GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 3rd November 2022, 9.30am to 12.45pm
By MS Teams

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** Lisa Cheek, Peter Hill	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 – 10)** Liam Coleman, Chair • 6 October 2022	✓	LC	Approve	
4.	**Outstanding actions of the Board (public) (page 11)**	✓	LC	Approve	
5.	**Questions from the public to the Board relating to the work of the Trust**	-	-	-	
6.	**Care Reflections – Staff Story – Journey from Clinical Site Manager to Matron for Clinical Operations and Patient Flow (pages 12 – 17)** Rachel Almond to present	Presentation	RA	Note	9.40
7.	**Chair's Report (pages 18 – 19)** Liam Coleman, Chair	✓	LC	Note	10.10
8.	**Chief Executive's Report (pages 20 – 28)** Kevin McNamara, Chief Executive	✓	KM	Note	10.20
9.	**Integrated Performance Report (pages 29 – 98)**			Assurance	10.40
	• Performance, Population & Place Committee Board Assurance Report (October) – Liam Coleman, Chair	✓	PH		
	• Quality & Safety Committee Board Assurance Report (October) – Nick Bishop, Non-Executive Director & Committee Chair	✓	NLB		
	• Finance, Infrastructure & Digital Committee Board Assurance Report (October) – Faried Chopdat, Non-Executive Director & Committee Chair	✓	FC		
	• People & Culture Committee Assurance Report (October) – Paul Lewis, Non-Executive Director & Deputy Committee Chair	✓	PL		

	• Integrated Performance Report • Maternity Performance • Reflect on progress of adoption of new version	✓ ✓ -	Execs LM All		
10.	**Mental Health Governance Committee Board Assurance Report (pages 99 – 102)** Lizzie Abderrahim, Non-Executive Director & Deputy Committee Chair	✓	EKA	Assurance	12.10
11.	**Ockenden Report – GWH Update (pages 103 – 110)** Luisa Goddard, Deputy Chief Nurse Lisa Marshall, Director of Midwifery & Neonatal Services to present	✓	LG/LM	Assurance	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.**				
12.	**Ratification of Decisions made via Board Circular/Board Workshop** Caroline Coles, Company Secretary	Verbal	CC	Note	12.35
13.	**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	-
14.	**Date and Time of next meeting** Friday 13 January 2023 at 9.30am, venue to be confirmed (hybrid meeting)	Verbal	LC	Note	-
15.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	

Board Meeting Timetable

2022	2023										
Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
Financial Sustainability			Workforce, Culture & EDI			Patient Voice			*To be confirmed*		

NHS
Great Western Hospitals
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC IN JAMES YOUNG SIMPSON ROOM, VYGON, PIERRE SIMONET BUILDING, SWINDON, SN25 4DL AND VIA MS TEAMS 6 OCTOBER 2022 AT 9.30 AM

Present:

Voting Directors

Liam Coleman (LC) (Chair)	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
Andy Copestake (AC)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Peter Hill (PH)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer

In attendance

Chris Bumford*	Matron Outpatients (item 132/22 only)
Peter Coutts*	Deputy Divisional Director Outpatients (item 132/22 only)
Naginder Dhanoa (ND)	Chief Digital Officer
Tim Edmonds	Associate Director of Communications & Engagement
Steve Haig (SH)	Deputy Medical Director
Patrick Ismond*	Lead for EDI (items 138/22, 139/22 & 140/22 only)
Claudia Paoloni (CP)	Associate Non-Executive Director
Sanjeen Payne-Kumar (SPK)*	Associate Non-Executive Director

Apologies

Caroline Coles	Company Secretary
Paul Lewis	Non-Executive Director
Jon Westbrook	Chief Medical Officer

Number of members of the Public: 2 members of public* (included 1 Governor: Chris Shepherd)

*Indicates those members attending virtually by MS Teams.

Matters Open to the Public and Press

Minute	Description	Action
127/22	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
128/22	**Declarations of Interest** There were no declarations of interest.	

Minute	Description	Action

129/22 **Minutes**

The minutes of the meeting of the Board held on 4 August 2022 were adopted and signed as a correct record with the following amendments:-

109/22 : Mental Health Governance Committee Board Assurance Report – typo in third bullet point – replace the word *"Libby"* with *"Liberty"*.

130/22 **Outstanding actions of the Board (public)**

The Board received and considered the outstanding action list.

131/22 **Questions from the public to the Board relating to the work of the Trust**

There were two questions from the public to the Board which were on staff wellbeing and waiting list communication. In response to a question asked by Nick Bishop, Non-Executive Director on patient communication preferences, Felicity Taylor-Drewe, Chief Operating Officer agreed that there was more work to be done this and communication options were being explored further.

132/22 **Care Reflections – Patient Story – EDI Complaint**

Peter Coutts, Deputy Divisional Director Outpatients, & Chris Bumford, Matron Outpatients, joined the meeting for this agenda item.

The Board received a patient story film that recounted the story of a patient with extensive physical accessibility needs who had their outpatient appointment cancelled at very short notice due to insufficient time allocated to support the use of a hoist for the patient. This action had significantly impacted both the patient and her carer and provided an extremely poor experience.

The presentation had detailed the findings from the departmental investigations along with associated actions taken and that the learning and improvements made were shared widely within the division and across all outpatient areas. It was noted that a full apology and actions for learning had been shared with the patient.

Peter Coutts and Chris Bumford outlined the rollout of the Accessible Information Standard (AIS) which would ensure that all patients and carers would have access to information to provide understanding of the full range of our services. A project had also commenced on the Robotic Process Automation (RPA) and Naginder Dhanoa, Chief Digital Officer agreed to review RPA further with Peter Coutts and Chris Bumford to exploit the functionality further.

Action: Chief Digital Officer **ND**

The story prompted a discussion on the culture of Improving Together work flagged at system level for learning and that there was a need to understand the learning to drive improvement on multi-dimensional engagement with our patients and if this highlighted broader issues to be reviewed to provide assurance.

The Board thanked Peter and Chris for sharing this story.

The Board **noted** the care reflection.

133/22 **Chair's Report**

The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally. Of

Minute	Description	Action

particular note was that three governor resignations had been received. Governor elections were currently being held across six of the Trust's constituencies and that results would be known in November.

The Board **noted** the report.

134/22 **Chief Executive's Report**

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

Bank Holiday, 19 September – The approach to the bank holiday announced at short notice was noted and the decision to continue with as much activity on that day as possible and the ability to continue with the majority of appointments for those patients already booked in. There had been positive feedback from patients on this action taken.

Covid-19 – The number of Covid patients had significantly increased since last month with a 150% increase in the past two weeks. A Covid escalation framework with various infection prevention and control measures was in place which would be dependent on a series of triggers.

Covid booster and flu vaccine – The staff Covid and flu vaccination programme had commenced and that 20% of staff had already been vaccinated.

Managing current pressures – Winter pressures were already being experienced by the whole health and social care system. A number of initiatives were in development for alternative hospital care and to improve the hospital flow, such as the Swindon Integrated Care Alliance Coordination Centre, and this also included initiatives to support the impact on delays caused to ambulance handovers.

Our Primary Care Network – Care Quality Commission – The CQC had indicated that the warning notices issued on our GP practices following the CQC inspection in May were to be lifted following good work from the team. The Board was pleased to hear this news and was assured that the practices were in a good position to potentially move this service to a new provider.

In response to a question raised by Lizzie Abderrahim, Non-Executive Director on the upgrading of the Wi-Fi across GWH and those teams that were not able to benefit from the upgrade, Naginder Dhanoa, Chief Digital Officer agreed to obtain feedback on this and what this would mean for some services.

Action: Chief Digital Officer **ND**

Faried Chopdat, Non-Executive Director asked about the challenges of current pressures and what measures were in place to address enabling for medical patients and how pathways could be influenced to move patients out of the hospital. Kevin McNamara, Chief Executive replied that he considered that health issues would further be exacerbated by the cost of living issue and that this could compound the back door problems and further impact on our services. He added that he hoped that initiatives, such as the Swindon Integrated Care Alliance Coordination Centre, would continue to make a difference to complex issues and that there would be regular contact with the Trust's South West partners. Further assurance on actions being taken was also provided by Felicity Tyalor-Drewe, Chief Operating Officer.

Minute	Description	Action

Liam Coleman, Chair reflected on the risk of the cost of living impact on the health and wellbeing of staff.

Steve Haig, Deputy Medical Director also commented on the potential industrial action and that it would be essential to continue to run as many of our services as possible. A working group made up of representatives from across the Trust had been established to consider the risks involved and mitigating actions.

The Board **noted** the report.

135/22 **Integrated Performance Report**

The Board received and considered the Board Sub-Committee Assurance Reports from the Board Committees to support the Integrated Performance Report. Commentary and progress on activity associated with key indicators in August 2022 was received.

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) around the IPR at its meetings on 24 August and 28 September 2022 and the following were highlighted:-

- Emergency Access – The service was performing well in terms of the 4-hour target in relation to other Trusts and the national average waiting time. However, the mean waiting time had now reached 8 hours during August with a significant number of patients waiting over 12 hours (15%). The reasons for this were noted which included non-criteria to reside which was affecting flow from ED to the wards. There was some improvement in delayed ambulance handover delays.
- Referral to Treatment Time – The Trust continued to perform well in terms of the number of 104 week waiters and reduction in 78 week waiters. There were concerns over the increase in over 52 week waiters and this would continue to be monitored.
- Diagnostics – This was at a similar position as previous months. However, CT and MRI showing early signs of improvement as planned. The assurance level score of red/amber the reasonable ambition for a realistic position.
- Cancer Service – The Trust was not delivering on any counts of the national standard for cancer and an action plan for improvement would continue to be monitored.
- Stroke Service – The performance remained good at a level B.
- Health Inequalities Trust Action Plan – Good early progress on the action plan along with its close ties to the Swindon ICA Group. Under the population and place element of the agenda, the Local Authority led Joint Strategic Needs Assessment (JSNA) was presented. Claire Thompson, Chief Officer of Improvement & Partnerships also provided the PPPC with updates on the emergent Integrated Care Strategy for BSW, the Provider Selection Regime which was replaced the requirement to competitively tender NHS services, and Swindon Communities Together, a key transformation programme which would impact our services.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (Q&SC) around the quality element of the IPR at the meetings held on 18 August and 22 September 2022 and the following were highlighted:-

- Freedom To Speak Up Annual Report – Whilst the report showed many positive aspects, when compared to the National Report, the main concerns related to the

Minute	Description	Action

failure to replace the Lead Guardian due to lack of funding (the previous was voluntary). One of the main issues arising from this was the inability to submit the Trust's FTSU data nationally.

Action: Chief Nurse **LC**

- Pressure Ulcers – A small but significant rise was reported in cases. Work on Teal Ward under Improving Together had led to significant falls in the number of pressure harms.
- Safer Staffing – Midwife recruitment has improved.
- Serious Incidents – Further reduction in the number of overdue investigations and that GWH was now the best in the South West Region for overdue investigations.
- Update on CQC Preparedness – Improvement Notices in Primary Care had been closed with the CQC applauding the Trust and the teams involved for their prompt actions. Level 3 safeguarding training remain challenging but improvement in the compliance rates continue to be made. The WHO checklist related action had been closed as it was now compliant.

Use of Resources

Finance, Infrastructure & Digital Committee Overview

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) around the use of resource element of the IPR at the meetings held on 22 August and 26 September 2022 and the following was highlighted:-

- Risk management – Concern remains about the £4m gap to address the critical risk that the Trust would not be able to deliver its efficiency target recurrently in 2022/23. There was a need for more robust actions to be taken on gaps in controls and risk mitigation ownership.
- Month 5 Finance position – Pay costs remain above plan within both Unscheduled Care and Integrated & Community Care Divisions and concern remains about the progress in bringing the run rate in line with the plan.
- Improvement and Efficiency Plan Update – The Committee received a paper outlining management actions and reporting on an increased forecast and achievement of efficiencies; however concerns remain that the full CIP of £11.1m would be achieved by year-end as there was a substantial gap of £4m yet to identify.
- Capital Plan – Capital expenditure on all schemes were below plan as at Month 5. The Capital Management Group would be monitoring actions to ensure that the Capital Plan would be delivered in 2022/23. The Committee has requested a further update at its October meeting as the slow progress of capital spending remains a concern.
- Divisional Year on Year WTE Analysis – The Committee received a well-informed presentation on the analysis of the Whole Time Equivalents changes from 2020 to 2022. The key themes were noted, together with partial assurance of actions taken to date and the steps to be taken to enhance the workforce productivity, stabilise community spend and WTE increases and deliver elective activity.
- Maternity Digital Strategy – Good paper on the Maternity Digital Strategy was received.
- Integrated Front Door FBC update – The FBC was submitted to the NHSE/I in August; however the target date for FBC review/approval would be undertaken in January 2023. This was to be monitored closely and determine the impact of the delays should this position worsen.

Minute	Description	Action

Lizzie Abderrahim, Non-Executive Director asked to have a better understanding on the rationale behind the amber score of the actions for the Month 5 position and also the ability to meet the Improvement and Efficiency Plan. Faried Chopdat, Non-Executive Director (and Chair of FIDC) replied that the position was to be monitored closely through enhanced monitoring of the Divisions by the Executives over the next two months with increased challenge to address concerns raised by FIDC about the progress in bringing the run rate in line with the plan. He added that management actions and reporting on an increased forecast were outlined at the FIDC on the achievement of efficiencies, but commented that an improvement plan across the system was yet to be identified and the challenges on the NHS in whole would have impact on that. Simon Wade, Chief Financial Officer added that the enhanced monitoring process being undertaken by the Executives was showing success and that a number of targeted actions had been implemented. There was to be a review of the whole time equivalent (WTE) growth over the next two years, however the entitlements and control plan were not improving as quickly as expected. Liam Coleman, Chair urged the Board to support FIDC to monitor the situation.

Our People
People & Culture Committee Chair Overview
The Board received an overview of the detailed discussions held at the People & Culture Committee around the people element of the IPR at the meeting held on 23 August 2022 and the following were highlighted:-

- Workforce Planning – The main ongoing concern related to the WTE levels being above plan, mainly due to temporary staffing and that this would continue to be monitored by the Divisions. Recruitment gaps remain an ongoing issue and plans were being developed to further improve the position.
- Employee Experience – The roadmap for culture development was reviewed and embedding STAR values and this would continue to be monitored.

Peter Hill, Non-Executive Director asked about the status of The Messenger Review of NHS leadership following recent changes in the Government. Jude Gray, Chief People Officer replied that the current status of the review was unknown but that the Trust would continue to move forward with the plan to address the recommendations from the report to provide assurance to the Board.

Integrated Performance Report
The Board received and considered the Integrated Performance Report (IPR) which was the first integrated report of the Trust's position using the Improving Together approach, building a culture of continuous improvement. The Board noted the structure of the report and that it aligned with watch metrics and key indicators to performance, care, people and finance to align with committee accountabilities.

Claire Thompson, Chief Officer of Improvement & Partnerships explained that the rationale for the chosen breakthrough objectives was to focus on those that would drive performance and delivery improvement. She outlined the board sub-committee process to monitor metrics on a forward looking basis and to manage strategic risks and help to inform the Board agenda for discussion. The IPR would provide forecasting and benchmarking around pillar metrics as it was important to demonstrate focus and how this was being embedded into the organisation.

Minute	Description	Action

The IPR was reviewed and discussed by the Board members and the following points were noted for inclusion and consideration when further developing the IPR:

- Preference for graphs alongside dashboards and a graph for every watch metric and an improvement trajectory to track performance against.
- Understanding of the business rules and narrative assurance against the tables to provide focus at the Board.
- Thresholds for escalation reviewed to ensure they are correct.
- One page summary page to be added based on the Company Secretary's risk template.
- Change the pillar metric finances to be GWH and not system based and are pillar metrics sufficiently focussed on safety.
- Confirm where the average length of stay is as a critical KPI.
- To not lose sight of the risks that are not currently measured and that KPIs should be forward looking, using trends and international comparators to create insights.
- Request for the metrics to be split out by committees to make the report usable at board sub-committee level; together with the need to provide a report that would be meaningful for public consumption.

Kevin McNamara, Chief Executive commented on the need for business rules to build confidence to have a professional judgement on areas of focus and to also develop behaviours to challenge metrics with a more focussed response on root causes. He added that Board Sub-Committee Assurance Reports would also strengthen narrative and focus Board conversation going forward.

Liam Coleman, Chair commented that there needed to be clarity about national standards against the Trust's plan and to provide narrative to mitigate any identified gaps in assurance.

Faried Chopdat, Non-Executive Director suggested that it would be useful for the Non-Executive Directors/Associate Non-Executive Directors to receive benchmarking information using Model Hospital data to provide insight from a national view and also how would this benchmark outside of the UK. It was agreed that consideration be given to this piece of benchmarking work and also how to share local intelligence with the Non-Executive Directors. **FTD**

Action: Chief Operating Officer

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

136/22 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) meeting on 3 August 2022 and the following were highlighted:-

Peter Hill, Non-Executive Director reported that discussion had been held on how to help staff more with hardship funds as this was flagged at the previous committee meeting. Signposting for staff was being explored. It had also been considered that unbadged funds could be used if a criteria could be agreed.

The Board **noted** the report.

Minute	Description	Action

137/22 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Audit, Risk and Assurance Committee (ARAC) meeting on 15 September 2022 and the following were highlighted:-

- Annual Accounts 2021/22 – Lessons Learned – A detailed action plan was received to ensure that the process for the Annual Accounts was robust for 2022/23. Specific actions requested improved communication with the Audit Committee and speedy escalation of issues. The ongoing plan would be monitored by the committee to provide assurance on the process.
- Divisional Risk Review – Integrated Care & Community – The Committee was pleased to note the actions being undertaken to mitigate the 15+ risks but further assurance was required as some actions were not fully embedded as long-term solutions to mitigate risks.
- Risk Register Report – Assurance received that processes for managing risk in the Trust were effective and that there had been a significant reduction in the number of overdue risk reviews since the last report. However, the committee continued to be concerned on the number of overdue action and risks with no actions and asked for this to be escalated to the Trust Management Committee for review and action.
- Internal Audit – Divisional Governance Structure – Concerns were raised by the committee on the lack of clinical staff engagement in Divisional Board meetings. This had now been escalated to the Quality & Safety Committee for review by the Chief Medical Officer.
- Internal Audit – Workforce and Finance Management – Concerns were raised by the committee on the potentially significant impact of the lack of operational control at a time of a challenging financial situation for the Trust; particularly in relation to the management of processes for the approval of agency costs and rates. This had now been escalated to the Executive as a matter of urgency and the Board agreed that the follow-up on the Internal Audit report recommendations should be monitored through the Finance, Infrastructure & Digital Committee.
  Action: Chief People Officer — **JG**

The Board **noted** the report.

138/22 **Equality, Diversity and Inclusion (EDI) Annual Report 2021-22**

Patrick Ismond, Lead for Equality, Diversity & Inclusion joined the meeting for this agenda item.

The Board received and considered the Equality, Diversity & Inclusion Annual Report which provided evidence of progress and achievements during the period for our workforce and patients. A presentation to accompany the report was given by Patrick Ismond, Lead for Equality, Diversity & Inclusion and covered:-

- Examples of progress under the EDI Strategy Pillars.
- Overview of the data collected on the Trust's performance against the 10 WDES metrics.
- Overview of the data collected on the Trust's performance against the 9 WRES standards.
- National reports and areas of focus for both WDES and WRES.
- The long-term culture change to ensure that EDI would become 'business as usual'. This would mean that all staff and patients would have equality of opportunity and care, staff would be confident to speak up about inequalities and that the population

Minute	Description	Action

served by the Trust would be represented and also be invited to inform our service improvements.

The Board requested that a summary of the report be provided to the Governors at a relevant meeting.
Action: Chief People Officer **JG**

The Board **noted** the findings in the report and supported future actions.

139/22 **Workforce Race Equality Standard (WRES) Annual Report 2021-22**
Patrick Ismond, Lead for Equality, Diversity & Inclusion joined the meeting for this agenda item.

The Board received and considered a paper which contained a summary of the Trust's results for this year's Workforce Race Equality Standards (WRES) reporting.

The key areas of change and/or progress were noted by the Board, together with those areas that required improvement and the Trust Action Plan 2022/23 and Trust and BSW ICS Action Plan 2021/22 to drive improvement were noted.

The presentation also outlined that focus areas arising from national reports related to Fostering Safe Spaces, Reducing Overt & Covert Discrimination, and Reducing Disparity & Progression Rations and the Board noted the actions being taken.

Liam Coleman, Chair reflected on the deterioration against WRES Indicator Six which related to the percentage of staff experiencing harassment, bullying or abuse from staff and the disproportionate increase for BME staff. He was concerned about this deterioration, noting that other trusts were also demonstrating similar trends too.
Action: Chief People Officer to review and feedback to People & Culture Committee **JG**

The Board **noted** the findings in the report and supported future actions.

140/22 **Workforce Disability Equality Standard (WDES) Annual Report 2021-22**
Patrick Ismond, Lead for Equality, Diversity & Inclusion joined the meeting for this agenda item.

The Board received and considered a paper which contained a summary of the Trust's results for this year's Workforce Disability Equality Standards (WDES) reporting.

The key areas of comparison with the previous year was noted by the Board. It was noted that since such low numbers of staff had declared a disability, and with a large disparity the ESR and NHS staff survey, it was difficult to draw firm conclusions. However, our Differently Enabled Network continued to build on the work being done to improve experiences for disabled staff. The Trust Action Plan 2022/23 and Trust and Action Plan for 2021-22 with areas developed with our system partners to drive improvement were noted.

The presentation also outlined that focus areas arising from national reports related to Improving the physical workplace, Increasing diversity at senior levels, and Improving data collection and the Board noted the actions being taken.

The Board **noted** the findings in the report and supported future actions.

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.

141/22 **Responsible Officer Annual Report**

The Board received and considered the Responsible Officer Annual Report which outlined the issues and actions that had taken place during 2021/22.

It was noted that oversight of the appraisal process and quality was through the monthly Medical Staff Support Group where any support or concerns could be identified. GWH had also recently upgraded its online appraisal and revalidation system to SARD in July 2022 and was linked to the GMC connect website to give timely and accurate information.

The Board **noted** the report summary and **approved** the Annual Responsible Officer Report for sign off by the Chair or Chief Executive.

142/22 **Ratification of Decisions made via Board Circular/Board Workshop**
None.

143/22 **Terms of Reference – Remuneration Committee**
The Board received and considered a paper that contained the outcome of the annual review of the Remuneration Committee terms of reference.

The Board **approved** the Terms of Reference for the Remuneration Committee.

144/22 **Urgent Public Business (if any)**
None.

145/22 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 3 November 2022 at the Double Tree by Hilton Hotel (MS Teams facility would also be available).

146/22 **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 1305 hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – November 2022				
PPPC - Performance, Population and Place Committee, PCC – People & Culture Committee, QSC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
06-Oct-22	132/22	**Care Reflections – Patient Story – EDI Complaint** Robotic Process Automation (RPA) to be reviewed to exploit the functionality further in relation to the Accessible Information Standard.	Chief Digital Officer	The Chief Digital Officer to input into the project on Robotic Process Automation.
06-Oct-22	134/22	**Chief Executive's Report** Feedback to be obtained on those services who did not benefit from the Wi-Fi upgrade across GWH and what this would mean for some services.	Chief Digital Officer	Any identified gaps within the wi-fi upgrade to be reported to the Finance, Infrastructure & Digital Committee.
06-Oct-22	135/22	**Integrated Performance Report – Our Care – Freedom To Speak Up Annual Report** Issue of inability to submit the Trust's FTSU data nationally to be reviewed.	Chief Nurse	Funding has been secured for a p/t FTSU Lead Guardian.
06-Oct-22	135/22	**Integrated Performance Report** NEDs/ANEDs to receive benchmarking information using Model Hospital data to provide insight from a national view and how would this benchmark outside of the UK.	Chief Operating Officer	Consideration being undertaken on how to provide benchmarking and local intelligence to Non-Executive Directors/Associate Non-Executive Directors.
06-Oct-22	137/22	**Audit, Risk & Assurance Committee Board Assurance Report – Internal Audit report on Workforce & Finance Management** Follow-up of Internal Audit report recommendations to be monitored through the Finance, Infrastructure & Digital Committee.	Chief People Officer	For Finance, Infrastructure & Digital Committee
06-Oct-22	138/22	**Equality, Diversity and Inclusion (EDI) Annual Report 2021-22** Summary of the report to be provided to the Governors at a relevant meeting.	Chief People Officer	EDI Annual Report to be presented at the next Council of Governors meeting on 8 November 2022.
06-Oct-22	139/22	**Workforce Race Equality Standard (WRES) Annual Report 2021-22** Deterioration against WRES Indicator Six which related to the percentage of staff experiencing harassment, bullying or abuse from staff and the disproportionate increase for BME staff data to be reviewed.	Chief People Officer	For People & Culture Committee.

Future Actions				
None				

Report Title	**Staff Story**				
Meeting	**Trust Board**				
Date	**3rd November 2022**	Part 1 (Public) [Added after submission]	X	Part 2 (Private) [Added after submission]	
Accountable Lead	Jude Gray - Chief People Officer				
Report Author	Rachel Almond - Matron for Clinical Operation and Patient Flow				
Appendices					

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):

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):

This is a staff story which describes the journey for Rachel Almond from Clinical Site Manager to Matron for Clinical Operations and Patient Flow.

	Safe	Caring	Effective	Responsive	Well Led
Link to CQC Domain – select one or more					
Links to Strategic Pillars & Strategic Risks – select one or more					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: No issues identified			

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **Note the Staff Story**

Accountable Lead Signature	Jude Gray
Date	20.10.2022

Great Western Hospitals NHS Foundation Trust

Journey From Clinical Site Manager to Matron for Clinical Operations and Patient Flow

Site Manager to Flow Matron

Rachel Almond

Great Western Hospitals NHS Foundation Trust

- Worked for the Trust for 20 years
- Background of Gastro/respiratory Nursing
- Ward Manager 2 years
- Site Management for 7 years working part time then…
- Asked if I would consider a secondment to Matron for 6 months

Clinical Site Manager

Great Western Hospitals NHS Foundation Trust

Roles and Responsibilities

1. *Present and lead on the site meetings (4 per day) to give a full position of the GWH*
2. *Escalation of Ambulance Holds/long waits in MEU/ED/SAU and Mental Health delays*
3. *Visit and liaise with wards to support and escalate any procedure/transport/discharge delays*
4. *Ensure right patient right ward*
5. *Make full use of the Discharge lounge for Suitable patients*
6. *Liaising with other Trusts to organise the repatriation of patients both in and out of the GWH*
7. *Support IC&C to ensure SWICC/Sunflower is full*
8. *Ensure all Routine Surgical/Trauma admissions have a bed*
9. *Out of hours, act as a senior support for the Trust and to escalate to the OCM/OCE of any incidences*
10. *Part of the Medical Emergency Bleep holders including Paeds, Trauma, Security, and Major Haemorrhage*
11. *Receiving of Mental Health Section paperwork on the behalf of the Hospital Managers, this includes booking of Secure Transport for Mental health patients*
12. *Manage Medical and Nursing Staffing overnight*
13. *Monitor CCU/ACU/STROKE capacity*

Flow Matron

Great Western Hospitals NHS Foundation Trust

Roles and responsibilities

1. *Supporting of the Clinical Site team and the Flow of the Hospital, acting as a point of contact for any actions following on from the Site Meetings*
2. *Escalation of any operational pressures such as Ambulance holds, long waits in ED/MEU/SAU and Mental Health reviews*
3. *Acting as a point of contact for DoDD and divisional silvers for escalation and support*
4. *To ensure prompt repatriation of patients transferring in and out of the GWH.*
5. *Supporting all stakeholders within the Navigation Centre*
6. *Supporting with SAFER identifying people who could be suitable for the Virtual Ward/SWICC/Homefirst/SeLECT*
7. *Supporting wards to escalate complex social situations to the right stakeholders*
8. *Ensure all Pathway 0 patients with NCTR are being discharged or have a valid reason for residing in the Trust and updating the Site Team*
9. *Monitor "Next Steps" and try to accelerate any procedure that could influence discharge*
10. *Ensure the robust use of the Discharge lounge for early flow and escalate any delays*
11. *Liaise with IC&C to guarantee that all beds in SWICC will be filled and have back up names as a safety net*

Flow Matron

Current and ongoing projects

Great Western Hospitals NHS Foundation Trust

- Updating and improving policies
- Currently looking into late (23:00-06:00) and multiple patient moves
- Putting together a business plan to re band the Clinical Site Co-Ordinator's to band 7
- Monthly site overviews
- Updating of the Site report
- Co Ordination Centre

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**3 November 2022**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

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):

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

The report provides information in respect of:-

- Council of Governors
- Non-Executive Directors
- Strengthening Board Oversight
- Local Update
- Key Meeting 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	6 September 2022

Chair's Board Report

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally during October 2022.

Council of Governors

The Trust welcomes two new governors: Mufid Sukkar representing Wiltshire Northern Constituency and Caryl Sydney-Smith as representative for Swindon Borough Council.

Public Health Talks - A public health talk, hosted by the governors, was held on 1 November 2022 on Health Inequalities by Claire Thompson, Chief Officer of Improvement & Partnerships.

Strengthening Board Oversight

Safety Visits - There was one Board safety visits during the period covered by this report as follows:-

Date	Area	Board Member
12 October 2022	ICU	Simon Wade, Chief Financial Officer Lizzie Abderrahim, Non-Executive Director

Key Meetings during August – October 2022

Meetings	Purpose
Bi-monthly meeting with Chair/Deputy Chair/ Senior Independent Director	Regular meeting to update and discuss any topical issues
Chairs & CEO ICS Health Meeting	Regular meeting bringing together healthcare providers within the BSW ICS
1-2-1 meeting with Chief Executive	Regular meeting
EPR Update	Monthly update meeting
Finance and Investment Committee	Attended Board committee as observer
Performance, People & Place Committee	Attended Board committee as observer
Mental Health Governance Committee	Committee member
New Governor Induction meetings	To meet with new Governors as part of their induction process into the organisation

Report Title	**Chief Executive's Report**				
Meeting	**Trust Board**				
Date	3 November 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 includes updates on:

- Current pressures, including Covid-19
- A review of the Maternity and Neonatal services in East Kent
- Freedom to Speak Up
- Political appointments and 'Our plan for patients'
- NHS England's operating framework and letter detailing further winter preparations
- Staff vaccination programmes
- Staff survey
- Black History Month
- Industrial action

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 the Covid and flu vaccination programmes. We know that Covid has a disproportionate impact on some ethnic groups, and also that there is reluctance within some groups to have the vaccine. We are working directly with staff within these protected groups to support them.

The report includes an update on the Staff Survey. This survey is designed to highlight a range of issues, and recent surveys have highlighted issues from staff who are from protected groups and how they feel about working for the Trust. We will use this information to continue to try to make improvements.

Some of the celebrations to mark Black History Month are detailed – this event was organised by our BAME Network to celebrate some of the inspirational stories and shine a light on the contribution staff from BAME backgrounds have made to the NHS.

Our silver award for the Defence Employer Recognition Scheme is highlighted in the report, in recognition of the work which the Trust has done ensure veterans and their families receive fair and equitable treatment.

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Note the report**	
Accountable Lead Signature	
Date	27.10.22

1. Operational updates

1.1. Managing current pressures

Our Winter plan is in place to help us to manage the demand upon us, and we are working closely with our partners this year in recognition that the whole health and social care system is stretched, and that the pressures we face generally impact upon us all.

The Swindon Integrated Care Alliance Coordination Centre is now fully staffed and will be an important part of our response to the increased operational demand we know we will experience over the forthcoming months.

It remains early days however the initial signs are positive and we will need to continue to embed this as a way of working to fully deliver the benefits.

The centre received widespread coverage following a recent BBC visit, including on BBC Points West, BBC Wiltshire, and BBC Politics West. There has also been interest from national media in visiting the centre and we will work to accommodate journalists in forthcoming weeks.

1.2. Covid-19

The recent wave of Covid-19 appears to be declining, with a fall in the numbers of inpatients who have tested positive and those who have Covid as their primary diagnosis.

We anticipate further waves this winter and are also conscious of the risks that a wave of flu could pose if this coincides with a rise in Covid cases.

1.3. Blood supply

We were asked by NHS Blood and Transplant to help optimise the overall supply of blood, after national blood stocks dropped to a lower than acceptable level, triggering an amber alert.

The threshold for an amber alert means blood stock levels have fallen below two days, with the alert initially in place for four weeks to enable blood stocks to be rebuilt.

Alongside NHS organisations across the country, this means we have been asked to put in place plans to protect blood stocks, so blood is prioritised for patients who need it most.

A review of services in the Great Western Hospital, the Swindon community and our GP practices has been undertaken to determine which surgeries or procedures are more likely to need the support of blood products.

We will continue to carry out any urgent, emergency or trauma surgery, cancer surgery, transplant surgery and blood transfusions and would only cancel non-urgent surgery in the event of needing to prioritise the availability of blood products for those in urgent need. Patients will be contacted directly if there is a change to their appointment date.

In accordance with national guidance, we have already reduced red blood cell stocks, including O negative and O positive units, however emergency units are still available in the main issue, theatre and blood obstetric fridges.

2. Quality

2.1. Maternity

Last month a review of the Maternity and Neonatal services in East Kent, 'Reading the signals', led by Dr Bill Kirkup, was published.

A series of recommendations were made to improve maternity and neo-natal care both at East Kent and nationally.

We will be studying the report and recommendations and, along with delivering what we are required to, we will be focussed on what else we can learn from what happened and applying this across the Trust.

At our Trust there is excellent visibility of maternity and neo-natal care at Board level with monthly updates, quarterly in-depth overviews, six monthly progress reports against national safety agendas such as Ockenden report.

The report says individual clinicians were not to blame but also states accountability lies with successive trusts boards and CEOs/Chairs – who the report says ignored warning signs, as did the system as a whole.

These are some of the key quotes from the report, and these indicate that the learning stretches beyond maternity and should be carefully considered by all teams.

"The origins of the harm we have identified...lie in failures of teamworking, professionalism, compassion and listening"

"Safety investigations were often conducted narrowly and defensively…a junior obstetrician or midwife was often found who could be blamed"

"We have found that the Trust wrongly took comfort from the fact that the great majority of births in East Kent ended with no damage to either mother or baby"

"…demonstrates the problems that occur when some consultants stubbornly refuse to change unacceptable behaviour"

"We have found divisions among the midwives which at times included bullying to such an extent that the maternity services were not safe"

"We found gross failures of teamworking...a series of problems between the midwives, obstetricians, paediatricians and other professionals...Some staff have acted as if they were responsible for separate fiefdoms, cultivating a culture of tribalism"
Whilst the learning for maternity may be more immediately obvious, we will need to consider what this means for other specialities.

2.2. Radiotherapy Centre

The Radiotherapy Centre has now opened and seen its very first patients, after receiving its Care Quality Commission registration on 4 October.

This is a really significant milestone for the delivery of healthcare in Swindon and will improve the experience of patients needing this treatment.

2.3. Freedom to Speak Up

Last month we marked the national Freedom to Speak Up month.

We know that teams work best when all their members feel safe and have a voice, and that this leads to safer and higher quality care. We strongly encourage anyone to speak up if they have a concern.

This year's theme recognises that everyone has the responsibility, and the support, to speak up for safety, civility and inclusion.

Freedom to Speak Up is an important scheme, but it is just one of the many different routes there are to raising a concern. Other routes include speaking to a manager or director, using the chaplaincy service, and speaking to HR.

3. Systems and Strategy

3.1. Politics and 'our plan for patients'

A new prime minister is now in place and Rishi Sunak's health team has been confirmed as:

- Secretary of State for Health and Social Care – Steve Barclay, who was in this role from July to September this year, and was also a health minister in 2018.
- Health Ministers Will Quince and Helen Whately.

The previous Health Secretary Therese Coffey announced 'Our plan for patients' in September, which had four cross-cutting themes underpinning its proposals:

1. Patients will be empowered to play a greater role in decision making about their health and care
2. Prevention services will move closer to people's homes
3. Primary care will meet public expectations with regards to accessing appointments
4. A focus on performance and productivity, in partnership with NHS England, will help to deliver improvements in care.

The plan sets out a focus on 'ABCD' – ambulances, backlogs, care, doctors and dentists.

We await guidance as to whether this plan will be continued by the Government.

3.2. NHS England operating framework

On 12 October NHS England published its new operating framework, setting out how the NHS will operate in the new statutory framework created by the Health and Care Act 2022.

It outlines the four core foundations which defines NHSE's purpose, areas of value, leadership behaviours and accountabilities, and medium-term priorities and long-term aim.

NHSE will focus its activities around eight key areas where it is uniquely placed to add value:

1. Setting direction
2. Allocating resources
3. Ensuring accountability
4. Supporting and developing people
5. Mobilising expert networks

6. Enabling improvement
7. Delivering services
8. Driving transformation

NHSE has committed to the following:

- Proportionate and streamlined approach to oversight and performance management
- Devolved approach
- 'No surprises' approach and mature, respectful and collegiate relationships between NHS England, ICBs and providers
- ICB annual assessments.

3.3. NHS England letter detailing further winter preparations

NHS England has written to Trust and system leaders setting out the further preparations needed ahead of winter, following a letter sent in August outlining plans to boost capacity, increase resilience and improve patient flow across systems.

New measures are needed given the service remains in a level 3 incident response, with significant pressures across physical and mental health services.

The letter details the following national plans to go further this winter:

Better support people in the community – reducing pressures on general practice and social care, and reducing admissions to hospital:

- Putting in place a community-based falls response service in all systems for people who have fallen at home including care homes
- Maximising the use of virtual wards, and actively considering establishing an acute respiratory infection hub to support same day assessment
- Providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates.

Deliver on our ambitions to maximise bed capacity and support ambulance services:

- Supporting delivery of additional beds
- All systems setting up a 24/7 system control centre to support system oversight and decision-making based on demand and capacity across sites and settings
- Ensuring all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene.

Ensure timely discharge and support people to leave hospital when clinically appropriate:

- Maintain focus on the high impact actions from the 100 day challenge
- The government recently announced £500m to support social care to speed up discharge across mental and physical health pathways.

Winter improvement collaborative

- NHS England said it would establish a new national clinically-led winter improvement collaborative by the end of October which will initially run for 10 weeks. It will focus on the root causes of delay in each area
- It will help identify, evaluate, quantify, and scale innovation and best practice in improving handover delays and response times, aiming to reduce unwarranted variation at pace.

In addition to the winter resilience plans, the letter sets out other requirements as follows:

Elective care: Sustaining elective activity remains a priority throughout winter to help the service eliminate waits over 78 weeks by the end of March 2023.

Cancer: To best manage the increase in demand for suspected cancer referrals the letter sets out specific recommendations for lower GI, skin and urology pathways.

Infection prevention and control measures, testing and staff vaccination: Existing UKHSA guidance on the management of Covid-19 patients remains in place. Local discretion can be used to test specific individuals or cohorts and symptomatic testing should continue for patients and staff. Symptomatic staff should test themselves using lateral flow devices and those testing positive should follow UKHSA's return to work guidance. Trusts should continue to encourage staff to receive both their flu and Covid-19 vaccines.

Oversight and incident management arrangements: NHS England will work with ICBs to provide oversight and support. NHS England will update the NHS Oversight Framework to reflect changes in the Board Assurance Framework to provide a more robust escalation process on winter resilience, cancer and elective recovery.

Our Deputy Chief Operating Officer, Al Sheward, is doing a gap analysis of our winter plan against the letter to determine other priorities for the next few months.

3.4. Integrated Care Partnership

The first meeting of the BSW Integrated Care Partnership was held last week.

This is a statutory committee as part of the BSW Integrated Care Board, and is chaired by Wiltshire Council leader Cllr Richard Clewer.

The BSW ICP will develop an integrated care strategy for local health and care services and advocate for innovation, new approaches and improvement to the way services are provided and run.

3.5. Visit of Regional Director

Later this month we are pleased to be hosting a visit to our Trust from NHSE Regional Director Elizabeth O'Mahoney.

We look forward to the opportunity to show her around, in particular areas such as the Swindon ICA Coordination Centre, SwICC and some of our recent site developments such as the Urgent Treatment Centre.

4. Workforce, wellbeing and recognition

4.1. Vaccination programmes

We are running our Flu and Covid booster vaccination programmes at the same time this year.

At the time of writing we had vaccinated more than half of staff against flu, with 48% of staff having received Covid boosters.

From last week we began offering flu jabs as part of drop-in clinics on weekdays – they previously had to be booked in advance. Covid jabs still need to be pre-booked.

4.2. Staff Survey

Our staff survey response rate up to 23 October, covering the first four weeks of the survey being open was 41%, more than 7% higher than the same time last year.

This is higher than the 25% average response rate for acute and community trusts working with Quality Health, the company we are using to administer the survey.

To help encourage survey completion, we are running a weekly competition which rewards teams and divisions with the highest completion rate.

We are also using mobile computers which are taken around to particular areas to help increase their response rates.

Everyone completing the survey receives a voucher for a free lunch or food shop voucher

The staff survey closes at 5pm on 25 November.

4.3. STAR of the Month

Our latest STAR of the Month is Dr Sherif Elhadary, whose caring behaviour goes beyond expectations. He is always putting the patients first, and their health and wellbeing is a priority for him. Sherif has a natural rapport with people and is very compassionate and kind. He takes great pride in his work and is always willing to help patients, families and colleagues - he also teaches every Friday and regularly offers support to junior doctors.

4.4. Locum bank working

We've partnered with Locum's Nest to bring staff an app which will improve access to locum bank working opportunities.

This also marks start of our part in a digital collaborative with Trusts in Gloucester, Bath, Salisbury and North Bristol to share and grow our bank pool of doctors.

4.5. Black History Month

Last week we held an event to celebrate Black History Month in the Academy, focussed on inspirational stories.

Among the speakers were the owner to Route 8 Barbers in Swindon, along with the creator of LammyLapp, and Dr Nnenna Osuji, the Chief Executive of North Middlesex University Hospital NHS Trust. Dr Osuji spoke about her experiences and shared some of her wealth of knowledge.

4.6. Silver recognition

Having achieved Armed Forces Accreditation for our work to become veteran aware, we continue to work to improve NHS care for veterans, reservists, members of the armed forces and their families. Last month we were presented with a certificate from the Lord Lieutenant of Swindon and Wiltshire to mark achieving Silver status in the Government's Defence Employer Recognition Scheme.

4.7. Recognising our AHPs

Last month we recognised the significant contribution our Allied Health Professionals make to our organisation as part of the national AHPs Day.

We also held our first AHPs Symposium in the Academy, which was themed around career journeys.

This event gave AHPs the opportunity to come together and share personal experiences, hear from inspirational speakers and understand more about how they can develop in their careers.

4.8. Industrial action

A number of unions have indicated that they are either balloting their members, or considering balloting them, about taking industrial action in response to disputes relating to the national pay settlement.

The Royal College of Nursing is the first union which could potentially go on strike. Its statutory ballot runs until 2 November, with the earliest possible date for industrial action being 18 November.

Unison is asking 350,000 NHS staff, including porters, nurses, paramedics and cleaners to vote in favour of strike action. Its ballot closes on 25 November.

Other major unions, including the Royal College of Midwives, GMB and Unite, have all started to, or are planning to, ballot members.

The GMB is already currently balloting its ambulance service members on strike action, with the ballot running until 29 November.

The BMA's junior doctors committee voted to go to a ballot for industrial action in early January.

Industrial action will clearly add a significant risk to service delivery, our recovery of services to bring waiting times down, and patient care during what will be a demanding winter.

We have an Industrial Action Working Group which is currently meeting weekly to look at the potential impact on our services and the mitigation which can be put in place.

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		26th October 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			ED/UTC performing relatively well against 4 hour target (74%) compared to other trusts and national average. However, the average waiting time now exceeds 8 hours with 16.6% of ED patients waiting in excess of 12 hours. Ambulance handover waits continue to be a concern, with approx. half of patients waiting in excess of 30 minutes and a 1/3 over 1 hour. Further specific improvement work is planned with the ambulance service week beginning 12th December. NCR patients (i.e those who do not need to be in hospital) remains very high at c.130.	Monitor Actions	November 22
Integrated Performance Report – Elective Access - RTT			Trust continues to have no patients waiting in excess of 104 weeks (1 of only 4 trusts in the south west). Continued improvement seen in the reduction of 78 week waiters, with a forecast of achieving 0 waiters by Feb/March 2023, although dermatology neurology remains a significant challenge. The number of 52 week waiters remains a concern.	Monitor Actions	November 22

Integrated Performance Report – Elective Access – DM01			The committee noted a significant improvement in MRI/CT/Echo waiting times, as forecast. Although, a further deterioration of wait times of scopes (noted – action plan for improvement in place)	Monitor Actions	November 22
Integrated Performance Report - Cancer			RAG rating moved to Red/Red due to a further deterioration in performance with no discernible improvement expected. The service is being supported by the trusts improvement planning process and the issue has been escalated to the CEO.	Monitor Actions	November 22
Theatres Programme Assurance Report			The committee received a presentation from the senior leadership team. Several good initiatives were noted with further improvements expected in November, with an increase in the number of all day lists and expected improvements in day case rates. Further progress report to PPPC in January 2023.	Monitor actions	January 2023

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

Board Committee Assurance Report*

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		20 October 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**

***Note that this is the first Board Assurance Report from the Quality and Safety Committee that includes the new version of the IPR. As such this may be subject to change over the coming months depending on views received.**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR:Overall			With the change to the new IPR which includes separation of the Maternity related reports, the Committee believed it was no longer necessary to provide an overall rating.		
Integrated Performance Report: **Pillar Metrics**	Amber	Amber	The two pillar metrics for this Subcommittee are 'Total Harms' and 'FFT Positive Responses'. The overall score for Total Harms includes the Breakthrough Objective of Pressure Harms plus Watch Metrics of Falls, Hospital Acquired Infections, Medication Incidents, Serious Incidents and Never Events.		
IPR **Breakthrough Objectives**: Pressure Ulcer Harms	Amber	Amber	The total number of Pressure Harms reduced slightly in both Acute and Community but numbers remain higher than September '21. Work continues under 'Improving Together' to continue to reduce these		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			numbers. New mattress overlays are now in use together with focused teaching and introduction of early assessments.		
IPR **Non-Alerting Watch Metrics**: Hospital Acquired Infections	Amber	Amber	Hospital acquired Covid infection increased significantly in September in line with the national trend. Imminent installation of air filtration units on wards and units at highest risk, should reduce this as those areas tested to date have shown a significant reduction in Covid cross infection rates. The Trust remains below trajectory for C.diff, MRSA and Pseudomonas and in line for Klebsiella. E.coli and MSSA rates remain a concern and further work is underway to address this.		
Falls:			Falls rates have decreased slightly this month. Falls now come under 'Non-Alerting Watch Metrics' so will only be rated if alerts occur.		
Friends and Family Test (FFT):			There was a wide disparity this month for positive responses. This ranged from 99% in Outpatients to 77% in the ED. Overall across the trust the positive rate was 83% and the negative 11%.		
Integrated Performance Report: Staffing	Amber	Amber	Safe Staffing now appears as a separate Monthly Report. See below.		
Perinatal Quality Surveillance Tool	Amber	Green	Midwife to birth ratio was back to 1:29, (target 1:29). 1:1 care in labour failed briefly for 1 woman dropping the rate to 99.1%. Progress has been made in meeting the CNST 10 Safety criteria with the expectation that the CO monitoring (smoking) at 26 weeks will be compliant by next month. Recruitment for midwives is going well with an expected cohort of graduate midwives starting soon. A recent visit from the Insight team found no safety issues, a dedicated and proud staff and a culture of openness.		
Ockenden update	Amber	Amber	Further progress has been made but this remains a long-term project.		
Q2 Maternity & Neonatal Q&S Report	Amber	Green	No major concerns. The Trust remains top in the Region for Avoiding Term Admissions In to Neonatal Units (ATAIN).		
Perinatal Mortality Review Tool Report	Green	Blue	100% compliance across all measures and the system remains embedded.		
Emergency Department Dashboard	Red	Amber	Increase in attendance and resultant drop in triage times reflecting high pressure. Staff are feeling the effects of continuous demands. Length of Stay within the department has increased due to pressure on beds.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			Some concerns have been reported about perceived lack of compassion by staff who are under intense pressure. This is being examined. SHINE Checklist has shown some deterioration mainly in early assessment of NEWS scores.		
Monthly Safe Staffing	Amber	Amber	Fill rates have been satisfactory overall but there are three wards within maternity that fell below expected levels.		
Update on CQC Preparedness	Not Rated	Not Rated	There has been further progress. There is a plan in place to address the Safeguarding Children Level 3 Training which remains at 50-60% instead of 90%.		

Issues Referred to another Committee	
Topic	Committee

NHS
Great Western Hospitals
NHS Foundation Trust

Board Committee Assurance Report

Finance, Infrastructure and Digital Committee – October 2022			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**24 October 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			
RISK MANAGEMENT & REPORTING					
Finance, Infrastructure, and Digital Risk Management	A	A	We are assured that the risk management process and reporting risks for Finance, Infrastructure and Digital are adequate and effective. Overall, we are pleased with the focus and attention to the risk management process, reporting of identified risks, and governance. However, greater emphasis and direction are required in identifying mitigation actions and ensuring ownership of the risk mitigation activities. For example, further focus and effort are needed to identify mitigation actions to address the £4m gaps to address the critical risk; mitigation actions, including ownership of activities, need to be identified for IT Clinical Risks.	Monitor monthly at FIDC	FIDC meetings 2022/23
OPERATIONAL					
BSW Consolidated Report	A	A	The Committee received an update on the overall financial position of the BSW ICB financial position at Month 5, including key risks, mitigations, and delivery of efficiencies. BSW ICB reports a surplus of £6.8m, whilst the providers are reporting a position of £4m behind plan with a combined deficit of £26.2m. This is a net position of £19.4m deficit, 3.9m behind the planned deficit of £15.5m.	Update requested on Governance, Risk Management and Controls assurance relating to BSW Finance.	
Month 6 Finance position	R	A	The overall position for month 6 is £1.9m against a planned deficit of £1.5m (£0.4 adverse to plan). ESRF drives these costs more than income (£0.4m), including continuing pressure on pay costs that is mitigated by the release of accruals. Capital Expenditure is £4.7m below	Monitor monthly through FIDC	FIDC meetings 2022/23

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			plan due to profiling and slippage; this is being actively managed at the monthly Capital Management Group.		
Improvement and Efficiency Plan – Update	R	A	The CIP target is 64% identified at month six against a target of £11.1m. In the month, £0.8m efficiency is delivered against existing schemes rather than determining new schemes. With the shortfall of efficiencies identified, the year-end forecast position is a gap of £4m. The limited increase in identified savings from the previous month due to increased focus on delivery constitutes a significant risk to our financial plan.	Monitor through FIDC and monthly update to the Board	FIDC meetings 2022/23
Financial Planning Process	A	A	The Committee received another update on the business planning progress for 2023/24. We are assured that communication of planning packs, timelines, and guidance from the COO is agreed upon with all working group representatives enabling a proactive and comprehensive approach across the organisation.	Monitor through FIDC and key updates to the Board as required	FIDC meetings 2022/23
BUSINESS CASES & UPDATES – for noting					
Additional Theatre Sessions	-	-	The Committee was requested to review the Theatre Capacity Proposal and agreed to a phased investment approach: Phase 1: Agency and Locum staffing uplift; Phase 2: Engagement of Substantive workforce; and Phase 3: Full establishment to optimise Theatre Capacity. This investment supports mutual aid for the broader system and the reinvigoration of private practice services, which is forecasted to improve the income stream for the Trust.	Monitor progress of phases of investment approach at FIDC.	FIDC meetings 2022/23
Health & Safety Annual Report	A	A	The Occupational Health & Safety, Fire & Security Annual Report summarised progress and issues identified over the past year. The Committee noted and approved the comprehensive and factual report and agreed to an acceptable level of assurance.	-	-
Shared EPR Programme – Update	R	A	The EPR Programme procurement is currently tracking to plan - the initial proposal received from bidders and mandatory compliance was completed, and a new programme director and EPR Project Manager started in September. A key risk noted is that pre-implementation activities are delayed due to a lack of resources.	Monitor through FIDC	FIDC meetings 2022/23
Consult Connect – Lessons Learnt	R	A	The Committee received a comprehensive paper on the essential judgement findings, lack of compliance with Public Contract Regulations 2015, lessons learnt, and best practices for all future BSW contracts following the recent legal case between BSW and Consult Connect. Actions are taken to address the: Use of Pre-Market Engagement, Use of Frameworks to procure, Conflict of interests, and Risk Mitigation.	Monitor procurement through FIDC	FIDC meetings 2022/23

Issues Referred to another Committee	
Topic	**Committee**
Impact of Clinical IT Risks on quality of care	Q&G

Board Committee Assurance Report

People & Culture Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	Paul Lewis		25th October 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			
Workforce Planning	R	A	The improved check & balance workforce planning controls, with both the Divisional Directors of Nursing Meetings and Medical Staffing Meetings, are having a positive impact. Recruitment plans are in place to further improve the staffing position, including the additional requirements for the Winter Plan. Absenteeism rates are reducing which is encouraging, although levels are still higher than target. The risk of industrial action remains a key concern in how this may affect workforce planning over coming months.	Review progress at the next meeting.	January 2023
Great Opportunities	A	A	Although the 'Stay & Thrive' approach has been well received, turnover levels are still a concern and plans are in place to improve the quality of career conversations to deploy and retain our staff more effectively. The new Appraisal process will also help with this.	Review progress at the next meeting.	January 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Employee Experience	A	A	Safety Visits and 'Walkabouts' are taking place and more are planned, so this will continue to provide further insight. The initial response rates for the latest Staff Survey are encouraging and we will review the next set of results in detail through this Committee There has been a detailed review of progress with our People Strategy and the report was well received by the Committee Members. At the next meeting we will complete a RAG review to establish an agreed rating of the progress made.	Review progress at the next meeting.	January 2023
Employee Development	A	A	There are plans to improve the appraisals process and documentation (which will include development reviews and discussions) and this will be reviewed in more detail at the next meeting.	Review progress at the next meeting.	January 2023
Great Leadership	A	A	We will await further clarity and guidance about the Messenger Report before initiating further actions (especially where additional funding will be required) particularly within the key recommendation area of 'management standards and accredited training'. In the meantime, we will continue to deliver our existing plans and initiatives to further improve Leadership capability.	Review progress at the next meeting.	January 2023

Issues Referred to another Committee	
Topic	**Committee**
None	N/A

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**3rd November 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 is currently under review supported by KPMG. The IPR sprint aims to being levels of reporting and assurance at the required levels across the Organisation and make the IPR fit for Board and Public reading. This process will complete in November 2022.

Our Performance

Key highlights from the report this month are:

OPERATIONAL PILLAR METRICS

Of the 6 Operational Pillar Metrics, 5 have deteriorated in month with Meantime in the Emergency Department UTC being the only Pillar Metrics delivering to plan.

Cancer 62 day - Cancer waiting times remain below standard. In August 2022 performance of 65.1% was recorded against an 85% target.

RTT 18 Week Compliance – September performance of 54.7% against a target of 92%. Capacity in outpatients is also reduced.

Emergency Care, Emergency Department Mean Stay – September mean time in ED rose to 494 from 473 mins in August 2022.

Emergency Care, Urgent Treatment Centre Mean Stay – Septembers mean time continues to deliver well within the scope of the National standard of 240 mins.
Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. There was an increase in September to 10,213 recognising the sustained pressure on Urgent and Emergency Care services.
Inpatient Spells, Number of Non-Criteria to reside (NC2R) days. The number of patients who remain in an Acute Hospital bed without a Criteria to Reside continues to increase. The Trust has seen little progress in the reduction of patients waiting system partners in September.

OPERATIONAL BREAKTHROUGH OBJECTIVES
Both breakthrough objectives show a deteriorating position in September with worsening percentage of patients in the department for >12 hours and increasing numbers of patients awaiting an update from the Community Single point of Access.

ALERTING WATCH METRICS
Of the 15-watch metrics 6 require update in the month of September. Of the remaining 9, all show deterioration in month. All measures are currently in close monitoring or improvement oversight arrangements.

Our Care
This section of the report presents performance to the two Strategic Pillar targets below

1. To achieve zero avoidable harm within 5-10 years
2. To achieve consistent positive response rates in excess of 86% from patient friends and family test.

Pressure ulcers/harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. The other harms are all presented as watch metrics later in the report.

Within the month we have seen a reduction in Pressure ulcers in both the acute and the community setting. Improvements have been seen across several wards and departments, following the purchase of new mattress overlays, focused teaching and the introduction of early assessments. The Pressure Ulcer Risk Assessment Tool (PURAT), has been updated and developed into a digitalised format so patients can be easily identified as being at risk, supporting earlier intervention to prevent harm. A trial will commence on Orchard, Forest, Sunflower Lodge and Jupiter wards in the next month.

In the community the Improving Together work streams have commenced with front line (West locality) and specialist services.

The continued decline in the complaint response rate has meant it has triggered as an alerting watch metric, close review of all complaints is being undertaken at a senior level and support put in place as required.

Significant points to note relating to non- alerting watch metrics include

- The number of concerns has increased, there has been no specific theme to explain the increase.
- The number of falls has decreased, resulting in 5.81 per 1000 bed days, this remains within normal variance.
- There has been an increase in C.*difficile* in month, but we remain below trajectory for Klebsiella. E.coli and MSSA numbers are concerning and work to reduce these, particularly focusing on care of intravenous devices and urinary catheters, is ongoing.
- There were 53 hospital acquired cases of COVID-19 (positive test more than 7 days after admission) in September 2022 – a significant increase on August's numbers. The number of outbreaks has increased in this period.
- For September, 83% of the Friends and Family Test (FFT) responses were positive, a slight reduction from the 87% for August.
- The negative responses at 11% are slightly higher than the 8% for August but remain in the trend of low teens of this year,

- A&E (ED & UTC combined) positive response rate at 74%, slightly lower than August.
- Inpatients show a 77% positive score, a decrease on previous months, whereas outpatients show an increase to 99%.
- The top positive and negative themes are consistent as staff attitude and environment, with waiting times being a further negative theme. Further development of the IPR this month will include clarification of adding meaningful thresholds to measure performance against.

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 September

The Trust vacancy KPI has decreased again in-month from 6.70% to 6.31%, a decrease of 18.45WTE. There has been an increase in establishment as a result of the phased safer staffing investment which included 15WTE in Meldon, Teal and Trauma wards, Medical vacancy factor has reduced from 6.53% to 3.64% (46WTE reducing to 26WTE).

Sickness absence decreased in-month (August) from 5.94% to 4.64%, of which 0.71% is Covid related absence and 3.93% is non-Covid related. September has seen a rise in COVID cases which is expected to impact the sickness KPI.

The in-month agency spend as a percentage of the total pay bill has decreased in month from 6.22% to 5.65%, below the Trust target (6%) although agency spend has increased in September. Nurse agency spend remains high at £754K compared to £400k in 2021/22, and Medical agency also continues to remain high at an average £640K per month, the introduction of Locum nest will support reduction in medical agency spend.

The workforce priorities for the month ahead include: promotion of the annual Flu and Covid-19 vaccination programme, promotion of the Staff Survey, supporting continued reduction of staff absence, annual retention plan, alignment of the SARD system with ESR; oversight of the increasing industrial relations landscape and implementation of Business Planning process.

Use of Resources

The Trust is reporting a deficit of £1.9m against a planned deficit of £1.5m in Month 6 (£0.4m adverse to plan). ESRF costs are above income in month (£0.4m) which is driving the in month adverse variance. Year to date the position is £2.2m adverse to plan which is driven by ESRF (£0.8m) and a overspends in pay costs predominantly within Unscheduled Care.

In month, £0.8m efficiency was delivered against a plan of £1.0m (£0.2m adverse to plan). Year to date the Trust is £1.2m below plan. A gap of £4.0m remains to find to deliver the full year plan.

The cash position at the end of September was £4.0m below plan. Capital expenditure is £1.5m to the end of Month 6, which is £4.7m below plan.

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	TMC & Trust Board
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	27th October 2022

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

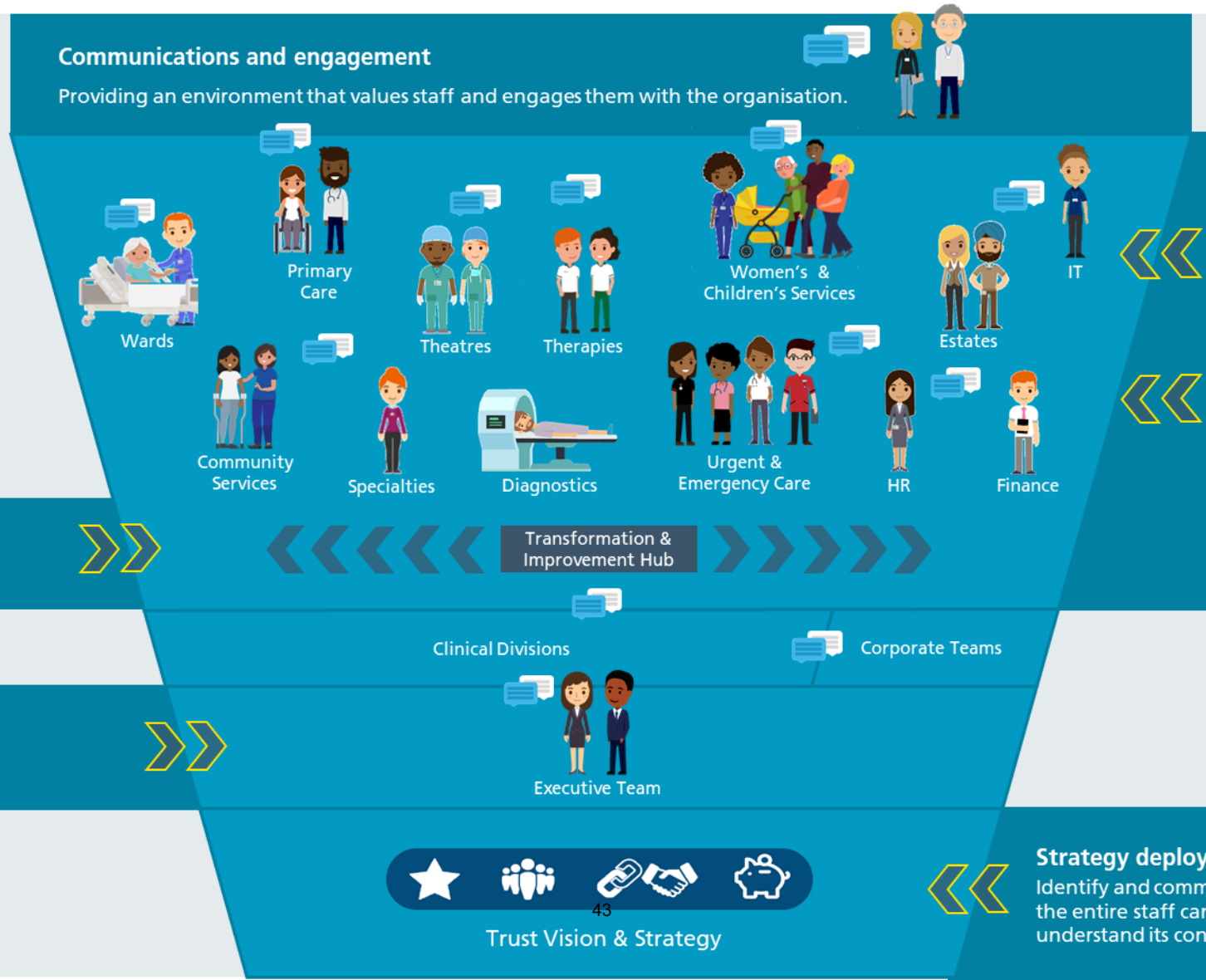
October 2022

August & September 2022 data period

Improving
together

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



Transformational projects
Using improvement methodology to create step-change improvement.

Operational Management System
A system of routines, behaviours and tools which ensure daily continuous improvement and performance excellence.

Transformation & Improvement Hub
Develop an internal capability to develop and sustain improvement journey.

Leadership behaviours
Develop new leadership styles at the top of the organisation, and capability to cascade this through management.

Strategy deployment
Identify and communicate a focused set of priorities to ensure the entire staff can align with the organisation's strategy and understand its contribution to achieving the strategy.

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

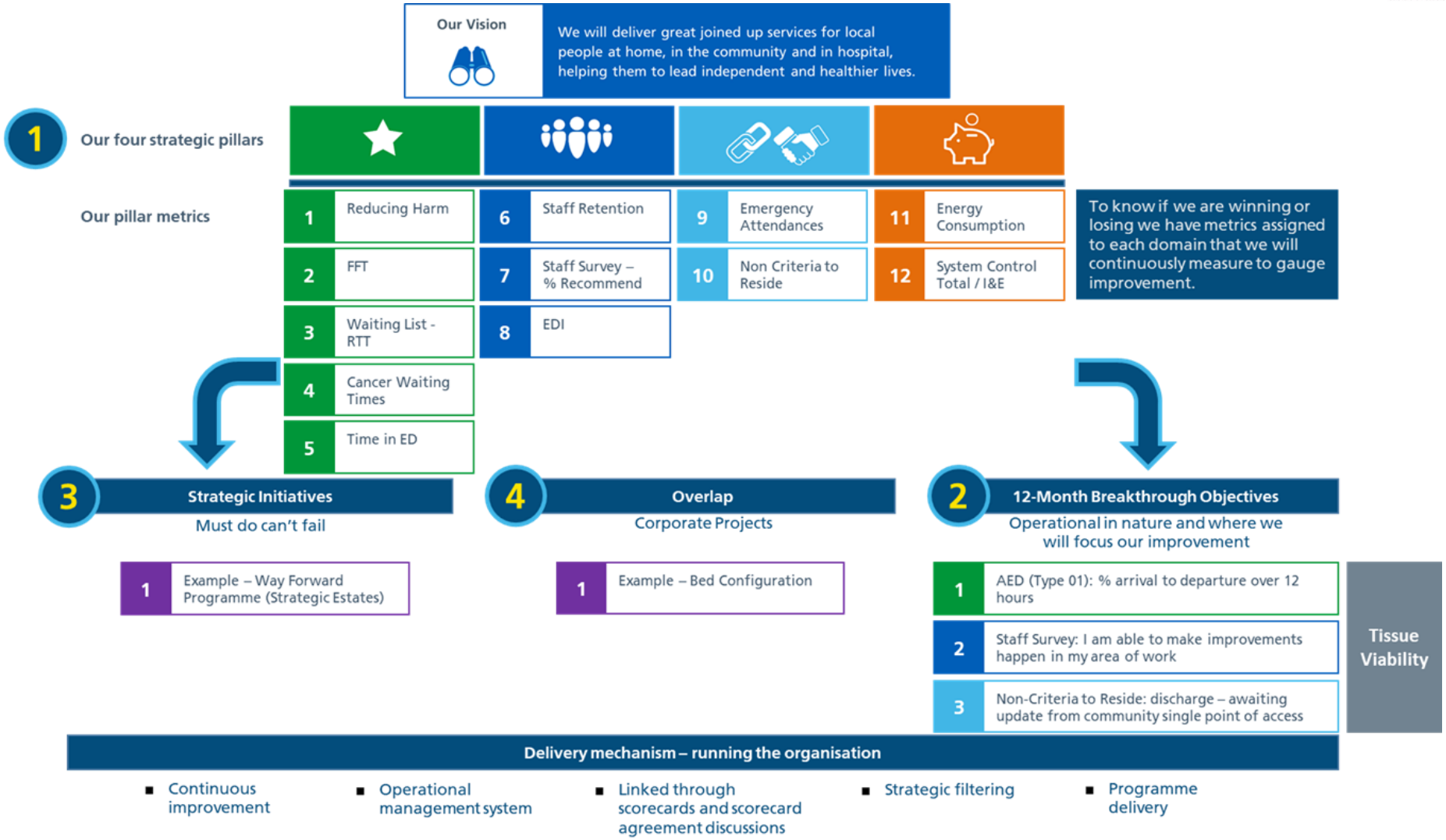
We will deliver great joined up services for local people at home, in the community and in hospital, helping them to lead independent and healthier lives.

Our four strategic pillars

- Outstanding patient care and a focus on quality improvement in all that we do
- Staff and volunteers feeling valued and involved in helping improve quality of care for patients
- Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers
- Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust



Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Total Harms

The Strategic Pillar target is to achieve zero avoidable harm within 5-10 years. Our calculation for total avoidable harms aggregates incidences of the following in each month;

- Pressure ulcers/harms
- Falls
- Hospital acquired infections (including Covid-19)
- Medication incidents
- Serious incidents
- Never Events

Pressure ulcers/harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. The other harms are all presented as watch metrics later in the report.

Lisa Cheek — Chief Nurse
Jon Westbrook — Medical Director

Patient Experience (FFT)

The Friends and Family Test is a national scheme which encourages patients to provide feedback about their experience of using our services. Patients are asked the question, Overall, how was your experience of our service? and have six options ranging from very good to very poor and don't know, there is also an area for free text comments, results are collated monthly.

The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall scorecard.

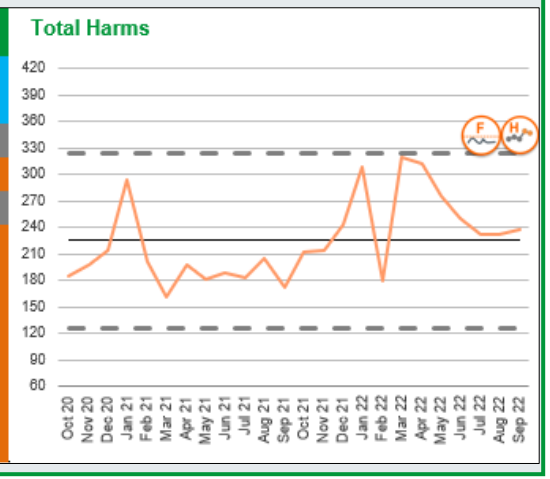
Lisa Cheek
Chief Nurse

Service | Teamwork | Ambition | Respect

Total Harms

To achieve and sustain zero avoidable harm.

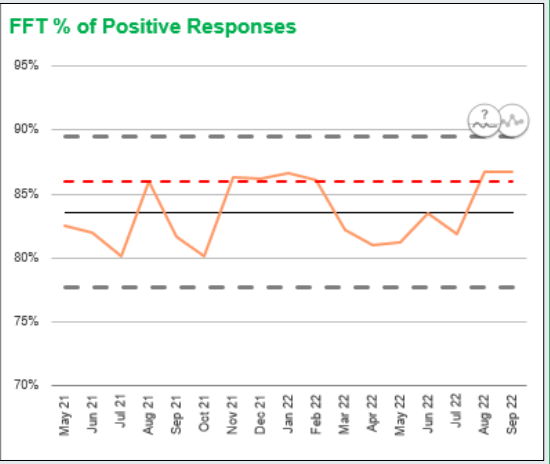
Timescale	Value
Oct 21	212
Nov 21	215
Dec 21	244
Jan 22	308
Feb 22	180
Mar 22	320
Apr 22	312
May 22	277
Jun 22	251
Jul 22	232
Aug 22	233
Sep 22	238



Patient Experience (Friends & Family Test)

To achieve consistent positive response rates in excess of 86% from patient friends and family test.

Timescale	Value
Oct 21	80.2%
Nov 21	86.3%
Dec 21	86.2%
Jan 22	86.6%
Feb 22	86.1%
Mar 22	82.2%
Apr 22	81.0%
May 22	81.2%
Jun 22	83.5%
Jul 22	81.9%
Aug 22	86.7%
Sep 22	86.7%



Counter Measures

- Hospital-acquired COVID numbers rose significantly in September. This is in line with the national trend. Estates and Serco are, with the support of IPC, planning imminent roll-out of air scrubbers in clinical areas. Trusts who have installed these have seen a marked reduction in hospital-acquired COVID. Areas with frequent outbreaks and front-door units will be the first priority areas.
- Teal Ward and Emergency Department have reduced their level of pressure harm to zero this month, following implementing new interventions and additional education.
- The AHP team on Forest ward have re-introduced daily exercise classes following covid. All patients that attend the classes have found them to be beneficial in aiding their progression through activity as well as allowing social interaction. This intervention aims to help reduce the risk of falling.

- New discharge co-ordination hub set up to enable joint working to support effective, safe discharge
- Carers Support Wiltshire introduction of new Carers Liaison service
- Carers Accreditation Panel for Outpatient department standards – 13th October
- New assessments on Nerve Centre to support Carers and Military Personnel for implementation in October
- Practice educators supporting improvements in personal care at ward level
- New training to focus on First Impressions for administration and reception staff to commence November
- New facility added to Signlive to support Deaf community
- Draft Trans Guide for staff approved for final ratification. ion
- Significant developments with the use of patient falls sensors and additional training

Executive Summary

Great Western Hospitals NHS Foundation Trust

Trust Access Standards - Cancer, Referral to Treatment (RTT) & Emergency Department (ED)

It is poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

In common with many other providers, the Trust has not consistently achieved the national access standards for ED and RTT, and nationally expectations are being reset around targets. Countermeasures for the deteriorations seen here are listed below

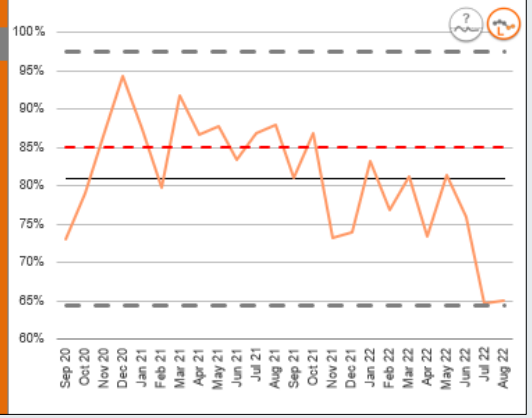
In August, we saw 13.5 breached in the Skin pathway that we have not historically seen. This is due to the capacity challenges we have seen along with the unprecedented level of demand.

Felicity Taylor-Drewe
Chief Operating Officer

Cancer 62 Day

To achieve and sustain 85% performance for patients on a Cancer pathway.

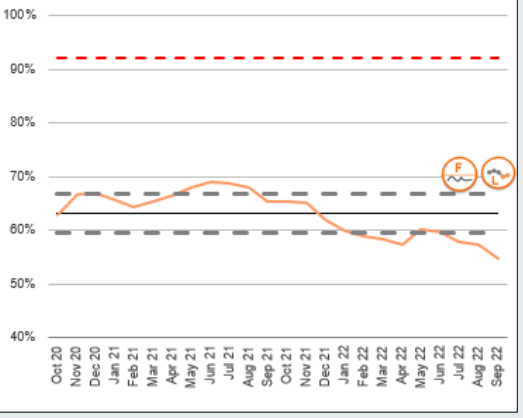
Timescale	Value
Sep 21	81.0%
Oct 21	86.8%
Nov 21	73.3%
Dec 21	74.0%
Jan 22	83.2%
Feb 22	76.8%
Mar 22	81.2%
Apr 22	73.5%
May 22	81.5%
Jun 22	76.0%
Jul 22	64.7%
Aug 22	65.1%



RTT: 18 Week Compliance

To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.

Timescale	Value
Oct 21	65.4%
Nov 21	65.2%
Dec 21	62.0%
Jan 22	60.1%
Feb 22	59.0%
Mar 22	58.5%
Apr 22	57.4%
May 22	60.2%
Jun 22	59.7%
Jul 22	57.8%
Aug 22	57.4%
Sep 22	54.7%



Counter Measures

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

Mitigation: Seeking further Mutual aid at Oxford agreed for treatment. Dermatology are holding clinics at Wootton Bassett from late September 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. The risk within capacity has been raised with the Cancer Alliance and NHSI SW team.

- Risk: For All Cancer Tumour Sites, capacity in outpatients to stage WLI activity is restricted by staff issues and space issues.

Mitigation: All services liaise with Outpatients to review any gaps in clinic utilisation on a weekly basis.

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

Mitigation: Registrar activity in lower GI is being used to free up clinic time for consultants to see their cancer patients.

- Risk: Staffing challenges in radiology due to vacancy and absence is placing increasing strain on capacity. Additional funding for external CT van in place until Mar 2023. Current waiting time for a CT Colon is 10 days.

Mitigation: Weekly meetings are held to escalate PTL concerns and booking times data is shared weekly. Radiology are actively managing and prioritising cancer referrals.

- Risk: Insufficient staffed theatre capacity to meet activity plan due to anesthetic and theatre staff absence and staffing of additional maternity elective list

Mitigation: Business proposal in development to staff all theatres 50 weeks per annum. Theatre timetable review to extend to all day lists and right size theatre schedule to demand due to be implemented Nov-22. Job planning to commence with new AMD to optimize funded resources. Weekend insourcing contract extended to December 2022. Weekend in house fee per case model launching with Gen Surg in Nov-22.

- Risk: Insufficient capacity to meet Activity plan.

Mitigation: Weekend payment per case activity planning underway for surgical specialties who do not undertake any insourcing activity. Additional capacity (including diagnostic) being provided in Endoscopy, Dermatology, Cardiology and Rheumatology in September and October 2022.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

Patients are delayed within the Emergency Department (ED). This is a marker of a crowded system resulting in delays in assessment, investigation, treatment and discharge.

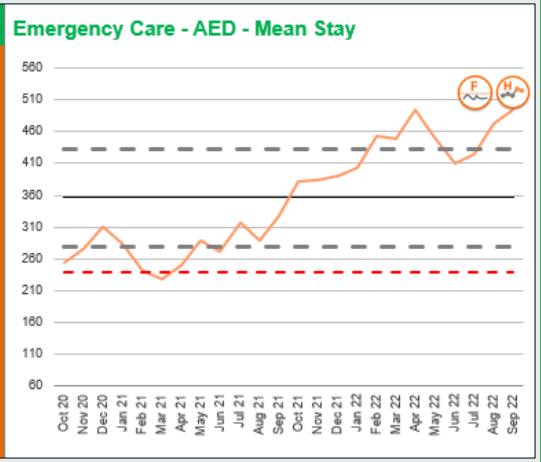
The total meantime wait for a patient in September 2022 was 494 minutes against the national standard of 240 minutes. Poor flow resulting from increases in length of stay (for both Criteria to Reside and Non criteria to reside patients) and COVID inpatients increasing has contributed to deterioration.

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

To achieve and sustain a mean time in department for all patients attending the Emergency Department.

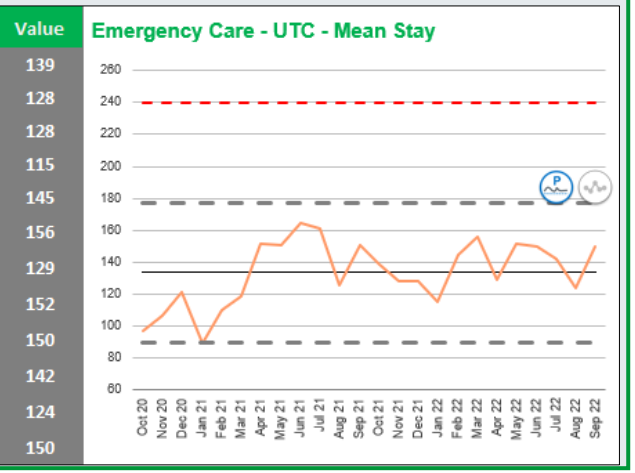
Timescale	Value
Oct 21	381
Nov 21	383
Dec 21	391
Jan 22	403
Feb 22	453
Mar 22	448
Apr 22	493
May 22	450
Jun 22	409
Jul 22	425
Aug 22	473
Sep 22	494



Emergency Care – Urgent Treatment Centre - Mean Stay

To achieve and sustain a mean time in department for all patients attending UTC.

Timescale	Value
Oct 21	139
Nov 21	128
Dec 21	128
Jan 22	115
Feb 22	145
Mar 22	156
Apr 22	129
May 22	152
Jun 22	150
Jul 22	142
Aug 22	124
Sep 22	150



Counter Measures

Context: A continued increase in Criteria To Reside (CTR) through September is contributing to a deterioration in flow out of the department and an increase in ambulance handover delays. Beds occupied by long stay patients is still high has started to reduce over the last 3 months

- Time to first assessment was good for most of September but small spike in last week.
- Introduction of a 2nd triage space in ED Major chairs to increase the capacity for triage. New triage space allows increased privacy and dignity for triage
- Review of nursing numbers in Triage space to increase capacity and reduce wait time for triage.
- Winter slippage monies bid for Pit-stop nursing has been submitted to provide clinical oversight of queue, start assessments early with potential for simple treatments and potential for discharge from ambulance with EPIC oversight

- Metric routinely meeting standard
- Roster change trial implemented for staff to increase staffing model mapped to key times of patient arrival – extended for a further 6 weeks
- Availability on late shifts and address poor fill rate and staff support. Monitoring in place for implications on performance.
- New clinical navigator role in place and being embedded into the model of care alongside the new GP roles which are highly effective
- Pathways between the emergency department and the urgent treatment center are being reviewed also alongside front door building work

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Care
Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC)

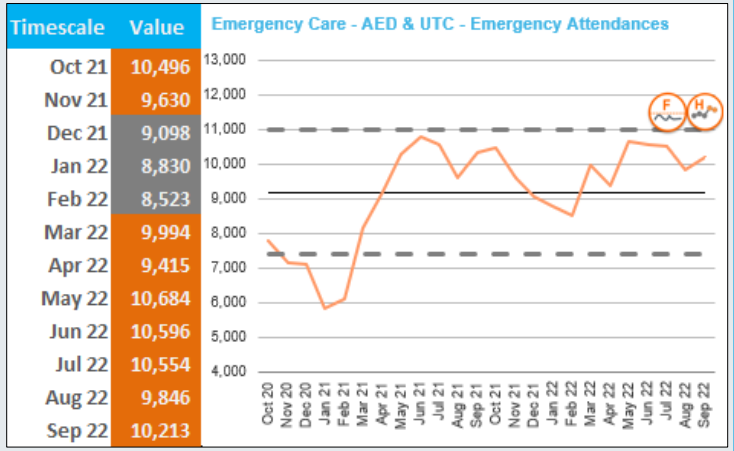
Inpatient Spells - GWH - Number Non-Criteria to Reside (NCTR) Days
This is when a referral for health and social care is made to partners and we are waiting the outcome from the social worker assessment or Single Point of Contact. re discharge pathway and planning.

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department & Urgent Treatment Centre - Emergency Attendances

To ensure patients are cared for in the appropriate setting

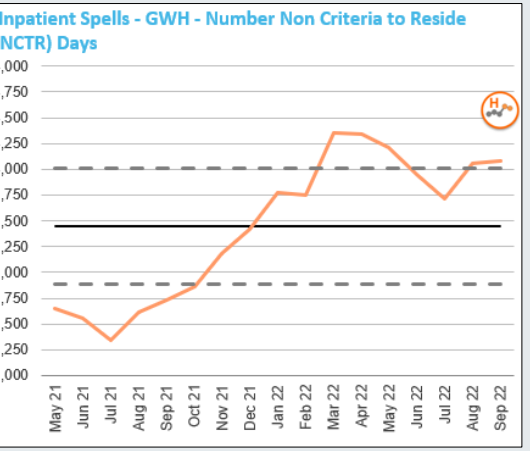
Timescale	Value
Oct 21	10,496
Nov 21	9,630
Dec 21	9,098
Jan 22	8,830
Feb 22	8,523
Mar 22	9,994
Apr 22	9,415
May 22	10,684
Jun 22	10,596
Jul 22	10,554
Aug 22	9,846
Sep 22	10,213



Inpatient Spells - GWH - Number Non-Criteria to Reside (NCTR) Days

To treat the right patients in the right place, to ensure delivery of high quality care.

Timescale	Value
Oct 21	1,862
Nov 21	2,186
Dec 21	2,417
Jan 22	2,772
Feb 22	2,747
Mar 22	3,357
Apr 22	3,343
May 22	3,209
Jun 22	2,953
Jul 22	2,712
Aug 22	3,057
Sep 22	3,083



Counter Measures

- Pre-Hospital
- Determination of correct response through the Navigation Hub working from the ICA Coordination Centre.
- Coordinate the person going to the right place

- Intra Hospital
- Internal ED flow improvement plan reported to Urgent Care and Flow Sub- committee
- Clinical Navigator lead at UTC front door and increased Triage Nurses at ED Front door
- Move to Singe Front door 5th Dec 22 also aligned to building work (Require 2nd navigator)
- Internal Same Day Care Pathway work for Medical and Surgical Patients
- Medical Getting it Right First Time (GIRFT) and Same Day Emergency Care Opportunity Work
- Direct access Pathways – Phase 1 General Surgery agreed
- Acute floor review & weekend working groups Oct & Nov 22

- Clinical assessor started induction in CC
- Head Injury pathway sent to ethics committee for managing care homes admissions with HI going forward.
- Intergrated care record training commenced to support triaging calls to hub

- Conversations around SAU pathways commenced
- New drive with Criteria Led Discharge , with better clinical engagement, using nerve center to sign post nurse and therapy led discharges.
- SAFER board rounds attended by medical outlier teams, mental health and Front teams have been extremely valuable to move patients in their new steps.
- OPEL and Bank -holiday demonstrated the value of that a hybrid weekend working model in the CC with fantastic consultant support.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Voluntary Staff Turnover (rate)

The annual turnover rate provides us with a high-level overview of Trust health.

Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Staff turnover has been stable over the last 3 years until Feb/March 2021. Since Feb/March 2021 we have started to see a steady increase in turnover levels.

Without staff retention, we can be overly reliant on our temporary staffing, see a reduction in staff morale and a detrimental impact on our finances.

Staff Recommendation as a Place to Work

The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

In the South West we are no. 17th as an organisation. We want to see an overall improvement in our staff survey results and our position in the South West. Our current performance could have an impact on our reputation as an employer, staff retention and staff morale.

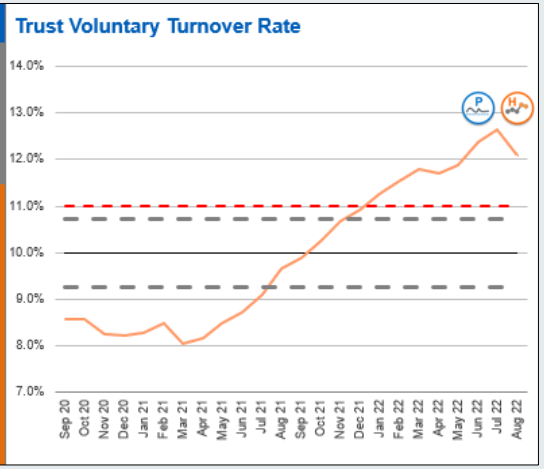
If staff currently felt more positive about their working experience at GWH this will translate positively in improvement in our patient's experience.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

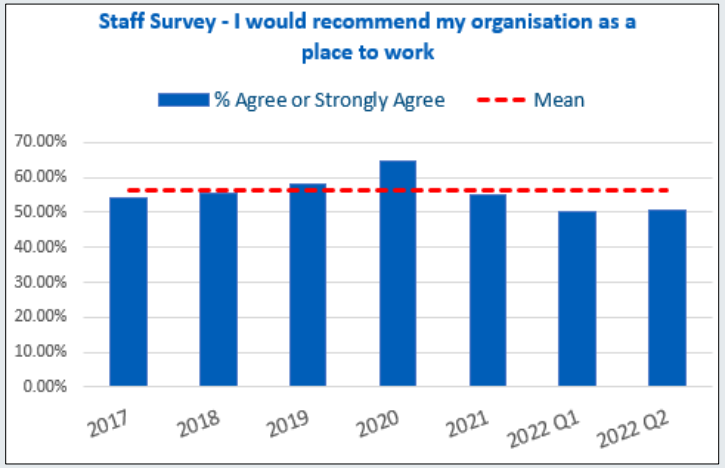
To achieve and maintain a maximum voluntary turnover rate of 11%.

Timescale	Value
Sep 21	9.9%
Oct 21	10.2%
Nov 21	10.7%
Dec 21	10.9%
Jan 22	11.3%
Feb 22	11.5%
Mar 22	11.8%
Apr 22	11.7%
May 22	11.9%
Jun 22	12.4%
Jul 22	12.6%
Aug 22	12.1%



Staff % recommend the organisation as a place to work

To improve our staff engagement score as demonstrated in the annual staff survey.



Counter Measures

- Recruitment team ensuring that new cohorts of internationally recruited staff are invited by default to participate in survey and the Trust 'Stay & Thrive' meetings. This has included in-month engagement with internationally recruited Podiatrists. Planned revision of 'Stay & Thrive' survey to understand the employment experience and gather richer data from these colleagues.
- A Trust retention plan has been developed to include themed feedback from the Staff Survey, Jungle Green survey, the Nursing & Midwifery self-assessment retention dashboard, and will include engagement with the BSW retention initiatives. Further to executive approval on 20th October the plan will outline countermeasures to be put in place to mitigate rising turnover.
- To support high turnover and national shortage of midwives, the transformational role of 'Nurse in Maternity Services' has commenced in September with 5 recruits. Additionally the Trust is recruiting to sponsor candidates to complete HEE Midwife Masters MSc programme with a view to future employment.
- The Trust held a happiness event on 28th September in the Academy, offering massage and art-therapy taster sessions, and various wellbeing events to positively engage and reward our staff. Further to positive feedback, future happiness event planned for early 2023.
- Trust commitment to the Armed Forces Covenant continues with in-month progress recording cadet instructors and staff who are spouses/partners of military personnel on ESR. A Trust representative party attending formal award ceremony on October 13th to collect the national ERS (employer recognition scheme) Silver Award and demonstrate our ambition to achieve Gold award in 2023.
- The Great West Fest took place on the 3rd September and over 2000 staff and family members attended
- Financial wellbeing plans underway including financial support webinars and drop in.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Disparity Ratio %

The trust has launched an ED&I strategy having identified this as an essential component to a satisfied and productive workforce and a inclusive workplace.

The trust has a focus on addressing health inequalities within the local population and an effective ED&I strategy and successful implementation of this within the trust can model this approach and more effectively leverage internal expertise in this area, as well as making GWH a strong anchor institution.

We want to measure ED&I across all areas and this is currently a work in progress to identify the right metric—workforce by ethnicity ca n be used as a proxy measure for now.

At GWH, some staff are unevenly represented through different levels, broadly with over representation at junior levels and under representation in senior leadership positions. The nature of some roles within the trust ca n be static at certain levels, resulting in under -representation of certain groups.

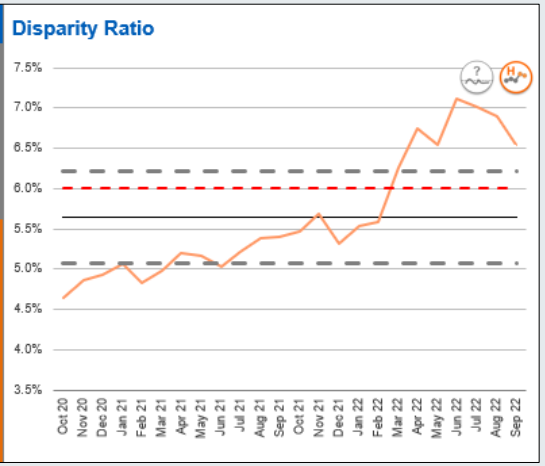
The complexities of addressing ED&I make it a challenge for the trust, however GWH are keen to have a representative workforce across all levels of the trust.

Jude Gray
Director of Human Resources (HR)

Disparity Ratio

To ensure a broad and diverse workforce to best represent the community we serve.

Timescale	Value
Oct 21	5.5%
Nov 21	5.7%
Dec 21	5.3%
Jan 22	5.5%
Feb 22	5.6%
Mar 22	6.3%
Apr 22	6.8%
May 22	6.6%
Jun 22	7.1%
Jul 22	7.0%
Aug 22	6.9%
Sep 22	6.5%



Counter Measures

- The Trust has appointed into the new role of Equality Lead Nurse whose focus will be to work with the Deputy Chief Nurse tackling inequality for BAME nursing staff, driving higher access to development opportunities and career progression within the Trust.

- The Trust is celebrating Black History Month, with the BAME network holding a special event on Black History Day, 26th October inviting keynote speakers, showcasing food and music, and a celebration of the important workforce contribution to the NHS.

- EDI Lead is analysing incidents (IR1s) in line with Dorset Trust best practice, to ensure the process captures the emotional impact of abuse to inform understanding and change.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Financial Position (I&E Margin)
There has been a significant and growing financial deficit over the last 3 years at the Trust. Large financial deficits undermine the public trust in the NHS and put the financial viability of the organisation at risk.

Carbon Footprint / Sustainability
Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and also for indirect emissions by 2045. In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032.

In lieu of our carbon footprint data from Greener NHS (anticipated for early Q3) this report focus is on electricity and gas consumption which forms a significant part of our direct carbon footprint.

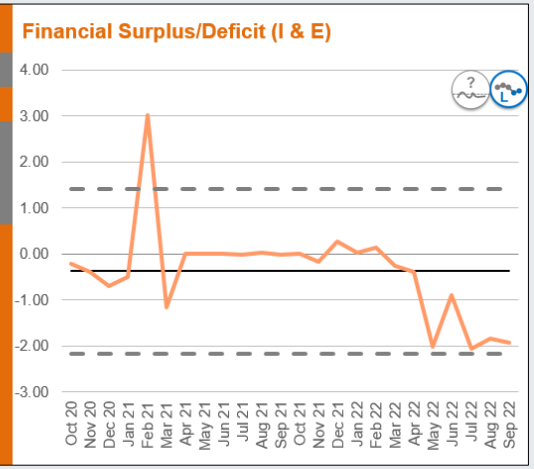
Over the coming years we will be focusing on the delivery of our Green Plan and ICS Green Plan which will be formally reported on annually and refreshed every 3 years.

Simon Wade
Chief Financial Officer

System financial performance - surplus / deficit (I & E)

To achieve and sustain a break even financial position.

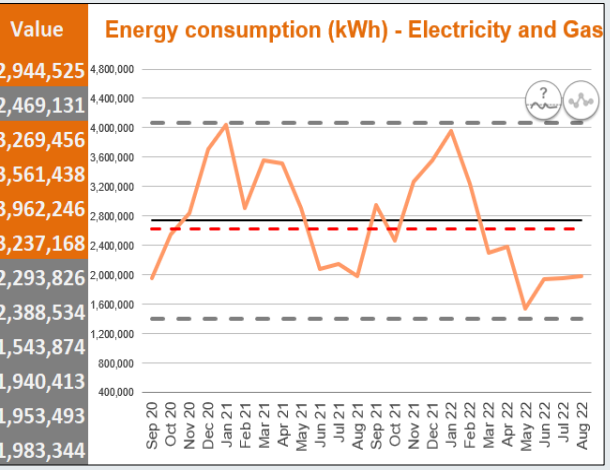
Timescale	Value
Oct 21	0.01
Nov 21	-0.17
Dec 21	0.28
Jan 22	0.03
Feb 22	0.14
Mar 22	-0.26
Apr 22	-0.39
May 22	-2.01
Jun 22	-0.89
Jul 22	-2.07
Aug 22	-1.85
Sep 22	-1.94



Energy consumption (kWh) – Electricity & Gas

To achieve an organisational carbon neutral footprint.

Timescale	Value
Sep 21	2,944,525
Oct 21	2,469,131
Nov 21	3,269,456
Dec 21	3,561,438
Jan 22	3,962,246
Feb 22	3,237,168
Mar 22	2,293,826
Apr 22	2,388,534
May 22	1,543,874
Jun 22	1,940,413
Jul 22	1,953,493
Aug 22	1,983,344



Counter Measures

- At Month 6 the year-to-date position is a surplus of £17m for the ICB which is £11m behind the planned position of £28m. The ICB is forecasting to deliver a surplus of £51.1m to support the planned ICS Provider deficit of £51.1m.
- At Month 6 GWH year-to-date position is a deficit of £11.3m which is £2.2m worse than plan.
- Countermeasures have been put in place
  - Relevant divisions in enhanced support
  - Focus on actions to reduce run rate
  - Enhanced workforce controls
  - Targeted work on efficiencies including driving out benchmarked opportunities
  - Drive on productivity including theatre rescheduling

•The board approved Green Plan has been published with targets and action plan agreed.
•Capital funding for sustainability projects has been agreed and work is underway on reducing emissions from nitrous oxide and entonox at GWH.
•GWH is the ICS Green Plan chapter lead for reducing emissions from Medical Gases.

2022/23 Breakthrough Objectives

Reduction of Pressure Ulcer/Harms

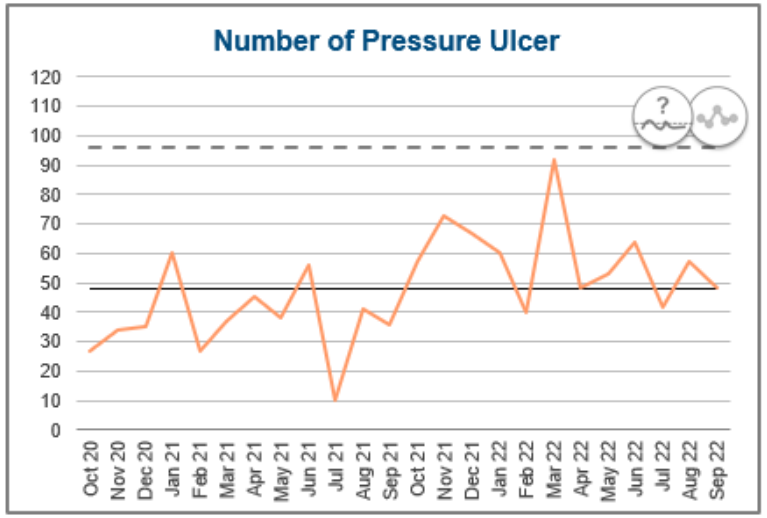
Great Western Hospitals NHS Foundation Trust

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
57	73	67	60	40	92	48	53	64	42	57	48

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	
Value	Number
Improvement Direction	Lower is Better

Common cause – no significant change

Variation indicates inconsistently hitting passing and falling short of the target



Understanding the Data

The number in the chart above represents the number of pressure area harms (pressure ulcers) that patients have developed whilst in hospital or under the care of a community nursing team. The number reflects the total number of harms not total number of patients i.e., one patient may have two or more pressure ulcers.

All pressure ulcer related harms are reported and then clinically validated to determine if they are hospital acquired.

Tissue viability is the overarching term that describes the speciality that primarily considers all aspects of skin and soft tissue wounds.

We are driving this measure because...

We know that pressure damage is an avoidable cause of harm to patients and believe that through using the evidence-based improvement methodology we can make a significant difference to patients.

Regular measurement is required to ensure front line teams and divisions identify themes and those actions required for improvement of pressure related harms. This will help reduce the level of pressure related harm and improve staff knowledge and skills in caring for our patients.

Performance

There were a total number of 174 incidents reported for pressure ulcer related harms during the month of September in the hospital setting.

- 20 of these incidents were hospital acquired and the remaining 202 incidents were a combination of PU harms which were present on admission.
- This is a decrease of 7 harms, following the 27 reported hospital acquired harms the previous month.
- There were a total number of 20 harms on 18 patients.
- There were zero medical device pressure related harms this month.
- Areas reporting high numbers include Orchard Ward (x4), Woodpecker Ward (x3) and Forest ward (x3).
- ED, and Teal ward have all had zero hospital acquired harm and Trauma Unit only one, these are all previous "hotspot" areas. The improvement is attributed to earlier patient assessments, new mattress overlays and additional Education training

In the community a total of 113 pressure ulcer related harm incidents were reported in September following validation 27 were deemed to be Community acquired pressure ulcers.

- This represents a small reduction when compared to last month
- 7 Deep Tissue Injuries have been reported in 3 patients, two of these patients are actively dying and there are no gaps or omissions in care.
- Improving Together work streams have commenced with front line (West locality) and specialist services.

Risks

In the Community 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

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

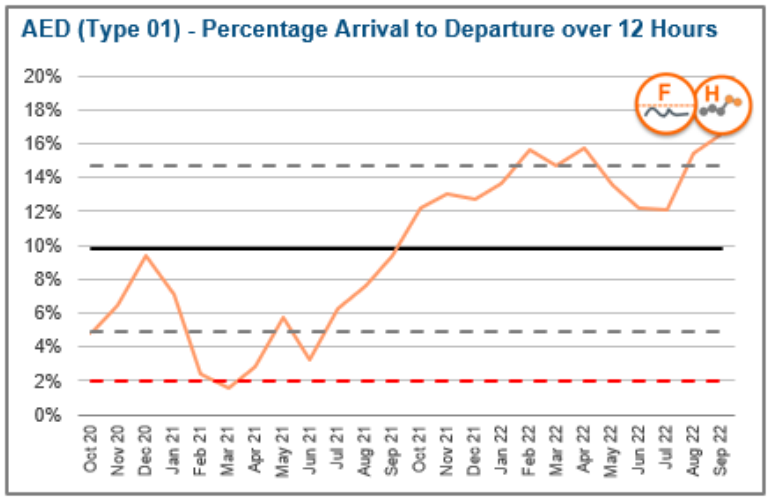
Emergency Department (Type 1) - Percentage Arrival to Departure over 12 Hours

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
12.2%	13.0%	12.7%	13.6%	15.7%	14.7%	15.8%	13.6%	12.2%	12.1%	15.4%	16.6%

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	2%
Value	Percentage
Improvement Direction	Lower is Better

H — Special cause of concerning nature or higher pressure due to (H)igher values

F — Variation indicates consistently (F)alling short of the target



Understanding the Data

Total number of patients who have a total time in ED (Type 1) over 12 hours from arrival to admission, transfer or discharge.

The clock starts from the time that the patient arrives in ED and it stops when the patient leaves the department on admission, transfer from the hospital or discharge is completed

We are driving this measure because...

To reduce the number of patients who have waited over 12 hours in A&E. The target is to achieve is to not have more than 2% of all patients who attended ED waiting over 12 hours.

Performance

%>12 hour waits in ED – increase through September associated with increase in mean ED time.

93 x 12-hour reportable Decisions to Admit (DTA) breaches – increase of 39 (Old criteria)

Clinically ready to proceed in place, uptake and completion challenging. Review on opt out process underway following specialty referral. This is a change from our current recording and referral processes and will make a difference as we know we are an outlier Oct/Nov 22

An increase in the LOS >21 days and bed availability at the right time have contributed to stays beyond 12 hours however % beds occupied by long stayers is now starting to drop across the Trust

Risks

Increases in COVID positive patients and processes for co-horting may impact on flow out of ED and contribute to increases in 12 hour waits.

LOS and % of longest stayers will impact on bed availability and flow out of ED resulting in increased time in ED and likelihood of 12 hour waits.

Increased surges of ED attendances, particularly out of hours, alongside bed availability could contribute to increases in 12 hours waits in ED.

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

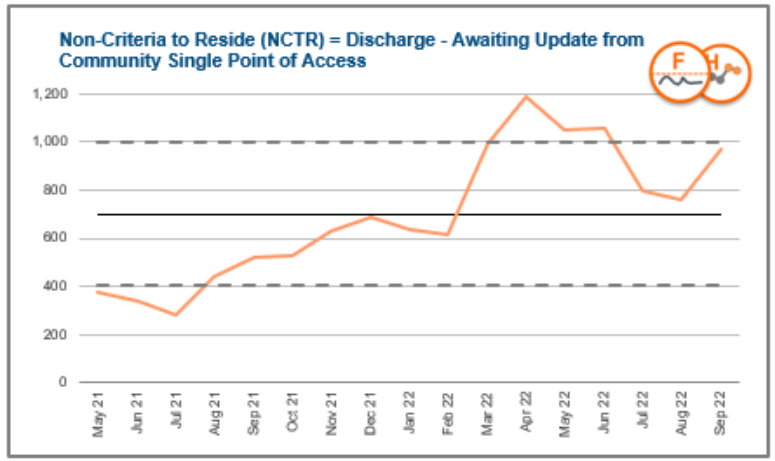
Non-Criteria to Reside (NCTR) - Partner Supported Discharge

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
531	633	690	636	618	993	1185	1053	1060	795	760	968

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	
Value	Number
Improvement Direction	Lower is Better

Variation indicates consistently falling short of the target

Special cause of concerning nature or higher pressure due to higher values



Understanding the Data

This Breakthrough objective will primarily capture PW1,PW2,PW3 patients as by definition PW0 are simple ward led discharges. A small number of patients on PW0 may require social care support outside of healthcare needs and this group will be inclusive within this modelling.

This is linked closely to the BSW improvement work of reducing NC2R patients by 30% from a Dec 2022 baseline.

The data surrounding updates from Single Point of Access is directly related to lost bed days and therefore the time patients wait to leave the Acute Trust.

We are driving this measure because...

In a 12-month period more than 10,000 bed days were lost within the discharge criteria 'Awaiting update from Community Single Point of Access'.

Internally the aim is to refer patients that require social care support for discharge as soon as this has been identified as a discharge care need. Different referral approaches from localities can be a barrier to being proactive with discharge planning from admission.

One of the aims of this breakthrough objective to use the data to demonstrate the value of being able to refer patients to partners before they a medically safe to leave hospital, building on a collaborative uniform ICA approach.

Further delays to patients' discharges can be increased waiting for social care assessment, outcomes and inventions required to proceed with that discharge. Patients with complex care needs can experience significant lengths of stay which increases further risk of harm to the patient. Improvements through internal professional standards set by time metrics, and implementation of assessments in the community using the D2A model will support reduction in the total bed days lost.

Performance

- The is a slight incline this month against awaiting update from community SPOA

- Analysis into wards attending SAFER against discharges has supported conversation of the importance of SAFER board rounds in the coordination centre. Staffing has been in the red/black high- risk domain over the past month and this may have contributed to the increase.

- **Counter Measure**

Identified delays in referrals to SPOA from front door and ambulatory areas. SAFER board rounds now commenced in the coordination centre with Step Down, Shalbourne and SAU etc.

Medical outlier team now start morning huddles in the coordination centre this will supports timelier referrals to SPOA with discussion in the room against potential date of medical fit.

Further analysis into the top 3 wards identified as the highest contributor against this discharge measure, snap- shot data over a month being collected as currently unable to pull timelines from BI reports.

Risks

The ongoing risk unchanged -maintaining good internal professional standards from time patient is fit to referral through constant surveillance. This is required throughout the day and not just from board round decisions.

There is an unknown risk against social worker demand and capacity caseloads when there is a current average of 50 patients on amber hold/watch list. This means a number of patients are referred to social care who wait in excess of 3 bed days to be assessed by the social work team.

There is a risk to batching of referrals on the day patients become fit increasing the potential for further bed days lost waiting for social worker allocation. This is in part to the Trusts approach to 5 day working.

Unable to deliver a 7 day service that is truly supported by localities working on patient case loads over weekends

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Staff Survey - I am able to make improvements happen in my area of work

2017	2018	2019	2020	2021	2022 Q1	2022 Q2
54.20%	55.60%	58.00%	64.50%	55.06%	50.31%	51.10%

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	
Value	Percentage
Improvement Direction	Higher is Better

Understanding the Data

The Staff Survey results are predominantly aimed at service improvement. It is important to know if staff could provide the care and service they aspired to give.

We are driving this measure because...

This staff survey feedback is extremely important. The result of this survey could help how staff feel about making improvements happen in their workplace.

Performance

•The Trust held "Improvement Week" W/C 27th September to promote the improving together methodology across the Trust. This included the launch of "Workspace" on the second floor allowing staff to collaboratively explore the methodology and access the Strategy Deployment Room. The T&I team visited sites providing face to face bitesize training sessions and introducing the wider workforce to the concepts of improving together.

•The Staff Survey Working Group is reviewing how best to use this platform to drive improvement on the Staff Survey pillar metric and breakthrough objective of staff being able to make improvements happen in their area of work.

•QR code surveys are conducted monthly within the divisions to seek regular feedback on staff engagement with making improvements happen. USC have had 1 response with a 100% positive score, SWC have received 17 responses with a 76% positive score, and ICC have had 29 responses with a 44% positive score.

Risks

•Limited time until next staff survey to impact on 2022 positivity rate, work over the next 12 months will aim to improve 2023 staff survey positivity response %.

•Improvement activity is happening within wider teams although may not be recorded currently as part of the go and see framework. The extension of improving together to further frontline teams will mitigate inconsistent practice.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
	No. of >=52 weeks waiters		1028	1215	1568	1926
	No. of >=70 weeks waiters		107	102	112	181
DM01	No. of patients on DM01 waitlist		12819	12398	12388	One month behind
	DM01 performance %	92%	48.2%	46.9%	43.9%	One month behind
	DM01 6 week wait breaches		6640	6588	6951	One month behind
Cancer	% Cancer 62 day performance	85%	76.0%	66.9%	65.1%	One month behind
	% Cancer 31 day performance	96%	93.4%	93.5%	85.6%	One month behind
	% Cancer 2 week wait	93%	89.1%	76.4%	68.0%	One month behind
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95%	76.6%	74.5%	75.0%	73.9%
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95%	58.7%	54.6%	54.9%	51.5%
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2.0%	12.2%	12.1%	15.4%	16.6%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	42.0%	41.1%	42.9%	42.0%	41.0%
	A&E Arrival to Departure Percentage over 12 Hours (All Patients)	2.0%	6.4%	6.5%	8.2%	8.4%
	A&E Arrival to Departure over 12 Hours (Admitted Patients)	2.0%	6.4%	6.5%	8.2%	8.4%
Flow	Elective Patients Average Length of Stay (Days)	3.0	3.5	3.2	3.52	3.4

Performance & Counter Measure

Overall, DM01 performance deteriorated in August to 43.9% but with an improvement in performance seen in Radiology services. The number of patients on the waiting list saw a small decrease and the overall waiting time has reduced in Radiology. The 2 Pads in Radiology continue to be fully utilised and activity numbers continue to exceed any previous levels. We continue to deliver scans within 2 weeks for cancer referrals and anticipate a recovering picture for the routine patients, which at present is in line with trajectory. Progress in activity in Ultra-sound and DEXA has also decreased the waits.

ED performance is similar to August with a small deterioration across all watch metrics apart from triage time which has improved slightly. Counter measures in place within the Breakthrough objective slides 7 and 8

Cancer waiting times remain below standard with an increasing number of referrals.

Counter Measure - The weekly Elective Access Meetings will support improvement work through monitoring of counter measures, identifying support and mutual aid options and review of individual patients within pathways to move on in pathway if required.

Risks

A clear deficit in capacity within Plastics that will impact the cancer pathway is unable to be mitigated further without significant staffing and / or investment. This is subject to a strategic service review.

Pressure to maintain flow and bed availability as we proceed into the winter months ahead, thereby with a potential to impact elective activity. This is mitigated by our Winter plan and work with system partners.

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Cancer	% 28 day faster diagnosis	75%	79.8%	75.5%	73.7%	One month behind
	No. of referrals received	1773	1735	1743	1842	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95%	96.6%	96.7%	97.7%	96.8%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2.0%	0.0%	0.1%	0.0%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	5397	5600	5597	5225	5164
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	49.0%	52.9%	54.3%	42.8%	44.4%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	42.0%	29.9%	33.3%	57.8%	48.5%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240	191	195	183	197
	Total Number of Ambulance Handovers	1895	1937	1995	1879	1769
	Total Hours Ambulance Handover Waits (over 15mins)	1344:00	1013:07	929:55	1579:59	1829:45
	Number of Ambulance Handover Over 15 Minute Waits	1116	1019	1096	1202	1147
	Percentage of Ambulance Handover Over 15 Minute Waits	59.1%	52.6%	54.9%	64.0%	64.8%

Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

An unscheduled improvement plan and BSW system group is supporting actions to reduce Handover Delays across the system

28 day previously delivered & will be reviewed as a non-alerting watch metric.

Risks

Increased pressure on our longest waiting patients, as the waiting list size is disproportionate to the capacity to support recovery.

Activity plans are below target, whilst this is being addressed, failure to deliver will result in increased pressure on our delivery of no patient waiting over 75 weeks by March 2023.

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
ED	Number of Ambulance Handover 30 Minute Waits	692	522	619	807	819
	Percentage of Ambulance Handover s Over 30 Minutes	36.8%	26.9%	31.0%	42.9%	46.3%
	Number of Ambulance Handover Over 60 Minutes Waits	439	290	345	563	558
	Percentage of Ambulance Handovers Over 60 Minutes	23.4%	15.0%	17.3%	30.0%	31.5%
Flow	Elective Patients Average Length of Stay (Days)	3.4	3.5	3.2	3.5	3.4
	Community Average Length of Stay (Days)	18.9	17.6	19.1	18.9	19.9
	Non - Admitted - Average Length of Stay in Department (mins)	295	278	291	298	312
	Non-Elective Patients Average Length of Stay (Days)	5.5	5.6	5.4	5.7	5.4
	Number of Stranded Patients (over 14 days)	129	127	117	134	138
	Number of Super Stranded Patients (over 21 days)	75	74	64	79	82
	GWH Acute Adult Bed Occupancy (%)	96.2%	95.8%	95.3%	97.9%	95.9%
	GWH Discharges by Noon (%)	15.9%	16.9%	15.5%	16.1%	15.2%

Performance & Counter Measure

There are several workstreams as part of the Improvement plan for the Emergency Department that support the non- alerting watch metrics.
These include

- Outlier model ward configuration
- Acute floor review (are we using our space in the optimum way) Oct 22
- Weekend working Nov 22
- Processing speed of empty beds
- Board round processes
- Surgical pathways – Phase 1 General Surgery & SAU pathways
- The ICA co-ordination Centre
- Home First
- ED 'pit stop' for patients – rapid review and transfer
- Acceleration of the Virtual ward model
- Acceleration of the Urgent Care response
- Review of CTR and NCTR pts over 21 days daily internally and with partners

This all forms part of the improvement plan for ED and the winter plan, where we have focused our resources on key areas.

Risks

NCTR numbers and Covid peak for a sustained period of time and do not enable bed availability and therefore flow.

Our Performance

Great Western Hospitals NHS Foundation Trust

Key Indicators

Measure Name	Mean/Thres.	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Total patients waiting more than 52 weeks	928	664	593	639	626	612	664	744	852	1028	1,215	1,568	1,926
Total patients waiting more than 78weeks	57	131	70	56	65	52	47	49	50	52	34	35	44
Total patients waiting more than 104 weeks	0.2	1	0	0	0	0	0	0	0	1	0	0	0
Total elective activity undertaken compared with 2019/20 baseline	100.0%	77.6%	88.2%	91.6%	87.1%	98.6%	127.0%	90.5%	95.5%	97.1%	86.1%	88.7%	72.8%
Total diagnostic activity undertaken compared with 2019/20 baseline	100.0%	78.9%	93.2%	95.3%	79.5%	89.0%	83.3%	88.7%	94.6%	92.4%	87.9%	90.5%	Reported one month behind
Total Cancer patients waiting over 62 days	199	109	156	170	169	170	154	181	216	247	310	310	One month behind
Proportion of patients meeting the faster cancer diagnosis standard	75%	80.7%	75.3%	77.3%	68.0%	79.3%	80.8%	81.6%	78.9%	79.4%	75.5%	73.3%	One month behind
Total patients treated for cancer compared with the same point in 2019/20 (first and	100.0%	89.8%	138.3%	156.0%	126.0%	114.2%	100.5%	71.7%	150.5%	85.5%	58.6%	107.1%	Reported one month behind
Outpatient follow-up activity levels compared with 2019/20 baseline	100.0%	76.4%	92.2%	92.8%	81.8%	84.3%	108.5%	85.6%	89.5%	85.9%	69.8%	80.6%	64.8%
Proportion of ambulance arrivals delayed over 30 minutes	35.7%	27.9%	25.0%	26.7%	29.6%	44.9%	39.5%	48.4%	38.9%	26.9%	31.0%	42.9%	46.3%
Proportion of patients spending more than 12 hours in an emergency department	2.0%	7.0%	7.2%	7.3%	7.5%	8.6%	8.0%	8.4%	7.4%	6.4%	6.5%	8.2%	8.4%
Ambulance average response times - Category 1	00:10:19	00:11:11	00:09:55	00:11:13	00:09:32	00:11:12	00:11:14	00:10:14	00:09:21	00:09:52	00:10:02	00:10:13	00:09:54
Proportion of patients discharged from hospital to their usual place of residence	94.1%	94.5%	94.3%	93.7%	94.5%	94.4%	94.3%	93.8%	94.1%	93.8%	94.2%	93.9%	94.3%
GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	23.3%	14.7%	19.5%	20.6%	23.5%	23.5%	26.6%	26.4%	24.8%	25.4%	24.5%	24.0%	26.1%
Average hours lost to ambulance handover delays per day	41.1	22.5	17.5	25.7	30.1	62.0	44.1	66.7	48.3	33.8	30.0	51.0	61.0
Adult general and acute bed occupancy	95.6%	95.8%	96.1%	94.8%	94.1%	94.7%	95.4%	95.7%	96.5%	95.8%	95.3%	97.9%	95.9%

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Concerns and Complaints	Trust overall complaint response rate	80%	64%	64%	58%	61%

Performance & Counter Measure

Complaints, concerns and PALs activity increasing., this is not related to a specific theme.
Divisions being supported by PALs team to help improve timeframes and agree robust process for extension of complaints.
New training being rolled out during November to support early resolution for the ward manager, matron and Head of Service level.

Risks

Divisions are reporting high workload causing challenges in responding within agreed timeframes. Response rate within agreed timeframe is declining. Weekly meeting s in place to monitor and provide support in place.

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Harm	Number of Falls in month	115	125	92	128	113
	Falls rate per 1000 bed days	5.9	6.6	4.7	6.4	5.8
	No. falls with moderate harm or above	2	3	1	2	2
	Medication incidents	9	5	17	6	7
	No. of serious incidents reported in month	4	5	1	4	4
Concerns and Complaints	No. of concerns received	145	99	118	159	205
	No. of complaints received	53	52	48	63	50
	Number of reopened complaints	3	0	2	5	6
IP&C	Clostridium difficile (C. diff) infections in month	4	2	2	3	7
	Escherichia coli (E. coli) infections in month	9	8	9	11	6
	Pseudomonas infections in month	1	1	1	1	1
	Klebsiella infections in month	2	2	2	1	4
	Methicillin-resistant Staphylococcus Aureus (MRSA) infections in month	0	0	0	0	0
	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections in month	3	5	1	3	3
	Covid – no. of hospital acquired	38	18	72	9	53
	Covid – no. detected in patients	177	159	304	99	145

Performance & Counter Measure

There has been a small reduction in the number of falls this month , resulting in 5.81 per 1000 bed days, this remains within normal variance. During September 2022 one inpatient fall resulted in a fractured Neck of Femur and one fall resulted in a subdural haemorrhage.

- The new Clinical Practice Educator for Falls and Enhanced Care has been successfully recruited and planned to start in November 22.
- National Falls Awareness week took place between 19th – 23rd September 2022. The national focus this year was on “Moving Matters”. Keeping active as we get older reduces the risk of falls by improving functional ability, better balance and muscle strength, and can reduce the severity and progression of frailty. In the Trust a number of activities took place to celebrate the week:-

There are no themes identified from newly reported Serious Incidents.

Concerns have increased in month, no specific themes identified to cause the increase Main themes relate to discharge arrangements, communication and waiting times. Focused work is being undertaken to understand if there are any themes relating to the reopened complaints.

The Trust remains below its trajectories for *C.diff*, MRSA and *Pseudomonas* infections and roughly in line for *Klebsiella*. *E.coli* and MSSA numbers are concerning and work to reduce these, particularly focusing on care of intravenous devices and urinary catheters, is ongoing. This includes the introduction of a new product for skin preparation prior to cannulation, plus increased training for clinical teams which is being supported and delivered by the manufacturers of cannula, catheter and skin preparation products.

Risks

Many of the IPC team are new to the speciality and do not yet have the specialist knowledge required for their roles. Each member of the team has met with their manager to identify individual training needs. Funding for training has been secured from NHS England. Courses have been identified and booked.

Our Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Safer Staffing	Safer Staffing – average fill rate RN (%)	95.0%	95.1%	96.3%	98.2%	99.0%
	Safer Staffing – average fill rate HCA (%)	95.0%	104.4%	103.6%	102.6%	103.1%
FFT	Overall response rate (%)	26%	27%	23%	27%	27%
	Positive response (%)	84%	84%	82%	87%	83%
	ED & UTC Response Rate	18%	15%	17%	20%	20%
	ED & UTC Positive Responses	74%	73%	71%	77%	74%
	Inpatients Response Rate	22%	24%	21%	22%	20%
	Inpatients Positive Responses	80%	83%	78%	81%	77%
	Daycases Response Rate	21%	20%	20%	23%	22%
	Daycases Positive Responses	93%	92%	93%	95%	92%
	Outpatients Positive Responses	97%	96%	95%	98%	99%
	Maternity Response Rate	18%	17%	21%	18%	17%
	Maternity Positive Responses	90%	90%	88%	90%	91%

Performance & Counter Measure

For September, 83% of the Friends and Family Test (FFT) responses were positive, a slight reduction from the 87% for August. This is based on the % of responses rated as 'very good' and 'good'.
The negative responses at 11% are slightly higher than the 8% for August but remain in the trend of low teens of this year, Based on responses rated as 'poor' and 'very poor'.

A&E (ED & UTC combined) positive response rate at 74%, slightly lower than August, within the range of low 70%'s of recent months.

Inpatients show a 77% positive score, a decrease on previous months. Outpatients show an increase to 99% from the range of 93% from the 95% of late.
Practice educators supporting improvements in personal care at ward level
New training to focus on First Impressions for administration and reception staff to commence November

For the combined areas of maternity services, the positive response rate of 90.8% reflects small increases across all aspects of maternity.

Top positive and negative themes are consistent as staff attitude and environment, with waiting times being a further negative theme.

Maternity are focusing on encouraging patients to complete the FFT cards as responses had reduced following the introduction of SMS texting.

ED are exploring ways to encourage and develop greater compassion in the department. In response to patient feedback the environment in Majors has been rearranged to ensure improved visibility for patients

Risks

The FFT contract is due for renewal November 2022, procurement is underway in conjunction with Salisbury Foundation Trust and Royal United Bath Hospitals for SMS text services.

Our Care

Great Western Hospitals NHS Foundation Trust

Key Indicators

Measure Name	Mean/Thres.	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
National Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	1	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	0	0	Waiting for data
Clostridium difficile infection rate	23.5	43.2	25.5	43.2	18.5	13.7	18.5	36.3	11.7	12.9	11.7	Waiting for data	Waiting for data
E. coli bloodstream infection rate	36.7	30.8	19.1	18.5	49.3	34.1	18.5	54.4	29.3	60.5	52.7	Waiting for data	Waiting for data
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Summary Hospital-level Mortality Indicator	0.89	0.90	0.89	0.89	0.89	0.88	0.88	0.87	0.86	0.88	0.90	0.93	0.95

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Use of Resources	Capital Expenditure (£'000)	248	410	131	225	225
	Pay (£'000)	23286	23054	21512	21995	26581
	Non Pay (£'000)	14358	13903	14153	15101	14274

Performance & Counter Measure

Risks

.

Use of Resources

Great Western Hospitals NHS Foundation Trust

Key Indicators

Measure Name	Mean/Thres.	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Financial efficiency - variance from efficiency plan (£'000)	+/-	-4	121	-54	-51	6	46	-34	-424	-209	-289	-268	-247
Financial stability - variance from break-even (£'000)	+/-	5	-173	279	28	141	-386	-2506	-2006	-888	-2068	-1848	-1938
Financial stability - variance from PLAN (£'000)	+/-	5	331	783	533	645	3552	-387	-335	-517	-326	-268	-408

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Workforce	Trust sickness absence rate	3.5%	5.1%	5.9%	4.6%	One month behind

Performance & Counter Measure

Sickness absence decreased to 4.64% in month, of which 2.40% is short term and 2.24% is long term. Of total sickness absence, 0.71% is Covid-19 related.

Risks

.

Our People

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Mean/ Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Workforce	% of leavers within 1st year of employment	31.2%	29.1%	32.9%	13.8%	One month behind

Plan Area	Metric	2017	2018	2019	2020	2021	2022 Q1	2022 Q2
Staff Survey	Staff Survey response rates	46.5%	43.6%	40.0%	53.4%	39.5%	21.4%	23.6%
	My immediate manager takes a positive interest in my health and well-being	68.8%	67.5%	74.8%	69.2%	64.4%	Not in Quarterly Survey	Not in Quarterly Survey

Performance & Counter Measure

The % of leavers within 1st year of employment has decreased month on month. The key themes of reason for leaving are 'Health' and 'Work/Life Balance'.

Quarterly staff survey response rates have increased in Q2, additional data will be available following the next staff survey in Q3

Risks

Our People

Great Western Hospitals NHS Foundation Trust

Key Indicators

Measure Name	Mean/Thres.	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Proportion of staff in senior leadership roles who are from BME background	4.9%	4.8%	4.8%	5.1%	5.1%	5.1%	4.7%	4.7%	4.5%	4.5%	4.7%	5.9%	Reported one month behind
Proportion of staff in senior leadership roles who are women	69.9%	70.2%	69.6%	70.8%	71.2%	71.3%	70.9%	70.3%	69.1%	68.9%	69.1%	67.0%	Reported one month behind

Measure Name	Mean	2017	2018	2019	2020	2021	2022
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	Reported annually
Staff survey engagement theme score	6.9	6.9	6.9	7	7	6.7	Reported annually
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	0.6	59.6%	54.1%	60.4%	57.1%	56.1%	Reported annually

Our People

Workforce Scorecard

Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
	Vacancy														
W	Vacancy Rate %	%	7.63%	6.52%	6.06%	6.55%	6.91%	6.77%	6.33%	8.03%	7.31%	6.94%	7.48%	6.70%	6.31%
W	Trust Vacancy WTE	WTE	-	330.01	306.31	332.42	350.82	343.65	321.55	415.32	377.16	358.52	386.57	347.09	328.65
W	Nursing Vacancy %	%	7.63%	5.13%	4.50%	5.20%	5.60%	5.31%	4.59%	7.40%	6.44%	5.27%	5.62%	4.88%	5.58%
W	Nursing Vacancy WTE	WTE	-	123.31	108.03	125.70	135.51	128.45	110.90	184.68	160.51	131.68	140.23	122.71	141.28
W	Medical Vacancy %	%	7.63%	7.44%	7.14%	6.93%	7.01%	8.08%	6.89%	9.00%	8.68%	8.94%	9.57%	6.53%	3.64%
W	Medical Vacancy WTE	WTE	-	50.68	48.60	47.44	47.99	55.32	47.14	63.55	60.96	62.75	67.19	45.84	25.59
W	STT/AHP Vacancy	%	7.63%	6.68%	6.68%	7.41%	7.92%	7.45%	7.36%	7.84%	7.11%	7.44%	8.94%	8.25%	7.57%
W	STT/AHP Vacancy	WTE	-	55.43	55.42	61.53	65.57	61.71	60.99	64.89	58.82	61.57	74.04	68.37	62.72
W	SMA Vacancy	%	7.63%	8.80%	8.24%	8.54%	8.88%	8.57%	8.95%	8.97%	8.50%	8.98%	9.21%	9.66%	8.68%
W	SMA Vacancy	WTE	-	100.59	94.26	97.75	101.75	98.17	102.52	102.20	96.87	102.52	105.11	110.17	99.06
W	Recruitment Time to Hire	Days	46.00	47.10	43.00	45.40	50.60	52.20	56.90	61.20	67.70	67.90	62.00	61.10	74.70
	Workforce Utilisation														
W	Budgeted vs Worked WTE Variance	WTE	-	118.95	149.10	129.81	149.44	129.31	240.44	57.48	89.92	91.14	138.16	180.75	121.30
W	Actual Worked vs Budgeted %	%	-	2.35%	2.95%	2.56%	2.94%	2.55%	4.74%	1.11%	1.74%	1.76%	2.67%	3.49%	2.33%
W	Total Workforce Cost £	£	-	£21.33M	£21.52M	£21.81M	£22.06M	£22.00M	£19.99M	£23.34M	£22.93M	£23.22M	£21.61M	£22.70M	£26.58M
W	Agency Spend as % of Total Spend	%	6.00%	6.38%	6.62%	6.86%	7.13%	7.74%	7.60%	6.82%	6.57%	6.36%	4.18%	6.22%	5.65%
W	Agency Spend £	£	-	£1.36M	£1.42M	£1.48M	£1.58M	£1.71M	£1.77M	£1.51M	£1.44M	£1.42M	£0.91M	£1.37M	£1.55M
W	Agency WTE	WTE	-	110.22	115.23	124.53	124.18	120.02	139.35	113.88	124.59	117.85	121.32	123.85	137.51
W	Bank WTE	WTE	-	308.47	307.07	305.88	350.76	320.03	386.55	315.69	311.77	304.96	377.97	375.45	285.71
W	Registered Nursing Bank Fill	%	55.00%	47.43%	47.16%	46.74%	46.48%	48.71%	47.78%	45.28%	44.86%	47.09%	44.52%	37.70%	46.57%
W	Unregistered Nursing Bank Fill	%	70.00%	61.58%	68.01%	62.64%	62.61%	62.23%	62.47%	63.53%	69.76%	75.59%	72.53%	69.81%	72.94%
	Retention														
W	All Turnover %	%	13.00%	13.97%	14.32%	14.51%	14.96%	15.26%	15.59%	14.89%	14.82%	15.46%	15.90%	15.00%	-
W	Voluntary Turnover %	%	11.00%	10.16%	10.58%	10.77%	11.24%	11.40%	11.66%	11.89%	11.88%	12.38%	12.64%	12.07%	-
W	Number of RN Leavers	Headcount	-	16.00	21.00	17.00	17.00	22.00	25.00	21.00	18.00	17.00	16.00	12.00	-
W	Registered Nursing Vol Turnover	%	-	8.06%	8.62%	8.84%	9.12%	9.56%	9.86%	10.31%	10.43%	10.41%	10.43%	10.06%	-
W	Number of Unreg Nursing Leavers	Headcount	-	11.00	12.00	12.00	6.00	11.00	14.00	10.00	12.00	22.00	13.00	15.00	-
W	Unregistered Nursing Vol Turnover	%	-	14.22%	14.73%	14.64%	14.29%	14.10%	14.19%	14.24%	14.12%	15.28%	15.58%	14.80%	-
W	Leavers within 1st Year of Employment	%	-	21.13%	21.43%	23.44%	26.67%	30.95%	29.87%	24.29%	33.33%	29.27%	32.93%	13.76%	-
W	Number of Trust starters	Headcount	-	50	79	27	97	61	85	92	88	70	56	99	-

Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
D	Sickness Absence %	%	3.50%	5.36%	5.36%	5.78%	6.50%	6.07%	6.60%	6.05%	4.66%	5.10%	5.94%	4.64%	-
W	Long Term Sickness %	%	2.00%	2.52%	2.46%	2.87%	3.97%	3.36%	3.85%	3.46%	2.09%	2.44%	3.34%	2.40%	-
W	Short Term Sickness %	%	1.50%	2.84%	2.91%	2.91%	2.53%	2.72%	2.75%	2.59%	2.58%	2.66%	2.61%	2.24%	-
W	Sickness Absence Cost £	£	-	£749k	£706k	£794k	£879k	£753k	£936k	£807k	£642k	£678k	£843k	£649k	-
W	WTE Days Lost	WTE	-	7,867.9	7,458.7	8,325.3	9,385.5	8,030.5	9,661.7	8,559.9	6,926.0	7,280.7	8,728.5	6,887.2	-
	Learning & Development														
W	Mandatory Training Compliance %	%	85.00%	87.18%	88.13%	88.85%	88.33%	87.60%	87.38%	87.36%	87.75%	87.87%	87.74%	87.74%	86.70%
W	Role Essential MT %	%	85.00%	88.95%	89.50%	90.16%	90.00%	86.06%	89.17%	89.05%	89.33%	89.62%	89.64%	89.64%	88.56%
W	CQC Safe MT %	%	85.00%	85.47%	86.80%	87.59%	86.72%	89.20%	85.64%	85.73%	86.22%	86.17%	85.91%	85.91%	84.90%
W	Appraisal Compliance %	%	85.00%	71.79%	73.78%	74.17%	73.27%	68.61%	68.85%	70.05%	73.03%	74.55%	75.56%	75.75%	75.04%
W	Non Medical Appraisal Compliance %	%	85.00%	72.24%	75.08%	77.42%	74.84%	70.16%	69.66%	71.44%	74.99%	77.85%	77.91%	78.12%	78.03%
W	Medical Appraisal Compliance %	%	85.00%	68.52%	64.55%	51.18%	62.18%	57.66%	63.13%	60.29%	58.82%	50.37%	58.38%	58.41%	53.44%
	Demographics														
W	Staff in Leadership Roles %	%	-	3.23%	3.24%	3.26%	3.39%	3.39%	3.37%	3.37%	3.43%	3.34%	3.32%	3.17%	3.08%
W	Staff in Leadership Roles WTE	WTE	-	188.00	189.00	190.00	197.00	197.00	197.00	197.00	202.00	197.00	195.00	188.00	184.00
W	% of Leadership Roles who are Female	%	-	67.02%	66.67%	67.37%	68.02%	67.51%	67.51%	66.50%	65.84%	65.48%	65.64%	67.02%	66.30%
W	% of Leadership Roles who from BME	%	-	5.85%	4.76%	5.26%	5.08%	5.08%	5.08%	5.58%	5.45%	5.58%	5.64%	5.85%	5.98%
W	Male % of Workforce	%	-	19.19%	19.13%	19.17%	19.20%	19.23%	19.24%	19.31%	19.37%	19.47%	19.44%	19.23%	19.42%
W	Female % of Workforce	%	-	80.81%	80.87%	80.83%	80.80%	80.77%	80.76%	80.69%	80.63%	80.53%	80.56%	80.77%	80.58%
W	BME % of Workforce	%	-	19.43%	19.37%	19.36%	19.49%	19.75%	20.03%	20.38%	20.63%	20.87%	20.97%	21.18%	21.41%
W	White % of Workforce	%	-	71.37%	71.37%	71.01%	70.62%	70.72%	70.52%	70.17%	69.80%	69.65%	69.70%	69.51%	69.26%

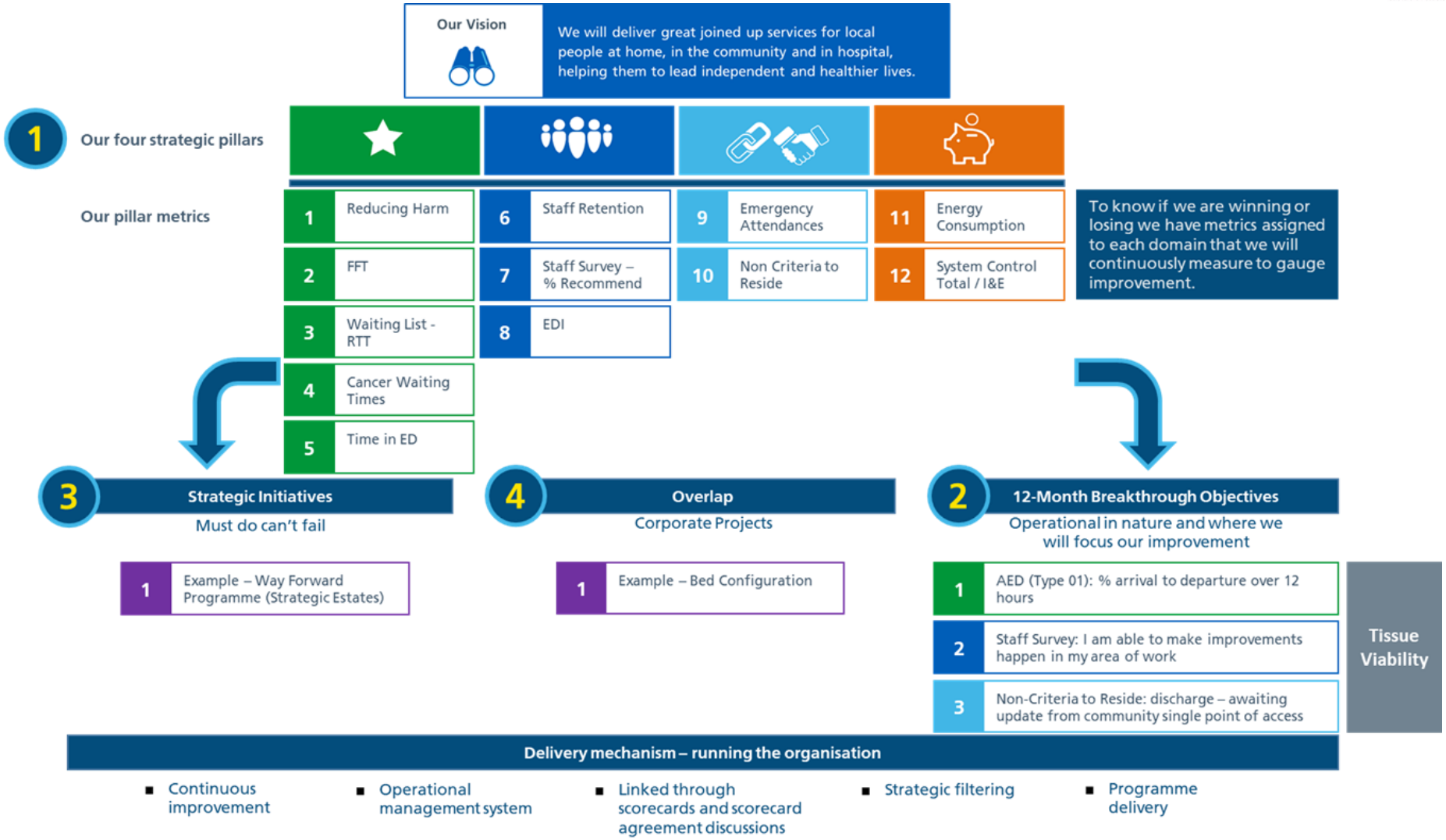
Appendices

Explaining the IPR

Improving
together

Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust



Explaining the IPR

Great Western Hospitals NHS Foundation Trust

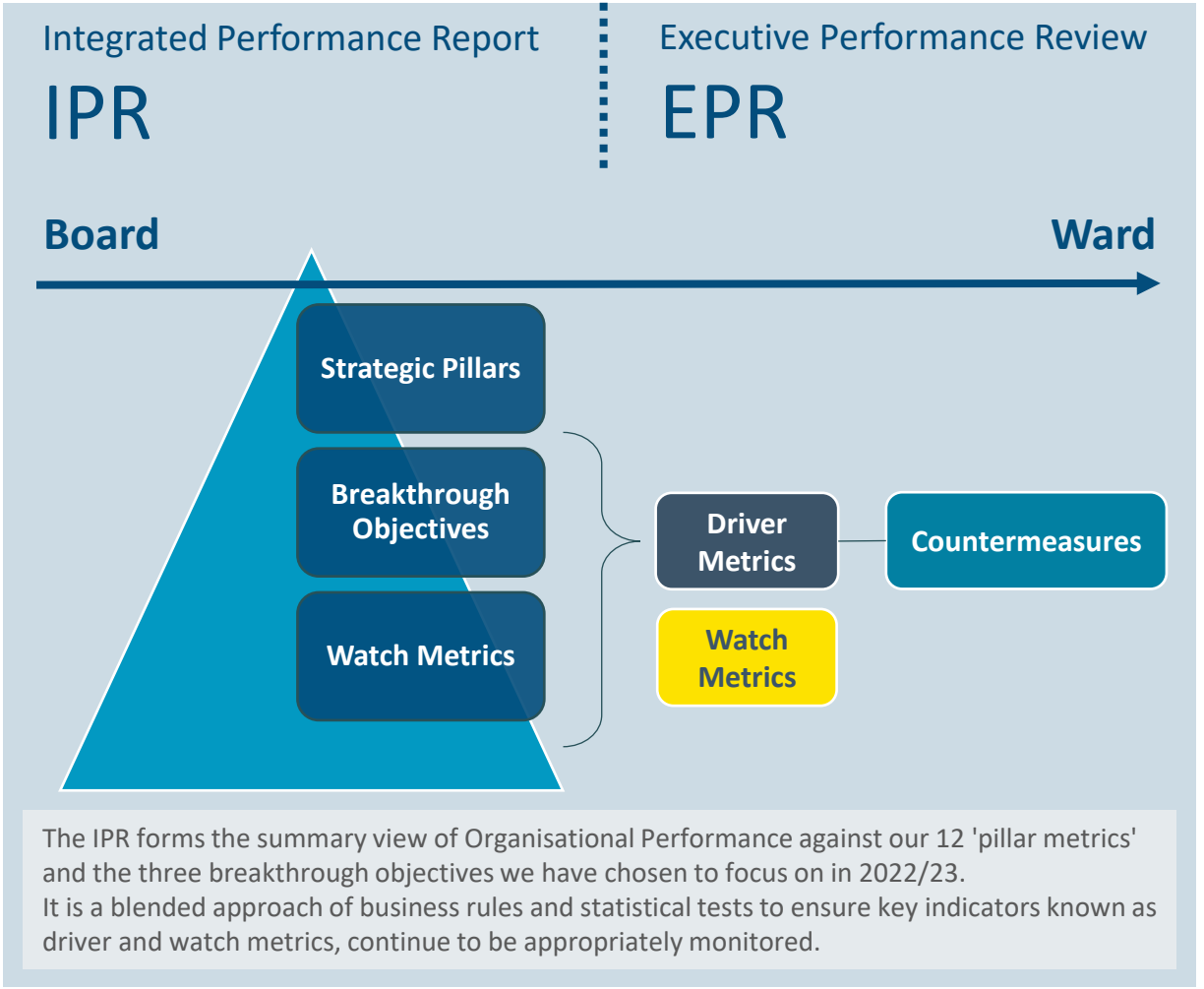
To turn our strategic themes into real improvements, we're focusing on three key objectives that contribute to these themes for the next year.

- Tissue viability – reducing pressure ulcers
- A&E arrival to departure over 12 hours
- Staff survey – I am able to make improvements happen in my area of work
- Non-criteria to reside – reducing patients waiting in hospital

We have chosen these four objectives using data to see where we can make the most significant improvements by focusing our efforts. We'll also use data to measure how much we're making a difference.

Frontline teams will lead improvements in these areas of focus. They will be supported by our Transformation and Improvement Hub, which will help give teams the training and tools they need, and our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

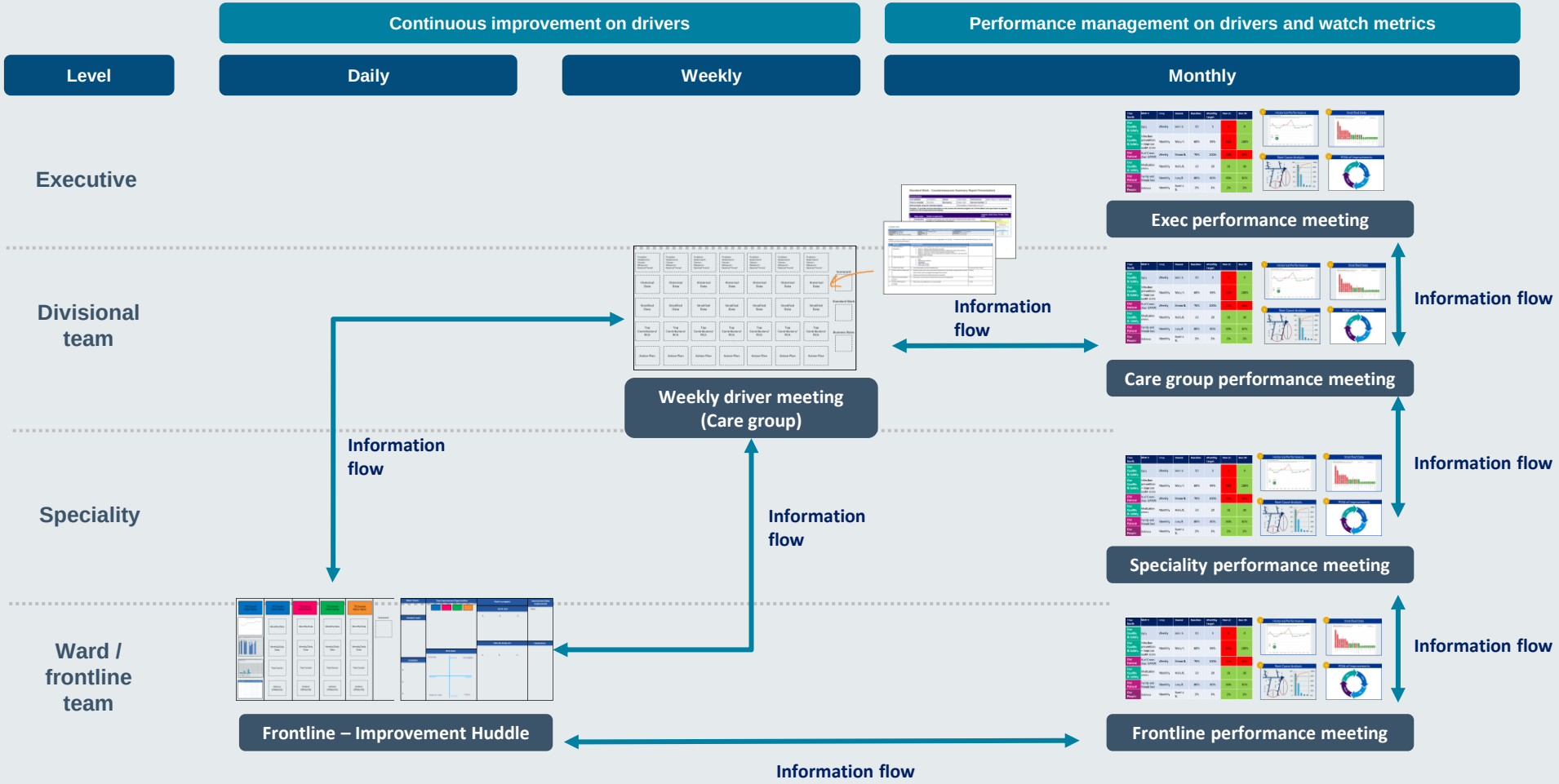
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.



The IPR forms the summary view of Organisational Performance against our 12 'pillar metrics' and the three breakthrough objectives we have chosen to focus on in 2022/23.
It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Performance business rules

		Alignment with Making data count	Rule	Actions
1		N/A	Driver is **Blue** for reporting period	Share success and move on
2	●	Blue dots – showing sustained improvement	Metric is positively outside SPC control limits for seven consecutive reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	●	**Orange** dot	Metric is negatively outside SPC control limits for 1 reporting period (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	●	**Orange** dot	Metric is negatively outside SPC control limits for 2 consecutive reporting periods (e.g. 2 months)	Produce Countermeasure summary performance report
5	●	**Orange** dot	Watch is **Orange** for 3 of the last 4 months (above / below the mean)	Move from Non alerting to Alerting Watch Metric Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Review thresholds
6	●	**Grey** dots	Metric is within control limits	Continue to maintain this performance

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

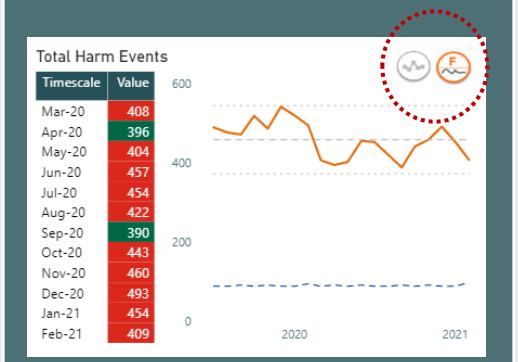
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

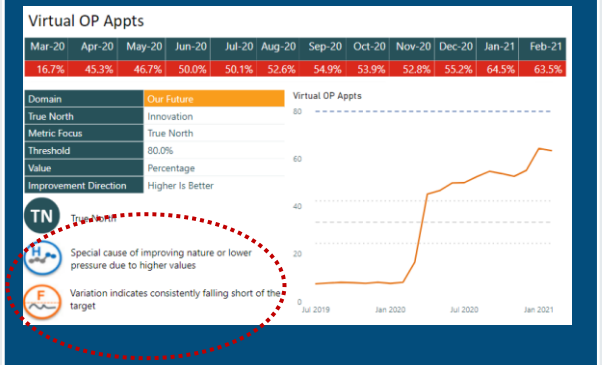
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them:

Strategic Pillars



Breakthrough Objectives



Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

Term	Description
A3	A methodology used as part of Improving Together to ensure that problems, ideas, and areas for improvement are all approached in the same way. A3 provides a template for thinking through a problem, so that teams gain a good understanding of the problem and causes, before reaching a solution. Coined 'A3' after the A3 sized paper used to map the process, it consists of eight steps, with questions to work through. This visual tool provides a complete picture of the problem, contributions, and solution, on one page which should be displayed for all involved to see.
Breakthrough Objectives	The few significant changes we need to meet in order to achieve our vision. Objectives should be achieved within a 12-month period and through teamwork across the organisation.
Business Rules	A set of rules used to determine how metrics are discussed in Performance Review Meetings.
Corporate Projects	Large complex projects identified as a priority by the Executive Team which require the involvement of more than one team, and/or significant capital investment.
Countermeasure	An action to prevent a problem from continuing. It's not a solution so further action may be needed in the future if performance does not improve.
Countermeasure Summary	A document that summaries the A3 information used to explore a problem or area for improvement. It is presented at monthly Performance Review Meetings.

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

Term	Description
Driver Lane	A visual management tool displayed on a team's Performance Board, containing driver metric information taken from A3 workings (e.g., problem statement, data, contributing factors, 3 C's or Action Plan). Driver lane information is discussed every day at Improvement Huddle boards and in more detail at driver meetings and monthly Performance Review Meetings.
Driver Meetings	Weekly meetings that update a team on progress against driver metrics. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings are also a way of checking progress to plan.
Driver Metrics	Metrics that a team chooses to focus on to help them achieve an improvement which will support one of the four pillars. Examples include, 'to reduce 30-day readmissions by 50%' or 'eliminate all avoidable surgical site infections.
Fishbone	A diagram used in the Root Cause section of the A3 template. It can be used to structure a brainstorming session to identify the potential causes of a problem.
Go and See	A visit to observe a specific problem or area for improvement and gain a better understanding of the process, engage with staff, and explore opportunities for improvement. While observing, visitors should ask open ended questions, lead with curiosity, and try to see the problem from different perspectives.
Important Project	A project that supports the four Pillars but is less of a priority than a Mission Critical Project.
Improvement Board	A visual tool to track daily improvement and operational activities. 1) Improvement activities will be identified when discussing the driver metric on the Performance Board. 2) Daily operational activities can be identified in the morning handovers/ward rounds.

Agreed Terms

Great Western Hospitals NHS Foundation Trust

Term	Description
Improvement Huddle Boards	A visual display used by teams to work through areas for improvement, track improvement work and daily operational activities. They should be used during daily improvement huddles, where staff can identify, and explore areas for improvement which align with the four pillars and vision. They aim to encourage conversation, involvement and team working. Improvement Huddle Boards need their own Standard Work document to ensure they are used effectively. Areas for improvement should be identified when discussing the Driver Metric on the Performance Board. Daily operational activities should be identified in morning handovers/ward rounds.
Improving together	Our new approach to improvement which will empower staff to make improvements in their own areas using a consistent approach to problem solving and exploring areas for improvement. This new way of working will help us to achieve our vision and the four pillars we want to be known for. It's important that every member of staff understands what our vision is, what the four pillars are, and how they can make improvements in their area to support these pillars, using the Improving Together approach.
Mission Critical Project	A critical project which may be mandatory, time sensitive, remove patient harm or form part of a wider system priority objective.
Operational Management System – Divisions	A way of working that enables the Improving Together approach to be applied routinely across the Divisions. Key elements of the system are: - To cascade the organisational priorities to Divisions and then frontline teams, ensuring everyone understands their contribution - Embedding a new performance framework - A focus on problem-solving at Divisions and team level, rather than waiting for solutions to be imposed from above - Embedding coaching behaviors to help support and develop colleagues.
Operational Management System - Frontline	A way of working that enables the Improving Together approach to be applied as part of the individual wards or departments daily work and routines. Key elements are: - A focus on problem-solving at a team, ward, or department level, rather than waiting for solutions to be imposed from above - Concentration on the Four Pillars and vision and ensuring everyone understands their contribution - The use of visual management tools that allow us to see and track improvement areas for our key priorities at a glance.
Performance Review Meeting	A monthly meeting where the scorecard is reviewed, and decisions are made to improve performance and resolve issues preventing improvement. The meeting is usually chaired by the manager and has all staff groups represented.
Plan Do Study Act (PDSA)	A four-stage problem solving model used for improving a process or carrying out change. It is particularly useful for small to medium sized ward or departmental problems. The PDSA cycle is a series of steps for gaining learning and knowledge for the improvement of a product or process. A PDSA Ticket is a proposed change which needs to be trialed. They are discussed at Improvement Huddles and can take 3-4 weeks to implement after planning, trying it out, observing the results, and acting on what is learnt.

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

Term	Description
Process Observation	Observing how a process or procedure is performing compared to the agreed standard. Benefits include creating stability and reducing the risk of deviation from the agreed standard. This process also creates opportunities for coaching, highlights any training or education needs, provides a baseline for improvement and aids problem solving.
Quick Win Ticket	Used to identify simple improvements during an Improvement Huddle (which can be made within 2-5 days). A method of problem solving used to identify the root causes of problems or barriers to improvement.
Root Cause Analysis	A method of problem solving used to identify the root causes of problems or barriers to improvement. A fishbone diagram, pareto charts and 5 why's are some of the tools used to guide a root cause analysis.
Scorecard	A visual management tool that lists the measures and projects a ward or department is focusing on. The purposes of a Scorecard is to: - Make strategy a continual process that involves everyone - Promote key measurements - Make clear the team's goals in relation to the Trust's four pillars - Provide a concise picture of the team's performance.
Scorecard Objectives	A formal conversation between two different levels in the organisation (e.g., Executive Directors and Divisional Leads) held annually to agree the next financial year's objectives, and the resources needed to achieve them. The aim being to: - Understand how each Division contributes to achieving the organisational priorities - Agree what additional local priorities each Division needs to achieve.
Standard Work	A written document with step-by-step instructions for completing a task using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task. The document should be regularly reviewed and updated.
Strategic Filter	A tool used to prioritise the different projects happening across the Trust.
Strategic Initiatives	Programme of work which are our must do, can't fail priorities for the organisation to support the four pillars and achieve our vision. They normally take place over a 3–5-year period.
Strategic Pillars	The Trust has four strategic pillars which we want to be known for and which will help us to achieve our vision. They are the four areas which we should be focusing on when making improvements. It's important that every member of staff understands what our vision is, what the four pillars are, and how they can make improvements in their area to support these pillars.

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

Term	Description
Strategy Deployment	A planning process which gives long-term direction to a complex organisation. It identifies a small number of strategic priorities for staff to focus on so that we can do these things well, rather than spreading ourselves too thinly on lots of things.
Strategy Deployment Matrix	A resource planning tool which provides an overview of resource commitments across all teams, so no team is overloaded.
Structured 1:1	A regular structured conversation between a leader and team member that lasts between 10 and 30 minutes. Open ended questions are used to guide the conversation linked with the Four Pillars. The questions aim to promote a coaching conversation about planning and mitigating any risks. These conversations form part of a chain of conversations at different levels of the organisation. Examples include, Nurse in Charge and Ward Manager (daily), Ward Manager and Service Manager (weekly), Service Manager and the Divisional Director (fortnightly), Divisional Director and Chief Operating Officer (Monthly).
Structured Verbal Update	A verbal update that follows the Standard Work Structure laid out. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	This is used if a Watch Metric is not on track, but not far off expected performance. A Tolerance Level can be applied against the metric, meaning as long as performance does not fall below the Tolerance Level, it can remain a Watch Metric.
Transformation and Improvement Hub (T&I Hub)	Our internal team of professionals embedding our new approach to improvement 'Improving together' across the organisation. Through training, coaching and support the T&I Hub are providing teams with the tools, routines and behaviours needed to solve problems and explore areas for improvement using a consistent approach. They can help teams to identify their vision for change, whether it be through problem solving, process mapping or developing plans. They will then support through a mixture of full day training sessions, bite sized coaching and work placed support.
Vision	Vision captures the few selected organisation wide priorities and goals or the strategic aims that guide all improvement work in an organisation. It can be developed by the Trust's executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch Metrics	Measures that are monitored for adverse trends.

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

September 2022 (M6 data)

Service Teamwork Ambition Respect

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

Executive Summary & Performance against key targets

Use of Resources

For Period Ended - 30th September 2022											
Financial Position	In Month				YTD				Full Year Forecast		
	Plan £000	Actual £000	Variance £000		Plan £000	Actual £000	Variance £000		Plan £000	Actual £000	Variance £000	
Patient Care Income	35,659	36,107	448		199,517	200,666	1,149					
Private Patient Income	177	188	11		1,041	1,102	62					
Other Income	2,349	2,621	272		13,913	12,634	(1,279)					
Total Income	**38,185**	**38,916**	**731**		**214,470**	**214,402**	**(68)**		**420,872**	**429,264**	**8,392**	
Pay - Substantive	(24,679)	(22,346)	2,333		(133,013)	(120,263)	12,750					
Pay - Bank/Locum	(274)	(2,019)	(1,746)		(1,567)	(9,892)	(8,325)					
Pay - Agency	(447)	(2,215)	(1,769)		(2,883)	(8,864)	(5,981)					
Total Pay	(25,400)	(26,581)	(1,181)		(137,463)	(139,019)	(1,557)		(273,517)	(282,731)	**(9,214)**	
Non Pay	(14,315)	(14,274)	42		(86,020)	(86,637)	(617)		(166,706)	(171,147)	**(4,441)**	
Total Expenditure	**(39,715)**	**(40,854)**	**(1,139)**		**(223,483)**	**(225,657)**	**(2,174)**		**(440,223)**	**(453,878)**	**(13,655)**	
Surplus/(Deficit)	**(1,530)**	**(1,938)**	**(408)**		**(9,013)**	**(11,254)**	**(2,242)**		**(19,351)**	**(24,614)**	**(5,263)**	
Capital	1,131	225	(906)		6,212	1,515	(4,697)		17,246	17,246	0	
Cash & Cash Equivalents	29,637	25,638	(3,999)						22,749	22,749	0	
Efficiencies	1,043	796	(247)		4,851	3,618	(1,233)		11,109	7,084	(4,025)	
Headcount (worked)	5,238	5,190	48									

Headlines:

The Trust is £0.4m off plan in Month 6, year to date £2.2m off plan. The in-month position is driven by ESRF costs in excess of income (£0.4m). Pay pressures continue and have been mitigated in month following a review of accruals that have been released.

Our forecast position is c.£5m worse than plan, predominantly linked to the forecast costs of ESRF in excess of guaranteed income. This forms part of an ongoing system conversation and is expected to be resolved in November.

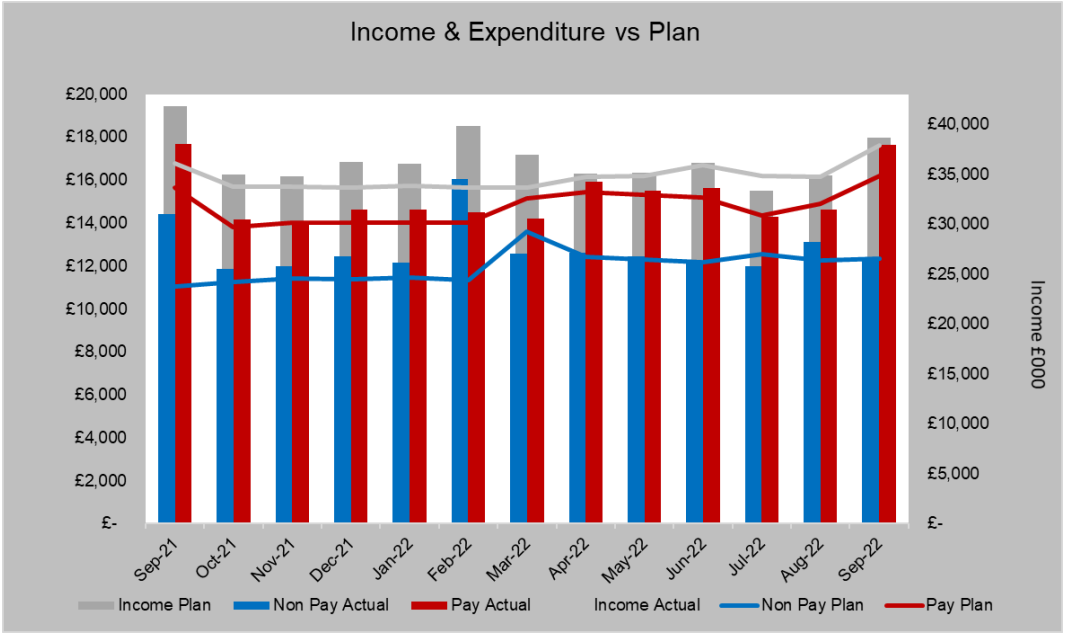
The cash balance at the end of Month 6 is £4.0m below plan, primarily due to a delay in payment of contract receivables which has been received in October.

Capital expenditure is £5.0m below plan year to date due to profiling and slippage – this is being addressed at the monthly Capital Management Group and is being actively managed to ensure we deliver our capital plan by year end.

Delivery of efficiency is also below in month (£0.2m) and year to date (£1.2m) and this is being addressed through the Improvement sub-committee and Divisional meetings.

Income and Expenditure - Run Rate

Use of Resources



Background

In month the I&E position is £1.9m deficit against a planned deficit of £1.5m.

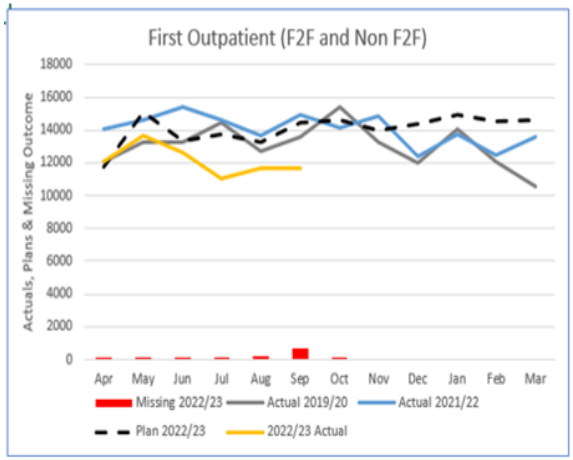
- Income run rate has increased by £3.7m in September and is £0.7m above plan in month. The in-month increase is driven by income received for the national pay award £3.2m as well as virtual ward income of £0.25m. ESRF income in Month 6 is based on pro rata 25% ICB and 100% NHSE allocations - £1.6m YTD compared to a plan of £2.4m

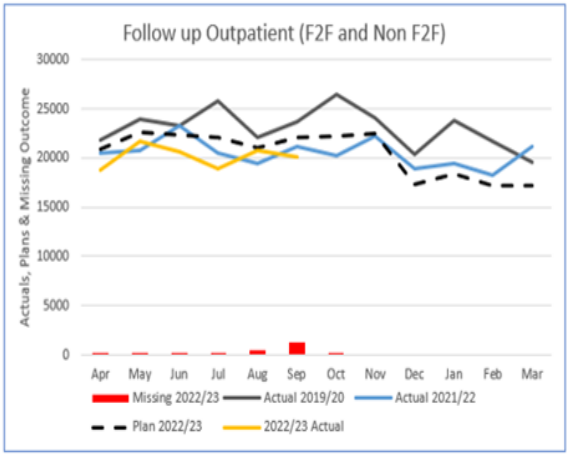
- The Pay run rate has increased by £4.6m in month, of which £4.5m relates to the National pay award. Pay run rate continues to be above budget, key drivers are Enhanced Care within Nursing and Medical staff costs in Unscheduled Care.

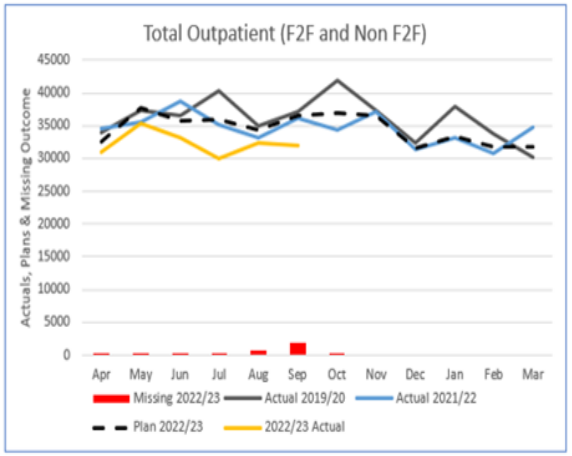
- The non-Pay run rate has decreased by £0.8m in month. Month 5 reported an increase in drugs costs and clinical supplies which has dropped back down in Month 6.

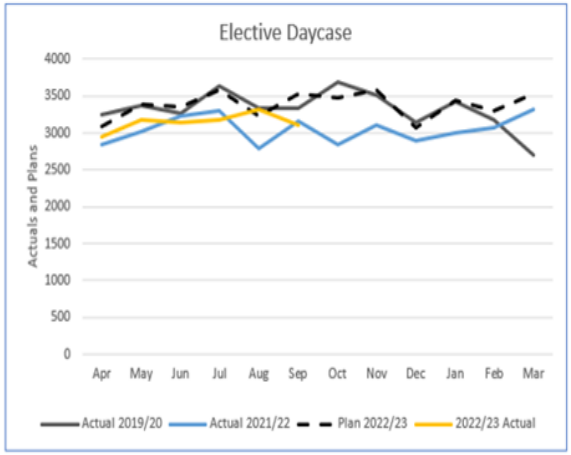
Point of Delivery – Activity Trendline

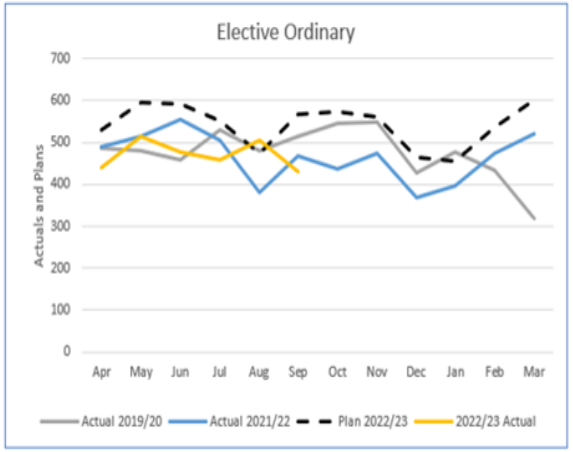
Use of Resources

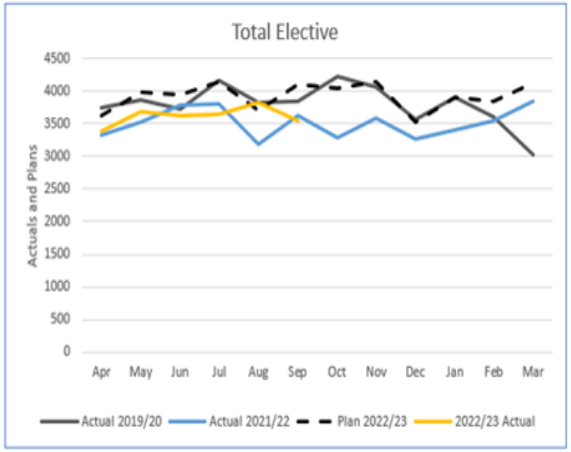












Income by Point of Delivery

Use of Resources

Acute activity type	August 2022 Year to date 19/20	21/22	22/23	22/23 v 19/20 Note 1	
Main ED (excl UTC)	7,455,655	6,061,846	5,934,592	76%	Omits shift to UTC since 19/20
Non Elective	47,565,745	52,692,850	50,092,637	101%	Sept 108%
Outpatient	21,670,089	18,931,455	19,416,058	86%	Sept 84%
Day case	11,953,951	11,157,275	10,757,488	86%	Sept 92%
Elective inpatient	8,650,182	8,240,687	7,977,481	88%	Sept 89%
Total	**32,485,714**	**32,018,922**	**30,011,139**	**92%**	Sept 96%

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. Although there is an emerging risk of a peripheral commissioner wanting to reduce payment through activity performance being lower than previous levels.

The above table show this year's income by main activity types against the same point in 19/20, if activity-based contracting (PbR) with national tariffs was still applied.

Focus on actuals:

For September, actual income on a PbR basis has been shown v prior year and the pre-Covid base of 19/20. Overall activity is c£2.5m below 19/20 levels and c£2m below 21/22.

Issues:

Non elective activity is higher than in 19/20 and Elective activity is lower. This will negatively impact on wait lists and will put pressure on ESRF performance.

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.

There is emerging risk that peripheral commissioners are now looking mor towards an activity basis for payment rather than fixed blocks.

Efficiency – Better Care at Lower Cost

Use of Resources

Background

The Trust started the year with a £10m cash releasing efficiency plan. In June, the Trust agreed to reduce its deficit plan, as part of this the efficiency target was increased non-recurrently by £1.1m to £11.1m. The additional target sits within Trust Wide.

Divisions and Directorates are asked to work to their budget, which is a proxy (non-recurrent) delivery of CIP for this year.

Cash Releasing - Division M06	Plan £000	Identified £000	Unidentified £000
Corporate	1,100	389	(711)
Integrated Care & Community	1,000	884	(116)
Surgery, Women & Children	3,209	1,957	(1,252)
Unscheduled Care	3,600	3,600	0
Trust Wide	2,200	247	(1,953)
Total	**11,109**	**7,077**	**(4,032)**

Cash Releasing - Division M06	In Month Plan £000	In Month Delivery £000	In Month Variance £000	YTD Plan £000	YTD Delivery £000	YTD Variance £000	Full Year Plan £000	Recurrent Forecast £000	Non Recurrent Forecast £000	Forecast Variance £000
Corporate	103	30	(73)	481	143	(338)	1,100	104	293	(703)
Integrated Care & Community	91	146	55	453	423	(30)	1,000	487	397	(116)
Surgery, Women & Children	301	162	(139)	1,404	1,096	(308)	3,209	1,284	673	(1,252)
Unscheduled Care	328	437	109	1,632	1,833	201	3,600	1,194	2,406	0
Trust Wide	220	21	(199)	880	124	(756)	2,200	247	-	(1,953)
Total	**1,043**	**796**	**(247)**	**4,851**	**3,618**	**(1,233)**	**11,109**	**3,315**	**3,769**	**(4,024)**

Improvement actions planned

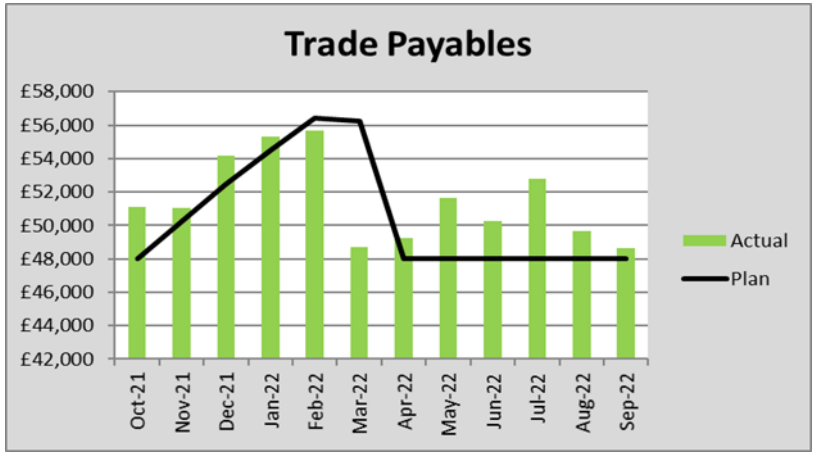
In month £0.8m efficiency has been delivered against a plan of £1.0m. Year to date reports £1.2m off plan. Within the year to date delivery, 63% has been delivered on a non recurrent basis. With the continued shortfall in efficiencies identified, the forecast year end position is a gap of £4.0m. Within the forecast, 53% is expected to be achieved through non recurrent delivery. Divisional platforms continue to address the unidentified plan and monitor delivery in year. A cross divisional working group has also been established. A detailed report on efficiency is presented at Finance and Infrastructure Committee monthly.

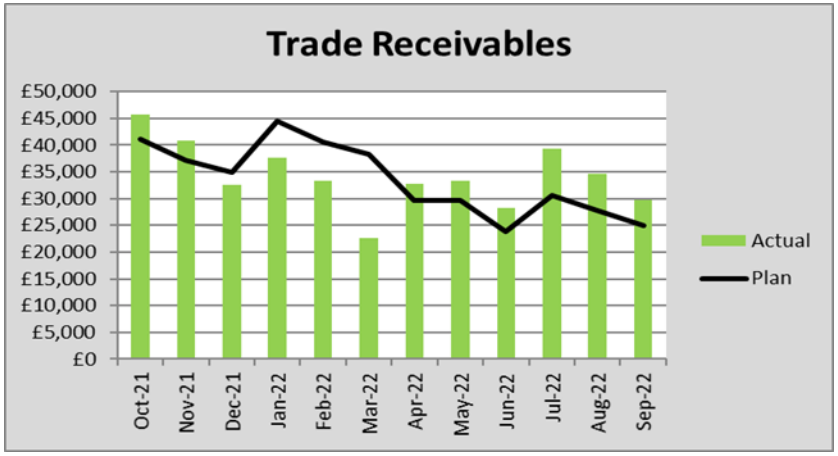
Risks to delivery and mitigations

The Trust does not 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.

Statement of Financial Position: Key movements

Use of Resources





Background

- Trade payables are £0.7m above plan due to an increase in Non-PO Accrued Expenditure
- Receivables are £5m above plan due to the high level of Accrued and Invoiced income.
- A full Statement of Financial Position is included in the appendices.

Risks to delivery and mitigations

- The Trust's application for Emergency Capital funding was approved in September and a cash flow for drawn down is being prepared for submission in October.
- The Trust is monitoring SBS actions around reducing processing times and working closely with Divisions and Procurement to ensure suppliers are paid as soon as possible.

Cash

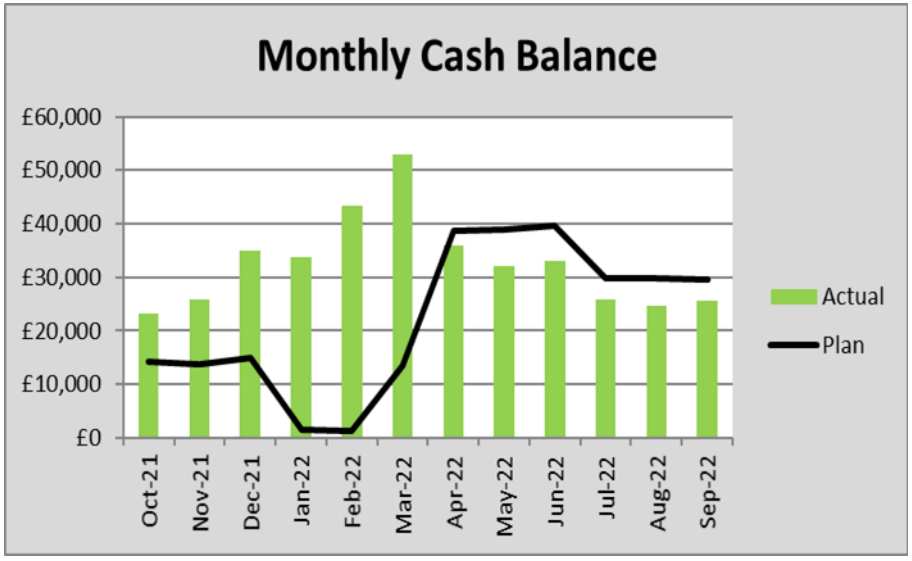
Use of Resources

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	22/23 Total	Rolling 12 Mths Oct 22 to Sep 23
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	**24,659**	**25,639**	**19,665**	**19,311**	**19,158**	**10,774**	**10,102**	**22,749**	**8,402**	**5,886**	**6,347**	**1,091**	**1,014**	**52,898**	25,639
Income															
Clinical Income	36,173	33,510	33,203	33,203	33,203	33,203	33,200	33,200	33,200	33,200	33,200	32,809	36,173	399,812	401,304
Other Income	4,206	7,247	1,225	1,225	6,292	725	1,228	7,247	1,225	1,225	7,247	1,225	1,225	39,404	37,336
Revenue Financing Loan / PDC							17,000				1,600	2,500	2,000	17,000	23,100
Capital Financing Loan / PDC		2,844	1,647	1,906	1,555	2,383	12,283							22,618	22,618
Total Income	**40,378**	**43,601**	**36,075**	**36,334**	**41,050**	**36,311**	**63,711**	**40,447**	**34,425**	**34,425**	**42,047**	**36,534**	**39,398**	**478,834**	**484,358**
Expenditure															
Pay	23,247	22,570	22,824	22,764	22,783	22,783	23,583	20,348	21,307	20,812	20,724	20,858	23,247	264,602	264,602
Revenue Creditors	12,878	11,642	11,269	11,187	11,472	11,187	12,030	15,124	13,517	11,284	13,512	15,033	12,878	150,134	150,135
Capital Creditors	735	2,369	2,277	2,536	2,185	3,013	12,913	6,327	2,059	1,868	131	721	735	37,136	37,136
PFI		12,994			12,994			12,994			12,937			51,919	51,919
PDC Interest	2,538						2,538						2,538	5,076	5,076
Financing			58						58					116	116
Total Expenditure	**39,399**	**49,575**	**36,429**	**36,487**	**49,434**	**36,983**	**51,064**	**54,793**	**36,941**	**33,964**	**47,303**	**36,612**	**39,399**	**508,983**	**508,984**
Closing Balance	**25,639**	**19,665**	**19,311**	**19,158**	**10,774**	**10,102**	**22,749**	**8,402**	**5,886**	**6,347**	**1,091**	**1,014**	**1,013**	**22,749**	**1,013**

Background

- Cash at the end of September was £26m. This was £4m below the planned level of £30m.
- This was due to:
  - Clinical income £1.7m lower than plan (due to a delay in payment of income from Swindon Borough Council, loan draw down delay of £5.3m and an increase in invoiced receivables.
  - Revenue Creditor payments are above plan and Capital Creditors £3.7m below plan

Capital financing has also been adjusted to reflect IFD drawdown and revised forecast of capital expenditure.



Capital Programme

Use of Resources

		2022-23									
Capital Scheme	Capital Group	Full Year Plan £000	Month 6 Plan £000	Month 6 Actual £000	Month 6 Variance £000	Month 6 YTD Plan £000	YTD Actual £000	Month 6 Accrual £000	YTD Total (Actual & Accruals) £000	YTD Variance £000	M12 Forecast £000
Estates Replacement Schemes	Estates	1,000	83	11	(72)	348	83	-	83	(265)	1,000
Service Development & Expansion - Aseptic Unit	Estates	2,166	307	-	(307)	342	-	-	-	(342)	2,166
Service Development & Expansion - WFP IFD	Estates	452	9	9	-	226	9	-	9	(217)	452
Service Development & Expansion - Other works	Estates	787	50	50	-	394	226	-	226	(168)	1,067
Service Development & Expansion - EPR & Path LIMs	IT	1,156		-	-	578	-	-	-	(578)	1,156
IT Emergency Infrastructure	IT	1,000	83	-	(83)	348	-	-	-	(348)	1,000
IT Replacement Schemes	IT	2,000	167	131	(36)	702	725	-	725	23	2,000
PACS - environment/replacement solution (Nov21)	IT	1,500	125	-	(125)	525	-	-	-	(525)	1,500
Equipment Replacement Schemes	Equipment	2,055	167	24	(143)	900	62	-	62	(838)	1,775
Contingency	CMG	379	-	-	-	-	-	-	-	-	379
Total Trust CDEL		**12,495**	**991**	**225**	**(766)**	**4,362**	**1,105**	**-**	**1,105**	**(3,257)**	**12,495**
Way Forward Programme		4,610	140	-	(140)	1,850	-	410	410	(1,440)	4,610
Finance Leases		141	-	-	-	-	-	-	-	-	141
Total Capital Plan (Excl PFI)		**17,246**	**1,131**	**225**	**(906)**	**6,212**	**1,105**	**410**	**1,515**	**(4,697)**	**17,246**

Risks to delivery and mitigations

Expenditure on schemes has been slow to commence but is expected to pick as we move into Q3.

Any slippage is reported to and managed by CMG

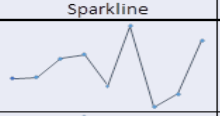
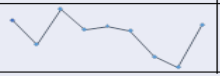
Background

- The Trust's CDEL plan for 2022/23 is £12.5m.
- Service Development Allocation includes Aseptic Suite (£2.2m), EPR (£0.8m), Electrical Upgrade (£0.2m), Ward Configuration (£0.2m), Sustainability (30.2m) and Co-ordination Centre (£0.3m).
- Total Capital Expenditure at Month 6 is £4.7m below plan. Of this, £3.3m relates to Trust CDEL schemes, with the remaining £1.4m slippage on externally funded schemes.
- During September the Capital team followed up with Procurement & Project Leads actions taken to address slippage on schemes and to obtain a revised forecast.
- Capital Management Group have reviewed schemes to be funded from slippage with final approval to schemes to be agreed on 14th October 2022.
- The Trust's application for Emergency Capital funding for £9.9m was approved by the National Team.

2. Patient Safety – Perinatal Quality Surveillance Tool

Data Quality Rating:

Are we Safe?

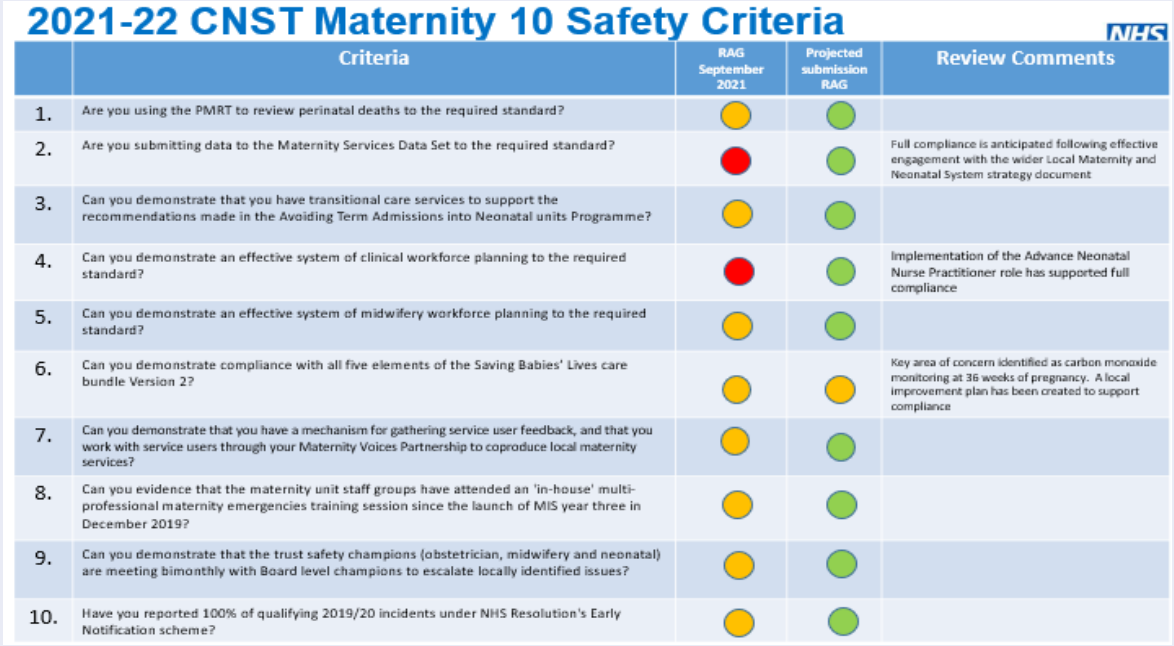
<table>
<tr><th>Measures</th><th>Comments</th></tr>
<tr><td>Minimum safe staffing in maternity to include Obstetric cover on delivery suite</td><td>
<table>
<tr><th>Measure</th><th>Aim / Target</th><th>July 22</th><th>Aug 22</th><th>Sep 22</th></tr>
<tr><td>Midwife to birth ratio</td><td>1:29</td><td>1:29</td><td>1:27</td><td>1:29</td></tr>
<tr><td>1:1 Care</td><td>100%</td><td>99.7%</td><td>99%</td><td>99.1%</td></tr>
<tr><td>Consultant presence in Delivery suite (Hours per week)</td><td>60 hours</td><td>74.5hrs</td><td>74.5hrs</td><td>74.5hrs</td></tr>
</table>
The midwife to birth ratio was on target for September. 1:1 care for one family for a short period of time during labour care is reflected in the -0.9% off target.
</td></tr>
<tr><td>Service User feedback</td><td>
• Feedback based on a family's recent experience will be instrumental in determining the improvements required in terms of the facilities for partners on Hazel ward.
• The SMS responses demonstrate the highest service user satisfaction with care in the community during the postnatal period (97%).
• No complaints have been received within maternity throughout September.
</td></tr>
<tr><td>Core20PLUS5– An approach to reducing health inequalities</td><td>
<table>
<tr><th>Measure</th><th>Aim/Target</th><th>June 22</th><th>July 22</th><th>Aug 22</th><th>Sep 22</th></tr>
<tr><td>BAME women on continuity of carer pathway</td><td>75%</td><td>42.70%</td><td>28.9%</td><td>19.05%</td><td>31.43%</td></tr>
<tr><td>Women with high index of multiple deprivation on continuity pathway</td><td>75%</td><td>61.90%</td><td>63.4%</td><td>38.71%</td><td>48.15%</td></tr>
</table>
The observed decrease for both groups is reflected by the changes to the continuity of carer(COC) teams, This was in response to the immediate and essential actions around safe staffing (Ockenden 2022). We now have one COC as opposed to two, with the decrease reflecting this change. Despite an increase in both numbers in September 2022, we do not expect to see any significant change to these figures until approximately March 2024
Ongoing workforce planning will focus on models for rollout that prioritise those most likely to experience poor outcomes, including ensuring rollout to 75% of women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived 10% of neighbourhoods by March 2024.
</td></tr>
<tr><td>Caesarean Sections</td><td>
<table>
<tr><th>Robson Group Descriptor</th><th>Robson Group No.</th><th>Sparkline</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th><th>Apr-22</th><th>May-22</th><th>Jun-22</th><th>Jul-22</th><th>Aug-22</th><th>Sep-22</th></tr>
<tr><td>Women/pregnant people in their first pregnancy with a head down, single baby at ≥37 weeks, in spontaneous labour that had a Caesarean birth*</td><td>1</td><td>  </td><td>6.98%</td><td>7.08%</td><td>8.87%</td><td>9.20%</td><td>6.25%</td><td>11.90%</td><td>4.33%</td><td>5.53%</td><td>10.53%</td></tr>
<tr><td>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. *</td><td>2</td><td>  </td><td>25.60%</td><td>31.86%</td><td>26.61%</td><td>32.70%</td><td>29.69%</td><td>23.80%</td><td>11.45%</td><td>14.65%</td><td>29.32%</td></tr>
<tr><td>Women/pregnant people that have had a previous Caesarean birth, with a head down, single baby at ≥37 weeks. *</td><td>5</td><td>  </td><td>30.20%</td><td>20.35%</td><td>35.48%</td><td>26.50%</td><td>28.13%</td><td>26.20%</td><td>15.17%</td><td>10.42%</td><td>28.57%</td></tr>
</table>
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.
Usually 'other Robson groups' represent a higher proportion of CS patient groups, however, IOL rate was higher in Sept which is proportional to a marginally higher birth rate. Only 30% of eligible women attempted a VBAC, which represents the increased number of women in group 5, with a success rate of 59% - in August the success rate was higher at 83% which may account for the significant increase of women in group 5.
</td></tr>
</table>

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)	
Ockenden Report (March 2022)	1 area has moved from amber to green in the overall RAG status within September 2022.
Findings of review of all perinatal deaths using the real time data monitoring tool	No reviews took place in September 2022
CQC Ratings	Nothing to report
Maternity Safety Support Programme	Not required as CQC ratings overall 'Good'
Coroner's Regulation 28	Nil

2021-22 CNST Maternity 10 Safety Criteria NHS

	Criteria	RAG September 2021	Projected submission RAG	Review Comments
1.	Are you using the PMRT to review perinatal deaths to the required standard?			
2.	Are you submitting data to the Maternity Services Data Set to the required standard?			Full compliance is anticipated following effective engagement with the wider Local Maternity and Neonatal System strategy document
3.	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?			Implementation of the Advance Neonatal Nurse Practitioner role has supported full compliance
5.	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
6.	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?			Key area of concern identified as carbon monoxide monitoring at 36 weeks of pregnancy. A local improvement plan has been created to support compliance
7.	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?			
8.	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?			
9.	Can you demonstrate that the trust safety champions (obstetrician, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?			
10.	Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?			

2. Patient Safety - Perinatal Quality Surveillance Tool

Are We Safe?

Ockenden progress update

Overview & Summary Review of Criteria RAG Status

September 2022

Current RAG Status /Action No.	Immediate & Essential Action	Number of Actions Under Each Heading Rated			Key action for progression
		RED	AMBER	GREEN	
1	Workforce Planning & 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
2	Safe Staffing	2 =	7 =	1 =	Ensuring that local escalation policies represent the entire workforce, 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 & Accountability	0 =	2 ↓	3 ↑	Consideration of maximising consultant obstetrician presence, and review of escalation policy
4	Clinical Governance - Leadership	1 =	4 ↓	2 ↑	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 & Complaints	0 =	6 ↓	1 ↑	Ensure effective monitoring of complaints themes and trends. Ensuring timely implementation of actions from Serious Incident Investigations
6	Learning From Maternal Deaths	0 =	2 =	1 =	Ensure timely implementation of learning, locally and from across the region
7	Multidisciplinary Training	0 ↓	4 ↑	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	0 =	4 =	1 =	Strengthen awareness and access to preconceptual care via the primary care network
9	Preterm Birth	0 =	0 =	4 =	Continue to share learning and successes across the region
10	Labour and Birth	1 =	4 =	1 =	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	1 =	4 =	3 =	Ensure alignment of local and national guidance and documentation standards. Continue multi-disciplinary simulation teaching. Including anaesthetic emergencies
12	Postnatal Care	0 =	4 =	0 =	Audit of time from admission to review for postnatal readmission to ensure early consultant involvement
13	Bereavement Care	0 =	2 =	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	0 =	3 =	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 incidences graded moderate or above and actions taken	• 2 incidents were graded as moderate harm for the perinatal services in September • Following a MDT review, these were downgraded as the level of harm was entered incorrectly

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

Serious Incidents (SI)

Case Ref	Overview	Date	Case Update
None			

On-going SI Investigation Update

Stage of investigation	June 2022	July 2022	August 2022	September 2022
Referred to HSIB – awaiting decision	0	0	0	0
Under local investigation (this may include insight from external reviewers)	0	0	0	0
Under HSIB investigation	1	1	0	0
Report complete & awaiting Serious Incident Review learning Group (SIRLG)	1	0	1	0
Submitted to CCG	3	3	1	0

Data correct as of 4th October 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,

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

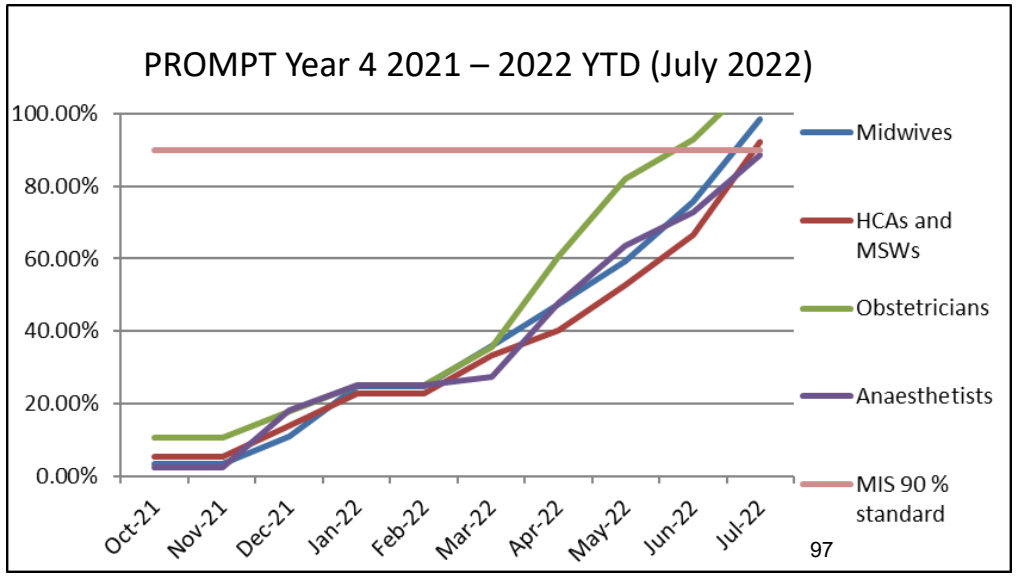
Great progress has been made in achieving ≥90% in all disciplines and the team are working to ensure this compliance is maintained.

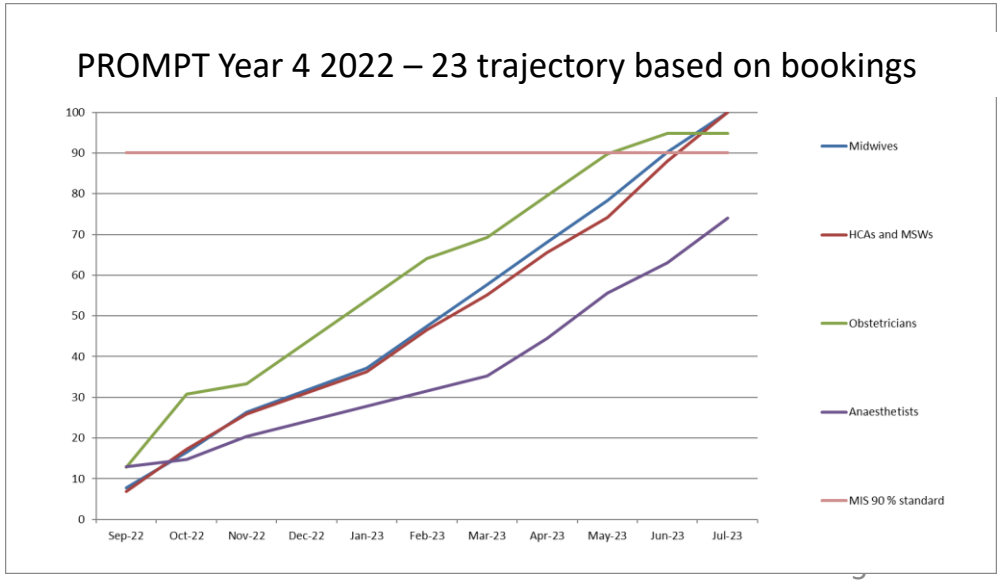
Face-to-face training for PROMPT began in September 2022. This included human factors training provided by external company 'Wing Factors' which was well received.

Risks to delivery and mitigations

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.

PROMPT



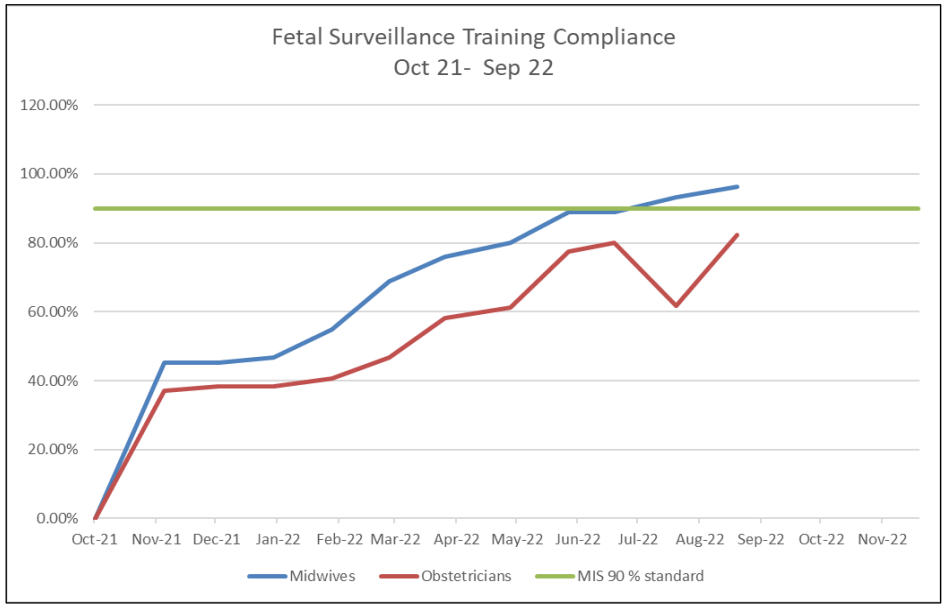


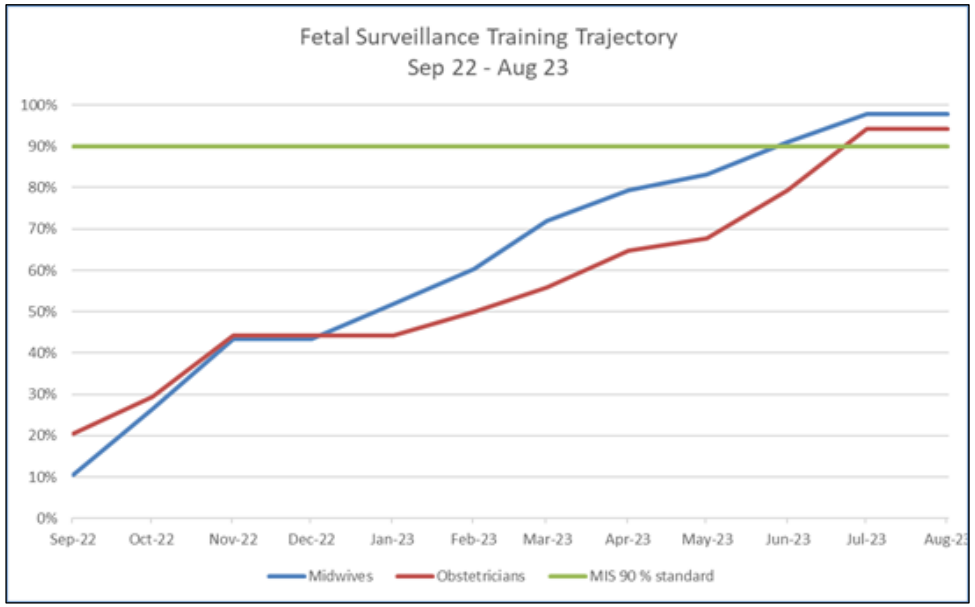
2. Maternity - PROMPT and Fetal Surveillance Training Update including Trajectory

Data Quality Rating:

Are We Responsive?

Fetal Surveillance Training





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**	**21 October 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] Q2			The risk rating remained as amber to reflect the challenges within the mental health system but the committee was sufficiently assured regarding the actions to revise the rating from amber to green, in particular by the impact that rapid escalation and robust pathways had had when there was a need to liaise with organisations outside of the BSW system.		
Mental Capacity Act [MCA]: Update			Ratings remained consistent. The committee noted that an LPS and MCA lead was now in post, that an electronic database was being piloted and that level 3 safeguarding training was above trajectory. However, there was a reported lack of confidence amongst staff and MCA practice therefore needed to be an area of continuing focus.		

[1] Safeguarding / Mental Health / DOLS

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
Report on the use of Deprivation of Liberty Safeguards [DoLS]			Ratings remained consistent. It continued to be the case that patients who were the subject of DoLs applications were not being assessed because of the pressures on the supervisory bodies and the committee noted that of the 184 applications that had been recorded in the reporting period none had been assessed. However, the committee remained assured that mitigations were in place to address the risks associated with the fact that these patients were being cared for by GWH whilst outside the protection of the legal framework and noted the information that showed compliance with DoLs training expectations.		
Update on Development of Liberty Protection Safeguards [LPS]			Ratings remained consistent. The committee noted the work that was continuing within GWH and regionally to prepare for implementation and that this had begun to quantify the resources that would be necessary, including an investment in IT infrastructure to support the reporting requirements. There was also a need for wider system work to address the funding of the approved mental capacity professional role.		
Changes to Legislation and Guidance			The committee was made aware of a number of changes to legislation and guidance, including changes that were yet to come into operation and received an assurance regarding the action being taken at GWH in response. Ratings remained consistent.		
Mental Health Governance Workplan Q2 Report			Ratings remained consistent. The committee was satisfied by the robustness of the workplan and noted that during Q2 progress was as expected.		
Risk Report			Whilst the committee was satisfied from the reporting that there was a process to manage risk it considered that more robust information could be provided regarding the mitigations that were in place and for this reason maintained an amber actions rating. However, the risk rating was reduced from red to amber to reflect audit findings in relation to practice and that there was continuing evidence from clinical incident reporting that mental health was not an associated factor.		
Audit Reports			The audit programme was going forward as planned. Two audits had been closed and actions completed. Three informal audits in relation to MCA, restraint and absconsion practice had been conducted and the committee was satisfied as to the actions that were being taken in relation to the findings. Ratings remained consistent.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
Emergency Department [ED] / Mental Health Liaison Team [MHLT] Update			An audit had been conducted of those patients were medically fit for discharge and who, under the RCP PLAN v7 guidelines, should receive a MHLT assessment within 1 hour of referral and a 'home vs MH admission' decision within 12 hours. The audit demonstrated that these guidelines were not being met and that patients remained in the ED observation bay for up to 10 days. These findings reflected the ongoing challenges presented by the lack of acute mental health beds and the recruitment challenges being experienced within the MHLT. In these circumstances the risk rating remained at red. However, the committee was assured by the collaborative work being done with AWP and BSW to mitigate the risks, in particular the work that had been done in response to the audit. Most recently this had included a case review, a revised escalation process and a series of focussed actions that included a pilot of a mental health response vehicle.		
Children's Services / Child and Adolescent Mental Health Service [CAMHS] Update			Ratings remained consistent. The workforce pressures that CAMHS was under continued as did the national shortage of specialist Tier 4 beds. These pressures meant the CAMHS liaison service was not able to fulfil expectations and patients remained for long periods in an acute setting whilst waiting for a specialist bed. In these circumstances GWH staff were having to care for an increasing number of children and young people whose mental health needs were becoming more complex. However, it remained the case that a range of measures were in place to manage these pressures [including robust internal processes, the provision of staff training and changes to the ward environment] and work had begun on a joint action plan to address the challenges. The committee also noted that an SLA with CAMHS was in the process of being agreed.		
Learning from Incidents			The committee received a report in this format for the first time. The report was able to draw on data from Datix and detailed the numbers of incidents relating to MCA and DoLs, the causes that underpinned those incidents and the level of harm recorded. In addition, data was provided about incidents of self-harm, absconsion and restraint. This data supported an amber risk rating. In relation to the actions rating, whilst some verbal information was made available about how learning was disseminated across GWH it was agreed that future reporting would benefit from this being done more robustly and within the report. On this basis an amber actions rating was agreed.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
AWP Mental Health Strategy			The committee had the opportunity to provide feedback on AWPs draft Mental Health Strategy and heard from the AWP CEO about how the draft had been developed and what the next steps were. Feedback from the committee included ensuring that AWP's strategy was built into the overarching system strategy, describing how the strategy would impact on AWP's partners, how different workforce models might be used and how the availability of central government funds to support the transformation of Mental Health Services would impact on the strategy.		

Report Title	**Ockenden Report – GWH Update**				
Meeting	**Trust Board**				
Date	**3rd November 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):

A progress update on the Immediate & Essential Actions (IEAs) outlined in the full Ockenden Report including key highlights for celebration and continued key risks. A brief overview of the newly released East Kent Report and subsequent recommendations.

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					
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:	
▪ **Understand the progress against the Immediate and Essential Actions and their impact on the development of the perinatal strategy for access to safe maternity care and potential risks of non compliance.**	
Accountable Lead Signature	
Date	26 October 2022

NHS
Great Western Hospitals
NHS Foundation Trust

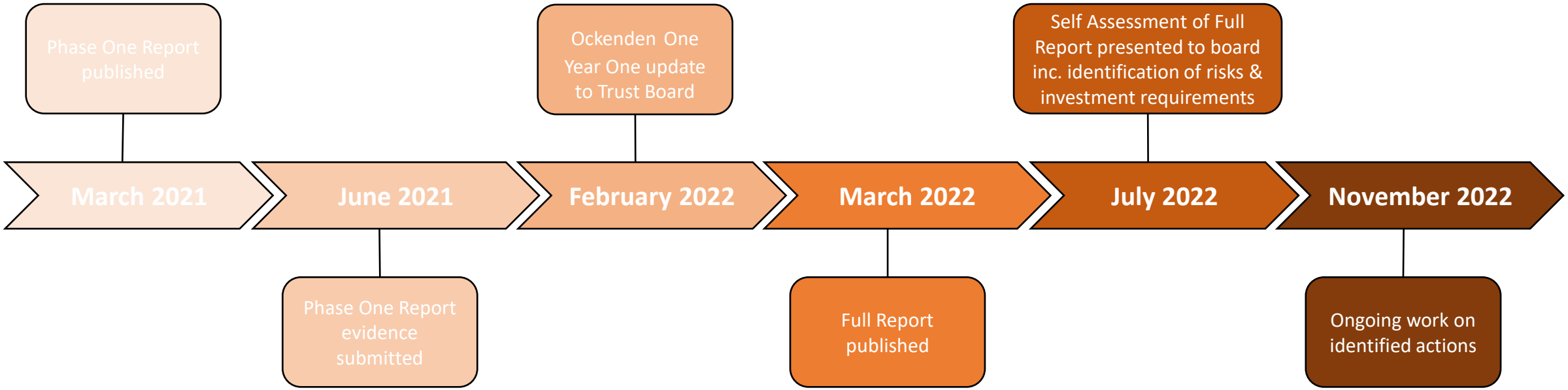
Ockenden Report – GWH Update

Lisa Marshall — Director of Midwifery and Neonatal Services

Kat Simpson — Head of Midwifery and Neonatal Services

Background of Ockenden Report & GWH Timeline

Great Western Hospitals NHS Foundation Trust

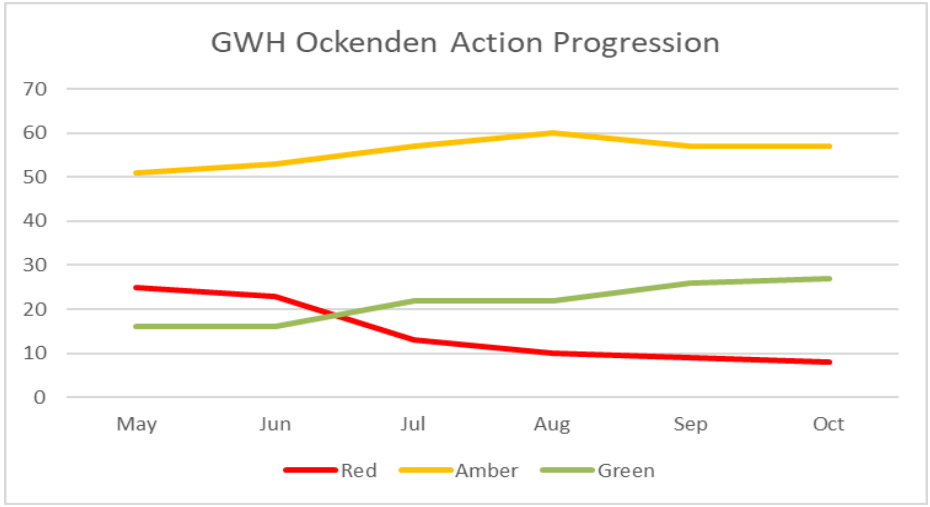


The Regional Insight visit to GWH took place on 17th October 2022. Immediate feedback was received with a full report expected in November 2022. The Regional team have conducted visits to all Trusts to seek assurance of implementation and embedding of the Ockenden Phase One report.

Key highlights from verbal feedback:

- Assurance of local implementation and embedding of the 7 Ockenden Immediate & Essential Actions
- Positive attitude from staff who were proud to work for the organisation
- Strong governance structure, clear training and education plans and visibility of senior leadership team
- Proposed areas for improvement identified included antenatal clinic capacity, continued work on personalised care and support planning and earlier involvement of service users in ongoing coproduction

Key Highlights for Celebration



NHS
Great Western Hospitals

	RED	AMBER	GREEN
May	25	51	16
June	23	53	16
July	13	57	22
Aug	10	60	22
Sept	9	57	26
Oct	8	57	27

- Demonstrable progress of continuous improvement across all 15 Immediate & Essential Actions (IEAs).
- Learning themes from clinical incidents now included in PROMPT & Fetal Surveillance study day from Sept 2022. Annual cycle of topic review to ensure training relevance and a robust three year plan to ensure local training needs meet national recommendations for multi-disciplinary teams.
- Updated guidance to ensure clarity on when consultant attendance is required. Monitoring process introduced to identify future areas of learning and improvement
- Established referral pathway for women with pre-existing medical conditions. Continued work with wider public health bodies & our Maternity Voice Partnership for improved access to maternity healthcare & communication to our service users
- National and international recognition of pathways of excellence for care of preterm babies
- Successful national funding bid achieved with money allocated (£67,720 non recurrent payment) to support:
  - Development of Bereavement Champion roles to ensure 24/7 access to service
  - Obstetric consultant governance PA
  - Development of Maternity Support Worker (MSW) workforce

Continued Key Risks

NHS Great Western Hospitals

IEA Detail	Key Risk	Ongoing Action Plan
• Implementation of nationally accredited education module for Labour Ward Coordinators	• Lack of suitably skilled workforce • Staff wellbeing & retention of workforce	• Continued engagement with Higher Education Institutions • Anticipated funding availability via Health Education England (HEE)
• Succession planning programme and development of ongoing leadership opportunities	• Lack of succession strategies may result in challenges for future proofing service	• Engagement in National Head of Midwifery network and use of Royal College of Midwives (RCM) Toolkit to undertake succession planning
• Risk assessment of competing workloads for combined consultant rotas for Obstetrics and Gynaecology	• Lack of dedicated obstetric rota may delay consultant presence	• Establishment of monitoring process for Consultant attendance outside of onsite hours with opportunities for learning & development reviewed at Trust and Regional levels • Divisional review of Risk Assessment • Potential increase in obstetric consultant workforce may require future investment over the next 2-3 years
• Growth of Practice Development team to provide supernumerary support across all areas of the service	• Lack of suitably skilled workforce • Potential impact on retention and support for existing workforce	• Two additional clinical skills facilitators to ensure access to support 24/7 to be included in business planning 2023/24 • Implementation of supernumerary Maternity Support Worker (MSW) educator (funding for one year via Ockenden national submission)
• Availability of transfer time information to facilitate to informed choice around place of birth	• 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.	• Implementation of localised Standard Operating Procedure and embed practice of information sharing to inform women/birthing people with subsequent audit for monitoring purposes.
• Establishment of national quality metrics for monitoring anaesthetic indicators to maximise engagement and compliance	• A lack of national alignment in anaesthetic core dataset may negatively impact learning from anaesthetic events	• Engagement with national professional bodies to ensure local core data sets are in line with national standards
• Regional rotational opportunities for Neonatal staff to prevent units working in isolation • Establishment of annual reporting of these opportunities to commissioners	• Lack of shared learning and experiences may reduce the skills and development in the Neonatal workforce	• Engagement with Neonatal Operational Delivery Network to establish Regional enhanced experience programme. • Achievement will be supported by implementation of the Advance Neonatal Nurse Practitioner workforce.

East Kent Report (October 2022)

The East Kent Report was released on 19th October 2022 following concerns raised about the quality and outcomes within the service. The investigation into maternity and neonatal care, led by Dr Kirkup identified recommendations and areas for key actions, as outlined below.

Key Action Area 1: Monitoring safe performance – finding signals among noise

Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance

Key Action Area 3: Flawed teamworking – pulling in different directions

Recommendation 3

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.
- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

Key Action Area 4: Organisational behaviour – looking good while doing badly

Recommendation 4

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership

Ockenden Report (2022)

NHS
Great Western Hospitals
NHS Foundation Trust

Enabling safer maternity care