Great Western Hospitals NHS Foundation Trust

# Agenda Board of Directors

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| **Date** | 6 May 2021 |
| **Time** | 9:30 - 14:55 |
| **Location** | 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 – 13)**

Liam Coleman, Chairman

- 1 April 2021 (public minutes)

**4** **Outstanding actions of the Board (public) (pages 14 – 15)**

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

**6** 9:40 **Chairman's Report, Feedback from the Council of Governors**

Liam Coleman, Chairman

**7** 9:50 **Chief Executive's Report (pages 16 – 22)**

Kevin McNamara, Chief Executive

**8** 10:05 **Patient Story**

Christina Rattigan, Head of Midwifery

- Hannah and Peter share their experiences throughout their pregnancy whilst under the care of EPU, Delivery Suite and SCBU

**9** 10:25 **Integrated Performance Report (pages 23 – 93)**

- 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 Mental Health Governance Committee Overview (pages 94 – 97)**
11:40 Lizzie Abderrahim, Non-Executive Director - Committee Chair

**11** **Staff Survey 2020 - Results, Analysis and Action Plans (pages 98 – 130)**
11:50 Jude Gray, Director of Human Resources

**12** **Gender Pay Gap (pages 131 – 145)**
12:05 Jude Gray, Director of Human Resources

*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.*

**13** **Ratification of Decisions made via Board Circular/Board Workshop**
12:15 Caroline Coles, Company Secretary

**14** **Terms of Reference of Committees (pages 146 – 155)**
Caroline Coles, Company Secretary

**15** **Membership of Committees (pages 156 – 161)**
Caroline Coles, Company Secretary

**16** **Register of Interests and Declaration of Interests at Meetings (pages 162 – 165)**
Caroline Coles, Company Secretary

**17** **Annual Self-Certifications (pages 166 – 174)**
Caroline Coles, Company Secretary

**18** **Urgent Public Business (if any)**
To consider any business which the Chairman has agreed should be considered as an item of urgent business

**19** **Date and Time of next meeting**
Thursday 3 June 2021 at 9.30am (MS Teams)

**20** **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"

**21** **Presentation by Public View**

12:20 Thomas Ridgeway, Director, Public View to present

Great Western Hospitals NHS Foundation Trust

# MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD VIRTUALLY IN PUBLIC ON 1 APRIL 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 |
| Jemima Milton (JM) | Non-Executive Director |
| Jim O'Connell (JO) | Chief Operating Officer |
| Claudia Paoloni (CP) | Associate Non-Executive Director |
| Sanjeen Payne-kumar(SPM) | Associate Non-Executive Director |
| Julie Soutter (JS) | Non-Executive Director |
| Helen Spice (HS) | Non-Executive Director |
| Simon Wade (SW) | Director of Finance & Strategy |

**In attendance**

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| Emma Churchill | Deputy Divisional Director |
| Linda Clements | Assistant Practitioner (agenda item 08/21 only) |
| Caroline Coles | Company Secretary |
| Peter Coutts | Deputy Divisional Director (agenda item 08/21 only) |
| Tim Edmonds | Head of Communications and Engagement |
| Amanda Fox | Deputy Chief Operating Officer |

**Apologies**

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| Tracey Cotterill (TC) | Interim Director of Improvement & Partnership |

**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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| 01/21 | **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. | |
| 02/21 | **Declarations of Interest**<br>There were no declarations of interest. | |

| Minute | Description | Action |
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| 03/21 | **Minutes**<br>The minutes of the meeting of the Board held on 4 March 2021 were adopted and signed as a correct record with the following amendments:-<br><br>395/20 / Chair of Mental Health Governance Committee Overview - Amend 2nd paragraph to "There followed a discussion with regard *to the concern over the* chronic lack of specialist *Children and Adolescent Mental Health Services (*CAMHS)*'* beds *which hindered the ability of the Trust to provide effective care to children in their care and* was a gap in assurance and *one out of their control.* It was also recognised this was not an isolated Swindon issue and was part of a wider concern around children's mental health and should be addressed through the BSW system. In light of this, it was agreed that the Chief Executive and Chair would raise this through the relevant BSW committees to ensure a system wide approach.<br>***Action : Chair & Chief Executive"*** | |
| 04/21 | **Outstanding actions of the Board (public)**<br>The Board received and considered the outstanding action list and noted that:-<br><br>393/20 / IPR / Our Care / SI Report - There followed a discussion on whether this was the right action however it was noted that a summary of all the serious incidents would be presented at the next Quality & Governance Committee.<br><br>393/20 / IPR / Use of Resource / Public View - There was a short paper on the agenda that provided an overview of the Trust's performance over the past year. It was noted that the Trust had received an offer from Public View to present an overview of their services. An invitation would be extended to the governors to attend once a date had been organised. | |
| 05/21 | **Questions from the public to the Board relating to the work of the Trust**<br>There were two questions from the public to the Board which were on the Integrated Performance Report and Covid Vaccinations.<br><br>With regard to the covid vaccinations and the hesitancy among black and other minority ethnic (BAME) groups the Chief Executive gave further data from a Trust staff perspective which had seen 88% of substantive staff vaccinated, however only 77% of staff from BAME backgrounds having had a first dose so far. With regard to BSW data there was a reluctance to publish data however a fuller picture would be provided on how the system was supporting our communities in the next Chief Executive Report.<br>**Action : Chief Executive** | KM |
| | Lizzie Abderrahim, Non-Executive Director noted that it was important to not just target the BAME group as there were other communities such as travellers, homeless people and inclusion should be used in its broadest sense. | |
| 06/20 | **Chair's Report, Feedback from the Council of Governors**<br>The Board received a verbal update which included:-<br><br>Welcomes - A warm welcome to Lisa Cheek as our new Chief Nurse, two new Non-Executive Directors, Faried Chopdat and Helen Spice, and two new Associate Non-Executive Directors, Sanjeen Payne-Kumar and Claudia Paoloni. | |

| Minute | Description | Action |
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Farewells – A sad farewell to Jemima Milton, Non-Executive who had come to the end of her term of office. The Board thanked Jemima for all her hard work and commitment to providing a continued focus on patients over the past 7 years and wished her well in the future.

It was also recorded that Rachel Skittrel appointed governor for Oxford Brookes University had decided to stand down and a replacement would be nominated in due course from the university.

Charitable Funds Committee - As Jemima Milton was stepping down as the Chair of the Charitable Funds Committee it was proposed that the new Chair would be Paul Lewis with Peter Hill as an additional Non-Executive Director member going forward.

Council of Governors Meeting – 25 March 2021 - The Council of Governors met on 25 March which included a briefing on the Integrated Care System (ICS), and approval of an amendment in our constitution with regard to the use of the Trust Seal. It was noted that the governors would receive in due course an attendance and presentation from the Chair of the ICS who had recently attended a Board meeting.

Board Development - The Board were involved in a Digital Leadership workshop held on 10 March 2021 which was facilitated by NHS Providers. The Chair had also attended a national Digital Conference in March which offered a good opportunity to speak to the wider community and gauge how the Trust was progressing in terms of the digital agenda. This had demonstrated that not only were the Trust not a slow adopter on the digital path but also how well we were working as a system in this area.

The Board **noted** the report.

07/21 **Chief Executive's Report**

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

Covid Position - The number of patients in Great Western Hospital had now fallen to single figures – a significantly improved position from January and February 2021.

Andy Copestake, Non-Executive Director commented that the rate of infection within the Swindon area was twice the national average and asked if there was any more insight and would this translate into increased admissions. Kevin McNamara, Chief Executive replied that Swindon was the highest in the South West for infection rates and had been a consistent feature in all waves. The Public Health team had done a good job in targeting local areas however the Trust would have to ensure that any assumptions would be factored into planning for 2021/22.

Marking one year of the pandemic - On 11 March 2021, one year after the Trust treated its first patient with covid, a virtual internal memorial service to remember those members of staff and volunteers who died during the year was held. Also BBC Wiltshire had produced a 20-minute special report featuring some of the staff video diaries which gave an insight into what it was like to work on the frontline during the pandemic.

Recovery programme - Although coronavirus remained present, the decline in patient numbers in recent weeks had meant a focus on the recovery programme which aimed to begin tackling the significant waiting time challenges the pandemic had caused. This

| Minute | Description | Action |
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remained a very significant quality, operational, financial and workforce challenge for all Trusts and the impact of the pandemic on the Trust's services and staff would be felt for some time.

Focus in 2021/22 - The main challenges and focus in 2021/22 were broadly grouped around four headings; reset on quality, restore elective activity, regroup as a team and replenish our wellbeing, and recover our finances. All in the context of a pandemic that is far from over and therefore the ability to flex and respond as needs arose to Covid would be central to the Trust's planning.

Vaccination programme - The vaccination programme continued to be a key priority and the Trust would maintain focus on vaccinating those in the national priority groups.

In the context of vaccine hesitancy it was noted the national report published on 31 March 2022 into racial and ethnic disparities in the UK. There was nothing contained within the report to stop focussing on the Trust's Equality, Diversity & Inclusion (ED&I) agenda for staff and the local community, however the Chief Executive had asked the ED&I Lead and BAME network to advice on what term should be used as an organisation with regard to the Black, Asian and Minority Ethnic (BAME) group.

Lizzie Abderrahim, Non-Executive Director welcomed the organisation revisiting the use of the term BAME as this was not as inclusive as intended.

NHS staff survey - The NHS staff survey results had been received. The Trust had its best ever response rate (53%) and the results are significant in providing a better understanding of how Covid-19 had impacted upon the organisation. The results would go through the normal governance routes in April with targeted actions.

Primary care - The Trust's Primary Care Network had a recent CQC inspection. The final report was yet to be received.

Recruitment to senior roles - Lisa Cheek had commenced in her new role as Chief Nurse. The Trust were also currently in the process of recruiting two further roles on our Executive team – Medical Director and Chief Operating Officer.

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

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

08/21 **Staff Story**

*Linda Clements, Assistant Practitioner joined the meeting for this agenda item.*

The Board received a presentation which centred on a member of staff who had to readjust to a completely different role together with working from home as a shielding member of staff during covid. The challenges faced from the staff member's perspective were described together with the support from both the Trust, particularly from team members, and family members. In addition the new ways of working that had been put in place, to enable an effective and stress free environment.

| Minute | Description | Action |
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The Board thanked Linda for sharing her story as it added value to the Board in terms of what the organisation had learnt through the pandemic and to take those changes and make the future better for its staff. The main lessons learnt were noted as:-

- ensure that changes and support were consistent between departments
- weekly meetings were invaluable
- the support from family as well as the organisation
- flexible working going forward.

The Board recognised how important the support from employees' families was not just in this example but in other aspects of hospital working life and extended their gratitude. A discussion followed on how the Trust could widen its appreciation beyond staff members to family. Kevin McNamara, Chief Executive added that a Family Day was planned for the summer, rules permitting.

The Board **noted** the patient story.

09/21 **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 February/March 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 around the IPR at its meeting on 24 March 2021 and highlighted the following:-

Emergency Access - Although the Trust were not achieving the national targets, performance was in the national upper quartile and the attitude and leadership of staff was impressive. A solid performance in challenging times.

Referral to Treatment Time (RTT) - A verbal update on the recovery plan had been received with the full Recovery Plan to be considered at the next meeting in April 2021.

Diagnostic Wait Times - Good performance in February 2021 which showed improvement. Further improvement was expected during the next few months.

Re-admissions - This was work in progress and the Committee expected to see plans for improvement in June 2021.

Community & Primary Care - Some services were under enormous pressures with increased demand, however this service was generally performing well under excellent leadership.

Sickness Absence - In the context of covid-19 sickness rates were good however the Trust did not meet its local target which was set before the pandemic of 3.5%. Plans were in place to improve performance.

| Minute | Description | Action |
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Agency Spend - Agency spend continued to be high however the Trust moved to the PSL contract from 1 April 2021 and therefore improvements were anticipated.

Liam Coleman, Chair highlighted that a realistic trajectory for agency usage would be required, in the context of pressures within the NHS and the BSW system, that could be delivered from both a financial and quality aspect. This challenge spanned the portfolios of the Chief Operating Officer, Director of Finance and Director of HR and a risk that would be constantly on the Committees' list of monitoring. There followed a discussion on this challenge in particular that it was much bigger than a single trust issue and was one for debate at system level. The Chair agreed to consider whether there was added value to organise a workshop at system level. LC

**Action : Chair**

Mandatory Training and Appraisal Rates - Performance was challenging during the pandemic however some improvements had been seen but it was recognised that there was still work to be done.

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

- Over the last several months, the Trust had seen a significant improvement in its Hospital Combined Performance score on Public View – it had achieved 48th position out of 123 Trusts (in March 2020 our ranking was 87th) and currently one of the most improved Trusts in England (8th).
- Performance against the 4 Hour Access standard had improved from 86.14% to 87.79% in month; however this continued to be below the 95% standard. Daily 'Criteria to Reside' calls continued and robust processes had been implemented for managing the flow of patients through the system. There was still inconsistency in discharging Golden Patients every day and this was now part of the Flow Transformation Project, led by the Chief Nurse.
- Overall, the Trust's RTT Incomplete Performance for January 2021 was 65.57%, which was a deterioration of 1.47% in month. January saw referrals at 76% of the prior year. The Patient Treatment List (PTL) had decreased by 293 in month. In terms of diagnostic waiting times, the DM01 performance saw a slight decline to 60.7% in January 2021 compared to 61.5% in December 2020.
- December's 62 day performance was 87.5% with the Trust achieving the national 62 day standard for the last three months. Prior to this, performance had been heavily impacted by Covid-19 with diagnostic/treatment delays.
- The Trust has achieved level B SSNAP performance (74%) for Q3, and had maintained level B for the last 12 months.
- National guidance had now been received with regard to phase 3 recovery with 6 priorities. It was noted that as the path to recovery evolved it would impact operationally and financially in terms of the Trust's own improvement plans. The Board recognised that there would be trade-offs to improve long term structure of the Trust and the ability to do things in the short term and recovery.

**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 18 March 2021 and the following highlighted:-

Mortality Review - This item was a referral from Audit, Risk & Assurance Committee as an issue raised by an internal audit. The Committee were assured that the Deputy Medical Director was progressing with actions and working closely with the Medical Examiners but recognised that this was work in progress.

Board Assurance Framework - The Committee supported the new refreshed report.

Integrated Performance Report (IPR) - The Committee were assured that appropriate actions were in place however recognised there was still work to improve pressure ulcers and falls rates.

Get It Right First Time (GIRFT) - The pandemic had had a negative impact on the introduction of some of the recommended practices but it had to be acknowledged that many predated Covid by a long time. Effort was being made however more action was required to move ahead with this.

Andy Copestake, Non-Executive Director asked what the prioritisation process was for the GIRFT action plan. Charlotte Forsyth, Medical Director replied that each department were reviewing their outstanding action list to ensure that it was relevant and up to date, before a prioritisation process commenced.

Patient Engagement & Experience - Good progress had been made on this with a detailed plan in place. In terms of the Inpatient Survey 2019 it was recognised that there were quite a few areas the Trust had scored down in however the recently appointed Head of Patient Experience and Engagement had developed a plan to address those ranked lowest.

Julie Soutter, Non-Executive Director had two points to highlight, firstly from the minutes of the last meeting it stated that a detailed report on falls would be presented to the March meeting, and secondly was there any data from Public View in terms of falls. Nick Bishop, Chair of Quality & Governance Committee replied that the falls report had not yet been presented to the Committee however the Committee recognised that the increase in falls was due to the severity of the patients during the covid period which was much worse than normal and not only were they falling because they were more frail but injuring themselves because they were more frail. The national data was not known however would be a question for Public View at their visit. JO
**Action : Operating Chief Officer**

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

Harm Free Care - A Pressure Ulcer Improvement Programme launch day was held on the 4th March 2021, all divisions and professions were well represented. Also

members of staff attended an RUH learning event to share learning across the system. It was recognised that any improvement would take time in terms of actions.

Andy Copestake, Non-Executive Director asked about one of the maternity serious incidents contained within the report around a second unnecessary procedure and asked if this was a cross trust issue. Charlotte Forsyth, Medical Director replied that this was not a widespread issue and in this incident was around the duplication in a patient's records between notes and a ward's whiteboard.

Patient Experience - There were a number of avenues to collate feedback from patients and carers. A lot of work was taking place to improve this process which included additional resource, updating the Friends & Family Test to revised guidance, and further use of social media and texting. In terms of the In Patient Survey the Great Care Campaign would involve visible listening and responding to patient voice together with empowering staff to make changes mapped to the CQC domains with tangible milestones.

Mortality Reviews - This was a priority focus of the Deputy Medical Director to address the issues raised in an internal audit review.

The Chair asked if it was possible for the Non-Executive Directors to have training on a mortality review and would leave the approach to the Quality & Governance Committee.
**Action : Medical Director** CF

The Chair of Audit, Risk and Assurance Committee (ARAC) added that this report was raised by internal audit at ARAC and it would therefore be helpful to understand what happens to the learning and assurance. CF
**Action : Medical Director**

**Part 3 : Our People**

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

Overall Performance : Areas of pressure for February 2021 were in workforce in terms of reliance on agency bank fill rate and sickness absence. An area of improvement was in vacancy rates, and turnover remained stable. There were also signs of improvement in mandatory training and appraisal rates.

Great Workforce Planning - The Trust were above target for agency spend which was the 7th month in a row due to robust scrutiny and challenge around agency spend. However Community Nursing was one area that continued to have the greatest demand for temporary staffing resource and although funding had been secured for an additional 25 nurses it would be a challenge to recruit this number and therefore the service would continue to rely on agency staff. GP practices were also reliant on locums to run the service and the Trust was looking at different ways to recruit.

Great Opportunity - Overall the vacancy rate versus the established rate decreased to 6.30% with the medical and nursing rate at a low 4%. A deep dive would be undertaken into key workforce areas to identify those small number of roles which are not filled but making a significant impact on the service and to look at offering more attractive propositions in what the Trust could offer.

Great Experience - The Trust continued to invest in the health and wellbeing plan with a number of initiatives now in place. The Trust was using the NHSI Framework to track and measure the impact of investments made.

In relation to the health and wellbeing diagnostic tool Lizzie Abderrahim, Non-Executive Director advised that on reviewing the assessment outcome the Trust had done a significant amount of work which was nationally recognised however it also highlighted the need to focus on prevention and further work would be required to work out what this meant and how this was to be measured and the Board would get more information as this progressed.

Great Employee - Overall mandatory training was just below the 85% target, with the elements of training the CQC take an interest in at 84% which was above the Trust's target. There continued to be challenges in recording compliance due to the IT system as manual input was required however a weekly task force was in place to move to a digitalised system by the end of May 2021.

Great Leadership - The appraisal rate compliance had significantly improved in February 2021 which was due to the positive decision in the summer to reintroduce and amend the appraisal form to include a section on health and wellbeing. Although there was increase this would continue to be monitored closely.

In addition the Trust was embarking on Organisational Development work with one of our partners. This was organisation wide from Board to ward.

Paul Lewis, Non-Executive Director asked if there were any plans to use SPC charts within the staff survey element of the Integrated Performance Report. Jude Gray, Director of HR replied that this was not currently planned however took the action to explore this option.

**Action : Director of HR** JG

**Part 4 - Use of Resources**

**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 22 March 2021 and the following highlighted:-

- A shorter report this month as all green assurance ratings however it was noted that this had been a very unusual year from a financial perspective. The Trust had started with a £24m deficit which moved to a forecast of breakeven; however there still remained an underlying deficit of £32-33m. The Trust had received extra funding this year because of covid, re-budgetted mid-year and now at breakeven.
- Capital expenditure had been a big achievement as the Trust was on track to spend £30.8m of £33.6m plan as predicted. This had been a tremendous performance to reach this level of spend over the last few months.
- The next financial year would be different and there was one red assurance which was around the budget setting and business planning. This was due to as there was yet no agreed budget due to the lack of national guidance particularly for the second half of the year.

- The Committee agreed to recommend the contract for the supply of Orthopaedic Prostheses for hips and knees.
- There had also been an additional paper around the Clover project as additional funding had been secured which would be used to extend the lease life for decant facilities.

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

- The Trust in month position was £3,008k surplus against a plan of £648k deficit which was £3,656k favourable variance. The YTD position was £1,195k surplus against a plan of £2,964k deficit which was £4,160k favourable variance.
- Pay was £1,776k overspent due to costs of Covid-19 Vaccination Programme, HDP, aspirant nurses, incentive payments, lateral flow testing staff and additional staffing required to meet Covid-19 surges. It was noted that there was a provision in medical pay which was due to the amount of time worked throughout the year and related to TOIL (time off in lieu).
- Non-pay expenditure was overspent by £1,776k due a number of factors which included costs of Covid-19 vaccination programme, estates dilapidation costs and carbon energy costs which were funded by additional income. Non-pay also included International Recruitment fees linked to NHSE/I funding, IT equipment and screens to support agile working. Clinical supplies and drugs were underspent due to reduction in elective activity during Covid-19 surges. .
- The forecast position for 2020/21 was, for purely operational purposes, breakeven however showed a potential deficit of £752k to reflect annual leave which had been agreed nationally and would be funded nationally.
- Cash had improved in month due to lost income received.
- The Trust capital plan for 2020/21 was £39,467k. This had increased by £1,593k in month relating to funding agreed for Pathology LIMs, IT Audio-visual and Remote Monitoring.
- For 2021/22 planning some guidance had now been received which outlined 6 key priorities for 2021/22 all underpinned by system working.
- Internal budget setting had been on-going for several month with the divisions with a draft plan submitted to Finance & Investment Committee in April and then to Board in May 2021.

***RESOLVED***

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

10/21 **Chair of Audit, Risk & Assurance Committee Overview**

The Board received an overview of the discussions held at the Audit, Risk & Assurance Committee at the meeting held on 11 March 2021 and the following highlighted:-

Divisional Risk Register – Unscheduled Care - Good grip on controls demonstrated with further strengthening as Division restructure continued to bed in.

Board Assurance Framework (BAF) - The Committee supported the new BAF format which started with Quality, Finance would be next and the others to follow. This was an iterative process.

15+ Risk Register - Risk management processes continued to be improved which included a new risk management system.

External Audit - There were no significant matters to report with year end reporting on track. It was noted that there were new requirements in terms of responsibility for year end going concern, and value for money. With regard to the Annual Report and Accounts it was confirmed that the Quality Accounts were no longer required to be included once again this year, and that there was a new requirement to include diversity and inclusion ambitions into the report.

Internal Audit and Counterfraud - New functional standards were being introduced for counterfraud however no detail had been received as yet hence the amber assurance rating.

Pre-employment Report - This report reviewed longer term employee records before current requirements were required on pre-employment checks. The Committee agreed a risk-based approach to achieve compliance as necessary. It was noted that current practice was compliant.

The Board **noted** the report.

11/21 **GWH Performance & Public View Data**

The Board considered a paper which provided the key performance standards in March 2020 and in terms of national benchmarking through public view data how the Trust had performed.

The Trust had improved during the year from ranking 87th out of 123 trusts to 48th. The first time in the top 50. It was noted that there were 10 indicators in public view that correlated with CQC ratings and the Trust had moved from 'Requires Improvement' to the 'Good' zone. Further work was still required for a more balanced approach however it demonstrated strong performance by the Trust.

The Board **noted** the report.

12/21 **Theatres and Outpatients Transformation**

The Board considered papers that provided an overview of both the Theatres and Outpatient transformation projects. It was noted that this was a top level oversight as the detailed reporting would be dealt with by Performance, People and Place Committee.

**Theatres Transformation**

A presentation outlined the improvement and project frameworks, approach and why it was different to previous approaches to improvements in theatres, the project work streams, the key performance indicators and programme governance.

There followed a discussion which included staff motivation/culture change, productivity and efficiency.

The Chair noted that this had been identified as a key focus as it was critical in helping the elective recovery process. A new approach had been outlined to galvanise and inject pace for short sharp steps for improvement. From a Board perspective oversight would be through Performance, People and Place Committee to track resources to

enable improvement but also to achieve improvements.

**Outpatients Transformation**
A presentation outlined the performance update, briefing on automation and review of the roadmap for 2021/20.

The Chair noted the excellent work. This service was the biggest volume of activity and biggest impact on most people and was a vital area.

The Chair added that any strategic questions for any of the projects should be sent through to the Chair of Performance, People and Place Committee.

The Board **noted** the reports.

13/21 **Ratification of Decisions made via Board Circular/Board Workshop**
The Board was asked to ratify two Board Circulars which had been approved since the last Board meeting:-

- The changes to the Trust Constitution in terms of the usage of the Trust Seal; and
- The contract for the purchase of Radiology equipment (computed tomography).

***RESOLVED***

***(a) to ratify the that the seal may be used between Board meetings, based on business need, at the discretion of the Chief Executive or Director of Finance and to amend the Trust's Constitution accordingly; and,***

***(b) to ratify to award the contract for purchasing the computed tomography to Siemens.***

14/21 **Terms of Reference of Committees**
The Board received and reviewed a paper to consider the annual review for the Board Committee structure and the terms of reference for Board Committees Audit, Risk & Assurance, Quality & Governance Committee, Finance & Investment Committee, Charitable Funds Committee and Remuneration Committee. The following was noted:-

- Each Board Committee had undertaken an open discussion to consider their effectiveness, including terms of reference.
- There were no issues or concerns to draw to the attention of the Board.
- The terms of reference of the Committees were circulated showing minor amendments.

***RESOLVED***

***(a) that it be agreed that there are no changes proposed to the Board Committee structure set out in this report, and;***

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

| Minute | Description | Action |
|---|---|---|
| 15/21 | **Urgent Public Business (if any)**<br>None. | |
| 16/21 | **Date and Time of next meeting**<br>It was noted that the next virtual meeting of the Board would be held on 6 May 2021 at 9:30am via MS Teams. | |
| 17/21 | **Exclusion of the Public and Press**<br><br>***RESOLVED***<br><br>***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……

| ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – May 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 | 03/21 | **Mental Health Governance Committee Overview**<br>Shortage of CAMHS beds to be addressed through the BSW system. | Chair/Chief Executive | This has been raised through the relevant BSW committees to ensure a system wide approach. |
| 01-Apr-21 | 05/21 | **Questions from the public / covid vaccinations hesitancy**<br>A fuller picture would be provided on how the system was supporting our communities with regard to vaccination hesitancy in the next Chief Executive Report | Chief Executive | Contained in the Chief Executive Report. |
| 01-Apr-21 | 09/21 | **IPR : Our Performance : Agency Spend**<br>To consider organising a workshop to debate agency spend and ways of working. | Chair | A standard item has been included in the private section of the Board for regular updates. |
| 01-Apr-21 | 09/21 | **IPR : Our Care : Falls : Public View Data**<br>Data on falls to be raised when Public View visit Trust | Chief Operating Officer | For when Public View visit Trust. |
| 01-Apr-21 | 09/21 | **IPR : Our Care : Mortality Reviews**<br>To determine an approach to provide mortality review training for Board members.<br><br>To present learning and assurance from the internal audit review to Audit, Risk and Assurance Committee. | Medical Director | For Q&GC<br><br>For ARAC |
| 01-Apr-21 | 09/21 | **IPR : Our People : SPC Charts**<br>Explore the use of SPC charts in the staff survey element of the IPR. | Director of HR | SPC's require a minimum number of data points – 25 is the recommended NHS standard so we would need 25 years of staff survey results per question in this case. |

| Future Actions | | | | |
|---|---|---|---|---|
| None | | | | |

Great Western Hospitals NHS Foundation Trust

# Chief Executive's Report

| | | | |
|---|---|---|---|
| **Meeting** | Trust Board | **Date** | 6 May 2021 |

**Summary of Report**

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

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

| | |
|---|---|
| **Executive Lead** | Kevin McNamara, Chief Executive Officer |
| **Author** | Kevin McNamara, Chief Executive Officer |
| Author contact details | |

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

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| | | |

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

**Link to relevant CQC Domain**

| Safe | x | Effective | x | Caring | x | Responsive | x | Well Led | x |
|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Link to relevant Trust Commitment** | |

**Consultations / other committee views**

N/A

**Recommendations / Decision Required**

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

# 1. Coronavirus

## 1.1 Current position

The number of patients we are caring for with coronavirus remains low, and our operational response has been considerably scaled down from our position earlier in the year.

The decrease in case numbers reflects the lower rate of the virus in the community and the successful roll-out of the vaccination programme.

However, we continue to closely monitor the case rate in Swindon which at the time of writing was above the average for the South West and also above the national average.

We are also paying particularly close attention to new variants of Covid-19, with all patients being asked about their recent travel history and those they have been in contact with.

We continue to retain the flexibility to be able to stand our response back up as and when needed in the event of future waves or spikes in demand.

Giving all patients the treatment they need as soon and as safely as possible is an absolute priority for us, and we have been able to convert the extra ICU capacity we have been using for Covid patients back in to regular theatre space, giving us more capacity to be able to re-start elective surgery.

Despite the reduction in Covid-19 patients, we have seen a significant increase in non-Covid urgent and emergency care admissions, which is much higher than we would normally see at this time of year. Of course, people should come to the Emergency Department or Urgent Treatment Centre if they need to, but we are also encouraging people to consider other healthcare options such as pharmacies and GPs. Anyone not sure what to do should call NHS 111.

## 1.2 Vaccination programme

We have now administered more than 50,000 first and second doses as part of our vaccination programme.

We continue to offer vaccinations in line with national guidance and have now expanded the cohorts slightly. We have also begun offering vaccinations for inpatients who meet the current criteria for being vaccinated.

Board members may have seen media coverage of an isolated incident in which a different second vaccine was given to a patient. We have apologised to the patient involved, and provided them with guidance which indicates they would still have received a boost to their immunisation level. We have reviewed our pathways to avoid this happening again.

In terms of our own workforce, over 90 per cent of our substantive workforce have now had a first dose. The number of BAME staff who have been vaccinated has increased but still only stands at just over 80 per cent. This reflects a wider trend of hesitancy among the BAME population and we continue to work with partners across the BSW area to do what we can to better understand the reasons behind this hesitancy and signpost people to information which will help them to make an informed decision.

### 1.3 System working on waiting lists

One of the consequences of the pandemic is that patients are having to wait much longer for treatment, and the scale of the challenge we face to recover our pre-pandemic position means that we will have to find different ways of doing things.

At present just under 2,000 people are waiting longer than a year for treatment, for which we apologise. These numbers mean that we cannot simply look at old ways of delivering care, we need to be creative and work as a system with other organisations if we are to bring waiting times down.

We are collaborating with trusts in Bath and Salisbury on tackling some of our waiting lists. Over one weekend, 38 of the longest waiters from RUH – waiting up to 74 weeks for oral surgery – were treated at Salisbury. More than 400 children are expected to be treated over a series of joint surgery weekends. The second weekend, which will also focus on both oral and ENT surgery, took place over the May Bank Holiday weekend.

In total 461 patients on the region’s joint waiting list will be treated and we will consider how we can open up this positive initiative to other specialties.

## 2. Way Forward Programme

### 2.1 Land purchase

The Trust has now signed the deal to buy the parcel of land next to the Great Western Hospital site from housing developers Persimmon Homes and Redrow Thames Valley as part of the Way Forward Programme.

The purchase of this land creates a strategic opportunity for future development on the site, to improve services and ensure we can meet the demand created by Swindon and North Wiltshire's rapid population growth.

The purchase of the land has been managed as part of our Way Forward Programme, under which a series of hospital improvement projects are being taken forward. These projects will enable the relocation of non-acute services to the expansion land, which will facilitate Urgent and Emergency Care capacity expansion in the main hospital, and will include the development of an Integrated Rehabilitation Facility (subject to funding).

The land purchase is not just a significant milestone in the Way Forward Programme, but a really exciting step forward in the development of Swindon and its healthcare services, both for now and for future generations.

### 2.2 Urgent Treatment Centre

A temporary Urgent Treatment Centre opened last month in the car park by Shalbourne and the Covid Assessment Unit while the new permanent UTC is being built. It has 16 clinic rooms and a waiting area with space for social distancing.

The UTC will stay in this facility under December, while the construction of the new, permanent treatment centre is completed.

Demolition of the old Clover unit will take place this month, after which construction of the new UTC will start. Boots and Pre-op have both been relocated from Clover and are running well in their new locations.

While there are clear longer term benefits to this work, we recognise that there is a considerable amount of disruption taking place on the GWH site currently, both for pedestrians and ambulances and other vehicles. Signage is in place to re-direct visitors as appropriate.

My thanks go to all those staff involved in the developments as part of the Way Forward Programme as we begin to see this piece of work really starting to take shape.

## 3. Primary care

The Care Quality Commission's report of its February inspection of Abbey Meads and Moredon Medical Centres was published last month and recognises the improvements that have been made.

It is the second time these practices have been inspected since we took them over in November 2019, and I'm pleased that inspectors have again seen positive changes.

Abbey Meads has moved up from Inadequate to Requires Improvement and has been taken out of special measures, in recognition of the significant improvements the team has made to the quality of care provided.

Moredon has retained its overall rating of Requires Improvement, having been moved up from Inadequate during the first inspection as part of the Trust in February 2020.

I was particularly pleased that the CQC rated us as being good in three of their five domains, effective, caring and responsive, and that they also recognised that the care being provided to our patients is good.

Patients are waiting less time to get through on the phones and to get an appointment, and when they do want to raise a concern we're listening and acting on what they tell us faster than we ever have before. We've also welcomed lots of new staff to the practices, including GPs, nurses, pharmacists and physios and this has had a huge impact on the speed and efficiency that patients are being seen.

Both practices were felt to be Requires Improvement for being safe and well-led. While big steps forward have been made, inspectors raised some safety concerns and we recognise there is still more we need to do and action plans are being developed to ensure this happens.

Our primary care improvement programme is ambitious and is focused on patient experience, accessibility, integration, efficiency and quality of care. We are also focused on working hard to make the practices financially sustainable.

## 4. Staff recognition

I've said many times that our staff have done a fantastic job throughout the pandemic, going above and beyond to put our patients first.

Whilst our teams don't do what they do for recognition, it's nice when they are acknowledged for what they've done so I was really pleased that our staff have been selected as finalists in so many categories of the Newsquest Swindon & Wiltshire Health & Social Care Awards 2021.

Our finalists are as follows:

- **Care Hero** – Dr Anthony Kerry, Dr Catherine Strait, Maxine Buyanga
- **Good Nurse** – Lisa Hocking, Laura Kirby-Deacon
- **Adolescent & Child Care** – Dr Sarah Bates
- **Dementia Carer of the year** – Tim Allen & Hannah Rogers, Wendy Johnson, Associate Director of Safeguarding, and Dr Sarah White, Consultant Geriatrician
- **Health Care Team** – ICU, Emergency Department
- **GP Practice** – Abbey Meads and Moredon
- **Health Care Employer** – GWH NHS Foundation Trust

Winners will be announced during a ceremony on 27 May.

Within the Trust there are a number of award schemes, and staff are encouraged to nominate teams and colleagues for all of them. We are also planning for a summer event for staff and their families, and plan to hold our staff awards ceremony once again later in the year.

## 5. Staff survey action plan

Following publication of the latest national staff survey results, we have approved Trust-wide and Divisional action plans to address each of the trends which has emerged.

The areas of focus include:

- Immediate manager / team working support
- Safe Environment (Harassment and Bullying)
- Equality, Diversity and Inclusion
- Quality of Care

Each of the actions contained within the plan has a dedicated lead so that there is a clear line of responsibility.

## 6. Ramadan

We have provided support to staff observing Ramadan, which began last month and lasts for 29-30 days, to be immediately followed by the festival of Eid.

It is a time of spiritual reflection and devotion to worship when healthy adult Muslims abstain from food and drink during the daylight hours (pre-dawn to sunset) every day.

I'm aware that many Muslims working in health and social care have taken the difficult decision not to fast as they felt it may compromise their safety or that of their patients.

It is important for staff to feel confident to have open conversations with their managers about their faith and potential periods of fasting. We have provided guidance to all of our staff about Ramadan so that they are able to support their Muslim colleagues at this time of year.

We have also given advice that the Covid vaccination is not considered to be nutrition and does not break your fast, so if you are fasting you can still get your vaccination.

## 7. Special Care Baby Unit

Our Special Care Baby Unit (SCBU) has changed its name to the Neonatal Unit – to better reflect the level of care services on offer and to recognise the level of expertise our neonatal care team provides, not only within the Trust but amongst other professionals, commissioners and networks that we work with.

## 8. Recruitment to senior roles

I would like to formally welcome Claire Thompson as our first substantive Director of Improvement and Partnerships. Claire joined the Trust last month and brings with her 15 years of experience in acute hospital management, leading on patient flow and working with partners on system wide performance.

| Integrated Performance Report (IPR) | | | |
|---|---|---|---|
| **Meeting** | Trust Board | **Date** | 6th May 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 the last 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 March 2021, performance against the 4 Hour Access standard has improved from 87.79% to 88.33% in month. However this continues to be below the 95% standard.

Covid-19 admissions to the Trust continue to reduce from a peak of 163 patients in January to 4 confirmed and 2 suspected patients on 13th April 2021.

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 PTL has increased by 404 in month. In terms of diagnostic waiting times, the DM01 performance saw a significant improvement to 74.94% in February compared to 60.7% in January.

62 day Cancer performance deteriorated to 79.7%.

**Our Care**

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

In line with the national picture numbers of patients diagnosed with COVID-19 continue to reduce significantly, there have been no hospital acquired cases.

There is a decrease in number of falls in March meaning the rate of falls per 1000 bed days has decreased from 8.6 to 6.1, and is under the current average of 7.5. A number of improvement projects are underway.

There have been 37 complaints and 171 concerns reported in month, the vast majority (67%) of concerns were resolved within 24 hours. The trust response rate for complaints is over 75%, this is reflected in Public View data where the Trust is ranked second in terms of response rates.

Maternity report an improvement in the trajectory to achieve compliance in relation to Practical Obstetric Multi Professional Training (PROMPT), this is a key requirement to ensure compliance with the Maternity Incentive Scheme, and plans are in place to ensure the 90% target is achieved.

**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.

The exceptions in March are – agency spend is 6.63% and exceeds the 6% target with average performance of 5.7%; Appraisal compliance has significantly improved to 81%; Mandatory training has also increased to 84.7% and approaching target of 85%.

**Workforce planning** - Improvement delivered in the Registered Nurse bank fill rate, which increased to 59% in March (vs. 56% Feb), demonstrating fill rate is not impacted by the removal of the incentive scheme at the end of February.

There has been an in-month increase in temporary workforce utilisation across both bank and agency adding to the 329wte above establishment worked in March. As the Trust improves and reduces the vacancy gap, a reduction in temporary staffing is expected and increase controls will be reviewed to ensure we reduce reliance on temporary staffing.

**Opportunities** - The Trust vacancy position improved in March to 5.45% from 6.30% (a decrease of 41.92 WTE vacancies Trust wide). Recruitment time to hire metric has improved to 48 days from advert live to start date confirmed. Following successful funding bids the Trust is recruiting 16 overseas nurses per month and total 112 registered nurses before Winter. From 1st April the Trust has successfully moved from a master vend nurse agency contract to a preferred suppliers list (PSL) removing all previous agreed rates to utilise NHSI Cap Rates.

**Experience** - Sickness absence has improved to 3.78% remaining above the 3.5% target. Health and Wellbeing leads have prepared the Trust Health and Wellbeing plan to share with the HWB oversight committee in April 2021, proposing priorities for the year ahead. A Health and Wellbeing dashboard has been prepared and will be reviewed and agreed at the HWB Oversight Committee. The EDI lead role is launching a number of initiatives to support the delivery of the Trust EDI strategy as outlined in the report.

**Employee Development** - The Academy continues to focus on maximizing the use of the Trust and HEE CPD funds, with the Trust CPD funding being underspent by only £3,802 by year end. Statutory

Mandatory training compliance has increased to 84.71%. The project to move training from Training Tracker onto ESR is on target to complete of 31st May 2021.

**Leadership -** There has been a further improvement in appraisal rates to 81.07% significant improvement since January.

The Leadership Development programme (cohort 1) continues to receive positive evaluations. The second session of the AMD development programme was well received.

**Use of Resources**

The Trust plan is £3,829k deficit. The in month position is a deficit of £1,167k against a plan of £865k deficit, an adverse variance of £303k. The draft full year position is £28k surplus against a plan of £3,829k deficit which is £3,857k favourable variance. The position includes £4,224k funding for Lost Operating Income and additional income from BSW CCG to cover in-year cost pressures which was not included in the original planned position.

Trust income is above plan by £28,448k year to date due to funding received to cover additional costs, lost income and technical pension adjustments. The Trust has received funding to cover the increase in Annual Leave accrual that is due to the Covid-19 pandemic. Funding has also been received from BSW to cover in-year pressures.

Pay is £4,794k overspent in month and £6,570k overspent for the full year. The in month position includes a provision for Birthday/Annual Leave in lieu of time and effort worked during the pandemic (£1,023k).

Non -pay expenditure is overspent by £16,488k in month and £18,021k full year. The in month position includes year-end provisions for anticipated costs relating to 20/21, stock adjustments and technical adjustments for notional pension costs (matched by income).

The Trust capital plan for 20/21 has increased by £1.1m since Month 11, this relates to the UEC Clover project. The full year capital plan is £40,567k, within this the PFI is forecast to overspend by £111k and the Way Forward Programme is forecast to underspend by £2,542k. These items sit outside the Trust CDEL target. The Trust is forecasting to spend the full CDEL allocation in 20/21.

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

| | |
|---|---|
| **Executive Lead** | |
| **Author** | Jim O'Connell, Chief Operating Officer<br>Simon Wade Director of Finance<br>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 | x | Effective | x | Caring | x | Responsive | x | Well Led | x | | |
| **Link to relevant Trust Commitment** | | | | | | | | | | | |
| **Consultations / other committee views** | | | | | | | | | | | |
| | | | | | | | | | | | |

## Recommendations / Decision Required

The Trust Board are asked to review and support:

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

NHS
Great Western Hospitals
NHS Foundation Trust

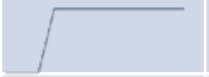
# Integrated Performance Report

## April 2021

Service Teamwork Ambition Respect

# Performance Summary

Great Western Hospitals NHS
NHS Foundation Trust

| KPI | Latest Performance | Trend (last 13 months) | Public View (Latest Published Data) | | | |
|---|---|---|---|---|---|---|
| | | | National Ranking | Bath Ranking | Salisbury Ranking | Month |
| Hospital Combined Performance Score | 5805 (Apr) |  | 44(5805) | 28(6140) | 18(6802) | Apr 21 |
| ED 4 Hour Access Standard (combined Types 1 & 3) | 88.33% (Mar) |  | 30 | 82(77.57%) | 29(87.87%) | Feb 21 |
| ED Median Arrival to Departure in Minutes (combined Types 1 & 3) | 160 (Mar) |  | 17 (145) | 87 (201) | 78(196) | Jan 21 |
| RTT Incomplete Pathways | 64.43% (Feb) |  | 61 | 60 (67.07) | 40(71.07) | Jan 21 |
| Cancer 62 Day Standard | 79.7% (Feb) |  | 07 | 51(75.20%) | 16(84.85%) | Jan 21 |
| 6 Weeks Diagnostics (DM01) | 74.94% (Feb) |  | 83 | 85(60.08%) | 21(86.13%) | Jan 21 |
| Stroke – Spent>90% of Stay on Stroke Unit | 88.8%(Q2 20/21) |  | 43 | 26 (91.5%) | 75(83.3%) | Q2 20/21 |
| Family & Friends (staff) – Percentage recommending GWH as a great place to work | 69.89% (Q3) |  | 88 | 22(81.98%) | 36(78.97%) | Q3 20/21 |
| YTD Surplus/Deficit* | -4.3% (Oct) |  | 82 | 8 | 37 | Q2 19/20 |
| Quarterly Complaint Rates (Written Complaints per 1000 wte) | 39.79 (Q4 20/21) |  | 112 | 32 | 47 | Q2 20/21 |
| Sickness Absence Rate | 4.34% (Nov) |  | 41 | 36 (4.22%) | 11 (3.61%) | Nov 20 |
| MRSA | 0 (Feb) | | 45 | 96 | 68 | Jan 21 |
| Elective Patients Average Length of Stay- (Days) | 2.99 (Mar) |  | | | | |
| Non-Elective Patients Average Length of Stay (Days) | 3.75 (Mar) |  | | | | |
| Community Average Length of Stay (Days) | 14.2 (Feb) |  | | | | |
| Number of Stranded Patients (over 14 days) | 72 (Mar) |  | | | | |
| Number of Super Stranded Patients (over 21 days) | 38 (Mar) |  | | | | |

*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 | | 24th March 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 | | | |
| COVID Recovery Plan | Red | Amber | The management team have taken as much action as possible given the limited guidance at this time. A more detailed draft action plan will be presented to the Committee in May, with the final action plan being due for submission in June 2021. | Further draft to be presented at the May Committee meeting. | May 2021 |
| NHS Elect/MBI/NECSU Report | Green | Green | The Committee was happy that actions have been completed with only a few outstanding still to complete. It is expected that these will be absorbed into the COVID Recovery Plan and may also feature in some of the deeper dives into Outpatients and Cancer Services. JL would come back to the September meeting to give an update on any remaining actions, data accuracy and timeliness. | Update September Committee meeting. | September 2021 |
| Theatre Transformation Update | Amber | Amber | The new management team coupled with the more targeted action plan seem to be having a positive impact in this area. Early successes were noted by the Committee and the next review of progress will come to PPPC in September. | Further update September Committee meeting. | September 2021 |
| Outpatients Update | Green | Green | Significant improvements had been achieved and ongoing improvement work will be part of the Recovery Programme. The Committee requested another deep dive in October 2021. | Deep dive to October Committee meeting. | October 2021 |

| | | | | | |
|---|---|---|---|---|---|
| Integrated Performance Report – Emergency Access | Amber | Green | The team are doing as much as they can in view of the increased demand. | To monitor actions. | Ongoing |
| Integrated Performance Report - RTT | Red | Red | To continue to be reviewed as part of the full Recovery Plan at the May 2021 meeting. | To monitor actions | May 2021 |
| Integrated Performance Report – Diagnostic Wait Times (DM01) | Amber | Green | There were encouraging figures showing improvement which the Committee are happy to see and will receive more details at its May meeting. | To monitor actions | May 2021 |
| Integrated Performance Report – Stroke | Green | Green | Good performance SNNAP score continues as a high B. | To monitor actions | Ongoing |
| Cancer Performance Update | Amber | Amber | There continues to be significant challenges within the Breast Service, however, a plan is in place to get back to where we need to be. There have also been delays with the building programme which have had an impact on recovery. | To monitor actions. | Ongoing |
| Update on COVID on Jr Doctors Training & Annual Report | Green | Green | The feedback from trainees is that they like coming to GWH and have a good experience while here. Supervisors are aware of the risks/problems that are being faced and working hard to deal with these. In the limited COVID 19 2020 GMC national trainee survey, training in Trauma & Orthopaedics, Paediatrics and Obs & Gynae at GWH were rated as excellent. | | |
| NHSI Learning Lessons to Improve Our People Practice | Green | Amber | While the Trust still needs to delivery on the action plan the Committee are assured that the Trust has taken on board learning as set out in Appendix 1 'NHSI Learning Lessons to Improve our People Practice and Appendix 2 '1st December 2020 Sharing good practice to improve our people practices, Prerana Issar, NHS Chief People Officer' and Trust policies are being reviewed. | | |
| Integrated Performance Report – Sickness Absence | Amber | Green | Plans are in place and it is expected that the Trust will hit its targets. | To monitor actions. | Ongoing |
| Integrated Performance | Red | Amber | With the reduction in vacancies, the new agency contract and shielding staff returning to work it is expected that agency usage will come down. | To monitor actions. | Ongoing |

| | | | | | |
|---|---|---|---|---|---|
| Report – Overall Agency Usage | | | | | |
| Integrated Performance Report – Mandatory Training | Amber | Green | Plans are in place and it is expected that the Trust will hit its targets | To monitor actions. | Ongoing |
| Integrated Performance Report - Appraisal Proposal | Amber | Green | Plans are in place and it is expected that the Trust will hit its targets | To monitor actions. | Ongoing |

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

Great Western Hospitals NHS Foundation Trust

# Part 1: Operational Performance

## Our Priorities

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

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

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

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

## How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

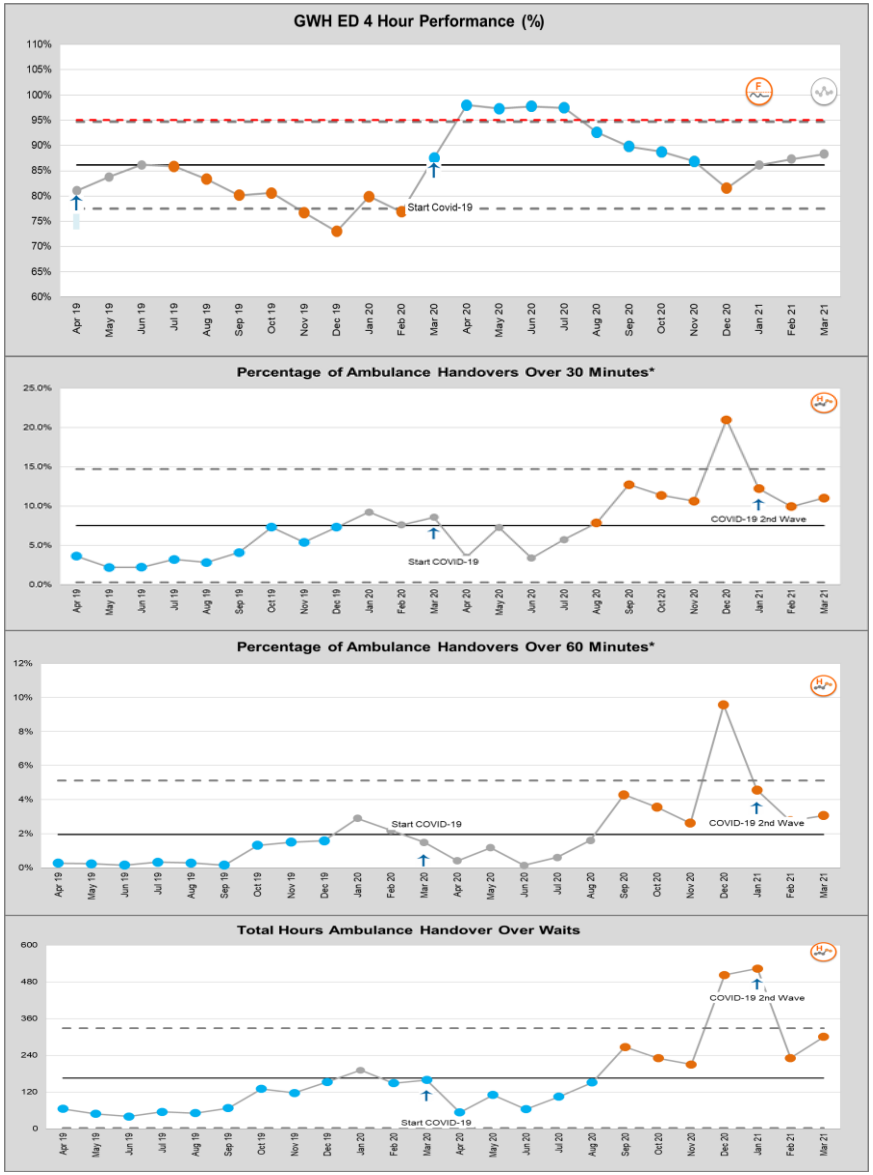
Are We Well Led?

Use of Resources

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

Data Quality Rating:

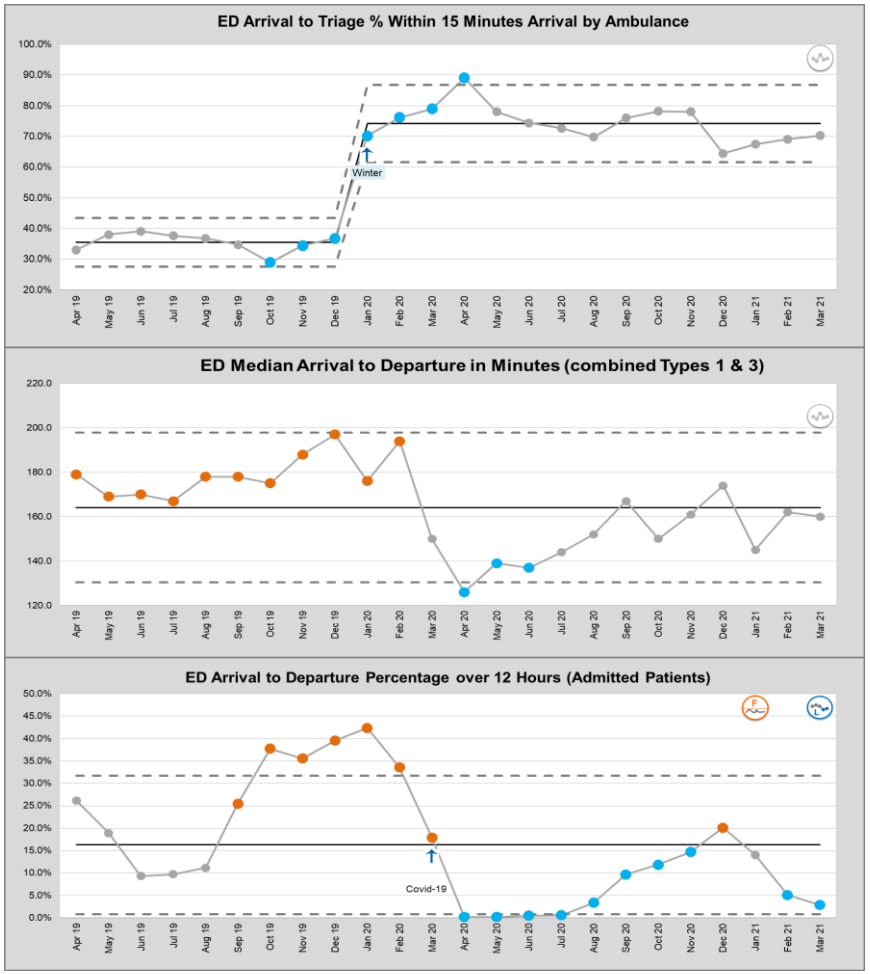
National Key Performance Indicators




Performance Latest Month: 88.33% (Mar)

Attendances:
Type 1 80.08%
Type 3 98.96%

12 Hour Breaches (from decision to admit) 1



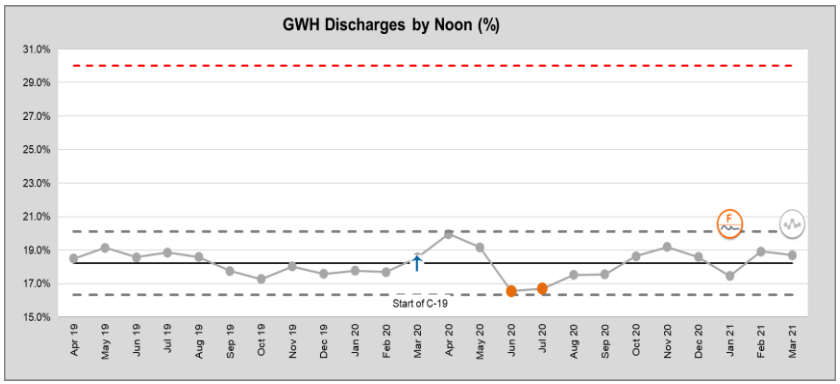

Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

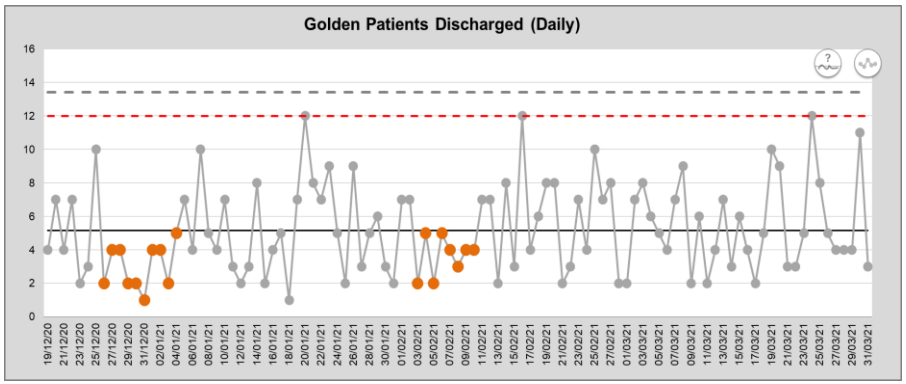
* Data from SWAST – 1 month lag

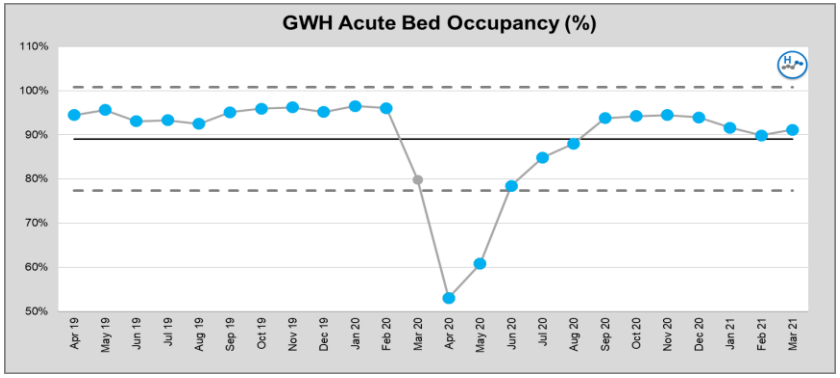
# 1. Emergency Access (4hr) - Patient Flow and Discharge

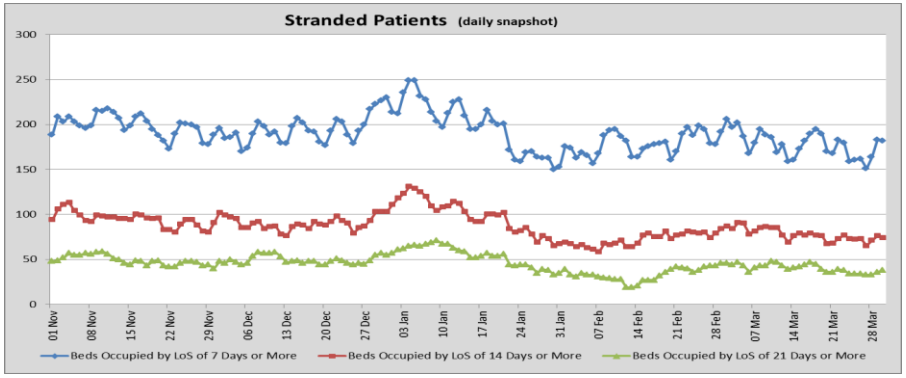
Data Quality Rating:

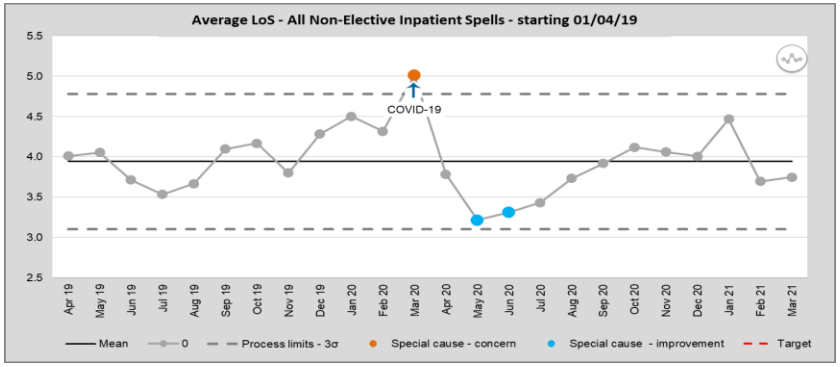
Are We Effective?

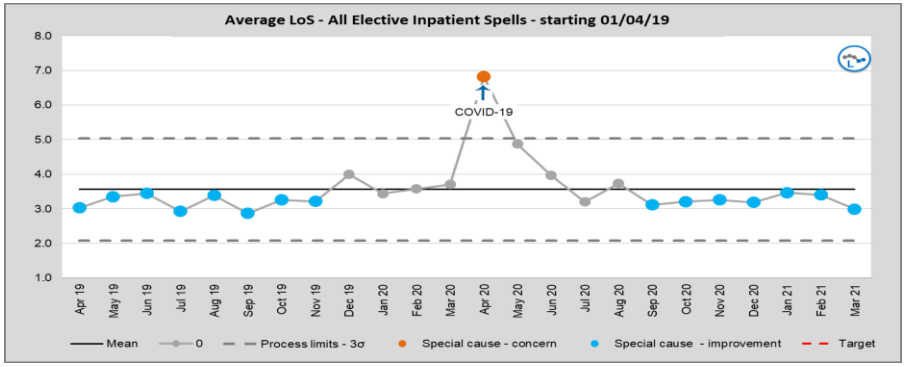



Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

# 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 an improvement of 0.54% in 4 hour breaches to 88.33% in March. There was 1 x 12 hour decision to admit breach in March which, an increase to the 0 reported in Feb. Attendances have increased in Feb by 2093 patients across both Type 1 (932) and Type 3 (1122). This is an average increase of 67 patients per day. The attendance numbers also have now increased on the same period last year by 474. The UTC has seen a 45.7% increase in patients from last month (1122 patients), an increase of 52% on March 2020 (1233 patients).

Breaches due to 'waits to be seen' in ED have risen to 21% the highest recorded since September 2020. Non admitted performance accounts for 20% of breaches, a increase of 13% on February.

**Key Impacts on Performance**

Flow from to ED to base wards continues to be compromised resulting in 62% of breaches related to waits for inpatient beds. 90.2% of the bed breaches relate to waits for a medical bed.

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 3% in March. 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 Jan to Mar (145 minutes to 160.) 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 March, with 60 minute handovers increasing to 3.5% unvalidated by SWAST, (from 3%) 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 considered for ED usage, to prevent bottle necks in flow a/w swab results, as turn around is much faster than PCR. **May 2021**
2. The 'Think 111 First' programme went live on 1 December 2020. UTC activity has increased through March. 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 21**.
4. Daily 'Criteria to Reside' calls continue and are chaired by the Head of Clinical Operations. These meetings expedite and unlock delays to discharges; support wards to identify 'Golden Patients' earlier and ensure their timely move to the Discharge Lounge and enables partners to speak directly to the wards to review and unblock medically fit patients over 7 days. **On-going**
5. Flow Action Cards were implemented in March 2021. Compliance will be monitored each month going forward.

**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 a Abbott point of care testing is being investigated, to be based in the ED.

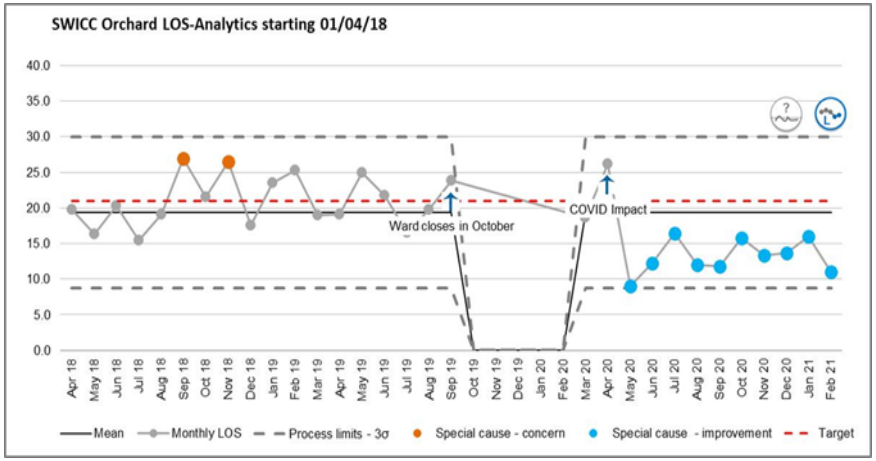
There is a risk that reduced nursing and medical staff, due to sickness and isolation, will impact on our capacity to manage flow. **Mitigation:** Daily review of staffing across the front door to ensure safety and timely assessment of patients.

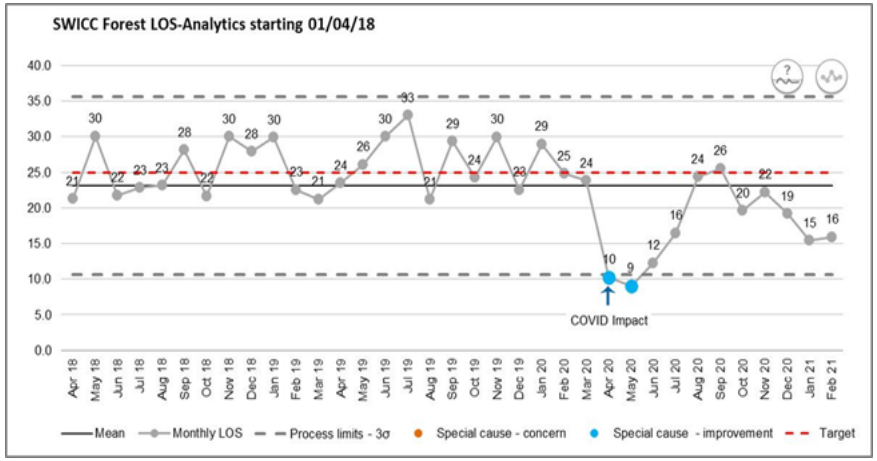
There is a risk that ambulance handover delays will continue to be seen due to a lack of flow out of ED. **Mitigation:** The split of blue and green beds across the Trust are reviewed 7 days a week in the 1pm Control Room meeting. In addition, the ED Team are working closely with SWAST to identify opportunities 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.

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

Are We Effective?




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

LoS remains below target for Forest Ward at 16 days however, the ward has been significantly below normal bed occupancy 66%. This was due to a change in policy for Covid swabs required within 24hrs rather than 72hrs. Further impacted by the lack of suitable green patients.

Orchard has seen a decrease in length of stay plus low bed occupancy of 50%. Over the month of Feb there was a need to switch from Blue to a green bed base due to hospital pressures. However countdown stopped and restarted on several occasions due to single patient Covid results. Also Covid recover IP&C admission criteria changed to 11 days post Covid.

For February there was a cohort of patients waiting for specialist rehabilitation level 1 and 2. Total number of bed days from referral to transfer was 47 days for 3 patients, 1 patient still remains as an inpatient.

Sunflower remained closed for the majority of Feb reopening on the 18th Feb. There was a staged approach to transferring patients to match the current staffing levels .

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

During March an audit will be undertaken internally into the timeliness of identification of patients and notification of patients requiring specialist rehabilitation. This will be shared at the SwICC Governance Meeting with any improvements identified.

Starting on the 8th March there will be an introduction of Integrated Discharge Calls, which are inclusive of SwICC, four times per week. There will be a further call on the Wednesday (Wicked Wednesday) for complex cases to be discussed as a whole trust, working collaboratively with partners to facilitate discharges. These will be monitored on a weekly basis with the view to decreased LoS for complex patients (stranded patients).

There has been a shortage of HCA's within SwICC and across the whole Trust. This has compromised the 1:1 cohort support. HCA recruitment is in progress with new starters expected in April. There has been a real improvement for medical cover across Orchard and Sunflower.

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## Risks to delivery and mitigations

Admissions to SwICC still remain challenging due to internal transport delays and the requirement for 24 hour swabs .

**Mitigation:** Delayed transfers are escalated on a daily basis to site. Names of patients are provided to site 24 hours prior to planned transfer to SwICC and Sunflower.

Identification of patients suitable for SwICC and Sunflower continues to be laborious. Covid patients appear to be more acutely unwell and are taking longer to become medically stable enough to transfer to SwICC which is impacting on the ability to optimise bed occupancy.

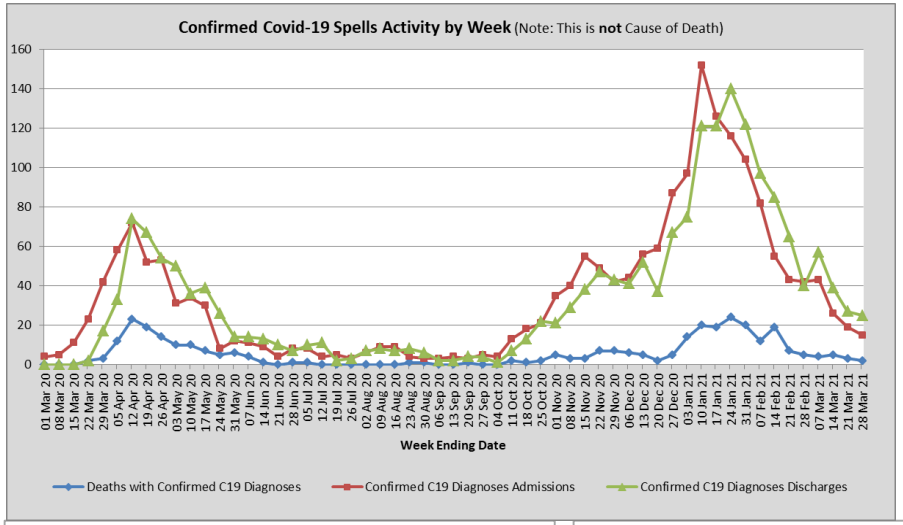
**Mitigation**: When all three wards are **"green bed base"** in March the flow of admissions will increase. The inclusion of SwICC on Integrated Discharge calls and Wicked Wednesday, will improve identification of patients to transfer.

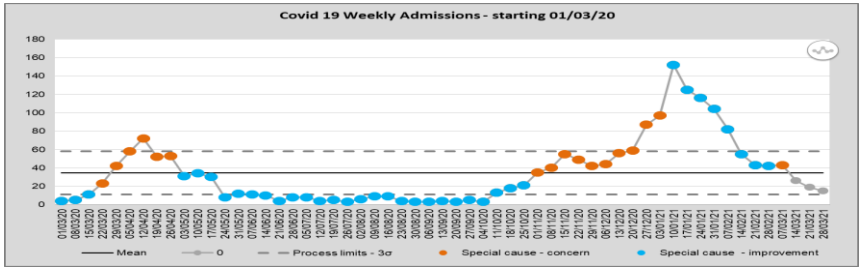
Staffing continues to be challenging with the number of vacancies and Covid related sickness/shielding both causing significant impact.

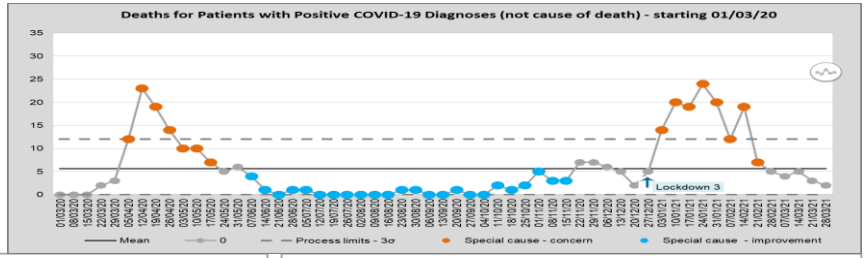
**Mitigation:** Daily calls across the divisions to identify where staffing can be reallocated. Recruitment of Nurse Associates is underway to mitigate this risk as well as International nurses. Planned pipeline of HCA's in April.

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

Are We Effective?




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

The graph above shows a continued decrease in Covid-19 admissions through February and March.

As a result, the Covid Assessment Unit (CAU) reduced to 5 trollies on the 19th of February. The remaining 6 beds were held empty and as general patient numbers have increased, these have been used 'ad hoc' for CAU overflow and/or ED ambulance queue support.

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.

The introduction of Abbott testing for ED from the Easter bank holiday weekend should further enhance this.

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 March outside of CAU.

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

1. Review of MAU/CAU current Medical model with potential 'Physician of the Day' role replacing need for Consultant based in CAU. **Completed**
2. Review of function of Shalbourne CAU 6 bedded area to confirm functionality, processes and data recording for reporting. **April 21**
3. On-going review of data to plan potential incorporation of CAU into total MAU bed base **August 21**
4. Increasing 'Covid Virtual Ward' catchment to include younger age group (50+) and Obstetric patients. **April 21**

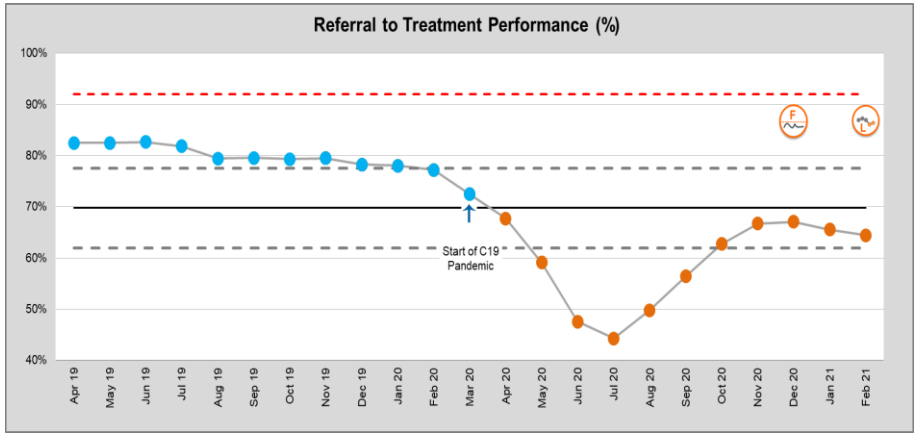
## Risks to delivery and mitigations

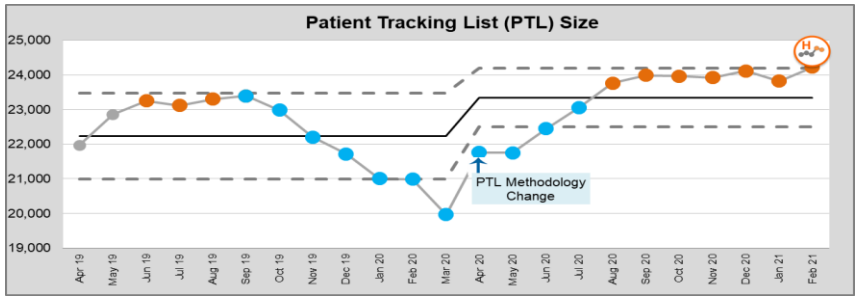
- There is a risk of delayed ambulance handovers in CAU due to delay in swab results limiting movement from CAU. **Mitigation** – Use of POCT/Cephid swabs and patients with high suspicion of COVID are managed with lateral flow testing at times of high escalation. Prioritisation of patient movement from 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 7 days a week on the COVID control call.

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

Data Quality Rating:

National Key Performance Indicators




| | |
|---|---|
| February Performance: | 64.43% |
| PTL Volume: | 24,224 |
| 52 Week Breaches: | R – 1,996, IM - 192 |

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

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 PTL increased by 404 in month, which puts us 977 adrift of our pre-Covid end of year trajectory. However, our current PTL is 4,008 below our Phase 3 Trajectory of 28,232 for February, primarily due to the fact that this forecast assumed a return to prior year referral levels which we are yet to realise.

In February, we reported 1,996 x 52 week reportable breaches against a trajectory of 2,014. This was an increase of 354 from January and of the 1,996 breaches, 389 (19.48%) of them are P5 and have opted to defer treatment until post-Covid. There were 192 in month 52 week breaches cleared in February which is a considerable decrease over the rolling 3 month average of 335 per month. This reduction is due to the reduction in Elective Theatres following ICU escalation into Recovery 1.

Of the 1,996 reportable breaches, 1,630 are Admitted, 282 are Non-Admitted and 84 are Diagnostic.

Our Phase 3 trajectory for 52 week breaches puts us at 2,269 reportable breaches at the end of March 2021, with a waiting list size of 28,995. Our PTL, at the end of February had 2,693 patients who have breached or are due to breach 52 weeks before the end of the year. Early indicators for March's breach position look to confirm a possible reduction over February's reportable position, which would comfortably see us below our Phase 3 Trajectory position.

**What will make the Service amber?**

- NHSE/I funding to use the Independent Sector (IS); either national contract or locally commissioned.
- Improving Theatre Utilisation (limited gains given the scale of the backlog).
- Improving Core Capacity through delivering Upper Quartile levels of productivity. Being explored as part of Elective Recovery.
- STP approach to RTT recovery/Wave 2 Recovery Plan delivery.

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

Recovery 1 was de-escalated beginning of March, and a return to full Theatres w/c 15th March. Daily Theatre Line Side Control meetings in place w/c 15th March, to monitor performance against required activity levels to deliver RTT performance.

Revised D&C Modelling being carried out as part of Elective Recovery, with a focus on increasing Core Capacity through increasing productivity levels 16/04/21. Initial KPI improvements are anticipated to be achieved in March 2021, when we return to 8-12 x Elective operating Theatres.

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. Discussions are on-going as to what capacity is available within BSW financial envelope.

RTT performance is being measured at the Weekly Access Meeting and underperforming services are escalated and discussed at RTT Oversight to identify support and recovery actions.

**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:** Business case approved in principal at Investment Committee, recruitment planned to commence mid-April.

There is a risk that PAC capacity does not increase as anticipated following the move to a new unit in April. Flow within the department is being assessed in line with IP&C guidance to establish if face to face capacity can be increased.

**Mitigation:** Maximise the use of Pre-Operative questionnaires and automation (Thoughtonomy) to improve clinic utilisation and reduce unnecessary PAC appointments (both telemed and face to face appointments). Dr Doctor is being explored as a digital platform for questionnaires.

There is a risk that we cannot secure the same level of IS capacity that we previously had access to.

**Mitigation:** Discussions are on-going with BSW and NHSE the capacity available within the BSW financial envelope.

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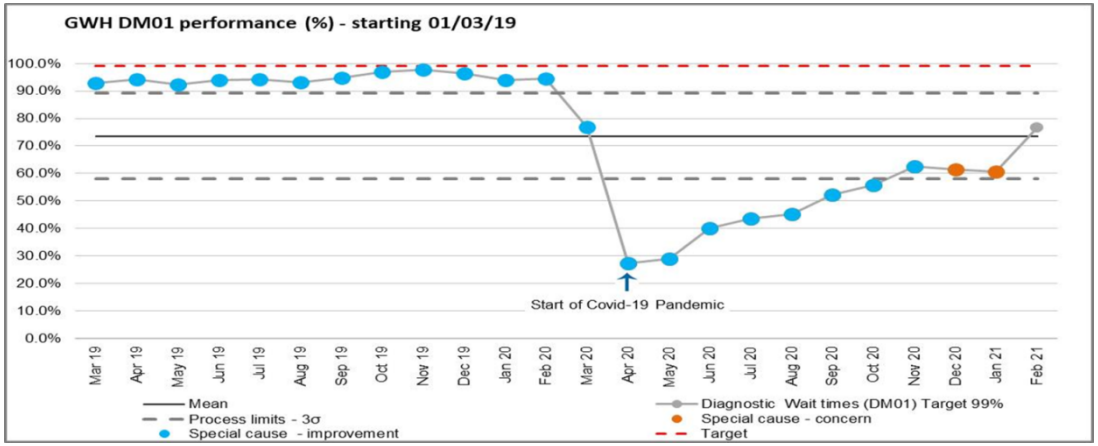
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

# 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 | 720 | 43 | **763** | 94.36% |
| Computed Tomography | 560 | 88 | **648** | 86.42% |
| Non-obstetric ultrasound | 1933 | 372 | **2305** | 83.86% |
| DEXA Scan | 161 | 0 | **161** | 100.00% |
| Audiology - Audiology Assessments | 205 | 2 | **207** | 99.03% |
| Cardiology - echocardiography | 28 | 7 | **35** | 80.00% |
| Neurophysiology - peripheral neurophysiology | 46 | 0 | **46** | 100.00% |
| Respiratory physiology - sleep studies | 8 | 11 | **19** | 42.11% |
| Urodynamic - pressures & flows | 1 | 0 | **1** | 100.00% |
| Colonoscopy | 242 | 456 | **698** | 34.67% |
| Flexi sigmoidoscopy | 101 | 208 | **309** | 32.69% |
| Cystoscopy | 8 | 7 | **15** | 53.33% |
| Gastroscopy | 134 | 193 | **327** | 40.98% |
| **Total** | **4147** | **1387** | **5534** | **74.94%** |

**February 2020**

| | |
|---|---|
| Performance Latest | 74.94% |
| Waiting List Volume: | 5534 |
| 6 Week Breaches | 2287 |

**Background**

Performance in February 2020 increased to 74.94% from 60.7% in January. Audiology performance in February achieved 99%, with all services increasing their month on month performance. Overall, the total waitlist size reduced from 5820 in January to 5534 in February (-286). The number of breaches has reduced from 2287 in January to 1387(-900). Covid continues to impede performance, however focused actions remain in place to stabilise and improve performance as expected from this month onwards.

**Improvement Actions**

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

- 7 CT van days in March, with conversion of routine to cardiac CT slots in CT1. 3 CT van days have been allocated in April.
- Additional MRI van capacity for Q4 2021 within forecasted budget – Jan – March 800 slots and April- May 540.
- Additional Payment Sessions are in place to support delivery of a further 300 slots for Ultrasound backlog clearance.
- Echo relocation from the Ridgeway to nationwide on the 12th of March.
- Independent sector support of Non Obstetric Ultrasound with additional capacity during March.
- 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 commencing in March 2021. Awaiting timeframe for completion.

**Risks** (Risk1855= 20) Failure to deliver DM01 for Imaging (risk remains the same). Insufficient capacity to recover the backlog remains the greatest risk to recovery. There was limited MRI van availability in 2020, however bookings have being confirmed for Q4,2021. CT van availability has been relocated regionally by NHSE and now remains in limited supply. Mitigations remain in place above to support Risk and detail 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 36% performance in February which is an increase of 10% from January. The number of referrals received in February increased from 506 to 666 but remains below the average of 997 referrals received each month from Oct to Dec 2020. There are 76 P5/P6 patients on the wait list. 527 of the reportable breaches in February were surveillance patients (46%.) and they remain a challenging cohort to book. Discussions started in relation to whether patients who DNA their swab can be managed in line with Trust Policy. GWH continue to provide more Endoscopy activity then SFT and RUH.

**Radiology:** Combined DM01 performance improved from 70.8% in January to 87.1% in February with a further reduction in waiting list size to 3877. There was a decrease in patients waiting over 6 weeks (-674) with a total of 503 breaches. Dexa is close to achieving the 99% target in February. NHSE have reallocated CT van capacity across the South West from the middle of March 2021. This will impede CT recovery trajectory during May, due to the loss of 230 slots in April.

**Echo:** Performance improved from 70.89% in January to 80% in February. February saw a slight drop in the overall wait list from 79 in January to 35 in February, with Aerosol generating procedures Trans Oesophageal Echo (TOE) and Stress Echo (DSE/ESE) solely comprising the wait list breach list of 7 referrals. Routine Echo is now being booked <6 weeks. Echo wait list activity reduced from 590 procedures in January to 492 in February due to the impact of annual leave including the half term.

## What will make the Service Amber?

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:** Paper discussed at Investment Committee in January which focused on activity and revenue options for Endoscopy in FY21/22 (including an increase in current levels). Awaiting confirmation on revenue spend for FY21/22. Weekend 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 will commence in March although awaiting final build timeframe to know completion date. Discussions started in relation to whether patients who DNA their swab can be managed in line with Trust Policy. Review of Imperial model of texting all patients on the wait list to confirm Endoscopy is available and to request patients call in. This will help ensure we are focusing on the patients willing to engage with the service.

**Radiology:** A further 27 days (540 slots) of MRI van capacity has been secured in April and May 2021 with recovery expected to deliver MRI DM01 in March. **CT**: CT van capacity is being sought from NHSE with a range of actions being implemented to mitigate the loss of van days. CT Cardiac slots have been increased on CT1 and booking in progress (oldest date for cardiac is November 20). NHSE are seeking a cardiac CT solution across the Southwest. An additional US is due to arrive in April. Recruitment of 2 WTE Sonographers is in progress following reallocation of budget.

**Echo:** Waiting List Initiative (WLI) will cease as of 31 March 20201. WLI activity will reduce in March due to the recovery of routine new patient echo <6 weeks. A new Echo Qualified Cardiac Physiologist started on 22 February with an additional 1 x Band 6 Physiologist starting in April. An advert has been placed for an additional Band 7 following the withdrawal of the 3rd potential candidate .

## 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 A&A 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.
- Cardiac CT slots reviewed as CT position improves with NHSE seeking further CT cardiac capacity.
- Care UK supporting US to limited extent.
- Additional US machine ordered.
- Bank Sonographer making up for CEV and maternity leave.
- Additional payments for sonographers (660 scans offered to date).
- Additional MRI van slots booked as per plan.

**Echo: T**here is a risk that there is not sufficient space to deliver Echo Cardiology in the Wiltshire Cardiac Centre (WCC) which will increase wait times. Echo at the BMI Ridgeway has ceased from the 11th of March 21 and the activity has now transferred back into the additional temporary clinic space created within the WCC, and supplementary activity is being delivered at the Nationwide Pavilion. Division of WCC Echo room is currently progressing and further planning is underway to explore the suitability of further internal reconfiguration and redesign of the WCC to provide 5/6 room of Echo capacity.

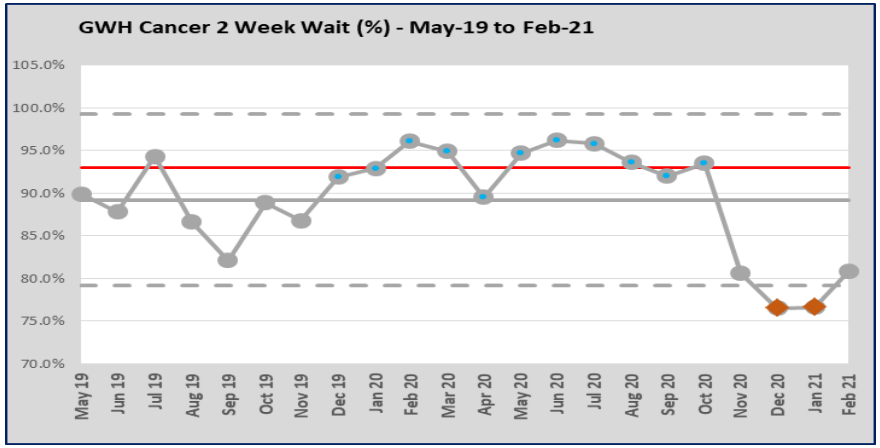
# Cancer 2 Week Wait Performance Target 93%

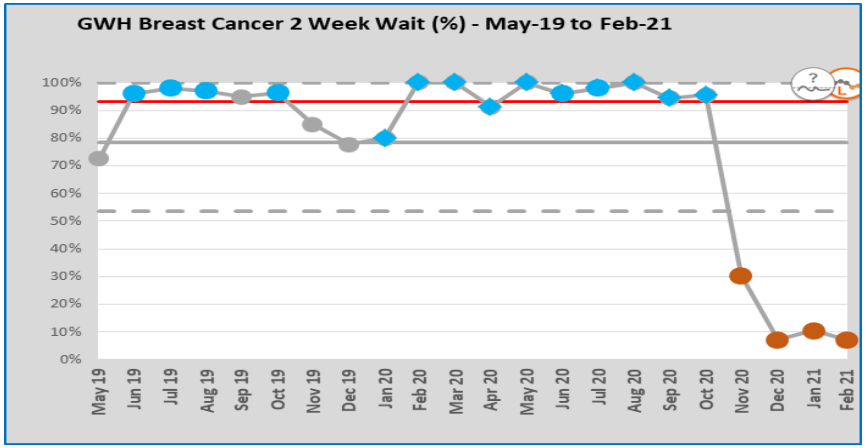
National Key Performance Indicators

Performance Latest Month: **February**

Data Quality Rating:

Two Week Wait Standard: 80.8% Two Week Wait Breast Standard: 7.1%




**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). 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. Through February the service has run no wait list initiative (WLI) clinics due to staffing (imaging assistants). As a result of the physical distancing requirements, at least one additional WLI clinic each week is required to maintain usual capacity for the unit. Work on demand and capacity has been undertaken by the service to predict future recovery. This is dependent on the breast reconfiguration work and staffing for additional WLIs. Breast build completion has moved from end of March to end of April. The trajectory was shared at the ESG meeting in February. Mutual aid declined in Bath Somerset Wiltshire (BSW) due to similar service pressures.

The standard was not achieved in colorectal due to patient choice and administrative delays to booking appointments. These delays were as a result of a change in triage, 2 cases of the referrals arriving on endoscopy late and the hospital cancelled patient not being booked onto a suitable list. These concerns are raised with Outpatients and Heads of Service to support improvements.

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

1. Breast 2ww demand and capacity work by service to support recovery completed in March. WLIs and weekend clinics have been planned through March & April to help recover position. The forecast and trajectories show that additional activity is likely to be required until September. The trajectories are predicated on the build works being completed in April. It is likely that the service will introduce triage of referrals with symptomatic patients being seen in clinic and imaging done at a separate appointment as there is not the capacity to maintain best practice of one stop clinics for this patient group.

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. Consideration of clinical triage of breast referrals and under 25 year olds accessing rapid access “light” clinic. Under 25 clinic piloted through February with some success, though numbers in this cohort may not support regular provision.

4. 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.

6. 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). 48.7% of referrals had Qfit completed in March. Navigators to work with primary care to increase completion.

**Risks to delivery and mitigations**

1. Risk: Delay implementing breast wait list initiative clinics (WLI) due to incentive payment request by imaging assistants.

**Mitigation**: Radiology team working with Human Resources and bank team to recruit additional staff to support clinics. Executive sign off for incentive payment agreed to support clinics in March and April.

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

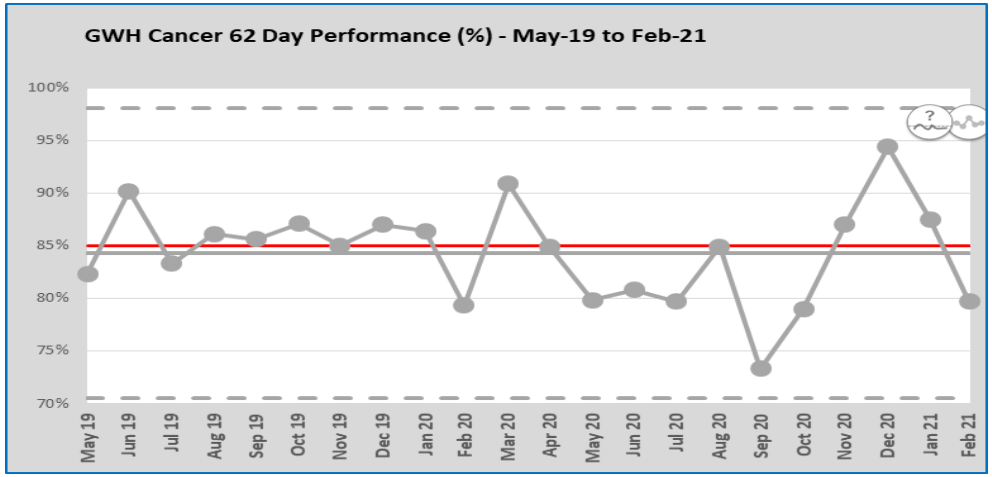
**Mitigation**: This has been escalated for Estate Executive to support imminent start to building work on 12th April.

3. Risk: Patient reluctance to attend during 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%

National Key Performance Indicators




Data Quality Rating:

Performance Latest Month: **February**

| | |
|---|---|
| 62 Day Standard (Target 85%): | 79.7% |
| 62 Day Screening (Target 90%): | 95.2% |
| 62 Day Upgrade (local standard 85%): | 92.0% |
| Q3 (Target 85%): | 86.3% |

**Background**

February 62 day performance is anticipated to be 79.7% with the Trust not achieving the national 62 day standard following three months of successful delivery. Prior to this performance was heavily impacted by the COVID 19 pandemic and diagnostic/treatment delays .

In February, patient pathways were delayed due to clinical capacity, errors in priority of requesting diagnostics, repeat diagnostics and pre-assessment capacity. Seven patients had additional diagnostics and discussions at MDT due to the complex nature of their cancer. One of these had a high grade prostatic cancer with all options offered as treatment. The treatment plans changed several times as a result of patient choice and clinical advice. Three of the complex pathways included potential metastatic disease leading to additional diagnostics. One breach was as a result of the patient not attending two of their arranged appointments in Plastic surgery, resulting in the pathway being referred to Oxford late. GWH Theatre capacity was reduced to 4 theatres due to recovery unit use as Covid ICU.

Seven pathways were referred to Oxford for treatment within 38 days and have not resulted in a breach to GWH. Five of these were on a Head & Neck pathway.

In February the screening standard was met. A colorectal screening pathway breached as a result of a complex pathway requiring Urology input before surgery could be arranged.

The upgrade standard was met in February. Two patients treated out of timeframe had been sent to OUH within 38 days resulting in no breach being recorded against GWH

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

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

2. Thames Valley Cancer Alliance (TVCA) transformation work continues with focus on lung and colorectal pathways. Following a Covid pause, the Rapid Diagnostic Service meeting with TVCA 10th March discussed funding to support the introduction of the new service.

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 are being arranged for the clinical teams.

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 & skin pathway process mapping exercise to support improvements in diagnostic pathway due in April.

**Risk to Performance Delivery**

1. Risk: March performance is also 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 of approximately 80.7%.

Pressures are being seen within theatres, pre-assessment clinic, outpatients and diagnostics. There were a number of complex pathways requiring additional diagnostics and changes to treatment plans. Four breaches were carried over from February as a result of complex pathways.

There has also been a reduction in CT capacity due to loss of CT van days as NHSE have allocated the vans to hospitals with longer wait times.

**Mitigation:** Continue twice weekly PTL meetings and fortnightly cancer recovery meetings to progress pathways and improvement work.

Gynae pathology delays are impacting patient pathways. This has been escalated with Oxford University Hospital (OUH )pathology services with a meeting between the pathology services and the clinical director. An improvement has been noted on the cancer PTL in late March.

Outpatient capacity issues in both the Upper and Lower GI pathways is resulting in delays to follow up activity. Registrar clinics commenced in March.

The skin pathway is being mapped to review improvements for patients requiring a diagnostic biopsy before surgery by the end of April.

Oncology capacity is 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).

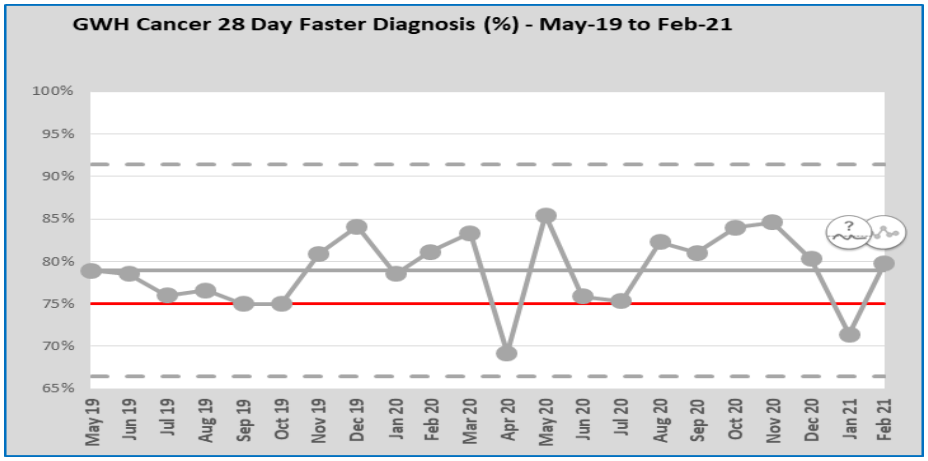
# Cancer 28 Day Diagnosis Target 75%

Are We Effective?

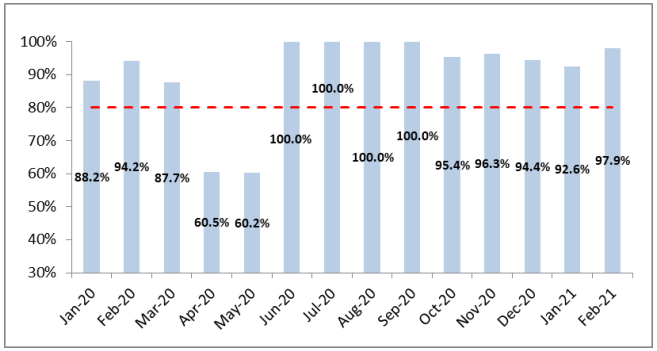
Performance Latest Month: **February**

28 Day FDS 79.8%

Data Quality Rating:




**Cancer 28 FDS Completeness**




**Background**

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

Planned national reporting from April 2020 is likely to remain suspended until September/October 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 a number of 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. TVCA funded colorectal straight to test nurses to commence in May 2021.

**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 suite 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 bank staff to support future clinics

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

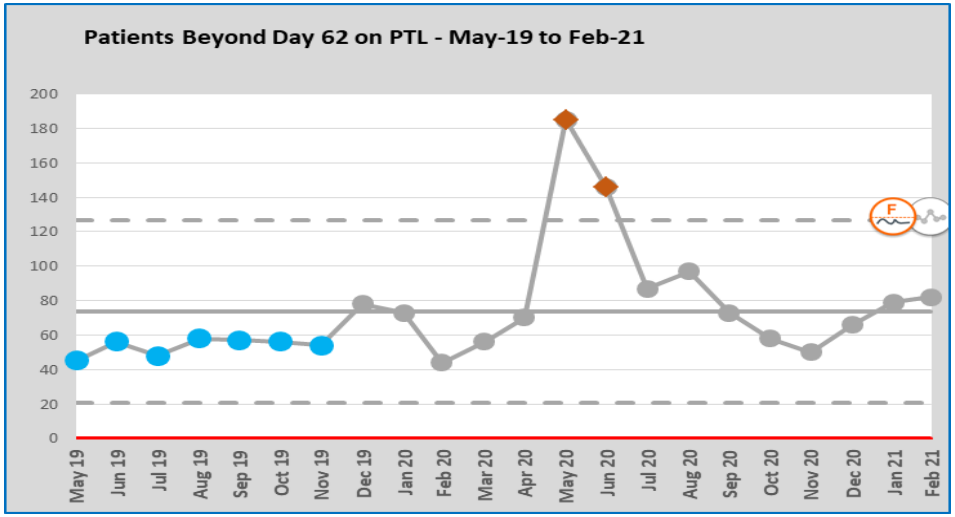
**Mitigation**: Escalated with OUH and pathology monitoring of key performance indicators working with clinical lead where deviations noted.

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

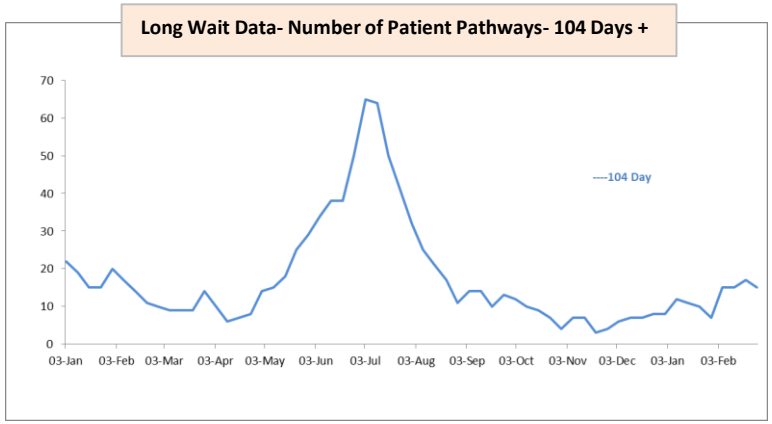
**Mitigation**: Colorectal service has recruited two registrars to support clinics commencing in March.

# 62 day + longer waiters including > 104 day

National Key Performance Indicators




Data Quality Rating:




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

104 Day Breaches: February: 6 Patients; 2.0 breaches

**Treated at GWH**

**Gynaecology: 1 patient-1.0 breach:** The pathway was slowed by delays in the booking of a hysteroscopy under GA. An earlier planned treatment had to be cancelled due to some adverse findings on an MRI that required discussion at the network MDT before treatment could commence. Gynae pathway process mapping exercise underway.

**Treated at OUH**

**Skin: 1 patient-0.5 breach:** Patients planned treatment had to be cancelled due to cardiac issues that required additional review before surgery could be undertaken. The pathway transfer to Oxford was delayed due to possible differential diagnosis'.

**Lung: 1 patient-0.5 breach**: This was complex pathway with delays as a result of the patient suffering from anxiety, leading to an early diagnostic being rescheduled. After transfer to the Royal Brompton the patient was not sent an appointment notification leading to delays in the treatment.

The other three breaches relate to pathways transferred to Oxford before day 38 on the pathway, therefore no breach is recorded against GWH. Two of these were in the Head & Neck site and the other was on an Upper GI pathway.

March is likely to see 4 patients breach 104 days on their pathway resulting in 1.5 breaches. Two patients had complex pathways requiring repeat diagnostics. Two patients were referred to OUH for treatment within 38 days and will therefore not result in breaches for GWH.

The high number of 104day+ pathways on the PTL is largely due to a high number of patients (7 out of 15) 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. Additionally 6 of the patients do not have cancer and are awaiting confirmation of their non cancer diagnosis.

## 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.

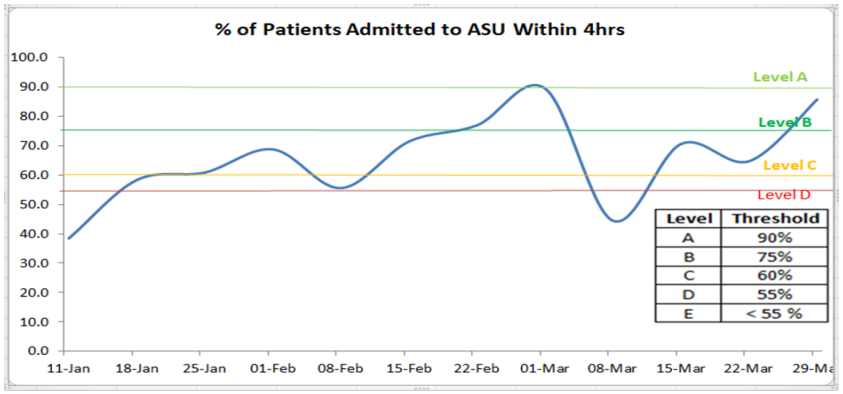
Pathology delays are being escalated with OUH.

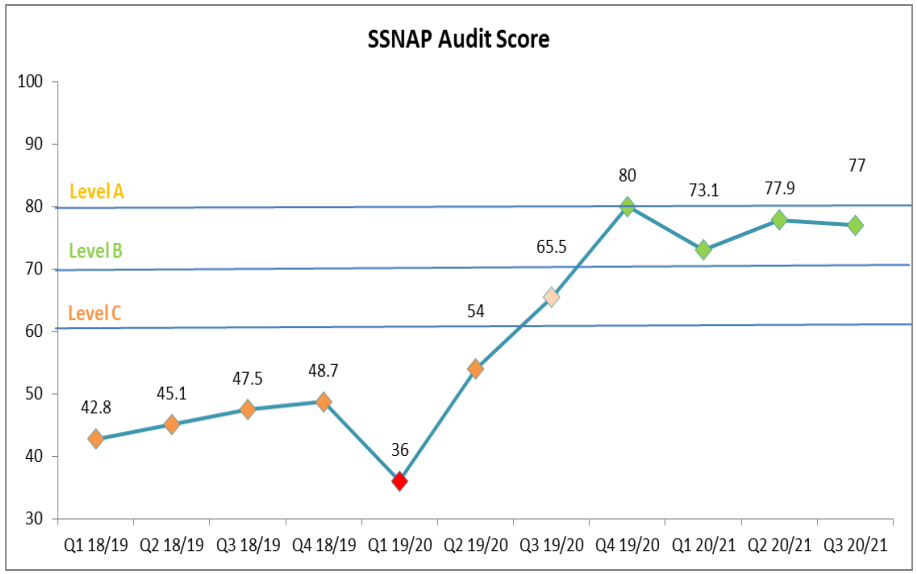
# Stroke Pathways

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 Q3 SSNAP score has been confirmed as Level B performance, with a score of 77. This gives confidence in the sustainability of Level B performance as business as usual.

Admission to the Acute Stroke Unit with the 4 hour performance window continues to be an area for further improvement, particularly out of hours.

There was a sharp drop in performance within this metric at the start of March as per the graph above. 7 out of the 10 breaches that week were out of hours and 5 of the 10 were late referrals from the Front Door. 3 of the 10 patients were identified as Stroke later in their pathway. This position has since recovered with admission performance improving well.

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

1. Delivery of ED Junior Doctor Stroke Training to cover; Management of Acute Stroke, Management of TIA, Stroke Mimics. **Apr 21**
2. Development of business case to support increased OOH stroke cover. **May 21**
3. Review OOH structure within other Trusts. **Apr 21**
4. ED Nurses to shadow Stroke Specialist Nurses to improve knowledge and confidence with Thrombolysis. **Apr 21**
5. ED to report and provide narrative on all 4hr breaches to establish root causes and drive improvements. **Apr 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.

**Update –** Regular weekly monitoring continues to demonstrate an improvement in admission times.

# Board Committee Assurance Report

| Quality & Governance Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Dr Nicholas Bishop** | Nick Bishop | | 22 April 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 | Green | Amber | Progress has been made in the areas of Dementia assessment, C. diff infections and VTE Assessments. Whilst falls and pressure ulcers remain higher than they should there is a good action plan in place and this is gradually proving to be effective. Patient safety incidents have reduced. | Continue with action plans. | |
| GWH Controlled drugs Annual Review | Green | Green | The report gave good assurance that our systems for identifying incidents related to CDs are robust. | Continue with monitoring and annual reports | April 2022 |
| Quarterly Mortality Report | Green | Green | The committee was disappointed that this report had to be presented verbally as the last 'quarterly report' was presented in November 2020. Nevertheless the Medical Director assured the committee that mortality rates remained within the expected range. | Ensure that a full written report is presented to the Q&G committee in June as planned. | June 2021 |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Summary Hospital Level Mortality Indicator (SHMI) | Green | Green | The Trust's SHMI has trended upwards since 2018 although it remains within the expected range. The purpose of this report was to analyse a random set of notes to see if this could be explained. The study excluded any patient coded for palliative care. Some patients may have benefited from such care at the end of life. Under-coding of end of life is a possible reason for our rising tend. There was no evidence of poor care as a contributing factor. | Encouraging doctors and care staff to recognise when a patient is dying or in the final stages of life could improve their quality of care as well as the SHMI | |
| Compliance with National Perinatal Mortality Review | Green | Green | There was only one relevant case and the was 100% compliance with requirements. | | |
| GWH Safeguarding Services update Q3. | Green | Amber | This was the first report that combined Adult, Children's and Maternity Safeguarding. Generally the report was assuring but some issues related to mandatory training were highlighted and some capacity issues. | Continue drive to improve uptake of mandatory training and attempt to quantify and address capacity issues. | Subsequent quarterly reports. |
| | | | | | |

| 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?

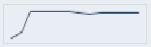
Are We Caring?

Are We Well Led?

Use of Resources

# Our Care Summary

NHS
Great Western Hospitals
NHS Foundation Trust

| KPI | Latest Performance | Trend (last 13 months) | Potential* National Ranking | Public View (Latest Published Data) | | | |
|---|---|---|---|---|---|---|---|
| | | | | National Ranking | Bath Ranking | Salisbury Ranking | Month |
| Dementia Assessment (Public View) | 86.1% (Feb 21) |  | 61 | 61 | 1 | 1 | Feb 20 |
| *C. Difficile (Hospital onset) per 1000 bed days* | 10.34 (Feb 21) |  | 20 | 18 | 51 | 38 | Jan 21 |
| VTE Assessment | 98.9% (Feb 21) |  | 5 | 18 | 114 | 1 | Dec 19 |
| Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death) | 1.5% (March 21) |  | - | 121 | 116 | 76 | Dec 20 |
| Hip Fracture Best Practice Tariff – 12 Month Rolling | 65.0% (Feb 21) |  | 37 | 37 | 86 | 4 | Feb 21 |
| Complaints Rates | 39.79 (Q3 20/21) |  | 119 | 112 | 32 | 47 | Q2 20/21 |
| Family and Friends Score – Percentage of Positive Responses - Inpatients | 83.87% (Mar 21) | | 120 | 103 | 19 | 7 | Feb 20 |
| Complaints Response Backlog | 0.09 (Q2 20/21) | | 2 | 2 | 90 | 59 | Q2 20/21 |
| MRSA all cases | 0 (Mar 21) | | | 45 | 96 | 68 | Jan 21 |
| Falls per 1000 bed days | 6.1 (Mar 21) |  | | | | | |
| Pressure Ulcers – Acute | 31 (Mar 21) |  | | | | | |
| Pressure Ulcers – Community | 25 (Mar 21) |  | | | | | |
| Never Events 20/21 | 3 | | | | | | |
| Serious Incidents | 3 (Mar 21) | | | | | | |

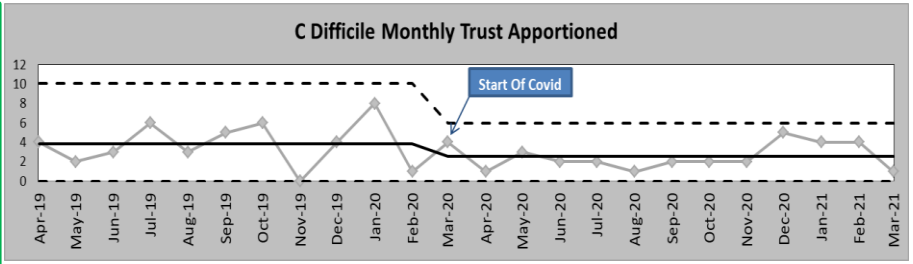


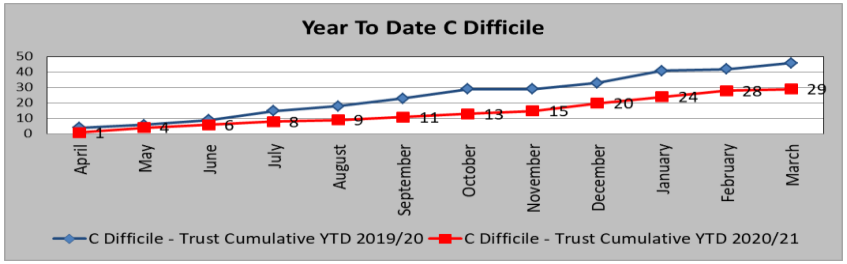
*Potential data ranking based on current performance against last available Public View data

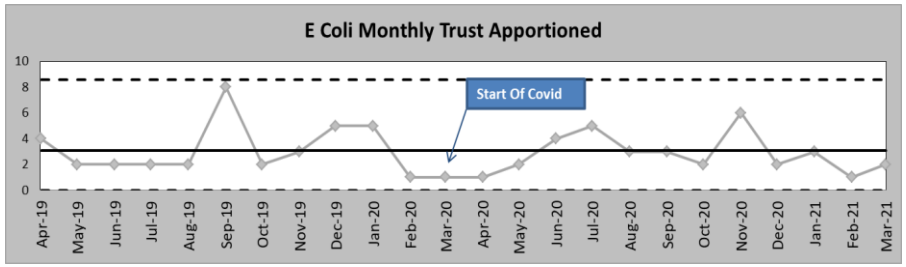
# 2. Patient Safety - Infection Control

Data Quality Rating:

Are We Safe?




| MRSA Bacteraemia | 2019/20 | 2020/21 |
|---|---|---|
| Trust Apportioned | 2 | 0 |

| Hand Hygiene | March |
|---|---|
| Audit Results | 95.6% |

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

***C. difficile*** – 29 infections have been reported to date in 2020/21. One case identified during March 2021 and identified as a hospital onset (48 hours after admission). A trajectory was not set for 2020/21 therefore adoption of 2019/20 trajectory of 47 has been used as a guide, current reported cases are under this level.

***C.difficile*** infections have reduced from 46 in 2019/20 to 29 in 2020/21, a reduction of 38%. The rate per 100,000 bed days has reduced by 20% which highlights that some of the reduction is due to the Trust seeing fewer inpatients. *

**Flu** – No flu cases have been identified so far in winter 2020/21. This reflects the national picture.

*Rate per 100,000 bed days if for Apr 20 – Feb 21. Full year's data pending from Public Health England.

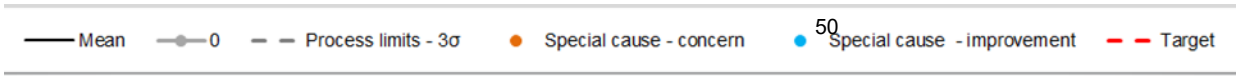
**Improvement actions planned, timescales, and when improvements will be seen**

***C. difficile*** - Following enhanced microbiology analysis there is no evidence of cross infection associated with previous cases reported.

**E.Coli** – Root Cause Analyses (RCA) are being undertaken for all hospital acquired infections, A theme has been identified relating to urinary tract infection and urinary catheter management. A training programme regarding improved management of urinary catheters and new fixation devices is being rolled out.

**Risks to delivery and mitigations**

Risk of increased incidents of C.difficile due to late sampling and identification. Training has been completed in key areas.



# 2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

| Covid 19 | Mar-21 | Feb-21 |
|---|---|---|
| Number of detected Inpatients | 72 | 155 |
| Number of Deaths in Hospital | 12 | 47 |
| Hospital Acquired Covid-19 Cases* | 0 | 7 |

| Covid-19 (Apr 20 – Mar 21) | |
|---|---|
| Number of detected Inpatients | 1458 |
| Number of Deaths | 324 |
| Hospital Acquired Covid-19 Cases* | 139 |

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

A total of 72 patients were diagnosed with COVID-19 during March 2021, compared to 155 in February 2021.

None of these cases were deemed to be hospital acquired. There have been no ward outbreaks during March.

Swindon continues to have the highest case rate per 100,000 [53.6] in the South West [19] and is above the England Average, which is 37.9 per 100,000.

The highest rate of positive testing in Swindon is in the 24-54 age group and this is reflected in hospital admissions. This age group has an average length of stay of 6.9 days.

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

The Trust has moved to 5 day national reporting of number of inpatients with Covid 19 in line with national guidance.

Isolation of patients with COVID -19 is proactively managed by the site team and the patients are informed of their COVID status by ward staff. Capacity is being managed with 11 dedicated 'blue' beds on one ward and up to 4 ICU beds.

The importance of PPE and social distancing within the wards and corridors of the Trust continues to be a focus for the infection control team and senior nurses. The monthly PPE audits are ongoing and monitored through Infection Control Committee.

The impact of the vaccine on the COVID-19 infection rate in the elderly and vulnerable group of patients continues to reduce the number of patients in this cohort requiring hospitalization.

An additional rapid testing platform is being tested by Microbiology, this will mean results can be achieved within 13 minutes, this will have a significant impact on our ability to place patients on appropriate wards.

**Risks to delivery and mitigations**

The impact of post lockdown measures easing and Easter mixing is being closely monitored, in terms of increased admissions.

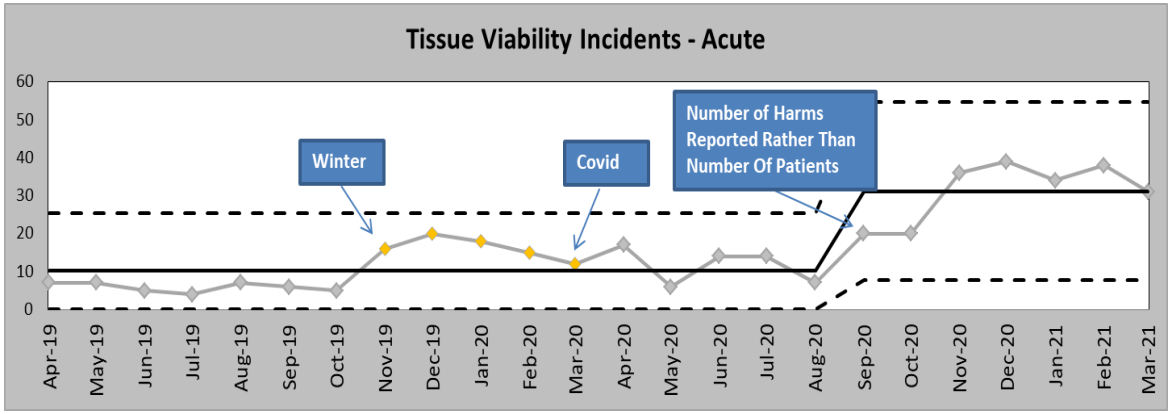


*Patients in Definite (15+ days post admission) and Probable Categories (8-14 days post admission), plus patients who were previously IP and may have been infected during that earlier admission.

# 2. Patient Safety - Pressure Ulcers- Acute

Data Quality Rating:

Are We Safe?




Incidents of harms by Category for March 2021:

| Category 2 PU | Category 3 PU | DTI | Device related PU | Total Incident of Harms |
|---|---|---|---|---|
| 11 | 0 | 9 | 4 | 24 |

| Number of Patients | Harms per Patient |
|---|---|
| 3 | 2 |
| 2 | 3 |

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

The number of hospital acquired reported harms related to Pressure Ulcers remain high this month.

6 harms have been attributed to the Emergency Department but this is likely due to poor skin inspections and documentation on admission.

ICU and Neptune are showing an improved position from previous months. ICU have 3 device related pressure ulcers and Neptune has one category 2.

Trauma Ward remains an area of focus and support but a reduction in harm is noted.

There is a theme associated with pressure damage to heels.

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

The Safer Skin Campaign is ongoing with monthly engagement events and messaging.

The sharing of learning from harms caused within clinical areas and across the Trust is being strengthened through safety briefing and ward boards.

A safety briefing on when to refer to Tissue Viability and importance of Image taking has been disseminated.

A process for validating Suspected Deep Tissue Injury (DTI) has been developed and disseminated.

New pressure reliving equipment (repose) is being delivered to each department on Monday 19th April. Education and information has been sent to ward managers and matrons. Educational training sessions planned for May with a focus on heel off loading.

Training Tracker Pressure ulcer prevention management module now implemented, compliance will be monitored monthly. Trauma unit have 100% completion for all clinical staff.

Focused support to ED, to improve skin inspections on admission and to Trauma to continue.

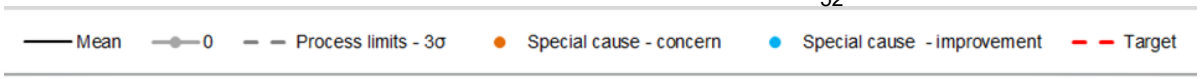
A spot check of mattress integrity on 2 wards highlighted issues with pressure distribution and infection control of several mattresses. Work is planned to take forward a Trust wide audit as the monthly checks and replacement programme is behind plan.

**Risks to delivery and mitigations**

Difficulties in accessing suitable environment to deliver face to face training.

Train the trainer packs are being developed to be delivered within the clinical areas.

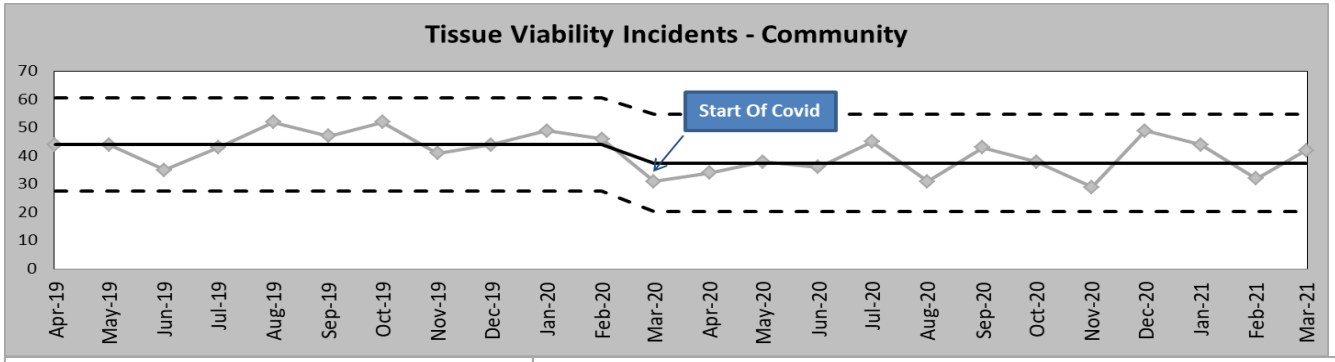




# 2. Patient Safety - Pressure Ulcers- Community

Data Quality Rating:

Are We Safe?




| March 2021 | | | | |
|---|---|---|---|---|
| **Locality** | **Cat 3** | **Cat 4** | **DTI** | **Totals** |
| North | 5 | 3 | 4 | 12 |
| South | 1 | 0 | 0 | 1 |
| West | 4 | 1 | 0 | 5 |
| Central | 1 | 0 | 3 | 4 |
| CICT | 0 | 0 | 0 | 0 |
| S/Flower | 0 | 0 | 0 | 0 |
| **Totals** | **11** | **4** | **7** | **22** |

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

- There has been an increase in the number of harms related to pressure ulcers this month with a theme on damage occurring when patients are at the End of Life (EOL). Analysis shows that a change in equipment or care provision was not always adapted when the patients' status changed.
- Of the 11 category 3 reported PUs, 5 were healing when reviewed by the specialist team.
- Suspected Deep Tissue Injuries (DTI) require further investigation from 72 hours onwards by TVN to determine if they evolve or resolve. March's audit has shown out of the 7 DTI's 4 patients were in end of life patients so unable to revalidate and 3 have resolved.
- All of the Category 4 PUs were previously reported at lower levels of harm (category 3 or unstageable in March 21).
- There are 5 device related (DR) harms all due to catheter's - 4 are mucosal membrane damage.

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

Category 2 pressure ulcers are now validated by Swindon Community Health Services (SCHS) TV service, and origin determined so able to clarify numbers acquired in SCHS.

A prevention of pressure ulcers at end of life pathway / education pack is being developed and will be distributed this month.

When patients are assessed as having pressure damage by community bank and agency nursing, who may not have access to the electronic referral system, a process has been developed to ensure the paper records are now scanned immediately. This ensures a quicker management plan from the TVN service.

Bi weekly training for community staff is ongoing with focus this month on pressure injury prevention and incontinence associated dermatitis (IAD).

Microsoft Teams monthly pressure ulcer prevention/management equipment training is on going.

The continence, infection control and TVN leads are rolling out training and implementation of new catheter packs / fixation devices with an aim to reduce device related harm from urethral catheters.

Next month 's focus / training will be on device related harm.

**Risks to delivery and mitigations**

High levels of temporary staff with a lack of familiarity with documentation and processes. Mitigated by new records process and inviting to training.

Increased number of new starters requiring additional education, support and Tissue Viability resources.

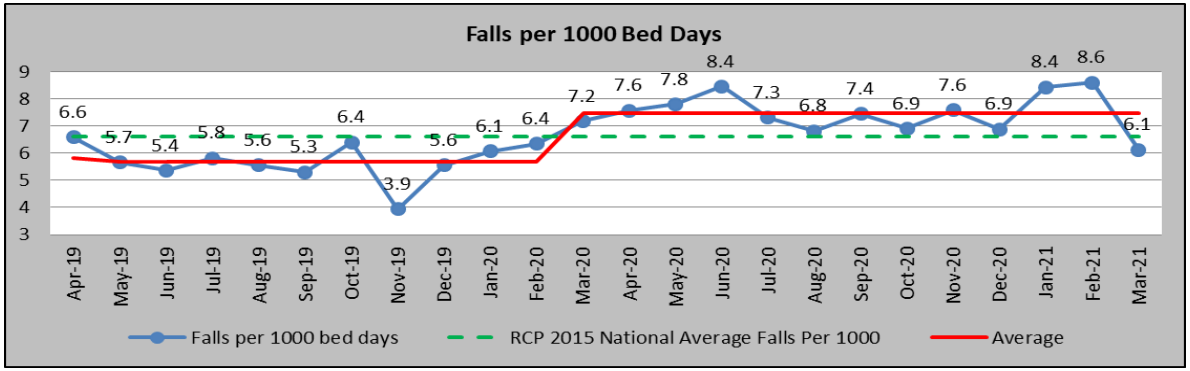
Increase in demand and complexity for the TVN service has been addressed through the successful recruitment of a new post that will start in May.

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

# 2. Patient Safety - Patient Falls

Data Quality Rating:

Are We Safe?




| March 2021 | | Feb 2021 |
|---|---|---|
| Falls Resulting in No Harm | 104 | 129 |
| Falls Resulting in moderate Harm or above | 2 | 2 |

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

Since September 20 there has been an increase in the average number of falls reported per month, from a 2019/20 average of 111 to 126.

The Trust has however seen a reduction in the number of falls from 131 in February to 106 in March, this is also lower than the number reported in March 2020 (121)

There has been a sustained increase in falls per 1000 bed days since January 2020 until March 21, which has reduced from 8.6 in February to 6.1.

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

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

- A trial of paper multifactorial risk assessment and care plan document has commenced in project areas on 29th March 2021 (Teal, Jupiter, Trauma SWICC wards, Sunflower).
- This trial includes falls documentation being taken off Nervecentre and replaced with paper assessments to test and amend the content of the documentation (assessments cannot be amended on Nervecentre).
- Initial findings and impact of the project has resulted in an increase from 0% to 75% of patients having falls interventions documented on their assessments. Further findings indicate significant improvements are required in evidencing interventions following transfer from an impatient area.
- Resource packs have been developed and distributed to Falls Champions
- Falls presentation boards for project wards in place detailing guidance on how to undertake a risk assessment, implement falls interventions, the use of bed rails and low beds and level of observations.
- Mint coloured curtains ordered which will make the bed areas lighter, helping to reduce the risk of falls.
- Staff survey due to be undertaken in April to establish staff thoughts on the new assessment documentation and gain insight for potential changes required.

**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'.

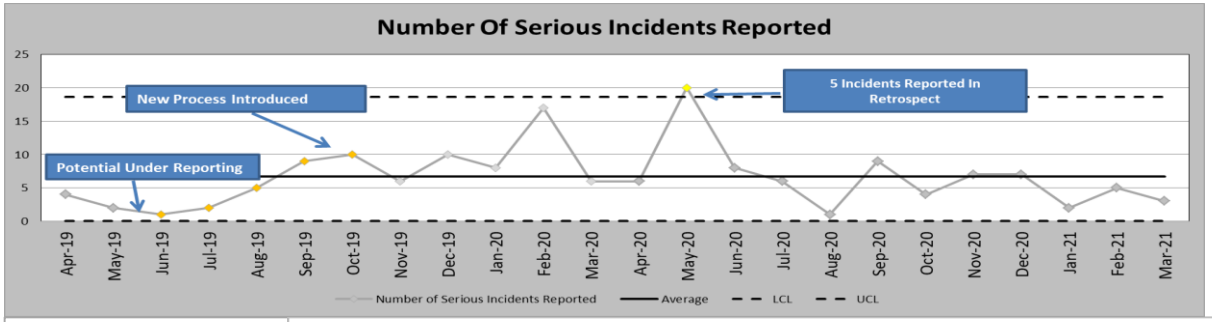
Planning in place to increased meaningful activities to increase mobility and mental stimulation.

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

# 2. Patient Safety - Incidents

Data Quality Rating:

Are We Safe?




| Serious Incidents Reported | | | Comparison |
|---|---|---|---|
| Jan-21 | Feb | Mar | Mar-20 |
| 2 | 5 | 3 | 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 36 on-going Serious Incident (SI) investigations, with 3 reported in March.

The number of SI's reported has decreased compared with February and remains below the Trusts average per month.

There continues to be good levels of incident reporting with a total of 876 Patient Safety Incidents reported in March, this is in line with reporting across our STP.

**Improvement update on improvement groups**

Two Improvement groups have achieved their objectives which are detailed below

**Access to the NHS Spine-**

Aim – to improve patient safety due to increased access to patient summary care records

- New review process in place to establish numbers of smart cards required and computers without smart card readers
- Roll out of Smart cards to Front Door Teams completed
- 80 additional staff members now have access, which allows improved access to patient summary care records
- IT will work with HR in facilitating issuance of smart cards at induction for junior doctors
- Training package established
- On-going information governance audits to ensure compliance

The success of this improvement group has led to reduced incidents regarding a lack of access to patients summary care records with no incidents reported in March 21.

**Anticoagulation Improvement Group –**

- Education & training for nurses & junior doctors in progress. Compliance to National Standards through completion of audit on the VTE assessments.
- Alerts and prescribing supports on EPMA
- Provision of access to information out of hours
- Implementing Super users
- Update noting forms to include critical medication and VTE assessment
- on-going support will continue for nurse super users, ward managers and nurses involved in incidents and hints and tips information will be provided.

The success of this improvement group has led to sustained reduction in incidents regarding anticoagulation.

**Improvement Groups continue in the following areas** - WHO checklist, BiPAP, NerveCentre and Safe discharge. Progress on the actions from these groups are monitored through the Safer Care Group and Patient Quality Committee.

**Risks to delivery and mitigations**

Shielding staff who had been supporting the Incident Investigation have now returned to their substantive roles. Currently reviewing governance / quality roles to ensure divisions have adequate support.



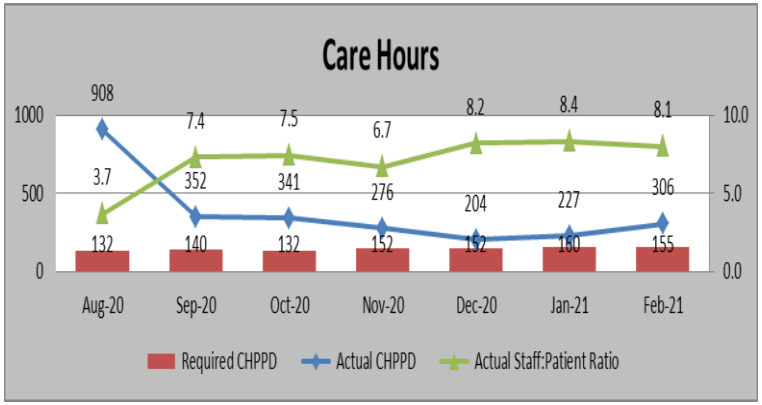
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

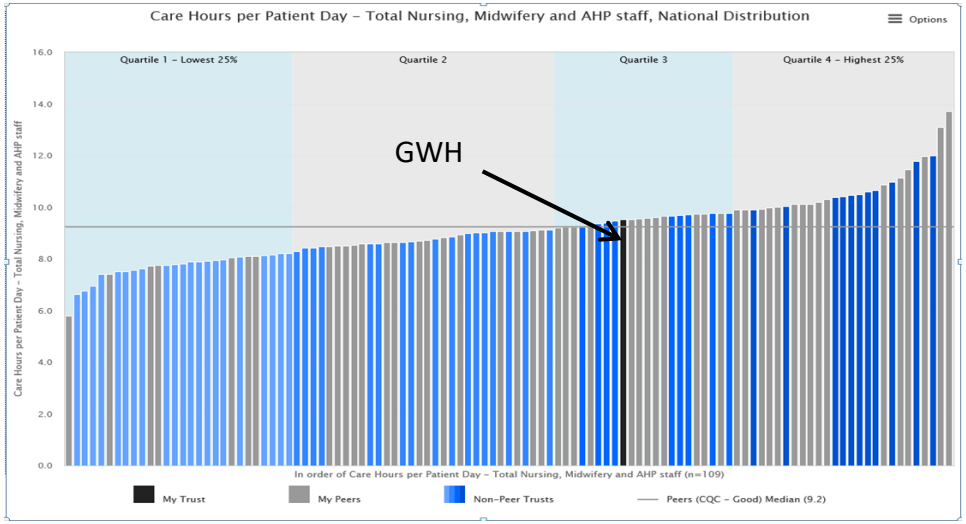
# 2. Patient Experience – Safer Staffing - Care Hours Per Patient Day (CHPPD)

Data Quality Rating:

Are We Safe?

*Graph 1 describes Care Hours per patient day required compared with actual and includes staff / patient ratio*




**Background and underlying issues**

Aligned to national acuity and dependency scoring the above graphs evidence that there are sufficient care hours per patient day supporting Safe Care.

This is further evidenced by Model Hospitals: Care Hours per Patient Day data where GWH rank in the 3rd Quartile for care hours with a score of 9.5 in January 2021 against a national average of 9.1.

| Trust | Care Hours Per Patient Day | Quartile |
|---|---|---|
| RUH Bath | 10 | 4th (Highest) |
| GWH | 9.5 | 3rd |
| Salisbury NHS FT | 7.8 | 1st (Lowest) |

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

- ICU are benchmarking with other Trusts in BSW on the utilization of Care Hours per Patient Day and recording acuity and dependency of this group of patients.
- Children's unit acuity and dependency has been added to SafeCare.
- Roster reviews are ongoing to ensure wards are complaint with E Roster KPIs. Themes identified are being addressed.
- 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 center.
- Plan to achieve zero Registered Nurse vacancies by December 2021. A further 80 Overseas Nurses joining in next 6 months.
- Divisional Directors of Nursing now chairing the SafeCare meetings and will continue to monitor agency usage.
- The review of the ward clerk role is part of the transformation workstream. The aim is to review working hours and strengthen their role in the process of admission, transfer and discharging patients freeing up clinical time.

**Risks to delivery and mitigations**

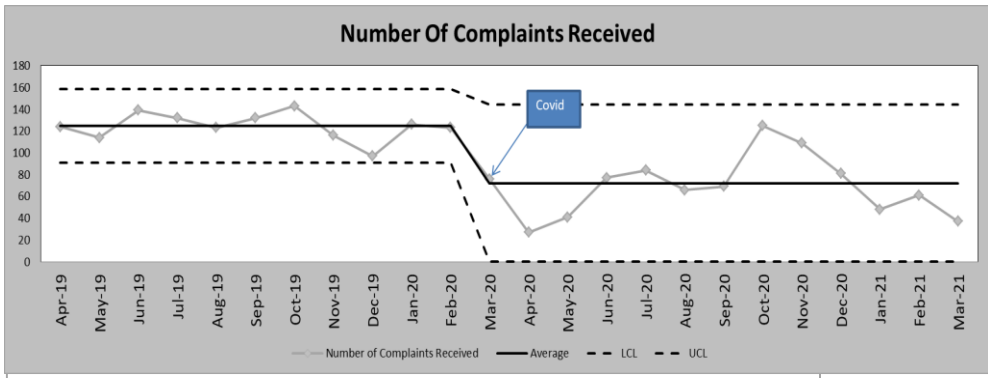
Risk of increased vacancies / turnover in registered nursing needs to be mitigated by focus on recruitment and retention.

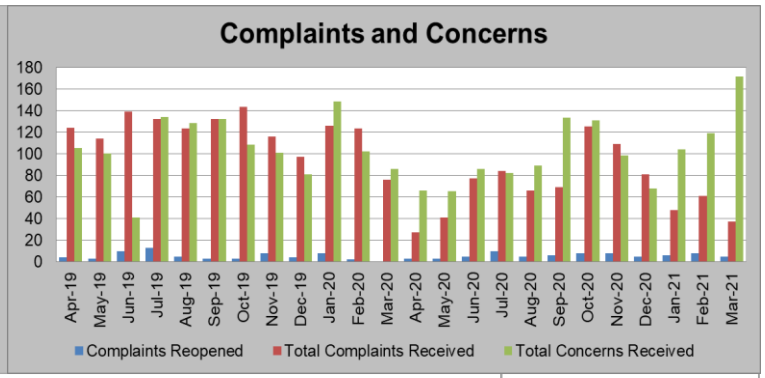
The national Safe Staffing submission to be reviewed in April in order to match current establishments. Fill rates per shift are being monitored closely on daily / monthly basis.

# 2. Patient Experience - Complaints and Concerns

Data Quality Rating:

Are We Caring?




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

**37** complaints (previous month 61) and **171** concerns (previous month 119) were received in March 2021.

Out of a total of **208** cases received from Complaints and Concerns in March, the overall top three themes were:

- **Telecommunications:** 28 (13%) – 2 complaints, 26 concerns.
- **Behaviour of Staff:** 26 (13%) – 7 complaints, 19 concerns.
- **Clinical Care:** 26 (13%) – 12 complaint, 14 concerns.

**Complaints**: 37 complaints were received, 33 were rated as (Low – Medium), 4 (High to Extreme).

Cases rated as High for March related to complex cases including:-

- A patient self discharged, safeguarding issues raised by family.
- Unhappy with care whilst recovering on the ward, patient received conflicting information from a number of doctors.
- Concerns raised with care provided by Moredon Medical Centre including delayed visits, skin care and abrupt staff.
- Further investigation required into allegation of inappropriate behaviour.

Three of the cases above are still in the investigation process.

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

**Telecommunications/Communication**
A Project group has now been set up to review all concerns and complaints raised related to telecommunication. Work streams have been agreed including information/direction for public, review of switchboard contacts, internal directory improvements, IT/telephony solutions and ward level support. Initial findings and plan – May 2021.

**Behaviour/Attitude of Staff**
The Head of Patient Experience and Engagement is working with HR and the OD lead to review themes and contributory factors in order to focus awareness, customer care training and support constructive conversations. Initial scoping – May 2021.

**Clinical Care**
The Matrons are leading on improvements with regard to personal care. Volunteers are in place with a new process to gain real time feedback with questions based on the inpatient survey. Plans to develop this as part of the perfect ward audit tool. Personal care work stream will be coordinated through the Great Care Campaign due to launch 29th April 2021.

**Risks to delivery and mitigations**

The project board for Datix implementation process is in place. Go live for Datix is anticipated for autumn 21.

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

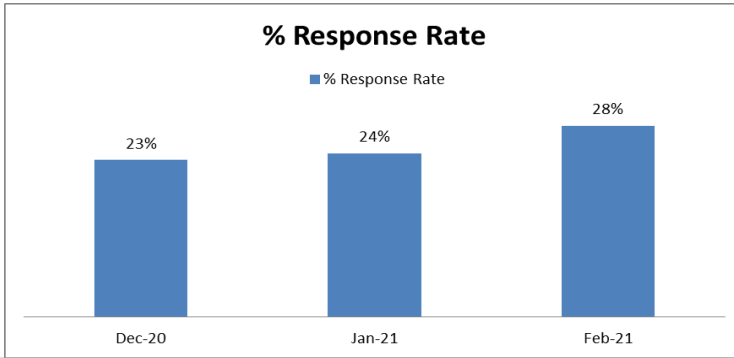
57

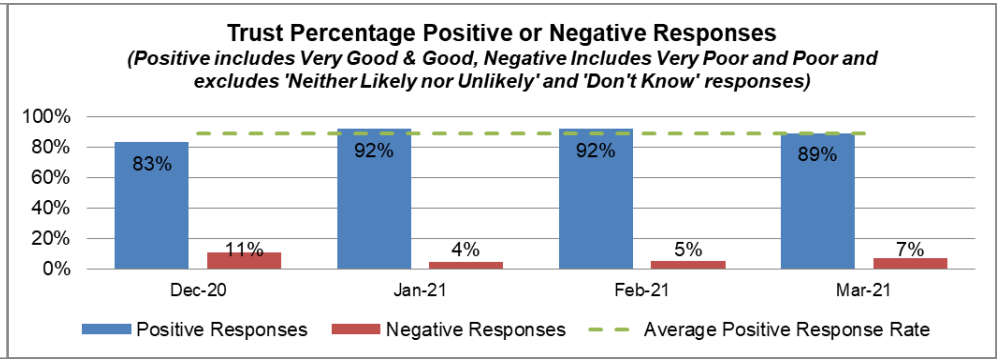
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

# 2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?




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

In March 89.2% of the of Friends and Family responses were positive. This is based on the % of responses rated as 'very good' or 'good'.

This was achieved by:

| | No. Text | No. Responses | Positive Responses |
|---|---|---|---|
| ED | 1,572 | 349 | 86.82% |
| Inpatients | 2,626 | 750 | 83.87% |
| Day Cases | 2,116 | 708 | 95.90% |

*(correct as of 7th April)*

Data is currently being collected via text messaging and online format.

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 why did you gave your answer and anything we could of done better.

*Response rate figures for March 2021 are not yet available.*

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

With the roll out of text messaging into Inpatient and Day Case areas this is now providing the trust with increased feedback which we are now able to identify themes both positive and negative in more detail to act upon.

Overall Positive themes for March free text responses:

- Staff Attitude (890 comments)
- Implementation of Care (589 comments)
- The Environment (443 comments)

Overall Negative themes for March free text responses:

- Staff attitude (93 comments)
- The Environment (90 comments)
- Implementation of Care (77 comments)

We are currently recruiting a FFT Patient Experience Coordinator who will review all data received and work with service areas/divisions to ensure that this feedback is shared, promoted and monitored in more detail. Detailed response rates are included within the divisional service reports and will now also be included in the overall divisional quality reports.

A meeting is planned to incorporate additional and specific questions that relate to concerns raised.

**Risks to delivery and mitigations**

Response rates remain low in all areas

Work ongoing to promote improved response rates and feedback with monthly improvement trajectory.

Need for thematic review of negative responses to be used as focus for improvement.

Thematic reviews to be shared at Senior Nurse meetings

# 2. Patient Safety - Perinatal Quality Surveillance Tool February 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 March for review (stillbirths or neonatal deaths).<br>• A multi-disciplinary team consisting of midwives, obstetricians and neonatologists, 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 March. Currently being triaged for eligibility for review by HSIB.<br>• 1 case currently with HSIB (October 2020). The final report is expected imminently. An Urgent Incident Review was completed by the Trust with immediate actions and any additional safety recommendations will be implemented following receipt of the final report. |
| Number of incidences graded moderate or above and actions taken | • Unexpected admission to GWH Neonatal Unit (LNU). No further action required.<br>• Unexpected admission to our LNU and transfer to regional NICU- Urgent Incident Review (UIR) identified need for local investigation<br>• Maternal Uterine rupture and unexpected admission of baby to LNU and transfer to regional NICU. Case meets the criteria for referral to HSIB<br>• Communication problem- this highlighted an additional step to be added to the bereavement checklist currently in use to avoid recurrence |
| Minimum safe staffing in maternity to include Obstetric cover on delivery suite | Safe midwifery staffing is monitored by the following actions : Birth rate plus acuity tool completed 4 hourly with relevant actions addressed. **March data** shows: Midwife to birth ratio 1:27 compliant with Birth-rate recommendations no change from previous month<br>1 to 1 care in labour 98.3% compliance, similar findings to the previous month. Team exploring ways of achieving 100% supernumerary Delivery Suite coordinator status, 4 occasions in March when not supernumerary. Definition of supernumerary status discussed with Team by Matron so consistency is maintained. Both at daily safety huddles and morning Matrons meetings staffing is reviewed and adjusted according to acuity. Consultant presence in Delivery suite continues at 60 hours which is complaint with national standards. |
| 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). Posters are displayed in the clinical areas to inform women of how they can be involved in generating feedback for maternity services. MVP use social media platforms to encourage women to provide feedback on the service. They are actively informing service users on updates during the COVID pandemic, working with the clinical team to ensure information is up to date. Feedback of key themes from the MVP is shared via the Maternity Services newsletter. Plans for FFT via text message to include maternity, final date to be confirmed. |
| Coroner's Regulation 28 | Nil |
| Concerns or requests for actions from national bodies | Ockendon 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. New CNST standards received at end of March, currently reviewing and gathering evidence to support where we benchmark against them. |
| Staff feedback from frontline | Open meeting to discuss the introduction of Continuity of Carer model. Concerns were raised here around introduction of Continuity Teams and the impact this will have on the staff wellbeing and work/life balance. 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 improvement s 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 |
|---|---|---|---|
| 155301 | Uterine rupture following induction of labour. The baby was born in poor condition and appropriately resuscitated, underwent therapeutic cooling and referral to the Regional Neonatal Intensive Care Unit.<br><br>Immediate learning identified:<br>• Implementation of SBAR stickers to facilitate effective handovers, highlighting the use of the labour risk assessment tool<br>• Inclusion of the effect of uterine activity on foetal hypoxia, via Cardiotocgraphy (CTG) teaching sessions that are run weekly<br>• Raise awareness of escalation to New-born Emergency Stabilisation and Transport Team (NEST) by neonatal nursing team, via simulation training . | 24/03/2021 | Mother and baby discharged home with no evidence of harm.<br><br>This case met criteria for referral to Health Safety Investigation Branch (HSIB), however the case has been declined following their triage process as no evidence of harm.<br><br>This case will now be investigated internally. |

## On-going Serious Incident investigation update

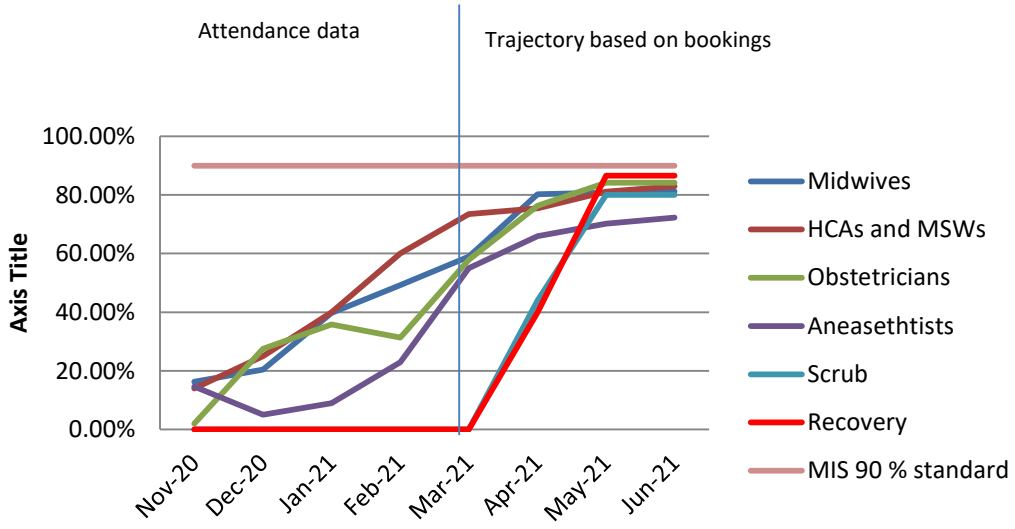
| Case ref | Overview | Date of case | Date due to CCG | Case update |
|---|---|---|---|---|
| 149966 | 28/40 neonatal death on SCBU | 03/11/2020 | 05-Feb-21 | Report complete and submitted for review at the Trust Serious Incident Review Learning Group (SIRLG). |
| 153099 | Birth injuries | 23/01/2021 | 28-April-21 | Report complete and submitted for review at SIRLG. |
| 153793 | Failure to perform hip screening | 06/12/2020 | 21-May-21 | Report complete and submitted for review at SIRLG. |
| 148774 | Neonatal cooling | 04/10/2020 | 08-Jan-21 | HSIB case. Final report received 18/04. |
| 149551 | Neonatal Death | 22/10/2020 | 09-Jun-21 | Report reviewed by SIRLG and submitted to CCG. |
| 146460 | Cluster investigation of postpartum haemorrhage cases | August 2020 | 04-Jun-21 | Report completed and submitted to the CCG. |

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

# 2. Patient Safety – Maternity Training Compliance

Data Quality Rating:

Are We Safe?




| Staff group | Total number | Trajectory number to complete training | Number of additional people required |
|---|---|---|---|
| Midwives | 213 | 173 | 18 |
| Obstetrician | 38 | 32 | 3 |
| Anaesthetist | 47 | 34 | 9 |
| Scrub staff | 25 | 20 | 3 |
| ODPs | 46 | 29 | 10 |
| Recovery | 15 | 13 | 1 |
| HCAs and MSWs | 53 | 44 | 4 |

**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 Practical Obstetric Multi Professional Training (PROMPT) day.
- Face to Face MDT training cancelled Feb 2020 onwards due to COVID restrictions . All training time revoked.
- From December 2020 weekly online PROMPT training offered to all staff groups with senior and IT support for staff to attend.

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

- Compliance in some groups will not meet deadline based on trajectory of bookings. Divisional Director Of Nursing and Midwifery has encouraged staff to attend and overtime offered. Training team have moved 2 dates to help theatre staff attendance. Awaiting bookings and predict that trajectory will greatly improve over next few weeks.
- Paediatric doctors and Neonatal unit nurses required to attend Neonatal Life Support session. Practice Development Midwife team are attending paediatric meetings to improve compliance.
- Maternity staff are required to complete additional maternity specific training which at present is monitored locally with plan to include on ESR. Plans to improve compliance for fetal surveillance training and suturing are in place, which both have been impacted by COVID restrictions on face to face training.

**Risks to delivery and mitigations**

- The graph currently shows the trajectory that we will not meet action 8 by the end of the extended period to end of June 2021 for 6 out of 7 staff groups. We are expecting to be able to meet trajectory with the improvements made.
- There are many HCAs shielding with no IT access at home therefore cannot train them until return from shielding.
- Midwives are given 12hours paid training time versus 80 hours required to complete all training requirements.
- All leads inform 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

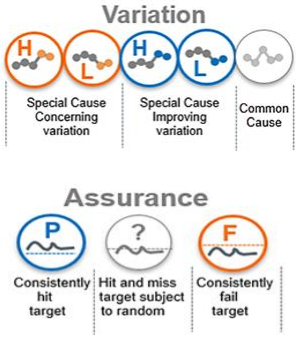
# Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

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

## 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 | H | ? | 6.63% | 6.00% | 3.96% | 7.33% | 5.65% |
| 2 | RN Bank Fill Rates | | F | 59.3% | 70.0% | 35.0% | 60.0% | 47.5% |
| 3 | Vacancy Rate | L | ? | 5.45% | 7.63% | 5.85% | 8.69% | 7.27% |
| 4 | Recruitment Time To Hire (Days) | | | 48.4 | 46.0 | 29.0 | 58.2 | 43.6 |
| 5 | All Turnover | H | ? | 13.51% | 13.00% | 12.18% | 13.55% | 12.86% |
| 6 | Voluntary Turnover | H | P | 8.40% | 11.00% | 9.10% | 10.07% | 9.59% |
| 7 | All Sickness Absence | H | ? | 3.78% | 3.50% | 3.26% | 4.61% | 3.94% |
| 8 | Statutory Mandatory Training Compliance | L | ? | 84.71% | 85.00% | 84.31% | 89.08% | 86.70% |
| 9 | Appraisal Compliance | | F | 81.07% | 85.00% | 71.30% | 82.00% | 76.65% |



# Trust Overview: Narrative

Great Western Hospitals NHS Foundation Trust

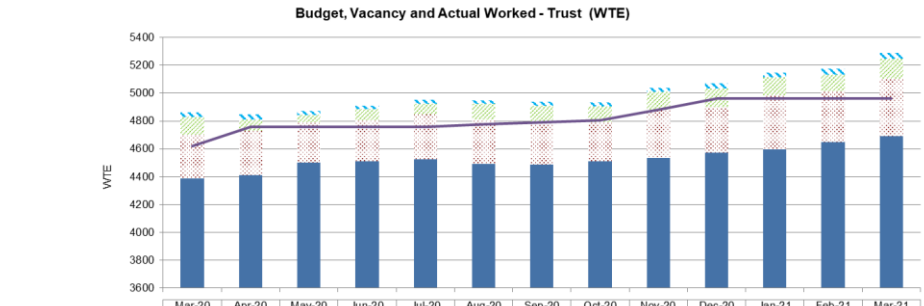
| "Great" Scoring | Indicator Score (1-4) | Self Assessment Score | Headline |
|---|---|---|---|
| **1 – Underperforming / Inadequate \| 2 – Requires Improvement \|3 – Good \| 4 – Outstanding** | | | |
| **Great Workforce Planning** | **2** | **3** | For the second successive month considerable improvement has been gained in respect of the Trust vacancy position (5.45% Mar vs 6.30% Feb), continuing to outperform the 7.63% KPI. Improvement was also delivered in the Registered Nurse bank fill rate, which increased to 59% in March (vs. 56% Feb). The Trust did, however, experience an increase in temporary workforce utilisation across both bank and agency in March. This resulted in an increase in workforce utilisation relative to budgeted WTE and an increase in the proportion of the Trust's total workforce spend attributed to agency (6.63% vs 6% KPI). From 1st April the Trust has successfully moved from a master vend nurse agency contract to a preferred suppliers list (PSL) removing all previous agreed rates to utilise NHSI Cap Rates. |
| **Great Opportunities** | **2** | **3** | The self assessment score remains at 3. The Trust vacancy position reduced in March to 5.45% from 6.30% (a decrease of 41.92 WTE vacancies Trustwide). Recruitment time to hire metric has improved to 48 days from advert live to start date confirmed. Following successful funding bids the Trust continues to commence 16 overseas nurses per month. Voluntary turnover has remained stable and continues to be consistently below the 11% target. |
| **Great Experience** | **2** | **2** | Sickness absence has improved to 3.78.% remaining above the 3.5% target with staff seeking support for work and personal related matters driving a KPI score of 2. The self assessment score is also reported again as 2 this month as the department returns focus to improve staff recognition through increasing numbers of retirement and long service awards and Hidden Heroes peer and STAR awards. Health and Wellbeing leads have prepared the Trust Health and Wellbeing plan to share with the HWB oversight committee in April 2021, proposing priorities for the year ahead. |
| **Great Employee Development** | **3** | **3** | The Academy continues to focus on maximizing the use of both the Trust and HEE CPD funds, with the Trust CPD funding being underspent by only £3,802 by year end. The HEE CPD continues to be allocated with a final report due to HEE by end of April 2021. The mandatory Training project is progressing well with additional support from the Programme management office which will move training from Training Tracker into ESR and is on target to complete of 31st May 2021 |
| **Great Leadership** | **2** | **2** | There has been a further improvement in appraisal rates in March rising to 81%, which whilst lower than the KPI target of 85% is encouraging. The Leadership Development programme (cohort 1)continues to receive positive evaluations. The second session of the AMD development programme was well received. The Trust is applying to host a further GMTS trainee. |

# Workforce

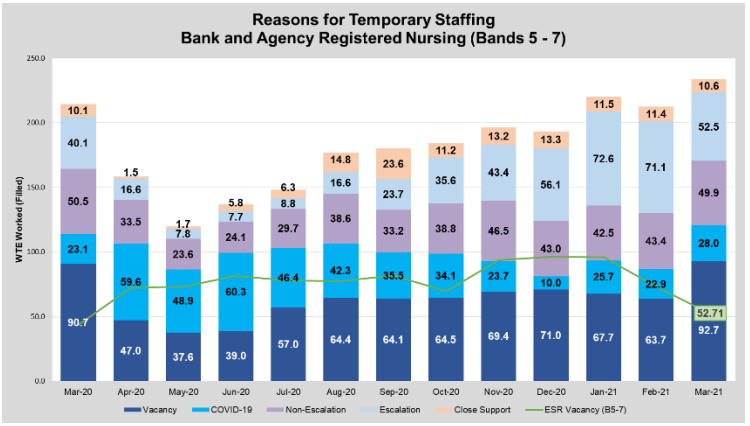
Use of Resources

## Great Workforce Planning

| Indicator Score | Self Assessment Score |
|---|---|
| 2 | 3 |




| | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overtime WTE - Trust | 35.60 | 38.66 | 29.83 | 24.57 | 24.83 | 24.23 | 25.95 | 28.71 | 31.11 | 37.78 | 31.46 | 40.12 | 45.04 |
| Agency WTE - Trust | 124.96 | 80.71 | 49.89 | 81.95 | 79.55 | 113.18 | 124.78 | 116.15 | 128.13 | 134.66 | 127.90 | 121.50 | 140.44 |
| Bank WTE - Trust | 313.52 | 315.77 | 288.87 | 293.17 | 321.94 | 318.66 | 299.75 | 278.58 | 345.51 | 326.34 | 391.31 | 362.41 | 413.49 |
| Staff in Post WTE - Trust | 4389.03 | 4412.23 | 4502.55 | 4509.84 | 4523.92 | 4493.39 | 4485.93 | 4511.75 | 4534.92 | 4572.71 | 4596.13 | 4650.22 | 4692.14 |
| Budget WTE - Trust | 4622.56 | 4757.91 | 4756.17 | 4759.73 | 4759.74 | 4775.33 | 4790.26 | 4806.92 | 4882.90 | 4960.19 | 4962.71 | 4962.76 | 4962.76 |
| Vacancy WTE | 233.53 | 345.68 | 253.62 | 249.89 | 235.82 | 281.94 | 304.33 | 295.17 | 347.98 | 387.48 | 366.58 | 312.54 | 270.62 |




### Background

The Trust utilised 5291WTE staff to deliver its services in March '21, an increase of 117WTE on the previous month and 329WTE in excess of budget.

Despite a noticeable improvement in the vacancy position for the second successive month, the Trust experienced increased usage of bank and agency resource in March. The primary reason remain vacancy cover and escalation, alongside the on-going need to supply registered nursing staff to deliver the COVID vaccination programme

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 requirement to cover Doctors either shielding or on restricted duties, alongside vacancy cover in General Medicine, ED, and Primary Care, continue to drive medical agency spend.

### Improvement actions

1. The new Consultant job description has been approved by the Medical Staffing Group.
2. In March a Medical Recruitment Working Group was formed to address the longstanding Consultant recruitment vacancies across the Trust and create a recruitment and retention plan to support the delivery of filling these vacancies
3. An agile working project group is underway and tasked with identifying staff across Commonhead and the Orbital where the opportunity to work flexibly exists.
4. Strong pipeline of HCA and Registered nurses and there has been approval to over recruit to turnover to support the Trust achieve 0 vacancies in nursing roles.

### Risk to performance and mitigations

The majority of Consultant vacancies are recognised nationally as difficult to recruit, with locum/agency used as an interim measure.

There is a risk that we continue to improve the Trust vacancy position however fail to reduce the reliance of temporary staff (bank and agency).



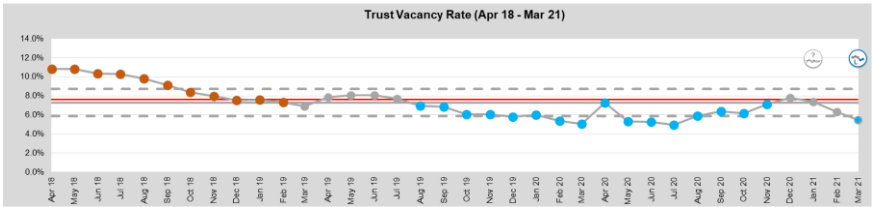
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

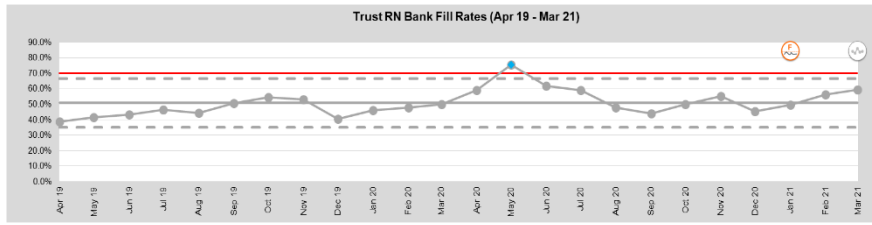
# Workforce

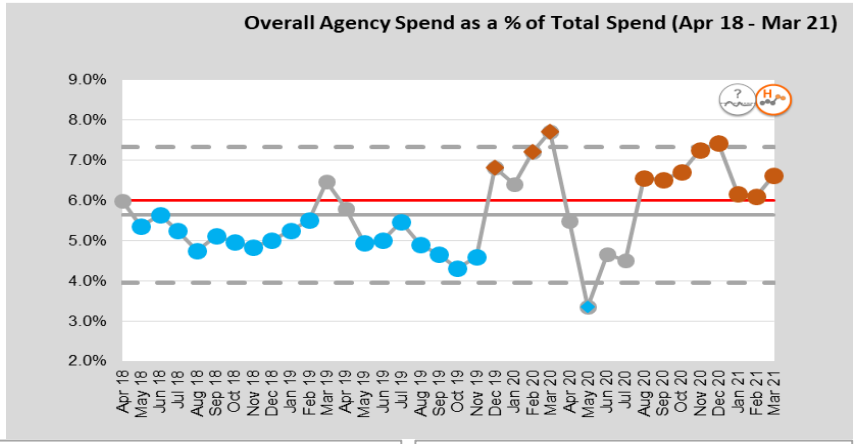
Use of Resources

## Great Workforce Planning

| Indicator Score | Self Assessment Score |
|---|---|
| 2 | 3 |




### Background

The Trust vacancy position improved noticeably to 5.45% in March, compared to 6.30% in February and equates to 270WTE vacant posts.

The Medical and Nursing vacancy rates are low at 3.74% and 3.46% respectively. The AHP staff group continues to represent the greatest vacancy challenge to the Trust, with March's vacancy figure of 8.82% equating to 71WTE vacancies, although this was an improvement on February's 9.87%//80WTE vacancy gap.

Registered Nursing bank fill rates achieved improvement for the fourth successive month, without the need for incentives (ended on 28th February 2021).

Agency spend was driven mainly by Medical Workforce at £728k (vs. £658k Feb), followed by Nursing spend of £578k (vs £554k Feb).

### Improvement actions

1. Safe-care has now also been extended to the Children's Unit
2. A monthly roster review process has been established in all areas, being led by the Transformation Lead and supported by HR and Finance. These reviews ensure rosters are built in accordance with budget and KPI's are being met (A/L planning, study leave etc.).
3. On 1st April the Trust moved to a Preferred Supplier List (PSL) agency framework, enabling access to ten agencies (including ID Medical) and thus enhancing the prospects of shifts being filled
4. An initial medical staffing E-roster build for early adopters Obs / Gynae departments is underway in conjunction with Allocate organisation. The anticipated build completion date is 7th May, with planned go-live on 10th May. The subsequent go-live date for the next phase of roster build is planned for July and the departments expressing interest are ED, General Surgery and Paeds. Roll plan to be aligned to Job Planning process.

### Risk to performance and mitigations

The availability of temporary staffing resource across both bank and agency is limited and on occasion may lead to an inability to supply, mitigated by on-going bank recruitment.

The adoption of Preferred Supplier List (PSL) has the potential to result in reduced agency cover in the short term, with transition and familiarity likely factors.

Continued Covid-19 related absence, whether through sickness, lateral flow tests and track & trace that return a positive result or self isolation, inevitably creates a need for backfill and thus a reliance on temporary staffing.

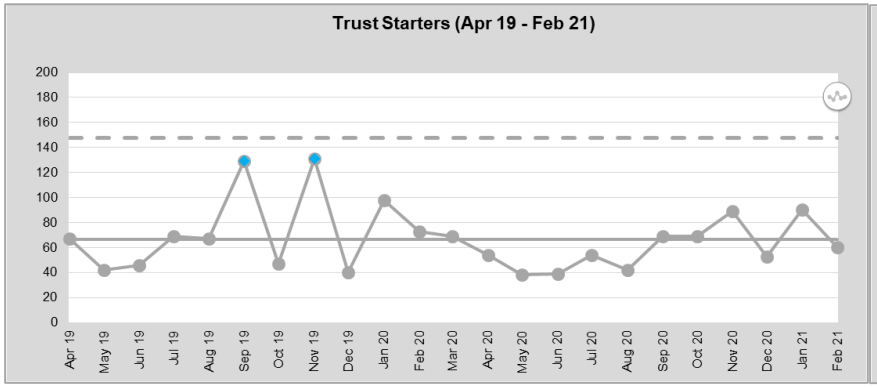


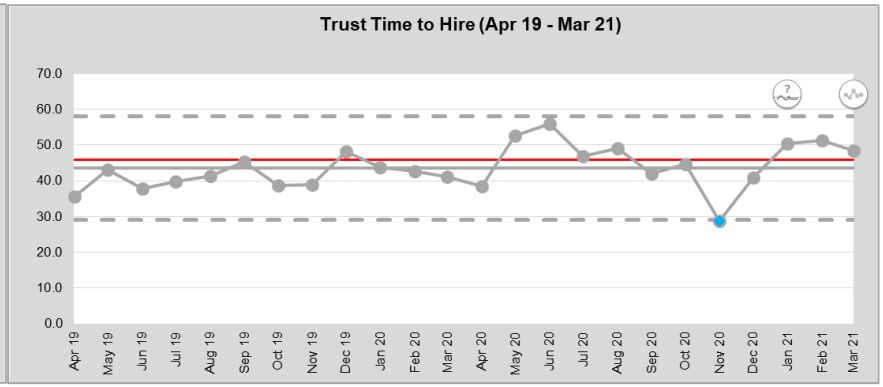
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

# Workforce

Use of Resources

| Great Opportunities | Indicator Score | Self Assessment Score |
|---|---|---|
| | 2 | 3 |




## Background

During February 2021, 85 new starters (77.47 WTE) commenced employment at the Trust. In addition to this 42 student nurses (33.41WTE) commenced as Aspirant Nurses.

The Trust has 96 candidates to date due to commence employment in April with additional inductions planned to support the increased HCSW pipeline.

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

## Improvement actions

1. On 15th March the Trust supported virtual AHP workplace experience placements. This event enabled the Trust to highlight to early years teams the different types of AHP professions and encourage local students to look towards AHP as a career. There is a further event scheduled for June 2021.

2. To support the vacancy position and reduction of agency spend Unscheduled Care Division has utilised international recruitment for radiographers. The first international radiographer commenced in April, with a further 2 due to arrive in May.

3. In April Maternity Services will be launching of a recruitment campaign for midwifery posts which focuses on the continuity of care model.

4. Theatre recruitment activity continues to be closely monitored by the Divisional Leadership Team and the HR Business Partner following concerns about the quality of the process within this department; including rationale for recruitment, review of adverts and job descriptions to ensure full compliance within the Trust's recruitment process. A 3 month review of process to be conducted by Divisional Leadership Team in May with any further recommendations and support to be communicated to ensure on-going improvements

## Risk to performance and mitigations

Launch of the recruitment microsite continues to be postponed, the Trust currently continues to utilise social media platform to support advertising vacancies. The Communications Team are finalising the microsite to launch in Q1.

Increase in recruitment activity the KPI metrics have remained slightly above the Trust KPI, monthly monitoring with HRBP's continues to identify hotspot areas and support reducing the overall KPI.



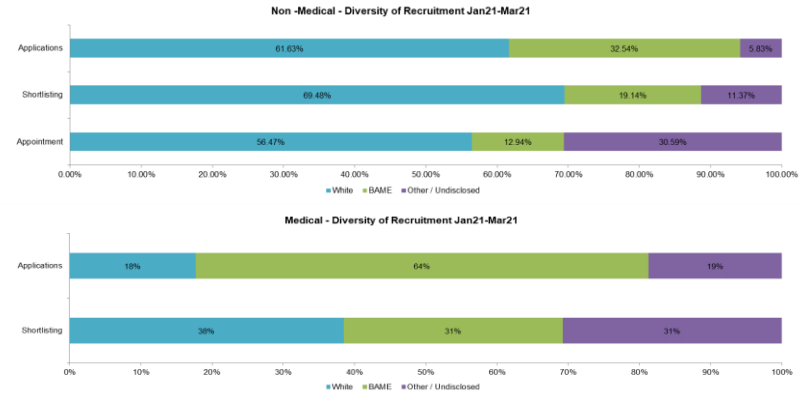
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

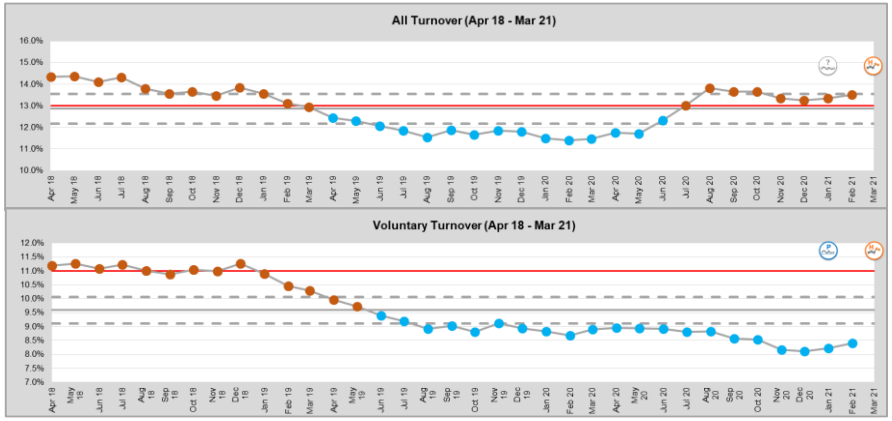
# Workforce

Use of Resources

## Great Opportunities

| Indicator Score | Self Assessment Score |
|---|---|
| 2 | 3 |




### Background

Within the period January – March 21, in medical recruitment of a possible 64% BAME applicants, 31% were taken forward at the shortlisting stage. A review is being conducted for Medical Staffing in the use of TRAC inputting/reporting.

Each stage of the non-medical recruitment there is a reduction in candidates who go through to the next stage.

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

Voluntary turnover has remained stable and continues to be consistently below the 11% target.

### Improvement actions

1. Licence to recruit is now available on training tracker, roll out plan underway, so that by, 1st April 22 all recruitment panel will have 1 person who has received the training. This will be managed and monitored via TRAC
2. International recruitment continues with 16 overseas nurses per month commencing with the Trust. The team continue to monitor and adapt cohorts due to international travel restrictions and are working with the Academy to support revised start dates ensuring the nurses date to take their OSCE exam is not impacted.
3. The Trust will be attending the Honda Virtual Career Event in April to support recruitment within the local community and attract candidates with a range of transferable skills.

### Risk to performance and mitigations

An identified risk to retention is staff choosing to leave the organisation due to exhaustion and loss of morale post the pandemic.

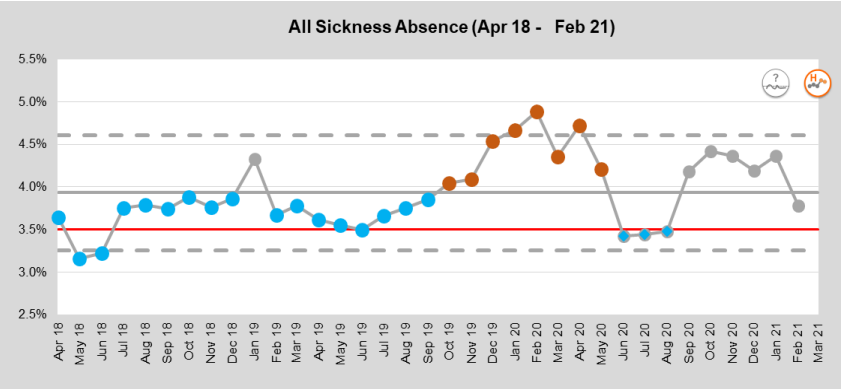


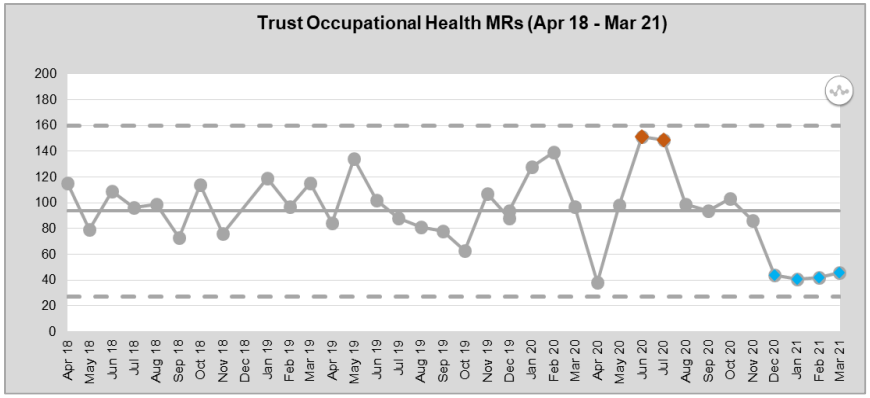
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

# Workforce

Use of Resources

| Great Employee Experience | Indicator Score | Self Assessment Score |
|---|---|---|
| | 2 | 2 |




## Background

Sickness absence continues to report above the 3.5% increasing in February 2021 at 3.78%.

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. The outsourcing of the pre-employment questionnaire activity was successfully introduced in March to positive feedback about service delivery and turnaround improving to within 2 days. This has increased capacity of the OH nurses to focus on management referral triage, clinics and other essential OH services.
2. OH resource plan has improved with the recruitment of a Band 6 senior occupational health nurse and a Band 5 nurse, both due to commence in May.
3. Planning will commence on the annual flu campaign 2021/22.
4. Draft Circle of Support and Plan is being reviewed by the Wellbeing Oversight committee
5. Wellbeing Champaign's have shared a number of ideas for Wellbeing – plan to implement underway

## Risk to performance and mitigations

Majority of clinic's remain virtual (no dedicated clinic space) – this is a challenge for Physiotherapy and other clinic where face to face would be a preference.



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

# Workforce

Use of Resources

| Great Employee Experience | Indicator Score | Self Assessment Score |
|---|---|---|
| | 2 | 2 |

**Employee Recognition**

| | | | |
|---|---|---|---|
| Long Service Awards | 2 | Hidden Heroes | 0 |
| Retirement Awards | 4 | STAR awards | 1 |

**Diversity/Inclusivity**

The EDI lead continues to successfully embed the role with following achievements in March:

- Appointed vice-chair of the SW EDI Network
- Evaluating a proposal for the community nursing teams to attract and retain international nurses.
- Trust's first Transgender policy developed, and will be sent to Stonewall (organisation concerned with promoting rights for LGBTQ+ staff) for analysis and review;
- Working with Stonewall to understand criteria for the Trust to become a 'Top 100' Stonewall employer
- Chaired the Trust's first Disability Equality Network meeting
- Set up a reverse mentoring scheme for staff and Board level senior executives (14 NED/Exec have signed up)
- Attended an EDI benchmarking meeting with Nationwide Building Society and other local partners

**Wellbeing Initiatives**

**The Trust Tea Trolley**: resumed 03/03/21 resourced by 35 "Project Wingman" airline volunteers. 3100 snacks and drinks distributed in March along with EAP and HWB information leaflets. The trolley aim is to offer staff the chance to take time to re-hydrate and refuel with colleagues.
**Massage Chairs:** April Rotation includes Mortuary, Mercury, Woodpecker, Physiotherapy services.
**Staff Step Challenge Reward**: Gift bags containing chocolates and toiletry items were given as prizes for the staff step challenge in February/ March as part of Surgery, Women and Children focus on health and wellbeing
**Yoga Class Referral Sessions**: This pilot scheme launched by Occupational Health on 15th March for staff referred for physiotherapy and mental health support. Evaluation to be completed in April

**Background**

In-month staff support uptake was offered to 33 staff with 100% attendance. Significant progress with improving waiting list with staff being referred for treatment within 2 days. Emergence support remains available.

In-reach activity for the month:

- Care for Self and Others – ED
- Self Care skills for Managers – Radiology / Breast Centre / SW&C
- Mindfulness & Relaxation – SW&C
- Wellbeing Self Care – Occupational Therapists
- Reflective Practice – Community nurses
- Sleep and Managing Pressure – SW&C
- Mindfulness – Trust HQ

**Improvement actions**

1. 12 Mental Health First Aid (MHFA) trainers trained in month bringing total to 140 trained within the organisation.
2. Trauma Incident management (Trim) training is on track and the next cohort of training planned for April and May. Plan for approx. 40 TRIM practitioner within the Trust and 8 TRIM Managers during 2021.
3. Health and Wellbeing Champions met in-month for a session on mindfulness and agreed their role is to support staff with health and wellbeing communication, events, education and identification of the champion role.
4. Wobble Rooms – Due to increase in business as usual clinical activity in Physiotherapy the Betjeman centre wobble room has had to close. Despite investigation no alternative is available at present.
5. Encouraging breaks - As a support intervention with rising sickness absence rates and to encourage staff to take breaks, a tea and coffee drinks delivery will be made mid April across 50 GWH areas and community locations In addition, twice weekly soft drink deliveries to 3 Blue Covid areas – ICU/Woodpecker/Neptune continued until the end of March.
6. The Health and wellbeing team continue to evaluate staff feedback about the service to capture best practice and learn from experience. Feedback in month about the service has been positive - 'Talking things through has helped me reframe how I was feeling and has made me feel more stable"
7. The Health and Wellbeing plan has been developed with annual objectives and will be shared with the HWB oversight committee in April 2021.

## Risk to performance and mitigations

Sickness absence rates are a measure of the health, wellbeing and morale of the workforce. As lockdown restriction are eased and we return to normal, we need to monitor the wellbeing of staff closely and ensure the right support is in place.

70

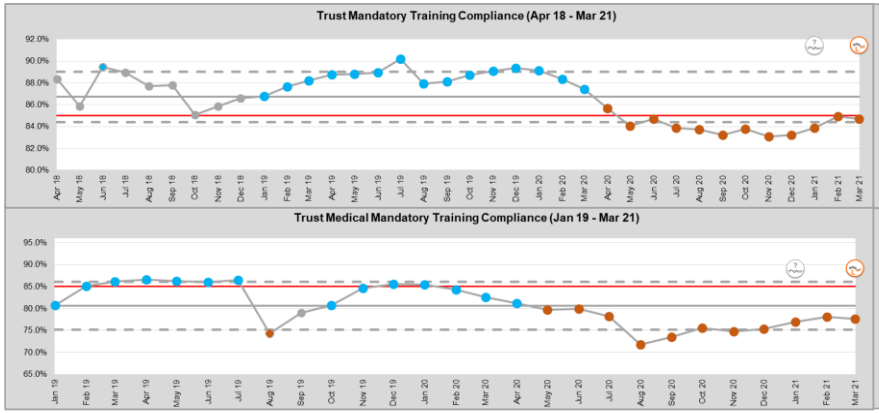
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

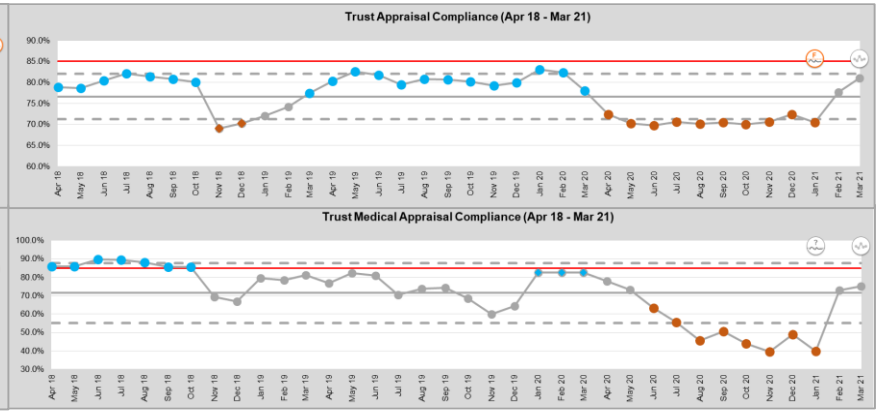
# Workforce

Use of Resources

## Great Employee Development

| Indicator Score | Self Assessment Score |
|---|---|
| 2 | 3 |










### Background

Mandatory Training compliance remains under target overall. However the % remains stable in March at 83.69% (83.73 % in February).

Role essential training in month also remains stable at 85.78% (86.2% In February).

Appraisal compliance has improved for the second month from 77.72% to 81.07% in March and has continued to improve since January, following close management by the Divisional Tri and HR BP and trajectories reviewed at Monthly Divisional IPR.

### Improvement actions

1. The risk register is reviewed on a monthly basis.
2. The mandatory training project continues to progress well. A full project plan and support from the programme management office is in place to assist with the project. All MT modules have been reviewed and are now ready to be transferred into ESR. Project to be completed by the end of May 2021.
1. A communications plan for staff is being prepared to ensure a smooth transfer to the system.

### Risk to performance and mitigations

The continued reduction of capacity at courses due to social distancing.

Additional courses for Mandatory Training are being made available to help drive up compliance



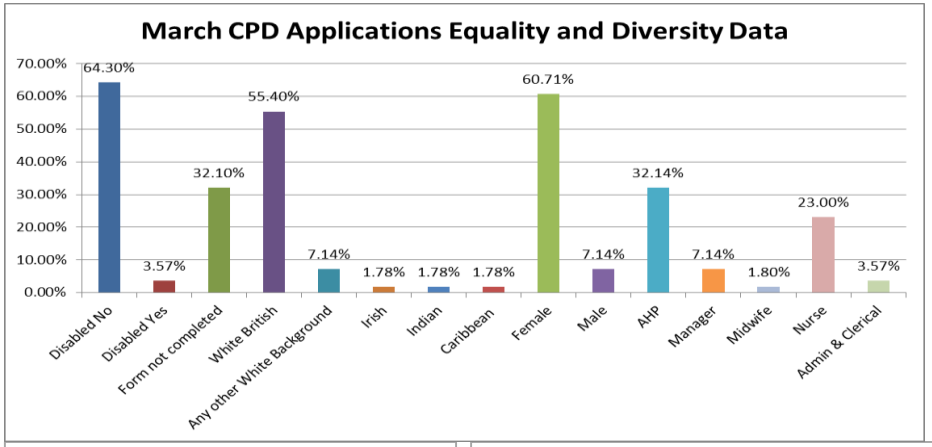
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

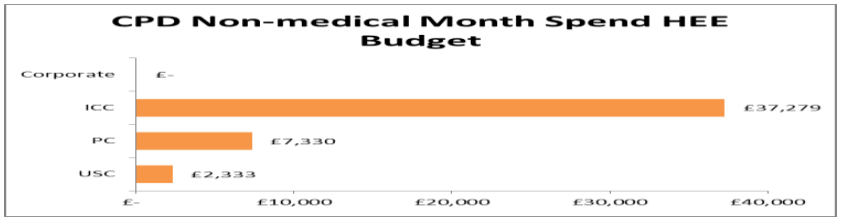
# Workforce

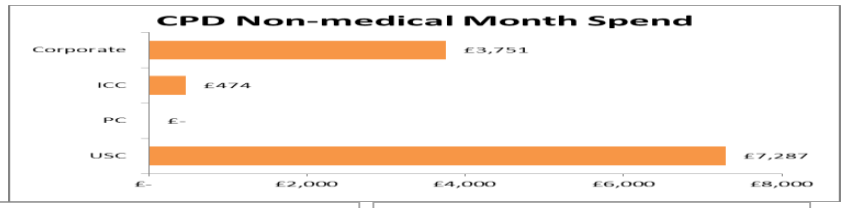
Use of Resources

## Great Employee Development

| Indicator Score | Self Assessment Score |
|---|---|
| 2 | 3 |




### Background

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

HEE budget spend to date is £340,151. of £516,000 In addition to the monthly course applications we have also purchased frequently applied for modules from University West England for the current financial year totaling £112,754.

We are continuing to block purchase and pre pay for courses to ensure the total budget allocated is utilised. HEE will require the final account by 30th April 2021.(There is provision for accrual for unspent monies) The graph on the top right highlights spends /committed for courses within March.

The Trust CPD allocation is underspent year to date by £3,802 against allocated budget of £240,000. There were a total of 56 non medical CPD Applications in March for up-skilling and leadership courses.

### Improvement actions

1. The Academy continues to work with the divisions and training providers to maximise the use of the Trust Non–medical CPD fund and HEE CPD funds.
2. Work will shortly begin on a systematic training needs analysis process to ensure that there are detailed plans in place for CPD spending. HEE have confirmed that further HEE Non medical, Nursing, Midwifery and AHP funding will again be allocated this financial year, date and amount yet to be confirmed.
3. Recruitment to Head of Learning and Development underway.

### Risk to performance and mitigations

Further funding allocations will require the divisions to have robust plans to ensure both the Trust CPD and HEE allocated CPD funds will be utilised within 21/22.



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

# Workforce

Use of Resources

| Great Leadership | | Indicator Score | Self Assessment Score |
|---|---|---|---|
| | | 2 | 2 |
| Leadership Roles at the Trust | 4.29% of staff | Equating to 172.19 WTE | |
| Leadership Development Programme *(cohort 1)* | 22 leaders | Undergoing Training | |
| Leadership Development Programme *(cohort 2)* | 19 leaders | Identified for next Iteration | |
| 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 Leadership Forum took place on the 24 March and focused on Equality, Diversity and Inclusion.

Work is continuing on the development of an EDI training module for inclusion in the Leadership Development Programme.

Cohort 2 of the Leadership Development programme will begin in April.

The BSW Acute Alliance AMD Development programme, initiated and run by GWH, is continuing to receive positive feedback. The second session on managing difficult conversations took place on the 26 March, led by Claire Radley, Director for People, RUH.

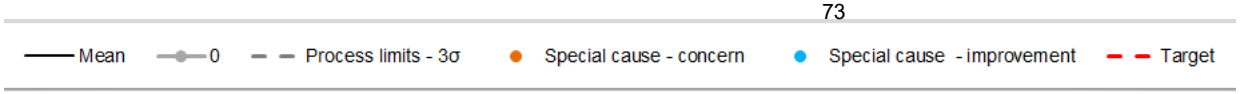
## Improvement actions

1. The Trust continues to work across the system with the BSW Acute Alliance AMD Development programme. Work is now underway to explore a similar approach to provide development opportunities for Clinical Leads across the patch.
2. The timetable for Phase 2A of the talent management programme was extended to allow sufficient time for all the talent management conversations to take place. The Talent Review Board for this group will now take place on the 19 April.
3. Phase 2B of the talent management programme will be concluded in May 2021.
4. The Head of Leadership, Talent Management and Succession Planning will continue to develop the leadership offer for Aspiring Leaders.

## Risk to performance and mitigations

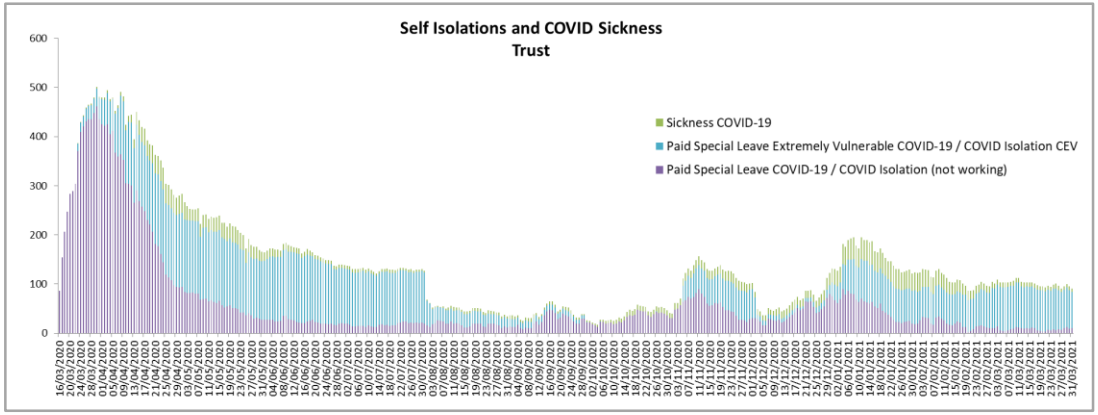
The capacity of staff to undertake the talent management conversations with direct reports. (Frequent reminders and support in the form of training and one to one sessions has taken place to mitigate this risk) Risks to the timetable have been escalated appropriately to the Director of HR.





# Exception 1 of 2: Covid-19 and Risk Assessments

Exception Report




| Risk Assessment Compliance | 97.23% | | |
|---|---|---|---|
| % done Mgmt Discussion | Category B | Category C | Category D |
| | 91.58% | 82.91% | 70.80% |
| Mgmt Discussion Compliance | 82.88% | | |

## Background

Updated Government guidance ended shielding from the 31st March allowing staff to return to work and ending the status of Clinically Extremely Vulnerable. Staff who are unable to return to work due to health consideration and risk continue to be offered working from home/redeployment options where possible. The remainder unable to return to work are recorded as sick or commenced maternity leave early where this is appropriate.

Numbers of COVID isolation episodes and sickness have decreased with early April reports as low as 6 staff members. Positive LFT or confirmed positive contact continue to be backfilled across departments where necessary.

Asymptomatic Testing continues to help mitigate spread between staff and to patients with sharp decrease in positive results (0 reported in March, 1 in April so far).

## Improvement actions

1. The roster system has been updated to remove use of CEV and encourage engagement from mangers with HR to ensure that staff are correctly managed in light of risk and health considerations.

2. The Wellbeing team are supporting staff to return to work with regular clinics and risk assessment advice and guidance.

## Risk to performance and mitigations

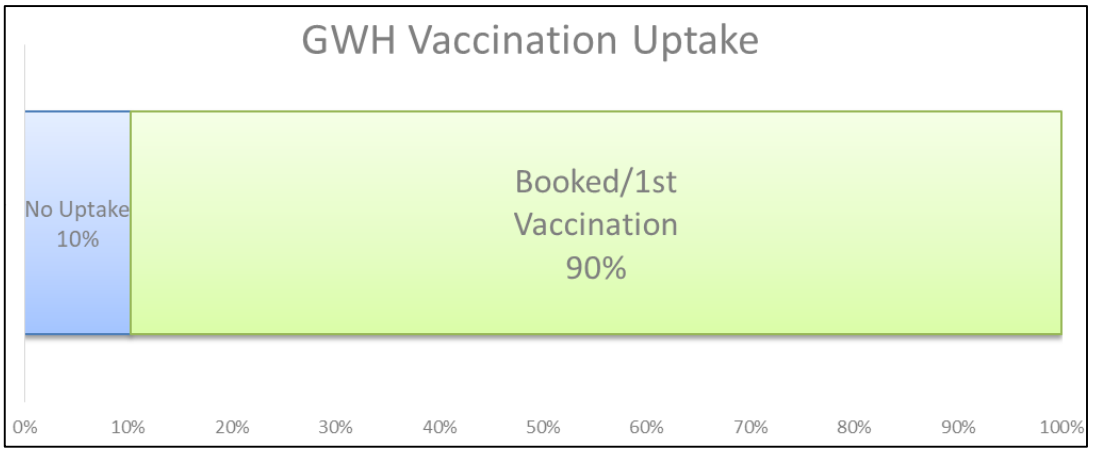
Lateral flow (asymptomatic) testing remains a small risk to increasing the number of staff who need to self isolate though as reported within March the numbers have significantly decreased from December 2020. Lateral Flow testing of patients within services continues to allow services to remain safe and Covid-19 free whilst maintaining Business As Usual.



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

# Exception 2 of 2: Vaccination Programme

Exception Report




| BME (including bank staff) | Total Staff | Vaccinated Dose 1 | % Vaccinated |
|---|---|---|---|
| BME | 1002 | 793 | 79% |
| Not Stated | 762 | 590 | 77% |
| White | 4349 | 3881 | 89% |
| **TOTAL** | **6113** | **5264** | **86%** |

## Background

To date 90% of the current substantive staff have engaged with the Vaccination Programme launched late 2020. 86% have all staff (including bank workers have received the vaccine).

Since 1-2-1 have been launched there have been an encouraging increase in all staff group uptake.

A dedicated clinical and operational team, Workforce Intelligence , volunteers and OH continue to supporting the implementation.

## Improvement actions

1. The vaccination programme is being coordinated by a dedicated clinical lead, and operational and booking managers.
2. The Astra Zenica vaccine was introduced in March and the arrangements for clear dilineation between AZ and Pfizer vaccine (signage and a colour coded system) implemented and working. Options appraisal completed for the introduction of a mixed vaccine clinic with several safety measures put in place to reduce risk
3. Further to update from MHRA regarding risk associated with AZ & blood clots, all recipients <30 can choose not to have AZ vaccine.
4. Volunteers are provided with support training and continue to support the coordination of the campaign. New booklet produced by a volunteer to support new-comer volunteers to the vaccination clinic

## Risk to performance and mitigations

The vaccine programme is being conducted from the Occupational Health department and deployment of some OH staff to support.



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

# Board Committee Assurance Report

| Finance & Investment Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Andy Copestake** | Andy Copestake | | 26 April 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 12 Income and Expenditure position | G | G | Excluding technical year-end adjustments, the position is in line with the forecast. The year ended with a £28k surplus (subject to audit). | Continue to monitor monthly I & E position through FIC | FIC meetings 2021/22 |
| Month 12 cash position | G | G | The year ended with a cash balance of £21.6m following the unwinding of front-loaded block contract payments. | Continue to monitor cash position through FIC | FIC meetings 2021/22 |
| Month 12 Capital Expenditure position | G | G | The final spend was £32.3m against a plan of £34.7m, following a concerted effort in the last quarter. | Continue to monitor capex through FIC | FIC meetings 2021/22 |
| BAF strategic risks | R | A | A good discussion took place on the new format of the BAF for Strategic Pillar 4 – Using our Funding Wisely. The Committee liked the new format and suggested a number of additions to the content, including an Executive Summary of the reasons for the Impact and Likelihood scores and evidence of independent oversight of actions being taken to mitigate the risks. | Quarterly review of BAF | July FIC meeting |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Financial Planning 2021/22 1st half year | G | A | The financial regime for the first 6 months of 2021/22 will broadly follow the pattern from 2020/21 with enhanced monthly block payments. There is an efficiency target and the Committee discussed the achievability of this, together with closing a £4m funding gap. After discussion, the Committee was happy to recommend approval of the H1 revenue budget to the Board. The amber rating on actions reflects the challenge re: delivering CIPs in the first half of the year, given the difficulty in doing this throughout 2020/21. | May FIC final approval on behalf of the Board | 24 May 21 |
| Financial Planning 2021/22 2nd half year | R | R | The second half of the year will 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 and Efficiency Plan. | Probably a discussion with a wider group of Directors at a future FIC | June or July FIC |
| Capital Plan for 2021/22 | A | G | A good paper from the Director of Finance on the Capital Plan for 2021/22 setting out the funding envelope at System and GWH level, the major projects that can be funded and those projects that, at this stage, cannot be funded. After discussion, the Committee was happy to recommend approval to the Board. The amber risk rating reflects the fact that there are still key areas which cannot be funded. The green rating on management actions reflects the Trust's track record from 2020/21 in this area. | Board | 6 May 21 |
| Sterile Services Business Case | R | A | The Committee discussed the revised OBC paper. The case for investment has been supported previously given the significant risk associated with this area and, after discussion, the Committee was happy to confirm its support for the revised OBC. The amber rating on actions reflects the challenge associated with funding and delivering this key project. | Board | 6 May 21 |
| Commercial Off the Shelf Software Partner Agreement | G | G | A good paper from the Procurement team on a System-wide proposal for software licence arrangements. The Committee agreed to recommend approval to the full Board. | Board | 6 May 21 |

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

Great Western Hospitals NHS Foundation Trust

# Part 4: Use of Resources

## Income and Expenditure

Use of Resources

| Income & Expenditure | | IN MONTH (March) | | | YTD (March) | | |
|---|---|---|---|---|---|---|---|
| | | Budget | Actual | Variance | Budget | Actual | Variance |
| | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Income | NHS Clinical Income | 30,725 | 41,904 | 11,180 | 361,119 | 379,247 | 18,128 |
| | Private Patients | 40 | 61 | 21 | 742 | 937 | 196 |
| | Other Non Mandatory/Non Protected Revenue | 64 | 9,772 | 9,708 | 715 | 10,472 | 9,758 |
| | Research & Development Income | 77 | 131 | 54 | 684 | 791 | 107 |
| | Education and Training Income | 964 | 2,140 | 1,177 | 11,644 | 12,986 | 1,342 |
| | Misc Other Operating Income | 689 | 7,524 | 6,836 | 8,438 | 15,352 | 6,914 |
| | | **32,558** | **61,533** | **28,975** | **383,341** | **419,786** | **36,444** |
| Expenditure | Pay Costs | (20,165) | (34,531) | (14,366) | (238,039) | (254,181) | (16,143) |
| | Non Pay | (7,844) | (21,430) | (13,586) | (88,534) | (104,324) | (15,790) |
| | Drugs Costs | (3,030) | (3,077) | (47) | (33,606) | (33,153) | 453 |
| | | **(31,039)** | **(59,038)** | **(27,999)** | **(360,179)** | **(391,659)** | **(31,479)** |
| **EBITDA** | | **1,518** | **2,495** | **976** | **23,162** | **28,127** | **4,965** |
| **EBITDA as % of Total Income** | | **4.7%** | **4.1%** | **-0.6%** | **6.0%** | **6.7%** | **0.7%** |
| | Depreciation | (821) | (66) | 756 | (8,899) | (8,143) | 756 |
| | Net Interest | (1,248) | (1,216) | 32 | (14,827) | (14,623) | 203 |
| | PDC Dividend | (268) | (87) | 182 | (3,221) | (3,039) | 182 |
| | Pension Unwinding | (45) | 4 | 49 | (45) | 4 | 49 |
| **Total Surplus/(Deficit)** | | **(865)** | **1,130** | **1,995** | **(3,829)** | **2,325** | **6,154** |
| **Total Surplus/(Deficit) Excluding Donated Assets Technical Adjustment** | | **(865)** | **(1,167)** | **(302)** | **(3,829)** | **28** | **3,857** |
| **Total Surplus/(Deficit) Excluding Lost Income Funding & Donated Assets Adj.** | | **(865)** | **(1,871)** | **(1,006)** | **(3,829)** | **(4,196)** | **(367)** |

A revised Financial Regime was in place in for 20/21 for the first 6 months of the year enabling the Trust to balance to a break even position by retrospective top up from NHSE following the agreement of costs and lost income. For the second 6 months of the year the Trust plan was £3,829k deficit.
The draft 20/21 Financial Position excluding technical adjustments for donated assets is £28k surplus and is subject to finalisation and audit.

# Income and Expenditure – Headline Variances from Plan

Use of Resources

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

The draft 20/21 Financial Position excluding technical adjustment for donated assets is £28k surplus and is subject to finalisation and audit.

The in month position is a deficit of £1,167k against a plan of £865k deficit, an adverse variance of £302k. The draft full year position is £28k surplus against a plan of £3,829k deficit which is £3,857k favourable variance. The position includes funding for Lost Operating Income and additional income from BSW CCG to cover in-year cost pressures which was not included in the original planned position.

The variances excluding the technical adjustments for donated assets are detailed below.

**Income variance** is £22,132k above plan in month and £29,600k above full year plan. This includes:

- Income of £630k to cover the costs of the Flowers Holiday Pay provision (matched by cost).
- Misc Other Operating Income of £160k below plan in month (£82k below plan full year)
- A credit note of £170k to NHSPS following agreement of final 19/20 charges
- Private Patient income £21k higher than plan in month (£196k above plan full year)
- Income of £9,572k to cover technical adjustment of notional pension adjustment (matched by cost).

**Pay variance** is £14,366k overspend in month and £16,143k overspend for the full year. The in month position includes:

- An increase in Annual Leave Accrual from prior year of £1,039k. This is an increase of £287k from forecast.
- Provision for Birthday/Anniversary leave of £1,023k in lieu of time and effort during the pandemic
- Covid-19 Vaccination Programme staffing costs £151k (£510k full year), matched by income
- HDP overspend £325k (£733k full year), also matched by income
- The underlying nursing overspend excluding central accruals and provisions is £801k in month (£2,110k full year)
- The underlying medical staffing overspend is £543k in month (£1,387k YTD).
- Technical adjustment for notional pension of £9,572k matched by income

Further analysis of the pay position is detailed on the following slides.

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

The 2020/21 financial position has benefited from non recurrent block funding. The underlying cost base has increased and it is vital that the Trust develops a plan to reduce the deficit in the next financial year. To facilitate this, the 2021/22 proposed budgets are currently being reviewed and challenged at Executive level and divisions are required to identify robust efficiency plans.

**Risks to delivery and mitigations**

There are no expected risks to the year end position

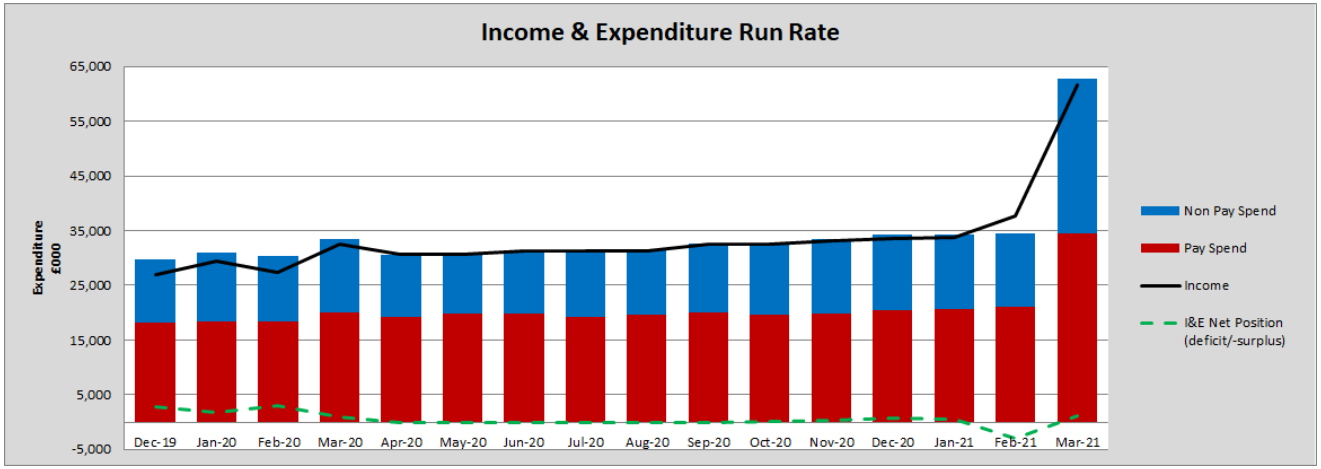


**Non Pay variance** is £8,067k overspend in month and £9,600k overspend full year. The position includes:

- Provisions of £4,534k for anticipated costs relating to 20/21

# Income and Expenditure - Run Rate

Use of Resources




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

The Trust net expenditure run rate has increased by £4,005k in Month 12 which is £302k more than plan (excluding donated assets adjustment). This includes the net nil income and expenditure impact of Notional Pension adjustment £9,572k and Flowers Holiday Pay accrual £630k.

Income run rate – has increased by £16,070k from last month. Key drivers of this are:

- Additional funding from BSW CCG of £5,350k
- Funding from NHSE for Annual and Anniversary Leave Accrual increase of £2,090k

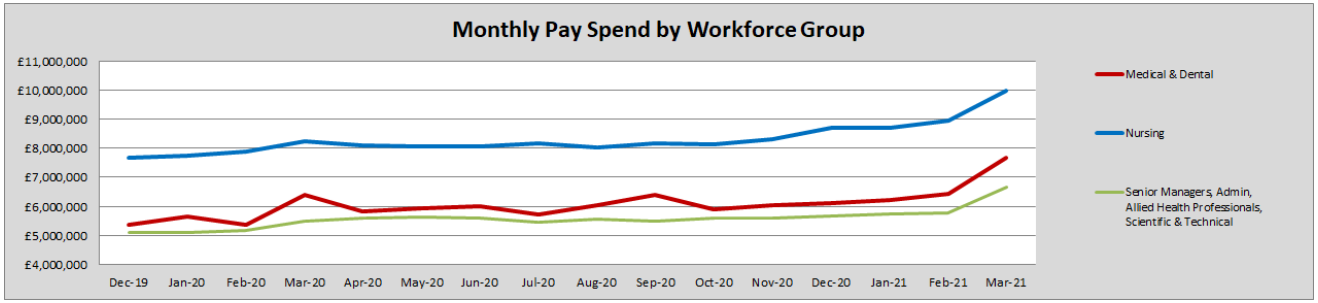
Pay run rate – has increased by £13,521k in month which is £14,366k higher than plan, explained in detail on the following Workforce slide.

Non Pay run rate increased by £6,554k and is £8,067k higher than plan and is driven by:

- Provisions for anticipated costs of rent, legal costs, taxation and bad debts, totalling £4,534k
- Divisional expenditure of £700k, including call system, mortuary unit, equipment software and environmental improvements
- Year End Stock Adjustments of £1,232k have been made in Month 12 for drugs, medical supplies and theatre stock.
- Increased Clinical Supplies expenditure reflecting increased elective activity which was 14% higher than last month.

## Pay Spend by Workforce Group

Use of Resources




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

Across all Staff Group the impact of the Annual and Anniversary leave accruals is evident and other areas within the Pay position not previously explained in the report include:

| | |
|---|---|
| **Nursing** | Run rate has increased by £153k and is £801k overspent. Recruitment continues on the wards with a strong trajectory for international nurses due to join the Trust each month. Nursing agency and bank costs have increased by £24k and £115k respectively due to HDP and relate to the additional costs incurred in winding down these services. |
| **Medical** | Spend has increased by £389k and includes costs of an additional adjustment for TOIL and locum cover for anaesthetics and ICU that has been built up in year during the pandemic. |
| **AHP/S&T** | Spend has increased by £115k of which £50k is due to HDP schemes which is matched by income. |
| **Admin/SM** | Spend has increased due to £114k of Training Team costs and Brighter Future Team costs, both of which are matched by income |

*The technical adjustment for notional pension has been excluded from this slide.*

# NHS Clinical Income – Variance from Plan

Use of Resources

| NHS CLINICAL INCOME | IN MONTH (March) | | | | YTD (March) | | | |
|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Value of Cost Offset | Budget | Actual | Variance | Value of Cost Offset |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Block NHS Clinical Income* | 30,360 | 31,062 | 702 | - | 355,971 | 360,180 | 4,209 | - |
| Additional NHS Clinical Income | | | | | | | | |
| Hospital Discharge Programme (HDP) | - | 794 | 794 | (981) | - | 2,725 | 2,725 | (2,912) |
| Vaccination Costs | - | 161 | 161 | (161) | - | 615 | 615 | (615) |
| Lateral Flow income | - | 78 | 78 | (78) | - | 140 | 140 | (140) |
| Covid income for PCN | - | 27 | 27 | (27) | - | 87 | 87 | (87) |
| Primary Care Dilapidations | - | - | - | - | - | 280 | 280 | (280) |
| Thames Valley Cancer Alliance | - | 226 | 226 | 226 | - | 492 | 492 | (492) |
| Urology | - | 81 | 81 | (81) | - | 81 | 81 | (81) |
| Cloud Backup IT funding | - | 140 | 140 | (140) | - | 140 | 140 | (140) |
| Critical Care | - | 45 | 45 | (45) | - | 45 | 45 | (45) |
| BSW additional funding | - | 5,350 | 5,350 | (5,350) | - | 5,350 | 5,350 | (5,350) |
| Annual Leave Accrual funding | - | 2,039 | 2,039 | (2,039) | - | 2,039 | 2,039 | (2,039) |
| Primary Care Q1 income adjustment | - | 755 | 755 | (775) | - | 755 | 755 | (775) |
| Cost & Volume Drug Adjustment | - | 166 | 166 | (166) | - | 343 | 343 | (343) |
| Other | 365 | 980 | 616 | - | 5,148 | 5,975 | 827 | - |
| Additional Total NHS Clinical Income | 365 | 10,842 | 10,478 | (9,617) | 5,148 | 19,067 | 13,919 | (13,299) |
| TOTAL | 30,725 | 41,904 | 11,180 | (9,617) | 361,119 | 379,247 | 18,128 | (13,299) |

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

The Trust has received £19,067k NHS Clinical Income in 20/21 in addition to block payments, of this £13,919k was not included in the budget. The majority of the additional income is offsetting costs that have been incurred either in month or in prior months related to the Covid-19 response.

The positive variance not offset by costs is driven by funding for Lost Operating Income funding received from NHSE/I in recognition of income potential lost during the Covid-19 pandemic, including private patients and car parking. This funding is not included in the budget and has enabled the Trust to deliver a small surplus.

The variance also includes income for Hospital Discharge Programme (HDP) that was received but not planned for. Income of £2,725k was received against spend of £2,912k for HDP, creating a deficit position of £187k. The programme will only continue for the first 6 weeks of 21/22 so the costs are now being wound down to align with the available financial envelope.

The month 12 position includes Annual and Anniversary Leave Accrual funding which is subject to confirmation from NHSE/I. The increase in the accrual from last year is £2,039k which has been matched by income.

# Income and Expenditure - Divisional Positions (Devolved Income)

Use of Resources

| April 2020 - Mar 2021 | | IN MONTH (MARCH) | | | | | | YEAR TO DATE (MARCH) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Income & Expenditure | Annual Budget | Budget v Actuals | | | Variances | | | Budget v Actuals | | | Variances | | |
| | | Budget | Actual | Variance | Income | Pay | Non Pay | Budget | Actual | Variance | Income | Pay | Non Pay |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Unscheduled Care | (5,618) | 1,106 | (401) | (1,507) | (845) | (483) | (179) | (5,618) | (13,939) | (8,321) | (6,710) | (1,986) | 375 |
| Surgery, Women & Children's | 16,114 | 3,179 | 955 | (2,224) | (289) | (396) | (1,538) | 16,114 | 4,894 | (11,220) | (9,532) | (674) | (1,013) |
| Integrated & Community Health | (8,278) | (636) | 491 | 1,127 | 2,002 | (440) | (435) | (8,278) | (6,386) | 1,891 | 3,298 | (544) | (863) |
| **CLINICAL DIVISIONS** | **2,218** | **3,649** | **1,045** | **(2,604)** | **868** | **(1,320)** | **(2,151)** | **2,218** | **(15,431)** | **(17,649)** | **(12,944)** | **(3,205)** | **(1,501)** |
| Corporate | (18,415) | (1,563) | (2,190) | (627) | 1,789 | (223) | (2,193) | (18,415) | (13,287) | 5,129 | 9,094 | (179) | (3,786) |
| **DIRECTORATES** | **(18,415)** | **(1,563)** | **(2,190)** | **(627)** | **1,789** | **(223)** | **(2,193)** | **(18,415)** | **(13,287)** | **5,129** | **9,094** | **(179)** | **(3,786)** |
| Non-Divisional | (1,908) | (169) | (5,168) | (4,998) | 17,046 | (12,823) | (9,221) | (1,908) | (7,505) | (5,597) | 17,107 | (12,759) | (9,945) |
| Trust Income | 41,267 | (398) | 8,808 | 9,206 | 9,274 | - | (68) | 41,267 | 64,349 | 23,082 | 23,187 | - | (105) |
| **EBITDA** | **23,162** | **1,518** | **2,495** | **976** | **28,975** | **(14,366)** | **(13,633)** | **23,162** | **28,127** | **4,965** | **36,444** | **(16,143)** | **(15,337)** |
| **EBITDA as % of Total Income** | **6.1%** | **4.7%** | **4.1%** | **-0.6%** | | | | **6.0%** | **6.7%** | **0.7%** | | | |
| Depreciation | (8,899) | (821) | (66) | 756 | - | - | - | (8,899) | (8,143) | 756 | - | - | - |
| Net Interest | (14,827) | (1,248) | (1,216) | 32 | - | - | - | (14,827) | (14,623) | 203 | - | - | - |
| PDC Dividend | (3,221) | (268) | (87) | 182 | - | - | - | (3,221) | (3,039) | 182 | - | - | - |
| Pension Unwinding | (45) | (45) | 4 | 49 | - | - | - | (45) | 4 | 49 | - | - | - |
| **Total Surplus/(Deficit)** | **(3,829)** | **(865)** | **1,130** | **1,995** | | | | **(3,829)** | **2,325** | **6,154** | | | |

Income assigned to divisions is based on activity done, priced at the 2020/21 national tariff that was intended to be the mechanism this year prior to Covid-19. Total commissioner income received by the GWH has actually been on a block basis based on previous expenditure levels and Covid-19 costs. This amounts to more than would have been earned under the National Tariff and the balance is shown on the Trust Income line.

## Income and Expenditure - Divisional Positions (Devolved Income)

Use of Resources

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

The devolved income plan for M7-12 is currently set at pre-Covid-19 levels as it was not possible to sign off plans due to the uncertainties faced with Covid-19 pressures.

***Unscheduled Care***

Income is £845k behind plan, driven by activity income being £1,000k behind the pre-Covid-19 plan in March. This is offset by additional income linked to the Vaccination Programme (off-setting costs).

Pay is £483k overspent in month, £151k on Covid-19 Vaccination Programme. Nursing is £200k overspent (excl. Vaccination costs); £70k on escalation (incl COVID 19) in LAMU (CAU), Neptune & Woodpecker, with the remaining pressure linked to Aspirant Nurse placements, RMN close support and supernumerary. Medical overspend of £157k is due to cover for continued restricted duties, an increase in fill rate for the outlier team and pressure from compliance with the new weekend rota affecting ED and Gen Medical.

Non Pay is £179k overspent driven by approved prior year purchasing of £162k.

***Surgery, Women & Children's***

Income is £289k behind plan, drive by activity income being £685k behind the pre-Covid-19 plan in March. This is offset by additional non-recurrent funding for projects including £81k from the South West Cancer Alliance for Urology Services and ICU staff well being resources of £45k. Additionally private patient activity has been above plan by £27k.

Pay costs are above budget by £396k, this is driven by £296k owed to Anaesthetic & ICU medical staff for additional PAs worked during the pandemic. ICU nursing costs remain £42k above plan, and spend on Maternity and Paediatric nursing was £60k above budget.

Non-Pay costs are overspent by £1,538k, substantially due to adverse stock movement of £1,311k driven by Theatres change from owned stock to consignment and some obsolete stock write-offs.

***Integrated & Community Care***

Income is £2,002k above plan in month with the main drivers being £793k Hospital Discharge Programme (HDP) income and £755K of PCN income, both of which off-set costs.

Pay is £440k above plan overall driven by Community HDP pressure of £326k, which includes an additional 6 weeks of programmes.

Non pay is £435k above plan. Key pressures are £127k in Cancer high cost drugs, agreed additional spend for ICC of £260k and HDP spend of £150k (including additional Princess Lodge rent).

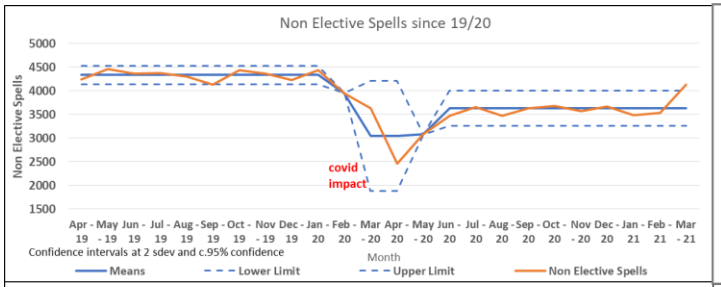
***Corporate***

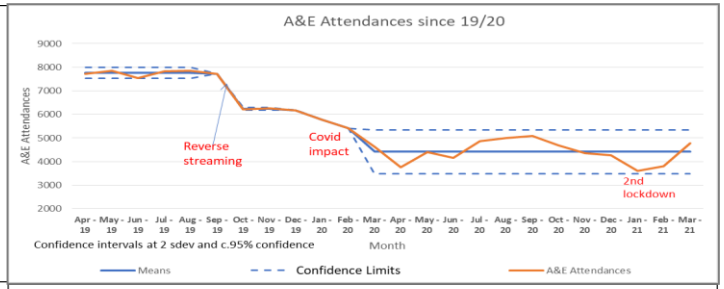
Income is £1,789k above plan driven by HEE income, for which additional incomes have been received in M12 (substantially off-set by costs).

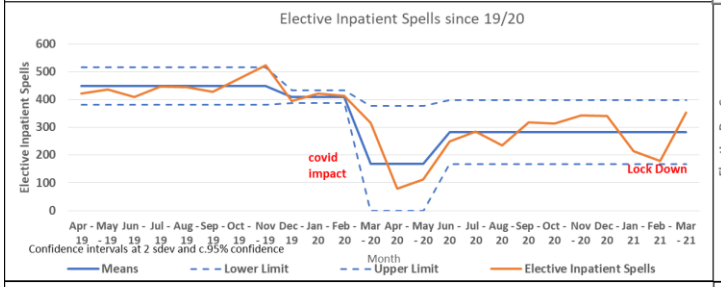
Pay is above plan £223k driven by HEE funded posts at £176k.

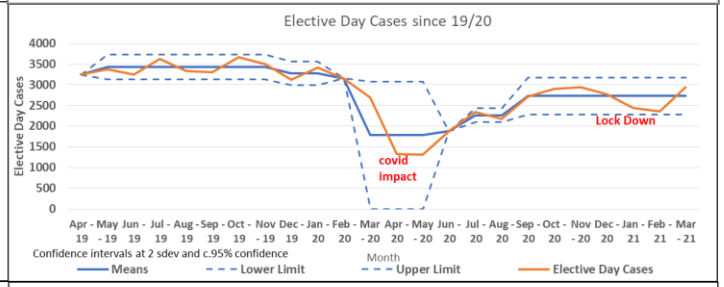
Non pay is above plan by £2,193k. Key adverse variances in month are: additional direct HEE costs of £366k, Serco invoices for Pandemic cover of £331k, cleaning and beds and variations of £171k, Utilities and Pseudomonas invoice (THC) £216k, cloud back up and System C license costs of £500k and year end Stock adjustments amounting to £173k.

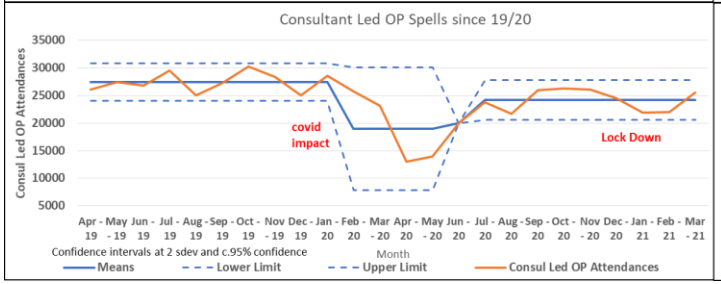
# Key Activity Trends to Inform Revenue Impact if National Tariffs Still Applied

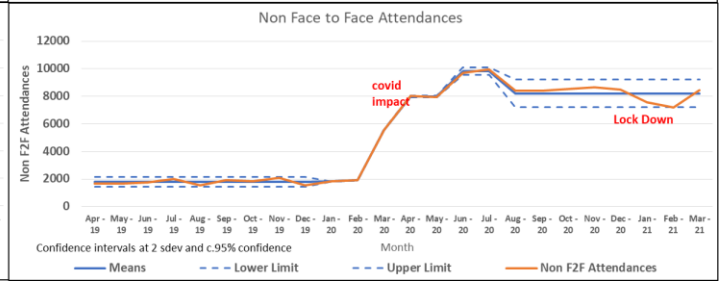


# Income and Activity Delivered by Point of Delivery

Use of Resources

**Context**

Due to Covid-19 20/21 funding has effectively been on a block contract basis, with the emphasis on covering reported costs.

The below statistics show performance by main activity types against the pre-Covid 20/21 Plan if PbR was still applied.

It gives a feel for the impact of Covid-19 and the likely scale of income recovery in future years when PbR becomes relevant again.

20/21 Full year - Actuals v pre-Covid Plan using National Tariff Pricing

| Activity Type | Activity Variance | Income Plan | Income actual | Income Variance | Income Variance |
|---|---|---|---|---|---|
| | | £k | £k | £k | |
| A&E | -32.7% | 12,863 | 9,626 | -3,237 | -25.2% |
| NEL | -23.3% | 106,419 | 93,855 | -12,565 | -11.8% |
| Outpatient (all) | -19.5% | 45,894 | 29,379 | -16,514 | -36.0% |
| Day Case | -34.9% | 25,012 | 15,494 | -9,518 | -38.1% |
| Elective Inpatient | -44.0% | 19,265 | 11,521 | -7,745 | -40.2% |

Key Points:

- A&E: Income is down less than activity (25% v 33%) as it is the least complex attendances that have fallen most.
- A&E: In 19/20 the bulk of Minor A&E attendances were diverted to UCC. This would reduce A&E income by c.£2.2m but the expectation is that commissioners will still pay this in future years as the patients and costs are still in the emergency block.
- NEL: Smallest reduction of all above activity types as one would expect, and lower than activity drop (12% v 23%)
- Outpatients: Income is down 36% but activity is only down by 20%. This is due to National Tariffs being much lower for non-consultant and non-FaceToFace activity which is where growth has occurred. Tariffs for these are expected to increase to reflect they are often doing work to replace what were Consultant FaceToFace.
- Day Case: Income broadly down in line with activity (38% v 35%) but a significant decrease in activity
  - Notable variances of c.50% of income plan are T&O (£2.7m), Ophthal' (£1.1m), Gynaecology (£0.5m)
  - Other large drops but with smaller %s are General Surgery (£1.6m and 34%), Gastroenterology (£1.3m and 38%)
- Elective Inpatient: Income broadly down in line with activity (38% v 35%) but a significant decrease in activity
  - T&O dominates the income drop at £6.3m and 61%
  - Other notable reductions are Gynae' (£0.7m and 44%), Urology (£0.4m and 33%), Cardiology (£0.25m and 64%)
  - ENT increased due to a large increase in low complexity admissions, presumably Covid linked (up £0.75m and 130%)

## Statement of Financial Position

Use of Resources

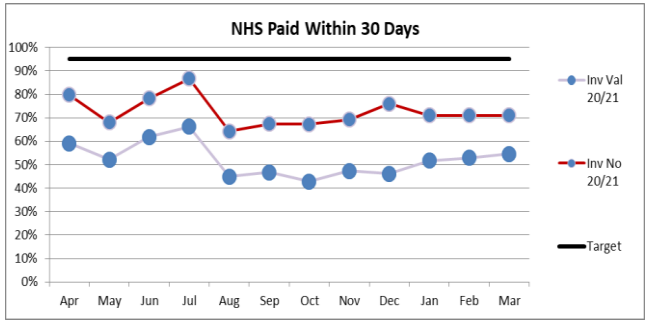
| | 2020-2021 Plan £'000 | Previous Month Feb-21 (£'000) | Current Month Mar-21 (£'000) | Movement (£'000) From Prior Mth | As at year-end Mar-20 (£'000) |
|---|---|---|---|---|---|
| **Non-Current Assets** | | | | | |
| Intangible assets | 1,781 | 3,447 | 3,447 | | 3,447 |
| Property, plant and equipment | 230,659 | 211,408 | 232,109 | 20,701 | 206,058 |
| Investments in associates & joint ventures | - | 10 | 10 | | 10 |
| Receivables - non-current | - | 612 | 656 | 43 | 612 |
| **Total Non-Current Assets** | 232,440 | 215,477 | 236,222 | 20,745 | 210,127 |
| **Current Assets** | | | | | |
| Inventories | 5,511 | 4,538 | 4,787 | 249 | 5,554 |
| Receivables: invoiced | 21,137 | 4,737 | 4,870 | 133 | 8,947 |
| Receivables: not invoiced | 18,359 | 33,911 | 32,348 | (1,563) | 23,043 |
| Cash and cash equivalents. | 8,304 | 41,213 | 21,558 | (19,655) | 9,140 |
| **Total Current Assets** | 53,311 | 84,399 | 63,563 | (20,836) | 46,684 |
| **Total Assets** | 285,751 | 299,876 | 299,785 | (91) | 256,811 |
| **Current Liabilities** | | | | | |
| Other liabilities: deferred income | 2,602 | 35,514 | 2,264 | (33,250) | 2,710 |
| Trade and other payables: invoiced | 5,931 | 6,564 | 8,806 | 2,242 | 12,165 |
| Trade and other payables: not invoiced | 11,602 | 30,208 | 31,707 | 1,499 | 21,082 |
| Provisions - current | 150 | 71 | 194 | 123 | 155 |
| Trade and other payables: capital | 2,594 | 12,114 | 10,207 | (1,906) | 5,058 |
| Borrowings: PFI, loans & finance leases | 14,791 | 675 | 113 | (562) | 69,944 |
| **Total Current Liabilities** | 37,670 | 85,145 | 53,291 | (31,854) | 111,114 |
| **Non current Liabilities** | | | | | |
| Other liabilities: deferred income | 973 | 790 | 790 | - | 904 |
| Provisions - non-current | 1,018 | 1,389 | 1,521 | 133 | 1,431 |
| Borrowings: loans & finance leases | 65,654 | 1,392 | 1,392 | - | 5,679 |
| PFI obligations | 86,538 | 95,448 | 95,448 | - | 95,447 |
| **Total Non-Current Liabilities** | 154,182 | 99,019 | 99,151 | 133 | 103,461 |
| **Total Assets Employed** | 93,899 | 115,712 | 147,342 | 31,630 | 42,236 |
| **Taxpayer's and Others Equity** | | | | | |
| Public dividend capital | 92,210 | 106,837 | 137,337 | 30,500 | 34,556 |
| Income and expenditure reserve | (35,248) | (29,821) | (28,691) | 1,130 | (31,017) |
| Revaluation reserve | 36,937 | 38,697 | 38,697 | - | 38,697 |
| Miscellaneous Other Reserve | | | | | |
| **Total Assets Employed** | 93,899 | 115,712 | 147,342 | 31,630 | 42,236 |

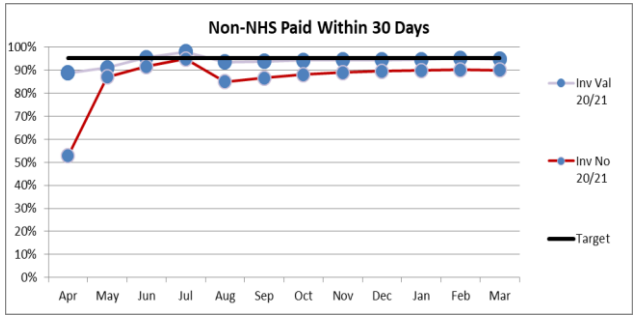
Note: The above is draft pending potential further adjustments to finalise the year end position. This is likely to include a review of the PFI current/non-current split and movements in payables and receivables.

# Working Capital

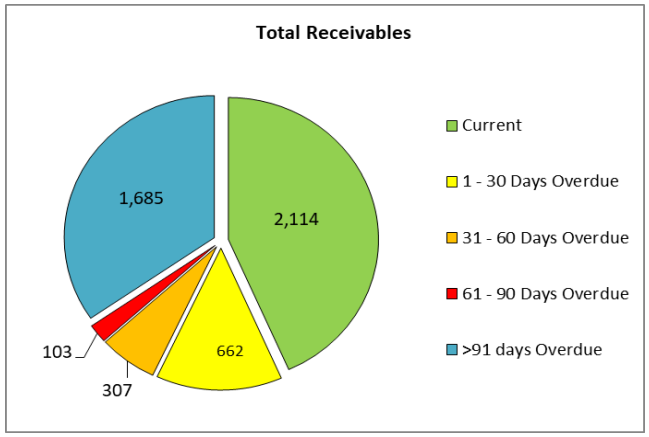
Use of Resources

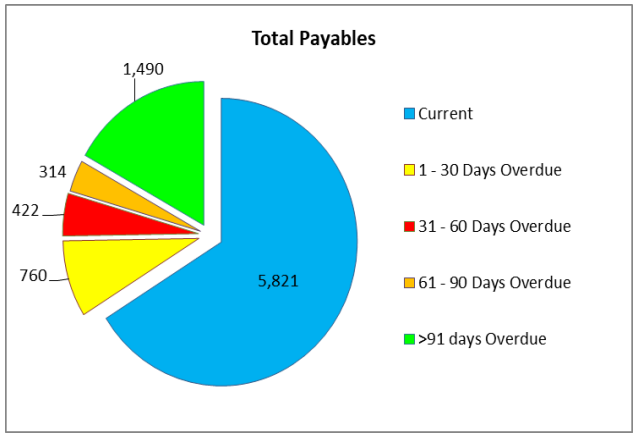
## Payments to Suppliers




## Outstanding Receivable and Payable Balances



# 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 has been revised to reflect latest guidance.
- The in month movement in property, plant & equipment relates to depreciation of £43k offset by expenditure of £20,744k. This includes donated assets from DHSC in response to the Covid pandemic.

**Total Current Assets** are lower than the previous month by £91k.

- Stock levels have increased by £249k due to drug purchases in month and adjustment to theatre stock (identified as part of Implementing the theatre stock system). 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.
- Current receivables are £1,430k lower than last month due to reduction in accruals at year end.
- Cash is £19,655k lower than last month due to the increased spend on capital and due to the double payment received in April 2020 which meant no main Block income received in March 21

- **Total Current Liabilities** have decreased by £31,854k from last month.
- The deferred income decrease of £33,250k relates to a monthly release of prepayments in Health Education England and CCG block payments.
- Invoiced trade payables have increased by £2,242k. This relates to invoices that have been received but are not yet approved for payment Non-invoiced payables have increased by £1,499k due to movements in accruals
- Capital payables have decreased by £1,906k compared to last month due to payment of prior year creditors offset by year end accruals for equipment.
- Borrowings decreased due to the monthly £546k PFI repayment, £16k finance lease payment.

## Risks to delivery and mitigations

**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 89.3% a small reduction from 89.4% last month.

**Cash** – Additional cash was received in March to enable payment of the 21/22 Q1 PFI payment and for Capital funding agreed since December 2020.

**Debtors** – Debtors have increased due to the increase in the PFI Prepayments and adjustment in income accruals.

# Rolling 12 Month Cashflow, Capital Programme

Use of Resources

| | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | 20/21 Total | Rolling 12 Mths Apr 21 to Mar 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | | | | | £'000 | £'000 |
| **Opening Balance** | **41,193** | **21,553** | **26,708** | **32,962** | **37,326** | **32,523** | **38,837** | **41,601** | **34,825** | **35,983** | **37,196** | **26,523** | **27,737** | **9,140** | 21,553 |
| **Income** | | | | | | | | | | | | | | | |
| Clinical Income | 11,312 | 30,668 | 30,668 | 30,668 | 30,668 | 30,668 | 30,668 | 27,517 | 27,517 | 27,517 | 27,517 | 27,517 | 27,517 | 392,293 | 349,110 |
| Other Income | 3,921 | 4,730 | 3,962 | 2,012 | 4,730 | 3,962 | 2,012 | 2,012 | 2,012 | 2,012 | 2,012 | 2,012 | 2,012 | 30,703 | 33,480 |
| Revenue Financing Loan / PDC | 4,975 | | | | | | | | | | | | | 72,107 | |
| Capital Financing Loan / PDC | 25,525 | 4,591 | 4,591 | 4,591 | 4,591 | 4,591 | 4,591 | 8,487 | 4,591 | 4,591 | 4,591 | 4,591 | 4,591 | 30,675 | 58,988 |
| **Total Income** | **45,733** | **39,989** | **39,221** | **37,271** | **39,989** | **39,221** | **37,271** | **38,016** | **34,120** | **34,120** | **34,120** | **34,120** | **34,120** | **525,778** | **441,578** |
| **Expenditure** | | | | | | | | | | | | | | | |
| Pay | 21,021 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 20,138 | 234,037 | 241,656 |
| Revenue Creditors | 10,936 | 10,230 | 8,307 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 8,302 | 124,408 | 101,551 |
| Capital Creditors | 19,424 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 4,467 | 26,378 | 53,606 |
| Prepayments | | | | | | | | | | | | | | | |
| PFI | 11,861 | | | | 11,886 | | | 11,886 | | | 11,886 | | | 58,477 | 35,658 |
| PDC Interest | 2,131 | | | | | | 1,600 | | | | | | | 2,823 | 1,600 |
| Financing | | | 55 | | | | | | 55 | | | | | 67,242 | 110 |
| **Total Expenditure** | **65,373** | **34,835** | **32,967** | **32,907** | **44,793** | **32,907** | **34,507** | **44,793** | **32,962** | **32,907** | **44,793** | **32,907** | **32,907** | **513,365** | **434,181** |
| **Closing Balance** | **21,553** | **26,708** | **32,962** | **37,326** | **32,523** | **38,837** | **41,601** | **34,825** | **35,983** | **37,196** | **26,523** | **27,737** | **28,950** | **21,553** | **28,950** |

## Capital Programme

| | Mar-21 | | | YTD | | | FOT | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £000 | Actual £000 | Variance £000 | Plan £000 | Actual £000 | Variance £000 | Plan £000 | Actual £000 | Variance £000 |
| PFI capital | 3,544 | 3,655 | 111 | 3,544 | 3,655 | 111 | 3,544 | 3,655 | 111 |
| Medical Equipment General | 125 | 161 | 36 | 1,550 | 1,746 | 196 | 1,550 | 1,746 | 196 |
| Radiology Equipment | 3,675 | 3,079 | (596) | 5,420 | 5,296 | (124) | 5,420 | 5,296 | (124) |
| Building / Estates General | 50 | 335 | 285 | 600 | 512 | (88) | 600 | 512 | (88) |
| Aseptic Suite | 198 | - | (198) | 198 | 198 | - | 198 | 198 | - |
| IM&T General | 62 | 490 | 428 | 700 | 490 | (210) | 700 | 490 | (210) |
| IT Infrastructure | - | 2,979 | 2,979 | 3,800 | 3,800 | - | 3,800 | 4,026 | 226 |
| IT LIMs Pathology | 1,530 | 1,530 | - | 1,530 | 1,530 | - | 1,530 | 1,530 | - |
| IT Remote Monitoring | 43 | 43 | - | 43 | 43 | - | 43 | 43 | - |
| IT Covid Response Audiovisu | 20 | 22 | 2 | 20 | 22 | 2 | 20 | 22 | 2 |
| Way Forward | 451 | 3,329 | 2,878 | 6,032 | 3,490 | (2,542) | 6,032 | 3,490 | (2,542) |
| Way Forward (CDEL) | 1,687 | - | (1,687) | 1,687 | 1,687 | - | 1,687 | 1,687 | - |
| Covid | - | (67) | (67) | 721 | 705 | (16) | 721 | 705 | (16) |
| Oxygen scheme | 492 | 443 | (49) | 492 | 572 | 80 | 492 | 572 | 80 |
| Clover UEC | 2,367 | 1,818 | (549) | 6,025 | 6,025 | - | 6,025 | 6,025 | - |
| Commonhead design | 115 | 47 | (68) | 115 | 115 | - | 115 | 115 | - |
| Critical Infrastructure | 195 | 195 | - | 195 | 195 | - | 195 | 195 | - |
| Critical Infrastructure 2 | 200 | 200 | - | 200 | 200 | - | 200 | 200 | - |
| Critical Care Resilience | - | 105 | 105 | 1,234 | 1,168 | (66) | 1,234 | 1,168 | (66) |
| GWH Clinic room | - | 283 | 283 | 300 | 300 | - | 300 | 300 | - |
| CT Enabling Infrastructure | - | 12 | 12 | 200 | 200 | - | 200 | 200 | - |
| Order Comms | 99 | 99 | - | 99 | 99 | - | 99 | 99 | - |
| Other | - | - | - | 11 | 11 | - | 11 | 11 | - |
| **Total** | **14,853** | **18,758** | **3,905** | **34,716** | **32,059** | **(2,657)** | **34,716** | **32,285** | **(2,431)** |
| CDEL | | | | | | | | | - |

- The rolling cashflow forecast assumes Commissioner income continues at the level received in the Month 1 block.
- The Capital variance relates to an underspend on the Way Forward programme offset by an overspend on PFI.
- The Trust has spent Capital in line with CDEL for 2020/21.

# Cash Position & Capital Programme

Use of Resources

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

The Cash Position in March was £8m better than expected due in part to the Trust receiving circa £5m funding from BSW. Capital draw downs and payments were high in the month but still left a £10m accrual as schemes were completed at the end of M12.

The total capital programme 20/21 is £40,577, excluding prior year brought forward accrual this is £34,715. This is an increase of £1,110k from prior month due to additional funds made available for Clover UEC.

| | |
|---|---|
| Capital Plan 2021 | 10,270 |
| IT Infrastructure Bid 1920 | 3,800 |
| Brought Forward 1920 | 5,862 |
| Additional Funding 2021 | 11,069 |
| Way Forward Programme 2021 | 6,032 |
| PFI capital adjustment 2021 | 3,544 |
| | 40,577 |

The full year spend was £32,285k with £3,655k relating to our PFI Capital Lifecycle spend and the remaining £28,630k relating to in year schemes funded by PDC drawdowns.

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

The Capital Programme is managed via the capital groups:

- Equipment Group
- Digital & IT Steering Group
- Estates and Facilities Management Group

In March 20/21 the focus was on completing Capital spend; ensuring invoices received and paid where possible and work started on programmes delayed due to Covid..

94% of the £40,577k has been committed, in year. The balance is:

- £2,542k – Way Forward c/f 21/22
- £114k - relates to prior year
- -£111k - PFI Lifecycle

The Way Forward Programme purchased the Expansion Land in March 2021 for £3,490k, including fees.

## Risks to delivery and mitigations

Total expenditure including accruals at Month 12 is £32,285k.

In year expenditure excluding accruals and brought forward from 19/20, is £21,940k The accrual, £10,345k, includes items ordered and work commenced in March.

YTD Spend by category:

- Equipment £6,732k
- Estates £12,005k
- IT £3,203k

The Trust's CDEL funded is on plan.

# Cost Improvement Plans – Better Care at Lower Cost

Use of Resources

| Division | In Month Plan £'000 | In Month Actual £'000 | In Month Variance £'000 | YTD Plan £'000 | YTD Actual £'000 | YTD Variance £'000 |
|---|---|---|---|---|---|---|
| Integrated and Community Care | 142 | 23 | (119) | 1,480 | 360 | (1,120) |
| Surgery, Womens & Childrens | 222 | 36 | (186) | 2,311 | 337 | (1,974) |
| Unscheduled Care | 248 | 65 | (183) | 2,578 | 729 | (1,849) |
| Corporate | 154 | 12 | (141) | 1,598 | 211 | (1,387) |
| Trust Wide | 99 | 0 | (99) | 1,032 | 0 | (1,032) |
| **Total** | **865** | **136** | **(729)** | **9,000** | **1,637** | **(7,362)** |
| **Percentage** | | **16%** | | | **18%** | |

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

The Cost Improvement Programme (CIP) delivery plan for March is £865k (£9,000k full year).

CIPs delivered in month were £136k (£1,637 full year) which is £729k below plan (£7,362k full year).

The full year delivery is 18% of plan. Covid 19 has had a significant impact on in year delivery savings.

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

Planning for 2021/22 is progressing and a number of schemes that were not delivered due to Covid-19 will form part of next years plan.

**Risks to delivery and mitigations**

Management efforts have been focused on Covid-19 response and restarting services which has reduced the CIP opportunities that have been progressed.

| Accountable Non-Executive Director | Presented by | | Meeting Date |
|---|---|---|---|
| **Lizzie Abderrahim** | **Lizzie Abderrahim** | | **9 April 2021** |
| **Assurance:** Does this report provide assurance in respect of the Board Assurance Framework strategic risks? | Yes | BAF Numbers | 1.4a[1] |

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 |
|---|---|---|---|---|---|
| Training of SERCO staff in the use of restraint | Risk | Actions | The committee was satisfied that whilst it could not be wholly assured it was satisfied that de-escalation training in challenging behaviours had been provided to current staff and that the provision of this training for new starters and plans for refresher training was under consideration | WJ to continue efforts to ensure, with Andy Wells, that this training is provided | Update to be provided to the Committee on 9 July 2021 |
| CAMHS: Availability of specialist beds | Risk | Actions | The committee noted the update provided by the CAMHS Associate Medical Director, in particular that [1] local commissioners have been made aware of the issues associated with a lack of beds [2] the CAMHS CEO has been involved in national discussions about adolescent beds [3] mitigating actions have been identified including the availability of funding to support processes to avoid admission to Inpatient Units [4] locally Marlborough House has bid for funding for day patient provision and there are several other national/ regional schemes re bed capacity to ensure equity of access across the country. In addition to the CAMHS information the committee noted that the GWH Board had agreed that the Chair and CEO should discuss with the commissioners how a lack of specialist beds impacted on GWH's ability to provide effective care to children and young people in its care. | Regular updates on progress to made as part of the CAMHS / Children's Services reports to the committee | Ongoing |

[1] Safeguarding / Mental Health / DOLS

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| Use of Mental Health Act [MHA] | Risk | Actions | The committee considered that risks associated with the use of the MHA are high [for GWH and for those subject to detention] and noted the data detailing the frequency and nature of MHA use, the uptake of mandatory training and the numbers of recorded incidents. It took limited assurance in respect of [1] the uptake of mandatory training and [2] the process whereby individuals are apprised of their rights under the MHA, in particular, how GWH follows good practice in re-reading a patient's rights to them. | [1] LG to discuss the uptake of mandatory training with the DDoNs. [2] WJ to provide further information to the committee | Update to be provided to the Committee on 9 July 2021 |
| Mental Capacity Act [MCA] Practice | Risk | Actions | The committee noted that whilst the risks associated with a failure to comply with the legislation were considerable the evidence from the bi-monthly snapshot audits of MCA practice indicated full compliance across the majority of measures with the exception of the Best Interest process which was not always followed appropriately. The committee was advised that a new set of MCA and Best Interests documentation had been developed to support compliance and it was agreed that the effectiveness of this documentation would be evidenced from data obtained from the continuing snapshot audits. | Bi-monthly MCA practice audits to continue with data reviewed by the MHGC | 9 July 2021 |
| Deprivation of Liberty Safeguards [DoLS] Practice | Risk<br>Risk | Actions [1]<br>Actions [2] | [1] The committee noted that a lack of capacity / resource coupled with an increase in numbers meant the supervisory bodies [Swindon Borough Council and Wiltshire Council] were not able to conduct a statutory assessment of all eligible patients with the result that some GWH patients may be cared for outside of a legal framework [a considerable risk for GWH and for individual patients]. The committee took some assurance from the fact that the Chief Nurse had raised concerns with both supervisory bodies and that the issue is monitored on the Trust risk register but remained concerned that any patient should be cared for outside of a legal framework designed to protect them. [2] The committee noted that the DoLS are to be replaced by Liberty Protection Safeguards [LPS] [now expected Spring 2022] and that this would have implications [including financial] for GWH. The committee took some assurance from the fact that discussions re the implementation of LPS have begun on a regional level but was concerned that there still needed clarity regarding the implications for GWH. | [1] Keep the numbers of patients awaiting statutory assessment under review.<br>[2] Chief Nurse to raise issue with the Executive Committee. | Updates to be provided to the Committee on 9 July 2021 |
| Response to White Paper re proposed Mental Health Act reforms | Risk | Actions | The committee noted the responses to the proposed changes to the MHA that had been drafted and agreed that these should be submitted on behalf of the Trust [it had been agreed at the last meeting of the committee that it would be appropriate for the Trust to respond to the proposed reforms to the MHA]. | Submit GWH response to consultation | 21 April 2021 |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| Terms of Reference [ToR] | Risk | Actions | The committee considered that for as long as its ToR deviated from those of other Board subcommittees it could not be fully assured that it was able to effectively carry out its duties and responsibilities as a statutory subcommittee of the Board and therefore recommended the revised ToR to the Board for approval noting that the revisions would bring the committee in line with other subcommittees. | Submission to Board for approval | 6 May 2021 |
| Mental Health Governance workplan 2020/21 Q4 | Risk | Actions | The committee was satisfied that the majority of actions identified under the workplan had been completed and noted that those that remained outstanding had been subject to intervening circumstances and would be carried forward into the 2021/22 workplan | | |
| Accuracy of mental health data [Risk Report] | Risk | Actions | The committee noted that whilst no new risks associated with mental health had been added to the risk register since the last meeting there were continuing concerns regarding the accuracy of mental health data and the impact that this had on risk reporting. The committee understood that the review of the current ULYSEES system which had been stalled was now anticipated [Spring 2020] and it was expected that once completed revisions would be made to the mental health data set/requirements. | | |
| Mental Health Liaison Service: KPI Performance | Risk | Actions | The committee noted the data detailing the AWP MHLT performance in respect of the KPIs (PLAN 2011) but was concerned that the manner in which the KPIs were being interpreted could serve to mask achievement, in particular regarding the impact that the use of observation had on performance data. | AC to raise issue of interpretation within AWP and provide an update to the MHGC | 9 July 2021 |
| CAMHS Hospital Liaison Service | Risk | Actions | The committee received an assurance that pending recruitment to a vacancy in the hospital liaison team the CAMHS service would draw on core staff from to ensure there is no impact on service delivery | | |
| Children's Services | Risk | Actions | The committee noted a number of service delivery challenges within children's services. These included having no dedicated space to accommodate children with challenging behaviour but no medical need, that general paediatric nurses do not have the competency and experience to care for these patients and being able to arrange timely consultant psychiatrist reviews. However, there was sufficient information in the report to assure the committee that appropriate mitigation was being pursued. | | |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| ED: Lack of acute beds within AWP and the impact this has on ED | Risk | Actions | It was reported that ED admits up to 20 high risk patients a month, that these are resource intensive and because there is a lack of acute beds within AWP their lengths of stay are too long. This is creating a situation where ED is functioning as a pressure vessel. It was noted that this can have a significant impact on ED but that there was currently an insufficiency of data available to draw any firm conclusions. | LC to meet with ED staff to identify how data might be captured | Update to be provided to the Committee on 9 July 2021 |
| Dementia Strategy | Risk | Actions | The committee noted that Covid-19 had significantly disrupted all dementia workstreams but received an assurance that training was expected to recommence over the coming months and the Dementia Champions programme was to be relaunched in May during dementia awareness week. The committee also noted that despite the negative impact of Covid-19 there had been some noteworthy achievements, including securing permanent funding for 2 Admiral nursing posts, obtaining funding for a Tovertafel projector and dementia being identified as the next major fund-raising campaign by Brighter Futures. A new draft dementia strategy which included an inequalities perspective was out for consultation and would be presented to the committee for approval at the meeting in July. | Review / approve new draft dementia strategy | MHGC: 9 July 2021 |

Great Western Hospitals NHS Foundation Trust

# Staff Survey 2020
# Results, Analysis and Action Plans

| | | | |
|---|---|---|---|
| **Meeting** | Trust Board | **Date** | 6th May 2021 |

**Summary of Report**


The National Staff Survey 2020 took place in the Autumn of 2020 across all staffing groups and all areas of the Trust. The response rate in 2020 was 53% compared with a response rate of 45% in 2019. We have 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.

Trust Staff Survey areas of focus for 2021/22 are;

- **Immediate Manager/ Team working**
- **Safe Environment (Harassment and Bullying)**
- **Equality, Diversity and Inclusion**
- **Quality of Care**
- **Morale**

**Trust Oversight Plan – Emerging Divisional Specific Theme**

- **Health and Wellbeing**

The full action plan can be found on slides 11, 12 and 13 followed by further analysis of the most recent results.


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

| | |
|---|---|
| **Executive Lead** | Jude Gray, HR Director of Human Resources and Organisational Development |
| **Author** | Ashley Oakshott, Head of HR and Health and Well-being and Suzie Allison-Green, HR Business Partner |
| Author contact details | a.oakshott@nhs.net<br>s.allison-green@nhs.net |

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

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| | | |

| | |
|---|---|
| **Legal / Regulatory / Reputation Implications** | Staff Survey results are published nationally and are open for all to see so can have reputation implications for the Trust being a good employer |

**Link to relevant CQC Domain**

| Safe | | Effective | | Caring | | Responsive | | Well Led | x |
|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Link to relevant Trust Commitment** | |

**Consultations / other committee views**

Report went to Executive Committee on the 20th April and will go to Board on the 6th May. Divisional reports and progress will be shared at Divisional Boards and Integrated Performance Board.

**Recommendations / Decision Required**

***The action plan is agreed, noted and supported***

Great Western Hospitals
NHS Foundation Trust

# Staff Survey 2020 – Key Messages

**Trust Board, 6th May 2021**

**Jude Gray, Director of Human Resources and Organisational Development**

**Presented by Ashley Oakshott, Head of HR and Wellbeing**

## The Staff Survey:

- National Staff Survey and questions are mandated
- 90 questions in 2019, 78 questions in 2020 + 4 COVID-19 questions
- Staff were surveyed between September and December 2020
- Highest response rate to date, **53.4%** compared to national median response rate of 45%.

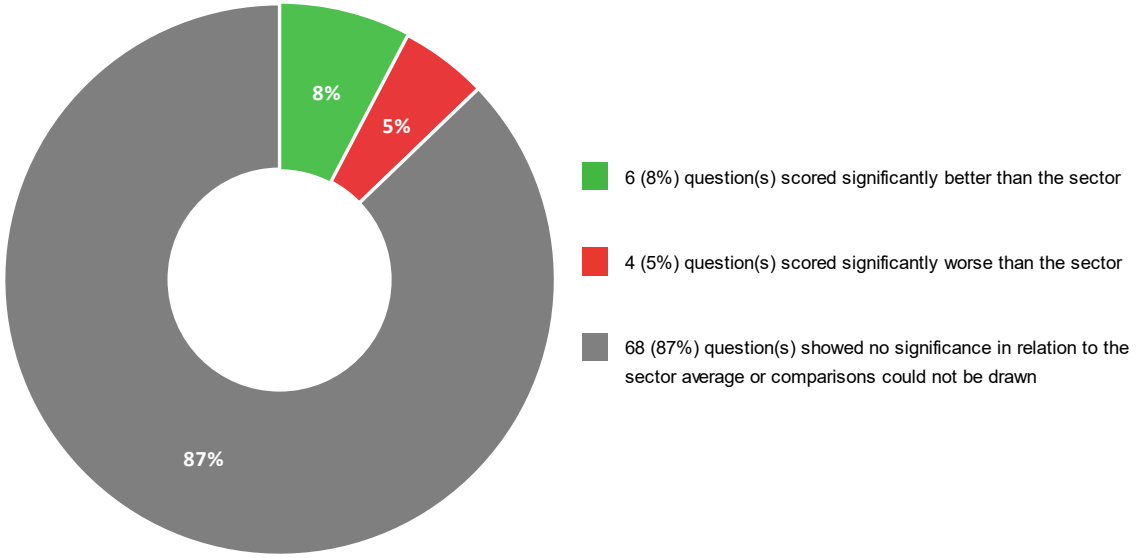
## Response Rate:

| | *Usable Sample* | *Completed* | *Response Rate* | |
|---|---|---|---|---|
| ***2020 Trust*** | 1,237 | 660 | 53.4% | Online Only |
| ***2020 QH*** | 568,073 | 257,321 | 45.3% | |
| ***2019 Trust*** | 1,241 | 496 | 40.0% | Online Only |
| ***2019 QH*** | 522,021 | 242,936 | 46.5% | |

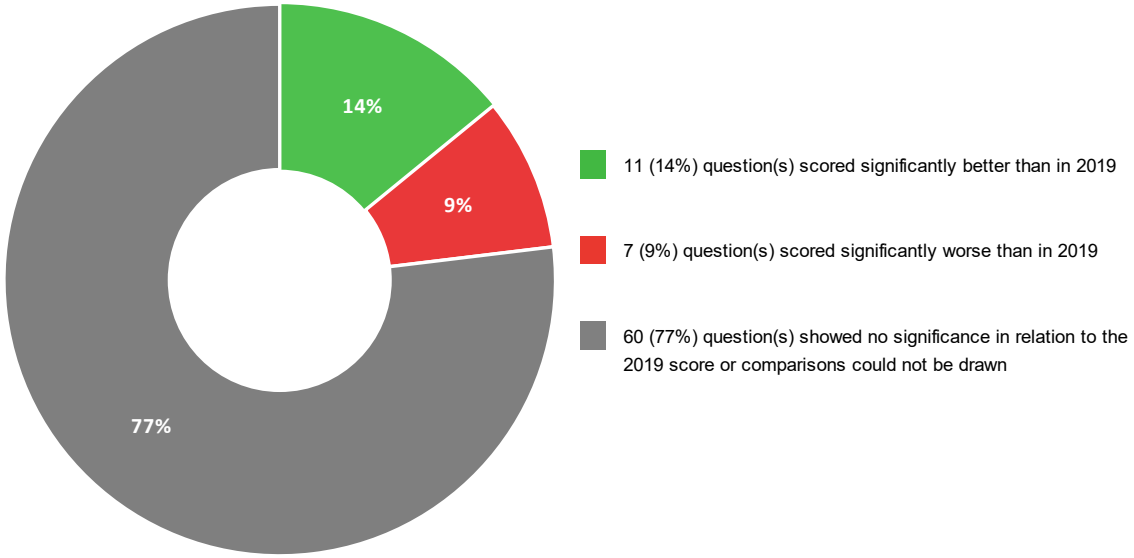
# Headline Results :

Great Western Hospitals NHS Foundation Trust

## National Results:




## GWH Results:




We have moved from being below average in 20 of the national indicators to being below average in 4 of the national indicators – reinforces how far we have come, but also more to do.

*Data Quality Health Surveyed Trust

# Staff survey

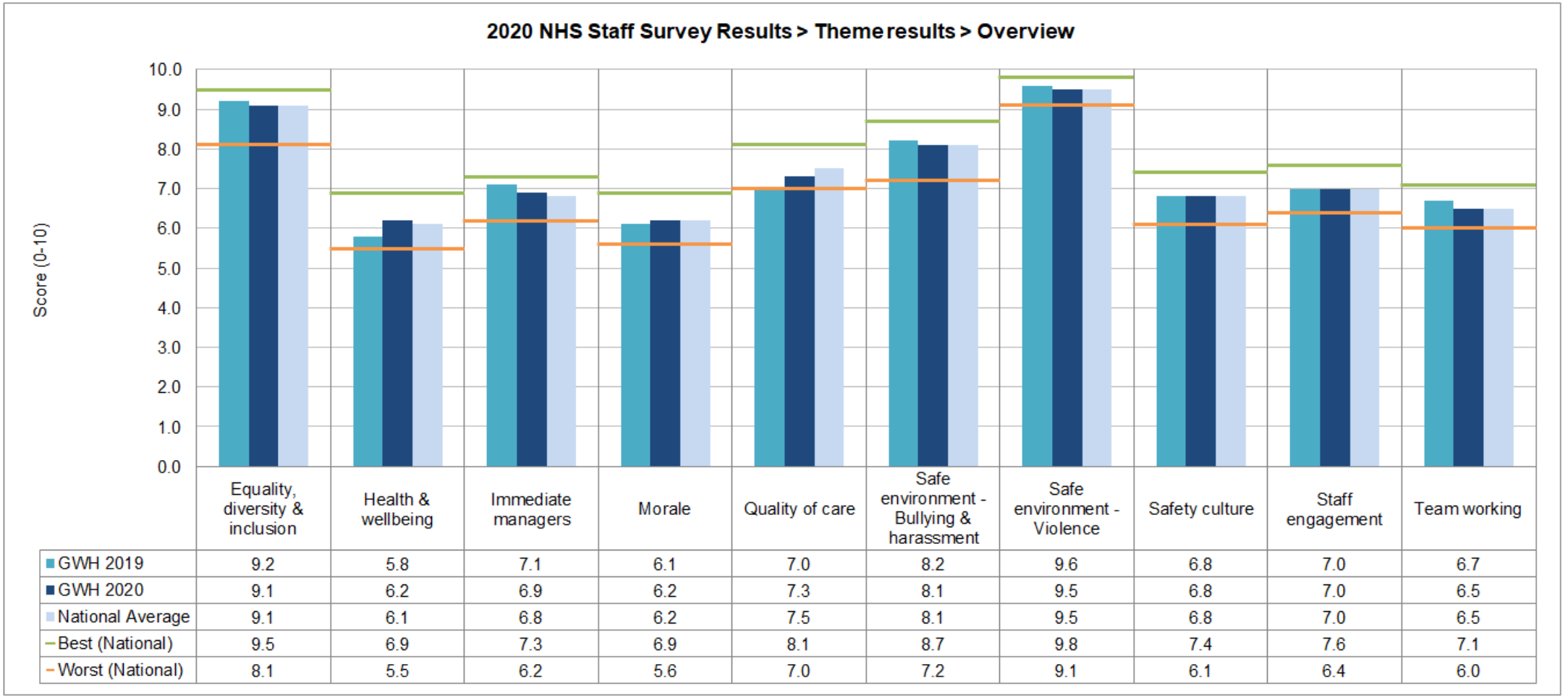
Great Western Hospitals NHS Foundation Trust

The table below presents the results of 'significance testing' conducted on this year's theme scores and those from last year and includes the number of responses. The final column presents the difference from 2019 and if the change was statistically significant or not.

| Theme | 2019 score | 2019 respondents | 2020 score | 2020 respondents | Statistically significant change? |
|---|---|---|---|---|---|
| Equality, diversity & inclusion | **9.2** | 488 | **9.1** | 656 | Not significant |
| Health & wellbeing | **5.8** | 490 | **6.2** | 657 | ↑ |
| Immediate managers † | **7.1** | 492 | **6.9** | 660 | Not significant |
| Morale | **6.1** | 479 | **6.2** | 658 | Not significant |
| Quality of care | **7.0** | 444 | **7.3** | 579 | ↑ |
| Safe environment - Bullying & harassment | **8.2** | 484 | **8.1** | 654 | Not significant |
| Safe environment - Violence | **9.6** | 488 | **9.5** | 657 | Not significant |
| Safety culture | **6.8** | 487 | **6.8** | 659 | Not significant |
| Staff engagement | **7.0** | 495 | **7.0** | 659 | Not significant |
| Team working | **6.7** | 490 | **6.5** | 651 | Not significant |

# The Results by Theme:

Great Western Hospitals NHS Foundation Trust




| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement | Team working |
|---|---|---|---|---|---|---|---|---|---|---|
| GWH 2019 | 9.2 | 5.8 | 7.1 | 6.1 | 7.0 | 8.2 | 9.6 | 6.8 | 7.0 | 6.7 |
| GWH 2020 | 9.1 | 6.2 | 6.9 | 6.2 | 7.3 | 8.1 | 9.5 | 6.8 | 7.0 | 6.5 |
| National Average | 9.1 | 6.1 | 6.8 | 6.2 | 7.5 | 8.1 | 9.5 | 6.8 | 7.0 | 6.5 |
| Best (National) | 9.5 | 6.9 | 7.3 | 6.9 | 8.1 | 8.7 | 9.8 | 7.4 | 7.6 | 7.1 |
| Worst (National) | 8.1 | 5.5 | 6.2 | 5.6 | 7.0 | 7.2 | 9.1 | 6.1 | 6.4 | 6.0 |

# Regional Comparison

Great Western Hospitals NHS Foundation Trust

| Acute Trusts (* Denotes Combined Acute & Community) | Latest CQC Rating | Response Rate | Equality, Diversity & Inclusion | Health & Wellbeing | Immediate Managers | Morale | Quality of Care | Safe Environment - Bullying & Harassment | Safe Environment - Violence | Safety Culture | Staff Engagement | Team Working | Total Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yeovil District Hospital NHS Foundation Trust | Requires Improvement | 65% | 9.1 | 6.9 | 7.2 | 6.6 | 7.7 | 8.4 | 9.4 | 7.0 | 7.4 | 6.7 | 76.4 |
| Northern Devon Healthcare NHS Trust* | Requires Improvement | 55% | 9.3 | 6.4 | 7.3 | 6.6 | 7.6 | 8.3 | 9.5 | 6.9 | 7.3 | 6.9 | 76.1 |
| The Royal Bournemouth and Christchurch Hospitals NHS Foundation Tru | Good | 37% | 9.1 | 6.3 | 7.1 | 6.6 | 7.7 | 8.3 | 9.5 | 7.0 | 7.4 | 6.9 | 75.9 |
| Somerset NHS Foundation Trust | Good | 49% | 9.3 | 6.5 | 7.1 | 6.6 | 7.5 | 8.2 | 9.5 | 7.0 | 7.3 | 6.8 | 75.8 |
| Royal Berkshire NHS Foundation Trust | Good | 50% | 9.0 | 6.4 | 6.9 | 6.4 | 7.7 | 8.0 | 9.3 | 7.1 | 7.4 | 6.7 | 74.9 |
| University Hospital Southampton NHS Foundation Trust | Good | 50% | 9.1 | 6.4 | 6.9 | 6.4 | 7.5 | 8.2 | 9.4 | 7.0 | 7.3 | 6.6 | 74.8 |
| Oxford University Hospitals NHS Foundation Trust | Requires Improvement | 53% | 9.1 | 6.3 | 7.0 | 6.3 | 7.5 | 8.1 | 9.5 | 6.9 | 7.2 | 6.6 | 74.5 |
| Dorset County Hospital NHS Foundation Trust | Good | 46% | 9.2 | 6.2 | 7.0 | 6.4 | 7.5 | 8.1 | 9.5 | 6.8 | 7.2 | 6.6 | 74.5 |
| University Hospitals Bristol and Weston NHS Foundation Trust | Outstanding | 53% | 9.2 | 6.3 | 6.8 | 6.3 | 7.4 | 8.3 | 9.5 | 6.9 | 7.1 | 6.4 | 74.2 |
| Poole Hospital NHS Foundation Trust | Good | 35% | 9.1 | 6.2 | 6.9 | 6.4 | 7.5 | 8.1 | 9.5 | 6.7 | 7.2 | 6.6 | 74.2 |
| Portsmouth Hospitals University NHS Trust | Good | 54% | 9.1 | 6.2 | 7.0 | 6.3 | 7.5 | 8.1 | 9.4 | 6.9 | 7.1 | 6.5 | 74.1 |
| Royal United Hospitals Bath NHS Foundation Trust | Good | 44% | 9.2 | 6.3 | 6.9 | 6.4 | 7.3 | 8.1 | 9.5 | 6.7 | 7.1 | 6.5 | 74.0 |
| Salisbury NHS Foundation Trust | Good | 54% | 9.1 | 6.2 | 6.9 | 6.3 | 7.4 | 8.2 | 9.4 | 6.7 | 7.2 | 6.4 | 73.8 |
| Royal Devon and Exeter NHS Foundation Trust* | Good | 44% | 9.2 | 6.2 | 6.7 | 6.3 | 7.2 | 8.3 | 9.5 | 6.7 | 7.1 | 6.4 | 73.6 |
| **Great Western Hospitals NHS Foundation Trust*** | Requires Improvement | 53% | 9.1 | 6.2 | 6.9 | 6.2 | 7.3 | 8.1 | 9.5 | 6.8 | 7.0 | 6.5 | 73.6 |
| Torbay and South Devon NHS Foundation Trust* | Good | 42% | 9.2 | 6.1 | 6.9 | 6.4 | 7.3 | 8.1 | 9.5 | 6.6 | 7.0 | 6.5 | 73.6 |
| Cornwall Partnership NHS Foundation Trust | Good | 38% | 9.2 | 5.9 | 7.0 | 6.3 | 7.3 | 8.1 | 9.5 | 6.7 | 7.0 | 6.6 | 73.6 |
| North Bristol NHS Trust | Good | 51% | 9.1 | 6.1 | 6.7 | 6.4 | 7.3 | 8.2 | 9.4 | 6.8 | 7.1 | 6.4 | 73.5 |
| Royal Cornwall Hospitals NHS Trust | Requires Improvement | 59% | 9.2 | 6.1 | 6.9 | 6.3 | 7.3 | 8.0 | 9.4 | 6.7 | 6.9 | 6.6 | 73.4 |
| University Hospitals Plymouth NHS Trust | Requires Improvement | 42% | 9.1 | 6.1 | 6.7 | 6.2 | 7.2 | 8.2 | 9.3 | 6.8 | 6.9 | 6.4 | 72.9 |
| Gloucestershire Hospitals NHS Foundation Trust | Good | 48% | 9.0 | 6.1 | 6.8 | 6.2 | 7.3 | 8.0 | 9.5 | 6.5 | 6.9 | 6.4 | 72.7 |
| **Average** | | 49% | **9.1** | **6.3** | **6.9** | **6.4** | **7.4** | **8.2** | **9.5** | **6.8** | **7.1** | **6.6** | **74.3** |
| **National Average Trend 2020 vs 2019** | | | → | ↑ | ↓ | ↑ | → | ↑ | ↑ | ↑ | → | ↓ | ↑ |
| **National Average 2020** | | | 9.1 | 6.1 | 6.8 | 6.2 | 7.5 | 8.1 | 9.5 | 6.8 | 7.0 | 6.5 | 67.1 |
| **National Average 2019** | | | 9.1 | 5.9 | 6.9 | 6.1 | 7.5 | 8.0 | 9.4 | 6.7 | 7.0 | 6.6 | 66.6 |

**KEY**

Above Average Score for this Group of Trusts

Average Score for this Group of Trusts

Below Average Score for this Group of Trusts

The Trust ranked 15th when benchmarked against the National Staff Survey themes for all organisations cross the South West (15th in 2019).

Great Western Hospitals
NHS Foundation Trust

# National Staff Survey 2020

## Great Western Hospitals NHS Foundation Trust

## Evaluation 2020/21 Action Plan & Draft Action Plan 2021/22

# Evaluation – Trust Action Plan 2020

Great Western Hospitals NHS Foundation Trust

| Objectives 2020/2021 | 2019 Result | 2020 Result | RAG Status |
|---|---|---|---|
| **Quality of Appraisals 5.2 (NA 5.5)**<br><br>**Desired Outcome: Target – to achieve a quality of appraisals score of 5.5** | | | |
| 19b Did it help you to improve how you do your job? | Due to Covid-19, these questions were not asked in the 2020 National Staff Survey and cannot be compared with the 2019 result | | |
| 19c Did it help you agree clear objectives for your work? | | | |
| 19d Did it leave you feeling that your work is valued by your organisation? | | | |
| 19e Were the values of your organisation discussed as part of the appraisal process? | | | |
| **Health and Wellbeing 5.8 (NA 6.0)**<br><br>**Desired Outcome: Target – to achieve a health and wellbeing score of 6.0** | | | |
| 11a Does your organisation take positive action on health and well-being? | 90.4% | 91.9% | |
| 11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? | 68.9% | 73.0% | |
| 11c During the last 12 months have you felt unwell as a result of work related stress? | 58.3% | 55.0% | |
| 11d In the last three months have you ever come to work despite not feeling well enough to perform your duties? | 44.1% | 53.2% | |
| **Morale, 6.1 (NA 6.2)**<br><br>**Desired Outcome: Target – to achieve a morale score of 6.2** | | | |
| 4c I am involved in deciding on changes introduced that affect my work area / team / department. | 52.6% | 51.0% | |
| 4j I receive the respect I deserve from my colleagues at work. | 75.5% | 69.9% | |
| 6a I have unrealistic time pressures. | 16.8% | 23.0% | |
| 6b I have a choice in deciding how to do my work. | 53.8 | 52.7% | |
| 6c Relationships at work are strained. | 45.8% | 49.5% | |
| 8a My immediate manager encourages me at work. | 72.4% | 70.0% | |
| 23a I often think about leaving this organisation. | 44.5% | 45.7% | |
| 23b I will probably look for a job at a new organisation in the next 12 months. | 53.0% | 55.3% | |
| 23c As soon as I can find another job, I will leave this organisation. | 63.1% | 60.5% | |
| **Quality of Care,7.1 (NA 7.5)**<br>**Desired Outcome: Target – quality of care score 7.0** | | | |
| 7a I am satisfied with the quality of care I give to patients / service users. | 74.2% | 78.4% | |
| 7b I feel that my role makes a difference to patients / service users. | 86.6% | 87.7% | |
| 7c I am able to deliver the care I aspire to. | 58.1% | 65.9% | |

# National Staff Survey - Trust

## 2021/22 Staff Survey Areas of focus

Great Western Hospitals NHS Foundation Trust

**Common Themes for both Trust Action Plan & Divisional priorities:**

1) **Immediate Manager/ Team working**
2) **Safe Environment (Harassment and Bullying)**
3) **Equality, Diversity and Inclusion**
4) **Quality of Care**
5) **Morale**

**Trust Oversight Plan – Emerging Divisional Specific Theme**

- **Health and Wellbeing**

# Action Plan 2021/22 (Emerging Themes)

Great Western Hospitals NHS Foundation Trust

The Trust Staff Survey action plan has common themes with the Divisional action plans except in the area of Health and Wellbeing, which emerges as an area of action required at Divisional level.

The health and wellbeing theme score improved significantly in 2020 to 6.2 when compared to 5.8 in 2019 and ranks above the national average of 6.1. The Trust performs better than the national average for:

- flexible working patterns
- staff perceived improvement in positive action on Health and Wellbeing, given investment and new leadership.

The Divisional action plans for 2020 present the requirement to continue to support staff in the following areas of health and wellbeing:

- Supporting staff with MSK issues;
- Taking positive action on health and wellbeing;
- Supporting those who feel unwell as a result of work-related stress;
- Sustaining opportunities for flexible working;
- Line manager supports and continues to include in team communication, all staff redeployed to another area;
- Mental health first aiders have protected time to complete training.

In addition the Trust is exploring options to undertake regular pulse check to ensure desired improvements are made – current options include staff friends and family, people pulse, go engage and culture barometer.

# Action Plan 2021/22 (Top Focus Areas)

Great Western Hospitals NHS Foundation Trust

| Trust Action Plan 2021/2022 | 2020 Result | Actions | Leads and Time Frame | Success Measure |
|---|---|---|---|---|
| **Immediate Manager/Team Working** | | | | |
| **Q8f - My immediate manager takes a positive interest in my health and well-being**<br><br>**Q4i - The team I work in often meets to discuss the team's effectiveness** | 2019 25%<br>2020 30.5%<br>NA 31.7% | Create management resource packs and toolkits to access the health and wellbeing service; | HWB Clinical Lead *July 2021* | ● Improve the Immediate Manager theme score to 7.3 - Best national average score for theme 2020. Current score 6.9 and national average 6.8.<br><br>● Implement HWB conversations and achieve 70% compliance within 6 months.<br><br>● 85% Appraisal Target met by every department<br><br>● Improve the Team working theme score to 7.1 - Best national average score for theme 2020. |
| | | Introduction of the Health and Wellbeing Conversation as an extension to the current risk assessment process. | Wellbeing Adviser *June 2021* | |
| | | Introduction of appraisal documentation to include Wellbeing conversation. Training to be updated and provided. | OD Lead *May 2021* | |
| | | Implement a Divisional briefing to replicate the concept of the CEO Senior Staff Briefing. | Divisional Tri *July 2021* | |
| | | Leaders and managers to own and cascade through annual appraisal objective setting the responsibility of every staff member to deliver the Divisional staff survey action plan | Divisional Tri/Senior Managers/Heads of Departments *April 2021* | |
| | 2019 61%<br>2020 55%<br>NA 56.7% | Implement and Promote the Trust Wellbeing plan (Circle of Support) | HWB Clinical Lead / Head of Communication *May 2021* | |
| | | As part of the Agile working group ensure that team meetings (virtual or otherwise) are run effectively, evaluate team needs met and produce guidance to disseminate the best practice. | Agile working group/HRBP *May 2021* | |

# Action Plan 2021/22 (Top Focus Areas)

Great Western Hospitals NHS Foundation Trust

| Trust Action Plan 2021/2022 | 2020 Result | Actions | Leads and Time Frame | Success Measure |
|---|---|---|---|---|
| **Safe Environment (Harassment and Bullying)** | | | | |
| **Q13a In the past 12 months how many times have you personally experienced harassment, bullying or abuse from patients, service users, their relatives or other member of the public?** | 2019 28%<br>2020 26%<br>NA 26% | Reintroduce the Zero Tolerance on staff abuse and harassment from patients. | Trust Comms and Patient Experience Lead *July 2021* | • Improve the Safe Environment (Violence) theme score to 9.8 - Best national average score for theme 2020. Current score 9.5 and national average is 8.5 |
| **Equality, Diversity and Inclusion** | | | | |
| **Q12c In the last 12 months how many times have you personally experienced physical violence at work from colleagues** | 2019 1%<br>2020 1.8%<br>NA 1.4% | Civility and Respect principles - adopt this as best practice across selected departments to improve staff experience<br>Just & Learning Culture - Introduce mediation and coaching training | OD Lead *May 2021* | • Serco security physical abuse incident reporting statistics<br>• Improve the Safe Environment (Harassment & Bullying) theme score to 8.7 - Best national average score for theme 2020. current score 8.1 and national average 8.1<br>• Achieve EDI objectives for year one as set out in the EDI strategy |
| | | Develop the wellbeing education programme to extend opportunity for preventative support training such as Mental Health First Aid Training and trauma incident management. | HWB Lead *April 2021* | |
| Q**13b In the past 12 months have you personally experienced discrimination at work from your manager, team leader or other colleagues?**<br><br>**The Trust score for BAME staff experiencing discrimination from Manager / team leader and/or colleague has deteriorated from 8.8% to 16%.* | 2019 6%<br>2020 6.3%<br>NA 6.2% | Implement the Trust EDI strategic aims including:<br>Introduce and pilot the reverse/reciprocal mentoring scheme to increase colleague awareness and understanding<br>Enhanced equality, Diversity and Inclusion training<br>Embed the Diversity Champion network and agenda to support staff to 'find their voice'<br>Develop community partnerships to enhance the EDI agenda - Stonewall. | EDI Lead *April 2021* | |
| | | Embed the principles of just and learning culture with civility and respect across the Division through business plan and ways of working. | Divisional Tri/OD lead *May 2021* | |
| | | Improve equality, diversity and inclusiveness of recruitment practice across the Trust. | Head of Resourcing and Recruitment *April 2021* | |

# Action Plan 2021/22 (Top 3 Focus Areas)

Great Western Hospitals NHS Foundation Trust

| Trust Action Plan 2021/2022 | 2020 Result | Actions | Leads and Time Frame | Success Measure |
|---|---|---|---|---|
| **Quality of Care** | | | | |
| **Q7a I am satisfied with the quality of care I give to patients/service users** | 2019 74%<br>2020 78.6%<br>NA 82% | Launch and implement the 'Great Care Campaign' | Deputy Chief Nurse *May 2021* | • Improve overall theme score to achieve national average of 7.5. Current score 7.3 and best score 8.1<br>• 100% success rate with the perfect ward accreditation scheme<br>• Move from the bottom 20% for care from the patient survey 2019 to top 20% |
| | | Deliver the improvement objectives of the work streams - Personalised Care, Harm Free Care, Improving the Environment, Expert Competent Care. | Deputy Chief Nurse | |
| | | Extend the success of the perfect ward and accreditation programme. | Deputy Chief Nurse *April 2021* | |
| **Staff Engagement / Morale** | | | | |
| The theme score has increased from 6.1 in 2019 to 6.2 in 2020 and equates to the National Average however further improvement still required across all question<br><br>Staff satisfaction with respect received from colleagues, motivation for their role with the organisation and feeling empowered to choose how to do their role. | 2019 63%<br>2020 69%<br>NA 74.3% | Further to the success of the 2019 initiative in SW&C, launch a Trust wide Ideas Programme to positively engage staff.<br><br>Staff Engagement and morale is intrinsically linked with successful achievement in all areas of this plan. Staff to feel supported with an extensive HWB programme, empowered to provide the quality of care they aspire to, work effectively with teams and colleagues with respect, civility and inclusion.<br><br>Promote the Mcleod and Clarke 'Enablers of engaging for success'' as part of management and leadership training | All Action leads/Divisional Tri's/PMO *July 2021*<br><br>OD Lead *June 2021* | • The Trust will improve its ranking from 15th in the regional comparison table.<br>• Improve recommending the organisation for a place to work from 64.5% to national average 66.9% and a place for care 69.6% to national average 74.3%<br>• Enabler for success measures –<br>Strategic leadership<br>Engaging Management<br>Employee voice<br>Organisation Integrity |

# Divisional Overview

# Divisional Comparison

| Theme | Corporate Services | | | Integrated & Community Care | | | Surgery, Women's & Children's | | | Unscheduled Care | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2020 Score | 2020 vs. 2019 | 2020 vs. National Average | 2020 Score | 2020 vs. 2019 | 2020 vs. National Average | 2020 Score | 2020 vs. 2019 | 2020 vs. National Average | 2020 Score | 2020 vs. 2019 | 2020 vs. National Average |
| Equality, Diversity and inclusion | 9.3 | ↑ | ↑ | 9.3 | ↓ | ↑ | 9.2 | ↑ | ↑ | 8.6 | ↓ | ↓ |
| Health and wellbeing | 6.5 | ↑ | ↑ | 6.3 | ↑ | ↑ | 6.0 | ↑ | ↓ | 6.1 | ↑ | → |
| Immediate managers | 7.5 | ↓ | ↑ | 6.9 | ↑ | ↑ | 6.6 | ↓ | ↓ | 6.9 | ↓ | ↑ |
| Morale | 6.3 | ↑ | ↑ | 6.4 | ↑ | ↑ | 6.1 | ↑ | ↓ | 6.1 | ↓ | ↓ |
| Quality of care | 7.0 | ↓ | ↓ | 7.4 | ↑ | ↓ | 7.2 | ↑ | ↓ | 7.4 | ↑ | ↓ |
| Safe Environment - Bullying and harassment | 8.6 | ↓ | ↑ | 8.3 | ↑ | ↑ | 7.9 | ↓ | ↓ | 8.0 | ↑ | ↓ |
| Safe Environment - Violence | 9.9 | ↑ | ↑ | 9.8 | ↓ | ↑ | 9.5 | ↓ | → | 9.0 | ↓ | ↓ |
| Safety culture | 6.7 | ↑ | ↓ | 6.7 | ↓ | ↓ | 6.8 | ↑ | → | 6.9 | ↑ | ↑ |
| Staff engagement | 7.0 | ↑ | → | 7.0 | ↓ | → | 6.9 | ↑ | ↓ | 7.0 | ↑ | → |
| Team working | 6.6 | ↓ | ↑ | 6.6 | ↑ | ↑ | 6.3 | ↓ | ↓ | 6.4 | ↓ | ↓ |

The Staff Survey was completed before and during the Divisional Restructure. The reports have been re-run to allow the new Divisions to review performance and look at opportunities for improvement.

# Staff Survey – Ownership & Oversight

# Reporting Cycle – proposed annual cycle

Great Western Hospitals NHS Foundation Trust

- **Q1 – (July 2021) – Divisional Boards** *(progress report) – Divisional Action Plans & Ownership – Led by HR Business Partner with Divisional Tri's*

- **Q2 – (October 2021) – Executive Committee –** *Executive Oversight & Ownership – Led by HRD and Divisional Leads*

*October to December Staff Survey Launched*

- **Q3 – (January 2022) Integrated Performance Boards –** *link between engagement & performance – Attendance and oversight HRD*

- **Q4 – (March 2022) – (Results and Progress) Executive Committee –** *Executive, Oversight & Ownership*

# Any questions?

# Appendix 1

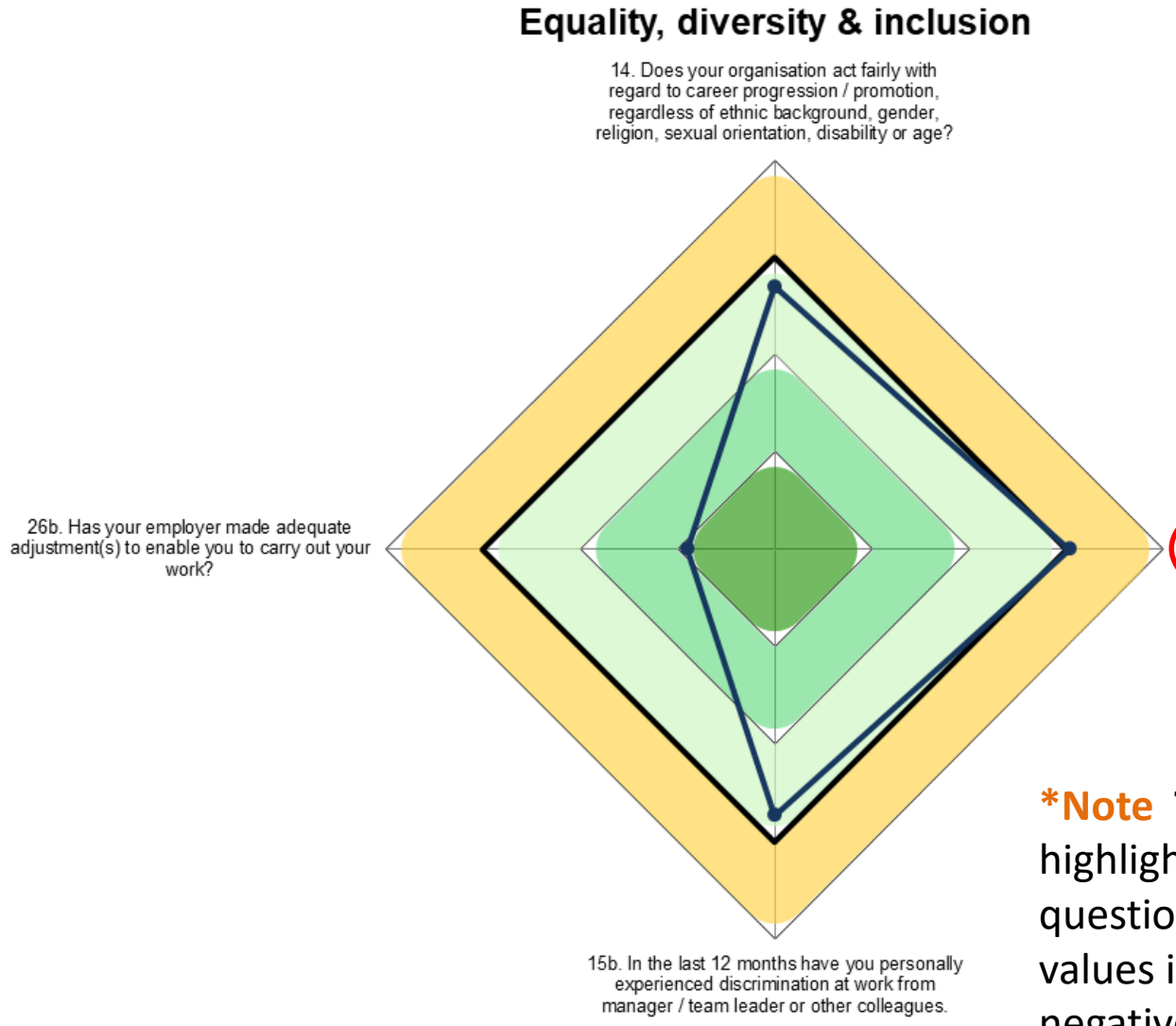
# Trust Staff Survey 2020 - Results Analysis

## Great Western Hospitals NHS Foundation Trust

## Detailed Analysis

# Theme – Equality, Diversity and Inclusion

Great Western Hospitals NHS Foundation Trust




- The EDI theme for the Trust is comparable with the national average.
- We are 6% better then the national average when it comes to making adjustments.
- Improvement work is required to be better than average with development of fair process for career progression and preventing discrimination.
- There has not been significant movement in scores when compared to the previous year.

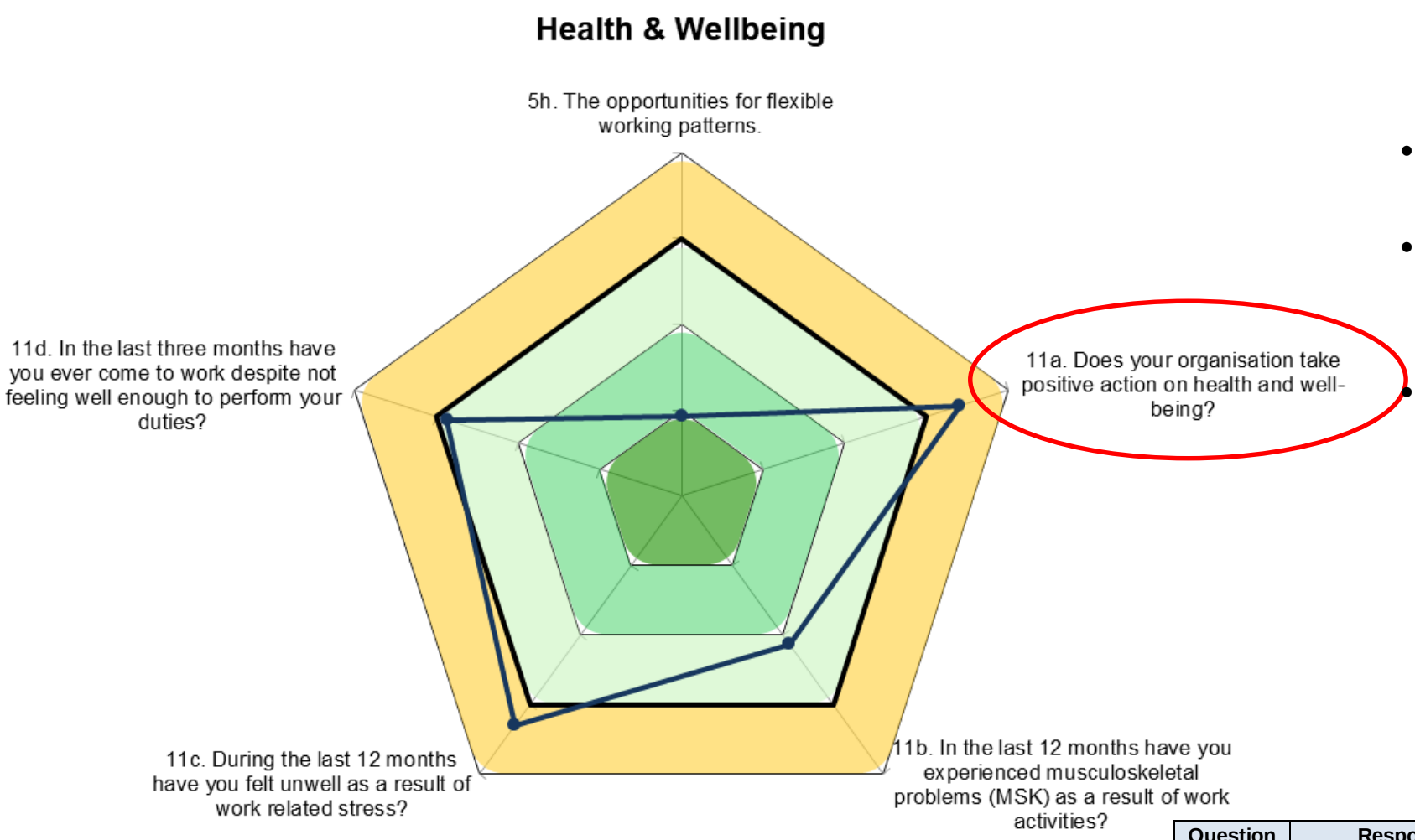
| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 14. | Yes | 85% | 85.8% | 84.9% | +0.9% |
| 15a. | Yes | 6% | 6.3% | 6.2% | -0.1% |
| 15b. | Yes | 4% | 7.1% | 7.9% | +0.8% |
| 26b. | Yes | 82% | 81.9% | 75.6% | +6.3% |

***Note** Themes: For highlighted questions, higher values imply negative impact

| |
|---|
| Between 9-12% better than the 2020 National Average for Acute and Acute & Community Trusts |
| Between 6-9% better than the 2020 National Average for Acute and Acute & Community Trusts |
| Between 3-6% better than the 2020 National Average for Acute and Acute & Community Trusts |
| Between 0-3% better than the 2020 National Average for Acute and Acute & Community Trusts |
| Between 0-3% worse than the 2020 National Average for Acute and Acute & Community Trusts |
| Between 3-6% worse than the 2020 National Average for Acute and Acute & Community Trusts |
| Between 6-9% worse than the 2020 National Average for Acute and Acute & Community Trusts |
| Between 9-12% worse than the 2020 National Average for Acute and Acute & Community Trusts |

# Theme - Health & Wellbeing

Great Western Hospitals NHS Foundation Trust

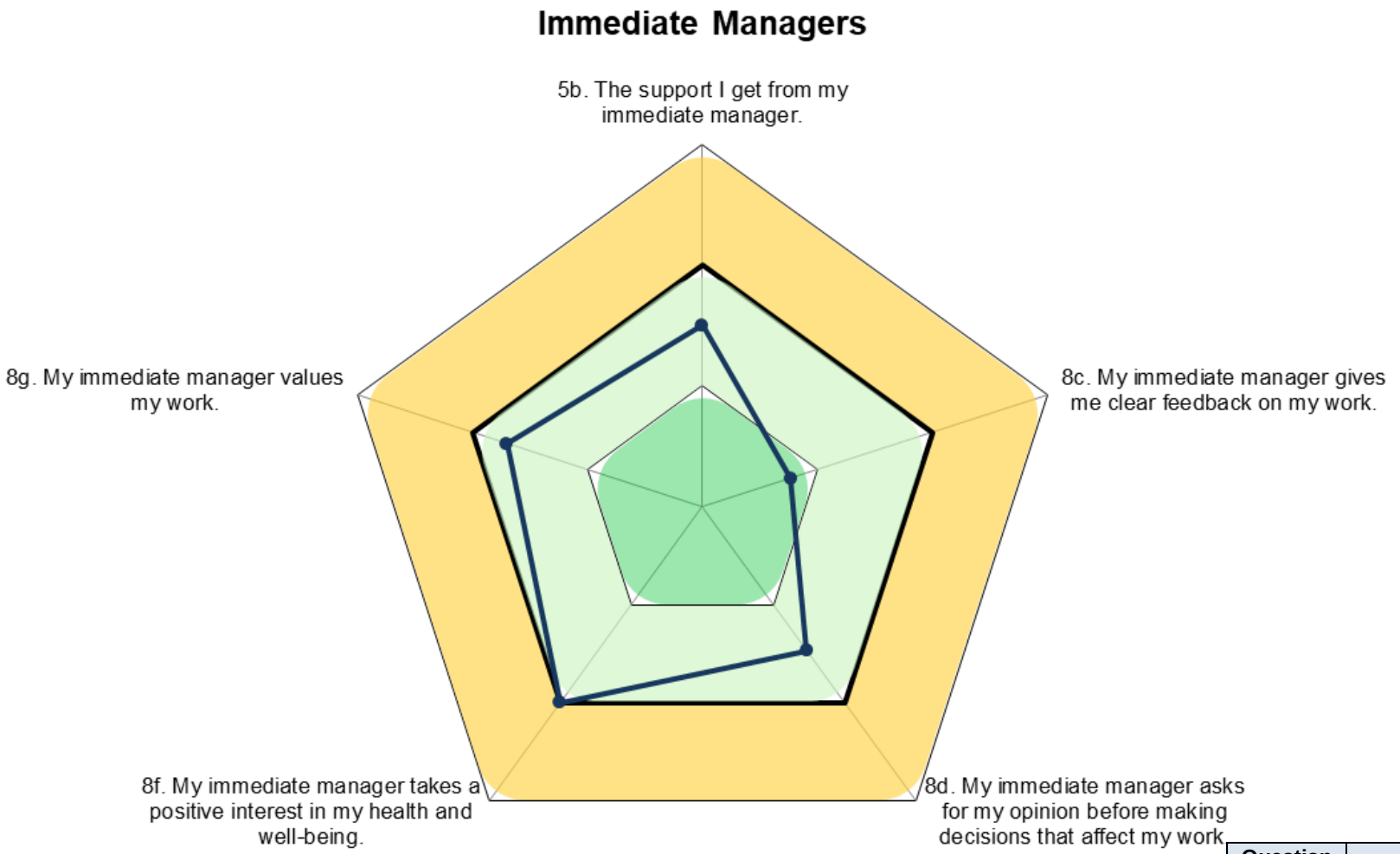



- Significant improvement when compared to last year.
- The Trust performs better than the national average for flexible working patterns.
- Focus attention this year to demonstrate the Trust takes positive action on Health and Wellbeing, given the recent investment and new leadership.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 5h. | Satisfied / Very satisfied | 55% | 61.7% | 55.5% | +6.2% |
| 11a. | Yes, definitely | 25% | 30.5% | 31.7% | -1.2% |
| 11b. | Yes | 31% | 26.2% | 28.8% | +2.6% |
| 11c. | Yes | 42% | 45.0% | 44.1% | -0.9% |
| 11d. | Yes | 56% | 46.2% | 46.6% | +0.4% |

# Theme - Immediate Managers

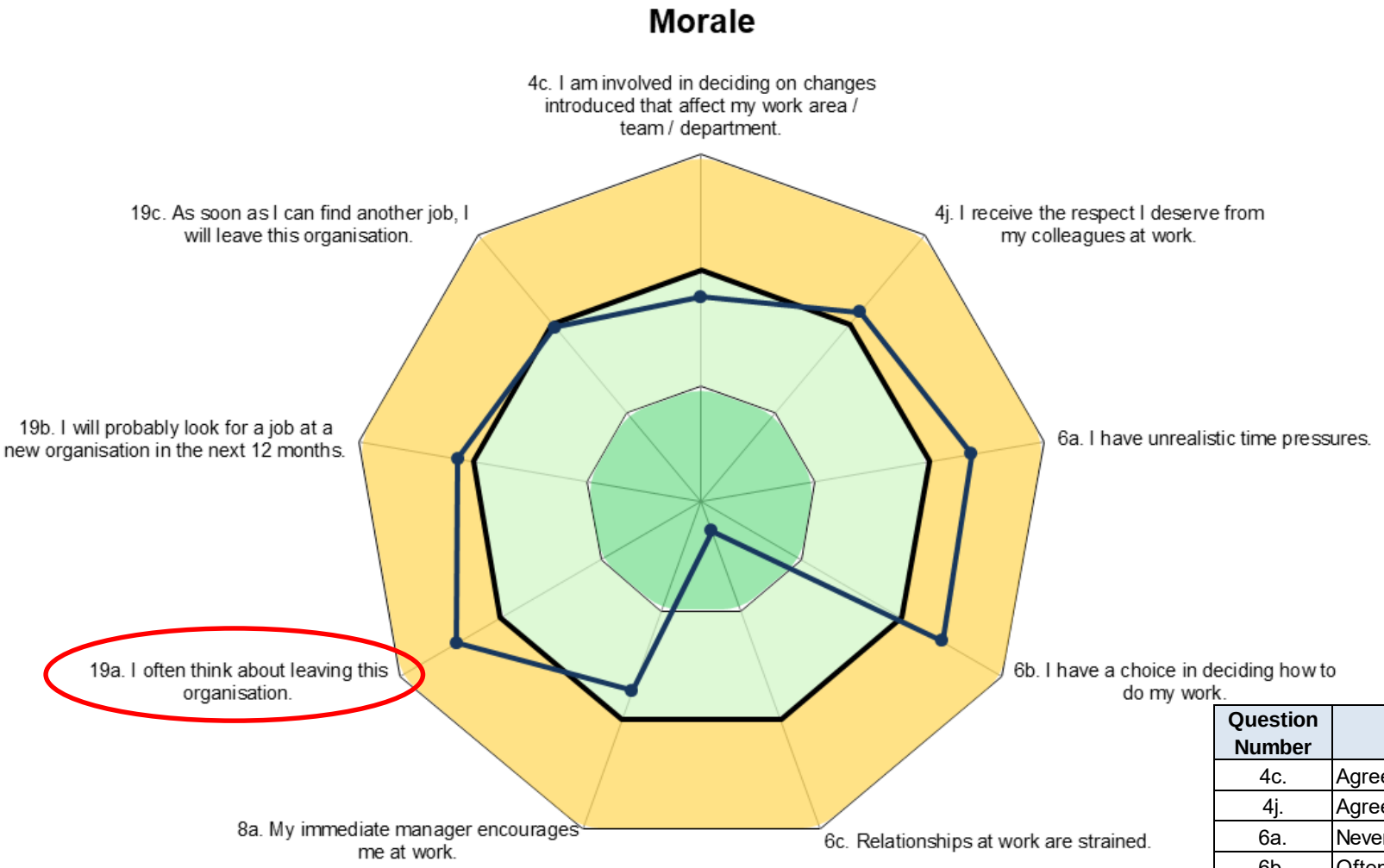
Great Western Hospitals NHS Foundation Trust




- Whilst there has been a small decline when compared to last year (not significant) the Trust still performed the same or better than the national average in all questions.
- Linked to the previous theme, the Trust should focus on immediate managers support for staff health and wellbeing.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 5b. | Satisfied / Very satisfied | 74% | 70.6% | 69.1% | +1.5% |
| 8c. | Agree / Strongly agree | 66% | 64.3% | 60.6% | +3.7% |
| 8d. | Agree / Strongly agree | 59% | 56.1% | 54.5% | +1.6% |
| 8f. | Agree / Strongly agree | 75% | 69.2% | 69.2% | +0.0% |
| 8g. | Agree / Strongly agree | 76% | 72.7% | 71.8% | +0.9% |

# Theme - Morale

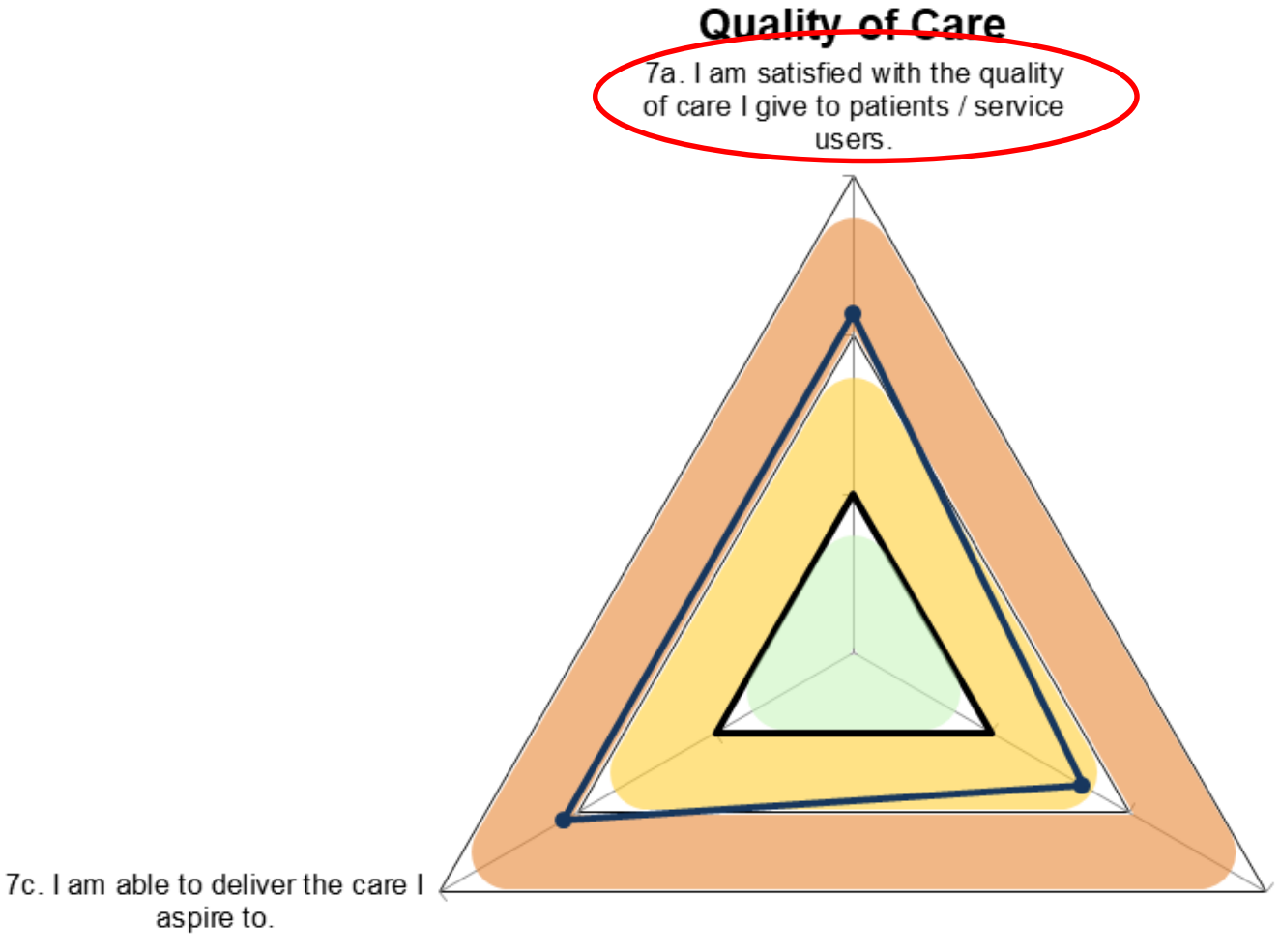



- The theme score has increased from 6.1 in 2019 to 6.2 in 2020 and is now performing the same as the national average.
- It is clear that staff feel they have strong relationships at work.
- This theme has shown improvement during a difficult year with Covid-19. Leadership development and engagement will support further improvement.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 4c. | Agree / Strongly agree | 53% | 51.0% | 50.3% | +0.7% |
| 4j. | Agree / Strongly agree | 76% | 70.0% | 70.4% | -0.4% |
| 6a. | Never / Rarely | 17% | 23.3% | 24.4% | -1.1% |
| 6b. | Often / Always | 54% | 53.1% | 54.3% | -1.2% |
| 6c. | Never / Rarely | 46% | 50.7% | 45.5% | +5.2% |
| 8a. | Agree / Strongly agree | 72% | 70.0% | 69.2% | +0.8% |
| 19a. | Strongly agree / Agree | 29% | 28.0% | 26.7% | -1.3% |
| 19b. | Strongly agree / Agree | 20% | 19.1% | 18.7% | -0.4% |
| 19c. | Strongly agree / Agree | 12% | 13.1% | 13.2% | +0.1% |

# Theme - Quality of Care

Great Western Hospitals NHS Foundation Trust

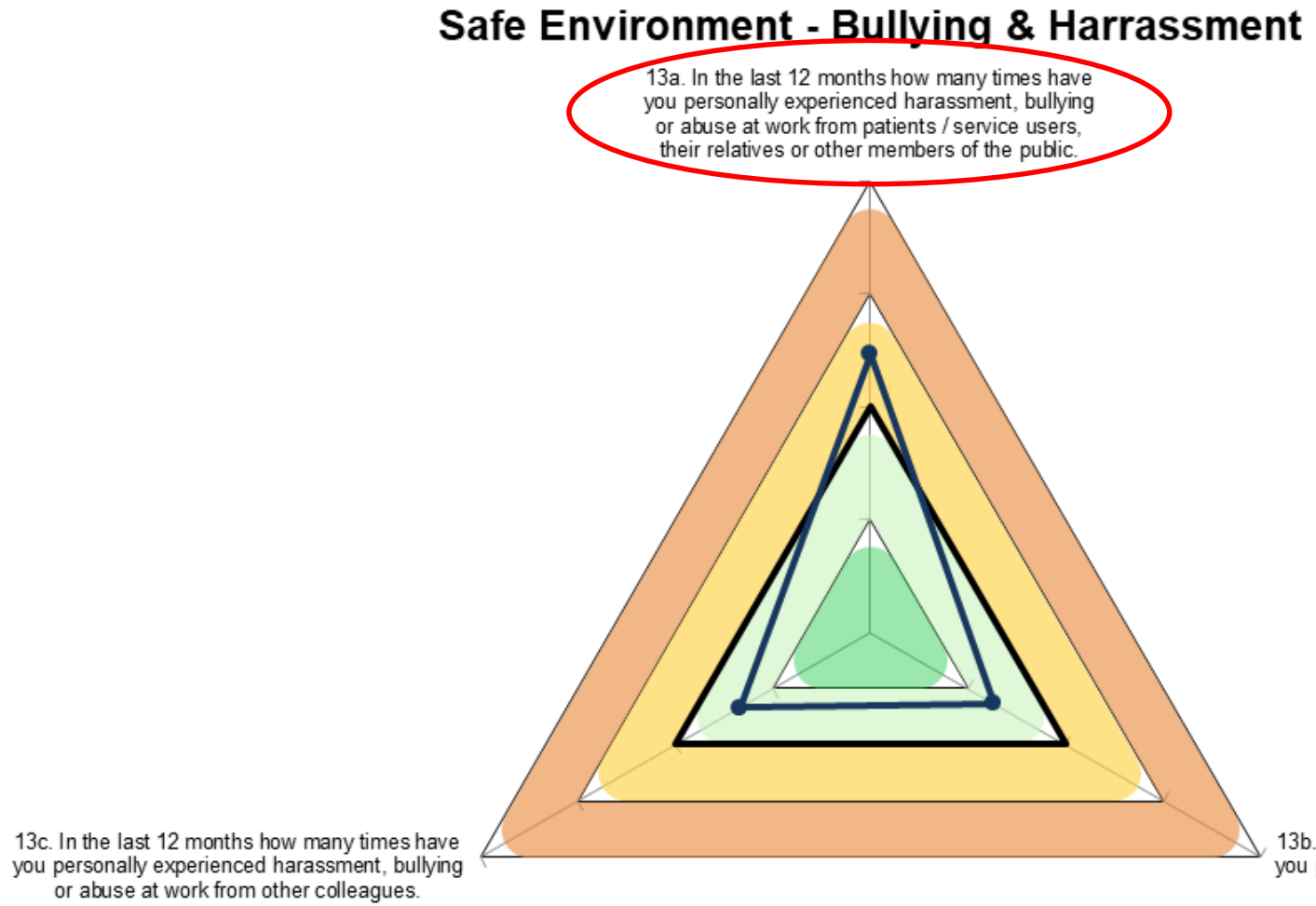



- This theme score has increased from 7.0 in 2019 to 7.3 which demonstrates strong improvement towards meeting and exceeding the national average this year.
- All scores have seen an improvement, when compared to last year and an 8% improvement in the question 'I am able to deliver the care I aspire to'.
- All questions remain slightly below the national average, however with continued focus in this area, the Trust should meet or exceed the national average this year.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 7a. | Agree / Strongly agree | 74% | 78.6% | 82.0% | -3.4% |
| 7b. | Agree / Strongly agree | 87% | 87.7% | 89.7% | -2.0% |
| 7c. | Agree / Strongly agree | 58% | 66.7% | 70.0% | -3.3% |

# Theme - Environment (Bullying & Harassment)

Great Western Hospitals NHS Foundation Trust




- This score remains comparable with the national average and no statistical change in scores.
- The Trust performance is stronger than the national average regarding bullying and harassment from colleagues and managers.
- The Trust performs slightly lower than the national average regarding bullying and harassment from service users/members of the public.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 13a. | Yes | 28% | 27.4% | 26.0% | -1.4% |
| 13b. | Yes | 8% | 10.4% | 12.6% | +2.2% |
| 13c. | Yes | 18% | 17.8% | 19.8% | +2.0% |

# Theme - Environment (Violence)

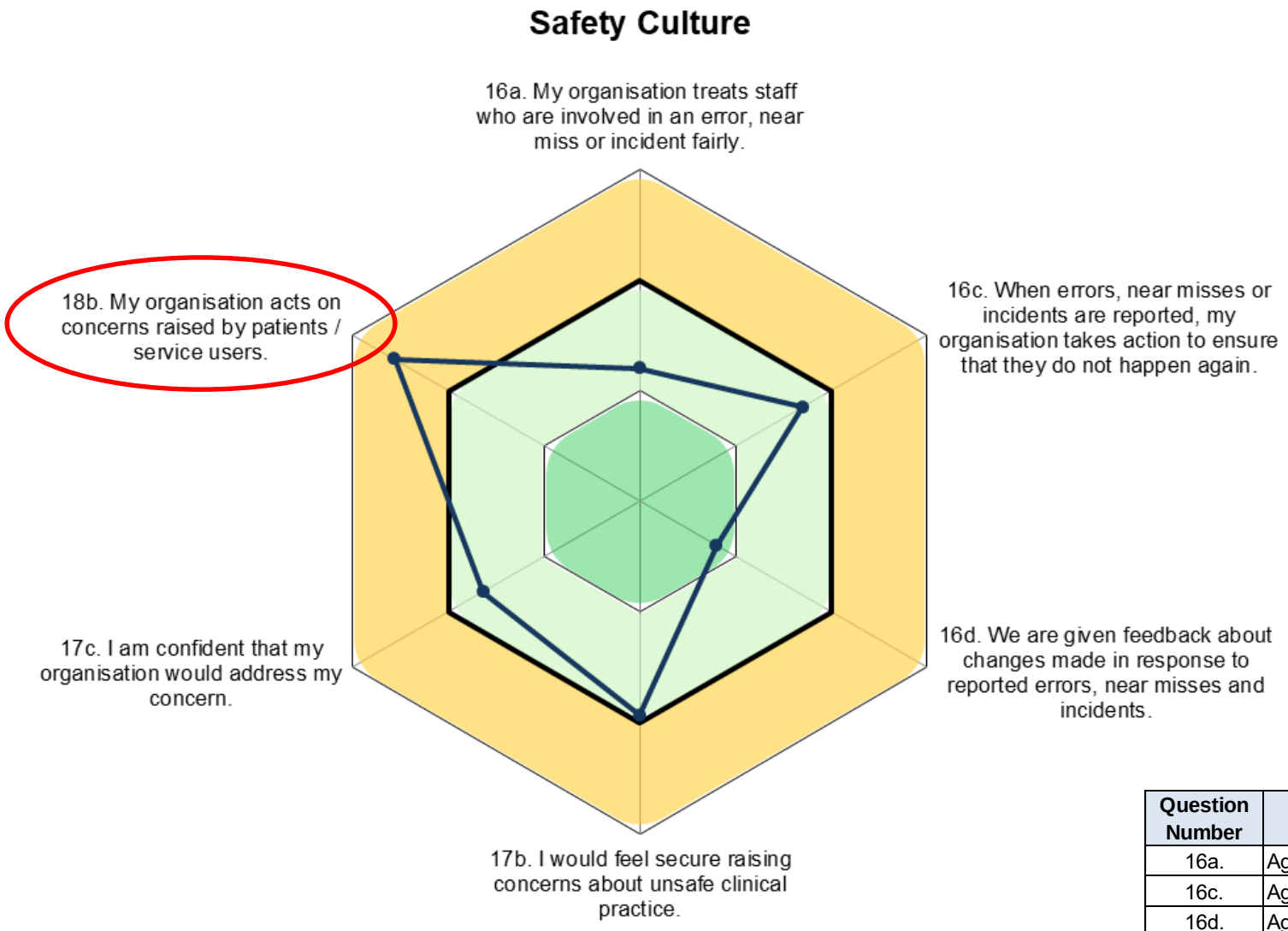
Great Western Hospitals NHS Foundation Trust


- The Trust theme has remained static and is comparable with the national average.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 12a. | Yes | 11% | 11.9% | 14.2% | +2.3% |
| 12b. | Yes | 1% | 0.3% | 0.5% | +0.2% |
| 12c. | Yes | 1% | 1.8% | 1.4% | -0.4% |

# Theme - Safety Culture

Great Western Hospitals NHS Foundation Trust

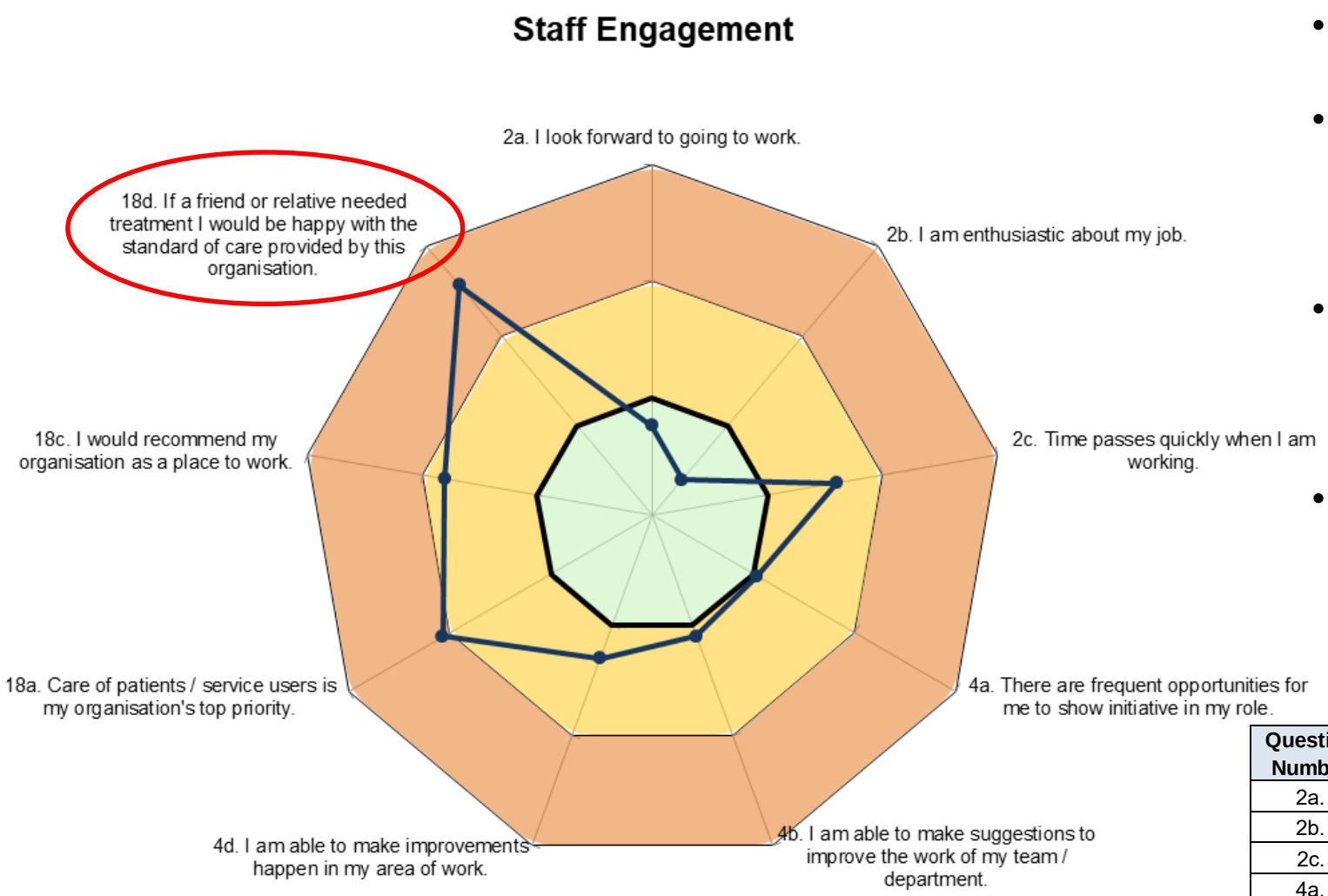



- The theme score remained at 6.8 which is the same as the national average score.
- There was a 3% decrease for feeling secure to raise concerns and a 2% decrease for confidence that concerns would be addressed.
- There was a small improvement for all other questions.
- The Trust broadly performed better than the national average.
- The Trust performance has increased by 3.6% which is better than the national average regarding feedback about changes made from errors reported.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 16a. | Agree / Strongly agree | 62% | 63.8% | 61.4% | +2.4% |
| 16c. | Agree / Strongly agree | 71% | 73.6% | 72.7% | +0.9% |
| 16d. | Agree / Strongly agree | 63% | 65.5% | 61.9% | +3.6% |
| 17b. | Agree / Strongly agree | 75% | 72.0% | 71.8% | +0.2% |
| 17c. | Agree / Strongly agree | 62% | 60.2% | 59.1% | +1.1% |
| 18b. | Agree / Strongly agree | 71% | 72.3% | 74.0% | -1.7% |

# Theme - Staff Engagement

Great Western Hospitals NHS Foundation Trust

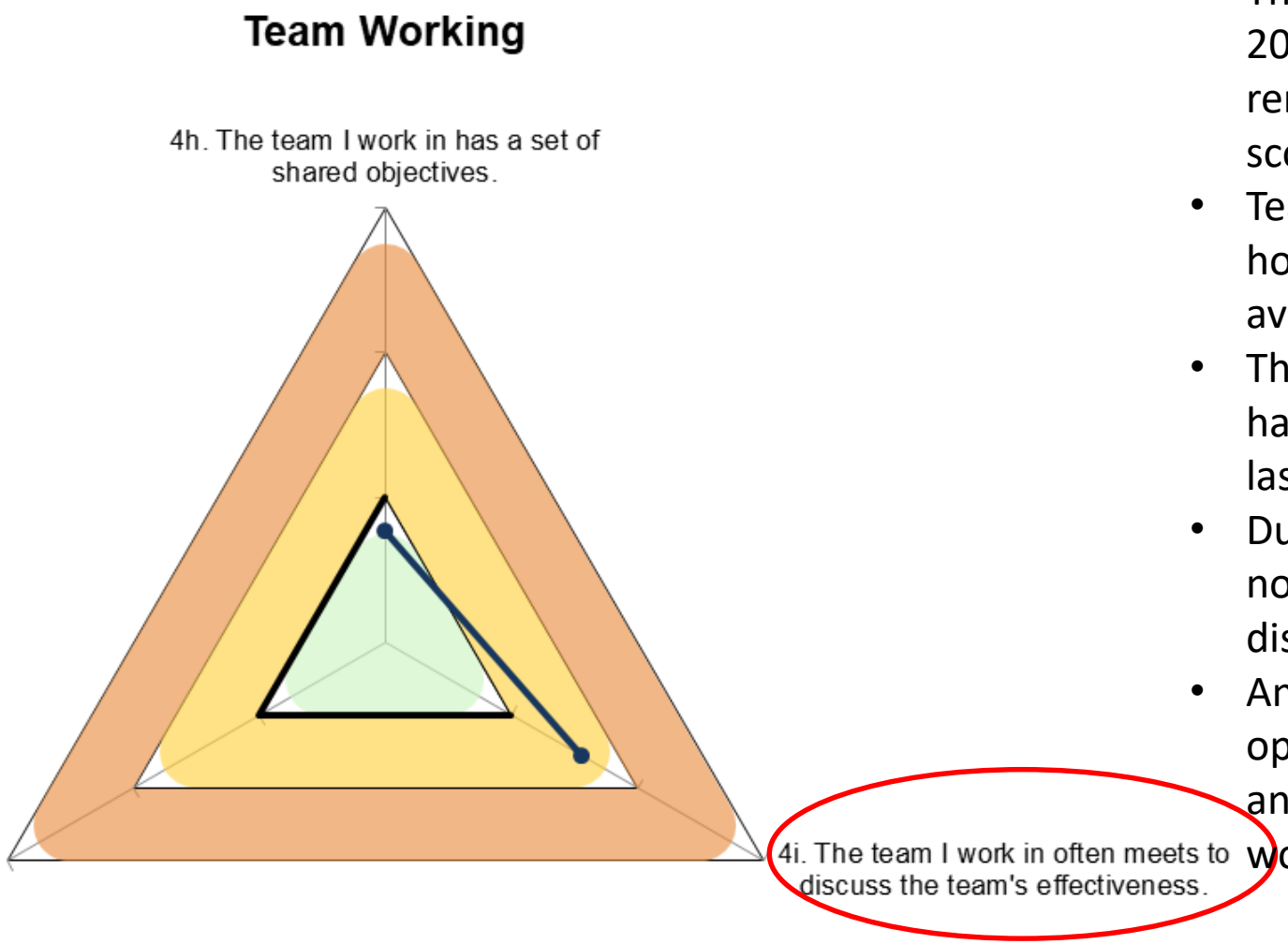



- The theme score remained the same at 7.0 and is in line with the national average score of 7.0.
- Since 2017 the Trust has achieved a 10% improvement when recommending the organisation as a place to work and is now only slightly below the national average.
- Since 2019 the Trust has seen a 6% improvement in recommending the organisation for treatment however still remains 4.7% below the national average.
- Recommending the organisation as a place to work and for treatment are the two key questions used when measuring engagement.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 2a. | Often / Always | 60% | 59.2% | 58.5% | 0.7% |
| 2b. | Often / Always | 76% | 74.9% | 73.1% | 1.8% |
| 2c. | Often / Always | 80% | 74.2% | 76.0% | -1.8% |
| 4a. | Agree / Strongly agree | 75% | 71.8% | 71.9% | -0.1% |
| 4b. | Agree / Strongly agree | 76% | 72.7% | 73.0% | -0.3% |
| 4d. | Agree / Strongly agree | 57% | 54.5% | 55.4% | -0.9% |
| 18a. | Agree / Strongly agree | 74% | 76.2% | 79.4% | -3.2% |
| 18c. | Agree / Strongly agree | 58% | 64.5% | 66.9% | -2.4% |
| 18d. | Agree / Strongly agree | 63% | 69.6% | 74.3% | -4.7% |

# Theme - Team Working

Great Western Hospitals NHS Foundation Trust




- The theme score has reduced from 6.7 in 2019 to 6.5 in 2020 however performance remains in line with the national average score (6.5).
- Team shared objectives has reduced by 3% however remains slightly above the national average.
- The team meeting to discuss effectiveness has also reduced by 6% when compared to last year.
- During the Covid-19 pandemic, teams may not have met regularly due to social distancing/shielding and working from home.
- An improvement area is to look at opportunities to maintain shared objectives and meet (virtually if required) to discuss work proactively and team effectiveness.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 4h. | Agree / Strongly agree | 75% | 72.3% | 71.6% | +0.7% |
| 4i. | Agree / Strongly agree | 61% | 55.0% | 56.7% | -1.7% |

# Extra Questions - Job Satisfaction

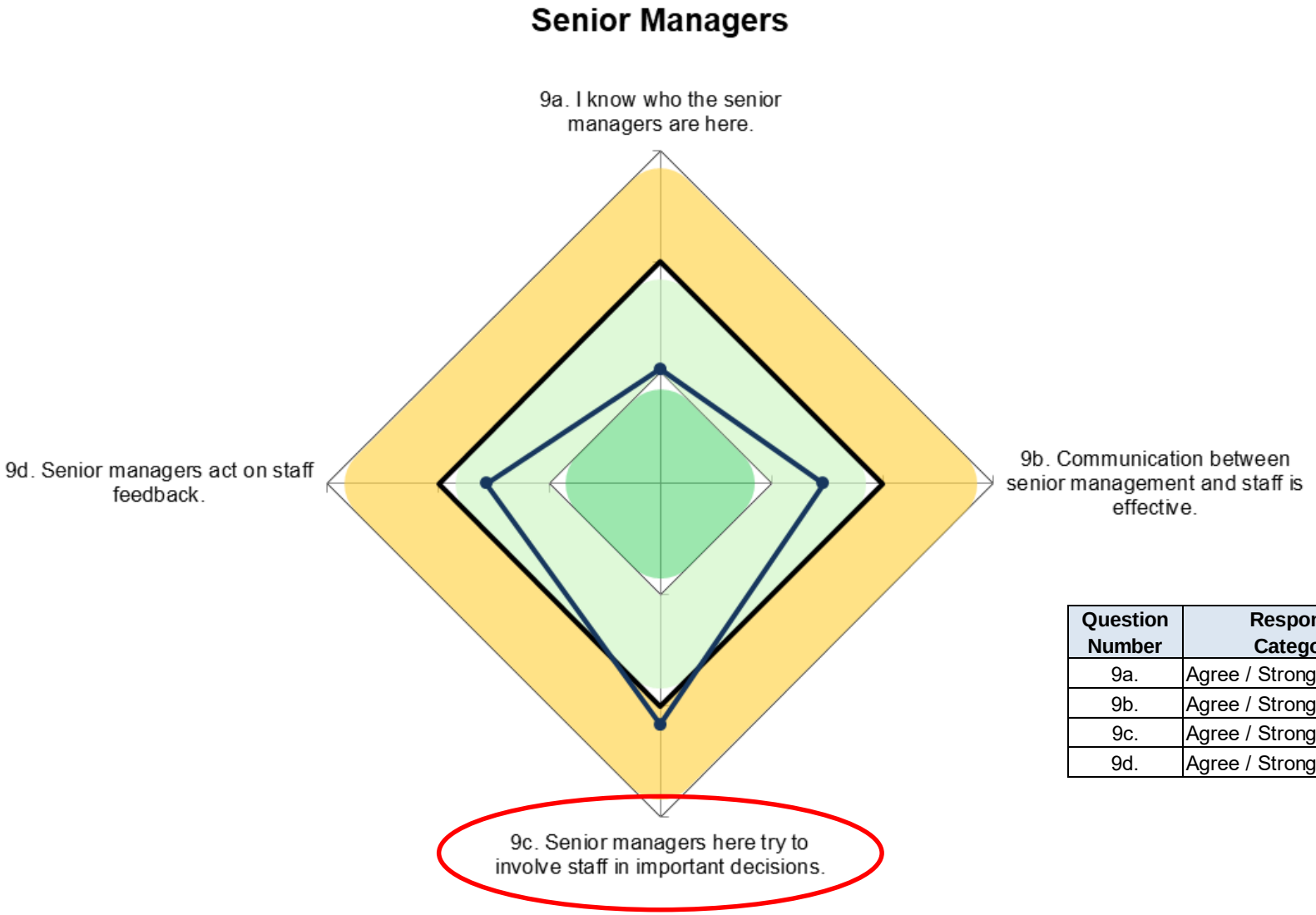
Great Western Hospitals NHS Foundation Trust


- These questions do not form part of the national theme reports.
- Majority of questions scored similarly to the national average.
- Two questions relating to enough equipment and enough staff to do their role properly both perform lower then the national average.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 3a. | Agree / Strongly agree | 91% | 85.7% | 86.5% | -0.8% |
| 3b. | Agree / Strongly agree | 92% | 91.5% | 91.2% | -0.3% |
| 3c. | Agree / Strongly agree | 75% | 79.9% | 80.6% | -0.7% |
| 4e. | Agree / Strongly agree | 36% | 44.1% | 47.6% | -3.5% |
| 4f. | Agree / Strongly agree | 41% | 50.7% | 58.5% | -7.8% |
| 4g. | Agree / Strongly agree | 21% | 30.5% | 37.0% | -6.5% |
| 5a. | Satisfied / Very satisfied | 56% | 57.7% | 56.3% | -1.4% |
| 5c. | Satisfied / Very satisfied | 86% | 81.1% | 80.7% | -0.4% |
| 5d. | Satisfied / Very satisfied | 75% | 74.6% | 74.3% | -0.3% |
| 5e. | Satisfied / Very satisfied | 73% | 71.4% | 71.7% | -0.3% |
| 5f. | Satisfied / Very satisfied | 42% | 45.2% | 47.0% | -1.8% |
| 5g. | Satisfied / Very satisfied | 33% | 35.9% | 36.1% | -0.2% |

# Extra Question Senior Managers

Great Western Hospitals NHS Foundation Trust

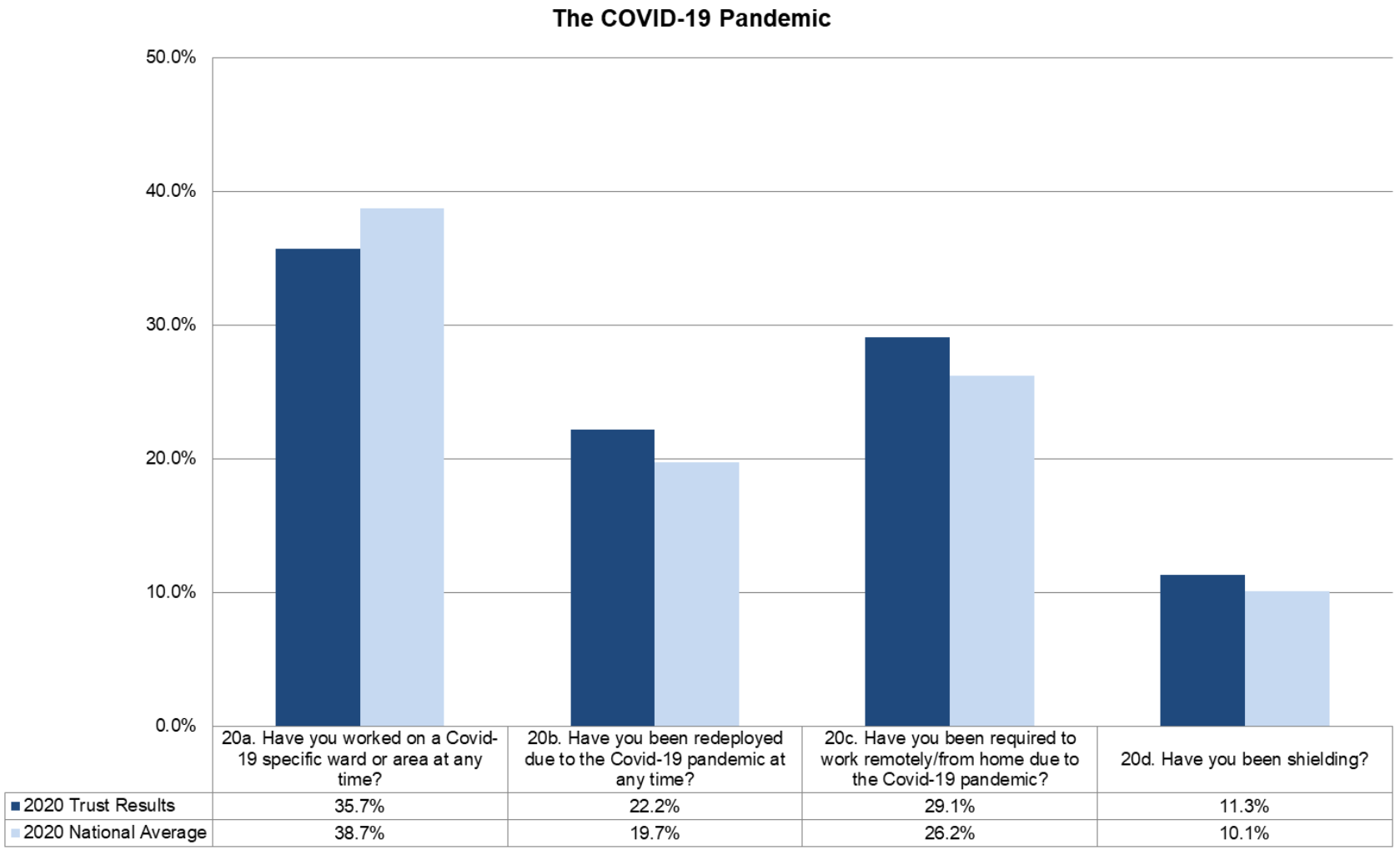



- Overall the Trust performs comparably to the national average.
- The Trust has improved by 6% compared to last year with regard to communication between senior management and staff being effective.

| Question Number | Response Category | 2019 Trust Results | 2020 Trust Results | 2020 National Average | Difference |
|---|---|---|---|---|---|
| 9a. | Agree / Strongly agree | 86% | 86.3% | 83.4% | -2.9% |
| 9b. | Agree / Strongly agree | 38% | 44.1% | 42.5% | -1.6% |
| 9c. | Agree / Strongly agree | 33% | 34.0% | 34.5% | +0.5% |
| 9d. | Agree / Strongly agree | 33% | 35.2% | 33.9% | -1.3% |

# COVID-19

Great Western Hospitals NHS Foundation Trust




| | 20a. Have you worked on a Covid-19 specific ward or area at any time? | 20b. Have you been redeployed due to the Covid-19 pandemic at any time? | 20c. Have you been required to work remotely/from home due to the Covid-19 pandemic? | 20d. Have you been shielding? |
|---|---|---|---|---|
| 2020 Trust Results | 35.7% | 22.2% | 29.1% | 11.3% |
| 2020 National Average | 38.7% | 19.7% | 26.2% | 10.1% |

- These questions were included for the first time in the staff survey in 2020 due to the Covid-19 pandemic.
- The questions are simple yes and no answers.
- The questions do not provide any insight into staff morale and engagement specifically related to Covid-19.
- All questions are comparable with the national average and it is clear that staff have worked flexibly during the pandemic.

# Gender Pay Gap

| Meeting | Trust Board | Date | 6th May 2021 |
|---|---|---|---|

**Summary of Report**

In order to meet its obligations under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, the Trust is required to publish gender pay gap data on a government website and the Trust website.

This paper summarises the results of the Gender Pay Gap analysis and background information.

The gender pay gap reporting uses six different standard measures which are;

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of males and females receiving a bonus payment
- The proportion of males and females in each quartile pay band

Gender pay gap reporting is required to be published by 30 March 2021 (for Public Sector Organisations) using a data snap shot from the 31 March 2020 (but note that due to the continuing impact of Covid-19, employers have an additional six months after the current reporting deadline to report their gender pay gap information). Staff employed by the Trust on this date includes GWH Acute Services, Swindon Community Health Services and Primary Care. The total number of staff included is 5160 with a split of 882 (17.09%) male and 4278 (82.91%) female.

Our findings and recommendations are in line with an independent review into gender pay gaps in medicine, commissioned by the Department of Health and Social Care. The report's main findings and recommendations are summarised in Appendix 1a, along with a link to that report, for further reference.

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

| | |
|---|---|
| **Executive Lead** | Jude Gray, HR Director |
| **Author** | Patrick Ismond, Equality, Diversity and Inclusion Lead |
| Author contact details | Patrick.ismond1@nhs.net; |

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

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| | | |

| | |
|---|---|
| **Legal / Regulatory / Reputation Implications** | Equality Act 2010<br>Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 |

**Link to relevant CQC Domain**

| Safe | | Effective | | Caring | | Responsive | | Well Led | x |
|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Link to relevant Trust Commitment** | |

**Consultations / other committee views**

Equality, Diversity and Inclusion (EDI) Group
Executive Committee
People Place and Performance Committee

**Recommendations / Decision Required**

***(a)*** **that the paper is noted**
***(b)*** **the information is agreed to be published as required (Subject to Board Approval)**

***(c)*** **that any further actions are agreed and documented**

## 1. What is in Our Report*

The purpose of a gender pay gap audit is to compare the pay of male and female employees and show the difference in average earnings. Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year (from April 2017). The areas of focus are:

- The median gender pay gap in hourly pay;
- The mean gender pay gap in hourly pay;
- The mean gender pay gaps for any bonuses paid out during the year;
- The median gender pay gap for any bonuses paid put during the year;
- The proportion of male and female staff that received bonus payments;
- The proportion of male and female staff in each quartile of the pay structure.

## 2. Our Gender Pay Gap Report 2021

Our Gender Pay Gap report for 2021 contains a number of elements:

- The specific information published on the government website for the snapshot date of 31st March 2020. The report will be published on the Trust website and on the relevant government website the following Board approval.
- A comparison with the 2019 figures.
- Existing and future recommended actions to reduce the Gender Pay Gap

## 3. Gender Pay Reporting and Equal Pay

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between males and females who carry out the same or similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman

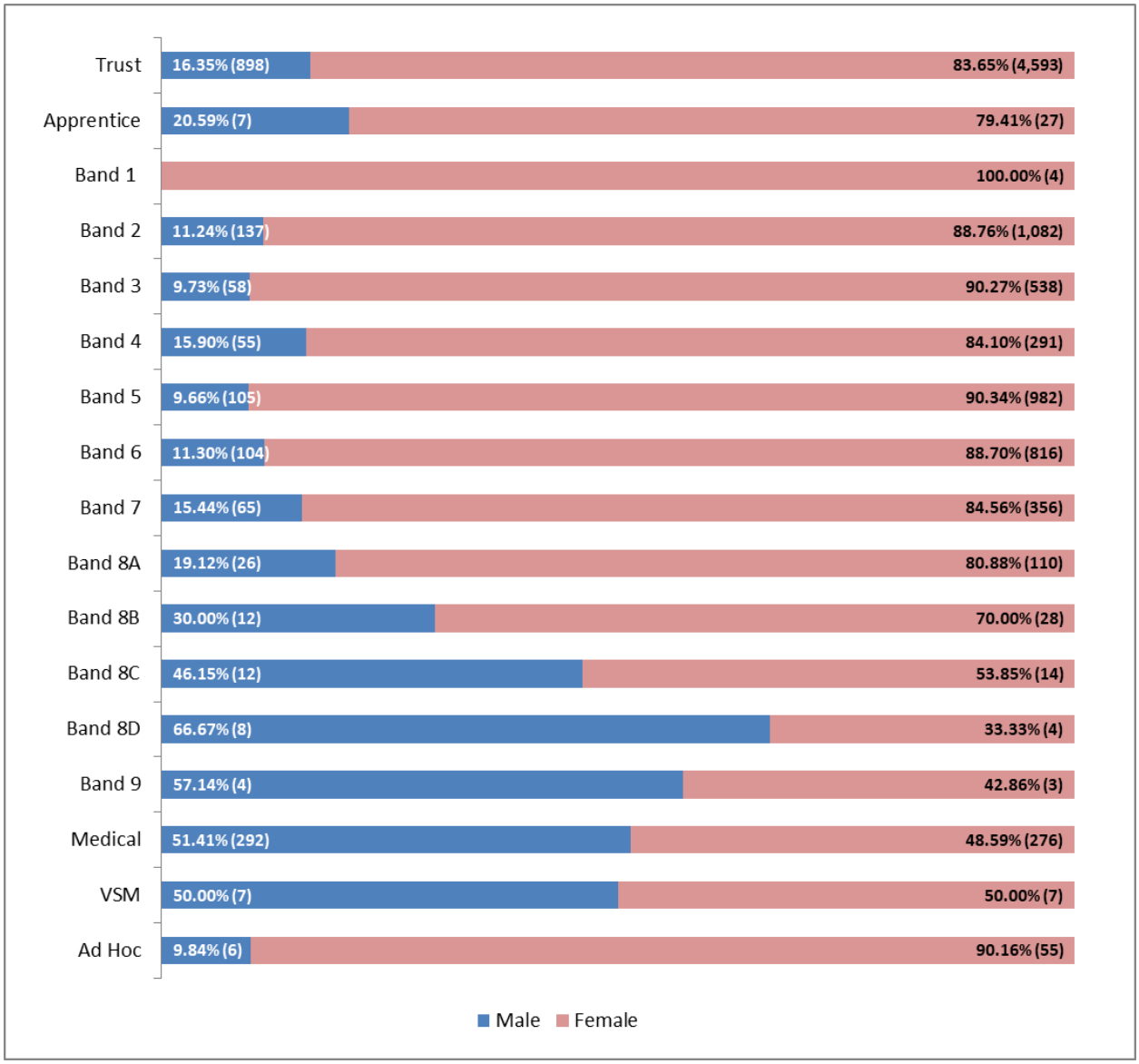
## 4. Gender Proportions at GWH as of 31 March 2020

At the time the snapshot was taken (31 March 2020), the Trust had 5160 employees/workers. The gender split is as follows:

| Gender | Headcount | Proportion of Workforce |
|---|---|---|
| Male | 882 | 17.09% |
| Female | 4278 | 82.91% |

## 5. Agenda for Change[1] Gender Breakdown

**The breakdown of the proportion of males and females in each banding is as follows.**




## 6. Mean Gender Pay Gap in hourly pay

**How is this calculated?**

The mean gender pay gap is the difference between the hourly pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce. A negative measure indicates the extent to which females earn more per hour, on average, than their male counterparts.

| | Mean Hourly Rate | | |
|---|---|---|---|
| | Year to 31/03/19 | Year to 31/03/20 | Difference (between 2019 and 2020) |
| Male | £23.03 | £22.91 | -£0.12 |
| Female | £15.67 | £16.11 | +£0.44 |
| Difference | £7.36 | £6.80 | -£0.56 |
| Pay Gap % | 31.99% | 29.66% | -2.33% |

Our Mean Hourly Pay Gap has **decreased**

## Excluding Medical and Dental Staff

| | Male | Female |
|---|---|---|
| Mean hourly rate of pay excluding Medical and Dental | £16.28 | £15.10 |
| % Mean GAP Ordinary Pay | ←7.30%→ | |

## What does our data tell us?

- Female staff are paid 29.66% less than male staff.
- The gap for the previous year's report was 31.99%, showing that the gap has decreased (improved).
- If medical and dental staff are excluded from the calculation then the mean average changes significantly, with females being paid 7.30% less than males, compared with 4.58% (in 2019) which is an increase (deterioration).

## % Mean Gap Ordinary hourly rate of pay

| Group/Band | Male | Female | Gap % This Year | Gap % Last Year |
|---|---|---|---|---|
| Apprentice | £5.16 | £5.34 | -3.51% | 1.25% |
| Band 1 | - | £9.03 | - | -9.20% |
| Band 2 | £10.57 | £10.87 | -2.86% | -4.67% |
| Band 3 | £10.49 | £10.70 | -1.95% | -0.48% |
| Band 4 | £11.43 | £11.84 | -3.64% | -2.93% |
| Band 5 | £14.78 | £15.75 | -6.55% | -10.54% |
| Band 6 | £18.49 | £19.38 | -4.80% | -3.48% |
| Band 7 | £21.94 | £21.94 | 0.00% | -2.58% |
| Band 8a | £24.52 | £24.67 | -0.63% | -1.05% |
| Band 8b | £29.01 | £29.86 | -2.93% | 1.31% |
| Band 8c | £34.77 | £33.19 | 4.55% | 2.54% |
| Band 8d | £41.97 | £43.16 | -2.85% | -5.33% |
| Band 9 | £49.81 | £47.65 | 4.33% | 2.87% |
| Medical | £36.30 | £31.19 | 14.07% | 21.42% |
| VSM* | £27.99 | £38.65 | -38.09% | -118.50% |

| | | | | |
|---|---|---|---|---|
| **Ad hoc** | £13.09 | £12.93 | 1.20% | 1.25% |

*Due to the TUPE transfer of Primary Care Services to the Trust in November 2019, there are staff on ad hoc terms and conditions as they TUPE'd across on their existing non-NHS terms and conditions of employment. This group are included in the ad hoc category of information.*

Disaggregated data shows that in the main females are paid more than males in each line, as illustrated by the figures in the second column from the right, table above. A negative measure (for example, a gap of -3.51 as indicated for the Apprentice group), indicates the extent to which females earn more per hour, on average, than their male counterparts.

**What else does the data tell us, when compared with last year?**

- The mean gender pay gap has been reduced for staff in Bands 2, 5, 7 and 8a; and for ad hoc and medical staff;
- Females now earn more than men at apprentice level and at Band 8b;
- The gender pay gap has increased for females at Bands 3, 4, and 6;
- There is an increase in the gender pay gap for males at Band 8c. Two of the 17 staff at this grade are males at the top of the pay scale, thus increasing the pay gap.
- There is an increase in the gender pay gap for males at Band 9 and 8C. The proportion of males at the top of the pay band is 80%. The majority of females (75%) are at a lower increment point.
- Although mean averages for females are higher than males for several of the Bands, the overall result is higher for males. This is due to a greater proportion of males in roles with higher pay: such as VSM, consultants, other medical, and Band 9.

## 7. Median Gender Pay Gap in hourly pay

NHS
Great Western Hospitals
NHS Foundation Trust

**How is this calculated?**

The median pay gap is the difference between the pay of the middle male and the middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

| | Median Hourly Rate | | |
|---|---|---|---|
| | Year to 31/03/19 | Year to 31/03/20 | Difference (between 2019 and 2020) |
| Male | £17.66 | £18.19 | +£0.53 |
| Female | £14.30 | £14.58 | +£0.28 |
| Difference | £3.36 | £3.61 | +£0.25 |
| Pay Gap % | 19.00% | 19.85% | +0.85% |

Our Median Hourly Pay Gap shows a slight **increase**

| Excluding Medical and Dental Staff | Male | Female |
|---|---|---|
| Median hourly rate of pay excluding Medical and Dental | £14.28 | £13.94 |
| % Median GAP Ordinary Pay | ←2.35%→ | |

**What does our data tell us?**

- Our median average pay gap has remained constant.
- If medical and dental staff are excluded from the calculation, the median average reduces significantly, and shows female's median gap is 2.35% less than males. Last year males median gap was 2.8% lower than females (-2.8%).
-

## % Median Gap Ordinary hourly rate of pay

| Group/Band | Male | Female | Gap % This Year | Gap % Last Year |
|---|---|---|---|---|
| Apprentice | £4.44 | £4.17 | 6.08% | 0.57% |
| Band 1 | - | £9.03 | - | -4.56% |
| Band 2 | £10.12 | £10.23 | -1.09% | -3.75% |
| Band 3 | £10.46 | £10.63 | -1.67% | -3.47% |
| Band 4 | £11.16 | £11.78 | -5.51% | -4.85% |
| Band 5 | £15.12 | £15.40 | -1.85% | -4.48% |
| Band 6 | £17.79 | £19.06 | -7.14% | -6.10% |
| Band 7 | £21.98 | £22.38 | -1.82% | -2.72% |
| Band 8a | £24.47 | £24.71 | -1.00% | 0.48% |
| Band 8b | £28.49 | £30.86 | -8.30% | 7.56% |
| Band 8c | £35.29 | £33.07 | -6.29% | -7.10% |
| Band 8d | £41.68 | £44.33 | -6.36% | -10.17% |
| Band 9 | £50.55 | £47.99 | 5.06% | -17.52% |
| Medical | £38.29 | £28.93 | 24.45% | 21.91% |
| Ad hoc | £10.00 | £11.28 | -12.80% | See[2] |
| VSM[3] | £7.26 | £52.65 | -625.21% | -153.79% |

*Due to the TUPE transfer of Primary Care Services to the Trust in November 2019, there are staff on ad hoc terms and conditions as they TUPE'd across on their existing non-NHS terms and conditions of employment. This group are included in the ad hoc category of information.*

Disaggregated data shows that in the main, females are paid more than males in the majority of the lines, as illustrated by the figures in the second column from the right, above table. The medical staff line includes all training grades, staff/career grade and consultants, doctors and dentists.

The VSM and Non-Executive line shows a large difference due to the much smaller salary that Non-Executive Directors are paid (five male, three female).

**What else does the data tell us, when compared with last year?**

- The median gender pay gap has been reduced for staff in Bands 2, 3, 5, 7;
- The median average is more for females in Bands 8a, 8b;
- The median average is more for females in Bands 8c and 8d, although the gap has been reduced;
- The female mean average is more for females than males at Bands 4, 6, and VSM level, and the gap has increased;
- The median average is more for males than females at Band 9
- The male median average remains higher than for females in medical and apprentice grades, and the gap has increased.

- The VSM and Non-Executive line shows a large difference due to the much smaller remuneration that Non-Executive Directors (NEDs) are paid and there is a higher proportion of NED males.

## 8. Bonus Gender Pay Gap as a Mean Average

NHS
Great Western Hospitals
NHS Foundation Trust

**What is included in bonus payments?**

- One-off recruitment and retention payments (in place for hard to recruit to roles).
- Incentive payments (for hard to fill shifts).
- Medical and dental staff's Clinical Excellence Awards, Discretionary Points and Distinction Awards. In this year, as a result of the pandemic, there was a national change to local Clinical Excellence Awards (CEA). All funding was evenly distributed between the eligible consultants (there were 154) instead of running a full CEA round, to allow focus on Clinical Work. Of the 154 Consultants who received the payments, 54 were female and 100 male.

| | Male | Female | Gap % (this year) | Gap % (last year) |
|---|---|---|---|---|
| % Mean GAP Bonus Pay | £7,269.63 | £801.49 | 88.97% | 88.63% |
| % Median GAP Bonus Pay | £3,092.00 | £480.00 | 84.48% | 84.62% |
| % Receiving Bonus (this year) | 10.62% | 16.40% | | |
| % Receiving Bonus (last year) | 19.05% | 21.70% | | |

**What does the data tell us?**

- That there is a significant difference between male and female pay mainly due to consultants receiving Clinical Excellence Awards, Discretionary points and Distinction Awards.
- A higher number of senior consultants earning higher value clinical excellence awards are male. At the highest consultant grade for example, 62.61% of staff are male, compared with 47.8% for all Medical & Dental roles.
- To understand the bonus pay gap further, we looked at non-medical bonus payments. If we categorise these as small, medium and large, then the proportion of males receiving any type of bonus was lower than last year. For example, the proportion of males receiving the middle bonus payments reduced by 14%, (18.09% to 3.57%).

**Bonus Pay (excluding medical and dental staff)**

| | Male | Female | Gap % | LY Gap % |
|---|---|---|---|---|
| % Mean GAP Bonus Pay | £393.68 | £508.75 | -29.23% | 29.24% |
| % Median GAP Bonus Pay | £165.00 | £420.00 | -154.55% | 33.33% |
| % Receiving Bonus Pay (this year) | 6.41% | 16.91% | | |
| % Receiving Bonus Pay (last year) | 16.57% | 22.62% | | |

**What does the data tell us?**

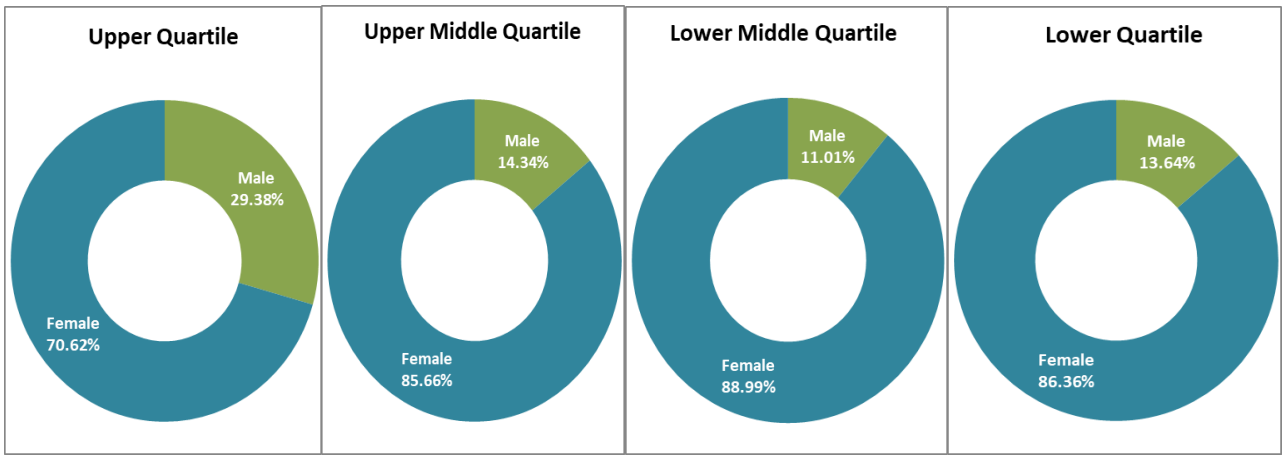
- If medical and dental staff are excluded from the calculation, the gender pay difference significantly reduces.
- However, the bonus pay gap between males and females remains high due to incentive payments.
- Incentive payments are the same for males and females.
- The median bonus pay gap has changed and is now significantly higher for females. Our incentive payments were reviewed around 18 months ago. Following the review, ad hoc

sessional payments were stopped, and the incentives were more focused on nursing which is a large and majority female workforce. Prior to the review, it is possible that high sessional/waiting list payments for male staff may also have had an impact on this figure.

## 9. Proportion of Males and Females in each Quartile

Quartiles are calculated by ranking all of our employees from highest to lowest paid, dividing this into four equal parts (quartiles) and working out the percentage of males and females in each of the four parts. Due to the proportion of doctors in the Upper Quartile, there is a decrease in the proportion of females in comparison to the other quartiles.

The Trust has a high proportion of females at Trust Board executive level, and Senior Management level. If medical staffing is excluded from the Upper Quartile, the proportion changes to 14.80% Male and 85.20% Female, which is more comparable to the other quartiles.




| | | | |
|---|---|---|---|
| 911 female staff | 1,105 female staff | 1,148 female staff | 1,114 female staff |
| 379 male staff | 185 male staff | 142 male staff | 176 male staff |

## 10. Gender Pay Gap Summary

NHS
Great Western Hospitals
NHS Foundation Trust

***Gender Proportions demonstrate more***

***Female than Male staff***

***Mean Average Hourly Pay has improved and is 29.66% higher for Males than for Females. This reduces to 7.30% when medical staff are excluded, but is an increase on last year's figures.***

***Median Average Hourly pay is higher for Males (the gap reduces to 2.35% when medical staff are excluded)***

***Proportionally there are more female staff receiving 'bonuses', though the amount is higher for males than females***

***Female staff are proportionately higher in hourly rates across all quartiles.***
***Male staff proportions are highest in the Upper Quartile of higher paid staff when you include medical staff.***

***The pay gap has increased for males in some Bands, and has increased for females in some Bands.***

## Conclusion

NHS
Great Western Hospitals
NHS Foundation Trust

Whilst we have made progress in reducing the gender pay gap between males and females across the majority of our bands, others have widened or remained constant. For example, the median gender pay gap has been reduced for staff in Bands 2, 3, 5 and 7; and increased for apprentice staff and those at Band 8b.

It should also be acknowledged that some elements of our gender pay gap have a historical /national context which will take a period of time to resolve. Over the last two years there has been a slight reduction in the overall pay gap. This amounts to 2.33%. At the same time, we have seen that females are paid more than males across some of the pay bands.

As can be seen from the above data, removing medical and dental staff from our calculations significantly lowers the gender pay gap. For this reason, our action plan will focus on
Medical grades that most affect the pay gap, and any barriers to progression.

**Notes**

**1 Agenda for Change: The NHS Pay Structure**

Agenda for Change was implemented to harmonise pay scales and career progression arrangements in the NHS, to ensure that there is equity and transparency in relation to pay arrangements. This is reflected in the Trust gender pay gap reporting which identifies a 7.30% gap (excluding medical staff).

The majority of staff are on NHS terms and conditions. Most staff are on the national Agenda for Change Terms and Conditions of Service which uses 9 pay bands and staff are assigned to one of these on the basis of the NHS Job Evaluation Scheme. Within each band there are a number of incremental pay progression points.

The largest disparity is within medical staffing and the Trust acknowledges that there could be greater female representation in the consultant workforce and this is reflected nationally. Nationally action has been taken to increase the number of female trainees, however the impact of this will take a number of years. This discrepancy is reflected in the Trust Action Plan which focuses on closing the gap for medical staffing.

Within the NHS there are also national Medical and Dental terms and conditions of service. Depending upon seniority there are a number of pay scales for basic pay. There are separate terms and conditions for Very Senior Managers, such as Chief Executives and Directors, which is based on benchmarking information and agreed by Remuneration Committee.

As an NHS Trust, our services are provided on a 24/7 basis, and therefore staff that work unsocial hours, participate in on-call rotas and work on general public holidays will often receive enhanced pay in addition to their basic pay. This mainly applies to clinical staff and non-clinical senior managers who undertake Senior Manager on-call duties, and non-clinical staff who provide 24/7 services such as Estates and IT.

## Appendix 1:
## What we are doing and planning to do, to address the gender pay gap

NHS
Great Western Hospitals
NHS Foundation Trust

**What we have achieved in the last 12 months:**

We produced an action plan to address the gender pay gap. The delivery of parts of the action plan (for instance, our commitment to ensuring that all clinical staff involved in recruitment decisions are trained in equality and diversity) has been affected by our response to the treatment and spread of the Covid-19 virus. In brief:

- We have a more gender balanced recruitment panel for all consultant and senior medical staffing positions. All senior interviews are now monitored, and currently 44% of panel members for these interviews are female.
- Our consultants are encouraged to apply for the National Clinical Excellence Awards, and there have been significant changes to the gender mix of staff receiving these in 2020. The Trust currently has three female and one male consultant in receipt of National Awards, with one female consultant holding a prestigious Silver award.
- This year, local award payments were evenly distributed amongst all eligible candidates, 65% males and 45% females received an equal share of the award payments

**Appendix 1a:**

A summary of *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England*

The above titled report found substantive gender pay gaps for hospital doctors, GPs and clinical academics, even when statistical methods were used to create hypothetical like-for-like comparisons of men and women across hours worked, grade, experience and specialty.

The report's analysis showed that the causes of these pay gaps were explained by several factors. For example:

- Women being more likely to work less than full-time (LTFT), which helps to explain why their pay is lower. Periods of LTFT working were seen to have long-term implications for women's career and pay trajectories as they reduced their experience and slowed down or stalled their progress to senior positions.

- Men reporting as working more unpaid overtime, which meant their effective pay was overstated.

- Men doctors more likely to be older, have more experience and hold more senior positions.

- Among hospital doctors, gaps in *total pay* – which includes Clinical Excellence Awards (CEAs), allowances and money from additional work – are larger than gaps in basic pay alone.

Following these findings, the report made several recommendations. These included:

- A review of pay-setting arrangements. Among hospital doctors, this would mean using fewer scale points and increased use of job evaluation, to ensure that gaps related to grade are justified.

- Increased transparency around additional allowances and individually negotiated pay (for example, for locums or waiting list initiatives).
- Monitoring the gender split of applications for CEAs;
- Changing the criteria to recognise excellent work in a broader range of specialties; and encourage more applications from women.
- Promoting flexible working for both men and women
- Advertising all jobs as available for LTFT.
- Reconsidering the structure of LTFT training, so that it focuses on competency not time served, to help reduce long-term career penalties.

**Further reading:**
**Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England**

**What we are planning to achieve in the next 12 months:**

Appendix 1b details our action plan going forwards. Our findings broadly align with the afore referenced independent review, and our action plan in part reflects the report's recommendations. For example, the report recommended increased transparency around additional allowances and individually negotiated pay; and monitoring the gender split of applications for Clinical Excellence Awards. We already promote flexible working for both men and women.

**Appendix 1b: Our Action Plan going forwards:**

| Objective | Action | Lead | Timescale | Desired Outcome |
|---|---|---|---|---|
| Better promotion of our senior vacancies to women and organisations that support women, including Medical and Dental vacancies. | Review of recruitment adverts for possible unconscious bias and gender specific terms, in particular for Medical and Dental vacancies. By:<br>• Selecting a sample of medical and dental job descriptions across a range of senior roles, to provide a snapshot;<br>• Working with partners to examine any evidence of unconscious bias in job descriptions or use of gender-specific language used that may deter female applicants.<br>• Guidance provided for changing wording of adverts, to further encourage female applicants.<br><br>Review of other print and social media outlets for placing job adverts, in addition to ones we already use. | EDI lead, supported by Medical HRBP and Head of Resourcing | October 2021 | A 10-15% increase in the number of female applicants for higher banded roles.<br><br>Reduction in pay gap within Bands 8c and 9. |
| Ensure that grades contributing to the pay gap are reduced and barriers to progression removed. | Put a process in place for Bands 8c and 9 to ensure equality for male and females for progression.<br><br>Consider implementing a formal governance process Executive Sign Off for payments outside AFC | EDI, supported by Head of Resourcing | May 2021 | Reduce gender pay gap across Bands 8c, and 9 |

| | | | | |
|---|---|---|---|---|
| Reduce barriers to progression. | Evaluate and promote support to female consultants to encourage an increase in applications for local Clinical Excellence Awards.<br>• Collaborate with partners to devise a new or review existing 'perception/reality' surveys;<br>• Distribute survey to a sample of senior staff (male and female) who are eligible for CEAs;<br>• Analyse results to see if these indicate a mismatch between candidates perception of their abilities, and reality, by gender;<br>• Determine next steps/ measures to put in place depending on findings. | EDI lead and HR BP for Medical Workforce | November 2021 | An increase in the number of applications for CEAs from female Consultants.<br><br>Qualitative data to better understand and reduce barriers to progression. |
| Ensure that grades contributing to the pay gap are reduced and barriers to progression removed. | Determine if other protected characteristics affect the gender pay gap.<br><br>Expand review on gender pay gap to include data on religion, sexuality, disability and 'race' Review this data across a range of occupations and directorates.<br><br>As part of WRES/DES, expand on actions that may impact on gender pay. | EDI lead, HR Business Partner and Head of Workforce Intelligence | September 2021 | Addressing the mixed picture as it exists across our Bands and reducing the gender pay gaps.<br><br>A better understanding of where the pay gaps are bigger, and gain more insight to plan further actions. |

**Appendix A – Equality Impact Assessment**

# Equality Impact Assessment

## Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

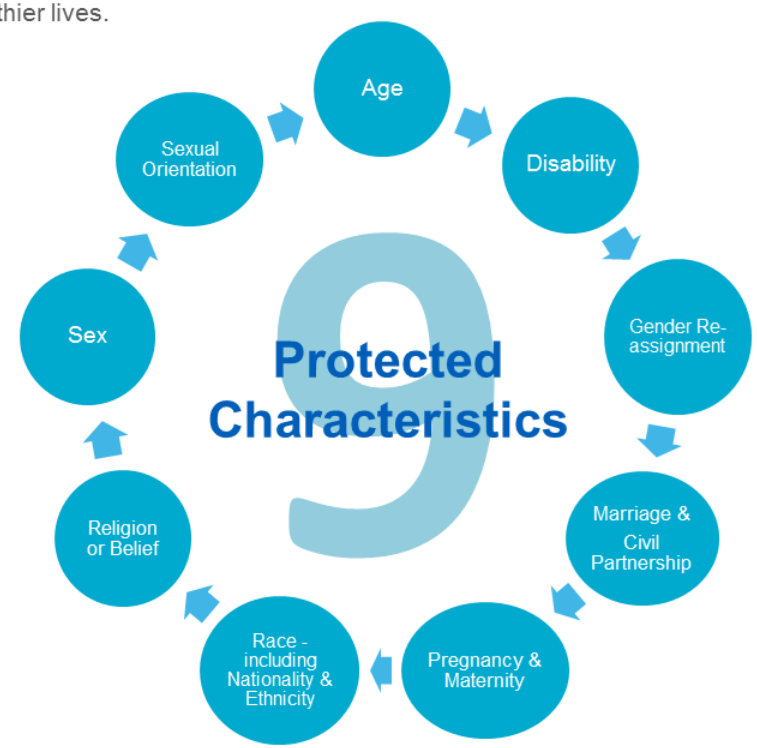
Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

## Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.




## Trust Equality and Diversity Objectives

| | | | |
|---|---|---|---|
| Better health outcomes for all | Improved patient access & experience | Empowered engaged & included staff | Inclusive leadership at all levels |

Great Western Hospitals NHS Foundation Trust

# Terms of Reference of Committees

| | | | |
|---|---|---|---|
| **Meeting** | Trust Board | **Date** | 6 May 2021 |

**Summary of Report**

This report invites the Board to refresh the Terms of Reference of the Board Committees as attached. Amendments have been made to reflect feedback from Directors.

The Board is advised that each of the Board Committees through open discussion have considered their effectiveness and terms of reference at their relevant meetings.

Appendix 1 : Performance, People & Place
Appendix 2 : Mental Health Governance Committee

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

| | |
|---|---|
| **Executive Lead** | Kevin McNamara, Chief Executive |
| **Author** | Caroline Coles, Company Secretary |
| Author contact details | Caroline.coles3@nhs.net |

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

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| - | - | - |

| | |
|---|---|
| **Legal / Regulatory / Reputation Implications** | n/a |

**Link to relevant CQC Domain**

| Safe | | Effective | | Caring | | Responsive | | Well Led | x |
|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Link to relevant Trust Commitment** | |

**Consultations / other committee views**

All Board Directors / Committees / Chairs of Committees

**Recommendations / Decision Required**

***that the Terms of Reference for each Committee as attached be approved.***

Great Western Hospitals NHS Foundation Trust

# PERFORMANCE, PEOPLE & PLACE COMMITTEE TERMS OF REFERENCE ~~2020-21~~ 2021-22

*Established by Trust Board*
*Reports and accountable to the Trust Board*
(Non-Statutory)

**Overview**
The Performance, People & Place Committee (the Committee) is a formally constituted Committee of the Board of Directors (Trust Board).
This is a non-statutory Committee.

**Summary of purpose and objectives**

The Performance, People & Place Committee is authorised to :

- Consider and advise the Board on the impact of operational management arrangements and to monitor arrangements in place for performance management.

- Ensure that the Trust's People Strategy and policies are aligned with the Trust's strategic aims and that a patient-centred, improvement culture, where engagement, development and innovation is maintained.

- Oversee, scrutinise and review the development, implementation and delivery of
  - estates and facilities management
  - IT strategy, services and infrastructure
  - informatics, including data quality
  - information governance
  - health & safety
  - security
  - business continuity
  - communications

- Seek assurance on behalf of the Board that strategic risks linked to strategic pillars (2) "staff and volunteers feeling valued and involved in helping improve quality of care for patients", and (3) "improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers", identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

**Role and duties**

| | 1. PERFORMANCE |
|---|---|
| 1.1 | To oversee operational performance and advise the Board on the arrangements in place for operational performance management. |
| 1.2 | To oversee the development of operational processes and reporting systems within the Trust. |
| 1.3 | To oversee flow and demand management. |
| 1.4 | To oversee activity planning. |
| 1.5 | To oversee the use of Model Hospital data. |
| 1.6 | To oversee specific service efficiencies. |

| | |
|---|---|
| **2. PEOPLE** | |
| 2.1 | To oversee the implementation of the People Strategy through progress reporting. |
| 2.2 | To oversee the development and implementation of the workforce planning framework and annual workforce plans. |
| 2.3 | To oversee Trust plans for learning and development, talent management, succession planning, staff engagement and reward and recognition policies. |
| 2.4 | To oversee the design of the workforce and to ensure the Trust's staffing capacity meets demand. |
| 2.5 | To oversee E-rostering efficiency and effectiveness. |

| | |
|---|---|
| **3. PLACE** | |
| 3.1 | To oversee strategy and performance relating to: -<br>- estates and facilities management<br>- communications<br>- equipment management<br><br>- IT strategy, services and infrastructure<br>- IT operational performance<br>- business continuity<br><br>- informatics, including data quality<br>- information governance<br><br>- health & safety<br>- security<br>- Way Forward operational design |
| 3.2 | On behalf of the Board, to receive and approve as necessary the Health & Safety Policy Statement of Commitment, Occupational Health, Safety and Fire Annual Reports. |
| **Responsibility / delegated authority** | |
| 1. | To seek assurance of behalf of the Board that activities and services within the remit of the Committee are being effectively managed to include an overview of internal audit service reviews (linking in with the work of the Audit, Risk and Assurance Committee). |
| 2. | The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. |
| 3. | To approve any policies, procedures or other documents as specified in the Scheme of Delegation to ensure that the organisation is getting maximum value from its paybill and that measures are in place to assess productivity. |

**Agendas**
The content of the agenda will be determined by the Chair of the Committee.

**Standing Agenda Items**
*(List of items which shall normally appear on the agenda for this Committee unless otherwise agreed by the Chair)*
The Performance, People & Place Committee will normally receive reports for each meeting as follows:-

- Operational Performance Report
- People Strategy progress report (at least twice per annum)
- Staff Survey Action Plan (at least once per annum)

- Workforce Report
- IT Quarterly Update
- Estate Update

The Committee will also consider as required: -

- Strategic risks aligned to the Committee (quarterly)
- Information Governance Annual Report
- Internal audit reviews
- Equality & Diversity Update

Minutes / reports (via other reports as considered necessary) of the following will be presented to the Committee: -

- Employee Partnership Forum
- Medical Staffing Group
- Nursing, Midwifery & AHP Oversight Meeting
- Learning and Development Steering Group
- Information Governance Steering Group (also reports into ARAC)
- Equality & Diversity Group

A forward planner of agenda items shall be determined by the Chair.

**Accountability / reporting requirements**

| | |
|---|---|
| 1. | This Committee is accountable to the Trust Board. |
| 2. | Minutes will be prepared after each meeting of the Committee and circulated to members and others as necessary. Minutes of the Committee will be reported to the Board. |
| 3. | The Chair of the Committee will submit to the Board, in public session, a written Chair's Report outlining the key issues discussed by the Committee drawing to the attention of Trust Board any issues that require disclosure to the Board, or require Executive action. The report should focus on the view taken by Non-Executive Directors |
| 4. | The Chair of the Committee shall draw to the Audit, Risk and Assurance Committee's attention any concerns that this committee activities might have and which may warrant, under the direction of the Audit, Risk & Assurance Committee, formal review by the internal auditors or any other professional review. |
| 5. | The Chair of the Committee will report to the Council of Governors on the work of the Committee. |

**Membership**

Members - The membership will comprise of at least 3 Non-Executive Directors and 2 Executive Directors; Director of HR and Chief Operating Officer.

Chair – The Trust Board will appoint the Chair of the Committee who shall be a Non-Executive Director.

**Meeting requirements**

| | |
|---|---|
| (a) | Quorum – The quorum for meetings of the Committee shall be 3 members (2 Non-Executive Directors and 1 Executive Director). |
| (b) | Voting – For voting purposes there will always be a majority of Non-Executive Directors. |
| (c) | Attendance – The Company Secretary is expected to attend. Any Non-Executive Director may attend. |
| (d) | Substitutes/Deputies - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.<br><br>Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the |

| | |
|---|---|
| | quorum. |
| (e) | Invitees – Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.<br><br>The Committee may call other officers of the Trust to attend as appropriate.<br><br>No other party may attend without the specific invitation of the Chair of the Committee. |
| (f) | Frequency of Meetings – The Committee will normally meet on a monthly basis with additional meetings being called where necessary. However, meetings that are not required will be cancelled. |
| (g) | Administration of Committee – The Secretariat shall provide appropriate administrative support, guidance and advice to the Chair and Committee members. |
| **Lead contacts for this Committee**<br>Chief Operating Officer | |
| **Monitoring effectiveness and review of Terms of Reference**<br>The Committee should consider its effectiveness and refresh its terms of reference | |

Great Western Hospitals NHS Foundation Trust

# MENTAL HEALTH GOVERNANCE COMMITTEE
## TERMS OF REFERENCE
## 2021/22

*Established by Trust Board*
*Reports and accountable to the Trust Board*
(Statutory)

**Overview**
The Mental Health Governance Committee (the Committee) is a formally constituted Committee of the Board of Directors (Trust Board).

This is a statutory Committee.

**Summary of purpose and objectives**

All hospitals should have governance arrangements in place to scrutinise the discharge of a range of responsibility under the Mental Health Act and the Mental Capacity Act. The Acts do not outline general requirement of governance arrangements and as such it is a matter for the Trust to determine. At GWH the Mental Health Governance Committee monitors the application of the Acts and advises the Trust Board on issues that may affect its duties under the Acts.

**Roles and Duties / responsibilities / delegated authority**

The Mental Health Governance Committee is authorised by Trust Board to:

(a) Make policy decisions concerning the Mental Health Act 1983 (as amended by the Mental Health Act 2007) [the MHA] and the Mental Capacity Act 2005 [the MCA] on behalf of the Board.

(b) Monitor the implementation of the ~~Mental Health Act 1983 (as amended by the Mental Health Act 2007)~~MHA and the ~~Mental Capacity Act 2005~~MCA and Deprivation of Liberty Safeguards [DoLS] throughout the Trust.

(c) Oversee compliance in relation to the ~~Mental Health Act 1983 (as amended by the Mental Health Act 2007)~~MHA and the ~~Mental Capacity Act 2005~~MCA throughout the Trust.

(d) Identify matters of risk relating to the Act, and develop policies and procedures to manage that risk.

(e) Identify ongoing training needs for all staff and ensure that programmes are devised and delivered and embedded.

(f) The Mental Health Governance Committee will monitor compliance with all relevant aspects of legislation.

(g) Instruct the Mental Health Governance Operational Group ~~Mental Health Act and Mental Capacity Act Operational Group~~ (Sub-group of this Committee) on all necessary work required to support this committee in fulfilling its objectives and functions.

(h) Support a culture of learning through case review and ensure the learning is disseminated throughout the organisation

(i) Support a culture of providing parity of esteem and ensuring respect and dignity for patients with mental health needs.

| Functions | |
|---|---|
| 1. | To initiate and manage, on behalf of the Board, the development of Trust policies and procedures in respect of current legislation. |
| 2. | To adopt, on behalf of the Board, Trust policies and procedures in respect of current legislation |
| 3. | To ensure that legislation and supporting policies and procedures are understood by staff and implemented appropriately. |
| 4. | Through an annual audit programme provide assurance to the board regarding compliance with policy and procedures |
| 5. | To develop education and practice on the Acts and the Codes of Practice for all personnel involved in the application of the Acts. |
| 6. | To ensure that the roles and duties of Hospital Managers, as defined in the Act, are undertaken effectively and consistently throughout the Great Western Hospitals NHS Foundation Trust. |
| 7. | To ensure that the services of Hospital Managers, as defined in the MHA are available to those detained under that Act and that those Hospital Managers exercise their duties effectively and consistently throughout the Great Western Hospitals NHS Foundation Trust. ~~staff undertaking duties delegated from Hospital Managers understand those duties, receive appropriate information and training, and work within agreed standards, policies and procedures.~~ |
| 8. | To monitor systems in place to ensure that people who are detained under the ~~Mental Health Act~~MHA in hospital are under the care of a 'responsible clinician'. (as 'approved' under section 12 of the Mental Health Act). |
| ~~9.~~ | ~~To facilitate Care Quality Commission visits to the Trust areas, (and to ensure that recommendations are implemented).~~ |
| ~~10~~9. | To monitor the use of the Acts in the Trust against national and local trends. |
| ~~11~~10. | To prepare an Annual Report for the Trust Board and an annual work programme. |
| ~~12~~11. | To contribute to the development of other policies and procedures as requested. |
| ~~13~~12. | To ensure the Department of Health returns are submitted on an annual basis outlining the application of the Mental Health Act over the previous year. |
| ~~14~~13. | To ensure that mental health service contracts with mental health providers meet, are robust and fulfil the requirement for an effective and efficient service. |
| ~~15~~14. | To ensure that mental health services meet agreed quality, effectiveness and outcome measures. |

**Standing Agenda Items**

At each meeting, the ~~The~~ Committee will receive reports under the following headings:

Part 1 [Statutory Information]:
- Mental Health Dashboard [to include data in relation to the use of the MHA]
- MCA and DoLS update
- Changes to legislation and guidance

Part 2 [Strategic Information]
- Mental Health Governance Workplan
- Risk Report [to include risks rated 12+]
- Mental Health Liaison Team update
- CAMHS update

- Children's Services update
- Emergency Department update
- Key updates from internal and external meetings

The following Minutes / reports will be presented to the Committee:

- Minutes of the Mental Health Governance Operational Group

On an annual basis the Committee will receive the following updates:

- Delivery of the Dementia Strategy
- A report from each Divisional Director of Nursing summarising Divisional MHA and MCA practice

- ~~Key Actions to Note from the Mental Health Act and Mental Capacity Act Operational Group~~
- ~~Risk Register~~
- ~~Annual standing agenda item:~~
- ~~Delivery of the Dementia Strategy~~
- ~~Divisional Director Nursing attendance to the Committee meeting on a rota basis once per year to provide the Committee with assurance of the work being undertaking regarding mental health within their Division.~~
- ~~CAMHS to provide an update on service delivery to the Committee on an annual basis.~~

**Accountability / reporting requirements**

| | |
|---|---|
| 1. | This Committee is accountable to the Trust Board. The Committee reports to the Trust Board. |
| 2. | Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee and others as necessary. Minutes of the Committee will be reported to the Board. |
| 3. | The Chair of the Committee will submit a written report to the Board outlining the key issues discussed by the Committee which it is considered should be drawn to the attention of the Board in public session (if any). An annual report shall be submitted to the Board on the work of Committee. |
| 4. | The Chair of the Committee shall draw to the attention of Trust Board any issues that require disclosure to the full Board, or require Executive action. |

**Membership**

The membership will comprise of at least 3 Non-Executive Directors and 2 Executive Directors.

Chair – The Trust Board will appoint the Chair of the Committee who shall be a Non-Executive Director.

~~The membership will comprise of~~

- ~~Trust Non-Executive Director (Chair)~~
- ~~Trust Non-Executive Director (Deputy Chair)~~
- ~~Trust Non Executive Director~~
- ~~Chief Nurse – Executive Lead for Mental Health Services (GWH)~~
- ~~Head of Mental Health and Safeguarding Adults at Risk (GWH)~~
- ~~Mental Health Act and Safeguarding Adults at Risk Administrator (GWH)~~
- ~~Medical Consultant Representative (GWH)~~
- ~~Representative from Child and Adolescent Mental Health Service (CAMHS) (Oxford Health)~~
- ~~Divisional Director of Nursing & Midwifery or Matron, Women's, Children's & Sexual Health Division, GWH~~
- ~~Responsible Clinician to Great Western Hospital, NHS Foundation Trust~~
- ~~Senior Representative from Adult Mental Health Services and Older People's Mental Health Services (Swindon Locality, AWP)~~
- ~~Mental Capacity Act Programme Manager (Swindon Borough Council and Swindon CCG)~~

~~Chair – The Trust Board will appoint the Chair of the Committee who shall be a Non-Executive Director.~~

**Meeting requirements**

| | |
|---|---|
| (a) | Quorum<br><br>The quorum for meetings of the Committee shall be 3 members (2 Non-Executive Directors and 1 Executive Director).<br>~~Minutes of the Mental Health Governance Committee to note the Quality and Governance Committee.~~<br><br>~~Divisional Directors of Nursing to attend the Committee meetings once a year to provide the Committee with assurance of the mental health work being undertaken within their Divisions.~~<br><br>~~CAMHS to attend the Committee meetings once a year to provide the Committee with assurance of the Service they are providing to the Great Western Hospitals NHS Foundation Trust~~ |
| (b) | Voting<br><br>For voting purposes there must always be a majority of Non-Executive Directors.<br><br>~~Quorum~~<br><br>• ~~2 Non-Executive Directors including the Chair or Deputy Chair.~~<br>• ~~GWH Head of Mental Health and Safeguarding Adults at Risk or Executive Lead for Mental Health~~<br>• ~~AWP Senior Manager~~<br>• ~~GWH Women's and Children's Division representative~~<br>• ~~1 Clinical representative~~<br>• ~~Mental Health Act and Safeguarding Adults at Risk Administrator / Administrative support~~ |
| (c) | Attendance<br><br>The following are expected to attend:<br>• Associate Director of Safeguarding<br>Mental Health Act, Safeguarding Adults at Risk, Mental Capacity Act and Deprivation of Liberty Safeguards Administrator.<br><br>~~Substitutes/Deputies – In the absence of the substantive member of the Committee a nominated person may act as substitute / deputy and this attendance will count towards the quorum.~~<br><br>~~Any person so nominated has the same rights as the substantive member in terms of decision making and voting.~~ |
| (d) | Substitutes/Deputies<br><br>Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.<br><br>Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.<br><br>~~Convenor – The Trust Manager of Mental Health Act.~~ |

(e) Invitees

Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

The Committee may call other officers of the Trust to attend as appropriate.

Additionally, the following external representatives may be in attendance at any meeting:

- Senior Representative from Child and Adolescent Mental Health Service (CAMHS) (Oxford Health)
- Senior Representative from Adult Mental Health Services and Older People's Mental Health Services (Avon and Wiltshire Mental Health Partnership Trust)
- Commissioner for Mental Health Services [BSW CCG]

No other party may attend without the specific invitation of the Chair of the Committee.

| | |
|---|---|
| (~~d~~f) | Frequency of Meetings – The Committee will meet quarterly. |
| (~~e~~g) | Administration of Committee – The Secretariat ~~The Mental Health Act and Safeguarding Adults at Risk Administrator~~ shall provide appropriate administrative support, guidance and advice to the Chair and Committee members. |

**Lead contact for this Committee**
Chief Nurse

**Monitoring effectiveness and review of Terms of Reference**
The Committee should consider its effectiveness and refresh its terms of reference annually.

# Membership of Committees

| Meeting | Trust Board | Date | 6 May 2021 |
|---|---|---|---|

**Summary of Report**

This paper invites the Board to approve changes to the membership of Board Committees from May 2021 as set out in Appendix 1, including the appointment of non-executive directors to supporting roles as in Appendix 2.

It should be noted that the role of Board Champions are designed to engender board level commitment and focus around key areas of service development or delivery. They provide a focus on a specific area of the Board's business from the perspective of an independent member of the Board and in some areas to support key areas of work that require a nominated non-executive director in order to comply with national guidance. The role also provides an opportunity to gain a deeper level of insight and knowledge around key areas with the aim of better equipping them and the whole Board to fulfil its role.

Currently there are no general NHS guidelines on 'Board Champions' however recently there has been an increased burden on NEDs in the number of ad hoc responsibilities that regulators are requesting. It should be noted that:-

- The essence of the board director role is that directors do not have portfolios in the boardroom.
- As a unitary Board they are jointly and severally responsible for the entire range of the board's work, not just part of it, and Board Executives and Non-Executive Directors share the same liability.
- If the champion role involves work outside the boardroom then this takes NEDs away from being non-executive and therefore detracts from their independence.
- Foundation trusts can only delegate to executive directors and committees of directors, so they cannot lawfully delegate a champion role to a NED if it involves any work outside the boardroom.

Different Foundation Trusts have different numbers of champions, those areas not covered by GWH are:-

- IT Transformation
- Overseas Development Opportunities
- Estates
- Well Led
- New business opportunities
- Clinical Excellence Awards
- Organ Donation
- Emergency Preparedness Resilience and Response (EPRR)
- Deaths in Hospital
- Gender Network
- Guardian of Safe Working
- BAME Network
- LGBT Network Charitable Funds Committee
- End of Life
- Learning from Deaths
- Sustainability

There are a number of changes to membership of the Board Committees due to:-

- New Non-Executive Directors and Associated Non-Executive
- Chair of the Charitable Committee vacancy due to end of term of an Non-Executive Director
- New Director of Improvement & Partnership

Appendices:-
Appendix 1 : Membership of Committees
Appendix 2 : Non Executive Champion Roles

| For Information | | Assurance | | Discussion & input | | Decision / approval | x |
|---|---|---|---|---|---|---|---|
| **Executive Lead** | Liam Coleman, Chair | | | | | | |
| **Author** | Caroline Coles, Company Secretary | | | | | | |
| Author contact details | Caroline.coles3@nhs.net | | | | | | |
| **Risk Implications - Link to Assurance Framework or Trust Risk Register** | | | | | | | |
| Risk(s) Ref | Risk(s) Description | | | | | Risk(s) Score | |
| - | - | | | | | - | |
| **Legal / Regulatory / Reputation Implications** | The Board is required to establish Board Committees and it is good governance to refresh the membership of those committees | | | | | | |
| **Link to relevant CQC Domain** | | | | | | | |
| Safe | | Effective | | Caring | | Responsive | | Well Led | x |
| **Link to relevant Trust Commitment** | - | | | | | | |
| **Consultations / other committee views** | | | | | | | |
| Non-Executive Directors<br>Chief Executive | | | | | | | |

## Recommendations / Decision Required

***(a) that the membership of Committees be approved as set out in appendix 1 to the report from May 2021;***

***(b) that the appointment of non-executive directors to the supporting roles set out in Appendix 2 be approved.***

| Effective from May 2021 | Audit, Assurance & Risk Committee | Finance & Investment Committee | Performance, People & Place Committee | Quality & Governance Committee | Mental Health Governance Committee | Way Forward Committee | Remuneration Committee | Charitable Funds Committee | Joint Nominations Committee | Executive Committee |
|---|---|---|---|---|---|---|---|---|---|---|
| Liam Coleman | | | | | | **CHAIR** | Member ● | | **CHAIR** | |
| Lizzie Abderrahim | Member | | Member | Member | **CHAIR** | Member | Member | | | |
| Nicholas Bishop | Member | | Member | **CHAIR** | | Member | **CHAIR** | | | |
| Andy Copestake | Member ● | **CHAIR** | Member | | | Member | Member | Member ● | | |
| Peter Hill | | Member | **CHAIR** | Member ● | Member | Member ● | Member | Member | Member | |
| Paul Lewis | | Member ● | Member | Member | Member ● | Member | Member | **CHAIR** | Member | |
| Julie Soutter | **CHAIR** | Member | Member ● | | | Member | Member | | | |
| Helen Spice | Member | Member | Member (Apr-Sept) | Member (Oct-Mar) | | Member | | | | |
| Faried Chapdat | Member | Member | Member (Oct-Mar) | Member (Apr-Sept) | | Member | | | | |
| Sanjeen Payne-Kumar | | Member | Member (Apr-Sept) | Member (Oct-Mar) | | Member | | | | |
| Claudia Paoloni | | | Member (Oct-Mar) | Member (Apr-Sept) | | Member | | | | |
| **Executive Directors/ Interim** | | | | | | | | | | |
| Chief Executive (KMc) | Attendee | Member | Attendee | Attendee | | Member | Member | Attendee | Attendee | **CHAIR** |
| Director of HR (JG) | | | Member | | | Member | Attendee | | Attendee | Member |
| Director of Finance (SW) | Attendee | Member | Attendee | | | Member | | Member | | Member |
| Medical Director (CF) | Attendee | | | Member | Member | Member | | | | Member |
| Chief Nurse (LC) | Attendee | | Attendee | Member | Member | Member | | | | Member |
| Chief Operating Officer (JO) | | Attendee | Member | | | Member | | | | Member ● |
| Director of Improvement & Partnership (CT) | | Attendee | | | | Member | | Member | | Member |

**Key**

| | |
|---|---|
| ● | Deputy Chair of Committees |
| | Highlights changes |

APPENDIX 2

| Area / Service | Non-Executive Director | Supporting Role | Board Sub-Committee Reporting |
|---|---|---|---|
| Freedom to Speak Up | Nick Bishop | Freedom to Speak Up Guardians will ensure that no person experiences poor treatment in the workplace. They will be expected to act as a role model – speaking up when something doesn't seem right. They will be driven to improve practice and help to create an inclusive organisation by recognising unacceptable behaviour. They will thus act as the first point of contact to support colleagues and signpost them to the relevant support accordingly. The Freedom to Speak Up Guardians will act in a genuinely independent and impartial capacity to support staff who raise concerns. The Policy requires nominated NED. If a member of staff feels that a matter has not been satisfactorily resolved after raising it internally, or if the matter is so serious that they cannot discuss it with any internal staff, then concerns should be raised with on of the Trust's Non-Executive Directors. The issue should be put in writing and addressed to the Non-Executive Director for F2SU c/o the PA to the Chief Executive. | Q&GC |
| Procurement | Andy Copestake | On 3 February 2016, every NHS Provider received a letter from either Monitor or the NHS TDA, co-signed with Dr Dan Poulter, Minister of State for Health. It highlights some immediate actions to take to improve procurement. This letter also asked for your organisation to nominate a Non-Executive Director to sponsor procurement. Please ensure this nomination is submitted to nhsprocurement@dh.gsi.gov.uk | FIC |
| Materinity Safety Champion | Paul Lewis | Ockenden Revew : The role of the trust board safety champion is to act as a conduit between staff,<br>frontline safety champions (obstetric, midwifery and neonatal), service users, LMS<br>leads, the Regional Chief Midwife and Lead Obstetrician and the Trust board to<br>understand, communicate and champion learning, challenges and successes. | Q&GC |

| | | | |
|---|---|---|---|
| Equality & Human Rights | Lizzie Abderrahim | To act as a Board champion to set an example and demonstrate that the Board is committed to promoting equality.<br>To challenge and promote the E&D agenda in the Trust.<br>Act as a voice at Board meetings for the E&D agenda.<br>To have oversight of the Equality & Human Rights agenda.<br>To actively participate in the Trust's E&D initiatives as necessary.<br>requested from Director of HR | PPPC |
| Security Fraud | Julie Soutter | In line with the NHS Counter Fraud Authority Standards and section 24 of the NHS Standard Contract, the Trust is required to put in place and maintain appropriate counter fraud arrangements. This includes Board level involvement and evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken. The role involves reviewing and supporting the work of the Local Counter Fraud Specialist. E-learning training is available, as well as guidance from the NHS Counter Fraud Authority (www.cfa.nhs.uk). | ARAC |
| Safeguarding | Nick Bishop | Safeguarding Policy requires nominated NED - The Non-Executive Director Lead for safeguarding will supports the Executive Lead in ensuring Board members understand their responsibilities.<br>(Safeguarding Adults at Risk Policy refers) | Q&GC |
| Children & Young Persons Champion | Paul Lewis | Champion Role - to provide a focus on a specific area of the Board's business from the perspective of an independent member of the Board | Q&GC |
| Research & Development Champion | Paul Lewis | Champion Role - to provide a focus on a specific area of the Board's business from the perspective of an independent member of the Board | PPPC |

| | | | |
|---|---|---|---|
| Falls | Peter Hill | Champion Role - to provide a focus on a specific area of the Board's business from the perspective of an independent member of the Board | Q&GC |

Great Western Hospitals NHS Foundation Trust

# Register of Interests and Declaration of Interests at Meetings

| | | | |
|---|---|---|---|
| **Meeting** | Trust Board | **Date** | 6 May 2021 |

**Summary of Report**

This report provides an annual reminder to members of the Board 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 reminds of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

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

Appendix 1 : Register of Interest Board April 2021

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

| | |
|---|---|
| **Executive Lead** | Kevin McNamara, Chief Executive |
| **Author** | Caroline Coles, Company Secretary |
| Author contact details | Caroline.coles3@nhs.net |

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

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| n/a | n/a | n/a |

| | |
|---|---|
| **Legal / Regulatory / Reputation Implications** | The Trust has a statutory obligation to maintain the Register of Directors' Interests. Directors have an obligation to abide by the Code of Conduct and the Constitution. |

**Link to relevant CQC Domain**

| Safe | | Effective | | Caring | | Responsive | | Well Led | x |
|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Link to relevant Trust Commitment** | n/a |

**Consultations / other committee views**

n/a

## Recommendations / Decision Required

***(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;***

***(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.***

## 1. Introduction

This report provides an annual reminder to members of the Board 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 reminds of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

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

## 2. NHS Code of Accountability

The NHS Code of Accountability which is incorporated into the Trust's Constitution requires members of the Board of Directors to declare:

- any pecuniary interest in any contract, proposed contract or other matter which is under consideration or is to be considered by the Board of Directors; and

- any interest including but not limited to any personal or family interests which are relevant and material to the business of the Trust,

irrespective of whether those interests are direct or indirect, actual or potential.

## 3. Relevant and material interests

Interests which are considered relevant and material include: -

(i) directorships, including non-executive directorships held in private companies or public listed companies (with the exception of those of dormant companies);

(ii) ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust;

(iii) majority or controlling share holdings in organisations likely or possibly seeking to do business with the Trust;

(iv) a position of authority in a charity or voluntary organisation in the field of health and social care;

(v) any connection with a voluntary or other organisation contracting for Trust services or commissioning Trust services;

(vi) any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

## 4. Requirement to register and declare interests

All members of the Board of Directors must declare such interests as soon as they become aware of them by completing and signing a declaration form and returning it to the Company Secretary as soon as possible and within 7 clear working days of becoming aware of the interest.

Directors should also ensure that the Register is kept up to date by making amendments or deletions to existing registered interests. Again this should be done by completing and signing a declaration form and returning it to the Company Secretary as soon as possible and within 7 clear working days of becoming aware of change in interest.

In addition to registered interests, if a member of the Board of Directors is present at a meeting of the Board and has an interest of any sort in any matter which is the subject of consideration, he shall at that meeting, and as soon as practicable after its commencement, disclose the fact and he must withdraw from the meeting and play no part in the relevant discussion and he shall not vote on any questions with respect to the matter. Best practice provides that the requirement to leave the meeting means to leave the meeting room and hence there is no doubt that the person with the interest was able to have any influence on the discussion.

It should be noted that the requirement to declare an interest at a meeting applies to any committee, sub-committee or joint committee of the Board of Directors and applies to any members of any such committee, sub-committee or joint committee (whether or not he is also a director).

Further details concerning requirements for the declaration of interests can be found in the Trust's Constitution - Standing Orders for the Practice and Procedure of the Board of Directors (paragraph 7), copies of which are available from the Director of Governance & Assurance (& Company Secretary).

## 5. Review of the Register

In accordance with best practice, the Trust Board is advised to receive a copy the Register of Interests for review on at least an annual basis. A copy of the Register as at the date of publication of this report is attached as an Appendix. In accordance with the Constitution, this register is maintained by the Company Secretary.

It should be noted that the relevant disclosures concerning interests made by directors for the year ending 31 March 2020 will also be referenced in the Trust's annual report.

The Board is asked to receive the Register and be assured that the requirements of the Constitution to maintain it are being met in respect of declaring and registering interests.

# Declarations of Interest Directors and NEDs April 2021

| Dare Confirmed | Title | First Name | Last Name | Position Title | Interests to declare | Description of interest | Dates To | Dates From | Type of interest: Clinical Private Practice | Strategic Decision Making | Employment/Directorships | Gifts and Hospitality | Loyalty | Shareholdings | Membership of Committees/Charites etc | Personal connections | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 22-Mar-21 | Ms. | Elizabeth | Abderrahim | Non Executive Director | Y | Gloucestershire Association for Refugees and Asylum Seekers - Trustee and Company Director | 28-Jun-19 | present | | | ✓ | | | | | | |
| | | | | | Y | Gloucester Relief in Sickness Fund - Trustee | 11-Feb-20 | 12-Nov-20 | | | | | | | ✓ | | |
| | | | | | Y | Gloucester City Council - Independent Person | ongoing | | | | | | | | | | |
| | | | | | Y | Gloucester City Council - Race Equality Commission | ongoing | | | | | | | | | | |
| | | | | | Y | South West Regional Clerk with Academies Enterprise Trust - Regional Clerk | 06-Apr-20 | present | | | ✓ | | | | | | |
| 15-Mar-21 | Dr | Nicholas | Bishop | Non Executive Director | Y | Distant family member work for BDO (not in any department which undertakes NHS work) | ongoing | | | | | | | | | ✓ | |
| 29-Mar-21 | | Lisa | Cheek | Chief Nurse from March 2021 | N | | | | | | | | | | | | |
| 30-Mar-21 | Mr. | Liam | Coleman | Chairman | Y | Defecto Member of Nationwide Building Society membership scheme | ongoing | | | | | | ✓ | | | | |
| | | | | | Y | Non Execuative Director of Financial Conduct Authority | 05-Nov-19 | present | | | ✓ | | | | | | |
| | | | | | Y | Wiltshire Health and Care - Partnership BoardMember on behalf of GWHNHS FT | ongoing | | | | | | | | | | |
| 24-Mar-21 | Mr. | Andrew | Copestake | Non Executive Director | Y | Close family member is a pshycosexual therpaist and occassionaly gets referals from Trust consultants in their private capacity | ongoing | | | | | | | | | ✓ | |
| 11-Mar-21 | | Tracey | Cotterill | Interim Director of Partnership and Improvement unitl end of april 2021 | Y | Governor - Hesters Way Primary School, Cheltenham | ongoing | | | | | | | | ✓ | | |
| | | | | | Y | Tramarco | ongoing | | | | ✓ | | | | | | |
| | | | | | Y | Trustee - Sustainablity First | ongoing | | | | | | | | ✓ | | |
| 24-Mar-21 | Dr | Charlotte | Forsyth | Consultant / Medical Director | N | | | | | | | | | | | | |
| 29-Mar-21 | Ms. | Judith | Gray | HR Director | Y | Chair of Trustees for ICP Support. ICP is a charity which supports women and their families who develop intrahepatic cholestasis of pregnancy | onging | | | | | | | | ✓ | | |
| | | | | | Y | close family member works for Deloitte | ongoig | | | | | | | | | ✓ | |
| 13-Apr-21 | Mr. | Peter | Hill | Non Executive Director | Y | Trustee Salisbury Hospice Trust | ongoing | | | | | | | | ✓ | | |
| 23-Mar-21 | Mr. | Paul | Lewis | Non Executive Director | Y | Close family member works in Trust | current | 1 April 2019 | | | ✓ | | | | | | |
| 25-Mar-21 | Mrs. | Julie-Anne | Marshman | Chief Nurse until March 2021 | N | | | | | | | | | | | | |
| 11-Mar-21 | Mr. | Kevin | McNamara | Chief Executive | Y | GWH member of the Board for Wiltshire Health and Care | ongoing | | | | | | | | | | |
| 22-Mar-19 | Mrs. | Jemima | Milton | Non Executive Director until 1 April 2021 | N | | | | | | | | | | | | |
| 21-Mar-19 | Miss | Carole | Nicholl | Director of Assurance and Governance until Decem | N | | | | | | | | | | | | |
| 25-Mar-21 | Mr. | Jim | O'Connell | Chief Operating Officer | Y | Managing Director of Jim O'Connell & Associates (dormant company) | 2013 | 2017 | | | | | | ✓ | | | |
| 09-Apr-21 | | Claudia | Paoloni | Non-Executive Director from April 2021 | Y | Director of Calm Water Ltd | ongoing | | | | ✓ | | | | | | |
| 09-Apr-21 | | Sanjeen | Payne-Kumar | Non-Executive Director from April 2021 | Y | Director of 715 Consulting Ltd | ongoing | | | | ✓ | | | | | | |
| 12-Mar-21 | Mrs. | Julie | Soutter | Non Executive Director | Y | Co-director and shareholder in Soutter Associates Ltd | ongoing | | | | | | | ✓ | | | |
| 13-Apr-21 | | Helen | Spice | Non-Executive Director from April 2021 | Y | Make a Wish Foundation - Non-Executive Director/Trustee | ongoing | | | | ✓ | | | | | | |
| | | | | | Y | Mental Health and Employment Partnership Limited - Non-Executive Director | ongoing | | | | ✓ | | | | | | |
| 19-Apr-21 | | Claire | Thomspn | Director of Improvement and Partnerships from 19 April 2021 | N | | | | | | | | | | | | |
| 14-Apr-21 | Mr. | Simon | Wade | Director of Finance | N | | | | | | | | | | | | |

# Annual Self-Certifications

G6(3) – Systems or compliance with licence conditions (31-May)
G6(4) – Publication of condition self-certification (30-Jun)
FT4(8) – Compliance with required governance arrangements - training of Governors (30-Jun)
CoS7(3) – Availability of resources & accompanying statement (31-May)

| **Meeting** | Board of Directors | **Date** | 6 May 2021 |
|---|---|---|---|

**Summary of Report**

NHS providers are required to complete self-certifications for publication which provides assurance that providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

1. Condition G6 - 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;
2. Condition FT4 - complied with governance arrangements; and
3. Condition CoS7 - for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS).

Attached to this report are the completed self-certifications for approval. See also a separate report on governor training.

Appendix 1 : FT4 self certification
Appendix 2 : G6 self certification
Appendix 3 : Governor training report

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

| | |
|---|---|
| **Executive Lead** | Kevin McNamara, Chief Executive |
| **Author** | Caroline Coles, Company Secretary |
| Author contact details | Caroline.coles3@nhs.net |

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

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| - | - | - |

| | |
|---|---|
| **Legal / Regulatory / Reputation Implications** | Compliance with NHS Provider Annual Reporting requirements |

**Link to relevant CQC Domain**

| Safe | | Effective | | Caring | | Responsive | | Well Led | x |
|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Link to relevant Trust Commitment** | n/a |

**Consultations / other committee views**

Provider Licence compliance report to Quality & Governance Committee Dec-20
Code of Governance Report to Quality & Governance Committee Dec-20
Governor Training Report to Council of Governors Mar-21

**Recommendations / Decision Required**

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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

# Self-Certification Template - Condition FT4

**Great Western Hospitals NHS Foundation Trust**

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)*
*Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)*

These self-certifications are set out in this template.

**How to use this template**

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

**Worksheet "FT4 declaration"** | **Financial Year to which self-certification relates** | **2020/21**

## Corporate Governance Statement (FTs and NHS trusts)

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one*

| | Corporate Governance Statement | Response | Risks and Mitigating actions |
|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | Risk around the amount of guidance published and ability to meet all requirements. A register of statutory and compulsory guidance is maintained and regularly refreshed with leads identified and assurances sought on compliance with the guidance. No issues of concern have been flagged. A compendium of guidance has been developed in response to COVID. This is reviewed through the I Respond Team to ensure all guidance has a lead and is being considered and implemented as necessary |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | Assurance and any potential for gaps in compliance with licence conditions are reported via a schedule to the Quality & Governance Committee on an annual basis. Furthermore that Committee considers compliance with the NHS Code of Governance, monitoring actions to address any potential gaps. Furthermore regular Board meeting cycle with 12 meetings per year along with Board Seminars for strategy and development work. A detailed planner enables new business and guidance to be brought to the attention of the Board in a timely manner. |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | Each year the Board undertakes a review of the Committee structure and of the effectiveness of Committees. This was completed in March 2020 and those Committees agreed that they remained effective, with only minor modifcation to Terms of Reference. The memberships of Committee is refreshed annually and this was completed in March 2020. Each Divisions within the organisation has its own governance structure, and the Divisions report into the Executive Committee. In addition there are Divisional Performance Review Meetings where Divisional Managers are held to account for their divisional performance. In 2020/21, the Scheme of Delegation was reviewed to ensure that it is effective and meets the needs of the Trust. |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | No risk identified around systems and processes.<br><br>Annual Governance Statement and Annual Report evidencing compliance with regulatory requirements.<br><br>Regular Board and sub committee meetings undertaking reviews of planned work including oversight of performance and financial information, corporate risks and the Board Assurance Framework.<br><br>Robust external and internal audit processes have confirmed there are no material concerns on key internal controls and processes. |
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | Confirmed | Quality issues are standing items on Board agendas along with reports to the Quality & Governance Committee, which meets monthly. The Quality & Governance Committee has regular oversight of all quality issues.<br><br>The Quality & Governance Committee also receives a wide variety of reports from an established governance framework on an exception basis.<br><br>There is a governor working group for Patiient Quality and a number of patient engagement groups which interacts with stakeholders and received feedback from a number of sources.<br><br>Although the requirement for a Quality Report has been suspended for 2020/21 Annual Report and Acounts wrok on the quality priorities for the Trust continues as part of the Trust's strategy.<br><br>The Trust continued to strengthe its data quality in 2020 by implementing a BI tool and recruited an Associate Director of Business Intelligence. |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | Confirmed | Risk around insufficient staffing levels. However, the Trust utilises bank, locum and agency staff to ensure sufficient personnel are in place. Also the Trust continues to roll out a recruitment and retention plan.<br><br>Regular Board and Committee reporting on the Trust's establishment along with recruitment and retention initiatives to ensure safe levels of staffing. The Remuneration Committee meets to consider succession planning, Executive Director recruitment, development and training. The Joint Nominations Committee meets to consider succession planning and the recruitment of NEDs recruitment, development and training. |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

**Signature** _____ **Signature** _____

**Name** Kevin MacNamara **Name** Simon Wade

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A n/a

## Worksheet "Training of governors"

**Financial Year to which self-certification relates** 2020/21

## Certification on training of governors (FTs only)

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.*

**Training of Governors**

| | | | |
|---|---|---|---|
| 1 | The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. | Confirmed | OK |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | Kevin McNamara | **Name** | Simon Wade |
| **Capacity** | Chief Executive | **Capacity** | Director of Finance & Strategy |
| **Date** | | **Date** | |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

# Self-Certification Template - Conditions G6 and CoS7

**Great Western Hospitals NHS Foundation Trust**

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
*Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)*

These self-certifications are set out in this template.

**How to use this template**

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

**Worksheet "G6 & CoS7"**

**Financial Year to which self-certification relates** 2020/21

# Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

*The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.*

## 1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed — OK

## 3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

**EITHER:**

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

**OR**

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

**OR**

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

**Statement of main factors taken into account in making the above declaration**

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust had received an external audit opinion arising from ongoing deficits and an ongoing requirement for distressed financing. However the Trust is deemed to be a going concern and plans to receive ongoing cash support from the Department of Health and Social Care, together with recompense for incurred covid-19 expenditure. The Trust has agreed a break-even control total for 2020/21 and expects to have the resources to deliver services for the following 12 months.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | Kevin McNamara | **Name** | Simon Wade |
| **Capacity** | Chief Executive | **Capacity** | Director of Finance |
| **Date** | | **Date** | |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

n/a

Great Western Hospitals NHS Foundation Trust

# Annual Self-Certification – Governor Training

FT4(8) – Compliance with required governance arrangements - training of Governors (30-Jun)

| | | | |
|---|---|---|---|
| **Meeting** | Board of Directors | **Date** | May 20201 |

**Summary of Report**

S151(5)of the Health and Social Care Act Health 2012 requires training of governors to ensure they are equipped with the skills and knowledge they need to undertake their role.

This report outlines an overview of the training to governors and invites the Board to approve a self-certification of compliance with training requirements (required before 30 June).

In addition to the training and development opportunities in this report, governors have access to the Board reports and have been provided with a very detailed welcome pack about governor specific roles and duties.

The Council of Governors at its meeting in March 2021 confirmed that it is satisfied with training requirements.

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

| | |
|---|---|
| **Executive Lead** | Kevin McNamara, Chief Executive |
| **Author** | Caroline Coles, Company Secretary |
| Author contact details | Caroline.coles3@nhs.net |

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

| Risk(s) Ref | Risk(s) Description | Risk(s) Score |
|---|---|---|
| - | - | - |

| | |
|---|---|
| **Legal / Regulatory / Reputation Implications** | Compliance with NHS Provider Annual Reporting requirements |

**Link to relevant CQC Domain**

| Safe | | Effective | | Caring | | Responsive | | Well Led | x |
|---|---|---|---|---|---|---|---|---|---|

| | |
|---|---|
| **Link to relevant Trust Commitment** | n/a |

**Consultations / other committee views**

Provider Licence compliance report to Quality & Governance Committee Dec-20
Code of Governance Report to Quality & Governance Committee Dec-120
Governor Training Report to Council of Governors Mar-21

See also separate paper on governor training.

**Recommendations / Decision Required**

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

## 1. Introduction

S151(5)of the Health and Social Care Act Health 2012 requires training of governors to ensure they are equipped with the skills and knowledge they need to undertake their role.

This report invites the Governors to consider the training provided to Governors (and Non-Executive Directors) during 2020/21 and to express a view as to whether the training has met the requirements of the Health and Social Care Act.

A summary of the training and learning outcomes is set out below. It should be noted that this year's training programme was against the back drop of a national pandemic and from March 2020 all training was undertaken virtually.

## 2. Background

The Board is required to submit an annual governance statement to NHS Improvement part of which includes a declaration around the training provided to Governors. This report seeks to inform the Board on the views of governors as to whether the training provided meets the requirements of the Act.

.

## 3. Training provided to Governors during 2020/21

Learning outcomes
1 – Knowledge of our Trust
2 – Learning about specific services
3 – Knowledge and skills for the Governor Role
4 – Networking Opportunities / Benchmarking / other organisations
5 – Corporate Induction
6 – Specific skills

| Training & Development | Date Provided | Learning Outcome |
|---|---|---|
| Trust Induction | Ongoing | 5 |
| **Public Lectures** | | |
| Vaginal Prolapse | 16-Jan-20 | 1 & 2 |
| Dying Matters (End of Life) | 05-Nov-20 | |
| MenoPause/PeriMenopause | 11-Feb-21 | |
| **Finance & Staffing Working Group Presentations** | | |
| NHS Finances/Regime | 20-Jul-20 | |
| People's Strategy | 20-Jul-20 | |
| External Audit Highlights (KPMG) | 07-Oct-21 | |
| **Patient Quality & Operational Performance Working Group Presentations** | | |
| Swindon Community and Health Services (SCHS) | 06-Jul-20 | |

| Governor Visits | | |
|---|---|---|
| Special Care Baby Unit (SCBU) | 24-Jan-20 | 1 & 2 & 3 |

| | | |
|---|---|---|
| Trauma Unit | 03-Feb-20 | |
| Community Services | 25-Jan-2021 | |
| **Council of Governor Meeting Presentations** | | |
| CQC Information Review | 20-Jan-20 | 1 & 2 |
| Developing a Business Plan 2020/21 | 09-Mar-20 | 1 & 2 |
| Local Quality Indicators | 09-Mar-20 | |
| People's Strategy | 09-Mar-20 | |
| COVID-19 Reset and Recovery | 11-Jun-20 | |
| Equality and Diversity Strategy | 18-Feb-21 | |
| **Informal Governor Meeting Presentations** | | |
| Way Forward Programme Update | 09-Dec-20 | 1 & 2 |
| Mental Health and Wellbeing Programme | 09-Dec-20 | |
| Audit, Risk and Assurance Chair Presentation | 19-Jan-21 | |
| **Others** | | |
| Governwell Training – Core Skills | 15-Sep-20 | 1 & 2 & 3 |
| Interpreting IPR Data (NHS1/E) | 16-Feb-21 | |

## 4. Governor Training and Development Working Group

The programme of training and development is overseen by the Membership & Governor Training and Development Working Group. Governors are encouraged to attend training throughout the year.