GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 7th July 2022, 9.30am to 12.45pm
By MS Teams (link to meeting provided on request)

AGENDA

Purpose			
Approve	**Receive**	**Note**	**Assurance**
To formally receive, discuss and approve any recommendations or a particular course of action	To discuss in depth, noting the implications for the Committee or Trust without formally approving it	To inform the Committee without in-depth discussion required	To assure the Committee that effective systems of control are in place

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome**	Verbal	LC	-	9.30
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	Verbal	LC	-	
3.	**Minutes of the previous meeting (public) (pages 1 – 9)** Liam Coleman, Chair • 5 May 2022	✓	LC	Approve	
4.	**Outstanding actions of the Board (public) (page 10)**	✓	LC	Approve	
5.	**Questions from the public to the Board relating to the work of the Trust**	-	LC	-	
6.	**Care Reflections – Patient Story – Navigation Hub (pages 11 – 14)** Alan Sheward, Deputy Chief Operating Officer & Annelli Nichols, Nurse Clinical Lead	✓	AS/AN	Note	9.40
7.	**Chair's Report (pages 15 – 18)** Liam Coleman, Chair	Verbal	LC	Note	10.00
8.	**Chief Executive's Report (pages 19 – 27)** Kevin McNamara, Chief Executive	✓	KM	Note	10.10
9.	**Integrated Performance Report (pages 28 – 112)**			Assurance	10.30
	• Performance, Population & Place Committee Board Assurance Report (May & June) – Peter Hill, Non-Executive Director & Committee Chair	✓	PH		
	Part 1: Operational Performance – Felicity Taylor-Drewe, Chief Operating Officer	✓	FTD		
	• Quality & Safety Committee Board Assurance Report (May & June) – Nick Bishop, Non-Executive Director & Committee Chair	✓	NLB		
	Part 2: Our Care – Lisa Cheek, Chief Nurse and Jon Westbrook, Medical Director	✓	LCh/JW		

	• People & Culture Committee (verbal report on first meeting) – Paul Lewis, Non-Executive Director & Committee Chair Part 3: Our People – Jude Gray, Director of Human Resources	- ✓ ✓	PL JG AC		
	• Finance & Infrastructure Committee Board Assurance Report (May & June) – Faried Chopdat, Non-Executive Director & Committee Chair Part 4: Use of Resources – Simon Wade, Director of Finance & Strategy	✓	SW		
10.	**Mental Health Governance Committee Board Assurance Report (pages 113 – 115)** Lizzie Abderrahim, Non-Executive Director & Committee Chair	✓	EKA	Assurance	11.30
11.	**Charitable Funds Committee Board Assurance Report (pages 116 – 117)** Paul Lewis, Non-Executive Director & Committee Chair	✓	PL	Assurance	11.40
12.	**Audit, Risk & Assurance Committee Board Assurance Report (pages 118 – 119)** Helen Lewis, Non-Executive Director & Committee Chair	✓	PL	Assurance	11.50
13.	**Full Ockenden Report – Immediate & Essential Actions (IEA) Breakdown (pages 120 – 141)** Lisa Cheek, Chief Nurse, Lisa Marshall, Director of Midwifery & Neonatal Services, and Kat Simpson, Lead Midwife for Risk & Governance for Maternity & Neonates	✓	LCh/ LM/KS	Assurance	12.00
14.	**Amendment to the Trust Constitution – Eligibility of Non-Executive Directors & Executive Directors (pages 142 – 143)** Caroline Coles, Company Secretary Director	✓	CC	Approve	12.20
	CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/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 process for consent items. The recommendations will then be recorded in the minutes of the meeting.**				
15.	**Ratification of Decisions made via Board Circular/Board Workshop** Caroline Coles, Company Secretary	Verbal	CC	Note	12.30
16.	**Safe staffing 6 month review for Nursing, Midwifery and Allied Health Professionals (pages 144 – 169)** Lisa Cheek, Chief Nurse	✓	LCh	Assurance	-
17.	**Quality Account 2021/22 (pages 170 – 236)** Lisa Cheek, Chief Nurse	✓	LCh	Note	-
18.	**Terms of Reference of Board Committees (pages 237 – 300)** Caroline Coles, Company Secretary	✓	CC	Approve	
19.	**Register of Interests and Declaration of Interests at Meetings (pages 301 – 303)** Caroline Coles, Company Secretary	✓	CC	Approve	

20.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	Note	-
21.	**Date and Time of next meeting** Thursday 4th August at 9.30am, DoubleTree by Hilton Hotel (hybrid meeting)	Verbal	LC	Note	-
22.	**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"*	-	-	-	12.45

2022					2023						
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC AT THE MARRIOTT HOTEL, SWINDON AND VIA MS TEAMS 5 MAY 2022 AT 9.30 AM

Present:

Voting Directors

Peter Hill (PH) (Chair)	Deputy Trust Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Nick Bishop (NB)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)*	Non-Executive Director
Jude Gray (JG)	Director of HR
Paul Lewis (PL)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Helen Spice (HS)*	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Director of Improvement & Partnerships
Simon Wade (SW)	Director of Finance & Strategy
Jon Westbrook (JW)	Medical Director

In attendance

Caroline Coles	Company Secretary
Naginda Dhanoa	Chief Digital Officer
Tim Edmonds*	Associate Director of Communications & Engagement
Simon Lovett*	Physio Lead (agenda item 34/22 only)
Claudia Paoloni	Associate Non-Executive Director
Sanjeen Payne-Kumar	Associate Non-Executive Director
Johnnie Watherston*	Volunteer (agenda item 34/22 only)
Ester Williams-Delhourn	Observer - Community Nursing Team

Apologies

Liam Coleman	Trust Chair
Andy Copestake	Non-Executive Director

Number of members of the Public: 5 members of public* (included 5 Governor: Pauline Cooke, Chris Shepherd, Rob Hammond, Judith Furse and Chris Callow)

*Indicates those members attending virtually by MS Teams.

Matters Open to the Public and Press

Minute	Description	Action
29/22	**Apologies for Absence and Chairman's Welcome** Due to the absence of Liam Coleman, Trust Chair, Peter Hill, in his role as Deputy Chair, chaired the meeting. The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	

Minute	Description	Action

30/33 **Declarations of Interest**
There were no declarations of interest.

31/22 **Minutes**
The minutes of the meeting of the Board held on 7 April 2022 were adopted and signed as a correct record.

32/22 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

33/22 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public for the Board.

34/22 **Care Reflections – Staff Story**
Johnnie Watherston, Volunteer and former patient Julian White joined the meeting for this agenda item

The Board received a reflection of care in connection with the invaluable contribution volunteers made to patient experience within the Trust. In this circumstances it was feedback from a patient who had received exceptional support from Johnnie Watherston, a Trust volunteer, whilst receiving care on Falcon Ward.

The Board acknowledged and thanked the fantastic work carried out by Johnnie, and, the other volunteers at the hospital and how they played an important part in aiding every aspect of a patient's recovery, making a difference by offering support, skills, kindness, care and above all a friendly face.

It also highlighted the need of a different approach to patients by the staff around first impressions. Lisa Cheek, Chief Nurse assured the Board that this experience and feedback would be used to make improvements in this area.

The Board **noted** the care reflection.

35/22 **Chair's Report, Feedback from the Council of Governors**
The Board received a verbal update and the following highlighted:-

Council of Governor Meeting – A Council of Governor meeting was held on 4 May 2022, which included an update on Integrated Care Systems and Anchor organisations. The council also approved the extension of the external auditors contract for a further 3 years and approved a second term of office for Lizzie Abderrahim, Non-Executive Director. The next meeting will be held on 6 September 2022.

Public Health Talk - There was a virtual public health talk held Monday 25 April 2022. It was presented by Adam Ward from the Macmillan Citizen Advice Bureau, Swindon on "The Taboos of Cancer" - maximising income. The next talk would be held on 10 May 2022 and would share updates on the Way Forward Programme which included projects that covered a number of exciting site developments to expand and improve services.

The Board **noted** the verbal update.

Minute	Description	Action

36/22 **Chief Executive's Report**

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

Covid-19 - The number of covid patients had declined and were now more in line with partner trusts, however the pandemic continued to present challenges as the Trust moved towards treating covid-19 as business as usual.

Managing Current Pressures - This year presented an unusual set of challenges with numerous bank holidays following close together however the teams had responded well. As a result the Trust had been asked by the system to lead a super MADE (multi agency discharge event) event based on the SAFER week model put in place to support bank holiday activity at the Trust.

Infection Prevention & Control (IP&C) – In line with national guidance the Trust had introduced a number of changes in managing covid within hospital under the leadership of the Chief Nurse. It was noted that a new Associate Director of Nursing for IP&C had started which would further strengthen IP&C management within the Trust.

Primary Care – The CQC had confirmed a visit to the Trust's GP practices. This would be an opportunity to highlight the continued progress made, whilst recognising that, given the scale of the improvement needed when we took over the practices, there was still some way to go, particularly as services emerged out of covid.

Nick Bishop, Non-Executive Director asked if there was any insight into how the practice staff would react to the visit. Lisa Cheek, Chief Nurse replied that there was a lot of positivity within the team especially around the changes that had been made. Jon Westbrook, Medical Director added that there were some specific challenges particularly outstanding correspondence however plans were in place to address these issues. Kevin McNamara, Chief Executive commented that the Trust had received the draft Royal College of GPs report, which had been commissioned jointly with the CCG, to understand the financial model, however it also gave a good insight into the feelings of staff which was a preference for more automomy.

Lizzie Abderrahim, Non-Executive Director asked if this report would come through the committee structure. Kevin McNamara, Chief Executive replied that the financial element would go through the appropriate governance route culminating in a Board discussion on finances/sustainability in due course.

Improving Together – The Trust had launched its Improving Together training for staff and the Board Seminar session in June 2022 would focus on the Board's role and the leadership behaviours that underpinned the Improving Together approach

World Professional Admin Day – The Trust marked World Professional Admin Day in recognition of the contribution of those staff who were often the unsung heroes of the NHS.

Staff Awards – The report highlighted the nominations and shortflist for the Staff Excellence Awards with the results being announced at an event to be held in June 2022.

It was also noted that Simon Lovett, Deputy AHP Lead had won the AHP Clinical Leadership Award in the Advancing Healthcare Award in recognition of his leadership within the Trust and congratulations had been passed on to him.

Minute **Description** **Action**

Great British Rail Bid - The Trust were backing the campaign, partnering with Swindon Borough Council, to support Swindon as the new national headquarters of Great British Railways, the new public organisation responsible for the country's railways.

In addition to the report, it was also noted that the Health and Care Bill had been granted Royal Assent this week and would be implemented from 1 July 2022.

The Board **noted** the report.

37/22 **Integrated Performance Report**

The Board received and considered the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in March / April 2022.

Part 1 : Our Performance

Performance, People and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, People and Place Committee (PPPC) around the IPR at its meeting on 27 April 2022 and the following highlighted:-

Emergency Access - The service remained under significant pressure and initiatives to improve the patient experience continued with examples being the expansion of Same Day Emergency Care (SDEC) to 7 day working.

The Committee also had an in-depth discussion with regard to ambulance handovers which remained a real challenge. The ambulance service (SWAST) and the Trust continued to work together to identify ways of improvement for example development of a Rapid Assessment and Treatment (RAT) model.

Performance in ED was directly affected by the high number of patients whose discharge from hospital was delayed due to issues outside of the Trust's control. Dialogue with the local authorities/social care continued with a view to seeing improvements.

Diagnostic Service (DM01) - Performance in February 2022 saw a slight improvement from January 2022. To support the recovery trajectory the service funded 23 CT van days in March 2022 as well as additional MRI van capacity and Endoscopy weekend lists.

Cancer Service - The Trust was performing well against other Trusts but was not meeting the national standard partly due to diagnostic capacity.

Theatres Assurance Report - The Committee received a presentation from the new Head of Service that identified progress to date along with upcoming initiatives. The Committee were pleased to note the major improvement with 100% compliance achieved in the adherence to the WHO checklist.

The Board received and considered the Operational element of the report and the Chief Operating Officer highlighted that now the number of covid patients had declined the focus had turned to the delivery of increased activity and decreasing the waiting lists for patients treating those in priority order.

Minute	Description	Action

Part 2 : Our Care
Quality & Governance Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Governance Committee (Q&GC) around the quality element of the IPR at the meeting held on 21 April 2022 and the following highlighted:-

Infection Prevention & Control (IP&C) - As was expected from the trajectory the number of C.diff cases exceeded this at year end. Ribotyping again showed this was not a result of cross-infection in wards but more likely related to antibiotic therapy. Extended hospital stays with 'Non-Criteria to Reside' also increased the risks of UTI and other infections requiring antibiotics. A new Lead for IP&C was now in post who would re-enforce the work in this area.

Mortality Report - Dr Foster reports were once again delayed so there was no up to date HSMR or SHMI data available however overall Trust deaths remained stable.

A review of Bowel Cancer deaths after a Dr Foster alert showed no evidence of poor care in the reviewed cases. Coding reviews were being undertaken for other alerts with updates to be taken at the Trust Mortality meeting. Concerns were again raised about the quality of the case notes and the Committee requested evidence of action by the Executive to address this. The Medical Director added that clear documentation notes were good medical practice from the GMC and he would lead on this work to address the issue.

The Board received and considered the quality element of the report and the Chief Nurse highlighted:-

- The work being untaken by the new Lead for IP&C focusssed on 5 areas; hand hygiene, PPE use, environmental cleaning, antibiotic use and ventilation, all in line with national guidance around fundamental care.
- Following the publication of the final Ockenden Report the maternity team had produced a plan to progress the 15 immediate actions and would be presented to Board in July 2022 for full oversight. LCh
  Action : Chief Nurse

The Chief Nurse noted that it was International Day of the Midwife and wished to formally thank the Midwifery Team for their heard work and dedication.

Part 3 : Our People
The Board received and considered the Workforce performance element of the report and the Director of HR highlighted the continued issues in staffing and sickness absent rates however there had been some success with regard to recruitment within Healthcare Assistants and Midwives. Kevin McNamara, Chief Executive added that the focus at system level would be on the domicilary care market, importance of the Ockenden report and reducing agency spend.

Paul Lewis, Non-Executive Director asked when the Board would get an update on understanding the plans and next steps around culture within the Trust in particular the behaviour side. Jude Gray, Director of HR replied that an update would go to the new People & Culture Committee. Kevin McNamara, Chief Executive added that the Board workshop in June 2022 would focus on the Board's role and leadership behaviours that

Minute **Description** **Action**

underpinned the Improving Together approach.

Lizzie Adberrahim, Non-Executive Director noted the recruitment of Healthcare Assistants (HCAs) and asked if there was an opportunity to work on retention of staff. Jude Gray, Director of HR replied that there was a broader piece of ongoing work being undertaken around retention which included a dedicated piece of work on retention of HCAs in terms of valuing their role, support and development.

Claudia Paoloni, Associate Non-Executive Director asked if there was a breakdown of non-covid related sickness absence as this appeared high in the report. Jude Gray, Director of HR replied that the main reasons were around stress and personal work/life balance.

There followed a discussion around the spend on temporary staff exceeding vacancies and establishing a workforce baseline. It was noted that an establishment review for nursing had been completed and a business case approved to invest in safer staffing, whilst the medical establishment review was currently underway. New processes had been put in place to further strengthen the grip and control around agency spend.

Part 4 : Use of Resource
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 23 April 2022 and the following was highlighted:-

Month 12 Position - The excellent end to the 2021/22 year with a final I & E result of £0.1m surplus, which was £5.9m better than plan. Congratulations were passed to the finance team for achieving this result however noting that the position going forward would present a very difficult financial challenge to 2021/22.

Benchmarking Opportunities - The Committee noted an update report on benchmarking opportunities and that a more focussed report would be required in future. Regular updates on benchmarking opportunities were scheduled quarterly and at the next meeting the opportunities should form part of the re-presented savings plans for the Trust.

Finance Risk Register - There were no major changes this month however now that the 2022/23 Plan had been approved the finance risks would be refreshed.

PFI Benchmarking Update - Good progress had been made with a proposal expected in June 2022.

Contract Awards - Two contract awards were supported for approval by Board; Contract for Aseptically Manipulated or Terminally Sterilised Products and Contract for Targeted Lung Healthcheck Mobile CT & Services.

The Board received and considered the Use of Resource performance element of the report and Director of Finance & Strategy highlighted that the end of year audit had commenced and gave an update on the progress on the submission of the 2022/23 Plan at both local and system level.

Lizzie Adberrahim, Non-Executive Director sought assurance around the robustness on the Trust's planning as the performance in month 12 was better than plan. Simon Wade,

Minute	Description	Action

Director of Finance & Strategy responded that at the time the Plan was submitted the additional funding from the system was not known however going forward the approach would be different in that there would be no additional funding only a distribution of funding.

Paul Lewis, Non-Executive Director commented that the biggest concern in 2022/23 was the efficiency savings and was assured that this would get greater visibility through the new Board committee structure

The Board **noted** the IPR and the on-going plans to maintain and improve performance.

38/22 **Staff Survey Results 2021**

The Board received and considered a paper that provided the results of the Staff Survey for 2021, together with next steps. The overall results demonstrated no significant change in the People Promise Themes, Staff Engagement and Staff Morale however there had been an overall decline in the Trust results which was aligned to the national trend.

It was noted that the Board had an initial discussion in the closed session of Board last month followed by a full presentation at the Performance, People & Place Committee and therefore were familiar with the results.

The next steps were considered which was a different approach to previous years and would be supported by the Improving Together methodology.

There followed a robust discussion which focussed on a number of areas within the results in particular insufficient supplies/equipment, equality, diversity and inclusion, the recognition of the impact of covid and the changes within the organisation over the past 12 months.

The Board were supportive of a new approach which would be strengthened by the new Board committee structure by establishing a People & Culture Committee.

The Board **noted** the report and endorsed the next steps in line with the Improving Together methodology.

39/22 **Freedom to Speak Up Bi-Annual Report**

The Board received and considered a paper that provided a summary of the freedom to speak up activity from July to December 2021.

It was recognised the numbers were low however this was not the only route to raise a concern. There followed a discussion around the frequency of the report in light of low numbers and whether an annual report would be more beneficial to the Board. It was noted full scrintiny of this report was undertaken at the Quality & Governace Committee.

Nick Bishop, Chair of Quality & Governance Committee confirmed this had been considered at the Committee and noted that a review of the freedom to speak up model was being undertaken. Lisa Check, Chief Nuse replied that this was still work in progress looking at the different options and models. The organisation currently had a network of 7 voluntary guardians across the Trust and triangulation of data from multiple sources was key to understanding a speaking up culture.

The Board **noted** the report.

Minute	Description	Action

Consent Items

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

40/22 **Ratification of Decisions made via Board Circular/Board Workshop**

None.

41/22 **Quality Strategy 2022-2026**

The Board received the Quality Strategy 2022-2026 which had been developed over a significant period of time and been through due process.

The Quality & Governance Committee had reviewed and approved the Strategy at its meeting in February 2022.

The Board **noted** the Quality Strategy 2022-2026.

42/22 **Annual Self-Certification – G6/FT4/ CoS7**

The Board received a number of self-certifications for Board approval prior to publication. The self-certifications were:-

- 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;
- Condition FT4 - complied with governance arrangements; and
- Condition CoS7 - the required resources available if providing commissioner requested services (CRS).

The Quality & Governance Committee had reviewed and agreed compliance with the Code of Governance and Provider Licence at its meeting held in January 2022 and the Council of Governors reviewed and agreed that the training received by governors during 2021/22 met the requirements of the S151(5) of the Health & Social Care Act 2012.

RESOLUTION

that the annual self-certifications G6 , FT4 & CoS7 be approved.

43/22 **Urgent Public Business (if any)**

None.

44/22 **Date and Time of next meeting**

It was noted that the next meeting of the Board would be held on 7 July 2022 venue to be confirmed (MS Teams facility would also be available).

Minute	Description	Action

45/22 **Exclusion of the Public and Press**

RESOLVED

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

The meeting ended at 1230 hrs.

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – July 2022				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIC – Finance & Infrastructure Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
5-May-22	37/22	**Integrated Performance Report : Our Care : Ockenden Report** Full report detailing the plans to progress the immediate actions.	Chief Nurse	On agenda.

Future Actions				
03-Mar-22	329/21	**IPR : Our Care : New Infection Prevention & Control Lead** Invitation to present to Board once new IP&C Lead at an appropriate time.	Chief Nurse	Aug/Sept-22

NHS
Great Western Hospitals
NHS Foundation Trust

Report Title	**Care Reflection (Patient Story)**				
Meeting	**Trust Board**				
Date	**7 July 2022**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek – Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement				
Appendices	Film – Presented by Alan Sheward, Deputy Chief Operating Officer and Annelli Nichols, Nurse Clinical Lead				

Purpose

Approve		Receive		Note		Assurance	x
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level

Assurance in respect of: process/outcome/other (please detail):

Significant		Acceptable	x	Partial		No Assurance	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

The presentation identifies significant work being undertaken to address the concerns raised in this Care Reflection

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

The Navigation hub is a new service currently being trialled within the Unscheduled care Division. It is a multi-organisational, multi-divisional and multidisciplinary team designed to support timely, proactive and appropriate triage of patients identified as likely needing our front door services, with the aim of preventing unnecessary admission and streamlining their pathway of care.

The film explains how the Navigation hub is working to support patients, their families and carers and describes how the multidisciplinary team are working collaboratively across divisional and organisational boundaries to provide the best possible care whilst reducing pressure on the Emergency Department.

The film recounts the story of Peter who together with his late partner, Roger, benefitted from the new service.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	NA				

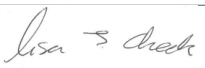
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The Care Reflection has been shared widely with staff and is available on the trust intranet for future learning
Next Steps	

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		x	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

- To receive the presentation as assurance of actions being taken to address areas of concern raised in the Care Reflection.

Accountable Lead Signature	
Date	30 June 2022

Care Reflection –July 2022

Navigation Hub

Alan Sheward, Deputy Chief Operating Officer
Annelli Nichols, Nurse Clinical Lead

Peters Story

- The Navigation hub is a new service currently being trialled within the Unscheduled care Division
- The service supports timely, proactive and appropriate triage of patients attending our front door services
- The aim is to prevent unnecessary admission and streamlining pathways of care whilst reducing pressure on the Emergency Department
- The team multidisciplinary team are working collaboratively across divisional and organisational boundaries to provide the best possible care
- The film recounts the story of Peter who together with his late partner, Roger, benefitted from the new service

Navigation hub Peter's story: https://youtu.be/fwM5mKBOans

Report Title	**Chair's Report**				
Meeting	**Trust Board**				
Date	**7 July 2022**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

Purpose							
Approve	x	**Receive**		**Note**	x	**Assurance**	
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Significant		**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

The report provides information in respect of:-

- Council of Governors
- Non-Executive Directors
- Strengthening Board Oversight
- Trust Board meetings
- Key Meetings Dates

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	-				**Risk Score**
	-				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	-				
Next Steps	-				

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			x
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	1 July 2022

Chair Board Report – May / July 2022

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally.

Council of Governors

- **New Governor –** welcome to a new governor representative for Wiltshire County Council, Cllr Nick Holder
- **A Joint Board and Council of Governors** meeting and workshop was held on 13 June 2022. The short Council of Governors meeting was called to approve two Non-Executive Directors re-appointments. The workshop covered the staff survey and a debate on the Trust strategy and how the governors can input into the process.

Non-Executive Directors

- Nick Bishop and Andy Copestake were-re-appointed as NEDs for up to a period of 12 months by the Council of Governors as mentioned above. This is to cover a transition period to replace both posts with the relevant experience and expertise required within the Board. Congratulations to them both.
- The appraisal process for both Chair and Non-Executive Directors has commenced with meetings taking place in June/July 2022.

Strengthening Board Oversight

- The first of the Board Seminar sessions, in line with the agreed new Board timetable, was held in June 2022 and the overall development objective was to progress our 'well led' status through greater understanding and application of our 'Improving Together' methodology for improvement and where we are in relation to our current gap analysis against the CQC well led domain. The day was split into two sessions; the morning focussed on the Board's role and leadership behaviours that underpin the Improving Together approach, and the afternoon focussed on an outside in well led themed view of the Trust from Aqua, an external consultancy which also included an update on CQC developments in this area.
- A Board safety visits took place during the period covered by this report to Maternity Services conducted by Paul Lewis, Non-Executive Director and Simon Wade, Director of Finance & Strategy.
- The new Board sub committee structure, as agreed at the April 2022 Board meeting, came into effect in June 2022 and the revised and newly established terms of reference being approved by Board later in the meeting.

Trust Board Meetings

- There was a short private session of Board convened in June before the Board Development session in order to accommodate timelines of various annual reports and for the Board to delegate authority for final approval, this included the Quality Report and the BSW Planning Submission.

Key Meetings during May – June 2022

To Note : The Chair was on annual leave between 6 – 24 May 2022 during this period Peter Hill deputised.

Meetings	Purpose
May 2022	
Nominations & Remunerations Committee	Re-appointment of two NEDs
Monthly Chair Lead Governors Meeting	Regular meeting to update and discuss Lead Governors any topical issues
Bi-monthly NED meeting	Regular meeting to update and discuss any topical issues
Meeting with Director of Improvement & Partnership & Company Secretary	To discuss planning for upcoming Board workshop
Wiltshire Health & Care LLP	Chaired members meeting
Chairs & CEO ICS Health Meeting	Regular meeting bringing together healthcare providers within the BSW ICS
June 2022	
Monthly Chair Lead Governors Meeting	Regular meeting to update and discuss with Lead Governors any topical issues
BSW Finance Summit Chairs/CEOs/CFOs	Attended meeting to review financial planning.
AHA Committee in Common	Chaired meeting of the Committee in Common between the three acute hospital trusts within the Bath and North East Somerset, Swindon and Wiltshire (BSW) Partnership – Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, and Salisbury NHS Foundation Trust.
Annual Joint Board and Council of Governors	Annual workshop. Topics discussed staff survey and Trust strategy
Audit, Risk & Assurance Committee	In attendance due to review of Annual Report & Accounts
Extraordinary Finance & Infrastructure Meeting 2022/23 Operational Plan	In attendance due to review of revised operational plan.
NHS Providers Chairs & Chief Executives Event	Networking event hosted by NHS Providers
Bi-monthly Chair/Deputy Chair/Senior Independent Director meeting	Regular meeting
Board EDI Development Session	Board development on ED&I and unconscious bias
Opening New Radiotherapy Centre at GWH	Hosted and spoke at the Opening ceremony for the new radiotherapy centre at GWH
Finance and Investment Committee	Attended Board committee as observer

Performance, People & Place Committee	Attended Board committee as observer
GWH Electronic Patient Records project workshop and update meeting	Attended and participated
Governor induction	Led new Governor induction session with Lead Governors
1-2-1 meeting with Chief Nurse	Regular meeting

Report Title	**Chief Executive's Report**				
Meeting	Trust Board				
Date	7 July 2022	**Part 1 (Public) [Added after submission]**	**X**	**Part 2 (Private) [Added after submission]**	
Accountable Lead	Chief Executive Officer				
Report Author	Kevin McNamara, Chief Executive Officer				
Appendices	N/A				

Purpose

Approve		**Receive**		**Note**	**X**	**Assurance**	
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level

Assurance in respect of: process/outcome/other (please detail):

Board members are asked to note the report.

Significant		**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

The Chief Executive's report provides an overview of a broad range of current issues at the Trust themed around operations, quality, systems and strategy, and workforce, wellbeing and recognition.

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

This report covers the months of May and June and, among other issues, includes updates on:

- Covid-19
- How we are managing current pressures
- Our electrical works
- Monkeypox
- System oversight framework
- Developments on site
- Staff Excellence Awards
- Our support for the Armed Forces community

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	**X**	**X**	**X**	**X**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	
Next Steps	

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	**X**		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	**X**		

The report includes an update on Monkeypox, a rare viral infection most common in remote parts of Africa. The disease, first found in monkeys, does not tend to spread easily between people but can be transmitted through close physical contact, including sexual intercourse.

The UK Health Security Agency has said that a notable proportion of early cases have been detected in gay and bisexual men and has urged members of those communities in particular to be alert.

The report mentions our internal awards, which include a Championing Health Inequalities category.

The report also highlights work the Trust is doing to provide support to members of the Armed Forces community, who can be disadvantaged by their careers.

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Note the report**	
Accountable Lead Signature	
Date	30 June 2022

1. Operational updates

1.1. Covid-19

NHS Chief Executive Amanda Pritchard and NHSE/I Chief Operating Officer Sir David Sloman announced on 19 May that the Coronavirus threat level had been reduced from Level 4 (National) incident to a Level 3 (Regional) Incident, reflecting the drop in community cases and hospital inpatient numbers.

Local systems were asked to ensure their resilience and capability to re-establish full incident responses in the event this becomes necessary.

Systems have been asked to move resources from focussing on Covid response to a focus on recovery of patient access, outcomes and experience and to reform for the future with integrated care systems, with an immediate focus on:

- Delivering timely urgent and emergency care and discharge
- Providing more routine elective and cancer tests and treatments
- Improving patient experience.

In June we lifted many of the remaining Covid restrictions in place in our buildings including social distancing and the requirement for staff, visitors and patients to wear face masks in the majority of areas. Mask-wearing remains a requirement in the Emergency Department and Urgent Treatment Centre.

Staff working in areas where there is a high flow of patients, such as assessment wards, outpatient areas and in our primary care practices are encouraged to wear masks.

We've also made changes to swabbing elective patients, with patients no longer required to come in to hospital to take a PCR test three days before an operation and then isolate at home. Instead they are asked to carry out a lateral flow test and bring the negative test result with them.

All of this highlights how we are living with Covid but the lifting of these restrictions nationwide, combined with more mixing over half-term and the long Jubilee weekend, and new strains of the virus, have coincided with an increase in cases and hospital admissions during June, following a decline in May.

The number of inpatients we have in Great Western Hospital with Covid-19 declined towards the end of April and through May, but we have seen an increase recently.

This really highlights the importance of maintaining excellent standards of infection control so we can keep our staff, patients and visitors safe not only from Covid but from other transmissible viruses.

1.2. Managing current pressures

In May we trialled a coordination hub working alongside colleagues in primary, community and social care and the ambulance service in an effort to coordinate improved patient flow through the system.

Across BSW a new best practice framework has been agreed to support staff to make decisions about admission to, and discharge from, acute hospitals. This has been worked on collaboratively in the hope that by following this framework, staff will be supported to take appropriate positive decisions, minimise collective harm, and use available resources to meet significant demand. In this way, we will seek to avoid unnecessary or prolonged admissions and reduce any delays to discharges, by exploring all possible options to get patients back into their usual environments with enough support if it is needed.

At GWH we have run an ongoing SAFER process with discharge coordinators and operational leads working together in our SAFER hub in close liaison with partners. We have seen, on some days, a reduction in the number of patients requiring support to leave the Trust and a real improvement in pathways to get patients to the right service first time. This has been significantly aided by cross-organisation and team working, but the system remains very busy.

From July onwards a coordination hub will be running from Monday to Friday to maintain focus on flow.

1.3. Electrical works

In May the final work to bring the whole GWH site back onto mains power with back up from the brand new generator system was completed. The new generators are the first replacements since the hospital was built and will offer greater resilience against mains power disruptions.

Serco, Estates and the coordination teams worked extremely hard to manage the switch over and the planned disruption to our systems and my thanks go to all those involved in ensuring that this went as smoothly as possible.

1.4. Monkeypox

Board members will be aware that UKHSA is investigating a number of cases of the rare infectious disease monkeypox in England. Evidence suggests that there may be transmission of the monkeypox virus in the community, spread by close contact.

Monkeypox is a viral infection associated with travel to West Africa. It is usually a mild self-limiting illness, spread by very close contact with someone with monkeypox and most people recover within a few weeks. Public health messaging has advised people with monkeypox symptoms, however mild, to call NHS 111 or a sexual health clinic immediately, and avoid close personal contact with others until they know this is not monkeypox.

We have developed plans for managing any patients who present with symptoms and are continuing to closely monitor emerging national guidance and the forthcoming roll-out of a vaccination programme which we will support through our Sexual Health Clinic.

At the time of writing there were more than 900 confirmed cases in the UK, but cases remain low in the South West.

2. Quality

2.1. Patient Safety Awareness Week

We held our first ever Patient Safety Awareness Week, with a number of talks, information stands and activities taking place in the Academy.

Talks included a patient sharing their experience of hospital, with teams including midwifery, care therapy, recruitment, quality and safety, tissue viability, and radiology among those showcasing some of their work.

2.2. Carer's Cafe

In May we re-launched our Carer's Café in the Refresh restaurant at GWH, with an open invitation to members of the public and staff who are carers to come along to meet staff and volunteers to ask questions and get information and advice to help support them in their roles as carers.

Carers play a key role in supporting our patients and we were pleased to be able to offer this opportunity once again.

3. Systems and Strategy

3.1. System oversight framework

As part of its oversight framework, NHS England allocates trusts and Integrated Care Boards to one of four segments based upon the scale and general nature of support needs. These ratings range from Segment 1, where no specific support is required, to Segment 4, where there is a requirement for mandated intensive support.

As a Trust we have retained our position in Segment 2. The RUH is also rated as 2, with Salisbury in Segment 3. Overall, the BSW ICS is Segment 2.

3.2. On site developments

The Great Western site has developed considerably in the last couple of years and some of these building projects are now coming to completion.

Radiotherapy Centre

Last month the OUH Radiotherapy Centre @Swindon was officially opened. This was a significant milestone not just for our Trust in partnership with Oxford University Hospitals NHS Foundation Trust, but also Brighter Futures, whose fund-raising efforts made this possible, and for Swindon itself. This is a really significant step forward for healthcare provision in the town and will make a positive difference to countless patients over the forthcoming years.

The centre is an expansion of OUH's radiotherapy service, meaning Swindon patients will no longer need to travel to Oxford for treatment and this will have a positive impact on the lives of patients needing radiotherapy.

The development was made possible thanks to the £2.9 million raised by Brighter Futures and the incredible support of local fund-raisers.

At the opening ceremony the ribbon was cut by two patients from Swindon, Fred Bassett and Sandra McGlone, alongside Liam Coleman, Chairman, Cat Weaver, Associate Director of Fundraising and Voluntary Services, and senior representatives from OUH. Guests were also invited to walk around the Radiotherapy Centre, and had the opportunity to see the two new linear accelerators - mostly used for external beam radiotherapy - and a CT scanner which was fundraised for by Brighter Futures.

The first patient is expected to be treated at the Radiotherapy Centre later this month.

Urgent Treatment Centre

Our new Urgent Treatment Centre, developed as part of our Way Forward Programme, will be officially opened tomorrow.

This milestone follows our successful bid for £15million of government funding to demolish and replace the Urgent Care Centre, with the new Urgent Treatment Centre. This new, larger building, has been constructed so that it can be extended upwards, up to a further four floors, at a later date.

Patients will receive a much better service in the new Urgent Treatment Centre – on arrival they'll be signposted to the most appropriate service for their needs, and there will be additional clinic rooms and more space in both the adult and paediatric waiting areas.

The first patients are expected to be seen next week.

Diagnostics

The first of the new mobile diagnostic units were delivered on site at the start of this month.

Our three new mobile diagnostic platforms will give us extra diagnostic capacity and, specifically, will allow a mobile PET-CT scanner to operate on the GWH site.

Community Open Day

Later this month we plan to open up our site for members of the community to have tours around the site to see how it has changed and hear more about what is planned for the future and to mark our 20th year.

This community event will see local people invited on to the site for a day of guided tours of all site developments and the chance to hear and talk to staff directly involved in the projects.

3.2. Improving Together

Our roll-out of Improving Together continues with staff embracing the opportunity to make improvements in their own area.

We have seen some good ideas come forward from staff and will now begin to share these with the rest of our organisation to highlight the good work being done.

Further bootcamps will take place in July for staff to be trained in the methodology and new way of working.

3.3. Integrated Care Board

Last week saw the Bath and North East Somerset, Swindon, and Wiltshire Together Integrated Care Board become a statutory body, in line with the reorganisation of the health system following on from the Health and Care Act 2022.

We recognise this change as an opportunity to work more closely with our partners than ever before to work together to meet increased demand and provide better joined up care.

3.4. NHS ConfedExpo

NHS ConfedExpo, the first joint conference of NHSE and the NHS Confederation, was held in Liverpool last month.

During her keynote speech NHS Chief Executive Amanda Pritchard outlined three challenges:

1. Access – how does the NHS make sure the people who need care can access it in a timely and convenient way?
2. Quality – when people do access care, how does the NHS ensure it is safe, clinically effective and early enough to prevent more extensive care later on? Whilst also treating patients as individuals.
3. Financial sustainability – how does the NHS not just balance the books, but invest to improve services and save money in the future?

Her speech also touched on an issue which has been highlighted locally with our growing population – the availability of beds within the system.

Amanda announced there would be a review of the NHS' capacity so that it could be right-sized considering what is needed in hospitals, in the community, and virtually.

3.5. Forthcoming visits

The relaxing of Covid restrictions means we are now once again able to showcase our work and new developments on site, in person.

Tomorrow we will be joined on site by Justin Tomlinson, MP for North Swindon, who will be shown around the GWH site and join us at the ribbon-cutting ceremony for our new Urgent Care Centre.

Later in the month we will host Elizabeth O'Mahoney, NHSE Regional Director for the South West, and welcome the opportunity to highlight some of our current challenges, along with recent successes and opportunities through integrated working.

4. Workforce, wellbeing and recognition

4.1. Staff Excellence Awards

Last month we held our Staff Excellence Awards – the first time this has been held in person since 2019.

More than 400 staff attended the event to celebrate the incredible achievements of their colleagues

The night was hosted by consultant radiologist Andy Beale and a number of acts performed throughout the evening with everything from contortionism to singing and magic and celebrity appearances.

This year's finalists were whittled down from over 200 nominations, and our 2022 winners are as follows:

- Team of the Year: Cardiology Physiology Team
- Star of the Year: Covid Vaccination Team
- Improving Patient Experience Award: Lauren Watts, nurse practitioner
- Improvement and Innovation Award: Perinatal Team
- Leading the GWH Way Award: Michele Grange, advanced clinical practitioner
- Excellence in Integration Award: Dr Patricia Monteiro and Dr Bushra Sohail
- Partnership Working Award: Navigation Hub Team
- Wellbeing at Work Award: Jerry Spary, rehabilitation assistant
- Championing Health Equalities Award: Justin Sysum, clinical audit and effectiveness facilitator and Esther Williams-Delhoum, safeguarding lead
- Patient choice Award: Lucy Loveday, community sister
- GWH Rising Star Award: Dr Nadiya Johal, cardiac physiologist
- GWH Lifetime Achievement Award: Dr Helen Jones, consultant

Congratulations go to all the winners and all of those nominated for an award this year.

My thanks go to the organising team who worked extremely hard to deliver a great event.

4.2. STAR of the Month

Our latest STAR of the Month is Mark Chapple, Head of Estates and Facilities.

Mark was nominated for some great work on top of his varied day job managing the service provided across all our sites including those provided through the PFI contract. He has managed the extra requirements of the pandemic, the £1m oxygen upgrade, and the £1.6m upgrade to hospital back-up generator, to name just some of the projects he has been involved in.

4.3. Parliamentary Awards

Our Admiral Nurses Tim Allen and Hannah Rogers won the South West Parliamentary Award in the Nursing and Midwifery category. They were successful among 87 nominees.

Tim and Hannah specialise in dementia care, operating an acute and community-based model so that patients and families can be supported in the hospital and in their own homes.

They went forward to the national awards ceremony in London which was due to be held yesterday (6 July).

4.4. PERIPrem

Colleagues working across our maternity and neonatal teams, local partners and new mums joined together to celebrate two years of the PERIPrem project in the Academy last month.

PERIPrem improves outcomes for babies born prematurely, and has reduced the risk of death by 22% across the South West.

The team also presented at NHS ConfedExpo in Liverpool last month, and Consultant Paediatrician and Neonatologist Dr Sarah Bates spoke to an international audience about the success of this ground-breaking work at the European Congress of Perinatal Medicine in Lisbon, Portugal.

4.5. Support for the Armed Forces Community

We marked Armed Forces Week last month and were pleased to use this as an opportunity to share the news that we have been awarded a Silver Employer Recognition Scheme Award.

The Silver Award recognises employers who actively demonstrate support made in their Armed Forces Covenant, and employ at least one member of the Armed Forces Community.

This is recognition for the work we have done so far to show our support for the people who make up our Armed Forces community; from currently serving troops to service families, veterans, reservists and cadets.

Across the Trust, we have already taken a number of steps to become a more veteran aware organisation. This includes setting up an Armed Forces Network to embed the Armed Forces Covenant and putting support in place for staff and patients.

Our aspiration now is to secure Gold recognition to reflect our status as an organisation which is doing everything possible to be a truly forces-friendly employer.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**7th July 2022**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Lisa Cheek, Chief Nurse				
Report Author	Al Sheward – Deputy Chief Operating Officer Rayna McDonald – Deputy Chief Nurse Claire Warner – Associate Director of HR Operations Elizabeth Hills – Head of Financial Management				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC Chart – Pay				

Purpose							
Approve		**Receive**		**Note**	x	**Assurance**	x
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Significant		**Acceptable**	x	**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

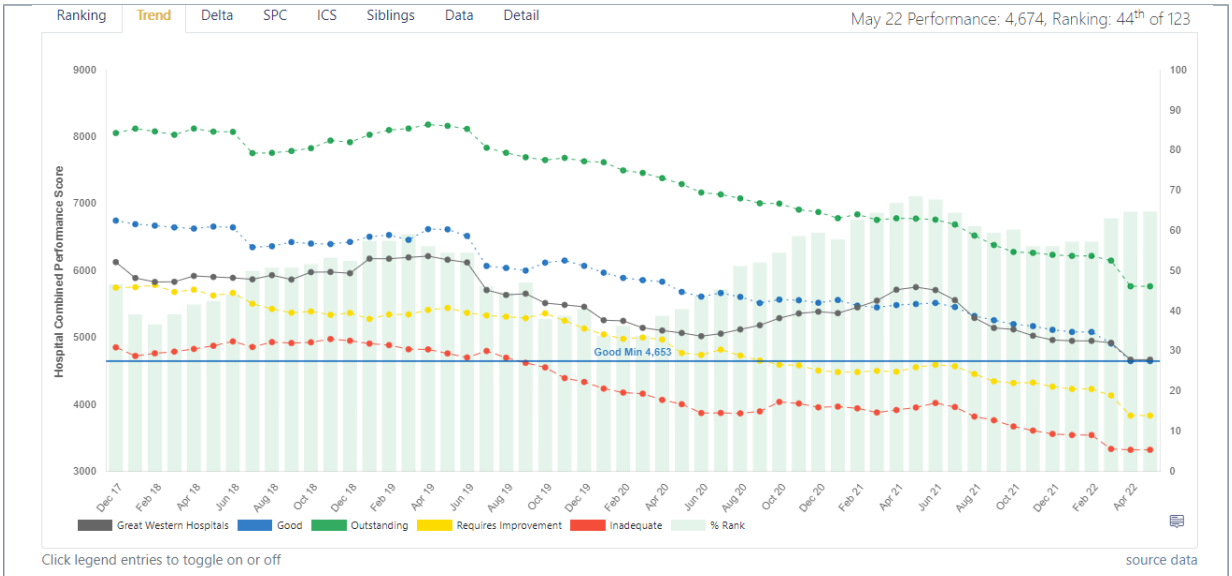
Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

The Integrated Performance Report provides a summary of performance against the CQC (Care Quality Commission) 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. The Trust continues to use other data sources to compare itself.

Key highlights from the report this month are:

Our Performance

Our ranking against the Hospital Combined Performance Score on Public view in May 2022 places us 44th out of 123 Trusts, an improvement from 47th out of 123 in April 2022. The trend chart below reflects our aggregate position against CQC measures, and our overall performance is tracking at 'Good.'



There were several metrics in which the GWH (Great Western Hospital) ranking deteriorated month on month, leading to the reduction in the Hospital Combined Performance Score (HCPS) in May, however the performance of GWH relative to other trusts nationally has seen our overall ranking rise compared to April position

- MSSA (Hospital Onset)
  - Feb 22 – 11.26 Rank 72
  - Mar 22 – 13.17 Rank 101
- C.Difficile (Hospital Onset)
  - Feb 22 – 16.38 Rank 69
  - Mar 22 – 17.22 Rank 76
- MRSA (Hospital Onset)
  - Feb 22 – 1.04 Rank 102
  - Mar 22 – 1.01 Rank 107
- A&E DTA to Admission
  - Mar 22 – 23.43% Rank 40
  - Apr 22 – 26.82% Rank 44
- RTT (Referral to Treatment) 18wk
  - Mar 22 – 58.45% Rank 136
  - Apr 22 – 57.40% Rank 138
- E Coli
  - Feb 22 – 14.8 Rank 29
  - Mar 22 – 14.2 Rank 31
- Summary Hospital Mortality Indicator
  - Dec 21 – 86.43 Rank 11
  - Jan 22 – 88.46 Rank 12

However, several metrics that drive the HCPS calculation have improved month on month:

- A&E 4-hour standard.
  - Mar 22 – 74.67% Rank 52
  - Apr 22 – 76.08% Rank 43
- Cancer 62 Day Classic
  - Feb 22 – 76.83% Rank 29
  - Mar 22 – 81.18% Rank 25

There were also several metrics where the GWH overall ranking had not changed as either no updated data has been published by NHS (National Health Service) England this month as these are quarterly updates or have been paused due to the pandemic.

- Staff Recommend Care
- Sickness Absence
- Complaints rate
- Financial YTD (Year to Date) Surplus / Deficit

URGENT & EMERGENCY CARE

Hospital Handover Delays (HHD) increased in May 2022 to 1480 from 952 hours lost. There has been a reporting change in month to include **ALL** ambulance delays and not just those previously considered to be "chargeable". Although there are more hours being lost, patients are overall waiting less time to be Handover to the Emergency Department.

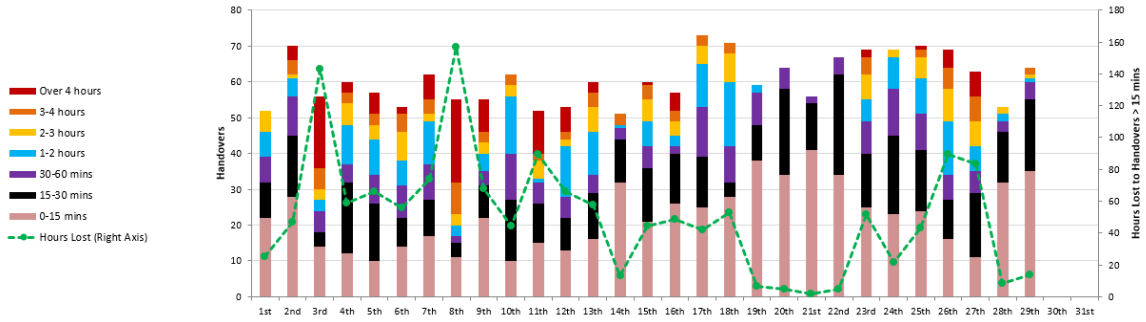
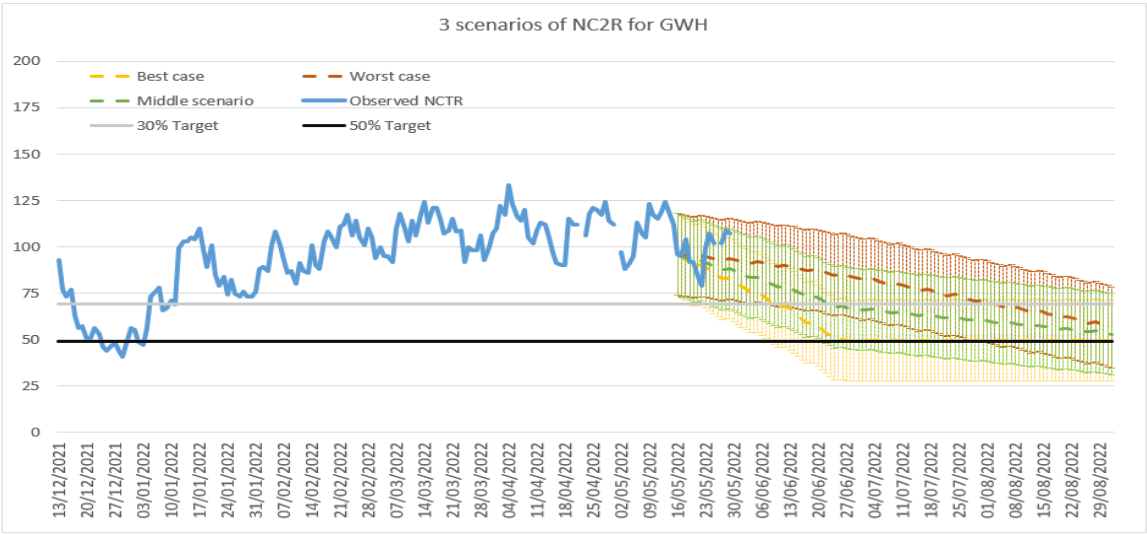


Table - Total Hospital Handover Delays May 2022

In May 2022 there has been a decrease in 4-hour performance of – 2.2%. Overall attendances have increased by 1269 patients from April. ED - 769 increase & UTC – 500 increase (UTC remains closed overnight). 4 Hour breaches have increased by 535 overall, ED – 446 increase, UTC – 89 increases. There were 98 x 12-hour reportable Decisions to Admit (DTA) breaches – equal to April. In the coming months all patients who wait >12 12 hours will be reported. The final reporting metrics are currently being consulted on.

Bed occupancy remained above 98% for the duration of the reporting period. The number of patients waiting to leave the Trust who require support from partner organisations increased in May again with the Integrated Care Alliance (ICA) not achieving the 30% reduction in patients with no criteria to reside non-Criteria to Reside (NC2R). The closure of the admissions lounge also took place in the month of May although no significant additional operational pressures were seen as a result of this.



DISCHARGES - The Trust is tracking against the worst-case scenario for patients with No Criteria to Reside (NC2R). In May this has averaged a run rate of 80-100 patients at any one time. 35% of patients waiting require support from the Wiltshire system. 60% require support from the Swindon system. Pathway zero run rate remains high. >85% of patients who leave the Trust leave on Pathway 0. Numbers of discharges at weekends falls significantly in all pathways including Pathway 0. The number of patients who have been in the Trust for >21 days waiting to be discharges continues at around 50 patients. The number of patients who have been in the Trust >50 days is has seen a

reduction from 22 to 14. GWh continues to use the implementation of the National Discharge Grant and work to reduce the number of patients arriving at the Trust continues with partners. A “soft launch” of the D2A process beings in early July 2022.

COMMUNITY - Average length of stay (LoS) for patients in the community wards increased in May 2022 to 19 days from 17 days in April. Medical cover has been more stable in month. The planned implementation of the D2A model is progressing well. May saw 799 referrals to the 2 Hour Rapid response service. The highest seen since reporting commenced. Response rates typically run at 85-95%. Virtual Ward (VW) referrals in May 2022 were 30. This is a reduction from April 2022 and may be related to the capacity being full and therefore wards not referring. Total VW face to face (f2f) contacts in May exceeded 200. GWH Primary Care access saw Average call wait times during May 2022 were 8.1 minutes (April 8.3mins). The trend over 3 months is an increase in call wait times.

COVID - Overall numbers of patients with Covid continue to decrease. Over 80% of inpatient covid is identified as an incidental finding. The number of patients requiring Level 3 care (ITU) continues to remain low with some periods of May without any patients in ITU with Covid 19. Work is underway to try and predict Covid Demand over the winter period.

RTT - The Trust reported an RTT Incomplete Performance of 60.15% in May 2022, an improvement of 2.76% in month. This is largely as a result of increased referrals and therefore the % of patients <18 weeks has increased. The number of patients with a Clock Stop has yet to show signs of improvement. The Trust reported a waiting list of 31,703 (an increase of 878 in month) against a trajectory of 32,025 (322 ahead of trajectory). The Trust received 10,504 referrals in May 2022, which is a 17% increase when compared to the previous month (likely to be due to the Easter break in April 2022). 852 x 52-week reportable breaches were declared in May 2022, an increase of 108 in month. There were no 104 breaches in May 2022. The number of patients over 78 weeks in April was 49 patients. In May 2022 there were 50.

DIAGNOSTICS - Performance was 49.9% in April compared to 54.3% in March a decrease of 4.33%. Overall, the total waitlist size has increased to 11,476 compared to 10,636 in March February (+840). Breaches have also increased to 5,471 from 4,861 (+610).

CANCER - (April's performance)

- **2 week wait April performance 91.6% -** The standard in April was not met, due to Colorectal (85.9%), Lung (88.2%), Upper GI (89.6%), Urology (90.5%), Gynaecology (91.0%) & Skin (91.7%) not achieving their target.
- **28 Day Diagnosis** - The standard was met in April with a performance of 81.6% (235 breaches).
- **Cancer 62-day** - April 62 day performance is 73.5% (73.5 treatments, 30 patient pathways breached resulting in 19.5 breaches) with the Trust not achieving the national 62-day standard. The performance had been predicted to be challenged, of the 22 predicted breaches for diagnosed patients:

Our Care

Medicines Safety

Number of medication incidents has increased in 2022, indicating improved reporting. The proportion of incidents resulting in harm continues to remain consistent across the year.

The work centred on reducing prescribing incidents, through consolidation of paper-based drug charts has been completed. The measurement of impact of this change is planned for June through a snapshot audit. The upgrade of the electronic prescribing and administration system (EPMA) is scheduled to go live in July 2022. This will improve user experience and patient safety through to improved processes and workflows relating to medicines use.

Infection Control

In May there was one reportable *C. difficile* infections which was a Healthcare Associated (HOHA) identified. The Trust has been set a trajectory of 48 *C.difficile* infections for 2022/23, which means that at the end of May 2022, we are slightly under trajectory.

Improvements in care are being targeted through a focus on the fundamental principles of good IP&C practice, including monthly focus topics on hand hygiene, environmental cleanliness, intravenous device care and antimicrobial stewardship. Hand hygiene was the focus topic throughout May, with events supporting hand hygiene day and glove awareness week.

The number of patients diagnosed with COVID-19 has decreased in May in line with the national and regional picture. There have been several outbreaks and clusters which were managed through the daily outbreak meetings. The new guidance and change in isolation for exposed patients has continued to result in a reduction in lost bed days. To date there is no evidence that the change has led to an increase in outbreaks. In line with national guidance a detailed review of Nosocomial deaths is underway.

Pressure Ulcers

There were a total number of 244 incidents reported for pressure ulcer related harms during the month of May. All of these were validated by the Tissue Viability Nurses (TVN's), with 20 of these incidents attributed as hospital acquired.

Training continues to be an area of focus with repose equipment training delivered in May and continuing throughout June. A Moisture Associated Skin Damage Training session was successfully delivered to SWICC (Swindon Intermediate Care Centre) and the Emergency Department with future sessions booked. There has also been a remarkable success with the Tissue Viability Nurse Educational Wound care drop-in study day for all Trust Staff review dressing choices and selections following current formulary over 130 attended and 30 Safer skin champions recruited.

Within the community setting the total number of harms reported in month is 93, this is an increase compared to last month. 36 harms occurred whilst on the community nursing caseload, this is also an increase from last month. There is a reduction in category 3's and 4's with an increase in lower-level harms, which could suggest earlier reporting.

There has been an improvement in catheter associated mucosal harms since the beginning of the year with a reduction from 3-5 harms per month to 1. Work continues to improve care of patients with catheters to prevent catheter associated damage and includes a review of the catheter passport and development of 'safe patient discharge' education package.

Falls

There were 147 reported inpatient falls in month, resulting in 7.40 per 1000 bed days, this remains within normal variance, with six falls which resulted in moderate/severe harm. During May 2022, there were six falls which resulted in moderate/severe harm. None of these patients had previously fallen as inpatients.

The final Swindon Falls and Bone Health Strategy document expected to be agreed at BSW Health and Wellbeing Board 26th July 2022. There is no commissioned Fracture Liaison Service for the Swindon population. The role of an FLS is to systematically identify, treat and refer to appropriate services all eligible patients within a local population who have suffered fragility fractures. The aim is to reduce their risk of subsequent (or secondary) fractures. Initial proposals for a local FLS are being taken to BSW CCG Ageing Well Board in July to determine commissioning intentions.

Patient Safety

At the time of reporting, there are a total of 25 ongoing Serious Incident (SI) investigations, with five incidents reported in May 2022. There are no themes identified on the newly reported SI's. Learning from incidents and SI's remains a priority and the development and roll out of the Learning Zone continues to provide a virtual platform for sharing.

There are currently nine different videos available to watch alongside other learning material within the Learning Zone including, Weight Based Medication Errors (Children), Getting Medicines Right (Oxygen) and Falls.

Safer Staffing

It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved. The Overall fill rate for both Average Fill Rate - Nurses/ Midwives (%) and Average Fill Rate – Health Care Assistant (HCA) (%) increased from last month. Hazel, Delivery & White Horse Birthing Centre were the only area that had below 90% average fill rate for both Midwives (%) and HCA on days. This has been reviewed by the Director of Midwifery.

HCA vacancy rate continues to improve, currently there are 38.7 whole time equivalent (WTE) band 2 vacancies, with 52.24 WTE in the pipeline going through pre-employment checks. Recruitment trajectories have been completed and work is underway in the divisions to ensure the new HCA establishments are being recruited to. Year 1 investment also included increasing the registered nurse to patient ratios to 1:8 on 4 wards and good progress is being made towards this. This is an important step to demonstrate compliance with the 1:8 national guidance across the Trust.

Patient Experience

For May, 81.5% of the Friends and Family Test (FFT) responses were positive, in line with the previous month April, at 81.5%. The negative responses at 12% are very slightly lower than last month at 12.6. This is based on the % of responses rated as 'very good' and 'good'.

There were 47 complaints received in May 2022 (previous month 44) and 88 concerns (previous month 130) were received in May 2022. Out of a total of 135 cases received from Complaints and Concerns in May, the overall top three themes were communication, behaviour and attitude of staff and clinical care.

Maternity

One incident was graded as moderate harm for the perinatal services in May. This case has been reviewed via an urgent incident review with multi-disciplinary engagement.

The PROMPT and Fetal Surveillance training trajectory of bookings and attendance exceeds the 90% requirement for bookings up to July 2022; the team will aim to maintain a rolling 90% compliance with annual updates. It is anticipated that both PROMPT and Fetal Surveillance training compliance will meet or exceed the 90% target for submission in January 2023.

The birth rate for May increased which is reflected in the midwife to birth ratio; this was an anticipated increase due to the booking projections and the midwife to birth ratio remains within the targeted range.

Our People

This section of the report presents workforce performance measured against the pillars of the 'People Strategy' – Great workforce planning, opportunities, experience, employee development and

leadership. Each area is measured with a KPI indicator achievement score and self-assessment score based on progress in month.

Exceptions in May: The Trust vacancy KPI has decreased significantly to 7.31% in month from 8.03% in April, a decrease of 38WTE.

The in-month agency spend as a % of the total pay bill has decreased further from 6.82% to 6.57%, although continues to remain above Trust target (6%). The increased demand on services continues as evidenced by the use of 90WTE exceeding the substantive budgeted WTE. The top contributing staff groups being – Unregistered nursing using 115WTE temporary resource (bank/agency) compared to a 46WTE vacancy position; and medical staff using 77WTE temporary resource (locums/bank) compared to 60.9WTE vacancy position.

Electronic Rostering roll-out has progressed during May for the Emergency Department and Obstetrics & Gynaecology. Triangulation of roster demand and templates against Finance and Job-Plan information has taken place to allow reconciliation of worked time against budgets within these departments.

Time to hire in May is 67 days and exceeding the Trust target of 46 days, attributable to delays with shortlisting and issue of offer letters.

The HCA vacancy position has improved to 11.30WTE and the introduction of the bespoke welcome pack has been favourably received by candidates. Recruitment campaigns for 'hard to fill' roles continue with positive results with the recruitment of substantive GP in Urgent Treatment Centre; advertising of specialist Consultant roles in Medical Oncology and Microbiology with competitive packages; and promotion of a Biomedical Scientist Day planned for 13th June 2022.

Sickness absence decreased in-month to 6.05% of which 2.08% is Covid related absence and 3.97% is non-Covid related. In addition to the on-going provision of a range of staff health and wellbeing support initiatives it is important to encourage Managers to engage with the training on offer for Mental Health First Aid and holding the HWB conversation with their teams.

Trust appraisal compliance is reported at 73% in May, increasing by 3% over the month and remains an area for further improvement impacting on the Trust leadership score and an important measurement of staff engagement.

The workforce priorities for the month ahead continues to be to understand and reduce the level of staff absence, continue with the improvements in our vacancy position and timely recruitment process, increase appraisal compliance rates and continue to improve the efficiency of process in place for medical workforce staff.

Use of Resources

The full year plan for the Trust is a deficit of £26.7m. The Trust is reporting a deficit in Month 2 of £2.0m against a planned deficit of £1.7m (£0.3m adverse to plan). Year to date the deficit is £4.5m against a planned deficit of £3.8m (£0.7m adverse to plan).
Income is above plan in month (£0.2m) driven primarily by high-cost drugs with the offset included within expenditure. The expenditure over spend in month is also driven by pay costs in excess of budget in Unscheduled Care, which is partially offset by vacancies elsewhere across the Trust.
The cash position at the end of April was £32.1m which is below plan of £38.6m. Year to date capital spend is below plan (£0.5m expenditure against a plan of £1.2m).

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		**x**	**x**	**x**
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Trust Board (Public)				
Next Steps					

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			**x**
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			**x**
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	
Date	30th June 2022

NHS
Great Western Hospitals
NHS Foundation Trust

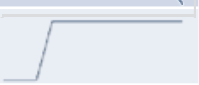
Integrated Performance Report

June 2022
May 2022 data period

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	4,674 (May)		44 (4,674)	48 (4,606)	19 (5,464)	May 22
A&E 4 Hour Access Standard (combined ED & UTC)	73.9% (May)		43 (76.1)	123 (57.7)	67 (71.7)	Apr 22
A&E Percentage Ambulance Handover over 15 Mins	62.2% (Apr)					
A&E Median Arrival to Departure in Minutes (combined ED & UTC)	200 (May)		60 (192)	119 (236)	91 (214)	Mar 22
RTT Incomplete Pathways	57.4% (Apr)		136 (58.4)	113 (63.3)	89 (65.9)	Mar 22
Cancer 62 Day Standard	73.5% (Apr)		25 (81.2)	86 (66.7)	66 (71.4)	Mar 22
6 Weeks Diagnostics (DM01)	49.9% (Apr)		151 (45.7)	123 (33.0)	46 (8.6)	Mar 22
Stroke – Spent>90% of Stay on Stroke Unit	79.4% (Q3 21/22)		54 (79.4)	45 (81.8)	2 (95.0)	Q3 21/22
Family & Friends (staff) – Percentage recommending GWH as a great place to work	61.1% (Q3)		160 (61.1)	65 (73.6)	108 (67.7)	Q3 20/21
YTD Surplus/Deficit*	-4.3% (Q2 19/20)		170 (-4.3)	27 (1.3)	109 (-1.4)	Q2 19/20
Quarterly Complaint Rates (Written Complaints per 1000 wte)	15.1 (Q2 21/22)		72 (15.15)	119 (21.9)	81 (16.5)	Q2 21/22
Sickness Absence Rate	5.3% (Nov)		78 (5.33)	74 (5.3)	16 (4.2)	Nov 21
MRSA	3.2 (Feb)		112 (3.2)	37 (1.0)	37 (0.7)	Feb 22
Elective Patients Average Length of Stay (Days)	4.1 (May)					
Non-Elective Patients Average Length of Stay (Days)	5.7 (May)					
Community Average Length of Stay (Days)	19.3 (May)					
Number of Stranded Patients (over 14 days)	136 (May)					
Number of Super Stranded Patients (over 21 days)	79 (May)					

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

**Based on English Acute & Combined Acute/Community Trusts

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		25th May 2022
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			
Winter Plans (lessons learnt)	Red	Amber	The Committee recognised the demand that COVID has placed on the service and its ability to delivery. There were positive stories to come out of the review of last year including the work done around SAFER as well as how the Trust works with the ambulance service. It was noted that ICA and ICS are still in the immature stage and therefore it is expected that there will be more progress to see moving forward. The Trust has a high number of NCR when compared to other Trusts and we are an outlier in Public View.	Update to Committee	July 2022
Integrated Performance Report – Emergency Access	Red*	Red	The service continues to remain under significant pressure with performance remaining below the 95% standard for April 2022. However, the beginnings of some improvements are being seen into May 2022 with the reduction of COVID patients and the reliance on the CAU. ED attendances decreased but remain at pre pandemic levels.	Monitor actions	June 2022
Integrated Performance	Red	Amber	RTT was just below 60% for April, with a waiting list increase of 790 in month. The Trust received 8,815 referrals, which is a 20% reduction compared to the previous month, and	Monitor actions	May 2022

Report – Elective Access/RTT			likely to be due to the Easter break. There is continued focus on 78-week position with the Trusts longest waiting patient currently at 95 weeks. Options such as internal insourcing activity to increase capacity and reduce number of long waiting patients.		
Integrated Performance Report – DM01	Red	Red	Performance reduced to 54.3% in March a decrease of 4.67% from February. To support the recovery trajectory the service is funding additional CT van days through to the end of June yielding a total of 1,404 slots. Additional MRI van capacity has also been secured yielding 720 slots until June. The additional pads for these mobile vans due to complete next month.	Monitor actions	May 2022
Integrated Performance Report – Stroke	Green	Green	Good SNNAP performance continues at Level B. The service continues to perform well despite being under pressure including the impact of COVID. It was noted the service is performing well compared to other Trust's where performance has been reported as deteriorating.	Monitor actions	May 2022
Integrated Performance Report – Cancer	Amber	Green	The service is performing well compared to others in the region despite not meeting the national target. The service is working towards the 28-day target being formalised, but will still report 2 week wait as this a KPI for GWH.	Monitor actions	May 2022
Primary Care (to include RCGP report & econsult)	Amber	Amber	The service had recently undergone a CQC inspection, the outcome of this inspection is eagerly awaited. The econsult system has been positively received and a reduction in incoming calls has been seen as a result. However there has been significant increase in the demand for the econsult service and therefore a reasonable cap will be applied to ensure demand can be managed.		
Annual Research & Innovation Report	Green	Green	The Committee were assured regarding the work being done in research and innovation, however a greater understanding is required regarding the financial aspects of this work. The DOF is already leading on a piece of working in this area.	Receive annually	May 2023
IT Performance & Infrastructure	Red	Red	Positive work is being see around the IT programme in general, with some ambitious goals which may face some challenges. The Committee has significant concerns around the EPR programme and asked for reassurance back to the June meeting, although it was acknowledged this may need to the Finance and Infrastructure Committee following the Board review.	Monitor actions	June 2022 (possibly FIC)
Health & Wellbeing Oversight Committee Update	Amber	Green	The Committee were pleased to see the good work that is being done in the area of Staff Health & Wellbeing. This had been reflected in some of the positive comments from the recent staff survey.		

Safer Staffing 6-month report	Green	Green	The Committee were assured regarding the process to support safer staffing across the Trust.	Review 6 monthly	November 2022
Integrated Performance Report - Workforce	Amber	Amber	It remains a challenging time for the Trust workforce, and the Committee recognised that work needs to be done on time to recruit. Mandatory training remains at a high level with a slight improvement in the appraisal rate noted. Sickness levels remained high in April (6%), however these had fallen to 4.5% at the time of the meeting.	Monitor actions	June 2022
IT Incident Final Report	Green	Green	The Committee were assured that a good assessment had been made following this incident in November 2021 in the Node Room. Corrective actions have been put in place and an ongoing programme of actions have been agreed.		

***Discharges were assessed as a system wide issue i.e. GWH plus other health and social care partners.**

Issues Referred to another Committee	
Topic	**Committee**

NHS
Great Western Hospitals
NHS Foundation Trust

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		29th June 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access			Performance against 4-hour standard was 73.9% (43rd in National rank out of 123 Trusts). The main issue remained the significant number of Non-criteria to reside patients in hospital beds (125) creating delays in moving patients through ED. Subsequently the number of Non-criteria to reside patients has reduced to below 100, as a result of ongoing partnership work particularly with SWAST, whose CEO has agreed to visit the Trust in August to discuss various issues affecting both organisations including Ambulance Handover delays.	Monitor Actions	July
Integrated Performance Report – Elective Access - RTT			A revised operating plan was required by NHSE which has meant a slight adjustment to the original elective plan. The Trust had 0 patients waiting over 2 years and 57 waiting over 78 weeks, making it the best performance Trust in the South West against these metrics.	Monitor Actions	July

			Over 52-week waiters increased and are included in the planning scrutiny at the new Weekly Access meetings.		
Integrated Performance Report – Elective Access – DM01			The Committee received a presentation from the Diagnostic team. The service remains under enormous pressure with only 50% of patients being seen within six-week standards. The improvement plan was discussed in detail and includes a new (replacement) DEXA scanner which will enable a 33% increased throughput, completed Capital scheme for CT and MRI pads in the grounds, increase in CT capacity for relevant patients as a result of the new Radiotherapy service and a relatively successful recruitment programme for some traditionally hard to fill posts. The trajectory suggests a steady improvement in long waiters over coming months.	Monitor Actions	July
Integrated Performance Report - Stroke			SNNAP performance remains good at Level B. The service continues to perform well despite being under pressure. The successful appointment of a long-term Locum Consultant should help boost medical input.	Monitor Actions	July
Integrated Performance Report - Cancer			Performance for a 2-week wait was 91.6% against the national target of 93%. The 28-day target was achieved. However, the Trust fell short on the 62-day treatment target (73.5% against a target of 85%) largely linked to the aforementioned pressure in the Diagnostic services.	Monitor Actions	July

Issues Referred to another Committee – IT Performance and Infrastructure	
Topic: Further assurance to be provided at the July's F&I Committee meeting surrounding challenges relating to the IT Programme	**Committee** Finance and Infrastructure 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?

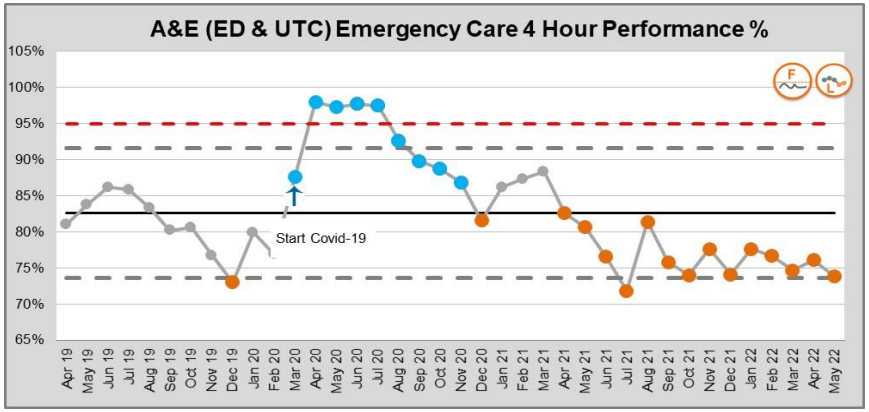
Are We Well Led?

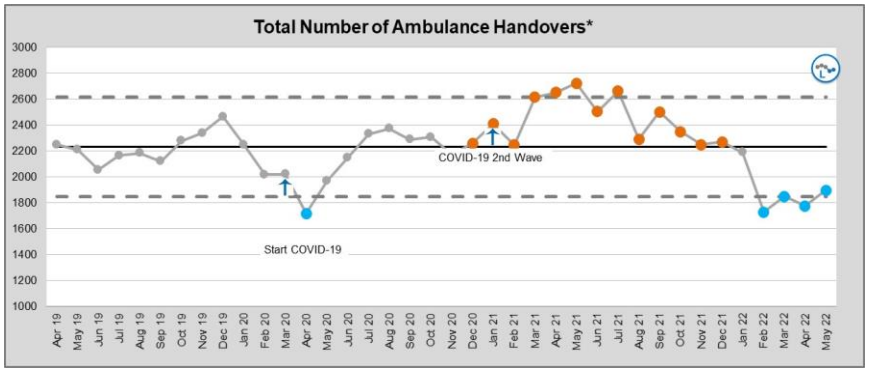
Use of Resources

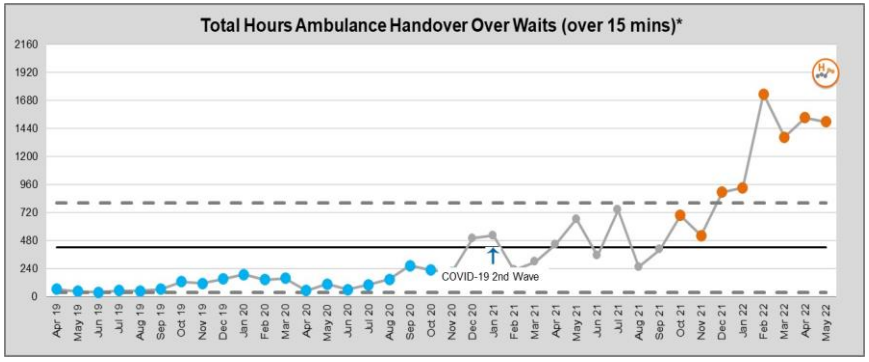
1. Emergency Access (4hr) Standard Target 95%

Data Quality Rating:

National Key Performance Indicators



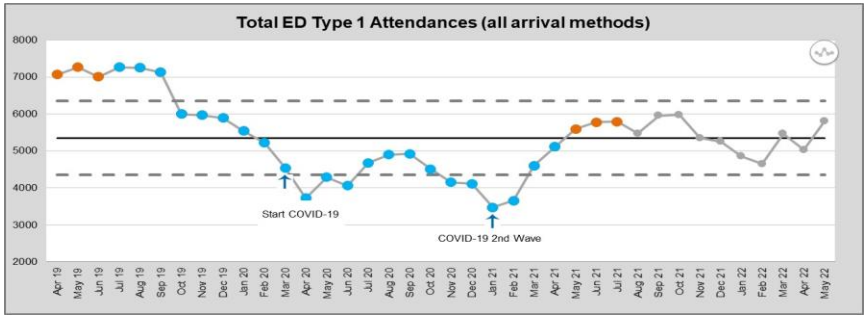


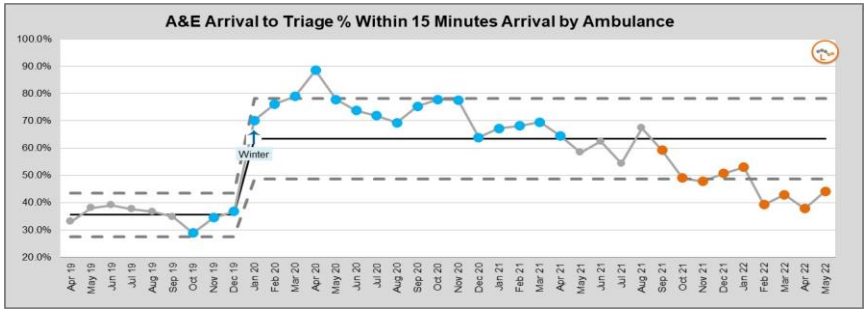


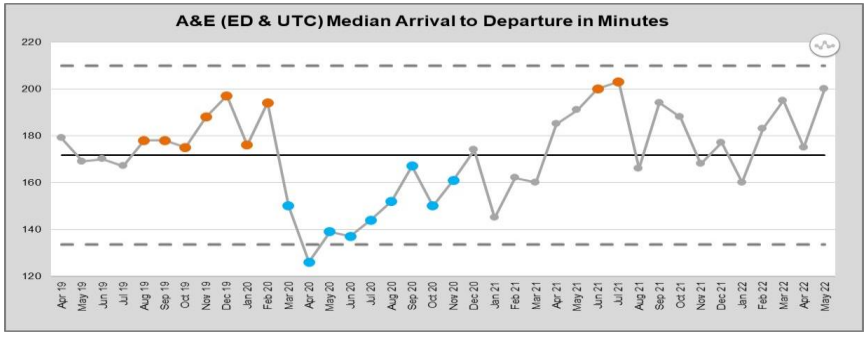
Performance Latest Month: 76.08% (Apr)

Attendances:
Type 1 ED 54.81%
Type 3 UTC 96.52%
Overall – 73.88%

12 Hour Breaches (from decision to admit) 98







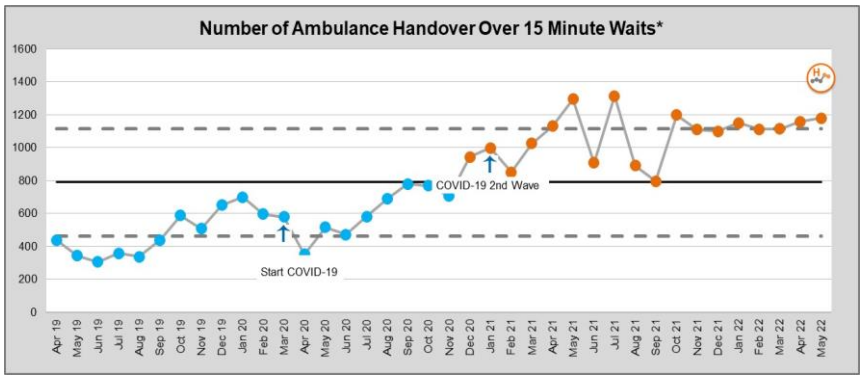
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

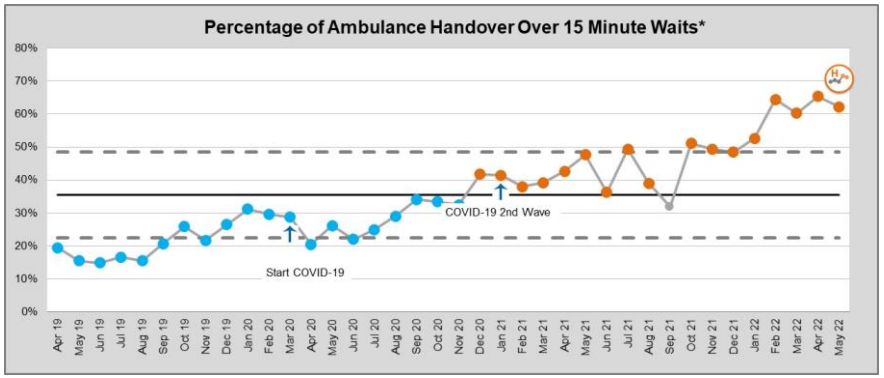
* Data from SWAST

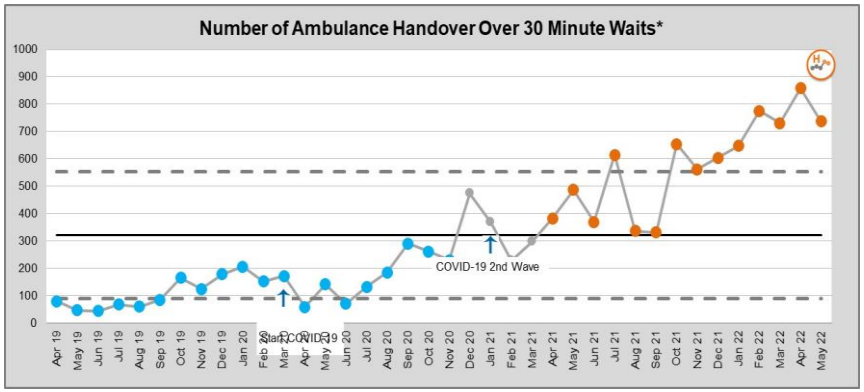
1. Emergency Care Standards – Ambulance Arrivals

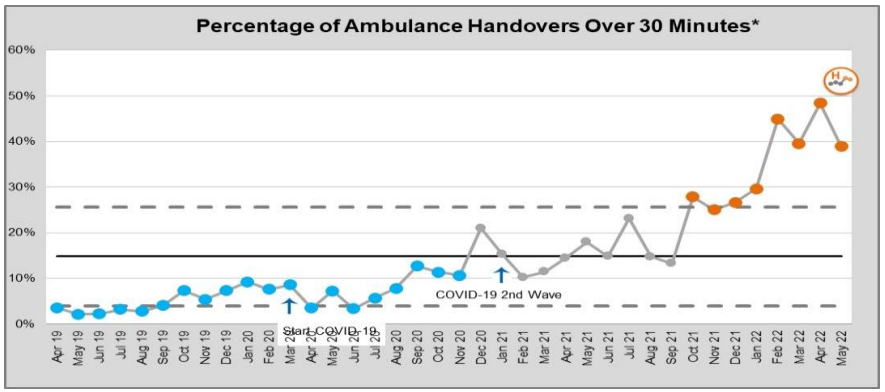
Data Quality Rating:

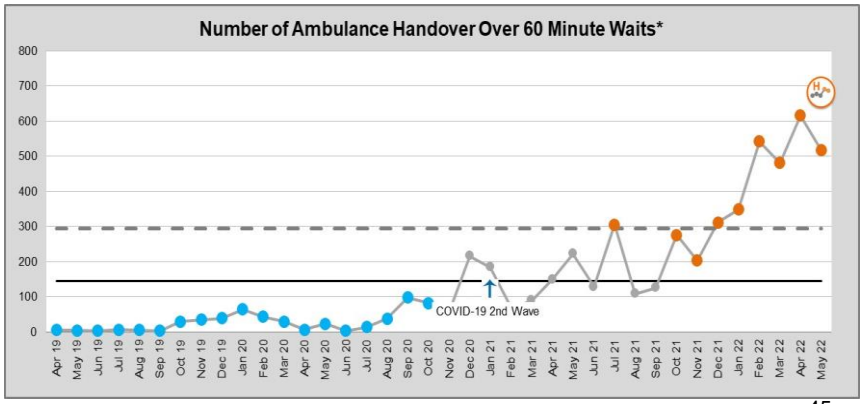
National Key Performance Indicators

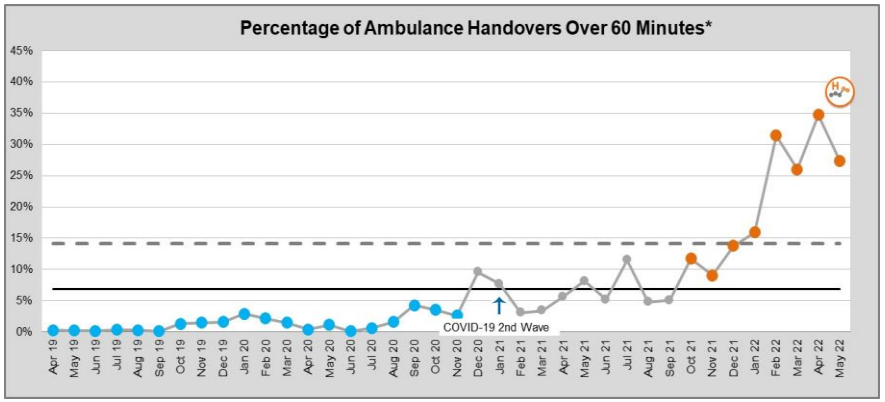












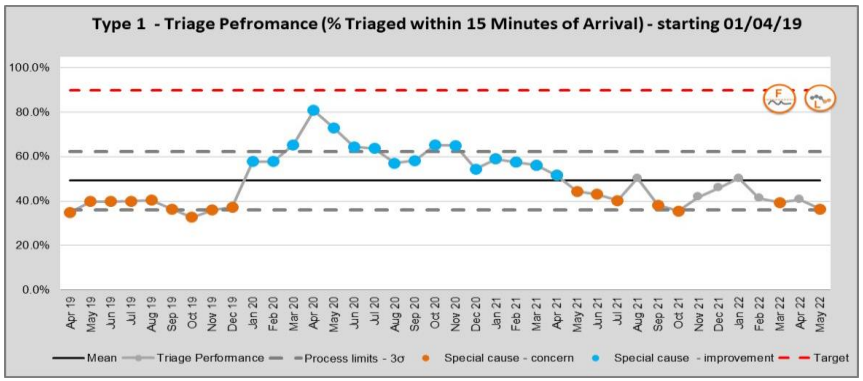
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

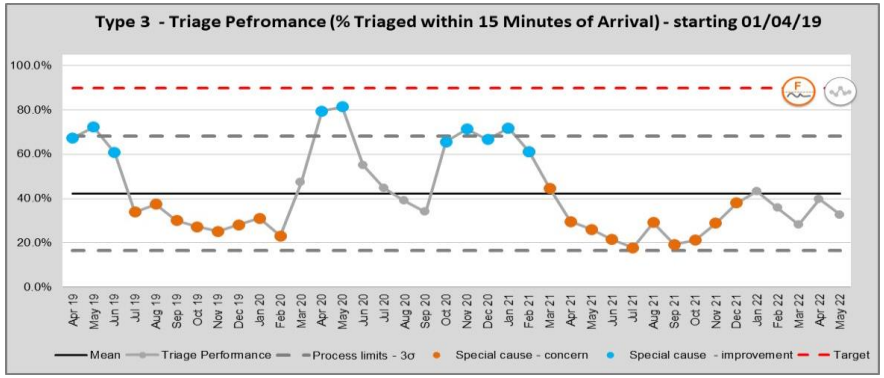
* Data from SWAST

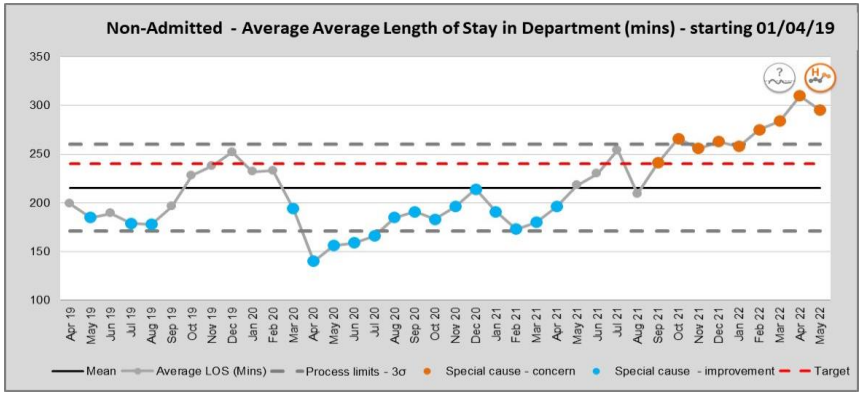
1. Emergency Care Standards – Front Door Flow

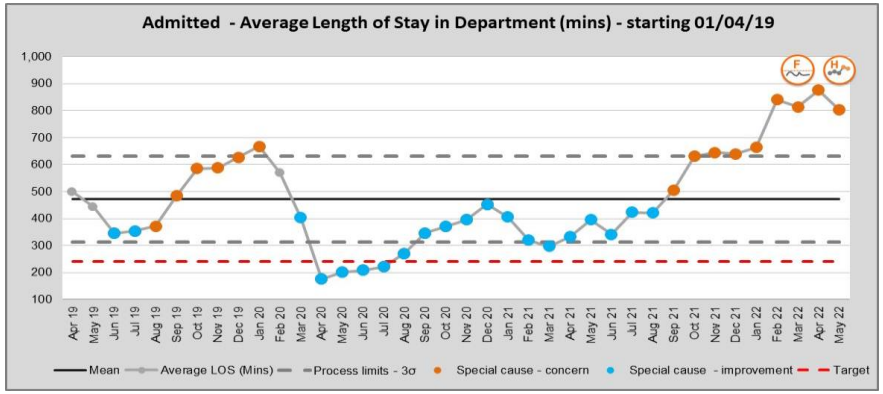
Data Quality Rating:

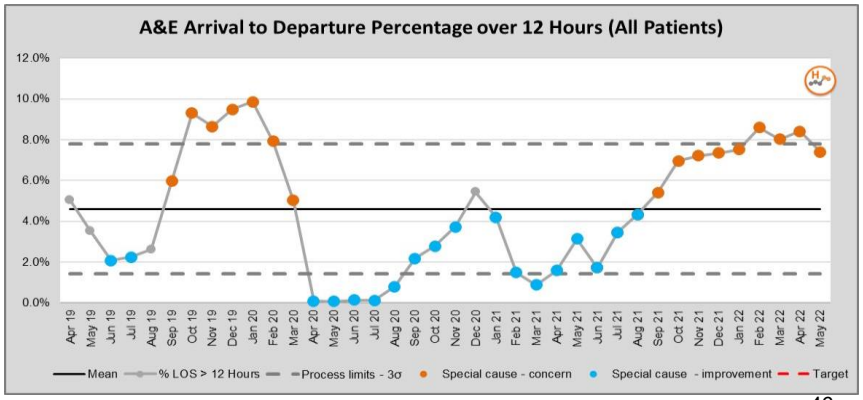
National Key Performance Indicators

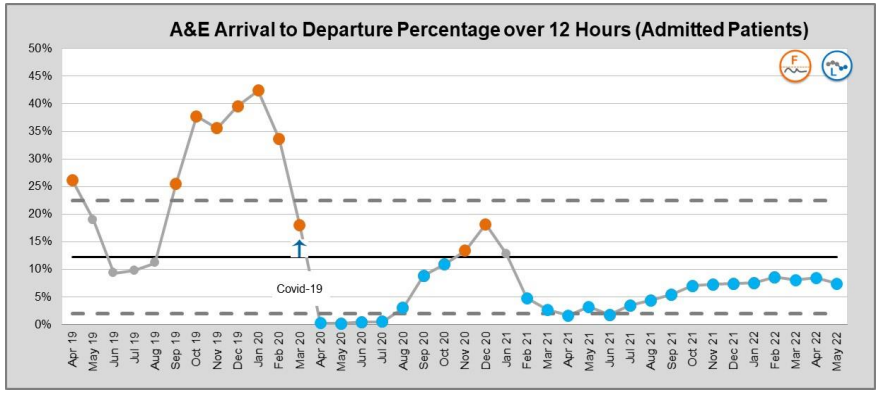












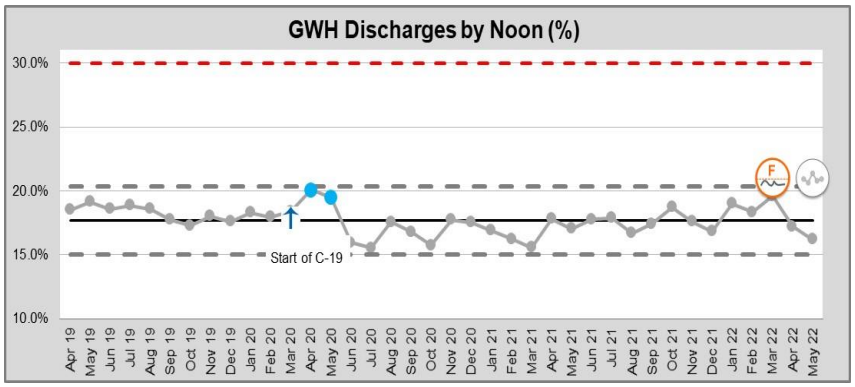
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

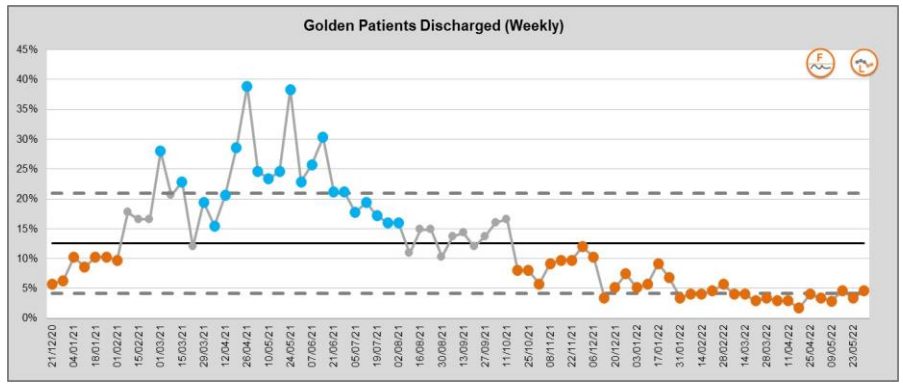
* Data from SWAST – 1 month lag

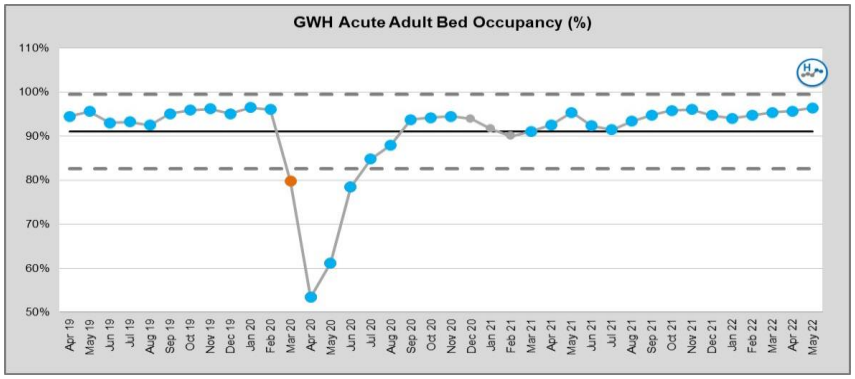
1. Emergency Access (4hr) - Patient Flow and Discharge

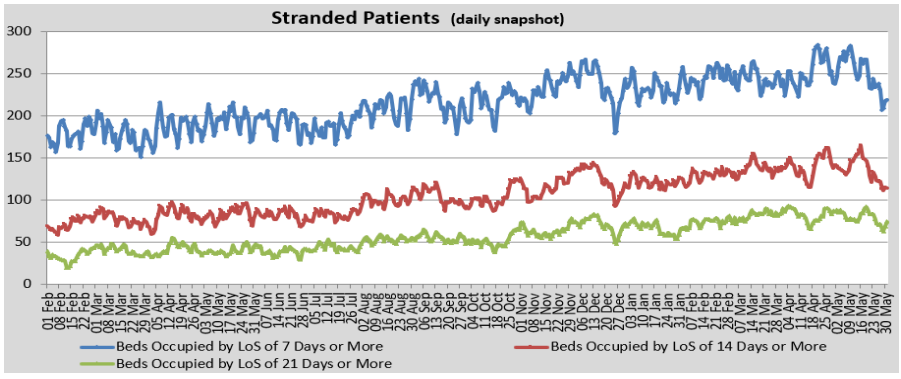
Data Quality Rating:

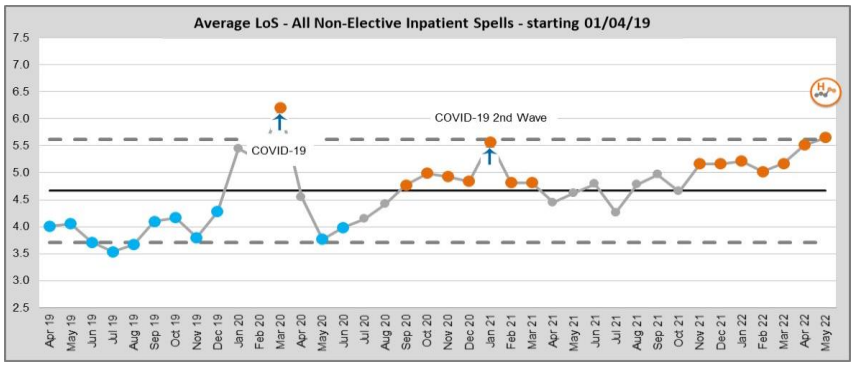
Are We Effective?

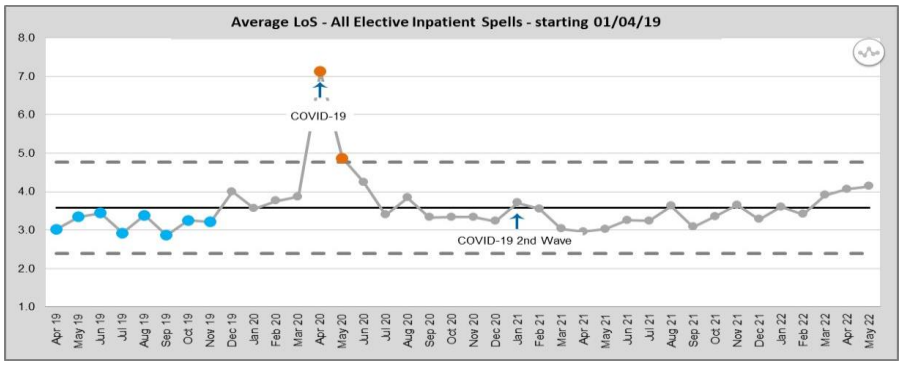












Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

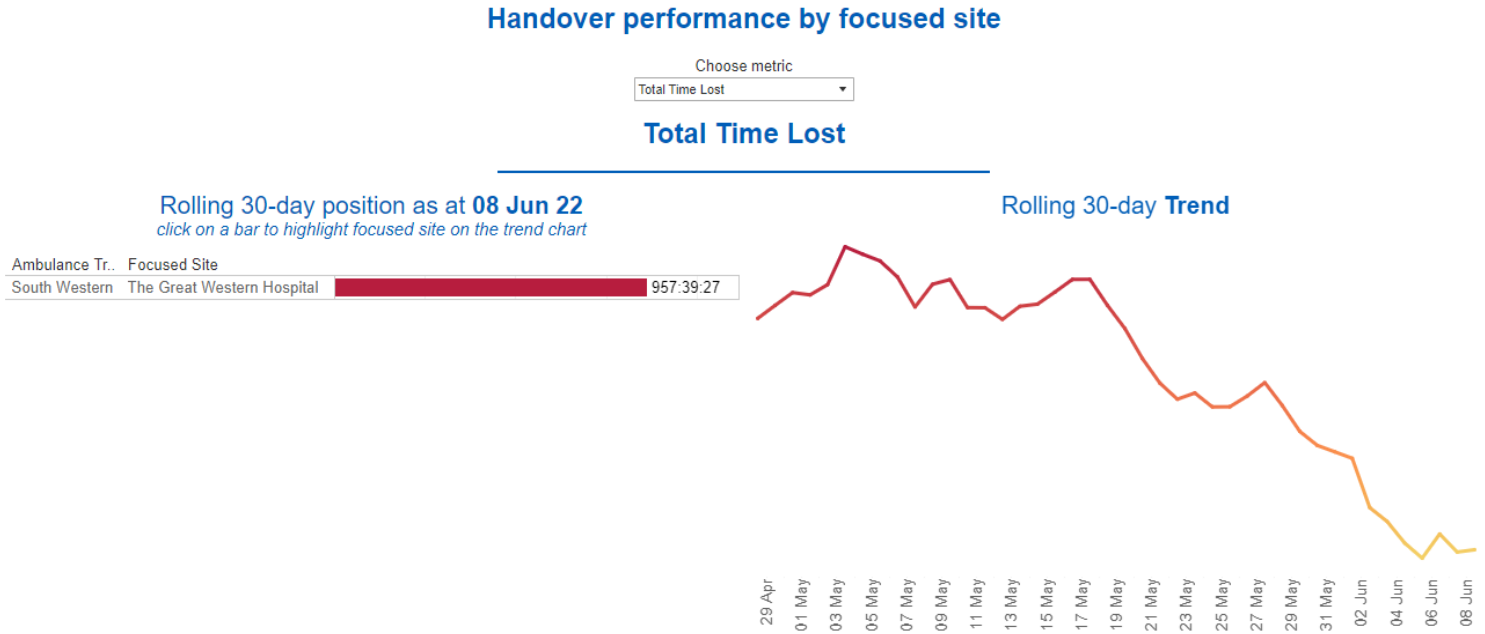
Ambulance Handover Delays

Great Western Hospitals NHS Foundation Trust

May 22

Ambulance Handover Delays

- Improvement from peak total handover loss of >1400 hrs in April
- May saw an improvement in handover times across all time parameters.
- Contributors to on-going delays include
    - COVID and other IPC issues led to sustained bed closures / delayed transfers in April.
    - Significant reduction in NCTR discharges due to COVID/NV outbreaks
    - Significant increase in LOS > 21 days overall
    - USC Navigation hub not currently in place routinely to support improved patient pathways



Hospital Ambulance Handover Delays

Data Quality Rating:

Are We Effective?

May 2022 - Background, what the data is telling us, and underlying issues (compared to previous month)

- The total number of Ambulance conveyances to the Emergency Department was 1752, increase of 111 (GWH total 1901).
- Handover delays reduced across all time measures - Handover delays over 1 hour decreased from 617 in April to 496 in May.
- Handover waits more than 15 mins has decreased to 1088 patients compared to 1158 patients in April.
- There were 113 ambulances who waited more than 4 hours to hand a patient over to the Emergency Department.

Key Impacts on Performance

- Bed availability post-ED requirement significantly impacting on flow out of the department and ED over-crowding.
- Increase in the number of patients accessing Urgent & Emergency Care who are unable to access appointments with General Practice.
- Marked increase in average LOS – highest in 3 years
- Pre-noon/golden discharges continued decrease
- Average LOS in ED decreased slightly, it still remains higher than previous 3 years
- >12 hour waits in ED – remain highest since Feb 2020
- Large surges in conveyance via SWAST and "walk-ins" contributing to handover delays.
- Appropriateness of conveyed patients variable coupled with no routine navigation hub support yet.
- Highest number of Non-Criteria to Reside patients in the Trust which has now peaked >100 patients.

What will make the Service green?

- Full implementation of Front Door Hub
- ED RAT (Rapid Assessment & Treat) arriving ambulances
- SDEC / HUB review of ED & Ambulance queue
- SWAST having direct access to all Assessment Units.
- Implementation of 'Inter Professional Standards ' allowing direct referral and admission to specialty beds.
- 7/7 SDEC service
- The 'Way Forward' programme: increasing size and capacity of front door areas.

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

1. Development of Front Door Hub / SPA, in-conjunction with ICS SWAST. Concurrent intermittent short-term response and long-term implementation. Finance to be secured – ongoing
2. Internal Ambulance Queue to be maintained, incorporating diagnostics & treatment. Processes agreed with ED Tri - June 2022
3. Maintain assessment processes identifying 'Fit to Sit' / alternate providers - Ongoing
4. Ongoing HALO+ presence & support to ED / ambulance queue - Ongoing
5. SDEC 7-day opening commenced 9/5/22. Develop weekend service provision - Ongoing
6. Need to Improve direct access process to admission areas (MAU, SAU, PAU, EPU) - 'Internal Profession Standards protocol agreed and implemented - Ongoing

Risks to delivery and mitigations.

- There is a risk that ambulance handover delays will continue to be seen due to a high demand and lack of flow out of ED. Future impact due to loss of SWAST cohort area in ED.
- There is a risk that patient safety and performance will be compromised given the significant increase in ED/UTC attendances.
- There is a risk for increased ambulance handover delays due the internal ambulance queue being unfunded.
- There is a risk to safety and quality to the Majors Chairs area of ED due to increased demand and acuity.

Mitigation:

- Review of ED Nursing and medical staffing to maximize cover, quality and safety to all areas of department.
- Maintain Ambulance internal queue area to ensure assessment and treatment.
- Majors Chairs to maintain staffing to ensure safe capacity, allowing ambulance offload
- Ongoing work to develop Front Door Hub including funding, staffing and links with other providers

Emergency Access (4hr)

Data Quality Rating:

Are We Effective?

May 2022 - Background, what the data is telling us, and underlying issues (compared to previous month)

- The ED performance remains below the 95% standard. There has been a decrease in 4-hour performance of –2.2%.
- Attendances have increased by 1269 patients from April
    - ED - 769 increase
    - UTC – 500 increase (UTC remains closed overnight)
- 4 Hour breaches have increased by 535 overall
    - ED – 446 increase
    - UTC – 89 increase
- 98 x 12-hour reportable Decisions to Admit (DTA) breaches – equal to April
- Average 15-minute Triage Times dropped, likely to increased attendance, although ambulance Triage improved.
- Ambulance delays decreased across all time measures.

Key Impacts on Performance

- ED attendances increased and are at pre-pandemic levels (3rd Q 2019).
- Social Distancing measures remain in place, restricting patient numbers in ED Majors
- Internal ambulance queue maintained, despite staff reduction
- Continued increase in non-elective LOS
- Continued decrease in Ward discharges pre-midday
- Total bed occupancy remains >98%
- Clinical Navigator ongoing (intermittent) assisting flow to UTC.
- Ambulance assessment by Senior ED/AMU clinician (in sweeps)
- Majors Step Down supported by Medical REG/SHO (Mon-Friday)
- Active pulling of patients to SDEC/MAU - ED & Ambulance queue
- SDEC increased to 7-day operation
- Admissions Lounge closed
- Front door Hub stopped at beginning of May

What will make the Service green?

- Full implementation of Front Door Hub
- ED RAT arriving ambulances
- SDEC / HUB review of ED & Ambulance queue
- SWAST having direct access to all Assessment Units.
- Implementation of 'Inter Professional Standards ' allowing direct referral and admission to specialty beds.
- System wide approach to how the public access Urgent and Emergency care.
- 7/7 SDEC service
- The 'Way Forward' programme: increasing size and capacity of front door areas.

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

1. Development of services in UTC in preparation for new build in the spring. Joint working with Primary Care & CCG - Ongoing / July 2022
2. Development of Front Door Hub / SPA, in-conjunction with ICS SWAST. Concurrent intermittent short-term response and long-term implementation. Finance to be secured – ongoing
3. Maintain internal ambulance queue, incorporating diagnostics & treatment – Processes agreed with ED Tri - June 2022
4. SDEC utilise Teaching room to provide increased clinical space. Alternate space identified in BTC, relocation actions in progress – June 2022
5. Ongoing review of MSD – CDU/revised AMU function. Working with AMU/ED teams. Changes due to Financial and WFP strategy – July 2022
6. Potential to bring Linnet AMU function to ground floor, consolidating AMU workforce & patient base. Delay due to due to Financial and WFP strategy – July 2022.
7. Review of CAU function and capacity. Potential to utilise OPD area to improve Medical Admissions management & flow – Implemented June 2022
8. Review ED & AMU Medical staffing models, maximising clinical coverage/cost benefit. Utilise Staffing protocol. ED working to place doctor's rota on R-roster – July 2022
9. Implementing findings of Nursing Staffing review. Staff uplift to improve Senior Staff provision agreed - July 2022
10. Chest Pain ED process & pathways under review in conjunction with Primary Care/Cardiology – June 2022
11. Implementation of CRTP on Care Flow for on-going patient movement – June 2022
12. Complete environmental changes to Majors chairs & Paeds. Chased with Estates, pending finance and confirmation – June 2022

Risks to delivery and mitigations.

- There is a risk that ambulance handover delays will continue to be seen due to a high demand and lack of flow out of ED. Future impact due to loss of SWAST cohort area in ED.
- There is a risk that patient safety and performance will be compromised given the significant increase in ED/UTC attendances.
- There is a risk for increased ambulance handover delays due the internal ambulance queue being unfunded.
- There is a risk to safety and quality to the Majors Chairs area of ED due to increased demand and acuity.

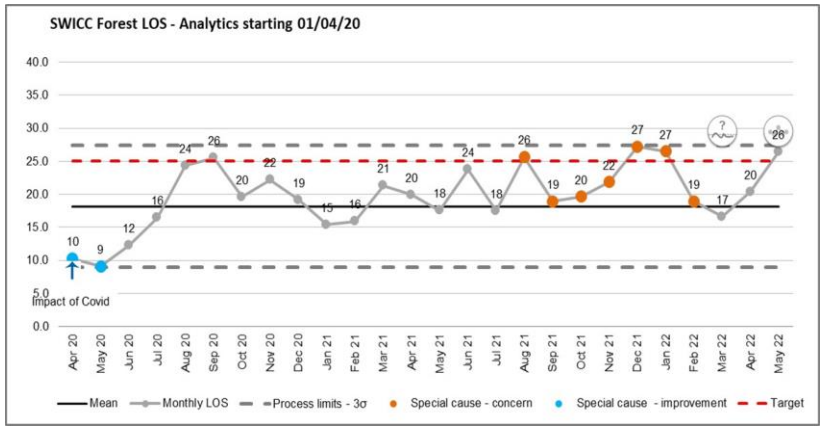
Mitigation:

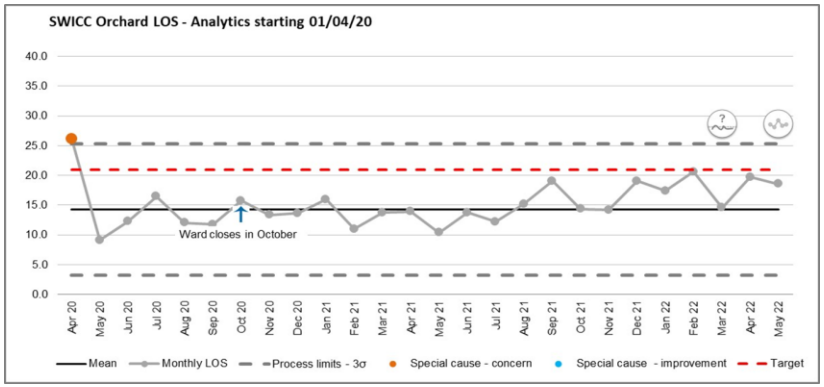
- Review of ED Nursing and medical staffing to maximize cover, quality and safety to all areas of department.
- Maintain Ambulance internal queue area to ensure assessment and treatment.
- Majors Chairs to maintain staffing to ensure safe capacity, allowing ambulance offload
- Ongoing work to develop Front Door Hub including funding, staffing and links with other providers

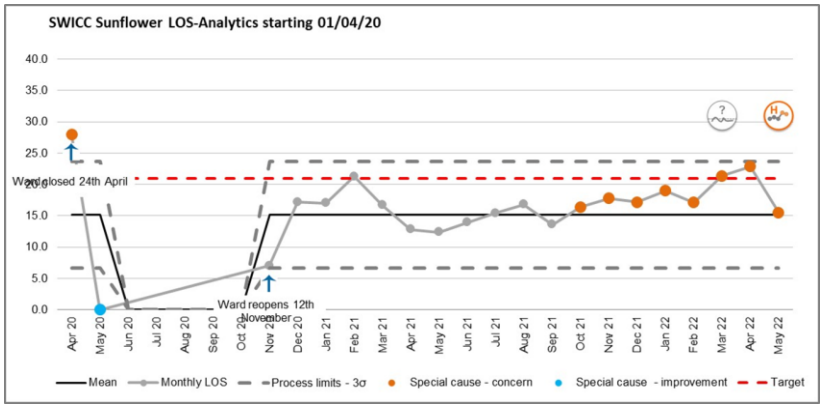
1. Emergency Access (4hr) - Community (SwICC) Length of Stay

Data Quality Rating:

Are We Effective?







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

In May the average **length of stay (LoS)** across all three wards is 19 days, all three wards remain within the target tolerance for LoS. Wiltshire patients LoS has been reduced to an average of 13 days which is a decrease of 10 days compared to April. 19% of patients had a 0 -5-day LoS which remains unchanged since March.

67% of patients returned to their own homes and **2%** temp care homes (d2A), **3%** permanent care homes.

Occupancy for all three wards remains **99%** which has been consistent for the last few months. **7%** readmissions to acute which (13% last month).

Flow: 130 discharges were achieved across the three wards. 18% (under 30% target) were discharged prior to midday. 11% of patients were discharged over a weekend period.

Improvement actions planned, timescales when improvements will be seen

Medical Cover has been more stable this month across the three wards. However, there is a concern with upcoming retirement that there needs to be a review of the current medical model for SwICC, henceforth a meeting has been scheduled for the 20th June to discuss options.

Forest has initiated the ***'Improving Together'*** programme, focussing on metrics to help measure and improve the delivery of rehabilitation. This is clinically led at a specialist level.

Risks to delivery and mitigations

Risk: likely exit from Sunflower Lodge during 2022/23 – replacing bed base with new discharge to assess (D2A) pathway.

Mitigation: interorganisational scoping and planning underway, with expected approach to implementation to involve running Sunflower and D2A concurrently, testing the pathway and capacity, to support low risk exit of Sunflower.

Urgent Community Response (UCR) Service

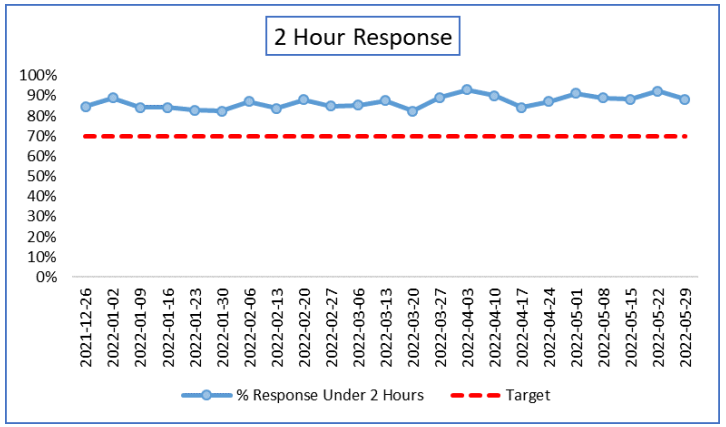
Are We Effective?

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

The UCR response times (<2 hrs.) have consistently exceeded the target of 70%, with actual response performance typically between 85-95%.

The community Single Point of Access includes clinical triage of incoming referrals – this process identifies referrals that sit outside of the UCR criteria and ensures appropriate signposting or response via planned community care.

Additional data is captured for UCR which provides a rich picture of the service and it's impact, these include; source of referral, primary reason, know or unknown patient, acute activity pos-referral. Increasing UCR activity to respond to an additional 10% of referrals during 2022/23 is a 'Driver' metric for ICC division.

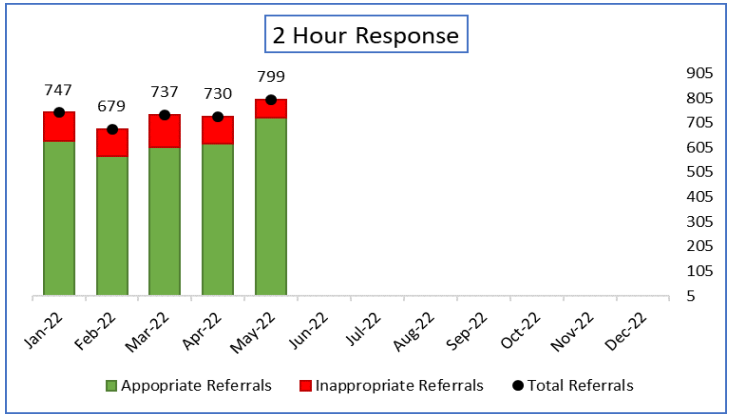


Improvement actions planned, timescales when improvements will be seen

Having been approached by the **MiDOS team and NHSEI**, during June a **pilot project** has been underway having, scoped, discussed and agreed the parameters in May.

The pilot is focused on accepting NHS 111 referrals directly from their call handling teams, without prior clinical triage. This requires the GWH UCR team to complete the triage on receipt of a phone call.

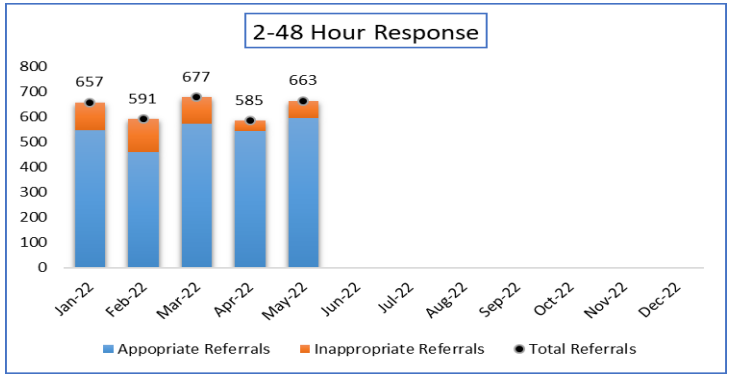
The pilot went live on 6th June and operates 24/7 throughout the month, with an evaluation scheduled at mid-point and end point. Although, there is an expectation that if successful the new process/pathway will be adopted substantively. An update will be provided in July.



Risks to delivery and mitigations

Risk: insufficient Therapy cover on Saturdays to respond within 2 hours, by the right professional

Mitigations: 7 day working consultation is underway, with the aim of ensuring Therapy cover is extended from 6 days per week to 7 days. & day working will be in place by August.



Community Virtual Ward

Are We Effective?

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

Activity in the Virtual Ward (VW) remains high, with face to face (F2F) contacts totaling 200 in May. The current level of investment provides a target of 25-30 virtual beds. This target is not yet consistently achieved – with average capacity between 10 – 15.

NHSEI have set a target of 40-50 VW beds per 100,000 population by Dec 2023, this means Swindon's target is circa 100. Therefore, exploratory collaborative work is underway between community and acute colleagues in GWH to agree and define the shared vision for our Hospital at Home model.

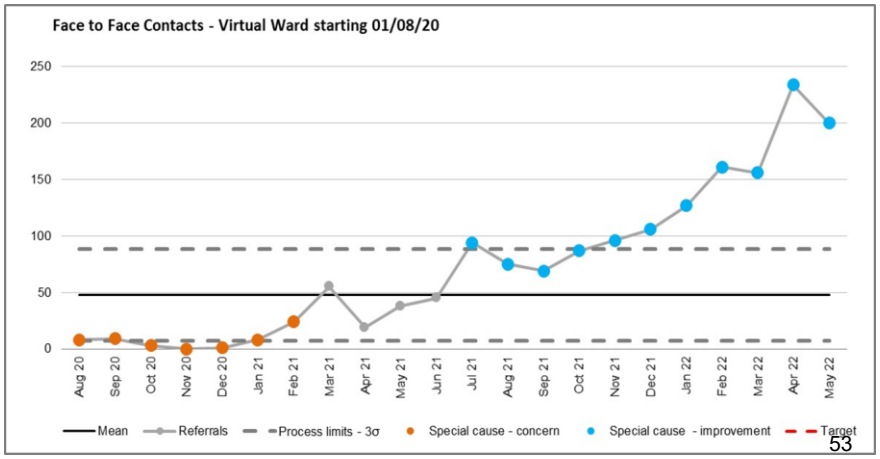
In May stakeholders across BSW met to discuss VW as a concept and start early conversations to better understand what the respective offer is across the system.

Improvement actions planned, timescales when improvements will be seen

A shared vision for the VW will be landed during July. Subsequently a project and milestone plan will be developed and initiated between July – September, with the implementation running up until Dec 2023. The project plan will help support a graduated increase in VW bed capacity – with workforce and technology playing crucial roles.

VW activity data is now part of a national mandatory data submission and a watch metric for the 'Improving Together' programme. A remote monitoring technology called Qardio is being tested in July and August – evaluated and results shared in September.

Virtual Ward Monthly Report	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	12 Month Totals
Number of Referrals	14	21	21	17	24	27	21	25	21	27	43	30	291
Number of New Patient Referrals	5	6	5	5	5	2	4	7	7	7	8	8	69
Number of Discharges	14	22	19	22	18	27	22	23	24	21	43	29	284
Patients on Virtual Ward	13	23	16	16	19	20	27	24	19	19	32	31	22
Patients Referred on to the VW Step Down Ward	0	0	0	0	0	0	0	0	3	18	22	17	0



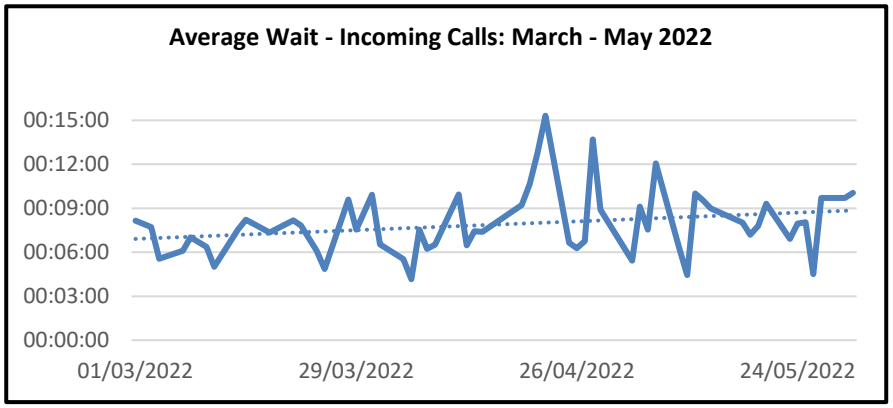
Risks to delivery and mitigations

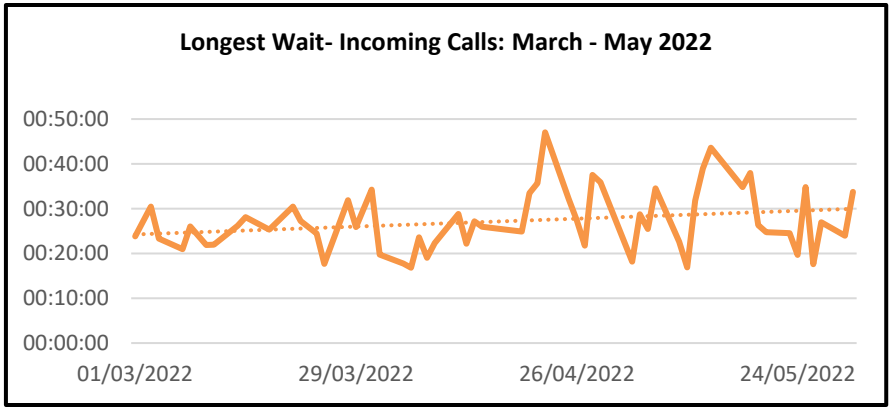
Risk: potential delays in recruiting additional workforce results in slow progress towards the requisite virtual bed no's.

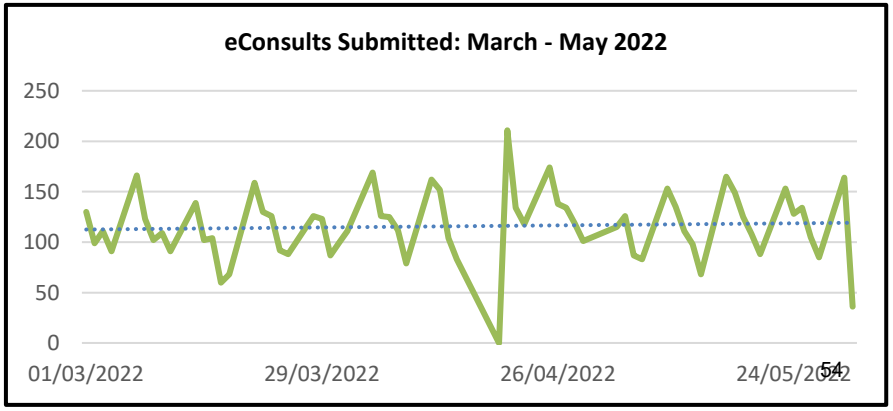
Mitigation: pull resources in from UCR and community nursing and develop flexible, rotational type clinical posts, by Aug 2022.

GWH Primary Care – Accessibility – May 2022

Are We Effective?







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

Average call wait times during May 2022 were 8.1 minutes (April 8.3mins). The trend over 3 months is an increase in call wait times. **Longest call wait times** during May were 17 - 43 minutes (Apr 16-47). The trend over 3 months is an increasing wait time. The additional phone lines installed in Jan & Feb 2022 allows more patients to be within the system waiting for their call to be answered, rather than receiving the engaged tone and redialling multiple times.

e-Consults is a popular channel for routine appointments and enquiries. The popularity has been both positive for patients, in terms of the accessibility and speed of the service they receive, but also, challenging for the PCN in terms of having a high number submitted daily. Restricting the hours eConsult is open, has ben tried and the results have not had the desired impact. Volume has remained the same, with all submitted within the specified time frame. An alternative approach will be tested – described in the box below.

Improvement actions planned, timescales for when improvements will be seen

The call hub is being disbanded during the last week of June and through July, as a catalyst for improving call handling performance. Call handlers will work across the four sites and develop closer working with reception teams. This trial will be evaluated through July, with results reported in August.

eConsult will be capped at 80 per day, reducing the currently uncapped channel. This will allow more effective rota management, allocation of clinical resources and help create more sustainable levels of clinical correspondence, including reducing tasks and correspondence.

Risks to delivery and mitigations

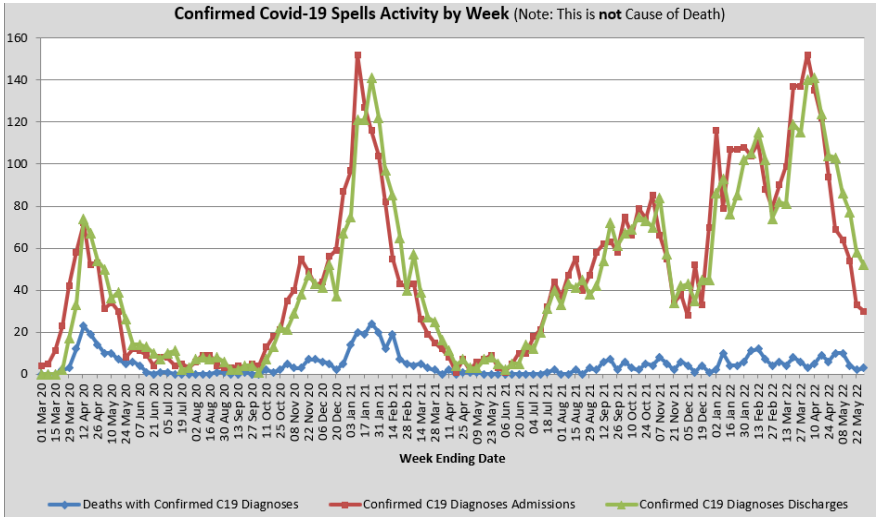
Risk: potential increase in complaints arising from capping the eConsult channel to 80 per day.

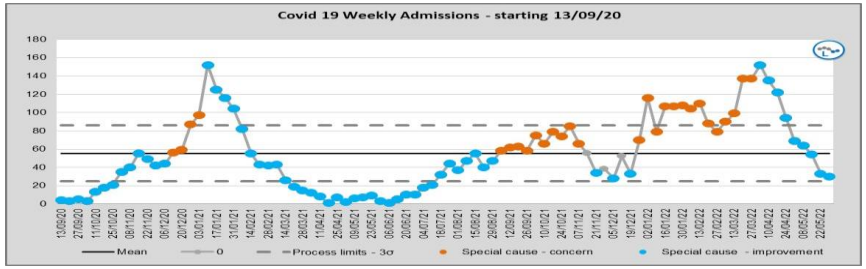
Mitigation: improved clinical rota management, freeing up more on day and routine capacity. Shortening the eConsult receipt and triage process – better utilisation of operations team.

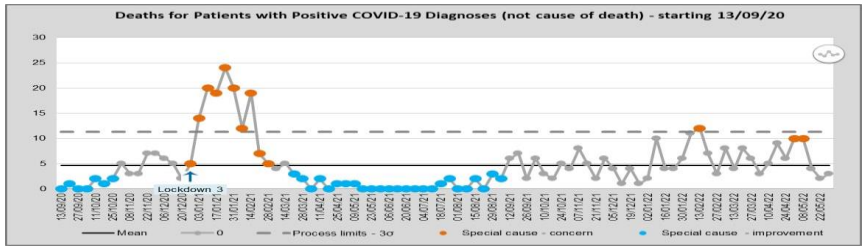
1. Emergency Access (4 Hours) Covid 19 Weekly Admissions

Data Quality Rating:

Are We Effective?







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

Attendances to the Covid Assessment Unit (CAU) have decreased through May comparable with post 1st wave levels. Covid positive patient numbers have reduced with corresponding green admissions identified.

CAU has maintained operation with 11 beds – Change function to Medically Expected Unit (MEU) in June.

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

1. Review function of CAU (national direction required) and capacity. Aim to utilise space for MAU/Front Door Triage & assessment – Implemented **June 2022**
2. Revision of Covid protocols for MAU & ED by Clinical Leads - **June 2022**

Risks to delivery and mitigations

There is a risk of delays for Covid patient placement with discontinuation of CAU function.

Mitigation: Close working between ED & AMU. Use of POCT/Cephid swabs and patients with high suspicion of COVID. Abbott tests for low risk / suspected Green patients. Trolley wait times escalated, utilise admission SOP

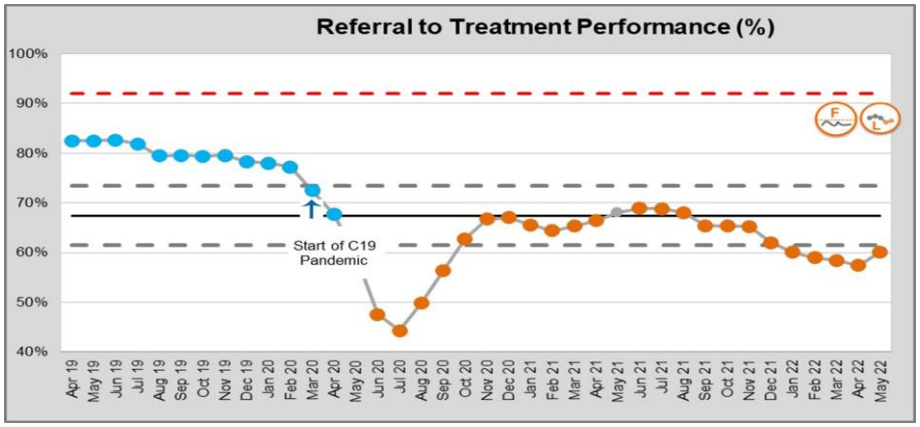
There is a risk of increased demand for 'Blue' beds due to increase in Covid variants.

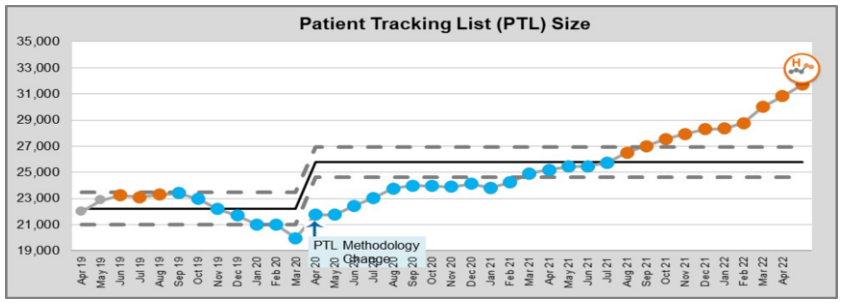
Mitigation: Daily monitoring of Blue/Green attendances. POCT testing maintaining. Close working with ED and joint SOPs updated. Flexible usage of CAU and MAU side rooms. Organisational review of Blue bed base requirement + pending national revised guidance.

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

Data Quality Rating:

National Key Performance Indicators





	April	May
RTT Performance	57.39%	60.15%
PTL Volume	30,825	31,703
Reportable 52 Week Breaches	744	852
In Month 52 Week Breaches	243	349

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

The Trust reported an RTT Incomplete Performance of 60.15% in May 2022, an improvement of 2.76% in month.

The Trust reported a waiting list of 31,703 (an increase of 878 in month) against a trajectory of 32,025 (322 ahead of trajectory). The highest movements from baseline were seen in General Surgery, Paediatrics and Neurology.

The Trust received 10,504 referrals in May 2022, which is a 17% increase when compared to the previous month (likely to be due to the Easter break in April 2022). T&O, Cardiology and Oral Surgery received the highest increase in referrals in month.

852 x 52-week reportable breaches were declared in May 2022, an increase of 108 in month. ENT, Dermatology and Neurology deteriorated the most from baseline, whilst T&O, Urology and Gynaecology improved from their baseline position.

322 x in month breaches were reported in May 2022, an increase of 79 x 52-week clock stops.

The number of patients waiting over 78 weeks at the end of April 2022 was 50, an increase of 1 in month.

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

- Additional booking and radiology resource secured to improve volume and case mix on weekend operating lists.
- Options appraisal to be presented to Executive team on 15th June 2022 to agree the mechanism to increase elective activity in line with the 2022/23 activity plan.
- Service deep dives scheduled for coming weeks to review cost effectiveness of services and opportunities to increase productivity. This includes the maximising the use of Patient Initiated Follow Up (PIFU), Advice and Guidance, and a reduction in follow ups where appropriate.
- Weekly check and challenge with services planned to commence on 20th June 2022 to improve scrutiny of waiting lists.
- Continued focus on 78 week and 52-week position, with the Trusts longest waiting patient currently at 94 weeks (a static position from the previous month)

Risks to delivery and mitigations

Risk: There is a risk that bed pressures and a high number of outliers in the surgical bed base may result in on the day cancellations for elective inpatient procedures.

Mitigation: Elective plan reviewed the day before and any risks highlighted to SWC Director of the Day by Silver and/or Matron of the Day.

Risk: There is a risk that the current staffing models in Theatres and Anaesthetics does not support the use of all elective operating capacity.

Mitigation: Agency and Waiting List Initiatives offered in advance. Staffing and theatre utilisation monitored at weekly 6-4-2 meeting.

Risk: There is a risk that the Trusts 52-week breach position begins to deteriorate over the next few months due to last year's referral rate increasing considerably from March-21 onwards.

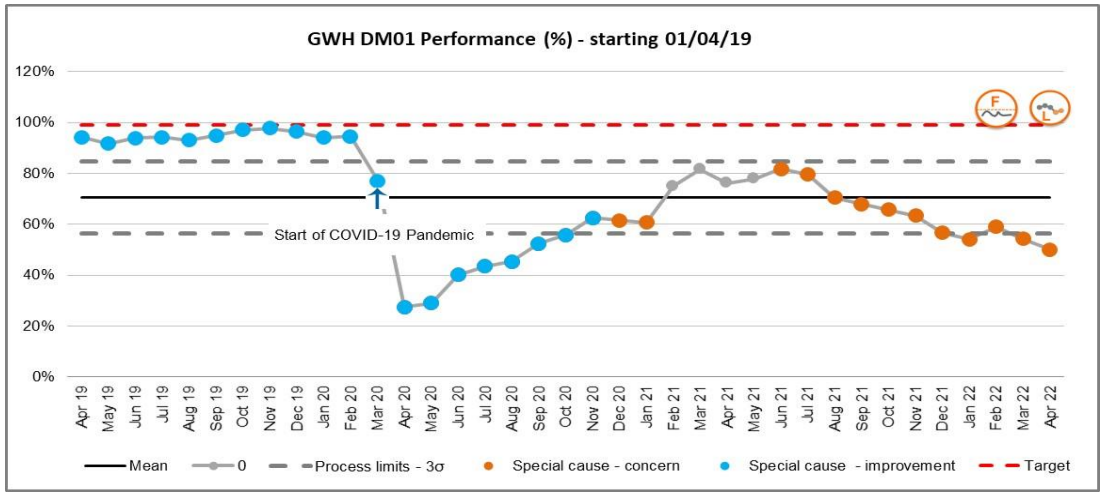
Mitigation: Services reviewing breach position/forecast over the coming months, alongside available routine capacity and feeding plans back through weekly access meeting. Insourcing activity increased to reduce number of long waiting patients.

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	620	1837	**2457**	25.23%
Computed Tomography	628	1409	**2037**	30.83%
Non-obstetric ultrasound	2213	1017	**3230**	68.51%
Barium Enema	0	0	**0**	N/A
DEXA Scan	211	502	**713**	29.59%
Audiology - Audiology Assessments	608	105	**713**	85.27%
Cardiology - echocardiography	454	142	**596**	76.17%
Cardiology - electrophysiology	0	0	**0**	N/A
Neurophysiology - peripheral neurophysiology	61	18	**79**	77.22%
Respiratory physiology - sleep studies	114	78	**192**	59.38%
Urodynamics - pressures & flows	0	0	**0**	N/A
Colonoscopy	376	404	**780**	48.21%
Flexi sigmoidoscopy	95	36	**131**	72.52%
Cystoscopy	120	141	**261**	45.98%
Gastroscopy	235	52	**287**	81.88%
Total	**5735**	**5741**	**11476**	**49.97%**

April 2022

Performance Latest	49.97%
Waiting List Volume:	11,476
6 Week Breaches:	5,741

Analysis – What is the data telling us?

Performance was 49.97% in April compared to 54.3% in March a decrease of 4.33%. Overall, the total waitlist size has increased to 11,476 compared to 10,636 in March February (+840). Breaches have also increased to 5,471 from 4,861 (+610). CT remains challenged to see 2ww and urgent patients, with no routine capacity, this is due to reduced CT van capacity during the month. Radiographer vacancies have improved significantly but remain high with 4.75 WTE vacant; this also contributes to running a fully staffed service.

The 2nd and 3rd Radiology pads will come on-line end at the beginning of July, and we are sourcing vans to run additional CT and MRI activity from then. ERF funding has allowed this and will also support additional Echo and Endoscopy WLI lists.

Improvement Actions

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

- **CT:** ERF money has allowed additional CT van days through to the end of September, this will commence once the new pads are on-line at the end of June. This will aid recovery of DM01 from July.
- **MRI:** Similar to CT above, additional MRI van capacity has been procured through to the end of September. This will also have a significant impact on DM01 recovery.
- **Dexa:** Further adhoc capacity from staff rota added in May.
- **Echo**: NP Referral rates have increased from 54 to 70 per week. WLI Echo to recommence Jun 22 (80 Appts per month for the remainder of the FY).
- **Endoscopy**: 5th procedure room funded and opened 16th May 2022. New procedure opportunities with RUH. TVCA capsule endoscopy pilot in progress. Increased capacity required to meet rising 2WW demand.

Risks Increasing demand which outweighs capacity is the biggest riskm to DM01 capacity. If ERF money continue then additional MRI, CT and Echo can be run which will have the largest impact on recovery. Radiology vacancies continue to impact recovery and performance. Mitigations remain in place above to support risk, detailed on next slide.

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

Data Quality Rating:

National Key Performance Indicators

Background, actions being taken and issues

Endoscopy:

1. 2ww referrals form a significant part of endoscopy demand. Once 43% of demand is breached by 2ww this will adversely affect our planned improvement trajectory. This is a continuing trend and waitlists continue to grow resulting from increased 2WW referral demand.

2. Weekend lists were delivered at 65%, 47 of the 52s list target during Apr 21. Weekend lists have reduced to 6 each weekend once the 4th Endoscopy room opens on 16th May 22. Productivity will be reduced (12pt lists from weekends will become 10 lists during week, losing over 8 lists of capacity each month). This is to allow for emergency work to be done over the weekend. WLI support continues to be essential to continue to meet 2WW demand and fill unforeseen endoscopist absence.

3. The recovery plan has been reviewed and the target date of Dec 21 has now moved to beyond Jun 22 as a result of 2WW increases. Reactive prioritised demand is pushing planned demand into the future, increasing waiting lists and length of delay. 21/22 referrals exceeded 19/20 annual total during Dec 21. Referral growth continued during the remainder of the financial year.

Radiology: Performance has declined in May and there are still pressures in the department due to staffing vacancies but 6 WTE have be recruited reducing the vacancy gap. (4.75 WTE).

Performance will stabilise moving forward into Q2 and there should be an improvement as the new pads and vans come on-line in July. . 2-week waits are being seen within 2-week window.

Echo:

NP referral rates have increased significantly from a weekly average of 54 to 70. The last week of May saw a sharp rise to 83 referrals received of which 35 were BNP pathway referrals.

FU active referrals should now form part of the DMO1 return (as directed in Jul 21). These are yet to be included in the return and need to be added at the earliest opportunity to prevent the presentation of a distorted picture of overall GWH wait list and performance.

What will make the Service Improve?

Endoscopy:

1. Capital funding (300k) received for the build of a fifth procedure room, which opened on 16 May 2022.

2. An opportunity to conduct Barrett's Reviews (Cyto sponge) with RUH Bath is under review by Dr Shetty.

3. TVCA Capsule Endoscopy pilot in progress. National results demonstrate only 30% of patients progress to full endoscopy after completing a Capsule Endoscopy.

4. Increased capacity is the key to meeting the growth in demand. The options are being considered to implementation in FY 2022/23.

Radiology:

1. **CT**: CT van capacity increasing from July. Number of days to still be confirmed.
2. **MRI**: MRI van capacity increasing from July. Number of days to still be confirmed.
3. Additional Ultrasound capacity, using ERF money, commenced in June

Echo:

Echo room capacity has increased from 3 rooms to 5. Current staffing levels support 4 Echo Rooms being used concurrently.

Weekly New Patient referral rates have increased from an average of 54 to 70. This is due to an increase in BNP referrals and also GP Direct to Test requests.

The department has been assigned £54K to conduct WLI Echo. This will allow the department to deliver 80 additional Echo appointments per month. WLI activity will commence 1 Jun 22.

Risks to delivery and mitigations

Endoscopy:

1. There is a risk of Endoscopy being bedded due to extreme site pressures.
Mitigation: the decision to bed Endoscopy requires Executive approval.

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

3. There is a risk concerning the replacement of UNISOFT the Endoscopy Management System because it is no longer supported by the provider from 31st March 2022. **Mitigation:** Medilogik is the agreed BSW EMS of choice, has been procured and implementation is now being progressed.

Radiology: (Risk2894). There is a risk to delayed patient treatment and increased patient harm as a result of delayed diagnostic outcomes due to staffing vacancies, skill mix limitations and increased demand on service

Mitigations include:

- Additional CT sessions offered to staff,
- Recurring recruitment meetings taking place weekly to promote ideas and drive improvements in strategy.
- Redevelopment and increase of pads

Echo: There is a risk that DMO1 performance will fail to recover to >99% due to the volume of Referrals for both NP and FU Echo. The recent addition of another Imaging Consultant has reduced wait time for DSE/ESE And TOE and WLI Echo funding will help to reduce the recovery timeframe from Jul 23 to Apr 23 (as long as the weekly referral rate does not continue to increase)

Cancer 2 Week Wait Performance Target 93%

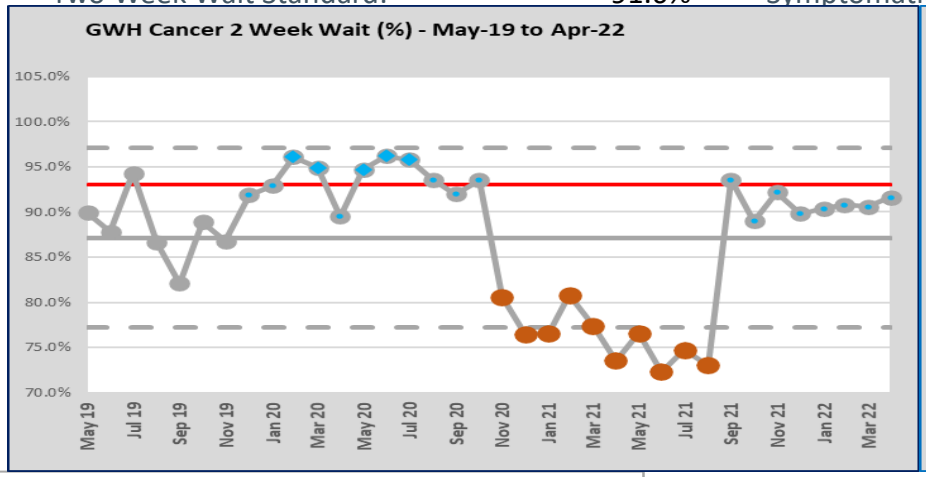
Data Quality Rating:

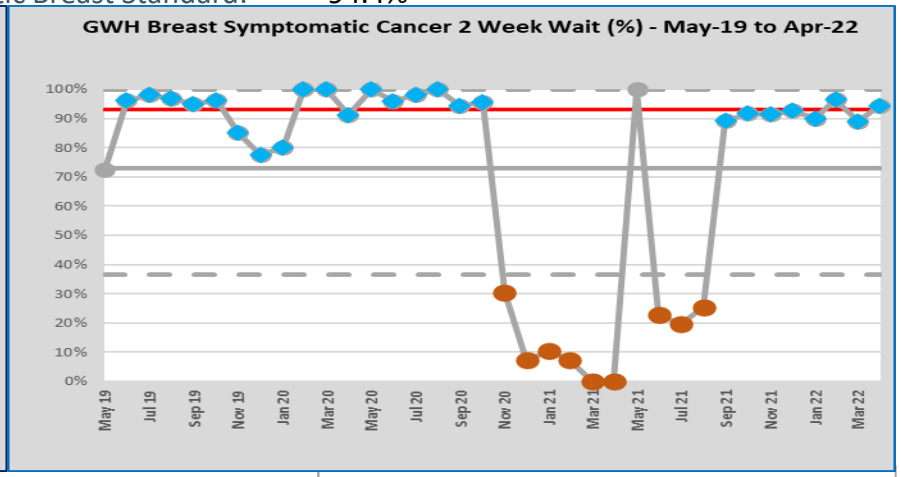
National Key Performance Indicators

Performance Latest Month: **April**

Two Week Wait Standard: 91.6%

Symptomatic Breast Standard: 94.4%





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

The standard in April was not met, due to Colorectal (85.9%), Lung (88.2%), Upper GI (89.6%), Urology (90.5%), Gynaecology (91.0%) & Skin (91.7%) not achieving their target.

We have seen an increase in referrals of 15% for year to April 2022 compared to the pre Covid levels recorded for year to April 2020. This combined with staffing challenges across many of the services has put pressure on this standard.

Patient choice continues to be the major factor in 2ww breaches.

1,449 patients were seen under the 2 week wait to first appointment rules, of which 131 pathways breached the standard. To achieve the standard, we needed to prevent 30 of the breaches. The majority of breaches were as follows:

Colorectal (85.9% - 35 breaches)
- 28 patient choice
- 5 issues with capacity in clinic (3) & radiology (2)

Lung (88.2% - 6 breaches)
- 4 issues due to CT capacity

Gynaecology (91.0% - 11 breaches)
- 6 patient choice
- 4 as a result of COVID

Skin (91.7% - 33 breaches)
- 28 patient choice
- 4 other reasons, including COVID & patient being unwell

Upper GI (89.6% - 11 breaches)
- 9 patient choice due to holidays and work commitments

Urology (90.5% - 11 breaches)
- 6 patients breached for other reasons including COVID and being too unwell
- 5 patient choice due to holidays and other

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

Work with CCG and GPs is ongoing to highlight appropriateness and timing of referrals when holidays and other commitments are known.

Colorectal
- Pathway navigators speak with patients to encourage attendance and work with PCNs.
- Further analysis of patient choices in first appointments is being undertaken and will be shared at a GP Forum in Q1.

Lung
- CT capacity in Radiology continues to adversely impact performance

Upper GI
- Further analysis of patient choices in first appointments is being undertaken and will be shared at a GP Forum in Q1
- Gastro Locum available to work outpatient clinics at weekends to support capacity.

Gynaecology
- Pathway mapping exercise to be completed to identify pinch points and potential improvements

Endoscopy
- Service are now adopting "on the day" lateral flow Covid testing, providing capacity following any short notice cancellations. We have seen this benefit in March 22.
- Room 4 becomes available for use in April, increasing the number of clinics

Risks to delivery and mitigations

Radiology
- CT capacity issues due to vacancies
  - Additional CT van days from **InHealth** are being arranged until June 2022.
  - Weekly wait data is supplied to cancer services team to help manage expectations and aid pathway planning. CT currently booking to 12 days and CTC booking to 14 days. Absences due to Covid, annual leave and vacancies have contributed to a worsening of wait times
  - Additional sessions are being run during the evenings and at weekends

Colorectal
- Risk of bedding Endoscopy through due to site pressure
  - Endoscopy to be protected as much as possible to help maintain cancer pathways
- Risk of the Dr's working on the Wards due to site pressures

Endoscopy
- Service use "on the day" lateral flow Covid testing, allowing short notice cancellation slots to be reused.

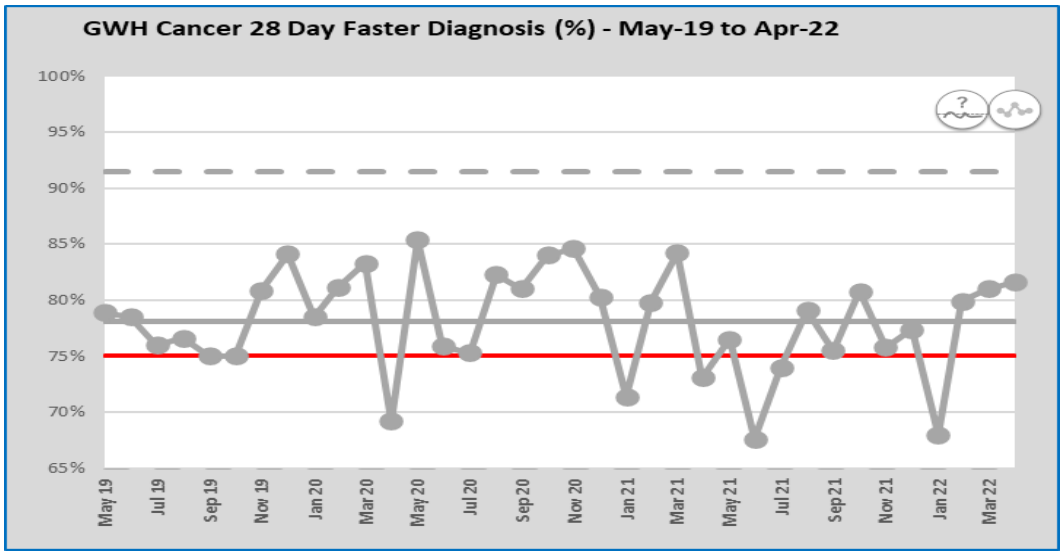
Patient Choice
- Patient choice poses a risk to the 2 week wait performance
- COVID continues to impact patient choice

Staffing
- Due to the increase in the number of Covid cases, absence has increased within Services which has impacted the 2ww standard

Cancer 28 Day Diagnosis Target 75%

Data Quality Rating:

Are We Effective?



Performance Latest Month: **April**

28 Day FDS - Total 81.6%

Background

The standard was met in April with a performance of **81.6%** (235 breaches). The performance standard for all referrals (2ww, symptomatic & screening) is reported by NHS Digital and via the Public View portal.

Urology (44.2% - 43 breaches)
- 14 pathways were delayed due in capacity in outpatients and imaging
- 9 clinical admin delays which included delays to dictating letters and delays to arranging follow ups
- 6 pathways delayed for other reasons, including appointments booked to limits of KPIs
- 5 patient-initiated delays
- 4 complex pathways with multiple and/or repeat tests

Haematology (60.0% - 2 breaches)
- 2 complex pathways, with 1 pathway transferring from Lung after day 28.

Colorectal (67.8% -- 68 breaches)
- 19 breached as a result of clinical capacity, mainly due to CTC capacity in Radiology
- 18 complex pathways where multiple diagnostics were required
- 14 were as a result of patient choice
- 14 clinical admin to review diagnostic tests and subsequent follow up tests.

Gynaecology (72.1% - 36 breaches)
- 27 pathways delayed for other reasons, including appointments booked to limits of KPIs and delays to pathology reporting
- 3 patient-initiated delays
- 2 breached as a result of clinical capacity

May performance is expected to meet the standard.

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

Task and finish group meets fortnightly to review the breach data and cancer pathways to help identify potential opportunities to improve performance.

- Lack of consistency with recording of breach reasons identified and addressed within cancer MDTc team. This has help more accurately see pathway issues.
- Working with all tumour sites to identify patients who have had cancer ruled out to ensure that letters are sent within expected timeframes

Additional clinics in Upper GI are being run to assist with demand & a locum is available to run additional clinics at the weekend as required.

Audit of Patient Choice reasons has been conducted. The scope of the audit has been increased, with a greater range of data to help inform and educate GPs to reduce this.

Additional van days to increase capacity for CT's is in place through to June.

Risk to Performance Delivery

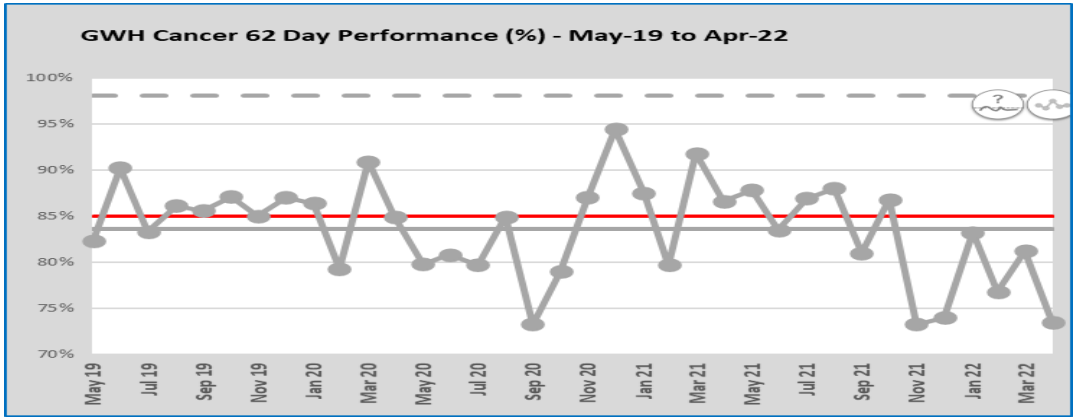
Colorectal
- Lack of consultant capacity, will impact on the delivery of diagnosis.
  - Colorectal service has recruited two registrars to support clinics releasing consultant capacity to see cancer patients.

Radiology
- Capacity due to vacancies,
  - CT van from **Inhealth** till June 22 approved.
  - Weekly wait data is supplied to cancer services team to help manage expectations and aid pathway planning. CT currently booking to 12 days and CTC to 14 days.

Cancer 62 Day Standards Performance Target 85%

Data Quality Rating:

National Key Performance Indicators



Performance Latest Month: **April**

62 Day Standard (Target 85%):	73.5%
62 Day Screening (Target 90%):	96.0%
62 Day Upgrade (local standard 85%):	100.0%

Background

April 62 day performance is 73.5% (73.5 treatments , 30 patient pathways breached resulting in 19.5 breaches) with the Trust not achieving the national 62-day standard. The performance had been predicted to be challenged, of the 22 predicted breaches for diagnosed patients:

- **9** pathways breached as forecast **(4.0)**
- 7 pathways rolled to May/June
- 6 pathways did not breach as a result of being treated in previous month

There were **20** unpredicted breaches in April **(14.5)**

- 8 pathways were in Plastics where capacity has been very challenged
- 2 patients had treatment dates in time but were cancelled due to COVID on day of surgery and bloods not being available leading to a postponement of chemotherapy
- 5 pathways were transferred to a tertiary centre for treatment on time, resulting in no breach to GWH.

The remaining pathways were complex with repeat/multiple diagnostics.

17 pathways had been tracked as suspicious for cancer with potential treatments in April if diagnosed:

- **1** suspicious pathway was diagnosed with a cancer and was treated in April **(1.0)**
- 11 patients did not have a cancer diagnosis,
- 5 patients remain undiagnosed, with their pathways rolling into May, 4 of these pathways are in Skin (Plastics)

Skin (9 patients, 8.0 breaches)

- 9 delayed due to capacity in Dermatology & Plastics

Urology: (3 patients, 3.5 breach)

- 3 complex pathway with multiple and additional diagnostics

Breast (1 patients, 1.0 breaches)

- 1 pathway breached due complex nature of case, patient had 2 primaries resulting in additional diagnostics and discussions before treatment could be planned.

Lung (5 patient, 3.5 breaches)

- 3 pathway was impacted be delays to diagnostic imaging due to capacity
- 1 was a complex pathway with multiple diagnostics
- 1 pathway was transferred to tertiary centre within 38 days, resulting in no breach to GWH

Gynaecology (4 patient , 2.5 breach)

- 3 pathways were impacted by clinical capacity issues
- 1 patient had a treatment within target which had to be cancelled due to COVID

Upper GI (6 patients, 1.0 breach)

- 1 complex cases requiring multiple tests, referral to OUH for treatment planning before returning to GWH for chemo
- 5 pathways were sent to Oxford within 38 days resulting in no breach being allocated to GWH

Head & Neck (2 patients, 0.0 breach)

- 2 pathways were sent to Oxford before day 38 resulting in no breach to GWH.

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

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

TVCA continue to monitor priority 2 (P2) patients to ensure patients are offered treatment in a timely manner across Alliance. Intensive care capacity is improving in Oxford to support complex surgeries particularly for head and neck and upper gastro-intestinal patients.

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 the Cancer Delivery Steering Group meetings.

Follow up capacity in colorectal has been challenged. The service has reviewed the job plans of the registrars to allow them to review more of the routine patients, freeing up clinic slots for the consultants to see their 2ww cancer patients.

Introduction of monthly cancer performance/data reviews from January with heads of service to ensure pathway and service issues are shared.

Review of Plastics pathway and processes completed. A booking SOP with escalation processes has been introduced.

Mutual Aid with OUH commenced in April, with 90 patients being transferred to Oxford for ongoing management and treatment.

In house template biopsies for prostate patients commenced in April with a small number of patients. Over time template biopsy will replace TRUS in the majority of cases. Previously patients would undergo a TRUSs biopsy at GWH before going on to have Template biopsy at Bristol, in house testing removes need tor less sensitive and more invasive TRUS biopsy.

Risk to Performance Delivery

Based on an average number of treatments and diagnosed cancers, it is not expected to achieve the standard in May with a forecast performance of 80.7% - 83.0 treatments & 16.0 breaches). Breached pathways were delayed for medical reasons , capacity issues (skin), delayed diagnostics due to capacity (lung). Other pathways have seen delays due to the need for additional diagnostics and complex pathways.

Risk: Capacity in Plastics is insufficient to see and treat patients.

Mitigation: Mutual aid at Oxford has been agreed with 90 patients sent for treatment. Dermatology are investigating holding some clinics at Wootton Bassett to help free up surgical space at GWH for Plastics to utilise. The Pathway has been mapped with the milestones assessed, potential improvements in both pathway and processes are being implemented. Concerns with capacity & operational processes have been raised and discussed with the divisional management team.

Risk: Outpatient capacity issues in both the upper and lower GI pathways continue to delay follow up activity. Registrar activity in lower GI is being used to free up clinic time for consultants to see their cancer patients.

Risk: Capacity in outpatients to stage WLI activity is restricted by staff issues and space issues

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

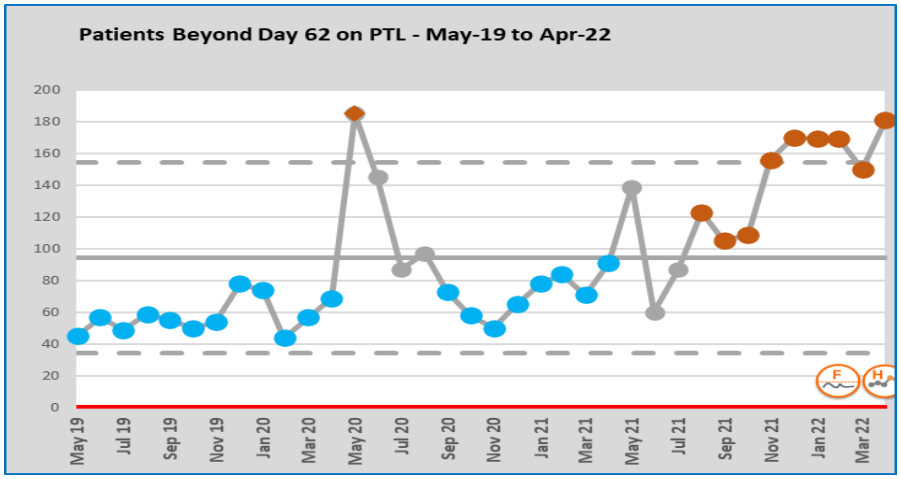
Risk: CT van sessions are in place to help support radiology during the replacement of the CT scanner this summer. This is impacting on the service being able to offer earlier scans to help bring pathway forward. Radiology are actively managing and prioritising cancer referrals. At the same time reduced staffing in radiology due to vacancy and absence is placing increasing strain on capacity. Additional funding for **Inhealth** CT van in place until June 2022. Current waiting time for a CT Colon is 14 days.

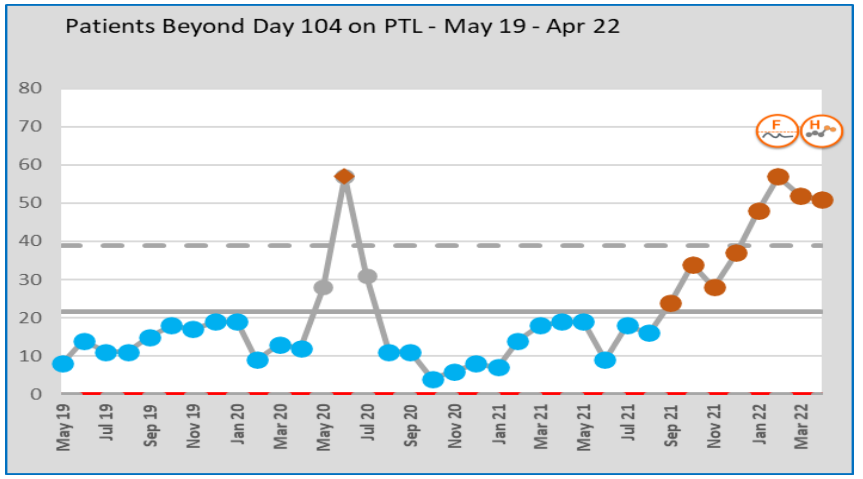
Mitigation: Weekly meetings are held to escalate PTL concerns and booking times data is shared weekly.

Cancer 62+ day & 104+ PTL. Confirmed 104 day breaches

Data Quality Rating:

National Key Performance Indicators





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

The number of 62day+ pathways increased through April (181): Skin (102), Upper GI (15) Colorectal (28) & Urology (13). There are a number reasons for the high number of pathways, including complex pathways, clinical administrative delays, delayed pathway information from Oxford as well as pathways impacted by the delays in endoscopy and radiology.

The number of patient pathways over 104 days fell through April (51) These delays are due to the capacity in plastics(37) and complex pathways in urology (6) and upper GI (6). Patient choice has played a part in 2 of there long wait pathways and a further 2 have been delayed for medical reasons

104-Day Breaches in April: 8 Patients; 6.5 breaches (IPT)

Treated at tertiary

Urology: 1 patient 0.5 breach: late ITR due to complexity of case, and capacity at NBT to treat in time.
Plastics: 1 patient 0.5 breach: pathway significantly delayed by capacity issues within the service
Lung: 1 patient 0.5 breach: multiple discussions at tertiary centres before treatment plans made, patient fitness led to change in in plan.

Treated at GWH

Skin: 2 patient 2.0 breaches: 2 delays due to capacity in plastics following initial reviews in Dermatology.
Lung: 2 patients 2.0 breaches: both pathways impacted by delays to imaging, 1 PET scan delayed by capacity and the other PET delayed by patient fitness. Both were complex cases requiring multiple diagnostics before treatment could be planned.
Urology 1 patient 1.0 breach: pathway delayed by need for repeat biopsies, pathway was also impacted by consultant absence due to COVID.

April is likely to see 10 patients breach 104 days on their pathway resulting in 7.5 breaches.

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

Introduction in February of weekly pathway reviews with Head of Cancer Services & Heads of Service to review all patients 62D+. We are seeing improvements in the data through March showing that this action is having a positive effect.

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

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

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

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

Weekly call with the Cancer Pathway Manager at Oxford is held to review and expedite pathways outside of the usual MDT-coordinator communications.

Risks to delivery and mitigations

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.

Risk: Tertiary centre theatre capacity remains challenged post Covid, particularly for patients requiring High Dependency Unit (HDU) recovery.
Mitigation: The monitoring of long waiting patients and HDU capacity steadily improving. Weekly update meeting held with OUH Cancer Pathway Manager to discuss and highlight issues with pathways transferred for care.

Risk: Delays to pathway communication from tertiary centres resulting in patients being on PTL longer than necessary.
Mitigation: weekly PTL updates from OUH, heads of service regular contact with counterparts where necessary. Weekly meeting with OUH Cancer Pathway Manager now in place to highlight pathway issues.

Risk: Clinical engagement with weekly 62D+ breach reporting
Mitigation: sharing 62D+ PTL patient data at MDT to be explored with services.

Risk: Plastics pathway unable to deliver required performance due to capacity since the service stopped sending cases to Oxford in November 21
Mitigation: Review and mapping of pathway has been completed to identify potential improvements. Mutual aid discussed and agreed with OUH for 90 patients to be sent for treatment. Additional capacity is being explored and SLA with OUH is under review. Senior divisional management discussions in respect of service delivery ongoing.

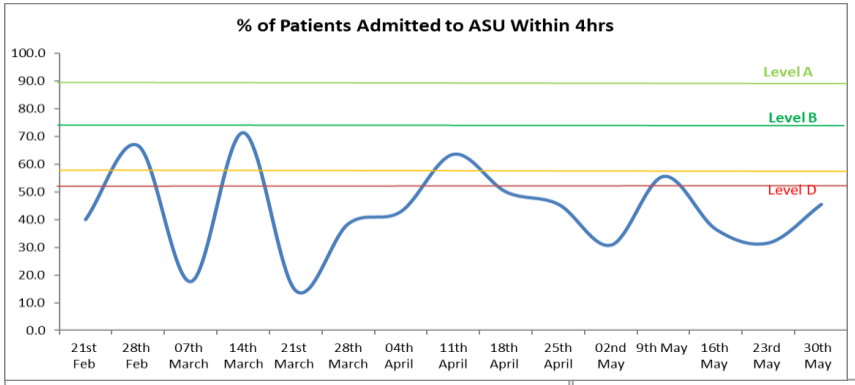
Stroke Pathways

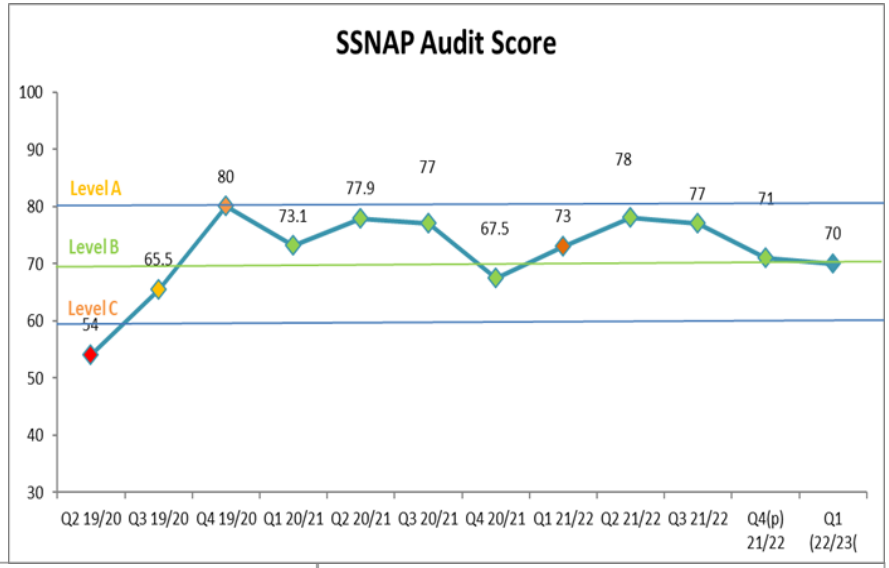
Data Quality Rating:

National Key Performance Indicators

GWH Sentinel Stroke National Audit Programme (SSNAP) Audit Score:

Year	Q1	Q2	Q3	Q4
2021 - 22	B	B	B	B
2022 - 23	B (p)			





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

SSNAP performance maintains Level B performance with Q4 21/22 results confirmed at Level B (71).

Performance for Q4 has seen improvements on Stroke Unit domain, going from E to D, however, reductions in performance in Specialist Assessments, MDT working and Discharge Process have reduced slightly. All other domains have maintained performance levels against Q3.Current Q1 predictions are showing a maintenance of Level B performance.

A lack of ring fenced beds on the ASU, particularly over the weekend and utilisation of these beds out of hours continues to impact performance. The lack of ring fenced beds has become worse over the last month. Due to a lack of Consultants, stroke patients outlied on other wards, are not routinely seeing a stroke physician during their hospital stay.

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

1. Long term locum Stroke Consultant now in post and established well on the ward. **Complete**

2. Engage directly with Hunter Clinical Resourcing Group to identify suitable candidates for substantive Stroke Consultant vacancy. **Ongoing**

3. Dr Rao (Registrar) now in post and established on the ward, bringing much needed Registrar support to the existing team. **Complete**

4. Existing Stroke Locum approached about joining GWH on the Bank in order to save against agency costs. This has been agreed and the process has now started. This will equate to an estimated saving of circa £40k pa against agency commission. **July 22.**

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. This risk is currently being reviewed with a view to escalate in light of the resignation of the Stroke Consultant and recent missed opportunities for thrombolysis.

Mitigation: Weekly monitoring of admissions to ASU by the Stroke Matron. IR1s are completed for breaches of the SOP and learning used to drive improvement performance. This is shared weekly with DD/DDD to monitor performance. Additionally, we meet with the MDT across the pathway to review performance and take appropriate actions as required.

Risk review requested to increase risk rating and out to advert for substantive Stroke Consultant.

Board Committee Assurance Report

Quality & Governance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		19 May 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	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			
IPR:Overall	Amber	Amber	The IPR was rated as shown this month with the following comments to note.		
Integrated Performance Report: Medicines Safety	Green	Green	Metrics remain below national averages with overall number of incidents having reduced during 2022.		
IPR:Infection Control	Amber	Amber	C.diff and MSSA rates increased this month. The trajectory figures have been received and currently we are above the line for C.diff. Decrease in Covid numbers I hospital but an increase in nosocomial infections cf. last month.	Current actions include a focus on hand hygiene and appropriate use of PPE to avoid overuse of latter at expense of former. Also focus on environmental cleanliness, antibiotic use and room ventilation.	Monthly monitoring.

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report: Pressure Ulcer Harms	Amber	Amber	Reduction in pressure harms noted this month in both acute and community.		
Integrated Performance Report: Falls	Amber	Amber	Falls rates have slightly increased again this month. A working group has been set up to draft a Swindon Falls Strategy. Final draft will be presented to the BSW Inequalities Strategy Group in June.		
Serious Incidents Monthly Report	Amber	Amber	2 reported Serious incidents in April. Ongoing investigations remain stubbornly consistent		
Integrated Performance Report: Staffing	Amber	Amber	Sickness levels remain high but Covid related absence is reducing. Good recruitment of HCAs this month but turnover in this group remains high.		
IPR:Perinatal Quality Surveillance Tool	Amber	Amber	Midwife to birth ratio 1:24 this month but in part due to lower birth rate. First month reporting Caesarean Sections under Robson Criteria so no comparison yet. Headroom currently 22% and ideally should be 28% but no funding for this.		
IPR:Ockenden update	Amber	Amber	Fifteen action headings listed, each including up to 11 actions with RAG ratings. A great deal of work is taking place to move towards green in these but for many this will take some time and additional funding.		
Serious Incidents Monthly Update	Amber	Amber	As above, this remains consistent. Requirement to complete each SI within 60 days not currently enforced due to pandemic. If this is reinstituted, we shall be in breach.		
Patient Experience Q4.	Amber	Green	A long and detailed report. Slight increase in complaints and concerns. Friends and Family Test responses have risen in maternity services with introduction of Texting. Positive responses across the Trust for FFT are 5-6 times negative ones.		
Clinical Audit and Effectiveness Q4	Amber	Green	Some further progress in dealing with delayed report sign offs especially since the report was written. Currently 5 overdue action responses and 17 Governance sign-off delays. Two National Cardiology Audits showed substantial assurance, both exceeding NICE standards.		

Issues Referred to another Committee	
Topic	**Committee**

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		23 June 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	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			
IPR:Overall	Amber	Green	The IPR was rated as shown this month with the following comments to note.		
Integrated Performance Report: Medicines Safety	Green	Green	Reported medication incidents have increased slightly but this is believed to be due to improved reporting.	Evidence requested.	
IPR:Infection Control	Amber	Amber	C.diff reduced. There is now a more focused approach with the new Lead person in place. Covid increased slightly but no outbreaks in spite of implementing new guidance.	June focus on Environmental cleaning, July on cannula care to reduce MSSA. More HCA Training	Monthly monitoring.
Integrated Performance Report: Pressure Ulcer Harms	Amber	Green	Reduction in pressure harms noted again this month in acute but slight rise in community where there has been an increase in Category 2 harms but 3 & 4 have reduced.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report: Falls	Amber	Amber	Falls rates have stabilised this month. Several work strands to analyse causes and reduce incidence.		
Serious Incidents Monthly Report	Amber	Amber	Numbers remain within control limits. Continued efforts to reduce outstanding investigations which are having some effect.		
Integrated Performance Report: Staffing	Amber	Amber	Sickness levels remain high but Covid related absence is reducing. Continued recruitment of HCAs this month.		
IPR:Perinatal Quality Surveillance Tool	Amber	Green	As expected, midwife to birth ratio reduced slightly as a result of increased birth rate. Now 1:28, still better than target (1:29).Management of the continuity pathway is changing slowly which has led to a reduction away from target but this is expected to improve as new system beds in.		
IPR:Ockenden update	Amber	Amber	Continued efforts to meet the many targets. Some improvements again with moved from Red to Amber and Amber to Green. This is a long term process with funding implications.		
Serious Incidents Monthly Update	Amber	Green	Good Progress. Reduction in outstanding investigations. A round table approach is being used by MDTs.		
Patient Experience and Engagement Framework Update			Postponed to July due to technical difficulties on the day.		
Electronic Discharge Summaries: Reports and Audit of Impact	Red	Amber	Still no progress in EDS rates of completion but this account gave a lot of detail about the challenges of this task and what is required to meet expectations. Some internal transfers are generating an expectation of EDS when this is not necessary as records are transferred or available. The clinical impact of failure to issue EDSs on time was audited in 27 random samples. No evidence of adverse impact was found.		
WHO Checklist compliance	Green	Green	This verbal report showed a great improvement to 99-100% compliance. This will continue to be monitored but is a significant advance in patient safety.		
Quality Accounts	Not Rated		Accepted and Approved on behalf of the Board. The report was lengthy but much improved on past ones and was considered well put together.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Part 2: Our Care

Our Priorities

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

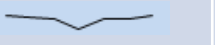
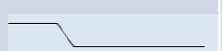
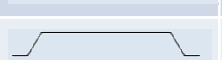
Are We Caring?

Are We Well Led?

Use of Resources

Our Care Summary

Great Western Hospitals NHS Foundation Trust

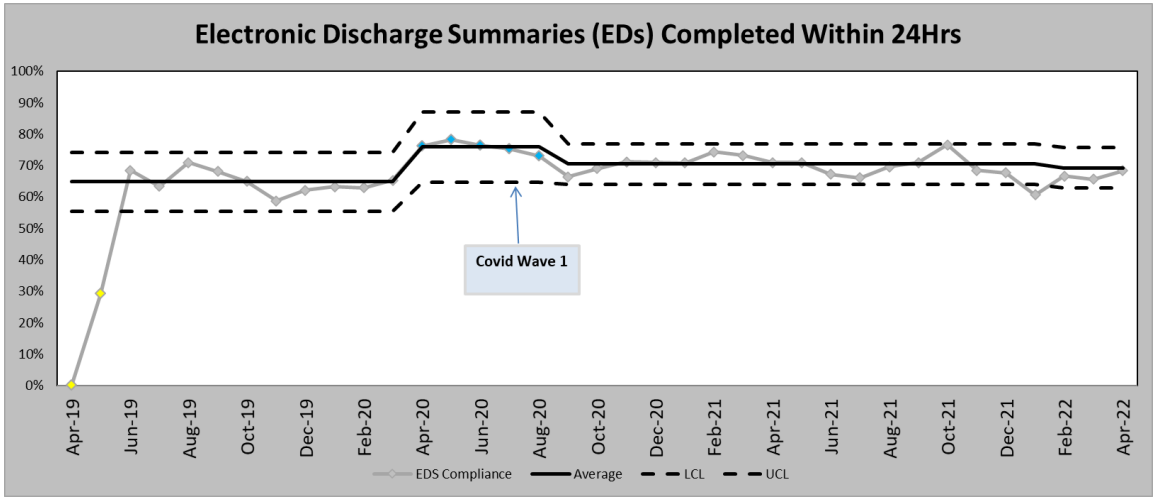
KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
C. Difficile (Hospital onset) per 1000 bed days	16.71 (Feb 22)		69	64	36	Feb 22
VTE Assessment	98% (Dec 21)		22	134	4	Dec 19
Hip Fracture Best Practice Tariff – 12 Month Rolling	43.7.% (Apr 22)		72	60	45	Apr 22
Complaints Rates	15.2 (Q2 21/22)		34	70	39	Q2 21/22
Family and Friends Score – Percentage of Positive Responses - Inpatients	81.5% (May 22)		112	35	25	Apr 22
Complaints Response Backlog	0.0 (Q2 21/22)		1	48	99	Q2 21/22
MRSA 22/23	0		100	47	16	Jan 22
Falls per 1000 bed days	7.4 (May 22)					
Pressure Ulcers – Acute	20 (May 22)					
Pressure Ulcers – Community	34 (May 22)					
Never Events 22/23	0					
Serious Incidents	5 (May 22)					
Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death)	0.56% (Dec 21)					
Hand Hygiene	99.80% (Jan 22)					

Public View Ranking is out of Acute and Combined Trusts Only (123 Trusts)

2. Electronic Discharge Summary (EDS)

Data Quality Rating:

Are We Safe?



	24 hours	48 hours	72 hours.
Jun-21	67.20%	70.88%	72.97%
Jul-21	66.12%	69.79%	73.33%
Aug-21	69.54%	74.05%	77.32%
Sept-21	71.00%	75.43%	77.72%
Oct-21	64.58%	68.75%	72.79%
Nov-21	70.08%	72.70%	74.41%
Dec-21	68.37%	71.20%	73.93%
Jan-22	60.63%	64.15%	67.19%
Feb-22	66.62%	69.35%	71.51%
Mar-22	65.65%	70.87%	73.62%
Apr-22	68.35%	72.59%	75.88%
May-22	Data not available		

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

At time of writing (27/05/2022) the latest available data is for April 2022 – this indicates overall EDS compliance at 68.35%.

Divisional backlog performance trend data has become available for Quarter 3 2021 (October to December 2021) and Quarter 4 (January to March 2022). The data available shows: -
•SWC – worsening backlog
•USC – improving backlog
•ICC – improving backlog

Comparison of March 2022 vs April 2022 shows a mixed picture in terms of backlog EDS with SWC (Surgery, Women's and Children) improving but both ICC (Integrated Community Care) and USC (Unscheduled Care) deteriorating with respect to backlog of EDS.

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

The EDS Task & Finish Group met in early May 2022.

Data quality concerns arising from the meeting prompted the following: -

- The EDS Task and Finish Group will increase the frequency of meetings to monthly
- The Deputy Medical Director met with representation from Business Intelligence to gain assurance over concerns regarding data quality and reporting
- A representative from the EDS Task and Finish Group was to attend the Careflow/EPMA (Electronic Prescribing and Medicines Administration) conference on 24/05/2022 to explore what EPMA generated EDS could offer the Trust and to feedback to the June Task and Finish Group meeting
- The EDS Task and Finish Group have invited representation from the Data Warehouse to the next task and finish group
- A meeting with a senior information analyst from the Informatics team is scheduled for mid-June 2022 to explore improving reporting on the current platform

In addition to the above, a report is being created for Quality and Governance in June 2022 to address concerns regarding EDS performance.

Risk 293 pertaining to EDS completion performance has been rewritten by the Deputy Medical Director to more accurately reflect concerns and actions around this care indicator – this is currently scored at 16 and there are plans to review this at the next Risk Committee meeting in June 2022.

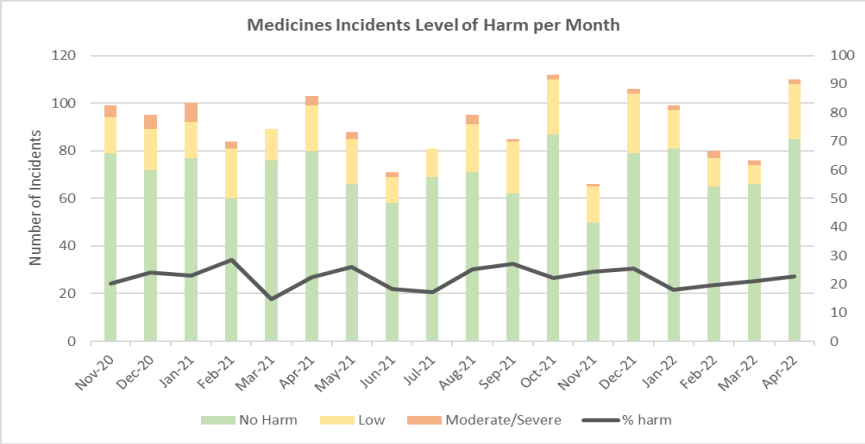
Risks to delivery and mitigations

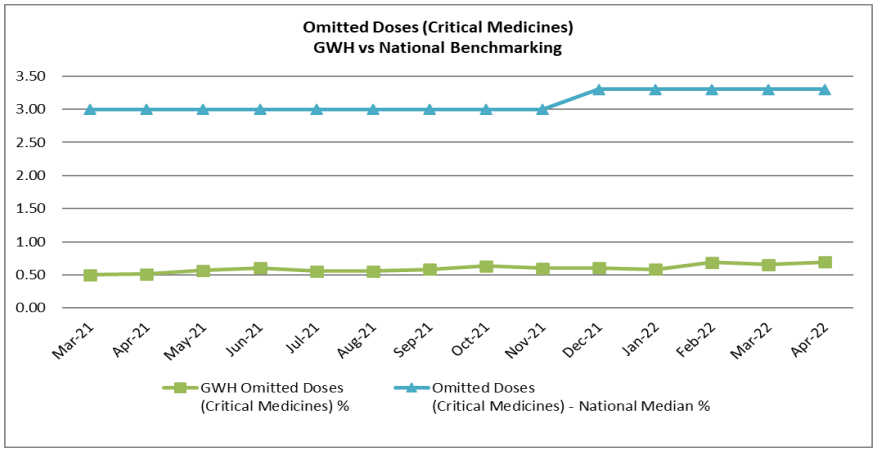
Both risk and mitigation of risk around EDS performance are multifaceted.
Issues include: -
• Confounding data – EDSs are currently generated from transfer (Acute to SWICC) and death
• Variability – More than 1 system of communicating in-patient/assessment/day case episodes exists
• Specialty reporting is hampered by 21 specialties mapping to 50 reporting areas
The potential solution of moving EDS production to a single platform provided by EPMA is not viable whilst this platform is not used in all Trust areas.

2. Medicines Safety

Data Quality Rating:

Are We Safe?





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

Medication Incidents

- Number of reported medication incidents has increased in 2022, indicating improved reporting.
- The proportion of incidents resulting in harm continues to remain consistent across the year.
- Benchmarking (regional and national) places GWH medicines incident reporting in the middle of the distribution curve. This indicates a good reporting and learning culture.

Omitted Critical Medicines

- The Percentage of unintended omitted critical medicines continues to remains consistently low throughout the Trust.
- Compared to the national median of acute hospital trusts (2021 national benchmarking*), Great Western Hospital (GWH) has a lower rate of unintended omitted critical medicines.

*Benchmarking value updated Dec 2021, next Update due in Nov 22

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

Medication Incidents

- Work centred on reducing prescribing incidents, through consolidation of paper-based drug charts has been completed, Measurement of impact of this change planned for June through a snapshot audit.
- Upgrade of electronic prescribing and administration system (EPMA) is scheduled to go live in July 2022 This will improve user experience and patient safety through to improved processes and workflows relating to medicines use.
- Rollout and implementation of medicines trolleys as an improvement programme continues in June.

Omitted Critical Medicines

- Robust systems are in place to ensure that all critical medicines are available 24 hours a day, leading to a consistently low percentage of omitted doses in the Trust.
- A tool is in development to have the omitted medicines data available to clinical areas to help drive local improvements. Upgrade of EPMA system has delayed development, and now expected at end of Q2 2022 after go live of new system.

Risks to delivery and mitigations

Medication Incidents
No specific risks to delivery identified at this stage.

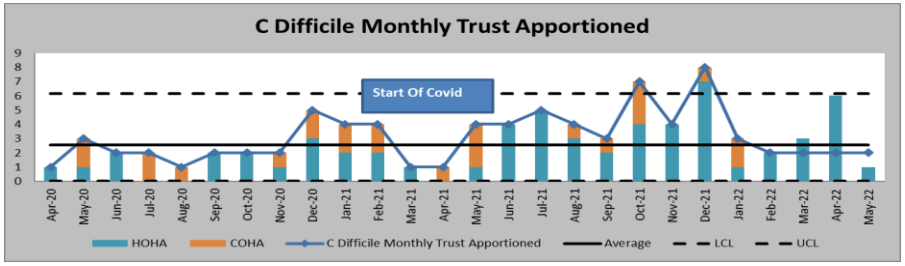
Improvement actions overseen through existing quality and safety governance routes, including Patient Quality Committee, Medicines Safety Group and the Serious Incident Learning Group.

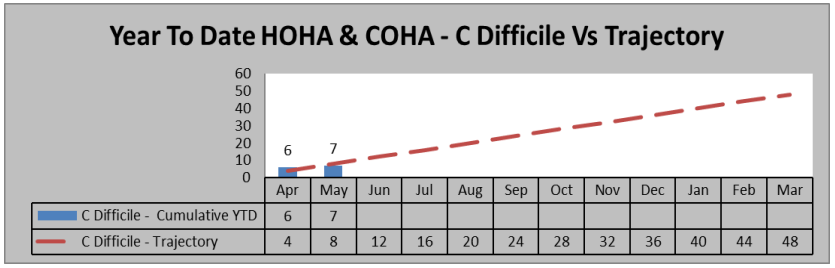
Omitted Critical Medicines
No specific risks to delivery identified at this stage.

2. Patient Safety - Infection Control

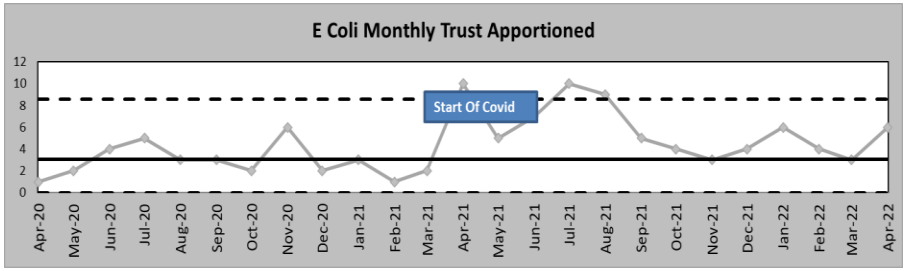
Data Quality Rating:

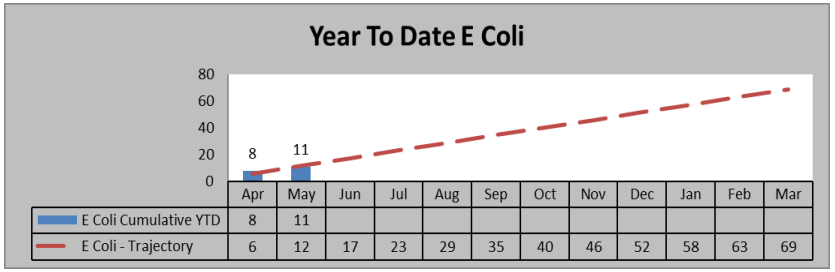
Are We Safe?





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C Difficile - Cumulative YTD	6	7										
C Difficile - Trajectory	4	8	12	16	20	24	28	32	36	40	44	48





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E Coli Cumulative YTD	8	11										
E Coli - Trajectory	6	12	17	23	29	35	40	46	52	58	63	69

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

C. difficile – In May 2022 there was one reportable *C. difficile* infections which was a Healthcare Associated (HOHA) identified on Linnet Ward. The Trust has been set a threshold of 48 *C.difficile* infections for 2022/23, which means that at the end of May 2022, we are slightly under the trajectory for that threshold.

Gram negative Bacteraemias -The Trust has been set thresholds of 69 *E.coli*, 23 *Klebsiella* and *19 Pseudomonas aeruginosa* bacteraemias for 2022/23. In May 2022, 3 *E.coli*, 2 *Klebsiella* and 0 *Pseudomonas aeruginosa* bacteraemia were identified, placing the Trust slightly over trajectory for *E.coli* but under trajectory for *Klebsiella* and *Pseudomonas aeruginosa.*

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

C. difficile – samples are sent to an external laboratory for ribotyping to look for links between cases; there have been no confirmed cases of cross contamination, however GWH ended last year over trajectory and therefore this remains a focus for improvement work in 2022/23. The ADIPC or Matron for IP & C are now attending all *C.diff* case review meetings and ward rounds. IP&C are reminding all areas to send a stool sample as per policy. Wards continue to be encouraged to complete stool charts on paper resulting in more accurate recording.

Gram negative - *E.coli* and *Klebsiella* are commonly found in the gut, so infections from these organisms are often associated with poor hand hygiene or with catheter care. *Pseudomonas aeruginosa* is an environmental organism, typically found in water. The IP&C team are working with Clinical and Estates colleagues to ensure good water hygiene practices are in place.

Improvements in care are being targeted through a focus on the fundamental principles of good IP&C practice, including monthly focus topics. Hand hygiene was the focus throughout May, with events supporting hand hygiene day and glove awareness week. The focus for June is environmental cleanliness, starting with an external trainer teaching clinical staff on the ward and a focused audit on ward cleaning processes. The focus for July will be cannula care, as recent cases of MSSA bacteraemia have been associated with cannulae.

There is also a review of the teaching of IP&C practice, in particular for new Healthcare Assistants, as HCAs deliver a very high proportion of direct care.

MRSA Bacteraemia	20/21	21/22	22/23
Trust Apportioned	0	2	0

Risks to delivery and mitigations

Maintaining cleanliness of the ward environment consistently, including patient care equipment remains a priority. The IP&C team are working closely with two wards, Beech and Neptune, to improve the standards of cleaning using cleaning check lists.

The IP&C team is currently impacted by high levels of long-term sickness absence and an interim plan is in place to support the team. The Associate Director of Infection Control is reviewing the structure of the team with a view to better aligning IP&C support with the Trust's divisional structure to enable closer joint working. A band 7 post has been out to advertisement and interviews are planned for June.

The Antimicrobial Stewardship comprises a microbiologist with IPC and pharmacy. GWH has shown the greatest reduction in DDD in the region at -17% (target 2%). Average ward compliance with guidance is 95% (86-100%)

Data correct as of 6th June 2022. The data in the preceding month may have changed due to timing of previous months reporting.

2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

Covid 19	Mar-22	Apr-22	May-22
Number of detected Inpatients	437	379	139
Number of Deaths in Hospital	21	23	15
Hospital Acquired Covid-19 Cases*	59	75	31

Covid-19 (Apr 22 – Mar 23)		(April 21- Mar 22)
Number of detected Inpatients	379	2440
Number of Deaths	23	162
Hospital Acquired Covid-19 Cases*	75	165

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

The number of patients diagnosed with COVID-19 has decreased in May in line with the national and regional picture.

In the week 9th-15th May the Swindon case rate was 86 per 100,000. The Wiltshire rate was 83 per 100,000, with the England average being 82 per 100,000.

There were 31 hospital acquired cases of Covid 19 (8 days +) May 2022. There were several outbreaks and clusters which were managed through the daily outbreak meetings.

Due to the new guidance and change in isolation for exposed patients, the reduction in lost bed days continues to be seen. To date there is no evidence that the change has led to an increase in outbreaks.

A detailed review of Nosocomial deaths is under way as per national guidance.

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

There was a significant decrease in nosocomial COVID infections in May, which continued to be managed through daily ward review /outbreak meetings, this ensured management of clinical areas with minimal bed closures wherever possible. Themes from the outbreak meetings are collated and disseminated through the safety briefs and Trust wide communication. There is a continual focus on meticulous adherence to infection control standards.

The divisional Matrons are ensuring that patients are swabbed throughout their admission according to the agreed protocol (on admission, day 3 and day 5, or if any COVID symptoms develop). This enables early identification of positive cases and reduces the risk of nosocomial spread.

The Personal Protective Equipment audits are ongoing and additional spot checks and communication with staff is being driven by the Divisional Directors of Nursing. Staff are also being reminded to complete regular lateral flow tests to reduce the risk of nosocomial transmission.

FFP3 masks are available to all patient-facing staff. Fit-testing for FFP3 masks is organised and recorded by clinical departments. Provision has been made to record fit-testing records centrally – using ESR – which is a recommendation of the NHSEI IPC Board Assurance Framework. The ADIPC is working with HR, Procurement and the NHSEI fit-testing programme lead, to ensure GWH meets the national recommendations on fit-testing, including record-keeping.

IP&C and Estates leads are working on a plan for the roll-out of “air scrubbers” across clinical areas, following a successful trial on Neptune Ward.

The new guidance indicates the use of LFTs for inpatient testing over PCR for non symptomatic screening on days 3 and 5 of an inpatient stay. Work is being done to facilitate this change across all areas. This should be in place in the next few weeks.

Risks to delivery and mitigations

Recent adjustments to patient pathways, swabbing regimens and isolation periods continue to require IP&C support to ensure they are embedded into practice.

The infection control team is currently impacted by high levels of long-term sickness absence and an interim plan is in place to support the team. The Associate Director of Infection Control is reviewing the structure of the team with a view to better aligning IP&C support with the Trust’s divisional structure to enable closer joint working.

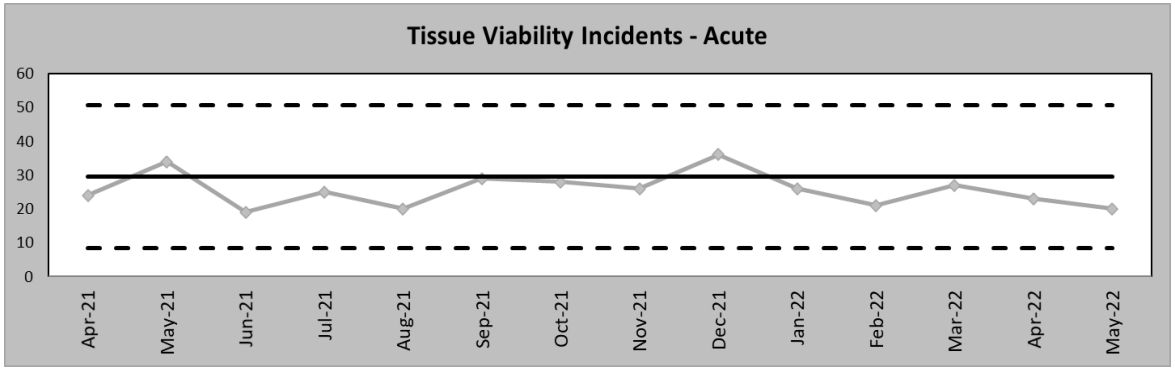
Data correct as of 6th June 2022. The data in the preceding month may have changed due to timing of previous months reporting.

*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 May 22:

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Unstagable	Total Incident of Harms
15	0	0	4	1	20

Number of Patients	Harms per Patient
20	1

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

There were a total number of 244 incidents reported for pressure ulcer related harms during the month of May. All of these were validated by the Tissue Viability Nurses (TVN's).

20 of these incidents were hospital acquired and the remaining 224 incidents were a combination of PU harms which were present on admission and not pressure ulcer damage.

This is a decrease of 4 harms, following 24 harms the previous month. There were a total number of 20 harms on 20 patients.

The one harm caused by a medical device was from a soft collar causing pressure damage to the patient's chin.

Hotspot area this month is ED with 4 harms.

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

Improvement action plans have now commenced with Woodpecker ward and the Trauma unit last month's hotspot wards/departments, which include trauma trialling a hybrid mattress range. A monthly pressure ulcer advisory group meeting has been arranged to review all hospital acquired harm. Trauma department will ensure that all hospital beds within their department will have a repose wedge in place. This is to reduce harm to heels by off loading pressure areas for all patients across the department.

Ongoing Trust wide standard foam mattresses audit booked for June 22 in parallel with monthly departmental audit to ensure all beds have the adequate pressure reliving properties to support patient's skin.

Training:

- Repose equipment with onward training has been delivered Trust wide throughout May and continues throughout June.
- Moisture Associated Skin Damage Training session successful for SWICC and ED with future sessions booked.
- Tissue viability Education Training delivered to the Preceptorship Nurses face to face.
- Health care assistant training delivered face to face with demonstrations of how to use Pressure relieving equipment appropriately.
- Foam Dressing Training support to all wards and departments throughout May –Upskilling staff on the correct product choice and assist appropriate wound management.
- Pressure ulcer training and wound care training delivered to Theatre's to upskill theatre staff in providing the correct wound care and identification of pressure damage.
- Great success with the TVN Educational Wound care drop-in study day for all Trust Staff review dressing choices and selections following current formulary over 130 attended and 30 Safer skin champions recruited.

Risks to delivery and mitigations

Attendance to training sessions remains challenging for staff within clinical settings due staff pressures from sickness and Covid.

Pressure Ulcer prevention vacancy within the Tissue Viability Team to support the delivery of education and training has now closed and currently being short listed for planned interviews for 17th June.

Currently Education being provided by Tissue Viability Team lead.

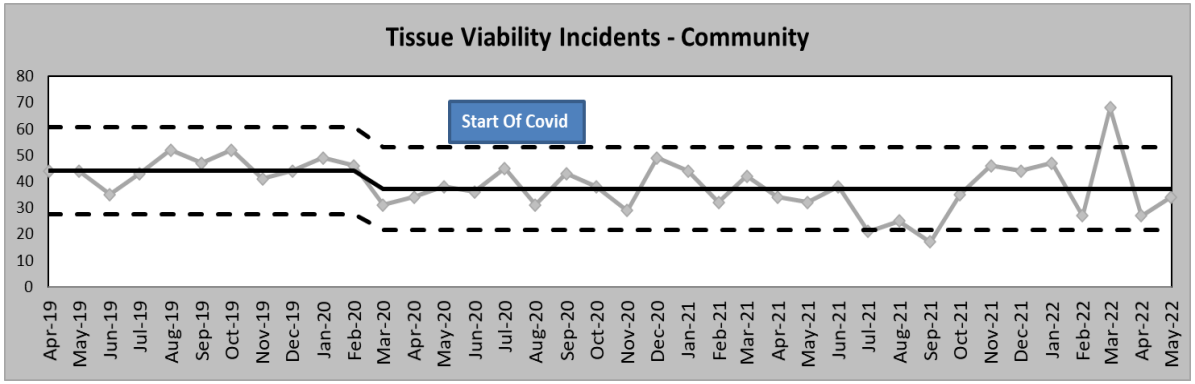
Data correct as of 8th June 2022.

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

2. Patient Safety – Community Pressure Ulcers

Data Quality Rating:

Are We Safe?



Incidents of Harms by Category for May 22:

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Unstagable	Total Incident of Harms
17	4	1	7	7	36

Number of Patients	Harms per Patient
1	2
34	1

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

Total number of harms reported this month 93, this is an increase compared to last month.

36 harms occurred whilst on the community nursing caseload, this is an increase from last month. There is a reduction in category 3's and 4's with an increase in lower-level harms, which could suggest earlier reporting. This increase is consistent with feedback from Tissue Viability groups nationally. .

25% of incidents are reported in patients that are end-of-life or actively dying.

Device related incidents this month were: anti-embolic stocking/incontinence pads/catheter bag however these harms were all present on admission.

1 x category 4 pressure ulcer reported this month, in a patient with multiple and complex co–morbidities – there were no gaps or omissions in care.

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

At the beginning of the year we were reporting 3-5 mucosal harms per month caused by a urinary catheter as a result of focused improvement work this has now reduced to 1 per month and a lower level of harm.

As part of this on-going work the catheter associated Urinary Tract Infection Group (CAUTI) working in partnership with Infection Prevention and Control (IPC) and Continence team, are planning further improvement work including

- Review of the catheter passport which is used to inform and support clinicians, patients and carers with aims to improve catheter maintenance across all healthcare providers to prevent CAUTI's and mucosal harm..
- A follow up safety notice reminding clinicians of the risks of not using a fixation device with any indwelling catheters, followed by compliance audit.
- Development of 'safe patient discharge' education package for patients with an indwelling catheter, to improve continuity of care across the patient health care journey and ensuring appropriate resources and follow up are available on discharge.

Risks to delivery and mitigations

The continuing high case load and difficulties in recruiting to establishment in the Community Nursing services and Tissue viability services can impact the ability to provide high quality pressure ulcer prevention management, specialist review and assessment and as a result pressure ulcer rates may increase.

This is being mitigated by:

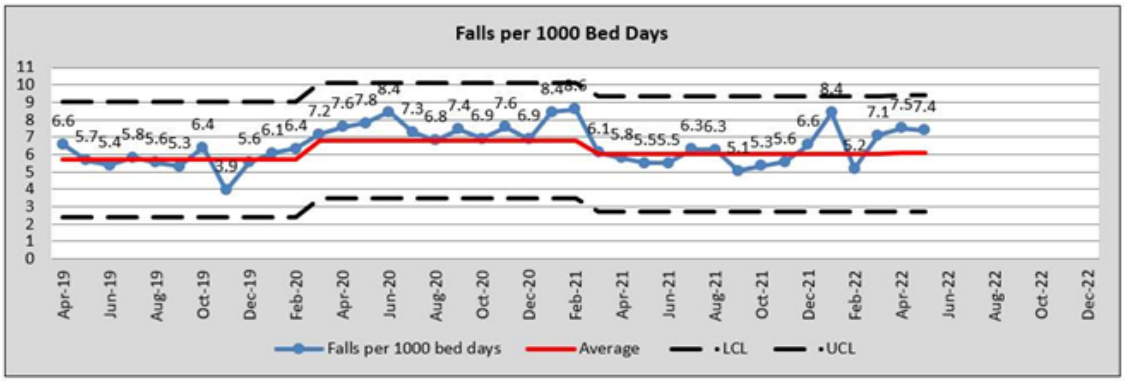
- Ongoing recruitment of community staff
- Case load reviews with Tissue Viability specialists
- Increased use of temporary staffing
- Education for temporary staff
- Use of Laptops and mobiles for temporary staff

Data correct as of 6th June 2022

2. Patient Safety – Safer Mobility (Falls Reduction)

Data Quality Rating:

Are We Safe?



	Total Falls	Falls resulting in moderate harm or above
Nov-21	108	3
Dec-21	126	4
Jan-22	160	3
Feb-22	88	1
Mar-22	140	4
Apr-22	142	3
May-22	147	6

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

147 reported inpatient falls, resulting in 7.40 per 1000 bed days, this remains within normal variance. On average each month 30.3% of falls involve patients who have fallen twice or more as an inpatient.

During May 2022, there were six falls which resulted in moderate/severe harm. None of these patients had previously fallen as inpatients

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

Falls Education Programme
Evaluation of first intake on Falls Education Programme has been completed, delivered over six-monthly sessions to 20 registered and unregistered nursing and therapy colleagues. Excellent feedback has been received, with recommendation from attendees to deliver over one day. From November 22 the programme will run over a full day, four times a year. This will increase capacity from 40 to 100 members of staff who can be trained during the year.

Falls Incident Investigations and thematic review
Thematic review of falls in the highest reporting wards has commenced to identify themes and develop ward specific improvement plans. This process has commenced with a review of 33 falls incidents on Trauma ward which were reported during March and April 22.

Swindon Falls and Bone Health Strategy 2022-27
- Draft Strategy out to consultation to Swindon Falls and Bone Health Collaborative
- Final document expected to be agreed at BSW Health and Wellbeing Board 26th July 22

Fracture Liaison Service (FLS) - currently no FLS for the local Swindon population.
- The role of a FLS is to systematically identify, treat and refer to appropriate services all eligible patients over 55 years, within a local population who have suffered fragility fractures. The aim is to reduce their risk of subsequent (or secondary) fractures by improving bone health and reducing risk of falls. Treatment includes bone health management to as well as multi factorial falls assessment, and referral for balance and strength exercise to reduce risk of falls.
- A working group has met for the first time with Clinical Commission Group (CCG), Public Health, GWH Orthogeriatrician, Consultant Rheumatologist, and Falls Specialist Nurse.
- Initial proposals for a local FLS are being taken to BSW CCG Ageing Well Board by Public Health Consultant and GWH Falls Specialist Nurse in July to determine commissioning intentions

Risks to delivery and mitigations

There are an increasing numbers of frail and deconditioned older people at high risk of falling in the community setting.

Around 300-350 patients a month are admitted with a fall as the primary diagnosis code, these patients are at high risk of falling again as an inpatient.

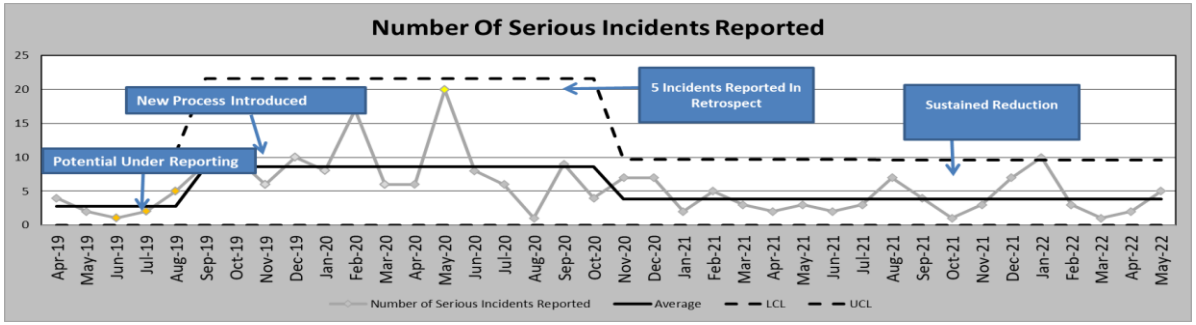
No commissioned Fracture Liaison Service for the Swindon population. This reduces the risk of secondary fractures for the cohort of at-risk individuals.

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
Mar-22	Apr-22	May-22	May-21
1	2	5	3

Never Events		
2020-21	2021-22	2022-23
2	3	0

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

At the time of reporting, there are a total of 25 ongoing Serious Incident (SI) investigations, with five incidents reported in May 2022.

The numbers remain within our expected control limits.

There are no themes identified on the newly reported SI's.

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

Learning from incidents, serious incidents, inquests and investigations:
Currently, there are nine different videos available to watch alongside other learning material within the Learning Zone including, Weight Based Medication Errors (Children), Getting Medicines Right (Oxygen) and Falls.

There has been a total of 3,515 views to all videos since the launch of the Learning Zone, with how to raise an incident being the highest overall viewed video and Care after Death the most viewed in March. April and May.

All opportunities are being used to share and promote the Learning Zone, including a trolley dash during the Patient Safety week (20th – 24th June), on the 22nd June that will include handouts of where to access the Learning Zone, how to add learning, as well as examples of the posters already available. There will be a guess the number of video views, and a staff survey to understand knowledge of the Learning Zone and how it can be improved. A Matrons monthly update is provided that includes a tracker of individual/teams that have agreed to submit work for the Learning Zone that is still pending. Our two Primary care practices do not have the same access to the Learning Zone as the acute side. It is therefore being explored if the Learning Zone or shared learning can be developed in these practices.

Improvement groups
There is now a rolling program of presentations from improvement groups that share the learning at the Patient Safety and Learning Group meeting and then through a monthly report to the Patient Quality Committee.

National Patient Safety Training levels one and two
The training was rolled out at the start of the year and there has been steady progress to complete both levels. Integrated Care and Community Division have 23% (cumulative) of staff complete in level one in May and have shown the greatest increase across all Divisions since March. All staff are expected to complete level one and those involved in investigations or in a senior role to complete level two as well. Although the training is not yet mandatory, there is a National expectation of compliance.

Risks to delivery and mitigations

Although Improvement, there are still 15 SI investigations that are overdue, which pose a risk of breach of contract should the Trust be measured against timeframes.

The clinical risk team meets with the divisional quality team on a weekly basis and provides updates. Weekly update on the SI's provided to the Chief Nurse and Medical Director and escalate the concerns over the overdue SI's.

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

2. Patient Experience – Safer Staffing

Data Quality Rating:

Are We Safe?

Table 1 - Average Fill Rate

Average Fill Rate (%)	
Nurses / Midwives	98.1%
HCA	100.3%

The wards with low fill rates (below the 90% fill rate) on **DAYS** were:

Ward	Average Fill Rate – Nurses / Midwives (%)
Hazel, Delivery & WHBC	83.6%
Orchard Ward SWICC	73.4%

Ward	Average Fill Rate - HCA (%)
Aldbourne	73.6%
Kingfisher SAU/SAW	74.7%
Hazel, Delivery & WHBC	60.2%
SCBU	52.8%

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

It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board. High level figures are provided here, and further information and analysis is provided in a separate more detailed report to the Board.

Table 1 below summarises the average fill rate and the wards that aren't achieving 85% fill rate during May 2022. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

The Overall fill rate for both Average Fill Rate - Nurses/ Midwives (%) and Average Fill Rate - HCA (%) increased from last month.

Hazel, Delivery & WHBC was the only area that had below 90% average fill rate for both Midwives (%) and HCA on days. This has been reviewed by the Director of Midwifery.

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

HCA vacancy levels
HCA vacancy rate continues to improve with the current recruitment process which includes weekly shortlisting and interviewing and monthly recruitment webinars.
Currently there are 38.7 whole time equivalent (WTE) band 2 vacancies, with 52.24 WTE in the pipeline going through pre-employment checks.

Sickness absence / staffing status
Overall sickness absence remains high in Nursing and Midwifery, short term sickness absence in hot spot areas is between 6-7% and additional actions are being undertaken to improve this.

Safer staffing investment
Recruitment trajectories have been completed and work is underway in the divisions to ensure the new HCA establishments are being recruited to. Year 1 investment also included increasing the registered nurse to patient ratios to 1:8 on 4 wards and good progress is being made towards this. This is an important step to demonstrate compliance with the 1:8 national guidance across the Trust.

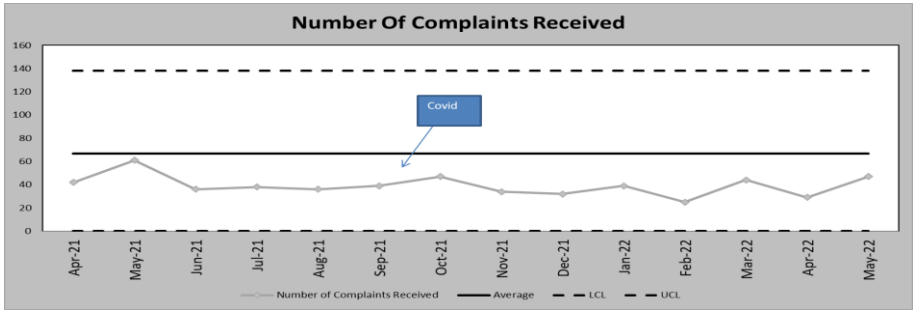
Risks to delivery and mitigations

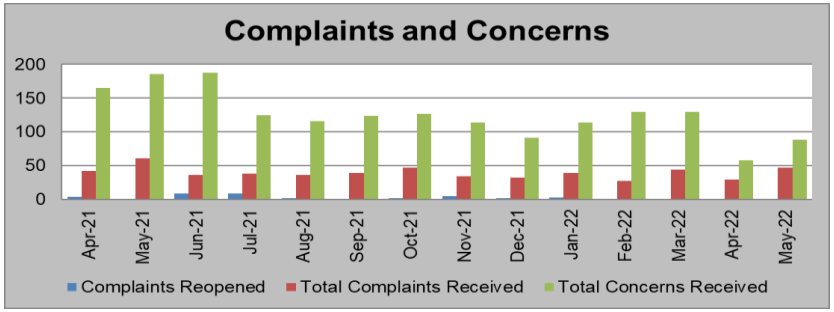
Maternity Staffing remains of concern due to high vacancies and maternity leave. There has been successful recruitment of students who are due to start in the Autumn and gaps are being filled by the agency midwives. There is also work ongoing to ensure nonclinical tasks are not completed by clinical staff and the development of new roles to support staff. There is very close monitoring of critical gaps and reporting of staffing and acuity by the Director of Midwifery.

The Emergency Department remains under significant operational and staffing pressures, a weekly staffing review is being presented to the Chief Nurse to ensure that there is consistent safe staffing in the Emergency Department. The skill mix work is under way which will increase the number of senior staff (band 6&7) to ensure that the national workforce standards are met.

2. Patient Experience - Complaints and Concerns

Are We Safe?





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

47 complaints received in May 2022 (previous month 44) and 88 concerns (previous month 130) were received in May 2022.

Out of a total of 135 cases received from Complaints and Concerns in May, the overall top three themes were:

Theme	Complaints	Concerns	%
Communication	7	16	18% ↔
Behaviour and attitude of staff (A&C)	4	14	14% ↑
Clinical Care	13	3	12% ↑

45 complaints were rated as Low – Medium, 2 complaints received were rated as High.

The complaint response rate was 67%, which has improved from 57% in April. 89% of concerns were resolved within seven working days (Internal KPI 80%).

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

Complaints Handling and Response Writing training has been developed in conjunction with new PHSO standards and will be available in July 2022.

First edition of a PALS newsletter was distributed in May, following positive feedback, it has been decided that this will become a quarterly distribution moving forward.

Two PALS open days have been arranged for June 2022 for Trust staff to visit PALS, meet the team within the department and learn more about what we do and how we can support them.

Work is increasing with volunteers around specific roles to support meaningful engagement using new activity resources which have been purchased and also supporting telephone calls and virtual visiting

A bank of 'Care reflections' has been created to share real patient stories told in audio or film. These are being used in team and divisional governance meetings, staff reflection etc.

New patient personal property boxes are being trialled across our wards. These are for items such as glasses, hearing aids etc and will be evaluated in July 2022

The Carers committee has been relaunched and new information packs and signage have been distributed to all wards.

A trial of good footwear to help prevent falls has commenced

A shadow shift programme between and therapy and nursing colleagues has commenced to better understand each other's roles

The ward new starters induction has been reviewed with changes to the induction day and pack agreed

Risks to delivery and mitigations

There has been reduced capacity due to a number of vacancies within the PALS and Complaints team. This pressure will continue until the posts are filled.

One of the posts have now been filled, and this person is being trained into the role.

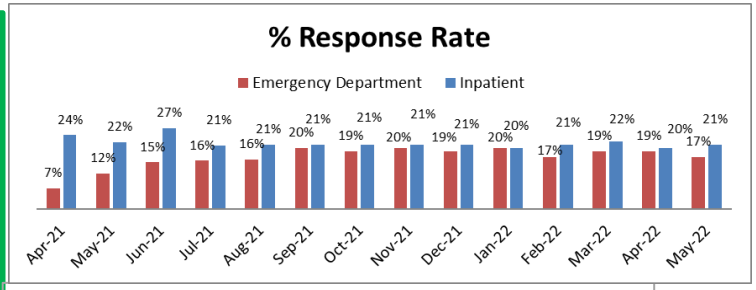
There is ongoing recruitment to fill the remaining vacancy.

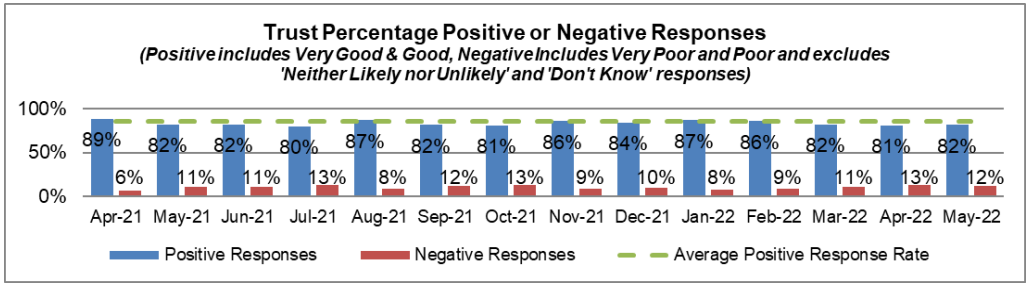
Data correct as of 1st June 2022.

2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?





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

For May, 81.5% of the Friends and Family Test (FFT) responses were positive, in line with the previous month April, at 81.5%. The negative responses at 12% are very slightly lower than last month at 12.6. This is based on the % of responses rated as 'very good' and 'good'.

	No. of Texts sent	No. of Responses	Total Response rate (%)	Positive Responses
A&E Combined	5,016	998	17% ↓	71% ↓
Inpatients	2,305	616	21% ↑	82% ↑
Day Cases	1,674	465	22% ↓	92% ↔
Outpatients	0	203	N/A	96% ↑
Maternity	844	155	20% ↓	94% ↑

A&E (ED & UTC combined) response rate at 71% is slightly lower than April at 74%.
Inpatients currently showing as 82% is noticeably higher than last month April at 75%.

Of the 203 responses received from Outpatients 96% were positive, this may alter when the patient numbers are reported via Unify.

May results for all areas of maternity services are showing an improvement, overall positive recommendation rate is up from April at 90% to 94% for May.

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

Overall positive and negative themes

Top 3 Themes	Positive		Negative	
	Apr- 22	May -22	Apr- 22	May -22
Staff attitude	1,200	1,135 ↓	255	210 ↓
Environment	528	503 ↓	218	199 ↓
Implementation of care	730	687 ↓	n/a	n/a
Waiting Times	n/a	n/a	198	182 ↓

Improvement Actions in response to Feedback: The Great Care initiative continues to drive improvements in personal care and environment and improvement actions were detailed in the May quarterly Patient Experience report.

Work to improve the hospital streets is ongoing including options for additional storage being explored, daily monitoring of the corridors and collaborating the company who supply OT equipment to ensure timely removal of items from our corridors

The 6 Carers chairs have been repatriated to the Equipment library where they have been checked and labelled to ensure that they can be clearly identified.

First impressions count project with a focus on 'my name is' and 'I see you'.

Compassionate conversations project with ongoing training to go out to teams and individuals.

Restful ward project to promote a conducive sleep environment

Risks to delivery and mitigation

PALS continue to support clinical divisions by attending divisional governance meetings in order to identify actions and learning as part of the PALS quality improvement project.

Data correct as of 6th June 2022.

2. Patient Safety – Perinatal Quality Surveillance Tool

Data Quality Rating:

Are we Safe?

Measures	Comments

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

Measure	Aim / Target	March 22	April 22	May 22
Midwife to birth ratio	1:29	1:27	1:24	1:28
1:1 Care	100%	100%	100%	100%
Consultant presence in Delivery suite (Hours per week)	60 hours	74.5hrs	74.5hrs	74.5hrs

The birth rate for May increased which is reflected in the midwife to birth ratio; this was an anticipated increase due to the booking projections and the midwife to birth ratio remains within the targeted range.

Service User feedback

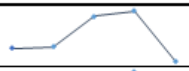
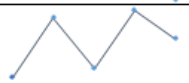
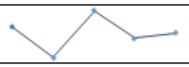
Visiting within Maternity was extended further in May (in response to patient feedback) to include partners being able to stay for both induction and postnatal care – number of nights no longer limited to 1 postnatally. Sibling access has also been expanded so they can attend throughout the day as this was previously limited to 2pm-5pm. This change supports patient feedback on restricted visiting and has been communicated via Trust communications and the Maternity Voices Partnership communications.

Core20PLUS5– An approach to reducing health inequalities

Measure	Aim/Target	Feb 22	March 22	April 22
BAME women on continuity of carer pathway	75%	47.92%	30.61%	42.42%
Women with high index of multiple deprivation on continuity pathway	75%	80.65%	75.00%	61.29%

This data is available a month in arrears. In response to recommendations made in the Ockenden Report the continuity of carer teams have been reduced to one larger team, with workforce modelling underway to support provision of a continuity of carer model for the majority of women by 2024.

Caesarean Sections

Robson Group Descriptor	Robson Group Number	Sparkline	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Women/pregnant people in their first pregnancy with a head down, single baby at ≥37 weeks, in spontaneous labour that had a Caesarean birth*	1		6.98%	7.08%	8.87%	9.20%	6.25%
Women/pregnant people in their first pregnancy with a head down, single baby at ≥37 weeks, experiencing an induced labour or caesarean birth before labour. *	2		25.60%	31.86%	26.61%	32.70%	29.69%
Women/pregnant people that have had a previous Caesarean birth, with a head down, single baby at ≥37 weeks. *	5		30.20%	20.35%	35.48%	26.50%	28.13%

**Robson group data is presented as a % of the total number of Caesarean births and therefore the % of births that each of these criteria represents.*

The data above demonstrates the new reporting format for caesarean birth analysis. This aligns the local dashboard with the National Maternity Dashboard. The variation in Robson Group 5 aligns with the local improvement plan following the analysis of the caesarean births undertaken in 2021/2022. Progress will be monitored via the Maternity Governance meetings.

2. Patient Safety - Perinatal Quality Surveillance Tool

Data Quality Rating:

Are We Safe?

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

Measures	Comments
Concerns or requests for actions from national bodies	None.
CNST 10 Maternity standards (NHSR)	Updates to the guidance was published in May, with submission delayed from July 2022 to January 2023. A full review of the revised guidance has been undertaken and at present the RAG status remains unchanged with 8 safety actions anticipated to achieve full compliance and the remaining 2 requiring further action for full compliance. A detailed breakdown will be provided in July 2022.
Ockenden Report (March 2022)	A gap analysis of the full Ockenden report has been undertaken to identify areas for focus for full compliance. The 15 Immediate and Essential actions are outlined on the following slide and a full update will be provided in July 2022.
Findings of review of all perinatal deaths using the real time data monitoring tool	No cases reviewed in May.
CQC Ratings	Ongoing preparations continue for an anticipated inspection with mock inspections highlighting areas for improvement.
Maternity Safety Support Programme	Not required as CQC ratings overall 'Good'
Coroner's Regulation 28	Nil

2. Patient Safety - Perinatal Quality Surveillance Tool

Are We Safe?

Ockenden progress update

Overview & Summary Review of Criteria RAG Status

NHS
Great Western Hospitals
NHS Foundation Trust

Current RAG status/ Action Number	Immediate and Essential Action	Number of Actions Under Each Heading Rated (arrows have been added to criteria to highlight changes within the last month)			Key actions for progression
		Red	Amber	Green	
1.	WORKFORCE PLANNING AND SUSTAINABILITY	↓2	↑9	→0	Review of maternity workforce to ensure there is funding for safe staffing levels and sufficient headroom provision to support essential training. Birth rate+ re-evaluation now received
2.	SAFE STAFFING	3	6	1	Ensuring that local escalation policies represent the entire work force, that staff are suitably skilled and developed for their roles and that channels of communication are utilised effectively. This includes a review of the continuity of carer model
3.	ESCALATION AND ACCOUNTABILITY	1	3	1	Consideration of maximising consultant obstetrician presence, and review of escalation policy.
4.	CLINICAL GOVERNANCE- LEADERSHIP	2	4	1	Presentation of National Maternity Self-Assessment Tool and improvement plan to Trust board in July. Strengthen multi-disciplinary approach to review of guidance.
5.	CLINICAL GOVERNANCE- INCIDENT INVESTIGATION AND COMPLAINTS	1	6	0	Ensure effective monitoring of complaints themes and trends. Ensuring timely implementation of actions from Serious Incident investigations
6.	LEARNING FROM MATERNAL DEATHS	0	3	0	Ensure timely implementation of learning, locally and from across the region.
7.	MULTIDISCIPLINARY TRAINING	2	2	3	Implementation of mandatory annual human factors training. Review of job plans to ensure release of staff for multi-professional engagement forums.
8.	COMPLEX ANTENATAL CARE	1	3	1	Strengthen awareness and access to preconceptual care via the primary care network.
9.	PRE-TERM BIRTH	0	0	4	Continue to share learning and successes across the region.
10.	LABOUR AND BIRTH	1	5	0	Partnership working with the ambulance service to ensure transfer times are regularly audited to facilitate informed choice for women around place of birth.
11.	OBSTETRIC ANAESTHESIA	2	6	0	Ensure alignment of local and national guidance and documentation standards. Continue multi-disciplinary simulation teaching, including anaesthetic emergencies.
12.	POSTNATAL CARE	1	3	0	Audit of time from admission to review for postnatal readmissions to ensure early consultant involvement.
13.	BEREAVEMENT CARE	1	1	2	Options appraisal for expansion of Maternity and Paediatric Support Service.
14.	NEONATAL CARE	↓2	→2	↑4	Reinforce collaborative working by exploring rotational posts for nursing staff across the region.
15.	SUPPORTING FAMILIES	3	0	0	Develop faculty for provision of maternal mental health scenario based training across Surgery, Women and Children.

2. Patient Safety – Summary of Incident Investigations

Data Quality Rating:

Are We Safe?

Moderate Harm Incidents	
Measure	Comments
Number of incidents graded moderate or above and actions taken	• 1 incident was graded as moderate harm for the perinatal services in May. • This case has been reviewed via an urgent incident review with multi-disciplinary engagement.

Serious Incidents (SI)			
Case Ref	Overview	Date	Case Update
None			

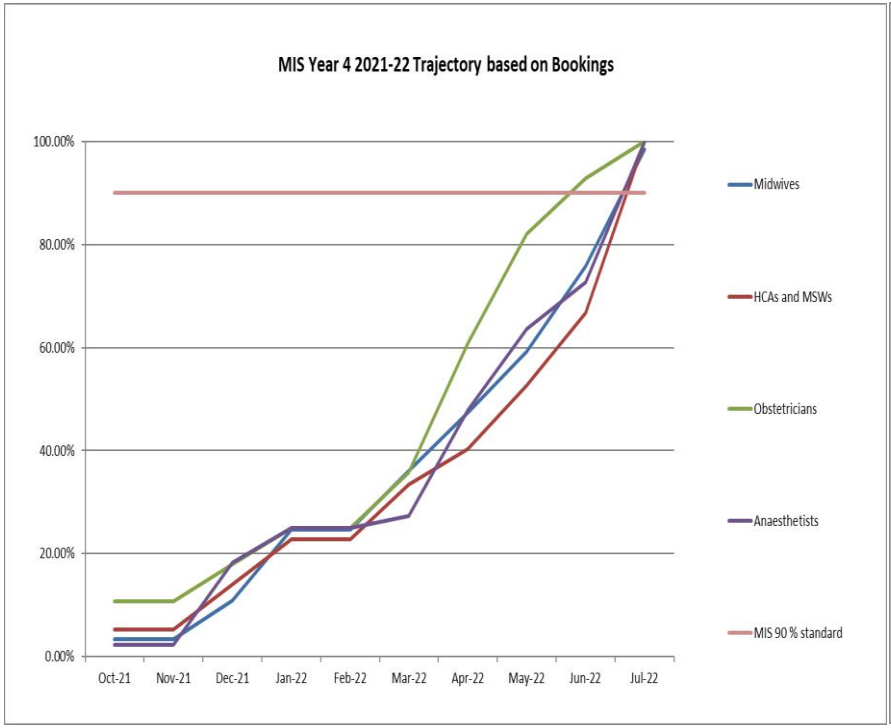
On-going SI Investigation Update			
Stage of investigation	March 2022	April 2022	May 2022
Referred to HSIB – awaiting decision	0	0	0
Under local investigation (this may include insight from external reviewers)	3	1	1
Under HSIB investigation	3	3	3
Report complete & awaiting Serious Incident Review learning Group (SIRLG)	1	0	0
Submitted to CCG	1	4	2

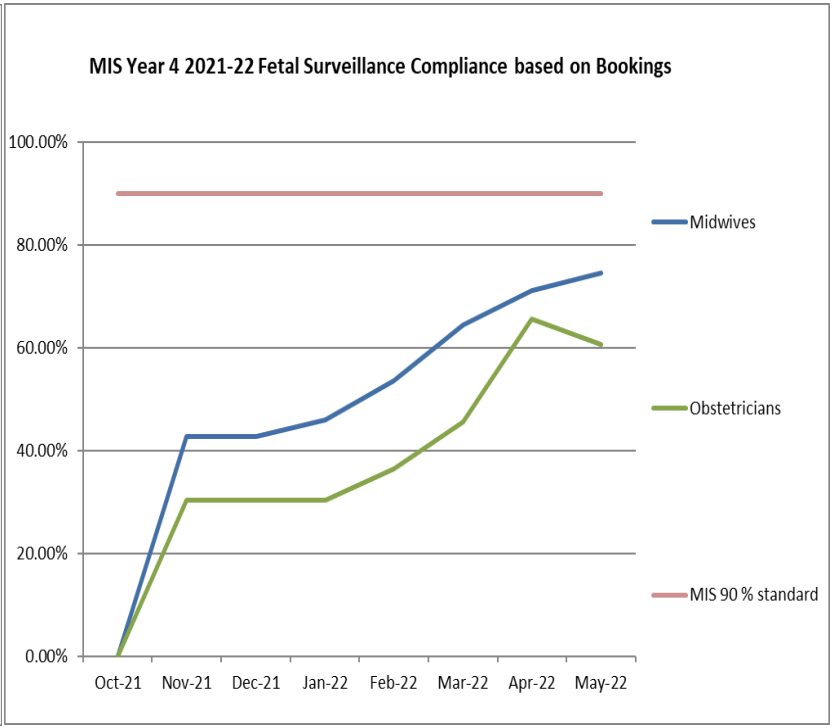
Data correct as of 1st June 2022. The data in the preceding month may have changed due to timing of previous months reporting.

2. Maternity - PROMPT and Fetal Surveillance Training Update including Trajectory

Data Quality Rating:

Are We Responsive?





Background and underlying issues

90% compliance for all staff groups working in Maternity has been mandated in the Clinical Negligence Scheme for Trusts (CNST) 2022-23 guidance, however it is recognised in Year 4 (2022/23) that this does not apply to theatre staff.

The trajectory of bookings and attendance exceeds the 90% requirement for bookings up to July 2022; the team will aim to maintain a rolling 90% compliance with annual updates.

It is anticipated that both PROMPT and Fetal Surveillance training compliance will meet or exceed the 90% target for submission in January 2023.

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

Implementation of face-to-face training has been arranged for PROMPT from September 2022 with the inclusion of human factors training provided by external company 'Wing Factors'.

The local fetal monitoring training program has now been implemented, with a monthly study day for the midwifery and obstetric teams. Within the first 7months of implementation 74% of midwives have received the training and 65% of the Obstetric team (this has reduced to 60% in May due to an increase in the Obstetric workforce).

Risks to delivery and mitigations

Staff sickness and absence may impact attendance however the virtual program may mitigate some of this risk to compliance.

It is essential that there is sufficient headroom in the maternity and obstetric staffing models to release staff for fetal surveillance and PROMPT training, to support the Ockenden Immediate and Essential Actions.

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 Caring?

Are We Well Led?

Use of Resources

Resources

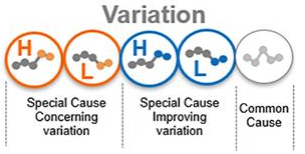
Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

"Great" Scoring	Indicator Score (1-4)	Self Assessment Score
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding		
Great Workforce Planning	2	2
Great Opportunities	1	1
Great Employee Experience	1	2
Great Employee Development	2	3
Great Leadership	1	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	?	6.57%	6.00%	4.28%	7.52%	5.90%
2	Trust RN Bank Fill Rates		F	44.86%	70.00%	37.95%	58.44%	48.20%
3	Vacancy Rate*		?	7.31%	7.63%	5.54%	8.53%	7.04%
4	Recruitment Time To Hire (Days)	H	?	67.70	46.00	33.13	58.61	45.87
5	All Turnover	H	?	14.89%	13.00%	12.46%	14.04%	13.25%
6	Voluntary Turnover	H	P	11.89%	11.00%	9.01%	10.43%	9.72%
7	All Sickness Absence	H	?	6.05%	3.50%	3.25%	5.29%	4.27%
8	Statutory Mandatory Training Compliance	H	?	87.75%	85.00%	84.46%	88.82%	86.64%
9	Appraisal Compliance	L	F	73.03%	85.00%	70.99%	81.21%	76.10%



Trust Overview: Narrative

Great Western Hospitals NHS Foundation Trust

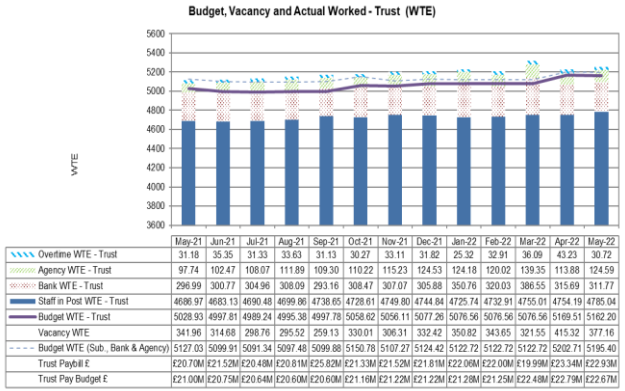
"Great" Scoring	Indicator Score (1-4)	Self Assessment Score	Headline
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding			
Great Workforce Planning	2	2	In May the Trust used 25WTE more staffing resources to deliver services compared to April, resulting in a usage of 90WTE in excess of budgeted WTE. Temporary staffing usage continues to be driven by the vacancy position and escalated staffing for Medical workforce in General Medicine, Outlier Cover and Emergency Medicine, and for Nursing staff within the Emergency Department and Community Nursing team.
Great Opportunities	1	1	The Trust vacancy position in May decreased to 377.16 WTE, which is a 7.31% vacancy rate across all staffing groups. This does not include planned increases to WTE for Safer Staffing (£2.2M investment) which equates to an additional 112WTE Healthcare Assistants and 32WTE Registered Nurses. Voluntary turnover increased to 11.89% in April 2022 above 11% target. The recruitment time to hire in May is 67 days which has remained above the Trust KPI of 46 days. Healthcare Assistant vacancy remains a risk however, the vacancy position decreased in May to 11.30 WTE. Recruitment are working with Divisions, Clinical Leads and HRBP's to explore options to support filling those 'hard to recruit to' roles.
Great Experience	1	2	Sickness reported in April 2022 was 6.05%, a decrease from last month (6.62%), with continued impact of Covid sickness (2.08%). In May, referrals for both 1:1 staff support and occupational health input were up compared to previous months (36 & 172 respectively). A further 10 members of staff were trained in Mental Health First Aid in May. The tea trolley has continued to visit staff areas throughout the month, and also supported various campaigns including Improving Together. During Mental Health Awareness week, a therapy dog spent time in the HWB hub, which attracted many staff to drop-in for some time-out. HWB Conversations training re-launched this month, and the HWB Admin Team were awarded STAR of the month winners.
Great Employee Development	2	3	Work has now begun on developing a strategic alliance with Swindon Borough Council and New College as part of our work to tackle health inequalities and use to best effect our respective positions as Anchor institutions. Workstreams are being finalized and will culminate in a joint delivery plan. Trust mandatory training compliance performance remains above the KPI of 85%, reporting at 87.75%.Trust appraisal compliance is reported at 73.03% in April, increasing by nearly 3% over the month. This performance continues to have an impact on the indicator score in the leadership section. Work continues to simplify appraisal and this will need to be considered in conjunction with the new 'Scope for Growth' talent management pilot.
Great Leadership	1	2	The OD team has delivered training for divisional and frontline teams in preparation for Improving Together. Both have received excellent feedback and KPMG has requested permission to share the materials used with other Trusts. The OD Team is actively supporting a number of services/teams across the organisation. This is encouraging , but is beginning to create some capacity issues. This is being monitored and the team will provide support in the design and delivery of some interventions on a consultancy basis where appropriate to support teams to deliver themselves.

Workforce

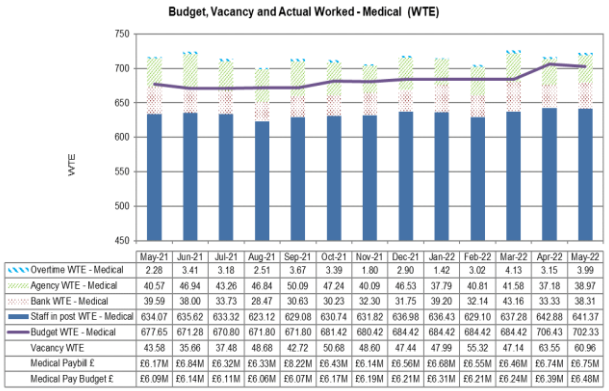
Use of Resources

Great Workforce Planning

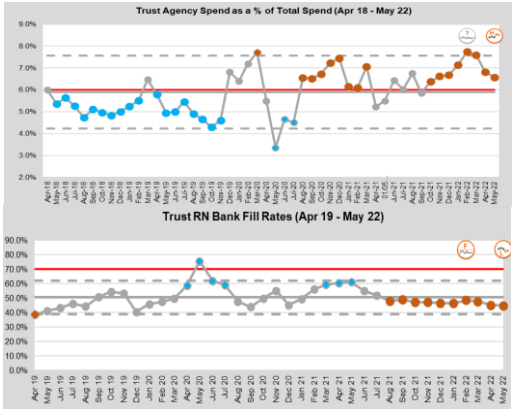
Indicator Score	Self Assessment Score
2	2



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Overtime WTE - Trust	31.18	35.35	31.33	33.63	31.13	30.27	33.11	31.82	25.32	32.91	36.09	43.23	30.72
Agency WTE - Trust	97.74	102.47	108.07	111.89	109.30	110.22	115.23	124.53	124.18	120.02	139.35	113.88	124.59
Bank WTE - Trust	296.99	300.77	304.96	308.09	293.16	308.47	307.07	305.88	350.76	320.03	386.55	315.69	311.77
Staff in Post WTE - Trust	4686.97	4683.13	4690.48	4699.86	4738.65	4728.61	4749.80	4744.84	4725.74	4732.91	4755.01	4754.19	4785.04
Budget WTE - Trust	5028.93	4997.81	4989.24	4995.38	4997.78	5058.62	5056.11	5077.26	5076.56	5076.56	5076.56	5169.51	5162.20
Vacancy WTE	341.96	314.68	298.76	295.52	259.13	330.01	306.31	332.42	350.82	343.65	321.55	415.32	377.16
Budget WTE (Sub , Bank & Agency)	5127.03	5099.91	5091.34	5097.48	5099.88	5150.78	5107.27	5124.42	5122.72	5122.72	5122.72	5202.71	5195.40
Trust Paybill £	£20.70M	£21.52M	£20.48M	£20.81M	£25.82M	£21.33M	£21.52M	£21.81M	£22.06M	£22.00M	£19.99M	£23.34M	£22.93M
Trust Pay Budget £	£21.00M	£20.75M	£20.64M	£20.60M	£20.60M	£21.16M	£21.22M	£21.22M	£21.28M	£21.25M	£22.48M	£22.79M	£22.67M



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Overtime WTE - Medical	2.28	3.41	3.18	2.51	3.67	3.39	1.80	2.90	1.42	3.02	4.13	3.15	3.99
Agency WTE - Medical	40.57	46.94	43.26	46.84	50.09	47.24	40.09	46.53	37.79	40.81	41.58	37.18	38.97
Bank WTE - Medical	39.59	38.00	33.73	28.47	30.63	30.23	32.30	31.75	39.20	32.14	43.16	33.33	38.31
Staff in post WTE - Medical	634.07	635.62	633.32	623.12	629.08	630.74	631.82	636.98	636.43	629.10	637.28	642.88	641.37
Budget WTE - Medical	677.65	671.28	670.80	671.80	671.80	681.42	680.42	684.42	684.42	684.42	684.42	706.43	702.33
Vacancy WTE	43.58	35.66	37.48	48.68	42.72	50.68	48.60	47.44	47.99	55.32	47.14	63.55	60.96
Medical Paybill £	£6.17M	£6.84M	£6.32M	£6.33M	£8.22M	£6.43M	£6.14M	£6.56M	£6.68M	£6.55M	£6.46M	£6.74M	£6.75M
Medical Pay Budget £	£6.09M	£6.14M	£6.11M	£6.06M	£6.07M	£6.17M	£6.19M	£6.21M	£6.31M	£6.21M	£6.24M	£6.39M	£6.48M



Background

The Trust utilised 5252WTE staff to deliver its services in May 22, an increase of 25WTE on March and 90WTE in excess of budgeted WTE. Temporary staff utilisation increase slightly in May, with Bank reducing by 4WTE and Agency increasing by 11WTE. The Trust KPI of percentage of pay bill spend on agency reduced again month on month, decreasing from 6.82% in April to 6.57% in May, although still above the target of 6%.

The top 3 highest users of nursing/midwifery bank and agency in-month are ED (28WTE), Community Nursing (27WTE) and AMU (27WTE). Within ED usage is driven by Vacancy (10.9WTE) and Escalated staffing (4.8WTE). For Community Nursing, usage is from additional staffing to maintain capacity secured through HDP funding. Vacancy (7.0WTE) along with Sickness (3.8WTE) and Parenting Leave (4.3WTE) are driving utilisation within AMU.

For medical staff, General Medicine including Outlier Cover (31WTE) and Emergency Medicine (14WTE) continue to be the largest users of locum and agency cover, being driven by vacancy cover, escalation, and medical outlier cover.

Improvement actions

1. Unscheduled Care have implemented a department led establishment review process in Acute Medicine, that enables improved vacancy control, forward planning for hard to recruit roles and early sight of factors affecting near term workforce supply e.g. maternity, flexible working. This strengthened approach to forward planning will now be replicated across other USC specialties.

2. Implementation of E-Roster for medical workforce is underway in ED and set to complete by the end of June '22. This will enable improved oversight, easier identification of rota gaps and support job planning.

3. Substantive GP recruitment has successfully taken place in the Urgent Treatment Centre, introducing not only a primary care focussed leadership presence but also the capability for the UTC to pursue strategic aims including medical and non-medical training. Commencement in role anticipated for September 2022.

4. A newly funded Dentist in training post has been introduced in Community Dental, boosting dental resource in the near term and developing long term clinical succession resilience in what is an increasingly difficult role to recruit.

5. In line with the new job planning policy, medical job planning reviews are underway in Surgery, Women's & Children's, This review process will standardise utilisation of SPA time and augment working patterns in line with service requirements.

Risks to Performance & Mitigations

The withdrawal of bank shift incentives in maternity has the potential to result in staff refusing bank shifts and instead opting to accept additional shifts via agency engagement. As a result, bank pay rates are under review jointly by HR and Divisional leadership.

Supply of registered imaging staff remains limited, with both 'on' & 'off' framework agencies unable to supply against a number of imaging vacancies, ultimately exacerbating workforce and performance recovery challenges.

Challenged supply of Registered Midwifery resource is impacting delivery of the Birth Rate plus staffing model. Mitigating initiatives such as the introduction of registered nursing presence within the maternity workforce model, return to practice and nurse to midwifery conversion routes, are all underway.

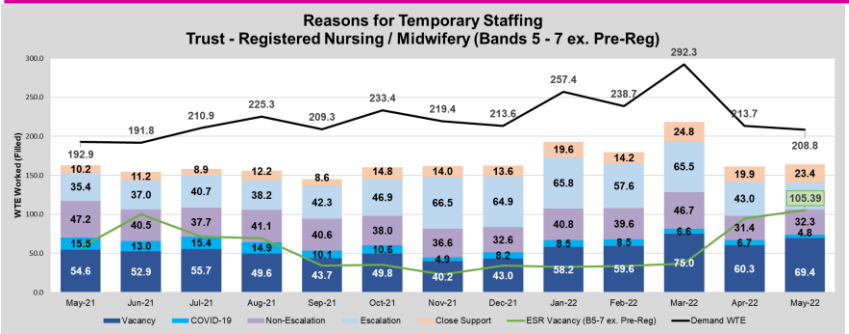
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

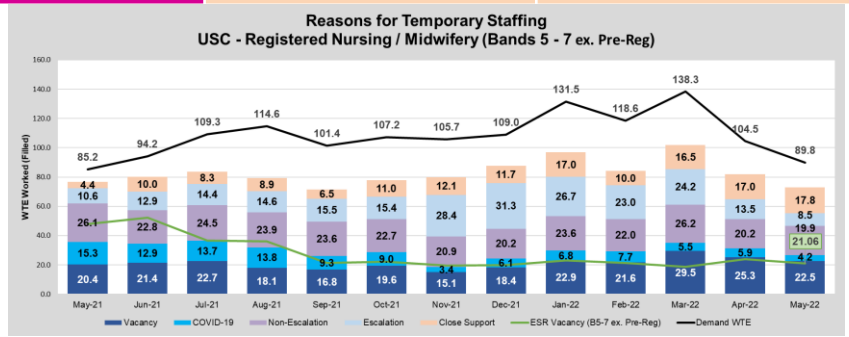
Workforce

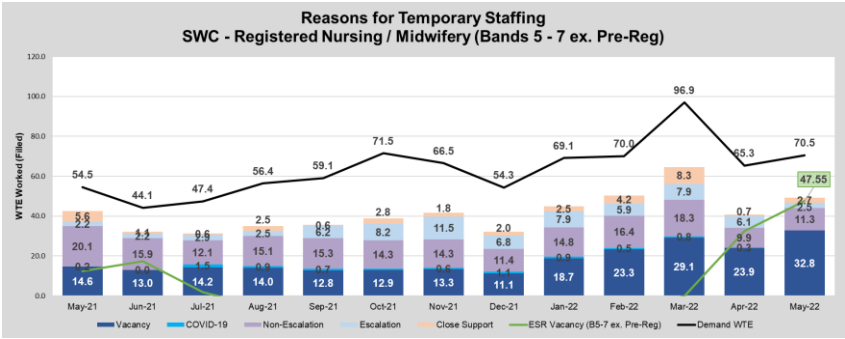
Use of Resources

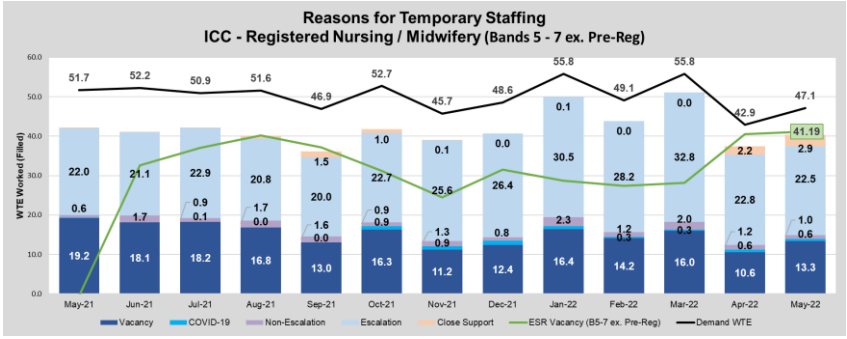
Great Workforce Planning

Indicator Score	Self Assessment Score
2	2









Background

In May there were 164.99WTE temporary staff (registered nursing/midwifery) used across the Trust against a vacancy of 105.39WTE (excluding pre-registered nurses) but including Corporate Nursing. The movement in vacancy factor of 68WTE (M12 to M02) comprises an increase to budget of 40WTE for bands 5-7 from resource model changes in:

- Neonatal Unit to meet national staffing guidance
- Maternity Unit to deliver the Continuity of Carer model
- CMDU (COVID Medicines Delivery Unit) – development of a new service
- Community Nursing delivering to HDP (hospital discharge programme) funding
- UTC increase for band 5 nursing as part of Way Forward Programme

Of the temporary staff WTE utilised, 79.16WTE was agency (compared to 72.76WTE in April) and 85.83WTE bank (compared to 89.39WTE in April).
For this staffing group we have a pool of 194 bank-only registered nurses, alongside 1,213 substantive staff with a bank assignment who can cover temporary staffing requirements.

Improvement Actions

1. Investment into nursing establishments from the Safer Staffing business case is planned, with increased WTE being finalised by the senior nursing teams. It is anticipated that budget will be recruited into from month 5, reducing the reliance on temporary staff as contract and budgeted WTE increases.

2. The nursing team are reviewing agency bookings weekly to cancel or redeploy demand where possible and increase control on worked WTE.

3. A refreshed weekly bookings report is being cascaded to the senior nursing team to facilitate scrutiny of agency bookings, with a view to reduce spend and usage.

Risks to Performance & Mitigations

The supply of agency midwives from non-framework agencies continues. The PSL are looking to source midwives compliant with capped rates to reduce spend.

Long term agency usage continues to be in place for RMN's. To prevent escalation to non-framework agencies, the PSL have supplied block bookings of RMNs for ad-hoc redeployment.

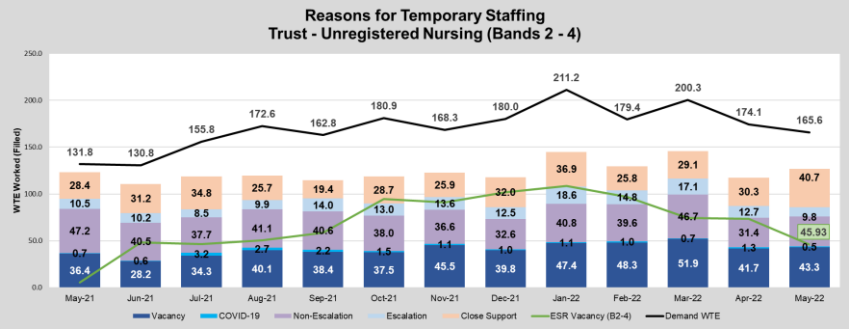
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

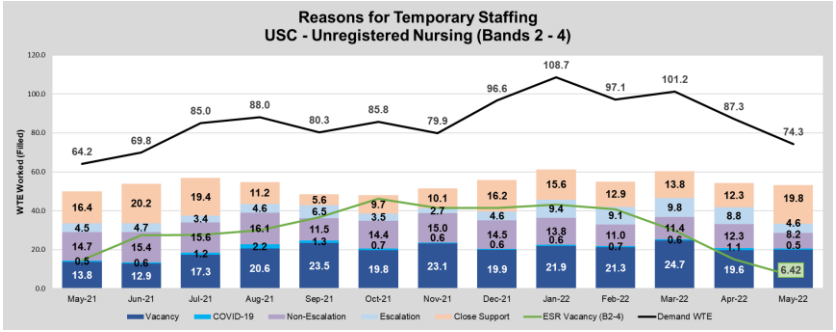
Workforce

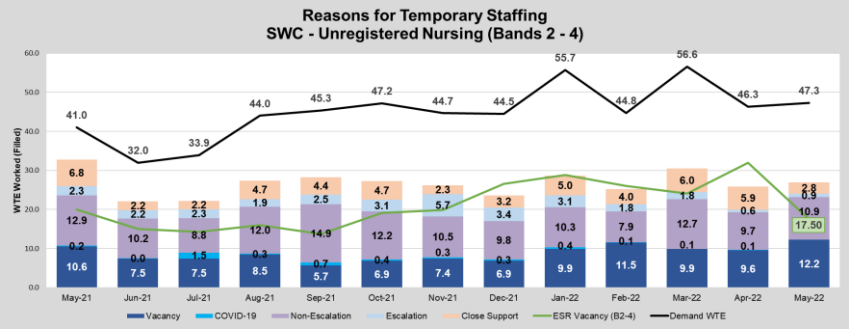
Use of Resources

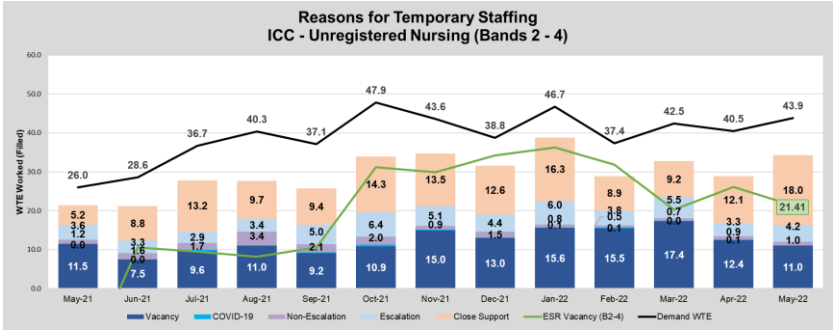
Great Workforce Planning

Indicator Score	Self Assessment Score
2	2









Background

In May there were 114.64WTE temporary staffing unregistered nursing/midwifery band 2-4 used across the Trust against a vacancy of 45.93WTE

May saw another drop in demand for unregistered nursing to 165.6WTE (previously 174.1), however, usage continues to remain above the vacancy position across all divisions.

- USC 53.16WTE used against 6.42WTE M02 vacancy
- SWC 27.20WTE used against 17.50WTE M02 vacancy
- ICC 34.27WTE used against 21.41WTE M02 vacancy

The Trust does not approve agency usage for unregistered nursing. The only source available is through the Trust's internal bank, there are 266 bank-only workers, alongside 607 substantive staff with a bank assignment available on the bank.

Improvement Actions

1. The Band 2 HCA vacancy position in May is 11.34WTE, with 48.13WTE candidates in the pipeline, of this 17.52WTE have a start date agreed. A further 30.54WTE exists in the pipeline.
2. Although the vacancy position in May has reduced, increased recruitment activity will continue to support high levels of turnover (14.24% Voluntary Turnover for Unregistered Nursing in April against Trust figure of 11.89%) and anticipated increases to establishment for Safer Staffing.
3. Two apprentice HCAs were successfully recruited in May, and are awaiting placement via the academy. A review of future apprentice HCA recruitment is underway with the nursing team.
4. The Trust's promotional HCA welcome packs were launched in May, and have been well received across all three inductions in which they were utilised.

Risks to Performance & Mitigations

The band 2-4 vacancy position is 45.93WTE, of this 11.34WTE is band 2 HCA only. Whilst the vacancy position has stabilised for this staffing group, temporary staffing requests remain higher than the vacancy level.

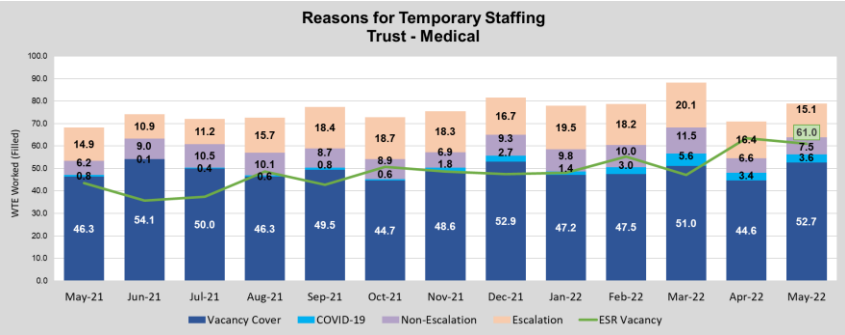
Activity between the Finance and HR Business partners to review the band 2-4 establishment has taken place in May, with the outputs from this exercise being reviewed in June with a view to update the ledger/ESR, aligning vacancy to correct budgets and removing vacancies which will not be recruited into.

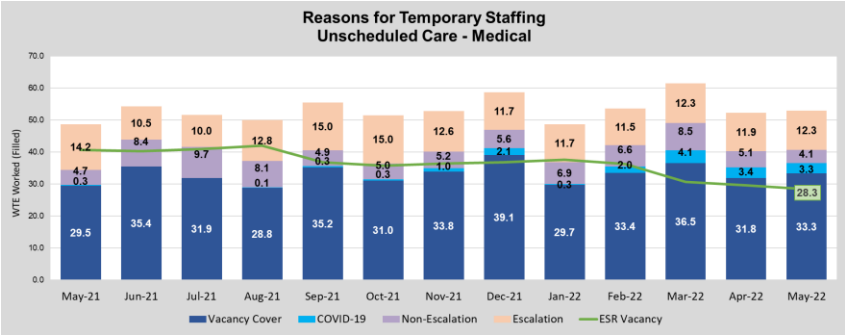
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

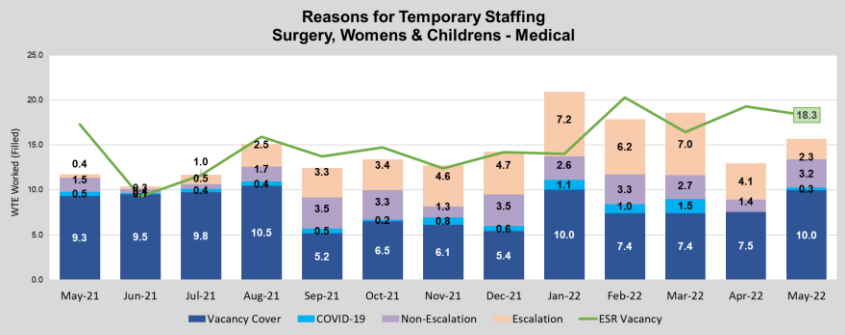
Workforce

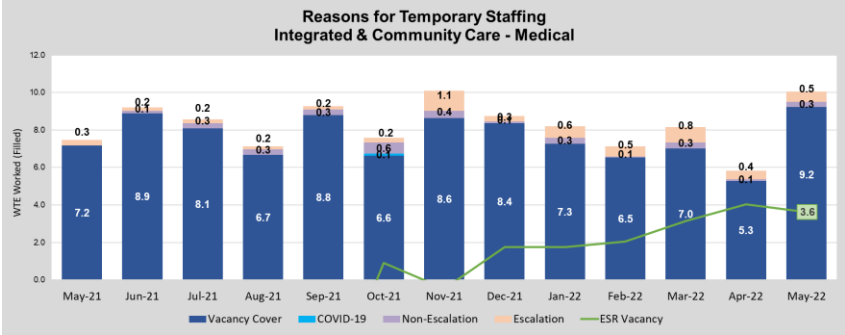
Use of Resources

Great Workforce Planning	Indicator Score	Self Assessment Score
	2	2









Background

The data represented in this slide comes directly from Liaison who operate the medical temporary staffing system and provides a more granular view of the reasons for cover for those staff booked through the system.

The data highlights in May 22, 78.8WTE Temporary Medical Workforce was used across the Trust.

- USC 52.9WTEused against 28.3WTE M02 Vacancy
- SWC 15.7WTE used against 18.3WTE M02 Vacancy
- ICC 10WTE used against 3.6WTE M02 Vacancy

**Note the WTE used figured does not include workers outside IR35 and booked via consultancy. The Trust currently has 7 outside IR35 workers.*

Across the Trust, the primary reason for medical temporary staffing continues to be vacancies (52.7WTE) and escalation (15.1WTE).

Improvement Actions

1. The escalated winter rates for bank have been approved to continue until the end of June 2022, and divisions are reviewing alternatives for July onwards.
2. The USC Strategic Medical Workforce Programme meetings have continued in May, with positive engagement from the division. A key focus from the meetings in may has been reviewing locum usage within the division with a view to identify and convert to more cost-effective routes of supply. Work has started in the Emergency Department to update agency locums to a 'direct engagement' model of pay, which if successful will reduce the cost of cover within the speciality.
3. Electronic Rostering roll-out has progressed for the Emergency Department and Obstetrics & Gynaecology within May. Triangulation of roster demand and templates against Finance and Job-Plan information has taken place to allow reconciliation of worked time against budgets within these departments.
4. Roll-out of the SARD system for revalidation and job-planning continued in May. System set-up is complete, and work is now starting on the population of appraisal and job-plan information, the outputs of which will allow for more robust review of worked activity.

Risks to Performance & Mitigations

Continued reliance on agency to support hard to recruit roles.

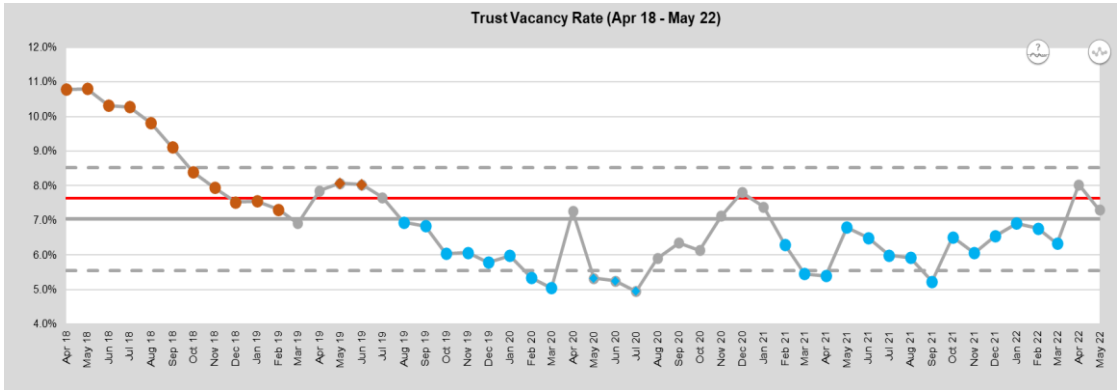
The roll out of electronic rostering for Medical workforce continues, with build concluding for three rosters making up Emergency Medicine. Financial sign-off is in progress and go-live anticipated in June. Implementation will continue with Acute Medicine and General Medicine, with divisional learnings from the ED implementation being reviewed.

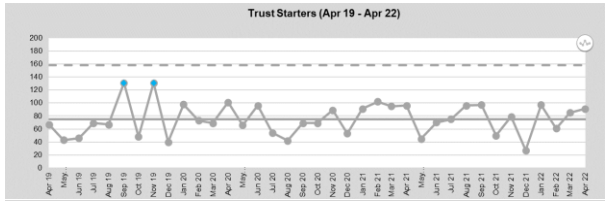
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

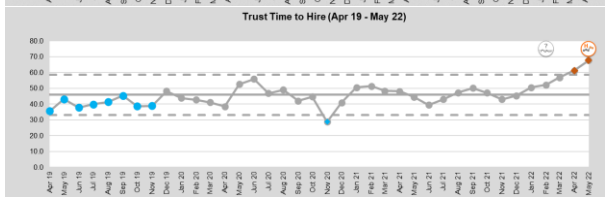
Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	1	1







Background

The Trust vacancy position in May decreased to 377.16 WTE (7.31%). The budgeted establishment WTE remained static, meaning the reduction in vacancy level was driven by a net increase to staff in post of 31WTE.

There were 89 headcount of new starters to the Trust in March, this is above the Trust average of 75.

New starters by staffing group;
- Admin & Clerical – 18
- Allied Health Professionals – 2
- Medical & Dental – 3
- Non-clinical Support – 3
- Registered Nursing & Midwifery – 15
- Scientific, Therapeutic & Technical – 7
- Unregistered Nursing & Midwifery – 41

The Trust has a provisional 74 candidates due to commence employment in June across all staffing groups with a further 41 slots available to allocate to new starters.

Vacancy by staffing group is;
- AHP & Scientific – 58.82WTE
- Medical & Dental – 60.96WTE
- All Nursing – 160.51WTE
- Senior Managers & Admin – 96.87WTE

Improvement actions

1. The recruitment's time to hire (TTH) in May remained above the Trust's KPI of 46 days; with a Trust average of 67 days from vacancy advertised to contract sent. Factors that contribute to the higher TTH, is the time taken to shortlist by recruiting managers; only 58% of those vacancies at shortlisting stage were completed within the target time of 3 working days. The HRBP's continue to raise awareness at Divisional meetings of the KPI target time and provide support to managers, offering further training as required from the recruitment team. A further area of low compliance which is contributing to the TTH, is the KPI for issuing offer letters; which has remained at 60% for May. This is due to the level of activity having remained high with a total of 165 offer letters being issued in May, the Recruitment manager is working with the wider recruitment team to bring this compliance rate up.

2. A Medical Oncology Consultant has been approved via a business case for 1 WTE; this is to reduce risk and wait times for the service. The role was advertised in May however we have not had any applicants; we have re-advertised with a view to add on an RRP. We will be pushing the advertising on social media and BMJ advertising alongside our normal advertising process.

3. A Microbiology Consultant role is being advertised after a previous unsuccessful round of advertising; we are utilising the BMJ who are going to advertise on their LinkedIn account.

4. The Pharmacy department have been working with the BSW on a collaboration to attract candidates into roles within the Pharmacy department; representatives from the Trusts Recruitment and Pharmacy teams along with the BSW representatives, attended the Clinical Pharmacy Congress in London on 12th & 13th May 2022. The team obtained 71 expressions of interest in potential roles and interest if working with any of the BSW Trusts. Initial contact has been made with all candidates, which included key contacts details, links to our current vacancies and recruitment support to progress any further interest.

Risk to performance and mitigations

Healthcare Assistant vacancies remain a Trust priority; we have a pipeline of 48.16WTE candidates, of this 17.52WTE have a start date agreed.

Centralised recruitment for Healthcare Assistants continues so we can maintain our pipeline to fill vacancies. Confirmation of the Safer Staffing business case is now agreed with the recommendation to appoint an additional 112WTE HCA's by the end of the financial year, alongside 32WTE Registered Nurses.

This activity continues to be overseen by Deputy Chief Nurse, Divisional Directors of Nursing and Head of Resourcing with weekly progress meetings taking place.

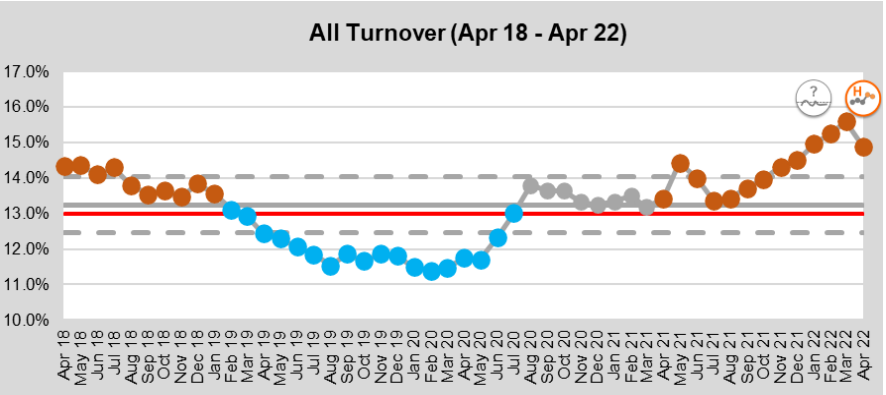
The Trusts international Nurse cohort for May was deferred due to, Visa delay issues in the candidate's home countries. We have therefore increased our cohort size from 6 to 8 per month over the next few months to accommodate the numbers.

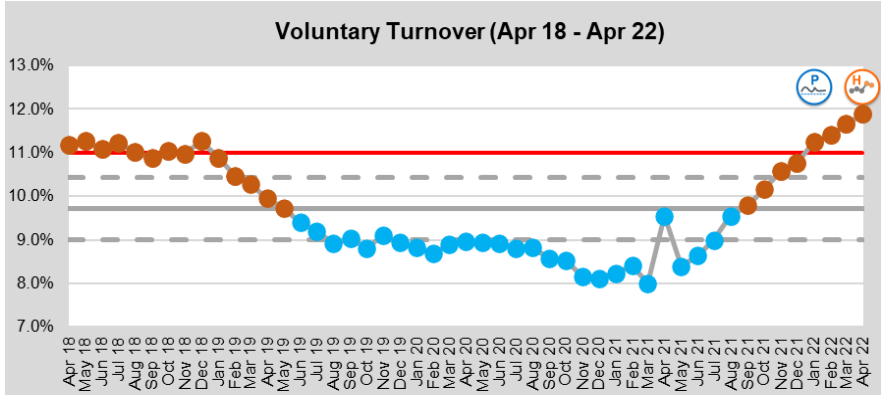
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	1	1





Background

All turnover reported at 14.89% in April, which whilst above the trust target of 13%, was a reduction on the previous month (15.59%).

Voluntary turnover is 11.89%, an increase from last month (11.66%). In April there were 53 voluntary leavers which is slightly higher than the Trust 12-month average of 46.

Leavers headcount by staffing group;
- Admin & Clerical – 12
- Allied Health Professionals – 8
- Non Clinical Support- 1
- Registered Nursing & Midwifery – 19
- Scientific, Therapeutic & Technical - 3
- Unregistered Nursing & Midwifery – 9
- Medical and Dental – 1

The top 3 reasons for leaving in April 2022 are;
- Work Life Balance
- Relocation
- Other/Not Known

Improvement actions

Retention of AHP:
- USC: Trust represented at the Clinical Pharmacy Congress in May to attract applicants to Pharmacy roles.
- ICC: Acute Therapy department exploring R&R premium for hard to fill band 6 role.

Retention of Unregistered nursing:
- SW&C: Band 2 and 3 Maternity Support Workers are completing care certificates to improve retention through skills development. A Midwifery apprenticeship programme is being developed aimed at bands 2,3 & 4. A competency framework has been developed linked to HEE core competencies, and a business case has been created applying for HEE funding for the first cohort.

Nursing retention strategy:
- SW&C: Theatre Matron leading R&R working group to develop career pathways and training opportunities for Theatre Practitioners; to attract students to consider as a compelling employment offer.

Medical & Dental retention strategy:
- The Trust has developed a Primary Care Remuneration Framework for Medics to inform equitable employment agreements. This will be presented at Medical Staffing Group as part of the wider initiative to increase transparency and consistency around Medical & Dental terms and conditions.

Risk to performance and mitigations

The in-month risk is the continued turnover rate of 14.89% which has decreased from 15.59% in March but still exceeds the Trust target of 13%.

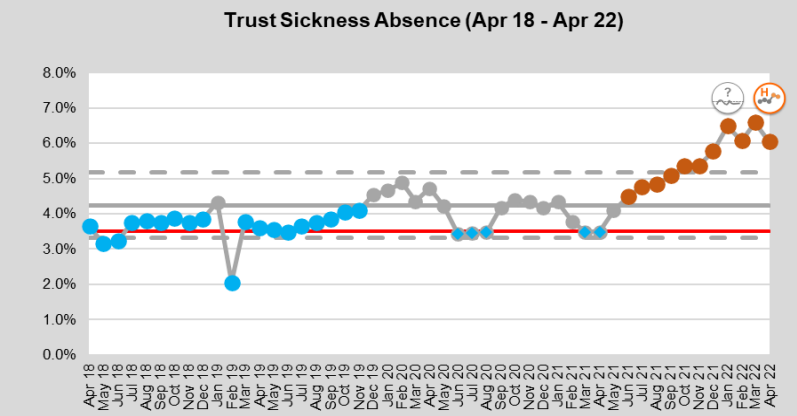
There are Trust wide retention initiatives in place to mitigate high turnover in specific professional categories.

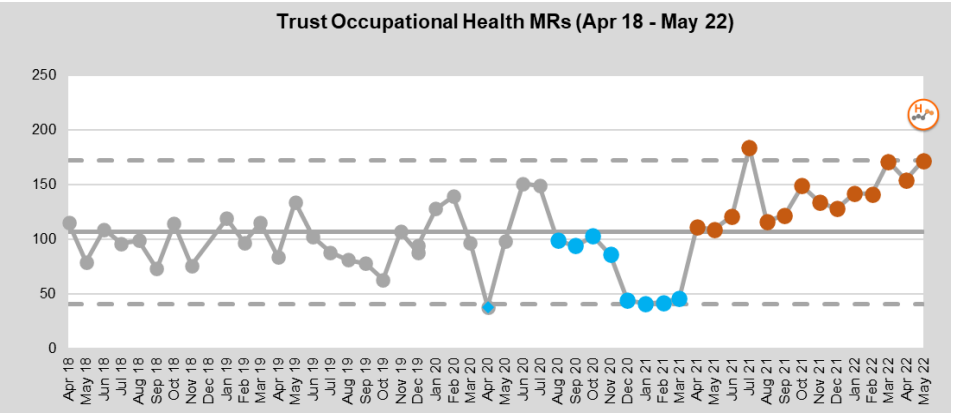
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce – Sickness Absence

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	2





Background

For April 2022, sickness absence is reported at 6.05%, which is a decrease from last month (6.62%). Of this, 2.08% is Covid sickness and 3.97% is non-Covid related.

172 OH management referrals were made in May - an increase compared to recent months (Jan 142, Feb 141, Mar 171, April 154).

Of these, 134 were GWH staff (Mar 130, Apr 115) :

- USC: 31 (Feb 34, Mar 44, Apr 41)
- SWC: 45 (Feb 34, Mar 43, Apr 41)
- ICC: 41 (Feb 33, Mar 36, Apr 20)
- Corporate: 17 (Feb 13, Mar 7, Apr 13)

MRs were triaged to:

- MHP 43 (Feb 42, Mar 37, Apr 29)
- OHA 42 (Feb 30, Mar 75, Apr 57)
- Physio 41 (Feb 36, Mar 35, Apr 38)
- OHP 37 (Feb 31, Mar 21, Apr 27)
- no longer required 9 (Feb 2, Mar 3, Apr 2)

183 pre-employment questionnaires were processed in May (Jan 265, Feb 236, Mar 325, Apr 276).

Improvement actions

1. 21/22 progress report regarding the HWB Service was presented in May's Exec Co and PPPC Meetings by the Clinical Lead.
2. The HWB Admin Team were awarded STAR of the month winners this month.
3. In-reach health checks for staff were scheduled to re-launch in May, but due to staff sickness have been rescheduled for June. Some departments have already signed up for this, and these in-reach sessions will continue on a regular basis throughout the year, staffed by the HWB team including OH clinic nurses.
4. The Great Care Campaign day this month was supported by HWB, with a presentation on Compassionate Communication. A talk on team psychological wellbeing was also presented this month to the current Aspiring Leaders Cohort.
5. Health and Wellbeing Conversations training re-launched in May, with 1 hour virtual sessions provided regularly throughout the month. Uptake was lower than expected, having been attended by a total of 27 staff; this was highlighted in PPPC with plans on how to improve uptake for subsequent months.
6. HWB have liaised with the Resuscitation Team in the Academy to facilitate the awareness and uptake of TRiM following potentially traumatic incidents. As part of this, TRiM now features within their training module.

Risk to performance and mitigations

Waiting times are as follows:

- OHA: 3-4 weeks
- MHP: 2-3 weeks
- Physio: 2-3 weeks
- OHP: 2-3 weeks
- Staff Support: 2-3 weeks

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

Workforce – Recognition, EDI and Wellbeing

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	2

Employee Recognition

Long Service Awards	4	Hidden Heroes	0
Retirement Awards	4	STAR awards	4

Diversity/Inclusivity

1. The Reciprocal Mentoring scheme is currently being rolled out, with the majority of pairs having met their matches for the initial meetings.
2. Data findings used to populate the national WRES and WDES reports are being analysed before incorporation into reports.
3. Planning for the Board EDI session has begun, with the subject focus being unconscious bias. An external facilitator has been sourced. This will be followed by an educational development session on trans issues (in September).
4. The latest quarterly EDI newsletter has been produced.
5. Planning for South Asian Heritage Month is underway, with a series of celebratory events marking key milestones and moments in South Asian history.
6. The Stay and Thrive Programme for internationally-recruited nurses is being regularly updated before proposed launch .
7. EDI lead has attended the national Workforce Race Equality Standard (WRES) Experts programme, and has been appointed the SW WRES Experts convenor. It is envisaged that the resulting dissertation will help to improve Trust WRES scores and staff survey findings.

Wellbeing Initiatives

Staff Tea Trolley - in May, it teamed up with the Transformation and Improvement team to support the Improving Together campaign, and also the HWB team for Mental Health Awareness week. It also supported the Death Café. More than 1,000 free drinks & snacks were given to staff across the month.

Theatre Staff Appreciation event and International Day of the Nurse - 20 pamper gift bags were made up for theatre staff to support their event to celebrate International Day of the Nurse & Operating Department Practitioners Day. The tea trolley supported this day, accompanied by one of the therapy dogs.

Yoga project - 36 of the 80 free places for the 4-week online class have been used so far. The HWB team are currently exploring the option of a face to face class.

Trust Thank You's – the purchase & provision of items for individual teams have now been completed. This comprised of 106 items in total (£8,135).

Background

In May, 36 self-referrals were made for 1:1 staff support - an increase compared to recent months (Feb 25, Mar 24, Apr 18). Of these, 31 were from GWH employees.

In-keeping with trends, common reason for referral were:
1. Personal: anxiety (56%), overload/stress (56%), low mood (50%)
2. Work-related: overload / stress (44%)

79 in-house staff support appointments were attended this month (Jan 82, Feb 102, Mar 81, Apr 84).
In addition to this, 16 contacts were made with the EAP.

In-reach psychology group sessions for teams were attended by a total of 32 staff this month, and included Orchard, CICT, Fracture Clinic, T&I.

73 staff dropped by into the HWB hub during Mental Health Awareness week, helped by the therapy dog.

Improvement actions

1. This month, Mental Health First Aid training was completed by 10 members of staff. Our current workforce who are trained in MHFA is 164.

2. Feedback from someone who completed therapy this month stated: *'I am a huge advocate of my team for wellbeing but have avoided it for myself up until now. On this occasion I knew I needed some additional help & the process couldn't have been easier. Dealt with care & compassion throughout. The psychologist made me feel very at ease & comfortable (talking about myself has never been easy). I felt safe talking to him & he has massively helped me process my bereavement & helped me get back to work & a job that I love'.*

3. Several suggestions were received into the Orbital's newly installed HWB comments box this month which are being taken forward by the HWB team, including a refresh of the terraced area, new artwork for walls to improve the office environment, & in-reach health checks.

4. The bi-monthly HWB Champions meeting was held this month, during which the focus was on promoting and disseminating information about the EAP, MHFA and HWB Conversations training, in addition to Schwartz Rounds (ahead of re-launch in September). 13 attended.

5. The long-covid-support group has paused its monthly meetings for now due to low attendance (this month 2).

Risk to performance and mitigations

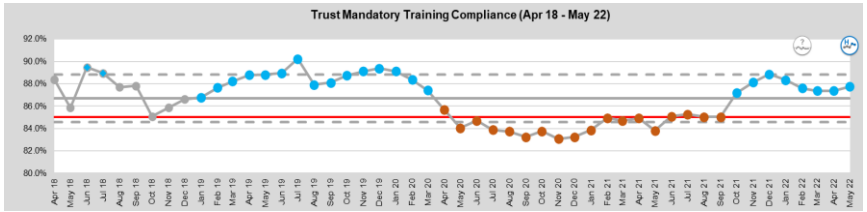
Due to the increase in 1:1 staff support referrals over the past year, the EAP Service is now being strongly recommended as a first port of call for counselling to help meet this increased demand.

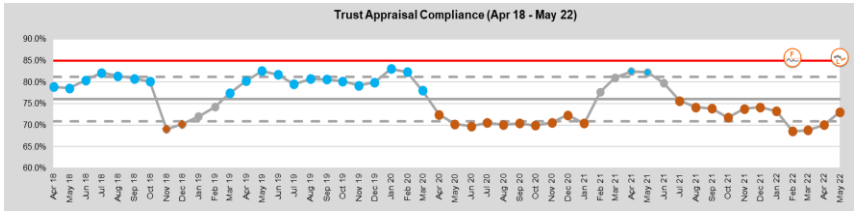
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

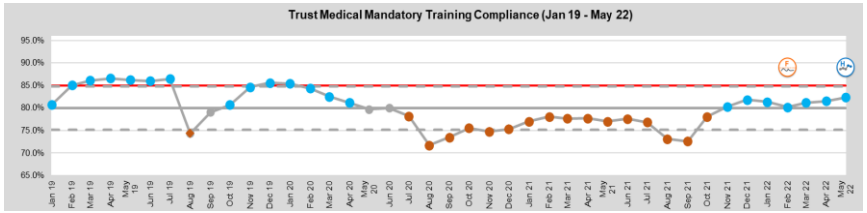
Workforce

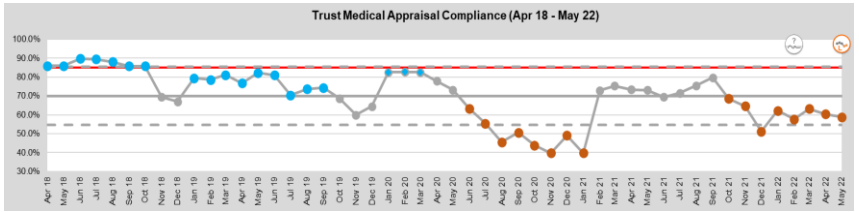
Use of Resources

Great Employee Development	Indicator Score	Self Assessment Score
	2	3









Background

Trust mandatory training compliance performance remains above the KPI of 85%. This, month it is at 87.75%. This is an increase of 0.39% from last month.

Trust appraisal compliance is reported at 73.03% in May, increasing by 2.98% over the month. This performance continues to have an impact on the indicator score in the leadership section

The group examining appraisal is continuing its work and plans a survey to gather staff views and how it could be improved/streamlined.

Improvement actions

1. The Trust met with Swindon Borough Council on the 23 May. Work has begun on creating a strategic alliance with SBC and New College to influence the design and development of courses which will equip students with the skills both organizations need. The focus initially in support of our anchor ambitions will be recruitment and entry routes into employment. Two working groups will work through initial plans and set objectives in each of these workstreams.
2. In order to provide more support to those nurse recruited internationally three webinars are being created and will be delivered to all internationally recruited nurses to the Trust in the last 9 months. The emphasis of these will be on development, career aspirations, mentoring and leadership.
3. In addition to the webinars above, the BAME development programme for Bands 5-6 has been designed and will consist of a 12-month programme for 12 nominated individuals. The draft programme will be presented to the Deputy Chief Nurse in June.
4. The paper created to establish a more robust process for booking rooms within the Academy will be presented to the Exec in June.
5. There is concern about the low compliance rate on the completion of care certificates within the Trust, a benchmarking exercise is being carried out to look at how other Trusts carry out this process. A proposal on how this should be tackled will be created in June.

Risk to performance and mitigations

There are some significant challenges in terms of delivering all the necessary education and training within the limited space in the Academy. New social distancing guidelines will enable larger capacity.

However, it is increasingly apparent that due to an increase in demand over recent years with increasing student numbers the Academy cannot accommodate all the requests it receives for room bookings. Options are currently being explored to provide a resolution.

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

Workforce

Use of Resources

Great Leadership		Indicator Score	Self Assessment Score
		1	2
Leadership Roles at the Trust	4.57% of staff	Equating to 189.6 WTE	
Leadership Development Programme *(Cohort 1)*	22 leaders	13 Completed Training	
Leadership Development Programme *(Cohort 2)*	14 Leaders	Paused and reallocated	
Leadership Development Programme *(Cohort 3)*	20 Leaders	Undergoing Training	
Leadership Development Programme *(Cohort 4)*	20 Leaders	Undergoing Training	
Aspiring Leaders *(Cohort 1 & 2)*	39 aspiring leaders	36 Completed Training	
Aspiring Leaders *(Cohort 3)*	21 aspiring leaders	Undergoing Training	
Network and Navigate	12 multidisciplinary delegates	Undergoing Training	
Health Economics Leadership programme	8 delegates	Undergoing Training	
Leadership Forum Members	300 managers	Members Engaged	
Latest Leadership Forum *(May)*	30 Managers	May 2022	
Ward Accreditation	24 of 24 departments	using the Perfect Ward App	

Background

- The first OD module for Frontline teams in readiness for Improving Together was held on 5 May, which focused on leadership behaviours and included staff engagement, active listening, coaching, manging conflict & difficult conversations, psychological safety, trust and civility. The day received excellent evaluations.
- The first module for frontline teams was also delivered and was also very positively received.
- Training commenced for four Scope for Growth Facilitators who will be responsible for training line managers / ambassadors in talent management/careers coaching.
- The OD team provided Team Away days for the Quality Team and Palliative Care Team with excellent feedback.
- GWH provided a BSW wide taster day for staff across the system to undertake training to become a mediator. The aim is to have a register of trained mediators across BSW.
- Whilst GWH submitted a successful stage one application for 2 GMTS trainees no suitable trainees have been identified by the NHS Leadership Academy to join GWH in September 2022. Of the eight BSW placements identified only three have been filled.
- All Leadership Training has been cross referenced to identify where adjustments are required to reflect Improving Together methodology.

Improvement actions

- Following the success of the OD module for the first group of frontline teams in readiness for Improving Together the leadership team will be delivering this module to the Deputy Corporate Divisional Directors and any staff who were unable to attend the 5 May module.
- The second phase of delivery of the OD module to frontline teams will take place in September

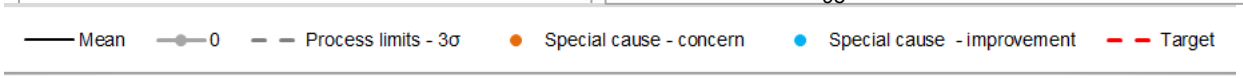
1. The Leadership Team will be supporting the upcoming away day for the Surgery, Women & Children's Division senior divisional team (Matrons, Heads of Service and business leaders) on the fundamental behaviours within Improving Together.
2. The Leadership Team will be providing an update at the Heads of Service Away Day to increase awareness on developmental opportunities for individuals and teams.
3. Following recent listening events with Consultants working within ED and staff in UTC the Leadership Team will be working with teams for UTC / ED to assist with the integration of front door services.
4. The Scope for Growth Talent Management facilitators will be working with line managers and ambassadors in July to deliver training sessions on how to conduct a career conversation and with individuals from the identified pilot groups – AHP staff in SWICC / International Nurses / BAME staff to raise awareness in readiness for the career conversations that will commence in August.
5. There will be a pilot of the career mapping tool that will commence in June with AHP's, the feedback from the pilot will influence amendments prior to wider consultation through roadshows planned for end of July.

Risk to performance and mitigations

The workload pressures in recovering elective activity and the level of operational pressure could impact on attendance at Leadership programmes. This is being monitored.

The request for OD support has continued to rise across the organisation, particularly for away days and team interventions. This is an encouraging indication that the service is valued, there is now a waiting time. Managers are being supported to deliver their own away days where appropriate with the OD team utilised in a consultancy capacity. The workload is being carefully monitored.

Scope for Growth career conversation could be viewed as an additional burden for already busy clinical line managers and consideration will need to be given to how this is managed in conjunction with appraisal.



Board Committee Assurance Report

Finance & Investment Committee – 23 May 2022			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Andy Copestake	**Andy Copestake**		**23 May 2022**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Month 1 Finance position	R	A	Month 1 was £0.4m adverse to plan, mainly as a result of Pay overspends – and mainly in Unscheduled Care. Although mitigating actions were planned, a number of these would take some months to take effect. The Committee was very concerned to see the level of overspend this early in the new financial year and urged the Executive to address this as a matter of urgency – specifically to look at measures to increase the pace of actions to bring the position back in line with plan.	Monitor through FIC	FIC meetings 2022/23
Finance Risk Register	A	A	The report this month reflected a detailed review of financial risks – resulting in a number of new risks, a number of closed risks and adjustments to existing risk scores. The Committee welcomed the detailed review and noted that the report would change in future months to reflect the new broader remit of the Finance & Infrastructure Committee.	Monitor through FIC	FIC meetings 2022/23

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Board Assurance Framework	A	A	The Board discussed the Q4 BAF and concluded that the strategic risks assigned to FIC were scored appropriately and were being managed effectively.	FIC	August 2022
Improvement & Efficiency Plan – focus on CIP	R	A	This was the main discussion item for FIC this month. Divisions attended and summarised the actions they are taking to meet the £10m CIP target for 2022/23. Whilst some progress had been made since the last meeting, the Committee was extremely concerned to note the £5.4m shortfall against the £10m target. More pace is needed, especially given the I & E shortfall in Month 1. The rating for management action was borderline Red and this will be reviewed at the June meeting.	Discuss each month until assurance increased to satisfactory level with confidence that the £10m will be delivered.	FIC meetings 2022/23
Critical Incident/IT failure Action Plan	A	A	A good report from the COO on the various elements of the air-conditioning failure which resulted in IT system failure in late 2021. The Committee felt this was an open, honest and thorough appraisal and supported the actions being taken to avoid a recurrence.	None	
Primary Care Improvement Plan & Cost Efficiencies	A	A	The Committee discussed and supported the challenging Primary Care Financial Improvement Plan for 2022/23 – looking to reduce the cost base by approx. £1m. The Committee also noted the need for a sustainable long-term solution for Primary Care, which would follow a full Board discussion later this year.	Board	July 2022
PFI Benchmarking Update	A	A	The Committee received a helpful update on progress with the 5 yearly benchmarking process for soft FM services provided under the PFI contract. Delegated authority would be sought from the Board to enable FIC to make a decision on the way forward in June.	Board/FIC	June 2022
Proactive Procurement update	G	G	A good update from the Director of Procurement on key procurement projects and service development initiatives. The Committee was particularly pleased to see good progress on procurement savings initiatives in collaboration with Divisions.	FIC	July 2022

Issues Referred to another Committee	
Topic	**Committee**
Centrally-mandated Internal Audit review of Finance Systems & Processes with a focus on Payroll controls	ARAC

NHS
Great Western Hospitals
NHS Foundation Trust

Board Committee Assurance Report

Finance & Infrastructure Committee – 27 June 2022			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**27 June 2022**
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 2 Finance position	R	A	The overall position for Month 2 is **£0.3m** adverse to budget, mainly due to overspending on Pay costs in Unscheduled Care, partially offset by vacancies across the Trust and income of **£0.2m** above plan. Further mitigation actions such as Enhanced Monitoring and Senior Management Review & Control will bring greater control to Unscheduled Care expenditure. Whilst plans are in place and management continues to focus on reducing overspend, the Committee remains concerned about the pace of progress to bring the spend in line with the plan.	Monitor through FIC	FIC meetings 2022/23
Finance Risk Register	A	A	All Finance risks and respective scores are subject to monthly review - 3 risks are closed, and four new risks are raised specifically around the Trust meeting its control total of **£19.4m** deficit and meeting challenging efficiency targets.	Monitor through FIC	FIC meetings 2022/23

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			The Committee was comfortable with the risk process and reporting of financial risks but requested management to reflect on and review the risk scores of the four new risks. The Committee asked for an insightful view and report on IT, Digital, and Infrastructure risks.		
Improvement & Efficiency Plan – focus on CIP	R	R	As part of the resubmission of the plan, the extraordinary FIC agreed to an additional **£1.1m** savings target, increasing the program to a cash-releasing target of **£11.1m**. Management identified a total **£5.6m**, of which 60% is recurrent. Management is yet to identify **£5.5m**. The Committee is assured that teams are currently allocating values across the organisation and further work is underway to identify cross-Divisional schemes to mitigate some of the unidentified gaps. The Committee remains concerned about the pace of identifying the gaps, delivery of the **£11.1m** CIP program and management's overall confidence in delivering the updated plan.	Discuss each month until assurance increased to satisfactory level with confidence that the £11.1m will be delivered.	FIC meetings 2022/23
Capital Plan Update	A	A	At Month 2 Capital spend is £524k against a plan of £1.206k. The Committee raised concerns about the pace of Capital spend and requested management to review processes, governance, and resourcing to accelerate Capital spend in line with the plan. The Committee was reassured that Capital spend is closely monitored by the Capital Management Group, Divisions, scheme leads, and support from Procurement and Finance.	None	FIC meetings 2022/23
Primary Care Future	A	A	The Committee discussed the performance against plan, transformation and forecast beyond the plan. The Committee also noted the need for a sustainable long-term solution for Primary Care and discussed options for the future, including securing an indemnity in the short term - this will require full Board discussion and consideration to agree on the way forward.	FIC/Board	July/August 2022
PFI Benchmarking Update	G	G	A detailed and helpful report was provided re: the five yearly benchmarking processes for soft FM services supplied under the PFI contract – 3 options were presented outlining key benefits and disadvantages. FIC was delegated by the Board and approved the commercial offer.	FIC	FIC meetings 2022/23
Way Forward Programme	A	G	A good update from the Way Forward Program Director focussing on action taken to achieve an affordable option for the Integrated Front Door Scheme, with an overview of the design option selection process. The Committee was particularly pleased to see excellent and speedy progress on the design solution considering inflationary and cost pressures.	FIC	FIC meetings 2022/23

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Procurement	G	G	A helpful and pleasing report was provided to the Committee on the Strategic and Operational Performance of Procurement, including key lessons learnt during 2021/22. Overall, the Committee was pleased to see good performance in light of the operational challenges experienced by the Procurement team and the ongoing collaboration across the three Trusts.	FIC	FIC meetings 2022/23

Issues Referred to another Committee	
Topic	**Committee**
None	n/a

Part 4: Use of Resources

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Financial Overview

Use of Resources

For Period Ended - 31st May 2022								
	In Month Plan £000	In Month Actual £000	In Month Variance £000		YTD Plan £000	YTD Actual £000	YTD Variance £000	
Total Operating Income	35,136	35,294	158		70,153	70,587	435	
Total Operating Expenditure	(36,808)	(37,300)	(492)		(73,943)	(75,100)	(1,156)	
Total Surplus/(Deficit) *excl donated assets*	(1,671)	(2,006)	(335)		(3,790)	(4,512)	(722)	
Capital	603	524	(79)		1,206	524	(682)	
Cash & Cash Equivalents	38,584	32,058	(6,526)					
Efficiencies	677	253	(424)		968	443	(525)	

Overview

Income & Expenditure: The Trust is reporting a deficit of £2.0m against a planned deficit of £1.7m in Month 2 (£0.3m adverse to plan). Year to date the position is £0.7m adverse to plan. Income is above plan in month (£0.2m) driven primarily by high-cost drugs with the offset included within expenditure. The expenditure over spend in month is also driven by pay costs in excess of budget in Unscheduled Care, which is partially offset by vacancies elsewhere across the Trust.

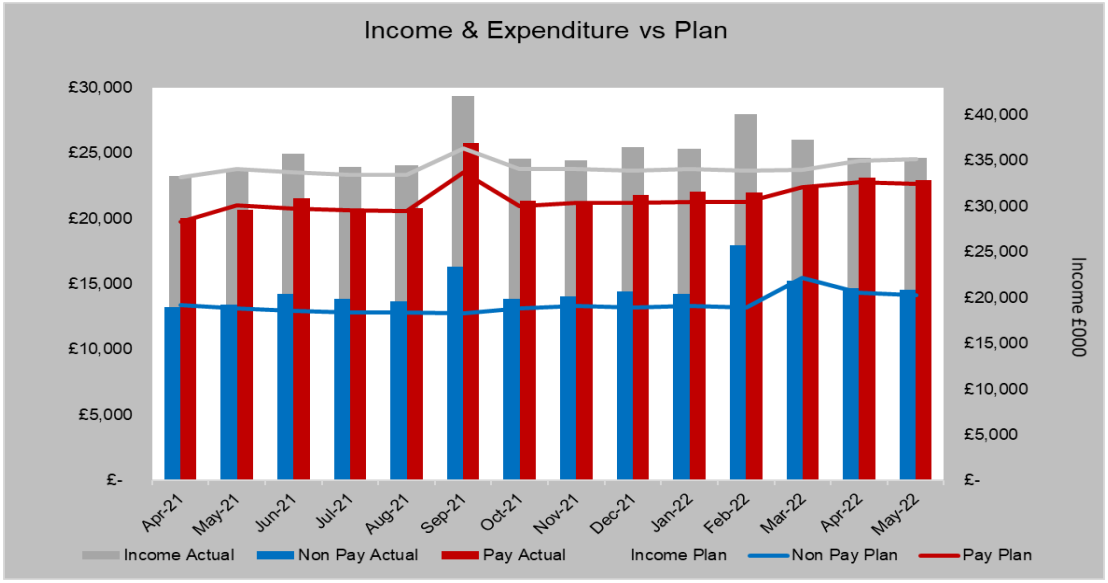
Cash – the cash balance at the end of May 2022 was £32.1m which was below the plan of £38.6m.

Capital – Capital expenditure is £0.5m as at the end of Month 2, £0.7m below plan.

Efficiencies – In month £0.3m has been delivered against a plan of £0.7m (£0.4m below plan in month, £0.5m year to date).

Income and Expenditure - Run Rate

Use of Resources



Background

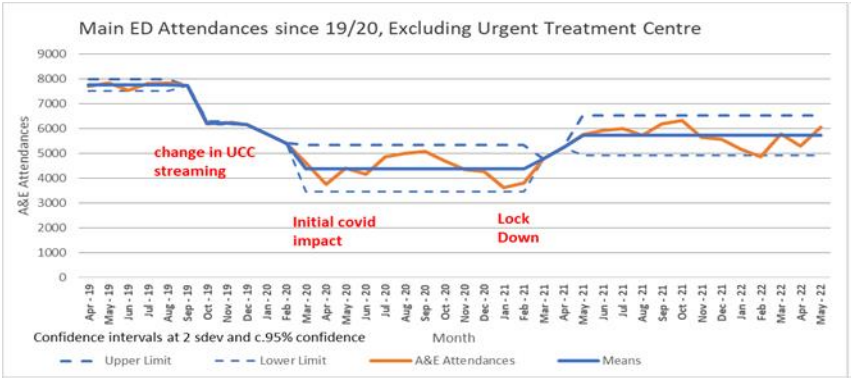
In month the I&E position is £2.0m deficit against a planned deficit of £1.7m. The run rate has reduced by £0.3m from April to May.

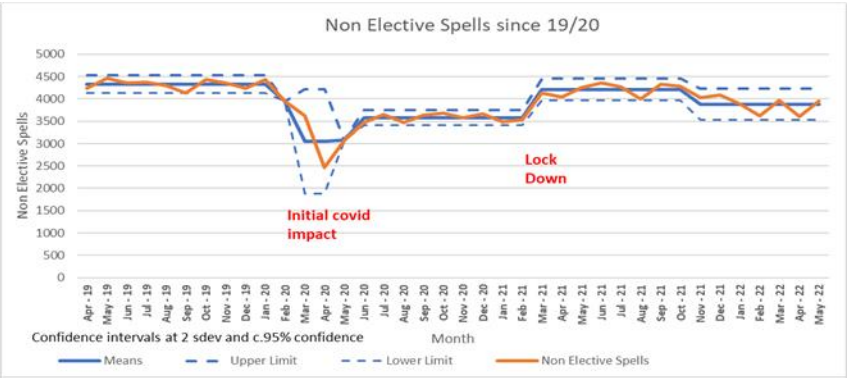
- Income run rate is in line with previous month and is £0.2m favourable to plan in month (£0.4m year to date). Additional income primarily relates to high-cost drugs, for which expenditure is above plan.
- The Pay run rate has reduced by £0.2m from Month 1 and is £0.3m above plan in month (£0.6m year to date).
    - The substantive run rate for Clinical Divisions is in line with prior months, the reduction relates to vacancies being carried within the Corporate division.
    - Agency and bank use for Clinical Divisions has reduced in month (£0.1m) however this is offset by an increase in substantive staff costs.
    - Vacancies within the Corporate division continue to support an overspend within Clinical divisions at month 2.

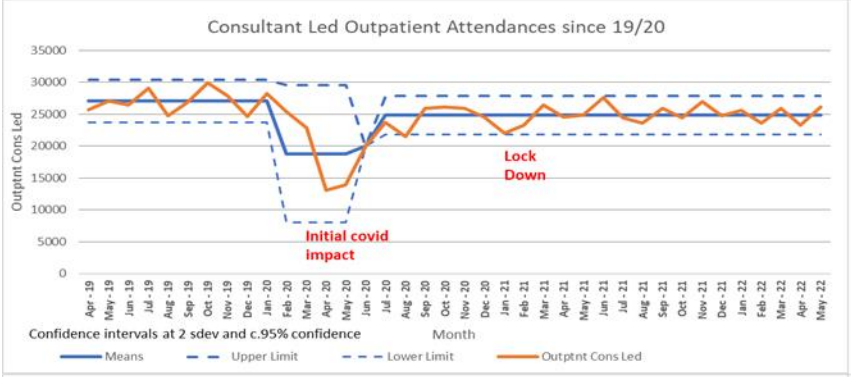
- Non Pay is above plan in Month 2 (£0.2m) and the run rate has reduced from Month 1 (£0.3m). The reduction in run rate mainly relates to reserves being released in May to offset costs of the 18 weeks contract within Surgery, Women's and Children's, as this can link to ESRF delivery.

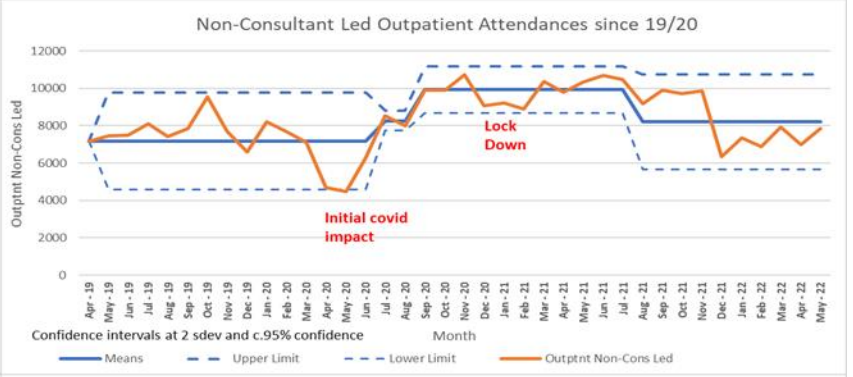
Key Activity Trends to Inform Revenue Impact if National Tariffs Still Applied

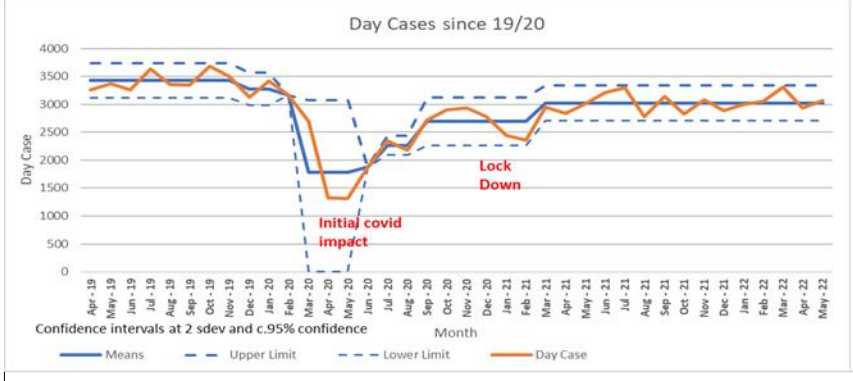
Use of Resources

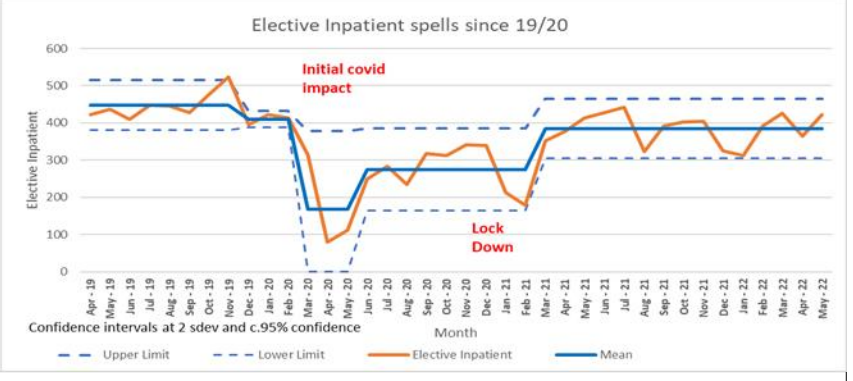












Background:
This is the activity trend collected to inform financial view on productivity, expenditure reported and notional income earned. This does not replace divisions' own view on their levels of activity.

Income by Point of Delivery

Use of Resources

Acute activity type	May 2022 Year to date 19/20	21/22	22/23	22/23 v 19/20 Note 1	
Main ED (excl UTC)	2,489,759	1,973,960	1,971,198	79%	Omits shift to UTC since 19/20
Non Elective	16,126,958	17,382,011	15,564,919	97%	May 98%
Outpatient	7,075,750	6,095,105	6,522,808	92%	May 97%
Day case	3,819,993	3,683,984	3,375,448	88%	May 89%
Elective inpatient	2,973,254	2,883,862	2,576,766	87%	May 88%
Total	32,485,714	32,018,922	30,011,139	92%	May 95%

Note 1: Between 19/20 and 22/23 tariffs have been uplifted by 4.8% and this is adjusted for here

Context

Due to Covid-19, funding is still being paid on a block contract basis, with the emphasis on covering reported costs.

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

It gives a feel for the impact of Covid-19 and the scale of income recovery back to 19/20 levels.

Focus on actuals:

The final plan for 22/23 is subject to an ongoing submission process. Once completed, the plan will be pulled into Finance systems to report v actuals. For May, actual income on a PbR basis has been shown v prior year and the pre-Covid base of 19/20.

Issues:

Non-elective and outpatients have recovered almost to 19/20 levels. Outpatients were reduced in the 3rd week of April due to bank holidays but May shows the general run rate at 97% of 19/20 after adjusting for tariff inflation.

Day case and elective patients are running at almost 90% of 19/20 with an expectation of increases later in year.

Risks:

The value of GWH activity needs to return to and exceed 19/20 levels both to support the BSW system earning ESRF funds, and to prepare for the rebasing of provider funding that will occur once the need for 'special' Covid funding blocks no longer exists.

GWH currently is running at c.95% of 19/20 values which is typical of other providers, but it still needs to go further.

Efficiency – Better Care at Lower Cost

Use of Resources

Division	Plan £000	Identified £000	Unidentified£ 000	In Month Plan £000	In Month Delivery £000	In Month Variance £000	YTD Plan £000	YTD Delivery £000	YTD Variance £000
Corporate	1,100	91	1,009	83	29	54	110	36	74
Integrated and Community Care	1,000	869	131	77	74	3	117	74	43
Surgery, Women's and Children's	3,200	1,213	1,987	240	24	216	320	49	271
Trust Wide	1,100	0	1,100	0	0	0	0	0	0
Unscheduled Care	3,600	2,604	996	278	137	141	421	284	137
Total	**10,000**	**4,777**	**5,223**	**677**	**263**	**414**	**968**	**443**	**525**

Background

The efficiency target and split by division has been agreed for 2022/23 – the cash releasing target is £10m. Divisions have been working to identify, cost and report schemes that are delivering against this plan. In month efficiency reported is £0.3m against a plan of £0.7m. There are a significant number of vacancies within Corporate that are not yet reported as efficiency, whilst these are non-recurrent they will support the achievement when reported retrospectively in Month 3.

Improvement actions planned

An update on the efficiency plans was reported to FIC at the end of May 2022. FIC will receive monthly updates on plans and delivery. Divisional meetings are continuing monthly, supported by Finance and T&I, to support development of plans. Work is ongoing to provide support for cross divisional schemes that could mitigate some of the remaining unidentified gap.

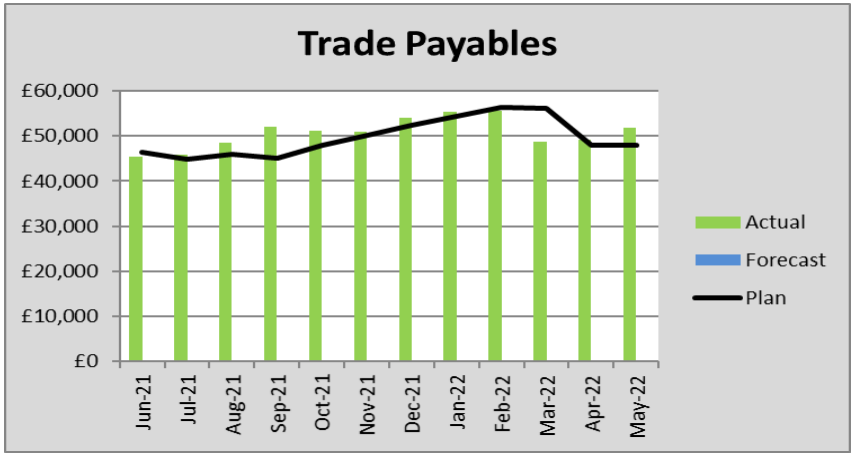
Risks to delivery and mitigations

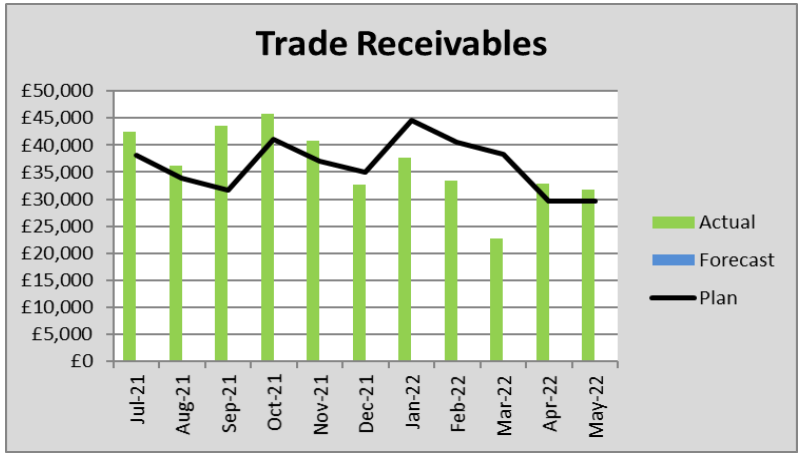
The Trust does not yet have a fully identified efficiency plan – this is being addressed through Divisional platforms as well as cross Divisional workshops to mitigate the risk to in year delivery.

As at Month 2, £0.2m of the £0.4m has been delivered non recurrently. Whilst this supports delivery of the 2022/23 plan, this poses a risk to the financial position in future years.

Statement of Financial Position: Key movements

Use of Resources





Background

- Trade payables are £3.8m above plan due to higher NON-PO Accrued Expenditure. Receivables is £2m above plan due to a higher Accrued income. An extensive accrual review is being undertaken to ensure these are linked to clearly-evidenced working papers.
- A full Statement of Financial Position is included in the appendices.

Risks to delivery and mitigations

- The Trust will require Emergency Capital funding in 2021/22 to support the capital programme. The Trust submitted its application for funding in May 2022.

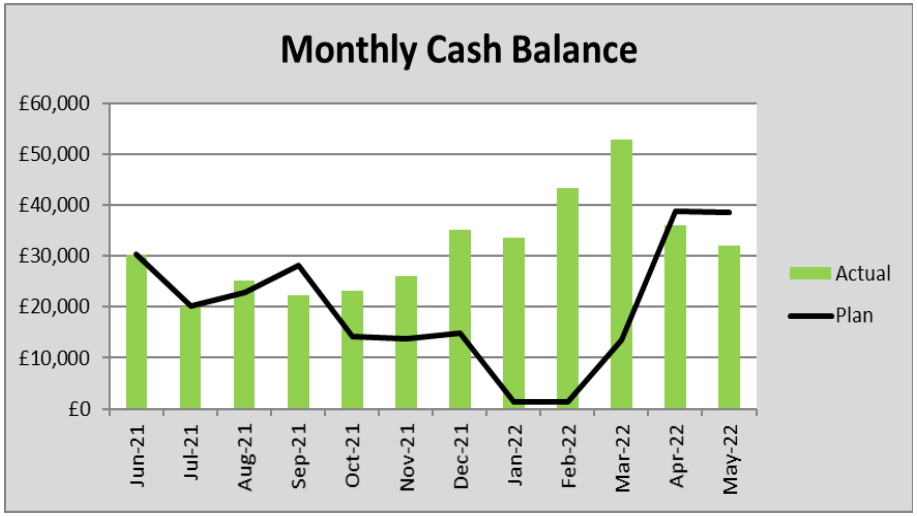
Cash

Use of Resources

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	22/23 Total	Rolling 12 Mths May 22 to Apr 23
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	**52,898**	**35,962**	**32,058**	**31,929**	**21,256**	**20,567**	**19,852**	**9,361**	**7,726**	**6,966**	**1,000**	**1,090**	**14,407**	**52,898**	35,962
Income															
Clinical Income	31,363	30,665	32,790	32,790	32,790	32,790	32,790	32,790	32,790	32,790	32,790	32,790	32,790	389,928	391,355
Other Income	6,494	2,372	1,358	7,133	1,358	1,358	7,133	1,358	1,358	7,133	1,358	1,358	1,358	39,771	34,635
Revenue Financing Loan / PDC										4,564	800	17,000	7,238	22,364	29,602
Capital Financing Loan / PDC			470	1,480	964	964	964	1,100	1,100	1,370	1,804	2,274		12,490	12,490
Total Income	**37,857**	**33,037**	**34,618**	**41,403**	**35,112**	**35,112**	**40,887**	**35,248**	**35,248**	**45,857**	**36,752**	**53,422**	**41,386**	**464,553**	**468,082**
Expenditure															
Pay	20,348	21,307	22,597	22,803	22,719	22,719	22,725	23,779	22,919	22,938	22,938	22,938	20,348	270,730	270,730
Revenue Creditors	15,124	15,576	8,218	13,444	11,992	9,456	15,668	11,802	11,573	15,243	11,821	7,410	15,124	147,326	147,326
Capital Creditors	6,327		3,932	4,090	1,090	1,090	1,245	1,245	1,515	1,903	1,903	7,195	6,327	31,535	31,535
PFI	12,994			11,740			11,740			11,740			12,994	48,213	48,213
PDC Interest						2,562						2,562		5,124	5,124
Financing		58						58						116	116
Total Expenditure	**54,793**	**36,941**	**34,747**	**52,076**	**35,801**	**35,827**	**51,378**	**36,884**	**36,007**	**51,824**	**36,662**	**40,105**	**54,793**	**503,044**	**503,044**
Closing Balance	**35,962**	**32,058**	**31,929**	**21,256**	**20,567**	**19,852**	**9,361**	**7,726**	**6,966**	**1,000**	**1,090**	**14,407**	**1,000**	**14,407**	**1,000**

Background

- Cash at the end of May was £32m which was £6.5m below the planned level of £38.5m.
- This was due to:
  - Clinical income £2m lower than plan offset by £1m higher than plan other income
  - Revenue Creditor payments in month £7.4m higher than plan, whilst pay was £1.2m below and Capital Creditors £1.2m below plan



Capital Programme

Use of Resources

Capital Scheme	Capital Group	2022-23 Full Year Plan £000	Month 2 plan	Month 2 Actual	Month 2 Variance	Month 2 YTD Plan £000	YTD Actual £000	Month 2 Accrual	YTD Variance £000
Service Development & Expansion	Estates	4,395	147	-	(147)	294	-	-	(294)
Estates Replacement Schemes	Estates	1,000	33	-	(33)	66	-	-	(66)
IT Emergency Infrastructure	IT	1,000	33		(33)	66		-	(66)
IT Replacement Schemes	IT	2,000	67	175	108	134	175	-	41
PACS - environment/replacement solution (Nov21)	IT	1,500	50	-	(50)	100	-	-	(100)
Equipment Replacement Schemes	Equipment	2,000	133	-	(133)	266	-	-	(266)
Contingency	CMG	600	-	-	-		-	-	-
Total Trust CDEL		**12,495**	**463**	**175**	**(288)**	**926**	**175**	**-**	**(751)**
Way Forward Programme		4,610	140	349	209	280	349		69
Finance Leases		141	-		-				-
Total Capital Plan (Excl PFI)		**17,246**	**603**	**524**	**(79)**	**1,206**	**524**	**-**	**(682)**

Risks to delivery and mitigations

Service Development Allocation not yet finalised but is expected to be signed off in June.

Background

- The Trust's CDEL plan for 2022/23 is £12.5m. Estates/IT and Equipment allocations have been prioritised by Capital sub groups and will be finalised in June along with the Service Development Allocation.
- Service Development Allocation will include schemes brought forward from 2021/22 (Aseptic Suite, CT installation).
- Total Capital Expenditure at Month 02 is £0.7m below plan. The majority of this underspend relates to CDE schemes with spend to date only on IT replacement schemes. Expenditure on Way Forward Programme is slightly ahead of plan (£0.07m)
- Capital sub-groups will provide monthly spending profiles once schemes have been confirmed and progress is monitored via CMG and monthly finance meetings.
- All CDEL schemes are expected to spend the full allocation by year end.
- The Trust submitted an application for Emergency Capital funding in May to support the capital plan. The value of the application is £9.9m and represents the gap between Trust's CDEL allocation and internally generated resources.

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Mental Health Governance Committee

Accountable Non-Executive Director	Presented by	Meeting Date
Lizzie Abderrahim	**Lizzie Abderrahim**	**8 April 2022**

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
	Risk	Actions			
Use of the Mental Health Act [MHA] Q4			The committee adjusted the risk rating to amber reflecting that some issues are outside the direct control of GWH [such as the availability of acute mental health beds] but it was satisfied that appropriate action plans were in place. Of particular note was the progress that had been made to ensure that [adult] patients receive a second reading of their rights and the robust approach taken in relation to the use of s.17 leave of absence.		
Mental Capacity Act [MCA]: Update			Ratings remained consistent. The committee continued to be assured that MCA practice was supported by the necessary training and that none of the clinical incident reporting over the reporting period had cited a lack of adherence to the MCA although a coroner's report had made recommendations in relation to MCA practice and plans were in place to address these. The committee noted that Datix was to be rolled out and that this would address concerns re the robustness of the data and allow future reporting to differentiate between MCA and DoLs.		

[1] Safeguarding / Mental Health / DOLS

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
Deprivation of Liberty Safeguards Update			A red risk rating was maintained. During the reporting period 173 applications had been made to the supervisory bodies and there continue to be issues in relation to the ability of the supervisory bodies to carry out those assessments. These issues are outside the direct control of GWH but the committee was satisfied that actions were in place to address the risks associated with patients being under the Trust's care outside of a legal framework.		
Liberty Protection Safeguards [LPS]: Consultation and Implementation Plan			Ratings remained consistent. A degree of uncertainty about the implementation of LPS although a consultation had begun of the Code of Practice and the Trust would be contributing to this as part of a wider BSW response. The committee noted the significant training and workforce issues associated with LPS and that the Trust was continuing to engage in planning activity [internally and across BSW] to address these.		
Mental Health Governance Workplan Q4Report			The committee remained satisfied by the robustness of the workplan and by the progress reported although it did note that it had not been possible to close some actions and that these would form part of the 2022/23 plan.		
Risk Report			The committee noted the risks reported and was satisfied that these were subject to regular review and that appropriate actions were in place to mitigate them. It did note that there was greater assurance in relation to adults than for children although no specific risk associated with the emergency department had been identified and the committee questioned this.		
Audit Reports			Audits reported on in the period demonstrated compliance with policy and guidance and where learning had been identified plans were in place to address this.		
Emergency Department Update			Amber ratings were maintained. No increase in mental health presentations nor any increase in severity had been seen over the last year. However, there were workforce issues in ED that had the potential to impact on how care is provided to patients presenting as non-suicidal and the AWP intensive team were increasingly unavailable overnight. The Committee also noted that there was some concern about how mental health-only ambulance patients (those without a medical problem) should be managed.		
Mental Health Liaison Team Update			The committee noted that no-one was present from AWP to present their report. This hindered discussion on the issues that were raised and, as a result, the committee raised the risk rating from amber to red.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
CAMHS			As no-one was present from CAMHS to present the report and there was therefore limited opportunity to discuss the contents. Of continuing concern to the committee are those issues outside the direct control of GWH, in particular the lack of Tier 4 specialist beds and the recruitment challenge within the CAMHS service and it was agreed that these merited a red risk rating.		
Children's Services			The committee raised the risk rating from amber to red. The numbers of young people waiting for a tier 4 specialist bed had increased and the committee noted the complexity of their mental health conditions and the challenges that this presented for staff and other patients and their families. It was also evident that length of stay had been impacted by a reduction in CAMHS liaison service. However, the committee was satisfied that there were robust actions in place to address this increased risk and maintained an amber rating [a green rating was considered but not agreed on the basis that a review of the service level agreement was not yet complete]		
Committee Effectiveness			The committee agreed that its effectiveness would be enhanced if some changes were made to the terms of reference. These changes included ensuring that the representation of partner agencies reflected the strategic focus of the committee and that the committee needed to take a strategic overview across the entirety of the Trust.		

Board Committee Assurance Report

Charitable Funds Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	**Paul Lewis**		**4 May 2022**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?			

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Fundraising	G	G	There were no concerns about the Fundraising Report, which was evaluated as G:G. Although there are some areas to improve with our Fundraising Appeal and Legacies, there is high confidence and assurance with our overall Fundraising position.	Review progress at the next meeting.	August 2022
Financial position	G	G	The Finance position is well controlled and no concerns were raised.	Review progress at the next meeting.	August 2022
Cases of Need	G	G	The changes made to improve the Cases of Need process have had a positive impact. There is a need for some further help from Cat Weaver and her team to support the Divsional Directors with their understanding of the sign-off process and where/how funding should be considered from Divisional spending before seeking monies from the General Fund; however, overall the process is working well.	Review progress at the next meeting.	August 2022
Charitable Funds	A	A	The Divisional Spending Plans were reviewed and no specific concerns were raised. There is considerable scope to increase Divisional spending and this will be incorporated within our plans to rationalise the 81 Charitable Funds. A detailed plan for this is being developed and will be presented for approval at the August meeting. This will include a communications plan to ensure there is appropriate staff engagement before the specific changes are implemented.	Review progress at the next meeting.	August 2022

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Finance Strategy	A	A	We have agreed to formally review and agree our Finance Strategy, which will be developed and then presented at the next meeting.	Review progress at the next meeting.	August 2022

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

NHS
Great Western Hospitals
NHS Foundation Trust

Board Committee Assurance Report

Audit, Risk & Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Helen Spice	Helen Spice		16 June 2022
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			
Annual Report and Accounts 2021/22	R	A	The Committee was disappointed that there had been a delay in the completion of the Annual Audit and as a result the Annual Report and DDAccounts will not meet the submission deadline of 22 June and particularly that they had not been informed of this delay in a timely manner. The Annual Report and Accounts and Audit Findings Review will now be reviewed and approved at the Private Board Meeting on 7 July so that they can be submitted before summer recess on 8 July. NHSE/I has been informed of the delay.		July 2022
BDO Internal Audit Annual Report 2021/22	G	A	The BDO Internal Audit Annual Report for 2021/22 provided an overall moderate assurance opinion. The Committee was assured that good progress has been made in the Control Design ratings over the last three years but although there is some improvement in Operational Effectiveness ratings there is still some work to be done.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Internal Audit – Data Security and Protection Toolkit	G	A	The committee noted that there is an overall moderate risk to the Trust's data security and protection toolkit.		
Internal Audit – Safeguarding Adults	G	G	This report noted substantial assurance for design and moderate assurance for operational effectiveness.		
Internal Audit – Plan for 2022/23	G	A	The internal audit plan was approved by Executive Committee on 21 March 2022. It was recognised that the timetable of audits to be conducted during the year needs to be reviewed so that the committee can be assured that they will be completed in a timely manner. NHSE/I has issued guidance for an additional review to be conducted on financial governance so the overall plan will need to be amended to incorporate this review and the plan reviewed at the next meeting.		
Internal Audit – follow up of recommendations	G	A	Progress is being made on outstanding actions with some long overdue actions now complete. The committee challenged the timeliness of the completion of the Data Warehouse recommendations and the Executive Team took an action to review and increase pace.		
Counter Fraud Annual Report 2021/22 and Annual Return	G	G	The committee received assurance from the counter fraud work undertaken in 2021/22. The Counter Fraud Functional Standards return was submitted on time in May 2022 and the committee noted that the overall compliance rating is green.		
Counter Fraud Annual Risk Review 2022/23	G	G	The committee received the results of the Fraud Risk Register review for 2022/23, the annual counter fraud survey, and benchmarking data available from the NHS Counter Fraud Authority (NHSCFA) and noted the plans for 2022/23. The committee was disappointed that only 80 responses had been received from Trust staff and that work needed to be done to improve this response rate in future years.	N/A	
Losses and Compensations Q4 2021/22	G	G	The committee approved the Loses and Compensations report for Q4 2021/22.	N/A	

Issues Referred to another Committee	
Topic	**Committee**

Report Title	**Full Ockenden Report – IEA Breakdown**				
Meeting	**Trust Board**				
Date	**7th July 2022**	Part 1 (Public) [Added after submission]	X	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek (Chief Nurse)				
Report Author	Lisa Marshall, Kat Simpson & Laura Little				
Appendices	None				

Purpose

Approve		Receive	X	Note		Assurance	X
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level

Assurance in respect of: process/outcome/other (please detail):

Significant		Acceptable	X	Partial		No Assurance	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

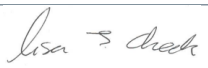
Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

An overview of the Immediate & Essential Actions (IEA) outlined in the full Ockenden Report (released March 2022) including current RAG ratings, anticipated actions, key risks and potential investment requirements.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more					
	X		X	X	X
Key Risks – risk number & description (Link to BAF / Risk Register)	2819				**Risk Score**
	Non compliance with the Immediate & Essential Actions mandated by the Ockenden Report may impact patient safety in Maternity & Neonatal Services				9
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	None				
Next Steps	Continued progress with local improvement plan				

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		X	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?		X	
Explanation of above analysis: This report focusses on the immediate and essential actions mandated by the Ockenden Report (2022). There are no specific EDI recommendations, however the anticipated outcome of full compliance is access to safe maternity care for all.			

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Understand the impact of the Immediate and Essential Actions on the peri-natal strategy for access to safe maternity care including anticipated timescales for delivery, potential investment requirements and potential risks of non compliance.**	
Accountable Lead Signature	
Date	30 June 2022

NHS
Great Western Hospitals
NHS Foundation Trust

Full Ockenden Report – IEA Breakdown

Lisa Marshall – Director of Midwifery and Neonatal Services

Kat Simpson – Risk & Governance Lead Midwife

Background

Great Western Hospitals NHS Foundation Trust

In 2017 Donna Ockenden was asked to review Maternity Services in the Shrewsbury and Telford NHS Hospital Trust by the Secretary of State.

The inquiry covered 1,592 clinical incidents involving 1,486 families between 2000 and 2019, during which time it found there were more than 200 avoidable baby deaths or brain damage cases as a result of poor maternity care, including 131 stillbirths, 70 neonatal deaths and 84 cases of brain damage

The first Ockenden report was published in December 2020 and identified seven Immediate and Essential Actions (IEAs). The final report published in March 2022 and identifies 15 new themes with a series of further recommendations. It contains **92 new actions**

Immediate and Essential Actions - first report

1. Enhanced Safety
2. Listening to women and families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Wellbeing
7. Informed Consent

❖ Workforce

Essential Actions - final report

1. Workforce planning and Sustainability
2. Safe Staffing
3. Escalation and Accountability
4. Clinical Governance – Leadership
5. Clinical Governance - Incident investigation and Complaints
6. Learning from Maternal Deaths
7. Multidisciplinary Training
8. Complex Antenatal Care
9. Preterm Birth
10. Labour and Birth
11. Obstetric Anaesthesia
12. Postnatal Care
13. Bereavement Care
14. Neonatal Care
15. Supporting Families

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 1: Workforce Planning & Sustainability

Financing a safe maternity workforce. The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented

Training. We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented

GWH Self Assessment (June 2022)

2	9	0

Immediate & Essential Action Detail (IEA 1 : Workforce Planning & Sustainability) - Financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
1. The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England	AMBER	
2. Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	AMBER	
3. Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	AMBER	
4. The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	AMBER	

Opportunities for improvement & next steps:

- Review of revised BirthRate Plus assessment and facilitation of a skill mix review of current workforce
- Increase of training uplift from 20% to 28%
- Scoping of investment requirements to ensure compliance for staffing establishment
- National review of feasibility and accuracy of BirthRate Plus tool

Key Risks of Non Compliance:

- Establishment of safe staffing levels in line with local acuity
- A validated safe staffing tool is essential for workforce planning

Investment Commentary:

- Revised BirthRate+ Report recommends an increase in funded establishment.
- An uplift in headroom to 28% is required to support additional training needs in Maternity Services
- This identified cost pressure will be considered during business planning 2023/24

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 1: Workforce Planning & Sustainability

Financing a safe maternity workforce. The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented

Training. We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented

GWH Self Assessment (June 2022)

2	9	0

Immediate & Essential Action Detail (IEA 1 : Workforce Planning & Sustainability) - Training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
5. All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this	AMBER	
6. All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	AMBER	
7. All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	RED	Engagement with UWE & LMNS to establish nationally recognised education module to be included in ongoing Maternity Education Programme (Target Date : September 2023)
8. All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development	AMBER	
9. All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	AMBER	
10. All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience	RED	Engagement in National Head of Midwifery network and use of Royal College of Midwives (RCM) Toolkit to undertake succession planning (Target Date : January 2023)
11. The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	AMBER	

Opportunities for improvement & next steps:

- Targeting High Dependency module to ensure 24/7 provision by suitably skilled staff
- Increase of training uplift from 20% to 28%
- Establishment of succession planning programme for Senior Managers and Clinical posts
- Scoping of investment requirements to ensure compliance for staffing establishment
- Access to nationally recognised Labour Ward Coordinator education module
- Engagement in nationally led discussions relating to the creation of Maternal Medicine Networks

Key Risks of Non Compliance:

- Lack of suitably skilled workforce
- Lack of succession strategies may result in challenges for future proofing service

Investment Commentary:

- Anticipated funding availability via Health Education England (HEE)

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 2: Safe Staffing

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

GWH Self Assessment (June 2022)		
2	7	1

Immediate & Essential Action Detail (IEA 2 : Safe Staffing)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
12. When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	AMBER	
13. In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	RED	Complete Risk Assessment and Improvement Plan (Target Date : October 2022)
14. All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	GREEN	
15. All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	AMBER	
16. The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	AMBER	
17. The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	AMBER	
18. All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	RED	Inclusion of additional roles within Business Planning and then undertake associated recruitment process (Target Date : September 2023)
19. Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	AMBER	
20. All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	AMBER	
21. All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction	AMBER	

Opportunities for improvement & next steps:

- Escalation Policy to include the visibility of staffing concerns and communication channels with Local Maternity & Neonatal System (LMNS)
- Full review of the Obstetric and Gynaecology workforce and provision of clear escalation policy for periods of competing workload
- Effective mentorship and coaching for senior midwives to support leadership and management
- Revised Continuity of Carer implementation plan based on reviewed BirthRate Plus data and national guidance
- Inclusion in business planning of supernumerary Clinical Skills Facilitators to ensure 24/7 availability

Key Risks of Non Compliance:

- Lack of dedicated obstetric rota may delay consultant presence
- Lack of suitably skilled workforce
- Potential impact on retention and support for existing workforce

Investment Commentary:

- Potential increase in obstetric consultant workforce may require future investment over the next 2-3 years
- Two additional clinical skills facilitators to ensure access to support 24/7 to be included in business planning 2023/24

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

NHS Great Western Hospitals

Immediate & Essential Action 3: Escalation and Accountability

Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.

GWH Self Assessment (June 2022)		
1	3	1

Immediate & Essential Action Detail (IEA 3 : Escalation & Accountability)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
22. All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	GREEN	
23. When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	RED	Complete Risk Assessment and Improvement Plan (Target Date : October 2022)
24. Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	AMBER	
25. There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit	AMBER	
26. There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	AMBER	

Opportunities for improvement & next steps:

- Consideration of further increase to Resident Consultant presence
- Escalation Policy to include clear guidelines for threshold of escalation to senior supporting team
- Audit of Consultant attendance for mandated emergency situations and escalation (as per CNST Safety Action 4 – Clinical Workforce)
- Workforce modelling for Obstetric team

Key Risks of Non Compliance:

- Lack of assurance mechanism for middle grade/trainee obstetrician

Investment Commentary:

- An increase in resident consultant presence will form part of long term workforce planning

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 4: Clinical Governance (Leadership)
Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.

GWH Self Assessment (June 2022)		
1	5	1

Immediate & Essential Action Detail (IEA 4 : Clinical Governance - Leadership)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
27. Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans	GREEN	
28. All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	AMBER	
29. Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	AMBER	
30. All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	AMBER	
31. All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	RED	Establishment of mandatory training for Maternity Governance Team (Target Date : October 2022)
32. All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	AMBER	
33. All maternity services must ensure they have midwifery and obstetric co-leads for audits.	AMBER	

Opportunities for improvement & next steps:

- Further development of in house training to ensure continual focus on “Human Factors”
- Identification of Obstetric Co-Lead for development of guidelines and audits
- Completion and presentation of National Maternity Self Assessment Tool
- Training Needs Analysis for Maternity Governance team to ensure development of effective skills in causal analysis and family engagement

Key Risks of Non Compliance:

- Lack of effective patient safety systems with maximum learning from patient experience

Investment Commentary:

- Ongoing consideration during job planning for consultant workforce

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals

Immediate & Essential Action 5: Clinical Governance (Incident Investigation & Complaints)
Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner

GWH Self Assessment (June 2022)

0	7	0

Immediate & Essential Action Detail (IEA 5 : Clinical Governance - Incident Investigation & Complaints)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
34. All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	AMBER	
35. Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	AMBER	
36. Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred	AMBER	
37. Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	AMBER	
38. All trusts must ensure that complaints which meet SI threshold must be investigated as such.	AMBER	
39. All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	AMBER	
40. Complaints themes and trends must be monitored by the maternity governance team.	AMBER	

Opportunities for improvement & next steps:

- Further strengthening of learning from events within local training provision
- Review timeline for implementing changes in practice following learning from Serious Incidents
- Introduction of Maternity specific Complaints Manager role to be based within the Maternity Governance team

Key Risks of Non Compliance:

- Missed opportunities for patient safety focused learning

Investment Commentary:

- Addition of a Maternity Complaints manager (0.4 WTE band 6) to be considered during business planning 2023/24

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 6: Learning From Maternal Deaths

Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

GWH Self Assessment (June 2022)		
0	2	1

Immediate & Essential Action Detail (IEA 6 : Learning from Maternal Deaths)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
41. NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	AMBER	
42. This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	GREEN	
43. Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	AMBER	

Opportunities for improvement & next steps:

- Alignment of local policies across the Local Maternity and Neonatal system to ensure alignment with revised National standard
- Ensure learning embedded within 6 months of sharing
- Review existing policies in line with anticipated National updates

Key Risks of Non Compliance:

- Potential delays associated with external reviews may impact on timely implementation of shared learning

Investment Commentary:

- No investment identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 7: Multidisciplinary Training

Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.

GWH Self Assessment (June 2022)		
1	3	3

Immediate & Essential Action Detail (IEA 7 : Multidisciplinary Training)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
44. All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	RED	Ensure prioritisation within ongoing job planning. Monitoring to be via Electronic Staff Record in line with HR policies. (Amber Target Date : November 2022) (Green Target Date : July 2023)
45. Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	GREEN	
46. All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	AMBER	
47. There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	GREEN	
48. There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	AMBER	
49. Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	GREEN	
50. Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	AMBER	

Opportunities for improvement & next steps:

- Increase of training uplift from 20% to 28%
- Establish revised training database to support full compliance with maternity specific mandatory training
- Formalisation of debriefing processes for staff
- Development of stand alone human factors training for all maternity staff

Key Risks of Non Compliance:

- Lack of dedicated time for shared multi-disciplinary education from patient experience and safety concerns may impact timely learning

Investment Commentary:

- Ongoing consideration during job planning for consultant and junior obstetric workforce
- Access to Local Maternity and Neonatal System funding for Human Factors train the trainer program
- Revised BirthRate+ Report recommends an increase in funded establishment. To be considered in business planning 2023/24

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 8: Complex Antenatal Care

Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

GWH Self Assessment (June 2022)		
1	3	1

Immediate & Essential Action Detail (IEA 8 : Complex Antenatal Care)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
51. Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	RED	Undertake options appraisal and operational evaluation of service provision. Engagement with wider primary care services to identify correct pathways for pre-existing medical disorders. (Amber Target Date : July 2023) (Green Target Date : 2024 / 2025)
52. Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	AMBER	
53. NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes	AMBER	
54. When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	AMBER	
55. Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	GREEN	

Opportunities for improvement & next steps:

- Focussed care pathways for complex care
- Tool for documentation of evidence based advice and decision making in partnership with women
- Antenatal clinic capacity
- Investment in preconceptual care services for women with pre-existing medical disorders

Key Risks of Non Compliance:

- Lack of access to pre-conceptual care for women with pre-existing medical disorders may negatively impact outcomes for women/birthing people and their babies

Investment Commentary:

- Options appraisal with primary care network to develop pathway for access to preconceptual care and explore available public health funding streams to support

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 9: Preterm Birth
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)

GWH Self Assessment (June 2022)		
0	0	4

Immediate & Essential Action Detail (IEA 9 : Preterm Birth)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
56. Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	**GREEN**	
57. Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	**GREEN**	
58. Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	GREEN	
59. There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	**GREEN**	

Opportunities for improvement & next steps:

- Continue learning from excellence locally, regionally and Nationally
- Implementation of recommendations from National audits to ensure appropriate birth setting

Key Risks of Non Compliance:

- No risks identified

Investment Commentary:

- No investment identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 10: Labour and Birth

Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units

GWH Self Assessment (June 2022)		
1	4	1

Immediate & Essential Action Detail (IEA 10 : Labour and Birth)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
60. All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	AMBER	
61. Midwifery-led units must complete yearly operational risk assessments	AMBER	
62. Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	GREEN	
63. It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	RED	Formulise localised Standard Operating Procedure and embed practice of information sharing to inform women/birthing people (Target Date : October 2022)
64. Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	AMBER	
65. Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	AMBER	

Opportunities for improvement & next steps:

- Increase skills drills in community settings
- Revision of local risk assessment tool for labour
- Development of clear pathway and close collaboration with South West Ambulance Service Trust to ensure access to transfer times and potential delay are minimised, and where unavoidable this information is available to women birthing in the community
- Implementation of funded central CTG monitoring system

Key Risks of Non Compliance:

- Lack of accurate and up to date information relating to transfer times results in women/birthing people not accessing the appropriate information to make an informed choice for birthing outside of a hospital setting.

Investment Commentary:

- Allocated funding from NHSE/I for implementation of centralised CTG monitoring systems, implementation underway

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

NHS Great Western Hospitals

Immediate & Essential Action 11: Obstetric Anaesthesia

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed

GWH Self Assessment June 2022)

1	4	3

Immediate & Essential Action Detail (IEA 11 : Obstetric Anaesthesia)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
66. Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	GREEN	
67. Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	AMBER	
68. All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	AMBER	
69. Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance	RED	Engagement with national professional bodies to ensure local core data sets are in line with national standards (Amber Target Date : January 2023) (Green Target Date : 2024 / 2025)
Obstetric anaesthesia staffing guidance to include: 70. The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	GREEN	
Obstetric anaesthesia staffing guidance to include: 71. The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity	AMBER	
Obstetric anaesthesia staffing guidance to include: 72. The competency required for consultant staff who cover obstetric services out-ofhours, but who have no regular obstetric commitments	GREEN	
Obstetric anaesthesia staffing guidance to include: 73. Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report	AMBER	

Opportunities for improvement & next steps:

- Audit of pathways to explore opportunities for further improvements to patient experience
- Active role in obstetric ward rounds

Key Risks of Non Compliance:

- A lack of national alignment in anaesthetic core dataset may negatively impact learning from anaesthetic events

Investment Commentary:

- No investment identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS

Immediate & Essential Action 12: Postnatal Care
Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times

GWH Self Assessment (June 2022)

0	4	0

Immediate & Essential Action Detail (IEA 12 : Postnatal Care)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
74. All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward.	AMBER	
75. Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	AMBER	
76. Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	AMBER	
77. Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	AMBER	

Opportunities for improvement & next steps:

- Audit of timeliness for reviews, particularly for women admitted overnight
- Continue to map consultant job planning to support timely review, with consideration of resident consultant presence
- National review of feasibility and accuracy of BirthRate Plus tool

Key Risks of Non Compliance:

- Lack of timely and effective care in postnatal period may result in poor patient outcomes

Investment Commentary:

- Potential increase in obstetric consultant workforce may require future investment over the next 2-3 years

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 13: Bereavement Care

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.

GWH Self Assessment (June 2022)		
0	2	2

Immediate & Essential Action Detail (IEA 13 : Bereavement Care)	GWH RAG (01.06.2022)	KAY ACTIONS & TIMESCALES
78. Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday	AMBER	
79. All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	AMBER	
80. All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	GREEN	
81. Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	GREEN	

Opportunities for improvement & next steps:

- Options appraisal of expansion of Maternity and Paediatric Support Service
- Team of bereavement champions who have received additional training to support enhance bereavement care out of hours, including post-mortem consent counselling

Key Risks of Non Compliance:

- Lack of access to appropriate bereavement care for birthing people and their families

Investment Commentary:

- Development Band 6 post (0.4WTE) to be included in business planning 2023/24

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 14: Neonatal Care

There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

GWH Self Assessment (June 2022)		
2	2	4

Immediate & Essential Action Detail (IEA 14 : Neonatal Care)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
82. Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	GREEN	
83. Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly	GREEN	
84. Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	GREEN	
85. Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	RED	Engagement with Neonatal Operational Delivery Network to establish Regional enhanced experience programme. (Amber Target Date : January 2023) (Green Target Date : 2024 / 2025)
86. Each network must report to commissioners annually what measures are in place to prevent units from working in isolation	RED	Engagement with Neonatal Operational Delivery Network to establish Regional enhanced experience programme. (Amber Target Date : January 2023) (Green Target Date : 2024 / 2025)
87. Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	AMBER	
88. Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	GREEN	
89. Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	AMBER	

Opportunities for improvement & next steps:

- Continued engagement with GIRFT neonatology deep dive
- Full recruitment in to the advance neonatal nurse practitioner (ANNP) pathway
- Establishment of rotational posts for nursing, advanced neonatal nurse practitioner (ANNP) and medical workforce with the operational delivery network for neonatal care

Key Risks of Non Compliance:

- Lack of shared learning and experiences may reduce the skills and development in the Neonatal workforce

Investment Commentary:

- Potential risk of increasing backfill costs to support rotation of staff attending other provider Trusts within Network. A model for rotation will be developed with the Operational Delivery Network for Neonatal Care
- Achievement will be supported by implementation of the Advance Neonatal Nurse Practitioner workforce. This will require additional funding for 2.0 WTE ANNPs and further guidance on funding sources are awaited

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 15: Supporting Families

Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care

GWH Self Assessment (June 2022)		
1	2	0

Immediate & Essential Action Detail (IEA 15 : Supporting Families)	GWH RAG (01.06.2022)	KEY ACTIONS & TIMESCALES
90. There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	RED	Short term improvement plan to enhance provision of education, standard operation procedures & referral pathways (Target Date : January 2023) Inclusion of additional roles within Business Planning and then undertake associated recruitment process (Target Date: September 2023)
91. Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences	AMBER	
92. Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	AMBER	

Opportunities for improvement & next steps:

- Formalise process for referral to Maternity and Paediatric Support Service
- Options appraisal of expansion of Maternity and Paediatric Support Service
- Division wide train the trainer program in order to ensure effective recognition of psychological distress

Key Risks of Non Compliance:

- Lack of access to appropriate psychological support may delay timely and effective care

Investment Commentary:

- Development Band 6 post (0.4WTE) to be included in business planning 2023/24

Next steps

Great Western Hospitals NHS Foundation Trust

External national support networks:

- Identify through South West LMNS where system support is required
- Commitment to aligning Maternity and Neonatal services at regional level to implement Ockenden recommendations
- Neonatal operation delivery network (ODN) have committed to support improvements in neonatal care through the Neonatal Implementation Board
- Health Education England have committed to collaborating on Ockenden workforce recommendations
- Collaborate with LMNS and the Maternity Voices Partnerships (MVP) to design clear communications to local population

GWH Maternity & Neonatal Service:

- Implementation of robust local improvement plan paying particular attention to the report's four key pillars:
    1. Safe staffing levels
    2. A well-trained workforce
    3. Learning from incidents
    4. Listening to families
- Continuing assessment of staffing position including a skill mix review
- Ongoing reporting through established governance routes to report to Trust Board and Local Maternity and Neonatal System
- Engagement and communication with local families in coproduction with Maternity Voice Partnership
- Review investment and business planning opportunities to support full compliance

Ockenden Report (2022)

NHS
Great Western Hospitals
NHS Foundation Trust

Enabling safer maternity care

Report Title	**Amendment to the Trust Constitution – Eligibility of Non-Executive Directors & Executive Directors**				
Meeting	**Trust Board**				
Date	**7 July 2022**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Trust Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices					

Purpose							
Approve	x	**Receive**		**Note**		**Assurance**	
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level

Assurance in respect of: process/outcome/other (please detail):

Process

Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

There have been two recent issues that have highlighted that the Trust's Constitution currently restricts both Non-Executives Directors and Executive Directors working with another trust. Firstly, our Chief Digital Officer is a joint appointment with Salisbury NHS FT and secondly a current Non-Executive Director has expressed a wish to join another NHS trust as a Non-Executive Director.

In terms of NEDs, there is no centrally imposed restriction on NEDs holding posts at more than one Foundation Trust. It should be noted that this would also allow the Governors to appoint strong NED candidates who also worked on other Boards, which could strengthen the Board by bringing in different perspectives and potentially encouraging collaboration between organisations. Governors would still be able to judge through the interview/appraisal process whether they felt that there were any specific conflicts of interest, and whether the individual would be able to give enough time to the role. There is a code of governance stipulation to ensure that NEDs are able to devote sufficient time to the role, and NEDs have a legal duty to avoid conflicts of interest.

In terms of Executive Directors, it is being encouraged by the establishment of integrated care systems for joint working by Executive Directors and this will become more common as the ICs/ICAs evolve.

In viewing other NHS FT trusts' constitutions this is common practice with some removing the restriction altogether and others (RUH NHS FT included) giving the Board of Directors a vote.

It is therefore proposed to update our Constitution as follows:-

Board of Directors – disqualification (paragraph 24.1.7)
The following may not become or continue as a member of the Board of Directors:-

Current Constitution	Proposed Change
24.1.7 a person who is a Governor of the Trust or an executive or non-executive director or a governor of another NHS Foundation Trust, an executive or non-executive director, chair, chief executive officer of another Health Service Body or a body corporate whose business includes the provision of health care services, or which includes the provision of any service to the Trust;	24.1.7 an executive director, non-executive director or a governor of another Health Service Body, unless approval is received from no less than 75% of the voting members of the Board of Directors; 24.1.8 a person who is a Governor of the Trust;

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
	n/a				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	None				
Next Steps	Approval from the Council of Governors				

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			x
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required
The Board/Committee/Group is requested to:

The Board is requested to approve the proposed amendment to the Trust's Constitution.

Accountable Lead Signature	Liam Coleman, Chair
Date	28 June 2022

Report Title	**Safe staffing 6 month review for Nursing, Midwifery and Allied Health Professionals**					
Meeting	**Board of Directors**					
Date	**7th July 2022**	**Part 1 (Public) [Added after submission]**	**x**	**Part 2 (Private) [Added after submission]**		
Accountable Lead	Lisa Cheek Chief Nurse					
Report Author	Luisa Goddard Deputy Chief Nurse					
Appendices						

Purpose							
Approve		**Receive**		**Note**		**Assurance**	**X**
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Significant		**Acceptable**	**X**	**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

The purpose of this paper is to provide assurance to the Trust Board on the safe systems and processes in place to manage Nursing, Midwifery and Allied Health Professionals staffing over the last 6 months. This is in line with national guidance on safe staffing and the recommendations from the National Quality Board (2016) and Developing Workforce Safeguards (2018). The last report was in November 2021 which focused on the Establishment Reviews for Acute Wards carried out by the Chief Nurse. This report focuses in detail on Maternity, Community and Allied Health Professionals staffing as well as detailing national, local context and key workforce metrics. The report also details the Safe staffing daily and monthly processes, the critical staffing framework developed as a response to the impact of the pandemic on winter staffing levels and benchmarking data.

The peak of the Omicron wave of the Covid 19 pandemic has had a significant impact of safe staffing levels in Nursing, Midwifery and AHP workforce, with large numbers of staff self isolating or on sickness absence.

Workforce metrics
The age profile of the Nursing and Midwifery workforce shows that a large number of staff who will be eligible for retirement in the next 5-10 years and this needs to be taken into account with the workforce planning and recruitment trajectory. The vacancy position for Band 5 registered nurses continues to improve with the International Recruitment programme and successful student nurse recruitment. The Band 2 Health Care Assistants (HCAs) vacancies have remained an area of concern with growing turnover and vacancy over the last 6 months. A HCA working group and focused recruitment plan is now in place to address these issues. Sickness absence rates is the other area for concern, especially in the health care assistant workforce. The report details the impact of the pandemic on sickness absence and Covid 19 related absence and the key actions being undertaken to address this.

Governance of Safe Staffing
The report details the daily processes in place to ensure safe staffing and the addition of the on site duty Matron role starting in April that will provide additional support and scrutiny to staffing out of hours. There is monthly oversight of staffing through the monthly returns that are published on the NHS Choices website and the role of the workforce Group in providing oversight and scrutiny.
The GWH Self Assessment against the Winter 2021 Nursing and Midwifery Safer Staffing Assurance Framework was completed and present to the Performance, People, Place Committee in February 2022. A new Critical staffing framework was developed and launched to ensure compliance with this framework and a BDO UK (external auditors) audit gave an assurance rating of substantial over the design and moderate over the effectiveness of the Trust's Safe Staffing processes.

Maternity and Neonatal staffing
The report describes in detail the Maternity and Neonatal staffing and covers the requirement set out in the Maternity Incentive Scheme to submit a staffing oversight report to Trust Board every 6 months. It highlights that staffing shortfall in Maternity remains a concern and details the actions being undertaken to improve the position. The key safe Maternity metrics and 'red flags' are presented and discussed. One to one care in active labour fluctuates between 96.7 and 100% with a target to be consistently at 100%. compliance. The Midwife to Birth ratio is recommended to be one midwife to 28 births and the Trusts performance is better than this.
The provision of adequate Neonatal staffing is a core requirement for the Clinical Negligence Scheme for Trusts, the report details the British Association of Perinatal Medicine standards, the current gap against these standards and the work underway to improve compliance as well as the recruitment and retention challenges.

Community staffing
Community staffing is described in detail with the challenges of deprivation, case load management, vacancies and need for a skilled specialist workforce. There is a proactive approach being undertaken to address these complex issues with bespoke recruitment, training programmes and case load management.

Allied Health Professionals
For the first time the report covers Allied Health Professionals highlighting that although the overall workforce is large when broken down into each professional group there are fragilities within services that require short and longer term mitigations. There is some innovative workforce developments with new and creative roles being developed.

Appendix 1 details the current risks relating to nursing and Midwifery staffing.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X		X	X	X
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps					

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		x	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?		x	
Explanation of above analysis:			

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ The committee is asked to note the contents of the paper	
Accountable Lead Signature	Lisa Cheek
Date	18/05/2022

1. Introduction

The purpose of this report is provide the Trust Board with assurance that wards and departments have been safely staffed in line with the National Quality Board guidance (2014) and Developing Workforce standards (2018).

The report also highlights the significant challenges to the professions safe staffing which have occurred over the last 6 months where there has been sustained pressure and impact from the pandemic, high urgent and emergency attendances and increased children and adult mental health attendances.

Following publication of the Francis Report (2013) and the subsequent “Hard Truths” (2014) document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels.

These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift
- Provide a 6 monthly report on nurse and midwifery staffing to the Board of Directors.

This report serves as the six monthly safe staffing review at Great Western NHS Foundation Trust. The Board of Directors last received a Safe Staffing Paper in November 2021, however this is the first report that includes Allied Health Professions safe staffing information. This report gives some in depth focus to Maternity and Community nursing staffing to ensure equal visibility of the risks and challenges as the acute wards.

The purpose is to give the Board assurance that the Trust is compliant with the National Quality Board (NQB) guidelines and recommendations (2016), which are highlighted in table 1.

Table 1- NQB: Safe, Sustainable and Productive Staffing

Right Staff	Right Skills	Right Place and Time
Evidence based workforce planning	Mandatory training, development and education	Productive working and eliminating waste
Professional Judgement	Working as a multiprofessional team	Efficient deployment and flexibility
Benchmarking speciality at a national level	Recruitment and Retention	Efficient employment and minimising agency

The NHS Improvement “Developing Workforce Safeguards” (October 2018) made further recommendations to ensure that Trust report on safe staffing information including all areas, departments and clinical services.

The Guidance highlights that Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes:

- evidence-based tools
- professional judgement
- outcomes

Developing Workforce Safeguards (October 2018) goes on to state it is critical that Trust boards oversee workforce issues and grasp the detail of any risk to safe and high quality care.

It should also be noted that demonstrating sufficient staffing is one of the essential quality and safety standards required to comply with the Care Quality Commission (CQC) regulation under the Safe Domain.

2. National / Local Context

There is increasing recognition that the people who work in the NHS are its greatest asset and are key to delivering high-quality care (NHS People Plan 2021, Kings Fund 2022). However, there is also recognition of the workforce challenge, the NHS is reporting 94,000 wte vacancies of which 39,000 are in nursing and effect of the pandemic on staff resilience and wellbeing. The number of Midwifes in post has had the largest fall in numbers since 2009 (NHS Digital 2021).

The peak of the Omicron wave of the COVID 19 pandemic had a significant impact on safe staffing in the nursing, midwifery and AHP workforce over the last six months. There have been large numbers of staff self-isolating or on Covid sickness absence.

The 2022/23 NHS operational planning guidance instructs systems to accelerate work towards growing and transforming their workforce.

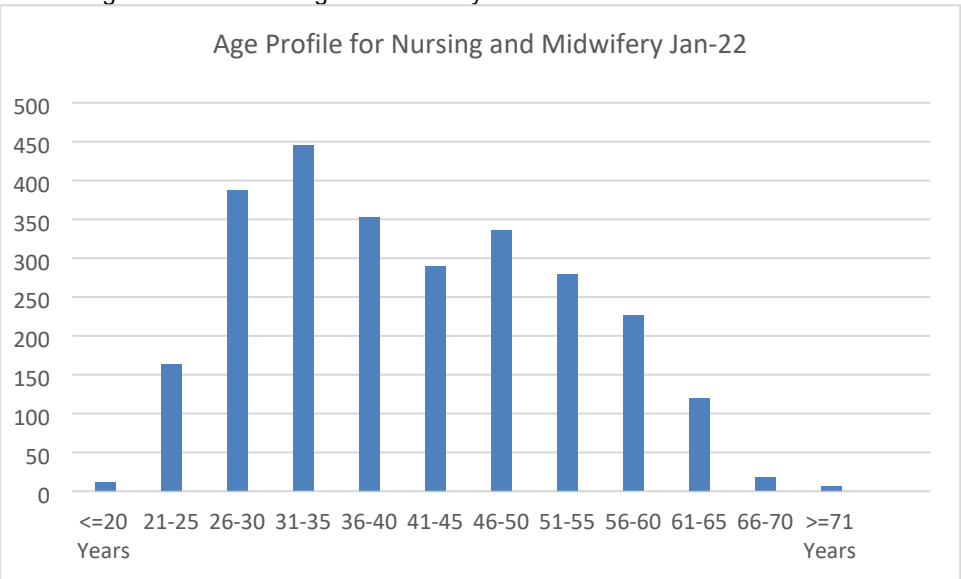
Student nursing and midwifery numbers are increasing and Trusts are supporting larger numbers of student placements, nationally from 2020: the number of student nurses rose 25 per cent compared from 2019, an increase of just over 6,000 in one year. GWH have provided 396 student nurse slots in 2021 for Oxford Brookes University, this compares to 327 in 2019 and 260 in 2020.

3. Workforce Metrics

3.1 Age Profile

Table 2 shows the age profile for Nursing and Midwifery staff, this demonstrates a high number of staff who will be eligible for retirement in the next 5 - 10 years. In addition, NHS pension arrangements are changing back to pre-pandemic arrangements, which may result in staff who have delayed retirement during the pandemic now progressing with their retirement. The age profile suggests that the high numbers of upcoming retirements in the next 5-10 years must be taken into account in current workforce plans.

Table 2 Age Profile for Nursing and Midwifery



3.2 Vacancies

Vacancies for Band 2 Health Care Assistants and Band 5 Registered Nurses are described in Table 3. Band 5 Registered Nurse vacancy continues to improve with the International Recruitment programme and successful student nurse recruitment.

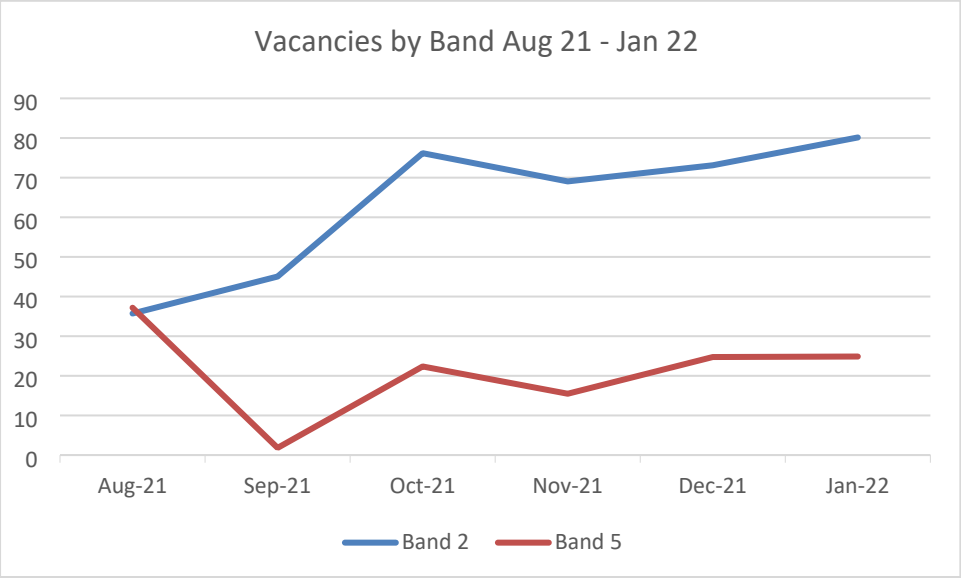
To maintain this position, more work is planned to increase recruitment activity for national / local recruitment of registered nurses. To support this a 'Return to Acute' programme is being developed alongside the existing Return to Practice course that is available.

The main areas of concern for Band 5 Registered Nurses / Midwifery vacancies are in the Emergency Department, Community Nursing and Midwifery services. There is a bespoke recruitment plan in place for each of these areas.

Band 2 Health Care Assistant Vacancies remain of concern, there has been a growing turnover and vacancy position over the last 6 months. A HCA Working Group has been set up to address these concerns and focus work on recruitment and retention. This group's work is called PRIDE- Praise, Recruitment, Induction, Development, and Education.

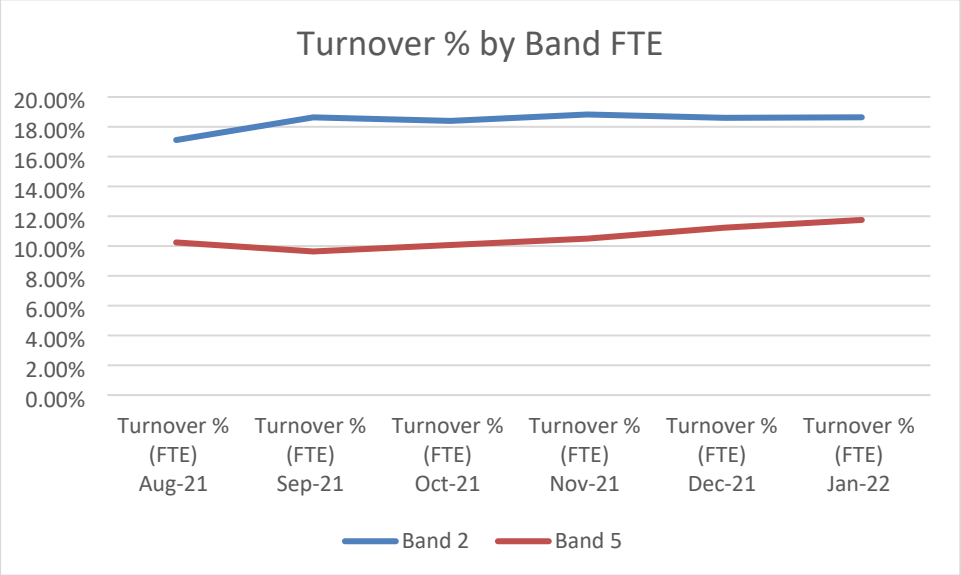
There is a weekly focus on HCA recruitment with weekly short listing, interviews, and meetings with the Divisional Directors of Nursing. These actions are ensuring that the pipeline of new starters is improving and the appointment of 3 practice educators are supporting the new HCAs into practice.

Table 3 Vacancies by Band



3.3 Retention / Turnover

Table 4 Turnover percentage by Band



The Turnover for Band 2 and Band 5 staff remains higher than the national benchmark and of concern. On Model Hospital GWH sits in the 3rd quartile (21% compared to national median of 18%), Trusts in the upper quartile sit at 16% or less.

The aim of the PRIDE work for HCAs is to reduce the HCA turnover and increase the job satisfaction and value they feel by the Trust. The Establishment Reviews in September 2021 recognised that the 1:10 HCA to patient ratio was impacting on turnover and is being taken through the prioritisation approach being used through business planning in 2022/23.

Registered Nurse band 5 turnover is also higher than the national benchmark and a similar retention work stream is being developed. There is a specific retention work stream for Internationally Recruited Nurses, known as Stay and Thrive.

3.4 Sickness absence

Table 5 Sickness absence % by band

Pay Grade	2021 / 08	2021 / 09	2021 / 10	2021 / 11	2021 / 12	2022 / 01
Band 2	9.32%	9.10%	8.30%	8.57%	10.20%	11.14%
Band 5	5.82%	6.19%	6.32%	6.39%	6.46%	8.70%

Table 5 demonstrates the sickness percentage by band for the last 6 months. It highlights that there is additional support required for the HCAs to manage health and well being.

The Ward Managers and Matrons are meeting regularly with the Human Resources team to ensure that sickness absence is managed according to policy and that staff are receiving sufficient support to return to work in a timely manner. A Nursing and Midwifery Sickness Absence Review is presented to the workforce group quarterly, this includes the top 3 reasons for absence by division, number of staff at amber and red markers and number of staff with active monitoring or case management.

The key themes for sickness absence are stress/ anxiety / depression, chest and respiratory and musculoskeletal problems.

Covid related absence has had a significant impact on staffing over the last 6 months. Table 6 describes this impact.

Table 6 Covid related absence for Nursing and Midwifery by Band

Sickness Covid-19 **Registered Nursing and Midwifery**

Month	Absence FTE %
2021/08	0.96%
2021/09	0.70%
2021/10	0.92%
2021/11	0.63%
2021/12	1.36%
2022/01	3.43%

Sickness Covid-19 **Unregistered Nursing and Midwifery**

Month	Absence FTE %
2021/08	0.67%
2021/09	1.00%
2021/10	1.37%
2021/11	0.79%
2021/12	1.83%
2022/01	4.04%

Isolation **Registered Nursing and Midwifery**

Month	Absence FTE %
2021/08	0.70%
2021/09	0.57%
2021/10	0.77%
2021/11	0.51%
2021/12	0.29%
2022/01	0.03%

Isolation **Unregistered Nursing and Midwifery**

Month	Absence FTE %
2021/08	1.08%
2021/09	0.72%
2021/10	1.18%
2021/11	0.86%
2021/12	0.57%
2022/01	0.07%

Covid absence management has changed according to national guidance and there has been good collaborative working to ensure a consistent approach across BSW.

There is robust daily reporting and visibility of the impact of the Covid related absence which helps to ensure staff are managed according the guidance.

4. Governance of safe staffing

Nursing and Midwifery staffing is monitored through monthly, weekly and daily actions that are described below.

4.1 Nursing, Midwifery and AHP Workforce Group

This group was set up by the Chief Nurse as part of the new Nursing, Midwifery and AHP communication / meeting structure. It provides governance and forward planning to the workforce challenges and is well attended by the Divisional Directors of Nursing and senior representatives from the Academy, HR, Finance and Workforce Intelligence.

4.2 HCA Working Group

This group reports into the Nursing, Midwifery and AHP Workforce Group and is chaired by one of the Deputy Chief Nurses and includes representation from the Academy, HR and Matrons. The work streams are Praise, Recruitment, Induction, Development, Education.

4.3 Advanced Practice

The last six months has seen considerable improvements in the governance for Advanced Practice. The Advanced Practice policy has been approved and the formation of an

Advanced Practice Assurance Group has been set up so there is good governance around all new Advanced Practice roles. An Advanced Practice Readiness Checklist and gap analysis has been completed and submitted to the South West Faculty of Advancing Practice.

There is also a Specialist and Advanced Practitioners Steering Group where best practice is shared and discussed.

4.4 Daily Safe Staffing process

The Trust has a staffing meeting chaired by a senior nurse three times a day Monday to Friday. The staffing meeting refers to the Safe Care Live 'wheel' in Health Roster. This provides an accurate staffing and acuity / dependency position for all inpatient areas across the Trust, allowing for areas at risk to be easily identified and staff to be moved appropriately. Weekend and out of hours safe staffing is currently managed by the band 7 Ward Manager and site managers. Additional support and scrutiny will be provided by the duty Matron when this starts in April 2022.

4.5 Monthly Safe Staffing returns

From April 2014, it became a national requirement for all hospitals to publish information regarding staffing levels on each ward each month. The published information lists the number of nurses, midwifes and care staff (planned and actual) working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

The results are available through the NHS Choices website, and daily on boards for patients and visitors at every ward and a summary is included in the monthly safe staffing slide as part of the integrated performance report. It is noted that the fill rate percentage in several areas have been reported as less than 80% (the national standard), especially in Maternity and for the Health Care Assistants on acute wards. These areas have been reviewed by the Divisional Directors of Nursing and mitigations on daily basis through the safe staffing meetings.

4.6 Assurance Framework

The GWH Self Assessment against the Winter 2021 Preparedness: Nursing and Midwifery Safer Staffing / NHS E/I Assurance Framework was completed and a gap analysis completed. This was presented to the PPP Committee in January 2022 and provided assurance that we were compliant with the recommended standards for safe staffing over Winter.

4.7 Critical Staffing framework

The safe staffing framework was modified to include 'critical staffing' as recommended in the Assurance Framework.

The Trust safe staffing status is reported thorough the staffing meetings to the Site operational meetings.

In January there were 18 days described as Critical staffing, mitigation included deployment of non clinical facing staff, use of volunteers and ward buddies.

Picture 1 Critical Staffing Framework

Level	Descriptor	Description
Low Risk	Business as normal	Normal staffing ratios apply No red flags Acuity and dependency within expected parameters
Heightened Risk	Patient safety and quality compromised / impact on service delivery	RN:patient ratio 1:11-14 Red flags identified Acuity and dependency elevated above expected for area Staffing escalation process mitigating risk
Significant risk	Significant clinical risk and inability to deliver all services Possible impact on quality of care with minimal impact on safety	RN:patient ratio 1:14-1:16 Red flags identified Acuity and dependency elevated above expected for area Red flags raised and actions taken to mitigate including use of other professionals and mutual aid. Staffing escalation process mitigating risk
High Risk	Significant clinical risk and inability to deliver all services Impact on quality of care expected and safety at risk	RN or HCA :patient ratio 1:16-1:19 Acuity and dependency elevated above expected for area Red flags raised and unable to mitigate
Critical / Highest Risk	Significant clinical risk and inability to deliver all services Impact on quality of care and safety at risk	RN or HCA :patient ratio >1:20 Red flags have been raised and unable to be mitigated. Acuity and dependency elevated above expected for area *In extremis options*

4.8 Care Hours Per Patient Day

CHPPD was developed, tested and adopted by the NHS to provide a single consistent way of recording and reporting deployment of staff on inpatient wards/units.

The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone. The data gives a picture of how staff are deployed and how productively they are used. It is possible to compare a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. If a wide variation between similar wards is found it is possible to drill down and explore this in more detail.

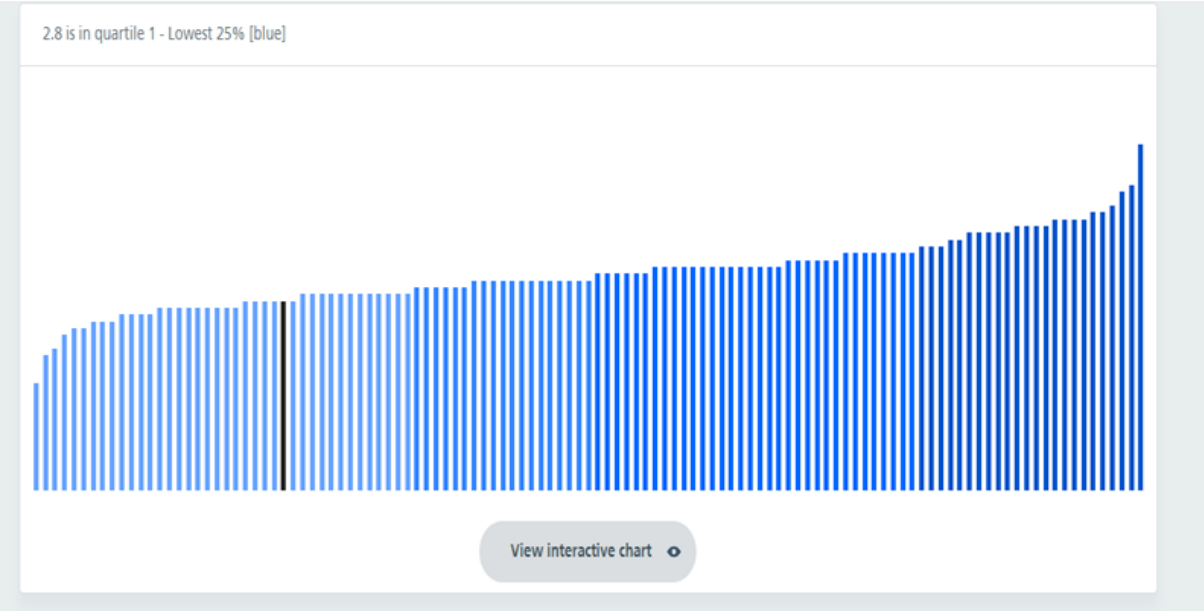
The CHPPD data is reviewed monthly comparing the required and actual CHPPD and quarterly using the benchmarking in Model Hospital.

4.9 Model Hospital

The Model Health System is a digital tool provided by NHSE/I to support the NHS improve productivity, quality and efficiency. It provides national benchmarking on productivity and quality. CHPPD is available as a benchmark against other Trusts, it is produced from actual whole time equivalents worked ie not funded establishments. This is reviewed monthly by the Deputy Chief Nurse as part of the safe staffing report.

The Trust has a value of 7.8 for Total Nursing and Midwifery staff, compared with the national median of 8.3. HCAs benchmark in the lowest quartile, 2.8 against a national median of 3.1 (RUH benchmark at 3.3).

Previous months have demonstrated that the Trust benchmarks below Royal United Hospitals Bath and Salisbury Foundation Trust. However the data for November 2021 shows the Trust is a more favourable position, this it testament to the success of our recruitment programme and the different rates of self isolation and sickness absence in other Trusts.
Picture 2 HCA Care Hours Per Patient Day Model Hospital Data Nov 2021



4.10 Roster Metrics

Roster metrics are reviewed at the monthly Nursing, Midwifery and AHP Workforce Committee. There is continual focus on ensuring compliance with key performance metrics associated with good roster management such as annual leave and roster approval. It is reassuring that the majority of rosters are being managed within these parameters.

4.11 Internal Audit Report Safer Staffing

BDO were commissioned to carry out an internal audit on Safer Staffing in February 2022. The report concluded that the Trust has a good system of controls in place, a clearly defined roster timetable is available to staff, any unfilled duties were approved at the time of roster sign off. Workforce committee meetings were held on a monthly basis, with high level data being provided to the Trust board on a regular basis. There are some improvements to be made to ensure that policies are kept up to date, rosters are approved in accordance with the roster timetable and that full data is provided on a regular basis to the workforce committee and that the associated action plan is utilised effectively. The auditors gave an assurance rating of substantial over the design and moderate over the effectiveness of controls. An action plan on the recommendations was presented to the Nursing, Midwifery and AHP workforce group.

5. Maternity staffing

5.1 National / regional context

This paper covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board on a six monthly basis , Maternity Incentive Scheme year 4.

Birthrate Plus (BR+) is a nationally recognised tool to calculate Midwifery staffing levels. The methodology underpinning the tool is the total midwifery time required to care for women on a 1:1 basis, throughout established labour.

The principles underpinning BR+ methodology is consistent with the recommendations in the NICE Safe staffing guidelines for Maternity settings and have been endorsed by the Royal College of Midwives and the Royal College of Obstetrics and Gynaecologists.

Trusts are expected to commission a BR+ report every 2-3 years, GWH's report in 2019 identified a registered midwife gap of 9.8wte. Funding has been received from NHSE/I in response to the Ockenden Report (2020) for 5.81 wte of this gap which has been recruited to.

GWH latest BR+ acuity tool licence has been funded by the Local Maternity and Neonatal System (LMNS) this is not ongoing funding. A BR+ review was undertaken in January 2022; the results are expected in April 2022.

It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has been under significant pressure due to increasing demand, rising vacancies, high maternity leave and high numbers of staff self-isolating due to Covid-19 or sickness absence.

The Trust is monitoring the impact of actions taken when in escalation such as redirecting staff from the community teams to the labour ward for short periods. Other actions such as ceasing home birth for short periods are only implemented in consultation with the LMNS and Trust Executive approval. An improved escalation process has been put in place to ensure that both the Trust and LMNS are aware when there have been changes to service delivery due to acuity.

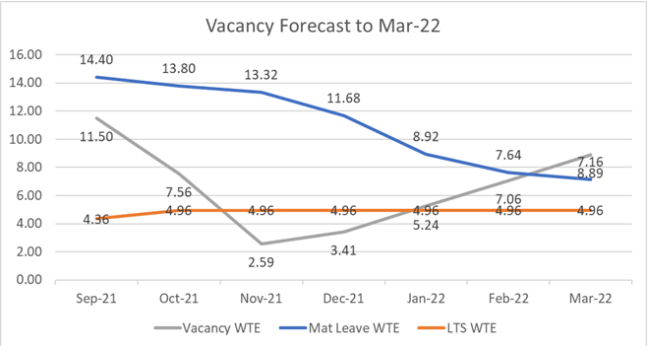
5.2 Skill mix review and on call planning

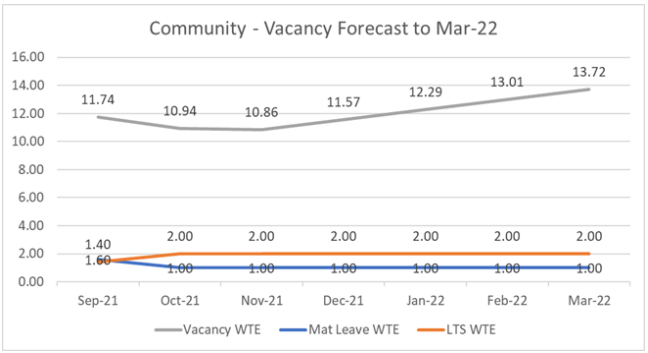
The Matron team are undertaking a skill mix review planned to report in April 2022 to identify new roles that could be used to support clinicians, considering the challenges to recruit trained midwives.

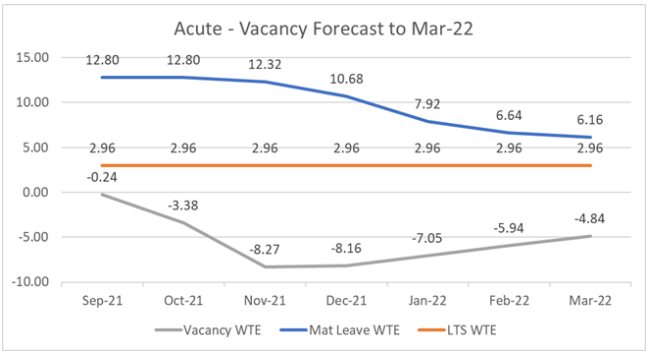
There will be a staff consultation launched in March 2022 to scope a unit on call process to enable the staffing model to be more flexible at times of high acuity. This system will reduce the impact on calling the community staff to support Delivery Suite, freeing them to support the provision of home birth, and to provide on call support to the Birth Centre. This will enable the Birth Centre to remain open, supporting the choice of place of birth and reduce activity on the Delivery Suite. There are similar on call consultations happening within the LMNS.

5.3 Current midwifery staffing position / vacancies / maternity leave / sickness absence

Midwifery vacancy position in February 2022 is 10.02wte, this includes the additional 5.81wte posts funded through Ockenden to help meet the BR+ requirement, further requirement is part of business planning for this year.







The three graphs show the vacancy forecast including maternity leave within the acute and community midwifery teams. The impact of Maternity leave can be seen clearly and should be considered when thinking of pressures on our staff and the service that we provide vs the actual number of vacancies, with a total of 13.76 WTE on maternity leave.

The below table illustrates the level of staff turnover across departments, on a monthly basis. In the past year, across all departments except from Hazel and Delivery, there has been a substantial increase in turnover volume by %.

Voluntary Turnover %													
Department	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Ante-Natal Screening - J65919	18.18%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%	22.22%	22.22%	18.18%	18.18%	0.00%
Birthing Centre - J65921	17.14%	17.14%	16.67%	28.57%	26.09%	25.00%	27.27%	31.58%	31.58%	30.00%	21.05%	11.11%	0.00%
Community Midwifery - J65918	8.40%	10.26%	8.55%	8.55%	8.70%	12.39%	12.61%	18.02%	18.69%	20.18%	22.02%	22.43%	19.64%
Day Assessment Unit - J65910	0.00%	4.44%	4.76%	5.00%	5.00%	5.00%	4.88%	5.26%	5.13%	4.65%	4.65%	4.55%	4.55%
Hazel & Delivery Staff - J65914	8.48%	8.51%	7.72%	7.12%	8.28%	9.80%	10.56%	8.47%	10.56%	11.22%	12.42%	13.82%	12.62%
Specialist Midwives - J65920	6.25%	6.06%	6.25%	6.67%	6.67%	6.90%	6.67%	6.67%	6.45%	6.67%	14.29%	6.90%	6.45%

The turnover rate is further impacted on by the sickness and retirement rates as shown in the two tables below.

Sickness rate as of Jan 2022				
Department	**Professional Group**	**ST**	**LT**	**% Sick**
Ante-Natal Screening - J65919	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Community Midwifery - J65918	Registered Nursing and Midwifery	1.68%	1.87%	3.55%
Continuity of Carer - Midwives - J65922	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Day Assessment Unit - J65910	Registered Nursing and Midwifery	4.81%	0.00%	4.81%
Hazel & Delivery Staff - J65914	Registered Nursing and Midwifery	5.39%	1.04%	6.43%
Specialist Midwives - J65920	Registered Nursing and Midwifery	0.23%	4.52%	4.75%

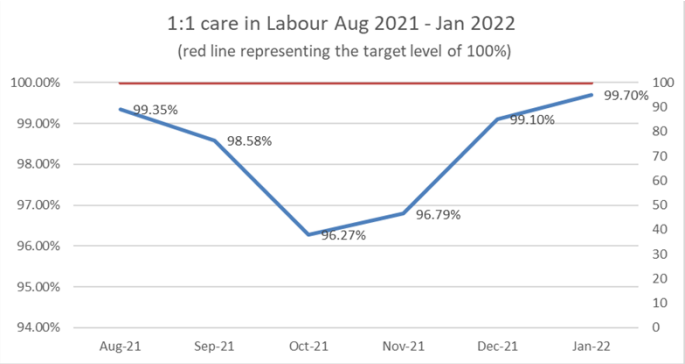
Midwives 55 or over who could retire in March 2022			
Department	**Total headcount**	**55 or over**	**% who could retire in March 2022**
Community Midwifery	48	14	29.5
Day Assessment Unit	18	8	44.4
Hazel and Delivery Staff	109	11	10.1
Specialist Midwives	14	7	50.0
Total	189	40	21.2

These figures are in the line with the current NHS Pension arrangements.

5.4 One-to-one care in Labour and Midwife to ratio

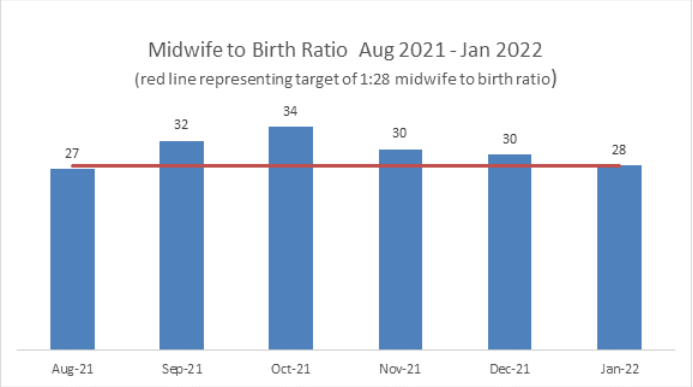
All women in active labour receive one-to-one (1:1) midwifery care. The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the graph below demonstrates that it fluctuates between 96.27% and 100% compliance over the 6-month period. The Team continue to work on ways to achieve 100% 1:1 care in labour within the current staffing vacancy factor.

The availability of 24-hour scrub nurses from November 2021 has supported the midwifery staff to demonstrate improved percentages of 1:1 care in labour.



The Maternity Service monitors and reports its Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer Childbirth (2007). The midwife to birth ratio is calculated using the planned establishment rather than the actual staffing numbers.

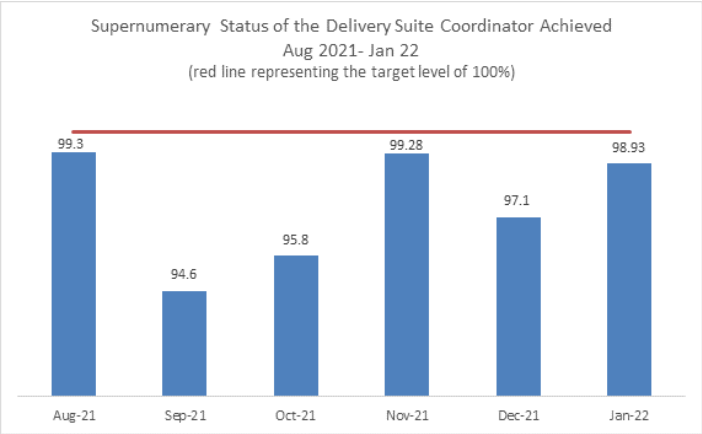
The highest number of births occurred in October 2021 which is reflected in the midwife to birth ratio below.



Midwifery workforce planning is supported by the year four Maternity Incentive Scheme safety action 5, to reach compliance there is a need for investment in maternity staffing.

5.5 Supernumery status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Over the six-month period August 21 – Jan 22 a compliance rate of 89% was achieved. The focus is on achieving 100% compliance and identifying measures to achieve this with the team within the current staffing vacancy factor.



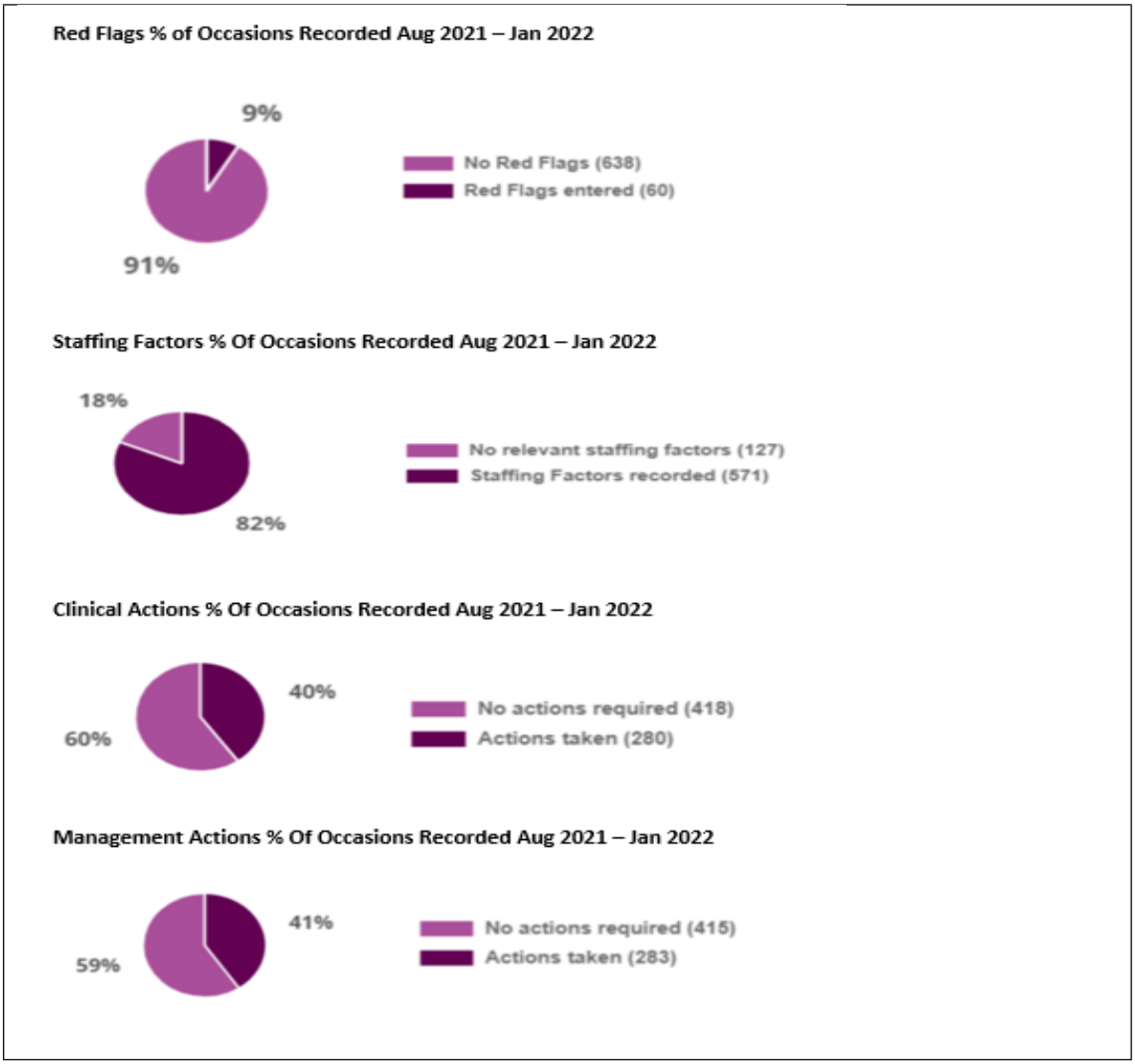
5.6 Red Flags

The Maternity unit uses a 'Red Flag' indicator for identifying critically low staffed shifts. It has identified 10 red flags which trigger escalation and follows a procedure for mitigation. This takes an overview of staffing across Maternity and relocates staff to areas of need as required, as well as outlining both clinical and management action.

The 10 red flags are as follows:

- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes for suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example diabetes medication)
- Delay of more than 30 minutes in providing pain relief
- Delay of more than 30 minutes between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delay recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
- Supernumerary status of Delivery Suite coordinator not achieved.

Red Flags as percentages:



The analysis of the data shows that staffing shortfall was a concerning feature. Several initiatives have been put in place to strengthen midwifery staffing as part of the recruitment and retention plan set out below.

5.7 Recruitment and retention

There is a recruitment and retention Divisional group who meet regularly, with a plan in place including:

- Recruitment campaign with a plan to consider value-based interviewing
- Senior staff attending university career presentations
- Retention lead midwife and senior leaders engaging with students from day one as future employees
- Scheduled meet and greets with divisional staff, new starters and students
- Review and refresh of preceptorship package
- Blended learning programme with University of West England
- Working with Universities to increase student midwife places
- Return to practice programme
- Successful International recruitment of Midwives bid (collaborative bid across BSW)
- Health and well-being programme

- Plans to discuss Divisional financial incentives- welcome bonus, refer a friend scheme, NMC fees year one to be paid
- Apprenticeship and Nurse Associate model to 'grow our own'.

There is a planned skill mix review between March and May 2022 of maternity staffing. This will be undertaken to enable the development of support roles for administration and patient facing support, releasing midwives to undertake roles and provide care that only a midwife can.

Funding of £133k has been secured for Maternity Support Worker development, to include increasing recruitment and retention activities, supporting newly recruited with enhanced induction training, funding to support maternity workforce growth.
Maternity Support Worker funding is short-term initially available until 31 Mar 2022.

Other action that has been taken/considered to overcome recruitment and/or retention issues:

- Working closely with the University of the West of England to promote the blended midwifery programme.
- Staff already have flexible working opportunities, CPD has increased for development and we continue to work with the recruitment team on reviewing alternative recruitment options if required.
- We recently won a national £50k bid. The funding from has been used to recruit a Retention Lead Midwife to continue growth, education, and development of our team. This will aid in some aspects of workforce retention but will do little to delay retirement.
- We submitted a collaborative bid with Salisbury and Gloucester Trusts for 8 international midwives at GWH. We were successful to obtain 5. Although this will help with staffing levels it will not tackle the retention or withdrawal of midwives.
- In August 2021 we re-started the Maternity Incentive Scheme for bands 5, 6 and 7. This is reviewed monthly and involves payment of £80 for a 12-hour shift and £40 for a short shift up to 7.5 hours. Since the scheme began, this has significant cost attached to it, and a saving of £160,000 per year could be made, in the longer term, if the R&R payments are approved for new starters and vacancies could be reduced.
- The Incentive Scheme will be reviewed in line with this RRP 6 months post-RRP implementation to see if it is feasible to reduce/withdraw the Maternity Incentive scheme. This would reduce the cost pressure involved with the RRP as we would make the associated savings.

5.8 Continuity of carer

This model to provide a named midwife for a woman through the perinatal pathway is a current key National deliverable for the Division in 2022/23. The Maternity Service is currently supporting 12% of women in two Continuity of Care teams, teams are focussed in areas of deprivation. The introduction of Continuity of Carer teams has impacted on the current establishment, reducing staff in some areas, whilst not being funded in budget for the increase in staffing required to deliver the model. Staffing and skill mix reviews are ongoing to address this whilst the teams are being embedded in practice.

Due to the COVID-19 pandemic development of the Continuity of Carer model has been paused nationally, GWH has successfully maintained the two teams during this time, this has not been mirrored in other Trusts within the LMNS. The regional chief Midwives are now re-launching this model of care with planning and support meetings re-starting in March 2022 to support providers with the model of care and full implementation (Delivering midwifery continuity of carer at full scale (2021)). The Ockenden report published on March

30th 2022 and advises reviewing the Continuity of Carer model to ensure the future model of care provision is supported by safe staffing.

The LMNS funding for the Better Births midwife ceases in March 2022 and will be a cost pressure within the Division, this role is key to supporting Continuity of Carer, transformation and change to the model of care. The Division is extending the contract for 6 months whilst a full review of staffing is undertaken. The Trust are committed to maintain the two current MCoC teams, however there is a level of caution to pushing forward to a full continuity of care model, due to staff reluctance to work in this model, leading to staff retiring. The Division is awaiting the Birthrate + report to inform the level of staffing required to fully implement the MCoC.

5.9 Midwifery safeguarding

Safeguarding concerns have significantly increased during the pandemic and this has not been accounted for in the BR+ model. This has been added to the risk register and plans are in progress to mitigate this risk.

Covid-19 has impacted on safeguarding supervision for staff and is currently at 0% compliance within the acute setting, and . There has also been an impact on safeguarding training at level 2/3, this is a key area of focus for the training lead midwife. The safeguarding lead has a recovery plan in place, the development of safeguarding champions, and group supervision has recommenced. The safeguarding supervision is on the Divisional risk register.

6. Neonatal staffing

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for are those who require short term intensive care (ITU), up to 48 hours, high dependency (HDU) care and low dependency care. The unit comprises of 8 HDU/ITU cots plus 10 low dependency cots. Neonatal units have an unpredictable and fluctuating activity level, and so should aim to operate at 80% capacity to allow for times of high acuity. National standards for neonatal nursing care, and medical provision have been developed to safeguard patient safety, and we have a duty to comply with these standards. The neonatal unit at GWH works within the South West Neonatal Network to provide the right level of high-quality care to each baby as close to home as possible.

The provision of adequate neonatal nursing staffing, including neonatal transitional care services, are core requirements for the CNST (Clinical Negligence Scheme for Trusts) Maternity Incentive Scheme.

In 2010, the British Association of Perinatal Medicine published the third edition of BAPM-Service Standards for Hospitals providing Neonatal Care.

In 2017, BAPM published Neonatal Transitional Care a Framework for Practice, these documents inform the NHS England Service Specification for Neonatal Critical Care Services, which states the **minimum** nurse to patient staffing ratios based on an average unit occupancy of 80% for neonatal services should be:

- 1:1 for Intensive Care (1 nurse to 1 patient, with no other responsibilities for that nurse)
- 1:2 for High Dependency
- 1:4 for Special Care.

- 1:4 for Transitional Care

These care levels are defined in specific detail by nationally set criteria. To meet BAPM/NHSE standards staffing levels on each shift should be:

- 2 nurses for 2 Intensive Care cots
- 2 nurses for 4 High Dependency cots
- 3 nurses for 12 Special Care cots
- 1.5 nurses for 6 Transitional Care cots
- 1 Supernumerary Shift coordinator on each shift

This means a target of 9.5 wte staff per nursing shift.

Currently only 3.54 wte Band 5 staff nurses hold the qualified in speciality (QIS) course with 2 wte currently undertaking the study programme. The requirement is for there to be 1 QIS nurse to 4 patients.

Over the last 5 years 29 skilled neonatal nurses have left the GWH workforce, with only 7 of the 29 leaving due to retirement, pregnancy, ill health, or the end of a fixed term contract. Staff have informed the leadership team that they have left due to poor staffing levels that impact on care delivery and staff morale.

Turnover Rates			
Department	Average Head Count	All leavers	All Turnover
SCBU- J65931	41	9	21.95%

The loss of nursing staff qualified in speciality (QiS) is particularly significant as it results in a significant loss of knowledge, skills and expertise that decreases patient safety.

Sickness rates also impact on the staffing shortages.

Sickness Rates			
Department	Short Term Sickness	Long term Sickness	Total % Sickness
SCBU- J65931	3.17%	3.26%	6.44%

Recruitment of nursing staff is underway following a successful business case, with the aim of staffing the neonatal unit to BAPM safe staffing standards. This will mean there will be 7 wte nurses per shift. This will reach BAPM standards following a operational delivery network (ODN) review of staffing against acuity.

Funding has been secured from the Neonatal network to fund some of these neonatal nurse roles to enable staffing to be at British Association of Perinatal Medicine (BAPM) standards. The recurring funding of £143,983 will support the development of the workforce and enable the Division to utilise internal funding for further development of the Advanced Neonatal practitioner role (ANNPs). Developing the ANNP work force would strengthen the clinical care delivered on the neonatal unit and allow enhanced service development work. These roles will also support career development opportunities within the workforce.

Funding has been identified to recruit to a 0.64 wte Practice Development Nurse to support the neonatal workforce. Creation of a training pathway for existing experienced nursing staff would increase retention and lead to a more stable, and skilled workforce. Recruitment to the LNU remains challenging and support from focussed Trust campaigns would be beneficial to attracting staff.

7.0 Community Nurse Staffing

7.1 Overview

Community Nursing encompasses several elements of community services such as the Locality Community Nursing Teams, Urgent Community Response Team, Community Intermediate Care Team, the Virtual Ward and a range of specialist teams. However, for the purpose of this paper it is the staffing levels within the Community Locality teams that provide planned care for patients in their own homes that will be addressed.

Currently Community Nursing Locality teams have 115 wte staff in post and 19 wte vacancies (vacancy rate of 17.83%) and is one of the largest users of bank and agency staff in the organisation. Many of these vacant posts are relatively new posts and have been created as a result of Hospital Discharge Funding to improve discharge from the acute wards. The developments of new service delivery models (Virtual Ward and Urgent Community Response) have also been recruited substantially in the last 6 months. There is a robust recruitment and retention plan in place, with weekly meetings to ensure the actions are being driven. Actions include refreshed advertising, rotations and working with the universities to attract newly qualified nurses into community roles. the development of career pathways for all staff from a band 3 progressing to become a Nurse Associate to a band 7 nurse on the Advanced Clinical Practitioner pathway is key to attraction and retention.

The Queen's Nursing Institute in 2021 (QNI) recommended that caseloads should be no larger than 150 patients and that a registered nurse should have no more than 9-10 visits per day nurse as both factors are seen as tipping points for deferral of visits. The QNI, (2021) refers to the "unremitting and unsustainable demand" in the community and regular deferral of visits will impact on the quality of care and the patient experience.

The GWH Community Nursing teams work hard to avoid deferral of patients by swapping patients around and using specialist teams when required. If patients are deferred this is done by a senior nurse based on risk and the number / impact is reported through the Trust's safe staffing meeting.

More robust data is being collated on the average number of visits per day and average case load per District Nurse to ensure that we are aligned with these standards. This will be presented more fully in the next safe staffing paper. The Trust is also undergoing bench marking with similar community services to share and learn.

7.2 Summary of challenges

7.2.1 Deprivation

Staffing models for community nursing are often based on available budgets or a ratio of the number of District Nurses per 1000 head of population however, if the population in question is in an area of high level of deprivation, health inequalities and chronic ill health the ratio needs to be adapted accordingly. This the case in some areas of Swindon and staff are distributed according to deprivation and the associated complexities of health care.

The current GWH model is that a qualified District Nurse has oversight of each caseload and manages a team of Staff Nurses, Nurse Associates and Health Care Assistants. There are several caseloads within each of the four localities which are overseen by a Locality Team Leader. The number of staff is determined by the level of deprivation in the area, the number of patients on the caseload and the geographical location / travelling time.

The current vacancies are six qualified District Nurses, ten Community Staff Nurses and three Nurse Associates. If fully staffed this establishment would meet the current demand and the recruitment plan and trajectory should help to address this gap in the next few months.

7.2.2 Training of District Nurses

Community Nurses require a Specialist Practice Qualification (SPQ) to become a District Nurse. This is a Degree or Masters level qualification that supports the skills required to manage a caseload. Good caseload management requires clinical skills to manage workload, patient experience and quality of care as well as knowledge and understanding of acuity, length of visits, competency of staff and the geographical area.

There are 8 places a year on the SPQ course to support community nurses development and this is supporting a pipeline of District Nurses for the Trust.

7.2.3 Impact of the pandemic

There has been an 11% increase in referrals over the 2 years of the pandemic and the associated lock down / isolation within vulnerable communities has led to significant decompensation and complexity. There are currently 1400 patients on the caseload, 200 more than pre pandemic and an increase in daily visits and care plans. Patients are remaining longer on the caseload or returning to the case load with greater frequency. Further work is planned to look at demand and establishments, including using the national community nursing acuity and dependency tool.

7.1.4 Sickness management

Long term sickness rate is currently 5% and short term sickness rate of 3.73%, the Matrons are working with the HR Business Partners to ensure that are staff are being managed according to the policy and accessing the Health and Well Services appropriately.

8. Allied Health Professionals

8.1 Workforce Summary

The Trusts Allied Health Professions (AHP) workforce consists of 9 of the 14 AHP groups (Dieticians, Diagnostic Radiographers, Occupational Therapists, Operating Department Practitioners, Optometrists, Physiotherapists, Paramedics, Podiatrists and Speech and Language Therapists), working across all Divisions within the Trust and in all settings, including Primary, Secondary and Community Care.

Although each profession has independent and nationally recognised methods by which to assess and benchmark the quality, effectiveness, and therefore safety of staffing levels, it is nationally recognised that a great deal of variance exists within the AHP workforce at individual Trust level. This is due to the differing make-up of clinical services at Trust level, which the AHP workforce exists within and help deliver. This makes assessing each profession’s workforce within the organisation and benchmarking against other similar organisations complex. The Trust currently lacks consistent and sufficiently detailed oversight of this and collaborative work is underway across the three divisions to analyse and provide a detailed understanding across the AHP groups, which will be reported through the divisions and into the Trust’s Nursing, AHP and Midwifery Workforce Group and in future

Safer Staffing Reviews. This reporting will align with Nursing and Midwifery and benchmark data against the professional recommendations of each AHP group and support the BSW AHP system analysis.

8.2 Key areas of concern

Although on mass the AHP workforce is large and the WTE is in line with system partners (GWH 404 WTE, RUH 465 WTE, SFT 303) WTE, when broken down into each professional group there are fragilities within services that require short term mitigation and longer-term actions to ensure workforce effectiveness. The workforce challenges faced by the Trust are also recognised and reflected at system, regional and national levels. The initiatives that commenced in October 2021 to address these are as follows:

- Workforce & finance data and intelligence analysis
- Retention and support for students and newly qualified workforce
- AHP to Return to Practice (RTP) programme
- AHP international recruitment programme
- AHP Apprenticeship growth
- Implementation of the AHP Support Workers Competency, Education and Career Development Framework
- AHP research programme

As these initiatives are explored, understood, and implemented they will support the Trust to understand and develop it's AHP workforce in a strategic, coordinated and evidenced manner.

8.3 New roles in the AHP Workforce

As part of the Trust's AHP workforce development the creation of new roles will continue to grow in order to realise the full potential AHP's can offer the organisation and the population we serve. Examples already exist within the Trust's AHP workforce that demonstrate the potential difference AHP's can make to address service needs in a more efficient and effective manner and consequently help address nursing, midwifery, and medical workforce challenges. Developing these new roles by learning from those already established will also enable our AHP's to offer a more coherent and competitive career progression within the organisation, thus helping improve recruitment and retention within the AHP workforce. Examples of these include Advanced Clinical Practitioners (ACP) and trainee ACP's in ED (paramedic and physiotherapy) undertaking medical roles to release ED medical time, First Contact Practitioners (FCP's) in primary care releasing GP time, Consultant Podiatric Surgeon's leading ankle and foot surgery, the Orthoptists role in retinopathy of prematurity screening (setting national precedent) and ultrasound scanning. Alongside these advanced practice roles, research opportunities are being developed to enable our AHP's to become more evidence based in clinical practice.

9. Trust Risk Register

As per NQB guidance, the Nursing and Midwifery staffing risks are on the Trust Risk Register. These risks will be reviewed monthly at the Nursing, Midwifery and AHP Workforce Group going forward. The risks are in appendix 1.

10. Update on Establishment Reviews

The establishment reviews have been written up and recommendations made for business planning. The yearly establishment reviews by the Chief Nurse are planned for October / November going forward to align with the business planning cycle.

11. Conclusion

Reviewing and aligning nursing and midwifery staffing against the care needs of our patients remains a high priority across the Trust. The last 6 months have been an extraordinarily challenging time due to the pandemic. There has been an increase in absence due to sickness for both non Covid and Covid related reasons coupled with an increase in turnover and demand for the use of temporary staff. The Chief Nurse and Divisional Teams have continued to review and monitor both short and long term staffing, skill mix and establishments, in line the principles of safe staffing in line with speciality specific guidance/recommendations the 'Developing Workforce Safeguards guidance' and the National COVID staffing recommendations.

There is detailed monthly reporting which provides fill rates by wards, red flag reporting and detailed analysis and review of all the safe staffing incidents reported, along with triangulation of impact on quality.

The committee can be assured that the Trust has had sufficient processes and oversight of its staffing arrangements in place to manage safe nursing and midwifery staffing levels. However, the impact of the pandemic on ensuring safe staffing over the past 12 months has presented significant challenge across all staff groups. It is anticipated that the next 6 months will continue with this level of demand on safe staffing along with the requirement to open extra capacity to manage the number of emergency patients and to increase the elective recovery programme. The next 6 monthly report will also include detailed staffing reports for theatres, Intensive Care out patients and day case staffing.

12. Recommendations

Improved reporting of the impact of staffing on patient quality outcomes at ward level which will continue to be monitored through the monthly Nursing, Midwifery and AHP Committee.

Focused work in required over the next six months to enable skills development, recruitment and retention of the existing workforce

Support for Advanced Practice and band 2 -5 pathway should be supported and developed further.

The development of a Nursing and Midwifery Workforce strategy will help focus on the development of the workforce over the next 2-5 years.

Subject to business planning the recommendations of the Establishment Reviews should be considered to meet national standards around skill mix.

Appendix 2 Staffing Risks relating to Nursing and Midwifery on Risk Register

Numbe	Division	Department	Description	Action Details	Progress	Risk Ra	Review Date
2313	Integrated & Community Care	Community Services Mgt SCHS	clinical knowledge and competencies underpinning the care and treatment that they provide to patients in their own homes.	list of unregistered B4 and B3 staff to identify areas of training required as per	practice educator to build a programme of	6	09/04/2022
2395	Integrated & Community Care	Divisionwide	reviewed by a registered nurse every 3rd visit. Due to the excessive demand and capacity on our workforce this is not always possible	SCHS has been lucky to obtain funding for 8 DNSPQ for the next academic year.	spreadsheet has been approved by the DDON,	9	28/06/2022
2164	Integrated & Community Care	Community Services Mgt SCHS	The night community nursing service needs to be more resilient to unexpected staff sickness as this is a difficult service to source experienced staff with community nursing skills and experience especially working alone during the hours of 10pm and 8am	to ensure resilience of the service in order to continue service delivery to patients in their own homes during the out of hours period	1.9 WTE staff have been appointed to both night and OOH posts, there will need to be a period	12	23/06/2022
2420	Planned Care	Childrens Unit	There is a risk that children with challenging / mental health behaviour will have a prolonged stay within the Children's Unit because of the lack of specialist beds / placements resulting in an extended stay and lack of specialist interventions. This will impact	Monitor situation. Complete incident form when incidents happen. Await what esclation to Trust Board enatails.	This action is more of a control. Now listed within control section.	15	14/04/2022
2475	Planned Care	ITU/HDU	critical inter-hospital transfers. CAUSE: lack of competent, available staff to facilitate. CONSEQUENCE: delay in time critical escalation of care / inter-hospital transfer,	Disseminate information about the new transfer service Retrieve.	disseminated by RP and RT Date Entered :	12	07/03/2022
2648	Unscheduled Care	Acute Cardiac Unit	There is a risk to the care provided to the acuity level 2 patients due to the current staffing model.	To submit skill mix review for approval - uplift in RNs at night not approved	done 24th September, awaiting outcome.	9	18/05/2022
2692	Unscheduled Care	Gastroenterology	Hepatology Nurse Specialist role. Following increased numbers of referrals into hepatology the CNS role has expanded rapidly. At	Hepatology business case is required to develop the service	HOS, action target date extended	9	24/04/2022
2082	Integrated & Community Care	Community Services Mgt SCHS	Community Nurses and therefore not all staff have the full compliment of clinical skills and competencies. This has resulted in	review to include those staff who still require training in bowel care, syringe	continues to develop a competency framework	9	23/06/2022
1956	Planned Care	Local Neonatal Unit (LNU)	Specification for Neonatal Critical Care Cause:Nursing staff model not previously benchmarked against	Recruitment for maternity leave cover to be converted to substantive posts.		8	24/04/2022
2807	Unscheduled Care	A & E/ED	have 2 RSCN's on duty each shift (in line with the national standard)	incorporates RSCN's regularly - Review advertising / promotion of GWH /	Date Entered :	8	29/06/2022
2668	Planned Care	Gynaecology	challenge as experienced gynae staff have resigned. Since returning to Beech Ward the team no longer have adequate	building roster - ensure speciality nurse on each shift. Staff swapped at short		9	25/05/2022
2854	Integrated & Community Care	Palliative Care/End Of Life	community. Due to this despite have a package of care for the day, where a family require night support this will delay patients	there being no night sits. To report to CGM		8	10/05/2022
2274	Planned Care	Childrens Outreach Nursing Ser	development or worsening outcomes of children with diabetes, leading to earlier complications - blindness, loss of limb, dialysis	diabetes nurse and extra 0.2 wte psychology. Business case planned for	staffing levels against SW region to provide up to	6	15/03/2022
2847	Integrated & Community Care	Oncology/cancer	timely way due to staff vacancies and insufficient skill mix across Dove/DTC/MDU/CWU for the next 6 months.	previously recruited staff with chemo competency	required for SACT competent staff to	9	29/06/2022
369	Corporate Departments	Infection Control	developing COVID whilst at work and or subsequently infecting others in the work environment despite the step being taken to	can be risk assessed back to work under exceptional circumstances if safety is a		6	29/06/2022
408	Corporate Departments	Human Resources	Significant financial risk associated with the use of agency staff due to gaps in trained staff in medical and nursing and AHPs/Scientific	through SNT to ensure progress is being made to reduce long term agency		12	05/04/2022
375	Corporate Departments	Trust wide	sickness and isolating (due to covid exposure) for nurses and health care assistants. There is evidence of deterioation of nurse sensitive indicators.	mitigations as per safe staffing policy, recruitment and retention, sickness absence and well being support	mitigations reviewed daily with monthly overview	20	05/04/2022

Maternity Staffing Risks

No	Date	Department	Description	Risk type	Score
2698	15/09/2020	Delivery (GWH)	Risk: Patient safety will be compromised Cause: Due to insufficient midwifery staff to fill roster requirements. Consequence: There is an increase in clinical risks which can be associated with staff shortage. On average there is a shortfall of 1 to 2 midwives on 4 to 5 shifts per week.	Staffing Levels	12
2443	08/01/2020	Community Midwifery (GWH)	Risk: We will not achieve compliance with; the ambition of 35% of pregnant women to be booked onto a continuity of carer model by 31st march 2020. Cause: Release of staff, skills training, and formation of new teams whilst continuing to provide the exisitng maternity service. Consequence: Unable to achieve the desired outcomes for continuity of carer model by end of march 2020	Service Planning And Delivery	10
2770	23/12/2020	Day Assessment Unit (GWH) O	Risk - There is an increase number of women requesting emergency appointments in Day Assessment Unit. Cause - operational changes in primary care in response to the pandemic. Consequence - Increased wait times for women using the service. Increased workload is not reflected in staffing model The increase in number may cause delay to women being reviewed and therefore a delay in treatment.	Staff Capacity	12

Report Title	**Quality Account 2021/22**				
Meeting	**Trust Board**				
Date	**7th July 2022**	Part 1 (Public)		Part 2 (Private)]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Rayna McDonald, Deputy Chief Nurse				
Appendices	n/a				

Purpose							
Approve		**Receive**		**Note**	x	**Assurance**	
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level							
Assurance in respect of: process/outcome/other (please detail):							
Process							
Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

The Trust is required under the Health & Social Care Acts 2009 and 2012 to produce Quality Accounts. The process has remained the same as previous years, with the following exceptions:

1. NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. NHS foundation trusts will continue to produce a separate Quality Account for 2021-22.
2. There is no national requirement to obtain external auditor assurance on the Quality Account with approval from within the Trust's own governance procedures deemed as sufficient.

The Trust Board delegated authority to the Quality and Safety Committee to approve the Quality Account 2021-22 at its meeting on the 23 June 2022, the Quality Account was approved. The Quality account 2021-22 has been uploaded to the Trust Website and a link sent to NHSE as required on the 30th June 2022.

The Quality Account 2021-22 is attached for the Board to note its contents.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks	n/a				**Risk Score**

– risk number & description (Link to BAF / Risk Register)		
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The Quality Account priorities 2022-23 have been developed in consultation with the Trust Management Committee, Trust Board, Council of Governors, and external stakeholders. The Quality Account have been shared with local external stakeholders to provide statements of assurance. The Quality Account 2021-22 will be tabled at the Trust Management Committee for noting.	
Next Steps		

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			**x**
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			**x**
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

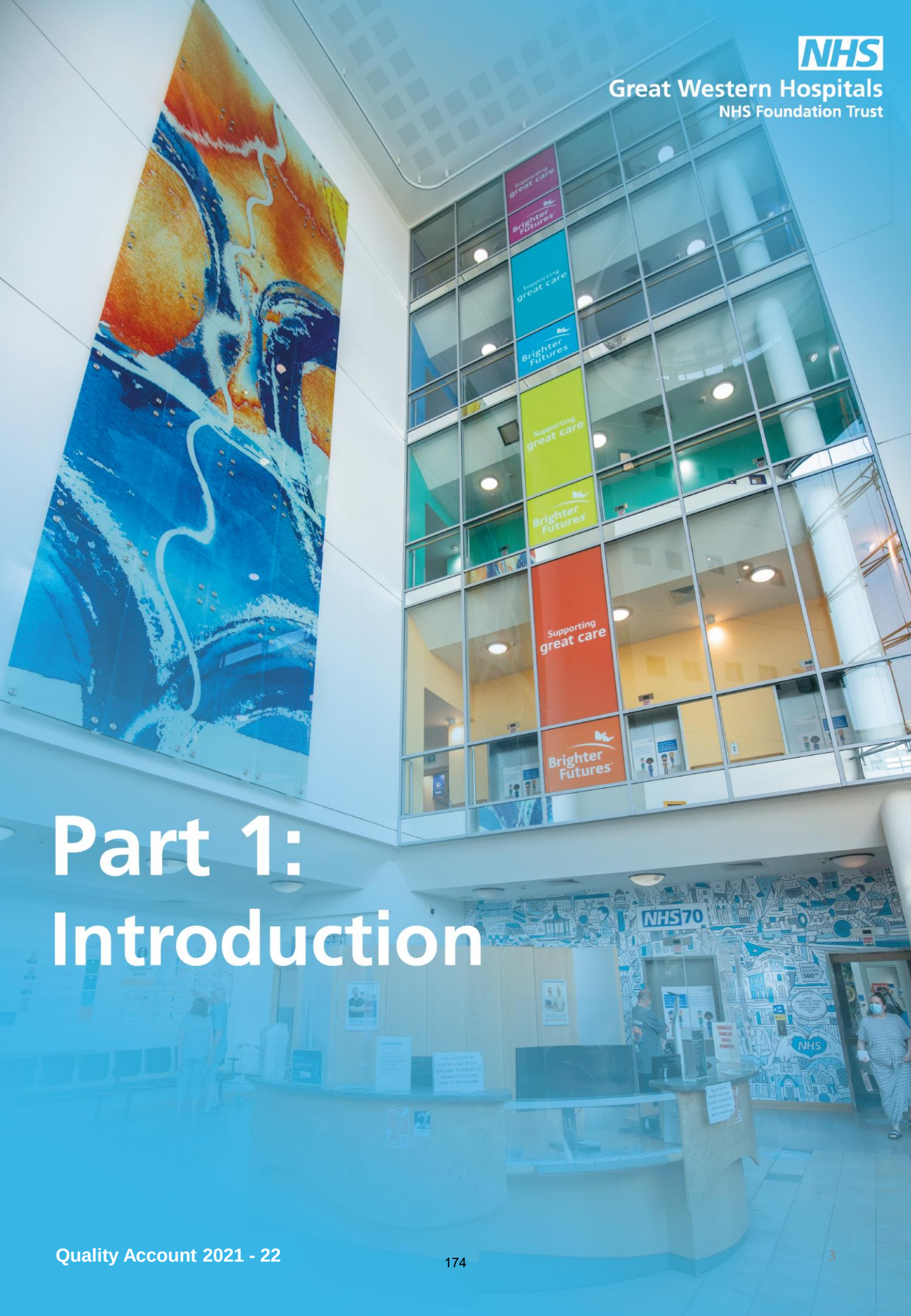
The Trust Management Committee is requested to note the content of the Quality Account 2021-22.

Accountable Lead Signature	Lisa S Drake
Date	30th June 2022

NHS
Great Western Hospitals
NHS Foundation Trust

Quality Account
2021-22

Contents



NHS
Great Western Hospitals
NHS Foundation Trust

Part 1: Introduction

Statement on quality from Chief Executive

| Kevin McNamara

I am pleased to present our Quality Accounts for 2021/22.

This report reviews the quality of patient care we have provided over the past 12 months and shares our priorities for the year ahead for improving the safety, outcomes and experience of our patients.

Throughout the year we have faced a number of significant challenges, with the continuation of the COVID -19 pandemic and very high number of patients needing urgent and emergency care, twinned with high numbers of patients who are in a hospital bed but who are medically fit and could be cared for elsewhere in our community – all of which present both quality and operational challenges. At busy times, this has created delays for ambulance crews handing over patients to us which has created real pressure for our ambulance colleagues and impacted on the response times to those who need an ambulance.

Although we have been able to reduce the number of patients waiting more than a year for treatment to 664, our overall waiting list now exceeds 30,000 people.

Our staff have continued to go above and beyond for a sustained period of time to do their best for our patients. On behalf of the Board, I would like to say how proud we are of how staff have responded to the pandemic and other pressures and their commitment to delivering the care our patients need.

In 2022/23 we will be investing £2.2m in Safer Staffing, which was the number one issue raised by staff in our staff survey, and I hope that this will enable us to provide consistently safe care.

As society learns to live with COVID -19, we must flex and adapt to the challenges the pandemic continues to present, while retaining a real focus on infection prevention and control measures.

This is of course needed not just because of COVID -19, the increases in cases of infections such as c.*Difficile* and Methicillin-resistant Staphylococcus aureus (MRSA) highlight the need for a renewed focus on Infection Prevention & Control best practice.

As Bath Salisbury Wiltshire's only integrated provider, we continue to do all we can to improve the pathways of care across primary, secondary and community care.

Our GP practices have been on a long-term programme of improvement since they joined us in November 2019 and have made some significant steps forward, notably in improving access to primary care. These practices were due to be inspected in May 2022.

In May 2021 we launched Great Care across the Trust, a co-ordinated focus on providing harm-free care, expert care, and personalised care, in an improved environment for delivering this care. This has been well-received by staff, and there is a continued programme of work to embed the improvements needed.

In 2022/23 we will publish our new Quality Strategy which will take us up to 2026 and sets out what we are doing to improve quality and how this will be given greater impetus though Improving Together which will embed continuous improvement every day.

Improving Together is a new way of working, which will give staff the skills and training they need to bring about positive change in their areas themselves.

Quality remains the golden thread running through everything we do and this year we have put forward three priorities to focus our efforts:

Priority 1: Explore a systematic approach oriented towards embedding learning from serious incidents in line with expectations within National Patient Safety Strategy.

Priority 2: Planning for a patient's discharge from hospital is a key aspect of effective care. We will reduce unnecessary delays and improve communication to support the discharge experience of our patients.

Priority 3: We will ensure that our patients receive optimal nutrition and hydration.

You can read more about why we've chosen these priorities, which I hope will resonate with our patients, elsewhere in this report.

As we look forward to 2022-23 we have a real sense of hope in seeing some long-standing programmes of work come to fruition and begin to start delivering improvements for patients.

This year alongside Oxford University Hospitals NHS Foundation Trust we will see the opening of the Swindon Radiotherapy Centre on our site, made possible by the fund-raising efforts of our community and our hospital charity Brighter Futures.

Our new Urgent Treatment Centre will open as part of our Way Forward Programme and presents the opportunity to deliver high quality urgent care in a purpose-built setting.

Finally, we are more aware than ever before of the potential that we, as a large organisation in Swindon, can play in increasing life chances, reducing health inequalities and improving population health. We have established a Health Inequalities Steering Group and are beginning to embed a greater understanding and awareness of our role in addressing inequality in our organisation.

I hope you enjoy reading about our progress and plans for the year ahead.

Kevin McNamara
Chief Executive

About us and the service we provide

The Trust's geographical area covers Wiltshire, parts of Bath and North East Somerset, parts of Hampshire, Dorset, Oxfordshire, West Berkshire and Gloucestershire, covering a population of approximately 1,300,000 people.

Great Western Hospital

The Great Western Hospital is a purpose built District General Hospital providing emergency care, elective (planned) surgery, diagnostics, paediatrics, maternity (both midwife and consultant led), and outpatient and day case services.

The Brunel Treatment Centre

At the Great Western Hospital, there is a purpose built centre for elective surgery called the Brunel Treatment Centre.
The centre has enabled the Trust to separate emergency from elective (planned) surgery.

Swindon Intermediate Care Centre (SwICC)

SwiCC is located in a separate building on the Great Western Hospital site. Patients receive therapy and further care here before being discharged to their own homes or to another community healthcare setting.

Community and GP services

The Trust is a provider of community health services across Swindon. These services are provided by community nurses and therapists, located at various GP practices, Health Centres and patients' homes.

The Trust also manages the provision of services for two GP practices, Abbey Meads Medical Group and Moredon Medical Centre. These practices provide GP services from four locations across Swindon, including Moredon Medical Centre, Abbey Meads Medical Practice, Crossroads Surgery and Penhill Surgery, providing care to over 30,000 people.

Our key achievements

April 2021- April 2022

April 2021

Care Quality Committee recognise improvements in primary care and we became the 5th most improved Trust in the country.

May 2021

Great Care campaign launched.

June and July 2021

Represented at National Parliamentary Awards.

August 2021

- Our first SAFER week was held.
- Marked Pride celebrations with new rainbow crossing.
- Roll-out of dedicated patient phones.
- First Nursing, Midwifery and Allied Health Professional Forum held.

September 2021

- Staff Facebook Group launched.
- Trust receives Veteran Aware Bonze accreditation.
- Pilot for new colon capsule endoscopy cameras to test for bowel cancer.

October 2021

- Our Oxygen capability was upgraded.
- Long COVID -19 support group launched.
- Launched the Matrons Leading with Impact programme.
- First podcast, Great to Talk, with a focus on Equality Diversity and Inclusion.
- Celebrated Black History Month.

November 2021

Staff Excellence Awards.

December 2021

Research and Innovation Team are first in the world to trial new pacemaker method.

Our key achievements

April 2021- April 2022

January and February 2022

New academy for health and care staff in Bath Salisbury Wiltshire.

March 2022

Trust introduces new escalation policy to manage pressure and demand on services.

April 2022

- Introduced patient-initiated follow-up (PIFU) appointments for patients to book in their own follow-ups to reduce the need for unnecessary routine review appointments.
- Improving Together training launches for staff.

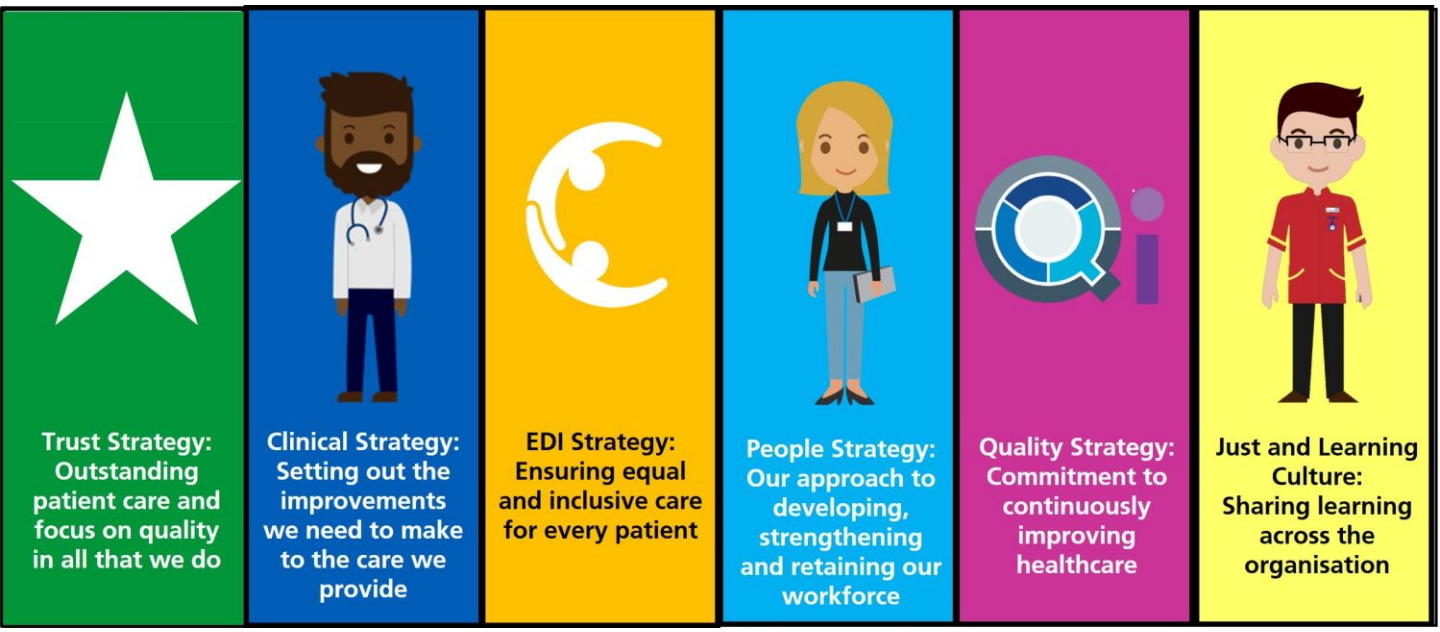
Improving together

Patient experience and engagement

Great Western Hospitals NHS Foundation Trust strives to provide the highest quality patient-centred care for our patients and their families across our acute, community and primary care settings. We are ambitious, and are working hard to improve our CQC rating and achieve an outstanding review.

Over the last year, we have developed our Patient Experience and Engagement Framework. Key to its development has been the collaboration with our staff, patients, public members and governors. The Framework closely aligns to the new CQC Strategy and their approach to regulation is being driven by peoples' needs and experiences of health care services.
The aim of this Patient Experience and Engagement Framework is to help us to understand what is important to our patients and their families, in order for us to make improvements to the care that we deliver.

We want to expand the opportunities for patients, families and carers to provide us with feedback and develop new patient involvement, partnership working and co-design processes in order to truly hear their voice in everything that we do.
This framework aligns closely to our Trust Strategy pillars, our Trust Vision and other evolving strategies and work streams, as outlined in the graphic below.



Our Quality Strategy

The Quality Strategy sets out our aims and objectives for 2022-26. It follows our overarching Trust strategy and describes the elements that drive our approach to quality. The strategy includes 'Improving Together' - an ambitious transformation programme to embed a culture of continuous improvement across the Trust.

Great Care Campaign

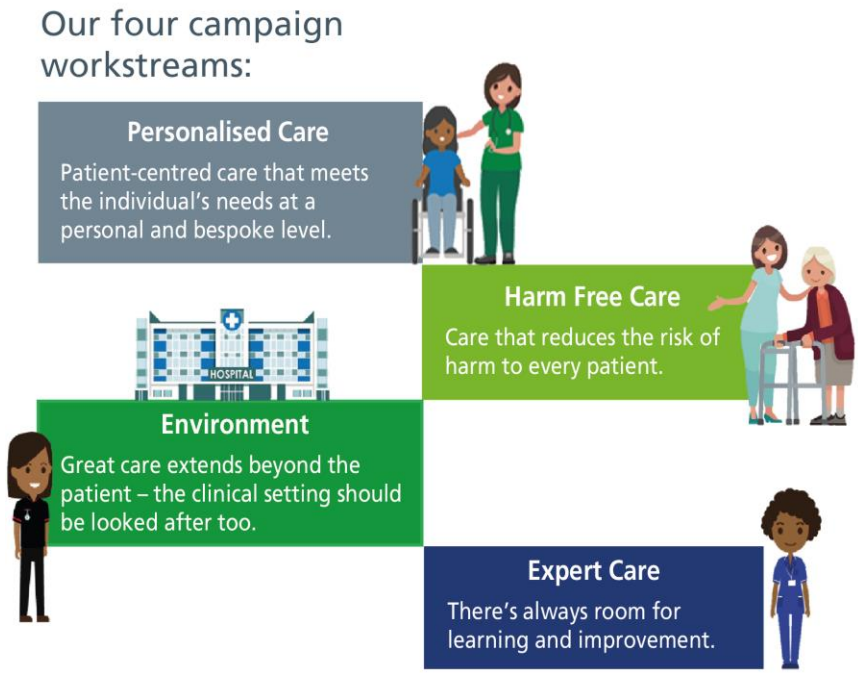
Care with compassion, getting the fundamentals right and keeping the patient front and centre is our start point, we want every patient to have the best possible experience when using our services. Our ambition is for all our patients to receive Great Care and we recognise that every staff member plays a vital part in that.

We launched the 'Great Care' campaign, to support existing and new improvement projects or ideas, our aims are to

- Deliver great care to every patient all of the time and seek to continually improve the care we provide to patients
- Receive regular feedback from patients, their families and carers
- Engage and empower staff to deliver great care

The key to this campaign is keeping the patient at the very centre of all that we are trying to do. This means proactively collecting feedback and listening intently to our patients and their families and carers, and ensure we respond in a timely and effective way so as to ensure a positive and sustainable impact on their care experience.

Our ambition is to develop a culture and a shared language across the Trust that is synonymous with Great Care.



Improving Together

Improving Together is our new Trust-wide approach to change, innovation and continuous improvement, introducing a consistent methodology across the organisation so that 'improving' becomes something we all do in the same way.

For this approach to work effectively, it is important that all staff are clear about how they can personally contribute towards, or lead, improvements.

Staff across the organisation will receive training, coaching and support, so that we all have the same tools, routines, and behaviours needed to make change happen and lead improvements in our areas.

Improving Together will help us to embrace the changes that are already happening in every corner of the organisation, on our hospital wards, in our GP surgeries and in patients' homes.

It's how we are going to deliver our vision and the four pillars that we want to be known for, and will become the golden thread that runs through all that we do to make this a safer place to receive care and a better place to work.

Healthwatch Enter and View Visit

It was a great pleasure to welcome Healthwatch to the organisation as part of the Enter and View visits. The purpose of the visit was to identify good practice which can be celebrated and shared, as well as to identify any concerns service users have, Healthwatch developed the summary below to reflect their findings.

NHS
Great Western Hospitals
NHS Foundation Trust

Part 2: Priorities for improvement and statements of assurance from the Board

About the Quality Account

Our Quality Account is our annual report to the public about the quality of the services we deliver as a health care provider. The Quality Account describes the Trust's approach to quality, and provides an opportunity for scrutiny, debate and reflection by the public.

The Quality Account publication this year reflects the impact of the pandemic on our Trust in terms of how this impacted our capacity to deliver services at a normal pace.

Whilst there were elements of our priorities that were impacted, the Trust continued to deliver improvements in many areas.

Each year, our Quality Account is both retrospective and forward looking. We look back at the year just passed and present a summary of our key quality improvement achievements and challenges.

We look forward and set out our quality priorities for the year ahead, ensuring that we maintain a balanced focus on the three key domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Our quality priorities are chosen following a process of review of current services, consultation with our key stakeholders and most importantly through listening to the feedback from our service users and carers.

Some of the content of the Quality Account is mandated by NHS Improvement and /or by The NHS (Quality Account) Amendment Regulations 2012, however other parts are determined locally and shaped by the feedback we receive.

"Quality runs through everything we do"

2.1 Priorities for improvement

Results and achievements for the 2021-22 Quality Account Priorities

In this section we outline the progress that we have made during 2021/22 in delivering the priorities.

2021-22 Priority 1: Listening and engaging with our patients, their families and carers

Why was this a priority?

We are committed to ensuring that our patients their families and the wider public have opportunities to understand, get involved and influence the care that we provide.

By involving patients and their families and ensuring that their voice is heard, we believe that this will have a positive impact on the outcome of their care and treatment. Patient, carer and family representation will bring important views, perspective and challenge into the work that we do and is essential in championing a service user viewpoint.

Aims and progress made in 2021-22

Achieved: Aim 1 – Develop and implement a Patient Experience and Engagement plan

- A Patient Experience and Engagement framework has been developed in collaboration with our staff, patients, public members and governors.
- The Framework articulates how we are providing more opportunities to hear more from our patients in order to improve our services and understand what is really important to them.

Not achieved: Aim 2 - Embed "care conversations" across the organisation

- Not all action could not be undertaken as anticipated due to the COVID -19 response, however a new Volunteers patient experience forum has now been set up to drive the process of care conversations.
- Care conversations have been introduced as part of the introduction of Ward Buddies to support during winter pressures.

Partially achieved: Aim 3 - Develop quality and feedback boards

- Not all action could not be undertaken as anticipated due to the COVID -19 response, however, new quality and feedback boards are on order along with additional media screens which will display information about what patients are telling us and the improvements that we have made as a result
- Several engagement and involvement opportunities have been advertised to our trust members
- We have multiple patient participation groups in place across the trust including: Cancer Partnership, Dementia/Admiral Nurses, Audiology, Podiatry, Learning Disability, Chaplaincy volunteers, Paediatrics Family voices group, Maternity Partners, SWIFT Neonates, Primary Care Public Participation Meeting, Swindon Eye patients
- We are working with local authorities including Voluntary Action Swindon, Swindon Equality Coalition and Healthwatch, Swindon Borough Council, Travelling and Gypsy communities, Asylum seekers and young mums
- We have also achieved Armed Forces Covenant Veteran Aware Bronze Accreditation

Partially achieved: Aim 4 - Implement clear, visible signposting across the organisation

- Not all action could not be undertaken as anticipated due to the COVID -19 response, however as part of the Great Care Campaign a refresh of all ward information boards is underway to ensure that signposting is clear for patients and families of who to contact with a concern

We are developing 'Care Reflections' which will provide real patient stories for staff to use in training, meetings and in their reflective work in order to bring the patients true experience to life

We are developing closer links with community partners and system colleagues to triangulate our work and ensure we are engaging more with seldom heard groups

We are helping our staff to understand the importance of hearing the patient voice in the work that they do and providing them with documentation and tools to ensure that they feel confident in involving patients

We are providing new patient involvement, partnership working and co-design opportunities that are advertised widely to our trust members and local communities

We continue to embed learning and providing visibility across the organisation to celebrate and advertise the improvement work taking place

2021-22 Priority 2:
Reduce the incidence of hospital acquired pressure ulcers

Why was this a priority?

At Great Western Hospitals Trust we do not want any of our patients to come to harm whilst they are in our care, we believe that by the implementation of effective systems and processes supported by education and training we will be able to reduce the incidence of pressure ulcers developing while patients are in our care.

Aims and progress made in 2021-22

Partially achieved: Aim 1 - Develop a bed and mattress replacement programme

- Due to the COVID -19 restriction we were unable to undertake the planned mattress audit, however the focus now is to re audit in May 2022 for the remaining mattresses.
- We are introducing a bi-annual mattress audit across the Trust in partnership with equipment library

Achieved: Aim 2 - Implement a rapid learning process to support early identification of learning

- Information is now shared across teams for learning and improvement
- System now in place to share data across the organisation as a result action plans are developed to mitigate any improvement actions identified.

Achieved: Aim 3 - Undertake a data quality exercise to ensure accurate reporting

- Data quality review undertaken by Tissue Viability Team

Partially Achieved: Aim 4 - Continue to develop and embed education and training

- Not all action could not be undertaken as anticipated due to the COVID -19 response, however a revised Pressure Ulcer education module now live
- Ongoing monitoring of compliance by the Tissue Viability Team

Achieved: Aim 5 - Continue to develop Safer Skin Champions for all areas

- Safer Skin Champions in place across areas within the organisation

Partially achieved: Aim 6 - Identify equipment required and develop plans for implementation across departments including training

- Due to restrictions during COVID -19 there were delays with implantation however Mattress trials are currently taking place in areas with future plans to roll out more widely once trial completed.
- The intensive Care Unit successfully evaluated bespoke pressure relieving equipment , these of these mattresses now in place

Next steps

Undertake the remaining 25% outstanding Mattress audit in May 2022

Introduce bi-annual audit across the Trust

Establish annual cycle of mattress review across the Trust to determine replacement programme .

Partially achieved: Aim 7 - Implementation of a digital pressure ulcer assessment tool

- The assessment tool is planned to be added to the digital platform, Nervecentre to encourage compliance, this will be supported by a programme of workshops and education.
- Introduce to staff a video of training to include:
    - Skin Assessment
    - Surface
    - Keep Moving
    - Incontinence & Moisture
    - Nutrition and hydration
    - Giving information

2021-22 Priority 3:
Achieving smooth and effective flow across the hospital and community

Why was this a priority?

The Flow programme is a whole system approach to ensure that patients are seen in the most appropriate or safe location by the right person in a timely way. Flow is key to preventing bottlenecks, which can result in patients not receiving the right care at the right time or in the right place.

When we do not have the right conditions for patients to flow through our Hospital and Community, patients experience unnecessary admissions to hospital resulting in physical deconditioning requiring additional interventions, prolonged lengths of stay and clinicians being unable to deliver effective, responsive, and safe care and treatment.

Flow is crucial to ensure the safety of patients arriving at the emergency department to ensure the swift transfer from ambulance care to hospital care and where possible back to their community.

Aims and progress made in 2021-22

Partially achieved: Aim 1 – Monitor compliance with hospital discharge policy and operating model

- Hospital Discharge Policy gap analysis completed to enable focused improvement work
- The testing of Safety Netting calls underway (Safety netting provides good aftercare and is best practise to ensure patients feel supported, especially for end-of-life patients and their families and carers.
- Established a non-criteria to reside pathway
- Built in multidisciplinary escalation processes

Partially achieved: Aim 2 – Ensure patients are only admitted to the hospital when all avenues have been exhausted

- Successful testing and implementation of the Navigation Hub which streamlines patients to other pathways within the Community or for planned admission reviews
- Success of re-routing through SAFER trials which were completed in January 2022
- Improvement strategy plans have been initiated to ensure patients are being seen by the correct services

Not achieved: Aim 3 – Support patients to move to the most suitable location as soon as possible

- Strategy in development to ensure bed moves at are a minimum for all patients

Achieved: Aim 4 – Work with partners to deliver care in the community

- Home first standard operating procedure in place and decision model commenced in November
- New discharge strategies in place including the Care Hotel
- Commissioning of live in carers within the Community
- GWH continue to explore options to bridge the gap to care with family / relatives to support patients discharge from hospital

Not achieved: Aim 5 – Keep bed moves to a minimum especially after 10pm

- Work ongoing to ensure we are time sensitive around moving patients and aim to do this by 10pm.

Partially achieved: Aim 6 – Make sure our services operate 24/7 to prevent unnecessary admissions

- Work to be done throughout the Trust to fully understand the need for 7-day services
- A SAFER weekend has been planned for March to gain further understanding of the services needed
- Work being completed in April to understand what stops patients from being discharged at the weekends, to understand the next steps needed to be taken

Partially achieved: Aim 7 – Ensure ambulances are effectively streamed to the correct patient pathway

- 15 internal pathways have been identified to direct patients to receive the correct care
- Continue to improve the Single Point of Access (SPOA) services for patients with minor injuries

Achieved: Aim 8 – Implement safer bundle, SAFER is suite of actions designed to help reduce delays for patients

- SAFER care weeks introduced and ongoing with great feedback from local partners (BSW)

Partially achieved: Aim 9 – Develop further admission avoidance pathways

- Ongoing Divisional work to streamline all referrals away from Emergency Department via the Navigation Hub
- Community have implemented a virtual ward to ensure patients are on the correct pathway, work continuing to develop the service
- Rapid response pathways being created
- Continue to look at Falls/Chest Pain pathways to re-direct these from Emergency Department.
- Work to be completed to improve the Mental Health pathways

Next steps

We are looking to develop and establish a pathway around 'Putting the Hospital to Bed' to reduce the amount of patient moves after 10pm

Ongoing work to improve the Navigation Hub to direct patients to the correct pathway and avoid unnecessary admission to the emergency department.

Work collaboratively with the Community to identify gaps in the Hospital Discharge Policy to ensure the standards are being met

Choosing our priorities for 2022-23

The following priorities have been agreed by the Trust for 2022-23. These will be reported in full in the 2022-23 Quality Account with quarterly reporting to the Patient Quality Committee and Executive Committee

The following sources were used to identify potential Improvement priorities

- Stakeholder and regulator reports and recommendations
- Clinical audit data
- Results from national In-patient surveys
- Local and national audit
- Feedback from Healthwatch through partnership working
- CQC inspection report and CQC insight reports
- Feedback from our Trust board
- Emergent themes and trends arising from complaints, serious incidents and inquests
- Complaints, concerns and FFT responses

The Trust Board, Senior leaders , Council of Governors, Clinical Commissioning Group and Healthwatch, were presented with various options to consider as Improvement priorities and invited to vote, this process established our Improvement Priorities for 2022/23.

Each priority has been aligned to a quality domain; patient safety, patient experience, and clinical effectiveness.

The progress against 'what will success look like' outlined against our quality priorities above will be reported and monitored by a quarterly report presented to the Patient Quality Committee

Our four pillars – what we want to be known for

2022-23 Priority 1: Explore a systematic approach oriented towards embedding learning from serious incidents in line with expectations within Patient Safety Strategy

Why is this a priority?

The Patient Safety Team recognises the importance of developing and embedding a system and culture that is committed to improving patient safety.

This culture will include enabling our patients and staff to feel empowered to discuss their concerns openly through supportive reporting and feedback methods, supported by clear and compassionate leadership. Leading to embedding robust learning through review and sharing from incidents and complaints.

The Trust has five patient safety priorities that each have a programme developed collaboratively by subject matter experts setting out improvement actions and monitoring their impact:

- Medicine management
- Fall
- Pressure damage
- Deteriorating patient
- Nutrition and Hydration

What are our aims for the coming year?

We will establish continuous improvement programmes to support ongoing learning associated with our patient safety priorities and other learning identified through patient safety incidents or complaints.
To do this we will:

1. Develop a platform for shared learning that is available to all staff across the organisation.
2. Develop a series of learning media for each scenario. Engage with leads for each action to use the learning scenarios for each action.
3. Develop a 'look back from learning' each year. A process of review for each serious incident, looking at the learning identified and explore where the learning was shared.
4. Establish a learning from patient safety group that has Trust wide representation.
5. Develop a newsletter for wider learning and sharing.

How will we monitor and measure our progress?

Monitor key performance indicators on the Learning Zone. (e.g. number of video views)

Review action plans for each SI and work with the identified lead to identify the shared learning media to be used.

Complete a 'look back from learning' report that can be shared across the organisation.

Build a Divisional sharing section into the Patient Safety and Learning group.

Review the quality improvement plans for each improvement group through the Patient Safety and Learning group.

Develop an annual programme of Patient Safety Summits to share learning.

2022-23 Priority 2: Planning for a patient's discharge from hospital is a key aspect of effective care. We will reduce unnecessary delays and improve communication to support the discharge experience of our patients.

Why is this a priority?

Our patients and their families are frequently telling us that they experience poor communication, a lack of information and feel unprepared for their discharge. We also know we have many patients in hospital who do not require hospital care, we want to work closely with our system partners to ensure patients get home as soon as they are medically fit.

What are our aims for the coming year?

1. Reduce the overall the number of complaints and concerns associated with discharge
2. By working with system partners reduce the number of patients who experience delayed discharge
3. Embed the process for implementing a safety netting call for patients (> 60years and LOS >72 hours) on the day after their discharge

How will we monitor and measure our progress?

- Patients to receive written information on discharge
- Develop digital platform to ensure safe discharge
- Monitor number of complaints and concerns
- Reduce number of patient moves
- Survey patients post discharge regarding their experience

2022-23 Priority 3: We will ensure that our patients receive optimal nutrition and hydration

Why is this a priority?

Adequate nutrition and hydration is a fundamental part of patient care. Optimising nutrition and hydration can lead to improved recovery & reduce length of stay in hospital, avoidance of hospital admission and improvements in quality of life.

What are our aims for the coming year?

1. That 95% of appropriate patients will have an accurate MUST score completed within 24 hours of admission
2. Embed correct use of coloured tray system red need assistance/monitoring, green/allergies, brown/everyone else
3. Embed the practice of protected meal time compliance with all wards
4. Ensure that Nutrition and hydration needs are met for all Infant, Children and Young people admitted to GWH though compliance with the Nutrition Clinical guidelines.

How will we monitor and measure our progress?

Reports from informatics quarterly, to measure compliance.

Audit use of correct trays,

Nutrition Champion's to audit their area.

Improvement in appropriate questions in the National In-patient Survey.

Pre and post training questionnaires. Dietetic referral data. Prescribed supplement usage.

2.2 Statements of assurance from the Board

Information on the Review of Services

During 2021/22 the Great Western Hospitals NHS Foundation Trust provided and/or subcontracted 8 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2021/22.

Clinical audit and national confidential enquiries

During 2021/22, 56 national clinical audits and four national confidential enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During that period Great Western Hospitals NHS Foundation Trust participated in 92% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2021/2022 are as follows alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1: Participation in national clinical audits and confidential enquiries

Clinical Audit / National Confidential Enquiries	Participation?	% Cases Submitted
National COPD Audit Programme - Secondary Care: 2021	Yes	100%
National Adult Asthma Audit Programme - Secondary Care 2021/22	No*	0%
National Paediatric Asthma - Secondary Care 2021/22	No*	0%
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation 2021/22	Yes	Data Collection Still in Progress
National Sentinel Stroke National Audit Programme (SSNAP)* 2021/22	Yes	Data Collection Still in Progress
National Sentinel Stroke National Audit Programme (SSNAP)* 2021/22	Yes	Data Collection Still in Progress
MBRRACE-UK 2021 : Perinatal Confidential Enquiries	Yes	Data Collection Still in Progress
MBRRACE-UK 2021 : Perinatal Mortality Surveillance	Yes	Data Collection Still in Progress
MBRRACE-UK 2021 : Maternal Mortality Surveillance and Confidential Enquiries	Yes	Data Collection Still in Progress
MBRRACE-UK 2021 : Perinatal Mortality Review Tool	Yes	Data Collection Still in Progress
National Neonatal Intensive & Special Care Audit (2021 Data)	Yes	Data Collection Still in Progress
National Paediatric Diabetes Audit 2021/22	Yes	Data Collection Still in Progress
National Pregnancy in Diabetes 2021	Yes	100%
NCEPOD - Child Health Programme - Transition from child to adult health services	Yes	Data Collection Still in Progress
NCEPOD - Community Acquired Pneumonia	Yes	Data Collection Still in Progress
NCEPOD - Crohns Disease	Yes	Data Collection Still in Progress
NCEPOD - Epilepsy Study	Yes	100%
National Severe Trauma Audit - TARN (21/22)	Yes	Data Collection Still in Progress
National Elective Surgery Audit - National PROMs Programme (2021-22)	Yes	Data Collection Still in Progress
National Case Mix Programme 2021/22	Yes	Data Collection Still in Progress
National Emergency Laparotomy Audit - Yr 9 NELA 2021/22	Yes	Data Collection Still in Progress
National Joint Registry - NJR (2021/2022)	Yes	100%
National Cardiac Arrest Audit NCAA 21/22	Yes	Data Collection Still in Progress
National Acute coronary syndrome or Acute myocardial infarction (MINAP)2021/22	Yes	Data Collection Still in Progress
National Cardiac Rhythm Management (CRM) 2021/22	Yes	Data Collection Still in Progress
National Falls and Fragility Fractures Audit Programme (FFFAP) 2021/22 - Hip Fracture Database	Yes	100%

Table 1: Participation in national clinical audits and confidential enquiries cont

Clinical Audit / National Confidential Enquiries	Participation?	% Cases Submitted
National Falls and Fragility Fractures Audit Programme (FFFAP) 2021 - Inpatient Falls	Yes	Data Collection Still in Progress
National Heart Failure Audit 2021/22	Yes	Data Collection Still in Progress
National Inflammatory bowel disease (IBD) Biological Therapies 2021/22	Yes	Data Collection Still in Progress
National Audit of Percutaneous Coronary Intervention (PCI) 2021/22	Yes	Data Collection Still in Progress
National Lung cancer Audit (NLCA) 2021/22 (2021 data)	Yes	Data Collection Still in Progress
National Rheumatoid and Early Inflammatory Arthritis 2021/22	Yes	Data Collection Still in Progress
National Oesophago-Gastric Cancer Audit (NOGCA) 2021/22	Yes	Data Collection Still in Progress
National Bowel Cancer Audit Programme (NBCA) 2021/22	Yes	Data Collection Still in Progress
National Prostate Cancer Audit (NPCA) 2021/22 (2020/2021 data)	Yes	Data Collection Still in Progress
National Diabetes Foot Care Audit 2021/22	Yes	Data Collection Still in Progress
Audit of Blood Transfusion against NICE Guidelines 2021	Yes	100%
National End of Life Audit 2021/22 (NACEL)	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA) 2021/22	Yes	100%
National Audit of Dementia: Carer questionnaire 2021/22	NA	Audit Withdrawn
National Diabetes Audit Core 2021/22	No*	0%
National Diabetes Audit Core 2021/22	Yes	Data Collection Still in Progress
National Diabetes Transition Audit (linkage with NPDA) 2021/22	No*	0%
National Diabetes Transition Audit (linkage with NPDA) 2021/22	Yes	Data Collection Still in Progress
LeDeR Programme 2021/22	Yes	Data Collection Still in Progress
National Maternity and Perinatal Audit (NMPA) 2021	Yes	100%
National Audit of Breast Cancer in Older Patients 2021/22	Yes	Data Collection Still in Progress
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme 2021	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) - 2020/21 - Cohort 3	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) - 2021/22 - Cohort 4	Yes	100%
Pain in Children 2021/22 (RCEM)	Yes	Data Collection Still in Progress
National Audit of Cardiac Rehabilitation 2021	Yes	Data Collection Still in Progress
National Diabetes Audit – NaDIA-Harms - 2021/22	Yes	Data Collection Still in Progress
National Child Mortality Database 2021/22	Yes	Data Collection Still in Progress
"RESECT - transurethral REsection and Single instillation mitomycin C Evaluation in bladder 19/20 Cancer Treatment "	Yes	Data Collection Still in Progress
BAUS Cytoreductive Radical Nephrectomy Audit	Yes	Data Collection Still in Progress
National Outpatient Management of Pulmonary Embolisms Audit 2021/22	No*	0%
National Audit of Cardiovascular Disease Prevention (Primary Care)	Planned	Data Collection not started
Management of the Lower Ureter in Nephroureterectomy Audit	Yes	100%
RCEM - Severe sepsis and septic shock (Care in Emergency Departments)	NA	Audit Withdrawn

*Not participated

Improvement actions taken as a result of national clinical audits reviewed

National Sentinel Stroke National Audit Programme (SSNAP) 2019/22

A Business Case is to be built to ensure the core determinants of the stroke unit with "dedicated beds and dedicated staff" is achieved and to also include -

- Improvements around the time stroke patients spend in a stroke unit
- Reduce the number of outliers in the stroke unit, to ensure this is limited as much as possible
- For the stroke team, to focus delivery of care to stroke patients only

National Falls and Fragility Fractures Audit Programme (FFFAP) 2019/20 - Hip Fracture Database

Outcomes from the national audit results demonstrate the Trust's performance to be above national average in multiple areas. Actions going forward include –

- Developing a formal rota of surgeons to be able to perform total hip replacement (THR) to cover weekends whilst maintaining THR during weekday trauma lists

Mental Health Care in Emergency Departments 2019/20

- Implement a Nurse Led Mental Health Triage system which identifies mental health patients within 15 minutes of arrival to ED and escalates patients for further review by a Doctor.
- Review the process for risk assessments to ensure information is entered on the system, which means it is completed each time when a patient is seen.
- Ensure learning identified following incident investigations . Is implemented and evaluated
- Ensure deaths following suicide are reviewed at Mortality & Morbidity meetings to ensure appropriate peer review.
- Undertake a local clinical audit to ascertain current practices and compliance.

Improvement actions taken as a result of national clinical audits reviewed

Society for Acute Medicine Benchmarking Audit (SAMBA) – January 2020 & 2021/2022

- Develop local key performance indicators which are in line with the national audit for internal monitoring and assurance, rather than relying on waiting for the national audit
- Undertake a review of patient flow to identify and improve inefficiencies to –
    - Improve Ambulatory Emergency Care (AEC) admissions and determine which patient pathways can be redirected to a more appropriate service
    - Review patients with a high number of readmissions to identify causes for 'failed discharges'
    - Review patient readmissions, identify preventable factors and ensure pathways are put in place to support patients in the community and access to community services before readmission to the acute trust.
- Audit Implementation of services in the community

National Audit of Dementia: Prescription of 'Psychotropic Medication' to people with dementia 2019/20

- Introduce systems to document 'target symptoms' when prescribing psychotropic medications and at the point of discharge by –
    - Working with Electronic Prescribing and Medicines Administration (EPMA) and IT team to incorporate prompts into Electronic Prescribing and Medicines Administration
    - Include guidance in existing clinical guidelines & pathways
    - Include relevant staff education programmes and courses in relation to prescribing psychotropic medications
    - communicate review plans for psychotropic medications to GPs
- Provide on-going education to all staff regarding non-pharmacological methods of managing Behavioural and Psychological Symptoms of Dementia (BPSD)

LeDeR Programme 2019/20

- Undertake LeDeR reviews through a lens of greater racial awareness by working with the head of Allied Healthcare Professionals (AHPs)to discuss integrated care physio practice and options for clinical staff training.
- Work with the Informatics Team to review and improve data capture to support adjustments to policy, guidance, systems, and processes by updating system fields
- Undertake an internal review of current patient positioning practice, staff guidance and education and working with the head of AHPs to discuss integrated care, physio practice and options for clinical staff training.

Improvement actions taken as a result of national clinical audits reviewed

Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme 2020

- Prevention of transfusion delays and anticoagulant reversal delays in patients with severe bleeding.
- A process to allow the storage of an emergency dose of Prothrombin Complex Concentrate (PCC) in ED as well as guidance on when a haematologist needs to be contacted for advice should be in place. This will allow the patient to be given the treatment rapidly in the emergency department.
- IT systems for blood tracking and administration must be maintained and improved to ensure they are effective and reliable. The testing and development of the electronic blood tracking and labelling system to Blood360 and 'Samplelite' will need to be implemented Trust wide as soon as possible to make use of new patient safety features.
- Whilst effective investigations of incidents and recommendations are made, there needs to be a system whereby practice can be followed up to ensure that the changes have been made and are embedded. Collaboration with clinical areas will need to be sought for auditing purposes.

National Diabetes Audit – NaDIA-Harms - 2019/20

- Regular communication to trust inpatient areas of requirement to report the 4 identified diabetes harms that occur in clinical areas -
    - Resend Trust wide comms to remind teams of HARMS audit and need to report all 4 harms to diabetes team.
    - Weekly communication to ward managers asking for identification of HARMS within their area.
- Support implementation of connected blood glucose meters to identify 3 of the 4 severe HARMS within the trust automatically.
- Requirement to improve reporting of HARMs within the trust to enable accurate data submission- requirement of all areas to be involved in diabetes HARMS awareness and requirement to report.
- Continued identification of the 4th HARM by podiatry and vascular nurse specialist team.

CQC registration and statement on CQC reviews or investigation

The Great Western Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC), its current registration status is “Requires Improvement”. The Great Western Hospital Foundation Trust does not have any conditions on registration. The Care Quality Commission has not taken any enforcement action against The Great Western Hospital Foundation Trust during 2021.

Our last CQC inspection was between 11 and 13 February 2020,the CQC inspected urgent and emergency care, medical care, surgery and maternity services, The Trust has delivered a comprehensive action plan in response to the feedback received from the CQC. The CQC will assess how well improvements have been sustained as part of future inspection activity.

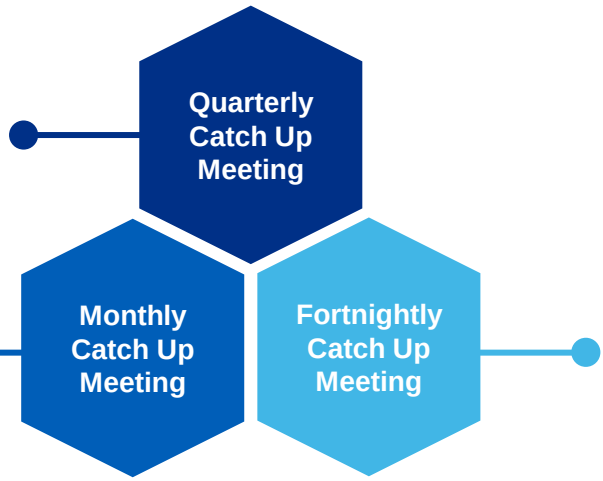
Overall rating	Safe	Effective	Caring	Responsive	Well-led
Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

During 2020/2021 the Trust has provided assurance to CQC in relation to two core services assessed as part of their transitional regulatory approach. Emergency Care & Maternity Care, the reviews were positive and whilst they did not result in a report or a change to ratings, assurance provided to the CQC informs future monitoring and regulatory activity.

Great Western Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by CQC during the reporting period.

We have had regular engagement meetings with CQC through 2020/21 to ensure we keep them informed of our service delivery and of any changes, these include:

To present developments, progress or specific focus on CQC domains



To discuss, initiatives, challenges, quality matters

To discuss, review and update CQC on their current enquiries – covering Serious Incidents, Complaints/Concerns, Whistle blows, Safeguarding and Outliers.

Research and development

Health Research is vital in generating knowledge and evidence to improve the health and wellbeing of patients, service users, carers, and the public and improving our health and social care systems. The Research & Innovation (R&I) team at Great Western Hospital is a growing, multidisciplinary team dedicated to delivering safe, effective health research at GWH.

COVID-19 is one the biggest public health challenges we have faced, and in 2021/22, Great Western Hospital NHS Foundation Trust has continued to support research in this area. The Trust has worked collaboratively with other NHS Trusts across the West of England to deliver clinical trials aimed at developing vaccines against the virus, as well as delivering several other studies aimed at finding treatments for the virus. The Trust has also restarted research in other clinical areas that had been put on hold due to the pandemic. 2021/22 has also seen Allied Health Professionals being supported to get involved in research.

In December 2021, the R&I team became the first in the world to trial a new method of pacemakers. In a bid to improve the lives of patients following a heart condition, the team recruited the world's first participant to the Conduction System Pacing Optimized Therapy (CSPOT) Trial. The Trust has also been one of the highest recruiting sites regionally to the RECOVERY trial, which is a trial exploring treatments to COVID-19. In recognition of the R&I team's achievements, we received nominations for four Research Awards from the National Institute of Health Research's West of England Clinical Research Network.

In 2021/22, the R&I department has generated income of approximately £520,000 for the Trust. In 2022/23, we aim to continue to support the growth of research within the organisation by developing a Research Champion Initiative to raise awareness of research taking place, and will be looking at ways that research can reach out into primary care and the community.

Research and development

The number of patients receiving relevant health services provided or subcontracted by Great Western Hospitals NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee is 1153.

During the 2021/22 financial year Research & Innovation and the wider research community at Great Western Hospital NHS Foundation Trust worked on 71 clinical studies of which (of which 11 were urgent public health studies).

Summary of COVID-19 related studies

1. Recovery trial

A range of potential treatments have been suggested for COVID-19 but nobody knows if any of them will turn out to be more effective in helping people recover than the usual standard of hospital care which all patients will receive. The RECOVERY Trial is currently testing some of these suggested treatments. At Great Western Hospital, we have recruited 438 patients to this trial.

REMAP – CAP study 2.

All patients who are treated in an Intensive Care Unit will receive therapy that consists of multiple different treatments, as many as 20 or 30. These treatments act together to treat both the infection and its effects on the body. When treating a patient, doctors choose from many different treatments, most of which are known or believed to be safe and effective. However, doctors don't always know which treatment option is the better one, as individuals or groups of individuals may respond differently. This study aims to help doctors understand which treatments work best. At Great Western Hospital, we have recruited 74 patients to this trial.

The Trust worked on 71 clinical studies (of which 11 were urgent public health studies).

There were 38 active Principal Investigators.

1,059 participants were recruited into research studies.

1,153 individual participants attended over 4,200 follow up appointments, either in person or by telephone.

4 new research studies were developed that are led by GWH staff.

Learning from deaths

During 2021/22 1377 of Great Western Hospitals NHS Foundation Trust patients died, 483 case record reviews and 26 investigations have been carried out in relation to the 1377 deaths in 2021/22. Seven of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.

The data for Q1-4 2021-22 is presented below

	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Total 21/22
No. of deaths	293	307	386	391	1377
Case record reviews*	91	74	162	156	482
Investigations*	1	8	12	5	25
No. of deaths with problems identified in care	1	2	0	4	7
No. of deaths >50% avoidable	1	2	0	4	7

* Numbers relate to reviews carried out for deaths that occur in 2021/22 only

What did we learn?

This year, we have learnt from the reviews and investigations that on average 83% of reviews recorded good or excellent care during admission, with evidence of swift diagnosis, well managed route to urgent surgery, good assessments and treatment plans, Sepsis and AKI tools completed.

Although we found a small number of isolated cases where care delivered during admission was felt could have been better; these cases were channelled through a secondary review lead by the Trust Mortality Lead and whilst the majority of cases did not identify any omissions in care, it was found Treatment Escalation Plans (TEP) forms were sometimes not in place and/or were not countersigned by a senior signatory. Other emerging areas for improvements were around documentation and the completeness of fluid balance charts and overuse of medical abbreviations.

End of life care overall was found to be consistently good or excellent throughout the year. Although a small number of isolated cases were found where it was felt end of life care should have commenced sooner, a secondary review of these cases identified an emerging theme of elderly patients presenting to the Emergency Department with rapid deterioration, and therefore providing little opportunity to initiate end of life care.

Learning from deaths

What actions did we take?

Specialities were invited to Trust Mortality Group Meetings to present key findings and shared learning from their local Mortality and Morbidity meetings, providing opportunities for rich discussions and shared learning, constructive challenge, and recommendations to take forward.

This year, the Trust Mortality Group also invited guest speakers to provide key messages and learning in response to issues or concerns identified from Structure Judgement Reviews (SJR);

The Trust Mortality Group have established a Trustwide newsletter, to inform staff across the organisation about relevant mortality and morbidity updates, themes, and shared learning from monthly meetings. This is with the aim of raising awareness of mortality and morbidity and to inform staff of the improvements they can make to deliver good care.

Medical Examiner

The Medical Examiner Service in Swindon was introduced in September 2020 and have been scrutinising all hospital deaths since August 2021. The aim of this service is to improve the accuracy of completion of the Medical Certificate of Cause of Death, advise on deaths that need coroner referral and establish pathways to alert Trust Mortality and Clinical Governance of any potential learning or need for structured judgement review. The Medical Examiners support families following a bereavement by discussing and explaining the death of their loved ones.

During 2021/2022, Trust Mortality Team working in partnership with the new Medical Examiners service also focussed on building and embedding practices into the existing trust mortality processes; this included establishing robust governance and processes for deaths referred for SJR, the facilitation of reviews and the dissemination of the learning outcomes they provide. This work continues as the service develops.

We now have a team of five medical examiners

Seven day service programme

Great Western Hospital NHS Foundation Trust continues to participate in the 7 Day Hospital Services Self-Assessments and is focussed on the four priority clinical standards for 7 Day Services. These have been actively monitored through the national audits.

The Trust meets three of these standards and therefore our focus continues to be on the following key standard: All emergency admissions must be seen and have thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. Previous audits have shown the Trust is not consistently meeting this standard. A number of actions were commenced to include compliance including

- Review of Job Planning Policy and strengthened job planning documentation
- Medical workforce program to review trainee and consultant out of hours rotas.

The COVID -19 pandemic has introduced additional pressures of work on the teams and on many occasions reduced available staff numbers due to sickness. The work will be continued in 2022/23 as the rota review and job planning program is rolled out. This will be subject to re-audit in the coming year.

Commissioning for Quality and Innovation (CQUIN) framework

A block payment approach for arrangements between NHS commissioners and NHS providers has been in place for 2021/22 in England. Block payments to NHS providers are deemed to include CQUIN. In 2022/23 CQUIN schemes will be operational (both CCG & specialised) and the Trust is working with commissioners to confirm which schemes apply to the GWH.

Records submission

The percentage of records in the published data:

- Which included the patient's valid NHS number was: 99.7% for admitted patient care 99.9% for outpatient care and 98.8% for accident and emergency care
- Which included the patient's valid General Medical Practice Code was: 99.8% for admitted patient care; 99.8% for outpatient care; and 99.7% for accident and emergency care

Payments by results

Great Western Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Data quality

Great Western Hospitals NHS Foundation Trust will be taking action to continue to improve data quality. Monitoring reports will be reviewed monthly by the Trust's Data Quality Steering Group (DQSG) and quarterly by the Trust's Information Governance Steering Group (IGSG).

These reports include data items which have been identified as causing concern. For example, coding completeness and validity, coverage of NHS numbers and ethnic groups, outpatient outcomes, review of external audit reports etc. The reports are used to allow management to improve processes, training, documentation, and computer systems.

The importance of good Data Quality has been recognised at Trust Board level. To this end, an awareness campaign is being finalised which will update all members of staff as to what good Data Quality is and how everyone is responsible for achieving it; the campaign will be launched late March / early April 2022.

Information Governance

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Digital Data Security & Protection (DSP) Toolkit. To maintain integrity, the Trust's DSP Toolkit is subject to an independent internal audit against the standards set by NHS Digital, on an annual basis.

In 2020/21, the DSP Toolkit submission deadline was pushed back to 30th June due to the pandemic. So information not available.

In 2021/22, NHS Digital confirmed that 30th June would be the permanent deadline each year.

Great Western Hospitals NHS Foundation Trust DSP Toolkit Assessment for 2020/21 was graded as 'Standards Met', with 110 out of 110 mandatory evidence items provided

2.3 Reporting against Core Indicators

The following set of national performance core indicators are required to be reported in the Quality Account using data made available to the trust by NHS Digital.

Summary Hospital-Level Mortality Indicator (SHMI)

The Summary Hospital-Level Mortality Indicator (SHMI) is the NHS' standard measure of the proportion of patients who die while under hospital care and within 30 days of discharge. It takes the basic number of deaths, and then adjusts the figure to account for variations in factors such as the age of patients and complexity of their conditions, so the final rates can be compared. The resulting SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the expected number based on average England figures, given the characteristics of patients treated at the Trust. The expected SHMI is one, though there is a margin for error to account for statistical issues. Summary Hospital-Level Mortality Indicator (SHMI) – deaths associated with hospitalisation, England (NHS Digital national benchmarking):

Table 1: Summary Hospital Level Mortality Indicator

Period	Value	SHMI banding
2021/22	Not available*	Not available*
2020/21	0.89	3 (lower than expected)
2019/20	0.99	2 (as expected)

The number of patients who died after being coded as under palliative care – relief of symptoms only – is collated nationally. This can affect mortality ratios, as palliative care is applied for patients when there is no cure for their condition and they are expected to die.(NHS Digital national benchmarking):

Table 2: Palliative Care

Period	Value
2021/22	**Not available***
2020/21	0.89
2019/20	0.99

* Data unavailable from the national portal

Patient Reported Outcome Measures (PROMS)

Patient-reported outcome measures (PROMs) are based on patients' own experiences. People are asked about their health status and quality of life both before and after four types of surgery – hip replacement, knee replacement, varicose vein and groin hernia. The scale runs from zero (poor health) to one (full health).The 'health gain' as a result of surgery can then be worked out by adjusting for case-mix issues, such as complexity and age, and subtracting the pre-operative score from the post-operative score.

Table 1: Description

Period	Procedure	Adjusted average health gain - EQ-5D index TRUST	Adjusted average health gain - EQ-5D index ENGLAND	Adjusted average health gain - EQ-VAS index TRUST	Adjusted average health gain - EQ-VAS index ENGLAND	Adjusted average health gain - Oxford Knee Score index TRUST	Adjusted average health gain - Oxford Knee Score index ENGLAND
2020/21	Knee Replacement Revision	Not available*	0.29	Not available*	4.20	Not available*	13.50
	Knee Replacement Primary		0.32		7.40		16.90
	Knee Replacement		0.32		7.30		16.70
2019/20	Knee Replacement Revision		0.29		5.50		13.80
	Knee Replacement Primary	0.29	0.33	4.70	3.00	17.10	17.50
	Knee Replacement	0.30	0.33	5.10	7.80	17.20	17.40

Period	Procedure	Adjusted average health gain - EQ-5D index TRUST	Adjusted average health gain - EQ-5D index ENGLAND	Adjusted average health gain - EQ-VAS index TRUST	Adjusted average health gain - EQ-VAS index ENGLAND	Adjusted average health gain - Oxford Knee Score index TRUST	Adjusted average health gain - Oxford Knee Score index ENGLAND
2020/21	Hip Replacement Revision	Not available*	0.34	Not available*	7.80	Not available*	15.40
	Hip Replacement Primary		0.47		15.10		23.00
	Hip Replacement		0.47		14.80		22.60
2019/20	Hip Replacement Revision		0.30		8.00		14.10
	Hip Replacement Primary	0.48	0.45	15.60	14.70	22.80	22.70
	Hip Replacement	0.46	0.45	14.90	14.30	22.70	22.30

* Data unavailable from the national portal

Re-admissions

Large numbers of readmissions to hospital after treatment might suggest patients had been discharged too early. Rates are therefore monitored nationally. The published 28 day readmission rate for the Trust is:

Table 1: Description

Period	Patients aged 0 - 15 (GWH)	Patients aged 0 – 15 (England)	Patients aged 16+ (GWH)	Patients aged 16+ (England)
2021/22	Not available *			
2020/21	12.9	11.9	16.1	15.9
2019/20	11.7	12.5	14.9	14.7
2018/19	11.4	12.5	15.4	14.6

2020/21 data shows that the patients aged 0-15 lies within the expected variation of the national average (95% confidence interval).

2020/21 data shows that patients aged 16+ lies within the expected variation of the national average (95% confidence interval).

* Data unavailable from the national portal

Responsiveness to the personal needs of patients

The Trust collects information on its responsiveness to patients' personal needs, augmenting the feedback collected as part of the national inpatient survey and Friends and Family Test. Patients are asked five questions in order to compile an overview:

1. Were you as involved as you wanted to be?
2. Did you find someone to talk to about worries and fears?
3. Were you given enough privacy?
4. Were you told about medication side-effects to watch for?
5. Were you told who to contact if you were worried?

Table 1: Description

Period	Indicator value (GWH)	Indicator value (England)
2021/22	Not available*	
2020/21	Not available*	
2019/20	63.40%	67.10%
2018/19	65.60%	67.20%

Staff who would recommend the Trust to their family or friends

The "Care" question from the staff survey asks how likely staff are to recommended the NHS services they work in to friends and family who need similar treatment or care.

Period	Agree (GWH)	Strongly agree (GWH)	Agree- Combined acute & Community (GWH)	Strongly Agree - Combined acute & Community (GWH)
2020	48%	12%	48%	12%
2019	55%	15%	54%	16%
2018	49%	12%	49%	14%

We have launched the 'Great Care' campaign, which will support existing and new improvement projects targeted to address areas of concern identified in the Staff and Inpatient survey

* Data unavailable from the national portal

Patients admitted to hospital who were risk assessed for venous thromboembolism

Venous thromboembolism (VTE) is a clot in the deep veins of the leg, which can break off and clog the main artery to the lungs. Known as a pulmonary embolism, this can be serious, or even fatal. It is therefore particularly important to make sure patients do not develop VTE in hospital, where the risk is often greater because people tend not to move around as much, making blood in the veins of the legs more vulnerable to clotting. Patients therefore need to have their VTE assessed, so drugs or stockings can be used to reduce the risks. The target is for at least 95% of patients to be assessed.

Table 1: Description

Period	VTE risk assessment (GWH)	VTE risk assessment (England)
Q4 2020/21	Not available*	Not available*
Q3 2020/21		
Q2 2020-21		
Q1 2020-21		
Q4 2019/20		
Q3 2019/20	98.95%	95.33%
Q2 2019/20	99.66%	95.72%
Q1 2019/20	99.59%	95.65%
Q4 2018/19	99.63%	
Q3 2018/19	99.59%	
Q2 2018/19	99.50%	
Q1 2018/19	99.42%	

Clostridium difficile infection

Clostridium difficile (C.difficile) is a dangerous infection, which can cause serious symptoms and even death. Although naturally present in some people, it can spread quickly in a confined environment like a hospital, where people are already unwell. The Trust has been working hard to combat this infection using different infection control techniques to keep patients safe.

Table 1: Description

Period	Rate - Total cases per 1000 bed days (GWH)	Rate - Total cases per 1000 bed days (England)
2021/22	Not available*	
2020/21	10.40	17.70
2019/20	13.57	15.46
2018/19	13.49	14.09

* Data unavailable from the national portal

Patient Safety Incidents

An incident may be defined as an event that has given rise to actual or possible harm such as injury, patient dissatisfaction, property loss or damage.

The Trust actively encourages staff to report all such incidents, so lessons can be learned and shared. Only a very small minority of incidents are at the top end of the scale, causing severe harm or death. These trigger the most rigorous of investigations.

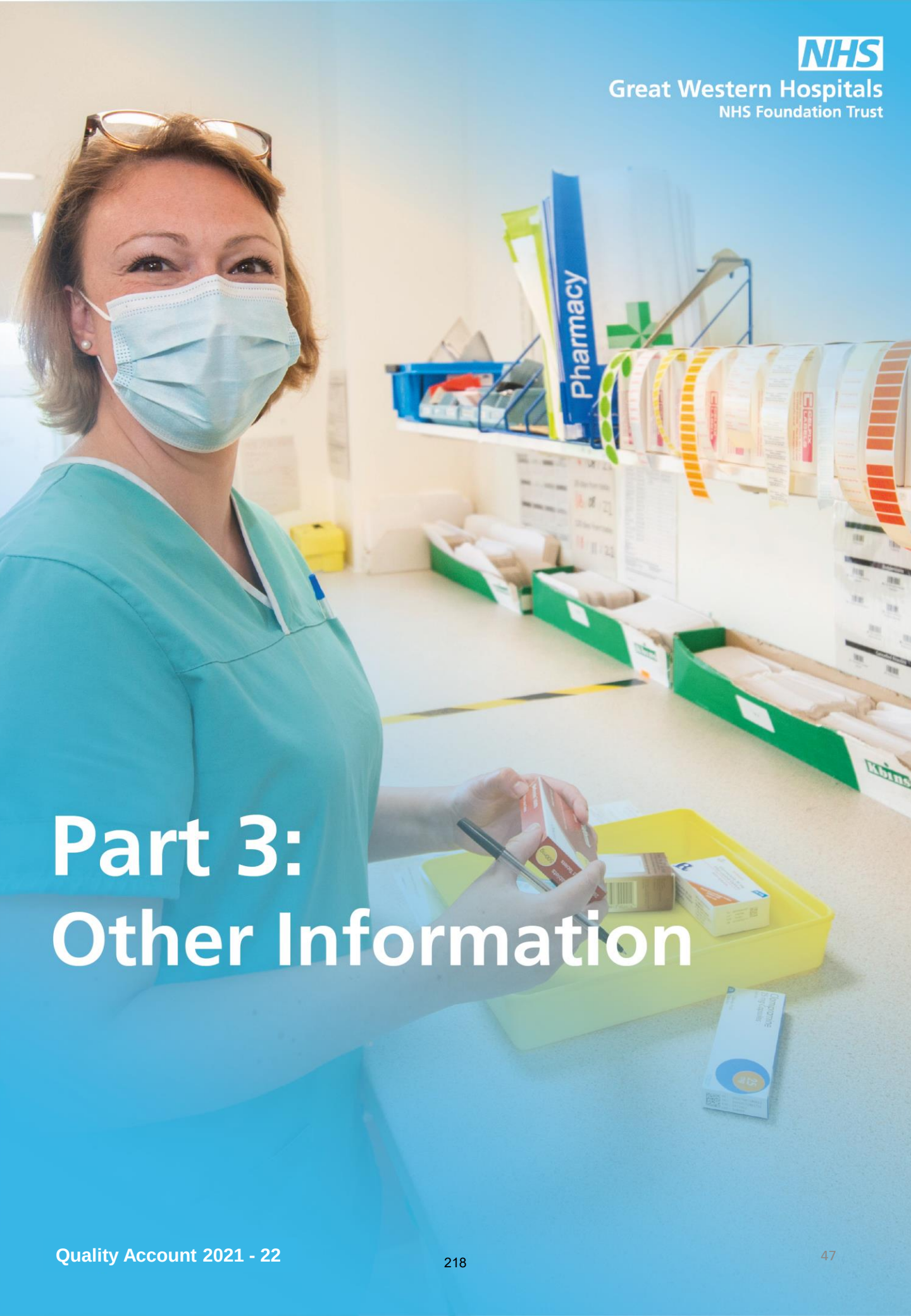
The Great Western Hospitals NHS Trust is committed to delivering quality patient care, ensuring high standards of health and safety, by providing a system of incident reporting which allows all staff to record any incident which causes harm, damage or loss or has the potential to do so. Incident reporting presents an important opportunity to learn from past events and ensure steps are taken to minimise recurrences. There is overwhelming evidence that NHS organisations with a high level of incident reporting are more likely to learn and subsequently increase safety for patients, staff and visitors.

The Trust ensures the right level of investigation is implemented whenever an incident is reported. The report into the investigation will ensure that local and organisational learning is taken and fed back to the relevant staff to ensure mitigation actions are put in place to prevent any recurrence.

Table 1: Description

Period	Number of Patient Safety Incidents	Rate of patient safety incidents per 1000 bed days	Number resulting in severe harm of death	Rate of incidents resulting in severe harm or death (per 1000 bed days)
Oct 20 - Mar 21	Not available*			
Apr 20 - Sep 20	Not available*			
Oct 19 - Mar 20	3479	32	34	0.3
Apr 19 - Sep 19	2860	27.2	23	0.8
Oct 18 - Mar 19	4232	40.6	19	0.18

* Data unavailable from the national portal



NHS
Great Western Hospitals
NHS Foundation Trust

Part 3: Other Information

3.1 Patient safety

The safety of our patients is at the heart of our approach and culture at the Trust. Patient safety incidents that are reported by our staff provide us with key insights into the safety of our patients

Freedom to Speak Up

Freedom to Speak Up (FTSU) is an initiative resulting from the Francis Report recommendations (Mid Staffordshire NHS Foundation Trust public enquiry) to give staff the opportunity to raise issues or concerns in a supportive forum. Effective speaking up arrangements help to protect patients and improve the experience of NHS staff. Staff who speak out have a number of channels available to them to speak up about issues or concerns they have, particularly those relating to quality of care, patient safety, and bullying or harassment. The trust actively invites staff to speak up and contribute to discussions and activities to improve both patient and staff experience.

The Trust has seven Freedom to Speak Up Guardians who work with individuals, teams and groups to promote speaking up including, for example, attending events such as: staff inductions; staff training and development events; local staff conferences and diversity and inclusion events.

In addition to this the Freedom to Speak Up Guardians work collaboratively with staff from Patient Safety and Human Resources and reports twice yearly to the Trust Board.

As part of embedding speaking up as ‘business as usual’ throughout the trust, for most situations, staff are encouraged to approach their line manager/supervisor/team leader. Because of the importance manager’s play at this stage and the value of good communication, training has been put in place to support these key staff members to have quality conversations with staff with further training currently is being embedded within the trust. Staff can also access support from a number of parties including directly from the Freedom to Speak Up Guardian; Human Resources, Health and Wellbeing Team, staff networks and the Diversity and Inclusion Team.

Staff are also advised of external reporting routes if they are unhappy with using any of the internal reporting routes or if they indicate that after raising a concern they do not feel the concern was investigated in line with Trust procedures, for example Care Quality Commission, and recognised professional or union body.

- We have strengthened intranet information about FTSU, including Guardian contact details and biographies; Guardian business cards were issued
- FTSU lanyards and badges for Guardians were provided;
- We strengthened reference to FTSU at Trust induction;
- Guardians attended various team meetings to talk about speaking up;
- We circulated an array of visual reminders such as large notices and posters.
- Development of a standard operating procedure to support Guardians with signposting appropriately.
- Development of a template to support managers in structuring their response to colleagues speaking up through the guardian route
- Nine awareness sessions have been held with staff including Theatres, Senior Managers and various at staff meetings, forums or group

Focus for 2022-2023

- Alignment with other work-streams in the Trust, e.g. 'just culture' and psychological safety;
- Revise our communications and awareness raising strategy
- Engagement with the Trust's BAME Networks via the network chairs
- Guardian engagement walkabouts
- Create a short report that helps managers reflect on the learning from a case and how they assure themselves that the learning prompts sustainable improvement.
- Ask the person that has spoken up to give their view on whether they can see improvement
- Add this information to case management systems so that we can collate information on learning themes and track which changes lead to sustained improvement.
- We are seeking permission from the person that spoke up and the manager involved to tell their stories about the learning from their case.

Guardian of safe working hours

We have a Guardian of Safe Working Hours who ensures our doctors are always working a safe number of hours and comply with the Terms and Conditions for Doctors and Dentists in Training (NHS England, update 2019). The Guardian acts as the champion of safe working hours and receives reports and monitors compliance. Where necessary the Guardian escalates issues to the relevant Medical Director for decision and action to reduce any risk to our patients' safety. Gaps in the rota for medical staff are monitored and managed at service level.

Safeguarding Adults

Great Western NHS Foundation Trust has a duty and responsibility to protect adults at risk of abuse or neglect due to their needs for care and support. Living a life that is free from abuse and harm is a fundamental human right of every person and an essential requirement for health and well-being. Healthcare staff are often working with patients who for a range of reasons who may be less able to protect themselves from neglect, harm, or abuse. Despite the challenges of safeguarding in the context of the COVID -19 pandemic adult Safeguarding advice, guidance and support to clinicians and practitioners has continued to be provided across the Trust system and wider safeguarding partnerships within the BSW.

Key Achievements

- Full delivery for 'cohort 1' of the Level 3 Adult Safeguarding training programme.
- Successful delivery of a collaborative project with Swindon Borough Council (SBC) to develop, trial and implement a new adult safeguarding e-referral for safeguarding adults in Swindon.
- Liberty Protection Safeguards (LPS): The national LPS code of practice and regulations has been delayed, however preparations have begun, scoping the assumed extent of the responsibilities to be transferred to the Trust from Local Authorities under the current Deprivation of Liberty Safeguards (DoLS) along with Trust representation at local LPS planning meetings.

- Domestic abuse related presentations increased across the system during the COVID-19 pandemic period. The introduction of a second Health Independent Domestic Violence Advisor (IDVA) has ensured full-service availability and delivery for both staff and Trust patients.
- System working: The Safeguarding Team participates in the Swindon Safeguarding Partnership (SSP) and the Safeguarding Vulnerable people Partnership (SVPP/Wiltshire). The service have been active partners in the domestic abuse, safeguarding adult/domestic homicide review and quality assurance sub-groups and within the partnership in identifying and contributing to learning for both the Trust and the wider safeguarding system.
- Mental Capacity Act (MCA) and Best Interests: Improvements have continued to be embedded, with continued provision of robust safeguarding advice and guidance, as well as direction and hands-on support with more complex challenging scenarios

Focus for 2022-2023

- Continue to develop positive partnership working within the BSW safeguarding system as the Trust works towards becoming an Integrated Care System (ICS).
- Work with divisional leads to ensure identified 'cohort 2' staff can access and receive Level 3 of training as per the safeguarding intercollegiate document.
- Supporting the Trust to prepare for the LPS and continue to embed and support best practice in the MCA and Best Interest process.
- Continue to share with the Divisions lessons and outcomes from safeguarding adult alerts raised by and against the Trust, Safeguarding Adult Reviews (SAR's), Domestic Homicide Reviews (DHR's) and safeguarding related clinical incidents and support staff to identify learning.

Safeguarding children

Working Together, 2018 states that 'Nothing is more important than children's welfare and that children who need help and protection deserve high quality and effective support as soon as a need is identified". We continually seek to safeguard and promote the wellbeing of children and families with the aim of improving outcomes and supporting their safety.

Many children and families have been adversely affected by the pandemic and this continues to impact on the health and development of children and specifically the anxiety and mental health of children and young people. Social isolation, loneliness, lack of physical exercise, and family stress has contributed to this. Ofsted's second report into the impact of the pandemic found that children who were hardest hit by school closures and restrictions have regressed in some basic skills and learning. Older children have lost strength in their reading and writing, some have lost physical fitness, others show signs of mental distress, including an increase in eating disorders and self-harm. The pandemic has heightened the vulnerability of children and young people to certain types of abuse, for example online abuse, abuse within the home, criminal exploitation and child sexual exploitation and parental stress, substance misuse and mental health problems has put children at an increased risk for maltreatment. The first 1,001 days of life are critical and unique period for a baby that sets the foundations for lifelong emotional and physical wellbeing.

In addition to an increase in activity, COVID-19 led to less oversight of vulnerable children and families particularly for those who are not formally known to the social care system, because day-to-day contacts with allied professionals (for example Teachers, Health Visitors, Family Support Workers) were reduced and many support services were withdrawn. This in turn put significant pressure on acute health services who were continuing to work 'business as usual' such as Maternity Services, Emergency Department, Urgent Care and Paediatrics. Each contact was vital to potentially identify vulnerability factors/ safeguarding concerns as well as provide support to those children and families in need. Face to face support, Safeguarding Supervision and Safeguarding Training were key to increasing staff awareness, confidence and competence in safeguarding practice as well as ensuring staff felt supported over this period.

Key Achievements 2021-2022

- Training has been developed to reflect the changing landscape of safeguarding and to include learning from audits/reviews for example 'Professional curiosity' training and bespoke training to the new Maternity Continuity of Carer Teams.
- The Maternity Safeguarding Team has developed interagency and multi-agency partnership to better support families we are working with e.g. New Beginnings providing support in the antenatal and immediate postpartum period to mothers who are likely to have children removed from their care and creating memory boxes for parents and babies prior to this.
- Introduction of the 'Safeguarding Theme of the Week,' which provided weekly updates to staff.
- To help staff achieve their safeguarding children's training, drop-in session arranged to discuss training requirements and how to fulfil this as well as signing off Safeguarding passports.
- Monthly community midwives' drop-in sessions for Q&A & safeguarding discussions

Focus for 2022-2023

- Further development of Virtual training provision to make training more accessible.
- Revision of the maternity risk notification pathway
- To support the 'Hidden Fathers' Agenda by including fathers in both assessing risk and inclusion of care of their children. Men play a very important role in children's lives and have a great influence on the children they care for. Despite this, research shows that there is a real lack of attention to fathers and father-figures, both in the data and research underpinning our understandings of the risks posed to babies, and in the design, delivery and evaluation of services that might better protect against harm.
- Improving safeguarding supervision rates across in line with the Safeguarding Children's Supervision Policy
- Support learning from local Children's safeguarding Practice Reviews and supporting Safeguarding Partnership Agendas.
- Building on the recommendations of Better Births and the commitments of the NHS Long Term

Learning disability practice

For a long time, people with learning disabilities and their advocates have been fighting for equality with the rest of the population. While progress has been made, there is still some way to go. People with learning disabilities still suffer inequality of treatment in healthcare settings and can face barriers to accessing healthcare that people without do not. The COVID -19 pandemic has accentuated these difficulties.

The Learning Disability (LD) Forum at the Great Western Hospital continues to work to reduce inequality in relation to both accessing and receiving healthcare through the delivery of an annual work plan. Due to the COVID -19 pandemic the established patient feedback programme was paused however people with Learning Disabilities and patient carers have continued to remain core members of the LD forum and assist the forum to better understand the service user perspective in relation to identifying areas of practice for focus and improvement. The Trust has developed an internal LeDeR Methodology mortality review programme to ensures any learnable lessons are understood and relevant internal actions taken.

Key Achievements 2021-2022

- Development of a LD register in Primary Care in relation to the provision of annual health checks and the launch of a bi-monthly MCA masterclass training opportunity open to all staff interested in developing this area of practice.
- Development of the Learning Disability (LD) Liaison Nurse role at the Trust to ensure staff are supported to provide reasonably adjusted, high quality care to patients with LD
- Undertaking an ‘LD patient pathway’ (in-patient experience audit) the findings of which will inform the 2022 LD forum workplan.
- Development of an ‘easy read’ patient feedback form for use on the Trust intranet
- Design, development, creation, and Implementation of a new ‘Enhanced Care’ process (including documentation) to support appropriate delegation of 1-1 care provision. This documentation ensures the person with LD who has care and support needs is looked after by the most appropriate person to meet their specific needs whilst an in-patient at the Trust.
- Development of a Complex care admissions care pathway for day case admissions
- Training: LD Awareness sessions were delivered by the Learning Disability Liaison Nurse to Foundation Doctors and a number of key staff from the Emergency Department (ED) and Theatres.

Focus for 2022-2023

- For LD Liaison to develop practice protocols in relation to areas of practice identified as requiring focus through the learning from National reports, clinical risk outcomes and internal LeDER methodology reviews
- Undertake a review of the available easy read leaflets with a view to refresh and expand the scope of leaflets available
- Expand the LD training programme to include autism considering the mandate to introduce the 'Oliver McGowan' autism training programmes into acute trusts.

NHSE & NHSI - Learning Disability (LD) and Autistic Spectrum (AS) Improvement Standards Review

The Trust continues to take part in the annual National NHSi LD and AS Improvement standards audit programme and receives annual outcome reports. The most recent report for the Trust was received in March 2021. The three standards applicable to the Trust are; respecting and protecting rights, inclusion and engagement and workforce.

In 2018 from the 14 measures, the number of actions identified to fully meet the standard was 35. As of March 2022, the number of actions from original benchmarking audit remaining open was five.

Four of the five of the original outstanding actions are partially delivered against the standard. Over the reporting period the Trust has continued to demonstrate improvement activity against the majority of the standards.

Consolidated annual report on rota gap for medical staffing including internal factors

The Trust currently has a total of 47.99 WTE vacancies across all grades and specialties of medical staff, this figure also includes doctors appointed pending start dates and candidates that are filling roles on a fixed term basis.

Internal factors:

In May 2021 a restructure occurred in Medical Workforce with a proportion of the team joining the wider Recruitment team, this new way of working has enabled a specific focus on Medical recruitment with a dedicated team supporting delivery.

We continue to hold a British Medical Journal subscription and have a lead account manager supporting the advertisement of our roles. Through using the BMJ we can advertise all our medical vacancies through their online portal, ensuring a high number of views nationally and internationally by doctors looking for work. We also have access to use their printed journal for advertising, but this is reserved for Consultant recruitment campaigns since usage is limited.

Vacancies are reviewed regularly at monthly Medical Staffing Group meetings We also take the opportunity to work with the Junior Doctors forum to promote roles that might interest their members and gain feedback on improvements that could be made to make roles more attractive.

Currently Job Planning is being undertaken on a mixture of manual and bespoke systems across the Trust, which cannot be collated and reported on centrally. There is a requirement from NHSE/I for Trusts to establish electronic Job Planning systems, and there is an opportunity for the Trust to procure a joint Job Planning and Revalidation system to fulfil this requirement whilst delivering a user-friendly system which will facilitate increased engagement with the job planning and revalidation processes. There are also potential improvements to productivity which could be realised through efficient job planning through a dedicated system.

Currently the Trust does not have a single accessible system for rostering its Medical Workforce, and does not have clear oversight of absence, worked time, and activity. There is no clear way of identifying gaps in resource, meaning that tight controls on temporary staffing cannot be delivered. Work is underway to deliver E Rostering for Medical staff, whilst also delivering a robust BAU model for divisions to ensure rosters are maintained to facilitate clear oversight, enable staff movements, and highlight opportunities for efficiency in resource utilisation.

External factors:

All remaining vacancies are covered by internal bank locums or agency locums, recent benchmarking was undertaken across the BSW with new locum rates created. Fill rate for bank locums at Junior Doctor level continues to remain high

3.2 Performance against key national priorities

An overview of performance in 2021 - 22 against the key national priorities. Performance against the relevant indicators and performance thresholds are provided.

Measure	National Target	Local Target 2021/22	Performance 2021/22
ED 4 hours Q1	95%	95%	77%
ED 4 hours Q2	95%	95%	75%
ED 4 hours Q3	95%	95%	74%
ED 4 hours Q4	95%	95%	Not yet avail
Stroke	n/a	C	Not yet avail
RTT Waiting List	WL at Jan 2021	23,247	Not yet avail
RTT 52 Weeks	0	2,269	Not yet avail
DM01 performance Q1	99%	99%	78%
DM01 performance Q2	99%	99%	68%
DM01 performance Q3	99%	99%	57%
DM01 performance Q4	99%	99%	
Cancer Performance (62 days) Q1	85%	85%	84%
Cancer Performance (62 days) Q2	85%	85%	81%
Cancer Performance (62 days) Q3	85%	85%	74%
Cancer Performance (62 days) Q4	85%	85%	Not yet avail
Cancer performance (2WW) Q1	93%	85%	72%
Cancer performance (2WW) Q2	93%	93%	94%
Cancer performance (2WW) Q3	93%	93%	90%
Cancer performance (2WW) Q4	93%	93%	Not yet avail

3.3 Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Statement from the Council of Governors

The Governors are of the opinion that the Quality Account presented are a realistic representation of the Trust's performance in 2021/2022. We would like to take this opportunity to acknowledge that's it's been another challenging year for the Trust with the aftermath of the Covid pandemic and exceptional high numbers of people seeking treatment. The Governing body would like to formally acknowledge the outstanding level of devotion and resilience that every member of staff has shown throughout the Trust.

Again, during this period, we were still not allowed to attend the hospital however, we have maintained virtual meetings on a monthly basis. These meetings covered talking to the staff as well as seeking assurances on the priority topics to ensure that the quality agenda and other monitoring was still carried out.

The GWH Trust covers such a wide geographical area and where possible we have Governors representing as many areas as we can therefore representing the needs of all our patients, carers and families.

The Trusts Priorities for Quality Improvement for last year: include listening and engaging with patients, their families and carers; reducing the incidence of hospital acquired pressure ulcers; achieving smooth and effective flow across the hospital and community. The Governing body throughout the year has continued to seek assurances from the Non-Executive Directors (NED's) that the quality agenda was being addressed and monitored the outcomes. It is fair to say that the Trust has tried to continue with as much of its quality agenda but due to the Covid pressures some of the targets were not fully achieved.

The report talks about its main priorities for the coming year and the Governing body will be monitoring these and challenging to ensure we see real change.

These areas are: Embedding learning regarding serious incidents, Improving the patient experience when being discharged from hospital, ensuring the optimal nutrition and hydration is given to our patients during their stay in hospital. The Governing body were consulted about these priorities and are fully supportive of these as the lead quality markers for the coming year.

Pauline Cooke
Lead Governor on behalf of the Council of Governors

Statement from Healthwatch Swindon, Healthwatch Wiltshire and Healthwatch West Berkshire

Healthwatch recognises the exceptional work undertaken by colleagues at Great Western Hospital during challenging times with the continuation of the covid 19 pandemic during 2021/22

- We welcome the Great Care Campaign keeping the patient at the very centre of all that the hospital do. And proactively collecting feedback and listening to your patients and their families and carers, and responding back effectively ensuring a positive impact on people's experience of care.
- We are pleased to see changes that have been made by the great western hospital directed by the Enter and View visits carried out by Healthwatch Swindon in collaboration with Healthwatch Wiltshire and Healthwatch Berkshire based on the feedback we heard. We welcomed specific changes made in reference to Carers being more involved and information given to patients when discharged - Safety Netting process calls patients once they've been discharged to ensure services are in place. We welcome the recognition and inclusion of small simple changes that can potentially make a big difference to the patient experience.
- We welcome priority 2 – Planning for a patient's Discharge from the hospital. This is an area in which we have received feedback and welcome the hospital improving communication to support the discharge experience of patients.
- We welcome the continuation of work carried out by the Learning Disability (LD) Forum at the great western in tackling to reduce inequalities in relation to both accessing and receiving healthcare through the delivery of an annual work plan. We commend the development of the Learning Disabilities Liaison Nurse's role at the Trust ensuring staff are supported to provide high-quality care to patients with Learning Disabilities.

"We look forward to seeing the completion of the work to meet the 2021-22 Priority 1: Listening and engaging with our patients, their families and carers - which it is noted were only partially completed.

The collection of patient, friends and family feedback is central to the success of the Trust's Great Care campaign and we look forward to this data being fully reported and the overall area of work of listening and engaging with patients, their families and carers being taken forward successfully.

We continue to work with the trust to ensure the patient voice is taken into account throughout the patients journey from admissions to discharge.

healthwatch

Statement from Bath and Northeast Somerset, Swindon, and Wiltshire Clinical Commissioning Group

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (CCG) welcome the opportunity to review and comment on the Great Western Hospital Quality Account for 2021/2022. In so far as the CCG has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the CCG via quality reporting routes and is presented in the format required by NHSE/I presentation guidance.

The CCG recognises that 2021/2022 continued to be a challenging year due to the COVID-19 Pandemic which impacted on services provided by GWH. The CCG would like to thank GWH for their sustained contribution to supporting the wider health and social care system during the pandemic and the transition into COVID-19 recovery phase.

It is the view of the CCG that the Quality Account reflects GWH on-going commitment to quality improvement and addressing key issues in a focused and innovative way. It is recognised that the achievement of several priorities during 2020/21 have continued to be affected by COVID-19, however, GWH has still been able to make achievements against many of their priorities for 2021/22, these include:

- Listening and engaging with patients, families, and carers through the introduction of a Patient Experience and Engagement Framework, giving patients the opportunity to share feedback on what is important to them in the services they receive to inform service improvement. Development of quality and feedback boards and implementation of clear visible signposting across the organisation were partially achieved. Embedding of care conversations was not achieved, however the CCG acknowledges the introduction of ward buddies and a volunteers' patient experience forum to take this forward.

- Reducing the incidence of hospital acquired pressure ulcers through the introduction of Safer Skin Champions and implementing learning to support early identification. The CCG notes the progress regarding implementation of a digital pressure ulcer assessment tool, staff education and training and a bed and mattress replacement programme. The CCG welcomes the continued focus on this important area of improvement.

- Achieving smooth and effective flow across the hospital and community to reduce delays for patients by implementing the SAFER suite of actions and greater working with partners to deliver care in the community. The CCG also notes progress in the development of a strategy to reduce patient moves.

Statement from Bath and Northeast Somerset, Swindon, and Wiltshire Clinical Commissioning Group cont.

The CCG supports GWH's identified quality priorities for 2022/23.

It is recognised that several of the priorities described in this Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance with a crucial focus on reducing inequalities. The CCG welcomes continued engagement in the agreed service improvement plan and focus on:

- Exploring a systematic approach oriented towards embedding learning from serious incidents in accordance with the NHS Patient Safety Strategy, enabling patients and staff to discuss concerns openly through supportive reporting and feedback methods.

- Reducing unnecessary delays and improved communication when planning discharges to support patients' discharge experience, including implementing 'safety netting' calls for patients the day after discharge.

- Ensuring patients receive optimal nutrition and hydration assessment and support to improve the patient's recovery and reduce their length of stay in hospital.

The CCG is pleased to note the continued programme of work to embed Great Care, that ensures a coordinated focus on providing harm free, expert and personalised care in an improved environment across the organisation, and the establishment of a Health Inequality Steering Group and would welcome the opportunity to work collaboratively and learn from this important work including a focus on this with the Elective recovery work. BSW CCG also looks forward to seeing the embedding of the new quality strategy that sets out how quality of care will continually improve and how this will compliment and enhance the 'Improving Together' continuous improvement programme.

NHS Bath and North East Somerset, Swindon and Wiltshire CCG, together with associated co-commissioners, are committed to sustaining strong working relationships with GWH and together with wider stakeholders, will continue to build on our collaborative approach to achieve shared priorities as the Integrated Care System develops in 2022/23.

Yours sincerely

Statement from Swindon Health Overview & Scrutiny Committee

The chair of Adult, Health and Housing Overview and Scrutiny Committee welcomes the Great Hospital Foundation Trust Quality Account.

The Council has worked closely with the Trust in delivering health and social care services through the most challenging time in history for health and care services. The partnership will now focus on the backlog of patients waiting for a health intervention and continue to support timely and supported discharge for some of our most vulnerable residents. It is a credit to the health and care system that even through this challenging time many residents comment on the excellent care they have received. We recognise the significant sacrifices staff have made to maintain services during the pandemic and we want to thank them for their extraordinary commitment. We also value the contribution Great Western Hospital Foundation Trust has made to the work of the Committee and the openness and transparency of the contributions

Statement of directors responsibilities for quality

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation Trust annual reporting manual 2019/20 and supporting guidance detailed requirements for quality reports 2019/20
- the content of the quality report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2021 to March 2022
    - papers relating to quality reported to the board over the period April 2021 to June 2022
    - feedback from commissioners dated 21/06/2022
    - feedback from governors dated 21/06/22
    - feedback from local Healthwatch organisations dated 14/06/22
    - feedback from overview and scrutiny committee dated 14/06/2022
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported monthly
    - the national patient survey June 2021
    - the national staff survey April 2021
    - CQC inspection report dated June 2020
- the quality report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Glossary of terms

AKI – Acute Kidney Injury
AWP - Avon and Wiltshire Mental Health Partnership
CCG – Clinical Commissioning Group
CQC - Care Quality Commission
CQUIN - Clinical Quality & Innovation
Criteria to reside - Term to describe eligibility for a patient to receive hospital treatment that can only be delivered in an acute hospital setting
DM01 - Diagnostic waiting times
DoLS - Deprivation of Liberty Safeguards
DSP - Digital Data Security & protection
Duty of Candour - The process of being open and honest with patients, service users or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.
EDI - Equality Diversity and Inclusion
EPMA - Electronic Prescribing and Medicine Administration
FFFAP - Falls and Fragility Fractures Audit Programme
FTSU - Freedom to Speak Up
GP - General Practioner
GWH - Great Western Hospitals NHS Foundation Trust
HCA - Health Care Assistant
HEE - Health Education England
Hospital Discharge Policy - Policy supporting the safe and timely discharge of people who no longer need to stay in hospital.
IGSG - Information Governance Steering Group
Integrated Front Door - The co-location of Urgent and Emergency care services on the ground floor of GWH
IT - Information Technology
LD - Learning Disabilities
Level 3 Adult Safeguarding - Level of training required for health and care staff who engage in assessing, planning intervening and evaluating the needs of adults where there are safeguarding concerns
LSAB -
MBRRACE - Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries
MCA - Mental Capacity Act
MDT - Multidisciplinary Team
NCEPOD - National Confidentiality Enquiry into Patient Outcome and Death
Nerve Centre - Software supporting electronic patient observations
NEWS2 - National Early Warning Score
NHS - National Health Service
NHSE - National Health Service England
NMPA - National Maternity and Perinatal Audit

Glossary of terms

OT - Occupational Therapy

PCN - Primary Care Network

PCP - Personal Contact Plan

Perfect Ward Mobile - App supporting ward quality inspections

PROMS - Patient Reported Outcome Measures

RCEM - Royal College of Emergency Medicine

RTT - Referral to treatment

SAFER - Senior review, all patients, flow of patients, early discharge, review

SFFT - Staff Friends and Family Test

SHMI - Summary Hospital Level Mortality Indicator

SI - Serious Incident

SJR - Structured Judgement Review

SSNAP - Sentinel Stroke National Audit Programme

SSP - Swindon Safeguarding Partnership

SWICC – Swindon intermediate Centre

SVPP/Wiltshire - Safeguarding Vulnerable people Partnership

TEP - Treatment Escalation Plan

U&EC - Urgent and Emergency Care

VTE - Venous Thromboembolism

Report Title	**Terms of Reference of Board Committees**				
Meeting	**Trust Board**				
Date	**7 July 2022**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Quality & Safety Committee Terms of Reference Appendix 2 – Finance & Infrastructure Terms of Reference Appendix 3 – People & Culture Terms of Reference Appendix 4 – Performance, Population & Place Terms of Reference Appendix 5 – Mental Health Governance Committee Terms of Reference Appendix 6 – Charitable Funds Committee Appendix 7 – Trust Management Committee				

Purpose

Approve	x	**Receive**		**Note**		**Assurance**	
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level

Assurance in respect of: process/outcome/other (please detail):

Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

The Board approved a number of changes to the Board committee structure in April 2022. As a result the terms of reference for each of the committees have been updated to reflect the changes, except for the People & Culture Committee which is a newly established committee.

Where amendments have been made these are highlighted in the version control box on page 2 and highlighted in the document in yellow.

Due to timing the following committees will be presented for approval at the August 2022 Board meeting:

- Audit, Risk & Assurance Committee
- Remuneration Committee

Each Committee has reviewed and agreed their terms of reference.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks	★				

– select one or more				
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a			**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Quality & Safety Committee Finance & Infrastructure People & Culture Committee Performance, Population & Place Committee Mental Health Governance Committee Charitable Funds Committee Trust Management Committee			
Next Steps	To align annual work plans to the terms of reference			

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			**X**
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			**X**
Explanation of above analysis:			

Recommendation / Action Required
The Board/Committee/Group is requested to:

The Board is requested to approve the terms of reference for the following Board committees:-

Quality & Safety Committee
Finance & Infrastructure
People & Culture Committee
Performance, Population & Place Committee
Mental Health Governance Committee
Charitable Funds Committee
Trust Management Committee

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	24 June 2022

Great Western Hospitals
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE

Review Date	May 2023
Board Approval	

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Quality & Governance Committee to Quality & Safety Committee and revised remit
V1.1	For review	May 2022	Quality & Governance Committee	Considered revised TofR for the Quality & Safety Committee. Amendments include: • New format • Reference to assigned strategic risk • Added deputies for Executive Directors and voting process • Clarify remit on safeguarding • Link to the Strategic Framework • Summary table of meeting remit

1. AUTHORITY

1.1 The Quality & Safety Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors (Trust Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2. The Committee is authorised by the Board of Directors (Trust Board) to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. ROLE / PURPOSE

2.1 To obtain assurance on behalf of the Trust Board that the Trust has in place the necessary structures and processes for the effective direction and control of the organisation so that it can meet its objectives, in particular, the provision of safe high quality patient care and that it complies with all relevant legislation, regulations and guidance that may from time to time be in place.

2.2 To seek assurance on behalf of the Trust Board that strategic risks linked to strategic pillar (1) "outstanding patient care and focus on quality improvement in all that we do", identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

3. MEMBERSHIP

3.1 The membership of the Quality & Safety Committee shall consist of:

- Three Non-Executive Directors (not including the Chair), at least one of whom will have a clinical background
- Two Executive Directors; Chief Nurse & Medical Director

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

4.1 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.

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

4.4 *Substitutes/Deputies* - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum.

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.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Leads, the Chief Nurse and Medical Director.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 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.

7. DUTIES

7.1 Patient Safety

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems except for compliance with the Mental Health Act (MHA), Mental Capacity Act (MCA) and Human Rights Acts and associated codes of practice which is monitored at the Mental Health Governance Committee.

7.2 Patient Experience

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 Patient Outcomes

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Trust Board, and monitor its delivery.

7.3.2 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 Quality Improvement

7.4.1 The Committee will make recommendations to the Trust Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Great Care Campaign and quality improvement activity.

7.5 Performance Monitoring

7.5.1 The Committee will advise the Trust Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS Oversight Framework.

7.5.4 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.5 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 Other

7.6.1 To oversee quality and safety Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.9.2 Take responsibility for gaining appropriate levels of assurance for those items related to safety and quality on the BAF for which the Committe has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Patient Quality Committee

10.2 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

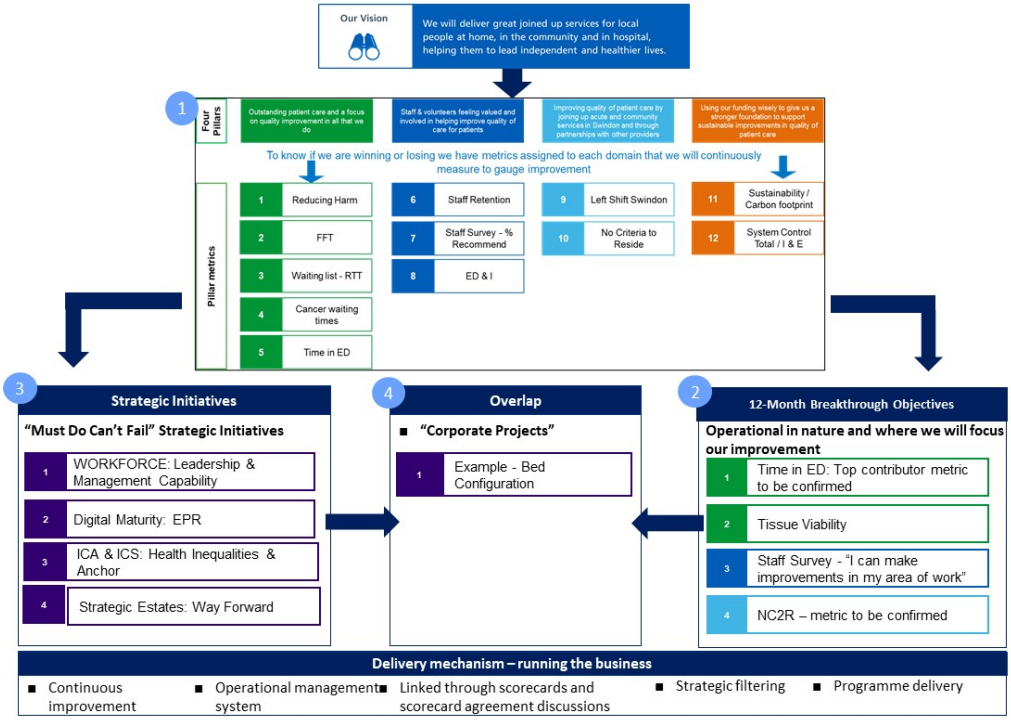
11.2. The terms of reference of the Committee shall be reviewed annually by the and approved Board of Directors.

Appendix 1 - Summary

Committee	Quality & Safety Committee - Summary
Chair Lead EDs	Nick Bishop, Non-Executive Director Lisa Cheek, Chief Nurse Jon Westbrook, Medical Director
Frequency	Monthly
Membership	3 x NEDs 2 X EDs
Quorum	2 x NEDs 1 x ED
Remit	Quality Performance - IPR Quality Strategy Patient experience including national and local surveys Complaints performance data Incident data / Never Events Clinical Risks Quality Report GIRFT oversight Clinical Audit Plan Clinical Effectiveness including NICE Learning from Deaths Infection Prevention & Control/DIPC Research and Development Approval of Resuscitation Policy End of Life Care Children & Young People Safeguarding Adults & Young Children Mortality and Morbidity Performance Maternity & Neonatal - Ockenden Medical device/equipment safety Medication safety Performance data Safer Staffing Freedom to Speak Report Quality Strategy Provider Licence / Code of Governance Compliance Clinical litigation Board Assurance Framework
Strategic Risk	Quality (S2)

Appendix 2

GWH - Strategic Planning Framework



FINANCE & INFRASTRUCTURE COMMITTEE
TERMS OF REFERENCE

Review Date	**May 2023**
Board Approval	

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Finance & Investment Committee to Finance & Infrastructure Committee and expanded remit
V1.1	For review	May 2022	Finance & Investment Committee	Considered revised TofR for Finance & Infrastructure Committee. Amendments include:- • New format • Revised membership • Incorporate oversight and assurance on estates and IT/digital matters • Reference to assigned strategic risk • Added deputies for Executive Directors and voting process • Link to the Strategic Framework • Summary table of meeting remit

1. AUTHORITY

1.1 The Finance & Infrastructure Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors (Trust Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2. The Committee is authorised by the Board of Directors to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. ROLE / PURPOSE

2.1 To support the implementation of the Board's Strategy by seeking assurance about the Trust's financial, estates and digital strategies.

2.2 To ensure that any material, long term financial or business risks identified are brought to the attention of the Trust Board to ensure they are reflected within the Trust's Risk register and Risk management process and to advise the Audit, Risk and Assurance Committee on the adequacy of any mitigation plan and recommend any areas requiring Audit scrutiny.

2.3 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillar (4) *"using our funding wisely to give us a stronger foundation to support sustainable improvement in quality of patient care"*, and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.4 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

3. MEMBERSHIP

3.1 The membership of the Finance & Investment Committee shall consist of:

- Three Non-Executive Directors (not including the Chair) – at least one of whom will have financial background
- Three Executive Directors; the Director of Finance & Strategy, Chief Operating Officer and the Director of Improvement & Partnerships.

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

4. ATTENDANCE

4.1 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.

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

4.4 *Substitutes/Deputies* - Any Non-Executive Director of the Trust, (excluding the Chair), may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum.

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.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Lead, the Director of Finance & Strategy

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 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.

7. DUTIES

7.1 Financial Strategy and Business Planning

7.1.1 Review the Trust annual and medium-term financial plans, assess the assumptions therein and the alignment with overall Trust objectives;

7.1.2 Review in-year performance against financial plan, particularly gaining an understanding of key assumptions and risks, and review the latest year end forecast outturn;

7.1.3 Review through 'Deep Dive Reviews' any areas requiring particular scrutiny;

7.1.4 Review levels of contingency within the Trust financial plans and the phasing of key developments and efficiency schemes, ensuring that the full impact of

any developments (including depreciation and cost of capital) have been appropriately included;

7.1.5 Review and develop reporting arrangements

7.2 Income and Contract Management

7.2.1 Review the Trust contracting approach with key commissioners

7.2.2 Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.

7.2.3 Consider material opportunities to grow new income streams and market share of existing services.

7.2.4 To review, approve and/or recommend to Board operational contracts in line with the financial limits within the Scheme of Delegation;

7.3 Improvement and Efficiency

7.3.1 Review the process for developing the Improvement & Efficiency Plans and for the oversight and delivery of the programme within the Trust, including the monitoring of efficiency savings;

7.3.2 Review the implementation of the Trust's strategies and plans to provide assurance on the delivery of both financial and non-financial benefits. In the case of non-financial benefits to highlight any shortfalls to the appropriate committee or to the Board;

7.3.3 Consider and recommend any major transformation programmes that the Trust should undertake;

7.3.4 Review the annual Improvement & Efficiency Plans to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable;

7.3.5 Receive assurances regarding efficient and effective resource planning, particularly with respect to staffing and the deployment of agency staff;

7.3.6 Receive benchmarking and other relevant information to assess Trust productivity and ensure targeting or efficiency programmes;

7.4 Major Capital Investment Scheme

7.4.1 The Committee has a duty to ensure that a Business Case is prepared which includes sufficient information on the business needs, benefits, risks, funding and affordability, available options, costs, clinical and quality outcome measures, project development milestones, project management and regulatory requirements for it to decide whether or not to approve the scheme or lease.

7.4.2 To review, and recommend, Outline Business Cases and Full Business Cases prior to submission to the Board in line with the financial limits within the Scheme of Delegation;

7.4.3 If major capital investment schemes are approved by the Committee, and by the Board of Directors if appropriate (see Section 2), the Committee will be responsible for reviewing the outcomes achieved following completion.

7.5 Key Commercial Arrangements

7.5.1 The Committee will review key commercial arrangements including long-term leases, partnership arrangements and major service developments. The Committee will track the progress of such developments, as appropriate.

7.6 Procurement

7.6.1 Review the Trust Procurement Strategy, systems and arrangements for obtaining best value;

7.6.2 Monitor progress against the NHS Standards of Procurement within the Trust.

7.7 Other – Financial

7.7.1 To advise on cash management strategies and levels of cash holding;

7.7.2 Review financial systems arrangements including those used for costing, income and service level reporting where appropriate.

7.8 Infrastructure (Estates & IT/Digital)

7.8.1 To approve for recommendation to the Board the Estate and IT strategic plans to ensure that it aligns with the Trust Strategy and operational objectives, including patient care delivery;

7.8.2 To seek assurance regarding operational delivery of estates and facilities (to include equipment management, health & safety, security, Way Forward Programme operational design) and IT plans including benefits realisation, value for money and approaches to the prioritisation of resources, data quality and informatics;

7.8.3 Seek assurance about the resilience of Digital services specifically in relation to the digital infrastructure, defending against, and recovery from, external threats;

7.8.4 To review key commercial partnerships as appropriate;

7.8.5 Consider the risks to the delivery of the IT programmes, Digital Services, and Estates and Facilities infrastructure in line with the review of the Board Assurance Framework and Corporate Risk Registers.

7.9 Other

7.9.1 To oversee Finance, Estates and Digital Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures

that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.9.2 Take responsibility for gaining appropriate levels of assurance for those items related to finance and infrastructure on the BAF for which the Committee has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Investment Group
- Infrastructure Committee
- Way Forward Programme Board

10.2 The Committee will also consider key assurance reports as outlined in appendix 1.

10.3 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

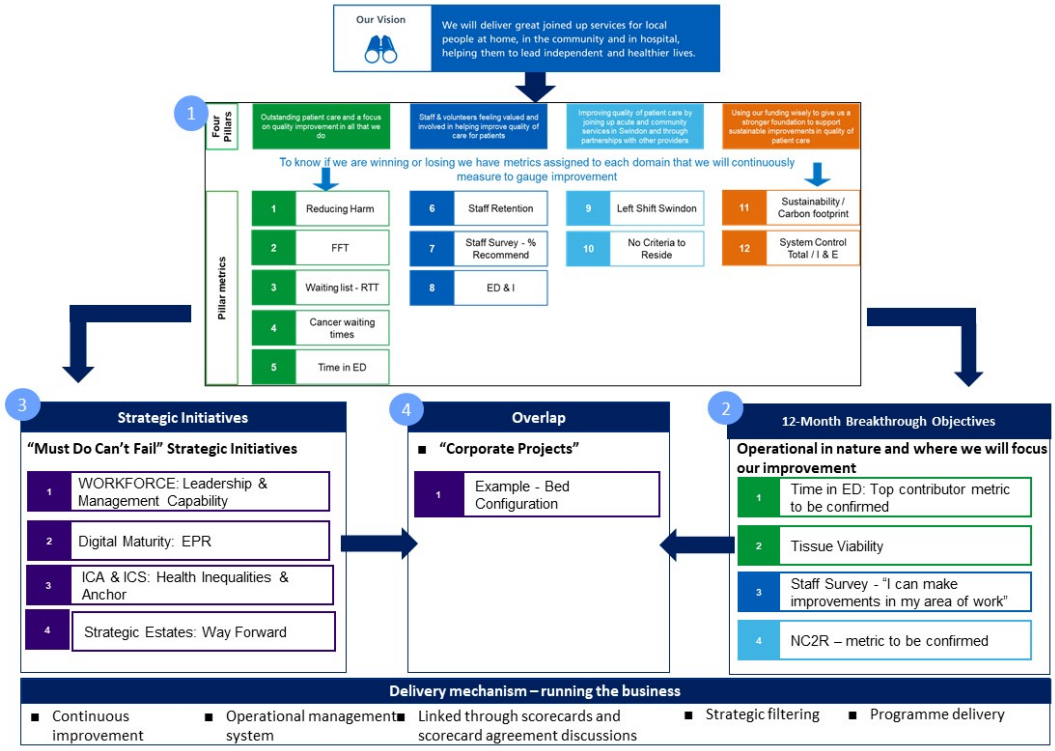
11.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Appendix 1 - Summary

Committee	Finance & Infrastructure Committee
Chair Lead EDs	Faried Chopdat, Non-Executive Director Simon Wade, Director of Finance & Strategy Felicity Taylor-Drew, Chief Operating Officer Claire Thompson, Director of Improvement & Partnerships
Frequency	Monthly
Membership	3 x NEDs 3 x EDs
Quorum	2 x NEDs 1 x ED
Remit	**Financial** Finance Report -IPR Financial strategy & policy management incl SFIs & SofD Business Planning – Operating Plans and Budget setting Reference Cost Submission Business case approval up to £500,000-£1m Improvement & Efficiency / Cost Improvement Programme Way Forward Programme Private Patients Performance data **Procurement** Contracting Report Review delivery of Procurement & Commercial services **Information Governance** SIRO Report (inc. Data Protection & Security Toolkit Performance) **IT Infrastructure** IT Performance Cyber security update **Estates & Facilities** Estates/infrastructure performance Health & Safety **Risks** Corporate risks - Finance, IT, Estates Board Assurance Framework
Strategic Risks	Use of Resources – Finance (S6) Use of Resources – Infrastructure (S7)

Appendix 2

GWH - Strategic Planning Framework



Great Western Hospitals
NHS Foundation Trust

PEOPLE & CULTURE COMMITTEE TERMS OF REFERENCE

Board Ratification	
Next Review Date	**May 2023**

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1	For review	March 2022	Company Secretary	New committee
V1.1	For approval	June 2022	Chair and Director of HR	For approval at first P&CC

1. AUTHORITY

1.1 The People and Culture Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2. The Committee is authorised by the Board of Directors to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. ROLE / PURPOSE

2.1 To monitor, review and report to the Board on the cultural and organisational development of the Trust, and to receive and provide the Board with assurance with regard to:

- the organisation's understanding of strategic workforce needs (including wellbeing, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them.
- the implementation of key HR controls, including recruitment and retention, and performance management including appraisal systems.
- the commitments of the NHS Constitution and the stated values of the Trust and standards of behaviour are being practiced at all levels of the organisation, based on evidence.
- the achievement of key deliverables in relation to the equality, diversity and inclusion (EDI) plan, and to monitor key metrics in relation to EDI.
- the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements.
- ensure engagement and consultation processes with staff reflect the ambition and values of the Trust and also meet statutory requirements

2.2 To seek assurance on behalf of the Board that the strategic risks linked to the strategic pillar (2) *"Staff and volunteers feeling valued and involved in helping improve quality of care for patients",* and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

3. MEMBERSHIP

3.1 The membership of the People and Culture Committee shall consist of:

- Four Non-Executive Directors
- Three Executive Directors - the Director of HR & Organisational Development, Chief Nurse and Medical Director.

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

4.1 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.

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

4.4 *Substitutes/Deputies* - Any Non-Executive Director of the Trust, (excluding the Chair), may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum.

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.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Lead, the Director of HR.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet on a bi-monthly basis with additional meetings called where necessary. However, meetings that are not required will be cancelled.

7. DUTIES

7.1 People

7.1.1. Review the development and delivery of the Trust's sustainable workforce strategy, focusing on:

- Strategic workforce information and planning.
- Recruitment and retention.
- Staff experience and engagement, reward, recognition, health and wellbeing
- Education, learning and organisational and leadership development.
- Equality, diversity and inclusivity

7.1.2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies.

7.1.3 Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities.

7.2 Culture and Values

7.2.1 The role of the committee would be to oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback.

7.2.2. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board.

7.2.3. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area.

7.3 Organisational Capacity

7.3.1 The role of the Committee would be to oversee the development and delivery of a strategy regarding a sustainable workforce (more generally). That would include development of new roles, recruitment and retention etc.

7.3.2. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management.

7.4 Education and Training

7.4.1 Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system.

7.4.2. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff.

7.5 Staff Health & Wellbeing

7.5.1 Oversee the development and delivery of a Trust Staff Health and Well-being Strategy

7.5.2. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics.

7.6 Other Duties

7.6.1 To refer to the Trust Board or other Board committee and/or the Executive Team any identified unresolved risks arising within the scope of these terms of reference that require Executive action or that pose significant threats to the operation, resources or reputation of the Trust.

7.6.2 To identify, assess and manage strategic risks in relation to the Committee's area of focus via the Board Assurance Framework. Review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Trust Board with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Employee Partnership Forum
- Joint Liaison Negotiation Committee
- Medical Staffing Support Group
- Nursing, Midwifery and AHP Workforce Committee
- Equality, Diversity & Inclusion Group
- HWB Oversight Committee

10.2 The Committee will consider the key assurance reports as outlined in appendix 1.

10.3 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

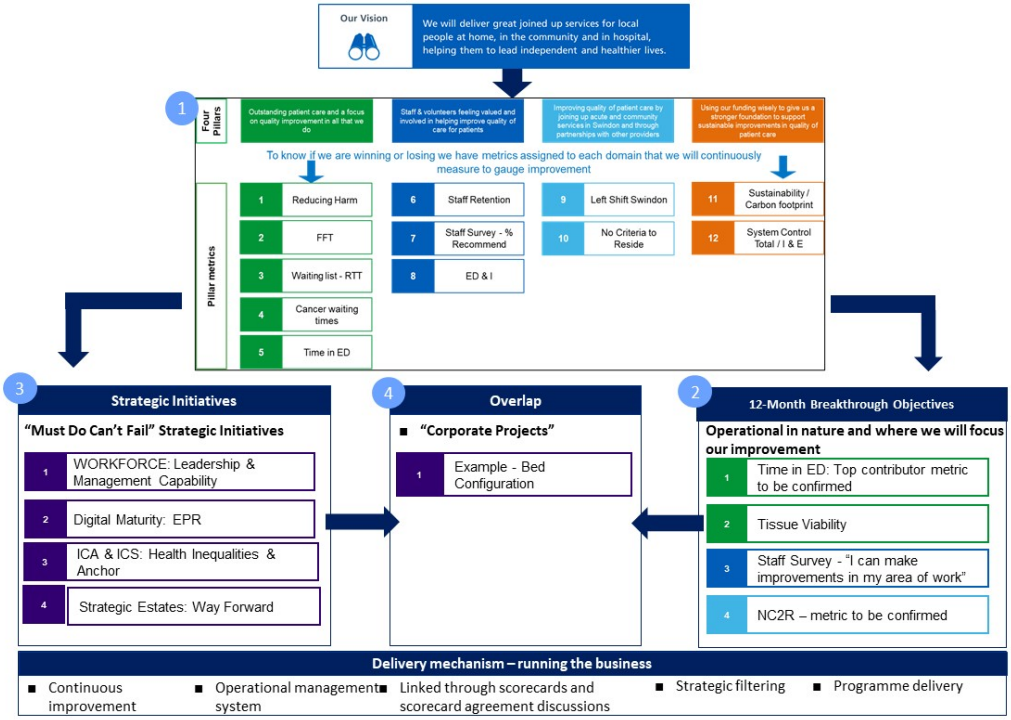
11.2. The terms of reference of the Committee shall be reviewed annually by the and approved Board of Directors.

Appendix 1 - Summary

Committee	People & Culture
Chair Lead ED	Paul Lewis, Non-Executive Director Jude Gray, Director of HR
Frequency	Bi-monthly
Membership	4 x NEDs 3 x ED (Director of HR, Chief Nurse & Medical Director)
Quorum	3 x members (2 Non-Executive Directors and 1 Executive Director).
Remit	People Strategy Workforce performance - IPR Equality, Diversity & Inclusion Nursing skill mix Medical revalidation inc. appraisal/MHPS report/GMC Guardian of Safe Working Staff survey and engagement Job planning compliance Education and Training Gender pay gap WRES performance data WDES performance data Organisational Development Clinical Excellence Awards Voluntary services Compliance with employment legislation Recruitment and retention Workforce digital solutions – e-roster, job planning etc.
Strategic Risk	Workforce (S2)

Appendix 2

GWH - Strategic Planning Framework



Great Western Hospitals
NHS Foundation Trust

PERFORMANCE, POPULATION & PLACE COMMITTEE

TERMS OF REFERENCE

Review Date	May 2023
Board Approval	

Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Performance, People & Place Committee to Performance, Population & Place Committee and revised remit
V1.1	For review	June 2022	Performance, Population & Place Committee	TofR of Performance, Population & Place Committee and approved subject to the following amendments: - 2.2 add 'healthcare' before needs and change we to 'how these are being met' - 7.3.1 delete across the entire population - Add to remit; JSNA annual review, ICS work programme plan, clinical networks and EPRR

1. AUTHORITY

1.1 The Performance, Population & Place Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2. The Committee is authorised by the Board of Directors (Trust Board) to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. ROLE / PURPOSE

2.1 Consider and advise the Board on the impact of operational management arrangements and to monitor arrangements in place for performance management.

2.2 Consider and advise the Board on the healthcare needs of the population we serve and how these are being met.

2.3 Consider and advise the Board on the development of our role at place in the ICS/ICA.

2.4 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillars (3) *"Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers*", and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.5 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

3. MEMBERSHIP

3.1 The membership of the Performance, Population & Place Committee shall consist of:

- Four Non-Executive Directors
- Two Executive Directors; the Chief Operating Officer and Director of Improvement & Partnerships.

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

4.1 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.

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 *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.

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.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Leads, Chief Operating Officer and Director of Improvement & Partnerships.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 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.

7. DUTIES

7.1 Operational Performance

7.1.1 To Seek assurance that the measures incorporated in the Integrated Performance Report to the Trust Board meet both internal requirements and those of external stakeholders. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented

7.2 Embedding Continuous Quality Improvement & Learning

7.2.1 To oversee the delivery and embedding of Improving Together approach to continuous quality improvement and learning.

7.3 ICS Development / Partnerships

7.3.1 To obtain assurance that Trust plans will positively impact on population health to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities.

7.3.2 To oversee the development of GWH as an anchor organisation.

7.4 Model of Care

7.4.1 To horizon scan for, be aware of, influence and respond to policy changes relating to models of care.

7.4.2 To ensure that changes in services at the Trust drive the outcomes required in the BSW model of care.

7.5 Other

7.5.1 To oversee Performance, Partnerships and Improvement Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.5.2 Take responsibility for gaining appropriate levels of assurance for those items related to Performance, Partnerships and Improvement on the BAF for which Committee has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee.

10.2 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

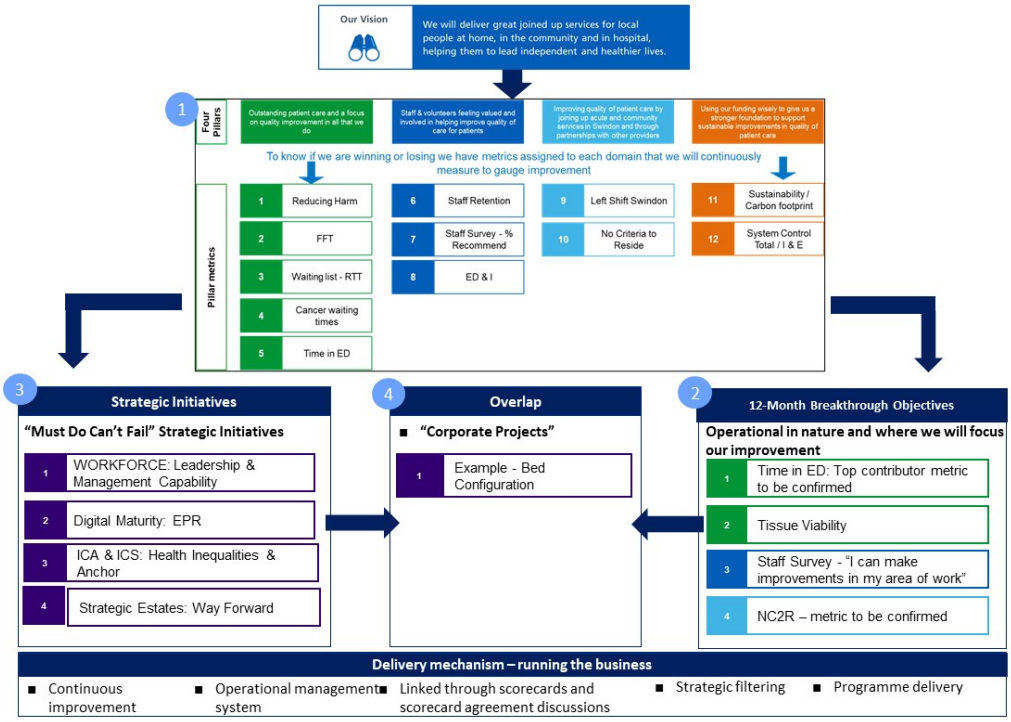
11.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Appendix 1

Committee	Performance, Population & Place Committee
Chair Lead EDs	Peter Hill, Non- Executive Director Felicity Taylor- Drewe, Chief Operating Officer Claire Thompson, Director of Improvements & Partnerships
Frequency	Monthly
Membership	4 x NEDs 2 x Eds
Quorum	2 x NEDs 1 x ED
Remit	Operational performance data - IPR Winter Plan EPRR Primary Care & Community Services Benchmarking & Model Hospital Report Oversight of ICS/ICA development JSNA review Population Health Management ICA work programme Clinical Networks BSW Academy Development Integration of Services Delivery of Improving Together PMO Performance Board Assurance Framework
Strategic Risks	Patient Care Through Joined Up Services – Model of Care (S3) Patient Care Through Joined Up Services - Performance (S4) Patient Care Through Joined Up Services – Partnerships (S5)

Appendix 2

GWH - Strategic Planning Framework



MENTAL HEALTH GOVERNANCE COMMITTEE
TERMS OF REFERENCE

Review Date	**May 2023**
Board Approval	

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For annual review	June 2022	Mental Health & Governance Committee	Amendments include:- - New format - Membership and attendance - Voting process - Deputies for NEDs and EDs - Name change of sub committee - Reword 8.7 - Delete 8.9 - Reference to strategic planning framework - Summary table of meeting remit

1. AUTHORITY

1.1 The Mental Health Governance Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors (Trust Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2. The Committee is authorised by the Board of Directors to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. ROLE / PURPOSE

2.1 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.

2.2 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

3. MEMBERSHIP

3.1 The membership of the Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the Chief Nurse and Medical Director

3.2 One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

4. ATTENDANCE

4.1 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.

4.2 The Committee may call other officers of the Trust to attend as appropriate. The following are expected to attend:

- Associate Director of Safeguarding

- Mental Health Act, Safeguarding Adults at Risk, Mental Capacity Act and Deprivation of Liberty Safeguards Administrator.

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]
- Senior representatives of the DoLS Supervisory Bodies

4.3 *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.

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.

4.4 *Voting* - For voting purposes there must always be a majority of Non-Executive Directors.

4.5 The work of this Committee will be supported by the Executive Director Lead, the Chief Nurse.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet quarterly.

7. DUTIES

The Mental Health Governance Committee is authorised by Trust Board to:

7.1 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.

7.2 Monitor the implementation of the MHA and the MCA and Deprivation of Liberty Safeguards [DoLS] throughout the Trust.

7.3 Oversee compliance in relation to the MHA and the MCA throughout the Trust.

7.4 Identify matters of risk relating to the Act and develop policies and procedures to manage that risk.

7.5 Identify ongoing training needs for all staff and ensure that programmes are devised and delivered and embedded.

7.6 The Mental Health Governance Committee will monitor compliance with all relevant aspects of legislation.

7.7 Instruct the Mental Health Governance Operational Group (Sub-group of this Committee) on all necessary work required to support this committee in fulfilling its objectives and functions.

7.8 Support a culture of learning through case review and ensure the learning is disseminated throughout the organisation

7.9 Support a culture of providing parity of esteem and ensuring respect and dignity for patients with mental health needs.

8. FUNCTIONS

8.1 To initiate and manage, on behalf of the Board, the development of Trust policies and procedures in respect of current legislation.

8.2 To adopt, on behalf of the Board, Trust policies and procedures in respect of current legislation

8.3 To ensure that legislation and supporting policies and procedures are understood by staff and implemented appropriately

8.4 Through an annual audit programme provide assurance to the board regarding compliance with policy and procedures

8.5 To develop education and practice on the Acts and the Codes of Practice for all personnel involved in the application of the Acts.

8.6 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

8.7 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.~~

8.8 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).

8.9 ~~To facilitate Care Quality Commission visits to the Trust areas, (and to ensure that recommendations are implemented).~~

8.9 To monitor the use of the Acts in the Trust against national and local trends.

8.10 To prepare an Annual Report for the Trust Board and an annual work programme.

8.11 To contribute to the development of other policies and procedures as requested.

8.12 To ensure, that as required, the Department of Health returns are submitted ~~on an annual basis~~ outlining the application of the Mental Health Act ~~over the previous year~~.

8.13 To ensure that mental health service contracts with mental health providers meet, are robust and fulfil the requirement for an effective and efficient service.

8.14 To ensure that mental health services meet agreed quality, effectiveness and outcome measures.

9. REPORTING RESPONSIBILITIES

9.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

9.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

10. MEETING ADMINISTRATION

10.1 The Trust Secretariat shall act as the secretary of the Committee.

10.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

10.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

10.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Mental Health Governance Operational Group

10.2 The Committee will also consider key assurance reports as outlined in appendix 1.

10.3 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

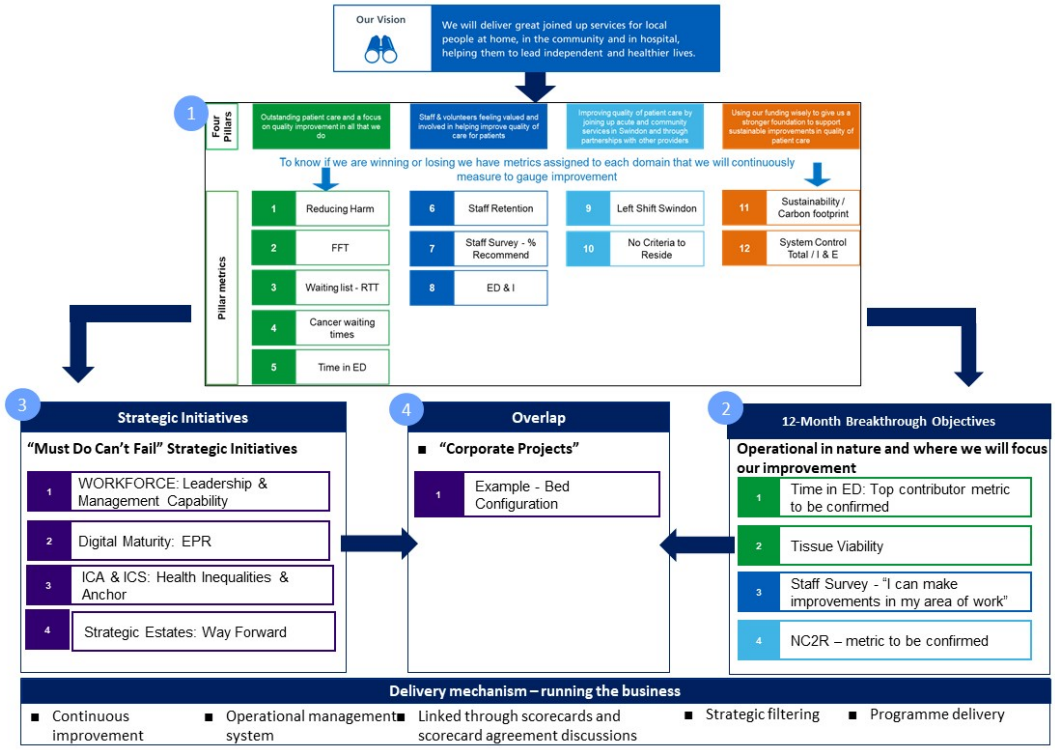
11.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Appendix 1 – Summary

Committee	Mental Health Governance Committee
Chair Lead EDs	Lizzie Abderrahim, Non-Executive Director Lisa Cheek, Chief Nurse Jon Westbrook, Medical Director
Frequency	Quarterly
Membership	3 x NEDs 2 x EDs
Quorum	2 x NEDs 1 x ED
Remit	Compliance with the Mental Health Act 1983 (as amended by the Mental Health Act 2007) [the MHA] and the Mental Capacity Act 2005 [the MCA] Monitor the implementation of the MHA and the MCA and Deprivation of Liberty Safeguards [DoLS] throughout the Trust. Changes to legislation and guidance Mental Health Governance Mental Health Risks (12+) Mental Health Liaison team CAMHS Dementia Strategy

Appendix 2

GWH - Strategic Planning Framework



CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

Review Date	**May 2023**
Board Approval	

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1	For review	Nov-21	Charitable Funds Committee	- Membership to reflect NED to be in majority - Divisional Directors to be included in the attendee list
V1.1	For review	Apr-22	Committee Effectiveness Review	- Include Wiltshire Health & Care in duties. Other amendments include:- - New format - Added deputies for Executive Directors - Link to the Strategic Framework - Summary table of meeting remit

1. AUTHORITY

1.1 Great Western Hospital NHS Foundation Trust Board, acting as a Corporate Trustee for GWH Charitable Fund (Charity Registration Number 1050892) has established a Charitable Funds Committee (the Committee).

1.2 The Committee is administered and managed by the Trustees who are responsible for the overall management of the Charitable Funds. This is a non-statutory Committee that reports to the Trust Board and has no powers other than those specifically delegated in these Terms of Reference.

2. ROLE

2.1 The purpose of this Committee is to oversee the management of Charitable Funds.

2.2 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

3. MEMBERSHIP

3.1 The membership of the Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the Director of Finance & Strategy and the Director of Improvement & Partnerships.

3.2 One of the Non-Executive members will be appointed Chair of the Committee by the Board

3.3 In the absence of the Chair, a Non-Executive Committee member will perform this role.

3.4 *Voting* – For voting purposes there must be a majority of Non-Executive Directors

4. ATTENDANCE

4.1 Other attendees will include but are not limited to:

Chief Executive
Associate Director of Fundraising
Head of Financial Control
Financial Accountant (or nominated Deputy)
Divisional Directors
Executive Assistant to Director of Finance (administrative support)

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 *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.

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.

4.5 The Trust Chair may attend meetings of the Committee (but not if specifically excluded by the Chair of the Committee), but may not chair meetings nor contribute to the quorum.

4.6 *Advisors* – External advisors may attend as necessary at the request of members to include any departments who have an interest in the current meeting, i.e. fundraising, finance, and any department submitting a case of need or external investment advisors.

4.7 *Administration of Committee* – The Executive Assistant to the Director of Finance & Strategy shall provide appropriate administrative support and guidance to the Chair and Committee members.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be two members to include one Non-Executive Director and one Executive or Non-Voting Board Director.

6. FREQUENCY OF MEETINGS

6.1 The Trustees shall normally meet four times per year and at such other times as the Trust shall require.

7. DUTIES

7.1 Ensure that best practice is followed in terms of guidance from the Charity Commission, Audit Commission, National Audit Office, Department of Health and other relevant organisations.

7.2 Ensure that the appropriate policies and procedures are in place to support the Charitable Funds Strategy and to advise Fund Managers on income and expenditure and that this is reviewed at regular intervals.

7.3 Ensure that fund objectives and spending plans are in line with Charitable objectives, spending criteria and priorities set by donors.

7.4 Ensure that all funds are correctly allocated as restricted or unrestricted and are accounted for accordingly. The number of funds should be reviewed on an annual basis to identify whether a programme of rationalisation is required.

7.5 Develop and review the Trust's Charitable Funds Strategy and Trustees' terms of reference on an annual basis and agree changes where appropriate.

7.6 Develop and review the Scheme of Delegation for charitable funds on a regular basis and recommend changes where appropriate.

7.7 Ensure that a separate register of interests is compiled for both Trustees and Fund Managers, and that this is reviewed and updated on a regular basis.

7.8 Review and approve fundraising policies in conjunction with the Director of Finance, ensuring that statutory requirements are complied with.

7.9 On an annual basis, review and approve summary level income and expenditure plans from Fund Managers, ensuring that they complement the strategy.

7.10 Ensure an effective mechanism exists whereby equipment needs are identified and satisfied (within resource constraints) through an equitable bidding process underpinned by business plans. (All equipment purchased by charitable funds will be recorded in a separate register.)

7.11 Oversee the management of investments. Where an investment broker is used, the Trustees will ensure the investment strategy has been appropriately communicated, the information required is specified and received in a timely manner, and that the service is market tested at regular intervals.

7.12 Ensure that all research monies paid into charitable funds meet the criteria for charitable status as specified by the Charity Commission.

7.13 Review and discuss all Audit Reports on Charitable Funds and recommend action to Trustees.

7.14 Review the Charity Annual Accounts and Trustee Annual Report and comment/recommend approval to the Trustees as appropriate.

7.15 Approve any request to set up new funds and cost centres (Charitable Funds only).

7.16 Agree and approve the bases of apportionment for investment income and administration costs, respectively.

7.17 Recommend to the Board any major fund raising appeals and plans, including any material changes to those plans already approved by the Board.

7.18 The charity also holds funds on behalf of Wiltshire Health & Care who have their own approval process, which is then ratified by the GWH Charity Committee subject to funds being available

8. REPORTING RESPONSIBILITIES

8.1 The Trustees are accountable to the Charity Commission for the proper use of the charitable funds and to the public as a beneficiary of those funds.

8.2. Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee and others as necessary. Once the Committee has approved the full minutes, a copy will be available, for information, to the Board at its next meeting.

8.3 The key issues of the Committee will be included in the Board of Directors agenda and papers as directed by the Chair of the Charitable Funds Committee and accepted by the Chairman of the Trust.

8.4 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.

8.5 The Committee will report to the Trust Board annually on the matters of business it has carried out.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

9.5 A forward planner of agenda items shall be determined by the Chair.

10. REVIEW

10.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

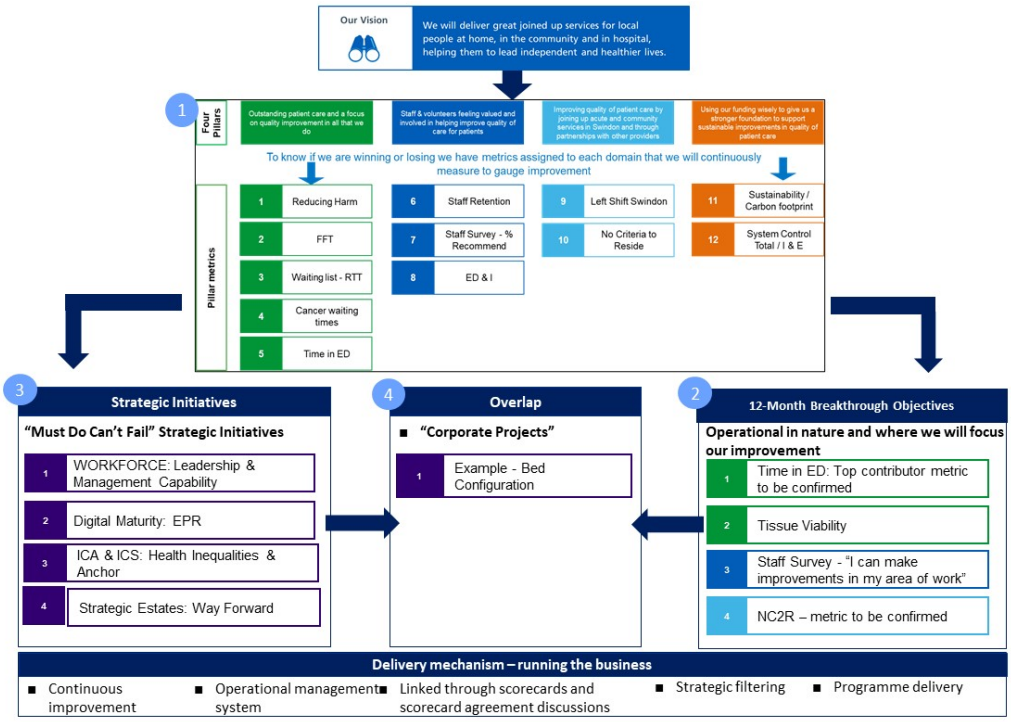
10.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Appendix 1 - Summary

Committee	Charitable Funds Committee
Chair Lead EDs	Paul Lewis Simon Wade, Director of Finance & Strategy Claire Thompson, Director of Improvement and Partnerships
Frequency	At least 4 times per year
Membership	3 x NEDs 2 x EDs
Quorum	1 x NED 1 x ED
Remit	Charitable Funds Performance Charitable Funds Strategy Funding Policies Management of Funds

Appendix 2 – GWH – Strategic Planning Framework

GWH - Strategic Planning Framework



TRUST MANAGEMENT COMMITTEE

TERMS OF REFERENCE

Review Date	**May 2023**
Board Approval	

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	May 2022	Company Secretary / Director of Improvement & Partnerships	Revised TofR due to the introduction to new ways of working in the form of 'Improving Together' approach and to refocus the work programme to strengthen oversight of key strategic area.
V1.1	For review	17 May 2022	Executive Committee	Comments/feedback received TofR
V1.2	Approved	23 June 2022	Trust Management Committee	Comments/feedback received TofR amended for ratification by Board

1. AUTHORITY

1.1 The Trust Management Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors (Trust Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings. It is a non-statutory Committee.

1.2. The Committee is authorised by the Board of Directors to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 The Committee has been constituted as the first tier executive decision-making group of the Trust. As such it is considered a strategic group which receives assurance and accepts escalation from a number of tactical sub-groups, which themselves receive assurance and escalation from a number of operational groups across the Trust.

2. ROLE / PURPOSE

2.1 The purpose of the Committee is to provide a mechanism for the Executive Directors to provide assurance to the Board concerning all aspects of delivering the Trust's strategy and supporting strategic plans, including the day to day operational management of the Trust. The Committee brings together the most senior leaders to role model our values, working in an integrated way to deliver conditions that support our colleagues to deliver our strategic objectives.

2.2 In carrying out their duties members of the TMC and any attendees must ensure that they act in accordance with the leadership framework of the Trust, which includes:

- Leadership behaviour
- Civility and respect
- Clarity about expectations (red lines)
- STAR values

The Committee will create a culture of collective leadership. It will provide a safe space to explore issues, provide solutions, and share learning.

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.4 Duties include:-

- To support the Trust Board in developing and implementing the vision and strategic direction for the Trust as part of the Swindon Integrated Care Alliance (ICA) and BANES, Swindon and Wiltshire Integrated Care System (ICS).
- To develop ideas and formulate proposals that will inform the Trust Board's discussions on the future strategy of the Trust.
- To implement the strategy to the key milestones using our Improving Together approach of strategy deployment and the use of a strategic filter.
- To have oversight of/gain assurance on the overall performance of the Trust ensuring all key quality, safety and performance indicators are achieved and early corrective action is taken to prevent variation from plan.
- To drive the annual business planning processes, ensuring the Board is presented with the correct information on which to take sound decisions.
- To provide staff with clear leadership and short, medium and long term direction and vision.
- To lead on the maintenance of effective processes to manage risk by triangulating management information across the Trust that enables a whole organisational view of risks and actions.

3. MEMBERSHIP

3.1 The membership of the TMC shall consist of:

Chief Executive
Director of Finance & Strategy
Chief Operating Officer
Director of Human Resources
Chief Digital Officer
Chief Nurse
Medical Director
Director of Improvement & Partnerships
Divisional Directors
Associate Medical Directors
Divisional Directors of Nursing
Director of Midwifery & Neonatal Services
Associate Director of Communications & Engagement
Director of Pharmacy & Medicine Optimisation
Deputy Chief Nurse(s)
Deputy Medical Director(s)
Deputy Chief Operating Officer
Deputy Director of Finance
Interim Director of IT
Company Secretary

3.2 **Chair** – The Chair of the Committee is the Chief Executive. In the absence of the Chair, any other Executive Director shall Chair the meeting.

4. ATTENDANCE

4.1 Non-Executive Directors will not attend meetings of the Executive Committee (unless otherwise agreed by the Chief Executive for a specific purpose).

4.2 *Substitutes/Deputies* - Each member of the Committee is permitted to send a substitute / deputy to attend in their absence but this will not count towards the quorum.

4.3 *Invitees* - Other persons may be invited to attend meetings of the Committee as required and agreed by the Chair of the Committee. Staff will be invited to present reports as considered appropriate.

4.4 *Compulsory Attendees* – Persons (or in their absence their representative) writing papers for this Committee are expected to attend meetings of the Committee to present their paper.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be:-

- 3 Executive Directors; and,
- representation from each Division – at least one of whom will be a clinician.

6. FREQUENCY OF MEETINGS

6.1 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.

7. RESPONSIBILITIES

The Committee will provide a forum in which to discuss and consider strategic issues which affect operational and corporate services. It will have executive-led tactical sub-groups that will ensure that he Committee is a point of escalation for any risks or issues that need wider operational or corporate consideration, decision, or dissemination. The main responsibilities of the Committee are to:-

7.1 To ensure the implementation of the strategic vision and direction (once agreed by the Board of Directors) in line with the timescales set out by the Board and with due consideration for the needs of the ICA/ICS.

7.2 To actively monitor achievement of the annual plan.

7.3 To carry out periodic strategic reviews of the environment and landscape to inform business planning.

7.4 To direct managers, via sub-committees and working groups, to undertake specific areas of work on its behalf.

7.5 To ensure implementation throughout the Trust of key policy actions.

7.6 To assure the Board that a quality, safety and performance management culture is embedded throughout the organisation and the external and internal targets are achieved, and where not, to implement and monitor achievement through action planning.

7.7 To develop, formulate and present ideas and proposals for the Board's consideration and approval.

7.8 To drive the annual business planning and clinical and service development cycle within the Trust.

7.9 To review and recommend business cases for onward approval to relevant committee, including business cases arising through the ICA/ICS taking into account financial, quality, workforce and operational performance considerations in line with scheme of delegation.

7.10 To authorise capital and revenue funding in line with scheme of delegation.

7.11 To provide leadership and management of the risk framework ensuring that the Assurance Framework is scrutinised and challenged and an overview is taken to check that the risks remain relevant; controls are adequate and that arrangements are in place to achieve the organisation's objectives and management of risks are effective and operating as intended and to regularly review, scrutinise and challenge risks; actions required to address those risks; and progress against actions as detailed in the Corporate risk register (al l15+ risks) and Divisional and Corporate Department risk registers. The Committee will:-

- recommend risks for escalation to the Board Assurance Framework where it is felt they have potential to materially impact upon delivery of the trust's strategy
- satisfy itself that risks scoring 15+ are being effectively managed and mitigated
- ensure that new risks scoring 15+ are accurately identified and scored and
- ensure that risks are being consistently reviewed, with timely action taken in mitigation by each Division or corporate department.

7.12 To review and approve estates, facilities management, equality and diversity and any other operational policies, procedures or other documents.

7.13 To receive minutes, notes or reports from sub-committees and groups convened to address particular issues relating to the day-to-day control and management of the organisation.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary of the meeting shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. Agendas

The content of the agenda will be agreed by the Chair of the Committee.

Standing Agenda Items
(List of items which shall normally appear on the agenda for this Committee)

The Trust Management Committee will normally receive reports for each meeting on activity under the following headings:

- **Strategic Initiatives** - Strategy Delivery, Commitments & Priorities
- **Pillar metrics** - Financial Management, Patient Safety and Quality of Care, Operational Performance, Workforce
- **Breakthrough objectives performance**
- **Strategic filter** – projects & programmes
- **Risk**

11. REPORTING/PROVIDING ASSURANCE

11.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

Minutes / reports from the following for **information only**: -

- Investment Committee (monthly)
- Divisional Operational Performance Review Board (monthly)
- Improvement Board
- Employee Partnership Forum (monthly)
- Equality & Diversity Group (quarterly)
- Patient Quality Committee (monthly)
- Risk Committee (monthly)

11.2 Working groups will be tasked to prepare supporting reports for the Committee.

11.3 A forward planner of agenda items shall be determined by the Chair.

11.4 The Committee will also consider key assurance reports as outlined in appendix 1.

12. REVIEW

12.1 The Committee should consider its effectiveness and refresh its terms of reference annually.

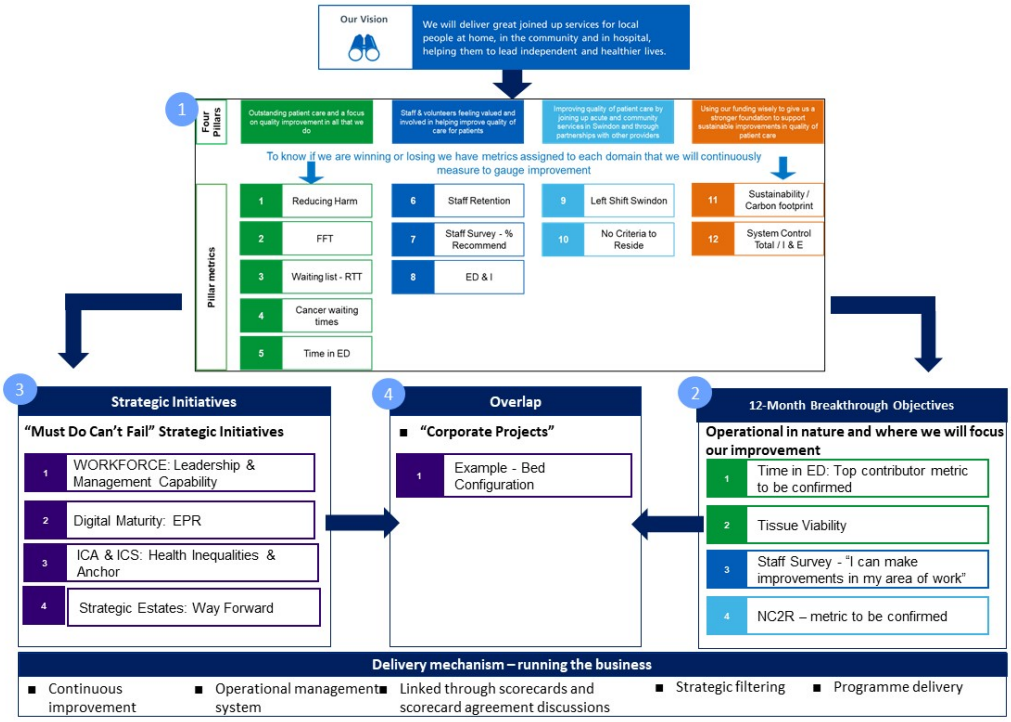
12.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Appendix 1

Committee	Trust Management Committee
Chair	Kevin McNamara
Frequency	Monthly
Membership	Senior Management Team
Quorum	3 Executive Directors; and, 1 x representation from each Division – at least one of whom will be a clinician
Remit	Trust Strategies Business & operational plans Corporate policies & procedures Major service developments Trust wide business cases Operational, clinical, quality and financial performance Strategic filter Improving Together ICA/ICS Strategy and Plans Risk Management Board Assurance Framework
Strategic Risks	All
Key Assurance Reports	IPR – highlight report Operational Reports Workforce reports National surveys Business Planning reports Quality Reports IT Performance Reports IG Reports Benchmarking Reports Sub committee escalation reports Estates & Facilities / H&S Report Board Assurance Framework & Risk Report

Appendix 2

GWH - Strategic Planning Framework



Great Western Hospitals NHS Foundation Trust

Report Title	**Register of Interests and Declaration of Interests at Meetings**				
Meeting	**Trust Board**				
Date	**7 July 2022**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 - Register of Interest Board June 2022				

Purpose

Approve	x	Receive		Note		Assurance	
To formally receive, discuss and approve any recommendations or a particular course of action		To discuss in depth, noting the implications for the Board/Committee or Trust without formally approving it		To inform the Board/Committee without in-depth discussion required		To assure the Board/Committee that effective systems of control are in place	

Assurance Level

Assurance in respect of: process/outcome/other (please detail):

Significant	x	Acceptable		Partial		No Assurance	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Report

Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

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.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks – risk number & description (Link to BAF / Risk Register)	-				**Risk Score**
	-				-
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Board members				
Next Steps					

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			x

Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

(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.

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	28 June 2022

Declarations of Interest Trust Board of Director June 2022

Date Confirmed	First Name	Last Name	Position Title	Interests to declare	Description of interest	Dates		Type of interest							
						To	From	Clinical Private Practice	Strategic Decision Making	Employment/Directorships	Gifts and Hospitality	Loyalty	Shareholdings	Committees/Charites etc	Personal connections
Voting Board Members															
05-Apr-22	Elizabeth	Abderrahim	Non Executive Director	Y	Trustee and Company Director - Gloucestershire Association for Refugees and Asylum Seekers Regional Governance Clerk - Academies Enterprise Trust. Company Secretary - Anawim Birmingham Womens Centre.	28-Jun-19	present			✓					
05-Apr-22	Nicholas	Bishop	Non Executive Director from August 2018	Y	Distant family member work for BDO (not in any department which undertakes NHS work)	ongoing									✓
29-Apr-22	Lisa	Cheek	Chief Nurse from March 2021	N											
29-Apr-22	Liam	Coleman	Trust Chair from February 2019	Y	Deferred Member of Nationwide Building Society membership scheme Non Executive Director / Chair of Audit Committee - The Financial Conduct Authority Board member on behalf of GWH NHS Foundation Trust Non Executive Director of Vivid Housing Ltd from Nov 2021	ongoing				✓					
05-Apr-22	Andrew	Copestake	Non Executive Director from July 2016	Y	Close family member is a psychosexual therapist and occasionally gets referrals from Trust consultants in their private capacity	ongoing									✓
08-Apr-22	Judith	Gray	HR Director from July 2019	Y	Trustee for ICP Support. ICP is a charity which supports women and their families who develop intrahepatic cholestasis of pregnancy	ongoing								✓	
06-Apr-22	Peter	Hill	Non Executive Director from April 2017	Y	Trustee Salisbury Hospice Trust	ongoing								✓	
09-May-22	Paul	Lewis	Non Executive Director from April 2018	N											
29-Apr-22	Kevin	McNamara	Chief Executive from March 2020	N											
29-Apr-22	Claire	Thompson	Director of Improvement and Partnerships from 19 April 2021	N											
06-Apr-22	Simon	Wade	Director of Finance & Strategy from November 2020	N											
06-Apr-22	Jon	Westbrook	Medical Director from September 2021	N											
29-Apr-22	Felicity	Taylor-Drewe	Chief Operating Officer from August 2021	Y	Non-Executive Director Wiltshire Health and Social Care (GWH nominated)	ongoing				✓					
28-Apr-22	Faried	Chopdat	Non Executive Director from April 2021	Y	Trustee and Chair of the Audit Committee of WorldSkills UK Non Executive Director Grant Thornton UK	Ongoing				✓				✓	
14-Apr-22	Helen	Spice	Non Executive Director from April 2021	Y	Make a Wish Foundation -Non Executive Director Trustee Mental Health and Employment Partnership Ltd, Non-Executive Director	Ongoing				✓					
Non-VotingBoard Members															
06-May-22	Claudia	Paoloni	Associate Non-Executive Director from April 2021	Y	Director of Calm Water Ltd Lecrahurst Ltd HCSA Executive Committee - Executive Members Consultant Anaesthetist, University Hospital Bristol & Weston Trust Hospital Medical Committee (Chair), University Hospital Bristol & Weston Trust	ongoing				✓					
29-Apr-22	Sanjeen	Payne-Kumar	Associate Non-Executive Director from April 2021	Y	Director of 715 Consulting Ltd	ongoing				✓				✓	
22-Jun-22	Naginder	Dhanoa	Chief Digital Officer (joint role with Salisbury NHS FT)	N											