GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 3rd February 2022, 9.30am to 12.20pm
Microsoft Teams

AGENDA

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

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chairman's Welcome**	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	
3.	**Minutes of the previous meeting (public) (pages 1 – 8)** Liam Coleman, Chair • 6 January 2022	✓	LC	Approve	
4.	**Outstanding actions of the Board (public) (page 9)**	✓	LC	Approve	
5.	**Questions from the public to the Board relating to the work of the Trust**	-	LC	-	
6.	**Chair's Report, Feedback from the Council of Governors** Liam Coleman, Chair	Verbal	LC	Note	9.45
7.	**Patient Story (pages 10 – 17)** Alison Marsh, Clinical Midwifery Manager, and Tracey Lait, Team Leader for Jasmine Team • This is a story of a patient who was supported through her pregnancy using the Continuity of Care Model	✓	AM/TL	Note	9.55
8.	**Chief Executive's Report (pages 18 – 21)** Kevin McNamara, Chief Executive	✓	KMc	Note	10.15
9.	**Integrated Performance Report (pages 22 – 99)**			Assurance	10.35
	• Performance, People & Place Committee Board Assurance Report – Peter Hill, Non-Executive Director & Committee Chair	✓	PH		
	Part 1: Operational Performance – Felicity Taylor-Drewe, Chief Operating Officer	✓	FTD		
	• Quality & Governance Committee Board Assurance Report – Nick Bishop, Non-Executive Director & Committee Chair	✓	NLB		
	Part 2: Our Care – Lisa Cheek, Chief Nurse & Jon Westbrook, Medical Director	✓	LCh/JW		

	• Part 3: Our People – Jude Gray, Director of Human Resources	✓	JG		
	• Finance & Investment Committee Board Assurance Report – Andy Copestake, Non-Executive Director & Committee Chair	✓	AC		
	Part 4: Use of Resources – Simon Wade, Director of Finance & Strategy	✓	SW		
10.	**Audit, Risk & Assurance Committee Board Assurance Report (pages 100 – 102)** Helen Spice, Non-Executive Director & Committee Chair	✓	HS	Assurance	11.35
11.	**Mental Health Governance Committee Annual Report 2020/21 (pages 103 – 139)** Lizzie Abderrahim, Non-Executive Director & Committee Chair Lisa Cheek, Chief Nurse	✓	EKA/ LCh	Approve	11.45
12.	**Operational response to health inequalities (pages 140 – 154)** Claire Thompson, Director of Improvement & Partnerships	✓	CT	Approve	11.55
	CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**				
13.	**Ratification of Decisions made via Board Circular/Board Workshop** Caroline Coles, Company Secretary	Verbal	CC	Note	12.10
14.	**Powers Reserved to the Board and Scheme of Delegation Limits (pages 155 – 161)** Caroline Coles, Company Secretary	✓	CC	Approve	-
15.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	Note	-
16.	**Date and Time of next meeting** Thursday 3rd March at 9.30am, DoubleTree by Hilton Hotel, Swindon (and MS Teams facility also available)	Verbal	LC	Note	-
17.	**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 IN PUBLIC VIA MS TEAMS 6 JANUARY 2022 AT 9.30 AM

Present:

Voting Directors

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

In attendance

Simon Billingham	Deputy Divisional Director Primary & Community Care (agenda item 246/21 only)
Caroline Coles	Company Secretary
Tim Edmonds	Head of Communications
Michele Grange	Head of Enhanced Care at Home Service ((agenda item 246/21 only)
Claudia Paoloni	Associate Non-Executive Director
Sanjeen Payne-Kumar	Associate Non-Executive Director (part – agenda items 277/21onwards)
Philippa Williams	Blue Grain - Observing

Apologies

None

Number of members of the Public: 1 member of public (included 1 Governor; Pauline Cooke)

Matters Open to the Public and Press

Minute	Description	Action
269/21	**Apologies for Absence and Chairman's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public via MS Teams. It was noted that amendments had been made to the schedule of the day in that the Board workshop planned to follow the meeting would be postponed due to operational pressures. Apologies were received as above.	
270/21	**Declarations of Interest** There were no declarations of interest.	

Minute	Description	Action

271/21 **Minutes**
The minutes of the meeting of the Board held on 2 December 2021 were adopted and signed as a correct record with the following amendment:-

246/21 : Staff Story - in 5th paragraph change word '*acknowledged*' to *'admired and praised'*.

272/21 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

273/21 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public for the Board.

274/21 **Chair's Report, Feedback from the Council of Governors**
The Board received a verbal update and the following highlighted:-

Non-Executive Directors - Helen Spice had now taken over the role of Chair of Audit, Risk & Assurance Committee following Julie Soutter's departure.

Governors - It was with regret to announce the passing of a recent past governor, Arthur Beltrami. The Board wished to send their condolences to his family and acknowledge the contribution that Arthur had made to the Trust during his time as a governor.

The Trust had received two resignations; Roger Stroud and George Cahill. Roger had been a longstanding governor and during his tenure had taken the role of both Lead and Deputy Lead Governor. The Board wished to thank Roger for his role as governor particularly for his support to the Chair and his service to the Trust which was unfailing and undertaken with huge energy. George had been with the Trust for 2 years and was a valued member of the Council of Governors and the Board also extended their thanks for his time and commitment to help the Trust understand the needs of the people of the Swindon area. The Board wished both well in any future endeavours.

As part of a governor induction our two new governors, Maurice Alston and Pamela Kemp met with the Chair, Lead Governor and Company Secretary on Tuesday 4 January 2022. This formed part of a structured induction to help establish a baseline of knowledge, however this was an ongoing process as the governors interact with the directors and other key people to sustain a broad understanding of the issues faced by the trust and how they are being addressed.

A New Approach to Non-Executive Director (NED) Champion Roles - A paper was considered that outlined the new guidance issued by the NHS on Non-Executive Director champion roles. NHSE/I had worked with stakeholders to consider a new approach with the conclusion that Board oversight would be enhanced through a change from NED champion roles to committee discharge with the exception of 5 NED champion roles; maternity, wellbeing, freedom to speak up, doctors disciplinary and security management.

The new approach was discussed and it was agreed that further additional champion roles should be considered with regard to equality, diversity & inclusion, children & young people and health inequalities. Other points to note included not all Board leads were Non-Executive Directors but also Executive Directors and that the Board remained

Minute	Description	Action

accountable for all its functions.

It was agreed to investigate the points raised and bring back to Board for further oversight.

Action : Chair/CEO LC/KM

The Board **noted** the verbal report.

275/21 **Chief Executive's Report**

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

Operational Pressures - A verbal up to date position on covid and the impact on the Omicron variant was given. The Bath & North East Somerset, Swindon and Wiltshire (BSW) system experienced significant operational pressures during December/January 2022. The Trust had worked with system partners taking diverts when other hospitals were under pressure which included those beyond the BSW boundaries. However on 4 January 2022 the Trust declared an internal critical incident due to operational pressures caused by sustained high levels of demand and availability of beds. This was replicated across the BSW region which demonstrated how pressurised the system was as a whole.

Liam Coleman, Chair wished to recognise the Board's gratitude to all the staff involved during this particularly busy and pressurised period, especially the Executive Directors in their commitment and effort in ensuring system working was effective.

Mandatory Vaccinations for NHS Staff – Work was underway to provide support and advice to staff that had not been double vaccinated following the Government's announcement that being fully vaccinated against covid would be mandatory for NHS staff in public facing roles from 1 April 2022.

Vaccination Programme - In December 2021 the Prime Minster accelerated the covid vaccine booster programme. The Trust responded by setting up a clinic at very short notice which delivered 600-800 vaccinations per day.

National Priorities - Nationally a Level 4 incident was declared in December 2021 and the Trust worked closely as a system to coordinate a response to the six priorities as set out in a letter by NHS England for preparing the NHS for the potential impact of Omicron and other winter pressures. The Trust's focus remained staff support, vaccination programme and maintain patient flow.

Peter Hill, Non-Executive Director asked in terms of partnership working had the letter been received by foundation trust hospitals with regard to the government funding to hospices to support the NHS tackle covid. Kevin McNamara, Chief Executive replied yes and the Trust had supported Prospect Hospice to secure the funding.

Nick Bishop, Non-Executive Director asked for clarification on the required isolation period for patients as recent media reports referenced that the current 14 day isolation period was blocking discharges. Lisa Cheek, Chief Nurse replied that the national guidance was still 14 days isolation for patients, which was different to the guidance for the public outside healthcare. However there was some challenge within the healthcare sector towards a more risk based approach.

The Board **noted** the report.

Minute	Description	Action

276/21 **Patient Story**

Simon Billingham, Deputy Divisional Director Primary & Community Care and Michele Grange, Head of Enhanced Care at Home Service joined the meeting for this agenda item.

The Board received a patient story which described the Enhanced Care at Home (virtual ward) Service which supported the most acutely unwell for a short period of time to stabilise them before moving on to planned care or a wider social healthcare service. Current evidence suggested a reduction in acute activity once patients were referred to this service. This particular example demonstrated how the service enabled an end of life patient to remain at home with family.

Andy Copestake, Non-Executive Director asked if, in the same circumstances, would the team have done anything differently. Michelle Grange, Head of Enhanced Home Care Service replied that this was a very complex case however lessons learnt would be to engage earlier in the patient's pathway in respect to end of life and respect forms, provision of an EDS and closer working between community and the wards. It was noted that the service was not widely opened up within the hospital due to resources however the CCG had agreed to fund expansion of the service and work was underway to determine capacity and develop roles.

Liam Coleman, Chair thanked both Simon and Michelle for sharing their innovative approach in how best to use limited resources to treat a larger caseload in a respectful and dignificed way.

The Board **noted** the patient story.

277/21 **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 October/November 2021.

Part 1 : Our Performance

Performance, People and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, People and Place Committee (PPPC) around the IPR at its meeting on 22 December 2021 . The Committee had been suitably assured that the management and clinical teams were performing to the best of their ability and the assurance report reflected the internal and external challenges faced in terms of covid, increase in demand and staff absences. The one concern to highlight was around estate & facilities. Simon Wade, Director of Finance & Strategy expanded on these issues highlighting that there had been a number of incidents experienced in November 2021 that had caused a certain amount of disruption. There were a number of reviews in progress which included an external commissioned piece of work around site resilience to highlight any areas of concern to address.

The Board received and considered the Operational element of the report.

Minute **Description** **Action**

Part 2 : Our Care
Quality & Governance Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Governance Committee (Q&GC) around the quality element of the IPR at the meeting held on 23 December 2021 and the following highlighted:-

Electronic Discharge Summary (EDS) - There was no significant change and this remained a concern.

Jon Westbrook, Medical Director added that as the Board were aware this was a long standing issue due to the current standalone EDS system however work was underway with trainee doctors who were keen to undertake a Qualtiy Improvement (QI) project to see what measures could be put in place to improve performance before an Electronic Patient System (EPS) solution was in place.

Infection Control - Klebsiella bloodstream infections were rising and this would be monitored closely.

Safeguarding - It was noted that levels of activity were increasing partly due to the pandemic with domestic abuse notably increased.

CQC Preparedness - There continued to be improvement in a number of actions met.

The Board received and considered the Quality element of the report and the Chief Nurse highlighted two areas. Firstly, safer staffing in terms of the International Recruitment Programme bid and the Trust participating in the Stay and Thrive programme. Secondly patient experience with regard to the increase in responses to the Friends and Family Test in the maternity department noting a significant increase from 15 responses in August to 129 in December 2021 with the aim to rollout electronic text service mid-January 2022.

Part 3 : Our People
The Board received and considered the Workforce performance element of the report and the Director of HR highlighted the level of sickness absence and the efforts to get staff well enough to safely return to work, whilst at the same time working across the Trust to improve leadership and capability.

Liam Coleman, Chair added that these were enormously challenging times with a workforce that had been at the front of this pandemic for an extended period of time and assured the Board that following discussions with the Chief Nurse the Trust were adopting an approach of lessons learnt from the previous waves of covid with what worked for staff and that the Executive team were close to the workforce in order to gage any change that was required.

Part 4 : 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 20 December 2021. The Committee received a high level of assurance in terms of the finance agenda with no major concerns with regard to risks or actions. The following were highlighted:-

Capital - It was noted that the £11.5m emergency capital bid had still not been

Minute	Description	Action

approved. There was likely to be slippage on a few key projects, however the Committee were reassured that there was considerable management effort to reprioritise projects between 2021/22 and 2022/23 to ensure that in-year capital departmental expenditure limit (CDEL) funding was not lost.

BSW H2 Plan Submission - The Committee noted the BSW H2 Plan which, whilst identifying a number of risks, demonstrated excellent collaboration between System partners and a fair resource allocation for GWH.

GWH H2 Submission - The GWH H2 Plan which showed good collaboration between Finance, HR and Operations. The Committee concluded that the plan was reasonable and achievable, and recommended approval to the Board.

Divisional Financial Plans - There was strong evidence of inter-divisional working and focus on grip and contol in each division. The Committee concluded that the plans were stretching but achievable, however recognised that they could be impacted by a significant change in Covid patient numbers over the remainder of the year.

Non-Emergency Patient Discharge Service Contract - The Committee agreed to recommend approval to the Board of a two year contract to E-Zec for Non-Emergency Patient Transport services. The amber rating reflected the need for future reports to explain how additional costs have been justified, either in terms of additional activity or additional services.

The Board received and considered the Use of Resource performance element of the report and the following highlighted:-

Capital - The emergency support capital programme had been escalated on a weekly basis. There was strong regional support and the Trust had been assured of a decision in January 2022.

Electronic Patient Record (EPR) Business Cases - The business case had progressed well through the system with support from all partners and had now been submitted to the regional team for the initial stage of the review.

Financial Position – One concern was the high cost agency spend and although there were extenuating operational pressures this was one to monitor closely.

Business Planning 2022/23 - Draft planning gudiance had now been published which indicated that the current financial regime would continue as a system-wide approach to planning and delivery. More detail around the financial envelope would be received in February 2022.

Action : Director of Finance & Strategy SW

Part 5 : Primary Care Newtwork

The Board received and considered an additional report which in future would be integrated into the Integrated Performance Report (IPR), with the following highlighted:-

Primary Care Access - In order to support access to primary care additional telephone lines had been added to help manage peak call times together with the introduction of e-consult which provided an outline portal for patients to access GPs.

Minute	Description	Action

Appointments & Resource - The Salaried GP recruitment campaign had been re-launched in August 2021 and so far 3 new GPs had been appointed with a pipeline developing of interested GPs.

There followed a discussion which included the positive developing relationship between the Trust and the Primary Care Network, the financial situation and benchmarking.

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

278/21 **Preparing the NHS for the potential impact of the Omicron variant and other Winter pressures**

The Board received a letter issued by NHS England and NHS Improvement (NHSEI) dated 13 December 2021 entitled "Preparing the NHS for the potential impact of the Omicron variant and other Winter pressures" in which the NHS declared a Level 4 National Incident. The letter outlined the 6 key focus areas to be put in place by every part of the NHS.

It was noted that the acceleration of the Covid vaccine booster programme at short notice had been a challenge however the Trust responded really well and in just a few days set up a vaccination clinic in the Academy with slots listed on the national booking system.

Faried Chopdate, Non-Executive Director asked what the impact would be on resource, budget and the winter plan. Felicity Taylor-Drewe, Chief Operating Officer replied these new requests were an adjunct to the winter plan in terms of escalation framework and covid framework with plans already in place for safer week to respond to winter. The difference was the staff in self isolation and sickness absence. Simon Wade, Director of Finance & Strategy added that early indication was that there would be no additional funding and was for the regional system to deal with.

The Board **noted** the update.

279/21 **Emergency Preparedness Resilience & Response Assurance Report**

The Board received and considered the Emergency Preparedness Resilience & Response (EPRR) Assurance Report which outlined the actions due for completion in June 2022 to enable a green assurance across all standards. It was noted that there was a new governance process in place to review and monitor progress through the EPRR Steering Group.

This report had been scrutinised at Performance, People & Place Committee (PPPC) and checked and challenged externally by BSW Clinical Commissioning Group (CCG).

Liam Coleman, Chair requested that the list of risks under the duty risk assessment be scrutinised by PPPC to ensure all risks were captured.

Action : Chief Operating Officer FTD

Nick Bishop, Non-Executive Director acknowledged that the critical incident with regard to the server overheating was under investigation however asked for assurance on how the situation would be different now. Simon Wade, Director of Finance & Strategy replied that contingency measures had been put in place in particular robust monitoring of the temperature of the room both in and out of hours. Nick Bishop further asked if there was any desk top exercise being undertaken to address any lack of monitoring or

Minute	Description	Action

contingencies elsewhere within the Trust. Simon Wade confirmed that this had been undertaken together with looking at ways to integrate this more into the Building Management System for areas run by SERCO.

The Board **noted** the report and were assured with the actions for completion by June 2022 to bring assurance to green across all standards.

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.

280/21 **Ratification of Decisions made via Board Circular/Board Workshop**
None.

281/21 **Directors Code of Conduct 2022-2024**
The Board received and considered the slightly revised Directors Code of Conduct for 2022-2024.

It was noted that this had been reviewed by the Remuneration Committee and supported the amendments for approval by the Board.

RESOLVED

to approve the Directors Code of Conduct 2022-2024.

282/21 **Urgent Public Business (if any)**
None.

283/21 **Date and Time of next meeting**
It was noted that the next virtual meeting of the Board would be held on 3 February 2022 to be held via MS Teams.

284/21 **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 1430 hrs.

Chair …….. Date……

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – February 2022				
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**
06-Jan-22	277/21	**Integrated Performance Report : Use of Resources : Business Planning 2022/21** More detail around the financial envelope to be received in February 2022.	Director of Finance & Strategy	On agenda in private session
06-Jan-22	279/21	**Emergency Preparedness Resilience & Response Assurance Report** The list of risks to be scrutinised at PPPC to ensure all risks captured.	Chief Operating Officer	For PPPC

Future Actions				
06-Jan-22	274/21	**Chair's Feedback Report : Non-Executive Director Champion Roles** Additional roles to be considered and a revised list to be brought back for further oversight.	Chair/Chief Executive	Mar-22

Patient Story

Continuity of Carer Model
Tracey Lait
Team Leader for Jasmine Team

Alison Marsh
Clinical Midwifery Manager

Patient Story

Great Western Hospitals NHS Foundation Trust

The Continuity of Carer Model

- Each woman has a named midwife- responsible for co-ordinating her care.
- The midwife is part of a same team of up to 8 midwives.
- The team provides a 24/7 antepartum cover for their team.
- Each midwife has a small caseload of women living in the most deprived areas of Swindon.

Why do we do this? Research has shown

- 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks.
- 24% less likely to experience premature birth.
- 15% less likely to require regional analgesia.
- 16% less like to have episiotomy.
- Increases maternal satisfaction.
- Greater Job satisfaction.

Patient Story- Anne

Great Western Hospitals NHS Foundation Trust

Background

This is Anne's second pregnancy, she has been cared for by staff from Great Western in both of her pregnancies.

In her last pregnancy the model of care was very different.

Anne received her pregnancy care from a traditionally based community team.

Traditional Midwifery Care

Each lady has a named midwife in the pregnancy and in the postnatal period.

When ladies go into labour at home, the White Horse Birth Centre or Delivery Suite are cared for by midwives who work in other area's.

Patient Story

Great Western Hospitals NHS Foundation Trust

- Anne lives in one of the most deprived areas of Swindon.
- Previous pregnancy was low risk.
- Spontaneous vaginal birth in the low risk unit at 40+3.
- Discharged from midwifery services 10 days.
- Artificial Feeding at discharge.

Anne was cared for by

- Three midwives in her antenatal period.
- Three midwives during labour and birth.
- Two midwives in her postnatal period.

This was the traditional pathway for midwifery care across the United Kingdom.

In 2016, there was a review of maternity services. One of the recommendations was that continuity of carer should be developed within the service.

Patient Story

Great Western Hospitals NHS Foundation Trust

Anne's Journey

- Anne was cared for by the Jasmine Team.
- In her second pregnancy.
- Anne lives in a deprived area of Swindon.
- Midwifery Led Care.
- Booked at 9/40 by named midwife.

Antenatal

- Seen named midwife for 6 appointments.
- Seen buddy midwife for 1 appointment.

Labour and Birth

- Named midwife provided all care.

Postnatal

- Seen by named midwife discharged at day 18.
- Breastfeeding at discharge.

Challenges Of Continuity

Great Western Hospitals NHS Foundation Trust

Midwife and Management Challenges

- Challenges working in this way.
- On call 2-3 times a week difficult for midwives.
- Working in all areas of midwifery rather than specialising in one.
- Workforce availability across the country is very challenging and often teams are diverted to the acute unit to work..
- Financial cost of setting up teams having to have two systems working at the same time.
- Due to staffing pressures a number of teams have not succeeded in England.
- But looking at Anne's care this time she was able to Breast Feed.
- Anne felt supported.
- Full roll out across maternity services by 2023.

Future Plans

Great Western Hospitals NHS Foundation Trust

- Plans of future teams at Great Western Hospital.
- 6 building blocks.
- Looking at different ways of working as a maternity wide team to provide continuity.
- A Team to be developed in town centre of Swindon with the aim of supporting the ethnic minority families who live in that area, improving outcomes of women.

Patient Story

Great Western Hospitals NHS Foundation Trust

Patient feedback

“Much better service second time around.

Felt like I knew my midwife and she knew me.

I struggled to breastfeed first time and the support was hit and miss.

My named midwife knew this was a worry so was able to give me additional support to help and I am still breast feeding at the time I was discharged.

I met another Jasmine midwife, was nice and also supportive.

I was sad to leave Jasmine team”.

From Survey Monkey August 2021

Report Title	**Chief Executive's Report**				
Meeting	**Trust Board**				
Date	**3 February 2022**	Part 1 (Public) [Added after submission]	X	Part 2 (Private) [Added after submission]	
Accountable Lead	Chief Executive Officer				
Report Author	Kevin McNamara, Chief Executive Officer				
Appendices					

Purpose

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

Assurance Level

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

N/A

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

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

The Chief Executive's report provides an overview of a broad range of current issues at the Trust.

Report

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

This report covers the Chief Executive's overview of current issues at the Trust including: Our response to Covid-19; Internal critical incident and current pressures; staffing; mandatory vaccinations; patient feedback; staff recognition.

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

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

Explanation of above analysis:

This report covers a broad range of issues. Where any group is adversely affected, this is detailed in the body of the report. In this report, the Covid-19 vaccination programme is referred to. Vaccinations have less take up from BAME groups across the country, and this is reflected in our staff with 98 of all substantive staff having had a first dose, but only 98% of those from a BAME background having done so (although this figure reflects a recent rise in take up).

Recommendation / Action Required The Board/Committee/Group is requested to: ▪ **Note the report.**	
Accountable Lead Signature	
Date	28 January 2022

1. Covid-19

In recent weeks we have seen Swindon's community case rate begin to fall but at the time of writing it still remained the highest in the South West.

Last month the local rate exceeded 2,000 cases per 100,000 people at one point, the highest it has ever been during the pandemic.

The number of inpatients we are currently seeing in hospital with Covid fluctuates but has recently been between 50 and 70 cases.

We have surge plans in place should we see a sudden rise in cases with potential areas for further escalation agreed. Although our hope is that these areas are not needed, we are prepared for an increase in cases should there be one.

Our modelling does indicate that the number of people in hospital with Covid will gradually decline, however it remains too early to say whether we have had our peak in this wave as so much of it depends on how people behave.

In late January we were able to take the decision to lift some of the restrictions on visiting, in response to the fall in community cases.

Although the Government has now lifted many of the Plan B restrictions the reality is that not much has changed at any of our buildings. Our staff continue to wear face masks, and of course the appropriate personal protective equipment at the appropriate time. We continue to remind staff of the importance of good infection prevention and control measures at all times, which is particularly important given the ease with which the Omicron variant appears to spread. Members of the public are asked to continue to wear masks, wash their hands and observe social distancing while in our hospital or GP practices.

Along with asking people to observe these important safety measures while in our buildings, more generally we also ask people in Swindon and Wiltshire to exercise caution and protect themselves and others from Covid by getting the vaccine, getting boosted and wearing face masks where they can. All these measures will help to stop Covid spreading.

2. Internal critical incident and current pressures

We declared an internal critical incident on 4 January in response to the number of patients with Covid, the number of patients arriving in our ED and UTC for a range of other conditions, and our very high staffing absence. Thanks to a really great team effort we were

able to stand this incident down on 7 January although we have remained very busy ever since.

We received positive feedback from system and regional leaders for our operational response to the incident and my thanks go to everybody involved for an incredible amount of hard work and dedication to keep our patients safe.

Our SAFER Fortnight was coincidentally planned for the first two weeks of January and we used the arrangements we already had in place, with a control room set up and most meetings cancelled to manage the internal critical incident and following days.

This coordinated effort enabled us to focus on discharging patients as quickly as safe to do so and we also worked very closely with the ambulance service, setting up an Emergency Hub in our ED alongside the ambulance service to enable us to alert colleagues to any patients that could be diverted away from hospital and even treated in the community.

3. Staffing

We continue to have a high number of staff off sick at this time – not just with Covid, but a range of other conditions as well.

We saw a peak on 5 January with 520 staff off sick, or needing to isolate. That number has fallen but still remains high at more than 300, around 6% of our workforce.

Staffing levels have caused us some operational difficulties at times, and our nursing team meets three times a day, and medical teams twice a day, to identify areas with particular difficulties so that we can move staff around as needed in order to continue to maintain a safe service.

Our corporate departments released some of their staff to act as ward buddies, providing administration support to wards, carrying out tasks such as tea rounds, replenishing stock, running errands and answering phone calls.

4. Mandatory vaccinations for NHS staff

The NHS has been clear that vaccination is the best protection against Covid-19, and while it has always been a recommendation for health and care staff to be vaccinated, it will become a legal requirement very soon.

Government legislation requires all patient-facing NHS staff to be fully vaccinated by 1 April in order to ensure they are protected from Covid-19 and, by doing so, protecting their colleagues and patients in turn.

Staff have until 3 February to have their first vaccination in order to give themselves enough time to have the second vaccination and meet the 1 April deadline. The vast majority of our staff have had the vaccine, but we have written to all those staff who our records show have not yet been double-vaccinated to advise them of the timescales by which they would need

to have their first vaccine in order to be able to have their second by the mandatory deadline.

For some time we have strongly encouraged all our staff to be double-vaccinated and take up the offer of a booster vaccine at the earliest opportunity and have put a range of support in place for those staff who have been hesitant to have the vaccination so far, including ensuring they have access to information and the opportunity to have one-to-one conversations to help alleviate their concerns and protect themselves.

5. Patient feedback

We received positive results in the National Cancer Patient Experience Survey 2020.

There are no comparison scores available, as not all NHS Trusts participated due to Covid pressures and the survey was voluntary, but our results tell us that patients are satisfied with the service.

The survey contained 61 questions covering care from the GP, diagnosis, treatment, support and discharge. It was sent to all patients aged over 16 and diagnosed with cancer and treated as a day case between April-June 2020.

We had a 58% response rate, with 305 patients giving their views and we received an average rating of 8.9 out of 10 – exceeding our 2019 score of 8.7, a great achievement particularly considering the disruption being experienced in April 2020 with the pandemic.

The feedback received will now be incorporated in to Great Care.

6. Staff recognition

Congratulations go to Dr Natasha Wiggins, Consultant in Palliative Medicine, who won our STAR of the Month award in recognition of her dedication and commitment. Natasha's drive and passion for excellent patient and family care is astounding, and she always ensures that patients and family members remain at the centre of decisions made. Natasha works tirelessly to promote the skills and dedication of the team, resulting in a 300% increase in the past year of patients reviewed by the team.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**3rd February 2022**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Lisa Cheek, Chief Nurse				
Report Author	As above				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC Chart – Pay				

Purpose

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

Assurance Level

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

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

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

Report

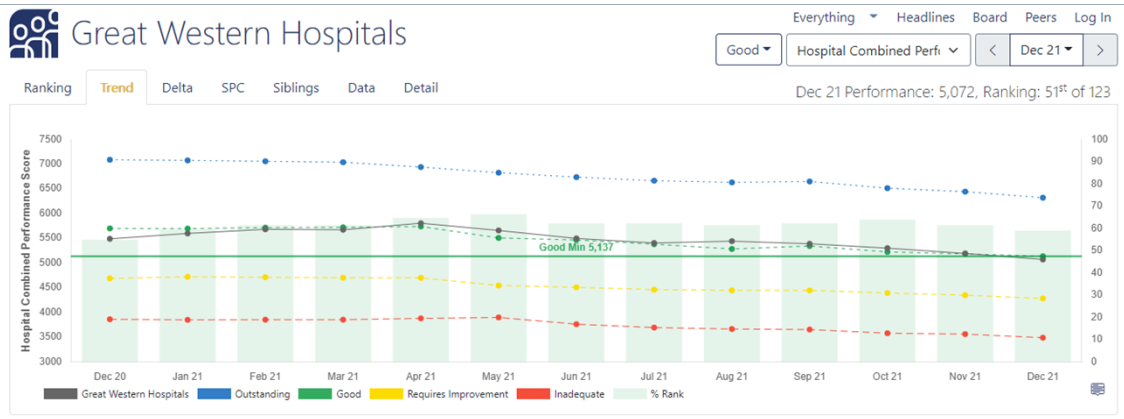
Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

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

Key highlights from the report this month are:

Our Performance

Our ranking against the Hospital Combined Performance Score on Public view in December 2021 places us 47th out of 124 Trusts. The trend chart below reflects our aggregate position against CQC measures, and our performance is tracking at 'Good.' It is likely many other Trusts are starting to show a deteriorating position given the current pressures.



In December 2021, our performance against the Emergency Care Standard (95%) decreased to 74.13% from the November position of 76.35%. Hospital Handover Delays (HHD) decrease in December to 656 hours lost compared to November where 524 hours were lost. As of 13th January 2022, there have been 266.9 hours lost compared to December at the same point where there had been 492.4 hours of hospital handover delays. There were 39 x 12-hour reportable Decisions to Admit (DTA) breaches for December which is a decrease of 6 from November.

Attendance have decreased in December (From November) by 532 patients, with 96 decrease in the ED and 436 in the UTC (Urgent Treatment Centre). The UTC remains closed overnight. 4 Hour breaches have increased in December with an increase of 55 in UTC and 144 in ED.

Bed occupancy has remained above 98% for the duration of the reporting period. The number of patients waiting to leave the Trust who require support from partner organisations increased in December to over 60 patients from a previously steady rate of 30-40 patients per month. Delays in Swindon have increased the most with 42% of patients waiting to leave the Trust Swindon facing. Wiltshire and Out of Area delays remain consistent.

Urgent Community Response for patients seen within 2-hour remains above 90%. 723 referrals were received in December 2021.

Primary Care eConsults maintain an average of 500 submitted per week, until Christmas week when the system was paused due to prioritising same day/urgent appointments and higher than usual staff shortages across the Christmas period.

Virtual face to face appointments in primary care continue to be higher than face to face.

Attendances to the Covid Assessment Unit (CAU) have remained at a consistent level through December, peaking in the 3rd week, with Covid positive patient numbers remaining comparable with Phase 1 of the Pandemic. As a result, CAU has maintained operation with 11 rooms.

The Trust's RTT (Referral to Treatment) Incomplete Performance has been updated to include the most recent complete calendar month. The Trust's RTT Incomplete Performance for December 2021 reduced to 62.01%, a deterioration of 3.22% in month.

In December 2021 there were 639 x 52-week reportable breaches. This is an increase of 46 in month. Only 1 is reported as a P5. Of the 639 reportable breaches in December; 491 are Admitted, 136 are non-Admitted and 12 are Diagnostic.

Performance was 63.5% in November, a decrease from 65.7% in October. Overall, the total waitlist size has increased to 8857 in November from 8834 in October (+23). Breaches have increased from 3027 in October to 3237 in November (+210) primarily driven by MRI (Magnetic Resonance Imaging) and CT (Computerised Tomography).

Cancer 2 week wait performance for November 2021 92.2% against a target of 93%. The standard in November was not met due to Lung (65.8%), Colorectal (83.2%) & Upper GI (89.5%).

The standard was met in November with a performance of 75.8% (356 breaches). The performance standard for all referrals (2ww, symptomatic & screening) is reported by NHS (National Health Service) Digital and via the Public View portal.
The number of 62day+ pathways rose through November (156): Skin (61), Colorectal (43), Upper GI (21) & Urology GI (13). There are several reasons for the high number of pathways, including complex pathways, clinical administrative delays, delayed pathway information from Oxford as well as pathways impacted by the delays in endoscopy and radiology.

Our Care

Infection Control – The star rating system for cleanliness has been rolled out on the Wards and will support the ongoing drive to increase standards.

The Trust is applying to join an NHS England and NHS Improvement project to improve hydration in people aged 65+, including those living in a care home, or receiving domiciliary care. The aim is to test interventions to help keep people well and hydrated, reduce Urinary Tract Infections (UTIs) and so reduce the need for antibiotics. The pilots will help improve our knowledge and understanding of the most effective hydration interventions to reduce UTIs, while supporting efforts to tackle the growing threat of antimicrobial resistance.

The number of patients diagnosed with COVID-19 started to increase again during December, although Swindon was behind the national high level for a number of weeks. There were six hospital acquired cases (8 days +) during December. Day two testing was introduced for emergency admissions to help prevent outbreaks as the Community rate rises again.

Pressure Ulcers – There is a risk that the long ambulance waits at the Emergency Department (ED) could increase the risk of patients developing Pressure Ulcers. This is being mitigated against by embedding the use of the Standard operating procedure for use of pressure relieving equipment with educational sessions.

There continues to be reported high levels of harm in December, whether acquired in our care or present on admission. This is in line with other regional organisations.

Falls – The number of falls reported has increased. Prior to December falls numbers were stable with a normal variation demonstrated on the run chart of falls reported daily. Since December there have been a number of data points running above the average line, and a number of data points above the upper control limit, indicating a change in the system.

Incidents - At the time of reporting there are a total of 29 on-going Serious Incident (SI) investigations, with 7 SIs reported in December.

Following a recent Medicine Safety Huddle there has been shared learning around positive patient identification, patient handover, initiation and administration of medicines to the correct patient. The first Human Factors (HF) training has been delivered to a group of anaesthetists and was very positively received. Further sessions are planned for junior doctors and HF training has been delivered as part of serious incident investigation training.

Patient Experience – A total of 32 complaints and 92 concerns were received in December, a reduction on previous months. The overall top three themes werecommunication, clinical care, follow up treatment, waiting times.

A new process has been implemented to undertake quality audits of the complaints process for cases closed in the previous month; this is in the early stages of implementation

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 December: Bank fill rates reporting 46.7%, below target, however remain stable, Sickness absence has reduced slightly in month to 5.29%, however exceeds target of 3.5%; appraisal compliance achieving 74.17%, Agency spend as a % of total spend is reporting 6.86% and above Trust target of 6%.

Highlights:

- In-month **KPI recruitment** time to hire is 45 days, within Trust target of 46 days
- **Medical vacancy position** of 47.4WTE which is a decrease in month from 7.14% to 6.93%, driven by an increased contracted WTE through recruitment activity. The Trust utilised 38.7WTE of bank and 43.0WTE of agency cover for Medical Workforce, indicating there was an additional usage of 34.2WTE above the vacancy position used to cover short term leave, Covid-19 isolation and extreme pressures on site.
- For **Medical staff**, General Medicine including Outlier Cover (31WTE) and Emergency Medicine (12WTE) continue to be the largest users of locum and agency cover.
- **Wellbeing Agenda:** High number of in-month referrals for counselling and psychological support, predominantly for anxiety and low mood reflecting the ongoing organizational pressures. The OH department supported the Covid-19 vaccination programme from the Academy, providing approx. 7000 vaccinations to staff and public from 16th to 31st December. The Executive and management team supported the daily staff tea trolley visiting each area across hospital, primary care and community venues giving over 5,000 drinks and festive treats.
- **Healthcare Assistant Recruitment -** the HCA vacancy position remains a risk with an increase to 72.62 WTE. The Trust secured £113,030 NHSEI funding to support achieving zero HCA vacancies by the end of the financial year. The funding has two elements 1) £30,000 to support accelerated recruitment, 2) £71,515 to support induction and ward transition.
- **Maternity Services -** secured £133k of funding to support the recruitment and retention of maternity support workers. This funding must be used within 2021/22 financial year and the Trust achieve zero vacancies position by March 2022. A working group led by Head of Midwifery is exploring the best utilization options the funding within the time period.
- **Mandatory training** continues to be above the Trust target of 85%, improving this month to 88.85% and continues to be above the Trust target of 85% since the transfer of modules to the ESR system.
- **Leadership and Development:** The Trust have spent 45% of the Trust CPD budget to date and 55% of the HEE CPD budget.

The RUH Clinical Leads programme has been expanded to two cohorts. This means that GWH will have access to a total of 12 places.

The AMD programme will recommence in April 2022 and it has been agreed that GWH will participate in a BSW wide bid for GMTS trainees.

- In-month **Appraisal** compliance increased slightly to 74.17%
- The **Flu Vaccination Programme** launched in September and 4536 vaccinations were provided within the initial 7 weeks. Vaccination compliance as at 12th January 2021 is 89.91% slightly behind last year's 89.03%
- **Trust Covid-19 timeline:** The Trust continues to monitor the different workforce status categories for Covid-19 related absence and isolation, since March 2020 and identifies the peak of related sickness absence in December 2021. Predicted worst case scenarios are forecasted as part of the wave 2 of the pandemic and the HR team support absent and isolating workforce with national guidance, FAQs, and access to lateral and PCR tests.
- **Corporate Buddy Scheme** – has been set up to invite non-clinical staff to support on the wards during high pressure peaks of workforce absence.

Use of Resources

The Trust plan is a deficit of £5.994m. The in-month position is £0.28m surplus and year to date position is £0.14m surplus which is a favourable variance to plan of £1.1m.

Trust income is above plan by £2.57m in month and £14.5m year to date.

Pay is £0.58m overspent in month and £3.97m overspent year to date. Nursing run rate has increased by £0.2m, mainly on substantive staffing spend and driven by winter pressures, staff absence and additional December enhancements. This is as well as of continuing pressures around enhanced care. Locum Medical staffing costs have increased by £0.3m predominantly across USC in support to outlying patients and in ED linked to agreed winter pressures funding. PCN GPs have also increased, this is anticipated to reduce moving forward as permanent appointments are now being made.

Non Pay is £1.2m overspent in month and £9.45m overspent year to date. Non Pay run rate has increased by £0.4m. The run rate pressure includes £0.2m on clinical supplies across SW&C (equipment and implants) and USC (MRI/CT costs and Testing & Swabbing costs) and £0.2m on other costs driven by corporate costs for consultancy and software/licence costs above plan.

The Trust capital plan for 21/22 is £33,493k. Spend is £13m as at the end of Month 9 against a YTD plan of £20.4m.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X		**X**	**X**	**X**
Key Risks					**Risk Score**

– risk number & description (Link to BAF / Risk Register)	Mandatory Covid-19 vaccination programme and patient-facing staff non-compliance. Risk of pressure on existing vaccinated workforce, and reduced WTE resource to deliver services. Risk of Employee Relations issues with staff refusing vaccine uptake.	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement		
Next Steps		

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

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

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	 Felicity Taylor-Drewe
Date	27/01/2022

NHS
Great Western Hospitals
NHS Foundation Trust

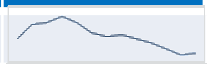
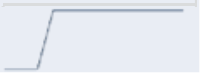
Integrated Performance Report

January 2022
December 2021 data period

Service Teamwork Ambition Respect

Performance Summary

Great Western Hospitals NHS
NHS Foundation Trust

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking**	Bath Ranking	Salisbury Ranking	Month
Hospital Combined Performance Score	5102 (Jan)		47 (5102)	28 (5661)	19 (5979)	Jan 22
A&E 4 Hour Access Standard (combined ED & UTC)	74.13% (Dec)		24 (77.62)	86 (64.06)	29 (76.71)	Nov 21
A&E Percentage Ambulance Handover over 15 Mins	51.16% (Dec)					
A&E Median Arrival to Departure in Minutes (combined ED & UTC)	177 (Dec)		42 (186)	104 (234)	72 (211)	Oct 21
RTT Incomplete Pathways	65.23% (Nov)		72 (65.36)	69 (65.71)	31 (72.78)	Oct 21
Cancer 62 Day Standard	73.3% (Nov)		59 (73.3)	97 (63.29)	19 (84)	Nov 21
6 Weeks Diagnostics (DM01)	63.45% (Nov)		96 (65.73)	84 (69.50)	1 (99.41)	Oct 21
Stroke – Spent>90% of Stay on Stroke Unit	72.3% (Q420/21)		77 (78.3)	34 (89.1)	52 (85.6)	Q1 21/22
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	4.80% (Aug)		45 (4.80)	48 (4.84)	5 (3.50)	Aug 21
MRSA	2 (Jun)		95 (3.31)	44 (1.62)	62 (2.15)	Sep 21
Elective Patients Average Length of Stay (Days)	3.28 (Dec)					
Non-Elective Patients Average Length of Stay (Days)	5.16 (Dec)					
Community Average Length of Stay (Days)	20.96 (Dec)					
Number of Stranded Patients (over 14 days)	125 (Dec)					
Number of Super Stranded Patients (over 21 days)	70 (Dec)					

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

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

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, People & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		26th January 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report – Emergency Access	Red	Amber	Service remains under pressure, partly due to difficulties with patient flow into the hospital. Due to difficulties with patient flow out of the hospital (non-criteria to reside patients). The Trust benchmarks well against neighbouring Trusts. The service has been actively engaged in the SAFER fortnight (3 weeks) initiative.	Monitor actions	February 2022
Integrated Performance Report - RTT	Red	Amber	RTT remains above 60% for December. The Elective Programme has been impacted by the recent surge in COVID demand, however, the trajectory shows that 104-week waiters will be at zero in a few weeks' time.	Monitor actions	February 2022
Integrated Performance Report – DM01	Red	Amber	Demand continues to exceed supply resulting in longer waiting lists and times. Staffing vacancies in radiology remain a challenge, additional capacity in echo cardiology and mobile CT/MRI vans was noted. To support the recovery trajectory key improvement actions are in place.	Monitor actions	February 2022
Integrated Performance	Green	Green	Good SNNAP performance continues at Level B. The service continues to perform well despite being under pressure.	Monitor actions	February 2022

Report – Stroke					
Cancer Services Assurance Report	Amber	Amber	The service delivery is good with excellent work from the team on bids that have been successful and provide more funding, however the service remains under pressure with high levels of demand. Patient survey acknowledged general improvements with a score of 8.9/10. Swindon reflects the national picture with demand outstripping capacity. The Committee recognised the team are doing all they can to mitigate risks and meet demand.	Monitor actions	February 2022
Community & Primary Care Performance	Amber	Green	There are number of success stories across the division and positive management actions are being taken e.g. Urgent Community Response (UCR) and Advance Care at Home (Virtual Ward).	Monitor actions	February 2022
IT Performance Update	Amber	Amber	IT infrastructure is being reviewed and actions are in place to improve call handling time on the helpdesk. Staff are now returning to work on site which is improving team morale. Good progress was being made on a number of projects, although there had been delays in some areas, partly due to delivery/supply issues.	Monitor actions	April 2022
Assurance Framework for Winter 2021 Preparedness (Nursing & Midwifery)	Amber	Green	The Committee were assured regarding the work being done although acknowledging that more management actions are needed e.g. auditing the compliance with the agency staff induction policy.		
VCOD Update	Amber	Green	The Committee were assured by the management actions being taken to support staff through this process, although it was recognised that final numbers of staff impacted will not be known until 1 April 2022.	Monitor actions	April 2022
Integrated Performance Report - Workforce	Amber	Amber	It remains a challenging time for the Trust workforce. Sickness levels remain above 5% (approximately 40% of sickness relating to COVID). Appraisal rate improved marginally (74.17%) but remain below the Trust's 85% target. Staff turnover was slightly above the Trust target of 13.9% and agency spend represented 6.86% against a target of 6%. The staff wellbeing agenda continues to be proactively pursued, along with the flu and COVID vaccination programmes.	Monitor actions	February 2022
Nursing Staffing Update	Green	Green	The Committee thanked Chris Bull and his team for the work that had been done and encouraged them to keep up the good work.		
Estates & Facilities update	Red	Amber	The Committee noted the management actions being taken to address risks that had been highlighted in the previous report. The Committee was advised of the improving relationship with THC and plans to monitor risks and actions are in place. It was agreed that the Committee would receive quarterly update reports.	Monitor actions	April 2022

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?

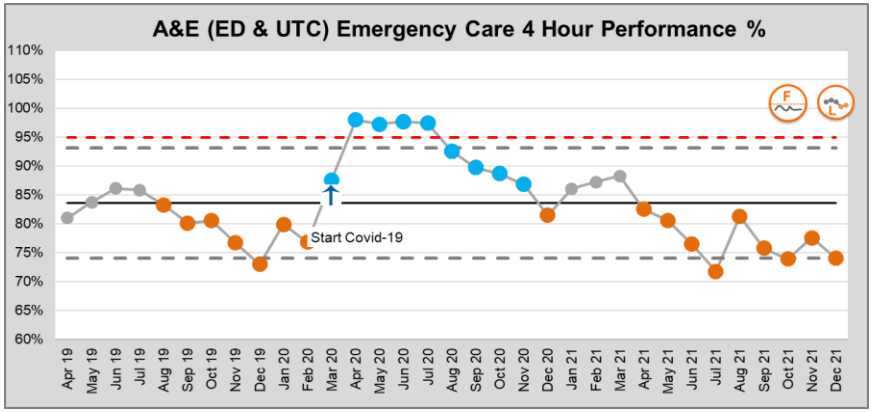
Are We Well Led?

Use of Resources

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

Data Quality Rating:

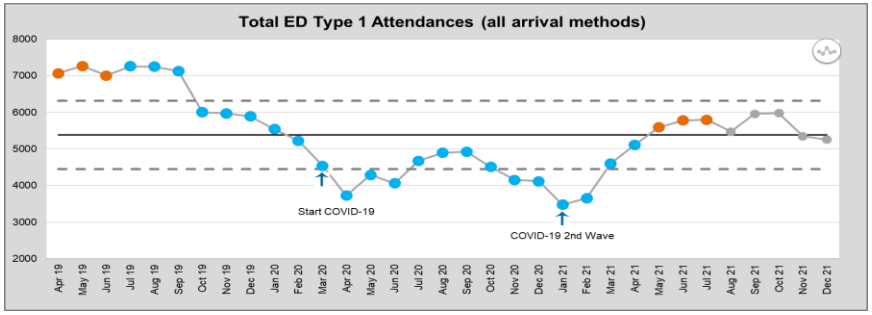
National Key Performance Indicators

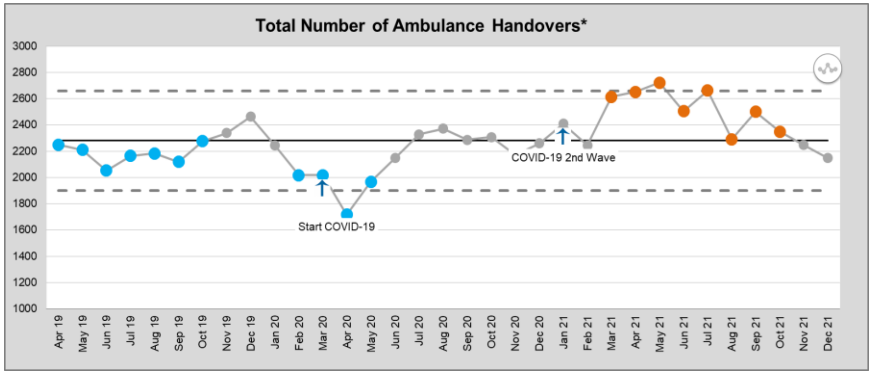


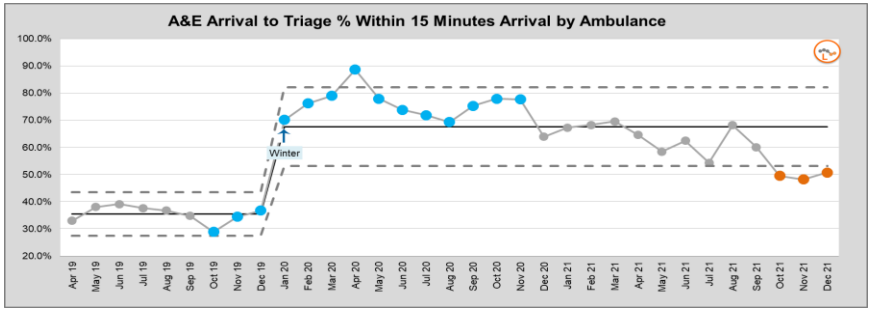
Performance Latest Month: 74.13% (Dec)

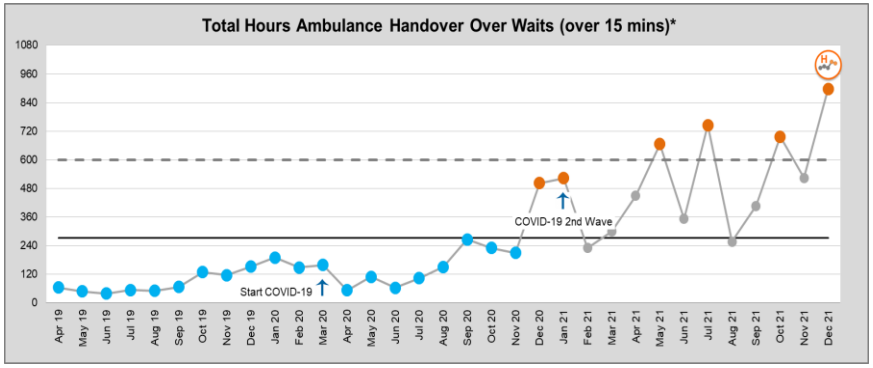
Attendances:
Type 1 ED 57.48%
Type 3 UTC 96.54%
Total – 74.13%

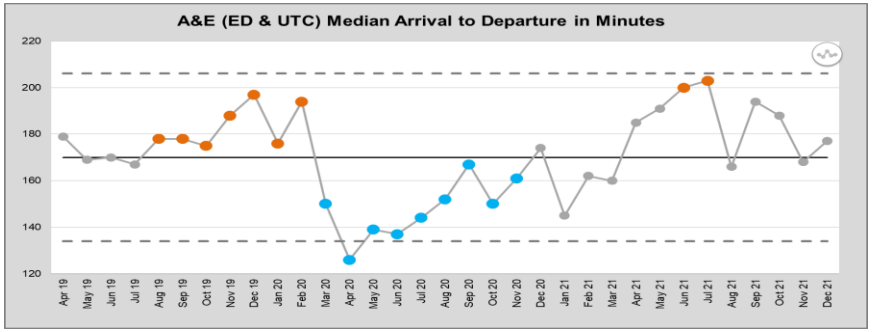
12 Hour Breaches (from decision to admit) 39









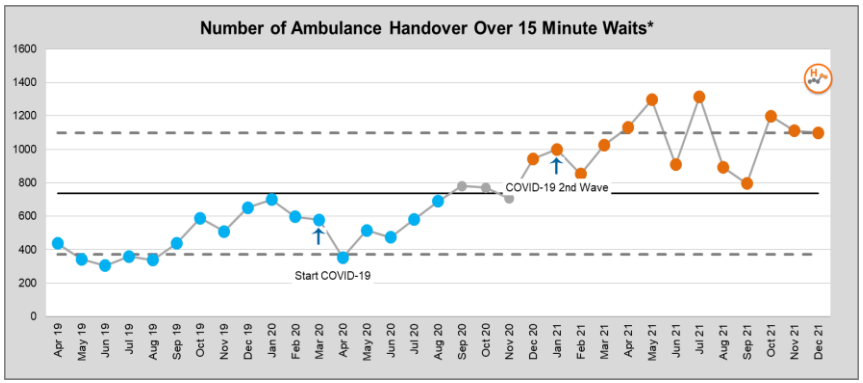


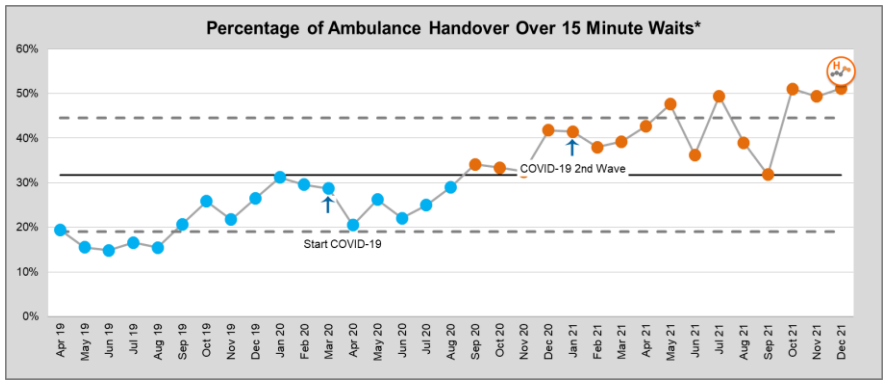
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

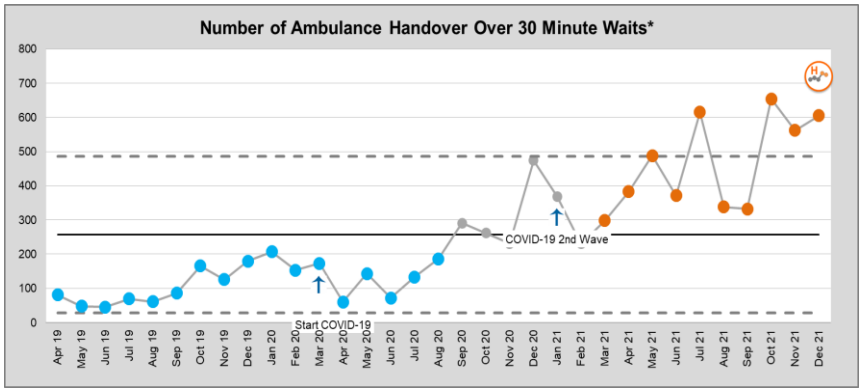
1. Emergency Care Standards – Ambulance Arrivals

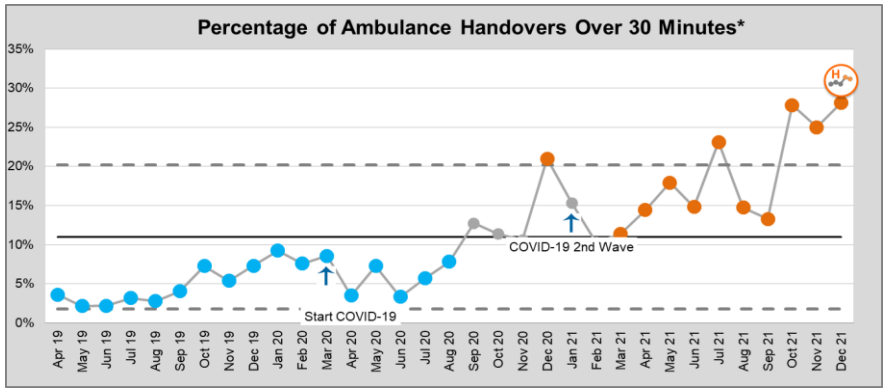
Data Quality Rating:

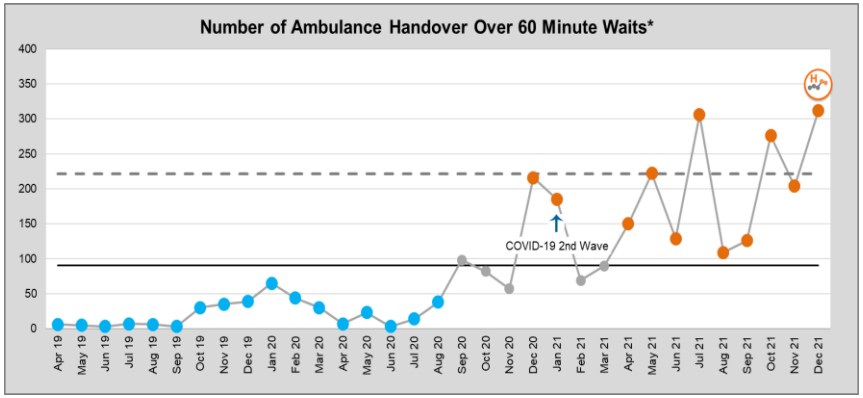
National Key Performance Indicators

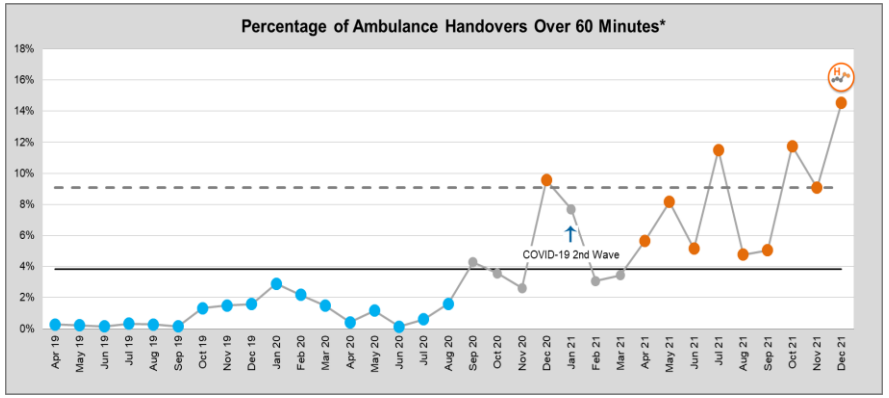












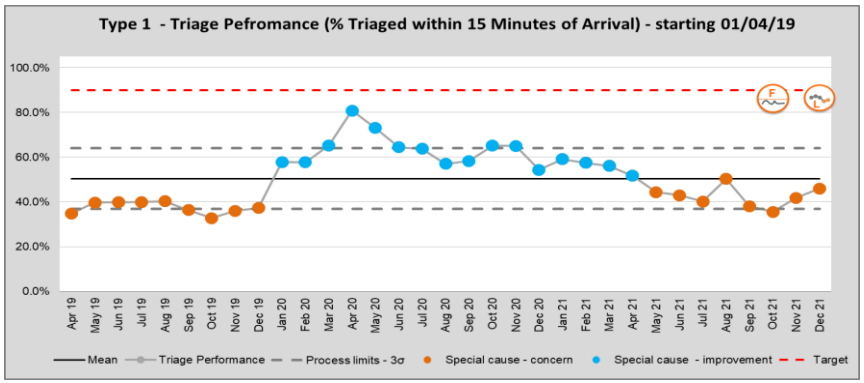
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

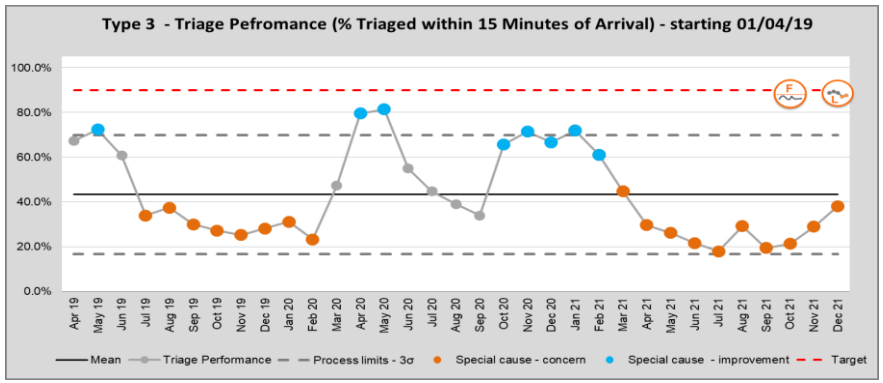
* Data from SWAST – 1 month lag

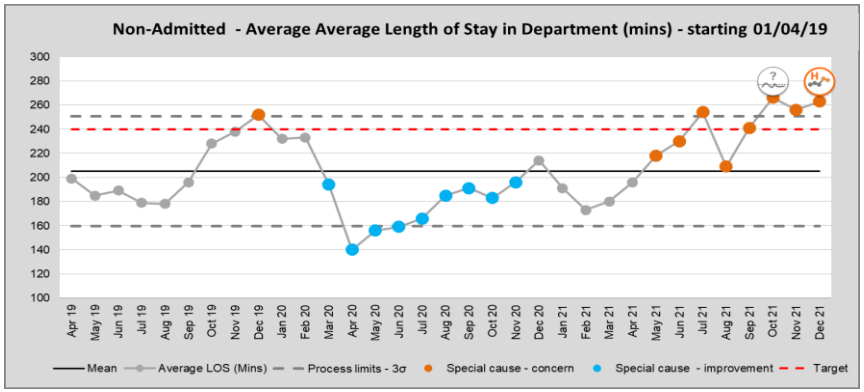
1. Emergency Care Standards – Front Door Flow

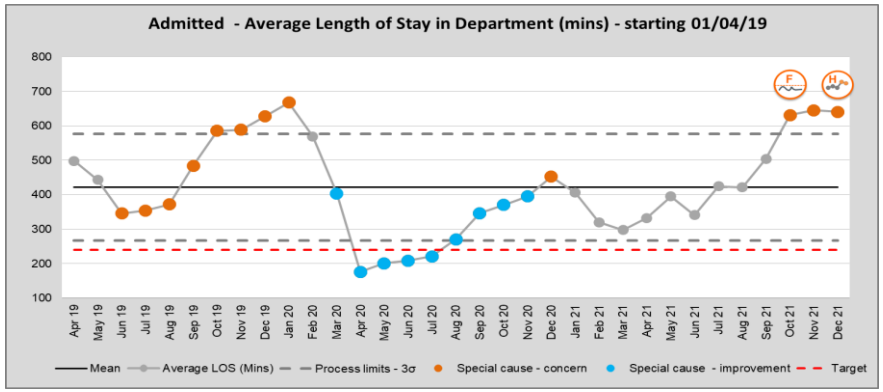
Data Quality Rating:

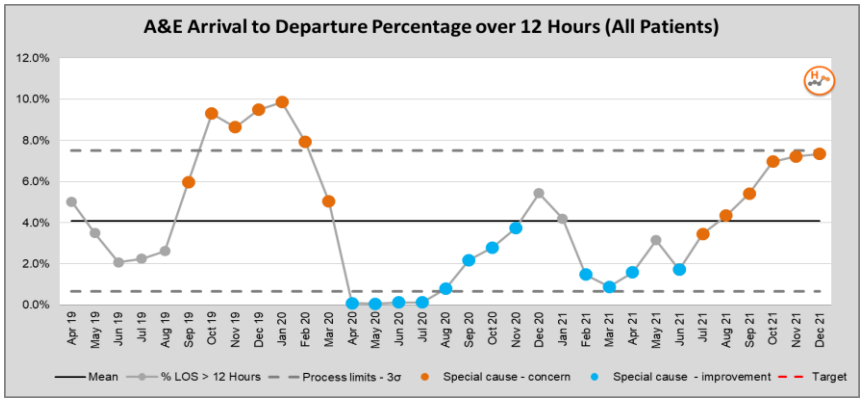
National Key Performance Indicators

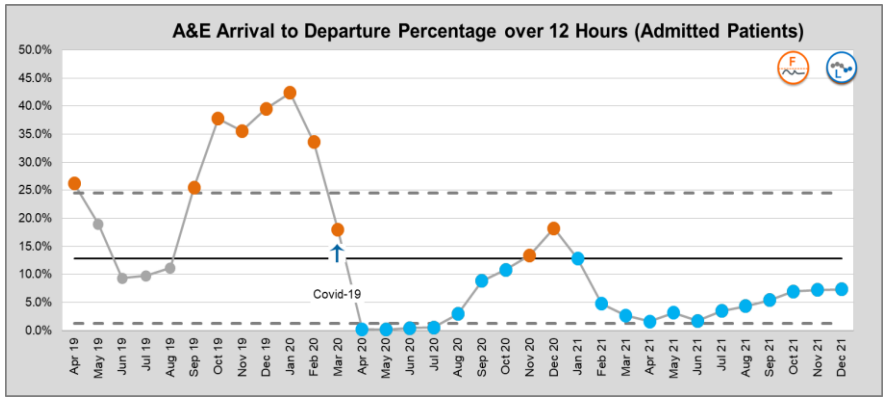












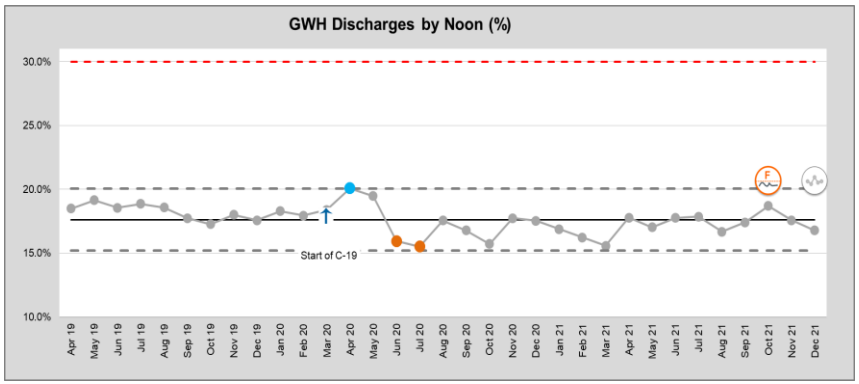
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

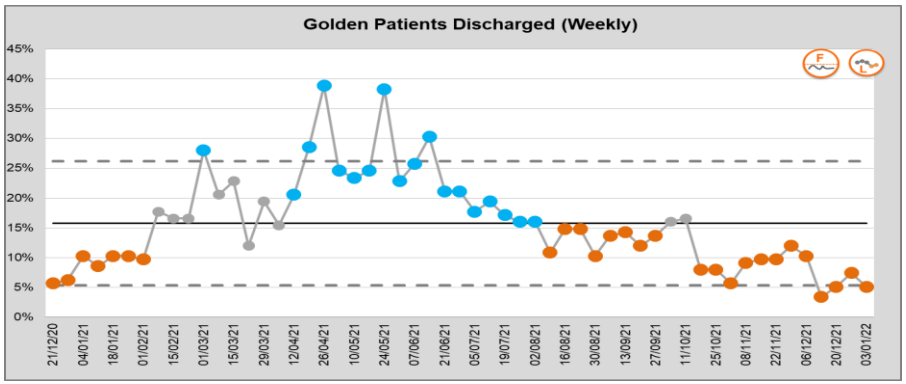
* Data from SWAST – 1 month lag

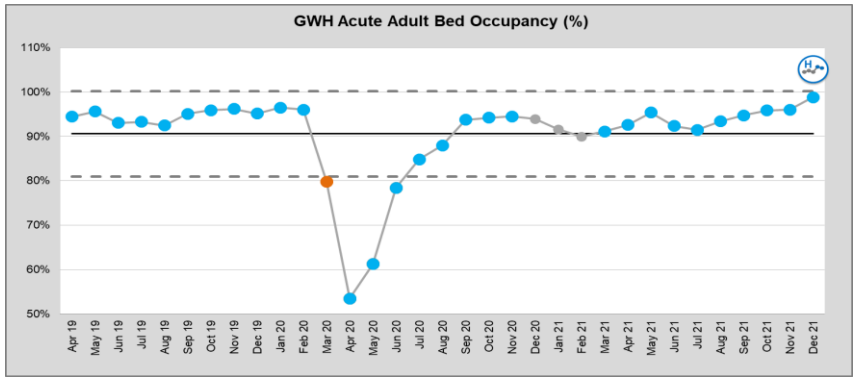
1. Emergency Access (4hr) - Patient Flow and Discharge

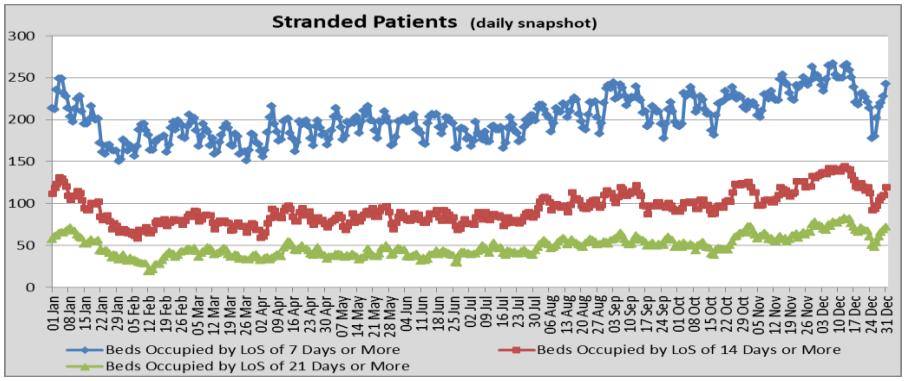
Data Quality Rating:

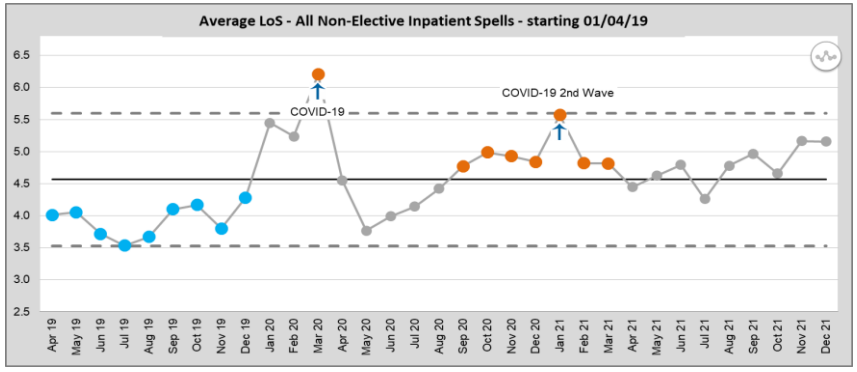
Are We Effective?

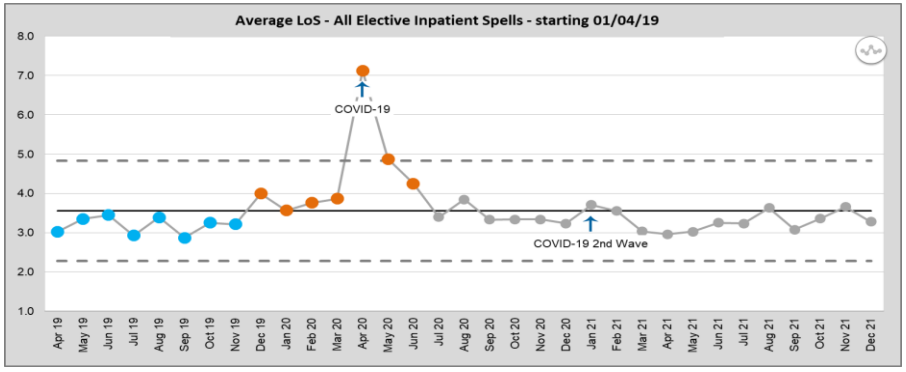












Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

1. Emergency Access (4hr)

Data Quality Rating:

Are We Effective?

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

- The ED performance chart shows that performance in December remains below the 95% standard. There has been a decrease in 4 hour performance of 2.22% from November.
- Attendance have decreased in December (From November) by 532 patients, with 96 decrease in the ED and 436 in the UTC. The UTC remains closed overnight. 4 Hour breaches have increased in December with an increase of 55 in UTC and 144 in ED.
- Breaches due to 'waits to be seen' in ED and UTC have increased in December from 54% to 64%.
- There were 39 x 12 hour reportable Decisions to Admit (DTA) breaches for December which is a decrease of 6.
- Non-admittance performance accounts for 39% of breaches an increase of 2% on last month.
- There has also been a decrease in Think 111 first booked appointment utilisation at 55.09% for December (decrease of 0.08% from November), with 9.6% of patients who DNA'd the appointment slot (Decrease of 1.68% from November) and 4.9% who left department without being seen (decrease from 2.43% in the previous month).

Key Impacts on Performance

- Attendances down from November but remain at pre-pandemic levels. Social Distancing measures remain in place, restricting patient numbers in ED.
- Majors Step-down (MSD) usage compromised by increasing patient acuity. Inability for MSD to function as true 'Clinical Decision Unit' as filled predominantly with Acute Medical patients for increased LOS.
- 'Admissions Area' in Discharge Lounge escalation remains in use.
- Cohorting area within the corridor in ED no longer staffed by SWASFT thereby impacting on delays
- 'Early' discharges in day reducing, onwards flow often not occurring until much later in day , after peak ED attendances.
- Total LOS in ED remains at pre-pandemic levels and has been consistent for last 3/12 . There was a reduction in 12hr DTA breaches in December.Ambulance Handover performance decreased in December.
- UTC continues to see high numbers of patients, but overnight closure has maintained improved performance (98%).
- Total bed occupancy remains high with Length of Stay (LOS) remaining higher than pre-pandemic levels and consistent with last month.

What will make the Service green?

•SWAST having direct access to all Assessment Units.
•Implementation of 'Inter Professional Standards ' allowing direct referral and admission to specialty beds.
•'Think 111 First' programme to ensure direction to correct service in condition appropriate timescales.
•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.Development of services in UTC in preparation for new build in the spring. Joint working with Primary Care & CCG - January 2022
2.SDEC 7 day opening approved as part of Winter Planning . Currently recruiting with phased expansion as staff join unit – January/February 2022
3.Divisional adoption of 'Internal Professional Standards' allowing improved admission processes – January 2022
4.Focus on reducing Ambulance Handover delays (15 min & 1hr), Utilising admin changes and implementation of HALO+ role. On-going but may be affected by SWAST 'cohort' decision which may negatively impact timings – January 2022
5.Implementing findings of Staffing review of nursing (still pending) and utilising Winter Money funding – Paeds escalation covered by Agency shifts, dependant on availability - January 2022
6.Implement 'Navigator' RN role to UTC & ED . Trial underway in both areas. - January 2022/Ongoing
7.Review Portering Audit data + need for dedicated porter/transfer team – January 2022
8.Clarify function of MSD and status of informatics reporting – aim to change CareFlow status. Provide dedicated Medical and Admin support – RAP for locum Registrar & SHO approved, pending cover. Ward Clerk out to Bank. – January 2022
9.Agreed overnight closure for UTC for remainder of financial year. Agreed uplift in staffing being recruited into. - March 2022
10.Action environmental changes to Majors chairs, Paeds and Ambulance Queue area (following Estates walkaround) – February 2022
11.Recruitment of substantive junior doctors completed, pending commencement of employment – February 2022
12.Implementation of CRTP on CareFlow for monitoring and prompt on-going patient movement – February 2022
13.Trial of Front Door Hub on SWAT reset days. Repeat in SAFER weeks + develop – **March 2022**

Risks to delivery and mitigations.

There is a risk that ambulance handover delays will continue to be seen due to a high demand and lack of flow out of ED. Future impact due to loss of SWAST cohort area in ED.

Mitigation: Physio Gym co-located with the Discharge Lounge opened as an 'Admission Lounge' when ED at capacity to ensure offload space.

Implementation of Direct Access pathways for SWAST (PAU,SAU,SDEC,UTC).

Implementation of 'Internal Professional Standards.

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

Mitigation:

Alternative areas for patient assessment in UTC has been reviewed - Eye room and sub wait area now being utilised.
Work is progressing 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 underway to look at alternative community options.

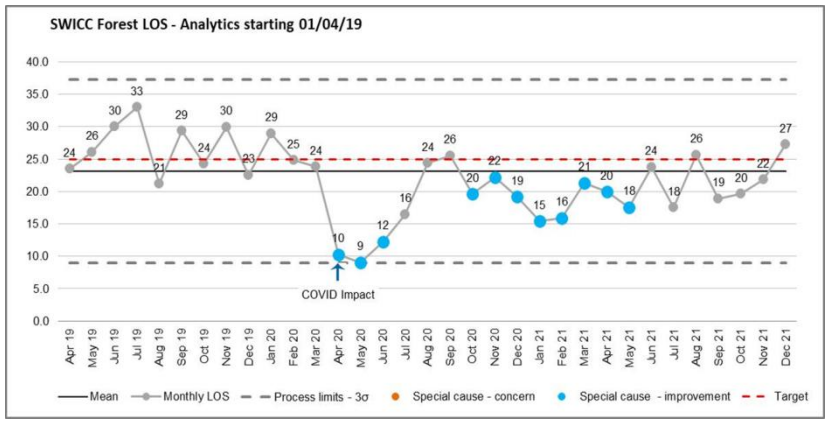
Review continues of any direct pathways to SDEC or Community services to reduce the pressure at ED. BSW wide focus.

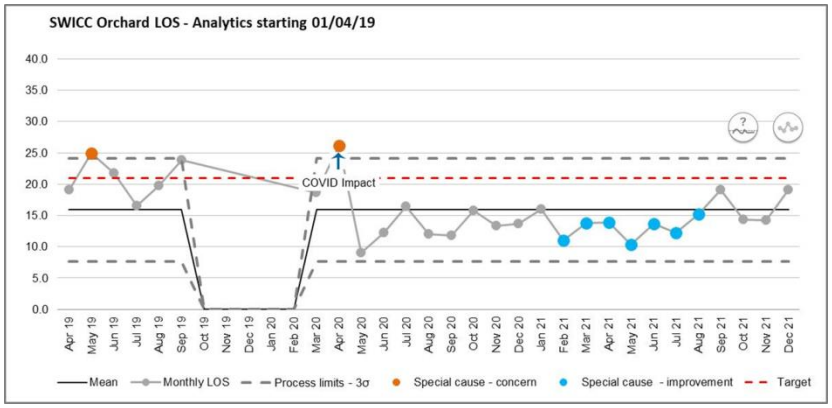
Discussions nationwide to collaborate ideas to manage the demand for urgent care that has a primary care need and pathways for minor injuries.

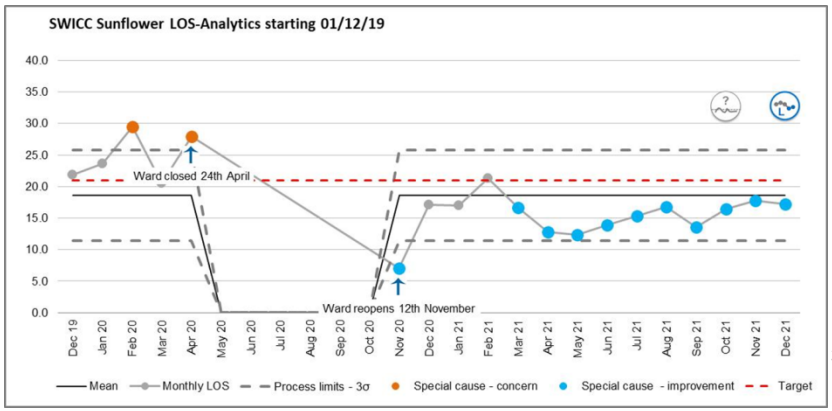
1. Emergency Access (4hr) - Community (SwICC) Length of Stay

Data Quality Rating:

Are We Effective?







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

The average length of stay (LoS) in December across all three units was 20 days, an overall increase on last month of 3 days and is directly linked to medical staffing shortage. LoS with 0–5 days attributing 33% of the overall discharges which is a increase from the previous month of 20%. This reflects increased number of patients outlying to SwICC to await support for discharge. Towards the end of December community therapy staff were utilised to bridge reablement packages to assist flow. Bed occupancy for Forest 90% and Orchard 89%, this is a decrease due to the bed closures on both wards for maintenance, these reopened 23rd December. Sunflower occupancy was 96% which is within the normal parameters. There has been a slight increase for OOA patient averages LoS rising to 15 days from the previous months 13 days. Wiltshire patients have also increased to 15 days average LoS. This can be attributed to availability of care/support within Wiltshire community and bed base.

Flow: Total number of discharges across the three units, stands at 128 which is an increase of 8 patients compared to last month. The closure of 8 beds within SwICC has had an impact on the number of discharges which normally are within the 155 region. **42% were discharged before midday which is for the first time above the target of 30%**. The bed management module on nerve centre has assisted with this. 29% of discharges were facilitated over the weekend/bank holiday period which is an improvement on last month.

Improvement actions planned, timescales when improvements will be seen

Discharge Management: NCTR Score cards are being used within the daily discharge calls as means of reviewing partner or internal delays. Community therapy Leads are now part of this call to share capacity and ability to bridge care. This is strengthened with daily stranded patient reviews to escalate any barriers to discharge. **Action:** To continue to monitor effectiveness

Patient transfer delays: There continues to be delays in transfers and this fluctuates over the month for varying reasons, which we will continue to monitor and report on. For the period of December 14% due to Medical cover, 12% swab delays, 7% changes to medical fitness and 3% transport delays. **Action:** Await outcome from the Transport Specification/Tender that was inclusive of SwICC.

BSW Involvement in Community bed Project: This work continues with a meeting to planned system wide towards the end of January. **Action:** Continue to be involved in submission of data

SAFER Week/s: During safety week/s SwICC will commence safety netting calls as we previously did during first wave of Covid. **Action:** To provide outcomes to PMO to collate as an overall Trust and identify any themes.

Risks to delivery and mitigations

Risk: Consistent medical cover across orchard and sunflower.

Mitigations: Temporary Staffing actively seeking locum support and successfully have booked till 4th Jan (potential extension until end of Jan and beyond). Medical staffing resource calls have been introduced across the Trust to seek opportunities to optimise medical workforce and reduce risk.

Urgent Community Response (UCR) Service

Are We Effective?

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

The UCR service is an MDT that includes Nursing, OT and Physiotherapists, working collectively to rapidly assess and meet the needs of community patients..

< 2 Hour response

723 referrals were received in December against a monthly average of 686 referrals since April. 467 (90%) were responded to within 2 hours, 54 outside of the target and 202 were deemed inappropriate for rapid response following clinical triage.

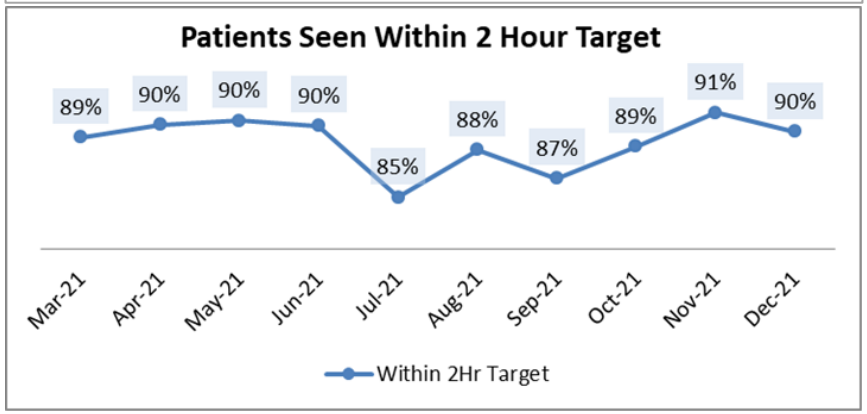
2 – 48 Hour response

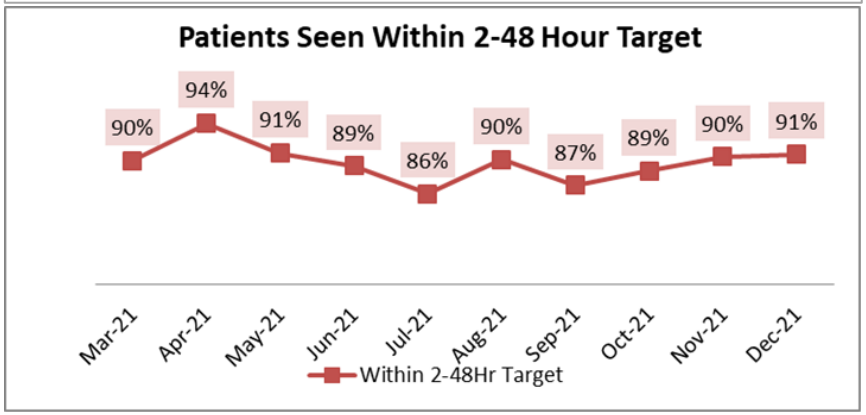
603 referrals were received in December against a monthly average of 585 monthly referrals since April. 364 (91%) were responded to within 48 hours, 38 outside of the target and 87 were deemed inappropriate following clinical triage.

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

Actions planned for January:

- Further roll out of training of SystmOne RTT module– this will improve data capture, accuracy and reporting.
- Meeting with SBC to review pathways and co-location of their rapid services.
- SWAST – continue strengthening through re-set and safer weeks
- Initial meeting with GWH communications team regarding promotion of UCR to referral sources
- Continued work with the MiDoS team, setting the UCR profile to help support with correct identification and referral from system partners e.g., SWAST, Primary Care, SBC
- The service (along with the Single Point of Access) will become 24 Hours in Feb/March 2022.





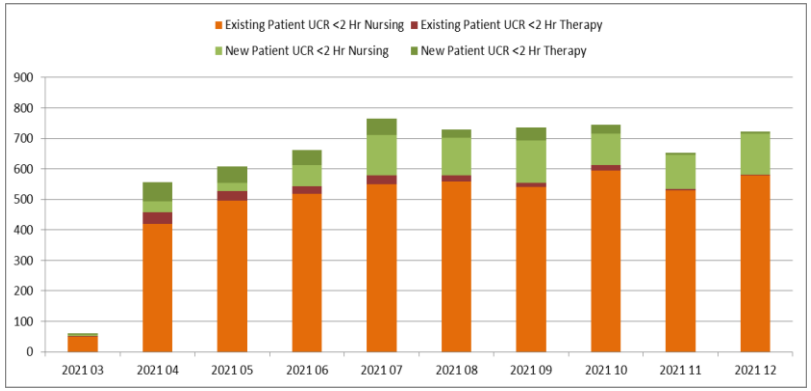
Risks to delivery and mitigations

Risk: Increasing demand as the service develops and referral pathways are opened and promoted. Move to 24 coverage creates a recruitment challenge.

Mitigation: Active recruitment across therapy and nursing and an emerging plan to provide a 24-hour service.

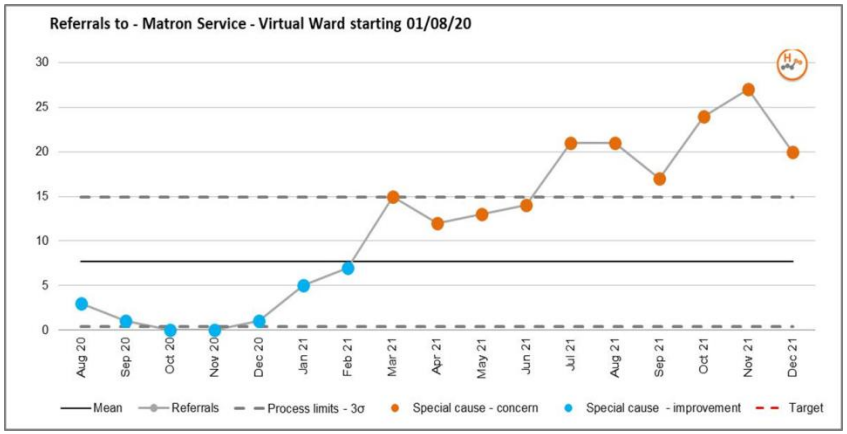
Risk: Known patients still account for most UCR referrals.

Mitigation: Ongoing investigation to explore alternative services if appropriate where patients are being referred more than 5 times. Regular report produced to review this activity and as a group analyse this to identify root causes of care needs escalating. Agree and action plan informed by the conclusions and inferences made.

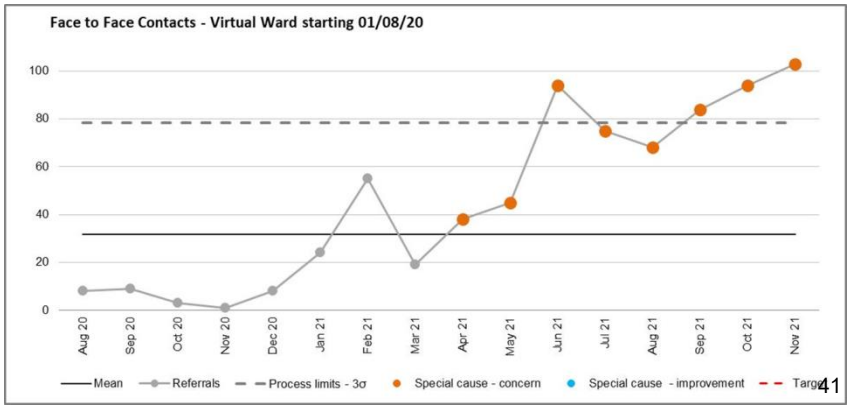


Enhanced Care at Home (Virtual Ward)

Are We Effective?



Virtual Ward Monthly Report	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Number of Referrals	12	13	14	21	21	17	24	27	20
Number of New Patient Referrals	5	6	5	6	5	5	5	2	4
Number of Discharges	14	11	14	22	19	22	18	27	20
Patients on Virtual Ward	12	13	13	23	16	16	19	20	27



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

The service supports patients with highly skilled clinicians who manage complex acutely unwell patients who would otherwise be treated in an acute setting. Patients are cared by a small team of clinicians who access technology called Qardio for remote monitoring of observations for some patients, supplementing and reducing the total number of home visits The average length of stay on the ward is 7 days. The number of referrals continue to sit above the upper process limits.

Investment has been secured as a workstream of the 'Winter Schemes', this is supporting recruitment and increasing capacity, from a typical patient caseload of between 4 – 10 to 20. Although patient caseload is only a single measure of activity and omits other crucial factors such as complexity and acuity of those patients. The posts funded by 'Winter Schemes' are currently being recruited to.

Patients are stepped down and monitored for a period of up to 4 weeks, to proactively manage their long-term conditions and reduce the likelihood of needing unplanned episodic acute care.

Improvement actions planned, timescales when improvements will be seen

Demand & Capacity: A new tool/technique will be developed with the ICC Informatics Manager to monitor the daily status of the service; this will be developed during Feb and March 2022.

Workforce: Continuing to recruit over the next 3 months, with new starters in January and February which will enable an increase in referrals to be accepted. Secondment of an ACP from February.

Caseload: Plan to increase daily ward numbers to 10 at any one-time during January.

Referrals: Open referrals for 3 more GP practices by the end of January

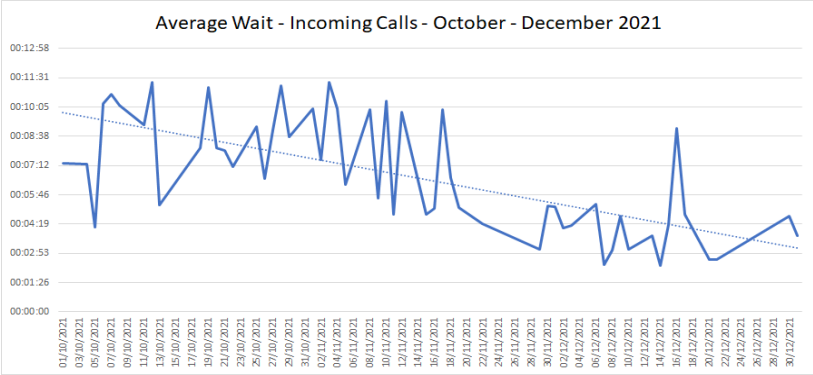
Risks to delivery and mitigations

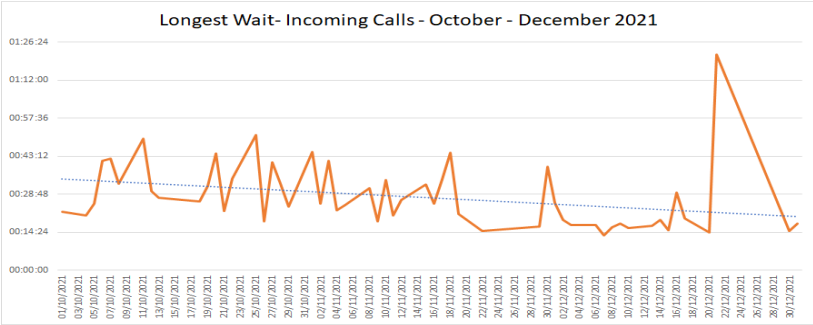
Risk: recruitment of the highly skilled posts (ACP's) remains a challenge and may become a limiting factor regarding >capacity

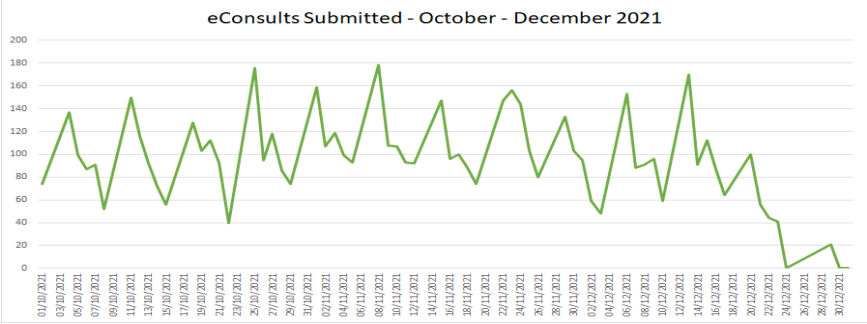
Mitigation: meeting with lead ACP and working with health education England to develop an ACP workforce plan for Community and Primary Care

GWH Primary Care - Accessibility

Are We Effective?







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

- **Average call wait times** during December were 4.1 minutes (Nov 7.4mins). The trend is a decrease in call wait times. Recent recruitment to substantive call handler posts has helped with improving call handling performance.
- **Longest call wait times** during December were 13-30 minutes (Nov 15-45mins), with the exception of one outlier that was over an hour. The trend line indicates a decrease over the past 3 months. 10 Additional phone lines have been procured (taking to total from 20 to 30), these will be added during January. This will help to reduce wait times.
- **eConsults** maintain an average of 500 submitted per week, until Christmas week when the system was paused due to prioritising same day/urgent appointments and higher than usual staff shortages across the Christmas period..

Improvement actions planned, timescales for when improvements will be seen

Call Handling Performance will continue to improve and KPI's developed to measure performance in a more targeted way. This will be enabled by the introduction of improved management information and reporting functions recently procured. New KPI's and reporting available from February.

eConsult activity will increase throughout January as the system resumes to pre-Christmas availability: Mon – Fri 24/7.

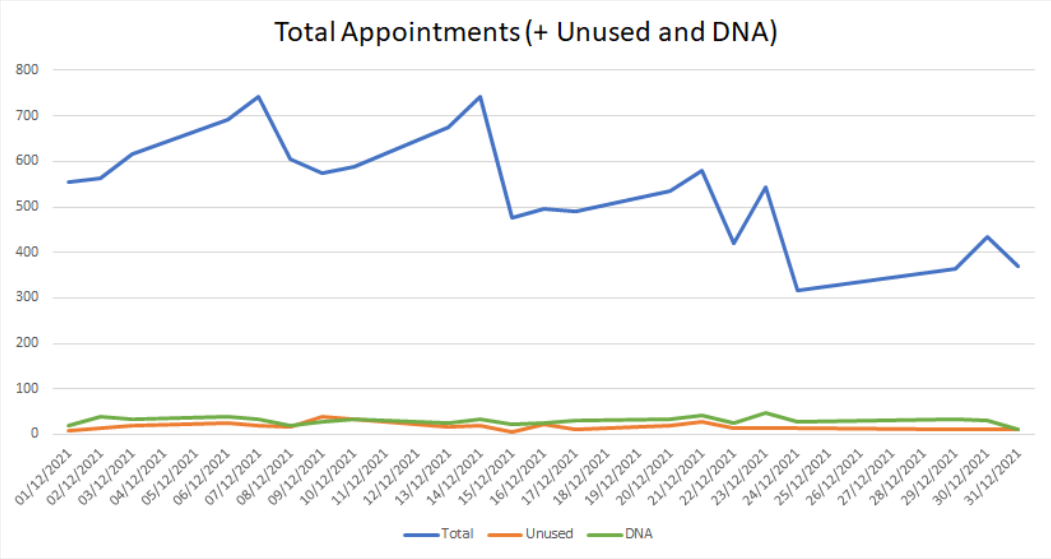
Risks to delivery and mitigations

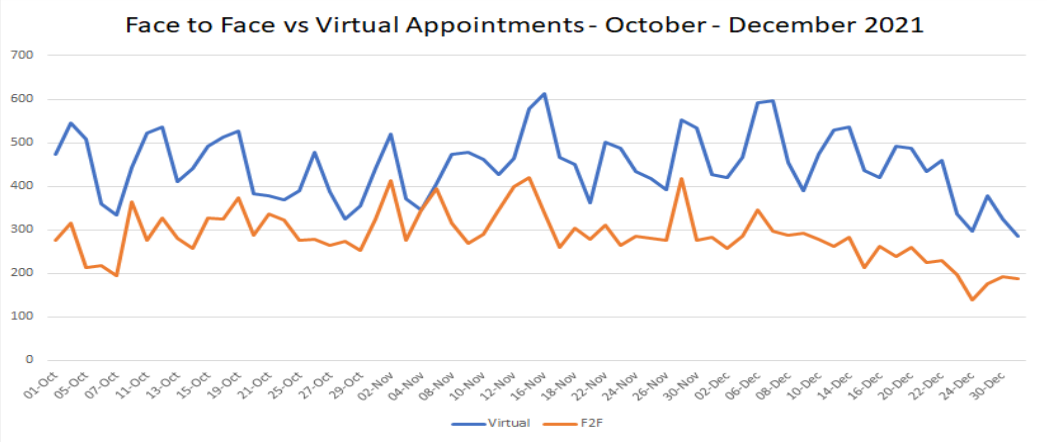
Risk: primary care demand increases with Omicron related calls and eConsults, negatively impacting the call handling and response times

Mitigation: admin staff picking up phone calls to support the call hub at peak times and restricting access via eConsult would be considered in extremis

Primary Care - Accessibility

Are We Effective?





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

During December the number of daily appointments provided across all patient facing professional groups ranged between 316-743. The reduction in appointments during the second half of December is anticipated seasonal dip, coupled with pausing eConsult and aligning resources to the priority set by NHSE for same day urgent appointments. Over the longer term (past 12+ months) there has been a significant increase in the no. of appointments offered.

A new First Contact Physiotherapist joined the team in December, increasing the number of AHP appointments available.

Improvement actions planned, timescales when improvements will be seen

Appointment capacity will increase in January with improved rota management, new salaried GP's joining and additional posts such as ACP's and Physiotherapists being recruited and on-boarded during January, February and March .

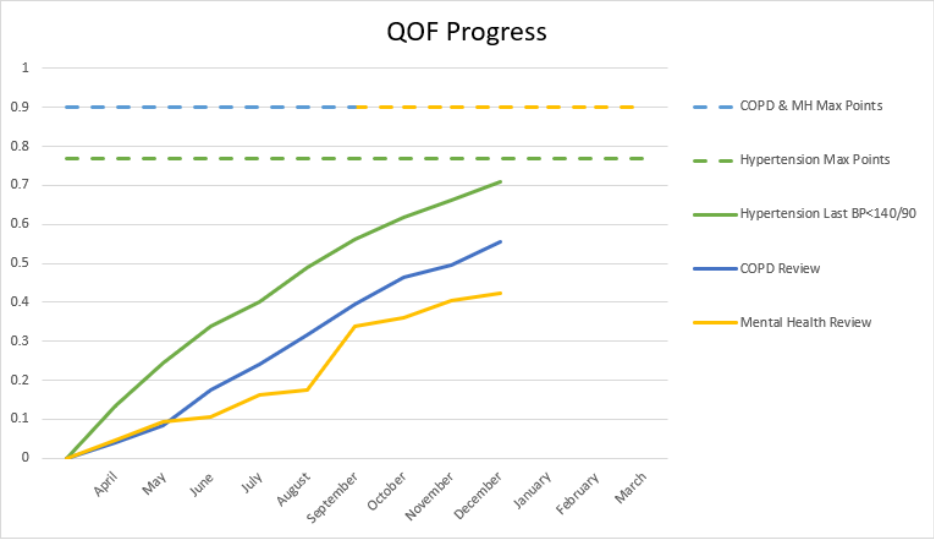
Risks to delivery and mitigations

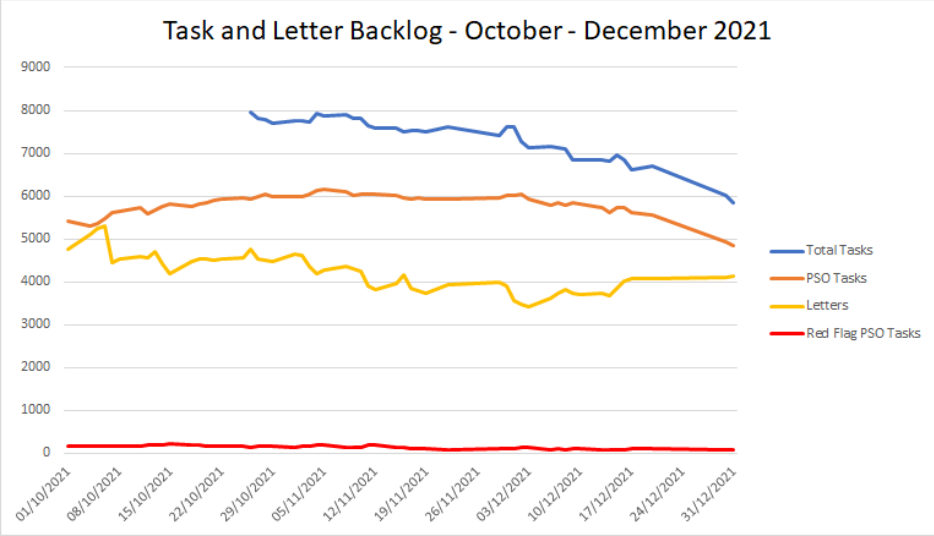
Risk – Appointments reduce due to gaps in the clinical rota as a symptom of high demand for Locum GP's and high levels of sickness absence with Omicron wave.

Mitigation – An additional salaried GP is joining in January. Additional Pharmacy and Physiotherapy resource has recently been recruited.

Primary Care – Quality and Performance

Are We Effective?





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

Quality Outcomes Framework (QoF) are evidenced based health improvement activities completed in Primary Care, typically supporting patients with, or at risk of developing chronic conditions. Achievement of the 68 clinical domain QoF indicators usually triggers payment. This payment is variable and solely based on the % level achieved. However, during the pandemic QoF dependent payment has been paused, with a small number of exceptions.

Clinical Correspondence Backlog: the task & letter backlog Team launched on 10th November, currently 1.3 WTE Admin and 8-10 clinical sessions per week. It is our goal to reduce this backlog to a point where all clinical correspondence in the system are 'current'. Currently 600+ tasks are generated per day.

Improvement actions planned, timescales when improvements will be seen

- **QoF:** The QoF trajectories detailed are likely to be improved upon. This is due to a planned ramp up of QoF activity in February and March, when it is hoped Covid related pressures will reduce, in line with the current modelling.
- **Task & Letters:** the backlog is being reduced week on week and will be within acceptable workflow levels by mid February

Risks to delivery and mitigations

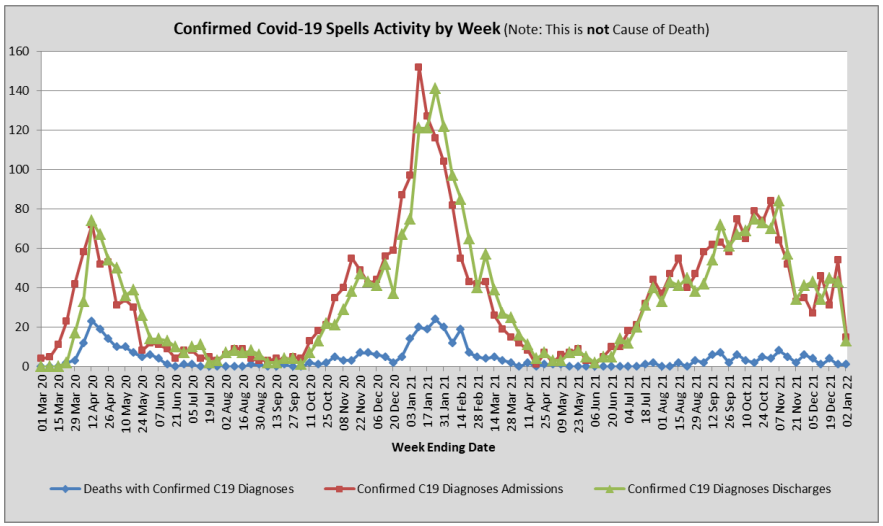
Risk: Resource required for Q4 QoF activity is otherwise engaged on Same Day urgent appointments

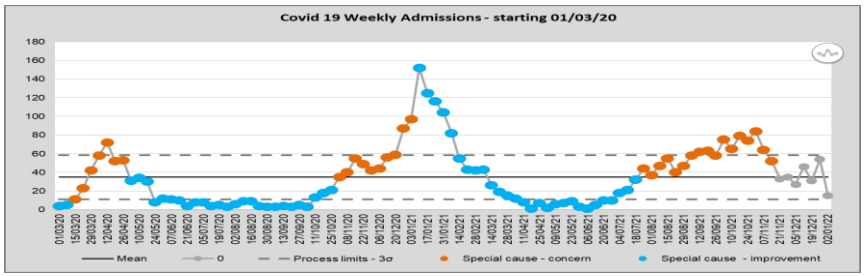
Mitigation: plan the GP, ACP, Nursing and HCA rotas and clinics now, reflecting the split of time between routine, urgent and QoF activity. Start prioritising QoF activity during Feb.

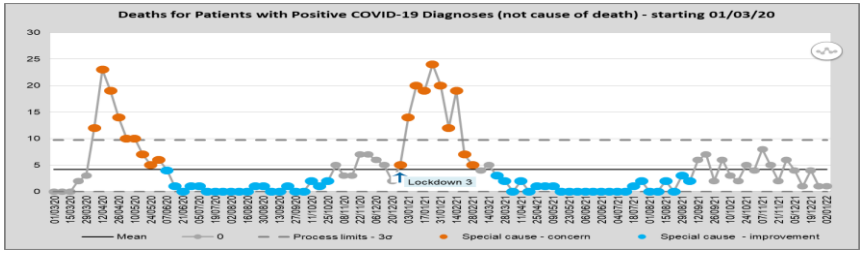
1. Emergency Access (4 Hours) Covid 19 Weekly Admissions

Data Quality Rating:

Are We Effective?







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

Attendances to the Covid Assessment Unit (CAU) have remained at a consistent level through December, peaking in the 3rd week, with Covid positive patient numbers remaining comparable with Phase 1 of the Pandemic. As a result, CAU has maintained operation with 11 rooms.

CAU has frequently been at maximum occupancy during December due to competing bed pressures with other Front Door services and overall demand. This has impacted on the ability to offload ambulances in a timely manner but robust processes are in place to limit significant time delays.

There were 4 Ambulance 1 hour delays at CAU for December.

There was 1 recorded admission from the Boarding Hotels (Holiday Inn Express).

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

1. On-going review of AMU Medical staffing. Identified Locum support for escalation areas allowing stable CAU cover - **January 2022**
2. Recruitment of Ward Clerk x1 wte for permanent CAU cover - **January 2022**
3. Implementation of Abbott Swab testing in CAU to maximise Cepheid supply - **January 2022**

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 increasing patient numbers.

Mitigation: Use of POCT/Cephid swabs and patients with high suspicion of COVID. Abbott tests for low risk / suspected Green patients. Trolley wait times escalated, utilise admission SOP and CAU given prioritisation of patient movement, if these exceed ED.

There is a risk of maintaining staffing provision within CAU, as extended area, particularly within the AMU Medical staffing model. Further impact with increased sickness/isolation.

Mitigation: Medical staffing model and Ward Clerk cover reviewed . Discussed with FBP - Locum support and recruitment respectively. Staffing reviewing including 'Defence Watch' type modeling.

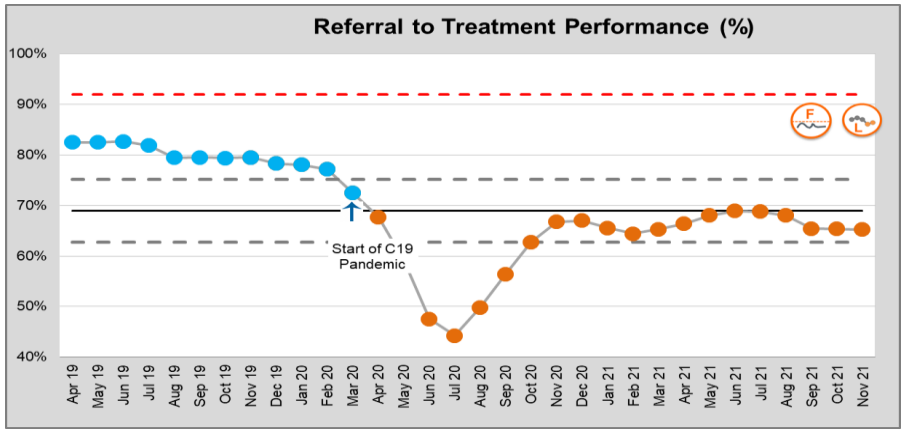
There is a risk of increased demand for 'Blue' beds due to increase in Covid variants.

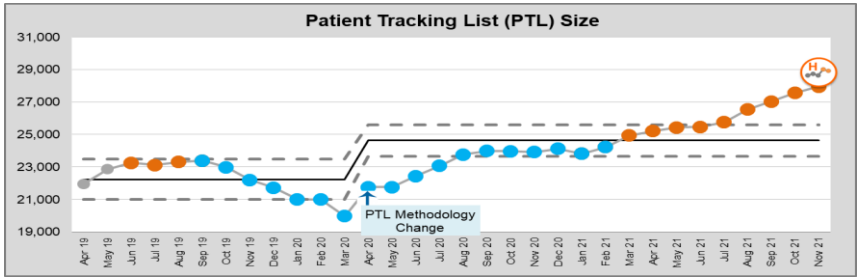
Mitigation: Daily monitoring of Blue/Green attendances. POCT testing maintaining. Close working with ED and joint SOPs updated. Flexible usage of CAU and MAU side rooms. Monitor for trigger escalation for CAU expansion.

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

Data Quality Rating:

National Key Performance Indicators





	October	December
RTT Performance	65.23%	62.01%
PTL Volume	27,943	28,296
Reportable 52 Week Breaches	593	639
In Month 52 Week Breaches	285	188

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 December 2021 reduced to 62.01%, a deterioration of 3.22% in month.

The Trust reported a waiting list increase of 368 in month, resulting in a waiting list size of 28,296 against a BSW Trajectory of 29,419 (1,123 less patients than forecast).

The Trust received 9,152 referrals in December 2021, which is 92% of the Pre-Covid 19 average referral rate.

In December 2021 there were 639 x 52-week reportable breaches. This is an increase of 46 in month.
Of the 639 reportable breaches in December; 491 are Admitted, 136 are Non-Admitted and 12 are Diagnostic.

188 in month 52-week breaches cleared in December 2021. We are working to address the objectives of no patients over 104 weeks in March and a reduction in the 78 week wait cohort.

The number of patients waiting over 78 Weeks at the end of December was 48, a reduction from 74 the previous month.
The RTT position is likely to deteriorate through to March, whilst we review the waiting list of all patients over 52 week waits both administratively and clinically.

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

- Insourcing mobilisation commenced 8th January 2022 with Urology, resulting in 19 patients being treated. Gynae due to commence 15th Jan, with 29 planned.
- The Trust continues to utilise 3 Independent Sector organisations; Cherwell, Circle Reading and Sulis Bath.
- Kingsgate recommendations are being operationalised in the Anaesthetic Department with work ongoing to address the resourcing of the service.

Risks to delivery and mitigations

There is a risk that the Elective Theatre Programme will be reduced if there is a surge in COVID demand and ICU needs to increase capacity.

Mitigation: Daily review of ICU acuity and demand across the Trust

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

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

There is a risk that our MRSA protected Ward, Aldbourne, in unable to re-open due to on-going bed pressures related to Covid-19 and Medical outliers.

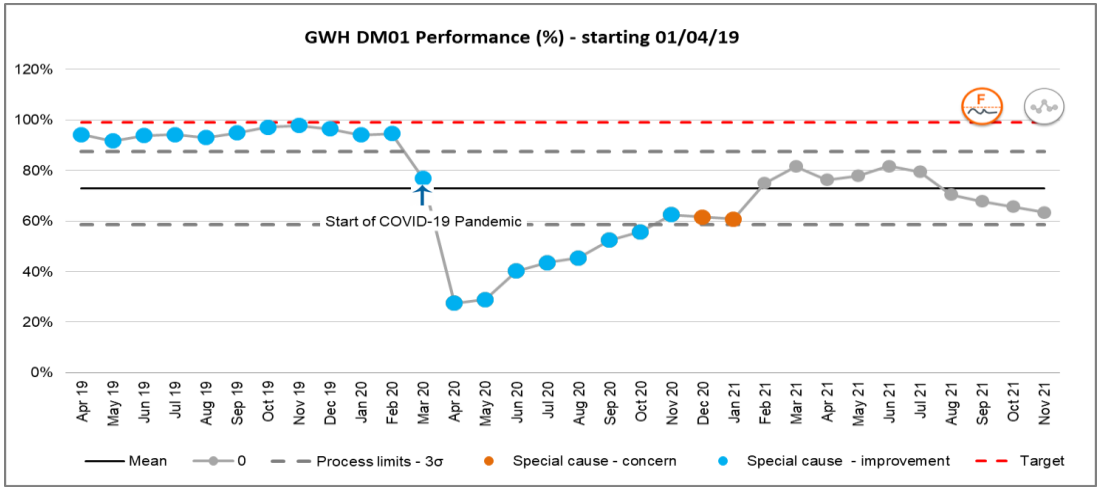
Mitigation: Trust launch of SAFER week and continued flow management by SWC Director of the Day/SLT, to mitigate bed pressures. Planning in January for DC work where possible (save Cancer) to support flow for surgical team. Additional outlier support 'in-week' to reduce outlier numbers.

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

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

Data Quality Rating:

National Key Performance Indicators



November 2021

Performance Latest	63.45%
Waiting List Volume:	9402
6 Week Breaches:	3237

Waiting	< 6 Weeks	> 6 Weeks	Total WL	Performance %
Magnetic Resonance Imaging	820	983	**1803**	45.48%
Computed Tomography	1092	1265	**2357**	46.33%
Non-obstetric ultrasound	2033	128	**2161**	94.08%
Barium Enema	0	0	**0**	N/A
DEXA Scan	208	370	**578**	35.99%
Audiology - Audiology Assessments	464	32	**496**	93.55%
Cardiology - echocardiography	307	85	**392**	78.32%
Cardiology - electrophysiology	0	0	**0**	N/A
Neurophysiology - peripheral neurophysiology	94	0	**94**	100%
Respiratory physiology - sleep studies	95	17	**112**	84.82%
Urodynamics - pressures & flows	0	0	**0**	N/A
Colonoscopy	239	267	**506**	47.23%
Flexi sigmoidoscopy	91	28	**119**	76.47%
Cystoscopy	43	3	**46**	93.48%
Gastroscopy	134	59	**193**	69.43%
Total	**5620**	**3237**	**8857**	**63.45%**

Background

Performance was 63.5% in November, a decrease from 65.7% in October. Overall, the total waitlist size has increased to 8857 in November from 8834 in October (+23). Breaches have increased from 3027 in October to 3237 in November (+210) primarily driven by MRI and CT. CT remains challenged to see 2ww and urgent patients, with no routine capacity. Due to reduced CT van capacity during the month, Radiographer vacancies (10.wte) and the overdue patients on the Cardiology surveillance list , we are predicting an increasing waiting list and breaches which will impact subsequent Trust DM01 performance to <65%.

Improvement Actions

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

- **CT:**. The service has funded 20 days in Dec, 22 in Jan, 20 in Feb and 23 days in March. Yielding a total of 2322 slots.
- **MRI:** Additional MRI van capacity has been procured through extension of Inhealth contract and within forecasted budget. 8 days Dec- March 22, yielding 880 slots.
- **Dexa:** Further adhoc capacity from staff rota added in December.
- **Echo**: Phase 2 (WCC Expansion from 3 x Echo Rooms to 5 x Echo Rooms) operational from W/C 6th Dec 21. Additional Cardiac Imaging Consultant commenced in Nov 21 to help recover TOE and Stress Echo wait lists.
- **Endoscopy**: Weekend lists are booked to 12 points (both OGD and Colonoscopy) where case mix allows. During November 40 WLI lists were delivered against a target of 64 due to limited endoscopy nurse availability. The plan for December WLI lists is to deliver 32 lists from a target of 64.

Risks There is a risk that the addition of FU Echo Wait list to DMO1 Echo Wait List would severely impact the reportable DMO1 Echo Performance. This risk has been mitigated through the provision of FU WLI Echo Weekend Lists until 31 Dec 21 and the funding of the WCC Clinic Room Expansion Project.. Radiology vacancies will substantially impact recovery and performance. Mitigations remain in place above to support risk, detailed on next slide.

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

Data Quality Rating:

National Key Performance Indicators

Background, actions being taken and issues

Endoscopy: At the end of November Endoscopy achieved 67% performance combined. This was a decrease from October's 68%. 40 weekend WLI Lists were completed in November 21 against a target of 64.

32 WLI lists were forecast for December 21 against a target of 64 and the recovery trajectory has been amended to reflect return to DM01. This is due to colonoscopy nurse non availability. This issue is being addressed by rostering shifts to cover weekend WLIs and the recruitment of 6 additional nurses to support the opening of the 5th endoscopy room in March 2022.

DNA levels for Endoscopy (both swabbing and procedure) are higher then anticipated . If a swab is DNA'd the Endoscopy slot can not be re-utilised. The DNA rate for swabs was 25% on average in November whilst on the day DNA rate is 1%.-2% with 7% cancellations. Some appointments are utilised by internal patients, but circa 10-15% of appointments cannot be utilised. The decision to relax IPC activity has been delayed with TVCA support, as a result of the emerging Omicron COVID 19 variant. The decision will be reviewed in the New Year.

Radiology: Performance has dropped in November 60.20% due to staffing vacancies and the inability to recruit. (10 WTE). CT 2 replacement program has been completed but has taken time for colleagues to train on the apps. The total number of patients waiting over 6 weeks in November reduced slightly to 2357 a decrease 104 from October. Further staffing vacancies will impede MRI and DEXA provision in December as capacity is used to support inpatient flow, cancer and urgent CT provision. Performance will continue to decline in Radiology which will affect the overall Trust DM01 from November onwards to approx. 60%, with recovery predicted in Q4 based on forecast improvements

Echo: Performance increased from 74% in Oct to 78% in Nov. There was a decrease in the overall wait list from 678 in Oct to 392 in Nov. This is due to additional routine NP weekday capacity created through the transfer of FU patients onto weekend FU WLI clinics. Echo activity increased slightly from 648 in Oct to 662 in Nov(this includes 146 WLI appointments). DMO 1 FU Clock start categorisations as per national Guidance will reduce Echo performance further when included in this report as at the end of Nov there was a total FU wait list of 346 which includes a breach total of 237.

What will make the Service Improve?

Maintaining Endoscopy activity to meet demand: by ensuring enough capacity is available. This is looking unlikely to be achieved by the end of the financial year as planned, because the 5th room is not available until end Mar 22 due to technical installation requirements for the new washers require phased installation for QA testing. Furthermore, limited availability of endoscopy nurses to support the weekend WLI lists is reducing WLI capacity.

Radiology: Recruit to further radiographers (8.5WTE)

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

Endoscopy:

1.Capital funding (£300k) received for the build of a fifth procedure room. **Now available end March 2022.**

2.The installation/replacement of washers to run 5 rooms. Has been funded and is in progress. **March 2022**

3.A paper is being collated to identify opportunities and costs to increase endoscopy capacity in the short term.

Radiology:

1.**CT**: CT van capacity from InHealth confirmed 11 days in November, 20 days in Dec, 22 days in Jan 20 in Feb and 23 days in March 2022 are scheduled. Appointment times for standard CTs have gone back to pre pandemic 15mins. Incentive payments are in place and a weekly recruitment meeting with HR is now undertaken

2.**MRI**: Inhealth van days - 12 days in November and 8 days in each month for Dec- April 22 have already been secured. Additional Bank staff due to start in October.

3.Bids for H2 money to support the service. recovery (upgrade of breast pad to facilitate additional mobile slots, mobile vans at additional sites, 3rd party CT scanning, CTCA capital investment case and use of a recruitment agency to reduce vacancies.

Echo: Phase 2, which began on 23 Nov will see the creation of 2 additional echo rooms taking the total to 5 echo rooms on completion on 19 Dec 21. WLI has been authorised for Dec which will deliver 148 additional appointments. The combination of WLI and 2 x Additional Rooms should see DMO1 Echo recover by early Mar 2022. Locum Imaging Consultant started 1 Nov 21. This will help reduce TOE and Stress Echo Wait Lists.

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:** The fifth room availability is now delayed (due to washer installation) so alternative mitigation is being sought.

There is a risk that patients will become more reluctant to agree to self isolate for 3 days between swab and Endoscopy procedure. **Mitigation:** relaxing IPC restrictions has been considered and the decision has been delayed due to the emergence of the omicron variant of COVID 19.

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:

- Approach IS to discuss/ reduce private patients.- Completed (Cobalt able to support with 25 patients per week)
- Additional Cardiac and CT sessions offered to staff, with incentive payments being well supported
- Additional MRI van slots booked with TVCA funding and further match funding. Completed.
- Recruitment meeting taking place fortnightly to promote ideas and drive improvements in strategy.
- Bids for H2 money to support the service. recovery (upgrade of breast pad to facilitate additional mobile slots, mobile vans at additional sites, 3rd party CT scanning, CTCA capital investment case and use of a recruitment agency to reduce vacancies)Some

Echo: There is a risk that the eventual inclusion on DMO1 returns of the active FU patient list, including referrals not seen within 6 weeks of their proposed review date, will markedly reduce the reportable DMO1 Echo performance for GWH.

Cancer 2 Week Wait Performance Target 93%

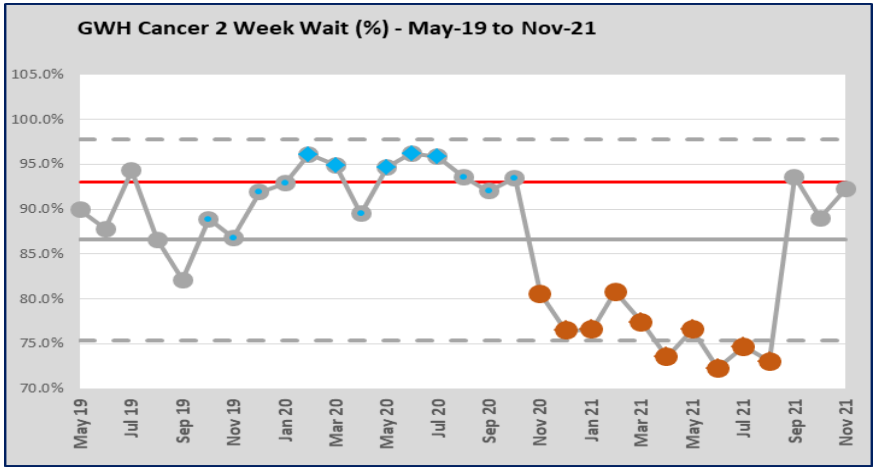
Data Quality Rating:

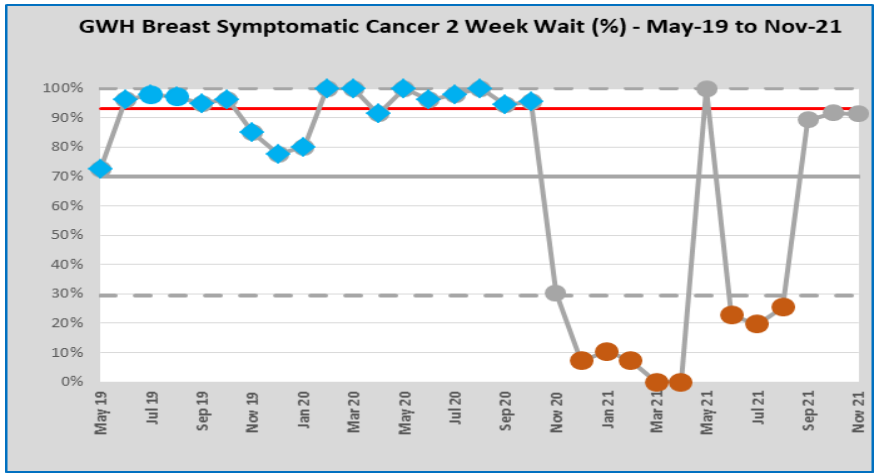
National Key Performance Indicators

Performance Latest Month: **November**

Two Week Wait Standard: 92.2%

Symptomatic Breast Standard: 91.4%





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

The standard in November was not met largely due to Lung (65.8%), Colorectal (83.2%) & Upper GI (89.5%).

The two gastro sites have been challenged over the last 6 months due to insufficient clinical capacity to meet the referral demand in Endoscopy and Radiology.

The Lung performance did not achieve due to the Radiology capacity.

1,458 patients were seen under the 2 week wait to first appointment rules, of which 114 pathways breached the standard, the majority of breaches were as follows:

Lung (65.8% - 13 breaches)
- 13 issues with CT capacity

Colorectal (83.2% - 45 breaches)
- 28 patient choice
- 12 issues with outpatient capacity

Upper GI (89.5% - 13 Breaches)
- 6 patient choice due to holidays and work commitments
- 4 issues with outpatient capacity

Breast (16) & Skin (15) saw breaches but met the standard achieving 94.7% & 95.4% respectively.

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

Colorectal
- Pathway navigator to speak with patients to encourage attendance and work with PCNs.
- Dedicated CT slots with a 48 hour turnaround due commenced in October
- Audit of Patient Choice reasons has been conducted. We are now looking at which GP surgeries these relate to so we can engage with them to help educate and reduce this.

Upper GI
- Planned routine and urgent patients continue to be moved into the future as a result of 2ww volume. Additional WLI clinics have been organised to meet demand.
- Gastro Locum available to work outpatient clinics at weekends to support capacity if required

Lung
- The service is working with radiology to source more protected CT slots
- Outpatient appointments are being booked where necessary

Risks to delivery and mitigations

Radiology
- CT capacity issues due to vacancies
- Additional CT van days from **InHealth** are being arranged until March 2022. (20 additional days in December)
  - Exploring additional sessions with **Cobalt** in Cheltenham.
  - Weekly wait data is supplied to cancer services team to help manage expectations and aid pathway planning. CT currently booking to 14 days and CTC booking to 17 days.
  - Bid for additional funding from TVCA for more CT van days
  - CT Superintendent commenced in post in January

Colorectal
- Risk of bedding Endoscopy through due to site pressure
  - Endoscopy to be protected as much as possible to help maintain cancer pathways

Endoscopy
- HoS work with clinical team and infection control to assess the guidance and impact on booking of scopes has been put on hold whilst the Trust responds to the new COVID strain.

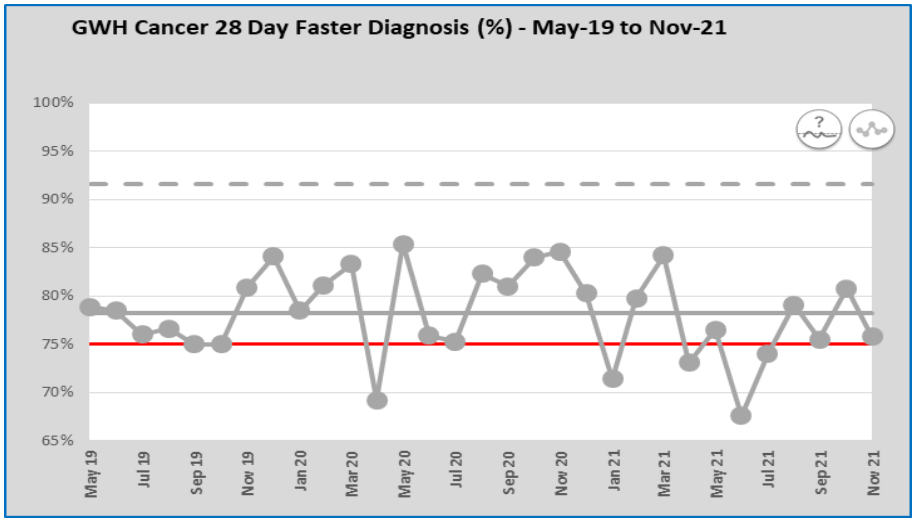
Cancer 28 Day Diagnosis Target 75%

Data Quality Rating:

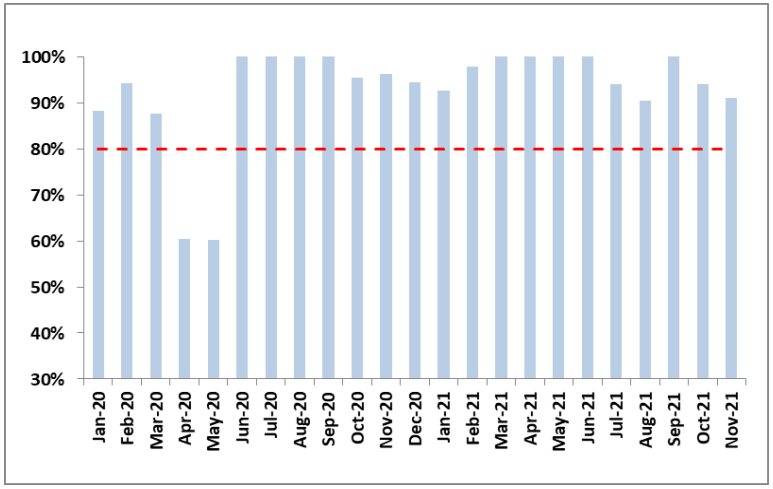
Are We Effective?

Performance Latest Month: **November**

28 Day FDS - Total 75.8%



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 was met in November with a performance of **75.8%** (356 breaches). The performance standard for all referrals (2ww, symptomatic & screening) is reported by NHS Digital and via the Public View portal.

Urology (46.5% - 54 breaches)
- 11 insufficient capacity for follow up in clinic to discuss diagnosis
- 8 clinical admin delays which included delays to dictating letters and delays to arranging follow ups.
- 13 pathways delayed for other reasons, including appointments booked to limits of KPIs
- 4 complex pathways with multiple and/or repeat tests
- 12 patient initiated delays to pathway

Colorectal (53.8% -- 126 breaches)
- 55 breached as a result of clinical capacity
- 20 clinical admin to review diagnostic tests and subsequent to follow up tests.
- 15 were as a result of patient choice
- 21 complex pathways where multiple diagnostics were required

Upper GI (62.6% - 40 breaches)
- 10 clinical admin delays, mainly because of delays to consultant review of diagnostics for next steps due to capacity
- 13 were as a result of a lack of capacity to book appointments and/or diagnostic tests
- 9 were due to complex pathways
- 7 were as a result of patient choice

Skin (66.8% - 85 breaches)
- 64 delays were as a result of capacity
- 11 clinical administration delays in respect of follow up appointments and letters

Gynae (79.1%- 26 breaches) also achieved the standard but saw a number of breaches due to general pathway delays (12) and complex pathways (3)

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

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

- Lack of consistency with recording of breach reasons identified and addressed within cancer MDTc team. This has help more accurately see pathway issues.
- Patients requiring a letter ruling out cancer in Gynae pathway are now identified earlier resulting in an improvement to performance
- Issues with the requesting priorities with endoscopy were highlighted, resulting in conversations between heads of service. Consultants are being reminded of the priority codes and the need to note conversations with patients where they have ruled out cancer to prevent escalation of priority.
- Bid for TVCA funding for additional van days submitted.

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

Audit of Patient Choice reasons has been conducted. We are now looking at which GP surgeries these relate to so we can engage with them to help educate and reduce this.

Risk to Performance Delivery

Skin
- Clinical capacity to review patients who require further management after first appointment
  - WLI's being run to help support demand
  - TVCA bid for additional dermatology clinic space at Wootton Bassett
  - Business case to acquire additional plastics sessions from OUH being made

OUH Pathology
- Delays will impact gynaecology pathways predominantly:
  - Escalation with OUH and monitoring of KPI's with clinical lead where deviations noted.

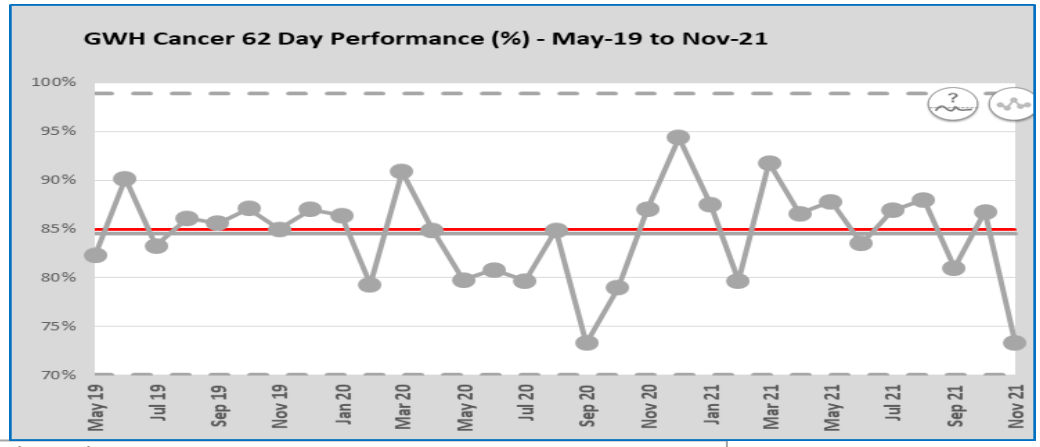
Colorectal
- Lack of consultant capacity, will impact on the delivery of diagnosis.
  - Colorectal service has recruited two registrars to support clinics releasing consultant capacity to see cancer patients.

Radiology
- Capacity due to vacancies,
  - CT van from **Inhealth** till March 22 approved.
  - Weekly wait data is supplied to cancer services team to help manage expectations and aid pathway planning. CT currently booking to 21 days.
  - Exploration of additional sessions at **Cobalt** in Cheltenham
  - Bid for TVCA funds for additional CT van days

National Key Performance Indicators

Cancer 62 Day Standards Performance Target 85%

Data Quality Rating:



Performance Latest Month: **November**

62 Day Standard (Target 85%):	73.3%
62 Day Screening (Target 90%):	91.9%
62 Day Upgrade (local standard 85%):	86.2%

Background

November 62 day performance is 73.3% (82.5 treatments , 32 patient pathways breached resulting in 22.0 breaches) with the Trust not achieving the national 62 day standard. The performance had been predicted to be challenged, of the 30 predicted breaches for diagnosed patients:

- 15 pathways breached as forecast **(10.5)**
- 9 pathways rolled to December
- 6 pathway did not breach as a result of being non reportable cancers or being treated in time.

There were 14 unpredicted breaches in October **(9.0)**

- 2 pathways had treatment dates time but were cancelled due to HDU availability and patient fitness on day of procedure (colorectal), (2.0)
- 4 skin pathways breached due to capacity issues (2.5)
- 2 patients were delayed by Oncology capacity (Upper GI) (1.5)
- 1 patient was delayed by their choice for treatment location (skin) (1.0)
- 1 patient did not stop his medications as instructed resulting in postponement (skin) (1.0)
- 1 pathway was delayed with no capacity to bring forward treatment (colorectal) (1.0)
- 3 further pathways were transferred to tertiary centre on time resulting in no breach to GWH

—

26 pathways had been tracked as suspicious for cancer with potential treatments in October if diagnosed:

- 3 suspicious pathway was diagnosed with a cancer will be treated in December **(2.5)**
- 14 patients did not have a cancer diagnosis,
- 9 patients remain undiagnosed.

Urology: 5 patients, 4.5 breaches)

- 2 complex all options pathways with additional and repeat diagnostics
- 2 incomplete TURBT pathways requiring additional procedure
- 1 patient initiated delays due to being out of the country after first OPA

Colorectal (10 patients, 9.0 breaches)

- 2 treatments in time cancelled due to HDU bed unavailability as a result of site pressure
- 4 complex pathways with multiple diagnostics
- 2 treatments cancelled for medical reasons
- 1 due to patient initiated delays and cancelation of diagnostics
- 1 due to insufficient clinical capacity to bring forward

Head & Neck 1 patient, 0.5 breaches)

- 1 transfer of care late due to patient cancellations and DNAs

Skin (7 patients, 5.5 breaches)

- 6 delayed due to capacity in Dermatology & Plastics
- 1 treatment in time canceled due to patient not stopping meds as instructed

Upper GI (3 patients, 2.0 breaches)

- 2 due to oncology capacity at OUH
- 1 due to patient fitness for procedure following an inpatient stay for a stroke

Lung (1 patient, 0.5 breach)

- 1 complex pathway

5 further pathways were transferred to tertiary centres for treatment on time resulting in no breach for GWH

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

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

Thames Valley Cancer Alliance (TVCA) transformation work continues with the following projects;

- **Rapid Diagnostic Service (RDS) pathways.**
- **Colon Capsule Endoscopy**
- **Funding for CT Van days**
- **Funding for U/S sonographer**
- **Additional funding being made available for improvement projects**

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

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

Follow up capacity in colorectal has been challenged. The service has 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.

Template biopsy kit has been delayed by an issue with the processing of the order at the suppliers, delivery is expected within the next 4 weeks.

Risk to Performance Delivery

Based on an average number of treatments and diagnosed cancers, it is not expected to achieve the standard in December with a forecast performance of 74.8%. There are also 2 suspicious pathways patient being tracked and if this were to result in a cancer, performance would likely be 73.4% 111.0 treatments & 29.5 breaches). Breached pathways were delayed for medical reasons , capacity issues (skin), cancelation of surgery due to site pressure(colorectal). Other pathways have seen delays due to the need for additional diagnostics.

Risk: CT van sessions are in place to help support radiology during the replacement of the CT scanner this summer. This is impacting on the service being able to offer earlier scans to help bring pathway forward. Radiology are actively managing and prioritising cancer referrals. PET CT van would assist capacity. At the same time reduced staffing in radiology due to vacancy and absence is placing increasing strain on capacity. Additional funding for **Inhealth** CT van in place until March 2022. Current waiting time for a CT Colon is 21 days.

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

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

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

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

Risk: Clinical oncology capacity remains challenged due to significant workforce gaps.

Mitigation: 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.

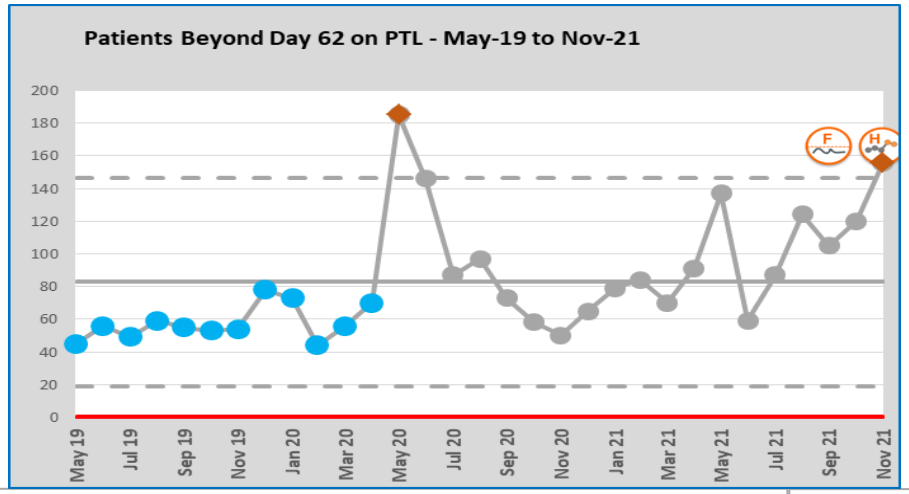
Risk: Capacity in theatres due to the repurposing of HDU beds as a result of site pressures has led to a number of procedures being postponed, resulting in breaches.

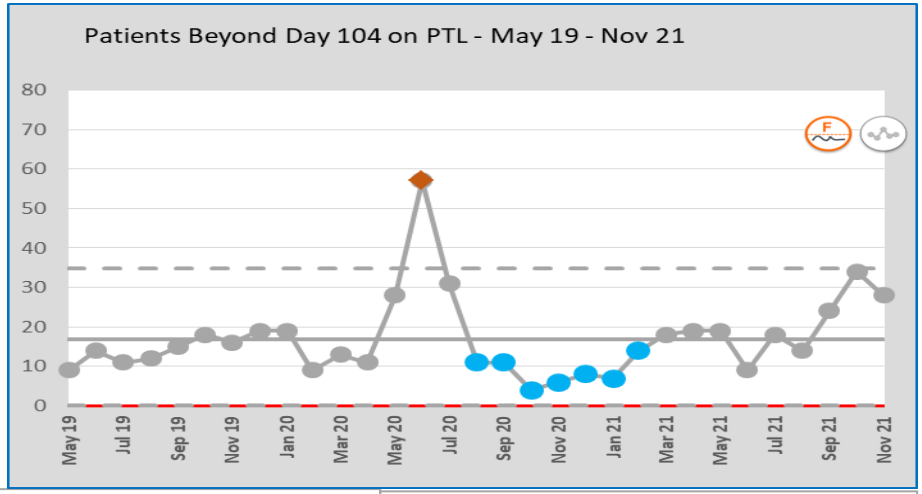
Mitigation: Cancelations are reviewed by senior divisional management before being cancelled

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

Data Quality Rating:

National Key Performance Indicators





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

The number of 62day+ pathways rose through November (156): Skin (61), Colorectal (43), Upper GI (21) & Urology GI (13). There are a number reasons for the high number of pathways, including complex pathways, clinical administrative delays, delayed pathway information from Oxford as well as pathways impacted by the delays in endoscopy and radiology..

The number of patient pathways over 104 days fell through November (28) These delays are due to the plastic capacity at OUH (9), dermatology capacity (5) and complex pathways in upper gi (4), colorectal (8), gynae (1) and urology (1).

104 Day Breaches in November : 9 Patients; 6.5 breaches (IPT)

<u>Treated at tertiary</u>

Head & Neck: 1 patient-0.5 breach: a complex pathway with multiple patient DNAs and cancelations before treatment delays at OUH due to capacity.
Colorectal: 2 patients 1.5 breach: Both complex pathway with multiple tests and discussion at OUH. One had a delay to Oncology before transfer of care to Oxford.
Urology: 1 patient 1.0 breach: All options prostate patient who required thinking time before deciding on treatment. The patient was treated within 24 days of the transfer of care resulting in a full breach to GWH.

<u>Treated at GWH</u>

Colorectal: 1 patient 1.0 breach: Patient chose to delay diagnostics, cancelling a treatment in time due to confusion.
Urology: 2 patient 2.0 breach: Patient underwent 2 incomplete resections at TURBT resulting in need for further procedures. Second patient was away for a period of time following their fist OPA, a follow up appointment was also DNA'd.
Upper GI: 2 patient 0.5 breach: One patient was medically unfit for their treatment as a result of a stroke, returning from OUH for treatment. The second patient was treated within 24 days of returning from OUH following an in time transfer of care to Oxford, resulting in no breach to GWH

December is likely to see 6 patients breach 104 days on their pathway resulting in 4.0 breaches.

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

Review of 62D+ PTL pathways with Head of Cancer Services & Heads of Service scheduled to ensure appropriate focus is in place

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

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

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

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

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

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

Risks to delivery and mitigations

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

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

Risk: 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.

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.
Mitigation: Pathology delays are being escalated with OUH via the GWH Lab Manager where they are identified during weekly PTL review meeting.

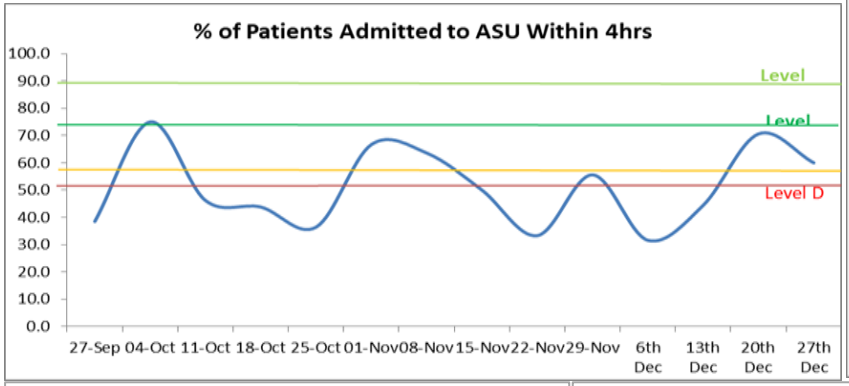
Stroke Pathways

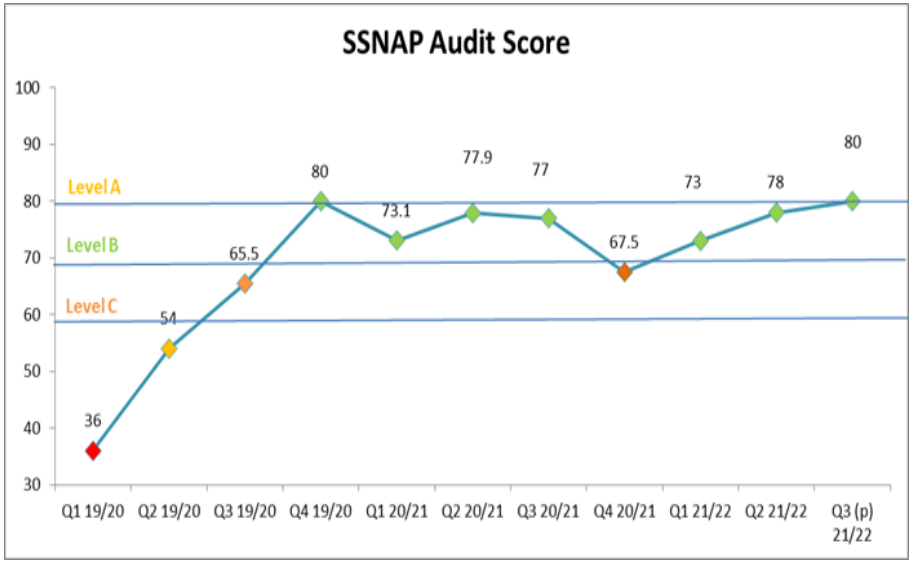
Data Quality Rating:

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	B	B (p)	





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

SSNAP performance remains consistently well within Level B performance with the Q3 prediction confirming a strong B once again.

All domains remain consistent with Q2 performance, but with improvements recorded in Thrombolysis, going from Level D to Level C. Performance in the Stroke Unit domain has slipped from C for Q2 to D for Q3, which was expected given the pressured placed on the Trust over this period. Although performance in this domain was at C for Q2, performance here is consistently at Level D, so is maintaining normal trend patterns as seen over a wider timeframe. Audit compliance continues to be at Level A.

Dec 21 has been a challenging month for stroke performance given the pressures placed on the Trust through staff sickness absence, and the Stroke & Neurology team have not been untouched by this. Despite this, the maintenance of a strong Level B performance gives assurance to the strength of processes and procedures currently in place, along with a strong and dedicated stroke team who always give the best they can in patient care.

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

1. Additional budget for Locum Neurology Consultants approved through TIF. Sourcing additional resource to support service until Mar 22. **Mar 22**
2. Final revisions are being made to a business case to improve resource levels and performance for the Stroke Service. **Jan 22**
3. Locum Stroke Consultant sourced with start date of 17 Jan 22. **Jan 22**
4. Lead Stroke Nurse substantive role out to advert. **Jan 22**
5. 5 x Tilt in Space chairs procured through CDEL funding to improve therapy outcomes for stroke patients. **Jan 22**

Risks to delivery and mitigations

Risk No 2756 (score 12): There is a risk that delays to stroke patients being admitted OOH to the ASU outside of the 4-hour timeframe will face reduced quality of care through delayed access to specialist stroke treatments. This risk is currently being reviewed with a view to escalate in light of the resignation of the stroke consultant, retirement of lead stroke nurse and recent missed opportunities for thrombolysis

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. This is shared weekly with DD/DDD to monitor performance.

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

Board Committee Assurance Report

Quality & Governance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		20 January 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report: Electronic Discharge Summary (EDS)	Red	Red	No separate report received this month due to IT issues. Work is continuing.		
Integrated Performance Report: Pressure Ulcer Harms	Amber	Amber	Number increased this month, mainly in Category 2 (least harm). Tissue Viability support provided in higher risk wards. Evaluation of hybrid mattresses in place. Trial of product in place on ICU.		
Integrated Performance Report: Medicines Safety	Green	Green	Important indicators remain low and stable.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report: Infection Control	Amber	Amber	C.diff infections rising. Further ward training in progress. Application to join NHS Improvement project to improve hydration and reduce UTIs.		
Integrated Performance Report: Falls	Amber	Green	Increased in number. Programme started measuring lying and standing blood pressure. Review of bed rails policy. Correlation with staffing numbers noted.		
Integrated Performance Report: Staffing	Amber	Amber	High sickness levels due to Covid, including isolation, continue and high HCA vacancy. Safe staffing meetings now held 3x a day plus weekly recruitment meeting.		
Integrated Performance Report: Maternity			Quarterly review coming next month. A deep dive is being undertaken into Caesarean Section rates which are high.		
Serious Incidents Monthly Report	Amber	Green	Serious incidents stable. Work continues to reduce delayed investigations but some are outside the trust's control.		
Mortality Update	Amber	Amber	The report was brief partly because Dr Foster information was delayed. Whilst GWR's SHMI & HSMR are below average levels, these figures exclude deaths with Covid. Forty-two Structured Judgement Reviews (SJRs) showed care to be good or excellent in 71%. However, these revealed sepsis not to have been considered on admission in an increasing number of cases. Also poor documentation continues to be a problem and is increasing. This also affects EDS completion.	More effort to improve quality of documentation.	
Emergency Department Dashboard	Amber	Amber	The metrics of the Shine checklist have improved. Due to the low incidence of fractured Neck of Femur (#NOF) the decision has been taken to rely on the information submitted to the national audit. Time to transfer from ambulances has increased and staffing levels have reduced. Patient feedback has led to more attention being paid to early pain relief.		
Maternity & Neonatal Quality & Safety Report Inc Review of Caesarean Section	Amber	Green	No areas of significant concern. The CNST 10 Safety criteria are the subject of continuing work. Investment is being made or requested to allow improved compliance. Currently it is estimated that 5/10 will be green on submission and the remainder amber. Costings are being carried out to compare costs with potential savings. The committee was pleased to hear that GWH now has 74 hours of consultant obstetrician time in the delivery suite. A separate paper reported the results of a review of Caesarean Section rates. These have been increasing. The report found that many women		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			who had had a previous CS elected to have subsequent deliveries this way. A plan to change this approach based on consultation with other trusts should lead to more Vaginal Births after CS. (VBACS). GWH has generally good outcomes for neonates especially those born prematurely, and a low admission rate for term infants to intensive care.		
National Children's and Young People's Survey	Green	Green	This was generally very positive. An action plan is in place to address main concerns around Wi-Fi, play time and communications.		
CQC Preparedness	Green	Green	Continued improvement in number of actions met.		
Provider Licence Annual Review of Compliance	Green	Green	This report showed compliance throughout.		
Code of Governance Annual Review of Compliance	Green	Green	This report showed compliance throughout.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Part 2: Our Care

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

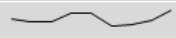
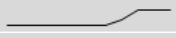
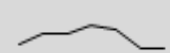
Are We Caring?

Are We Well Led?

Use of Resources

Our Care Summary

Great Western Hospitals NHS Foundation Trust

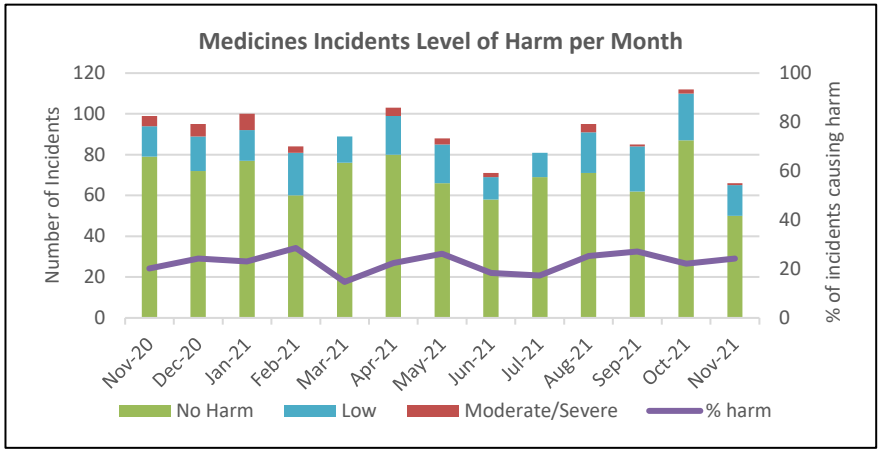
KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
C. Difficile (Hospital onset) per 1000 bed days	14.36 (Sept 21)		50	51	26	Jun 21
VTE Assessment	98% (Dec 21)		22	134	4	Dec 19
Hip Fracture Best Practice Tariff – 12 Month Rolling	56.4% (Sept 21)		56	70	71	Sept 21
Complaints Rates	27.9 (Q4 20/21)		104	50	22	Q4 20/21
Family and Friends Score – Percentage of Positive Responses - Inpatients	83% (Dec 21)		110	54	11	Oct 21
Complaints Response Backlog	0.8 (Q4 20/21)		4	35	43	Q4 20/21
MRSA all cases	2 (2021/22)		84	68	77	Aug 21
Falls per 1000 bed days	6.6 (Dec 21)					
Pressure Ulcers – Acute	36 (Dec 21)					
Pressure Ulcers – Community	44 (Dec 21)					
Never Events 21/22	3					
Serious Incidents	7 (Dec 21)					
Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death)	0.56% (Dec 21)					
Hand Hygiene	98.7% (Dec 21)					

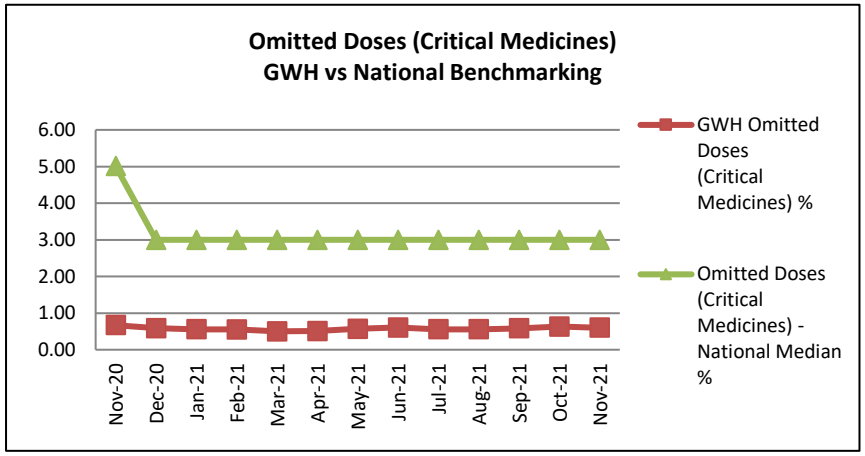
Public View Ranking is out of Acute and Combined Trusts Only (123 Trusts)

2. Medicines Safety

Data Quality Rating:

Are We Safe?





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

Medication Incidents

- In November, the proportion of incidents leading to harm remained stable, though there was a reduction in errors reported.
- The main trends remain consistent with incidents relating to medication administration and prescribing.

Omitted Critical Medicines

- The percentage of unintended omitted critical medicines remains consistently low throughout the Trust.
- Compared to the national median of acute hospital trusts (2020 national benchmarking*), Great Western Hospital (GWH) has a lower rate of unintended omitted critical medicines.
  *Benchmarking value updated Dec 2020

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

Medication Incidents

- Engagement with Medicines Safety Huddles have allowed medicines safety issues to be escalated widely. Insufficient IT equipment has been resolved on individual wards and fed back into wider projects in the Trust.
- Medicines Management audits are being conducted by Matrons which have been supporting wards with their drug storage and monitoring to ensure that medicines are stored safely.
- Drug Trolley procurement is in process from December 2021 and should support some issues raised.

Omitted Critical Medicines

- Robust systems are in place to ensure that all critical medicines are available 24 hours a day, leading to a consistently low percentage of omitted doses in the Trust. New reports will run in the new year to identify omitted medicines on specific wards.

Risks to delivery and mitigations

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

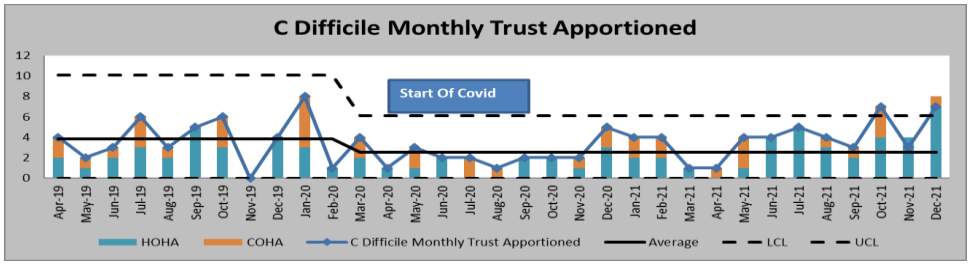
Improvement actions overseen through existing quality and safety governance routes, including Medicines Safety Group and Serious Incident Learning Group.

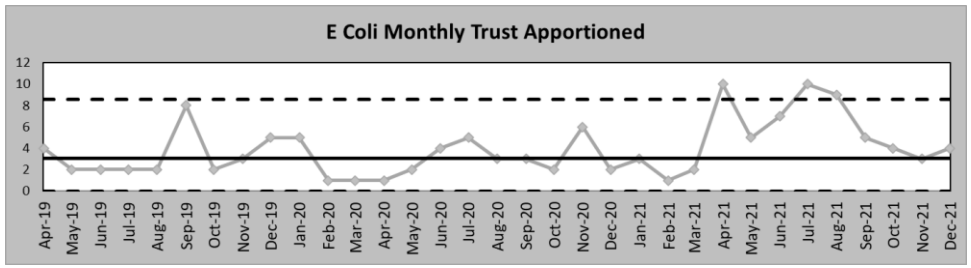
Omitted Critical Medicines
No specific risks to delivery identified at this stage.

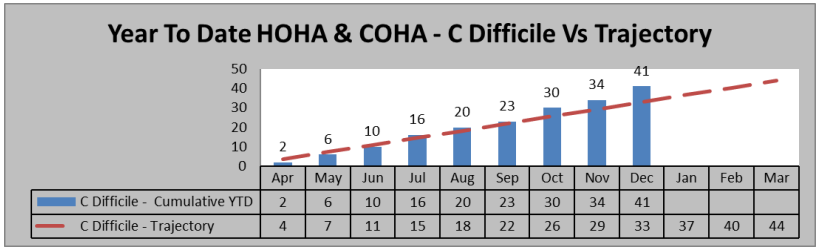
2. Patient Safety - Infection Control

Data Quality Rating:

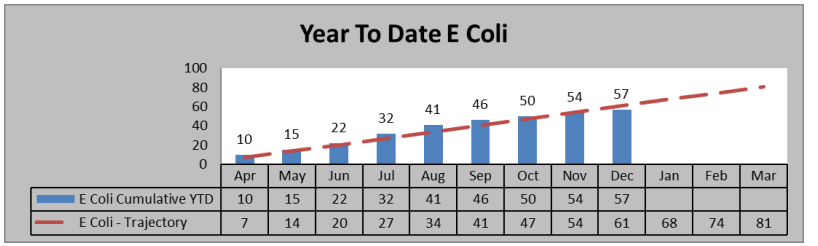
Are We Safe?







	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C Difficile - Cumulative YTD	2	6	10	16	20	23	30	34	41			
C Difficile - Trajectory	4	7	11	15	18	22	26	29	33	37	40	44



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E Coli Cumulative YTD	10	15	22	32	41	46	50	54	57			
E Coli - Trajectory	7	14	20	27	34	41	47	54	61	68	74	81

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

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

C. difficile – In December there has been 7 reportable C. difficile infections. Six were Healthcare Associated (HOHA), and one was Community Onset – Healthcare Associated (COHA). The Trusts total is currently 41 against a trajectory of 44.

MRSA Bacteraemia – 0 cases reported for December.

Gram negative Bacteraemias - The trust has been set a trajectory of 81 E.coli bacteraemia. 3 cases were identified in November 2021 and 3 in December.

We have identified 20 Klebsiella bacteraemia (against a trajectory of 18) and 15 Pseudomonas Aeruginosa bacteraemia (against a trajectory of 19). No avoidable root causes have been identified, further work to be undertaken to explore any wider contributary factors.

There have been no Influenza cases in GWH or across BSW in the last month.

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

GWH is over its trajectory for CDI at the end of Q3, but is performing comparably with other Trusts and is positioned towards the middle of the organisations within the South west. Scrutiny to the standards of IPC practice including cleaning standards is applied to prevent avoidable cases of CDI.

Introduction of the star rating system for cleanliness has been rolled out on the Wards and will support the ongoing drive to increase standards.

The Trust is applying to join an NHS England and NHS Improvement project to improve hydration in people aged 65+, including those living in a care home, or receiving domiciliary care. The aim is to test interventions to help keep people well and hydrated, reduce Urinary Tract Infections (UTIs) and so reduce the need for antibiotics. The pilots will help improve our knowledge and understanding of the most effective hydration interventions to reduce UTIs, while supporting efforts to tackle the growing threat of antimicrobial resistance.

Respiratory Syncytial Virus (RSV) in children is currently not being detected, this is in line with normal seasonal trends.

Risks to delivery and mitigations

Maintaining cleanliness of the ward environment consistently, including patient care equipment remains a priority.

The spot check audit programme with SERCO, Matrons, Estates and Facilities have been put on hold until the end of January, due to vacancies and sickness.

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

2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

Covid 19	Oct-21	Nov-21	Dec-21
Number of detected Inpatients	310	180	226
Number of Deaths in Hospital	18	24	8
Hospital Acquired Covid-19 Cases*	6	2	6

Covid-19 (Apr 21 – Mar 22)		(April 20- Mar 21)
Number of detected Inpatients	1338	1458
Number of Deaths	83	324
Hospital Acquired Covid-19 Cases*	27	139

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

The number of patients diagnosed with COVID-19 started to increase again during December, although Swindon was behind the national high level for a number of weeks.

As of the 25th December 2021, the Swindon case rate was 993.28 per 100,000. The Wiltshire rate was 908.96/100,000, with the England average being 1.352.24/10000.

There were six hospital acquired cases (8 days +) during December.

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

Day two testing was introduced for emergency admissions to help prevent outbreaks as the Community rate rises again.

Since December 2021, staff have been supported to wear FFP3 masks when working a shift on COVID positive ward. This is in light of Omicron being thought to be more infectious.

Non essential visiting stopped on the 30th December 2021 due to increase community infection rates and ward closures, however end of life and compassionate visits and those with care needs such as LD have continued to be supported.

The patient pathway and management of patients on Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (BiPAP), especially outside of specialist areas is under review to ensure safe delivery of care and minimising the risk of nosocomial infection. Isolation Is recommended until 2 negative results are obtained and clinically there are no signs of COVID infection.

In light of the national guidance promoting increase ventilation requirements, Neptune ward's ventilation has been enhanced with a 6 week trial period using air purifying units.

Risks to delivery and mitigations

Risk of reduced compliance with staff completing lateral flow tests and reporting results to the national portal as supplies became an issue. This has been supported with additional supplies from CCG stock.

The risk of reduced adherence to Personal Protective Equipment (PPE) from patients and visitors whilst in the Trust is being addressed through regular Public Health and Trust communications.

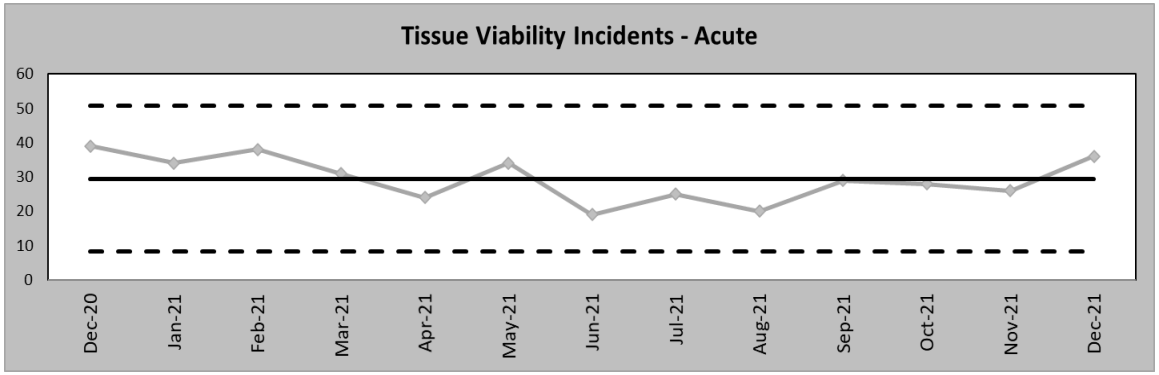
PPE audits have been add to Tendable (previously known as perfect ward), matrons are completing these monthly.

*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 Dec 21

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Unstagable	Total Incident of Harms
22	1	0	11	2	36

Number of Patients	Harms per Patient
32	1
2	2

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

There were a total number of 215 Incidents for pressure ulcer related harms reported during the month of December. All of these were validated by the TVN's.

Of the 36 harms hospital acquired harms 60% were vaildated as low harm. From identifying and introducing prevention measures have mitigated the risk of futher deterioration to higher levels of harm.

A number of these relate to respiratory devices due to the number of COVID patients.

9 harms have not been validated with no origin of harm investigated. 5 are DTI's awaiting revalidation and 4 harms are CAT 2's.

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

Tissue Viability Support has been provided to Neptune Ward in risk assessment and documentation training. Sessions have been delivered to clinical staff in reducing harm and increase awareness. Monthly meetings booked with Matron and Ward Manager to offer on-going support.

An evaluation of Hybrid mattresses has been undertaken on Forrest and Orchard wards, hybrid mattresses are a cost-effective approach for at risk patients to facilitate effective pressure relief and reduce the demand for dynamic mattress provision. This will support the development of a protocol for the use of appropriate mattresses/aids for at risk patients.

Intensive Care Unit (ICU) has commenced a trial of a product for reduction of moisture that is a key component in tissue damage development for all patients at risk. Multiple training sessions have also been booked for the department throughout January. The clinical educator facilitator has introduced an improvement plan within the department, there have been initial improvement within month.

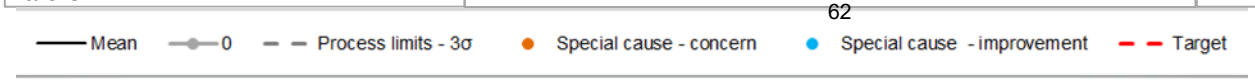
Risks to delivery and mitigations

There is a reduction in face-to-face education and training for staff to reduce the incidence of hospital acquired pressure damage. This is being mitigated by encouraging the use of electronic learning and sharing learning during the investigations.

There is a risk that staffing levels are impacting on ability to provide high quality pressure ulcer prevention care, especially in high acuity areas and with complex patients. This is being mitigated by the safe staffing process to redeploy staff appropriately and support from the specialist team.

There is a shortages of dynamic air mattresses across the Trust increasing the risk to all patients deemed at risk of harm and deterioration. Wards are unable to provide the correct level of pressure relief for patients in all cases.

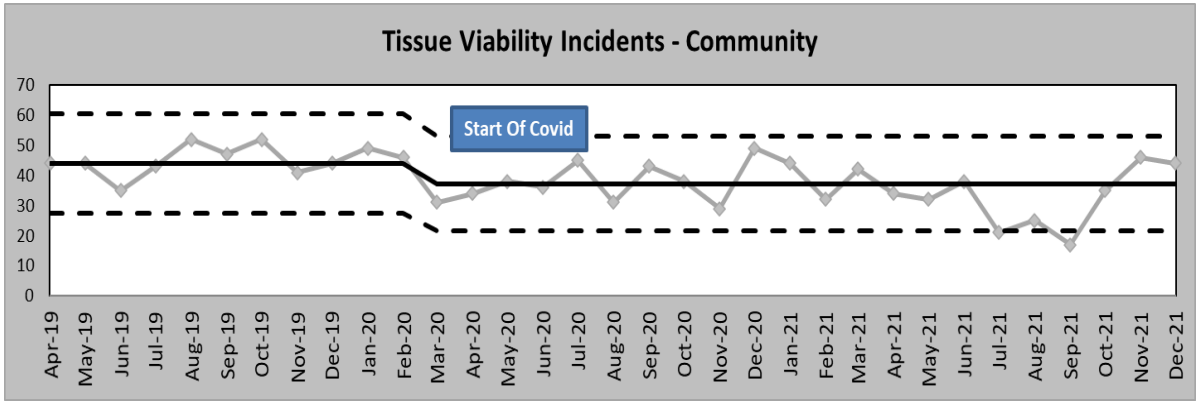
There is a risk that the long ambulance waits at the Emergency Department (ED) could increase the risk of patients developing Pressure Ulcers. This is being mitigated against by embedding the use of the Standard operating procedure for use of pressure relieving equipment with educational sessions.



2. Patient Safety – Community Pressure Ulcers

Data Quality Rating:

Are We Safe?



Incidents of Harms by Category for Dec 21

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Unstagable	Total Incident of Harms
17	6	3	7	11	44

Number of Patients	Harms per Patient
39	1
1	2
1	3

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

There continues to be reported high levels of harm in December, whether acquired in our care or present on admission.

22% of harms were recorded on patients who are receiving Palliative Care, this is in line with reporting from regional and national Tissue Viability Forums.

Device related harm: x 3

Devices include hosiery and oxygen tubing.

3 x high levels of harm. All these patients have high complex needs or are End of Life.

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

Implementation of new aSSKINg bundle part of the risk assessment tool in the electronic system. Training commences January 2022.

Training on pressure ulcer prevention and incontinence associated dermatitis focusing on early recognition and intervention continues to be provided.

Superficial mucosal harm was recognised and reported early this month due to additional training and interventions put in place for resolution.

Work stream established for review of core stock levels of Pressure Relieving Equipment with Rehab Specialist Services and Equipment Library as the demand for higher spec equipment has risen in line with improved risk assessment and patient complexity.

Risks to delivery and mitigations

There is a risk that covid isolation and staffing levels within Community Nursing services will impact on the ability to provide high quality pressure ulcer prevention and management and increase demands on specialist services to include Tissue Viability.

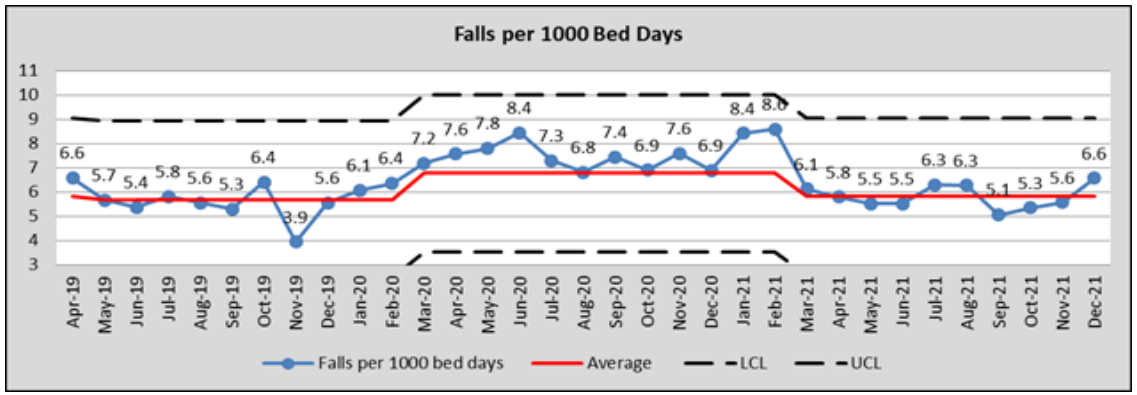
This is partially being mitigated by ongoing recruitment of community staff, use of temporary staffing with bank enhancements for community nursing and urgent case load reviews.

Pressure Ulcer prevention pathways and resources are given out to all temporary workers to aid standardisation of processes and care, however complex.

2. Patient Safety – Safer Mobility (Falls Reduction)

Data Quality Rating:

Are We Safe?



	Total Falls	Falls resulting in moderate harm or above
Jun-21	97	2
Jul-21	113	4
Aug-21	94	2
Sept-21	96	2
Oct-21	105	4
Nov-21	108	3
Dec-21	126	4

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

There has been an increasing trend in falls per 1000 bed days.

Four falls with moderate/severe harm with two investigations completed.

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

The New Falls and Mobility Assessment documentation is now uploaded on Nervecentre. Testing has been completed and final amendments made. Implementation across all inpatient areas with training delivered during January and February 2022.

The National Audit of Inpatient Falls has been revised nationally to include procedural standards for completion of lying and standing blood pressure assessment. The Lying and standing blood pressure (BP) assessment tool on Nervecentre meets the required requirements. Virtual training has been developed to provide information on orthostatic hypotension (sudden drop of blood pressure on standing) and guidance of performing a lying and standing BP using the correct assessment tool.

Junior doctors have registered an audit on measurement of lying and standing BP and appropriate treatment of postural hypotension. Audit expected to commence in February 2022.

Virtual training and demo of Lying and standing BP assessment tool prepared, along with knowledge assessment. To commence on Trauma in February 2022.

Review of the Bedrails Policy has been completed for ratification in January 2022.

Risks to delivery and mitigations

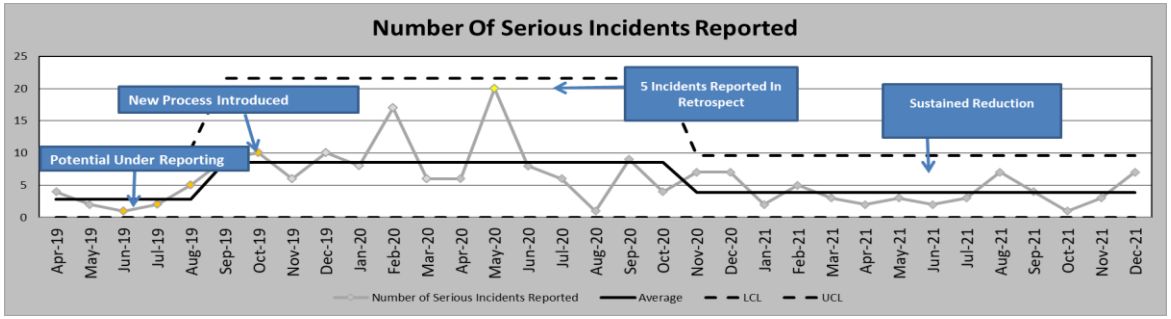
Due to demand on the service , the number of falls reported has increased. Prior to 8th December falls numbers were stable with normal variation demonstrated on run chart of falls reported daily. Since 8th December there have been a number of data points running above the average line, and a number of data points above the upper control limit. In the first week of January (01/01/22 to 06/02/22) reported falls are double the 'normal' average'.

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
Oct-21	Nov-21	Dec-21	Dec-20
1	3	7	6

Never Events	
2020-21	2021-22
2	3

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

At the time of reporting there are a total of 29 on-going Serious Incident (SI) investigations, with 7 SIs reported in December.

This includes,

1. Delay of diagnosis and Treatment of an infant.
2. Incident following mislabelling of breast milk.
3. Treatment delay.
4. Complication following Colonoscopy.
5. Delay in triaging new born

6. & 7. Hospital acquired infections

Improvement Groups continue in the following areas –

Allergies Working Group - Application for funding for interface between NerveCentre & EPMA in progress. Draft guidelines for recording of all allergies and intolerances have been produced.

Sharing of Learning – Following a recent Medicine Safety Huddle there has been shared learning around positive patient identification, patient handover, initiation and administration of medicines to the correct patient. The first Human Factors (HF) training has been delivered to a group of anaesthetists and was very positively received. Further sessions are planned for junior doctors and HF training has been delivered as part of serious incident investigation training.

The Endoscopy Group – The electronic referral form that is available through Medway has been tested within the test environment. The initial feedback from the junior doctors has been reviewed and shared with IT, who will be producing a work plan to resolve the issues identified prior to a retest of the system. A Standard Operating System for booking an endoscopy has been developed and will be rolled out to improve this part of the pathway.

BiPAP Working Group – The patient pathway and management of patients on Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (BiPAP), especially outside of specialist areas is under review to ensure safe delivery of care and minimising the risk of nosocomial infection. Non Invasive Ventilation (NIV) competencies for nurses have been updated and are awaiting Trust wide sign off. There is need to mandate Oxygen (O2) delivery models on NerveCentre to ensure patient safety- costs for this have been shared with Unscheduled Care (USC) division.

Risks to delivery and mitigations

There are 16 SI investigations overdue that pose a risk to early identification of learning.

The mitigations include robust monitoring, increased awareness and oversight of the process.

The implementation of the Datix management system is paused due to pending resolution of issues. Date for implementation for the incident module to be determined.

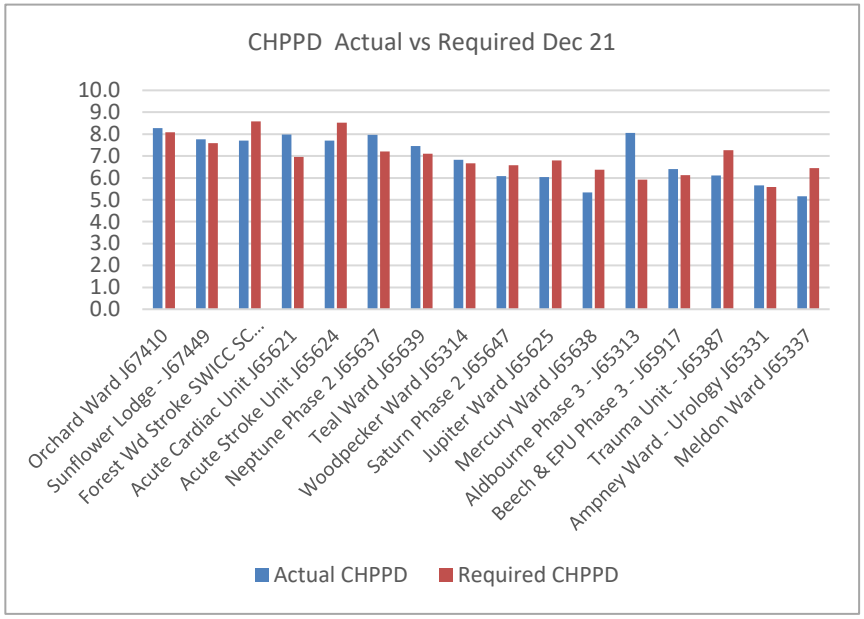
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

2. Patient Experience – Safer Staffing

Data Quality Rating:

Are We Safe?

Graph 1



Actual vs Required Care Hours Per Patient Day

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 measures patient acuity and dependency and the nurse staffing levels required.

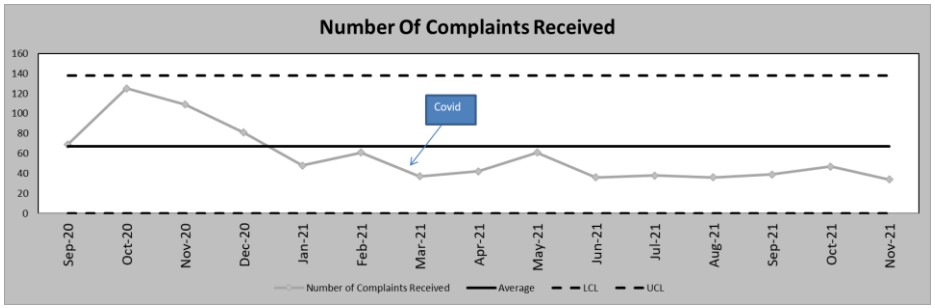
The chart shows the following wards required hours greater than the actual hours available; Forest, Stroke Unit, Mercury, Saturn, Jupiter, Trauma and Meldon. Meldon has seen a significant rise in acuity this month related to 3 patients. These areas have been reviewed by the Matron and Divisional Director of Nursing to ensure there is no safety concerns.
Wards reporting below required hours have been supported by the Supervisory Ward Sisters and nurses in non clinically facing roles working clinically.

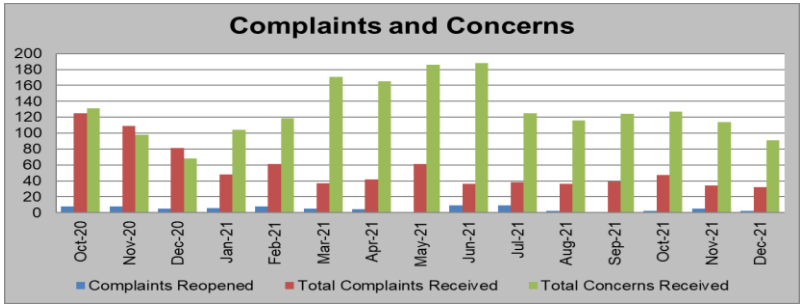
Graph 2 shows the model hospital for Health Care assistants in Oct 21 compared across the South West, although it should be noted that the HCA role at GWH compasses more non clinical tasks than other organisations.

December 2021 has continued to see significant challenges to ensure safe staffing levels throughout nursing and midwifery, with the impact of continuing high sickness absence, absence relating to Covid 19 isolation and Health Care Assistant vacancies.
The percentage fill rates for health care assistants during the day is of concern, overall percentage fill is 86%, with the following wards being of note; Neptune 61.8%, Teal 76.2%, Trauma 82.8% Kingfisher SAU 74.2%. This is mitigated by moving staff on a shift by shift basis and the redeployment of non clinically based staff to support personal care. There is a recruitment plan for health care assistants with weekly activity (interviewing, short listing etc) and the pipeline of new starters is improving with 28 wte of which 11 have start dates.
Registered Nurse fill rate is 99.9% during the day and 101.8% during the night shift (this will include registered Mental Health Nurses providing additional specialist support). However the Registered Midwives fill rate is 80.8% during the day and 76.4% during the night. There is a robust escalation process for critical maternity shifts and a recruitment and retention plan.
The 3 times a day staffing meeting ensures that all areas are as safely staffed as possible and risk is shared across the Trust.
Community nursing continues to report high registered nurse vacancies and increasing demand, this is monitored through the safe staffing meeting with quality metrics such as how many unallocated patients or patients moved to a different day reported. There is a weekly recruitment meeting and a robust action plan in place to address this.
The updated safe staffing policy was approved at the Nursing and Midwifery Workforce Committee and now includes 'safest' or critical staffing procedure. The Nurse and Midwifery staffing status is reported through the Operational Sit rep 3 times a day.

2. Patient Experience - Complaints and Concerns

Are We Safe?





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

32 complaints (previous month 34) and 92 concerns (previous month 114) were received in December 2021. The reduction in concerns received relate to the Bank Holidays in December when the PALS service was closed.

Out of a total of 124 cases received from Complaints and Concerns in December, the overall top three themes were:

Theme	Complaint	Concerns	%
Communication	1	20	17%
Clinical Care	10	7	14%
Follow Up Treatment	5	7	10%
Waiting Time	1	11	10%

Complaints: 30 complaints were rated as Low – Medium. 2 complaints received were rated as High.

- Lack of privacy due to being in an extra bed space with no curtain. Poor communication between staff regarding patients needs.
- Basic nursing care not provided for hard of hearing patient. Lack of hydration and nutrition and support with washing.

Response rates: Overall complaint response rate was 75%. 34% of concerns were resolved within 24 hours, 77% were resolved within 7 working days (Internal KPI 80%).

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

Throughout January we will continue to provide public engagement opportunities, working with our members and governors in key areas: -

- Quality Improvement
- Recruitment
- The Way Forward Programme
- Patient Safety Partners

We are also working with Bath, Swindon and Wiltshire (BSW) colleagues to further engage with seldom heard groups and launch focussed engagement activity with Maternity services and Travelling and Gypsy communities, to gain feedback from a wide and diverse section of our service users.

A new process has been implemented to undertake quality audits of the complaints process for cases closed in the previous month; this is in the early stages of implementation.

The audits look at each of the closed cases against meeting target timeframes for acknowledgements, making first contact by telephone, quality of responses and ensuring that actions and learning recorded takes place. Full details of the audits will be shared with the divisional management teams and detailed in the quarterly Patient Experience reports.

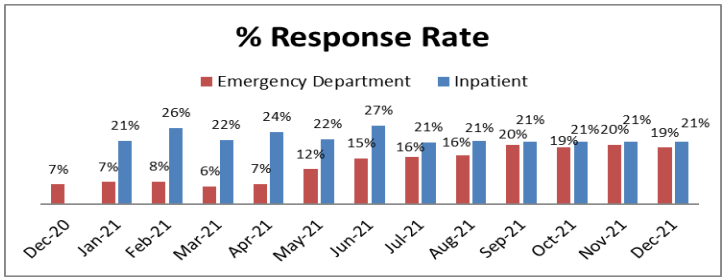
Risks to delivery and mitigations

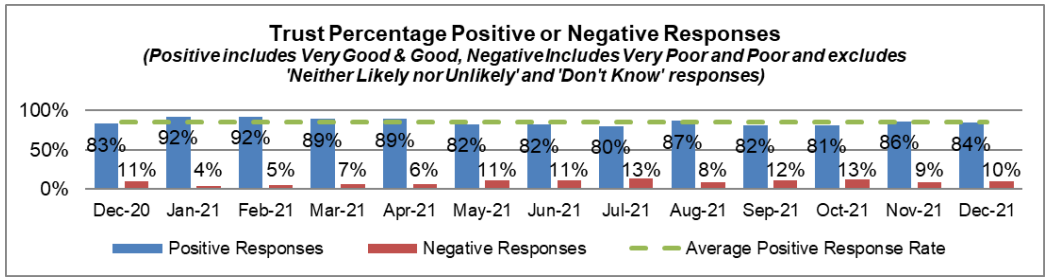
Investigation Managers continue to familiarise themselves with using the Datix system. Close support and training is being provided as and when required.

2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?





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

For December 86% of the Friends and Family Test (FFT) responses were positive, level with the previous month. This is based on the % of responses rated as 'very good' and 'good'.

This has been achieved by:

	No. of Texts sent	No. of Responses	Total Response rate (%)	Positive Responses
ED	4556	976	19%	80% ↑
Inpatients	2312	617	21%	83% -
Day Cases	1785	492	22%	95% -
Maternity	0	129	-	99% ↑
Outpatients	0	230	-	96% ↑

(correct as of 12th January 2022) Symbols relate to previous months activity)

- The Emergency Department 76% (same as previous month) and the Urgent Treatment Centre at 84% (78% previous month) overall 80%.
- Maternity services, in particular postnatal wards by proactively gathering feedback via IPad's has resulted in a month by month increase in positive comments and sustained a high recommendation rate.
- Outpatient areas, 230 responses received, 217 by FFT card. Less than half of the 455 responses received in November. Despite a low response rate, the positive recommendation score is sustained at 96%.

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

Overall Positive themes for December:

Staff Attitude 1123 comments (previous month 1358).
Implementation of Care 722 comments (previous month 756).
The Environment 469 comments (previous month 541).

Overall Negative themes for December:

Staff attitude 163 comments (previous month 186).
The Environment 142 comments (previous month 153).
Implementation of Care 125 comments (previous month 153).

It is noted that for a second month all negative comments have reduced.

The following work will be carried out throughout January:

- Maternity FFT SMS: Continue comparison of daily data final testing for "go live" mid-January.
- A communication pack is to be rolled out across Community Midwives to invite FFT feedback via the QR code/online facility. The pack will include the collation and sharing of actions resulting from patient feedback received.
- To liaise with Maternity Voices Partnership, to ensure sight of maternity engagement via Facebook and to also build in further opportunities to initiate dialogue.
- National Data Opt-Out (NDOO) requires further clarification across all SMS text services, which may require additional steps in file preparation.
- Continued data testing for the possibility of FFT SMS to be sent out via Dr Doctor for Outpatient attendances.

Risks to delivery and mitigation

Maternity SMS scoping and requirements have been completed, testing has taken place throughout December. Anticipated go-live date of mid-January.

Limited information has been provided to PALS to demonstrate the actions and learning from the Friends and Family Feedback. Additional engagement will be carried out to ensure that outcomes and learning is captured and shared widely.

2. Patient Safety – Perinatal Quality Surveillance Tool

Data Quality Rating:

Are we Safe?

Measures

Comments

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

Measure	Aim / Target	October 21	November 21	December 21
Midwife to birth ratio	1:29	1:34	1:30	1:34
1:1 Care	100%	98.9%	99.12%	99.1%
Consultant presence in Delivery suite (Hours per week)	60 hours	57 hours	57 hours	57 hours

The new Obstetric Consultant rota commenced on 4th January and will ensure that in excess of 60 hours of consultant presence on Delivery Suite is achieved. This will provide a second consultant led ward round, the opportunity for increased educational support for junior doctors and improved continuity of care for women and their families.

Service User feedback

Compliments: For Hazel Ward 94.62% of the responses to Friends and Family are positive, with an increasing response rate. Outpatient areas, which include Community Midwifery, Antenatal Clinic and the Day Assessment Unit have seen a low response rates to date with overwhelmingly positive responses. The response rates in the intrapartum areas (Delivery Suite and the White Horse Birth Centre) remain low and the Ward leads are working together to share learning around increasing response rate.

Complaints: One complaint was received which related to an unnecessary caesarean section. The Obstetric Lead is working with the family to establish learning for the wider team.

Caesarean Sections

	October 21	November 21	December 21	Comments
Combined Caesarean Section (C Section) rate (percentage of babies born > 24 weeks via C Section)	38.5%	40.1%	36%	
Elective C Section	12.8%	16.3%	12.5%	12 Caesarean sections were performed for maternal choice
Emergency C Section	25.7%	23.8%	23.5%	

This month demonstrates a lower caesarean section rate, despite an increase in maternal requests for caesarean birth. A full detailed review of the caesarean section rate will be presented to Patient Quality Committee in January. This includes a detailed action plan for a Quality Improvement initiative to improve patient experience during the antenatal and intrapartum periods. A dedicated team now provide care for women undergoing elective caesarean births, in order to minimise delays and improve patient experience and flow through the acute areas.

2. Patient Safety - Perinatal Quality Surveillance Tool

Data Quality Rating: 

Are We Safe?

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

Measures	Comments
Concerns or requests for actions from national bodies	A detailed evaluation of the evidence submitted and reviewed by the National Ockenden team will be presented to Patient Quality Committee in January with an update on outstanding actions.
CNST 10 Maternity standards (NHSR)	The projected RAG status for the 10 safety actions are indicated in the table below. A full cost projection will be presented to Exec Committee in February.
Findings of review of all perinatal deaths using the real time data monitoring tool	The previously observed increase in still births in 2021/22 has reverted to below the National average per 1000 births. Use of the Perinatal Mortality Review Tool has provided an opportunity to review the tool currently in use to estimate birthweight centiles, avoiding unnecessary additional antenatal scans and reducing the need for unnecessary neonatal interventions.
CQC Ratings	Ongoing preparations continue for an anticipated inspection with mock inspections highlighting areas for improvement.
Maternity Safety Support Programme	Not required as CQC ratings overall 'Good'
Coroner's Regulation 28	Nil

	Criteria	RAG September 2021	Projected submission RAG	Review Comments
1.	Are you using the PMRT to review perinatal deaths to the required standard?			
2.	Are you submitting data to the Maternity Services Data Set to the required standard?			Upgrades required now installed. Continuing data cleansing and submissions for compliance on National Dashboard and CQIMs
3.	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?			Investment required in neonatal medical workforce to meet BAPM standards
5.	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
6.	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?			Effective audit strategy planned. Current limitations include the lack of a dedicated pre-term birth clinic, which has been escalated to the Service leads
7.	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?			
8.	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?			Compliance in 2 staff groups required for compliance
9.	Can you demonstrate that the trust safety champions (obstetrician, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?			Compliance requires continuity of carer action plan progression which will require ongoing investment and recruitment
10.	Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?			

2. Patient Safety – Summary of Incident Investigations

Data Quality Rating:

Are We Safe?

Moderate Harm Incidents

Measure	Comments
Number of incidences graded moderate or above and actions taken	• 2 incidents were graded as moderate harm for maternity services. • 1 case was reported as no harm for the neonatal unit, however following review this will be investigated following the Serious Incident framework to ensure learning from the case is effectively identified. • 1 case will be investigated following the HSIB process. • A second case has been referred to HSIB and is currently under review following their triage process.

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

Serious Incidents (SI) Reported in Month - None

Case Ref	Overview	Date	Case Update
165490	Incident following mislabelling of breast milk. No harm occurred, however this will be investigated as a Serious Incident due to the potential for harm.	11/12/2021	Raised as Serious Incident on 29/12/2021. Investigator to be allocated. Families will be invited to be involved in the investigation.
165717	Baby born in poor condition requiring cooling therapy following an instrumental birth.	16/12/2021	For investigation following HSIB process confirmed 05/01/2021. This will be raised as a Serious incident in line with Ockenden recommendations.

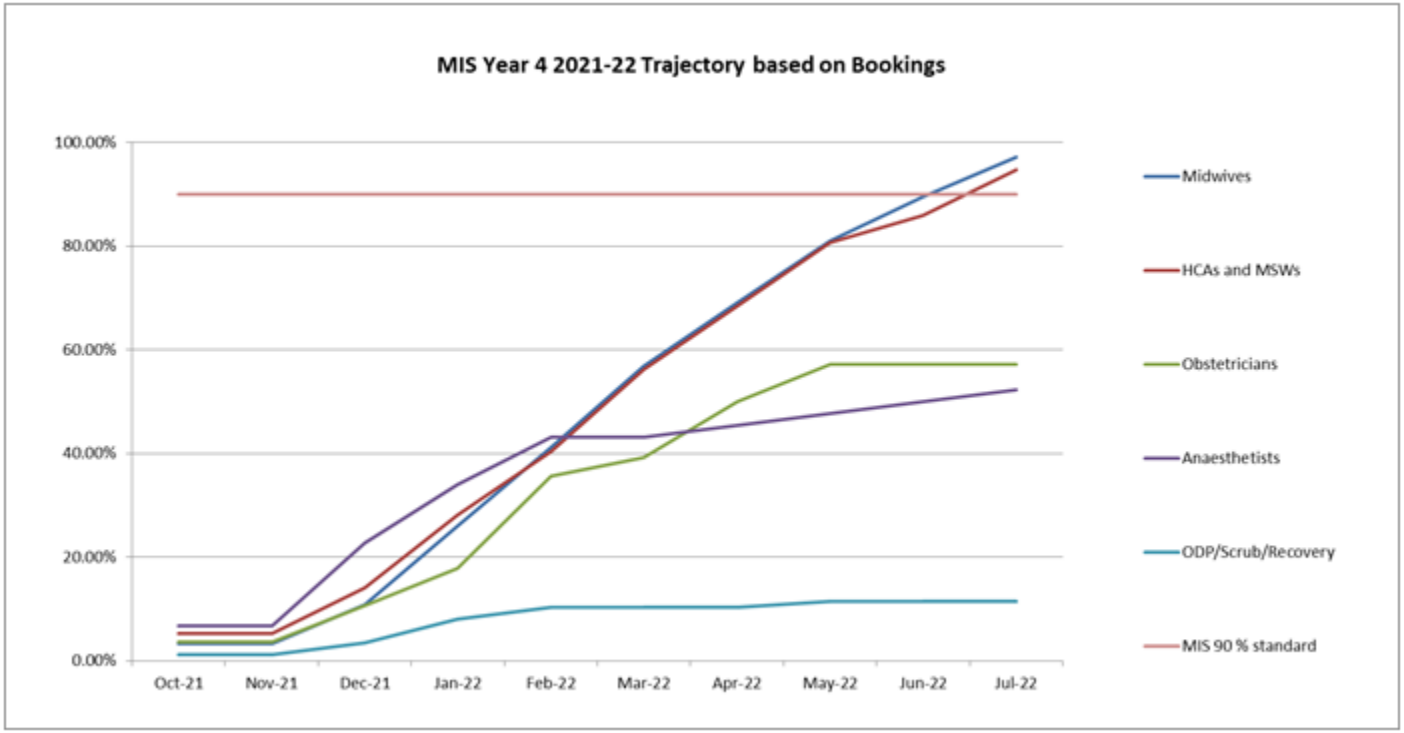
On-going SI Investigation Update

Stage of investigation	October 2021	November 2021	December 2021
Referred to HSIB – awaiting decision	1	0	1
Under local investigation (this may include insight from external reviewers)	4	3	4
Under HSIB investigation	3 (2 final reports expected Nov 21)	0	1
Report complete & awaiting Serious Incident Review learning Group (SIRLG)	0	0	0
Submitted to CCG	1	1	0

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

Data Quality Rating:

Are We Responsive?



Background and underlying issues

90% compliance for all staff groups working in Maternity has been mandated in the Clinical Negligence Scheme for Trusts (CNST) 2021-22 guidance. Virtual training may be included if required, however face to face training will continued to be offered preferentially in order to focus on multi-disciplinary collaboration and effective team working.

The revised CNST standards for year 4 mandate 90% compliance for all staff groups with fetal monitoring training, including a competency-based assessment has been mandated by CNST 2021-22.

Nationally data collection for CNST is currently paused due to COVID, however the local attendance will continued to be monitored and reported.

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

Face to face Practical Obstetric Multi Professional Training (PROMPT) training was reimplemented in October 2021 however has reverted to virtual at present following a revised COVID risk assessment.

Virtual training has now been included as accepted in CNST year 4 scheme.

Risks to delivery and mitigations

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

The projected non-compliance for the relevant staff has been escalated to the team leads in order to facilitate bookings and consider whether adaptations to the proposed dates are required.

Great Western Hospitals NHS Foundation Trust

Part 3: Our People

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Caring?

Are We Well Led?

Use of Resources

Resources

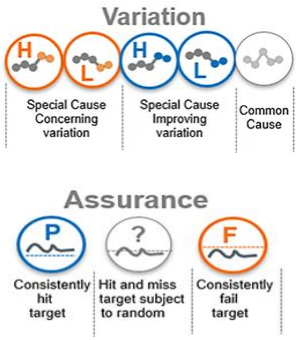
Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

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

Summary Dashboard - Workforce Performance

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Overall Agency Spend as a % of Total Spend	H	?	6.86%	6.00%	4.08%	7.43%	5.76%
2	Trust RN Bank Fill Rates		F	46.74%	70.00%	37.34%	59.40%	48.37%
3	Vacancy Rate*	L	?	6.55%	7.63%	5.57%	8.49%	7.03%
4	Recruitment Time To Hire (Days)		?	45.40	46.00	31.20	56.95	44.07
5	All Turnover	H	?	14.32%	13.00%	12.28%	13.81%	13.05%
6	Voluntary Turnover	H	P	10.58%	11.00%	8.82%	10.24%	9.53%
7	All Sickness Absence	H	?	5.29%	3.50%	3.08%	5.03%	4.05%
8	Statutory Mandatory Training Compliance	H	?	88.85%	85.00%	84.21%	88.83%	86.52%
9	Appraisal Compliance		F	74.17%	85.00%	71.48%	81.74%	76.61%



Trust Overview: Narrative

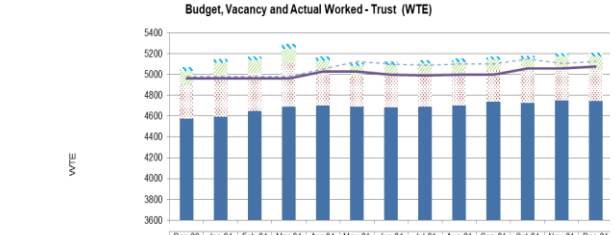
Great Western Hospitals NHS Foundation Trust

"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	Workforce planning reports the effective utilisation of workforce to meet service demands. In December the Trust utilised 130wte more then budget and increase in month by 34wte when compared to November. The Trust utilised 38.7WTE of bank and 43.0WTE of agency cover for Medical Workforce, indicating there was an additional usage of 34.2WTE above the vacancy position used . Due to increase of workforce demand in key areas, the Trust did not deliver within its 6% agency spend target, reporting at 6.86%. Areas of high agency usage are: Medical Workforce - Emergency Medicine, General Medicine, and Medical Outliers; Nursing – Emergency Department, Community Nursing, Neptune.
Great Opportunities	2	2	The Trust vacancy position in December increased to 332.42 WTE (6.55%). Medical vacancy position has decreased in month from 7.14% to 6.93%, driven by an increased contracted WTE through recruitment activity. Voluntary turnover continues to increase month on month to 10.58% in Nov 21 just below the 11% target. The recruitment time to hire in December remains below KPI at 45 days from vacancy advertised to contract sent. Healthcare Assistant vacancy remains a risk and the vacancy position increased to 72.62 WTE, the Trust was successful in securing £113,030 NHSEI funding to support achieving zero HCA vacancies by the end of the financial year. The funding has two elements 1) £30,000 to support accelerated recruitment, 2) £71,515 to support induction and ward transition.
Great Experience	1	2	Sickness reported in November 2021 was 5.29%, which although a slight decrease from last month, exceeds the Trust target and reflects the current pressures staff are under. This pressure is also reflected by the consistently high number of referrals for counselling and psychological support, predominantly for anxiety and low mood. As well as continuing with the flu vaccination programme this month, OH also supported with the Covid-19 vaccinations from the Academy, providing approx. 7,000 vaccinations to members of staff and the public between 16th – 31st December. The tea trolley visited each area in the hospital this month and festive treats were provided to all primary care and community venues giving over 5,000 drinks and minced pies, which was well received by staff.
Great Employee Development	2	2	Mandatory training continues to be above the Trust target of 85%, rising again this month to 88.85% which is encouraging. The Trust has consistently achieved its overall mandatory training target since the transfer of MT to ESR. Work continues on the improved HCA induction programme with an emphasis on a more comprehensive training package to prepare HCAs for the ward environment. GWH is taking the lead for the South West for the Stay and Thrive project, which aims to provide support and development to nurses originally recruited internationally, and to encourage them to pursue a career in the NHS. The Trust have spent 45% of the Trust CPD budget to date and 55% of the HEE CPD budget.
Great Leadership	1	2	The RUH Clinical Leads programme has been expanded to two cohorts. This means that GWH will have access to a total of 12 places. The AMD programme will recommence in April 2022. It has been agreed that GWH will participate in a BSW wide bid for GMTS trainees. The Head of Leadership has begun her work on assessing the development needs of newly appointed consultants which will provide the intelligence we need to begin to design appropriate interventions-in collaboration with others within BSW.

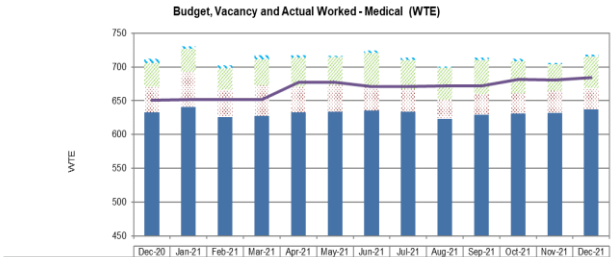
Workforce

Use of Resources

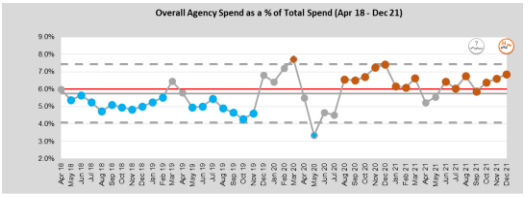
Great Workforce Planning	Indicator Score	Self Assessment Score
	2	2

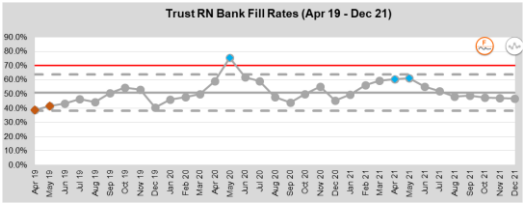


	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Overtime WTE - Trust	37.78	31.46	40.12	45.04	44.43	31.18	35.35	31.33	33.63	31.13	30.27	33.11	31.82
Agency WTE - Trust	134.66	127.90	121.50	140.44	106.52	97.74	102.47	108.07	111.89	109.30	110.22	115.23	124.53
Bank WTE - Trust	326.34	391.31	362.41	413.49	323.09	296.99	300.77	304.96	308.09	293.16	308.47	307.07	305.88
Staff in Post WTE - Trust	4572.71	4596.13	4650.22	4692.14	4701.31	4686.97	4683.13	4690.48	4699.86	4738.65	4728.61	4749.80	4744.84
Budget WTE - Trust	4960.19	4962.71	4962.76	4962.76	5028.93	5028.93	4997.81	4989.24	4995.38	4997.78	5058.62	5056.11	5077.26
Vacancy WTE	387.48	366.58	312.54	270.62	327.62	341.96	314.68	298.76	295.52	259.13	330.01	306.31	332.42
Budget WTE (Sub., Bank & Agency)	4978.95	4981.47	4981.52	4981.52	5049.89	5127.03	5099.91	5091.34	5097.48	5099.88	5150.78	5107.27	5124.42
Trust Paybill £	£20.49M	£20.66M	£21.16M	£24.33M	£20.03M	£20.70M	£21.52M	£20.48M	£20.81M	£25.82M	£21.33M	£21.52M	£21.81M
Trust Pay Budget £	£20.08M	£20.06M	£20.14M	£20.16M	£18.53M	£21.00M	£20.75M	£20.64M	£20.60M	£20.60M	£21.16M	£21.22M	£21.22M



	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Overtime WTE - Medical	6.16	3.29	3.76	6.40	3.93	2.28	3.41	3.18	2.51	3.67	3.39	1.80	2.90
Agency WTE - Medical	35.71	34.56	32.31	38.75	42.95	40.57	46.94	43.26	46.84	50.09	47.24	40.09	46.53
Bank WTE - Medical	37.78	51.85	40.33	44.56	37.45	39.59	38.00	33.73	28.47	30.63	30.23	32.30	31.75
Staff in post WTE - Medical	632.59	640.38	625.70	627.49	632.92	634.07	635.62	633.32	623.12	629.08	630.74	631.82	636.98
Budget WTE - Medical	651.10	651.89	651.89	651.89	677.65	677.65	671.28	670.80	671.80	671.80	681.42	680.42	684.42
Vacancy WTE	18.51	11.51	26.19	24.40	44.73	43.58	35.66	37.48	48.68	42.72	50.68	48.60	47.44
Medical Paybill £	£6.10M	£6.22M	£6.43M	£7.67M	£6.07M	£6.17M	£6.84M	£6.32M	£6.33M	£8.22M	£6.43M	£6.14M	£6.56M
Medical Pay Budget £	£6.01M	£5.99M	£6.03M	£6.04M	£5.43M	£6.09M	£6.14M	£6.11M	£6.06M	£6.07M	£6.17M	£6.19M	£6.21M





Background

The Trust utilised 5,207WTE staff to deliver its services in December '21, an increase of 34WTE over November and 130WTE in excess of budgeted WTE. Bank and overtime usage reduced slightly compared to November, however this was countered by an increase in agency usage. The Trust spent 6.86% of its pay bill on agency in December, with this being an 0.24% increase on the previous month and above target.

The top 3 highest users of nursing/midwifery bank and agency are ED (35WTE), Community Nursing (27WTE) and Neptune (16WTE). Escalated staffing remains the driver for usage in ED alongside vacancy and sickness cover, and in Community Nursing additional WTE to secure capacity continues to be used. In Neptune the largest portion of usage was for enhanced care, followed by additional staffing required for the increased acuity of patients and covering staff sickness.

For medical staff, General Medicine including Outlier Cover (31WTE) and Emergency Medicine (12WTE) continue to be the largest users of locum and agency cover. Vacancy and additional/escalated activity continue as the top reasons for sourcing cover, being driven by both a vacancy position for medical staff of 47.4WTE and continued elective recovery demand.

Improvement actions

1. The Winter Incentive scheme continues to be available to 31/01/2022 to support the fill of shifts via the bank in high risk areas ED, UTC, escalation areas and Neptune Ward, however evidence that this improves fill is limited.
2. In readiness for June '22 opening Urgent Treatment Centre workforce planning advanced with service specification discussions with commissioners and a plan to enhance clinical capability through task delegation, competency development and skill mix improvement. Increased UTC activity continues to exceed budgeted staffing model and funding provided until March '22 allowing to-date the recruitment of additional GP and MSK Physio support.
3. A new Finance Business Partner structure will take effect from 1st February following consultation, resulting in strategic capability aligned to Divisional needs
4. Consultation in the PMO team is underway with a view to creating dedicated functionality to both project manage and facilitate transformational improvement. The latter will be focussed on a coaching approach, with transformation delivered through empowerment and support of management teams.
5. Consultation in Outpatients will commence in January '22, in order to re-align job roles, responsibility changes and banding mix emerging as a result of new complexity and skill requirements associated with digital integration.

Risks to Performance & Mitigations

IC&C Division: Community nursing continues to rely heavily on bank and agency shifts requesting 20 x shifts per day.

USC Division: ED continue to work to an escalated staffing model, to provide sickness and vacancy cover

With all front-line patient facing staff requiring double vaccination, there is a risk that non-compliant staff will require re-deployment where available or alternative review. Many of these staff hold professional registration and if unable to remain in their present roles this could impact the registered workforce availability. HRBP led discussions are actively underway with affected individuals to mitigate this possibility through supported education about the vaccine and employment implications.

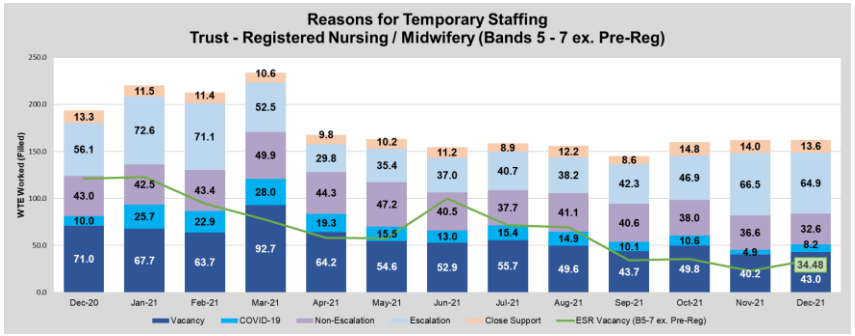
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

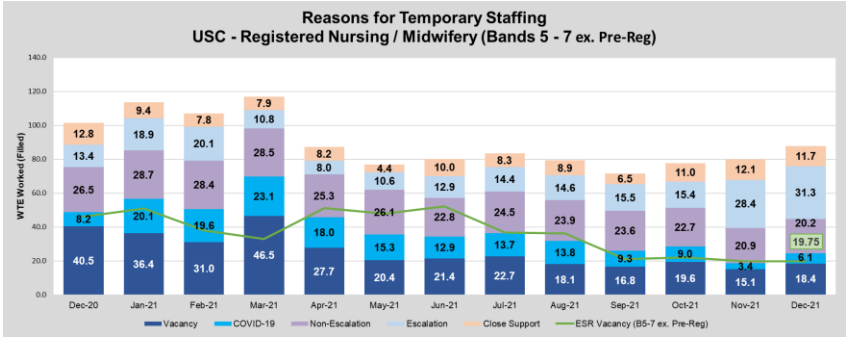
Workforce

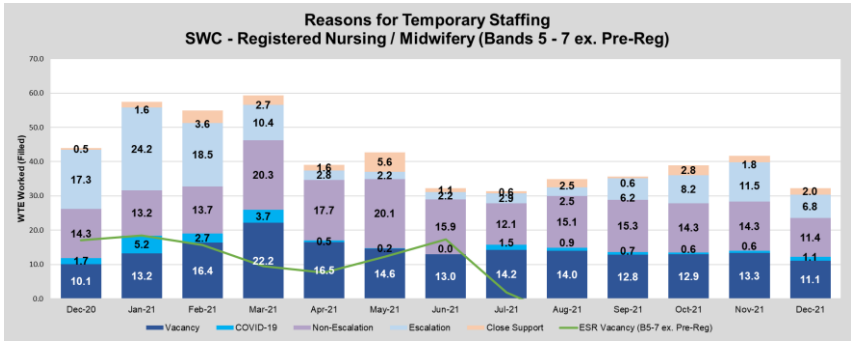
Use of Resources

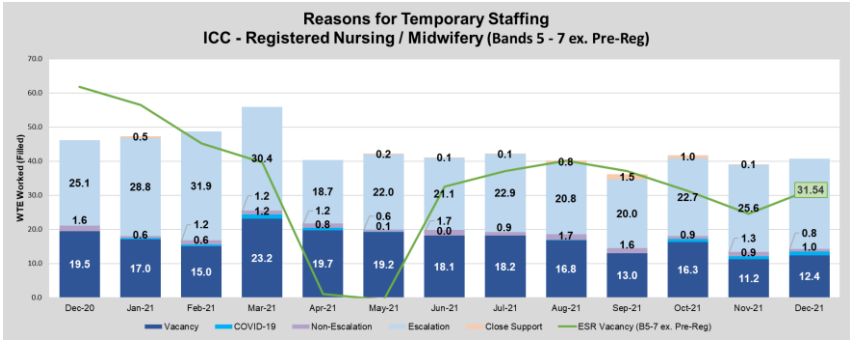
Great Workforce Planning

Indicator Score	Self Assessment Score
2	2









Background

In December 21 there were 162.31WTE temporary staffing registered nursing/midwifery used across the Trust against a vacancy of 34.38wte (excluding Pre Registered Nurses). Of this, 72.21WTE agency and 90.10WTE bank. This usage has remained consistent for the last 3 months. The data shows that across all divisions the Temporary Staffing resource utilised is exceeding the vacancy position.

- USC 87.63WTE used against 19.75 WTE M9 vacancy
- SWC 32.27WTE used against -14.81WTE M9 vacancy
- ICC 40.70WTE used against 31.54WTE M9 vacancy

For this staffing group cover is provided by both bank and agency staff. We have a pool of 163 bank-only registered nurses, alongside 1,184 substantive staff with a bank assignment who can cover temporary staffing requirements for this staffing group.

Improvement Actions

1. Long line bookings and winter escalation rates for high risk areas continues to be in place until March 2022.
2. Continue to engage with the PSL to maximise fill and booking at NHSI Cap rate. Monthly performance KPI meetings are in place with the agencies on the PSL to monitor.
3. Approval process in place with DDON signings off roster and DDON and Deputy Chief Nurse approval for off framework agency.
4. Deep dive in SWC has not identified any areas for improved controls

Risks to Performance & Mitigations

It is anticipated escalation areas will continue to use agency when fully recruited due to Covid isolation and staff sickness.

There continues to be a lack of supply of Enhanced Care Support Workers through AWP, due to this RMN's will continue to be required via agency. The Trust currently does not recruit substantively to this role although initial discussions are taking place to explore this option.

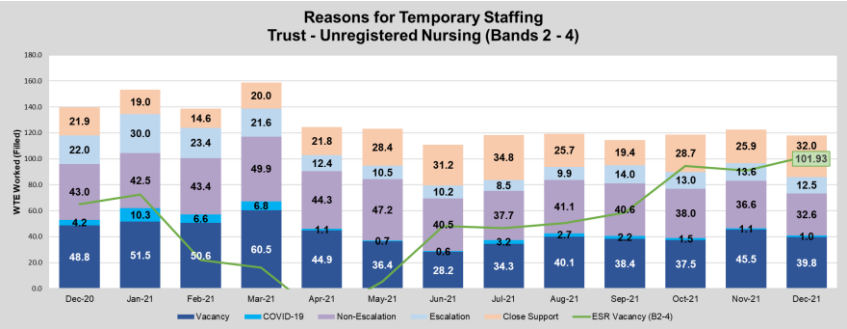
Nursing winter incentive scheme continues to be available for high risk areas until 31st January 2022.

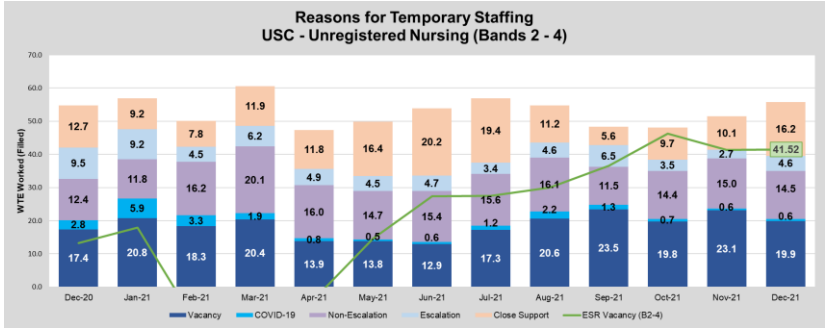
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

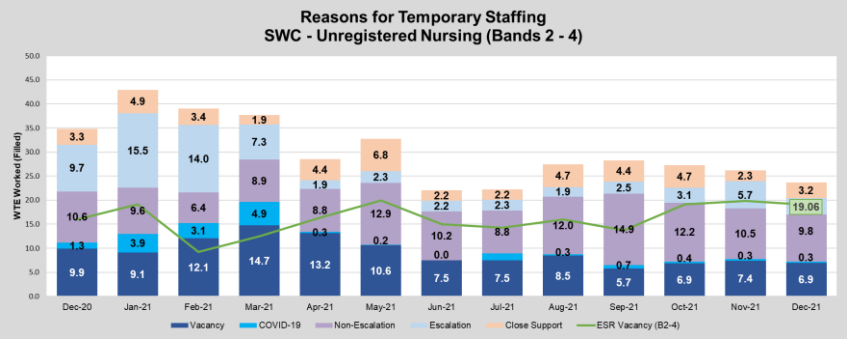
Workforce

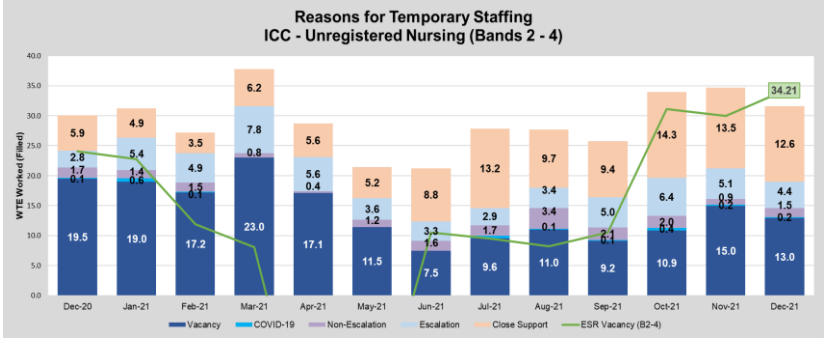
Use of Resources

Great Workforce Planning	Indicator Score	Self Assessment Score
	2	2









Background

In December 21 there were 111.14WTE temporary staffing unregistered nursing/midwifery band 2-4 used across the Trust against a vacancy of 101.33wte. Fill rate has remained consistent since April and vacancy position doesn't impact the number of filled shifts (fill is the same as April with 0 vacancy compared to December where there are 101.33wte vacancies). Further analysis is required to understand the rationale for this.

- USC 55.80WTE used against 41.52WTE M9 vacancy
- SWC 23.64WTE used against 19.06WTE M9 vacancy
- ICC 31.58WTE used against 34.21WTE M9 vacancy

For this staffing group no agency is approved, the only source is through the Trust's internal bank. We have a pool of 224 bank-only workers, alongside 621 substantive staff with a bank assignment who can cover temporary staffing requirements for this staffing group.

Improvement Actions

1. The HCA working group continues to meet bi-weekly to review recruitment and development pathways. Progress is reported through the Nursing, Midwifery and AHP Workforce group.

2. The Trust was successful in securing £113,030 NHSEI funding to support achieving zero HCA vacancies by the end of the financial year. The funding has two elements;
   1) £30,000 to support accelerated recruitment
   2) £71,515 to support induction and ward transition.

3. Review of recruitment process underway and benchmarking. Recommendation currently been reviewed.

Risks to Performance & Mitigations

The band 2-4 vacancy position is 72.62WTE, it is anticipated with the vacancy gap, winter and Covid-19 there will be an increase in HCA temporary staffing requests.

HCA winter incentive scheme continues to be available for high risk areas until 31st January 2022.

Trust buddy system will increase support of the ward for admin duties, telephone call etc.

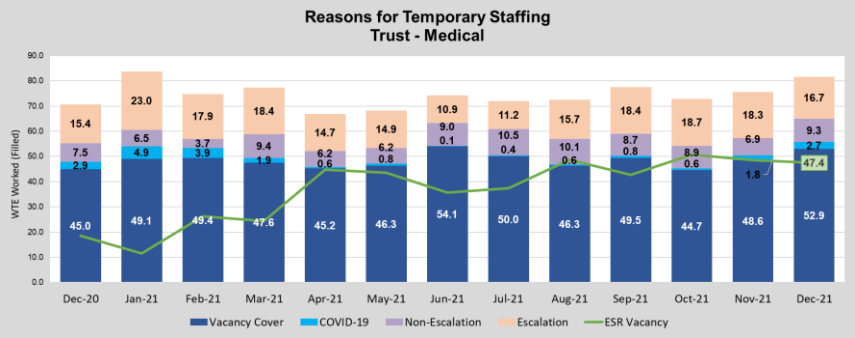
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

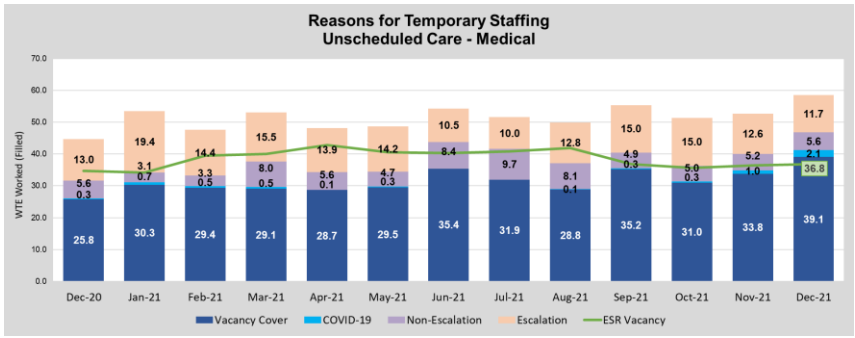
Workforce

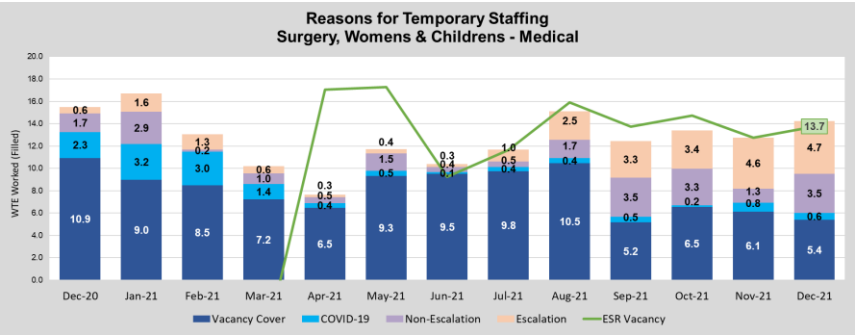
Use of Resources

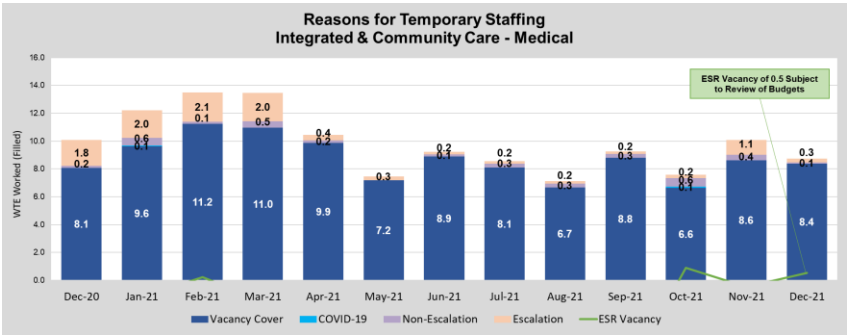
Great Workforce Planning

Indicator Score	Self Assessment Score
2	2









Background

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

The data highlights we are bringing in 81.66WTE Temporary Medical Workforce across the Trust.

- USC 58.57WTE used against 36.8WTE M9 Vacancy
- SWC 14.23WTE used against 13.7WTE M9 Vacancy
- ICC medical budgets remain under review

Across the Trust, the primary reason for medical temporary staffing continues to be vacancies and escalation.

Improvement Actions

1. Feedback from medical/operational managers on the draft SOP for Long/Short term agency/locum bank is being reviewed, with Divisional meetings to discuss due to take place in January 22.
2. The Temporary Staffing team continue to work with Liaison and agencies to increase direct engagement savings.
3. A review of budget to be completed as vacancy numbers are potentially underrepresented

Risks to Performance & Mitigations

Impact of winter and Covid-19 could cause a potential increase in additional agency usage to manage recovery and increase activity.

Reliance of agency to support hard to recruit roles.

Absence of an E-roster system for Medical Workforce to manage absence and planned activity gives limited oversight of resource. There is an essential requirement for greater transparency and oversight of job planning to understand available and required resource.

Additional outliers were required in January to manage flow.

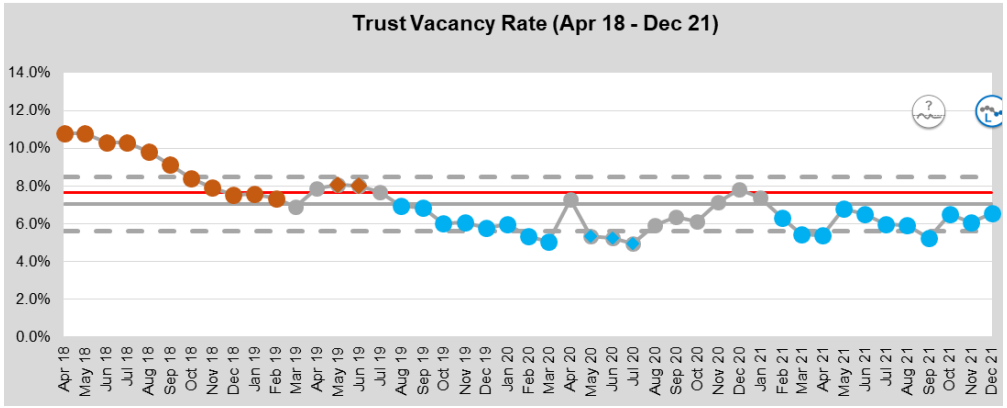
Medical resourcing meeting held twice a day.

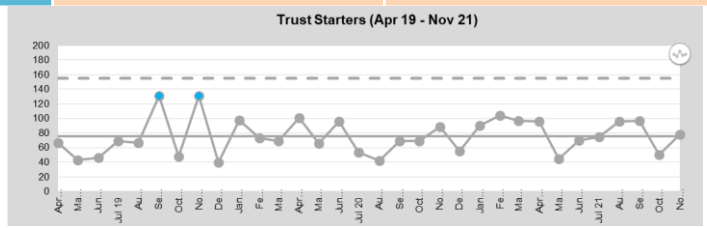
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

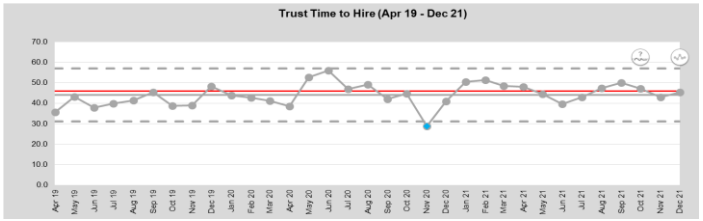
Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	2







Background

The Trust vacancy position in December increased to 332.42 WTE (6.55%).

There were 78 headcount of new starters to the Trust in December, this is above the Trust average of 75.

New starters by staffing group;

- Admin & Clerical – 16
- Allied Health Professionals – 6
- Medical & Dental – 6
- Non-clinical Support – 4
- Registered Nursing & Midwifery – 15
- Scientific, Therapeutic & Technical – 5
- Unregistered Nursing & Midwifery – 26

The Trust has a provisional 77 candidates due to commence employment in January across all staffing groups.

The recruitment time to hire in December remains below KPI at 45 days from vacancy advertised to contract sent.

Improvement actions

1. Maternity Services were successful in securing £133k of funding to support the recruitment and retention of maternity support workers. This funding must be used within 2021/22 financial year and the Trust achieve zero vacancies position by March 2022. A working group led by Head of Midwifery is exploring the options available to best utilize the funding within the time period.

2. Unscheduled Care continue to explore introducing Enhanced Care Worker (B3) as a trial within DOME service. The trial would allow existing HCA's to have the opportunity for increased training and development. A working group has been formed to develop and drive the project forward.

3. The Resourcing Team is planning to attending the following events with clinical representatives from the Trust;
   Local Universities – for all Staffing Groups
   Occupational Therapist/Physiotherapist Event, April 2022
   Swindon Job Fair, May 2022

4. HRBPs are escalating KPI performance in Divisional Board and the Recruitment Manager is working with HRBPs to establish if bespoke additional training is required to support with recruiting managers KPI delivery. The key areas of focus are;
   - Recruitment manager completing shortlisting within 3 days achieving (57.84%)
   - Recruiting manager following selection process, update TRAC with the interview outcome (69.29%)

Risk to performance and mitigations

Healthcare Assistant vacancy remains a risk. The vacancy position has increased to 72.62 WTE. Centralised recruitment plans are in place which includes a weekly rota of adverts, numeracy and literacy assessments and interviews. This activity is overseen by Deputy Chief Nurse, Divisional Directors of Nursing and Head of Resourcing.

Budget setting in April may impact the vacancy position if new roles/investment is approved.

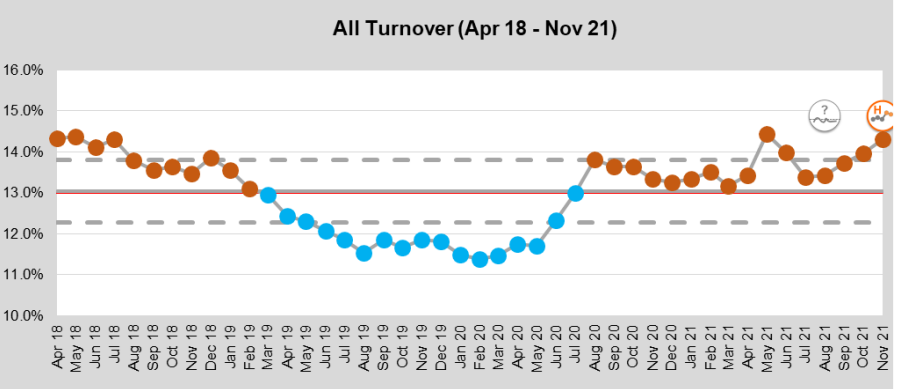
80

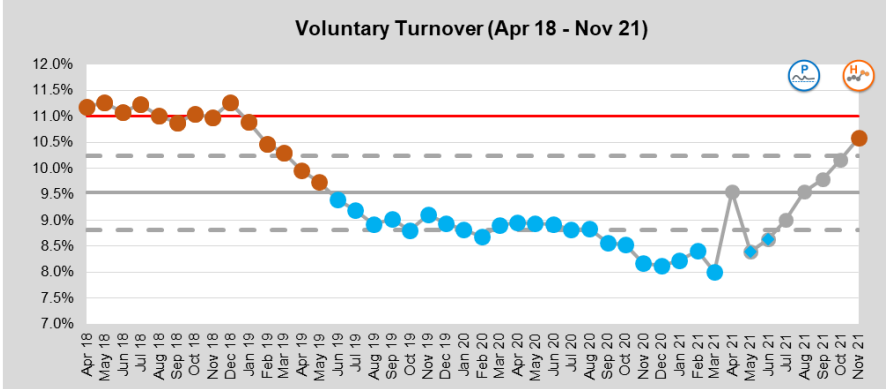
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	2





Background

Performance for all turnover worsened from last month remaining above target at 14.32%. Voluntary turnover is 10.58%, also worsened slightly from last month (10.16%) just below the 11% target this is aligned to the national trend.

In November there were 53 voluntary leavers which is above the Trust 12-month average of 46.

Leavers headcount by staffing group;

- Admin & Clerical – 8
- Allied Health Professionals – 8
- Registered Nursing & Midwifery – 18
- Scientific, Therapeutic & Technical - 6
- Unregistered Nursing & Midwifery – 10
- Medical and Dental – 3

The top 3 reasons for leaving in November 2021 are;

- Work Life Balance – 20
- Relocation – 8
- Better Reward Package - 7

Improvement actions

1. **Retention of AHP** Recruitment & Retention payment remain in place for AHPs in the Radiology department until October 2022.
2. **Retention of Unregistered nursing** - USC set up working group to trial Enhanced Care Worker B3 role in DOME (Elderly Care) for HCA career development. A key focus for the HCA working group is retention.
3. **Nursing retention strategy** - Recruitment team have appointed member of team to be allocated to the specific pastoral care of international nurses and engage in the Stay and Thrive agenda to support retention.
4. **Medical & Dental retention -** tabled as an agenda item for January 2022, MSG monthly meeting.

Risk to performance and mitigations

All turnover is reporting at 14.32% exceeding the Trust target of 13%.

Outliers for all turnover (Dec 20 to Nov 21):

- Unregistered Nursing – 22.21%
- AHPs – 18.05%
- Admin & Clerical – 14.48%

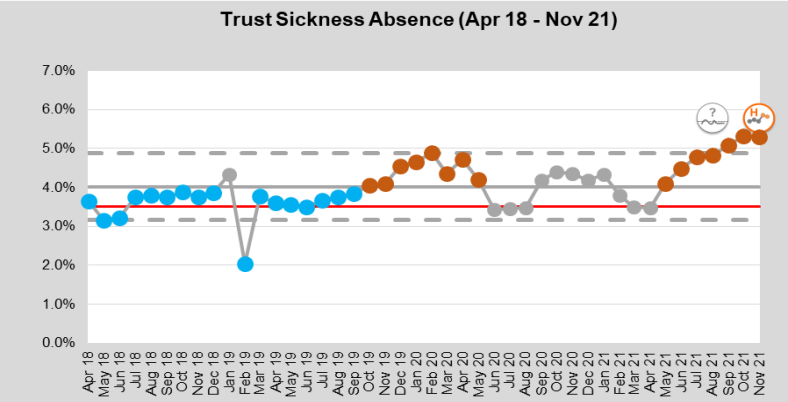
There are Trust wide retention initiatives in place to mitigate high turnover in specific professional categories

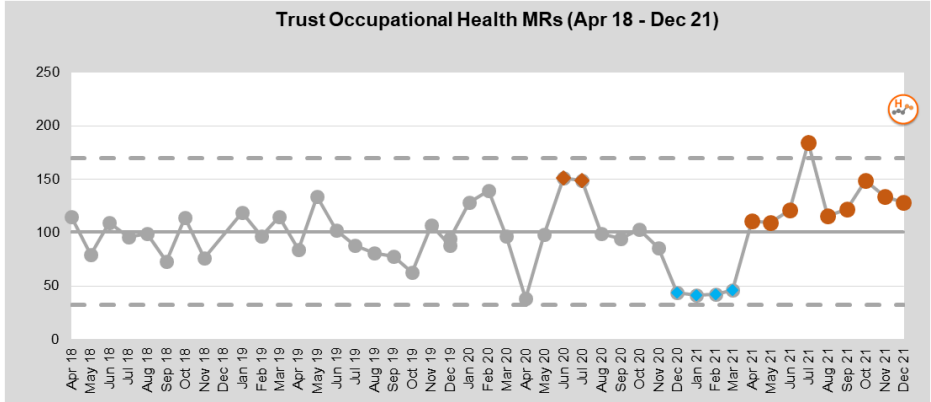
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

Workforce – Sickness Absence

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	2





Background

For November 2021, sickness absence is reported at 5.29%, which is a slight decrease from last month (5.41%) although above the Trust average of 4.0%, but in line with winter trends.

128 management referrals were made to the department this month, of which 86 were for GWH staff. The divisional breakdown for these are:

- 28 USC
- 27 Integrated
- 25 SW&C
- 6 Corporate

Main reasons for referral were mental health difficulties and musculoskeletal issues

Improvement actions

1. A total of 5,186 flu vaccinations were given by the end of December - at week 16, the Trust was at 88.13% compliance slightly behind last years results of 89.03%.
2. OH supported the Covid vaccination programme that started in the Academy last month. Nearly 7000 vaccinations were provided to staff and members of the public during the period 16th - 31st December (of which, 406 were boosters for staff)
3. Management Referrals requiring OHA were allocated to Team Prevent to enable the diversion of OH nursing resource to the vaccination center. Management Referrals for all other disciplines continued in-house
4. Wellbeing Wednesdays continued to run throughout December, and the tea trolley was re-located to the Staff HWB Hub during Wednesday lunchtimes
5. The HWB Clinical Lead attended this month's Junior Doctors Forum to provide an overview of the HWB support mechanisms available, and representatives have been identified to join the HWB Oversight Committee
6. The OH physio-led Pilates class due to start on 4th Jan has been postponed until the Academy reverts back; re-scheduled dates are currently being planned
7. The third long-Covid staff support group took place in December, attended by 4 individuals who are currently off work sick
8. In collaboration with ED, in-house videos for staff regarding TRiM have been produced to help promote this & facilitate the management of traumatic incidents

Risk to performance and mitigations

Current waiting times are:

- OHA: 1-2 weeks
  (0 waiting for allocation)
- Physio: 1-2 weeks
  (2 waiting for allocation)
- OHP: 2-3 weeks
  (2 waiting for allocation)
- MHP: 2-3 weeks
  (2 waiting for allocation)
- Cllr / psych: 1-2 weeks
  (5 waiting for allocation)

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

Workforce – Recognition, EDI and Wellbeing

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	1	2

Employee Recognition

Long Service Awards	2	Hidden Heroes	25
Retirement Awards	3	STAR awards	13

Diversity/Inclusivity

1. Four EDI podcasts were launched in 2021, focusing on the importance of role models, Allyship, Neurodivergence and effects of the menopause.
2. A Reciprocal Mentoring participants video has been produced and promotes success of this pilot scheme.
3. Preliminary results of an external EDI audit were very positive, with an assessment of 3/5 in three categories, and 4/5 in two categories.
4. The Trust's draft trans policy steering group met several times to further review and refine the policy. A facilities audit has been completed and next steps are being planned. It is planned that a draft trans policy will be presented at Exec Co. in February
5. Several short training EDI sessions scheduled for wards/Teams in January.
6. BSW ICS: Working with system partners to develop a regional EDI web page with organisation links and resources; and review recruitment practices to incorporate EDI more into interview processes. We have contributed several audio and audio-visual examples for the regional EDI web pages.
7. EDI Lead will facilitate discussion on improving the experiences and provision for our 'international' nursing cohorts in January, to our BSW ICS partners.

Wellbeing Initiatives

Festive Tea Trolley
a visit was made to all areas in December, accompanied by members of the Executive team, staff members & volunteers, giving out over 5000 drinks & mince pies. Chocolates & mince pies were delivered to our primary care practices & community sites. Feedback from staff was overwhelming positive, with comments about how this initiative really boosts morale

Massage chairs
These are currently located in the Orbital, ICU, Woodpecker, Commonhead, Oral Surgery, & Orthopaedics

Yoga project
this is now available to all staff on a first come first serve basis, advertised via the weekly HWB communication - 12 individuals signed up to this in December

Background

This month, 23 referrals were made to staff support.

The most common reasons for referral were:
1. personal: anxiety (67%), low mood (63%)
2. work-related: overload / stress (42%)

90 individual appointments were attended this month
An additional 22 contacts were made with the EAP service.

17 individuals attended bitesize wellbeing sessions
14 attended this month's MHFA supervision group

In-reach bespoke psychology group sessions were conducted with various teams across the Trust in December, reaching a total of 82 individuals attended.

Improvement actions

1. This month, 14 staff were trained in Mental Health First Aid & a further 8 in Suicide First Aid

2. Feedback from staff who attended MHFA training included *'This was an excellent course & provided practical information & guidance on how to support those who need help. Knowing what to say & do in a crisis is always difficult, but the course explains in detail what you can do & that it is ok to address the issues practically and sensitively. Although as professionals we come into contact with many different people with many different complexities, I have always found MH harder to deal with, but I feel I will be able to address this more confidently going forward'*

3. Great West Fest and Staff Awards event planning is underway for 22.

4. ED body cameras pilot was implemented mid December

5 Staff Survey results will be available early February.

Risk to performance and mitigations

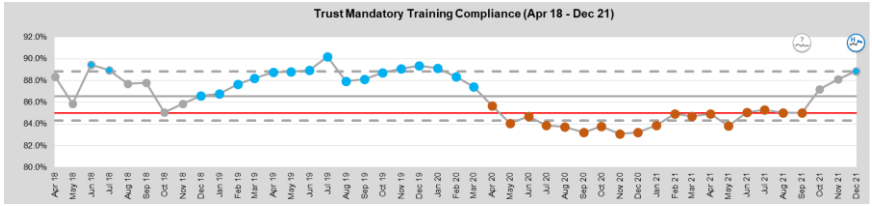
The use of bank counsellors as our main provider for 1:1 staff support is making it challenging to maintain a timely service, especially this month as many took holiday compounded by an increase in number of referrals. This is being actively monitored to ensure long-term sustainability of this approach

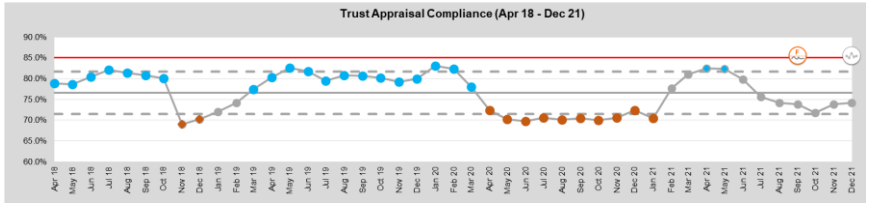
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

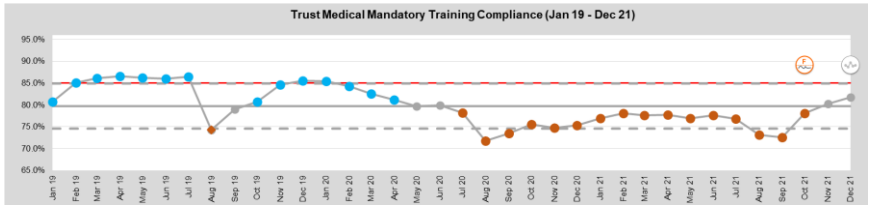
Workforce

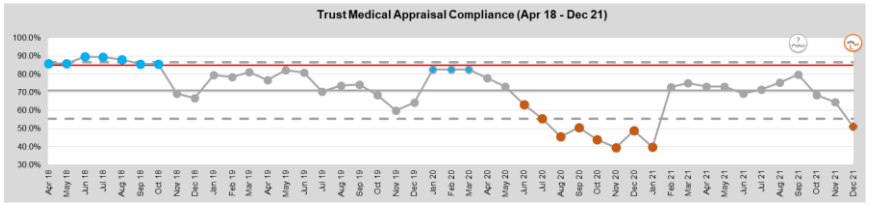
Use of Resources

Great Employee Development	Indicator Score	Self Assessment Score
	2	2









Background

Trust mandatory training compliance performance remains above the KPI of 85% . This, month it is at 88.85%. This is an increase of 0.7% from last month.

Trust appraisal compliance is reported at 74.17% in December, increasing by 0.4% over the month. This performance continues to have an impact on the indicator score in the leadership section.

The level of operational pressure over recent months and higher sickness absence rates will have contributed to this level of performance.

Salisbury NHS Foundation Trust and Royal United Hospitals Foundation Trust are also reporting appraisal rates significantly below KPI.

The Academy continues to provide 2-weekly reports on appraisals to support managers in monitoring compliance.

Improvement actions

1. The Academy is undergoing some refurbishment and redecoration to improve the environment for learners and a local school has been involved in designing artwork to brighten up the space. The children are visiting the Academy on the 28 January.
2. GWH is taking the lead for the South West for the Stay and Thrive project, which aims to provide support and development to nurses originally recruited internationally. The programme is designed to encourage them to pursue a career in the NHS .
3. The Head of Learning and Development is exploring the use of an electronic booking system in the Academy which would support more efficient use of the space. The funding options to support this are being explored.
4. Work continues on the improved HCA induction programme with an emphasis on a more comprehensive training package to prepare HCAs for the ward environment.
5. The Conflict Resolution pilot took place in November/December. A review meeting, including H & S took place on 13 December. Further benchmarking taking place and a final decision will be made on 6 January
6. An AHP Education Lead has been appointed which will strengthen the expertise and support available to this group, and provide opportunities for more multi-disciplinary working in the Academy.

Risk to performance and mitigations

The Academy became a vaccination centre from mid- December until the 3 January 2021. This had an impact on training delivery.

The requirement for social distancing continues to have an impact on capacity and throughput.

The space available in the Academy continues to be a constraining factor. Options to use other external venues as an alternative for some training are being explored, although this will incur a cost.

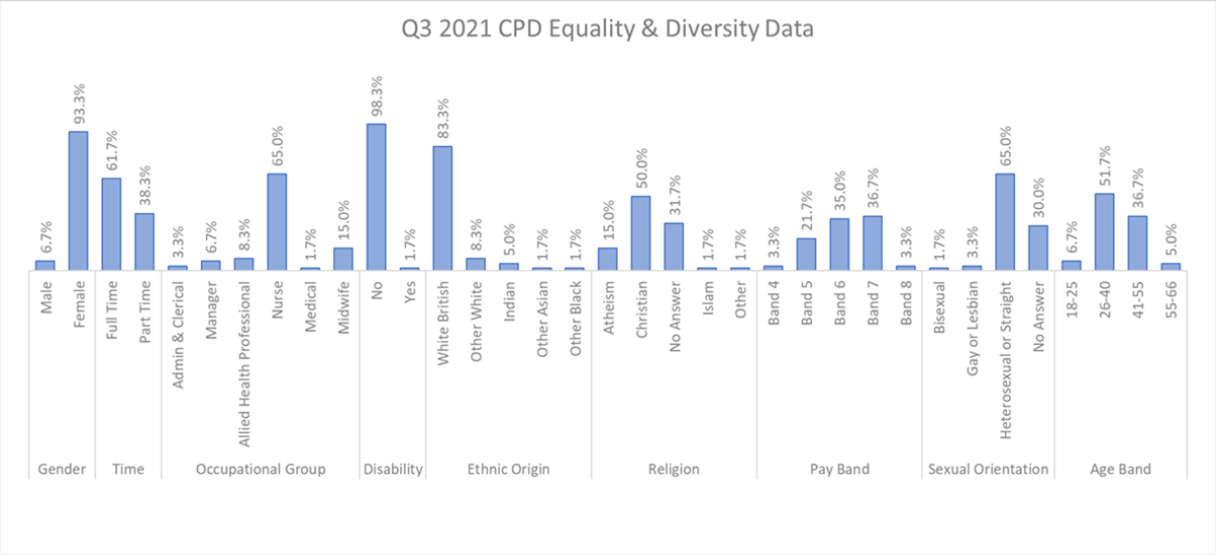
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

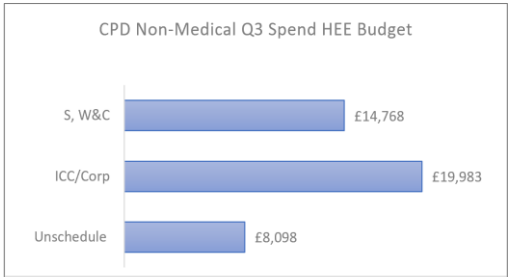
Workforce

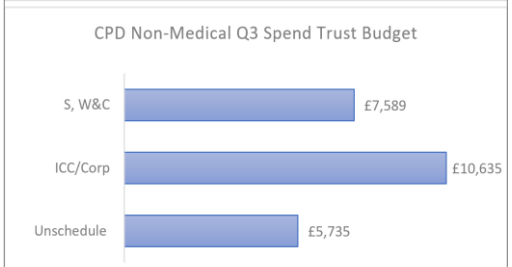
Use of Resources

Great Employee Development

Indicator Score	Self Assessment Score
2	2







Background

1. The Trust CPD Budget spend to date is £108,498. The annual budget is £240,000, meaning we have spent 45% of the fund to date. The HEE CPD budget spend to date is £346,149. The annual budget is £632,000, meaning that we have spent 55% of the fund to date.

2. By Division CPD application % falls 12% Admin and clerical, 14% AHP, 72% Registered Nursing and Midwifery, 2% Scientific, Therapeutic and Technical, 0% medical and dental, 0% non clinical support and 0% unregistered nursing and midwifery.

3. Benefit value per staff member across Q3 was of the 5263 staff there was a HEE total spend of £52,705 and a HEE average spend per person of £10.01. Total CPD Trust spend was 28,396 and a CPD average spend of £5.40 per person. Total spend was £81,101 and per person was £15.41. End of year review to determine how outstanding CPD Trust and HEE money will be spent. Meeting next week to finalise

4. The EDI data demonstrates that the majority of staff accessing CPD are female, and the biggest occupational group to access it are nurses. The Bands most likely to access training are Band 6 and 7 staff. It is also notable that a significant proportion of staff do not provide an answer to the question about sexual orientation. The age group most likely to access CPD are aged between 26-40.

Improvement actions

1. The new Head of Learning and Development is developing a refreshed application process for CPD to ensure it is more streamlined. This is currently being tested with a look to roll out across the Trust in late February

2. The Trust's bid to host NHS Cadets was successful. The first Cadets are to arrive in March. This scheme is specifically designed to encourage those from socially deprived backgrounds to consider volunteering/a career in health and care and is aimed at 14-18 year olds.

3. BSW has developed the first joint programme for DDONS-and the pilot is due to begin in January. The Trust will have access to 6 places. This will be led by the RUH. This demonstrates our continued commitment to working across the system-and is in line with the approach taken with the AMD programme led by GWH and the Clinical Leads programme led by RUH.

4. The Trust has submitted its updated report on the use of the HEE CPD funding for nurses, midwives and AHPs and HEE is satisfied with the plan and progress made to date.

5. Looking at the CPD data it appears that there is work to do to promote the availability of the CPD fund across the organisation to encourage others to access it. This will be done in conjunction with the Comms team before the new financial year. Plan for 22/23 will to be more proactive with our Training Needs Analysis and less reactive. Plan to look at skill gaps, upcoming future plans and what is needed and ensure CPD is spent on the correct projects. Non-clinical people focus needed for CPD as seen in figures above

Risk to performance and mitigations

The key risk to performance will be the ability of staff to access CPD during the winter period which may prove to be challenging. This will be kept under close review.

85

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

Workforce

Use of Resources

Great Leadership	Indicator Score	Self Assessment Score
	1	2

Leadership Roles at the Trust	4.40% of staff	Equating to 180.79 WTE
Leadership Development Programme *(Cohort 1)*	22 leaders	13 Completed Training
Leadership Development Programme *(Cohort 2)*	14 Leaders	Undergoing Training
Leadership Development Programme *(Cohort 3)*	20 Leaders	Undergoing Training
Aspiring Leaders *(Cohort 1)*	21 aspiring leaders	19 Completed Training
Aspiring Leaders *(Cohort 2)*	18 aspiring leaders	Undergoing Training
Leadership Forum Members	300 managers	Members Engaged
Latest Leadership Forum *(23 November)*	27 managers	Actively Attending
Ward Accreditation	24 of 24 departments	using the Perfect Ward App

Background

The Clinical Leads programme led by the RUH on behalf of the three Acute Trusts will begin in March 2022.

The plan is now to run two programmes concurrently. Six Clinical Leads have been nominated and there is now an opportunity for a further six from GWH to join the programme.

The AMD programme will continue in April 2022 to avoid the winter period and increase the chances that AMDs will be able to attend.

An expression of interest has been submitted to participate in the NHS E/I Talent Management 'Scope of Growth' pilot scheme. This will impact on our continued implementation of talent management in the organisation.

The leadership team have been working with several teams / departments across the organisation to provide focus groups or ongoing support with team / individual development.

The Leadership prospectus has been completed and will be published on the intranet.

Improvement actions

1.The Trust has again been asked to consider hosting further GMTS trainees as part of a BSW system bid.. A paper will be presented to Weekly Execs on the 10 January to evaluate the scheme benefits and reach a view about future cohort size.

2.The BSW Clinical Leads programme will be facilitated by the RUH, but speakers including those from GWH will be actively participating in the delivery of training sessions to ensure that knowledge and experience is not only shared across the system but that participants benefit from a range of speakers from different backgrounds and organisations.

3. The Head of Leadership has received approval to evaluate the development needs of newly appointed consultants with a view to ensuring a thorough understanding of the support required. The aim would be to ensure that any programme developed as a result would also be on a BSW wide basis.

4. A forecast of OD interventions for 2022/ 2023 which requires CPD funding will be submitted to the BSW education group. This will be significantly increased compared to 2021/2022.

5. The Head of Leadership and the Team Development Manager will be attending an accredited facilitation course in January. This is part of the drive to improve internal leadership development expertise. The Associate Director of OD and Learning will complete the second part of the structural dynamics training. This will mean there are two SD practitioners within the Trust.

Risk to performance and mitigations

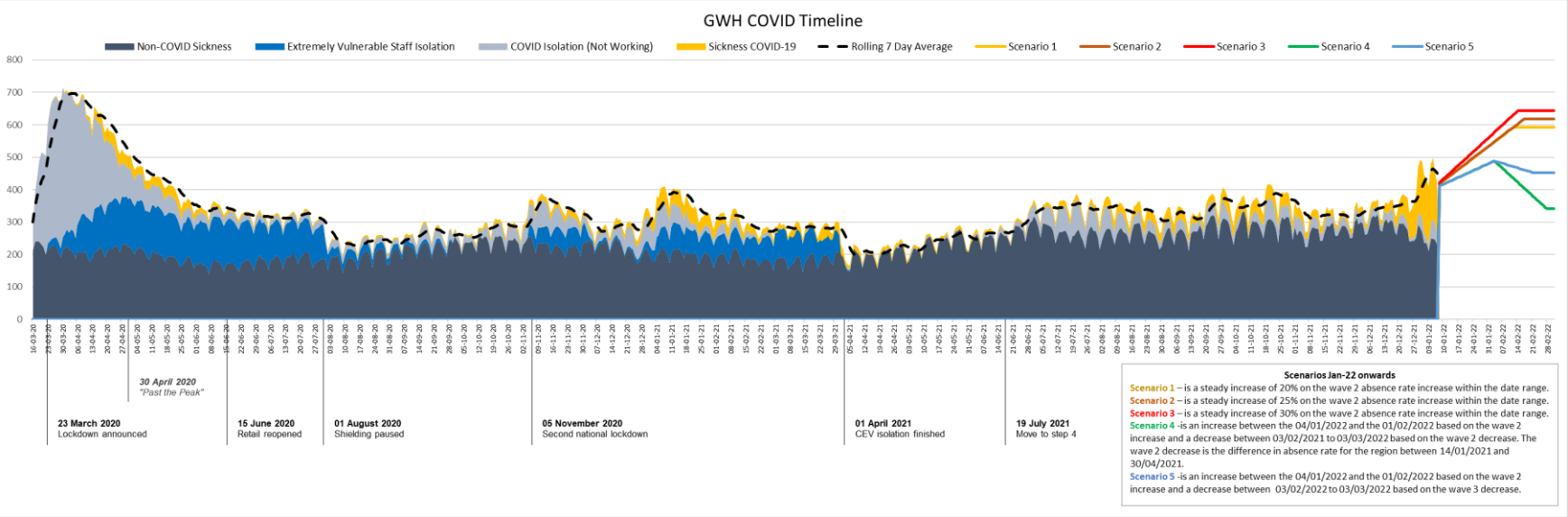
Depending on the length and severity of the Omicron wave of the pandemic combined with the usual winter pressures , it is possible that attendance at any leadership development activity will be challenging.

The decision to cancel the January Leadership Forum has already been made given the current pressures and the timing of the Forum.

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

Exception – COVID Staff Sickness & Isolation

Exception Report



Background

On 4th January, the Trust declared a critical incident owing to a high number of inpatients coupled with staffing concerns due to sickness and COVID related absences. On the date of the incident there were 399 workforce absences, of which 186 were related to COVID.

The position has improved marginally, and as of 11th January there are 383 staff absent from work, of which 154 are off due to a COVID related reason.

Improvement actions

1. **Trust Covid-19 timeline:** The graph presents the Covid-19 timeline in terms of different workforce status categories since March 2020, culminating in the peak of Covid-19 related sickness in December 2021. The predicted trends are outlined in the Scenario definitions forecasting the range of potential increase and decrease in absence rates during Wave 2 of the pandemic.

Since December 2021, the HR team are providing the following Wave 2 pandemic response support service as part of the Contingency plan:

1. **Workforce Resourcing Hub –** The HR team are attending the on-site hub set up in hospital, level 2, and supporting 7-days week leading the following HR advisory service:

2. **AskHR Advice Line:** Daily telephone and email advisory service responding to members of staff as required on all aspects of national guidance – including changes to guidance, FAQs, supporting with accessing lateral flow testing and booking PCR tests.

3. **Staff Testing:** The HR team coordinated the provision of PCR tests for isolating members of staff experiencing delays with the national booking system. Tests were available from 8am – 8.30pm daily with a 6-8 result response turnaround. This service ended 10 Jan 2022 covering the peak period of absence and national delay.

4. **COVID Reporting team –** Workforce Intelligence Team produce daily reports to monitor workforce Covid-19 absence / isolating status, track the evidence of the lateral flow and PCR tests and provide the information to accurately inform workforce support and guidance.

5. **Corporate buddies –** HR supporting senior clinicians to design and introduce with effect from the 10th January 2022, rota for members of the non-clinical workforce to volunteer to cover short shifts on wards and departments with appropriate patient facing support services.

Risks to Performance & Mitigations

The Trust is experiencing a peak in workforce absence rates due to Covid-19 related absence which is impacting on service provision during winter period. Contingency planning has required a priority response from multi-disciplinary teams including the HR team.

To alleviate primary care pressure the ability for an individual to self-certify sickness for 28 days (instead of 7), has been introduced nationally. This creates the possibility of extended lengths of sickness without requiring certification, potentially resulting in an individual(s) sickness extending for longer than otherwise the case. Sickness policy implementation and proactive monitoring remain as mitigating actions.

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

Exception – Mandatory COVID Vaccinations

Exception Report

Division	No Doses	Had First Dose Only	Had Both Doses	Grand Total	% Had No Doses	% Had First Dose Only	% Had Both Doses	% Had at least 1 Dose	Eligible for Booster	Booked for Booster	Had Booster	% of those Eligible who have had Booster	Not Double Vaccinated: Applying for Exemption (medical or non patient facing)	Not Double Vaccinated: Exempt (medical or non patient facing)	Not Double Vaccinated: Not Exempt
Corporate Services Division	18	7	647	672	3%	1%	96%	97%	645	3	596	92%	16	0	9
Integrated and Community Care Division	41	9	1233	1283	3%	1%	96%	97%	1204	4	1126	94%	13	1	36
Surgery, Women's & Children's Division	37	24	1722	1783	2%	1%	97%	98%	1696	8	1568	92%	8	0	53
Unscheduled Care Division	47	44	1602	1693	3%	3%	95%	97%	1564	11	1393	89%	10	0	81
Trust Total	143	84	5204	5431	3%	2%	96%	97%	5109	26	4683	92%	47	1	179

Background

As of 9th January 97% of the Trust have had at least one dose of the vaccine and 96% have had two doses of the vaccine. 92% of those substantive staff that are eligible, have now had their Covid Booster vaccine

There are currently 227 substantive staff who are not double vaccinated. Of these, 5 say they have had both doses and we are awaiting their evidence, 1 is leaving, 102 intend to have both doses and 47 believe they are exempt or applying for exemption.

This leaves 42 who have not yet responded (8 of whom have already had their first dose), 4 refusing to answer, 7 undecided and 20 who have stated they do not intend to have both doses by April.

Improvement actions

1. 1-2-1 with line managers underway with 227 staff who have not yet had the vaccine to understand rationale and intentions.
2. Mandatory Vaccine working group has been established with representative from across the Trust and Serco. A number of actions are underway.
3. National guidance is due to be shared on the 14th January.
4. GWH Vaccine Support group has been established with experts on the vaccine, representative from medical, EDI, Pharmacy, nursing.
5. Video message from Chief Nurse and Medical Director regarding the mandatory vaccine and the importance

Risks to Performance & Mitigations

Risk of service delivery is staff leave, or dismissed on or before April.

A departmental risk assessment has been developed to identify risk and mitigation including actively recruiting to role where staff have indicated that they will not have the vaccine.

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

Board Committee Assurance Report

Finance & Investment Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Andy Copestake	Andy Copestake		24 January 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Month 9 Finance position	A	A	A very good result for Month 9. A favourable I & E variance to date of £1.1m, Cash of £35m at the end of December and a strong CIP achievement, which was slightly below plan in-month but £418k above plan year to date. The Amber rating reflects a concern from the Committee that although the bottom line was strong, Non-Pay costs and Agency costs were both significantly over budget in-month.	Monitor through FIC	FIC meetings 2021/22
Finance Risk Register	A	G	Again, there were no major changes to the Finance Risk Register this month. The Trust has been told by the region that the Emergency Capital bid of £11.5m **has** been approved; however, the Amber rating reflects the fact that this has still not been confirmed in writing.	Monitor through FIC	FIC meetings 2021/22
BSW Consolidated Finance Report	A	A	A good verbal report from the DoF. Still good collaboration between the System partners. The Amber rating reflects emerging concerns over Capital funding for 2022/23.	Monitor through FIC	FIC meetings 2021/22
Business Planning & Budget Setting 2022/23	G	G	The Committee is assured that the planning process for 2022/23 is progressing well, building on the improvements in the H2 planning process.	Monitor through FIC	FIC meetings 2021/22

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
PFI Benchmarking Report	A	G	A good discussion on the 5 yearly benchmarking process for Soft FM services under the PFI contract. The process is tried and tested. The Amber rating reflects the significant cost pressure in the initial figures provided by the Hospital Company. The Committee supported the proposal to keep all options open at this stage.	FIC	21 February 2022
2022/23 Improvement & Efficiency Draft Plan	R	R	The report outlined a number of areas where good progress is being made together with a list of 70 schemes where there is savings potential; however, the Red rating reflects real concerns from the Committee on scale and pace. £7.9m of possible savings have been identified to date but most of these schemes are currently rated Red for achievability. The likely efficiency target for 2022/23 is likely to be more than £10m so there is a substantial gap and the Committee would like to see more emphasis on delivering in areas where significant cash-releasing savings are possible e.g. Agency/ Locum spend.	FIC	FIC meetings 2021/22
SLR/Costing Assurance update	G	A	The regular update report on the GWH costing process. The Committee was assured that GWH is in a reasonably good position re: meeting targets and providing cost returns to NHS Central, but the Amber rating reflects the need to use the information to deliver real value to GWH through reinvigorating engagement internally.	FIC	July 2022
Internal Audit Financial Systems report	G	G	The Committee congratulated the Finance Team on receiving such a good IA report on key Finance systems, which provides a very solid platform to build upon.	None	
Update on Proactive Procurement	G	G	A good report from the Director of Procurement setting out good progress on a range of issues.	Update	April 2022
Powers Reserved to the Board and Scheme of Delegation	G	G	Subject to a couple of small proposed changes, the Committee was happy to recommend approval to the Board.	Board	3 February 2022
Provision of Pathology Rapid PCR Testing System Reagent	G	G	The Committee recommends approval of a 2 year contract (with an option to extend for 3 years) for PCR testing and Reagents to Cepheid UK.	Board	3 February 2022

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

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 December 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	33,931	36,505	2,574		306,252	320,782	14,529	
Total Operating Expenditure	(34,435)	(36,226)	(1,791)		(307,210)	(320,637)	(13,428)	
Total Surplus/(Deficit) *excl donated assets*	(504)	279	783		(957)	144	1,102	
Capital	3,849	1,930	(1,919)		20,352	13,042	(7,310)	
Cash & Cash Equivalents	14,857	35,038	20,181					
Efficiencies	445	391	(54)		2,607	3,025	418	

Overview

Income & Expenditure: The Trust in month position is £0.3m surplus against a deficit plan of £0.5m. Operating Income is £2.6m favourable against plan and Operating Expenditure is £1.8m adverse against plan.

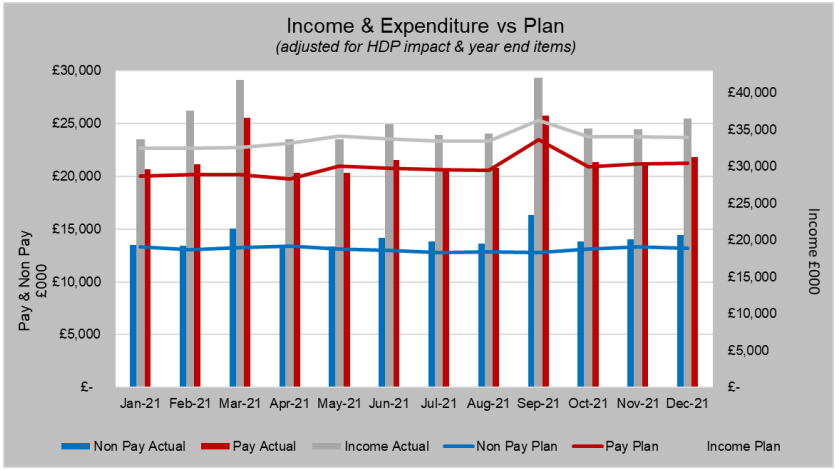
Cash – the cash balance at the end of December was £35m which is above plan of £14.9m.

Capital – Capital expenditure is £13m as at the end of Month 9, £7.3m below plan.

Efficiencies – £3m YTD has been delivered, which is above plan by £0.4m.

Income and Expenditure - Run Rate

Use of Resources



Background

The December position is £0.3m surplus against a planned deficit of £0.5m. The position includes Elective Recovery costs of £0.65m over budget.

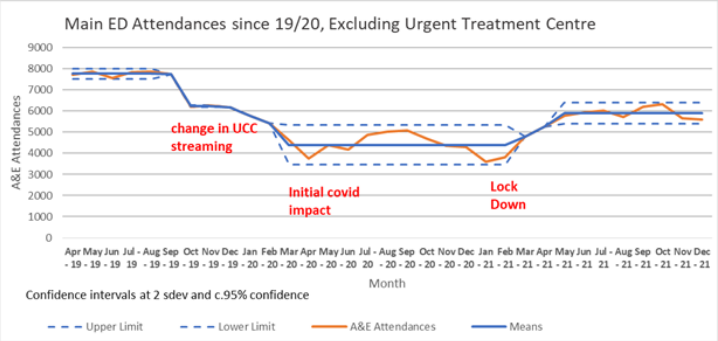
- Income run rate has increased by £1.47m. This is driven by NHS Clinical Income increasing by £1.13m from November. This is driven by system income for H2 YTD having been released from the CCG.

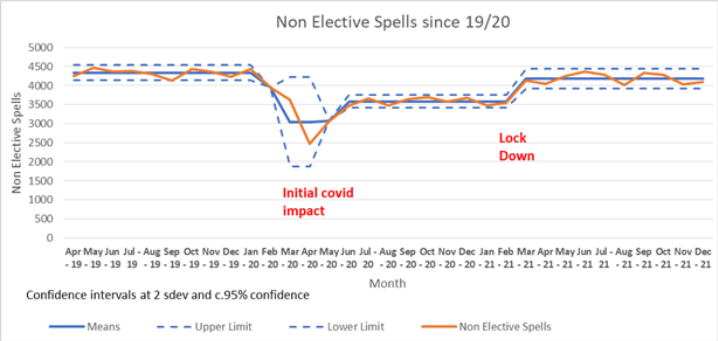
- Monthly Pay run rate has increased by £0.6m.
    - Nursing run rate has increased by £0.2m, mainly on substantive staffing spend and driven by winter pressures, staff absence and additional December enhancements. This is as well as of continuing pressures around enhanced care.
    - Locum Medical staffing costs have increased by £0.3m predominantly across USC in support to outlying patients and in ED linked to agreed winter pressures funding. PCN GPs have also increased, this is anticipated to reduce moving forward as permanent appointments are now being made.

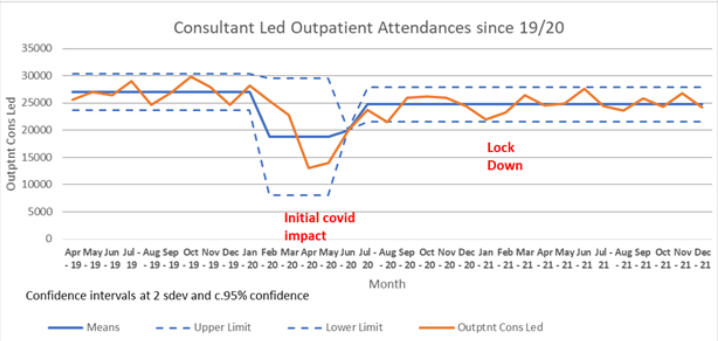
- Non Pay run rate has increased by £0.4m. The run rate pressure includes £0.2m on clinical supplies across SW&C (equipment and implants) and USC (MRI/CT costs and Testing & Swabbing costs) and £0.2m on other costs driven by corporate costs for consultancy and software/licence costs above plan.

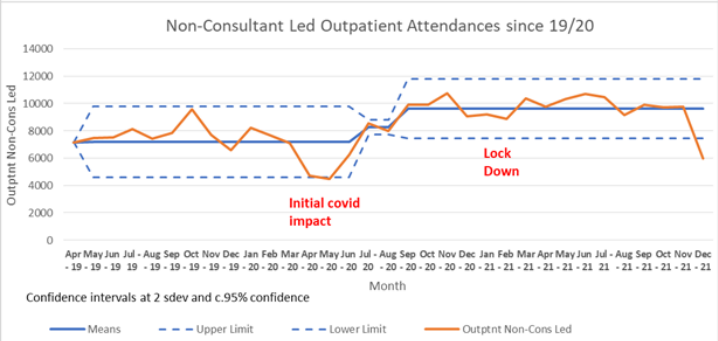
Key Activity Trends to Inform Revenue Impact if National Tariffs Still Applied

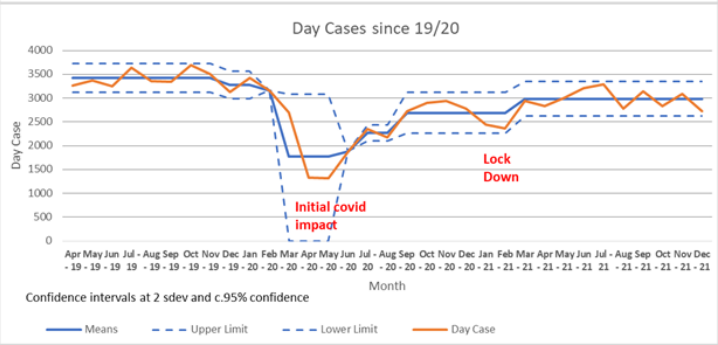
Use of Resources

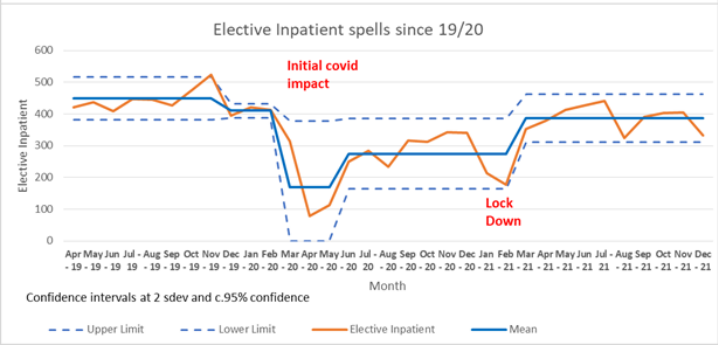












Background:
This is the activity trend collected to inform financial view on productivity, expenditure reported and notional income earned. This does not replace divisions' own view on their levels of activity.

Income and Activity Delivered by Point of Delivery

Use of Resources

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

Activity Type	Activity Variance	19/20 Income	21/22 Income	Income Variance	Income Variance	Comment (comparing income and activity variances)
	%	£'000	£'000	£'000	%	
Main ED (Excl UTC)	-19.5%	10,589	8,982	-1,607	-15.2%	Minor activity affected more than major + impact of increased streaming since 19/20
NEL	-3.2%	68,816	76,188	7,371	10.7%	Minor activity affected more than major
Outpatient (All)	-3.8%	32,627	28,449	-4,178	-12.8%	Due to switching to Non face to Face
Day Case	-11.9%	17,913	16,149	-1,764	-9.8%	Minor activity affected more than major
Elective Inpatient	-11.7%	13,840	12,728	-1,112	-8.0%	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.

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

Issues:

Income that would have been earned if PbR was in place is reduced from previous years due to Covid-19 reducing throughput. 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.

Emergency attendance and non elective admission are relatively consistent with November, however elective services have decreased by 12% (day case) and 18% (elective overnight).

Risks:

If the previous cost and volume funding approach was reintroduced, activity based income for the year would be c£1.8m lower than 2019/20 income levels due to reduced throughput. Reduced day case throughput will mean elective recovery is put under increased pressure.

Actions & mitigation:

The contracts team is continuing to track income both from existing streams and new and emerging sources for 21/22.

Work is commencing across BSW looking at the payment regime that is likely to be in place for 2022/23 to understand the impact it may have on the Trust. PbR is not expected to return in it's previous form. A combination of block payments for urgent and emergency care, and marginal activity based payments to incentives elective recovery are being discussed with the potential for quality based performance on CQUIN and best practice tariffs.

Efficiency – Better Care at Lower Cost

Use of Resources

Background

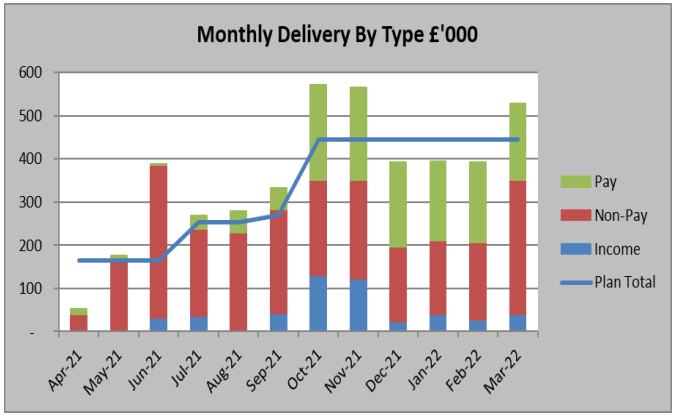
Cost Reduction identified and delivered in month is £0.39m which is £0.05m below plan.

Delivery for the year to date is £3.02m, which is over plan by £0.42m.

The total target for the year is £3.94m.

Future months indicate the forecast delivery for the period to 31 March 2022, is anticipated to overachieve by £0.40m.

Efficiency target for 22/23 is anticipated to be higher than 21/22, around the level of 3/4%.



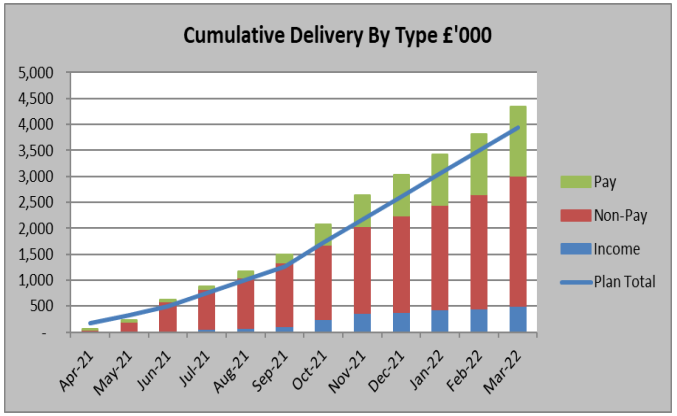
Improvement actions planned

Work is now underway on 22/23 planning, which incorporates assessment of the full year effect of the 21/22 efficiencies to bring the draft budgets to a normalised position.

Assessment of continued opportunities within the improvement programme areas is underway, with peer review and gap analysis continuing. Finance and T&I colleagues are working with divisions to bring forward focus on these opportunities and putting plans in place to enable delivery from 1st April 2022.

Review of the transformation and improvement support across the Trust is underway, which will lead to further prioritisation of the programme opportunities to ensure resource to deliver is most effectively applied to the programmes. This is linked to the roll out of the improving together programme underway.

Development of summary reporting for FIC continues following update of reporting for Improvement Board.



Risks to delivery and mitigations

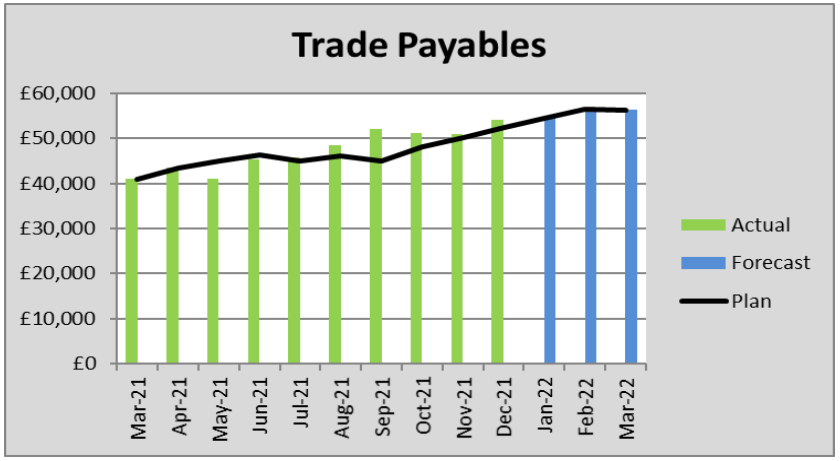
2021/22 forecasts continue to indicate full achievement will be made against the H2 target.

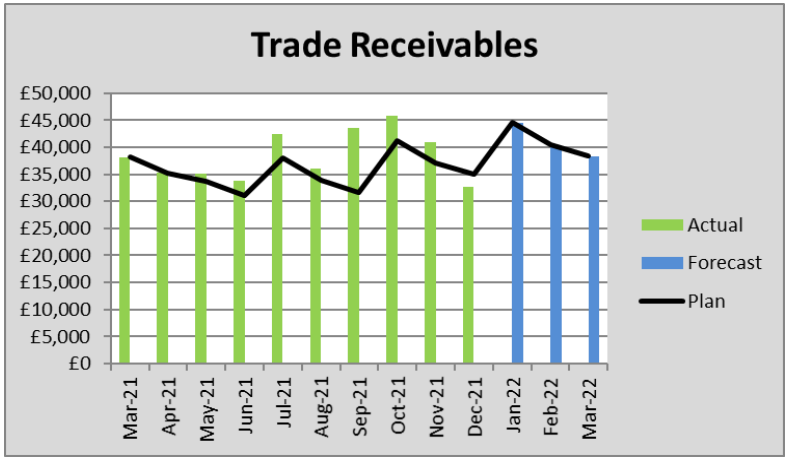
Risk continues to be higher around the effective progression of cost avoidance and productivity opportunities, which enable run-rate management. SRO's have been identified at divisional level and regular meetings have been established around the larger opportunity of benchmarking to support the progression of this area.

A high proportion of the 21/22 efficiency remains non-recurrent. Non-recurrent efficiency does not support the longer term management of the Trusts financial position and focus needs to be on driving recurrent efficiency through the improving together programme moving forward.

Statement of Financial Position: Key movements

Use of Resources





Background

- Payables are slightly above plan in month.
- Receivables are below plan which is driven by increased income received from BSW CCG.
- A full Statement of Financial Position is included in the appendices.

Risks to delivery and mitigations

- We have received correspondence from NHSI to suggest that the Trust Emergency Capital funding application has been approved and await formal confirmation in the coming days.
- The funding applications for the Energy Centre (£2.3m) remains outstanding so the scheme is progressing at risk. This continues to be chased with the regional and national teams.

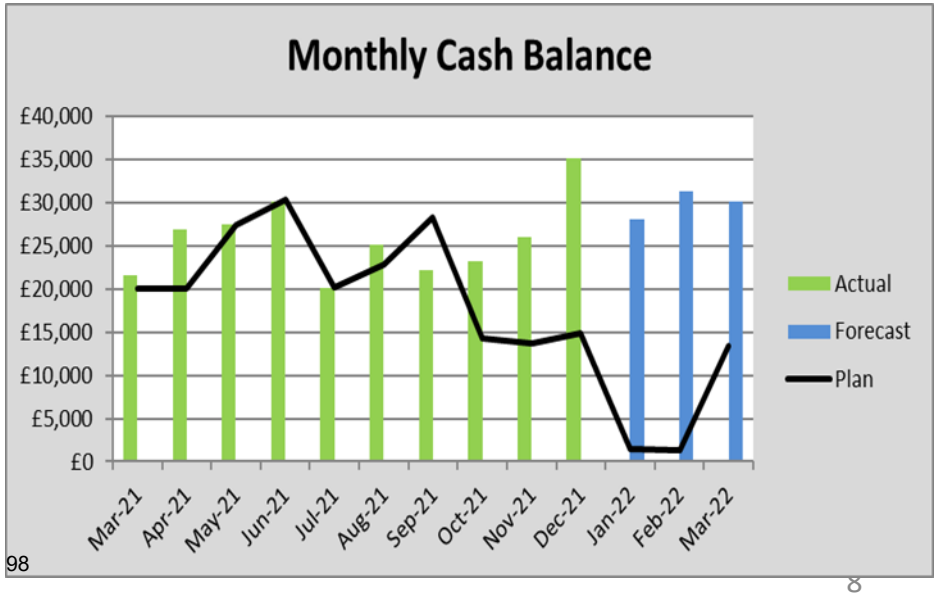
Cash

Use of Resources

	Mar-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	21/22 Total	Rolling 12 Mths Jan 22 to Dec 22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	**41,193**	**25,954**	**35,039**	**28,090**	**31,221**	**30,117**	**18,711**	**18,902**	**19,668**	**8,781**	**9,547**	**10,313**	**3,488**	**1,000**	**21,553**	35,039
Income																
Clinical Income	11,312	39,746	31,088	31,088	31,088	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	389,149	340,917
Other Income	3,921	3,029	2,740	4,257	2,403	2,403	2,403	1,619	1,619	1,619	1,619	1,619	1,619	1,619	47,606	25,535
Revenue Financing Loan / PDC	4,975											4,062	8,399	10,887		23,348
Capital Financing Loan / PDC	25,525		6,230	1,894	3,234	3,234	3,234	4,537	4,537	4,537	4,537	4,537	4,537	4,537	13,430	49,585
Total Income	**45,733**	**42,775**	**40,058**	**37,239**	**36,725**	**33,154**	**33,154**	**33,673**	**33,673**	**33,673**	**33,673**	**37,735**	**42,072**	**44,560**	**450,185**	**439,385**
Expenditure																
Pay	21,021	20,783	20,504	20,503	20,449	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	242,565	242,698
Revenue Creditors	10,936	9,868	12,177	12,670	14,447	8,302	8,302	8,302	8,302	8,302	8,302	8,302	8,302	8,302	138,599	114,007
Capital Creditors	19,424	3,039	2,672	936	808	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	20,896	44,621
PFI	11,861		11,653			11,653			11,653			11,653	11,653	11,653	35,376	69,918
PDC Interest	2,131				2,125										4,076	2,125
Financing							55								110	55
Total Expenditure	**65,373**	**33,690**	**47,006**	**34,109**	**37,829**	**44,560**	**32,962**	**32,907**	**44,560**	**32,907**	**32,907**	**44,560**	**44,560**	**44,560**	**441,622**	**473,424**
Closing Balance	**21,553**	**35,039**	**28,090**	**31,221**	**30,117**	**18,711**	**18,902**	**19,668**	**8,781**	**9,547**	**10,313**	**3,488**	**1,000**	**1,000**	**30,117**	**1,000**

Background

- Cash at the end of Month 9 was £35.0m which was above the planned level of £14.9m.
- The cash balance is above the forecast for Month 9 (£20.5m). This is due to the cumulative impact of additional H2 Commissioner funding as well as cash for ERF and slippage on the capital programme. This is partly offset by delay in drawing down PDC Capital.
- The Trust has met its target for the Better Payment Practice Code to pay 95% of invoices within 30 days in month. Detail can be found in Appendix 2.



Capital Programme

Use of Resources

Capital Scheme	Capital Group	2021/22 Full Year Plan £000	Month 9 plan	Month 9 Actual	Month 9 Variance	Month 8 YTD Plan £000	YTD Actual £000	YTD Variance £000
Aseptic Suite	Estates	1,903	302	-	(302)	1,522	170	(1,352)
Oxygen	Estates	500	-	-	-	500	500	-
Estates Replacement Schemes	Estates	1,050	225	3	(222)	575	9	(566)
Utilities (LV & Heating) Project	Estates	2,300	511	281	(230)	2,300	743	(1,557)
Pathlake (national funds requires matching)	IT	260	25	-	(25)	155	-	(155)
Pathology LIMS (network procurement)	IT	510	-	-	-	151	-	(151)
IT Emergency Infrastructure	IT	3,000	32	-	(32)	2,190	2,569	379
IT Replacement Schemes	IT	1,404	156	83	(73)	936	335	(601)
PACS - environment/replacement solution (Nov21)	IT	800	133	73	(60)	399	243	(156)
Equipment Replacement Schemes	Equipment	1,450	161	101	(60)	966	201	(765)
Contingency	Equipment	541	45	-	(45)	405	-	(405)
Total Trust CDEL		**13,718**	**1,590**	**541**	**(1,049)**	**10,099**	**4,770**	**(5,329)**
Way Forward Programme		9,690	914	112	(802)	4,205	581	(3,624)
Clover UEC		10,085	1,345	1,277	(68)	6,048	7,691	1,643
Total Capital Plan (Excl PFI)		**33,493**	**3,849**	**1,930**	**(1,919)**	**20,352**	**13,042**	**(7,310)**

Risks to delivery and mitigations

Slippage continues to be monitored through the Capital Management Group (CMG) to ensure a robust forecast and mitigations are in place.

Background

- Total Capital Expenditure at Month 8 is £7.3m below plan. Of this, £5.3m relates to Trust CDEL schemes, with the remaining £2.0m slippage on externally funded schemes.
- In line with previous months, all CDEL schemes are expected to spend the full allocation by year end with the exception of:
    - **Aseptics** – there continue to be contract discussions with this scheme which has resulted in further slippage in start date. Value of slippage is still estimated to be £1m but will be confirmed in the next month.
    - **Pathology LIMS** – a project group is being set up to identify and report in year expenditure and the impact this has on 22/23 allocations
- Slippage, risks and mitigations continue to be addressed through Capital Management Group with divisional and scheme representatives.
- Additional items to pull forward have been prioritised with Divisions, Procurement and Finance and approval to proceed has been given by CMG. This will mitigate in year slippage on the capital programme to ensure the full CDEL is spent by year end.
- Slippage on the Way Forward programme has been discussed and agreed with NHSI and the forecast for 2021/22 is £2.6m.
- The forecast for Clover UEC is to be on plan by year end.

Board Committee Assurance Report

Audit, Risk and Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Helen Spice	Helen Spice		13 January 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Divisional Risk Review – Integrated Care & Community	A	G/A	Good session with Integrated and Community Care team on their approach to managing their risks and the controls they have in place to mitigate their risks and the effectiveness of those controls. There are significant risks in delays to care that are impacting the division thus the amber rating for Risk. They are managing their risks well – thus the green rating. However if the actions rating is related to their process for managing risk this would be rated Amber as some concerns were raised on the process.	Report to ARAC at next divisional presentation.	TBC
Risk Register Report	A	A	The risk to patient safety for those who require emergency treatment has increased to 20 although there is no increase to the overall level of 15+ risks. There is ongoing challenges with the Datix implementation due to the transfer of data and so implementation has been paused. There has also been a loss of a small number of documents, although not relating to a complaint, investigation or response. These issues are being addressed but are not yet resolved.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Cyber Security Update Report	G	G	There is good progress with the cyber security action plan and ongoing investment. There has been no successful cyber attack on GWH computer systems and the GWH network has not been comprised over the reporting period. The committee were agreed that this risk is well managed and it is recognised that the NHS approach is seen as exemplar compared to other government areas. There is also good collaboration across BSW in this area.		
Theatre Programme Assurance Report	A	A	Update report on actions since the internal audit conducted in January 2020. Progress has been made in a number of areas but although a remedial delivery plan is in place there are still outstanding actions particularly in workforce. There is a lack of consistency in the job planning process which is impacting theatres but is also a wider issue across the trust. Useful benchmarking across 50 other NHS trusts shows GWH doing comparatively well in some areas but possibly challenged in Trauma and Orthopedics. The committee recognised there could be a number of reasons for this – specifically the outsourcing of straightforward cases.		
2020/21 Audit Plan	G	G	The committee received the Deloitte planning report for the 31 March 2022 audit detailing the plan for the audit, an update on the audit risks and the impact of regulatory changes. The handover from KPMG has gone well and the initial planning is underway with the interim work starting in the next few weeks.		
Internal Audit Progress Report	G	A	Audit work for the year is progressing well but due to the operational pressures at the Trust one review has been removed and a few others are delayed. BDO do not expect this to impact on their ability to provide overall assurance for the year but this needs to be monitored over the next few months to ensure work is not delayed further.		
Internal Audit – Key Financial Systems	G	G	This report noted Substantial for design and Substantial for Operational Effectiveness with two low priority recommendations, one of which has already been completed. The GWH finance team were congratulated on their achievements.		
Internal Audit – WHO Checklist	A	A	This report gave Limited assurance for Operational Effectiveness and Moderate assurance for design. This raised some concerns with the committee as this is the first Limited assurance report this year. There is one high priority recommendation with respect to the learnings from serious incidents and two medium priority recommendations on reporting issues from WHO audits and the reporting and escalation of high risk issues. There		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			is already focus on the WHO checklists by the Quality & Governance committee and action being led by the Medical Director to ensure improvement in this area. There will be a regular report to the committee on speedy completion of the actions.		
Internal Audit – Follow Ups	G	A	Progress continues to be made on outstanding actions but more information is required on long outstanding actions to give the committee assurance that timely action is being taken. It was agreed that in future the follow up on actions from internal audits should be led by Trust management who have the direct responsibility for completion of the actions.		
Counter Fraud Progress Report	G	G	Good update and progress on the work being undertaken. Two allegations have been received, one is now resolved and one is progressing. Both related to HR issues with no anticipated loss to the trust. The resolutions are being led by the HR team.		
Security Management Specialist Annual Report 2020/21	G	G	The annual report on the Trust's compliance with security standards was received with good compliance in all areas.		
Single Tender Actions	G	G	The committee reviewed the waivers carried out between 1 June and 30 November 2021 and agreed that good controls were in place to manage this process. It was noted that there were no waivers in this period in relation to Covid-19. One significant item accounted for around 50% of the total value of waivers and this had been approved by Finance and Investment Committee.		
Losses and Compensations Q3	G	G	Low level of write offs for Q3, the majority related to overseas debt. The committee approved the write offs but requested further information on the operation of the overseas patient process and on a salary overpayment.		

Issues Referred to another Committee	
Topic	**Committee**

Report Title	**Mental Health Governance Committee Annual Report 2020/21**				
Meeting	**Board of Directors**				
Date	**3 February 2022**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Wendy Johnson / Luisa Goddard				
Appendices	Annual Report				

Purpose

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

Assurance Level

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

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

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

Report

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

The Mental Health Governance Annual Report is attached in appendix 1. The purpose of the annual report is to ensure the Trust Board has oversight on the provision of the mental health component of care for our patients and our compliance with the relevant legislation between 01 April 2020 and 31 March 2021.

It describes the strong governance arrangements within the Trust to support patients with mental health concerns whilst in the Trust's care. The Trust had a Mental Health Operational Group which reported to the Mental Health Governance committee. MHGC is a sub board committee chaired by a Non-Executive Director (NED).

The report demonstrates how the Trust was compliant with the national guidance on how acute Trusts should care for patients who have a mental health component to their care.

The report highlights the collaborative working with Avon and Wiltshire Partnership Mental Health NHS Trust and with Oxford Health NHS Foundation Trust's Children and Adolescent Mental Health Services in providing the Trust's Mental Health services. However it also recognises the national and local challenges in Mental Health services and the actions taken to mitigate.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X			X	
					Risk Score
Key Risks – risk number & description (Link to BAF / Risk Register)	1125 Patients with mental health conditions requiring treatment in specialist Mental Health in-patient services may not have their mental needs fully met whilst at the acute Trust and awaiting transfer to the relevant specialist service due to the Trust being primarily an acute physical health care provider.				12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps					

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		X	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?		X	
Explanation of above analysis: the report provides the Trust with assurance that patients with mental health concerns are treated equitably.			

Recommendation / Action Required

The Board/Committee/Group is requested to:

- The Board is asked to approve the annual report

Accountable Lead Signature	Lisa S Cheek
Date	14/01/22

Great Western Hospitals NHS
NHS Foundation Trust

MENTAL HEALTH GOVERNANCE COMMITTEE

ANNUAL REPORT TO THE TRUST BOARD

April 2020– March 2021

The purpose of this report is to inform the Trust Board on the care of patients with Mental Health Concerns whilst under the care of Great Western NHS Foundation Hospitals between 01 April 2020 and 31 March 2021.

Contents

1. Introduction

The Great Western Hospitals NHS Foundation Trust will be referred to as 'the Trust' throughout this document.

This annual report provides assurance to the Board that the Trust met its statutory obligations and provided a quality Mental Health service to patients at the Trust between 01 April 2020 and 31 March 2021. The report will also ensure the Trust Board has oversight on the provision of the mental health component of care for our patients and compliance with the relevant legislation for 2020/21.

To support the delivery of high quality integrated mental health care the Trust had a Mental Health Operational Group (MHOG) which reported to the Mental Health Governance committee (MHGC). MHGC is a sub board committee chaired by a Non-Executive Director (NED).

The report will demonstrate how the Trust was compliant with the national guidance on how acute Trusts should care for patients who have a mental health component to their care[1/2/3/4] the main guidance being:

The Five Year Forward View for Mental Health (NHSE Mental Health Task Force Feb 2016) outlines the priority areas for Mental Health including the following for acute Trusts.

- Access to Mental Health Care 24/7 in Acute Trusts
- A 7-day NHS – right care, right time, right quality
- Integrated Care across the physical and mental health pathways
- Mental health promotion and poor mental health prevention

The report will also demonstrate the Trust's compliance in 2020/21 with the legislation detailed below.

2. Background

Under the requirements of the Mental Health Act[5] 1983, (MHA) and the Mental Capacity Act[6] 2005, (MCA) the Trust has a key responsibility for ensuring that patients with mental health issues are assessed, treated, monitored, and discharged/transferred under the requirements of the Acts as detailed below.
The Trust must:

- Ensure that patients who require detention are detained under the correct legal framework i.e., Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).
- Ensure that patients' treatment and care accords fully with the provisions of the Acts.
    - Patients are fully informed of, and supported in, exercising their rights.
- Patients' cases are dealt with in line with other relevant statutory legislation including Human Rights Act 1998, Mental Health Act 1983, Mental Capacity Act (including Deprivation of Liberty Safeguards) 2005, The Equality Act 2010, The Race Relations Act, Disability Discrimination Act 1995, or Data Protection Act 2018.

2.1 Mental Health Strategy

For 2020/21 the Mental Health Governance Committee agreed that a standalone Trust Mental Health strategy was not required given the detail of the work-plan and the swiftly changing landscape of Mental Health Policy and Practice.

3. Core Mental Health Services within the Trust

Provision of Specialist Mental Health Services at GWH was provided by Avon and Wiltshire Partnership (AWP). This was contracted through the Clinical Commissioning Group (CCG) to provide Mental Health Liaison Services for the Trust and the other acute hospitals in BaNes, Swindon, and Wiltshire area (BSW).

The Service Level Agreement was last updated in 2018/19. Due to the block contract arrangements during the pandemic, it was agreed to continue with this agreement in 2020/21. The Service Level Agreement covered all patients 18 years and above presenting to Emergency Departments and / or admitted to the acute hospitals.

Avon and Wiltshire NHS Partnership Trust Mental Health Liaison Service (AWP MHLT) had the following Key Performance Indicators (KPI) for referral to assessment time:

- 1 hour emergency in hours
- Urgent same day
- Non-urgent referrals 24hrs*

*The Mental Health Liaison Team at GWH followed the PLAN accreditation standards for 'Routine' referrals of 48 hours, although few referrals were considered 'routine'.

The quality indicators were laid out in the Service Level Agreement and were monitored through the CCG and the Mental Health Governance Committee.

3.1 Mental Health Liaison Team - Adults of Working Age

The service was provided by the Avon and Wiltshire NHS Partnership Trust Mental Health Liaison Service between the hours of 8am and 10pm seven days a week. The Mental Health Liaison Service completed assessments with patients coming through the Emergency Department as well as providing a service on the wards. The Avon and Wiltshire NHS Partnership Trust Intensive Team covered the out of hours service (10pm - 8am) and were based in the Observation Ward at the Trust. The Intensive Team's remit was to complete Emergency Department assessments. The service did not cover the wards at night. There was a Trust 'IRespond' (serial Number 00.036) for managing mental health concerns 'out of hours' with contact numbers and mitigations if required.

3.2 The Dementia Specialist Team and Older Adults Liaison (Dementia and Later Life Liaison team)

The service covered both the acute hospital and care homes across Swindon. The liaison function was to support older people with mental health problems who were admitted to the hospital and to support a smooth discharge back to the community. The care home function was to offer assessment and intervention for people with Mental Health illness who resided in care homes to promote wellbeing and to avoid hospital admissions where possible. The service operated between 8am – 8pm Monday to Friday. Referrals were accepted from across the hospital. There was no commissioned service for Older Adults over weekends, although the Adults of Working Age team provided advice in emergencies for older adults with functional illness.

3.3 Substance Misuse Liaison Service

The service operated throughout the hospital and offered assessment and brief intervention for service users with problematic drug and/or alcohol issues of any severity. The service also linked the Trust with the community drug and alcohol service 'Turning Point' and supported onward referrals for service users referred to them as appropriate. The service covered the inpatient wards and Emergency Department only, so outpatient and day services referred directly to 'Turning Point'. The substance misuse liaison service operated Monday to Friday with varying hours daily between 8am - 8pm.

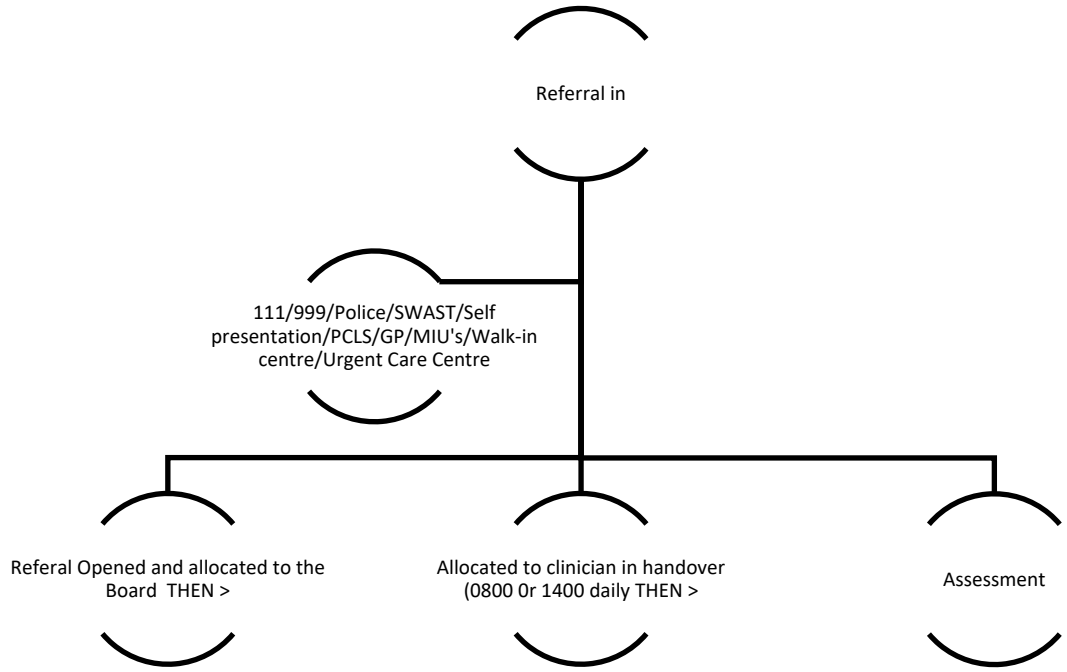
3.3.1 Dual Diagnosis Drop in Clinic

A joint project between Avon and Wiltshire NHS Partnership Trust and the Trust's Emergency Department commenced in July 2019 and continued throughout 2020/21. The service offered patients with identified alcohol intake concerns presenting at the Emergency Department a referral for a same day face-to-face consultation with the substance misuse service. The service provided early intervention opportunities and supported the work with high intensity users. Clinic appointments were available Wednesday and Thursday 11am - 12pm.

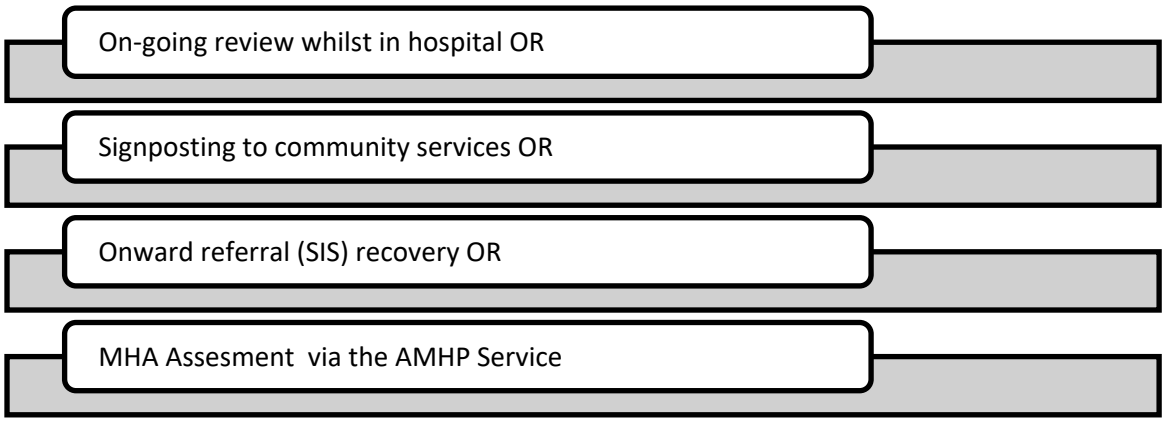
Table 1. Statistics of referrals to the Mental Health Liaison Service and the Substance Misuse Service

Service	**Numbers of referrals 2020/21**	**Numbers of referrals 2019/20**
Adults of Working Age	2001	2046
Older Adults – Dementia and Later Life	(hospital referrals) 536	(hospital referrals) 472
Substance Misuse	555	458

The process for Adults of Working Age awaiting mental health assessment or mental health placement/follow up review during 2020/21 is described below in picture 1.



With the following onward referral options:



Picture 1. Patients waiting mental health assessment or mental health placement/follow up review.

The working practice for the Avon and Wiltshire NHS Partnership Trust Mental Health Liaison Service is described below:

- Patients were seen in order of priority but within key performance indicators
- 'Priorities' were patients presenting with high risk and/or violence/aggression behaviours
- The Trust's staff completed the Mental Health risk matrix assessment to help guide who required urgent or emergency mental health assessment.

3.4 Emergency Department Observation Ward

Most patients who attended the Trust with mental health concerns also had physical health needs and a requirement to attend the Emergency Department. However, once a patient's physical health needs had been addressed, many patients required further mental health assessment, either informally or more formally under the Mental Health Act.

In line with national guidance, the Emergency Department has a separate area which is a suitable environment to support someone in mental health distress. This area is known as the 'Observation Area'. The environment was assessed as meeting Psychiatric Liaison (PLAN) accreditation standards and includes two assessment rooms, a 'ligature free' bathroom, two and four bed bays with mix of recliner chairs and beds, a multi-disciplinary team office which included members of the mental health liaison team and alcohol liaison nurse. The nurses' station is located to ensure 'line of sight' observation of all patients in the in-patient area making this an appropriate clinical area to support patients with mental health concerns and safe working area for staff. The electronic security system was in place and live in this area.

There was an agreed admission criterion for admission to this area, any admission decision was led by the most senior clinician on duty, and this was usually an Emergency Department Consultant.

The national shortage of specialist mental health beds and increased pressure on mental health services because of the pandemic resulted in increased length of stays in this area for patients either waiting assessment or specialist inpatient beds. These delays were monitored closely throughout the year and individual patients were escalated appropriately. The Trust worked collaboratively with the CCG and Avon and Wiltshire NHS Partnership Trust to support alternatives to the emergency department and other work streams to improve the situation across BSW.

3.5 Maternity and Children Mental Health

3.5.1 Perinatal Mental Health

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of women and covers a wide range of conditions. If left untreated, it can have significant and long-lasting effects on the woman and her family. Perinatal mental health problems can also have long-standing effects on children's emotional, social, and cognitive development.

Over 2020/21, Maternity services worked closely with the Specialist Perinatal Mental Health team to plan and coordinate care for those women at the highest risk. In line with the NHS Five Year Forward view[1], there was an expansion of Perinatal services to deliver assessment and intervention for those who have experienced loss, for example miscarriage or bereavement, and to women with a presenting need of Post Traumatic Stress Disorder. New Maternal Mental Health clinics were set up that integrate maternity, reproductive health, and psychological therapy.

Service improvement actions for 2020/21 included increasing the availability of specialist community care for women who needed on-going support from 12 months after birth to 24 months. There was also work, in recognition of the important role that partners play, for mental health checks and signposting to support for partners of those accessing specialist Perinatal Mental Health community services.

Alcohol and substance use in pregnancy can result in poor perinatal outcomes such as miscarriage, preterm birth, and low birth weight along with long-term consequences for children such as neurological changes.

During pregnancy women with problematic substance use continued to be offered rapid access to local support from 'Turning Point' Drug and Alcohol service. Turning Point worked alongside Maternity and Social Care to support individuals.

A key element of the 'Saving Babies Lives' care bundle was to reduce smoking in pregnancy. To meet this improvement action, Community Midwives recorded the smoking status of every woman at the booking appointment. All women had a Carbon Monoxide (CO) screening, and the results were documented in the notes. Women who smoked or who had high CO levels are referred to the Smoking Cessation Midwife.

In 2020/21 there was work within Maternity to develop further links with Sexual Health services to offer postnatal contraception to women in the first few days following birth, before discharge from the postnatal ward. This service was particularly helpful for vulnerable women who may have found it difficult to access services in the community. The Contraceptive Outreach Team were proactive in following up and engaging vulnerable groups.

3.5.2 Children and Adolescent Mental Health Service (CAMHS)

Oxford Health NHS Foundation Trust continued their CAMHS transformation work across Banes, Swindon, and Wiltshire (BSW) throughout 2020/21. CAMHS were one of the agencies contributing to the Community Services Framework which aimed to create community hubs with joint working between all age mental health and physical health services. These projects had new funding attached and business plans were submitted for CAMHS roles as part of these services. At the start of 2021 CAMHS received funding for new CAMHS eating disorder clinical posts in five teams and commenced a recruitment process for these new posts.

CAMHS also received funding to set up a new Crisis and Home Treatment Service, which aimed to offer an enhanced crisis service with a more comprehensive and intense home treatment offer. The CAMHS service started the recruitment and operational plans to deliver this service in quarter 4 of 2020/21.
The main challenges for Oxford Health CAMHS in 2020/21 were the increasing number of referrals for children and young people with an eating disorder and for those with urgent and severe mental health difficulties. This included a significant increase in hospital liaison referrals. This was compounded by the national shortage of CAMHS clinicians and the difficulties recruiting to some posts.

The CAMHS service continued to run the 'Thames Valley Tier 4 single point of access system', coordinating psychiatric inpatient beds. In 2020/21 the national shortage of Children and Young Adult inpatient beds was further compounded by the closure of some beds in the South West due to staffing issues. The CAMHS inpatient psychiatric unit in Swindon, Marlborough House, was one of several units across the country trialling a 'hospital at home' treatment offer to support Children and Young Adult to leave hospital earlier or to prevent admission. The success of this project will in evaluated in 2021/22.

The CAMHS Hospital Liaison continues across BSW. The second liaison post at the Trust has been made permanent which gives similar level of service across the acute Trusts in BSW. This post has been recruited to and expected to start in early 2021/22. CAMHS developed three new roles, one at each acute Trust for a CAMHS eating disorder liaison clinician.
All Covid 19 based restrictions on liaison hours ended in the second half of the year.

Avon and Wiltshire NHS Partnership Trust commenced an independent review of children and young people's mental health services in Swindon, focused primarily on CAMHS, TAMHS and the mental health in school's trailblazer team. The outcome will be published in October 2021.

3.5.3 Children's Ward and Paediatric Emergency Department

In line with national trends the Trust Children's ward supported increasing numbers of children requiring mental health support. The ward received support from the CAMHS team and uses specialist registered mental health nurses when required. There were regular meetings between the senior ward staff and CAMHS team to improve the care of patients with mental health concerns on the ward.
This collaborative working resulted in additional training for staff, reflective sessions, and the introduction of meetings to discuss complex patients and discharge planning.
A 'Safe holding /restraint' policy has been developed and implemented by the ward manager.

The Ward senior staff began to develop plans to have a Mental Health 'safe room' on the Children's ward to support children and young adults in mental health distress. In addition, a Mental Health proforma was developed and implemented to support staff in the risk assessment of the young person with Mental Health concerns and the necessity for specialist registered mental health nurse's support.
Planning was started for the implementation of Liberty Protection Safeguards for the children's service, the new process will include young people aged 16 and 17 years old. It is not currently known when this new legislation will be introduced.

3.6 SDASS Health Independent Domestic Abuse Advocate (IDVA)

The Health IDVA service was commissioned by the Wiltshire Police and Crime Commissioner's office and provided through the Swindon Domestic Abuse Service (Formally Women's Aid).

The Health IDVA provided information, advice and support to victims of domestic abuse (staff and patients). The postholder also provided training to staff on the identification of domestic abuse and how to refer into the service. The post holder worked closely with the safeguarding, mental health liaison, alcohol liaison and sexual health teams.

The Health IDVA provided a weekday service between 9am – 5pm with the IDVA being on site at the Trust during 9am – 2pm. Outside of these times is covered by the Swindon Domestic Abuse Service 24-hour Helpline.

Table 2 shows the referral of cases from the Trust to the Health IDVA for 2020/21. The Covid19 pandemic lock down had a significant impact on domestic abuse cases with evidence of a surge from June 2020. This figure continued to rise throughout the year.

Table 2: Referral of cases from GWH to the GWH Health IDVA

Referrals by Quarter	Q1	Q2	Q3	Q4
Total	**87**	**74**	**101**	**84**

Training /awareness sessions provided by the IDVA were put temporarily on hold due to the pandemic. These were recommenced during quarter 4 2020/21 and included student nurse training at Oxford Brooks University and medical student training. The Health IDVA also set up regular drop in sessions within the Sexual Health Department.

Domestic Abuse and Violence / Modern Slavery and Human Trafficking were standing agenda items on the Safeguarding Adults at Risk Operational group meetings.

3.7 Duty to Refer - Homelessness

Changes to the Homelessness Reduction Act (2017) were brought into force in October 2018, introducing 'Duty to Refer' to respective authorities' patients who are homeless or at risk of homelessness. Stand-alone guidance for staff were developed and fully implemented. Links were made with relevant partner agencies and a homeless action plan completed. To support the Homelessness Duty to Refer agenda, and through honorary contracts, Housing Officers from Swindon Borough Council Housing Options Team had been based on site at the Acute Trust site two days per week. This arrangement was paused due to COVID-19 restrictions but will be resumed when national work-place guidance advises it safe to do so.

Table 3: Trust referrals to the Housing Options team 2020/21

Referrals by Quarter	Q1	Q2	Q3	Q4
Total	**15**	**11**	**4**	**4**

4 Key Mental Health Services outside the Trust

4.1 Bluebell, Place of Safety Devizes (Section 136 Mental Health Act)

'Bluebell Place of Safety' is the service designed to support timely access to MHA assessment for patients placed under a Section 136 of the MHA by the police. Since inception the service has been working well however there are instances whereby it is used by other counties when their 'place of safety' is at full capacity. This can impact on the availability for the Police to access Bluebell for people under Section 136 from the Swindon and Wiltshire area.

Lack of capacity at the Bluebell Unit also has the potential to impact on the Emergency Department at the Great Western Hospital as those under Section 136 will be brought to Emergency Department as a 'place of safety' even though they have no physical reason to be in Emergency Department. A lack of under 18 years of age Mental Health beds can also impact on the capacity of Bluebell as if a child is in the unit, it cannot be used for others under Section 136.
Nationally, the default when there is no space at the Place of Safety is for Police officers to wait with their Section 136 detainees in the Emergency Department of the local hospital.

In mitigation, the Trust lead for Mental Health developed a local Section 136 protocol for use between the Police and Emergency Department to ensure both agencies agreed regarding situations where prolonged police presence was required to maintain both patient and staff safety. Impact on the Trust was monitored throughout the year and discussed at the Mental Health Operational Group, the numbers noted were minimal and there was appropriate management and escalation.

The main concern was the lack of onward flow from the Place of Safety. Before the pandemic there were a small number of breaches (patients in the Place of Safety over 24hrs) each month however there was a significant increase in breaches in 2020/21. This impacted the Trust on occasion when the Place of Safety was full and resulted in longer waits in the Emergency Department.

4.2 Engagement with key multi-agency partner agency

The Associate Director for Safeguarding, Lead for Mental Health attended the following relevant meetings with key partner agencies:

1. Mental Health, LD, Autism Partnership: BSW/CCG recovery meeting
2. DA and VAWG (Domestic Abuse) Board
3. Serious Violence Reduction Meeting
4. Emergency Department, police, mental health, safeguarding interface meeting
5. MACCP meetings (Multi agency care planning meetings)
6. BSW Mental Health Crisis Concordat meeting
7. Suicide Prevention Group meetings

5. Governance Arrangements

All hospitals must have governance arrangements in place to scrutinise the discharge of a range of responsibilities under the Acts. The Acts do not outline a general requirement of governance arrangements and, as such, it is a matter for the Trust to determine. Integrated governance arrangements (involving mental health liaison and senior clinical staff) are also recommended through NICE (2017) and must be in place with Emergency Department and other general hospital departments.

5.1 Mental Health Practice Assurance

A key responsibility of a governing body is gaining assurance that significant risks to the achievement of strategic organisational objectives are being effectively managed. Assurance was provided to the Mental Health Governance Committee through the dashboard.

The Dashboard has been developed over the past two years and includes mandatory training compliance, audit, risk management and incidents in relation to what is happening in relation to Mental Health risk across the Trust. The trends and themes identified inform the direction of policy development and practice guidance. Focused support can be provided for areas identified via the risk monitoring process and themes were disseminated through the Divisional Governance routes to ensure wider opportunities for learning, and for sharing best practice. The learning from the dashboard also informed the content of the annual work plan.

Agreed Key performance indicators (KPI's) for the AWP Mental Health Liaison Service (MHL) were also monitored via this dashboard and the Trust monitored, and escalated when appropriate, regarding AWP service delivery and adherence to key performance indicators.

5.2 Management of Risk

The Trust has embedded policies and procedures in relation to managing violence and aggression and work with the Police and SERCO to manage situations and work to differing procedures dependent on the persons Mental Capacity at the time of any events. Risk was monitored through operational meetings, the Mental Health Dashboard and through quarterly audit. Governance was through the Mental Health Operational Group to the Mental Health Committee.

Risk registers for Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards[7] were in place and monitored through the Mental Health Governance Committee and the Operational Group. Risks were managed in accordance with the new Governance framework and were reviewed at each committee and operational group meeting. Risks were included on the Trust Risk Register and were monitored at the Audit Committee.

5.2.1 Serious Incidents (SIs)

There was one incident reported (2019/19835) directly relating to patients with a primary mental health presentation that met the criteria for a serious incident investigation. Learning from Serious Incidents and case reviews were a standing agenda item on the Trust Mental Health Operational Group and Mental Health Committee agendas. Learning was also reflected in the mental health work plans and contextually relevant action plans. There was a robust system in place for identifying, monitoring, and responding to contextual risk.

5.2.2 Risk Register

There is currently 1 risk on the risk register (1125) in relation to Mental Health Service Provision at the Trust with mitigations in place to reduce the risk.
Risk overview:
'*Patients with mental health conditions requiring treatment in specialist Mental Health in-patient services may not have their mental needs fully met whilst at the acute Trust and awaiting transfer to the relevant specialist service due to the Trust being primarily an acute physical health care provider Safe Mental Health'*

Risk escalation and monitoring of actions/ mitigations was through the Mental Health Governance committee.

5.2.3 Coroner's Inquests

The Trust was involved in four Coroner Inquest cases during 2020/21 regarding mental health/mental capacity patients. Two of the four cases were Wiltshire Coroner cases with a third being Manchester coroners' case, and a fourth case being Gloucestershire. Two of the cases have dates set for the Coroner's Inquest with two cases yet to be set Inquest dates.

The Trust Lead for Mental Health identified learning for the Trust from other agency Coroners Cases and presented relevant cases at the Mental Health Governance Committee to ensure shared learning and organisational awareness of any potential issues or areas of good practice are identified. 'Coroners' inquests' is a standing agenda item at the Mental Health Governance Committee Operational Group meetings.

5.2.4 Acute Behaviour Disturbance (ABD)

Acute Behaviour Disturbance is a very specific presentation of violence and aggression carrying significant clinical risk. The behaviour can be related to drug abuse or serious mental illness. Concerns have been raised from the Trust's Emergency Department, Police, AWP, and the Approved Mental Health Professional (AMHP) regarding this group of people as, due to their presentation of violence and aggression, it is very difficult to assess the person to decide regarding best practice, appropriate treatment, or appropriate treatment location.

Where identified, risk in this regard was monitored through the Mental Health Governance operational group and the liaison meetings with Emergency Department, Mental Health Liaison and Police Liaison. Updates and any concerns were taken to the Mental Health Governance Committee.

6. Mental Health Governance Committee

At the Trust, the Mental Health Governance Committee monitored the application of the Acts and advised the Board on issues that may affect its duties under the Acts. The Committee met four times in 2020/21 and minutes of the Committee were noted at Trust Board.

The committee membership had a change in the Chairperson during this year as the current Chair stood down and a new Non-Executive Director (NED) joined. The Committee are waiting confirmation of the third NED to join the Committee.

The Committee's Terms of Reference were also reviewed an updated in line with the Sub Committees of the Trust Board.

On behalf of the Mental Health Governance Committee, the Associate Director for Safeguarding, Trust Lead for Mental Health, Learning Disability and Prevent, links in with key partners to ensure that there is an integrated approach to delivery of care. This includes Swindon Advocacy Movement (SAM) regarding Independent Mental Health Advocates (IMHA), Independent Mental Capacity Advocates (IMCA) and DoLS Paid Relevant Person's Representative (PRPR) services, Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) and Supervisory Bodies for Swindon and Wiltshire.

Divisions provided an annual update to the Committee on their work and any concerns they had within their Division regarding mental health. The Committee also received an annual update on work being undertaking on Trust wide Dementia projects.

6.1 The Mental Health Governance Committee Operational Group

The NICE Evidence based treatment pathway (2017) requires Trusts to have regular meetings involving professionals from both mental health and acute medicine, with clear reporting lines to hospital boards and links to other relevant in- hospital professional groups. The Mental Health Governance Committee Operational Group at the Trust fulfils this requirement, reviewing existing systems and processes and sharing learning across agencies, to support the delivery of mental health services according to the relevant Acts. The group met bi-monthly and reported to the Mental Health Governance Committee. The Operational group is a sub-group of the Mental Health Governance Committee and was chaired by the Associate Director for Safeguarding, Trust Lead for Mental Health, Learning Disability and Prevent.

This group met bi-monthly and had a multi-agency membership that include Great Western Hospital NHS Foundation Trust, Avon & Wiltshire Mental Health Partnership NHS Trust (Adults of Working Age and Older People Liaison Service), Oxford Health NHS Foundation Trust (CAMHS), Approved Mental Health Professionals (AMHP's – Swindon and Wiltshire Local Authority), Swindon Advocacy Movement (IMHA and IMCA), Wiltshire Police Mental Health Liaison Officer, Mental Capacity Act/Deprivation of Liberty Safeguards Team, Swindon Borough Council and Serco Health.

The meeting provided a collaborative, multi-agency forum for the Trust and other agencies to identify day-to-day mental health issues that arise within the Trust.

The operational group provided assurance to the Mental Health Governance Committee, developed robust system and processes to meet the requirements of the Acts and advised the Trust on aspects of policies, standards, clinical pathways, and service delivery that are pertinent to the Acts.

6.2 Mental Health Partner Agency Interface Meeting

The Mental Health Partner Agency interface meeting was chaired by the AWP MHLT manager and was an interface meeting between the Trust's Emergency Department Consultant, Emergency Department Mental Health Link Nurse, Associate Director of Safeguarding, SERCO security team, the Trust's Risk Manager, AWP Mental Health Liaison Team and Wiltshire Police Mental Health Liaison Officer. This meeting was held monthly, although some were missed due to operational issues.

The meeting was a partner agency opportunity to learn from incidents and discuss risks with a view to understanding operational challenges, and any need for pathway change or development. This meeting has proved very successful in building positive working relationships and therefore, supports the delivery of high-quality mental health care across the system. Routine agenda items included any adverse incidents/incident reports, practice in Emergency Department observation ward, Police/ Emergency Department interface or any cases to discuss, Mental Health projects and management of repeat attenders.

7. Staff training and Education

Healthcare staff have a duty to make a holistic and systematic assessment of physical, mental health, emotional, psychological, cultural, spiritual, and social needs. To do this they need access to training and education that will support confidence in this field, promote excellence in practice, and will service to ensure there is a parity of esteem between physical and mental health aspects of care. To this end further collaborative work has been undertaken in 2020/21

between the Trust's Mental Health and Academy leads, and AWP to create practical and sustainable solutions to capability and capacity building for mental health care in the acute service.

The core competence training is the mandatory Mental Health Level 1 and 2 e-learning platform modules, which have been live since May 2017. The Trust offered the following training opportunities for Trust staff in 2020/21:

1. Level 1 and 2 stand-alone Mental Health E-Learning Platform modules for both patient and non-patient facing staff. These modules consider the importance and management of both patients' and staff mental health concerns
2. Internal referral process to AWP for any patients who require enhanced care to support around appropriate medication and behaviour management
3. Regular study days for clinical staff in the Emergency Department, supported by AWP, as part of the regular Emergency Department Education programme. In 2020/21 the following subjects were covered:
    - Risk assessment
    - Risk management
    - Application of the Mental Health Act, Mental Capacity Act, Consent and Capacity in Emergency Department
    - Human Trafficking/Human Exploitation
    - County Lines
    - Domestic Abuse/DASH risk assessment
4. Named person from AWP worked collaboratively with the Intensive Care team regarding complex case management
5. Aligned courses were available through the Academy:
    - SCOPE Course (Older Persons Care)
    - Compassionate Care Course (Management of behaviours that challenge)
    - Cavendish Certificate (Care Certificate HCA's)
    - Wide-reaching Dementia Care Programme
1. An Advanced Mental Health Act (MHA) e-learning platform module has been developed for Clinical Site Managers (CSM's) and was launched in October 2019
2. With the inception of the new perinatal Mental Health Service there is an internal training focus on perinatal Mental Health

The following were also offered as standalone (on request) face to face or TEAMS training sessions:

1. Hoarding and self-neglect
2. County lines
3. Modern Slavery / Human Exploitation
4. Sexual Exploitation
5. Case study risk assessment/ Management psychological harm
6. Homelessness, Duty to Refer
7. Safeguarding Adults including supervision
8. Mental Capacity Act
9. Deprivation of Liberty Safeguards (DoLS)
10. Consent for Clinical Staff
11. Consent and Capacity/Decision making/MCA
12. Domestic Abuse and DASH
13. MCA Consent, Capacity and Best Interest Module developed and launched in Quarter 1 2020/21. This module has been developed as part of the MCA 'Safer Care' work stream

The following new courses were available from quarter 4 2020/21:

1. The Adult Safeguarding team offered a bi-monthly MCA 'Master classes via TEAMS to support staff confidence and competence in consent and best interest processes. The training was advertised via the Trust Academy website and was facilitated by the Associate Director of Safeguarding
2. The Associate Director of Safeguarding worked with AWP MHLT to develop a training programme for staff who works with patients with mental health concerns. This programme will be launched in May 2021 for any staff member who has a role for which this training would be relevant and useful.

8. Psychiatric Liaison Accreditation Network (PLAN) Standards

PLAN works with services to assure and improve the quality of psychiatric liaison in hospital settings. PLAN engages staff and patients in a comprehensive process of review, through which good practice and high-quality care are recognised and services are supported to identify and address areas for improvement.

The current Emergency Department observation ward that houses the mental health assessment rooms and the MDT team, has been designed according to PLAN accreditation standards. Accreditation assures staff, patients and carers, commissioners, and regulators of the quality of the service being provided.

The Trust have benefitted from the AWP MLHT service being a PLAN accredited since 2017. The MHLT completed the review process in November 2020 and will be advised of the outcome in August 2021.

9. Policies/Protocols/Guidelines

Robust policies and practice guidance empower staff to act appropriately when faced with clinical situations that can be complex and challenging.

Several policies and protocols/guidelines relevant to the provision of safe and effective mental health practice were developed and/or reviewed and were accessible for all staff at the Trust under their specific speciality on the Trust wide documents on the T drive.

The documents include:

- Clinically Challenging Behaviour in Adult In-patients Management Guidelines – new guidance ratified December 2020
- Minimising the Risk of Self-Harm (Including Ligature Risk and Search for Harmful Objects) for Adult In-Patients Clinical Guideline – reviewed and ratified July 2020
- Positive Behaviour Management (Physical Restraint) in clinically violent and Aggressive Adult In-Patients Policy – reviewed and ratified May 2020
- Mental Capacity Act (MCA) (2005) Policy and Procedures – reviewed and ratified July 2020
- Admission Transfer and Discharge of Adult Inpatients in the Acute Trust Policy – reviewed and ratified September 2020.

10. National Institute of Clinical Excellence (NICE) Guidance

10.1 'Core 24' NICE Guidance

There is no single NICE guideline or quality standard for urgent and emergency mental health that defines NICE recommended treatment and care in liaison mental health services, but the Expert Reference Group considered the following to be directly relevant:

- Alcohol-use Disorders: Diagnosis and Management (NICE quality standard 11)
- Borderline Personality Disorder: Recognition and Management (NICE clinical guideline 78)
- Dementia: Support in Health and Social Care (NICE quality standard 1)
- Personality Disorders: Borderline and Antisocial (NICE quality standard 88)
- Self-harm (NICE quality standard 34)
- Service User Experience in Adult Mental Health Services (NICE quality standard 14)
- Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services (NICE clinical guideline 136)
- Violence and Aggression: Short-term Management in Mental Health and Health

The guide sets out an evidence-based treatment pathway for people presenting in hospital settings in mental health crisis who require urgent or emergency mental health care.

The Department of Health requires at least 50% of all Acute Trusts to have 'Core 24' mental health services by 2021. The Trust does not currently benefit from a full 'Core 24' service for either service or performance but does offer a robust mental health service in some form to our patients who present to both Emergency Department as emergencies and as in-patients. The service did not meet core targets for MHLT response times and performance was monitored via the Mental Health Dashboard. The Trust was sighted on how the commissioned service benchmarks against 'Core 24' standards and contributed at relevant BSW meetings where service development is discussed.

10.2 NG108 Decision Making and Mental Capacity

The above guidance was published in October 2018. Regarding the 140 standards within the NICE Guidance 97 were relevant to Acute Trusts and consequently, were subsequently benchmarked against current Trust practice. Positively, all standards were either partially or fully met. A formal SMART multi-disciplinary action delivery plan has been developed and was worked through in relation to all partially met standards. Internal monitoring of progress is through the Patient Quality Committee and the Mental Health Governance Committee.

11. Domestic Homicide Reviews (DHR's)

The Trust Lead for Safeguarding and Mental Health was actively involved in the multi-agency DHR's, producing involvement reports when required and are actively engaging in the learning process. Any Trust actions and opportunities for learning are logged and delivered throughout the Trust through various governance routes via the Safeguarding Adults Team. A DHR action tracker was developed to ensure oversight and delivery on actions and monitored through both the Mental Health Governance Committee and the Maternity, Adult and Children Safeguarding Forum.

12. Audit Programme

The audit programme for 2020/21 reflected the themes coming through the risk management and review of mental health incidents and was designed to focus on specific areas of practice of concern. Consequently, the following audits were undertaken in 2020/21.

12.1 Absconding from the Hospital Risk and Process Evaluation Audits

Quarterly informal multi-agency audits took place with SERCO/ the Trust and Police to provide assurance regarding Trust staff practice in relation to response to missing persons and appropriate use of restraint. In previous years this audit has been formally undertaken annually, however, by undertaking the audit quarterly a timelier review of staff practice has been enabled and in turn, an increased knowledge of both presenting risk and the appropriateness of the risk response has been acquired. This process has served to inform operational level changes in practice for SERCO, Wiltshire police and the Trust. The police have advised that we are the only Acute Trust they work with, that undertakes this level of practice scrutiny.

12.2 MCA and Safeguarding Adults at Risk Annual Audit Programme

The Safeguarding Adult at Risk, MCA and DoLS Audit has been carried out annually since 2015. The audit looks in detail at compliance in Safeguarding Adults at Risk, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

All elements of 2019/20 safeguarding and MCA audit actions have been completed. The 2020/21 audit has been completed (CP-174/1) with indication showing improvement across all audited areas of practice.

Table 4 The Safeguarding Adult at Risk, MCA and DoLS Audit 2018-20

OVERALL TRUST COMPLIANCE	**2018**	**2019**	**2020**	**% Variance 2018/19 – 2019/20**
Safeguarding	52/54 (96%)	50/57 (88%)	68/74 (92%)	↑**4%**
Deprivation of Liberty	51/61 (84%)	62/71 (87%)	85/91 (93%)	↑**6%**
Mental Capacity	320/363 (88%)	239/274 (87%)	59/65 (91%)	↑**4%**
Total:	423/478 88%	**351/402 87%**	**212/230 (92%)**	↑**5%**
Overall compliance year in year improvement	**88%**	**87%**	**92%**	↑**4%**

The audit sample provided assurance that staff were able to recognise the acid test for DOLS and are making appropriate applications. There is also evidence to suggest that staff were embedding the MCA to support decision making.

The following areas were identified for improvement and an action plan has been developed to address:

- Best Interest decision making
- Professional curiosity in domestic abuse situations where the perpetrator is not the partner
- Patient information leaflets distribution on every occasion a patient is placed under a Deprivation of Liberty (DoLS) order

13. Use of the Mental Health Act in the Trust

Use of the Mental Health Act was reviewed by the Mental Health Governance Committee and its Operational Group on a quarterly basis via the Mental Health Dashboard. The Mental Health Governance Committee considered the data at each meeting and the annual figures were included in the Trust's Annual Report. From 1 April 2020 – 31 March 2021 the Mental Health Act was used on 86 occasions in regard of Sections 5(2), 2, 3, 17, 19, 23, 136 for a total of 71 patients. (Anonymous data presented in Appendix 2). The Board can be assured that all Section 2 and Section 3 detentions were subject to Medical Scrutiny within the legal framework.

14. Managers Hearing

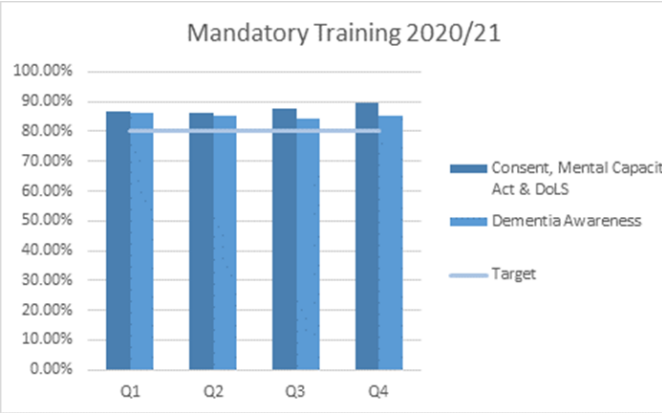
There were no requests for Managers Hearings during 2020 – 2021.

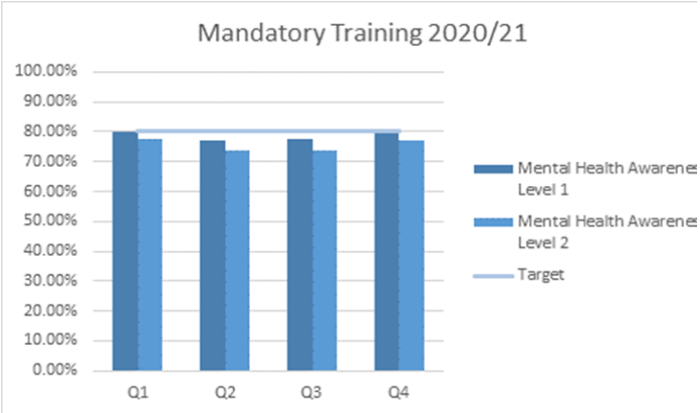
15. Mental Health First Tier Tribunal

There were no requests for Mental Health First Tier Tribunal during 2020 – 2021.

16. Mandatory Training and Education

The training compliance rates were taken from the Electronic Staff Record (EPR) and comprised of a mix of face to face, basic awareness induction and training tracker (e-learning).





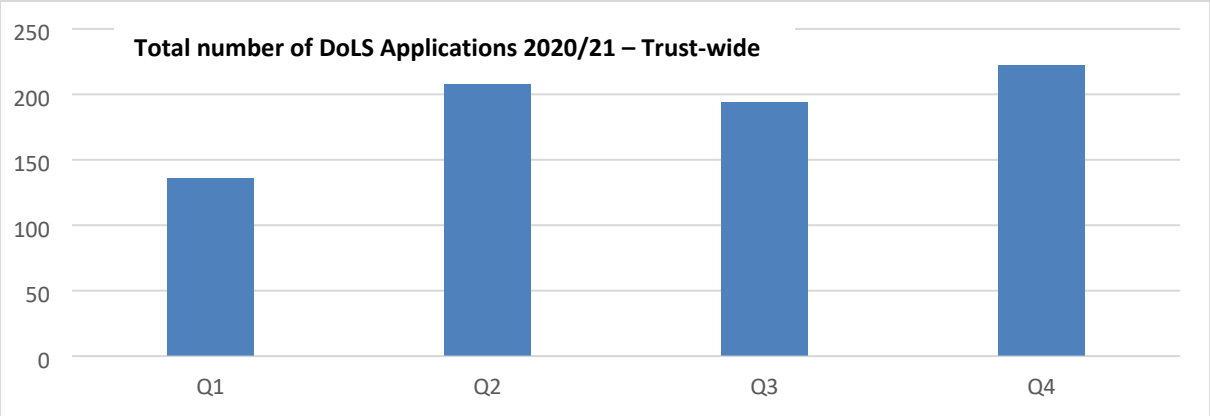
17. Mental Capacity Act

17.1 Deprivation of Liberty Safeguards (DoLS) applications

The team continued to be responsible for maintaining a Trust wide monitoring database of all inpatients who meet the acid test requirements of what now constitutes a Deprivation of Liberty as laid down by the Supreme Court Judgement in March 2014 and the Trust have made a formal application for authorisation to detain the patient in their best interests under the Safeguards.

The total number of applications made across all inpatient areas for 2020/21 was 762, this should be contrasted against a total of 626 during 2019/20.

The Chart below details the number of quarterly DoLS applications made by the Trust and illustrates stability in the number of applications across the organisation.



The data identifies that not all eligible patients received the statutory assessments required by the Supervisory body (due to demand on Supervisory Bodies following the increase in eligible patients) to authorise the standard application. Therefore, once the Urgent and the Extension of the Urgent authorisation period has expired these patients remain under the Trust's care outside of a legal framework. This risk is acknowledged and is on the Trust Risk Register as we recognise the patient is potentially being deprived of their liberty without the legal safeguards in place potentially interfering with their Article 5 Human Rights. As an organisation every such case is evidenced and logged via the Trust's Incident Reporting system.

17.2 Deprivation of Liberty Standards (DoLS) > Liberty Protection Safeguards (LPS)

Liberty Protection Safeguards' (LPS) are the proposed new set of statutory restriction safeguards that will replace DoLS legislation. LPS stipulates that whoever is providing or comissionning care (i.e the Trust) will become the 'responsible body' with responsibility for arranging assessments, authorising detentions, monitoring and take responsibility for reviews and appeals.

The legislation received Royal Assent in May 2019 with a forward plan for national role out from 01 October 2020, however due to the impact of the COVID-19 pandemic this has now been postponed with the date to be confirmed. The Trust continues to wait the Code of Practice and training plans. The Trust has begun an implementation plan and worked with relevant professionals across BSW to ensure a standard approach.

18. Key Successes 2020/21

1. Launch of pilot projects in ED regarding 'High Intensity Users' (HIU) and Substance Misuse same day referral to support timely access to appropriate mental health services/planning and to effect a reduction in ED Attendance (See 15.1)
2. Delivery of the Mental Health work plan 2020/21
3. Level 1 and 2 Mandatory Training >80% Trust-wide compliance
4. AWP Mental Health Liaison (MHL) service maintained Psychiatric Liaison Accreditation Network (PLAN) status accreditation
5. Emergency department Observation Build: Plans to ensure the build encompasses the need to meet PLAN accreditation Standards including the provision of mental health assessment rooms
6. Agreed Trust electronic noting access for MHLT staff to improve information sharing across teams.

7. Regular, well attended multi-agency Interface Meetings to increase collaborative working opportunities and ensure shared learning
8. Development and robust risk monitoring and escalation electronic dashboard
9. Provision of AWP MHLT services 24/7at the Front Door
10. Employment of Dementia Specialist Admiral Nurses
11. Expansion of the substance misuse service
12. Partnership working: SDASS IDVA onsite service (service extended to 5 days a week in 2019)
13. Contribution to Domestic Homicide Reviews (DHR's) and dissemination of learning
14. Delivery of audit programme
15. Quarterly interface absconding and restraint practice review Police/SERCO/GWH NHSFT
16. Development of a new Specialised Community Perinatal Mental Health Service
17. CAHMS Mental Health Liaison Service is now based at GWH NHSFT
18. Policy development regarding the management of challenging behaviour
19. Policy and protocol development regarding enhanced care provision (formally 'Close support)
20. MCA e-learning platform module development: Consent, capacity, and Best interests
21. Consultant Dementia Lead ED: Consultant in the Emergency Department has become a member of the Dementia Strategy Group. Their role in this group will help support work for Dementia support at the front door service.
22. LD Specialist Nurse had been appointed to the Trust
23. SERCO's BWV cameras are now live, being worn on the Officers uniforms. When switched on, the footage will support the robust review and learning from incidents.
24. Absconders are now included as part of the Security Leads monthly D.A.R.T (Data Analysis Report).
25. The Clinical Site Manager Mental Health annual refresher was delivered.

18.1 High Intensity Users Project – Emergency Department

The High Intensity User project was led by a Trust Emergency Department Consultant using a collaborative approach with services within Swindon (MedVivo) and Wiltshire (CIL). The project members identified and reviewed the case histories of patients who attended the Emergency Department several times over a given period, and direct actions for either internal speciality or community service follow-up.

The project was supported by the Oxford Academic Science Network to fund a High Impact Users co-ordinator post and 1 PA for the Consultant. About 60% of the cases reviewed had a mental health requirement and the project lead worked closely with AWP in relation to the management of these cases, working on collaborative management plans designed to support patients only accessing Emergency Department when contextually relevant to do so.

19. Covid-19

The Safeguarding Adult team worked collaboratively over the COVID-19 pandemic to ensure full strategic and operational delivery of the service. The team also worked with relevant partner agencies to support full delivery of their services also (i.e., SDASS Health IDVA service, AWP Mental Health Liaison Service (List not exhaustive). Full use of technology has enabled a strengthening of internal and external multi-agency communication in relation to adult safeguarding risk escalation and management.

Following the easing of lockdown restrictions, across the BSW a surge in safeguarding, domestic abuse and mental health activity was experienced and the Head of Safeguarding was involved in local response plans.

The safeguarding adults at risk team continue to monitor concerns and act accordingly in conjunction with the safeguarding adult's team within Local Authorities and within the Trust i.e., Maternity Safeguarding and Safeguarding Children.

20. Reporting period Priority actions 2020/21

1 Support delivery of the system wide response to COVID19
2 Supporting safe and effective practice in Emergency Department and Emergency Department Observation ward including a pilot of new mental health triage form to reduce absconsion risk
3 Attendance and contribution at BSW Mental Health Crisis Concordat meetings and other relevant BSW meetings that support the development of mental health service practice within and outside the Trust in line with 'Core 24' NICE Guidance.
4 With Emergency Department develop business case to extend the multi-service/multi agency frequent attender pilot project
5 Extend Substance Misuse on-site Emergency Department clinic pilot
6 Further development of processes and procedures to ensure that all patient facing contact actions are underpinned by the principles of the MCA (2005)/MHA (1983). This would be relevant to both adult and paediatric services
7 Raise awareness and support practice relating to supporting the County Lines , Human Trafficking and Human Exploitation agenda
8 Application of QI methodology to service improvement projects
9 Contribute to project regarding security restraint practice

20.1 Policy and Practice development for 2020/21

1. Voluntary Mental Health Attendance at Hospital (Person Accompanied by Police)
2. Development of a MCA Consent and Capacity support tool to empower nurses to undertake capacity assessments with confidence
3. Collaborative work with Women's and Children's Division identified mental health lead and CAHMS
4. MCA (2005) compliance with focus on the management of cases involving 'unwise decision making' and 'coercion and control' (Through the 'Safer care group)
5. Access to specialist education for front line practitioners to enable to appropriate management of complex cases
6. Ratification and dissemination of the 'Challenging behaviour management' Policy

21. System Challenges

There was a system wide exponential increase in demand for Adult Mental Health Services. The Trust continued to work with AWP to integrate mental health and physical health approaches to acute care to meet the important 'parity of esteem' agenda as set out in the Mental Health Five Year Forward View Plans.

Local and BSW areas of focus were as follows:

- Standardisation of ECDS Coding/Data (Internal practice)
- Sophistication of the IR Mental Health risk data – ULYSEES System
- Availability of AWP Section 12 Doctors

- Achieving Core 24 standards for transferring patients (4h emergency/24h for urgent cases)
- Primary Care: Provision of ready access to GP appointments
- Work with the 111 Service regarding ED referral thresholds
- Accessibility of Section 136, Mental Health inpatient and specialist EMI beds

BSW projects: Alternatives to Emergency Department attendance

1. 'Out of hours' (OOH) services/Intensive teams review, a BSW project looking at the OOH service delivery
2. Crisis Cafés for people in Mental Health Distress Swindon and Wiltshire
3. Development of a 'Personality Disorder' pathway

22. Horizon scanning

1. The challenges of supporting patients in mental health distress in Emergency Department have the potential to be positively influenced in relation to the proposed Emergency Department redesign/expansion. Mental health leads in the organisation and AWP are expecting invitations to relevant planning meetings
2. There are number of funding bids being submitted to support the Mental Health transformational work going on across BSW including liaison transformational funding opportunities for staff working in acute Trusts in both liaison and in the Crisis intensive service.
3. The Trust continues to integrate mental health and physical health approaches to acute care to meet the 'parity of esteem' agenda as set out in the Mental health Five Year Forward View Plans
4. The Trust is running projects to support timely intervention and reduce re-attendance in Emergency Department. This support and aligns to the prevention agenda.
5. Mentally healthy communities (Including healthy workforce) form a key part of Trust Staff Strategy
6. There is a National focus on suicide prevention
7. Mentally healthy communities work (Including healthy workforce)

23. Opportunities 2021/22

1. BSW work regarding the response to COVID19 pandemic
2. Information relating to the success of the pilot project in 2020/21 for 'High Intensity Users' (HIU) presenting to Emergency Department will form the basis of a business plan in 2021/22 to extend the project and embed as a permanent practice within the department.
3. Continuation of the Substance Misuse same day referral to support timely access to appropriate mental health services/planning and to affect a reduction in Emergency Department Attendance
4. Development of a multi-agency Voluntary Mental Health attendance at Hospital Protocol to ensure clear lines of responsibility and accountability regarding the cohort of patients who require mental health support but are not detainable under sections 135 or 136 of the Mental Health Act.
5. Attendance and contribution at MHCC and wider BSW meetings related to development of system wide MH services across the STP
6. Delivery of the training requirements as specified in the Adult Safeguarding intercollegiate document (2018) for level 1 – 6 training.
7. Emergency Department expansion to incorporate mental health triage assessment and treatment area into main Emergency Department/

24. Conclusion

Activity suggests that there was an increase in demand for Adult Mental Health Services both nationally and locally. Whilst there were local and national challenges, the Trust had excellent working practices in place to support patients who attend the Trust with a need for mental health support. Mental health activity and risk is monitored and responded to in an effective and timely way. To meet this additional demand there was a lot of proactive work during the year within the Trust and collaboratively across the BSW to address this.

The main achievements of 2020/21 for the Trust have been in relation to delivering core formal Mental Health Governance work plans, the embedding of an assurance dashboard, developments in education, practice support, focused clinical audit, policy development and improved risk response, all of which have served to improve the delivery of high quality, safe care to vulnerable and at-risk patients who present at the Trust in mental health distress.

The Trust continued to work with AWP to integrate mental health and physical health approaches to acute care to meet this important 'parity of esteem' agenda as set out in the Mental Health 'Five Year Forward View' plans.

Report author:
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Associate Director for Safeguarding, Trust Lead for Mental Health and Learning Disabilities

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6. Mental Capacity Act (MCA) Mental Capacity Act - NHS (www.nhs.uk)
7. Deprivation of Liberty Safeguards (DoLS) Deprivation of liberty safeguards: resources - GOV.UK (www.gov.uk)

Appendix 1 Mental Health Work plan 2020/21

1. Knowledge and staff competence	Lead	Target Date	Ambition: We will have a safe and effective workforce who will have confidence in relation to their roles and responsibilities re application of the MHA and will demonstrate consistent practice. We will develop training plans to ensure GWH has a safe and effective workforce/knowledgeable and confident staff.	
Priorities			**How will we achieve this?**	**Implementing & Embedding Practice updates**
Ensure everyone at individual and organisational level is clear about their roles and responsibilities in relation to the MHA/MCA and has the tools to deliver the remit (Duty of care)	Wendy Johnson / Jonathan Newman	Mar-21	Support compliance with the Mental Health Level 1 and 2 and Site Managers E-Learning platform modules. Monitor and report progress against the plan	Q1: MHA E-Learning Module for Site Managers refreshed. Q2: Currently at 100% Q3: Learning from an SI re absconsion and MCA/MHA interface - module to be refreshed. KPI Jan 2021
	Wendy Johnson	Oct-20	Support launch of the LD Acute Nurse liaison post at GWH NHSFT establishing KPI's within 4 months of appointment. This will include LD patient experience practice audit Q3	Q1: Maria C starts inducts into the Trust 29 June 2020 Q2: Person in post. KPI meeting September 2020. Audit part of annual audit plan Q3: Referral criteria/Electronic referral from Jan 2021
	Wendy Johnson/Lesley Biles/Jonathan Newman	Feb-21	Develop e-learning platform module on Consent/Undertaking a 2-stage capacity assessment and BI processes (Aligns to BDO consent action plan)	Q1: Draft module out for consultation and feedback. Aim launch by August 2020 Q2: Module finalised. With academy for approval and agreement on 'mandatory' status Q3: As previous. MCA masterclasses have been rolled out to MCA Divisional leads (New) Nov-Dec 2020 and to Matrons/Ward managers Jan - Feb 2021 To be available bi-monthly as a training option from April 2021.
	Wendy Johnson/Jonathan Newman	Sep-20	Identify MCA measures against which Divisions can benchmark and then audit their practice against	Q1: MCA audit development. Benchmark audit June 2020. Aim monthly data capture from Sept 2020 Q2: First snapshot audit in diary for sept 2020 Q3: 2nd MCA snapshot audit completed

	Wendy Johnson	Quarterly updates	Deliver against the NICE108 Consent and Capacity guidance (Year 2) Note: May not be completed in its entirety by year end	Q1: Plan updated as per progressQ2/3: Updated Q3. Separate action plan Q4: See separate action plan. Action progress against all elements
	Safeguarding Team	Mar-21	Provide requested support from Divisions to deliver against the CQC KLOE - in particular in relation to knowledge and application of the MCA (Aligns to WSAB priority 2019 - 2020)	Q1: ITU MCA training planned for Sept 2020. Cardiology MCA consent and BI practice report completed Q2: New MCA documentation in planning (See 'safer care' MCA action plan) Q3: 'Peer to peer' MCA sessions planned Feb 2021
	Lesley Biles/Wendy Johnson	Mar-21	Delivery of a MCA Consent form 1/2/3 update project Ensuring (Montgomery ruling compliance) culminating in Trust roll out (+ amnesty of older forms/changes to ordering process)	Q1: Part of MCA wider action plan. Consent form 1 updated and in draft form/out for consultation. Forms 2/3 to follow Q3: Completed and will be rolled out once old stock used up BDO audit completed
	Wendy Johnson	Dec-20	Deliver the actions within the BDO Consent action plan (Commenced 2019) (Separate larger action plan)	Q1: Update reports to QGC via MD Q2: Update sent to BDO audit lead (external) Separate action plan Q3: Dec 2020. BDO audit closed to auditor's satisfaction
	Wendy Johnson	Quarterly updates	SMART goal delivery of the NHSI LD and ASD Improvement Standards (Year 2) (Note: Will not be achieved within the 12-month period and will roll over to the 2021 - 2022 work plan)	Q1: Await outcomes of National audit data submission exercise 2019. Action plan updated for Q1 Q2: Updated Q2. Separate action plan Q3: NHSi National audit open again for data collection 2019 - 2020 Q4: Data submitted for 2019 audit as per KPI. Await report. Action log updated for Q4.
	Wendy Johnson / Jonathan Newman	Mar-21	Deliver MCA master classes to identified key colleagues to support divisional MCA practice (At least 2 per Division)	Q1: Part of MCA project. Face to face module to be developed. Launch programme Oct 2020 Q2: Divisional MCA lead identified. Training dates in planning Q3: MCA Masterclasses delivered Nov- Dec 2020 to MCA Divisional Leads

2. Strengthening leadership & professional practice (Learning and improving organisation)	Lead	Target Date	Q2	
Priorities			**How will we achieve this?**	**Implementing & Embedding Practice updates**
Being a learning and improving organisation on the journey to outstanding	Jonathan Newman/Esther Williams Delholm (SWICC)	Dec-20	Support delivery of the Mental Health elements of the Ward accreditation framework (WAAF) if MH sections is launched in 2020	Q1: Await re-launch of the WAAF programmeQ2: WAAF relaunch Sept 2020 Contributed to final suite of questions Q3:Await first reports
	Wendy Johnson	Bi-Monthly	ED/AWP/Wiltshire Police monthly interface meetings: Ensure identified learning is disseminated as appropriate	Q1:Interface meeting suspended re COVID-19 W1. Recommence Sept 2020 Q2: Meeting arranged for 19 09 2020 Q4: Meetings continue
	Wendy Johnson/Tash Ester	Monthly	Start a new AWP GWHNHSFT clinical risk interface meeting for closer collaboration in relation to mental health risk that involves both the Trust and AWP MHPT	Q1: To start: Review case both agencies have undertaken separate reviews on. Consider next steps Q2: 1 meeting held to date. Further meetings set in diary
	Doug Henry//Nathan Webb/Wendy Johnson	Mar-21	Work with clinical risk to ensure the ULYSEES upgrade addresses the MH data accuracy issues and provides accurate and relevant data in relation to MH IR's	Q1: Part of a wider corporate team agenda. Await start date for commencement of any project Q2/3: As above Q4: Roll over to 2021 - 2022 programme as have been unable to progress 2020
	Wendy Johnson	Monthly	Maintain and analyse the MH Governance Dashboard with responsive approach to any identified learning	Q1: Dashboard updated (On MH Ops and Gov. agendas) Q2: Agenda item MHGC. Updated
	Wendy Johnson	Possibly Spring 2022	Deliver the LPS mandate. A separate action plan will be required for this project	Q1: No National activity/ No publication of CoP yet. Await National update Q2: Paused until Spring 2022. 12-month lead in time.Q4: Continue to await COP. Cannot plan without this. Have been unable to progress 2020

	Wendy Johnson/Jonathan Newman/Lesley Biles	Monthly	Contribute to the weekly safety huddle/clinical risk newsletter for Divisional dissemination to include learning from incidents/audits/law updates	Achieved
	Natasha Easter	Nov-20	Support data collection for re-assessment for PLAN accreditation due Autumn 2020	Q2: Data collection has commenced Sept 2020Q3: Focus group meetings held Dec 2020
	Wendy Johnson	Quarterly	Quarterly data triangulation review (using 1 month's data per quarter): IR/SERCO/Clinical risk re reporting assurance and learning dissemination regarding absconsion and restraint practice	Q1: Audit for Q1 planned for July 2020 Q2: Audit programme planned for 2020 - 20201
3. Partnership working/Inter-agency Procedures (Healthcare governance and interagency procedures)	**Lead**	**Target Date**	**Our Ambition: We will work in partnership to ensure effective mental health services. We will continue to engage with current partners and secure new partnerships in response to changes to the mental health landscape.**	
Priorities			**How will we achieve this?**	**Implementing & Embedding Practice updates**
Continued engagement with current partners and secure new partnerships in response to changes to the Mental Health landscape	Wendy Johnson/Jog Gobey/Jonathan Newman	As required/ Programme	Analyse and report results of the internal rolling audit programme to MH Ops/MHGC (Quarterly)	Q1: MCA audit conducted June 2020. Plan snapshot audits monthly from 2020. Msept Multi-agency MHA audit planned for Sept 2020. Await MHCC audit report Q3: Absconision and ligature risk audits completed.
	Wendy Johnson	Mar-21	Deliver the COVID mandate ensuring collaborative working across partner agencies and whole system working to maximise access to mental health services at times of social restriction	Q1: Full plans in place Q2: Close monitoring of MH activity - National and local level. Report to be produced for MHGC Oct 2020 Q3: relevant reports submitted

	AWP Michael O/Wendy Johnson/Joy Gobey/Jonathan Newman	Feb-21	Deliver planned MHA audit: Legal and documentation compliance	Q1: Planned for Sept 2020 Q2: 30th Sept. Facilitated at GWH Q3: Report and findings/actions - report pending from clinical audit Q4: Covid restrictions caused Significant issues with this audit. Draft report now ready for discussion. Will be completed by end Q4
	Claire Barker/Helen Booth/Wendy Johnson/Louise (OH)	Oct-20	Support world mental Health day 10 10 2020	Q1: N/AQ2: Will need to plan 'virtual' activitiesQ3: Delivered
	Celia Moore/Darren Hiller/Wendy Johnson	TBC	Act in relation to SDIPS (No.9) audit results once data analysed, and report published	Q1: No report received to date Q2: No report received to date (MHCC) Q3: As above Q4: No report ever received. Unable to progress
	Wendy Johnson	Quarterly	MHCC: Trust representation and contribution as required. Report BSW plans and progress through MHGC and MH Ops	Q1: No meetings to report Q2: MHCC workshop 08 09 2020. Twice monthly local MH recovery meetings happening with GWH representation Q3: Meetings now re-established
	Wendy Johnson/Lynn Williams (SBC)	Mar-21	Work with SBC to facilitate further Domestic Abuse: DASH risk assessment training for Trust staff. Align to level 3 adult safeguarding year 1 priority staff list.	Q1: Need to move to virtual meeting methodology and structure. Plan to D/W SBC lead Q2: DASH training commenced virtually Sept 2020. Further training planned
	Wendy Johnson	N/A	Contribute to the new Trust Clinical Ethics Advisory Group (CEAG) with particular interest in consent/capacity/refusal of treatment/advanced directives	Q1: Head of Adult Safeguarding and Mental Health is a contributor Q2: As above
	Jonathan Newman	N/A	Contribution at the new 'Virtual partner' meetings Wiltshire MASH	Q1: JN is attending and contributing to these meetings Q2: As above

4. Governance	Lead	Target Date	Our ambition: We will invest in and build an effective system for prevention, reporting, responding, and learning	
Priorities			**How will we achieve this?**	**Implementing & Embedding Practice updates**
	Wendy Johnson/Gary Crisp	Quarterly	Analyse the MH dashboard (Inc. AWP KPI data) to ensure SI/RCA/IR1 and other risk data is collected and examined to identity opportunities for learning.	Q1: Monthly review. Learning to MH Ops and Governance Q2: Process established
	Val Mortimer/Chris Bumford with support from WJ	Mar-21	Children's Service review of mental health pathway including environment and ligature risk assessment. SMART action plan to be developed by end Q4	Q1: W + C Division to Lead. Updates via VM quarterly. Meeting planned July 2020Q2: Q2: CB new MH lead for Paeds. Initial meeting held. Update meeting Oct 2020Q3: Current issue report penned. Standing agenda item at MHGCQ4: Action plan in place
	Wendy Johnson	Jan-21	Chemical restraint use audit 6/12 following publication of the 'management of challenging behaviour' guidance for staff	Q1: Policy not yet ratified. Progress once done Q2: Policy ratified at PGG August 2020. Circulated for committee ratification before Trust launch Q3: Launch Dec 2020. Aim audit 6/12
	TBC	Dec-20	From the 'Analysis of Mortality data' report Feb 2020: Coding at the front door is limited to primary presentation in line with the National coding system. This has the potential to create a gap in attendance data regarding patients with LD/As and Downs who do not progress to in-patient areas and limited opportunity for SJR case review/thematic analysis: Clinical/IT interface: 1. Review of coding process at the front door – internal decision whether to add relevant co-morbidity codes	Q1: Part 3 - completed/Closed. Parts 1 and 2 to progress Q2: Internal decision - no change to codes. Part 3 to progress/Complete by Q3 Q3: Internal RIP process established

			2. Reduce the number of codes available to code against in relation to need for 'reasonable adjustments' 3. Internal process to capture RIP in ED to ensure compliance with the LeDeR programme and learning reviews are undertaken and reported	
	Christina Rattighan/Maternity safeguarding lead (TBC)/Jonathan Newman/Tash Easter	Mar-21	Maternity Service review of current MH, MCA and DoLS practice and deliver any actions against the review by end Q4	Q1: Review to commence when new maternity safeguarding lead is in post Q2: Lead appointed. Start date at the Trust TBCQ3: Maternity Safeguarding lead commenced at the Trust Dec 2020. Review to form part of the Ockendon report response Q4: Propose forward to 2021 – 2022
	Claire Warner/Wendy Johnson	Mar-21	Make amendments to relevant HR policies in relation to the adoption of the South West Region 'Adult position of Trust' framework	Q1: Collaboration with HR has commenced Q2: Risk assessment template developed/Est. advice links with HR business partners. IDVA connection with HR established
	Wendy Johnson/Tash Easter	Feb-21	Work with AWP to identify further opportunities to better understand the patient experience (PEM's), analysis collected data and use this data to inform our practice	Q1: Not yet started Q2: First meeting October 2020 Q3: Further meeting planned Jan 2021 Q4: Remains outstanding. Covid restrictions. Forward to work-plan 2021
5. Policy frameworks	**Lead**	**Target Date**	**Q4:**	
Priorities			**How will we achieve this?**	**Implementing & Embedding Practice updates**

We will be responsive to changes in the mental capacity/health landscape (Including Policy development)	Wendy Johnson	TBC	We will be responsive to changes in case law and legislation: Monitor Liberty Protection Safeguard development (Law from 01 10 2020) and plan in response to final Code of Practice once published	Q1: No LPS updates to report. Q2: LPS paused until Spring 2022. 12-month lead in time. Await COP Q3: As Q2 Q4: As Q3. Local meetings have been planned Roll-over to 2021 plan
	Rosemary Pike/Wendy Johnson	Mar-21	Deliver planned Adult Service 'Therapeutic Holds' Policy once decisions have been made regarding curriculum for the Advanced Conflict Resolution training	Q1: CR training report pending. RP leading Q2: RP update required Q3: Options appraisal with the academy Q4: Unable to progress until ACR plans agreed. Forward to 2021 plan
	Wendy Johnson	Dec-20	Policy refresh as part of the internal Trust policy and clinical guidance programme:**Refresh:**1. Minimising the risk of self-harm for adult in-patients2. Positive behaviour management in clinical violent and aggressive adult in-patients (Physical restraint)3. Contribute re the mortuary policy - death under MHA4. DoLS once LPS plans confirmed**New:**1. Clinical guidance for the management of challenging behaviour (Behaviour de-escalation and chemical restraint) •2. WSAB discharge multi agency discharge audit planned for Q1 2020 focus will be on MCA 3. SSP also undertaking MCA audit when programme recommences post COVID-19	Q1: Self harm/Restraint polices for ratification July 2020 MHG meetingChallenging behaviour Mgt policy in final draft formSafeguarding Board Audits Q1: Focus on MCA Q2: Refresh 1/2 completed. Mortuary policy contribution pending. New policy: Mgt clinically challenging behaviour - ratified at PGG August 2020. For final ratification at MHGCQ3: All polices now updated/made live
	Wendy Johnson	Quarterly	Attend and contribute to the Public health led Suicide Prevention multi-agency meetings	Q1: One meeting held June 2020 Q2: Further meetings arranged

	Jonathan Newman	Oct-20	Support lead for patient flow re updating of the 'Admission, Transfer and discharge policy with emphasis on updating the 'Discharge against Medical advice' proforma (IMCA, 2005)	Q1: Self discharge proforma has been updated to reflect current legal and MCA requirements. Form with printing company. Aim to launch form August 2020 Q2: Refreshed policy ratified Sept 2020. New form included
6. Operational and Escalation processes	**Lead**	**Target Date**	**Our ambition: We will continue to develop our operational and escalation processes to provide positive quality assurance that safe and effective processes and systems are in place to effectively safeguard all patients who access services across the Trust**	
Priorities			**How will we achieve this?**	**Implementing & Embedding Practice updates**
We will ensure our operational and escalation processes are fit for purpose and support best practice	Natalie Whittam/Tash Easter/Celia Moore	Bi-annual	Monitor impact of GWH NHSFT ED High Intensity Users of services (HIT) project - Feedback via MHGC and MH Ops	Q1: Progress update requestedQ2: Currently re-establishing post covid-19 wave 1. Anecdotally evidence that 60% of case reviews have involved MHQ4: HIU meetings now est. in the Trust
	Darren Hiller/Tash Easter/Wendy Johnson	Jan-21	At relevant points contribute to the ED/Front Door build/extension project in relation to ED Build layout/MH Considerations against PLAN accreditation	Q1: Await relevant invites Q2: As above Q3: First invite Dec 2020 for front-door/Closer build. Further invites to follow Q4: WJ part of planning and consultation team
	Jonathan Newman	Sep-20	Intranet: Full transfer to new system Inc. refresh all links/docs/flowcharts/Partnership board interface docs – Mar 2020. System refresh includes mental health and MCA	Q1: Achieved
	Kevin Clarke (ED)/Luke McNeil (AWP)/Darren Hiller (ED)/Wendy Johnson/Ian Mitchell (AWP)	Jan-21	Re-establish Dual Diagnosis drop-in clinics (Evenings) (Post COVID19)	Q1: AWP update required Q2: Planned re-launch October 2020 Q3: Now room identified for use in ED plan re-launch Jan 2021
	Wendy Johnson	Mar-21	Delivery of the BDO External Consent Audit recommendations (2019) Fuller action plan in existence	Q1: Reported through QGC and Safer care group Q2: Separate action plan updated Q3: Completed Dec 2020

	Wendy Johnson/joy Goby	Feb-21	Establish a process to ensure patients are re-read their rights under the MHA/referral to IMHA is offered in a timely manner and documented within the patient clinical medical notes this has happened (Aligns to CQC monitoring MHA 2018/2019 report GWH benchmarking outcomes)	Q1: Audit practice as per MCA audit plan Sept 2020. Actions to followQ2: Audit planned 30 September 2020. Review with resultsQ4: Await final audit on which to inform changes to practice
	Linda Webb/ SaLT service	Mar-21	Support (Inc. PEG) to develop robust MCA processes and suite of support documents with a view (longer term) to use Trust-wide	Q1: PEG meetings suspended re COVID-19. Q2: PEG meetings to be re-established with new lead Oct 2020
	Wendy Johnson/Joy Gobey	Mar-21	Develop 'Voluntary MH attendance at hospital (Person Accompanied by police) proforma' to align to AWP/Wiltshire Police Sec 136 protocol by end Q4	Q1: Not yet commenced Q2: Start planning Nov 2020 Q3: Draft form out for comment Q4: Looking to create dual form for voluntary attendance and Sec 136 attendance. On track to delivery by end Q4
	Wendy Johnson/lisa Quinn/Jonathan Newman/Tash Easter	Mar-21	Strengthened the Trust links with military veterans services/signposting information on the Intranet	Q1: Not yet commenced Q2: Contact needs to be established Q3: Through E + D group - closed
	Wendy Johnson	Sep-20	Revisit restraint guidance once SERCO restraint practice education programme is finalised and agreed. Links to wider restraint action plan	Q1: Revisited. For ratification at MHGC July 2020 and for PGG August 2020 Q2: Re-ratified August 2020. Live on the T drive Sept 2020

Appendix 2 Patients Detained Under the Mental Health Act 2020/21

Use of the Mental Health Act at The Great Western Hospitals NHS Foundation Trust
1 April 2020 to 31 March 2021

Type of Section	Number for use of the Mental Health Act
Report on Hospital In-Patient Section 5(2)	57
Compulsory Admission for Assessment Section 2	1
Compulsory Admission for Treatment Section 3	3
Emergency Admission for Assessment Section 4	0
Authorisation for Leave of Absence to GWH Section 17	17
Authority for Transfer from Hospital to Another Under Different Managers Section 19	1
Order of Discharge from Detention by Responsible Clinician Section 23	4
Police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety Section 136	3
Appeal to Managers Hearing	0
Appeal to Mental Health First Tier Tribunal	0
TOTAL Number of Patients	**71**
TOTAL use of the Mental Health Act	**86**

Report Title	**Operational response to health inequalities**				
Meeting	**Trust Board**				
Date	**3 February 2022**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Claire Thompson, Director of Improvement & Partnership Felicity Taylor Drewe, Chief Operating Officer				
Report Author	Claire Thompson, Director of Improvement & Partnership				
Appendices	Appendix 1 - Draft BSW Inequalities Strategy 2021-25				

Purpose

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

Assurance Level

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

Assurance in respect of our response to the challenge of health inequality outlined in the August 2021 Board workshop; through the development of changed processes, policies and procedures to address the impact of structural inequalities on health outcomes.

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

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

There is a need for the national priorities and BSW strategy to be translated into a series of actions for GWH. This will not be a stand-alone action plan that will be the preserve of one functional portfolio, as the requirements are far reaching in every aspect of our operation – including business intelligence, use of resources, HR policy and procedure (including recruitment and retention), clinical practice and prioritisation.

Report

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

This report summarises the national and local context for health inequalities policy, following previous presentation of the key health inequality trends for our population to the board.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
	x	x	x	x	X
Links to Strategic Pillars & Strategic Risks – select one or more					
	x		x	x	X

Key Risks – risk number & description (Link to BAF / Risk Register)	BAF S3	**Risk Score**
	There is a risk that the current model of health & care services is unsustainable unless we work with partners to fundamentally re-focus services on anticipatory care and early intervention for our population.	12

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Executive Team and Executive Committee have considered the attached paper and endorsed the approach to the wider organisation

Next Steps	Creation of steering group, amendments to corporate governance

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	**x**		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	**x**		
Explanation of above analysis: The developments outlined in the attached paper are intended to provide assurance, and where any protected group is more favourably treated this will be in order to address health inequalities			

Recommendation / Action Required

The Board/Committee/Group is requested to:

- Note the national planning guidance on addressing health inequalities
- Note the draft BSW strategy
- Approve the operationalisation of this approach through indicative actions & steering group
- Ensure health inequalities are part of the considerations of every board subcommittee and establish which board level committee will take the lead.

Accountable Lead Signature	
Date	24/01/22

1. Background

The Board has received a presentation from the SBC Director of Public Health and GWH Director of Improvement and Partnership on the nature and impact of health inequalities nationally and locally. There are stark differences in healthy life expectancy for those with protected characteristics and those in the least and most deprived wards within Swindon, that require a fundamental shift in the way we plan and organise services.

This paper outlines the national priorities and directions issued as well as the draft local BSW strategy, noting that the creation of ICSs are key in delivering the population health management approach that will enable effective segmentation of at risk groups and proactive management of population cohorts – for example by directing smoking and obesity prevention programmes at those from minority ethnic communities or those with the most socio-economically deprived backgrounds.

2. National Context

Nationally it is acknowledged that the pandemic has laid bare the structural inequalities that lead to poorer health outcomes, and clearly this cannot be tackled by individual providers alone. The creation of ICSs and greater integration of services around strengthened local communities will play an important role and so our place in driving forward the work of the Swindon ICA will be significant in the longer term. However there are clearly actions we can take alone and these need to be collectively identified and prioritised within our operational plans.

2.1 Five priorities 2021/22

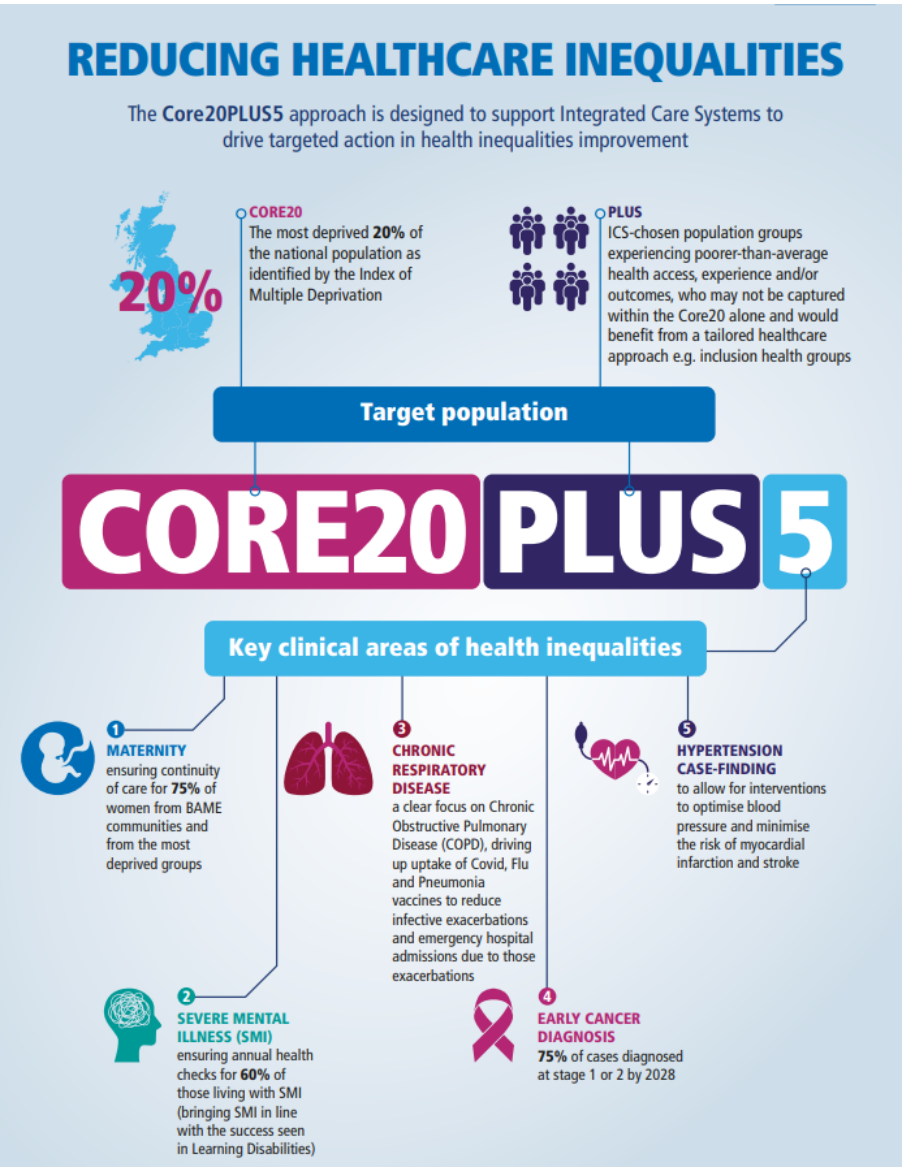
NHS England laid out 5 key priorities for addressing health inequalities and these are outlined below with actions taken or planned by GWH:

Priority area	Action taken / ***planned*** by GWH
Restore services inclusively	Elective waiting lists analysed by IMD & other protected characteristics, upgrading in priority of specific cohorts of patients with recognised poorer outcomes. ***Routine presentation of performance and activity datasets by deprivation & protected characteristic***
Mitigate against digital exclusion	Development of text messaging validation tool for elective waiting lists – allowing resources to be specifically focussed on those likely to experience digital exclusion ***Ongoing recognition and awareness of the risk of digital exclusion in all uses – specific digital champion role?***
Ensure datasets are complete and timely	New connections between CCG & GWH datasets to ensure fields are routinely updated ***Future focus on training and patient awareness of importance of capturing complete and accurate personal data***
Accelerate preventative programmes	Cancer Alliance work to target cancer checks and screening uptake in most at risk cohorts of population
Strengthen leadership & accountability	Lead Executive Director appointed ***Specific Board sub-committee responsibility*** ***Potential non-executive and service champion/leads to be agreed***

2.2 Core 20 PLUS 5 approach

As outlined below this approach has been designed to provide a uniform focus in tackling health inequality by the NHS, and is currently undergoing consultation. The core 20% most deprived population and specific local at risk population groups are to be identified and specific actions developed to support their health outcomes.

In addition there are 5 priority clinical areas where health inequalities are apparent nationally and action is already being taken to address these.



2.3 Planning guidance 2022/23

The messages in the sections above have been amplified in the most recent planning guidance with population health management, a focus on prevention and Core 20 PLUS 5 forming one of the 10 priorities for the NHS in 2022/23.

In particular systems are asked to focus on reducing inequality in screening and immunisation uptake, to drive personalised care approaches and continue the development of culturally competent approaches to vaccination uptake.

For providers specifically there is a requirement to focus on diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks, which we need to ensure are being managed in our PCN. Within secondary and community care there is a requirement to enact the recognised high impact actions to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation, including remote and digital models, and increasing respiratory, hypertension, atrial fibrillation and high cholesterol detection and monitoring/control to pre-pandemic levels.

3. Draft BSW Strategy

As attached in appendix 1, the BSW Inequalities Strategy Group (chaired by the Swindon Director of Public Health) has drafted a strategic response to this guidance for all partners within the ICS. This is subject to engagement currently and comments on it are welcomed.

4. Conclusion and recommendations

As part of reframing our corporate governance structure and in planning for 2022/23 it is proposed that a Health Inequality Steering Group is established. This would have the remit for:

- establishing a work programme for corporate and divisional areas, building on the actions already identified above;
- having oversight of inequalities guidance and improvement initiatives;
- embedding an understanding and awareness of our role in addressing health inequality throughout the organisation.

Proposed membership:

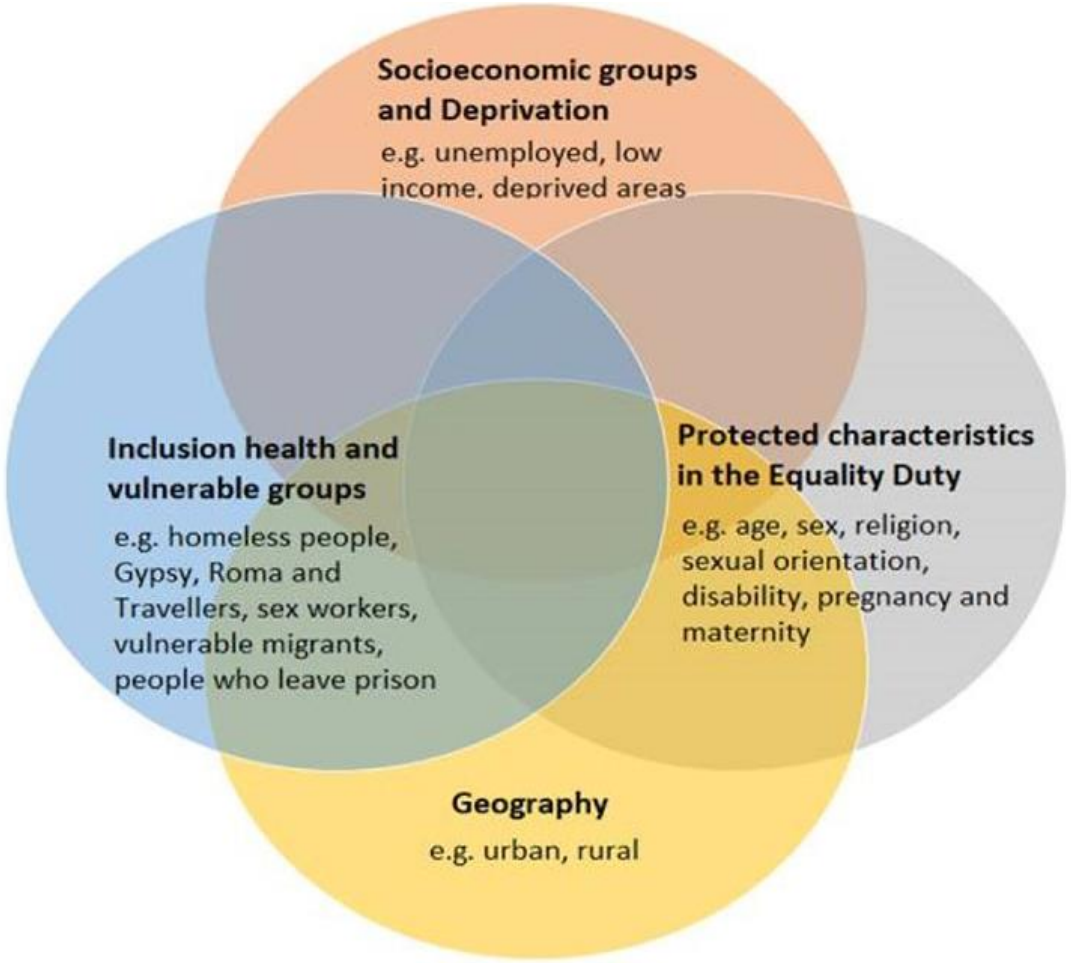
Chair & Board lead	Director of Improvement & Partnership
Vice chair & corporate ops link	Deputy Recovery Director
Unscheduled Care Division	Senior manager / clinician link
Integrated & Community Care Division	Senior manager / clinician link
Surgery, Women's & Children's Division	Senior manager / clinician link
Link role to EDI group / work plan	Trust EDI Lead
IT	Senior management link
Finance	Senior management link
Human Resources	Senior management link
Corporate nursing (covering quality/risk management/PALs/patient experience)	Deputy Director of Nursing Head of Patient Experience & Engagement
Estates & facilities	Senior management link
Communications Team	Link role
? Research / Education / Academy representative	TBC as required

Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

BSW Inequalities Strategy 2021-2025

In draft

Overlapping dimensions of Inequality



Taken from: Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

Forming Inequalities Strategy for BSW

1. Awareness Raising

2. Anchor Institutions

3. Core20+5 programme

4. Service Improvements

5. Review Process

Forming Inequalities Strategy for BSW

1. Awareness Raising

What will we do?	How will we do it?	How will we know we're doing it?
Data	Improve data recording Use the right data in the right places - ?Embed HI data into routine strategy and service planning	• X% of ethnicity and deprivation data recorded in x services • Use representation at ISG to ensure distribution across the system • Share resources for accessing the right data
Training	Deliver a training programme for organisations and stakeholders	• X% of people trained
Leadership/learning sets		

Forming Inequalities Strategy for BSW

2. Anchor Institutions

Signpost/link: e.g. Building healthier communities: the role of the NHS as an anchor institution - The Health Foundation

What will we do?	How will we do it?	How will we know we're doing it?
Address the wider determinants of health by consciously adopting an anchor mission within our communities	Establishing anchor institutions	• All three acute hospitals in BSW achieve chartered anchor institution status by 2025
Pursue changes in each domain of anchor influence and with other anchors and partners across place	Define/map the domains of anchor influence within BSW and partners within place	• ?Anchor Institutions Network • ?Staff • ?Greener NHS/sustainability/climate adaptation

Forming Inequalities Strategy for BSW

3. Core20+5 programme

NHS England » Core20PLUS5 – An approach to reducing health inequalities

What will we do?	How will we do it?	How will we know we're doing it?
Focus on improving access, experience and outcomes for a target population cohort – the 'Core20PLUS'	Routinely identify our Core20PLUS through robust data collection and target these groups across the system, including prevention	• x% minimum completeness of data collected on ethnicity and deprivation across the system • ?targets for equity of access, experience and outcomes for these groups
Focus on improving access, experience and outcomes across '5' focus clinical areas requiring accelerated improvement	Focus on 5 key clinical areas: • Maternity • Severe mental illness (SMI) • Respiratory • Cancer • CVD	• Continuity of care for 75% of women from BAME communities and most deprived groups • Annual health checks for 60% of those living with SMI • ?Target for vaccine uptake (resp) • 75% of cancer cases diagnosed at stage 1 or 2 by 2028 • ?Target for hypertension case finding (CVD)

5 Clinical Focus Areas

Wider determinants
Include the environmental, social and economic contexts of lives (e.g., education, employment, income and housing)

CVD	Cancer	Respiratory	Maternity	Mental Health (inc. CYP)
• Hypertension case finding to allow for interventions to optimise BP and minimise risk of MI and stroke	• 75% cases diagnosed at stage 1 or 2 by 2028	• Focus on COPD, driving uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency admissions	• Ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups	• Ensuring annual health checks for 60% living with SMI

Prevention
Proactively engage people at greatest risk in prevention

Forming Inequalities Strategy for BSW

4. Service Improvements

https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/

What will we do?	How will we do it?	How will we know we're doing it?
Restore Services Inclusively	Breaking down performance reports by patient ethnicity and indices of multiple deprivation (IMD) quintile	?
Accelerate Preventative Programmes	Flu and COVID-19 vaccinations, annual health checks for those with severe mental illness and learning disabilities, continuity of carers for maternity services, targeting long-term condition diagnosis and management	
Leadership & Accountability	System and provider health inequality leads having access to Health Equity Partnership Programme training, as well as the wider support offer, including utilising the new Health Inequalities Leadership Framework	
Ensure datasets are timely & complete	Improving data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning	
Mitigate against digital exclusion	Identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile	

Five Key Priorities

Restore Services Inclusively

•breaking down performance reports by patient ethnicity and indices of multiple deprivation (IMD) quintile

Mitigate against digital exclusion

•identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile

Ensure datasets are timely & complete

•improving data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning

Accelerate Preventative Programmes

•flu and COVID-19 vaccinations, annual health checks for those with severe mental illness and learning disabilities, continuity of carers for maternity services, targeting long-term condition diagnosis and management.

Leadership & Accountability

•which is the bedrock underpinning the four priorities above.

Forming Inequalities Strategy for BSW

5. Review Process

Board Assurance Tool - Leadership Framework for Health Inequalities Improvement.pdf (nhsconfed.org)

Health Equity Assessment Tool (HEAT) - GOV.UK (www.gov.uk)

What will we do?	How will we do it?	How will we know we're doing it?
Proactively engage people at greatest risk in prevention	Outreach/work with partner organisations to understand background to data	• ?Evidence of proactive engagement
Systematically address health inequalities and equity-related to a programme of work or service and identify what action can be taken to reduce health inequalities and promote equality and inclusion	HEAT	• ?BSW targets HEAT

Report Title	**Powers Reserved to the Board and Scheme of Delegation Limits**				
Meeting	**Trust Board**				
Date	**3 February 2022**	Part 1 (Public)	X	Part 2 (Private)	
Accountable Lead	Kevin McNamara, Chief Executive				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Powers Reserved to the Board Appendix 2 – Scheme of Delegation Limits (summary)				

Purpose

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

Assurance Level

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

Process

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

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

Report

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

Both the Standing Financial Instructions and detailed Scheme of Delegation are currently being refreshed to align with a revised finance team structure and new ways of working.

In the meantime, this paper sets out the proposals to update the current limit of delegation levels, which will be included in the final SFIs as an appendix, and the Powers Reserved to the Board. The changes made to each document are outlined below and highlighted in yellow in the documents:-

Powers Reserved to the Board

Ref	Current Wording	Proposed Change
2(f)	Approval of significant changes to organisational structures, processes and procedures to facilitate the discharge of business by the Trust as determined significant by the Chief Executive in consultation with the Director of Human Resources	Approval of significant changes to organisation structures that require formal consultation under relevant legislation.
4 (d)	Approval of proposals for ensuring quality and developing clinical governance in services provided by the Trust.	Approval of strategy for ensuring quality and clinical governance in services provided by the Trust.
4 (e)	Approval of proposals for ensuring equality and diversity in both employment and the delivery of services.	Approval of strategy for ensuring equality and diversity in both employment and the delivery of services.

5 (d)	Approval of arrangements for dealing with complaints	Delete.
7 (d)	Consideration and approval of the Trust's Annual Report including the Annual Accounts and the Quality Accounts.	Consideration and approval of the Trust's Annual Report including the Annual Accounts and the Quality Accounts. The Board of Directors may choose to delegate authority to approve the Annual Report & Accounts to the Audit, Risk & Assurance Committee to meet NHSEI's deadline for submission of the Annual Report & Accounts.

Scheme of Delegation Limits

- Change the Financial Controller job title to Assistant Director of Finance and add new delegated limits.
- Add a further column to include Approval of Income (sales orders) as recommended by an internal auditor's report 'Key Financial Systems' (Dec-21).
- Add ***Director of Procurement is able to sign a procurement recommendation report up to £350k.*

Both documents will be kept under review as the ICS develops and the requirement to capture any decision-making powers more formally.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	n/a				n/a
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Director of Finance Assistant Director of Finance Chair Chief Executive Finance & Investment Committee – 24 January 2022				
Next Steps	Implement revised documents.				

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

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

- **To approve the updated Scheme of Delegation limits and Powers Reserved to the Board.**

Accountable Lead Signature	Kevin McNamara
Date	25 January 2022

Scheme of Delegation Limits 2022/23

Financial Limits	Expenditure Revenue/ Capital	Tender Waivers	Sign Expenditure Contracts	Disposal /Write off of Physical Assets	Losses & Special Payments/ Debt Write Off	Charitable Funds	Approval of Income* (sales orders)
Trust Board	£1m+	£300k+		£500k+	£500k+	£500k+	
Finance & Investment Committee	£500k-£1m						
Charitable Funds Committee						£5k+	
Chief Executive	£500k	£300k	£1.5m+	£500k	£500k		£1m+
Director of Finance	£500k	£200k	£1.5m	£150k	£150k		£1m+
Exec Board Members	£50k						
Deputy Director of Finance	£50k	£50k	£100k-£350k	£10k	£10k	£5k	£250k
Assistant Director of Finance	£50k	£50k	£250k	£10k	£10k	£5k	£100k
ExecCo Members	£10k						£10k
Chief Pharmacist (Specific items)	£50k						£10k
Deputy Director of HR	£10k						
Head of Temporary Workforce (specific items)	£10k						
Head of Medical Workforce (specific items)	£10k						
Director of Procurement			£100k-£350k**				
Deputy Director of Procurement			£100k				
Heads of Service/General Manager/Matrons	£5K			£5k	£5k		
Service Managers	£3K			£3k	£3k		£5k
Budget Manager/Fund Manager	£1k			£1k	£1k	£5k	£5k

*Outside heallthcare contracts

**Director of Procurement is able to sign a procurement recommendation report up to £350k

The above delegations must only be applied in accordance with the Standing Financial Instructions.

Particular attention should be paid to the following SFI Excerpts at s2.5.2

The Chief Executive shall require budget holders to seek to deliver the financial outturn targets set by the Trust Board within the approved annual budget plan and the adjustments to those targets reflected in the re-forecasts performed during the year.

Budget holders shall be accountable for their service responsibilities within the limits of the financial outturn targets set for them. Financial and other resources shall only be used for the purposes for which they are provided, as approved by the Chief Executive, Director of Finance and the Trust Board.

Any budget not required for its designated purpose(s) shall revert to the immediate control of the Chief Executive, subject to any authorised transfers of budget.

Each Budget Holder is responsible for ensuring that:

a. Any likely overspending or reduction of income which cannot be met by transfer from other budget areas is not incurred without the prior consent of the Trust Board;

b. The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised; and

c. No permanent employees are appointed without approval through the designated governance structure, other than those provided for in the authorised budgeted establishment

Reservation of Powers to the Board 2022-23

The Board of Directors remains accountable for all of its functions, including those which have been delegated. To enable exercise of those functions and responsibilities, the Board is required to draw up a schedule of decisions reserved to the Board and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out what powers are reserved to the Board and may not be delegated to a Committee, Sub-Committee or member of staff.

1. General Enabling Provision

The Board may determine any matter it wishes in full session within its statutory powers.

2. Regulation and Control

(a) Approval of the Constitution (in accordance with approval framework), a schedule of matters reserved to the Board, Standing Orders and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

(b) Approval of a scheme of delegation of powers from the Board to employees.

(c) Requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.

(d) Requiring and receiving the declaration of interests from employees which may conflict with those of the Trust via the Audit, Risk & Assurance Committee.

(e) Considering instances of failure to comply with the Authorisation, Provider Licence, Constitution and Standing Financial Instructions and taking action where appropriate.

~~(f) Approval of significant changes to organisational structures, processes and procedures to facilitate the discharge of business by the Trust as determined significant by the Chief Executive in consultation with the Director of Human Resources.~~ Approval of significant changes to organisation structures that require formal consultation under relevant legislation.

~~(g)~~(f) To receive reports from committees including those which the Trust is required by the Secretary of State, the Constitution, Standing Financial Instructions or other regulations to establish and to take appropriate action thereon.

~~(h)~~(g) To approve the recommendations of the Trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all board committees (and other committees if required).

~~(i)~~(h) Ratification of any urgent decisions taken by the Chairman or Chief Executive in accordance with the Constitution, Scheme of Delegation or Standing Financial Instructions and Standing Orders.

~~(j)~~(i) Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust, such as charitable funds.

~~(k)~~(j) Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

3.	**Appointments**	
	(a)	The establishment, approval of terms of reference, approval of membership including Chairs, reporting arrangements and disbanding of all committees of the Board.
	(b)	The appointment of members to any committee of the Trust and the appointment of representatives on outside bodies.
	(c)	Approval of the Senior Independent Director (having regard to the views of the Council of Governors) from amongst the Non-Executive Directors of the Trust.
4.	**Strategy and Plans**	
	(a)	Development and approval of the strategic aims, objectives and priorities of the Trust.
	(b)	Approval of the Integrated Business Plan, Operational Plan and Annual Budget (including capital budget) and 5 Year Plan.
	(c)	To approve any joint venture or merger with external organisations and acquisitions, subject to requirements set out in the Constitution.
	(d)	Approval of ~~proposals~~ strategy for ensuring quality and ~~developing~~ clinical governance in services provided by the Trust.
	(e)	Approval of ~~proposals~~ strategy for ensuring equality and diversity in both employment and the delivery of services.
5.	**Policy Determination**	
	(a)	Approval of strategy and policy in accordance with the provisions of the Scheme of Delegation.
	(b)	Approval and monitoring of the Trust's policies and procedures for the management of risk.
	(c)	Approval of the Trust's Health & Safety Policy.
	~~(d)~~	~~Approval of arrangements for dealing with complaints.~~
6.	**Financial and Performance**	
	(a)	Approval of plans in respect of the application of available financial resources.
	(b)	Approval of the opening or closing of any bank or investment account.
	(c)	Approval of any borrowing.
	(d)	Acquisition, disposal or significant change of use of land and/or buildings (including leases and licences) and approval of the associated financial limits. The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £5m, over the contract period, £1m in the case of capital spend.
	(e)	Approval of expenditure in excess of £15m with NHS Improvement / NHS England approval.
	(f)	Approval of individual compensation payments (patients, former patients, carers and other non-staff) non NHS Resolution above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) as referred to in the Scheme of Delegation.
	(g)	To approve proposals for action on litigation against or on behalf of the Trust which are over £50,000 except where these are made in accordance with NHS Resolution instructions.
	(h)	Approval of any applications for public dividend capital.

7.	**Reporting Arrangements**	
	(a)	Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and employees of the Trust.
	(b)	All monitoring returns and submissions required by NHS Improvement, the Care Quality Commission, the Charity Commission and any others will be approved by the Board via the Finance & Investment Committee.
	(c)	Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.
	(d)	Consideration and approval of the Trust's Annual Report including the Annual Accounts and the Quality Accounts. The Board of Directors may choose to delegate authority to approve the Annual Report & Accounts to the Audit, Risk & Assurance Committee to meet NHSEI's deadline for submission of the Annual Report & Accounts.
	(e)	Receipt and approval of the Annual Report(s) for funds held on trust (e.g. charitable funds).
8.	**Investment Policy**	
	(a)	To approve the investment policy for exchequer funds and discharge of trustee responsibilities in relation to non-exchequer funds.
	(b)	To approve Private Finance Initiative (PFI) proposals.
	(c)	To approve any purchase of shareholding.
	(d)	To review and approve alternatives to NHS Resolution risk pooling schemes.
	(e)	To approve any substantive changes to the Trust's insurance or indemnity arrangements in relation to Directors and staff liability.
9.	**Audit Arrangements**	
	(a)	The receipt of the annual management letter from the external auditor and agreement of action on the recommendation where appropriate of the Audit, Risk and Assurance Committee.
	(b)	The receipt of the annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

Delegation of powers to committees and sub-committees

The Board may determine that some of its powers can be exercised by Committees. The Board has delegated some functions to a number of committees, details of which are set out in their respective Terms of Reference.

The Board will determine the reporting requirements in respect of those committees. In turn those committees may delegate functions to a number of sub-committees or groups, details of which are set out in their respective Terms of Reference, but the delegate of powers to sub-committees must be expressly authorised by the Board.

Delegation of powers to employees

The Board has drawn up a Scheme of Delegation, which sets out authority delegated to employees. This document shows the "top level" of delegation within the Trust and should be used in conjunction with established policies and procedures and the Trust's Standing Financial Instructions.

Staff are authorised to act in accordance with their terms of appointment and in accordance with Trust policies and procedures.

The Constitution also specifies delegated authority to directors and the Company Secretary.

Accountability
The Board of Directors remains accountable for all of the Trust's functions and responsibilities, including those which have been delegated and therefore expects to receive information about the exercise of delegated functions to enable its monitoring role.