Great Western Hospitals NHS Foundation Trust

Agenda Board of Directors

Date	2 September 2021
Time	9:30 – 12:20
Location	MS Teams
Chair	Liam Coleman

Agenda

1 9:30 **Apologies for Absence and Chairman's Welcome**

2 **Declarations of Interest**

Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust.

3 **Minutes (pages 1 – 11)**

Liam Coleman, Chairman

- 5 August 2021 (public minutes)

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

5 **Questions for the Board (pages 13 – 14)**

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

Liam Coleman, Chairman

7 9:55 **Chief Executive's Report (pages 15 – 18)**

Kevin McNamara, Chief Executive

8 10:15 **Patient Story**

To be presented by Hayley Moore, Ward Manager Beech Ward

- A video clip of a patient sharing their overall experience whilst a patient on Beech Ward

9 10:35 **Integrated Performance Report (pages 19 – 91)**

- Performance, People & Place Committee Board Assurance Report - Peter Hill, Non-Executive Director & Committee Chair
  Part 1: Operational Performance - Felicity Taylor-Drewe, Chief Operating Officer

- Quality & Governance Committee Board Assurance Report - Nick Bishop, Non-Executive Director & Committee Chair
  Part 2: Our Care - Lisa Cheek, Chief Nurse & Jon Westbrook, Medical Director

- Part 3: Our People - Jude Gray, Director of Human Resources

- Finance & Investment Committee Board Assurance Report - Andy Copestake, Non-Executive Director & Committee Chair
  Part 4: Use of Resources - Simon Wade, Director of Finance & Strategy

10 **Mental Health Governance Committee Board Assurance Report (pages 92 – 95)**
11:35
Lizzie Abderrahim, Non-Executive Director & Committee Chair

11 **Responsible Officer Annual Report (pages 96 – 111)**
11:45
Jon Westbrook, Medical Director

12 **Equality, Diversity and Inclusion (EDI) Annual Report 2020/21 (pages 112 – 162)**
11:55
Jude Gray, Director of Human Resources
Patrick Ismond, Lead for Equality, Diversity & Inclusion to present

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

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

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

15 **Date and Time of next meeting**
Thursday 7 October 2021 at 9.30am (Doubletree by Hilton Hotel)

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"

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD VIRTUALLY IN PUBLIC ON 5 AUGUST 2021 AT 9.30 AM, BY MS TEAMS

Present:

Voting Directors

Liam Coleman (LC) (Chair)	Trust Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Andy Copestake (AC)	Non-Executive Director
Charlotte Forsyth (CF)	Medical Director
Jude Gray (JG)	Director of HR
Peter Hill (PH)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Claudia Paoloni (CP)	Associate Non-Executive Director
Julie Soutter (JS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Claire Thompson (CT)	Director of Improvement & Partnerships
Simon Wade (SW)	Director of Finance & Strategy

In attendance

Caroline Coles	Company Secretary
Emma Colgrave	Member of Differently Abled Network (agenda item 139/21 only)
Tim Edmonds	Head of Communications
Felicity Pullan	KPMG - observing
Al Sheward	Deputy Chief Operating Officer (agenda item 137/21 only)

Apologies

Nick Bishop	Non-Executive Director
Paul Lewis	Non-Executive Director
Jim O'Connell	Chief Operating Officer
Sanjeen Payne-Kumar	Associate Non-Executive Director

Number of members of the Public: 6 members of public (5 Governors; Chris Shepherd, Maggie Jordan, Arthur Beltrami and Janet Jarmin and Judith Furse).

Matters Open to the Public and Press

Minute	Description	Action
130/21	**Apologies for Absence and Chairman's Welcome** The Chair welcomed all to the virtual Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
131/21	**Declarations of Interest** There were no declarations of interest.	
132/21	**Minutes** The minutes of the meeting of the Board held on 1 July 2021 were adopted and signed	

Minute	Description	Action

as a correct record with the following amendments:-

- On page 13 paragraphs 1 and 2 and page 14 1st sentence amend spelling of Chief Nurse.

133/21 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

134/21 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

135/21 **Chair's Report, Feedback from the Council of Governors**
The Board received a verbal update which included:-

- The revised anticipated date to move to hybrid meetings was September 2021, however once again this would be dependent on government advice. Further details would be found on the Trust's website.
- There were two governor working groups that took place in July 2021; Finance & Staffing Working Group, where the governors had a presentation on the PFI and Staff Survey Results, and, a Patient Quality & Operational Performance Working Group.
- On 13 July 2021 the Trust held an Extraordinary Council of Governors Meeting which approved the appointment of the Trust's External Auditors, Deloitte LLC. KPMG were appointed to provide External Audit Services to the Trust in late 2020 however through mutual agreement KPMG terminated the service in June 2021 in order to perform other work within the Trust. Deloitte were part of the original competitive market tender and as the existing auditor had resigned within 6 months of the tender conclusion the Trust were able to appoint Deloitte without going out to re-tender.
- There was an Informal Governors meeting with the Chair of the Finance & Investment Committee, Andy Copestake invited to the meeting.
- There was also the regular monthly meeting between the Chair and the Lead Governors.

The Board **noted** the report.

136/21 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report and the following was highlighted:-

Continued Pressure on the Local Health System - In July 2021 the Trust reached Opel 4, the highest alert level, due to the very high level of demand coupled with a large amount of staff shortages due to Covid-19 sickness or self-isolation. As a result the Trust decided to close the Urgent Treatment Centre overnight on weekdays for a period of time. The Trust had also seen a rise in conveyances of patients by ambulance causing surges in arrivals. The Trust was working closely with South West Ambulance Service to finalise a plan which was aimed at supporting the ambulance service to reduce the clinical risk of members of the public who are unable to get an ambulance in a timely manner.

Rising Demand from Covid-19 - The Trust had seen a very definite upward trend in covid patients and, for the first instance in several weeks, this had had some impact on ICU.

Minute	Description	Action

Workforce – Staffing during the month had been challenging across the Trust due to absences mainly as a result of being pinged by the Test and Trace App. A staff risk assessment had been put in place for their safety to return to work.

Elective Activity Recovery - The programme of work introduced to reduce the Trust's waiting lists caused by the pandemic was well underway and the Trust was now seeing a positive impact from this.

Primary Care - Last month the GP Practice 2021 Survey results were published and they reflected the challenges the Trust continued to face in this sector. A number of improvements were being considered which included improvements to the telephony system, online triage and regular patient engagement forums.

Recruitment to Senior Roles - A recruitment campaign had been launched for a Chief Digital Officer, which would be a joint role with Salisbury NHS Foundation Trust, together with recruitment for two Deputy Nurse roles.

Supporting the Armed Forces - The Trust had been accredited as a Veteran Aware Hospital in recognition of the Trust's commitment to improving NHS care for veterans, reservists, members of the armed forces and their families.

In addition to the report the Chief Executive advised of a temporary black out in the hospital earlier in the week. No harm had been caused and successful tests had been completed since however this pointed to the discussion at Performance, People & Place Committee around site resilience and the importance of unblocking the PFI to obtain an upgrade to the electrical system.

Liam Coleman, Chair picked up on the last point with regard to the Board getting an understanding from a strategic perspective, via Performance, People & Place Committee, of the wider issues around the PFI contract and renewal process. Any further questions from the Board on the specific blackout issue should be directed to the Director of Finance & Strategy.

Action : Director of Finance & Strategy SW

Julie Soutter, Non-Executive Director asked how the Trust could improve communications to ensure that people were directed to the right place for treatment. Kevin McNamara, Chief Executive replied that the Trust was working across the BSW on focussed communications and sharing best practice across the South West.

Lizzie Abderrahim, Non-Executive Director asked if the Trust were confident in managing members of staff absence, demands in the system and hospital together with staff health and wellbeing. Kevin McNamara, Chief Executive responded that the Trust had been juggling all these issues, as well as seasonal events such as junior doctors hand over and staff taking annual leave, and was the reason why the Urgent Care Centre was closed overnight. Other difficult options may need to be considered to keep patient and staff safe in the coming months.

Andy Copestake, Non-Executive Director asked if the oxygen work on site had been finalised. Simon Wade, Director of Finance & Strategy responded that tests had been completed successfully over the last couple of weekends and the full programme of work was due to finish in September 2021. Kevin McNamara, Chief Executive added that over the course of the past few weeks not only had there been planned weekend tests but

also the black out and many staff had juggled these events and wished to thank all those staff concerned.

Liam Coleman, Chair asked if the ambulance service had been given any additional resource to manage the influx of people due to summer holidays. Kevin McNamara, Chief Executive replied that emergency funding to provide additional resource together with those normally deployed for significant incidents was offered however this was limited. Response calls were also being prioritised and the SW ambulance service had, in addition, put in a bid for further national funding and awaited an outcome.

The Board **noted** the report.

137/21 **Integrated Performance Report**

The Board received and considered the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in May/June 2021.

Part 1 : Our Performance

Al Sheward, Deputy Chief Operating Officer joined the meeting for this agenda item.

Performance, People and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, People and Place Committee (PPPC) around the IPR at its meeting on 28 July 2021 and highlighted the following:-

Recovery Programme - The Trust had an excellent Q1 in terms of elective recovery with additional finances secured however Q2 would be more challenging and unlikely to achieve the Elective Recovery Fund as the national rules had changed.

Re-admissions - There was a good level of understanding of the issues faced and potential risks. An action plan was in place to deal with the risk and appropriate actions were being taken. The Committee asked for a report on Unscheduled Care to be brought to the October 2021 Committee meeting.

Stroke - Current issues had been addressed and performance was looking positive moving forward with the expectation that an improvement would be seen in the SNNAP score for Q1.

Emergency Department - In line with the national trend demand on the ED department and UTC continued to be extremely high. Work was being undertaken to understand the different pressures and possible actions across ED and UTC. Specific improvement was not expected in the next few months.

Referral to Treatment Time (RTT) - This was linked to the recovery programme and performance remained steady with elective care activity maintained despite the impact of Covid and the rising number of cases. The number of 52 week waiters continued to decrease.

Workforce - Whilst acknowledging risks the Committee was assured on the actions that the HR team were putting in place to manage these risks.

Site Utility & Resilience - As mentioned previously there were concerns that surrounded the timelines and the blackout risk and more Executive scrutiny was required. The

Minute	Description	Action

Committee would receive back progress at an appropriate time.

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

Emergency Care Standards - An imminent change to the Emergency Care standards was expected and therefore shadow reporting had commenced and would feature in future reports.

Ambulance Handover - Flow into ED and the UTC had significantly increased over the last 6 weeks. The number of ambulance handovers had also increased which caused surges in arrivals especially in the afternoon. The Trust were working closely with South West Ambulance Service to identify opportunities to both support the crews delayed and identify and implement actions that reduced holding.

Liam Coleman, Chair asked for greater insight into the plans to improve ambulance handovers particularly those that were in the Trust's control and those outside of the Trust's control. Al Sheward, Deputy Chief Operating Officer responded that a more detailed report would go to Performance, People & Place Committee with a wider perspective of a patient's journey rather than just signposting from the hospital front door.
Action : Chief Operating Officer JO

Part 2 : Our Care

Quality & Governance Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Governance Committee around the quality element of the IPR at the meeting held on 22 July 2021 and the following highlighted:-

Electronic Discharge Summary (EDS) - The performance of EDS had not changed for some time despite best efforts. More options were being considered which included an increased amount of time at junior doctor's induction and the Committee would continue to monitor closely.

Charlotte Forsyth, Medical Director advised that induction of junior doctors had taken place this week and confirmed that the new intake were clearly told about EDS and the safety issues in delayed EDS.

Integrated Performance Report - A suite of reports highlighting a range of matrices on quality of care with most indicating positive outcomes, including a reduction in falls and pressure ulcers.

Perinatal Safety – Quality Surveillance Tool - Caesarean Section (C-section) rates were included for the first time in the IPR after the Committee requested it. Some concerns were expressed at the high rate in April 2021 but this reduced over May & June 2021. Included in this report was an update on CNST which reported that it was failing in 2 of the 10 standards.

Charlotte Forsyth, Medical Director added that the rate of C-sections within the Trust was high compared to national figures. Although there was no immediate concern the department were undertaking a deep dive and the outcome. Lisa Cheek, Chief Nurse added that a maternity safety report was being developed drawing all the elements of

Minute	Description	Action

safety in maternity not just focussing on Ockenden and building a strong governance route up to Quality & Governance Committee. LCh

Action : Chief Nurse

Perinatal Mortality Review Tool - The Trust were compliant in achieving this standard.

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

Medicine Safety - The rate of medication incidents and the proportion causing harm remained stable. However this remained a key focus area particularly in 3 areas; medicine on discharge, oxygen delivery and medicine administration in order to gain a greater understanding of the impact on medicine errors on patients and the systems and processes.

Patient Experience - Another area of focus was patient experience through the Great Care Campaign with the commitment to working closer with patients and their families and carers to hear about their experiences as well as their expectations. This included the launch of a Learning Zone on World Patient Safety Day on 17 September 2021 where all the good work would be streamlined and shared between every team in the organisation so that learning was embedded and every team was provided the same level of quality care.

Liam Coleman, Chair asked if through all the patient experience surveys did the Trust have clarification on what the patient's expectations were. Lisa Cheek, Chief Nurse replied that this was on-going work however was challenging as people had different expectations in different areas. A mapping exercise was currently underway to identify those areas were the Trust gained feedback with patients and the community which would feed into the governance route up to Quality & Governance Committee in September/October 2021. LCh

Action : Chief Nurse

Faried Chopdat, Non-Executive Director asked if the Great Care Campaign initiative accounted for long term sustainability of embedding processes and systems. Lisa Cheek, Chief Nurse replied that it was early days however this would be measured against the outcomes of national surveys, serious incidents and harm free care. The initiatives would constantly evolve and it was work in progress.

Part 3 : Our People

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

- A number of Key Performance Indicators (KPIs) were not trending as green as previous months and it was anticipated that this would not improve next month. This was due to the significant pressures around demand on services and the number of staff not available to work.

- A deep dive into all turnover had been undertaken with the outcome that demonstrated the reasons the performance remained above target were due to fixed term contracts and retirement.

Minute	Description	Action

Julie Soutter, Non-Executive Director commented that looking at the figures for safer staffing and fill rates some areas were over allocated with staff and other areas struggling particularly with the increase of mental health support required. Lisa Cheek, Chief Nurse replied that the safer staffing was not helpful in the way it was presented and a different format was being looked at to gain better assurance. The Trust did even out staffing on acuity and dependence and there were 3 daily meetings to ensure staff were re-allocated to the right areas. A full establishment review was being undertaken during August/September 2021 to fully understand the nurse/patient ratio and models of care and this would take into consideration safer staffing.

There followed a discussion on the increase in demand for mental health support which included direct access to mental health bed capacity, AWP involvement and work on-going to improve the situation. It was agreed to invite the relevant BSW colleague to a Board Committee to discuss this issue further and that the Chair and Chief Executive took the action to organise the next steps on who and where. LC/KM

Action : Chair/Chief Executive

Finance & Investment Committee Overview

The Board received an overview of the detailed discussions held at the Finance & Investment Committee around the financial element of the IPR at the meeting held on 26 July 2021 and the following highlighted:-

Monitoring benefits from Business Cases - This was a referral from Performance, People and Place Committee. The Committee concluded that there was currently a gap and there was a need for regular reporting of the achievement or non-achievement of benefits to be able to learn lessons. It was noted that the QI programme was already picking this up as a key requirement and would be reported back to the Finance & Investment Committee.

National Cost Collection 2019/20 Report - This was a referral from Audit, Risk & Assurance Committee who had asked for more information on 2 specific areas; firstly an explanation of why the GWH elective inpatient cost had risen by 6% when the national average had fallen by 5% and, secondly, why the outpatient procedure costs were nearly 20% below the national average figures. This would be reviewed at the next Finance & Investment Committee.

Month 3 Finance Position - All the main indicators were green with a favourable I & E variance to date of £9k, cash of £30.2m at the end of June 2021, good performance with regard to the Elective Recovery Fund in Q1 and good progress in spending the Capital budget. Also, CIP achievement to date was £99k above plan.

Finance Risk Register - The processes around the risk register were robust with regular updates. One risk was added around Ockenden funding and it was noted the potential risk if the pay award was not fully funded.

Cost Improvement Plans (CIPs) - The Committee received a good report on CIP achievement in the first 3 months of the year. Better buying was significantly ahead of plan resulting in a favourable position overall but some of the Divisions were significantly below their respective plan targets. The red rating reflected the need to address a number of worrying underlying cost trends as well as responding to a much higher expected CIP target in H2.

Minute	Description	Action

Capital Plan - The Trust had re-profiled its Capital Plan. Spend to date was broadly in line with the new plan. The amber rating reflected the fact the Trust was still waiting for confirmation that the plan was fully funded.

Improvement & Efficiency Plan - The Committee received a follow up report on the Improvement & Efficiency Plan which helpfully addressed a number of concerns and questions raised at the previous meeting.

GMP and main contract on Urgent Treatment Centre (UTC) - The Committee received a detailed report from the Way Forward team on the considerable amount of work undertaken to reach an acceptable Guaranteed Maximum Price for the new UTC building. The Committee was satisfied that due process and agreed to approve the GMP of £8,445,988 and to sign off the Main Construction (Stage 4) Contract under the delegated authority approved by the Board.

Liam Coleman, Chair asked what the understanding was with regard to agreeing the budget element in the next 6-18 months. Simon Wade, Director of Finance & Strategy confirmed that no further guidance had been received however the expectation was that the financial envelopment for the second half of the year (H2) would be received in September 2021 followed by a 2 month planning period to November 2021. Planning guidance for 2022/21 was anticipated in November/December 2021 for planning rounds to commence January to March 2022. From an internal planning perspective there was no significant change except for efficiency targets which would be greater.

Liam Coleman, Chair asked if the resources were available to deliver the CIPs against the backdrop of demand and staffing challenges. Andy Copestake, Chair of Finance & Investment Committee replied that this dovetailed with the QI programme and that there was a concern in H2 as there was likely to be an increase of 3% in the efficiency target which equated to £5m. Those areas falling short had been identified and actions were in place to address them. Simon Wade, Director of Finance & Strategy added that the system was looking at ways to use resources more efficiently and in a different way in order to reduce premium agency spend where the savings could be found.

Lizzie Abderrahim, Non-Executive Director queried the CIP graph which indicated that the savings in the latter part of the year would be non-pay not pay. Simon Wade, Director of Finance & Strategy responded that this was down to categorisation not where the savings would be made. Those targets with no plans were categorised as non pay in the first instance. It was agreed the graph was confusing and would be reviewed for the next month.

Action : Director of Finance & Strategy SW

Faried Chopdat, Non-Executive Director commented that with all the various challenges within the Trust around demand exceeding supply and the resource model under pressure how was the £5m savings going to be made. Simon Wade, Director of Finance & Strategy replied that a lot of work would be done through the Improvement Board and the focus would be on key schemes for example theatre, flow programme with a balance between transactional and transformation. The benefits would be more in the new financial year. Claire Thompson, Director of Improvement & Partnerships confirmed that ground work for transformation in 2022/23 within the system had commenced which looked at value and real opportunities as well as transactional delivery in H2.

Minute	Description	Action

There followed a discussion on the other challenges in terms of not releasing cash savings which included the underlying deficit and borrowing for cash purposes.

The Board received and considered the Use of Resource performance element of the report and there were no further comments.

RESOLVED

to review the IPR and the on-going plans to maintain and improve performance.

138/21 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received an overview of the discussions held at the Audit, Risk & Assurance Committee at the meeting held on 15 July 2021 and the following highlighted:-

Risk Management - A good discussion on the development of the Board Assurance Framework which was well received together with a good grip on risk management within the Trust. It was noted that a Board workshop was being held on Risk Management in September 2021. Also at the meeting was a deep dive into Corporate risks; Estates and FM, IT, HR, Quality (IP&C, Safeguarding & PALS), Clinical Quality (Risk, FTSU). Assurance on processes with focussed action proposed on KPIs, training and more detail on IT Cyber risks.

Annual Report on Cyber Security - Although no successful cyber attacks in reporting period, risk of attacks was increasing overall and some key staff leaving the Trust. Further work was requested.

Internal Audit – Staff Engagement - This was not a formal audit report. This report was based on staff. Based on staff survey across specific clinical directorates. Good practice and quality noted on a range of communications approaches, with 2 medium recommendations.

Internal Audit – Integrated Learning - Rated moderate for Design and Effectiveness. Good practice noted with 2 medium recommendations.

Counter Fraud - New report format to match new standards. No new allegations received since last committee meeting. Work progressing as planned.

Anti-Fraud and Corruption Policy - The policy was updated.

National Cost Collection 2019/20 - Report covered recent outcome of 2019/20 exercise. Assurance on process and improvements to quality controls pre submission. Some questions over specific areas within overall figure to be explored by Finance & Investment Committee.

Freedom to Speak Up (FTSU) Annual Review - Assurance on on-going initiatives and actions to promote open and supportive culture. Work planned to look at best practice, recovering the profile of FTSU after impact of Covid on activities and link to initiatives on Just Culture.

Single Tender Actions - Good assurance. Report on 'waivers' with discussion on recent improvement to controls and scrutiny. Further work being done by task and finish group linked to Counter Fraud submission.

Minute	Description	Action

Losses and Compensations Q1 21/22 - The Committee were assured that all losses had been through a robust process. Discussion on controls for improving collection processes going forward with assurance on finance processes and further reviews planned.

Claudia Paoloni, Non-Executive Director asked how the recorded incidences and outcomes in connection with FTSU were reported back to individuals. Jude Gray, Director of HR replied that regular reporting was done through Executive Committee where cases were discussed together with actions and learning. However with regard to individual feedback the Director of HR would take the action to find out.
Action : Director of HR JG

The Board **noted** the report.

139/21 **Staff Story**
Emma Colgrave, Member of the Trust's Differently Abled Network joined the meeting for this item.

The Board received a staff story which highlighted the experiences of an individual with dyslexia. The story outlined a personal story regarding a less positive experience outside of the Trust and the more positive experience on joining and working for the Trust. It described how people viewed individuals with dyslexia and what could be achieved as a dyslexic person. Each individual with the condition would have a unique pattern of strengths and weaknesses.

The Board thanked Emma for sharing her story which was very insightful and honest. There followed a discussion on what the Trust could still do to learn within its Equality, Diversity & Inclusion agenda for now and for future employees. It was concluded that phraseology was key especially around the words 'to declare' which should be changed to a softer approach for instance 'sharing information' as this was perceived as more supportive.

Further discussion ensued around the broader challenges around the approach when talking to differently abled individuals, and also the adjustments to accommodate dyslexic patients particularly literature.

The Board **noted** the staff story.

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.

140/21 **Ratification of Decisions made via Board Circular/Board Workshop**
The Board was asked to ratify one Board Circular which had been approved since the last Board meeting:-

- To approve delegated authority to the Performance, People & Place Committee to sign off the final Premises Assurance Model (PAM) before submission. It was noted that this would be required for the August 2021 meeting and not July 2021

as stated in the circular.

RESOLVED

to ratify the approval to delegate authority to the Performance, People & Place Committee to sign off the final Premises Assurance Model (PAM) before submission.

141/21 **Complaints Policy**
The Board received and considered the Complaints Policy.

The Quality & Governance Committee had discussed the policy in detail and had approved the policy and recommended the Board ratify the policy.

RESOLVED

to ratify the Complaints Policy.

142/21 **Urgent Public Business (if any)**
None.

143/21 **Date and Time of next meeting**
It was noted that the next virtual meeting of the Board would be held on 2 September 2021 at 9:30am via MS Teams.

144/21 **Exclusion of the Public and Press**

RESOLVED

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

The meeting ended at 1445 hrs.

Chair …… Date……

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – September 2021				
PPPC - Performance, People and Place Committee, Q&GC - Quality & Governance Committee, RemCom - Remuneration Committee, FIC – Finance & Investment Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
05-Aug-21	136/21	**Chief Executive's Report : PFI Contract** A report to focus on the wider issues of the PFI contract and renewal process.	Director of Finance	For PPPC
05-Aug-21	137/21	**IPR : Our Performance : Ambulance Handovers** Detailed report on plans to improve ambulance handover performance	Chief Operating Officer	For PPPC
05-Aug-21	137/21	**IPR : Our Care : Maternity** Deep dive into C-section rates.	Chief Nurse	For Q&GC
05-Aug-21	137/21	**IPR : Our Care : Patient Experience** Mapping exercise to identify those areas were the Trust gained feedback with patients and the community which would feed into the governance route up to Quality & Governance Committee in September/October 2021.	Chief Nurse	For Q&GC
05-Aug-21	137/21	**IPR : Our People : Mental Health** To review mental health provision system-wide invite relevant BSW colleague to a Board committee.	Chair/Chief Executive	Chair/CEO to determine next steps on who and where.
05-Aug-21	137/21	**IPR : Use of Resources : CIPs** Review graphics used to show Cost Improvement Plans.	Director of Finance	Included in next report.
05-Aug-21	138/21	**Audit, Risk & Assurance Committee Board Assurance Report** Clarification on the process of reporting back to individuals on the outcome of Freedom to Speak Up cases.	Director of HR	Update at meeting.

Future Actions				
None				

Great Western Hospitals NHS Foundation Trust

Questions for the Board

Meeting	Trust Board	**Date**	2 September 2021

Summary of Report

This paper reports the questions and responses (where available at the time of writing) asked of the Board by governors and members of the public.

For Information		Assurance		Discussion & input	x	Decision / approval	

Executive Lead	
Author	Caroline Coles, Company Secretary
Author contact details	caroline.coles3@nhs.net 01793 605396

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score
n/a	n/a	n/a

Legal / Regulatory / Reputation Implications	n/a

Link to relevant CQC Domain

Safe		Effective		Caring	x	Responsive		Well Led	

Link to relevant Trust Commitment	n/a

Consultations / other committee views

Recommendations / Decision Required

that the questions and responses be considered by the Board.

Questions to the Board				
Topic	**Questioner**	**Question**	**Responder**	**Board Response**
Radiology	Karen Hawkins, Staff Governor	1. First contact practitioners are being employed as a recommendation from NHS England to help manage the demand in GP practices. The FCP's are often requiring x-rays to be performed to help move the patient through the pathway. First contact Practitioners/ advanced practitioners in other parts of BSW are able to order x-rays at Salisbury and Bath, please can you inform us as to why this is not the case at GWH and why Swindon patients are not treated equitably. 2. Does the radiology department have any concerns regarding increase in demand in imaging, if they allow FCP's to order x-rays – do they have evidence that the APPS within the MATS service have increased demand for imaging? - nationally the evidence is that APPs consistently refer for fewer investigations than medical colleagues. 3. What are the issues that would need to be overcome to allow FCP's (especially Physiotherapists) to be able to order x-rays?	Lorraine Austen, Director Integrated Care and Community and Lisa Cheek, Chief Nurse	1. Development of appropriate policies, procedures and resources to facilitate extending the non-medical referrers cohort outside of the Trust was delayed due to Covid and work is again underway to get this back on track to ensure this happens in accordance with the IRMER regulations. 2. Any concerns regarding an increased demand can be mitigated and managed once appropriate policies, procedures, and resources to facilitate extending the non-medical referrers cohorts are in place and staff have supervisors in place for discussing and naming on referrals. 3. Policy, procedure and resource work needs to be completed, named supervisors identified and collaborative working between non-medical cohorts and Radiology department to take this work forward would be welcomed.

Great Western Hospitals NHS Foundation Trust

Chief Executive's Report

Meeting	Trust Board	**Date**	2 September 2021

Summary of Report

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

For Information	x	Assurance		Discussion & input		Decision / approval	

Executive Lead	Kevin McNamara, Chief Executive Officer
Author	Jim O'Connell, Deputy Chief Executive
Author contact details	

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score

Legal / Regulatory / Reputation Implications	N/A

Link to relevant CQC Domain

Safe	x	Effective	x	Caring	x	Responsive	x	Well Led	x

Link to relevant Trust Commitment	

Consultations / other committee views

N/A

Recommendations / Decision Required

This report is for information only.

1. Current pressures

The whole health system is still experiencing very high non-elective demand and we continue to see record levels of demand upon us.

Last week we once again reached our highest state of demand, Opel 4, reflecting the pressure upon not just our Trust, but the wider health and care system.

The pressure on our Emergency Department has led to increased delays for ambulance crews handing over their patient to us in a timely way, which has the potential to cause harm to them and others in our communities who need to access the 999 service.

We held our second 'SAFER week' last week to focus our efforts on safe and timely discharge to help ensure a good flow of patients through the hospital in the run up to the Bank Holiday weekend.

We also focused on follow up calls, telephoning patients the day after they have been discharged from hospital to check on their overall condition and to assess if they need any additional support.

Some patients in the Emergency Department do not benefit from being seen here and would be better seen in a more suitable place. We continue to advise the public to access care in the right setting and work with system partners to signpost people appropriately, particularly highlighting the use of 111.nhs.uk.

We have also seen an increased number of admissions of children with respiratory syncytial virus (RSV), and we are closely monitoring this trend.

2. Covid-19

We have seen an increase in the number of patients in Great Western Hospital with confirmed or suspected Covid-19 in recent weeks. A verbal update on numbers will be provided at the Board meeting.

An increasing number of these patients have needed treatment in our Intensive Care Unit and we continue to monitor this very carefully, as we are very conscious that further pressure on intensive care raises the risk of needing to cancel some elective activity which would impact upon our work to reduce our waiting list.

At the time of writing Swindon's case rate was higher than the national average, but below the South West average. Our modelling indicates that we should expect the number of hospital admissions through September to continue to rise and we have surge plans in place to enable us to manage this increase as best we can.

3. Vaccination programmes

3.1 Covid-19

We have now administered more than 90,000 Covid-19 vaccinations and last month began offering the vaccine to 16 and 17-year-olds. There was a great response from this age group to our walk-in clinics with our first session becoming full very quickly.

There is a local and national push to encourage pregnant women to get vaccinated – the vaccine offers pregnant women the best protection against Covid-19 which can be serious in later pregnancy for some women. The Covid vaccines available in the UK have been shown to be effective and have a good safety profile. These vaccines do not contain live coronavirus and cannot infect a pregnant woman or her unborn baby in the womb.

3.2 Flu

Our annual flu vaccination campaign will launch on 12 September, with staff able to make appointments to have the jab through Occupational Health.

We are currently recruiting peer vaccinators, who will have a key role to play in delivering another successful campaign and help protect our staff, and their colleagues, families, and patients.

4. Recovering our elective activity

We know that many people have been waiting a long time to receive the treatment they need because of the cancellation of procedures earlier in the pandemic.

During this time, we know that many patients' circumstances will have changed and they may no longer need to be on our waiting list.

This week we began a trial to contact people on some of our waiting lists for surgery to ask them if they still need an operation at GWH.

We started this pilot by sending text messages to those on waiting lists for an orthopaedic or a gynaecology operation. We will monitor the impact of this initiative before deciding whether to roll it out more widely.

5. Staff recognition

5.1 STAR of the Month

Congratulations to Emergency Department consultant Dr Natalie Whitton who is our latest STAR of the month winner, in recognition of her outstanding work to support those patients who frequently attend our Emergency Department to get the help they need to keep them out of hospital.

5.2 Staff Awards

The shortlist for our Staff Excellence Awards will be announced shortly, ahead of the ceremony which will take place on 5 November.

5.3 Great West Fest

Our Great West Fest event takes place on Saturday (4 September).

We arranged this event as a thank you not just to our staff but also their families who have supported them through such a challenging period.

We will have very strict infection prevention and control procedures in place, including monitoring of numbers entering and leaving, hand sanitisers and a Track and Trace QR code.

6. Celebrating Pride

Last month members of our LGBTQ+ network, supported by other Trust staff, volunteered at the Swindon and Wiltshire Pride Festival held at Swindon Town Gardens.

To celebrate and support the community, we unveiled our new rainbow crossing at the front of the hospital ahead of the festival, after the idea was raised by a member of staff.

Next week we will be supporting Pride in the NHS Week (6 to 10 September) and its concluding NHS Virtual Pride finale.

7. Senior appointments

7.1 Executive Directors

Board members will join me in welcoming two new members of our Executive Team to the Trust.

Felicity Taylor-Drewe joined us as Chief Operating Officer from Gloucestershire Hospitals NHS Foundation Trust last week and Jon Westbrook has joined as Medical Director from Oxford University Hospitals NHS Foundation Trust.

7.2 Deputy Chief Nurses

Congratulations to Rayna McDonald and Luisa Goddard who have been appointed to our two substantive Deputy Chief Nurse roles.

8. Governor elections

Local people are invited to stand for election to become a public governor at our Trust, for the following constituencies:

- Central and Southern Wiltshire
- Northern Wiltshire
- West Berkshire, Oxford, Gloucestershire, Bath and NE Somerset

Applications for the Governor positions opened today (2 September), and will close on 30 September.

The Council of Governors is made up of people of all ages and backgrounds, who all have one thing in common - the continued development of the Trust.

There is no experience or particular skills necessary to become a public governor, however potential candidates should:

- Have an interest in healthcare and the strategic issues affecting the Trust
- Contribute towards the future plans of the Trust
- Act and behave in the interests of the Trust
- Represent the views of local people
- Help to develop the membership of the Trust.
  Interested applicants should visit www.cesvotes.com/gwh2021, where they will be able to complete a nomination online.

9. Annual Members' Meeting

Board members will note that our Annual Members' Meeting will be held on Tuesday 21 September, at 5.00pm.

We have begun promoting this meeting to members, local residents, patients and their families and hope for a good attendance at the meeting, which will again be held virtually.

We will update attendees on current pressures, our response to Covid-19, our recovery programme, along with our financial position and some of our good news and successes. As always, there will be an opportunity for anybody attending to ask questions.

Integrated Performance Report (IPR)

Meeting	Trust Board	Date	2nd September 2021

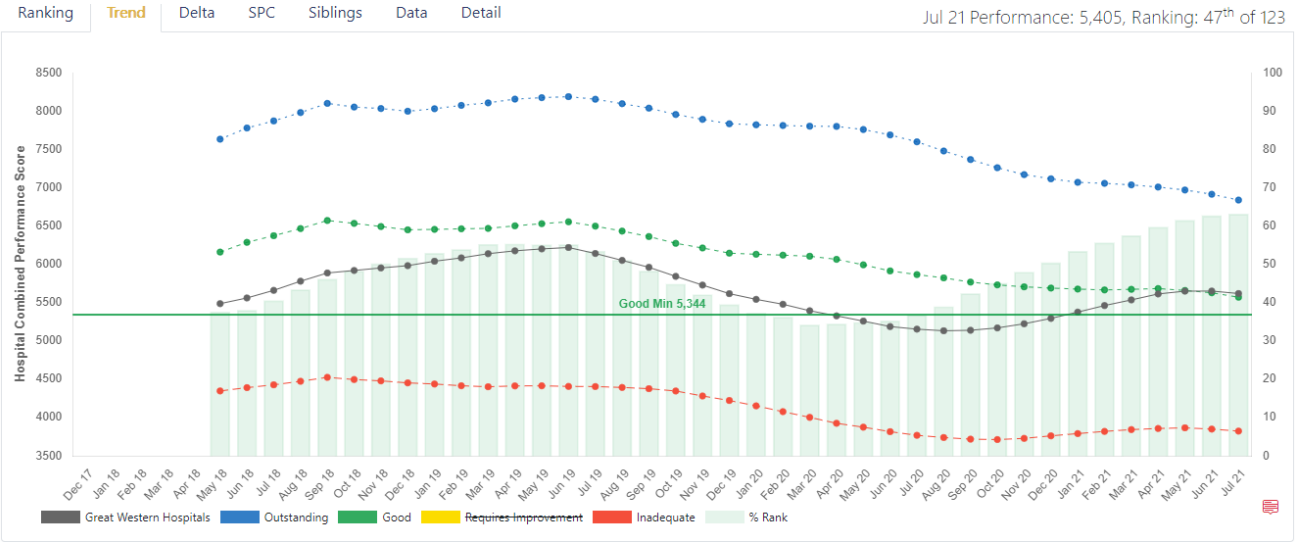
Summary of Report

The Integrated Performance Report provides a summary of performance against the CQC domains and the 4 pillars of the Trust Strategy. The summary provides an overview of performance against key performance measures and a comparison to national and peer performance using Public View data. Please note that in most cases, Public View data is at least one month behind the data available in the Trust.

Key highlights from the report this month are:

Our Performance

Our ranking against the Hospital Combined Performance Score on Public view in July 2021 places us 47th out of 123 Trusts (44th June 2021). The trend chart below reflects our aggregate position improving against CQC measures and our performance is tracking slightly above 'Good'.



In July 2021 our performance against the Emergency Care Standard (95%) worsened by 4.69% to 71.84% (76.53% June). Hospital Handover Delays (HHD) also saw an increase in July 2021. 650 hours lost to Hospital Handover Delays (June 352.2) hours. Attendances have decreased in July (from June) by 180 due to a reduction in Type 3 attendances (200) driven by the closure of the UTC overnight. There has been an increase in Type 1 attendances that has also coincided with increased numbers of patients with Covid 19, reduced staffing due to sickness and the impact of the Covid 19 proximity app suggesting staff should self-isolate. Breaches due to 'waits to be seen' in ED have risen to 66%, the highest recorded.

July saw the highest attendance for patients with Covid 19 since March 2021. An average of 20 in-patients per day in July. The Trust reported 1 Respiratory Syncytial Virus (RSV) child admission in July 2021.

The Trusts Referral to Treatment (RTT) performance was maintained at 68.81% in July 2021 (68.89% June). The Trust saw a waiting list increase of 290 patients in July seeing an increase in waiting list size to 25,755. An overall reduction against the plan of 26,510 (755 ahead of trajectory). The Trust received 9,093 referrals in July 2021, which is a reduction of 537 in month and 92% of the Pre-Covid 19 average referral rate. The total number of patients waiting more than 52 weeks for treatment reduced in July by 161 to 824 patients.

In June 2021 Diagnostic Wait Times (DMO1) performance was 81.7%. An improvement on May's position of 77.9%. Recovery has largely been seen in Non-Obstetric Ultrasound (NOUS) as planned. Due to reduced CT van capacity, significant radiography vacancies and the recognition of the number of overdue surveillances lists in Audiology and Cardiology, we are predicting an increasing waiting list and breaches, which will impact Trust DM01 performance from July onwards as patients are seen.

Cancer 2 Week Wait performance for June was 72.3% against a target of 93%. This continues to be related to the 2-week breast service with recovery expected in October 2021.

Cancer 28 Day Diagnosis performance was 67.8% against a target of 75%. The Q1 position was 72.7%. Specific actions required across a range of specialities. Expected to recover in August 2021 with cross divisional support to review the most complex pathways.

Cancer 62 Day Standard for June was 83.5% against a target of 85%. 2021/22 Quarter 1 performance was achieved at 85.7%

Our Care

The Electronic Discharge Summary (EDS) – The Electronic Discharge Summary (EDS) working group was originally set up in 2018 and is led by the Deputy Medical Director (DMD), with quarterly meetings. Part of the project is observing ward practices in regard to EDS completion. The findings suggest that there is a need for standard processes to be reinforced and as a consequence information on the EDS process has been recirculated. Medical Workforce is also ensuring that the information is disseminated locum Doctors. The Clinical Consultant Information Officer (CCIO) is updating the IT induction training pack for new doctors this will also include the EDS element of the induction Pack.

Medicines Safety - The rate of medication incidents and the proportion causing harm remains stable across the year. A reduction in the number of reports was seen in June but there is one specific incident involving oxygen prescribing in the Trust which has been raised on StEIS as a Serious Incident (SI).

This oxygen incident has been overseen by the Medicines Safety workstream of the Great Care Campaign. An improvement group has been formed to implement changes within the Trust in relation to oxygen prescribing. These include actions relating to prescribing, delivery devices, administration, process for escalation and an action plan is due for approval by Medicines Assurance Committee in early August.

The Medicines Safety workstream within the Great Care Campaign, will be responsible for developing strategies to change the culture surrounding medicines administration in the Trust, with the aim of reducing the number of incidents in relation to administration.

Infection Control - All cases of C. difficile are typed (analysed to identify different strains) to ensure that there can be identification of any cross infection. This is a proactive approach and gives assurance that there has been no episode of cross infection.
The new C. difficile NICE Guidance has been released promoting the use of Vancomycin as first line treatment for all C. difficile cases and Fidaxomicin as second line for severe C. difficile cases. This will mean a change in current guidelines from Metronidazole which will be implemented across the Trust within the next 2 months. There will be an education plan for prescribers once the new guidance has been approved.

The C. difficile Improvement Collaborative is due to meet in August to review pathways and evaluation of CDI cases across BSW, this will be reviewed next month.

Pressure Ulcers – Themes from the swarms (an immediate review at ward/department level) include: timely skin inspections; thorough documentation, and early intervention with appropriate repositioning and pressure relieving equipment. Trust wide and local action plans have been developed for these themes and discussed at the weekly meeting with Divisional Directors of Nursing and Deputy Chief Nurse.

Working with the Quality Matron, the nursing documentation has been reviewed and updated to make it simpler to record skin inspections.

THINK SKIN poster - Jupiter ward identified 6 hospital acquired harms in June 2021 which prompted implementation of the THINK SKIN poster at the bedside for patients at increased risk. There have been no harms reported in July 2021.

Moisture Associated Skin Damage (MASD) pathway launched with 64 delegates in July 21. Incident reporting training for Community Nursing teams to include risk assessment and duty of candour process and responsibilities is planned for August 21. This will support improved reporting of pressure ulcers.

Falls - New falls assessment documentation is in the process of being uploaded to Nervecentre (electronic record keeping system).

Royal College of Physicians post fall 'hot debrief', a process where the multi-disciplinary team reviews cause of a patient fall, commenced on Swindon Intermediate Care Centre (SWICC) and Sunflower wards on 14th June. In June 55.5% of falls had a post fall debrief, in July 70.80% of falls had a debrief. Learning from the debriefs has been collated to be presented to the new SWICC falls group and Safer Care Group in August 2021.

National Falls Safety Week 20th – 26th September 2021 involving activities to raise awareness of falls safety.

Incidents - At the time of reporting there are a total of 28 on-going Serious Incident (SI) investigations, with three reported in July. Although the number of SI's reported has increased compared to June it remains below the average reported per month from November 2020.

Complaints and Concerns - Clinical care continues to be one of our top complaint themes but there are various strands that fall within this overarching theme. Quality improvement workstreams continue in several key areas i.e., End of Life care, discharge planning and personal care. Many of these workstreams are being managed through the Great Care Campaign.

Behaviour/attitude has been identified as a recurring complaint theme. The Patient Advice and Liaison and Complaints team have worked with Human Resources and the Academy, to ensure that the complaints process provides assurance that concerns, and complaints are managed and acted on appropriately. The Trust Culture and Organisation Development work is focussed on supporting improvements for patient and staff experience combining just and learning culture, civility and respect and compassionate leadership.

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

1:1 care in labour - where one to one care in labour is not achieved, care is reviewed in order to establish why this has not occurred so that themes can be identified and quality improvement implemented. Reasons identified include women who have unexpectedly birthed before arrival to hospital or data entry errors, and identification of these factors allow for targeted education where indicated.
Service User feedback - The Trust is working collaboratively with the Maternity Voices Partnership to review the social media platforms currently available to service users. Development of a Great Western Hospital Maternity specific Facebook page is currently being considered to improve service user engagement earlier in pregnancies or pre-conceptually, which would also provide a platform for public health information relevant to the target population.

Evidence to support the Trust Ockenden action plan was submitted on the 30th June 2021. Analysis of the data submitted to support the Ockenden Action plan is awaited.

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: In-month KPI exceptions to report are overall agency spend as % of total spend is 6.03% marginally above Trust target of 6%; Bank fill rates reporting 52% below the Trust target of 70%; Sickness absence increasing to 4.5% and exceeding target of 3.5% and appraisal compliance achieving 75.6% below Trust target of 85%.

Highlights:

- Significant increase in the number of staff receiving 'Track and Trace' notification resulted in a national response to risk assess staff to support staff with low risk contact back to work. As at 11th August, the team have safely returned 179 staff to work through this risk assessment process (92 - Registered and Unregistered; 16 AHP & Scientific; 24 Medical & Dental and 47 Admin)
- Significant reduction in Band 5 registered nurse vacancies (excluding Midwives, Corporate and COVID Vaccine); there are only 8.69wte vacancies (this takes into account the arrived pre-registered

nurse recruitment pipeline). Excluding pre-registered nursing, there are 50.08WTE and this means on the current trajectories the Trust will move into a fully recruited and in some areas over recruited position for registered nursing from October.

- Gradual increase in number of staffing engaging in the 'In-Reach' wellbeing sessions and the wellbeing team have introduced Core-10 measures to evaluate counselling services.
- Mandatory Training achieving 85% KPI.
- The Trust successfully completed Junior Doctor Rotation on the 4th August for circa 150 individuals. The most significant change is the introduction of the new medical registrar rota with increased resource for night cover.
- New Quarterly Pulse Staff Survey which was launched on the 5th July 2021 and encouraging response rate of 37% compared to national average of 21%.
- A review of the talent management process and the learning from it with the Executive team has been completed. The succession plans for Executive Directors, senior corporate staff and Divisional Directors have been RAG rated and includes identification of high potential for movement and contingency.

Use of Resources

The Trust plan is breakeven. The in month position is £4k deficit and year to date position is £4k surplus which is a favourable variance of £4k.

Trust income is above plan by £878k in month and £3,073k year to date. Elective Recovery Fund (ERF) income of £1,714k is included in the position. The funding covers the additional costs incurred to deliver activity during M1-4.

Pay is £159k underspent in month and £594k overspent year to date. Pressures continue due to covering vacancies, close support and escalation, although difficulties in filling shifts means that medical spend reduced slightly in month.

Non -pay expenditure is overspent by £1,041k in month and £2,475k year to date. This includes an accrual of £498k for a potential theatre stock adjustment which will be reviewed in August & September.

The Trust capital plan for 21/22 is £33,493k. Spend is £5,411k as at the end of Month 4 against a plan of £4,798k.

For Information	x	Assurance		Discussion & input		Decision / approval	

Executive Lead	
Author	Jim O'Connell, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Lisa Cheek, Chief Nurse
Author contact details	jim.o'connell@nhs.net jude.gray@nhs.net lisacheek@nhs.net simon.wade5@nhs.net

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score
792 1357 1917	1. 4 Hour Standard 2. 2.RTT Standard 3. Cancer	

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

Link to relevant CQC Domain

Safe	X	Effective	X	Caring	X	Responsive	X	Well Led	X

Link to relevant Trust Commitment	
Consultations / other committee views	

Recommendations / Decision Required

The Trust Board is asked to review and support:

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

NHS
Great Western Hospitals
NHS Foundation Trust

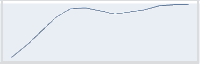
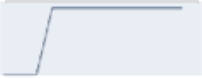
Integrated Performance Report

August 2021

Service Teamwork Ambition Respect

Performance Summary

Great Western Hospitals NHS
NHS Foundation Trust

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking**	Bath Ranking	Salisbury Ranking	Month
Hospital Combined Performance Score	5442 (Aug)		48 (5442)	33(5815)	20(6344)	Aug 21
A&E 4 Hour Access Standard (combined ED & UTC)	71.84% (Jul)		75 (76.5%)	66(78.0%)	64(78.3%)	Jun 21
A&E Percentage Ambulance Handover over 15 Mins	49.40% (Jul)					
A&E Median Arrival to Departure in Minutes (combined ED & UTC)	203 (Jul)		77 (190)	81 (191)	83 (192)	May 21
RTT Incomplete Pathways	68.81% (Jul)		68 (68.03)	50 (70.78)	46 (71.57)	May 21
Cancer 62 Day Standard	83.5% (June)		7 (87.76)	44 (77.95)	28 (81.48)	May 21
6 Weeks Diagnostics (DM01)	81.72% (June)		71 (77.91)	89 (71.20)	20 (95.02)	May 21
Stroke – Spent>90% of Stay on Stroke Unit	72.3% (Q420/21)		72 (75.7)	72 (75.7)	68 (77.2)	Q4 20/21
Family & Friends (staff) – Percentage recommending GWH as a great place to work	69.89% (Q3)		88 (70.0)	22(82.0%)	34(79.0%)	Q3 20/21
YTD Surplus/Deficit*	-4.3% (Oct)		82 (-4.3)	8 (1.3)	37 (-1.4)	Q2 19/20
Quarterly Complaint Rates (Written Complaints per 1000 wte)	27.9 (Q4 20/21)		104 (27.9)	50 (16.2)	22 (11.3)	Q4 20/21
Sickness Absence Rate	3.48% (Mar)		34 (3.48)	57 (3.91)	28 (3.33)	Mar 21
MRSA	2 (Jun)		29 (1.22)	100 (3.51)	67 (2.33)	Apr 21
Elective Patients Average Length of Stay (Days)	3.23 (Jul)					
Non-Elective Patients Average Length of Stay (Days)	4.25 (Jul)					
Community Average Length of Stay (Days)	14.51 (Jul)					
Number of Stranded Patients (over 14 days)	82 (Jul)					
Number of Super Stranded Patients (over 21 days)	43 (Jul)					

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

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

Board Committee Assurance Report

Performance, People & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		25th August 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Recovery Programme	Red	Amber	The Committee acknowledge that the Trust has failed to meet the revised national target and the target that GWH set itself, but work was progressing within specialties to improve recovery.	Monitor actions	September meeting
BAF	Amber	Amber	Concerns surrounding BAF3 regarding partnership working that need to be discussed by Exec Committee. It was felt a more robust action plan is needed to manage risks down and JS asked that minutes, actions and comments on the assurance report from all Committees be pulled together so that the BAF can be discussed in more detail at Audit Committee. More work is required and Exec Committee will discuss at their meeting on 21st September.	Discussion at Exec Committee	21st September 2021
Integrated Performance Report – Emergency Department &	Red	Amber	High demand and lengthy ambulance turnaround continue. The Trust is awaiting further guidance on the new standards that are about to be introduced and a new management plan is in place, but the Trust is still waiting to see improvement and the Committee will monitor closely for the next few months.	Monthly review	September meeting

Ambulance Handovers					
Integrated Performance Report – RTT	Amber	Amber	The Trust performance remains static. July saw a decrease of 161 patients waiting over 52 weeks, with 61 additional patients wishing to defer treatment for the time being. There are some concerns around anaesthetic staffing and its impact on Elective activity, this is being reviewed and recommendations are expected to be made that will form part of a recovery plan for the service.	Monitor actions	September 2021
Integrated Performance Report – DM01	Amber	Amber	Performance has improved from May to June and a decrease was seen in the wait list size. Waiting lists and breaches are expected to increase due to reduced CT van capacity, staff vacancies and overdue surveillance lists which will impact on Trust performance going forward.	Monitor actions	September 2021
Integrated Performance Report – Cancer	Amber	Amber	There have been ongoing issues around two week wait and recovery will be delayed until October. The Committee acknowledged the pressure on the system. A deep dive is scheduled for the next meeting.	Deep dive	September 2021
Integrated Performance Report – Stroke	Green	Green	Stroke performance had been discussed in more depth at the July meeting and since then an increase had been seen in demand with multiple patients arriving on site at the same time which had caused some delays in admittance.	Monitor actions	September 2021
IT Performance Update	Amber	Amber	Good progress made but the digital and IT roadmap remains challenging. Current Director of IT leaves the Trust this month, recruitment process is progressing.	Monitor actions	November 2021
Community & Primary Care Performance	Amber	Green	There are a number of risks and a lot of pressures within the community and primary care division that the team are working hard to overcome and make improvements.	Monitor actions	January 2022
IPR – Workforce – Vacancy, Turnover & Recruitment	Amber	Green	There has been positive news around Band 5 recruitment while still seeing 300 WTE vacancies across the board. There are positive recruitment plans in place and the team recognise the hotspots e.g. consultant medical staff.	Monitor actions	September 2021
IPR – Workforce – Use of agency	Amber	Green	A reduction had been seen in the use of agency and where it is utilised it is done so on a controlled basis in services including Primary Care, Community Nursing, UTC, Imaging, ED & Acute Medicine. Improved roster based controls are resulting in a sustained improvement in nurse agency usage.	Monitor actions	September 2021
IPR – Workforce – Sickness	Amber	Green	A number of staff had been pinged by Track and Trace, however, much effort is going into the occupational health led risk assessments and mental health first aid initiative to help reduce the impact of staff sickness.	Monitor actions	September 2021
IPR – Workforce –	Amber	Amber	Positive improvement has been seen in mandatory training and there is positive news on	Monitor actions	September

Other KPIs			CPD funding and leadership initiatives. The Trust continues to fail to meet its target for appraisals, in July this was due to operational pressures that needed to be addressed in month.		2021
EDI Report	Green	Green	The Committee were pleased to read the work that was being done around EDI as presented in the Annual Report.		
WRES & WDES Report	Amber	Green	Good progress noted.		
Improving People Practice	Green	Green	The Committee could see that the Trust had taken seriously the instructions from NHSE/I to look at this piece of work and rag rate our own performance.		
Health & Safety Annual Report	Green	Green	The report highlighted very positive progress in most areas.		
PAM Submission	Green	Amber	The Committee were assured on behalf of the Trust Board to approve the submission, whilst noting that there were several issues to be addressed going forward (as identified in the submission).		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Part 1: Operational Performance

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

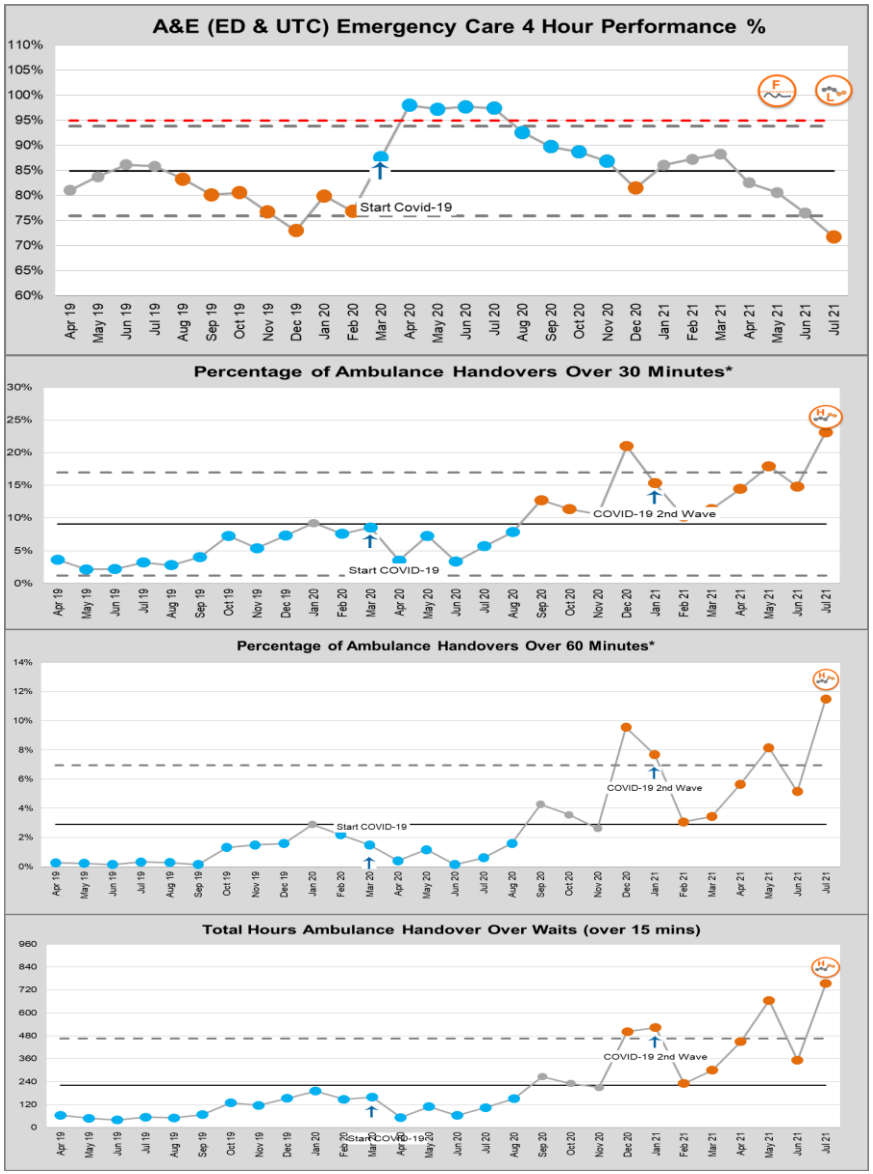
Are We Well Led?

Use of Resources

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

Data Quality Rating:

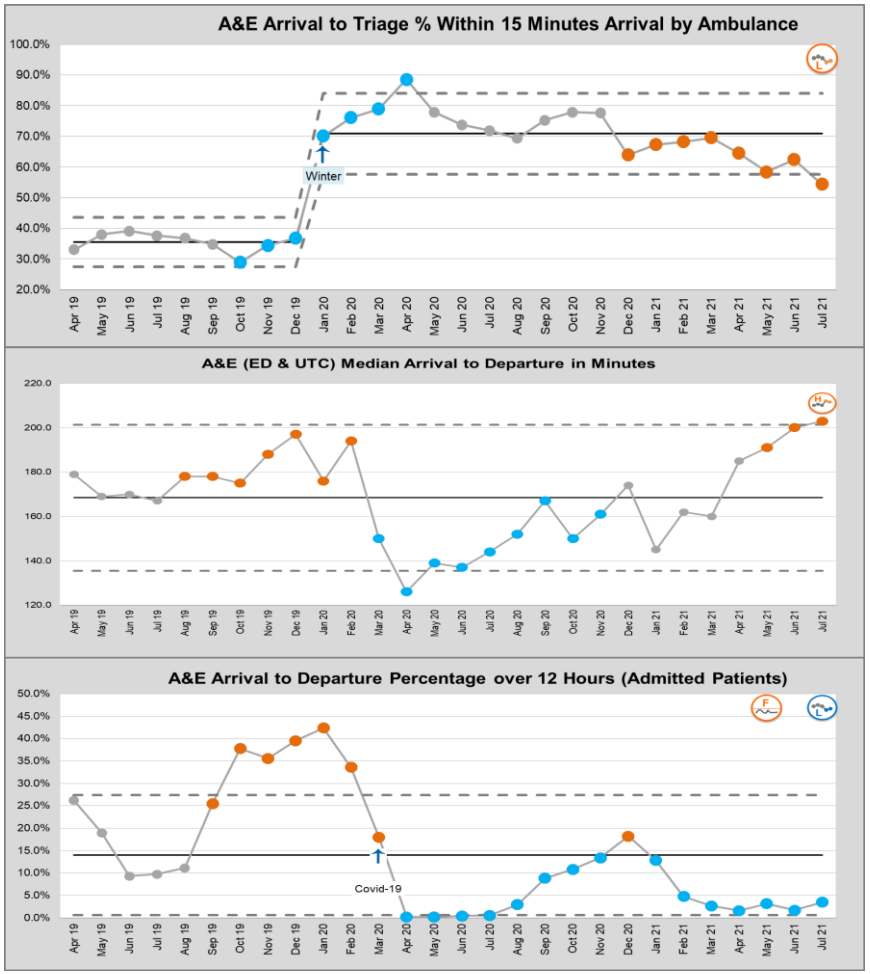
National Key Performance Indicators



Performance Latest Month: 71.84% (Jul)

Attendances:
Type 1 ED 57.32%
Type 3 UTC 89.33%
Total – 71.84%

12 Hour Breaches (from decision to admit) 0



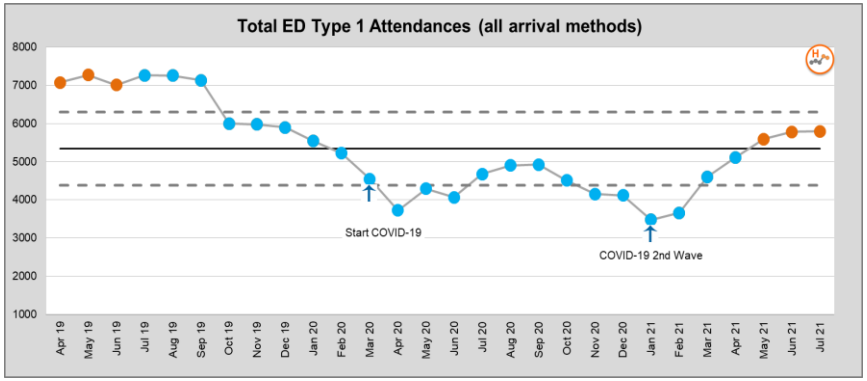
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

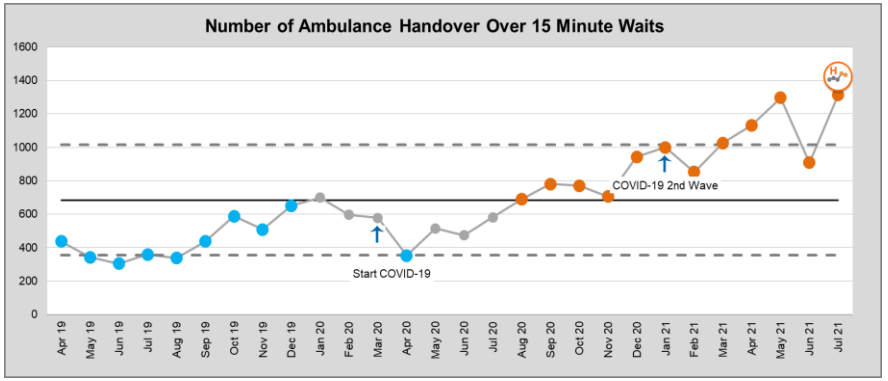
* Data from SWAST – 1 month lag

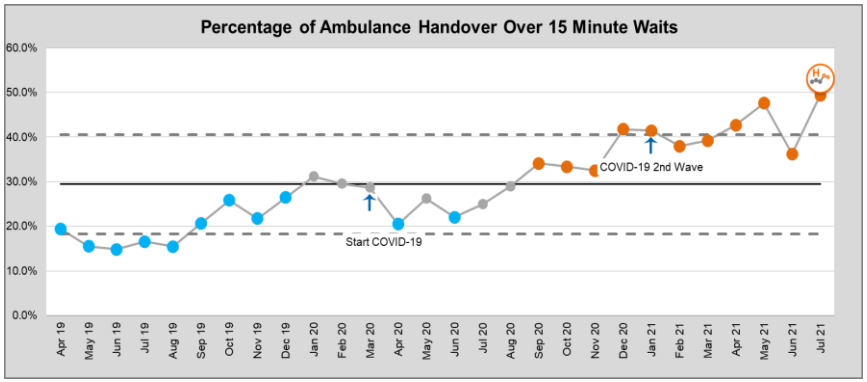
1. Emergency Care Standards

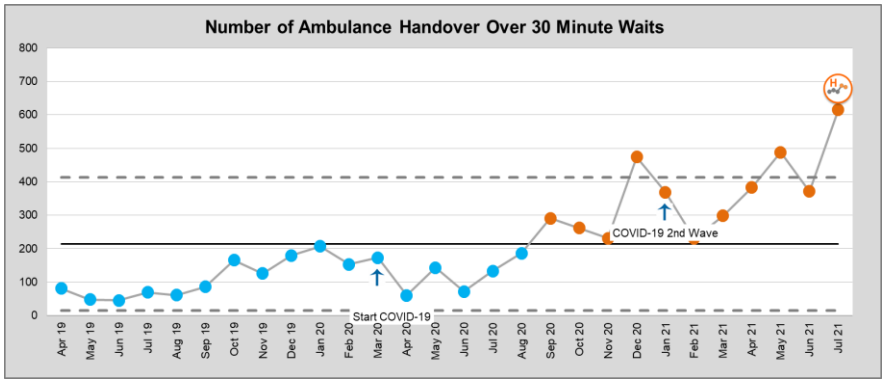
Data Quality Rating:

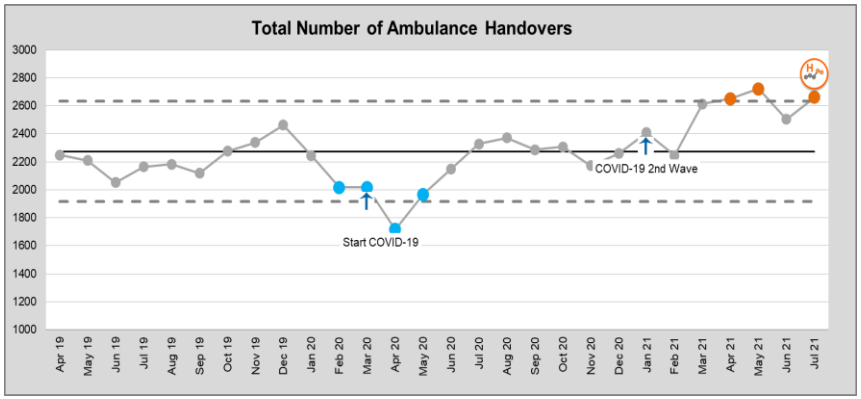
National Key Performance Indicators

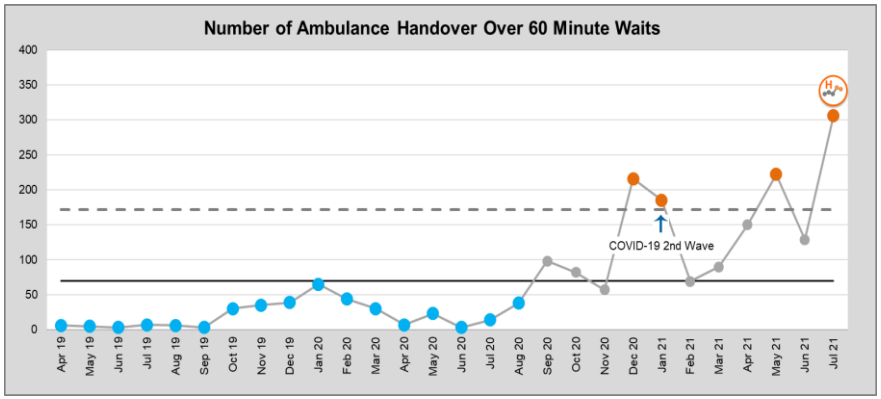












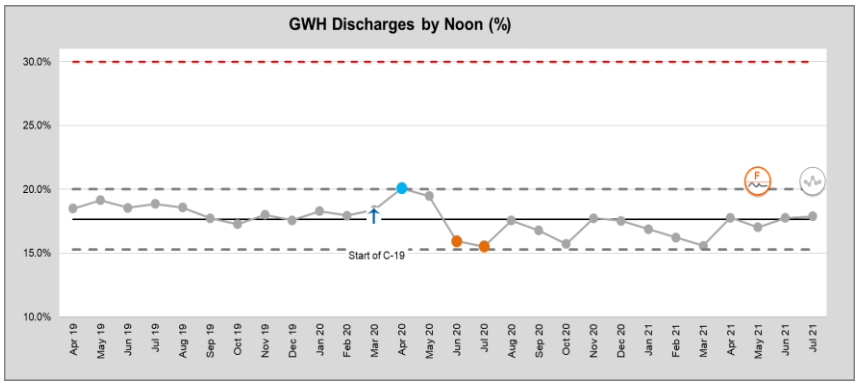
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

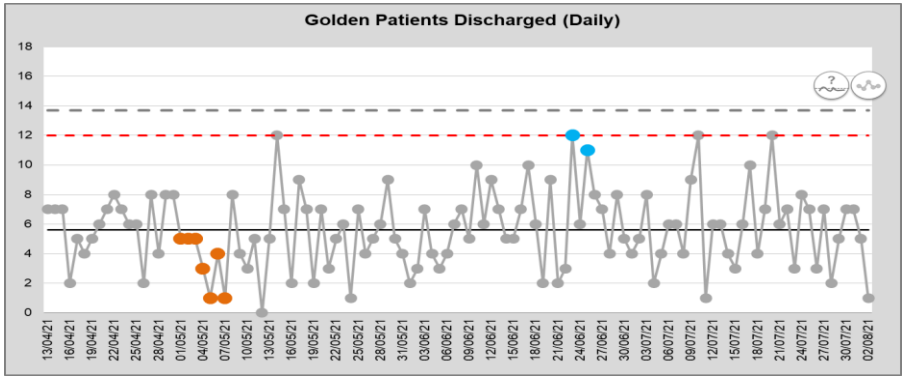
* Data from SWAST – 1 month lag

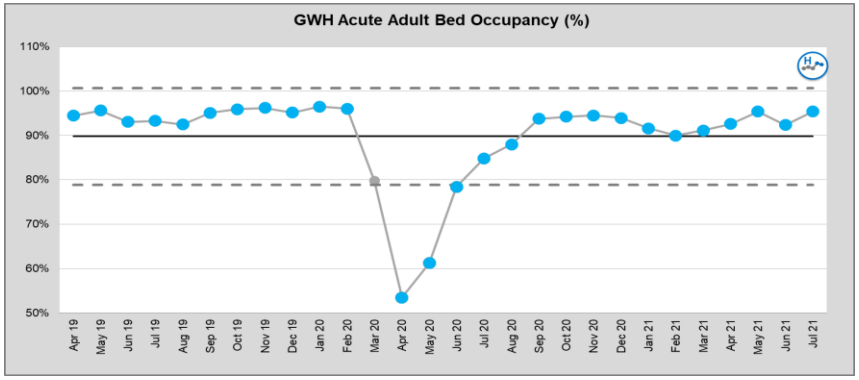
1. Emergency Access (4hr) - Patient Flow and Discharge

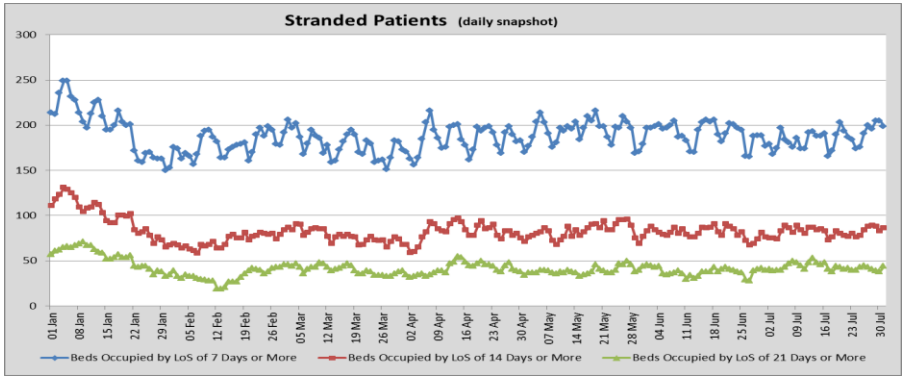
Data Quality Rating:

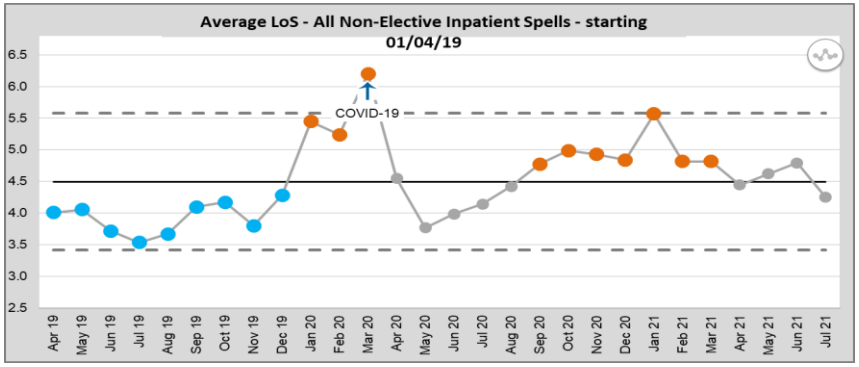
Are We Effective?

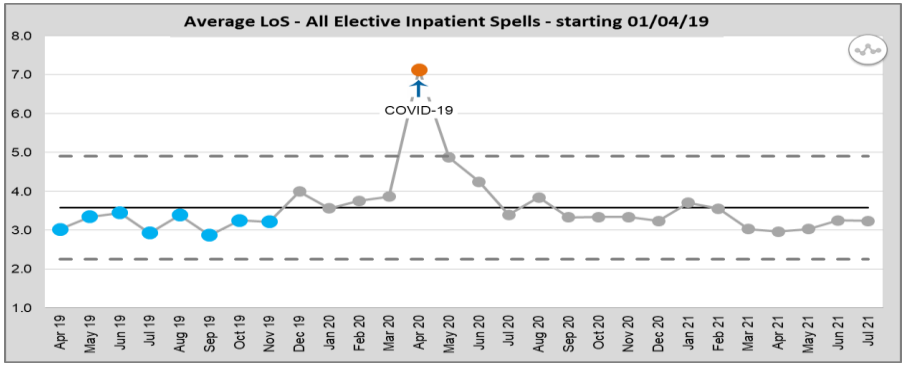












Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

1. Emergency Access (4hr)

Data Quality Rating:

Are We Effective?

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

The ED 4 Hour Performance chart shows that performance in month continues to remain below the 95% standard. There has been a decline of 4.69% in 4 hour breaches to 71.84%. There were no 12 hour reportable decision to admit (DTA) breaches in July. Attendances have decreased in July (from June) by 180 due to a reduction in Type 3 attendances (200) driven by the closure of the UTC overnight. There was an increase in Type 1 attendances (20.) 4 hour breaches within the UTC decreased in July by 92 to 489. Breaches due to 'waits to be seen' in ED have risen to 66% the highest recorded. Non admitted performance accounts for 55% of breaches, an increase of 1% on last month. This reflects the shift in patients choosing same day emergency and urgent care, as well as the change in the way primary care are managing patients. Think 111 first booked appointments utilisation sits at 55.4% for June , with 11% patients DNA the appointment slot (reduction of 2% from July, and 7% left without being seen.

Key Impacts on Performance

Flow into ED and the UTC via walk in attendances have significantly increased. Time lost for the ambulance service over 30 minute has deteriorated in month with an increase in delays over 15, 30 and 60 minutes. Each saw the worst performance in July since April 19. Delays to be seen by clinicians contributes to worsening performance. The ability for clinicians to assess patients is compromised due to ED and UTC overcrowding at times (volume of patients attending) as well as the number of clinicians being insufficient to see the volume of patients. If attendances continue to be at current level, the Trust will see over 120,000 patients through Emergency and Urgent care.

Flow from to ED to base wards is at times compromised but has improved from 22% in June, to 18% in July, however there are a number of patients that are classified as 'late referrals' (10%) that are referred to speciality within 4 hours but the delay to see clinician is over 60 minutes so coded as a 1st assessment breach. This is also a reflection of ambulance handover performance not being within target, resulting in more '1st assessment' delays.

There has been a decrease in performance in July relating to the number of patients waiting over 12 hours in the department, increasing from 1% to 4%. One of the factors in this reduction is the creation of the Clinical Decision Unit (CDU) for patients to wait in a ward environment for diagnostics and treatments, Front Door Team (FDT) review and transport home. This area continues to function well and has additional support from community in-reach to facilitate admission avoidance.

What will make the Service green?

- Ability to offer SWAST alternatives to front door attendance. Including direct access to SDEC.
- Improvement in flow into inpatient beds, 24/7, to ensure patients move within an hour of referral.
- Development of the 'Think 111 First' programme to include access to SDEC and the change in culture of the local population's use of Emergency and Urgent care services.
- Trust wide escalation plans to support the timely flow and discharge of patients.
- Review and implementation of interprofessional standards for access to inpatient beds – ED consultants to have 'admission rights' to empty specialty beds in the trust to allow flow straight into empty beds.
- System wide approach to how the public access Urgent and Emergency care
- The 'Way Forward' programme: increasing size and capacity of front door areas.

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

1. Complete **SAFER** Week which has identified several improvements that need to be made related to flow across the Trust. August's SAFER Week planning in place.
2. Commissioned review of the UTC to focus on; staffing profile, attendance profile (whether the current patient attendance is reflective of the current function and ability of the UTC)and opportunities to work with primary care to drive alternative community options. Await formal report from ECIST. **August 2021**
3. Business Case (draft) to move SDEC to a seven-day service completed. Case has been reviewed by Divisional Tri and draft will now be discussed with partners at ICA Urgent Care and Flow Delivery Board. **August 2021**
4. Focus on reducing 15- and 30-minute ambulance handover delays. Ensure that handover process is embedded so that 'clock stops' at the point ED receive patient. Time in motion study to be completed in August to ensure process for handover within ED is efficient. **August 2021**
5. Identification of a 'holding area' to ensure no ambulances wait more then 15 minutes to handover. Physio Gym co-located with the Discharge Lounge ready to open as an 'Admission Lounge' when ED at capacity to always ensure offload space. **Completed**
6. BSW review of minor injury management. Task and finish group to understand system pressures in minor injury management and how increase in presentations can be managed more effectively and reduce overcrowding and surges in attendances. **August 2021**
7. Review of UTC workforce and opening hours – UTC will remain closed overnight (22.00 to 07.00) through August**. Completed.**
8. Review of medical shift patterns - from August SHO and Registrar rotas changing to bring late and night shifts forward to match demand on the service. ACP recruitment continues to support backfill of the weekend gaps due to DRs contractual changes (interviews in July). Currently high reliance on locum cover which can reduce flow through department due to not being aware of local policies and procedures. Case has been submitted to increase SHO/Registrar support in ED with agreement for 2 week trial, if able to cover with locums.

Risks to delivery and mitigations

There is a risk that ambulance handover delays will continue to be seen due to a high demand and lack of flow out of ED.

Mitigation: Identification of a 'holding area' to ensure no ambulances wait more then 15 minutes to handover. Physio Gym co-located with the Discharge Lounge ready to open as an 'Admission Lounge' when ED at capacity to always ensure offload space.

Urgent review underway of any direct pathways to SDEC or Community services to reduce the pressure at ED.

There is a risk that patient safety and performance will be compromised given the significant increase in ED/UTC attendances**.**

Mitigation: Work is underway with Primary Care to understand measures they can take to help reduce attendances e.g., minors' task and finish group, (BSW wide).

Commissioned review of the UTC to focus on; staffing profile, attendance profile (whether the current patient attendance is reflective of the current function and ability of the UTC) and opportunities to work with primary care.

Options appraisal to look alternative community options.

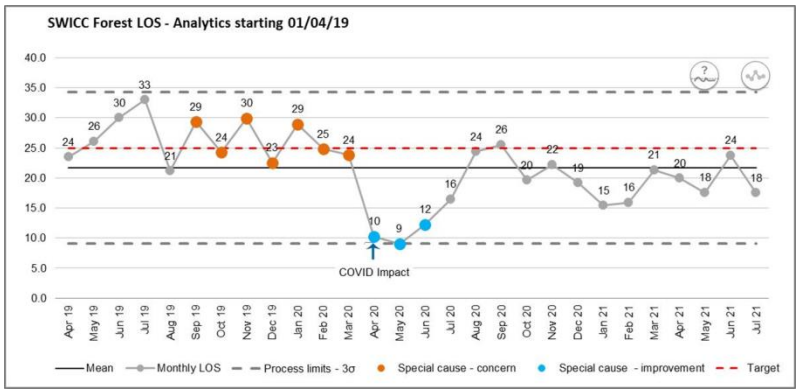
Review continues of any direct pathways to SDEC or Community services to reduce the pressure at ED. BSW wide focus.

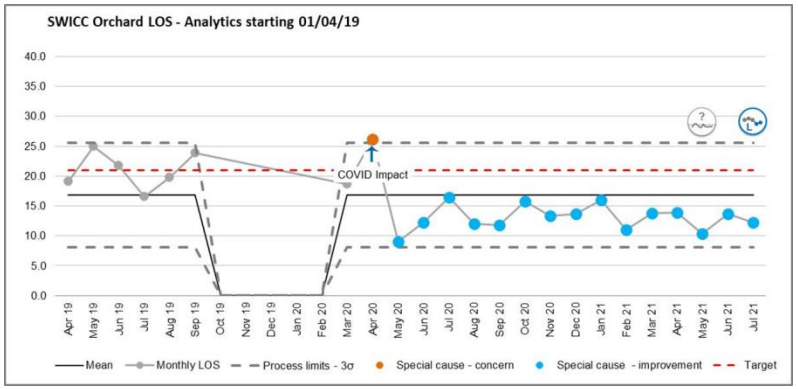
Discussions nationwide to collaborate ideas to manage the demand for urgent care that has a primary care need and pathways for minor injuries.

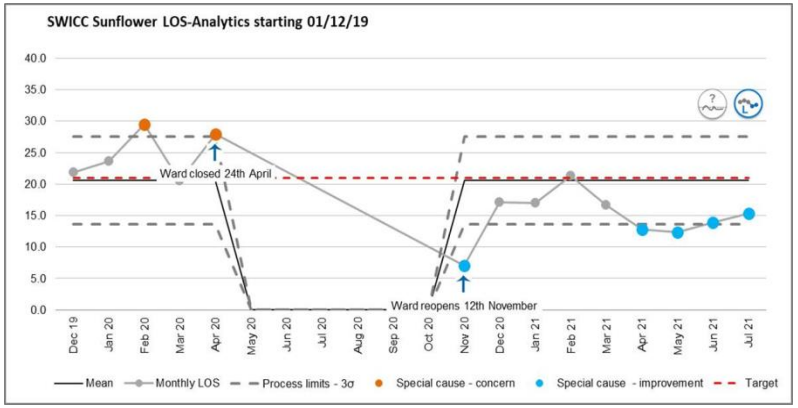
1. Emergency Access (4hr) - Community (SwICC) Length of Stay

Data Quality Rating:

Are We Effective?







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

LoS: The average patient length of stay (LoS) within SwICC remained within target in all three wards. For Forest, this is 25 days, a figure last breached in September 2020. Orchard and Sunflower, where the target is 21 days, have remained within target since fully re-opening after Covid-19 issues. The average LoS of Swindon patients is slightly longer than patients than Wiltshire/OOA in July due to a delay in accessing larger Packages of Care across the whole system.

Flow: Patient flow remains high with 161 discharges from SwICC wards in July contributing to an average of 166 patients per month since April 21. 16% of these discharges are being facilitated over the weekend period. Forest and Orchard average 114 monthly discharges compared to a figure of 80 pre Covid-19. Occupancy levels for July for all wards stood at 99.2%. Out of Area discharges accounted for 35% of patients in July, with 8 of those patients having occupied beds for longer than 21 days.

Improvement actions planned, timescales when improvements will be seen

Patients LoS >21 days: In response to the increase in numbers of super stranded patients at the start June, a twice weekly review of patients was introduced. For July this increased to daily reviews across all three wards to ensure that flow was optimized working collaboratively with SBC. There has been a slight decrease in stranded patients for the last two months. Further analysis of the data is necessary to ensure this is maintained.

Discharge Management: Nerve Centre has been adjusted and is compliant with the Community Sit Rep reporting data requirements. Training has been carried out at a ward level with increased compliance/completion. Unfortunately access to a live report via Nerve Centre is not yet visible. This is being pursued with IT/Informatics as to the delay.

Risks to delivery and mitigations

Risk: Delayed transfer and admissions to SwICC caused by internal transport delays and the requirement for 24 hour Covid-19 swab tests. Transport related delays had accounted for the majority of delays in June.

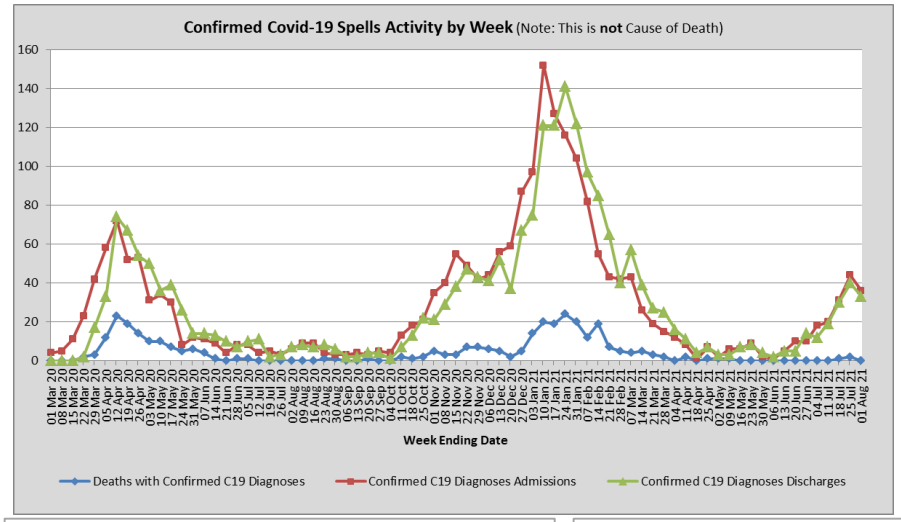
Mitigation: A detailed review was undertaken in July to comprehensively understand contributing factors for delays. A monitoring tool is being finalised for implementation end of August.

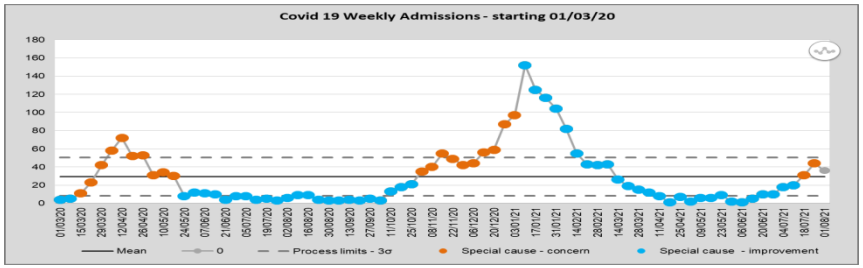
Throughout July site managers were sent updates through out the day as to bed status and golden patients (Discharges booked for the morning) for the next day. July saw a rise in patients being discharged before midday (27%), an increase of 6% on previous month.

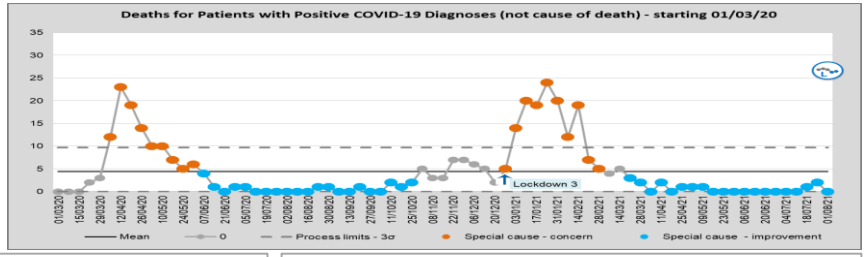
1. Emergency Access (4 Hours) Covid 19 Weekly Admissions

Data Quality Rating:

Are We Effective?







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

The graph above shows that attendances to the Covid Assessment Unit (CAU) increased during July with a corresponding increase in Covid positive patients. As a result, CAU was extended back to 11 trolley spaces with a review planned for mid-August.

CAU has frequently been at maximum occupancy during July due to competing bed pressures with other Front Door services.

There has been a slight downturn in numbers of patients / positive cases at the beginning of August.

During July there have been 2 attendances to CAU from the Swindon Covid Quarantine Hotel.

There have been no Ambulance 1 hour delays at CAU for July.

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

1. Review of CAU requirement and options for Covid patient management ongoing. Paper submitted to Exec team for consideration of options going forward. (June). **Delayed due to upsurge in attendances and positive cases – August 21**
2. Expansion of CAU back to 11 beds. **Completed**
3. Daily review of clinical model for CAU to ensure senior decision making to limit admissions. **August 21**

Risks to delivery and mitigations

There is a risk of delayed flow and impact to ambulance handovers in CAU due to lack of time target pressure and clinical demands.

Mitigation: Use of POCT/Cephid swabs and patients with high suspicion of COVID Trolley wait times escalated and CAU given prioritisation of patient movement, if these exceed ED.

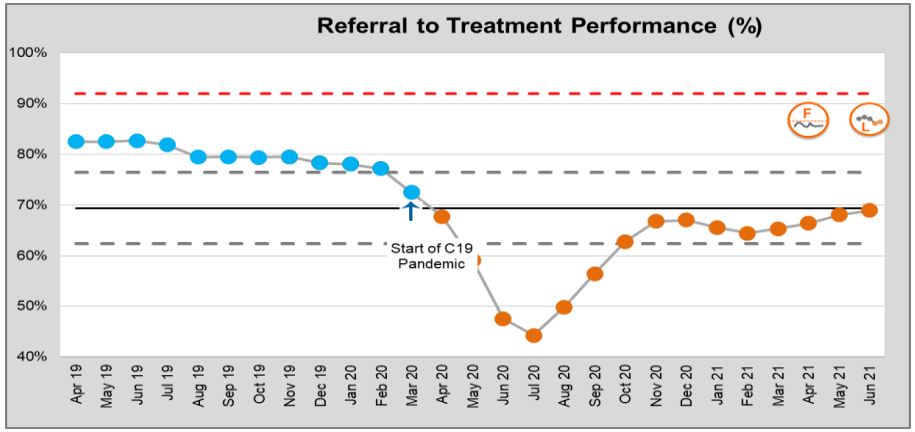
There is a risk of increased Covid Blue pathway attendances due to Covid variants, provision of the 'Quarantine Hotel' and relaxation of 'lockdown' measures.

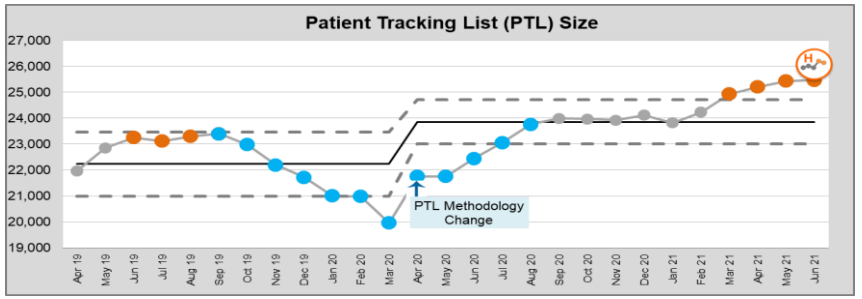
Mitigation: Review attendances and act on trigger levels as per CAU SOP. (+ Review CAU requirement).

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

Data Quality Rating:

National Key Performance Indicators





	June	July
RTT Performance	68.89%	68.81%
PTL Volume	25,465	25,755
Reportable 52 Week Breaches	985	824
In Month 52 Week Breaches	408	324

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

The Trust's RTT Incomplete Performance has been updated to include the most recent complete calendar month. The Trust's RTT Incomplete Performance for July 2021 remained static at 68.81%.

The Trust reported a waiting list increase of 290 in month, resulting in a waiting list size of 25,755 against a BSW Trajectory of 26,510 (755 ahead of trajectory).

The Trust received 9,093 referrals in July 2021, which is a reduction of 537 in month and 92% of the Pre-Covid 19 average referral rate.

In July 2021 there were 824 x 52-week reportable breaches. This is a decrease of 161 in month. Of the 824 breaches, 61 (7.4%) of them are P5 and have opted to defer treatment until post-Covid. This reduction continues to be driven by a reduced volume of patients who were due to breach 52 weeks in July, as a direct result of reduced referral levels in 2020. Of the 824 reportable breaches in July; 712 were Admitted, 91 were Non-Admitted and 21 were Diagnostic.

There were 322 in month 52-week breaches cleared in July 2021 which is a reduction over the rolling 3-month average of 389 per month. Of the 324, 186 were admitted clock stops and 138 were non-admitted clock stops.

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

- Elective Recovery Fund clinics have been planned for Ophthalmology from July to September 2021, and Gynae are delivering super Saturday clinics in August.
- The Trust continues to utilise 3 Independent Sector organisations; Horton Treatment Centre, Circle Reading and BMI Bath Clinic. To date we have transferred 200 patients care to the IS.
- In addition to the 3 providers we are already working with, we are in discussions with BMI Ridgeway and Sulis Bath to agree additional capacity. This capacity would assist with Urology
- Ongoing focus on clearing our 78 week + patients. The overall number of 78 week + patients is 262, which is a reduction of 25 on the previous month. The number of patients waiting 100 wks + is Zero, which is a reduction of 2 on the previous month.
- Kingsgate review of Anaesthetic staffing and its impact on Elective activity due to conclude early August with feedback sessions planned w/c 9th August. The recommendations from this report will form a recovery plan for the service.
- Insourcing tender process complete, and contract is in the process of being finalised to mobilise in H2.

Risks to delivery and mitigations

There is a risk that we lose core Elective Theatre capacity, due to supporting the Anaesthetic 3rd On Call Rota gaps. Recruitment has been delayed due to candidates withdrawing.

Mitigation: Recruitment due to be completed by end of August, with successful candidates in post from October. Implementing the recommendations within the Kingsgate report.

There is a risk that despite identifying surgical provision for Admitted and Non-Admitted Elective Recovery weekend work, we may struggle to find Support staffing who are able/willing to work.

Mitigation: Plan the weekend lists at least 4-6 weeks in advance, and look to utilise Bank and Agency where possible, and safe to do so.

There is a risk that we cannot fully utilise the IS capacity being provided due clinical and surgical restrictions, as well as patient choice and a reluctance to travel. This may result in patients being treated out of time order to ensure capacity is utilised.

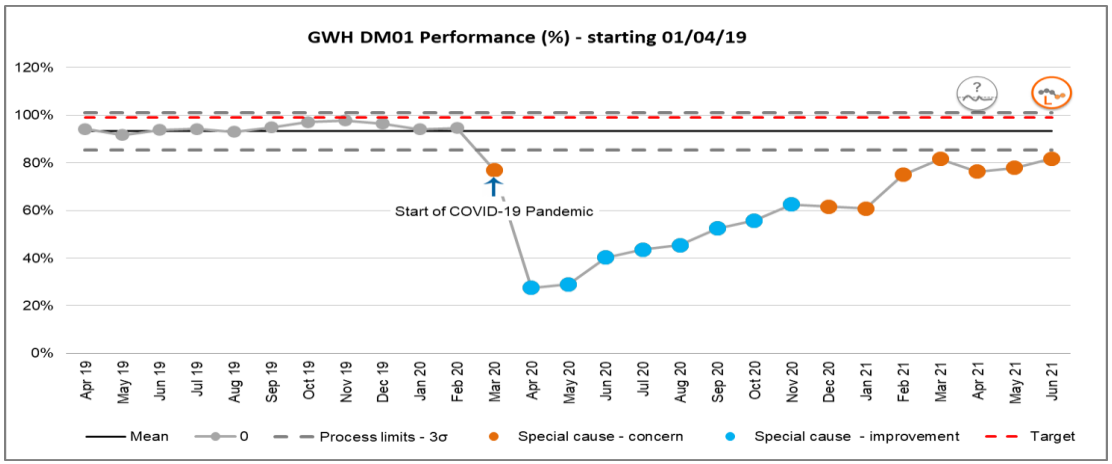
Mitigation: Ensure patient communication clearly explains the current challenges and waiting times and is being done at the appropriate level.

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

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

Data Quality Rating:

National Key Performance Indicators



Waiting	< 6 Weeks	> 6 Weeks	Total WL	Performance %	Total tests / procedures
Magnetic Resonance Imaging	953	67	**1020**	93.43%	**1009**
Computed Tomography	827	225	**1052**	78.61%	**3147**
Non-obstetric ultrasound	2036	323	**2359**	86.31%	**2764**
Barium Enema	0	0	**0**	N/A	**0**
DEXA Scan	222	20	**242**	91.74%	**117**
Audiology - Audiology Assessments	399	0	**399**	100.00%	**1099**
Cardiology - echocardiography	313	59	**372**	84.14%	**774**
Cardiology - electrophysiology	0	0	**0**	N/A	**0**
Neurophysiology - peripheral neurophysiology	114	1	**115**	99.13%	**27**
Respiratory physiology - sleep studies	67	6	**73**	91.78%	**71**
Urodynamics - pressures & flows	0	0	**0**	N/A	**0**
Colonoscopy	236	286	**522**	45.21%	**311**
Flexi sigmoidoscopy	104	132	**236**	44.07%	**160**
Cystoscopy	38	6	**44**	86.36%	**168**
Gastroscopy	142	94	**236**	60.17%	**345**
Total	**5451**	**1219**	**6670**	3781.7%	**9992**

June 2021

Performance Latest	81.7%
Waiting List Volume:	6670
6 Week Breaches	1219

Background

Performance was 81.7% % in June an increase from 77.9% in May Overall, the total waitlist size decreased from 6881 in May to 6670 in June (-211), driven by Non-Obstetric Ultrasound (NOUS) recovery. Breaches have decreased from 1521 in May to 1219 in June (-302) primarily driven by NOUS. Due to reduced CT van capacity during the month, radiography vacancies and the number of overdue surveillance lists in Audiology and Cardiology, we are predicting an increasing waiting list and breaches, which will impact Trust DM01 performance from July onwards as patients are seen.

Improvement Actions

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

- 4 x adhoc CT van days were allocated in June and 4 in July with NHSE providing 5 van days per week in August for CT2 replacement.
- Additional MRI van capacity sought through extension of Inhealth contract and within forecasted budget. 8 days confirmed for September and additional 4 days in August planned around CT van allocation from NHSE/I.
- Bank sonographer recruited into vacancy and 750 slots supported through additional staff payments to sonographers.
- WLIs to Validate patients on Surveillance lists in Cardiology.
- Weekends lists are being booked to 12 points (both OGD and Colonoscopy) where case mix allows so that social distancing can be maintained. Fifth room build expected to be completed by the end of August although all five washers need to be in place to run five rooms.

Risks (Risk1855 = 15) Failure to deliver DM01 for Imaging. There is a risk that insufficient capacity to recover the backlogs (including surveillance patients) remains the greatest risk to recovery. In addition, DM01 Surveillance clock start categorisations will lead to breaches in Echo and Audiology as full validation is completed.

Mitigations remain in place above to support risk, detailed on next slide.

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

Data Quality Rating:

National Key Performance Indicators

Background, actions being taken and issues

Endoscopy: Combined, Endoscopy achieved 48.4% performance in June which is a decrease of 4.5% from May and 6.3% below trajectory (54.7%). The total number of patients over 6 weeks decreased by 120. By the end of June, the trajectory showed a wait list of 450 over 6 weeks and the service closed the month on 512 (62 behind.) The number of patients under 6 weeks remains lower then earlier in the year (from average 550 to 488) and so our denominator is impacted. Endoscopy saw an increase in total referrals in June (+118.) Lists continue to be booked to 12 points at weekends. DNAs continue to be a concern with 10% of Covid swabs being DNA'd on average a month. DNAs combined with cancellations have seen an average of 15% of slots not being utilised in 3 of the last 5 months. GWH is a confirmed pilot site for Capsule Endoscopy and two Consultants are currently undertaking training. Aim of pilot is to see a reduction in Endoscopy procedures required on the 2ww pathway and the first clinics will hopefully be established in September. The build of the fifth room continues to be on track to see completion at the end of August. HSDU are also completing a replacement of the four washers within Endoscopy as well as installation of the fifth. Timeline for this is being confirmed. All five washers need to be operational to run five rooms.

Radiology: Combined DM01 performance has increased to 86% for June from 83.1% in May. The total number of patients waiting over 6 weeks in June was 615 a decrease from 827 in May (-202), primarily due to the Ultrasound backlog clearance, whilst the waiting list for MRI has increased by 255, due to lack of staff. NHSE have reallocated CT van capacity across the Southwest, which will impede the CT recovery trajectory from June onwards due to the loss of between 230 and 360 slots per month. It is predicted that this will lead to rises in both Waiting list and breaches delivering reductions in CT DM01 (73%- 78%) performance during this period.

Echo: Performance dropped from 86.55% in May to 84.14% in June. June saw a slight decrease in the overall wait list from 409 in May to 372 in June with Aerosol generating procedures Trans Oesophageal Echo (TOE) and Stress Echo (DSE/ESE) solely comprising the DMO1 breach list of 59 referrals. Routine NP Echo is now being booked <6 weeks. Echo wait list activity decreased slightly from 482 in May to 471 in June. Clock start categorisations as per national Guidance will reduce Echo performance from July onwards as the team completes validation of the surveillance waiting lists. A further review of the follow up list is underway to determine the impact.

What will make the Service Green?

Maintaining Endoscopy activity as is. Option 3 in the business case submitted has been approved which will allow for this as well as see a reduction in WLI spend. To switch to option 3, all five rooms need to be operational.

Radiology: Recruitment to further Cardiac Radiologist (1WTE).

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

Endoscopy:

1. Revenue and activity options submitted via Investment Committee in February. Awaiting feedback as to whether Endoscopy can increase their activity once the fifth room is built through maintaining current WLI levels**. Completed**
2. Dependant on feedback as per above action, review of further growth in Endoscopy activity against ERF to be completed. **July 2021**
3. GWH a confirmed pilot site for Capsule Endoscopy and two Consultants are currently undertaking training. **September 2021**
4. Review of booking to 12 points in the week. **July 2021**
5. Build of fifth room to be completed by the end of August. **August 2021**

Radiology:

1. **CT**: Adhoc CT van capacity sought from NHSE , who have confirmed 5 days per week in August due to CT replacement. A range of actions are being implemented to mitigate the loss of van days (see risk column). Ad hoc cardiac slots have been increased on CT1 and booking in progress (oldest date for cardiac is 16th of December 20). Additional hours have been offered to run extra CT lists. **July 2021**
2. **U/S** Room now completed in June. Recruitment of 1.6WTE Sonographer's is completed, 1 WTE commenced in June with 0.6 WTE start date in August. 750 Sonographer APS have been approved, with 381 diarised for June 2021 and a further 269 additional slots provided through Room 11 in June 2021.
3. MRI: A further 17 van days of MRI van capacity was secured in May and June 2021 (220 slots) . Due to loss of MRI capacity extension of the van contract with Inhealth has been undertaken. 8 days confirmed for September and 4 additional days in August to be confirmed and planned around CT van.
4. **Echo:** An Echo flexi list has been introduced to take advantage of ECG/Treadmill Room when not in use. Where Echo takes place in 2 bays in the same room, patients have been staggered to support social distancing measures without reducing output. Phase 1 Redesign Work to divide the TOE room into 2 separate Echo Rooms was completed 27 June. Action plans re follow up patients' breaches are being developed

Risks to delivery and mitigations

Endoscopy: There is a risk that if the number of referrals being received continue to be higher then Pre Covid levels, the recovery trajectory will not be met (especially if the increase is seen in 2WWs.) **Mitigation:** Fifth room will provide more capacity M-F and 12-point lists providing more capacity with no additional expenditure.

There is a risk that as lockdown is lifted, patients will become more reluctant to agree to self isolate for 3 days between swab and Endoscopy procedure. **Mitigation:** Raised concern with Endoscopy Adopt and Adapt network who are looking at comms to Patients and Primary Care. Also requesting to treat a swab DNA in line with Access Policy.

There is a risk that with the reduction of CT capacity due to the loss of the mobile, 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.

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

- NHSE approached weekly for further CT van capacity with 6 ad-hoc van days in May 4 in June & 4 in July.
- Approach IS to discuss/ reduce private patients. - Completed
- Additional Cardiac and CT sessions offered to staff
- Approached NHSE to provide CT van cover during CT replacement in August –Completed, proposed 5 van days a week during August. Awaiting confirmation NHSE/I on dates.
- Additional US machine delivered. U/S room completed and in use in June 2021.
- Additional sonographer recruited (1 WTE) , with 0.6 WTE due to commence in August.
- Additional MRI van slots booked as per plan.

Echo: There is a risk that there is insufficient space to deliver echo cardiology within in the Wiltshire Cardiac Centre (WCC) reducing capacity to see follow up patients and increasing wait times. An Investment bid will be submitted for consideration to convert admin rooms 001/002 into 2 x Echo Bays while relocating the Diagnostic Reporting Team and Booking Team to offered rooms within Oral Surgery.

There is also a risk that the inclusion on DMO1 returns of FU patients that have not been seen with 6 weeks of their proposed review date will reduce the reportable DMO1 Echo performance for GWH.

Cancer 2 Week Wait Performance Target 93%

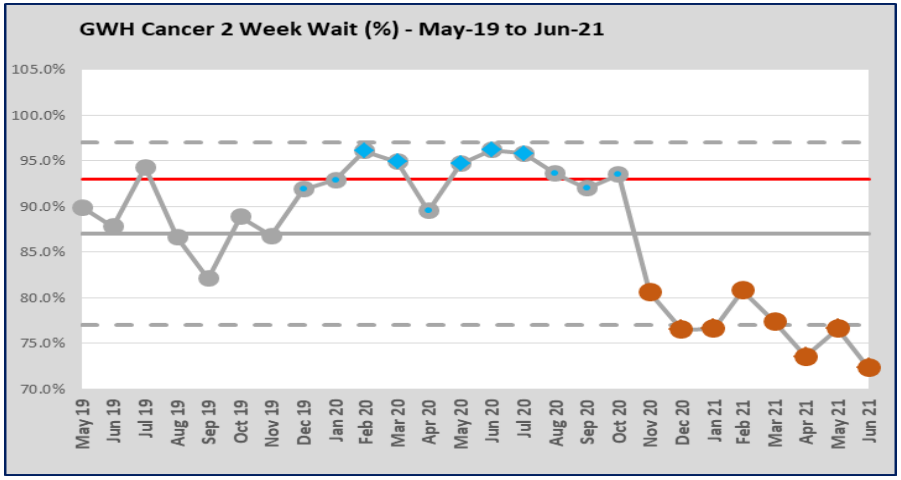
Data Quality Rating:

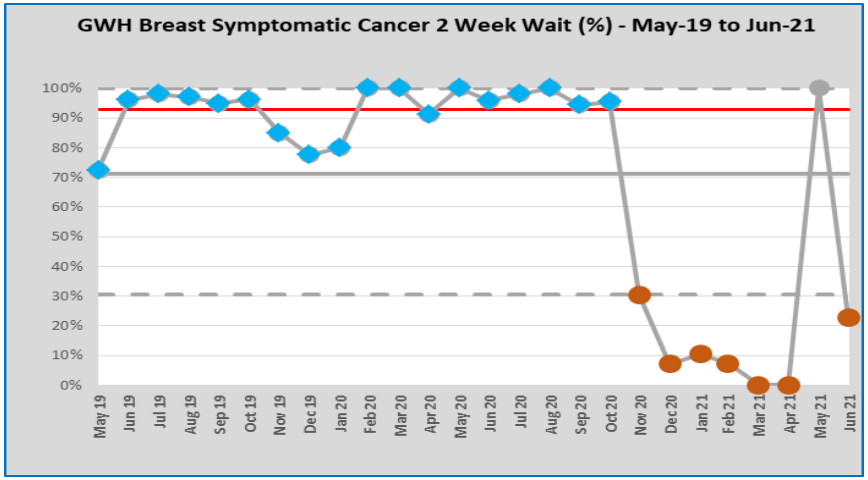
National Key Performance Indicators

Performance Latest Month: **June**

Two Week Wait Standard: 72.3%

Symptomatic Breast Standard: 22.7%





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

Two Week Wait (2WW) performance was inconsistent through 2019 due to pressures within breast, skin and colorectal. In 2020 the standard was achieved except for April, September, November and December due to breast & colorectal pathway pressures. Recent poor performance is mainly driven by pressures in the breast and skin services.

Referrals into the breast service increased following breast cancer awareness month (October 2020) as anticipated. From this point the breast service have been unable to maintain 2ww performance due to capacity and physical distancing requirements in the breast unit as a result of COVID restrictions. To maintain usual demand the team needs to deliver 1 wait list initiative (WLI) clinic each week. This had not been possible due to staff fatigue and request for incentive payment. This resulted in an increasing backlog. The same team also support the breast screening recovery work. In June there were 4 WLI evening clinics resulting in 48 additional patients being seen. As at 5 August the average booking time was 16 days.

The Breast Symptomatic performance improved incorrectly in May. This was due to the CAS team stopping recording the symptomatic referrals separately. This has now been addressed and June's performance is correct.

The standard was not met in Upper GI as a result of limited outpatient capacity due to 2 consultants being stranded in India due to COVID and annual leave. Patient choice and the reluctance of patients to attend the hospital as a result of COVID remains a challenge within endoscopy.

Performance in Skin has not been met due to capacity issues due to staffing and the service has seeing a record number of referrals in 2021.

Performance in Head & Neck was impacted by planned paternity leave being taken later than anticipated.

Q1 performance was 74.1%

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

1. Breast 2ww recovery plan is now in place with WLIs and weekend clinics through July (4) & August (3) to help recover position. The forecast and trajectories show that the additional WLI clinics are required to recover and maintain 2ww performance. Recovery is now expected to occur in October following a review of the trajectory.

Recovery has been affected by consultant absence due to illness, a RAP for Locum cover has been approved to provide 2 months cover to assist with capacity. The post is out to offer with an expected start date of 23 August

2. Endoscopy continues to deliver procedures within 2 weeks. TVCA requested that Endoscopy services be protected through the COVID recovery and that Gastroenterologists not to be working on Trust medical rota. Endoscopy Service have recovery plan and have maintained cancer activity.

3. qFIT (faecal testing) was introduced in primary care for LGI 2ww pathway. The number of 2ww referrals including qFIT results are shared monthly with the Primary Care Network (PCN). 51.2% of all Lower GI referrals had Qfit completed, that required one, in July. Swindon PCN is proactively managing non-compliance, 58.0% of referrals from Swindon GPs included a qFIT result where required.

4. Routine clinic appointments in Dermatology have been cancelled to help support new referral activity from 27 July. Additionally, a locum joins the team from 2 August to provide additional capacity. WLIs continue to be used to support demand, with 2 confirmed and 5 provisional sessions in August.

5. Teledermatology continues to help reduce the number of patients seen on a 2ww pathway with 177 of the 373 patients reviewed being redirected onto a more suitable pathway.

6. The Upper GI consultants stranded in India returned to work at the beginning of July, therefore capacity will improve through July & August.

Risks to delivery and mitigations

1. Risk: Unable to deliver WLI activity in Breast service will impact recovery trajectory

Mitigation: close monitoring of activity and of staff well being.

2. Risk: UGI clinic capacity

Mitigation: WLI's in place to support activity and Saturday lists for Endoscopy.

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

Mitigation: Patient navigators and clinical nurse specialists supporting patients to attend appointments and diagnostics. Trust communications on social media to support attending is regularly provided.

4. Risk: Capacity in Dermatology unable to meet demand over summer.

Mitigation: cancelation of routine clinics to provide additional capacity. Additional WLI's are planned through August. Consultant maternity leave from early July will be covered by locum, who commences in post on 2 August.

5.Risk: Capacity to deliver CT & MRI through the summer during CT replacement works.

Mitigation: additional CT van days are being arranged through August. Request for MRI van being made to help support the service. Annual leave and radiographer vacancies will put pressure on service's ability to deliver scans within KPIs

Cancer 28 Day Diagnosis Target 75%

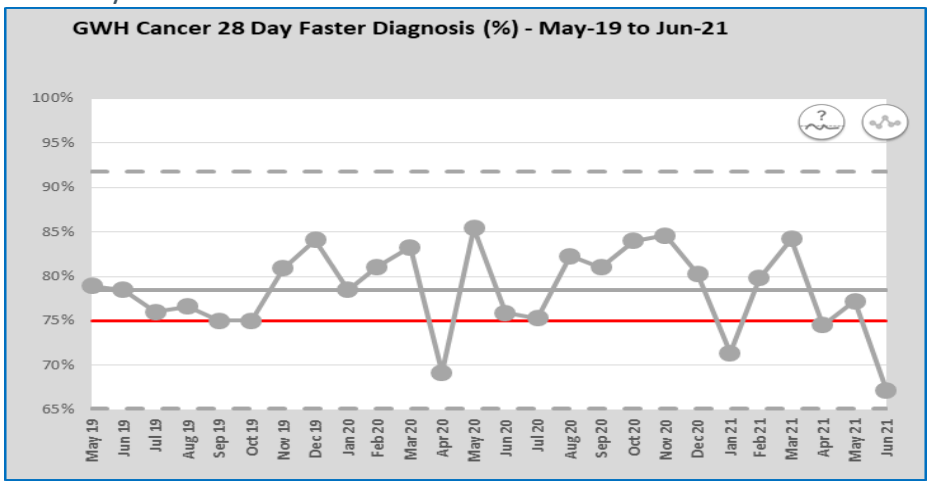
Are We Effective?

Performance Latest Month: **June**

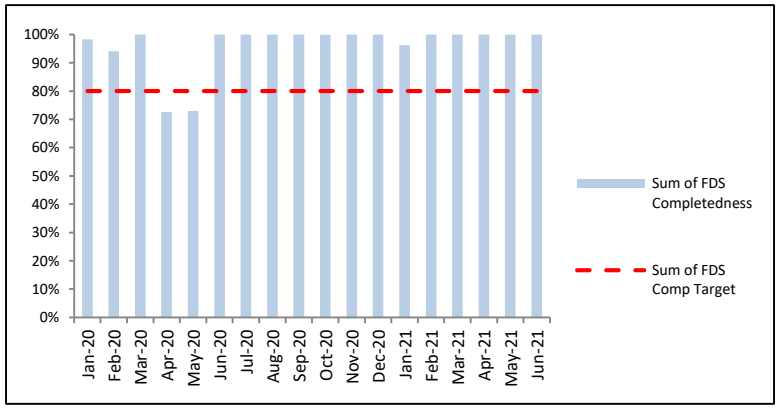
Data Quality Rating:

28 Day FDS 67.8%

Q1 Performance: 72.7%



FDS Completeness



Background

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

The standard will be informally reported in the Public View domain from June 2021, with the more formal management from quarter 3.

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

The standard was not met in June with a performance of 67.8%, with a number of sites falling short.

To achieve the 28 day FDS in the Gynae pathway requires a timely first appointment and good turnaround times from OUH Pathology. Currently the average time for first appointment is 12 day. Pathology samples need to then be prepared, sent and returned within 12 days. Due to the volume of work at OUH, the 12 days is not always met.

The Head & Neck pathways were impacted by a number of complex cases requiring additional diagnostics before a diagnosis could be given. A small number were also impacted by the follow up appointment capacity issues as a result of the paternity leave.

Colorectal performance has dropped further since May 21. Patients who have a non-cancer diagnosis at endoscopy but further test are requested are being kept on the pathway. We also have some delays to consultant reviews and follow up appointments following diagnostic tests with pathology results as a result of clinical capacity. The job plans for the registrars have been revised to see more routine patients freeing up time for the consultants to see their cancer pathway patients.

Upper GI performance dropped in May 21 for the same reasons as Colorectal.

The Urology performance was affected by capacity for virtual follow up appointments after diagnostics tests.

A drop in performance for both Breast & Dermatology attributed to not meeting this standards. This was due to the knock on effect with the pressures on their 2ww performance.

July is forecast to be compliant with the standard.

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

Virtual outpatient follow up remains in place across several sites to communicate the exclusion of a cancer diagnosis. Teams to review this is adequate for the service.

Thames Valley Cancer Alliance (TVCA) transformation work restarts with focus on lung and colorectal (2022) pathways and scoping for rapid diagnostic services. GWH has focused on the lung pathway with baseline mapping undertaken in April.

Review of process for the recording of the communication of diagnosis completed. Patients will remain on the Cancer PTL until they have had their diagnosis communicated. An audit of the Colorectal and Upper GI patients with a non-cancer diagnosis kept on the Cancer PTL to review if any cancers were found. Audit to be reviewed at Cancer management to decided if we can remove these patients from the pathway.

Two clinicians in Upper GI have now returned to work following an extended stay in India due to COVID and the necessary isolation on their return to the UK. Additional clinics are being run to assist with demand which will help cancer pathways.

Gap analysis and plans to achieve the standard will be discussed at the August Cancer Delivery Steering Group meeting.

Bi monthly TVCA audit of 28day FDS records commenced in July to ensure there is consistent reporting across the Alliance.

Risk to Performance Delivery

1. Risk: Delayed access to diagnostic tests will impact on ability to book outpatient follow up within 28 days . Any suspension of Endoscopy services will compromise this standard. Lower GI, Upper GI & Urology all use the unit for early pathway diagnostics. Reduction in CT van availability will also impact

Mitigation: Service recovery plans in place protecting diagnostics and endoscopy unit.

2.Risk: Gynae Pathway 1st appointment and OUH Pathology Delays

Mitigation: A review of this pathway is underway to see if we can see patients for their first and subsequent appointments in a more timely manner.

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

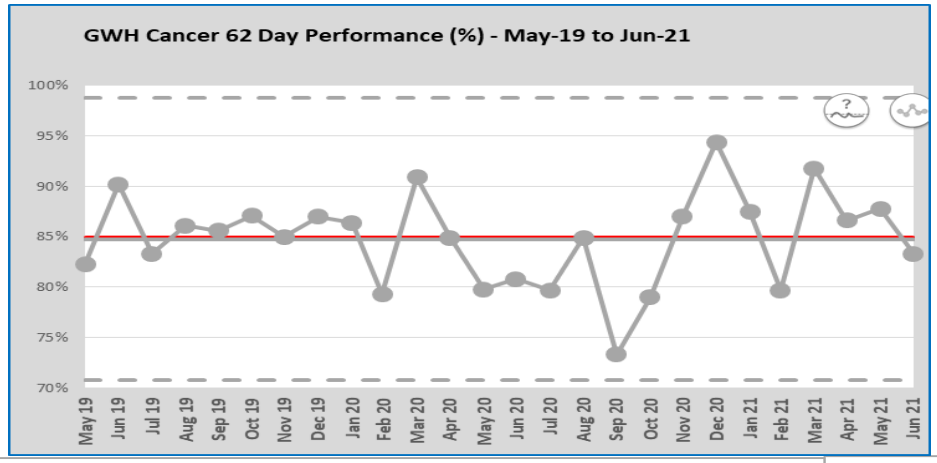
3. Risk: Delays to follow up appointments in colorectal and upper GI, as a result of consultant capacity, will impact on the delivery of diagnosis.

Mitigation: Colorectal service has recruited two registrars to support clinics releasing consultant capacity to see cancer patients

Cancer 62 Day Standards Performance Target 85%

Data Quality Rating

National Key Performance Indicators



Performance Latest Month: **June**

62 Day Standard (Target 85%):	83.5%
62 Day Screening (Target 90%):	84.4%
62 Day Upgrade (local standard 85%):	97.7%
Q1 2021/22	85.7%

Background

June 62 day performance is anticipated to be 83.5% with the Trust not achieving the national 62-day standard. Performance in the last year has been heavily impacted by the COVID 19 pandemic with diagnostic/treatment delays since March 2020 .

The performance for June had been predicted to be more challenged, of the 18 predicted breaches for diagnosed patients:

- 12 pathways breached as forecast
- Five pathways did not breach as forecast, 4 due to being treated in time and one was found not to have cancer on review of pathology.
- One pathway required additional diagnostics and rolled to July.

10 pathways had been tracked as suspicious for cancer with potential treatments in June if diagnosed. None of these resulted in a breach:

- Six patients did not have a cancer diagnosis,
- One was found to have cancer but was treated in time,
- Three patients have now been diagnosed with cancer with treatment planned in July.

There were eight unpredicted breaches in June, one pathway was delayed by patient choice (lung), one treatment was brought forward from July (urology) and the other six included; five complex pathways needing additional diagnostics (3 skin, 1 breast, 1 upper gi) and a change in treatment plan (breast). June also saw higher than average treatments (102.0).

June breach reasons included eleven complex pathways, of which five Urology breaches were complex high grade prostatic cancers with all options offered, two cases (colorectal & haematology)were delayed by Oncology capacity issues, two pathways (urology & skin)were delayed due to patient fitness, one patient with advanced disease required additional diagnostics (upper gi) and a further breach (colorectal) was as a result of the patient requesting a second opinion before surgery.

Additionally, two Breast breaches were due to the delays to the first appointment as a result of the capacity issues in the service. Three Skin breaches were as a result of delays to a biopsy following the patient's first OPA. Eight pathways were impacted by clinical and diagnostic capacity issues at tertiary providers, two of these delays resulted in breaches being attributed to GWH, with the others resulting in no breach. A further pathway (lung) was delayed by a patient wishing to attend a specific provider for a diagnostic scan.

In June, the screening standard was not compliant. Five Colorectal pathways were impacted by delays to the requesting of first diagnostic test following first OPA. One of these cases was also affected by consultant leave delaying surgery, the procedure could not be performed by another surgeon.

The upgrade standard was met in June. A breached pathway in Gynae was as a result of delays to a diagnostic test and the reporting of the pathology from OUH. A colorectal pathway breached as a result of the need for repeated diagnostics and an inpatient stay. A further breach in upper GI was transferred to OUH within 38 days, resulting in no breach being recorded against GWH

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

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

2. Thames Valley Cancer Alliance (TVCA) transformation work continues with focus on lung and colorectal Rapid Diagnostic Service (RDS) pathways with the TVCA arranging local meeting with clinical teams in June.

3. 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.

4. 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 cancer delivery meetings.

5. Follow up capacity in Lower GI has been challenged. The service has been reviewing the job plans of the registrars to review more of the routine patients, freeing up clinic slots for the consultants to see their 2ww cancer patients.

6. Template biopsy kit is now with procurement and is due to be ordered imminently with an expected delivery time of 6-8 weeks.

Risk to Performance Delivery

Risk: July performance is expected to achieve the standard; however this forecast is based on only diagnosed patients. Suspicious pathways are being tracked and if these were to result in a cancer diagnosis performance would likely be 85.5%.

July breaches are impacted by capacity issues at OUH in clinical oncology and surgery with three pathways effected (colorectal & 2 sarcoma). Three pathways were delayed for medical reasons (colorectal, 2 urology). Four pathways were delayed by service issues, including delays to follow up appointments and letters (breast, colorectal, skin & urology). Other pathways have seen delays due to the need for additional diagnostics.

CT van sessions are in place to help support the radiology during the replacement of the CT scanner this summer. This may have an impact on the service being able to offer earlier scans to help bring pathway forward. Radiology are actively managing and prioritising cancer referrals. PET CT van would assist capacity. Reduced staffing in radiology due to vacancy and absence is placing increasing strain on capacity.

Mitigation: Twice weekly PTL meetings continue to be held and cancer delivery meetings to progress pathways and improvement work. PTL discussions with the Lab manager and the Radiology manager are held to highlight pathways that require escalation.

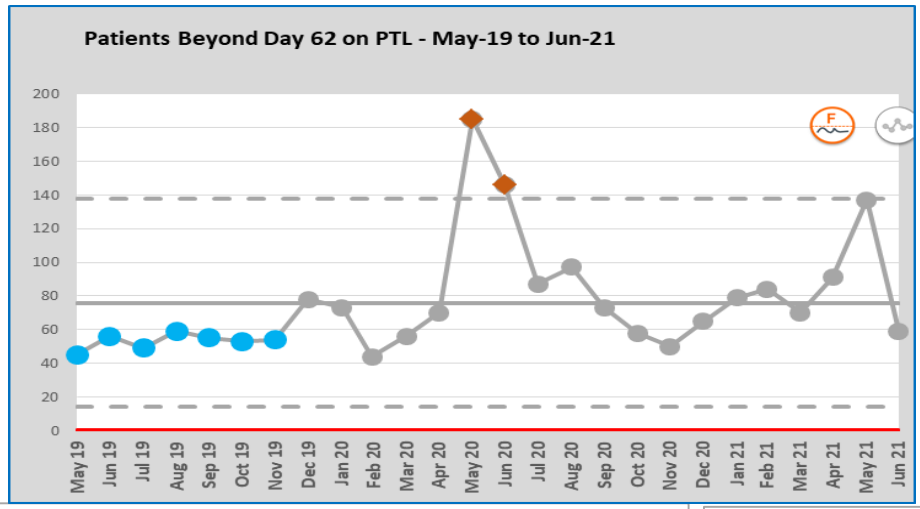
Outpatient capacity issues in both the upper and lower GI pathways continue to delay follow up activity. Registrar activity in lower GI is being used to free up clinic time for consultants to see their cancer patients.

Oncology capacity remains challenged due to significant workforce gaps. Workforce modelling is underway with discussions with Oxford University Hospitals (OUH). OUH have identified a clinical oncologists in Breast & Urology who is able to start in December 2021.

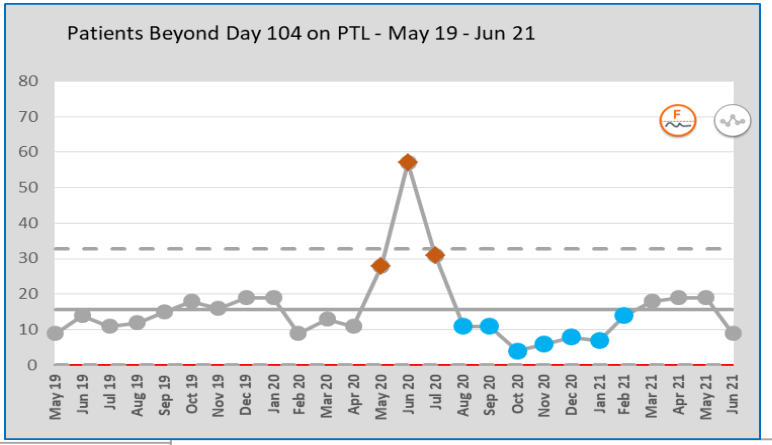
Delays to Breast first appointments are now impacting the 62 day performance with 1 pathway being impacted in July. A weekly PTL review and surgical update meeting is held to help identify patients who need to be escalated.

Cancer 62 day + longer waiters including > 104 day

National Key Performance Indicators



Data Quality Rating:



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

104 Day Breaches: June: 3 Patients; 1.0 breaches (IPT)

<u>Treated at OUH</u>

Skin: 1 patient-0.5 breach: pathway impacted by need for joint operation with orthopaedic team at Oxford. Patient fitness for procedure lead to several postponements.

Haematology: 1 patient-0.5 breach: complex case, patient referred in under Head & Neck service where a repeat biopsy was needed before passing over to the Haem pathway. As a result the ITR for treatment to OUH was late , radiotherapy delayed at OUH due to oncology capacity.

Sarcoma: 1 patient-0.0 breach: patient was ITR'd to OUH early in pathway, surgical capacity at OUH delayed treatment.

July is likely to see 5 patients breach 104 days on their pathway resulting in 2.5 breaches.

The number of patient pathways over 104 days has reduced significantly through June due to the closing of a number of non cancer records on a Skin pathway, these pathways had been delayed by the issues with typing times. This is also true for the improvements in the number of 62day+ pathways.

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

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 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

Risks to delivery and mitigations

1. Risk: Patient pathway delays are seen when diagnostic, outpatient and theatre capacity is challenged and also in the treatment preparation (COVID management pre-assessment & theatre capacity).
Mitigation: Working with elective booking teams highlighting delays in PTL meetings.

2. Risk: Tertiary centre theatre capacity challenged during Covid particularly for patients requiring High Dependency Unit (HDU) recovery.
Mitigation: The monitoring of long waiting patients and HDU capacity steadily improving.

3. Risk: Patient reluctance to attend pre-vaccination.
Mitigation: Patient navigators and clinical nurse specialists supporting patients to attend appointments and diagnostics. Trust communications on social media to support attending is regularly provided.

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

Pathology delays are being escalated with OUH where they are identified during weekly PTL review meeting.

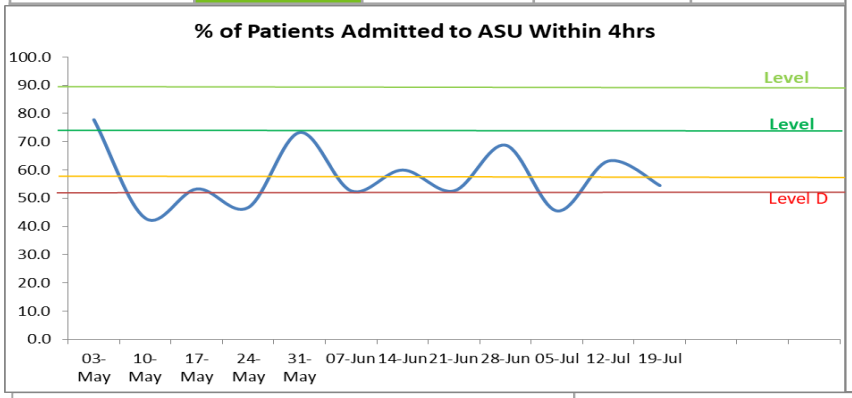
Stroke Pathways

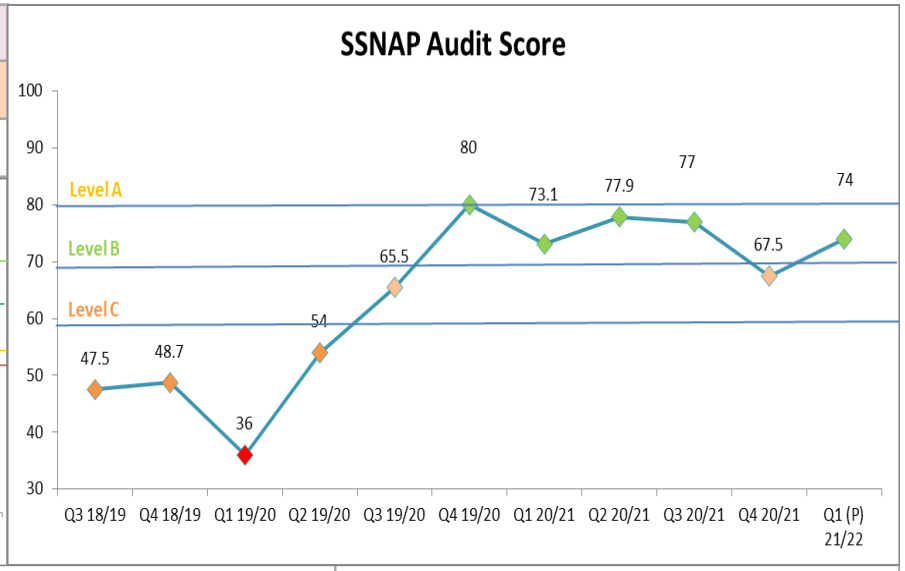
Data Quality Rating:

National Key Performance Indicators

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

Year	Q1	Q2	Q3	Q4
2020 - 21	B	B	B	C
2021 - 22	B (p)			





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

The Trust is projecting performance at SSNAP Level B (74) for Q1 of 21/22 which exceeds the target set in the preceding business case where approval was predicated on maintaining performance at level C. The Level B performance rating is a reflection of the level of investment from colleagues across the whole Stroke Pathway and further mitigation and resolution for the key elements that drove the reduction to Level C performance in Q4 20/21, for example, 3 WTE vacancies within PT/OT teams across the Stroke Pathway have recently been recruited to.

In Q4 20/21 we saw a slight decline in the metric 'Stroke – Spent>90% of Stay on Stroke Unit' from 75.4 in Q3 20/21 to 73. During Q4 20/21, GWH declared a critical incident due to Covid-19 which led to more patients having to outlie. Another key consideration is that a number of patients are not identified as Stroke until later in their inpatient stay. Performance in this metric for Q1 21/22 is projected to improve and for context, this metric forms part of Domain 2 within SSNAP which has remained at Level D throughout Q3 and Q4 20/21 so the score reduction did not impact overall performance.

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

1. PT/OT Team recruited to posts in SwICC : 3 x therapists due to start in Aug 21. **Aug 21**
2. Final revisions are being made to a business case to support increased OOH stroke cover. **Aug 21**
3. ED Nurses to shadow Stroke Specialist Nurses to improve knowledge and confidence with Thrombolysis. **Sept 21**
4. ED SHINE documentation to be uploaded to reflect swallow screening to be moved to 2 hour intervals. **Aug 21**
5. Review and update of Stroke Assessment Proforma to ensure Thrombolysis data being captured accurately. **Aug 21**

Risks to delivery and mitigations

Risk No 2756 (score 12): There is a risk that delays to stroke patients being admitted OOH to the ASU outside of the 4-hour timeframe will face reduced quality of care through delayed access to specialist stroke treatments.

Mitigation : weekly monitoring of admissions to ASU by the Stroke Matron. IR1s are completed for breaches of SOP and learning used to drive improvement performance.

Risk there is a very short term risk that before the PT/OT new recruits start later in Aug, the vacancies could impact the overall performance of Stroke until post holders have started and inducted.

Mitigation : redeployment of staff across the Stroke pathway to minimise impact. Weekend therapy provision to ASU has been maintained to ensure flow and new assessments. Criteria for Forest is now inclusive of all geographical areas to support ASU flow. Regular discussions with Therapy team to identify any pressures and put 'on the day' mitigation in place.

Great Western Hospitals NHS Foundation Trust

Part 2: Our Care

Our Priorities

How We Measure

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

Our Care Summary

Great Western Hospitals NHS Foundation Trust

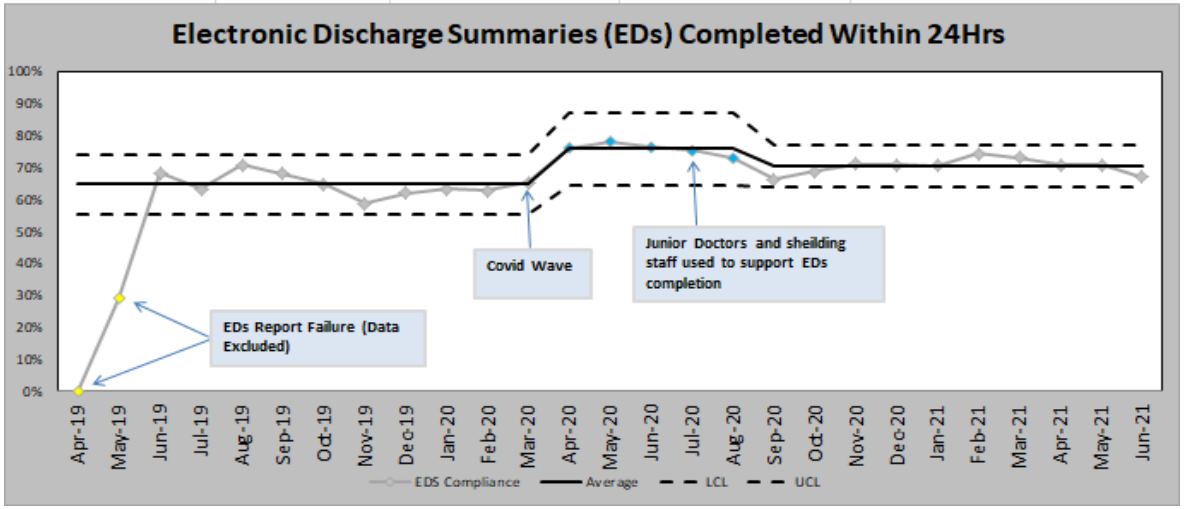
KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
C. Difficile (Hospital onset) per 1000 bed days	10.4 (Apr 21)		14	61	24	Apr21
VTE Assessment	99.1% (Jun 21)		18	114	1	Dec 19
Hip Fracture Best Practice Tariff – 12 Month Rolling	67.1% (Jun 21)		42	95	6	Jun 21
Complaints Rates	27.9 (Q4 20/21)		104	50	22	Q4 20/21
Family and Friends Score – Percentage of Positive Responses - Inpatients	80.18% (Jul 21)		114	26	3	May 21
Complaints Response Backlog	0.1 (Q4 20/21)		4	35	43	Q4 20/21
MRSA all cases	0 (Jul 21)		29	100	67	Apr 21
Falls per 1000 bed days	6.3 (Jul 21)					
Pressure Ulcers – Acute	25 (Jul 21)					
Pressure Ulcers – Community	21 (Jul 21)					
Never Events 21/22	0					
Serious Incidents	3 (Jul 21)					

*Public View Ranking is out of Acute and Combined Trusts Only

2. Electronic Discharge Summary (EDS)

Data Quality Rating:

Are We Safe?



	24 hours	48 hours	72 hours.
Sep-20	66.47%	71.24%	74.65%
Oct-20	69.05%	73.49%	76.99%
Nov-20	71.14%	75.67%	78.62%
Dec-20	71.08%	75.59%	79.81%
Jan-21	70.81%	75.43%	78.50%
Feb-21	74.36%	74.84%	77.55%
Mar-21	73.22%	77.53%	81.36%
Apr-21	70.95%	75.28%	78.90%
May-21	70.94%	76.03%	79.42%
Jun-21	67.20%	70.88%	72.97%
Jul-21	Awaiting Data		

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

All in-patients discharged from our organisation should receive a copy of their Electronic Discharge Summary (EDS).

There is a contractual agreement between the Trust and the Clinical Commissioning Group (CCG) for discharge summaries to reach the GP within 24 hours.

The data above demonstrates that on average the number of EDS that reach the GP surgery within 24 hours is 64.34% and by 72 hours this figure increases to 72.93%.

Day case patients discharged from our organisation receive a paper version of the discharge summary called a Final Consultant Episode (FCE). A copy of the FCE is sent to the GP via the patient.

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

The Electronic Discharge Summary (EDS) working group was originally set up in 2018 and is led by the Deputy Medical Director (DMD), with quarterly meetings.

The working group has good representation from the Deputy Medical Director (DMD), Quality Matron, Ward Clerk, Medical Staff, Nursing Teams, Physiotherapy, Pharmacy, Matron, Discharge Team, Emergency Care Improvement Supportive Team (ECIST) and the Transformation & Improvement Hub (T&I). Part of the project is observing ward practices in regard to EDS completion. The findings suggest that there is a need for standard processes to be reinforced and as a consequence information on the EDS process has been recirculated. Medical Workforce is also ensuring that the information is disseminated locum Doctors.

The Clinical Consultant Information Officer (CCIO) is updating the IT induction training pack for new doctors this will also include the EDS element of the induction Pack.

Risks to delivery and mitigations

Due to the age of the current EDS system we are unable to make any further changes to the system.

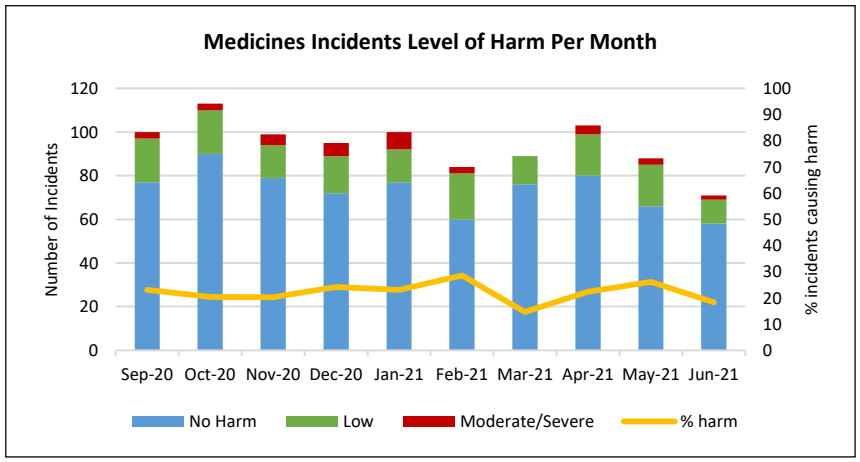
The current EDS system is a standalone system, there are plans to update the Care Centre (Medway) system. Further work is ongoing to assess the impact of this on the EDS system.

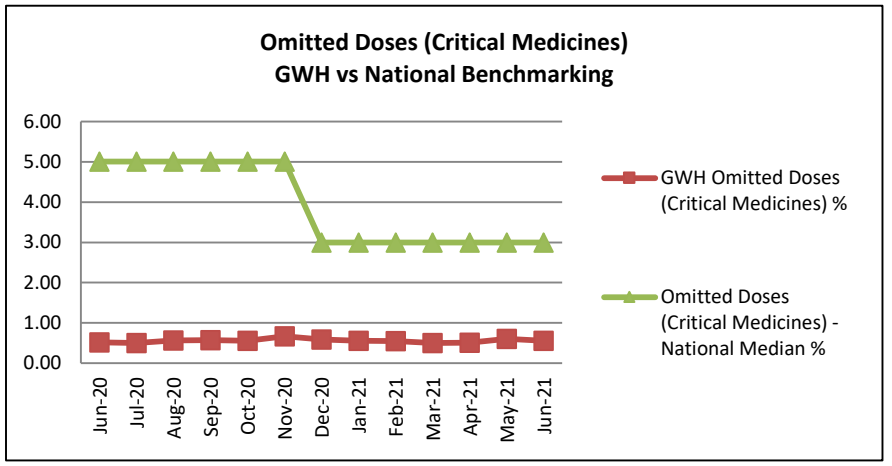
Regular change over of Medical staff affects EDS performance. The Junior Doctor revised training pack on induction will hopefully mitigate this risk.

2. Medicines Safety

Data Quality Rating:

Are We Safe?





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

Medication Incidents

- The rate of medication incidents and the proportion causing harm remains stable across the year. A reduction in the number of reports were seen in June.
- One specific incident involving oxygen prescribing in the Trust which has been raised on StEIS as a Serious Incident (SI).
- Trends remain consistent with the main themes of incidents around medication administration.

Omitted Critical Medicines

- Percentage of unintended omitted critical medicines (all administrations of medicines) remains consistently low.
- Great Western Hospital (GWH) continues to have a lower rate of unintended omitted critical medicines in comparison to national benchmarking.

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

Medication Incidents

- The oxygen incident has been overseen by the Medicines Safety workstream of the Great Care Campaign. An improvement group has been formed to implement improvements within the Trust in relation to oxygen prescribing. These include actions relating to prescribing, delivery devices, administration, process for escalation and an action plan is due for approval by Medicines Assurance Committee in early August.
- The Medicines Safety workstream within the Great Care Campaign, will be responsible for developing strategies to change the culture surrounding medicines administration in the Trust, with the aim of reducing the number of incidents in relation to administration.
- Regular updates on activity to be provided to Patient Quality Committee monthly and Medicines Safety Group quarterly.

Omitted Critical Medicines

- Work is on-going within the pharmacy team to identify any particular medicines which are omitted and therefore enable a more focused approach to further reduce this number.

Risks to delivery and mitigations

Medication Incidents

No specific risks to delivery identified at this stage.

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

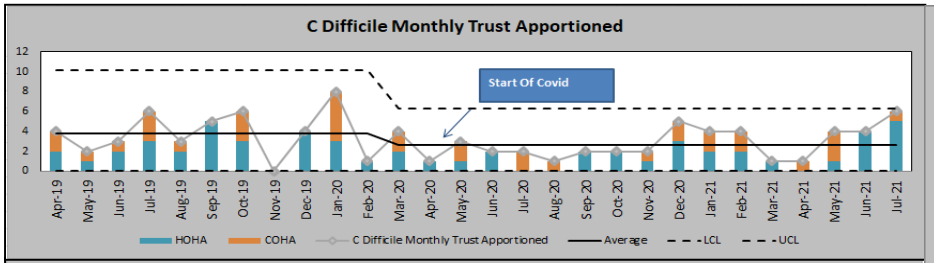
Omitted Critical Medicines

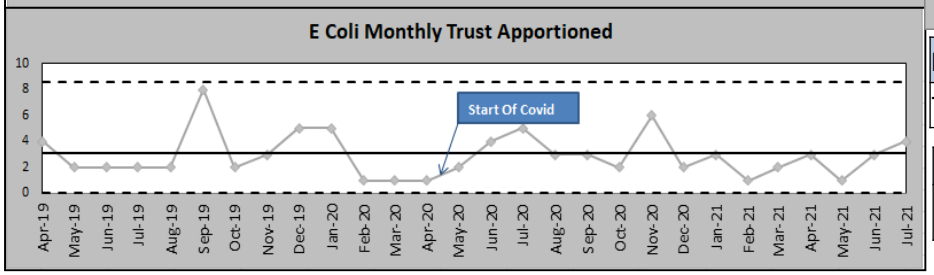
No specific risks to delivery identified at this stage.

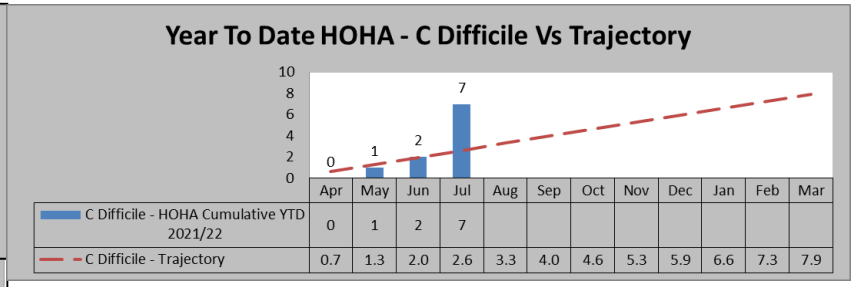
2. Patient Safety - Infection Control

Data Quality Rating:

Are We Safe?







	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C Difficile - HOHA Cumulative YTD 2021/22	0	1	2	7								
C Difficile - Trajectory	0.7	1.3	2.0	2.6	3.3	4.0	4.6	5.3	5.9	6.6	7.3	7.9

MRSA Bacteraemia	2020/21	2021/22
Trust Apportioned	0	2

Hand Hygiene	July
Audit Results	99.70%*

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

C. difficile – In July there has been five Hospital Onset Healthcare Associated infection identified. One on Ampney, one on Mercury and three cases on Teal Ward. Two Teal Ward cases have been declared as avoidable.

Teal Ward will now be on a further Period of Increased Incidence (PII) to monitor antibiotic prescribing, environmental cleanliness and adherence to care bundle. The review meeting found there was no obvious link between the cases but ribotyping has been requested for all patients affected to determine if there has been nosocomial infection.

MRSA Bacteraemia – 0 cases reported for July.

The two MRSA post infection reviews for June have been discussed at the Serious Incident Review Group, some learning identified although this may not have prevented the infection due to the underlying health conditions of the patients.

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

C. difficile - All cases of *C. difficile* are typed (analysed to identify different strains) to ensure that there can be identification of any cross infection. This is a proactive approach and gives assurance that there has been no episode of cross infection.

The new *C. difficile* NICE Guidance has been released promoting the use of Vancomycin as first line treatment for all *C. difficile* cases and Fidaxomicin as second line for severe *C. difficile* cases. This will mean a change in current guidelines from Metronidazole which will be implemented across the Trust within the next 2 months. There will be an education plan for prescribers once the new guidance has been approved.

The C. *difficile* Improvement Collaborative is due to meet in August to review pathways and evaluation of C. *difficile* cases across BSW, this will be reviewed next month.

There have been no Influenza cases identified over the last month and there are no current signs of any cases within BSW.

Respiratory Syncytial Virus (RSV) in children remains a risk, to date the Trust has only seen one case in June.

Risks to delivery and mitigations

Maintaining cleanliness of the ward environment consistently, including patient care equipment. Assurance is provided by spot check audits.

New intake of junior doctors will need support and direction to use Microguide and promote appropriate antibiotic prescribing and changes to *C.difficile* management.

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

2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

Covid 19	May -21	Jun -21	Jul-21
Number of detected Inpatients	24	29	125
Number of Deaths in Hospital	1	0	3
Hospital Acquired Covid-19 Cases*	1	0	0

Covid-19 (Apr 21 – Mar 22)		(April 20- Mar 21)
Number of detected Inpatients	199	1458
Number of Deaths	8	324
Hospital Acquired Covid-19 Cases*	1	139

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

Numbers of patients diagnosed with COVID-19 continues to increase in line with the national picture.

Maternity services have detected 4 positive cases in July as a result of admission screening, which is possibly reflective of the community cases within the age group of the population.

There have been zero nosocomial infections identified during this July 2021. Of the 125 patients detected 61 were unvaccinated, 49 of the cases were below the age of 36 and one was a readmission.

The Swindon case rate has increased to 317 per 100,000 between 20 July – 26 July 2021, which is above the Wiltshire (281 per 100,00) and England (307 per 100,000) levels.

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

All Tier three precautions remain in place within the Trust including 2 metre social distancing and personal protective equipment (PPE) usage.

All staff are now submitting lateral flow tests though the National Reporting system and this message has been reiterated through the Trust communication structures.

A robust risk assessment process in line with NHSE/I guidance is in place to support the return to work of clinical staff who have been alerted via the NHS Test and Trace proximity app. This is a thorough process which is being carefully monitored to ensure staff are returned back to work in a safe manner where appropriate. The impact of the change in regulations expected in August 2021 will be considered and the process adapted if necessary.

Risks to delivery and mitigations

Staffing due to self isolation continues to have an impact on all areas due to the easing of lockdown.

This is impacting on the numbers of staff having to self isolate following a track and trace alert. There is a risk staff and visitors will have reduced compliance for social distancing and PPE in hospital as restriction lift nationally. This is being addressed through regularly messaging of the higher risk of spread in hospital.

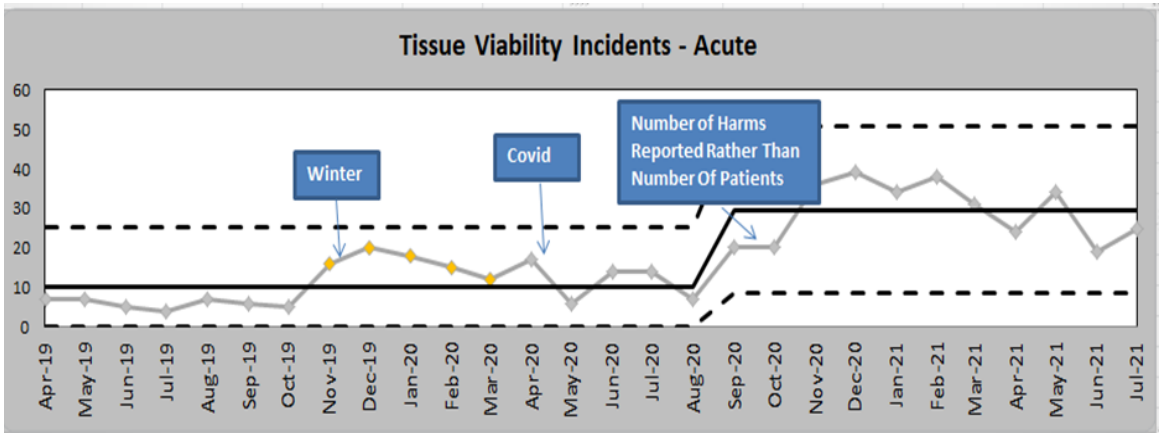
Risk of staff testing positive once risked assessed to return to work during their official 10 day isolation period. This is being closely monitored against the sickness reports.

*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 July 2021:

Category 2 PU	Category 3 PU	DTI	Device related PU	Unstagable	Total Incident of Harms
14	0	5	1*	6	25

* Included within DTI total

Number of Patients	Harms per Patient
19	1
3	2

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

There were a total number of 25 harms (in 22 patients) in July 2021, this is an increase of 6 harms. This increase is predominately is in category 2 pressure ulcers which reflects the trend of better reporting at lower harm.

3 patients had more than one harm.

There was 1 Device related harm which was due to an anti embolic stocking (Deep tissue injury (DTI), this is similar to last month and identified as a theme.

The majority of the pressure ulcers were to heels (17) and 8 pressure ulcers to sacral/buttocks.

7 Suspected Deep Tissue Injuries were reported but following re-validation they all resolved, and no harm attributed.

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

Themes from the swarms (an immediate review at ward/department level) include: timely skin inspections; thorough documentation, and early intervention with appropriate repositioning and pressure relieving equipment. Trust wide and local action plans have been developed for these themes and discussed at the weekly meeting with DDON's and Deputy Chief Nurse.

Working with the Quality Matron, the nursing documentation has been reviewed and updated to make it simpler to record skin inspections.

Jupiter ward identified 6 hospital acquired harms in June 2021 which prompted implementation of the THINK SKIN poster at the bedside for patients at increased risk. There have been no harms reported in July 2021.

Risks to delivery and mitigations

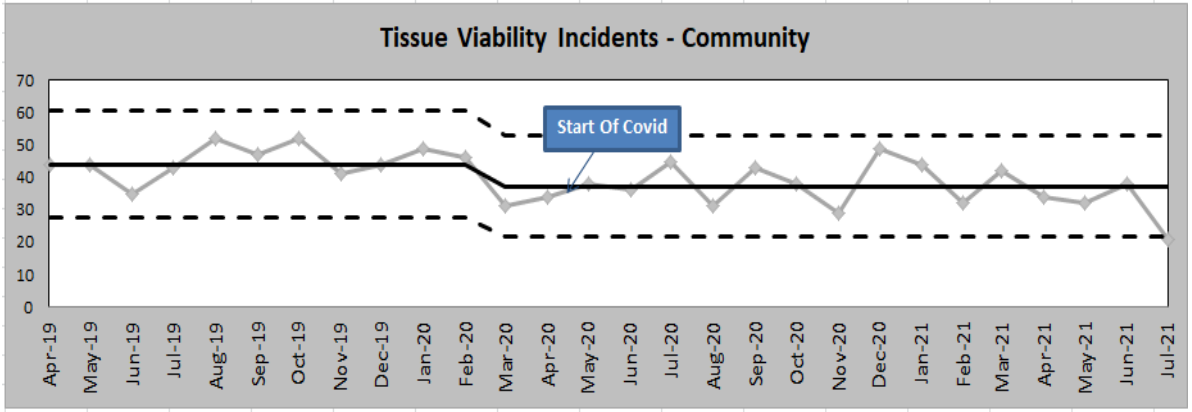
Pressure ulcer rates remain high, and the specialist team continue to be under pressure to support the wards clinically and provision of required education and training. Additional admin support to the team is being provided by redeployed staff.

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

2. Patient Safety – Community Pressure Ulcers

Data Quality Rating:

Are We Safe?



Cat 2	Cat 3	Cat 4	DTI	Unstageable	Device related	Total harms
10	9	0	0	1	1 MPrU	21

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

A total of 21 pressure ulcers were seen in July 21, this is a reduction of 15 from June 21.

- No Category 4 or Deep Tissue Injury's (DTI) reported this month.
- There has been a small increase in category 3 pressure ulcers.
- 1 device related harm related to a urinary catheter. Mucosal pressure ulcer (MPrU)

It is too early to determine if this is a sustained reduction related to the additional training and awareness raising.

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

Moisture Associated Skin Damage (MASD) pathway launched with 64 delegates in July 21.

Incident reporting training for Community Nursing teams to include risk assessment and duty of candour process and responsibilities is planned for August 21. This will support improved reporting of pressure ulcers.

The reduction in harms due to urethral catheters this month may be due to the on-going work stream with continence care and infection control. This work is ongoing including further training and audit.

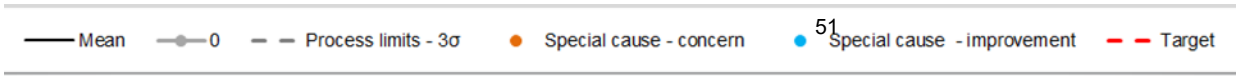
Risks to delivery and mitigations

There continues to be frequent use of temporary staff in community nursing who are less familiar with the equipment, and resources available to prevent pressure ulcers. Images are unable to be taken due to governance issues.

This is mitigated by:

The successful recruitment into substantive posts, although this is not likely to impact until September / October 21.

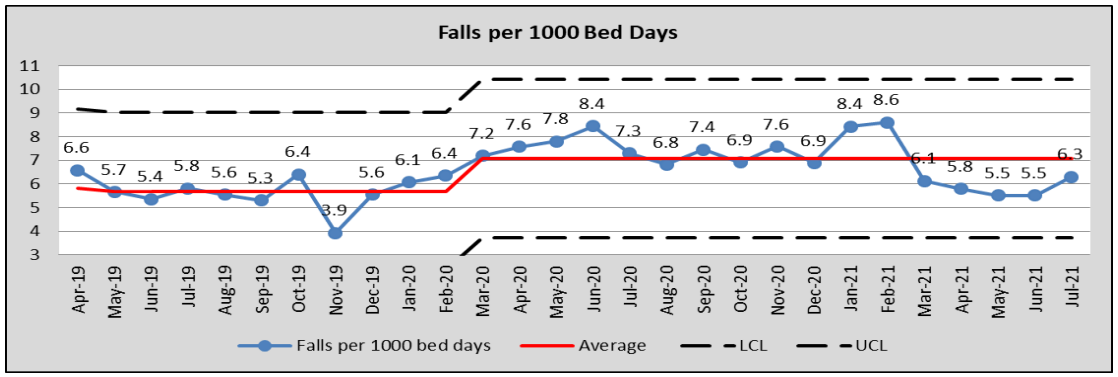
A patient allocation process is in place to ensure complex patients have substantive staff allocated. This supports escalation to the rapid response team if any harm is identified.



2. Patient Safety – Safer Mobility (Falls Reduction)

Data Quality Rating:

Are We Safe?



	Mar 2021	April 2021	May 2021	Jun 2021	Jul 2021
Falls Resulting in No Harm	104	99	101	97	113
Falls Resulting in moderate Harm or above	2	2	3	2	4

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

Over the last 5 months we have seen a decrease in falls per 1000 bed days, reducing from 8.6 in February 2021 to 5.5 in June 2021. however, this has increased in July to 6.3.

This will be closely monitored to see if this is an increase or a natural variation.

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

- New falls assessment documentation is in the process of being uploaded to Nervecentre (electronic record keeping system).
- Royal College of Physicians post fall 'hot debrief', a process where the multi disciplinary team reviews causes of a patients fall, commenced on SWICC and Sunflower wards on 14th June. In June 55.5% of falls had a post fall debrief, in July 70.80% of falls had a debrief. Learning from the debriefs has been collated to be presented to the new SWICC falls group and Safer Care Group in August 2021.
- Guidance on implementing the 'hot debrief' process and running a Multi-disciplinary Team (MDT) debrief has been drafted and a demonstration video will be filmed in September 2021. Role out to next ward (Trauma) will commence from September 2021.
- First audit of appropriateness of documentation of falls interventions is planned for 12th August 2021 on Forest Ward.
- Safe footwear project to review published evidence and NICE recommendations for non-slip socks and safe footwear is planned to start September 2021.
- **National Falls Safety Week 20th – 26th September 2021 involving activities to raise awareness of falls safety, including falls champion quizzes, and pledges to reduce falls in clinical areas.**

Risks to delivery and mitigations

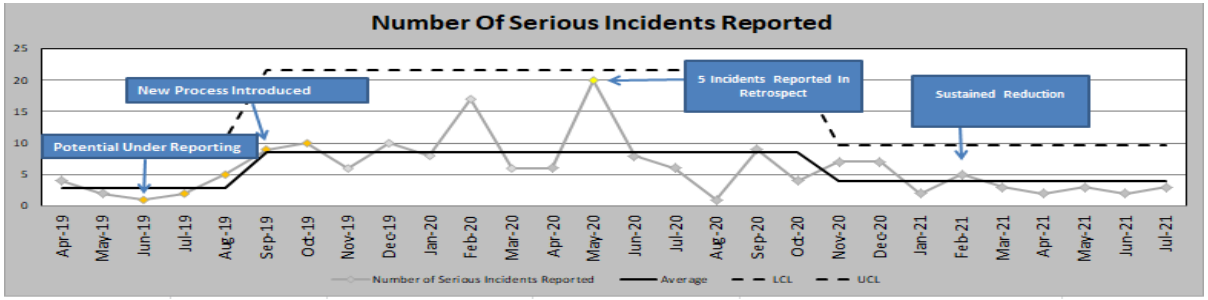
A multi factorial falls assessment and falls care plan trust wide continues to be a key step in the progression of the falls improvement plan. Currently 6 wards are trialing the new assessment in paper format.

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

2. Patient Safety - Incidents

Data Quality Rating:

Are We Safe?



Serious Incidents Reported			Comparison
May-21	Jun-21	Jul-21	Jul-20
3	2	3	8

Never Events	
2020-21	2021-22
2	0

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

At the time of reporting there are a total of 28 on-going Serious Incident (SI) investigations, with three reported in July.

Although the number of SI's reported has increased compared to June it remains below the average reported per month from November 2020.

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

Improvement Groups continue in the following areas – World Health Organisation (WHO) safety checklist, Bilevel Positive Airway Pressure, (BiPAP), NerveCentre and Safe discharge. Although not all groups have met over the last month, work is still ongoing.

BiPAP / Non-Invasive Ventilation (NIV) –
A joint teaching session is planned for the new Junior Doctor intake in August which will cover basic interpretation of arterial blood gasses (ABG), when to start patients on NIV or transfer to Neptune Ward.

Allergies improvement group –

Two separate task and finish groups have been developed. One with an Emergency Department (ED) focus. One action is to take forward allergies as a mandatory field on each electronic discharge summary. A shared care record system called Graphnet is now live, supporting access to Primary Care records.

Referrals

The improvement group focusing on paper referrals in Endoscopy continues to explore the electronic solutions with clinical testing now live and feedback to the group expected next month.

Sharing of Learning –

- The Learning Zone is being developed as part of the 'Great Care Campaign'. The Learning Zone will provide a virtual platform to patient safety incidents and learning which will be housed on the front of the intranet page. Work is underway to ensure that the development of the platform, including the branding (name) and visual appearance, support an ethos of learning from patient safety incidents, complaints and concerns. The platform will be a space for continuous improvement and support embedding a learning culture across the organisation. A Governance process has been developed, with slots booked at Divisional Quality meetings to raise awareness and a soft launch is planned at the start of September to tie in with World Patient Safety Day with a 'go live' date planned for the 17th of September.

Risks to delivery and mitigations

Despite improvement there are still multiple overdue Serious Incident investigations which pose a risk to breach of contract should the Trust be measured against timeframes. The Trust are committing to complete all overdue Serious Incident investigations be the end of September.

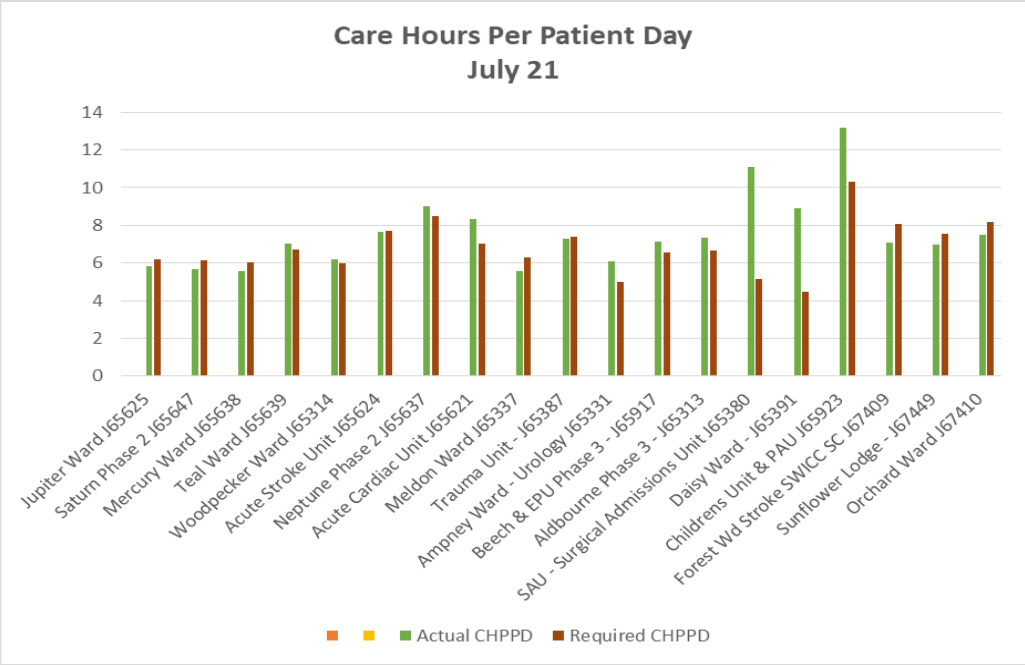
The contract for Datix Incident management system is progressing. Configuration of the module is moving forward however there are concerns related to the medicines section of the incident form. This is under review with Datix and solutions are being sought which input from the Trust Pharmacy team.

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

2. Patient Experience – Safer Staffing –Average Shift Fill Rate

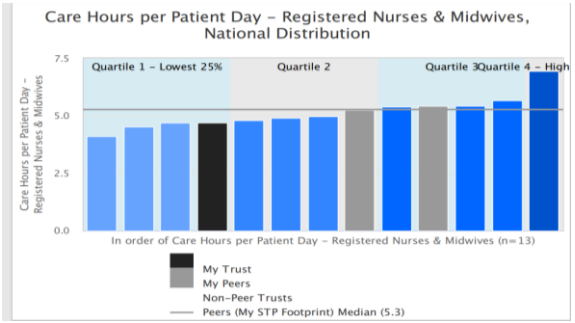
Data Quality Rating:

Are We Safe?



It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board.
This chart demonstrates the Care Hours Per Patient Day (CHPPD). CHPPD metric was developed to provide a consistent way of recording and reporting deployment of nursing staff providing care in inpatient ward settings. The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone.

From Model Hospital Comparison of CHPPD across Trusts in South West for May 21



The past month has seen highly pressured demand on both Emergency services and in-patient areas across the Trust which has required close management of safe staffing to be balanced across all areas. Clinical areas are encouraged to report staffing incidents to ensure clear visibility. There was also an increase in the number of red flag incidents reported. Each of these incidents are reviewed, investigated and feedback provided by the Divisional Director of Nursing.
There are several wards who have consistently worked at staffing levels below their agreed establishment; In order to provide support to the wards, Supervisory Sisters and nurses in non clinically facing roles have been supporting clinically.
The amount of temporary staffing including non framework agencies has increased due to the challenges associated with self isolation absence.
The pipeline of registered nurses both national and international due to start over the next three months will make significant progress and impact on the number of vacancies across the Trust.

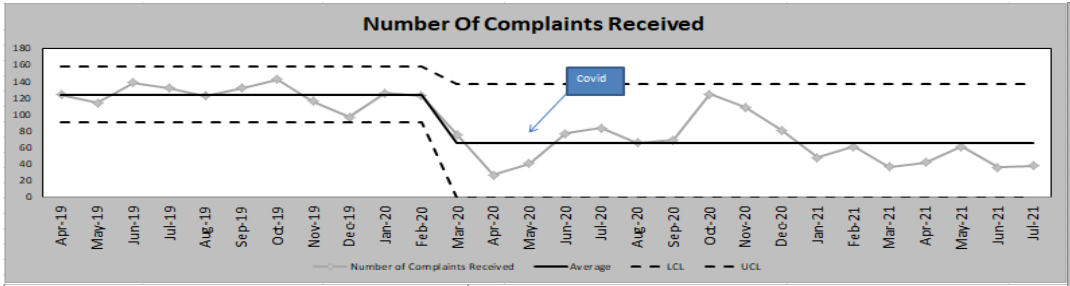
The CHPPD chart for July reflects this trend of the required hours being greater than the actual hours available in 5 wards, this is a reflection of the higher acuity levels seen in July across the Trust. The actual hours for the Childrens ward reflects the high numbers of RMNS required in addition to the registered nurse establishment. Surgical Admissions Unit (SAU) is higher due to requiring additional staff for the assessment unit.

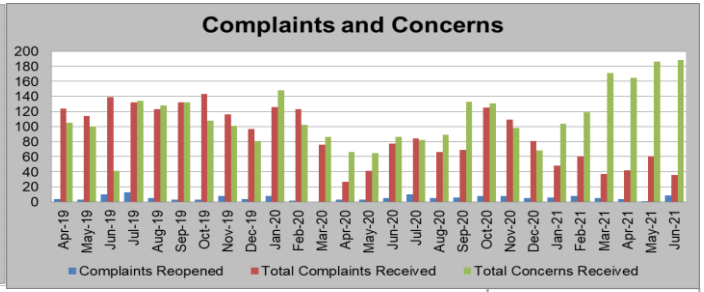
Maternity staffing is reported on the Perinatal Quality surveillance tool but remains a concern with high vacancies. However, this is being mitigated by senior staff covering critical shifts.

Community staffing is improving and is monitored through the daily staffing calls with the number of patient calls uncovered (and moved to the next day if safe to do so) is recorded.

2. Patient Experience - Complaints and Concerns

Are We Safe?





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

38 complaints (previous month 36) and **125** concerns (previous month 188) were received in July 2021.

Out of a total of **163** cases received from Complaints and Concerns in July, the overall top three themes were:

- **Clinical Care: 28** (17%) – 15 complaints, 13 concerns.
- **Waiting time 26** (16%) – 1 complaint, 25 concerns.
- **Behaviour/Attitude of staff: 21** (13%) – 4 complaints, 17 concerns.

Complaints: **38** complaints were received; all were rated as Low – Medium.

Response rates: Overall complaint response rate was **72**%. **48**% of concerns were resolved within 24 hours, **69**% were resolved within 7 working days (Internal KPI 80%).

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

Clinical Care

Clinical care continues to be one of our top complaint themes although there are various strands that fall within this overarching theme. Quality improvement work steams continue in several key areas i.e., End Of Life care, discharge planning and personal care. Many of these work streams are being managed through the Great Care Campaign.

Waiting time

A range of initiatives are underway to address the waiting lists, with streamlining of pathways and focusing on two week wait appointments. Utilising other local independent sector hospitals to transfer patients where appropriate, is being explored together with increasing weekend procedure slots. Communication with patients whilst on the waiting list is also being reviewed.

Behaviour/Attitude

Identified as a recurring complaints theme the PALS and Complaints team have worked with Human Resources and the Academy, to ensure that the complaints process provides assurance that concerns, and complaints are managed and acted on appropriately. A report from Human Resources was submitted to the Quality and Governance Committee in June 2021 detailing the process and assurance. The Trust Culture and Organisation Development work is focussed on supporting improvements for patient and staff experience combining just and learning culture, civility and respect and compassionate leadership.

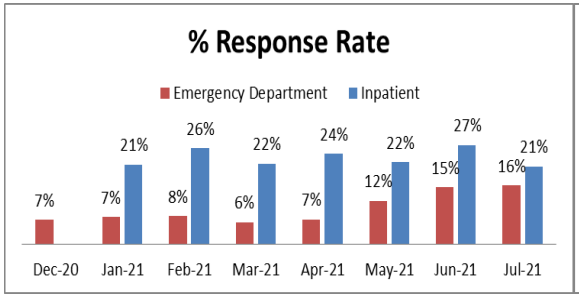
Risks to delivery and mitigations

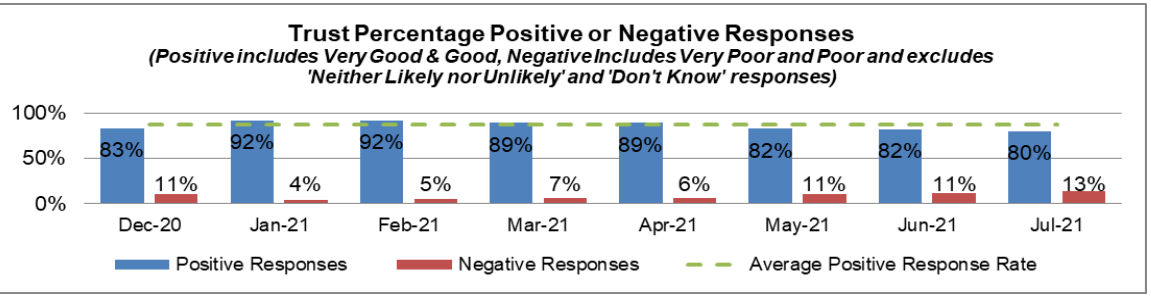
The contract for Datix complaints management system is progressing with a “go live” date of 1st October 2021.A risk to tracking of responses has been identified and a solution is being agreed.

2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?





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

For July, 80.18% of the Friends and Family Test responses were positive, (previous month 81.94%). This is based on the % of responses rated as 'very good' and 'good'.

This was achieved by:

	Number of Text sent	Number of Responses	Positive Responses
ED	5660	1173	70.08%
Inpatients	2775	715	83.22%
Day Cases	2288	664	95.03%

(correct as of 4h August)

- The recommendation score for Emergency Department has remained stable at 69.99% in and 70.08% in July.
- Day case recommendation score has dropped slightly, 95.03% in July, previous month 95.32%.
- Inpatient recommendation score has decreased from 89.13% to 83.22% for July.

Response rates and reports for July are not yet available.

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

Overall Positive themes for July :

- **Staff Attitude 1074** comments (previous month 1424).
- **Implementation of Care 733** comments (previous month 911).
- **The Environment 564** comments (previous month 684).

Overall Negative themes for July:

- **Staff attitude 262** comments (previous month 280).
- **Waiting Time 230** comments (previous month 247) .
- **The Environment** 226 comments (previous month 233).

The following work will be carried out throughout August:

- Business cards and posters will continue to be rolled out to all areas for the promotion of real time feedback.
- Detailed analysis will be shared with service areas, negative comments will be shared and discussed for improvements to be made with Divisional teams.
- A video clip will be made available in ED and Urgent Care in the waiting areas promoting FFT and the importance of responding to the text message to allow us to act on patient feedback.
- Urgent Care will be focusing on actions from negative feedback.
- Liaising with maternity staff, promoting the completion of FFT cards and making patients aware of QR codes for online feedback.

Risks to delivery and mitigations

Text messaging for Outpatient areas has been delayed as not within current contractual funding.

Testing has taken place and a "go live" date will be agreed with the provider once funding has been agreed.

The development of text messaging is planned for Maternity Services for October.

2. Patient Safety - Perinatal Quality Surveillance Tool July 2021

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.

<table>
<tr><th>Measures</th><th>Comments</th></tr>
<tr><td>Minimum safe staffing in maternity to include Obstetric cover on delivery suite</td><td>
<table>
<tr><th>Measure</th><th>Aim / Target</th><th>May 2021</th><th>June 2021</th><th>July 2021</th></tr>
<tr><td>Midwife to birth ratio</td><td>1:29</td><td>1:28</td><td>1:27</td><td>1:30</td></tr>
<tr><td>1:1 Care</td><td>100%</td><td>98.3%</td><td>95.3%</td><td>95.56%</td></tr>
<tr><td>Consultant presence in Delivery suite (Hours per week)</td><td>60 (Hrs.)</td><td>57 (Hrs.)</td><td>57(hrs)</td><td>57 hours</td></tr>
</table>
For all cases where one to one care in labour is not achieved, care is reviewed in order to establish why this has not occurred so that themes can be identified, and quality improvement implemented. Reasons identified include women who have unexpectedly birthed before arrival to hospital or data entry errors, and identification of these factors allow for targeted education where indicated.
</td></tr>
<tr><td>Service User feedback</td><td>The Trust is working collaboratively with the Maternity Voices Partnership to review the social media platforms currently available to service users. Development of a Great Western Hospital Maternity specific Facebook page is currently being considered to improve service user engagement earlier in pregnancies or pre-conceptually, which would also provide a platform for public health information relevant to the target population.

Maternity Voices Partnership met with the Maternity and Neonatal Safety Champions in July in order to strengthen the relationship and understanding between the Trust and service user voice.

Themes in complaints responded to include delay in planned caesarean sections and women not feeling listened to during their pregnancies. Actions around these themes are in place.
Where the Trust has initiated reviews of the care provided, effective communication with families is maintained by the Risk and Governance team, in order to hear the voices of the families throughout the investigation process.</td></tr>
<tr><td>Caesarean Sections</td><td>
<table>
<tr><th></th><th>May</th><th>June</th><th>July</th><th>Comments</th></tr>
<tr><td>Combined C Section rate (percentage of babies born > 24 weeks via C Section)</td><td>38%</td><td>32%</td><td>41%</td><td>A significant increase in clinical indication for an elective caesarean birth resulted in an increased rate in July.</td></tr>
<tr><td>Elective C Section</td><td>16%</td><td>12%</td><td>19%</td><td>6 Caesarean sections were performed for maternal choice, 56 were performed for clinical indications</td></tr>
<tr><td>Emergency C Section</td><td>22%</td><td>20%</td><td>22%</td><td></td></tr>
</table>
All decisions to proceed to a C Section are made by a Consultant Obstetrician to allow for a detailed discussion between clinician and mother. Multiple national drivers continue to impact the C-section rate including the Saving Babies' Lives Care Bundle, which promotes early intervention, and maternal choice factors supported by NICE guidance.
</td></tr>
</table>

2. Patient Safety - Perinatal Quality Surveillance Tool July 2021

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	Evidence to support the Trust Ockenden action plan was submitted on the 30th June 2021. Analysis of the data submitted to support the Ockenden Action plan is awaited.
CNST 10 Maternity standards (NHSR)	CNST evidence presented to the Board and compliance declared with 8 of the 10 safety actions on 22nd July 2021. For the 2 elements where compliance was not achieved comprehensive action plans have been developed to ensure on-going compliance with the recommendations. Progression with these actions will be monitored via the Maternity Governance meeting.
Findings of review of all perinatal deaths using the real time data monitoring tool	Recommendation made for minor adjustment to the Trusts 'Bereavement Checklist' that is used to guide personalised care plans for families. Reviews continue on a monthly basis.
CQC Ratings	Overall Good in the 5 domains (2020)
Maternity Safety Support Programme	Not required as CQC ratings overall 'Good'
Coroner's Regulation 28	Nil

2. Patient Safety – Summary of Maternity Incident Investigations

Data Quality Rating:

Are We Safe?

Moderate Harm Incidents

Measure	Comments
Number of incidences graded moderate or above and actions taken	• 6 incidents graded moderate or above. Each case has been evaluated with immediate learning identified and on-going investigations where appropriate. • 5 cases raised due to unexpected term admissions to the neonatal unit. • 1 of these cases referred to HSIB- case did not meet criteria for HSIB investigation. Excellent demonstration of effective team working which will be evaluated to establish the Learning from Excellence. • Themes will be evaluated in order to identify educational needs to support immediate learning • 1 case of major obstetric haemorrhage

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

Serious Incidents (SI) Reported In Month

Case ref	Overview	Date of Incident	Case update
159572	Major Obstetric Haemorrhage. (Agreed recordable on StEIS on 4th August 2021)	**13/07/2020**	Urgent incident review undertaken with recommendations for a review of the Trust escalation process for Major Haemorrhage within maternity to ensure a maternity specific pathway is embedded in practice.

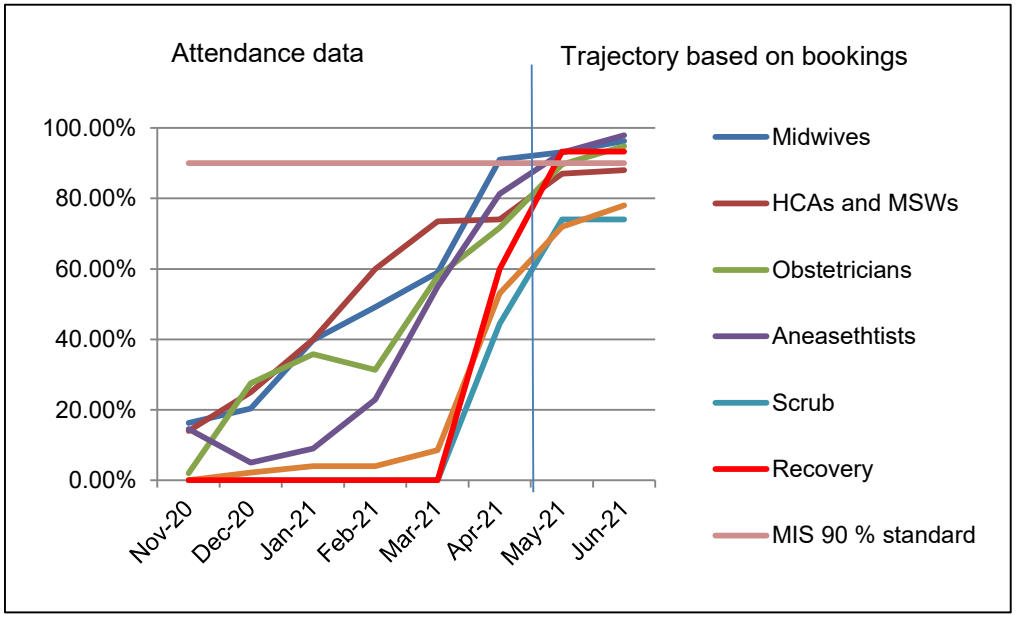
On-going SI investigation update

Stage of investigation	July 2021	June 2021	May 2021
Referred to HSIB awaiting decision	0	0	1
Under local investigation	4	5	3
Under HSIB investigation	2	2	2
Report complete awaiting Serious Incident Review Learning Group (SIRLG)	0	0	1
Submitted to CCG	1	3	5

Maternity training update and training plan

Data Quality Rating:

Are We Responsive?



This data is correct as no training has been delivered in July 2021 in order to support safe staffing levels in clinical areas.

Background and underlying issues

- Compliance in all staff groups for PROMPT training reached 90% compliance in June 2021 in line with the CNST recommendation (although this figure was not mandated in 2020/21).
- The need for a specific mandatory training day for Fetal Monitoring which includes a competency based assessment has been identified, with an action plan created for implementation.

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

- PROMPT training will revert to face to face from October 2021 with an aim to maintain 90% compliance in all staff groups.
- A specific action plan for implementation of the Fetal Monitoring Training will be monitored via Maternity Governance meetings, with an aim for 90% compliance in all staff groups by July 2022.
- CPD funding has been approved to support internal education provision by an external provider in November 2021.

Risks to delivery and mitigations

- Release of staff from the clinical area.
- PROMPT trainer availability- an in house train the trainer program will be run to ensure a multi professional faculty is available to support the re-implementation of face to face training.

Great Western Hospitals NHS Foundation Trust

Part 3: Our People

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Resources

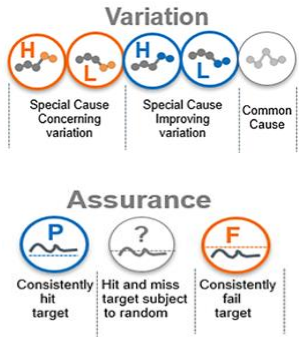
Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

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

Summary Dashboard - Workforce Performance

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Overall Agency Spend as a % of Total Spend			6.03%	6.00%	3.94%	7.38%	5.66%
2	RN Bank Fill Rates			52.0%	70.0%	36.5%	60.4%	48.5%
3	Vacancy Rate			5.99%	7.63%	5.72%	8.59%	7.16%
4	Recruitment Time To Hire (Days)			43.0	46.0	30.0	57.2	43.6
5	All Turnover			13.99%	13.00%	12.22%	13.73%	12.97%
6	Voluntary Turnover			8.60%	11.00%	8.95%	9.96%	9.45%
7	All Sickness Absence			4.50%	3.50%	3.23%	4.63%	3.93%
8	Statutory Mandatory Training Compliance			85.28%	85.00%	84.18%	88.83%	86.51%
9	Appraisal Compliance			75.67%	85.00%	71.63%	82.36%	76.99%



Trust Overview: Narrative

Great Western Hospitals NHS Foundation Trust

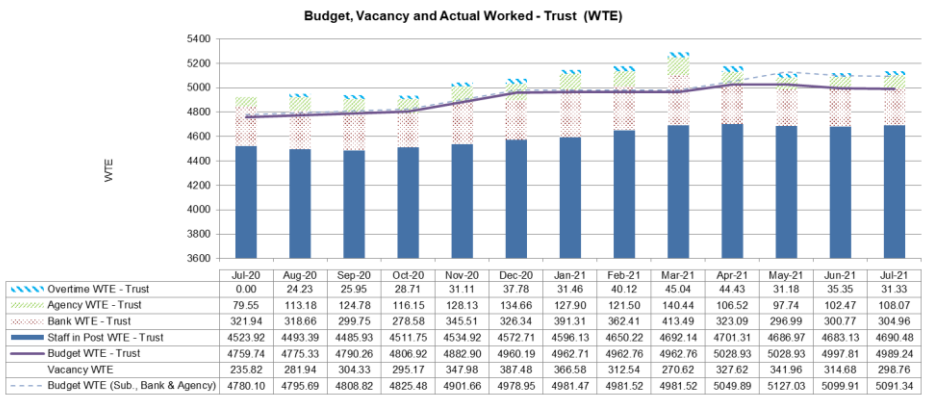
"Great" Scoring	Indicator Score (1-4)	Self Assessment Score	Headline
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding			
Great Workforce Planning	2	2	In M4 the Trust achieved a small improvement in the vacancy position, which reduced to 5.99% and falls well inside the 7.63% target. The Nursing vacancy rate (band 5) experienced the most improvement in month which despite the recent uplift in funded establishment, only 8.48WTE vacancies when pre registered staff are included (excluding COVID vaccine, midwifes and Corporate) and 50.08 excluding pre registered staff. A noticeable £116k reduction in agency spend was achieved in M4 compared to the previous month, though despite this improvement 6.03% of the Trust's total pay bill was spent on agency, which falls just outside the 6% KPI target. Where agency resource is utilised, it is done so on a controlled basis in services including Primary Care, Community Nursing, Urgent Treatment Centre, Imaging, ED and Acute Medicine, whilst consistently improving roster based controls are resulting in a sustained improvement in nurse agency expenditure.
Great Opportunities	2	3	In M4 the Trust vacancy position decreased to 5.99%% (298.76 WTE). The voluntary turnover reliably achieving below the 11% target, however there has been small increases over the last 3 months. The recruitment Time to Hire (TTH) metric increased slightly to 43 days from vacancy advertised to contract of employment but remains within the Trust TTH target of 46 days. A Recruitment & Retention plan (RRP) has been approved for Maternity Services; with a RRP being developed for the imaging department to focus on recruitment of Radiographers.
Great Experience	1	3	Sickness reported in June 2021 was 4.50% which is above the Trust target of 3.5%. OH have been leading on the test and trace risk assessments since the end of July, supporting employees to safely return to work. Referrals for counselling / psychology support have been increasing, and individuals are being offered support within a timely manner. The uptake of proactive in-reach psychological support within teams is improving, embedding preventative health and wellbeing (HWB) mechanisms. The continued increase in Mental Health First Aid training is also supporting the HWB agenda..
Great Employee Development	2	3	The Trust submitted its bid for HEE funding for nurses, midwives and AHPs and this has now been approved by the HEE Panel. Spend against this budget is carefully monitored to ensure maximum impact. Mandatory training compliance rate is now 85.28%. The newly established mandatory training review group will assess all requests for training to be made mandatory and review the list of existing modules. The task and finish group to improve compliance in relation to Children's Safeguarding Level 3 in ED will meet on 6 August.
Great Leadership	2	3	The Trust is now reviewing the developing leadership competences/behaviours for leaders within the ICS and the requirements of the KPMG Improving Together model to assess whether there is an appetite for an acute alliance/system wide leadership framework. The Trust has made significant progress in talent management and completed a number of succession plans. This will inform both development of individuals and managing any risks identified by the exercise. Appraisal rates are 75.67%.

Workforce

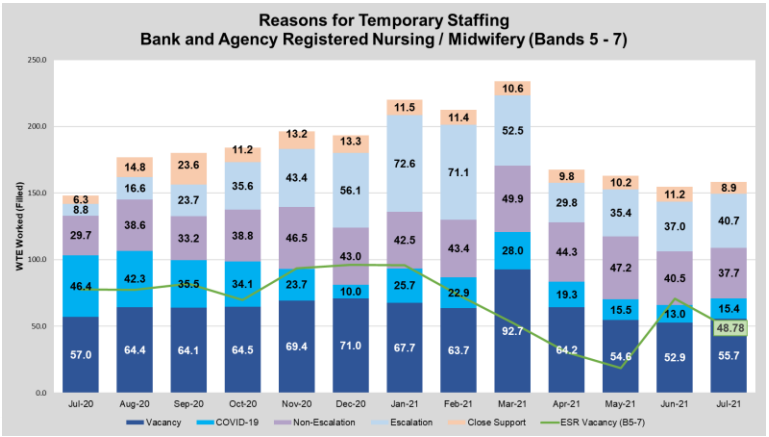
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
2	2



	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Overtime WTE - Trust	0.00	24.23	25.95	28.71	31.11	37.78	31.46	40.12	45.04	44.43	31.18	35.35	31.33
Agency WTE - Trust	79.55	113.18	124.78	116.15	128.13	134.66	127.90	121.50	140.44	106.52	97.74	102.47	108.07
Bank WTE - Trust	321.94	318.66	299.75	278.58	345.51	326.34	391.31	362.41	413.49	323.09	296.99	300.77	304.96
Staff in Post WTE - Trust	4523.92	4493.39	4485.93	4511.75	4534.92	4572.71	4596.13	4650.22	4692.14	4701.31	4686.97	4683.13	4690.48
Budget WTE - Trust	4759.74	4775.33	4790.26	4806.92	4882.90	4960.19	4962.71	4962.76	4962.76	5028.93	5028.93	4997.81	4989.24
Vacancy WTE	235.82	281.94	304.33	295.17	347.98	387.48	366.58	312.54	270.62	327.62	341.96	314.68	298.76
Budget WTE (Sub., Bank & Agency)	4780.10	4795.69	4808.82	4825.48	4901.66	4978.95	4981.47	4981.52	4981.52	5049.89	5127.03	5099.91	5091.34



Background

The Trust utilised 5134WTE staff to deliver its services in July '21, an increase of 13WTE on the previous month and 145 WTE in excess of substantive budgeted WTE. July saw a marginal reduction in the amount of overtime worked, offset against +10WTE bank & agency utilised in July compared to June. Since April '21 there has been a noticeable reduction in bank & agency registered nursing usage and although this crept up very slightly in July, the positive overall trend continues.

July saw a small adjustment to the Trust budgeted WTE, which reduced by 8WTE in month.

Temporary staffing fill continues to exceed the Trust vacancy position for nursing (registered nurse/midwifes band 5 – 7) the main contributing factors are Community Nursing continues to be the highest, spend due to the on-going approval to secure up to an additional 20 registered nurses per day, with funding for this agreed until the end September 2021.

Temporary resource utilisation across medical workforce is most prevalent in ED, General Medicine and Primary Care, predominantly due to vacancy cover, escalation and in some instances the impact of track and trace. Meanwhile the requirement for Consultant level cover in Acute Medicine specialties including Diabetes, Respiratory, Cardiology and Geriatrics, remains on-going and is largely due to vacancy cover in hard to recruit specialties.

Improvement actions

1. Urgent Care in the community is set to be strengthened through the introduction of a two hour Urgent Community Response service. This service will involve integrated working with Swindon Borough Council and First City Nursing. Commissioner funding has now been secured and a recruitment campaign for 16 WTE multi-professional staff will commence in August.
2. The approval process for medical workforce agency requests in Unscheduled Care and SWC has been strengthened, through the introduction of a reconciliation process led by the Finance BP.
3. The digitisation of patient records is on track and set to conclude by September '21, resulting in increased efficiency equating to a 7WTE reduction in staffing requirement in Health Records. Re-deployment is being secured for displaced individuals on a supernumerary basis until March '22.
4. GWH access to 30 AWP band 3 enhanced HCA support will take effect in early September and will minimise the occasions in which high-cost mental health support is required. The implementation of an enhanced care risk assessment will support this further, with this tool enabling ward areas to distinguish between the need for enhanced care and close support.

Risks to Performance & Mitigations

UTC and ED attendances currently outstretch the workforce model. A Betjemin Centre proposal to alleviate front door queuing has been approved, though if enacted will require +2WTE RGN & +2WTE HCA additional capacity.

Increased UTC attendances create demand for support services such as Imaging, who currently face supply and retention challenges. Five long term agency bookings have been authorised pending successful substantive recruitment, whilst an SBAR for the re-introduction of an RRP is under development.

The maternity workforce is heavily disrupted at present due to high levels of maternity and sickness, incidentally, occurring alongside the phased implementation of Continuity of Carer. Incentive payments have been introduced as a mitigating action for 3 months, pending a review of roster efficiency.

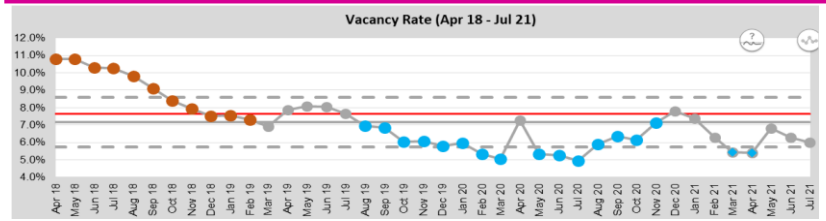
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

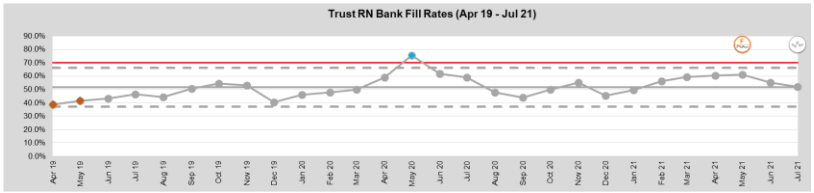
Workforce

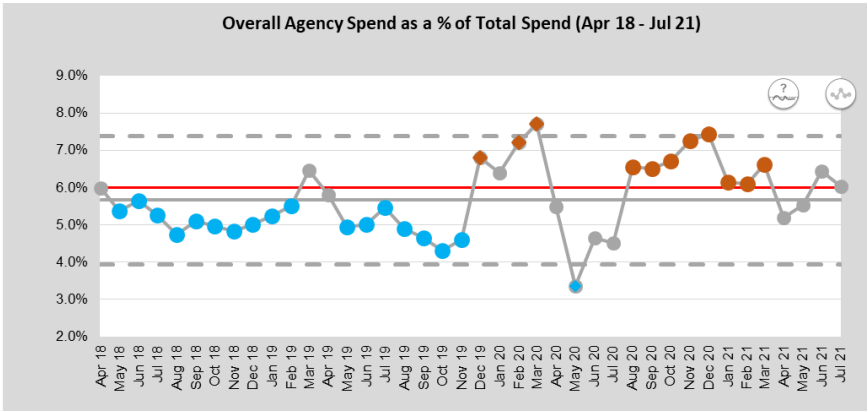
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
2	2







Background

The Trust vacancy rate improved marginally to 5.99% compared to 6.30% in June. This improvement is in part due to the impact of recruitment and partly due to a reduction in budgeted WTE.

The vacancy rate equates to 300WTE vacant posts, with 111WTE of these belonging to the Nursing staff group, 59WTE Allied Health Professional & Scientific, 37WTE Medical & Dental and 91WTE Senior Manager & Admin.

The Nursing vacancy rate experienced an improvement in both registered and un-registered vacancy rates in July, with successful recruitment contributing to an overall increase of 11WTE in month.

There are 111WTE vacant all nursing posts, 47WTE vacant posts exist across band 2-4 and 48.78WTE vacant posts are evident at band 5-7, with the main gaps being 29WTE band 2 and 50.08wte band 5 (excluding pre registered nurses). The data includes COVID vaccine vacancy and Corporate Nursing.

Registered Nursing bank fill rates decreased in July to 52% which is a step back from June (55.1%), with fill rates typically affected during the summer holiday period. .

Agency spend as a proportion of total pay in July was 6.03%, which represents an improvement on June (6.25%) and an in month reduction of £116k. The vast majority of agency spend was driven by Medical Workforce at £773k (vs £898k last month) and Nursing at £384k (vs. £406k last month), though both achieved an in month reduction in spend compared to the previous month.

Improvement actions

1. A targeted bank recruitment campaign for Community Nursing aimed specifically at workers that wish to work on a casual (bank) basis only, took place in July and yielded a number of registered nursing recruits at various bands.

2. A quarterly review has been established between the Temporary Staffing Team and Liaison to review how direct engagement for Medical Staffing is being utilised. An increase in locums booked via direct engagement will increase the cost saving to the Trust through the avoidance of VAT payments.

3. Urgent Treatment Centre continued usage of agency workers to support with service demands. The department has been temporarily closed at night in July to support with safety due to lack of staffing which will continue until September 2021. Staff have been moved to day shifts or temporarily redeployed to the Emergency Department during this period.

4. The impact of Covid Test and Trace has had a significant impact on all areas across the Trust resulting in last minute request for bank and agency. The Trust Risk Assessment process is now established and supporting with reducing the self-isolation timescales where safe to do so.

Risk to performance and mitigations

The availability of temporary staffing resource across both bank and agency is limited dependent on speciality and demand, particularly Allied Health and Scientific professions. Bank recruitment campaigns remain ongoing and have lately been focussed on priority areas such as community nursing.

With agency fill rates through PSL suppliers lower than when sourced through ID Medical in some specialist areas, there is a risk that unfilled shifts will be supplied at premium rate by Thornbury and thus drive cost.

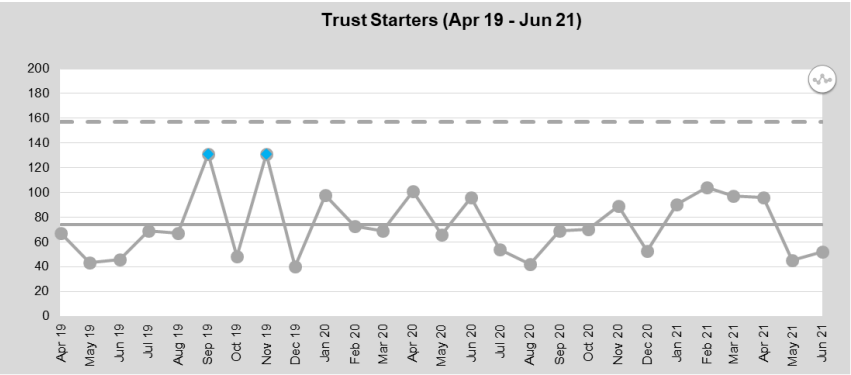
Medical workforce changeover in August has the potential to affect workforce availability and as a result potentially create a need to access temporary staff. The accrual of untaken annual leave and a reduced willingness amongst rotating junior doctors to accept additional shifts, have historically appeared as factors within August changeover.

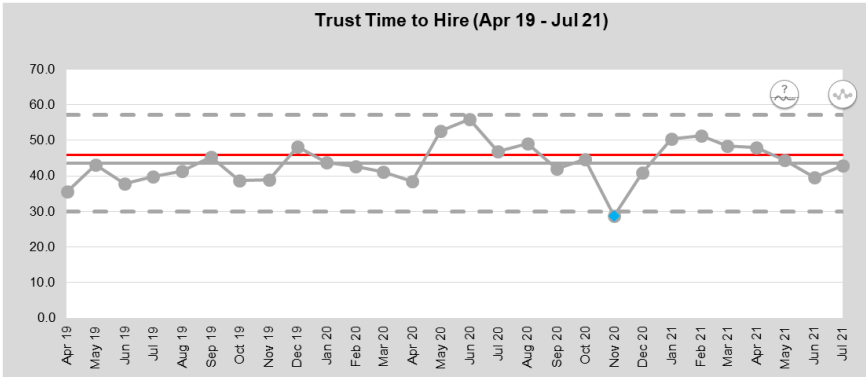
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	3





Background

The number of Trust new starters for July is confirmed as 56 headcount; this falls below the Trust average of 75 however this continues to follow the annual trend of a decrease in new starters from April to July period.

The Trust has a provisional 111 candidates due to commence employment in August; which includes 13 international Nurses and 3 international Radiographers.

The recruitment time to hire in July increased from June's TTH data slightly to 43 days, which as shown on the SPC chart, remains below the Trust target of 46 days and drives the self assessment score of 3.

Improvement actions

1. Surgery, Women's and Children's division have developed a Recruitment & Retention Plan (RRP) for maternity services which includes a social media recruitment campaign, international recruitment, refer a friend scheme, relocation package and on-boarding package for new recruits. The RRP has been endorsed by the Execs on 27th July 2021 and is live with immediate effect to attract midwife application. The social media recruitment campaign due to be launched in the Autumn 2021 includes 'A Day in the Life' video and the introduction of 'keeping in touch days' for newly qualified midwives.

2. Medical recruitment for Surgery, Women & Children's activity continues to be an area of focus for the improvement working group who have identified key priority areas as Anaesthetics and ITU. The working group are reviewing adverts, job descriptions and working with the Comms team to develop effective advertisement.

3. Further to the success of the recent Community nursing recruitment campaign and recruitment of 18 substantive nurses, the Division have launched a centralised bank recruitment campaign tailored for community clinicians with the opportunity for shadowing and informal visits across all departments. Initial application is encouraging, and it is anticipated that the successful recruitment of the substantive and bank workers should positively impact on Agency spend by year end, when newly recruited staff have achieved their competencies.

4. The advert for the substantive Theatre Head of Service is live until 19th August and subject to application, interview date is planned for early September. The Temporary Staffing Team are seeking alternative suitable support from the interim market.

5. Recruitment continue to support the redeployment of Health Records staff affected by the digitilisation change management programme, holding and promoting suitable vacancies for the 7 WTE B2/3 members of staff in the redeployment pool. The project and redeployment programme is on track for conclusion by September 2021.

Risk to performance and mitigations

We continue our areas of focus for the Time to Hire KPI's outlined below;

- Recruiting manager completing shortlisting within 3 days achieving 59%; which is an improvement on the previous months data. (47%)
- Recruiting manager confirming interview date and selection criteria within 5 days achieving 66%; which is also an improvement on the previous months data. (56%)

Recruitment team continue to work with HR business partners and provide training or support to recruiting managers.

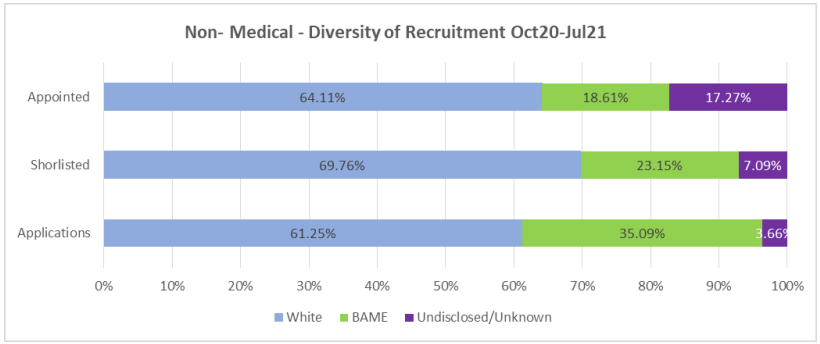
Resource in Theatres continues to be a risk with the late withdrawal of an Interim Theatre Head of Service, due to start in August and the vacant Matron role. The relevant teams of the HR department are working closely with the Division to support with mitigation for this risk.

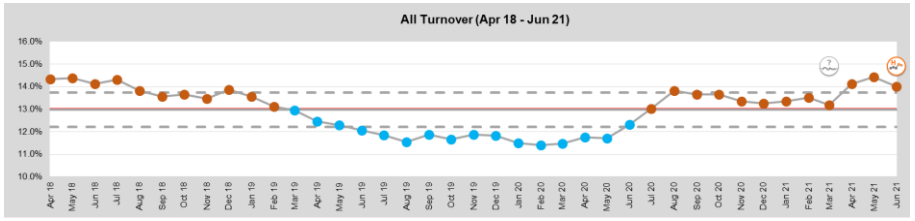
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

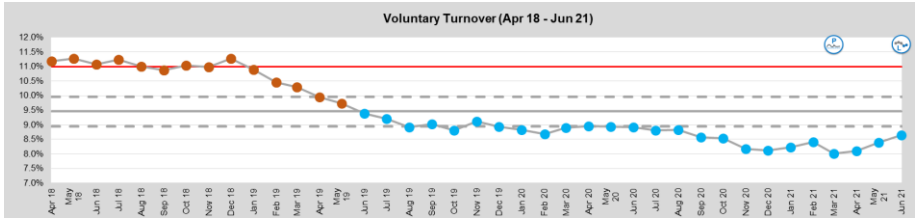
Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	3







Background

For non-medical recruitment within the period October 2020 – July 2021, our EDI data:

- 23.15% of applicants shortlisted were BAME
- 18.61% of staff who were appointed were BAME
- 7.09% of shortlisted applicants were other/undisclosed and this group represented 17.27% of staff that were appointed.

For Medical recruitment with the period October 2020 – July 2021, our EDI data:

- 32.46% of applicants shortlisted were BAME
- 16.67% of staff who were appointed were BAME
- 14.66% of shortlisted applicants were other/undisclosed and this group represented 25% of staff that were appointed

Performance for all turnover has remained above target at (13.99%), a deep dive was conduct last month.

Voluntary turnover is 8.64% so up slightly from last month (8.39%) but still well below the 11% target. Turnover will be monitored closely over the coming months in post pandemic impact.

Improvement actions

1. Recruiting at risk in Urgent Treatment Centre (UTC) by 1.00 WTE (over recruited position) Band 8a Advanced Practitioner to support with turnover and due to start in October
2. The Head of Nursing post for ICC has been approved and advertised with a closing date of 26th August 2021 and will improve leadership within the community nursing teams.
3. Deputy Chief Nurse posts have been approved and advertised. Interview scheduled for the end of August.
4. The Imaging department are developing a Recruitment and Retention Plan (RRP), exploring option of a 'Golden Hello' , international recruitment, trainee development roles and approval to recruit to turnover an additional 3WTE Radiographers (B5/6). The Imaging leadership are submitting an SBAR to continue existing RRP payments due to cease in October 2021.
5. Cancer Services have successfully appointed 2 Speciality Doctors for Oncology (1 medical and 1 clinical) also a Medical Oncology Registrar due to start in August 21
6. The I&CC Division continue to explore options around implementing international recruitment for community nurses; this is also being discussed with the BSW.
7. The Trust has attended its first face to face School careers event at Kingsdown School on 6th July to promote careers and opportunities at the Trust. The recruitment team will also be attending the following events;
   - Swindon Pride, 6th–8th August 2021
   - Adult Transitions Roadshow, 22nd September 2021
   - Student Nurses (OBU Summer 2022 Cohort) Careers Evenings, 18th-21st October 2021 (67 students expected)

Risk to performance and mitigations

UTC remains closed over night and will continue to remain closed until September 2021 due to resource.

The Imaging department is an area of concern due to high sickness and an increased number of Radiographer resignations. Emerging themes evidence resignations linked to the social impact of the pandemic such as staff relocating and seeking new careers. Impacted also by competitive recruitment initiatives offered by local Trusts, such as a 10% RRP. (Oxford)

Trusts B5 nursing vacancy position including pre-registered nurses is 8.48 WTE (excludes corporate Services and Covid Vaccination), with a pipeline of 49 WTE B5 student nurses due to join between July – October.

We are continuing to explore with the BSW and NHSE/I options to mitigate the risk of the Trust not having the vacancies to meet the additional 95 expected international nurses based on current vacancy levels and expected turnover.

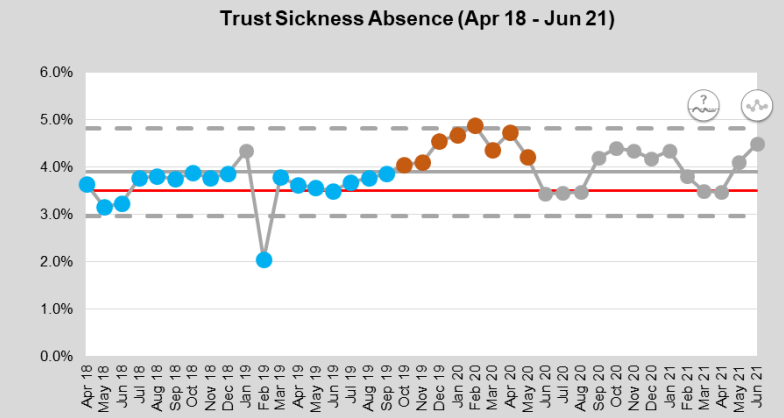
Community nursing and medical resource remains an area of focus.

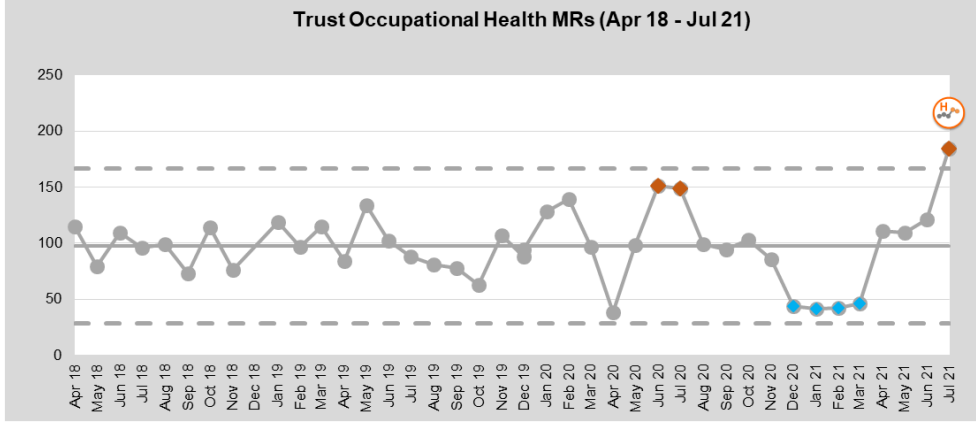
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce – Sickness Absence

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	3





Background

For June 2021, sickness absence is reported at 4.50% which is above the Trust average of 4.0% and above the Trust target of 3.5%.

OH received 88 management referrals in July.

Main reasons for referral were musculoskeletal issues, followed by mental health difficulties.

Improvement actions

1. OH have led on the test and trace risk assessment, supported Between 22nd – 4th August, this resulted in 100 staff being able to successfully return to work via the risk assessment
2. Possibility of an additional OH clinic room within a primary care venue is being pursued, which will help improve availability and accessibility of OH clinical activity
3. Face-to-face OH clinics on site in GWH are now running again (in addition to ongoing virtual clinics) following the conversion of a Commonhead office into a clinic room.
4. Recruitment for OH manager is underway – interviews to comments WC 10th August
5. Health and Wellbeing Audit is underway – outcome expected at the end of August. Learning and actions will be reviewed and incorporated in the actions within the Health and Wellbeing Oversight Committee
6. Work is underway to re-submit the funding bid for the outdoor gym (deadline is September)
7. In the EDI newsletter from now on, there will be 2 HWB sections – one on physical wellbeing, and one on psychological wellbeing
8. This month, over 100 self-care hampers were distributed to our estates staff based within Wiltshire services (e.g. Savernake, Chippenham & Warminster)
9. 25 clinical areas across GWH have now had staff rooms fully re-painted - we are awaiting additional furniture and woodland scene artwork (to be completed within the next 2 months)

Risk to performance and mitigations

Physician wait is approx. 6 weeks – an additional clinic has been planned for August in order to offer timely appointments to the recent 'urgent' referrals requiring medical input.

Availability of clinic nurse appointments has increased to 40/month. Plan to build in an additional clinic end of August to continue to bring the wait down (currently approx. 6weeks). Further improvement to waiting time should be seen in September.

Flu and COVID vaccination campaign is due to start in September. National Guidance continues to be shared and scenario planning is underway. The Trust will need to be agile with changing and new guidance, with short timescales for implementation.

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	3

Employee Recognition

Long Service Awards	3	Hidden Heroes	27
Retirement Awards	3	STAR awards	14

Diversity/Inclusivity

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

- Reciprocal Mentoring pilot. All initial meetings have taken place, pairs have received and returned their Relationship Agreements outlining their mutual expectations. A summary document will be produced in September, with participant feedback and analysis.
- Educational resource developed for staff to understand more prevalent forms of discrimination in the workplace, and colleagues have 'lent their voice' to this initiative to develop case study recordings. Three 15 minute Youtube videos have been produced, with content fully edited and available to view.
- The EDI Annual Report, WRES report (which includes Model Employer data and information on 'disparity ratios') and WDES report have been completed and reviewed, and are now available for Exec Co on 17 August.
- Differently Abled Network (DAN) now has a vice chair, and plans to review two Neurodiversity toolkits (from WSC and AWP), to raise understanding and awareness of range of conditions under this term. Toolkits are still being produced. A short awareness piece about ND has been produced for Trust Comms, and will appear in August. A DAN member is sharing her story with the Trust Board on 05 August. Her focus is on the issues faced as someone with a learning disability.
- Trust will recognise and promote Swindon Pride in August
- ICC and USC divisions committed to three EDI areas of action. Action plans developed. Discussion of staff survey results for USC delayed due to Trust's OPEL 4 status. Met with SWC division on 16 July, and discussed EDI priority areas.
- EDI Podcast pilot series being developed. Outside guest identified. EDI Lead will discuss top tips for being an Ally with outside guest.
- Produced a survey to better understand the difficulties facing staff with a BAME background when progressing in their careers, and to seek input into ways we can tackle them. Survey was distributed 28 June, and results collected on 19 July. 65 responses.
- EDI Leadership training scheduled for 27 July but postponed, due to Trust OPEL status.
- EDI Lead due to speak at Leadership Forum Event – You Cannot Be What You Cannot See. Event postponed, due to Trust OPEL 4 status.

Wellbeing Initiatives

Tea Trolley
went out Tuesday to Thursday each week during July to support the Great Care Campaign, accompanied by Senior leads for each pillar to raise awareness & answer staff questions. Drinks & snacks were given out to all areas during the month

Ice cream van & cold drinks
on 22nd July using charitable funds staff were treated to a free ice cream at GWH with a visit from the Ice cream van,. 300+ ice creams were given out, and 150 staff at the Orbital were treated to a cold drink/ice cream. This was to say thank you for their continued hard work during a time of increased pressure made even more challenging due to spell of extremely hot weather

Yoga Class Referral Sessions
an additional 2 OH clients were referred tot his scheme in July, bringing the current total to 14

Background

In July, 26 individuals self-referred for 1:1 counselling / psychology.

During the month, 73 contacts were made with individuals, including 1 TRiM assessment. Additionally, 29 contacts were made with the EAP.

The most common reasons stated for referral were:
- personal: anxiety (57%)
- work-related : overload / stress (52%)

15 in-reach sessions were conducted, including:
- pharmacy HWB awareness / promo (50 attended)
- reflective self-care group for Orbital community team (11 attended)
- mindfulness group for the community stroke team (12 attended)
- supporting the Great Care Campaign by co-leading Compassionate Conversations sessions (40 attended)

Improvement actions

1. In July, a further 15 staff members were trained in MHFA, bringing the total to 150
2. Feedback from some staff who attended this training included: 'The course was excellent. I found it really interesting & it certainly made me feel more confident with the subject of mental health' ' Instructors were brilliant…one of the best courses I have ever attended' 'Very informative & interesting. I have already told people how good it is & encouraged them to do it. I feel privileged to be part of the team'
3. 8 individuals completed the CORE-10 measure in July following completion of their counselling appts – pre/post scores reliably improved for 7 (of which 6 were 'clinically significant')
4. Feedback from an individual who completed their counselling this month said; 'I had never heard of this treatment and was quite sceptical about its ability to help. I tried to be open minded and I was completely shocked at the effect that it had. Aside from this, the sessions themselves were extremely beneficial. The therapist was absolutely excellent. She was very attentive, understanding and warm. She also treated me like a human being rather than just something she does at work. I would 100% recommend her to anyone'
5. Psychologist drop-in clinics for staff now running monthly from August in the Orbital
6. Monthly in-reach psychologist-led wellbeing group sessions now established for AMU doctors in Cherwell, community multi-disciplinary team in the Orbital, CTFs & undergrad admin team in the Academy, & the Transformation and Improvement Team
7. Teaching sessions on HWB Conversations will be available to all from start of August
8. Psychologist-led supervision group to the FTSU Guardians scheduled each month from August

Risk to performance and mitigations

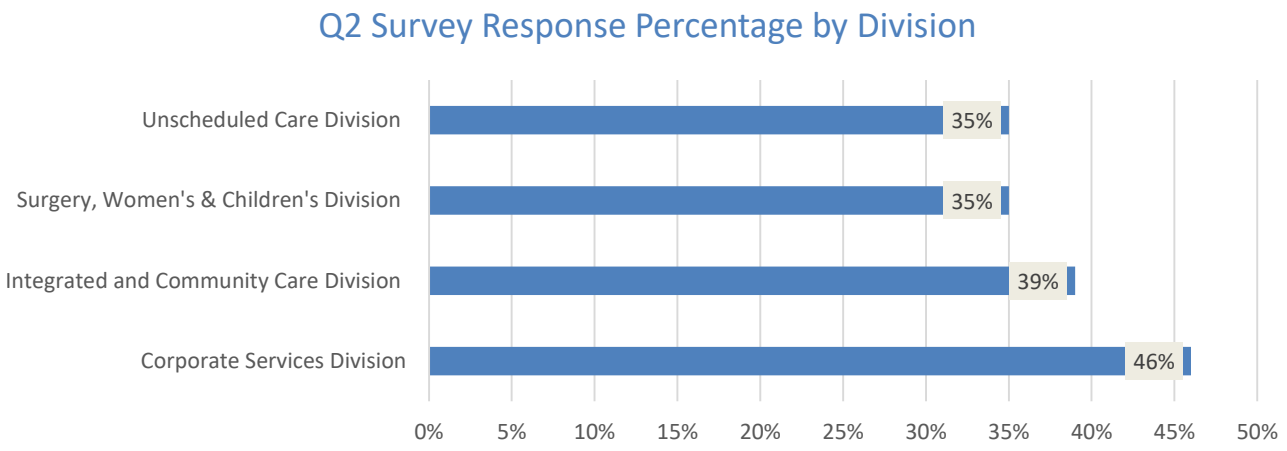
The first Suicide First Aid training session was planned for July, with a full cohort of 20 booked on. Unfortunately, this had to get cancelled on the day due to IT issues with the e-training materials needed – this is being rectified, so that it can get rolled out successfully each month from August

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

Workforce - Staff Engagement

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	3



Invitations Sent 5,295
Surveys Completed 1,964

Response Rate

37 %

Background

NHS England and NHSI have introduced a new Quarterly Pulse Staff Survey which was launched on the 5th July 2021. This is to ensure that every member of staff has a voice as outlined in the NHS People Promise. The Quarterly Pulse Staff Survey will be run each year in Q1, Q2 and Q4 with the National Annual Staff Survey continuing to take place in Q3.

Improvement actions

1. The response rate results for the Q2 Quarterly Pulse Staff Survey have been received and the Trust achieved a 37% response rate. Picker, the external company who coordinate the survey for the Trust report that the average response rate for other NHS Trusts that they coordinate is 21% and as such the GWH response rate is encouraging.
2. Results will be analysed this month by Division and Trust wide and next steps will be provided next month.
3. The 9 staff engagement questions seek staff feedback about motivation, ability to make improvements and suggestions and whether they would recommend the Trust as place for care and work. The results for the 9 staff experience questions will be received during August and reported next month. This will include the results for the two additional questions that were asked
    1. What does engagement mean to you
    2. How would you like to be engaged in what is happening at the Trust
4. Preparation is underway for the annual staff survey – feedback has indicated that a number of the questions will be changed this year to reflect the NHS People Plan.
5. In September a review and progress against actions plans will be completed Trust wide and by Division.

Risk to performance and mitigations

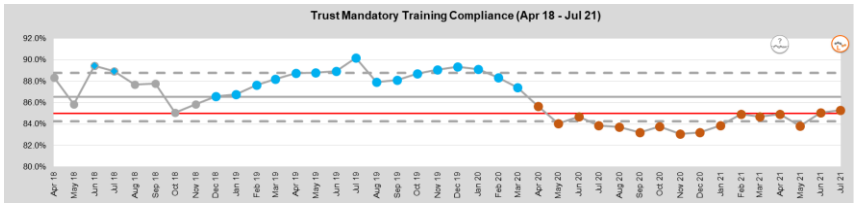
Staff Surveys are in place to ensure that Staff have a voice as detailed in the NHS People Promise which enables them to share positive and negative feedback for improvement and learning.

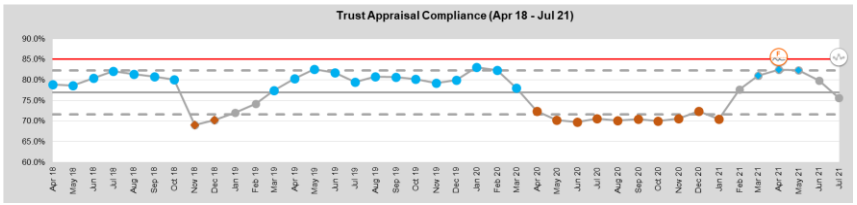
Actions and improvements will need to be visible and experienced by staff to sustain confidence in the survey and sustain high participation.

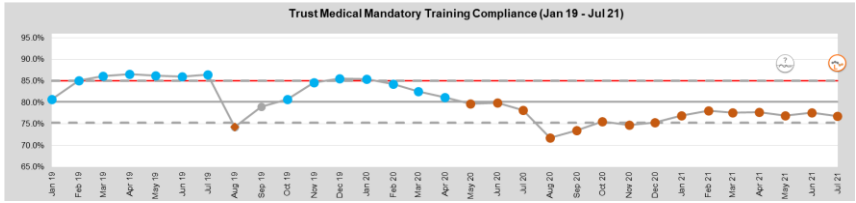
Workforce

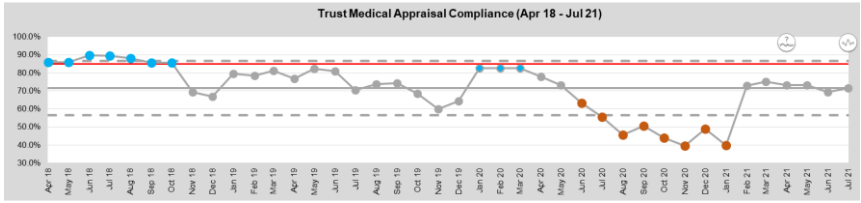
Use of Resources

Great Employee Development	Indicator Score	Self Assessment Score
	2	3









Background

Trust mandatory training compliance performance is now above the KPI of 85%-and is 85.28%.

Trust appraisal compliance is reported at 75.67% in July, decreasing by more than 3% over the month.
(the June figure was 79.82%).

This reduction in appraisal rates may be partially due to the site pressures experienced in July and the cancellation of non urgent activity. The HRBPs will continue to monitor this and support Divisions to increase their compliance.

Improvement actions

1. The new Head of Learning and Development (L and D) took up post on the 19 July 2021. She received a thorough handover from the Interim Head of Learning and Development.

2. The first meeting of the Task and Finish Group to address the level of compliance with Safeguarding Children –Level 3 within ED will take place on the 6 August (delayed due to annual leave of key group members) This work will be completed by the 31 October 2021, but this timescale is being reviewed to identify whether additional bank support could bring this date forward to the end of September 2021.

3. The Trust has established a Mandatory Training Review Group with medical, nursing, operations and HR staff. This group will review any requests for training to become mandatory and also the current list of modules. The first meeting was on the 21 July t to review a request for Respect Training to be mandatory.(The Respect process replaces the current DNR approach)

4. The Trust has reviewed the Southampton approach to refresher mandatory training and the new Head of L and D will be responsible for assessing how this could be introduced.

Risk to performance and mitigations

Capacity continues to be a challenge for some courses due to the requirements of social distancing. Room audit underway to minimise waste.

In response to the current site pressures non-essential training has been cancelled throughout August. This will have an impact on compliance, however critical courses, such as NLS,ALS will continue.

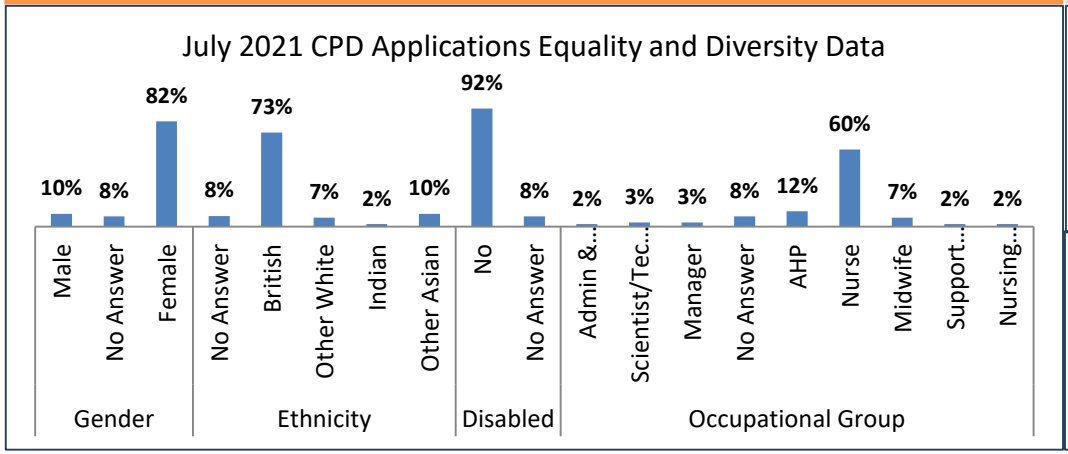
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

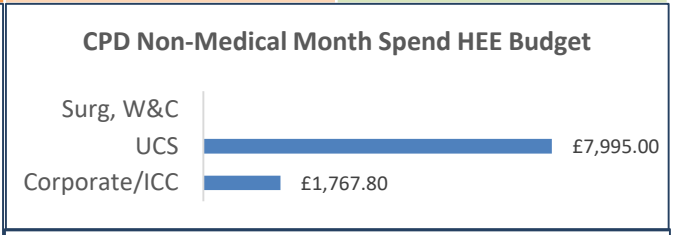
Workforce

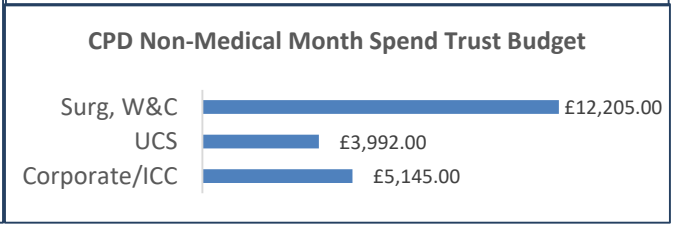
Use of Resources

Great Employee Development

Indicator Score	Self Assessment Score
2	3







Background

Trust CPD budget

The spend to date is £44,736 The annual budget is £240,000, so at the end of Q2 we would hope to achieve a spend of around £120,000 if the spend is evenly profiled across the year. This position is being closely monitored and will be reviewed by the Head of Learning and Development to ensure these monies are fully utilized.

The committed /spent money to date against the HEE budget of £632,000 is £292,227. However, the vast majority of the proposed spend (£630k) has been identified.

Improvement actions

1. The Interim Head of Learning and Development worked to improve resilience within the team in terms of cover for specific tasks-eg CPD reporting. She also developed a systematic process to capture the clinical skills of team members to support occasions when Academy staff need to be redeployed to support clinical activity.

2. The HEE CPD funding bid for nurses, midwives and AHPs for 2021/2 was submitted early to ensure that there was sufficient time for queries to be raised with the Interim Head of Learning and Development. The bid has now been assessed by the HEE panel and approved. However, that unlike last year this funding cannot be used to support Fixed Term contracts.

3. The substantive Head of Learning and Development will be working with the Associate Director of OD and Learning over the coming weeks to engage with key stakeholders to develop a new vision and strategy for the Academy. This will complement and support the development of the BSW Academy.

Risk to performance and mitigations

The transition from the Interim Head of Learning and Development and the substantive recruit was managed successfully.

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

Workforce

Use of Resources

Great Leadership		Indicator Score	Self Assessment Score
		2	2
Leadership Roles at the Trust	4.27% of staff	Equating to 173.33 WTE	
Leadership Development Programme *(cohort 1)*	22 leaders	Undergoing Training	
Leadership Development Programme *(cohort 2)*	17 leaders	Undergoing Training	
Aspiring Leaders *(cohort 1)*	21 aspiring leaders	Undergoing Training	
Leadership Forum Members	300 managers	Members Engaged	
Latest Leadership Forum *(27 May)*	52 managers	Actively Attending	
Ward Accreditation	24 of 24 departments	using the Perfect Ward App	

Background

Whilst the feedback to date on the Aspiring Leaders has been positive, the format of delivery has been evaluated and will be changed for cohort 2 with pre-recorded knowledge sessions to allow more time for group interactions and application of knowledge to practice.

Both Leadership Development Programmes (bands 8a/7) have had to have a session postponed recently due to the cancellation of non-essential training in August in response to site pressures. These sessions will be rescheduled which will extend the duration of the programmes beyond the expected completion date. Unfortunately, two Belbin sessions with the Pharmacy team also had to be postponed.

The Leadership Team is now able to offer team development days. Feedback from the first away day with wheelchair services was very positive and an action plan has been produced.

The NHS Leadership Academy have reopened their leadership programmes with a virtual offer in the majority of cases.. These opportunities will form part of the leadership offer and can be funded via the Trust's CPD monies, or HEE monies.

Improvement actions

1. The Trust has been developing its thinking around leadership at a system level. There is now a 'Leadership Compact' which has been developed nationally. There is an expectation that this compact will be adopted at ICS level. The Associate Director of OD and Learning is working on how this could be incorporated into the Trust's leadership framework , encapsulate the KPMG leadership behaviours and the work undertaken by the South West Leadership Academy in defining the success profile for Executive Directors. This work could be the basis of an acute alliance/system wide leadership framework.-and associated leadership development offer. Discussion is ongoing about the feasibility of this approach.
2. There has been a formal review of the talent management process and the learning from it with the Executive team. The succession plans for Executive Directors, senior corporate staff and Divisional Directors have been RAG rated and an initial flight risk assessment has been made. This plan will be regularly reviewed, and individual Directors will ensure that the development activities identified for individuals are progressed. Phase 3 of the talent management process will begin in the Autumn.
3. The existing development triangles will be evaluated and where appropriate aligned to a multi pathway career route , proving greater clarity on the different options available to enter a leadership role.
4. The Trust will begin work on an internal management & leadership programme for new consultants, working closing with the new Medical Director once in post.
5. To increase the breath of development opportunities for individuals the Trust is supporting a High Potential Trait Indicator leadership assessment through Thomas International. A member of the Leadership Team is to undertake the required accreditation training and will be able to offer this service from September 2021.

Risk to performance and mitigations

There is a risk that the demand for team development interventions exceeds capacity, but this is being carefully monitored.

The review of the timing of the Leadership Forum has been completed. This data is being analysed, but no consistent view has emerged about the optimum time for the Forum.

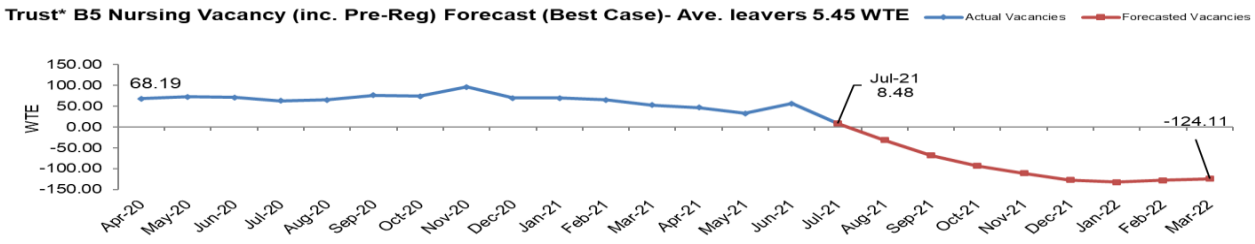
RUH has not yet confirmed it has the capacity to lead the BSW Acute Alliance Clinical Lead Development programme. If this is not possible SFT may be able to do so.

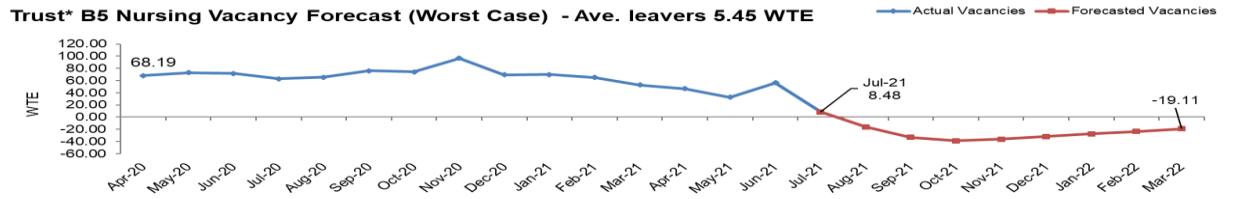
The July Leadership Forum had to be cancelled due to the significant site pressure on that date. The session will now take place in September.

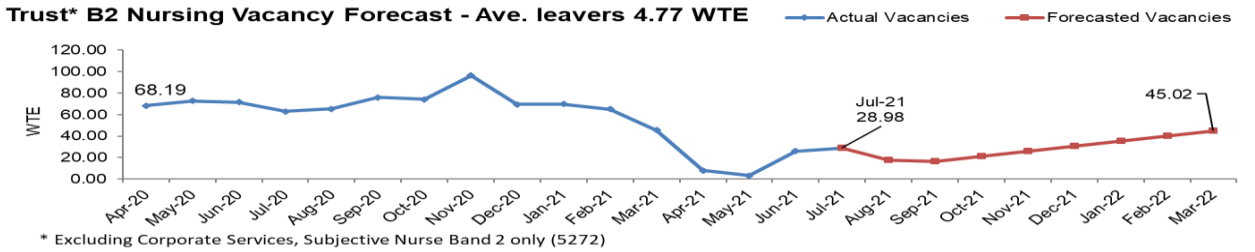
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Exception 1 of 2: Recruitment Trajectory

Exception Report







* Excluding Corporate Services, Subjective Nurse Band 2 only (5272)

Assumptions:

- 100% conversion of Internationally Recruited Nurses (Best Case Scenario)
- 0% start rate for Internationally recruited nurses (Worst Case Scenario) (95 nurses)
- Similar dispersion of internationally recruited nurses across the divisions until year end (25% to IC, remainder evenly across SC and UC)
- Current Budget WTE unchanging until year end
- Recruitment to Subjective Code 5269 (Nurse Band 5) and 5272 (Nurse Band 2) only
- Turnover (Leavers) will be the same/similar as the previous 12 months.

Background

In M4 the Trust B5 Nurse vacancy position including pre-registered nurses is 8.48 WTE (excludes corporate Services and COVID Vaccination).

There are 49 WTE B5 student nurses due to join the Trust (16 have started and 33 due to start before the end of September).

In M4 the Trust B2 Nurse vacancy position is 28.98 WTE.

Improvement actions

1. To ensure the B2 Healthcare Support Worker vacancy position remains stable, the Trust has submitted on 22nd July 2021, an expression of interest to NHSEI for continued funding to support the HCSW Programme into 2021/22; including funding for Trainee Nursing Associate (TNA) roles.

2. Following the lifting of the international travel from India in June 2021; the Trust increased its monthly intake number of Nurses to make up for the decreased number of Nurse arrivals from April 2021 – June 2022. Thus ensuring the Trust is able to meet the required funded numbers through the NHSI/E Strand B/B+ bids.

Risk to performance and mitigations

Overseas nurses entering or travelling from a red list country require hotel quarantine costing £1,750. From April NHSI will reimburse £1,000 per nurse and Trust are required to pay the remaining £750 per nurse. This currently only applies until 30th September 2021 and is under review by NHSI. This continues to be an additional cost pressure due to international nurses predominately arriving from red list countries. We are working with our agencies to source Nurses from non red list countries in a bid to reduce the overall cost pressure.

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

Exception 2 of 2: Medical Consultant Recruitment Update

Exception Report

Overview

In June 21 the Consultant vacancy gap across the Trust was 36.08 WTE (excluding Corporate), with an incurred locum spend of £318,339 (based on Consultant locums with a booking reason of covering a vacancy). The high vacancy gap has been driven due to hard to recruit roles, newly approved roles with additional funding, flexible working requests and retirements (full and retire/return, note an increase in retirements was driven by national pension taxation issues).

	Jun-21			
Division	Budgeted FTE	Contracted FTE	Vacancy FTE	Pipeline FTE
ICC	27.55	19.83	7.72	N/A
SWC	119.52	113.81	5.71	4.8
USC	114.74	91.37	23.37	4
TOTAL	261.81	225.01	36.8	8.8

Recruitment Governance Process

The governance process for recruitment falls into three categories;

- Replacement: there are no changes and the role is replacing someone who has left, the department/division are able to make a local decision to advertise.
- New (with funding received): funding has been received to create a new or additional WTE role. Medical Staffing Group to review and confirm approval to advertise.
- New (requiring funding): a business case required for funding, on receipt of funding Medical Staffing Group to review and confirm approval to advertise.

Following funding and divisional approval the recruitment process is undertaken in the following order;

1. Royal College Approval of job descriptions,
2. Advertisement for a minimum of 4 weeks and included in two journals,
3. Shortlisting – participants include Medical Director (or deputy), AMD for the division, Clinical Lead or local consultant and a member of the Resourcing team,
4. Interviews – the panel included Lay Chair, CEO, MD, AMD, Local Consultant, External/Royal College rep and HR (note, only the AMD is additional to the roles specified in the national AAC guidance),
5. Appointment and recruitment checks process is commenced.

Note: candidates are often required to work a 3 months' notice period and many wish to complete fellowships or training schemes, this impacts the timeline for Consultant recruitment from between 3-18 months from offer to starting in post.

Locum Governance Process

All consultant level agency requests must go via Locum RAP, a weekly meeting with the Deputy Director of Finance and Deputy Medical Director is held to review requests with views of both Clinical and Financial implications considered prior to approving. In addition to all Consultant level requests, long term requests for more junior levels is also processed through Locum RAP. All forms submitted for review must be signed off by divisional management and Finance Business Partners.

In accordance with policy for Junior Doctors if a rota gap is out of hours, due to a vacancy or sickness an automatic fill is sourced with no authorisation required. For any additional cover outside of this full authorisation by the division is required.

Unscheduled Care Division

USC Consultant vacancy gap in M3 was 23.37 WTE, of this 4 WTE candidates are in the recruitment pipeline and is recorded on the risk register with a score of 9 (Risk No 2053). The risk is currently being mitigated by the employment of locum doctors and substantive staff taking on additional Direct Clinical Care (DCC) work. Further to the Trust wide governance the division's senior team attends a reoccurring monthly meeting with HR/Finance to review resourcing, validate requirements and monitor the financial risk.

The gaps at junior doctor level also driving the need for locums are due to vacancy, sickness and trainees who require additional support across a number of areas within the division, active recruitment continues and three candidates are under offer awaiting to start.

The division has prioritised three areas of initial focus;
DOME, 3.3 WTE vacancy gap in M3, due to increase in retirement and long standing issues with senior level recruitment. DOME has key involvement with the General Medicine on call rota and significantly contributes to ward based care within the trust.
Respiratory, 2.61 WTE vacancy gap in M3, there has been recent success in appointing a candidate to fill one of the vacancies, however, other vacancies remain. Respiratory has key involvement with the General Medicine on call rota and significantly contributes to ward based care within the trust.
Acute Medicine, 4.27 WTE vacancy gap in M3, the establishment was increased a number of years ago, by the then Chief Exec due to minimal staffing levels to cover a growth in service cover to 8pm weekdays. There has been long standing historical issues recruiting staff, despite some success with 1.2 WTE due to start in July 2021 (which has now been delayed due to relocation issues for the candidate), vacancies remain. This department has key involvement with the General Medicine rota and is pivotal in flow through the Trust.

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

Exception 2 of 2: Medical Consultant Recruitment Update

Exception Report

Surgery, Women's and Children Division

The divisions Consultant vacancy gap in M3 was 5.71 WTE of this, 4.8 WTE candidates in the recruitment pipeline. The vacancy gap is currently being mitigated through the use of locums, regular use of WLIs and fixed term contracts. Further to the Trust wide governance the division will be implementing from August monthly resourcing reviews with attendance from AMD, DD, Finance and HR.

The division has prioritised the following areas for initial focus;
Urology, 0.45 WTE vacancy gap in M3, there have been long standing vacancy gaps and the department are reviewing plans with a possible business case to change the way they work, moving towards an enhanced rota (scoping as part of long term plans). *Note: the Urology department sits within the General Surgery Budget (J65329) which does affect the vacancy representation.*
Anaesthetics, 0.23 WTE vacancy gap in M3, the cost centre covers two separate areas Anaesthetics and ICU and are exploring routes to increase WTE funding. There have been long standing recruitment difficulties for this department leading to resourcing pressures, these are worsened by reduced capacity on the on call rotas. Currently an external team Kingsgate are reviewing capacity for the on call rotas to support and facilitate improvements for staff wellbeing. There have been a number of recent appointments made into Anaesthetics but no new ICU consultants have been appointed for a couple of years causing difficulties specifically for ICU. *Note: the two areas under one cost code affects the vacancy representation.*

Integrated Community Care Division

The divisions Consultant vacancy gap in M3 was 7.72 WTE, the risk is currently being mitigated through the use of locums and in applicable areas the use of alternative grades to Consultants e.g. Dermatology. The division does not include any additional governance above the Trust wide governance.

The division has one priority key are of focus;
General Practice, 8.14 WTE vacancy gap in M3, there have been long standing historical issues recruiting staff which has been transferred to the Trust following the Primary Care TUPE. There has been recent success with the conversion of three locum GPs into substantive into leadership/clinical roles and the recently revamped Job Description and Advert. Currently in the process to procure a direct award contract to Menlo Park Recruitment agency to support the sourcing of substantive GP's.

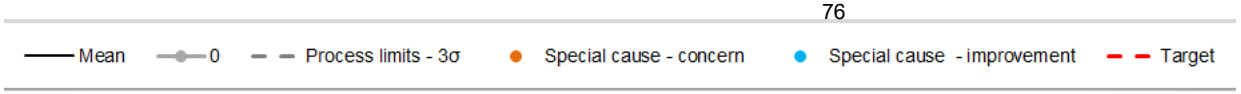
Improvement Actions

The Resourcing Team and Medical HRBP are working with each Division and their high risk areas with the following actions underway;

- Review of the job descriptions in partnership with the AMD and Clinical Leads
- Redesigning the job adverts including increase advertisement on TRAC, NHS Jobs, BMJ Online and the Trust's social media platforms
- Exploring recruitment premiums e.g. Golden Handshake
- For roles that remain vacant skill mix reviews will be conducted to identify opportunities to explore recruitment to other grades where appropriate

Whilst each division is proactively managing their Consultant vacancy position there are a number of Trustwide initiatives underway;

- Consultant Recruitment Working Group - Led by the Medical Director, this group provides the accountability and monitoring of progress with actions for each of the Divisions
- Progress is underway to align all Divisions to follow the same governance process for recruitment, locum and agency cover
- Overhaul of consultant recruitment process underway
- Monthly meeting with AMD, HRBP and Head of Resourcing to monitor the progress of recruitment activity, if hard to recruitment roles continue alternative options to be explored e.g. utilisation of new "Specialist" role to be an alternative to long term vacancies
- Talent retention programme to capture training consultants as they move through the hospital. Explore facilitating our own internal Consultant Interview Preparation Course, this is being designed by one of our previous Chief Registrars to help candidates develop interview skills. This will help us by creating relationships with candidates that we might never meet through rotations in the area and enable us to promote our good facilities.
- Consultant feedback with less than 12 months service with the Trust to ascertain why the individual joined us along with any thoughts they may have on how our recruitment campaigns could be broadened / developed
- A range of recruitment and communication initiatives, these include new photographs that can be utilised across the Trust, social media, recruitment campaigns; launch of the recruitment microsite; divisional specific videos; increased social media activity; candidate prospectus with greater focus on the Trust being an integrated organisation when advertising roles.



Board Committee Assurance Report

Finance & Investment Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Andy Copestake	Andy Copestake		23 August 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Month 4 Finance Position	G	G	Another good month with all the main indicators green – a favourable I & E variance to date of £4k, Cash of £20.1m at the end of July, continuing good performance re: the Elective Recovery Fund and good progress in spending the Capital budget. CIP achievement was £88k above plan year to date. The only concern this month is Theatre stocks where an accrual of £498k has been made to correct a potential stock discrepancy. This is being investigated.	Continue to monitor monthly through FIC	FIC meetings 2021/22
Expenditure trends	R	A	The Committee welcomed the first report of its kind on expenditure trends in the Trust over recent years, accepting that Covid has had a marked effect on expenditure levels over the last 18 months. Various suggestions were made to enhance the report, including linking expenditure to activity and workforce – and comparing expenditure trends to a peer group. The red risk rating reflects the significant challenge to reduce expenditure levels post-Covid and the amber rating on management actions reflects that this report is work in progress.	6 monthly review	FIC Feb 22
Finance Risk Register	A	A	A good discussion on the Finance Risk Register. The amber rating on management actions reflects the need to address a small number of housekeeping and timing issues.	Monitor through FIC	FIC meetings 2021/22

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Board Assurance Framework	R	A	The Committee discussed the revised BAF and was assured that there was good linkage between the Finance Risk Register and the BAF. The new layout appeared to work well, including an extensive list of flags and associated actions. The Committee discussed the need to link the various Committee reports and how the key issues could then feed in to a Board discussion. The Committee felt more emphasis should be given to the need to eliminate the underlying deficit. Whilst this was still work in progress, the Committee was assured that the strategic risk was being managed effectively.	Q2 discussion	FIC Nov 21
Strategic Framework	A	A	A good paper from the Associate Director of Strategy setting out a revised approach to system and organisational planning. The Committee welcomed the paper and was pleased to see good linkage between Finance, Operations and HR in the planning process. The Committee approved the new approach; however gave an Amber/Amber rating on the basis of emergent timelines, responsibilities and links to overall system approach.	October planning discussion	FIC Oct 21
Send Away Samples contract extension	A	A	The Committee approved a one year extension to the contract for outsourced diagnostic services to University Hospitals Southampton NHS FT. The amber rating reflects a concern that for a contract of this size and complexity a full competitive tender should ideally have been undertaken.	September 2022	FIC Sept 22

Issues Referred to another Committee	
Topic	**Committee**
£498k adverse variance within Theatre Stock – review of processes and controls	Audit, Risk & Assurance Committee

Part 4: Use of Resources

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Financial Overview

Use of Resources

For Period Ended - 31st July 2021	In Month Plan £000	In Month Actual £000	In Month Variance £000		YTD Plan £000	YTD Actual £000	YTD Variance £000	
Total Operating Income	33,440	34,318	878		134,459	137,532	3,073	
Total Operating Expenditure	(33,440)	(34,322)	(883)		(134,459)	(137,528)	(3,069)	
Total Surplus/(Deficit)	0	(4)	(4)		0	4	4	
Capital					4,798	5,411	(613)	
Cash & Cash Equivalents	19,918	20,111	193					
Efficiencies	254	254	0		751	839	88	

Overview

Income & Expenditure: The Trust in month position is £4k deficit against a plan of breakeven. Operating Income is £878k favourable against plan and Operating Expenditure is £883k adverse against plan. This includes Pay costs that are £159k favourable against plan and Non-Pay costs that are £1,042k adverse against plan.

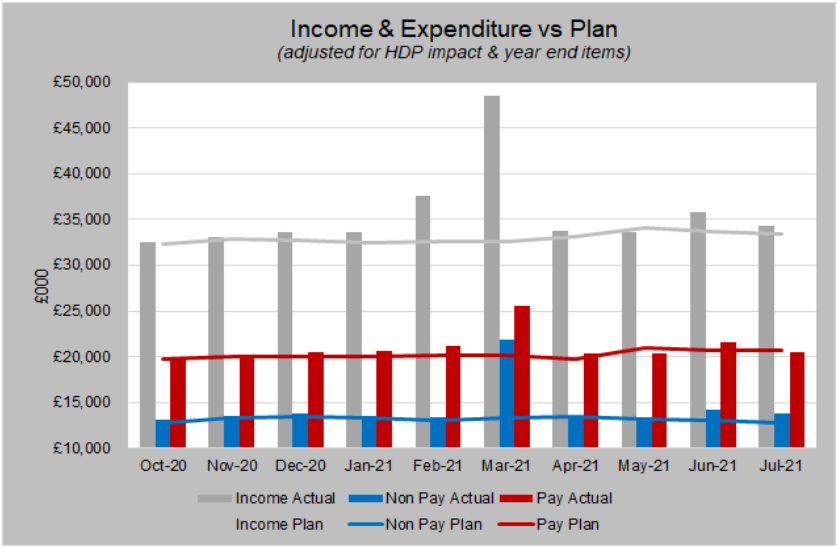
Cash – the cash balance at the end of July was £20,111k which was slightly above plan.

Capital – Capital expenditure is £5,411k YTD which is £613k above plan.

Efficiencies – £839k YTD has been delivered, which is above plan by £88k. This continues to be driven by over-performance within the Better Buying workstream. Further divisional opportunities are being driven through engagement at divisional improvement groups, underspend reviews and benchmarking reviews.

Income and Expenditure - Run Rate

Use of Resources



Background

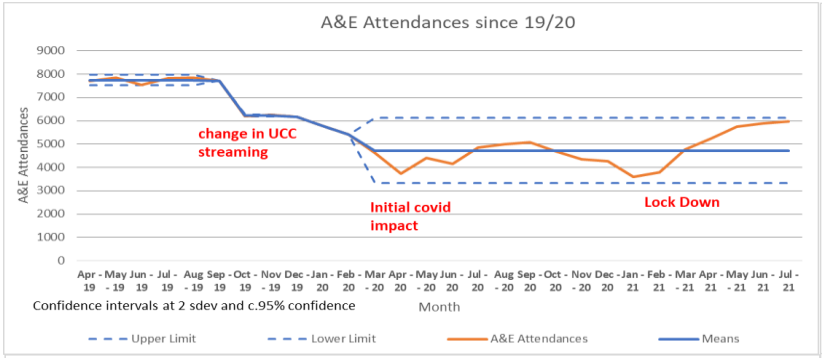
The July position is £4k deficit against a breakeven plan.

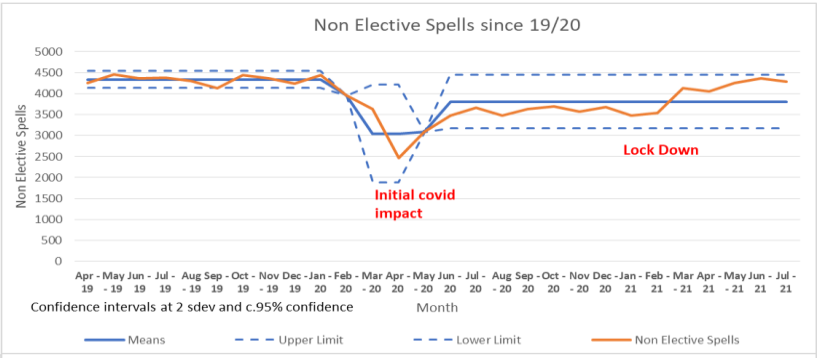
- Elective Recovery Fund (ERF) income for July is £600k (£1,714k YTD).
- Pay run rate has reduced by £1,060k and is slightly underspent in month by £159k (0.7%). The reduction is primarily due to one off costs and accruals incurred in the prior month totalling £808k. The underlying reduction is £252k.
    - The underlying nursing reduction is £62k. Agency and permanent costs have reduced due to vacancies being filled and nurses who were supernumerary last month receiving their PINs and working independently in July. Bank costs have increased by £61k driven by HDP spend which is funded by income.
    - The underlying medical staffing reduction is £200k. Agency and locum costs have reduced by £88k due to difficulties filling shifts with acute medics, primary care GPs and pathologists. Permanent costs have reduced by £100k due to fewer Waiting List Initiative (WLI) payments being made due to lower outpatient activity, although spend remains high due to delivering ERF activity.
- Non Pay run rate has reduced by £397k and is overspent in month by £1,041k. The prior month included £741k ERF related costs. With these excluded, the underlying movement is an increase of £344k. The increase is due to an accrual of £498k for a potential theatre stock adjustment which will be reviewed in August & September. Drugs costs in cancer and neurology have reduced back in line with trend following an exceptionally high month in June.

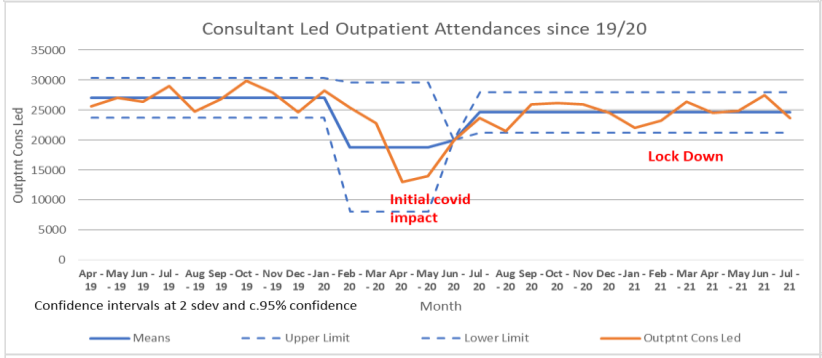
Emerging issues, improvement actions and risks are explained in the earlier slide.

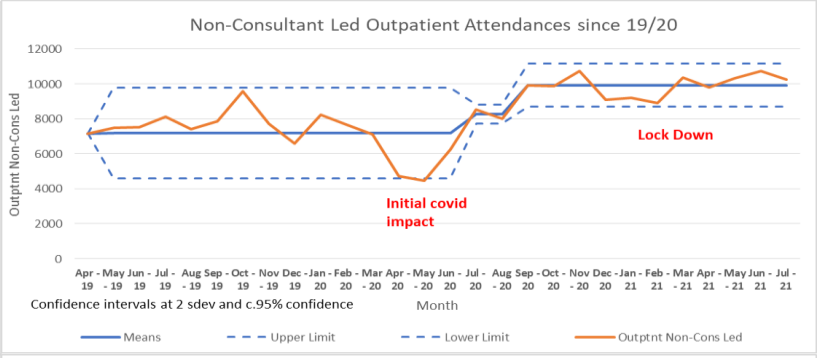
Key Activity Trends to Inform Revenue Impact if National Tariffs Still Applied

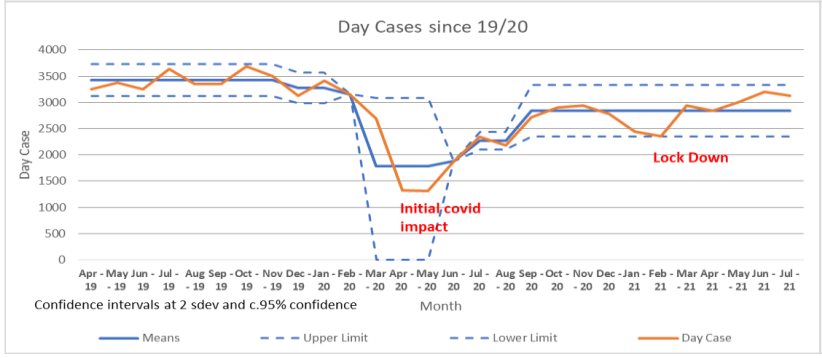
Use of Resources

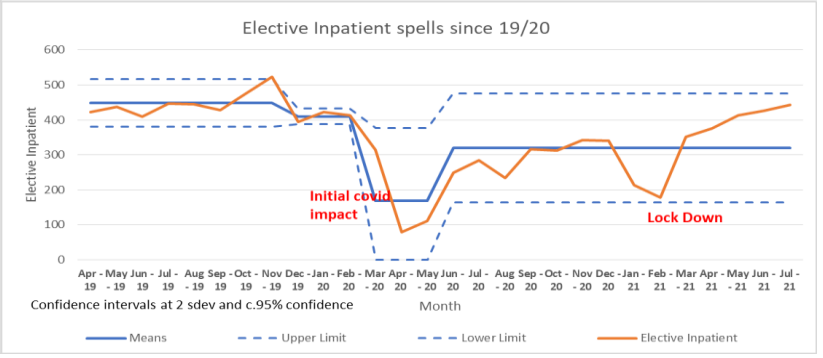












Background:
This is the activity trend collected to inform financial view on productivity, expenditure reported and notional income earned. This does not replace divisions' own view on their levels of activity.

Income and Activity Delivered by Point of Delivery

Use of Resources

2021/22 Income vs 2019/20 Income - YTD at July

Activity Type	Activity Variance	19/20 Income	21/22 Income	Income Variance	Income Variance	Comment (comparing income and activity variances)
	%	£'000	£'000	£'000	%	
A&E	-26.0%	4,973	4,029	-944	-19.0%	Minor activity affected more than major + impact of increased streaming since 19/20
NEL	-2.9%	30,756	33,597	2,841	9.2%	Minor activity affected more than major
Outpatient (All)	-2.4%	14,551	12,707	-1,844	-12.7%	Due to switching to Non face to Face
Day Case	-9.9%	8,011	7,653	-358	-4.5%	Minor activity affected more than major
Elective Inpatient	-3.3%	5,917	5,888	-29	-0.5%	Minor activity affected more than major

Context

Due to Covid-19, 21/22 funding is paid on a block contract basis in the first half of the year, with the emphasis on covering reported costs.

The above table show this year's performance by main activity types against the same point in 2019-20, if activity based contracting (PbR) was still applied.

Issues:

Income that would have been earned if PbR was in place is reduced from previous years due to Covid-19 reducing throughput. In June and July activity has returned close to pre Covid-19 levels for ED, NEL and ELIP. Notional PbR income has dropped less than activity, as low complexity work has reduced most. The exception is outpatients where a switch to non face to face delivery attracts a lower tariff.

Risks:

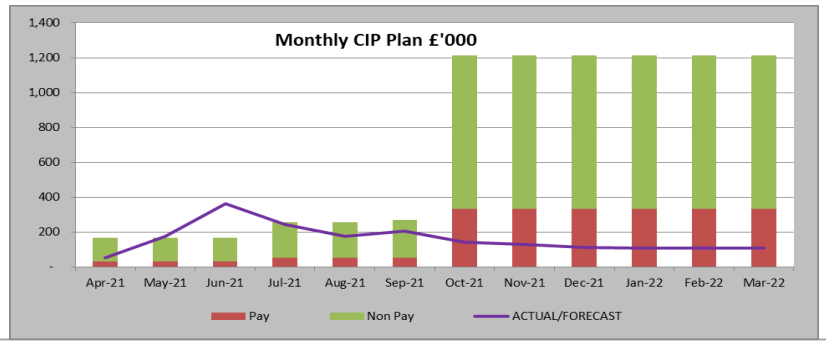
If the previous cost and volume funding approach was reintroduced, activity based income for the year would be c£1.3m lower than 2019/20 income levels due to reduced throughput.

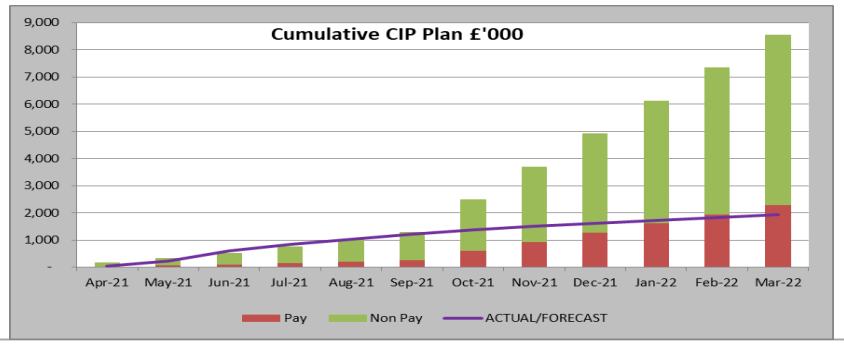
Actions & mitigation:

PbR is not going to be reintroduced in 2021/22 and block funding will remain in place. The Trust is working with the BSW system to maximise income for the Trust by staying up to date with the few income streams that exist and are created outside the blocks such as ERF, Vaccination and other NHSE/I development initiatives.

Cost Improvement Plans – Better Care at Lower Cost

Use of Resources





Background

- The Cost Improvement Programme (CIP) delivery plan for July is £254k.
- The total for H1 of the year is £1,272k, c. 0.7% of total budgets.
- CIPs identified and delivered in month were £254k (£839k YTD) which is on plan (£88k above plan YTD).
- Delivery year to date is currently 112% of plan in overall terms, driven by Better Buying.
- Delivery against divisional targets remains below plan at £367k YTD against plan of £536 YTD (68% delivery rate).
- The values attached to the charts above for H2 are indicative based on an assumed 4% of budget requirement and are therefore subject to change as the plan for H2 has not been agreed.

Improvement actions planned

Divisional surgeries have been rescheduled for the coming month to enable these sessions to be fully inclusive platforms covering strategy, financial planning and improvement & efficiency.

The approach around improvement & efficiency at these divisional platforms will include work around High-Volume, Low-Complexity and the launch of monthly review of outlying variation in the Model Hospital latest data sets.

Risks to delivery and mitigations

Divisional CIP remains lower than plan and wider improvement programmes continue to see challenge in identifying cashable savings.

Finance Business Partners are engaging through divisional improvement groups to identify further operational CIP and are undertaking a review of under spending cost centres to facilitate both H2 planning and CIP identification.

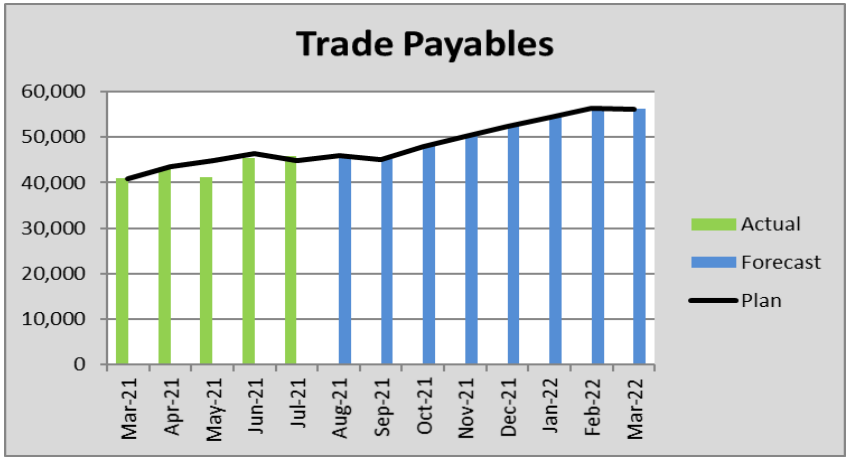
Review of governance around the transformational improvement programme areas is due to follow programme reprioritisation and this will enable Finance Business Partners and T&I colleagues to further support and challenge on these programmes.

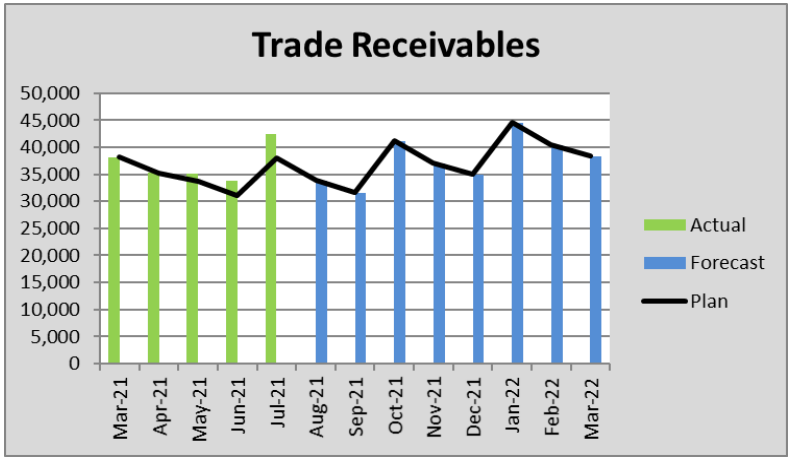
Finance Business Partners and T&I colleagues are working to identify peer variations from benchmarking data including through LoS analysis and Model Hospital to enable Operational Leads to investigate and implement further transformation.

Overachievement against plan of the Better Buying Programme continues to mitigate the H1 position.

Statement of Financial Position: Key movements

Use of Resources





Background

- The monthly plan has been updated to reflect the H1 and H2 I&E plans signed off by Trust Board
- Payables are broadly in line with plan in month,
- Receivables are above plan. This includes the quarterly PFI prepayment of £6m and the Swindon Borough Council £1m Prepayment for rates. NHS Property Services remain our largest longer-term debtor (£0.3m reduced from £0.5m last month) and this continues to be pursued. Invoiced debtors total £5m of which £2.7m is current debtors.
- A full Statement of Financial Position is included in the appendices.

Risks to delivery and mitigations

- A review of Aged Debt process is underway to ensure any risks to the receivables balance is identified.

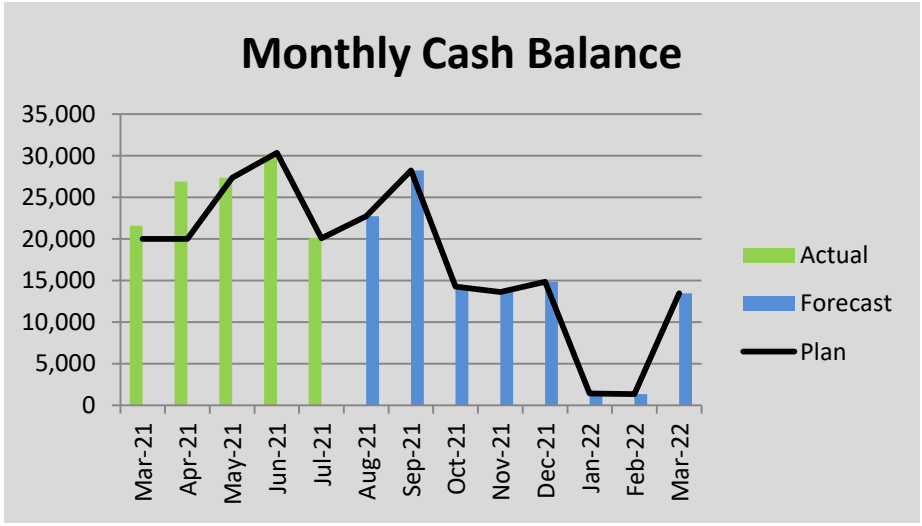
Cash

Use of Resources

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	21/22 Total	Rolling 12 Mths June 21 to May 22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	**30,164**	**20,111**	**22,754**	**28,254**	**14,282**	**13,641**	**14,869**	**1,437**	**1,349**	**13,467**	**2,580**	**3,291**	**4,057**	**21,553**	27,373
Income															
Clinical Income	30,943	31,084	31,086	27,500	27,435	27,435	27,435	27,435	27,435	27,517	27,517	27,517	27,517	351,368	344,974
Other Income	3,483	3,230	1,287	1,900	3,568	1,624	1,960	3,563	1,619	1,619	1,619	1,619	1,619	34,202	26,781
Revenue Financing Loan / PDC							1,000		13,500				7,831	14,500	14,500
Capital Financing Loan / PDC		1,121	8,071	1,929	1,929	5,594	1,614	1,614	4,537	4,537	4,537	4,537	4,537	26,409	35,483
Total Income	**34,426**	**35,435**	**40,444**	**31,329**	**32,932**	**34,653**	**32,009**	**32,612**	**47,091**	**33,673**	**33,673**	**33,673**	**41,504**	**426,479**	**421,739**
Expenditure															
Pay	19,494	20,181	20,194	20,130	20,105	20,105	20,099	20,098	20,044	20,138	20,138	20,138	20,138	238,190	240,509
Revenue Creditors	11,087	9,425	9,387	10,102	9,907	9,880	10,224	9,889	10,219	8,302	8,302	8,302	8,302	123,329	115,632
Capital Creditors	2,036	3,186	3,233	3,417	3,505	3,440	3,465	2,713	2,585	4,467	4,467	4,467	4,467	33,514	38,494
PFI	11,861			11,653			11,653			11,653			11,653	35,167	46,820
PDC Interest			2,130						2,125					4,255	4,255
Financing					55						55			110	110
Total Expenditure	**44,478**	**32,792**	**34,944**	**45,302**	**33,572**	**33,425**	**45,441**	**32,700**	**34,973**	**44,560**	**32,962**	**32,907**	**44,560**	**434,566**	**445,820**
Closing Balance	**20,111**	**22,754**	**28,254**	**14,282**	**13,641**	**14,869**	**1,437**	**1,349**	**13,467**	**2,580**	**3,291**	**4,057**	**1,000**	**13,467**	**3,291**

Background

- Cash at the end of Month 4 was £20,111k which was slightly above the planned level of £19,918k.
- The cash forecast still anticipates revenue PDC will be required in 2022 to support PFI payments in future months (January £1m, March £13.5m and July £7.8m)



Capital Programme

Use of Resources

Capital Scheme	Capital Group	2021/22 Full Year Plan £000	Month 4 YTD Plan £000	YTD Actual £000	YTD Variance £000
Aseptic Suite	Estates	1,903	200	170	(30)
Oxygen	Estates	500	379	378	(1)
Estates Replacement Schemes	Estates	750	-	-	-
Utilities (LV & Heating) Project	Estates	2,300	299	334	35
Site Reconfigurations Urology/R&D etc	Estates	300	-	-	-
Pathlake (national funds requires matching)	IT	260	27	-	(27)
Pathology LIMS (network procurement)	IT	510	151	-	(151)
IT Emergency Infrastructure	IT	3,000	2,030	2,297	267
IT Replacement Schemes	IT	1,404	156	82	(74)
PACS - environment/replacement solution (Nov21)	IT	800	-		-
Equipment Replacement Schemes	Equipment	1,450	161		(161)
Contingency	Equipment	541	180	-	(180)
Way Forward Programme		9,690	548	301	(247)
Clover UEC		10,085	667	1,849	1,182
Total Capital Plan (Excl PFI)		**33,493**	**4,798**	**5,411**	**613**

Background

- Capital Expenditure as at Month 4 is £613k above plan. This is driven by:
- IT:
  - IT Emergency Infrastructure scheme is £267k above plan due to orders being placed ahead of schedule (Dell). The project is forecast to be in line with plan by year end.
  - IT replacement schemes are £74k below plan but on track to spend in full by year end.
  - Work is ongoing with leads for Pathology LIMs and PathLake projects, orders have been raised for LIMs and ICE OCS interface and Sunsetting solution but work has yet to commence so not reporting any spend at Month 4.
- Equipment
  - Equipment Replacement scheme is £161k below plan, several schemes are on track to complete in Quarter 2 and the full allocation will be spent by year end.
- Estates:
  - Clover UEC is above plan (£1,182k). This is due to early orders required to be placed as part of the GMP with IHP to enable work to progress. The project is expected to be in line with plan by year end, with completion expected in late March/early April.
  - Slippage on Way Forward (IFD) (£247k) is reported year to date. This is due to project delays caused by the requirement to redesign the project to ensure it fits within the allocation envelope as construction material costs have risen.

Risks to delivery and mitigations

The Trust continues to spend at risk until Emergency Financing has been approved by NHSI.

The Way Forward Programme Board have been made aware of potential slippage in year, values are still being worked through.

Appendices

Use of Resources

1. Statement of Financial Position
2. Working Capital
3. Income & Expenditure – Variance Run Rate

1. Statement of Financial Position

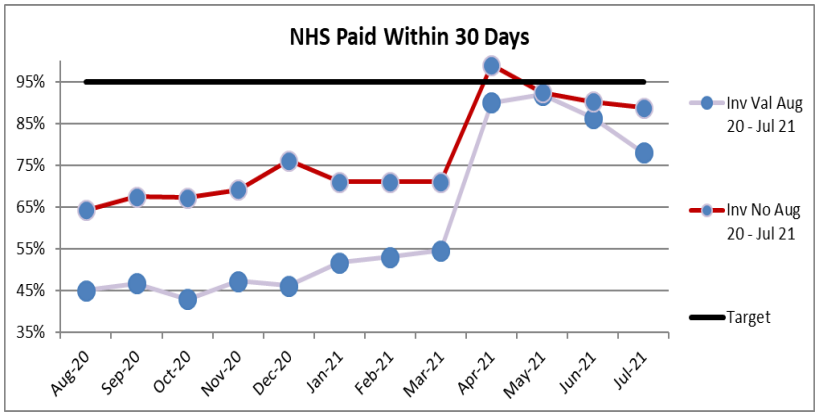
Use of Resources

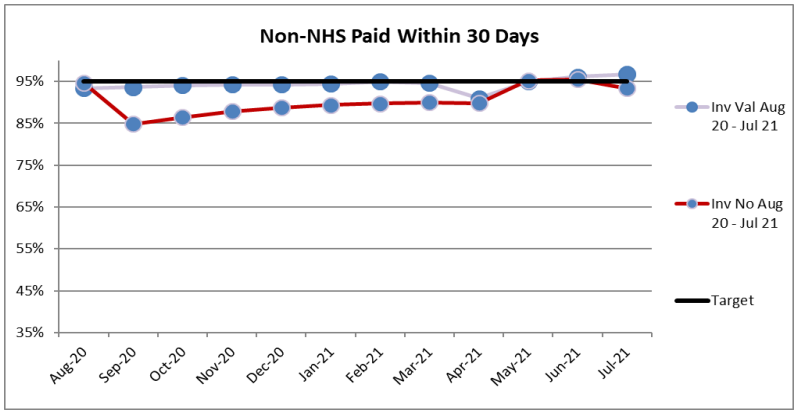
	Previous Month JUN-21 (£'000)	Current Month JUL-21 (£'000)	Movement (£'000) From Prior Mth	As at year-end Mar-21 (£'000)
Non-Current Assets				
Intangible assets	5,399	5,398	-	5,399
Property, plant and equipment	230,012	232,028	2,017	230,331
Investments in associates & joint ventures	70	70	-	70
Receivables - non-current	656	656	-	656
Total Non-Current Assets	236,136	238,153	2,017	236,455
Current Assets				
Inventories	4,891	4,565	(326)	4,787
Receivables: invoiced	4,348	5,094	745	4,870
Receivables: not invoiced	29,474	37,616	8,142	33,309
Cash and cash equivalents.	30,164	20,111	(10,053)	21,566
Total Current Assets	68,878	67,386	(1,491)	64,532
Total Assets	305,013	305,539	526	300,987
Current Liabilities				
Other liabilities: deferred income	4,159	4,524	365	4,303
Trade and other payables: invoiced	5,773	6,508	735	8,806
Trade and other payables: not invoiced	39,567	39,558	(9)	30,119
Provisions - current	154	115	(38)	156
Trade and other payables: capital	10,304	10,500	196	10,207
Borrowings: PFI, loans & finance leases	6,536	5,816	(720)	8,764
Total Current Liabilities	66,493	67,022	529	62,355
Non current Liabilities				
Other liabilities: deferred income	676	676	-	790
Provisions - non-current	2,177	2,177	-	2,177
Borrowings: loans & finance leases	1,169	1,169	-	1,174
PFI obligations	87,002	87,002	-	87,002
Total Non-Current Liabilities	91,023	91,023		91,144
Total Assets Employed	147,497	147,494	(3)	147,489
Taxpayer's and Others Equity				
Public dividend capital	137,337	137,337		137,337
Income and expenditure reserve	(28,624)	(28,627)	(3)	(28,632)
Revaluation reserve	38,784	38,784		38,784
Total Assets Employed	147,497	147,494	(3)	147,489

2. Working Capital

Use of Resources

Payments to Suppliers





Outstanding Receivable and Payable Balances

Payables	Current (£'000)	1 - 30 Days Overdue (£'000)	31 - 60 Days Overdue (£'000)	61 - 90 Days Overdue (£'000)	>91 days Overdue (£'000)	Total O/S Payables (£'000)
NHS	949	690	39	422	712	2,811
Non-NHS	184	2,291	283	104	834	3,697
Grand Total	**1,133**	**2,980**	**322**	**526**	**1,546**	**6,508**

Receivables	Current £000	1 - 30 Days Overdue £000	31 - 60 Days Overdue £000	61 - 90 Days Overdue £000	>91 days Overdue £000	Total Debt £000
NHS	2,486	137	149	18	168	2,959
Non-NHS	165	307	105	27	1,530	2,134
Grand Total	2,651	445	254	46	1,698	5,094

Background

We have an objective to pay creditors within 30 days and Budget holders are actively chased by system emails and the AP team to minimise delay in coding and approval. Even though NHS paid within 30 days has gone down, due to the volume of our Non-NHS compared to NHS payments overall our BPPC rate for the number of invoices paid within target is 95% which means we have attained our target this month and an increase of 0.5% from 94.5% last month.

3. Income and Expenditure – Variances from Plan

Use of Resources

For Period Ended - 31st July 2021									
	In Month Plan £000	In Month Actual £000	In Month Variance £000	YTD Plan £000	YTD Actual £000	YTD Variance £000	H1 Plan	H1 Forecast	H1 Variance
NHS Clinical Income	31,559	32,601	1,042	126,291	128,805	2,514	189,408	197,124	7,716
Other Income	1,881	1,717	(164)	8,167	8,727	559	11,823	11,823	0
Total Income	**33,440**	**34,318**	**878**	**134,459**	**137,532**	**3,073**	**201,230**	**208,946**	**7,716**
Pay									
Medical & Dental	(6,112)	(6,316)	(204)	(24,380)	(25,403)	(1,023)	(36,497)	(38,432)	(1,935)
Nursing	(8,678)	(8,519)	159	(34,278)	(34,573)	(295)	(51,657)	(54,522)	(2,864)
AHP & Scientific	(2,717)	(2,577)	141	(10,819)	(10,339)	480	(16,255)	(16,255)	0
Senior Managers and Admin	(3,129)	(3,067)	62	(12,671)	(12,427)	244	(18,958)	(18,958)	0
Total Pay	**(20,636)**	**(20,478)**	**159**	**(82,149)**	**(82,743)**	**(594)**	**(123,367)**	**(128,167)**	**(4,800)**
Drugs Costs	(3,008)	(3,092)	(84)	(12,035)	(12,222)	(187)	(18,067)	(18,685)	(618)
Supplies (Clinical & Non Clinical)	(2,660)	(3,383)	(723)	(11,244)	(12,180)	(936)	(16,580)	(18,382)	(1,802)
PFI Cost	(1,142)	(1,178)	(36)	(4,567)	(4,721)	(153)	(6,851)	(6,851)	0
Other Costs	(3,502)	(3,703)	(201)	(14,497)	(15,721)	(1,223)	(21,417)	(21,913)	(496)
Non Pay	**(10,312)**	**(11,356)**	**(1,044)**	**(42,344)**	**(44,843)**	**(2,499)**	**(62,915)**	**(65,831)**	**(2,916)**
EBITDA	**2,491**	**2,484**	**(7)**	**9,966**	**9,946**	**(20)**	**14,948**	**14,948**	**0**
Non-Operating Costs	(2,491)	(2,495)	(4)	**(9,966)**	**(9,970)**	(4)	(14,990)	(14,990)	0
Surplus/(Deficit)	**(0)**	**(11)**	**(11)**	**(0)**	**(24)**	**(24)**	**(42)**	**(42)**	**(0)**
Remove I&E impact of capital donations	0	7	7	**0**	**28**	28	42	42	0
Adjusted Surplus/(Deficit)	**(0)**	**(4)**	**(4)**	**(0)**	**4**	**4**	**(0)**	**(0)**	**(0)**

Forecast includes ERF £6,850k, Testing Income £466k and Cost & Volume Drugs £400k

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Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Mental Health Governance Committee

Accountable Non-Executive Director	Presented by	Meeting Date
Lizzie Abderrahim	**Lizzie Abderrahim**	**2 July 2021**

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	1.4a[1]

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
Risk Report	Risk	Actions	Difficulties with the collection of accurate mental health data under the current system continue. However, the committee was assured that with, regard to the legislative risks, processes are in place and are followed. With regard the corporate risks		
Use of the Mental Health Act [MHA]			Risks associated with the use of the MHA remain high [for GWH and for those subject to detention] and the data detailing the frequency and nature of MHA use was noted. The committee was concerned about failures to meet the mandatory training requirements and that patients were not being apprised of their rights under the MHA in accordance with best practice [specifically ensuring that there is a second reading of their rights]. It was also noted that the arrangement with Oxford Health NHS FT to provide medical scrutiny of the documentation was coming to an end and, at the time of the meeting there was no information about what alternative arrangements were being made. However, there is evidence that any associated risk was mitigated by	Review of best practice guidance and what barriers exist to hinder a second reading of MHA rights	Update at October meeting

[1] Safeguarding / Mental Health / DOLS

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
			processes that ensured mental health assessments were undertaken, that reviews by a consultant psychiatrist took place and of arrangements made for transfer to specialist mental health care or for discharge into the community		
MCA Practice			Risks associated with a failure to comply with the legislation remain and there was concern that the provision of Adult Safeguarding Level 3 training continued to be impacted by social distancing restrictions. However, risk was being mitigated through the provision of bi-monthly masterclasses offered via Microsoft Teams, MCA policies were current, an Enhanced Care policy had been developed together with associated guidance and documentation and bi-monthly audits continue to provide some evidence of embedded practice.	Bi-monthly MCA practice audits to continue with data reviewed by the MHGC	
Deprivation of Liberty Safeguards [DoLs] Practice			[1] DoLs applications had noticeably increased between April and May and the statutory bodies remain unable to complete statutory assessments of all eligible patients. In these circumstances, the risk of patients remaining under GWH care but outside the legal framework remained high. Some assurance was provided by the fact that both supervisory bodies had been made aware of the Trust's concerns, that the issue is monitored on the Trust risk register and that action was being taken to ensure that care plans were the least restrictive whilst also addressing patient needs and ensuring they were safeguarded.	To remain under review	October meeting
Liberty Protection Safeguards LPS]			It remains the case that enactment of LPS is expected in the Spring 2022 and that no Code of Practice has been issued and, in these circumstances, GWH has been unable to start planning for implementation across the Trust and it remains unclear what the implications will be [including financial]. Limited assurance was provided by the fact that regional discussions are taking place and some work has begun on a local plan	To remain under review	October meeting
Dashboard			The committee reviewed the various items covered under the dashboard and noted the information provided but was concerned about: 1. Compliance with mandatory training. 2. The existence of ligature risk. 3. How actions arising from coroners' cases are being implemented across the Trust.	To remain under review	October meeting
Divisional Update: Surgery Women's and Children			There remain a number of service delivery challenges within Children's services which continue to represent a significant risk. Of particular concern is the delay in obtaining specialist Tier 4 beds and the associated need to use agency RMNs. Divisional compliance with expectations re mental health training was also not as it should be and safeguarding supervision targets in		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
			maternity were not being met. These issues contributed to the degree of risk within the division. Actions being taken to address the risks included: ▪ The development of a "different workforce" to address the need for agency RMNs. ▪ Rates of compliance with mental health training being pushed at both divisional board and clinical governance meetings ▪ Work with WJ to support the management of complex cases in maternity. ▪ Exploring ways of managing challenging adults with substance abuse issues on adult base wards.		
Workplan 2021-22			A robust plan is in place for 2021/22 and actions expected in Q1 were on track. Progress against the plan to be monitored at future meetings	To remain under review	October meeting
Audit Reports			The following audits were reviewed: 1. Missing Persons' Policy Adherence Audit 2020. Whilst results suggested a high level of adherence further actions had been identified to improve performance. 2. Compliance with Ligature Risk and Self Search Audit 2020. Whilst not fully compliant the majority of standards had been met and the need for staff to understand the ligature risk had been identified as a key issue to be followed up. 3. Multi-Agency Assessment of Mental Health Procedures in GWH NHSFT Audit 2020. Whilst results provided some key assurances, issues were identified re communication and a lack of consistency in documentation and a comprehensive audit action plan with an associated time frame was to be agreed and accepted by partner agencies.	Update on actions to be provided	October meeting
Mental Health Liaison			The committee noted the data detailing the AWP MHLT performance in respect of the KPIs (PLAN 2011) and remained concerned that the manner in which the KPIs were being interpreted could serve to mask achievement, in particular regarding the impact that the use of observation had on performance data in ED. LC [in attendance on behalf of AWP] was unable to provide any response as she had not been made aware of the concern that had been raised at the meeting in July. The committee also noted that AWP had advised they are not in a position to fully meet the PLAN (6th Ed) standards and it was unclear what the implications of this were for GWH	Updates to be provided	October meeting

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
CAMHS			Recruitment gaps that had the potential to impact on GWH were noted but an assurance was provided that these were being covered by core staff until such time as vacancies were filled.	To remain under review	October meeting
			It was evident that a positive working relationship existed between CAMHS and GHW Children's Service and whilst this served to mitigate some of the challenges associated with the availability of specialist Tier 4 beds the risks to GWH and the children and young people subject to the delay remain significant,		
Children's Services			The availability of Tier 4 beds continued to present challenges and it was also noted that there could also be difficulty in arranging discharge into the community. The risks associated with these challenges were being mitigated by continued collaborative working with CAMHS to address the needs of children and young people impacted by the lack of Tier 4 beds and through the development of a multi-disciplinary approach to community discharges alongside Local Authority Social Services.	To remain under review	October meeting
ED			The continued lack of acute mental health beds within AWP was continuing to impact significantly on ED where resource intensive high-risk patients have lengths of stay that are too long and a high agency spend was incurred because of the need to use RMNs to provide for their care. It was noted that the issue had been raised informally within BSW and it was agreed to refer the matter to the Executive Committee where consideration could be given as to how to raise it more formally.	To remain under review	October meeting
Learning from incidents			The committee was assured that there was a framework for learning from incidents and noted an overview of actions that had been undertaken to support practice and better understanding. However there remained a need to bring learning together across GWH and for this to be built into quality improvement and it was agreed that WJ, RM and LG would examine how this might be achieved.	Update to be provided by WJ, RM and LG	October meeting

Great Western Hospitals NHS Foundation Trust

Responsible Officer Annual Report

Meeting	Board of Directors	**Date**	2 September 2021

Summary of Report

The Responsible Officer annual report outlines the issues and actions that have taken place during 2020/2021. Due to COVID this report was not submitted in 2020.

Appraisals were suspended due to COVID by the GMC from April 2020 - October 2020. GWH restarted the appraisal process in July 2020 with the emphasis on health and wellbeing. The appraisal paperwork was reduced nationally to provide a simpler process for doctors undertaking their appraisal.

Appraiser training was undertaken in May 2021 with 12 doctors being trained to undertake appraisals. There are now 117 appraisers with each undertaking no more than 5-6 appraisals each.

Oversight of the appraisal process and quality continues through the Revalidation committee and there is now a new process of reporting issues to the Board through a monthly report.

Actions for next year include improving the data that medical staff have to upload into their appraisal, fully embed the new system of allocation of appraisers and continuing to develop the Revalidation committee to include oversight of revalidation recommendations.

For Information	x	Assurance	x	Discussion & input		Decision / approval	

Executive Lead	Charlotte Forsyth / Jon Westbrook
Author	Isabelle Turner, Administrator for Revalidation
Author contact details	Isabelle.turner1@nhs.net

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score

Legal / Regulatory / Reputation Implications	'Good Medical Practice' - General Medical Council 'Maintaining High Professional Standards in the Modern NHS' – Department of Health

Link to relevant CQC Domain

Safe		Effective		Caring		Responsive		Well Led	x

Link to relevant Trust Commitment	

Consultations / other committee views

Medical Revalidation Committee

Recommendations / Decision Required

a) Board is asked to note and accept this summary.
b) The Chair or CEO is asked to sign the statement of compliance.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Great Western Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 28th September 2021 Action from last year: Submit report as per national requirements Comments: Appraisals were suspended in 2020 due to COVID and all revalidation dates were deferred by 1 year. Appraisals restarted at GWH in July 2020. Action for next year: Continue with current oversight for submission of AOA.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: The Deputy Medical Director is to undertake Responsible Officer training so that they are able to support the Responsible Officer. Comments: The Medical Director is the Responsible Officer and this will be changing from Charlotte Forsyth to Jon Westbrook on 1st September 2021. Due to COVID and increasing clinical commitments the Deputy MD was unable to complete RO training during 20/21. Action for next year: To ensure the RO undertakes the appropriate CPD training for the role.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Continue to provide these resources and provide enough time for Study and Professional leave for all involved in the Appraisal and Revalidation process. This will be monitored at the appraisal of the Clinical Lead and Responsible Officer. Comments: A Clinical Lead for Appraisals receives 1 PA. A medical workforce administrator dedicates around 22 hours a week and an apprentice around 27 hours a week to provide support to both the Clinical Lead and the Responsible Officer. Action for next year: Continue to work within the resources available to deliver the service.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to maintain the record.

Comments: A live list of all medical practitioners with a connection to the Trust can be viewed via the GMC connect website. Automatic emails are sent to the revalidation inbox when a doctor adds or removes their connection to GWH so all other records can be kept up to date. GMC connect is also updated manually by keeping track of monthly new starters and leavers. We also have an appraisal database to reflect this information.

Action for next year: Continue to maintain an up to date record of connections.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Upload the new policy to the T drive when finalised. Ensure that the changes that have been made to the policy are embedded into the appraisal process. This will be monitored at the monthly Revalidation meeting.

Comments: This policy has now been uploaded to the T drive.

Action for next year: Continue to ensure that the changes made in the policy are fully embedded.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None

Comments: Due to COVID no external peer review has been undertaken. However, the appraisal process has been reviewed regularly at the Revalidation meeting.

During 2021 the process of allocating appraisers has changed. Previously, doctors could choose their appraiser. They are now allocated an appraiser when they have completed 3 appraisals with the same appraise. This allows for a better distribution of appraisals across the appraisers and ensures that they are all completing a satisfactory number to maintain their appraisal skills.

Action for next year: Facilitate an external peer review.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: There has always been an induction for all locum staff when they start with the Trust. Following learning from the COVID

pandemic, changes have been made to the induction of locums into GWH. The booking length that identifies a locum has long term has been reduced from 3 months to 6 weeks. At 6 weeks they will now have access to a trust IT account. This will give them access to emails and Site Comms which will support their professional development.

Report to be taken to PPPC to confirm that the changes have been made and that induction process is compliant.

Comments: The new process of identifying locums as long term from 6 weeks is now embedded and a report was taken through PPPC. Transfer of information forms are completed if requested.

Action for next year: Continue to support locum and short-term placement doctors while they are working at GWH.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Develop a robust process to cross check information declared about external employment is included in the appraisal process. This will be part of the Paterson recommendation Task and Finish group.

Comments: Following conversations with the Executive Director of Ridgeway a process has been agreed where any concerns that are raised at the Ridgeway will be flagged to the GWH Medical Director.

All doctors that are connected to GWH are reminded by the Revalidation HR Business Partner when their appraisal is due. The doctors are also sent an email containing information about any complaints or incidents that they have been named in for inclusion in their appraisal. Doctors that work in other organisations, this is predominantly the Ridgeway Hospital, are required to complete an 'other practice form'. This allows for evidence of any complaints or incidents to be shared with GWH. This also occurs with the doctors from the Prospect Hospice.

Action for next year: Continue to monitor the information that is included on 'other practice forms' to ensure that there is robust transfer of data.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue monitoring the appraisal process.

Comments: At the monthly Revalidation committee all overdue appraisals are discussed. If there are mitigating reasons these are documented. If not, a plan is developed to support the doctor to achieve their appraisal. If there is

continuing non-engagement with the appraisal process the doctor is discussed with the GMC ELA and if appropriate a Non-Engagement Referral is made.

Action for next year: Continue to monitor the appraisal process.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Review last year's policy. An updated policy is being finalised and will replace the 2017 version as soon as possible.

Comments: The Medical and Dental Registration and Revalidation Policy was approved by both the JLNC & Medical Staffing Group Committee. It was approved on 27th January 2021 and is due for review on 27th January 2024

Action for next year: Monitor implementation of the updated policy.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: We are hoping to continue appraiser training on a yearly basis. We have been informed of an online course taking place in mid-January 2021 which will be advertised internally and hopefully one later in the year to give medical staff more notice so they can arrange work commitments.

Comments: The trust currently has 117 trained appraisers although not all are currently undertaking appraisals. Each appraiser should complete 5-6 appraisals per year. Appraisal training was completed in May 2021 and a further 12 appraisers went through the training. There has not been any refresher training in the past 12 months/

Action for next year: Undertake a refresher appraisal course during 21/22.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Ensure each Appraiser receives a copy of their evaluation to include in their own appraisal so this can be reflected on and improvements can be made. Continue to keep appraisal system up to date reflecting the latest GMC guidance. Investigate other performance reporting systems such as Dr Foster.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: This action hasn't been completed but continues to be discussed with the Clinical Lead for Appraisal to develop the processes.

Each appraisal is appraised by the appraisee and the appraisals are quality checked by either the Clinical Lead for Appraisal or the RO before final sign off.

Action for next year: To complete the action above to ensure that the appraisers are reflecting on their appraisals and learning during the year.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Quality assurance is maintained by monthly medical revalidation committee meetings. These are attended by the Medical Director, Appraisal Lead, Head of Medical Workforce, Medical workforce administrator & apprentice and at least 1 Lay Governor. The committee regularly review quality assurance and create actions on an ad hoc basis as required.

Comments: Quality assurance is maintained by monthly medical revalidation committee meetings.

Action for next year: Strengthen the monthly meeting to include discussions about revalidation recommendations.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Invite the GMC ELA to talk to the New Consultant group and further sessions with the Clinical Leads.

Comments: This was completed and will be on-going this year.

The RO has monthly meetings with the GMC ELA to discuss all investigations that are on-going and any concerns about engagement in the appraisal process.

Action for next year: Continue to engage with the GMC ELA and invite them to present to consultant groups so that the medical staff are aware of changes in GMC registration and revalidation process.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue with the current policy.

Comments: Where a deferral has been made the RO will write to the doctor involved to explain the reasoning behind the decision. If appropriate the Clinical Lead for Appraisal and Revalidation HR Business Partner are included so that they are able to support the doctor. The most common reason this year has been the lack of evidence of colleague or patient feedback.

Action for next year: Continue with the current policy.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: A job planning review for senior doctors is underway that will ascertain if staff are achieving their SPA time.

Comments: The job planning process has been delayed but is now underway. Different departments are at different stages of the process. A consistency panel has been formed, chaired by the Deputy MD, to assess any issues that arise from the process.

Action for next year: Await the outcome of the job planning process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: The Dr Foster reports were delayed due to COVID and so will be introduced during the next year.

There will be further training for Case Investigators and for Medical Workforce who support investigations. A small number of staff will also be trained in becoming Case Managers.

Comments: The introduction of the Dr Foster reports continues to be delayed but there is the expectation that doctors will submit evidence from their log books as part of the scope of practice section of the appraisal. Significant events (IR1's), complaints, mandatory training, national audits are all provided with the appraisal reminder paperwork.

The Trust has also increased the number of consultants who have completed their Case Investigator and Case Manager training. This allows for a more robust system when concerns are raised about conduct or capability.

Action for next year: Continue discussions with Dr Foster about using their reports in the appraisal process. Continue training and feedback for the new cohort of Case Investigators and Case Managers.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Review investigations to ensure that the investigation followed policy and if there is any learning for change.

Comments: Correct. This is covered in the Medical and Dental Revalidation and Appraisal Policy.

Action for next year: To continue to review investigations when they are completed to ensure that the correct process was followed and illicit any learning from the investigation process.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Create a new process map to improve consistency of the way any concerns are dealt with.

Comments: The Medical Director and Head of Medical Workforce meet weekly to discuss any on-going investigations or concerns. The Medical Director meets monthly with the nominated Non-Executive Director to discuss on-going investigations to ensure that the correct process is being followed. A monthly report is presented to Board with anonymous data on current investigations and exclusions or restrictions in practice.

Work is on-going within HR to produce a 6 monthly report of investigations that are completed that will include details of protected characteristics.

Action for next year: Complete the report process including protected characteristics.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: During the year there have been a number of instances where information needs to be shared between GWH and other organisations. There have been no issues in these RO-RO conversations.

The GPs working in the GWH Primary Care Network are not connected to GWH but to NHS England. This relationship has strengthened over the past 12 months with a more robust system for raising and discussing concerns.

Action for next year: Continue to build a clear structure for notifying NHS England of concerns about GPs, if issues arise.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: To develop the Revalidation meeting to include conduct or capability investigations into any doctors. This will allow greater scrutiny of these investigations.

Comments: The Revalidation meeting continues to have lay representation to add scrutiny to the process. All members are up to date with Equality and Diversity training.

Action for next year: Continue to develop the Revalidation meeting to ensure robust oversight.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

Comments: Following the introduction of the TRAC recruitment system, all processes and checks are monitored throughout the year in conjunction with the general recruitment team to standardise processes.

Pre-employment checks include: GMC check, national insurance number, right to work checks (Passport/Visa), DBS check, an occupational health check, forms including Confidentiality, Data Protection & Caldicott Statement and Self Declaration.

Action for next year: Continue to monitor pre-employment checks.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions**

- The Medical and Dental Registration and Revalidation Policy was completed and published.
- Started to introduce the allocation of appraisers.
- Held a training session for new appraisers.
- Improved resilience of investigations due to training of Case Investigators and Case Managers.

- **Actions still outstanding**

- To link further Trust collected data such as research to individual appraisals. This was set back due to covid however we are still looking to start including individual performance reports.
- The allocation of appraisers is not fully in place yet but the process is approved and will be expanded during 21/22.
- Further development of the Revalidation meeting to include oversight of revalidation recommendations or deferrals.

- **Current Issues –** No new issues

- **New Actions:**

- Set all future appraisal due dates to the 1st of the month. This allows doctors to have an 'appraisal month' and is easier for both them and the administration team to track when their appraisal is overdue.

Overall conclusion:

Following the suspension of appraisals in March 2020 we restarted appraisals in July 2020, ahead of the GMC deadline. There was good communication with doctors about the use of the Academy of Medical Royal Colleges Appraisal template. This required less evidence than previous appraisal and has been used by a number of staff for documenting their evidence. Appraisers were asked to include a section on health and wellbeing and it was suggested to doctors being appraised that they used the opportunity to debrief on their experience during COVID.

We have continued with holding fortnightly meetings between the medical revalidation administrators and appraisal lead to keep on top of all appraisals. Appraiser training has taken place within the last year with good feedback about the course. Appraiser allocation has been introduced to ensure that the number of appraisals undertaken per appraiser is more even and therefore it is predicted to help appraisals be planned sooner and take place in a more timely manner. Overall the appraisal team are happy with the actions achieved despite the unexpected circumstances and are continuing to sustain all key outputs

highlighted last year.

Section 7 – Statement of Compliance:

The Board of Great Western Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Great Western Hospitals NHS Foundation Trust

Equality, Diversity and Inclusion (EDI) Annual Report, 2020/21

Meeting	Trust Board	**Date**	02 September 2021

Summary of Report

The EDI Annual Report for 2020/2021 provides evidence of progress and achievements during the period, and the commitment to equality, diversity and inclusion. Specifically, the focus is on:

- Evidence of EDI progress and achievements during the period for our workforce, and our patients;
- A demographic profile picture of our staff and patients, through data on their personal protected characteristics (mainly age, ethnicity, and gender);
- An outline of the range of staff and patient services we have developed to improve patient care (including the creation of a new staff network), and better support our workforce.
- An outline of Trust performance in relation to the national context of statutory, mandatory and regulatory requirements.

The annual report is informed by our EDI Strategy, 2020-2024. A key message of our Strategy is the commitment to move beyond compliance. This means providing evidence that we are being proactive, heading in the right direction, and that equality and inclusion for all is inherent in everything that we do.

For Information	x	Assurance		Discussion & input		Decision / approval	

Executive Lead	Jude Gray, HR Director Lisa Cheek, Chief Nurse
Author	Patrick Ismond, Equality, Diversity and Inclusion Lead
Author contact details	Patrick.Ismond1@nhs.net

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score

Legal / Regulatory / Reputation Implications	Equality Act 2010 Public Sector Equality Duty

Link to relevant CQC Domain

Safe		Effective		Caring		Responsive		Well Led	

Link to relevant Trust Commitment	

Consultations / other committee views

This report will go to:

- Executive Committee; Performance, People and Place Committee; and Patient Quality Committee, during August 2021;
- Board in December 2021.

Great Western Hospitals
NHS Foundation Trust

Equality, Diversity and Inclusion Annual Report

2020-2021

Contents

Our Commitment

Over the last 18 months, the killing of George Floyd in the United States, the conviction stemming from the death of Dalian Atkinson, the rise in profile of the Black Lives Matter movement, and the Covid-19 pandemic are among the events that have helped to bring many of the issues surrounding inequality into really sharp focus.

During this year we launched a new Equality, Diversity and Inclusion Strategy, an important step on our journey as an organisation to challenge injustice, proactively work to reduce inequality and begin to create opportunities for everyone, so that it is not only health we improve, but life chances too.

We have also introduced a new EDI Lead role which will help us to drive forward the change that is needed, but we know this isn't an issue which can be tackled by one person alone – it is everyone's responsibility and we are asking staff at every level to bring EDI to the forefront of their minds and think about how we can all make positive improvements.

Swindon and the surrounding area has a diverse population and we must do all we can to ensure our organisation, at all levels, is reflective of the community it serves and celebrates diversity.

Our Board is beginning to become more representative of our local communities which is a positive step forward but we know there is more to do.

This is supported by new and evolving opportunities for patients to get involved in improving the services we offer, and sharing constructive feedback on areas that aren't yet accessible or inclusive for all.

At this time, the issue of EDI generates strong views in some quarters against why we should focus our energies on tackling these issues or, indeed, whether they are too big for us to tackle as a Trust.

All the evidence points to some people in our community – our friends, relatives and neighbours – having poorer health outcomes and dying earlier because of their skin colour, their sexuality or a disability. As an organisation whose reason for being is to change and save lives, it is as important to our mission as responding to the pandemic.

We, therefore, all have the opportunity to work together to make this organisation a supportive and inclusive workplace for all and the large amount of work which has been done to do just that is detailed in this report.

We have made progress this year, but we aren't yet in a position where we can say we are truly proud of what we've done or say we've gone far enough. We must all keep pushing forwards to build on the work we've done until we can be strongly assured that our organisation is completely supportive and inclusive for all.

Kevin McNamara
Chief Executive

Report Summary

The Equality, Diversity and Inclusion (EDI) Annual Report for 2020-2021 has a number of parts. It seeks to present a 'painted by numbers' profile picture of our staff and patients, through data on their personal protected characteristics (mainly age, disability, ethnicity, and gender). Alongside this, the report outlines the range of staff and patient services we have developed to improve patient care (including the creation of a new staff network), and better support our workforce.

The supporting efforts have assumed an added importance when we reflect on the impact of the Covid-19 pandemic, which has placed our staff under increased levels of pressure, and called for monumental levels of resilience.

A summary of our progress against national reporting requirements is also included, focusing on the gender pay gap, and workforce improvement standards for 'race' and disability.

Over the last year, our workforce has increased by 515, with the highest staff numbers in the area of Registered Nursing and Midwifery. Our workforce continues to be predominantly female, aged between 26 and 60 years, and identifies as White British. This profile also reflects the national picture. Our Black, Asian and Minority Ethnic (BAME) workforce has increased in the last year, by 5.3%, and data collection on ethnicity reveals an increasingly wide range of backgrounds, and countries of origin (see *A Note on the use of the acronym BAME*, page 34).

The picture for staff and patients appears less certain when we consider other protected personal characteristics – specifically religion and belief, sexuality and disability. We recognise that our data collection in these areas is uneven, inconsistent, and therefore not necessarily reflective of the organisation as a whole. We are adopting a new data collection system in September that will standardise and improve consistency levels when it comes to data collection. Alongside this, we are working with staff to understand and address their fears about data safety, and to re-emphasise the importance of data collection, as a way to improve services.

We're seeking more ways to ensure that our patients' voices are heard, and learn from their experience. Patients were involved in the design of our new Urgent Treatment Centre, and our Covid-19 Task and Finish Group has provided important insights into understanding the barriers that Swindon's BAME groups face about coming forward to receive the Covid-19 vaccine.

Where possible, we have compared our position with that of our local partners in the **Bath and North East Somerset, Swindon and Wiltshire Integrated Care System**. The significance of partnership working to alleviate health inequalities is emphasised by Rex Webb, the BSW systems EDI Lead. In his words: "Equality, Diversity and Inclusion is a golden thread which runs through the work of all our organisations. In the past 12 months we have been reminded about the importance of this work to combat long standing health inequalities and to create a compassionate, equitable and inclusive workplace" (see Appendix 3 for Rex's full statement).

Datasets extracted from the South West Workforce Planning and Intelligence Systems Information Pack were used to create a quarterly report for the BSW/South West Region, and any compatible metrics have been taken from the report released in December 2020.

Finally, we are pleased to announce that **Ifem Onuora** has contributed the foreword to this annual report. He is the English Premier League's first Head of Equality, Diversity and Inclusion, and has close links with Swindon, having been a player and then general manager of Swindon Town football club. He has also managed the England national under-21 football team.

Patrick Ismond
Lead for Equality, Diversity and Inclusion

Foreword

The last year or so has proved as tumultuous as any I've experienced in my lifetime, and I'm sure it's the same for many of you too. The onset of Covid-19 in early 2020 became part of a wider narrative in society around issues of race and social justice, that's still being played out in 2021. In total they created a perfect storm, as lockdown and protest became the backdrop to combatting a health pandemic that few of us had any prior experience of.

I know from my time living in Swindon and having family still based in the South West, that the effects of discrimination were felt disproportionately among poorer sections of the population.

This was reflected in the high death rates from Covid-19 recorded for minority ethnic communities, who often comprise this demographic. This is a local as well as national issue, and has prompted a collective soul-searching against the backdrop of a disease that has claimed thousands of lives prematurely.

Nearly a year on, and the vaccination programme has been a huge success in mitigating against the worst effects of Covid-19, and lowering hospital admissions. However, the wider societal issues persist. In my new role as the English Premier League's first Head of Equality, Diversity and Inclusion, I'm looking to use my extensive experiences within the game, both as player, manager and player's representative, to overcome the challenges that remain in football, and make it as inclusive as possible. In particular, the lack of Black and Asian people in key decision-making positions both in boardrooms and the coaching fraternity, indicate there is still much work to be done, though I detect a greater willingness now from the game as a whole, to affect change.

Though the health of the national game is important, it shouldn't detract from other key sectors in society in meeting similar changes within their own environments. Whether it be education, business, media or the health sector, each has its own distinct constituency. Yet the issues of under-representation amongst marginalised groups is a common thread throughout society, and to truly be inclusive, tolerant and equitable, its incumbent on those of us in visible positions to drive the change that needs to happen.

Some progress is being made, but much more still needs to be done. I admire enormously the commitment to these goals that your CEO, EDI lead and staff have demonstrated, and I know that the people of Swindon will support them as they continue their work. We all have a part to play in this movement for change, even if only on a small scale. Previous generations have faced similar challenges and society can only progress and move forward through the commitment of ordinary men and women. Whether it be in your own homes, schools or workplaces, you can always make a difference!

Ifem Onuora
Head of Equality, Diversity and Inclusion
English Premier League

Our Patients

Tania Currie

In December 2020, the Trust recruited Tania Currie (pictured left) as its new Head of Patient Experience and Engagement.

The post provides a strategic focus to ensure that patient and carer voices are heard; and that we use opportunities to learn from their experience, actively seek their engagement in service development and patient experience work streams, and ensure that diverse groups, vulnerable groups, children and young people are included.

We are committed to ensuring that our patients, their families and the wider public have opportunities to understand, get involved and influence the care that we provide. By involving patients and their families and ensuring that their voice is heard, we believe that this can have a positive impact on the outcome of their care and treatment.

Patient, Carer and family representation brings important views, perspectives and challenge to the work that we do, and is essential in championing a service user viewpoint and driving improvements.

Collaborative working

healthwatch Swindon

Voluntary Action Swindon

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

SWINDON EQUALITY COALITION

Bath & North East Somerset, Swindon and Wiltshire Maternity Voices Partnership Plus
Working in partnership to improve maternity services

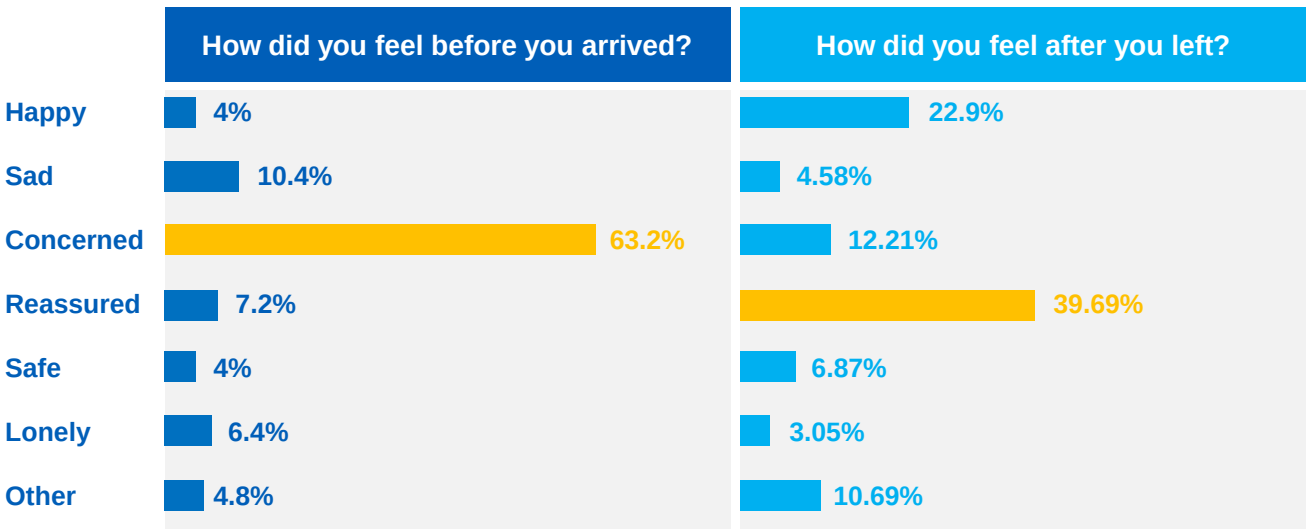
External links have been established with various third sector organisations including: Healthwatch, Voluntary Action Swindon, Bath & North East Somerset, Swindon and Wiltshire CCG, Swindon Equality Coalition, Maternity Voices Partnership, Learning Disability Partnership Board and Disability Experts in order to work collaboratively and ensure we are meeting the needs of our wide and diverse community.

Our Patients

A new Urgent Treatment Centre

A patient experience survey was carried out to collect views from our patients regarding their experience of the current Urgent Treatment Centre. The feedback was based on how patients were 'feeling' throughout their journey and has been used to help inform our plans for the new Urgent Treatment Centre.

The questions included a specific Equality, Diversity and Inclusion (EDI) focus to ensure that we are meeting the needs of all patients and their families. The feedback in relation to EDI considerations was gathered and reviewed to ensure that they were within the current scope and plans of the Way Forward Programme for the new Urgent Treatment Centre.



Changing Places

Funding has been agreed to establish an accessible bathroom facility within both the new Urgent Treatment Centre and the Children's Unit.

The Head of Patient Experience and Engagement is working with patient groups and individual parents in order to ensure that the facility is co-designed and all requirements are considered.

This will ensure that we are able to provide accredited Changing Places facilities for both children and adults accessing our services.

Our Patients

Swindon BAME COVID-19 Task and Finish Group

The Head of Patient Experience and Engagement joined the group to gain an understanding of the barriers in Swindon for the BAME community coming forward for the COVID-19 vaccination, in order to improve uptake. Work included raising awareness of the importance of vaccination and myth busting around concerns. A report is expected to be presented to the local Health Overview and Scrutiny Committee in October 2021.

Patient Led Assessment of Care Environment (PLACE)

The PLACE audit reviews maintenance, environment and food supply within the Great Western Hospital. Feedback from the 2019 PLACE, has led to a project to raise money through Brighter Futures to install special clocks to support dementia care as this was raised as an area of concern. In some outpatient areas, a lack of a varied range of seating and in some cases space to accommodate wheelchairs was identified.

Actions to address this have unfortunately stalled due to the COVID-19 pandemic but are now being revisited. However, due to changes in the way the departments are now functioning these issues have not been of such concern. Unfortunately the 2020 PLACE audit was cancelled due to the COVID-19 pandemic and we await confirmation of the 2021 audit.

Interpreting and Translation Services

We continue to offer the Sign Live (SKYPE British Sign Language -BSL) service to all deaf and hearing-impaired patients that require communication support, either at their outpatient appointments or whilst an inpatient on the ward. This ensures that staff can communicate using BSL with their patients at all times throughout their stay.

Sign Live is regularly used by deaf and hearing-impaired patients as a method of contacting the hospital using the Sign Live app. This method of communication is where a patient can speak in the comfort of their own home using an online interpreter. The Interpreter will telephone the hospital informing the hospital staff of the patient's requests/wishes or confirming a hospital appointment as a three way conversation with the patient.

Feedback received from patients - "this has been a huge improvement and has given back independence and an easier method of communicating with the hospital".

Our Patients

Leaflets

We ensure that all documentation and Patient Information Leaflets are available in other languages. Some of our leaflets are now accessible on the Trust Website.

Engagement Event

An Engagement Event took place in March 2020, working with patients with Learning Disabilities who require additional support. The event was to promote the PALS service and to ensure that patients who require additional support know who and how to make contact. This was an important event to ensure that we are listening to patients to understand their preferred method of contact.

An Easy Read PALS/Feedback form has been produced and is available for patients to complete on the Trust website.

Communication

Our Patient Advice and Liaison Service (PALS) has developed a range of Easy Read leaflets and feedback forms that are available on our website for patients to read and complete.

Environment

A government-commissioned review of hospital food made recommendations on improving choice, nutritional value and minimising food waste. The report was published on 26 October 2020, and includes a number of recommendations to improve food safety, based largely on evidence provided by the Foods Standards Agency.

This includes the importance of healthy, nutritious and tasty food for physical health and wellbeing, and the nation's dietary health; and the importance of ensuring that food service is understood and integrated within patient recovery, governance and staff training.

It also includes ensuring that a wide variety of dietary needs are met. The Trust's Nutritional Steering Group are working within a three-year programme to implement these improvements to support and empower our patients to take better ownership of their own health and care.

Our Patients

Our Learning Disability Service

There is a wide range of activities to support people with learning disabilities in our locality. Principal among these are:

The Learning Disability (LD) Forum, which:

- Delivers an annual work plan, to reduce inequality of access to healthcare. The Trust has an established patient feedback programme to ensure the patient is at the heart of all our service delivery and planning.
- Has a collaborative working model with multi-professional engagement from the acute site, community, service users, carers, community care providers and advocacy groups.

The annual LD plan 2021/2022 incorporates national and local audit recommendations. Key projects correlating to the equality and diversity agenda included the following:

- Progressing compliance against the NICE108 (2018) (Consent and Decision-making)/NHSi LD and Autistic Spectrum Improvement Standards (IS) (2018);
- Embedding an LD risk dashboard with clear escalation and feedback reporting, to ensure early identification and management of risk and learning opportunities;
- The LD Liaison Nurse has started training across the Trust to raise awareness and create critical discussion around the needs of individuals with LD from an inpatient and day case perspective. Sessions have been delivered to (among others) include theatre staff, and the foundation doctor programme.

Matt's Hospital Visit film and training toolkit, which includes a fictional case study to explain the principles behind improving the quality of care for people with learning disabilities in hospital. It continues to be used across the organisation and has been recognised nationally.

Our Patients

LD Liaison Nurse

Maria Cozens

Maria Cozens (pictured right) was appointed as our LD Liaison Nurse, in June 2020. Her three main areas of focus are:

- Administering a system for internal and external referrals, with a range of specialist input options, including specialist LD reviews, with reference to challenging behaviours, complex decision making, liaison and support for internal and external stakeholders;
- Providing teaching sessions and one-to-one support for ward staff;
- Developing a complex day case admission pathway, and engaging with groups to raise the profile of individuals with LD across the hospital, such as our staff network groups.

Learning Disabilities Mortality Review (LeDeR) Programme

This programme was established to explore local death in individuals with LD and identify learning from these deaths. Within the Trust, internal LeDeR reviews are carried by the LD Liaison Nurse. Any noteworthy learning has been shared directly back to the wards and in some cases feedback has been given directly back to the medical team and relevant departments. The LD Liaison Nurse has been nominated to be a LeDeR reviewer across the Bath, North East Somerset, Swindon and Wiltshire region.

Learning Disability Patient Board (LDPB)

GWH continues to work closely with the Learning Disability Patient Board (LDPB) looking at practice in the local area. A core focus of work has related to improving the uptake of annual health checks in the local area. One of our primary care services has employed a LD nurse one day a week to complete the annual health checks, and this has been working very well.

Other Improvements impacting patient outcomes include:

- A sepsis easy read leaflet, produced by our radiology department;
- We have received approval for the Changing Spaces Project;
- Introduction of an internal and external direct referral system for LD Liaison Nurse support for either inpatient admission or day case admission;
- We have an increased number of professional /MDT meetings during hospital admission;
- Improved and early discharge planning for patients with LD requiring complex discharge planning;
- Support for patients needing complex admission who are COVID-19 swab phobic.

Note: we do not currently collect demographic data on the numbers and personal protected characteristics of patients who access our LD services, and are currently reviewing the ways this data is collected.

Our Patients

The people we serve

During the financial year 2020/21, Great Western Hospitals NHS Foundation Trust cared for 149,858 patients, from new born babies to people aged 90 and over.

Information on these patients can be seen in the infographic below, which contains basic demographic data for all individual patients who had contact with the Trust during the financial year 2020/21.

At present, we do not have access to the level of data that would indicate sexual orientation or disability. However, ethnicity, religion, gender and age range are recorded. We are currently reviewing the way equality data is recorded in the Trust.

149,858 patients

by sex:

- 68,008 male
- 81,809 female
- 41 not specified

by ethnicity:

- 85% (126,777) – White
- 9% (23,081) – BAME
- 6% (8,899) – not stated

by religion and belief:

- 33,887 - Church of England
- 23,106 - not known
- 14,981 - other religion
- 9,650 - Catholic
- 3,842 - not religious
- 1,852 - Muslim
- 456 - Sikh
- 282 - Agnostic
- 120 - Hindu
- 98 - Spiritualist
- 85 – Jewish
- 77 – Pagan

by age:

- 0-9 yrs - 15,900
- 10-19 yrs - 11,276
- 20-29 yrs - 14,615
- 30-39 yrs - 18,529
- 40-49 yrs - 16,696
- 50-59 yrs - 20,562
- 60-69 yrs - 18,562
- 70-79 yrs - 18,563
- 80-89 yrs - 11,857
- 90+ yrs - 3,298

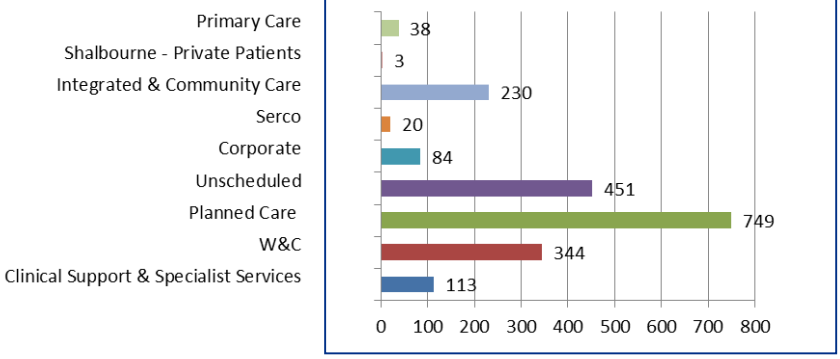
Note: The data sets include all patients who have had either an outpatient appointment; an Accident and Emergency (A&E) attendance; an inpatient admissions visit, and any contact by the community nursing team. The data set only counts individual patients once, so even if they had multiple A&E or Outpatient attendances (for instance) they would only appear once in the data. Also excluded are missed/cancelled appointments and a community home visit.

Our Patients

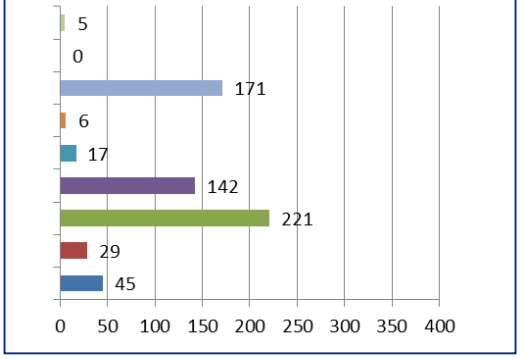
Concerns, complaints and compliments

The following data on concerns, complaints and compliments is for the period April 2020 to March 2021.

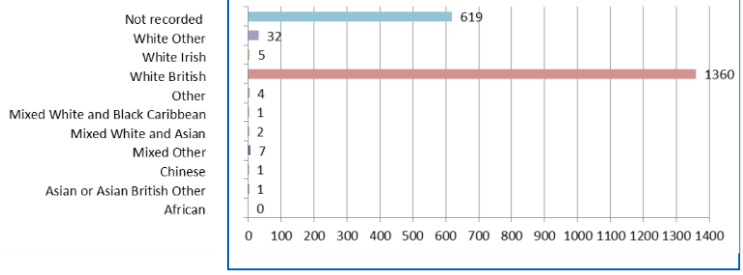
Concerns and complaints



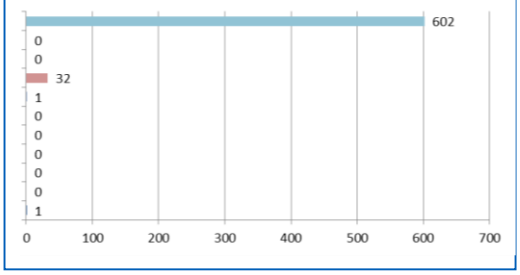
Compliments



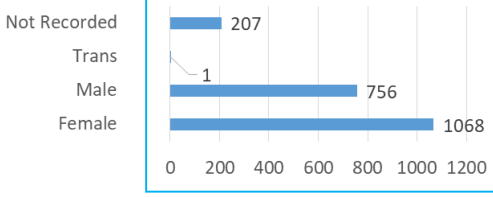
Concerns and complaints by ethnicity



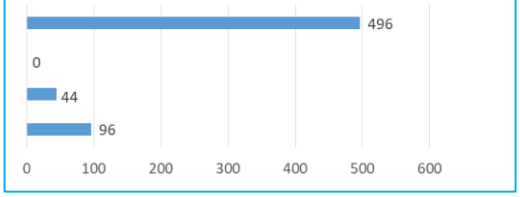
Compliments by ethnicity



Concerns and complaints by gender



Compliments by gender



Note: At the moment we do not record all the protected characteristics, and are limited with what we can pull from our recording current system. As part of our data collection review, we are due to change our data systems from 1 September 2021, which will enable us to gather more detailed information.

- The recorded data shows that our Unscheduled and Planned Care divisions receive the most concerns and complaints, with Planned Care also recording the most compliments. These are also the areas that record the highest patient numbers.
- There are low or 'negligible' responses by ethnic category, with the highest category being 'not recorded.'
- The highest category for compliments by gender is, again, 'not recorded.'

Our Patients

Our Chaplaincy Service

Our Chaplaincy Service is religion-non-specific, denominationally neutral, and thus able to offer generic spiritual and pastoral care to all patients and their carers, family and friends, staff and volunteers to help deal with the experiences of illness and injury, life and death and to process issues of personal meaning and purpose.

"Chaplains are trained and experienced in listening to and supporting people in difficult situations and offer a sensitive and discreet support. The team can also help with cultural and religious routines and rites of passage."

Rev Christopher Mattock
Chaplaincy Team Leader

We have one whole time lead and two part-time Chaplains (pictured right), supported by 33 chaplaincy volunteers from a range of social and religious backgrounds.

Rev George Mireku-Yeboah

Our Roman Catholic Chaplaincy is provided by the Swindon RC Deanery and we have close links with the Swindon Interfaith Group, Thamesdown Islamic Association and Swindon Hindu Temple.

The Chaplaincy Centre and multi-faith room is on the First Floor of the hospital, near Main Theatres and the Daisy Unit. It is open at all times for reflection, quietude and if wished, prayer. Local religious communities and faith groups supply the chaplaincy with a range of religious texts from the major world religions to be available for staff and patients.

Rev Jean Brown

Within the multi-faith room are artefacts from the Christian, Muslim, Sikh, Hindu, Buddhist and Jewish religions kept in bespoke cabinets which can be opened, or closed, as appropriate

Our Patients

Our Chaplaincy Service

2020 brought significant changes…

- In March we stood down our chaplaincy volunteers, stopped our regular teaching and training and increased our staff support role.
- We were early adopters of virtual visiting technology using iPads and mobiles phones to assist families of patients unable to visit the hospital. We were also able to use the same technology to enable local religious leaders to connect with patients for prayers and other religious rituals.
- From the beginning of Covid-19 we were concerned to keep the multi-faith room open for private prayer and reflection; particularly as a space for staff to take time out of an intense working day or as a place for decompression following a difficult shift. By restricting numbers in the room, frequent cleaning and sanitation and the use of disposable prayer mats we have been able to keep the room available at all times.
- An emergency religious contacts list has been approved by Swindon Interfaith Group and is available to all staff on the Chaplaincy intranet page.
- Quran for Hospitals (www.quranforhospitals.co.uk) have donated 5 Quran Cubes which are mp3 players loaded with a full recitation of the Quran in Arabic and English. These have been checked and approved by Mufti Belim of Swindon Mosque.
- The Gita Project (https://thegitaproject.org/) have donated copies of the Bhagavad Gita Hindu text to the chaplaincy to be made available for patients and staff
- Gideons International have provided Bibles and New Testaments and Psalm for patients and staff.

The last set of meaningful statistics are from 2019 and we look forward to returning to this level of activity in 2022. Here are our significant episodes of spiritual/religious care' recorded as contacts:

6920
total contacts

4760 patients
1826 visitors
334 staff

Of these contacts, 1993 people sought religious care

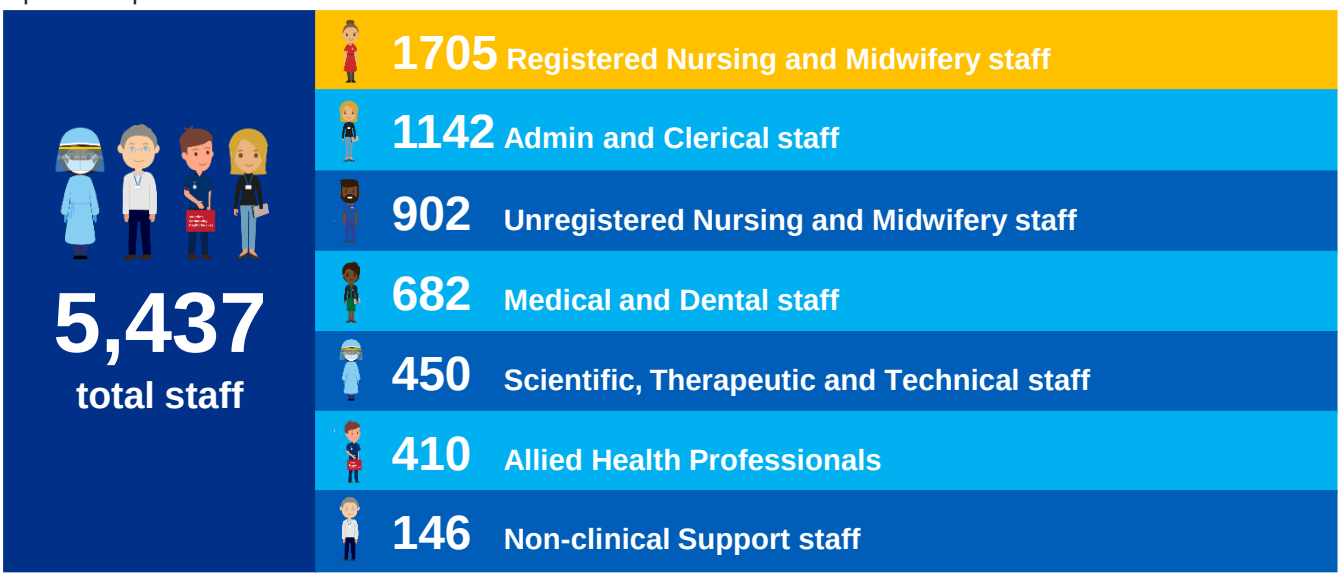
Reverend Chris Mattock,
Chaplaincy Team Leader

Our Workforce

Our Workforce Demographics

By staff group

At the time the snapshot was taken (to 31 March 2021), the Trust had 5437 staff (by headcount). The following infographic shows the breakdown of our staff by occupational group, and where data is recorded for their personal protected characteristics.



This shows that Registered Nursing and Midwifery staff group makes up the largest proportion of our workforce, whilst Non-Clinical Support is our smallest proportion.

Note: The above staff groups are recognised by the Trust. They differ from those used by national teams, or when data is extracted manually from the Electronic Staff Record (ESR).

By sex

More than four in five of our staff are female. This is slightly above the national average, according to a **recent study from NHS England**, which found that around 77% of all NHS staff are female.

Our Workforce

By age

The majority of our staff (14%) are aged between 31 and 35. This varies slightly from the national picture. According to **research from NHS Digital**, the largest age group employed is staff between 35-39 years.

Our workforce by age			
< 20 years	47	46-50 years	680
21-25 years	359	51-55 years	641
26-30 years	737	56-60 years	544
31-35 years	760	61-65 years	324
36-40 years	666	66-70 years	63
41-45 years	584	>71 years	32

Workforce aged 55 and over

BSW ICS Average	GWH NHS FT
21.1%	17.7%

Our Trust also has a younger workforce than the average within the BSW ICS.

By sexual orientation

58% (3,136)	33% (1,776)	7% (397)	1% (67)	1% (31)
Heterosexual/ straight	Not stated/ response declined	Blank/ no response	Gay/ Lesbian	Bisexual

Modern data collection processes are safe, secure, and the results yielded are key to service improvement. Nonetheless, a sizeable proportion of our staff (40%) chose not to declare their sexual orientation. This abstention reflects a national trend, and mirrors findings from the Equality and Human Rights Commission. Their study found that staff felt uncomfortable disclosing their sexual orientation in a monitoring form if the reasons for being asked, how the data would be used, and whether it would remain anonymous and confidential, were not fully explained. In addition, the evidence shows that some individuals, employers and service providers still consider sexual orientation to be more 'private' than other characteristics for monitoring purposes.

LGBT+ workforce declaration

BSW ICS Average	GWH NHS FT
2.4%	1.8%

This low reporting trend is also mirrored in the BSW ICS data.

Our Workforce

By ethnicity

72% (3,928) White	17% (916) BAME	11% (593) Not stated

The majority of our staff (3674, 68%) identify as White British. There is an additional level of White ethnic diversity to be seen when we look at data for staff who do not identify as British, shown in the chart below.

White ethnic diversity

143	46	36	11	5	3	2
Any other white background	White – other European	White – Irish	White – Polish	White – Greek	White – Welsh	White – Scottish
2	**1**	**1**	**1**	**1**	**1**	**1**
White- Italian	White - Turkish	White – Other Ex Yugoslav	White – Mixed	White – Cypriot	White – Cornish	White - Unspecified

In 2020/21, when this snapshot was taken, our Black, Asian and Minority Ethnic (BAME) workforce increased by 5.3% (185) on the previous year, and now makes up around 17% of our total workforce (headcount 916). We can see that their number (excluding non-recorded responses) is composed of multiple ethnic identities, as shown in the chart below, the largest being Asian or Asian British – Indian.

BAME ethnic diversity

290	158	99	54	42	32	23
Asian/ Asian British - Indian	Any other Asian background	Black/ Black British - African	Black - Nigerian	Filipino	Asian/ Asian British - Pakistani	Black/ Black British - Caribbean
14	**13**	**13**	**11**	**10**	**8**	**7**
Mixed – White & Black Caribbean	Mixed – Any other mixed background	Chinese	Any other Black background	Mixed – White & Black African	Asian - Unspecified	Black - Mixed
6	**6**	**5**	**4**	**3**	**3**	**3**
Mixed – White & Asian	Asian/ Asian British - Bangladeshi	Malaysian	Asian - British	Black British	Asian – Sri Lankan	Asian – Mixed
2	**2**	**2**	**2**	**1**	**1**	
Black - unspecified	Mixed – Asian & Chinese	Mixed – Chinese & White	Mixed – Other/ Unspecified	Mixed – Black & Asian	Black - Somali	

Our Workforce

By religion and belief

The majority of our staff (2087, 38%) either follow the Christian faith; or did not wish to disclose their religion/belief. A further number left the data form blank (380). The religious preferences of the other staff can be seen in the chart above, which shows that the majority of these staff (51%) identify as atheist.

By disability

A very small percentage of our staff (l.5%) have indicated that they have a disability, equating to 83 people. A significant number of staff (1421) reported not know or prefer not to say. The Workforce Disability Standard (WDES) Report, referred to later, shows that the number of our people identifying with a disability in the NHS Staff Survey is much higher, and does not reflect this number. We are working with the Differently Abled Network (formerly called the Disability Equality Network) to encourage our people to feel confident to disclose their relevant disabilities.

As stated earlier, our Trust emphasises that data collection is safe, secure, and a vital way to improve services. Nonetheless, small numbers of staff have declared a disability. This reflects a national trend, and mirrors findings from the Equality and Human Rights Commission. The evidence shows that some individuals, employers and service providers still consider disability to be more ‘private’ than other characteristics for monitoring purposes.

Our Workforce

Starters and Leavers

+ 515 staff headcount	**+ 1,162** staff joined
	- 647 staff left

In the year 2020/21, a total of 1162 staff joined the Trust and 647 left, giving a net increase of 515. Demographic information on our starters and leavers is shown in the charts below.

Starters and Leavers Demographics

By sex

Starters	
79% (916) female staff	**21% (246)** male staff

Leavers	
85% (550) female staff	**15% (97)** male staff

By age

Starters			
< 20 years	34	46-50 years	70
21-25 years	253	51-55 years	50
26-30 years	267	56-60 years	33
31-35 years	210	61-65 years	12
36-40 years	145	66-70 years	1
41-45 years	87		

Leavers			
< 20 years	19	46-50 years	50
21-25 years	87	51-55 years	52
26-30 years	91	56-60 years	55
31-35 years	91	61-65 years	52
36-40 years	78	66-70 years	15
41-45 years	51	>71 years	6

The age profiles of our starters and leavers also broadly reflects the profile of our pre-existing (recruited and in post before 2021) workforce.

Our Workforce

By sexual orientation

A significant percentage of both our starters and leavers (25% of starters; 29% of leavers) chose not to declare their sexual orientation. It is likely that this is for the reasons already discussed, and is consistent with findings for our pre-existing workforce.

Sexual orientation	Starters	Leavers
Heterosexual/ straight	685	342
Not stated/ response declined	291	186
Blank/ no response	151	109
Gay/ Lesbian	22	4
Bisexual	13	5

By disability

In common with our pre-existing workforce, the vast majority of our starters and leavers have declared that they do not have a disability.

Response	Starters	Leavers
No	961	495
Yes	17	9
Prefer not to answer	1	0

By ethnicity

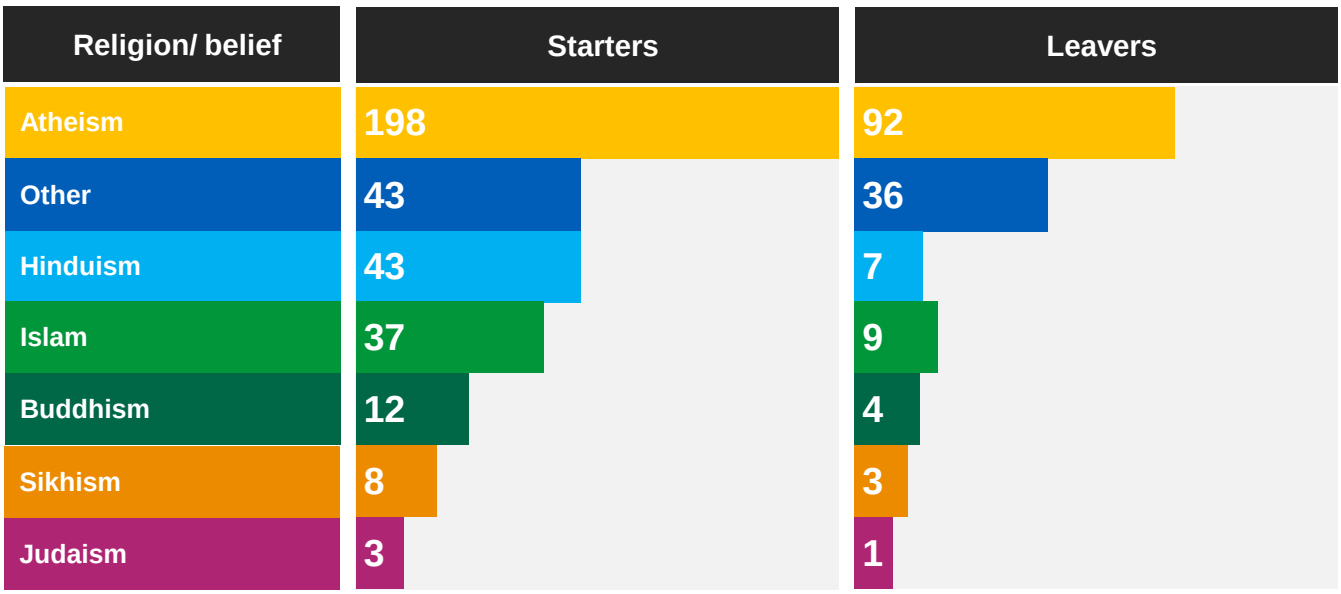
The majority of our starters and leavers are White British, and this is consistent with our pre-existing workforce.

Response	Starters	Leavers
White	683	486
BAME	323	94
Unknown	156	67

Our Workforce

By Religion and Belief

The majority of our starters and leavers (an aggregate total of 553, or 31%) follow the Christian faith; whilst a similar total did not wish to disclose their religion/belief. A further number left the data form blank (258). The religious preferences of the other starters and leavers can be seen in the bar chart below.



Note: This data includes:

- Maternity leave, but excludes those on career breaks;
- Substantive staff only;
- Staff in post, based on the official data from our Electronic staff Records.

Our Workforce

Volunteers

During the Covid-19 pandemic, the majority of volunteers have not been attending the hospital site. As we slowly return our volunteers back to their roles, we will request that they complete new equality information and next year we will have a more complete picture of the volunteers on site. The following graphs show the equality data relating to our team of 438 volunteers, of which 112 joined the Trust in 2020.

When comparing our volunteers with the pre-existing workforce:

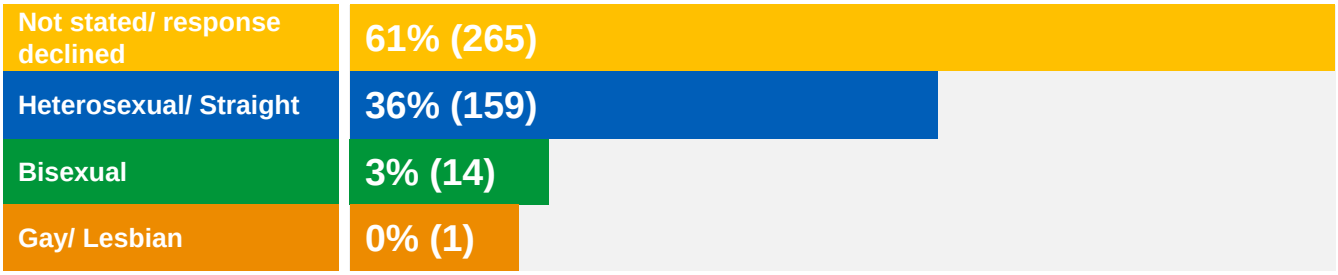
Data on our volunteer workforce is similar to that of our paid workforce. For example, the vast majority of our volunteers are female, and most volunteers chose not to declare information about their sexual orientation.

Volunteers Demographics

By sex

By age

By sexual orientation



Note: A lot of our volunteers were recruited before 2019. After that date, we changed our application form in line with the one used for staff recruitment. Prior to 2019, questions about sexuality were not asked, and this information recorded as 'not disclosed.'

Our Workforce

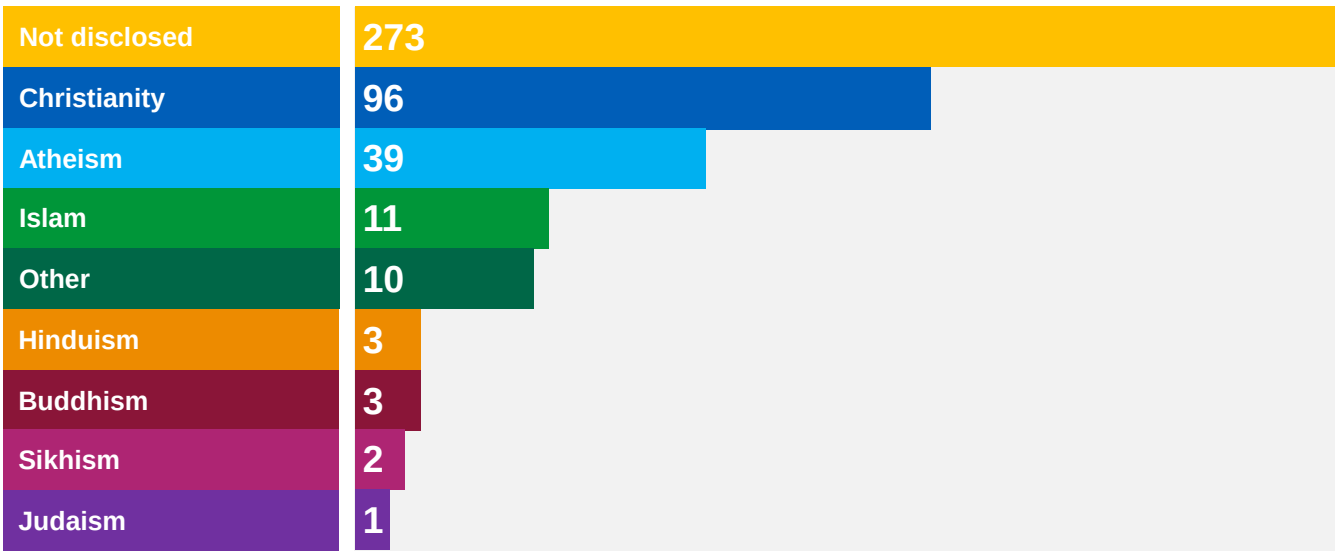
By disability

By ethnicity

Ethnic diversity

311 White - British	41 Not stated	31 Asian/ Asian British – Indian	19 Asian/ Asian British – Any other	14 White – Any other	6 Black/ Black British - African	5 Asian/ Asian British - Pakistani
3 Black/ Black British – Any other	3 Mixed – White and Asian	2 Black/ Black British - Caribbean	1 Any other ethnic group	1 Asian/ Asian British - Bangladeshi	1 White - Irish	

By religion



Training and Development

Effective leadership is crucial to ensure the smooth operational running of the Trust, develop and gain the best from each member of staff, and provide all of our staff with an equal opportunity to contribute. Our training and development has been affected by the Covid-19 pandemic, with some programmes and plans delayed. Despite this, the Trust has continued to develop its leadership offer, and below shows the progression and plans for 2020 and 2021. We have reviewed our leadership programs to ensure that diversity and inclusion is contained throughout our Talent Management and Leadership Development Programmes.

Leadership Development Program

Our Leadership Development Programme (for staff at Bands 7 and 8a), includes a mandatory EDI training module. This year we have added an audio-visual resource that focuses on the following:

- Identifying different forms of Institutional Discrimination;
- Developing our approaches to tackling these forms, and the most effective ways to lessen the chances of these situations recurring;
- Understanding how and why other strategies for combating discrimination (such as ‘positive action’ and unconscious bias training) are interlinked.

Training Data

Over the last year (to 31 March 2021) compliance data across our mandatory EDI courses is around 80%. We are working to increase training compliance rates.

License to Recruit Training

The Trust has developed an online in-house training programme called ‘License to Recruit’ that focuses on three key areas;

- Safer Recruitment;
- Equality, Diversity and Inclusion;
- Unconscious Bias.

All recruiting managers will be able to access this module via ESR E-learning, and this information will be monitored and reported.

Training and Development

The Leadership Forum

The Leadership Forum was launched in October 2019. The first Forum was used as an opportunity to co-produce the Trust's first Leadership Framework (based on the Leadership Principles). This document sets out the Trust's expectations of its leaders, including their responsibilities in relation to equality, diversity and inclusion.

The forum has met several times since, including once in 2021. The first meeting in 2021 included a focus on diversity and inclusion, and provided an opportunity for leaders from diverse backgrounds to share their learning and experience. A second meeting is scheduled, and will focus on the lived experiences of our BAME staff. It will include:

- Their experiences about developing in to a place of leadership;
- Who has been their influence/role model;
- The support/struggles/positives and/or negatives that have helped them to succeed

The first meeting was attended by around 45 members of staff and was well received. We are anticipating similar numbers and feedback for this second meeting.

Leadership at Four Levels

The Leadership framework has four defined levels. These describe the behaviours expected at each level and is supported by a developing 'leadership offer'. The Leadership Framework is explicit in the expectation that leaders support and create a diverse and inclusive workforce.

- Aspiring Leaders – Leading myself.
  Under this level, we are currently seeking to increase awareness of aspiring leaders, through sharing positive stories.
- First Line Leaders – Leading others;
- Established Leaders – Leading a service/department/division;
- Senior Leaders – Leading the Trust and within the Integrated Care System/Sustainability and Transformation Plan.

The aim is to clearly set out the appropriate development offer which will support staff to become leaders, and this work is progressing.

Training and Development

Talent Management – a phased, tailored approach

The Trust has introduced a phased approach to Talent Management. This will be rolled out further across the organisation over the coming months and will enable honest conversations about an individual's aspirations and potential. It will include understanding the individual's placement on a talent grid, and should support discussion about future career paths, barriers and development needs.

Stepping Up Programme

The NHS Leadership Academy delivers the 'Stepping Up' programme aimed at BAME staff in Bands 5-7; and along with other relevant targeted programmes, it will continue to be promoted in future. The programme was suspended in 2020 due to the Covid-19 pandemic, but reopens in August 2021, with the first cohort due in November 2021.

In the interim, and as a foundation to this work, we are seeking to understand the barriers to promotion faced by our BAME staff at Bands 5 and 6 (the issue of career progression for BAME staff at these Bands has been recognised more widely, throughout the South West). We have produced a confidential survey about barriers to career progression. The survey was completed by 60 staff members, and following this we are holding a series of facilitated staff focus groups to develop action plans and agree our next steps.

Freedom to Speak Up (FTSU)

The Freedom To Speak Up initiative is a key element of equality, diversity and inclusion as it allows staff a safe way of raising issues of patient safety concern. The Freedom to Speak Up Guardians report an improved Board focus and clear leadership governance from the Trust Chairman, Chief Executive and the Senior Independent Director who maintain access to the Guardians and involvement with the FTSU framework.

The Trust has successfully introduced and integrated the FTSU service model across the acute, community and primary care services and promotional events, such as a Freedom to Speak Up drop in session, tea trolley visits to wards and departments have taken place to raise the visibility of the Guardians and the role and support that they offer.

See elsewhere in this report for more detail on the work of our FTSU ambassadors.

Training and Development

EDI and Board Development

Reciprocal Mentoring is commonly recognised as an important way for organisations to embed the EDI agenda into Board development. Our pilot scheme was introduced in May 2021. It involved 13 Board members and senior Executives being mentored by an equal number of more junior colleague from a different background to that of the senior leader, and who therefore experience their careers differently. Key outcomes for Board members include:

- Gaining a new perspective on some complex diversity issues within the Trust;
- Improving understanding and knowledge of equality issues by sharing learning with our Network staff;
- Stimulating creative thinking about how to develop diversity in the workforce and practical strategies for increasing diversity; and
- Gaining increased confidence about the diversity agenda and ways in which they can be agents of change, through harnessing candid and honest feedback

Initial feedback from Board members has been extremely positive. We will evaluate the programme when the pilot is finished, with a view to extending it to all staff in the Trust. In addition, we are consulting with our new and existing Non-Executive Directors, to shape the content of EDI Board development; and are ensuring that personal stories, regarding the issues and challenges faced by staff with personal protected characteristics, are regularly shared with our Board.

Widening Participation

As an anchor institution (one whose long-term sustainability is tied to the wellbeing of the populations they serve), we seek to improve and increase entry routes for staff from diverse backgrounds, to facilitate better access to development and career opportunities. Current projects include:

- Collaboration with an award-winning advertiser and film-maker to create a free training program for young adults in the locality. The program will be targeted at our most disadvantaged communities, with a proposed start date of September 2021.
- Scoping and creating opportunities to enable children and young people to aim high through work experience opportunities, mentorship and coaching and employment opportunities;
- Supporting Local Authorities in their role as corporate guardians, to secure the best outcomes, for looked after children and young people.
- Supporting and exploring projects that examine routes into employment and training, and making a positive impact on local communities. For example, the Cadet Scheme.

Training and Development

The Early Years Careers Service

Rachel Smith

Rachel Smith (left) is our Early Years Careers Advisor. The Early Years Careers Service (EYCS) aims to attract a wide diversity of students through multiple routes, such as the school careers advisory service, local council careers hubs and social media outlets.

Our data shows that around 24% of our programme intake identify as Black, Asian and Minority Ethnic (BAME), and our programmes are tailored more widely to meet diverse student interests, needs and academic abilities.

The table below several ongoing EYCS projects over the last year. We do not currently collect full demographic data on the numbers and personal protected characteristics of people who access our EYCS, and are currently reviewing ways this data is collected.

Project	Description	Target Audience	Male	Female	BAME	Total
Primary School Day	We went to Colebrook primary school to try to target young students and teach them about the different roles within hospitals, specifically doctor roles. We did different activities such as: dressing up in scrubs, using stethoscopes, flash cards, practicing bandaging and a simulation session	Primary School Students			12	226
Nursing day	Focus was to inform students about routes into nursing	Ages 12 - 18				53
AHP Day	The focus was to educate students on the different AHP professions, what they do and how to get into the professions	Ages 12 - 18				91
Springpod **1613 applicants, 409 places offered.**	We ran a 2 week virtual programme where students learnt about a range of different professions, attended live webinars to meet our staff, completed activities and quizzes as well as watched videos and read the information supplied (10 hours worth of work)	Ages 14 -18 - high achieving students	102	307	102	409
Princes Trust - 25 spaces	We ran a 3 day programme where the aim was to support the young people into employment. Currently we have around 10 of these young people working as HCAs within the Trust	Ages 18 - 30 - unemployed individuals	1	18	6	19
Pathway (Feb) - 123 spaces offered	The focus of the session was Nursing, we helped to show students the different routes to become a nurse	Ages 14 - 18 - high achieving students	6	117	28	123
Pathway (June) - 162 spaces offered	The focus of the session was apprenticeships and entry level roles	Ages 14 -18 - low achieving students	Awaiting report	Awaiting report	Awaiting report	162
Swap Student	We were asked to support one student with a 2 week placement for their course (Kickstart).	1 student	1	0	0	1
Learn Live	The sessions ran 10am-2pm for students and 5pm-7pm for parents. The	Secondary Schools				4840
	Total				148	5924

EDI Activity

Our Equality, Diversity and Inclusion (EDI) Strategy was developed and published in February 2021. The strategy identified areas of priority to work on over a four year period, to improve equality, diversity and inclusion at the Trust.

To support the delivery of the strategy, the Trust created two new roles, an Equality, Diversity and Inclusion Lead and a Patient Experience and Engagement Lead. The strategy was developed with valuable input from staff in our Black, Asian and Minority Ethnic (BAME) and Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ+) staff networks. Our highlights include:

Holding our second Diversity Day

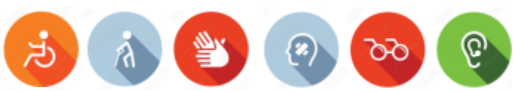
A second Diversity Day was held virtually in October 2020. Guest speakers from across the country were invited, shared their experiences of securing roles in senior positions, and offered advice to the Trust on how we can improve our recruitment processes.

Over 200 staff joined the online sessions and spoke about their own experiences and difficulties in career progression within the NHS, to make our organisation more inclusive and diverse. Members of staff made individual pledges, outlining what each person would do to drive forward positive change. Since the Diversity Days, regular contact has been maintained between the guest speakers and the organisation, and our Chief Executive has built lasting relationships.

Appointing an Equality, Diversity and Inclusion Lead

In 2020 we recruited an Equality and Diversity Lead, to help us drive forward more action on this essential agenda.

Creating a Disability Equality Network



A new Disability Equality Network, created in February 2021, as a space for staff to connect, share experiences and information (see page 37).

EDI Activity

Developing training resources

Several training and instructional resources, in audio-visual, case study format, focused on common scenarios faced by staff; areas including ‘zero tolerance’, abuse from patients, and recognising forms of institutional discrimination. Staff can access these resources for suggestions on how to tackle these situations when they occur, and to understand how the Trust will support them.

Quarterly EDI Newsletter and annual calendar


Equality, Diversity and Inclusion Newsletter

Welcome to the new EDI newsletter, a place to share information and promote engagement.

A Trust-wide EDI newsletter as a source of information and guidance. The bi-monthly publication includes staff interviews and a regular focus on our wellbeing initiatives.

An annual calendar of regional, national and international EDI events and celebrations, some with hyperlinks for further reading.

Trans policy and guidance

Developing a draft Trans policy/guidance document, to ensure that Trans staff receive equal treatment, and partnered with a reputable organisation to advance this agenda.

Community links

Developed strong links with community groups and services to reduce any inequalities identified through their feedback. This was particularly relevant for the Covid-19 pandemic. Several radio interviews, vaccine journey podcast helped to dispel myths and misinformation about the Covid-19 vaccine, and thereby encourage take-up.

EDI Activity

Gender Pay Gap Report

We published our Gender Pay Gap report (see page 44) alongside an action plan to reduce the pay gap between males and females.

Progressing the EDI agenda with our divisions

Our three clinical divisions (Unscheduled Care, Women's, Surgery and Children's, and Intermediate Critical Care) have each committed to progressing three areas of the EDI agenda.

Note: See elsewhere in this report to learn about the work of our Learning Disabilities Service, our Differently Abled Network and our Chaplaincy.

Staff Support Networks and Services

BAME Network

Our BAME* (Black, Asian and Minority Ethnic) Network supports and celebrates the contribution and ethnic diversity of staff who work and study at The Great Western Hospitals NHS Foundation Trust.

We support staff towards improving and progressing in their chosen career paths with the support of the Trust for all of our BAME staff.

“We hear a lot of negativity in the press and more so lately, asking what has changed in the last year for inequality. I find myself deep in thought. It starts negatively and then turns to positivity.”

Alicia Messiah
Chair, BAME Network

In the last year, we have started from a fresh perspective due to the pandemic and also the coverage of inequalities such as Black Lives Matter. We held a Black History Month in October, have seen the Network grow, and connections made both in and outside of the GWH. We have asked more allies to join the network and see and hear from our staff about their experiences and what we can do to support.

Members of our Board (Executive and Non-Executive Directors) have met staff to more fully understand what’s happening ‘on the ground’, and the day-to-day running of the trust. Going forward, we are planning to work with Pride, develop a BAME leadership event, and celebrate dates such as Diwali and Windrush day.

The Network meetings take place monthly, although we are flexible about this, to try and reach staff who can’t attend a meeting and also to sustain momentum. Meetings can have anything from five to 30 people attending; and have been held virtually, due to the pandemic. Going forwards, we’re looking to use both face-to-face and virtual meetings, to maximise attendance.

Staff Support Networks and Services

We are having more challenging conversations within the BAME network and more staff have understood different points of view. We've heard those people at the top listening to our Network. Hearing real stories in real time about experiences from staff and how we go forward with staff needs and experiences.

Our Chief Executive made a pledge to support the BAME Network and EDI and so far he has delivered. He's spoken to the BAME Network and is happy to support what we do. We have an EDI lead that can also bring forward the work the BAME network does and the feelings we have and support any actions that the WRES network needs to implement. We have seen more concerns and complaints and more openness in the organisation and more actions being taken.

Covid-19 highlighted inequalities in health, how different our bodies and minds are. The inequalities with poorer and richer areas and accessibility to health care. We hear about what different cultures think about health care and vaccines. It highlighted that as a country, government, NHS, we have a lot of work to do to educate and change people's mindsets. Its celebrated cultures and what they bring to the table. BLM started a movement which has been around for a long time to the forefront of our minds again.

This network isn't to focus on negativity but to hear the points of view and celebrate what we do. We are all different colours and lets embrace and acknowledge this, not hide this. We are not all races but one human race.

Alicia Messiah
Chair, BAME Network

***A Note on the use of the acronym 'BAME'**

A number of terms have been used, by successive British governments and in society more generally, to collectively refer to Britain's ethnic minority populations. These include "Black and Minority Ethnic" (BME), "Black, Asian and Minority Ethnic" (BAME) and "Black and Ethnic Minority" (BEM). The terms have been challenged on a number of grounds: for example, for excluding national minorities such as the Cornish, Welsh, Scottish and Northern Irish from the definition of ethnic minorities; and for suggesting that black people (and Asian people, specifically South Asians with regards to BAME) are racially separate from the minority ethnic population.

Our Trust network, in common with The National Centre for Diversity (TNCD), has decided to retain the term BAME. This is because, in common with TNCD, our Network recognises the changing, cyclical nature of language in the area; that one label will not encompass the entirety of experiences and identities in a way that we all agree; and that the most important consideration is to disaggregate data within the label, to get an accurate picture of health inequalities, and staff progression. It is important to then use the monitoring data to understand where the gaps are, and develop strategies and action plans to close them.

We have therefore used our staff network's BAME acronym throughout this report, for consistency and ease.

The relevant article from The National Centre for Diversity can be accessed here.

Staff Support Networks and Services

LGBTQ+ Network

Our LGBTQ+ Staff Network was established to increase awareness of issues specifically faced by LGBTQ+ staff, actively influence Trust Policies and strategies that impact on LGBTQ+ staff, and to build a safe space for all.

The Network exists to provide first-level support to LGBTQ+ staff who feel they are being bullied or harassed on the grounds of sexual orientation or sexual identity.

"The Network was once described as an escape from the pressures and challenges of working through a pandemic, which expresses how valuable it is becoming."

Ryan Jary
Chair, LGBTQ+ Network

The Trust places great importance on, and is committed to, equality for all staff and the network gives staff a voice to face inequalities at all levels.

In February, The network celebrated LGBTQ+ History Month, an annual celebration of lesbian, gay, bisexual, Trans, and non-binary history, including the history of LGBTQ+ rights and related civil rights movements. The celebrations took place virtually calling for staff to show their support by sharing pictures of themselves and their rainbow badge.

This coincided with the appointment of an LGBTQ+ Network chair and deputy chair and the network 'relaunch'. The network had previously been inactive and in an effort to engage staff in this new climate the network believed that LGBT history month was the perfect opportunity to promote the network.

Whilst not yet published the Network turned their attentions to supporting our Trans colleagues at work and drafted the first 'supporting Trans staff' Trust policy within the BSW and are excited to launch this to the wider Trust.

Staff Support Networks and Services

The LGBTQ+ staff Network have proudly pledged to be a 'Stonewall Diversity champion', joining one of the UK's largest equality networks. As an employer, being a champion will showcase our commitment to inclusion and attract diverse talent and will give us access to resources such as empowerment programs for members and allies alike.

Access to national LGBTQ+ research Stonewall will facilitate informed discussions and access to a Recruitment advertising platform specifically for the LGBTQ+ community. The Network is committed to working towards the diversity and equality workplace index and aim for accreditation in 2022.
The network has seen significant growth since December 2020, going from five active members across predominantly non-clinical corporate services to 21 active members across all divisions, including clinical and medical representation.

The Network aims to meet every 6 weeks and following a recent review will now vary the days and times of each meeting to capture different staff, possibly unable to attend a set meeting as they are on shift.

The LGBTQ+ Network, like many other groups has faced significant challenges in last year (Covid-19) one being on building our membership. With the move from face-to-face meeting to virtual the network has struggled to engage with staff Trust wide. Staff Networks relied upon attending events and meeting people face to face which we have not be able to do and have forced many to think outside the box.

Whilst we have faced challenges during the last year we take pride in being a small part of a wider agenda that strives to build a truly inclusive environment for all staff.

Staff Support Networks and Services

Differently Abled Network

The Differently Abled Network (or DAN) was formed in February 2021, and had its first meeting in March. Following discussion at our last meeting, the Disability Equality Network has changed its name, and will now be called the Differently Abled Network.

"The Network felt that the term 'disability' had too many negative connotations, and defined staff by their limitations. By contrast, 'differently abled' was seen to embrace a more empowering, complex, 'can do' identity."

Patrick Ismond
Chair, Differently Abled Network

We are aware that other Trusts and organisations do not use this term, so 'disability' may be also be used when liaising with other outside networks, for ease and familiarity.

To date, activities and projects have focused on:

- Finalising the Network Terms of Reference;
- Providing a 'sense check' on disability issues in the Trust (for example, how to address staff reluctance to declare their disability status on the Electronic Staff Record);
- Joining the SW Disabled Staff Network;
- Attending the South West Disability Summit;
- Agreeing several areas of focus in the coming six months: mainly around promotion, engagement, raising awareness;
- Publicising Information about Leader: Disability Confident Level III;
- Updating the New Starter Pack to include information on the DAN;
- Assessing a Neurodiversity Toolkit to raise awareness and cascade for staff use and guidance.

Staff Support Networks and Services

Freedom To Speak Up

Freedom to Speak Up Guardians (FTSUGs) help to make raising concerns the norm in NHS organisations, and standardise how NHS organisations support staff when concerns are raised.

We have taken several steps to embed and normalise a culture of raising concerns when necessary. For example:

- Providing information on Trust intranet pages about our FTSUG, including Guardian contact details and biographies;
- Increasing FTSUG visibility by issuing Guardian business cards, badges and FTSU lanyards;
- Sharing green FTSU ribbons across the Trust, so that our Guardians were instantly recognisable;
- Ensuring our Trust induction program for new staff makes reference to the role of our FTUSGs and the importance of the service generally.
- Guardians got out and about, either together or individually to meet people and spread the message that speaking up is a positive step. Ward tea trolley rounds provided a great opportunity to do this;
- Hosting several drop-in sessions to meet Guardians in the acute, community and primary care settings

The Trust vision on speaking up incorporates:

- Promoting an open and transparent culture across the organisation
- Ensuring that all members of staff feel safe and confident to speak out
- Continuing to develop a culture of speaking up so that it is instilled throughout the organisation
- Modelling behaviours which promote a positive culture in the organisation
- Senior leaders readily articulating the Trust's FTSU vision and key learning issues that workers have spoken up about, as well as regularly communicating the value of speaking up

Staff Support Networks and Services

Freedom to Speak Up Index Scores

Measuring the effect of culture change can be difficult, and the acid test is the view of staff. In NHS Trusts we can seek to measure the impact of improvements that have been put into place through responses to the NHS Annual Staff Survey.

The annual NHS staff survey contains several questions that are helpful indicators of speaking up culture, and the questions and response rates from the most recent survey are detailed below. Responses are shown as a percentage. Comparisons are made between figures from 2020/21, and national averages, to rate our 'direction of travel', with an assessment of positive or negative referring to the indicator's impact on staff.

	Staff Survey Indicator	2019/20 (benchmark year)	2020/21	National Score	Trust 2020/21 Comparison with National Averages	
16a	% of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly	61.8 %	63.8%	61.4%	Up +ve	⇧
16b	% of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents.	92.8%	90.7%	88.2%	Up +ve	⇧
17a	% of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it.	95.8%	93.6%	94.6%	Similar	⇔
17b	% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice.	74.7%	72%	71%	Similar	⇔

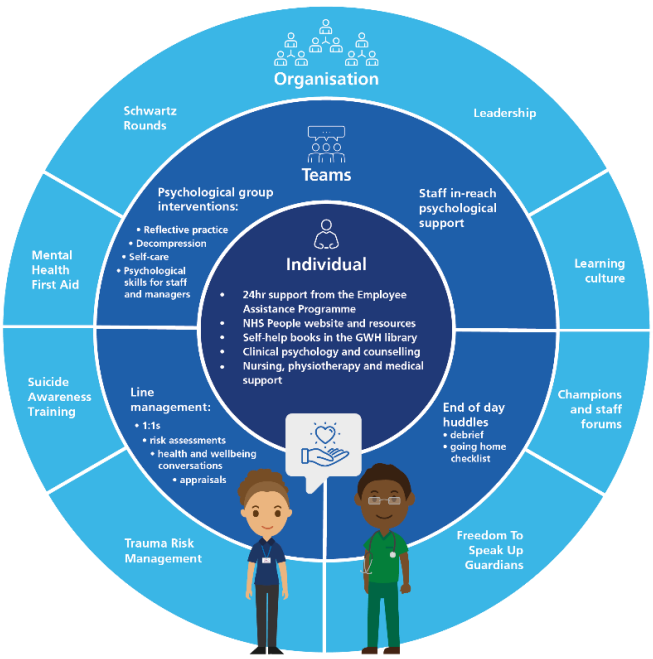
Improvement for staff Similar findings

The above table shows that although our scores for 2020/21 are generally above or comparable with the national averages, they are slightly down on the preceding Trust Survey results.

The FTSU index is calculated as the mean average of responses to the four questions above, resulting in a score of 79.6%. This represents an overall decrease from the 2020 score of 82%, resulting in the Trust being rated as having the greatest overall decrease in the index score. The score demonstrates there is room to improve the culture within the organisation regarding 'speaking up'.

Staff Support Networks and Services

Staff Health and Wellbeing



Our Circles of Support (pictured left) is the umbrella term for our Health and Wellbeing Plan.

Read our Health and Wellbeing Plan.

It highlights all of the health and wellbeing interventions and strategy in place within the organisation.

"We are supporting staff teams who have had particularly challenging experiences during the pandemic, including the death of a colleague and exceptionally high patient deaths in some departments (which we are managing by providing drop-in / in-reach support to those departments), including running group reflective practice sessions for them."

Jon Freeman
Clinical Lead for Staff Health and Wellbeing

Mental health training in numbers

137 staff trained in Mental Health First Aid (MHFA)

47 staff trained in Trauma Risk Management (TRiM)

National Report Summaries

The Workforce Race Equality Standard (WRES) Report 2021

Read our **WRES Report 2021**

The Workforce Race Equality Standard (WRES) was launched and mandated for all NHS Trusts in 2015/16, with the first report published in June 2016. It was introduced to ensure employees from Black, Asian and Minority Ethnic (BAME) backgrounds have equal access to career opportunities, and receive fair treatment in the workplace.

There are nine WRES indicators, including four relating to the workplace covering recruitment, promotion, career progression and staff development, as well as one which specifically measures BAME representation at Board level. The remaining four indicators cover harassment, bullying or abuse from managers, colleagues, patients, relatives or the public.

The aim is for results to be published annually in order to support organisations, particularly those with lower scores, to continuously improve standards. Trusts can compare their performance with others in the same region or providing similar services.

Key areas of progress from our 2021 WRES report are:

- A 5.5% (382) overall increase in BAME staff numbers since 2019;
- The greatest movement for BAME clinical staff into Band 5 (from 18.8% to 32.8% of clinical staff);
- Noticeable increases in the proportions of trainee grade (from 16.1% to 25%) and Band 8c (from 10% to 28.6%) for BAME clinical staff;
- White applicants are more likely to be appointed to job roles from shortlisting than BAME applicants, but the ratio is closer to parity now than in 2020;
- BAME staff were less likely than White staff to enter the formal disciplinary process. This bucks the national trend, and is an improvement on our own position from 2020.

National Report Summaries

There are areas where our progress is less marked. Namely:

- There are no BAME staff at Board level in the Trust in 2020-21 (although this position has changed for the Trust Board through Non-Executive Director appointments and this change will be reflected in our next report).
- Harassment, bullying or abuse from manager, team leader or other colleague towards BAME staff has risen from 8.8% to 16.0%. Harassment, bullying and abuse from patients, relatives or the public remained the same (around 23%); and equal opportunities for career progression and promotion remained the same.
- The Disparity Ratio has been developed as a metric by the national WRES team to help set trajectories and monitor them. It is the difference in proportion of BAME staff at various AfC bands in a Trust compared to proportion of White staff at those bands. Our disparity ratio is 5.12. This means that White staff are 5.12 times more likely to progress from lower to the upper employment bands as BAME staff.
- The national WRES findings indicate that BAME Band 5 clinical staff struggle to attain promotions to higher grades and bands.
- There is a percentage drop for BAME non-clinical staff at Band 9 level (from 20% to 11%). This appears more marked, given the small numbers of BAME staff at that level.

National Report Summaries

The Workforce Disability Equality Standard (WDES) Report 2021

Read our **WDES Report 2021**

The NHS Workforce Disability Equality Standard (WDES) launched on 1 April 2019. The overall aim is to make the NHS an exemplar employer for disabled people and to address the issues they face.

There are nine WDES indicators. Key areas covered include representation across pay Bands, recruitment, involvement in formal capability processes, and experiences of bullying and harassment. The aim is for results to be published annually in order to support organisations, particularly those with lower scores, to continuously improve standards. Trusts can compare their performance with others in the same region or providing similar services.

Our data presents a broadly positive picture regarding career progress and work experiences for staff with disabilities. The majority of indicators for the WDES show an improvement on scores from previous years, and when viewed against the national averages.

When compared with previous years, our staff who declare a disability are:

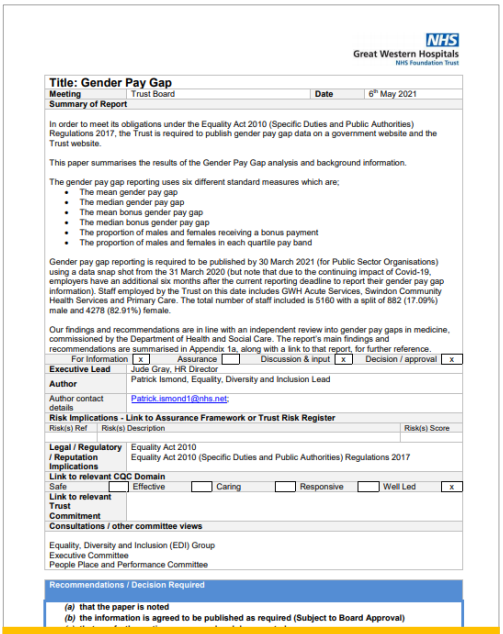
- More likely to be appointed to roles once shortlisted;
- Less likely to enter the formal capability process;
- Less likely to experience abuse from managers and members of the public;
- Increasingly more satisfied with adjustments made to the workplace, and with the value our organisation places on them and their work.

There are areas where our progress is less marked. Namely:

- We have yet to have a declared disability at Board level;
- Outside of Board level, very few staff (83, or 1.5%) have self-declared a disability;
- Staff have felt more pressured than in previous years to come to work, when not feeling well enough to perform their duties;
- There is a disparity between the numbers of staff declaring a disability through the ESR, and the numbers of staff declaring a disability when completing the National NHS Staff Survey.

National Report Summaries

The Gender Pay Gap Report 2021



NHS
Great Western Hospitals
NHS Foundation Trust

Title: Gender Pay Gap

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

Summary of Report

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

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

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

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

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

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

For Information [x] Assurance [ ] Discussion & input [x] Decision / approval [x]

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

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score

Legal / Regulatory / Reputation Implications	Equality Act 2010 Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

Link to relevant CQC Domain

Safe [ ] Effective [ ] Caring [ ] Responsive [ ] Well Led [x]

Link to relevant Trust Commitment

Consultations / other committee views

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

Recommendations / Decision Required

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

Read the full report here.

Our organisation shows a slight reduction in the overall pay gap, from 31.99% to 29.66%. This amounts to a 2.33% narrowing of the gap, and shows that we are moving in the right direction. However, the picture is mixed.

Despite mechanisms in place to harmonise pay scales and career progression arrangements, some elements of our gender pay gap have a historical /national context which will take a period of time to resolve. This partly explains why males continue to be paid more than females.

The overall picture, therefore, is mixed.

We have made progress, because:

- When excluding medical and dental staff from the calculations, the overall pay gap narrows significantly, from 29.66% to 7.30%.
- We have reduced the gender pay gap between males and females across the majority of our bands. For example, the median gender pay gap has been reduced for our staff in Bands 2, 3, 5 and 7.

There are areas where our progress is less marked. Namely:

- Some pay gaps have widened or remained constant. For example, the median gender pay gap has increased for our apprentice staff and those at Band 8b.
- The pay gap has increased for males in some Bands, and increased for females in some bands. For instance, the gender pay gap has increased for females at Bands 3, 4, and 6, and has increased for males at Bands 8c and 9.

As stated above, removing medical and dental staff from calculations significantly lowers the gender pay gap. For this reason, our 2021 action plan focuses on the Medical grades that most affect the pay gap, and any barriers to progression.

National Report Summaries

A national independent review looking at gender pay gaps in medicine showed that the causes of these pay gaps were explained by several factors. For example:

- Women being more likely to work less than full-time (LTFT). Periods of LTFT working were seen to have long-term implications for women's career and pay trajectories as they reduced their experience and slowed down or stalled their progress to senior positions.
- Men reporting as working more unpaid overtime, which meant their effective pay was overstated.
- Male doctors more likely to be older, have more experience and hold more senior positions.

Our findings explaining the gender pay gap broadly align to the national independent review, and consequently our action plan in part reflects the report's recommendations. For example, our action plan will focus on increasing transparency around additional allowances and individually negotiated pay; and monitoring the gender split of applications for Clinical Excellence Awards. We already promote flexible working for both men and women.

The gender pay audit obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. As an organisation that employs more than 250 people and listed in Schedule 2 to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 we must publish and report specific information about our gender pay gap.

The national independent review can be accessed here.

Conclusions and Recommendations

Future influencing factors

The following initiatives will influence and effect our approach to EDI over the coming months:

- The NHS People Plan
- The NHS Long Term Plan
- Annual contributions to the WRES and WDES programmes
- Annual reporting against the Gender Pay Gap
- A Model Employer – NHS England
- The Learning Disability programme
- The Equality Delivery System
- The NHS staff Survey
- Covid-19 pandemic response
- Disability Confident Employer Scheme

Work has commenced across the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System to identify EDI resources and opportunities to promote the inclusion agenda. An EDI Leads Network has been developed across the system to identify areas of joint working to create an inclusive and fair culture.

Conclusions

This report presents progress made during 2020/21 to improve equality, diversity and inclusion for staff and patients. With this in mind, our EDI Strategy identified areas of priority to work on over a four year period, and that work has already begun. The work is being supported by our Lead for Equality, Diversity and Inclusion, and our Lead for Patient Experience and Engagement.

Examples of ongoing work include:

- A developed Patient Experience and Engagement Plan;
- Patient feedback systems extended to improve patient services;
- A Reciprocal Mentoring Programme for Network staff and senior leaders;
- A new staff network formed for staff with disabilities;
- Stronger links developed with community groups and services to reduce any inequalities identified through their feedback;
- EDI training to ensure diverse and representative Board and leaders;
- Audio-visual resources created to tackle discrimination in the workplace;
- Several ongoing initiatives to help people from more diverse backgrounds to access development and career opportunities;
- A talent management programme rolled out across the organisation.

Conclusions and Recommendations

Recommendations

Further to the priorities identified for 2021/22 in the WRES, WDES and Equality, Diversity and Inclusion Strategy, the Trust is committed to improve both staff and patient experiences through increased awareness, and to continue to take practical steps to develop and embrace a culture of equality, diversity and inclusion.

It is recommended that The Trust should consider the following actions to continue our equality, diversity and inclusion journey:

- The Lead for Equality, Diversity and Inclusion to work with Information Governance to develop an Equality Monitoring Policy to ensure that a standard set of equality data is recorded across all directorates in the Trust. At the moment we do not record all the protected characteristics. The plan is to look at these when we move to a more advanced patient records system.
- The Lead for Equality, Diversity and Inclusion to continue to ensure EDI is embedded in all training provided by the Trust.
- The EDI Group to develop a mechanism for identifying and collecting EDI related work across all directorates.
- The Trust continues to provide appropriate resources to ensure the development of efficient and effective staff support networks.
- Our overall ambition for EDI within the Trust is to empower our diversity networks to be able to implement the actions prioritised by the ED&I Group, and for the networks to drive the agenda going forward.
- As part of BSW, and our commitment to delivering the People Plan, we will work with our regional partners to develop a joined up approach to EDI for the future.
- We will complete an EDI self-assessment audit of our current position, in October 2021. The audit's purpose is to help ensure that an effective approach to Equality, Diversity and Inclusion becomes embedded across the Trust, by highlighting areas where processes could be improved.

Author and Sponsor

Author: Patrick Ismond

Sponsor: Jude Gray

Appendices

Appendix 1: The Public Sector Equality Duty

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society.

It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it's unlawful to treat someone.

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the general duty, and all public authorities must pay 'due regard' to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general duty is underpinned by a set of actions and assurances termed the specific duties. These serve as guidance on how the general duty can be met, through a range of actions and the provision of evidence in varied formats. The specific duties are to:

- Publish Information outlining how they will comply with the general duty by 31/1/2012 (Annually thereafter).
- Formulate at least one Equality objective

All information published on how they will meet the equality duty must be presented in such a manner that it is accessible to the public.

Appendices

Appendix 2: Snapshot of Swindon (see also Notes below)

Equality, Diversity & Inclusion

Understanding our community

The information below sets out broadly what we know about the profile of different groups of people in Swindon, and helps us to understand better the equality, diversity and inclusion issues which may impact on the people who may use our services. We know that many people, outside of Swindon, in North Wiltshire also access our care. There are many similarities in these communities with those in Swindon but we will be working closely with Wiltshire Council and local community groups in the coming years to better understand this part of the county and any specific needs they may have.

A snapshot of Swindon in 2019

25% under 16

- 14,000 children live in poverty, 42% are located in the most deprived wards
- 72 teenage pregnancies
- 1 in 20 15 year olds smoke
- 3.5 children (per 1,000) die under the age of 1
- Choking, suffocation, poisoning, burns and drowning most common cause of death in under 5s

59% 16 - 64

- 1/6 smoke
- 2/3 of adults are overweight / obese
- 421 hospital alcohol admissions
- 17 substance misuse deaths

16% over 65

- 1/7 provide unpaid care
- 7 in 10 have a long term condition
- 1/3 over 65 and 1/2 over 80 fall at least once
- 1/2 over 65 and almost 9 in 10 over 75 are socially isolate
- 1/6 have dementia

Age

Gender

- Women live 12 years less in the most deprived parts of the town
- Men live 14 years less in the most deprived parts of the town

Disability

- 860 have a moderate to severe learning disability
- 3,500 have severe hearing loss
- 10,750 live with a moderate physical disability, a further 3,200 live with a severe one
- 27,600 live with a mental health condition

220,000 people live in Swindon

Sexual Orientation

- 1.7% identify as LGB
- 0.5 – 1% identify as Transgender

Ethnicity

- 15.4% (32,128) are from a BME background
- BME varies significantly between wards, half of people in central wards to just 1 in 20 in others
- 1 in 8 people born outside of the UK and 2,296 report that they cannot speak English well or at all

Wider Determinants of Health

- 1 in 20 deaths as a result of poor air quality
- Educational attainment is below the national average
- Deprivation is most severe in the education, skills and training measure where Swindon is the 47th most deprived out of 152 local authorities – the driver appears to be children and young people's indicators

22% of Swindon's population is retired

42% Growth in Swindon population from 2001 to 2031

11,000+ New homes planned for Swindon by 2026

3

Appendices

Notes:
The data we used to create the snapshot of Swindon has been provided by Swindon's Joint Strategic Needs Assessment (JSNA). The JSNA has not updated that data, due to the impact of the Covid-19 pandemic.

We wanted to present an equivalent data set for North Wiltshire. However, this has been researched, and only data for the whole of Wiltshire is available.

Appendix 3: Statement in Support of Joint Working

I would like to thank you for inviting me to contribute to the Great Western Hospital NHS Foundation Trust annual Equality Report. In December 2020 I was seconded to the role of Equality, Diversity and Inclusion (EDI) Lead for the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (ICS).

Since December I have been working to identify the EDI Leads in each of the organisations which make up the ICS.

We have brought those people together in an EDI Leads network which meets at regular intervals. Our role as a network is to work together to identify areas of best practice and joint working in the EDI arena.

It is clear that Equality, Diversity and Inclusion is a golden thread which runs through the work of all our organisations. In the past twelve months we have been reminded about the importance of this work to combat long standing health inequalities and to create a compassionate, equitable and inclusive workplace.

The BSW EDI Leads Network is committed to working together with our colleagues across the Integrated Care System to achieve positive cultural change within our organisations and also within the communities we serve.

I look forward to working with many of you over the coming months to identify and develop creative ways to move the EDI agenda forward #StrongerTogether.

Rex Webb
BSW EDI Lead