GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 4th August 2022, 9.30am to 12.15pm
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** Simon Wade, Jon Westbrook, Sanjeen Payne-Kumar (Johanna Bogle & Steve Haig deputising)	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 – 11)** Liam Coleman, Chair • 7 July 2022	✓	LC	Approve	
4.	**Outstanding actions of the Board (public) (page 12)**	✓	LC	Approve	
5.	**Questions from the public to the Board relating to the work of the Trust**	-	LC	-	
6.	**Care Reflections – Staff Story – Covid Medicine's Delivery Unit** Patricia Monteiro, ED Consultant, & Bushra Sohail, ED Consultant, to present	Presentation	PM/BS	Note	9.40
7.	**Chair's Report (pages 13 – 15)** Liam Coleman, Chair	✓	LC	Note	10.10
8.	**Chief Executive's Report (pages 16 – 23)** Kevin McNamara, Chief Executive	✓	KM	Note	10.20
9.	**Integrated Performance Report (pages 24 – 102)**			Assurance	10.40
	• Performance, Population & Place Committee Board Assurance Report (July) – Peter Hill, Non-Executive Director & Committee Chair	✓	PH		
	Part 1: Operational Performance – Felicity Taylor-Drewe, Chief Operating Officer	✓	FTD		
	• Quality & Safety Committee Board Assurance Report (July) – Nick Bishop, Non-Executive Director & Committee Chair	✓	NLB		
	Part 2: Our Care – Lisa Cheek, Chief Nurse	✓	LCh		

BREAK (10 minutes)					
	• Part 3: Our People – Jude Gray, Director of Human Resources	✓	JG		
	• Finance, Infrastructure & Digital Committee Board Assurance Report (July) – Faried Chopdat, Non-Executive Director & Committee Chair Part 4: Use of Resources – Johanna Bogle, Deputy Director of Finance	✓ ✓	FC JB		
10.	**Mental Health Governance Committee Board Assurance Report (pages 104 – 105)** Lizzie Abderrahim, Non-Executive Director & Committee Chair	✓	EKA	Assurance	11.50
11.	**Audit, Risk & Assurance Committee Board Assurance Report (pages 106 – 108)** Helen Spice, Non-Executive Director & Committee Chair	✓	HS	Assurance	12.00
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	12.10
13.	**Terms of Reference of Board Committees – Audit, Risk & Assurance Committee (pages 109 – 120)** Caroline Coles, Company Secretary	✓	CC	Approve	-
14.	**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	-
15.	**Date and Time of next meeting** Thursday 6th October at 9.30am, MS Teams	Verbal	LC	Note	-
16.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	12.15

2022				2023							
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
Developing our Digital Strategy			Financial Sustainability			Workforce, Culture & EDI			Patient Voice		

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLE TREE BY HILTON, SWINDON AND VIA MS TEAMS 7 JULY 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)	Director of HR
Peter Hill (PH)	Non-Executive Director
Paul Lewis (PL)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Director of Improvement & Partnerships
Simon Wade (SW)	Director of Finance & Strategy

In attendance

Caroline Coles	Company Secretary
Tim Edmonds*	Associate Director of Communications & Engagement
Annelli Nichols*	Nurse Clinical Lead (agenda item 70/22 only)
Claudia Paoloni	Associate Non-Executive Director
Sanjeen Payne-Kumar	Associate Non-Executive Director (part – to agenda item 73/22)
Al Sheward*	Deputy Chief Operating Officer (agenda item 70/22 only)
Kat Simpson*	Risk & Governance Lead Midwife (agenda item 77/22 only)

Apologies

Naginda Dhanoa	Chief Digital Officer
Jon Westbrook	Medical Director

Number of members of the Public: 4 members of public* (included 1 Governor: Chris Shepherd and 2 staff members observing)

*Indicates those members attending virtually by MS Teams.

Matters Open to the Public and Press

Minute	Description	Action
65/22	**Apologies for Absence and Chairman's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
66/22	**Declarations of Interest** Declarations of interest were received from two members:-	

Minute	Description	Action

- Helen Spice, Non-Executive Director who had a personal interest in agenda item 78/22. Helen remained in the meeting however did not participate in the final decision-making.
- Nick Bishop, Non-Executive Director who had a personal interest in the private session agenda item 99/22 in so far as it related to the appointment of the Senior Independent Director. Nick left the meeting during this item.

67/22 **Minutes**

The minutes of the meeting of the Board held on 5 May 2022 were adopted and signed as a correct record.

68/22 **Outstanding actions of the Board (public)**

The Board received and considered the outstanding action list.

69/22 **Questions from the public to the Board relating to the work of the Trust**

There were no questions from the public for the Board.

70/22 **Care Reflections – Patient Story**

Alan Sheward, Deputy Chief Operating Officer & Annelli Nichols, Nurse Clinical Lead joined the meeting for this agenda item

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

A short video was shared with the Board which explained how the Navigation Hub was working to support patients, their families and carers and described how the multidisciplinary team were working collaboratively across divisional and organisational boundaries to provide the best possible care whilst reducing pressure on the Emergency Department. The film recounted the story of Peter who together with his late partner, Roger, benefitted from the new service in connection with end of life care.

There followed a discussion which included partnership working, system involvement and the role of the GP.

The Chair thanked both Al and Annelli for sharing what is the first step on a journey to help patients navigate a very complex healthcare structure. The pilot had the full support of the Board particularly in bringing all parties across health and social care to the table to embed this initiative further.

The Board **noted** the care reflection.

71/22 **Chair's Report, Feedback from the Council of Governors**

The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally, this included:-

- The Trust had welcomed a new Governor representative for Wiltshire County Council, Cllr Nick Holder.

Minute **Description** **Action**

- The re-appointment of two Non-Executive Directors; Nick Bishop and Andy Copestake.
- The appraisal process for both Chair and Non-Executive Directors had commenced.
- The first Board Seminar session in line with the agreed new Board timetable was held in June 2022 based on well led and the Board's role and leadership behaviours that underpinned the Improving Together approach.
- The Board Safety visit to the Maternity services.
- The new Board sub committee structure that came into effect in June 2022,
- The short Board meeting held in private in June 2022 to accommodate timelines of various annual reports and the BSW Planning re-submission.
- Key meeting dates, with particular note of the opening of the new Radiotherapy Unit.
- In addition it was noted that the new Urgent Treatment Centre would also be opened tomorrow, 8 June 2022.

The Board **noted** the report.

72/22 **Chief Executive's Report**

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

Covid Position – Although the number of patients with covid declined through April/May 2022 the numbers had increased significantly in the past week. The incident control meetings had been scaled up for visibility and senior decision making and the Trust had also re-introduced mask wearing.

Operational Pressures – The Trust were working within the ICS Acute Alliance to support operational pressures including offering mutual support throughout the South West.

Faried Chopdat, Non-Executive Director commented that a lot of work in processes and structures had been put in place to deal with operational pressures and asked what work had been done to help staff to build new compentancies and skills in order to deal with these challenges. Kevin McNamara, Chief Executive replied that over the past 18 months there had been several opportunities to test people's resilience with lessons learnt through the Emergency Preparedness, Resilience and Response team who build on the skills and experience. This was also self assessed by ICB colleagues as a critical friend to ensure the skills are in place.

Site Resilience - Major projects had been completed over the past few months to support and improve site resilience which included increase in oxygen capacity and transition to a new electricial system.

Monkeypox – The Trust had developed plans for managing any patients who presented with systems of Monkeypox however cases remained low in the South West.

System oversight framework - As part of its oversight framework, NHS England allocated trusts and Integrated Care Boards to one of four segments based upon the scale and general nature of support needs. These ratings range from Segment 1, where no specific support is required, to Segment 4, where there is a requirement for mandated intensive support. As a Trust we had retained our position in Segment 2.

Minute **Description** **Action**

Developments on site - The first of the three new mobile diagnostic units were delivered on site at the start of this month. This would give the Trust extra diagnostic capacity and, specifically, would allow a mobile PET-CT scanner to operate on the GWH site.

Nick Bishop, Non-Executive Director asked if additional radiologists would be required with the expansion of mobile diagnostic. Felicity Taylor-Drewe, Chief Operating Officer replied that employed staff were part of the bundle for the new pads, however it was noted that good progress had been made in recruitment in this area and the gap had been reduced considerably.

Staff Excellence Awards – Last month the Trust held its Staff Excellence Awards. Congratulations went to all the winners and those nominated for an award this year. Thanks also went to the organising team who worked extremely hard to deliver a great event.

Congratulations also went to our Admiral Nurses, Tim Allen and Hannah Rogers, who won the South West Parliamentary Award in the Nursing and Midwifery category.

Paul Lewis, Non-Executive Director asked if these awards would be posted on the Trust's website. Tim Edmonds, Assoicate Director of Communications & Engagement replied that a revamped 'Book of Great' was being worked on together with fine tuning the website for a permanent home and legacy.

Lizzie Abderrahim, Non-Executive Director commented that the Staff Excellence Awards had been excellent and also gave credit to those involved in making the event such a success.

The Board **noted** the report.

73/22 **Integrated Performance Report**

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

Part 1 : 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 meeting on 25 May and 29 June 2022 and the following highlighted:-

Diagnostic Service - The service remained under enomormous pressure however lots of improvement plans were in place which included the mobile diagnostic platform, new radiotherapy unit and dexa scan replacement together with success in recruitment programme for some traditionally hard to fill posts.

Emergency Access - Although the service continued to be under significant pressure there had been improvement due to the reduced number of non-criteria to reside patients as a result of ongoing partnership work particularly with South West Ambulance Service.

Referral to Treatment Time - The Trust had excellent performance with patients waiting over 2 years and waiting over 78 weeks, the best performance Trust in the South West, however over 52-week waiters had increased and were included in the planning scrutiny at the new Weekly Access meetings to improve the position.

Minute **Description** **Action**

Liam Coleman, Chair welcomed the above points as the RTT key performance indicator (KPI) on the performance summary did not show the good performance and highlighted the fact that there were multiple factors that affected this performance and the narrative should be more informative to reflect this. Felicity Taylor-Drewe, Chief Operating Officer advised that the Integrated Performance Report would shortly change and would be presented to Performance, Population & Place Committee in July 2022 and the two formats would double run during the transition period. Paul Lewis, Non-Executive Director remarked that he would be interested to see how benchmarking would be captured in the new IPR.

The Board received and considered the Operational element of the report and the Chief Operating Officer highlighted the following:-

- There was a national focus on utilising mutual aid to deal with the impact of covid on patient care, particularly 104 week waits. All providers had been requested to indicate what offers of support could be provided both at a local and system level. The Board would be kept appraised with this new ask through the Performance, Population & Place Committee particularly around any impact on performance.
- The main impact of covid numbers was not bed capacity but staff sickness.

Lizzie Abderrahim, Non-Executive Director asked for clarity on the geographical area covered for the mutual aid request particularly that outside the region as this had the potential to impact on the Trust's performance. Felicity Taylor-Drewe, Chief Operating Officer replied that the remit covered the South West but predominantly Devon and Bristol, North Somerset and South Gloucestershire (BNSG).

Andy Copestake, Non-Executive Director commented that the length of stay of patients appeared to be going in the wrong direction and asked how much focus there was on reducing this from both an efficiency and patient care prospective. Felicity Taylor-Drewe, Chief Operating Officer responded that there was a two fold action plan. Firstly to ensure the data was robust and secondly to strengthen the non-criteria to reside process which has been factored in as part of the winter planning.

Claudia Paoloni, Non-Executive Director commented that the new scanner would increase efficiency and asked if a review of all equiment was undertaken to upgrade in order to improve efficiency. Felicity Taylor-Drewe, Chief Operating Officer responded that there was a clear replacement programme and the specialty teams worked with the estates team to ensure this was completed in a timely manner.

Part 2 : 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 meeting held on 19 May and 23 June 2022 and the following highlighted:-

Assurance - From an assurance perspectives there were some improvements as there were more green ratings.

Medicine safety - Reported medication incidents had increased slightly but this was believed to be due to improved reporting.

Minute **Description** **Action**

Infection Prevention & Control - C.diff had reduced and remained within its trajectory for the year.

Pressure Ulcers - There had been a reduction in pressure harms noted again this month in acute but a slight rise in community where there had been an increase in Category 2 harms but 3 & 4 had reduced.

Staffing – There was continued success in the recruitment of Healthcare Assistants (HCAs).

Serious Incidens – Numbers remained within control limits. There was continued efforts to reduce the number of outstanding investigations which were having some effect.

Electronic Discharge Summaries (EDS) - A detailed report was considered at the Committee which highlighted the number of challenges. Some internal transfers were generating an expectation of EDS when this was not necessary as records are transferred or available. It was noted that without an upgrade of IT software this issue would continue for some time. An audit was performed and there was no evidence of adverse impact on patient care found.

WHO Checklist - There had been significant improvement in compliance with the WHO checklist and the Medical Director was congratulated for achieving 99-100% compliance.

Liam Coleman, Chair expressed his thanks to the Committee for driving this improvement and also the Medical Director and his team who worked on this important piece of work.

Quality Accounts 2021/22 - The Committee approved the Quality Accounts for 2021/22 as delegated by the Board. It was noted that this was much improved and well put together report.

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

- The focus continued on infection prevention and control (IP&C) led by the new IP&C Lead to reduce the ebb and flow challenges within IP&C due to the impact of covid.
- The other concern over the past few months had been antibiotic prescribing. A deep dive had been undertaken by the Chief Pharmacist and the initial results showed that the increase in incidents was not correlated to patient harm but a good reporting culture. Once the full review had been undertaken it would be presented to the Quality & Safety Committee. It was also noted that the Deputy Medical Director would take over the lead in this area.

Part 3 : Our People

People & Culture Committee Chair Overview

The Board received a verbal update of the detailed discussions held at the People & Culture Committee (P&CC) around the workforce element of the IPR at the meeting held on 28 June 2022 and the following highlighted:-

- Overall a good first meeting which signed off the terms of reference and reviewed the workforce element of the IPR .
- The only area of concern was workforce planning in part due to the WTE levels against budget and the challenges with locum and agency with new recruits in.

Minute **Description** **Action**

Assurances were gained from the Chief Nurse and Medical Director that actions were being taken and the issue being managed tightly.

- Future agenda items were considered particulary how the Committee would bring in the culture element into the agenda, people and culture risks and the approach in reporting the recommendations from the recent Messenger report.

There followed a discussion on the remit of the new Committee which included the key performance indicators for culture and sickness management. It was noted that an internal audit would be undertaken on culture maturity which would feed into this Committee.

The Board received and considered the Workforce performance element of the report and the Director of HR highlighted the key areas in the Messenger Report, the fluctuation in staff sickness absence and the new national process in terms of reporting sickness due to covid.

Part 4 : Use of Resource
Finance & Infrastructure Committee Overview
The Board received an overview of the detailed discussions held at the Finance & Infrastruture Committee around the financial element of the IPR at the meeting held 25 May and 27 June 2022 and the following was highlighted:-

- This was the first meeting under the new remit, taking in Estates and IT with a new Chair, Faried Chopdat.
- Assurance was given for all reports which were of high quality and reflected the Executive and their teams' effort to make them comprehensive and informative.
- In month 1 & 2 there was a huge number of red and amber risks as the financial position changed from last year. The Trust was in a less favourable position this year and month 2 was adverse to plan with continued conern around the Unscheduled Care Service (UCS) albeit the Executive had placed the service into enhanced monitoring.
- The Committee was comfortable with the risk process and reporting of financial risks but requested management to reflect on and review the risk scores of the four new risks. The Committee asked for the risk report to include IT, Digital, and Infrastructure risks.
- The Improvement and Efficiency Plan was considered which focusssed on the CIP programme and its associated risks especially the pace of identifying the gaps and the delivery of the £11.1m target.
- A detailed report was provided with regard to the five yearly benchmarking processes for soft FM services supplied under the PFI contract – 3 options were presented outlining key benefits and disadvantages. The Finance & Infrastructure Committee were delegated by the Board and approved the commercial offer.
- A good report was provided to the Committee on the performance of Procurement services which included key lessons learnt during 2021/22. Overall, the Committee were pleased to see good performance in light of the operational challenges experienced by the Procurement team and the ongoing collaboration across the three acute trusts.

There followed a robust discussion around the concern on the delivery of the CIP programme particularly the tighter controls and pace required and further assurance was sought by the Board on management actions being taken to tackle this significant risk. The initiatives put in place were described which included enhanced monitoring and a

Minute	Description	Action

grip and control self assessment together with the transformational opportunities. It was noted that a full report would be presented to the Finance & Infrastruture Committee followed by an update at Board in August 2022.

Action : Director Improvement and Partnerships CT

The assurance ratings within the Board Committee Assurance Report were also discussed particularly escalation to Board when the assurance rating was red. The Chair clarified that in terms of CIP delivery he was satisfied that the Finance & Infrastruture Committee were applying the right challenge, frequency and pressure and that new ways of working were being embedded. Any escalation for Board support would come from the appropriate Board Committee Chair.

The Board received and considered the use of resource element of the report and the Director of Finance & Strategy highlighted the achievements of the Way Forward Team in the completion of the Urgent Treatment Centre and the Board thanked the team for all their hard work and effort in this significant milestone for the Trust.

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

74/22 **Mental Health Governance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Mental Health Governance Committee (MHGC) meeting on 8 April 2022 and the following highlighted:-

- The Committee wished to formally thank the Trust staff for their efforts and care for patients that were treated in the hospital due to issues outside the Trust's control specifically the availability of acute mental health beds.
- The significant amount of work associated with the implementation of the new Liberty Protection Safeguards (LPS).

The Board **noted** the report.

75/22 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) meeting on 4 May 2022 and it was highlighted that there was considerable scope to increase Divisional spending which would be incorporated within the plans to rationalise the 81 Charitable Funds.

The Board **noted** the report.

76/22 **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 16 June 2022 and it was highlighted that the internal auditor's annual report for 2021/22 had provided an overall moderate assurance opinion for the Trust. The Committee was assured that good progress had been made in the Control Design ratings over the last three years but although there was some improvement in Operational Effectiveness ratings there was still some work to be done. It was noted that no trust had achieved a substantial rating.

The Board **noted** the report.

Minute	Description	Action

77/22 **Full Ockenden Report – Immediate & Essential Actions (IEA) Breakdown**
Kat Simpson, Risk & Governance Lead Midwife joined the meeting for this agenda item

The Board received and considered a paper that provided an overview of the Immediate & Essential Actions (IEA) outlined in the full Ockenden Report (released March 2022) including current RAG ratings, anticipated actions, key risks and potential investment requirements.

The following was noted:-

- The current Head of Midwifery would be retiring in September 2022 and Kat Simpson was the replacement. The Board welcomed Kat to the meeting.
- Ockenden was a part of maternity safety which was scrutinised in totality at the Quality & Safety Committee however there was a requirement for the Board to see full progress and this would intermittently be presented to Board.
- The detailed update on local progress on the recommendations.
- That the longer term actions were wider than maternity and would be part of transformational work within the Trust.

Paul Lewis as the Non-Executive Director Maternity Champion confirmed his level of confidence in the robustness of reporting recognising that there were long term actions.

There followed a robust discussion on the action plan which included over cautiousness on rag ratings, the level of increase in training uplift, the increasing pay incentive rates in neighbouring areas, prioritisation of actions and governance.

The Chair thanked the maternity team for all their hard work and Paul Lewis for his oversight as an Non-Executive Director.

The Board **noted** the report.

78/22 **Amendment to the Trust Constitution – Eligibility of Non-Executive Directors & Executive Directors**
Helen Spice, Non-Executive Director declared an interest in this agenda item and did not participate in the decision-making.

The Board received and considered a paper that provided a proposal to amend the Trust's Constitution in order to lift the restrictions for both Non-Executives Directors and Executive Directors to work with another trust, this adjustment was particularly timely with the establishment of Integrated Care Systems for joint working by Executive Directors which would become more common as the ICS/ICA's evolved.

Following consideration of the risks particularly around conflicts of interest and the mitigating factors the Board supported the amendment. The next stage was to seek approval from the Council of Governors.

RESOLVED

to approve the proposed amendment to the Trust's Constitution.

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.

79/22 **Ratification of Decisions made via Board Circular/Board Workshop**

None.

80/22 **Safe staffing 6 month review for Nursing, Midwifery and Allied Health Professionals**

The Board received the paper that provided assurance on the safe systems and processes in place to manage Nursing, Midwifery and Allied Health Professionals staffing over the last 6 months.

The Performance, People & Place Committee had reviewed and scrutinised the report at its meeting held in May 2022.

The Board **noted** the report.

81/22 **Quality Account 2021/22**

The Board received the final Quality Accounts for 2021/22 which had been reviewed and approved on behalf of the Board by the Quality & Safety Committee in June 2022.

RESOLVED

to ratify the Quality Accounts for 2021/22.

82/22 **Terms of Reference of Board Committees**

The Board received a paper that provided the updated terms of reference for the Board Committees following the changes to the Board Committee structure in June 2022. The paper contained the terms of reference for the following Committees:-

Quality & Safety Committee
Finance & Infrastructure Committee
People & Culture Committee
Performance, Population & Place Committee
Mental Health Governance Committee
Charitable Funds Committee
Trust Management Committee

It was noted that the Audit, Risk & Assurance Committee and Remuneration Committee would be presented to Board for approval at a later due to timeliness of meeting dates.

RESOLVED

to approve the terms of reference for the Board committees as outlined above.

Minute	Description	Action

83/22 **Register of Interests and Declaration of Interests at Meetings**

The Board received a paper that provided an annual reminder to members of the Board of their obligation to register any relevant and material interests as soon as they arise or within 7 clear days of becoming aware of the existence of the interest and to also make amendments to their registered interests as appropriate. It also provided a a copy of the Register of Interests of the Board of Directors for review, which best practice suggested should be undertaken on at least an annual basis.

RESOLVED

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

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

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

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

84/22 **Urgent Public Business (if any)**

None.

85/22 **Date and Time of next meeting**

It was noted that the next meeting of the Board would be held on 4 August 2022 at the Double Tree by Hilton Hotel (MS Teams facility would also be available).

86/22 **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 1608 hrs.

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – August 2022				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
07-July-22	73/22	**Integrated Performance Report : Use of Resources** Full report detailing the actions taken to assure the Board on the delivery of the CIP programme particularly the tighter controls and pace required.	Director of Improvement & Partnership	On agenda in the private session of Board

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

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**4 August 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):

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
- System 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	26 July 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 July 2022.

Council of Governors

The Council of Governors bid farewell to two appointed governors, Nick Ware and Amanda Webb whose terms of office came to an end with the closure of the Bath & North East Somerset, Swindon & Wiltshire (BSW) Clinical Commissioning Group (CCG) and the establishment of the BSW Integrated Care System (ICS). On behalf of the Council of Governors and the Trust I would like to thank both Nick and Amanda for their time and commitment during their tenure as governors.

Non-Executive Directors

The Board approved the re-appointment of Nick Bishop as Senior Independent Director (SID) at its Board meeting held in private session in July 2022. This appointment will be held until Nick's end of term, 31 July 2023 and succession planning for this role is currently being considered.

Strengthening Board Oversight

Two Board safety visits took place during the period covered by this report, one planned, to Theatres conducted by Nick Bishop, Non-Executive Director and Tobenna Onyirioha, Deputy Medical Director and one, unannounced, to the Special Care Baby Unit (SCBU) & Neonatal Service, by Lizzie Abderrahim, Non-Executive Director and Jon Westbrook, Medical Director.

Local Update

- The Board approved the Trust's Annual Report and Accounts 2021/22 for submission to NHSE/I and to Parliament at its Board meeting held in private session in July 2022.
- On Friday 8 July 2022, the new Urgent Treatment Centre was formally opened on the hospital site. The ribbon-cutting ceremony marked one of the biggest milestones for the Trust in recent years and follows the opening of the new OUH Radiotherapy Centre on the GWH site two weeks ago. The new facility was made possible after the Trust successfully bid for £15m of funding and demolition began on the old Urgent Care Centre last May.

System Working Update

The Chair and Chief Executive attended an Acute Hospital Alliance (AHA) Away Day in July 2022 which focussed on developing a clear set of priorities to focus on across the three acute trusts in the Integrated Care System (ICS). There is much to be gained through partnership working with the Acute Alliance and a shared sense of commitment in areas where we are all grappling with the same issues. Further sessions are planned post-summer.

Key Meetings during July 2022

Meetings	Purpose
Monthly Chair/ Lead Governors Meeting	Regular meeting to update and discuss any topical issues.
Bi-monthly NED meeting	Regular meeting to update and discuss any topical issues.
Chairs & CEO ICS Health Meeting	Regular meeting bringing together healthcare providers within the BSW ICS.
AHA Committee in Common Away Day	An Away Day (as referenced above) between the three acute hospital trusts within the Bath and North East Somerset, Swindon and Wiltshire (BSW) Partnership – Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, and Salisbury NHS Foundation Trust.
Opening New Urgent Treatment Centre at GWH	Attended the Opening ceremony for the new Urgent Treatment Centre at GWH.
Leading Healthy Cultures Sessions	Facilitated by NHSE/I SW region to embed the wellbeing framework in the region and to develop the leadership role in shaping healthy cultures.
1-2-1 meeting with Chief Executive	Regular meeting.

Report Title	**Chief Executive's Report**				
Meeting	**Trust Board**				
Date	4 August 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:

- Covid-19
- The Covid-19 vaccine booster programme
- Managing current pressures
- Our response to a critical incident
- Re-accreditation for the endoscopy service
- Opening of our new Urgent Treatment Centre and community open day
- Covid-19 public inquiry
- Improving Together
- 2022/23 NHS Pay Award
- Our latest STAR of the Month winner
- Celebrating South Asian Heritage Month

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 opening of our new Urgent Treatment Centre. This building was designed with input from patients and carers who had used our services before in order to ensure it met their needs from a design perspective.

The building also houses the Trust's first ever Changing Places facility for children and adults with disabilities, after this issue was raised by Mums on a Mission, a local group who have campaigned for some time for these facilities to be introduced.

There is also an update on the Covid booster vaccination programme. The pandemic has disproportionately affected some groups of people and patients with pre-existing conditions which means they are more vulnerable to the impact of catching the virus.

Recommendation / Action Required
The Board/Committee/Group is requested to:

- **Note the report**

Accountable Lead Signature	Kevin McNamara
Date	29 July 2022

1. Operational updates

1.1. Covid-19

Latest patient numbers will be provided at the Board meeting.

Since the last Board meeting, we have seen an increase in inpatients with Covid and this has remained high for the past few weeks, peaking towards the end of the month before slowly dropping again.

Although the majority of patients do not have Covid as their primary diagnosis, there are indications that this has started to increase.

We have also seen significant numbers of staff off sick with Covid, and although this has shown signs of reducing, staffing levels have been challenging at times when set alongside other issues such as annual leave.

Current safety measures remain in place with mask-wearing in clinical areas, corridors and staircases.

1.2. Covid booster vaccine

All adults over the age of 50, frontline heath and care workers and people under 50 who are deemed to be more at risk of falling seriously ill with coronavirus will be invited to receive Covid booster vaccines in the autumn.

The autumn booster offer is also being extended to carers over the age of 16 and those who share a home with someone who has a weakened immune system.

Recently, people over the age of 75 were invited to take part in the spring booster vaccine programme.

Vaccinations continue to be available from a range of locations across the region, including the Steam Museum in Swindon, Bath Racecourse, and Salisbury City Hall.

Many smaller community venues are also providing a vaccination service, including pharmacies and GP practices. People can find their nearest vaccination centre, as well as book their vaccine appointment, by visiting www.nhs.uk

1.3. Managing current pressures

Patients with no criteria to reside in hospital and delays in the handover of patients to us from ambulance crews continue to cause operational challenges and present a real risk to patient safety and experience.

We are embedding the new Swindon Integrated Care Alliance Coordination Centre within the system at the hospital and this will be formally launched next month.

This initiative has brought our staff in to the same room alongside staff from Swindon Borough Council, Wiltshire Council, SWASFT and others together as single team to support patients in accessing care they needed and reduce pressure on the ambulance service and our Emergency Department. Early indications show a positive impact from the navigation hub – part of the coordination centre – bringing new energy and ideas to a long-standing issue.

1.4. Critical incident

On 20 July we declared a critical incident due to issues with a number of IT systems at the Trust.

The impacted systems included:

- Internet connectivity
- Appointment booking system
- Nervecentre
- Careflow
- ICE in radiology and pathology
- Discharge and flow systems
- Some printers

Switchboard and other phone lines across the Trust worked as normal and affected teams used their business continuity plans while the IT Department worked to resolve the issues as quickly as possible.

Following a reboot, the systems were up and running and the critical incident was stood down after around four hours.

An investigation is being carried out in to what caused the incident, along with a debrief of how we responded to it as an organisation.

2. Quality

2.1. Endoscopy

Following an assessment of the Endoscopy service in May, we have received official confirmation from the Royal College of Physicians Joint Advisory Group (JAG) on GI Endoscopy that the service has been re-accredited.

The team have worked hard to make improvements since last year's visit and provided good assurance and evidence to JAG over the last few months.

JAG accreditation is for five years, subject to successful completion of an annual review. In the fifth year a full re-accreditation assessment is undertaken to renew this accreditation.

2.2. Diagnostic capacity

We are now working with InHealth, the UK's largest specialist supplier of diagnostic solutions to offer PET CT scans on the GWH site.

The team are currently on site one day a week and can see 20 patients in one day, meaning they do not need to travel to other hospital sites for scans and can have diagnostic treatment much closer to home. The PET CT scanner is in addition to the mobile MRI scanner now on site.

3. Systems and Strategy

3.1. Reducing spending on agencies

Nationally all systems have been asked to significantly reduce the spend on agency staffing, with control targets set for Integrated Care Boards.

The amount our Trust spends on agency staff will need to be significantly reduced and we will be working closely with colleagues across BSW to work together to explore the potential for developing a collaborative bank which will enable us to plug staffing gaps at reduced costs.

Systems' performance on reducing spending on agencies will be closely monitored as part of the NHS Oversight Framework.

3.2. Urgent Treatment Centre

Our new Urgent Treatment Centre opened its doors at 7am on 27 July to treat its first patient.

The opening follows the official ribbon-cutting for the centre earlier in July, by staff and patient Jane Hawkins, one of the patients who provided input into the design of the centre.

The new centre has additional clinic rooms and space in both the adult and paediatric waiting areas and also houses new plaster and ophthalmology rooms.

The centre uses calming colours, a nature theme in the children's waiting area and displays artwork donated by local children, depicting their NHS hero.

It also has the Trust's first ever changing places facility for children and adults with disabilities, after this issue was raised by local group Mums on a Mission.

3.3. Community Open Day

Around 200 members of the public attended our community open day which offered guided tours around the site, and some services attended to talk about their work members of the public. A history exhibition took place in the Academy, where visitors

could also watch virtual tours of the Urgent Treatment Centre and Radiotherapy Centre, which were not open to the public at that point.

We held the open day to say thank you to our community who have been so supportive of us, and to update them on the site development to date and an overview of what's planned for the future.

3.4. Covid-19 public inquiry

The public inquiry into the UK's Covid-19 response, chaired by Baroness Hallett, has opened and is likely to run for a number of years.

The inquiry is very wide ranging, but the parts of its terms of reference most directly relevant to our Trust includes:

- Primary care; care delivered in the home; care homes
- Management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels.

Caroline Coles, Company Secretary, will coordinate for the Trust and work is underway to ensure documentation of decision-making during the pandemic is in good order.

3.5. Improving Together

Improving Together continues to be rolled out and embedded within the Trust and where the huddles have been introduced, these are working really well. For the first time, we held our quarterly Chief Executive team reviews with each of the clinical Divisions using the Improving Together methodology.

There were some clear successes – notably substantive recruitment in primary care, a significant drop in ambulance handover delays, development of the coordination hub, and a consistent delivery of the WHO checklist in surgery for the first time.

Some clear themes also emerged for areas where we need to focus – including delivery while facing a very high degree of uncertainty, and our financial performance.

In addition a number of the Executive team had the opportunity to see our first improvement huddle in action in SwICC. This was an impressive display of energy, positivity and ideas generated by the team to make and own improvement in their area.

4. Workforce, wellbeing and recognition

4.1. Pay award

The Government announced the annual pay award for NHS staff last month.

NHS Pay Review Body: Staff on NHS terms and conditions will receive a minimum uplift of £1,400 in pay backdated to 1 April 2022. Those on lower pay bands will receive the biggest uplift.

Doctors and Dentist Review Body: Doctors within the review body remit for this year will receive a 4.5 per cent pay rise. The Government has stated that those staff already covered by multi-year pay deals were not in scope of the review body recommendations for this year, so junior doctors will not get an additional uplift.

At the time of writing we were waiting for confirmation of how the pay award affects each band and will pay staff their new salary, and backdated pay to April 2022, as soon as possible.

It is frustrating that not all staff groups will benefit from the increase as we are one team working together, whatever our roles, to ensure that our patients receive the highest quality care possible.

Although we acknowledge the pressure on the public purse, we also recognise that with the cost of living significantly increasing, this represents a below-inflation pay award.

An additional £2bn will be allocated to systems to cover additional cost of pay increases above the level allocated but the full impact on Trusts of the pay award is not yet clear. Funding to support the allocation will be redirected nationally from other investment priorities including digital and diagnostics.

4.2. STAR of the Month

Our latest STAR of the Month winner is Healthcare Assistant Amanda Smith, from Falcon Ward, who was recognised for the amazing patient care she provides. She initiated an idea to buy a hair washing facility to enable staff to wash bed-bound patients' hair. Amanda brings in multiple varieties of toiletries to ensure there's always something the patient will like.

4.3. Great West Fest

Our second Great West Fest will take place on Saturday 3 September in Town Gardens, Old Town, Swindon.

All the 2,000 tickets for the event were booked within three days of announcing the event would take place.

We held the event for the first time last year as a chance for staff to come together in person with friends, family and colleagues and it proved to be very popular.

This year's event will feature a great line-up of artists, bands and performers, funfair rides, a circus skills area, food vendors, face painting and more.

4.4. South Asian Heritage Month

This month marks South Asian Heritage Month. At our Trust we have more than 400 staff of South Asian descent and we marked their contribution by producing a short film in which some of our colleagues share what makes them smile about their culture and some of the differences they notice with British culture. The main GWH restaurant has also been offering a themed South Asian menu.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**4th August 2022**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Lisa Cheek, Chief Nurse				
Report Author	Al Sheward – Deputy Chief Operating Officer Rayna McDonald – Deputy Chief Nurse Claire Warner – Associate Director of HR Operations Elizabeth Hills – Head of Financial Management				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC Chart – Pay				

Purpose

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

Assurance Level

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

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

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

Report

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

The Integrated Performance Report provides a summary of performance against the CQC (Care Quality Commission) domains and the 4 pillars of the Trust Strategy. Unfortunately, due to the focus on identifying additional financial efficiencies at the Trust it was decided not to renew the Public View licence and so the usual comparison to national and peer performance using Public View data is no longer available.

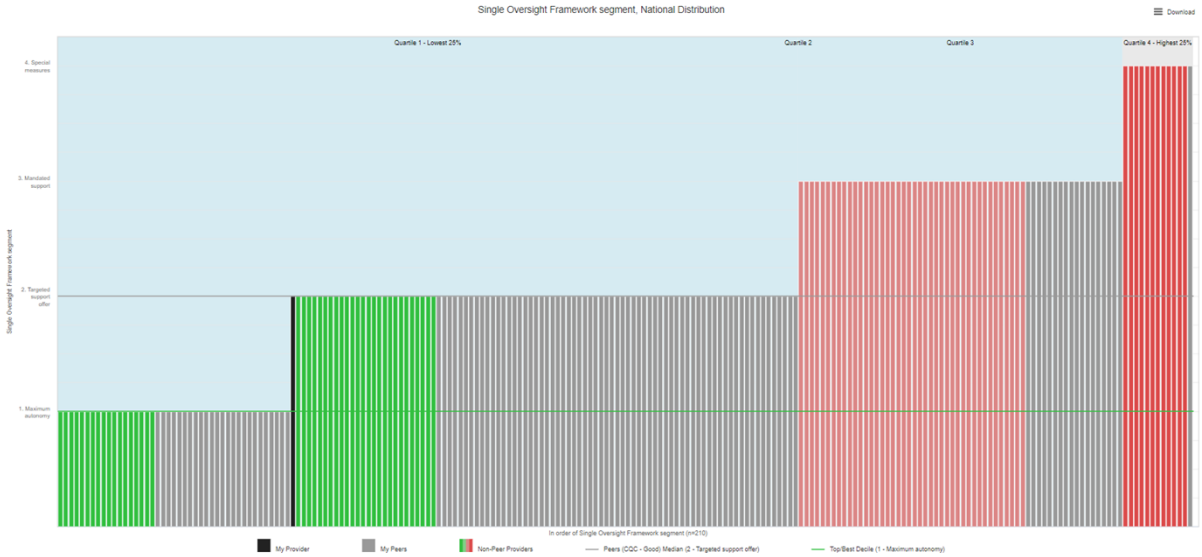
However, similar comparative data against peers and CQC cohorts has been sourced from Model hospital for this month, though as with Public View, the available data is often several months in arrears.

Key highlights from the report this month are:

Our Performance

Measured against the Model Hospital Single Oversight Framework (SOF), Great Western Hospital falls within the Targeted Support Offer segment, though we are situated on the cusp of Maximum Autonomy

when ranked in order of SOF segment. The below graph shows all Trusts nationally, with those with a CQC rating of 'Good' shown in grey, highlighting our favourable position in comparison to much of this cohort.



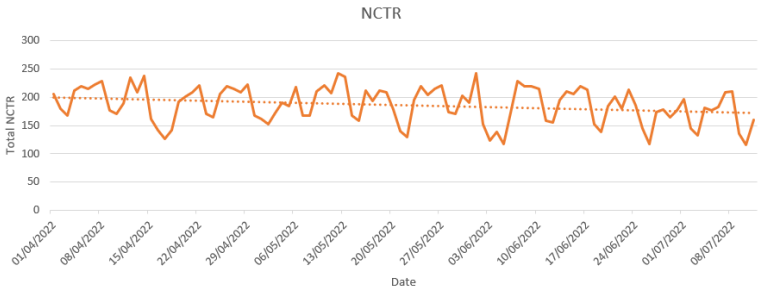
There are several metrics tracked within the Single Oversight Framework within Model Hospital, which provide a useful comparison to both those Trusts rated as 'Good' by the CQC as well as our direct peers within BSW of RUH and SFT:

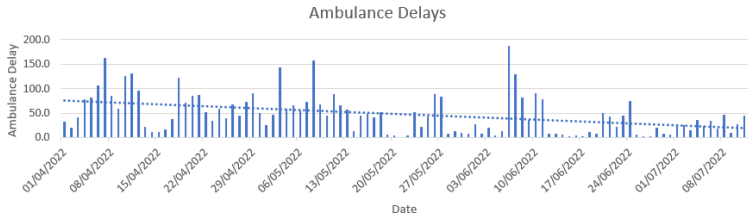
- A&E 4 Hour Wait Performance (May 2022)
  - GWH – 73.92%
  - CQC 'Good' Median – 71.89%
  - BSW Median – 69.12%
- RTT – 18-week incomplete wait (April 2022)
  - GWH – 57.40%
  - CQC 'Good' Median – 65.07%
  - BSW Median – 64.86%
- Diagnostic – 6 week waits (April 2022)
  - GWH – 49.97%
  - CQC 'Good' Median – 75.07%
  - BSW Median – 74.91%
- Cancer – 62 day wait from urgent GP referral (April 2022)
  - GWH – 73.47%
  - CQC 'Good' Median – 68.68%
  - BSW Median – 74.56%
- Cancer 62 day wait – NHS cancer screening service referral (April 2022)
  - GWH – 96.00%
  - CQC 'Good' Median – 78.17%
  - BSW Median – 31.43%

URGENT & EMERGENCY CARE

Hospital Handover Delays (HHD) reduced from 1480 in May to 1013 hours lost in June. 71 patients waited more than 4 hours to leave an Ambulance in June with 918 patients waiting more than 15 minutes. There has been a reporting change in May 2022 to include **ALL** ambulance delays and not just those previously considered to be "chargeable". Overall Ambulances conveyances have increased since April 2022 despite SWAST reporting a below national average conveyance rate. Overall, there has been an overall reduction in patients waiting the longest times with a reduction in patients waiting more than 60, 15 and 15 minutes.

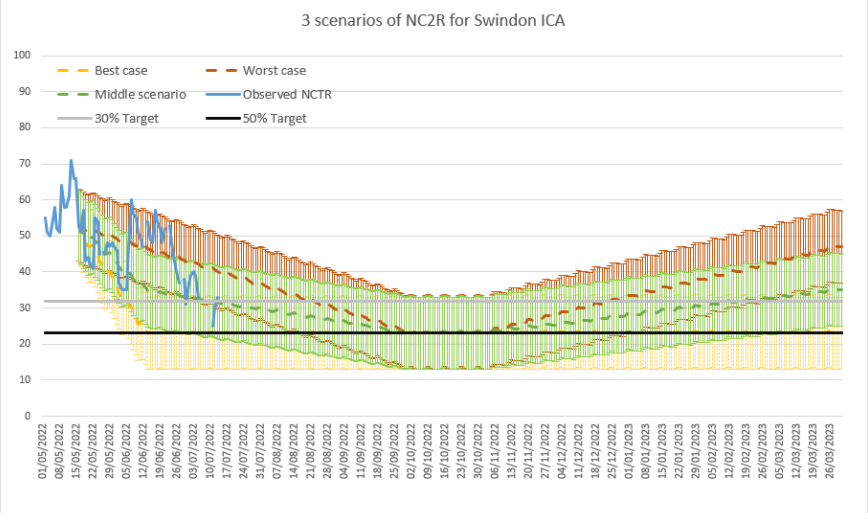
- Since April 2022 GWH have seen a reduction in the number of patients with NC2R awaiting partner supported discharge to the near 30% reduction.
- This corelates with a reduction in the number of Hours Lost to Ambulance Handover delays for the same period.





In June 2022 there has been an improvement in 4-hour performance of 2.69%. There has been a small reduction in ED attendances in Just 199 in ED Type 1 and 323 in ED Type 3. The Urgent Treatment Centre remains closed overnight. There were 67, 12-hour reportable Decisions to Admit (DTA) breaches which is a reduction from May where there were 98. In the coming months all patients who wait >12 hours will be reported. The final reporting metrics are currently being consulted on. The department is working on an A3 improvement plan for Time to initial assessment. Clinically Ready to Proceed (CRtP) measures are now in place.

Model



The models frame uses 16th of May as a baseline, includes demand an adjusted trend line for BSW that uses recent trend. Intervnetions as outlined on the assumption page are added into the model. Each scenario inputted into the model influences the frame in different ways:

Best case reduces the trajectory by the intervention assumptions

Worst case adds 50% uplift to demand and reduces the intervention assumptions to 50% estimated.

Middle case is middle line between the two.

DISCHARGES - The number of patients waiting to leave the Trust who require support from partner organisations Decreased in July almost achieving the 30% reduction for Swindon residents. However, the combined NC2R position for all patients including Swindon, Wiltshire and Out of area remains above the 30% and 50% reduction for the 4th month. The Integrated Care Alliance (ICA) has a specific action plan in place to address this.

Pathway zero run rate remains high. >95% of patients who leave the Trust leave on Pathway 0. Numbers of discharges at weekends falls significantly in all pathways including Pathway 0. The number of patients who have been in the Trust for >21 days waiting to be discharges has reduced to 42 from 50 patients. The number of patients who have been in the Trust >50 days is has seen a reduction from 14 to 11. Community services, in conjunction with Swindon Borough Council have commenced a Discharge to Assess (D2A0 programme which aims to see one patient discharged on a D2A pathway. This will support increased level of support and assessment in the community.

COMMUNITY – Urgent Community Response continues to exceed the national target of 85% - 95%. Average call Wait times for General Practice have continued to worsen since April 2022. Wait times have increased from 25mins to 35 mins. Number of referrals to the Virtual Ward continued in June 2022. However, number of new patient referrals remains low. The run rate of people in the Virtual Ward continues to increase to 33 in June. Average LOS across the 3 wards is 17.63, a reduction compared with May. LOS benchmarks well against intermediate bed services in BSW SwICC = shortest and remain below the average LOS across BSW which is 27 days.

COVID - Overall numbers of patients with Covid continue to increase. The peak of Covid cases in June 2022 was 65 patients. Over 80% of inpatient covid is identified as an incidental finding. The number of patients requiring Level 3 care (ITU) continues to remain low with some periods of June without any patients in ITU with Covid 19. Staff absence in response to Covid 19 remains high.

RTT - The Trust reported an RTT Incomplete Performance of 59.65% in June 2022, a deterioration of 0.50% in month. The Trust reported a waiting list of 32,579 (an increase of 876 in month) against a trajectory of 31,968 (611 behind trajectory). The highest movements in month were Derm, Paeds & Gen Surg. The Trust received 9,678 referrals in June 2022, which is 8% lower when compared to the previous month. Cardiology, Orthotics and Oncology received the highest increase in referrals in month. 1,028 x 52-week reportable breaches were declared in June 2022, an increase of 176 in month. Neurology, Gastro and Dermatology saw the biggest increases in month, whilst T&O, Ophthalmology, ENT & Oral all saw reductions. 2022, an increase of 176 in month. Neurology, Gastro and Dermatology saw the biggest increases in month, whilst T&O, Ophthalmology, ENT & Oral all saw reductions.323 x in month breaches were reported in June 2022, a reduction of 26 over the previous month.

DIAGNOSTICS - Performance was 49.867% in May compared to 49.97% in April 2022. Overall, the total waitlist size has increased to 11,810 compared to 11,476 in April. Breaches have also increased from 5,471 to 5,922.

CANCER - (Mays performance)

- **Cancer 2 Week Wait -** The standard in May was not met, in main due to Colorectal (88.1%), Skin (89.5%) & Upper GI (78.2%). Patient choice continues to be the major factor in 2ww breaches.
- **Cancer 28 Day Diagnosis** - The standard was met in May with a performance of 78.9% (321 breaches). The performance standard for all referrals (2ww, symptomatic & screening) is reported by NHS Digital and via the Public View portal.
- **Cancer 62 Day Standard** - May 62 day performance is 81.5%% (89.0 treatments , 23 patient pathways breached resulting in 16.5 breaches) with the Trust not achieving the national 62-day standard. The performance had been predicted to be challenged, of the 24 predicted breaches for diagnosed patients:

Our Care

Medicines Safety

The Number of reported medication incidents has increased in May 22, there was no increase in incidents associated with moderate harm or above. The proportion of incidents resulting in any level of harm remains consistent, despite increase in incidents reported in May 22. GWH medicines incident reporting is mid-range when compared to hospitals as part of 21/22 national benchmarking. Actions in June involved a review a deep dive into medicines incidents, and the correlation with serious incidents involving medicines. No obvious correlation found but work is ongoing during July to understand and learn from themes.

Medicines safety improvement group established in May 22 to focus on trust wide learning.

Infection Control

In June 2022 there were two reportable *C. difficile* infections which were Healthcare Associated (HOHA) cases identified on Teal Ward. The Trust has been set a threshold of 48 *C.difficile* infections for 2022/23, which means that at the end of June 2022, we are under the trajectory for that threshold. In June 2022, 8 *E.coli*, 2 *Klebsiella* and 1 *Pseudomonas aeruginosa* bacteraemia were identified, placing the Trust slightly over trajectory for *E.coli* and *Klebsiella* but under for *Pseudomonas*

aeruginosa. The Trust reported 5 hospital acquired MSSA infections in June 2022 bringing the total for the year to 12 against our full year internally set threshold of 22.

GWH are participating in the BSW Integrated Care Board's Gram-Negative Bloodstream Infection Collaborative, as part of work to investigate and drive down *E.coli* rates across the region. Additionally, the IPC team are leading the Catheter-Associated Urinary Tract Infection (CAUTI) Group, which is a multidisciplinary group working across all Divisions to standardise and improve practice in both acute and community settings. Finally, the IPC Improvement Plan includes a focus on catheter care in August.

The number of patients diagnosed with COVID-19 has increased in June in line with the national and regional picture. There were 18 hospital acquired cases of Covid 19 (8 days +) in June 2022. There were several outbreaks and clusters which were managed through the daily outbreak meetings. The number of deaths reported refers to deaths within 28 days of testing positive. Many of these are not caused by COVID-19. A review panel has been convened to investigate all nosocomial COVID-19 deaths.

Pressure Ulcers

There were a total number of 242 incidents reported for pressure ulcer related harms during the month of June. All of these were validated by the Tissue Viability Nurses (TVN's).

32 of these incidents were hospital acquired and the remaining 210 incidents were a combination of PU harms which were present on admission and not pressure ulcer damage

The South West Ambulance Service have commenced a regional improvement strategy to update all their documentation, IT systems and educate all crew members how to identify a pressure ulcer and correctly document and hand over to ED staff. This workstream is encouraging all Trusts within the South West to provide Repose companion trolley mattress to Ambulance crews within their ED's to ensure that any patient at risk will have access to pressure reliving equipment to place over the ambulance trolley. GWH has demonstrated that the equipment is utilised by crews and fully supporting the workstream with TVNs providing clinical expertise to the group.

Within the community setting the total number of pressure ulcers reported this month is 88 this is a slight reduction compared to last month. Of these 32 occurred on the community nursing caseload, this is a reduction from last month.

Falls

125 reported inpatient falls reported in June 2022, resulting in 6.60 per 1000 bed days, this remains within normal variance. On average each month 30.3% of falls involve patients who have fallen twice or more as an inpatient. In June 26.7% of falls involved patients who had fallen twice or more.

Implementation of the Falls Sensor Mats and Bathroom Alarms continues with training on the use of the mats and alarms being delivered to 138 members of staff across the acute wards. Bathroom alarms have been fitted to all bays in Jupiter, Trauma and Teal Wards. and leads identified on these wards to provide training in bathroom alarms.

Quick reference guidance sheets have been created on the following topics: - safe use of bedrails, safe seating, medicines and falls risk, use of low beds, and safe footwear. These documents have been approved, sent to all Falls Champions, and uploaded onto the Falls intranet pages.

Patient Safety

At the time of reporting, there are a total of 24 ongoing Serious Incident (SI) investigations, with five incidents reported in June 2022. There are no themes identified on the newly reported SI's.

Patient Safety week was held within the trust academy from 20th of June to the 24th of June 2022, with positive feedback from staff, particularly in regard to a patient story around the psychological impact of witnessing an untoward event on an inpatient ward. Datix DCIQ the new patient safety database went live across the trust on Friday July the 1st 2022. Incident reporting numbers have not decreased, indicating ease of use of the new system. Training is underway amongst Divisional Quality Teams to support in incident management and incident reporting.

Safer Staffing

The Overall fill rate on days for Nurses/ Midwives is 95.1%, this is an increase from last month. The average Fill Rate on day shifts for HCAs is 104%, this continual improvement in the HCA fill rate is reflective of the recruitment work undertaken. Wards with over 100% fill rate is due to patients that require additional support or 'enhanced care' for example if the patient is confused. Hazel, Delivery & WHBC continue to be the only area that had below 90% average fill rate for both Midwives and HCA on days. There remains significant oversight and actions on safe staffing in Midwifery by the Director of Midwifery.

HCA vacancy rate continues to improve, and a strong pipeline is in place. Wards are now recruiting to the new safer staffing establishments. Current vacancy is 15.48wte with 42.47 in the recruitment pipeline. The trajectory for Band 5 registered nurses has been updated to include latest turnover data and the new safer staffing establishments. A bid for a further 30 wte Internationally Recruited Nurses has been submitted to maintain a zero vacancy position at year end.

Patient Experience

For June, 84% of the Friends and Family Test (FFT) responses were positive, in line with the previous months. The negative responses at 11% are slightly lower than last month at 12%. This is based on the % of responses rated as 'very good' and 'good'.

There were 49 complaints received (previous month 47) and 99 concerns (previous month 88) were received in June 2022. Out of a total of 148 cases received from Complaints and Concerns in June, the overall top three themes were communication, waiting times and clinical care.

Maternity

Three incidents were graded as moderate harm for the perinatal services in June, these cases have been reviewed via an urgent incident review with multi-disciplinary engagement.
one of these incidents is subject to a level 1 Internal investigation

Our People

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

Exceptions in June:

The Trust vacancy KPI has decreased significantly to 6.94% in month from 7.3% in May, a decrease of 18.63WTE.

The Trust HCA vacancy is in an overrecruited position of 11.77wte compared to approx. 100wte vacancies earlier in the year. (Excluding safer staffing investment).

Sickness absence decreased in-month to 4.7% from 6.05%, of which 0.78% is Covid related absence and 3.93% is non-Covid related. The Trust has 13 individuals on long-Covid related sickness absence. In line with national guidance, the Trust communicated on the 6th July 2022 that the indefinite payment of sick pay to these individuals will revert with effect from the 1st September 2022, to their contractual sick pay entitlement. Consultation to take place with these individuals.

The in-month agency spend as a percentage of the total pay bill has decreased further from 6.57% to 6.36%, although continues to remain above Trust target (6%). The increased demand on services continues as evidenced by the use of 91WTE in excess of Trust workforce budget in June.

Temporary staff utilisation above the Trust vacancy position continued in month, with 163WTE of Registered Nursing staff being used against a vacancy of 108WTE, 118WTE Unregistered Nursing used against a vacancy of 11WTE, and 73WTE Medical staff used against a vacancy of 63WTE.

Electronic Rostering roll-out has progressed and both the Emergency Department and Obstetrics & Gynaecology are live with effect from mid-June 2022. Build continues with Acute Medicine with high levels of department engagement with clinical and administrative staff. Anticipated go-live in end of August in line with General Medicine due to launch.

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

Trust appraisal compliance is reported at 74.55% in May, increasing marginally over the month. In month progress does include the update of the SARD system to improve user experience for Medical and Dental staff and enable their refreshed access to conduct online appraisal and improve their appraisal compliance rates.

The workforce priorities for the month ahead continue to be to understand and reduce the level of staff absence, continue with the improvements in our vacancy position and timely recruitment

process, increase appraisal compliance rates with focus on medical and dental staff and continue to improve the efficiency of process in place for medical workforce staff

Use of Resources

The full year plan for the Trust has been updated following the resubmission in June and is now a deficit of £19.4m. The Trust is reporting a deficit in Month 3 of £0.9m against a planned deficit of £0.4m (£0.5m adverse to plan). Year to date the deficit is £5.4m against a planned deficit of £4.2m (£1.2m adverse to plan).
Income is above plan in month (£0.2m) driven primarily by high-cost drugs with the offset included within expenditure. Pay costs continue to be above plan within Unscheduled Care (£0.5m), being the key driver of the overspend year to date. A high-level forecast has been included for Month 3 showing a projected deficit of £24.6m against a planned deficit of £19.4m (£5.3m adverse to plan, driven by a gap against the cash releasing efficiency target).
The cash position at the end of June was £33m which is below plan of £39.8m. Capital expenditure is £0.5m as at the end of Month 3, £1.9m 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	PPPC				
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	28th July 2022

NHS
Great Western Hospitals
NHS Foundation Trust

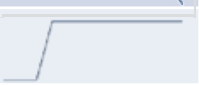
Integrated Performance Report

July 2022
May & June 2022 data period

Service Teamwork Ambition Respect

Performance Summary

Great Western Hospitals NHS
NHS Foundation Trust

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking**	Bath Ranking	Salisbury Ranking	Month
Hospital Combined Performance Score	4,591 (July)		50 (4,591)	48 (4,385)	22 (5,083)	Jul 22
A&E 4 Hour Access Standard (combined ED & UTC)	76.6% (Jun)		43 (76.1)	123 (57.7)	67 (71.7)	Apr 22
A&E Percentage Ambulance Handover over 15 Mins	52.6% (Jun)					
A&E Median Arrival to Departure in Minutes (combined ED & UTC)	191 (Jun)		60 (192)	119 (236)	91 (214)	Mar 22
RTT Incomplete Pathways	60.2% (May)		136 (58.4)	113 (63.3)	89 (65.9)	Mar 22
Cancer 62 Day Standard	81.5% (May)		25 (81.2)	86 (66.7)	66 (71.4)	Mar 22
6 Weeks Diagnostics (DM01)	49.86% (May)		151 (45.7)	123 (33.0)	46 (8.6)	Mar 22
Stroke – Spent>90% of Stay on Stroke Unit	79.4% (Q3 21/22)		54 (79.4)	45 (81.8)	2 (95.0)	Q3 21/22
Family & Friends (staff) – Percentage recommending GWH as a great place to work	61.1% (Q3)		160 (61.1)	65 (73.6)	108 (67.7)	Q3 20/21
YTD Surplus/Deficit*	-4.3% (Q2 19/20)		170 (-4.3)	27 (1.3)	109 (-1.4)	Q2 19/20
Quarterly Complaint Rates (Written Complaints per 1000 wte)	15.1 (Q2 21/22)		72 (15.15)	119 (21.9)	81 (16.5)	Q2 21/22
Sickness Absence Rate	4.7% (May)		78 (5.33)	74 (5.3)	16 (4.2)	Nov 21
MRSA	3.2 (Feb)		112 (3.2)	37 (1.0)	37 (0.7)	Feb 22
Elective Patients Average Length of Stay (Days)	3.5 (Jun)					
Non-Elective Patients Average Length of Stay (Days)	5.6 (Jun)					
Community Average Length of Stay (Days)	17.6 (Jun)					
Number of Stranded Patients (over 14 days)	127 (Jun)					
Number of Super Stranded Patients (over 21 days)	74 (Jun)					

32

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

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

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, People & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		27th July 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access			Performance against 4-hour standard remains at circa 76% making it the best performing Trust in BSW and above average performance against the region and nation. Service remains under extreme pressure. A significant and noteworthy improvement in ambulance handover delays was noted by the committee.	Monitor Actions	August
Integrated Performance Report – Elective Access - RTT			The Trust continues to have no patients waiting over 2 years and ahead of trajectory for the over 78 week waiters. However, an increase in the over 52 week waiters was noted. These are the subject of weekly scrutiny.	Monitor Actions	August
Integrated Performance Report – Elective Access – DM01			Similar position to previous month as forecast. The Committee received the improvement plan at it's last meeting (June Report refers). Improvement expected in Quarter ¾.	Monitor Actions	August

Integrated Performance Report - Cancer			The committee received the presentation on the Annual Cancer Performance Report which demonstrated good performance across most services and KPIs. A significant increase in referrals year on year coupled with patient-initiated cancellations and pressure on diagnostic facilities meant that some targets were missed e.g. Cancer 2 week wait (91.6% against national target of 93%).	Monitor Actions	August
Integrated Performance Report - Stroke			The SNNAP performance remains good at Level B.	Monitor Actions	August
Community & Primary Care Performance			Following the CQC inspection, maintaining at "Requires Improvement". The team expects to respond to the issues raised within the warning notice by the CQC's deadline of 23rd August. Community services continues to be under pressure but delivering a good service eg Virtual Ward and Urgent Community Response.	Monitor Actions	August
Theatres Programme Assurance Report			Partial assurance provided. Theatre schedule completed and work towards improving day case rates. Clinically led Task & Finish Group for Anaesthetic job plans to be implemented. Good working progress has been made, however, some results have yet to be seen.	Monitor Actions	August

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

Great Western Hospitals NHS Foundation Trust

Part 1: Operational Performance

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

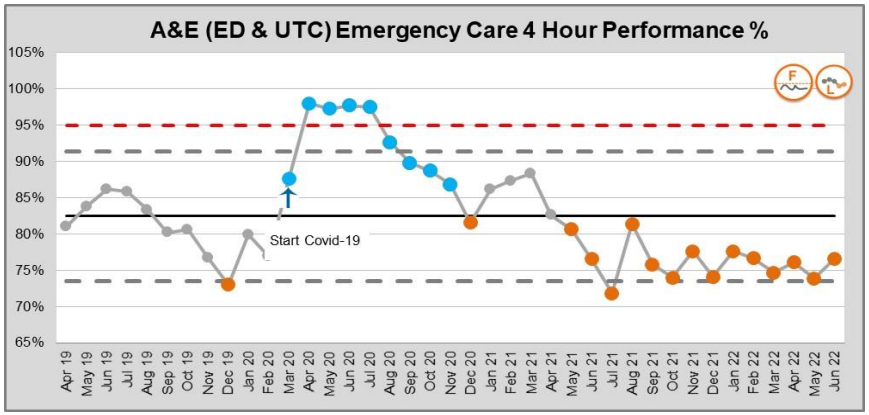
Are We Well Led?

Use of Resources

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

Data Quality Rating:

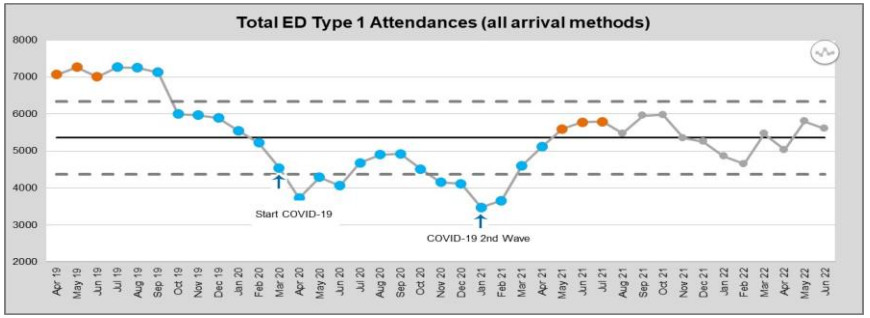
National Key Performance Indicators

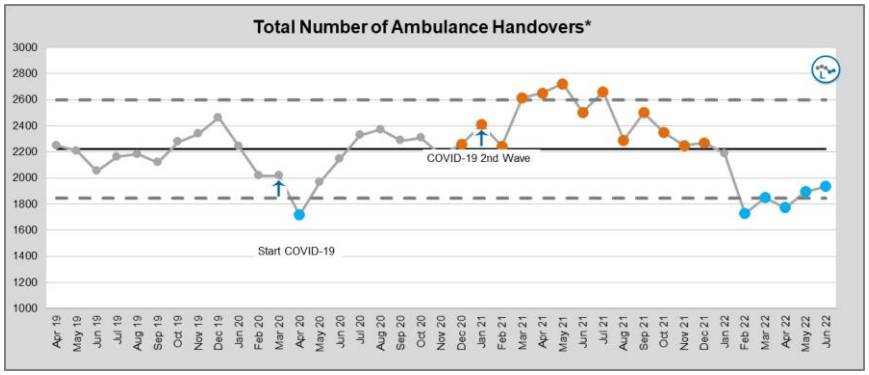


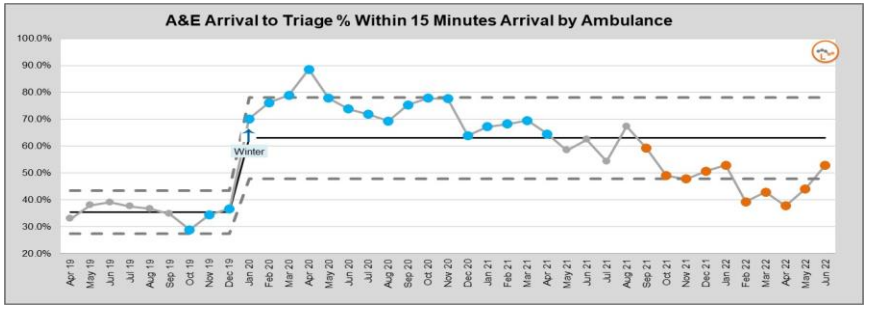
Performance Latest Month: 73.88% (May)

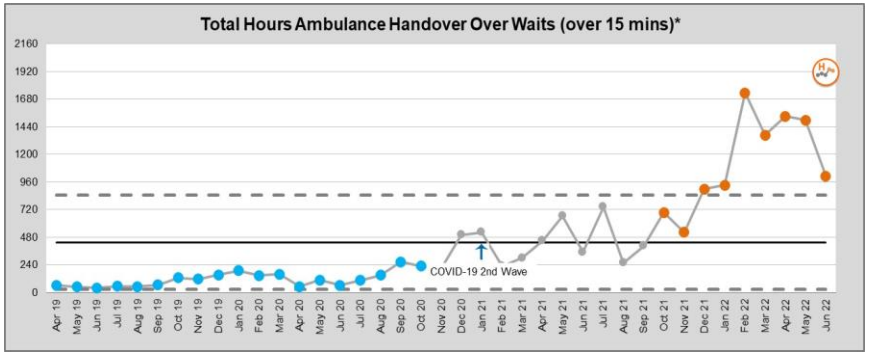
Attendances:
Type 1 ED 58.73%
Type 3 UTC 96.25%
Overall – 76.57%

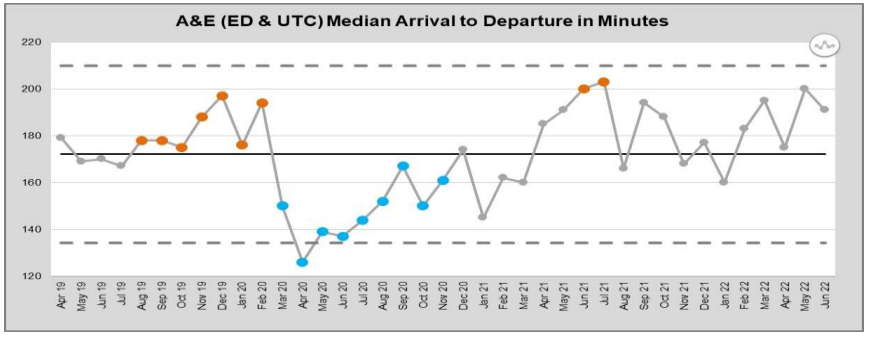
12 Hour Breaches (from decision to admit) 67











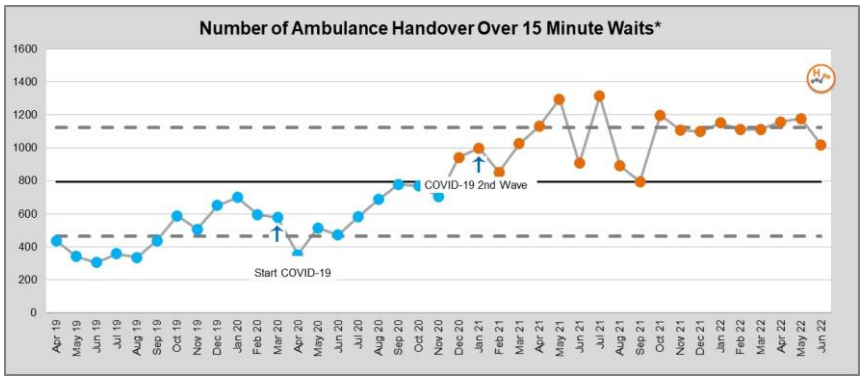
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

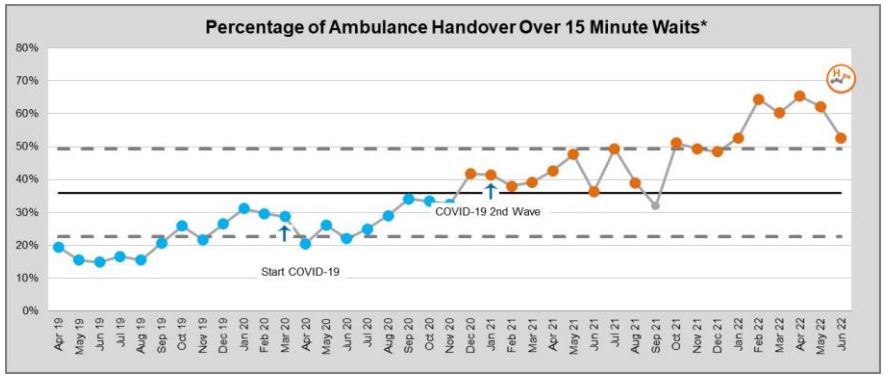
* Data from SWAST

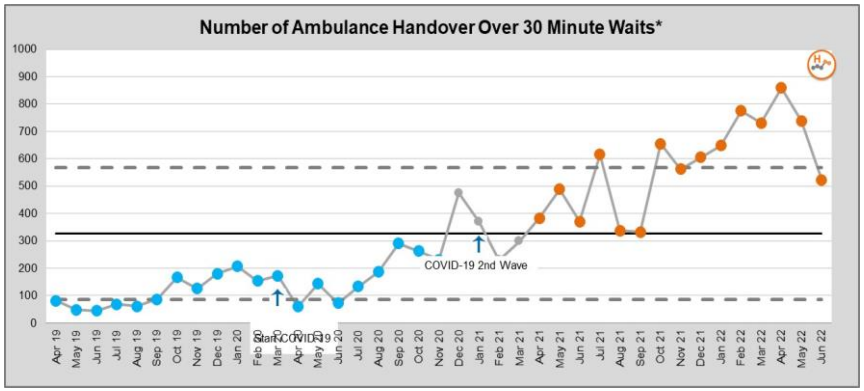
1. Emergency Care Standards – Ambulance Arrivals

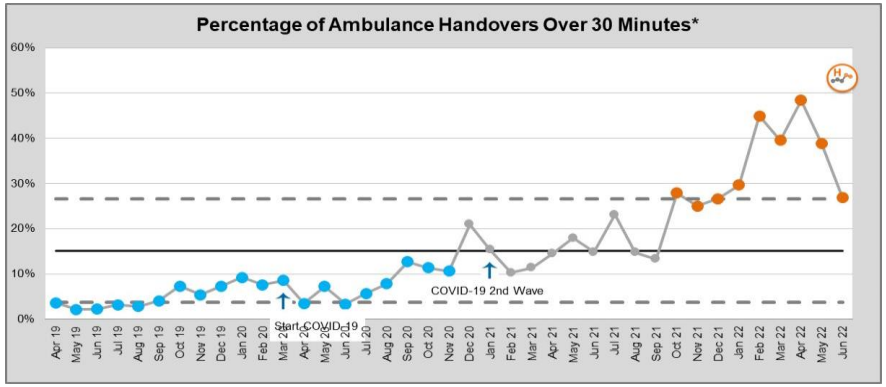
Data Quality Rating:

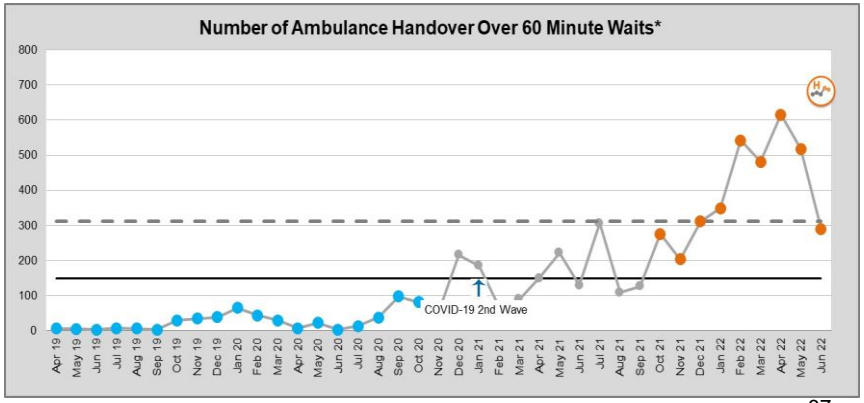
National Key Performance Indicators

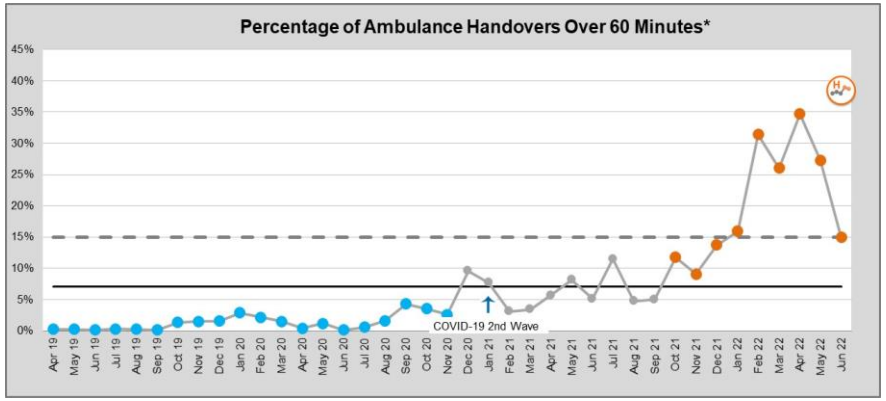












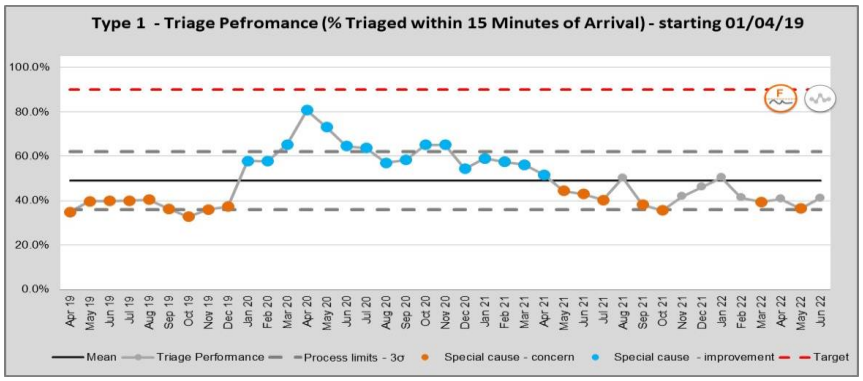
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

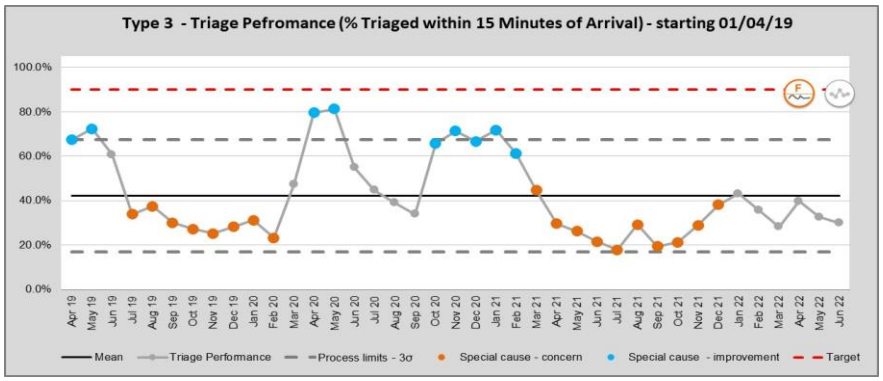
* Data from SWAST

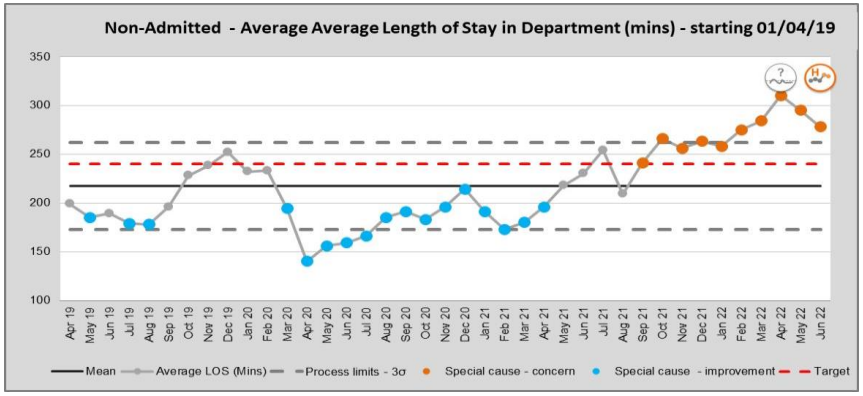
1. Emergency Care Standards – Front Door Flow

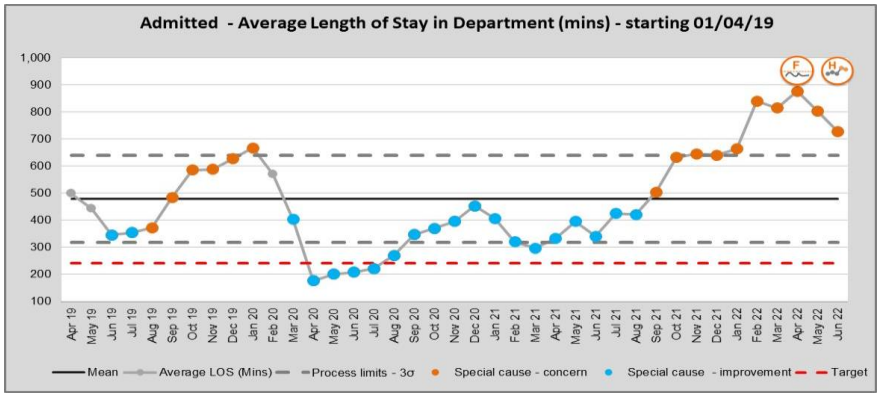
Data Quality Rating:

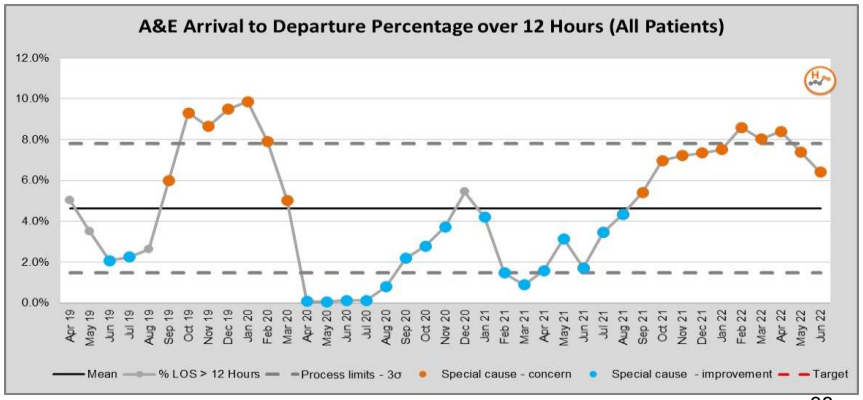
National Key Performance Indicators

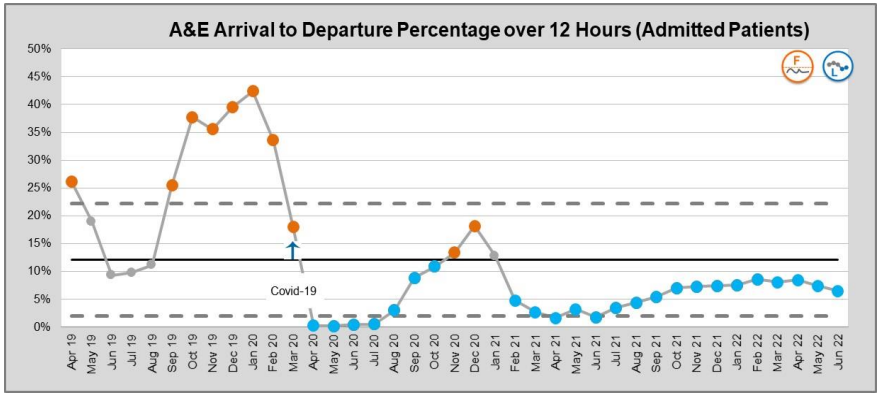












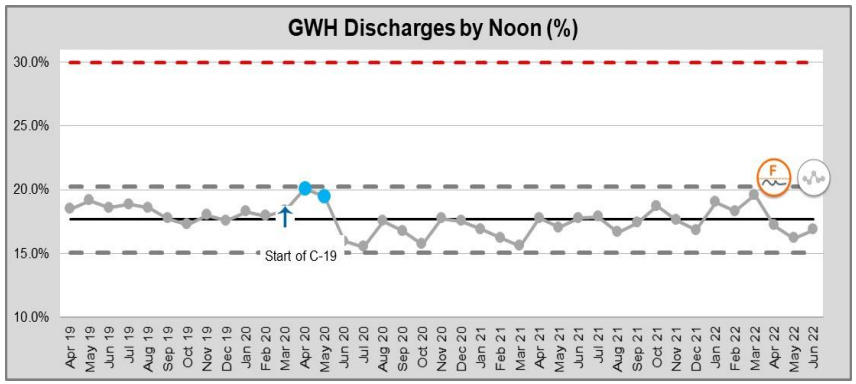
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

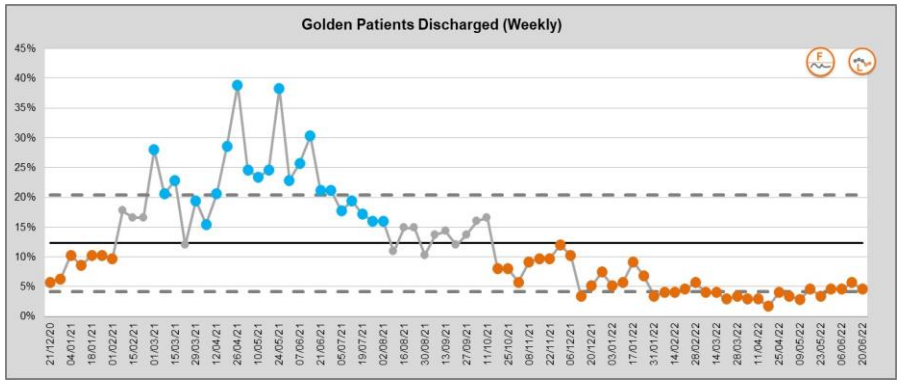
* Data from SWAST – 1 month lag

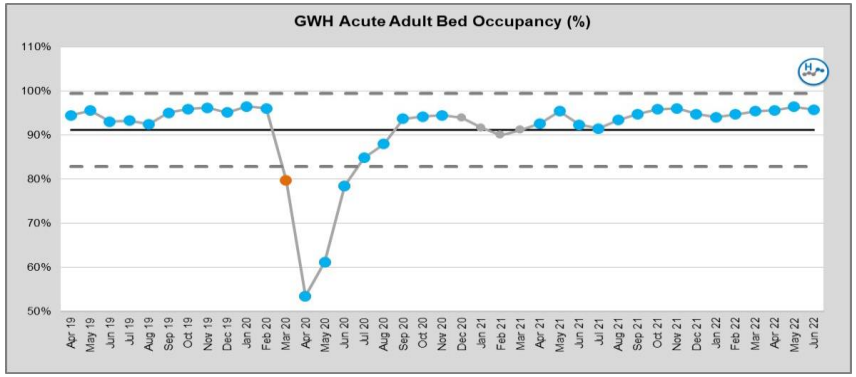
1. Emergency Access (4hr) - Patient Flow and Discharge

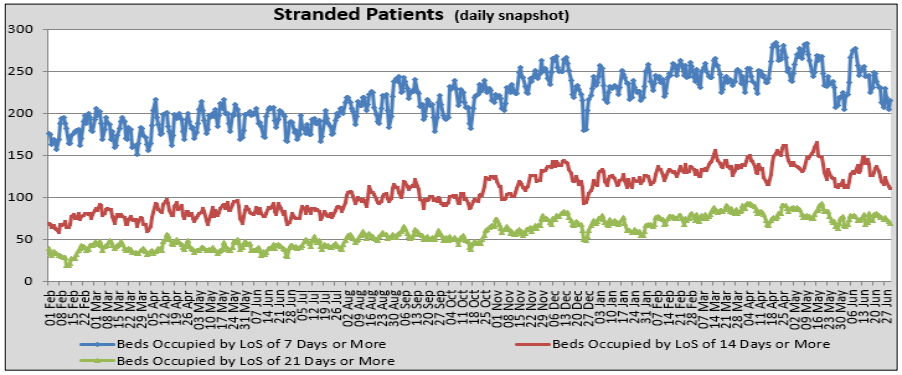
Data Quality Rating:

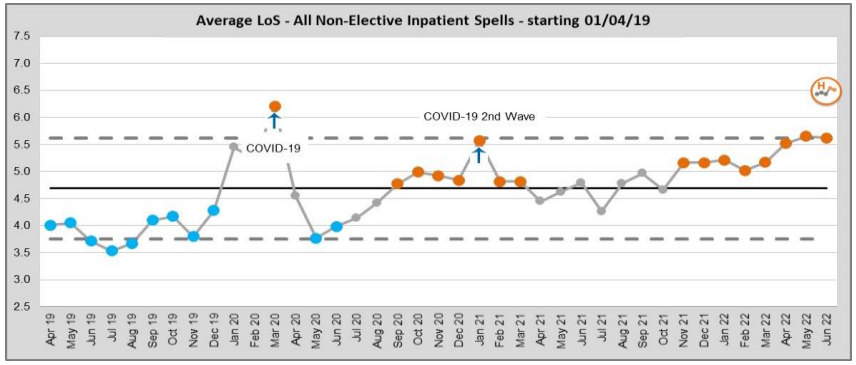
Are We Effective?

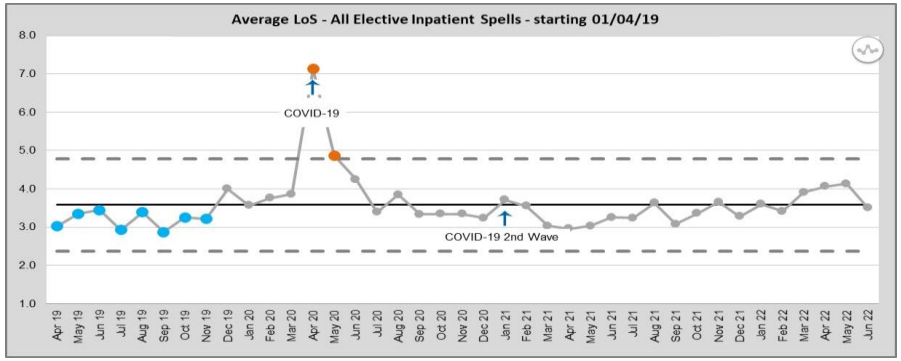












Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

Hospital Ambulance Handover Delays

Data Quality Rating:

Are We Effective?

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

- The total number of Ambulance conveyances to the Emergency Department was 1825, an increase of 73 (GWH total 1939).
- Handover delays reduced across all time measures. Handover delays over 1 hour decreased from 496 in May to 284 in June
- Handover waits more than 15 mins has decreased to 968 patients compared to 1088 patients in May
- There were 71 ambulances who waited more than 4 hours to hand a patient over to the Emergency Department.
- Ambulance 15-minute Triage times improved for 3rd consecutive month

Key Impacts on Performance

- Decrease in attendances from last month
- Availability / timeliness of beds for onward flow from ED
- Access to services other than ED/UTC remains limited
- Average non-elective LOS – remains similar to last month, at 3 year high
- Golden discharges continued decrease.
- Pre-noon discharges improved slightly
- Average LOS in ED decreased for 2nd consecutive month
- %>12 hour waits in ED – decreased and lowest since October 2021
- Ambulance delays decreased across all time measures.
- 20% drop in last 2 months for handovers over 60 minutes.

What will make the Service green?

- Full implementation of Ambulance Navigation Hub
- Introduction of Swindon ICA Coordination Centre
- Trust wide response to patient flow, incorporating 'Safer' programme.
- SDEC / HUB review of ED & Ambulance queue
- SWAST having direct access to all Assessment Units.
- Implementation of 'Inter Professional Standards ' allowing direct referral and admission to specialty beds.
- 7/7 SDEC service
- Improved access to admission areas
- Reduction in COVID positive patients

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

1. Implementation of Ambulance Navigation Hub as part of Trust Coordination Centre. Recruitment of Clinical Lead – **September 22.**
2. Internal Ambulance Queue to be maintained - **Ongoing**.
3. EPIC/Nurse assessment of arriving ambulances with direction to appropriate ED, or alternate Admission Unit (Utilise Internal Professional Standards) - Ongoing.
4. Ongoing HALO+ presence & support to ED / ambulance queue - **Ongoing**
5. SDEC 7-day open. Develop weekend service provision - **Ongoing**
6. Review Front Door 'footprint', locations and service provision. Revision to maximise patient flow – **August 22**
7. Improving Together – USC Driver Metric Time in ED with weekly and monthly counter measures reviewed

Risks to delivery and mitigations.

- Flow out of ED remains challenging and dependent on ward-based discharges, reduced IP&C concerns (COVID) & LOS.
- Inappropriate conveyance of patients to ED by ambulance Trust when not using appropriate community and primary care services available.
- Significant increases in attendance and large surges through the day increase the likelihood of increased handover delays.
- There is a risk to safety and quality to the Majors Chairs area of ED due to increased demand and acuity.

Mitigation:

- Ongoing work to develop Front Door Hub (Co-ordination & navigation hub)
- Continuation of SAFER ward-based review and support across the Trust.
- Maintain Ambulance internal queue area to ensure assessment and treatment.
- Review of ED Nursing and medical staffing to maximize cover, quality and safety to all areas of department.
- Majors Chairs to maintain staffing to ensure safe capacity, allowing ambulance offload

Emergency Access (4hr)

Data Quality Rating:

Are We Effective?

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

- The ED performance remains below the 95% standard. There has been an improvement in 4-hour performance of 2.69%.
- Attendances decreased by 88 patients from May
  - ED - 199 decrease
  - UTC – 323 decrease (UTC remains closed overnight)
- 4 Hour breaches have decreased by 306 overall
  - ED – 309 decrease
  - UTC – 3 increase
- 67 x 12-hour reportable Decisions to Admit (DTA) breaches – reduction of 31
- Average ED 15-minute Triage Times improved
- Ambulance delays decreased across all time measures.

Key Impacts on Performance

- ED attendances decreased slightly but remain at pre-pandemic levels (3rd Q 2019).
- Social Distancing measures remain in place, restricting patient numbers in ED Majors (Trolleys)
- Internal ambulance queue maintained, despite staff reduction
- Continued increase in non-elective LOS
- Improvement in Ward discharges pre-midday
- Total bed occupancy remains >95%
- Ongoing Co-ordination Hub and 'Safer' programme
- Clinical Navigator ongoing (intermittent) assisting flow to UTC.
- Ambulance assessment by Senior ED/AMU clinician (in sweeps)
- Majors Step Down supported by Medical REG/SHO (Mon-Friday)
- SDEC 7/7 - Active pulling from ED
- Front door Hub 2/7 week (Friday/Monday)

What will make the Service green?

- Increased availability and timely access of ward based beds for ED patients to flow into.
- Increased pre-noon discharges.
- Direct access to non-ED assessment areas for IPS supported transfer.
- Full implementation of Front Door Coordination & Navigation Hub
- SDEC / HUB review of ED & Ambulance queue
- SWAST having direct access to all Assessment Units.
- Implementation of 'Inter Professional Standards ' allowing direct referral and admission to specialty beds.
- System wide approach to how the public access Urgent and Emergency care.
- 7/7 SDEC service

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

1. Review consolidation of 'Outlier' patients in one area, improving management and reduce LOS – **September 2022**.
2. Implementation of Front Door Hub as part of Trust Co-ordination Hub. Recruitment of Clinical Lead – **September 22.**
3. Reconfiguration of CAU to Medical Expected Unit – 1st Assessment model to direct patients to admission/SDEC pathways – June 2022/Ongoing
4. Implementing findings of Nursing Staffing review. Staff uplift to improve Senior Staff provision agreed - **August 2022**
5. Implementation of CRTP on Care Flow for on-going patient movement – **June 2022/Ongoing**
6. Maintain internal ambulance queue, incorporating diagnostics & treatment – **Ongoing**
7. Review and reconfiguration of Front Door 'footprint' (ED/AMU/SAU) – **September 2022**
8. Review ED & AMU Medical staffing models, maximising clinical coverage/cost benefit. Utilise Staffing protocol. ED working to place doctor's rota on R-roster – **August 2022**
9. Improving Together – USC Driver Metric Time in ED with weekly and monthly counter measures reviewed

Risks to delivery and mitigations.

- Flow out of ED remains challenging and dependent on ward-based discharges, reduced IP&C concerns (COVID) & LOS.
- Inappropriate conveyance of patients to ED by ambulance Trust when not using appropriate community and primary care services available.
- Significant increases in attendance and large surges through the day increase the likelihood of increased handover delays.
- There is a risk to safety and quality to the Majors Chairs area of ED due to increased demand and acuity.

Mitigation:

- Review of ED Nursing and medical staffing to maximize cover, quality and safety to all areas of department.
- Maintain Ambulance internal queue area to ensure assessment and treatment.
- Majors Chairs to maintain staffing to ensure safe capacity, allowing ambulance offload
- Ongoing work to develop Front Door Hub
- Maintain Co-ordination Hub & SAFER program

Virtual Ward (Hospital at Home)

Are We Effective?

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

Activity in both the VW & the stepdown VW has demonstrated an ongoing increase since February. The expected increase in step down patients support complex patient monitoring and reduce risk of readmission

New referrals remains low although a small increase is noted following collaborative work to identify patient cohorts. Closer working to advertise the VW with navigation hub, consultants and PCNs. Considerable variation in daily occupancy through June with planning work underway to achieve 30 patient daily occupancy rate.

Improvement actions planned, timescales when improvements will be seen

Stratified 4 stage patient journey through VW from admission to step down and discharge. This enables the effective use of skill mix through patient cohort and provides clarity on patient acuity.

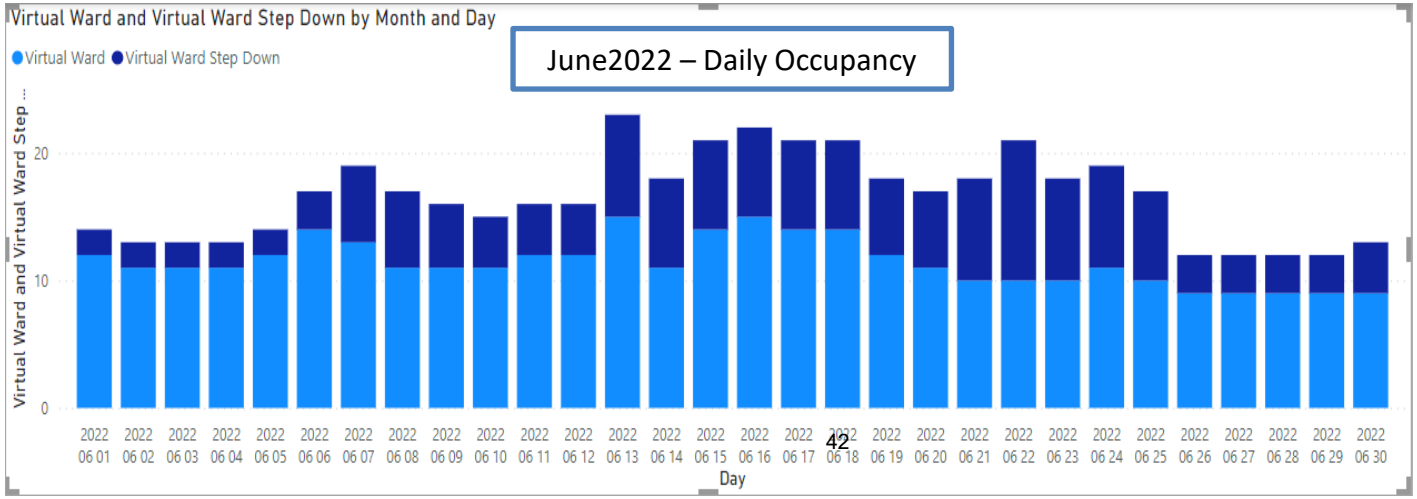
Increase number of referrals through the promotion of virtual ward criteria directly with PCNs to enable identification of appropriate patient cohorts. F2F contact at GP meetings to increase awareness.

Close working and clinical attendance in Clinical Navigation of Hub (CNH) undertaken, shadowing ACP on TOPSSU and awareness raising with consultants.

Workforce plan – 2 WTE rotational band 7 enhanced community practitioner roles currently advertised which will shore up CNH clinical attendance. On-boarding new starters expected in September and October.

Isansys remote patient monitoring equipment currently being trialed, with a view to releasing clinical capacity, enable increased occupancy and create efficiencies. Evaluation of the trial to be completed end of Sept.

Virtual Ward Monthly Report	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	12 Month Totals
Number of Referrals	21	21	17	24	27	21	25	21	27	43	30	37	314
Number of New Patient Referrals	6	5	5	5	2	4	7	7	7	8	8	11	75
Number of Discharges	22	19	22	18	27	22	23	24	21	43	29	41	311
Patients on Virtual Ward	23	16	16	19	20	27	24	19	19	32	31	33	23
Patients Referred on to the VW Step Down Ward	0	0	0	0	0	0	0	3	18	22	17	25	7



Risks to delivery and mitigations

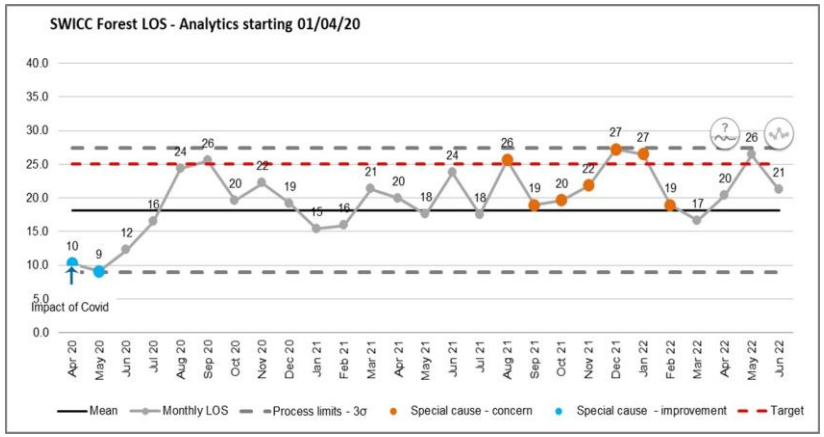
Risks – inadequate number of referrals received from PCNs or secondary care resulting in reduced occupancy

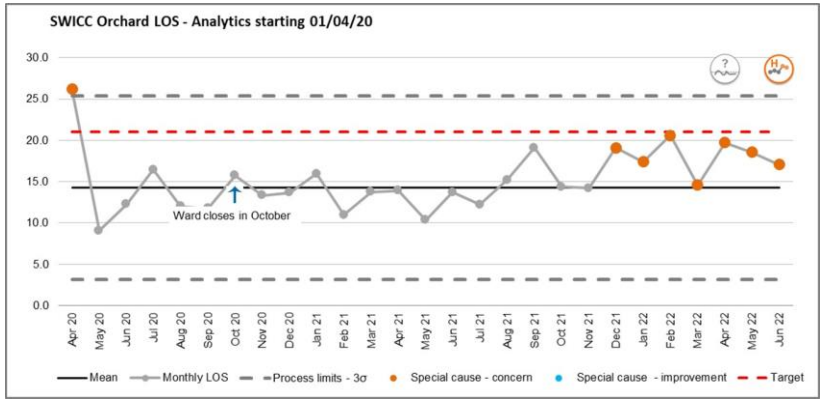
Mitigations - Improve visibility of capacity and seek referrals by joining the CNH and collaboration with USC

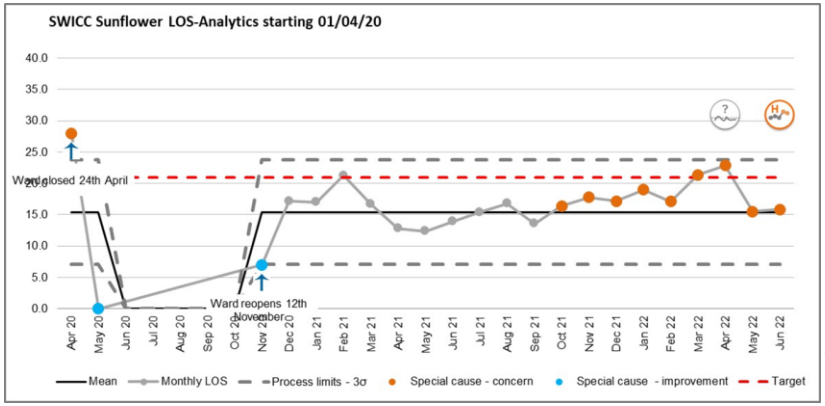
Emergency Access (4hr) - Community (SwICC) Length of Stay

Data Quality Rating:

Are We Effective?







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

- Average LOS across the 3 wards is 17.63, a reduction compared with May. LOS benchmarks well against intermediate bed services in BSW – SwICC = shortest and remain below the average LOS across BSW which is 27 days.
- 64% of patients returned to their usual place of residence.
- 7% of patients were transferred and admitted back into GWH which is a reduction compared to May, due to the reduced covid outbreaks on the ward.
- 129 discharges were achieved across the 3 wards which is marginal reduction but 39% of discharges were completed before mid-day which exceeds target (30%).
- 6.97% of discharges were over a weekend – this is linked to having less discharge coordinator cover.

Improvement actions planned, timescales when improvements will be seen

- The application of the 'Improving Together' approach including huddles on forest ward is expected to highlight potential delays before they happen, reducing the LOS for patients on the ward.
- Medical cover in June improved, as a result of a weekly touch point with Temp staffing team which allows an early opportunity to address ay areas / days of concern and agree countermeasures.
- The AMD has led discussions with DOP Consultants to initiate a review of the current GP led model in Orchard and to strengthen SwICC rehabilitation pathways. A revised model is expected to be agreed by end of August
- Five band 6 RN's across the 3 wards have been recruited which will support quality and continuity of care. Start dates have been agreed during July/Aug and Sept?

Risks to delivery and mitigations

- **Risk:** Reduced Therapy cover resulting from recent sickness absences and staff leaving.
- **Mitigations:** Adverts are out for locums. Community staff have been able to cover access visits. A bid is being developed to apply for HEE funds for international recruitment of OT's this will be submitted by the 15th July.
- **Risk:** missed opportunities to identify patients to transfer to SwICC and Sunflower
- **Mitigation:** SOP for transfers to SwICC/Sunflower has been designed and shared widely across the trust in June.

Urgent Community Response (UCR) Service

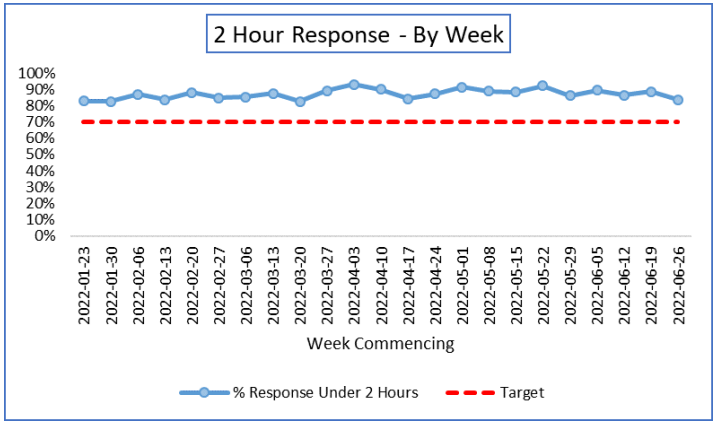
Are We Effective?

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

The service continues to operate 08.00 – 22.00 7 days per week and provide a consistent 2 hours response time over target achieving around 80-90%. The recent recruitment to additional night nursing team has provided an opportunity to extend the >2HR response through the night 22.00 – 08.00.

The national KPI of responding within 2 hours continues to be exceeded, remaining consistently between 85% - 95% .

Referral rates remain high in June, matching the numbers received in May. During June a pilot was agreed and implemented with NHSEI, MiDoS and NHS 111 teams. This pilot was centred on opening referrals to NHS 111 call handlers, without the need for any prior triage. The pilot was a success, with 30 direct referrals, this referral pathway remains open.



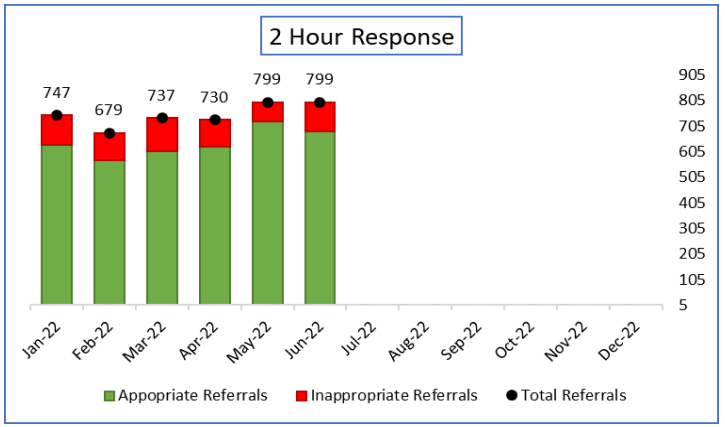
Improvement actions planned, timescales when improvements will be seen

1. NHS111 direct referrals (without clinical triage) are now accepted, following a successful pilot in June 2022

2. New metric will be reported (as a watch metric): unscheduled acute activity in following month from referral to UCR (indication is 80% of patients have zero acute activity one month post referral). This supports the aim of reducing unplanned acute activity and improving outcomes for these patients.

3. Night nursing service is now more resilient and can respond to <2HR UCR referrals through the night – from June onwards. Time of referrals will be monitored to ensure planned responses are not delayed until a 'night shift'.

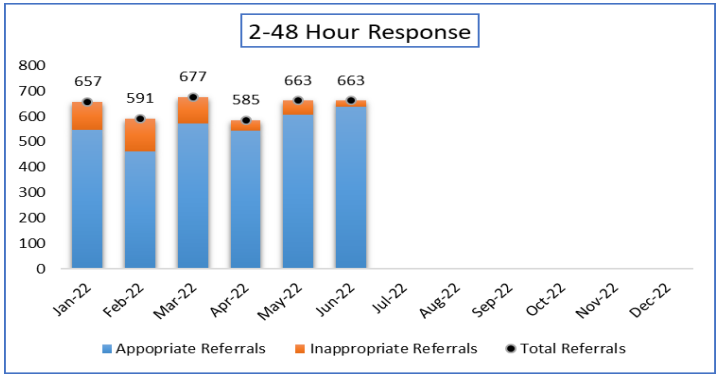
4. High intensity users of UCR are regularly reviewed by MDT/Clinical leads, under evaluation but is demonstrating early signs of reducing number of contacts with community services. Impact reporting/evaluation will be made available in Q3.



Risks to delivery and mitigations

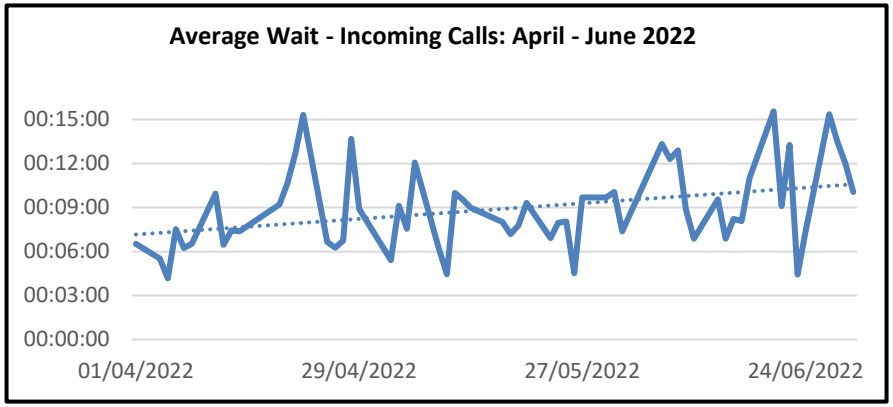
Risk: the review of HIU could result in additional pressure on planned community care

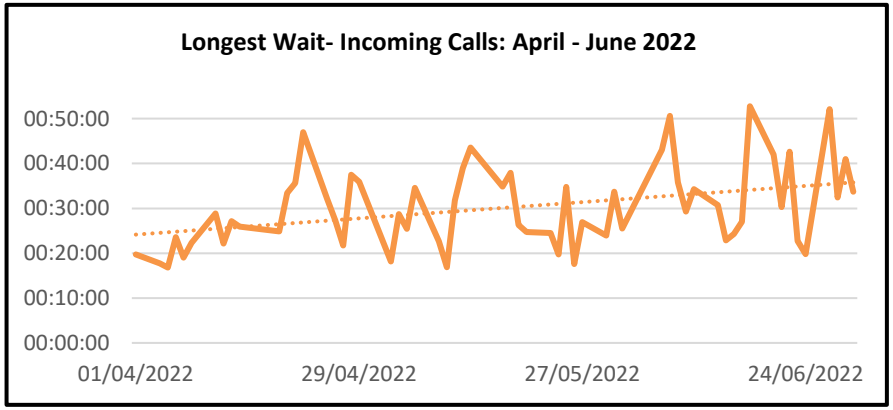
Mitigations: include colleagues from the planned community teams in the HIU reviews and involve social care to help address wider determinants of health (target date Sept)

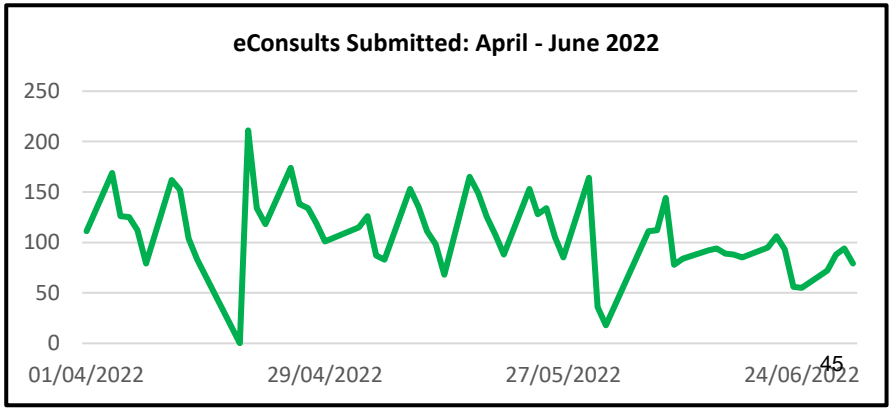


GWH Primary Care – Accessibility – June 2022

Are We Effective?







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

Average call wait times: have increased since April by approximately 4 minutes, from 7mins to 11 mins. Since reducing eConsult to 80 per day in June, additional incoming calls have been received, which is challenging the call handling performance.

Longest call wait times: have also increased since April by approximately 10 minutes, from 25 mins to 35 mins.

e-Consults: have been reduced during June to 80 per day, to help balance demand against available clinical resource.

Improvement actions planned, timescales for when improvements will be seen

Call Handling Performance: assessments are underway to better review peaks and troughs in demand vs. available call handling resource. This will be used to inform workforce planning (as part of financial recovery and QI plan).

Testing the disbanding of the hub and integration of the call handling team with reception will be progressed through July, August and Sept, with a target of being concluded by Oct (following a consultation process)

eConsult: the capping of 80 per day allows accurate planning and allocation of clinical resource to demand. Two clinicians per day will be allocated to eConsult. Analysis suggests 50% of the incoming eConsult require a subsequent GP appointment.

Risks to delivery and mitigations

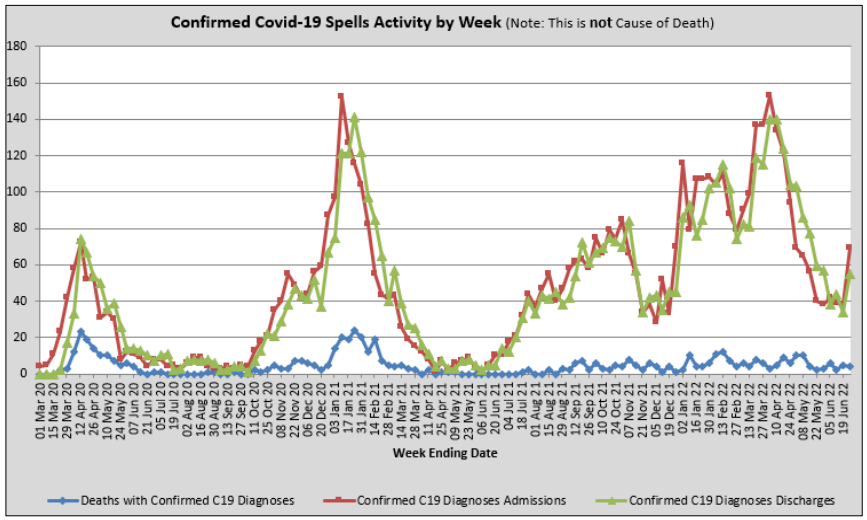
Risk: call handling performance continues to worsen

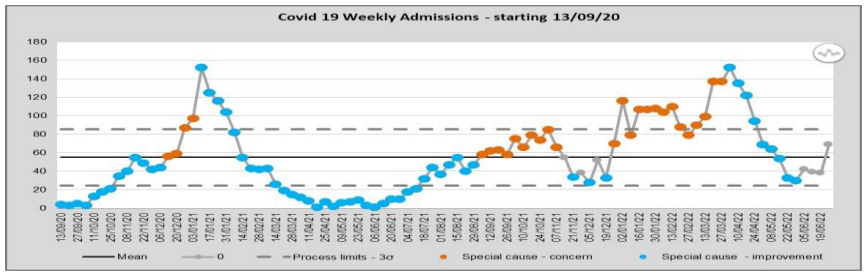
Mitigation: Additional management support and oversight to be provided from July onwards. Recruitment to new joint posts during August and Sept reflecting the integration plan (Receptionist and Call Handler as a single function).

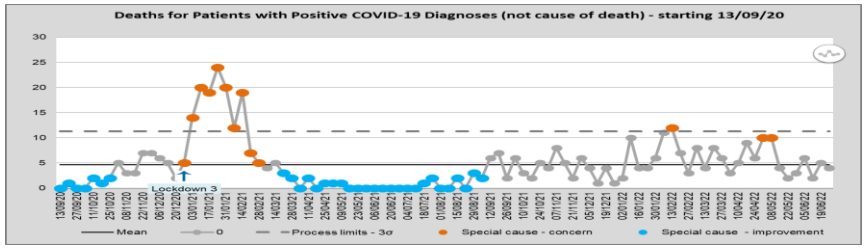
1. Emergency Access (4 Hours) Covid 19 Weekly Admissions

Data Quality Rating:

Are We Effective?







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

Attendances and Covid cases have increased towards end of June, with increased positive cases for staff. A cyclical wave like increase and decrease is beginning to become apparent.

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

1. CAU incorporated into Medically expected Unit (MEU) model with CAU continuing to function as a Covid admissions unit for suspected and confirmed Covid patient attendances. Patients not suspected or symptomatic go through ED and are tested on admission - **June 2022**
2. Revision of Covid protocols for MAU & ED by Clinical Leads - **June 2022**

Risks to delivery and mitigations

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

Mitigation: Close working between ED & AMU. Maintain POCT for all admissions. Abbott tests for low risk / suspected Green patients. Trolley wait times escalated, utilise admission SOP. Positive/High suspicion patient escalated for side room placement

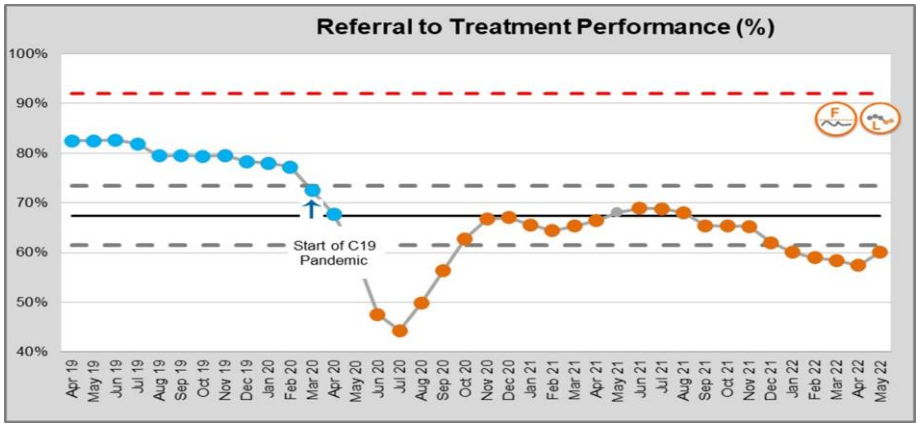
There is a risk of increased demand for 'Blue' beds due to increase in Covid variants.

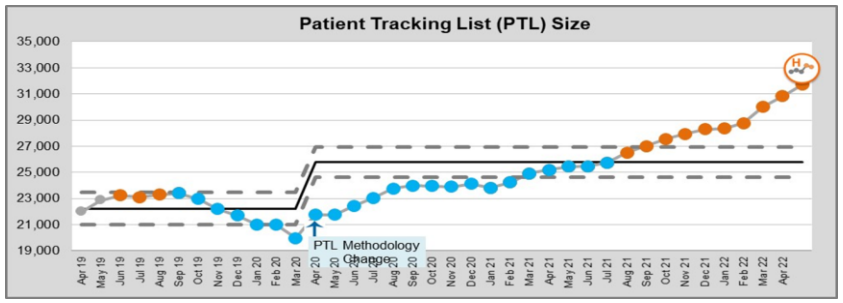
Mitigation: Daily monitoring of Blue/Green attendances. POCT testing maintaining. Close working with ED and joint SOPs updated. Flexible usage of MAU/Trust side rooms.

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

Data Quality Rating:

National Key Performance Indicators





	May	June
RTT Performance	60.15%	59.65%
PTL Volume	31,703	32,579
Reportable 52 Week Breaches	852	1,028
In Month 52 Week Breaches	349	323

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

The Trust reported an RTT Incomplete Performance of 59.65% in June 2022, a deterioration of 0.50% in month.

The Trust reported a waiting list of 32,579 (an increase of 876 in month) against a trajectory of 31,968 (611 behind trajectory). The highest movements in month were Derm, Paeds & Gen Surg.

The Trust received 9,678 referrals in June 2022, which is 8% lower when compared to the previous month. Cardiology, Orthotics and Oncology received the highest increase in referrals in month.

1,028 x 52-week reportable breaches were declared in June 2022, an increase of 176 in month. Neurology, Gastro and Dermatology saw the biggest increases in month, whilst T&O, Ophthal, ENT & Oral all saw reductions.

323 x in month breaches were reported in June 2022, an reduction of 26 over the previous month.

The number of patients waiting over 78 weeks at the end of June 2022 was 52, an increase of 2 in month.

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

- Options appraisal presented to Executive team on 15th June 2022, with mechanisms to increase elective activity in line with the 2022/23 activity plan approved.
- Check and challenge taking place through the new weekly Access meeting, with continued focus on 78 week and 52-week position.
- Deep dive into current activity levels vs plan, with bridge analysis and recovery options to commence through weekly access meetings 19/07/22.
- Cotswold Surgical Partners are being commissioned by BSW to provide support to Dermatology and Plastics, which should reduce 52 week breach position for Dermatology. Activity to commence mid-August.
- Neurology locum joining in August, which will reduce long waiting patients and improve RTT performance.
- Validation process being reviewed, to identify ways in which services can be notified once next step in pathway is complete, to help expedite patients pathways and reduce waiting times.

Risks to delivery and mitigations

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

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

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

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

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

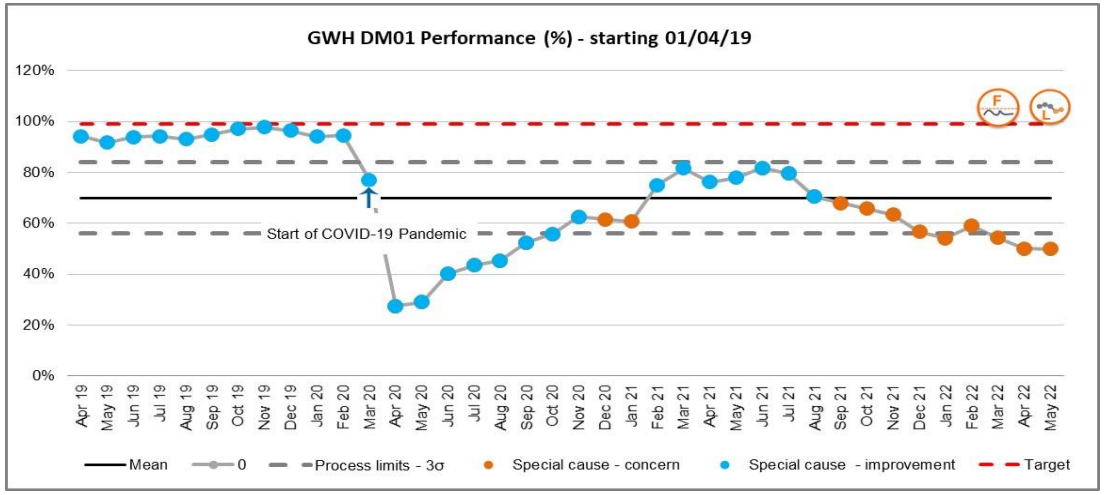
Mitigation: Services reviewing breach position/forecast over the coming months, alongside available routine capacity and feeding plans back through weekly access meeting. Insourcing activity increased to reduce number of long waiting patients.

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

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

Data Quality Rating:

National Key Performance Indicators



May 2022

Performance Latest	49.86%
Waiting List Volume:	11,810
6 Week Breaches:	5,922

Waiting	< 6 Weeks	> 6 Weeks	Total WL	Performance %
Magnetic Resonance Imaging	774	1753	2,527	30.63%
Computed Tomography	589	1336	1,925	30.60%
Non-obstetric ultrasound	2279	1249	3,528	64.60%
Barium Enema	0	0	-	N/A
DEXA Scan	252	556	808	31.19%
Audiology - Audiology Assessments	658	105	763	86.24%
Cardiology - echocardiography	455	198	653	69.68%
Cardiology - electrophysiology	0	0	-	N/A
Neurophysiology - peripheral neurophysiology	76	0	76	100.00%
Respiratory physiology - sleep studies	101	103	204	49.51%
Urodynamics - pressures & flows	0	0	-	N/A
Colonoscopy	343	393	736	46.60%
Flexi sigmoidoscopy	95	33	128	74.22%
Cystoscopy	75	148	223	33.63%
Gastroscopy	191	48	239	79.92%
Total	**5888**	**5922**	**11,810**	**49.86%**

Analysis – What is the data telling us?

Performance was 49.867% in May compared to 49.97% in April compared. Overall, the total waitlist size has increased to 11,810 compared to 11,476 in April. Breaches have also increased from 5,471 to 5,922. CT remains challenged to see 2ww and urgent patients, with no routine capacity, this is due to reduced CT van capacity during the month. Radiographer vacancies have improved significantly but remain high with this. There is also significant Covid related sickness in Radiology.

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

Improvement Actions

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

- **CT:** ERF money has allowed additional CT van days through to the end of September, this will commence once the new pads are on-line at the end of June. This will aid recovery of DM01 from July.
- **MRI:** Similar to CT above, additional MRI van capacity has been procured through to the end of September. This will also have a significant impact on DM01 recovery.
- **Dexa:** Further adhoc capacity from staff rota added in May.
- **Echo**: NP Referral rates have increased from c. 54 to 70 per week. WLI Echo to recommence Jun 22 (80 Appts per month for the remainder of the FY).
- **Endoscopy**: The 4th procedure room opened 16th May 2022. New procedure opportunities with RUH. TVCA capsule endoscopy pilot in progress. Increased capacity required to meet rising Fast Track demand.

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

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

Data Quality Rating:

National Key Performance Indicators

Background, actions being taken and issues

Endoscopy:

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

2. Weekend lists were delivered at 88%, 46 of the 52 list target during May 22. Weekend lists have reduced to 6 each weekend since the 4th Endoscopy room opened on 16th May 22. Productivity has been reduced (12pt lists from weekends will become 10pt lists during week, losing 8 lists of capacity each month). Opportunities to increase capacity are being identified. WLI support continues to be essential to continue to meet Fast Track demand and fill unforeseen endoscopist absence.

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

Radiology: Performance has declined in May and there are still pressures in the department due to staffing vacancies but 6 WTE have be recruited reducing the vacancy gap. (6.75 WTE). However there has been a further 2 resignations this week.

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

Echo:

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

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

What will make the Service Improve?

Endoscopy:

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

2. Dr Hegde is looking into lower bowel capsule endoscopy as an alternative to full endoscopy demand.

3. TVCA Capsule Endoscopy pilot in progress. National results demonstrate only 50% of patients progress to full endoscopy after completing a Capsule Endoscopy.

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

5. Th opportunity to increase weekend WLI lists has been stopped by the inability of the decontamination unit (scope cleaning) to support any list increases at weekends.

Radiology:

1. **CT**: CT van capacity increasing from July to have a mobile on site daily
2. **MRI**: MRI van capacity increasing from July. to have a mobile on site daily
3. Additional Ultrasound capacity, using ERF money, commencing in July

Echo:

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

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

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

Risks to delivery and mitigations

Endoscopy:

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

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

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

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

Mitigations include:

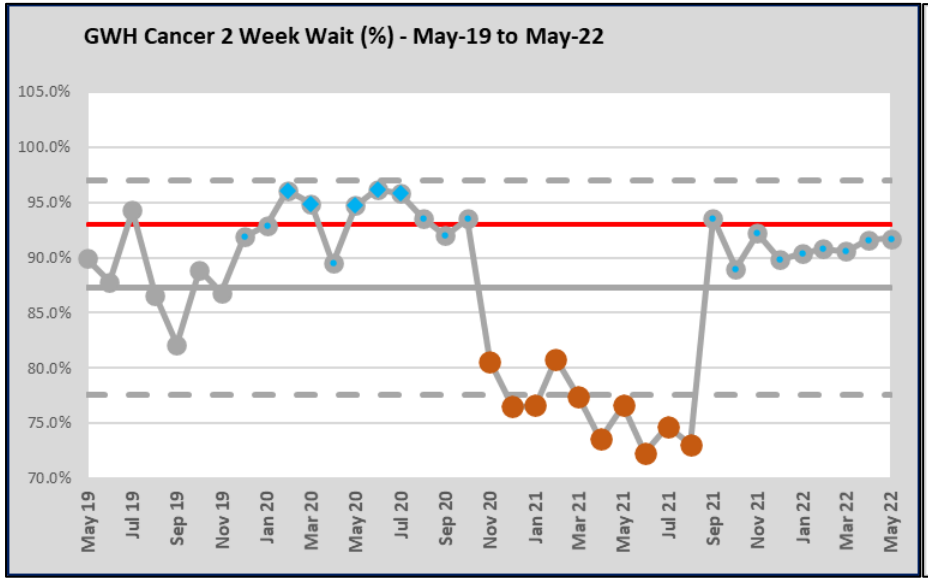
- Additional CT sessions offered to staff,
- Recurring recruitment meetings taking place weekly to promote ideas and drive improvements in strategy.
- Redevelopment and increase of pads

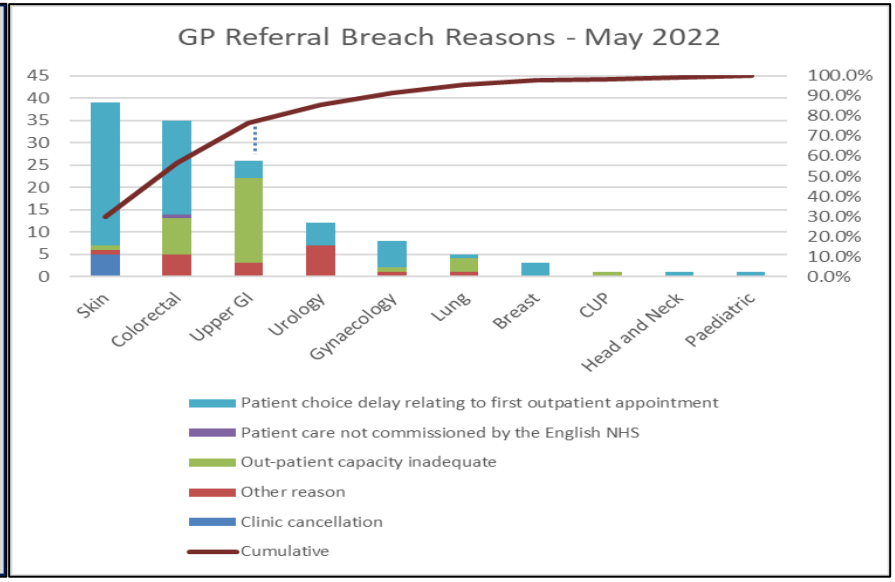
Echo: There is a risk that DMO1 performance will fail to recover to >99% due to the volume of Referrals for both NP and FU Echo. The recent addition of another Imaging Consultant has reduced wait time for DSE/ESE And TOE and WLI Echo funding will help to reduce the recovery timeframe from Jul 23 to Apr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

Cancer 2 Week Wait - May 2022 Achieved: 91.7%

Data Quality Rating:

National Key Performance Indicators





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

The standard in May was not met, in main due to Colorectal (88.1%), Skin (89.5%) & Upper GI (78.2%),.

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

1,573 patients were seen under the 2 week wait to first appointment rules, of which 130 pathways breached the standard. To achieve the standard, we needed to prevent 20 of the breaches. The majority of breaches were as follows:

Patient Choice (74)
- 32 Skin
- 21 Colorectal
- 6 Gynaecology

Outpatient Capacity (33)
- 19 Upper GI
- 8 Colorectal

Other Reasons (18)
- 18 other reasons including COVID, admission for unrelated reasons and requirement for translator

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

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

Patient choice
- Further analysis of patient choices in first appointments is being undertaken and will be shared at a GP Forum in Q3.

Outpatient capacity
- Upper GI capacity challenged, additional lists are being added where possible.

Endoscopy
- Service are now adopting "on the day" lateral flow Covid testing, providing capacity following any short notice cancellations. We have seen this benefit from March 22.

Risks to delivery and mitigations

Radiology
- If CT capacity issues return
  - Additional CT van days from **InHealth** have been arranged from July 2022 for 3 months plus 1 month rolling until April 2023.
  - Weekly wait data is supplied to cancer services team to help manage expectations and aid pathway planning. CT currently booking to 12 days and CTC booking to 14 days. Absences due to Covid, annual leave and vacancies have contributed to a worsening of wait times
  - Additional sessions are being run during the evenings and at weekends

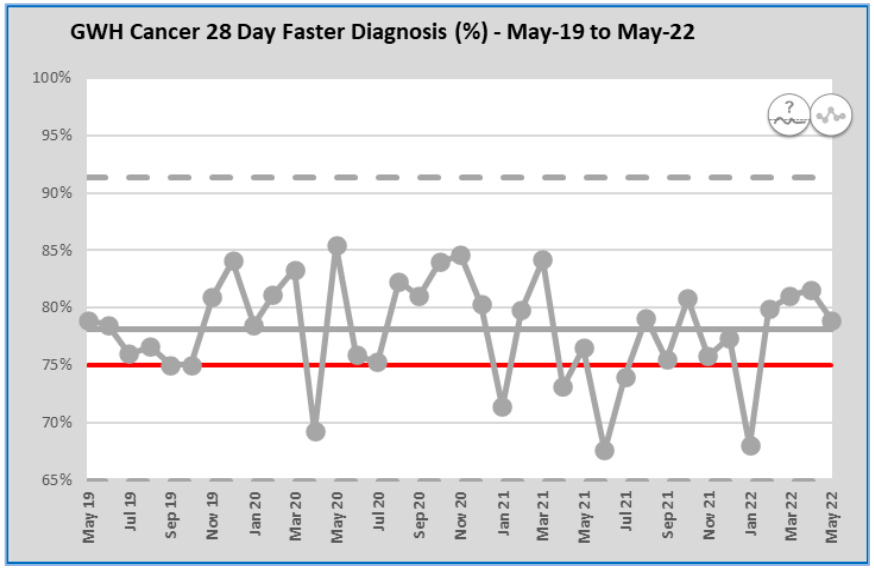
Patient Choice
- Patient choice poses a risk to the 2 week wait performance
- COVID continues to impact patient choice

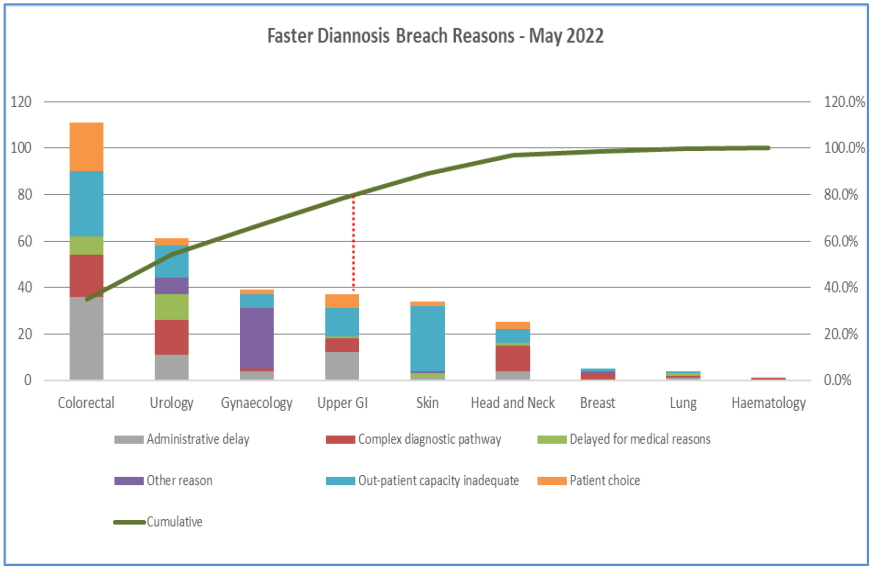
Staffing
- Due to the increase in the number of Covid cases, absence has increased within Services which has impacted the 2ww standard.

Cancer 28 Day Diagnosis - May 2022 Achieved: 78.9%

Data Quality Rating:

Are We Effective?





Background

The standard was met in May with a performance of **78.9%** (321 breaches). The performance standard for all referrals (2ww, symptomatic & screening) is reported by NHS Digital and via the Public View portal.

In May 22 of the breaches (6.9%) related to patients being told they had a cancer.

This can be further broken down by site.

Urology – 9 (Complex pathway – multiple diagnostics)

Upper GI – 4 (Clinical Capacity to review diagnostic results)

Gynae – 3 (Delay in Pathology reporting)

Colorectal – 2

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

Working with 4 main sites to identify potential pathway improvements

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

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

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

In colorectal a template letter is being drawn up by the clinical lead to help speed up the communication of non cancer diagnosis', especially at times of consultant leave.

The colorectal STT nurse are to start triaging a small umber of referrals to help streamline first OPAs/diagnostics.

Risk to Performance Delivery

Colorectal

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

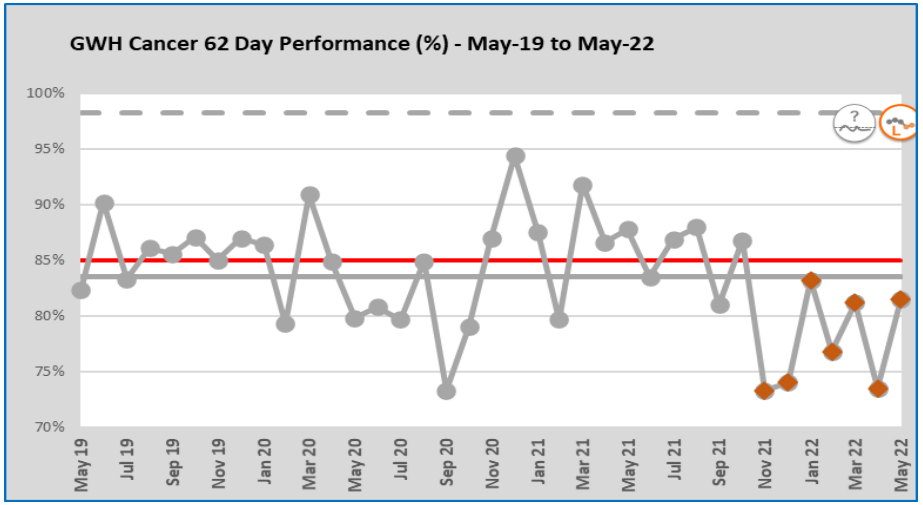
Radiology

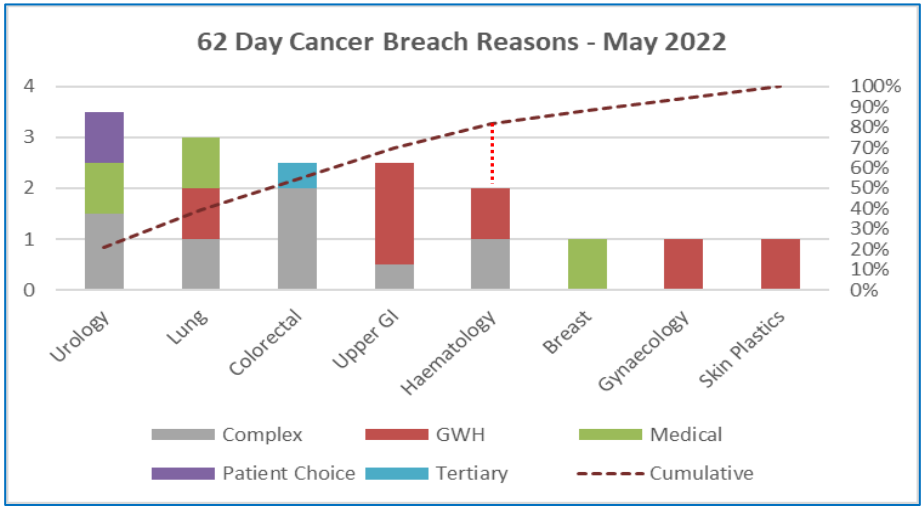
- Capacity due to vacancies,
  - CT van from **Inhealth** till June 22 approved.
  - Weekly wait data is supplied to cancer services team to help manage expectations and aid pathway planning. CT currently booking to 12 days and CTC to 14 days.

Cancer 62 Day Standard – May 2022 Achieved: 81.5%

Data Quality Rating:

National Key Performance Indicators





Background

May 62 day performance is 81.5%% (89.0 treatments , 23 patient pathways breached resulting in 16.5 breaches) with the Trust not achieving the national 62-day standard. The performance had been predicted to be challenged, of the 24 predicted breaches for diagnosed patients:

- **12** pathways breached as forecast **(8.5)**
- 6 pathways rolled to June
- 6 pathways did not breach as a result of being treated in previous months

There were **10** unpredicted breaches in April **(7.0)**

- 3 pathways were in Urology, 1 pathway was all options, 1 was delayed by patient choice and 1 for medical reasons
- 2 Upper GI pathways were delayed by capacity issues in Oncology
- 1 Haem pathway was impacted by delay to post MDT follow up.
- 1 Lung pathway was severely impacted by delays to PET Scan ahead of treatment planning
- 5 pathways were transferred to a tertiary centre for treatment on time, resulting in no breach to GWH.

8 pathways had been tracked as suspicious for cancer with potential treatments in May if diagnosed:

- **1** suspicious plastics pathway was diagnosed with a cancer and was treated in May **(1.0)**
- 5 patients did not have a cancer diagnosis,
- 2 patients remain undiagnosed, with their pathways rolling into June,

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

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

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

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

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

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

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

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

Risk to Performance Delivery

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

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

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

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

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

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

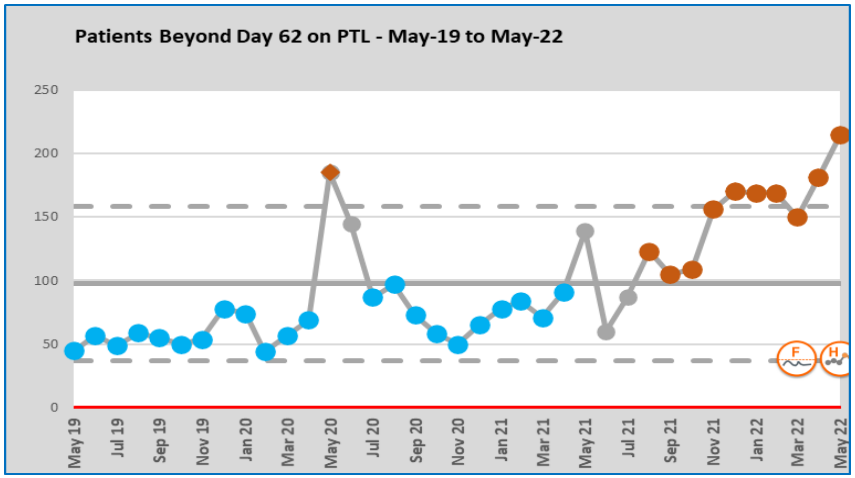
Risk: CT van sessions are in place to help support radiology during the replacement of the CT scanner this summer. This is impacting on the service being able to offer earlier scans to help bring pathway forward. Radiology are actively managing and prioritising cancer referrals. At the same time reduced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

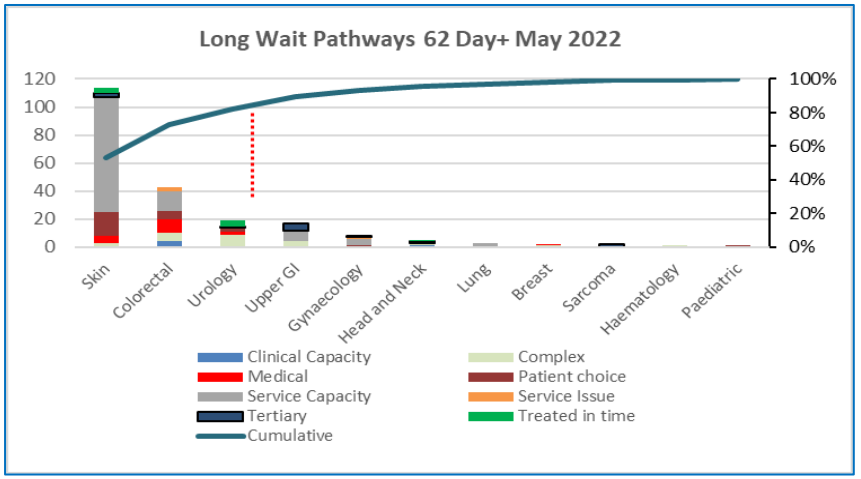
Mitigation: Weekly meetings are held to escalate PTL concerns and booking times data is shared weekly.

Cancer 62+ day

Data Quality Rating:

National Key Performance Indicators





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

The number of 62day+ pathways increased through May (215). Skin (114), Colorectal (43) and Urology (19) were the main sites with pathway delays. There are a number reasons for the high number of pathways, including complex pathways, clinical administrative delays, delayed pathway information from Oxford as well as pathways impacted by the delays in endoscopy and radiology.

The service capacity issues in Plastics account for 74 of the 114 long wait pathways in May, with the other 7 relating to patients on a Dermatology pathway. There is an element of patient choice within the cohort along with 4 patients awaiting pathology who have been treated in time.

Colorectal pathways have been delayed by clinical capacity, this is impacting the time taken to review the results of diagnostics and the booking of follow up appointments. There are also 6 complex pathways on the PTL where repeat/multiple diagnostics are required and 10 patients with medical needs that have delayed their pathways.

Urology pathways are in the main impacted by the complex nature of the investigations and treatment planning for all option prostate patients.

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

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

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

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

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

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

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

Weekly update to Exec on the details of the longest waiting patients on a Plastics pathway has been initiated.

Monthly reporting of long wait data and any potential harm at PQC

Risks to delivery and mitigations

Risk: Patient pathway delays are seen when diagnostic, outpatient and theatre capacity is challenged and in the treatment preparation (COVID management pre-assessment & theatre capacity).

Mitigation: Working with elective booking teams highlighting delays in PTL meetings.

Risk: Tertiary centre theatre capacity remains challenged post Covid, particularly for patients requiring High Dependency Unit (HDU) recovery.

Mitigation: Weekly update meeting held with OUH Cancer Pathway Manager to discuss and highlight issues with pathways transferred for care.

Risk: Delays to pathway communication from tertiary centres resulting in patients being on PTL longer than necessary.

Mitigation: Heads of service regular contact with counterparts where necessary. Weekly meeting with OUH Cancer Pathway Manager to highlight pathway issues.

Risk: Clinical engagement with weekly 62D+ breach reporting

Mitigation: sharing 62D+ PTL patient data at MDT to be explored with services.

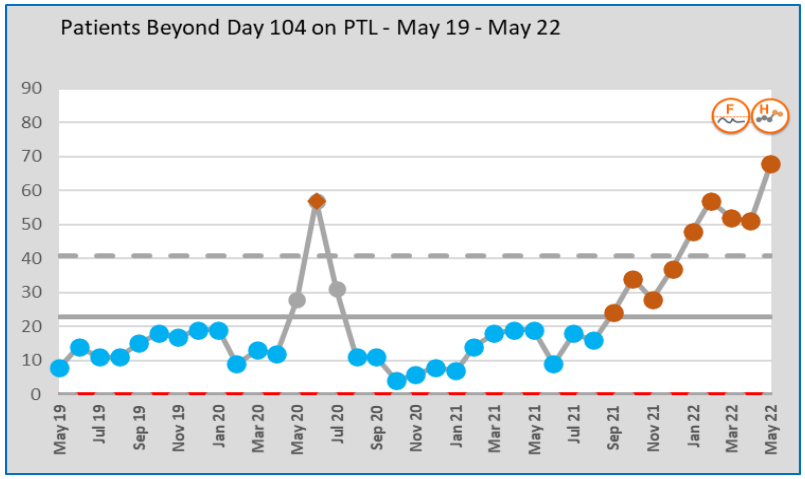
Risk: Plastics pathway unable to deliver required performance due to capacity since the service stopped sending cases to Oxford in November 21

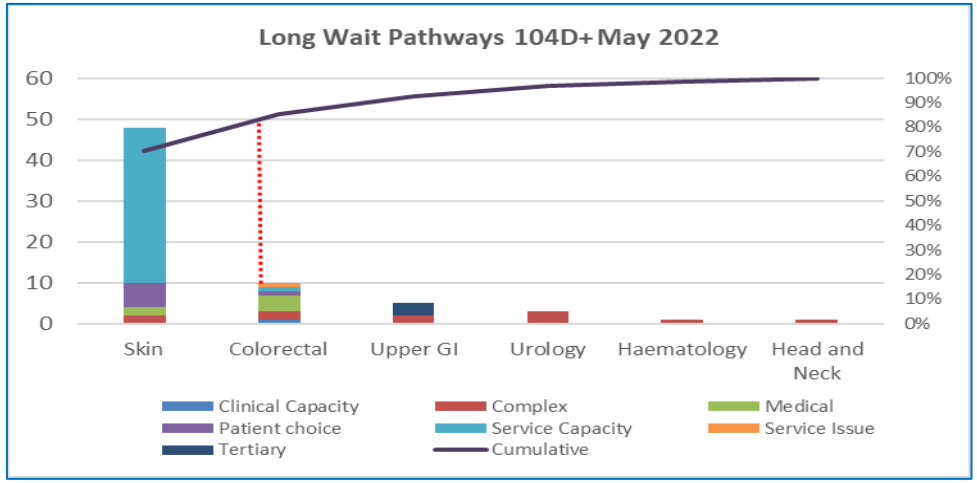
Mitigation: Review and mapping of pathway has been completed to identify potential improvements. Additional capacity is being explored and SLA with OUH is under review. Senior divisional management discussions in respect of service delivery ongoing. Second round of mutual aid patients are being identified for transfer to Oxford.

Cancer 104+ PTL & Confirmed 104 day breaches

Data Quality Rating:

National Key Performance Indicators





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

The number of 104day+ pathways increased through May (63): Skin (48) & Colorectal (10) accounted for most of these pathways. Service capacity is the main reason for the delays, with 38 skin pathways delayed. 31 of the delayed skin pathway relate to patients waiting for a treatment/follow up in Plastics. There were a small number of pathway delayed by patient choice (7) and complexity (11)

104-Day Breaches in May: 6 Patients; 5.0 breaches (IPT)

Treated at tertiary

Urology: 1 patient 0.5 breach: late ITR due to complexity of case, and capacity at NBT to treat in time.

Treated at GWH

Skin: 1 patient 1.0 breach: 2 delays due to capacity in plastics following initial reviews in Dermatology.
Lung: 1 patients 1.0 breach: pathway impacted by delays to PET scan and change in treatment plan.
Urology 1 patient 1.0 breach: diagnostic element of pathway delayed by need for patient to recover from broken leg
Haematology: 1 patient 1.0 breach: complex pathway requiring multiple diagnostics that commenced in Breast. Changes in treatment plans also added to delays.
Upper GI: 1 patient 0.5 breach: complex pathway with need for second opinion from MDT, patient transferred back from Oxford and treated within 24 days, resulting in shared breach

June is likely to see 7 patients breach 104 days on their pathway resulting in 5.0 breaches.

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

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

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

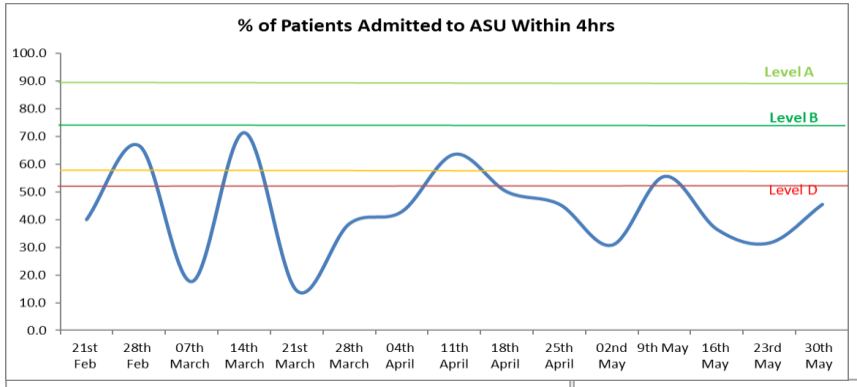
Stroke Pathways

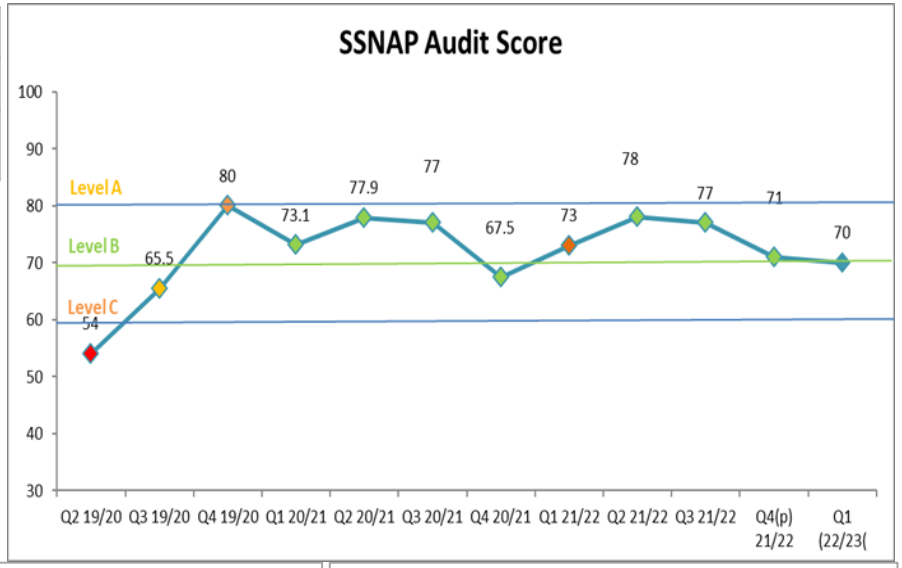
Data Quality Rating:

National Key Performance Indicators

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

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





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

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

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

A lack of ring fenced beds on the ASU, particularly over the weekend and utilisation of these beds out of hours continues to impact performance.

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

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

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

3. Candidates for substantive Stroke Consultant post identified and in the process of applying. **Sep 22**

4. A new inpatient Thrombolysis pathway has been developed, agreed and established. This avoids the use of Resus and will be underpinned by an SOP. **July 22**

Risks to delivery and mitigations

Risk No 2756 (score 16): There is a risk that out of hours, delays to stroke recognition and assessment is resulting in prolonged door to need time (greater than 1 hr) and missed opportunities to Thrombolyse eligible patients. Additionally patients being admitted to the Acute Stroke Unit outside of the 4 hour quality performance measure will face reduced quality of care through delayed access to specialist stroke treatments.

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

Out to advert for substantive Stroke Consultant.

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		21 July 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR:Overall	Amber	Green	The IPR was rated as shown this month with the following comments to note.		
Integrated Performance Report: Medicines Safety	Green	Green	Reported medication incidents have increased again this month but we remain in the mid range compared to other Trusts and there was no change in the number associated with moderate harm or above.		
IPR:Infection Control	Amber	Amber	C.diff reduced. GWH is currently below the set trajectory for this. We are slightly above for E.coli and Klebsiella. MSSA has risen with cannula insertion and care within cardiology an outlier. Work is concentrating on this area with further training.		Monthly monitoring.
Integrated Performance	Amber	Amber	Numbers have increased in Acute but are stable in Community. RAG has slipped from A/G to A/A as a result. There has been an increase in		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Report: Pressure Ulcer Harms			the number of high risk patients admitted. Work has begun to focus on special mattress availability (86 were not supplied within 2 hours of request) and involvement of SWAST in assessment and recognition of pressure harm.		
Integrated Performance Report: Falls	Amber	Amber	Falls rates remain stable but there were resulting harms in three patients that are subject to investigation. 26% of falls were in patients who had fallen twice or more previously with 300-350 patients admitted each month as a result of a fall.	Recruitment of Clinical Practice Educator for Falls and Enhanced Care. Falls sensor matts and Bathroom alarms with associated training. Safe footwear audits carried out.	
Serious Incidents Monthly Report	Amber	Amber	Numbers remain within control limits. Continued efforts to reduce outstanding investigations which are having some effect.		
Integrated Performance Report: Staffing	Amber	Amber	Sickness levels remain high plus maternity leave in Maternity services. HCA vacancy rate improving.	Successful recruitment of Student midwives who are due to start in Autumn.	
IPR:Perinatal Quality Surveillance Tool	Amber	Green	Midwife to birth ratio improved slightly to1:26, better than target (1:29). Management of the continuity pathway continues with but still short of target for CORE20PLUS5.		
IPR:Ockenden update	Amber	Amber	Further progress has been made but this remains a long term project.		
Serious Incidents Monthly Update	Amber	Green	Good Progress. Further reduction in outstanding investigations.		
Patient Experience and Engagement Framework Update	Amber	Amber	Report presented showing good progress in many areas but with others that require improvement eg. Friends and Family Inpatient score and staff recommending GWH as a place to work		
Mortality Report	Green	Green	This included a full report from Telstra Heath UK (which used to be Dr Foster). Figures show GWH to be among the best performing in the SW for mortality. When considering this it must be remembered that GWH has had a high number of patients dying from Covid and these are excluded from the HSMR & SHMI data.		
Maternity & Neonatal Q&S Report.	Green	Green	All metrics are favourable with no Serious Incidents reported in Q1. 100% of women received 1:1 care in labour. We have the lowest rates in the SW Region for referral of Term Infants to a Neonatal Unit.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Perinatal Mortality Review Tool	Green	Blue	Once again all the scores are green with all but one at 100%. For this reason the Committee believed that the good practices were embedded within the unit and justified a 'Blue' rating.		
Infection Prevention and Control Annual Report	Amber	Amber	A much improved quality of report which reflects a lot of work carried out in the last few months. There have been staffing issues in the last year which are now improved. The report includes an improvement plan to address issues where we have a higher than expected infection rate. Sharps injuries have at last come down but there is room for further improvement.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Part 2: Our Care

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

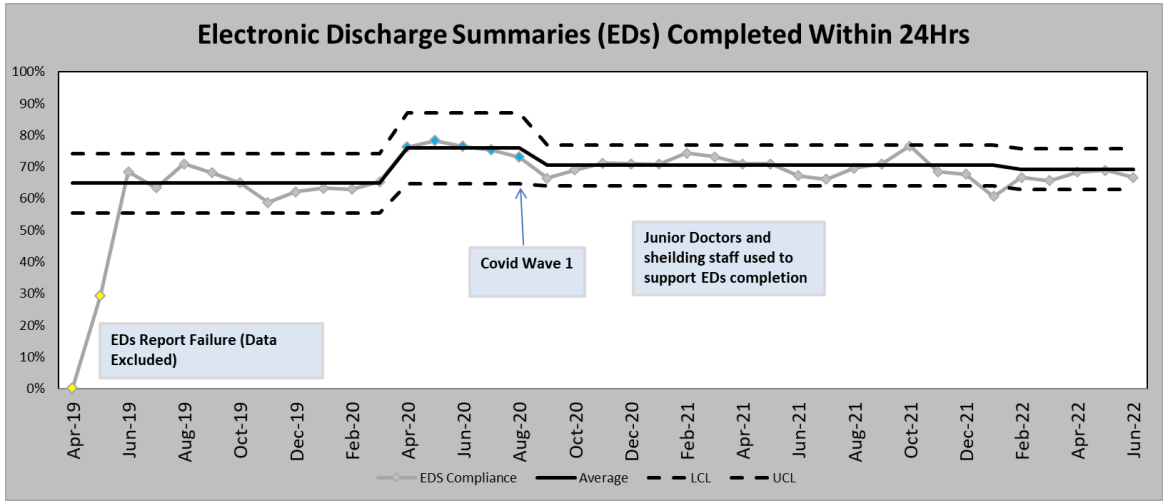
Are We Well Led?

Use of Resources

2. Electronic Discharge Summary (EDS)

Data Quality Rating:

Are We Safe?



	24 hours	48 hours	72 hours.
Jul-21	66.12%	69.79%	73.33%
Aug-21	69.54%	74.05%	77.32%
Sept-21	71.00%	75.43%	77.72%
Oct-21	64.58%	68.75%	72.79%
Nov-21	70.08%	72.70%	74.41%
Dec-21	68.37%	71.20%	73.93%
Jan-22	60.63%	64.15%	67.19%
Feb-22	66.62%	69.35%	71.51%
Mar-22	65.65%	70.87%	73.62%
Apr-22	68.35%	72.59%	75.88%
May-22	68.87%	72.66%	75.19%
Jun-22	66.70%	70.26%	73.06%

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

EDS 24-hour completion rates for May and June are now available with the caveat that June figures may be subject to change following the production of this report (27/06/2022).

May performance was 68.87% at 24 hours. Non-completed performance for the same time period was 12.3%.

Respective figures for June 2022 are 66.7% and 22.52%.

Backlog of EDS (data collected manually) in May 2022 suggested an improved position in ICC division with static positions overall in USC and SWC.

The Medical Admissions unit, Wiltshire Cardiac Centre and Woodpecker ward were all areas that made significant improvement . Meldon, PAU and Children's departments were areas of concern in SWC.

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

A paper on Electronic Discharge Summaries was presented at the June Quality and Governance board. The paper outlined:

- Current methodology around EDS production – variation in processes
- Data quality – the quality of data that is currently acquired is in question
- Strategy for improvement – a key driver is the choice of metric (dependent on reporting capacity)

A recommendation to support the EDS Task and Finish group to provide stewardship for improvement was accepted.

The EDS Task and Finish group will meet monthly in response for the clear imperative for action.

A planned meeting with Business Intelligence (Information Analysis) for June has been delayed until mid-July to explore improvements in data reporting.

The EDS Task and Finish group meets on 29/06/2022 – at this meeting it is anticipated that feedback regarding the capabilities of CareFlowEPMA upgrade will be presented – this will inform around the ability to change production platforms.

In parallel the Same Day Emergency Care service (SDEC) has gained approval from the Chief Clinical Information Officer (CCIO) to change to a bespoke discharge summary from July 2022.

Risks to delivery and mitigations

Datix risk 293 – current score 16.

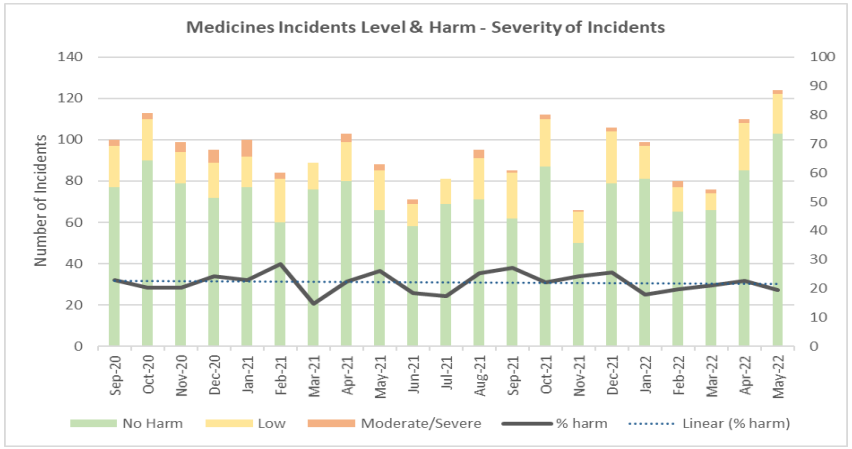
The controls and management around this risk are limited by:

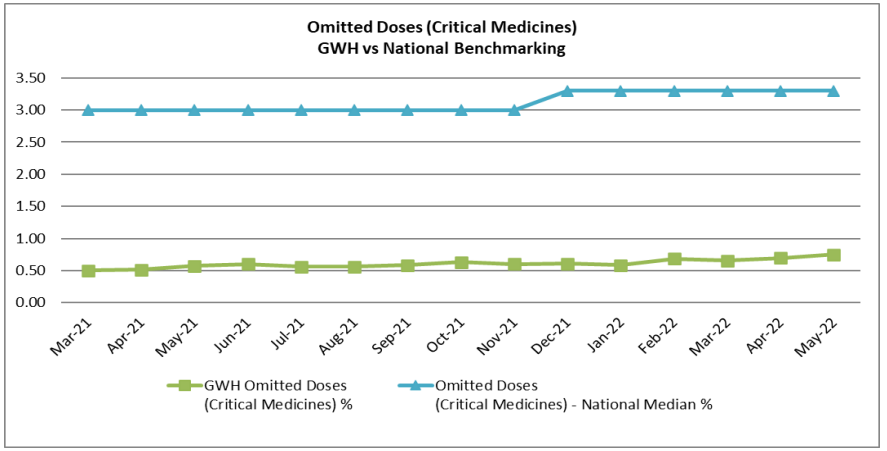
- Data quality – limits ability to choose improvement metrics
- 21 specialties currently mapping to 50 'ward' areas limiting ability to identify teams to improve
- Individual areas utilising more than 1 system e.g. Daisy (FCE and EDS).

2. Medicines Safety

Data Quality Rating:

Are We Safe?

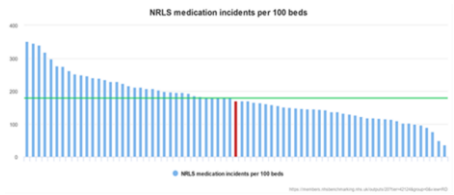




Background, what the data is telling us, and underlying issues

Medication Incidents

- Number of reported medication incidents has increased in May 22.
- No increase in incidents associated with moderate harm or above.
- Proportion of incidents resulting in any level of harm remains consistent, despite increase in incidents reported in May 22.
- GWH medicines incident reporting is mid range when compared to hospitals as part of 21/22 national benchmarking.



Omitted Critical Medicines

- Small increase in level of unintended omitted critical medicines in May 22. However, this rate is still below national benchmarking levels.

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

Medication Incidents

- Actions in June involved a review a deep dive into medicines incidents, and the correlation with serious incidents involving medicines. No obvious correlation found but work is ongoing during July to understand and learn from themes.
- Medicines safety improvement group established in May 22 to focus on trust wide learning. Initial projects have focused on medicines cold chain storage, and introduction of a just culture for medicines incidents.
- Future improvement work to include medicines safety simulations (Q3 22/23) and improving pain management in clinical areas.
- Rollout and implementation of medicines trolleys as an improvement programme continues in June.

Omitted Critical Medicines

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

Risks to delivery and mitigations

Medication Incidents

No specific risks to delivery identified at this stage.

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

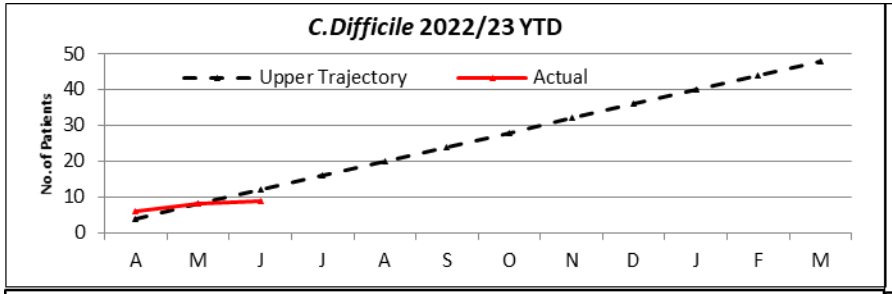
Omitted Critical Medicines

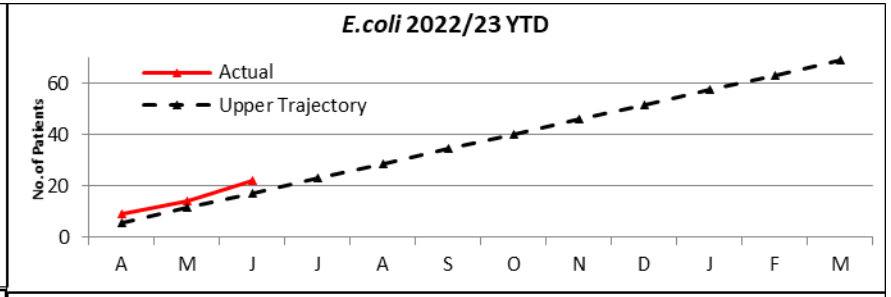
No specific risks to delivery identified at this stage.

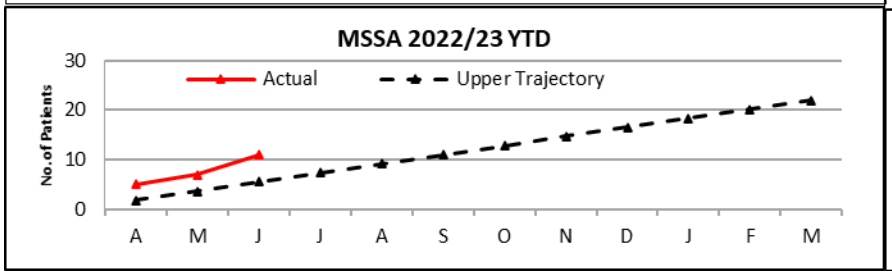
2. Patient Safety - Infection Control

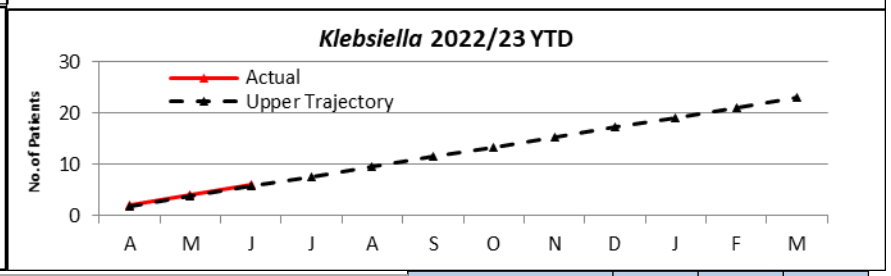
Data Quality Rating:

Are We Safe?









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

C. difficile – In June 2022 there were two reportable *C. difficile* infections which were both Healthcare Associated (HOHA) cases identified on Teal Ward. The Trust has been set a threshold of 48 *C.difficile* infections for 2022/23, which means that at the end of June 2022, we are under the trajectory for that threshold.

Gram negative bacteraemias -The Trust has been set thresholds of 69 *E.coli*, 23 *Klebsiella* and 19 *Pseudomonas aeruginosa* bacteraemias for 2022/23. In June 2022, 8 *E.coli*, 2 *Klebsiella* and 1 *Pseudomonas aeruginosa* bacteraemia were identified, placing the Trust slightly over trajectory for *E.coli* and *Klebsiella* but under for *Pseudomonas aeruginosa*.

MSSA – The Trust reported 5 hospital acquired MSSA infections in June 2022 bringing the total for the year to 12 against our full year internally-set threshold of 22. Five of these 11 samples relate to patients on the Acute Cardiac Unit and further investigation and a SWARM have been undertaken.

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

C. difficile – although the Trust is now under trajectory this remains a focus, given high rates last year and in April. The ADIPC or IPC Lead continue to attend all *C.diff* case review meetings and ward rounds, working closely with the Infection Control Doctor and Antimicrobial Pharmacists to maintain scrutiny.

Gram negative - *E.coli* and *Klebsiella* are commonly found in the gut, so infections from these organisms are often associated with poor hand hygiene or with catheter care. *E.coli* rates are rising nationally and regionally, with the increase appearing to be community-driven. GWH are participating in the BSW Integrated Care Board's Gram-Negative Bloodstream Infection Collaborative, as part of work to investigate and drive down *E.coli* rates across the region. Additionally, the IPC team are leading the Catheter-Associated Urinary Tract Infection (CAUTI) Group, which is a multidisciplinary group working across all Divisions to standardise and improve practice in both acute and community settings. The IPC Improvement Plan includes a focus on catheter care in August.

MSSA – as a common skin organism carried by 1 in 3 people, MSSA is often associated with intravenous devices and/or poor skin decontamination. An external audit of intravenous cannula practice against national and international best-practice standards is taking place during the first week of July and will inform any required quality-improvement work for the rest of July, for which the focus in the IPC Improvement Plan is cannula care.

Four patients have developed MSSA bacteraemias associated with inpatient stays on the Acute Cardiac Unit (with one of those patients having a repeat positive sample after 14 days, thus counting as another case for external reporting purposes). IPC have piloted a new, more in-depth, investigation tool with the ACU team for the investigation of these cases. Learning has been identified, including the need for timely and documented skin checks (both of wounds and of cannulas) and the unit has already shared this with their staff. A documented action plan is being formulated with support from IPC and will be shared at the next Infection Control Committee.

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

Risks to delivery and mitigations

The workload of the IPC team is again impacted by rising numbers of COVID cases, which are a significant demand on team members' time. A new Band 7 IPC Practitioner has been appointed and is expected to start in September. A location within the acute hospital has been identified for the team, which will locate them closer to wards than their current base in Commonhead, enabling more efficient use of time and increased physical presence on wards.

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.

Data correct as of 4th July 2022. The data in the preceding month may have changed due to timing of previous months reporting.

2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

Covid 19	Apr-22	May-22	Jun-22
Number of detected Inpatients	379	139	159
Number of Deaths in Hospital	23	15	7
Hospital Acquired Covid-19 Cases*	75	31	18

Covid-19 (Apr 22 – Mar 23)		(April 21- Mar 22)
Number of detected Inpatients	704	2440
Number of Deaths	49	162
Hospital Acquired Covid-19 Cases*	121	165

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

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

There were 18 hospital acquired cases of Covid 19 (8 days +) in June 2022. There were several outbreaks and clusters which were managed through the daily outbreak meetings.

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

The number of deaths listed above refer to deaths within 28 days of testing positive. Many of these are not caused by COVID-19. A review panel has been convened to investigate all nosocomial COVID-19 deaths.

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

Numbers of nosocomial COVID infections continued to decline through June, with any occurrences investigated by the IPC team and through Outbreak Control Meetings.

The Personal Protective Equipment audits are ongoing. Staff are also being reminded to complete regular lateral flow tests to reduce the risk of nosocomial transmission from staff to patients.

In order to reduce the risk of patient-to-staff transmission, improved availability of fit-testing for FFP3 masks began in June with the introduction of a full-time, on-site fit-testing service provided by NHS England. Improving fit-testing compliance is an important measure in providing safe working conditions for our staff and is an objective of the 2022/23 IPC Improvement Plan. The IPC team are working with HR, Procurement and the NHS England fit-testing service to ensure GWH meets the national recommendations on fit-testing, including record-keeping.

Capital funding has been approved for the initial phase of the roll-out of “air scrubbers” across clinical areas, following a successful trial on Neptune Ward. Estates are liaising with suppliers and installers and a roll-out schedule is expected in July.

The changes to guidance on COVID-testing indicated the use of LFTs for inpatient testing over PCR for non symptomatic screening on days 3 and 5 of an inpatient stay. Work is being done to facilitate this change across all areas. This currently sits with IT who are building the necessary software infrastructure (on NerveCentre) to implement the change.

Risks to delivery and mitigations

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

Rises in COVID prevalence in the community, which are predicted with the emergence new of sub-variants of the virus, are highly likely to affect staff sickness and patient nosocomial rates. Changes to COVID restrictions in the hospital may be required in mitigation. The need for this is being monitored closely by the DIPC, ADIPC, Medical Director and Deputy Chief Nurse.

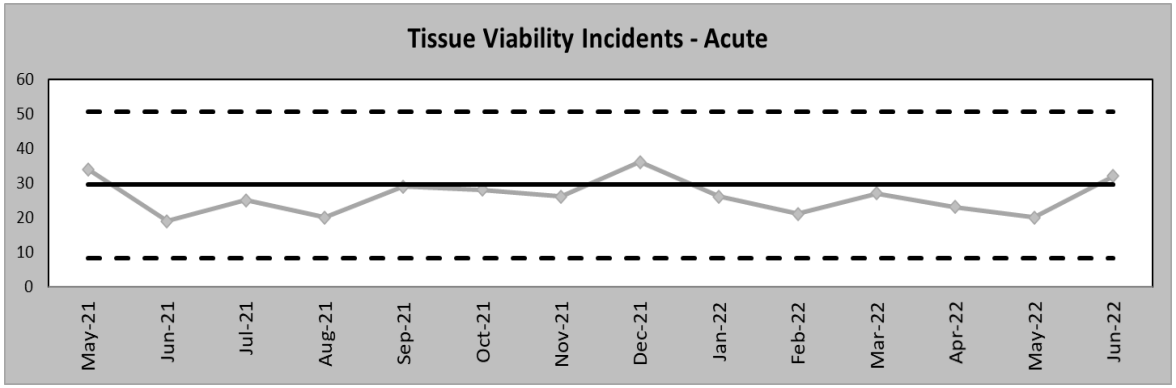
Data correct as of 4th July 2022. The data in the preceding month may have changed due to timing of previous months reporting.

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

2. Patient Safety – Pressure Ulcers ACUTE

Data Quality Rating:

Are We Safe?



Incidents of Harms by Category for June 22:

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Unstagable	Total Incident of Harms
14	1	0	5	12	32

Number of Patients	Harms per Patient
30	1
1	2

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

There were a total number of 242 incidents reported for pressure ulcer related harms during the month of June. All of these were validated by the Tissue Viability Nurses (TVN's).

32 of these incidents were hospital acquired and the remaining 210 incidents were a combination of PU harms which were present on admission and not pressure ulcer damage

This is an increase of 12 harms compared to 20 harms in May. month. There were a total number of 32 harms on 31 patients.

The medical devices related harm, were Oxygen tubing over ears and a Plaster of Paris to a leg.

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

Emergency Department (ED) monthly pressure ulcer meeting has commenced in June, reviewing all themes and actions required for improvement of pressure related harms within the department. This will help reduce the level of pressure related harm and improve staff knowledge and skills for caring for our patients.

The South West Ambulance Service, have commenced a regional improvement strategy to update all their documentation, IT systems and educate all crew members how to identify a pressure ulcer and correctly document and hand over to ED staff. This workstream is encouraging all Trusts within the South West to provide Repose companion trolley mattress to Ambulance crews within their ED's to ensure that any patient at risk will have access to pressure reliving equipment to place over the ambulance trolley. GWH has demonstrated that the equipment is utilised by crews and fully supporting the workstream with TVNs providing clinical expertise to the group.

The second Trust wide annual standard foam mattresses audit was completed in June, ensuring all beds have the adequate pressure reliving properties to support patient's skin. The report identified that 64% of mattress passed the audit, 29% where not audited and 8% failed. The failed mattress identified were mainly due to covers being stained, punctured or snagged or from a foam issue through staining, odour and bottoming out. All failed mattresses were replaced. Next steps to work with the equipment library and infection control team to improve processes and staff education.

Repose Training has continued across all wards and departments educating staff on the ward with bitesize sessions.

Pressure Ulcer prevention education facilitator has been appointed and will commence the role mid-August.

Risks to delivery and mitigations

Staffing across wards and departments has been reduced due to sickness absence, this is impacting on nursing time available to ensure thorough patient skin assessments are completed and patients are moved 2 hourly.

There has also been limited dressing resources available due to supply chain issues. Alternative products required as temporary solutions.

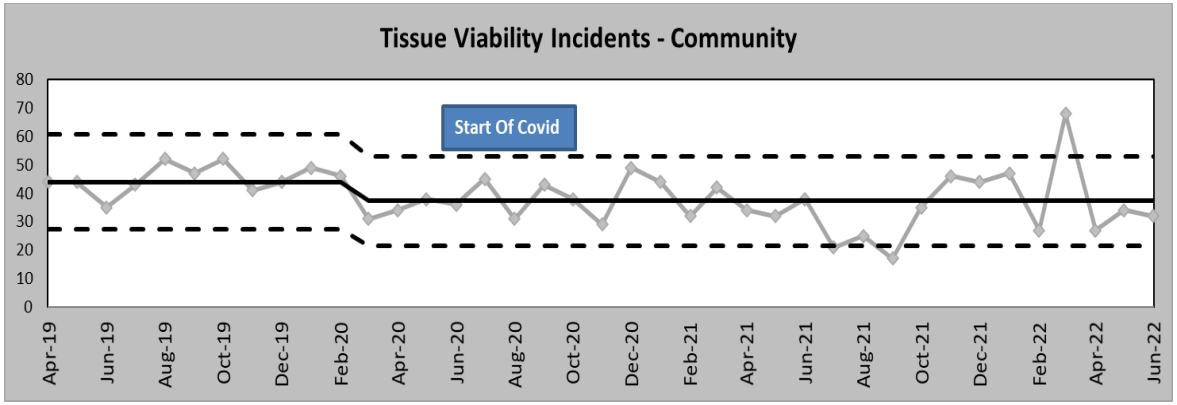
There is an identified shortage of pressure relieving air mattresses Trust wide. Demand has increased as staff are assessing risk more. The Equipment Library is reviewing stock and working with the TVNs to improve the situation.

Data correct as of 6th July 2022.

2. Patient Safety – Community Pressure Ulcers

Data Quality Rating:

Are We Safe?



Incidents of Harms by Category for June 22:

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Unstagable	Total Incident of Harms
14	1	3	6	8	32

Number of Patients	Harms per Patient
1	3
1	2
27	1

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

Total number of pressure ulcers reported this month is 88 this is a slight reduction compared to last month. Of these 32 occurred on the community nursing caseload, this is a reduction from last month.

13 harms are reported in patients that are end-of-life, actively dying or have died.

7 harms were on patients which occurred within a care home setting.

12 harms were on patients have complex care packages – excluding End of Life (EOL) patients.

1 Device related (Cat 2) incident this month related to a neck collar.

3 patients with Category 4 pressure ulcers were reported this month, all reside within a care home and are actively dying or have died.

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

As a result of the partnership working to reduce mucosal injury from urethral catheters a continued reduction is noted this month as no harms were reported. This is the first time since November 2021. This work is on-going.

The NHSI Pressure Ulcer Categorisation guidance has been updated to reflect the change to the incident reporting system and embed the rationale for referral to the Tissue Viability service from community services. This has been circulated to all community clinicians and has been added to the Tissue Viability Intranet page.

The Pressure Ulcer categorisation template that clinicians are required to complete electronically within the patients record when a pressure ulcer has been identified is being reviewed and updated to prevent delays in care planning

Risks to delivery and mitigations

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

This is being mitigated by:

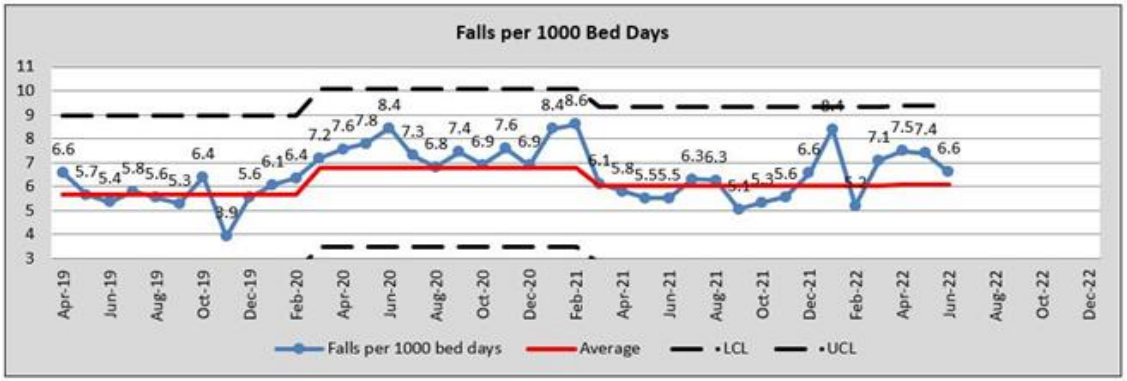
- Ongoing recruitment of community staff
- Case load reviews with Tissue Viability specialists
- Increased use of temporary staffing
- Education for temporary staff
- Use of Laptops and mobiles for temporary staff

Data correct as of 1st July 2022

2. Patient Safety – Safer Mobility (Falls Reduction)

Data Quality Rating:

Are We Safe?



	Total Falls	Falls resulting in moderate harm or above
Dec-21	126	4
Jan-22	160	3
Feb-22	88	1
Mar-22	140	4
Apr-22	142	3
May-22	147	6
Jun-22	125	3

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

125 reported inpatient falls reported in June 2022, resulting in 6.60 per 1000 bed days, this remains within normal variance.

On average each month 30.3% of falls involve patients who have fallen twice or more as an inpatient. In June 26.7% of falls involved patients who had fallen twice or more.

During June 2022, there were three patients who sustained falls which resulted moderate/severe harm, and death. One moderate harm, one severe harm and one death. The patient who sustained severe harm (#NOF) fell four times as an inpatient, sustaining a fractured NOF as a result of the fourth fall.

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

Physical activity and meaningful occupation (engaging in an activity that has significance to the individual or is purposeful and leads to a greater sense of self or well being) is essential to reducing the risk of deconditioning, as well as promoting psychological and social wellbeing for patients in hospital. A meaningful activity patient voices survey has been completed between Feb – May 22. Two Trust volunteers conducted interviews with 20 inpatients who had been in hospital for two weeks or more. This provides the baseline data to measure improvement, plans are underway for meaningful activity volunteers to be recruited. Brighter Futures have purchased two trolleys and stocked with activities for use on the wards.

Recruitment of Clinical Practice Educator for falls and enhanced care ongoing.

Falls Sensor Mats and Bathroom Alarms
- Training on the use of falls sensor mats and bathroom alarms has been delivered to 138 members of staff across the acute wards.
- Falls sensor mats are now available for order from the equipment library.
- Bathroom alarms have been fitted to all bays in Jupiter, Trauma and Teal Wards. Nominated leads in these wards to provide training in bathroom alarms.

Quick reference guidance sheets have been created on the following topics: - safe use of bedrails, safe seating, medicines and falls risk, use of low beds, and safe footwear. These documents have been approved, sent to all Falls Champions, and uploaded onto the Falls intranet pages.

Safe footwear audits have been completed on Orchard and Trauma, and planned on Teal in July. Results to be presented in July.

Risks to delivery and mitigations

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

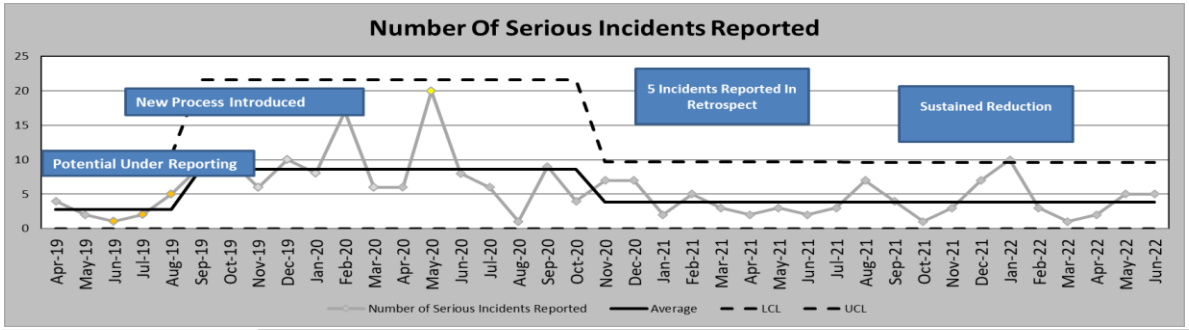
Around 300-350 patients a month are admitted with a fall as the primary diagnosis code, these patients are at high risk of falling again as an inpatient.

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

2. Patient Safety - Incidents

Data Quality Rating:

Are We Safe?



Serious Incidents Reported			Comparison
Apr-22	May-22	Jun-22	Jun-21
2	5	5	1

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

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

At the time of reporting, there are a total of 24 ongoing Serious Incident (SI) investigations, with five incidents reported in June 2022.

The numbers remain within our expected control limits.

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

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

Learning from incidents, serious incidents, inquests and investigations:
Patient Safety week was held within the trust academy from 20th of June to the 24th of June 2022, with positive feedback from staff, particularly in regard to a patient story around the psychological impact of witnessing an untoward event on an inpatient ward.
Datix DCIQ – the new patient safety database went live across the trust on Friday July the 1st 2022. Incident reporting numbers have not decreased, indicating ease of use of the new system. Training is underway amongst Divisional Quality Teams to support in incident management & incident reporting.
The Learning Zone Work is underway to improve the accessibility and layout of the Learning Zone, with an aim to increase staff awareness of the Learning Zone. This has included a trolley dash, ward visits and planning for a Learning Zone wall within the academy which will centre on, 'Learning from Excellence and a Positivity Wall.'

Fluid balance – roll out of the electronic fluid balance charts continues with a pilot on several wards. Procurement have sourced samples of drinking vessels that once agreed will become standard across all areas.
Mouthcare matters - an update was provided following a patient safety investigation, with key learning including the importance of denture assessment as part of a mouth care assessment.
National Patient Safety Training levels one and two.
Progress continues to be achieved in the roll out of the National Patient Safety training. 15% of all Trust staff have now completed level one, with Integrated Care and Community leading the Divisional completion rates at 23%. The training was also a feature promoted in Patient Safety week.

Risks to delivery and mitigations

Despite the improvement, there are still 9 SI investigations that are overdue, which pose a risk of breach of contract should the Trust be measured against timeframes.

Divisions provided a monthly closure trajectory for each SI.

The clinical risk team meets with the divisional quality team on a weekly basis and provides updates.

Weekly update on the SI's provided to the Chief Nurse and Medical Director and escalate the concerns over the overdue SI's.

Overdue SI actions - it has been identified there are (as of 23rd of June) 77 overdue actions from SI investigations which presents a risk in implementing learning. Plan is in place for the Clinical Risk team to support Divisions to reduce the number. Trajectory will be monitored via SIRLG meeting and from August 2022, any remaining overdue actions will be recorded on Datix where can be effectively monitored.

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

2. Patient Experience – Safer Staffing

Data Quality Rating:

Are We Safe?

Table 1 - Average Fill Rate

Average Fill Rate (%)	
Nurses / Midwives	95.1%
HCA	104.4%

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

Ward	Average Fill Rate – Nurses / Midwives (%)
Hazel, Delivery & WHBC	81.7%
ITU	66.2%
SCBU	83.8%
Orchard Ward SWICC	75.5%
Ward	**Average Fill Rate - HCA (%)**
Kingfisher SAU/SAW	78.2%
LAMU & SHAL MAU/SSU	80.0%
Hazel, Delivery & WHBC	71.0%

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

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

The Overall fill rate on days for Nurses/ Midwives is 95.1% , this is an increase from last month. The average Fill Rate on day shifts for HCAs is 104%, this continual improvement in the HCA fill rate is reflective of the recruitment work undertaken. Wards with over 100% fill rate is due to patients that require additional support or 'enhanced care' for example if the patient is confused.

Hazel, Delivery & WHBC continue to be the only area that had below 90% average fill rate for both Midwives and HCA on days. There remains significant oversight and actions on safe staffing in Midwifery by the Director of Midwifery.

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

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

HCA vacancy
HCA vacancy rate continues to improve and a strong pipeline is in place. Wards are now recruiting to the new safer staffing establishments. Current vacancy is 15.48wte with 42.47 in the recruitment pipeline.

Registered Nurse vacancy
The trajectory for Band 5 registered nurses has been updated to include latest turnover data and the new safer staffing establishments. A bid for a further 30 wte Internationally Recruited Nurses has been submitted to maintain a zero vacancy position at year end.

Risks to delivery and mitigations

Maternity Staffing remains of concern due to high vacancies and maternity leave. There has been successful recruitment of students who are due to start in the Autumn and gaps are being filled by the agency midwives. There is very close monitoring of critical gaps and reporting of staffing and acuity by the Director of Midwifery.

ICU currently has 3wte vacancies for registered nurses and is actively recruiting. The low fill rate is reflective of reduced activity / acuity and not of clinical concern.

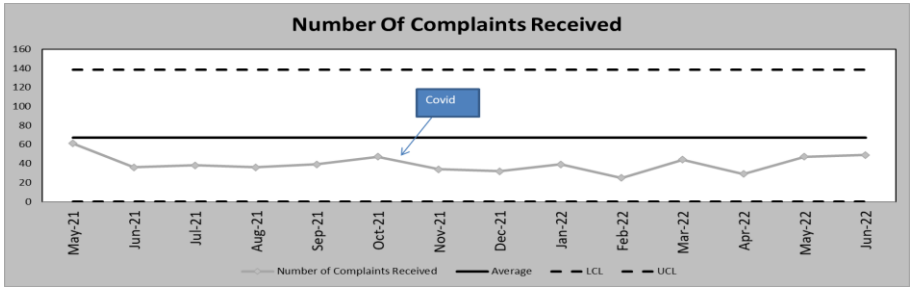
The Emergency Department and Urgent Care Treatment Centre remains under significant operational and staffing pressures. The ED skill mix work is under way which will increase the number of senior staff (band 6&7) to ensure that the national workforce standards are met.

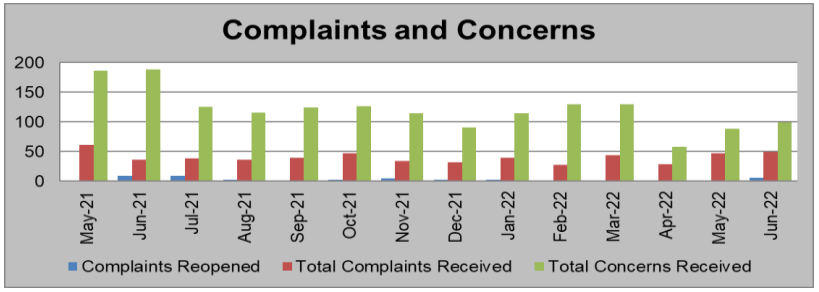
Agency Reduction plan

The agency reduction plan is discussed monthly along side the recruitment and retention plans at the Nursing and Midwifery Workforce Committee. The Divisional Directors of Nursing also present the weekly position to the Chief Nurse.

2. Patient Experience - Complaints and Concerns

Are We Safe?





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

49 complaints received (previous month 47) and 99 concerns (previous month 88) were received in June 2022.

Out of a total of 148 cases received from Complaints and Concerns in June, the overall top three themes were:

Theme	Complaints	Concerns	%
Communication	4	33	25%
Waiting Times	3	19	15%
Clinical Care	15	2	11%

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

The complaint response rate was 81% (69% in May). 75% of concerns were resolved within seven working days, (89% in May). (Internal KPI 80%).

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

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

Two PALS open days have taken place in June 2022 for Trust staff to visit PALS and meet the team within the department. The team met several staff from across the Trust and shared information about PALS processes and how we can support them with the feedback they receive.

An accessible communication audit is underway, being led by the PALS and Complaints Team Leader. This audit will include auditing areas of the hospital to ensure they are set up correctly to deal with patients whose first language is not English and those living with any form of hearing loss or impairment and to better understand how we can ensure the Trust is accessible to these groups. This audit is in progress, and we hope to have preliminary results and an action plan by early August.

As part of the falls, end PJ paralysis and meaningful activity workstreams we have completed a patient voices meaningful activity survey. The results of this are being used to target improvements and implement new activities at ward level.

Large new 'Great Care', Way Forward Programme' and 'Improving Together' display Boards now being placed across the trust to highlight the improvement work taking place.

Our suite of 'Care Reflections' from our patients and families is growing and now has a dedicated intranet site.

Progress has been made in supporting both patients and staff with military connections and we are very pleased to have achieved the Silver Employee Recognition award.

Significant developments have been led under the Carers agenda with the launch of a new Carers Charter which forms the basis and direction of our work.

Risks to delivery and mitigations

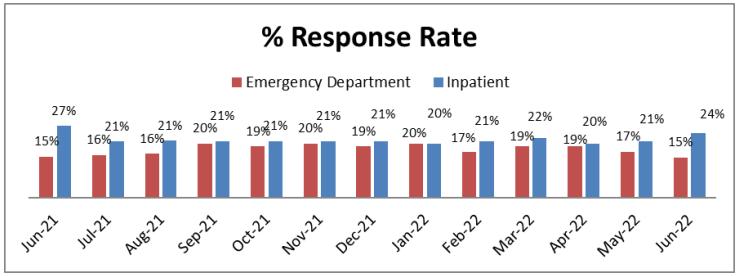
There has been reduced capacity due to a number of vacancies within the PALS and Complaints team. Both vacancies are now filled and currently training into the role.

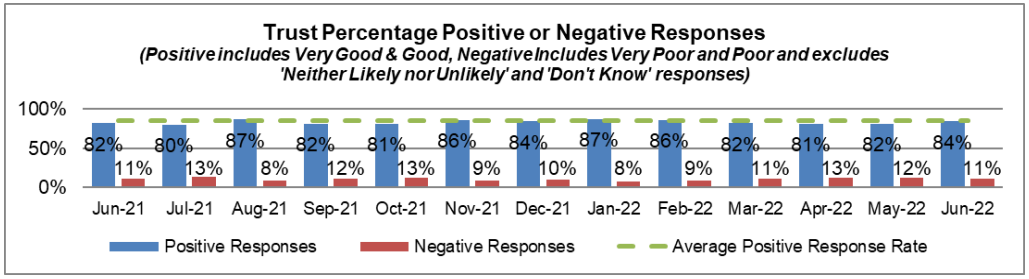
Data correct as of 4th July 2022.

2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?





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

For June, 84% of the Friends and Family Test (FFT) responses were positive, in line with the previous months. The negative responses at 11% are slightly lower than last month at 12%. This is based on the % of responses rated as 'very good' and 'good'.

	Number of text sent	Number of responses	Response rate	Positive responses
ED & UTC	5,456	1,192	15% ↑	73% ↑
Inpatients	2,319	1,067	17% ↓	86% ↑
Day Cases	1,544	389	20% ↓	92% →
Outpatients	0	728	n/a	96% →
Maternity	1,064	177	17% ↓	90% ↓

**Data verified by Unify/Informatics team 11 July 2022.*

A&E (ED & UTC combined) recommendation rate at 73% is in line with the range 70% to 73% of recent months. Inpatients currently with an 86% recommendation rate has increased over recent months. Outpatients has a sustained recommendation rate of 96% with an increasing volume of feedback from patient completed cards. For the combined areas of maternity services, the recommendation rate shows a gradual decline: April 93%, May 92% to 90% for June. Birth and Postnatal Community aspects remain high with 94% and 97% respectively.

Overall positive and negative themes :

Top 3 Themes	Positive		Negative	
	May-22	Jun-22	May-22	Jun-22
Staff attitude	1,135	1,583 ↑	210	244 ↑
Environment	503	633 ↑	199	213 ↑
Implementation of care	687	891 ↑	n/a	n/a
Waiting times	n/a	n/a	182	199 ↑

Improvement Actions in response to Feedback:

The 'Sort Our Streets' forum is addressing issues regarding cluttered corridors, additional storage and embedding processes to prevent inappropriate items being left in public areas.

Scoping is underway to build a suite of training opportunities to support staff with a focus on First Impressions and Early Resolution. Target September 2022.

The Great Care Campaign is embedding improvements regarding meaningful engagement. Results of a patient survey acknowledged patients wishes to be involved in daily activity. New engagement trollies are now on site and along with dedicated volunteers to support activities will be rolled out during August.

Risks to delivery and mitigation

The FFT contract is due for renewal November 2022. The procurement plan is currently being discussed.

Data correct as of 11th July 2022.

2. Patient Safety – Perinatal Quality Surveillance Tool

Data Quality Rating:

Are we Safe?

Measures	Comments

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

Measure	Aim / Target	April 22	May 22	June 22
Midwife to birth ratio	1:29	1:24	1:28	1:26
1:1 Care	100%	100%	100%	100%
Consultant presence in Delivery suite (Hours per week)	60 hours	74.5hrs	74.5hrs	74.5hrs

The midwife to birth ratio and 1:1 care data continues to fall in the targeted range. A consultation process in underway to explore the implementation of an alternative on call system for the intrapartum areas. This will aim to facilitate improved choice in the location of birth for women by ensuring available staff for both hospital and community births during periods of high acuity.

Service User feedback

Compliments reviewed via the Friends and Family service and directly to the ward managers focus on caring, welcoming staff and a sense of feeling safe with one service user stating 'Your department and Great Western Hospital are backbone of the values for what the NHS stands for and provides'.

The quarterly feedback from the Maternity Voices Partnership has been evaluated with improvements implemented. One key area for concern highlighted was a lack of connection between the neonatal unit and the postnatal ward. In order to continue to align the perinatal service the matron roles have been reviewed, with the Matron for Inpatient Services for Maternity now having responsibility for the Neonatal Unit.

Core20PLUS5– An approach to reducing health inequalities

Measure	Aim/Target	March 22	April 22	May 22	June 22
BAME women on continuity of carer pathway	75%	30.61%	42.42%	43.18%	42.70%
Women with high index of multiple deprivation on continuity pathway	75%	75.00%	61.29%	67.44%	61.90%

The 'Bluebell' continuity team continue to provide care to a targeted geographical area. Ongoing workforce planning will focus on models for how rollout will be prioritised to 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.

Caesarean Sections

Robson Group Descriptor	Robson Group Number	Sparkline	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Women/pregnant people in their first pregnancy with a head down, single baby at ≥37 weeks, in spontaneous labour that had a Caesarean birth*	1		6.98%	7.08%	8.87%	9.20%	6.25%	11.90%
Women/pregnant people in their first pregnancy with a head down, single baby at ≥37 weeks, experiencing an induced labour or caesarean birth before labour. *	2		25.60%	31.86%	26.61%	32.70%	29.69%	30.10%
Women/pregnant people that have had a previous Caesarean birth, with a head down, single baby at ≥37 weeks. *	5		30.20%	20.35%	35.48%	26.50%	28.13%	28.50%

**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.*

Adjustment of the data is informing the ongoing caesarean section action plan with a particular focus on the 'Biomechanics of labour'. A team of midwives and obstetricians attended a workshop to explore simple movement techniques to facilitate avoidance of delays in the first and second stage of labour.

The Trust is participating in a research trial on the use of oxytocin in labour with a focus on birth outcomes, including mode of birth and labour indicators that may impact on the decision process for a caesarean birth.

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)	**2021-22 CNST Maternity 10 Safety Criteria** (NHS)
Ockenden Report (March 2022)	A gap analysis of the full Ockenden report has been undertaken to identify areas for improvement, highlight key risks and investment required for full compliance which has been presented to Trust board 7th July 2022.
Findings of review of all perinatal deaths using the real time data monitoring tool	No cases reviewed in June.
CQC Ratings	There is a planned walkabout on 19th July by the local inspection team, who will visit the maternity unit to meet the teams during the Quarterly Engagement.
Maternity Safety Support Programme	Not required as CQC ratings overall 'Good'
Coroner's Regulation 28	Nil

	Criteria	RAG September 2021	Projected submission RAG	Review Comments
1.	Are you using the PMRT to review perinatal deaths to the required standard?	Amber	Green	
2.	Are you submitting data to the Maternity Services Data Set to the required standard?	Red	Green	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?	Amber	Green	
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Red	Green	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?	Amber	Green	
6.	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Amber	Amber	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?	Amber	Green	
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?	Amber	Green	
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?	Amber	Green	
10.	Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?	Amber	Green	

2. Patient Safety - Perinatal Quality Surveillance Tool

Are We Safe?

Ockenden progress update

Overview & Summary Review of Criteria RAG Status

July 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	1 =	3 =	1 =	Consideration of maximising consultant obstetrician presence, and review of escalation policy
4	Clinical Governance - Leadership	1 ↓	5 ↑	1 =	Presentation of National Maternity Self-Assessment Tool and improvement plan to Trust Board in July. Stregthen multi-disciplinary approach to review of guidance
5	Clinical Governance - Incident Investigation & Complaints	0 ↓	7 ↑	0 =	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	1 ↓	3 ↑	3 =	Implementation of mandatory annual human factors training. Review of job plans to ensure release of staff for multi-professional engagement forums
8	Complex Antenatal Care	1 =	3 =	1 =	Strengthen awareness and access to preconceptual care via the primary care network
9	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 involvment
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	1 ↓	2 ↑	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	• 3 incidents were graded as moderate harm for the perinatal services in June. • These cases have been reviewed via an urgent incident review with multi-disciplinary engagement. • 1 of these incidents is subject to a level 1 Internal investigation.

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

Serious Incidents (SI)

Case Ref	Overview	Date	Case Update
None			

On-going SI Investigation Update

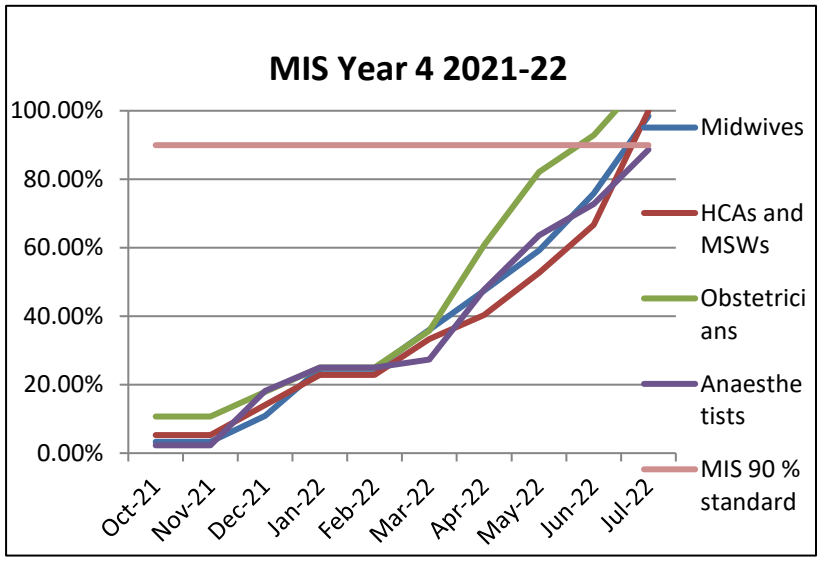
Stage of investigation	April 2022	May 2022	**June 2022**
Referred to HSIB – awaiting decision	0	0	0
Under local investigation (this may include insight from external reviewers)	1	1	0
Under HSIB investigation	3	3	1
Report complete & awaiting Serious Incident Review learning Group (SIRLG)	0	0	1
Submitted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

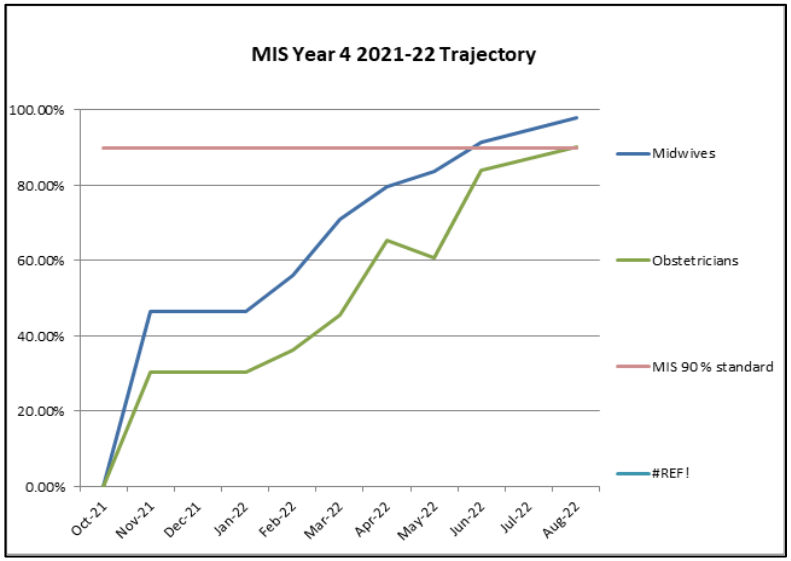
Data correct as of 6th July 2022. The data in the preceding month may have changed due to timing of previous months reporting.

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

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

Risks to delivery and mitigations

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

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

Great Western Hospitals NHS Foundation Trust

Part 3: Our People

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Caring?

Are We Well Led?

Use of Resources

Resources

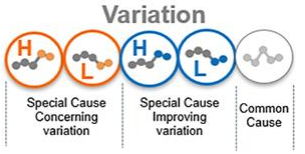
Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

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

Summary Dashboard - Workforce Performance

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Overall Agency Spend as a % of Total Spend	H	?	6.36%	6.00%	4.31%	7.50%	5.91%
2	Trust RN Bank Fill Rates		F	47.09%	70.00%	38.01%	58.33%	48.17%
3	Vacancy Rate*		?	6.94%	7.63%	5.55%	8.52%	7.03%
4	Recruitment Time To Hire (Days)	H	?	67.90	46.00	34.01	58.85	46.43
5	All Turnover	H	?	14.82%	13.00%	12.50%	14.06%	13.28%
6	Voluntary Turnover	H	P	11.88%	11.00%	9.07%	10.45%	9.76%
7	All Sickness Absence	H	?	4.71%	3.50%	3.21%	5.35%	4.28%
8	Statutory Mandatory Training Compliance	H	?	87.75%	85.00%	84.53%	88.79%	86.66%
9	Appraisal Compliance	L	F	74.55%	85.00%	70.99%	81.16%	76.07%



Trust Overview: Narrative

Great Western Hospitals NHS Foundation Trust

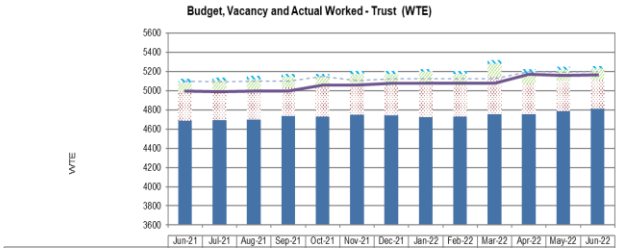
"Great" Scoring	Indicator Score (1-4)	Self Assessment Score	Headline
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding			
Great Workforce Planning	2	2	In June the Trust utilised 5259WTE of staffing resource to deliver its services, an increase of 7WTE compared to May. This resulted in a usage of 91WTE in excess of budgeted WTE. Temporary staffing usage remains high and above the vacancy position, being driven by vacancy cover and continued escalated staffing for Medical workforce in General Medicine, Outlier Cover and Emergency Medicine, and for Nursing staff within the AMU, Community Nursing, and Maternity Inpatient teams. Introduction of medical locum process to increase control of escalated rates has been implement.
Great Opportunities	1	2	The Trust vacancy position in June decreased to 358.52WTE, bringing the vacancy rate across all staffing groups to 6.94%. The current vacancy position does not reflect planned increases to WTE for Safer Staffing (£2.2M investment) which equates to an 112WTE Healthcare Assistants and 32WTE Registered Nurses, this is planned to be phased into establishments from August. The Trust has made significant improvements on the HCA vacancy position which is now over recruited, however direct correlation with reduced temporary staffing is yet to be seen. Voluntary turnover decreased to 11.82% in May 2022, although is still above the 11% target. The recruitment time to hire in May is 67 days which has remained above the Trust KPI of 46 days. Areas for review include, manager shortlisting KPI and Offer letter KPI.
Great Experience	1	2	Sickness reported in May 2022 was 4.71%, a significant decrease from last month (6.05%). In June, referrals for 1:1 staff support and occupational health input remain high (22 & 159 respectively). A total of 191 pre-employment checks were made this month. Across June, 5 members of staff were trained in Mental Health First Aid and a further 5 in Suicide First Aid. The tea trolley has continued to visit staff areas throughout the month, and also supported with Patient Safety Awareness week. In-reach health checks for staff re-launched in June. Holistic staff HWB initiatives in development currently include financial wellbeing and dietetic advice, in addition to support with Stay Conversations. The Trust Annual Staff Award also took place.
Great Employee Development	2	3	The Trust continues to meet its overall mandatory training target, and compliance this month is 87.87%. Work is ongoing to support specific areas-eg Childrens Safeguarding and this included moving to an electronic passport. The Trust has received £700,000 from HEE to support CPD for nurses, midwives and AHPs. This is the last year of a 3 year agreement to provide support in this area. The Trust has returned its plan to spend this funding after a TNA exercise. There will be a focus on providing BAME staff with the opportunity to complete the Aspiring Leaders programme in the Autumn. There is also an increased focus and project plan to improve the Trust's performance in Care Certicate compliance for HCA staff.
Great Leadership	1	2	The Trust has participated in a BSW initiative to procure mediation training and seven staff from within GWH will be trained alongside BSW colleagues. This will ensure there is a list of BSW mediators which should create internal capacity and support a reduction ins costs associated with external mediation. The Scope for Growth pilot is progressing well and will become the basis for our approach to Talent Management-although consideration is being given to how this would work with senior roles. The Trust continues to provide regular Aspiring Leaders and Leadership Development programmes. Consultation is continuing on the STAR behaviours and red lines. The appraisal rate has improved slightly and this month stands at 74.55%.

Workforce

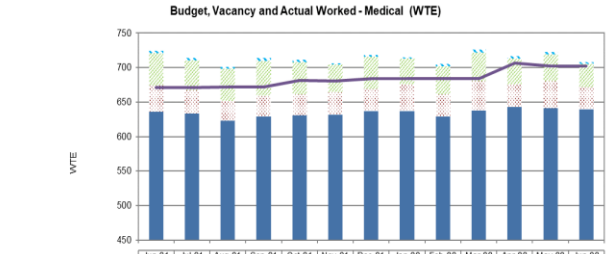
Use of Resources

Great Workforce Planning

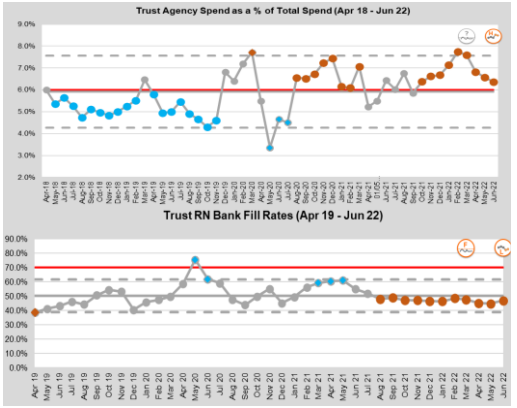
Indicator Score	Self Assessment Score
2	2



	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Overtime WTE - Trust	35.35	31.33	33.63	31.13	30.27	33.11	31.82	25.32	32.91	36.09	43.23	30.72	26.85
Agency WTE - Trust	102.47	108.07	111.89	109.30	110.22	115.23	124.53	124.18	120.02	139.35	113.88	124.59	117.85
Bank WTE - Trust	300.77	304.96	308.09	293.16	308.47	307.07	305.88	350.76	320.03	386.55	315.69	311.77	304.96
Staff in Post WTE - Trust	4683.13	4690.48	4699.86	4738.65	4728.61	4749.80	4744.84	4725.74	4732.91	4755.01	4754.19	4785.04	4809.78
Budget WTE - Trust	4997.81	4989.24	4995.38	4997.78	5058.62	5056.11	5077.26	5076.56	5076.56	5076.56	5169.51	5162.20	5168.30
Vacancy WTE	314.68	298.76	295.52	259.13	330.01	306.31	332.42	350.82	343.65	321.55	415.32	377.16	358.52
Budget WTE (Sub., Bank & Agency)	5099.91	5091.34	5097.48	5099.88	5150.78	5107.27	5124.42	5122.72	5122.72	5122.72	5202.71	5195.40	5201.50
Trust Paybill £	£21.52M	£20.48M	£20.81M	£25.82M	£21.33M	£21.52M	£21.81M	£22.06M	£22.00M	£19.99M	£23.34M	£22.93M	£23.22M
Trust Pay Budget £	£20.75M	£20.64M	£20.60M	£20.60M	£21.16M	£21.22M	£21.22M	£21.28M	£21.25M	£22.48M	£22.79M	£22.67M	£22.48M



	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Overtime WTE - Medical	3.41	3.18	2.51	3.67	3.39	1.80	2.90	1.42	3.02	4.13	3.15	3.99	2.47
Agency WTE - Medical	46.94	43.26	46.84	50.09	47.24	40.09	46.53	37.79	40.81	41.58	37.18	38.97	34.25
Bank WTE - Medical	38.00	33.73	28.47	30.63	30.23	32.30	31.75	39.20	32.14	43.16	33.33	38.31	31.73
Staff in post WTE - Medical	635.62	633.32	623.12	629.08	630.74	631.82	636.98	636.43	629.10	637.28	642.88	641.37	639.48
Budget WTE - Medical	671.28	670.80	671.80	671.80	681.42	680.42	684.42	684.42	684.42	684.42	706.43	702.33	702.23
Vacancy WTE	35.66	37.48	48.68	42.72	50.68	48.60	47.44	47.99	55.32	47.14	63.55	60.96	62.75
Medical Paybill £	£6.84M	£6.32M	£6.33M	£8.22M	£6.43M	£6.14M	£6.56M	£6.68M	£6.55M	£6.46M	£6.74M	£6.75M	£6.84M
Medical Pay Budget £	£6.14M	£6.11M	£6.06M	£6.07M	£6.17M	£6.19M	£6.21M	£6.31M	£6.21M	£6.24M	£6.39M	£6.48M	£6.37M



Background

The Trust utilised 5259WTE staff to deliver its services in June 22, an increase of 7WTE on May and 91WTE in excess of budgeted WTE. Temporary staff utilisation decreased in June, with both bank and agency decreasing by 7WTE each. In June the percentage of pay bill spend on agency reduced again, decreasing from 6.57% in May to 6.36% in June.

For June the top 3 highest users of nursing bank/agency were AMU (28WTE), Community Nursing (27WTE) and Maternity Inpatients (24WTE). In AMU usage is being driven by vacancy (8WTE), parenting leave (8WTE), and sickness (5WTE). Community nursing usage continues to be driven by increased staffing funded by the hospital discharge programme. Maternity Inpatients is predominantly covering Vacancy (18WTE) and Sickness (5WTE).

For medical staff, General Medicine including Outlier Cover (23WTE) remains the highest user of temporary resource, followed by Emergency Medicine (14WTE). Whilst there has been a reduction in usage in both areas in-month, it still remains high being driven by Vacancy, and Escalated Staffing.

Improvement actions

1. Change Management paper for the 7-day working for Community Rehabilitation Therapy team being presented at IC&C Divisional Board on 13th July 2022 with view to EPF in August. Extending the Urgent Community Response to 7-day service with approved external funding. Successful 3-month pilot scheme concluding and high levels of staff engagement.

2. The Division is preparing to submit a BSW system bid to Executive Committee for proposal for viability of international recruitment of AHPs. The Division reviewing the basis for a pilot trial.

3. Roster implementation/planning has commenced in Acute Medicine which will take approx. 14 weeks and will include- Gen Med, Stroke/Neuro, Cardiology, Endocrine/Diabetes, Acute Medicine, Respiratory, Gastro and DOPS

4. Advanced Clinical Practitioners are being recruited to SWC in Gynae, Hospital at Night and T&O with further appointment planned in SAU. Division group currently lead by Deputy Divisional Director Nursing to oversee induction, development and mentor support.

Risks to Performance & Mitigations

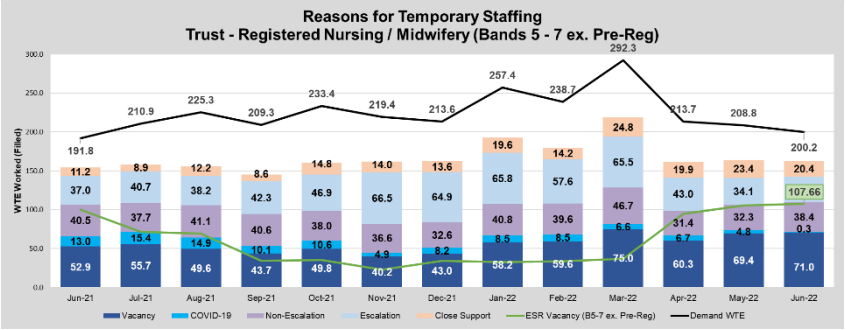
The Trust continues to focus on the Safer Staffing tool and review of staffing requirements against the acuity of patients. Recruitment activity is planned in line with the Safer Staffing investments to increase the establishment for Band 5 and Band 2 nursing. As a temporary mitigation ward managers are working clinically to maintain safer staffing ratios.

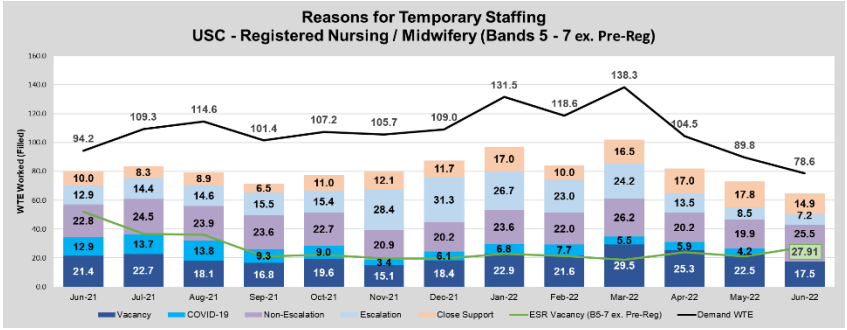
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

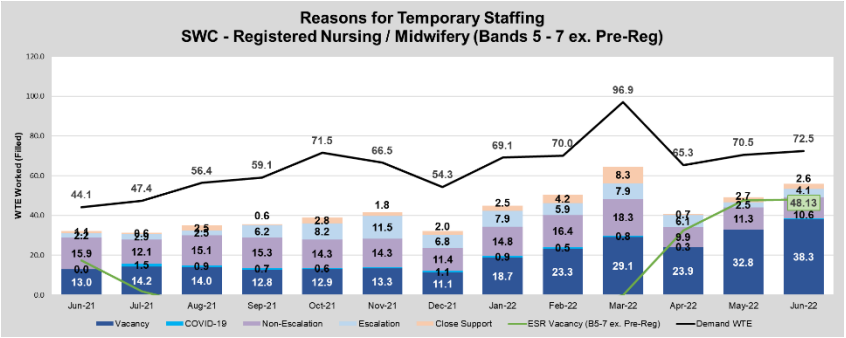
Workforce

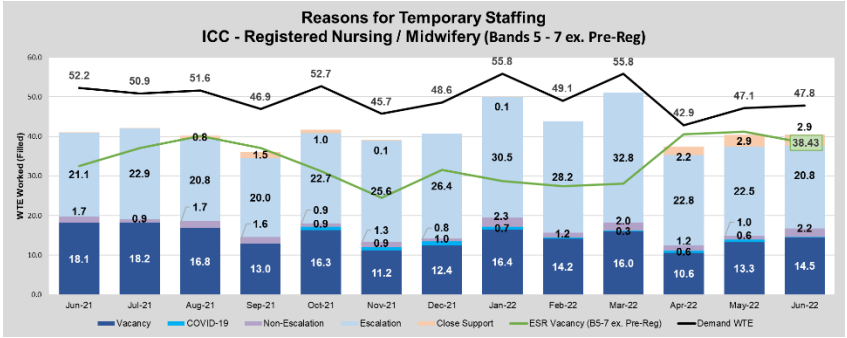
Use of Resources

Great Workforce Planning	Indicator Score	Self Assessment Score
	2	2









Background

In May there were 163.06WTE temporary staff (registered nursing/midwifery) used across the Trust against a vacancy of 107.66WTE (excluding pre-registered nurses) but including Corporate Nursing.

Demand decreased month on month in June, dropping from 209WTE to 200WTE, however the amount filled remained broadly the same resulting in an increase of overall temporary staffing fill from 79% in May to 81% in June.

- USC 65.0WTE used against M03 Vacancy of 27.9WTE
- SWC 56.3WTE used against M03 Vacancy of 48.1WTE
- ICC 40.5WTE used against M03 Vacancy of 38.4WTE

Of the temporary staff WTE utilised, 75.3WTE was agency (compared to 79.2WTE in May) and 87.8WTE was bank (compared to 85.8WTE in May).

For this staffing group we have a pool of 195 bank-only registered nurses, alongside 1,220 substantive staff with a bank assignment who can cover temporary staffing requirements.

Improvement Actions

1. Unscheduled care are targeting reduced RMN usage and reliance by introducing tighter challenge and control through daily staffing meetings and a weekly data review.
2. Continued scrutiny of agency bookings is being undertaken across the senior nursing team on a weekly basis, with bookings being challenged and cancelled where possible whilst balancing staffing ratios within departments.
3. ICC division have planned a Community Nursing recruitment open day for September to attract new staff to the department, which will help reduce reliance on Temporary Staffing usage.

Risks to Performance & Mitigations

Across all divisions there is high demand of nursing agency and bank due to vacancy factor and sickness levels. Recruitment activity including overseas recruitment continues as a mitigation to high vacancy levels.

An increase in nursing establishments is due to be phased into budgets from August following on from Safer Staffing investments. Senior nursing teams will proactively monitor temporary staff bookings to prevent escalation of this demand to bank and agency.

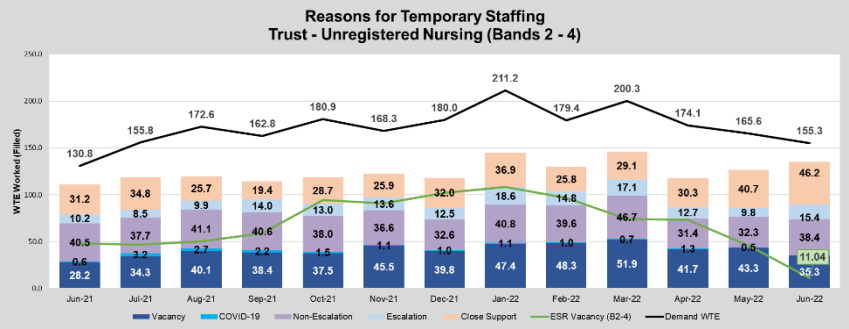
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

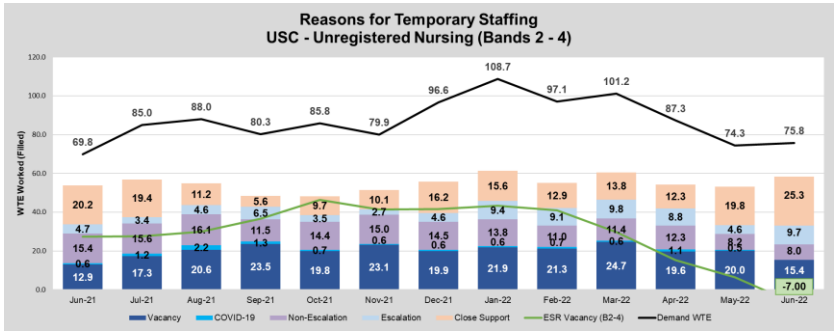
Workforce

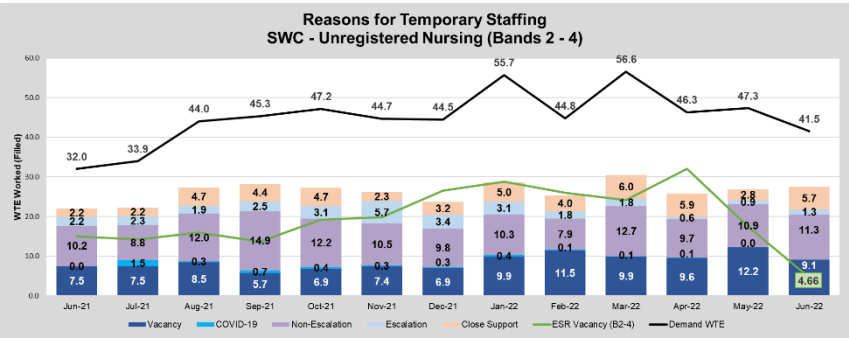
Use of Resources

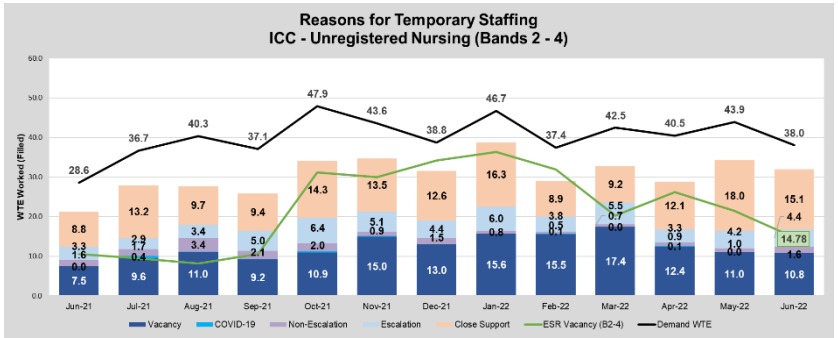
Great Workforce Planning

Indicator Score	Self Assessment Score
2	2









Background

In June there were 117.9WTE temporary staffing unregistered nursing/midwifery band 2-4 used across the Trust against a vacancy of 11.0WTE

Demand continues to decrease for unregistered nursing, dropping in June to 155.3WTE (165.6WTE in May). In all divisions, temporary staff usage continue to be above the vacancy WTE position.

- USC 58.4WTE used against M03 Vacancy of -7.0WTE
- SWC 27.6WTE used against M03 Vacancy of 4.7WTE
- ICC 31.9WTE used against M03 Vacancy of 14.8WTE

The Trust does not approve agency usage for unregistered nursing. As you can see from the trend line there is no direct correlation between vacancy rate and hca temporary staffing usage.

Improvement Actions

1. The Band 2 HCA vacancy position in June is -11.77WTE, with 42.3WTE candidates in the pipeline. Of this 17.1WTE have a start date agreed and 25.4WTE are undergoing pre-employment checks.
2. An increase in HCA interview panels for July have been scheduled to help support an increased pipeline of candidates to meet the investment plan.
3. Theatre Recruitment campaign under review, to include University links, Virtual open day and to publish all Theatre adverts on to social media.

Risks to Performance & Mitigations

The band 2-4 vacancy position is 11.04WTE, broken down into an over-established position of -11.77WTE for band 2 and 22.81WTE vacancy for bands 3-4.

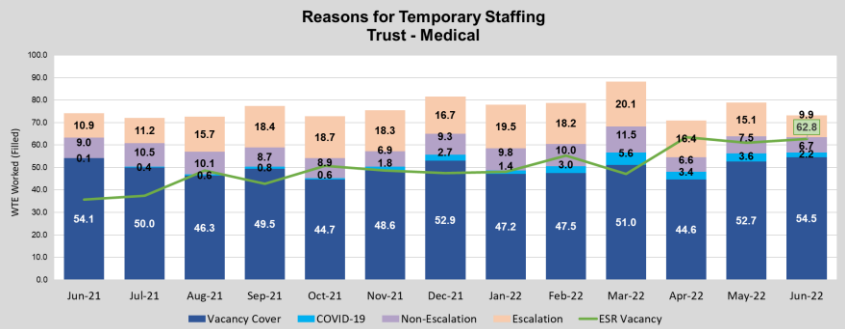
Whilst the vacancy position overall has stabilised for this staffing group, temporary staffing requests continue to be higher than the vacancy level.

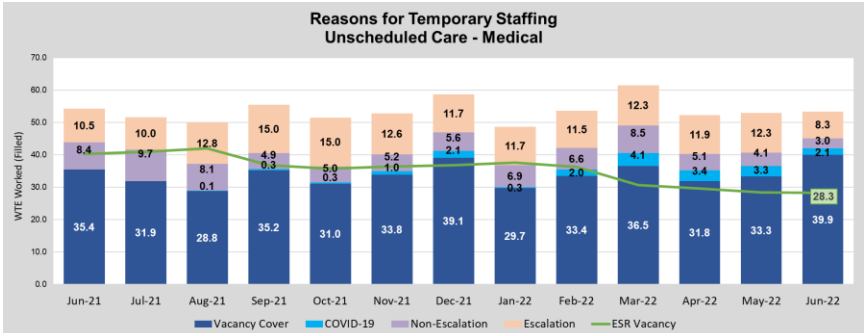
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

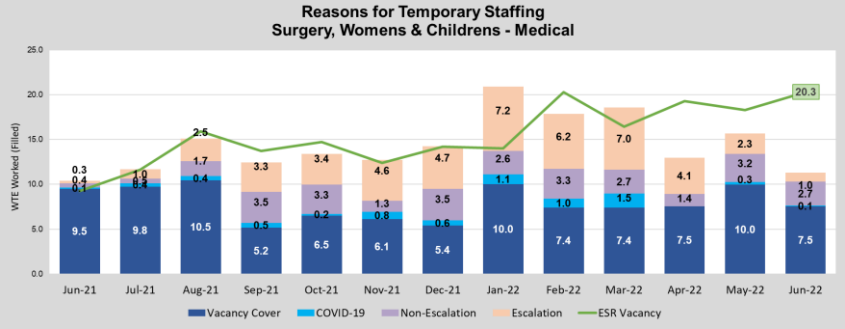
Workforce

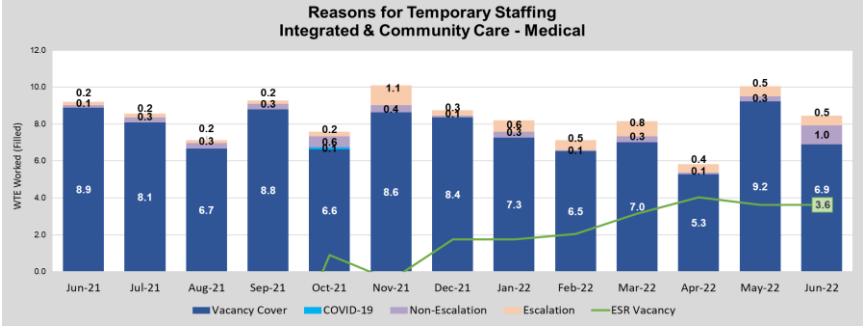
Use of Resources

Great Workforce Planning	Indicator Score	Self Assessment Score
	2	2









Background

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

The data highlights in June 22, 73.3WTE Temporary Medical Workforce was used across the Trust.

- USC 53.4WTEused against 28.3WTE M03 Vacancy
- SWC 11.3WTE used against 20.3WTE M03 Vacancy
- ICC 8.5WTE used against 3.6WTE M03 Vacancy

**Note the WTE used figured does not include workers outside IR35 and booked via consultancy. The Trust currently has 10 outside IR35 workers.*

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

Improvement Actions

1. Work within USC to review the current staff in post has progressed in month with areas of high agency spend being prioritised to ensure there is a correct baseline vacancy position. This work is informing displacement of long term agency workers with recruitment activity.
2. In June USC successfully recruited a Medical Support Worker within Cardiology. The division continues to review skill mix within medical specialties, with a view to implementing new models of staffing where appropriate.
3. The Electronic Rostering roll-out programme for Medics has continued in June, with both Obstetrics & Gynaecology and the Emergency Department running their current rosters live from the system. Key reporting outputs from the system are being explored with Unscheduled Care to provide a fuller picture of activity within the Emergency Department.
4. The SARD system for Revalidation successfully went live in June, and implementation work is now focussed on completing the enablement works for the job-planning module. A dedicated analyst has started the Trust's workforce team to monitor data outputs from SARD, and provide intelligent insight into worked activity against timetabled activity.

Risks to Performance & Mitigations

There is a continued reliance on temporary resource to fill harder to recruit medical roles throughout the Trust.

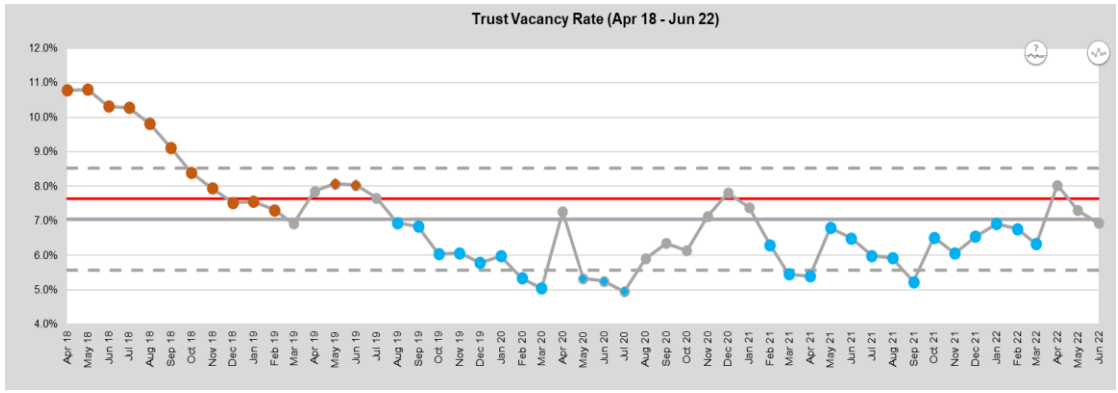
Continued Medical locum usage in General Medicine and the Emergency Department presents an ongoing risk. Tighter controls on locum sign-off within the division are facilitating scrutiny of requests, and monitoring of the Electronic Roster within the department will allow for greater visibility of usage in-month.

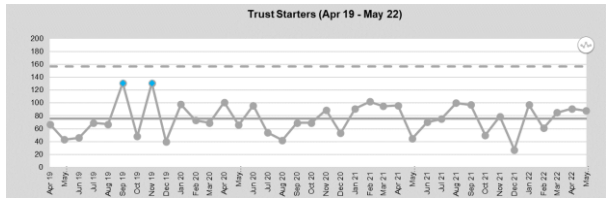
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

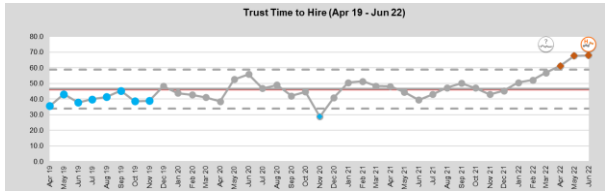
Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	1	2







Background

The Trust vacancy position in June decreased to 358.53WTE (6.94%). Budgeted WTE increased by 6WTE, however a net increase to staff in post of 25WTE offset this increase and improved the vacancy position in-month.

There were 87 headcount of new starters to the Trust in May, this is above the Trust average of 77.

New starters by staffing group;
- Admin & Clerical – 12
- Allied Health Professionals – 9
- Medical & Dental – 4
- Non-clinical Support – 3
- Registered Nursing & Midwifery – 11
- Scientific, Therapeutic & Technical – 6
- Unregistered Nursing & Midwifery – 42

The Trust has a provisional 48 candidates due to commence employment in July across all staffing groups with a further 65 slots available to allocate to new starters.

Vacancy by staffing group is;
- AHP & Scientific – 61.57WTE
- Medical & Dental – 62.75WTE
- All Nursing – 131.68WTE
- Senior Managers & Admin – 102.52WTE

Improvement actions

1. The recruitment's time to hire (TTH) in June remained above the Trust's KPI of 46 days; with a Trust average of 67 days from vacancy advertised to contract sent, and an average of 28 days from offer to Contract sent. Factors that contribute to the higher TTH, as identified in the above the average is the turn around time of occupational health clearances; this is currently at 2 weeks to clear a candidate, additionally the continued low % of managers completing there shortlisting is sitting around 57%. The HRBP's continue to continue to raise awareness at Divisional meetings of the KPI target time and provide support to managers, offering further training as required from the recruitment team to get shortlisting completed. Our continued high volume of offers has kept our KPI for issuing of offer letters within 3 working days, at 57%. The recruitment team continue to support the current Band 2 vacancy within the team to ensure phones and emails are managed.
2. A micro-project is underway with Occupational Health to drive attraction of Physiotherapists and specialist Advisors. We're planning to develop a marketing campaign to reinvigorate our presence in the market due to the demand for band 6 Physiotherapists in the Trust.
3. We have successfully appointed to the Acute Medical Director and a Deputy Acute Medical Director for Unscheduled care and Acute Medical Director for Surgery, Women's and Children's; start dates to be confirmed.
4. We are working on a theatre recruitment campaign to recruit in for various roles; this includes a virtual open day being discussed with Comms team, Social Media being used for all theatre roles and building links with universities, to develop student engagement.
5. An apprenticeship route for Maternity Support Worker to develop in to Registered Midwives has been scoped, and approval has now been received for 3 x Level 3 apprentices. The cohort will commence in Sept 2022 for a 15-month training programme with view to then support through Level 5 leading to qualified midwife status.
6. A bid has been submitted to increase our Internationally Educated (IE) Nurses recruitment by an additional 30WTE to land by 31st December 2022. This planned increase will help achieve safer staffing modules for Registered Nurses.

Risk to performance and mitigations

Healthcare Assistant vacancies remain a Trust priority; we have a pipeline of 42.47WTE candidates, of this 17.11WTE have a start date agreed.

Centralised recruitment for Healthcare Assistants continues with a view to increase our applicants and pipeline to ensure we mee tour safer staffing model by the end of the year.

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

The Trusts international Nurse cohorts remains a risk due to June and July cohorts being smaller than expected, this was due to the continued visa issues.
The additional bid for 30extra IE Nurses will have an impact on staffing allocation due to increase in monthly cohort sizes from 8 to 14.

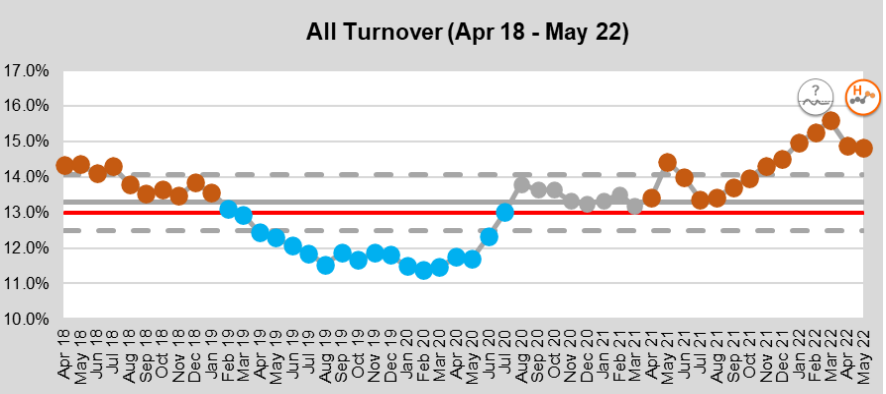
We have additional risk that OSCE exam dates are not currently available within the 12 weeks required of an IE Nurse commencing with the Trust; NHSE/I are aware, and this is being reported monthly.

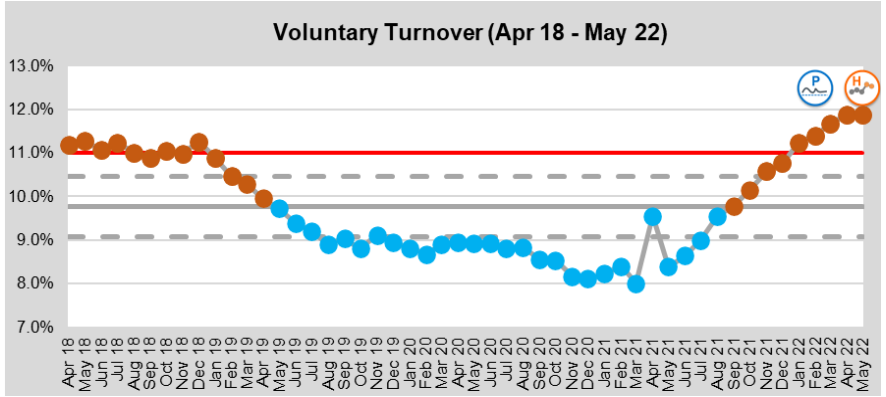
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	1	2





Background

All turnover reported at 14.82% in May, which was a small reduction on the previous month (14.89%) however still above the Trust target of 13%.

Voluntary turnover for May was 11.88%,remaining static compared to the previous month (11.89%). In May there were 46 voluntary leavers which is slightly below than the Trust 12-month average of 47.

Leavers headcount by staffing group;

- Admin & Clerical – 8
- Allied Health Professionals – 2
- Non Clinical Support- 1
- Registered Nursing & Midwifery – 15
- Scientific, Therapeutic & Technical - 5
- Unregistered Nursing & Midwifery – 11
- Medical and Dental – 4

The top 3 reasons for leaving in May 2022 are;

- Work Life Balance
- Relocation
- Other/Not Known

Improvement actions

Retention of AHP:

- The IC&C Division is preparing to submit a BSW system bid to Executive Committee for proposal for international recruitment of AHPs. The Division considering best fit and numbers for departments.

Retention of Unregistered nursing:

- Trust-wide Matron project to redesign the HCA development programme under the remit of the Great Care Campaign.
- Teal Ward training on 'Improving Together Methodology' across all teams to measure engagement and shared improvement ideas.
- Meldon and Trauma wards have a recruitment plan with focus on opportunities for B4-5 qualified Nursing Associate Trainees.

Nursing retention strategy:

- The Trust 'Stay & Thrive' programme continues to embed positive benefits for international nurses with CPD development opportunities, a leadership programme for BAME / internationals, and a Q2 survey to inform future improvement. The learning from this group should inform the business case for system recruitment for international AHPs within IC&C Division.
- SW&C exploring the CPD programme with Worcester University to support RGN on 'fast track' midwife training.

Risk to performance and mitigations

The in-month risk is the continued turnover rate of 14.82% which has decreased from 14.89% in April but still exceeds the Trust target of 13%.

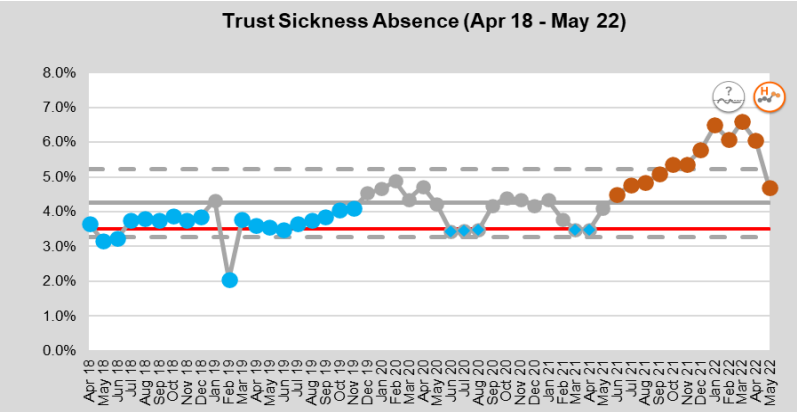
There are Trust wide retention initiatives in place to mitigate high turnover in specific professional categories.

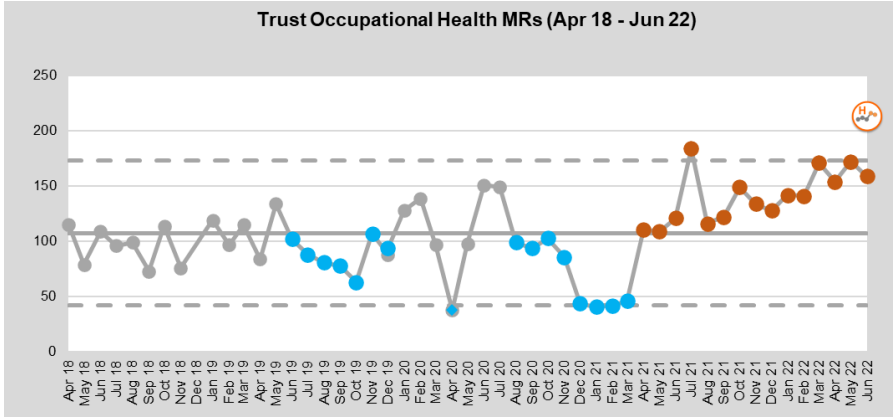
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce – Sickness Absence

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	2





Background

For May 2022, sickness absence is reported at 4.71%, which is a significant decrease from last month (6.05%).

159 OH management referrals were made in June, which is in-keeping with recent months (Feb 141, Mar 171, April 154, May 172).

Of these, 113 were GWH staff (Mar 130, Apr 115, May 134):
- ICC: 36 (Feb 33, Mar 36, Apr 20, May 41)
- USC: 33 (Feb 34, Mar 44, Apr 41, May 31)
- SWC: 31 (Feb 34, Mar 43, Apr 41, May 45)
- Corporate: 13 (Feb 13, Mar 7, Apr 13, May 17)

MRs were triaged to:
- OHP 41 (Feb 31, Mar 21, Apr 27, May 37)
- Physio 39 (Feb 36, Mar 35, Apr 38, May 41)
- OHA 38 (Feb 30, Mar 75, Apr 57, May 42)
- MHP 36 (Feb 42, Mar 37, Apr 29, May 43)
- no longer required 5 (Feb 2, Mar 3, Apr 2, May 9)

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

Improvement actions

1. In-reach health checks for staff re-launched in June, with initial visits made to the neonatal team, attended by 8 members of staff. Dates & departments for July have been arranged, with involvement from OH clinic nurses.
2. A member of the Dietetic Department will complete a placement with the HWB Service in August, as part of their Masters degree, following which a leaflet on healthy eating and recommended sources of support for staff will be provided.
3. 5 staff members attended Health and Wellbeing Conversations training this month. These will run a couple of times each week throughout the Summer, with liaison with HR BPs and Ward Managers to help promote.
4. The HWB Service is supporting the Stay Conversations initiative launched this month, supporting staff who identify the areas of work/life balance and/or health & wellbeing.
5. HWB are coordinating a working group to develop a financial wellbeing advice and resource package for staff, which will be established in July.
6. The TRiM process was activated on Meldon Ward this month following a traumatic incident. All staff who were potentially affected by this incident were invited to the TRiM Incident Briefing meeting (facilitated by Ward Manager and HWB Clinical Lead) and were also sent the documents outlining best practice self-help recommendations and signposting for further support.

Risk to performance and mitigations

Waiting times are as follows:

- Physio: 6 weeks*
- OHP: 4 weeks
- OHA: 3 weeks
- MHP: 2 weeks
- Staff Support: 2 weeks

*impacted by annual leave and the physio vacancy. Interview for the candidate shortlisted for this vacancy is scheduled for July.

Following interview for the OHA vacancy, recruitment processes are underway for the successful candidate.

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

Workforce – Recognition, EDI and Wellbeing

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	2

Employee Recognition

Long Service Awards	13	Hidden Heroes	5
Retirement Awards	1	STAR awards	3

Diversity/Inclusivity

1. The Reciprocal Mentoring scheme (phase one) has been rolled out, with all pairs having met their matches at least twice.
2. Data findings used to populate the national WRES and WDES reports have been analysed and are currently being incorporated into reports.
3. A Board EDI session on the subject of unconscious bias, was facilitated by an external consultant. The session was well received. There will be an educational development session on trans issues (scheduled for 1 September).
4. Planning for South Asian Heritage Month is complete, with a series of celebratory events marking key milestones and moments in South Asian history. Two or three staff members of South Asian heritage are being interviewed as part of the celebrations.
5. The Stay and Thrive Programme for internationally-recruited nurses is close to readiness for launch.
6. The Trust first staff trans policy has been noted by PPPC and is ready for EPF subgroup.

Wellbeing Initiatives

Staff Tea Trolley – in June, it supported the Patient Safety Team to help raise awareness of patient safety week. A new 4-week rota for has been introduced to ensure all areas are visited. An advertisement to recruit additional volunteers has gone live to support with this ahead of increased rounds over winter.

Bike to Work Week - we celebrated National Bike to Work Week in June. Staff from Swindon Borough Council's Active Travel Team were on site offering staff the opportunity to have their bike security marked & their details entered onto the national database. 20 staff took this offer up & many more visited the stand at the hospital entrance to talk to the team & collect leaflets & maps.

Yoga project - the HWB team have reviewed this offer and a new proposal was accepted by the HWB committee to offer each division 9 places on a yoga retreat based in the local area. 4 retreat dates will be provided by the external provider, & the remaining yoga project budget will cover this.

Background

In June, 22 self-referrals were made for 1:1 staff support – previous months: Feb 25, Mar 24, Apr 18, May 36.

In-keeping with trends, most common referral reasons:
1. Personal: low mood (82%), overload/stress (73%), anxiety (73%)
2. Work-related: overload / stress (50%).

99 in-house staff support appointments were attended this month (recent months: Jan 82, Feb 102, Mar 81, Apr 84, May 79).
In addition to this, 12 attended bitesize wellbeing sessions and 7 contacts were made with the EAP.

51 staff members attended in-reach psychology group sessions this month, comprised of the following: T&I, Business Intelligence, Forest Ward, Anesthetic Trainees, Apprentices, Community Stroke, Patient Safety & Quality.

Improvement actions

1.Mental Health First Aid training was completed by 5 members of staff in June, and Suicide First Aid by an additional 5. Our current workforce who are trained in MHFA and SFA is 212 & 63 respectively.

2. Feedback from an individual who completed 1:1 staff support this month stated: *'The counsellor was amazing at listening to me without judgement & helped me through a difficult time from being in crisis mode to being able to cope with the daily challenges in my life. She has supported me & encouraged me to keep going through all the challenges as well as reminding me to be more compassionate towards myself. I was in crisis mode & on the verge of a breakdown but she recognised that I was just stuck feeling overwhelmed from the difficult situation and that despite having suicidal thoughts I don't actually want to die'.*

3. Following suggestions received in the Orbital's HWB comments box, there are now plans to refresh the outdoor terrace space there and to provide a cold drinks & snacks vending machine.

4. Schwartz Rounds will re-launch on Thurs 29th Sept in the Academy, and HWB are liaising with the Comms Team to support promoting this over the Summer months.

5. For the first time, the service will be commencing 12-month placements for UWE trainee counselling psychologists completing their final year of the doctorate programme this October.

Risk to performance and mitigations

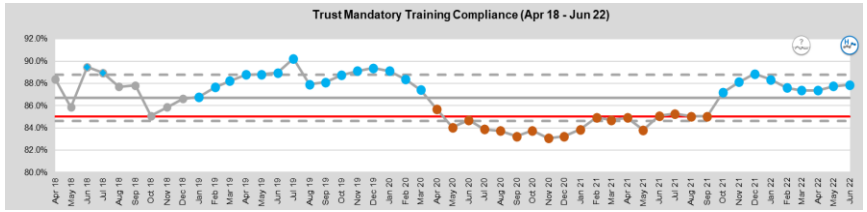
The staff health & wellbeing intranet page and self-referral form for 1:1 staff support have both been updated this month to facilitate access of the EAP as the initial step for support.

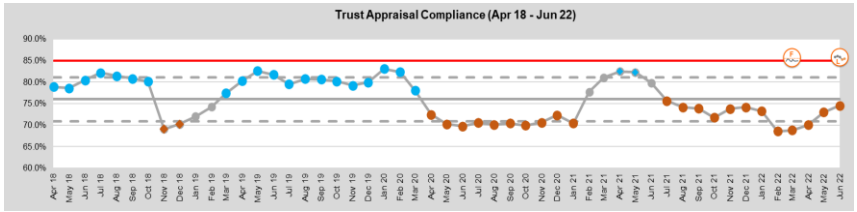
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

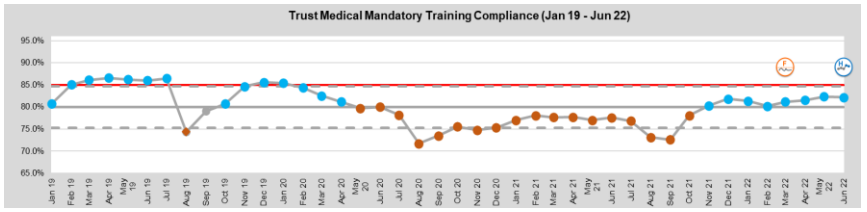
Workforce

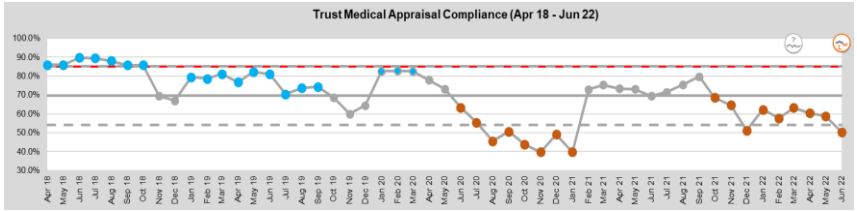
Use of Resources

Great Employee Development	Indicator Score	Self Assessment Score
	2	3









Background

Trust mandatory training compliance performance remains above the KPI of 85%. This, month it is at 87.87%. This is an increase of 0.22% from last month.

Trust appraisal compliance is reported at 74.55% in June, increasing by 1.52% over the month. This performance continues to have an impact on the indicator score in the leadership section

Improvement actions

1. The two senior leads at the Trust and Swindon Borough Council are meeting at the end of July to create an action plan into how we now start to achieve our short-term objectives identified at the meeting in May.
2. The Trust HEE return for 22/23 has now been submitted. The Academy is ensuring that there is appropriate governance and management of the spend. This is the final year of a 3 year agreement to invest in CPD for registered nurses, midwives and AHPs. The Trust received £700,000 this year from HEE to support the development of this group.
3. It has been agreed that the pilots for the BAME and International Development Aspiring Leaders programmes will start in the Autumn. Arrangements are currently being finalized.
4. The Executive team supported the proposal for a new room booking process within the Academy. Final details are being agreed with the intention that an official communication will be shared with the Trust in July. The new process will start immediately but the complete process will start early 2023
5. A project plan to improve our position with the completion of care certificates has been agreed. The aim is to streamline the process, simplify the documentation and increase awarenesss in clinical areas about how the documentation needs to be completed. The Academy is looking to provide additional administrative support in a co-ordination capacity to ensure this project meets its objectives in a timely manner

Risk to performance and mitigations

Now that the Academy rooms can now accommodate larger number of people, we are now able to increase our numbers for all our training. However, the growth of the Academy offers continues to put pressure on space.

Due to the number of International recruits, additional support in midwifery inductions and preceptorships, we are exploring what additional support can be provided within current capacity.

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

Workforce

Use of Resources

Great Leadership	Indicator Score	Self Assessment Score
	1	2
Leadership Roles at the Trust	4.57% of staff	Equating to 189.6 WTE
Leadership Development Programme *(Cohort 1)*	22 leaders	13 Completed Training
Leadership Development Programme *(Cohort 2)*	14 Leaders	Paused and reallocated
Leadership Development Programme *(Cohort 3)*	18 Leaders	Undergoing Training
Leadership Development Programme *(Cohort 4)*	20 Leaders	Undergoing Training
Aspiring Leaders *(Cohort 1 & 2)*	39 aspiring leaders	36 Completed Training
Aspiring Leaders *(Cohort 3)*	21 aspiring leaders	Undergoing Training
Network and Navigate	12 multidisciplinary delegates	Undergoing Training
Health Economics Leadership programme	8 delegates	Undergoing Training
Leadership Forum Members	300 managers	Members Engaged
Latest Leadership Forum *(May)*	30 Managers	May 2022
Ward Accreditation	24 of 24 departments	using the Perfect Ward App

Background

The first cohort of accredited coaches came to together to celebrate the end of their training programme, once their final assignments have been successfully **submitted,** they will join the GWH coaching register, offering coaching opportunities across the Trust.

- The Scope for Growth Facilitators Talent Management training has concluded. GWH is making good progress compared to other organisations involved in phase 2 of the national pilot.
- Following a BSW taster session 7 individuals from GWH have applied for the mediation training to join colleagues from the RUH and WH&C.
- The leadership team successfully supported the away day for the Surgery, Women & Children's Division senior divisional team (Matrons, Heads of Service and business leaders) on engagement and the fundamental behaviours within Improving Together.
- Applications were opened for the next cohort of Senior Leaders (Masters) Apprenticeship due to start in September.
- The leadership team has delivered a team away day for the Stroke Team.

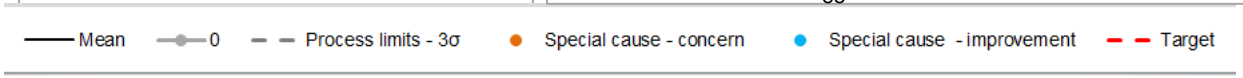
Improvement actions

1. The Leadership Team will be supporting maternity services in the development of the Band 7 midwives to increase team cohesiveness and provide opportunities for collaborative working and empowerment.
2. Following the successful recruitment of 7 individuals to undertake mediation training, the Leadership Team will be working closely with the BSW group and programme participants to design the process to enable an offering of mediation within GWH. This involves identifying a gatekeeper role who can assess and allocate resources appropriately.
3. Following the success of the presentations from matrons on the Leading with Impact Leadership course the Leadership Team will be working with this group of staff to design future initiatives for aspiring matrons.
4. The Head of Leadership is working with the Deputy Chief Nurse and AHP Education and Development Lead to ensure a collaborative approach is taken to bring multiple workstreams focused on career development together to ensure a unified approach for support workers and admin and clerical staff. This will incorporate the new Scope for Growth career conversations for talent management. Training for line managers, ambassadors and individuals will commence in July 2022.
5. The Leadership Team will continue to support the OD modules in readiness for the Improving Together methodology with dates planned for July for Divisional Deputies and September for the second wave of frontline staff.

Risk to performance and mitigations

The request for OD interventions continues to increase, with several requests to support conflict within teams, resulting in delays waiting for intervention. The Leadership will continue to support priority areas and offer support and guidance for managers in the short term in preparation for any team intervention.

The quality of the Scope for Growth Career Conversations could be reduced if line managers are unable to provide sufficient time to support, engagement from ambassadors from across the Trust to support the facilitators will be encouraged



Exception 1 of 2: Health and Wellbeing

Exception Report

KPI 1 - initial appt. offered within 10 working days of referral	Apr-22		May-22		Jun-22	
	New referral appts made	% of initial appts at KPI	New referral appts made	% of initial appts at KPI	New referral appts made	% of initial appts at KPI
Psychology/Counselling	18	100%	36	94.4%	22	100%
Occupational Health	140	33.6%	151	27.8%	150	20.6%

KPI 2 - on a scale of 0 (not at all) – 10 (completely), how has the support from the service improved your overall health & wellbeing	**KPI 3** - would you recommend this service to a colleague?	**KPI 4** - reports provided within 48 hours
Mean score = 8 Median score = 8 Mode score = 10	Yes - 100% (n=54)	Yes (n=286 / 71.5%) No (n= 114/ 28.5%)

Background

Staff HWB activity has continued to increase over the year.

Here is an overview of quarterly KPI data since these were refreshed in July 2021

	KPI#1 – initial appt offered within 10 working days		KPI#2 - improvement on overall HWB (0-10)			KPI#3 - recommend the service to a colleague		KPI#4 - reports provided within 48hrs	
Quarter	Psych/Cllr New Referrals: total number, % at KPI	Occ Health New Referrals: total number, % at KPI	Mean	Median	Mode	Yes	No	Yes	No
Jul-Sept 21	80 86.6%	326 6.8%	8.8	8	10	19	1	91 (24.3%)	284 (75.7%)
Oct-Dec 21	64 68.3%	411 13%	8.8	9	10	16	0	212 (58%)	153 (42%)
Jan-Mar 22	90 89.3%	454 74.8%	8	8	8	23	0	302 (83%)	63 (17%)
Apr-Jun 22	76 98.1%	441 27.3%	8	8	10	54	0	286 (71.5%)	114 (28.5%)

Improvement actions

The newly revised feedback form, & process for this, for OH clients is working well with much improved return this quarter compared to previous quarters.

Improvements noted in last quarter regarding report writing times have remained across this quarter.

Risk to performance and mitigations

OH recruitment has remained challenging, with 0.6wte physiotherapy and 1.0wte specialist nurse vacancies.

0.4wte OH MHP post has been made substantive this quarter, which should facilitate staff retention.

Considerable effort to signpost individuals wanting counselling to the EAP as a first port of call has been made during this quarter to help meet increased demands of 1:1 staff support.

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

Exception 2 of 2: COVID-19 Withdrawal of the COVID 19 section of the T&C

Exception Report

Phase	Timescales	NHS Employers Guidance	Impact	Action
1	7th July 2022 onwards	The staff terms and conditions section of the COVID-19 guidance will be withdrawn in its entirety. This includes: • Access to full sick pay for new episodes of COVID-19 sickness (positive to COVID) • Access to COVID-19 special leave for the purposes of self-isolation (e.g. if not double vaccinated or isolation prior to surgery).	From the 7th July, any employees who test positive to COVID and is therefore not able to attend work or work from home will be recorded as normal sickness for pay and trigger reporting purposes in accordance with Trust policy and NHS Terms and Conditions. Any new absences from the 7th July onwards will count towards triggers as detailed in the Trust Absence Management Policy. For staff who are absent due to COVID prior to the 7th July will not be included in sickness triggers until the 1st September onwards.	• Trust wide Comm's cascaded on the 7th July 2022 outlining changes to terms and conditions. Isolation requirements remain but the pay aspect is in line with contractual sick pay. • HR Team to receive overview and direction on next steps. Update provided at EPF 04/07/22. • HR Team to cascade changes within Divisions and liaise directly with managers who have staff absent due to long COVID. • COVID FAQ's updated on the Intranet. • Roster reasons to be updated and removal of COVID isolation for new episodes.
2	7th July 2022 - 3rd August 2022	From this date, managers and HR are required to start meeting staff who are absent due to positive COVID or long COVID (prior to the 7th July 2022) on a one-to-one basis to explain the changes. This should include details of when the formal transition period begins and ends. All employees must have had a meeting with their manager and HR (in person or virtually) by the 3rd August 2022	As of 11/07/22 there are 11 employees absent in the Trust due to long COVID- **ICC = 4 employees** **USC = 3 employees** **SWC = 4 employees**	• Meetings with managers supported by HR to be arranged with all employees recorded as long COVID prior to the 7th July 2022. All meetings to be completed by the 3rd August 2022. • Staff to be informed during their meeting of their sickness leave entitlement (will vary subject to length of service). • Discussions to be documented and followed up in a formal letter.
3	4th August 2022	The formal notice period for staff transitioning back to normal contractual sick pay arrangements will begin. This period will run from 4th to 31st August 2022 inclusive.		All staff who are absent due to long COVID to have had a meeting and received letter confirming changes and timescales.
4	1st September 2022	Staff who were in receipt of COVID-19 sick pay as a result of being unwell prior to the 7th July 2022, and continue to be unwell, will be transitioned back to their normal contractual sick pay entitlements unless they have already returned to work. Any period of sickness paid as COVID-19 sick pay, regardless of length, will not count in the aggregation of previous absences for the purposes of calculating entitlement to contractual sick pay. From this date, all staff, regardless of their reason for sickness absence, will be paid in line with their normal contractual sick pay arrangements	All long term sickness due to COVID will transition from the 1st September to the Trust long term sickness process in line with Trust Policy and NHS Terms and Conditions and therefore sickness pay will be determined on length of service	Staff who are absent due to long COVID to be transferred on the roster to Sickness- COVID.

Background

Following on from the Government's plans for living with COVID-19 published in February, the DHSC communicated to the NHS Staff Council its intentions to withdraw the COVID-19 section of the staff terms and conditions.

Confirmation of the above timeline was provided on 29th June 2022, and The Trust are now working through communicating this change to staff who will be affected.

Improvement actions

1. A Trust-wide comms was sent out to staff on 7th July advising of changes to terms and conditions. The HR team have been actively engaging with managers who have staff absent due to COVID in their departments to provide guidance and ensure application of the guidance from NHS Employers.
2. Currently there are 11 employees absent due to long-COVID. Managers are conducting individual conversations with staff, supported by HR, by 3rd August to ensure notice is given to employees of the updated sickness arrangements.
3. A review of reporting reasons on the Electronic Roster and ESR systems is underway to ensure appropriate coding of absence moving forward and correct pay for staff.

Risk to performance and mitigations

There is a risk of staff disengaging with the testing and isolation process due to the impact it could have on sickness markers and pay. Trust communication is focussed on compliance with infection control measures that are currently in place for other infectious illnesses, and employees will be encouraged to continue with current IP&C measures through the Trust's weekly COVID comms.

Board Committee Assurance Report

Finance, Infrastructure and Digital Committee – 25 July 2022			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**25 July 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 Risk Register	R	A	The Committee was comfortable with the risk management process and reporting of financial risks however requested management to focus on reviewing mitigation actions, particularly relating to the risks: (1) The Trust does not meet its control total of £19.3K deficit; and (2) The Trust does not deliver its efficiency target recurrently in 2022/23. Mitigation actions will be reviewed at the August FIDC following further work to be undertaken with the Divisions.	Monitor through FIDC and (significant risk to be reviewed quarterly at Board).	FIDC Meetings 2022/23
Infrastructure Risk Register	A	A	Following the Committee's request, Estates and Facilities risks were presented to the Committee. We were assured that the risk management process and reporting are operating effectively. The Committee discussed an important risk (score 15) that the current and future utilities (e.g., electrical) might not be enough for planned developments, leading to	Monitor through FIDC	FIDC Meetings 2022/23

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			expensive mitigations. Whilst long-term solutions are developed, cost-effective interim solutions are explored.		
IT and Digital Risk Register	A	A	Following our request, IT and Digital risks were presented to the Committee. We were assured that the IT and Digital Risk Register is reviewed and updated monthly through the IT Governance Meeting; however, further work is progressing to align and identify all IT-related clinical risks following the move to Datix. We expect IT to continue improving processes and identifying new risks that are not directly assigned to IT within Datix; progress will be monitored in future FIDC meetings.	Monitor through FIDC	FIDC Meetings 2022/23
OPERATIONAL					
Month 3 Finance position	R	A	The overall position for month 3 is **£0.9m** against a planned deficit of **£0.4** (**£0.5** adverse to plan). Pay costs remain above plan within Unscheduled Care, the critical driver of overspending year to date. A high-level forecast highlights a projected deficit of **£24.6** against a planned deficit of **£19.4**. The Committee remains concerned about the pace of progress to bring the run rate in line with the plan highlighting that this risk may trend higher should the mitigations be considered ineffective.	Monitor through FIDC	FIDC meetings 2022/23
2022/23 CIP Update	R	R	A revised saving target of **£11.1m** superseded the plan for **£10m** savings in June 2022. The CIP target is **53%** identified as of month 3, and the gap of **47%** constitutes a significant risk to the Trust's financial plan (highlighted in the finance risk report). The Committee remains concerned about the delivery of the **£11.1m** CIP program, notwithstanding the trade-off decisions that may be required to deliver this.	FIDC/Board Discuss each month until assurance increased to satisfactory level with confidence that the £11.1m will be delivered.	FIDC meetings 2022/23
Financial Sustainability – Enhanced Financial Control	A	A	A self-assessment exercise was performed following the publication of the HFMA briefing titled "Improving Financial Sustainability". The results demonstrate the need for improvement and outline the steps to ensure best practice is embedded across the Trust. The Committee was appraised of the plans to address gaps identified and the performance of a mandatory internal audit of financial controls to be carried out in Aug/Sept.	Update at FIDC and ARAC (following publishing of the Internal Audit Report).	FIDC meetings 2022/23
Benchmarking Opportunities	G	A	A benchmarking analysis considering different sources highlights opportunities for efficiency and productivity. Where genuine opportunities exist with ongoing improvement plans, these have been aligned to workstreams, such as improving together. However, the Committee is yet to see evidence of delivery of efficiency/productivity resulting in partial assurance.	Monitor through FIDC	FIDC meetings 2022/23

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Debtors	A	A	The Committee noted improvements in the current position and the continued focus on collecting and managing aged debt; however, it requested management to undertake further work and reinforce controls relating to it. Any debts deemed to be uncollectable will be approved by ARAC.	FIDC to review progress.	FIDC meetings 2022/23
BUSINESS CASES & UPDATES					
Way Forward Programme	A	G	The Integrated-Front Door entire business case was presented and discussed with the Committee, reflecting on, and challenging several business case assumptions, the risk of scope creep, and impacts due to possible delays. The Committee was particularly pleased to see excellent and speedy progress and a high level of responsiveness given the challenges faced by the project, including inflationary and cost pressures.	FIDC	FIDC meetings 2022/23
Site Utility & Resilience		G	The Committee was appraised of the critical issues facing the Trust about site infrastructure and resilience. Management has action plans to mitigate the problems best, including undertaking consultancy studies to ensure the site is future proofed and there is awareness of the resilience and challenges the Trust faces.	FIDC to review biannually	FIC meetings 2022/23
ERIC Report – Annual Update	G	G	The Estates Return Information Collection (ERIC) annual return was completed and submitted. The process involved collating a range of costs and statistics relating to the NHS Estate, including building, maintaining, and equipping hospitals, utilities, and provision of services.	None	
Digital Project Gateways	A	G	A paper outlining the approval process/gateways of digital projects where funding is already identified was presented. The Committee was assured that capital-funded schemes follow a documented process and are monitored through appropriate governance structures, including the FIDC and the Board (where projects are of a significant value >£1m).	FIDC	FIDC meetings 2022/23

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

Part 4: Use of Resources

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Financial Overview

Use of Resources

For Period Ended - 30th June 2022	In Month Plan £000	In Month Actual £000	In Month Variance £000		YTD Plan £000	YTD Actual £000	YTD Variance £000		Ful Year Plan £000	Forecast Outturn £000	Forecast Variance £000	
Total Operating Income	36,115	36,361	246		106,267	106,948	681		420,377	422,977	2,600	
Total Operating Expenditure	(36,485)	(37,248)	(763)		(110,428)	(112,348)	(1,920)		(439,728)	(447,616)	(7,888)	
Total Surplus/(Deficit) *excl donated assets*	(371)	(888)	(517)		(4,161)	(5,400)	(1,239)		(19,351)	(24,639)	(5,288)	
Capital	463	524	61		2,819	463	(2,356)		17,246	17,246	0	
Cash & Cash Equivalents	39,746	33,164	(6,582)									
Efficiencies	787	578	(209)		1,755	1,090	(665)		11,109	5,837	(5,272)	

Overview

Income & Expenditure: The plan figures within this report are in line with the June plan resubmission (full year planned deficit £19.4m). The Trust is reporting a deficit of £0.9m against a planned deficit of £0.4m in Month 3 (£0.5m adverse to plan). Year to date the position is £1.2m adverse to plan. Income is above plan in month (£0.2m) driven primarily by high-cost drugs with the offset included within expenditure. Pay costs continue to be above plan within Unscheduled Care (0.5m) and are the key driver of the overspend year to date. A high level forecast has been included for Month 3, this is being worked through with divisions in July.

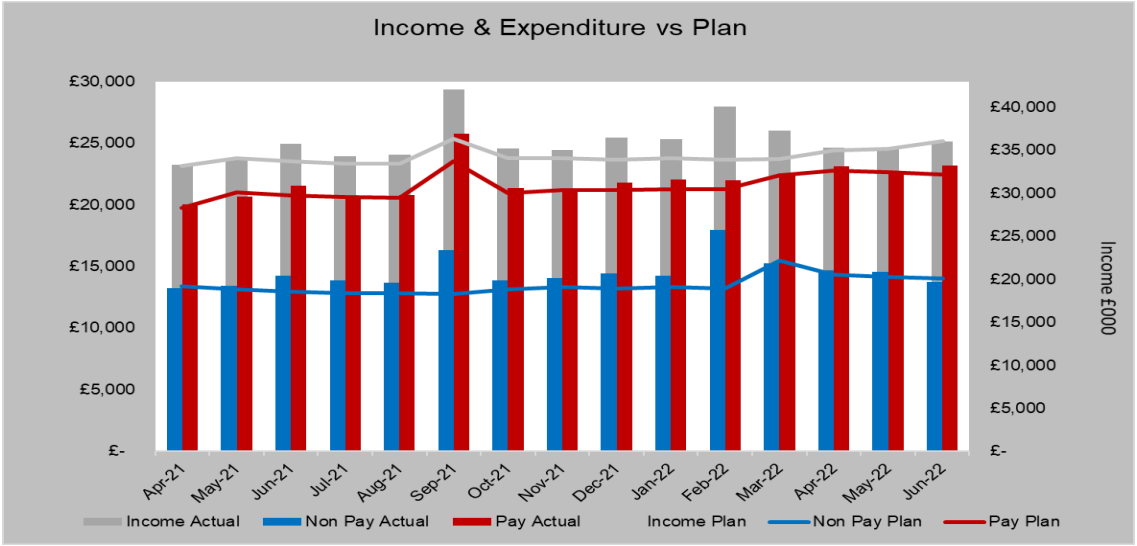
Cash – – the cash balance at the end of June 2022 was £33m, £6.6m below the plan of £39.8m. This is due to an increase in Contract Receivables, lower than planned Capital Expenditure offset by delay in drawdown of PDC and the higher than plan deficit.

Capital – Capital expenditure is £0.5m as at the end of Month 3, £1.9m below plan. Original spend plan was spread evenly across the year. Changes to phasing of planned spend was agreed in June to include changes in lead time on projects. Slippage is addressed at the monthly Capital Management Group.

Efficiencies – In month £0.6m has been delivered against a plan of £0.8m (£0.2m below plan in month, £0.7m year to date). As at Month 3, c. £5.3m is unidentified. This is broadly equivalent to the current forecast variance to plan.

Income and Expenditure - Run Rate

Use of Resources



Background

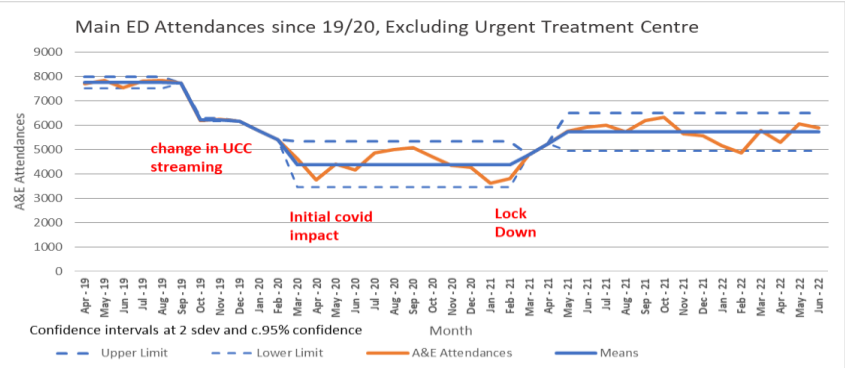
In month the I&E position is £0.9m deficit against a planned deficit of £0.4m.

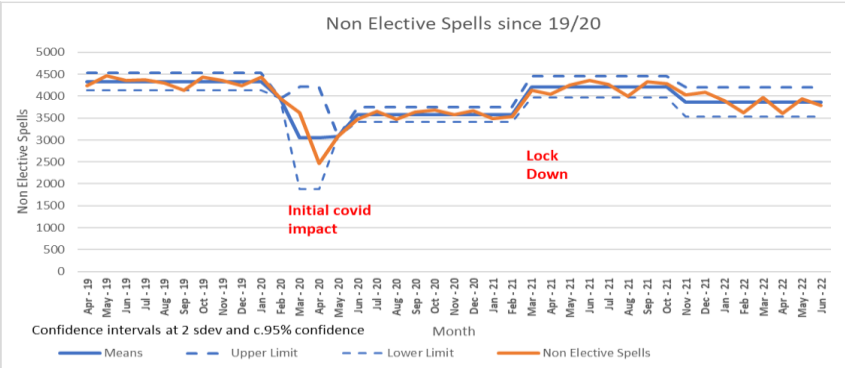
- Income run rate has increased by £1.1m from May and is £0.2m favourable to plan in month (£0.7m year to date). An increase of £0.9m relates to additional block income to fund inflationary pressures (Month 1-3) as part of the resubmitted annual plan and the remaining increase is due to multiple smaller drivers.
- The Pay run rate has increased by £0.3m from May and is £0.6m above plan in month (£1.0m year to date).
    - Corporate pay run rate has increased by £0.3m as a result of additional focus on costs with new finance staff in post to review corporate areas in detail. A full review of Corporate budgets is being completed over July and August to ensure accurate reporting going forwards.
    - Surgery, Women's and Children's run rate has increased by £0.2m in month due to increased use of agency cover within Maternity (historically not used but now in place to cover gaps that cannot be filled through bank) and backpay for locums and WLI's coming through in month for the year to date and old year.
    - Central reserves held for premium agency costs of £0.2m has been released in month to mitigate premium costs seen in divisions.

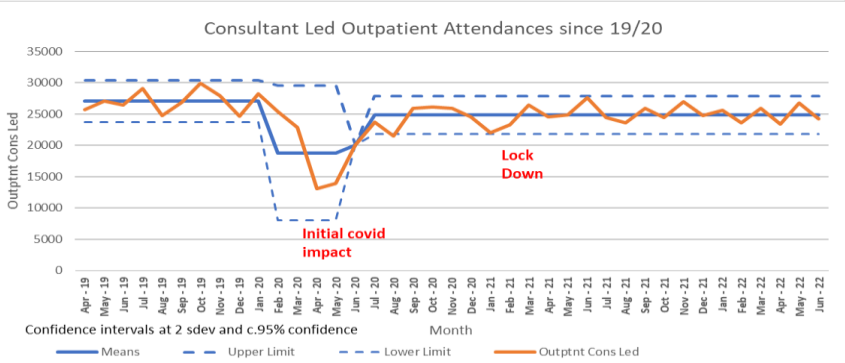
- Non Pay is in line with plan in month and the run rate has reduced from May (£0.7m). Key drivers of this are:
    - Corporate (£0.3m reduction in month) – additional focus on costs with new finance staff in post to review corporate areas in detail. A full review of Corporate budgets is being completed over July and August to ensure accurate reporting going forwards
    - Surgery (£0.3m in month) – Drugs costs have reduced in month, mainly within Ophthalmology. A review of the 18 week support costs has resulted in a reduced accrual, and a more accurate year to date position.

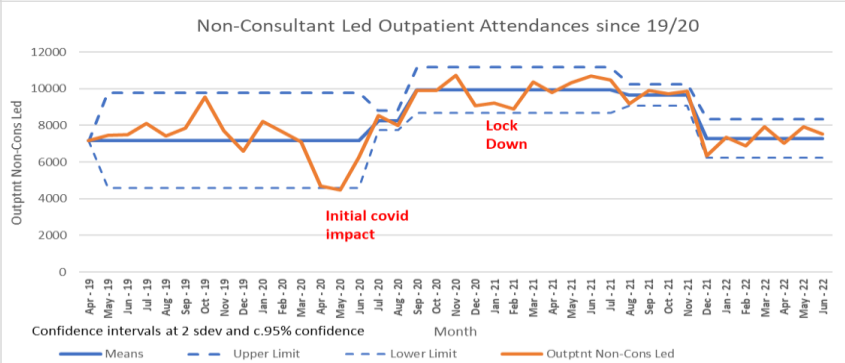
Key Activity Trends to Inform Revenue Impact if National Tariffs Still Applied

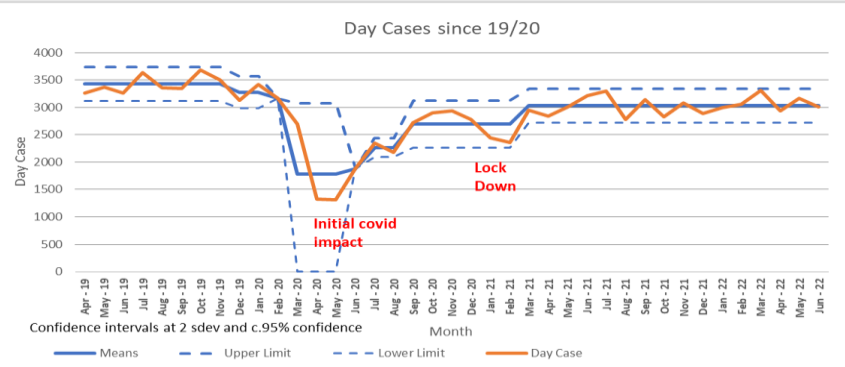
Use of Resources

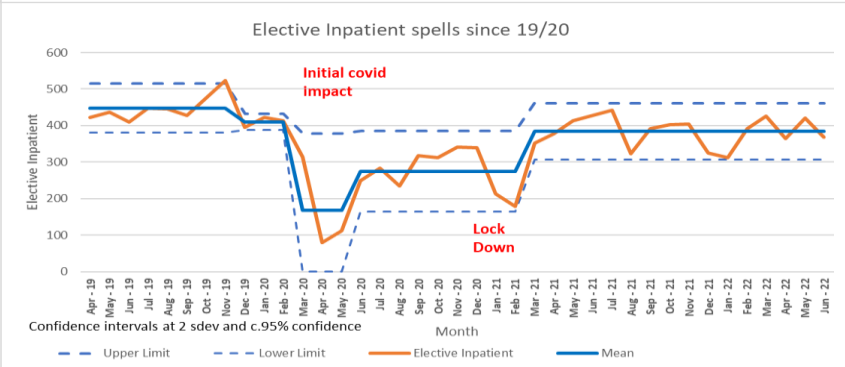












Background:
This is the activity trend collected to inform financial view on productivity, expenditure reported and notional income earned. This does not replace divisions' own view on their levels of activity.

Income by Point of Delivery

Use of Resources

Acute activity type	Jun 2022 Year to date 19/20	21/22	22/23	22/23 v 19/20 Note 1	
Main ED (excl UTC)	3,713,228	3,008,384	2,979,055	80%	Omits shift to UTC since 19/20
Non Elective	24,154,781	26,219,371	23,717,700	98%	June 96%
Outpatient	10,672,605	9,519,055	9,819,431	92%	June 92%
Day case	5,773,263	5,755,063	5,131,564	89%	June 84%
Elective inpatient	4,337,266	4,330,887	3,901,791	90%	June 90%
Total	**32,485,714**	**32,018,922**	**30,011,139**	**92%**	June 92%

Note 1: Between 19/20 and 22/23 tariffs have been uplifted by 4.8% and this is adjusted for here

Context

Due to Covid-19, funding is still being paid on a block contract basis, with the emphasis on covering reported costs.

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

It gives a feel for the impact of Covid-19 and the scale of income recovery back to 19/20 levels.

Focus on actuals:

For June, actual income on a PbR basis has been shown v prior year and the pre-Covid base of 19/20. The activity plan is being processed into the GWH reporting system following the resubmission of system plans and will be available for July reporting.

Issues:

Non-elective activity is running at c98% of 19/20 levels in financial terms although fewer, more complex cases are being seen. Outpatients are running at 92% of 19/20 levels. It should be noted that the pricing methodology for ESRF differs from standard tariff included above so should not be directly compared – this affects non consultant and non face to face activity which are given equal value to consultant led attendances in ESRF process.
Elective and day case are c89-90% behind 19/20 levels, with increases expected later in the year.

Risks:

The value of GWH activity needs to return to and exceed 19/20 levels both to support the BSW system earning ESRF funds, and to prepare for the rebasing of provider funding that will occur once the need for 'special' Covid funding blocks no longer exists.
GWH currently is running at c.92% of 19/20 values (latest month) and reviews of performance vs other providers will be carried out imminently at reinstated BSW Finance and Information Group (FIG) meetings.

Efficiency – Better Care at Lower Cost

Use of Resources

Background

The Trust started the year with a £10m cash releasing efficiency plan. The split for this was agreed by Division and work is ongoing to identify plans to achieve this target.

In June, the Trust agreed to reduce its deficit plan, as part of this the efficiency target has increased by £1.1m. The delivery of this additional target is yet to be confirmed and needs to be identified as soon as possible.

Cash Releasing - Division M03	Plan £000	Identified £000	Unidentified £000
Corproate	1,100	491	609
ICC	1,000	864	136
SWC	3,209	1,524	1,685
Trust Wide	1,100	247	853
USC	3,600	2,719	881
To be confirmed	1,100	-	1,100
Total	**11,109**	**5,845**	**5,264**

Cash Releasing - Division M03	In Month Plan £000	In Month Delivery £000	In Month Variance £000	YTD Plan £000	YTD Delivery £000	YTD Variance £000	Full Year Plan	Recurrent Forecast £000	Non Recurrent Forecast £000	Forecast Variance £000
Corproate	83	29	53	193	44	148	1,100	91	401	608
ICC	77	106	- 29	194	180	14	1,000	487	397	116
SWC	240	208	32	560	257	303	3,209	1,330	195	1,684
Trust Wide	110	21	89	110	62	48	1,100	247	-	853
USC	278	231	47	699	564	135	3,600	1,379	1,310	911
To be confirmed	110	-	110	110	-	110	1,100	-	-	1,100
Total	**897**	**595**	**303**	**1,865**	**1,107**	**759**	**11,109**	**3,534**	**2,303**	**5,272**

Improvement actions planned

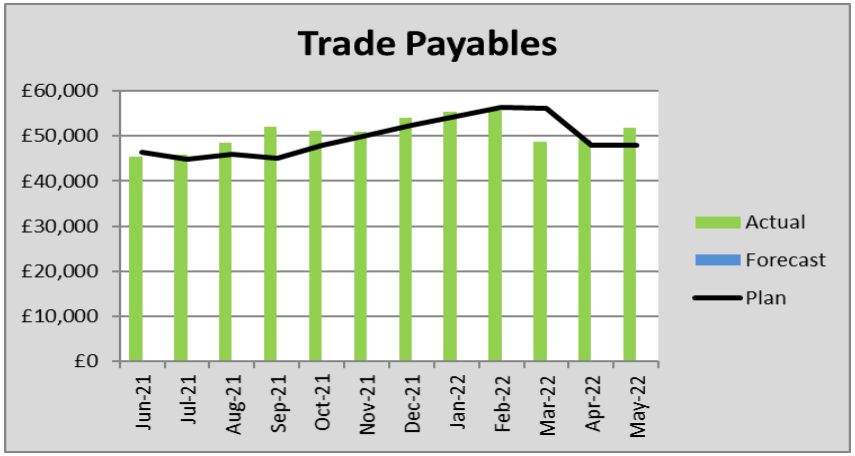
There is a shortfall of efficiency delivery in month (£0.3m) and year to date (£0.8m). A significant value within the plan remains unidentified (£5.3m) and as a result the full year forecast remains below plan. Within the forecast, a large amount is expected to be delivered non recurrently. Divisional 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.

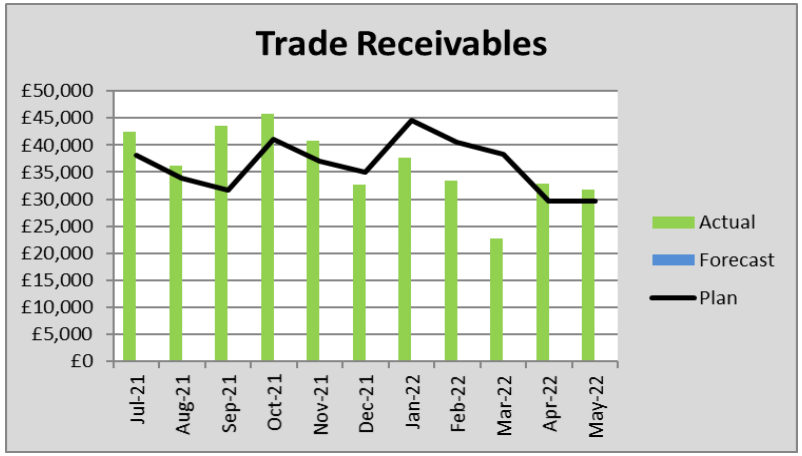
Risks to delivery and mitigations

The Trust does not yet have a fully identified efficiency plan – this is being addressed through Divisional platforms as well as cross Divisional workshops to mitigate the risk to in year delivery.

Statement of Financial Position: Key movements

Use of Resources





Background

- Trade payables are £3.8m above plan due to higher NON-PO Accrued Expenditure. Receivables is £2m above plan due to a higher Accrued income. An extensive accrual review is being undertaken through July and August to ensure these are linked to clearly-evidenced working papers.
- A full Statement of Financial Position is included in the appendices.

Risks to delivery and mitigations

- The Trust will require Emergency Capital funding in 2021/22 to support the capital programme. The Trust submitted its application for funding in May 2022 and is actively chasing the Region for resolution.

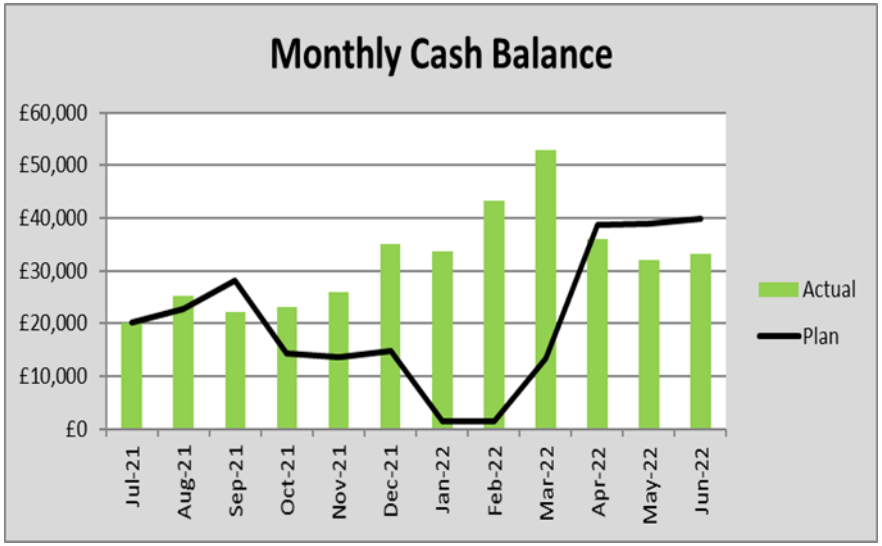
Cash

Use of Resources

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	22/23 Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	**52,898**	**35,962**	**32,058**	**33,164**	**22,494**	**22,389**	**19,604**	**11,925**	**10,564**	**10,072**	**2,383**	**2,306**	**11,599**	**1,000**	**52,898**
Income															
Clinical Income	31,363	30,665	30,972	32,746	32,860	32,860	32,860	32,860	32,860	32,860	32,860	32,857	32,857	32,857	388,624
Other Income	6,494	2,372	4,097	7,108	1,225	1,225	6,892	1,225	1,225	6,292	725	1,228	1,228	1,228	40,109
Revenue Financing Loan / PDC				824	824	824	990	990	990	1,754	1,654	18,170	10,110	2,856	27,020
Capital Financing Loan / PDC				140	140	140	110	110	380	650	650	860			3,180
Total Income	**37,857**	**33,037**	**35,070**	**40,818**	**35,049**	**35,049**	**40,852**	**35,185**	**35,455**	**41,556**	**35,889**	**53,115**	**44,195**	**36,941**	**458,933**
Expenditure															
Pay	20,348	21,307	20,812	22,648	22,564	22,564	22,570	23,624	22,764	22,783	22,783	22,783	20,348	21,307	267,549
Revenue Creditors	15,124	13,517	11,284	11,691	11,435	11,382	11,642	11,269	11,187	11,472	11,187	11,190	15,124	13,517	142,380
Capital Creditors	6,327	2,059	1,868	4,156	1,156	1,325	1,325	1,595	1,996	1,996	1,996	7,288	6,327	2,059	33,087
PFI	12,994			12,994			12,994			12,994			12,994		51,975
PDC Interest						2,563						2,562			5,125
Financing		58						58						58	116
Total Expenditure	**54,793**	**36,941**	**33,964**	**51,488**	**35,155**	**37,834**	**48,530**	**36,546**	**35,947**	**49,245**	**35,966**	**43,823**	**54,793**	**36,941**	**500,232**
Closing Balance	**35,962**	**32,058**	**33,164**	**22,494**	**22,389**	**19,604**	**11,925**	**10,564**	**10,072**	**2,383**	**2,306**	**11,599**	**1,000**	**1,000**	**11,599**

Background

- Cash at the end of June was £33m which was £6.4m below the planned level of £39.8m.
- This was due to:
  - £7.9m Increase in Receivables relating to Contract Income
  - Capital expenditure £0.5m below plan but offset by £2.4m PDC not drawn down.
  - Deficit higher than plan £1.2m



Capital Programme

Use of Resources

Capital Scheme	Capital Group	2022-23 Full Year Plan £000	Month 3 Plan £000	Month 3 Actual £000	Month 3 Variance £000	Month 3 YTD Plan £000	YTD Actual £000	Month 3 Accrual £000	YTD Total (Actual & Accruals) £000	YTD Variance £000	M12 Forecast £000
Service Development & Expansion	Estates	4,395	147	176	29	441	176	-	176	(265)	4,395
Estates Replacement Schemes	Estates	1,000	33	38	5	99	38	-	38	(61)	1,000
IT Emergency Infrastructure	IT	1,000	33	-	(33)	99	-	-	-	(99)	1,000
IT Replacement Schemes	IT	2,000	67	310	243	201	310	-	310	109	2,000
PACS - environment/replacement solution (Nov21)	IT	1,500	50	-	(50)	150	-	-	-	(150)	1,500
Equipment Replacement Schemes	Equipment	2,000	133	-	(133)	399	-	-	-	(399)	2,000
Contingency	CMG	600	-	-	-	-	-	-	-	-	600
Total Trust CDEL		**12,495**	**463**	**524**	**61**	**1,389**	**524**	**-**	**524**	**(865)**	**12,495**
Way Forward Programme		4,610	1,150	-	(1,150)	1,430	-	410	410	(1,020)	4,610
Finance Leases		141	-	-	-	-	-	-	-	-	141
Total Capital Plan (Excl PFI)		**17,246**	**1,613**	**524**	**(1,089)**	**2,819**	**524**	**410**	**934**	**(1,885)**	**17,246**

Risks to delivery and mitigations

Expenditure on schemes has been slow to commence and a revised plan has been requested from all scheme leads.
Any slippage is reported to and managed by CMG

Background

- The Trust's CDEL plan for 2022/23 is £12.5m. Estates/IT and Equipment allocations have been prioritised by Capital sub groups and will be finalised in July.
- Service Development Allocation was agreed at Capital Management Group in June 2022.
- Total Capital Expenditure at Month 3 is £1.9m below plan. Of this, £0.9m relates to Trust CDEL schemes, with the remaining £.1m slippage on externally funded schemes.
- All CDEL schemes are expected to spend the full allocation by year end. Any slippage will be reported to Capital Management Group and action will be agreed by CMG to ensure schemes can be brought forward from 2023/24 to ensure CDEL can be spent.
- The Trust' application for Emergency Capital funding for £9.9m has been reviewed by NHS E South West Capital Team. The Trust has provided feedback and is awaiting an update on progress.

Board Committee Assurance Report

Mental Health Governance Committee

Accountable Non-Executive Director	Presented by	Meeting Date
Lizzie Abderrahim	Lizzie Abderrahim	8 July 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] Q1			The committee maintained an amber risk rating to reflect issues outside the direct control of GWH [such as the availability of acute mental health beds] and that during Q1 individuals without any physical health needs but detained under s.136 had been brought to ED rather than taken to the place of safety. The actions rating was adjusted the from green to amber on the basis that discussions were ongoing in relation to the arrangements for children and young people to receive a second reading of their rights and that rates of mandatory mental health act training were non-compliant.		
Mental Capacity Act [MCA]: Update			Ratings remained consistent. The committee continued to be assured that MCA practice was supported by the necessary training and that none of the clinical incident reporting over the reporting period had cited a lack of adherence to the MCA. The committee was pleased to note that progress had been made in relation to the implementation of Datix as this would address concerns re the robustness of the data and that an LPS MCA Lead had been appointed.		

[1] Safeguarding / Mental Health / DOLS

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
Deprivation of Liberty Safeguards [DoLS] Update			Ratings remained consistent. During the reporting period 175 applications had been made to the supervisory bodies - there continue to be issues in relation to the ability of those bodies to carry out the assessments but the committee received an assurance that it was by exception that authorisations were not completed and actions were in place to address the risks associated with those patients who then remained under the Trust's care but outside of a legal framework. Compliance with mandatory DoLS training was noted.		
Liberty Protection Safeguards [LPS]: Update			Ratings remained consistent. It was noted that GWH had responded to the consultation on the LPS Code of Practice and whilst there would be significant training and workforce issues associated with the introduction of LPS the committee was satisfied that work was continuing to prepare for implementation – a clear work plan had been developed with a working party meeting monthly to progress this and an LPS Lead had been appointed.		
Changes to Legislation and Guidance			The committee noted the introduction of the Mental Health Units [Use of Force] Act 2018 and the implications that this had for GWH and that whilst, in the main, policy and guidance requirements were being met an action plan was being developed to address reporting requirements and the use of restraint – an update on this to be provided at the next meeting of the committee.		
Mental Health Governance Workplan Q1 Report			The committee was satisfied by the robustness of the workplan and noted the progress that had been made during Q1.		
Risk Report			Ratings remained consistent. The committee noted that risks had been reviewed by the divisions and that a new corporate risk had been added in relation to the availability of SERCO to provide restraint. It was agreed that future reporting of risk should provide greater assurance in relation to mitigations.		
Audit Reports			Ratings remained consistent. The committee reviewed the audit plan for 2022/23 and noted that the two audits conducted in Q1 [MCA Legislation and Policy Adherence and Adult Safeguarding and DoLS Legislation and Policy Adherence] both demonstrated compliance.		
CQC Preparedness			The committee reviewed the CQC should do requirements and noted the progress that had been made to ensure compliance in relation to the Best Interests and MCA practice and documentation, in particular the focus that there had been on training and improving staff confidence.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
Emergency Department [ED] / Mental Health Liaison Team [MHLT] Update			The red risk rating reflects the pressures that the MHLT is under including the national shortage of acute mental health beds and the workforce challenges experienced by AWP. These pressures impact directly on ED with patients staying longer than is optimal and MHLT performance not fulfilling expectations. However, an amber risk rating was justified on the basis that measures continued to be in place to address these pressures with the committee noting that there had been no increase in mental health presentations and staff morale in ED had improved as a result of CCG involvement.		
Children's Services / Child and Adolescent Mental Health Service [CAMHS] Update			The red risk rating reflects the pressures that the CAMHS continues to be under including the national shortage of specialist Tier 4 beds and the workforce challenges that CAMHS is under. As with adult patients these pressures impact directly on GWH with children and young people remaining as in patients in an acute setting whilst waiting for a specialist bed and the CAMHS liaison service not fulfilling expectations and the committee noted the extremely challenging cases that had been managed by staff in Children's Services. However, 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.		
Development of a Mental Health Strategy.			Gill May [Chief Nurse for BSW ICB] and Lucy Baker [BSW Director of Planning and Transformational Programmes] attended for this item and a useful discussion took place regarding the BSW Vision For Mental Health and Wellbeing [the Thrive Strategy] and what the GWH contribution to that strategy was and might be.		

NHS
Great Western Hospitals
NHS Foundation Trust

Board Committee Assurance Report

Audit, Risk & Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Helen Spice	Helen Spice		14 July 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			
Divisional Risk Review – Surgery, Women's and Children's	A	A	Surgery, Women's and Children's Division provided a good report on their management of risk and the controls they have in place to mitigate their risks and the good progress they have made in the last year. They have some old open risks that need to be reviewed and closed and some old accepted risk that require review for closure and or clear mitigations. The Committee was assured that the process for managing risks is robust.		
Risk Register Report	A	A	The Committee was pleased to hear that Datix is now fully operational and congratulated the team on their achievement. The Committee noted progress in some areas but were disappointed that overall the overdue actions and risks with no actions continued to increase and requested further updates on progress at the next meeting.	Divisional improvement on risk KPIs.	September 2022
External Audit			Deloitte confirmed that the Annual Report and Accounts for the year ended 31 March 2022 have now been submitted in line with the delayed timeline. A joint report from the Trust Finance team and Deloitte will be provided to the	Lessons learnt.	September 2022.

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			next meeting of the Committee on the lessons learned during the audit process.		
BDO Internal Audit Progress Report	A	A	The Committee received the updated plans and progress for the current year. Plans are progressing but are a little delayed and a query was raised by the Committee that due to the addition of the required HFMA Financial Sustainability Audit whether there was adequate coverage of all four pillars of the strategy, particularly around patient care.	Executive Review	September 2022
Internal Audit – Waiting List Management Report	A	A	The Waiting List Management Report noted moderate assurance for both design and operational effectiveness and there were two medium recommendations. The Committee were pleased to note that one had been completed but raised a concern that an internal coding system was being used to prioritise patients rather than the required national categorisation for coding.		
Internal Audit – follow up of recommendations	G	A	The Committee noted the progress being made on closing actions but requested further follow up from Trust Executive on the outstanding actions on Data Warehouse and the DSP Toolkit.		September 2022
Counter Fraud Progress Report	G	G	The Committee noted the progress to date.		
National Cost Collection 2021/22	G	G	The Committee approved the plans for submission on the 2021/22 national cost collection and recognised that the team were working to tight deadlines for submission.		
Single Tender Actions Report Q1 2022-23	G	G	The Committee acknowledge the progress made in reducing the number and value of single tender actions year on year and that the controls are in place to manage this appropriately.		
Losses and Compensations Q4 2021/22	G	G	The Committee approved the write offs for quarter 1 2022/23 and noted the losses for the quarter. The Committee asked for further assurance that overseas debts are being managed for review on a timely basis and noted the actions being taken to review the losses which had increase from prior periods.		
Conflicts of Interest in the NHS 2021/22	G	G	The Committee noted that compliance for the Trust in managing Conflicts of Interest although it has not quite reached 100% across all areas processes are being reviewed to ensure improved compliance.		
ARAC Terms of Reference	G	G	The Committee approved the amended Terms of Reference.		

Issues Referred to another Committee	
Topic	**Committee**
Theatre Programme Internal Audit Report Action on consultant surgeon job plans.	Performance, Population and Place Committee

Report Title	**Terms of Reference of Board Committees**				
Meeting	**Trust Board**				
Date	**4 August 2022**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Audit, Risk & Assurance Committee				

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

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

Report

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

The Board approved a number of changes to the Board committee structure in April 2022. As a result the terms of reference for each of the committees have been updated to reflect the changes. The Audit, Risk & Assurance Committee terms of reference are attached for Board approval. The amendments are as follows:-

- 2.3 added to reference Improving Together methodology
- 3.1 added 'Trust' before Chair
- EPRR paragraph deleted as moved to Performance, Population & Place Committee
- FTSU paragraph deleted as moved to Quality & Safety Committee
- 8.3 amended reporting process to Council of Governors
- Information Governance deleted as moved to Finance, Infrastructure & Digital Committee

The Audit, Risk & Assurance Committee has reviewed and agreed their terms of reference.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Audit, Risk & Assurance Committee				
Next Steps	To align annual work plans to the terms of reference				

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to approve the terms of reference for Audit, Risk & Assurance Committee.

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	28 July 2022

AUDIT, RISK & ASSURANCE COMMITTEE
TERMS OF REFERENCE

Review Date	**May 2023**
Board Approval	

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For annual review	July 2022	Audit, Risk & Assurance Committee	• 2.3 added • EPRR paragraph deleted as moved to PPPC • FTSU paragraph deleted as moved to Q&SC • 8.3 amended reporting process to CofG • Information Governance deleted as moved to FIDC • 3.1 added 'Trust' before Chair

1. AUTHORITY

1.1 The Audit, Risk & Assurance Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors (Trust Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2. The Committee is authorised by the Board of Directors to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. ROLE / PURPOSE

2.1 This Committee shall provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

2.2 In addition this Committee shall

- provide assurance of independence for external and internal audits;
- ensure that appropriate standards are set and compliance with them monitored, in non-financial, non-clinical areas that fall within the remit of this Committee; and
- monitor corporate governance (e.g. compliance with terms of authorisation, Constitution, Codes of Conduct, Standing Orders, Standing Financial Instructions, maintenance of registers of interest).

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

3. MEMBERSHIP

3.1 The membership of the Audit, Risk & Assurance Committee shall consist of:

- Three Non-Executive Directors (not including the Trust Chair) – at least one of whom will have financial background and one member with be Chair of Quality & Safety Committee

The Chairman of the Trust and Chief Executive shall **not** be a member of the Committee.

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

4. ATTENDANCE

4.1 Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

4.2 *Compulsory attendance* - The Director of Finance (or in their absence their deputy and another Executive Director) is expected to attend regularly. The External and Internal Auditors shall normally attend as agreed by the Chair of the Committee. The Counter Fraud Specialist shall attend at least 2 meetings each year as agreed by the Chair of the Committee.

The Chief Executive, as Accounting Officer, shall be invited to attend meetings and should discuss at least annually with the Committee, the process for assurance that supports the annual governance statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

Other Executive Directors and Non-Voting Board Directors shall be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. The Committee may call other officers of the Trust to attend as appropriate.

4.3 *Substitutes/Deputies* - Any Non-Executive Director of the Trust, (excluding the Chair), may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

4.4 The work of this Committee will be supported by the Executive Director Lead, the Director of Finance & Strategy who will normally attend and ensure appropriate attendance from other directors and officers.

4.5 *Voting* - Only the Non-Executive Directors who are members of the Committee or in their absence their substitute may vote.

4.6 *Additional meetings* – The External Auditor, the Head of Internal Audit and Counter Fraud Specialist have a right of direct access to the Chair. The Accounting Officer, external auditors, or Head of Internal Audit may request a meeting of the Committee if they consider that this is necessary. At least once each year the Committee will meet privately with the internal and external auditors.

5. QUORUM

5.1 The quorum shall be two of the 3 Non-Executive members.

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet as a minimum five times per year with additional meetings being called where necessary.

7. DUTIES

7.1 Internal Control, Risk Management and Governance

The Committee will review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the Trust's principal objectives. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements (including the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board.
- The structures, processes and responsibilities for identifying and managing key risks facing the organisation and controlling the same. This includes the underlying assurance processes.
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Annual Governance Statement and other relevant guidance.
- Any significant audit adjustments and changes in accounting policies and practices.
- The operational effectiveness of policies and procedures.
- Systems and processes for ensuring effective compliance with health & safety legislation and Standards for Better Health.
- Systems and processes for ensuring compliance with NHS Improvement, CQC and other relevant regulators.
- Arrangements for ensuring compliance with Local Security Management Directions.
- Arrangements for ensuring compliance with counter fraud standards and requirements.
- Keep under review the systems and processes of governance, assurance and their operational effectiveness and impact for the Trust.
- Oversight of systems, processes, controls and governance (compliance with Regulations, Single Oversight Framework, GIRFT & Model Hospital)
- Receive the 15+ Risk Register and Board Assurance Framework at least 2 times a year to take assurance that the processes for managing risks are effective.

7.2 Internal Audit

The Committee will ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit, Risk & Assurance Committee, Chief Executive and Trust Board, by the:

- Consideration of the provision of the internal audit service and associated costs, ensuring it has adequate resource and appropriate standing.
- Review and approval of the internal audit plan, ensuring that there is consistency with the audit needs of the organisation as identified in the Assurance Framework and co-ordination with the work of external audit.
- Consideration of the major findings of internal audit work and management responses and ensuring the co-ordination between internal and external audit to optimise use of audit resources.
- Monitor and review of the effectiveness of the internal audit function

7.3 External Audit

Review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by the following:

- The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process, including the review of the work, findings and management responses to the work. This will be achieved by:
- Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external auditor.
- Reporting to the Trust Board and the Council of Governors identifying any matters where action or improvement is needed and making recommendations for action.
- Reviewing and monitoring of the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.
- Discussing and agreeing with external auditors before the audit commences, the nature and scope of the audit for the Annual Audit. This includes the evaluation of audit risk, assessment of the organisation and impact on the audit work and fee.
- Approving the remuneration and terms of engagement of the external auditor, supplying information as necessary to support statutory function of the Board of Governors to appoint, or remove, the auditor.
- Reviewing all external audit reports, including those charged with governance, before submission to the Board, together with the appropriateness of management responses.

The Committee will:

- Develop and agree with the Council of Governors, the criteria for the appointment, re-appointment and removal of the external auditors.
- Make recommendations to the Council of Governors in relation to the above.

7.4 Financial Reporting

Monitor the integrity of the financial statements of the Trust, including its operating and financial review and significant financial returns to regulators, before clearance by the auditors and before submission to and approval by the Board, and shall review significant financial reporting issues and judgements which they contain. Additionally, the Audit Committee will review the Annual Report and Accounts before submission to the Board, focusing particularly on:

- Wording in the annual governance statement and other disclosures relevant to these terms of reference
- Changes in, and compliance with, accounting policies, practice and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

The Audit, Risk & Assurance Committee will also:-

- Monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing any significant financial reporting judgements.
- Ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

7.5 System Working, Managing Change & Transformation

- Oversight of system working, managing change and transformation, notably our role in the Integrated Care System (ICS), partnership working (Wiltshire Health & Care LLP), new projects and transformation schemes.

7.6 Other Assurance Functions

The Audit Committee will refer to the work of other committees within the organisation, whose work can provide relevant assurance to the Audit, Risk & Assurance Committee's own scope of work. In particular, the Audit, Risk & Assurance Committee will refer to the work of the People & Culture Committee, Quality & Safety Committee, Performance, Population & Place Committee and Financial & Infrastructure Committee.

The People & Culture Committee provides assurance that the relevant legal and regulatory requirements relating to the workforce are met. The Quality & Safety Committee coordinates and implements all the responsive actions being taken by the organisation in relation to quality and provides assurance to the Board of Directors that the quality agenda is being embedded in line with the Quality Strategy, and the Performance, Population & Place Committee provides assurance that performance is measured and monitored, tackling health inequalities and the development of an Anchor organisation . The Financial Investment Committee provides an objective

view of the financial performance, and financial strategy of the Trust, together with an understanding of the risks and assumptions within the Trust financial plans and projections, together with oversight of the infrastructure of IT and estates.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

8.3 The Chair of the Committee reports to the Council of Governors through the statutory annual report and accounts process, and in relation to the performance of the external auditor to enable the Council of Governors to consider whether or not to re-appoint the external audit firm. In addition, the Chair of the Committee will report any other significant issues to the Council of Governors.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

11.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Appendix 1 - Summary

Committee	Audit, Risk & Assurance Committee
Chair Lead EDs	Helen Spice, Non-Executive Director Simon Wade, Director of Finance & Strategy
Frequency	A minimum five times per year
Membership	3 x NEDs
Quorum	2 x NEDs
Remit	Overseeing the probity and internal financial control of the Trust, working closely with external and internal auditors. Ensuring effective internal and external audit function Ensuring effective governance, risk management and internal controls Ensure effective counter fraud provision Review of annual report accounts and associated documentation before they are submitted to the Board.

Appendix 2 – Strategic Planning Framework

GWH - Strategic Planning Framework