.22%, compared to 6.27% in the previous month.</p> <p>There were reductions within three staff groups. The largest staff group reduction was seen within Healthcare Scientists, reducing to 2.1% from 2.8% compared to the previous month.</p>
<p>Actions:</p>	<ul style="list-style-type: none"> • Respondents of June’s wellbeing survey suggest an increase in burnout and stress since 2022, resulting in a collective effort of the Wellbeing services to address cited issues within available resource. • Psychological Health Service delivered a peer support session on 27 July connecting reflection and resilience to prevent/reduce ‘moral injury’ and other ethical dilemma among individuals and teams. • Following a retender exercise competed in July; a new Employee Assistance Programme provider is to be awarded a 2 year contract to commence on 6 September. • Safety and Corporate Wellbeing leads are collaborating on the provision of Health and Safety Executive (HSE) management standards including a stress audit with a plan to develop and rollout new manager training sessions later in Quarter 2 for implementation Trust wide. • A partnership approach between UHBW, North Bristol Trust and Sirona is supporting development of improved Occupational Health Service management data to inform respective workforce strategies including preventative/proactive approaches to boost workplace wellbeing. • A revision of the reasonable adjustment process is in place enabling colleagues to escalate quickly and effectively resolving any barriers. • A new Health and Sickness at Work Policy incorporating a fresh approach to managing the absence and or adjustments needed for those with long term or underlying health conditions.



STANDARD OUR PEOPLE: WORKFORCE STAFF VACANCY

Performance:

Overall vacancies reduced to 6.2% (742.4 Full Time Equivalents, FTE) compared to 66.3% (745.5 FTE) in the previous month. The largest divisional increase was seen in Women’s and Children’s where vacancies increased to 116.5 FTE from 96.6 FTE in the previous month. The largest divisional reduction was in Trust Services, where vacancies reduced to -5.4 FTE (over established) from 11.9 FTE the previous month. The largest staff group reduction was seen in Nursing, where vacancies reduced to 341.0 FTE from 358.5 FTE the previous month. The largest staff group increase was in Allied Health/Scientific Professions, where vacancies increased to 97.8 FTE from 82.0 the previous month. Consultant vacancy has reduced to 22.7 FTE (2.9%) from 34.7 FTE (4.5%) in the previous month.

Unregistered nursing vacancies can be broken down as follows;

Band	Vacancy
AfC Band 2	209.9 FTE
AfC Band 3	-61.7 FTE
AfC Band 4	-182.9 FTE

The significant vacancy at band 2 and over-establishment at band 3 are due to the movement of healthcare support workers from band 2 to band 3. Staff have been moved but the funded establishment has not been transferred in the finance ledger yet. The work will be incorporated into budget setting for 2023/24 but has not yet been actioned. The combined (band 2 and 3) picture is unaffected.

The band 4 over establishment is where there is a large number of newly qualified nursing staff awaiting their Nursing & Midwifery Council PINs. Once these staff become fully qualified and have received their PIN, this should reduce the over establishment, reduce the registered nursing vacancy position and increase the unregistered nursing vacancy position, which is a much more accurate reflection of the nursing vacancy position.

Actions:

Work taking place during July to reduce the vacancy rate is as follows:

- 33 new internationally educated nurses joined the Trust including four displaced/refugee Nurses.
- The Trust has been organising the next recruitment trip to Dubai and India, planned for the second week of August. The aim is making 100 nursing offers to support the ambitious target for 2023. This will be the fourth overseas recruitment trip the Trust has completed since the IEN programme began.
- 682 Internationally Educated Nurses have now arrived at the Trust since the beginning of the programme, with an additional 30 due to arrive in August.
- 22 substantive Healthcare Support Workers (HCSW) started in the Trust and another 37 have been offered. 38 Bank Healthcare Support Workers (HCSW) started in the Trust during July and another 38 have been offered.
- Planning has started for the second Trustwide HCSW Hiring Event planned to take place in September, there will also be the introduction of Maternity Services Support Workers (MSSW’s) recruitment into this event to help vacancy rates in Women’s services.
- The Trust has recruited 11 candidates onto the Trainee Nursing Associate (TNA) programme. An assessment centre is being organised for the month of August to bolster the pipeline of 20 TNA’s to start in the October cohort in Adult services.

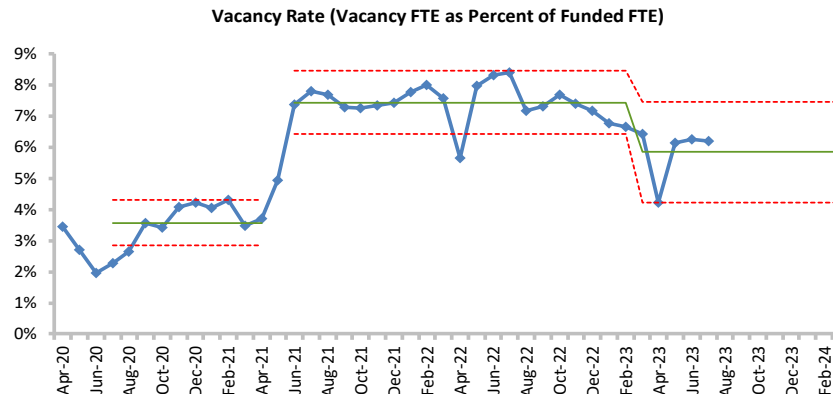
Reporting Month: July 2023

STANDARD OUR PEOPLE: WORKFORCE STAFF VACANCY

Actions (continued):

- After three successful assessment centres, 44 Registered Nurse Degree Apprentices have been offered a position across all divisions. These candidates are due to start in October 2023 and March 2024. The remaining 15 candidates who were successful but did not get a space on the programme, have been redirected to either a TNA role of a Trainee Senior Healthcare Support Worker (TSHCSW) role.
- 31 candidates have been recruited to the Accelerated RNDA (two-year) programme. These candidates are expected to start next October.
- 12 substantive Allied Health Professionals and 16 substantive Healthcare Scientists joined the Diagnostics and Therapies division as well as one Bank Healthcare Scientist and four Bank Allied Health Professionals.
- A further Reporting Sonographer candidate completed their pre-employment checks and has now booked their start date for the beginning of September. This is the second appointment for the Ultrasound department in the last two months.
- The Adults Therapies department is now accepting CVs from NHSP for internationally educated Occupational Therapists with interviews scheduled for the end of July. Results to follow. The Trust also has a continuous advert live for Band 6 Rotational Occupational Therapists.
- The Trust welcomed three internationally educated Radiographers and have a further three candidates due to arrive at the end of August. Radiology also welcomed four Newly Qualified Radiographers in the month of July.
- The Trust held its fourth admin and clerical mass recruitment event at the South Bristol Skills Academy, which resulted in sixteen offers and ten candidates being added to the talent pool.
- Two clinical fellows and one consultant started in Weston in the month of July. A further two clinical fellows and two career grade doctors were cleared for start dates in August.
- The Trust offered a further six non-consultant grade doctors and one consultant across the Weston site and nine clinical fellows and one consultant are currently going through pre-employment checks for the Weston site to support rota gaps.

Risks: Strategic Risk 737: Risk that the Trust is unable to recruit sufficient numbers of substantive staff



STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
<p>Performance:</p>	<p>At the end of July:</p> <ul style="list-style-type: none"> 6,134 patients were waiting 52+ weeks against the Operating Plan trajectory of 5,241. 1,933 patients were waiting 65+ weeks against the Operating Plan trajectory of 1,670. 203 patients were waiting 78+ weeks. 0 patients were waiting 104+ weeks. <p>For 2023/24 the Operating Plan assumes that no patients will be waiting over 78 weeks. The next national ambition is to have no patients waiting 65+ weeks by the end of March 2024.</p> <p>NB: dispensation for industrial action continues to inform the revision of in-year trajectories</p>
<p>National Data:</p>	<p>For June 2023, across all of England, 5.2% of the waiting list was waiting over 52 weeks. UHBW's performance was 8.7% (5,865 patients) which places UHBW as the 13th highest Trust out of 170 Trusts that reported RTT wait times.</p>
<p>Actions:</p>	<ul style="list-style-type: none"> At the end of July 2023, 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 had shown improvement throughout 2022/23. Industrial action contributed towards a deterioration in the reported position at the end of June, when there were 215 patients waiting in excess of 78 weeks. This position has improved in July, with the number of patients waiting 78 weeks or longer reducing to 203 and the Trust continues to work towards reducing long waits through specific initiatives including the expansion of insourcing in clinical genetics and dental specialties. Of the 203 patients waiting 78 weeks or longer at the end of July, 21 related to cornea grafts. There is currently a national shortage of cornea graft material which is contributing to delays in treating these patients. There is a nationally led process to allocate graft material to Trusts based on the clinical priority and length of waiting time. As part of the 2023/24 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 March 2024. The number of patients waiting in excess of 65 weeks at the end of July was 1,933 which shows a deterioration against the operational planning trajectory of 1,670. This is in part due to the deterioration in clearance of the 78+ week waits due to industrial action. <p>Actions being taken to reduce the number of long waiting patients includes:</p> <ul style="list-style-type: none"> Dental services have additional Independent Sector capacity under contractual agreements with both Nuffield and Spire to support their recovery in Cleft services. The service are also insourcing using KPI Health for paediatric dental clinics and extractions which commenced mid-January, with schedules being provided each month. The contract agreement with KPI Health has been extended for 2023/2024.

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Reporting Month: July 2023

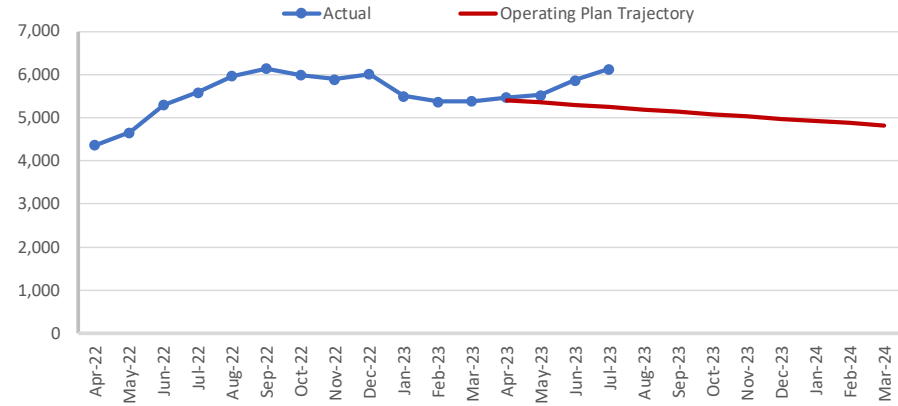
STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
<p>Actions (continued):</p>	<ul style="list-style-type: none"> • Within General Surgical Specialties, the service has been working with Somerset Surgical Services (SSS) to support provision of additional treatment to be undertaken on the Weston site. To date, 269 patient have been identified as suitable for treatment at SSS, 146 have been contacted thus far, 126 have consented to be transferred and the service continue to contact patients to transfer 200 patients in total. • The Trust appointed a cleft locum who started on 23rd June and in May there were adverts for a Restorative Dentistry Consultant with interviews scheduled in August 2023. Interviews are also planned on 7th September for an additional Oral medicine consultant to support the backlogs in this service. • Patients currently waiting for treatment dates are being contacted to ask if they would accept treatment at an alternative provider. Should patients consent, each patient is added to NHS England Digital Mutual Aid system (DMAS). • The Trust continues to bolster additional capacity through other insourcing providers and waiting list initiatives. • Paediatric Urology Consultants agreed to additional treatment lists and had booked patients into dates during July with the plan to ensure that there will be no Paediatric Urology patients waiting longer than 78 weeks by the end of July. However, due to BMA industrial action the patients who were booked on industrial action dates have had to be cancelled and August dates are currently being identified to re-book affected patients. This initially would result in the divisional clearance plan not being met until August, but with further industrial action planned during August and the number of trauma cases that the service has experienced, it is unlikely that all Paediatric Urology patients waiting 78 weeks will be cleared by September. • 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 program to maximise across all sites 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 restraints (including High Dependency) and staff shortages.
<p>Risk:</p>	<p>Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met</p>

Reporting Month: July 2023

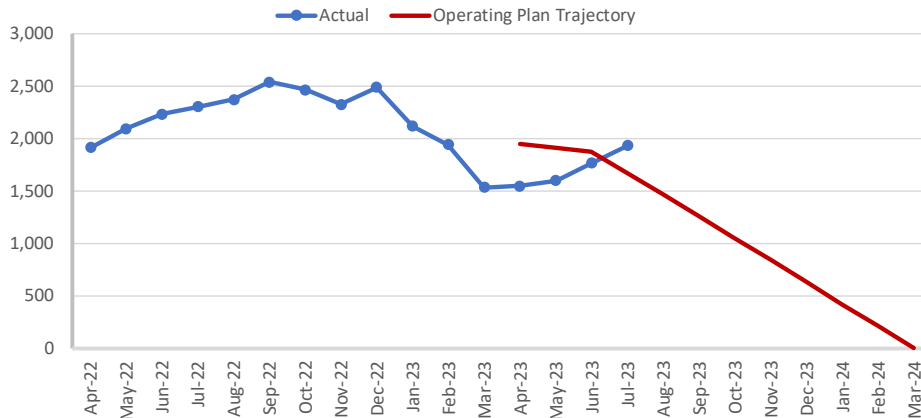
STANDARD REFERRAL TO TREATMENT (RTT) LONG WAITS

	Jul-23		
	52+ Weeks	65+ Weeks	78+ Weeks
Diagnostics and Therapies	0	0	0
Medicine	1,172	249	0
Specialised Services	187	75	21
Surgery	3,847	1,289	148
Women's and Children's	928	320	34
Other	0	0	0
UHBW TOTAL	6,134	1,933	203

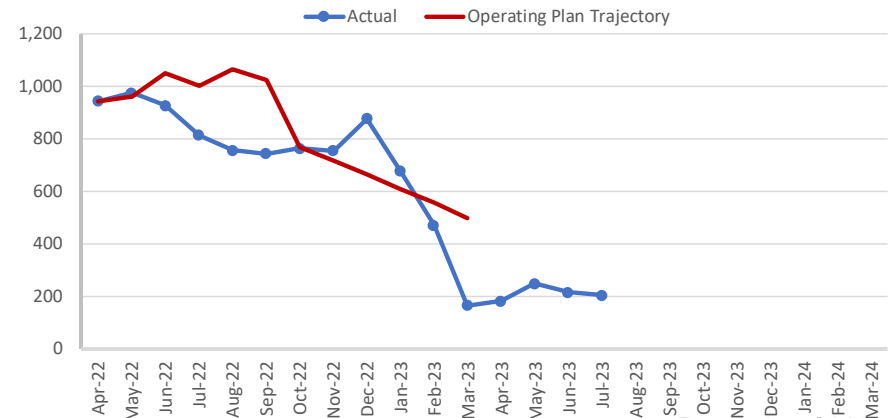
Number of Ongoing Patients Waiting 52+ Weeks at Month End



Number of Ongoing Patients Waiting 65+ Weeks at Month End



Number of Ongoing Patients Waiting 78+ Weeks at Month End



Performance Report

Public Board



11. Performance Report
 University Hospitals
 Bristol and Weston
 NHS Foundation Trust

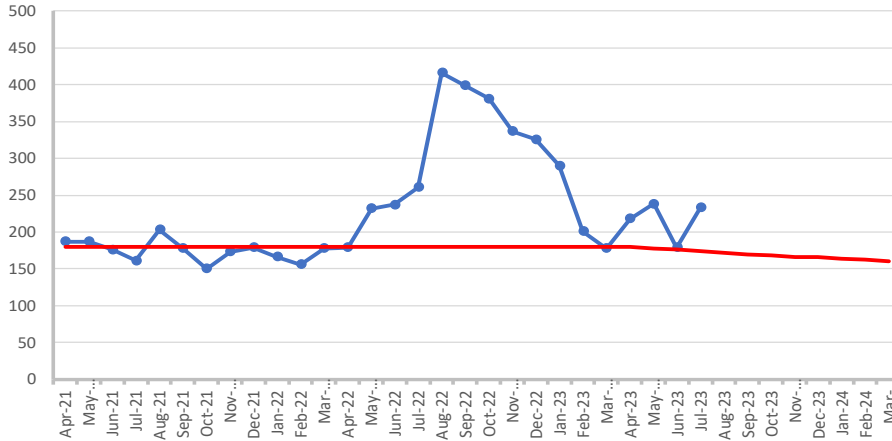
Reporting Month: Jun/Jul 2023

STANDARD	CANCER WAITING TIMES
Performance	<p>At the end of July, the Trust had 233 patients waiting 62+ days on a GP suspected cancer pathway. The Trust has an operating planning trajectory of not exceeding 174 patients at the end of July 2023, reducing to 160 by March 2024.</p> <p>The performance for patients treated within 62 days of an urgent GP referral is reported a month in arrears. For June, 66.0% of patients were seen within 62 days. The national constitutional standard remains at 85%.</p> <p>The “Faster Diagnosis Standard” (FDS) is also reported a month in arrears, and this measures time from receipt of a suspected cancer referral from a GP or screening programme to the date the patient is given a cancer diagnosis, or told cancer is excluded, or has a decision to treat for a possible cancer. This time should not exceed 28 days for a minimum of 75% patients. The Trust’s improvement trajectory returns to 75% by March 2024. Performance in June was 61.6% against the improvement trajectory of 67.5%. The predicted under-performance against trajectory due to ongoing issues in dermatology is being supported by NHS England.</p>
National Data:	<p>National data for patients treated within 62 days of an urgent GP referral is shown on the next page.</p> <p>Latest national data for quarter 1 2023/24 shows UHBW at 67.1% against an England average of 59.6%. This puts UHBW 47th out of 142 Trusts.</p>
Actions:	<p>The Trust was compliant with the trajectory for patients waiting 62+ at the start of July, but this deteriorated by the end of the month following industrial action, with the Trust reporting 233 patients waiting 62+ days. Due to the further industrial action in August, recovery of compliance is not now expected until October. The Trust continues to strive to reduce the number of long waiting patients, working towards the operational planning target of no more than 160 patients waiting 62+ days by the end of March 2024. Actions focus on replacing activity lost to industrial action and continue to concentrate on reducing waits in gynaecology, lower GI and skin through use of locums and additional permanent capacity where required.</p> <p>The Faster Diagnosis Standard trajectory was met during March 2023 but has deteriorated in the three months since due to the impact of industrial action. The position has been broadly stable since that initial deterioration (April: 60%, May: 61.5%, June 61.6%) but is below the 67.5% recovery trajectory set for the end of June. Recovery to compliance with the 75% standard by the end of the financial year is still attainable, dependent on impact of future industrial action. Actions to improve the position include ensuring prompt first appointments in high volume specialities and reducing waiting times for key diagnostic tests such as hysteroscopy, CT, ultrasound and endoscopy. As referenced above, the predicted under-performance against trajectory due to ongoing issues in dermatology is being supported by NHS England.</p> <p>In June, the Trust continued to achieve the subsequent radiotherapy and subsequent chemotherapy treatment standards. Performance against the other retrospective standards remains non-compliant due to the impact of industrial action.</p> <p>The Trust continues to work towards delivering its improvement action plan which is progressing well, as demonstrated by the temporary recovery of the 62+ day standard between the periods of industrial action during April and July. Hysteroscopy capacity has been significantly increased at the Weston site and an outsourcing option is also being explored. The Trust’s nurse hysteroscopists will be attending a further training course in the autumn which will enable them to perform a greater range of hysteroscopic procedures and national changes to the colorectal referral pathway have been fully implemented and are now well embedded. The true positive impact of these actions is currently diluted by the impact of industrial action.</p>
Risk:	<p>Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met</p>

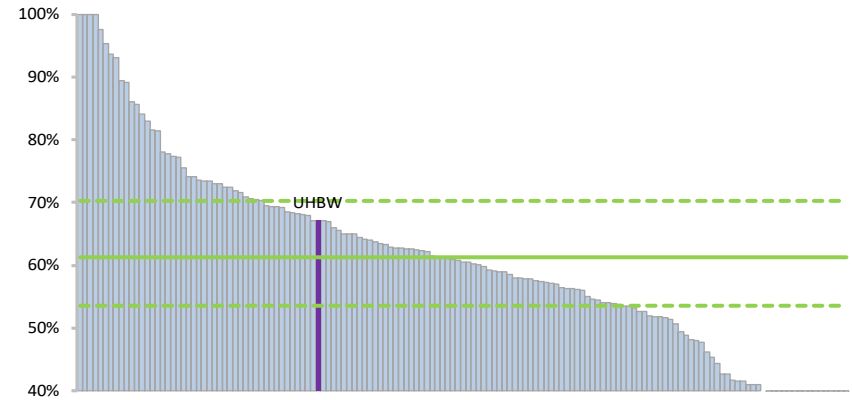
Reporting Month: Jun/Jul 2023

STANDARD CANCER WAITING TIMES

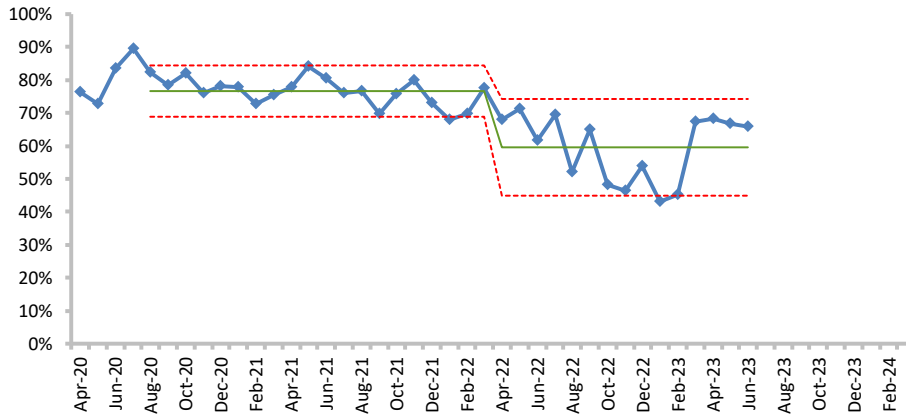
Cancer 62+ Day Standard - Numbers Waiting 62+ Days



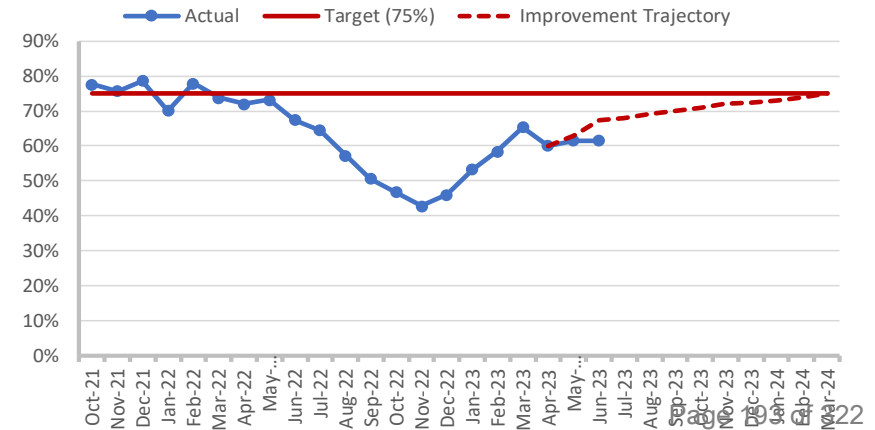
Benchmarking: Percentage Treated Within 62 Days of GP Referral - 2023/24 Quarter 1



Cancer 62 Day Referral To Treatment (Urgent GP Referral)



28 Day Cancer Faster Diagnosis Standard



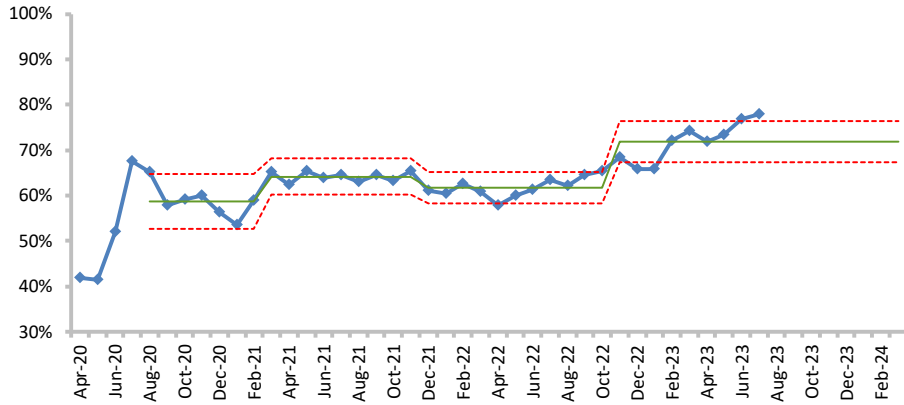
Reporting Month: July 2023

STANDARD	DIAGNOSTIC WAITING TIMES
<p>Performance:</p>	<p>The ambition set as part of the Trust's operational planning submission is that 83.3% of patients will be waiting under six weeks by end of March 2024. The performance trajectory set for end of July is 75.6%, against which the Trust achieved 78.0%. At the end of July 2023, there were a total of 188 patients waiting 26+ weeks which is 1.2% of the waiting list. The target for end of July was 188 and an expectation to have zero patients waiting 26+ weeks by October 2023. At the end of July 2023, there were a total of 1,007 patients waiting 13+ weeks which is 6.6% of the waiting list. The target for end of July was 1,005 and an expectation to have zero patients waiting 13+ weeks by March 2024.</p>
<p>National Data:</p>	<p>For June 2023, the England total was 74.0% of the waiting list under six weeks. UHBW's performance was 76.8% which places UHBW 95th of 159 Trusts that report diagnostic wait times.</p>
<p>Action/Plan:</p>	<ul style="list-style-type: none"> • Diagnostic performance against the six week wait standard improved to 78.0% in July from 76.8% in June 2023. This is ahead of the performance trajectory set as part of the operational planning submission and the strongest performance since March 2020. • The Trust is in a strong position to achieve the March 2024 target of 83.3% of patients waiting less than six weeks for a diagnostic test, however there is an increasing risk to the improvement needed due to continued industrial action and a deterioration in the Sleep modality. Whilst the trajectory for long waiters over 13 weeks was narrowly missed, improvements continue and July was the 10th consecutive month that +13 weeks and +26 week waiters have both reduced. • Challenges in MRI and Dexa have been described previously. Performance was maintained in July 2023 for both modalities, and long waiters over 13 and 26 weeks also reduced. Despite continued challenges in some niche paediatric MRI sub-modalities, long waiters over 26 weeks have reduced for the 11th consecutive month. Progress in these two modalities will continue to be reviewed closely with Divisions. • Long waiters in Endoscopy (adults) continue to reduce, however 6-week wait performance deteriorated in July 2023. The performance deterioration is attributed to seasonal fluctuation (during periods of increased annual leave), continued industrial action across various staff groups, and the complexity of some patients on the waiting list requiring slots where capacity is limited. Actions are in place to mitigate risk wherever possible, and Endoscopy (adults) is no longer the greatest risk to diagnostic performance. • Challenges in non-obstetric ultrasound are acknowledged as potential risks to overall diagnostic performance, particularly in reducing to zero patients waiting over 13 weeks by March 2024. Despite this, performance in this modality increased in July 2023, and long waiters over 13 weeks also reduced. • The emerging risk to Diagnostic performance and recovery sits within the Sleep modality. A Sleep Service Recovery Group has been established to support the Service around their recovery efforts and the Division is currently working to further develop their Sleep Service recovery plans and performance improvement trajectories. • Modality-level trajectories and plans for 23/24 have been agreed across the Trust. The key risks to diagnostic performance and improvement are industrial action and complex patients needing general anaesthetic or theatre slots where capacity is more limited and prioritised for the most clinically urgent patients. The Trust continues to utilise transferred capacity and outsourcing to the independent sector which are integral to the diagnostic recovery plans for 23/24.
<p>Risk:</p>	<p>Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met</p>

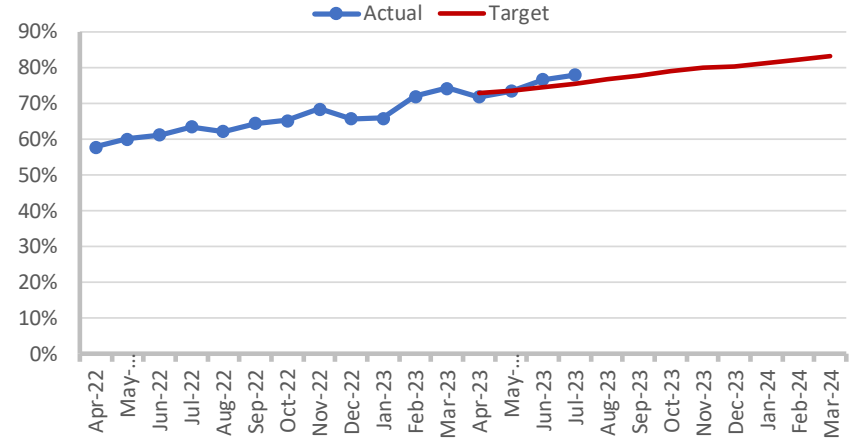
STANDARD

DIAGNOSTIC WAITING TIMES

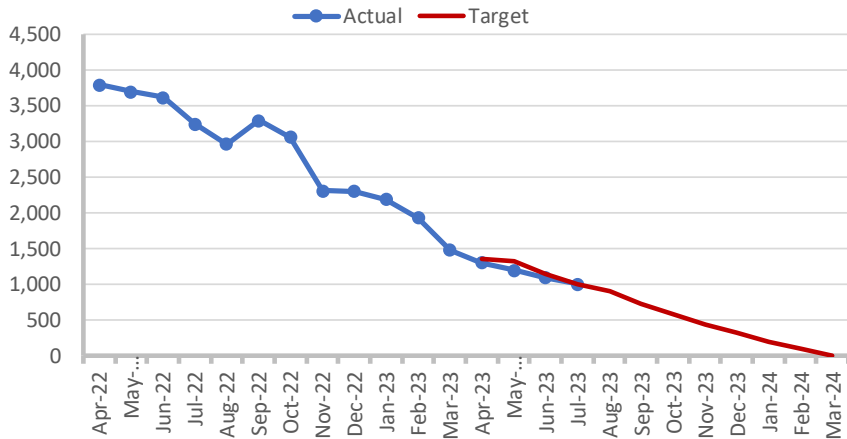
Diagnostics Under 6 Week Wait (15 Key Tests)



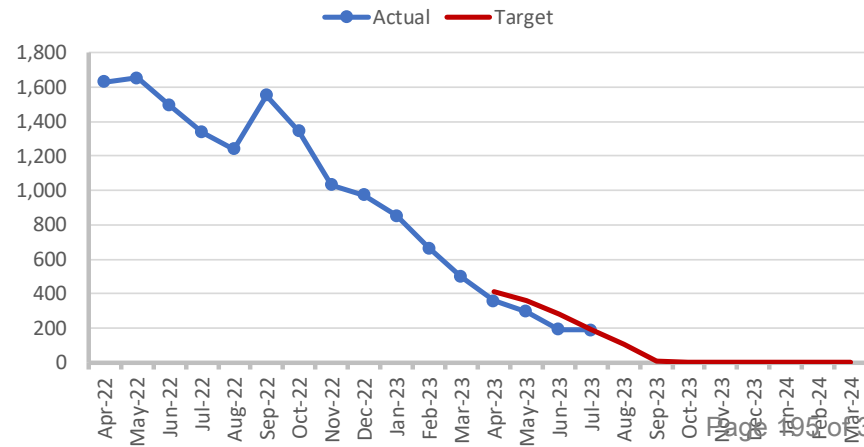
Diagnostics Percentage Waiting Under 6 Weeks



Diagnostics Numbers Waiting 13+ Weeks



Diagnostics Numbers Waiting 26+ Weeks

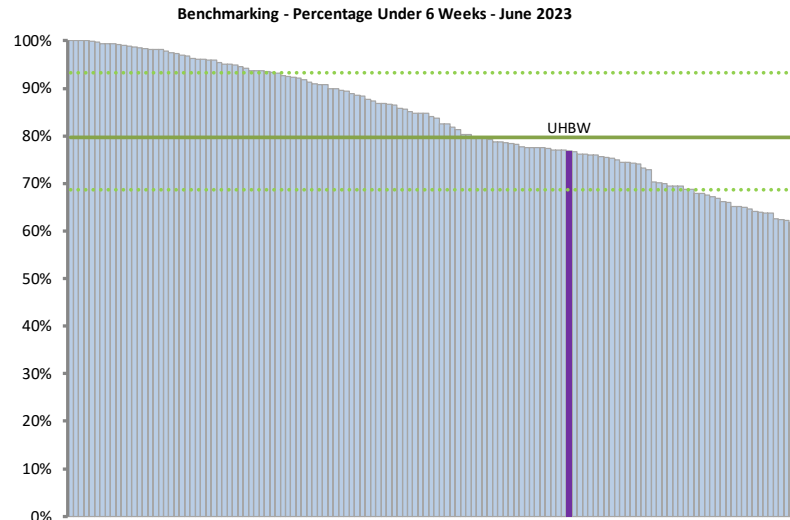


Reporting Month: July 2023

STANDARD DIAGNOSTIC WAITING TIMES

End of July 2023

Modality	Total On List	Under 6 Weeks			13+ Weeks		26+ Weeks	
		Number	Percentage	Mar24 Target	Number	Percentage	Number	Percentage
Audiology Assessments	481	19	96%	97%	7	1%	0	0%
Colonoscopy	378	217	43%	53%	141	37%	20	5%
Computed Tomography (CT)	2,475	158	94%	81%	10	0%	2	0%
DEXA Scan	905	409	55%	68%	97	11%	7	1%
Echocardiography	1,886	378	80%	85%	5	0%	0	0%
Flexi Sigmoidoscopy	111	67	40%	53%	40	36%	9	8%
Gastroscopy	428	221	48%	55%	111	26%	20	5%
Magnetic Resonance Imaging (MRI)	3,038	345	89%	95%	172	6%	64	2%
Neurophysiology	256	15	94%	99%	2	1%	0	0%
Non-obstetric Ultrasound	5,020	1,418	72%	83%	355	7%	4	0%
Sleep Studies	186	86	54%	51%	67	36%	62	33%
Other	0	0			0		0	
UHBW TOTAL	15,164	3,333	78.0%	83.3%	1,007	6.6%	188	1.2%



STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS & WAITS IN A&E FROM ARRIVAL TO DISCHARGE, ADMISSION OR TRANSFER
<p>Performance</p>	<p>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:</p> <ol style="list-style-type: none"> The “4 Hour Standard”. This is the standard that has been reported in previous years and had a constitutional standard of 95%. For 2023/24, Trusts are required to return performance to 76% by March 2024, i.e. 76% of ED attendances should spend less than 4 hours in ED. The “12 Hour Standard”. This standard has a new definition from April 2023 related to the proportion of Service Users attending ED who wait more than 12 hours from arrival to discharge, admission or transfer, with an operational standard of no more than 2%. <p>Note: both these standards apply to all four emergency departments in the Trust. During July, 75.3% of attendances spent less than 4 hours in an emergency department (ED), from arrival to discharge or admission. Performance against this standard continues to improve each month this year and is ahead of the operational planning trajectory of 63.1%, with July being the highest performing month since March 2021. The Trust is on-track to achieving the March 2024 national target of 76% of patients waiting less than 4 hours in ED. The number of patients spending 12 hours or more in ED also improved significantly in July 2023. The national ambition is that no more than 2% of patients spend 12 hours or more in ED and July saw the performance improve to 0.9%, the best reported position in more than four years.</p> <p>12 Hour Trolley Waits This metric is for patients who are admitted from ED, and measures from the Decision To Admit (DTA) time to the Admission Time. This is a standard that has been reported in previous months and will continue to be reported in 2023/24. During June, there were 34 12 Hour Trolley Waits: 11 in Bristol and 23 at Weston, which is a significant reduction on previous months across both sites.</p> <p>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 exceed 15 or 30 minutes. The NHS Standard Contract sets the target that “all handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes”. This has continued to improve over the last eight months and in July there was a significant improvement in the delays associated with ambulance handovers. Of the 3,906 ambulance handovers in July:</p> <ul style="list-style-type: none"> 1,899 ambulance handovers were in excess of 15 minutes which was 48.6% of all handovers (62.0% in June) 666 ambulance handovers were in excess of 30 minutes which was 17.1% of all handovers (27.3% in June)
<p>National Data</p>	<p>There are 19 hospitals in the South-West that the Ambulance Service report data for. For July 2023, overall number of handovers over 15 minutes was 63.7% across these hospitals. The chart on page 17 shows the distribution: Weston was 5th highest at 73%, BRI was 3rd lowest at 38.7% and BRHC was lowest at 22.9%. For Type 1 ED 4 hour performance (excluding the Eye Hospital), the England performance was 65.6%, with UHBW at 65.9%. See slide on page 15 for more detail.</p>

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
<p>Actions:</p>	<p>A range of initiatives are being progressed across adult services to reduce overcrowding, ambulance queueing and long waits including:</p> <ul style="list-style-type: none"> Expansion of Surgical SDEC capacity: 3 x WTE band 8a Associate Practitioners have been recruited, due to start in September. Post advertised for additional 1 x WTE band 8a Associate Practitioner. New role description for Ambulatory Coordinator is being finalised and 1 x PA of clinical lead time has been allocated to formalise clinical leadership within the service. Expansion business case has been finalised – for review at the next Urgent Care Steering Group. Development of the SDEC offer at Weston: 546 patients were seen in Weston SDEC in July with a 7.5% admission rate, averaging 18.2 patient per day. All staff vacancies for SDEC have now been filled, and remaining posts are awaiting start dates. BRI Medical SDEC saw 631 patients in July 2023, which was 9% of ED attends across the month and 20% of the Medical Take. 17% of all patients seen were admitted. The average Length of Stay in SDEC in July was 04:21 compared to 04:26 in June. Frailty in reach options are being explored to support the unit. Cardiac SDEC Pilot started March 2023, two of the four AP posts have been filled, with all posts due to be filled by October. Work is ongoing to improve automated data capture for ongoing monitoring. <p>A review and update of Internal Professional Standards (IPS) is now underway following an A3 approach. Workshops with clinical teams are scheduled for October 2023. In preparation, ‘GEMBA’ walks for ED and surgical take teams are planned, and semi structured interviews and surveys will be conducted throughout August to support design of new standards to support urgent care and flow.</p> <p>In BRI ED:</p> <ul style="list-style-type: none"> A dedicated ED porter has started on 25th July. The new Operational Hub model is working very effectively to support ambulance handovers and flow. Careflow ward handovers re-launched on 19th July to Medicine Assessment Units and will soon be rolled out at Weston. A new pilot has been approved to support direct admissions for non-ambulant patients to Acute Medical Unit. Plans are being scoped regarding having a dedicated senior doctor for Rapid Assessment and Triage. Ambulance bay CCTV is also being added to the welcome desk in A300. Ambulance time lost in ED in July has reduced by 66% in July compared to June. 47% of ambulance handovers were under 15 mins, which has improved every month since January (in January 7.7% of handovers were completed in less than 15 minutes). There were 57 12-hour breaches in July compared to 250 in June and 426 in May. 4-hour performance increased to 67% in July – a 7% improvement compared to June, and 13% improvement compared to May. <p style="text-align: right;"><i>...continued over page</i></p>

Reporting Month: July 2023

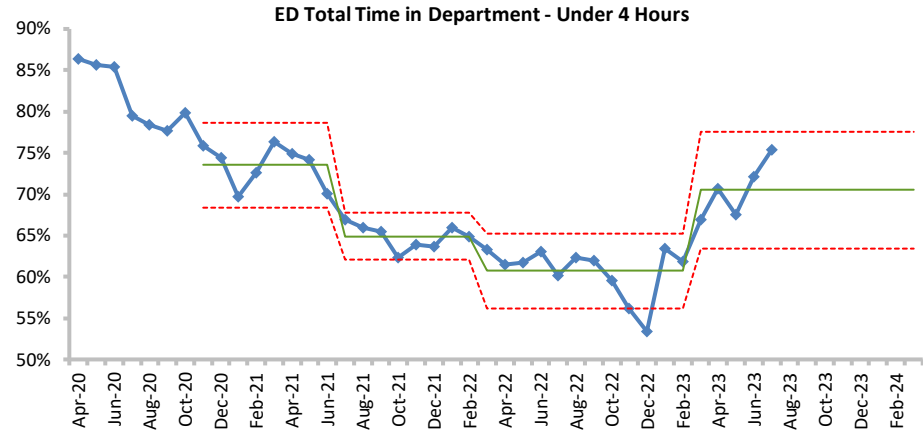
STANDARD		EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
Actions (continued):	In Weston ED:	<ul style="list-style-type: none">Plans are progressing to develop a dedicated ED observations unit and options for reconfiguration of existing spaces within the ED footprint are being reviewed.There has been a 4.3% increase in the proportion of ambulance handovers completed within 15 minutes since January 2023.There were 79 12-hour breaches in July compared to 271 in June and 398 in May.4-hour performance increased to 68.2% July – a 4% improvement compared to May and June.
Risks:		Corporate Risk 910: Risk that patients in ED do not receive timely and effective care 4700: Risk that a patient may deteriorate whilst being held in the ambulance bay

Reporting Month: July 2023

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

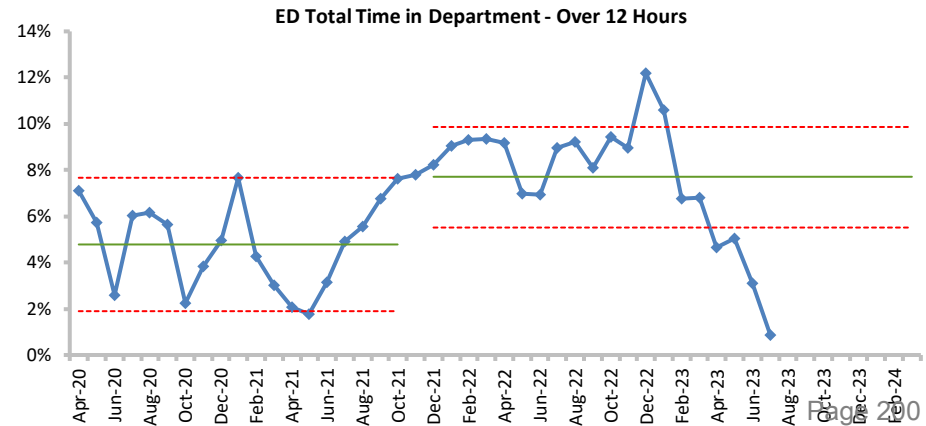
Patients Who Spend Under 4 Hours In ED (Arrival to Discharge/Admission)

4 Hour Performance	Jul-23	2023/24	2022/23
Bristol Royal Infirmary	66.75%	60.2%	46.14%
Bristol Children's Hospital	87.54%	83.03%	71.14%
Bristol Eye Hospital	94.76%	95.72%	95.97%
Weston General Hospital	68.15%	64.82%	55.05%
UHBW TOTAL	75.34%	71.32%	60.94%



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

12 Hour Performance	Jul-23	2023/24	2022/23
Bristol Royal Infirmary	1%	3.9%	12%
Bristol Children's Hospital	0.1%	0.7%	2%
Bristol Eye Hospital	0%	0%	0%
Weston General Hospital	1.7%	7%	15%
UHBW TOTAL	0.9%	3.4%	8.7%

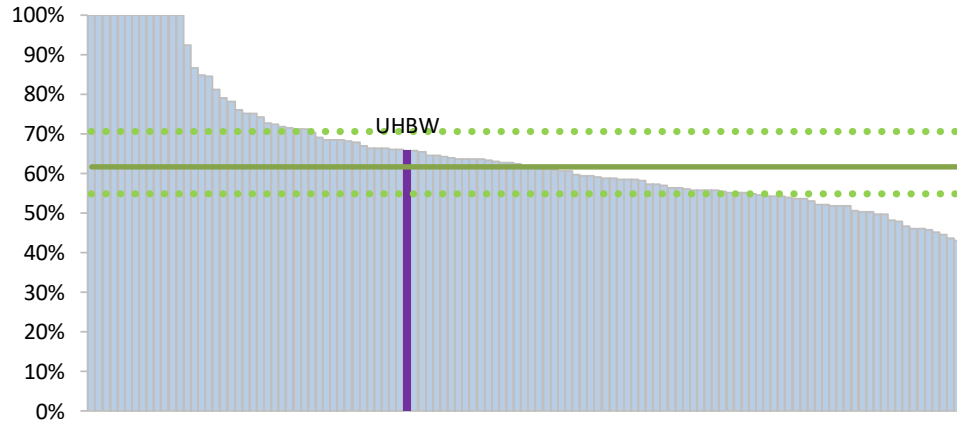


Reporting Month: July 2023

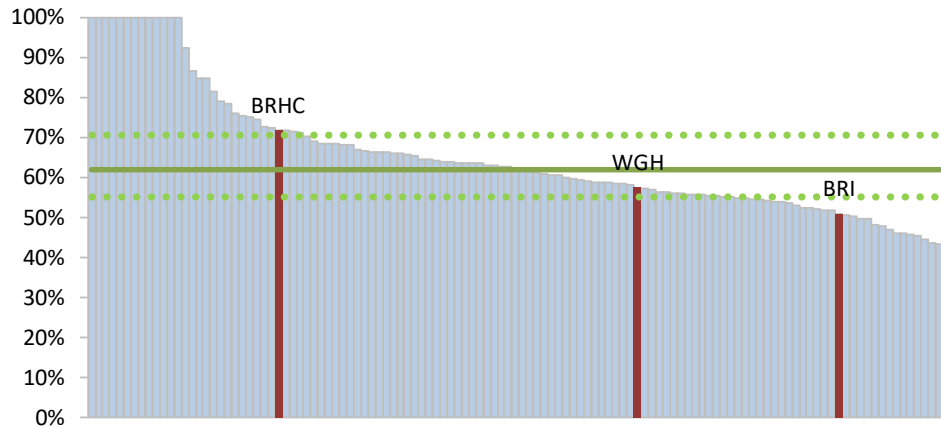
STANDARD

EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E

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



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



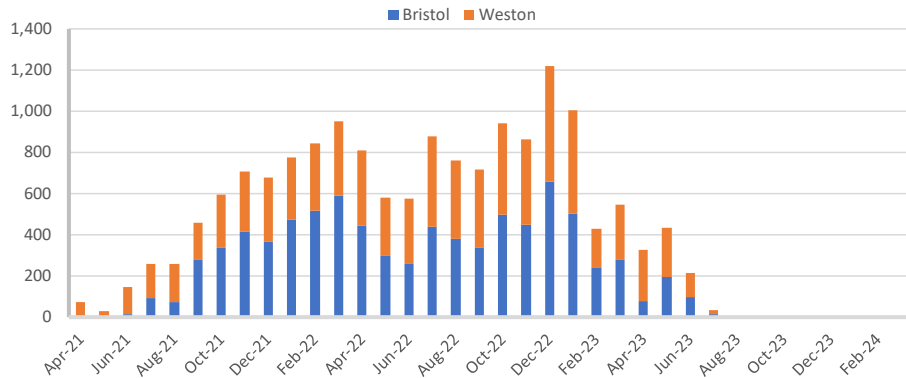
Reporting Month: July 2023

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

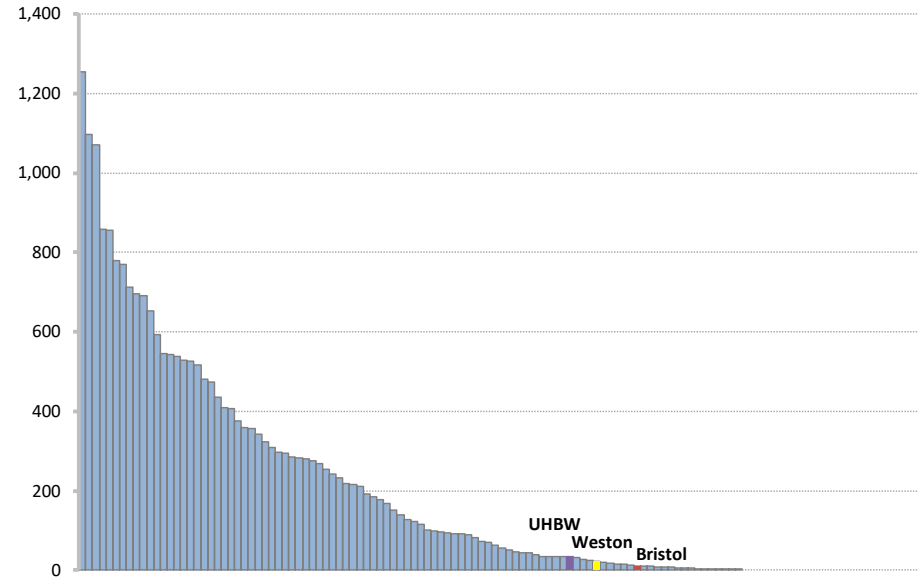
12 Hour Trolley Waits – Admitted Patients Who Spend 12+ Hours from Decision To Admit (DTA) Time to Admission Time

	2022/2023												2023/2024											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bristol	443	297	257	437	379	334	496	449	659	500	235	278	74	192	95	11								
Weston	366	282	319	441	379	383	445	413	558	506	192	267	250	243	119	23								
UHBW	809	579	576	878	758	717	941	862	1217	1006	427	545	324	435	214	34								

12 Hour Trolley Waits Per Month



Benchmarking - 12 Hour Trolley Waits - July 2023



Reporting Month: July 2023

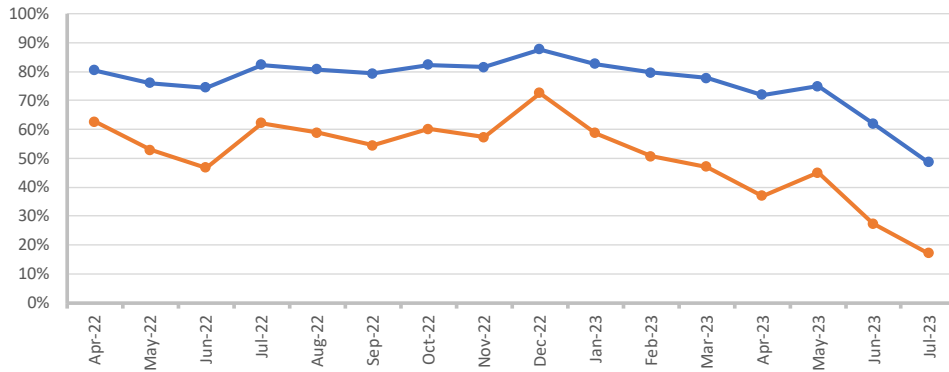
STANDARD EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E

Ambulance Handovers

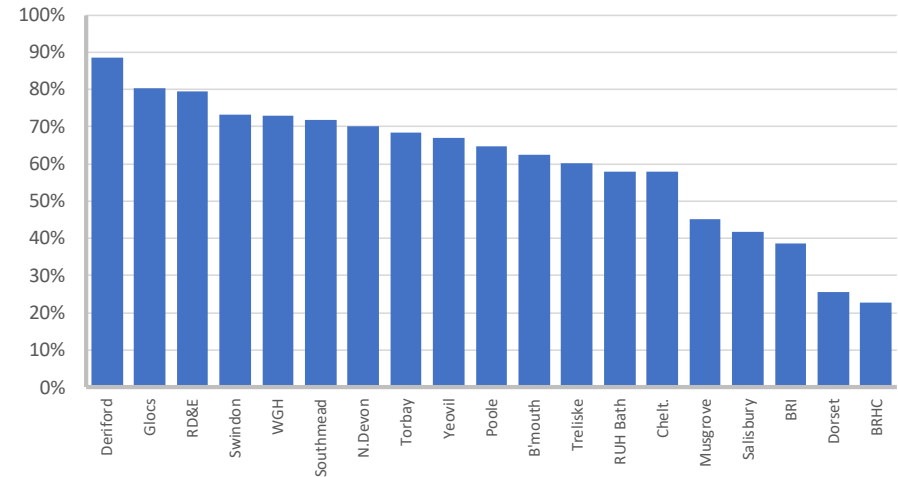
Jul-23					
	Total Handovers	15+ Mins	% 15+ Mins	30+ Mins	% 30+ Mins
Bristol Royal Infirmary	2,441	976	40.0%	289	11.8%
Bristol Children's Hospital	455	134	29.5%	40	8.8%
Weston General Hospital	1,010	789	78.1%	337	33.4%
UHBW Total	3,906	1,899	48.6%	666	17.1%

UHBW handovers exceeding 15 & 30 Minutes (% of all handovers)

● % 15+ Mins ● % 30+ Mins



Percentage of Handovers Over 15 Minutes - July 2023



STANDARD	EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)
<p>Background:</p>	<p>The Every Minute Matters (EMM) programme has four work streams.</p> <ol style="list-style-type: none"> 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.
<p>Performance:</p>	<p>Three metrics are reported as the high-level priorities:</p> <ol style="list-style-type: none"> 1. Percentage of patients with a “timely discharge” (before 12 noon). July had 22.5% discharged before 12 noon. The SAFER bundle standard is to achieve 33% although this is the best performance across the last 15 months. 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 26.2% of eligible discharges went through the Weston or BRI Discharge Lounges. This was 538 patients, averaging 25.6 patients per working day. <ol style="list-style-type: none"> a. BRI achieved 25.3%, with 337 patients. This averages to 16 patients per working day. b. Weston achieved 27.9% with 201 patients. This averages to 9.6 patients per working day. 3. At the end of July there were 126 No Criteria To Reside (NCTR) patients in hospital. 4. During July, the daily average number of patients with no criteria reside was 135. 5. Of the patients discharged during July, the total number of NCTR bed days was 4,060. This figure is calculated by counting the number of NCTR bed days for each patient discharged and is reported in the month that the patient was discharged.

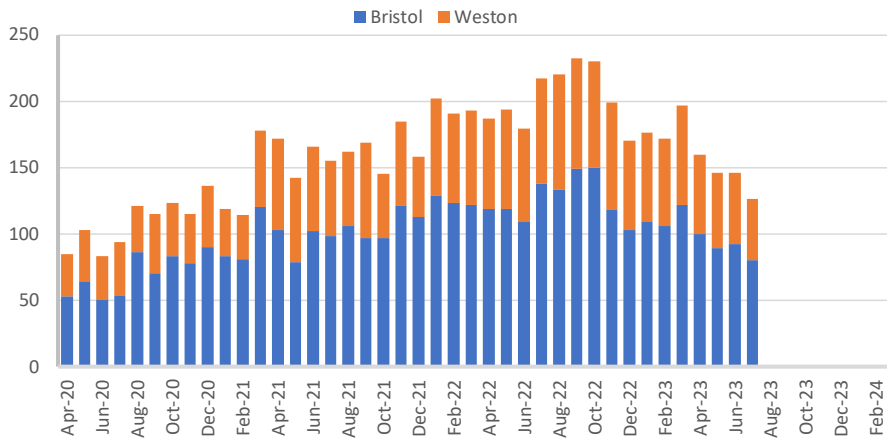
STANDARD	EVERY MINUTE MATTERS - TIMELY DISCHARGE
<p>Actions:</p>	<ul style="list-style-type: none"> • Active Hospitals-six pilot wards selected for launch in Q3. Linking with Arts and Culture team to identify opportunities for patient engagement and activity. Confirmation that the Active Hospital Coordinator role has been extended to March 2024. Environment, Resource, and Education & Training subgroups now under-way to progress key actions and develop core materials. Exploring opportunities to work with UWE OT students. • Weekend discharges; weekend review planned for Weston Hospital on 19th August for all inpatients to understand opportunities to support weekend discharges, both during the weekend period and the weekend preparations. Feedback to be discussed in Task and Finish group. • EMM Improvement practitioner started in post on 24th July. EMM Clinical Lead joining on 14th August. These roles will primarily support sustainability and embedding of continuous improvement approach of core EMM principles, including divisional oversight. Two Proactive Hospital Improvement Coaches are joining the team on 11th September. Funding identified for Medical PA lead – to be recruited. • Value stream mapping for TTA processes underway with a pilot ward to identify any bottlenecks within this process. • Changes to MCAP to only capture mandatory criteria to reside information to reduce ward time commitments to data entry and release time to care were implemented from 1st August. No systems issues to report. • Tap to Transfer relaunch in progress for Weston hospital – focus week under-taken in July with new training , ward visits and additional ward support. Significant improvements in bed reservations seen. Phase 2 medicine inpatient to inpatient roll-out due to commence mid-August. • Work ongoing to evaluate desired functionality and requirements of digital flow systems has been handed over to digital transformation teams and Chief Nurse Information Officer. Review of NBT systems was recently undertaken to inform proposals. • Review of use of discharge checklists on adult inpatient wards completed. Work ongoing to merge and simplify existing discharge checklists . Digital version of new discharge checklist has been developed in test environment. • Criteria led discharge (CLD): <ul style="list-style-type: none"> • BHI: for cardiac surgery the cohort of patients that will be considered for CLD has been expanded. An audit is being undertaken to understand the reasons for ‘unsuitability’ for CLD, supported by divisional Quality Lead. • TAVI CLD pathways - go live date proposed for early September. Pacemaker to follow pending outcomes of TAVI pathway. • Blank clinical note for CLD (for custom criteria at individual patient level) will be piloted on Sandford ward from 31st August. • CLD pipeline created to support new pathways coming on board across all sites and divisions. • Scoping work commenced to review impact and use of no criteria to reside wards (ensuring pull model), and support efficient use of cross-divisional bed capacity through identification and prompt movements for the most appropriate patients to outlie. Kewstoke working group has been stood back-up. Action underway to review patient criteria SOP and related performance data. Selecting patients to outlie or board SOP (NCTR patients) to be included in the Getting Ready for Winter process. • Work initiated to support increased IDS involvement in board rounds, to encourage identification of earlier discharge opportunities including community pathways. Team survey underway with actions to be agreed after evaluation of responses. • The Trust have commenced recruiting into a 24-hour, seven day a week model in the BRI Discharge Lounge. There will be additional capacity during the day to enable a greater proportion of discharging patients to leave via the Discharge Lounge. At night there will be bedded capacity to care for people going out the next day on planned discharge to assess pathways.
<p>Risks:</p>	<p>Strategic Risk 423: Risk that demand for inpatient admission exceeds available bed capacity Page 43</p>

Reporting Month: July 2023

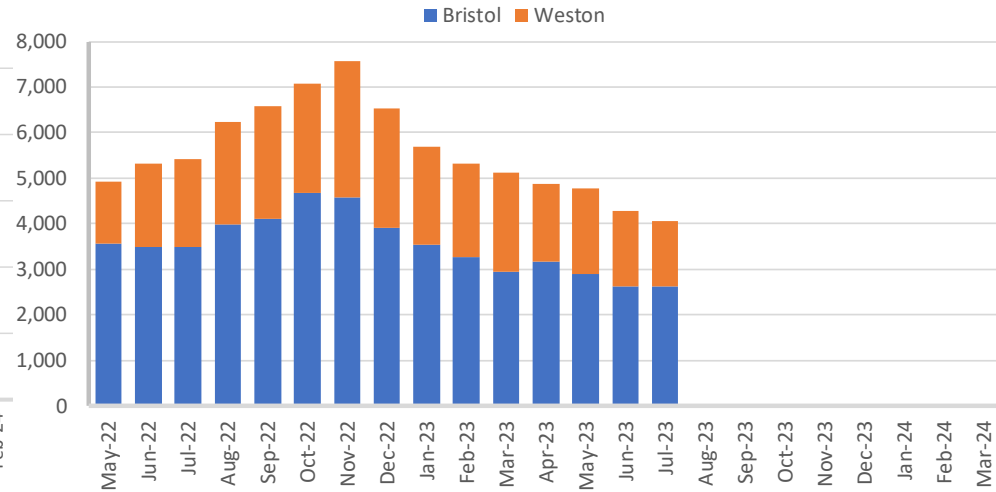
STANDARD EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)

No Criteria To Reside (NCTR) Summary

Number of Patients - Last Thursday in the Month



Total Beddays Occupied by NCTR Patients Discharged in the Month

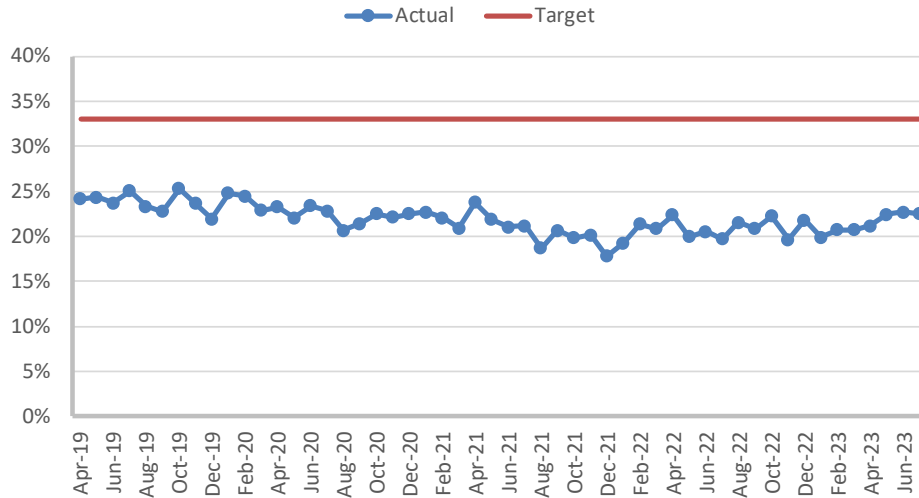


Reporting Month: July 2023

STANDARD EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)

Timely Discharge (Before 12 Noon)

Timely Discharges as a Percentage of all Discharges



Summary of High Volume Specialties - July 2023

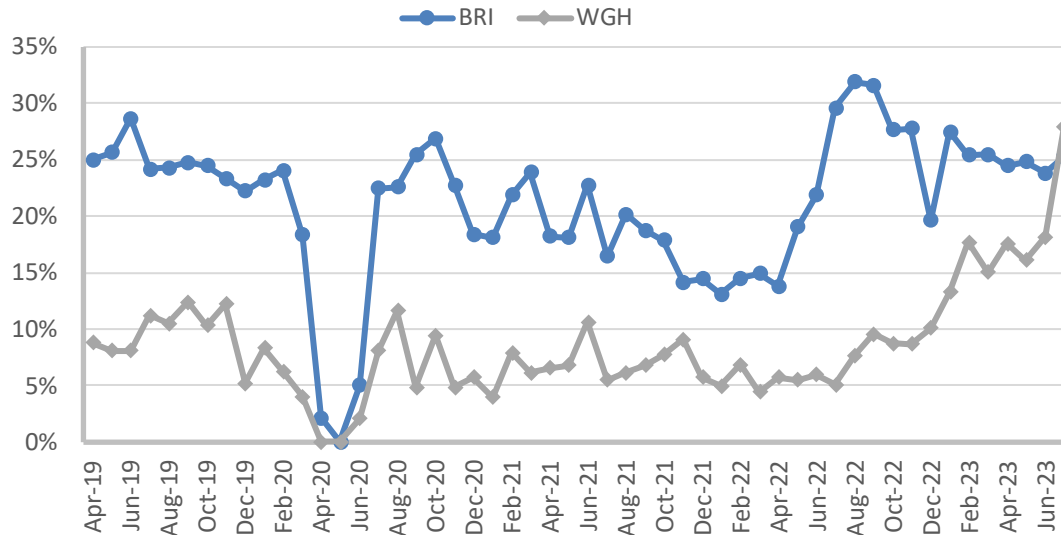
	Total Discharges	% Before Noon
Cardiac Surgery	80	7.5%
Cardiology	311	16.4%
Clinical Oncology	69	23.2%
Colorectal Surgery	102	20.6%
ENT	106	21.7%
Gastroenterology	152	16.4%
General Medicine	654	17.0%
General Surgery	119	19.3%
Geriatric Medicine	243	54.7%
Gynaecology	134	24.6%
Ophthalmology	84	47.6%
Paediatric Surgery	81	23.5%
Paediatrics	139	18.0%
Thoracic Medicine	136	11.0%
Trauma & Orthopaedics	197	32.5%
Upper GI Surgery	92	12.0%
UHBW TOTAL	3,628	22.5%

Reporting Month: July 2023

STANDARD EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)

Discharge Lounge Use Summary

Percentage of Discharges Through the Discharge Lounge



Summary of High Volume Specialties - July 2023

	BRI	WGH	TOTAL
Accident & Emergency	8.1%	33.3%	10.3%
Cardiac Surgery	67.8%	-	67.8%
Cardiology	47.9%	42.3%	47.2%
Colorectal Surgery	25.0%	12.5%	23.7%
ENT	1.5%	-	1.5%
Gastroenterology	7.7%	23.5%	18.5%
General Medicine	16.2%	27.0%	23.0%
General Surgery	12.5%	33.3%	26.4%
Geriatric Medicine	39.3%	19.4%	36.1%
Hepatobiliary and Pancreatic Surgery	21.8%	-	21.8%
Maxillo Facial Surgery	12.0%	-	12.0%
Thoracic Medicine	13.3%	16.7%	14.3%
Thoracic Surgery	26.0%	-	26.0%
Trauma & Orthopaedics	17.8%	42.3%	30.5%
Upper GI Surgery	21.1%	24.0%	22.2%
UHBW TOTAL	25.3%	27.9%	26.2%

STANDARD	NO CRITERIA TO RESIDE (NCTR) AND TRANSFER OF CARE HUB (ToCH)
<p>Actions:</p>	<p>A programme of continuous improvement is in place, managed through the Trust's Integrated Discharge Group, which mirrors the Every Minute Matters core 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 experience this delay for.</p> <p>No Criteria to Reside (NCTR):</p> <ul style="list-style-type: none"> • Improvements evident in patients discharged home with family support or to await therapy in the community. • Maximising system capacity by reducing discharge cancellations. • Reviews of Pathway 2 and Pathway 3 patients with action plans developed. • Reduction in NCTR length of stay (particularly for the longest waiting patients), through weekly multi-disciplinary team (MDT) escalation reviews. • Establishing 2 Transfer of Care Hubs with system partners at BRI and Weston, with 77% of new posts recruited to date creating Home First Team. • There will also be a pathway redesign and improvement element to the joint working which has already commenced, this will be system wide with NBT to ensure standard approach where possible. A shared vision and mission statement has just been signed off by all partners. • Both ToCH's have realigned the workforce into 3 workstreams, Front door(ED and assessment units) Complex patients and Delayed patients • 19 ward-based Discharge and Flow co-ordinators being recruited across UHBW(17/19 recruited) to support patients from admission to discharge and will extend to simple discharges (PO pts) <p>Bristol Transfer of Care Hub (ToCH):</p> <ul style="list-style-type: none"> • 19/21 (90 %) of UHBW staff posts offered, all with start dates by end of September 2023. • 7/7 working in September 2023 for UHBW staff. • Priority is redesigning the operational model to be innovative. Move from a “we can’t” to a “ how can we” approach. • 9 Discharge and Flow co-ordinators started <p>Weston Transfer of Care Hub (ToCH):</p> <ul style="list-style-type: none"> • 9/9 (100%) of UHBW staff posts offered, with 6/9 (67%) in post by end of September 2023, and 100% by end November 2023. • 7/7 working in September 2023 for UHBW staff • North Somerset Council have 1 OT and 1 SW currently undergoing induction • Priority is redesigning the operational model to be innovative. Move from a “we can’t” to a “ how can we” approach • Plan to trial an MDT Navigation process involving all partners including Voluntary sector being developed in September with a focus on getting it right first time and to explore opportunities to navigate pts with MDT input to alternative pathways, and provide a more holistic approach to support patients and carers <p>Governance</p> <ul style="list-style-type: none"> • System oversight group established with partners, led by UHBW Chief Operating Officer. • Draft Memorandum of Collaboration with System partners for review and approval. • Communication Strategy developed.
<p>Risks:</p>	<p>6789 and 6788: Risk that a Bristol and Weston location for Transfer of Care Hub site will not be found 6874: Risk that ways of working are not changed ToCH partners will operate in silo impeding the teams ability to discharge patients.</p>

FINANCIAL SUMMARY

YTD Income & Expenditure Position

- Net I&E deficit of £9,446k against a deficit plan of £5,818k (excluding technical items).
- Total operating income is £11,162k favourable to plan due to higher than planned income from activities of £9,828k (of which c£5,000k is related to the pay award) and higher than planned other operating income of £1,334k.
- Operating expenses are £16,514k adverse to plan due to higher pay (£10,140k of which c£5,000k is related to the pay award) and non-pay expenditure (£6,191k). Depreciation is broadly in line with plan.
- Financing items are £1,631k favourable to plan mainly due to interest receivable.

Key Financial Issues

- *Recurrent savings delivery below plan* – Internal CIP delivery is £5,769k or 92% of plan, of which recurrent savings are £2,493k, 40% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full will result in the Trust failing to meet the financial plan.
- *Delivery of elective activity recovery below plan* – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m, resulting in the Trust not achieving its financial plan. At M4, the value of elective activity is £1.7m ahead of plan.
- *Corporate mitigations not delivered in full* – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan.
- *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.

Strategic Risks

- Assessment and implications of the financial arrangements relating to Healthy Weston 2 Phase 2 – pending completion of the business case in December 2023;
- Understanding the operational risks and mitigations associated with the Trust’s legacy estate and how the CDEL limit and system prioritisation restricts future strategic capital investment – pending completion of the ICB and Trust draft medium term capital plan in October 2023;
- Understanding the implications of the Trust’s recurrent revenue deficit of c£60m, i.e. the requirement to present a medium-term financial plan in October 2023 to address the Trust’s recurrent deficit and the impact this will have on future clinical strategy and Trust autonomy.

TRUST YEAR TO DATE FINANCIAL POSITION

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	83,002	83,395	393	326,763	336,591	9,828
Other Operating Income	9,273	10,852	1,579	37,092	38,426	1,334
Total Operating Income	92,275	94,248	1,973	363,855	375,017	11,162
Employee Expenses	(54,678)	(58,494)	(3,816)	(221,328)	(231,468)	(10,140)
Other Operating Expenses	(35,230)	(34,946)	284	(133,507)	(139,698)	(6,191)
Depreciation (owned & leased)	(3,032)	(3,050)	(18)	(11,758)	(11,941)	(183)
Total Operating Expenditure	(92,940)	(96,490)	(3,550)	(366,593)	(383,107)	(16,514)
PDC	(1,037)	(1,037)	(0)	(4,148)	(4,149)	(1)
Interest Payable	(221)	(224)	(3)	(884)	(908)	(24)
Interest Receivable	250	586	336	1,000	2,679	1,679
Other Gains/(Losses)	0	0	0	0	(23)	(23)
Net Surplus/(Deficit) inc technicals	(1,673)	(2,917)	(1,244)	(6,770)	(10,491)	(3,721)
Remove Capital Donations, Grants, and Donated Asset Depreciation	238	7	(231)	952	1,045	93
Net Surplus/(Deficit) exc technicals	(1,435)	(2,910)	(1,475)	(5,818)	(9,446)	(3,628)

Key Facts:

- The position at the end of July is a net deficit of £9,446k against a deficit plan of £5,818k. The adverse position against plan of £3,628k is primarily due to the estimated financial impact of industrial action at £2,572k and the shortfall on savings delivery at £1,041k.
- Year-to-date, the Trust has spent £2,225k on costs associated with internationally educated nurses.
- Pay expenditure in July is £3,816k higher than plan. This is mainly driven by additional staffing costs of covering the industrial action, increased bank costs and a higher number of substantive staff in post.
- Agency expenditure in month is £2,064k, compared with £2,389k in June. Bank expenditure in month is £3,432k, compared with £2,931k in June.
- Other operating expenditure is £284k lower than plan in July.
- Total operating income is ahead of plan in July by £1,973k, of which £1,579k is Other Operating Income, £1,000k of which relates to funding from NHS England to support Internationally Educated Nurse (IEN) recruitment.
- The financial position of the clinical divisions deteriorated by £1,737k in July to a YTD overspend against budget of £6,342k or 2.1%. Excluding the cost of industrial action, this reduces to £4,150k or 1.4%.
- The majority of the £1,737k deterioration remains in two Divisions: Surgery £492k; and Women's & Children's £737k. Specialised Services improved its position by £178k in July.

Meeting of the Trust Board of Directors in Public on Tuesday 12 September 2023

Report Title	Infection Prevention and Control Annual Report 2022 - 2023
Report Author	Dr Martin Williams, Director of Infection Prevention and Control Trevor Brooks, Deputy Director of Infection Prevention and Control
Executive Lead	Prof. Deirdre Fowler, Chief Nurse and Midwife / Exec Lead for IP&C

1. Purpose

This is the Trust Annual report for Infection Prevention & Control 2022/23. The document provides the annual summary of organisational performance for Infection Prevention and control in UHBW across the year. The mandatory compliance is linked to the ten criteria within the code of practice on the prevention and control of infection (updated 13/12/22).

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

1. The annual report 2022/23 will be shared with NHSE, ICS and will be available through the Trust Board in public.
2. The report includes a self-assessment summary approved by the DIPC of compliance with the 10 criteria with the IP&C code of practice, that the organisation is obliged to deliver. Of the criteria all 10 were acknowledged to be compliant.
3. Input for the report had been received from colleagues in the Safety Department, Occupational Health, IP&C, Facilities, Estates, Pharmacy, Decontamination, with specific elements of the report being written by them. The IP&C Annual Report has threads through each clinical pathway for every patient across the whole of UHBW.
4. The performance figures for Healthcare Acquired Infections (HCAI) infections, namely *C.difficile* and MRSA where the Trust had exceeded the NHSE set limits.
5. The impact of SARS-CoV-2 and the pandemic continued through 2022/23 with significant impact on the services within UHBW.

3. Strategic Alignment

The DIPC report is the quarterly and the first level of IP&C assurance with the IP&C annual report 2022/23 is the summary through the year of this assurance. The IP&C Board Assurance Framework is also used to provide additional scrutiny and has subsequently been updated throughout the year and shared with Clinical Divisions and the Executive Team.

4. Risks and Opportunities

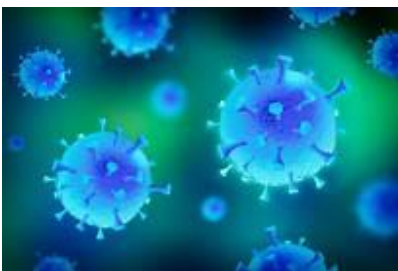
The risks associated with IP&C have been reviewed throughout the year and are held on the risk registers with corporate services or in Divisions. The one specific IP&C on the corporate risk register was number 4651 associated with the risk of transmission of COVID-19, but this has since been downgraded. See risk entry below.

Risk & Datix number	Current risk rating
6013 <i>The risk that UHBW exceeds its NHSE/I limit for Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia's</i>	Risk rating - 16 Very High Risk
3216 <i>Risk that new national C.difficile criteria will increase the number of Trust apportioned cases</i>	Risk rating -12 High Risk
4651 <i>Risk that SARS-CoV-2 is transmitted between patients and staff in areas within the Trust</i>	Risk rating - 9 High Risk
5265 <i>Risk that we are unable to screen all patients carbapenemase-producing Enterobacter ales (CPE) on admission to hospital again</i>	Risk rating - 9 High Risk
5745 <i>Risk that the Trust is non-compliant with standards of care for peripheral vascular Cannulae</i>	Risk rating - 9 High Risk
5. Recommendation	
<p>The Trust Board is asked to note the annual summary of organisational performance for Infection Prevention and control in UHBW across the year and to approve the Annual Report for Infection Prevention and Control for 2022/23.</p>	
6. History of the paper Please include details of where paper has <u>previously</u> been received.	
Infection Control Group	26 th July 2023
Clinical Quality Group	2 nd August 2023



University Hospitals Bristol & Weston NHS Foundation Trust

Infection Prevention and Control Annual Report 2022/2023





University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

Infection Prevention and Control (IP&C) annual report 2022/2023

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1. Foreword

The SARS-CoV-2 pandemic continued to impact on our services throughout 2022/23, with Infection Prevention and Control (IPC) restrictions continuing to be an ongoing operational challenge, to deliver the 'Hierarchy of Controls' and therefore using a risk managed approach to keeping patients and staff safe. Our team have been required to demonstrate additional resilience to maintaining their focus on safety, recognising the operational pressures this has created across our hospitals. The profile and importance of IP&C is ever increasing.

Infections such as *clostridioides difficile* (*C.diff*) and *Methicillin resistant staphylococcus aureus* (*MRSA*) that had less of a focus during the pandemic, and might have been considered to have been hibernating, are emerging as an increasing threat that requires every member of the clinical team in UHBW to have diligent approach to IP&C and effective leadership.

The fundamental principles of IP&C cannot be underestimated; from hand hygiene and robust cleaning of the healthcare environment and decontamination of patient equipment, and effective stewardship with how and when we use antibiotics. The professionalism, commitment and discipline of our staff is at the heart of IP&C success.

Delivering on the IP&C agenda involves not only individuals, staff and patients within UHBW, but increasingly collaboration across our Integrated Care System (ICS), with acute and community partners and as a region and indeed a nation.

We will continue to fight against infection as we harness technology to support our approach. This includes investment in surveillance and management systems for IP&C, in collaboration with North Bristol Trust in 2022/23, as well as the forthcoming introduction of electronic prescribing to enhance antibiotic stewardship in clinical practice.

The Trust Board acknowledges the highest importance of IP&C as a patient safety theme for the IP&C and all multi-professional teams across the Trust who should be commended for their responsiveness in the implementation of guidance issued, with the surges at different stages of the pandemic.

***Professor Deirdre Fowler, Chief Nurse and Midwife
Executive Sponsor for Infection Prevention and Control
at University Hospitals Bristol and Weston NHS Foundation Trust***





2. Executive summary

The Annual Report for 2022/2023 informs patients, public, staff, Trust Board members and the Integrated Care Board (ICB) of the IP&C activities undertaken within the Trust and demonstrates progress against the required performance targets.

It has been another unprecedented year for IP&C associated with the SARS-CoV-2 (COVID-19) pandemic.

- The Trust has not met its *Clostridioides* (previously *Clostridium*) *difficile* objective of no more than 89 Trust apportioned cases in 2022/2023, finishing the year with 100 cases. In total, 77 hospital onset–healthcare associated (HOHA) and 13 community onset–healthcare associated (COHA) were identified.
- There were seven Trust apportioned MRSA bloodstream infections in 2022/2023 against a zero trajectory; this is unchanged on the previous year. All cases are investigated to identify if learning can be found to decrease the likelihood of recurrence.
- Ninety Trust apportioned *E. coli* bloodstream infections were reported during 2022/2023. Each case has been reviewed.
- In 2022/23 the organisation delivered 8,064 influenza vaccinations to staff. The SARS-CoV-2 vaccination hubs set up during the pandemic, in both Bristol and Weston, have continued delivering booster vaccinations as per the Joint Committee on Vaccination and Immunisation’s (JCVI) guidelines. During the autumn booster phase, they vaccinated 7,668 healthcare workers.
- Hand hygiene compliance remained excellent during 2022/23, with an average compliance rate of 96.5%. The use of the ‘Tendable’ app has provided us with assurance over required standards being met.
- The IP&C Team completed their annual programme of work in 2022/ 23. The work plan included policy reviews, audit, as well as education and training alongside post-infection reviews that have continued for hospital acquired infections.
- A Trust wide enhanced approach to Surgical Site Infection (SSI) surveillance has been prioritised with the focus of a senior IP&C nurse leading this work stream. Mandatory reporting is now across all UHBW sites in both Bristol and Weston supported by the SSI element of the IP&C team.
- Antimicrobial Stewardship auditing has once again been instigated; however, the planned introduction of an electronic prescribing tool will significantly enhance the ability of antibiotic stewardship and enhance oversight.
- The monthly cleanliness auditing has continued. The implementation of Cleanliness Standards for Healthcare (2021) has been delivered.
- The Patient Led Assessment of the Care Environment (PLACE) has been completed in the autumn of 2022/23 for the first time in two years, having been in abeyance due to the pandemic. The action plan is in progress, and the final prioritisation of capital resources for improvements is underway in collaboration with divisions and the Estates department.
- Plans and ambitions for 2022/23 for the IP&C have been linked to the constantly changing demands of the operational service and the reprioritisation of objectives.
- The IP&C team in collaboration with North Bristol NHS Trust have implemented an updated ICNET Clinical Surveillance Software system. This technology is to be further deployed in the year ahead including electronic tools for the implementation of outbreak management and surgical site wound surveillance.





3. Introduction

The purpose of the report is to inform patients, public, staff, Trust board members and the Bristol, North Somerset and South Gloucestershire (BNSSG) ICB, of the IP&C related activities undertaken in 2022/23 within UHBW NHS Foundation Trust. All NHS organisations must have effective systems in place to control healthcare associated infections as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance updated in December 2022. Infection Prevention and Control is part of UHBW NHS Foundation Trust's overall risk management strategy. This report provides assurance to the Board that the Trust has discharged its responsibilities as per the Act. The significance of the SARS CoV-2 pandemic is referenced as the continuing impact has been significant on the UHBW services and the staff and patients within the organisation.

The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on Occupational Health, Decontamination, Facilities and Estates, and Pharmacy.

4. Director for Infection Prevention & Control Report to the Board

Corporate Responsibility

The Chief Nurse is the Executive Director sponsor for IP&C and reports to the Chief Executive and the Board of Directors. The Director for Infection Prevention and Control (DIPC) is a consultant microbiologist in the Trust with a deputy DIPC.

Infection Prevention and Control and Trust Governance

The Infection Control Group (ICG) is responsible for ensuring that there is internal oversight and assurance of compliance with national IP&C standards, local policies, guidelines, and external assessments, e.g., decontamination standards, Care Quality Commission standards and the Patient Led Assessments of the Care Environment (PLACE). The ICG is chaired by the Deputy Chief Nurse and the group meets quarterly. Reports are received at each meeting from the subgroups which are Decontamination Board, Antimicrobial Stewardship Group, Facilities and Estates, Occupational Health, the monthly Trust-wide Infection Control Operational Group and reports from each clinical division. ICG reports to the Clinical Quality Group, and Quality and Outcomes Committee (Board sub-committee).

DIPC Reporting to UHBW Board of Directors

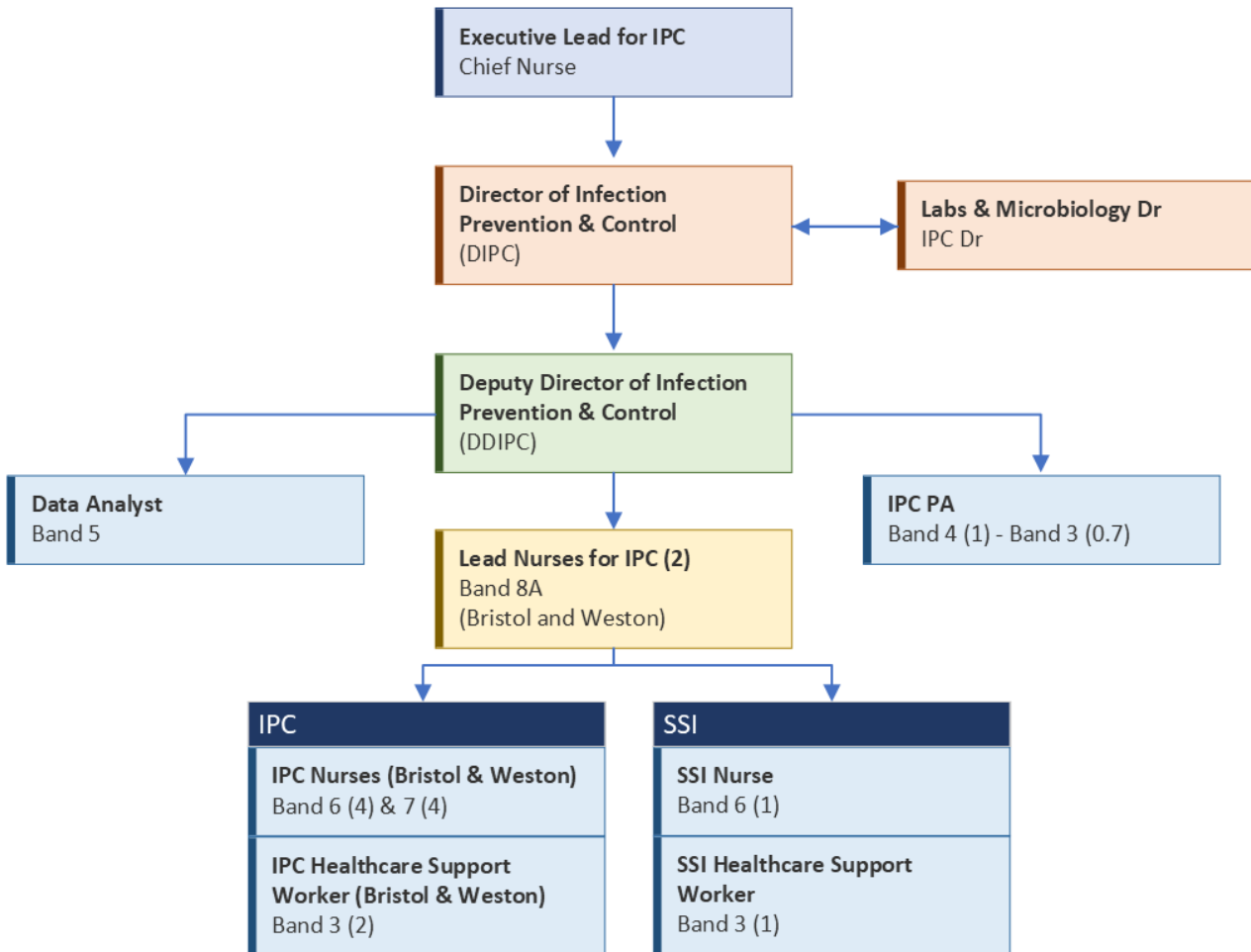
The DIPC reports quarterly to the Quality and Outcomes Committee. Key IP&C performance metrics are reported monthly as part of the Board Integrated Quality Performance (IQPR) report. The IP&C annual report is submitted to the Board of Directors. An additional requirement throughout the pandemic has been assessment of the Trust's compliance with the NHSE Infection Prevention and Control Board Assurance Framework. The IP&C Board Assurance Framework has been updated at different stages. The Trust assessment of compliance has been scrutinised through the Trust's governance structure with summary documents presented to the ICG for assurance.





5. Infection Prevention and Control Team Structure (2022/23)

The IP&C team is structured as below:



For UHBW, the Infection Control Doctor role is provided by the medical microbiology team who are contracted from the UK Health Security Agency (UKHSA) with 24 hours on-call microbiology provision. The provision of Infection Control Doctor role at Weston Hospital is by the on-site microbiologists and including out-of-hours support from the North Bristol NHS Trust. The DIPC in UHBW, maintains accountability across all sites.

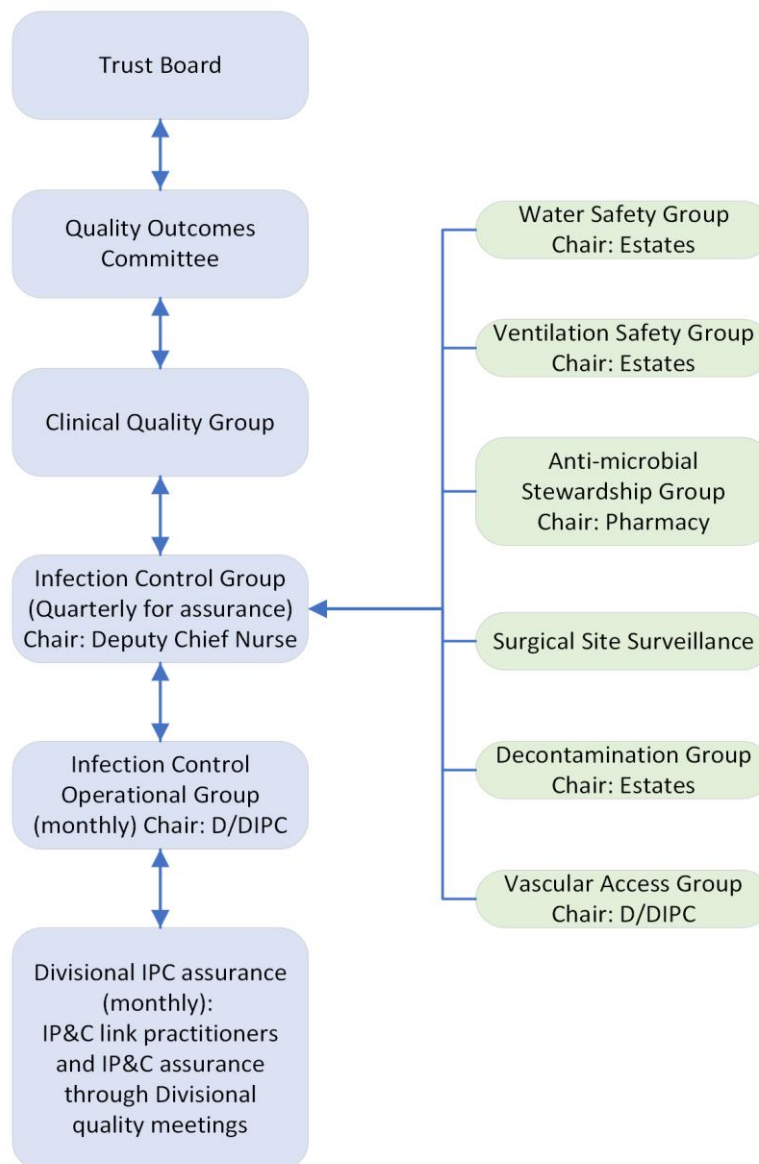




6. The governance structure for IP&C in UHBW

The Trust IP&C governance structure for UHBW is summarised in the diagram below:

A series of groups formally report into the Trust ICG for assurance purposes, with Divisions providing summary reports. The ICG then, in turn, reports into the Clinical Quality Group & Quality and Outcomes Committee.





7. Compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (updated 13/12/22).

The updated guidance in December 2022 has moved its emphasis to focus on the importance of delivering cleaning standards and antimicrobial stewardship. A risk assessment that delivers effective IP&C strategies is required, with appropriate mitigation. The responsibilities for individual roles have added clarity, as well as robust and visible leadership.

The table below details the 10 domains of the Code of Practice for Infection Prevention and Control and summarises achievements of the overall compliance criteria.

Compliance Criterion 1. Systems to manage infection.

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

- Section 5 above details the IP&C team structure in UHBW.
- Section 6 above details the governance reporting arrangement in UHBW.
- The IP&C Team has an annual work plan which is monitored by the quarterly ICG.
- IP&C related incidents are managed through the Trust's incident reporting process (Datix) and any risks that relate to IP&C are managed via the Trust's risk management process. The ICG reviews and monitors all IP&C corporate and divisional risks, relating to IP&C. Divisional reports to the group include updates on IP&C risks and their management.
- There is a programme of cleanliness auditing conducted in high and very high-risk areas as directed by the National Standards of Healthcare Cleanliness (2021). The reports from these audits are presented through the monthly operational ICG by Divisions for local action and re-audit accordingly.
- If non-compliance is noted in cleaning standards, local departmental Efficacy audits are led by the Facilities team, with Divisional, clinical and IP7C input to review the area of non-compliance.
- Reportable healthcare associated infections are reported via the Datix Incident Management System mandatory external report and via the UKHSA data capture system.
- All IP&C training is mapped against the UK Core Skills Training Framework Statutory/ Mandatory Subject Guide, Version 1.4 (2017). This includes measures to prevent risks of infection.
- The IP&C are responsible for the development and updating of Trust wide infection prevention and control policies which are ratified through the ICG.
- Audits to monitor compliance against key policies are undertaken as per the annual audit plan. This includes monthly hand hygiene audits, use of personal protective equipment (PPE) and other audits relating to Aseptic Non-Touch Technique (ANTT) practice, using the 'Tendable' system.





- The Trust Water Safety Group oversees the work to deliver the requirements set out in the Health Technical Memorandum (HTM) 04-01 revision. This multidisciplinary group ensures that there are systems and processes in place to manage the complex water systems and a water safety plan is in place.
- The Trust Ventilation Safety Group provides a means for the joint review of issues relating to the effective management and review and co-ordination of aspects of the performance of the site's ventilation systems in accordance with HTM 03-01 ventilation systems.

Compliance Criterion 2. Clean Environments.

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

The Trust has designated leads for environmental cleaning, and decontamination of equipment.

- Annual audits relating to decontamination are conducted by external auditors to monitor compliance.
- There is a system in place to ensure decontamination before equipment is maintained/ serviced/ repaired, whether within the area or transferred from the area via a DC1 form. Staff members complete this form when returning items to the Medical Equipment Management Organisation (MEMO) for repair.
- MEMO is audited by the British Standard Institution twice a year as part of the ISO 13485:2016 quality management standard.
- Weekly or monthly cleanliness audits are carried out by the Facilities Auditing team within all clinical areas depending on the cleaning risk category. Areas for improvement are identified and follow-up audits are undertaken to ensure improvements in standards have been made. Multi-disciplinary efficacy audits are completed on a rotational basis targeting areas of non-compliance across the Trust.
- Individual department 'star ratings' for cleanliness and cleaning schedules are available for public view within each clinical area.
- There are suitable handwashing facilities in all clinical areas (where appropriate) as well as alcohol hand gel.
- The Trust has a cleaning responsibilities framework, standard operating procedures and policies in place to manage the clinical environment and ensure appropriate cleaning mechanisms are used at all times. This includes cleaning an environment after a patient with an infection is discharged.
- When an enhanced or deep cleaning is undertaken due to an infection, the standards of cleaning are signed off by a senior person within the clinical area to confirm they meet the requirements.
- All clinical staff receive training on IP&C which includes decontamination and cleaning of equipment. Compliance with infection control training at the end of 2022/23 was 90%. The standard for compliance is 90%, however some clinical divisions have not achieved this performance target. This is reported quarterly to ICG with the response for action being held by the Divisional Director of nursing and Clinical Chair for respected divisions.
- The Trust's linen policy specifies that used and clean linen are segregated throughout the collection and distribution functions. Quarterly contract performance review meetings are held with the supplier,





where compliance is confirmed / evidenced. There are agreed Key Performance Indicators (KPIs) with the Trust. Used linen is placed in disposable colour coded linen bags.

- The regulatory documentation for the provision of linen is HTM 01-04 – Decontamination of Linen for Health and Social Care, which the organisations assures compliance with.
- An external auditing body conducts annual audits in Central Sterile Services Department (CSSD) against the ISO 13485:2016 standard for medical devices.

Compliance Criterion 3. Antimicrobial use.

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

- Joint specialist pharmacist / microbiologist ward rounds were suspended during the first waves of the SARS-CoV-2 pandemic. These have now been reinstated, including auditing antimicrobial prescriptions for compliance with the anti-infective guidelines, providing advice on the management of all infections where appropriate, and applying the Start Smart Then Focus (SSTF) principle to all prescriptions. Application of the Sepsis Six toolkit ensures patients with sepsis are treated promptly and the review team follow them up to ensure therapy is narrowed where possible.
- The paper drug charts at UHBW were amended in 2021 to incorporate the ARK (Antibiotic Review Kit). ARK is a bundle of strategies developed to help ensure antibiotic use is appropriate, and the drug chart prompts a review at 72 hours or sooner. The design enables easier switching to oral therapy, narrowing of spectrum or cessation altogether. Mandatory training is available for all prescribers to explain the rationale behind the kit.
- Electronic Prescribing and Medication Administration (EPMA) will be rolled out across the Trust in the 2024; the Antimicrobial Pharmacists (AMPs) have been working closely with Pharmacy IM&T to introduce several measures and reporting tools that will steer prompt reviews and compliance with Trust guidelines. EPMA will allow the team to have oversight of all anti-microbial prescriptions and thus, will guide specialist ward rounds, reporting and providing feedback to prescribers.
- The Antimicrobial Steering Group (ASG) meet quarterly and discuss compliance with guidelines, expenditure, anti-infective incidents, guidelines, Anti-Microbial Resistance (AMR) CQUIN targets and other items relating to antimicrobial use. Membership includes the medical director, the DIPC, consultant microbiologists, paediatric I D, senior clinicians representing the divisions, representation from the Non Medical Prescribers (NMPs), representation from IP&C, the Director of Pharmacy, the Consultant Pharmacist Anti-infectives and the specialist NHS@Home Pharmacist. Antimicrobial prescribing compliance is monitored through the ASG and reported monthly to the Trust board, divisional leads, and consultants throughout the Trust.
- A dedicated Anti-fungal Stewardship multi-disciplinary team (MDT) meets weekly to discuss complex patients with invasive fungal infections; anti-fungal stewardship aims to improve patient outcomes and ensure anti-fungal medications are used appropriately, thus limiting resistance.
- The team have introduced a weekly Infective Endocarditis MDT (IE MDT) in light of recommendations from the Joint British Societies; the team discuss patients from the wider BNSSG area, with the aim of ensuring all aspects of IE, including infection management, are considered.





- The Trust has an Anti-Infective Prescribing Policy and guidelines. These are available on the Trust’s intranet (dedicated anti-infective pages) via the “Microguide” app (Horizon Strategic Partners Ltd.) which is freely available for all users. Anti-microbial compliance is monitored weekly. A newly introduced Intravenous-to-Oral-Switch decision support tool (IVOS) has been launched to help support the prescribers and the 2023/24 CQUIN target.
- Regional and national benchmarking is undertaken; the Trust has participated in an annual Point Prevalence Audit within the Southwest Region, and the Southwest Regional Antimicrobial Group that meet quarterly. National benchmarking is available on the NHSE Fingertips website, UHBW submit data for inclusion. The Refine and Define reporting tools allow comparison with other acute trusts within the SW region, nationally and against the Trust’s past consumption.
- Antimicrobial Consumption (NHS E Standard Contract): the Standard Contract target for 2023/24 aims to reduce the consumption of broad-spectrum antibiotics across the Trust. The AMPs work closely with microbiology to limit the use of these drugs where appropriate. Trust consumption is monitored monthly. The target for 2022/23 was to achieve a 4.5% reduction in Watch and Reserve antibiotics against the FY 2018 baseline and UHBW met this target with an overall reduction of 10.6%.
- Microbiology systems provide readily accessible computer data and telephone advice both in and out-of-hours on microbiological data and susceptibility results.
- The Anti-infective Consultant Pharmacist is an active member of both BNSSG, South West and national AMS groups, collaborating with colleagues to improve AMS in these areas.
- Trust induction covers expectations and signposting to guidelines etc., for those prescribing antimicrobials. Foundation Year 1s (FY1s) are provided with a teaching session that covers antimicrobial resistance, common infections and the rationale for stewardship practices. Anti-infective pharmacists provide ad-hoc teaching to FY1s on any other related topics as required.

Compliance Criterion 4. Information on infections.

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

- The NHSE Infection Prevention & Control manual (2022) is available within the Trust, with associated Trust guidelines and Standard Operating Procedures.
- National information is utilised for patient and public information on IP&C where appropriate are available with links through the Trust document management service.
- Trust patient information leaflets for IP&C related matters are submitted to the patient experience group for review and approval and the Trust communications team.
- Posters, leaflets, and signage are used to promote good hand hygiene practices, inform patients and visitors of any requirements for IP&C, and provide public health information and advice. The central Communications Team continues to support corporate messaging.
- Information is also available on the Trust website and relevant information is sent out using social media. Patient confidentiality is maintained at all times and information is only shared with other organisations in accordance with Data Protection principles.





Compliance Criterion 5. Those at risk of infection.

That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

- The Trust IP&C team work closely with other healthcare organisations including the NHSE regionally, UKHSA, the Bristol, North Somerset and South Gloucestershire (BNSSG) ICB and other healthcare providers to ensure any information regarding infections within the local area is known and action is taken accordingly.
- The NHSE and UKHSA is informed of all notifiable infections, and any outbreaks or serious incidents are notified to UKHSA and the ICB.
- The responsibility for IP&C is devolved to all groups in the organisation and Trust-wide representation from a senior Divisional representee at the quarterly infection control group is to ensure timely and effective cascading of information to all areas.
- The additional Infection Control Operational group, chaired by the deputy Director of IP&C allows direct engagement with Divisional representation from the facilities team, Divisional matrons and the IP&C team.
- A Trust specialist 'IP&C bronze cell' operates when required to allow timely response to policy update requirements during the pandemic on an 'ad-hoc' basis when required; this is chaired by the Divisional Director for Diagnostics and Therapies or Deputy Chief Nurse or DIPC, with representatives across Divisions, from IP&C and the central operations team.

Compliance Criterion 6. Registered providers' responsibility to health and social care workers and those in care settings (including contractors and volunteers)

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

- All staff, including volunteers, receive IP&C training on induction to the Trust. This is predominately online with some face-to-face training as required. IP&C update training is mandatory every three years. Compliance for mandatory IP&C training is formally reported through ICG.
- The Trust adheres to the UK Core Skills Training Framework on all training including updates.
- IP&C is a core element within all job descriptions for staff employed across the UHBW.
- Additional training and competencies are in place for skills such as Aseptic Non-Touch Technique and urinary catheterisation and supporting the development of healthcare support workers and international recruited registered nurses.





- Updated information including leaflets are available for all staff including contractors, for different infections / organisms. ‘All staff’ operational bulletins (Newsbeat) are circulated weekly and include specific IP&C related updates, as required, if guidance for patients has changed.
- Individual IP&C risks are discussed directly by the Estates maintenance and capital project teams managers and IP&C, as required.
- Departmental observations of aspects of IP&C practice such as use of peripheral venous cannula (PVC), hand hygiene, personal protective equipment is monitored using ‘Tendable’ monthly.

Compliance Criterion 7. Isolation Facilities

The provision or ability to secure adequate isolation facilities.

- The trust 1,135 beds which does not include additional capacity bed spaces for winter pressures, of which 331 are single patient rooms (as listed in table 1.1). Each single patient room has dedicated equipment when possible. All sites are challenged at time to provide isolation facilities in a timely way.
- The Weston site has the smallest proportion of its bed base as single patient rooms which poses particular challenges for prompt isolation of patients with an infection.
- The Trust does not have a formal organisational strategy to increase the single patient room capacity for IP&C requirements.
- The Trust has some specialist ventilation single patient rooms for isolation. Specialist ventilation rooms are required for patients with specific infections or for patients who are severely immunocompromised.
- The Trust has policies in place for the appropriate isolation of patients as required.
- There is a ward on the Bristol site (ward A900) that can be converted into a 6-bedded cohort ward should this be required in the situation of an outbreak.
- For safe management of patients side room facilities were prioritised to protect patients and staff with access restrictions in place. If Cohorting of patients with single infections, arrangements are required they are agreed with IP&C team, who are available 7 days per week.

Table 1.1 below shows the breakdown of the isolation/ side room facilities across the Trust by Division /location:

Division / Location	Specialist ventilation isolation rooms	Side rooms with <i>en suite</i>	Side rooms only (no <i>en suite</i>)	Total side rooms
Medicine (excl. ED)	2 (1 in ED)	69	04	73
Weston	1 (out of action)	29	18	47
Surgery	8 (6 in ICU)	58	12	70
Women’s Services	0	06	17	23
Children’s (Bristol)	4	42	25	67
Specialised Services	9	48	03	51
			Total	331





Compliance Criterion 8. Laboratory support.

The ability to secure adequate access to laboratory support as appropriate.

There are two laboratory facilities in UBHW – at the Bristol Royal Infirmary (BRI) and at Weston General Hospital (WGH). Additional facilities are contractually delivered by ‘Severn Pathology Service’ based at the North Bristol NHS Trust.

The Trust laboratories, “Microbiology”, are accredited to UKAS ISO: 15189 standards. Appropriate policies and procedures and governance are in place.

Point of Care Testing (POCT) / near patient testing is used in numerous locations for different requirements including blood gases analysis, blood glucose measurement or SARS-CoV-2 etc. This is managed through the laboratory service for assurance. There is a Trust wide point of care testing group which is led by a clinical chemistry specialist, with pathology, Divisional and IP&C input.

Compliance Criterion 9. Policies.

That they have and adhere to policies designed for the individual’s care, and provider organisations that will help to prevent and control infections.

- There is now a NHSE National IP&C manual available since April 2022.
- The Trust has policies within each of the areas specified for this criterion and audits are undertaken where appropriate to identify compliance. The process is being reviewed and can be streamlined in line with the NHSE manual.
- All policies are available to staff on the internal intranet website and are updated in accordance with their requirements on the document management service.
- All new or amended Trust wide IP&C policies are approved through ICG and the Clinical Quality Group prior to being disseminated.
- All IP&C related policies have been reviewed and some extended, but all remain current linked to best practice, current evidence and alignment with NHSE IP&C manual.
- Standard Operating Procedures are held within Divisions, some of which replate to IP&C, all of which will have been through the Trust’s approval route.

Compliance Criterion 10. Occupational health

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

- All staff can access occupational health services or appropriate occupational health advice between 08:00–17:00, with the advice line being open 08:30–15:30, 5-days-a-week.





- There is a website that includes guidance on general matters as well as a guidance on referrals on the organisation’s HR Web.
- Occupational Health policies on the prevention and management of communicable infections in care workers are in place including the management of inoculation injuries.
- Occupational Health have risk assessment categories according to post that are applied at the time of commencing work, instigated by the recruitment process.
- In keeping with Occupational Health recommendations, an independent confidential recording system is in place for the maintenance of staff health records.
- All health risks are assessed pre-employment and clearance is based on the Department of Health Guidance. Vaccination compliance is also addressed at the time of screening, with managers being informed of the applicant’s vaccination status.
- Those staff at constant risk due to non-conversion (protection against Hepatitis B) and who are involved in exposure prone procedures (EPP) are recalled annually to prove they are infection free.
- Occupational Health liaises with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (BBV) when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed; clinicians see each affected staff member and monitor as needed.
- A risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids is undertaken.
- Out-of-hours contamination injuries initially go via the clinical site manager following a pre-defined standard operating procedure (SOP). If deemed high risk the staff member should attend the Emergency Department where an out-of-hours post-exposure prophylaxis (PEP) treatment may be commenced following risk assessment.
- Arrangements are in place for the provision of influenza, and SARS-CoV-2 vaccination for healthcare workers (as summarised below)
- The 2022/2023 COVID-19 Booster and Seasonal Influenza Vaccination Programme commenced at UHBW in September 2022. The campaign ended in February 2023.

Vaccines administered up to 3rd March 2023	Total in cohort	Flu uptake	Flu %	COVID uptake	COVID %
All Staff groups	15,308	8,064	52.7%	7,668	50.1%

The vaccination team continued to evolve in partnership with the BNSSG Vaccination Programme. The programme team’s focus is now on planning for the 23/24, beginning in the autumn.

SARS-CoV-2 (COVID-19) vaccinations

Vaccination hubs were set up in both Bristol and Weston, vaccinating seven days per week providing seasonal influenza and COVID boosters as required to both staff, and defined patient cohorts including maternity.





8. Staff Health - Occupational Health

Jacquie Chapman – Lead Occupational Health Nurse IP&C and Lyn Harvey from Health and Safety.

Avon Occupational Health Partnership (AOHPS) provides services across UHBW for our employees.

The Trust recognises the critical importance of maintaining staff health and protecting them from the risk associated with infection exposure.

Immunisations and vaccinations:

Vaccination programmes continue except for the long-standing hold on the provision of the Bacillus Calmette–Guérin (BCG) vaccines. Following changes in national guidance, any new staff with patient contact who has spent more than three months in a high-risk tuberculosis (TB) country in their lifetime are to be screened for latent TB using an interferon-gamma release assay (IGRA) test. This has increased the number of referrals to the TB team for follow up and treatment for latent TB.

The new Occupational Health I.T programme has the potential to send new starter staff information relating to the immunisation requirements for their post in UHBW, it can request their immunisation history as well as arrange a review appointment with Occupational Health as soon as they start in their new post.

Contact tracing

Contact tracing and prophylaxis medication has been provided for staff if and when required by Occupational Health.

Skin or mask issues

Staff experiencing any skin or mask related health problems, such as dermatitis have access to the Occupational Health Advice Line Monday. These issues are prioritised to be dealt with as soon as possible.

FFP3 Respirator Fit Test Service

Managed through the Safety Department the Trust central team for Fit Testing has established assessment sessions in both Bristol and Weston sites for new, and existing staff and students. This has continued throughout 2022/23. In addition to our regular testing sessions site visits to department are possible to assist with retesting in busy clinical environments.

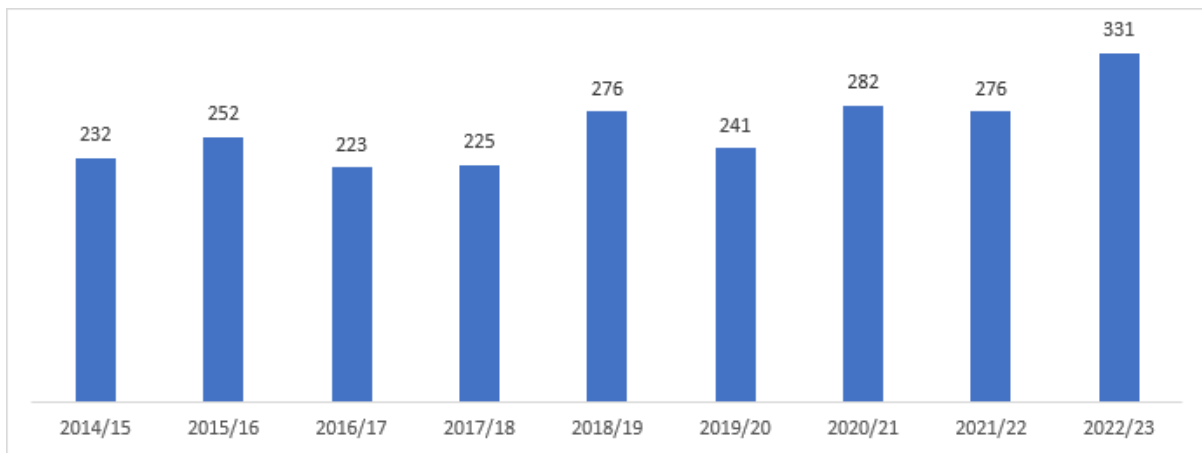
The team is now working on ensuring that staff who were tested previously, return for their two-yearly re-test to ensure that they remain protected against any respiratory illness of concern. This is part of a resilience strategy to safeguard against any future respiratory virus threat that may emerge, as staff are now aware of what they can wear to keep themselves safe.

The Fit Test service has now completed in excess of 25,000 tests on approximately 12,400 staff and students since mid-2020.

Sharps and potential inoculation injuries

Annual comparison of clinical sharps incidents since 2014 is graphically depicted below:





With the implementation of the ‘Sharps in Healthcare’ Regulations in 2013 safer sharps devices should be the norm in practice in most clinical areas across UHBW. The total number of sharps incidents has increased by 20% this year. Further analysis is underway to understand the likely causes.

The majority of the incidents (79%) are graded as ‘Low risk’ which will typically include near miss or no-harm incidents. 69+ and Occupational health dept review the incident monthly to assure the data is accurate. Three incidents involving clinical sharps injuries were reported under RIDDOR legislation to the HSE and were fully investigated to identify learning opportunities.

The Trust Safer Sharps group re-started in October 2022 to review practice related to using ‘safer sharp’ devices. There have been supply chain issues noted in UHBW and at different stages of the pandemic, which have meant ‘safer sharps’ have not always been available to all clinical teams.

Contact with enforcing authorities.

The Health and Safety Executive (HSE) carried out an inspection on the Weston Hospital site in November 2022, to review the ‘Management and Prevention of Sharps Injuries’. The inspection included a review of policies, documentation, site visits and interviews with both managers and employees. The result of the inspection was that the Weston site was served with two Improvement notices which has proven to be an invaluable opportunity for review of our service and to raise awareness of the safe management of sharps.

A robust action plan has seen the improvement notice concerns addressed.





SARS-CoV-2 (COVID-19) Pandemic

On 11th March 2020, the World Health Organisation (WHO) declared a global pandemic of SARS-CoV-2 (COVID-19), with an end declared to the global health emergency on 5th May 2023. The impact on the Trust, its patients and staff cannot be underestimated, which continued through 2022 /23 and it required a high level of resilience and determination to maintain patient and staff safety throughout the most challenging last three years. The IP&C team have been at the heart of the response. The various surges in activity have been demanding with unprecedented activity across the organisation and local system. Throughout the pandemic the focus has been to maintain patient and staff safety, whilst delivering high-quality services through adversity and numerous challenges, adapting, and adjusting whenever updated guidelines have called for a different approach.

Responsive communications have continued to ensure that all clinical staff receive timely messages about IP&C guidance, something that has required a level of agility in how messages are shared through the organisation. The regular COVID-19 staff briefing is circulated at least twice per week and increases in frequency if additional messaging is required. Direct messaging from IP&C to clinical teams, staff groups and management teams provides a further safety net for dissemination. Summary outlines of staff and patient testing, and isolation requirements, are available on the Trust’s intranet, whilst the relevant policies are available in full on the Document Management System.

9. HCAI Statistics and Surveillance against National Limits

Overview

UHBW NHS Foundation Trust continues to take part in mandatory surveillance of methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Escherichia coli* (*E.coli*), *Klebsiella* species and *Pseudomonas aeruginosa* bloodstream infections and *Clostridioides* (*Clostridium*) *difficile* infections.

The gram-negative reportable organisms (*E.coli*, *Klebsiella* and *P.aeruginosa*) account for more than 70% of all healthcare associated gram-negative bloodstream infections (GNBSI). GNBSIs continue to increase in England and cause significant morbidity and mortality in our patients.

The definitions of hospital or community acquired infections set by the UKHSA are summarised below.

For the Trust, those infections that are considered hospital onset–healthcare associated (HOHA) and community onset–healthcare Associated (COHA) are the cases that Trust performance is measured against with national limits set by NHSE/I. These targets are referred to as “limits”.

UKHSA definitions of healthcare associated infection are:

- **Hospital Onset – Healthcare Associated:** Patient is an inpatient in an Acute Trust and has 3 or more days between admission and positive specimen.
- **Community Onset – Healthcare Associated:** Patient returns as positive specimen within 28 days of discharge from an elective or emergency hospital admission within the reporting Trust.
- **Community Onset – Indeterminate Association (C.Diff only):** Patient returns a positive specimen between 28 and 84 days of discharge from an elective or emergency hospital admission within the reporting Trust.





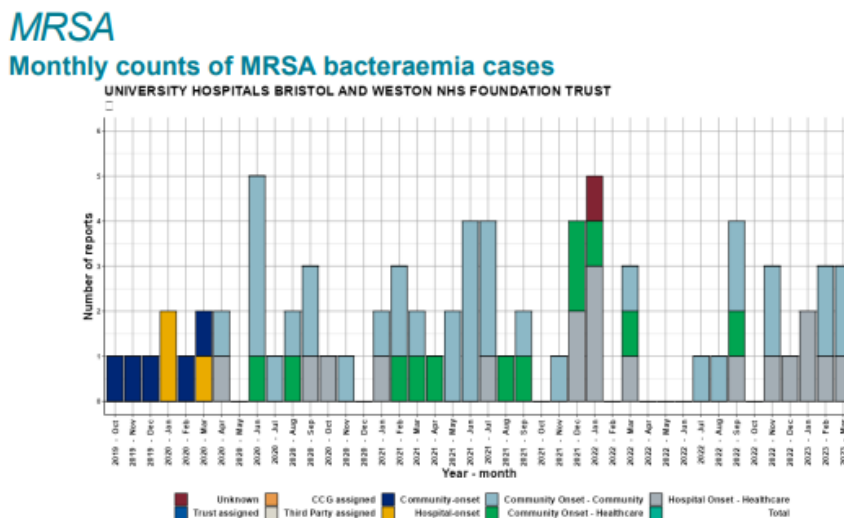
- **Community Onset – Community Associated:** Patient has not been discharged from an elective or emergency hospital admission in the reporting Trust in the last 84 days for *C.Diff* and 28 days for all other organisms.

Please refer to HCAIDCS user guide for more information on trust exposure definitions [Clarification of prior trust exposure definitions \(phe.org.uk\)](#)

National limits of infections for the Trust are set by NHSE and link to contractual obligations of the organisation. The process of monitoring the incidence of infection, and therefore an indicator of Trust performance, is through internal governance processes monthly, and directly notified to the ICS as a benchmark of quality and patient safety within the organisation.

Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections

S.aureus is a gram-positive bacterium carried harmlessly in the nose of approximately a third of the population. In healthcare settings, where patients are often undergoing invasive procedures, it can cause serious illness including wound, respiratory and bloodstream infections. MRSA is a strain that has acquired resistance to flucloxacillin (an antibiotic commonly used to treat *S.aureus* infections) and is often resistant to other classes of antibiotics.



The limit for MRSA bloodstream infections is zero. In UHBW there have been seven cases in 2022/23, which is the same as the previous year. A full post-infection review takes place in the Trust to identify potential gaps in care delivery are identified. Learning from the post infection reviews is shared internally with resulting actions taken to address themes.

MRSA screening has continued for specific groups of patients on the Bristol and Weston sites.

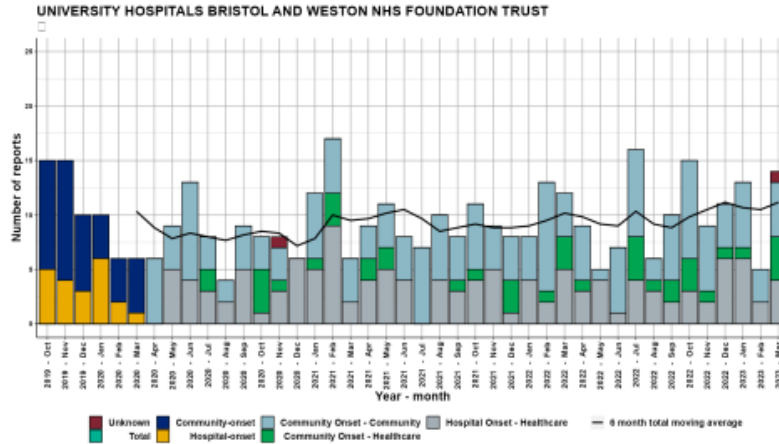
The Trust Vascular Access Group restarted in March 2022 as the group to help address the risk of sub-optimal vascular line practice and reinvigorate the approach to robust line management, contributing to reducing the infection risk.





Methicillin-sensitive *S.aureus* (MSSA) bloodstream infections

MSSA Monthly counts of MSSA bacteraemia cases



The standard for cases that could be Trust attributed is measured by patients in hospital for more than two days. The Trust limit was no more than cases in the year in 2022/23. The Trust reported 46 cases in 2022/23, which is an increase, and is a higher number than expected. A review of all the cases was undertaken to identify any improvement themes such as cannula care, robust documentation, and Visual Infusion Phlebitis score (VIP) recording.

All Trust attributed MSSA bloodstream infections are investigated. A post-infection review is completed, an action plan generated and recorded in the Datix system for each infection.

Clostridioides (Clostridium) difficile infections (CDI)

The limit set for CDI for 2022/23 was 89; the Trust reported 100 cases. In total, 77 of the cases were assessed as HOHA (hospital acquired) and 23 COHA (community acquired). Both of these categories are attributed to the Trust. All cases are investigated by the IP&C team. The ICB review, with a summary of learning for the cases, following post infection reviews is shared with other providers as a system, rather than trying to focus purely on numbers and "a lapse in care".

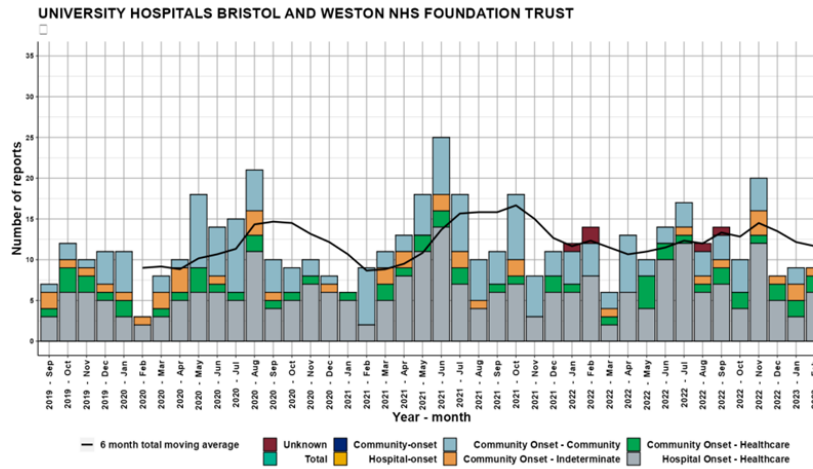
It is of note that the incidence across the Southwest region for *C.difficile* is higher than the national position. The regional *C.difficile* collaborative is actively working to engage commissioners and providers in quality improvement approaches. UHBW has been working with system partners in BNSSG to support this initiative including redefining the *C.difficile* review process going forward to offering shared learning across the local healthcare system.





C. difficile

Monthly counts of C. difficile infection cases



In the absence of the formal validation process from the ICB for *C.difficile*, the IP&C and medical Microbiology teams have continued to undertake the clinical review of cases.

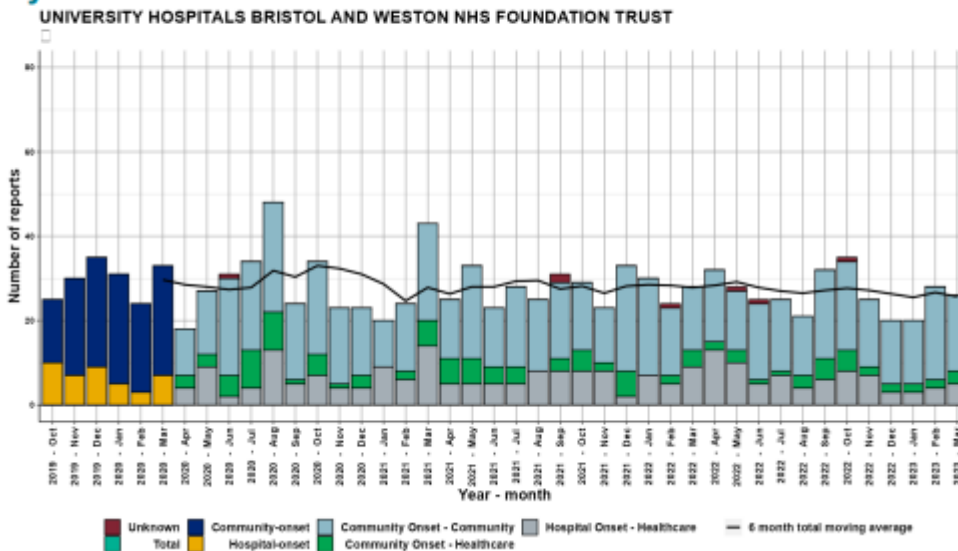
E. coli

The UK has seen a steady increase in the number of *E.coli* bloodstream infections (BSI) in the past few years. This is despite the reduction in the number MRSA bloodstream infections and *C.difficile* cases.

E.coli bloodstream infections

E. coli

Monthly counts of E. coli bacteraemia cases





10. Mandatory Surgical Site Infection Surveillance

(Lead SSIS Nurse Sam Hogg-Davies)

The Surgical Site Infection Surveillance (SSIS) team collect data and carry out surveillance on the following UKHSA categories: mandatory surveillance for knee and hip replacements, repair of neck of femur, reduction of long bone fracture (Weston site only) and voluntary surveillance of large bowel surgery, small bowel surgery, gastric surgery, cholecystectomy (non-laparoscopic), adult and paediatric cardiac surgery, and coronary artery bypass grafts. Orthopaedic data at the Bristol site is managed and reported separately by an ‘audit nurse’ funded by Trauma & Orthopaedics.

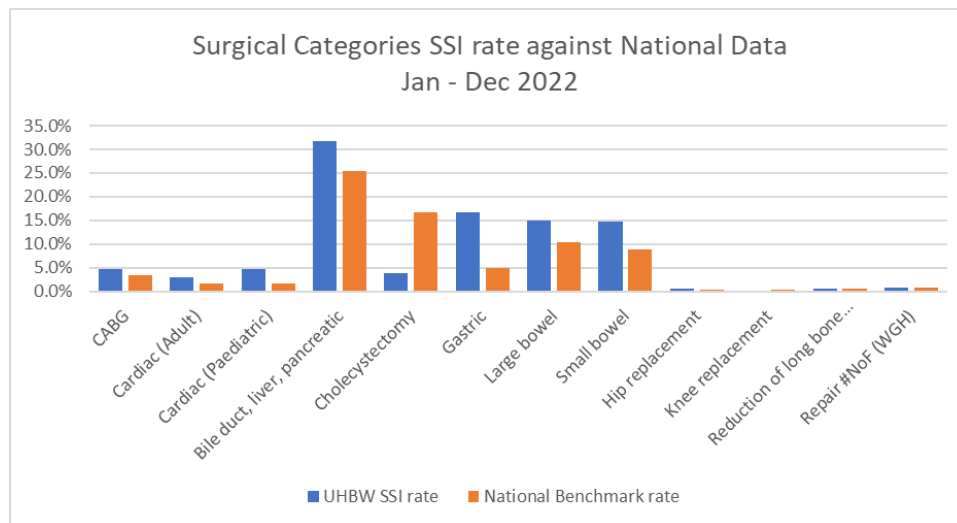
University Hospitals Bristol & Weston (UHBW) continuously collect and submit data for each of the above surgical categories to the United Kingdom Health Security Agency (UKHSA) database via a secure weblink. The UKHSA generates a quarterly report comparing UHBW NHS Trust’s SSI rate against the National benchmark (national percentile) rate for each surgical category. These reports are designed to provide a comparative benchmark SSI rate as a performance indicator for individual Trusts/hospital sites against all participating hospitals in the UK.

The following table is a summary of Surgical Site Infection data submitted to the UKHSA for UHBW in 2022, bench marked against the national percentile rates.

Surgical Categories SSI rate against National Data (Jan-Dec 2022)

Surgical Category	UHBW SSI rate	National benchmark rate
CABG	4.7 %	3.4 %
Cardiac (adult)	2.9 %	1.8 %
Cardiac (paediatric)	4.8 %	1.8 %
Bile duct, liver, pancreatic	31.7 %	25.4 %
Cholecystectomy	3.8 %	16.8 %
Gastric	16.7 %	5.0 %
Large bowel	15.0 %	10.5 %
Small bowel	14.8 %	8.9 %
Hip replacement	0.6 %	0.5 %
Knee replacement	0.0 %	0.4 %
Reduction of long bone fracture	0.6 %	0.7 %
Repair #NOF (WGH)	0.8 %	0.9 %





It is important to note, when interpreting Trust rates against the national benchmark, not all Trusts/hospital sites submit data on a continuous basis, which is viewed as the ‘Gold Standard’, and may only participate in mandatory data submission (one quarter per year) or provide intermittent data submissions by surgical category or data period. *Ad hoc* reporting in this manner will skew the national percentile, therefore outlier rates alone should be interpreted with caution.

UHBW is an outlier in some SSIS reporting categories; this is formally acknowledged through the Trust’s governance structure. The organisational risk is on the risk register. The approach has been scrutinised and changed and ongoing work within the Divisions of Specialised Services and Division of Surgery continues.

The role of the SSIS Team is to enhance the quality of patient care, by providing data and feedback to assist surgical and nursing teams in making effective treatment/care pathways, aimed at reducing the rate of SSI. This is done by continuous data capture, working collaboratively with the MDT/surgical teams, providing accurate reports and consistent feedback to the surgeons. The team capture patient SSIS data throughout the inpatient stay and highlight any potential SSIs to the responsible consultant surgeon for validation. All suspected and validated deep or organ space SSIs should be reported through the Datix system to ensure they are captured and investigated at the earliest opportunity. Patients are followed up at 30 days (and at 12 months for any implant surgery) with a post discharge phone call using the UKHSA Post Discharge Questionnaire to capture post-discharge infections. It is important to review infection trends over time noting any interventions prescribed/initiated by MDT and if their impact is beneficial or detrimental to patient outcomes.

As part of quality improvement within the SSI service we have recently trialled a data sharing application that allows post discharge surveillance questionnaires to be electronically sent and collected from patients, it also has the capacity to collect images for clinician review. Further exploration for this type of data capture needs to be undertaken to achieve paperless data collection in future. The team also anticipate the delivery of the ICNet SSI module purchased as part of the wider ICNet Infection Prevention and Control result and record system.





11. Untoward Incidents including Outbreaks

Overview

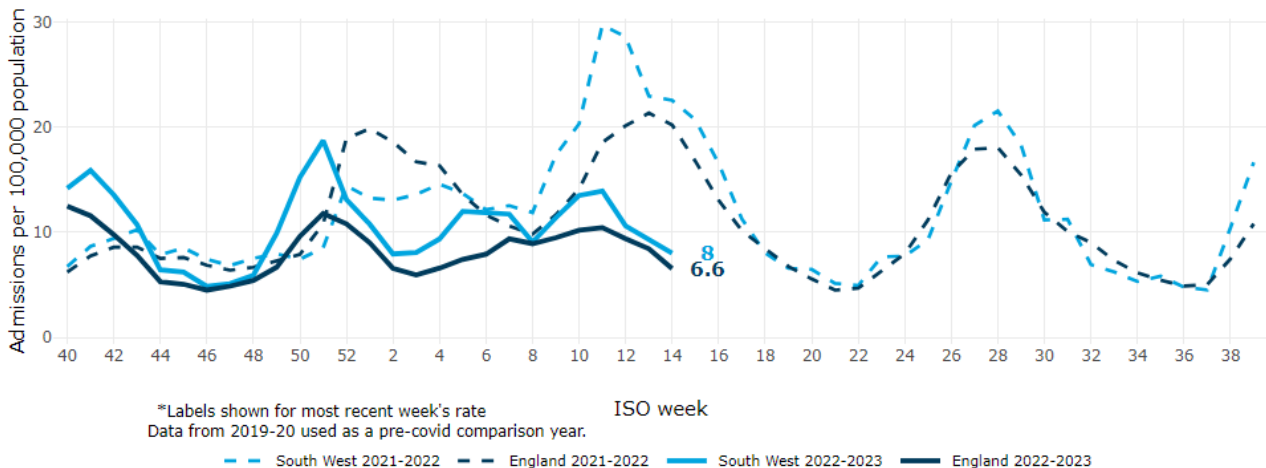
Untoward infection control incidents are those infection occurrences which have been flagged as a concern, as a single case of an unusual or unexpected organism, high consequence infection or a number of cases that could be linked. Incidents, such as decontamination-related failures, are also formally managed in this way. All outbreaks are reported locally via the Datix incident management system. Notifiable diseases and outbreaks (two or more linked cases of infection) are also formally reported via the NHSE electronic portal to discharge organisational statutory responsibilities.

SARS-CoV-2 (COVID-19) Pandemic

As a consequence of the pandemic, and waves of increased community incidence of infection and transmission, there have been a number of SARS CoV-2 outbreaks in UHBW wards with a significant impact on operational service delivery models, mainly in the Bristol Royal Infirmary and Weston Hospitals. The national recommendations for screening of all patients, in an elective or non-elective pathway, has been delivered with appropriate isolation when required. The focus latterly has been on screening symptomatic patients only. Arrangements are in place to de-escalate patients after day 5, from their positive diagnosis are in place when appropriate.

The graphs below demonstrate hospital admissions and surges in activity as reported by the UKHSA (13.4.23 data set).

Figure 5. Hospital admissions with confirmed SARS-CoV-2 – SARI Watch (Mandatory Surveillance)

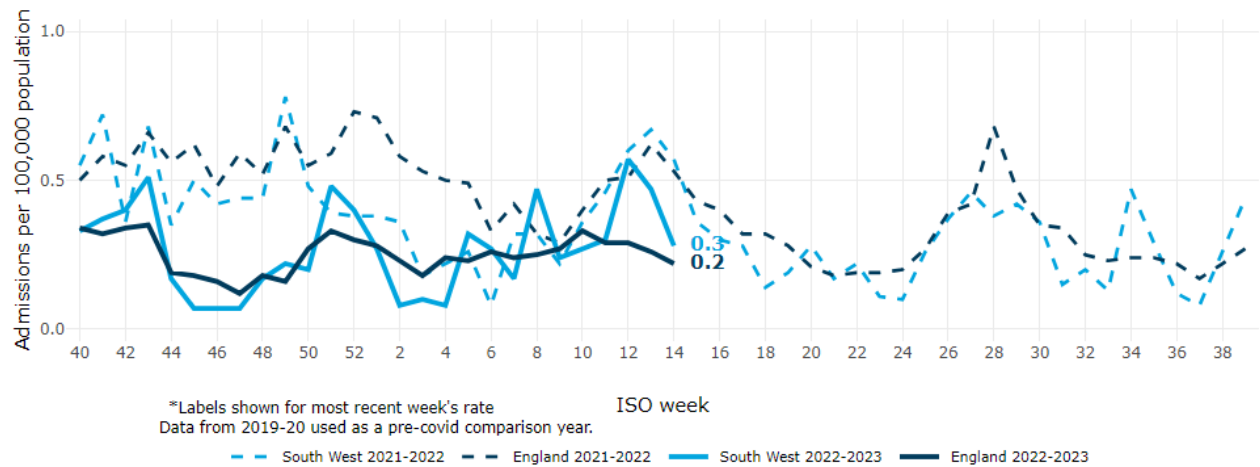


Of note is the impact of Intensive care admission, related to SARS-CoV-2, is lower in 2022/23 than the previous year.





Figure 6. ICU/HDU admissions with confirmed SARS-CoV-2 – SARI Watch (Mandatory Surveillance)



Nosocomial (healthcare-related transmission) UKHSA definitions for SARS CoV-2 were established in June 2020, and are highlighted below based on the days of admission before the infection was identified:

Duration from admission	Acquisition
2 days or less	Community acquired
3-7 days	Indeterminate acquisition
8-14 days	Probable hospital-acquired
15+ days	Definite hospital-acquired

The operational impact of the pandemic has continued to be significant in 2022 /23 with some ward closures in different hospital sites. All outbreaks are managed by the IP&C team, and any lessons learned are shared during the outbreak review meetings and directly with Divisions, with appropriate containment / patient isolations approaches.

There remains a risk, which is formally logged by the organisation, of nosocomial transmission of SARS-CoV-2 within the organisation with some older estate which has sub-optimal ventilation systems, especially in the Queen’s building, BRI and at Weston. At Weston, air filtration units have been installed in some multiple occupancy inpatient bays as a mitigating measure, where there is little or no mechanical ventilation, and a prevailing risk of SARS-CoV-2 transmission.

Influenza

The national guidance is updated seasonally and requires the Trust to implement symptomatic patient testing to include influenza. Blood sciences at the BRI and Weston have the resources to deliver this. The results were reported back to the clinical areas within approximately two hours. This is integrated into the bundle of testing with SARS-CoV-2 when required. This was enacted in November 2022 and stood down in April 2023. The advantage of symptomatic patient testing allowed for isolation when required and therefore minimising the nosocomial influenza transmission. In Children’s service a robust plan for cohorting patients, when seasonal surges were seen was put in place. The impact of the UKHSA health alert streptococcus A infection did impact, not with significant numbers of this infection but in an increased service demand of concerned patients and families expecting antibiotic treatment.





***Staphylococcus warneri* in cardiac surgery**

A formal outbreak has been declared in 2020 linked to three cases of patients who had undergone cardiac surgery in Bristol Heart Institute. Predominately this was valvular surgery. This was initially thought that a significant factor was the powered respirator hoods worn by the surgeon. This was formally flagged to the National Patient Safety Agency (NPSA) and formal guidance has been issued across the NHS as a consequence (NatPSA/2021/009/NHSPS). Subsequently, seven further cases have been identified under the supervision of the Trust Chief Medical Officer and the DIPC an investigation has been completed by the Division of Specialised Services. A group of patients who had also undergone cardiac surgery have been informed of a potential risk and are being screened as they could have a risk of an identified infection linked with the outbreak. Support and guidance from NHSE, UKHSA and the ICB has been provided with ongoing scrutiny.

***Clostridioides Difficile (C.difficile)* Outbreak Weston General Hospital**

In May 2022, an outbreak was declared on one ward at Weston General Hospital with a number of cases of *C.difficile* declared. This was formally managed as an outbreak. Three cases were definitively linked by ribotyping. A formal action plan, was put in place and some improvements to the Estates were noted as required, including additional handwash sinks in some bays.

Norovirus Activity

The incidence of norovirus positive cases, based on pre-pandemic levels, have been low. Patients are managed and tested in accordance with local and national policy, reporting cases through the UKHSA. The IP&C team support the areas being restricted and reopened as it is safe to do so. Levels of norovirus activity in the community had been low but latterly in 2022 / 23 prevalence increased with a number of outbreaks reported in wards in BRI / BHI and Weston.

Monkeypox (MPOX) Monkeypox, now referred to as MPOX, was initially designated a high consequence infectious disease (HCID), but as the landscape of infection evolved it was downgraded, with the associated reduction in the control measures required. MPOX was first identified as an organism of concern in March 2022, which emerged into an urgent response. UHBW became a collaborative partner as part of the system response for Bristol and the wider population.

The UHBW Pharmacy and Unity Sexual Health were both key players, as the risk group of patients was identified, with a strategy rapidly agreed for screening, assessment and vaccination of those at risk with Public Health colleagues.

This quickly evolved as patients were robustly managed in an outpatient setting with Unity Sexual Health being the main UHBW service that was impacted.

12. Summary IP&C risks of note for UHBW (2022/23)

There are five IP&C risks on the UHBW risk register, held within the Divisions that are of note. These risks are actively managed and reviewed quarterly at the Trust Infection Control Group and presented to the Quality and Outcomes committee through the DIPC report. There was one risk on the corporate risk register related to Infection Prevention and Control (Datix 4651) which has since been downgraded to be held divisionally.





The table below is a summary of the five risks of note:

Risk & Datix number	Current risk rating
6013 <i>The risk that UHBW exceeds its NHSE/I limit for Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia's</i>	Risk rating - 16 Risk level - Very High Risk
3216 <i>Risk that new national C.difficile criteria will increase the number of Trust apportioned cases</i>	Risk rating -12 Risk level - High Risk
4651 <i>Risk that SARS-CoV-2 is transmitted between patients and staff in areas within the Trust</i>	Risk rating - 9 Risk level - High Risk
5265 <i>Risk that we are unable to screen all patients carbapenemase-producing Enterobacter ales (CPE) on admission to hospital again</i>	Risk rating - 9 Risk level - High Risk
5745 <i>Risk that the Trust is non-compliant with standards of care for peripheral vascular Cannulae</i>	Risk rating - 9 Risk level - High Risk

13. Audit and Quality improvement (including Hand Hygiene and IP&C audit using Tendable)

Hand hygiene and PPE auditing has continued throughout 2022/2023, using the “Tendable” app. However, there have been some challenges with data uploading and system changes, with Divisional reporting and visibility of results. Tendable is focused on inpatient departments including wards and specialist units for reporting. A unified hand hygiene auditing approach to include outpatient departments is formally noted as a risk as Tendable does not currently include outpatient settings. This is a separate system available on the Trust intranet for outpatient reporting.

Hand hygiene audit results for Q4 across UHBW divisions, as reported via ‘Tendable’, are as follows: (N.B – it is not possible to extract 1 year of data from Tendable)

2023 Q4 Divisions	January	February	March
Medicine	98.5	98.8	98
Specialised Services	96.8	97.7	99.4
Surgery	99.3	99.3	96.9
Women’s and Children	93.3	95.6	94.2
Weston	92.5	92.3	94.3
Trust	96.2	96.7	96.5

The management of PVC compliance remains a risk which is currently being reviewed as we have an electronic system using CareFlow Vitals and a paper based one using the drug prescription chart; two systems that do not align completely. This is noted as a risk and is being reviewed.





Urinary catheter practice and aseptic non-touch technique ANTT have been audited in 2022/23 and identified some good practice but also some necessary improvements – data associated has been shared with divisions. There is a joint working group with local partners NBT/Sirona to share urinary catheter expertise between organisations. ANTT practice is linked formally to the Vascular Access Group and ongoing improvements in practice have continued throughout 2022/23.

14. Board Assurance Framework (Version 1.11 – September 2022)

The Board Assurance Framework (version 1.11) is a comprehensive assessment of the areas of IP&C compliance across the Trust. The document covers the 10 domains of IP&C related to the Infection Prevention Control Code of Practice (updated December 2022) and compliance is formally reported into the Trust Quality and Outcomes Committee with the evidence of compliance held centrally. The evidence against each domain has been reviewed, with each iteration of the framework as there have been several, with a multidisciplinary panel review process. The panel includes Divisional representation, Facilities and Estates, Health and Safety and the Chief Nurse team.

The table below gives the high-level summary of the 123 elements that are grouped within the 4 domains within the framework:

Totals	Compliance rating	Summary of all elements
10 domains with 97 elements	Red (non-compliant or evidence gaps)	1 (element 3.3)
	Amber (partially compliant)	6 (element 2.4, 2.6, 3.1, 3.2, 2.12, 7.1)
	Green (Fully compliant)	90
	Total elements	97

The areas of *amber* non-compliance relate to different locations and gaps in assurance as below: The risks related to non-compliance have been identified and mitigations are in place wherever possible.

Element (non or partial compliance)	Summary of the element
2.4	Enhanced cleaning in FR2 isolation rooms assurance
2.6	Cohort areas – enhanced cleaning assurance
2.12	Ventilation compliance improvement plan
3.1	Medical lead for AMS identified
3.2	Assurance of NICE standards for AMS
3.3 (non-compliant)	Assurance of robust optimisation for all patients in the use of antimicrobials
7.1	Audit of face mask compliance for patients in clinical areas

A further update to the Board Assurance Framework has been provided in a different format and will be updated prospectively into 2023/24.

Action required to address identified short comings in compliance are scrutinised through ICG.





15. Antimicrobial Stewardship

The term “antimicrobial stewardship” is defined as “an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness” (NICE, NG15, August 2015). Antimicrobial Stewardship operates across all clinical areas of UHBW as part of the Trust’s antimicrobial stewardship programme. The activity of the antimicrobial stewardship team is monitored through the Trust wide Anti-infective Steering Group (ASG).

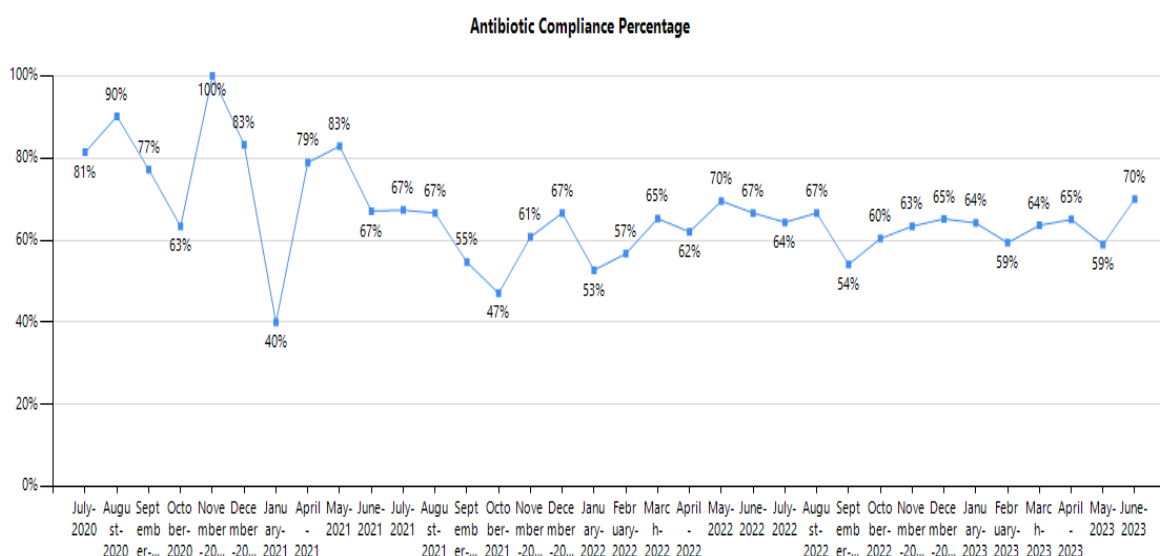
The ASG regularly review prescribing compliance, expenditure, antimicrobial CQUIN delivery, meeting the requirements of the NHS Standard Contract, incident trends, update and produce new guidelines, feedback audits and deliver education and training, in line with the recommendations from the Department of Health (DoH) on the delivery of a robust Antimicrobial Stewardship Programme. The outcomes are reported to the Trust quarterly IP&C meetings.

Prescribing Compliance

MDT ward rounds are being undertaken on both the Bristol and Weston sites with the aim of all wards being visited on at least a two-weekly basis. Compliance data is emailed monthly to all consultants to share with their teams. Microbiologists continue to provide advice daily to the Intensive Care Units and Trust wide via telephone enquiries.

Ward rounds include a review of complex patients with deep seated infections or resistant organisms with many interventions made on these rounds which have significant influence on patient care.

Both sites input compliance data into the same live reporting system, providing a record of any interventions or recommendations for each patient seen. The details are visible as a clinical note attached to each patient. This allows clinicians to see the results of prescription reviews, any recommendations made, and which member of the team carried out the review.



The Paediatric team continued to provide antimicrobial ward rounds and data collection across the Bristol Children’s Hospital (BCH) and St Michael’s hospital throughout 2022 and into 2023.





The lack of electronic prescribing in the Trust remains a rate-limiting step in the collection of compliance data, the collection of data to inform CQUIN and NHS Standard Contract challenges; ward rounds remain time consuming as individual patient prescribing data can only be found by interrogating drug charts.

When electronic prescribing is in place, data collection will inevitably change but will enable a more focussed approach to stewardship, however the team aim to maintain a visible presence on wards, providing patient-specific advice and teaching at the point of prescribing.

Electronic Prescribing and Medicines Administration (EPMA)

The antimicrobial pharmacy team have been working closely with the pharmacy informatics team attempting to build stewardship into the new EPMA system. All antimicrobial prescriptions will have a default stop date and require the prescriber to add an indication to each prescription. The AMPs continue to work closely with Pharmacy IM&T to ensure appropriate reporting is available to guide stewardship ward rounds.

Antimicrobial CQUIN 2022/2023

The NHSE Antimicrobial CQUIN for the year 2022/23 focussed on urinary tract infections (UTIs), (lower, upper and catheter associated UTIs). The AMPs collected the data with 100 cases being audited across both sites each quarter. The team provided education and training via a communications campaign to remind prescribers of the importance of appropriate prescribing for these patients.

The lower threshold was 40% and the upper was 60% and the data demonstrated that good practice was being followed and the CQUIN criteria was met in all quarters (Q1 = 64%, Q2 = 75%, Q3 = 74%, Q4 = 74%)

CQUIN 2023/24

The CQUIN for 2023/24 focuses on prompt IV to PO switch. The aim is to achieve 40% (or lower) patients still receiving IV antibiotics past the point at which they meet the national switch criteria. In preparation for this we have incorporated the national switch criteria and built a clinical decision support tool which is available through Microguide. Ward based teaching and communication will also be delivered.

Antifungal stewardship MDT

A dedicated antifungal stewardship team continue to meet virtually once a week; complex patients are reviewed with mycology, microbiology and pharmacy and the relevant clinical teams; antifungal prescribing practice is also carefully monitored. In 2023 the MDT was expanded to include colleagues from North Bristol and is now a system wide approach.

UHBW Endocarditis MDT

A specialist weekly MDT meeting to discuss patients with Infective Endocarditis has been established at UHBW, with expert input from Cardiology, Cardiac Surgery, Microbiology, and the AMS Pharmacy team in light of consensus recommendations from the Joint British Societies. The team discuss patients from across the wider BNSSG area as patients are referred into UHBW's Bristol Heart Institute; the aim is to ensure all aspects of Infectious Endocarditis are considered and to improve patient outcomes in this challenging condition.





Total Antibiotic Consumption 2022/2023

A reduction in total antibiotic consumption (1% reduction on previous year) has been part of the NHS Standard Contract since 2018 and this too was affected by the pandemic. This target was not achieved by UHBW or many other trusts; many COVID -19 patients were prescribed antibiotics. This has been superseded by the requirement to achieve a reduction in Watch & Reserve antibiotics (see below).

NHS Standard Contract

The World Health Organisation (WHO) Antibiotics list was adapted by NHSE in 2019 and Define Daily Dose (DDD) for each antibiotic are subsequently grouped into the three UK Access, Reserve and Watch (AWaRe) categories. The Access category includes the narrowest-spectrum antibiotics, Watch includes broader-spectrum drugs, often used in hospitals and the Reserve category includes those drugs that should only be used on the advice of microbiology or for specific indications.

The target for 2022/23 was to achieve a 4.5% reduction in Watch and Reserve antibiotics against the Financial Year 2018 baseline. UHBW met this target with an overall reduction of 10.6%.

For 2023/24, the standard contract has been amended to align with the UK AMR National Action Plan. The requirement is now for a 10% cumulative reduction by 31st March 2024 against the 2017 baseline.

N.B. The NHSE Standard Contract does state that the contractual requirement remains for “reasonable endeavours” to be used to achieve the reduction and there is, of course, no expectation that efforts to deliver the overall reduction should prevent individual patients from receiving necessary medication where clinically appropriate.”

Guidelines

The Antimicrobial Guidelines are available Trust wide on Microguide, with access via the Microguide app and available on desktops. The vancomycin calculator is also now hosted on this platform along with an IV to PO switch decision support tool.

Audit and Quality Improvement in antimicrobial stewardship

Expenditure

Anti-infective expenditure continues a slight downward trajectory for both Bristol and Weston sites. The availability of a number of generic antifungals and the success of the antifungal stewardship group has almost certainly contributed to this success.

Anti-Microbial Pharmacist (AMP) Team

The team has been challenged in 2022/23; one of our AMPs has undertaken a Health Education England (HEE) Fellowship for two 3-month blocks and the OPAT (out-patient parenteral antimicrobial therapy) team has expanded to include the management of other conditions, including the NHS@Home service. The AMPs maintain oversight of any patients being discharged on antimicrobials, working closely with microbiology to ensure appropriate prescribing, and limiting IV therapy wherever appropriate. Future projects will require adequate staffing levels as the workload has significantly increased in recent months.





System & Regional Working

The team continue to work with colleagues across the BNSSG system and are active members of the local and regional (SW) AMR groups. As the remit broadens to include antimicrobial stewardship with Infection Prevention & Management in light of the 5-year National Action Plan to reduce antimicrobial resistance.

16. Infection Prevention and Control Guidelines and Policies

The IP&C team have continued to deliver a timely response to changes in guidelines for the management of SARS-CoV-2 and seasonal respiratory viruses for rapid implementation, often at very short notice. This is to ensure that the organisation complies with guidance as far as possible.

There are standard operating procedures that have evolved from the guidelines and management packs, which have been built, to reflect the needs of the service responsive to developing IP&C related scenarios in a timely way.

IP&C related policies have been informally reviewed and extended when required and will be reviewed in 2022/2023 to unify and simplify the approach that satisfies mandatory IP&C requirements and offers accessible advice to clinical teams when they need it. The National IP&C manual (2022) will be the basis of the approach with rapid access to policy guidance as required.

17. Education and Training

Infection Prevention and Control (IPC) is one of the eleven core skills recognised nationally per the UK Core Skills Training Framework. The Trust compliance target for this core skill is 90%. Compliance with mandatory IPC training amongst some staff groups was lower than the standard and stood at 85% at the end of July 2022. There has been a gain in compliance of at least 4% in 2022/2023, with compliance standing at 89.1%, just shy of the Trust's compliance target.

IP&C remains a mandatory component of staff induction and update training across the Trust. All induction and annual updates are provided by recognised NHS Skills for Healthcare e-learning using the national infection prevention and control resources, and placed on the Kallidus learning management system. Training compliance for each Division is reported at the quarterly ICG as part of the DIPC report, whilst breakdown compliance of the two different levels of IP&C training are also shown in monthly compliance reporting.

Training for 'FIT' testing to ensure the safe use of different makes of FFP3 masks is referenced earlier in this document.

The IP&C team continue to provide local training in clinical departments as requested by Divisions including hand hygiene and areas of focused improvement such as the understanding of some organisms and management of *C.difficile*.

18. Decontamination Annual Report 2022 / 23

Decontamination: (Annette Giles, Trust Decontamination Manager)

The Trust Decontamination Board formally meet quarterly and report into the Trust Infection Control Group.





Decontamination Risks

A critical incident occurred for central sterile services department (CSSD) in December 2022 as a result of failure of the Reverse Osmosis (RO) plant that feeds the steam sterilisers. Assistance with sterilising clean and packed instrument sets was sought and provided by North Bristol Trust sterile services until the onsite plant could be repaired. Capital monies have been obtained to purchase a second RO plant as contingency to manage any future failures.

The 7 decontamination related risks on the Trust wide register which require action are summarised below:

Risk Numbers	Risk theme requiring action
5113 5057	Endoscope decontamination related risks including electronic tractability and the ageing profile of decontamination equipment
5052 3627 2739	Decontamination of equipment related risks including ultrasonic machine failure, inability to decontaminate heat labile instruments due to machine failure and not being able to perform automated decontamination processes in OPD's
3200	General IPC and equipment risk relating to poor cleaning of instruments due to presence of sticky tape
1344	Damage to external packaging of sterilised instruments, which render them unsterile and unable to be used.

Successes for the year 2022-23 in Decontamination services

- The CSSD department retained accreditation to ISO 13485:2016 through external audit of its quality system and department practices.
- The appointed Authorised Engineer for Decontamination (AED) undertook annual decontamination audit of the units that perform local decontamination of medical devices across the Trust.
- Improvements in practice and services provided by all areas were noted as well as areas for improvement, which were made known to the relevant departments via individual departmental reports.
- CSSD at BRI finally ceased using steam to power decontamination equipment and is now powered entirely by electricity.

Projects of works for 23-24

- Continue rolling out an electronic track and trace system for theatres and endoscopy decontamination units. This is an extension of the track and trace system used in CSSD.
- CSSD to receive training on the processing of instruments relating to the introduction of Robotic Assisted Surgery.
- Capital investment to be secured so that essential decontamination equipment in CSSD and SBCH can be replaced.
- A CSSD staff consultation and additional recruitment is to be undertaken in relation to the service moving to operating 24 hours a day.





19. Facilities and Estates Summary

Facilities Report - Phil Body, Assistant Director of Facilities

The continued impact of the COVID-19 on the Facilities department during 2022/23 has been significant, however the profile and requirement of cleaning services has been closely aligned to patient safety and infection prevention and control.

The National Standards for Healthcare Cleanliness 2021 implemented and included reviewing the cleaning policy, risk categories, auditing frequency, cleanliness responsibility framework, cleaning practices, cleaning schedules etc. In addition:

- New star ratings for cleanliness were displayed in patient facing areas in the autumn of 2022.
- The cleanliness charter will be completed and displayed in early 2023 in patient facing areas.
- Efficacy management audits for cleanliness and infection control in wards started in 2022. This included clinical and non-clinical staff assessing cleaning processes. The outcomes inform the ward accreditation process.

Over 200 different locations or departments are audited each month covering frequency risks (FR)1 which is the highest risk. FR1 areas required to be audited at least 4 times per month.

The table below shows the yearly average scores for cleanliness in 2022/23 by hospital. This covers for facilities (general cleaning), clinical cleaning (clinical equipment used for patients) and estates cleaning (ventilation grills etc):

Facilities FR1		Clinical FR1		Estates FR1	
Apr 22-Mar 23		Apr 22-Mar 23		Apr 22-Mar 23	
Year avg		Year avg		Year avg	
WGH	98.47	WGH	97.41	WGH	97.43
SBCH	98.27	SBCH	98.78	SBCH	96.73
BRI	97.45	BRI	94.10	BRI	96.83
BHI	97.52	BHI	96.94	BHI	98.64
BRCH	97.49	BRCH	94.92	BRCH	97.03
BHOC	97.64	BHOC	94.72	BHOC	97.66
SIM	97.09	SIM	95.11	SIM	97.71
BEH	97.60	BEH	95.88	BEH	98.59
Facilities FR2		Clinical FR2		Estates FR2	
Apr 22-Mar 23		Apr 22-Mar 23		Apr 22-Mar 23	
Year avg		Year avg		Year avg	
CHC	96.42	CHC	94.22	CHC	97.93
BDH	93.47	BDH	97.13	BDH	98.72
WGH	97.16	WGH	96.20	WGH	96.08
SBCH	97.65	SBCH	96.48	SBCH	97.39
BRI	95.80	BRI	94.47	BRI	97.61
BHI	95.78	BHI	95.15	BHI	99.01
BRCH	97.02	BRCH	93.02	BRCH	98.48
BHOC	97.60	BHOC	98.30	BHOC	99.25
SIM	95.69	SIM	94.01	SIM	98.65
BEH	96.93	BEH	95.73	BEH	96.66
Facilities FR3		Clinical FR3		Estates FR3	
Apr 22-Mar 23		Apr 22-Mar 23		Apr 22-Mar 23	
Year avg		Year avg		Year avg	
WGH	96.70	WGH	98.92	WGH	98.75
BRI	97.27	BRI	100.00	BRI	97.21
SIM	95.09	SIM	100.00	SIM	97.02
Facilities FR4		Clinical FR4		Estates FR4	
Apr 22-Mar 23		Apr 22-Mar 23		Apr 22-Mar 23	
Year avg		Year avg		Year avg	
CHC	95.09	CHC	98.06	CHC	99.22
BDH	90.60	BDH	98.92	BDH	99.01
WGH	94.68	WGH	98.19	WGH	96.73
SBCH	98.16	SBCH	99.35	SBCH	98.58
BRI	93.82	BRI	93.49	BRI	97.76
BHI	92.78	BHI	90.82	BHI	98.70
BRCH	94.18	BRCH	94.47	BRCH	96.52
BHOC	91.96	BHOC	98.85	BHOC	98.14
SIM	94.37	SIM	93.11	SIM	99.36
BEH	95.23	BEH	95.17	BEH	97.10
Facilities FR5		Clinical FR5		Estates FR5	
Apr 22-Mar 23		Apr 22-Mar 23		Apr 22-Mar 23	
Year avg		Year avg		Year avg	
BRI	94.60	BRI	100.00	BRI	100.00





PLACE (Patient Led Assessment of the Care Environment)

PLACE was completed in 2022 at seven hospitals with inpatient beds. The results were issued by NHS England at the end of March 2023. A list of actions was prioritised by the Directors of Nursing, Estates and Facilities. The next assessment will be September to November 2023.

Catering services.

The external auditing of the Trust's ward kitchens and pantries in place is required with food safety regulations. No corporate IP&C risks have been identified linked to the provision of catering services within the organisation.

Linen services

The contracted laundry suppliers continue to meet service needs appropriately in all areas at all sites. The Trust reports compliance to HTM standards as previously referenced in this report.

Estates - Water Safety and Ventilation (Matt James, Assistant Director of Estates)

Water Safety

The Trust Water Safety Group meets quarterly and oversees the requirements set out in the HTM 04-01, Approved Code of Practice (ACoP L8) and associated guidance notes (HSG274 Part 2) in accordance with the requirements of the CQC and HSE). This multi-disciplinary group ensures that there are governance, systems, and processes in place to manage the complex water systems. This is detailed within the Trust water safety policy and water safety plan/written scheme of control and reviewed at each quarterly meeting. Estates share information and provide assurance around maintenance activities undertaken, share water sample results taken and identify risks in line with guidance documentation. The group shares knowledge, learning from past experiences and ensures that the governance structures are in place. Background levels of *P.aeruginosa* within the augmented care areas are monitored and microbiology highlight areas of concern. Investigations take place as required and exception reports are progressed and escalated through Infection Control Group and the Trust Health and Safety Committee as required. The group is functioning well and has cross divisional representation as well as key stakeholders from IP&C team and Health and Safety.

Risks and incidents are managed through the Trust risk management system (Datix) and monitored at the Water Safety Group.

The Trust has an appointed Authorising Engineer for water safety as recommended in HTM 04-01 and they have undertaken an annual audit. The findings of the annual report have been shared with the Water Safety Group and actions are being monitored through that group as well as water risk assessment recommendations accepted by the Trust into the water action plan.

The Weston Estate has been integrated into the current Trust governance process and management systems.

Ventilation Safety

The Trust Ventilation Safety Group provides a means for the joint review of issues relating to the effective management and review / co-ordination of aspects of the performance of the Trusts specialist ventilation systems including the development of strategies and approaches to manage risks associated with those





ventilation systems and accepts ownership of, and to be accountable for Ventilation Risk Management in accordance with all current legislation and guidance documentation.

The group has developed and approved a Trust ventilation safety policy and provides a risk-management approach to the safe operation of ventilation systems.

The Trust has an appointed Authorising Engineer for ventilation as recommended in HTM 03-01 and they have undertaken an annual audit. The findings of the annual report have been shared with the Ventilation Safety Group and actions are being monitored through that group.

Specialised ventilation systems are assessed and verified annually by a specialist sub-contractor and actions arising from these verifications are recorded and monitored 'by exception' through the Ventilation Safety Group. Operational ventilation group meetings have since been scheduled monthly, to support with progressing reactive maintenance works identified within the annual verifications, whilst ensuring that planned maintenance is undertaken prior to annual verifications to further drive improvement throughout the Trust.

Sustainable and compliant waste management

The Trust has a collaborative group focused on sustainable waste management with involvement from key stakeholders. The group have oversight of incidents and risks related to waste management across UHBW and reviews waste management audits, both internally and externally and identifies gaps in compliance and supporting staff education where required.

Health Technical Memorandum (HTM) 07-01 outlines the Trust responsibilities for Safe management of healthcare waste but also in context of the NHSE approach to a greener NHS. Work is ongoing across UHBW to assure compliance with all waste management streams, and where non-compliance is identified this is addressed proactively with departmental teams. An integral part of this is the introduction of waste management education both face to face and via the Trust eLearning portal.

The waste management team is currently working with the Estates and Facilities team to further strengthen the auditing process and ensure a robust approach to reporting and a clear escalation process in place for all Trust divisions. The introduction of monthly walkarounds with IP&C and Facilities have facilitated regular reviews of waste management processes on the ground.

The Trust is reviewing its waste approach which have clear sustainable environmental objectives and targets. Progress against these targets going forward will be monitored and reported through the Estates and Facilities Divisional Management Board as well as the ICS Green Plan Implementation Group.

20. Infection Prevention and Control Team Achievements

- The IP&C team is now an integrated team, following the organisational merge. A successful away day for the UHBW IP&C Team was held in September 2022. This provided a mixture of both educational and wellbeing sessions for the team and allowed staff who work at different main sites of the Trust to network. It also allowed a period of reflection for the team in a safe environment as the IP&C team has been at the forefront of the pandemic response.
- Several members of the team are currently undertaking enhanced education as Master's level study modules in IP&C; thereby underpinning their current knowledge, developing new skills, and sharing this with the wider team.





- UHBW had representation at the National Infection Prevention Society conference in September 2022 and several study days across the Southwest and been involved in NHSE quality improvement collaboratives.
- Despite continued operational pressure for the IP&C team, a significant proportion of the annual plan work was completed in 2022/23. Patient safety remains the priority.
- ICNET, the IP&C software, version 7, upgrade was deployed in September 2022. This is a shared platform with NBT and is a significant Trust investment. The deployment to Weston has stalled, because of the co-dependency with other I.T systems being upgraded and is unlikely to be delivered before Spring 2024

21. Infection Prevention and Control Plans and Ambitions 2022/2023

- Surgical Site Infection and the collaboration between the IP&C team and clinical divisions is gaining momentum with a critical focus on pre, peri and post operative care as an multi-disciplinary team, led by the surgeons seeking further improvement in care.
- The delivery of the Patient Incident Response Framework (PSIRF) to rationalise post infection review process focusing on delivering interventions for improvement. The outline structure for UHBW has been confirmed, with national guidance awaited to take the next step forward for rapid implementation.
- Delivering a significant change in IP&C policies for UHBW in 2023/24 as a collaboration with NBT. This will be to adopt the NHSE National Infection Prevention and Control Manual (2022) as the essential IP&C related policy with any gaps addressed in streamlined and more accessible policies and clinical guidelines. The gap analysis is completed, the streamlined policies are developing with delivery in autumn of 2023.
- Continue with regional and national engagement with IP&C agenda for UHBW to be a flagship organisation for IP&C practice with a voice in national, regional and local forums as we recover from the pandemic.
- IP&C auditing will move onto a new platform; AMAT then with accessible data use this effectively to support quality improvement and change linked to the fundamental principle of IP&C as a golden thread that entwines through all specialities. IP&C is an effective quality marker which underpins the strength of the organisation.
- It is of note that the IP&C team has developed and expanded with additional roles such as a data analyst and healthcare support workers and the team has moved to formally deliver a seven-day service through the year.

The challenge of IP&C is ever more important to proactively maintain our patients' safety, using every resource and all the tools available to us, to move from prevention as the emphasis of the work we do. The ongoing support of the regional IP&C teams with NHSE Southwest and the Integrated Care System (ICS), has been maintained in a collaborative approach throughout the pandemic, which will further consolidate as new ways of working in ICS and as IP&C practice evolves.





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NHSE – COVID-19 guidelines for secondary care

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IP&C for Seasonal Respiratory Infections in healthcare settings (including SARS-CoV-2) for winter 2021 to 2022 (withdrawn)

[\[Withdrawn\] Infection prevention and control for seasonal respiratory infections in health and care settings \(including SARS-CoV-2\) for winter 2021 to 2022 - GOV.UK \(www.gov.uk\)](#)

Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures

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<https://www.who.int/news/item/01-10-2019-who-releases-the-2019-aware-classification-antibiotics>

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23. List of Abbreviations

- AER – Automated Endoscope Repressor
- AMAT – Audit Management and Tracking
- AMP – Antimicrobial Pharmacist
- AMR – Antimicrobial Resistance
- AMS – Antimicrobial Stewardship
- ANTT – Aseptic Non-Touch Technique
- AOHP – Avon Occupational Health Partnership
- ARK - Antibiotic Review Kit
- ASC - Antimicrobial Steering Committee
- ASG - Antimicrobial Steering Group
- BBV - Blood Born Viruses
- BDH – Bristol Dental Hospital
- BHI – Bristol Heart Institute
- BNSSG – Bristol, North Somerset and South Gloucestershire (System)
- BRI – Bristol Royal Infirmary
- C. diff – Clostridium Difficile
- COHA – Community onset healthcare associated
- CQC – Care Quality Commission
- CQUIN – Commissioning for Quality and Innovation
- DIPC – Director Infection Prevention and Control
- EPMA – Electronic Prescribing and Medication Administration





- EPP – Exposure Prone Procedures
- GNBSI – Gram-Negative Bloodstream Infection
- HCAI – Healthcare Associated Infections
- HOHA – Hospital onset-healthcare associated
- HR – Human Resources
- HSE – Health and Safety Executive
- HTM – Health Technical Memorandum
- ICB – Integrated Care Board
- ICG – Infection Control Group
- IE – Infective Endocarditis
- IP&C – Information Prevention and Control
- IVOS – Intravenous-to-Oral-Switch
- JCVI - Joint Committee on Vaccination and Immunisation
- KPI – Key Performance Indicator
- MDT – Multi Disciplinary Team
- MEMO - Medical Equipment Management Organisation
- MMR – Measles, Mumps, Rubella (vaccination)
- MRSA – Methicillin-Resistant Staphylococcus Aureus
- NBT – North Bristol Trust
- NHS – National Health Service
- NHSE – NHS England
- PEP – Post Exposure Prophylaxis
- PLACE – Patient Led Assessment of the Care Environment
- PPE – Personal Protective Equipment
- PVC - Peripheral Venous Cannula
- SBCH – South Bristol Community Hospital
- SOP – Standard Operating Procedure
- SSI – Surgical Site Infection
- SSIS – Surgical Site Infection Surveillance
- SSTF - Start Smart Then Focus
- UHBW – University Hospitals Bristol and Weston
- UKAS – United Kingdom Accreditation Service
- UKHSA – UK Health Security Agency
- UTI - Urinary Tract Infections
- VIP – Visual Infusion Phlebitis
- WGH – Weston General Hospital
- WHO – World Health Organisation





Meeting of the Trust Board of Directors in Public on Tuesday 12 September 2023

Report Title	Clinical Research Network West of England (hosted body) Annual Plan and Report
Report Author	Ifan Jones, Chief Operating Officer, Clinical Research Network West of England
Executive Lead	Stuart Walker, Chief Medical Officer and Host Nominated Executive Director for the Clinical Research Network West of England

1. Purpose

University Hospitals Bristol and Weston NHS Foundation Trust hosts the National Institute for Health and Care Research (NIHR) Clinical Research Network West of England (CRN WE). With a £15.9m annual budget, the CRN WE supports patients, the public and health and care organisations across the West of England to participate in high-quality research, thereby advancing knowledge and improving care.

The CRN WE submits the Annual Plan and Report for Approval. The newly developed Regional Strategy and 'Year in numbers' infographic are also included for additional context.

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

Regional Strategy

The Regional Strategy was developed in collaboration with key stakeholders from across the 3 Integrated Care Systems which form the West of England. Its aim is to provide clarity and direction for the CRN WE and our Partner Organisations in delivering against the national NIHR and CRN ambitions at a local level.

The Strategy was launched in June 2023 and covers the period up until the end of the CRN WE contract in September 2024.

23/24 Annual Plan

This document explains how the strategy will be operationalised in 23/24.

22/23 Year in numbers

This infographic includes key performance metrics achieved in 22/23

22/23 Highlight Report

This report was submitted to the CRN Coordinating Centre to be incorporated into the National CRN Report which is submitted to DHSC. It should be noted that the contents of this report doesn't cover the full breadth of work undertaken by the CRN WE because a) each region was limited to only one page and b) the headings were selected to focus on non 'business as usual' activities. However, it does give an insight into some projects managed across the region.

3. Strategic Alignment

The 5 strategic pillars introduced in the Regional Strategy were developed from the collated strategic research aims from Partner Organisations alongside national strategic direction.

4. Risks and Opportunities

Opportunities

Engagement in research provides Partner Organisations across the region with a variety of opportunities. For example: a) early access for patients to innovative treatments which may improve / extend their lives b) It has been demonstrated that organisations that carry out research provide better overall care (even to patients not taking part in studies) c) Research participation improves job satisfaction for clinicians, helping them build new transferable skills, preventing burnout and supporting the retention of staff.

Risks

The included documents have already been reviewed/approved at CRN WE Executive and Partnership Groups with no risks escalated. On the 1st of October 2024 the CRN will transition into the Research Delivery Network, the structure / function of which is still being formed. Risks to the trust concerning the transition may emerge during the transition period.

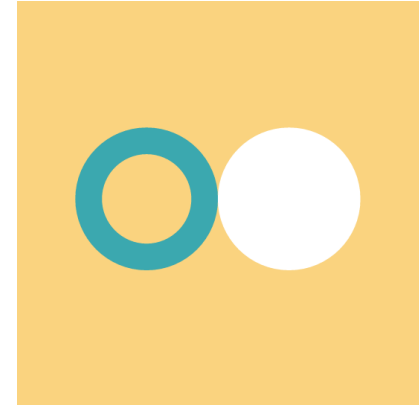
5. Recommendation

The Board is asked to approve the CRN WE 23/24 Annual Plan and the 22/23 Annual Report.

6. History of the paper

Please include details of where paper has previously been received.

CRN WE Partnership Group	June 2023
CRN WE Executive Group	June 2023



Regional Strategy 2023 to 2024

Introduction

I'm really excited to be able to share the Regional Strategy for the NIHR Clinical Research Network (CRN) West of England with you.

This strategy sets out our mission which aligns with that of the NIHR (*to improve the health and wealth of the nation*) and our vision as part of the CRN (*where research is an integral part of health and care for all*). It explores how we will achieve that vision and what things will look like when we do. It will be delivered until September 2024, during the transition period from the CRN to the Regional Research Delivery Network (RRDN).

This strategy comes after an unprecedented few years caused by the pandemic, where our ways of working have had to change and adapt. During this time we've also reflected on the way we measure success, moving away from metrics focused on the number of patients recruited into studies to those focused on widening participation and the experience of participants.

At the CRN West of England, we're passionate about improving access to research for everyone. Through research, we're able to find new

diagnostics, treatments, therapies and practices of care that save and improve lives. Research gives our patients and communities access to cutting-edge medicines and treatments before they're more widely available. During the pandemic we worked collaboratively and cross-regionally to offer research opportunities to the public no matter where they were. Our flexible working team, the WE ReACH team, does great work supporting research in out-of-hospital settings, again ensuring equitable access to research opportunities. Through the Participant in Research Experience Survey (PRES), we listen to feedback from participants and use this to improve the experience of taking part in research. We've also made efforts to increase our community engagement work, recognising that this is a big step in making research more inclusive and accessible.

We're also passionate about supporting and developing our research workforce. Supported by our broad range of learning and development opportunities, we promote and champion research delivery careers and we showcase and

share successes and best practice. In March 2022, we held our first CRN West of England Awards to celebrate and showcase all the incredible achievements of those working in research throughout the region. We plan to hold a second awards ceremony in 2023.

This commitment to the research workforce and to participants and the public is reflected in our strategy. There are lots of exciting opportunities in the year ahead for us to build on the work we've already done and continue to improve the health and wealth of the region. We look forward to working together with all of you to bring our vision to life.

Dr Kyla Thomas, Clinical Director



Louise Ting, Public Contributor

There has never been a greater need for research that is inclusive, representative, and easy to access for all. The pandemic highlighted the health disparities that exist in our society, with communities most affected by Covid-19 the least likely to participate in research.

Having collaborated with the CRN for a number of years, I am excited to see and be a part of the initiatives strengthening the CRN's work in engaging under-served groups. By involving people from all kinds of backgrounds through the Research Ready Communities project, we are able to raise awareness of research in different communities whilst addressing existing barriers, which will lead to more equal access to research opportunities.

It is vital that we consider working

with the public and patients as a two-way street, where both parties benefit (which has not been the case historically) and are able to meaningfully shape the way that research is delivered. That way, we can build trust, lasting relationships, and opportunities for people with different needs to take part.

The CRN is using a variety of mechanisms to make sure that the views of patients and the public are listened to and acted upon: through the Participant in Research Experience Survey; a new training programme that is being developed for people interested in volunteering as Research Champions; and outreach work where we directly engage with diverse under-served communities. I look forward to seeing this work evolve and better research outcomes for all.

Helen Lewis-White,
Deputy Director of Research,
North Bristol NHS Trust

Research offers patients and the public the opportunity to regain or take dominion over their bodies, sometimes through interventional studies but often by participating in research aimed at understanding an aspect of health and wellbeing. For all research participants, their personal research journey is no less inspiring as it offers the opportunity to empower individuals and shape healthcare now and in the future.

To realise this opportunity, to empower and enable patients and the public across our diverse, complex, interconnected communities, is not something that any one organisation can achieve in isolation. As our healthcare delivery moves to cross organisational boundaries so must our research

delivery.

The Covid pandemic embedded an approach to collaboration which ensured the successful delivery and expansion of research, and, as importantly, embedded the collegiate, collaborative working relationships which has seen the diversity of our research participants grow to reflect an ever-greater proportion of our populations whether from cities, rural, or coastal communities.

CRN WE provides the infrastructure and platform which allows, enables, and facilitates the continuation of these relationships and practices, encapsulating within this strategy the individual organisations' research strategies, hopes and ambitions, enabling us all to move into 2023-24 knowing that each part of the network is working towards common goals.

Our mission and vision

Our mission sets out why we exist and why we do what we do. As part of the National Institute for Health and Care Research (NIHR), we share a common purpose of improving the health and wealth of the nation through research, specifically achieving this by supporting the delivery of research.

Our vision describes the future we aspire towards and the impact that we aim to have on the world. The Clinical Research Network is designed to deliver a harmonised service across England, working across all regions as “One CRN”, with a vision to create a research positive culture across the NHS and all health and care settings, where patients, public and staff feel empowered and supported to participate in research. Our vision of research being “an integral part of health and care for all” is one shared across the CRN nationally.

The ways in which we set out to achieve this vision at a local level are outlined in pages 6 to 11, and are grouped into five core themes.

This work is supported by our values, which are what we hold to be important and guide our ways of working. These values are introduced on page 13.



Our mission:
To improve the health and wealth of the nation through research delivery

Our vision:

Research is an integral part of health and care for all



What will people say when we achieve our vision?

Patients and the public

The opportunity to be part of research will be easily accessible to everybody, regardless of their location, socio-demographics, or health conditions. Research will be seen as a standard and important part of health and care.

“My GP was well informed and helped me access all the research opportunities relevant to my condition.”

“I didn’t think research was for somebody like me - but it was all made super easy, the research team visited me at home and they were so knowledgeable about my different health conditions”

Research delivery workforce

Those who deliver research, or who manage and support the delivery of research, will be valued and empowered by their organisations and the wider research infrastructure.

“Research is part of our NHS Trust’s core business. Our Executive Board are a real champion and investor in research - we all think that it’s vital for providing the best patient care.”

“It was quick and easy to get our studies set-up and delivered; everybody across our different organisations knew what to do, the process was joined up, and everybody was truly collaborative.”

Health and care professionals

Research will be part of the every day for everyone working in health and care, for all professions, clinical and non-clinical. Research career development will be available for all, right through from student and trainee levels.

“Research is just part of my everyday work: my Job Plan recognises the role we all play in research, and it’s an important part of my career development and the enjoyment I get from my work!”

“I speak to all of my patients about research; it’s a critical piece of their care plan.”

Sponsors and funders

Research sponsors will be able to easily place their studies at any health and care provider in the country, and be able to access research ready populations and generate findings that represent the diversity of our population.

“We were able to access a wide variety of sites across the country, including those we hadn’t thought of before, which provided us with a really rich and diverse dataset.”

“We’d rather bring our studies to the UK. The research landscape is so joined up, making set-up and delivery quick, seamless and efficient. It felt like we were dealing with one organisation that worked consistently across the country.”

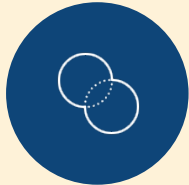
How we achieve our vision



Delivering people-centred research: We provide opportunities for people to participate in research that meets the needs of our local populations, ensuring equity of access to opportunities across people, geography, speciality and setting.



Supporting and developing our research workforce: We attract, develop and support a research workforce that delivers high-quality health and care research.



Embedding research into health and care: We strive to embed research as an everyday part of health and care practice through engaging and supporting health and care professionals, organisations and the public.



Fostering an effective and sustainable research delivery infrastructure: We foster and grow an effective, sustainable and agile research delivery infrastructure that meets both current and future needs.



Collaborating across the health and care system: We collaborate with a wide range of partners, working across traditional boundaries, to shape a cohesive and internationally competitive research system.

1. Delivering people-centred research

We provide opportunities for people to participate in research that meets the needs of our local populations, ensuring equity of access to opportunities across people, geography, speciality and setting.

Patients and the public are at the heart of health and care research; without them, many of the discoveries and advances we make would simply not be possible.

Involving, engaging and connecting people is essential in improving the reach, quality and impact of our research. The research we deliver needs to make a difference for our local communities, and, regardless of socio-demographics, should be accessible to all.

We also need to hear the voices of, and consider the views of, those in our local area in order for our services to meet their needs, and to continue to guide the development of the NIHR.

We put people at the heart of research by:

- Involving public contributors in determining, developing and delivering CRN priorities and activities.

- Providing opportunities for health and care organisations to become research active, particularly in emerging and under-served settings or geographies.
- Understanding our local populations and their needs through data and community engagement.
- Leading initiatives to increase research opportunities for under-served populations, identifying and addressing barriers to access.
- Engaging with communities to promote research awareness, activation and participation.
- Collecting and acting on feedback from research participants to improve the research delivery experience.



2. Supporting and developing our workforce

We attract, develop and support a research workforce that delivers high-quality health and care research.

We fund and support over 800 research delivery colleagues across the West of England. Only by attracting, investing in, and retaining a diverse workforce are we able to offer and grow health and care research opportunities for the public.

Developing and valuing an expert and confident workforce is key to delivering high-quality research and creating a positive research experience for our participants.

By bringing together a united workforce across settings and geographies, we encourage collaboration and provide a support network that facilitates learning and development, continuous improvement and resilience.

We support and develop our workforce by:

- Providing a broad range of learning and development opportunities for research delivery and management staff.
- Facilitating opportunities for networking and peer learning, making use of our network to support connection and sharing of best practice.
- Advocating for the research delivery workforce at local, regional and national levels, promoting and recognising the diversity of professions in health and care.
- Recognising and showcasing successes and best practice, both in terms of research delivery and in people support and development.
- Enabling and developing a network of facilitators and champions to draw on our collective knowledge and foster local engagement.
- Promoting and championing research delivery careers, and supporting research delivery and management staff in their career development.
- Driving and facilitating innovation in workforce models for research delivery, making use of opportunities for cross-organisational collaboration and harmonisation.



3. Embedding research into health and care

We strive to embed research as an everyday part of health and care practice through engaging and supporting health and care professionals, organisations and the public.

Research as part of core business for all health and care organisations enables more opportunities for staff to engage with research and provides a seamless experience throughout the research journey for both participants and research sponsors.

By embedding research, we increase the awareness and accessibility for participation in research, providing participants with timely access to cutting-edge treatments and care.

Even for those individuals not participating in research, there is evidence to demonstrate that research-active hospitals provide better patient-care outcomes than those not research-active.

We embed research into health and care by:

- Facilitating the awareness of research and its importance amongst all health and care staff, including students, non-clinical roles, support departments, and temporary staff.

- Supporting cultural change in organisations that facilitates research being an integral and expected part of patient care.
- Building partnerships to embed research in public health and social care.
- Advocating for research delivery within the health and care system, especially at leadership level.
- Providing opportunities for health and care professionals to learn about research and get involved in research in their organisation.
- Leading and supporting initiatives to engage with the public and promote research as part of the patient experience.
- Drawing on the expertise and support of our specialty and settings leadership, including specialty leads and champions.



4. Fostering an effective and sustainable research delivery infrastructure

We foster and grow an effective, sustainable and agile research delivery infrastructure that meets both current and future needs.

The CRN West of England distributes around £15m of funding each year to facilitate the delivery of health and care research. Ensuring the effective utilisation of resources within the region is pivotal to equitable research activity delivery and the sustainability of the industry.

As demonstrated during the pandemic, agility is key in enabling a quick and effective response to urgent national and local needs, and emerging challenges and opportunities. This is supported by our focus on innovative working and continuous improvement, which strengthens our practice and makes us globally competitive.

We build, maintain and grow an effective research delivery infrastructure by:

- Facilitating return on investment and meaningful scientific results through study performance monitoring and support.
- Supporting local Chief Investigators in designing and leading high quality, deliverable portfolio studies.
- Funding partner organisations (including NHS Trusts, GP practices and hospices) through our annual model and strategic development funding, balancing stability and growth.
- Acting as an ally and champion for Research and Development management and leadership, acting as a critical friend in maximising efficiency of local operations.
- Identifying and supporting a future talent pipeline, including engagement with trainees and students.
- Adapting in a timely, pragmatic and sensitive manner to changing external factors and government priorities.
- Facilitating a smooth transition to the new Regional Research Delivery Networks.
- Developing relationships with industry partners, maximising the diversity of income streams for Partner Organisations.
- Offering a Direct Delivery Team that can deliver research in non-NHS settings and can respond flexibly to evolving needs.



5. Collaborating across the health and social care system

We collaborate with a wide range of partners, working across traditional boundaries, to shape a cohesive and internationally competitive research system.

Research is a collaborative endeavour and every study relies on effective partnership working and trusting relationships.

Our joined-up, harmonised working as part of the NIHR is designed to create a user experience that is simple, effective and replicable, reducing silos and duplication between regions and different stages of the research pathway. Collaborative working also allows us to truly understand the needs of our population and services in order to effectively plan and place research, and perform to the highest standards.

Partnering with industry is a key priority for the CRN, as we develop a globally competitive offering and provide world-leading opportunities for our partners and our local population.

We collaborate with others by:

- Identifying and nurturing opportunities for sharing best practice, learning and collaborative working across partner organisations and within specialties.
- Facilitating the integration of research across settings (e.g. between secondary and primary care, between NHS and non-NHS) to match patient care pathways.
- Linking with other elements in the research pathway, such as design (e.g. RDS/RSS, HEIs), early phase research (e.g. BRCs, CRFs) and implementation (e.g. AHSN, ARCs).
- Working nationally across CRN regions and NIHR arms to share best practice, avoid duplication, and create connections.
- Building and maintaining effective relationships with current and future commercial and non-commercial sponsors.



Measuring our performance

The CRN West of England is governed by a series of documents and objectives set by the Department of Health and Social Care (DHSC), known as the **Performance and Operating Framework** (POF).

Published annually, this sets out our objectives, measures and targets, and defines mandatory operational structures, processes and systems and sets standards to ensure consistency across LCRN regions.

The performance of the NIHR CRN in meeting its purpose is measured against the CRN **High Level Objectives** (HLOs). We aim to meet and, if possible, exceed the HLO “ambitions” set on an annual basis by DHSC.

In addition to national objectives, we set local goals to enable successes that meet the needs of our region. This includes Local Specialty Objectives for each of the thirty-one research specialities, and strategic and operational plans for workstreams such as Communications, Patient and Public Involvement and Engagement, and Workforce Development.

High Level Objectives, 2023/2024

High Level Objective	Measures
Efficient study delivery Deliver NIHR CRN Portfolio studies to recruitment target	Percentage of: <ul style="list-style-type: none"> • Closed commercial studies which achieved target • Closed non-commercial studies which achieved target • Open commercial studies predicted to achieve target • Open non-commercial studies predicted to achieve target
Participant experience Demonstrate to participants that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	<ul style="list-style-type: none"> • Number of Participant in Research Experience Survey (PRES) responses
Expanding work with the life sciences industry Sustain or grow commercial contract research	<ul style="list-style-type: none"> • Number of new commercial studies entering the CRN Portfolio as a percentage of MHRA (Medicines and Healthcare products Regulatory Agency) clinical trial approvals for Phase II-IV studies

Our values

Impact

- We understand and appreciate the bigger picture, wider context and political environment so that we can have greater societal impact.
- We utilise data to assess our impact and inform our future direction.
- We direct our resources to high quality activities to ensure impactful outcomes.

Excellence

- We are dedicated to workforce and researcher development, investing in our people to build an exceptional workforce.
- We foster a culture of excellence within our team and with our partners, working with honesty, transparency, and ensuring good governance.
- We embed Continuous Improvement in our approach and culture.

Inclusion

- We embrace diversity in our workforce and incorporate a wide range of experiences into our decision making.
- We utilise data to identify unmet needs and let this lead positive change across our working.
- We welcome the opinions, experiences and knowledge of everyone we connect with.

Collaboration

- We listen to and value the contributions of current and future partners, recognising their unique outlook and priorities.
- We engage in proactive outreach to increase connectivity with other organisations “in our world”.
- We are One NIHR and part of a harmonised CRN.

Effectiveness

- We foster a supportive environment, sharing learning and celebrating success.
- We are curious and reflective, looking for ways to improve and have a culture of change to benefit effectiveness.
- We pride ourselves on our consideration for public resources entrusted to us, and in our commitment to ensuring value for money.

**The NIHR shares
five core operating
principles that guide
the way in which we
work.**

Our priorities for 2023/2024

As we emerge from the worst of the COVID-19 pandemic, one of our key priorities is supporting the DHSC-led **Research Reset** programme. This programme aims to free up capacity across the research system to make CRN portfolio delivery achievable within planned timelines and sustainable within current NHS capacity.

2023-2024 will also be the last year of the CRN before the launch of the **NIHR Research Delivery Network**. Supporting this transition will be a key priority for our organisation.

As well as working as One CRN on a shared Annual Business Plan, we have identified a number of priority projects that we will locally pursue this year. These are presented in line with our five strategic themes.

People-centred research:

- Growing our research infrastructure in hospices and care homes.
- Reporting on the disparities between local health and care needs and the local research portfolio.

- Expanding our community organisation collaborations and our co-production funding initiative.
- Increasing the diversity of studies that deliver the Participant in Research Experience Survey (PRES), and leading continuous improvement projects to respond to participants' feedback.

Our workforce:

- Developing and recognising the Clinical Research Practitioner role, supporting registration and developing a community.
- Refreshing and refining our research delivery competency frameworks.

Embedding research:

- Assisting secondary care partners with the identification and resolution of difficulties in accessing support services for research activity.
- Focusing on growing the number of Associate Principal Investigators (API) and increasing the number of West of England led studies registered for the API scheme.

- Developing a specialty leadership review and appraisal process, ensuring support for colleagues and value for money.

Infrastructure:

- Overseeing and locally managing the national Research Reset Programme.
- Evaluating the impact and effectiveness of strategic pump-prime funding.
- Supporting the smooth transition to the Regional Research Delivery Network.
- Overseeing and managing the local implementation of the Pre-Funding Feasibility programme.

Collaboration:

- Hosting a supra-regional social care event to create links with more research naive organisations in our region.
- Working as "One CRN" nationally to support the government's strategic partnerships with commercial sponsors.

Appendix: How we got here

The role of a regional strategy

This local strategy, collaboratively developed in late 2022, will be delivered until September 2024 during the transition period from the LCRN to the Regional Research Delivery Network (RRDN).

The aim of this strategy is to provide clarity and direction for the CRN WE and our Partner Organisations in delivering against the national NIHR and CRN ambitions at a local level.

As part of a national harmonised network, our work is aligned with that of the other LCRNs and CRN Coordinating Centre. Our aspiration is to be nationally collaborative and internationally competitive. Our ways of working and performance measures have moved away from regionally competitive gains to nationally cohesive successes.

Key strategic documents

This strategy has developed within the context of the following national strategies and plans, which the CRN West of England supports and with which we align our work:

- Best Research for Best Health (2021), the National Institute for Health and Care Research's strategy, with seven identified areas of strategic focus.
- Saving and Improving Lives: The Future of UK Clinical Research Delivery, a DHSC policy paper outlining a vision and strategy for UK clinical research delivery.
- NIHR Clinical Research Network (CRN): Primary Care Strategy.
- Life Sciences Vision, a policy paper outlining the government and life science sector's ambitions for the life sciences sector.

Our process

- This work was led by a Steering Group, which included representatives from the LCRN and three Partner Organisations (POs). This formed part of our local Continuous Improvement Programme.
- We collated strategic aims from all Partner Organisations and, considering these alongside national strategic direction, identified and refined the 5 strategic pillars introduced in this document.
- We carried out idea generation exercises and invited consultation on draft versions from a number of our governance and operational groups, including public representatives and regional colleagues.
- Appreciating the short timeframe of this strategy, a key driver has been that both process and output should be proportionate.

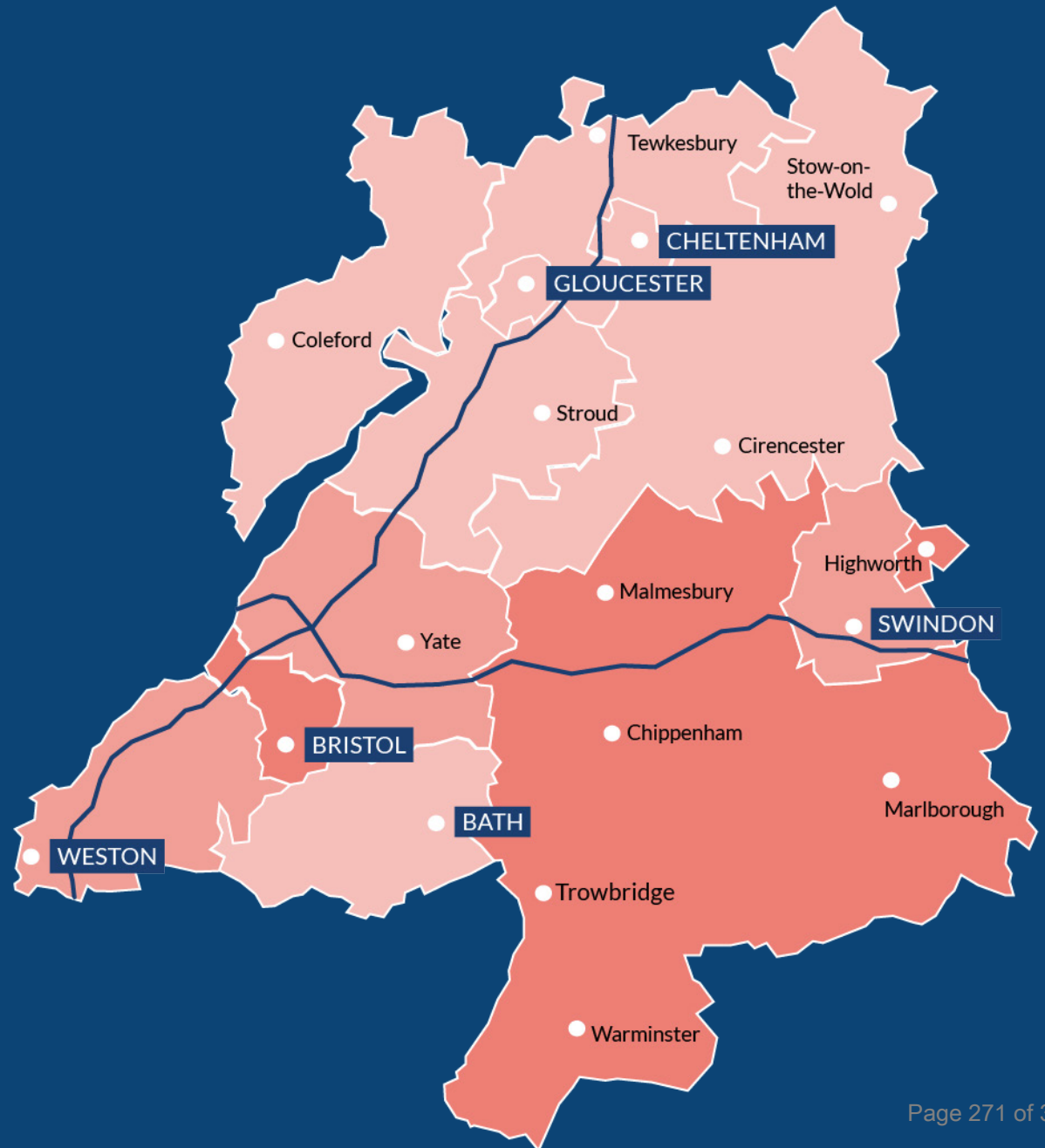
Key acronyms:

AHSN: Academic Health Science Network
 ARC: Applied Research Collaboration
 BRC: Biomedical Research Centre
 CRN (WE): Clinical Research Network (West of England)
 DHSC: Department of Health and Social Care
 HEI: Higher Education Institution

HLO: High Level Objective
 LCRN: Local Clinical Research Network
 NIHR: National Institute for Health and Care Research
 PO: Partner Organisation
 PRES: Participant in Research Experience Survey
 (R)RDN: (Regional) Research Delivery Network
 RDS: Research Design Service

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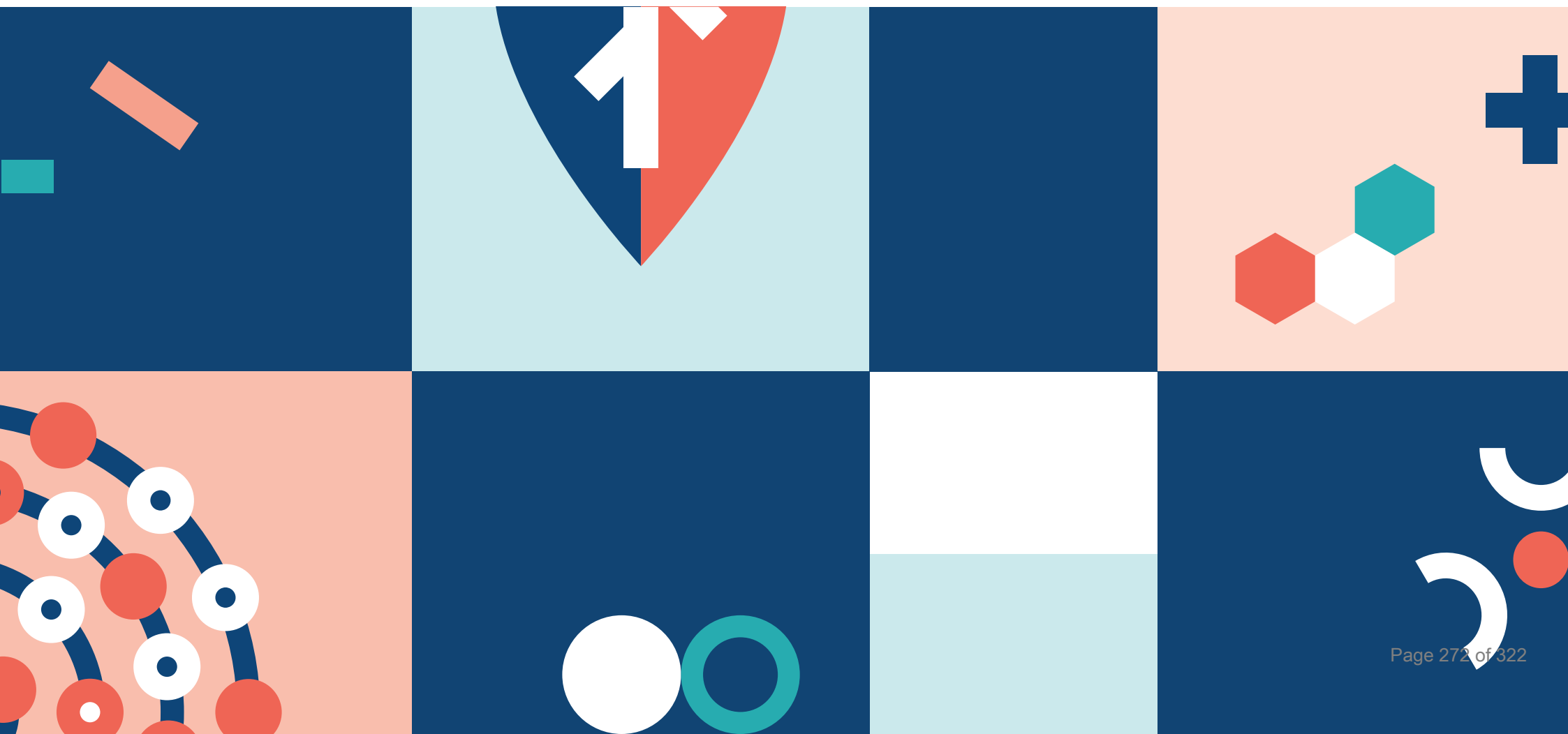
e: westengland@nihr.ac.uk

t: @CRNWestEngland

13. NIHR CRN Annual Plan and Annual Report (hosted body report)

2023/24 Annual Business Plan

Version 1.0, June 2023



CRN WE Annual Plan

In March 2023, the CRN West of England (CRN WE) Partnership Group approved a new regional strategy that will guide the CRN's work from April 2023 to September 2024.

Developed in collaboration with our Partner Organisations, our Specialty Leadership and our Public Contributors, this strategy bridges the gap between national strategies and programmes and our Partner Organisations' objectives to identify and communicate how we work at a collaborative, regional level.

This document - our Annual Plan - sets out how we operationalise this strategy and make it happen. It is important that the vital work that we set out in our strategy does not just remain in a glossy brochure, but makes a meaningful difference to our local communities, health and care professionals and organisations, and researchers and industry partners.

The development of this plan has prompted plentiful discussion and challenge and is designed as a 'living' document that can be updated and refined as projects develop, and as opportunities and challenges emerge.

Priority Projects

As part of our annual planning, we identified several priority projects on which we will focus our regional efforts over the coming year. These are projects and programmes that will require a notable focus, resource, or change in working.

Each project has a designated lead, and we have identified a series of key milestones and, where appropriate, specific targets.

Strategic Themes: Activity Map

In this section, we outline the day-to-day work that we carry out in support of each of the themes and mechanisms in our strategy.

We also link to relevant contractual support documents. The table works as a 'map' to explore how different activities inter-relate and also helps us to identify any gaps and opportunities in our work.

Although not detailed in this document, our work is also directed and measured against the following objectives:

High Level Objectives: The Department of Health and Social Care measures the performance of the NIHR CRN against the CRN High Level Objectives (HLOs). We aim to meet and, if possible, exceed the HLO "ambitions" set on an annual basis.

Local Specialty Objectives: Each of our 31 research specialities has a designated Local Specialty Research Lead (LSRL) and (Assistant) Research Delivery Manager (RDM) who guide programmes of work specific to that speciality. As part of our annual planning process, LSRLs and RDMs define specialty objectives, and then report on these throughout the year to the CRN's Senior Leadership Team and Divisional Research Leads governance group. Page 273 of 322



CRN West of England Core Team, February 2023

Ref	Project	People	Milestones and/or targets
1. People-centred research			
1a	Growing our research infrastructure in hospices, care homes and other non-NHS environments.	<p>Led by: Chris Voisey (RDM, Division 5, Primary Care)</p> <p>Supported by: David Rea (Senior RDM) Claire Matthews (ARDM, Division 1, Hospices) Harriet Downing (RDM, Division 4, Care Homes) Sarah Kidd (WE ReACH Team Lead) Sarah Jones (Communications and Events Officer)</p> <p>SLT link: Ifan Jones</p>	<p>Q1: The new entrants on the Hospice Funding Scheme (Weston Hospice Care; Prospect House, Swindon; and Children's Hospice South West, Charlton Farm, Somerset) will be supported to become research active. Initial activities will include: - CRN induction/training (including explaining the broader research landscape) - Join the established hospice Community of Practice meetings - Build relationships with the CRN Direct Delivery Team</p> <p>Q1: Renew direct engagement with all ENRICH care homes in the West of England (26 sites) and initiate contact with care providers who are new to research with a view to introducing research. Explore and implement best practice identified from other CRN regions with well established ENRICH groups.</p> <p>Q2: Begin planning for a hospice event to be held in Q4. This may include collaborating with neighbouring networks to deliver a joint event.</p> <p>Q3: Review of Direct Delivery Team skills to ensure they are best able to support studies within hospices and care homes alongside other non-NHS environments. Plan for the skillset of the team to meet these needs.</p> <p>Q4: Review of hospice funding scheme, assessing progress at funded sites. Propose amendments to 24/25 scheme with possible expansion to new sites. Explore prospective funding for care homes in 24/25.</p>
1b	Reporting on the disparities between local health and care needs and the local research portfolio.	<p>Led by: Mike Lacey (Business Intelligence Manager)</p> <p>Supported by: Calum Masterton (Senior PF, BI) David Rea (Senior RDM) Jo Williams (LSRL, Public Health)</p> <p>SLT link: Ifan Jones</p>	<p>Q1-Q2: Secondary data analysis of: a) The demographic profile of the CRN WE b) The communities and geographies under-served by research c) The disparities between local health and care needs and the local research portfolio.</p> <p>These will be produced using publicly available health datasets and include linking with ICBs who are already working in this area.</p> <p>Q3: Publish report with recommendations for areas needing increased focus in 24/25.</p>
1c	Building on our community organisation collaborations and co-production funding initiative.	<p>Led by: Tamsin Pearce (Community Engagement Officer)</p> <p>Supported by: Holly Ayres (Comms and Engagement Manager)</p> <p>SLT link: Stephen McGlynn</p>	<p>Q1: Celebration and evaluation event with community organisations. Feedback from this event to feed into an analysis and report of 22/23 projects, identifying successes and things that can be improved.</p> <p>Q1: Planning for 23/24 projects, looking at how we continue to work with existing organisations and engage with additional organisations.</p> <p>Q2: Support ongoing projects with organisations from 22/23. Put out call to work with new organisations and hold training with representatives from those organisations. Connect all organisations to aid network building.</p> <p>Q3: Support ongoing projects with organisations from 22/23 and new organisations who have joined.</p> <p>Q4: Evaluation of 23/24 projects. Bring organisations together to continue to build and strengthen the network.</p>

1d	Increasing the diversity of studies that deliver the Participant in Research Experience Survey (PRES), and leading continuous improvement projects to respond to participants' feedback.	<p>Led by: Holly Ayres (Comms and Engagement Manager)</p> <p>Supported by: Chris Voisey (RDM, Division 5, Primary Care) Tamsin Pearce (Community Engagement Officer) WE ReACH PRES Champions Hannah Williams (CI Lead)</p> <p>SLT link: Stephen McGlynn</p>	<p>Targets: * Primary Care response rate (5% of participants to eligible studies) * ALSPAC response rate (10% of participants to eligible studies) * Diversity of studies, measured by number of studies (40% of portfolio)</p> <p>Q1-Q4: Identify open studies that we are not receiving responses for and follow up with local sites to encourage delivery of the survey. Work with local sites to overcome any issues/barriers to delivering the survey for these studies. This will include a continuation of the focused monitoring and support for Primary Care sites and ALSPAC.</p> <p>Q2-Q3: Based on feedback from 21/22 survey, create materials to communicate experience of taking part in research e.g. consent, results. Develop alongside and with support of research champions to ensure they meet participants requirements.</p> <p>Q1-Q2: Analysis of PRES data from 22/23 including recommendations for improvement projects. Hold focus groups with research delivery staff and Research Champions/participants to identify priority projects.</p> <p>Q3-Q4: Develop and implement improvement projects based on outcomes from focus groups.</p>
2. Supporting and developing our workforce			
2a	Refreshing and refining our research delivery competency frameworks.	<p>Led by: Tori McIntyre (Workforce Development Manager)</p> <p>Supported by: Stephen McGlynn (Co-WFD Lead) Research Competencies Working Group</p> <p>SLT link: Stephen McGlynn</p>	<p>Q1: Analysis of feedback from engagement sessions with Primary and Secondary Care colleagues, establishing new themes and priority actions based on feedback</p> <p>Q2: Circulate first draft of refined framework with small stakeholder group for feedback</p> <p>Q3: Further refine from feedback and redesign for aesthetics and accessibility. Soft launch of revised framework across a small number of partners to explore whether the revised framework works in practice and identify any further improvements or edits that would help.</p> <p>Q3: Explore options for integration on NIHR Learn, aligning development resources and offerings to each competency. If feasible, pilot alongside soft launch.</p> <p>Q4: Hard launch of full framework, including promotion of the new framework across our partners to boost engagement and socialisation. This will include a year-long communications plan to support embedding the framework in research delivery practice.</p> <p>Q1-Q4: Connect with other LCRNs to identify opportunities for collaboration and to share learning and outputs.</p>

2b	Developing and recognising the Clinical Research Practitioner role, supporting registration and developing a community.	<p>Led by: Tori McIntyre (Workforce Development Manager)</p> <p>Supported by: Zoe Lampshire (CRP Engagement Lead) Ifan Jones (COO, CRP national working group) Sarah Kidd (WE ReaCH Team Lead) Holly Ayres (Comms and Engagement Manager)</p> <p>SLT link: Stephen McGlynn</p>	<p>Q1: Design and develop a suite of offers to support CRP Registration, aligned with our locally developed cohort framework that identifies different CRP groups and how best to support them with registration, such as those who are on the directory, in progress, or system supporters who can act as registration advocates. Establish focus areas for session development through engaging with partners to gauge trust-level needs for CRPs in local teams. Design sessions based on these needs and offer a blend of bespoke sessions and readily made sessions to aid rapid deployment.</p> <p>Q1: Engage with our partners to offer and schedule workshop opportunities. Existing sessions available include support for reflective practice, top tips for registrants and managers, documentation resources, and protected space to work on registrations with support.</p> <p>Q3: Engage with registered WE CRPs to build an ongoing community, develop promotional communications and ongoing communities of practice by Autumn 2023. Work with Comms and Engagement and CRP Engagement Lead to showcase CRPs in the West of England and the contribution they make and the value of registration - perhaps aligned with national campaigns around CRPs.</p>
3. Embedding research into health and care			
3a	Assisting secondary care partners with the identification and resolution of difficulties in accessing support services for research activity.	<p>Led by: Claire Matthews (ARDM, Division 1)</p> <p>Supported by: Senior RDM and all A/RDMs</p> <p>SLT link: Ifan Jones</p>	<p>Q1: Scope issues concerning support services at sites across CRN WE. Distribution of ring-fenced clinical support service funding.</p> <p>Q2: If a number of common problem areas are identified, then one or more working groups of representatives from partner organisations will be formed with the task of planning to address those issues. Depending on the nature of issues, proposed solutions may be based on best practice from within the region, within the supra region or from the rest of the CRN. They could include system-based solutions (e.g. creating communities) or funding-based solutions (e.g. funding new posts).</p> <p>Q3: Enact plans proposed in Q2, including possible use of in-year underspend.</p> <p>Q4: Review models / funding delivered as part of this project. Propose extending successful elements into 24/25 Annual Planning.</p>
3b	Focusing on growing the number of Associate Principal Investigators (API) and increasing the number of West of England led studies registered for the API scheme.	<p>Led by: Tori McIntyre (Workforce Development Manager)</p> <p>Supported by: All A/RDMs Jo Bagshaw (Study Support Service Manager) Stephen McGlynn (Co-WFD Lead)</p> <p>SLT link: Stephen McGlynn</p>	<p>Targets: * At least 40% of eligible specialties to have a study registered on the API Scheme * At least 30% of eligible specialties to have an individual registered on the API Scheme * At least 3 more lead network studies registered on the API Scheme</p> <p>Q2: Work with our Partner Organisations, Chief Investigators and key research leads to promote and grow the number of regional studies currently open to APIs. Have at least 3 more Lead Network studies registered to support API scheme, working with Research Delivery Managers and the CRN Early Contact and Engagement Service to identify potential suitable studies. Engage with LSRLs and specialty events/communities of practice to promote the API scheme and how to register eligible studies.</p> <p>Q3: Hold at least one networking opportunity for current / alumni APIs in region to connect . Input into national API alumni community work, with a launch of a local area on NIHR Learn for alumni resources.</p>

3c	Developing a specialty leadership review and appraisal process, ensuring support for colleagues and value for money.	<p>Led by: David Rea (Senior RDM)</p> <p>Supported by: Kyla Thomas (Clinical Director) Helena Ferguson (People and Operations Manager) Stephen McGlynn (Deputy COO) All A/RDMs</p> <p>SLT link: Stephen McGlynn</p>	<p>Q2: Consult with specialty leads, RDMs and the Senior Leadership Team, and co-create an appraisal process for DRL, LSRL and Champion roles. This process will be designed to provide a timely and consistent mechanism that can: help shape local speciality objectives (through goal setting); evaluate engagement, output and progress in the role; support succession planning; and provide a space for reflection and feedback where specialty leads can identify support and development need.</p> <p>Q3: Launch and/or pilot appraisal process for speciality leadership.</p>
4. Fostering an effective and sustainable research delivery infrastructure			
4a	Oversee and locally managing the national Research Reset Programme.	<p>Led by: Jo Bagshaw (Study Support Service Manager)</p> <p>Supported by: All A/RDMs</p> <p>SLT link: Ifan Jones</p>	<p>Q2: Finalise a local guide to embed Reset processes into CRN WE .</p> <p>Q1-Q4: Produce reports on the status of lead LCRN studies on Reset</p> <p>Q2-Q4: Monitor performance and address issues as they arise. Respond locally to national changes to the Reset Programme, ensuring local stakeholders are aware and that they are adopted into routine processes.</p>
4b	Evaluating the impact and effectiveness of strategic pump-prime funding.	<p>Led by: Hannah Williams (RDM, Division 3)</p> <p>Supported by: Senior RDM and all A/RDMs</p> <p>SLT link: Ifan Jones</p>	<p>Q2-Q3: Scope both the effectiveness of the current methodology for distributing strategic funding (with local partners) and alternative models (those used by other LCRNs).</p> <p>Q3-Q4: Report on the short- and long-term impact of strategic funding alongside proposed improvements to the 24/25 distribution model. Ensure findings are disseminated to members of the national team responsible for designing the finance models for the Research Delivery Network to ensure local best practice can inform and is embedded into the future national funding model, and potentially inform other funding initiatives across the NIHR and DHSC.</p>
4c	Supporting the smooth transition to the Regional Research Delivery Network.	<p>Led by: SLT</p>	<p>Q2: CRN WE COO to start secondment as South West Central RRDN Transition Lead in July, beginning with a 2 day induction with the National Coordinating Centre Team. It is expected that major tasks/ activities supporting the smooth transition to the Regional Research Delivery Network will be determined nationally with corresponding national timelines. It is therefore difficult to set these out in a local plan before national plans are released.</p> <p>Q1-Q4: SLT to respond to national developments in a timely and compassionate manner ensuring the current high-performance and people-centric culture within the current network translates into the new structure.</p> <p>Q1-Q2: Support staff development and wellbeing through the Uncertainty Experts programme, an evidence-based intervention to increase uncertainty tolerance.</p> <p>Q3: Carry out the CRN's third Engagement and Experience Survey.</p>

4d	Oversee and manage the local implementation of the Pre-Funding Feasibility programme.	<p>Led by: Jo Bagshaw (Study Support Service Manager)</p> <p>Supported by: All A/RDMs</p> <p>SLT link: Ifan Jones</p>	<p>Q1-Q2: As this national project involves working at a much earlier phase in the funding of research studies compared to currently, new relationships and processes may be required to ensure success of the project. Workshop sessions will be held with all involved local groups (i.e. from both NHS trusts and Universities who sponsor studies) to share the national outline of the project and determine how to best embed it within existing local structures / processes.</p> <p>Q2-Q4: Local guidance will be continually reviewed and updated as the pilot phase completes and activities become business as usual. Local experiences of, and learning from, the project will be fed back into national oversight groups.</p>
5. Collaborating across the health and social care system			
5a	Hosting a supra-regional social care event to create links with more research naive organisations in our region.	<p>Led by: David Rea (Senior RDM, Social Care)</p> <p>Supported by: Harriet Downing (RDM, Division 4) Sarah Jones (Communications and Events Officer)</p> <p>SLT link: Ifan Jones Stephen McGlynn</p>	<p>Q1: Supra-regional social care leads and Local Specialty Research Leads will form a planning group for an event to be held in Q3. Early considerations will include the nature of the event (virtual vs. face to face), date/timings, target attendees and the agenda.</p> <p>Q2: Save the date sent alongside regular event planning. Given poor awareness of the NIHR / CRN amongst social care specialists, a bespoke communications campaign will be developed to reach potentially interested individuals (e.g. local authority links, principal social workers and care home staff and managers).</p> <p>Q3: Hold event and carry-out a post-event evaluation.</p> <p>Q3-Q4: Follow up activities from the event such as acting on workshop suggestions and building on relationships initiated at the event.</p>
5b	Working as "One CRN" nationally to support the government's strategic partnerships with commercial sponsors.	<p>Led by: Ifan Jones (Industry Operations Manager)</p> <p>Supported by: David Rea (Senior RDM) All A/RDMs</p> <p>SLT link: Ifan Jones</p>	<p>Q1-Q4: "One CRN"-related industry activities include:</p> <ul style="list-style-type: none"> * Locally enacting the CRN response to the Lord O'Shaughnessy report. * Continuing the roll-out of the National Contract Value Review project. * Local preparation for and delivery of the national Vaccine Innovation Pathway (for infectious diseases) and the Cancer Vaccine Launchpad. <p>Q1-Q4: Other local industry-linked projects for 23/24 include:</p> <ul style="list-style-type: none"> * Continuing support for the Primary Care Commercial Community of Practice Group with increased cross-working with our Secondary Care-based Industry Group. This is with the intention of increasing research referrals between Primary and Secondary Care. * Support the roll out of Cognizant Shared Investigator Platform across sites in the CRN WE. * Continue to develop new promotional materials via the Commercial Identity Working Group. * Increase direct industry sponsor engagement, with a view to promoting local sites and resolving local issues (e.g. delayed opening times, low recruitment).

Strategic Themes: Activity Map

Public Board

13. NIHR CRN Annual Plan and Annual Report (hosted body report)

Ref	Workstream mechanisms	How we achieve this through our day-to-day work and "business as usual" activities	Priority projects for 2023-2024 (Refer to the 'Priority Projects' document)	Supporting contractual documents (Performance and Operating Framework and Contract Support Pages)
1. People-centred research				
1.1	Involving public contributors in determining, developing and delivering CRN priorities and activities.	<p>Our Partnership Group membership includes two members of the public who play an important role in setting the strategic direction of the LCRN and in holding the Senior Leadership Team to account.</p> <p>Our strategy document has been developed in collaboration with members of the public. We regularly hold project-specific focus groups with members of the public, especially for communications and engagement projects. We also run a Research Champions programme, where public volunteers help deliver outreach activities.</p>		<p>POF:</p> <ul style="list-style-type: none"> * 14 - General Management * 20 - Patient and Public Involvement and Engagement <p>CSPs:</p> <ul style="list-style-type: none"> * 003 - LCRN Leadership and Management * 058 - Public and Patient Involvement and Engagement * 070 - Participant in Research Experience Survey * 072 - Public and Patient Involvement and Engagement Impact Framework
1.2	Providing opportunities for health and care organisations to become research active, particularly in emerging and under-served settings or geographies.	<p>The CRN provides funding to support research in a variety of health and care organisations, including:</p> <ul style="list-style-type: none"> * £14m of annual funding for our Partner Organisations, including the Research Site Initiative Scheme for Primary Care organisations * £0.5m of strategic funding (CRN Development Bids), to which partners can apply to pump-prime projects that support the growth and development of research capacity and capability. This includes funding for projects such as "GPs in the Deep End" that aim to support GP practices in geographies that are under-served by research to become research active. * Funding for research in new settings, such as care homes (the ENRICH scheme) and hospices * £0.75m towards the CRN-managed Direct Delivery Team, who deliver research in non-NHS Settings <p>We also offer non-financial support, such as:</p> <ul style="list-style-type: none"> * Linking Partner Organisations with Community Champions and Organisations * Engaging with Integrated Care Boards to promote research 	<ul style="list-style-type: none"> * Project 1a (hospice and care home funding) * Project 1b (demographic profile) 	<p>POF:</p> <ul style="list-style-type: none"> * 15 - Financial Management * 16 - CRN Specialities * 17 - Research Delivery * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development <p>CSPs:</p> <ul style="list-style-type: none"> * 093 - Research Ready Communities * 074 - Public Research Champions * 095 - NIHR CRN Under-served 2% Guidance * 078 - Health and Care Services Engagement * 068 - NIHR CRN Support for Research in Wider Health and Care Settings
1.3	Understanding our local populations and their needs through data and community engagement.	<p>Our Business Intelligence Team support in both the collection of data from research delivery (e.g. the NHS number pilot work in which demographic data is integrated across research and clinical systems) and the analysis of data from primary and secondary sources.</p> <p>Our Community Engagement Team engage directly with local communities to learn more about our local populations and their needs, including through our Research Ready Communities programme, our community organisation co-production funding initiative, and through involving public contributors in our work. This is supported by intelligence gathered from the Participant in Research Experience Survey (PRES).</p>	<ul style="list-style-type: none"> * Project 1b (demographic profile) * Project 1c (community engagement funding) 	<p>POF:</p> <ul style="list-style-type: none"> * 16 - CRN Specialities * 18 - Information and Knowledge * 20 - Patient and Public Involvement and Engagement * 21 - Health and Care Services Engagement <p>CSPs:</p> <ul style="list-style-type: none"> * 058 - Public and Patient Involvement and Engagement * 070 - Participant in Research Experience Survey * 072 - Public and Patient Involvement and Engagement Impact Framework * 074 - Public Research Champions * 093 - Research Ready Communities * 099 - Year of Birth
1.4	Leading initiatives to increase research opportunities for under-served populations, identifying and addressing barriers to access.	<p>A key route through which we increase research opportunities is through our work to support health and care organisations to become research active (see 1.2), with particular consideration for ensuring equity of access across geography and settings. This is supported by our Development Bids Scheme and our 2% ring-fenced funding for initiatives designed to increase research opportunities for under-served populations. Our Direct Delivery Team allow us to provide research infrastructure in non-NHS settings, allowing us to deliver research in new sites and settings.</p> <p>The intelligence gained from our community engagement work and the PRES allow us to identify barriers to access, which then aim to address through our continuous improvement work, through our communities of practice, and through sharing case studies of stories of best practice.</p>	<ul style="list-style-type: none"> * Project 1a (hospice and care home funding) * Project 1c (community engagement funding) 	<p>POF:</p> <ul style="list-style-type: none"> * 16 - CRN Specialities * 20 - Patient and Public Involvement and Engagement <p>CSPs:</p> <ul style="list-style-type: none"> * 074 - Public Research Champions * 093 - Research Ready Communities * 095 - NIHR CRN Under-served 2% Guidance

1.5	Engaging with communities to promote research awareness, activation and participation.	This is an area which we have rapidly grown over the past two years, particularly with the establishment of a dedicated Engagement Team and the appointment of a Community Engagement Officer. Some of our flagship programmes in this area include Research Ready Communities, community engagement co-production funding and Public Research Champions. We now regularly attend community events, promoting awareness of research and supporting registrations to the Be Part of Research and Join Dementia Research registries.	* Project 1c (community engagement funding)	POF: * 19 - Communications * 20 - Patient and Public Involvement and Engagement CSPs: * 058 - Public and Patient Involvement and Engagement * 072 - Public and Patient Involvement and Engagement Impact Framework * 074 - Public Research Champions * 093 - Research Ready Communities
1.6	Collecting and acting on feedback from research participants to improve the research delivery experience	The Participant in Research Experience Survey (PRES) is our main mechanism by which we gather feedback from those who take part in research. We support with the delivery of PRES by our Partner Organisations, distributing materials and monitoring performance to help track success and areas of missed opportunity. We provide feedback to sites in a timely fashion, both through our live data dashboard and by highlighting qualitative comments that might provide a motivational boost or that need urgent feedback relevant to the safety or quality of study delivery. Our annual PRES report summarises responses and identifies key themes and trends, and we work with research delivery staff and public contributors to identify and deliver continuous improvement projects based on the findings of PRES each year.	* Project 1d (PRES)	POF: * 8 - CRN Participant in Research Experience * 20 - Patient and Public Involvement and Experience CSPs: * 058 - Public and Patient Involvement and Engagement * 070 - Participant in Research Experience Survey * 072 - Public and Patient Involvement and Engagement Impact Framework * 074 - Public Research Champions * 093 - Research Ready Communities
2. Supporting and developing our workforce				
2.1	Providing a broad range of learning and development opportunities for research delivery and management staff.	Our Workforce Development Team provides a range of learning and development opportunities, including our flagship programmes of Good Clinical Practice (GCP), Informed Consent and Principal Investigator (PI Essentials). This is supported by the design, development and delivery of courses and initiatives to meet local needs, including bespoke training where appropriate. We employ a Digital Learning Designer across the South West supra-region who supports in the design and development of digital learning assets. Programmes are provided across a range of modes, including face-to-face, virtual, e-learning and blended. Our learning interventions include both traditional formal (e.g. training) and informal (e.g. action learning) learning initiatives. We work as one national network, through the National Learning Directory to share and co-design learning assets and where appropriate deliver at a supra-regional level.	* Project 2a (competency framework)	POF: * 22 - Workforce Learning and Organisational Development CSPs: * 025 - NIHR CRN Good Clinical Practice Programme * 026 - National Learning and Development Programmes (NIHR National Learning Directory)
2.2	Facilitating opportunities for networking and peer learning, making use of our network to support connection and sharing of best practice.	Our learning and development courses are designed around peer learning, allowing attendees to network, to share best practice and experiences across our regional network. This networking and peer learning is embedded in our day-to-day work through the specialty-specific communities of practice and events that our Research Delivery Managers facilitate. We have specific capacity-building networking schemes such as the hospice network and the ENRICH care home initiative.	* Project 4b (strategic funding evaluation) * Project 1a (hospice and care home funding)	POF: * 16 - CRN Specialities * 22 - Workforce Learning and Organisational Development CSPs: * 025 - NIHR CRN Good Clinical Practice Programme * 026 - National Learning and Development Programmes (NIHR National Learning Directory) * 092 - NIHR ENRICH Delivery in Local Clinical Research Networks * 050 - CRN Study Support Service Early Contact and Engagement Standard Operating Procedure

2.3	Advocating for the research delivery workforce at local, regional and national levels, promoting and recognising the diversity of professions in health and care.	<p>Our Senior Leadership Team, Lead NMAHP role and Workforce Development Team play important roles in advocating for the research delivery workforce. The CRN has formal representation on a number of regional and national groups, including ICB research committees, the NHS England (HEE) South West Strategic Research Workforce Steering Group, and the NIHR at Bristol Training group. Workforce also forms a standing agenda item on all LCRN governance groups and on the monthly R&D Managers' meeting.</p> <p>The Workforce Development Team and Lead NMAHP roles, in particular, work as part of a national collaboration to promote research careers and the diversity of professions - with a number of a specific campaigns and programmes for nurses, midwives, AHPs, medics, Clinical Research Practitioners and pharmacists.</p> <p>Our Early Contact and Engagement service plays an important role in shaping research design at an early stage, advocating for our Direct Delivery Team and providing constructive challenge to help inform protocol development and recognise other professions that may improve deliverability (e.g. recognising CRPs).</p>	* Project 2b (CRP promotion and engagement)	<p>POF:</p> <ul style="list-style-type: none"> * 14 - General Management * 16 - CRN Specialities * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development <p>CSPs:</p> <ul style="list-style-type: none"> * 003 - LCRN Leadership and Management
2.4	Recognising and showcasing successes and best practice, both in terms of research delivery and in people support and development.	<p>Our Communications Team showcases successes and case studies across traditional and social media channels, highlighting staff stories and case studies of best practice. We recognise the hard work and achievements of our regional workforce through an annual awards event.</p> <p>Our specialty-specific communities of practice and events provide an avenue for colleagues to highlight successes and share best practice.</p>	* Project 4b (strategic funding evaluation)	<p>POF:</p> <ul style="list-style-type: none"> * 16 - CRN Specialities * 17 - Research Delivery * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development <p>CSPs:</p>
2.5	Enabling and developing a network of facilitators and champions to draw on our collective knowledge and foster local engagement.	<p>Our learning and development offering is delivered by a network of facilitators, who are drawn from our regional research delivery community. This provides an opportunity for staff to develop new skills and introduce new variety to their role. By having experienced research delivery colleagues deliver our courses, we are able to draw and share their wisdom and experience. The facilitator community is supported by our Workforce Development Team and through specific facilitator training and CPD.</p>		<p>POF:</p> <ul style="list-style-type: none"> * 22 - Workforce Learning and Organisational Development <p>CSPs:</p> <ul style="list-style-type: none"> * 025 - NIHR CRN Good Clinical Practice Programme * 026 - National Learning and Development Programmes (NIHR National Learning Directory)
2.6	Promoting and championing research delivery careers, and supporting research delivery and management staff in their career development.	<p>Our Communications Team promote research delivery careers through our communications, most notably through our annual 'Your Path in Research campaign'. This is supported by targeted work by the Workforce Development Team and our Lead NMAHP who proactively connect and support those new to research across the region. This includes our flagship Research Scholars' Programme.</p> <p>Career development is supported through our learning and development programme, our strategic development funding and specialty-specific events.</p>	* Project 2b (CRP promotion and engagement) * Project 3b (API scheme engagement)	<p>POF:</p> <ul style="list-style-type: none"> * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development <p>CSPs:</p>
2.7	Driving and facilitating innovation in workforce models for research delivery, making use of opportunities for cross-organisational collaboration and harmonisation	<p>Workforce is one of our standing agenda items as part of our monthly R&D Managers' meeting and we regularly consider ways in which we innovate in this area. Workforce models and collaborative opportunities form a core part of our annual planning process for our Partner Organisations.</p> <p>Recent innovations in this area include our regional memorandum of understanding for the movement of staff between organisations. We also have regional coordination roles (e.g. a regional vaccine trial manager and a teenager and young adult cancer research nurse), a regional vaccine delivery model and a hospice network.</p>	* Project 4b (strategic funding evaluation)	<p>POF:</p> <ul style="list-style-type: none"> * 16 - CRN Specialities * 17 - Research Delivery * 22 - Workforce Learning and Organisational Development <p>CSPs:</p> <ul style="list-style-type: none"> * 073 - Embedding Continuous Improvement across the NIHR CRN
3. Embedding research into health and care				
3.1	Facilitating the awareness of research and its importance amongst all health and care staff, including students, non-clinical roles, support departments, and temporary staff.	<p>A range of resources and support is available from our Communications and Workforce Development Teams to support our Partner Organisations in raising awareness of research across their organisations. We are growing links with our local Higher Education Institutions to support with research awareness and understanding at a student level.</p> <p>Our specialty events support in developing awareness and our Direct Delivery Team play an important role in boosting research understanding in new settings, particularly in Primary Care and outside the NHS.</p>	* Project 3a (clinical support services) * Project 3b (API scheme engagement)	<p>POF:</p> <ul style="list-style-type: none"> * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development <p>CSPs:</p> <ul style="list-style-type: none"> * 078 - Health and Care Services Engagement

3.2	Supporting cultural change in organisations that facilitates research being an integral and expected part of patient care	Organisational development expertise is available from our Workforce Development Team who are regularly asked to support with culture change and discovery projects. Recent projects to support cultural change include our work in hospices and care homes (ENRICH), and the work by our Direct Delivery Team across Primary Care and non-NHS sites.	* Project 1a (hospice and care home funding)	POF: * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development CSPs:
3.3	Building partnerships to embed research in public health and social care	CRN funds a number of roles leading and supporting research within Local Authorities across the region. This work is supported by our current Public Health Specialty Lead who will soon be joined by a new Social Care Specialty Lead. Support for Research Delivery is provided by our Direct Delivery Team who have experience working in schools, care homes, hospices and other public health / social care settings.	* Project 5a (social care event) * Project 1a (hospice and care home funding)	POF: * 17 - Research Delivery * 21 - Health and Care Services Engagement CSPs: * 078 - Health and Care Services Engagement * 092 - NIHR ENRICH Delivery in Local Clinical Research Networks
3.4	Advocating for research delivery within the health and care system, especially at leadership level.	The Senior Leadership Team and Lead NMAHP advocate for research delivery at senior levels, liaising with executive and senior colleagues across the health and care system. Our research delivery managers and specialty leadership advocate for research delivery at a specialty-specific level and our Direct Delivery Team advocate for research delivery in out-of-hospital settings.	* Project 3c (specialty leadership appraisal)	POF: * 14 - General Management * 16 - CRN Specialities * 19 - Communications * 21 - Health and Care Services Engagement CSPs: * 003 - LCRN Leadership and Management
3.5	Providing opportunities for health and care professionals to learn about research and get involved in research in their organisation.	As part of our learning and development offer, we offer a number of training courses and micro-learning resources to support health and care professionals learn about research. This is supported by the work of our Communications Team through our use of staff stories and the annual Your Path in Research Campaign. Through our development funding and setting-specific projects (e.g. hospice funding model, ENRICH, Direct Delivery Team), we facilitate opportunities to engage and support those new to research.	* Project 3b (API scheme engagement) * Project 1a (hospice and care home funding)	POF: * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development CSPs: * 016 - Communications * 078 - Health and Care Services Engagement
3.6	Leading and supporting initiatives to engage with the public and promote research as part of the patient experience.	Our community engagement work - including the Research Champions and Research Ready Communities programmes - offers a route to directly engage with the public and promote research. We provide a range of resources to our Partner Organisations to support them in promoting research to patients.	* Project 1c (community engagement funding)	POF: * 19 - Communications * 20 - Patient and Public Involvement and Engagement * 21 - Health and Care Services Engagement CSPs: * 016 - Communications * 058 - Public and Patient Involvement and Engagement * 070 - Participant in Research Experience Survey * 072 - Public and Patient Involvement and Engagement Impact Framework * 074 - Public Research Champions * 093 - Research Ready Communities
3.7	Drawing on the expertise and support of our specialty and settings leadership, including specialty leads and champions.	The LCRN benefits from the wisdom and guidance of c40 leaders across a diversity of specialties, settings and organisations. This includes paid roles such as our Divisional Research Leads, Local Specialty Research Leads, GP Champions and volunteers such as champion roles and sub-specialty leads. The DRL group is a governance group of the LCRN, working with the Senior Leadership Team and Research Delivery Managers to direct, review and drive forward CRN business. At a specialty and setting level each LSRL meets regularly with their RDM counterpart. Together they set annual specialty objectives, organise events and communities of practice. They engage with colleagues across the region, providing feedback and expertise to national specialty groups and networks.	* Project 3c (specialty leadership appraisal)	POF: * 14 - General Management * 16 - CRN Specialities CSPs: * 003 - LCRN Leadership and Management * 080 - National Specialty Group Terms of Reference * 081 - Local Specialty Research Lead (LSRL) Appointment Recommendations and Role Description * 087 - Local Champion * 089 - Local Imaging Champion * 098 - Local Speciality Research Lead Induction Checklist

4. Fostering an effective and sustainable research delivery infrastructure

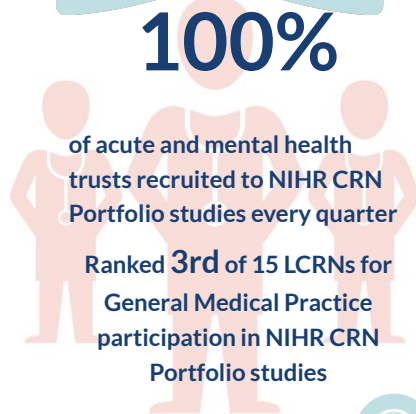
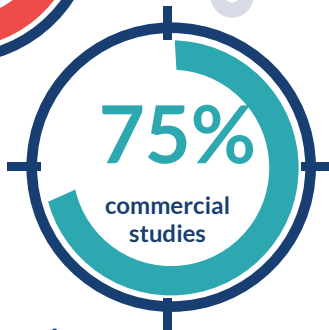
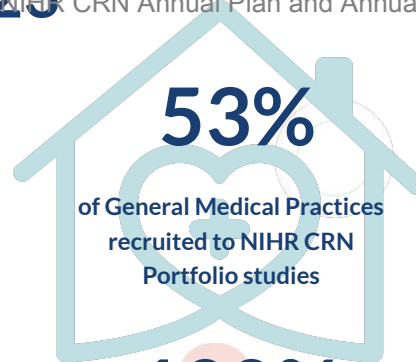
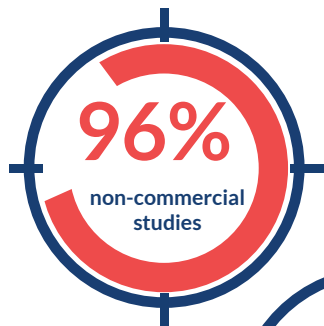
4.1	Facilitating return on investment and meaningful scientific results through study performance monitoring and support.	<p>The LCRN provides the tools that allow for the performance management and monitoring of studies across the NIHR portfolio. This includes the provision of EDGE; our local portfolio management system to our Partner Organisations. Our Business Intelligence Team supports colleagues in using these systems and is responsible for analysis and reporting at a regional level. The timely and accurate completion of data is supported by our portfolio facilitators.</p> <p>Where issues or opportunities are identified through performance monitoring, Research Delivery Managers and Local Specialty Research Leads are able to help troubleshoot and identify solutions. They share intelligence and experience across our national CRN network, connect sites together to share best practice and offer cross-organisational support.</p> <p>Our Research Delivery Managers assume the Performance Review Lead as standard across both commercial and non-commercial studies.</p>	* Project 4a (Research Reset)	<p>POF:</p> <ul style="list-style-type: none"> * 14 - General Management * 15 - Financial Management * 16 - CRN Specialities * 17 - Research Delivery * 18 - Information and Knowledge * 23 - Business Development and Marketing <p>CSPs:</p> <ul style="list-style-type: none"> * 004 - NIHR CRN Funding Reporting * 006 - Income distribution from NIHR CRN Industry Portfolio Studies * 007 - LCRN Minimum Financial Controls * 052 - CRN Study Support Service Study Performance Monitoring
4.2	Supporting local Chief Investigators in designing and leading high quality, deliverable portfolio studies.	<p>Our Study Support Service assists in the planning, placing and performance of studies. We strive to support studies in delivering to time and target and to meet sponsor and funder expectations.</p> <p>This includes our Early Contact and Engagement service, who offer a protocol review service to advise on deliverability within the health and care system. We can link with and signpost to opportunities and other relevant organisations such as the Research Design Service. Our specialty leadership are able to provide specialty-specific expertise, both at local level and as part of the national specialty group structure. We are piloting the pre-funding feasibility review process, again providing advice and expertise to help improve the success of studies in their delivery.</p> <p>We run specific programmes and learning events to support Chief Investigators, including our Research Scholars' Scheme and talks at our specialty events.</p>	* Project 4a (Research Reset) * Project 3c (maximising their reach) * Project 4d (Pre-Funding Feasibility Programme)	<p>POF:</p> <ul style="list-style-type: none"> * 16 - CRN Specialities * 17 - Research Delivery * 22 - Workforce Learning and Organisational Development <p>CSPs:</p> <ul style="list-style-type: none"> * 042 - Principles and Process for Setting and Amending Study and Site Targets; Standard Operating Procedure * 043 - CRN Study Support Service Principles for Local CRN Site Identification Process for Commercial Studies - Standard Operating Procedure * 049 - CRN Study Support Service for Activity Attribution Support and Review * 050 - CRN Study Support Service Early Contact and Engagement Standard Operating Procedure * 052 - CRN Study Support Service Study Performance Monitoring * 054 - CRN Study Support Service Optimising Delivery and Effective Study Start-up for Non-Commercial Studies Standard Operating Procedure * 071 - Principles for Provision of a Support Service for Non-NHS Settings, including Local Set-up Activities
4.3	Funding partner organisations (including NHS Trusts, GP practices and hospices) through our annual model and strategic development funding, balancing stability and growth.	<p>The CRN provides funding to support research in a variety of health and care organisations, including:</p> <ul style="list-style-type: none"> * £14m of annual funding for our Partner Organisations, including the Research Site Initiative Scheme for Primary Care organisations * £0.5m of strategic funding (CRN Development Bids), to which partners can apply to pump-prime projects that support the growth and develop of research capacity and capability. This includes funding for projects such as "GPs in the Deep End" that aim to support practices in geographies that are under-served by research become research active. * Funding for research in new settings, such as care homes (the ENRICH scheme) and hospices * £0.75m towards the CRN-managed Direct Delivery Team, who deliver research in non-NHS Settings <p>Our annual funding model has been developed in collaboration with our Partner Organisations, including at R&D Manager level and is based around a series of shared principles that balance stability and growth. This model is debated and approved by our Partnership Group.</p>	* Project 1a (hospice and care home funding) * Project 3a (clinical support services) * Project 4b (strategic funding evaluation)	<p>POF:</p> <ul style="list-style-type: none"> * 15 - Financial Management <p>CSPs:</p> <ul style="list-style-type: none"> * 004 - NIHR CRN Funding Reporting * 006 - Income distribution from NIHR CRN Industry Portfolio Studies * 007 - LCRN Minimum Financial Controls * 052 - CRN Study Support Service Study Performance Monitoring * 068 - NIHR CRN Support for Research in Wider Health and Care Settings * 096 - Payment of Clinical Commissioning Group Excess Treatment Costs Standard Operating Procedure

4.4	Acting as an ally and champion for Research and Development management and leadership, acting as a critical friend in maximising efficiency of local operations.	The LCRN is placed in a key role for championing and advocating for local issues at a national level. We maintain close relationships with R&D Managers in our Partner Organisations, including through our locality link roles and regular R&D Managers' meetings; we discuss shared challenges and approaches and build local intelligence to guide national activity. Through R&D partnerships with Senior Leadership, A/RDM and workstream leads, we are able to offer support and constructive challenge where appropriate. We involve R&D Managers in the work of the CRN, through representation on our Operational Management Group and R&D colleagues have played a key role in the development of our regional strategy.		POF: * 14 - General Management * 16 - CRN Specialities * 21 - Health and Care Services Engagement * 23 - Business Development and Marketing CSPs: * 078 - Health and Care Services Engagement
4.5	Identifying and supporting a future talent pipeline, including engagement with trainees and students.	Our Communications and Workforce Development teams support national initiatives to support trainees and students, including the annual Your Path in Research campaign and materials for undergraduate nursing courses. This is supported by local initiatives to engage with Severn Deanery trainee networks at a specialty specific level (including funding the national PACT Primary Care network), our Research Scholars' programme, the Associate PI Scheme and events aimed at those new to research.	* Project 3b (API scheme engagement)	POF: * 16 - CRN Specialities * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development CSPs: * 016 - Communications
4.6	Adapting in a timely, pragmatic and sensitive manner to changing external factors and government priorities.	We have developed a governance and operational management structure that allows us to respond to emerging issues in a timely and proportionate way. As part of our continuous improvement work we have reflected and learned from our response to the Covid-19 pandemic and the ways we were able to model an agile response to changing needs. Our Direct Delivery Team, in particular, allows us to pivot our research delivery support quickly. Our strategic development funding allows us to support emerging needs.	* Project 4a (Research Reset) * Project 5b (commercial partnerships)	POF: * 14 - General Management * 21 - Health and Care Services Engagement * 23 - Business Development and Marketing CSPs: * 003 - LCRN Leadership and Management * 090 - LCRN Risk Register * 097 - LCRN Planning, Reporting, Review and Monitoring * 091 - NIHR CRN Urgent Public Health Response
4.7	Facilitating a smooth transition to the new Regional Research Delivery Networks.	The COO has been appointed as an RRDN Transition Lead, forming part of a national group supporting the transition as well as navigating the move from LCRN to RRDN at a local level with our host organisation. We have a particular focus on the wellbeing and support of our Core Team. As well as our day-to-day development and wellbeing offer we have boosted efforts to obtain timely feedback and provide targeted support in relation to change and uncertainty.	* Project 4c (RRDN transition)	POF: * 14 - General Management * 22 - Workforce Learning and Organisational Development CSPs:
4.8	Developing relationships with industry partners, maximising the diversity of income streams for Partner Organisations.	As part of the Study Support Service, A/RDMs conduct study start up calls with sponsors/ CROs for new commercial lead network studies to discuss how the CRN can help in the smooth set up and delivery of the study and to identify challenges and opportunities. As standard A/RDMs in the West of England take on the Performance Review Lead role for all commercial lead network studies making them the study specific main point of contact in the CRN for these sponsors/ CROs. The NCVR is a standardised approach to costing for commercial research and the iCT tariffs are adopted by all CRN WE sites, thus making the set up of commercial studies simple and efficient in the West of England. We have Industry Community of Practices (COPs) covering both primary and secondary care which share best practice and collectively work on challenges as a group. Representatives from commercial sponsors/ CROs are invited to speak at region-wide events and community of practice meetings to showcase the current and future portfolio of work. The Commercial Identity group was formed as part of our Continuous Improvement work, and is led by R&D Management from UHBW, NBT and Primary Care. The group focuses on how we strengthen and communicate our regional identity and ways of working for commercial research, while preserving individual site identity. This includes creating promotional material for Primary Care, sponsor specific 'meet and greet' events to facilitate introductions and relationships between sponsors/ CROs and sites for future work, and evaluating and sharing lessons learned from models of working for key commercial studies to inform future ways of working.	* Project 5b (commercial partnerships)	POF: * 17 - Research Delivery * 23 - Business Development and Marketing CSPs: * 055 - CRN Study Support Service for Effective Study Start-Up - Commercial Studies Standard Operating Procedure

4.9	Offering a Direct Delivery Team that can deliver research in non-NHS settings and can respond flexibly to evolving needs.	In response to the Transforming Research funding provided from 2021 we grew our existing WE ReACH Direct Delivery Team, capitalising on the learning and success of that team. We have developed clear principles for DDT support, including essential and weighted criteria for assessing referrals for support, and monitoring the team's impact through a quarterly report. The team includes a number of site and setting specific link roles to support the growth of research in non-NHS settings.		POF: * 14 - General Management * 17 - Research Delivery CSPs:
5. Collaborating across the health and social care system				
5.1	Identifying and nurturing opportunities for sharing best practice, learning and collaborative working across partner organisations and within specialities.	<p>Our learning and development courses are designed around peer learning, allowing attendees to network and to share best practice and experiences across our regional network. This is supported by our communications activity, with staff stories and case studies used to share examples of best practice and by our annual awards event where we recognise and showcase staff and site successes.</p> <p>This networking and peer learning is embedded in our day-to-day work, through the speciality-specific communities of practice and events that our Research Delivery Managers facilitate, and specific capacity-building schemes such as the hospice network and the ENRICH care home initiative. Our Direct Delivery Team also support the sharing and role modelling of best practice across Primary Care and non-NHS settings.</p> <p>Our annual planning process with Partner Organisations is designed around sharing best practice and identifying opportunities for collaboration and for continuous improvement. This is supported by our ongoing continuous improvement programme, overseen by our Operational Management Group.</p>	* Project 3b (API scheme engagement)	POF: * 16 - CRN Specialities * 19 - Communications * 22 - Workforce Learning and Organisational Development CSPs: * 016 - Communications
5.2	Facilitating the integration of research across settings (e.g. between secondary and primary care, between NHS and non-NHS) to match patient care pathways.	<p>CRN WE encourages research across settings by providing opportunities for colleagues to come together and discuss collaboration, develop new processes and share best practice. Examples of this include the Primary Care Commercial Community of Practice group which provides a space for commercially active primary care sites to come together and invites other settings to bring ideas for development and evaluation.</p> <p>Our Direct Delivery Team are experienced in working across settings and provide knowledge and resource to facilitate working across boundaries.</p> <p>Representatives from the Integrated Care Boards have been invited to attend the CRN WE Partnership Group to ensure these settings are contributing to the planning and decision making related to research delivery in the region.</p> <p>The operationalisation of national projects and recommendations from the Primary Care National Strategy like the Patient Identification Centre project are making collaboration between settings equitable and ensuring incentivisation and visualisation of research activity conducted in both NHS and non-NHS settings.</p> <p>CRN WE continues to develop knowledge, promote CRN services and engage new settings in Social Care and Public Health settings to provide opportunities for these areas to engage with research.</p>	* Project 5a (social care event)	POF: * 17 - Research Delivery * 21 - Health and Care Services Engagement CSPs:
5.3	Linking with other elements in the research pathway, such as design (e.g. RDS, HEIs), early phase research (e.g. BRCs, CRFs) and implementation (e.g. AHSN, ARCs).	<p>CRN WE maintains strong relationships with research partners across the region, both as part of collaborative forums (e.g. NIHR at Bristol, People in Health West of England, NIHR Communications South West) and through representation on each others' partnership boards (e.g. ARC, AHSN).</p> <p>We maintain excellent relationships at operational levels, with our Study Support Service benefiting from effective working relationships with the RDS and HEIs. The Workforce Development Team share resources across these organisations.</p>	* Project 5b (commercial partnerships) * Project 4d (Pre-Funding Feasibility Programme)	POF: * 21 - Health and Care Services Engagement CSPs:

5.4	Working nationally across CRN regions and NIHR arms to share best practice, avoid duplication and create connections.	<p>The model of the CRN is designed around collaborative working between regions and local colleagues are part of many national working groups and programmes. Almost all workstreams and job roles have a national forum and a supra-regional forum where shared opportunities, challenges and projects are discussed. In our most recent annual review the CRN Executive commented on the CRN WE's notable role in being involved and/or leading national programmes and groups.</p> <p>This model of collaborative working is replicated locally through groups such as the NIHR at Bristol group, the NIHR at Bristol Training group, and People in Health West of England.</p>	<ul style="list-style-type: none"> * Project 4b (strategic funding evaluation) * Project 5a (social care event) * Project 5b (commercial partnerships) 	<p>POF:</p> <ul style="list-style-type: none"> * 14 - General Management * 16 - CRN Specialities * 17 - Research Delivery * 18 - Information and Knowledge * 19 - Communications * 21 - Health and Care Services Engagement * 22 - Workforce Learning and Organisational Development <p>CSPs:</p>
5.5	Building and maintaining effective relationships with current and future commercial and non-commercial sponsors.	<p>We engage with commercial and non-commercial sponsors on a per study basis through the Early Contact and Engagement elements of the Study Support Service; offering advice, signposting and support. A/RDMs conduct study start up calls with study teams to identify challenges and opportunities, and as the Performance Review Lead they work with the Portfolio Facilitators to provide a comprehensive performance monitoring service for all lead network studies which enables early intervention and support to be given as needed. Our Industry Senior Facilitator also engages with Industry sponsors on a more strategic level, promoting the region alongside trouble shooting issues.</p> <p>The SSS Manager and AcoRD Specialists work with grant award teams for non-commercial sponsors in the NHS and HEIs when they are working on grant submissions as well as through the study approval process and applications to the NIHR portfolio. We host a regional AcoRD meeting and we have representatives from all our HEIs and NHS Sponsors.</p>	<ul style="list-style-type: none"> * Project 5b (commercial partnerships) 	<p>POF:</p> <ul style="list-style-type: none"> * 17 - Research Delivery * 23 - Business Development and Marketing <p>CSPs:</p> <ul style="list-style-type: none"> * 055 - CRN Study Support Service for Effective Study Start-Up - Commercial Studies Standard Operating Procedure

CRN WE's Year in numbers 2022/23



131% of our annual stretch ambition of 1,956 PRES responses



Sites recruited to **643** studies

Ranked **2nd** of 15 LCRNs for recruitment per million population to NIHR CRN Portfolio studies

closed to recruitment achieving their recruitment target where CRN WE was lead LCRN

Ranked **3rd** of 15 LCRNs for General Medical Practice participation in NIHR CRN Portfolio studies

CRN West of England Highlight Report

Reset - Reset forms a standing agenda item for Clinical Research Network West of England's (CRN WE's) monthly Research and Development (R&D) Management community meeting and the LCRN actively facilitates the sharing of best practices across sites. Study Performance Review Lead responsibilities are distributed across CRN WE's Research Delivery Managers and Portfolio Facilitators who maintain relationships with all study teams in the region, with a particular focus on Reset studies. Data are routinely chased for accuracy and system-wide solutions offered for struggling studies.

Life Sciences Industry - Encouraging collaboration across Primary and Secondary Care, CRN WE brought together an established trust-based industry leads group and a group of commercially active/interested primary care sites. Together, the aim is to increase patient referrals between settings. Projects have been developed to address identified barriers. CRN WE's work coordinating the HARMONIE trial (CPMS ID: 51978) further exemplifies cross-setting collaborations. CRN WE had 5 primary care sites recruiting into the HARMONIE trial and, in turn, achieved high levels of recruitment into the trial from GP practices. Throughout 2022/23, CRN WE recruited strongly from primary care settings in general. As part of the Commercial Performance Review Lead (COMPeaRL) initiative, CRN WE has taken on Performance Review Lead responsibilities for all new, locally-led industry studies.

Local Initiatives - CRN WE's Direct Delivery Team continues to be hugely successful in non-hospital research delivery, supporting 27 studies across six settings, including GP surgeries, local authorities, care homes, hospices, universities and the wider community. A particular highlight has been CRN WE's contribution to AvonCAP GP (CPMS ID: 51111), a locally-led surveillance study of respiratory infections in primary care. CRN WE supported the recruitment of over 1,800 participants and helped to develop Standard Operating Procedures for recruitment in care homes and the consent of adults lacking capacity. This year, team members have also taken on new 'link roles', supporting hospices, community engagement, Enabling Research in Care Homes (ENRiCH) and Participant in Research Experience Survey (PRES) delivery.

CRN WE introduced a new hospice funding model in 2022/23, funding research infrastructure in three hospice sites and dedicated time from a research nurse in the most research active hospice to mentor the more research-naïve sites. Following a successful pilot, the LCRN is expanding the scheme to six sites in 2023/24.

CRN WE is actively building relationships with the new Integrated Care Boards (ICBs) including CRN WE forming part of steering groups, promoting research benefits and supporting the formation of new ICB-level research oversight groups.

Building on last year's PRES successes, CRN WE received 2,566 responses across 203 studies. This reflects the LCRN's focus on encouraging survey engagement in primary care and non-NHS settings and across a diversity of studies. In July 2022, CRN WE appointed its first Community Engagement Officer. This brand new role across the national CRN Network has allowed CRN WE to share learning with other LCRNs. CRN WE also led a call aimed at community organisations across the region, inviting ideas and awarding funding for five engagement projects to promote awareness of health and care research. This complements the LCRN's Research Ready Communities project, where CRN WE partnered with members of the Goan community in Swindon.

This year, CRN WE launched its inaugural Research Scholars' Programme, providing funding and learning and development support for five future research leaders. CRN WE is also proud of the findings from its second annual Core Team Engagement and Experience Survey, where 92% of colleagues reported being satisfied with the LCRN as a place to work, up from 71% in 2021. CRN WE also ran the survey on behalf of two other LCRNs, allowing for benchmarking between each other and the sharing of best practice.



Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Reporting Committee	Finance, Digital and Estates Committee July 2023
Chaired By	Martin Sykes, Non-Executive Director
Executive Lead	Neil Kemsley, Chief Financial Officer Neil Darvill, Chief Digital and Information Officer

For Information

The committee received the monthly update on progress against the Digital Strategy. The new CDIO had instigated a review of digital governance including risk management and strategy development. An externally supported review of the Trust infrastructure and cybersecurity resilience had also been scheduled.

The project to implement digital noting in 141 outpatient subspecialties was nearing completion and the Committee commended the team for the rapid and successful rollout. It was noted however that this had not been without some disruption to services (reduced clinic capacity for example). The Committee discussed how learning might be applied to other large-scale implementations.

In response to an earlier request from the Committee a report on telephony within the Trust was presented and discussed. In a typical day in June there were more than 30,000 calls (18,000 external and 12,000 internal) of which 13,000 were unanswered (3,000 busy and 10,000 unanswered). The transformation team were reviewing the data with a view to improving processes and the Assistant Chief Nurse is examining ward-based calls with a view to improving responsiveness and advice. The Committee supported both reviews and will follow-up at the appropriate time.

The monthly finance report and update was noted. The Q1 position showed a £2.1m deficit against plan arising through a shortfall on savings (£0.8m) and addition costs of strike action (£1.4m).

A number of actions were highlighted and discussed, including enhanced support to Divisions with the greatest variances. An additional report from the Deputy Chief Nurse highlighted an opportunity to review and strengthen internal nurse rostering controls to reduce reliance on high-cost agency (although good progress had already been made in this area).

This was the first meeting to incorporate Estates and Facilities. At this stage the discussion was limited to an update on the fire improvement plan and a discussion on how best to incorporate Estates into the meeting. An immediate issue was that the meeting would need to be longer.

For Board Awareness, Action or Response

The contract to provide additional community diagnostic services in Weston has now been finalised and signed.



Key Decisions and Actions	
An outline business case to potentially centralise aseptic pharmacy services within BNSSG was reviewed and supported.	
Additional Chair Comments	
Date of next meeting:	26 th September 2023

Meeting of the Trust Board of Directors in Public on Tuesday 12 September 2023

Report Title	M4 Trust Finance Performance Report
Report Author	Jeremy Spearing, Director of Operational Finance
Executive Lead	Neil Kemsley, Chief Financial Officer

1. Purpose
To inform the Trust Board of the Trust's overall financial performance from 1 st April 2023 to 31 st July 2023 (month 4).
2. Key points to note <i>(Including any previous decisions taken)</i>
<p>The Trust's net income and expenditure position is a net deficit of £9.4m against a planned deficit of £5.8m. The adverse position against plan of £3.6m is due to higher than planned operating expenditure driven by the estimated financial impact of industrial action of £2.6m and the shortfall on savings delivery of £1.0m.</p> <p>The Trust delivered savings of £6.1m year to date, £1.0m behind plan. All services are being supported to identify 100% of their recurrent savings target by the end of September.</p> <p>The value of elective activity was £3.5m (or 1%) ahead of plan in the period including over-performance on pass-through drugs and devices of £1.8m despite the impact of industrial action.</p> <p>The Trust delivered capital investment of £9.8m year to date.</p> <p>The Trust's cash position was £108.1m as at the 31st July 2023.</p>
3. Strategic Alignment
This report is directly linked to the Patient First objective of 'Making the most of our resources'. Achieving break-even ensures our cash balances are maintained and therefore we can continue to support the Trust's strategic ambitions subject to securing CDEL cover.
4. Risks and Opportunities
416 – Risk that the Trust fails to fund the strategic capital programme. Unchanged risk score of 20 (very high).
5. Recommendation
This report is for Assurance. The Board is asked to note the Trust's financial performance for the first four months of the financial year.
6. History of the paper
Please include details of where paper has <u>previously</u> been received.
N/A

Trust Finance Performance Report

Reporting Month: July 2023

YTD Income & Expenditure Position

- Net I&E deficit of £9,446k against a deficit plan of £5,818k (excluding technical items).
- Total operating income is £11,162k favourable to plan due to higher than planned income from activities of £9,828k (of which c£5,000k is related to the pay award) and higher than planned other operating income of £1,334k.
- Operating expenses are £16,514k adverse to plan due to higher pay (£10,140k of which c£5,000k is related to the pay award) and non-pay expenditure (£6,191k). Depreciation is broadly in line with plan.
- Financing items are £1,631k favourable to plan mainly due to interest receivable.

Key Financial Issues

- *Recurrent savings delivery below plan* – Internal CIP delivery is £5,769k or 92% of plan, of which recurrent savings are £2,493k, 40% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full will result in the Trust failing to meet the financial plan.
- *Delivery of elective activity recovery below plan* – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m, resulting in the Trust not achieving its financial plan. At M4, the value of elective activity is £1.7m ahead of plan.
- *Corporate mitigations not delivered in full* – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan.
- *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.

Strategic Risks

- Assessment and implications of the financial arrangements relating to Healthy Weston 2 Phase 2 – pending completion of the business case in December 2023;
- Understanding the operational risks and mitigations associated with the Trust's legacy estate and how the CDEL limit and system prioritisation restricts future strategic capital investment – pending completion of the ICB and Trust draft medium term capital plan in October 2023;
- Understanding the implications of the Trust's recurrent revenue deficit of c£60m, i.e. the requirement to present a medium-term financial plan in October 2023 to address the Trust's recurrent deficit and the impact this will have on future clinical strategy and Trust autonomy.

Reporting Month: July 2023

Successes	Priorities
<ul style="list-style-type: none"> • Delivery of capital investment of £9.8m at the end of July. • The Trust’s cash position remains strong at £108.1m. • BPPC continues to be maintained with 92% of invoices by value and 91% by volume paid within 30 days. • The value of elective activity is £3.5m ahead of plan. • Trust is one of the few organisations within the South-West within its planned spend for agency (see Appendix 2). • Reduction in the use of Tier 4 agency shifts maintained and c85% less compared with July 2022. • Significant improvement in productivity across BNSSG (+7.7%) since May 2022 (see Appendix 3). • Continued and significant improvement in emergency inpatient average length of stay from 4.3 days in June 2023 to 3.8 days in July 2023 (25% improvement on 5.1 days in July 2022). 	<ul style="list-style-type: none"> • Review the Trust’s core financial controls against NHS England’s “grip and control” measures. • Divisions to prioritise the delivery of their 2023/24 operating plans, including recovery of elective activity to planned levels to enable the Trust to retain ERF. • Divisions and Corporate Services to ensure recurrent CIP schemes are fully identified by the end of quarter 2 to deliver the 2022/23 recurrent CIP shortfall and the 2023/24 recurrent target. • Delivery of the Trust’s non-recurrent corporate mitigations. • Development of the Trust’s revenue Medium-Term Financial Plan and Medium-Term Capital Plan. • EROS requisitioners and budget managers must receipt orders and code invoices promptly to ensure payment within 30 days. • Securing national capital funding for to the Trust’s capital plan.
Opportunities	Risks & Threats
<ul style="list-style-type: none"> • NHS England have confirmed it is reducing the threshold to earn additional Elective Recovery Funding (ERF) for all systems by 2% and will pay 84% of systems planned ERF in recognition of the financial impact of industrial action in April. 	<ul style="list-style-type: none"> • The financial positions of the Trust’s Divisions deteriorate further and potentially undermine the delivery of the Trust’s break-even financial plan. • Workforce supply challenges in hard to fill vacant posts and staff absences continues to impact on the Trust’s ability to meet emergency and elective demand. • Potential for below plan elective recovery during the Winter given system challenges with patient flow. • Under-delivery on the Trust’s savings program will result in the Trust failing to deliver the break-even plan and will contribute to a significant deterioration in the Trust’s underlying deficit. • CDEL, the recurring revenue deficit of the Trust at c£60m and the system at c£98m is likely to constrain the Trust’s strategic capital plans over the next three to five financial years.

Income & Expenditure Summary

Public Board

July 2023

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	83,002	83,395	393	326,763	336,591	9,828
Other Operating Income	9,273	10,852	1,579	37,092	38,426	1,334
Total Operating Income	92,275	94,248	1,973	363,855	375,017	11,162
Employee Expenses	(54,678)	(58,494)	(3,816)	(221,328)	(231,468)	(10,140)
Other Operating Expenses	(35,230)	(34,946)	284	(133,507)	(139,698)	(6,191)
Depreciation (owned & leased)	(3,032)	(3,050)	(18)	(11,758)	(11,941)	(183)
Total Operating Expenditure	(92,940)	(96,490)	(3,550)	(366,593)	(383,107)	(16,514)
PDC	(1,037)	(1,037)	(0)	(4,148)	(4,149)	(1)
Interest Payable	(221)	(224)	(3)	(884)	(908)	(24)
Interest Receivable	250	586	336	1,000	2,679	1,679
Other Gains/(Losses)	0	0	0	0	(23)	(23)
Net Surplus/(Deficit) inc technicals	(1,673)	(2,917)	(1,244)	(6,770)	(10,491)	(3,721)
Remove Capital Donations, Grants, and Donated Asset Depreciation	238	7	(231)	952	1,045	93
Net Surplus/(Deficit) exc technicals	(1,435)	(2,910)	(1,475)	(5,818)	(9,446)	(3,628)

Note: Plan will be adjusted in M5 to reflect additional income and costs associated with the Agenda for Change pay award.

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	(463)	(371)	(92)	(463)	(1.4%)
Medicine	(947)	(687)	(260)	(409)	(0.8%)
Specialised Services	119	(59)	178	284	0.50%
Surgery	(1,447)	(955)	(492)	(1,123)	(1.8%)
Weston	(827)	(493)	(334)	(150)	(0.8%)
Women's & Children's	(2,777)	(2,040)	(737)	(2,289)	(3.2%)
Total	(6,342)	(4,605)	(1,737)	(4,150)	(1.4%)

Key Facts:

- The position at the end of July is a net deficit of £9,446k against a deficit plan of £5,818k. The adverse position against plan of £3,628k is primarily due to the estimated financial impact of industrial action at £2,572k and the shortfall on savings delivery at £1,041k.
- Year-to-date, the Trust has spent £2,225k on costs associated with internationally educated nurses.
- Pay expenditure in July is £3,816k higher than plan. This is mainly driven by additional staffing costs of covering the industrial action, increased bank costs and a higher number of substantive staff in post.
- Agency expenditure in month is £2,064k, compared with £2,389k in June. Bank expenditure in month is £3,432k, compared with £2,931k in June.
- Other operating expenditure is £284k lower than plan in July.
- Total operating income is ahead of plan in July by £1,973k, of which £1,579k is Other Operating Income, £1,000k of which relates to funding from NHS England to support Internationally Educated Nurse (IEN) recruitment.
- The financial position of the clinical divisions deteriorated by £1,737k in July to a YTD overspend against budget of £6,342k or 2.1%. Excluding the cost of industrial action, this reduces to £4,150k or 1.4%.
- The majority of the £1,737k deterioration remains in two Divisions: Surgery £492k; and Women's & Childrens £737k. Specialised Services improved its position by £178k in July.

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Savings – Cost Improvement Programme

Public Board



University Hospitals
Bristol and Weston
NHS Foundation Trust

July 2023

Division	YTD					Forecast Outturn				
	Plan £'000	Recurring £'000	Non- Recurring £'000	Total £'000	Variance (Fav/(Adv)) £'000	Plan £'000	Recurring £'000	Non- Recurring £'000	Total £'000	Variance (Fav/(Adv)) £'000
Diagnostics & Therapies	858	100	895	995	137	2,383	435	2,323	2,757	374
Medicine	579	376	393	768	189	2,112	924	1,160	2,084	(29)
Specialised Services	484	352	218	570	86	1,658	1,192	760	1,952	294
Surgery	959	166	277	443	(516)	2,932	887	799	1,686	(1,247)
Weston	166	251	50	301	135	510	591	150	741	230
Women's & Children's	1,244	614	815	1,429	184	3,787	1,904	2,427	4,331	544
Estates & Facilities	329	134	201	334	6	1,028	498	430	928	(100)
Finance	82	82	-	82	0	245	245	-	245	0
HR	45	33	22	56	11	135	100	67	167	32
Digital Services	219	3	55	57	(162)	574	8	185	193	(381)
Trust HQ	190	50	17	67	(123)	569	151	50	201	(369)
Corporate	464	333	333	667	203	1,391	1,000	1,000	2,000	609
OP Transformation & Demand Management	625	-	-	-	(625)	1,875	-	-	-	(1,875)
Divisional Sub Totals	6,243	2,493	3,276	5,769	(474)	19,200	7,935	9,349	17,284	(1,916)
Urgent & Emergency Care Transformation Plans	872	305	-	305	(567)	7,850	766	-	766	(7,084)
Grand Totals	7,116	2,798	3,276	6,074	(1,041)	27,050	8,701	9,349	18,050	(9,000)

Key Points:

- The Trust's 2023/24 savings target is £27,050k. This includes £7,850k attributable to Urgent & Emergency Care Transformation Plans.
- Urgent & Emergency Care Transformation savings are planned to begin delivery from July 2023.
- At the end of July, the Trust had achieved savings of £6,074k, or 85% against a plan of £7,116k, resulting in a shortfall of £1,041k.
- The current year forecast outturn for 2023/24 is £18,050k against a plan of £27,050. £7,084k of the shortfall currently assumes under delivery of Urgent & Emergency Care Transformation savings, pending assessment.
- The recurring forecast outturn for 2023/24 is £9,192k resulting in a recurring savings shortfall of £17,858k.
- At month 4, all divisions apart from Finance & Weston, had a shortfall against their recurring plans and five of the divisions had a shortfall against their non-recurring plans.
- Currently, 48% of forecast identified savings are non-recurrent, which is a major cause for concern. A significant step change in the identification and delivery of savings is paramount to securing the full delivery of CIP on a recurring basis.

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Appendix 1 – Action Log

Public Board

Summary of Recovery Actions

Ref	Date	Description of Action	Action Own	Date Due	Committee Month	Status	Revised date	Update
014	Jun-21	Present the Trust Five Year Financial Strategy	OpDoF	Oct-21	November	Open	Q2 2023/24	Pending the release of the BNSSG ICB Joint Clinical Strategy – expected June 2023
030	May-22	Include a summary of the ICS financial position	HoFFP	TBC		Open	TBC	Reporting of the ICS financial position currently under discussion
036	Jun-22	Development of a financial recovery plan	CFO	Nov-22	December	Open	Q2 2023/24	BNSSG ICB will require a three year financial recovery plan by the end of Q2 2023 that addresses the Trust's recurrent deficit.
044	Jul-22	Review and address increased costs for patient transport services. (Trust Services)	HoFMI	Aug-22	September	Open	TBC	Subject to system wide procurement of non-emergency patient transport during Q4 - system process not yet concluded (March 2023)
047	Nov-22	Focus on increasing Somerset Surgical Services activity through theatres.	HoFMI	Mar-23	April	Open	Q1 2023/24	Work on-going.
052	Dec-22	HFMA C2 - Review where run-rate reporting is being used routinely and identify where additional reporting may be beneficial.	HoFFP	Apr-23	May	Closed	Q2 2023/24	Run rate reporting is available to budget holders via ProFin. Run rate reporting is also used at divisional and Trust level to identify trends. The use of run rate reporting as a tool to manage the financial position will be included within the financial training programme for new budget holders.
054	Dec-22	HFMA G5 - Review policies to identify gaps	HoFFP	Jan-23	February	Open	Q1 2023/24	Review has been re-prioritised due to operational planning commitments. However, the department is represented in the membership of the Trust's Policy Group. Current finance policies remain in date.
055	Dec-22	HFMA H - Rollout revised financial training programme	HoFFP	Apr-23	May	Open	Q2 2023/24	Planning for the financial training programme will commence Q2 2023/24.

Key:

Role	Description	Name
CFO	Chief Financial Officer	Neil Kemsley
OpDoF	Operational Director of Finance	Jeremy Spearling
HoFMI	Head of Financial Management & Improvement	Dean Bodill
HoFFP	Head of Finance - Financial Performance	Kate Herrick



**Meeting of the Trust Board of Directors in Public on Tuesday 12 September
2023**

Reporting Committee	People Committee on Tuesday 27 July 2023
Chaired By	Bernard Galton, Non-executive Director
Executive Lead	Emma Wood, Chief People Officer

For Information

The meeting focussed on items relating to the People Strategy pillars: Inclusion and Belonging Looking after our People together with emerging strategic items. Agenda items included:

- Two Way Communication Tools
- Trust Equality Reports
- Conflict and Bullying Report Annual Health and Safety Report
- Violence and Aggression Report
- Retention Strategy

For Board Awareness, Action or Response

The Director of Communications gave an excellent presentation on the opportunities that exist to make a step change in the way we improve two-way communications with Trust employees. The development will require investment and needs to be coordinated with the work currently underway on Branding and Patient First. The Committee agreed that this item should be brought back for a discussion at the November meeting.

An update on the current Industrial Action was provided by the CPO and the Chief Medical Officer who aired his concerns about the ongoing Junior Doctors dispute. The Provider collaborative work on a future recruitment Shared Service was commended but it was felt that this needed a more detailed Committee discussion later in the year.

The positive position on International Nurse recruitment was noted but concern was expressed about the ongoing problem with sourcing appropriate living accommodation in Bristol.

The Equality Reports demonstrated improvements with many of the WRES and WDES indicators but there is still much to be done. The Bridges development programme was sighted as a very positive initiative and plans to expand the programme were discussed.

The Committee noted the significant work being undertaken to improve the management and resolution of issues relating to Violence and Bullying. The different policies are being brought together as the "Respecting Everyone" initiative with a launch of the new policies on 13th November which is World Kindness Day

The HR business Partner for Medicine gave a very interesting presentation on workforce issues within that Division and the work being undertaken to improve Flexible Working options for staff.



Key Decisions and Actions	
<p>The Freedom to Speak Up report evidenced a reduction in issues raised during the last quarter. Whilst this was seen as positive, it was felt that further could be done to make it easier for staff to raise issues and to improve responses and resolution times. Jayne Mee suggested that this may be the time to have a Big Conversation on this topic across the organisation and it was agreed that this should be taken forward.</p>	
Additional Chair Comments	
<p>I thanked Charlotte Nicol for her excellent work as the People EDI manager and wished her well in her new role in at the Royal United Hospitals in Bath.</p>	
Update from ICB Committee	
<p>I attended the ICB People Committee on Monday 31st July. The Workforce Strategy is developing, and clear progress has been made on a significant collaborative project on Temporary workforce. The overall financial and operating improvements demonstrate what can be achieved by a system collaborative approach.</p>	
Date of next meeting:	28 September 2023



Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Report Title	Framework of Quality Assurance for Responsible Officers and Revalidation Annex D annual board report and statement of compliance
Report Author	Anne Frampton, Deputy Chief Medical Officer
Executive Lead	Stuart Walker, Chief Medical Officer

1. Purpose
To demonstrate compliance with regulations and key national guidance related to appraisal and revalidation
2. Key points to note (Including any previous decisions taken)
<p>Overall appraisal and revalidation at UHBW has continued in a positive direction since the end of the covid 19 pandemic though continued work pressure and the junior doctor industrial action have all impacted on the ability to improve the appraisal rate further. All of the actions from the previous board report have been completed with the exception of reviewing the appraisal and revalidation policy which was due for review in March 2023. This will be a priority for the coming year.</p> <p>The HLRO visit in October 2022 was welcomed and very positive and the actions from this are now all underway or complete.</p> <p>The piece of work on EDI was received positively when presented and discussed with appraisers and provides a good baseline for us to build on.</p> <p>In July 2023 a new appraisal lead was appointed and she will take up post in Oct 2023 after a period of handover, and the new deputy RO will also commence their post at this time.</p> <p>Overall conclusion: Overall a good year for revalidation and appraisal, with compliance and revalidation recommendations in line with other similar sized organisations.</p>
3. Strategic Alignment
Statutory reporting requirement
4. Risks and Opportunities
None.
5. Recommendation
<p>This report is for Approval</p> <p>The board is asked to approve this report which provides assurance regarding appraisal and revalidation activity at UHBW prior to submission to NHSE</p>

6. History of the paper Please include details of where paper has <u>previously</u> been received.	
Executive Committee	23 August 2023

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

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

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

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

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

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

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

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of UHBW can confirm that:

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

Action from last year: Nil

Comments: Professor Stuart Walker remains as CMO and RO for UHBW

Action for next year: The deputy RO is stepping down from the post in October 2023 and therefore a handover to the new deputy needs to take place prior to this date. A successor has been identified and this is in action.

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

Yes

Action from last year: Work with clinical chairs to understand the barriers to this and implement appropriate remuneration for all appraisers in line with the trust job planning guidance

Comments: This work has been completed and demonstrates that appraisal capacity within the organisation is sufficient for its requirements. The report and actions are attached as appendix A to this board report

Action for next year: Ensure actions completed and that the number of appraisers within the organisation is maintained and appropriately remunerated for the role.

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

Action from last year: None

Comments: The online appraisal toolkit automatically links to the GMC to ensure visibility of all connected doctors. Regular review of the list of prescribed connections is undertaken to ensure it remains up to date, though bank doctors remain a challenge to ensure they are accurately recorded due to turnover.

Action for next year: Continue to maintain lists

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

Action from last year: Review revalidation policy in Feb 2023 and update as required.

Comments: this has not yet happened due to additional pressures partly as a result of the JDIA and remains a priority for 2023/4

Action for next year: Review and update the revalidation policy before year end 23/4

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

Actions from last year: Peer review visit planned in October 2022

Comments: This review has taken place and the outputs are attached as appendix B along with the action plan. Overall the visit was extremely positive and highlighted areas of good practice as well as some suggestions for improvement around the quality assurance process which has already been completed. All actions are complete or in progress.

Action for next year: Complete any outstanding actions on the plan

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

Action from last year: Nil

Comments: Yes, these doctors are attached and are supported in maintaining their portfolios. All have access to Fourteen Fish and an appraiser, as well as supporting material, to ensure they are aware of their requirements. They are all contacted on an individual basis by the DMD for Revalidation and Appraisal and an individualised plan is made for each depending on their own circumstances.

For clinical fellows our compliance has increased significantly, and we have good visibility of locum and bank doctors though as noted above these doctors remain the most challenging group to identify.

Action for next year: continue

Section 2a – Effective Appraisal

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

Action from last year: Nil

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

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

The new appraisal format and the QA process has highlighted the need for robust summaries as not all information is now uploaded to portfolios. The new change to the appraisal template for 2022/3 is welcomed as this provides a better balance of information and verbal reflection and support appraisers better in providing a balanced summary of the meeting.

Feedback from doctors is that they prefer the new format and find it less onerous to complete.

Action for next year: Nil

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

Action from last year: Implement a quarterly revalidation and appraisal review meeting to highlight those doctors where we are struggling to engage them locally and where no other reason for not undertaking appraisal has been identified and agree issuing of REV 6 notifications.

There remain a few doctors who find it difficult to engage with appraisal and who require multiple attempts and reminders to complete an annual appraisal. Where a doctor has not completed an appraisal in year (other than approved missed appraisals) the appraisal date is bought forward to the beginning of the next year to ensure that the length of time between

¹ For organisations that have adopted the Appraisal 2020 model (recently updated by the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

appraisals is minimised. As an organisation we have not to date actively used the REV 6 notification option for non-appraisers, preferring instead to try to engage them locally, particularly during the pandemic where other factors are often relevant to not appraising. However now that we are returning to business as usual, we should consider using this route where we are finding it difficult to engage doctors locally

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

Action for next year: Continue

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

Action from last year: Review the Appraisal and Revalidation policy in Feb 2023

Comments: this has not yet happened due to additional pressures partly as a result of the JDIA and remains a priority for 2023/4

Action for next year: This remains a priority for 23/24

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

Action from last year: To review both the number of appraisers and the number of appraisals undertaken to ensure that this remains the case post-merger

Comments: This has now been completed and the report is attached as an appendix to this board report (Appendix A)

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

10. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers² or equivalent).

² <http://www.england.nhs.uk/revalidation/ro/app-syst/>

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

Comments: Yes, this was instigated in 2019 and continues and the appraisal system has been updated to allow appraisers to receive feedback on the quality of their appraisals. In addition, 6-8 annual events are held across the 2 sites to ensure access for appraisers from both organisations. A record of attendance of these events is maintained and access to material discussed at the events is made available to all appraisers on the workspace on the Trust intranet. Topics included feedback from GMC / updates from NHSE and Wellbeing and Support

Action for next year: Continue to develop this process

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

Action from last year: Develop and refine this process

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

Action for next year: continue

Section 2b – Appraisal Data

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

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	1124
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	983
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	131
Total number of agreed exceptions	27

Section 3 – Recommendations to the GMC

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

Action from last year: None

Comments: 120 doctors came under notice for revalidation in 2022/3 and 102 positive revalidation recommendations were made. This was a quieter year for revalidation as it was the first year of the 3rd revalidation cycle. 18 doctors were deferred, 14 due to insufficient appraisal activity (5 of those doctors were relatively new to the UK but had held a licence abroad), 2 doctors were on extended leave (parental or sick leave) and 2 were missing feedback. Two doctors who were deferred were deferred for a second time due to lack of appraisal activity- they have now engaged and both are expected to revalidate in September and October 2023. Our deferral rate is in line with other organisations of a similar size and for comparable reasons (information taken from GMC connect).

Action for next year: None identified.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Nil

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

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

Action for next year: No other actions identified

Section 4 – Medical governance

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

Action from last year: Nil

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

Action for next year: None identified

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

Action from last year: None

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

Action for next year: Nil identified

3. There is a process established for responding to concerns about any licensed medical practitioner's¹ fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue to develop the ROAG group as a vehicle for overseeing the capability/ conduct and FTP cases.

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

Action for next year: Nil additional

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

Action from last year: None

Comments:

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

Other Measurement and Key performance indicators comprise:

- The number of Speaking Up concerns raised.

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

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

Action for next year: Nil additional

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

Action from last year: None

³ This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

⁴ The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: <http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

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

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

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

Action for next year: No additional actions identified

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

Action from last year: none

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

Action for next year: nil identified

Section 5 – Employment Checks

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

Action from last year: None

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

Action for next year: Nil identified

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Overall appraisal and revalidation at UHBW has continued in a positive direction since the end of the covid 19 pandemic though continued work pressure and the junior doctor industrial action have all impacted on the ability to improve the appraisal rate further. All of the actions from the previous board report have been completed with the exception of reviewing the appraisal and revalidation policy which was due for review in March 2023. This will be a priority for the coming year.

The HLRO visit in October 2022 was welcomed and very positive and the actions from this are now all underway or complete.

The piece of work on EDI was received positively when presented and discussed with appraisers and provides a good baseline for us to build on.

In July 2023 a new appraisal lead was appointed and she will take up post in Oct 2023 after a period of handover, and the new deputy RO will also commence their post at this time.

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

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _____

Name: _____

Signed: _____

Role: _____

Date: _____

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Publication reference: PR1844

Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Report Title	Register of Seals Report
Report Author	Mark Pender, Head of Corporate Governance
Executive Lead	Eric Sanders, Director of Corporate Governance

1. Purpose
This report provides a summary of the applications of the Trust Seal made since the previous report in June 2023.
2. Key points to note <i>(Including any previous decisions taken)</i>
<p>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.</p> <p>1 sealing has taken place since the last report, as per the attached list.</p>
3. Strategic Alignment
N/A
4. Risks and Opportunities
N/A
5. Recommendation
This report is for Information
The Board is asked to note the Register of Seals report.
6. History of the paper Please include details of where paper has <u>previously</u> been received.
N/A



Register of Seals

June 2023 – August 2023

Reference Number	Document	Date Signed	Authorised Signatory 1	Authorised Signatory 2	Witness
888	Deed of Surrender, Part of St James' Court, Bristol BS1 3HL, between UHBW and Oak Tree Mobility	05/07/23	Neil Kemsley	Jane Farrell	Mark Pender

Meeting of the Board of Directors in Public on Tuesday 12 September 2023

Report Title	Governors' Log of Communications
Report Author	Mark Pender, Head of Corporate Governance
Executive Lead	Eric Sanders, Director of Corporate Governance

1. Purpose
The purpose of this report is to provide the Board of Directors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous meeting. The Governors' Log of Communications is a means of channelling communications between the governors and the officers of the Trust.
2. Key points to note <i>(Including any previous decisions taken)</i>
Since the previous Board of Directors meeting held in public on 15 th June: <ul style="list-style-type: none"> • Two questions have been added to the Governor's log relating to UHBW online presence and strategic outlook of the UHBW estate. • Three questions have been closed. • One question is overdue, relating to the UHBW online presence.
3. Strategic Alignment
N/A
4. Risks and Opportunities
None
5. Recommendation
This report is for Information
6. History of the paper Please include details of where paper has <u>previously</u> been received.
N/A

Governors Log September 2023

Governors questions reference number	Coverage start date	Governor Name	Description	Executive Lead	Coverage end date	Response	Status
257	25/05/2023	John Rose	<p>What guidance is there for staff in the A&E department at Weston Hospital regarding how to help people who have been waiting in A&E for an hour or more and are still there at 2200hrs?</p> <p>The background is that an elderly person involved in a serious car accident had presented themselves at Clevedon MIU with serious back pain and needed radiological investigation, but after a long wait was told to go to Weston. After another long wait at Weston they were told that they might get a bed overnight at Weston or they could go home and present themselves at NBT the following day. Although the doors closed at 2200 hrs the care continued well into the early hours of the following morning with scans and xrays etc. It was a 13 hour spell but apart from the long wait the care received was exemplary and should be commended for the attention and care given to the lady.</p>	Executive Managing Director (Weston)	29/06/2023	<p>Whilst the Weston Emergency Department closes at 22:00, it is staffed by a consultant and junior doctors until midnight and middle grade doctors 24 hours per day and therefore no patient should be advised to go elsewhere during the evening, particularly when they have already been redirected to Weston as this would impact on the quality of their experience.</p> <p>If there is a longer than usual wait to be seen, a senior member of the Emergency Department team will make an announcement in the waiting room to advise what the waiting time is and how many patients are still waiting to be seen, so that patients are aware how long they may have to wait, but they are specifically asked not to leave without being seen first.</p> <p>During the announcements other community services, such as GP and pharmacist are signposted, but we are clear that if a patient wants to wait, they will be seen. We never redirect to another acute provider without seeing the patient. Below is the prepared announcement used at these busy times:</p> <p>"The Emergency Department is extremely busy now with (state the number of patients in the dept) and the wait time to be seen by a clinician is (state length of time). Some of you who are waiting to be seen may find it more appropriate to access your local pharmacy, Urgent Treatment Centre/Minor Injury Units, make an appointment with your GP, or return to the Emergency Department tomorrow.</p> <p>We would ask that you do not leave prior to being assessed by the triage nurse. If you have been triaged, please inform a staff member at the Emergency Department reception if you choose to leave.</p> <p>Thank you for your cooperation."</p>	Awaiting Governor reponse
258	26/05/2023	Annabel Plaister	<p>I saw a good and long-standing friend who is an ANP in ED in Weston and proudly told me how well they are doing – one of the top performers in UK – it was so lovely to see, for several years it's been more doom and gloom from the Weston staff when I bump into them. She told me they have rooms off the reception now and easy cases are seen by her and other ANP quickly and in and out within 40 minutes, Healthy Weston changes including the SDEC have really helped, staff are settled, less vacancies and they are excited to be getting the junior Dr's back in a few months. Her only frustration is that technically minor injuries should be re-directed to Clevedon and Clevedon have had a lump of money to facilitate this, in reality they find it hard to send their typical type patients up to Clevedon so deal with them and it seems unfair that Weston hasn't had a financial injection. Clevedon is amazing and perfect for patients in Clevedon, Nailsea and Portishead etc. Is the Board aware of this issue and what can be done to either ensure more people are attending minor injuries for minor injuries, or to facilitate this kind of unit closer to Weston?</p>	Executive Managing Director (Weston)	29/06/2023	<p>The redirection to Clevedon MIU is well embedded into the department and works well, with consistent communication between the teams. All patients with minor injuries are usually redirected to Clevedon if they can accept. However, an exception to this would be if the Weston ENPs have capacity to see and treat the patient very quickly and the redirection would lengthen their treatment time then we will see them in Weston. The chart (attached to the email) shows the numbers of patients redirected over the last 6 months.</p>	Closed
259	13/06/2023	John Chablo	<p>We still have UHB images all over the place, and the same with the Weston site. Same with the logos, but I half understand why they are still in place on the websites. It just looks a confusing mess to me, and makes Bristol and Weston appear as separate entities. I know it's a major change to put all the hospitals under one UHBW domain, but how many years has it been since the merger? With no sign of a new website imminent either. Very disappointing as it's probably our first point of contact for many people. Can you confirm what the Trust is doing to make sure the website and patient facing areas are showing the UHBW brand and logos?</p>	Chief Executive Officer	11/07/2023		Assigned to Executive Lead

260	12/07/2023	Martin Rose	<p>What is the long term vision for the fragmented buildings around the city centre? I expect we are pretty much at the end of the potential building out/extending, with the only option being to build upwards; but could there be scope to use outside central hospital spaces such as South Bristol Community Hospital?</p>	Chief Financial Officer	09/08/2023	<p>As part of our approved Estates Strategy 2022, we will continuously seek to explore opportunities to rationalise our estate, some specific examples are the potential disposal of Central Health Clinic in Bristol and Drove Road in Weston. We are also engaged with Bristol City Councils Broadmead development plans where we will be exploring near but off-site opportunities to relocate ambulatory and / or diagnostic services, releasing space on our main campus for the expansion of specialist and tertiary services.</p> <p>We are continuing to work closely with ICS system partners who are leading on the optimisation of SBCH usage. As one of several providers delivering services from this site we will continue to work collaboratively with the ICS, Sirona and Bristol Community Health.</p> <p>In relation to future on site developments, we have generated Site Development Plans and identified Marlborough Hill as a potential development site at Bristol, with multiple development opportunities identified on the Weston site.</p>	Closed
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