Great Western Hospitals NHS Foundation Trust

Agenda Board of Directors

Date	05/08/2021
Time	9:30 - 14:10
Location	Microsoft Teams
Chair	Liam Coleman

Agenda

1 9:30 **Apologies for Absence and Chairman's Welcome**

2 **Declarations of Interest**

Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust.

3 **Minutes (pages 1 – 16)**

Liam Coleman, Chairman

- 1 July 2021 (public minutes)

4 **Outstanding actions of the Board (public) (page 17)**

5 **Questions from the public to the Board relating to the work of the Trust**

6 9:45 **Chairman's Report**

Liam Coleman, Chairman

7 9:55 **Chief Executive's Report (pages 18 – 24)**

Kevin McNamara, Chief Executive

8 10:20 **Integrated Performance Report (pages 25 – 94)**

- Performance, People & Place Committee Board Assurance Report - Peter Hill, Non-Executive Director & Committee Chair
  Part 1: Operational Performance - Jim O'Connell, Chief Operating Officer

- Quality & Governance Committee Board Assurance Report - Peter Hill, Non-Executive Director & Deputy Committee Chair
  Part 2: Our Care - Lisa Cheek, Chief Nurse & Charlotte Forsyth, Medical Director

- Part 3: Our People - Jude Gray, Director of Human Resources

- Finance & Investment Committee Board Assurance Report - Andy Copestake, Non-Executive Director & Committee Chair
  Part 4: Use of Resources - Simon Wade, Director of Finance & Strategy

9 **Audit, Risk & Assurance Committee Board Assurance Report (pages 95 – 97)**

11:35 Julie Soutter, Non-Executive Director & Committee Chair

10 **Staff Story (pages 98 – 102)**

11:45 Emma Colgrave is a member of our Differently Abled Network (formerly named Disability Equality Network). This is her personal story regarding less positive experiences having a LD elsewhere and more positive experiences in the Trust.

Consent Items Note – these items are provided for consideration by the Board. Members are asked to read the papers prior to the meeting and, unless the Chair / Company Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with the process for Consent Items. The recommendations will then be recorded in the minutes of the meeting.

11 **Ratification of Decisions made via Board Circular/Board Workshop**

12:10 Caroline Coles, Company Secretary

12 **Complaints Policy (pages 103 – 147)**

Lisa Cheek, Chief Nurse
(approved at Quality & Governance Committee 22 July 2021 for Board final ratification)

13 **Urgent Public Business (if any)**

To consider any business which the Chairman has agreed should be considered as an item of urgent business

14 **Date and Time of next meeting**

Thursday 2 September 2021 at 9.30am (face to face meeting at external venue)

15 **Exclusion of the Public and Press**

The Board is asked to resolve:-
"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD VIRTUALLY IN PUBLIC ON 1 JULY 2021 AT 9.30 AM, BY MS TEAMS

Present:

Voting Directors

Liam Coleman (LC) (Chair)	Trust Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Andy Copestake (AC)	Non-Executive Director
Charlotte Forsyth (CF)	Medical Director
Jude Gray (JG)	Director of HR
Peter Hill (PH)	Non-Executive Director
Paul Lewis (PL)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Jim O'Connell (JO)	Chief Operating Officer
Sanjeen Payne-Kumar (SP-K)	Associate Non-Executive Director
Claudia Paoloni (CP)	Associate Non-Executive Director (part)
Julie Soutter (JS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Claire Thompson (CT)	Director of Improvement & Partnerships
Simon Wade (SW)	Director of Finance & Strategy

In attendance

Caroline Coles	Company Secretary
Tim Edmonds	Head of Communications
Alex Harrington	Head of Podiatry Therapy (agenda item 108/21 only)
Jill Kick	Head of Integrated Services & Community Therapy (agenda item 108/21 only)
Christina Rattigan	Head of Midwifery (agenda item 110/21 & 111/21 only)
Emma Churchill	Deputy Divisional Director, Women & Children Service ((agenda item 110/21 & 111/21 only)

Apologies

Nick Bishop (NB)	Non-Executive Director

Number of members of the Public: 6 members of public (4 Governors; Chris Shepherd, Maggie Jordan, Arthur Beltrami and Janet Jarmin).

Matters Open to the Public and Press

Minute	Description	Action
101/21	**Apologies for Absence and Chairman's Welcome** The Chair welcomed all to the virtual Great Western Hospitals NHS Foundation Trust	

Minute	Description	Action

Board meeting held in public.

Apologies were received as above.

102/21 **Declarations of Interest**
There were no declarations of interest.

103/21 **Minutes**
The minutes of the meeting of the Board held on 2 June 2021 were adopted and signed as a correct record with the following amendments:-

80/21 / IPR / Our Care / Maternity & Neonatal Safety : Change the word '*investment'* to '*incentive'* in the 2nd paragraph 1st line.

80/21 / IPR / Our Care / Mortality : Change *'next month'* to *'October 2021'* in last paragraph last line.

80/21 / IPR / Our People : Change the word '*headcount'* to *'temporary workforce'* in the 1st bullet point 1st line.

80/21 / IPR / Our People : Change '*Tracey'* to '*Felicity'* in last paragraph 3rd line.

104/21 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list and noted that:-

80/21 / IPR / Our Care - The report around recognition of dying patients was due in October 2021 not July 2021 to Quality & Governance Committee.

The Board **noted** the questions

105/21 **Questions from the public to the Board relating to the work of the Trust**
There were two questions from the public to the Board which were on staffing in the Swindon Intermediate Care Centre (SwICC) and Waiting Lists.

106/21 **Chair's Report, Feedback from the Council of Governors**
The Board received a verbal update which included:-

- The Trust had hoped to move to hybrid meetings for this month's Board meeting, however due to the continued covid restrictions in place this had not been possible The revised anticipated date to move to hybrid meetings was September 2021, however once again this would be dependent on government advice. Further details would be found on the Trust's website. The Chair noted that various options for locations had been put forward by a number of parties however the suitability of any venue would have to meet a variety of criteria.

- A Joint Board and Council of Governors meeting was held on 14 June 2021 and the governors were given updates on the Integrated Care System (ICS), site developments and organisational restructure.

- The governors held a virtual visit with the ICU team on 16 June 2021.

The Board **noted** the report.

107/21 **Chief Executive's Report**

The Board received and considered the Chief Executive's Report and the following was highlighted:-

Covid Position - There had been a slight rise in the number of patients with confirmed Covid within the hospital over the last few weeks, although numbers remained low in comparison to the first and second waves. In addition to Covid, the Trust were also planning for a potential increase in cases of paediatric respiratory syncytial virus (RSV) due to Covid as there had been almost two seasons of children who may have no immunity due to decreased social interaction.

Andy Copestake, Non-Executive Director asked what the profile of the covid patients were and whether there was any pressure on ICU. Charlotte Forsyth, Medical Director replied that the patients were younger in age, not vaccinated and not requiring intensive care. However in relation to intensive care this was not the case with the Trust's two neighbouring hospitals and there was a concern that this could change.

Liam Coleman, Chair asked about the plans for a booster vaccination. Charlotte Forsyth, Medical Director replied that no information had been received as such however it was anticipated that this would be business as normal and driven by the primary care networks as per the flu vaccination. Kevin McNamara, Chief Executive added that this would result in the Trust scaling down its vaccine response at the end of September 2021 and focus on staff support in this area.

Vaccination Programme - The vaccination programme had hit a significant milestone with 1m vaccines administered.

CQC - The CQC had published its new strategy, which places a real focus on relationship-building and indicates a move away from scheduled inspections to a more flexible and targeted approach.

Julie Soutter, Non-Executive Director asked if the Key Lines of Enquiries (KLOEs) would change as these were linked to a variety of documents within the Trust. Lisa Cheek, Chief Nurse replied that the framework that underpinned the strategy had not changed at the moment.

Integrated Care System (ICS) Development - A 2-day workshop had been attended by

Minute	Description	Action

various Executive Directors to develop the Swindon Place-Based element of the ICS which would underpin the Memorandum of Understanding (MOU) to be signed by the end of the summer.

The Board **noted** the report**.**

108/21 **Patient Story**

Jill Kick, Head of Integrated Services & Community Therapy and Alex Harrington, Head of Podiatry joined the meeting for this item.

The Board received a patient story which highlighted how integrated care supported a vulnerable patient in managing appointments. This story was a good example of a different way of approach in delivering patient care whilst utilising established pathways. As a result of the new approach the podiatry and dental treatments were completed in one session for this patient.

Lizzie Abderrahim, Non-Executive Director asked what would have happened to the patient if this different approach had not been undertaken. The response was that the patient would have been referred for further intervention and added to a waiting list.

Liam Coleman, Chair recognised that the benefit of hearing patient's stories was so the organisation could learn from their experiences to continually improve the services the Trust provided and asked if there was anything that the Trust could do to make integration more effective. The response was for all services to focus on patient pathways and for all staff to understand their roles and responsibilities within those pathways. There were many examples of services that were working in this way however further work was required in this area.

Liam Coleman, Chair thanked Jill and Alex for sharing their story and recognised the importance of integration to the organisation as the Trust was not just an acute hospital but also had community and primary care services and therefore had to learn how to truly integrate.

The Board **noted** the patient story.

Claudia Paoloni joined the meeting.

109/21 **Integrated Performance Report**

The Board received and considered the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in April / May 2021.

Minute	Description	Action

Part 1 : Our Performance

Performance, People and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, People and Place Committee (PPPC) around the IPR at its meeting on 23 June 2021 and highlighted the following:-

Cancer - The Committee were assured that based on the current trajectory and management plan improvements would be seen in the Breast Service by August 2021. Short term access issues had been experienced in G.I. due to 2 doctors who were required to quarantine on their return from India.

Emergency Department - Good leadership and lessons learnt within the department. Demand for the service continued to increase with significant numbers trying to access the service. This mirrored the national situation.

Referral to Treatment Time (RTT) - Solid progress had been made with a very challenging target. The Committee were particularly heartened to see the reduction in the over 52 week waiters.

Diagnostics - Steady progress made with challenges on the way.

Stroke - There had been an unexpected dropped in the SNNAP score to a C partly as a result of the breaches getting onto the Stroke Unit. The Committee would scrutinise this in a deep dive that was on the agenda for the July 2021 meeting.

Workforce - The Committee felt that the current position was incredibly positive and the quality of reporting from the Workforce team gave a significant amount of assurance. Whilst appreciating the substantial progress that had been made it was acknowledged by the team that there was still room for improvement. The on-going issues were being addressed and the Committee were comfortable with the work undertaken to monitor and improve them.

Staff Engagement - The Committee had seen significant effort by the Leadership team to promote staff engagement over recent months. Several indicators (including Public View) suggested this was having a positive effect.

Safer Staffing - The Committee received the review on safer staffing which demonstrated good control systems on a daily basis, coupled with good recruitment overall, although the national position with regards to Midwife and Community Nursing recruitment were challenging.

The Board received and considered the Operational Performance element of the report with the following highlighted:-

Emergency Department (ED) : The 4 Hour Emergency Care Standard deteriorated from 82.59% to 80.63% in May 2021. ED attendances had increased by 12% and emergency admissions had increased by 6%. Covid admissions to the Trust continued to reduce form the peak of 163 in January 2021.

Referral to Treatment Time (RTT) - Overall the Trust's RTT Incomplete Performance for May 2021 was 68.02% which was an improvement of 1.64% in month.

Cancer - 62 Day Cancer performance in April 2021 was 86.6% against a national and local target of 85%.

Stroke - Stroke performance unexpectedly reduced to a Level C for Quarter 4 (67.5%). This was not in line with the Bournemouth prediction tool for the first time. Recovery actions had been put in place.

Diagnostics - Diagnostic Wait (DMO1) Performance in April 2021 was 76.2% a decrease from 81.57% in March 2021 driven primarily by increases in Ultrasound breaches (+391) due to the CT van moving to another area. Actions were in place to address this issue.

Liam Coleman, Chair asked about the progress on waiting times particularly in the context of the continued pressures of covid together with the increased demand on both diagnostics and emergency care. Jim O'Connell, Chief Operating Officer replied there was a lot of focus both locally and nationally on how to improve these issues for our patients. With regards to diagnostics new national guidance had been published outlining new ways of working with one of the key recommendations being Community Diagnostic Hubs. In terms of emergency care new national standards were being introduced with the focus on ambulance handover delays and a move to booked appointments. Kevin McNamara, Chief Executive added that the NHS Oversight System Metrics for 2021/22 had been published and the link was distributed to Board members in the meeting for information.

There followed a discussion on the difficulties on managing A&E demand in particular when sometimes there was a disconnect between national guidance and media messages.

Part 2 : Our Care

Quality & Governance Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Governance Committee around the quality element of the IPR at the meeting held on 17 June 2021 and the following highlighted:-

Integrated Performance Report - The overall assurance ratings were green. This did not mean there were no issues, for incidence pressure ulcers, however there were

robust actions plans in place to address these matters.

Mortality - Mortality had been scrutinised frequently and the Committee were assured of its performance especially with the development of the Medical Examiners service. Charlotte Forsyth, Medical Director added that Mortality performance had been on the watch list for a while with lots of work on different aspects undertaken which had not identified anything of concern causing the slight increase in SHMI, albeit it had continued to be under the expected range. However, the Trust had a much better oversight with focus on improved learning especially with the appointment of the new Medical Examiners.

Getting It Right First Time (GIRFT) - Many outstanding actions had been safely closed on the basis that they were out of date or evidence had changed, however the Committee noted that there was still some work to be done to achieve full GIRFT Compliance.

The Board received and considered the Quality element of the report with the following highlighted:-

Medicine Safety - An additional slide on Medicine Safety had been introduced due to a theme coming out of incident reporting. There were 2 key areas of focus; administration in ED and allergies and documentation. Focussed improvement work was underway in both areas. It was noted that the numbers of unintended omitted medicines remained consistently low and well below national levels.

Pressure Ulcers - The number of pressure ulcers continued to be high even though good action plans were in place. External scrutiny from NHSI had given assurance that the Trust were taking the right actions and perseverance and close monitoring were key.

Patient Experience - Owing to changes in process the number of concerns had increased but the number of complaints had reduced. The new approach was to ask people how they wished their issue to be addressed. Concerns tended to be resolved much quicker bringing earlier resolution. It was noted that although the top theme in complaints and concerns was staff behaviour and attitude the Chief Nurse put this in to context in that the Trust received over 1,000 positive comments on staff attitude.

Paul Lewis, Non-Executive Director praised the positive changes around recording and evaluation of complaints and concerns however asked for assurance that both categories captured the learning. Lisa Cheek, Chief Nurse replied that all complaints and concerns were treated seriously and the level of investigation was exactly the same with all learning captured.

Paul Lewis, Non-Executive Director asked if the Trust was still on track to roll out the Friends and Family Tests (F&FT) electronic messaging in Maternity in July 2021. Lisa

Cheek, Chief Nurse responded that this had been delayed and was currently establishing the reason why. In the meantime the PALS team had been asked to explore other options to collect feedback with oversight through Quality & Governance Committee.

Helen Spice, Non-Executive Director asked for clarification about the roll out of the electronic F&FT in Outpatients which was to be completed once financial sign off agreed. Lisa Cheek, Chief Nurse replied that in the original paper roll out for texting was for In-patients and ED departments only and Maternity and Outpatients were not included. However since then the Trust had been able to negotiate a reasonable price for Maternity. There were still costs implications for Outpatients however work was underway to determine whether this was still the best solution for the department.

Helen Spice, Non-Executive Director asked when a concern was raised was feedback given to the person. Lisa Cheek, Chief Nurse responded that feedback was given to confirm that the concern had been rectified and the learning from them.

Part 3 : Our People

The Board received and considered the workforce performance element of the report with the following highlighted:-

- The Key Performance Indicators (KPIs) remained the same as last month or improving. One area that had dipped was mandatory training recording however this was due to a change in IT systems and was anticipated to improve over the coming months.
- The next area for deep dive would be for all turnover to understand the drivers in the increase to 14% above target.
- There had been positive results to the Aspiring Leadership course which would start in September 2021.
- There had been significant effort by the Leadership team to promote staff engagement over recent months which included a new NHS quarterly staff survey.
- There had been an increase in the level of rigour in medical resourcing in those areas of concern in terms of the approach to recruitment campaigns. The HR team had also been reorganised to focus on those areas that had persistent vacancies.
- The Equality, Diversity & Inclusion (EDI) Group had met this month. This was an important time of year in the EDI agenda with the preparation of the Annual Reports. The agenda for September 2021 would focus on inequalities and approach to transgender individuals and links with Stonewall.

Liam Coleman, Chair asked what the general feeling was within our workforce. Jude Gray, Director of HR replied that there was a huge degree of tiredness with concerns around winter challenges to come. There was a robust set of services around mental health and the next step was to focus on physical health. Charlotte Forsyth, Medical Director added that from a medical perspective a large number of consultants had

retired and returned and the concern was that conditions had changed significantly due to covid which could potentially force consultants to leave all together leading to extra pressures on staff due to gaps in recruitment. The Medical Director was working closely with HR with the recruitment campaigns.

Paul Lewis, Non-Executive Director added that from a NED insight following a walk about in Maternity he could confirm that overall there was genuine optimism albeit genuine tiredness.

Finance & Investment Committee Overview

The Board received an overview of the detailed discussions held at the Finance & Investment Committee around the financial element of the IPR at the meeting held on 21 June 2021 and the following highlighted:-

Month 2 Financial Position - All the main indicators had an assurance rating of green. One point of note was that the Trust, for the first time, achieved the 95% target for paying creditors within 30 days and the team were to be congratulated. The amber rating on management actions reflected concerns over escalating pay costs, especially close support, and a shortfall in CIP achievement.

Finance Risk Register - A good update report on Finance risks, which now included a new table setting out the possible £ value associated with each key risk.

Procurement - The Committee approved the business case for the establishment of a single procurement service across the 3 Acute hospitals from 1 October 2021. The Committee also considered the novation of 5 further Pathology contracts into the Beckman Coulter Managed Service Contract resulting in significant VAT savings as well as other benefits and recommended approval by the Board. This followed the novation of 6 Pathology contracts last month.

Business Planning and Budget Setting Process - The Committee discussed a helpful paper commissioned by the Chief Executive produced by the Director of Finance which highlighted a number of business planning and budget setting issues that had emerged from the production of the first half year (H1) budget. The paper included a clear set of actions which the Committee welcomed. Divisions would be invited to the Finance & Investment Committee to give assurance that the key issues were being addressed.

Improvement Plan - The Committee received an update on the financial savings opportunities associated with each of the key work streams under the Improvement Plan. The Committee acknowledged that the numbers in the report were subject to validation but were concerned on 2 points; firstly that the savings opportunities appeared to be lower than in the original plan and, secondly, that a number of savings opportunities and initiatives were not included in the report. The Committee asked that all the relevant work was brought together and reported in one place and that the gap was identified between the original savings target included in the Efficiency &

Improvement Plan and the new total, so any necessary action can be taken to plug the gap.

Model Hospital - This was linked to the Improvement Plan and highlighted the top 10 financial opportunity areas produced by Model Hospital based on 2019/20 data. The assurance red rating reflected the Committee's view that there could be better linkage between Model Hospital and GIRFT data and that the apparent savings opportunities needed to be validated.

The Board received and considered the Use of Resource performance element of the report with the following highlighted:-

Elective Recovery Fund (EDF) - There had been strong performance against the elective recovery trajectory as the Trust had exceeded the threshold by a good level. Confirmation of income levels would be confirmed in July 2021.

Pay - There was a marginal reduction in run rate and agency usage was slightly down however it was noted that pay costs had increased over the last 18 months and the Trust would have to look at efficiencies going forward as this could not be managed in the second part of the year.

Non-Pay - Non -pay expenditure was overspent in month and year to date. Costs of clinical supplies had increased in month which reflected the additional elective activity to achieve the EDF target and it was anticipated that this would be offset from the income from this achievement.

Cost Improvement Programme (CIP) - The CIP had under achieved however there had been a significant increase in month 2. The efficiency requirement for the second half of the year was still to be quantified as it would depend on the financial settlement.

Balance Sheet - There was good performance with regard to the Better Pay Practice Code and the cash position was stable.

Capital Spend - The capital plan was overspent due to a rephrasing of the plan which would be presented to Finance & Investment Committee in July 2021.
Action : Director of Finance SW

Capital funding for the future was extensive across the system with not the appropriate funds. Constructive discussions at system level to prioritise urgent schemes for the benefit of patients had taken place.

H2 Planning - Lessons from H1 planning would be taken on board for H2 with the right accountability and ownership in place. Work had started however guidance was still to be published.

RESOLVED

to review the IPR and the on-going plans to maintain and improve performance.

Minute	Description	Action

110/21 **Safer Staffing – Six Monthly Skill Mix Review**

The Board received and considered the report on safer staffing which provided assurance to the Board of Directors that nursing and midwifery clinical areas had been safely staffed over the last 6 months.

It was noted that the report was longer and more detailed as the last report was in March 2020 mainly due to the pandemic.

The key points highlighted were:-

- The Trust had been experiencing unprecedented challenges on its workforce due to the pandemic. However the Trust had attained safe staffing during this period.
- There were two key challenged areas to maintain safe staffing; Maternity due to vacancies, maternity leave and sick leave. Daily measures were in place to ensure the department was safe. The current risk level scored 9 however this was under review and the score would be increased until recruitment had been achieved. The second area was Community Nursing Services as demand and activity levels had increased and therefore more community nurses were required. An active and successful recruitment plan was underway and the risk level would now be decreased as a result.
- There had been positive work around reducing the nurse vacancies which was reliant on the overseas programme which had been managed well despite the challenges.
- The report had been scrutinised at Performance, People and Place Committee.

Liam Coleman, Chair recognised safer staffing was ultimately a Board responsibility with full oversight although still flowed through the Board sub committee. Lisa Cheek, Chief Nurse confirmed that there was a requirement to come to formal Board however the sub committee had undertaken robust and detailed discussions which provided assurance that the right system and processes were in place to maintain safe staffing.

Peter Hill, Chair of Performance, People & Place confirmed that there had been a robust and appropriate challenging discussion and the Committee were suitably assured that a good control system on a daily basis was in place that matched the evidence. The assurance level was amber in the risk but green for management actions.

Liam Coleman, Chair added that this was less about absolute numbers in the roster but in filling vacancies with the right people which was a national challenge. Lisa Cheek, Chief Nurse confirmed that this was definitely a national challenge with the Ockenden report and CNST magnifying the challenge as we were all fishing from the same pool. Although challenging the Trust had robust oversight and plans going forward.

Andy Copestake, Non-Executive Director asked for clarification that future reports may wish to include Medical and Allied Health Professionals (AHP). Lisa Cheek, Chief

Nurse replied that the latest guidance suggested that there should not always be scrutiny on a single discipline but to look wider to give assurance across the whole organisation, which the Trust would work towards for future reports. Charlotte Forsyth, Medical Director added that historically there had been no issues or concerns around medical staff however as trusts used more locums it was now relevant that the whole workforce was included not just the nursing element.

RESOLVED

that the Board:

(a) notes the actions being taken to ensure nurse staffing levels are safe; and,

(b) notes the report as assurance of compliance against the expectations of the National Quality Board 2016.

110/21 **Ockenden Quarterly Report**

Christina Rattigan, Head of Midwifery and Emma Churchill, Deputy Divisional Director Women & Children Services attended the meeting for this item.

The Board received and considered a report that provided an update on progress with recommendations laid out in the Ockenden Report (written following an independent review of maternity and neonatal services at Shrewsbury and Telford Hospital NHS Trust) and the Trust's actions to achieve full compliance. It also described the investment that would be required in the Maternity workforce and the plan to meet Midwifery staffing standards.

Paul Lewis, Non-Executive Director gave an overview of the responsibilities as the NED Safety Maternity Champion together with the outcomes of a recent visit and walkabout to the Maternity Department. Overall the Trust was in a good place with robust actions. There were 3 core challenges around resource levels, more robust patient feedback and an overall cautious culture which was not overtly opportunistic. There was clear evidence that the Trust were supportive and listened to staff.

There followed a discussion on how this new role, which was one of the findings form the Ockenden report, would be embedded together with the plans to strengthen patient and family feedback.

It was noted that the Ockenden submission had been submitted on 30 June 2021 for review nationally. In terms of evidence and submission this had been on time with good evidence and a robust sign off. The outcome date was yet not known.

The action plans would be monitored through the Divisional Governance with added scrutiny by the Maternity Safety Champion Group and through Quality & Governance Committee.

Lizzie Abderrahim, Non-Executive Director asked for clarity with regard to the midwifery leadership. Lisa Cheek, Chef Nurse confirmed that the structure had been changed so the Head of Midwifery was professionally accountable to the Chief Nurse and managerial accountable to Divisional Director of Nursing and Midwifery and this was compliant with the standard.

Faried Chopdat, Non-Executive Director asked when would all the actions be completed and had the audit programme identified any specific concerns relating to compliance or any additional issues. Lisa Cheek, Chef Nurse confirmed that the majority of the actions would be completed within 3 months with 1 or 2 workforce business cases taken into the next financial year. Timeframes were clear in the action plans which would be monitored closely and ultimately go to the Safety Champions for sign off. With regard to the audit this had not shown any surprises as work was already on-going. It was noted that this was only the first part of the Ockenden report and there would be a second part that would highlight other areas to focus.

RESOLVED

that the Board notes the progress to meet the recommendations outlined in the Ockenden Report and the on-going work to ensure full compliance.

111/21 **Maternity Incentive Scheme – NHS Resolution 10 Criteria**

Christina Rattigan, Head of Midwifery and Emma Churchill, Deputy Divisional Director Women & Children Services attended the meeting for this item.

The Board received and considered a report that provided an update regarding the evidence or associated action plans to demonstrate the Trust's assessment against the 10 Maternity Safety Actions to the required standards requested by NHS Resolution (NHSR).

It was noted that the report had been presented to the Quality & Governance Committee outlining the position the Trust thought it was at the time, on track towards full compliance, against guidance that indicated that certain number of safety standards could be provided with action plans. However since the meeting changes had meant that the submission would now not be compliant against all the standards particularly in one area where evidence could not be provided due to historical monthly feedback from staff walkabouts in January and February 2020.

Lizzie Abderrahim, Non-Executive Director asked if the walkabouts in 2020 that could not be evidence did actually happen. Christina Rattigan, Head of Midwifery replied that informal walkabouts in maternity took place all the time but for these particular months no evidence could be found however the Trust now had a robust system in place and these would be more formal going forward.

Andy Copestake, Non-Executive Director asked what the financial impact was in not

achieving full compliance. Lisa Cheek, Chef Nurse replied that the financial risk was not yet known however other trusts had experienced similar difficulties and there was a possibility that some monies would still be given even if non-compliant.

The Board thanked the team for their effort and diligence in terms of safety and service and supplying the evidence in what was a moving feast.

RESOLVED

that the Board:-

(a) notes the compliance status in regard to Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme; and,

(b) delegates authority to the Chief Executive to sign off the final submission before the deadline of 15 July 2021.

112/21 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received an overview of the discussions held at the Audit, Risk & Assurance Committee at the meeting held on 2 June 2021 and the following highlighted:-

Annual Report and Accounts - The meeting focussed on the approval of the Annual Report and Accounts 2020/21. The Committee expressed its thanks to all involved in delivering the Annual Report and Accounts to such a tight timescale and still within challenging times, particularly the Company Secretary, Finance team and Auditors.

Risk Tolerance & Appetite - Robust discussions on statement and usage including applicability, decision making, clarity and consistency. This would be part of a Board workshop on Risk Management planned for September 2021.

External Audit - Year end report and annual report had progressed well this year. Some audit completion work was outstanding but nothing significant expected. Audit risks stable or reduced. No unadjusted audit differences. One adjusted audit difference corrected with nil impact on trust results. No subsequent events identified.
Going concern confirmed on basis of revised definition (continuation of services principal). Unqualified audit opinion issued with no significant weaknesses in VFM arrangements.

Internal Audit Annual Report - Overall moderate assurance that there was sound system of internal control. Good assurance/confidence on management's positive approach and actions to address areas for improvement. All audits were either significant or moderate for design, moderate for effectiveness, with only 1 Limited Assurance for effectiveness which was an area known to management and being addressed.

Data Quality Internal Report - Discussion on data quality impact across organisation. Actions required to improve data access, awareness, training, support and resources - as well as understanding of responsibilities - across all teams. Understanding, communication and use of policies also discussed. Policy approval process to be reported to ARAC for further discussion.

Risk Management Advisory Review - Advisory review requested in anticipation of new system and impact of recent changes to divisional structures and management. Discussion centred around achieving good risk identification and description; consistency of risk management and reporting; and governance. Opportunity for new system to enable better quality risk management across Trust. This would be part of the Board workshop on Risk Management planned for September 2021.

Data Security and Protection Toolkit - Some gaps in compliance with new and tougher Toolkit requirements. Plan to address for June 2021 submission. GWH in top quartile of Trusts audited.

The Board **noted** the report.

113/21 **Integrated Care System (ICS) Development Update**

The Board received and considered a presentation that summarised the latest guidance relating to Integrated Care System (ICS) from the Design Framework published on 16 June 2021. The following was highlighted:-

- The respective roles of the ICS Partnership and ICS Body
- The membership of the ICS NHS Board
- Options for place-based leadership and delivery
- Requirements for provider collaboration.

The Board **noted** the update.

Consent Items

Consent Items Note – these items are provided for consideration by the Board. Members were asked to read the papers prior to the meeting and, unless the Chair / Company Secretary received notification before the meeting that a member wished to debate the item or seek clarification on an issue, the items and recommendations would be approved without debate at the meeting in line with the process for Consent Items. The recommendations would then be recorded in the minutes of the meeting.

114/21 **Ratification of Decisions made via Board Circular/Board Workshop**

None.

115/21 **Urgent Public Business (if any)**

None.

116/21 **Date and Time of next meeting**

It was noted that the next virtual meeting of the Board would be held on 5 August 2021

Minute	Description	Action

at 9:30am via MS Teams.

117/21 **Exclusion of the Public and Press**

RESOLVED

that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

The meeting ended at 1500 hrs.

Chair …… Date……

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – August 2021				
PPPC - Performance, People and Place Committee, Q&GC - Quality & Governance Committee, RemCom - Remuneration Committee, FIC – Finance & Investment Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
1-July-21	109/21	**Integrated Performance Report – Use of Resources** Re-phased capital plan to be presented to Finance & Investment Committee in July 2021.	Director of Finance & Strategy	Finance & Investment Committee

Future Actions				
None				

Great Western Hospitals NHS Foundation Trust

Chief Executive's Report

Meeting	Trust Board	**Date**	5 August 2021

Summary of Report

The Chief Executive's report provides a summary of recent activity at the Trust.

For Information	x	Assurance		Discussion & input		Decision / approval	

Executive Lead	Kevin McNamara, Chief Executive Officer
Author	Kevin McNamara, Chief Executive Officer
Author contact details	

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score

Legal / Regulatory / Reputation Implications	N/A

Link to relevant CQC Domain

Safe	x	Effective	x	Caring	x	Responsive	x	Well Led	x

Link to relevant Trust Commitment	

Consultations / other committee views

N/A

Recommendations / Decision Required

This report is for information only.

1. Continued pressure on the local health system

In my last report I highlighted the intense pressure upon the health system with very high numbers of people seeking appointments at their GP surgery or urgent or emergency appointments at the Great Western Hospital.

This pressure has continued to increase, with record attendances at our Urgent Treatment Centre, and our urgent and emergency care services seeing around 400 people each day.

The pressure is felt right through the hospital with the high numbers putting demand on our inpatient areas which are already struggling with reduced bed capacity due to the continued need for social distancing in healthcare settings.

The flow of patients through the hospital and then home, or to onward care, is really important but it has not always been possible to achieve the level of discharges we would like to see, reflecting the level of demand across the health and social care system.

Last month we reached Opel 4, our highest alert level, due to the very high level of demand coupled with a large amount of staff shortages due to Covid-19 sickness or self-isolation.

We took the decision to close the Urgent Treatment Centre overnight on weekdays for a period of time due to lack of staffing, allowing remaining staff to be redeployed to support the Emergency Department. I am sorry for the inconvenience this caused but this was a necessary step to ensure the care we are providing is safe.

Of those coming to the Urgent Treatment Centre, we know that some people could have received care in another healthcare setting, such as with a GP or pharmacist and we continue to encourage people to access care in the right setting and work with system partners to signpost people appropriately, particularly highlighting the use of 111.nhs.uk. But we recognise that all parts of the system are seeing unsustainable levels of demand against a backdrop of staffing absences.

Alongside an increase in walk-in attendances, we have also seen a rise in conveyances of patients by ambulance causing surges in arrivals, particularly in the afternoon.

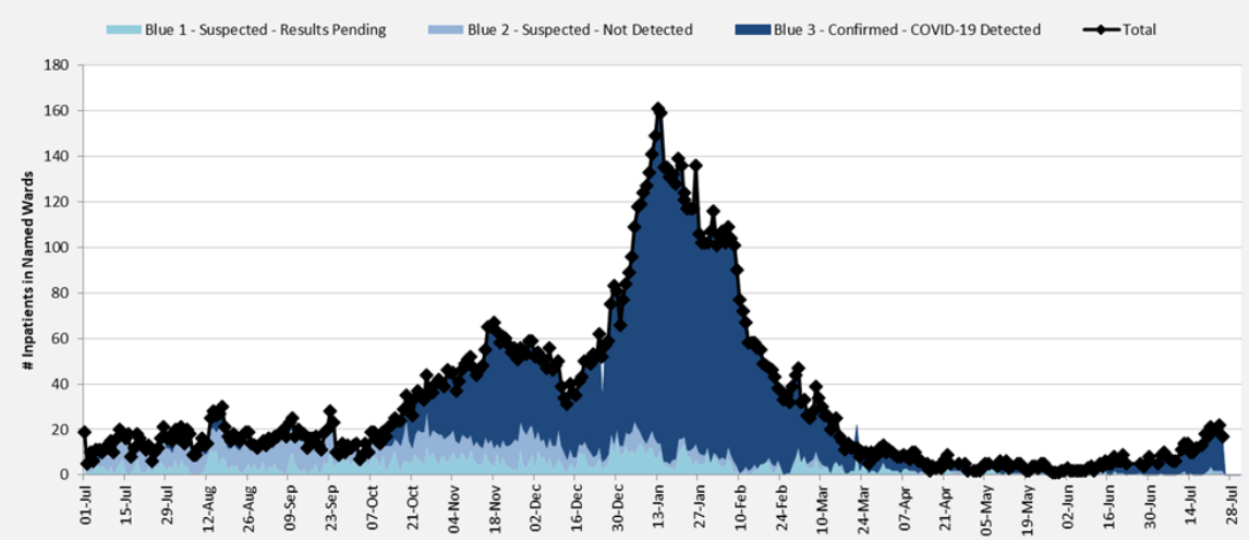
We know that this build up of patients causes considerable lost time for the ambulance service, whose crews must wait to safely hand over the patient to our teams. We are working closely with South Western Ambulance Service NHS Foundation Trust to support their crews while they are delayed and also do what we can to reduce the time they need to wait. We know that the ambulance service is also seeing record levels of activity and we must do everything we can to reduce their time at hospital so they are freed up to respond to potentially life-threatening 999 calls as soon as possible. At the time of writing we are finalising a plan which is aimed at freeing up ambulance crews at handover with the aim of supporting the ambulance service to reduce the clinical risk of members of the public who are unable to get an ambulance in a timely manner.

2. Rising demand from Covid-19

Due to the rapidly changing situation with numbers of Covid patients I will provide a verbal update on how this is affecting us at the Board meeting.

However, we have seen a very definite upward trend and, for the first time in several weeks, this has had some impact upon ICU.

The below chart shows the number of inpatients with Covid-19 at GWH over the last year with the large peak from January through to end of July showing an upward trend:



Although Swindon is currently lower than the national average, there is a high rate of community transmission and our modelling suggests this will rise over the next few weeks following the lifting of lockdown restrictions.

Inpatients with Covid are a mix of those who have been vaccinated and those who have not. They are generally staying much less time – around three or four days – rather than the very long stays we saw during the earlier waves.

We have restored our Covid control meetings to five times a week and have a surge plan in place should numbers rise much further.

2.1. Vaccination programme

Last month we reached another milestone in our vaccination programme, as we passed 80,000 first and second doses and we continue to offer a mix of walk-in clinics and booked appointments made via the National Booking System at our Commonhead clinic.

We are preparing for a booster campaign for the winter, along with an expanded flu campaign, and will maintain focus on this programme which appears to be key to helping the country to move out of the pandemic.

3. Infection prevention and control

It is important to note that although lockdown restrictions have been lifted, there has been no change in restrictions in health settings so we continue to require staff, patients and visitors to wash their hands, wear a face mask or covering, maintain a two metre distance, observe one way systems, and staff must wear appropriate PPE in line with Trust policy.

These measures do restrict our capacity, but they are essential to stop transmission as much as we can in order to keep COVID-19 under control, and ensure we are protecting our patients, staff and visitors. We are keeping our visiting times under review and should community cases increase significantly and/or we see increased impact on our services we may have to reduce visiting to site.

4. Workforce

On several days we have seen more than 100 staff off with Covid, or self-isolating. Coupled with other non-Covid related absences we have seen well over 200 staff not at work on some days.

Much of the staff absence has been due to being pinged by the Test and Trace App. Staff deemed to be in critical roles who have had both vaccinations and been pinged by the app are being risk

assessed for their safety to return to work. These staff must use PPE in line with Trust policy, carry out daily lateral flow testing, not take breaks with colleagues, and only leave isolation for work purposes – i.e. not going to shops.

Last month we introduced a new messaging system which we will use to share critical messages when faced with business continuity incidents, or larger critical and major incidents. We have used the Alert Cascade system to send a text message every day asking for staff to respond with their current isolation position – i.e. if they were isolating, sick with Covid, or unaffected by Covid.

While this has given us a good understanding of the workforce pressures affecting us, the number of absences remains high and this comes at a time when staff are quite rightly taking annual leave over the summer break.

5. Recovering our elective activity

We are doing all we can to ensure that our services continue to run, and we will not postpone or cancel any treatment because of Covid unless we really have to.

Our programme to reduce our waiting lists caused by the pandemic is well underway and we are now seeing the positive impact of this.

Back in February we had just under 2,000 patients who had been waiting for more than a year for treatment, and I'm pleased we've been able to reduce that to 985 patients at the end of June. That's still too many people who have been waiting too long though, and we are absolutely committed to see everyone as quickly as we can and my thanks go to the incredible efforts of staff to treat patients as soon as possible.

Planning is underway on our plan for supporting and maintaining elective activity during what is certain to be an extremely challenging winter.

While we continue to work to recover our elective programme, it should be noted that a significant rise in cases of patients with coronavirus – particularly if this begins to impact more upon ICU – would affect the progress made.

6. Developments on site

6.1. Way Forward Programme

The Clover centre has now been completely demolished and piling work has started on the site ready for construction work on the new Urgent Treatment Centre to start in the coming months.

A final design has been agreed for a new energy centre that will sit between the PFI land and the expansion land. It will provide energy to the new urgent and emergency care developments, and will have the potential to be enhanced in the future. It will also reflect our move to become a more sustainable organisation.

Work is underway to agree finishing for the new UTC – this is being influenced by feedback from staff, patients and the public to ensure the building meets the needs of the population we serve.

6.2. Radiotherapy Centre

Really good progress has been made on the Radiotherapy Centre and I was pleased that representatives from our biggest donor, the Rotary Club, were able to come on site for a socially-distanced tour of the development and see first-hand the impact their fund-raising efforts have made.

We are planning for a formal topping out ceremony to be held in the autumn.

7. Primary Care

Last month the GP Practice 2021 Survey results were published and they reflect the challenges we continue to face in this sector.

We know the practices have improved since we took them over in November 2019, and this has been recognised by the CQC, but there is still some way to go to ensure that our patients are receiving the GP services they deserve.

Among other findings, the survey indicates a high level of concern among patient with being able to make appointments, low satisfaction with the appointment offered, and a low overall rating for the experience of making an appointment. We have been aware that making appointments has been a source of frustration for patients for some time and we are looking at how to improve the telephony system along with introducing a new online triage system which will help with phone waiting times and access to advice.

We are now holding regular patient engagement forums to keep patients informed and better understand their views.

We are actively recruiting more GPs, against a national shortage, and have appointed a new Head of Operations who is now in post and will lead the continued roll-out of our improvement programme.

8. Our staff

8.1. Staff support

Our staff continue to do an exceptional job and are currently balancing managing the demands of Covid-19 and the uncertainty of this wave of the pandemic, along with treating record numbers of urgent patients and also working to bring the waiting list backlog down.

I would like to highlight that staff have been working under sustained pressure for a very long period of time. While staff have gone above and beyond throughout the pandemic, it should not be forgotten that the Covid outbreak happened when staff were coming out the back of a busy winter period. As we approach this winter, already seeing unprecedented demand, we must not lose sight of the fact that staff have been working under significant emotional and physical pressure for almost two year and it is important that as a Board we keep their wellbeing front and centre of our decision making.

This makes it all the more important that we continue to support our staff with a wide-ranging health and wellbeing package, develop this further in line with best practice and feedback, and do everything possible to protect breaks and annual leave, as it's more important than ever that staff get time to rest and recharge as much as they can.

8.2. Staff recognition

Later this month we will be announcing the shortlist for our Staff Excellence Awards.

We've had a great response, with 223 nominations received including 30 nominations for the STAR of the Year award. The awards ceremony will take place later this year on 5 November.

Our Health and Wellbeing Project Manager, Sam Walklett, represented the South West in the national NHS Parliamentary Awards' Wellbeing at Work category last month. Back in November 2020, Sam won the regional South West award and was invited to represent the region in the national awards in this category. Although Sam did not win the national award, we should all be proud of her achievement to get this far along with winning the regional award last year, in recognition for the hard work she has put into the Trust's staff health and wellbeing programme, both before and during the pandemic.

Pete Coutts, Deputy Divisional Director of Outpatients, is our latest STAR of the Month winner. Pete has been instrumental in mainstreaming automation across Outpatients which has resulted in significant improvements in efficiency and savings. The work he is leading at the Trust has been well

regarded at system level and he has also had positive feedback from regional colleagues. He was also instrumental in driving our move from an almost exclusively face-to-face service to a virtual outpatient service where more than 30 per cent of appointments are now done using technology.

9. Recruitment to senior roles

9.1. Chief Digital Officer

We have launched a recruitment campaign for our final Board role – Chief Digital Officer, which will be a joint role with Salisbury NHS Foundation Trust.

This is a pivotal role for both Trusts, so we're carrying out a national search for an exceptional candidate to play a central role in creating and driving forward a clear and coherent digital strategy.

The Chief Digital Officer will provide strategic oversight and leadership to both organisations in all aspects of our digital healthcare agenda to drive improvements in digitally enabled care, quality, safety, effectiveness, productivity and efficiency of services.

The post-holder will oversee the development and delivery of aligned Business Intelligence and digital strategies in the context of wider strategic partnerships, enabling the wider integration of services which are built around patient care.

The recruitment campaign runs until the end of the month.

9.2. Deputy Chief Nurses

We are also recruiting for two Deputy Chief Nurses. These roles will be separated into two main focuses: quality and workforce. Each Deputy Chief Nurse will lead on one focus, driving forward real change and ambition within these areas. Those appointed will be responsible for supporting the Chief Nurse to deliver improvements in quality and safety and will ensure that patient experience, through our Great Care Campaign, is at the heart of the organisation. They will promote excellence in clinical care and professional standards across the Trust, as well in the new Integrated Care System across Swindon and Wiltshire.

10. Supporting the Armed Forces

Last week we were informed by The Veterans Covenant Hospital Alliance that we have been accredited as a Veteran Aware Hospital in recognition of our commitment to improving NHS care for veterans, reservists, members of the armed forces and their families.

This accolade acknowledges our commitment to a number of key pledges, including:

- Ensuring that the armed forces community is never disadvantaged compared to other patients, in line with the NHS' commitment to the Armed Forces Covenant.
- Training relevant staff on veteran specific culture or needs;
- Making veterans, reservists and service families aware of appropriate charities or NHS services beneficial to them, such as mental health services or support with financial and/or benefit claims;
- Supporting the armed forces as an employer.

11. Appointment of BSW Partnership Integrated Care Board chair-designate

Congratulations to Stephanie Elsy, who has been confirmed as chair-designate of the BSW Partnership Integrated Care Board.

Stephanie will take up the post from April 2022 should Parliament confirm the current plans to formally establish ICSs and give their governing bodies – including an NHS Integrated Care Board – a broader range of responsibilities, empowering them to better join up health and care, improve population health and reduce health inequalities.

We look forward to continuing to work closely with Stephanie to build on the progress we have made so far.

12. Appointment of NHS England Chief Executive

Last week it was announced that Amanda Pritchard has been appointed as the Chief Executive Officer of NHS England, replacing Lord Stevens.

As the current Chief Operating Officer of the NHS, Amanda is already well-known to us in BSW and has a wealth of experience including being Chief Executive of Guy's and St Thomas' NHS Foundation Trust and Deputy Chief Executive at Chelsea and Westminster NHS Foundation Trust.

Integrated Performance Report (IPR)

Meeting	Trust Board	Date	5th August 2021

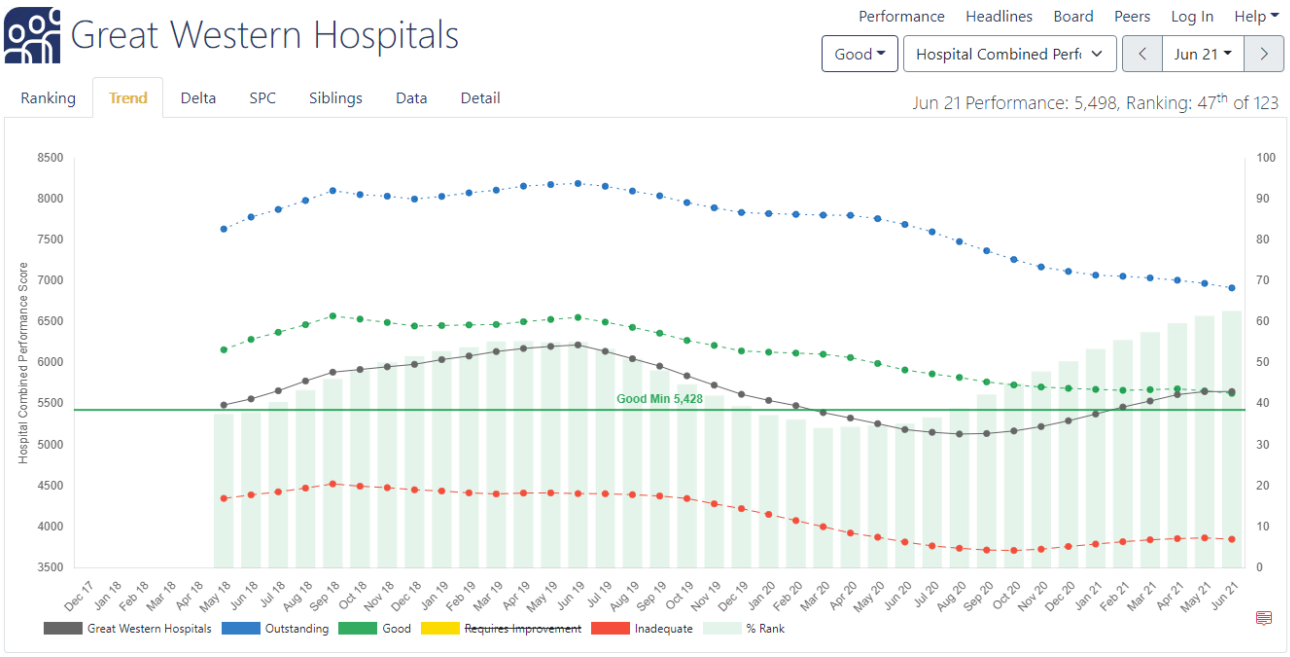
Summary of Report

The Integrated Performance Report provides a summary of performance against the CQC domains and the 4 pillars of the Trust Strategy. The summary provides an overview of performance against key performance measures and a comparison to national and peer performance using Public View data. Please note that in most cases, Public View data is at least one month behind the data available in the Trust.

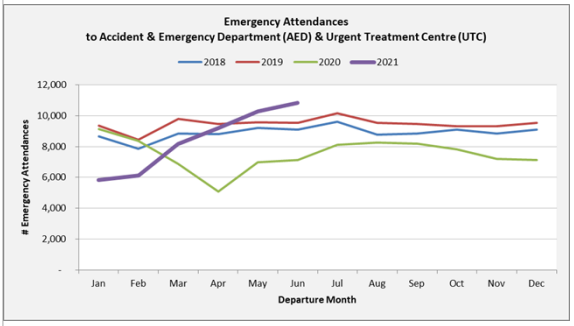
Key highlights from the report this month are:

Our Performance

Our ranking against the Hospital Combined Performance Score on Public view in June 2021 places us 44th out of 123 Trusts (42nd In May 2021). The trend chart below reflects our aggregate position improving against CQC measures and our performance is tracking as 'Good'.



In June 2021, our Emergency Care Standard Performance showed a decline of 4.1% to 76.53% against the current requirement of 95%. Mindful of the immediate changes expected in the reporting of the Emergency Care Standards, shadow reporting has commenced and will feature in future reports.



We have seen a second month of increased attendances to the ED (6% in Month) across both Type 1 & Type 3. There has been an increase in the number of patients breaching in ED in June. Restrictions are currently in place including swabbing and social distancing resulting in less flexible use of space in the ED footprint. Overcrowding has increased with surges in attendances in the UTC and the Majors department. 61% of breaches in month are related to "waits to be seen". Think 111 first performance for June currently sits at 57% with 13% of patients not attending their appointment. There have been improvements in hospital handover delays following a focused piece of improvement work. Hours lost in month have reduced from

543hrs (May) to 352hrs (June). As reported in last month's report, if the current levels of attendances continue, GWH will see more than 120,000 patients annually.

Although activity in the Covid Assessment unit has remained low, the number of inpatients with Covid has increased. The total number of inpatients remains below Wave 2 & 3 inpatients. On average 50% of patients admitted with Covid have received the Covid vaccination. Daily reviews of patients admitted with Covid is currently underway. We have seen 3 attendances in June from the local Covid Hotel which is averaging 400-500 guests at any one time.

Overall, the Trust's RTT Incomplete Performance for June 2021 was 68.89% which was an improvement of 0.87% in month. June saw an increase in the overall PTL of 31 patients (25,465) against a BSW Trajectory of 25,910 (445 ahead of trajectory). The Trust received 9480 RTT referrals in June 2021, a reduction of 82 in month. Current referrals are at 95.5% of the pre-Covid 19 average referral rates.

In June 2021 there were 985 52-week reportable breaches. This is a decrease of 282 in month. There were 408 in month 52-week breaches cleared in June 2021 which is a considerable increase over the rolling 3-month average of 280 per month.

The National Elective Recovery Fund threshold for June has been achieved. Confirmation from NHSE of our position is awaited. NHSE/I have announced the thresholds for Q2 will be raised to 95%. June activity run rate has exceeded plan.

Diagnostic Wait Times (DM01) performance was 77.9% in May, an improvement from 76.2% in April. Overall, the total waiting list size increased from 6283 in April to 6881 in May (+598). Breaches have increased from 1493 in April to 1521 in May (+ 28). Additional capacity is currently being created to support CT and Ultrasound. A business case is currently being finalised to increase Endoscopy capacity. Echo performance has seen an increase. A review of ECHO follow-up is currently underway. An audit programme of RTT and DM01 waiting lists is currently being scoped.

Cancer 2 week wait performance was 76.6% in May against a target of 93%. This is largely related to the breast service.

62 Day Cancer performance for May was 87.8% against a target of 85%.

Stroke Pathways has seen a recovery in June following the disappointing drop in Stroke rating to level C in Q4.

Our Care

The Care Section of the Integrated Performance Report provides commentary and progress on activity associated with key safety and quality indicators.

The Electronic Discharge Summary (EDS) working group was originally set up in 2018 and is led by the Deputy Medical Director (DMD), with quarterly meetings.
The DMD is supported by Transformation & Improvement Hub (T&I) the Quality Improvement Lead and Emergency Care Improvement Supportive Team (ECIST). There is good representation from the Ward Clerk, Medical Staff, Nursing Teams, Physiotherapy, Pharmacy, Matron and the Discharge Team.

As part of the QI project, work has been undertaken to observe ward rounds and the provision of EDS in preparation for discharge. The results of these observations will be discussed at the next EDS meeting to inform the next steps in improvement.
Training packs for Junior Doctors, who complete EDS, are being rolled out for the next changeover of doctors in September.

Medicines Safety is a focus area of the Great Care Campaign. The overall aim will be to reduce the harm from medicines incidents. Themes will be identified from previous incidents and triangulated with quality and safety work streams across the Trust. Initial work streams plan to focus on accurate administration of medicines and the prescribing of regular medicines on admission; this will contribute to improving communication on discharge.

The process for identifying omitted medicines is via an audit on the Perfect Ward App (the Trust's electronic audit programme). Information on omitted medicines has recently been updated and circulated to ward areas; this also details how to securely order medication out of hours. Work is on-going with the pharmacy team to identify any particular medicines which are omitted and therefore enable a more focused approach.

There has been 2 cases of MRSA Bacteraemia reported for June.
One patient with complex health issues was admitted to intensive care following trauma. The patient was found to be colonised with MRSA on admission and the bacteraemia was detected 15 days into admission. An investigation is underway and action plan being developed.
The second case was a patient with on going infection that had a repeat positive culture whilst an inpatient in GWH, according to the national database definition this will be attributed to GWH. This has been discussed with NHSE/I and there are no care concerns.

The numbers of patients diagnosed with COVID-19 is increasing line with the national picture. Six of the 29 hospital reported cases were previously community detected COVID-19 cases and one was a readmission and repeat positive for the month. 15 of the 29 admissions were unvaccinated; all bar one was under the age of 36.

There has been a reduction in number of pressure ulcers reported this month in the acute wards with a total number of 19 harms on 12 patients. Five patients had multiple harms.
2 device related (x1 Plaster of Paris x1 anti embolic stocking).
Themes from SWARM (an immediate review at ward/department level) include: timely skin inspections; thorough documentation, appropriate selection of pressure relieving equipment.

Falls over the last four months have decreased per 1000 bed days, reducing from 8.6 in February 2021 to 5.5 in June 2021. Improvement work includes the development of a falls assessment document which can be used on Nervecentre (electronic record keeping system), once funding has been identified. The Royal College of Physicians post fall 'hot debrief' project commenced on the Swindon Intermediate Care Centre (SWICC) and Sunflower ward on 14th June. Guidance on implementing the 'hot debrief' process and running a Multi-Disciplinary Team debrief is being drafted, this will ensure learning is immediately disseminated. A Safe footwear project is commencing in July to review published evidence relating to the use of non-slip socks for falls reduction and NICE recommendations for safe footwear.

At the time of reporting there is a total of 27 on-going Serious Incident (SI) investigations, with two reported in June. One never event has been downgraded following completion of the investigation it was clear that the incident did not meet the criteria for never event submission.

In June, 36 complaints (previous month 61) and 188 concerns (previous month 186) were received, all were rated a low – medium, with none related as high or extreme. Complaint response rate of 86%. 61% of concerns were resolved within 24 hours, 85% were resolved within 7 working days (KPI 80%).

Our People

This section of the report presents workforce performance measured against the pillars of the 'People Strategy' – Great workforce planning, opportunities, experience, employee development and leadership. Each area is measured with a KPI indicator achievement score and self-assessment score based on progress in month.

Exceptions in June: In-month KPI exceptions to report are overall agency spend as % of total spend is 6.43% above Trust target of 6%; Bank fill rates reporting 55% below the Trust target of 70%; Sickness absence increasing to 4.06% and exceeding target of 3.5% and appraisal compliance achieving 79.82% below Trust target of 85%. All Turnover remains high at 14.43% in month and exceeding the Trust target of 13.5%.

The Trust is on track with the Junior Doctor rotation in August and the recruitment 'time to hire' metric has improved again in month to 39 days achieving the Trust stretch KPI of 40 days.

Use of Resources

The Trust plan is breakeven. The in month position is £1k deficit and year to date position is £9k surplus which is a favourable variance of £9k.

Trust income is above plan by £2,035k in month and £2,195k year to date. Elective Recovery Fund (ERF) income of £1,112k is included in the June position. The funding covers the additional costs incurred to deliver activity during Q1.

Pay is £774k overspent in month and £753k overspent year to date. The overspend is due to ERF costs, close support & escalation nursing costs, and medical staffing pressures.

Non -pay expenditure is overspent by £1,262k in month and £1,433k year to date. This includes ERF costs of £657k. Drugs have increased by £523k in month, of which £409k is pass-through and funded by additional income.

The Trust capital plan for 21/22 is £33,493k. Spend is £2,510k as at the end of Month 3 against a plan of £2,359k.

For Information	x	Assurance		Discussion & input		Decision / approval	

Executive Lead	
Author	Jim O'Connell, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Lisa Cheek, Chief Nurse
Author contact details	jim.o'connell@nhs.net jude.gray@nhs.net lisacheek@nhs.net simon.wade5@nhs.net

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score
792 1357 1917	1. 4 Hour Standard 2. 2.RTT Standard 3. Cancer	

Legal / Regulatory / Reputation Implications	Regulatory Implications for some indicators – NHSi, CQC and Commissioners

Link to relevant CQC Domain

Safe	X	Effective	X	Caring	X	Responsive	X	Well Led	X

Link to relevant Trust Commitment	

Consultations / other committee views

Recommendations / Decision Required

The Trust Board is asked to review and support:

- the continued development of the IPR
- the ongoing plans to maintain and improve performance

NHS
Great Western Hospitals
NHS Foundation Trust

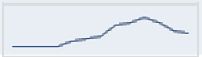
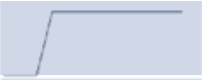
Integrated Performance Report

July 2021

Service Teamwork Ambition Respect

Performance Summary

Great Western Hospitals NHS
NHS Foundation Trust

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
Hospital Combined Performance Score	5405 (Jul)		47(5405)	27(5968)	21(6227)	Jul 21
A&E 4 Hour Access Standard (combined ED & UTC)	76.53% (Jun)		93(80.6)	97(80.0%)	69(84.1%)	May 21
A&E Median Arrival to Departure in Minutes (combined ED & UTC)	200 (Jun)		87(185)	109 (196)	102 (190)	Apr 21
RTT Incomplete Pathways	68.89% (Jun)		112(68)	93 (70.8)	87 (71.6)	May 21
Cancer 62 Day Standard	87.8% (May)		21(86.6)	70 (77.3)	83 (74.2)	Apr 21
6 Weeks Diagnostics (DM01)	77.90% (May)		99(76.2)	124(68.5)	37(94.2)	Apr 21
Stroke – Spent>90% of Stay on Stroke Unit	72.3% (Q420/21)		73(77.1)	33 (87.8)	9 (92.3)	Q3 20/21
Family & Friends (staff) – Percentage recommending GWH as a great place to work	69.89% (Q3)		85(70.0)	22(82.0%)	33(79.0%)	Q3 20/21
YTD Surplus/Deficit*	-4.3% (Oct)		82(-4.3)	8(1.3)	37(-1.4)	Q2 19/20
Quarterly Complaint Rates (Written Complaints per 1000 wte)	39.79 (Q4 20/21)		112(33.5)	32(12.8)	47((15.3)	Q2 20/21
Sickness Absence Rate	3.80% (Feb)		37(3.80)	117 (4.8%)	35 (3.74%)	Feb 21
MRSA	2 (Jun)		58(1.74)	108(3.38)	80(2.24)	Feb 21
Elective Patients Average Length of Stay- (Days)	3.24 (Jun)					
Non-Elective Patients Average Length of Stay (Days)	4.78 (Jun)					
Community Average Length of Stay (Days)	16.4 (Jun)					
Number of Stranded Patients (over 14 days)	82 (May)					
Number of Super Stranded Patients (over 21 days)	39 (May)					

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, People & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		28th July 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Recovery Programme	Amber	Green	The Committee is assured that the Trust is taking all the necessary actions, but there are still risk uncertainties while the rules are changing nationally and beyond GWH control.	Monitor actions	August meeting
Readmission Update	Amber	Green	There is a good level of understanding of the issues being faced and potential risks. An action plan is in place to deal with the risk and appropriate actions are being taken. The Committee asked for a report on Unscheduled Care to be brought to the October Committee meeting.	Report on Unscheduled Care	October meeting
Stroke Update	Amber	Green	Current issues have been addressed and things are looking positive moving forward with the expectation that an improvement will be seen in the SNNAP score for Q1.	Monitor actions	August meeting
Integrated Performance Report – Emergency Department	Red	Red	In line with the national trend demand on the ED department and UTC continues to be extremely high with 10,800 attendances in the last month. There had been a large number of breaches and staffing issues, some related to staff being contacted by the NHS app. Work is being undertaken to understand the different pressures and possible actions across ED and UTC. Specific improvement is not expected in the next few months.	Deep dive	August meeting
Integrated	Amber	Green	Performance remains steady with elective care activity being maintained despite the	Monitor actions	August 2021

Performance Report – RTT			impact of COVID and the rising number of cases. The number of 52 week waiters continues to decrease.		
Integrated Performance Report – DM01	Amber	Amber	There has been an increase in wait list size and breaches from April to May. Due to reduced CT van capacity, ultrasound backlog and overdue surveillance lists the Trust is expecting a continued increase in waiting lists and breaches that will impact Trust performance.	Monitor actions	August 2021
Integrated Performance Report – Cancer	Amber	Amber	There have been ongoing issues around two week wait and recovery will be delayed until October. The Committee however acknowledged the Trust is achieving other targets including the national 62 day standard.	Monitor actions	August 2021
Integrated Performance Report – Workforce	Amber	Green	While acknowledging risks the Committee is assured by what it sees and hears the team are doing to deal with these risks. EKA expressed concerns around mandatory training and the fact that the Trust fails to achieve the KPIs it sets and believes that this impacts on the care that can be given.	Monitor actions	August 2021
Site Utility & Resilience	Red	Amber	KMc has some concerns surrounding the timelines and the blackout risk and more exec visibility is needed on ventilation.	Exec Committee scrutiny	

Issues Referred to another Committee	
Topic	**Committee**
Consequence of 3% pay award	Finance & Investment Committee

Great Western Hospitals NHS Foundation Trust

Part 1: Operational Performance

Our Priorities

Outstanding patient care and a focus on quality improvement in all that we do

Improving quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers

Staff and volunteers feeling valued and involved in helping improve quality of care for patients

Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

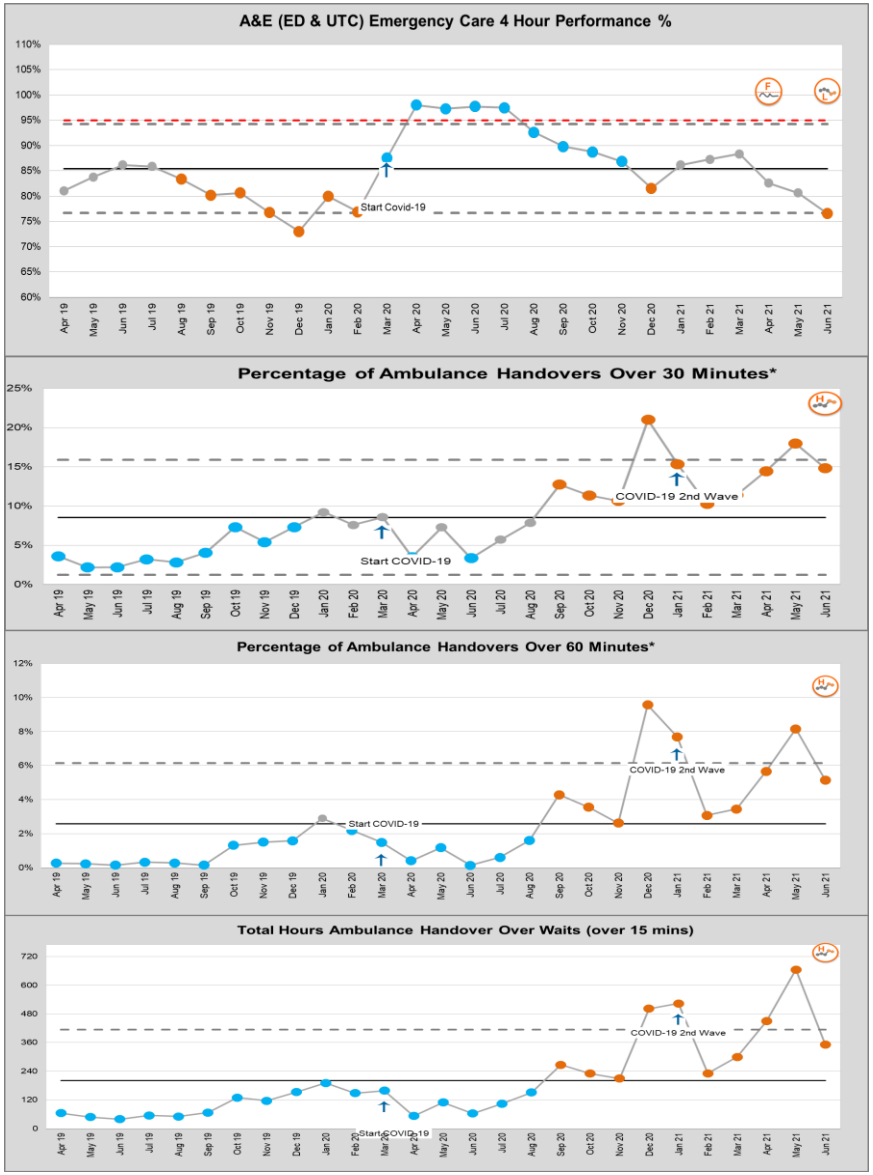
Are We Well Led?

Use of Resources

1. Emergency Access (4hr) Standard Target 95%

Data Quality Rating:

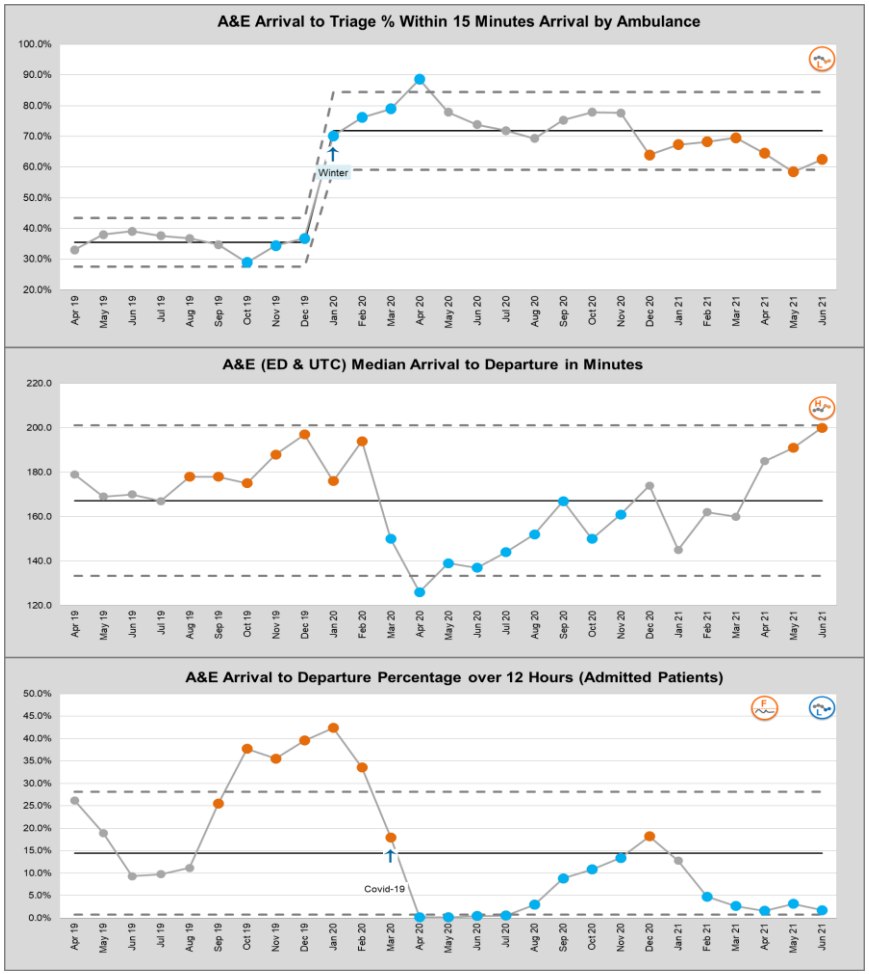
National Key Performance Indicators



Performance Latest Month: 80.63% (May)

Attendances:
Type 1 ED 66.29%
Type 3 UTC 88.24%
Total – 76.53%

12 Hour Breaches (from decision to admit) 0



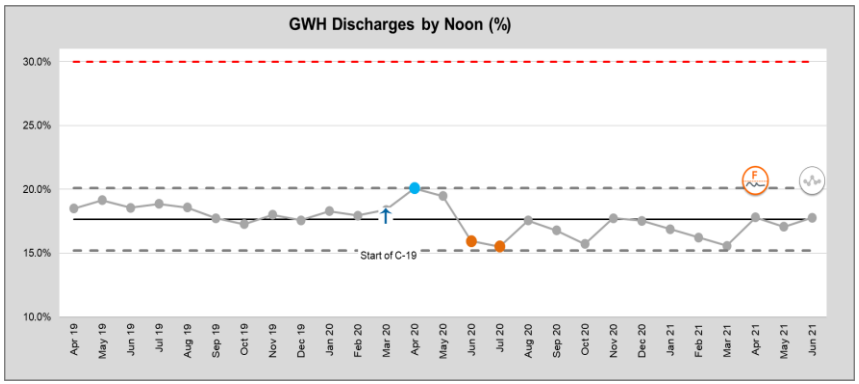
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

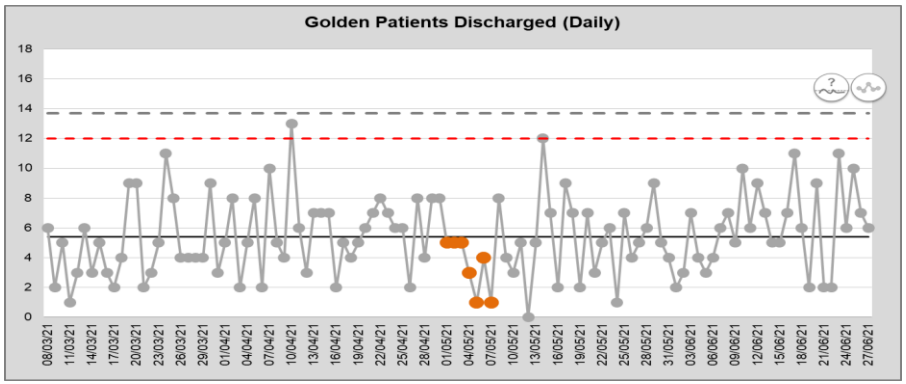
* Data from SWAST – 1 month lag

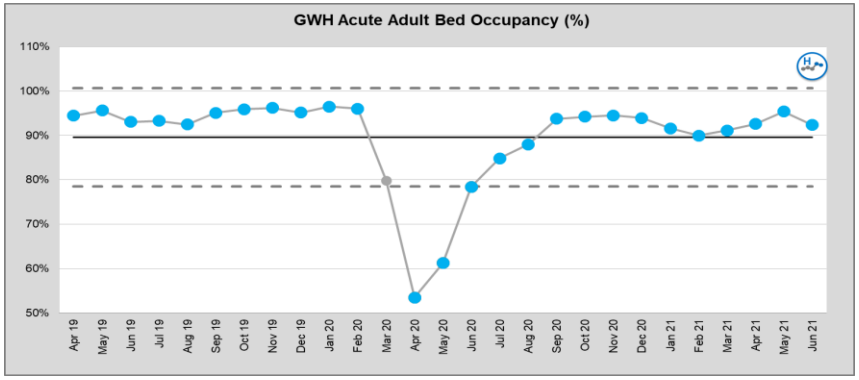
1. Emergency Access (4hr) - Patient Flow and Discharge

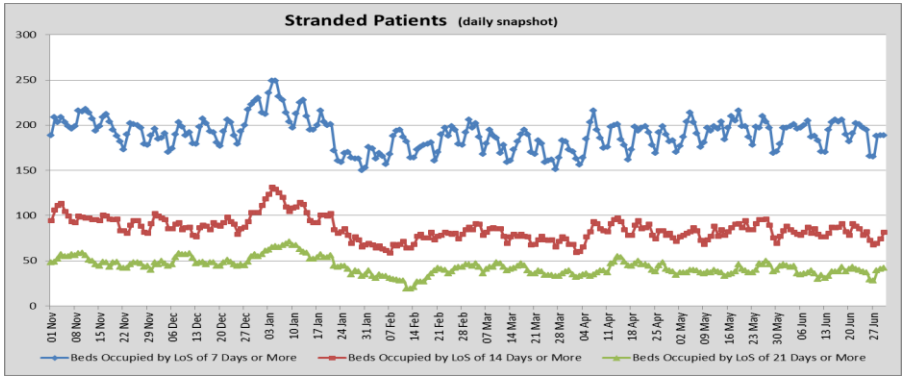
Data Quality Rating:

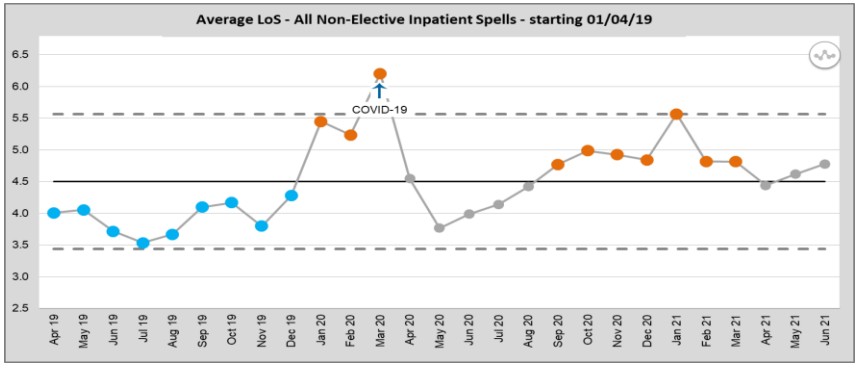
Are We Effective?

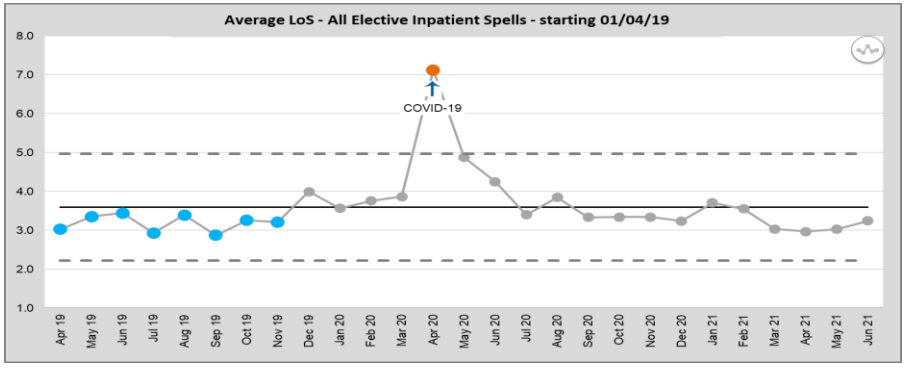












Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

1. Emergency Access (4hr)

Data Quality Rating:

Are We Effective?

Background, what the data is telling us, and underlying issues

The ED 4 Hour Performance chart shows that performance in month continues to remain below the 95% standard. There has been a decline of 4.1% in 4 hour breaches to 76.53%. There were no 12 hour reportable decision to admit (DTA) breaches in June which is an decrease to the 7 reported in May.
Attendances have increased in June (from May) by 651 (6%) patients across both Type 1 (183) and Type 3 (353). 4 hour breaches within the UTC increased in June by 350, (244 reported in May and 594 in June, 143% increase). Breaches due to 'waits to be seen' in ED have risen to 61% the highest recorded. Non admitted performance accounts for 54% of breaches, an increase of 16% on last month. This reflects the shift in patients choosing same day emergency and urgent care, as well as the change in the way primary care are managing patients. Think 111 first booked appointments utilisation sits at 57% for June , with 13% patients DNA the appointment slot, and 7% left without being seen.

Key Impacts on Performance

Flow into ED and the UTC via walk in attendances have significantly increased over the last 6 weeks. The number of SWAST conveyances have also increased causing surges in arrivals especially in the afternoon. Time lost for the ambulance service over 30 minute (15% from 17% in May) and 60 minute (5% from 8% in May) improved in month.
Delays to be seen by clinicians contributes to worsening performance. The ability for clinicians to assess patients is compromised due to ED and UTC overcrowding at times (volume of patients attending) as well as the number of clinicians being insufficient to see the volume of patients. If attendances continue to be at current level, the trust will see over 120,000 patients through Emergency and Urgent care.
Flow from to ED to base wards is at times compromised but has improved from 37% in May to 22% in June, however there are a number of patients that are classified as 'late referrals' (11%) that are referred to speciality within 4 hours but the delay to see clinician is over 60 minutes so coded as a 1st assessment breach. This is also a reflection of ambulance handover performance not being within target, resulting in more '1st assessment' delays. There has been a increase in performance in June relating to the number of patients waiting over 12 hours in the department, decreasing from 4% to 1%. One of the factors in this reduction is the creation of the Clinical Decision Unit (CDU) for patients to wait in a ward environment for diagnostics and treatments, Front Door Team (FDT) review and transport home. This area continues to function well and has additional support from community in-reach to facilitate admission avoidance.

What will make the Service green?

- Ability to offer SWAST alternatives to front door attendance. Including direct access to SDEC.
- Improvement in flow into inpatient beds, 24/7, to ensure patients move within an hour of referral.
- Development of the 'Think 111 First' programme to include access to SDEC and the change in culture of the local population's use of Emergency and Urgent care services.
- Trust wide escalation plans to support the timely flow and discharge of patients.
- Review and implementation of interprofessional standards for access to inpatient beds – ED consultants to have 'admission rights' to empty specialty beds in the trust to allow flow straight into empty beds.
- System wide approach to how the public access Urgent and Emergency care
- The 'Way Forward' programme: increasing size and capacity of front door areas.

Improvement actions planned, timescales, and when improvements will be seen

1. Complete **SAFER** Week which has identified several improvements that need to be made related to flow across the Trust. August's SAFER Week planning in place.
2. Commissioned review of the UTC to focus on; staffing profile, attendance profile (whether the current patient attendance is reflective of the current function and ability of the UTC)and opportunities to work with primary care to drive alternative community options. Await formal report from ECIST. **July 2021**
3. Business Case to move SDEC to a seven-day service completed. Case with Divisional Tri for review and to be presented at business planning meeting for approval. **August 2021**
4. Focus on reducing 15 and 30 minute ambulance handover delays. Ensure that handover process is embedded so that 'clock stops' at the point ED receive patient. BSW event in July to review system wide response to ambulance delays. SW collaboration to standardise trust escalation response to ambulance delays.
5. ED streaming tool – NHS England supported digital tool to enable patients to be triaged with 111 algorithms at the front door, in an aim to stream away to more appropriate services - scoping meetings underway to understand if appropriate for GWH. **July 2021.**
6. BSW review of minor injury management. Task and finish group to understand system pressures in minor injury management and how increase in presentations can be managed more effectively and reduce overcrowding and surges in attendances. **August 2021**
7. Review of UTC workforce and opening hours - sickness increased from 5% to 11% in one month. Well-being support being provided. Review of agency requesting process and incentive offering to staff to ensure shifts are covered. SBAR currently with division to approve**. July 2021**
8. Review of medical shift patterns - from August SHO and Registrar rotas changing to bring late and night shifts forward to match demand on the service. ACP recruitment continues to support backfill of the weekend gaps due to DRs contractual changes (interviews in July). Currently high reliance on locum cover which can reduce flow through department due to not being aware of local policies and procedures. Case being submitted to increase SHO/Registrar support in ED.

Risks to delivery and mitigations

There is a risk that ambulance handover delays will continue to be seen due to a high demand and lack of flow out of ED.

Mitigation: The ED Team are working closely with SWAST to identify opportunities to both support the crews delayed and identify and implement actions that reduce holding. Urgent review underway of any direct pathways to SDEC or Community services to reduce the pressure at ED. Greater emphasis needs to be placed on planning for SWAST surges.

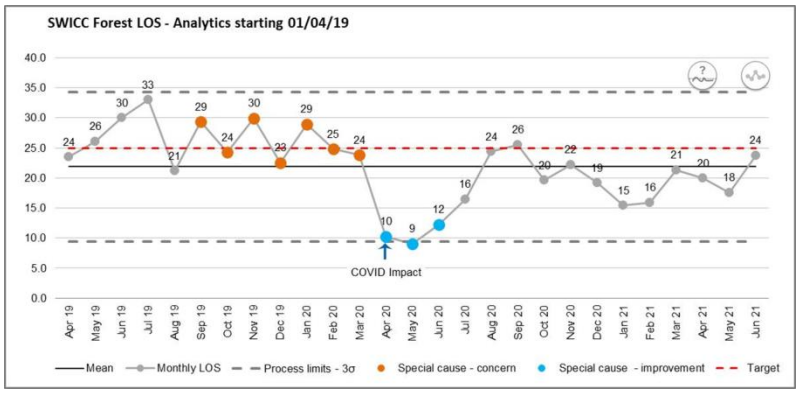
There is a risk that patient safety and performance will be compromised given the significant increase in ED/UTC attendances**.**

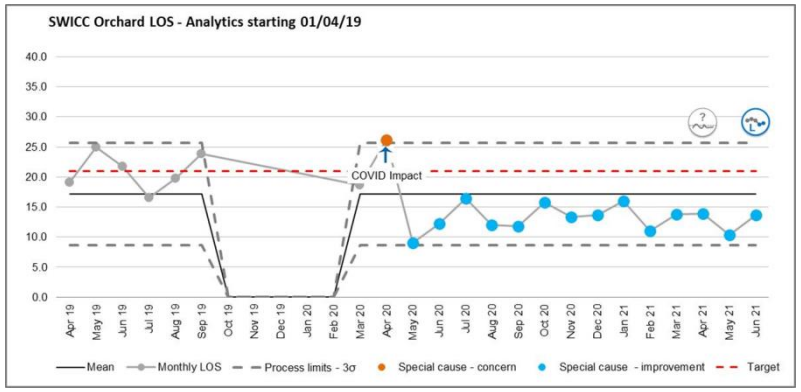
Mitigation: Work is underway with Primary Care to understand measures they can take to help reduce attendances e.g. minors task and finish group, (BSW wide). Commissioned review of the UTC to focus on; staffing profile, attendance profile (whether the current patient attendance is reflective of the current function and ability of the UTC) and opportunities to work with primary care.
Urgent actions underway to look at staff wellbeing and increasing numbers on shift to deal with demand. Focus on a stable workforce is a key priority. Options appraisal to look alternative community options. Review continues of any direct pathways to SDEC or Community services to reduce the pressure at ED. BSW wide focus. Discussions nationwide to collaborate ideas to mange the demand for urgent care that has a primary care need, and pathways for minor injuries.

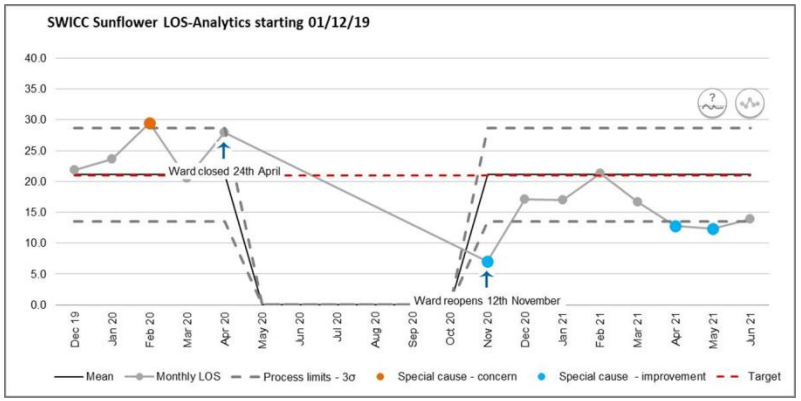
1. Emergency Access (4hr) - Community Length of Stay

Data Quality Rating:

Are We Effective?







Background, what the data is telling us, and underlying issues

Length of Stay - During June the average length of stay increased across all three wards, but remains within typical variation and below the target of 25. In **Forest Ward** the average length of stay was 23 days. In **Orchard Ward** the average length of stay was 13 days. In **Sunflower Lodge** the average length of stay was 13 days, with 4 patients length of stay over 21 days.

Discharges - Remain high, having seen a modest decrease. 162 in June compared with 177 in May. OOA patients account for 29 % of the bed base across the three wards and have and a longer average LOS, at 35 days.

Occupancy – current occupancy levels are between 95%-98% across the three wards.

Stranded Patients - There are currently 9 stranded patients which has decreased from 16 at the end of May. 6 Patients are super stranded.

Improvement actions planned, timescales when improvements will be seen

Stranded & Super Stranded Patients: in response to the increase in numbers of super stranded patients at the start June. A twice weekly review was completed by ward managers/therapy leads for Forest and Orchard. This was effective and reduced stranded patients by 7, in month. This approach will be replicated in Sunflower at the start of July.

Discharge Management: Nerve Centre has been adjusted and is compliant with the Community Site Rep reporting data requirements.

Further training needs have been identified to ensure all necessary colleagues are confident at completion, to a high degree of accuracy. This training will be completed during July and August.

Risks to delivery and mitigations

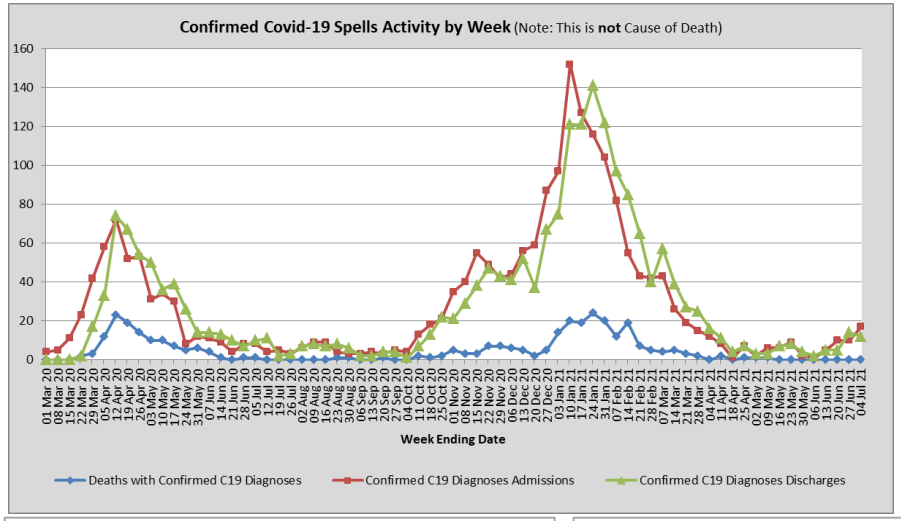
Risk: Delayed transfer and admissions to SwICC. caused by internal transport delays and the requirement for 24 hour covid swab tests. Transport related delays accounted for the majority of delays in June.

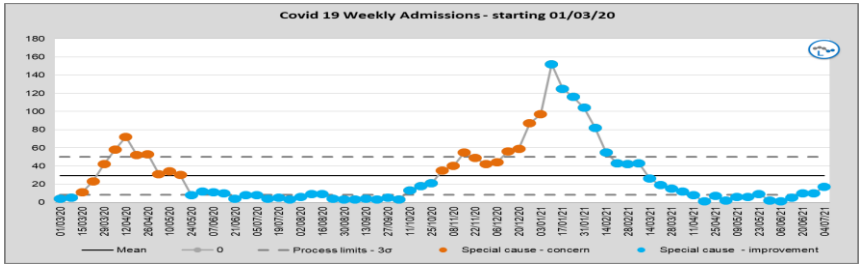
Mitigation: A detailed review will be undertaken in July to comprehensively understand all casual factors. This will facilitate remedial actions to be taken in August.

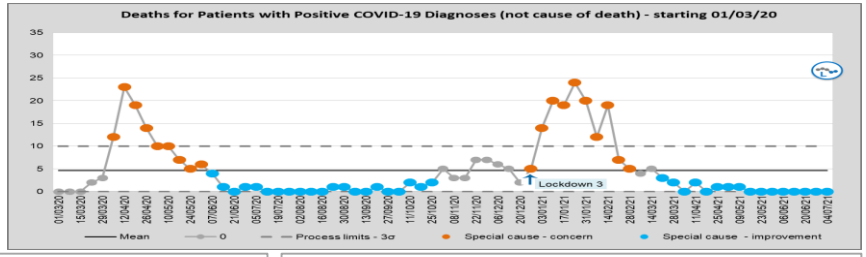
1. Emergency Access (4 Hours) Covid 19 Weekly Admissions

Data Quality Rating:

Are We Effective?







Background, what the data is telling us, and underlying issues

The graph above shows that whilst attendances to the Covid Assessment Unit (CAU) have remained low through June, there has been an increase in Covid positive patients. This increase has continued through July and CAU will be extended back to 11 trolley spaces (from the current 6.) The objective is for this to happen before the 17th July with a review in one month. This will allow for us to manage the increase in attendances we are seeing, as well as being prepared for any impact of all Covid restrictions lifting on the 19th July.

A review of the number of Cephid swabs available for CAU is underway (currently 20 a day) to ensure suitable capacity.

During June there have been 3 attendances to CAU from the Swindon Covid Quarantine Hotel.

Improvement actions planned, timescales, and when improvements will be seen

1. Review of CAU requirement and options for Covid patient management ongoing. Paper submitted to Exec team for consideration of options going forward. **July 21**
2. Expansion of CAU back to 11 beds (from current 6.) **17 July 21**
3. Review of number of Cephid swabs available for CAU (currently 20 per day.) **July 21**
4. Review of clinical model for CAU to try and ensure senior decision making to limit admissions. **July 21**

Risks to delivery and mitigations

There is a risk of delayed flow and impact to ambulance handovers in CAU due to lack of time target pressure and clinical demands.

Mitigation: Use of POCT/Cephid swabs and patients with high suspicion of COVID Trolley wait times escalated and CAU given prioritisation of patient movement, if these exceed ED.

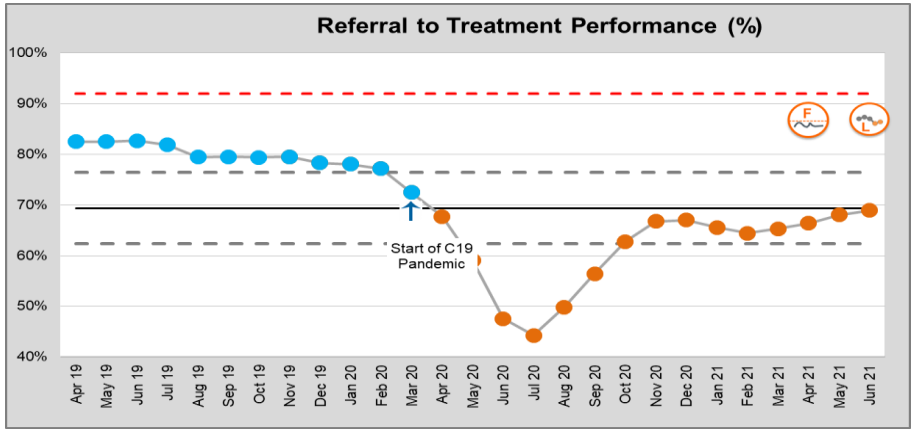
There is a risk of increased Covid Blue pathway attendances due to Covid variants and provision of the 'Quarantine Hotel'.

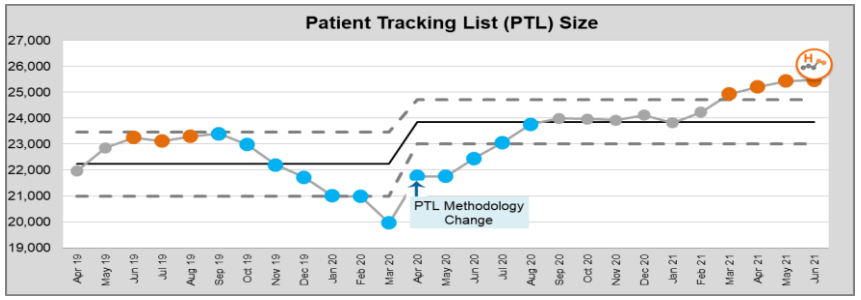
Mitigation: Review attendances and act on trigger levels. (+ Review CAU requirement).

2. Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

Data Quality Rating:

National Key Performance Indicators





	May	June
RTT Performance:	68.02%	68.89%
PTL Volume	25,434	25,465
Reportable 52 Week Breaches	1,276	985
In Month 52 Week Breaches	438	408

Background, what the data is telling us, and underlying issues

The Trust's RTT Incomplete Performance has been updated to include the most recent complete calendar month. The Trust's RTT Incomplete Performance for June 2021 was 68.9%, which was an improvement of **0.9%** in month.

The Trust reported a waiting list increase of 31 in month, resulting in a waiting list size of 25,465 against a BSW Trajectory of 25,910 (445 ahead of trajectory).

The Trust received 9480 referrals in June 2021, which is a reduction of 82 in month and 95.9% of the Pre-Covid 19 average referral rate.

In June 2021 there were 985 x 52-week reportable breaches. This is a decrease of 282 in month. Of the 985 breaches, 37 (3.8%) of them are P5 and have opted to defer treatment until post-Covid. This reduction is primarily driven by minimal patients who were due to breach 52 weeks in June, as a direct result of reduced referral levels in April and May 2020. Of the 985 reportable breaches in June; 838 were Admitted, 122 were Non-Admitted and 25 were Diagnostic.

There were 408 in month 52-week breaches cleared in June 2021 which is a considerable increase over the rolling 3-month average of 280 per month. Of the 408, 230 were admitted clock stops and 178 were non-admitted clock stops.

Improvement actions planned, timescales, and when improvements will be seen

- Elective Recovery Fund weekend lists have commenced with T&O, Urology and Gynaecology successfully completing Saturday list. Plans are in place to continue weekend operating until the end of September 2021.
- Elective Recovery Fund clinics have been planned for Ophthalmology from July to September 2021.
- The Trust will continue utilising 3-4 Independent Sector organisations for part/all of 2021/22. T&O capacity secured from Horton Treatment Centre and Circle Reading. Ad Hoc capacity agreed with BMI Bath Clinic.
- Daily Theatre Line Side Control meetings in place to monitor performance against required activity levels to deliver RTT performance. Throughput of Elective activity has increased from 992 cases performed in April 2021 to 1170 cases performed in June 2021.
- Ongoing focus on clearing our 78 week + patients, with all P5 & P6 patients being contacted and clinically validated.
  Overall number of 78 week + patients as at the end of May 2021 was 312, which has reduced to 287 at the end of June 2021.

Risks to delivery and mitigations

There is a risk that we lose core Elective Theatre capacity, due to supporting the Anaesthetic 3rd On Call Rota.

Mitigation: Recruitment due to be completed by end of June, with successful candidates in post from August.

There is a risk that despite identifying surgical provision for Elective Recovery Fund weekend lists, we may struggle to find Anaesthetic, Theatres and Support staffing who are able/willing to work.

Mitigation: Plan the weekend lists at least 4-6 weeks in advance, and look to utilise Bank and Agency where possible, and safe to do so.

There is a risk that we cannot fully utilise the IS capacity being provided due clinical and surgical restrictions, as well as patient choice and a reluctance to travel. This may result in patients being treated out of time order to ensure capacity is utilised.

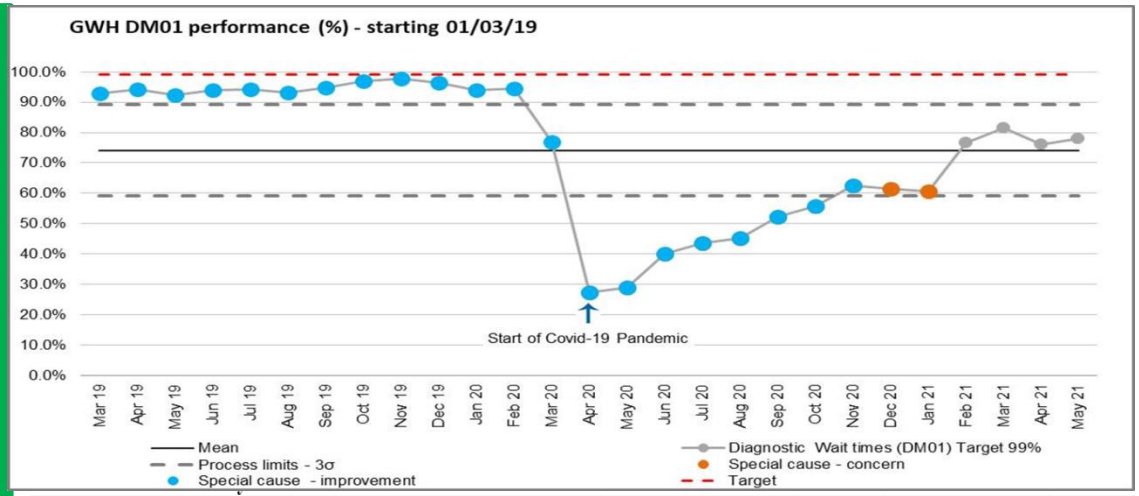
Mitigation: Ensure patient communication clearly explains the current challenges and waiting times and is being done at the appropriate level.

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

3. Diagnostic Wait Times (DM01) (Target 99%)

Data Quality Rating:

National Key Performance Indicators



Waiting	< 6 Weeks	> 6 Weeks	Total WL	Performance %	Total tests / procedures
Magnetic Resonance Imaging	758	7	**765**	99.08%	**974**
Computed Tomography	850	173	**1023**	83.09%	**3101**
Non-obstetric ultrasound	2266	646	**2912**	77.82%	**1933**
Barium Enema	0	0	**0**	N/A	**0**
DEXA Scan	185	1	**186**	99.46%	**122**
Audiology - Audiology Assessments	302	0	**302**	100.00%	**1012**
Cardiology - echocardiography	354	55	**409**	86.55%	**701**
Cardiology - electrophysiology	0	0	**0**	N/A	**0**
Neurophysiology - peripheral neurophysiology	90	0	**90**	100.00%	**39**
Respiratory physiology - sleep studies	35	4	**39**	89.74%	**85**
Urodynamics - pressures & flows	1	0	**1**	100.00%	**0**
Colonoscopy	229	313	**542**	42.25%	**320**
Flexi sigmoidoscopy	97	166	**263**	36.88%	**163**
Cystoscopy	31	3	**34**	91.18%	**170**
Gastroscopy	162	153	**315**	51.43%	**333**
Total	**5360**	**1521**	**6881**	**77.9%**	**8953**

May 2021

Performance Latest	77.9%
Waiting List Volume:	6881
6 Week Breaches	1521

Background

Performance was 77.9% in May and increase from 76.2% in April. Overall, the total waitlist size increased from 6283 in April to 6881in May (+598).

Breaches have increased from 1493 in April to 1521 in May (+ 28). Due to reduced CT van capacity during the month, Ultrasound backlog and the number of overdue surveillance lists increasing, we are predicting an increasing waiting list and breaches which will impact Trust DM01 performance from June onwards.

Improvement Actions

To support the recovery trajectory, the following key actions are in place. (Please see next slide for more detailed actions)

- 4 x adhoc CT van days have been allocated in June and 4 in July with NHSE providing 5 van days per week for CT2 replacement.
- Additional MRI van capacity sought through extension of Inhealth contract and within forecasted budget. 8 days confirmed for September and additional days in August to be confirmed and planned around CT van allocation from NHSE/I. Proposed 5 days a week of CT van capacity for August.
- Bank sonographer recruited into vacancy and 750 slots supported through additional staff payments to sonographers to support delivery of Ultrasound. New room now operational from W/C 7th June.
- Planned expansion of WCC into Oral health to accommodate echo. Review of surveillance lists. WLIs to be approved via ERF funding.
- Weekends lists are being booked to 12 points (both OGD and Colonoscopy) where case mix allows so that social distancing can be maintained. Fifth room build expected to be completed by the end of August.

Risks There is a risk that DM01 Surveillance clock start categorisations will lead to breaches in Echo, Audiology and cystoscopy which will substantially reduce Trust performance.

(Risk1855= 15) Failure to deliver DM01 for Imaging). There is a risk that insufficient capacity to recover the backlogs (including surveillance patients) remains the greatest risk to recovery along CT van availability has been relocated regionally by NHSE. CT replacement and radiology vacancies may further impact recovery. Mitigations remain in place above to support risk, detailed on next slide.

3. Diagnostic Wait Times (DM01) (Target 99%)

Data Quality Rating:

National Key Performance Indicators

Background, actions being taken and issues

Endoscopy: Combined, Endoscopy achieved 43.6% performance in May which is a decrease of 0.6% from April and 4% below trajectory (47.6%). The total number of patients over 6 weeks decreased by 61. By the end of May the trajectory showed a wait list of 600 over 6 weeks and the service closed the month on 632 (32 behind.) The number of patients under 6 weeks also declined in May (from 550 to 488) and so our denominator was impacted. If we had maintained 550 under 6 weeks, we would have achieved 47%. Endoscopy saw a decrease in total referrals in May, however, the number of 2ww referrals continues to exceed pre-Covid levels (+73.) Lists continue to be booked to 12 points at weekends. DNA's continue to be a concern with 10% of Covid swabs being DNA'd on average a month. DNAs combined with cancellations have seen an average of 15% of slots not being utilised in 3 of the last 5 months. GWH a confirmed pilot site for Capsule Endoscopy and two Consultants are currently undertaking training. Aim of pilot is to see a reduction in Endoscopy procedures required on the 2ww pathway. Endoscopy providing 115% of activity in comparison to 19/20 and BSW providing 155% in comparison to PY.

Radiology: Combined DM01 performance remains the same in May at 83.1% .The total number of patients waiting over 6 weeks increased in April to 731 with a further increase in May to 827 (+96). Dexa and MRI achieved the 99% target in May. NHSE have reallocated CT van capacity across the Southwest, which will impede the CT recovery trajectory from May onwards due to the loss of between 230 and 360 slots per month. It is predicted that this will lead to rises in both Waiting list and breaches delivering reductions in CT DM01 (70%- 75%) performance during this period.

Echo: Performance increased from 78.37% in April to 86.55% in May. April saw an increase in the overall wait list from 245 in April to 409 in May with Aerosol generating procedures Trans Oesophageal Echo (TOE) and Stress Echo (DSE/ESE) solely comprising the DMO1 breach list of 55 referrals. Routine NP Echo is now being booked <6 weeks. Echo wait list activity increased slightly from 461 procedures in April to 482 in May. Clock start categorisations as per national Guidance will reduce Echo performance from July onwards as the team completes validation of the surveillance waiting lists. A further review of the follow up list is underway to determine the impact.

What will make the Service Green?

Endoscopy: Completion of the fifth Endoscopy room which will increase capacity M to F and can increase overall activity if we also maintain weekend WLIs as they are now.

Radiology: Recruitment to further Cardiac Radiologist (1WTE).

Improvement actions planned, timescales and when improvements will be seen.

Endoscopy:

1. Revenue and activity options submitted via Investment Committee in February. Awaiting feedback as to whether Endoscopy can increase their activity once the fifth room is built through maintaining current WLI levels**. June 2021.**
2. Dependant on feedback as per above action, review of further growth in Endoscopy activity against ERF to be completed. **June 2021**
3. GWH a confirmed pilot site for Capsule Endoscopy and two Consultants are currently undertaking training. **August 2021**
4. Review of booking to 12 points in the week. **July 2021**
5. Build of fifth room to be completed by the end of August. **August 2021**

Radiology:

1. **CT**: Adhoc CT van capacity is being sought from NHSE (6 in May, 4 in June, and 4 in July) with a range of actions being implemented to mitigate the loss of van days (see risk column). Ad hoc cardiac slots have been increased on CT1 and booking in progress (oldest date for cardiac is 18th December 20). Additional hours have been offered to run extra CT lists. **June 2021**
2. **U/S** Room now has an earlier completion date (**June 21**). Additional US machine arrived in April. Recruitment of 1.6WTE Sonographer's is completed, 1 WTE commenced in June with 0.6 WTE start date in August. 750 Sonographer APS have been approved, with **381 diarised for June 2021 and a further 269 additional slots provided through Room 11 in June 202**1.
3. **MRI**: A further 17 van days of MRI van capacity has been secured in May and June 2021 (220 slots) . Due to loss of MRI capacity extension of the van contract with Inhealth has been undertaken. 8 days confirmed for September and additional days in August to be confirmed and planned around CT van.
4. **Echo:** An Echo flexi list has been introduced to take advantage of ECG/Treadmill Room when not in use. Where Echo takes place in 2 bays in the same room, patients have been staggered to support social distancing measures without reducing output. Phase 1 Redesign Work has been endorsed and funded to divide the TOEs room into 2 separate Echo Rooms completed late June. Action plans re follow up patients breaches are being developed

Risks to delivery and mitigations

Endoscopy: There is a risk that if the number of referrals being received continue to be higher then Pre Covid levels, the recovery trajectory will not be met (especially if the increase is seen in 2WWs.) **Mitigation:** Fifth room will provide more capacity M-F and 12-point lists providing more capacity with no additional expenditure.

There is a risk that as lockdown is lifted, patients will become more reluctant to agree to self isolate for 3 days between swab and Endoscopy procedure. **Mitigation:** Raised concern with Endoscopy Adopt and Adapt network who are looking at comms to Patients and Primary Care. Also requesting to treat a swab DNA in line with Access Policy.

There is a risk that with the reduction of CT capacity due to the loss of the mobile, the volume of referrals to Endoscopy will increase. **Mitigation:** weekly report highlighting number of referrals received into Endoscopy in place. Monitored through weekly access and Cancer Oversight.

Radiology: (Risk1855). There is a risk to patient outcomes and inability to deliver cancer waiting times and DM01. Mitigations include:

- NHSE approached weekly for further CT van capacity with 6 ad-hoc van days in May, 4 in June & 4 in July.
- Post code review of referrals underway to determine opportunity for mutual aid from SFT - Completed
- Approach IS to discuss/ reduce private patients. - Completed
- Additional Cardiac and CT sessions offered to staff
- Approached NHSE to provide CT van cover during CT replacement in August –Completed, proposed 5 van days a week during August. Awaiting confirmation NHSE/I on dates.
- Additional US machine delivered. U/S room completion due early June and escalated to complete sooner – Completed and in use in June 2021.
- Additional sonographer recruited (1 WTE) , with 0.6 WTE due to commence in August.
- Shielding staff member now returned to work
- Additional MRI van slots booked as per plan.

Echo: There is a risk that there is insufficient space to deliver echo cardiology within in the Wiltshire Cardiac Centre (WCC)reducing capacity to see follow up patients and increasing wait times. An Investment bid will be submitted for consideration to convert admin rooms 001/002 into 2 x Echo Bays while relocating the Diagnostic Reporting Team and Booking Team to offered rooms within Oral Surgery.

Cancer 2 Week Wait Performance Target 93%

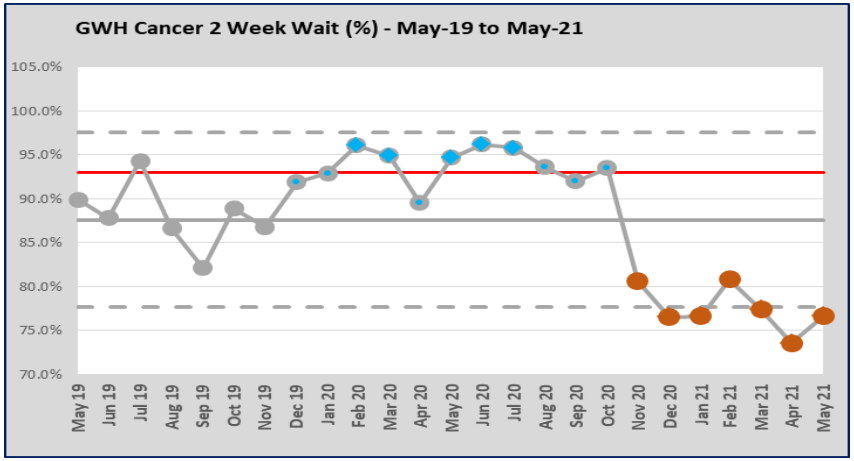
Data Quality Rating:

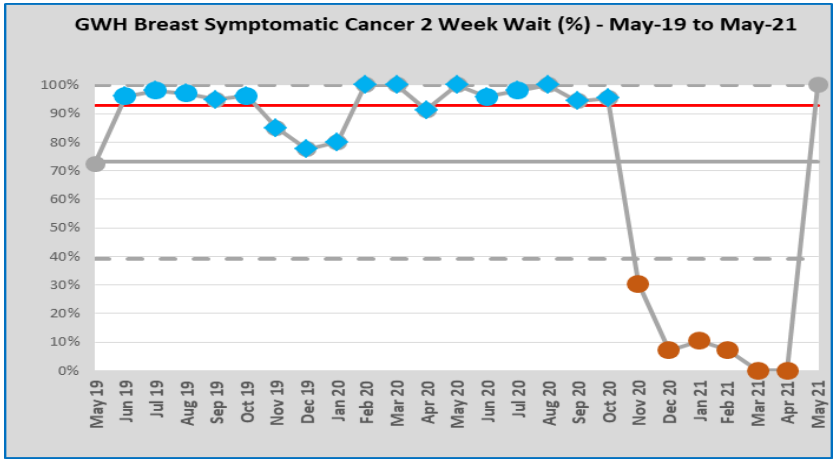
National Key Performance Indicators

Performance Latest Month: **May**

Two Week Wait Standard: 76.6%

Symptomatic Breast Standard: 100.0%





Background, what the data is telling us, and underlying issues

Two Week Wait (2WW) performance was inconsistent through 2019 due to pressures within breast, skin and colorectal. In 2020 the standard was achieved except for April, September, November and December due to breast & colorectal pathway pressures. Recent poor performance is mainly driven by pressures in the breast service.

Referrals into the breast service increased following breast cancer awareness month (October 2020) as anticipated. From this point the breast service have been unable to maintain 2ww performance due to capacity and physical distancing requirements in the breast unit as a result of COVID restrictions. To maintain usual demand the team needs to deliver 1 wait list initiative (WLI) clinic each week. The same team also support the breast screening recovery work.

In May there were 3 WLI evening clinics resulting in 36 additional patients being seen. The breast team are reviewing the trajectory to deliver recovery in August. Current booking time is 22 days.

The standard was not met in upper GI as a result of limited outpatient capacity partly as a result of 2 clinicians being unable to return from India due to COVID restrictions. Patient choice and the reluctance of patients to attend the hospital as a result of COVID remains a challenge within endoscopy.

GWH will be a pilot site for Colon Capsule Endoscopy (CCE). Training commenced in June.

Improvement actions planned, timescales, and when improvements will be seen

1. Breast 2ww recovery plan is now in place with WLIs and weekend clinics through June(4) to help recover position. The forecast and trajectories show that the additional WLI clinics are required to recover and maintain 2ww performance. Recovery is expected to occur in August.

2. Endoscopy continues to deliver procedures within 2 weeks. TVCA requested that Endoscopy services be protected through the COVID recovery and that Gastroenterologists not to be working on Trust medical rota. Endoscopy Service have recovery plan and have maintained cancer activity.

3. qFIT (faecal testing) was introduced in primary care for LGI 2ww pathway. The number of 2ww referrals including qFIT results are shared monthly with the Primary Care Network (PCN). 45.5% of all Lower GI referrals had Qfit completed in June Swindon PCN is proactively managing non-compliance, 51.0% of referrals from Swindon GPs included a qFIT result.

4. The teledermatology trial in Dermatology continues with 370 referrals to date. In total 177 referrals have been returned to GP with advice or routed to non 2ww pathway since January.

5. Colorectal pathway mapping exercise completed on 9 June explored possible improvements and shared pathway delay issues.

6. The Upper GI doctors, who had been isolating following their prolonged stay in India as a result of COVID, have now returned to duty. Additional sessions are being put on to help meet demand for new and follow up appointments

Risks to delivery and mitigations

1. Risk: Unable to deliver WLI activity in breast service will impact recovery trajectory

Mitigation: close monitoring of activity and of staff well being.

2. Risk: UGI clinic capacity

Mitigation: WLIs in place to support activity and Saturday lists for Endoscopy.

3. Risk: Patient reluctance to attend during easing of national lockdown.

Mitigation: Patient navigators and clinical nurse specialists supporting patients to attend appointments and diagnostics. Trust communications on social media to support attending is regularly provided.

4. Risk: Capacity in dermatology unable to meet demand over summer.

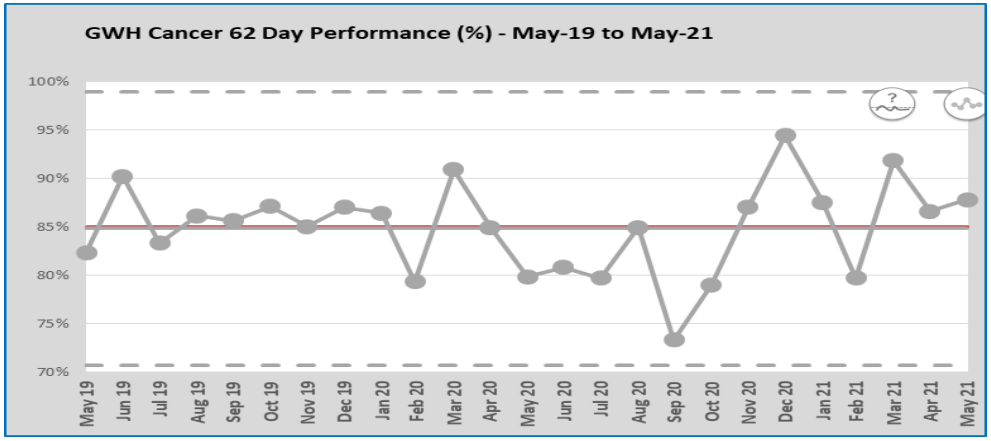
Mitigation: cancellation of routine clinics to provide additional capacity. Additional WLI's are planned through July. Vacancies have now been filled with Associate Specialists starting in July and August. Consultant maternity leave from early July will be covered by locum, which is currently out for recruitment.

5.Risk: Capacity to deliver CT & MRI through the summer during CT replacement works.

Mitigation: additional CT van days are being arranged through July & August. Request for MRI van being made to help support the service. Annual leave and radiographer vacancies will put pressure on service's ability to deliver scans within KPIs.

Cancer 62 Day Standards Performance Target 85% Data Quality Rating:

National Key Performance Indicators



Performance Latest Month: **May**

62 Day Standard (Target 85%):	87.8%
62 Day Screening (Target 90%):	100.0%
62 Day Upgrade (local standard 85%):	88.6%

Background

May 62 day performance is anticipated to be 87.8% with the Trust achieving the national 62-day standard. Performance in the last year has been heavily impacted by the COVID 19 pandemic with diagnostic/treatment delays since March 2020 .

The performance for May had been predicted to be challenged. Four diagnosed pathways rolled to June due to capacity with the tertiary provider(Colorectal & Upper GI), a Skin patient with a delayed biopsy and an all-options Urology case. Two forecasted breaches were treated in April, one case was treated in time and a further patient's pathology revealed no cancer. Four predicted suspicious patients did not have a cancer diagnosis.

May breach reasons included a complex pathway that required additional diagnostics. A further pathway was delayed by a patient needing to isolate as a result of COVID before their first diagnostic test. Two Gynae pathways were delayed by OUH histology reporting (23 & 28 days to report). A colorectal patient delayed their first diagnostic test following their initial outpatient appointment. Three colorectal pathways were delayed as a result of the ongoing capacity issues in oncology. A high-grade prostatic patient was offered all options, the pathway also included a 2-week delay to a follow up appointment as a result of patient choice. A further skin patient was transferred to OUH on time resulting in no breach to GWH.

In May, the screening standard was fully compliant.

The upgrade standard was also met in May. A breached pathway in Gynae was as a result of delays to a diagnostic test and the reporting of the pathology from OUH. A colorectal pathway breached as a result of the need for repeated diagnostics and an inpatient stay. A further breach in upper GI was transferred to OUH within 38 days, resulting in no breach being recorded against GWH

Improvement actions planned, timescales, and when improvements will be seen

1.Weekly PTL review meetings continue to be held to help advance pathways and identify outstanding actions.

2. Thames Valley Cancer Alliance (TVCA) transformation work continues with focus on lung and colorectal Rapid Diagnostic Service (RDS) pathways with the TVCA arranging local meeting with clinical teams in June.

3. TVCA continue to monitor priority 2 (P2) patients to ensure patients are offered treatment in a timely manner across alliance. Intensive care capacity is improving in Oxford to support complex surgeries particularly for Head and Neck and Upper gastro-intestinal patients.

4. Current breaches are as a result of diagnostic , pre-assessment, theatre and clinic capacity delays as services recover activity in accordance with social distancing guidelines. This will be monitored at cancer delivery meetings.

5. Follow up capacity in Lower GI has been challenged. The service has been reviewing the job plans of the registrars to review more of the routine patients, freeing up clinic slots for the consultants to see their 2ww cancer patients.

6. Template biopsy kit is now with procurement and undergoing a tender process. It is anticipated that this will take one month.

Risk to Performance Delivery

Risk: June performance is not expected to achieve with a number of patients being treated outside timeframes yet to have a formal diagnosis. Current forecast suggests a performance of approximately 80%.

June breaches are impacted by capacity issues at OUH in oncology and surgery with 7 pathways effected (2 skin, 2 head & neck, 2 sarcoma, & 1 colorectal). 2 pathways (colorectal and lung) have involved patient choice, with one requiring a second opinion before treatment could be organised and the other choosing the location of their PET scan. 12 pathways (2 breast, 1 haematology, 2 upper GI, 2 skin, 5 urology) have involved complex cases where additional diagnostics were required and/or the cancer was difficult to diagnose. Other pathways have seen delays due to clinical capacity and delays to due to oncology capacity.

CT van sessions are in place to help support radiology during the replacement of the CT scanner this summer. This may have an impact on the service being able to offer earlier scans to help bring pathway forward. Radiology are actively managing and prioritising cancer referrals. PET CT van would assist capacity. Nuclear medicine is challenged impacting the breast sentinel node biopsy pathway.

Mitigation: Twice weekly PTL meetings continue to be held and cancer delivery meetings to progress pathways and improvement work. PTL discussions with the Lab manager and the Radiology manager are held to highlight pathways that require escalation.

Outpatient capacity issues in both the upper and lower GI pathways continue to delay follow up activity.

Straight to Test Nurse posts are now in place resulting in the improved triage of colorectal patients to their first appointment or diagnostic. This will also support the communication of diagnosis.

Oncology capacity remains challenged due to significant workforce gaps. Workforce modelling is underway with discussions with Oxford University Hospitals (OUH). GWH will recruit locally for clinical oncologists with the satellite unit expected early 2022. These posts will be GWH based and include some OUH activity (2 days).

Delays to Breast first appointments are starting to have an impact on 62 day breaches with 3 pathways being impacted in June. A weekly PTL review and surgical update meeting is held to help identify patients who need to be escalated.

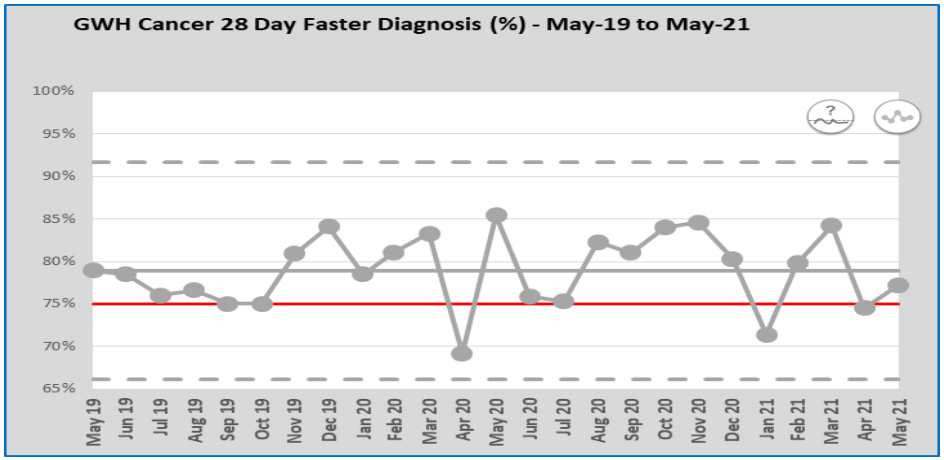
Cancer 28 Day Diagnosis Target 75%

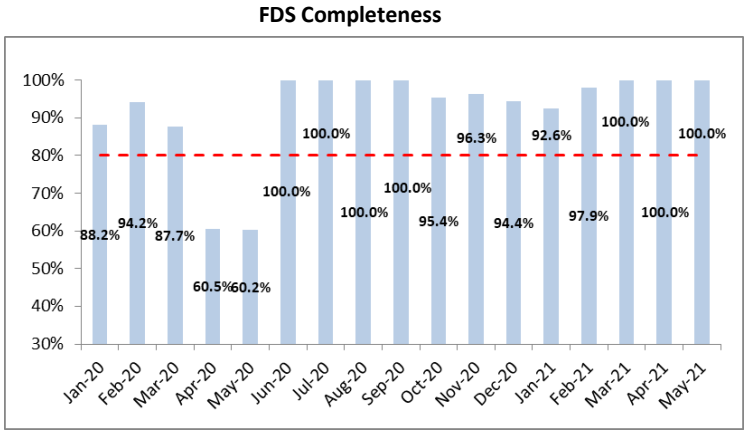
Data Quality Rating:

Are We Effective?

Performance Latest Month: **May**

28 Day FDS 77.2%





Background

The delays to diagnostic testing and outpatient activity through the COVID pandemic has led to delays with communicating cancer diagnosis with patients.

The standard will be informally reported in the Public View domain from June 2021, with the more formal management from September.

The standard was met in May with a performance of 77.2%, however some sites fell short.

Gynae pathways were delayed by waiting times for letters post appointment and a number of pathways requiring histology to confirm diagnosis. Delays to pathology reporting by OUH continues to impact pathways

Colorectal performance continues to be adversely affected by the delays to follow up appointments following first diagnostic tests with pathology results and following MDT as a result of clinical capacity. Delays to typing of letters and clinical reviews of test results impact this standard..

Upper GI pathways were delayed due to typing of letters following review of test results and clinics. Capacity to see patients post first diagnostic test also played a part in a number of breaches.

The Urology performance was affected by capacity for virtual follow up appointments following diagnostics tests.

June is not forecast to be compliant with the standard. Colorectal, gynae, skin, upper GI and Urology are currently not meeting the standard with administrative delays to letters and follow ups being the main reasons for the breaches.

Improvement actions planned, timescales, and when improvements will be seen

Virtual outpatient follow up remains in place across several sites to communicate the exclusion of a cancer diagnosis. Teams to review this is adequate for the service.by August 2021.

Thames Valley Cancer Alliance (TVCA) transformation work focuses on lung and colorectal pathways for rapid diagnostic services. GWH will focus on lung pathway with first patient expected September.

Review of process for the recording of the communication of diagnosis completed. Patients will remain on the Cancer PTL until they have had their diagnosis communicated. 28d FDS PTL being developed to highlight pathways to heads of service, it is anticipated that this will go live at the end of July.

Colorectal mapping session to review pathway and potential improvements completed.

Two clinicians in Upper GI have now returned to work following an extended stay in India due to COVID and the necessary isolation on their return to the UK. Additional clinics are planned to support demand which will help cancer pathways.

TVCA funded colorectal straight to test nurses commenced in May 2021.

Best practice from Bournemouth shared at Cancer Delivery meeting to assist with focus on plans to achieve the standard consistently. Gap analysis and plans to achieve are being discussed at July meeting.

Bimonthly TVCA audit of 28day FDS records commences in July to ensure there is consistent reporting across the Alliance.

Risk to Performance Delivery

1. Risk: Delayed access to diagnostic tests will impact ability to book outpatient follow up within 28 days . Any suspension of Endoscopy services will compromise this standard. Lower GI, Upper GI & Urology all use the unit for early pathway diagnostics. Reduction in CT van availability will also impact

Mitigation: Service recovery plans in place protecting diagnostics and endoscopy unit.

2. Risk: Typing times for services delays progression of patients on the cancer PTL

Mitigation: Divisions are working on cover plans for services and bank typists.

3. Risk: OUH pathology delays will impact gynaecology pathways predominantly.

Mitigation: Escalated with OUH and pathology monitoring of key performance indicators working with clinical lead where deviations noted.

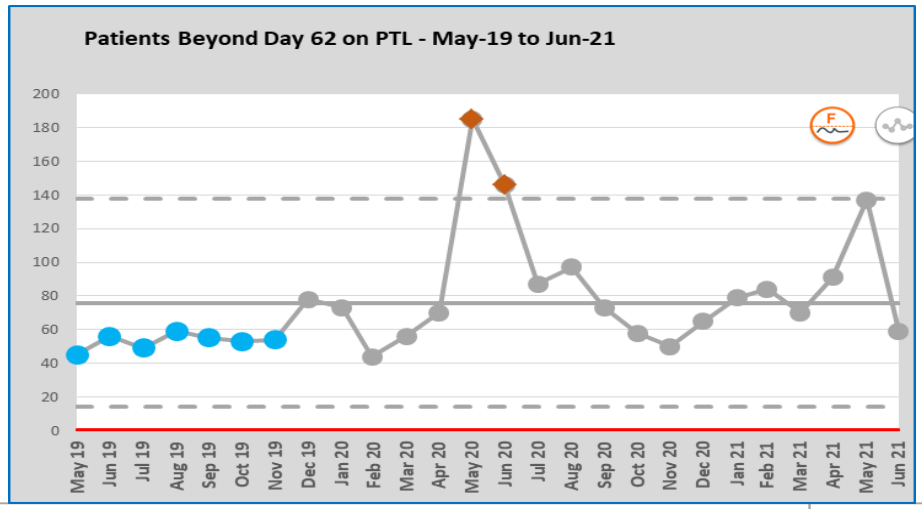
4. Risk: Delays to follow up appointments in colorectal and upper GI, as a result of consultant capacity, will impact on the delivery of diagnosis.

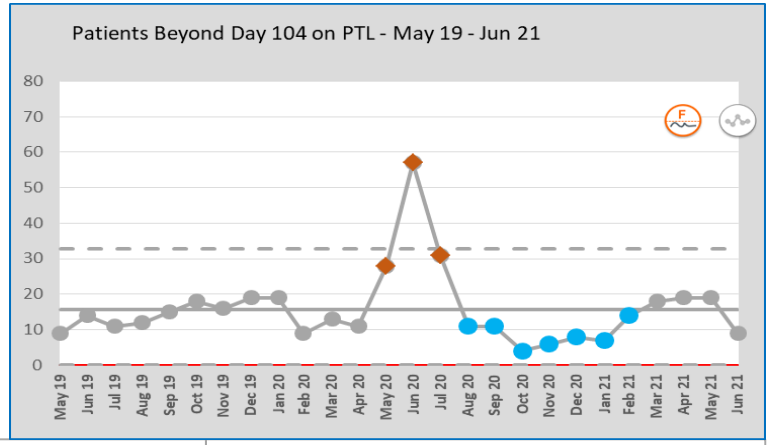
Mitigation: Colorectal service has recruited two registrars to support clinics releasing consultant capacity to see cancer patients.

Cancer 62 day + longer waiters including > 104 day

Data Quality Rating:

National Key Performance Indicators





Background, what the data is telling us, and underlying issues

104 Day Breaches: May: 6 Patients; 4.5 breaches (IPT)

Treated at OUH

Colorectal: 1 patient-1.0 breach: pathway heavily impacted by capacity issues within Oncology. There were also delays to follow up appointments post MDT.

Gynaecology: 2 patients-1.0 breach: pathway delayed by wait for pathology from OUH before late ITR for treatment, surgery delayed at OUH due to surgical capacity. Second patient pathway experienced the same delays.

Treated at NBT

Urology: 1 patient-0.5 breach: all options patient whose pathway was impacted by delays to clinical follow ups due to patient choice and capacity.

Treated at GWH

Gynaecology: 1 patient- 1.0 breach: complex pathway which included OUH pathology delays and a change in treatment plan.

Urology: 1 patient-1.0 breach; patient tested positive for Covid thus delaying first appointment. There was also a delay to the follow up appointment due to clinical capacity.

June is likely to see 2 patients breach 104 days on their pathway resulting in 1.0 breach. The Skin and Haematology patient had complex pathways.

The number of patient pathways over 104 days has reduced significantly through June due to the closing of a number of non cancer records on a skin pathway, these pathways had been delayed by the issues with typing times. This is also true for the improvements in the number of 62day+ pathways.

Improvement actions planned, timescales, and when improvements will be seen

The "Managing Long waiting cancer patients (62 day+)" Standard Operating Procedure (SOP) proactively monitors all patients over 62 days on the Patient Tracking List (PTL) and is business as usual for teams and has resulted in the number of patients over 104 days reduce to pre-Covid levels.

This report continues to be shared with the Medical Director for executive clinical oversight monthly.

62 day breach reports and long waiting patients are now reviewed by MDT coordinators with the CNS team ahead of being shared with the service leads. These are being produced shortly after treatment has been completed.

62day+ report is supplied to TVCA on a monthly basis to inform Alliance on cross trust issues

Risks to delivery and mitigations

1. Risk: Patient pathway delays are seen when diagnostic, outpatient and theatre capacity is challenged and also in the treatment preparation (COVID management pre-assessment & theatre capacity).
Mitigation: Working with elective booking teams highlighting delays in PTL meetings.

2. Risk: Tertiary centre theatre capacity challenged during Covid particularly for patients requiring High Dependency Unit (HDU) recovery.
Mitigation: The monitoring of long waiting patients via OUH PTL with HDU capacity steadily improving.

3. Risk: Patient reluctance to attend pre-vaccination.
Mitigation: Patient navigators and clinical nurse specialists supporting patients to attend appointments and diagnostics. Trust communications on social media to support attending is regularly provided.

4. Risk: Delays to pathway communication from tertiary centres resulting in patients being on PTL longer than necessary.
Mitigation: weekly PTL updates from OUH, heads of service regular contact with counterparts where necessary.

Pathology delays are being escalated with OUH where they are identified during weekly PTL review meeting.

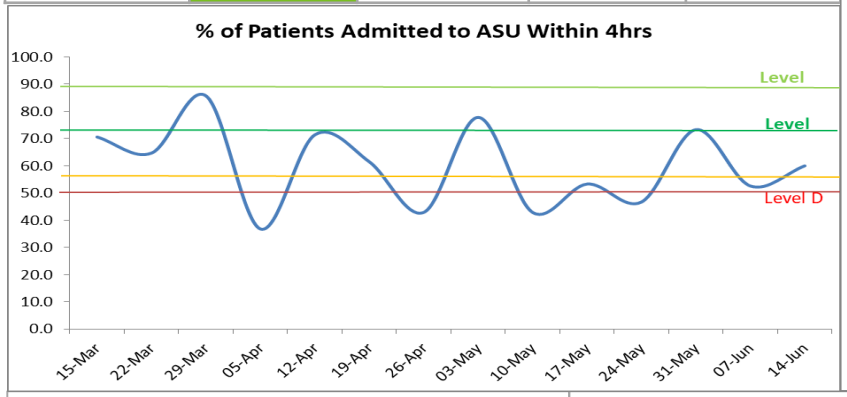
Stroke Pathways

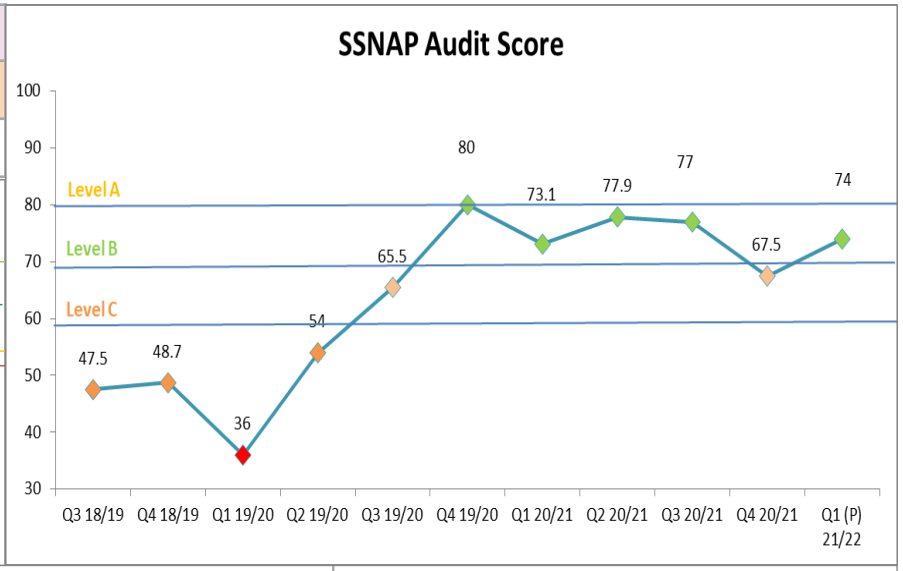
Data Quality Rating:

National Key Performance Indicators

GWH SSNAP Audit Score:

Year	Q1	Q2	Q3	Q4
2020 - 21	B	B	B	C
2021 - 22	B (p)			





Background, what the data is telling us, and underlying issue

The Trust scored at Level C performance for Q4 20/21. This was due to points lost across the Physiotherapy/Occupational Therapy domains (this team are carrying 3 WTE vacancies) as well as points lost on Audit Compliance due to the unplanned absence of the Stroke Data Administrator. Although performance across the 10 domains returned Level B, points lost in audit compliance put us below the threshold required for Level B.

In month performance for June has seen a recovery in both of these areas with SSNAP predicted scores of B and A for Physiotherapy and Occupational Therapy respectively, with audit compliance predicted at level A.

June has proved to be particularly challenging in maintaining direct admission to the stroke unit, with 26 breaches out of 53 admissions up to 24th June21.

Q1 21/22 is currently predicted at Level B/74.

Improvement actions planned, timescales, and when improvements will be seen

1. PT/OT Team recruited to 3 x therapists due to start in Aug 21. **Aug 21**
2. Development of business case to support increased OOH stroke cover. **Jul 21**
3. ED Nurses to shadow Stroke Specialist Nurses to improve knowledge and confidence with Thrombolysis. **Jul 21**
4. Review of Bournemouth Predictor Tool to understand Q4 performance over prediction. Awaiting feedback from Bournemouth. **Jul 21**
5. Regular meetings from Therapy teams to identify pressures which may affect stroke patients and put mitigation in place to maintain performance. **Aug 21**

Risks to delivery and mitigations

Risk No 2756 (score 12) – There is a risk that delays to stroke patients being admitted OOH to the ASU outside of the 4-hour timeframe will face reduced quality of care through delayed access to specialist stroke treatments.

Mitigation : Stroke Matron monitors admissions to the ASU on a weekly basis . IR1s are completed for any breaches of SOP to drive improvement performance. Overall site pressures have influenced further SOP breaches and a marked decline in direct admission performance.

There is a risk that the PT/OT team vacancies will continue to impact the overall performance of Stroke until filled in Aug 21.

Mitigation : Recruitment has been made to vacancies with start dates to be confirmed. Redeployment of staff across the Stroke pathway to minimise impact. Regular discussions with Therapy team to identify any pressures and put mitigation in place.

Board Assurance Report

Quality & Governance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		22 July 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - EDS	Amber	Amber	We await the outcome of recent observations of pre-discharge ward rounds in relation to EDS completion. Induction of new junior doctors will take place, stressing the importance of EDS completion. Currently the number completed within 24 hours is only 64%. Patients discharged from day case stays receive a paper Final Consultant Episode (FCE) summary and a copy is sent to the GP via the patient.	Continue monthly monitoring	
Integrated Performance Report	Green	Green	This is an overall rating for those items not listed separately. Pressure Ulcer numbers have fallen since last month. Falls have remained at the same level at 5.5/1000 bed days cf. 8.6 in February. Serious Incident reports have further reduced and a Never Event reported last year has been downgraded as it did not meet the criteria for a NE. Overall "safer staffing" measures remain safe though some do not meet recommended levels. Work is ongoing to recruit to ED & Midwifery to address this.	Continue monthly monitoring	

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Perinatal Safety-Quality Surveillance Tool	Amber	Amber	Caesarean Section rates were included for the first time in the IPR after the committee requested it. Some concerns were expressed at the high rate in April but this reduced over May & June to 32%. Included in this report was an update on CNST. Last month we were told that we were failing on only one of the ten standards. However this has now slipped to two. In addition we are told that still only 57 hours of consultant obstetrician cover is available on the delivery suite, instead of 60.	We will continue to monitor this and if figures remain over 30% a more detailed understanding of interventional delivery rates will be requested to include forceps and Ventouse. The Executive will be pursuing this with CNST in an attempt to secure the funding.	
Perinatal Mortality Review Tool	Green	Green	There were four relevant cases and the Trust was 100% compliant in meeting standards for their review.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Part 2: Our Care

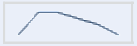
Our Priorities

How We Measure

Are We Effective?	Are We Responsive?
Are We Safe?	Are We Caring?
Are We Well Led?	Use of Resources

Our Care Summary

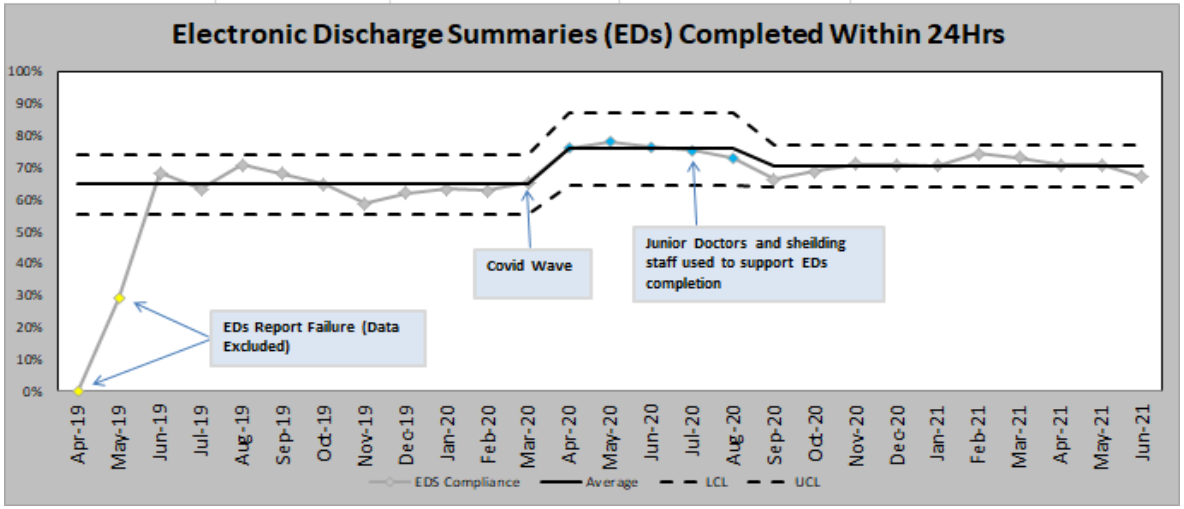
Great Western Hospitals NHS Foundation Trust

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
C. Difficile (Hospital onset) per 1000 bed days	10.4 (Apr 21)		21	71	32	Apr 0421
VTE Assessment	99.1% (Jun 21)		18	114	1	Dec 19
Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death)	1.1% (June 21)		120	20	100	Dec 20
Hip Fracture Best Practice Tariff – 12 Month Rolling	69.7% (May 21)		32	85	6	May 21
Complaints Rates	27.9 (Q4 20/21)		104	50	22	Q4 20/21
Family and Friends Score – Percentage of Positive Responses - Inpatients	81.9% (Jun 21)		129	30	4	May 21
Complaints Response Backlog	0.1 (Q2 20/21)		1	17	23	Q4 20/21
MRSA all cases	2 (Jun 21)		40	112	78	Apr 21
Falls per 1000 bed days	5.5 (Jun 21)					
Pressure Ulcers – Acute	19 (Jun 21)					
Pressure Ulcers – Community	36 (Jun 21)					
Never Events 21/22	0					
Serious Incidents	2 (Jun 21)					

2. Electronic Discharge Summary (EDS)

Data Quality Rating:

Are We Safe?



	24 hours	48 hours	72 hours.
Sep-20	66.47%	71.24%	74.65%
Oct-20	69.05%	73.49%	76.99%
Nov-20	71.14%	75.67%	78.62%
Dec-20	71.08%	75.59%	79.81%
Jan-21	70.81%	75.43%	78.50%
Feb-21	74.36%	74.84%	77.55%
Mar-21	73.22%	77.53%	81.36%
Apr-21	70.95%	75.28%	78.90%
May-21	70.94%	76.03%	79.42%
Jun-21	67.20%	70.88%	72.97%

Background, what the data is telling us, and underlying issues

All in-patients discharged from our organisation should receive a copy of their Electronic Discharge Summary (EDS). Their General Practitioner (GP) should receive a copy of the EDS within 24 hours of discharge.

There is a contractual agreement between the Trust and the Clinical Commissioning Group (CCG) for discharge summaries to reach the GP within 24 hours.

The data above demonstrates that on average the number of EDS that reach the GP surgery within 24 hours is 64.34% and by 72 hours this figure increases to 72.93%.

All Day case patients discharged from our organisation receive a paper version of the discharge summary called a Final Consultant Episode (FCE). A copy of the FCE is sent to the GP via the patient.

Improvement actions planned, timescales, and when improvements will be seen

The Electronic Discharge Summary (EDS) working group was originally set up in 2018 and is led by the Deputy Medical Director (DMD), with quarterly meetings.

The DMD is supported by Transformation & Improvement Hub (T&I) the Quality Improvement Lead and Emergency Care Improvement Supportive Team (ECIST). There is good representation from the Ward Clerk, Medical Staff, Nursing Teams, Physiotherapy, Pharmacy, Matron and the Discharge Team.

As part of the QI project, work has been undertaken to observe ward rounds and the provision of EDS in preparation for discharge. The results of these observations will be discussed at the next EDS meeting to inform the next steps in improvement.

Training packs for Junior Doctors, who complete EDS, are being rolled out for the next change over of doctors in August.

The Clinical Consultant Information Officer (CCIO) and Clinical Nurse Information Officer (CNIO) are reviewing and updating the IT induction training pack for new doctors this will also include the EDS element of the induction Pack and they will link in with the clinical fellows producing the EDS training pack.

Risks to delivery and mitigations

Due to the age of the current EDS system we are unable to make any further changes to the system.

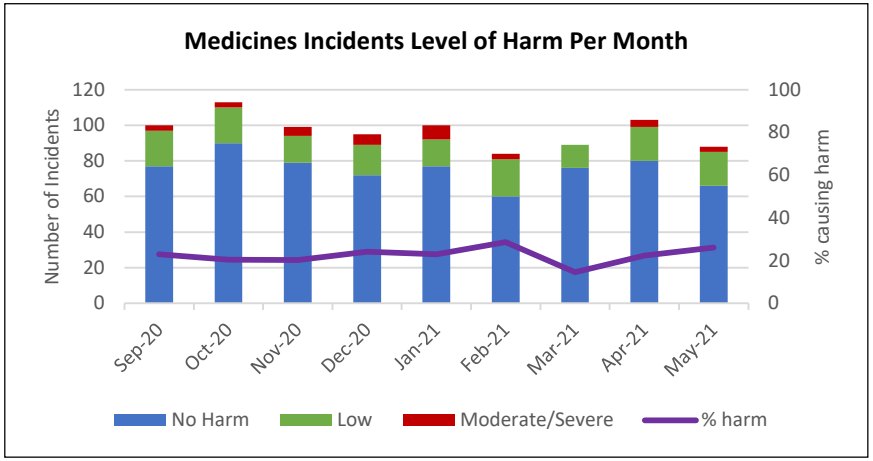
The current EDS system is a standalone system, there are plans to update the Care Centre (Medway) system. Further work in ongoing to assess the impact of this on the EDS system.

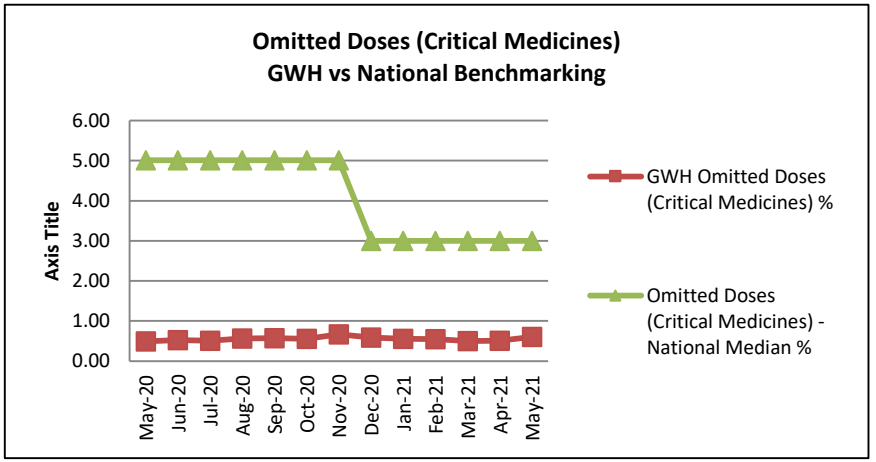
Regular change over of Medical staff affects EDS performance. The Junior Doctor revised training pack on induction will hopefully mitigate this risk.

2. Medicines Safety

Data Quality Rating:

Are We Safe?





Background, what the data is telling us, and underlying issues

Medication Incidents

- The rate of medication incidents and the proportion causing harm remains stable across the year.
- No new trends and themes identified in May.
- Specific incidents reviewed in May involve transfer of information on discharges to Primary Care. These incidents to be monitored closely in future months.

Omitted Critical Medicines

- Percentage of unintended omitted critical medicines (all administrations of medicines) remains consistently low.
- Compared to the national median of acute hospital trusts (2020 national benchmarking*), Great Western Hospital (GWH) has a lower rate of unintended omitted critical medicines.
  *Benchmarking value updated Dec 2020

Improvement actions planned, timescales, and when improvements will be seen

Medication Incidents

- Medicines Safety is a focus area of the Great Care Campaign. The overall aim will be to reduce the harm from medicines incidents. Themes will be identified from previous incidents and triangulated with quality and safety work streams across the Trust. Initial work streams plan to focus on accurate administration of medicines and the prescribing of regular medicines on admission, this will contribute to improving communication on discharge.

Omitted Critical Medicines

- The process for identifying omitted medicines is via an audit on the Perfect Ward App (the Trust's electronic audit programme). Information on omitted medicines has recently been updated and circulated to ward areas, this also details how to securely order medication out of hours. Work is on-going with the pharmacy team to identify any particular medicines which are omitted and therefore enable a more focused approach.

Risks to delivery and mitigations

Medication Incidents

No specific risks to delivery identified at this stage.

Improvement actions overseen through existing quality and safety governance routes, including Medicines Safety Group and Serious Incident Learning Group.

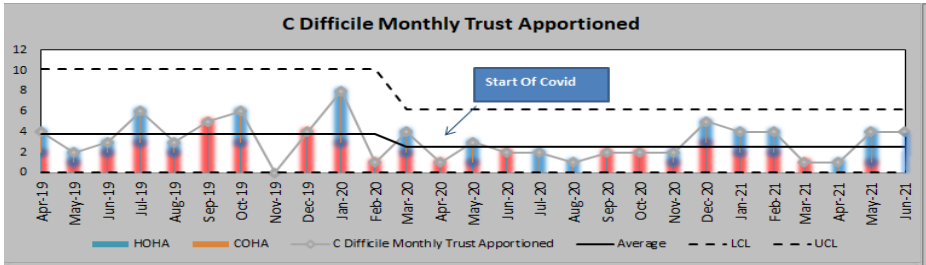
Omitted Critical Medicines

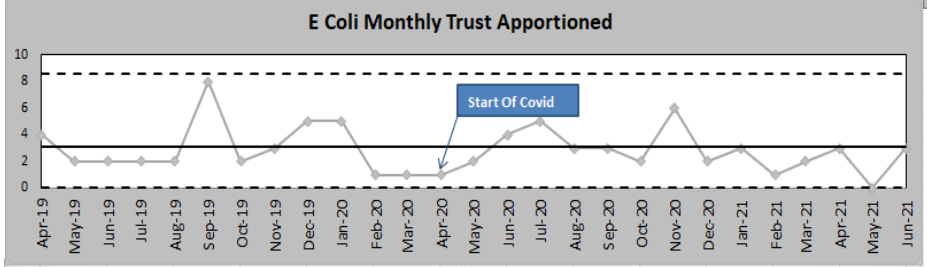
No specific risks to delivery identified at this stage.

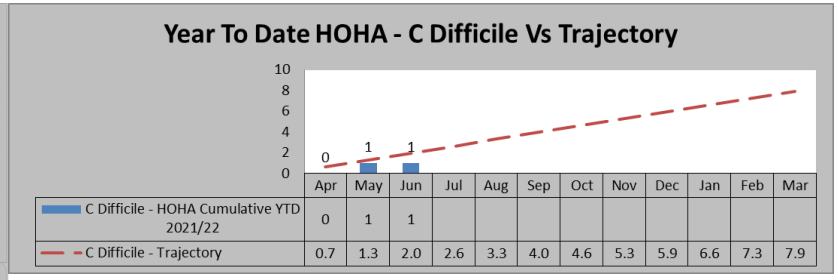
2. Patient Safety - Infection Control

Data Quality Rating:

Are We Safe?







	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C Difficile - HOHA Cumulative YTD 2021/22	0	1	1									
C Difficile - Trajectory	0.7	1.3	2.0	2.6	3.3	4.0	4.6	5.3	5.9	6.6	7.3	7.9

MRSA Bacteraemia	2020/21	2021/22
Trust Apportioned	0	2

Hand Hygiene	June
Audit Results	99.54%

Background, what the data is telling us, and underlying issues

C. difficile – In June there has been one Hospital Onset Healthcare Associated infection identified on Mercury Ward.

The Trust reports all *C. difficile* detected on inpatients, this includes all those acquired outside of the hospital (community) setting and those within the acute setting.

MRSA Bacteraemia –2 cases reported for June.

One patient with complex health issues was admitted to intensive care following trauma. The patient was found to be colonised with MRSA on admission and the bacteraemia was detected 15 days into admission. An investigation is underway and action plan being developed.

The second case was a patient with on going infection that had a repeat positive culture whilst an inpatient in GWH, according to the national database definition this will be attributed to GWH. This has been discussed with NHSE/I and there are no care concerns.

Improvement actions planned, timescales, and when improvements will be seen

C. difficile - All cases of *C. difficile* are typed (analysed to identify different strains) to ensure that there can be identification of any cross infection. This is a proactive approach and gives assurance that there has been no episode of cross infection.

The new *C. difficile* NICE Guidance is due to be released in July with likely changes in prescribing of antibiotics to improve patient outcomes. There will be an education plan for prescribers once the new guidance has been approved.

There is also the commencement of a South West Health Care Associated *C. difficile* Collaborative, which is looking at improving prevention and treatment.

There has been no Flu identified over the last year. There is concern that Respiratory Syncytial Virus (RSV) in children may be increasing nationally. To date the Trust has not detected any RSV, However, the national reporting system will be kept open this year to assist with on-going surveillance.

Risks to delivery and mitigations

Maintaining cleanliness of the ward environment consistently, including patient care equipment. Assurance is provided by spot check audits.

Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

Covid 19	Apr -21	May -21	Jun -21
Number of detected Inpatients	22	24	29
Number of Deaths in Hospital	4	1	0
Hospital Acquired Covid-19 Cases*	0	1	0

Covid-19 (Apr 21 – Mar 22)		(April 20- Mar 21)
Number of detected Inpatients	75	1458
Number of Deaths	5	324
Hospital Acquired Covid-19 Cases*	1	139

Background, what the data is telling us, and underlying issues

Numbers of patients diagnosed with COVID-19 is increasing in line with the national picture.

Six of the 29 hospital reported cases were previously community detected COVID-19 cases.

One was a readmission and repeat positive.

15 of the 29 admissions were unvaccinated.

28 of the cases were below the age of 36.

The Swindon case rate has increased to 60.6 per 100,000, which has been below the Wiltshire average (87.5 per 100,00), the South West average has increased to119.5 per 100,00 and the England average 146.8 is per 100,000.

Improvement actions planned, timescales, and when improvements will be seen

2 metre social distancing and personal protective equipment (PPE) usage remains in place for staff and visitors in the Trust.

With the easing of national lockdown during July 2021 there are no anticipated changes anticipated within health to social distancing and mask wearing.

All staff are now submitting lateral flow tests though the National reporting system.

Risks to delivery and mitigations

The easing of lockdown is impacting on the numbers of staff having to self isolate following a track and trace alert. This is being managed through the daily staffing processes.

There is a risk staff and visitors will have reduced compliance for social distancing and PPE in hospital as restriction lift nationally. This is being addressed through regularly messaging of the higher risk of spread in hospital.

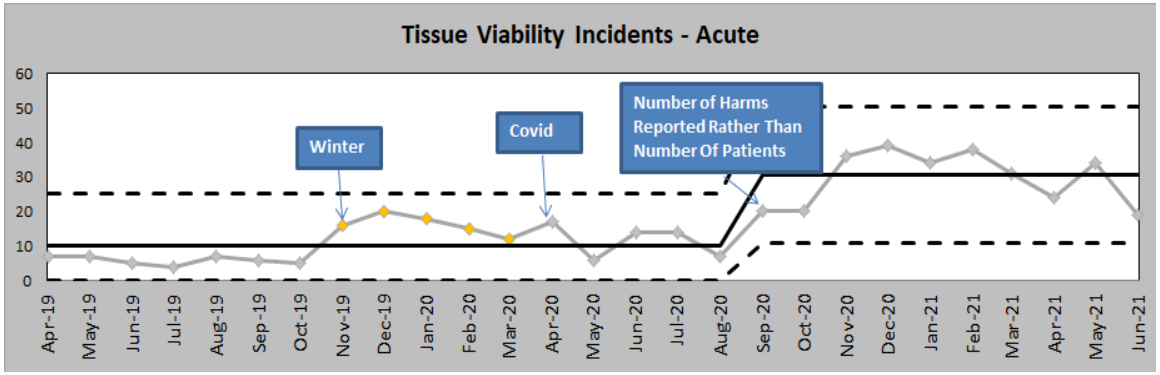
Reduced oversight on how many staff are completing lateral flow tests on a weekly basis. This is being addressed through messages to staff on the importance of accurate reporting and recording.

*Patients in Definite (15+ days post admission) and Probable Categories (8-14 days post admission), plus patients who were previously IP and may have been infected during that earlier admission.

2. . Patient Safety – Acute Pressure Ulcers

Data Quality Rating:

Are We Safe?



Incidents of harms by Category for June 2021:

Category 2 PU	Category 3 PU	DTI	Device related PU	Unstagable	Total Incident of Harms
9	0	3	2	5	19

Number of Patients	Harms per Patient
7	1
3	2
2	3

Background, what the data is telling us, and underlying issues

There has been a reduction in number of pressure ulcers reported this month with a total number of 19 harms on 12 patients in the acute setting. Five patients had multiple harms.

2 device related (x1 Plaster of Paris x1 anti embolic stocking).

Themes from SWARM (an immediate review at ward/department level) include: timely skin inspections; thorough documentation, appropriate selection of pressure relieving equipment.

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Improvement actions planned, timescales, and when improvements will be seen

Improved investigation processes are ensuring thorough investigation and learning at time of harm identified, which is immediately shared with the ward. Continual improvement on these processes is ongoing.

Training ‘at the elbow’ in areas with recurring levels of harm continue with the focus on recurring themes. Training also includes a new equipment guide on the Tissue Viability (TV) Intranet site.

‘Ward Walk Around’ – Tissue Viability Nurses (TVN’s) to trial a new approach to learning and support for all wards and departments to commence July.

Key learning is also sent out as part of the weekly safety briefing.

Risks to delivery and mitigations

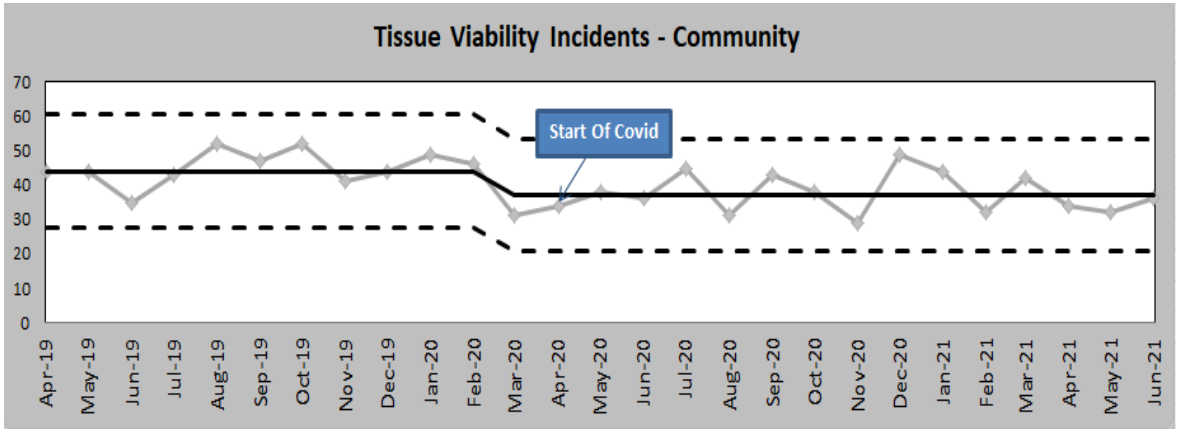
Pressure ulcer rates remain high, and the specialist team continue to be under pressure to support the wards with the education and training required. A short term educational post is being recruited to support this improvement work.

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

2. Patient Safety – Community Pressure Ulcers

Data Quality Rating:

Are We Safe?



Incidents of harms by Category for June 2021:

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Device related PU	Unstagable	Total Incident of Harms
14	7	2	2	3	8	36

Background, what the data is telling us, and underlying issues

36 harms in total.

2 Category 4 pressure damage

- x1 the patient has curvature of the spine (kyphosis) causing pressure to chest from their chin, the patient is nursed at home with three times a day care.
- X1 relates to a patient managed in a residential care home. Additional support is now in place to support the home.

3 device related harms related to urinary catheters

The higher numbers at lower grades reflects earlier reporting and initial intervention, helping to prevent further deterioration .

Improvement actions planned, timescales, and when improvements will be seen

Moisture Associated Skin Damage (MASD) pathway was launched planned across Bath, Swindon and Wiltshire (BSW, CCG) on 14th July 2021.

Training sessions continue for all staff on key aspects of pressure ulcer prevention.

All staff are completing new electronic learning package and compliance is being monitored through the division.

The work stream with continence care and infection control continues to raise awareness of device related harm from catheters. This includes pressure ulcer awareness within catheter and continence training.

Risks to delivery and mitigations

There are high numbers of temporary staff who are less familiar with the equipment, and resources available to prevent pressure ulcers.

This is mitigated by:

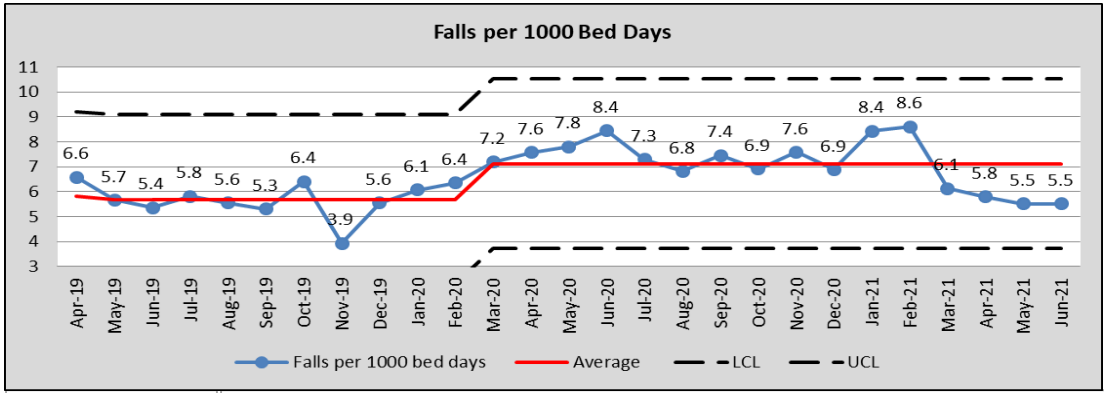
- Ongoing recruitment.
- Additional training available for all community teams including End of Life (EOL) teams, new starters and regular bank staff.
- Review of appropriate patient allocation.

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

2. Patient Safety – Safer Mobility (Falls Reduction)

Data Quality Rating:

Are We Safe?



	Feb 2021	Mar 2021	April 2021	May 2021	Jun 2021
Falls Resulting in No Harm	129	104	99	101	97
Falls Resulting in moderate Harm or above	2	2	2	3	2

Background, what the data is telling us, and underlying issues

Over the last four months we have seen a decrease in falls per 1000 bed days, reducing from 8.6 in February 2021 to 5.5 in June 2021.

Improvement actions planned, timescales, and when improvements will be seen.

Improvement work includes:

- Development of a falls assessment document which can be used on Nervecentre (electronic record keeping system), once funding has been identified.
- The Royal College of Physicians post fall 'hot debrief' project commenced on the Swindon Intermediate Care Centre (SWICC) and Sunflower ward on 14th June 2021.
- Guidance on implementing the 'hot debrief' (immediate review of the incident with as many members of the Multi-Disciplinary Team (MDT) in attendance as possible) process and managing MDT debrief is being drafted.
- A Safe footwear project is commencing in July to review published evidence relating to the use of non-slip socks for falls reduction and NICE recommendations for safe footwear.
- Final formatted falls assessment document has been sent to Nervecentre (electronic record keeping system) and will be added to the system.
- **National Falls Safety Week 20th – 26th September 2021 involving a week of activities to raise awareness of falls safety.**

Risks to delivery and mitigations

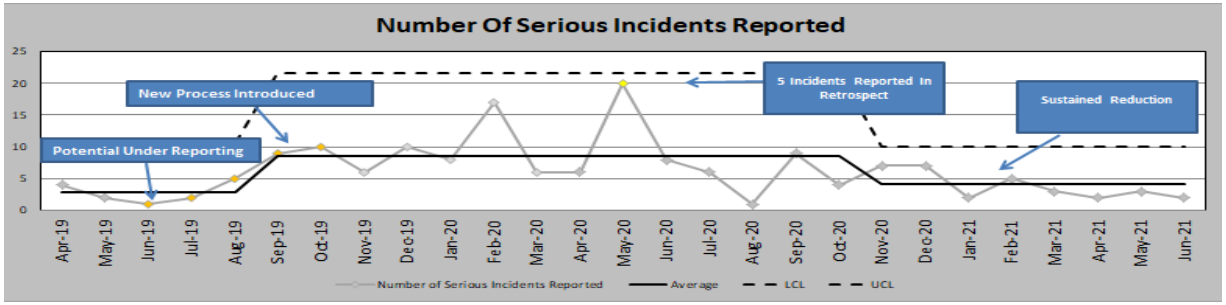
Patients are presenting with higher levels of de-conditioning in relation to mobility and falls due to the recent national 'lock down'. This is resulting in increasing demand on the falls service.

Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

2. Patient Safety - Incidents

Data Quality Rating:

Are We Safe?



Serious Incidents Reported			Comparison
Apr	May-21	Jun-21	Jun-20
2	3	2	8

Never Events	
2020-21	2021-22
2	0

Background, what the data is telling us, and underlying issues

At the time of reporting there are a total of 27 on-going Serious Incident (SI) investigations, with two reported in June

The number of SI's reported has decreased compared with June 2021.

One never event reported in 20/21 has been downgraded; following completion of the investigation it was clear that the incident did not meet the criteria for never event

Improvement actions planned, timescales, and when improvements will be seen.

Improvement Groups continue in the following areas – World Health Organisation (WHO) surgical safety checklist, Bilevel Positive Airway Pressure, (BiPAP), NerveCentre and Safe discharge. Progress on the actions from these groups are monitored through the Safer Care Group and Patient Quality Committee.

BiPAP / Non Invasive Ventilation (NIV) –

- NIV guidelines and care bundles have been updated.
- Focused teaching on blood gases, ensuring junior doctors are provided with blood gas logon details once trained, including a review of inclusion of blood gas results to Medway.
- Audit how quickly patients are started on NIV. (The standard is 1 hour)
- Trial use of grey bracelets stating saturations of 88-92%.
- Arterial Blood Gas (ABGs) teaching has started within the Emergency Department (ED) & Neptune ward, with opportunities within ED to invite external speakers.
- Video for interpretation of gasses produced and an ABG sticker started within the ED.

Allergies improvement group –

- A video has been produced raising awareness about allergies.
- Graphnet is planned to launch in July which gives information on allergies, medication, electronic discharge summaries, admission-discharge-transfer information, clinical letters and end of life records.

Sharing of Learning –

- Learn Zone is being developed as part of the 'Great Care Campaign'. The Learn Zone will provide a virtual platform to patient safety incidents and learning.

An improvement group focusing on paper referrals and identification of a suitable electronic process has been developed. The initial focus will be endoscopy referrals but will progress to other areas of concern across the organisation.

Risks to delivery and mitigations

Multiple overdue Serious Incidents – not externally measured against timeframe at present but should this change, the Trust could be in breach of contract.

Additional clinical risk expertise is being identified to support the completion of the backlog of serious incident investigations

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

2. Patient Experience – Safer Staffing –Average Shift Fill Rate

Data Quality Rating:

Are We Safe?

Org: RN3 Great Western Hospitals	Fill rate indicator return Staffing: Nursing, midwifery and care staff							
May 2021	Day				Night			
Ward name	Average Fill Rate - Registered Nurses/ Midwives (%)	Average Fill Rate - Non-registered Nurses/ Midwives (%)	Average Fill Rate - Registered Nursing Associates (%)	Average Fill Rate - Non-registered Nurses Associates (%)	Average Fill Rate - Registered Nurses/ Midwives (%)	Average Fill Rate - Non-registered Nurses/ Midwives (%)	Average Fill Rate - Registered Nursing Associates (%)	Average Fill Rate - Non-registered Nurses Associates (%)
Dove	100.0%	89.1%	-	100.0%	100.4%	-	-	-
Aldbourne	90.5%	66.3%	-	100.0%	83.9%	128.8%	-	-
Ampney	98.6%	102.0%	-	-	100.0%	129.0%	-	-
ITU	78.3%	59.7%	-	-	80.0%	130.4%	-	-
Meldon	99.5%	100.8%	-	100.0%	99.2%	105.1%	-	-
Kingfisher SAU/SAW	98.2%	86.0%	-	100.0%	100.8%	90.2%	-	100.0%
Trauma Unit	113.0%	147.0%	-	100.0%	121.7%	146.9%	-	-
ACU	98.9%	97.6%	-	-	100.4%	103.2%	-	-
Falcon	98.9%	102.6%	48.4%	0.0%	100.0%	126.1%	-	-
Jupiter	95.8%	100.4%	-	-	103.5%	105.7%	-	-
LAMU & Shal MEU & SSU	105.1%	93.2%	-	100.0%	107.5%	104.6%	-	-
Mercury	94.6%	97.5%	-	-	93.6%	108.6%	-	-
Neptune	98.5%	104.4%	-	-	104.1%	115.5%	-	-
Saturn	100.6%	123.5%	-	-	101.1%	116.2%	-	-
Teal Wards	103.3%	92.7%	-	100.0%	109.1%	184.3%	-	-
Woodpecker	92.8%	105.0%	-	-	96.8%	119.0%	-	-
Beech & EPU	100.0%	123.5%	-	100.0%	101.6%	149.1%	-	-
Childrens	102.7%	171.7%	100.0%	-	113.3%	-	100.0%	-
Hazel, Delivery & WHBC	79.1%	70.3%	-	-	82.8%	88.2%	-	-
SCBU	96.6%	68.0%	-	100.0%	88.8%	95.5%	-	100.0%
Forest Ward SWICC	93.4%	100.1%	100.0%	100.0%	98.9%	128.8%	-	100.0%
Orchard Ward SWICC	92.1%	99.6%	100.0%	100.0%	104.4%	124.2%	-	100.0%
Sunflower	145.7%	95.4%	-	-	102.8%	103.3%	-	-
Overall Total	97.9%	97.1%	67.3%	82.1%	97.3%	116.8%	100.0%	100.0%

It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board. High level figures are provided here. The data is reported against Registered Nurse (RN) and Unregistered Nursing Assistant (NA) shifts.
This data is uploaded on UNIFY for NHS Choices and is publically available.

The combined figures for GWH show a Registered Nurse fill rate of 97.9% for day shifts and 97.3% for night shifts and for Unregistered Nursing 97.1% for day shifts and 116.8% for night shifts.

Areas flagging red or over establishment are reviewed by the DDONs and narrative is included in submission. No care or quality concerns have been raised.

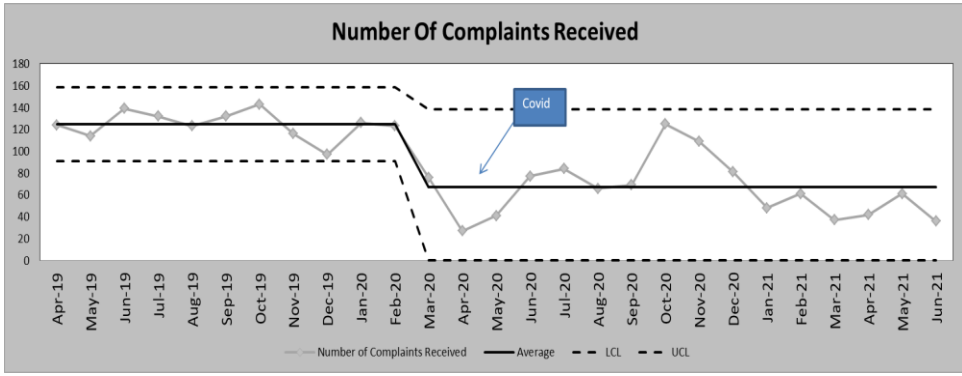
- Aldbourne – bed base has been fluctuating due to reduced activity with some staff redeployed to other units, resulting in low HCA day cover, and night swapping RNS for HCA to support Trust wide staffing.
- ITU – due to lower acuity of patients admitted in May.
- Hazel, Delivery & WHBC – low registered midwives due to vacancies and increased establishment – Recruitment plan in place, currently mitigated by seniors supporting clinically. Nurse Associates low due to low numbers in establishment and no back fill for AL / sickness / mitigated by HCAs over establishment

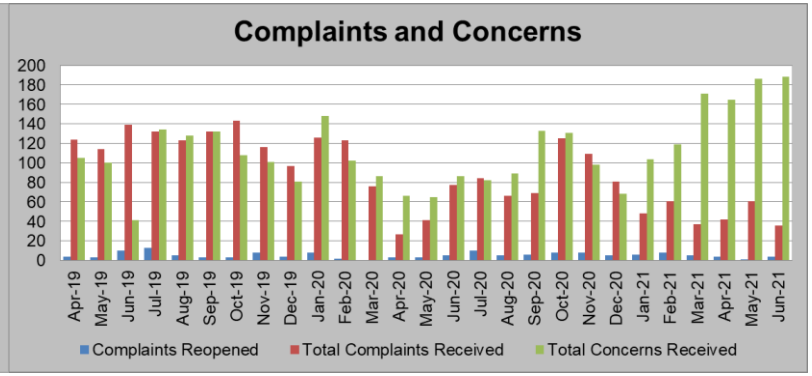
Areas are monitored through the daily staffing process and supplemented where required. Areas showing over 100% are related to enhanced care or RMN usage, this is an area of focus for improvement, including the RMN reduction plan..

The Registered to unregistered ratios are within national guidance.

2. Patient Experience - Complaints and Concerns

Are We Safe?





Background, what the data is telling us, and underlying issues

In June 36 complaints (previous month 61) and 188 concerns (previous month 186) were received, all were rated a low – medium, with none related as high or extreme.

Out of a total of **224** cases received from Complaints and Concerns in June, the overall top three themes were:

- **Waiting time: 36** (16%) – 0 complaints, 36 concerns.
- **Behaviour/Attitude of staff: 27** (12%) – 5 complaints, 22 concerns.
- **Communication:** 25 (11%) – 8 complaints, 17 concerns.

Response rates: Complaint response rate of 86%. 61% of concerns were resolved within 24 hours, 85% were resolved within 7 working days (KPI 80%).

Improvement actions planned, timescales, and when improvements will be seen

Waiting time
A quality Improvement project has been launched to address the significant and understandable backlog of appointments and procedures following the COVID pandemic. The project has four over aching themes with seven identified work streams. The work forms part of our wider 'Refresh, Restore, Regroup, Recover' focus in response to the Pandemic and our aim to return to business as usual.

Behaviour/Attitude
Working with HR, our processes provide assurance that concerns and complaints are managed, as we develop a Just and Learning culture, impact will be monitored monthly.

Communication
Following a successful trial on Teal ward of a dedicated Patient/family telephone line we have secured charitable funding to roll these out across all wards in the organisation including SWICC.

The trial demonstrated that the telephone was used on 400 occasions over the two-month trial period. This reduced the number of calls to switchboard freeing up the team to manage other calls. Patient and staff feedback was extremely positive both from a quality experience point of view and also streamlining the process for the nursing staff.

Risks to delivery and mitigations

Icasework contract is due for renewal in September,

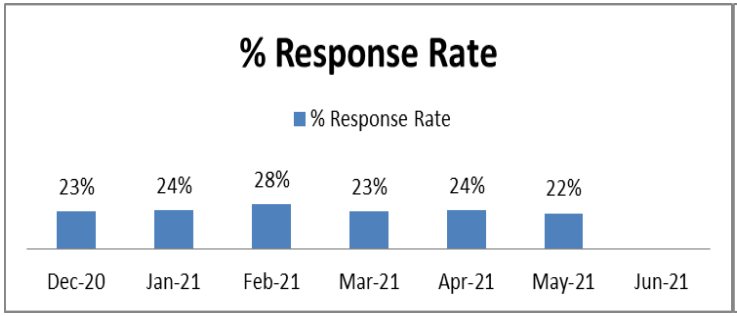
Datix is planned for September for the complaints module, all project targets have been achieved to date.

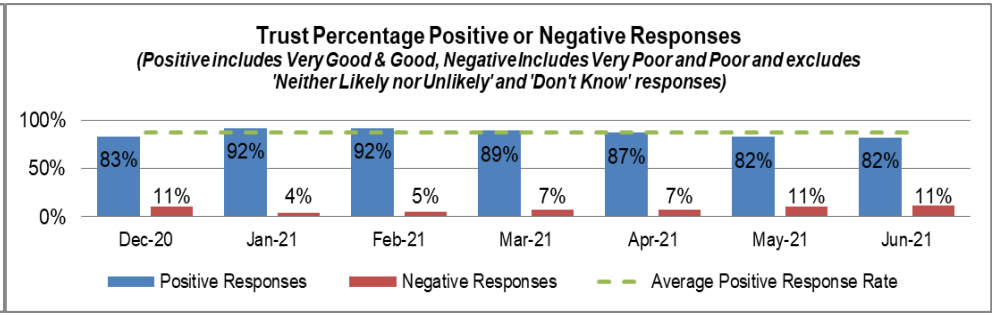
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?





Background, what the data is telling us, and underlying issues

For June, 81.94% of the Friends and Family Test responses were positive, (previous month 82.42%). This is based on the % of responses rated as 'very good' and 'good'.

This was achieved by:

	Number of Text sent	Number of Responses	Positive Responses
ED	5594	1171	69.74%
Inpatients	2779	711	84.56%
Day Cases	2285	683	95.46%

(correct as of 6th July)

The Friends and Family card has been reintroduced into all areas, complemented by text messaging in ED, Inpatient and Day Case areas.

Maternity services and Outpatient areas are unable to move forward with the introduction of SMS at this time, however card collection will continue, and other methods of collection are being introduced with an aim to increase overall feedback received.

Improvement actions planned, timescales, and when improvements will be seen

Overall Positive themes for June :

- **Staff Attitude** 1424 comments (previous month 1021).
- **Implementation of Care** 911 comments (previous month 689).
- **The Environment** 684 comments (previous month 525).

Overall Negative themes for June :

- **Staff attitude** 280 comments (previous month 210 comments).
- **Waiting Time** 247 comments (previous month 165)
- **The Environment** 233 comments (previous month 180).

The following work will be carried out throughout July:

- To work with divisions to understand, develop actions and learning from the negative feedback received.
- Promotional material, posters and business cards will be distributed to all areas throughout July. Raising awareness on how patients can leave feedback together with the promotion of the importance of responding to Friends and Family Test (FFT) texts when received.
- Introduction of QR codes directing patients to online FFT links as part of real time feedback.
- Maternity QR codes and links have been shared with patients as part of Maternity Voices and this will now continue.

Risks to delivery and mitigations

The development of text messaging for Maternity Services is delayed due to unavailability of an experienced data analyst to move this forward until October. Other resources are being explored to move this forward before this date.

An option appraisal is being prepared to consider the adopting Text messaging for Outpatient areas.

2. Patient Safety - Perinatal Quality Surveillance Tool June 2021

Data Quality Rating:

Are We Safe?

The following slides form part of the new quality surveillance model implemented nationally to ensure consistent oversight of Maternity and Neonatal services at Board level on a monthly basis.

Measures

Minimum safe staffing in maternity to include Obstetric cover on delivery suite

Measure	Aim / Target	April 2021	May 2021	June 2021
Midwife to birth ratio	1:29	1:27	1:28	1:27
1:1 Care	100%	97.7%	98.3%	95.3%
Consultant presence in Delivery suite (Hours per week)	60 (Hrs.)	57 (Hrs.)	57 (Hrs.)	57(hrs)

Service User feedback

Feedback continues to be received in a variety of ways and the Trust has a valuable collaboration with the Maternity Voices Partnership (MVP). They are actively informing service users on updates during the COVID pandemic, working with the clinical team to ensure information is up to date. MVP representatives attend the Maternity Clinical Forum to ensure that service user feedback can be heard effectively to guide developments in the service. 3 formal complaints were received in June relating to delay in planned Caesarean Section (C Section), delay in induction of labour and lack of effective communication. There is ongoing work to separate emergency and planned theatres in Maternity with separate teams to support each theatre. Business case will be developed to reflect the need for additional resources. Staff have been reminded of the importance of good effective communication at all times.

Caesarean Sections

	April	May	June	Comments
Combined C Section rate (percentage of babies born > 24 weeks via C Section)	42%	38%	32%	
Elective C Section	25%	16%	12%	Total of 137 elective C sections in Q1, 15 (11%) maternal choice. 122 (89%) clinically indicated, previous C Section being the highest clinical indication.
Emergency C Section	27%	22%	20%	Total of 216 Emergency C Sections performed in Q1.

All decisions to proceed to a C Section are made by a Consultant Obstetrician to allow for a detailed discussion between clinician and mother. Multiple national drivers continue to impact the C-section rate including the Saving Babies' Lives Care Bundle, which promotes early intervention, and maternal choice factors supported by NICE guidance.

2. Patient Safety - Perinatal Quality Surveillance Tool June 2021

Data Quality Rating: 

Are We Safe?

The following slides form part of the new quality surveillance model implemented nationally to ensure consistent oversight of Maternity and Neonatal services at Board level on a monthly basis.

Measures	Comments
Concerns or requests for actions from national bodies	The submission of evidence to support the Ockenden action plan was completed on 30th June 2021. Evidence was provided to support all elements of the action plan. This data will be analysed by the National team who will provide a report for each Trust. The Regional team will provide an overview in order to develop an on-going action plan.
CNST 10 Maternity standards (NHSR)	Submission date extended to 22/7/21. Revised CNST standards have been published in March and evidence collected accordingly. Continuing to work on progressing on all standards and gathering the final evidence to support the standard requirements.
Findings of review of all perinatal deaths using the real time data monitoring tool	Recommendation made for implementation of a 'Golden Hour' tool to support effective stabilisation of preterm infants admitted to the Local Neonatal Unit.
CQC Ratings	Overall Good in the 5 domains (2020)
Maternity Safety Support Programme	Not required as CQC ratings overall 'Good'
Coroner's Regulation 28	Nil

2. Patient Safety – Summary of Incident Investigations

Data Quality Rating:

Are We Safe?

Moderate Harm Incidents

Measure	Comments
Number of incidences graded moderate or above and actions taken	• 4 incidents graded moderate or above. Each case has been evaluated with immediate learning identified and on-going investigations where appropriate. • Wound infection – for further investigations with another NHS provider to review the organisation of care. • 2 incidents of unexpected admissions to the neonatal unit. Immediate learning identified and shared. • Drug error (see below).

*Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as SI. This may account for an increase in SI reported by Maternity.

Serious Incidents (SI) Reported In Month

Case ref	Overview	Date	Case update
158185	Delay in recognition of a deteriorating patient	**01/06/2021**	Urgent incident review undertaken with recommendations for immediate actions. Full investigation on-going
158880	Drug error	**20/06/2021**	Urgent incident review undertaken with recommendations for immediate actions. Full investigation on-going

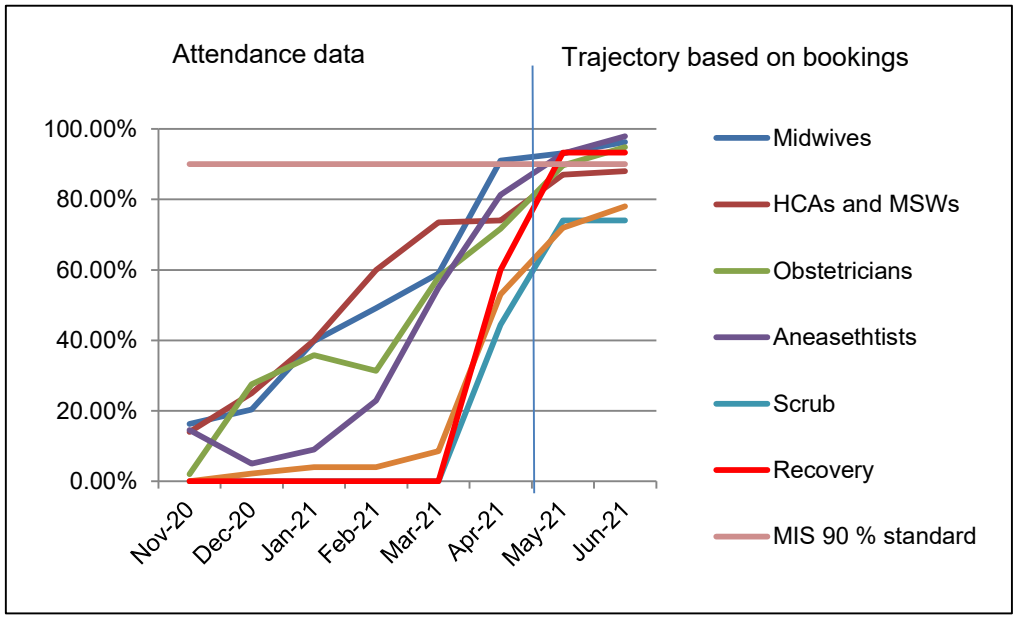
On-going SI investigation update

Stage of investigation	June 2021	May 2021	April 2021
Referred to HSIB awaiting decision	0	1	1
Under local investigation	5	3	2
Under HSIB investigation	2	2	2
Report complete awaiting Serious Incident Review Learning Group (SIRLG)	0	1	1
Submitted to CCG	3	5	5

Maternity – Prompt training update including a trajectory

Data Quality Rating:

Are We Responsive?



Staff group	Total number	Trajectory number to complete training	Number of additional people required
Midwives	190	183	NA
Obstetrician	39	37	NA
Anaesthetist	43	42	NA
Scrub staff	27	20	5
ODPs	47	37	6
Recovery	15	14	NA
HCAs and MSWs	54	48	2

Background and underlying issues

In July 2019 we achieved Action 8 of the Maternity Incentive Scheme (MIS) – 90% compliance for all staff groups attending face to face (FtF) mandatory training (MDT) skills and drills training (PROMPT) day.

FtF MDT training cancelled Feb 2020 onwards due to COVID restrictions. All training time revoked.

From December 2020 weekly online PROMPT training offered to all staff groups.

Improvement actions planned, timescales, and when improvements will be seen

Compliance to the trajectory is at risk in three groups, there is an action plan in place to mitigate this and it is being closely monitored.

Paediatric Doctors and Neonatal nurses required to attend newborn life support (NLS) update; 1 session provided by PDM team was sufficient to meet this.

Maternity staff are required to complete additional maternity specific training which at present is not captured on the electronic staff record (ESR).

Risks to delivery and mitigations

- Staff not being released for training due to staffing pressures and high levels of shortages, there is a mitigation plan in place.
- Midwives are given 12 hours paid training time versus 80 hours required to complete all training requirements. This is currently under review through the staffing establishment review process.

Great Western Hospitals NHS Foundation Trust

Part 3: Our People

Our Priorities

Outstanding patient care and a focus on quality improvement in all that we do

Improving quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers

Staff and volunteers feeling valued and involved in helping improve quality of care for patients

Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Resources

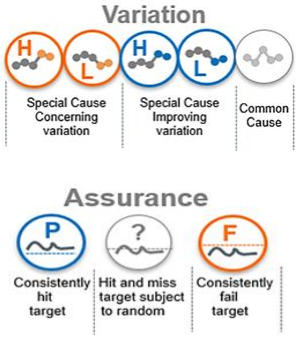
Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

"Great" Scoring	Indicator Score (1-4)	Self Assessment Score
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding		
Great Workforce Planning	2	2
Great Opportunities	2	3
Great Employee Experience	1	3
Great Employee Development	2	3
Great Leadership	2	3

Summary Dashboard - Workforce Performance

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Overall Agency Spend as a % of Total Spend			6.43%	6.00%	3.92%	7.39%	5.65%
2	RN Bank Fill Rates		F	55.1%	70.0%	36.3%	60.4%	48.4%
3	Vacancy Rate			6.30%	7.63%	5.74%	8.63%	7.19%
4	Recruitment Time To Hire (Days)			39.5	46.0	29.9	57.4	43.6
5	All Turnover	H		14.43%	13.00%	12.20%	13.69%	12.95%
6	Voluntary Turnover	H	P	8.40%	11.00%	8.98%	9.97%	9.47%
7	All Sickness Absence	H		4.06%	3.50%	3.22%	4.60%	3.91%
8	Statutory Mandatory Training Compliance	L		85.08%	85.00%	84.16%	88.91%	86.54%
9	Appraisal Compliance		F	79.82%	85.00%	71.81%	82.24%	77.03%



Trust Overview: Narrative

Great Western Hospitals NHS Foundation Trust

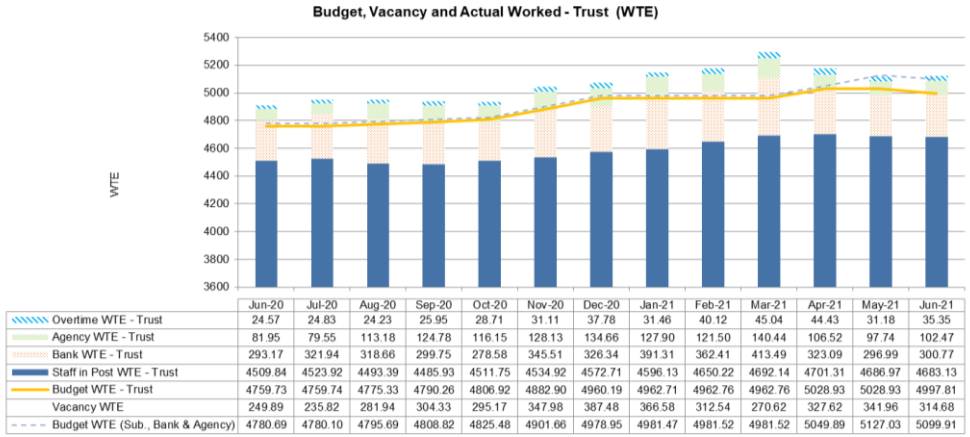
"Great" Scoring	Indicator Score (1-4)	Self Assessment Score	Headline
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding			
Great Workforce Planning	2	2	June saw a small improvement in the Trust vacancy rate, though alongside this the Trust experienced an increase in agency spend, a reduced bank fill rate compared to the previous month and an overall increase in workforce utilisation. The improvement in vacancy arose mainly due to an adjustment to budgeted WTE rather than an increase in contracted WTE, whilst on-going pressures in the community and across medical staffing in key departments areas such as Emergency and General Medicine, continue to drive medical agency spend. A number of short and medium term improvement initiatives are underway, though June's regression in KPI performance accounts for a requires improvement scoring of '2'.
Great Opportunities	2	3	In M3 the Trust vacancy position decreased 6.3% (314.68 WTE). The Trusts International recruitment leads will be attending an International Community Spotlight session lead by NHSEI on 20th July, this will support understanding to explore implementing international recruitment for community nurses. There continues to be a sustained improvement in voluntary turnover reliably achieving below the 11% target and performance for all turnover remains above Trust target at 14.43%. A deep dive is included in this report. The recruitment time to hire metric continued to improve at 39 days from vacancy advertised to contract of employment.
Great Experience	1	3	Sickness reported in May 2021 was 4.06%, which is above the Trust target of 3.5%. Referrals for OH and counselling / psychology support have been increasingly, reflecting the current challenges facing the workforce. Resource difficulties within OH are improving, which will facilitate more timely access, and in-reach psychological support across the organisation continues to increase, helping shift the culture regarding health and wellbeing within the Trust and also providing more preventative work.
Great Employee Development	2	3	Work continues to define the CPD requirements for nurses, midwives and AHPs to ensure we maximise the use of the HEE CPD monies. (£632,000 for 2021/22) We now understand how the majority of this money will be committed through working closely with the Deputy Chief Nurse and Divisions. The Trust has met its KPI for mandatory training following the implementation of the new ESR based system which is encouraging.
Great Leadership	2	3	There has been a very positive response to the introduction of the Aspiring Leaders programme with three cohorts planned. The Trust is involved in the BSW leadership community of practice and is working on collaboration in a number of areas. The coaching development opportunity (ILM 5 AND 7) will be made available to other Trusts in the acute alliance with the aim of developing a coaching register. Appraisal rates have reduced slightly and are below KPI so this will continue to be an area of focus.

Workforce

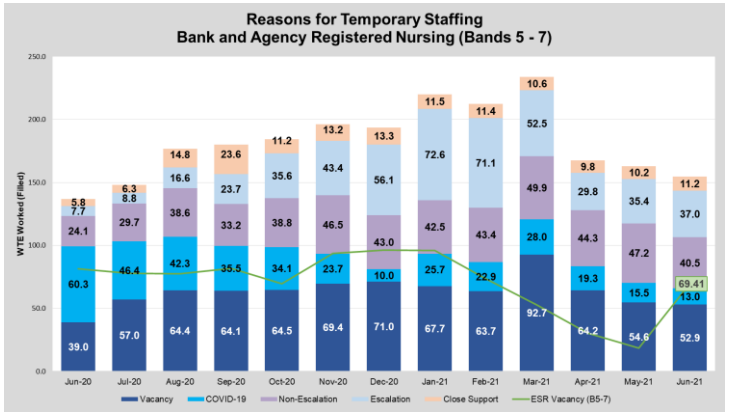
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
2	2



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Overtime WTE - Trust	24.57	24.83	24.23	25.95	28.71	31.11	37.78	31.46	40.12	45.04	44.43	31.18	35.35
Agency WTE - Trust	81.95	79.55	113.18	124.78	116.15	128.13	134.66	127.90	121.50	140.44	106.52	97.74	102.47
Bank WTE - Trust	293.17	321.94	318.66	299.75	278.58	345.51	326.34	391.31	362.41	413.49	323.09	296.99	300.77
Staff in Post WTE - Trust	4509.84	4523.92	4493.39	4485.93	4511.75	4534.92	4572.71	4596.13	4650.22	4692.14	4701.31	4686.97	4683.13
Budget WTE - Trust	4759.73	4759.74	4775.33	4790.26	4806.92	4882.90	4960.19	4962.71	4962.76	4962.76	5028.93	5028.93	4997.81
Vacancy WTE	249.89	235.82	281.94	304.33	295.17	347.98	387.48	366.58	312.54	270.62	327.62	341.96	314.68
Budget WTE (Sub., Bank & Agency)	4780.69	4780.10	4795.69	4808.82	4825.48	4901.66	4978.95	4981.47	4981.52	4981.52	5049.89	5127.03	5099.91



Background

The Trust utilised 5121WTE staff to deliver its services in June '21, an increase of 9WTE on the previous month and 124WTE in excess of substantive budgeted WTE (22 WTE in excess of Substantive, Bank and Agency Budgeted WTE). June saw marginal increases in the utilisation of overtime, bank and agency relative to the previous month. On the nursing front however, band 5-7 bank and agency usage continues to reduce, with June's performance continuing the positive quarter 1 trend.

June saw an adjustment to the Trust budgeted WTE, which resulted in an overall reduction of 31WTE in the funded establishment following updates and reconciliation with Finance.. This primarily resulted in a reduction in admin & clerical budget allocation and an increase in nursing budget allocation, with Community Nursing, and Maternity being the key department level changes, and small increases in other departments such as ED.

Community Nursing continues to be the highest exponent of temporary workforce resource, due to the on-going approval to secure up to an additional 20 registered nurses per day, as a measure to cope with additional community nursing demand and avoid hospital admissions. Funding for this additional activity has been agreed until September 2021. Medical workforce vacancies across Primary Care, Emergency Medicine and General Medicine specialties including Diabetes, Respiratory and Geriatrics, remain as the key temporary workforce drivers of Medical workforce spend.

Improvement actions

1. A PCN workforce planning initiative is underway and is aligned to the Additional Roles Reimbursement Scheme (ARRS). It's purpose is to alleviate the GP capacity deficit through the introduction of ACP, Physio, Pharmacy and Social Prescribing roles, ultimately designed to re-direct non-specific GP work

2. Urgent Care in the community is set to be strengthened through the introduction of a two hour Urgent Community Response service. This service will involve integrated working with Swindon Borough Council and First City Nursing. The workforce model for this service is under development, subject to confirmation of the funding envelope with the CCG

3. In anticipation of an Aseptic Services build in Pharmacy, planning is underway to ensure the recruitment and training of staff to deliver the service, is aligned to the pace of the build, the risk of dis-alignment being a lack of staffing readiness or an over-supply (and cost) of staff resource

4. Work is underway in ICU and Anaesthetics, facilitated by Kingsgate consultancy, to optimise existing workforce availability by addressing sub-optimal practices in respect of flexible working and On-Call

5. HEE funding has been secured to recruit a mental health liaison role, with intent to develop capability and build competency across both registered and un-registered colleagues, with sufficient internal capability built to minimise agency spend on RMN support in the future. Alongside this, discussions are underway with Avon & Wiltshire Mental Health Partnership, with a view to GWH accessing AWP HCA resource and again avoid resorting to agency RMN support

Risk to performance and mitigations

As the Trust moves into recovery phase of 21/22, an increase in unfunded activity to deliver recovery is likely to be necessary, therefore impacting workforce costs through the use of temporary resource.

A variety of factors have combined to result in a significant and consistent increase in Urgent Treatment Centre attendances. This heightened level of demand outstretches the existing workforce model. In the near term additional contingency staffing has been authorised, though timescales are uncertain. Similarly, increased UTC attendances create demand for support services such as Imaging who have recently experienced a number of leavers. Five long term agency bookings have been authorised pending successful substantive recruitment.

Hard to recruit Consultant medical roles are recognized nationally and whilst a project approach is being adopted to target this, there is a possibility that a relative dearth in workforce supply will result in only a marginal impact.

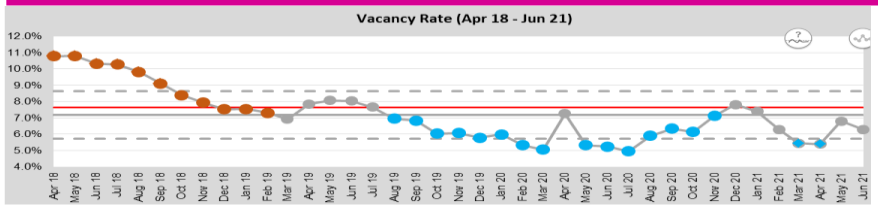
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

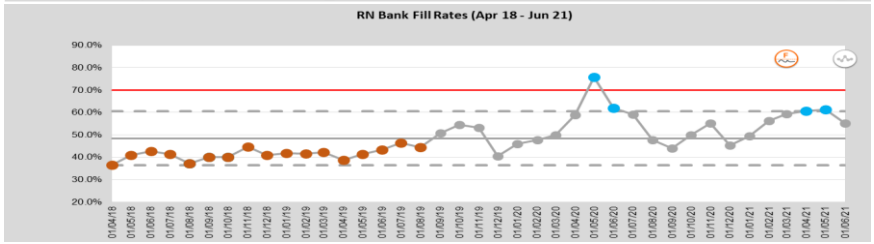
Workforce

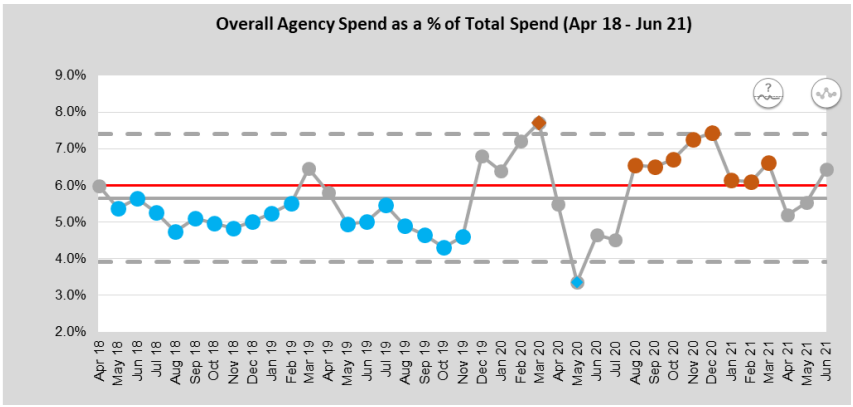
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
2	2







Background

The Trust vacancy rate improved marginally to 6.3% in June from 6.80% in May, due mainly to a reduction in budgeted WTE rather than an increase in substantive staffing. The vacancy rate equates to 315WTE vacant posts, with 135WTE of these belonging to the nursing staff group. This staff group has, however, been bolstered by 79WTE (59 in Integrated care and 29 in Unscheduled Care) being added to the budgeted WTE in month which has effectively served to double the nursing vacancy rate. The opposite budgetary allocation is evident in the remaining staff groups and as a result the reverse is evident with medical, AHP and admin vacancy rates all reducing.

Registered Nursing bank fill rates decreased in June to 55.1% which is below target and mirrors a similar drop between May and June 2020.

Agency spend as a proportion of total pay in June was 6.25%, a noticeable increase on May (5.39%) and slightly above the 6% KPI. The vast majority of agency spend was driven by Medical Workforce at £898k (13.13% of staff group spend vs. 12.20% previous month) and Nursing £406k (4.49% of staff group total spend vs. 3.38% previous month).

Improvement actions

1. Divisional Director's of Nursing have now been provided with access to the temporary staffing system, enabling contemporaneous oversight of agency requests and therefore an early opportunity for intervention. In Surgery, Women's & Children's, this functionality has also been extended to Matrons which alongside the disablement of 'auto transfer' of shifts (to agency), enables Matrons early sight of potential agency escalations and the opportunity to exhaust resourcing options via internal means

2. An Allocate E-Roster software improvement has been implemented, meaning an improved user experience against some long held frustrations, alongside the ability to switch on functionality over time to improve user engagement further e.g. bank worker ability to self-cancel shifts

3. A quarterly review has been established between the Temporary Staffing Team and Liaison to review direct engagement for Medical Staffing only. Direct engagement for Medical Staff has the potential to result in a cost saving by avoiding payment of VAT, with an initial baseline suggesting room for improvement. The purpose of the on-going review process is to maximise direct engagement opportunities

4. The implementation of E-Roster for medical staffing continues to progress and provides earlier oversight of staffing gaps and thus more time to arrange contingency cover and thus avoid temporary workforce escalation. Implementation in ED is currently underway and set to complete in early August, with implementation then scheduled for Paediatrics, Dentistry and General Medicine

Risk to performance and mitigations

The availability of temporary staffing resource across both bank and agency is limited dependent on speciality and demand. The Temporary Staffing team monitor the fill rate with Senior Leads to ensure appropriate escalation for cover is in place where necessary, whilst bank recruitment remains ongoing.

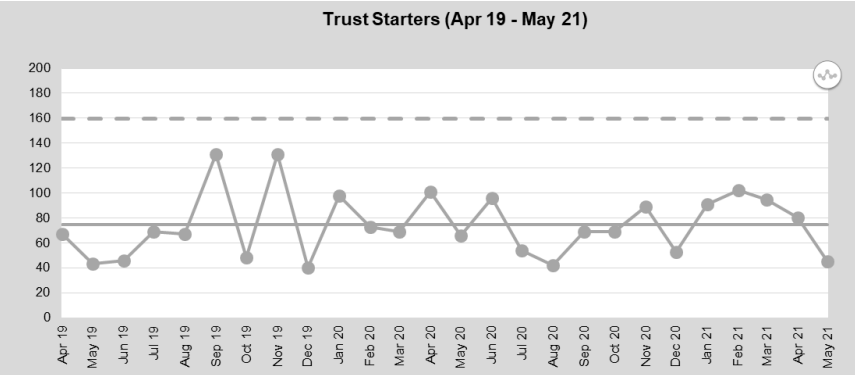
There is a risk that despite improvements in the vacancy position that temporary workforce spend continues above establishment. Avoidance of this is reliant on effective divisional roster based controls being in place. In the absence of an E-roster system for medical staff, control of the risk is dependent on non-automated excel spreadsheets for managing planned activity which provides limited oversight of utilisation. Some degree of mitigation is provided by a web-based locum resource system with timesheet platform.

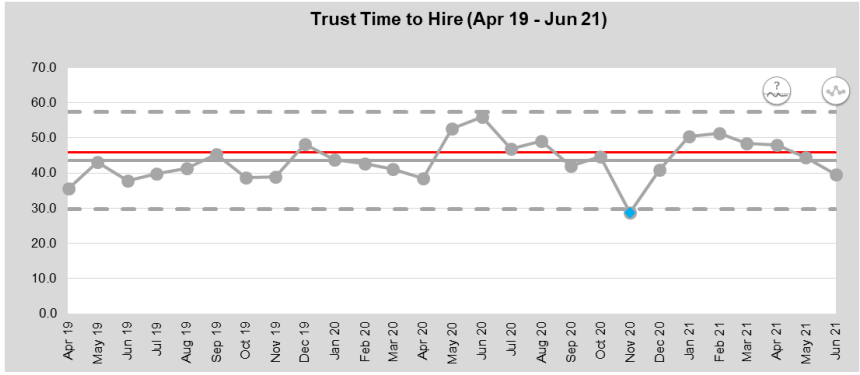
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	3





Background

The number of Trust new starters in May was 45, this is below the Trust average of 75 but following the annual trend of a drop in new starters from April to May as shown in the SPC chart.

The Trust has 76 candidates to date across all staffing groups due to commence employment in July.

The recruitment time to hire in June significantly improved at 39 days which as shown on the SPC chart remains below the Trust target of 46 days. Comparatively this is also considerably lower than the previous year (59) and demonstrates continuous improvement from February to June 2021.

Improvement actions

1. Surgery, Women's and Children's division will be recruiting to a Director of Maternity Services position which will be a key appointment in leading transformational changes required within maternity services.
2. Monthly meeting with Head of Resourcing, Associate Medical Director and HR Business Partner for each division to review progress on medical recruitment and priority areas.
3. A focus on recruitment for the Imaging department following an influx of Radiographer resignations. Recruitment action plan is being populated ensuring all options are considered e.g. international, trainee roles.
4. Community Nursing has received funding to recruit an additional 20 nurses, a bespoke recruitment campaign has commenced which will include a new video from a nurse that has recently achieved their preceptorship to showcase their positive experience within Community Nursing. In addition to this a bank campaign has also been launched with shadowing opportunities to enable nurses the opportunity to experience the difference of nursing in the community. Recent recruitment has been successful and there are 18 candidates offered and in the pipeline.
5. New portfolio of Trust photographs will be taken w/c 19th July with a day scheduled within each Division and around the Trust various sites. These visuals will be utilised for our recruitment campaigns, in our social media, recruitment microsite and the new Trust intranet due to launch in the summer.

Risk to performance and mitigations

The areas of focus below time to hire KPI were recruiting manager completing shortlisting at 47% and recruiting manager confirming interview date and selection criteria 56%. Monthly meetings with HR business partners are in place to discuss the KPI's and where required additional training or support provided.

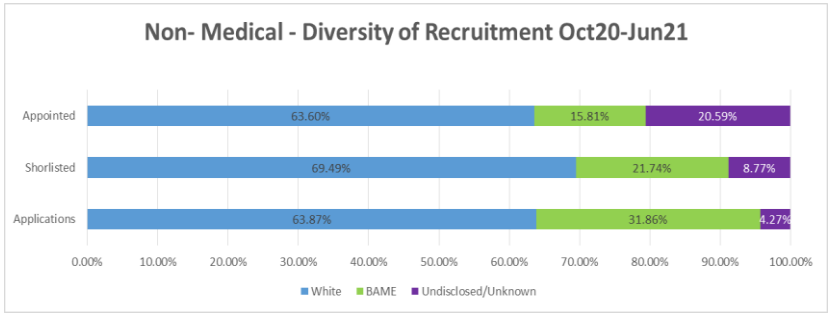
This year the Deanery has implemented that all departing trainees must be released from night shifts the night before August rotation. A scoping exercise is underway to identify the impact and ensure appropriate cover is put in place, there is a risk due to the high volume not all shifts will be filled leaving significant vacancy gaps.

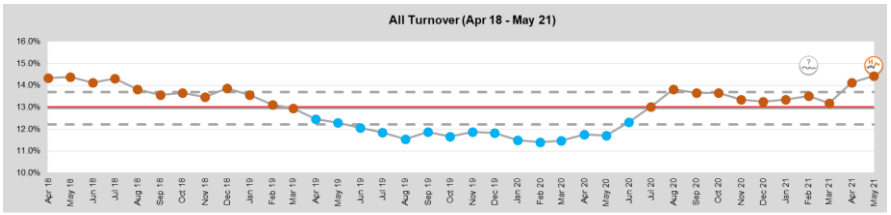
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

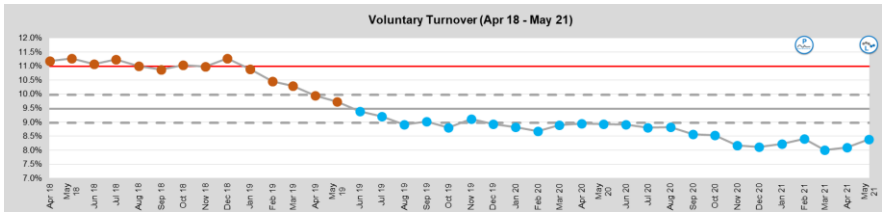
Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	3







Background

EDI continues to be monitored throughout the recruitment process. For Non-Medical recruitment within the period October 2020 – Jun 2021, 22% of applicants shortlisted were BAME, 16% of staff who were appointed were BAME. 9% of shortlisted applicants were other/undisclosed and this group represented 21% of staff that were appointed.

Performance for all turnover has remained above target at (14.4%), continuing to be above Trust KPI of 13%. Please refer to exception slide for further information.

Voluntary turnover also remains stable continuing the sustained significant improvement since 2019, as shown by the SPC chart icons. The SPC chart icons also identify that the Trust will continue to reliably achieve the 11% target each month.

Improvement actions

1. Recruitment and retention premiums continue to be utilised in Pathology with requests submitted for a six month extension.
2. A recruitment and retention plan has been developed for Maternity Services which includes a social media recruitment campaign, international recruitment, refer a friend scheme, relocation packages and on-boarding package for incoming employees.
3. The Trust will be attending the following recruitment events;
   - Kingsdown School Careers Fair, 6th July 2021
   - Swindon Pride, 6th–8th August 2021
   - Adult Transitions Roadshow, 22nd September 2021
   - Student Nurses (OBU Summer 2022 Cohort) Careers Evenings, 18th-21st October 2021 (67 students expected)
4. A refresh of the Trust's refer a friend scheme is underway and will be utilised to support hard to recruit areas such as maternity, community services and radiology.
5. The Trusts International recruitment leads will be attending an International Community Spotlight session lead by NHSEI on 20th July, this will support understanding to explore implementing international recruitment for community nurses

Risk to performance and mitigations

Trusts B5 nursing position is 60.61 WTE (including corporate Services and pre-registered Nurses), with a pipeline of 54.20 WTE B5 student nurses due to join between July – September and an additional 110 WTE NHSE/I Strand B/B+ funded nurses planned to arrive between now and December 2021. There is a risk the Trust will not have the turnover or vacancies to support the volume of nurse recruitment, mitigations are being explored to allocate international recruitment candidates across our BSW and/or reduce the funded numbers.

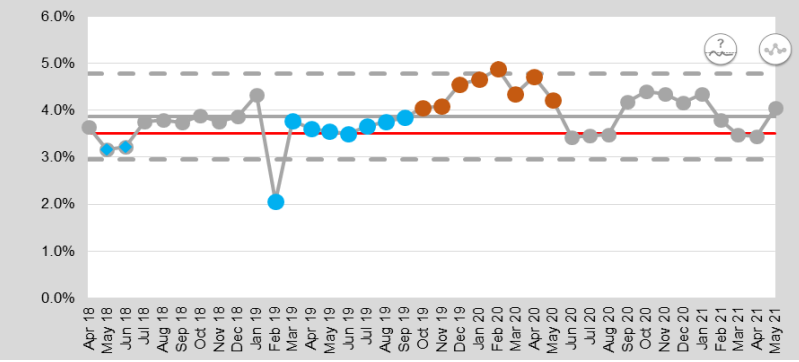
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce – Sickness Absence

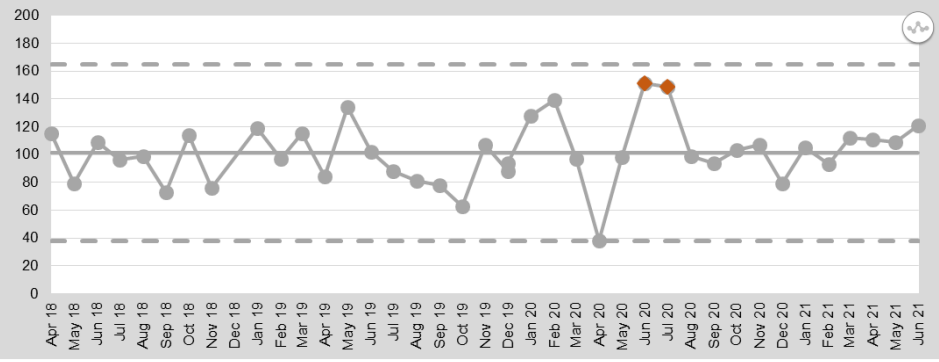
Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	3

Trust Sickness Absence (Apr 18 - May 21)



Trust Occupational Health MRs (Apr 18 - Jun 21)



Background

For May 2021, sickness absence is reported at 4.06% which is below the Trust average of 3.9% and above the Trust target of 3.5%.

121 OH management referrals were received in June. Main reasons for referral were regarding anxiety/stress and musculoskeletal difficulties.

Improvement actions

1. The physiotherapy vacancy has been successfully appointed, and due to start 0.5wte in September.
2. Two additional OH physician clinics were provided in June to help reduce the waiting time for those needing specialist medical consultation.
3. Regular meetings across departments regarding the annual flu campaign are ongoing, and a paper has been prepared to go to PPPC regarding the proposed plan for implementation in the Autumn – national guidance regarding the flu / covid booster is expected in July.
4. The conversion of a Commonhead room into an OH clinic room completed this month, enabling face-to-face physiotherapy to be offered again (for the first time since the pandemic) and also nurse clinics to be offered more regularly.

Risk to performance and mitigations

The department remains short of clinic rooms, since its move within Commonhead. Additional clinic space is being investigated, including within our primary care venues, to enable increased provision of OH clinics.

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce – Recognition, EDI and Wellbeing

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	3

Employee Recognition

Long Service Awards	2	Hidden Heroes	19
Retirement Awards	3	STAR awards	8 Nominations

Diversity/Inclusivity

The Trust EDI agenda is progressing with pace and a range of developing initiatives.

- Reciprocal Mentoring pilot. 11 of 13 initial meetings have taken place, all 11 pairs have received their Relationship Agreements and introductory slides.
- Educational resource developed for staff to understand more prevalent forms of discrimination in the workplace and colleagues have 'lent their voice' to this initiative to develop case study recordings. Three 15 minute Youtube videos produced, content will be fully edited and available by end of w/b 07 July.
- Drafts of EDI Annual Report, WRES report (which will include Model Employer data and information on 'disparity ratios') and WDES report to be completed by 07 July, for review by end of second/third week in July.
- Disability Network now called Differently Abled Network (DAN). Meeting held on 24 June. Nominations for vice-chair received; and plans to review two Neurodiversity toolkits (from WSC and AWP), to raise understanding and awareness of range of conditions under this term. Short awareness piece about ND to be produced for Trust Comms;
- Network Chairs met to share ideas and updates (scheduled monthly meetings). Chairs will also attend each other's Network meetings to share ideas and progress with members;
- Trust recognised LGBTQ month, Learning Disability Week, UK Windrush Day and Armed Forces Day (all were in June).
- ICC and USC divisions committed to three EDI areas of action. Action plans developed. Staff survey results for USC to be discussed on 05 July. SWC division to meet on 16 July, and will discuss EDI priority areas.
- EDI Podcast pilot series being developed. Examples of themes are: Top tips for being an Ally; Common misconceptions/misunderstanding about equality and inclusion (with Network member/s).
- Produced a survey to better understand the difficulties facing staff with a BAME background when progressing in their careers, and to seek input into ways we can tackle them. Survey has been distributed in w/b 28 June.

Wellbeing Initiatives

Massage Chairs – new locations have been sourced for next month, and so rotations will now include Urgent Care, Woodpecker, and The Academy.

Tea Trolley Support
- during carers week , it went out daily accompanied by the GWH carers support network & representatives from Swindon Carers , and gave over 600 drinks & snacks
- the tea trolley supported hydration week by going out daily with the ASK team, dieticians & leads for nutrition & hydration, giving information & support to staff on the wards whilst handing out nearly 1000 drinks & snacks. Staff who visited the trolley were entered into a prize draw at the end of the week to win one of 8 Contigo reusable drinks bottles
- tea trolley in a bag service was provided to the Urgent Care Centre to offer an alternative to the tea trolley, hot & cold drinks and also snacks with take away tea and coffee were delivered
- it was accompanied by the wingman team on ED Pride day to support the department's Pride day celebrations

Yoga Class Referral Sessions - this pilot was started in March for Occupational Health clients ; an additional 4 were referred in June, bringing the current total to 12

Background

In June, 51 staff were seen for 1:1 counselling / psychology support. In addition, 40 contacts were made with the EAP.

The most common reasons for referral were:
- personal: low mood (57%), anxiety (57%) stress (43%)
- work-related : overload / stress (39%)

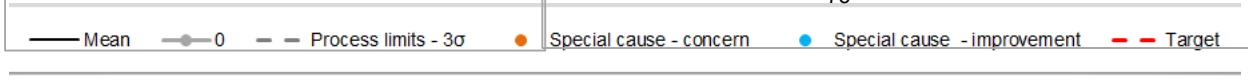
In-reach activity & numbers attended include:
- 29 'bite size' virtual wellbeing sessions covering various topics; the best attended was one on mindfulness (11)
- reflective self-care group for AMU doctors (11)
- mindfulness group for the front door team (11)
- compassionate conversations talk to Quality Team (17)
- self-care session for HR (15)
- self-care session for the community team (8)

Improvement actions

1. In June, a further 10 staff members were trained in MHFA, bringing the total within GWH to 135. There will be new cohorts trained each month for the remainder of the year.
2. Awareness of trauma and the Trauma Risk Management (TRiM) process started in ICU and Maternity Service last month – further awareness training will be rolled out in other departments this quarter, starting in the Respiratory Wards.
3. 9 individuals completed the CORE-10 measure in June following their counselling – pre/post scores reliably improved for all 9 (7 of which were 'clinically significant' i.e. post-score no longer within the 'clinically distressed' range)
4. Feedback from an individual who completed counselling in June stated: "My counsellor has not only given me some fab techniques to help me manage the issues but she has also helped me to accept that it is ok to reflect & think about the tough things and not to neatly package them up & mentally file them away & to actually start to look after me without feeling selfish about it, & she has helped me in so many more ways. Whilst the issues at home could continue for years, I feel much more equipped to deal with them, which impacts positively on all aspects of my life. I have also been really open with my team about the counselling sessions as I wanted them to see that I might be their boss & hold a senior role but that we are all human & at times need support and that its ok to ask for it"

Risk to performance and mitigations

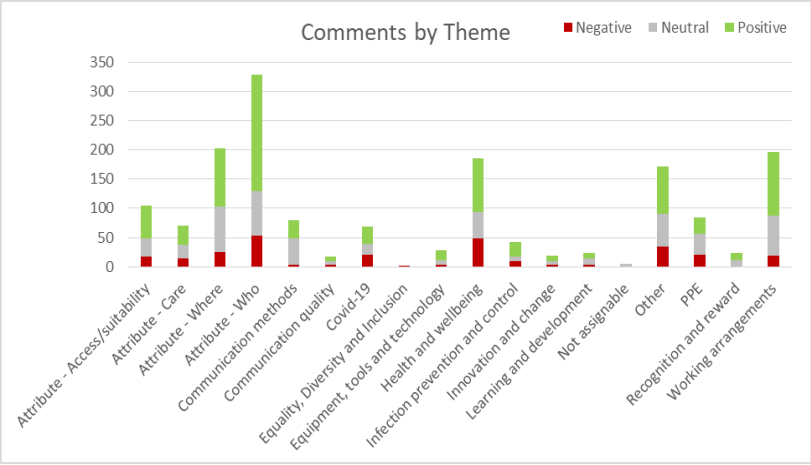
A substantive staff member is due to go on maternity leave in October, leaving the service at reduced capacity in terms of counselling & MHFA training . An advertisement to backfill is underway, and one of the bank counsellors who is a qualified MHFA trainer can support the monthly MHFA training

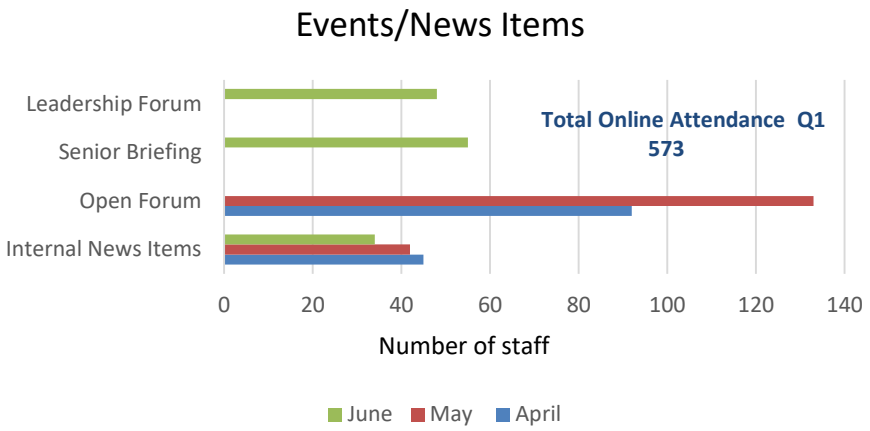


Workforce - Staff Engagement

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	3





Background

The 2020 National NHS Staff Survey free text has been received and divided into the themes and attributes as detailed above with colour coded range of positive to negative by theme While there were a number positive comments especially regarding the increased provision for Health and Wellbeing there is further improvement needed in the areas of working arrangements, in particular improving the process of temporary redeployment, Infection control and quality of care during the Pandemic.

.

NHS England and NHSI have introduced a new Quarterly Pulse Staff Survey starting in July 2021 and will be run each year in Q1, Q2 and Q4 with the National Staff Survey continuing in Q3. Emails and have been sent to staff, with a link to complete the survey and will be open until the end of July.

Improvement actions

1. In the free text from the 2020 National NHS Staff Survey free text, there were some negative comments which have been shared with the relevant senior managers and head of department . The comments will be considered and actions added to the Staff Survey Action Plan if appropriate.

2. To increase participation in the Quarterly Pulse Staff Survey, the Communications Team is sending out a reminder comms each week while the survey is open and publicizing a prize draw.

3. Our GWH working group has produced 7 draft statements which attempt to capture the culture we are trying to create. These will now be tested and refined with focus groups of staff to ensure they are co-created and meaningful.

4. The Trust is committed to developing a just and learning culture and work on this has begun with some benchmark data gathered and a plan to take this forward.

Risk to performance and mitigations

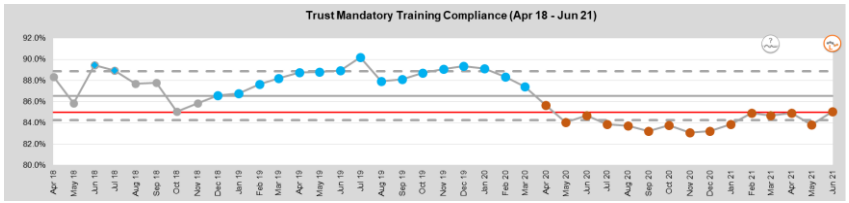
Staff Survey's are in place to ensure that Staff have a voice as detailed in the NHS People Promise and are able to feedback negative and positive information. Actions and improvements will need to be visible and seen by staff otherwise participation will decrease in future surveys

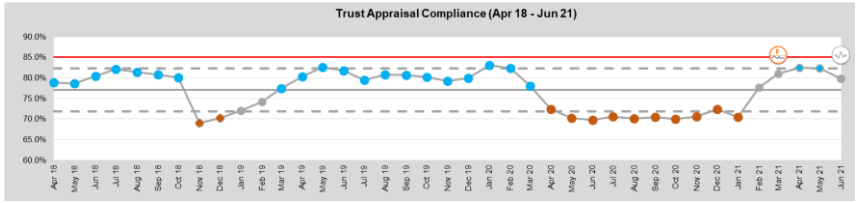
Workforce

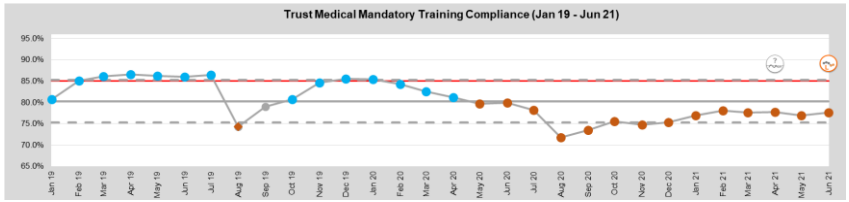
Use of Resources

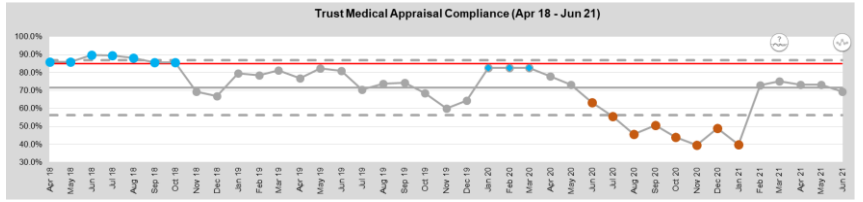
Great Employee Development

Indicator Score	Self Assessment Score
2	3









Background

Trust mandatory training compliance performance is now above the KPI of 85%-and is 85.08%.

Since our move to a new eLearning platform (ESR), we can see an increase on May's performance of 1.27%.

Trust appraisal compliance is reported at 79.82% in June, decreasing by more than 2% over the month.
(the May figure was 82.47%).

Improvement actions

1. The risk register is reviewed on a monthly basis.
2. The mandatory training project was successfully completed, achieving the transfer from Training Tracker to ESR by 31 May 2021.
3. The process for allocating levels of Child Protection Safeguarding Level 3 training to posts, medical compliance levels (particularly in ED) is the subject of a Task and Finish Group to improve both the process and the compliance levels.
4. All training modules are now uploaded and are available for staff to complete.
5. An audit of Academy rooms is underway to ensure we are utilising the space as efficiently as possible – communication plan to be developed regarding timely cancellations to minimise room wastage
6. The Trust is reviewing other approaches to mandatory training-specifically University Hospitals Southampton NHS FT.
7. HRBPs will continue to work with managers to support an improvement in appraisal rates. The system for recording appraisals is also under review.

Risk to performance and mitigations

Capacity continues to be a challenge for some courses due to the requirements of social distancing. Room audit underway to minimise waste.

Additional courses for Mandatory Training will continue to support increased compliance.

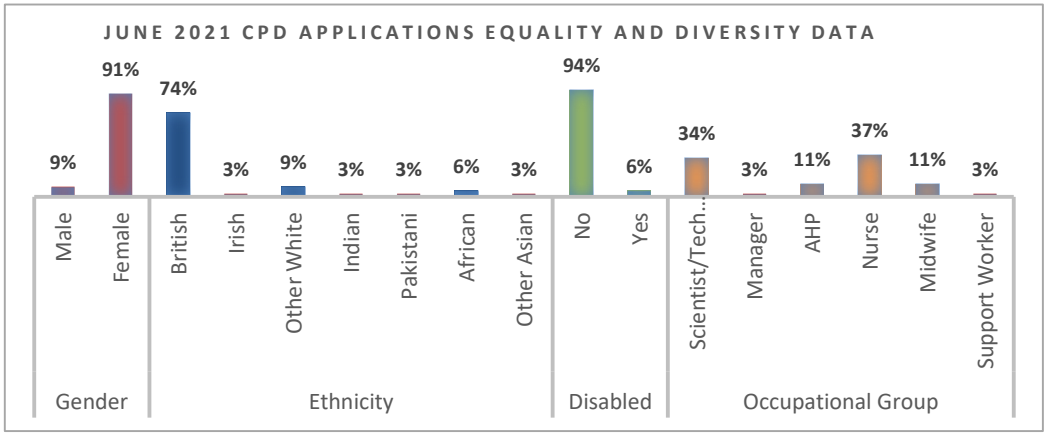
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

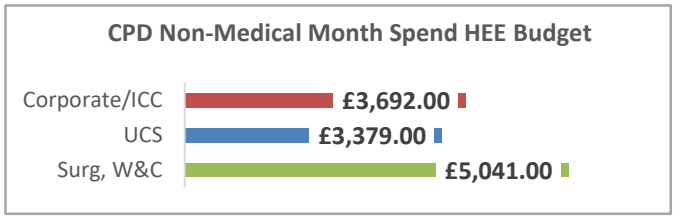
Workforce

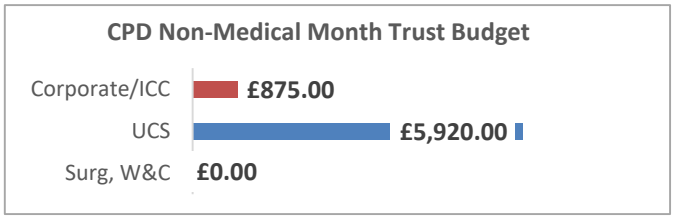
Use of Resources

Great Employee Development

Indicator Score	Self Assessment Score
2	3







Background

Trust CPD budget

The spend to date is almost £35,000. The annual budget is £240,000, so at the end of Q2 we would hope to achieve a spend of around £60,000 if the spend is evenly profiled across the year. Work is ongoing with Divisions to ensure monies are allocated-although this is made more challenging by the level of HEE investment.

HEE Funding for Non-medical Clinical Staff: - Nursing, Midwives and AHP

The Interim Head of Learning and Development has been working with senior nurses and Divisions to identify what is required in terms of CPD for nurses, midwives and AHPs.

The committed /spent money to date against the HEE budget of £632,000 is .£255,500. However, the vast majority of the proposed spend (£630k) has been identified.

Improvement actions

1. The Interim Head of Learning and Development has commenced in post and will be covering until the substantive candidate joins the Trust in late July. A handover period of 2 weeks is planned to ensure continuity for both the service and team.
2. HEE CPD funding for nurses, midwives and AHPs for 2021/2 has been confirmed as £632,000 – and will be distributed in 2 payments over the financial year, the first in Q2 of this financial year.
3. Detailed work already underway with all stakeholders to ensure the trust is ready to submit our 21/22 CPD investment plans to HEE by 30th July 2021. Subject to the submission and acceptance of plans, the financial allocation will be paid in full (remaining 50%).
4. The substantive Head of Learning and Development will take up post on the 19 July 2021.

Risk to performance and mitigations

The transition from the Interim Head of Learning and Development and the substantive recruit could lead to a period of instability within the Academy. However, there is a 2 week period of handover to ensure this is minimised. This risk will be mitigated by the oversight of the Associate Director of OD and Learning.

Detailed plans for the CPD HEE funding will be required for the submission on 31th July 2021, planning with the services/divisions is in place to deliver on time and to maximise available funding.

Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

Workforce

Use of Resources

Great Leadership	Indicator Score	Self Assessment Score
	2	3

Leadership Roles at the Trust	**4.27% of staff**	**Equating to 173.33 WTE**
Leadership Development Programme *(cohort 1)*	**22 leaders**	**Undergoing Training**
Leadership Development Programme *(cohort 2)*	**17 leaders**	**Undergoing Training**
Leadership Forum Members	**300 managers**	**Members Engaged**
Latest Leadership Forum *(27 May)*	**52 managers**	**Actively Attending**
Ward Accreditation	**24 of 24 departments**	**using the Perfect Ward App**

Background

The Aspiring Leaders programme has proved popular and two cohorts are planned for June 2021 for Band 6 staff ,and October for Bands 4 and 5. There is waiting list for cohort three in early 2022.

The start of the coaching training has been deferred to September 2021 for both the level 5 and 7 due to the low numbers of applications for June. We plan to offer any unfilled places out to BSW partners with the aim of creating a BSW coaching register and enhancing our internal coaching capacity across the system.

The leadership team now has two accredited Belbin facilitators and is exploring options to offer the High Potential Trait Indicator leadership assessment through Thomas International.

We have been successful in our application for a general management trainee through the Leadership Academy starting September 2021, with the first year placement in Maternity.

The leadership team is now able to support departments with team building interventions.

Improvement actions

1. The Trust 's Associate Director of OD and Learning is participating in the development of the BSW Academy. The two senior roles of Academy Director and Programme Manager are now out to advert. The BSW Academy will provide a vehicle for more structured collaboration in a number of areas.
2. The Trust is now working with RUH and Salisbury on the development of the Clinical Leads programme. It is proposed that RUH takes the lead on this programme.
3. Talent Grids and Succession plans are in place for Executive Director roles and senior corporate roles. Completion of Phase 2B has been delayed until mid September, largely due to diary pressures and unavailability of key staff members during the holiday period.
4. The Trust is now an active member of the Leadership Community of Practice and will continue to work within BSW partners to scope out opportunities for sharing best practice and resources including the option of system wide training and development activities relating to leadership.
5. The Trust will continue to support leadership development through the apprenticeship route by exploring new options available in partnership with the Leadership Academy who are offering opportunities for blended qualifications, incorporating both the apprenticeship and leadership qualification e.g. Edward Jenner and level 3 HR Support apprenticeship.

Risk to performance and mitigations

There is a risk that the demand for team development interventions exceeds capacity, but this is being carefully monitored.

The review of the timing of Leadership Forum may impact on the ability of medical staff to attend, so a survey will be undertaken to assess the best options.

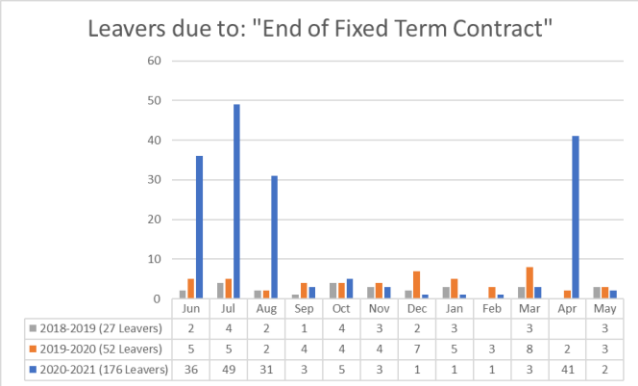
Recording of sessions is being considered to improve accessibility.

RUH has not yet confirmed it has the capacity to lead the BSW Acute Alliance Clinical Lead Development programme. If this is not possible SFT may be able to do so.

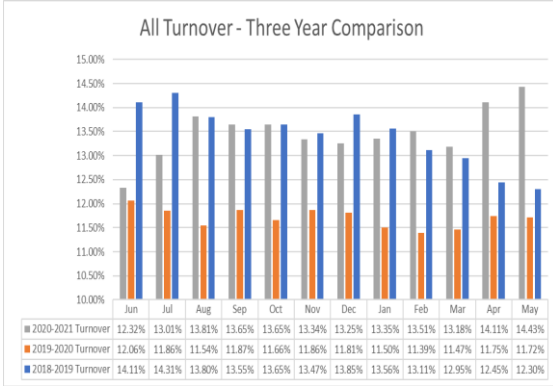
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Exception 1 of 3: All Turnover

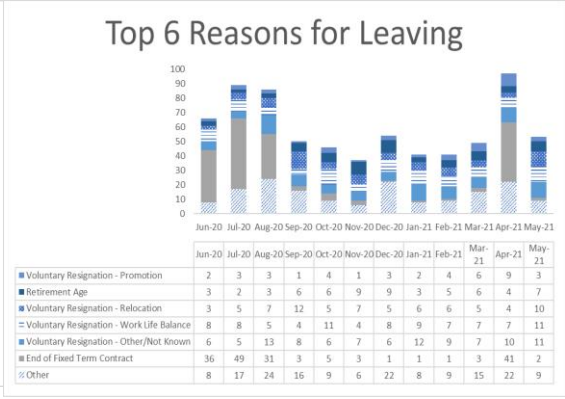
Exception Report



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2018-2019 (27 Leavers)	2	4	2	1	4	3	2	3		3		3
2019-2020 (52 Leavers)	5	5	2	4	4	4	7	5	3	8	2	3
2020-2021 (176 Leavers)	36	49	31	3	5	3	1	1	1	3	41	2



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2020-2021 Turnover	12.32%	13.01%	13.81%	13.65%	13.65%	13.34%	13.25%	13.35%	13.51%	13.18%	14.11%	14.43%
2019-2020 Turnover	12.06%	11.86%	11.54%	11.87%	11.66%	11.86%	11.81%	11.50%	11.39%	11.47%	11.75%	11.72%
2018-2019 Turnover	14.11%	14.31%	13.80%	13.55%	13.65%	13.47%	13.85%	13.56%	13.11%	12.95%	12.45%	12.30%



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Voluntary Resignation - Promotion	2	3	3	1	4	1	3	2	4	6	9	3
Retirement Age	3	2	3	6	6	9	9	3	5	6	4	7
Voluntary Resignation - Relocation	3	5	7	12	5	7	5	6	6	5	4	10
Voluntary Resignation - Work Life Balance	8	8	5	4	11	4	8	9	7	7	7	11
Voluntary Resignation - Other/Not Known	6	5	13	8	6	7	6	12	9	7	10	11
End of Fixed Term Contract	36	49	31	3	5	3	1	1	1	3	41	2
Other	8	17	24	16	9	6	22	8	9	15	22	9

Background

The Trust 'All Turnover' rate in May is 14.43% and reporting above KPI target of 13.5% and a marginal increase from 14.11% in April for all staffing groups. Turnover is a 12-month metric. All turnover includes Voluntary, FTC, dismissal and retirements. It excludes TUPE transfers and Medical rotations.

There has been an unprecedented increase in All Turnover, for the period June 2020/ May 2021 and the reasons for this include:

Retirement-

- June 2018 / May 2019 - 52 WTE retired
- June 2019 / May 2020 - 51 WTE retired
- June 2020 / May 2021 - 63 WTE retired

The increased number of employees taking the decision can be linked with recent changes in the NHS pension scheme (1995 scheme) and emergence from the COVID-19 pandemic during which some delayed retirement dates.

Fixed Term Contracts (FTC)-

- June 2018 / May 2019 - 27 WTE FTC concluded
- June 2019 / May 2020 - 37 WTE concluded
- June 2020 / May 2021 - 176 WTE concluded

To support with the pandemic there were a total of 136 employees recruited as Aspirant nurses / midwives / Physio's who were employed on 3 month FTC over two cohorts. Of these cohorts 81 Aspirant nurses terminated in June 2020 and a further 43 in April 2021. During the pandemic there was an opportunity made available by the NMC for recently retired nursing professionals to return to practice to support with the COVID 19 pandemic on fixed term contracts. In summary there was increased deployment of temporary staff to support the pandemic on FTCs.

Improvement actions

1. In departments that exceed the Trust turnover KPI of 13.5%, departments are required to develop a retention plan.
2. Within SWC Maternity services have implemented a retention plan focusing on a social media recruitment campaign, international recruitment, refer a friend scheme, relocation package and on-boarding package for incoming employees. There is also analysis being conducted within the Children's Unit looking at exit interviews, age profile of leavers, etc.
3. ICC are also looking at the leaver data and review every leaver to be able to pick up any trends or patterns and will continue to do so.
4. USC are working closely with hotspot areas to help support managers and aspiring leaders to develop positive team dynamics, helping them to try to engage the staff group to be able to identify any key issues/concerns which could be resolved, alongside sharing the positive messages of working within the departments.
5. Review of exit interview and leaver questionnaire process to improve quality of information.

Risk to performance and mitigations

The current risk is that the Trust All Turnover rate is 14.43% which exceeds the Trust KPI Target of 13.5% and that this continues to increase.

Turnover is a rolling 12-month metric and therefore All Turnover will remain high during this period until 12-month period has lapsed post the FTC end dates.

Any further waves of COVID-19 may require further recruitment on FTCs further exacerbating the turnover levels.

Increases in All Turnover places additional pressure on substantive workforce which may lead to increased levels of sickness absence, negative impact on work-life balance and health and wellbeing impacting morale and productivity and increased reliance on temporary workforce.

Exception 2 of 3: Employee Relations Cases

Exception Report

Financial Year	Number of Conduct Cases	Number of Conduct Investigations that resulted in informal actions	Number of Conduct Investigations that resulted in no case to answer	Number of conduct cases that went disciplinary hearing	Number of conduct cases resulted in a sanction/dismissal	Number of conduct cases (went to disciplinary hearing) resulted in informal action	Number of cases (went to disciplinary) and outcome was no case to answer
20/21	31	14	2	15	15	0	0
19/20	75	37	8	30	25	4	1
18/19	72	33	9	30	24	4	2

Year	Number of Capability case	Number of Capability cases that were PIP/information	Number of Capability cases went to hearing	Number of capability cases resulted in a sanction/dismissal	Number of capability cases (that went to disciplinary hearing) resulted in informal action	Number of capability cases (went to disciplinary) and outcome was no case to answer
20/21	8	5	3	3	0	0
19/20	25	22	3	2	1	0
18/19	19	14	5	4	1	0

Background

NHS England endorse the introduction of the Just and Learning culture – where equal emphasis is placed on staff as service users through restorative justice when things don't go as planned and the onus is on fairness, accountability and learning. A paper was shared in June 2021 with the Quality and Governance Committee that summarised the Trust policies when responding to concerns regarding staff conduct and performance. The paper outlined the desire of the organisation to create an environment where staff feel supported and empowered to learn when things go wrong.

Further to the NHSI mandated outcomes from the Amin Abdullah case in 2019, there is a requirement to provide Board oversight of the number of cases, trends and analysis information to provide assurance that the Trust disciplinary processes are being implemented and managed appropriately.

Mersey Care NHS FT used case data to determine whether a Just and Learning culture was being embedded and focused on reducing the number of formal cases with 'No Case to Answer' and reducing the number of overall formal cases.

In 2020/21 at GWH, there were 31 cases and 8 capability cases of which only 2 cases resulted in 'No Case to Answer' evidencing the Trust is taking appropriate action when concerns are raised. There were 14 cases resulting in informal action and implementation of the Commissioning Manager Decision Making Tree may help to decide on informal action at an earlier stage going forward.

Improvement actions

- Trust-wide Staff Survey action plans focus on improving and supporting teamwork, morale and line management.
- Embedding the Just and Learning Culture – Decision Making tool to be used by 100% of Commissioning Managers; Investigation and Hearing Manager refresher training to promote principles of dignity and fairness; adopting the Imperial Healthcare Disciplinary process as developed in line with Just and Learning principles.
- Trust Health and Wellbeing Plan 2021-25 outlines the health and wellbeing interventions for individual, team and organisation with a 5-year focus on – Mental Health First Aid training to achieve gold standard (10% workforce); Suicide First Aid; Trauma Incident Management training; Funding Schwartz Rounds; increasing wellbeing champion role and networks.
- Building the skills and confidence of HR staff has meant they feel empowered challenge behaviour that doesn't feel consistent with the organisation's just culture approach and Trust Values
- The Associate Director of L&D OD is leading 'Our GWH Working Group' for development of the Just and Learning culture with representation from across the Trust including Staff Side.

Risk to performance and mitigations

Further to the pandemic response, risks include staff exhaustion and anxiety, fragmented team working and an increase in reporting of long-Covid cases. All factors which can impact on the Employee Relations case profile in 2021/22.

To embed a just and learning culture requires time, energy and long term commitment during a period of increased operational pressure and in the approach to winter.

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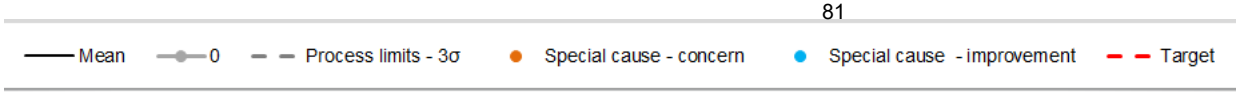
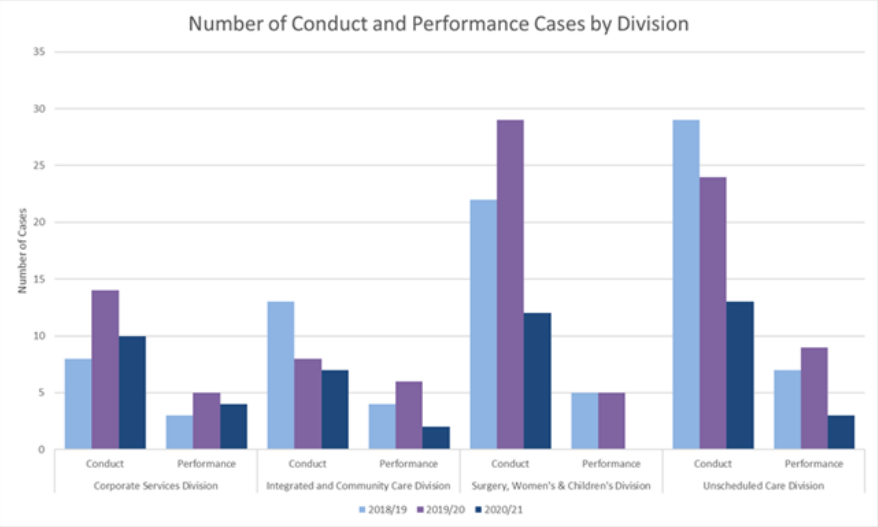
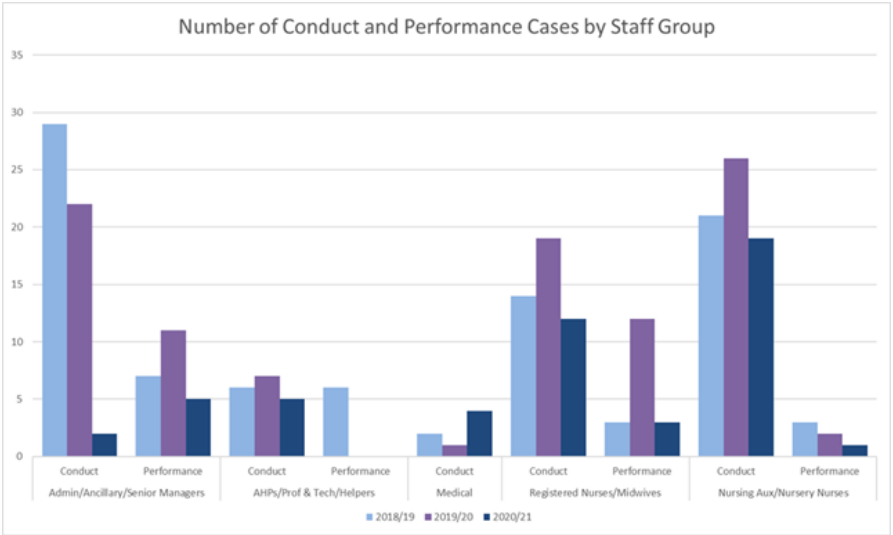


Exception 2 of 3: Employee Relations Cases

Exception Report





Background

2018/2019 Key Conduct Themes:

1. Behaviour/Communication - 38% , 2. Patient Care/Record Keeping/Drug Errors – 18%, 3. Bullying & Harassment – 9.8%

2019/2020 Key Conduct Themes

1. Behaviour/Communication – 26.7%, 2. Patient Care/Record Keeping/Drug Errors – 12%, 3. Breach of Confidentiality – 10.7%, 4. Bullying & Harassment – 10.7%

2020/2021 Key Conduct Themes:

1. Behaviour/Communication – 33.3%, 2 Breach of Confidentiality – 14.3%, 3. Patient Care/Record Keeping/Drug Errors – 9.5%, 4. Theft – 9.5%

The key conduct theme for the past few years has been 'Behaviour/Communication', this includes inappropriate language used and failure to follow management instruction. There was a drop in Behaviour/Communication cases for 2019/20 but then a further increase for 20/21. There was a drop in overall number of cases for 2020/21 due to Covid-19, however, 20/21 saw increases in Theft and Lapse in Registration cases. Patient Care / Record Keeping and Drug Errors can be impacted by human error, demands on the workforce, high levels of skill mix resulting from international and newly qualified nurses and cross-ward redeployment during the pandemic affecting continuity of cover. Individuals are supported with outcomes by the Academy, shadowing and the Great Care Campaign workstreams maintain a focus on supporting staff with providing great care. .

During the period of 2018/19, 8.3% of the conduct cases involved employees of a minority ethnic background. Within 2019/20, this increased to 14.6%, and in 20/21 there was a reduction reporting at 9.5%. The WRES data also reports BME staff are less likely than white staff to enter a formal disciplinary process.

Improvement actions

- The HR Advisor Team are reviewing the ER database and developing a guidance document on how to use the ER database effectively allowing a consistent approach, which in turn will enable accurate and meaningful reporting.
- Embedding the Just and Learning Culture - adaptations to the ER database to include a record of use of the Decision Making tree, to ensure that these are completed for all relevant cases.
- With the increase in 'Lapse in Registration Cases', a review will be completed against the Registration/Revalidation Reports and how this is monitored.

Risk to performance and mitigations

During COVID all cases were closed and all serious misconduct cases were progressed impacting the general trend.

Achieving the balance of a just and learning culture, whilst maintaining accountability will need to be monitored.

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Exception 3 of 3: Health and Wellbeing

Exception Report

KPI 1 – appt. offered within 10 working days	Apr-21		May-21		Jun-21	
	Total Appts	% at KPI	Total Appts	% at KPI	Total Appts	% at KPI
Psychology/Counselling	21	76%	20	90%	30	97%
Occupational Health	141	45%	175	49%	154	53%

KPI 2 - on a scale of 0 (not at all) – 10 (completely), how has the support from the service improved your overall health & wellbeing	KPI 3 - would you recommend this service to a colleague?	KPI 4 - reports provided within 48 hours
Average score 7.5	100% Yes	None requested for any psychology / counselling clients; system in place now for recording for OH clients

Background

The KPIs for the service have been refreshed by the Clinical Lead for Wellbeing. During COVID these KPI were not monitored and therefore a robust monitoring process has been implemented and will be monitored by the clinical

As such these 4 refreshed KPIs now go across both Occupational Health and Psychology / Counselling functions within HWB.

The client feedback for counselling / psychology was updated in April and responses will be used to monitor

1. how has the support from the service improved your overall health & wellbeing
2. would you recommend this service to a colleague?

From Model Health System, 2020 data (from staff survey report)
Psychological Safety:

- does your organisation take positive action on health & wellbeing - Trust value 6.1 (peer median 6.1, national median 6.3)
- my immediate manager takes a positive interest in my health & wellbeing - Trust value 7.3 (peer median 7.3, national median 7.2)

Improvement actions

1. As these are new & only agreed in June, much of the data for this quarter is missing. There is now, however, a system in place for the regular recording & monitoring of these. As such the data will be complete for the next quarter.
2. The return of the psychology / counselling feedback forms has been lower than hoped, & so we are now actively reinforcing the importance of these & sending reminders to clients to help improve the response rate.

Risk to performance and mitigations

The number of referrals has been increasing since the start of the year.

We will monitor this to ensure this is sustainable with the current bank counsellors having capacity to pick up the majority.

Additional OH clinics have been offered in the second half of this quarter, & there are new staff starting & seconded staff returning next quarter, which will help reduce waiting time.

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Board Committee Assurance Report

Finance & Investment Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Andy Copestake	Andy Copestake		26 July 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Monitoring benefits from Business Cases, including IT investment	A	A	The Committee discussed a referral from PPPC re: the ongoing monitoring of benefits from Business Cases. The Committee concluded that there was currently a gap and that there was a need for regular reporting of the achievement or non-achievement of benefits to be able to learn lessons, etc. The Committee noted the QI programme was already picking this up as a key requirement.	QI programme to develop methodology and report back to FIC	TBA (probably Q4)
National Cost Collection 2019/20 report	A	A	The Committee discussed a referral from ARAC re: the 2019/20 report and asked for more information on 2 specific things, firstly an explanation of why the GWH elective inpatient cost had risen by 6% when the national average had fallen by 5% and, secondly, why the outpatient procedure costs were nearly 20% below the national average figures.	Review at next FIC meeting	FIC – 23 August
Month 3 Finance position	G	G	Again, all the main indicators are green. A favourable I & E variance to date of £9k, Cash of £30.2m at the end of June, good performance re: the Elective Recovery Fund in Q1 and good progress in spending the Capital budget. Also, CIP achievement to date is £99k above plan.	Continue to monitor monthly through FIC	FIC meetings 2021/22
Finance Risk Register	A	G	One risk added re: Ockenden funding (the risk score may be increased). FIC noted the potential risk if the Pay award is not fully funded.	Monitor through FIC	FIC meetings 2021/22

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Quarterly update re: CIPs	R	A	The Committee received a good report on CIP achievement in the first 3 months of the year. Better buying was significantly ahead of plan resulting in a favourable position overall but some of the Divisions were significantly below their respective plan targets. The red rating reflects the need to address a number of worrying underlying cost trends as well as responding to a much higher expected CIP target in H2.	Monitor through FIC	FIC meetings 2021/22
Capital Plan – in depth report	A	G	A good report on the Trust's reprofiled Capital Plan. Spend to date is broadly in line with the new plan. The Committee welcomed the clear report and the focus the plan was receiving. The amber rating reflects the fact the Trust is still waiting for confirmation that the plan is fully funded.	Monitor through FIC	FIC meetings 2021/22
Improvement Plan update	A	A	The Committee received a follow up report on the Improvement & Efficiency Plan which helpfully addressed a number of concerns and questions raised at the June meeting including the overall financial target, how the plan would be prioritised and how the plan would dovetail with the QI programme.	Update with more precise information on targets in key areas	October FIC meeting
GMP and main contract on UTC	G	G	The Committee received a detailed report from the Way Forward team on the considerable amount of work undertaken to reach an acceptable Guaranteed Maximum Price for the new UTC building. The Committee was satisfied that due process had been followed (with external input as necessary) and agreed to approve the GMP of £8,445,988 and to sign off the Main Construction (Stage 4) Contract under the delegated authority approved by the Board.	Track as a key part of the Trust's Capital Plan	FIC meetings 2021/22
Records Management contract	G	G	The Committee discussed a system-wide proposal to award a new 4 year contract (with 2 x 24 month extension options) for Document Storage and Retrieval and Scanning. Whilst noting that there would be a small additional cost to GWH for each of the first 4 years, the Committee supported the proposal and agreed to recommend approval of the award to Restore PLC for document storage and retrieval and to Hugh Symons for document scanning.	Board approval	5 August 2021
Overseas Visitor Policy	G	G	The Committee approved an updated Overseas Visitor Policy	None	

Issues Referred to another Committee	
Topic	**Committee**
None	

Great Western Hospitals NHS Foundation Trust

Part 4: Use of Resources

Our Priorities

Outstanding patient care and a focus on quality improvement in all that we do

Improving quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers

Staff and volunteers feeling valued and involved in helping improve quality of care for patients

Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Financial Overview

Use of Resources

For Period Ended - 30th June 2021	In Month Plan £000	In Month Actual £000	In Month Variance £000		YTD Plan £000	YTD Actual £000	YTD Variance £000	
Total Operating Income	33,744	35,779	2,035		101,019	103,214	2,195	
Total Operating Expenditure	(33,744)	(35,780)	(2,036)		(101,019)	(103,205)	(2,187)	
Total Surplus/(Deficit)	0	(1)	(1)		0	9	9	
Capital					2,359	2,510	(151)	
Cash & Cash Equivalents	30,345	30,164	181					
Efficiencies	165	402	237		496	595	99	

Overview

Income & Expenditure: The Trust in month position is £1k deficit against a plan of breakeven. Operating Income is £2,035k favourable against plan and Operating Expenses are £2,036k adverse against plan. This includes Pay costs that are £774k adverse against plan and Non-Pay costs that are £1,262k adverse against plan.

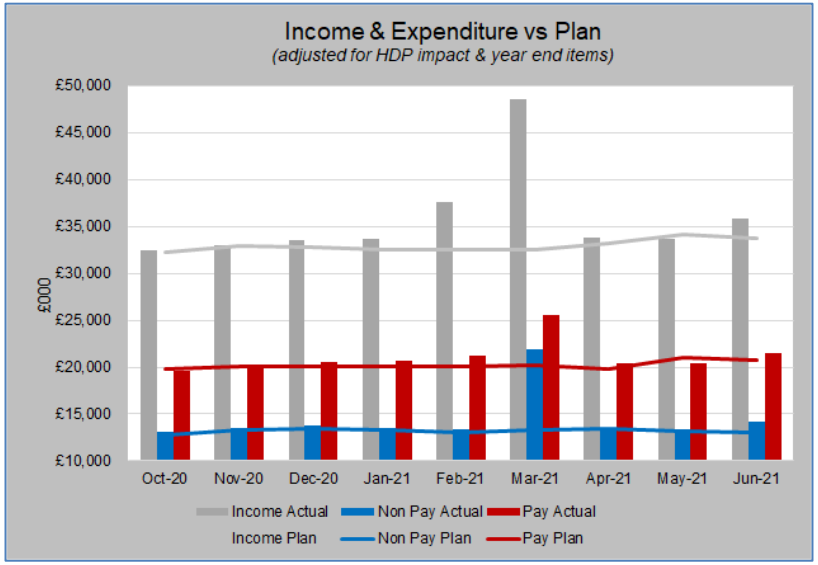
Cash – the cash balance at the end of June was £30,164k which was slightly under plan.

Capital – Capital expenditure is £2,510k as at the end of Month 3. The full year plan has been re-profiled and in month reporting processes have been reviewed – as a result there is an adjustment in Month 3 to reflect the correct year to date position.

Efficiencies – £595k YTD, above plan by £99k, which is driven mainly by over-performance within the Better Buying workstream. Efficiency schemes continue to be developed at divisional level and opportunity surgeries have been scheduled in July to help facilitate this.

Income and Expenditure - Run Rate

Use of Resources



Background

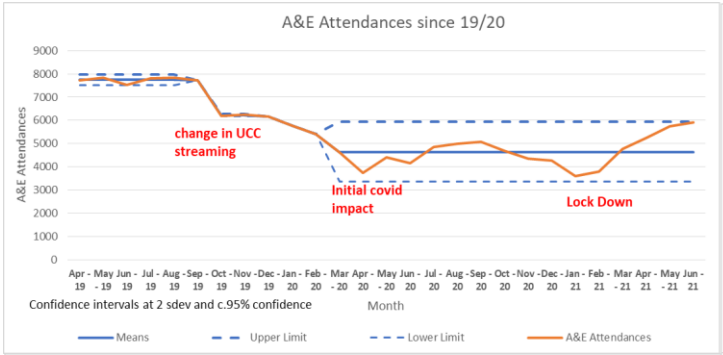
The June position is £1k deficit against a breakeven plan.

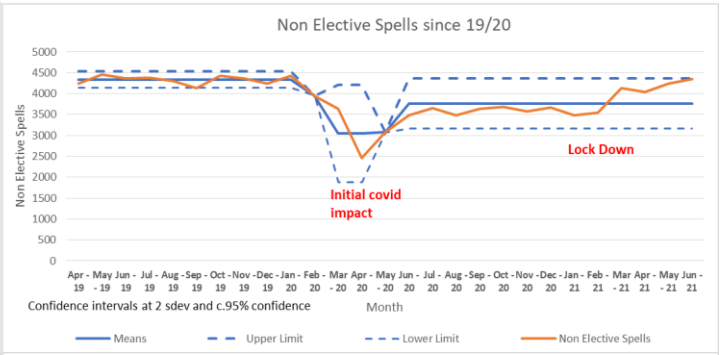
- Elective Recovery Fund (ERF) income of £1,112k is included in the June position. The funding covers the additional costs incurred to deliver activity during Q1.
- Pay run rate has increased by £840k and is overspent in month by £774k. This includes £455k in WLI costs to deliver ERF activity.
    - The underlying nursing increase is £248k, of which £111k is agency expenditure driven by close support and vacancy cover. Substantive nursing costs have increased by £100k due to enhancements relating to May being paid in June.
    - Medical costs have increased by £197k (excluding ERF costs) and are driven by temporary staffing pressures in USC including additional shifts in ED to meet demand, a third outlier consultant needed to meet site pressures and providing cover for medical vacancies and staff stranded abroad.
- Non Pay run rate has increased by £812k and is overspent in month by £1,262k. This includes ERF costs of £657k. Drugs costs have increased by £523k in month, of which £409k are high cost pass through which are offset by income. Clinical Supplies (excl ERF) have reduced by £311k following an exceptionally high month in May. The reduction in spend on Medical & Surgical equipment (£211k) and prostheses (£35k) is in line with T&O elective activity which is 17% lower than last month.

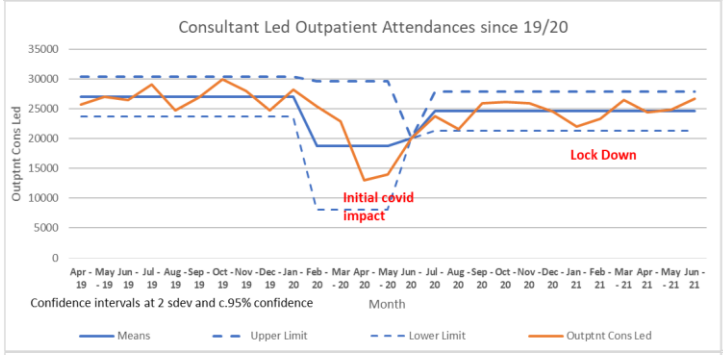
Emerging issues, improvement actions and risks are explained in the earlier slide.

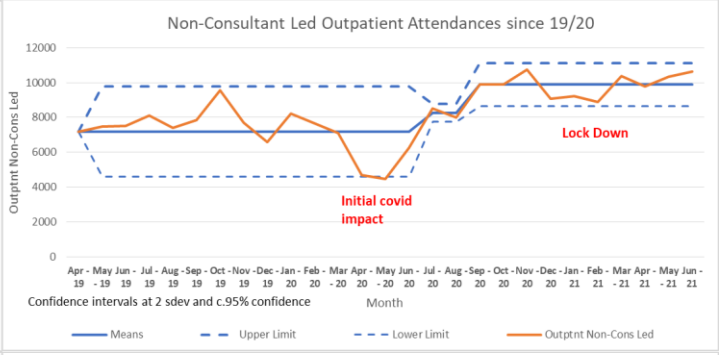
Key Activity Trends to Inform Revenue Impact if National Tariffs Still Applied

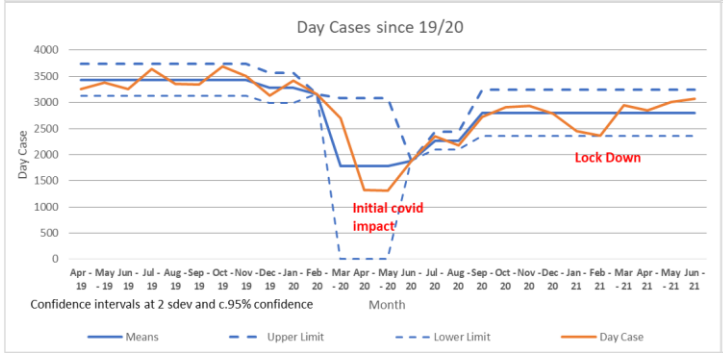
Use of Resources

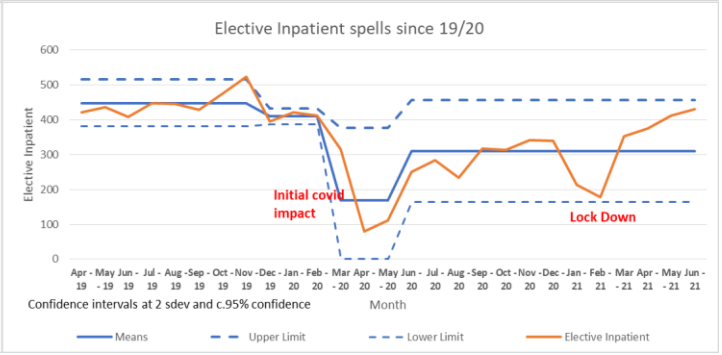












Background:
This is the activity trend collected to inform financial view on productivity, expenditure reported and notional income earned. This does not replace divisions' own view on their levels of activity.

Income and Activity Delivered by Point of Delivery

Use of Resources

2021/22 Income vs 2019/20 Income - YTD at June

Activity Type	Activity Variance %	19/20 Income £'000	21/22 Income £'000	Income Variance £'000	Income Variance %	Comment (comparing income and activity variances)
A&E	-26.9%	3,713	2,994	-719	-19.4%	Minor activity affected more than major + impact of increased streaming since 19/20
NEL	-3.3%	23,276	24,366	1,090	4.7%	Minor activity affected more than major
Outpatient (All)	0.5%	10,624	9,569	-1,054	-9.9%	Due to switching to Non face to Face
Day Case	-9.9%	5,773	5,719	-55	-0.9%	Minor activity affected more than major
Elective Inpatient	-3.9%	4,436	4,422	-14	-0.3%	Minor activity affected more than major

Context

Due to Covid-19, 21/22 funding is paid on a block contract basis in the first half of the year, with the emphasis on covering reported costs.

The above table show this year's performance by main activity types against the same point in 2019-20, if activity based contracting (PbR) was still applied.

It gives a feel for the impact of Covid-19 and the likely scale of income recovery in future years should activity based payment be reintroduced.

Issues:

Income that would have been earned if PbR was in place is well below current costs due to Covid-19 reducing throughput, although activity is returning close to pre Covid-19 levels in some areas. Notional PbR shows income is affected less than activity, highlighting it is work of a lower complexity that has reduced. Within outpatients there is a switch to delivery through non face to face means which has a lower notional tariff. Within A&E there was a change in pathway in October 2019 resulting in the majority of minors being streamed to UTC as well as the impact of Covid-19 reducing attendances from Feb 2020.

Risks:

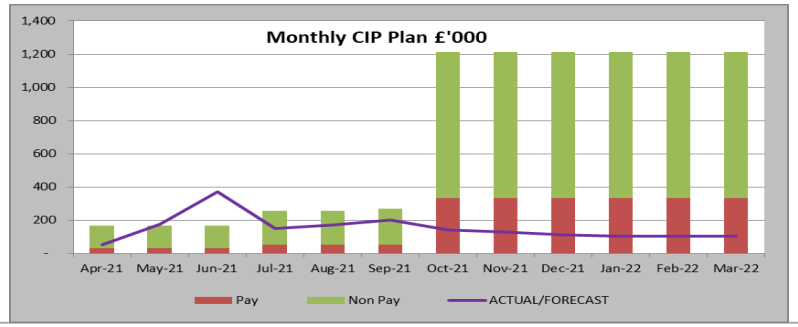
- If the previous cost and volume funding approach was reintroduced by NHSE/I, with current GWH run rates, it would lead to a deficit in the region of £3.0m per annum on major PbR income streams.

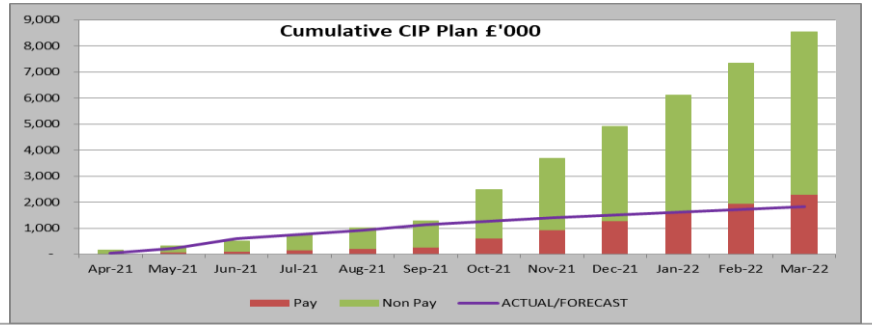
Actions & mitigation:

- Finance are keeping in close contact with NHSE/I to clarify future funding arrangements as soon as there is further intelligence.
- The current view, but not confirmed, is that PbR is not likely to be reintroduced in 21/22.

Cost Improvement Plans – Better Care at Lower Cost

Use of Resources





Background

- The Cost Improvement Programme (CIP) delivery plan for June is £165k.
- The total for H1 of the year is £1,272k, c. 0.7% of total budgets.
- CIPs identified and delivered in month were £402k (£595k YTD) which is £237k above plan (£99k YTD).
- Delivery year to date is currently 120% of plan in overall terms, driven by Better Buying.
- Delivery against divisional targets remains low at £244k YTD against plan of £355 YTD (69% delivery rate).
- The values attached to the charts above for H2 are indicative based on an assumed 4% of budget requirement and are therefore subject to change as the settlement for H2 still requires confirmation.

Improvement actions planned

Reporting is being reviewed in order to recognise where improvements and efficiencies are making non cash releasing savings, or aiding cost avoidance.

The Trust chaired the SW Improvement Network in June, which focussed on productivities and efficiencies, a follow up meeting is scheduled to learn from another Trusts success around automation of coding co-morbidities.

Work is underway by Procurement to identify the split of savings across national / local initiatives for the better buying workstream.

Governance of programmes is under review alongside the prioritisation work that T&I are leading on, this will include financial representation on every prioritised programme area to ensure that the projects within are validated and the boards are challenged to consider the financial opportunities within those improvements.

Risks to delivery and mitigations

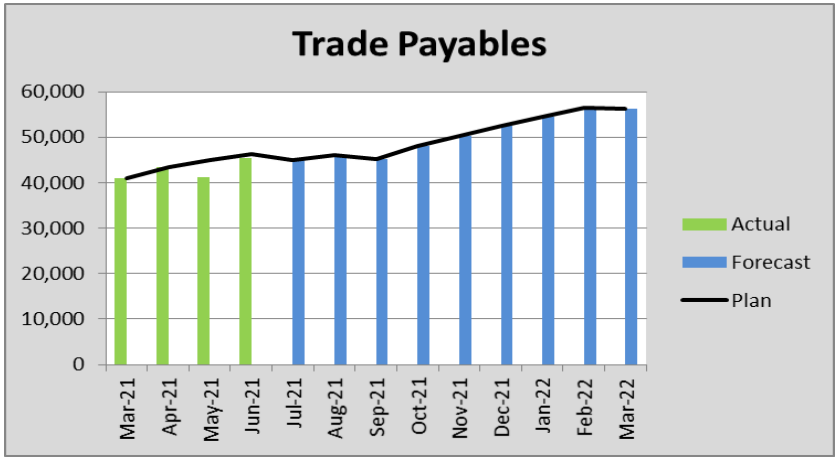
Divisional CIP therefore remains lower than plan and few wider improvement programmes have identified cashable savings.

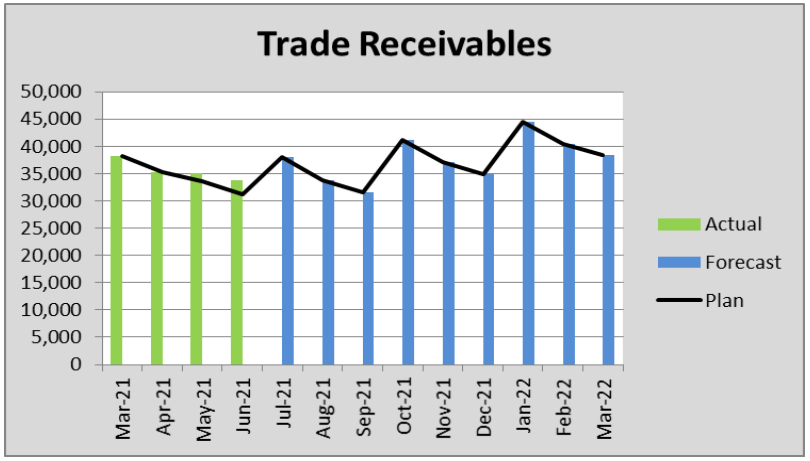
Divisional Opportunity Surgeries are scheduled for July to drive further opportunities . T&I and Finance continue to challenge for CIP prioritisation within divisions.

Overall level of CIP achieved for H1 is looking healthy, however this is significantly driven by overachievement against plan of the Better Buying Programme, which is now forecasting £630k (£1,025k full year effect) against a plan of £363k for H1. The H2 plan for Better Buying - Procurement was originally outlined at £530k and there is already forecast achievement of £395k in H2 against this.

Statement of Financial Position: Key movements

Use of Resources





Background

- The monthly plan has been updated to reflect the H1 and H2 I&E plans signed off by Trust Board
- Payables are broadly in line with plan in month – Capital payables have reduced from prior month as a number of invoices have now been received and paid.
- Receivables are above plan (£33,823k compared to a plan of £31,164k). This is primarily driven by a prepayment for rates not included in the plan (£1m) and HDP invoice to Swindon Borough Council (£0.6m). It is anticipated that this will be paid in July.
- An adjustment to Non Current Assets has been made at Month 3 to reflect the corrected Capital reporting, presented in more detail on the Capital slide that follows.
- A full Statement of Financial Position is included in the appendices.

Risks to delivery and mitigations

- A summary of prior year capital creditors has been shared with Capital project leads to identify actions required to clear these promptly.
- A review of the Debt Management process is underway to ensure aged debt recovery is maximised.

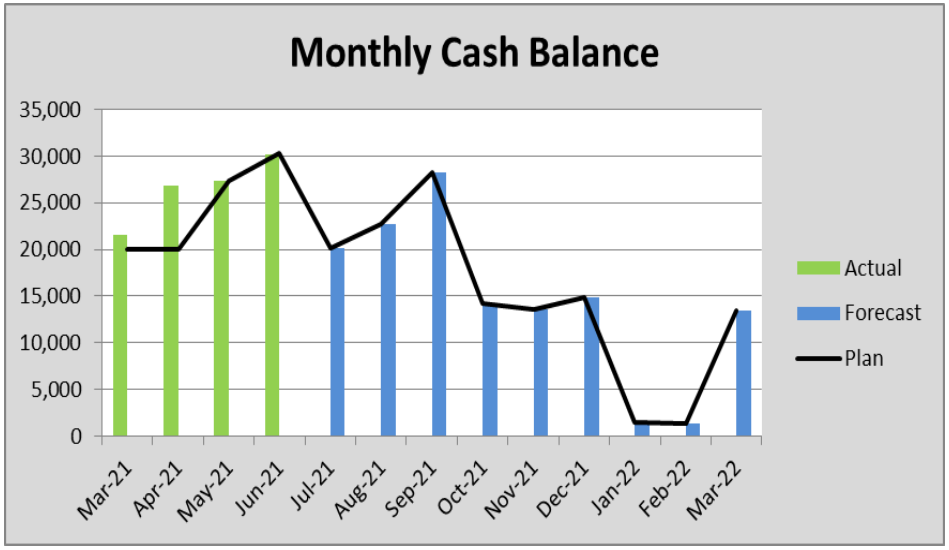
Cash

Use of Resources

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	21/22 Total	Rolling 12 Mths May 21 to June 22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	**27,373**	**30,164**	**19,918**	**22,560**	**28,061**	**14,089**	**13,448**	**14,676**	**1,244**	**1,155**	**13,273**	**2,386**	**3,152**	**21,553**	30,164
Income															
Clinical Income	32,152	31,084	31,084	31,086	27,500	27,435	27,435	27,435	27,435	27,435	27,517	27,517	27,517	351,509	340,480
Other Income	1,311	4,174	3,230	1,287	1,900	3,568	1,624	1,960	3,563	1,619	1,619	1,619	1,619	34,893	27,780
Revenue Financing Loan / PDC								1,000		13,500				14,500	14,500
Capital Financing Loan / PDC		1,120	1,121	8,071	1,929	1,929	5,594	1,614	1,614	4,537	4,537	4,537	4,537	27,529	41,140
Total Income	**33,463**	**36,378**	**35,435**	**40,444**	**31,329**	**32,932**	**34,653**	**32,009**	**32,612**	**47,091**	**33,673**	**33,673**	**33,673**	**428,431**	**423,900**
Expenditure															
Pay	19,783	20,198	20,181	20,194	20,130	20,105	20,105	20,099	20,098	20,044	20,138	20,138	20,138	238,895	241,568
Revenue Creditors	8,909	9,802	9,425	9,387	10,102	9,907	9,880	10,224	9,889	10,219	8,302	8,302	8,302	122,044	113,740
Capital Creditors	1,980	4,884	3,186	3,233	3,417	3,505	3,440	3,465	2,713	2,585	4,467	4,467	4,467	36,362	43,830
PFI		11,740			11,653			11,653			11,653			35,046	46,699
PDC Interest				2,130						2,125				4,255	4,255
Financing						55								110	55
Total Expenditure	**30,672**	**46,624**	**32,792**	**34,944**	**45,302**	**33,572**	**33,425**	**45,441**	**32,700**	**34,973**	**44,560**	**32,907**	**32,907**	**436,712**	**450,146**
Closing Balance	**30,164**	**19,918**	**22,560**	**28,061**	**14,089**	**13,448**	**14,676**	**1,244**	**1,155**	**13,273**	**2,386**	**3,152**	**3,918**	**13,273**	**3,918**

Background

- Cash at the end of Month 3 was £30,164k which is slightly below the planned level of £30,345.
- The cash forecast anticipates that revenue PDC will be required in January (£1m) and March (£13.5m) to support PFI payments and maintain a working cash balance.



Capital Programme

Use of Resources

Capital Scheme	Capital Group	2021/22 Full Year Plan £000	2021/22 Month 3 YTD Plan £000	2021/22 YTD Actual £000	2021/22 YTD Variance £000
Aseptic Suite	Estates	1,903	124	60	(64)
Oxygen	Estates	500	77	77	-
Estates Replacement Schemes	Estates	750	-	-	-
Utilities (LV & Heating) Project	Estates	2,300	65	65	-
Site Reconfigurations Urology/R&D etc	Estates	300	-	-	-
Pathlake (national funds requires matching)	IT	260	-	-	-
Pathology LIMS (network procurement)	IT	510	-	-	-
IT Emergency Infrastructure	IT	3,000	1,867	2,163	296
IT Replacement Schemes	IT	1,404		35	35
PACS - environment/replacement solution (Nov21)	IT	800	-		-
Equipment Replacement Schemes	Equipment	1,450			-
Contingency	Equipment	541	135	-	(135)
Way Forward Programme		9,690	91	93	2
Clover UEC		10,085	-	18	18
Total Capital Plan (Excl PFI)		**33,493**	**2,359**	**2,510**	**151**

Background

- The Capital plan has been re-profiled at Month 3 following discussions with scheme leads now that schemes have been worked up. Detailed changes will be presented to Finance and Investment Committee in July. Capital expenditure reflects the work done to date on each project, rather than invoices paid and orders place.
- As a result of the above improvements, significant movements from Month 2 are noted on the following schemes:
    - Oxygen – Month 2 expenditure included the full order placed (£503k) however only £77k of this work has been completed to date.
    - Utilities/Way Forward/Clover UEC – Month 2 expenditure included work that had been funded by 2020/21 creditors, this has now been corrected in the Month 3 position.
- Expenditure year to date is £151k above plan, primarily driven by an overspend in IT which is expected to be offset in Month 4.
- The Trust anticipates to deliver the capital programme in line with the planned value by year end.

Risks to delivery and mitigations

Emergency Financing bid has not yet been approved as described on the Emerging Issues slide.

Market volatility within the construction sector is a risk to the cost of strategic build projects. Work is ongoing to agree GMP to mitigate this risk.

Board Assurance Report

Audit, Risk & Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Julie Soutter	Julie Soutter		15 July 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

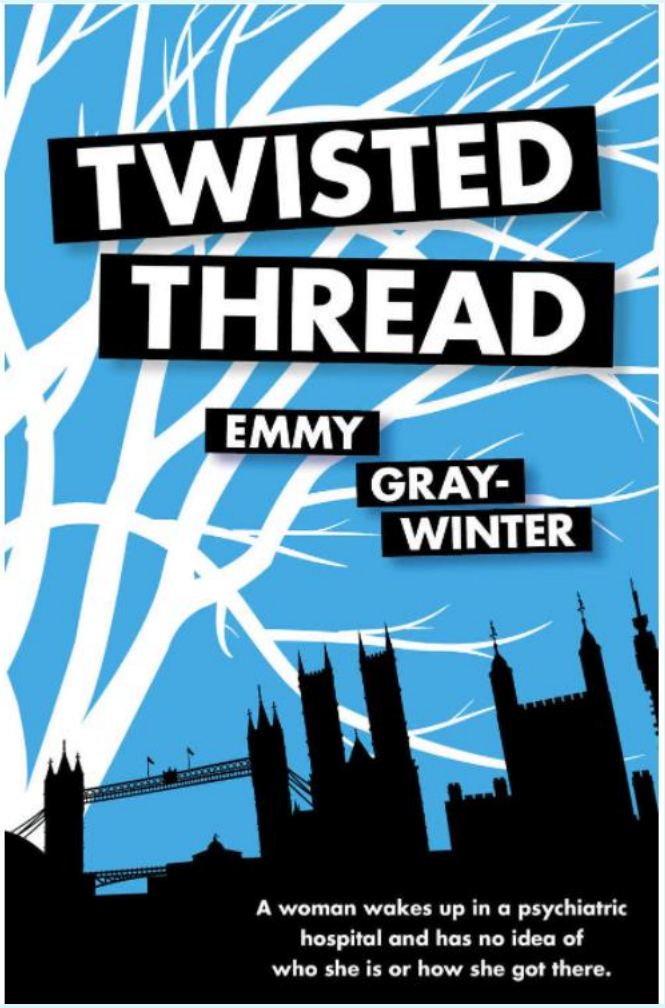
Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
BAF – Refresh	G	G	Good discussion and assurance on development new BAF. Well received new format and content. Further work planned to refine controls, assurances including strength, gaps and actions. Input required from Board workshop Sep 21. Update for Q1 for review in committees.	Board workshop Committee reviews Q1	Sep 21 Tbc
15+ Risk Register	G	A	Good grip on risks. Risk reviews done by divisions, ExecCo and Risk Cttee resulting in changes to risk scores, numbers of risks and process (scrutiny, challenge and sign off). Support and training also being provided. New risk system proceeding as planned. IA recommendations being addressed.	ARAC updates	Sep 21
Corporate Risk Report	G	A	Risk known and analysis discussed across Estates and FM, IT, HR, Quality (IP&C, Safeguarding & PALS), Clinical Quality (Risk, FTSU). Assurance on processes with focussed action proposed on KPIs, training and more detail on IT Cyber risks. Support/learning resources provided by Quality Team	Cyclical reporting as with divisions	TBC

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Annual Report on Cyber Security	R	A	Good and robust discussion on risks. Although no successful cyber attacks in reporting period, risk of attacks is increasing overall and some key staff leaving the Trust. Further work requested to refine action plans linked to disaster recovery planning and system wide working, Also more information requested for future reports on risk management, performance on alerts, line of sight on contract renewals, and plans for addressing any remaining unsupported systems. External collaboration across system confirmed in joint posts and capability proposals. Possible Board training to be confirmed.	Update	Nov 21
Internal Audit Progress Report	G	G	Sector update provided. Plan progressing as expected with some work being pulled forward where possible to lighten year end pressures.		
Internal Audit Review – Staff Engagement	A	G	Not formal internal audit report so no ratings given. Based on staff survey across specific clinical directorates. Good practice and quality noted on range of communications approaches. 2 medium recommendations on commencement of staff engagement group and cascade of CEO Open Forum information. Good discussion on results of survey including staff ability to engage especially at sub divisional level and actions to be taken		
Internal Audit Report – Integrated Learning	G	G	Moderate for Design and Effectiveness. Good practice noted. 2 medium recommendations – 1. register of initiatives and improvement actions for Great Care campaign and 2. Improve system for recording, investigating and actioning and learning from incidents across all levels of harm. Q1 initiatives noted with patient safety a focus.		
Internal Audit Follow up of Recommendations	G	G	Generally progressing as planned. Overdue actions currently on hold due to Covid19 and operational pressures to be progressed (2 from 2019/20 and 5 from 2020/21). Expected to close some recommendations shortly once new policies formally approved. Reporting to show where deadlines moved.		
Counter Fraud Report	G	G	Good update with new separate report to provide assurance across range of of required standards. No new allegations received since last committee meeting. Work progressing as planned.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Anti-Fraud and Corruption Policy	G	G	Policy updated. Dissemination through induction and ongoing training. Framework to be articulated for escalation of cases (eg to potential prosecution if advised)		
National Cost Collection 2019/20	G	A	Report covered recent outcome of 19/20 exercise. GWH reported a NCCI of 98 (97 after MFF) where 100 is national average. Assurance on process and improvements to quality controls pre submission. Some questions over specific areas within overall figure – to be explored by FIC.		
Freedom to Speak Up Annual Review	A	A	Assurance on ongoing initiatives and actions to promote open and supportive culture. Good discussion on staff survey feedback, resourcing models and actions required to increase staff confidence in raising concerns. Work planned to look at best practice, recovering the profile of FTSU after impact of Covid on activities and link to initiatives on Just Culture.		
Single Tender Actions 6m May 2021	G	G	Report on 'waivers' with discussion on recent improvement to controls and scrutiny. Further work being done by task and finish group linked to Counter Fraud submission. Good assurance.		
Losses and Compensations Q1 21/22	G	G	Compensation payments <£4k. Write offs £77k relating to irrecoverable overseas debt (£64k) and old invoices (£13k). Discussion on controls for improving collection processes going forward with assurance on finance processes and further reviews planned eg Private Patients processes.		

Issues Referred to another Committee	
Topic	**Committee**

AIXELSYD and Me



DYSLEXIA & Me

- **How people view me.**
- They think I can't read.
- They think I can't write
- I have been told that I shouldn't practice as a nurse
- Do the RCN know about my illness.

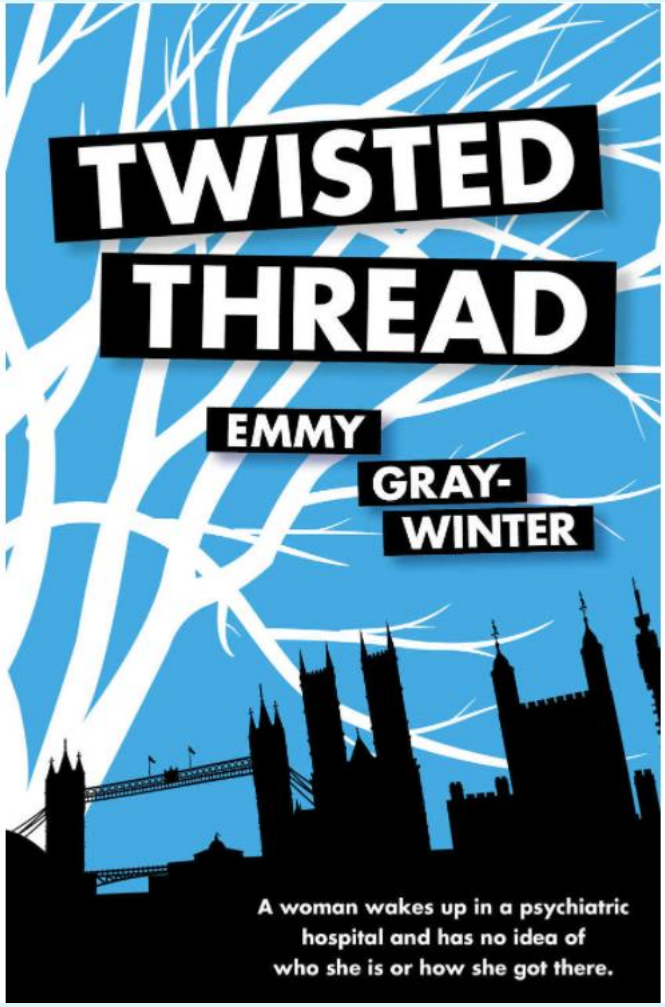
- **The reality is**
- Registered General Nurse
- Registered Midwife
- Specialist community public health nurse (Health Visiting)
- Nurse prescriber
- PCT board nurse
- Teaching qualification.

Previously

- Misconceptions
- Prejudice
- Lack of understanding
- Unwilling to take on reasonable adjustment
- Bullied
- Unfair dismissal
- Culture of “you do as I say”

GWH

- Understanding
- OH assessment at interview stage
- Discussion with line manager of how they can help.
- Reasonable adjustment
  - Written information, prior to meeting.
  - Video links
- TIME
- No discrimination – differently abled


TWISTED
THREAD
EMMY
GRAY-
WINTER
A woman wakes up in a psychiatric
hospital and has no idea of
who she is or how she got there.

Great Western Hospitals NHS Foundation Trust

Complaints Policy

Meeting	Trust Board	**Date**	5 August 2021

Summary of Report

A review has been carried out of the Complaints Policy to ensure that a clear process is in place whilst giving the Trust robust assurance, that complaints are effectively managed and lessons can be learnt.

This policy is how individuals can make, and how the Trust will manage complaints and other forms of feedback whilst fulfilling the need to implement a complaints management procedure, that is easy to understand and simple to use, ensuring that all patient feedback is documented.

The Trust will follow the principles for "Good Complaint Handling" as identified by the Parliamentary Health Service Ombudsman (PHSO).

For Information	x	Assurance		Discussion & input		Decision / approval	

Executive Lead	Lisa Cheek, Chief Nurse
Author	Deborah Tapley, Head of PALS and Complaints
Author contact details	d.tapley@nhs.net 01793 604394

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score

Legal / Regulatory / Reputation Implications	Complaint Regulations 2009

Link to relevant CQC Domain

Safe		Effective		Caring		Responsive		Well Led	x

Link to relevant Trust Commitment	

Consultations / other committee views

Quality Governance – 22nd July 2021

Recommendations / Decision Required

For final ratification.

Below are the key changes made from the previous policy.

- **Concerns -** A clearer definition, with an extended timescale to 7 working days.
- **Complaint - Trigger points and Extensions** (the 25 working day timeframe will remain when responding to complaints). If a longer response time is required or if a meeting with the complainant within this timescale cannot be achieved, the division can ask the Complaints Facilitator to negotiate an extension of an additional **35** working days (giving a maximum of **60** working days). Trigger points will be put in place at day 40 by the Complaint's Facilitator as a progress update, to ensure that the complainant is advised on how the investigation is progressing.
- **Support to patients with additional needs (AIS)**
  PALS will ensure that wherever possible the individual needs of complainants are identified and met. This will include meeting the needs of patients with learning disabilities, physical disabilities or communication difficulties such as hearing or visual impairment.
- **To ensure that Learning takes place**
  A divisional audit will be carried out by the DDON/DD and Head of PALS and Complaints monthly to discuss key learning and divisional action trackers.
- **Training and support**
  All investigation managers must attend the Complaint Response Writing training, ideally before any cases are assigned to them to investigate.
- **Complaints related to a Serious Incident**
  Complaints which are related to a serious incident will be closed in agreement with the complainant to allow for the Serious Incident Investigation to take place. The complainant will be informed that their complaint will be closed in the Duty of Candour letter (DOC).

Trust-wide Document

Great Western Hospitals NHS Foundation Trust

Complaint Handling Policy

Document No		**Version No**	4.0
Approved by	Policy Governance Group	**Date Approved**	
Ratified by		**Date Ratified**	
Date implemented (made live for use)	07.08.18	**Next Review Date**	06.09.23
Status	Draft		
Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.		All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy	
Special Cases			
Accountable Director		Chief Nurse	
Author/originator – Any Comments on this document should be addressed to the author		Head of PALS and Complaints	
Division and Department		PALS & Complaints (Corporate)	
Implementation Lead		Head of PALS & Complaints	
If developed in partnership with another agency ratification details of the relevant agency			
Regulatory Position	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 The National Health Service (Complaints) Regulations 2006. The Care Quality Commission inspections rely on information based on sound data. The Data Protection Act 2018 requires that personal data is processed in accordance with the Data Protection Principles. The Freedom of Information Act 2000 requires organisations to make some documents publicly available. The Access to Health Records Act 1990.		
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

Great Western Hospitals NHS Foundation Trust

Contents

1 Introduction & Purpose

1.1 Introduction & Purpose

Great Western Hospitals NHS Foundation Trust (the Trust) is committed to listening to the views of all stakeholders. By listening, the Trust can understand how the services it offers are received and can continue to develop and improve.

The Trust recognises that sometimes things go wrong, and that there is a need for a formal process through which stakeholders can raise concerns. This gives the Trust the opportunity to put matters right if needs be, and learn from past experience. Under the National Health Service (NHS) Constitution (Ref 29), people have the right to have their complaint dealt with efficiently.

The complaints function of the Trust is managed by two teams the Patient Advice and Liaison Service (PALS) and the Complaints team. Both teams are led by the Head of PALS and Complaints and responsible to the Head of Patient Experience and Engagement.

The PALS and Complaints team actively seeks the views of patients and the public about the quality of the Trust's services. The team works with other departments to ensure appropriate action is taken to improve services as a result of feedback.

Compliments, Comments, Complaints and Suggestions from patients are encouraged and welcomed. Should patients be dissatisfied with the care provided they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously. Under no circumstances should patients be treated any differently as a result of making a Complaint or raising a Concern.

This document is the Trust-wide policy on how individuals can make, and how the Trust will manage complaints and other forms of feedback.

The purpose of the Complaints Policy is to explain how the Trust acknowledges and implements the National Health Service Complaints Regulations (Ref 1) along with demonstrating how it listens to the views of its patients.

The aims of this policy are to:

- Ensure that the Trust's commitment to listen to, and learn from, patient feedback is acted upon, robustly actioned and clearly documented.
- Satisfy the complainant by conducting a thorough investigation and providing a full explanation, addressing all issues raised in a detailed complaint response. Lessons are learnt and actions are in place to ensure learning has taken place.
- Fulfil the need to implement a complaints management procedure that is easy to understand and simple to use, whilst giving the Trust a robust assurance, that complaints are effectively managed and lessons can be learnt.
- Support Trust employees to conduct investigations which are thorough, fair, responsive, and open.
- Demonstrate that the Trust will learn from complaints and use them to improve the services for service users.
- Ensure that the Trust's service is accessible to everyone.
- Show the Trust will respect individuals' rights to confidentiality.

- Ensure the Trust Board is accountable for improving the quality of services.
- Ensure that service users are not treated differently as a result of making a complaint and ensure that everyone is treated with compassion and understanding of their circumstances.
- Reinforce positive behaviour by celebrating Compliments.

The Trust will follow the principles for "Good Complaint Handling" as identified by the Parliamentary Health Service Ombudsman (PHSO).

The PHSO principles for Good Complaint Handling (Ref 8) is:

- Getting it right
- Being Customer Focused
- Being Open and Accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

CCG	Clinical Commissioning Group
Complaints	Facilitators of the complaint handling process.
CQC	Care Quality Commission
DD	Divisional Director
DDON	Divisional Director of Nursing
EIA	Equality Impact Assessment
IP&C	Infection Prevention and Control
NHS	National Health Service
PALS	PALS front door service (Concerns, Compliments, Queries, Interpreting)
PALS & Complaints Team	Joint teams PALS and Complaints
PHSO	Parliamentary Health Service Ombudsman

2 Main Document Requirements

2.1 Overview

This policy is mainly concerned with the management of Concerns and Complaints; however the Trust recognises that all types of feedback (which include Complaints, Compliments, Suggestions etc.) must be managed appropriately and listened to in order to develop services.

Although in everyday language, terms such as 'complaint' and 'concern' may be interchangeable, in this policy:

- A ***Concern*** is an expression of dissatisfaction that can usually be resolved in one working day. On certain occasions it may require a longer timeframe to be resolved successfully and an extension of up to a maximum of 7 working days can be agreed.

- A ***Complaint*** is an expression of dissatisfaction requiring a formal investigation and a written response or a meeting.
- A ***Comment*** is an expression of views which may or may not require a response.
- A ***Compliment*** is an expression of appreciation and/or recognition.
- A **Suggestion** is an idea for service development and may or may not require a response.

Under the Government's guidance on the implementation of the NHS Complaints Procedure (Ref 1) there are two stages for dealing with complaints:

- Stage 1 - Local Resolution.
- Stage 2 - Parliamentary and Health Service Ombudsman.

Complaints may be made about any matter reasonably connected with the exercise of the functions of the Trust, including any matter reasonably connected with:

- Its provision of health care or any other services.
- The function of commissioning health care or other services under an NHS contract or making arrangements for the provision of such care or other services with an independent provider or an NHS Foundation Trust.

Matters excluded from consideration under the arrangements are:

- A complaint made by an NHS body, which relates to the exercise of its functions by the Trust.
- A complaint made by an independent provider or an NHS foundation trust about any matter relating to arrangements made by the Trust with that independent provider or NHS foundation trust.
- A complaint made by an employee of the Trust about any matter relating to his or her contract of employment.
- A complaint which is being or has been investigated by the Parliamentary Health Service Ombudsman.
- A complaint arising out of the Trust's alleged failure to comply with a data subject access request under the GDPR/Data Protection Act 2018 (Ref 28) or a request for information under the Freedom of Information Act 2000 (Ref 29).
- A complaint about which the Trust is taking or is proposing to take disciplinary proceedings in relation to the substance of the complaint against a person who is the subject of the complaint.

2.2 Who can Provide Feedback?

Complaints may be made by:

- A Patient or Service User.
- The Carer of a Patient, with the Patient's consent.
- Any persons who are affected by or likely to be affected by, the action, omission or decision of the Trust.

General feedback, including comments, concerns and compliments can be received from anyone.

A complaint may be made by a representative acting on behalf of a patient or any person who is affected by or likely to be affected by the action, omission or decision of the Trust, where that person:

- Has died.
- Is a child who cannot demonstrate Gillick competence *(see section 2.4.2).*
- Is unable by reason of physical or mental incapacity to make the complaint themself.
- Has requested a representative to act on their behalf and given consent for this.
- Has appointed a legal power of attorney, which has been enacted.
- Is a Member of Parliament acting on behalf of their constituents.

Where the patient or person affected has died or is unable to raise concerns themselves, the representative must be a relative or other person who, in the opinion of the PALS and Complaints team, has a sufficient interest in their welfare and is a suitable person to act as representative.

Complaints Facilitators are responsible for determining whether the complainant has 'sufficient interest' in the deceased or incapable person's welfare to be suitable to act as a representative. The need to respect the confidentiality of the patient is a guiding principle, guidance and advice may be taken from the Legal Services Team.

If in any case the Complaints Facilitator establishes that a representative does not have a sufficient interest in the person's welfare or is unsuitable to act as a representative that person is to be notified of this in writing and the reasons for the decision are to be provided.

In the case of a child, the representative must be a parent with parental responsibility, guardian or other adult person who has care of the child and where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the local authority or the voluntary organisation.

2.3 Ways to Make a Complaint

We always encourage our patients and families to raise a concern with the department or ward manager in the first instance, all employees should be able to help those wishing to provide feedback. Our focus is on resolving any concerns promptly for our patients and their families.

The PALS and Complaints team is the central team responsible for administering Concerns, Complaints, Comments and Compliments.

The PALS and Complaints team can be contacted by:

- Visiting their office based at the Great Western Hospital on the ground floor.
- Via email to gwh.pals@nhs.net
- Via telephone to 01793 604031
- In writing to The Patient Advice and Liaison Service, Great Western Hospitals NHS Foundation Trust, Marlborough Road, Swindon, SN3 6BB.
- Using the online contact form available on the Trust website https://www.gwh.nhs.uk/patients-and-visitors/patient-advice-and-liaison-service-(pals)/contact/

The PALS and Complaints team are available from 9.00am until 5.00pm, Monday to Friday. Out of hours telephone messages may be left and a telephone call will be returned on the next working day.

2.4 Confidentiality

Some types of feedback will be made and responded to in the public domain, for example through the website 'NHS Choices (Ref 30); however the general principle is that all feedback should be confidential, unless consent is given for it to be disclosed.

The information about a complaint and all the people involved is strictly confidential, and will only be disclosed to those with a demonstrable need to know.

Complaint records will be kept separate from health records, subject to the need to record information which is strictly relevant to a person's health in their health records.

Correspondence about complaints will not be included in the patient's health records; however informal discussions about concerns can be documented in the clinical records.

Employees are to be aware that should they be asked by the Investigating Manager to make a statement in relation to a complaint, this forms part of the complaint record and may be made public (disclosed to the complainant and others involved in the investigation). A standard format for an employee statement is shown at Appendix F; this statement should be saved on the Complaint Management System.

2.4.1 Consent

Where a complaint is made on behalf of an existing or former patient, consent must be obtained from the patient to disclose personal health information and the results of any investigation in order to uphold the duty of confidentiality to the patient. The complainant will be asked to return a consent form to the PALS and Complaints team within seven days. A longer time scale can be agreed.

Day one of investigation will commence on the day consent is received to the PALS and Complaints team.

If a patient is deemed to not have capacity to consent to a complaint investigation or if the patient is an inpatient the PALS and Complaints team will make contact with the ward manager to confirm that the patient does not have capacity and next of kin details. It is then the decision of the PALS and Complaints team to commence the investigation in the interest of the patient.

Should a consent form not be received the PALS and Complaints team will write a follow up letter to the patient copied to the complainant advising the case will be closed as consent has not been received.

The PALS and Complaints team will request consent from patients of ages 16 and 17 where a complaint is made on their behalf. If this is not possible, the case will be referred to the Safeguarding Lead Nurse for their input prior to forwarding the case for investigation.

If the patient has died then consent will be taken from the person who has a legal interest in the deceased's estate (in some cases the person raising the complaint will have a legal interest in the estate negating the need to explicit consent) a blood relative or someone who can satisfy the complaints team of the patient details. The Trust will respect any known wishes that had been expressed by the patient.

Where a complaint has been made on behalf of a patient by a Member of Parliament (MP) it will be assumed that implied consent has been given by that patient. If however, the Complaint relates to a third party, consent will need to be obtained from the patient prior to the release of personal information.

If a complaint is received from the local Commissioning Group (CCG), Care Quality Commission (CQC), Healthwatch or any other Advocacy Service a copy of the consent form will be requested for the case file by the PALS and Complaints team.

Where it is known that the complaint involves a vulnerable adult, vulnerable child or patient with Learning Difficulties the Executive Lead for Safeguarding or Learning Difficulties Lead will be informed.

2.4.2 Gillick Competence

Gillick competences state that a child below the age of 16 can consent for their own medical treatment if they demonstrate sufficient understanding. This principle is adopted within the complaints process and therefore, there is no minimum age for a young person to raise concerns about the care they have received. The young person will be offered support by the PALS and Complaints team, and signposted to any additional resources such as Swindon or Wiltshire Healthwatch (Ref 22) or the Carers Centre (Ref 23) if required.

2.4.3 Confidential Marking

All letters regarding the complaint will be marked 'Private and Confidential'. All internal e-mails regarding the complaint must be marked 'Confidential' and where possible should not contain patient identifiable information in the email heading. Where possible the email contents should also be anonymised.

By ensuring that all complaints are dealt with in the strictest of confidence the scope for patients, relatives or carers being treated differently as a result of the complaint will be minimised.

2.5 Time Limits

Normally a complaint should be made within twelve months of the date on which the matter which is the subject of the complaint occurred or within twelve months of the date on which the matter which is the subject of the complaint came to the notice of the complainant.

Where a complaint is made after these times, the Head of PALS and Complaints may choose to investigate if they are of the opinion that the complainant had good reason for not making the complaint within that period and it is still possible to investigate the complaint effectively and efficiently.

Those who wish to complain should be encouraged to do so as soon as possible after an event so that the investigation can be most effective.

In any case where the Head of PALS and Complaints decides not to investigate a complaint on the grounds that it was not made within the time limit, the complainant will be informed in writing with further guidance if necessary. The complainant can ask the Parliamentary Ombudsman (PHSO) to consider their complaint for an Independent Review.

In accordance with the Records Management Code of Practice for Health and Social Care 2016 (Ref 21) complaint files will be kept for 10 years from the date of closure of the case.

Complaint files about babies and children where there is the possibility of future legal proceedings are kept until their 25th birthday. If the baby or child has died, the complaint file is kept for ten years.

2.6 Management Process

When a complaint is made, the Trust aims to resolve the issue as quickly and as fully as possible, by putting things right if they have gone wrong, and developing learning for the future.

A flow chart showing the entire process is attached as Appendix E.

2.6.1 On the Spot Resolution

The objective of 'On the Spot' resolution is to listen and respond to patient concerns and resolve issues at the same time. This might involve doing something, for example swapping a plate of food that is not hot enough.

Patients and relatives should be encouraged to raise concerns or make complaints as soon as possible and directly to the member of staff involved or to the manager of the ward/department.

The complainant's concerns should be addressed constructively and where possible will be dealt with immediately by the employee approached. The complainant's concerns must be treated with compassion and understanding and cared for sensitively and in an open and constructive manner. If the member of staff approached is unable to deal with the issue, they should promptly refer this to the more senior member of staff on duty at the time i.e. Senior Sister/Charge Nurse/ Matron/Deputy or Divisional Director (DD)/Head of Service (HOS) or Site Manager. Employee guidance for how to deal with 'On the Spot' resolution is set out at Appendix D.

Where it is not possible to deal with the concern or complaint immediately, or if the complaint requires a fuller investigation or if the complainant wishes to address their concerns/complaint to somebody not involved, they should be referred to the PALS and Complaints team, who will assist them further.

Whether the concern or complaint is being dealt with by the member of staff/ department concerned or the PALS and Complaints team, the complainant should be given a contact name and telephone number as a point of contact.

Concerns/Complaints resolved 'on the spot' are normally less serious and do not need to be formally logged, although good practice would be for all issues to be recorded to capture themes. Actions resulting or any learning from the concern/complaint should be discussed in the next available team meeting and documented in the minutes of that meeting.

2.6.2 Lost Property

It is the responsibility of the ward to look for any lost property associated with a complaint and any reimbursements or ex gratia payments will be at the discretion of the DD/ DDON/HOS please refer to the Patient Property Policy.

2.6.3 Triage

If a complaint was not able to be resolved on the spot, or if it was received directly by the PALS and Complaints team, the first step is for it to be triaged.

The receiving Complaints Facilitator will read or listen to the Complainant, understand the complaint and rate its level of 'seriousness' according to the matrix in Appendix H. They will also try to understand what the complainant would like to happen as a result of their complaint and the resolution they are hoping for. The Complaints Facilitator may need to telephone and speak to the complainant to ascertain additional information. Once the complaint is passed to the Investigation Manger and they feel that as part of their investigation the complaint can be downgraded, the Investigation Manager will need to discuss the reason for the change with a member of the division's tri and Head of PALS and Complaints.

The Complaints Facilitator will try to manage expectations at this stage and will advise complainants if the Trust cannot give the desired outcome – for example, financial compensation cannot be given as a result of a complaint investigation.

In all complaints literature and during the triage process, patients will be advised of independent advocacy services which can help them raise concerns, such as Healthwatch (Ref 22) and Support Empower Advocate Promote (SEAP) Advocacy (Ref 25) (depending on where they live).

At this point there are two possible routes to manage resolution. Depending on the issues raised, its seriousness and possible resolution, it could be treated as a 'Concern' or a 'Complaint'.

2.6.4 Concerns

'Concerns' are typically less serious issues which can usually be resolved within 24 hours, and are generally made verbally. The Local Authority Social Services and National Health Service Complaint Regulations 2009 s8 (1) (c) (Ref 10) excludes this type of feedback from being recorded as a 'complaint'. It is recognised that more information may be required to resolve successfully and may take a little longer than 24 hours. In all cases the aim will be to resolve a concern within 7 working days. At this stage the Head of PALS and Complaints or PALS and Complaints Team Leader will assess to agree if the case needs to be escalated to a complaint.

An example might be a concern in relation to parking, or a cleaning issue in a public space where the resolution is to do something – e.g., arrange for a cleaner to undertake an additional clean of a public toilet.

Although the regulations exclude this type of feedback, the Trust recognises that recording it and responding to it is important to help develop services. Concerns are managed by the PALS team, and a PALS Assistant with the support from the relevant service area to establish what might have happened to cause the concern. All concerns must aim to be resolved within 24 hours and are likely to conclude in a telephone call to provide the response. The Pals team will monitor the response time and ensure contact is maintained with the person raising the concern.

Unlike 'On the Spot' issues, 'concerns' are formally logged and will be reported. Actions will be recorded as well as possible learning to prevent future concerns.

If an issue cannot be resolved through the 'Concerns' process, or if it is more serious, is in writing or will need investigation, it will progress to the 'Complaints' process and will be handled by the Complaints team.

2.6.5 Complaints

As well as including concerns unresolved after 7 working days, complaints may often need formal investigation.

The Complaints team are the central team responsible for complaints, working alongside the PALS team. 'Complaints' are likely to be in writing, but not exclusively, and are subject to the same triage process set out above.

Where a complainant wishes to make a complaint and receive a response electronically, patient confidentiality is a guiding principle. Where any patient's personal information is to be disclosed electronically, the patient's consent must be received in writing.

When letters of complaint are received by the Chief Executive's office, they will be date stamped and passed to the PALS and Complaints team, who will deal with them on behalf of the Chief Executive.

All complaints will be logged onto the complaint management system and will be acknowledged by the Complaints Facilitators. The team aims to do this within one working day, and no later than within three working days.

The acknowledgment will include information about the right to ask for an independent review if the complainant is not fully satisfied with the Trust's response.

The complaint leaflet which includes this information is set out at Appendix F.

First responsibility on receipt of a complaint is to ensure the patient's immediate health care needs are being met. This may require urgent action being taken before any matters relating to the complaint are dealt with.

The complaint will be sent by the Complaints team (via e-mail/complaint management system) to the appropriate Division Investigating Manager to start the investigation. Some complaints may involve more than one Division or service; in this case the Complaints team will allocate a lead Division which will be responsible for ensuring the complaint is fully investigated. The Complaints Facilitator will work jointly with the lead investigator to help with the facilitation of gaining comments for the overall joint response. When a complaint involves other trusts a lead Trust will be agreed in collaboration.

Under this process the previously used terms 'formal' and 'informal' complaint are not used and are not part of the process.

2.6.6 Additional Needs

PALS will ensure that wherever possible the individual needs of complainants are identified and met. This will include meeting the needs of people with learning disabilities, physical disabilities or communication problems such as hearing or visual impairment.

2.6.7 Complaint Training

All investigation managers must attend the Internal Complaint Response Writing training, before any cases are assigned to them to investigate. In addition, training on the Complaints Management system will also be provided as 1:1 training by the relevant Complaints Facilitator, this is to set up the user on the system and to ensure that the required level of access has been arranged correctly. Training will be provided on navigation of the Complaints management software and the use of template letters.

A "Buddy" system will be put in place to support new investigation managers with the writing and quality checking of response letters.

2.6.8 Complaints and Incidents (SI)

When complaints are received to the Complaints team, a discussion should take place if relevant between the Complaints Facilitator and the Investigation Manager about whether an Incident Form needs to be completed. This is documented on the complaints management system. A prompt for consideration of an incident form to be completed is in the template of the complaint response letter.

The Head of PALS and Complaints and the Clinical Risk Manager will meet monthly to discuss complaints and if a serious incident has been identified, the case may be taken forward under the Incident Management Policy (Ref 11) as a serious incident requiring investigation (SI). The complainant will be kept informed by the Clinical Risk Team of the status of the investigation and will be offered a meeting to discuss the outcome of the SI investigation.

Complaints which are related to a serious incident will be closed in agreement with the complainant to allow for the Serious Incident Investigation to take place. The complainant will be informed that their complaint will be closed in the Duty of Candour letter (DOC). If this has already been sent out an additional letter will be sent to the complainant to inform them of the closure. Please refer to the Duty of Candour (Being Open) Policy (Ref 12) and the Incident Management Policy (Ref 11), and the Data

Security and Protection Incident Reporting Procedure, all available on the t drive, for more information.

If not all aspects of the complaint are covered by the SI TOR then a separate complaints response will run concurrently. The procedures for managing complaints, incidents and claims for negligence are dealt with under separate policies. However, if during investigating an incident, a complaint is received, the incident procedure should take precedence in terms of investigation.

If the investigation of a complaint reveals the need to act under the serious incident procedure, the investigator should inform the Clinical Risk Team and Complaints Facilitator. Again, the incident procedure should take preference in terms of investigation. This will be discussed at the weekly PERF meeting to ensure that a clear direction of managing the complaint/SI is documented and all parties informed of how the complaint/SI will actively be managed and agreed timeframes.

Any complaints that involve a sudden unexpected death, allegation of abuse, potential safeguarding issues, suicide or serious self-harm, data loss and information security should be immediately escalated to the Head of PALS and Complaints or PALS and Complaints Team Leader who will discuss the management of the complaint with the most appropriate Head of Service/Lead Clinician and take for discussion at the weekly PERF meeting.

However, during the course of the complaint investigation, it is noted that potentially serious harm has occurred; it is the Investigating Manager's responsibility to escalate their concerns to the divisions Complaint Facilitator and the Clinical Risk Manager. If it is felt that the incident should be investigated under the Serious Incident Investigation (SI) or Clinical Review (CR) process, the Clinical Risk Manager will keep the complainant informed of the progress of the investigation.

If the complainant has raised serious concerns that are not being investigated under the serious incident investigation, or question raised within the complaint is not covered by the scope of the review, then they will be investigated under a Complaint Process. It is essential that lines of communication is maintain between the Clinical Risk department and the Complaints Facilitator and the Investigating Manager; to ensure of a cohesive approach to the feedback in the Clinical Risk report.

If the complainant feels that all issues of the complaint were not fully responded to in the Clinical Risk report, the complaint can be reopened and responded to.

2.6.9 Investigation Manager

The allocated Investigation Manager will assess the complaint and either investigate themselves or allocate an appropriate senior member of their team to undertake the investigation. The Investigating Manager will review the complaint and make contact with the complainant within 48 working hours and if necessary clarify any issues raised in the complaint and provide a point of contact should the complainant wish to raise any questions during the investigation. This telephone call timeframe will be monitored by the complaints team and discussed at the divisional complaint review/audit meetings.

The investigation manager should notify the Complaints team if the complaint assigned to them has not been sent to the correct person/service to investigate. If the Complaints team are not notified within 3 working days the complaint will remain with the allocated division/service. Only in exceptional circumstance will this be changed.

Investigation Managers should not have any more than four cases assigned to them to investigate. If an Investigation Manager has four cases already assigned to them and a new case is received to investigate, the Complaints Facilitator will speak with the divisional tri for guidance on who the new case should be assigned to.

2.6.10 Record Keeping and Responding

Full records of the investigation should be kept by the Investigating Manager and detailed on the complaint management system. These notes should include a record of discussions with employees and the support offered. Guidance on writing and collecting information can be found at Appendix F. Notes should also be uploaded onto the case via the complaint management system.

The Trust has a standard 25 working day response timeframe for complaints. Depending on the level of seriousness identified during the triage process which is carried out by the complaint's facilitator using the Seriousness Matrix, from the DH guide 'Listening, Responding Improving' Appendix H, the response will either be signed off by the relevant Divisional Director or Divisional Director of Nursing (DDON), or the Chief Executive. All investigations (unless an extension has been granted) should be completed by day 20, to allow five working days for sign off.

Any complaints which have been passed to the Trust to investigate and respond to from the local Commissioning Group (CCG) or the Care Quality Commission (CQC) should be responded to within 15 working days, these complaint responses should be checked by the Head of PALS or PALS Team Leader (after approval has been given by the DD or DDON) before sending a copy to the local CCG or passed to the Head of Patient Experience and Engagement for final checking and forwarding to CQC.

Regardless of who will sign the response, DD or DDON remains responsible for producing a response that:

- Communicates to the recipient compassion and understanding.
- Addresses all the issues raised.
- Is accurate.
- Gives a full and honest explanation.
- Provides an apology (or apologies) if appropriate.
- Explains the actions that have been/will be taken to improve the situation (action plans can be included where appropriate).
- Explains the monitoring arrangements to ensure actions will be implemented.

If, due to the seriousness rating the Complaint is due to be signed off by the Chief Executive, the draft response and all supporting documents should be sent to the Complaints Facilitator by the end of day 20. In this instance the Complaints Facilitator will send the response as quickly as possible to the Chief Executive for sign off and will file all the complaint paperwork on the complaints management system.

If the response is due to be signed off by the Divisional Director (DD) /Associate Medical Director (AMD) / Divisional Director of Nursing DDON, then the Investigating Manager should send the draft response and all paperwork to them by the end of day 20.

By completing the investigation by day 20, the Chief Executive or DD/AMD/ /DDON will have several days in which to review the response and make any final changes. Once signed, Chief Executive signed letters will be uploaded onto the complaints management system. DD/AMD /DDON signed letters should be sent out by the Divisions with a final signed copy uploaded to the complaints management system and the initial author of the complaint response in order that lessons are learnt about the appropriate style of response.

If the Chief Executive is unavailable, then a nominated deputy will assume responsibility.

Although most 'complaints' will be responded to in writing, the Trust will use the most effective method of communication, and will aim to match the communication preferences of the person making the complaint.

A complete documentary record of the handling and consideration of each complaint is kept on the complaints management system and is kept separate from health records.

The Complaints team will ensure that all information relevant to the investigation of the Complaint is recorded on the complaints management system and is available without unnecessary delay to the Parliamentary Health Service Ombudsman (PHSO) if requested.

2.6.11 Extending the Investigation Period

Although the investigation and draft response should be completed within 20 working days, the Trust acknowledges that some complaints may require longer due to the complexity to thoroughly conclude the investigation and provide a full detailed response.

If a longer response time is required or if a meeting with the complainant within this timescale cannot be achieved, the division can ask the Complaints Facilitator to negotiate an extension of an additional 35 working days (giving a maximum of 60 working days). However trigger points will be put in place at day 40 by the Complaint's Facilitator, as a progress update to ensure that the complainant is advised of the progress of the investigation and to ensure that the target date will be met.

If this is required, the Investigation Manager will need to contact the complainant to discuss this extension and advise the Complaints Facilitator that this has taken place and a Holding Delayed Letter will be sent by the Complaint's Facilitator detailing the response due date. The date will be amended on the Complaint Management System by the Complaints Facilitator.

Only one extension will be granted as the expectation is that the complaint investigation will be completed within the 60 working day timeframe. In extreme circumstances where the investigation is expected to go over the 60 working days (i.e. due to an external investigation) the Head of Patient Experience and Engagement or Head of PALS and Complaints will agree this with the Divisional Tri, a case will be put together and final approval will be made at the Patient Experience Review Forum (PERF).

2.6.12 Informing the Complainant of the Trust's Review Process

All final responses from both the Chief Executive or the DD/AMD/DDON, will inform the complainant that if they have any outstanding or further concerns or feel that the complaint has not been satisfactorily resolved, they may contact the Investigating Manager for further information. It will also advise of details of the Trust's review process and how to refer the complaint to the PHSO should they remain dissatisfied.

2.6.13 Learning from Complaints

As a learning organisation, the Trust is committed to learning from complaints and taking action where an investigation has identified a need to alter practice.

The AMD/DD/DDON are responsible for ensuring any action plans resulting from the complaint investigation are implemented within the agreed timescale with actions being included in their monthly Divisional Quality meeting. Support and monitoring with learning will be provided to the divisions from the Complaints team with action trackers sent out weekly detailing learning and actions from learning on all closed complaint cases.

Progress on action plans will be recorded though the complaints management system and included in the monthly Quality Report to enable organisational learning from complaints. Where agreed with the

complainant, they should be kept informed on the progress of the actions by the Investigation Manager. Outstanding tasks will be included in the monthly and quarterly reports.

A divisional audit will be carried out by the DDON/DD and Head of PALS and Complaints monthly to discuss key learning and divisional action trackers.

2.6.14 Investigation Review

Although the Trust uses a quality approach to the investigation of complaints, there will be occasions when it will not be possible to resolve a complaint during the initial investigation.

In these cases, the reasons for continuing dissatisfaction should be discussed with the Complaints team. If particular questions haven't been fully answered the complaint could be sent back to the Division, or if a review is needed then the Complaints Facilitator will acknowledge the review request and will arrange for the complaint file to be sent to an appropriate senior, and preferable executive level, employee. The review should be carried out by an independent investigation manager.

The review will consider if the appropriate process was followed and if the outcome of the complaint was right. The review investigating manager will have 20 working days to consider the review and draw up a formal response which will then be sent to the Chief Executive for signing to be sent out by day 25. An extension may be applied if complex following the same rules as detailed in 2.6.11.

If the complainant remains dissatisfied with the response and consideration has been given to no additional actions (i.e. one more meeting) to be carried out to change the outcome of the investigation, the complainant should be referred to the PHSO detailing that all areas of local resolution have been exhausted.

2.6.15 Parliamentary and Health Service Ombudsman (PHSO)

The Complaints Team will be the single point of contact for the PHSO. The complaints Team will manage all requests and will ensure deadlines are met. The team will arrange any conciliatory/ex-gratia payments recommended by the PHSO and agreed by the Trust. Any such payments would be at a cost to the relevant service area/Division.

Any action plans requested by the PHSO are the responsibility of the DD/ HOS /DDON who will be held accountable for their creation and quality. In most cases, the PHSO give three months or a specific date for an action plan to be created and sent back to them, on occasions the local CCG or CQC may be requested by the PHSO to receive a copy of the action plan.

Action plans should be drawn up and signed off by the appropriate Division within one month before the agreed timeframe. This then gives time for consideration by the Chief Nurse or Medical Director (whoever is the most appropriate) who will provide 'sign off' on behalf of the Trust. The process for signing off and sending will be facilitated by the Complaints Team, who will also advise if these timescales alter.

2.6.16 Independent Advice

All complainants have access to information about independent help, guidance or support service, provided through Healthwatch (Ref 22) and SEAP (Ref 25) advocacy when making a complaint. This information is available from the PALS and Complaints team, and is included in the complaints leaflet.

2.6.17 Legal Implications

If the complainant has instigated formal legal action the complaints procedure should continue as long as it does not compromise or prejudice a concurrent legal investigation. This is at the discretion of the Head of PALS and Complaints and the Legal and Inquest Manager, with the complainant and person identified in the complaint being advised appropriately in writing.

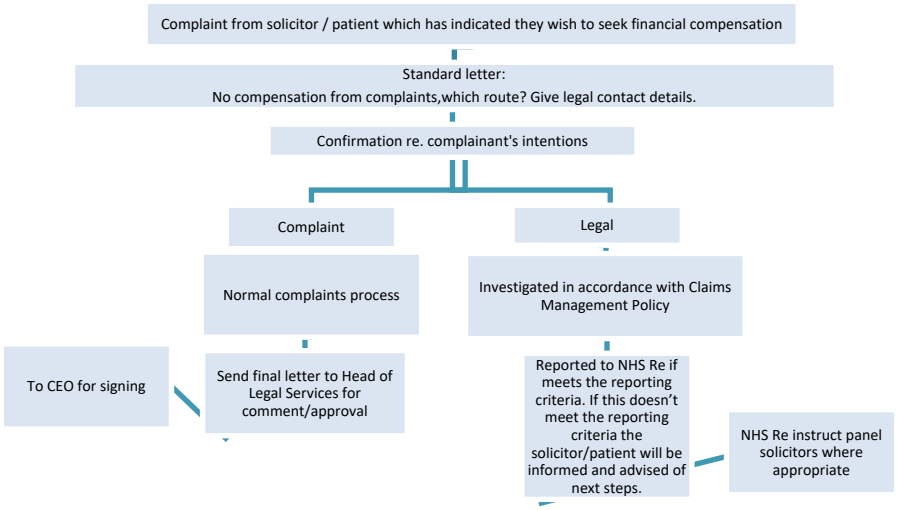
Employees should not be concerned that an apology is an admission of negligence. The NHS Resolution (NHS Re) provides guidance on the principles of 'Being Open' with the Trust's patients and their carer's. All professional bodies have also endorsed the principle of being open.

Potential complainants are informed that the Trust does not pay compensation as a result of the complaints process in the Trust's 'How to Make a Complaint' information leaflet.

Where a complaint wishes to seek compensation for medical negligence, they should be advised that this is not possible though the complaint process, but their complaint will still be investigated. PALS or the investigating manager should notify Legal Services of this complaint and send the final draft to them for review.

Legal Services team can be contacted and asked to review any complaint which the investigator feels may pose a legal risk.

The flowchart below shows the process to be followed:



2.6.18 Support for Employees Involved in a Complaint

As well as supporting complainants, the Trust must also ensure that it supports employees involved in a complaint investigation. Complaint responses should be shared with staff who are named in a complaint before sending for approval to the divisional tri.

Immediate sources of support: internal
Employees who are named in a complaint are to be supported by their line manager. HR Business Partners for the clinical Divisions copied into the complaint investigation email to the AMD/DD/DDON which contains the letter of complaint.

Immediate source of support: external
Employees will also be notified of the support offered by Occupational Health and Staff Support Services in respect of access to external counselling services, should that be appropriate.

On-going support: internal
Line managers will continue to be a source of advice and support throughout the complaint process and will keep employees informed about the progress of the complaint. If the Complaints team become concerned that employees are distressed during the process of the complaint investigation, this will be raised with a member of the Divisional management team.

If line managers are concerned that the employee is not coping well with the complaints process, he or she will discuss this with the employee and refer them to Occupational Health if appropriate.

On-going support: external
Staff support services are able to offer support to employees named within a complaint.

2.6.19 General Feedback and Compliments

Along with complaints, the PALS and Complaints team will also maintain a record of feedback left and compliments received. These will be included in relevant reports to give a balanced picture. All compliments should be passed to the PALS team for logging, and where applicable acknowledged, this does not include thank you letters received to the ward/service area.

2.6.20 Serious Allegations and Disciplinary Investigations

The complaints procedure is not intended to be used for the investigating of employee disciplinary issues. The purpose of the complaints procedure is to thoroughly investigate complaints with the aim of satisfying complainants, whilst being fair to employees.

However, complainants may identify information about serious matters and the Trust may feel it appropriate to consider disciplinary investigation at any point during the complaints procedure. Consideration as to whether or not disciplinary action is warranted is a separate matter for the Trust.

The information gathered during a complaint investigation may be made available for a disciplinary investigation, although the consideration of disciplinary action is separate from the complaints procedure. The Trust has a duty to maintain employee confidentiality and must not share information regarding action against employees with the complainant other than that Human Resources Policies have been followed. (Please note that the duty of confidentiality does not extend to statements made as part of the complaints process – see Section 2.4 and Appendix F).

Where a complaint indicates the need for a referral to the disciplinary procedure, one of the professional regulatory bodies or agency such as the Police, the investigation under the complaints procedure will only take place if it does not compromise or prejudice the concurrent investigation. Where necessary other Trust-wide policies and procedures may need to be applied and could preclude compliance with this policy.

2.6.21 Employee Grievances

Employee grievances are handled outside of this document. The Trust has local procedures for handling employee concerns about health care issues, and established grievance and openness procedures. Employees should refer to the 'Duty of Candor (Being Open) Policy on the t drive for further advice and guidance. Employees can only use the Trust complaints procedure if their complaint relates to their own health care or if they are acting on behalf of a third party. In both situations they are acting as a patient or member of the public and not an employee

2.6.22 Complaints Brought by Members of Parliament (MP) on Behalf of Constituents

MPs in receipt of complaints about health services from members within their constituency often address personal letters to the Chairman or Chief Executive. These are acted upon in the same way as any other letter of complaint, recorded centrally and passed to the appropriate Investigation Manager for investigation and responded to formally within the recommended time scales. Letters from MPs on behalf of members of their constituency will automatically assume consent for the release of personal information.

2.6.23 Fraud and Corruption

Any complaint which concerns allegations of possible fraud or corruption is passed immediately to the Director of Finance for action.

2.6.24 Internal Evaluation of the Complaints Process

A section in the monthly Integrated Performance Report will be compiled by the Head of PALS and Complaints and the Head of Patient Experience and Engagement related to PALS/Patient Experience. This will be sent to the Executive Committee, Trust Board, Quality Governance and quarterly to the CCG. This will include the numbers of complaints received, themes and trends of complaints and the associated actions and learning.

Evaluation letters will be sent to complainants who have recently used the complaints process to gather feedback on how their complaint was handled. These letters will be sent by the PALS and Complaints team and feedback will be provided to the divisions monthly.

The Governor Patient Quality Working Group will receive a copy of the monthly Integrated Performance Report and will receive a presentation from the Head of Patient Experience and Engagement a quarterly basis to enable the governors to fulfil their duty to hold the Non-Executive Directors to account for the performance of the Board of Directors.

A secure electronic complaints management system will be maintained for all Complaints and PALS contacts. Information from the management system can be used as an early warning trigger tool identifying themes and trends.

Records will be maintained for all contacts, the number and outcomes of CQC, the number and outcomes of PHSO requests and letters of praise formally received.

Each DD/DDON is responsible for ensuring that the Trust's Complaints Policy is followed and that in their absence alternative measures are put in place and the PALS and Complaints Team notified of these measures.

Each DD/DDON will meet with the Head of PALS and Complaints to discuss complaint themes and any concerns regarding the complaints process. A monthly audit will be carried out on closed cases to ensure process is being followed and discussed at the divisional meeting ensuring that actions which have been identified from learning of closed cases are carried out.

A Quality Audit of complaint response letters will also be carried out and reported in the quarterly Patient Experience report.

2.6.25 External Evaluation of the Complaints Process

The PALS and Complaints team will contribute to the Trust's annual report on its complaint handling and performance of responding to complaints within timeframe.

2.6.26 Complaints about Services Provided by Other Agencies

If the Trust receives a complaint that is solely concerned with areas dealt with by another health body or by a body outside the NHS, the Complaints team will inform the complainant and forward the complaint to the correct body, with the permission of the complainant. If there are any doubts over which body is responsible for handling the complaint, this must be resolved before the complaint is dispatched.

Where the Trust receives a complaint which is mainly concerned with services provided by the Trust, but includes issues regarding an external agency, the Complaints team will forward a copy of the complaint as appropriate for investigation, consent must be gained from the patient prior to any

discussions or sharing of documents with another party. The Complaints team will incorporate the response from the external agency into the Trust's final response. Where a complaint involves more than one NHS provider or one or more other bodies such as a local authority, there will be full cooperation in seeking to resolve the complaint through each body's local complaints procedure. The Trust and local authorities will ensure that all matters of concern are addressed.

Complaints which require 'Independent Review' under the NHS Complaints Procedure (Ref 1)and also involve either Social Services, or fall within the remit of the Care Quality Commission (relating to patients who are or have been detained under the Mental Health Act), remain subject to both the NHS and the local authority or Care Quality Commission procedures. The Trust advises complainants of what matters fall under which procedure.

2.6.27 Complaints about the Data Protection Act 2018 and the Freedom of Information Act 2000

The Trust may consult the Information Commissioner's Office (ICO) about complaints arising out of an alleged failure to comply with a data subject access request under the Data Protection Act 2018 (Ref 31) and with requests made under the Freedom of Information Act 2000 (Ref 32). It is standard practice to conduct an internal review before this step.

2.6.28 Complaints about Serco Facilities Management (including Closed Circuit Television (CCTV) Access)

Complaints about Facilities Management will be passed to the Director of Serco Facilities Management for investigation and a full response, and will be copied to the Trust's Head of Estates and Facilities Management.

A written response will be sent to the Complaints team to review and forward to the patient with a covering letter. Serco are encouraged to speak to complainants and are to send a file note and update to the relevant Complaints Facilitator.

Subject Access Requests for Closed Circuit Television (CCTV) footage will be sent to the Head of Security (GWH) for them to action. They are to keep the Complaints team updated with the progress of these requests.

2.6.29 Complaints Regarding Private Care

The complaints procedure will cover any complaint made about the Trust's employees or facilities relating to care in the Trust's private patient unit, but not to the private medical care provided by the Consultant in line with the NHS Complaint Procedure.

Complainants will be advised to contact the Consultant directly if they have concerns regarding private medical care.

Complaints regarding fixed prices will be forwarded to the Private Practice Manager and recorded on the Complaints management system and facilitated by the PALS and Complaints team.

Direct complaints about private health care services within the Trust will be dealt with within the Planned Care Division, recorded on the Complaints management system as a division called Shalbourne Private Patients to be kept separate from NHS complaints.

2.6.30 Access to Health Records

Complainants may request access to or copies of their medical records under the Data Protection Act 2018. They can access their own medical records or a child's medical records (if they have parental responsibility). Consideration must be given to the duty of confidentiality owed to the child. The law regards young people aged 16 or 17 to be adults in respect of their rights to confidentiality. The PALS

and Complaints team are able to provide complainants with an Access to Health Records Form. Further information is available from the Department of Health and Social Care.

The Access to Health Records Act 1990 (AHRA) (Ref 20) provides a small cohort of individuals with a statutory right to apply for access to information contained within a deceased person's health record.

The Department of Health and Social Care accepts that the duty of confidentiality continues beyond death and this is reflected in their guidance. The AHRA defines these individuals as 'the patient's personal representative and any person who may have a claim arising out of the patient's death. (A personal representative is the executor or administrator of the deceased person's estate). Therefore individuals other than the personal representatives, who have a legal right of access under the AHRA, must establish a claim arising from a patient's death. Further guidance on a case-by-case basis can be sought from the Trust's Data Protection Officer or the Information Governance Team.

2.6.31 Recording Complaint Meetings

Where a client wishes to make a recording of a complaint meeting, a formal request must be made to the PALS and Complaints team or the Investigating Manager in advance of the meeting in order that the consent of all parties may be sought. All parties must consent to the recording being made.

A copy of the recording will be sent with a covering letter outlining the key responses to the concerns raised. It needs to be made clear to the complainant (and their representatives) that the minutes will not be transcribed if a recording has been requested.

It is the responsibility of the Division involved to arrange for any minutes of meetings to be taken and typed up. The complainant (and their representative) need to be informed that a summary of the discussions that took place will be sent, covering the key aspects of the complaint, and not a verbatim transcript.

To aid with ensuring that request for medical notes and minute takers have been arranged, the Complaints Facilitator will email the Investigation Manager a template for the meeting of what should be taken to ensure everything has been fully arranged so that the meeting can be resolved appropriately.

Microsoft Teams meetings may be offered when it is not appropriate or not possible to hold face to face meetings. A recording of the meeting may be requested prior to the meeting to the complaints facilitator; consent will be gained from all parties attending.

2.6.32 Media Interest

Members of staff are to refer any media interest in a complaint to the Trust's Communications team. The Trust's Communications Manager is to be briefed where any complainant expresses their intention to contact the media.

2.7 Procedure for Handling Unreasonably Persistent Complainants

2.7.1 Definition of an Unreasonably Persistent Complainant

Complainants (and, or anyone acting on their behalf) may be deemed to be unreasonably persistent complainants where previous or current contact with them shows that they meet one or more of the following criteria:

a) The complainant persists in pursuing a complaint where the Trust's complaints procedure has been fully and properly implemented and exhausted.

b) The complainant continually raises new issues or seeks to prolong contact by continually raising further concerns or questions upon receipt of a response or whilst the complaint is being investigated (care must be taken not to discard new issues which emerge as a result of the investigation or the response. These might need to be addressed as either reviews of previous complaints or separate complaints). Independent advice services could be called upon to assist in such circumstances, ensuring that new and legitimate issues are answered.

c) Despite the best endeavour of staff to confirm and answer the complainant's concerns and, where appropriate, involving Independent Advice Services, the complainant does not accept the response and/or where the concerns identified are not within the remit of the Trust.

d) In the course of addressing a registered complaint, the complainant has had an excessive number of contacts with the Trust, which have placed unreasonable demands on employees. A contact may be in person or by telephone, email, letter or fax. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section, using judgement based on the specific circumstances of each individual case.

e) The complainant has harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. Employees must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this.

f) The complainant is known to have recorded meetings, face-to-face or telephone conversations without the prior knowledge and consent of other parties involved and used these recordings without prior permission.

g) The complainant has focussed on a matter to an extent which is out of proportion to its significance and continues to focus on this point. It is recognised that determining what is justified can be subjective and careful judgement must be used in applying this criterion.

h) The complainant displays unreasonable demands or patient/complainant expectations and fails to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

i) The complainant has threatened or used actual physical violence towards staff or their families or associates at any time.

j) The complainant has sent indecent or offensive items to employees or their families or associates in the post, or has hand-delivered indecent or offensive items to employees or their families or associates at any time.

2.7.2 Options for Dealing with Unreasonably Persistent Complaints

Where complainants have been identified as unreasonably persistent in accordance with the above criteria, the Chief Executive (or nominated deputy), will determine what action to take. The Chief Executive (or nominated deputy) will implement such action and will notify complainants in writing of the reasons why they have been classified as unreasonably persistent complainants and the action to be taken. This notification may be copied for the information of others already involved in the complaint, e.g. GPs, Independent advice services and Members of Parliament. A record must be kept for future reference, in the complaint file of the reasons why a complainant has been classified as unreasonably persistent. This will not form part of their or their family's medical notes.

The Chief Executive (or nominated deputy) may decide to manage complainants in one or more of the following ways:

i. Try to resolve matters, before invoking this procedure by drawing up a signed 'agreement' with the complainant (if appropriate, involving the relevant advocate in a two-way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint, reference to the Minimising Violence and Aggression in the Workplace Policy (Ref 15). If these terms are contravened, consideration would then be given to implementing other action as indicated in this section.

ii. Once it is clear that the complainant meets any **one** of the criteria above, it may be appropriate to inform them in writing that they may be classified as an unreasonably persistent complainant, copy this procedure to them, and advise them to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate, at this point, to suggest that the complainant seeks advice in processing their complaint, e.g. through an Advocacy Service.

iii. Decline contact with the complainant either in person, by telephone, by email, by fax, by letter or any combination of these, provided that one form of contact is maintained or alternatively to restrict contact to liaison through a third party.

iv. If employees are to withdraw from a telephone conversation with a complainant it may be helpful for them to have an agreed statement available to be used at such times.

v. Notify the complainant in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint, but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainant should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered. They should be informed of their right to appeal and of their right to go to the Ombudsman.

vi. Enforce the Trust's Minimising Violence and Aggression in the Workplace Policy (Ref 15).

2.7.3 Withdrawing 'Unreasonably Persistent' Status

Once complainants have been determined 'unreasonably persistent' there needs to be a mechanism for withdrawing this status. For example:

(i) The complainant subsequently demonstrates a more reasonable approach
(ii) If the complainant submits a further complaint for which the normal complaints procedures would appear appropriate.

Staff should previously have used discretion in recommending unreasonably persistent status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Discussion will be held with the Chief Executive (or nominated deputy) and subject to their approval normal contact with the complainant and application of the Trust's Complaints Procedure will then be resumed.

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	**Monitoring / audit method**	**Monitoring responsibility** (individual / group /committee)	**Frequency of monitoring**	**Reporting arrangements** (committee / group to which monitoring results are presented)	**What action will be taken if gaps are identified**
The process for listening and responding to patients, their relatives and carers	Complaints database	Head of PALS & Complaints	Monthly	Incorporated into Integrated Performance report (slides) and the quarterly Patient Experience Report	
	Patient Experience Report	Head of PALS & Complaints	Monthly	Executive Committee / Trust Board / Quality Governance, Commissioners	Executive Committee will agree corrective action as necessary and will escalate risks to the Board
	External Report	Head of PALS & Complaints	Quarterly	Copied to Commissioners	
The process by which the organisation aims to improve as a result of concerns and complaints being raised	Patient Experience Report	Head of PALS & Complaints	Monthly	Executive Committee & Trust Board	As above
	Complaint response writing Training	PALS/Complaint Facilitator	Ad hoc basis	PALS training file	As above
Actions for managers or individuals to take if employees involved with a complaint is experiencing difficulties associated with the complaint.	Audit of complaints policy	Head of PALS & Complaints /External Auditors	Ad hoc	Clinical Managers, Patient Quality Committee	Action plan drawn up
	HR copied into emails to Division Managers containing complaint letters	PALS/Complaints Facilitator	As they come through	Head of Human Resources	Action agreed as necessary depending on the case

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive (or nominated deputy) is accountable for ensuring effective management of complaints across the Trust and is the responsible signatory for complaints rated at High or Extreme 'seriousness' as set out in the matrix (see Appendix H)

4.2 Executive Directors

The Chief Nurse / Head of Patient Experience and Engagement have the delegated responsibility for ensuring the efficient and effective implementation of the Complaints Policy and for the PALS and Complaints Team. Complex cases will be discussed with the Chief Nurse or Medical Director.

4.3 The Chairman and Non-Executive Directors

The Chairman and Non-Executive Directors will receive a quarterly Patient Experience report, including complaints and will monitor the effectiveness of the Complaints process.

4.4 Governors

Governors are provided with upon their induction a copy of the - Governor Guideline on how to deal with a complaint or concern (Ref 31). Governors provide an important link between the hospital and the local community, enabling the Trust to reflect the interest of current and prospective service users. While welcoming ideas, suggestions and general comments, it is not the responsibility of Governors to deal with individual personal complaints about the hospital, or the care and treatment received.

Governors have a duty to inform the PALS and Complaints team of any patient concerns and complaints they are made aware of as swiftly as possible.

4.5 Associate Medical Directors, Divisional Directors, Divisional Directors of Nursing

AMDs, DD and DDONs are accountable for the thorough investigation of complaints within their Division. They are responsible for ensuring the investigation is carried out in line with this policy and where an action is identified it is implemented. AMDs/DD/DDONS should, as a minimum, discuss complaints/responses each month. AMDs/DD/DDONS should ensure that anonymised complaints and the annual complaints reports are discussed at the Division and/or Division Clinical Governance meetings (whichever they feel is most appropriate). DDs/DDONs are responsible for the responses sent from their Division. The DD/DDON is responsible for ensuring the draft response, together with any supporting evidence and administration documents are returned to the Complaints Team within 20 (or 25) working days.

4.6 Managers (Matron/ Deputy /Senior Sister/Charge Nurses)

Managers are responsible for ensuring that staff in their areas are aware of the complaints policy. They are to carry out a thorough investigation of a complaint and give a full response to the DD or DDON. Managers are responsible for implementing changes identified through a complaint investigation. Senior Managers are to encourage staff to meet with complainants at the earliest opportunity to resolve complaints locally. Managers are to offer support to staff in their areas both with investigating complaints and where they are named in complaints. Posters are to be displayed in ward and department areas giving the name of the Senior Sister/Charge Nurse and Matron.

4.7 PALS and Complaints Team

The PALS and Complaints Team are responsible for administering the complaints process, ensuring thorough replies are provided to the complainant within the required timescales. Through the Chief Nurse or Head of Patient Experience and Engagement they will provide regular reports and keep the Trust Board informed of complaint themes and trends, the actions which have been taken to rectify problems and improvements in the quality of the services provided by the Trust. Each Division has a

Complaints Facilitator assigned, who acts as a point of contact for the complainant and keeps the complaint log up to date on the complaints management system whilst also ensuring that outcomes from investigations are recording and monitoring that learning has taking place.

4.8 All Staff

All staff have a duty to listen to concerns and complaints raised by the Trust's patients and their carer's, and to try to resolve these locally. Guidance for employees can be found at Appendix C.

4.9 Ward Managers, Matrons and Heads of Service for Non Clinical Services

All Ward Managers, Matrons, Managers, and Heads of Service for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

4.10 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.11 Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	The NHS Complaints procedure	http://www.nhs.uk
2	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	http://www.legislation.gov.uk
3	Statutory Instrument 2006 No. 2084. The National Health Service (Complaints) Amendment Regulations 2006	http://www.legislation.gov.uk
4	The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report)	http://www.midstaffspublicinquiry.com/
5	Everyone Counts: Planning for Patients 2013/14	http://www.england.nhs.uk
6	Complaint Handling in NHS Trusts (Patient Association)	http://www.patients-association.com
7	Good Practice Standards for NHS Complaint Handling (Patients Association)	http://patients-association.com
8	NHS Governance of Complaints Handling (Parliamentary and Health Service Ombudsman)	http://www.ombudsman.org.uk
9	Health and Social Care (Community Health and Standards) Act 2003	http://www.legislation.gov.uk
10	Social Services Complaints Procedure for Adults	http://www.adviceguide.org.uk
11	Incident Management Policy	T:\Trust-wide Documents
12	Duty of Candour (Being Open) Policy	T:\Trust-wide Documents
13	Child Protection Procedures	T:\Trust-wide Documents
14	Safeguarding of Vulnerable Adults Policy	T:\Trust-wide Documents
15	Minimising Violence and Aggression in the Workplace Policy	T:\Trust-wide Documents
16	Health Records Subject Access Requests Procedure	T:\Trust-wide Documents
17	Freedom of Information Requests Procedure	T:\Trust-wide Documents
18	Parliamentary and Health Service Ombudsman Principles of Good Complaint Handling	http://www.ombudsman.org.uk
19	Listening Responding Improving: a guide to better customer care. (including Seriousness Assessment)	http://webarchive.nationalarchives.gov.uk
20	Department of Health Records Management Code of Practice for Health and Social Care 2016	www.gov.uk
21	Access to Health Records Act 1990	http://www.legislation.gov.uk
22	Swindon Health Watch	www.healthwatchswindon.org.uk

Ref. No.	Document Title	Document Location
23	Swindon Carers Centre	www.swindoncarers.org.uk
24	Clwyd/Hart complaints review	www.gov.uk
25	The Advocacy People (SEAP)	https://www.theadvocacypeople.org.uk/
26	Complaint Regulations 2009	http://www.legislation.gov.uk
27	The NHS Constitution	www.gov.uk
28	Data Protection Act 2018	www.gov.uk
29	Freedom of Information Act 2000	www.gov.uk
30	NHS Choices	*https://www.nhs.uk/services/hospital/the-great-western-hospital/P1661/ratings-and-reviews*
31	Governor Guidelines on how to deal with a complaint or concern	*Available from the Trusts Governance and Membership officer*

5.2 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Governance Facilitator	23/09/2020
Divisional Director Planned Care	24/09/2020
Head of Health and Safety	
Legal and Inquest Manager	17/06/2020
Primary Care Lead	28/05/2020
Regulatory & Compliance Manager	15/12/2020
Head of Information Governance and DPO	05/08/2020
Community Services Lead	
Complaints Facilitator	04/08/2020
PALS and Complaints Team Leader	13/08/2020
Clinical Risk	30/06/2020
Associate Director of Quality	09/09/2020
Deputy Chief Nurse	26/08/2020
Chief Nurse	18/09/2020

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A.

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? Complaints policy		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? A policy to support the complaint handling process throughout the trust to ensure that concerns, complaints are dealt with promptly, lessons are learnt to improve services from direct feedback from service users.		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?	**No**	
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?	**No**	

Signed by the manager undertaking the assessment	D L Tapley
Date completed	16/12/2020
Job Title	Head of PALS and Complaints

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Great Western Hospitals NHS Foundation Trust

Appendix B - Employee Guidance (Leaflet)

Dealing with a concern raised by a patient

Great Western Hospitals NHS Foundation Trust

Introduction

This leaflet explains the part you can play in dealing with concerns raised by patients, and how to try to avoid concerns turning into complaints.

Resolving an issue quickly and feeding back to the person concerned what you have done in response, is often enough to stop it becoming a formal complaint. It also helps the patient feel as if their views are taken seriously.

Valuing Feedback

The Trust welcomes feedback from patients about the care and treatment they receive. This helps us to learn how to improve the way we do things and put things right if we get them wrong. But often patients will not know who or to whom they can raise a concern. All employees have an important role to play in openly and actively encouraging patients to speak up, so that we can alleviate and resolve concerns promptly.

Equally as an employee you may be unfamiliar with what you should do if a patient raises a concern. We want staff across the Trust to feel empowered to deal with any issues a patient raises. Below are some top tips to help you to do this.

What is a concern?

Concerns are issues which cannot be resolved on-the-spot, but are typically less serious issues than complaints which can usually be resolved within 24 hours. On occasions resolution may take up to 7 days. Concerns are usually made verbally. A concern might be made in relation to the cleanliness of a public space; where the resolution is to arrange for a cleaner to undertake an additional clean of a public toilet.

All employees have a duty to listen to concerns raised by patients, their representatives and their carer's. On receiving a concern, you should inform the PALS Team who will log the concern and assign a PALS Officer to investigate what might have happened to cause the concern.

Top tips for dealing with concerns

- **Take time to listen.** Many concerns are the result of a misunderstanding. Taking time to speak to the patient and understand exactly what they are unhappy about and how we can help to resolve the issue.

- **Take personal responsibility for dealing with the issue.** All employees should feel empowered to deal with any concerns. If you cannot deal with the issue yourself, seek support from your line manager or a more senior employee

- **Resolve the issue as quickly as possible.** Generally concerns are straightforward and can be resolved on the spot with an apology and action to put the matter right.

- **Keep the patient informed of progress.** If the issue is going to take some time to resolve, keep the patient informed of actions you have taken and tell them when you expect the issue to be resolved.

- **Seek advice from a senior employee.** If the patient is still unhappy or the issue you are dealing with is too complex, seek advice from your line manager or a more senior employee.

- **Manage expectations and keep your promises.** If you promise to resolve an issue within a certain time frame keep that promise. If, due to unforeseen events, you cannot respond in the timeframe promised, let the patient know the reasons for doing this. Manage expectations and do not leave the patient wondering what's going on.

- **Try to avoid a complaint.** The majority of patients that raise a concern don't want to make a complaint; they just want their issue resolved promptly. Do not automatically direct the patient to the Patient Advice and Liaison Service (PALS) or advise the patient to make a complaint. The majority of issues can be resolved within the ward or department.

PALS Team

The PALS Team can provide support to you as an employee if you are trying to resolve a concern or complaint from a patient or service-user. If the patient wishes to speak with a member of our team about their concern, they can call 01793 604031 or email GWH.PALS@nhs.net. Alternatively, they can visit us at the address below.

The Patient Advice Liaison Service (PALS)
The Great Western Hospital
Marlborough Road
Swindon
SN3 6BB

An online form can be completed https://www.gwh.nhs.uk/patients-and-visitors/patient-advice-and-liaison-service-(pals)/contact/

If you have tried to resolve the concern through the route above but the patient still wishes to make a complaint, please direct them to the PALS Team. The PALS Team are responsible for managing the complaints process on behalf of the Trust.

What happens next?
On receiving a concern, the PALS Officer assigned to the case will log the concern and investigate what has happened. They will look at all the information and speak to the employee/s involved. Any resulting actions will be logged and the patient will be responded to within 24 hours, ideally either by telephone or face-to-face.

Need help or advice? Call PALS on: 01793 604031.
Feedback

If you referred the complaint to another person to deal with, that person should provide you with feedback about what happened.

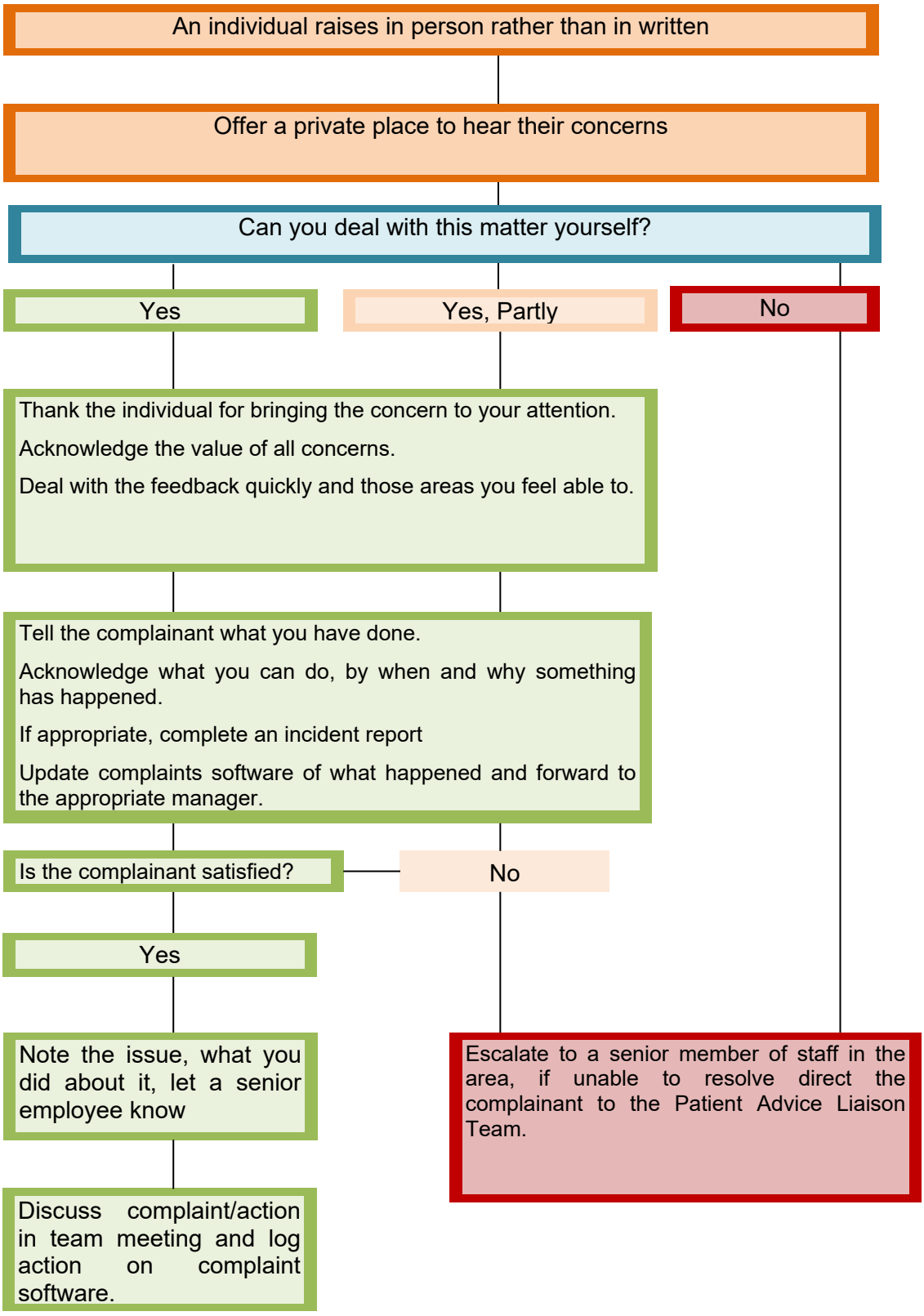
Further Queries

If you have any further queries please speak to your line manager in the first instance or the PALS Team on 01793 604031. Out of hours, contact the On-Call Manager.

Great Western Hospitals NHS Foundation Trust

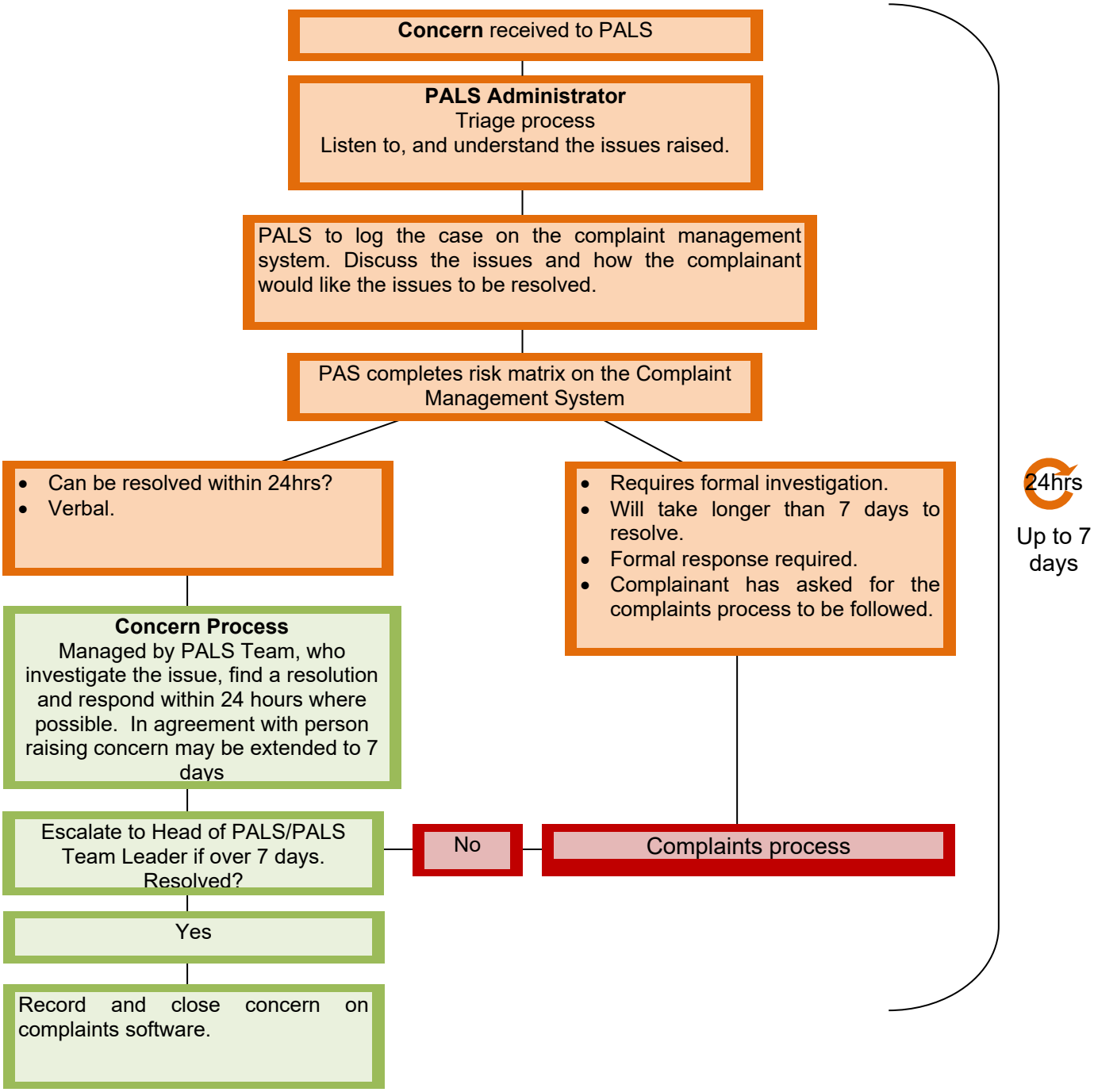
Appendix C – Employee Guidance for Resolving 'On the Spot' Issues

Employee Guidance for Managing Concerns communicated verbally



Great Western Hospitals NHS Foundation Trust

Appendix D – Concerns Process – Managed by the PALS Team



Great Western Hospitals NHS Foundation Trust

Trust Wide Complaints Process

Complaint received by PALS Team

PALS Assistant (PAS) /Complaints Facilitator (CF)

Acknowledge receipt within 3 working days.
Confirm consent, obtain if required.
Allocate on complaints software to investigating manager (no more than 4 per manager)
If immediate issues need to be addressed i.e. an inpatient CF to escalate to the most appropriate manager/clinician.

Investigating Manager

- Telephone the complainant within 2 working days of receiving the complaint to introduce yourself, agree verbal or written reply and clarify concerns/scope of investigation (divisions may delegate this to a PA).
- Provide the complainant, the option to perform Teams or a Face to Face meeting with them to determine which route they would like to take and how they would like their feedback addressed.
- If manager feels that complaint has been allocated incorrectly contact the complaints facilitator within 3 working days for reallocation.
- Undertake initial review and ensure contact made with any employees to gain feedback, medical records ordered, other divisions contacted etc. within 3 working days of contact with complainant, ensuring that all notes of the investigation are documented on the Complaint Management system.
- If written response, list every point of concern with the appropriate response. Ensure all points of concerns are replied to.
- Identify learning and actions in place to ensure the learning takes place and document on the complaints software.

Complaints team to send divisions weekly dashboards of all open cases, highlighting upcoming cases.

If the investigation cannot be completed within 25 working days, the Investigation Manager must contact the complaints facilitator ASAP, explain why and ask them to negotiate an extension up to a maximum of 60 working days. A 40 day trigger will be added to the case for an update.

The Complaints Facilitator to advise the complainant of delays and new target date.

Investigating Manager sends draft response to DD/DDD/DDON for approval
DD/DDD/DDON to review initial complaint and response together to ensure all concerns have been answered, the letter is factually accurate and addresses all the issues raised and actions and learning are approved.

Low/Medium Seriousness

Signed by investigating manager and sent out

High/Extreme Seriousness

Send to the Complaints Facilitator

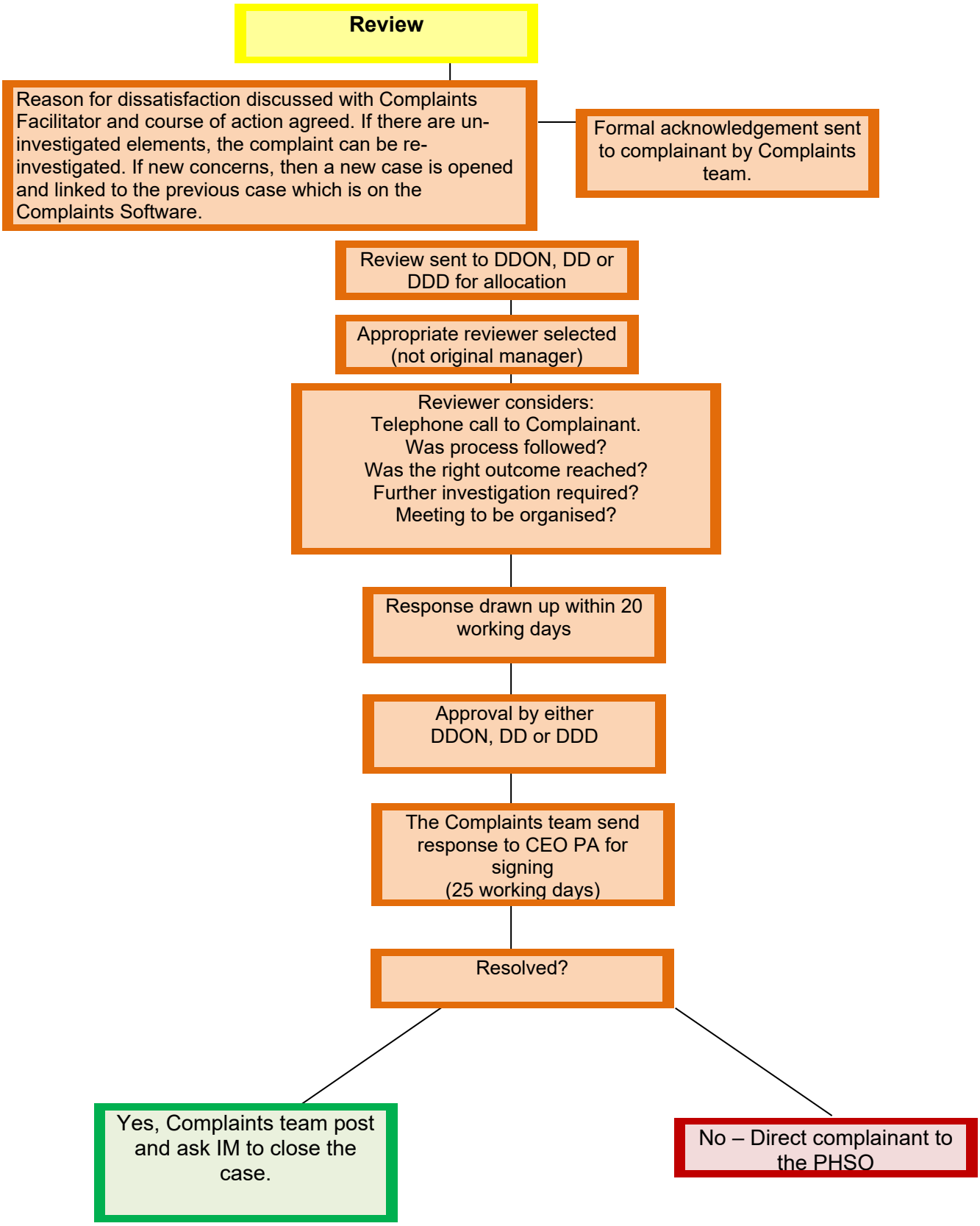
Send to CEO PA,
Signed and returned back to complaints facilitator to post.

Investigating manager updates complaint software (letter sent, actions logged, complaint closed with outcome, learning and actions).

Investigating manager
To record Learning and Actions
Inform leads of actions to be implemented.

Great Western Hospitals NHS Foundation Trust

Review Process



Exemplar complaint handling process

- Start & conclude the investigation quickly (within 25 working days)
- Conduct the investigation in a manner that is supportive to those involved and takes place in a blame free atmosphere
- List every point of concern
- Obtain and examine all the paperwork
- Establish sequence of events and employees involved
- Decide who to interview, and who to ask for statements
- Inform employee of the reasons for the investigation
- Ask for written statements, giving timescales
- Interview employees involved, using open questions to gain facts
- Ensure employees feel supported and are informed of support services available
- Listen to and record responses in writing
- Remain objective and keep an open mind
- Analyse all the information logically
- Make decisions
- Construct an action plan
- Draft response with employees involved, keep staff informed of progress
- Saving on the Complaints Management system records, such as your notes, gathered statements, clinical pathways, observations and findings as evidence.

Great Western Hospitals NHS Foundation Trust

Appendix E – Employee Guidance

Obtaining Information for Complaint Investigations

Introduction

Any Trust employee directly involved in a complaint may be asked to provide information in connection with the investigation. Employees asked to provide information will be supported in this process by the Investigating Manager, their line manager and the DD's /DDON or HOS. Further advice and support can be obtained from the PALS Team.

Patient Consent
The PALS Team is responsible for ensuring that appropriate patient consent for the release of personal information is obtained.

A copy of any information that is given is kept in the complainants management system complaint file for that complaint, and may be passed on if the complainant requests an Independent or Parliamentary Health Service Ombudsman's Review of their complaint.

General Principles in Obtaining Information

Any written information you obtain or provide for a complaint should be:

- Written in ink or typed
- Legible and concise
- Factual, accurate and relevant
- Avoid abbreviations
- Explain any technical words, phrases or procedures and avoid jargon

Format - the following format should be followed when obtaining information to ensure to consistency and completeness of investigations into complaints:

Title - the title should indicate the date, place and time of the issue complained about.

Opening paragraph - please give the following information as it applied when the events under investigation occurred:

- Your Name
- Address
- Post in the Trust
- How you can be contacted most easily

Narrative of events – please provide a narrative of the events, keeping to the facts.
In date and time order state:

- When and what you did and why.
- Where relevant, identify your contributions to clinical notes, adding explanations if you feel there is any ambiguity.

Final Checks - as a trust we must be 100% confident with what we are saying.

- Remember your statement could be made public. Always reread what you have written.
- Once you are confident with your statement, date and sign it.
- Give your signed, written statement to your line manager, keeping a file copy for yourself.

Great Western Hospitals
NHS Foundation Trust

Statement form

Complaint No:……

Patient Name:……

Hospital Number……

I, …….. currently employed by the Great Western Hospitals

NHS Foundation Trust, as …….

Contact telephone number/extension……

Narrative/statement of events:

Signature…… Date…….....

Great Western Hospitals
NHS Foundation Trust

Appendix F – Advice for the Public (Leaflet)

Making a Complaint

We Value Your Feedback
The Trust works hard to provide everyone that uses its services with an excellent experience. However we recognise that sometimes things go wrong. When this happens we want to learn from what people tell us so we can put things right and stop it happening again.

We are committed to listening to the views of our customers and have a team dedicated to helping you through the complaints process. Our PALS Team acts on your behalf to ensure that all complaints are dealt with fairly and thoroughly, and resolved quickly.

What is a complaint?
A complaint is any concern or issue you have with the service, care or treatment you have received from the trust which cannot be resolved with 24 hours. Complaints are usually made in writing, but can also be made in person or over the phone.

Some patient's worry that making a complaint will affect their care. Please be assured, raising a concern or making a complaint will not affect the care you or a loved one receives.

Who can complain?
Anyone who is receiving or has used our services can make a complaint. If you are unable to do so yourself then someone else (usually a close relative, friend or a carer) can complain for you. If someone is making a complaint on your behalf then written consent is needed.

Are there time limits on making a complaint?
Yes. It is important that you make your complaint as soon as possible after the event. At the latest, all complaints must be made **within twelve months** of the problem occurring or within twelve months of it coming to your attention.

How do I make a complaint?
If you have a concern, we would always recommend that you first let an employee know at the time. For example, if you are staying in hospital, you could speak to the nurse in charge or ward manager. They will listen to you and try to resolve your concern on-the-spot.

If you have done this and are not happy with the outcome, or you wish to raise your concern with someone not directly involved in your care, the PALS Team can advise you on making a complaint.

Please put your complaint in writing and send it to the address below, or email it to gwh.pals@nhs.net
You can also visit the PALS and Complaints Team in person or speak to a member of the team by calling: 01793 604031.

PALS & Complaints
The Great Western Hospital
Marlborough Road
Swindon
Wiltshire
SN3 6BB.

The PALS and Complaints Team are available Monday to Friday, 09.00am-5.00pm.

What will happen next?
Your complaint will be acknowledged by the PALS Team within three working days. It will be assigned to a PALS Officer who will contact you to find out what you would like to see happen as a result of making your complaint.
The Trust aims to resolve and inform patients of the outcome of all complaints within 25 working days, although sometimes it does take a little longer if your complaint is complex.

Can I get help to make a complaint?

Yes. Our PALS Team can offer you help and advice on making a complaint.

Alternatively, you can get free and impartial advice on making a complaint from HealthWatch or SEAP (Advocacy Service)

Healthwatch Swindon, Sanford House, Sanford Street, Swindon, SN1 1HE.
info@healthwatchswindon.org.uk Telephone: 01793 497777
or if you live outside of Swindon, but within Wiltshire:
Healthwatch Wiltshire, The Independent Living Centre, St Georges Place, Semington, Trowbridge, BA14 6JQ
info@healthwatchwiltshire.co.uk Telephone: 01225 434218

Or

SEAP Hastings, Upper Ground Floor, Aquila House, Breeds Place, Hastings, East Sussex, TN34 3UY. info@seap.org.uk Telephone: 0330 4409000

What if I am not happy with how my complaint was handled?

If you are not happy with the way the trust has dealt with your complaint or the outcome, you can request an independent review from the Parliamentary and Health Service Ombudsman (PHSO). You can contact the PHSO by calling: 0345 0154033, or you can write to them at:

The Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP

For further information, you can visit their web site at www.ombudsman.org.uk

Exclusions to this NHS Complaints Process

As a general rule, the NHS complaints process cannot be used for the following:

- **If you are taking legal action against the hospital – the complaints process will cease once legal action has been taken.**
- **If you are seeking compensation from the Trust – claims for compensation cannot be sought through the complaints process.**
- **If your complaint is about private medical care – you should address your concerns directly to the consultant in charge of your care.**

Getting this leaflet in another format

If you would like this information in another format, i.e. large print or another language, please contact the PALS Team on: 01793 604031.

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Appendix G – Seriousness Matrix, from the DH guide 'Listening, Responding Improving'

Step One
Decide on the 'Seriousness'

Seriousness	Description
Low	Unsatisfactory service or experience not directly related to patient care. No impact or risk to provision of patient care. OR Unsatisfactory service or experience related to patient care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of patient care or the service. No real risk of litigation.
Medium	Service or patient experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.
High	Significant issues regarding standards, quality of patient care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity.
Extreme	Serious issues that may cause long-term damage to an individual, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.

Step Two
How likely is it to re-occur?

Likelihood	Description
Rare	Isolated or 'one off'
Unlikely	Rare – unusual but may have happened before
Possible	Happens from time to time – not frequently or regularly
Likely	Will probably occur several times a year
Almost Certain	Recurring and frequent, predictable

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Step Three
Categorise the risk

Seriousness	**Likelihood of Recurrence**				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
LOW	LOW				
MEDIUM		MODERATE			
HIGH/EXTREME			HIGH	EXTREME	

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Appendix I – CQC Case Handling Process

CQC Enquiry form received from the Trusts CQC inspector. Normally emailed directly to the Deputy Chief Nurse, who will forward the case to an investigation manager and cc to gwh.pals@nhs.net for the complaints team to log on the complaints management system.

CQC Safeguarding Enquiry form received from the Trusts CQC inspector. Normally received by the Deputy Chief Nurse or Safeguarding Lead, who will forward the case to the investigation manager and cc to gwh.pals@nhs.net for the complaints team to log on the complaints management system.

Complaints Facilitators to log the case as a CQC complaint, CQC safeguarding or CQC incident and to liaise with the investigation manager, advise of the process and the complaints management system case number. The Complaints Facilitator may need to contact CQC or the care home for further patient information such as the full name, DOB, NHS number.

The Deputy Chief Nurse will acknowledge the email to CQC inspector and copy to the gwh.pals@nhs.net.

Any notifications received from CQC will have consent already received.

The CQC template should be added onto icasework for the investigation manager to complete if only responding to CQC. If responding to the complainant but cc to CQC a normal response letter should be completed.

The CQC Enquiry number (ENQ …….) to be noted in the summary box and CQC box ticked on the complaint management system so that the case is on the CQC dashboard in the Enterprise Report.

With all CQC cases responses are to be approved by the division and Deputy Chief Nurse within **15 working days** (The complaint management system will need to be amended for dates).

The final approved response should be sent to the Deputy Chief Nurse for her to email the CQC Inspector for the case to be closed, please do not send to the complainant until agreed by the Deputy Chief Nurse. Complaints team to mark the case as sent and inform the investigation manager to outcome the case.

Learning should be added by the investigation manager in the normal way and tracked to ensure the improvements are made.