Great Western Hospitals NHS Foundation Trust

# Agenda Board of Directors

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| **Date** | 3 June 2021 |
| **Time** | 9:30 - 15:15 |
| **Location** | Microsoft Teams |
| **Chair** | Liam Coleman |
| **Description** | |

**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 – 11)**

Liam Coleman

- 6 May 2020 (public minutes)

**4** **Outstanding actions of the Board (public) (page 12)**

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

**6** 9:45 **Chairman's Report, Feedback from the Council of Governors**

Liam Coleman, Chairman

**7** 9:55 **Chief Executive's Report (pages 13-17)**

Kevin McNamara, Chief Executive

**8** 10:10 **Staff Story (pages 18 – 21)**

Charmaine Durrant, Occupational Health Nurse - Working through the COVID-19 Pandemic

**9** 10:40 **Integrated Performance Report (pages 22 – 88)**

- Performance, People & Place Committee Chair Overview - Peter Hill, Non-Executive Director & Committee Chair

  Part 1: Operational Performance - Jim O'Connell, Chief Operating Officer

- Quality & Governance Committee Chair Overview - Nick Bishop, Non-Executive Director & 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 Chair Overview - Andy Copestake, Non-Executive Director & Committee Chair

- Part 4: Use of Resources - Simon Wade, Director of Finance & Strategy

**10** **Chair of Charitable Funds Committee Board Assurance Report (pages 89 – 90)**

11:55 Paul Lewis, Non-Executive Director & Committee Chair

*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**

12:05 Caroline Coles, Company Secretary

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

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

**13** **Date and Time of next meeting**

Thursday 1 July 2021 at 9.30am

**14** **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 6 MAY 2021 AT 9.30 AM, BY MS TEAMS

**Present:**

**Voting Directors**

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| Liam Coleman (LC) (Chair) | Chair |
| Lizzie Abderrahim (EKA) | Non-Executive Director |
| Nick Bishop (NB) | Non-Executive Director |
| Lisa Cheek (LCh) | Chief Nurse |
| Faried Chopdat (FC) | Non-Executive Director |
| Andrew 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 |
| Claudia Paoloni (CP) | Associate Non-Executive Director |
| Sanjeen Payne-Kumar (SP-K) | Associate 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**

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| Caroline Coles | Company Secretary |
| Tim Edmonds | Head of Communications and Engagement |
| Christina Rattigan | Head of Midwifery (agenda item 39/21only) |

**Apologies**

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| Julie Soutter (JS) | Non-Executive Director |

**Number of members of the Public**: 9 members of public (including 7 Governors; Arthur Beltrami, Chris Shepherd, Roger Stroud, Janet Jarmin, Pauline Cooke, David Halik and Ashish Channawar)

**Matters Open to the Public and Press**

| Minute | Description | Action |
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| 32/21 | **Apologies for Absence and Chairman's Welcome**<br>The Chair welcomed all to the virtual Great Western Hospitals NHS Foundation Trust Board meeting held in public.<br><br>Apologies were received as above. | |
| 33/21 | **Declarations of Interest**<br>There were no declarations of interest. | |
| 34/21 | **Minutes**<br>The minutes of the meeting of the Board held on 1 April 2021 were adopted and signed as a correct record. | |

Great Western Hospitals NHS Foundation Trust

| Minute | Description | Action |
|---|---|---|

35/21 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list and noted that:-

05/21 : Covid Vaccination Hesitancy - A further briefing note would be circulated with regard to the vaccination programme.
**Action : Chief Executive** KM

09/21 : Our People : SPC Charts - The response to this action was questioned however the action sought was to obtain an insight in trends emerging in which ever methodology was thought appropriate. It was agreed to close the action however the Director of HR would explore the options to include in the report.

36/21 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

37/21 **Chair's Report, Feedback from the Council of Governors**
The Board received a verbal update which included:-

- Welcome to Claire Thompson in the role of Director of Improvement & Partnership and also to Faried Chopdat and Helen Spice as Non-Executive Directors and Sanjeen Payne-Kumar and Claudia Paoloni as Associate Non-Executive Directors. Induction programmes had commenced for the new members of the Board and would continue over the coming months.
- A Board Development process was underway and the first two workshops took place on 19 & 28 April 2021 with further sessions planned over the next few weeks.
- Three governor workshops took place in April 2021 around finance, quality, performance and membership and an update from the respective chairs would be presented to the next Council of Governors meeting on 20 May 2021. The Chair also continued with regular meetings with the Lead Governors.
- Options were being explored on how to return to physical meetings. Priority was for the safety and security of all parties attending as well as recognising that virtual meetings worked well.

The Board **noted** the report.

38/21 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report and the following was highlighted:-

- The reduction in the number of Covid patients continued to be low however Swindon had the highest community rate in the South West.

- The Trust had now administered more than 50,000 first and second doses as part of its vaccination programme. There had been an isolated incident in which a different second vaccine had been given to a patient. The Trust had apologised to the patient involved, and provided guidance which indicated they would still had received a boost to their immunisation level. The Trust had reviewed its pathways to avoid this happening again.

- One of the consequences of the Pandemic was that patients had to wait much longer for treatment. The Trust was collaborating with Royal United Hospitals Bath

| Minute | Description | Action |
|---|---|---|

and Salisbury Hospital on tackling some of the waiting lists and to find different ways of doing things.

The Chair assured the Board and public that system working on waiting lists was a high priority as it was recognised that as standalone trusts this would not be addressed in a meaningful timescale.

- The Trust had now signed the deal to buy the parcel of land next to the Great Western Hospital which created a strategic opportunity for future development on the site, to improve services and ensure we could meet the demand created by Swindon and North Wiltshire's rapid population growth.

The Chair recognised that there were many developments being undertaken on the hospital site and was very conscious of the potential impact on access and parking for patients and staff. The Trust would endeavour to minimise this impact.

- The Care Quality Commission's report of the inspection of Abbey Meads and Moredon Medical Centres GP practices undertaken in February 2021 was published last month and recognised the improvements that had been made.
- Claire Thompson joined the Trust this month as Director of Improvement and Partnerships. Recruitment was currently underway for the roles of Medical Director and Chief Operating Officer.

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

39/21 **Patient Story**

*Christina Rattigan, Head of Midwifery joined the meeting for this agenda item.*

The Board received a video which centred on a couple's experience of the maternity and neonatal services. The story highlighted the different experiences and approaches the couple had received throughout their pregnancy.

The Board reflected on the story and recognised the importance of treating patients as individuals and how easy it was to forget that.

Paul Lewis, Non-Executive Director asked how this patient story was going to be shared with staff and involve them in discussing potential learning to improve family experience. Christina Rattigan, Head of Midwifery replied that valuable feedback from all levels was important and that the video would be shared at various meetings

Nick Bishop commented that it was up to the professional to get the fine balancing act in carrying out routine safe procedures and to understand that patients were still individuals and required assurance.

The Chair recognised that the benefit of hearing patient's comments was so the organisation could learn from their experiences to continually improve the services the Trust provided. This particular story would be picked up through the patient experience team to create learning zones and through the Great Care Campaign under the theme of personalised care in terms of compassionate conversations.

The Chair thanked the team for sharing this story.

| Minute | Description | Action |
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The Board **noted** the patient story.

40/21 **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 March/April 2021.

**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 28 April 2021 and highlighted the following:-

Covid Recovery Plan - The Committee were satisfied by the actions taken by the management team given the limited national guidance received.

NHS Elect/MBI/NECSU Reports - The Committee were assured in terms of data quality and use of information and satisfied that the majority of the actions had been completed. The outstanding actions would be absorbed through the Integrated Performance Report or through quarterly deep dives.

Theatre Transformation - Early successes were noted by the Committee and the next review of progress would come to PPPC in September 2021.

Outpatients Transformation - Significant improvements had been achieved and on-going improvement work would be part of the Recovery Programme. The Committee requested another deep dive in October 2021.

Junior Doctors Training & Annual Report - A positive report despite the challenges faced over the past year.

NHSI Learning Lessons to Improve Our People Practice - The Committee were assured that the Trust had taken on board learning.

Overall Agency Use - With the reduction in vacancies, the new agency contract and shielding staff returning to work it was expected that agency usage would come down.

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

ED Performance - Performance against the 4 Hour Access standard had improved from 87.79% to 88.33% in month (March 2021). However this continued to be below the 95% standard. It was noted that increased pressures were being experienced in the ED as attendances increased.

Covid Recovery - Overall, the Trust's RTT Incomplete Performance for February 2021 was 64.43% which was a deterioration of 1.14% in month. February saw referrals at 87% of the prior year. The Patient Treatment List (PTL) had increased by 404 in month. As mentioned previously the Trust was collaborating within the system to develop ways to resolve this issue.

Diagnostics - DM01 performance saw a significant improvement to 74.94% in February 2021 compared to 60.7% in January 2021. In March 2021 performance was over 80% however this would level off for a while as the region had taken the CT van to focus on other areas.

62 day Cancer - Performance had deteriorated to 79.7% due to covid and demand.

The Chair thanked the Chief Operating Officer and his team in evolving the Operational Integrated Performance Report to maintain strategic board focus rather than operational.

The Chair asked what the cause was in the increase in attendance in ED. Jim O'Connell, Chief Operating Officer replied that in part it was because of the number of people who had kept away during covid. The difficulty was that due to the restrictions in place the Trust would have to do things differently in order to move patients through more quickly. Another impact was the different ways of working within the health care system for instance the closure of the walk-in centre and GP virtual clinics.

**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 22 April 2021 and the following highlighted:-

Summary Hospital Level Mortality Indicator (SHMI) Data Review Report - The Trust's SHMI had trended upwards since 2018 although it remained within the expected range. The purpose of this report was to analyse a random set of notes to see if this could be explained. There was no evidence of poor care as a contributing factor. Under-coding of end of life was a possible reason for the rising trend.

Charlotte Forsyth, Medical Director added that this was one of many reviews that had looked at different areas of the mortality journey. This report was based on patients who died within 30 days of discharge and confirmed that it had not shown any areas of concern around care however had highlighted an issue of recognition of dying by clinicians and palliative care as disease trajectories were often unpredictable, and difficult for clinicians to identify when a patient was nearing end of life. Work was being undertaken to make improvements and Quality & Governance Committee would be updated in due course. CF

**Action : Medical Director**

From a Board perspective the Chair took confidence that this analysis had been undertaken and as a result, supported by Dr Foster, the Trust did not have any underlying materially negative trend.

Safeguarding Services Update - This was the first report that combined Adult, Children's and Maternity Safeguarding and would be reported on quarterly in the future.

| Minute | Description | Action |
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The Board received and considered the Quality element of the report with the following highlighted:-

Pressure Ulcers - This was a key focus for the organisation looking at three themes, early identification, right preventative measure and right equipment.

Falls - There had been a reduction in the number of falls which had been a result of a Quality Improvement (QI) approach. Five wards had trialled a number of initiatives and 4 out of the 5 had seen significant improvement in the number of falls. Analysis would be undertaken to understand what had made a difference before taking the learning across the organisation.

Patient Experience - There had been a shift in the number of formal complaints to concerns. This had been a purposeful piece of work to signpost patients and carers to the right people for the right action to achieve an early resolution. The next step would be to look at the themes and trends from the early resolutions.

There were several initiatives to strengthen patient and carer feedback taking place which included the Family & Friends Test roll out to Outpatients in June as part of a gradual roll out trust wide, introduction of a patient experience question in the Matron Audit Survey, volunteers going out to patients to understand the results from the In-patient survey and the launch of the Great Care Campaign on 19 May 2021.

**Part 3 : Our People**

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

- Good progress had been made in reducing the vacancy rate.
- Turnover was stable and sickness absence higher than target.
- Reliance on temporary staff continued to be high with the primary reason vacancy cover and escalation, alongside the on-going need to supply registered nursing staff to deliver the Covid vaccination programme. Community Nursing continued to have the greatest demand for temporary staffing resource, which was supported by the approval to secure up to an additional 20 registered nurses per day.
- Since the report had been written the position with regard to international nurses had changed. The NHS had suspended the recruitment of doctors and nurses from India amid concerns over healthcare professionals leaving the country when they were most needed during India's covid second wave. The Trust was also supporting members of staff who had family in India.

Faried Chopdat, Non-Executive Director asked whether agency staff were included in the Trust's training statistics. Jude Gray, Director of HR replied that agency staff were required to have their training up to date and checks and balances were undertaken to ensure this was in place.

**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 26 April 2021 and the following highlighted:-

| Minute | Description | Action |
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Year End Position - Key targets had been achieved at the year end due to the covid financial regime, and ended with a small surplus of £28k (subject to audit).

Board Assurance Framework (BAF) - The new format of the BAF for Strategic Pillar 4 – Using our Funding Wisely was considered. The Committee liked the new format and suggested a number of additions to the content.

Financial Planning 2021/22 - The main discussion of the meeting focussed on next year's financial regime which would be split into first half of the year (H1) and the second half (H2). The financial regime for the first 6 months of 2021/22 would broadly follow the pattern from 2020/21 with enhanced monthly block payments. There was an efficiency target and the Committee discussed the achievability of this, together with closing a £4m funding gap. After discussion, the Committee were happy to recommend approval of the H1 revenue budget to the Board. The second half of the year would be much more challenging from a finance perspective. Central guidance had still not been produced and if the regime reverted to the pre-Covid regime the Trust would, again, be facing a substantial operating deficit.

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

- The draft full year position was £28k surplus against a plan of £3,829k deficit which was £3,857k favourable variance.
- The BSW system achieved its year end target.
- Trust income was above plan by £28,448k year to date due to funding received to cover additional costs, lost income and technical pension adjustments. The Trust had received funding to cover the increase in annual leave accrual that was due to the Covid-19 pandemic. Funding had also been received from BSW to cover in-year pressures.
- Pay was £4,794k overspent in month and £6,570k overspent for the full year. The in month position included a provision for Birthday/Annual Leave in lieu of time and effort worked during the pandemic.
- Non -pay expenditure was overspent by £16,488k in month and £18,021k full year. The in month position included year-end provisions for anticipated costs related to 2020/21, stock adjustments and technical adjustments for notional pension costs (matched by income).
- The Trust capital plan for 2020/21 had increased by £1.1m since Month 11, this related to the Urgent Emergency Care (UEC) Clover project. The full year capital plan was £40,567k, within this the PFI was forecast to overspend by £111k and the Way Forward Programme was forecast to underspend by £2,542k. These items sat outside the Trust CDEL target. The Trust was forecasting to spend the full CDEL allocation in 2020/21.

  The Chair commented that there had been a real step change in the Trust's ability to utilise money positively and delivery on projects.

  Lizzie Abderrahim, Non-Executive Director asked why performance was better in regard to non-NHS suppliers vs NHS suppliers and what were the consequences of

| Minute | Description | Action |
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failure. Simon Wade, Director of Finance & Strategy replied that there were no consequences and the Trust adhered to the standard, however there was historically a number of issues with NHS suppliers in terms of contracts not formalised and the Trust were working to improve the statistics. It was noted that the Trust were not measured on non-NHS suppliers and ensured that local businesses were not put at risk with late payments.

***RESOLVED***

***to review and support the continued development of the IPR and the on-going plans to maintain and improve performance.***

41/21 **Chair of Mental Health Governance Committee Overview**

The Board received an overview of the discussions held at the Mental Health Governance Committee at the meeting held on 9 April 2021 with the areas of concern around availability of specialist beds and funding envelope.

Paul Lewis, Non-Executive Director commented that as a member of the committee and reading the summary he was more assured that the Committee was focussing on its key remit with regular significant updates.

Faried Chopdat, Non-Executive Director stated there were a number of red and amber assurance levels and asked if there was anything else the Board could do to address these issues to move them to a better rag status. Lizzie Abderrahim, Non-Executive Director replied that most of these issues were created outside the Trust's immediate control. Kevin McNamara, Chief Executive added that the partnership element was important and that the Trust's new Director of Improvement and Partnerships would have an input in some of these area to formalise some of the processes to resolve collectively as a system.

The Board **noted** the report.

42/21 **Staff Survey 2020 – Results, Analysis and Action Plans**

The Board received and considered a paper that provided the key messages from the Staff Survey 2020, together with an action plan. The following was highlighted:-

- The response rate in 2020 was 53% compared with a response rate of 45% in 2019.
- The Trust moved from being below the national average for 20 indicators to being below in only 4 in 2020.
- The Trust improved significantly in two themes for Health and Well-being and Quality of Care during a difficult year with Covid-19.
- The Trust remained ranked 15th in the South West.
- The areas of focus for 2021/22.

Paul Lewis, Non-Executive Director asked if there would be clear Trust wide standard/expectations and commitment reflecting the key themes and what support would managers receive to fulfil this expectation. Jude Gray, Director of HR replied that there would be some element in personal objectives but not a Trust wide objective as it would be left to Divisions to lead from their surveys through the appraisal process. As for support this would be part of the leadership development that was currently taking place and visibility would be seen through Performance, People & Place Committee.

| Minute | Description | Action |
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Faried Chopdat, Non-Executive Director asked if there were other ways of capturing concerns other than the questions and commented that Unscheduled Care had a few more issues than the other Divisions and was there something specific within this Division. Kevin McNamara, Chief Executive replied that the Trust had not yet received the written text from the survey which would be key to show any other issues that had not been captured. In terms of Unscheduled Care the results reflected the intensity of an emergency care service. The Division had good team leaders who take their issues incredibly seriously and had recently launched a Civility and Respect framework. There were no concerns structurally with the driver purely around the intensity of the service.

Paul Lewis, Non-Executive Director stated that the level of openness and engagement from the Executive had improved dramatically however asked if this had been translated down to middle managers/divisional managers. Kevin McNamara, Chief Executive responded that the Executive team had a key role in setting the standard for staff to adopt and role model. However, there was further work to be done through communication, development of the Clinical Strategy in terms of deeper engagement within the organisation and through trust wide leadership development.

Nick Bishop, Non-Executive Director asked if we received more complaints/grievances about equality, inclusion and diversity last year. Jude Gray, Director of HR replied that there had not been a significant increase however more concerning, in discussions with the EDI Lead, were the number of people not coming forward and steps were being taken to address this.

***RESOLVED***

***(a) to note the staff survey results; and,***

***(b) to approve the action plan***

43/21 **Gender Pay Gap**

The Board received and considered a paper that provided the results of the Gender Pay Gay analysis together with an action plan which was in line with an independent review into gender pay gap in medicines commissioned by the Department of Health and Social Care.

Peter Hill, Chair of Performance, People & Place Committee (PPPC) reported that this had been robustly discussed at PPPC with the amendments proposed reflected in this report, which made for a more balanced view.

The Board were assured that there was no evidence of unfair pay within the Trust.

***RESOLVED***

***to approve the information for publication.***

**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.*

Great Western Hospitals NHS Foundation Trust

| Minute | Description | Action |
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44/21 **Ratification of Decisions made via Board Circular/Board Workshop**
None.

45/21 **Terms of Reference of Committees**
The Board received and reviewed a paper to consider the annual review for the terms of reference of Performance, People & Place Committee and Mental Health Governance Committee.

***RESOLVED***

***that the Terms of Reference for each Committee as circulated separately with the agenda be approved.***

46/21 **Membership of Committees**
The Board received and reviewed a paper to consider the annual review of committee membership and Non-Executive Director supporting roles.

The Chair advised that further discussion was required with regard to the core membership of Performance, People & Place Committee and Quality & Governance Committee in terms of spreading the load amongst the Non-Executive Directors. In terms of the supporting roles this would form part of the Board development in order to look at those areas to focus on going forward.

***RESOLVED***

***to approve the committee membership and NED supporting roles for 2021/22 noting that a further review of core membership of Performance, People & Place Committee and Quality & Governance Committee.***

47/21 **Register of Interests and Declaration of Interests at Meetings**
The Board considered a report that provided an annual reminder to Directors of their obligation to register any relevant and material interests as soon as they arise or within 7 clear days of becoming aware of the existence of the interest and to also make amendments to their registered interests as appropriate.

The report also reminded of the requirement to declare interests at meetings when matters in which there was an interest were being considered and the requirement to withdraw from the meeting during their consideration.

Furthermore, the report asked the Board to receive a copy of the Register of Interests of the Board of Directors for review, which best practice suggested, should be undertaken on at least an annual basis.

***RESOLVED***

***(a) that the requirement of directors to register their relevant and material interests as they arise or within 7 clear days of becoming aware of the existence of an interest be noted;***

***(b) that the requirement to keep the register up to date by making amendments to any registered interests as appropriate be noted;***

| Minute | Description | Action |
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***(c) that the requirement to declare the existence of registered interests or any other relevant and material interests at meetings be noted including the requirement to leave the meeting room whilst the matter is discussed; and***

**(d)** ***that the Director's Register of Interests be received and it be agreed that the Board is assured that the requirements of the Constitution to maintain a register of interest of Board Directors are being met.***

48/21 **Annual Self-Certifications**

The Board received and considered a number of self-certifications for Board approval prior to submission to NHSI/E. The self-certifications were:-

- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
- Complied with governance arrangements (condition FT4); and
- For NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

***RESOLUTION***

***that the annual self-certifications be approved.***

49/21 **Urgent Public Business (if any)**

None.

50/21 **Date and Time of next meeting**

It was noted that the next virtual meeting of the Board would be held on 3 June 2021 at 9:30am via MS Teams.

51/21 **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 1530 hrs.

Chair …… Date……

Great Western Hospitals NHS Foundation Trust

| ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – June 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** |
| 01-Apr-21 | 05/21 | **Questions from the public / covid vaccinations hesitancy**<br>A further briefing to be sent out to governors. | Chief Executive | Completed. **Closed** |
| 06-May-21 | 40/21 | **Integrated Performance Report / Our Care / Summary Hospital Level Mortality Indicator (SHMI) Data Review Report**<br>No areas of concern were raised in the report around care however had highlighted an issue of recognition of dying by clinicians and palliative care as disease trajectories were often unpredictable, and difficult for clinicians to identify when a patient was nearing end of life. Work was being undertaken to make improvements and Quality & Governance Committee would be updated in due course. | Medical Director | For Q&GC |

| **Future Actions** | | | | |
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| None | | | | |

Great Western Hospitals NHS Foundation Trust

# Chief Executive's Report

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| **Meeting** | Trust Board | **Date** | 3 June 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 | |
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| **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 |
|---|---|---|
| | | |

| | |
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| **Legal / Regulatory / Reputation Implications** | N/A |

**Link to relevant CQC Domain**

| Safe | x | Effective | x | Caring | x | Responsive | x | Well Led | x |
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| **Link to relevant Trust Commitment** | |

**Consultations / other committee views**

N/A

**Recommendations / Decision Required**

***This report is for information only.***

## 1. Staff recognition

Our staff do fantastic jobs every day of the week and I'm delighted that their hard work and dedication was recognised at the Newsquest Swindon and Wiltshire Health and Social Care Awards 2021.

Well done to all the members of staff and teams who were shortlisted for the award and I'm really pleased that we had a number of winners on the night. These were:

- The Health Care Employer Award – the Trust.
  This is such an achievement for all of our staff who have pulled together as one big GWH family to look after all our patients during the COVID-19 pandemic. A huge team effort and one that every member of staff should be so proud of.
- The Health Care Team Award – ICU.
  Our ICU team have been integral to our response to Covid-19 and have looked after more than 120 patients.
- The Good Nurse Award – Lisa Hocking.
  Lisa has led on our infection prevention and control measures during the pandemic, ensuring that patients, visitors and staff members have been kept safe and that we've done all we can to reduce the spread of infection. This is a really important role and Lisa should be so proud of all she has done.
- The Care Hero Award – Dr Anthony Kerry.
  Dr Kerry has worked as a consultant on our respiratory ward, Neptune, throughout the pandemic, caring for patients who have needed oxygen support due to the virus.
- The Adolescent and Child Care Award – Dr Sarah Bates.
  During the pandemic, Dr Bates and the team on SCBU have continued to place the family at the centre of all they do, supporting mothers and families whose babies require additional support after birth in a hospital environment.
- GP Practice of the Year – Abbey Meads and Moredon.
  This award is testament to the commitment of staff working to turn around the practices since they were taken over by the Trust. There's been some really great work by the teams working across Abbey Meads, Moredon, Penhill and Crossroads surgeries and our primary care improvement journey will continue.

Internally, we continue to recognise the contributions of our staff and our latest team of the month award went to the Audiology Team who worked throughout the pandemic to ensure that patients were offered a remote service to assist them with communication.

The department has been essential for helping hearing-impaired patients to prevent social isolation, improve mental health and quality of life during this time.

The hard work, goodwill and dedication of staff in bringing referral to initial diagnostic assessment to within six weeks whilst maintaining other activity has been a testament to their drive for patients to be at the centre of the service.

## 2. Coronavirus

### 2.1 Current position

Numbers of patients with confirmed Covid-19 within Great Western Hospital are low, but coronavirus is still present and remains a concern. At the time of writing the Swindon case rate was lower than the England average, but higher than that of the South West.

Since the Board last met, the Department of Health and Social Care designated a hotel in Swindon, the Jury's Inn, as part of its Managed Quarantine Service for travellers returning from

abroad. We continue to work with our system partners to minimise the impact of this development on our services locally as much as possible.

### 2.2 Vaccination programme

We have now administered more than 62,000 first and second doses as part of our vaccination programme.

This is a significant achievement and I am pleased that we have been able to continue to offer vaccinations from our Commonhead offices every day since we gave one of the first vaccinations in the world in December 2020.

We also continue to play a leading role in the roll-out of the vaccination programme across the Bath and North East Somerset, Swindon and Wiltshire partnership.

## 3. Pressure on the hospital

We have seen a significant increase in the volume of patients attending our urgent and emergency services which has put pressure on the whole hospital.

We have worked closely with system partners across BSW to provide support to our teams with discharging patients as soon as possible.

Last week we introduced a new initiative called SAFER Week, which asked all clinicians and nursing staff working on wards to focus on each of the following SAFER elements every day of the week.

**S** – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions. This should be informed by a multi-professional assessment, where appropriate, and clear consideration of social and environmental factors to facilitate discharge.

**A** – All patients, and their families will be involved in the setting of an Expected Discharge Date based on the clinical and functional criteria for discharge. This is set assuming ideal recovery and no avoidable delays.

**F** – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely have patients transferred from assessment units will ensure that the first patient arrives on the ward by 10am.

**E** – Early discharge – More than 33% of patients will be discharged from inpatient wards before midday on their day of discharge. Where possible, medication to take home for planned discharges should be prescribed and with Pharmacy by 3pm the day prior to discharge.

**R** – Review – A systematic multi-disciplinary team review, including patients and their families for those with extended lengths of stay (more than six days) with a clear ‘home first' mind set.

The aim of the week was to help patients to leave hospital as soon as they are well enough and to free up bed capacity within the hospital for new patients needing acute care and we hope to embed the learning and good practice from this week so that it becomes business as usual.

## 4. Great Care campaign

We have launched a new Great Care campaign which will seek to align all initiatives, schemes, quality improvement project and other good work around improving the patient experience under one umbrella.

Learning will then be shared across the Trust so that processes become standardised in every area.

Whilst our staff have always provided the best level of care, we do recognise that sometimes things don't always go to plan and we are committed to making improvements to our services and the experience our patients receive.

The campaign is made up of our four work streams –

- Harm free care, including areas such as reducing falls and pressure ulcers.
- Expert care, to support with career development for staff.
- Personalised care, which means tailoring the care we provide to the patient who is receiving it and meeting any additional needs they might have.
- Environment, which makes sure that our ward and waiting areas are inviting, supporting and safe for all.

Offering the best quality patient care all the time is paramount to our staff. We hope that this campaign, which will be embedded across the organisation over the coming weeks, will mean that every patient receives a positive and supportive experience when spending time in hospital, being visited by community teams or when being treated in our primary care services.

## 5. Clinical strategy

Last month Executive Committee came together physically – safely – for the first time in more than a year.

Senior staff began early discussions on our emerging clinical strategy, which we view as critical to have in place to ensure we have set ourselves a really clear direction for how we continue to deliver the best possible care in line with population needs as we emerge from the pandemic.

We're starting the process by focusing on two services in each of our divisions and are involving staff within these services to ensure they have a say in the future of the care they provide.

We will be asking each service to consider how people currently access services along with what they need from us now and may need in the future.

This is an opportunity to consider how we can better integrate our services and work together to provide a better experience and sustainable way of working.

## 6. Way Forward Programme

The Great Western Hospital site continues to change on what seems like a daily basis, and our Way Forward Programme has really taken off over the last few weeks.

The demolition of the old Clover building was completed last week marking an important milestone in the programme to build our new Urgent Treatment Centre. Non-Executive Director Andy Copestake was featured in a video recorded on site during the demolition, and highlighted the role non-executive directors play in large programmes of work such as this.

Work is progressing well and we continue to work towards a completion date of December this year for the new building to open.

## 7. Dying Matters Week

Over the last year the COVID-19 pandemic has put death and loss at the forefront of the nation's consciousness.

It is really important that people are able to die in the way that they choose – in the right place and with the right people around them.

However, only 13% of adults have told a family member or friend where they would like to die and many people have no idea how to arrange for that to happen when the time comes.

Those choices will be different for everybody; but it is important for families to think about it, to talk about it, and to plan for it. We marked Dying Matters week last month with a selection of staff talking about their dying wishes to help encourage conversations about advance planning.

## 8. Staff support

### 8.1 Health and Wellbeing Plan

The health and wellbeing of our staff has always been important but this has really been highlighted during the pandemic.

We already have a really good health and wellbeing offer for our staff, which was nationally recognised with a Nursing Times award last year.

We want to build on this and, with input from Executive Committee members, have now produced a health and wellbeing plan which looks to the next five years.

This plan outlines how we will continue to develop our health and wellbeing interventions, reflecting on what we have been doing well, where we can improve, and how we can measure this.

The plan is broken down into three key areas of support:

- Individual
- Teams
- Organisation

It evidences the support available within each of these three groups, as well as detailing plans to be further developed over the coming years.

### 8.2 Mental health support and awareness

In May we placed extra focus on raising awareness among staff of mental health issues.

This included hearing staff stories and ensuring staff are aware of the package of support in place for them.

We also used this as an opportunity to raise awareness across the Trust of the more than 70 Mental Health First Aiders who have already been trained and are working to support colleagues who may be struggling with their mental health.

These staff have been taught skills in listening, identifying signs of mental health issues, providing reassurance, and helpful ways to respond, including empowering someone to access appropriate support.

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# My Experiences of Working through the COVID – 19 Pandemic

Charmaine Durrant

3rd June 2021

Great Western Hospitals NHS Foundation Trust

# My Story – 2020

- **I was redeployed to the swabbing team from the out-patients department in March 2020.**
  - Seven day week service
  - Swabbing staff with COVID-19 symptoms
  - Working outside in all weathers in full PPE
  - Data inputting, checking results, phoning & emailing results to all staff and booking new appointments


- **Following this I supported and helped set up the antibody testing service for staff across GWH**
  - Booking appointments for blood tests
  - Securing rooms and consumables
  - Checking & delivering results

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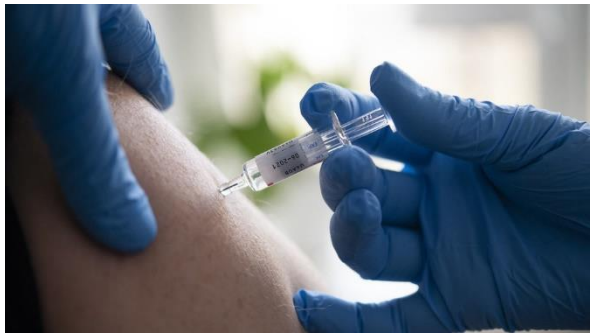
## Sept – Dec Flu campaign with OH

- Join the OH team
- Supporting the campaign through delivering the vaccine on wards and within PALS



## COVID-19 vaccinating

- Seconded to Band 6 lead nurse within the vaccination team
- Future – return to OH to plan the Flu strategy and possible COVID-19 booster vaccine for staff.



Service Teamwork Ambition Respect

# My Personal Development

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Newly qualified

Redeployed to OH

Seconded to band 6 lead nurse in the vaccination team

Future

Great Western Hospitals NHS Foundation Trust

# Integrated Performance Report (IPR)

| Meeting | Trust Board | Date | 3rd June 2021 |
|---|---|---|---|

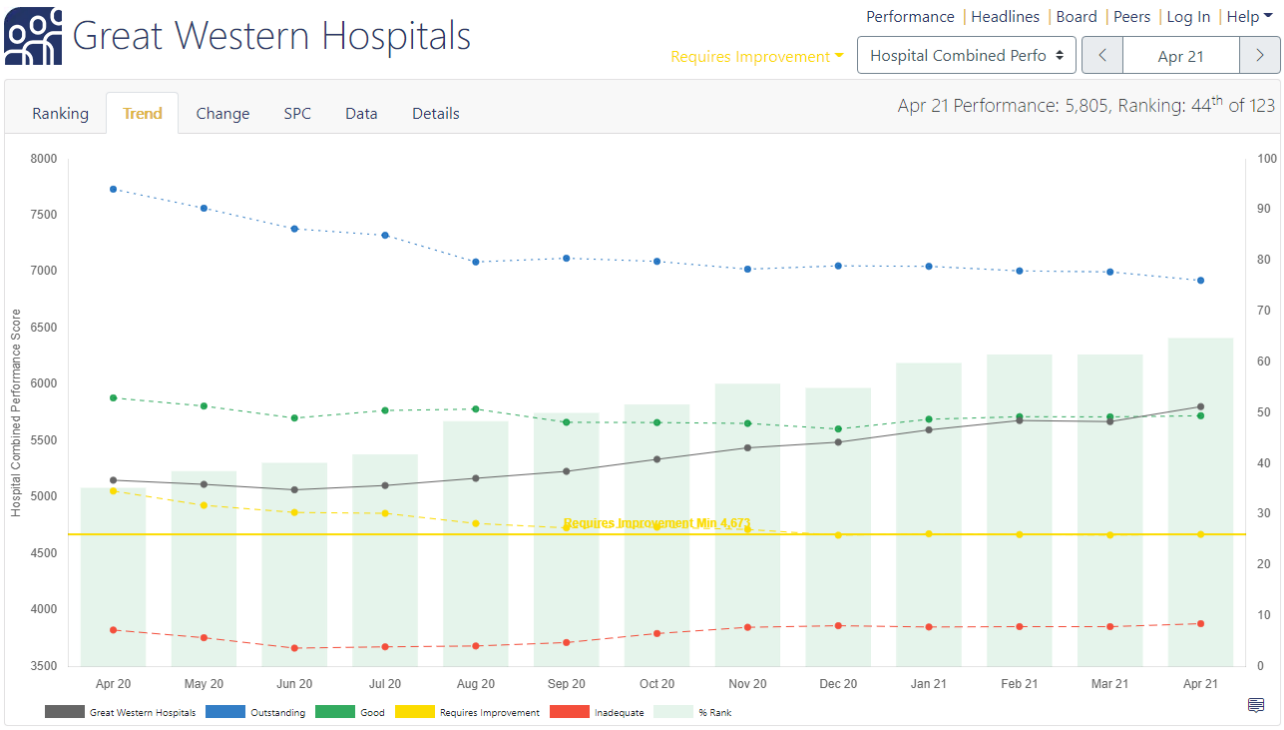
**Summary of Report**

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**

The improvement we have seen over several months in our Hospital Combined Performance score on Public View continues. We are now ranked 44th (up from 48th) out of 123 Trusts, an improvement on our ranking in March 2020 of 87th. We are now the 5th most improved Trust in England. The trend chart below reflects our aggregate position improving against CQC measures and our performance is tracking as 'Good'.




Turning to April 2021, performance against the 4 Hour Emergency Care Standard (ECS) deteriorated from 87.79% to 82.59% in month. We continue to be below the current 95% standard. Revised *Transformation of Urgent and Emergency Care Standards* are expected in Q1 2021.

Attendances have increased in April by 908 patients across both Type 1 (505) and Type 3 (403). The Urgent Treatment Centre (UTC) saw a 45.7% increase in patients in March (1122 patients) and a further increase of 12.5% in April. 4-hour breaches within the UCC increased in April by 181 (34 reported in March and 215 In April.)

Covid 19 admission, to the Trust, continue to reduce form the peak of 163 in Jan 2021. During April, an average of 2 patients per day have been admitted with Covid 19.

Overall, the Trust's RTT Incomplete Performance for March 2021 was 65.31% which was an improvement of 0.88% in month. March saw referrals at 136% of the prior year. In March, the Trust received 9843 referrals, an increase of 1563 compared to February 2021. This is aligned to the Trusts current recovery plan and in line with the Pre-Covid 19 average.

Of the 1,949 reportable 52 week breaches, 1,597 were Admitted, 272 were Non-Admitted and 80 were a Diagnostic wait. The PTL increased by 705 in month, which places us 1,682 adrift of our pre-Covid end of year trajectory. However, our current PTL is 4,066 below our Phase 3 end of year Target of 28,995.

62 Day Cancer performance in March was 92.3% against a National and Local target of 85%. This was a 13.5% improvement in month.

**Our Care**

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

Reporting is now in place to capture information regarding medication incidents and omitted medicines, focused improvement work is underway in the Emergency department in relation to identification and management of patients with a penicillin allergy. Numbers of unintended omitted medicines remains consistently low and well below national levels.

Reporting of harm relating to pressure remains high in both the community and acute settings. Improvements have been seen with numbers reducing slightly and the level of harm in the community decreasing. "Swarms" are being implemented to ensure early learning from pressure damage across the Trust, and there is a continued focus on education and training.

For the third month in a row, we have seen a decrease in the number of falls reported, the new documentation developed is now being transferred to Nervecentre, in addition assessments for assessing use of bed rails and for monitoring Lying and Standing Blood Pressure have both been added to Nervecentre, both are key assessments in supporting the management of patients at risk of falling.

Two serious incidents have been reported this month both are maternity related incidents, immediate learning identified and implemented, investigations are on-going.

Maternity report a significant improvement in their requirement to achieve compliance in relation to Prompt training, they have 11 individuals to train out of the required 344 to achieve the 90% target by the end of June 2021, this is a key requirement to ensure compliance with the Maternity Incentive Scheme.

**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 April**: Agency spend has reduced to 5.23% achieving the 6% target further to removal of the Master Vend process and introduction of rigorous controls for clinical usage. 61% Bank fill rate continues to perform positively and for the third month exceeds the average usage of 50%. Mandatory training has also increased to 85% achieving Trust KPI target. Recruitment of international nurses from India is presenting as an exception with the pause on international recruitment from the region due to the pandemic, and scenario planning underway for impact on trajectories.

**Workforce planning** -. April saw a significant improvement in the proportion of total pay spend on temporary workforce, improvement in the RN bank fill rate percentage for the fourth successive month and a small improvement in the Trust's already relatively low vacancy rate. A combination of a low vacancy rate and improving divisional controls related to use of E-Roster and the Safer Nursing Care tool have been important factors in mitigating the use of temporary staffing, with this contributing to 124WTE less bank & agency staff being used in April compared to March. It should be noted, however, that in month1 of the new financial year, 206wte extra workforce was utilised when compared to budget.

**Opportunities** - The Trust vacancy rate continues to improve and is reported at 5.40% (267.83 WTE) in April, significantly lower than the Trust target of 7.6%. There continues to be a sustained improvement in voluntary turnover achieving below the 11% target. Recruitment time to hire metric remains above KPI at 48 days from vacancy advertised to contract of employment. The Trust anticipates an impact on overseas nurse's intake due to an immediate pause on all nurse international travel from India as a result of the Red Country status due to the Covid-19 pandemic.

**Experience** - Sickness absence remains stable at 3.47% and below 3.5% target, the sustained improvement evidences emergence from winter months, positive impact of close management of long term sickness cases and supports the improved KPI score of 3. The report highlight initiative from the Trust well-being programme such as the 'Bitesize' wellbeing sessions. The Equality, Diversity and Inclusion agenda is progressing with pace with a range of initiatives as also outlined in report

**Employee Development** - The Academy has reported progress to Health Education England (HEE) in terms of the CPD spend as requested by 30 April 2021. The Mandatory Training project is on track and the new system for accessing and undertaking mandatory training will go live on the 1st June 2021. A communication plan has been prepared to ensure all staff are aware of the changes and able to access the new system. The Trust is investing in coaching training for staff to ensure it has internal capacity to support staff who require coaching as part of their ongoing development.

**Leadership -** There has been an increase in appraisal rates in April to 82.47% for the third consecutive month. Whilst this remains lower than the KPI target of 85% it is, nevertheless, encouraging. The second cohort of the Leadership Development programme began in April with 17 participants. The third session of the AMD development programme was well received and work is on-going in the development of a system wide Clinical Leads program.

**Use of Resources**

The Trust plan is breakeven. The in month and year to date position is a deficit of £2k against a plan of breakeven, an adverse variance of £2k.

Trust income is above plan by £293k year to date due to Education & Training funding received from HEE and Carbon Energy Fund, both of which are matched by costs.

Pay is £145k overspent in month and year to date. The in month position includes nursing overspend of £299k and medical overspend of £48k which are offset by underspends within scientific, technical and admin staff.

Non -pay expenditure is overspent by £150k in month and year to date. The in month position includes a savings target of £169k of which £34k has been achieved.

The Trust capital plan for 21/22 is £33,493k including the UEC Clover project and Way Forward Programme. A contingency of £541k (CDEL) is being held centrally to mitigate any potential risks arising in year.

| For Information | x | Assurance | | Discussion & input | | Decision / approval | |
|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Executive Lead** | |
| **Author** | Jim O'Connell, Chief Operating Officer<br>Simon Wade Director of Finance |

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| | |
|---|---|
| | Jude Gray, Director of HR<br>Lisa Cheek, Chief Nurse |
| Author contact details | jim.o'connell@nhs.net<br>jude.gray@nhs.net<br>lisacheek@nhs.net<br>simon.wade5@nhs.net |

**Risk Implications - Link to Assurance Framework or Trust Risk Register**

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| 792<br>1357<br>1917 | 1. 4 Hour Standard<br>2. 2.RTT Standard<br>3. Cancer | |

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

**Link to relevant CQC Domain**

| Safe | | Effective | | Caring | | Responsive | | Well Led | |
|---|---|---|---|---|---|---|---|---|---|
| | x | | x | | x | | x | | 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 on-going plans to maintain and improve performance

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# Integrated Performance Report

## May 2021

Service Teamwork Ambition Respect

# Performance Summary



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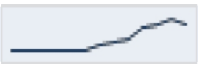
| KPI | Latest Performance | Trend (last 13 months) | Public View (Latest Published Data) | | | |
|---|---|---|---|---|---|---|
| | | | National Ranking | Bath Ranking | Salisbury Ranking | Month |
| Hospital Combined Performance Score | 5659 (May) |  | 42(5659) | 28(6105) | 20(6453) | May 21 |
| A&E 4 Hour Access Standard (combined ED & UTC) | 82.59% (Apr) |  | 40(88.3) | 57(84.9%) | 24(90.9%) | Mar 21 |
| A&E Median Arrival to Departure in Minutes (combined ED & UTC) | 185 (Apr) |  | 39(162) | 95 (197) | 55 (171) | Feb 21 |
| RTT Incomplete Pathways | 65.31% (Mar) |  | 61(64.4) | 49 (67.85) | 51(67.63) | Feb 21 |
| Cancer 62 Day Standard | 92.3% (Mar) |  | 23(79.7) | 39 (75.59) | 62 (71.57) | Feb 21 |
| 6 Weeks Diagnostics (DM01) | 81.57% (Mar) |  | 62(74.9) | 82(67.60%) | 14(93.44%) | Feb 21 |
| Stroke – Spent>90% of Stay on Stroke Unit | 72.3%(Q4 20/21) |  | 43(88.8) | 26 (91.5%) | 75(83.3%) | Q2 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 | 4.19% (Dec) |  | 23(4.16) | 67 (5.26%) | 4 (3.45%) | Dec 20 |
| MRSA | 0 (Mar) | | 48(1.74) | 95(3.38) | 69(2.24) | Feb 21 |
| Elective Patients Average Length of Stay- (Days) | 2.79 (Apr) |  | | | | |
| Non-Elective Patients Average Length of Stay (Days) | 3.48 (Apr) |  | | | | |
| Community Average Length of Stay (Days) | 16.2 (Apr) |  | | | | |
| Number of Stranded Patients (over 14 days) | 81 (Apr) |  | | | | |
| Number of Super Stranded Patients (over 21 days) | 46 (Apr) |  | | | | |

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*The figure is impacted by the current financial regime in place due to Covid-19

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 | | 26th May 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 – Emergency Access | Amber | Amber | Significant increase in demand was whilst still maintaining COVID safe measures. Appropriate actions being taken with a specific focus by the new Deputy COO who will update PPPC next month. | To monitor actions. | June meeting |
| Integrated Performance Report - RTT | Red | Amber | Incredibly challenging position however there has been a reduction in 52 week waiters and a better than expected recovery in month 1 (April). | To monitor actions | June meeting |
| Integrated Performance Report – Diagnostic Wait Times (DM01) | Amber | Amber | A slight downturn had been seen partly due to the fact the mobile CT van is no longer available. | To monitor actions | June meeting |
| Integrated | Green | Green | Good performance SNNAP score continues as a high B. | To monitor actions | June meeting |

| | | | | | |
|---|---|---|---|---|---|
| Performance Report – Stroke | | | | | |
| Integrated Performance Report - Cancer Performance | Amber | Amber | There continues to be significant challenges within the Breast Service, however, actions against the improvement plan are looking positive and an improvement in performance is expected by the summer. Good performance continues across most cancer services against the various targets. | To monitor actions. | June meeting |
| IT Performance Report | Amber | Amber | Further work needs to be commissioned to understand the risks around the benefit realisation for many of the schemes. | To be referred to FIC | To be determined |
| Research & Innovation Progress Report | Green | Green | The Committee received very positive assurance with regards to R&I at GWH. | | |
| Integrated Performance Report – Sickness Absence | Green | Green | The Trust had been on a journey which has seen additional impact due to COVID-19 but improvements are now being seen. | To monitor actions. | June meeting |
| Integrated Performance Report – Overall Agency Usage | Amber | Amber | Improvements have been seen following the introduction of the PSL. | To monitor actions. | June meeting |
| Integrated Performance Report – Turnover | Green | Green | Staff turnover remains comfortably within the Trusts target. | To monitor actions. | June meeting |
| Integrated Performance Report – Mandatory Training | Amber | Green | Continued improvement noted. JG would review the mandatory training list. | To monitor actions. | July meeting |
| Integrated Performance Report - Appraisal Proposal | Amber | Green | Continued improvement noted. | To monitor actions. | June meeting |
| Integrated Performance Report - Vaccinations | Green | Green | The GWH lead vaccination programme continues to impress with good take up and roll out to staff and public. | To monitor actions | June meeting |

Great Western Hospitals NHS Foundation Trust

| Issues Referred to another Committee | |
|---|---|
| **Topic** | **Committee** |
| IT Risk Assessments | Finance & Investment Committee |

Great Western Hospitals NHS Foundation Trust

# Part 1: Operational Performance

## Our Priorities





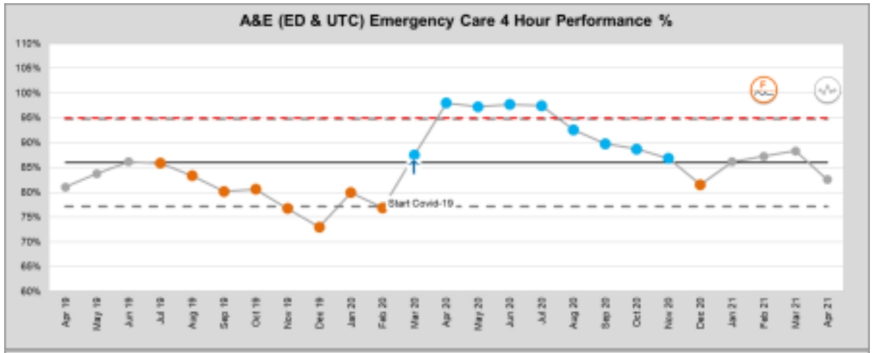
## How We Measure

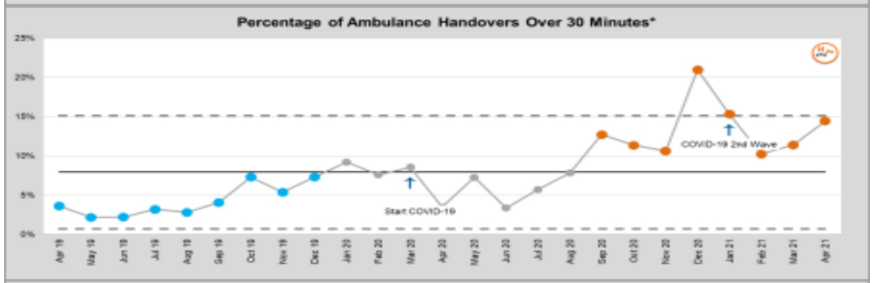
| | |
|---|---|
| Are We Effective? | Are We Responsive? |
| Are We Safe? | Are We Caring? |
| Are We Well Led? | Use of Resources |

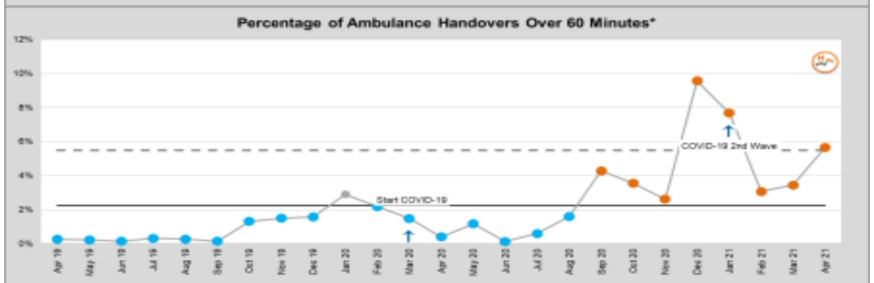
# 1. Emergency Access (4hr) Standard Target 95%

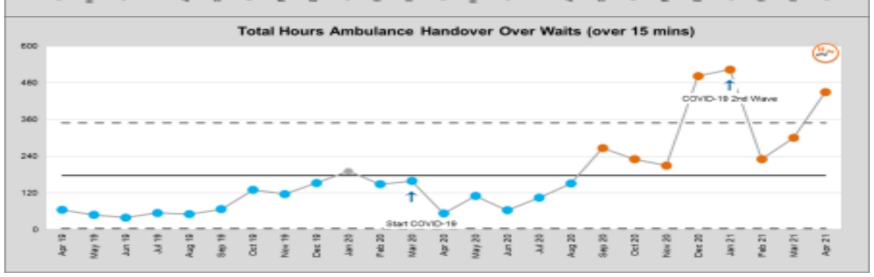
Data Quality Rating:

National Key Performance Indicators



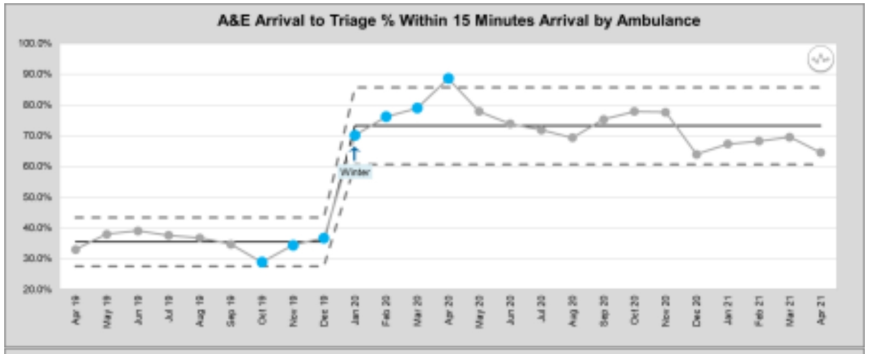



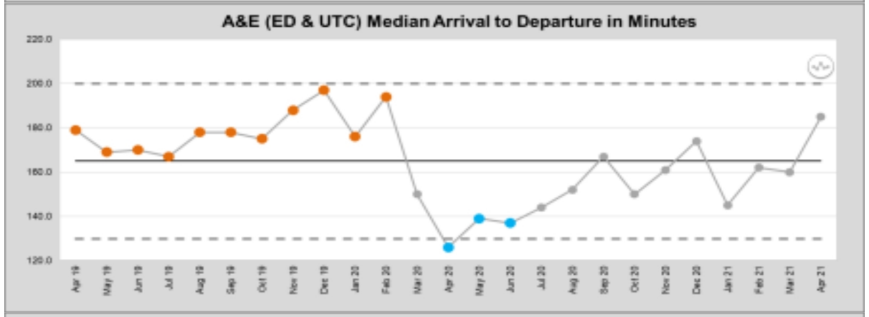



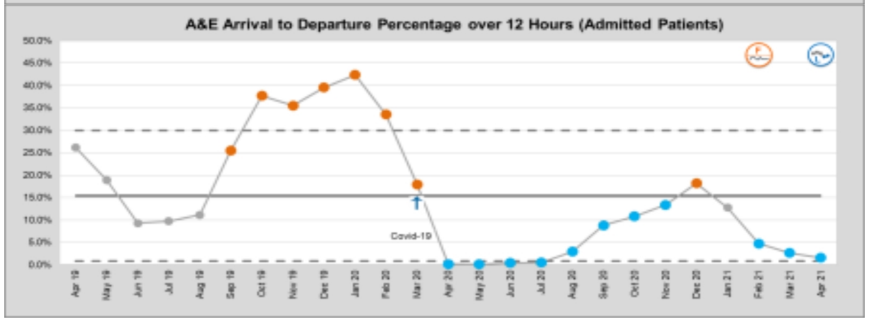

Performance Latest Month: 82.59% (Apr)

Attendances:
Type 1 72.97%
Type 3 94.04%

12 Hour Breaches (from decision to admit) 0

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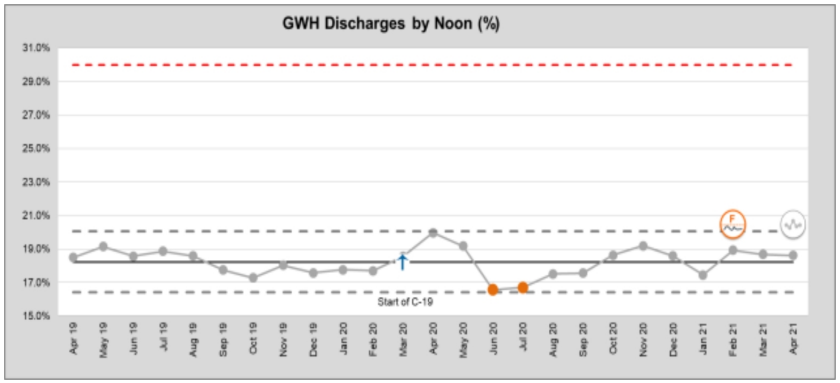
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

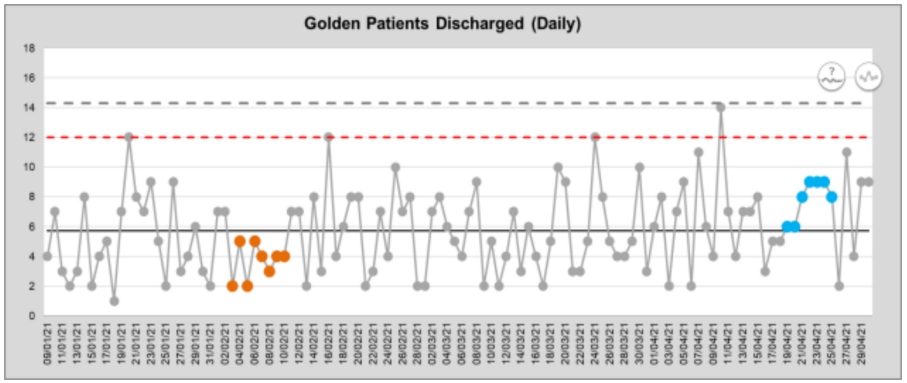
* Data from SWAST – 1 month lag

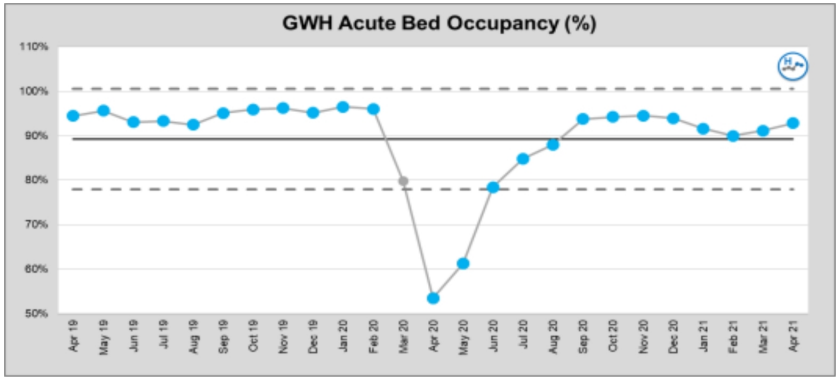
# 1. Emergency Access (4hr) - Patient Flow and Discharge

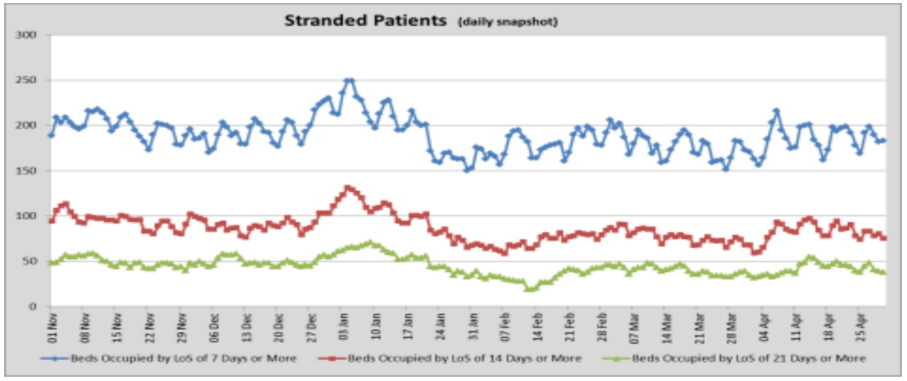
Data Quality Rating:

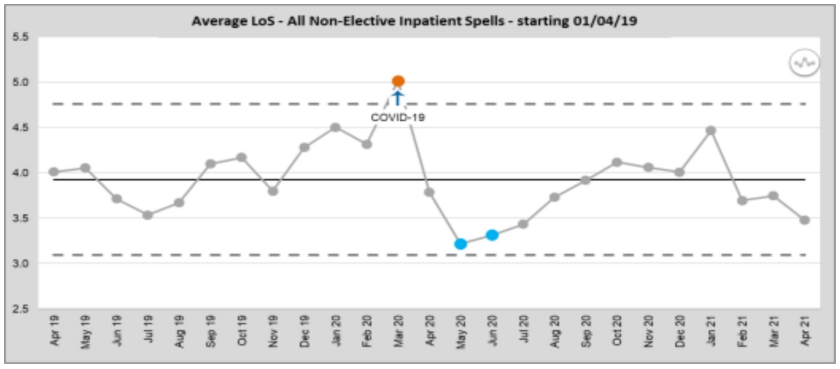
Are We Effective?

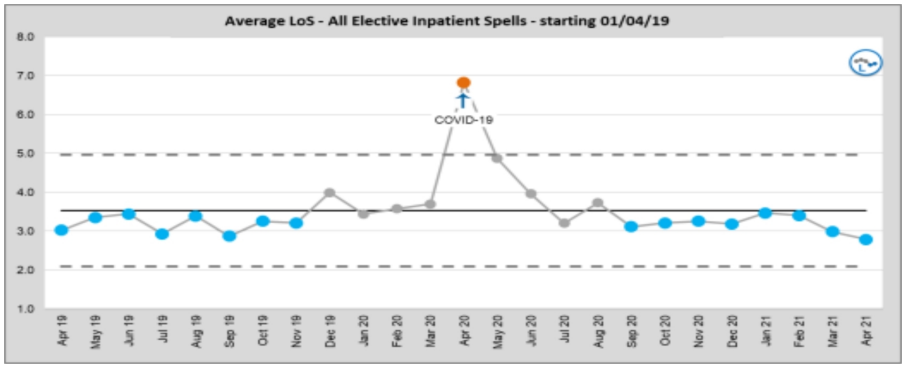



Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

# 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 5.71% in 4 hour breaches to 82.59% in April. There were 0 x 12 hour reportable decision to admit breach in April which is an decrease to the 1 reported in March.
Attendances have increased in April (from March) by 908 patients across both Type 1 (505) and Type 3 (403). The UTC saw a 45.7% increase in patients in March (1122 patients) and a further increase of 12.5% in April. 4 hour breaches within the UTC increased in April by 181 (34 reported in March and 215 In April.)
Breaches due to 'waits to be seen' in ED have risen to 45% the highest recorded since August 2020. Non admitted performance accounts for 30% of breaches, an increase of 10% on last month.

**Key Impacts on Performance**

Flow from to ED to base wards continues to be compromised resulting in 38% of breaches related to waits for inpatient beds. This is an improvement on last month (62%) and is a reflection of the decrease in ambulance handover performance resulting in more wait to be seen breaches.
There is a continual improvement in the number of patients waiting over 12 hours in the department, from a peak of over 20% in December reducing to 0% in April. One of the factors in this reduction is the creation of the Clinical Decision Unit (CDU) This is for patients to wait in a ward environment for diagnostics and treatments, Front Door Team (FDT) review and transport home.
Although we have seen a reduction in the number of patients waiting over 12 hours, the median length of time spend in ED has worsened by 15 minutes from Mar to April (160 minutes to 185.) This is due to bottle necks occurring awaiting for swab results (being addressed through improvement action 1) as well as an increase in attendances in UTC which is resulting in elongated length of time there.
The movement from assessment areas to inpatient beds is still not aligned to the demand profile in ED, resulting in late flow out of the department. As a result, this can impact on ambulance handover times and triage within 15 minutes.
Ambulance handovers delays over 60 and 30 minutes have increased in April, with 60 minute handovers increasing to 6% unvalidated by SWAST, (from 3.5%) but remaining below the high of 10% in December.

## What will make the Service green?

- Improvement in flow into inpatient beds, patients to move within an hour of referral.
- Flow to meet the demand of ED attendances to reduce probability of overcrowding or ambulance handover delays.
- 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
- The 'Way Forward' programme.

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

1. Lateral flow testing remains live in ED and CAU. The Abbott POC testing is being implemented in ED, to prevent bottle necks in flow / awaiting swab results, as turn around is much faster than PCR. **17 May 2021**
2. The 'Think 111 First' programme went live on 1 December 2020. UTC activity has increased through April. With fluctuations in local 111 providers, calls can be diverted to alternative systems. External systems do not all have access to the UTC booking system. Training process is being rolled out by CCG which will improve utilisation. **May 2021**
3. A review of Majors Step-down is being undertaken to ensure pathways remain effective in reducing admissions to inpatient beds. Work to integrate community rapid response services with step down are underway, along side the new 2-hour response time for rapid response services. **May 2021**.
4. Recent new starters in ED - Consultant mentorship has been introduced to ensure minimal delays in seen times. **June 2021.**
5. Review of patients transferred to ED via ambulance to understand the % who are discharged from ED with no treatment provided. **May 2021.**
6. ECIST will be onsite and in ED on Wed 12th May to undertake an observation review of ambulance handovers and ambulance delays to identify any ways in which they may be able to help and support. **12th May 2021.**
7. Amendment to 'wait to be seen' validation to include a second 'ambulance delay, wait to be seen' option. This will help identify whether the wait to be seen performance is improving once the patient is within the department. **May 2021.**



## Risks to delivery and mitigations

There is a risk that if patients continue to require Covid swabs when admitted to wards Cepheid swabs will not be sufficient to prevent bottle necks in flow. which in turn will put increased pressure on flow from ED. **Mitigation:** Cepheid swabs are run through labs in hours. The use of an Abbott point of care testing (POC) will be made available within ED in early May and testing takes minutes.

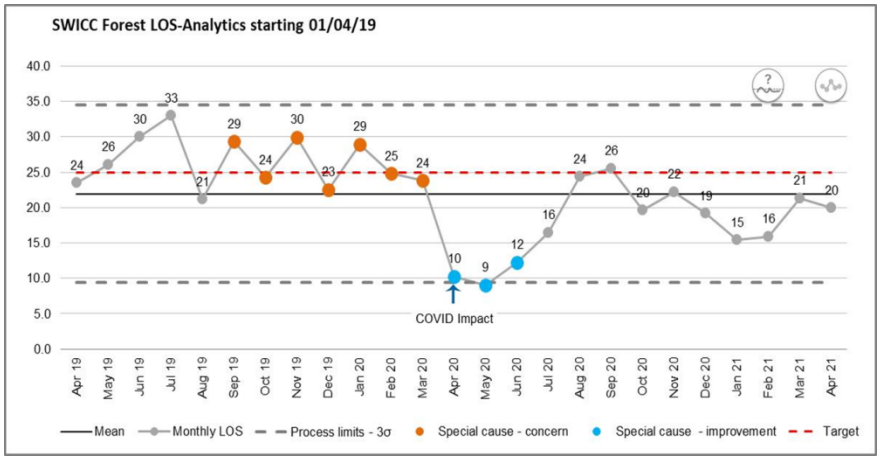
There is a risk that ambulance handover delays will continue to be seen due to a lack of flow out of ED. **Mitigation:** The split of blue and green beds across the Trust are reviewed 3 days a week in the 1pm Control Room meeting. At times of extreme pressure, further medical amber beds are created i.e., SAU to assist with flow. In addition, 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.

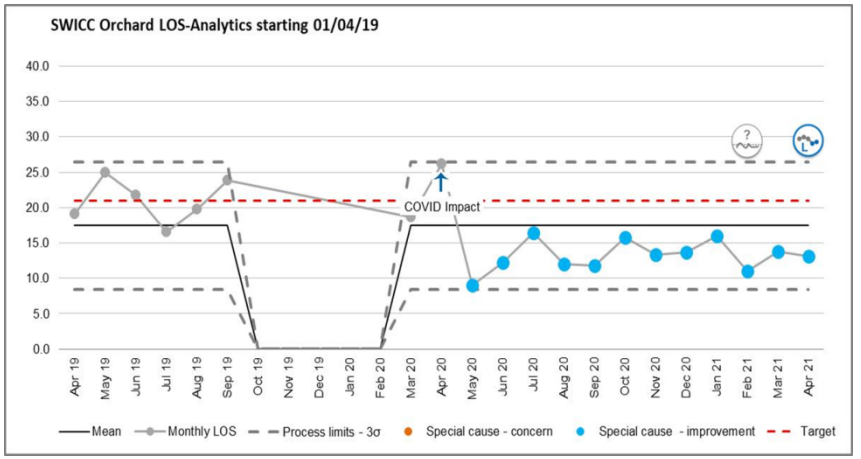
There is a risk that performance will be compromised given the significant increase in ED attendances**. Mitigation:** Work underway with Primary Care to understand measures they can take to help reduce attendances i.e. re=establishment of community wound care service at Moredon (staff had been redeployed from this service to support with pandemic response) 30 May 21. Review of DOS with 111 to ensure that the UTC is appropriately ranked as an option post triage. (31 May 21). UTC undertaking g a month audit of attendances to understand what other methods of health care people had attempted to access before attending and whether they were suitable to be seen in primary care (June 21.)

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

Data Quality Rating:

Are We Effective?




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

During April, the average LoS in Forest Ward was marginally below the 20-day target. Occupancy has increased to 98%. The average LoS in Orchard ward has decreased marginally from March to 14 days and occupancy returned to expected levels of 95%. These measures are within typical range (upper and lower SPC limits).

The average number of patients per month on the Stroke pathway is 15. During April there were 19 patients. This increase is likely to correspond directly with the increase in occupancy levels. This assumption will be checked.

Medically fit patients in Falcon ward were transferred the same day as declared medically fit 100% of the time in April. The integrated stroke pathway from end to end enables oversight of capacity and a flexible approach to ensuring that there is availability of a ring-fenced bed for a stroke patient.

Sunflower fully opened on the 18th Feb and occupancy levels have increased from 89% in March to 94% in April. The LoS for Sunflower stands at 13 days.

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

**Specialist Rehabilitation Pathway:**

A 'task and finish' group has formed and met initially on 29th April. The scope of this group is to address the current delays in access to specialist rehabilitation Units and to identify any internal process factors and to influence commissioners and external providers to achieve more timely responses

**Discharge Management:**

SwICC team join Integrated Discharge Calls 4 times a week to discuss complex cases. This regular dialogue proactively drives discharge decisions and promotes effective communication between the service and partners agencies.

## Risks to delivery and mitigations

**Risk:** delayed transfer and admissions to SwICC. Caused by internal transport delays and the requirement for 24-hour swabs .

**Mitigation:** Delayed transfers continue to be escalated daily. The names of patients are provided to site 24 hours prior to planned transfer. There is scope to further improve this, and an action plan will be developed.

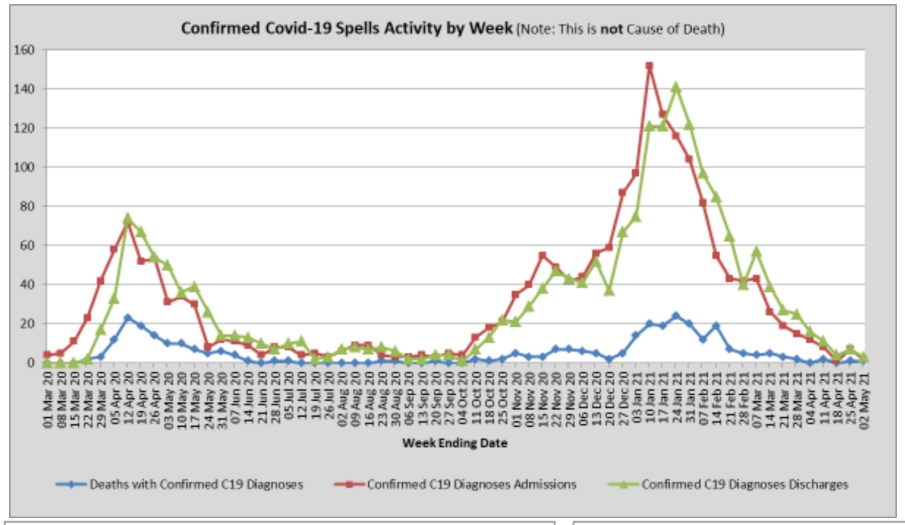
**Risk:** A lack of funding to maintain Sunflower which could significantly impact the Elective Recovery programme

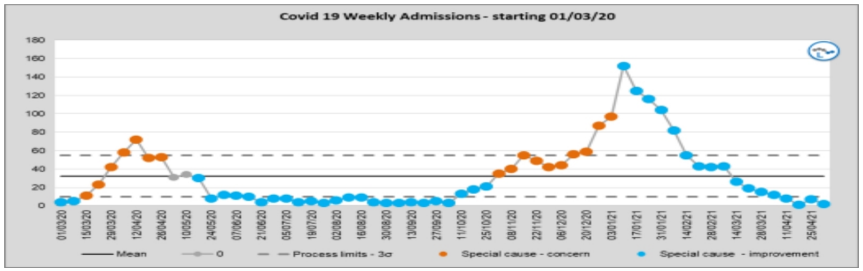
**Mitigation**: HDP funding secured for Q1 and Q2 with ongoing negotiation with CCG and SBC to secure full year funding of Sunflower and all D2A schemes in Swindon

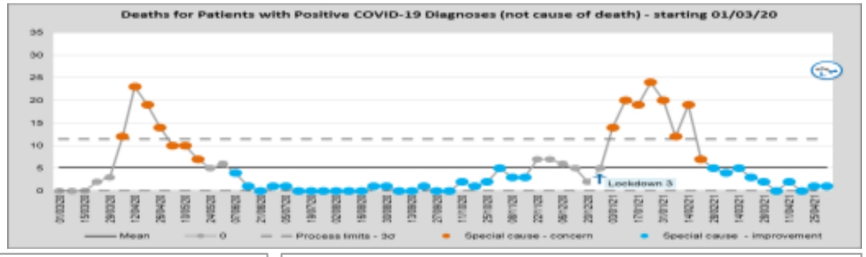
# 1. Emergency Access (4 Hours) Covid 19 Weekly Admissions

Data Quality Rating:

Are We Effective?




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

The graph above shows that attendances to the Covid Assessment Unit (CAU) have remained low through April. There have been an increased number of days with maximum occupancy, but most patients seen throughout the month have been determined as 'Green' pathway.

CAU continues to use point of care testing (POCT) for Covid-19 with allocated capacity of 10 fast-track swabs a day. Staff are managing this limited capacity, balancing clinical need versus flow, whilst ensuring samples are available overnight when there is no Pathology processing.

Referrals are ongoing to 'Covid Oximetry @ Home' and the 'Covid Virtual Ward' facilitating admission avoidance and allowing for earlier discharges.

Escalation and Ambulance SOPs are in place and there were no reportable ambulance delays in April for CAU.

The requirement to maintain a CAU was reviewed in April and the team are currently working up plans to close CAU in mid-June , subject to outcome of relaxation in lockdown rules / increased attendances. This may need further revising pending the 'Quarantine Hotel' opening, which is expected in May.

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

1. Review of CAU requirement and bed capacity. Likely need to maintain facility, and potential to re-open Shalbourne 6 bedded area. **June 21**

2. Review of CAU admission criteria (CS/EB) – this will apply to CAU as current set up or revise to enable patient admission through ED, dependant on #1. **May 21**

3. Increasing 'Covid Virtual Ward' catchment to include younger age group (50+) and Obstetric patients. **May 21**



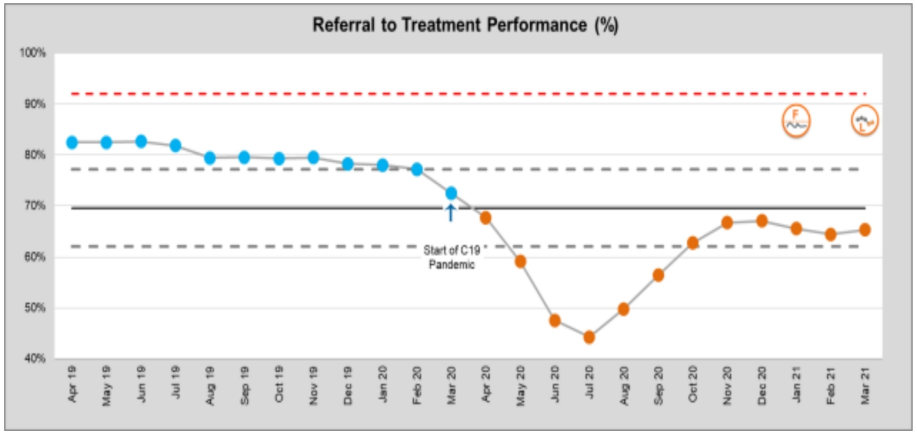
## Risks to delivery and mitigations

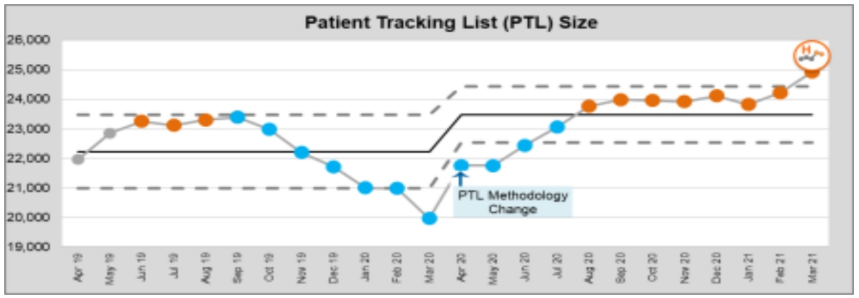
- There is a risk of delayed ambulance handovers in CAU due to delay in swab results limiting movement from CAU. **Mitigation** – Use of POCT/Cephid swabs and patients with high suspicion of COVID are managed with lateral flow testing at times of high escalation. Prioritisation of patient movement from CAU to free capacity.
- There is a risk of reduced flow from CAU due to allocation of Blue/Green beds. **Mitigation** – Flow and bed availability monitored throughout day. Green/Blue bed split in the hospital reviewed 3 days a week on the COVID control call.
- There is a risk of increased Covid Blue pathway attendances from mid-May due to provision of the 'Quarantine Hotel'
  **Mitigation –** Review attendances and act on trigger levels. Plan to extend Blue bed capacity into Shalbourne 6 beds (1), extend into MAU (2) and review if numbers continue to increase.

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

Data Quality Rating:

National Key Performance Indicators




| | |
|---|---|
| March Performance: | 65.31% |
| PTL Volume: | 24,929 |
| 52 Week Breaches: | R – 1,949, IM - 470 |

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

The Trust's RTT Incomplete Performance for March 2021 was 65.31%, which was an improvement of 0.88% in month. March saw referrals at 136% of the prior year and in line with the Pre-Covid 19 average.

The PTL increased by 705 in month, which puts us 1,682 adrift of our pre-Covid end of year trajectory. However, our current PTL is 4,066 below our Phase 3 end of year Target of 28,995. The main reason for this is primarily due to the forecast assumed a return to prior year referral levels which was only realised in March.

In March, we reported 1,949 x 52-week reportable breaches against a trajectory of 2,269. This was a decrease of 47 from February and of the 1,949 breaches, 426 (21.85%) of them are P5 and have opted to defer treatment until post-Covid. There were 470 in month 52-week breaches cleared in March which is a considerable increase over the rolling 3-month average of 243 per month. This increase is due to the increase in Elective Theatres following ICU de-escalation in Recovery 1.

Of the 1,949 reportable breaches, 1,597 are Admitted, 272 are Non-Admitted and 80 are Diagnostic.

Early estimates for April show a large reduction in 52-week reportable breaches, and we are estimating 1,650 post-validation. The main driver for this reduction is the number of patients who were due to breach in April was very low compared to previous months, due to a downturn in referrals during April-20.

**What will make the Service amber?**

- Utilising the Independent Sector (IS) capacity to aid RTT Recovery
- Improving Theatre Utilisation (limited gains in relation to the scale of the backlog).
- Improving Core Capacity through delivering Upper Quartile levels of productivity and throughput e.g., 4 Joint/8 Cataracts Lists
- STP approach to RTT Recovery/Recovery Plan delivery.

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

Daily Theatre Line Side Control meetings in place w/c 15/03/21, to monitor performance against required activity levels to deliver RTT performance. Key themes identified impacting utilisation. Utilisation in March (+4.3%) and April (+4.0%) has improved

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 and discussions ongoing with BMI Ridgeway to identify potential capacity. 189 patients transferred to IS in Q4 20/21, and 41 transferred April-21 following the mobilisation of the new arrangement.

Ongoing focus on clearing our 78 week + patients, with all P5 & P6 patients being contacted and clinically validated. So far P5 patients have reduced by 38% and P6 by 57% since 23/04/21, due to either being booked or treated.

Overall number of 78 week + patients reduced by 4% for the first week since monitoring began early May, with a submitted position of 316 patients on 07/05/21.

**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 May.

There is a risk that long waiting patients are cancelled due to bed pressures within the Trust, particularly MRSA protected beds for our long waiting Joint patients, who may go on to breach 104 weeks as a result.

**Mitigation:** Any potential non-clinical cancellations need to be escalated to Surgery, Women and Children's DD/DDD's to ensure all options are explored. Divisional DDoN working with clinical teams to try and reduce outliers.

There is a risk that we cannot fully utilise the IS capacity being provided due patient choice and a reluctance to travel, which 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.

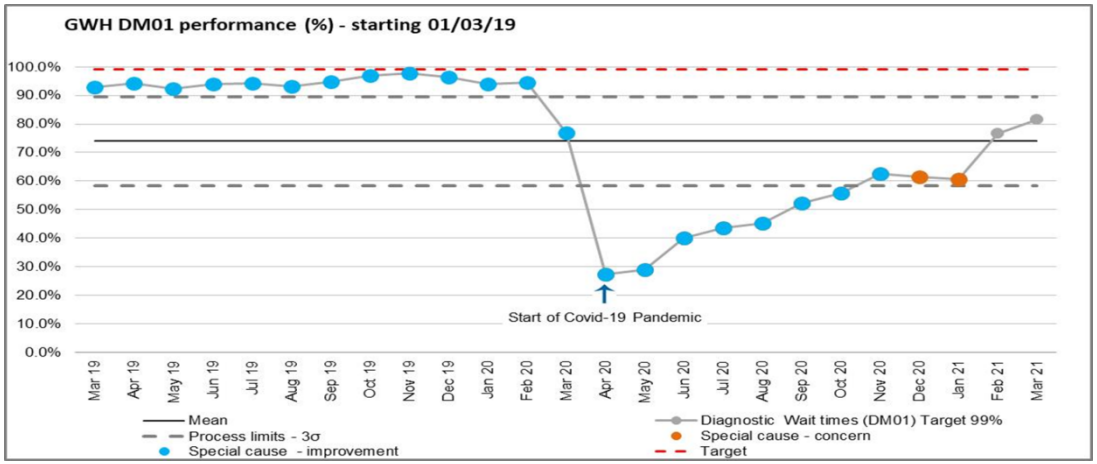


Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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

Data Quality Rating:

National Key Performance Indicators




| Waiting | < 6 Weeks | > 6 Weeks | Total WL | Performance % |
|---|---|---|---|---|
| Magnetic Resonance Imaging | 604 | 4 | **608** | 99.34% |
| Computed Tomography | 799 | 112 | **911** | 87.71% |
| Non-obstetric ultrasound | 2340 | 204 | **2544** | 91.98% |
| DEXA Scan | 165 | 0 | **165** | 100.00% |
| Audiology - Audiology Assessments | 256 | 1 | **257** | 99.61% |
| Cardiology - echocardiography | 194 | 37 | **231** | 83.98% |
| Neurophysiology - peripheral neurophysiology | 63 | 0 | **63** | 100.00% |
| Respiratory physiology - sleep studies | 69 | 36 | **105** | 65.71% |
| Colonoscopy | 256 | 374 | **630** | 40.63% |
| Flexi sigmoidoscopy | 111 | 210 | **321** | 34.58% |
| Cystoscopy | 23 | 13 | **36** | 63.89% |
| Gastroscopy | 191 | 155 | **346** | 55.20% |
| **Total** | **5071** | **1146** | **6217** 38 | **81.57%** |

**March 2021**

| | |
|---|---|
| Performance Latest | 81.57% |
| Waiting List Volume: | 6217 |
| 6 Week Breaches | 1146 |

## Background

Performance in March 2021 increased to 81.57% from 74.94% in February, with all services improving during the month. MRI and Audiology achieved 99% , Dexa and Neurophysiology achieving 100%, with Ultrasound at 91%. The number of breaches has reduced from 1387 in February to 1146 in March (-241). Overall, the total waitlist size increased from 5534 in February to 6217 in March (+683). Due to lack of CT van capacity during the month, we are predicting a drop in performance in CT to around 85% for April with an overall Trust DM01 prediction of 75%. It is currently predicted from May onwards this will continue to impact the overall Trust DM01 performance.

## Improvement Actions

To support the recovery trajectory, the following key actions are in place.

- Conversion of routine CT slots to cardiac CT slots. 3 adhoc CT van days have been allocated in April, with 4 in May.
- Additional MRI van capacity for Q1 within forecasted budget April-May extra 540 slots.
- Bank sonographer to be recruited into vacant to support delivery of a further 300 slots for Ultrasound backlog clearance.
- Echo relocation to nationwide until June with planned expansion of WCC to oral health once Nationwide finishes.
- 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 commenced in March 2021. Awaiting timeframe for completion.

**Risks** (Risk1855= 15) Failure to deliver DM01 for Imaging (risk remains reduced). Insufficient capacity to recover the backlog remains the greatest risk to recovery. CT van availability has been relocated regionally by NHSE and now remains in limited supply. 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 44% performance in March which is an increase of 8% from February. The number of referrals received in March increased from 666 to 913 and so becoming more in line with the average of 997 referrals received each month from Oct to Dec 2020. There are 58 P5/P6 patients on the wait list (reduced from 75 in February). 370 of the reportable breaches in March were surveillance patients (50%.) This has reduced from the 527 in February but is a higher % total of the wait list. Lists are now being booked to 12 points at weekends. Text initiative commenced to remind patients they are on the wait list so to contact to book an appointment with a 30% response rate to date. DNAs continue to be a concern, but no approval received to enact Trust Access Policy. BSW are providing one of the highest rates of Endoscopy procedures per 100,000 population nationally and are the best performing system in the Southwest. Awaiting approval options submitted as part of the Endoscopy recovery business case.

**Radiology:** Combined DM01 performance improved from 87.1% in February to 92.43% in March with an increase in waiting list size to 4228. There was a further decrease in patients waiting over 6 weeks (-182) with a total of 320 breaches. Dexa and MRI achieved the 99% target in March. NHSE have reallocated CT van capacity across the Southwest, which will impede the CT recovery trajectory from May on-going 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 79% of CT DM01 performance during this period.

**Echo:** Performance improved from 80% in Feb to 83.98% in March. March saw a significant increase in the overall wait list from 35 in Feb to 231 in March, (Infomatics CVIS data grab adjustment rather than increase in demand) with Aerosol generating procedures Trans Oesophageal Echo (TOE) and Stress Echo (DSE/ESE) solely comprising the wait list breach list of 37 referrals. Routine Echo is now being booked <6 weeks. Echo wait list activity increased from 492 procedures in Feb to 571 in March.

## 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) and Cardiac Radiographers (3WTE) to increase capacity for cardiac CT provision.

**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. **April 2021.**
2. Review of whether the service can provide two evening weekday sessions a week with current staff and the cost associated for review**. May 2021.**

**Radiology:** A further 27 days (540 slots) of MRI van capacity has been secured in April and May 2021 with recovery expected to continue to deliver MRI DM01 in April and May. **CT**: CT van capacity is being sought from NHSE with a range of actions being implemented to mitigate the loss of van days. No IS capacity is CT Cardiac slots have been increased on CT1 and booking in progress (oldest date for cardiac is 24 November 20). NHSE are seeking a cardiac CT solution across the Southwest. Additional hours have been offered to run extra CT lists.

**US**: An additional US machine has arrived in April. Recruitment of 2 WTE Sonographer's in progress following reallocation of budget.

**Echo:** Waiting List Initiative (WLI) ceased as of 31 March 2021. A new Echo Qualified Cardiac Physiologist started on 22 February with an additional 1 x Band 6 Physiologist starting in April. An offer has been made to another Band 6 candidate following successful interview. 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 on both clinics.



## Risks to delivery and mitigations

**Endoscopy**: There is a risk that the sickness and vacancies within the Endoscopy booking team will not be resolved in month. **Mitigation** - an additional substantive booker has been recruited and support is being provided from across the other Divisions.

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.

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

- NHSE approached for further CT van capacity and have agreed 4 ad-hoc van days in May.
- Additional Cardiac CT sessions offered to staff
- NHSE seeking further CT cardiac capacity.
- Additional US machine delivered, room, being prepared for use.
- Bank Sonographer in post covering maternity leave, additional sonographer recruited.
- Shielding staff member back at 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) which will increase wait times. Work to conduct the splitting of room 042 has been approved to double its capacity and will commence May 21. A bid has been submitted 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.

# Annual Cancer Performance 2020/21

Data Quality Rating:

National Key Performance Indicators

| Measure | National Target | Local Target 2020/2021 | Performance 2020/2021 |
|---|---|---|---|
| Cancer Performance (62 days) Q1 | 85% | 85% | 82.0% |
| Cancer Performance (62 days) Q2 | 85% | 85% | 79.3% |
| Cancer Performance (62 days) Q3 | 85% | 85% | 86.3% |
| Cancer Performance (62 days) Q4 | 85% | 85% | 86.9% |
| Cancer Performance (62 days) 2020-21 | 85% | 85% | 83.6% |
| Cancer performance (2WW) Q1 | 93% | 93% | 93.8% |
| Cancer performance (2WW) Q2 | 93% | 93% | 93.8% |
| Cancer performance (2WW) Q3 | 93% | 93% | 83.7% |
| Cancer performance (2WW) Q4 | 93% | 93% | 78.2% |
| Cancer performance (2WW) 2020-21 | 93% | 93% | 86.7% |

Cancer performance has been well maintained through a challenging year coping with the pandemic. Endoscopy services were restricted during wave one of the pandemic as it is an aerosol generating procedure resulting in many long waiting patients. With appropriate infection control and prevention measures, services recommenced and with clinical nurse specialist support many of the long waiting patients attended diagnostic investigations with quarter two seeing these patients treated. Through wave two, there has been close management of the patient tracking list working closely with services and clinicians to ensure pathways have continued and patients felt confident in attending. Whilst we have seen some monthly variation in performance, overall we have achieved quarter three and four performance for 62 day performance and for the year overall 62 day performance of 83.6%.

Two week wait (2ww) performance has been challenging, initially due to diagnostic capacity and latterly due to pressures within breast services due to an increased number of referrals following breast cancer awareness month and social distancing requirements within the unit. Staff have been undertaking additional wait list initiatives to maintain baseline activity, this has not managed the backlog. The team have a trajectory to support recovery this financial year which is dependent on delivering weekly wait list initiative clinics and appropriate staffing. Despite not achieving 2ww performance we have maintained 62 day performance not compromising patient care and outcomes

# Cancer 2 Week Wait Performance Target 93%

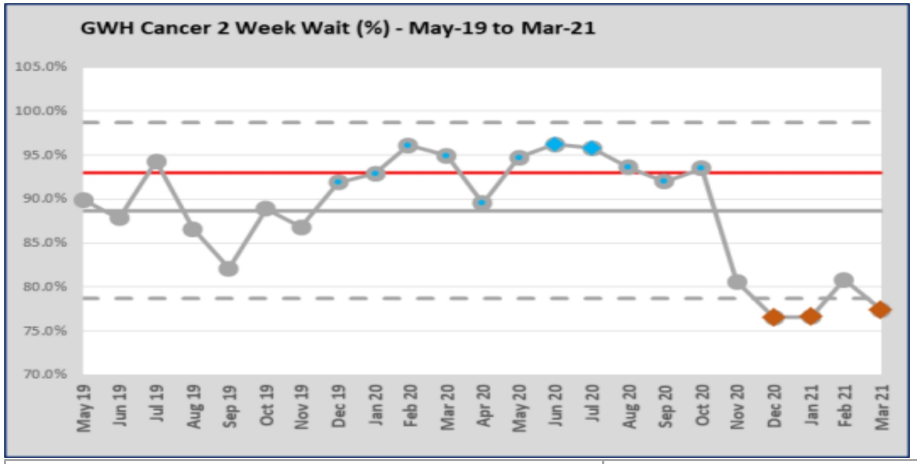
Data Quality Rating:

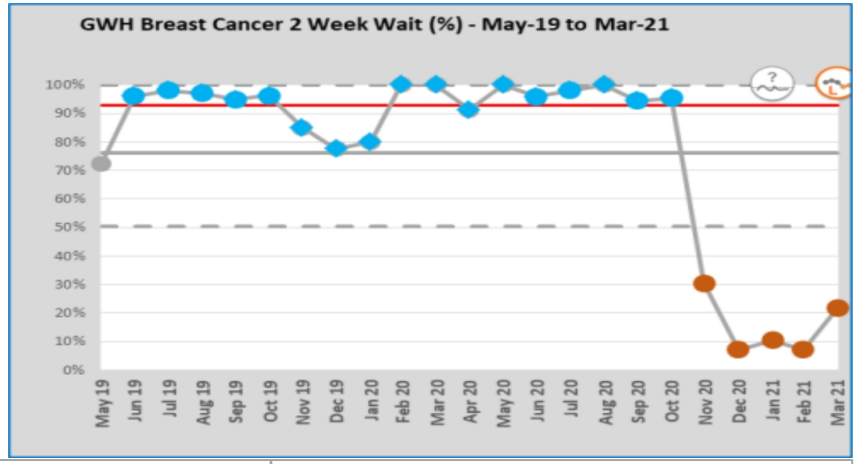
National Key Performance Indicators

Performance Latest Month: **March**

Two Week Wait Standard: 77.4%

Two Week Wait Breast Standard: 21.7%




**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 during breast cancer awareness month (October) as anticipated From this point the breast service have been unable to maintain 2ww performance due to physical distancing requirements in the breast unit as a result of COVID restrictions. To maintain usual capacity the team, need to deliver 1 wait list initiative (WLI) clinic each week. This had not been possible due to staff fatigue and payment resulting in a backlog. March has seen an improvement in performance due to additional activity being undertaken as part of the recovery plan. The service is currently booking first appointments up to 27 days from referral.

The standard was not met in upper GI as a result of outpatient capacity, patient choice and processing delays in the cancer administration team (OPD). Patient choice and the reluctance of patients to attend the hospital as a result of COVID remains a challenge within endoscopy.

**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 April, May & June to help recover position. The forecast and trajectories show that the additional WLI clinics are required to recover and maintain 2ww performance. The service are auditing the updated 2ww referral form to guide triage if required and most suitable first appointment.

2. Review of breast 2ww pathway at Thames Valley Cancer Alliance (TVCA) breast clinical advisory group (CAG) with further TVCA GP training event in April.

3. A review of job plans is being undertaken within the Breast service, including the provision of the weekend clinics and screening administration to review service requirements and workforce.

3. Endoscopy continues to deliver procedures within 2 weeks. TVCA request to protect Endoscopy services and Gastroenterologists not to be working on Trust medical rota. Endoscopy Service have recovery plan and maintained cancer activity.

4. 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). 41.7% of all Lower GI referrals had Qfit completed in April. Swindon PCN is proactively managing non-compliance.



**Risks to delivery and mitigations**

1. Risk: Delays to breast unit build will impact recovery trajectory

Mitigation: The completion date for handover of the room is the 10 June.

2. Risk: UGI clinic capacity

Mitigation: Locum recruited to support activity and Saturday lists Endoscopy.

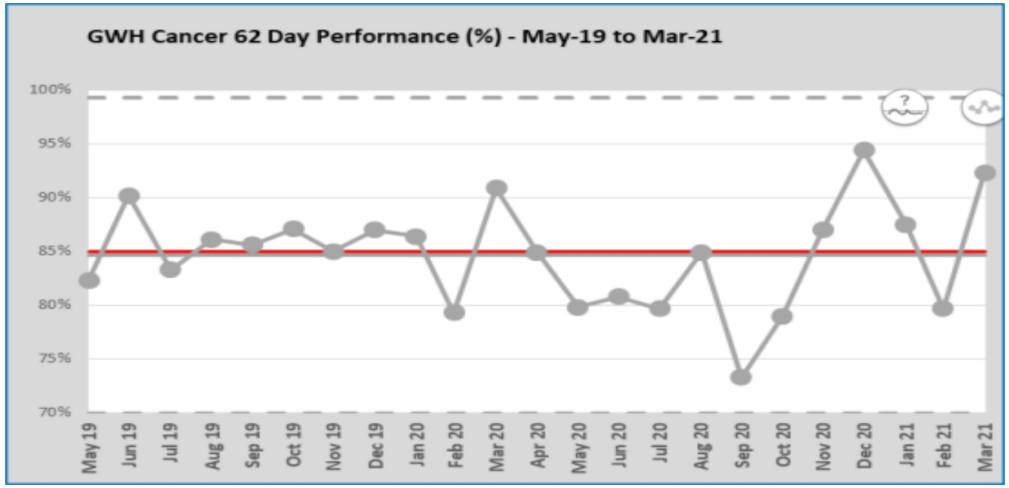
3. Risk: Patient reluctance to attend during easing of national lockdown.

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.

# Cancer 62 Day Standards Performance Target 85%

Data Quality Rating:

National Key Performance Indicators




Performance Latest Month: **March**

62 Day Standard (Target 85%): 92.3%

62 Day Screening (Target 90%): 91.4%

62 Day Upgrade (local standard 85%): 90.6%

**Year end performance**

| 2020/21 | Q1 | Q2 | Q3 | Q4 | Total YTD |
|---|---|---|---|---|---|
| 62 Day | 82.0% | 79.3% | 86.3% | 86.9% | 83.6% |

**Background**

March 62 day performance is anticipated to be 92.3% with the Trust achieving the national 62-day standard.

The performance for March 2021 had been predicted to be challenged, however due to 7 diagnosed pathways rolling to April or May and a higher number of treatments than anticipated, the standard will be met with a performance of 92.3%. Capacity at tertiary provider accounted for 4 of these cases(2 Gynae, 2 Urology), patient choice 1 (Gynae) and complex cases the other 2(Skin & UGI).

March pathway breach reasons included delays for pathology(Urology), delays for outpatient follow up (Breast & LGI)and the cancelation of a procedure due to clinical priority(Skin). There were also 4 complex pathways (Gynae, Haem, Lung & H&N) that required additional diagnostics and discussion before treatment could be planned. Also, 4 pathways had been referred to a tertiary centre before day 38 resulting in no breach to GWH.

In March the screening standard was met. A breast patient was sent to GWH on day 80 of the pathway. Patient required second opinion on treatment options before proceeding. A bowel screening patient breached the pathway standard due to delays with the colonoscopy following their first OPA. There were also delays with the booking of the treatment due to surgical capacity.

The upgrade standard was also met in March. Two lung patients treated out of timeframe had been sent to OUH outside of 38 days due to first appointments being cancelled through patient choice. A Sarcoma patient was sent to the OUH within 38 days and will not result in a GWH breach.

**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.

3. TVCA dashboard completed for reporting Alliance and Trust cancer performance and is now live with drop in training events completed for operations managers. Training events in April for the clinical teams were held.

4. TVCA continue to monitor priority 2 (P2) patients to ensure patients offered treatment in a timely manner across alliance and mutual aid brokered by COOs. Mutual aid discussed fortnightly at secondary care clinician call. Intensive care capacity improving across region supporting complex surgeries particularly for Head and Neck and Upper gastro-intestinal patients.

5. 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 fortnightly cancer recovery meetings.

6. Gynae, urology, colorectal & skin pathway process mapping exercise to support improvements in diagnostic pathway are being completed in April.

7. 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. This saw 204 slots freed up in March.

**Risk to Performance Delivery**

1. Risk: April performance is expected to be challenged with a number of patients being treated outside timeframes yet to have a formal diagnosis. Current forecast based on only diagnosed patients is showing the standard performance being met, however the undiagnosed risks could see performance low 80%.

The impact of fewer CT van sessions is impacting on the service being able to offer earlier scans to help bring pathways forward. Radiology actively managing cancer referrals.

Mitigation: Twice weekly PTL meetings continue to be held and fortnightly cancer recovery meetings to progress pathways and improvement work.

Outpatient capacity issues in both the upper and lower GI pathways is resulting in delays to follow up activity. Lower GI registrar clinic streams increased in March which helped create 204 additional slots for consultant outpatient activity. Further work to review the registrar clinic templates is underway which will help increase the number of follow up slots for benign work.

The skin pathway is being mapped to review improvements for patients requiring a diagnostic biopsy before surgery by the end of April. This will also help support earlier referrals to the plastics team.

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

Delayed first appointments in the Breast service may start to impact the 62-day target where capacity for follow ups is lost/repurposed. The weekly PTL review meeting with the heads of service and the weekly surgical review meeting is mitigating some of this risk by identifying patient pathways suspicious for cancer as early as possible and plans put in place to expedite where needed.

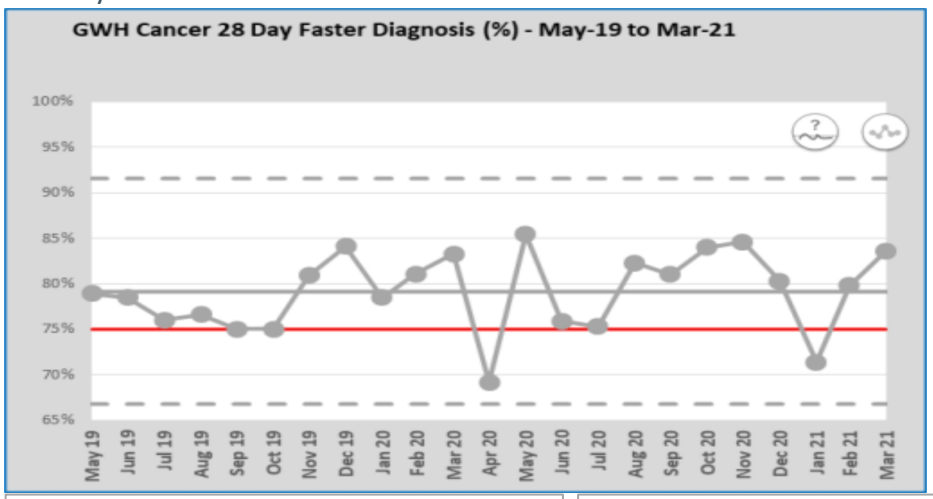
# Cancer 28 Day Diagnosis Target 75%

Data Quality Rating:

Are We Effective?

Performance Latest Month: **March**

28 Day FDS 84.0%




Year end performance

| 2020/21 | Q1 | Q2 | Q3 | Q4 | Total YTD |
|---|---|---|---|---|---|
| 28 FDS | 75.5% | 79.1% | 82.9% | 78.6% | 79.4% |

**Background**

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

Planned national reporting from April 2020 is likely to remain suspended until September 2021 and in the interim, we will continue to shadow report.

For many tumour sites, multiple diagnostics are needed before a cancer diagnosis can be excluded providing challenges in achieving 28-day faster diagnosis standard. There have also been delays with producing results letters following a review of completed diagnostics.

Gynae pathways are being affected by delays with Oxford pathology reporting and with follow up reviews due to clinical capacity (consultant maternity leave).

March is forecast to be compliant with the standard.

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

1. Virtual outpatient follow up remains in place across several sites to communicate excluding a cancer diagnosis.
2. Thames Valley Cancer Alliance (TVCA) transformation work restarts with focus on lung and colorectal pathways and scoping for rapid diagnostic services. GWH will focus on lung pathway with baseline mapping undertaken in April.
3. 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. A process for noting these in the PTL and for notifying the heads of service was implemented in February and monitored via cancer recovery fortnightly meetings.
4. FDS improvement work with each service to support sustainable model for communicating diagnosis within 28 days to be undertaken Q1.
5. TVCA funded colorectal straight to test nurses to commence in May 2021.

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**Risk to Performance Delivery**

1. Risk: Delayed access to diagnostic tests will impact on 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: Breast 2ww pathway delays will result in delays to faster diagnosis standard.

Mitigation: Incentive payment to imaging assistants to undertake wait list initiative clinics and training of additional staff to support future clinics. Clinics planned for April. May and June. Job plan reviews being undertaken to assess ability to continue this activity as business as usual.

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.

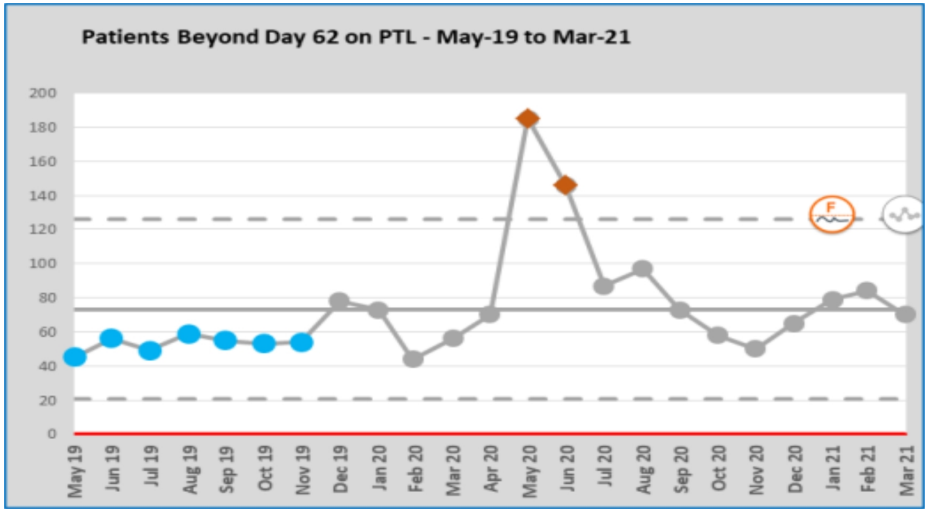
4. Risk: Delays to follow up appointments in colorectal, as a result of consultant capacity, will impact on the delivery of diagnosis.

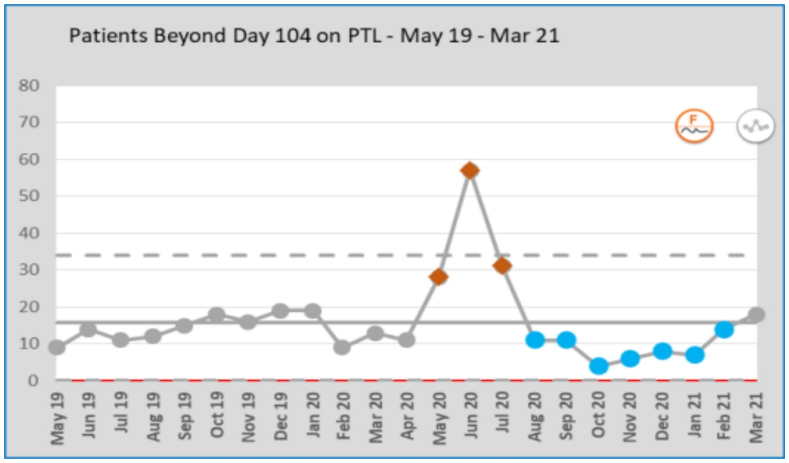
Mitigation: Colorectal service has recruited two registrars to support clinics commenced in March. Additional slots for consultant clinics have been identified.

# 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: March: 4 Patients; 2.0 breaches (IPT)

**Treated at OUH**

**Skin: 1 patient-1.0 breach:** Appointment for biopsy had to be cancelled at short notice due to the clinical urgency of another patient. This resulted in a delay to the patient being referred to the plastics team, where further biopsies were required of other lesions before treatment was planned at OUH. ITR beyond day 38, full breach to GWH

**Urology: 1 patient-0.5 breach**: Early diagnostics booked to KPI limits, the pathology from Bristol was delayed resulting in a relist of patient at MDT leading to a late treatment discussions and subsequently the transfer to Bristol for surgery. Patient was for 'all options' with choice and thinking time delaying the pathway further

**Haematology: 1 patient- 0.5 breach:** This was complex pathway that started in Head & Neck before moving over 19 days into the pathway. Repeated PET scans and Ultrasounds were required before treatment could commence. There was a change in planned management of the disease from excision to radiotherapy.

The other breach related to a Skin pathways transferred to Oxford before day 38 , therefore no breach is recorded against GWH..

April is likely to see 3 patients breach 104 days on their pathway resulting in 2.0 breaches. (IPT)

The high number of 104day+ pathways on the PTL is in part due to a high number of patients (9 out of 18) that do not have cancer and are awaiting confirmation of their non cancer diagnosis. Of these 3 are in the plastics service. Additionally, there are 6 patients on a Plastic pathway at OUH awaiting pathology from procedures completed or dates for procedures. OUH provide weekly updates on GWH patients under their care.

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

1. The "Managing Long waiting cancer patients (72 day+)" Standard Operating Procedure (SOP) proactively monitors all patients over 72 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.
2. This report continues to be shared with the Medical Director for executive clinical oversight fortnightly.
3. 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.

**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: TVCA monitoring long waiting patients and HDU capacity steadily improving.

3. Risk: Patient reluctance to attend during lockdown and 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.

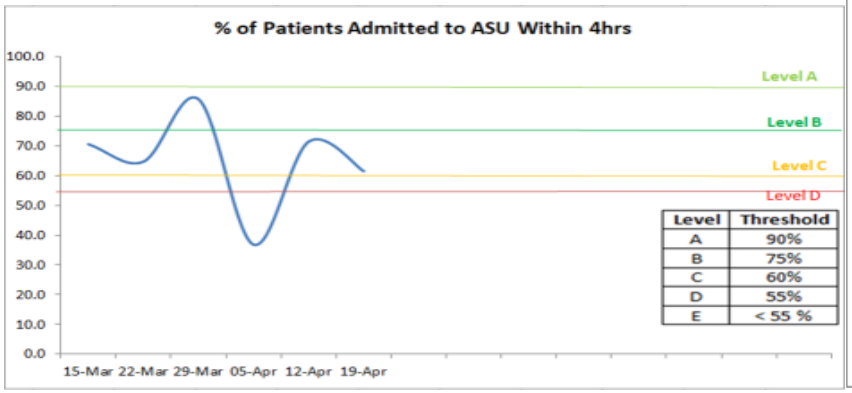
# Stroke Pathways

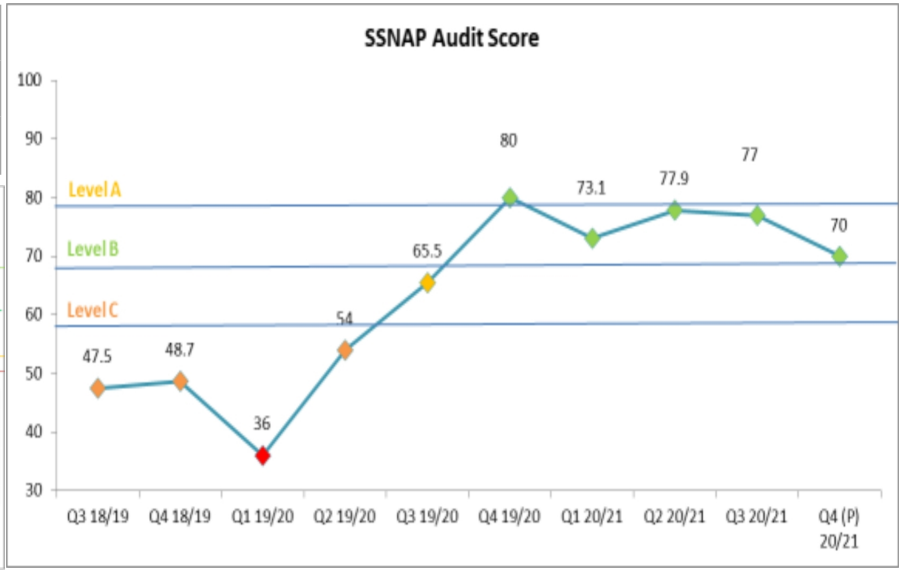
Data Quality Rating:

Are We Effective?

## GWH SSNAP Case Ascertainment Audit Score:

| Year | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 2019-20 | E | D | C | B |
| 2020-21 | B | B | B | B |




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

The latest SSNAP prediction for Q4 is at Level B. We have seen a slight decline in performance in Q4. This is attributed to the Physiotherapy/Occupational Therapy (PT/OT) teams carrying 3 vacancies at present across the Acute and Rehab team and so are currently stretched. The PT/OT metric is the only SSNAP performance that is predicted to lower for Q4.

Confirmation of the B performance is expected in Mid June from SSNAP. For the last 4 quarters ,the final confirmed score has been 3-4 points higher than the prediction and so current expectations is for the final score to be 73 to 74 (B)

Admission to the Acute Stroke Unit within the 4 hour performance window has seen some improvements over the Q4 reporting period.

There was a dip in performance within this metric at the start of April however. Analysis showed that of the 12 breaches, 8 were not felt to be stroke on admission, 1 was clinically unstable to move, 1 had no male bed available, 1 was awaiting swab results (no side room available) and 1 was Fast positive – awaiting ED narrative. Of the 12 breaches, 83% occurred Out Of Hours.

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

1. PT/OT Team currently out to recruitment for 3 x therapists. **Jun 21**
2. Development of business case to support increased OOH stroke cover. May 21
3. ASU to record time of admission to GWH as part of board round in order to allow for early consultant review in time order of arrival where appropriate. **May 21**
4. ED Nurses to shadow Stroke Specialist Nurses to improve knowledge and confidence with Thrombolysis. **May 21**
5. Meet with SWICC to improve patient transfers from ASU to SWICC to efficiently free up beds. **May 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 and feeds back to Divisional Director on performance. IR1s are completed for any breaches of SOP to drive improvement performance. **No breaches since w/c 11 Jan 21**

There is a risk that the PT/OT team vacancies will continue to impact the overall performance of Stroke whilst they remain unfilled.

**Mitigation** – Currently out to recruitment for WTE gaps. Review of current team is underway to understand and then redeploy resource where safe to maximise capacity available.

Great Western Hospitals NHS Foundation Trust

# Board Assurance Report

| Quality & Governance Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Dr Nicholas Bishop** | Dr Nicholas Bishop | | 20 May 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 | | | |
| Trust Mortality Audit | Amber | Green | There remain some outstanding actions in relation to fulfilling the functions of a Trust Mortality Team and the appointment of a fourth Medical Examiner. The leadership of this has item improved and progress has been made | Updates will be provided at future Quarterly Mortality Updates.<br>A copy of the paper will be referred to next ARAC. | |
| IPR | Amber | Green | General assurance on all items. Under the Perinatal Quality Surveillance Tool the Trust remains just short of compliance with 1:1 labour care at 97.7%. Also Consultant presence on the labour ward is at 57 hours/week not 60. The team is working on this and plans to reach compliance in the next month or two. The committee expressed a wish to return to provision of Caesarean Section rates in future reports in order to compare with national benchmarks. | Address compliance with maternity indicators<br><br>Provide CS rates | |
| ED Dashboard | Amber | Green | Attendances to the Emergency Services had increased significantly since Feb '21 and are now at a higher level than Pre-Covid. This is putting | | |

Great Western Hospitals NHS Foundation Trust

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| | | | pressure on the department and on the bed state but there remains a determination not to revert to corridor care. Length Of Stay (LOS) within the dept have increased with deterioration in compliance with targets including delayed Ambulance offloads.<br>Compliance with the Shine Checklist is green throughout. However since March five additional standards have been added to the list by the department. These relate to Skin assessment and progress is already being made though not yet green. This will assist our reduction in Pressure Ulcers. | | |
| Patient Experience | Green | Green | Good progress is being made. Complaints numbers have reduced but Concerns have increased. Friends and Family responses continue to increase since text responses were introduced. Many of the themes in these responses featured in both positive and negative but the positive ones far outweighed the negative. Eg. Staff attitude 2658 + v. 222 - | | |
| Clinical Audit and Effectiveness Quarterly Update and Effectiveness Programme | Amber | Green | Some deadlines for completion of reports remain overdue although there have been improvements generally. The committee encouraged senior medical management to look into these late reports as there was a potential performance issue relating to individuals. | MD and Deputy MD to look into late reports by individuals. | |
| Quality Accounts | | | The Chief Nurse informed the committee that Quality Accounts that had been shelved by NHSE because of the pandemic, were now required to be submitted by end of June. This left little time to address and almost no time for full consultation with outside parties. The CN had decided that the focus for the QAs would be 3 items: 1. To reduce Pressure Ulcers 2. Listening to Patients and 3. Flow of patients. The Committee agreed this decision. | | |
| | | | | | |

| Issues Referred to another Committee | |
|---|---|
| **Topic** | **Committee** |
| | |

Great Western Hospitals NHS Foundation Trust

# Part 2: Our Care

## 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?

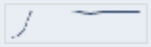
Are We Caring?

Are We Well Led?

Use of Resources

# Our Care Summary

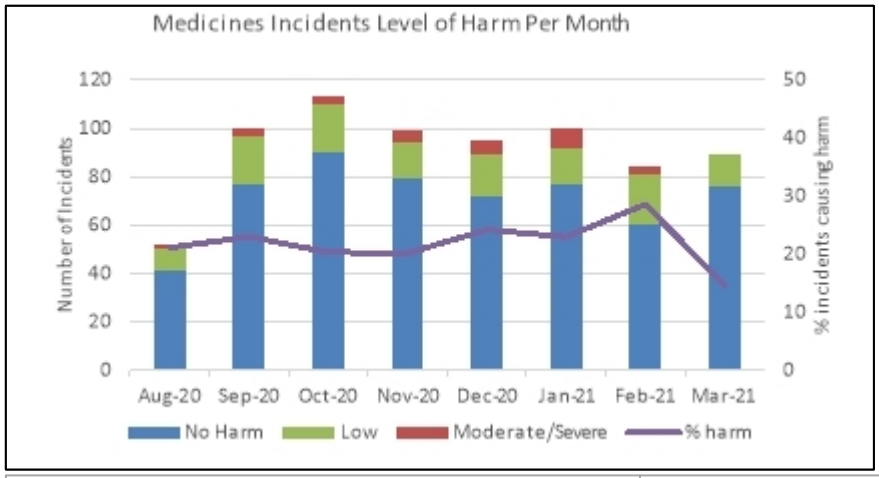
Great Western Hospitals NHS Foundation Trust

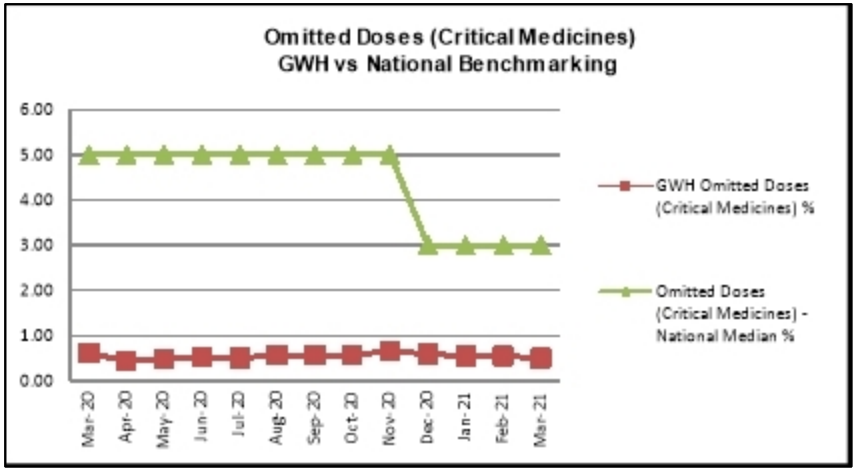
| KPI | Latest Performance | Trend (last 13 months) | Public View (Latest Published Data) | | | |
|---|---|---|---|---|---|---|
| | | | National Ranking | Bath Ranking | Salisbury Ranking | Month |
| Dementia Assessment (Public View) | 86.1% (Feb 21) |  | 61 | 1 | 1 | Feb 20 |
| *C. Difficile (Hospital onset) per 1000 bed days* | 11.2 (Feb 21) |  | 22 | 51 | 37 | Feb 21 |
| VTE Assessment | 98.9% (Feb 21) |  | 18 | 114 | 1 | Dec 19 |
| Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death) | .91% (April 21) |  | 121 | 116 | 76 | Dec 20 |
| Hip Fracture Best Practice Tariff – 12 Month Rolling | 68.1% (Mar 21) |  | 36 | 89 | 4 | Mar 21 |
| Complaints Rates | 25.7 (Q4 20/21) |  | 112 | 32 | 47 | Q2 20/21 |
| Family and Friends Score – Percentage of Positive Responses - Inpatients | 83.8% (Apr 21) | | 103 | 19 | 7 | Feb 20 |
| Complaints Response Backlog | 0.1 (Q2 20/21) | | 2 | 90 | 59 | Q2 20/21 |
| MRSA all cases | 0 (Apr 21) | | 48 | 95 | 69 | Feb 21 |
| Falls per 1000 bed days | 6.1 (Apr 21) |  | | | | |
| Pressure Ulcers – Acute | 26 (Apr 21) |  | | | | |
| Pressure Ulcers – Community | 18 (Apr 21) | | | | | |
| Never Events 20/21 | 3 | | | | | |
| Serious Incidents | 2 (Apr 21) | | | | | |

# 2. Medicines Safety

Data Quality Rating:

Are We Safe?




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

**Medication Incidents**

- Rate of medication incidents and the proportion causing harm remains stable across the year. This indicates a consistent reporting culture and systems in place that prevents harm to patients.
- Trends Identified in March:
  - Medicines administration identified as causative factor in approximately half of incidents.

**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*), 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**

- All medication incidents are reviewed at the Medicines Safety Group to ensure learning, identification of trends and themes, and collaboration across the BSW healthcare system on improvements.
- Quality Improvement Project underway within the Emergency Department to focus on penicillin allergy incidents. Task & Finish group to oversee QI work expected to share learning and improvement in May.
- Medicines Administration Errors identified as a priority area of focus through the Medicines Safety Group. Working group currently in development to explore and understand root cause of areas, and sustainable improvement strategies.

**Omitted Critical Medicines**

- Omitted Medicines are audited as part of Perfect Ward App. The information has recently been updated and circulated to ward areas which details how to securely order medication out of hours.

**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.

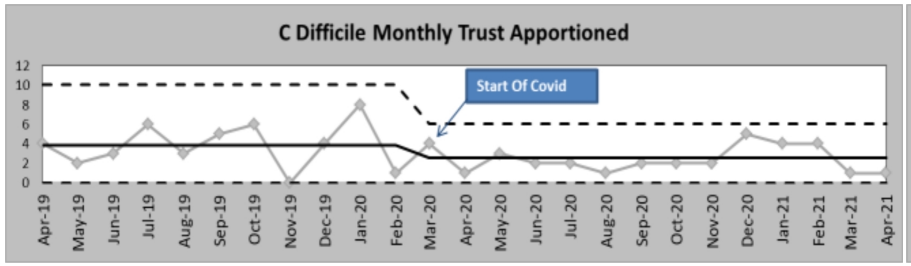
**Omitted Critical Medicines**

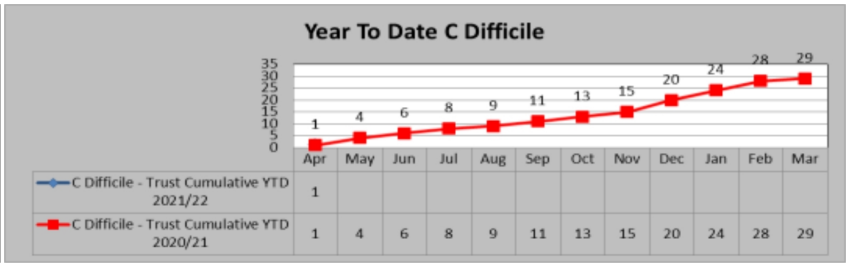
No specific risks to delivery identified at this stage.

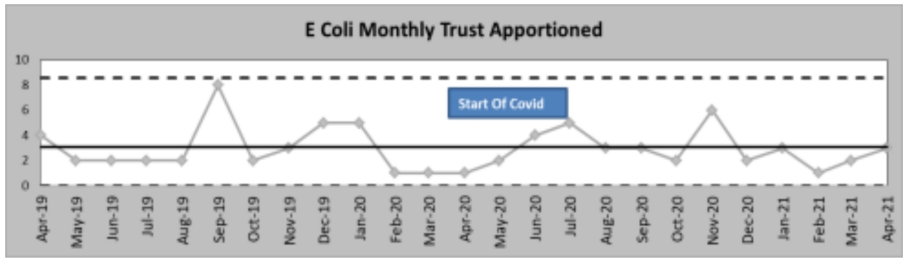
# 2. Patient Safety - Infection Control

Data Quality Rating:

Are We Safe?




| MRSA Bacteraemia | 2020/21 | 2021/22 |
|---|---|---|
| Trust Apportioned | 0 | 0 |

| Hand Hygiene | April |
|---|---|
| Audit Results | 99.73% |

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

***C. difficile*** – 1 infection has been reported to date in 2021/22. This was identified as a community onset healthcare associated case within 28 days of a previous admission.

**Flu** – No flu cases have been identified so far in winter 2021/22. This reflects the national picture.

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

***C. difficile*** - Ribotyping has been requested on all cases of C. Difficile Infection (CDI) within the Trust to give assurance around any cross contamination. The returned reports for cases for 20/21 has not identified any cross infection between cases to date.

**RCA's for *C. difficile*** have shown that there are concerns around antibiotic prescribing and the intravenous to oral switch. Medical staff are being encouraged to review specimen cultures with reference to prescribing antibiotics. This is being supported by the Antimicrobial Pharmacy Team with the help of Mircoguide (electronic antimicrobial guidance at point of care) which supports prescribers to switch to more narrow spectrum antibiotic specific to the culture results.

**E.Coli** – RCA's are being undertaken for all hospital acquired infections and are currently showing that 44% are of a urinary origin with 21% of those related to catheters. Further work is being completed with reference to the roll out of the Bard Comprehensive Catheter Pack introduction and a new Catheter Passport to support the gram-negative reduction plan.

**World Hand Hygiene Day 2021** - IP&C supported workshops on the wards over 5 days, with a focus on the importance of hand hygiene for all staff, with additional focus on environmental cleaning and bare below the elbows.

**Risks to delivery and mitigations**

Antibiotic prescribing has been highlighted as a risk, to mitigate the Antimicrobial Pharmacy Team will provide additional support and training to new clinicians.

# 2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

| Covid 19 | Apr-21 | Mar-21 |
|---|---|---|
| Number of detected Inpatients | 22 | 72 |
| Number of Deaths in Hospital | 4 | 12 |
| Hospital Acquired Covid-19 Cases* | 0 | 0 |

| Covid-19 (Apr 20 - Apr 21) | |
|---|---|
| Number of detected Inpatients | 1480 |
| Number of Deaths | 328 |
| Hospital Acquired Covid-19 Cases* | 139 |

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

Numbers of patients diagnosed with COVID-19 continues to decline in line with he national picture. There have been no hospital acquired Covid-19 cases.

Swindon continues to have the highest case rate per 100,000 [35.1] and remains the highest in both the South West [34.4] and above the England Average, which is 22.4 per 100,000.

The effect and impact of the vaccine on the COVID-19 infection rate continues to demonstrate a change in the patient demographics, which has reduced the vulnerable group who are being admitted/attending the Trust and the severity of the symptoms that are being reported.

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

Proactive isolation of patients with COVID-19 is being monitored to ensure patients continue on the right pathway. An area within Neptune ward has 11 beds designated for Covid-19 patients. There is additional capacity of up to 4 ICU beds, which is currently meeting our needs.

The importance of PPE and social distancing within the wards and corridors of the Trust has been promoted and challenged when standards can be improved upon. Further work with the Deputy Chief Nurse is being completed looking at Bare Below the Elbows and PPE compliance, to support the staff in challenging poor practice.

A point of care testing room has now been commissioned within ED to house the Abbott Rapid testing platform. Training has been provided to ED staff, and the service commenced on 7th May; it is anticipated this will help to improve the front door flow.

Good progress is being made on the Post Infection Reviews (PIR) for the hospital acquired COVID-19 cases. Each of the reviews will feed into the individual ward outbreak reports.

**Risks to delivery and mitigations**

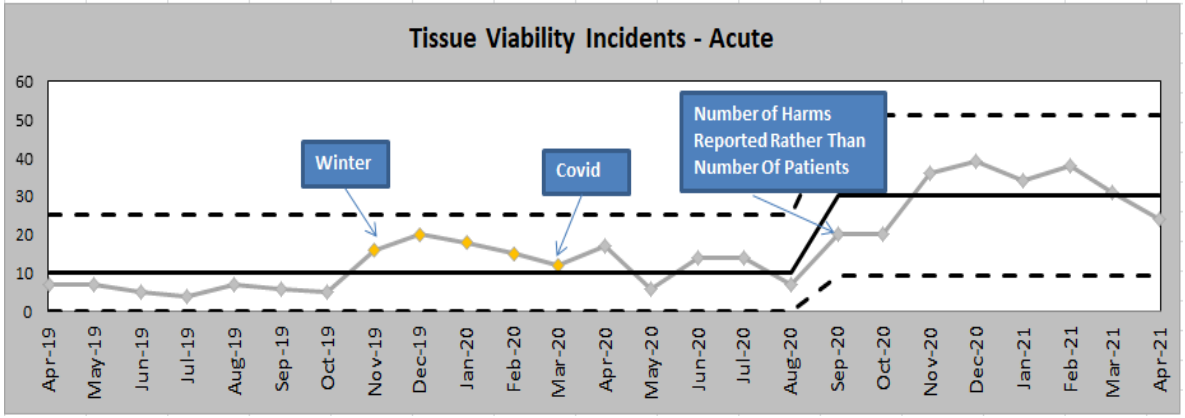
The impact of overseas travel on the current COVID -19 figures may increase admissions of patients with a Variant Under Investigation (VUI).

*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 - Pressure Ulcers- Acute

Data Quality Rating:

Are We Safe?




Incidents of harms by Category for April 2021:

| Category 2 PU | Category 3 PU | DTI | Device related PU | Unstageable | Total Incident of Harms |
|---|---|---|---|---|---|
| 14 | 0 | 4 | 2 | 4 | 24 |

| Number of Patients | Harms per Patient |
|---|---|
| 22 | 1 |
| 2 | 2 |

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

The number of harms associated with pressure ulcers remain unacceptably high.

The majority of harms were to the sacrum (15) or heels (5). There is a slight reduction in heel damage this month.

1 patient developed Grade 2 pressure damage from Oxygen tubing.

Moisture Associated Skin Damage (MASD) continues to be a theme and is contributing to pressure damage.

The level of Deep Tissue Injuries and Unstageable pressures ulcers remain a concern. These are being reviewed and followed up to determine level of harm. Once confirmed the reports are amended to reflect this.

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

Information sharing – wards are ensuring the levels of harms occurred are discussed and learning disseminated. Safer Skin Ward Boards are being put up on all wards.

An education programme drive has commenced to ensure all clinical areas have completed E-learning on pressure ulcer prevention and management.

The worksteam looking at ensuring all mattresses are meeting pressure relieving and infection control standards is on track. Education including a video of correct procedure has been developed and a review of the audit programme will be completed by the end of May 2021.

New pressure reliving equipment has been delivered with training in April and a training day on Friday 14th May is planned, this is a drop in session for 15 minutes. User guides to this equipment posted on the intranet.

Joint work stream with IPC, Academy and Continence Service in reducing harm from mucosal membrane injuries due to urinary catheters.

Trial of 'Swarms' for Pressure ulcers commenced in May to capture learning and develop better knowledge of the themes.

**Risks to delivery and mitigations**

Poor re-taking of images for revalidation of DTI's. Process developed and if images are not obtained then the level of moderate harm will reside with the department.

Poor compliance with mattress inspections, being addressed through mattress integrity workstream.

Duplication of IR1 reporting across the patient journey, being addressed through data workstream.

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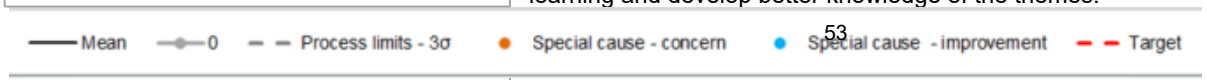


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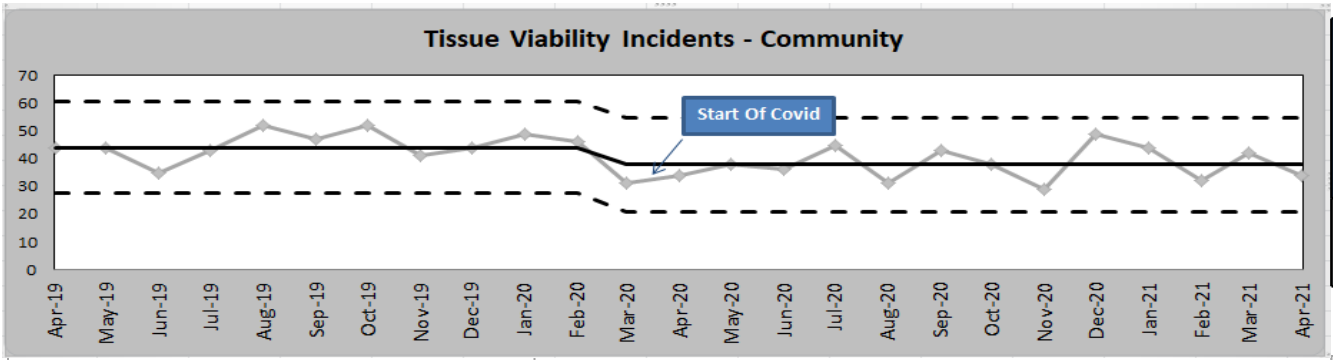
# 2. Patient Safety - Pressure Ulcers- Community

Data Quality Rating:

Are We Safe?




| Category 2 PU | Category 3 PU | Category 4 PU | DTI | Device related PU | Unstageable | Total Incident of Harms |
|---|---|---|---|---|---|---|
| 16 | 5 | 1 | 4 | 3 | 5 | 34 |

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

Data is showing that the levels of significant harm have reduced this month by 19%.

There is a small increase in low levels of harm and reduction of higher harms which suggests better reporting and earlier intervention.

Out of the 7 category 3's - 5 were improving after intervention.

There is no association with locality and high levels of harm.

**Device related harms**

Device related harms have reduced to 3 and were related to a urinary catheter, a Suprapubic Catheter and a neck collar.

**Themes**

Lack of timely wound assessment / documentation and images.

Lack of timely intervention with appropriate pressure relieving equipment.

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

- Additional pressure relieving equipment training being delivered during May 21 using MS teams.
- The new equipment ordering process is simpler to use and helps ensure the right equipment is ordered. The process is included as part of the training programme.
- Additional training delivered to community nursing on the importance of /documentation/wound assessment and image taking.
- Wound assessment training video completed and will be added to the intranet by end of month
- Working group commenced to review education and training on catheter and continence management to reduce levels of harm due to catheters, with IP & C/ Continence/ Tissue Viability with implementation of new catheter packs due by 31.5.21.
- The use of a TOTO turning system (automated lateral turning system for patients), for patients at the end of life, has been expanded in the community and trialled in the acute wards.

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**Risks to delivery and mitigations**

High use of temporary staffing in Community Nursing, results in variable levels of competency and compliance with documentation of escalation of pressure ulcers.

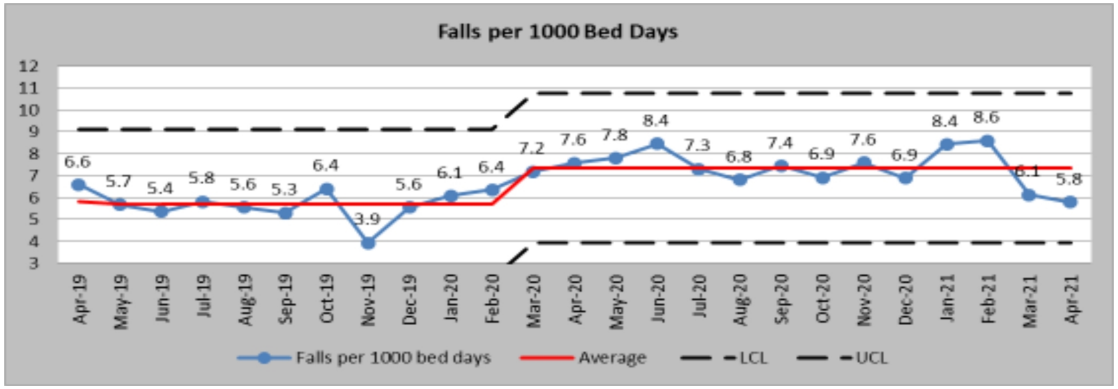
Tissue viability services continuing to provide education and support.

Staff encouraged to complete e learning as well as attend face to face.

# 2. Patient Safety - Patient Falls

Data Quality Rating:

Are We Safe?




| | April 2021 | Mar 2021 | Feb 2021 | Jan 2021 |
|---|---|---|---|---|
| Falls Resulting in No Harm | 99 | 104 | 129 | 141 |
| Falls Resulting in moderate Harm or above | 2 | 2 | 2 | 2 |

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

Over the last three months we have seen a month on month decrease in the total number of falls reported, each month reducing from 143 in January 2021 to 101 in April 2021.

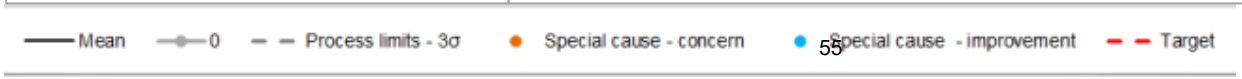
**Improvement actions planned, timescales, and when improvements will be seen.**

Progress with the falls improvement plan continues, with the following key activities underway during April.

- The trial of a revised multifactorial falls assessment and care plan document has continued throughout April 2021 in the six project areas (Teal, Jupiter, Trauma SWICC wards, Sunflower). Initial findings of the project has evidenced an increase from 0% to 75% of patients having falls interventions documented on their assessments. A staff survey has been sent to all staff on project wards to obtain feedback.
- Next steps during May 2021 are to transfer the revised assessment and care plan document onto Nervecentre to spread to all other inpatient clinical areas. A mapping exercise with the Clinical Nurse Information Officer is taking place on 11/05/2021.
- The lying and standing blood pressure and bedrail assessments have been inputted to the Nervecentre test system and have been demonstrated to ward managers. Agreed to implement on wards during May 2021 with appropriate training support in place.

**Risks to delivery and mitigations**

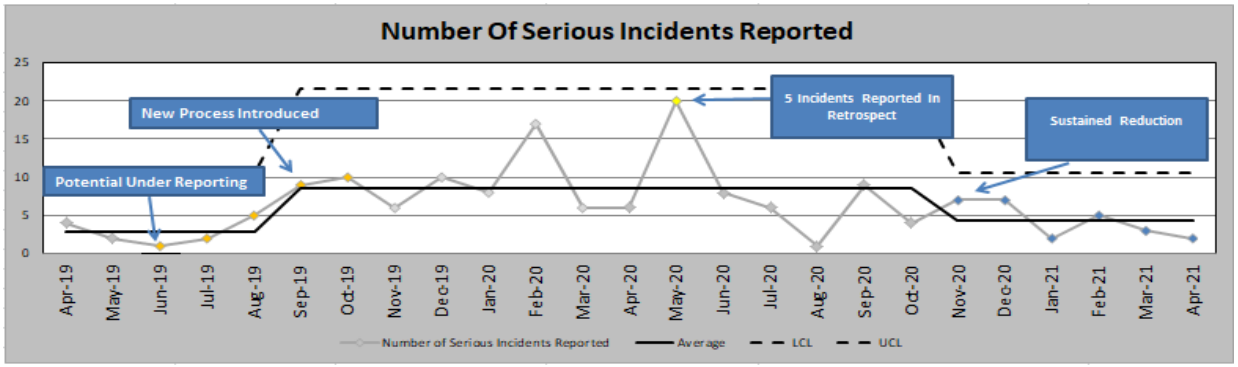
Patients are presenting with higher levels of de-conditioning in relation to mobility and falls due to the recent national 'lock down'.



# 2. Patient Safety - Incidents

Data Quality Rating:

Are We Safe?




| Serious Incidents Reported | | | Comparison |
|---|---|---|---|
| Feb | Mar | Apr | Apr-20 |
| 5 | 3 | 2 | 6 |

| Never Events | |
|---|---|
| 2019-20 | 2020-21 |
| 2 | 3 |

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

At the time of reporting there is a total of 37 on-going Serious Incident (SI) investigations, with 2 reported in April.

The number of SI's reported has decreased compared with March 2021 and significantly less than the same period last year.

There continues to be good levels of incident reporting with a total of 991 Patient Safety Incidents reported in April 2021. This continues to be in line with reporting across BSW (Bath and North East Somerset, Swindon and Wiltshire).

Due to increased demands on front door services coupled with inpatient capacity and Covid distancing restrictions, we expect to see this level of incident reporting maintained or increased, specifically the number of incidents pertaining to delayed transfer of care.

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

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

Actions in progress include;

- WHO - a safety survey being undertaken across services that undertake invasive procedures
- BiPAP – Training on BiPAP and ABG's delivered to staff on ED and Neptune
- BiPAP - Nervecenter now has an option to chose oxygen mode of delivery i.e. facemask.
- BiPAP guidelines has been updated and released

Following identification of a patient safety theme relating to allergies (all allergies), a new improvement group has been initiated, which is in the process of formalising terms of reference and the scope of the improvement group

**Risks to delivery and mitigations**

A substantive vacancy for the Clinical Risk & Patient Safety Manager presents a potential risk of delayed delivery of SI Investigations, effective dissemination of learning ..

In order to mitigate this risk the Lead Quality Governance Facilitator is providing support to the Clinical Risk Management Team.



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

# 2. Patient Experience – Safer Staffing - Care Hours Per Patient Day (CHPPD)

Data Quality Rating:

Are We Safe?

**Care Hours Per Patient Day for April 21 from Health Roster**

| Unit | Actual CHPPD | Required CHPPD | Actual Staff:Patient Ratio | Actual RN:Patient Ratio | Required Staff:Patient Ratio | % Utilisation |
|---|---|---|---|---|---|---|
| Acute Cardiac Unit J65621 | 9.0 | 8.2 | 1:2.61 | 1:3.73 | 1:2.91 | 91.32 |
| Acute Stroke Unit J65624 | 9.2 | 9.5 | 1:2.47 | 1:4.21 | 1:2.53 | 103.05 |
| Aldbourne Phase 3 - J65313 | 8.2 | 6.1 | 1:2.97 | 1:4.48 | 1:3.91 | 75.31 |
| Ampney Ward - Urology J65331 | 6.5 | 5.6 | 1:3.53 | 1:5.89 | 1:4.26 | 86.98 |
| AMU Nursing J65634 | 37.8 | 6.7 | 1:0.67 | 1:1.12 | 1:3.56 | 17.84 |
| Beech & EPU Phase 3 - J65917 | 8.0 | 6.5 | 1:2.93 | 1:5.70 | 1:3.71 | 80.37 |
| Childrens Unit & PAU J65923 | 13.2 | 9.7 | 1:1.77 | 1:2.23 | 1:2.48 | 73.36 |
| Daisy Ward - J65391 | 9.1 | 4.7 | 1:2.58 | 1:3.60 | 1:5.13 | 51.31 |
| Dove - DTC & CWU Nursing- J65029 | 8.3 | 7.6 | 1:2.84 | 1:3.49 | 1:3.17 | 91.15 |
| Forest Wd Stroke SWICC SC J67409 | 7.3 | 8.0 | 1:3.17 | 1:9.39 | 1:3.00 | 110.08 |
| ICU & HDU J65355 | 30.5 | 21.1 | 1:0.79 | 1:0.88 | 1:1.14 | 69.18 |
| Jupiter Ward J65625 | 6.2 | 6.8 | 1:3.71 | 1:7.47 | 1:3.55 | 108.14 |
| Meldon Ward J65337 | 5.6 | 6.2 | 1:4.12 | 1:7.43 | 1:3.87 | 111.12 |
| Mercury Ward J65638 | 5.8 | 6.3 | 1:4.02 | 1:7.84 | 1:3.83 | 108.52 |
| Neptune Phase 2 J65637 | 8.1 | 7.8 | 1:2.94 | 1:5.56 | 1:3.08 | 96.10 |
| Orchard Ward J67410 | 10.0 | 8.2 | 1:2.34 | 1:5.92 | 1:2.94 | 81.51 |
| Saturn Phase 2 J65647 | 7.0 | 6.3 | 1:3.30 | 1:6.30 | 1:3.80 | 90.05 |
| SAU - Surgical Admissions Unit J65380 | 11.0 | 5.4 | 1:2.12 | 1:4.03 | 1:4.47 | 48.89 |
| Sunflower Lodge - J67449 | 8.9 | 7.5 | 1:2.51 | 1:6.31 | 1:3.19 | 85.05 |
| Teal Ward J65639 | 6.1 | 6.7 | 1:3.90 | 1:7.56 | 1:3.58 | 109.68 |
| Trauma Unit - J65387 | 7.0 | 7.0 | 1:3.31 | 1:7.45 | 1:3.42 | 100.23 |
| Woodpecker Ward J65314 | 6.5 | 6.3 | 1:3.63 | 1:7.66 | 1:3.81 | 97.38 |

**Background and underlying issues**

The CHPPD for April are within safe staffing limits.

4 wards flag as requiring more CHPPD than actual.

The data for the assessment units and ICU need further work to capture activity

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

- Areas flagging with lower than required CHPPD in April are being reviewed and monitored closely for trends. The data over the last 6 months demonstrates this is not a trend and no red flags of concern were raised.
- Staffing reviews of all areas will occur with the Chief Nurse from June to August.
- ICU are benchmarking with other Trusts in BSW on the utilization of CHPPD and recording acuity and dependency. A report will be presented to the Nursing and Midwifery Group in June.
- Roster KPIs reviews are now completed, learning identified and a report will be presented at Senior Nurse Team meeting.
- New Preferred Supplier List (PSL) for agencies commenced 1st April. Areas of non compliance with NHS cap rates are RMNs, community nursing and Practitioners in Urgent Care Treatment Centre.
- Overseas recruitment from India has ceased, impact on Overseas Recruitment programme is being assessed.
- Work completed to improve the accuracy of the nationally required Safe Staffing submission.

**Risks to delivery and mitigations**

Risk of increased vacancies / turnover in registered nursing needs to be mitigated by focus on recruitment and retention.

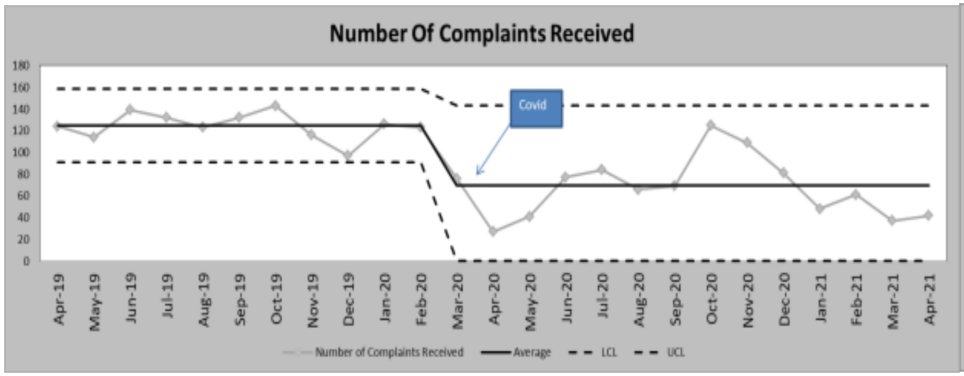
The pausing of Overseas Recruitment from 'RED' countries may affect getting to 0 vacancies by Dec 21. The recruitment team are working with the agencies to source from alternative countries.

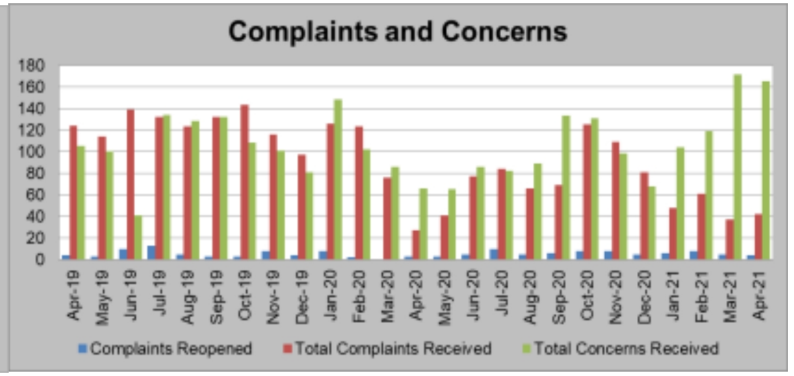
# 2. Patient Experience - Complaints and Concerns

Data Quality Rating:



Are We Safe?




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

**42** complaints (previous month 37) and **165** concerns (previous month 171) were received in April 2021.

**90**% of complaints were responded to within expected timeframe
**63**% of concerns were resolved within 24 hours
**85**% of concerns were resolved within 7 working days (KPI 80%).

Out of a total of **207** cases received from Complaints and Concerns in April, the overall top three themes were:

- **Clinical Care:** 37 (18%) – 10 complaints, 27 concerns.
- **Telecommunications:** 25 (12%) – 1 complaint, 24 concerns.
- **Communication:** 24 (12%) – 6 complaints, 18 concerns.

Two complaints were rated as High due to the complexity and number of issues raised, both cases were regarding patients at the end of their life.

1. Lack of communication between care professionals and family, poor discharge, conversations not clear regarding end of life to the family.
2. Misdiagnosis following discharge from the Urgent Care Centre from a fall at home, readmitted to ICU with breathing difficulties.

Both cases are still under investigation.

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

**Clinical Care**
Quality improvement work streams continue in several key areas i.e. EOL communication, discharge planning, personal care with key actions and KPI's to address the issues raised from concerns and complaints received.

Key actions include a new patient survey which has been added to Perfect ward to capture feedback regarding personal care and noise at night and the matrons have been working with their teams to ensure nail care equipment is now in place in all areas and that staff are aware of their responsibilities.

**Telecommunications/Communication**
The telephony improvement project continues aiming to address many of the concerns identified in the telecommunications and communication theme.

An improvement project commenced in April on Teal ward, this relates to the trial of an additional dect we need to say what a dect phone isphone for 6 weeks. This number is a designated patient / family only phone. The number is given to families when the patient is admitted. The phone itself is marked so that it does not get used for other calls and is answered by the Ward Clerks during the day and an HCA outside of those hours. Throughout April Teal ward did not receive any negative feedback related to telecommunications. If successful this trial will be extended to other areas.

**Risks to delivery and mitigations**

The contract for Datix complaints management system is progressing, working groups have been identified for successful implementation.

The risk of the current provider giving notice before a new system is in place remains.

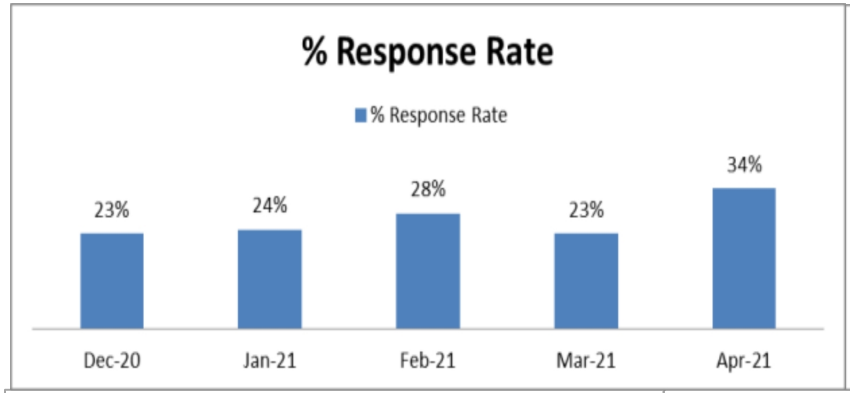
58

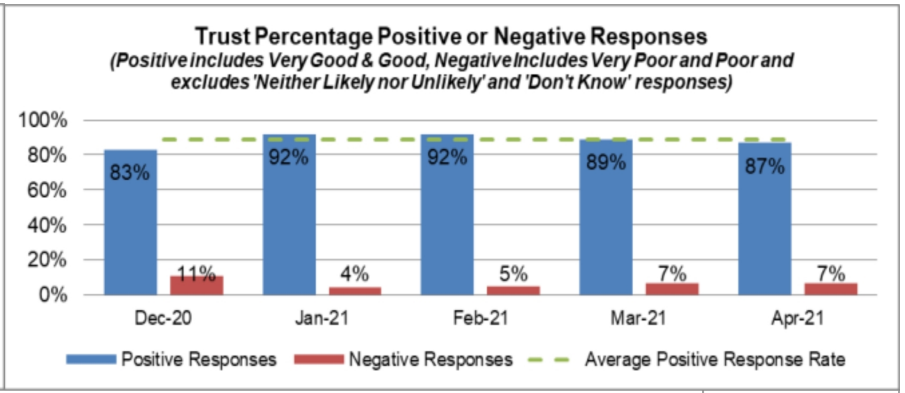
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

# 2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?




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

Positive response rates remain broadly similar to previous months, overall response rate has improved by 11% from March.

This was achieved by:

| | Number of Text sent | Number of Responses | Positive Responses |
|---|---|---|---|
| ED | 1946 | 450 | 79.33% |
| Inpatients | 2623 | 767 | 83.83% |
| Day Cases | 2028 | 667 | 95.65% |

*(correct as of 6th May)*

Data is currently being collected via text messaging, online survey and a small number of cards as this format has now been reintroduced across the Trust.

Questions asked are 'overall how was your experience of our service?' with options including 'Very good, good, neither good nor poor, poor, very poor, don't know". We also ask free text questions including reasons for your answer and is there anything we could of done better.

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

Predicted date for FFT text messaging to be introduced to outpatients is early June, testing will take place towards the end of May for successful implementation. Inpatient and Day Case areas continue to receive increased feedback. We are now able to identify themes (positive/negative) in more detail to act upon.

Overall Positive themes free text responses:

- **Staff Attitude** (909 comments, previous month 890 comments)
- **Implementation of Care** (637 comments, previous month 589 comments).
- **The Environment** (459 comments, previous month 443 comments).

Overall Negative themes for April free text responses:

- **Staff attitude** (126 comments, previous month 93 comments).
- **The Environment** (111 comments, previous month 90 comments).
- **Implementation of Care** (100 comments, previous month 77 comments).

The FFT Patient Experience Coordinator is now in post and she will work with service areas/divisions to ensure feedback is shared, promoted and monitored. Linking the feedback with various work streams, campaigns and service improvement work.

A thematic review of negative responses is to be used as focus for improvement with data to be shared at Senior Nurse meetings.

**Risks to delivery and mitigations**

There is a risk that we are not capturing feedback on a widespread and consistent basis , which may lead to poor patient experience.

A work plan is in place to increase the opportunities to collect patient feedback and understand themes, identify learning and implement improvements. In conjunction with patients.

# 2. Patient Safety - Perinatal Quality Surveillance Tool April 2021

Data Quality Rating: 

Are We Safe?

| Measures | Comments |
|---|---|
| CQC ratings | Overall Good in the 5 domains (2020) |
| Maternity Safety Support Programme | Not required as CQC ratings overall 'Good' |
| Findings of review of all perinatal deaths using the real time data monitoring tool | • No babies born in April for review (stillbirths or neonatal deaths).<br>• A multi-disciplinary team, review all cases using a real time data monitoring tool. This is a national tool, which facilitates evaluation of the care provided. |
| Referrals and findings of HSIB reports | • One new case referred to HSIB in April. Currently being triaged for eligibility for review by HSIB. |
| Number of incidences graded moderate or above and actions taken | • 3 incidents graded moderate or above<br>• 2 of these have been identified as Serious incidents and are detailed on the next slide. |
| Minimum safe staffing in maternity to include Obstetric cover on delivery suite | Safe midwifery staffing continues to be monitored via the following actions :4 hourly completion of Birth rate plus acuity tool continues with relevant actions addressed. April data shows the Midwife to birth ratio of 1:27 is consistent for the last 3 months.-continues to be compliant with Birth-rate recommendations.<br>1 to 1 care in labour of 97.7% compliance is similar findings to the previous month. Team focusing on ways to achieve 100% compliance.<br>On review of Consultant presence in Delivery suite it has been identified that cover is less that 60 hours (57 hours) and this risk will be added to the risk register and monitored as this does not comply with the prescribed national standard. A proposal has been developed to provide the additional cover.<br>Maternity unit coordinator role implemented to ensure a senior midwife has a wider operational overview of the service to ensure patient safety and safe staffing levels. |
| 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. |
| Coroner's Regulation 28 | Nil |
| Concerns or requests for actions from national bodies | Ockenden action plan has been produced and is being monitored through both Maternity and Divisional Governance meetings. Awaiting final date from the National Team for access to the portal to submit evidence to support the self assessment. |
| CNST 10 Maternity standards (NHSR) | Submission due: 15/7/21.Revised safety actions published end of March are being followed and the relevant evidence collected to achieve compliance for all 10 safety actions. |
| Staff feedback from frontline | Concerns being addressed by Senior Team and regular meetings set up to provide an effective voice for staff. |

This new quality surveillance model seeks to provide for consistent oversight of maternity and neonatal services. The on-going learning and insight will help to inform improvements in the provision of perinatal services.
The measures outlined will be reported to Trust Board on a monthly basis so oversight is continuously monitored.

# 2. Patient Safety – Summary of Maternity Serious Incident Investigations

Data Quality Rating:

Are We Safe?

| Case ref | Overview | Date | Case update |
|---|---|---|---|
| 156713 | Baby born requiring full resuscitation following induction of labour. The baby was effectively resuscitated and transferred to the NICU in Bristol for therapeutic hypothermia.<br>Immediate learning identified:<br>• Ensure effective escalation of CTG concerns even if birth appears to be imminent | 29/04/2021 | Baby remains on NICU (correct 04/05).<br><br>This case met criteria for referral to HSIB and has been appropriately referred |
| 155767 | Baby admitted to Local Neonatal Unit following observation of a seizure. MRI identified haemorrhage in both cerebral hemispheres, likely to be associated with birth trauma.<br>Immediate learning identified:<br>• Investigating the effectiveness of using of foetal pillows to facilitate extraction of deeply impacted head at caesarean section. | 06/04/2021 | Case to be reviewed by round table group, with external insight to ensure objective insight. |

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.

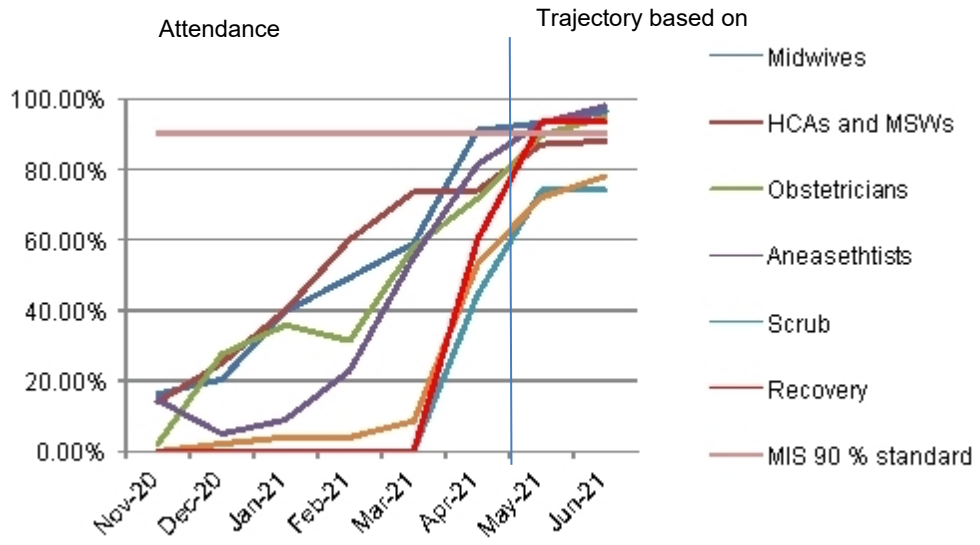
## On-going SI investigation update

| Stage of investigation | April 2021 | March 2021 |
|---|---|---|
| Referred to HSIB awaiting decision | 1 (case above) | 1 |
| Under local investigation | 2 (including case above) | 3 |
| Under HSIB investigation | 1 | 0 |
| Report complete awaiting Serious Incident Review Learning Group (SIRLG) review. | 1 | 0 |
| Submitted to CCG | 5 | 2 |

# 2. 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 percent compliance for all staff groups attending Face to Face Practical Obstetric Multi-Professional Training (PROMPT) day.
- From December 2020 weekly online PROMPT training offered to all staff groups.

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

- Significant improvement in the number of staff trained in each group is evident. Last month 45 individuals required training, this has now improved to 13.
- Compliance now being addressed with individual staff via line managers
- Where possible provisions have been made to adjust dates and programs to ensure accessibility of training for staff.

**Risks to delivery and mitigations**

- Staff not being released for training due to staffing pressures and high levels of shortages, some staff have been rebooked twice due to this. Some HCAs need to be rebooked following shielding as had no IT access, managers to address.
- Midwives are given 12hours paid training time versus 80 hours required to complete all training requirements.
- All leads informed of non bookings or cancellations to chase staff.

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

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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 | 3 | 3 |
| Great Opportunities | 2 | 2 |
| Great Employee Experience | 3 | 3 |
| Great Employee Development | 3 | 3 |
| Great Leadership | 2 | 2 |

**Month 1 budgets are pending Executive approval and as such have not been received at the time of reporting*

## 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 | | | 5.23% | 6.00% | 3.90% | 7.38% | 5.64% |
| 2 | RN Bank Fill Rates | | | 60.55% | 70.00% | 35.62% | 60.06% | 47.84% |
| 3 | Vacancy Rate* | | | 5.40% | 7.63% | 5.83% | 8.61% | 7.22% |
| 4 | Recruitment Time To Hire (Days) | | | 48.10 | 46.00 | 29.79 | 57.77 | 43.78 |
| 5 | All Turnover | | | 13.51% | 13.00% | 12.18% | 13.56% | 12.87% |
| 6 | Voluntary Turnover | | | 8.40% | 11.00% | 9.04% | 10.04% | 9.54% |
| 7 | All Sickness Absence | | | 3.78% | 3.50% | 2.95% | 4.80% | 3.88% |
| 8 | Statutory Mandatory Training Compliance | | | 84.91% | 85.00% | 84.32% | 88.98% | 86.65% |
| 9 | Appraisal Compliance | | | 82.47% | 85.00% | 71.50% | 82.12% | 76.81% |

# Trust Overview: Narrative



Great Western Hospitals NHS Foundation Trust

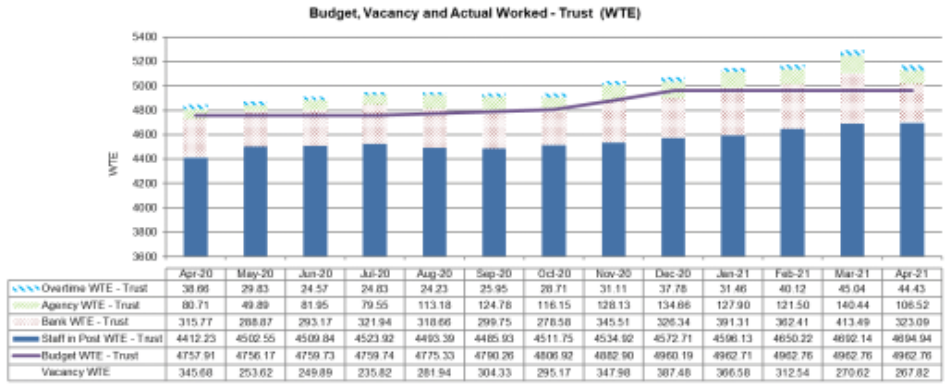
| "Great" Scoring | Indicator Score (1-4) | Self Assessment Score | Headline |
|---|---|---|---|
| **1 – Underperforming / Inadequate \| 2 – Requires Improvement \|3 – Good \| 4 – Outstanding** | | | |
| **Great Workforce Planning** | 3 | 3 | April saw a significant improvement in the proportion of total pay spend on temporary workforce, improvement in the RN bank fill rate percentage for the fourth successive month and a small improvement in the Trust's already relatively low vacancy rate. As a result the self assessment score is rated as "Good", though with consistency and continued improvement across all KPIs including the RN bank fill rate on-going aims. A combination of a low vacancy rate and improving divisional controls related to use of E-Roster and the Safer Nursing Care tool have been important factors in mitigating the use of temporary staffing, with this contributing to 124WTE less bank & agency staff being used in April compared to March. It is recognised that WTE usage remains above budget, however there is an improvement when compared to previous months. |
| **Great Opportunities** | 2 | 2 | The Trust vacancy rate continues to improve, reported at 5.40% (267.83 WTE) in April, significantly lower than the Trust target of 7.6%. There continues to be a sustained improvement in voluntary turnover achieving below the 11% target. Recruitment time to hire metric remains above KPI at 48 days from vacancy advertised to contract of employment. The Trust will see an impact on our upcoming overseas nurses intake due to an immediate pause on all nurse international travel from India. 16 nurses have arrived before the restrictions were put in place and currently in quarantine. |
| **Great Experience** | 3 | 3 | Sickness absence remains stable at 3.47% which is below 3.5% target, the improvement correlates with our emergence from winter months, wellbeing initiatives and positive impact of close management of long term sickness cases and supports the improved KPI score of 3. The self assessment score is also reported as 3 this month further to increased performance with long service award celebration and increased offer to the well being programme as outlined in the report. The Equality, Diversity and Inclusion agenda is progressing with pace and a range of developing initiatives as also outlined in report. |
| **Great Employee Development** | 3 | 3 | The Academy has reported progress to HEE in terms of the CPD spend as requested by 30 April 2021. The Mandatory Training project is on track and the new system for accessing and undertaking mandatory training will go live on the 1 June 2021. A communication plan has been prepared to ensure all staff are aware of the changes and able to access the new system. The Trust is investing in coaching training for staff to ensure it has internal capacity to support staff who require coaching as part of their ongoing development. |
| **Great Leadership** | 2 | 2 | There has been an increase in appraisal rates in April to 82.47% an improvement for the third consecutive month. Whilst this remains lower than the KPI target of 85% it is, nevertheless, encouraging. The second cohort of the Leadership Development programme began in April with 17 participants. The third session of the AMD development programme was well received and work is on-going on the development of a system wide Clinical Leads programme. |

# Workforce

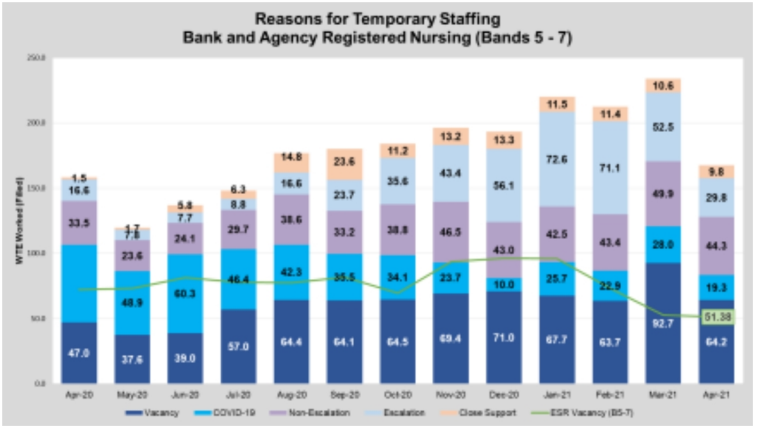
Use of Resources

## Great Workforce Planning

| Indicator Score | Self Assessment Score |
|---|---|
| 3 | 3 |




| | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overtime WTE - Trust | 38.66 | 29.83 | 24.57 | 24.83 | 24.23 | 25.95 | 28.71 | 31.11 | 37.78 | 31.46 | 40.12 | 45.04 | 44.43 |
| Agency WTE - Trust | 80.71 | 49.89 | 81.95 | 79.55 | 113.18 | 124.78 | 116.15 | 128.13 | 134.66 | 127.90 | 121.50 | 140.44 | 106.52 |
| Bank WTE - Trust | 315.77 | 268.87 | 293.17 | 321.94 | 318.66 | 299.75 | 278.58 | 345.51 | 326.34 | 391.31 | 382.41 | 413.49 | 323.09 |
| Staff in Post WTE - Trust | 4412.23 | 4502.55 | 4509.84 | 4523.92 | 4493.39 | 4485.93 | 4511.75 | 4534.92 | 4572.71 | 4596.13 | 4650.22 | 4692.14 | 4694.94 |
| Budget WTE - Trust | 4757.91 | 4756.17 | 4759.73 | 4759.74 | 4775.33 | 4790.26 | 4806.92 | 4882.90 | 4960.19 | 4962.71 | 4962.76 | 4962.76 | 4962.76 |
| Vacancy WTE | 345.68 | 253.62 | 249.89 | 235.82 | 281.94 | 304.33 | 295.17 | 347.98 | 387.48 | 366.58 | 312.54 | 270.62 | 267.82 |




### Background

The Trust utilised 5169WTE staff to deliver its services in April '21, a decrease of 122WTE on the previous month though still 206WTE in excess of budgeted WTE.

The Trust's recent improvement in vacancy rate has been maintained though unlike last month did result in a significant reduction in bank and agency usage in month (124WTE reduction), which was contributed to heavily by reductions in temporary staffing requests related to vacancy cover and escalation.

Community Nursing continues to have the greatest demand for temporary staffing resource, which is supported by the approval to secure up to an additional 20 registered nurses per day extended until the end of May

The use of Locums in Primary Care continues to be the leading driver of medical workforce temporary spend, closely followed by A&E and General Medicine vacancy cover, the latter driven by vacancies in hard to recruit specialities. In the case of Geriatrics, speciality demand is high and has necessitated the introduction of agency sourced Consultant Geriatrician cover.

The requirement to cover shielding Doctors has diminished significantly, though temporary staffing arrangements are still required to cover those working under restricted duties. A review of each is underway.

### Improvement actions

1. An Improvement Board has been established in Unscheduled Care in April, focusing on 4 key spend priorities – Junior Doctor, Consultant, Urgent Treatment Centre and Close Support and progress will be reported next month
2. Surgery, Women's & Children Division have implemented a daily Quality & Safety huddle to identify immediate staffing requirements and enable mobilisation of staff to areas of greatest need to reduce requests for temporary staffing
3. Increased use of Safer Nursing Care Tool across the Trust to assess acuity and safety, providing an evidence based means to inform temporary workforce decisions
4. Removal of automatic bank & agency escalation, with requests now screened by each Divisions Matron of the day prior to submission for DDoN approval
5. CCG Project Manager support has been obtained within ICC (PCN Nursing), providing dedicated PCN expertise to inform workforce planning and overcome existing high levels of spend
6. Agency Reduction – HR BP (Medical) is currently working with finance BPs to tighten tracking controls relating to locum doctors. USC FBP, HRBP(M) and USC management team are meeting twice a month to review booked locums against approvals so that in month decisions can be made to adjust bookings based on divisional plans
7. As part of a planned Nursing Workshop, Senior Nursing have agreed a revised reporting output to better review and investigate temporary staffing usage and roster practice within their services. Alongside this revision, it has been agreed that agency targets will be agreed with the relevant Senior Nurses to ensure a collaborative approach between the clinical services and Finance to support achievable figures of spend and cost avoidance where applicable.

### Risk to performance and mitigations

As the Trust moves into recovery phase and the development of the operational plan 21/22, increase activity to reduce waiting lists will have an impact on workforce costs which may be unfunded and use of temporary resources required.

Long term delay on international recruitment (India) will have an impact on closing the vacancy gap for nursing. Options are been explored for alternative recruitment options.

Medical hard to recruit roles are nationally recognized, and efforts to improve attractiveness may not have the desired outcome.

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

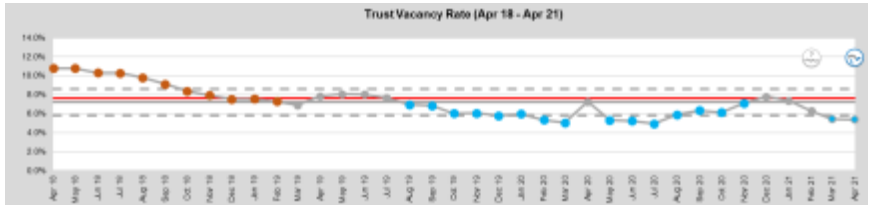
# Workforce

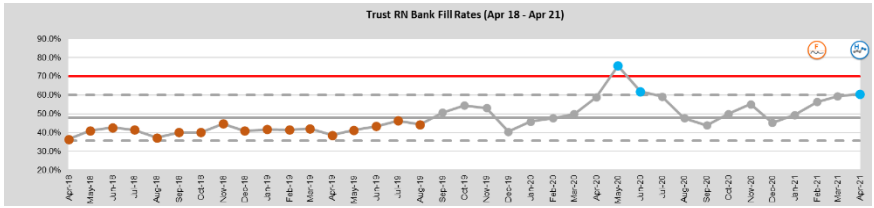
67

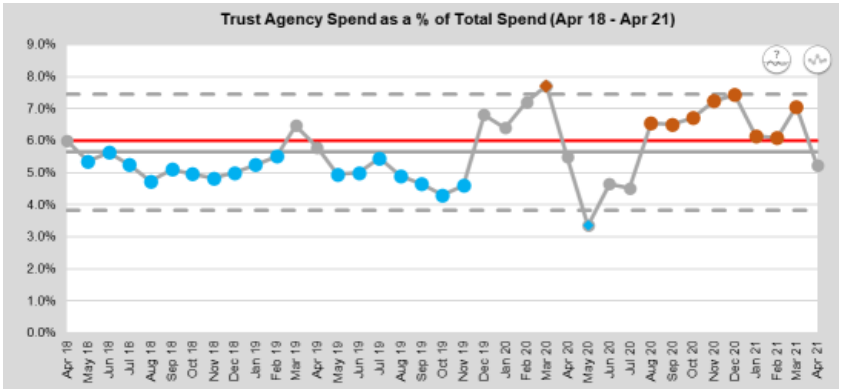
Use of Resources

## Great Workforce Planning

| Indicator Score | Self Assessment Score |
|---|---|
| 3 | 3 |




### Background

The Trust vacancy position improved marginally to 5.40% in April from 5.45% in March and equates to 267WTE vacant posts. Medical & Dental (3.46%), Nursing (3.00%) and Allied Health Professional (8.61%) vacancy rates each improved for the second successive month, with Medical & Dental and Nursing particularly low. Senior Managers & Admin represent the Trust's largest vacancy gap at present, with 105WTE vacant posts equating to a vacancy rate of 9.03% for this staff group, with a net loss of 11WTE Senior Manager & Admin staff in April.

Registered Nursing bank fill rates achieved improvement for the fourth successive month, with April's fill rate of 61% comparing favourably to the 59% fill rate achieved in March and mean performance overall.

Agency spend as a proportion of total pay in April (5.23%) reduced significantly relative to the previous month, in fact reaching it's lowest point since July '20. Agency spend was driven mainly by Medical Workforce at £699k (11.53% of staff group total spend) and Nursing £337k (4.06% of staff group total spend).

### Improvement actions

1. As part of the Preferred Supplier List (PSL) model introduced from April, revision to escalation, agency processes and reporting have seen a positive response in reported cap rate from 10.6% (8.4% Nursing) reported in the final week in March to 42% (73 % Nursing) reported to date. Areas requiring escalation have gone through the new escalation route and break glass (NHSI Cap +15%) has been used by exception

2. The medical staffing E-roster build for early adopter Obstetrics & Gynecology is complete and ready to go live on the 14th May. The roster improves oversight, enables electronic administration of time, attendance, leave and optimises workforce shift availability. Lessons learnt from this pilot are being incorporated with Allocate into the project plan for the build and implementation of the roster for the ED department which commences in May.

3. Following the scanning project for health records department, a review of the department workforce and skill mix is underway and the staff are engaged in change management programme with support for redeployment options. Change effective from 1st September 2021.

### 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.

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, the risk is a dependency on non-automated excel spreadsheets for managing planned activity and limited oversight of resource spend. Some mitigation provided by the web-based locum resource system with timesheet platform.

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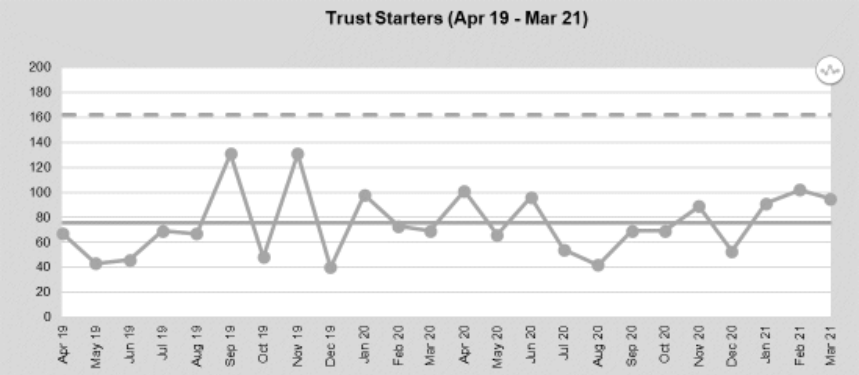
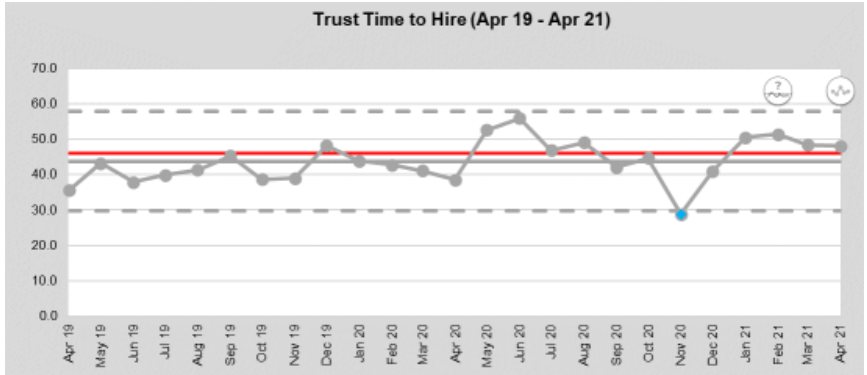
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

# Workforce

Use of Resources

| Great Opportunities | Indicator Score | Self Assessment Score |
|---|---|---|
| | 2 | 2 |




## Background

The number of new starters to the Trust is not changing significantly, reported at 95 (86.64 WTE) during March 2021. Although there remains wide variation in the number of new starters to the Trust each month, this is above the Trust average of 75 per month.

The Trust has 78 candidates to date across all staffing groups due to commence employment in May.

The recruitment time to hire has had no significant change at 48 days in April.

## Improvement actions

1. Due to the COVID pandemic situation in India there has been an immediate pause on all nurse international travel from India to take up employment within the NHS until further notice. This will have an impact on our upcoming international intakes of 16 per month as we predominately recruit our overseas nurses from India. We will be working with our agencies to review our pipeline and options.
2. Therapies continue to have a high vacancy gap. In May a recruitment video will be created that will provide a unique visual way to promote and market the career opportunities available at the Trust. In addition to this other advertising platforms are being explored alongside our social media.
3. License to Recruit is now live on training tracker, the launch of this new training module will be added to Site Comms. Team Brief in May and all current recruiting managers in TRAC will be advised of the new module and its required completion. The aim is for all recruiting managers to be 100% compliant by the end of December 2021, with any new recruiting managers required to undertake the training before they are provided access to TRAC.
4. Executive recruitment is underway to appoint a new Chief Operating Officer and Medical Director, both recruitment events are planned to occur in May.
5. From 10th May the Medical workforce team will transition into either Temporary Staffing or Recruitment to commence the first phase of working as a one function Resourcing Team. This new way of working will enable the streamlining of processes and ensure fair, transparent and inclusive processes irrespective of the role i.e. Agenda for Change/Very Senior Managers/Medical Staff.

## Risk to performance and mitigations

The target for NHSI funding nurses to have arrived in the UK and passed their OSCE has been extended from end of March to 11th June 2022.

Previously, NHSI reimbursed the Trust full cost (£1,750) for an overseas nurses that were entering from a red list requiring hotel quarantine. From April NHSI will now reimburse £1,000 per nurse and Trust are required to pay the remaining £750 per nurse. This currently only applies until 30th September 2021.

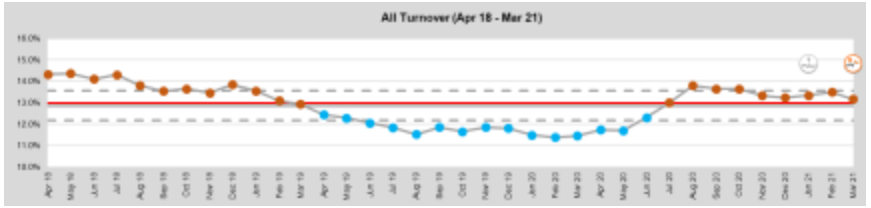


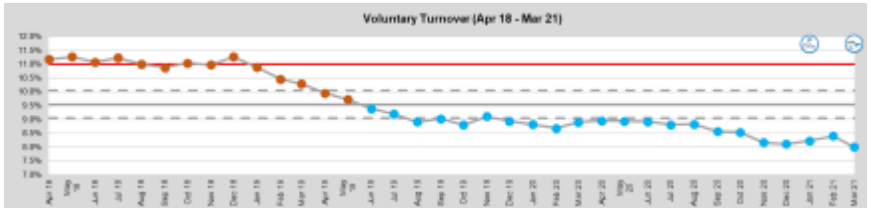
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

# Workforce

Use of Resources

| Great Opportunities | Indicator Score | Self Assessment Score |
|---|---|---|
| | 2 | 2 |


## Background

For non-medical recruitment within the period February – April 21, there was a noticeable variation at the shortlisting to appointed stage, 68% of White applicants shortlisted to 46% appointed against, 17% BAME applicants shortlisted to 15% appointed and 15% of Other/Undisclosed shortlisted to 39% appointed

Performance for all turnover has remained inline or slightly above Trust KPI of 13% since July 20, this is due to flexible workforce required during COVID.

There has been a sustained significant improvement in voluntary turnover since 2019, the Trust will reliably achieve the 11% target each month.

## Improvement actions

1. The Children's Ward is highlighted as an area of high turnover (11 leavers within the last 12 months) with most citing 'work-life balance' as the main reason for leaving. Exit interviews are being reviewed with the Ward Manager and a review of the staffing model/roster to take place in Q1 to identify if the model is fit for purpose and allows staff to have a work/life balance. Findings to be presented in M4.
2. Recruitment is collaborating with Leads for each of the Trusts Equality Diversity and Inclusion Networks to create a New Starter Welcome Leaflet that will be sent to new employees with their contract of employment providing an overview of the Trust's Disability Equality Network, LGBTQ Network and BAME Network including how to join.
3. Pathology and Radiology continue to utilise Recruitment and Retention premiums. Due to the change in vacancy and turnover position the Radiology staff have been given notice of their premiums ending on 31st October 2021. Pathology premiums are due to be reviewed in July 2021 to determine whether they are required to continue or if they can be removed.
4. Medical Recruitment - A Consultant Working Group is meeting on a weekly basis to assess and target recruitment to specific departments. AMDs, MD, HR and resourcing team participating. A document is being prepared to actively track all consultant vacancies and will enable the working group to prioritise and actively manage the vacancies.
5. Hard to fill Consultant appointment made in Respiratory Medicine on 30th April. Strong candidate being interviewed for the Consultant Radiologist post on 7th May.

## Risk to performance and mitigations

EDI reporting remains inaccurate for Medical appointed candidates. Following the alignment of Medical Workforce to the Recruitment Team in May an overhaul of the recruitment process for inputting on TRAC and additional training will be provided to enable effective reporting.

Monitor voluntary turnover as we move into recovery, the NHS is expecting an increasing in turnover post pandemic, due to effects of COVD and staff wellbeing.



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

# Workforce

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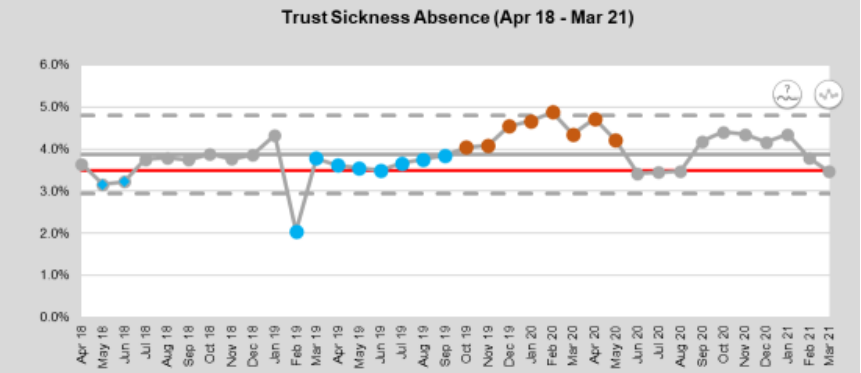
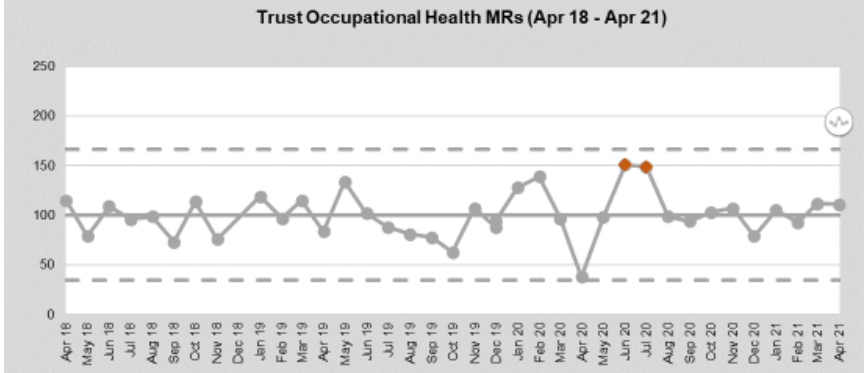
Use of Resources

| Great Employee Experience | Indicator Score | Self Assessment Score |
|---|---|---|
| | 3 | 3 |




## Background

For March 2021, sickness absence is reported at 3.47% which is below a Trust average of 3.9%, following seasonal trend for this time of year and Trust target of 3.5%.

Key themes from OH management referrals remain unchanged :

- Covid related (mainly returning to work as shielding ended)
- MSK/back and shoulder pain
- stress/mental health
- long term and chronic medical conditions

## Improvement actions

1. Significant improvement with the resource model for the OH department enabling skill mix review of the service to support resumption of some on-site services - Band 5 OH nurse 3rd May with experience and capacity for the annual staff flu campaign; Band 6 specialist OH nurse due to start in June with experience of management and leading occupational health and wellbeing campaigns and projects and a clinical psychologist will start in May.
2. Collaboration with Trust colleagues in Pharmacy and nursing teams has commenced in preparation for the annual staff flu campaign. Meeting arranged for 7th May to plan annual flu campaign launch for 2021/22, which may be combined with a COVID booster vaccine.
3. Planning underway to convert a room in Commonhead offices into a clinic room to help with professional provision of the on-site service to our staff.

## Risk to performance and mitigations

Planning for the annual flu campaign is commencing this month with the requirement to align with the on-going Covid-19 vaccination programme. This will be mitigated through appropriate planning and discussion with key stakeholders for both programmes.



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

# Workforce

Use of Resources

| Great Employee Experience | Indicator Score | Self Assessment Score |
|---|---|---|
| | 3 | 3 |

## Employee Recognition

| | | | |
|---|---|---|---|
| Long Service Awards | 16 | Hidden Heroes | 17 |
| Retirement Awards | 2 | STAR awards | 7 Nominations |

## Diversity/Inclusivity

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

- Piloting a reverse mentoring scheme in May, to pair our Board Executives with colleagues from diverse backgrounds to share career and life experience.
- Launching an educational resource 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.
- The 'Early Years Careers' team has created a virtual work experience programme attracting diversity of student application with 24% BAME uptake. Reaching audience through social media and school / council careers hubs.
- The LGBTQ+ Network next meets on the 27th May 2021 and seeks individuals to participate in an 'Alter Ego' day and the BAME network next meets on the 13th May 2021.
- The Trust will recognise - Mental Health Awareness Month in May; 17th May - International Day Against Homophobia, Transphobia and Biphobia; 12th & 13th May - EID al-Fitr (Festival of Breaking the Fast); 1st June - Global Day of Parents; 18th June - Autistic Pride Day to recognise the importance of positive changes in the broader society.

## Wellbeing Initiatives

**The Trust Tea Trolley:** resumed 03/03/21 and 1130 drinks and snacks given out. Additional deliveries over the Easter period included Easter eggs and Lindt chocolates, Snack bars and noodle packs for lunches

**Massage Chairs:** April Rotation continues in Mortuary, Mercury, Woodpecker, Physiotherapy services.

**Divisional Wellbeing Activities** – 250 Community gift bags were made up with the help of volunteers. Bags contained 'Thank you' branded nivea cream, noodle snack pack, juice carton, glasses lens wipe, hand gel tissues, snack bar and staff support leaflets and were delivered by senior managers to off-site community teams who rarely touch base and to include them in health and wellbeing initiatives.

**Yoga Class Referral Sessions**: This pilot scheme launched by Occupational Health on 15th March as a pilot for clients referred for physio and mental health services. 4 clients referred in April and further promotion planned.

## Background

In April, 31 staff were seen and 32 individual counselling sessions were offered. 99% attendance with 1 DNA. Key support themes include:

Work related – stress, trauma and Covid-19 related.

Personal – Anxiety, stress and relationship/mood /bereavement.

In-reach activity for the month:

17 'Bitesize' wellbeing sessions were held by team in April – 20 minute sessions accessible to all staff – Themes: Self-care, Managing stress, mind management, lifestyle balance, switching off your brain, relaxation, psychological safety in teams, mindfulness.

Self Care sessions held for the Breast Centre and Community teams.

Mindfulness session held in Forest Ward, SwICC

## Improvement actions

1. 16 Mental Health First Aiders (MHFA) trained in April bringing total to 156 trained Trust-wide.
2. 8 staff trained in Trauma Risk Management (TRiM) in April, and 4 existing TRiM practitioners trained to be TRiM managers. Following a further cohort of TRiM practitioner training in May, TRiM awareness and referral processes will be disseminated throughout the Trust.
3. Health and Wellbeing Champions increase their engagement and contribution to the wellbeing agenda and 2 in-reach self-care sessions conducted in April, were as a result of champion recommendation for their respective teams.
4. This month, the health and wellbeing team introduced a standardised outcome measure, to be used at the start and then again at the end of 1:1 counselling, to be able to report objective scores in therapeutic effectiveness – pre/post data will be available from next month.
5. One of the wellbeing team members completed training this month in Suicide First Aid and further to training provider post-course verification, training sessions in Suicide Awareness and Suicide First Aid can be made available to staff.
6. The team's therapists started providing 'Bitesize' (20mins) health and wellbeing sessions on MS Teams in April available to all staff, covering various topics including mindfulness, psychological safety in teams, relaxation – these were well attended, and the team will continue with these, offering at least one for most weekdays throughout May

## Risk to performance and mitigations

Sickness absence rates are a measure of the health, wellbeing and morale of the workforce.

Some recovery is evident from the improved sickness absence rate and indicative of emergence from the challenges of winter and improved support for long term sickness cases.

It is essential that we closely monitor the wellbeing of staff to support psychological and physical recovery, to include providing reasonable adjustment to enabling those members of staff with long Covid-19 to feel supported back to work.





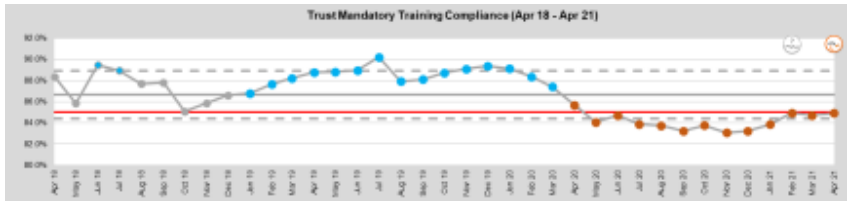
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

# Workforce

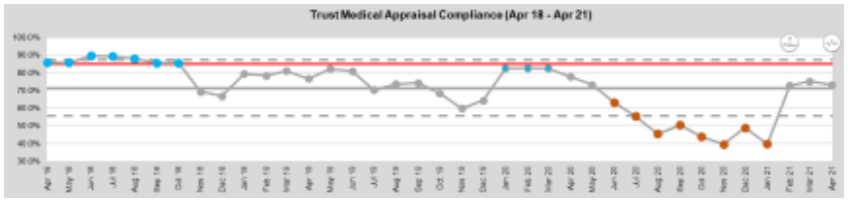
Use of Resources

## Great Employee Development

| Indicator Score | Self Assessment Score |
|---|---|
| 3 | 3 |






### Background

Trust mandatory training compliance continues to improve with overall performance remaining **just** below the 85% target, reported at 84.91% in April.

Role essential training continues to meet the target, reported at 85.47% in April.

Trust appraisal compliance is reported at 82.47% in April. a very marginal increase since March(81.07%) which reflects an improving trend over the last quarter.

Medical appraisal compliance has remained stable since February.

### Improvement actions

1. The risk register is reviewed on a monthly basis.
2. The mandatory training project is on track to achieve a transfer from Training Tracker to ESR by 31 May 2021. The new system will go live on the 1 June and will improve the timeliness and accuracy of reporting.
3. A communications plan for staff is being prepared to ensure a smooth transfer to the system and will include a user guide.

### Risk to performance and mitigations

Capacity continues to be a challenge for some courses due to the requirements of social distancing.

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

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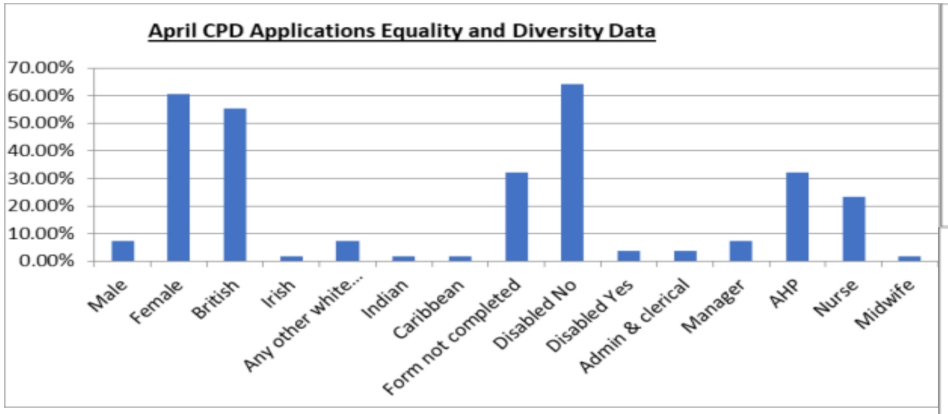
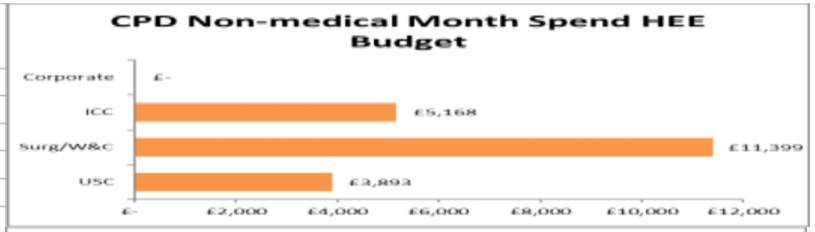
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

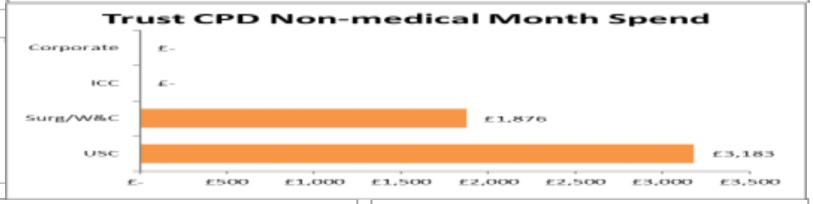
# Workforce

Use of Resources

| Great Employee Development | Indicator Score | Self Assessment Score |
|---|---|---|
| | 3 | 3 |




## Background

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

HEE budget spend to date is £360,611. (with an accrual of the reminder of the money) of £516,000 In addition to the monthly course applications we have also purchased further frequently applied for modules from University West England for the current financial year totaling £15,044.

The required return to HEE confirming spend has been submitted.

There were a total of 56 non-medical CPD Applications in April for up-skilling and leadership courses.

## Improvement actions

1. The Head of Learning and Development has moved from another role within the Trust. A recruitment exercise has led to the offer of a post to an external candidate. There is cover planned during the interim period, and this will be undertaken by an experienced manager with a background in learning and development.

2. The Trust has been able to approve more requests for CPD from the Trust CPD budget as a result of having secured the additional funding from HEE for CPD for nurses. midwives and AHPs, which has been positively received.

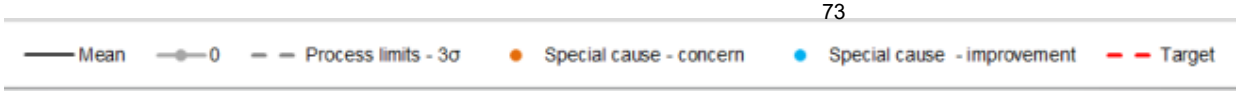
3. The Trust is anticipating receiving a similar sum of money this year for CPD for nurses, midwives and AHPs. The focus of the interim Head of L and D will be the introduction of a systematic training needs analysis (TNA).

## Risk to performance and mitigations

The introduction of an interim Head of Learning and Development could lead to a period of instability within the Academy. However, this individual appointed has the internal knowledge required and relevant expertise. This risk will be mitigated by the oversight of the Associate Director of OD and Learning.

The careful planning of CPD requirements as part of a TNA should assist in planning the spend over 2021/22.





# Workforce

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Use of Resources

| Great Leadership | Indicator Score | Self Assessment Score |
|---|---|---|
| | 2 | 2 |
| **Leadership Roles at the Trust** | **4.24% of staff** | **Equating to 172.45 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** *(24 March)* | **45 managers** | **Actively Attending** |
| **Ward Accreditation** | **24 of 24 departments** | **using the Perfect Ward App** |

## Background

The second cohort of the Leadership Development programme (for Bands 7/8A) began in April. This means there are now 39 leaders on the programme in total.

The new EDI module will now be included on the programme as part of the Trust's commitment to improving the capability of leaders in this area.

The third session of the BSW AMD Acute Alliance programme focused on cultural and behavioural change.

Talent Review Boards for Phase 2A of the talent management implementation plan were held on 19 April and 6 May. The final one will be on 24 May. This covers those reporting to corporate leads in HR, Finance, Transformation, Nursing, Informatics, Contracting, Estate and Facilities.

## Improvement actions

1. The Trust is tracking the usage of the training and development component of its subscription to NHS Elect. The quarterly performance management of this subscription includes monitoring the numbers of staff who access NHS Elect webinars. (216 in 2020/21) and the use of the 3 allocated coaching places.
2. The Trust continues to use Leadership Forum to showcase innovations in leadership and stimulate interest in new approaches. The Forum start time has moved to 6pm and this has encouraged more medical staff to join. The focus in May will be on civility and respect, and will promote the work done in ED in this area.
3. The Trust continues to contribute to the development of the BSW Academy and explore the possibilities of much closer collaboration . The AMD programme is an example of this, and the work on a similar programme for Clinical Leads continues-although given the numbers involved this is likely to require several cohorts.
4. The Head of Leadership, Talent Management and Succession Planning has now appointed the Leadership and Team Development Manager post. Both post holders will work with teams as required and both will be accredited to use Belbin. The intention is to develop significant expertise in house to ensure self sufficiency and sustainability.
5. The Trust will be providing coaching training to staff at ILM levels 5 and 7. This will develop in house capacity to support the development of staff where coaching has been identified as an appropriate intervention.
6. Phase 2B of the Talent Management implementation plan is underway. This phase covers those reporting to Divisional Directors, Deputy Chief Nurses, Divisional Directors of Nursing, Associate Medical Directors, Medical Director, Deputy Medical Director, Head of Midwifery,and Director of Pharmacy and Medicines Optimisation. The first Talent Review Board will take place on the 20 May, but given the volume of individuals to be reviewed there will be additional TRBs in June to complete this phase.

## Risk to performance and mitigations

The capacity of staff trained in coaching to deliver coaching within the organisation. This will be mitigated by a formal agreement between the individual and their manager that they will undertake a specified amount of coaching as a condition of being released to undertake the course.

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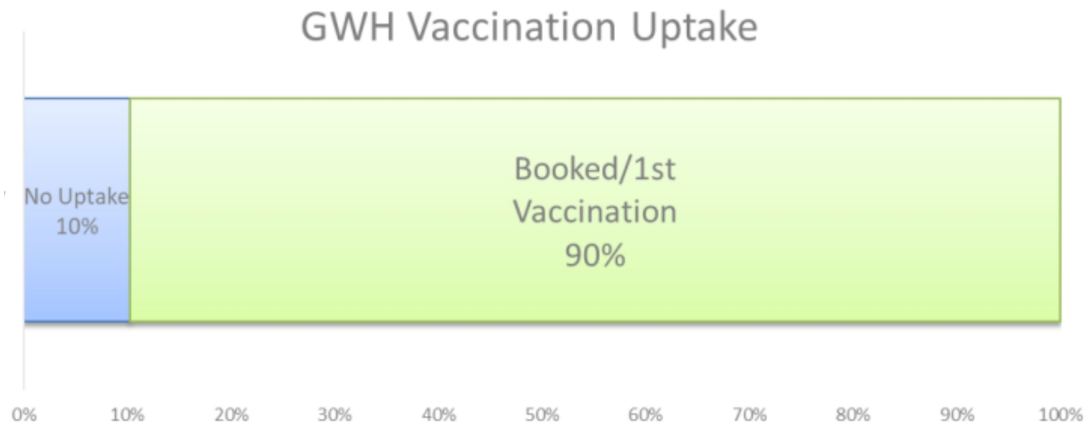
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

# Exception: Vaccination Programme

Exception Report




| BME (including bank staff) | Total Staff | Vaccinated Dose 1 | % Vaccinated |
|---|---|---|---|
| BME | 1022 | 819 | 80% |
| Not Stated | 747 | 585 | 78% |
| White | 4372 | 3923 | 90% |
| **TOTAL** | **6141** | **5327** | **87%** |

## Background

Ninety per cent of substantive staff have been vaccinated or are due to be vaccinated at the end of April 2021 with the highest percentage achieved within Surgery Women's and Chldren's Division at 91% of their substantive staff.

143 departments have achieved 100% compliance with vaccination uptake to date and one to ones with staff who have no recorded engagement continue to be completed where agreed with the staff member. Findings show that the majority of declined vaccinations (59%) and declined one to one meetings (28%) are due to pregnancy or breast feeding concerns.

Benchmarking -
Salisbury = 85.57%
AWP = 79%
GWH = 90%

## Improvement actions

1. Targeted and supportive vaccine specific 'myth busting' 1-1 meetings have prompted some staff to reconsider having the vaccine which has impacted positively on uptake.
2. Clinical Lead has contacted the GWH in-patient ward managers for the wards who have 75% or less staff vaccinated with an offer of support to encourage staff to come forward for vaccination.
3. Clinical incident occurred with the inadvertent administering of the incorrect type of second dose to recipient which resulted in some media interest. Root Cause Analysis (RCA) review currently being written to present when completed at Covid-19 Vaccination Operational group & PQC Quality Forum.
4. Successfully commenced in-patient vaccination referral and vaccination services and have vaccinated 14 in-patients during April 2021.

## Risk to performance and mitigations

The Covid-19 vaccine programme is being conducted from the Occupational Health department and resourced by substantive / bank workforce and volunteers.

NHS
Great Western Hospitals
NHS Foundation Trust

# Board Committee Assurance Report

| Finance & Investment Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Andy Copestake** | Andy Copestake | | 24 May 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 | | | |
| Month 1 Income and Expenditure position | A | A | Month 1 only a £2k deficit against a breakeven budget. However, the amber rating reflects concerns from the Committee on the shortfall in CIP achievement in the month. Also, pay costs are above plan, which is a cause for concern this early in the financial year. | Continue to monitor monthly I & E position through FIC | FIC meetings 2021/22 |
| Month 1 Cash position | G | G | Cash balance is £27m at month end. No immediate concerns for the first half of 2021/22, but we await the central guidance for the second half of the year. | Continue to monitor Cash position through FIC | FIC meetings 2021/22 |
| Month 1 Capital Expenditure position | A | A | There are a number of unfunded projects in the new financial year. Also, the Committee was keen to see the phasing of the 2021/22 budget to ensure that there isn't undue pressure to spend in the latter part of the year. | Continue to monitor capex through FIC | FIC meetings 2021/22 |
| Finance Risk Register | A | G | The Finance team has undertaken a thorough review of their risks, resulting in a number of new risks and regrading some existing risks. | Monitor through FIC | FIC meetings 2021/22 |
| Financial Planning 2021/22 - 1st half year | G | A | The financial regime for the first 6 months of 21/22 will broadly follow the pattern from 2020/21 with enhanced monthly block payments. The Committee approved the H1 revenue budget on behalf of the Board. The amber rating on actions reflects concerns over CIP delivery and Pay control within the agreed plan. | Monitor through FIC | FIC meetings 2021/22 |

Great Western Hospitals NHS Foundation Trust

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Financial Planning 2021/22 – 2nd half year | R | R | The second half of the year will probably be much more challenging from a finance perspective. Central guidance has still not been produced and if the regime reverts to the pre-Covid regime the Trust will, again, be facing a substantial operating deficit. Given this working assumption, the Committee was keen to open up a dialogue with the Executive Team and Divisions at the earliest opportunity to set expectations re: the need to achieve financial sustainability in the medium term, reverse the worsening of the Trust's reference cost position, the Trust's ability to fund cost pressures and the need to push on with the Improvement & Efficiency Plan. | Additional FIC meeting to be arranged to discuss key assumptions for H2 when central guidance received. | To be agreed |
| Debtors in depth review | A | A | A good paper from the new Head of Financial Control which showed good progress in resolving a number of long-standing issues in this area and reducing debt levels. The amber rating reflects the need for a more robust process with regard to financial arrangements between different parts of the ICS to avoid confusion and disagreement in the future. | Review in 6 months | FIC - October 2021 |
| Automated Endoscope Washer/Dryer Business Case | A | A | After considerable discussion about the pros and cons of outright purchase versus the proposed Pay per Use solution, the Committee approved this Business Case. The Committee agreed that the PPU proposal gave much needed flexibility over the next few years whilst the larger HSDU solution was progressed. | None | |
| Contract for the replacement and maintenance of Automated Endoscope Washers | G | A | The Committee approved the award of the contract to Wassenburg Medical for 3 years but asked for confirmation that an extension could be granted without incurring significant additional cost in the event that the HSDU solution was delayed. | Monitor as part of HSDU project | To be agreed |
| Novation of 6 Pathology contracts | G | G | The Committee approved the novation of 6 Pathology contracts into the Beckman Coulter Managed Service Contract, resulting in significant VAT savings as well as other benefits. | None | |
| Maintenance of Siemens Radiology equipment | G | G | The Committee supported the proposal to award a 5 year contract to Siemens. | Board | 3 June 2021 |

| 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

# Income and Expenditure

Use of Resources

| Income & Expenditure | | IN MONTH (April) Budget £'000 | IN MONTH (April) Actual £'000 | IN MONTH (April) Variance £'000 | YTD (April) Budget £'000 | YTD (April) Actual £'000 | YTD (April) Variance £'000 | H1 FORECAST H1 Budget £'000 | H1 FORECAST H1 Forecast £'000 | H1 FORECAST H1 Variance £'000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Income | NHS Clinical Income | 31,094 | 31,116 | 22 | 31,094 | 31,116 | 22 | 186,618 | 186,618 | - |
| | Private Patients | 166 | 122 | (44) | 166 | 122 | (44) | 997 | 997 | - |
| | Other Non Mandatory/Non Protected Revenue | 77 | 58 | (19) | 77 | 58 | (19) | 469 | 469 | - |
| | Research & Development Income | 68 | 60 | (7) | 68 | 60 | (7) | 407 | 407 | - |
| | Education and Training Income | 994 | 1,227 | 233 | 994 | 1,227 | 233 | 5,963 | 5,963 | - |
| | Misc Other Operating Income | 604 | 713 | 109 | 604 | 713 | 109 | 3,611 | 3,611 | - |
| | | 33,003 | 33,296 | 293 | 33,003 | 33,296 | 293 | 198,064 | 198,064 | - |
| Expenditure | Pay Costs | (19,884) | (20,029) | (145) | (19,884) | (20,029) | (145) | (120,549) | (120,549) | - |
| | Non Pay | (7,586) | (7,773) | (187) | (7,586) | (7,773) | (187) | (44,289) | (44,289) | - |
| | Drugs Costs | (3,042) | (3,008) | 34 | (3,042) | (3,008) | 34 | (18,277) | (18,277) | - |
| | | (30,512) | (30,810) | (299) | (30,512) | (30,810) | (299) | (183,115) | (183,115) | - |
| EBITDA | | 2,491 | 2,486 | (5) | 2,491 | 2,486 | (5) | 14,949 | 14,949 | - |
| EBITDA as % of Total Income | | 7.5% | 7.5% | -0.1% | 7.5% | 7.5% | -0.1% | 7.5% | 7.5% | 0.0% |
| | Depreciation | (877) | (877) | 0 | (877) | (877) | 0 | (5,263) | (5,263) | - |
| | Net Interest | (1,260) | (1,256) | 4 | (1,260) | (1,256) | 4 | (7,558) | (7,558) | - |
| | PDC Dividend | (354) | (354) | (0) | (354) | (354) | (0) | (2,128) | (2,128) | - |
| | Pension Unwinding | - | - | - | - | - | - | | - | - |
| Total Surplus/(Deficit) | | 0 | (2) | (2) | 0 | (2) | (2) | 0 | 0 | - |

The 2021/22 Budget is made up of two halves: April 21 – September 21 (referred to as H1) and October 21 - March 22 (referred to as H2). The Trust will be in receipt of enhanced block payments for the first 6 months of the year. The plan is to deliver a breakeven position with an overall Trust efficiency requirement of £1,272k.

# Income and Expenditure – Headline Variances from Plan

Use of Resources

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

The Month 1 2021/22 Financial Position is £2k deficit against a plan of breakeven. The variances are detailed below.

**Income variance** is £293k above plan in month and year to date. This includes:

- Private patient income is £44k lower than plan. Activity has been limited due to reduced capacity in Aldbourne (Trauma and Orthopaedics activity).
- Education & Training Income is £233k higher than plan following notification from HEE of the quarter 1 funding allocation. The increased income is matched by costs.
- Other Operating Income is £109k higher than plan due to Carbon Energy Fund (CEF) & overseas recruitment income released to match costs.

**Pay variance** is £145k overspend in month and year to date. The in month position includes:

- Nursing overspend of £299k including close support and patient acuity costs which, despite reducing by £10k from prior month, have driven an overspend of £145k.
- Supernumerary costs of 10 new nurses were incurred in April which will reduce the reliance on temporary staffing in future months to help recover the financial position, particularly in ICU.
- Medical overspend of £48k is driven by the premium costs of covering vacancies and Primary Care GP costs which are £36k higher than plan.
- Vacancies within Scientific & Technical and Senior Managers & Admin are driving an underspend of £171k. Further analysis of the pay position is detailed on the following slides.

**Non Pay variance** is £150k overspend in month and year to date. The position includes:

- Savings target of £170k of which £34k has been achieved. Drugs underspend of £33k
- Carbon Energy Fund costs, education & training and overseas recruitment costs of £65k matched by income.

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

Services are looking to upskill existing staff and work with CAMHS and mental health partners to reduce the use of agency for close support.

An Improvement Board has been established in Unscheduled Care in April, focusing on 4 key spend priorities – Junior Doctor, Consultant, Urgent Treatment Centre and Close Support.

Recruitment packages for permanent Primary Care GPs have been agreed and timescales for implementation are being discussed.

Vacant corporate admin roles will be reviewed prior to recruitment to determine if there is an opportunity to deliver an efficiency through vacancy lag.

Efficiency and improvement plans will be shared with divisions during May supported by the Transformation & Improvement Team.

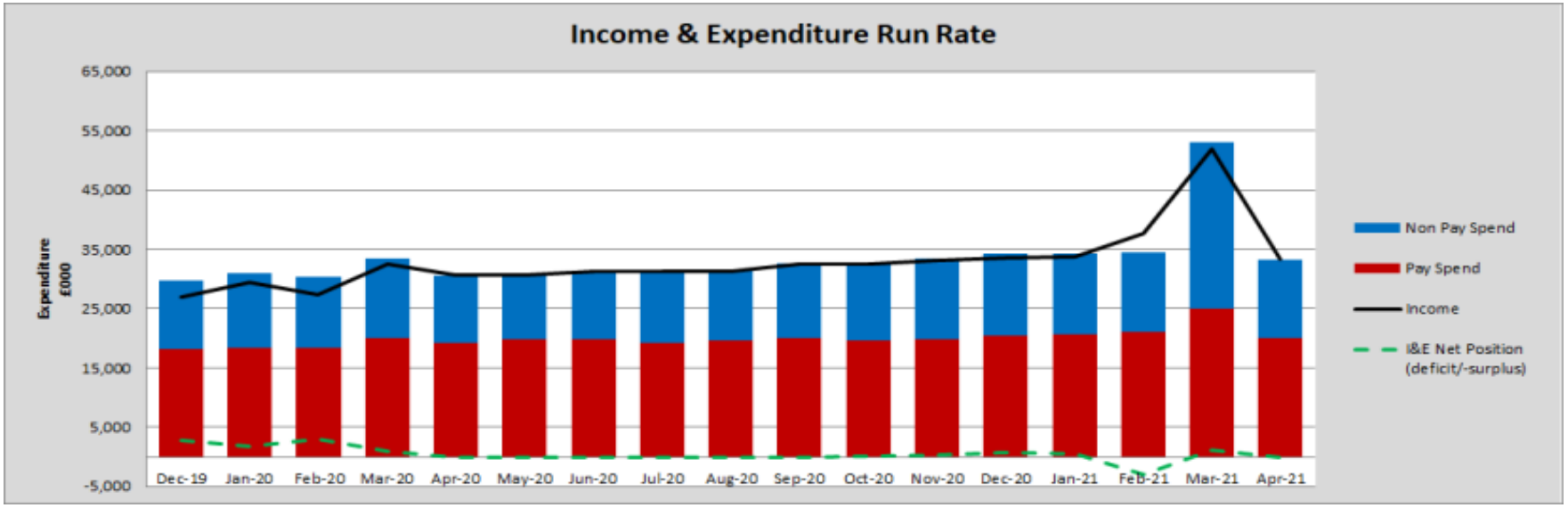
**Risks to delivery and mitigations**

There is an emerging risk that the cost of recovery exceeds budget. Operational teams are developing a recovery plan which will be assessed in terms of affordability.

Long term delay on international recruitment (India) will have an impact on closing the vacancy gap for nursing. Options are been explored for alternative recruitment options.

# Income and Expenditure - Run Rate

Use of Resources




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

The April Income and Expenditure position is considerably different to March due to a number of technical and year end adjustments that were made last month. Comparisons have therefore been made against the average run rate from December 20 to February 21.

Income run rate – has reduced by £1,658k. Key drivers of this are:

- NHS Clinical Income has reduced by £1,828k due to change in block contract funding and HDP income ending.
- Education and Training income has increased by £197k due to notification of Q1 funding allocation being received from HEE. This increase is matched by costs.

Pay run rate – has reduced by £744k but is £145k higher than plan. The reduction in run rate is explained in detail on the following Workforce slide.

Non Pay run rate reduced by £315k but is £150k higher than plan and is driven by:

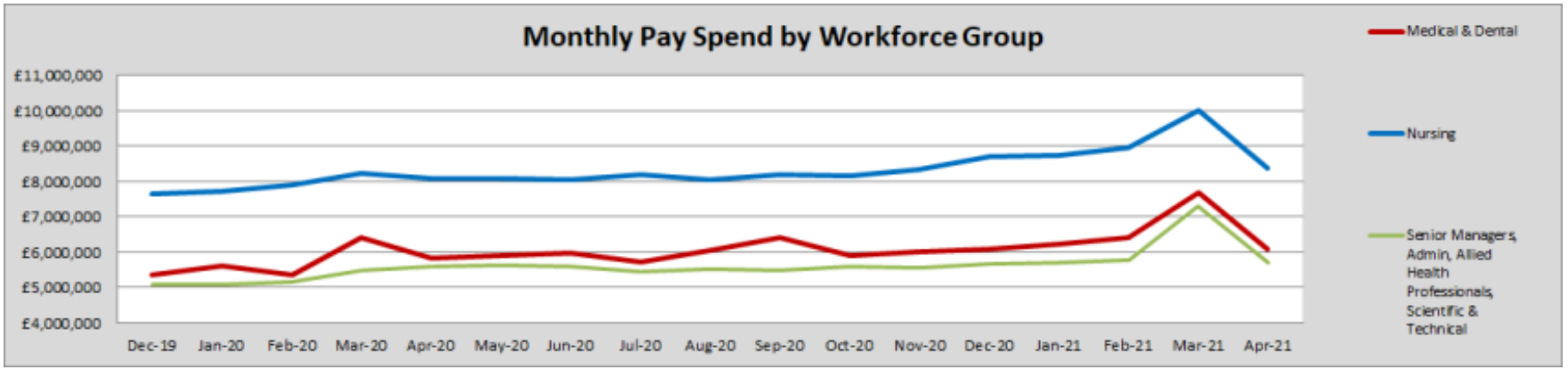
- Provisions and accruals were made in Q4 which means that spend is lower in April
- HDP spend has reduced by £59k
- Depreciation and PDC have increased by £176k as expected following capital investment made in 2020/21.

**Improvement actions planned, timescales, and when improvements will be seen** are explained in the previous slide

**Risks to delivery and mitigations** are explained in the previous slide

# Pay Spend by Workforce Group

Use of Resources




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

April spend is considerably lower than March due to a number of large year end adjustments that were made last month. Spend has therefore been compared to the average run rate from December 20 to February 21.

**Nursing**

- Run rate has reduced by £495k although remains overspent for the reasons described in the earlier slide. Temporary staffing spend has reduced by £637k and permanent staffing spend has increased by £141k. Temporary nursing costs have reduced due to fewer shifts being requested and the hourly rate per shift reducing. The Trust has switched to a Preferred Supplier List procurement model, which has led to more shifts being covered at the cap rate rather than inflated levels, with premium escalation costs only being incurred in extreme cases. Nursing vacancies across the Trust are reducing and spend on agency vacancy cover is 22% lower in April that it was during the average of December 20 –February 21.

**Medical**

- Run rate has reduced by £176k although remains overspent for the reasons described in the earlier slide. Locum spend is £225k lower due to reduced accruals for time owed to Anaesthetic ICU medical staff, and reduced vacancy cover for Obs & Gynae, Ophthalmology and outliers although this is partially offset by increase in permanent staff as vacancies are filled.

**AHP/S&T**

- Spend has reduced by £63k due to vacancies and reduction in temporary staffing cover. Spend is expected to increase as recruitment takes place in forthcoming months.

**Admin/SM**

- Spend has increased by £6k due to vacancies filled within estates.

**Improvement actions planned, timescales, and when improvements will be seen** are explained in the income & expenditure slide

**Risks to delivery and mitigations** are explained in the income & expenditure slide

# Statement of Financial Position

Use of Resources

| | Previous Month Mar-21 (£'000) | Current Month APR-21 (£'000) | Movement (£'000) From Prior Mth | As at year-end Mar-21 (£'000) |
|---|---|---|---|---|
| **Non-Current Assets** | | | | |
| Intangible assets | 5,399 | 5,399 | - | 5,399 |
| Property, plant and equipment | 230,331 | 231,882 | 1,551 | 230,331 |
| Investments in associates & joint ventures | 70 | 70 | - | 70 |
| Receivables - non-current | 656 | 656 | - | 656 |
| **Total Non-Current Assets** | 236,455 | 238,006 | 1,551 | 236,455 |
| **Current Assets** | | | | |
| Inventories | 4,787 | 4,636 | (151) | 4,787 |
| Receivables: invoiced | 4,870 | 3,323 | (1,547) | 4,870 |
| Receivables: not invoiced | 33,309 | 31,960 | (1,349) | 33,309 |
| Cash and cash equivalents. | 21,566 | 26,880 | 5,314 | 21,566 |
| **Total Current Assets** | 64,532 | 66,799 | 2,267 | 64,532 |
| **Total Assets** | 300,987 | 304,805 | 3,818 | 300,987 |
| | | | | |
| **Current Liabilities** | | | | |
| Other liabilities: deferred income | 2,263 | 4,558 | 2,296 | 2,263 |
| Trade and other payables: invoiced | 8,806 | 4,434 | (4,373) | 8,806 |
| Trade and other payables: not invoiced | 32,159 | 38,996 | 6,837 | 32,159 |
| Provisions - current | 156 | 154 | (2) | 156 |
| Trade and other payables: capital | 10,207 | 10,005 | (202) | 10,207 |
| Borrowings: PFI, loans & finance leases | 8,765 | 8,029 | (736) | 8,765 |
| **Total Current Liabilities** | 62,357 | 66,176 | 3,819 | 62,357 |
| **Non current Liabilities** | | | | |
| Other liabilities: deferred income | 790 | 790 | - | 790 |
| Provisions - non-current | 2,177 | 2,177 | - | 2,177 |
| Borrowings: loans & finance leases | 1,174 | 1,174 | - | 1,174 |
| PFI obligations | 87,001 | 87,002 | 1 | 87,001 |
| **Total Non-Current Liabilities** | 91,142 | 91,143 | 1 | 91,142 |
| **Total Assets Employed** | 147,489 | 147,487 | (2) | 147,489 |
| | OK | | | OK |
| **Taxpayer's and Others Equity** | | | | |
| Public dividend capital | 137,337 | 137,337 | - | 137,337 |
| Income and expenditure reserve | (28,632) | (28,634) | (2) | (28,632) |
| Revaluation reserve | 38,784 | 38,784 | - | 38,784 |
| **Total Assets Employed** | 147,489 | 147,487 | (2) | 147,489 |

# Statement of Financial Position

Use of Resources

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

**Non-Current Assets**

- The £656k receivable relates to a clinician tax reimbursement provision recognised at year-end. This was revised at the end of 20/21 to reflect latest guidance.
- The in month movement in property, plant & equipment relates to capital additions offset by depreciation.

- **Total Current Assets** are higher than the previous month by £2,267k. This is primarily driven by an increase in cash (£5,314k) – further detail can be found on the cash slide.
- Stock levels have decreased by £151k due to drug purchases in month. PPE stock (£325k) given free of charge to the Trust by DHSC is now included in the year end stock value in line with National guidance.

- **Total Current Liabilities** have increased by £3,819k from last month.
- The deferred income increase of £2,296k relates to Health Education England paying quarterly in advance.
- Invoiced trade payables have decreased by £4,373k. This relates to invoices that have been received but are not yet approved for payment Non-invoiced payables have increased by £6,837k due to movements in accruals.
- Capital payables have decreased by £202k compared to last month due to payment of prior year creditors
- Borrowings have been updated to show the correct breakdown of debt between non-current to current liabilities less £664k PFI payment and £23k Finance lease payment and a review of a Finance Lease

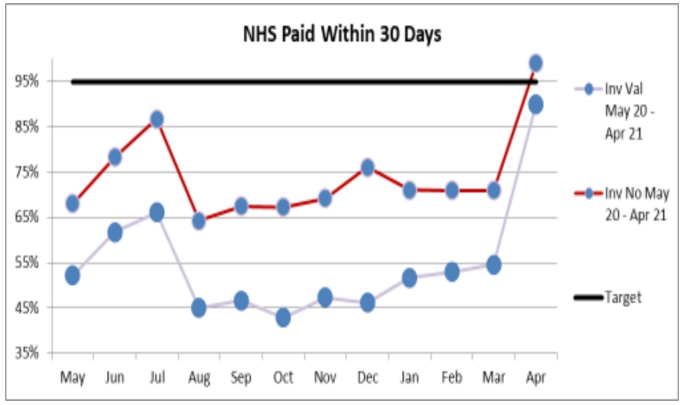
## Risks to delivery and mitigations

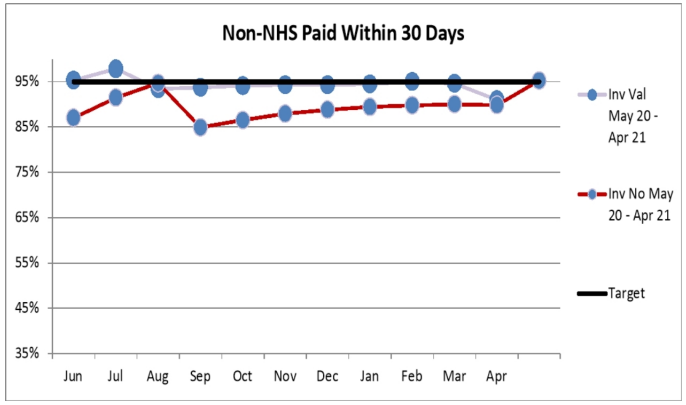
The risk is that creditors and debtors increase which put pressure on the cash position. This will be mitigated by close monitoring of debt and actively chasing budget holders to ensure that creditor invoices are approved on time.

# Working Capital

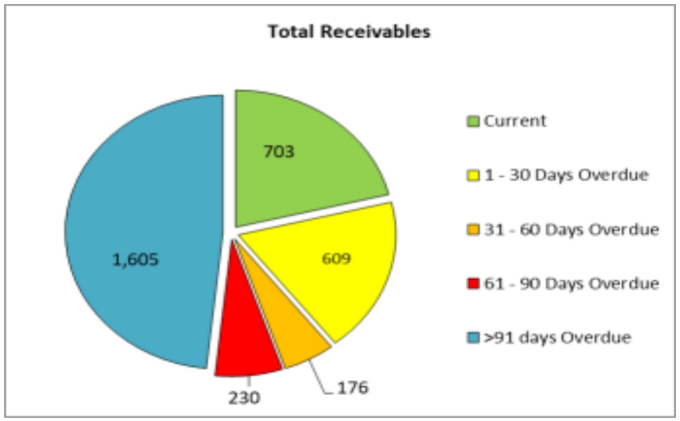
Use of Resources

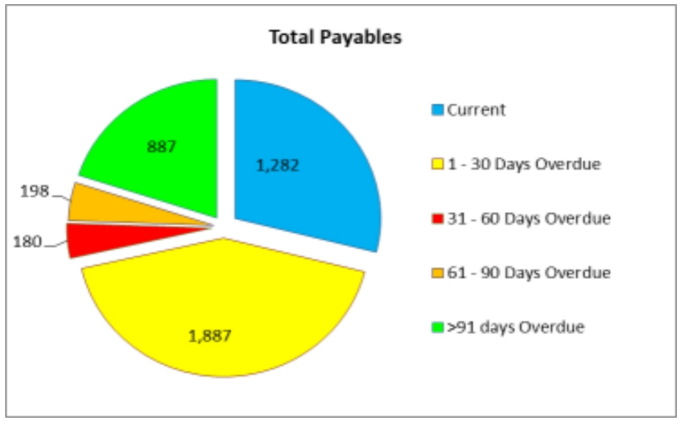
## Payments to Suppliers




## Outstanding Receivable and Payable Balances




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

**Creditors** - We have an objective to pay creditors within 30 days and Budget holders are actively chased by system emails and the AP team to minimise delay in coding and approval. Overall our BPPC rate for the number of invoices paid within target is 90.9% a small increase from 89.3% last month.
BPPC performance is below 95% due to delays in invoice approval and where supplier credit terms are 60 days.

**Debtors** – Debtors have decreased which gives additional flexibility with working capital

# Cash [86]

Use of Resources

| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | 21/22 Total | Rolling 12 Mths May 21 to Apr 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | | | | | | £'000 | £'000 |
| **Opening Balance** | **21,553** | **26,880** | **33,135** | **37,499** | **32,695** | **39,010** | **41,774** | **34,997** | **36,155** | **37,369** | **26,696** | **27,909** | **29,122** | **21,553** | 26,880 |
| **Income** | | | | | | | | | | | | | | | |
| Clinical Income | 30,668 | 30,668 | 30,668 | 30,668 | 30,668 | 30,668 | 27,517 | 27,517 | 27,517 | 27,517 | 27,517 | 27,517 | 27,517 | 349,110 | 345,959 |
| Other Income | 9,309 | 3,962 | 2,012 | 4,730 | 3,962 | 2,012 | 2,012 | 2,012 | 2,012 | 2,012 | 2,012 | 2,012 | 2,012 | 38,058 | 30,761 |
| Revenue Financing Loan / PDC | | | | | | | | | | | | | | | |
| Capital Financing Loan / PDC | | 4,591 | 4,591 | 4,591 | 4,591 | 4,591 | 8,487 | 4,591 | 4,591 | 4,591 | 4,591 | 4,591 | 4,591 | 54,397 | 58,988 |
| **Total Income** | **39,977** | **39,221** | **37,271** | **39,989** | **39,221** | **37,271** | **38,016** | **34,120** | **34,120** | **34,120** | **34,120** | **34,120** | **34,120** | **441,565** | **435,708** |
| **Expenditure** | | | | | | | | | | | | | | | |
| Pay | 18,692 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 240,210 | 241,656 |
| Revenue Creditors | 10,504 | 8,307 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 101,826 | 99,623 |
| Capital Creditors | 5,454 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 54,593 | 53,606 |
| Prepayments | | | | | | | | | | | | | | | |
| PFI | | | | 11,886 | | | 11,886 | | | 11,886 | | | 11,886 | 35,658 | 47,544 |
| PDC Interest | | | | | | 1,600 | | | | | | | | 1,600 | 1,600 |
| Financing | | 55 | | | | | | 55 | | | | | | 110 | 110 |
| **Total Expenditure** | **34,650** | **32,967** | **32,907** | **44,793** | **32,907** | **34,507** | **44,793** | **32,962** | **32,907** | **44,793** | **32,907** | **32,907** | **44,793** | **433,997** | **444,139** |
| **Closing Balance** | **26,880** | **33,135** | **37,499** | **32,695** | **39,010** | **41,774** | **34,997** | **36,155** | **37,369** | **26,696** | **27,909** | **29,122** | **18,449** | **29,122** | **18,449** |

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

- Cash at the end of April was £26,880k, an increase of £5,314k from the prior month. The movement in cash balance is due to an increase in non clinical income including Education & Training funding.
- The rolling cashflow forecast below assumes Commissioner income continues at the level received in the Month 1 block for the first 6 months of 2021/22 in line with the funding regime for H1.

**Risks to delivery and mitigations**

Due to the fluctuations and sensitivity of cash balances this will continue to be reviewed on a monthly basis

# Capital Programme

Use of Resources

| Capital Scheme | Capital Group | 2021/22 Full Year Plan £000 | 2021/22 YTD Plan £000 | 2021/22 YTD Actual £000 | 2021/22 YTD Variance £000 |
|---|---|---|---|---|---|
| Aseptic Suite | Estates | 1,903 | 12 | | (12) |
| Oxygen | Estates | 500 | | | - |
| Estates Replacement Schemes | Estates | 750 | | | - |
| Utilities (LV & Heating) Project | Estates | 2,300 | | 20 | 20 |
| Site Reconfigurations Urology/R&D etc | Estates | 300 | | | - |
| Pathlake (national funds requires matching) | IT | 260 | 7 | | (7) |
| Pathology LIMS (network procurement) | IT | 510 | | | - |
| IT Emergency Infrastructure | IT | 3,000 | 15 | 2,588 | 2,573 |
| IT Replacement Schemes | IT | 1,404 | | 7 | 7 |
| PACS - environment/replacement solution (Nov21) | IT | 800 | | | - |
| Equipment Replacement Schemes | Equipment | 1,450 | | | - |
| Contingency | Equipment | 541 | 45 | | (45) |
| Way Forward Programme | | 9,690 | 404 | | (404) |
| Clover UEC | | 10,085 | 1,120 | 9 | (1,111) |
| **Total Capital Plan (Excl PFI)** | | **33,493** | **1,603** | **2,624** | **1,021** |

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

The Capital Programme for 2021/22 is managed via the capital groups with the following allocations:

- Equipment Group - £5,753k (CDEL)
- Digital & IT Steering Group - £5,974k (CDEL)
- Estates and Facilities Management Group - £1,450k (CDEL)
- Way Forward Programme - £9,690k
- Clover UEC - £10,085k

Work is underway to prioritise, cost and sign off schemes to ensure allocations are fully committed in year. A contingency of £541k (CDEL) is being held centrally to mitigate any potential risks arising in year.

The Capital plan and profile included below was submitted to NHSI in April 2021. The monthly phasing of the plan will need to be reviewed once all schemes are fully worked up.

In month spend and variance primarily relates to the order placed by IT for the hybrid cloud. This project is on track to spend the full allocation by year end. Clover is behind plan due to delays experienced earlier in the year and the project is on plan for completion in 2021/22



**Risks to delivery and mitigations**

Risk of non delivery or delay if prioritisation is not completed in the coming weeks.

Capital groups are focusing on expenditure plans to report into Investment Committee to ensure all allocations are spent in year.

# Cost Improvement Plans – Better Care at Lower Cost

Use of Resources

| Scheme Area | In Month Plan £'000 | In Month Actual £'000 | In Month Variance £'000 | YTD Plan £'000 | YTD Actual £'000 | YTD Variance £'000 |
|---|---|---|---|---|---|---|
| Better Buying | 48 | 34 | (14) | 48 | 34 | (14) |
| Integrated and Community Care | 15 | - | (15) | 15 | - | (15) |
| Surgery, Womens & Childrens | 44 | - | (44) | 44 | - | (44) |
| Unscheduled Care | 50 | - | (50) | 50 | - | (50) |
| Corporate | 13 | - | (13) | 13 | - | (13) |
| Total | 170 | 34 | ( 136) | 170 | 34 | ( 136) |
| Percentage | | 20% | | | 20% | |

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

The Cost Improvement Programme (CIP) delivery plan for April is £170k.

The total for H1 of the year is £1,272k, c. 0.7% of total budgets.

As at month 1 due to the later than usual approval of the budget there is delay in the capture of achievement. Where possible these are shown, otherwise the M1 achievement will be captured alongside M2.

CIPs identified and delivered in month were £34k (£34k full year) which is £136k below plan (£136k full year).

Delivery to date is currently 20% of plan.

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

Planning for 2021/22 is continuing alongside delivery of live schemes, with a number of schemes that were not delivered due to Covid-19 in 2020/21 forming part of the current years' plan.

The efficiency requirement for the second half of the year is still to be quantified as it will depend on the budget for the second half of the year.

Work is continuing to identify efficiency projects driven by opportunity identified in the improvement programme and through divisional initiatives and ideas programmes.

**Risks to delivery and mitigations**

The key risk to delivery is delay in actions taken to deliver efficiencies

This is partially addressed through the profiling of the target, which is lighter in Q1 to reflect projects still requiring work up and commencement.

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# Board Committee Assurance Report

| Charitable Funds Committee Meeting – May 2021 | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Paul Lewis** | **Paul Lewis** | | 5 May 2021 |
| **Assurance:** Does this report provide assurance in respect of the Board Assurance Framework strategic risks? | 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 | | | |
| Fundraising | A | A | Q4 of our financial year is historically our quietest time for fundraising activities and COVID has continued to impact our ability to organise events. As a result we have some challenges with our fundraising income for this year, but we are in the process of reviewing and updating our 2021 Plan which will be reviewed and agreed at the next meeting. | Review and publish our 2021 Plan | 31 May 2021 |
| Finance Strategy | A | A | We need to review and agree our Finance Strategy to ensure we achieve the right balance between managing our Fund Balances effectively whilst maximising growth potential where appropriate | Review and publish our proposed Finance Strategy for our Fund Balances | 31 May 2021 |
| Case of Needs | A | A | The current Case of Needs process is well managed, but we have an opportunity to further simplify and improve the form and approach taken. We have requested a proposal to agree how we achieve this | Review and simplify our Case of Needs Process | 30 June 2021 |
| Staff Recognition Events | A | A | We have agreed plans for 2021 but due to fundraising challenges, we need to ensure there will be sufficient funds available to cover the costs when due | Double check available funds to cover all costs for the Staff Recognition Events | 31 May 2021 |

Great Western Hospitals NHS Foundation Trust

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