

Agenda Board of Directors

Date 4 March 2021
Time 9:30 - 15:45
Location Teams
Chair Liam Coleman
Description

1	Agenda	
2	Apologies for Absence and Chairman's Welcome	
9:30		
3	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.	
4	Minutes	
	Liam Coleman, Chairman	
	<ul style="list-style-type: none"> 4 February 2021 (public minutes) 	
5	Outstanding actions of the Board (public)	
6	Questions from the public to the Board relating to the work of the Trust	
7	Chairman's Report, Feedback from the Council of Governors	
9:45	Liam Coleman, Chairman	
8	Chief Executive's Report	
9:55		
9	Patient Story	
10:15	Helen Brown, Lead Palliative Care and End of Life Nurse to present	
10	Integrated Performance Report	
10:35	<ul style="list-style-type: none"> Performance, People & Place Committee Chair Overview - Peter Hill, Non-Executive Director & Committee Chair Part 1: Operational Performance - Jim O'Connell, Chief Operating Officer Quality & Governance Committee Chair Overview - Nick Bishop, Non-Executive Director & Committee Chair Part 2: Our Care - Julie Marshman, Chief Nurse & Charlotte Forsyth, Medical Director Part 3: Our People - Jude Gray, Director of Human Resources 	

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

11 Chair of Charitable Funds Committee Overview

11:50 Jemima Milton, Non Executive-Director & Committee Chair

12 Chair of Mental Health Governance Committee Overview

12:00 Lizzie Abderrahim, Non-Executive Director & Committee Chair

13 Armed Services Community Covenant Agreement

12:10 Jude Gray, Director of Human Resources

14 Ratification of Decisions made via Board Circular/Board Workshop

12:25 Caroline Coles, Company Secretary

15 Urgent Public Business (if any)

16 Date and Time of next meeting

Thursday 1 April 2021 at 9.30am (MS Teams)

17 Exclusion of the Public and Press

12:30 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"

**MINUTES OF A MEETING OF THE BOARD OF DIRECTORS
HELD VIRTUALLY IN PUBLIC ON 4 FEBRUARY 2021 AT 9.30 AM,
BY MS TEAMS**

Present:

Voting Directors

Liam Coleman (LC) (Chair)	Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Nick Bishop (NB)	Non-Executive Director
Andrew Copestake (AC)	Non-Executive Director
Tracey Cotterill (TC)	Interim Director of Improvement & Partnership
Charlotte Forsyth (CF)	Medical Director
Jude Gray (JG)	Director of HR
Peter Hill (PH)	Non-Executive Director
Paul Lewis (PL)	Non-Executive Director
Julie Marshman (JMa)	Chief Nurse
Kevin McNamara (KM)	Chief Executive
Jemima Milton (JM)	Non-Executive Director
Jim O'Connell (JO)	Chief Operating Officer
Julie Soutter (JS)	Non-Executive Director
Simon Wade (SW)	Director of Finance & Strategy

In attendance

Lisa Cheek	Observer – Chief Nurse Designate
Caroline Coles	Company Secretary
Tim Edmonds	Head of Communications and Engagement
Francis Stickland	Observer – Blue Grain Ltd
Dr Jon Freeman	Clinical Psychologist (agenda item 359/20 only)
Sam Walklett	Health & Wellbeing Project Manager (agenda item 359/20 only)
Philippa Williams	Observer – Blue Grain Ltd

Apologies for Absence

None

Number of members of the Public: 7 members of public (including 7 Governors; Pauline Cooke, Arthur Beltrami, Chris Shepherd, David Halik, Janet Jarmin, Badri Chandrasekaran and Ashish Channawar)

Matters Open to the Public and Press

Minute	Description	Action
352/20	<p>Apologies for Absence and Chairman's Welcome</p> <p>The Chair welcomed all to the virtual Great Western Hospitals NHS Foundation Trust Board meeting held in public.</p> <p>Apologies were received as above.</p>	
353/20	<p>Declarations of Interest</p> <p>There were no declarations of interest.</p>	
354/20	<p>Minutes</p> <p>The minutes of the meeting of the Board held on 7 January 2021 were adopted and signed as a correct record with the following amendments:-</p>	

Minute	Description	Action
	<u>328/20 : Chief Executive's Report</u> - Add 'for' after 'care' in the 8 th paragraph 7 th line	
	<u>330/20 : Integrated Performance Report : Referral to Treatment Time (RTT)</u> - amend sentence '....state of flux <i>due to the impact of covid-19</i> not	
	<u>330/20 : Integrated Performance Report : Surgical Pathway</u> - amend sentence '....that red was not <i>intended to indicate a lack of understanding</i>'.	
	<u>330/20 : Integrated Performance Report</u> - End the sentence at 'waits' in the paragraph after stroke performance, line 7.	
	<u>330/20 : Integrated Performance Report</u> - Change 'Paulton Down' to ' <i>Porton Down</i> ' in the 2 nd paragraph after complaints, 34 th line down.	
355/20	<p>Outstanding actions of the Board (public) The Board received and considered the outstanding action list and noted that:-</p> <p><u>330/20 : Integrated Performance Report : Getting it Right First Time (GIRFT)</u> - The plan of actions for the Transformation Programme would be discussed at the Finance & Investment Committee.</p> <p><u>334/20 : Responsible Officer's Annual Report on Appraisal and Revalidation</u> – Once the appropriate governance route for quality assurance at Board level had been formalised Performance, People and Place Committee would determine whether this required further Board oversight.</p> <p>Action : Medical Director</p>	CF
356/20	<p>Questions from the public to the Board relating to the work of the Trust There were no questions from the public to the Board.</p>	
357/20	<p>Chair's Report, Feedback from the Council of Governors The Board received a verbal update which included:-</p> <p><u>Monthly Chair / Lead Governors meeting</u> - There was a meeting held between the Chair and Lead Governors on 18 January 2021 and the issues discussed included the current Covid situation, an update on the Ockenden Report as well as the People agenda in terms of recruitment, and the Integrated Care System.</p> <p><u>Governor Development</u> - As the governors had not been able to visit the hospital for some time a virtual governor ward visit was piloted last month with the governors talking to the staff in Community Services to obtain an overview of the service and to share any areas of success or concerns. It was very well received and another visit will be organised in due course. Also organised was an informal governor briefing which Julie Soutter, Non-Executive Director was invited to give an overview of her role as both NED and Chair of the Audit, Risk and Assurance Committee. There was also a presentation on 'Interrupting the Data'.</p> <p>The Board <u>noted</u> the report.</p>	
358/20	<p>Chief Executive's Report Firstly the Chief Executive wished to mark the sad news of the death of Captain Sir Tom Moore as the Trust had been privileged to receive a significant amount of funding through his work and the incredible response from the public. The Trust, through Brighter Futures, had heavily invested in the staff wellness programme to help staff</p>	

Minute	Description	Action
	<p>manage their physical and mental wellbeing during the pandemic, and beyond. The Board received and considered the Chief Executive's report and the following was highlighted:-</p> <p><u>Vaccination Programme</u> - Along with the response to covid, the Trust had maintained focus on the vaccination programme and last month reached the milestone of 10,000 people having had a first dose of the vaccine. There was a particular concern around vaccine hesitancy amongst the BAME population and a local and system-wide communications focus would be undertaken to dispel some of the myths that had been circulating.</p> <p>Jemima Milton, Non-Executive Director asked how the Trust was going to support and encourage SERCO staff with regard to vaccinations. Kevin McNamara, Chief Executive replied that SERCO staff were considered as part of the GWH family and would be targeted the same as GWH staff within the communications plan.</p> <p><u>Covid Update</u> - The rate of covid cases in Swindon had recently dropped however the number continued to remain around the 100 mark with 22% of the beds occupied by covid patients. Unfortunately the number of deaths had increased since the last Board meeting which put into context the real human factor of the pandemic.</p> <p>The very high number of patients seen recently had put significant pressure on bed capacity which in turn led to delays in the Emergency Department and as a result the Trust declared an internal critical incident on 13 January 2021. The following day, a critical incident was also declared more widely across BSW reflecting the system-wide issue. The Trust's own internal critical incident was stood down a few days later however the hospital remained very busy, and a coordinated system-wide response remained in place, along with a focus on discharging patients as soon as they can go home or for on-going care elsewhere.</p> <p>It was noted that even if the numbers of patients decreased at the front door there would continue to be significant pressure both in the hospital and system-wide due to the higher numbers of seriously unwell patients staying in hospital for a much longer length of time.</p> <p><u>Staff Appointments</u> - Following a competitive recruitment process the Trust had appointed Claire Thompson as its first substantive Director of Improvement and Partnership. The new Chief Nurse, Lisa Cheek would commence in role at the end of March 2021 and Julie Marshman, current Chief Nurse, had offered to step in to manage the transition so that there was not a gap in cover. Also the Trust had reached agreement with Salisbury hospital to jointly recruit a Chief Digital Officer to develop the IT infrastructure.</p> <p><u>GWH Site Development</u> - The Trust continued to make progress on a number of key strategic developments on site which included the Urgent Care Centre and Radiotherapy Centre.</p> <p>Julie Soutter, Non-Executive Director highlighted media attention on the disruption to training of junior doctors caused by the pandemic and asked if the Trust had seen this filter through, and if so what were the plans to mitigate this risk. Charlotte Forsyth, Medical Director replied that in the short term any disruption to training was being managed with the deanery, however longer term this could lead to a potential shortage of consultants coming through the system. It was agreed to refer this to the Performance, People and Place Committee to understand the national and regional</p>	

Minute	Description	Action
	<p>context in terms of mitigating the risk(s).</p> <p>Action : Medical Director</p> <p>Lizzie Abderrahim, Non-Executive Director informed the meeting of her new role as health and wellbeing guardian representing the Board. There followed a discussion on the type of support now required by the staff which was more preventative and it was acknowledged that the Trust had already embarked on developing these new measures however recognised there was further work to be done to enhance the staff wellbeing programme further.</p> <p>The Board noted the report.</p>	CF
359/20	<p>Staff Story</p> <p><i>Dr Jon Freeman, Clinical Psychologist and Sam Walklett, Health & Wellbeing Project Manager joined the meeting.</i></p> <p>The Board received a presentation which centred around the changes made last year to support staff health and wellbeing during covid-19 and the planned actions to enhance the wellbeing programme going forward.</p> <p>It was acknowledged that, although the wellbeing team was small in number, a lot of the success had been due to their physical visibility within the hospital. It was noted that to improve the reach and impact of this service Dr Jon Freeman's role would become full time from April 2021.</p> <p>Julie Soutter, Non-Executive Director asked if the programme extended to the community and GP practices. Dr Jon Freeman, replied that sessions with the community nurses had already taken place, together with contact with Princess Lodge and Primary Care. The aim was to embed staff wellbeing within every team on and off site.</p> <p>Paul Lewis, Non-Executive Director commented that there had been challenges with staff wellbeing around breaks with PPE and pressures of demand and asked if there were any ideas to support staff physically having a break. Dr Jon Freeman, replied this was a challenge due to the reduction in space however more wobble rooms had been created to help give staff covid respite, and added that breaks should be compulsory and this message should come from the top.</p> <p>Lizzie Abderrahim, Non-Executive Director congratulated the team on its well-deserved Nursing Times Workforce Award and as the Board wellbeing guardian asked how the Board wished information to be fed from the process and planning. Liam Coleman, Chair agreed to take this action to assess how to take this forward.</p> <p>Action : Chair</p> <p>The Board wished to thank the team for their incredible commitment and effort during this most challenging time. The Board were completely supportive and committed to staff wellbeing and this would continue to be a focus of Board's attention.</p> <p>The Board noted the staff story.</p>	LC
360/20	<p>Integrated Performance Report</p> <p>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 November/December 2020.</p>	

Minute	Description	Action
	<p>Part 1 : Operational Performance</p> <p>Performance, People and Place Committee Chair Overview The Board received an overview of the detailed discussions held at the Performance, People and Place Committee around the IPR at its meeting on 27 January 2021 and highlighted the following:-</p> <p><u>NHS Elect/NBI/NECSU Reports</u> - Assurance level amber. These reports had been commissioned from the committee's disquiet on quality of data. The action plans were very good and in general progress had been made however had been hampered by covid. It was anticipated that the plans would be signed off in April 2021.</p> <p><u>Cancer Performance</u> - Assurance level amber. The revised rating (previously green) related to difficulties experienced at the Tertiary Centre (Oxford). The Chief Executive had sent a letter to the Oxford Chief Executive outlining a number of areas where reassurances were required. It was noted that a response had now been received and the immediate issue had been resolved.</p> <p><u>Referral to Treatment Time</u> - Assurance level red. Good progress had been made however once again performance had been hampered by covid as surgical activity, except for urgent and cancer operations, had been taken down.</p> <p><u>Diagnostics</u> - Assurance level red. Similar to RTT above, activity had been hampered by covid however improvements in waiting times over recent months had been helped from the independent sector. The Committee was assured that priority was given to cancer and other clinically urgent patients.</p> <p>The Board received and considered the operational performance element of the report and the following highlighted:-</p> <p><u>ED Performance</u> - Performance against the 4 hr access standard had dropped in December to 81.5% however increased in January 2021 to 86.3%. However it was noted the data masked other factors which included a critical incident declared on 13 January 2021 due to significant increased admissions of covid patients. Daily 'Criteria to Reside' calls with partners continued to support patient flow.</p> <p><u>Cancer Performance</u> - The Cancer 62 Day standard had seen a significant improvement in performance in December 2020 however had dipped in January 2021. The cancer performance had not been immune to covid impact due to stops and starts and patient choice.</p> <p><u>Referral to Treatment Time (RTT)</u> - The gradual improvement in performance against the Referral To Treatment standard continued however performance was still well below target due to the on-going impact of Covid. It was noted that performance would fluctuate in coming months due to taking down surgical activity, except for urgent and cancer patients, in the current wave of the pandemic.</p> <p><u>Diagnostics</u> – Space restrictions to do with social distancing due to covid impacted on the 6 weeks delivery standard; however performance varied in different specialties. Neighbouring trusts had achieved better numbers and any learning would be taken through the Performance, People and Place Committee.</p> <p>Paul Lewis, Non-Executive Director observed that not all KPIs had rag ratings around</p>	

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	<p>data quality and asked if it was possible to have this on all the KPIs. Jim O'Connell, Chief Operating Officer agreed to include these ratings with the caveat that until the data was automated this was a manual exercise and therefore could lead to some errors.</p> <p>Action : Chief Operating Officer</p> <p>In summing up the Chair drew attention to the two main areas of focus which were RTT and diagnostic waiting times. The Board acknowledged the red rag ratings were an accurate score but with good visibility on what was required with a realistic plan for achievement. This in turn raised another point which was the assurance piece, a format which had just been introduced and work in progress. The concept was to determine a route to improvement from a specific rated colour, to include how long it would take with critical points for assessment by the Board sub-committees. This, along with the Board Assurance Framework, would result in Board agenda items considered from a risk perspective and prioritised accordingly.</p> <p>Part 2 : Our People</p> <p>The Board received and considered the workforce performance element of the report with the following highlighted:-</p> <p><u>Workforce</u> - Continued Covid related absence inevitably created a need for backfill and thus a reliance on temporary staffing, however the availability of temporary staff resource across both bank and agency was limited and therefore was an increase pressure on staff and divisions.</p> <p><u>Mandatory Training & Appraisals</u> - Compliance remained under target overall. Part of the issue was IT together with a decision to pause certain training to deal with the pandemic. Divisional improvement plans were in place and the appraisal process was under review to develop a simpler form with a focus on wellbeing.</p> <p>There followed a discussion on appraisals and mandatory training which included medical staff, learning, culture and compliance. It was acknowledged that these were work in progress from moving from one point to a better point and was one for Performance, People and Place Committee to oversee progress.</p> <p>Lizzie Abderrahim, Non-Executive Director asked for clarification on the data around the number of disabled identified staff accessing CPD. Jude Gray, Director of HR took the action to get clarification for the next Performance, People and Place Committee.</p> <p>Action : Director of HR</p> <p>Part 3 : Our Care</p> <p>Quality & Governance Committee Chair Overview</p> <p>The Board received an overview of the detailed discussions held at the Quality & Governance Committee around the quality element of the IPR at the meeting held on 17 December 2020 and the following highlighted:-</p> <p><u>WHO Checklist</u> – Assurance level red. This audit of compliance within surgical services demonstrated some failure to comply with standard procedures for safe practice within several surgical specialties. The narrative was deliberately robust in order to bring to the Board's attention and to cascade throughout the organisation that non-compliance would result in formal action against those responsible.</p>	<p>JO</p> <p>JG</p>

Minute	Description	Action
	<p>Julie Soutter, Chair of Audit, Risk & Assurance Committee added that discussions around incidents, learning, and compliance had resulted in commissioning an internal audit review to look at how to triangulate the data to gain assurance that processes and controls were working. Julie Marshman, Chief Nurse added that this review was being scoped with the auditors and once completed would be reported back to Audit, Risk & Assurance Committee.</p> <p>Action : Chief Nurse</p>	JMa
	<p><u>Clinical Audit and Effectiveness Annual Report</u> - Assurance level red. Clinical Audits had been seriously affected by the pandemic at both a local and national level. It was recognised that a timely review would be sensible to identify those overdue audits that would be meaningless if pursued with oversight and challenge of the final list by Quality & Governance Committee.</p> <p>Action : Medical Director</p>	CF
	<p><u>Primary Care</u> - Assurance level green. Significant progress within Primary Care had been made in addressing the many shortfalls in performance that the Trust had inherited and the staff was commended with such excellent progress.</p> <p>Kevin McNamara, Chief Executive added that great work had taken place within Primary Care however this had come with significant financial cost and recognised that a risk was emerging in terms of financial implications to the Trust once the indemnity expired and one question for the Board to consider in the near future.</p> <p>The Board received and considered the workforce performance element of the report with the following highlighted:-</p> <p><u>Patient Safety / Tissue Viability</u> - Tissue viability incidents remained an area of concern with increased number of harms recorded in both the acute and community settings. The Tissue Viability team were working closely with the Deputy Chief Nurses and RUH Bath to develop a reinvigorated campaign to improve awareness and engagement with improvement plans to embed best practice. This was a priority focus on the preventable harm agenda, followed by falls.</p> <p>Liam Coleman, Chair asked what the timescale to see improvements in this area was. Julie Marshman, Chief Nurse replied that some actions would see improvements fairly rapidly for instance those connected with processes and documentations. Regular progress reports and oversight would be through Quality & Governance Committee.</p> <p><u>Patient Safety / Safer Staffing</u> - New safe staffing meetings were now in place to ensure safe staffing across the organization. Staff had been redeployed between and across the divisions using the Safer Nursing Care Sundial Information to ensure safety was maintained where there was a significant shortfall in required hours. It was noted that 3rd year nursing students had entered the temporary register to work in the Trust and this would greatly contribute to the skill mix however recognising that this cohort of students still required a learning environment and did not replace permanent staff.</p> <p>Paul Lewis, Non-Executive Director commented that he was hugely encouraged by the progress made in complaints given all the challenges within the organisation, and, thanked the team for responding and applied learning where appropriate.</p>	

Minute	Description	Action
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Part 4 - Use of Resources

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 21 December 2020 and the following highlighted:-

Finance Recovery and Efficiency - The assurance rating had moved from red to amber due to an excellent report from Tracey Cotterill, Interim Director of Improvement and Partnership. The draft paper set out a clear financial recovery plan across a number of key areas.

There followed a discussion on how the financial recovery plan fits within the overall transformation and improvement programme and it was noted that a more integrated improvement strategy was being prepared with the next iteration to be presented at the Finance & Investment Committee in February 2021 and ultimately to Board in due course.

Action : Interim Director of Improvement and Partnership

TC

Business Planning and Budget Setting - Assurance level red. The Trust had been informed that the planning process had been delayed by 3 months and the current financial regime would continue into Q1 2021/22.

Forecast Income and Expenditure Position - Assurance level amber. Despite concerns over escalating Pay and non-Pay costs, the forecast appeared to be achievable, especially as the loss due to the Elective Incentive Scheme was now likely to be considerably lower than £1m.

Agency Usage and Staffing Levels - Assurance rating amber. A deep dive was undertaken as the Committee had been concerned that agency staffing levels and costs increased in August despite Covid-related activity and acuity apparently falling. There had been a good discussion and paper which outlined the reasons for the high agency spend with a number of conclusions and lessons learned that should be helpful as the Trust looked to de-escalate staffing levels post-Covid.

Forecast Capital Expenditure position - Assurance rating amber. Whilst it now appeared unlikely that the Trust would spend the full £31.7m in the plan, the Committee was assured that in most cases, any underspends should be able to be carried forward into 2021/22.

Following a comment from a governor around research funding, there followed a discussion around the opportunities to access potential research funding. It was confirmed that this would be part of the business planning process for next year.

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

- The financial year end position was £130k below plan.
- The financial position for end month 9 was £71k below plan.
- Trust income was above plan by £1,228k year to date due to funding received to cover costs in relation to Thames Valley Cancer Alliance (TVCA), Carbon Energy Fund, high cost drugs and estates dilapidation work in Primary Care sites.
- Pay was £147k overspent year to date due to costs of Covid vaccination

Minute	Description	Action
	<p>programme, December incentive payments and temporary staffing pressures.</p> <ul style="list-style-type: none"> • Non-pay expenditure was overspent year to date by £951k due to costs of the covid vaccination programme, TVCA, estates dilapidation costs and carbon energy costs which are funded by additional income. Vaccination costs had not been budgeted for however costs would be recovered. • The two main financial risks were escalation of pay and the capital programme. • The capital programme current underspend was £4.4m with covid having had a significant impact, however with mitigating actions in place any underspends should be carried forward into 2021/22. • Business planning had been delayed for 3 months with the 1st quarter of 2021/22 under a block contract similar to the 2nd half of 2020/21. <p>RESOLVED</p> <p><i>to review and support the continued development of the IPR and the on-going plans to maintain and improve performance.</i></p>	
361/20	<p>Chair of Audit, Risk and Assurance Committee Board Assurance Report</p> <p>The Board received and considered a paper which summarised key issues considered by the Audit, Risk and Assurance Committee at the meeting held on 14 January 2021 and the following was highlighted:-</p> <p><u>Risk Management – Integrated Care and Community</u> - Assurance level amber. Good progress to implement consistent and robust risk management processes across the new Directorate.</p> <p><u>15+ Risks</u> - Assurance level red due to the number of top risks. Development of risk management underway with a new focus on the Risk Committee and Executive Director lead for key risks.</p> <p><u>External Audit Plan 2020/21</u> - Assurance level green. Audit risks remained stable except Going Concern (reduced risk). Timetable changes noted - ARAC May meeting would be moved in line with annual report and accounts submission deadline. It was noted that Quality Accounts was likely to be deferred.</p> <p><u>Internal Audit & Counter Fraud update</u> - Assurance level green. Positive report on internal audit and counter fraud work. Good assurances on key financial systems.</p> <p><u>Internal Audit Follow up report</u> - Assurance level green. There were a number of overdue recommendations however all being monitored and progressed with some agreed delays due to restructure of Divisions and covid.</p> <p><u>Internal Audit Draft Plan 2021/22</u> – Assurance level green. Final plan to be agreed at March 2021 meeting.</p> <p><u>Committee Effectiveness Annual Review</u> – Assurance level green. A number of areas identified which included succession planning for Chair and improvement in reporting in risk management and Board Assurance Framework which was under development.</p> <p>The Board noted the report.</p>	
362/20	<p>Immediate and Essential Actions from the Ockenden Report</p> <p>The Board received and considered a paper which provided the assessment and effective assurance of the immediate and essential actions from the Ockenden report.</p>	

Minute	Description	Action
	<p>The report also described the Trust's commitment to meet the BirthRate Plus standard by 31 January 2021.</p> <p>The Board had received an earlier report at its meeting in January 2021 and this was the next stage which was to submit an Assurance Assessment Tool to NHSE&I on 15 February 2021. There were eight areas identified that were not fully compliant and robust action plans with deadlines to achieve full compliance produced.</p> <p>Liam Coleman, Chair thanked the team for all their hard work in pulling together the report in such short timescales and confirmed that the governance route for overseeing and monitoring was through the Quality & Governance Committee with any concerns or timescales not reached escalated to Board.</p> <p>The Board felt strongly that this was a really important agenda and were committed to implementing all of the actions within the report however recognised that there was a significant financial burden against achieving these recommendations, in particular to achieve the required increase in workforce numbers to meet the revised standard.</p> <p>In terms of recruitment, this had been identified as a gap and in reality to find another 10 midwives on top of the current vacancies was a significant challenge for the Trust however it was emphasised that the Trust had the required level of midwives per population birthing levels and the last CQC inspection, in February 2020, had rated the maternity service as 'good' across all domains.</p> <p>A robust discussion followed around the financial implications especially in the context of the wider system and at national level, notwithstanding the reality of the serious shortage of midwives and obstetricians. It was noted that these financial risks had been raised through various channels to national level to consider funding implications and pipelines for midwives in the future.</p> <p>Paul Lewis, Non-Executive Director maternity champion confirmed his independent review and input into the assessment tool following a detailed session.</p> <p>RESOLVED</p> <p><i>to approve the Assurance Assessment Tool to be submitted to NHSE&I in response to the recommendations outlined in the Ockenden Report and the on-going work to ensure full compliance.</i></p>	
363/20	<p>Ratification of Decisions made via Board Circular/Board Workshop</p> <p>None.</p>	
364/20	<p>Urgent Public Business (if any)</p> <p>None.</p>	
365/20	<p>Date and Time of next meeting</p> <p>It was noted that the next virtual meeting of the Board would be held on 4 March 2021 at 9:30am via MS Teams.</p>	
366/20	<p>Exclusion of the Public and Press</p> <p>RESOLVED</p> <p><i>that representatives of the press and other members of the public be excluded</i></p>	

Minute	Description	Action
	<i>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.</i>	

The meeting ended at 1605 hrs.

Chair Date.....

DRAFT

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – March 2021

JG – Jude Gray, JMa – Julie Marsham, KM – Kevin McNamara, CF – Charlotte Forsyth,
TC – Tracey Cotterill, JO – Jim O'Connell, SW – Simon Wade, CC – Caroline Coles

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
4-Feb-21	355/20	Outstanding actions : Responsible Officer's Annual Report Once the appropriate governance route for quality assurance at Board level had been formalised Performance, People and Place Committee would determine whether this required further Board oversight.	CF	For PPPC
4-Feb-21	358/20	Chief Executive Report : Junior Doctor Training To explore the risk of junior doctor training due to covid in both the short and term and local and national context.	CF	For PPPC
4-Feb-21	359/20	Staff Story : Board Well-being Guardian Determine how the Board Well-being Guardian fed information from the process and planning into Board.	LC	To be agreed outside the meeting.
4-Feb-21	360/20	IPR : Operational Performance : Data Quality Add rag ratings to all KPIs in terms of data quality.	JO	Included in the IPR. Closed.
4-Feb-21	360/20	IPR : Our People : Workforce Clarification requested on the data around the number of disabled identified staff accessing CPD.	JG	For PPPC
4-Feb-21	360/20	IPR : Our Care : Internal Audit Review Controls and Processes Once the internal audit review had been completed the results would be considered at ARAC and any areas identified for further deep dives to be referred to the appropriate committee.	JMa	For ARAC
4-Feb-21	360/20	IPR : Our Care : Overdue Audits The identification of overdue audits that would be meaningless and removed from the list to have final oversight and challenge by Quality & Governance Committee.	CF	For Q&GC
4-Feb-21	360/20	IPR : Use of Resources : Financial Recovery Plan Next iteration of the Financial Recovery Plan to be presented to the Finance & Investment Committee in February 2021.	TC	For FIC
Future Actions				
None				

Chief Executive's Report

Meeting	Trust Board	Date	4 March 2021
Summary of Report			
The Chief Executive's report provides a summary of recent activity at the Trust.			
For Information	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>
		Discussion & input	<input type="checkbox"/>
		Decision / approval	<input type="checkbox"/>
Executive Lead	Kevin McNamara, Chief Executive Officer		
Author	Kevin McNamara, Chief Executive Officer		
Author contact details			
Risk Implications - Link to Assurance Framework or Trust Risk Register			
Risk(s) Ref	Risk(s) Description		Risk(s) Score
Legal / Regulatory / Reputation Implications	N/A		
Link to relevant CQC Domain			
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>
		Caring	<input checked="" type="checkbox"/>
		Responsive	<input checked="" type="checkbox"/>
		Well Led	<input checked="" type="checkbox"/>
Link to relevant Trust Commitment			
Consultations / other committee views			
N/A			

Recommendations / Decision Required

This report is for information only.

1. Coronavirus

1.1 Current position

We have started to see the number of patients we are treating with coronavirus decline and, for the first time in many months, this figure dropped below 50 last month.

There has also been a reduction in community infection rates, with Swindon's case rate now the lowest it has been all year.

These are really positive developments. Although we still have COVID patients in the hospital, the overall operational impact is less than it was a few weeks ago. However, COVID is still having an impact on our activity, in particular the number of patients with COVID who need intensive care means that we are continuing to use space which would have normally been used for theatres to care for these patients. This means we are still having to cancel some surgery.

At the time of writing we had COVID patients in our COVID Assessment Unit, ICU, the additional ICU space created in Recovery, and on two wards.

1.2 Waiting times and our recovery programme

There has been widespread coverage of the number of people waiting very long periods to start hospital treatment in England with waiting lists now at their highest since 2008.

The cancellations we made during the first wave, and then again in the latest wave, have unfortunately increased the time patients are having to wait for treatment.

Our latest position is that 1,312 patients have been waiting more than 52 weeks for treatment – compared to almost zero before the pandemic.

We clearly don't want any patient to have to wait this amount of time and it is imperative that we get our elective programme back up and running as soon as we can.

However, we need to overcome a number of challenges to be able to do so, not least needing to see a sustained reduction in the number of COVID patients requiring intensive care in order to re-open our theatres. It must be recognised even with that, it will be a significant operational and financial challenge to reduce that very large backlog.

1.3 One year of the pandemic

I am extremely proud of our Trust's response to coronavirus and the incredible work our staff have done over a sustained period of time in order to deliver care to every patient with COVID who needed it – it is a remarkable achievement.

Our staff have worked extremely hard for a year to respond to coronavirus and we shouldn't forget that they have risen to this unprecedented professional challenge at a time when we were all facing significant disruption in our personal lives.

We will formally mark the year anniversary in a number of different ways, including thanking every member of staff, but I think it is appropriate that on 11 March, one year to the day that we saw our first COVID patient, we will be holding a memorial service to remember those we lost.

It is a sad reflection of the time we are living in that one year on, this kind of service will still need to be held virtually, but it will be an important opportunity to remember those members of staff and our volunteers we lost during the year, both from COVID and other causes, and to reflect on the more than 300 patients who have very sadly died at our hospital.

In the longer term we are continuing to work to create a permanent space to enable us all to reflect on the pandemic and the experiences we have taken from it.

1.4 Lifting of lockdown

The current restrictions as part of the third national lockdown have been in place for some time and I welcome the cautious nature of the Government's proposed exit from the national lockdown, particularly the phased approach being based on conditions being met.

While we all look forward to lives being restored to some sort of normality, the fact remains that coronavirus is still present and while the vaccination programme is rolling out at pace, it will still be a few months before the vast majority of the population has received a first dose, and even longer until second doses have been rolled out. We must also recognise that Covid will be with us over the coming years and we will need to continue to manage everything we do in that context.

1.5 Vaccination programme

The Government's emphasis on the lifting of lockdown being partly dependent on the vaccination roll-out means that we have a really important role to play in building on the success of our own vaccination programme and, in doing so, helping to get the country back to normal.

Last month we reached the milestone of administering our 20,000th first dose, and in March we are on target to reach 30,000. This is a great achievement and the vaccination team has worked extremely hard to get to this point.

We continue to vaccinate groups in accordance with the national criteria and one of these groups is of course our own staff and other health and social care workers. To date we have vaccinated over 80 per cent of our workforce and are now focusing our efforts on those staff who have so far been hesitant to have the vaccine.

It is noticeable that people from BAME backgrounds are more reluctant to have the vaccine and we are working with this group of staff to understand the reasons for their hesitancy in order to provide them with reassurance that the vaccine is safe to have.

2. Care Quality Commission inspection of Primary Care

Last week the Care Quality Commission carried out a full inspection of our primary care services. This was a physical inspection with a further day of interviews and data collection.

Inspectors focused on improvement plans, speaking with patients and staff, looking at patient records and quality data under the Key Lines of Enquiry domains.

We await the results of the inspection but hope the CQC will recognise the significant improvements we have made since we agreed to take on these services in November 2019.

The CQC last inspected these services in February 2020 when inspectors recognised the improvements made in our first 12 weeks - Moredon was rated as 'requires improvement' with Abbey Meads 'inadequate'.

3. Way Forward Programme

We have recently had the full business case for the land purchase approved as part of our Way Forward Programme. This means we are a big step closer to owning the land adjacent to the hospital site that will accommodate a number of new service developments, including our ambitious plans for a Centre of Excellence for Rehabilitation.

We expect to transfer the funds by the end of March, and are currently working through some of the last legal requirements that come with buying and selling of land.

Once purchased, this land will unlock many possibilities for us to continue to expand and improve our services in years to come.

The approval of the business case is testament to the hard work of the Way Forward Programme team who have invested a lot of time and resource into securing the land for our important site developments.

4. Recruitment to senior roles

Following Charlotte Forsyth's decision to stand down as Medical Director we will be recruiting externally for this role imminently.

This is a critical role for the Trust, with the pandemic really highlighting how important strong clinical leadership has been. We therefore hope to fill this position as soon as possible and I'm pleased that Charlotte has agreed to remain in her position and support with the transition process to the new Medical Director.

There are a couple of other senior level roles out for recruitment (Deputy Chief Operating Officer and Divisional Director of Surgical, Women's and Children's) and we hope to announce appointments to these positions very soon.

Patient Story

October 2020

Patient Story

Background

- x is aged 39 years old with metastatic cervical cancer, diagnosed in 2016.
- x had her last cycle of chemotherapy in October 2020.
- x knew that this was the last treatment option available. If scans were to show further disease progression then x would need to consider trials in London.
- x was admitted early December with lethargy and vomiting. This was second admission in a month.

Admission

- x was admitted with hypercalcaemia, shortness of breath, lethargy and community acquired pneumonia.
- Recent CT Scans showed disease progression in the lung with widespread metastatic bone lesions.
- x was aware of disease progression.
- X knew that the plan was for symptom management and end of life care.
- Three days of being in hospital, medical notes state 'bloods, continue observations and treatment for further 24hrs'. However, x had expressed a wish that home was the preferred place of care with husband and children.
- Ward staff acted as patient advocate and challenged the decision for a further 24hr treatment, recognising the patient was deteriorating and wanted to go home.

A Plan was put in to place for discharge:

- Oxygen was ordered for home delivery. It was delivered within 4 hours.
- Referral to Swindon EOL Community Team (SELeCT). Team leader visited ward and met x to introduce service and explore x's wishes.
- Just in case medications prescribed, administration paperwork completed to enable the community team to give medications and 'Tablets to Take Away' (TTA)'s received from pharmacy.
- Palliative care team visited patient to support the ward and co-ordinate rapid discharge.
- Treatment Escalation Plan (TEP) form updated to reflect x's wish not to be readmitted to hospital.
- Ward staff referred to district nursing service.
- Occupational Therapist (OT) organised hospital bed to be delivered and visited home to ensure all equipment in place as required.
- Referral to Prospect Hospice.
- Family were communicated with and made aware of and in agreement of the discharge plan. They organised for x's bed to be brought downstairs as this was x's preference over hospital bed.

Care in Community:

- SELeCT carers met x at home.
- SELeCT provided a twice daily package of care initially but were able to increase this to three times a day as x deteriorated. .
- Community night nurses visited to administer medication.
- SELeCT team leader visited to meet x and family in order to have end of life discussions and complete documentation.
- SELeCT set up a syringe pump so that x had continuous symptom relief.
- Prospect at home provided night sits.
- Rapid response community paramedic attended to verify patient following death.
- x had three days at home surrounded by family before she died.
- **4 hours** after the staff challenged the medical team x was at home surrounded by her family.

Shared Learning

- Patient Story to be shared to the EOL Committee meeting and divisional leads can share within their divisions
- Share with EOL managers and EOL champions
- Extracts to be included in the EOL safety brief.

Integrated Performance Report (IPR)

Meeting	Trust Board	Date	4 th March 2021
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Summary of Report

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

Key highlights from the report this month are:

Our Performance

Performance against the 4 Hour Access standard has improved from 81.5% to 86.14%, however this continues to be below the 95% standard. Daily 'Criteria to Reside' calls are continuing and are chaired by the Head of Clinical Operations. These meetings focus on unblocking any delays to discharges and providing support to wards to identify earlier 'Golden Patients'. Covid-19 admissions to the Trust increased significantly in January and on 13 January, the Trust declared a critical incident. Numbers reached 163 patients in mid-January - significantly higher than our April 2020 peak of 95.

Overall, the Trust's RTT Incomplete Performance for December 2020 was 67.04%, which was an improvement of 0.34% in month. December saw referrals at 92% of the prior year. For the first time in 3 months, the PTL has increased in size (196). In terms of diagnostic waiting times, the DM01 performance saw a slight decline to 61.5% in December compared to 62.5% in November.

December's 62 day Cancer performance was 94.4% with the Trust achieving the national 62 day standard for the last two months. Prior to this, performance was heavily impacted by Covid-19 and the diagnostic/treatment delays.

The Trust continues to maintain SSNAP Level B performance. Q2 improved further on Q1 performance (73.1% v 77.9%) and Q3 is predicted to continue within Level B performance despite increasing pressure on stroke beds in December.

Our Care

The number of inpatients testing positive to Covid -19 has increased dramatically in January to 437 when compared to 197 in December. A total of 54 of these cases were hospital acquired. During January the Trust has seen the highest number of deaths recorded with a positive Covid -19, 89 deaths reported in January and a total of 258 between April 20 and January 21.

The number of pressure ulcers reported in all settings remains high, of 30 reported incidents in the acute setting 10 of these patients were in ITU and the harm related to the impact of proning. Work is underway in terms of education, training and national benchmarking. A Pressure Ulcer Improvement Programme launch day is planned for 4th March 2021, all divisions and professions will be represented. Themes and working groups include, skin inspections and 'react to red', SSKIN care bundle, reducing device related harm, investigation and learning, training and education.

Two incidents have been reported as Serious Incidents in January. This is the lowest monthly reported number of Serious Incidents since August 2020 and less than in January 2020. In total there are 34 on-going SI investigations.

A new slide has been inserted to meet the requirements for Board reporting in response to the Ockenden Report. This new quality surveillance model seeks to provide consistent oversight of maternity and neonatal services. The on-going learning and insight will help to inform improvements in the provision of perinatal services.

There have been 48 complaints reported in month, a decrease on previous months and 104 concerns an increase received throughout January 2021. The PALS and Complaints team have strengthened processes

in line with Trust policy and increased direct communication with patients and families resulting in more immediate resolution of concerns and issues.

Friends and Family Test (FFT) text messaging was introduced from the 1st January 2021 for inpatient areas, with over 2000 messages with a response rate of 27%. In response to the question “*How likely are you to recommend our services to your friends and family*” 89% of patients gave a positive response. It is planned to introduce text messaging to outpatient areas and maternity by 1st April 2021.

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 for January are increasing agency spend, deteriorating performance in appraisal compliance and below targeted performance for Mandatory Training compliance.

Agency spend in January was £564K over plan (£3.5M above target year to date). Trust activity and Covid-19 related impact has resulted in a significant increase in demand for additional staffing resulting in 185WTE worked above budget.

The Trust vacancy position has decreased marginally in January to 7.4% from 7.8%, of this AHP 12.5%, Scientific 6.7%, Medical & Dental 1.8%, All Nursing 7.5% and Senior Managers & Admin 8.9%. There have been minimal budget changes applied to January (+3WTE). 53 new starters in-month (48.13 WTE) commenced employment at the Trust and the time to hire for January was 51 days (outside of KPI target) from advert live to start date confirmed.

Sickness rate for December is 4.17% which is lower than the same time point the previous year (4.5%)

There has been no significant improvement in overall mandatory training performance which is 83.85% and remains below target of 85%. Appraisal rate has declined to 70.43% from 72.35% and remains below the 85% target. Phased compliance trajectories are being developed for every Division to support realistic improvement across departments during the critical pressures of the pandemic.

The staff health and wellbeing offer for 2021 is focused on enabling a Trust-wide culture of wellbeing where staff are encouraged that seeking support is an investment in themselves and not a weakness.

The first HWB champions meeting was held on 2nd February with 46 attendees. Discussions on HWB initiatives and a mapping exercise is currently underway with the HWB Champions to identify Trust-wide representation. Outsourcing resource options have been explored for pre-employment vetting, immunisation and post-induction clinic service for candidates. A preferred supplier has been identified and work is now in place to agree an implementation plan for March 2021.

Promotion of the benefits of the staff Employee Assistance Programme (EAP) continues with a training session in January for HR, OH and HWB to highlight the range of tools available to staff. 40 staff from the HR function attended and will share this learning to promote and increase the awareness of this service to staff.

Equality and Diversity actions are underway with the re-launch of an EDI newsletter expected by the end of February. Key priorities have been identified in the Trust with an action plan based on case studies to tackle institutionalised racism in progress. In addition accessibility and use of Occupational Health support for the Community staff are being reviewed to ensure an equal service and support to all staff.

Use of Resources

The Trust plan is £3,829k deficit including the impact of Elective Incentive Scheme (EIS). The Trust in month position is £508k deficit against a plan of £882k deficit which is £374k favourable variance. The YTD position is £1,812k deficit against a plan of £2,316k which is £504k favourable variance.

Trust income is above plan by £2,411k year to date due to funding received to cover costs in relation to Hospital Discharge Programme (HDP), Lateral Flow Testing, Thames Valley Cancer Alliance (TVCA), Carbon Energy Fund, high cost drugs and estates dilapidation work in Primary Care sites. Private Patient activity and income has reduced in January but is above plan year to date. Pay is £751k overspent due to costs of Covid-19 Vaccination Programme, HDP, incentive payments and temporary staffing required to meet Covid-19 surges. Non-pay expenditure is overspent by £1,157k due to costs of Covid-19 vaccination programme, HDP, TVCA, estates dilapidation costs and carbon energy costs which are funded by additional income. Non-

pay also includes clinical supplies and drugs which are underspent due to reduction in elective activity during Covid-19 surges. The position also includes PFI costs for additional cleaning, portering and gas.

The forecast for 20/21 is £4,381k deficit excluding the estimated £1,000k penalty for the EIS (Elective Incentive Scheme). The forecast is £552k higher than plan due an increase in the accrual for annual leave that will be owed to staff at the end of the financial year. The Trust is required to reflect this as a liability in its accounts but it is not a cash payment.

The Trust capital plan for 20/21 is £37,874k including Order Comms, Priory Covid-19 projects, rebuilding Clover, Way Forward Programme, Critical Care Resilience, Endoscopy Clinic Room , Medical Oxygen scheme and IT infrastructure.

For Information	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Discussion & input	<input type="checkbox"/>	Decision / approval	<input type="checkbox"/>
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Executive Lead

Author	Jim O'Connell, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Julie Marshman, Chief Nurse
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Author contact details	jim.o'connell@nhs.net jude.gray@nhs.net julie.marshman1@nhs.net simon.wade5@nhs.mail
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Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score
792	1. 4 Hour Standard	16
1357	2. RTT Standard	16
1917	3. Cancer	16

Legal / Regulatory / Reputation Implications	Regulatory Implications for some indicators – NHSi, CQC and Commissioners
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Link to relevant CQC Domain

Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>	Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>	Well Led	<input checked="" type="checkbox"/>
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Link to relevant Trust Commitment

Consultations / other committee views

Recommendations / Decision Required

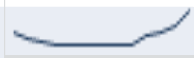






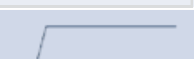









The Trust Board is asked to review and support:

- the continued development of the IPR
- the on-going plans to maintain and improve performance.

Integrated Performance Report

February 2021

Performance Summary

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
Hospital Combined Performance Score	5682 (Feb)		48	30	21	Feb 21
ED 4 Hour Access Standard (combined Types 1 & 3)	86.14 (Jan)		14	68	52	Jan 21
Total Time in ED (Type 1) in Minutes (Median)	173 (Dec)		52	99	49	Dec 20
RTT Incomplete Pathways	67.04% (Dec)		67	63	46	Dec 20
Cancer 62 Day Standard	94.4% (Dec)		2	67	36	Dec 20
6 Weeks Diagnostics (DM01)	61.5% (Dec)		88	86	17	Dec 20
Stroke (to note - Q3 SSNAP score projection is Level B / 74)	68 (Dec)		45	27	77	Q2 20/21
Family & Friends (staff) – Percentage recommending GWH as a great place to work	66% (Q4)		89	53	1	Q2 19/20
YTD Surplus/Deficit	-4.3% (Oct)		84	8	38	Q2 19/20
Quarterly Complaint Rates (Written Complaints per 1000 wte)	39.79 (Q4 20/21)		114	56	48	Q2 20/21
Sickness Absence Rate	4.17% (Aug)		36	31	25	Sep 20
MRSA	0 (Jan)		32	119	23	Nov 20
Elective Patients Average Length of Stay- (Days)	3.46 (Jan)					
Non-Elective Patients Average Length of Stay (Days)	4.47 (Jan)					
Community Average Length of Stay - Days	17.1 (Dec)					
Number of Stranded Patients (over 14 days)	67 (Jan)					
Number of Super Stranded Patients (over 21 days)	35 (Jan) ²⁶					

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

Board Committee Assurance Report

Performance, People & Place Committee		
Accountable Non-Executive Director	Presented by	Meeting Date
Peter Hill	Peter Hill	24 February 2021

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”
Partially assured	Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives

Key Issue	Assurance Level	Committee Update	Next Action(s)	Timescale
Integrated Performance Report – Emergency Access	Green	It was noted that GWH was ranked 14 th in terms of performance in the country despite the challenges being faced largely due to the COVID demand. The team have shown great flexibility during the COVID pandemic and are seeing a positive impact of the 111 scheme and civility matters campaign.	To monitor actions.	Ongoing
Integrated Performance Report – Cancer	Amber	There have been challenges within the breast service (increased demand, COVID restrictions, consultant sickness) that the department are facing and this is shown in the report. There are also ongoing issues with the Tertiary centre.	To monitor actions.	Ongoing
Integrated Performance Report - RTT	Red	COVID has had a major impact on this, recovery plan being formulated.	Action plan to be reviewed at the next meeting.	March 2021
Integrated Performance Report –	Red	COVID has had a major impact on this, recovery plan being formulated.	Action plan to be reviewed at the next meeting.	March 2021

Key Issue	Assurance Level	Committee Update	Next Action(s)	Timescale
Diagnostic Wait Times				
Stroke Update	Green	A deep dive into Stroke Service was presented. The SSNAP score is at B but the service remains under pressure.	To monitor actions.	Ongoing
COVID Recovery Plan	Red	The Committee will receive the draft recovery plan for 2021/2022 at its next meeting.	Draft plan to be presented to next meeting.	March 2021
Integrated Performance Report – Sickness Absence	Amber	Performance is good considering the current organisation pressures and levels of COVID in the community.	To monitor actions.	Ongoing
Integrated Performance Report – Overall agency spend	Red	Continued high use of agency. GWH has signed up to a new agency contract from 1 April 2021.	Monitor use of new contract	Ongoing
Integrated Performance Report – Mandatory Training	Amber	It was noted that the current systems issues make it unclear as to what the actual level is regarding mandatory training and that there is no immediate fix for this.	To monitor actions.	Ongoing
Integrated Performance Report - Appraisal Proposal	Amber	Monitor the roll out of the new appraisal form (part of IPR)	To monitor actions.	Ongoing
Integrated Performance Report – Vaccinations	Green	GWH was leading and delivering an excellent and highly regarded programme.	To monitor actions.	Ongoing
EDI Lead Priorities 2021/2022	Green	The Committee was happy with the presentation that outlined what is intended in the next year.	To monitor actions.	Ongoing
IT Performance Update	Green	There were a number of key developments presented which were being positively received.	To monitor actions.	Quarterly

Other Comments	
Topic	Comment

Issues Referred to another Committee	
Topic	Committee

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 Safe?

Are We Well Led?

Are We Responsive?

Are We Caring?

Use of Resources

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

Data Quality Rating:



National Key Performance Indicators

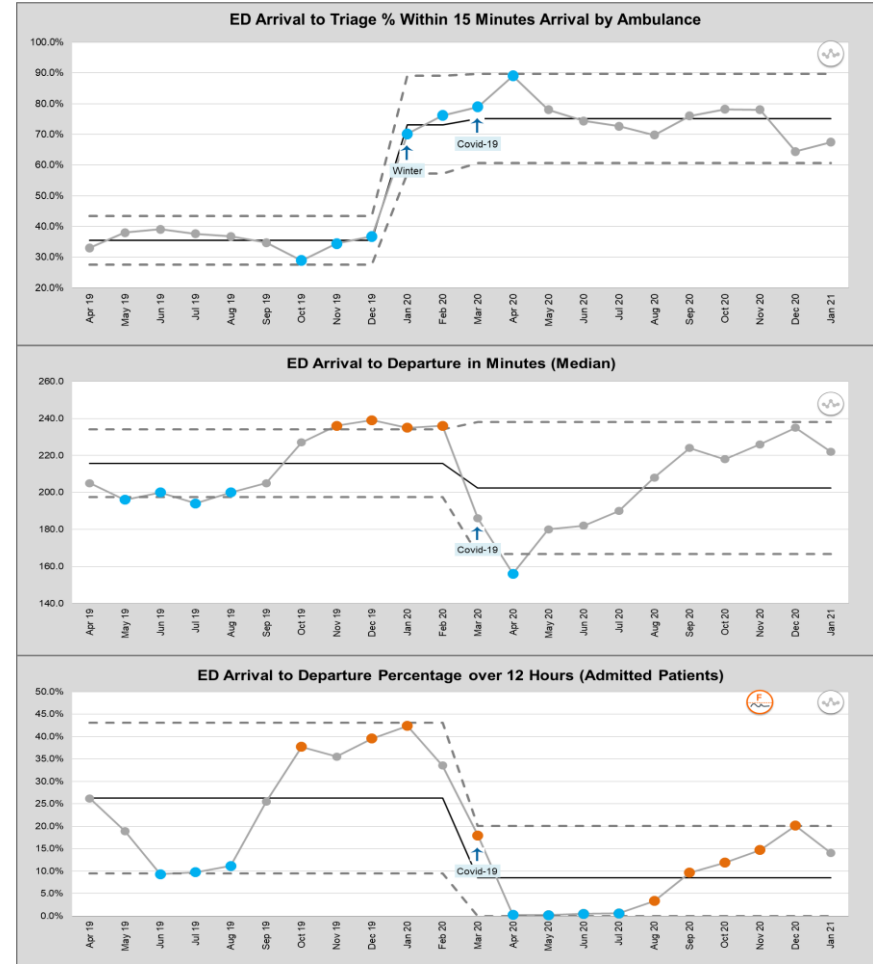
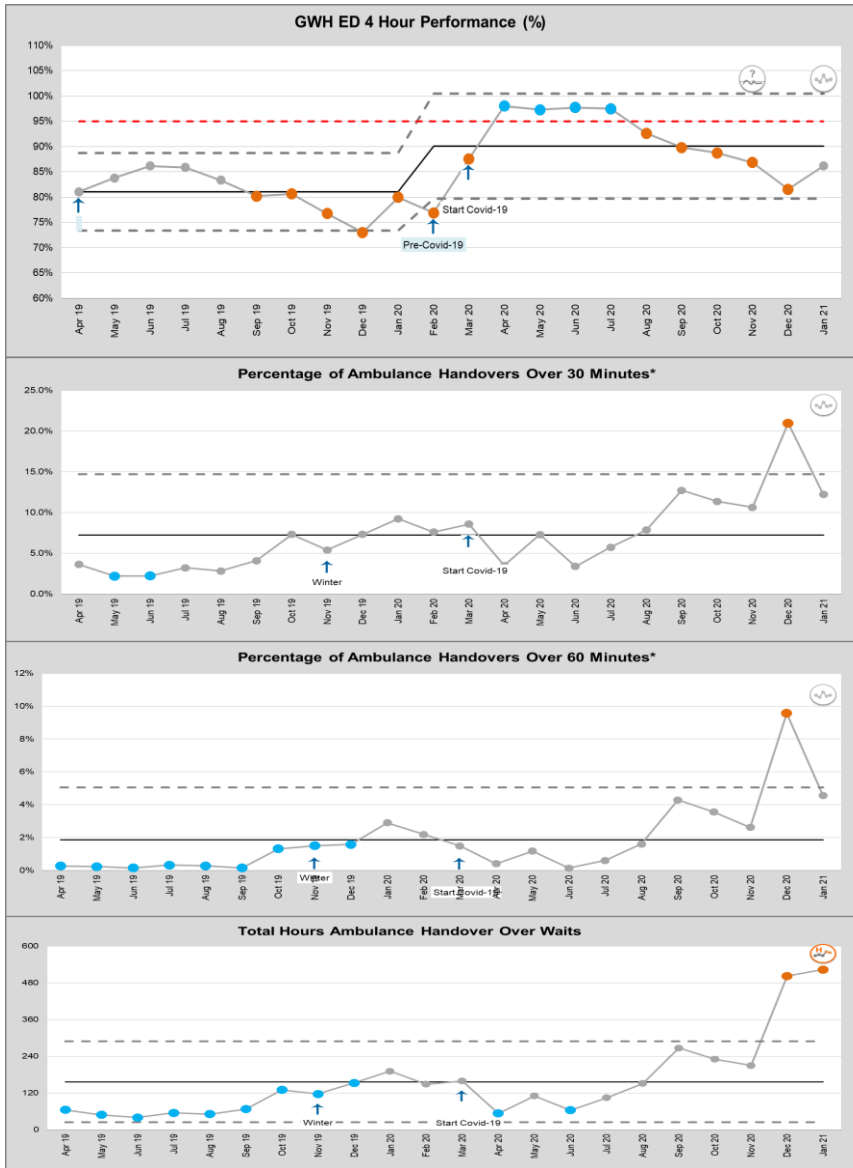
Attendances:

Performance Latest Month: 86.14% (Jan)

Type 1 3478

Type 3 2068

12 Hour Breaches (from decision to admit) 25



31

* Data from SWAST – 1 month lag

2

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

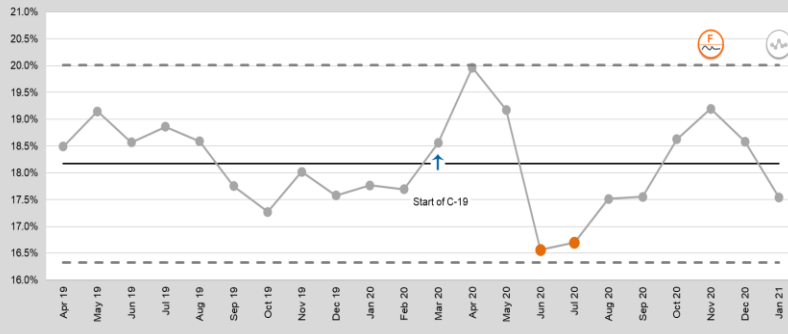
1. Emergency Access (4hr) - Patient Flow and Discharge

Data Quality Rating:

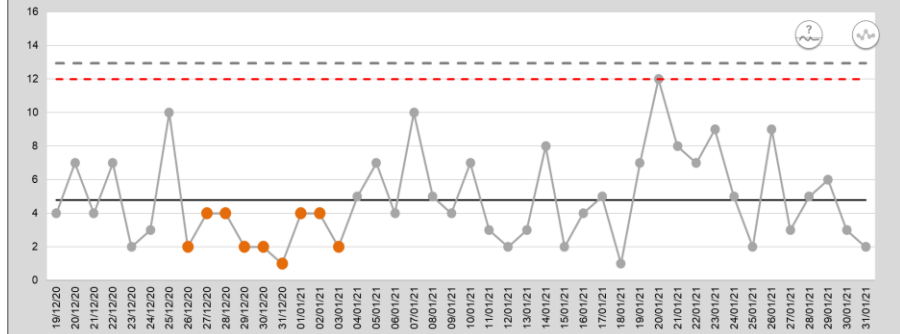


Are We Effective?

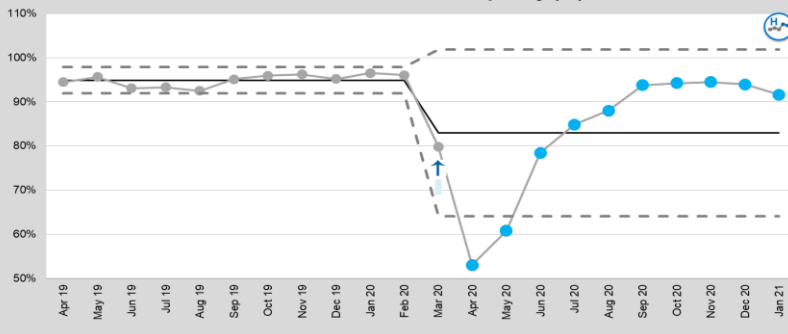
GWH Discharges by Noon (%)



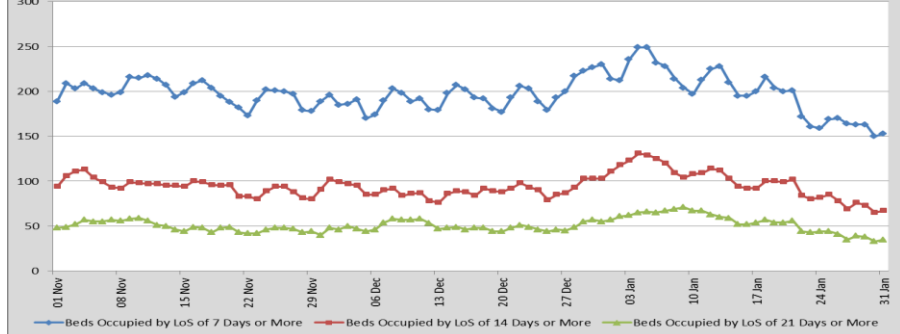
Golden Patients Discharged (Daily)



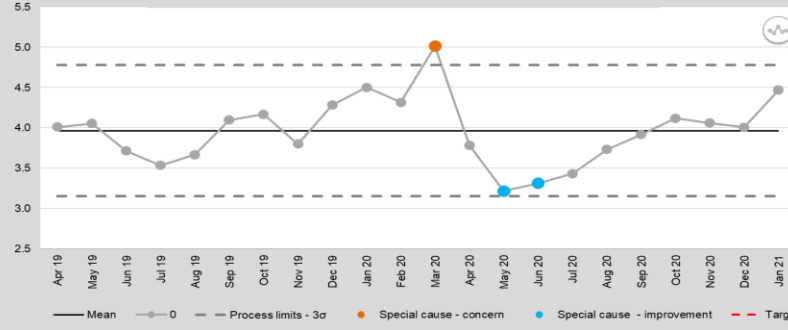
GWH Acute Bed Occupancy (%)



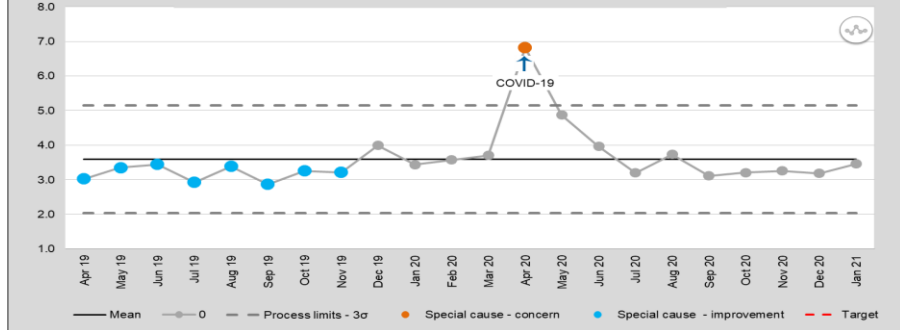
Inpatients by Length of Stay Band (daily snapshot)



Average LoS - All Non-Elective Inpatient Spells - starting 01/04/19



Average LoS - All Elective Inpatient Spells - starting 01/04/19



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



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

The ED 4 Hour Performance chart shows that performance in month continues to remain below the 95% standard. There has been an improvement of 4.56% in 4 hour breaches. However, there were 25 x 12 hour decision to admit breaches in January (increased by 24 from December). Attendances have decreased in January by 1097 patients across both Type 1 and Type 3. This has been mainly in response to national lockdown and a critical incident being declared on 13 January, with a communication drive to avoid unnecessary attendance to hospital. Breaches due to 'waits to be seen' in ED have decreased substantially to 3.7% from 16.4% in December, and from a high of 44% in August.

Key Impacts on Performance

Flow from to ED to base wards has been severely compromised resulting in 84.4% of breaches related to waits for inpatient beds. 92.9% of the breaches related to waits for a medical bed. There has been an increase in patients waiting over 12 hours in the department as well as an increase in patients length of stay within the organisation. Whilst improving, we still do not consistently achieve 6 Golden Patients discharged per day per Division and the number of discharges before noon have decreased again in January. In terms of ambulance handovers, delays over 30 minutes have decreased from 20% in December. We continue to have challenges which include:

- Timely availability of beds, and lack of flow especially out of hours;
- Limits on safe capacity within the department which mean ambulances are held outside until the unit decompresses; and
- Un-validated data (examples of where the Trust disagree with the handover time has been shared with SWAST and the BSW Winter Director).

What will make the Service green?

- Improvement in flow into inpatient beds, patients to move within an hour of referral
- Development of the 'Think 111 First' programme to include access to SDEC and the change in culture of the local population's use of emergency and urgent care services
- Trust wide escalation plans to support the timely flow and discharge of patients
- The 'Way Forward' programme

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

1. New (draft) 'Ambulance Delay Escalation Handover' SOP which sets out trigger points, actions and escalation needed at each level if we are approaching full capacity in ED/CAU and ambulance handover delays are likely to occur. New front door manager role in place until 31 March 2021 to support On-Call Teams. **Completed**
2. Lateral flow testing is live in ED and CAU, however, delays with PCR swabbing has led to bottlenecks in flow impacting the front door. The Trust now has an additional 400 Cepheid swabs and testing device which will be located on the Linnet Ward. This will ensure swabs results are back in a timely manner. Limited to 3-4 weeks of improvement due to stock allowance. **February 2021**
3. The 'Think 111 First' programme went live on 1 December 2020. Activity has been high but is now starting to stabilise. Enhanced clinical validation has been undertaken at Medvivo and has shown a reduction in the number of inappropriate attendances self presenting at ED and UTCs across the system. A rota has been established on a Friday, Saturday, Sunday and Monday. A full rota is still to be achieved across the STP. **February 2021**
4. The Consultant Rota in the Emergency Department has been adapted to provide senior cover in the CAU from 12h00 to 00h00 daily. This was put in place to manage the increases in attendances to CAU. **February 2021**
5. Daily 'Criteria to Reside' calls continue and are chaired by the Head of Clinical Operations. These meetings expedite and unlock delays to discharges; support wards to identify 'Golden Patients' earlier and ensure their timely move to the Discharge Lounge and enables partners to speak directly to the wards to review and unblock medically fit patients over 7 days. **On-going**
6. The flow scorecard is now operational in Nerve Centre. It provides live data to support managing daily flow and discharge. **Completed**

Risks to delivery and mitigations

There is a risk that if Covid numbers remain as they are, or increase, the number of green beds will continue to be limited which in turn will put increased pressure on flow from ED. **Mitigation:** The split of blue and green beds across the Trust are reviewed 7 days a week in the 1pm Control Room meeting.

There is a risk that as the green GP take begins to increase (much reduced during the peak of the second wave) there will be increased pressure in ED. **Mitigation:** Green GP take numbers are reviewed in the daily Site Meetings.

There is a risk that reduced nursing and medical staff, due to sickness and isolation, will impact on our capacity to manage flow. **Mitigation:** Daily review of staffing across the front door to ensure safety and timely assessment of patients.

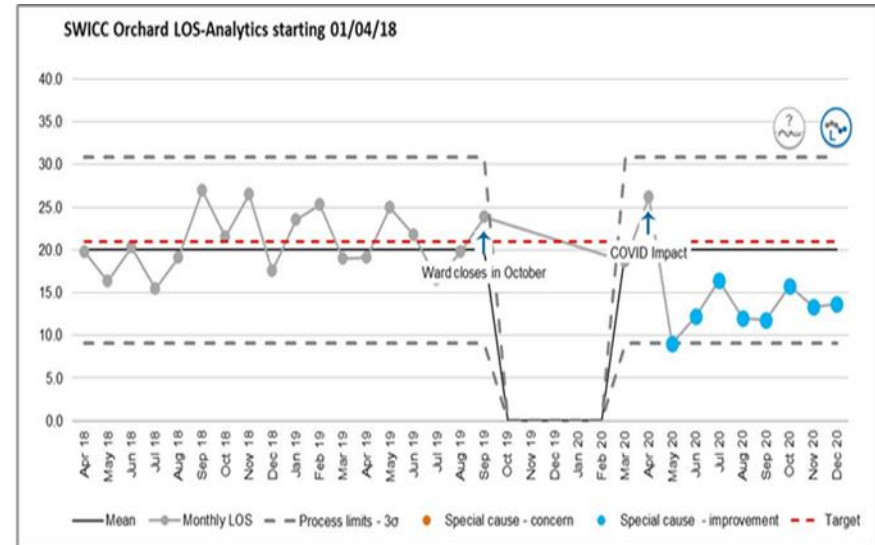
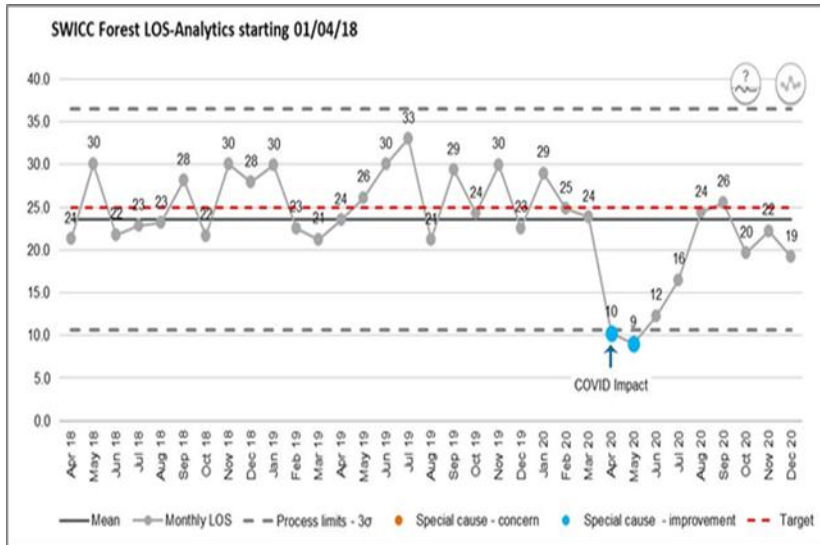
There is a risk that ambulance handover delays will continue to be seen due to a lack of flow out of ED. **Mitigation:** The split of blue and green beds across the Trust are reviewed 7 days a week in the 1pm Control Room meeting. In addition, the ED Team are working closely with SWAST to identify opportunities to both support the crews delayed and identify and implement actions that reduce holding.

1. Emergency Access - Community Length of Stay

Data Quality Rating:



Are We Effective?



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

Forest Ward length of stay (LoS) has remained below target for three consecutive months reducing to 19 days. For most of December, the beds on Forest Ward were ring-fenced for non-Covid pathway patients. Occupancy has therefore decreased by 4% reflecting the agreement to maintain a Green rehabilitation pathway.

Flow through Orchard Ward has remained good despite converting to a blue pathway. LoS has remained for the second month below 15 days. However, occupancy has decreased to 82% which is attributed to the ward changing to a blue pathway on the 19 December 2020.

There has been a steady increase of OoA patients being admitted to SwICC, this has increased to 35%. OoA LoS is longer as pathways especially to Oxfordshire and Gloucestershire are less responsive. CtD reviews are in place and all delays escalated.

Improvement actions planned, timescales when improvements will be seen

A review of LoS took place in December to ensure the availability of Sunflower bed capacity was achieving optimum flow.

Whilst LoS is remaining on target, further reductions are limited due to the need to manage Covid outbreaks and the safe management of Covid positive, Covid MFFD and non-Covid patients.

This has significantly reduced capability to move patients between Orchard and Sunflower to optimise patient recovery and hospital flow which was highly successful last winter.

The service continues to work closely with the Trust's IP&C Leads to ensure optimal step down bed capacity.
On-going

Risks to delivery and mitigations

There is a risk that Covid swabbing continues to be escalated to site on a daily basis to minimise delays in transferring patients. This position improved towards the end of December.

There is a risk that Medical and Nursing resources continue to be challenging. This continues to be monitored and escalated across the Trust via the twice daily nursing resource calls to identify where support is needed and prioritised. In addition, the AMD and DD are undertaking a review of medical staffing to ensure a more sustainable model in the future.

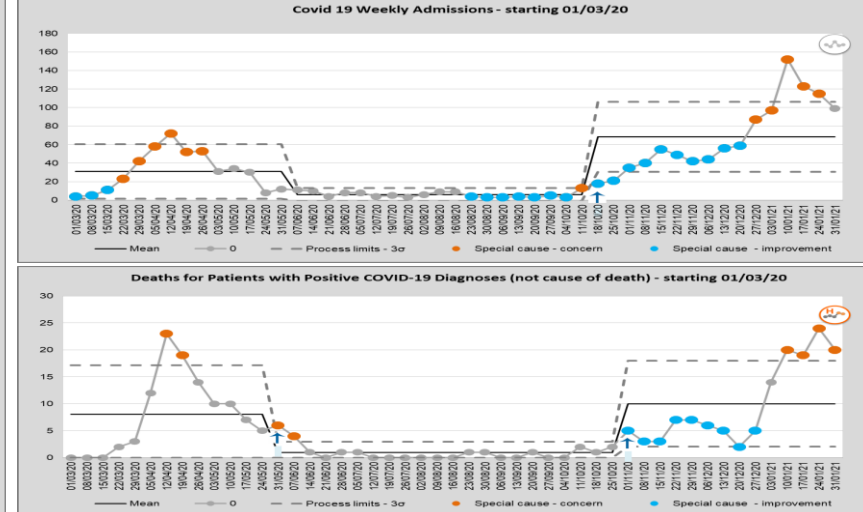
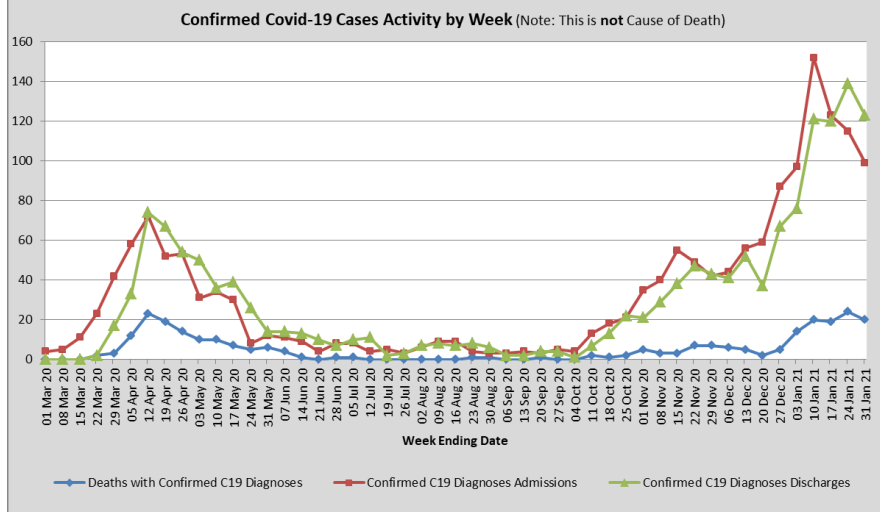
There is a risk that our beds in SwICC are occupied with Covid patients which will impact on our step down provision for non-Covid patients. This was a challenge in December, however pro-active collaboration with SBC and IP&C ensured robust recovery plans in place to balance the availability of blue and green beds.

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

Data Quality Rating:



Are We Effective?



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

The chart above shows increasing weekly Covid-19 admissions through December, with a marked increase after Christmas, peaking in the first week of January. CAU expanded its bed base to 25 on 11 January, however despite this, numbers reached a peak on the evening of 12 January with ambulances queuing outside both CAU and ED. Further to this, a Critical Incident was declared on 13 January, resulting in reduced attendances to CAU with a continued trend into February, possibly due to the lockdown.

CAU continues to use a point of care testing machine (POCT) for Covid-19 with the capacity to deliver 10 fast track swabs (90 minutes) a day. This limited capacity is proving to be insufficient with lab results taking 4-6 hours to process in-hours, leading to further delays. Lack of overnight lab testing (unable to recruit staff) is leading to a number of patients awaiting swabs on wards which in turn is delaying moves and flow.

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

1. An order of 400 Cepheid swabs along with an additional POCT device in the Linnet Ward will support quicker swab results which in turn will improve onward flow. **Early February**
2. Escalation & Ambulance Delay Escalation Handover SOPs in place with clear processes and triggers for the Site Team, On-Call Teams and GOLD. **Completed**
3. The USC Division are re-reviewing their internal processes in a 'swab and flow' meeting. **12 February 2021**

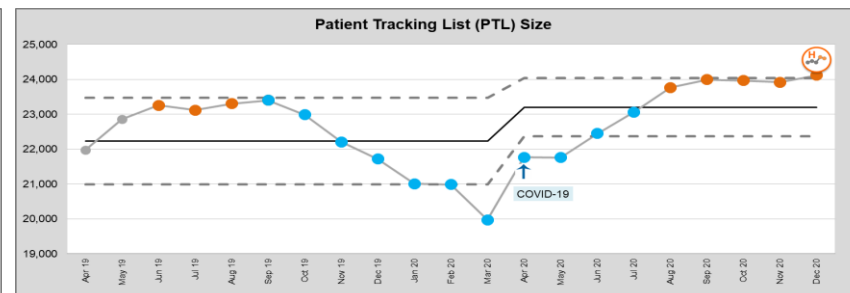
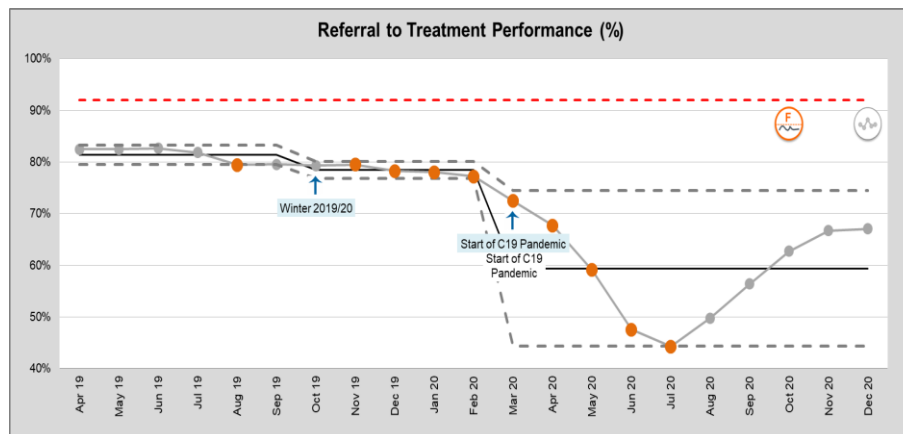
Risks to delivery and mitigations

Risk 2774: There is a risk that due to the turn around time of routine testing results, patients may be delayed from moving into the main bed base. This leads to reduced flow until later in the day and increases the risk of ambulance handover delays.

Mitigation: Actively monitor and plan patient moves as soon as results available each day. In addition, 400 Cepheid swabs along with an additional POCT device in the Linnet Ward will provide quicker swab results that will support an improvement in flow.

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

Data Quality Rating:



December Performance:

67.0%

PTL Volume:

24,119

52 Week Breaches:

R – 1,241, IM – 466

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

Overall, the Trust's RTT Incomplete Performance for December 2020 was 67.04%, which was an improvement of 0.34% in month. December saw referrals at 92% of the prior year.

For the first time in 3 months, the PTL has increased in size. The increase of 196 puts us 866 adrift of our pre-Covid end of year trajectory. However, our current PTL is 2,883 below our Phase 3 Trajectory of 26,996 for December, primarily due to the fact that this forecast assumed a return to prior year referral levels which we are yet to realise.

In December, we reported 1,312 x 52 week reportable breaches against a trajectory of 1,802. This was an increase of 71 from November and of the 1,312 breaches, 202 (15.4%) of them are P5 and have opted to defer treatment until post-Covid. There were 360 in month 52 week breaches cleared in December, which is an increase over the rolling 3 month average of 306 per month. This demonstrates continuous progress with regards to clearing routine long waiters. Of the 1,312 reportable breaches, 1,111 are Admitted, 125 are Non-Admitted and 76 are Diagnostic.

Our Phase 3 trajectory for 52 week breaches puts us at 2,269 reportable breaches at the end of March 2021, with a waiting list size of 28,995. Within our current PTL, we have around 4,015 patients who have breached or are due to breach 52 weeks between now and the end of the year, highlighting the amount of work that is required to meet our 52 week breach trajectory. Given recent levels of escalation and the reduction in elective theatres there is a significant risk that these trajectories will not be achieved.

What will take the make the Service amber?

- NHSE/ funding to use the Independent Sector (IS); either national contract or locally commissioned.
- Improving Theatre Utilisation (limited gains given the scale of the backlog).
- Improving Outpatient Utilisation.
- STP approach to RTT recovery.

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

All services are currently working on RTT Recovery Plans and trajectories in partnership with Informatics. The first draft of data will be reviewed by Services by 26 February 2021. RTT performance is being measured at the Weekly Access Meeting and reported against the previous year's activity as part of the Phase 3 Recovery Programme. Underperforming services are escalated and discussed at RTT Oversight to identify support and recovery actions. The Trust is now utilising 4 Independent Sector organisations to maximise the number of patients that can be treated from February 2021 onwards. This includes Inter Provider Transfers for surgical patients who will be removed from our PTL following transfer. Pre-Assessment Clinic (PAC) and Elective Admission Team Recovery Plans are now in place to map and improve current processes to enable improved levels of efficiency and Theatre Utilisation. Initial KPI improvements are anticipated to be achieved in March 2021.

Risks to delivery and mitigations

There is a risk linked to the continued impact and uncertainty of Covid-19. Our Phase 3 plans have made no allowance for a reduction in elective activity due to increased levels of Covid-19 during Q4. The flipping of Recovery 1 into additional critical care capacity is a significant risk and we need to ensure that we de-escalate as soon as possible by accessing mutual aid. There is a process in place to ensure all elective P2 surgery is accommodated as planned.

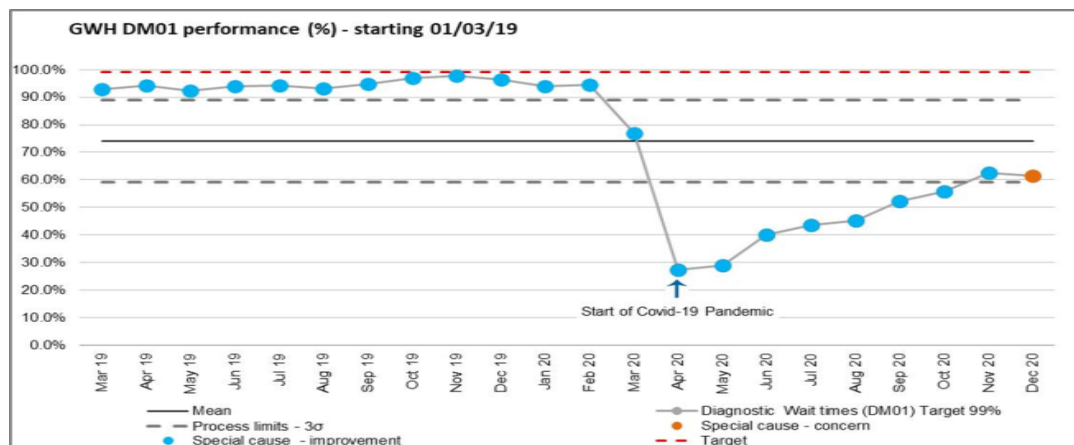
There is a risk linked to bed pressures which are not expected to improve with our slowly declining Covid-19 numbers. Elective surgical beds and Recovery 2 must be ring-fenced in order to deliver our Phase 3 activity plans and breach trajectory.

There is a risk that PAC capacity continues to be a challenge. Pre Covid-19 we were assessing 1,300 patients per month. In December we assessed 811 patients compared to a 6 month rolling average of 677. A weekly Recovery Meeting has been established and PAC staff are being ring-fenced to protect PAC activity.

Although the new IS framework contracts / activity plans are in place, there is a risk that we cannot secure the same level of IS capacity that we previously had access to. There is also a risk that IS capacity will be needed to support a Covid surge. This is being managed with support from BSW and NHSE/I.

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

Data Quality Rating:



December 2020

Performance Latest 61.5%

Waiting List Volume: 6769

6 Week Breaches 2605

Background

Performance in December 2020 reduced to 61.5% compared to 62.54% in November 2020, with MRI and Ultrasound the primary drivers of reduced DM01 performance in month. Overall, the total waitlist size reduced from 7023 in November 2020 to 6769 in December 2020 (-254). This reduction in the waiting list size, whilst positive, has impacted the overall DM01 % performance. The number of breaches has reduced from 2631 to 2605 (-26) in December 2020. Covid continues to impede performance, however focused actions remain in place to stabilise and improve performance from February 2021 onwards.

Improvement Actions

To support the recovery trajectory, the following key actions are in place.

- 17 CT Van days have been secured for January 2021 with an additional 11 in February.
- Additional MRI van capacity for Q4 2021 within forecasted budget (10 in January, 15 in February and 16 in March).
- Additional Payment Sessions are in place to support delivery of a further 300 slots for Ultrasound backlog clearance.
- The Independent Sector continued to support Echo cardiology, and Non Obstetric Ultrasound with additional capacity during January.
- 12 point list will commence for Endoscopy in February 2021 and evening sessions proposed.

Risks (Risk1855= 20) Failure to deliver DM01 for Imaging (risk remains the same). Insufficient capacity to recover the backlog remains the greatest risk to recovery. There was limited MRI van availability in 2020, however bookings have been confirmed for January, February and March 2021.

Waiting	< 6 Weeks	> 6 Weeks	Total WL	Performance % December
Magnetic Resonance Imaging	660	487	1147	57.54%
Computed Tomography	314	197	511	61.45%
Non-obstetric ultrasound	1871	612	2483	75.35%
DEXA Scan	145	73	218	66.51%
Audiology - Audiology Assessments	279	138	417	66.91%
Cardiology - echocardiography	126	47	173	72.83%
Cardiology - electrophysiology	0	0	0	N/A
Neurophysiology - peripheral neurophysiology	76	0	76	100.00%
Respiratory physiology - sleep studies	43	1	44	97.73%
Urodynamics - pressures & flows	3	0	3	100.00%
Colonoscopy	312	462	774	40.31%
Flexi sigmoidoscopy	129	247	376	34.31%
Cystoscopy	25	10	35	71.43%
Gastroscopy	181	331	512	35.35%
Total	4164	2605	6769	61.52%

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

Data Quality Rating:



Background, actions being taken and issues

Endoscopy: Combined, Endoscopy achieved 37% performance in December which is a slight reduction in November's 38% performance. Given the Christmas break during December however maintaining performance has been an achievement for Endoscopy. The number of referrals received in January has greatly reduced (506) compared to previous months (972 in December) which means the denominator for DM01 performance will be less.

Radiology: Combined DM01 performance declined from 75% in November to 68.6% in December with overall waiting list reductions of 510. There was an increase in patients waiting over 6 weeks (155) with a total of 1370 breaches (driven by MRI and Ultrasound capacity). CT has returned to higher levels of activity than the pre Covid-19 run rate yielding a reduction in patients waiting over 6 weeks (-197). Additional CT van days were put in place (20 in December), with the clinical focus remaining to reduce the cardiac CT backlog. Independent Sector provision of MRI services came to an end on 24 December. Ultrasound saw an increase in patients waiting over 6 weeks (141) in December due to one member of staff (0.6) shielding and staff isolation.

Echo: Performance improved from 61.74% in November to 72.83% in December. December saw a slight increase in the overall wait list from 149 in November to 173 (24) in December, with Aerosol generating procedures such as Trans Oesophageal Echo (TOE); Exercise Stress Echo (ESE) and Bubbles requiring medical capacity to undertake (capacity which remains limited). Routine Echo is now being booked <6 weeks. Echo activity remained static (635 procedures in November and 636 in December).

Audiology: There was a total of 138 breaches in December (262 in November) that improved performance to 67% (52% in November) with 417 on the waiting list. That was an improvement of 124 patient breaches and 15% performance in month. The main patient cohort that are breaching in December are specialist areas including paediatrics and specialist adult diagnostics rather than routine adults. Audiology has been supporting ENT as per pre-Covid levels, but the expectation for Audiology is that January will show further improvements above trajectory.

What will make the Service Amber?

Endoscopy: Completion of the fifth Endoscopy room which will increase capacity.

Radiology: Recruitment to further Cardiac Radiologist (1WTE) and Cardiac Radiographers (3WTE) to increase capacity for cardiac CT provision.

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

Endoscopy: Paper discussed at the January meeting of the Investment Committee which focused on activity and revenue options for Endoscopy in FY21/22 (including an increase in current levels). Devices capacity secured until 31 March 2021, although this has been reduced from 20 to 10 patients a week. Service maintaining full utilisation of all 4 rooms over the weekend. Aiming to begin 12 point OGD lists in February and reviewing the option to run two evening sessions in the week with current staff.

Radiology: MRI van capacity has been secured from January 2021 with 800 slots available in Q4. A further 27 days (540 slots) have been secured during April and May 2021 with recovery predicted for April 2021. Static CT cardiac applications undertaken on 27 January to increase CT cardiac slots. Cardiac slots have also been increased on CT1 and booking in progress. Cardiologists have been approached to supplement cardiac CT delivery with one session every two weeks proposed from mid February. An additional US machine has been agreed via capital and an order will be placed by 12 February. Sonographer recruitment in progress following reallocation of budget.

Echo: Waiting List Initiative (WLI) activity remains high and January and February offers from Cardiac Physiologists will ensure that the current levels of activity are maintained. A specific Bubbles WLI list of 19 patients will be held on 23 January to reduce AGP totals on the New Patient Wait List. We have a new Echo Qualified Cardiac Physiologist starting on 20 February with 2 x Band 6 trainee Physiologists (approximately 12 months from exam to log book completion) accepting offers of employment.

Audiology: DMO1 activity and the service continues to focus on face to face activity. The ability to treat patients with remote care has allowed more patients to be seen face to face for diagnostics and hence the increase in DMO1 activity had we not invested. DMO1 recovery improvements will be seen in January and February with Choose and Book Face to Face implemented. Expectation is to improve performance in January and nearly fully recover in February. We are returning in February to a balanced approach with resources concentrated on DMO1 and also reducing waiting lists for planned / unplanned activity.

Risks to delivery and mitigations

Endoscopy: There is a risk that the sickness and vacancies within the Endoscopy booking team will not be resolved in month. To mitigate, an additional substantive booker has been recruited and support is being provided from across the other Divisions.

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

- Care UK supporting US to limited extent
- Additional US machine to be ordered by 12 February
- Bank Sonographer making up for CEV and maternity leave
- APS for Sonographer 360 to date, further 300 agreed
- Additional MRI van slots booked in the first 5 months of this year
- Cardiac CT slots reviewed as CT position improves

Echo: There is a risk that there is not sufficient space to deliver echo cardiology in the Wiltshire Cardiac Centre (WCC) which will result in diagnostic delays. The BMI Ridgeway has agreed to an extension of the 2 Echo rooms covering the period 1 January through to 12 March. Planning is underway to explore the suitability of the internal reconfiguration of the WCC to deliver additional Echo rooms and the suitability of external locations that could temporarily house an Echo Diagnostic Hub. Recruitment to cardiac physiology commencing 20 February.

Audiology: There is a risk that ENT RTT recovery may reduce the rate of recovery if additional Audiology capacity is needed to support ENT in the coming months. To mitigate, Audiology will continue to offer overtime to the team and utilise additional capacity when ENT reduce clinics with appropriate notice (this has worked well in January). There is a risk that priority clinical patients on the planned activity waiting list will need to be booked/seen alongside of routine DMO1 diagnostics (currently 60% overdue). To mitigate this risk, overtime will continue to be offered to staff, and a robust clinical triage process is in place to limit the impact on DM01 performance whilst meeting clinical needs.

Cancer 2 Week Wait Performance Target 93%

Data Quality Rating:



National Key Performance Indicators

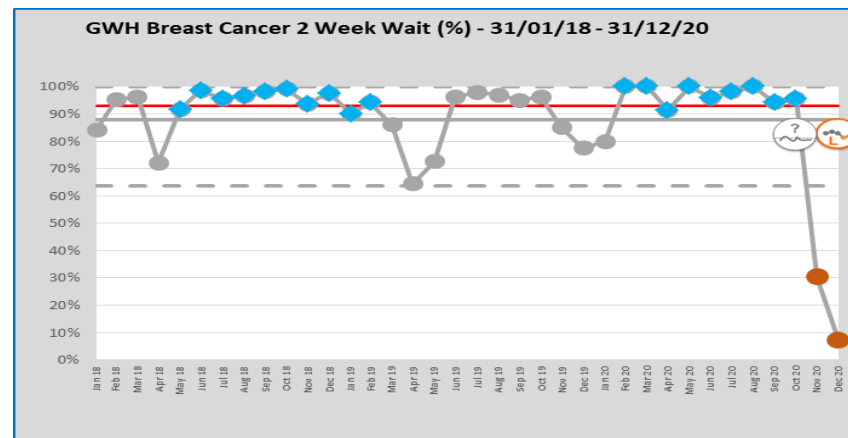
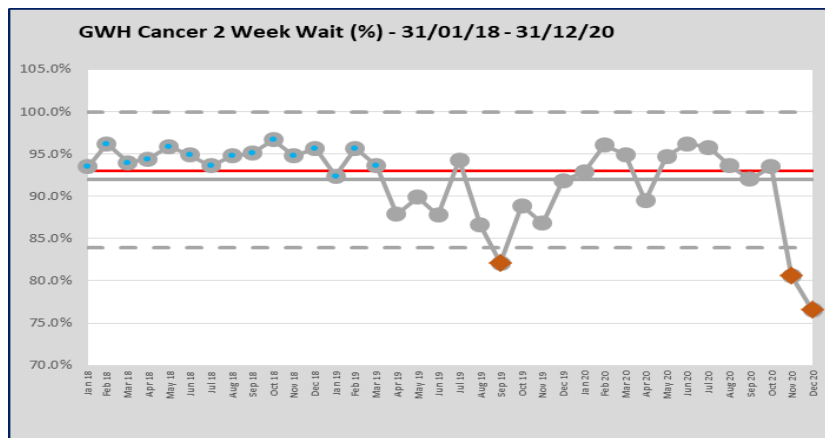
Performance Latest Month: **December**

Two Week Wait Standard:

76.5%

Two Week Wait Breast Standard:

7.2%



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

Two Week Wait (2ww) performance was inconsistent in 2019 due to pressures within breast, skin and colorectal. In 2020 the standard was achieved except for April and September. Pressures in both Breast and Colorectal services have resulted in a fall in performance in November and December.

Referrals into the Breast service increased during 'Breast Cancer Awareness' month (October). In November and December the Breast service was unable to maintain 2ww performance due to physical distancing requirements in the Breast Unit. In December, there was also Consultant emergency leave and Consultant sickness. The service completed one Wait List Initiative (WLI) clinic each week to maintain baseline capacity, however this did not meet demand and there is now a backlog of patients that need to be seen. Further work on demand and capacity is being undertaken by the service to give a projection for future recovery. This is dependent on breast build completion and staffing for additional WLIs.

Whilst Breast 2ww has not achieved, 62 day performance was achieved in December and breaches are expected in January.

Straight to Test (STT) Colorectal pathway resumed on 28 September 2020. This improved Colorectal 2ww performance although the standard was not achieved (91.4%).

Gynae-oncology did not achieve the 2ww standard due to a decision to change how the first appointment is recorded. This will enable better pathway management for diagnostic tests after the first appointment. Diagnostic Ultrasound will be completed before first appointment. January performance is expected to be below standard as a result of aligning the diagnostics with clinic templates.

Two week wait performance in skin was compromised as a result of a Consultant breaking his arm and annual leave. Not all appointments could be accommodated within the 2 weeks.

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

1. Breast 2ww demand and capacity work by service to support recovery due in February (dependent on staff availability). Imaging assistant support is required; radiology working with bank office to increase staff pool. Breast Unit building work due for completion by April 2021.
2. Review of Breast 2ww pathway at Breast Clinical Advisory Group (CAG) on the 9 February 2021 to consider alliance wide strategy/mutual aid.
3. Consideration of clinical triage of breast referrals and under 25 year olds accessing rapid access "light" clinic by late February.
4. Breast surgeon lead joined BSW GP webinar in January to discuss new 2ww referral form and support physical examination and use of breast guidelines.
5. Endoscopy delivering procedures within 2 weeks. Thames Valley Cancer Alliance (TVCA) request to protect Endoscopy services in surge 2 and Gastroenterologists not to be working on Trust medical rota. Team currently cover the ward. Endoscopy Service has a Recovery Plan in place.
6. qFIT (faecal testing) introduced in primary care for LGI 2ww pathway. Number of 2ww referrals including Qfit results are shared monthly with the PCN. GP education events are planned for February. 46% of referrals had Qfit completed in December.
7. Gynae rapid access clinics are to be booked within 2 weeks of the referral. It is expected that will be reflected in the February performance.
8. Review of 2ww referral booking SOP to ensure a robust process is in place for the handling and processing of referrals. This is due to be signed off in February.

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Risks to delivery and mitigations

Fatigue of staff supporting additional wait list initiatives in the Breast Unit; teams monitoring health and well being of staff and delivery of additional activity.

Imaging assistants requesting incentive pay for additional clinics. Radiology team working with Human Resources and bank team to recruit additional staff to support clinics. This is stopping WLIs from taking place in February and March. Backlog increasing each week.

Breast build needs to remain on time to allow further clinic capacity from April 2021.

Staff sickness reducing clinic and diagnostic capacity.

Two week wait performance may be compromised due to surge in the pandemic reducing access to diagnostics such as endoscopy. Trust Plan in place to protect Endoscopy and to continue with reduced service if unit bedded overnight.

Patient reluctance to attend during lockdown. Patient navigators and Clinical Nurse Specialists supporting patients to attend appointments and diagnostics. Trust communications on social media to support attending is regularly provided.

It is expected that we may see a reduced number of referrals during lockdown which will result in patients referred later and with more advanced disease. Cancer Alliance and public health initiatives continue.

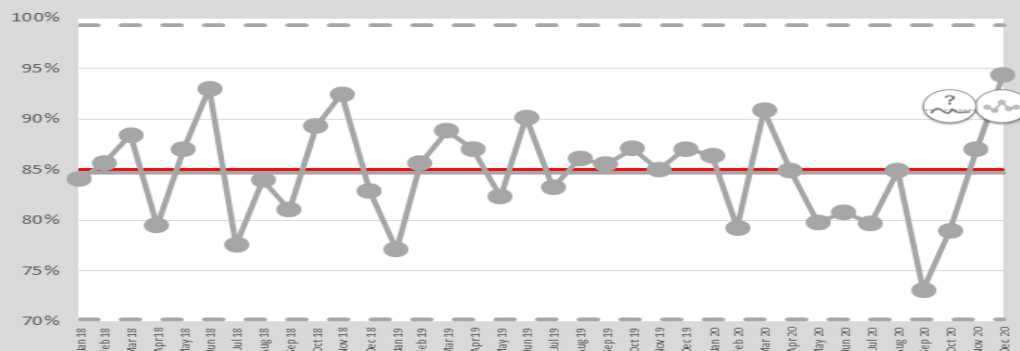
Cancer 62 Day Standards Performance Target 85%

Data Quality Rating:



National Key Performance Indicators

GWH Cancer 62 Day Performance (%) - 31/01/18 - 31/12/20



Performance Latest Month: **December**

62 Day Standard (Target 85%): 94.4%

62 Day Screening (Target 90%): 94.4%

62 Day Upgrade (local standard 85%): 82.6%

Q3 performance 86.3%

Background

December 62 day performance was 94.4% with the Trust achieving the national 62 day standard for the last two months and **quarter 3 (86.3%)**. Prior to this performance was heavily impacted by COVID 19 and the diagnostic/treatment delays.

In December, the patient pathways were delayed due to requesting appointments post MDT and subsequent diagnostics. Two pathways were delayed by the need for additional diagnostics due to the complex nature of their cancer. Additionally, one pathway was slowed by the patient's frailty and access to hospital from his care home.

In December, the screening standard was met. A colorectal screening pathway breached as a result of delays to a CTC and delays to surgery.

The upgrade standard was not met in December. Two upgrade pathways breached the standard with one colorectal patient being diagnosed with a UTI on day of planned surgery. A second colorectal pathway experienced delays with the booking of an MRI (due to pacemaker) and the time taken to arrange a first diagnostic scope. The transfer of care was therefore late to Oxford.

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

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

2. Thames Valley Cancer Alliance (TVCA) transformation work continues with a focus on lung and colorectal pathways and scoping for rapid diagnostic services in November. This has been paused during the recent surge.

3. TVCA dashboard in development for reporting Alliance and Trust cancer performance was signed-off January 2021.

4. TVCA mutual aid plan in place with support brokered by COOs. Mutual aid discussed weekly at secondary care clinician call which was recommenced in December.

5. Current breaches are as a result of diagnostic delays as services recover activity in accordance with social distancing guidelines.

6. Work to ensure patient pathways were not compromised over the Christmas period due to missed MDTs was completed. A process to review patients outside of the MDT was put in place to help patient discussions and to ensure pathways were not adversely impacted.

Risk to Performance Delivery

January cancer performance is anticipated not to be achieved with a number of breaches as a result of delays in pathways from December and 2 patient treatments rolled into January. Pressures were seen within theatres, pre-assessment clinic, outpatients and diagnostics. There were a number of complex pathways requiring additional diagnostics and changes to treatment plans. Performance is expected to be in the region of 81.5%.

February performance is also expected to be challenged with a number of patients being treated outside timeframes yet to have a formal diagnosis. Current forecast based on only diagnosed patients is showing the standard performance being met, however the undiagnosed risks could see performance of approximately 80%.

Capacity issues in the Breast service is multi faceted as a result of physical distancing and Consultant emergency leave/illness. This will have an impact on the 62 day performance for any patients requiring additional diagnostics to usual timed pathway. Patients are being identified as early as possible requiring surgery to hold a surgical date in time.

Gynae pathways are being changed to align diagnostics and first appointment to reduce delays. Where a Hysteroscopy under general anaesthetic is required; these patients breach 62 day pathway if diagnosed. Earlier first appointments are expected to help identify those in need of more complex diagnostics sooner.

Plastics outpatient capacity continues to be challenged due to OUH Consultant availability. The Service Manager is meeting the OUH Plastics Manager this month to review further support and dating of OUH surgery.

Outpatient capacity issues in both the Upper and Lower GI pathways resulted in delays to follow up activity. The Gastro Team continue to provide ward coverage during the Covid response.

Cancer 28 Day Diagnosis Target 75%

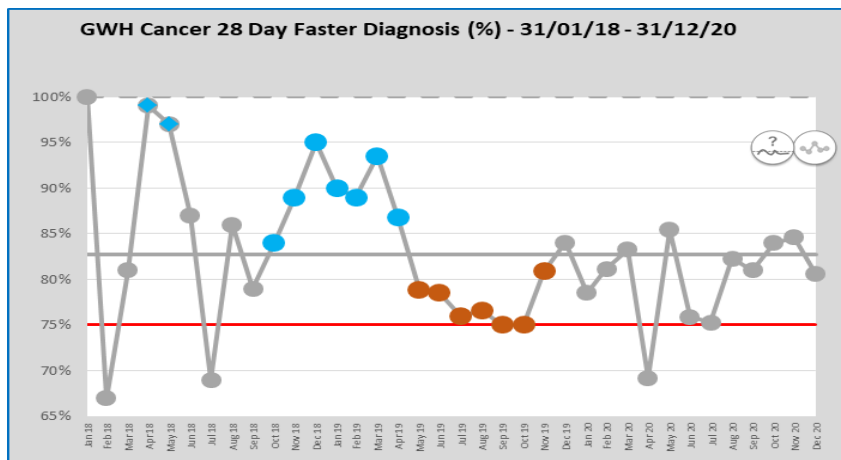
Data Quality Rating:



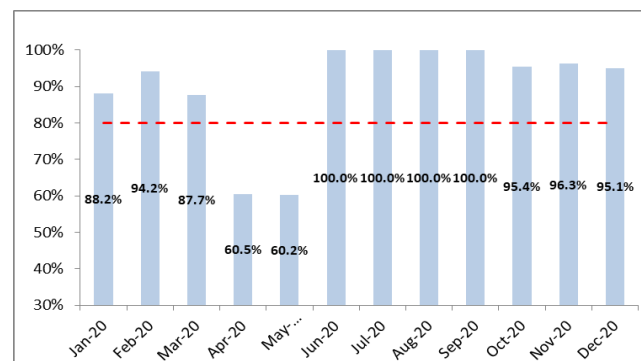
Performance Latest Month: **December**

28 Day FDS

80.3%



Cancer 28 FDS Completeness



Are We Effective?

Background

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

Planned national reporting from April 2020 suspended until April 2021 and remains a shadow report.

For many tumour sites, multiple diagnostics are needed before a cancer diagnosis can be excluded. This provides challenges in achieving 28 day faster diagnosis standard.

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

1. Virtual outpatient follow up remains in place across a number of sites to communicate excluding a cancer diagnosis.
2. Thames Valley Cancer Alliance (TVCA) transformation work continues with a focus on lung and colorectal pathways and scoping for rapid diagnostic services.
3. Review of process for the recording of the communication of diagnosis completed. Patients will remain on the Cancer PTL until they have had their diagnosis communicated. A process for noting these in the PTL and for notifying the Heads of Service is being implemented in February.

Risk to Performance Delivery

Endoscopy capacity currently at approximately 2 weeks. Risk that ongoing issues with winter pressures and worsening COVID cases may impact ability to deliver Endoscopy and other diagnostic services.

Delayed access to diagnostic tests will impact on ability to book OP follow up within 28 days . Any suspension of Endoscopy services will place this standard under pressure. Lower GI, Upper GI and Urology all use the suite for early pathway diagnostics.

The issues with the Breast first appointments not being delivered within 14 days may have an adverse impact on this standard.

The change in the Gynae early pathway process to support the delivery of the 62 day standard, may delay the communication of a diagnosis in the short term. Patients are being first seen beyond the 14 days, though capacity exists to bring this back within timeframe and help support the delivery of faster diagnosis.

Delays to follow up appointments in Colorectal, as a result of Consultant capacity, will impact on the delivery of diagnosis.

The deployment of the Gastro team onto the wards to provide cover has impacted the ability to provide timely follow ups and may lead to delays to communicating a diagnosis.

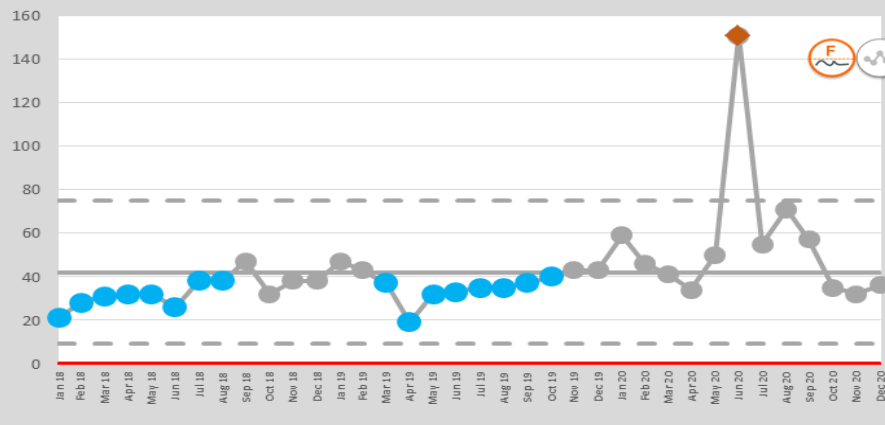
72 day + longer waiters including > 104 day

Data Quality Rating:

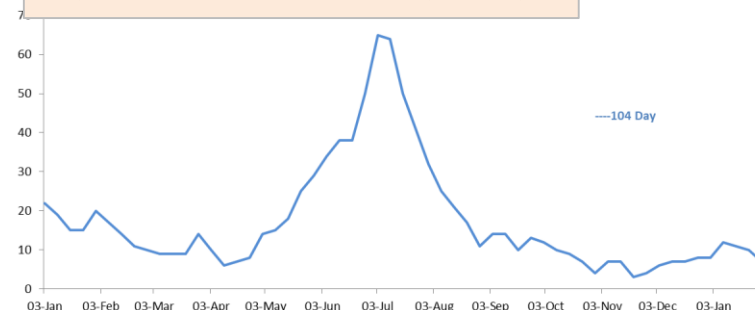


National Key Performance Indicators

Patients Beyond Day 72 on PTL - 31/01/18 - 31/12/20



Long Wait Data- Number of Patient Pathways- 104 Days +



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

104 Day Breaches: December: 1 Patient; 1.0 breach

Treated at GWH

Urology: 1 patients/ 1.0 breach

The pathway was slowed by the requesting of a CT Scan as urgent rather than as a potential cancer case. The TURBT the patient under\went was reported as incomplete. At this time the patient had gone to Spain to recuperate and had to self isolate for 14 days upon his return before he could re-engage with the pathway.

January is likely to see 3 pathways breach 104 days (2.5 breaches).

The small increase in 72 day+ patients in December; of the 36 pathways beyond day 72, 18 related to patients transferred to Oxford for treatment.

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

1. The "Managing Long waiting cancer patients (72 day+)" Standard Operating Procedure (SOP) proactively monitors all patients over 72 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.
2. This report continues to be shared with the Medical Director for executive clinical oversight fortnightly.
3. Review of 62 day breach reports and long waiting patients with a pilot currently being run with MDT coordinators producing the reports contemporaneously with review by CNS and Heads of Service.

Risks to delivery and mitigations

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

Diagnostic capacity remains challenged and will continue to be monitored against their Key Performance Indicators (KPIs).

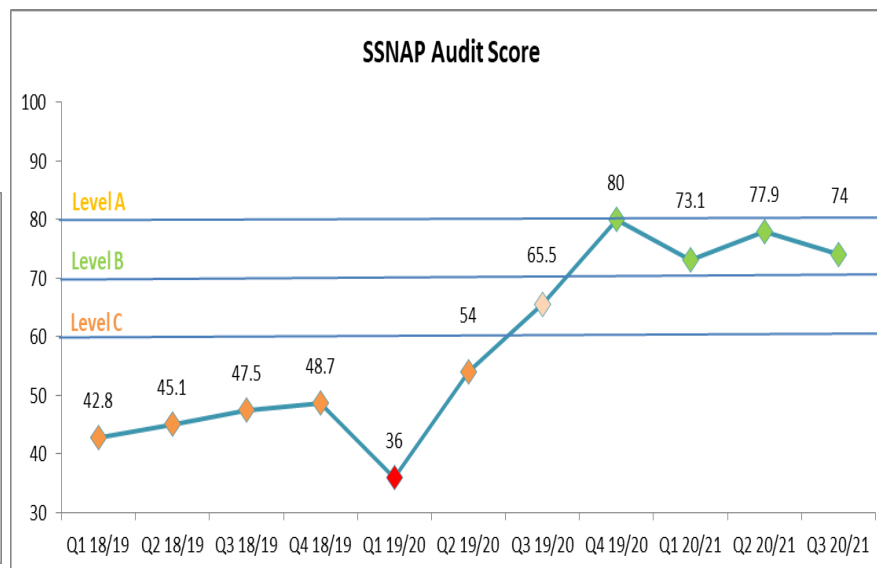
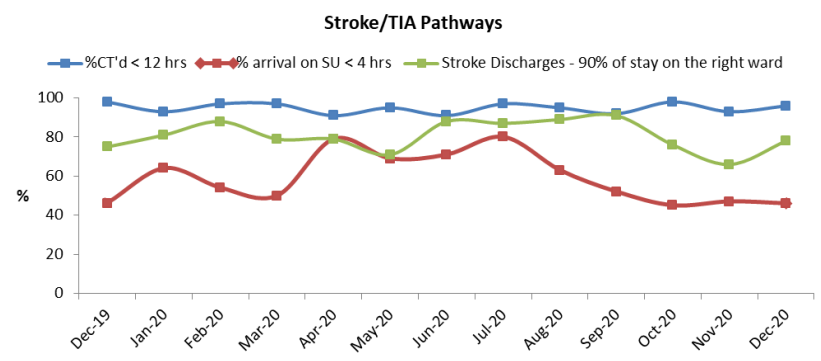
Any suspension of Endoscopy and Theatre services due to COVID and winter pressures will risk cancer performance and will result in an increased number of patients over 72 days, similar to the first surge.

Workforce challenges during the pandemic will also impact timeliness of next step in all timed pathways.



GWH SSNAP Case Ascertainment Audit Score:

Year	Q1	Q2	Q3	Q4
2019-20	E	D	C	B
2020-21	B	B	B *projected	



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

The Trust continues to comfortably maintain SSNAP Level B performance. Q2 improved further on Q1 performance (73.1% vs 77.9%) and Q3 is predicted to continue within Level B performance.

To maintain Level B performance against the backdrop of Covid and winter pressures, we are ensuring that our improvement actions are embedded and working effectively.

Admission to ASU (Falcon Ward) with the 4 hour performance window continues to be an area for further improvement.

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

1. Monthly SSNAP performance meetings for all Stroke Stakeholders across all SSNAP domains reinstated to focus on all aspects of Stroke performance. **Delayed due to Critical Incident. Now February 2021**
2. Review and adapt ED nursing safety check sheet to escalate the time swallow assessments to be completed from 4 hours to 2 hours. **Completed**
3. Junior ED doctor training to raise stroke awareness. **Completed**

Risks to delivery and mitigations

Risk No 2756: There is a risk that delays to stroke patients being admitted OOH to the ASU outside of the 4 hour timeframe will face reduced quality of care through delayed access to specialist stroke treatments. **Mitigation:** the Stroke Matron monitors admissions to ASU on a weekly basis and provides feedback on performance to the Divisional Director. IR1s are completed for any breaches of the SOP to drive improvements in performance.

Risk No 2773: There is a risk that reduced availability of OOH CT angiography delays effective stroke treatment and referral to tertiary neurological centers. **Mitigation:** Head of Service for Imaging to assess OOH capability and feedback. Monitor and raise IR1 as appropriate.

Board Assurance Report

Quality & Governance Committee		
Accountable Non-Executive Director	Presented by	Meeting Date
Dr Nicholas Bishop	Dr Nicholas Bishop	18 February 2021

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"
Partially assured	Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives

Key Issue	Assurance Level	Committee Update	Next Action(s)	Timescale
Integrated Performance Report (Care)	Green	There has been significant progress in Friends & Family Test (FFT) responses in those areas where texting has been implemented. The committee welcomed this and encouraged wider rollout of this method across the trust. A drop in reported numbers of Serious Incidents to 2 occurred in January. Total number of complaints received fell again but concerns increased. Falls and Pressure Ulcers remain relatively high but have improved slightly. Actions are in place to further improve. Electronic Discharge Summary rates at 24 hours remain largely static. New Junior Doctors arrived on February 1 st	Continue with current action plan. Texting to be spread to Maternity & Outpatients Further training of new staff needed.	April 2021
Sharps Injuries report	Amber	Total number of reported sharps injuries has remained static since 2017. This disproportionately involved medical staff with commonest reasons related to syringe/needle combination and IV cannulae.	A ten-point action plan is being implemented, targeting those most at risk.	March/April 2021
Infection Prevention & Control BAF	Green	This report assesses compliance with Public Health England's and other's guidance relating to Covid-19 Infection Prevention & Control. The Committee was assured by the Trust's performance and the assessments against standards. These were almost all green with some amber and no red. The amber ratings did not imply non-compliance.	Address amber ratings where possible to move to green	
Patient Advice & Liaison Service (PALS)	Green	Overall the committee was assured. Response times to complaints have improved. FFT (as above) is showing 86% of >1000 responses would recommend our ED services. There was an interesting alignment of the themes		

Key Issue	Assurance Level	Committee Update	Next Action(s)	Timescale
		of feedback to the trust with Staff Attitude, Implementation of Care, and Environment being the top three for both positive and negative comments. Positive comments far outweighed negative ones.		
Clinical Audit and Effectiveness Quarterly Update.	Green	This was seen as a positive report. Data collection has largely resumed post Covid. Participation in National Clinical Audits remains at 100% with all data submitted. As has been previously reported, there will be a cull of audits where the information is seen as outdated and unlikely to be useful.		
Ockenden Review	Green	This was received as a written update on progress with implementing the requirements of the Ockenden Report into Maternity Services. In the main the RAG ratings showed green or amber with good compliance. Some Red ratings are the result of requirements that will need substantial funding and resources to be complaint. Notable among these are the need to recruit more midwives and obstetricians. This will be a national issue as there are insufficient numbers of trained staff available to recruit.		

Other Comments	
Topic	Comment

Issues Referred to another Committee	
Topic	Committee

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 Safe?


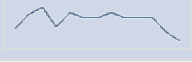


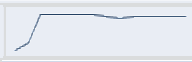




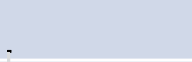



Are We Well Led?

Are We Responsive?

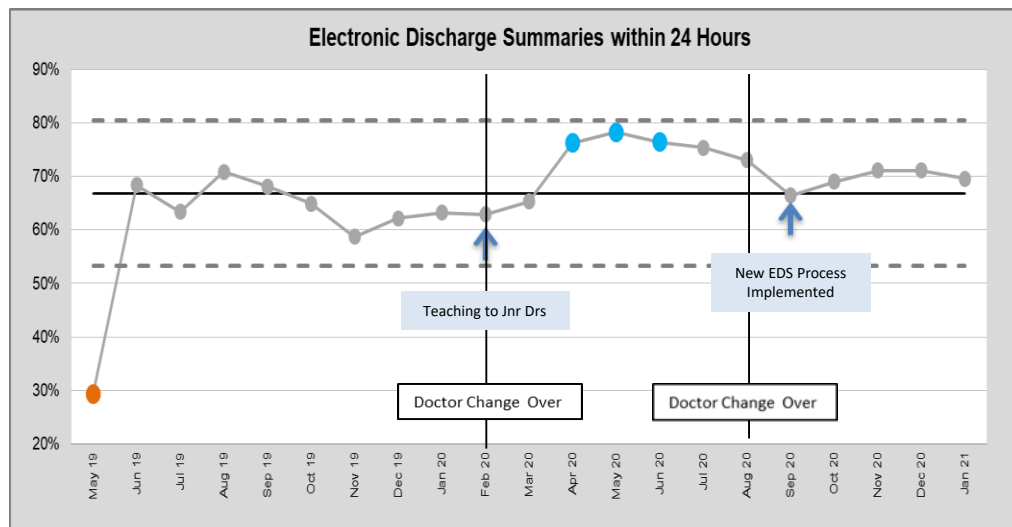
Are We Caring?

Use of Resources

Our Care Summary

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
Dementia Assessment (Public View)	87.2% (Dec 20)		62	1	1	Feb 20
<i>C. Difficile (Hospital onset) per 1000 bed days</i>	10.34 (Nov 20)		29	53	35	Nov 20
VTE Assessment	97.7% (Dec 20)		18	116	1	Dec 19
Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death)	1.35% (Jan 20)		121	94	72	Nov 20
Hip Fracture Best Practice Tariff – 12 Month Rolling	75% (Oct 20)		34	81	6	Dec 20
Complaints Rates	39.79 (Q4 20/21)		114	32	48	Q2 20/21
Family and Friends Score – Percentage of Positive Responses - Inpatients	89% (Jan 21)		89	53	1	Feb 20
Falls per 1000 bed days	8.2 (Jan 21)					
Pressure Ulcers – Acute	30 (Jan 21)					
Pressure Ulcers – Community	44 (Jan 21)					
Hand Hygiene Audits	98.9% (Jan 21)					
Never Events 20/21	3					
Serious Incidents	2 (Jan 21)					

1. Patient Outcomes – Electronic Discharge Summaries (EDS)



	24 hours	48 hours	72 hours.
Feb-20	62.88	67.94	71.43
Mar-20	65.3	70.89	75.35
Apr-20	76.28	82.68	85.92
May-20	78.26	83.98	86.77
Jun-20	76.44	82.96	85.81
Jul-20	75.36	81	84.64
Aug-20	73.07	78.3	81.75
Sep-20	66.47	71.24	74.65
Oct-20	69.05	73.49	76.99
Nov-20	71.14	75.67	78.62
Dec-20	71.08	75.59	79.81
Jan-21	70.81	75.43	78.50

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

Over the past three months the completion rate of EDS compliance has declined, but there is an improvement on the same months last year.

The table above shows performance up to 72 hours post discharge. At the end of the month on average 5% of our Electronic discharge summaries remain incomplete on the system.

The data below compares the 2019/20 with 2020/21 performance.

Nov 19 – Jan 20	%	Nov 20 – Jan 21	%	Variant
Nov 2019	58.74	Nov 2020	71.14	↑12.4
Dec 2019	62.18	Dec 2020	71.08	↑8.9
Jan 2020	63.26	Jan 2021	70.81	↑7.55

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

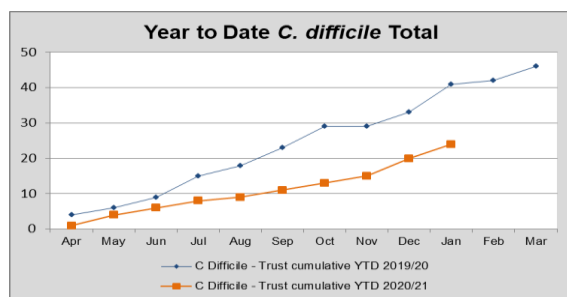
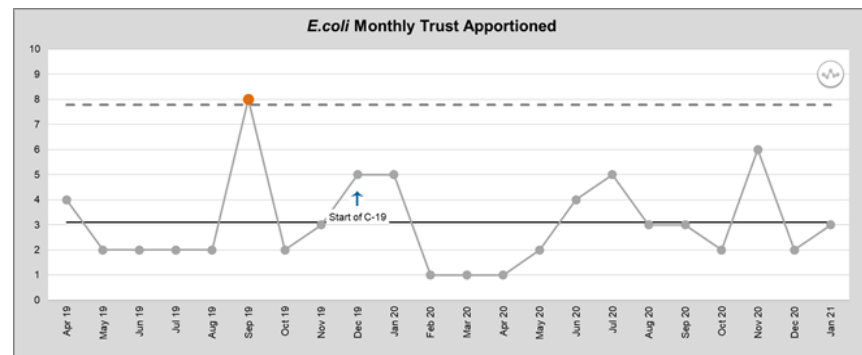
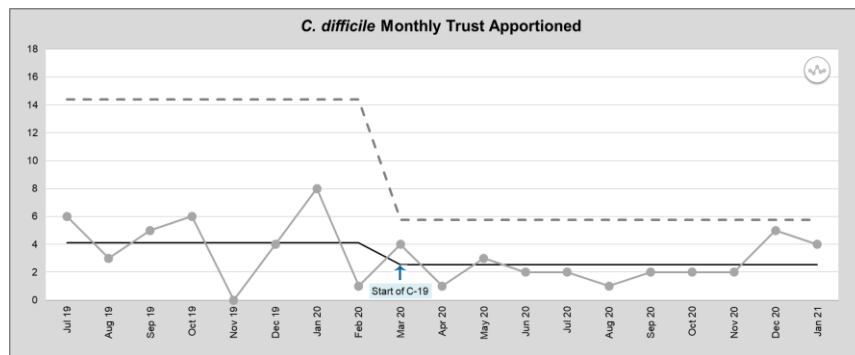
The data is shared with the Divisional tri on a monthly basis, including performance by speciality and is discussed at the Divisional Performance Review meetings.

Reporting now includes the top 5 areas with the highest numbers of outstanding EDS. The areas within the top 5 have been informed and this has led to initial improvements, which we hope to see continue.

Risks to delivery and mitigations

Risk to delivery include changeover of doctors in February and lack of familiarity with the system. Winter pressures and Covid- 19, redeployment of staff to cover areas that have gaps in their staffing model may also have an impact.

2. Patient Safety - Infection Control



Covid 19 (January 21)	
Number of detected Inpatients	437
Number of Deaths	91
Hospital Acquired Covid-19 Cases*	54

Covid-19 (April 20 – January 21)	
Number of detected Inpatients	1230
Number of Deaths	258
Hospital Acquired Covid-19 Cases*	132

Hand Hygiene	January
Audit Results	98.9%

MRSA Bacteraemia	2019/20	2020/21
Trust Apportioned	2	0

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

Coronavirus – There has been an increase in cases during January 2021, up from 197 in December. A total of 54 of these cases were deemed to be hospital acquired.

C. difficile – Twenty-four cases of *C. difficile* infection reported to date in 2020/21. Of the four cases of *C. difficile* identified in January, Two were identified as hospital acquired, no themes were identified

E.coli – Three Trust apportioned *E.coli* was identified in January 2021.

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

Coronavirus – Daily monitoring and reporting of results continues. Contact tracing of any hospital acquired COVID is completed to, prevent further spread, pinpoint root cause and share learning. Continued focus on compliance with PPE usage including increased use of eye protection for staff and encouraging mask usage for patients at all times when safe to do so.

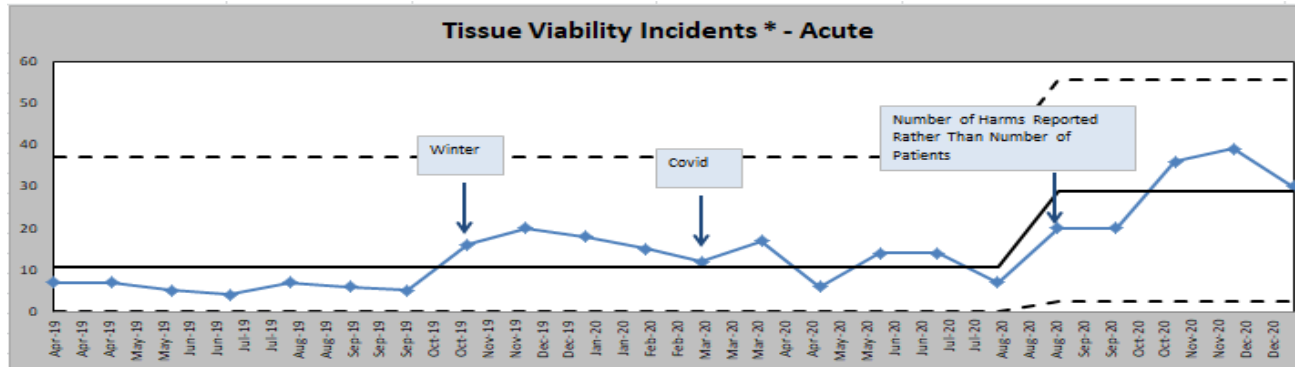
C. difficile - Each case has been thoroughly investigated issues identified include inadequate use of PPE, delayed isolation and sample acquisition. Learning and additional training has been delivered and a full PPE observational audit is in process across the trust to look at PPE compliance and cleaning.

E.Coli – RCA's undertaken for all hospital acquired infections. No patterns noted.

Risks to delivery and mitigations

There is a risk of an increase in the rate transmission of Covid-19 with the continued surge of patients associated with Wave 3. Therefore, continued testing and the management of transmission is essential to ensure reduction in hospital acquired infections.

2. Patient Safety - Pressure Ulcers- Acute



Record of Incidents of harms by Category for January 2021:

Category 2 PU	Category 3 PU	DTI	Device related PU	Total Incident of Harms
12	0	7	11	30

Themes noted from the validated IR1's –

Number of harms	Themes	Findings
10 incidents of harm	Proning	A total of 8 patients were all proning patients and Covid positive (2 pts had multiple harms).
11 incidents of harm	Device related equipment	The devices consisted of – NG Tubes, ET tubes, ET ties, CPAP Masks, Catheter tubing, Catheter clamp and a Boot.

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

30 incidents of harm, involving 28 patients (5 patient's had more than 1 harm).

Number of Patients	Number of harms per patient
1	3
4	2

There remains concerns about the consistency of skin inspections, patient assessments and documentation. However, improvements are noted this month in the Emergency Department with improved identification of harms / skin damage on admission and improvements in image capture on Jupiter has allowed improved verification.

Intensive support by the Tissue Viability Nurses to Trauma unit and Neptune Ward has resulted in reduced harms, Trauma unit reporting 0, Neptune 4 reported, 2 x were device related.

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

Pressure Ulcer Improvement Programme launch day planned for 4th March 2021, all divisions and professions represented. Themes and working groups include, skin inspections and 'react to red', SSKIN care bundle, reducing device related harm, investigation and learning, training and education.

Improvement work is on-going in regard to device related harms, this is a particular risk when proning in ITU. The Tissue Viability Nurses are seeking national advice and benchmarking.

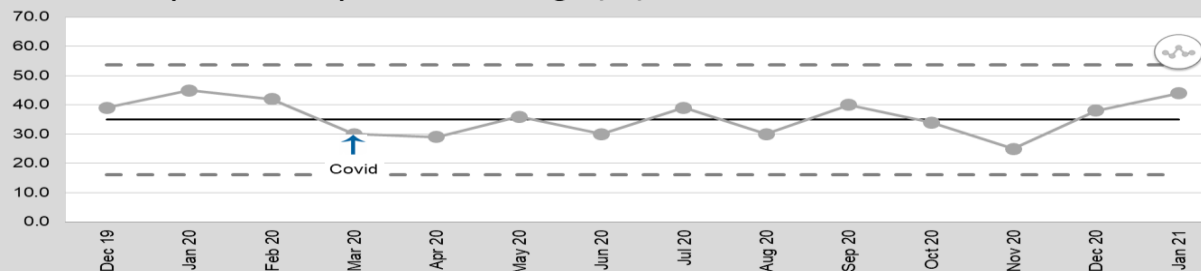
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Risks to delivery and mitigations

Training and improvement plan resource with the Tissue Viability Team, review underway with Deputy Chief Nurses.

2. Patient Safety - Pressure Ulcers- Community

Community Tissue Viability Incidents*- starting 01/12/19



January 2021					
Locality	Cat 2	Cat 3	Cat 4	DTI	Totals
North	3	3	1	3	10
South	3	2	0	2	7
West	4	3	1	3	11
Central	6	5	3	1	15
Sunflower		1			1
TOTAL	16	14	5	9	44

Device related PU's

Category	Device
Category 3	Riser recliner chair
DTI	Rubber toe protector
DTI	Slippers

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

There has been an increase in harms by 6 (mainly category 3 harms).

5 device related harms related to patients own equipment.

16 category 2 harms reported but not validated by Tissue Viability team due to workload.

3 patients with 2 harms.

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

- Risk assessment paperwork realigned for ease of completion by bank and agency staff.
- Improved process for feedback following visits from bank and agency staff and improved scanning times for documentation.
- Training being delivered including for pressure injury prevention, 'react to red' and incontinence.
- Bi weekly Pressure Ulcer Action group continues – locality managers attend.

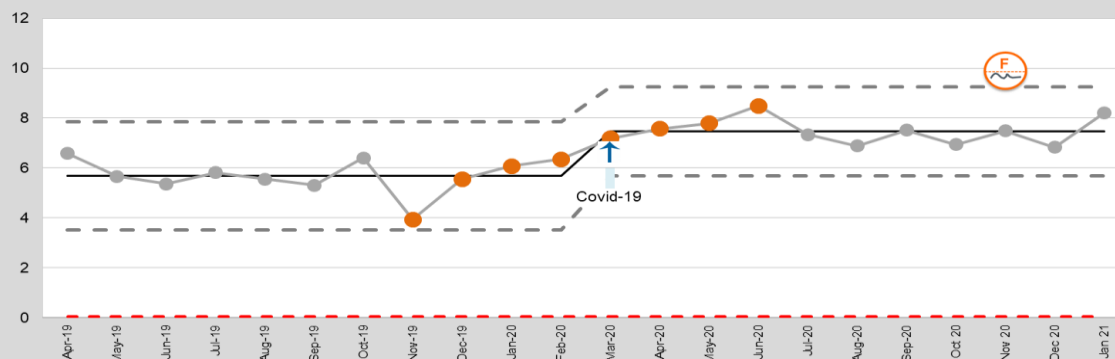
Risks to delivery and mitigations

- Staffing challenges in Integrated Care and increased number of patients being managed by the community team, including rapid discharges from acute may have contributed.
- Some delay in referrals / escalation of harms from families due to shielding.

2. Patient Safety - Patient Falls

Are We Safe?

Falls Rates Per 1000 Bed Days



January

Falls Resulting in No Harm	134
Falls Resulting in Harm	6

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

The chart evidences an increasing trend in falls per 1000 bed days from January 2020 (8.2).

There is also a shift in the average bed days from 5.7 to 7.5 falls per 1000 bed days.

In January 6 falls resulted in moderate harm or above including 4 fractures, 1 subdural Haematoma and 1 musculoskeletal injury.

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

A falls improvement plan including key milestones and outcome and process measures plan has been drafted. Initial work streams focus on the following key priority areas: multifactorial risk assessment and care planning, multiply falls, un-witnessed falls, falls involving patients with cognitive impairment and bed rail safety.

Planned activity during February and March 2021:-

Teal and Jupiter –Redesign, test and implement revised falls assessment and care planning documentation, this will then lead onto a plan for rapid roll out across all adult inpatient areas.

Mercury – Continue to measure safe use of bed rails (baseline data collected in January) and deliver training to all ward staff to raise awareness during February 2021. Adjust bedrail assessment document and develop easy to read accessible guidance for use of bedrails, low beds, care rounding and increased levels of supervision.

Mercury –Review lighting on the ward including colour of curtains. Samples of curtains ordered by Serco.

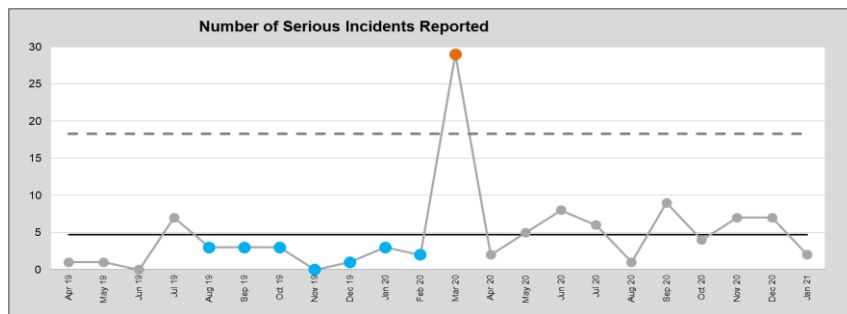
Teal – Ward Manager developing and testing a criteria to ensure handover of the patients most at risk of falls at safety briefings.

All pilot areas –Review the Royal College of Physicians post fall guidance published in January 2021, which includes documentation for post fall ‘hot debrief’ and ‘after action review’. Test in pilot areas to replace the Trusts current process for post fall ‘SWARM’, which is currently implemented to a varying standard across the Trust.

Risks to delivery and mitigations

There is a risk to the pace and implementation of improvement work due to Covid 19, winter pressures and the increases in the number of staff isolating due to Covid 19.

2. Patient Safety - Incidents



Serious Incidents Reported			Comparison
Nov -20	Dec	Jan-21	Jan -20
7	7	2	8

Never Events	
2019-20	2020-21
2	3

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

Two incidents have been reported as a SI within January. This the lowest number of SI reported since August 2020 and less than in January 2020. In total there are 34 on-going SI investigations .

Throughout January 1182 incidents were reported , of which 965 were patient safety incidents which is in line with historical reporting. The top 5 themes for the month include

- Tissue viability incidents – including both tissue damage present on arrival and acquired tissue injuries
- 140 Slips trips and Falls
- 108 Treatment or procedure incidents – including delays to treatment (9), delays in performing an operation (11) and failure to follow procedure (24)
- 105 Infection control incidents – these include 84 incidents concerning Covid-19 and 12 regarding the vaccination centre.
- 102 medication incidents – including 12 missing medications , 15 missed medications, and 19 wrong does incidents

We have seen an increase in the moderate harm incidents due to the increase in hospital acquired Covid infections.

Improvement update on working groups

Discharge Improvement Work Stream - A preliminary meeting has taken place with a focus on the new DOH guidelines, our own contractual agreement with the CCG's and what support mechanisms are available in the community to support the rapid patient discharge process from the Trust.

Patient Identification – There have been a number of near miss incidents relating to incorrect patient identification which could of led to harm. Therefore, we are proactively creating a Task & Finish group which aims to understand the potential issues and barriers and identifying solutions to reduce the risk of reoccurrence.

WHO Checklist Working Group - Within Theatres a WHO checklist cultural survey will be undertaken. Additionally, the working group will also conduct a snap shot audit of the use of the WHO checklist for chest drains and lumbar punctures undertaken on wards.

BiPAP Working Group- The working group are reviewing assessment forms for COPD patients with an aim of producing an NIV Passport and training package.

Anti-coagulation Group- The working group are presenting at divisional governance meetings to raise awareness about the importance of safe practice in prescribing and administration of anti-coagulants.

Risks to delivery and mitigations

There is a risk of reduced levels of incident reporting during times of increased demand on services or due to increases in the number of staff isolating due to Covid 19. This can also potentially impact on working groups and as a result, actions may not progress as planned.

In order to mitigate this risk the following mitigation is in place

- The Clinical risk team are streamlining serious incident investigations by undertaking an SI investigation in a day approach.
- Working closely with teams to ensure there is cohesion between investigation action plans and ongoing overarching improvement plans
- Working closely with the CCG to identify SIs that can be closed without extensive investigations if the themes are already known
- Utilising existing communications to share learning to a wide audience, such as the weekly patient safety briefing.

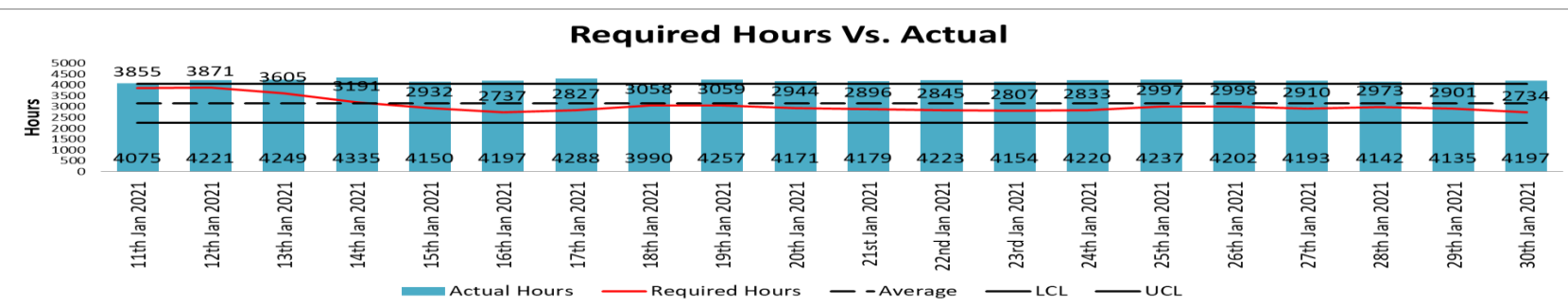
2. Patient Safety - Perinatal Quality Surveillance Tool

Measures	Comments
CQC ratings	Overall Good
Maternity Safety Support Programme	No
Findings of review of all perinatal deaths using the real time data monitoring tool	No eligible cases
Referrals and findings of HSIB reports	1 eligible case. Recommendations : staff supported to follow clinical guidelines & monitor compliance. Healthcare professionals to make holistic assessment of fetal & maternal wellbeing & maintain situational awareness .Consultant presence at vaginal breech births
Number of incidences graded moderate or above and actions taken	3 Incidents graded moderate or above. Of the 3 - 1 downgraded to low & 2 incidents awaiting decision from Trust clinical risk group.
Training compliance	Multidisciplinary PROMPT training provided virtually during COVID-19, monitored as per CNST safety actions & in line with the core competency framework. Current compliance is 21.4% and a trajectory of achieving 90% by July 2021—sessions are run weekly until the end of April and 2 weekly up until July
Minimum safe staffing in maternity to include Obstetric cover on delivery suite	Midwifery Staffing monitored via roster any shortfalls covered as required via bank office. 60 hours Consultant presence on the delivery suite. Any shortfalls in Obstetric staffing is addressed by acting down or use of locums
Service user feedback	Via the Maternity voices partnership(MVP)Monthly thematic report shared via the governance team.
Coroner's Regulation 28	Nil
Concerns or requests for actions from national bodies	Nil .Ockendon assurance report to be submitted to the National team by 15/2/21
CNST 10 Maternity standards (NHSR)	Submission due: 15/7/21. Current Concerns: MSDS, Training compliance & SBLV2 implementation
Staff feedback from frontline	Discussed at Maternity Safety Champion meeting, reviewing feedback process.

This new quality surveillance model seeks to provide for consistent oversight of maternity and neonatal services. The on-going learning and insight will help to inform improvements in the provision of perinatal services. The measures outlined will be reported to Trust Board on a monthly basis so oversight is continuously monitored.

3. Patient Experience – Safer Staffing - Care Hours Per Patient Day (CHPPD)

Table 1 Results of 20 day acuity and dependency data collection January 21. Graph compares Required hours vs Actual



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

20 day collection of acuity and dependency data completed. Compares 'Care Hours per Patient Day' required and actual. The overall picture is reassuring that staffing is safe but further analysis and break down planned as part of establishment reviews.

Data also being triangulated with nurse sensitive quality indicators.

Compliance and accuracy with the 3 X acuity / dependency submission into Safe Care Live is great improved. This ensures the Trust has accurate picture of safe staffing levels.

Bank fill rates remain at 55%, currently mitigated by agency and incentive scheme.

Overall shift fill rate reported on Unify for registered nurses is 99.7% and for unregistered is 99.4% but there is further work to align new establishments to improve the data set accuracy.

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

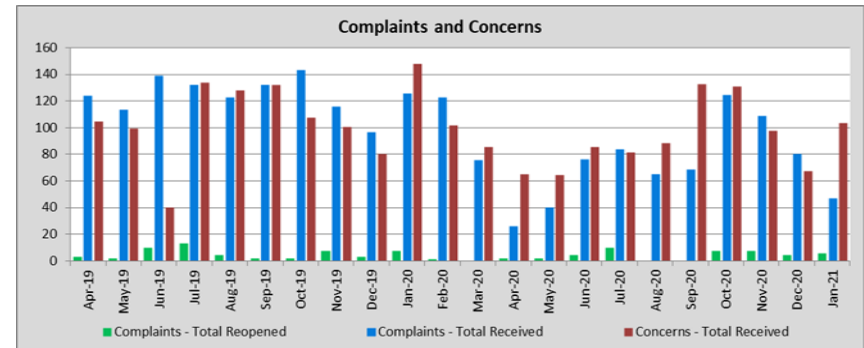
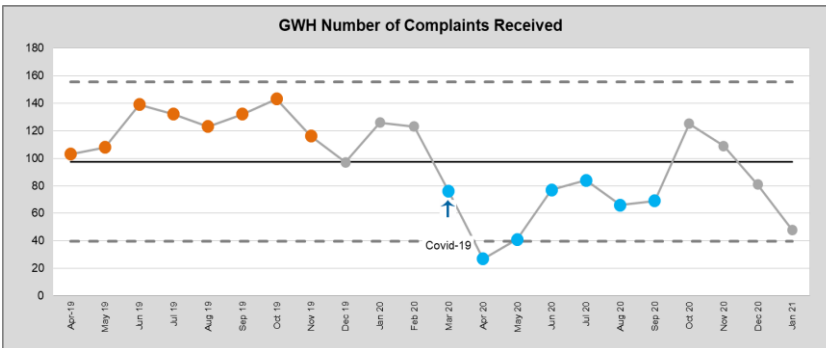
- Launch of Safe Staffing process; all shifts safe, effective use of resources, shared understanding of risk, compliance with national guidance.
- Roster review process started to check and challenge and provide assurance that rosters are within agreed KPIs
- New preferred supplier list for agencies from 1st April, opportunity to reset and reduce high cost agency.
- Further 80 Overseas Nurses joining in next 6 months including 16 this month.
- NHSE/I funding to fill HCA vacancies by 1 April (current gap 55wte)
- 41 Oxford Brookes University 3rd Year students on paid placements for 12 weeks from 2 February until 26 April.

Risks to delivery and mitigations

Risk of increased vacancies / turnover in registered nursing needs to be mitigated by focus on recruitment and retention as well as well being initiatives.

The national safe staffing submission onto Unify is still working on pre Covid 19 establishments so needs further work to improve accuracy.

3. Patient Experience - Complaints and Concerns



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

48 complaints (previous month 81) and 104 concerns (previous month 68) were received throughout January 2021.

The PALS and Complaints team have strengthened processes in line with trust policy and increased direct communication with patients and families in order to increase early resolution.

Out of a total of 152 cases received from Complaints and Concerns in January, the overall top three themes were:

- **Communication** 24 (16%) – 5 complaints, 19 concerns.
- **Clinical Care** 19 (13%) – 15 complaints, 4 concerns.
- **Telecommunications** 16 (11%) – 1 complaint, 15 concerns.

PALS: 104 concerns, 55 queries and 9 comments were received and resolved by the PALS team throughout January. These 168 cases were managed proactively by the team to reach early resolution or our patients and families. 80% were resolved within 24 hours (KPI 80%).

Complaints: 48 complaints were received, 45 were rated as (Low – Medium), 3 (High to Extreme).

Response rates: 78% L-M Complaints, 80% H-E complaints. (KPI 80%) completed within prescribed timeframes.

At the close of January, 6 cases were reported as over target date. Delays have been due to further details required to be included in the response or additional support required for the Investigation Manager to close within timeframe.

6 cases were reopened as a review, these relate to further explanations required to the complainant.

56

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

Communication and Telecommunication theme

It has been highlighted due to limited visiting, families are requiring additional updates of how their family members are and the care they are receiving. We are working with the Volunteers to focus on supporting virtual visiting and ensuring proactive calls to families. The Head of Patient Experience is also working with Serco and Trust Communications to improve delays in contacting switchboard and the wards.

Clinical care

The Matrons are leading some focused work in response to the inpatient survey. This will address concerns raised regarding lack of support with Personal Care.

The PALS and Complaints team are seeing a theme of patients/families contacting them related to patient property going missing in particular hearing aids/dentures, jewellery and electrical items. Volunteers are working to support wards, ensuring that all property is documented correctly and stored appropriately. The Head of Patient Experience is currently working with a national group, reviewing the patient property policy and ward processes.

Risks to delivery and mitigations

The contract for the complaints management system is currently still under procurement. The risk of the current provider giving notice before a new system is in place remains.

3. Patient Experience – Other Feedback Sources

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

Friends and Family Test (FFT)

ED – 1,082 text messages were sent with 296 replies (27%) received, 4 online forms were also completed. Patients gave an overall recommendation score for ED of 89.67%.

FFT text messaging was introduced from the 1st January 2021 for all Inpatient and Day Case areas.

Inpatients – 2,078 messages were sent with 567 replies (27%) received, 2 online forms were completed. Patients gave an overall recommendation score for Inpatient areas of 89.10%.

Day Case – 1,822 texts were sent with 602 replies (33%) received. Patients gave an overall recommendation score for Day Case areas of 96.51%

NB: Recommendation scores relate to the question “How likely are you to recommend our services to your friends and family”.

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

Friends and Family Test (FFT)

There has been a significant improvement in response rates since rolling out text messaging.

Due to the suspension of card collections Outpatient, Community, Maternity and Primary Care received very small amounts of feedback. The next stage of implementation is to introduce text messaging to outpatient areas and maternity. Target date:- 1st April 2021.

Opportunities for real time feedback gathering with volunteers is also planned for implementation March 2021. As a result of increased FF&T response rates themes will now be addressed in future reporting.

Risks to delivery and mitigations

No risks identified

Part 3: Our People



Resources

Trust Overview: Summary

“Great” Scoring

1 – Underperforming / Inadequate | 2 – Requires Improvement | 3 – Good | 4 – Outstanding

	Indicator Score (1-4)	Self Assessment Score
Great Workforce Planning	1	3
Great Opportunities	1	2
Great Experience	2	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			6.15%	4.50%	3.87%	7.34%	5.61%
2 RN Bank Fill Rates			49.5%	70.0%	34.4%	59.3%	46.9%
3 Vacancy Rate			7.39%	7.63%	6.00%	8.71%	7.35%
4 Recruitment Time To Hire (Days)			50.5	46.0	27.6	58.5	43.0
5 All Turnover			13.25%	13.00%	12.12%	13.53%	12.83%
6 Voluntary Turnover			8.12%	11.00%	9.18%	10.15%	9.66%
7 All Sickness Absence			4.17%	3.50%	3.27%	4.58%	3.93%
8 Statutory Mandatory Training Compliance			83.85%	85.00%	84.38%	89.23%	86.81%
9 Appraisal Compliance			70.43%	85.00%	71.67%	81.31%	76.49%



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	1	3	The Indicator Score remains 1 in January on account of 6.15% of the Trust's total workforce spend being attributed to agency (vs. 4.5% KPI), and, a Registered Nurse bank fill rate in January of 49.5% (vs. 70% target). This needs to be viewed against the context of responding to an internal critical incident arising from our response to managing the COVID19 pandemic. The self assessment score reflects this and has improved to a rating of 3 in month, as both the bank fill rate and particularly the % of spend on agency, achieved improvement in month. In respect of agency spend particularly, £235k less was spent in January than December with this contributed to by in month reductions of £149k (Medical & Dental) and £63.5k (Nursing) respectively. In April Nurse Agency contractual arrangement will move from a Master Vend to a Preferred Supplier List increasing opportunities to fill nurse agency at a lower rate.
Great Opportunities	1	2	The indicator score has reduced to 1 in December due to the increase in KPI to 51 days from advert live to start date confirmed. The microsite launch has been postponed until March 2021 due to Covid-19 pressures. The self assessment score is reported at 2 due as the Trust vacancy position decreased in January to 7.39% from 7.81% (a decrease of 20.90 WTE vacancies Trustwide). All turnover in December 2020 is now stable and is between the expected standards of 12.1% and 13.5%. Successful bid of £133k funding to support the recruitment and embedding of 50wte HCSW's, this funding will be used for enhanced on-boarding arrangements, training, mentoring and pastoral support.
Great Experience	2	2	Sickness absence in-month is 4.17% remaining above the 3.5% target with staff seeking support for work and personal related matters driving a KPI score of 2. The self assessment score is reported as 2 to mirror this sickness absence level and the drop in management referrals that are evident from the Occupational Health Service. Detailed, proactive support underway is outlined later in this report. Equality and Diversity actions are underway with the launch an EDI newsletter expected by the end of February. Key priorities have been identified in the Trust with an action plan based on case studies to tackle institutionalised racism in progress. In addition accessibility and use of Occupational Health support for the Community staff are being reviewed to ensure an equal service and support to all staff. Celebration of LGBTQ history month is planned for February and a meeting with Stonewall is scheduled this month.
Great Employee Development	2	2	Divisions continue to review and monitor their Mandatory Training compliance monthly and highlight any areas of concern regarding reporting to the Academy. Performance is monitored and escalated at Divisional meetings and where appropriate face to face training is being reintroduced with courses being expanded. The Academy continues to work on the project to move MT modules from training tracker to ESR to improve accuracy of compliance.
Great Leadership	1	2	The indicator score continues to be 1 for January, driven by the appraisal rates for the Trust of 70.43% against a KPI of 85%. A paper proposing a simplified appraisal process was considered by PPPC in January. This will be rolled out in the coming months. The focus of the new process will be to cover well-being and inclusion, appraisal and opportunities for learning and to ensure that the requirements of the national People Plan are met. The Leadership Development Programme (Cohort 1) will restart on the 24 February after a short pause. Cohort 2 will begin in April.

Great Workforce Planning

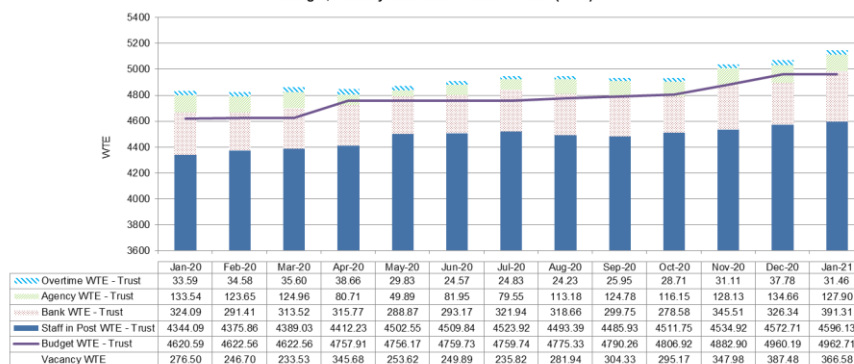
Indicator Score

1

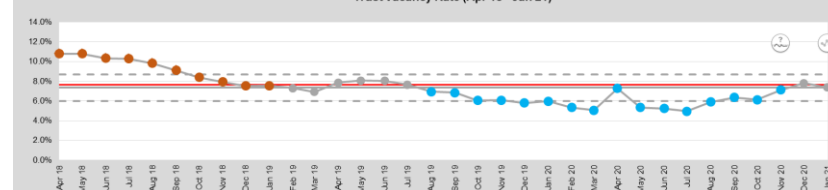
Self Assessment Score

3

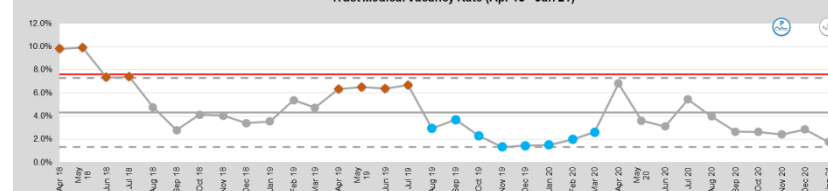
Budget, Vacancy and Actual Worked - Trust (WTE)



Trust Vacancy Rate (Apr 18 - Jan 21)



Trust Medical Vacancy Rate (Apr 18 - Jan 21)



Background

The Trust utilised 5147WTE staff to deliver its services in January '21, an increase of 76WTE on the previous month and 185WTE in excess of budget.

Successful recruitment resulted in a 24WTE growth in substantive establishment in January and whilst there was a reduction in overtime and agency utilisation compared to the previous month, there was a 65WTE increase in Bank workforce utilisation compared to December.

The increase in bank utilisation is largely attributed to the supply of registered nursing staff to deliver the Covid vaccination programme.

High bank and agency staffing has been utilised in ICU, Trauma and SAU, relating to Covid-19 escalation and vacancies arising through ward re-configuration. Utilisation in Unscheduled Care is also attributed to Covid-19 escalation

Agency usage encountered in ICC is driven by the approval to secure up to an additional 25 registered nurses per day and locum GP vacancy cover in Primary Care.

General Medicine medical vacancies continue to drive medical agency spend.

Improvement actions

- In response to a critical incident being declared, 140 staff (79 re-deployed, 61 volunteers) were mobilised to support clinical areas
- A monthly initiative reviewing the top 10 Locum and Agency medical workforce spend is in place, aimed at targeting priority areas with a view to migrating Agency resource to Locum (GWH bank) and thus reduce cost
- Progress with existing Consultant recruitment is evident with appointments now made to Consultant roles in Gastro, Oncology and Haematology, whilst the arrival of a substantive ENT Consultant in January will ameliorate current ENT agency spend
- Theatre transformation board re-established. Workforce development milestones have been submitted which include the development of a career pathway for staff, attached to an educational plan and aligned with appraisal goals
- Recruitment and retention initiatives are in place in Imaging and Pathology aimed at stabilising existing workforce, enhancing attraction from a limited local/national supply pool and ultimately scaling back agency reliance
- ACP mobilisation from PCN to Sunflower, mitigating GP cover shortfall and supporting improved flow

Risk to performance and mitigations

The majority of Consultant vacancies are recognised nationally as difficult to recruit, with locum/agency used as an interim measure. Review of the resourcing function is underway and a Head of Resourcing role has been appointed. A key part of this role will be to work with clinical lead to improve the attractiveness of roles.

Covid-19 disruption to workforce availability with many staff unable to perform their normal roles, often creating a need for backfill that cannot be achieved through re-deployment, mitigated by use of temporary resource.

Budget setting for the new financial year has been paused as per the normal planning exercises. This removes the usual cost avoidance or efficiency exercises being established, creating the likelihood that existing spend will be maintained.

Great Workforce Planning

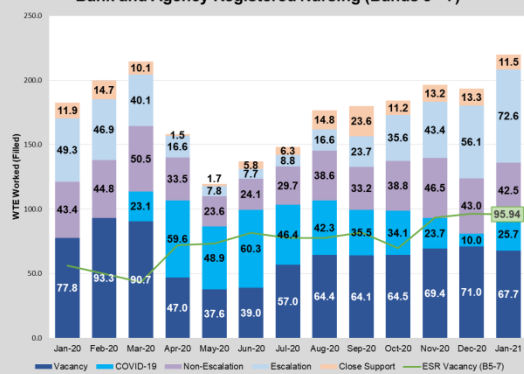
Indicator Score

1

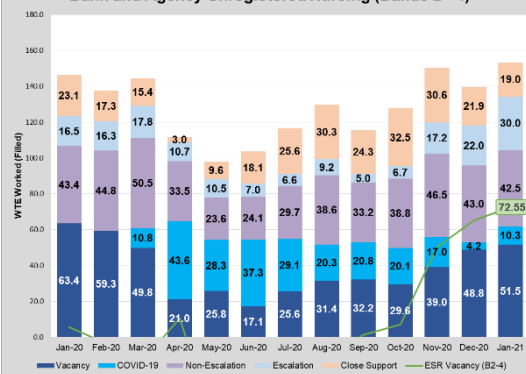
Self Assessment Score

3

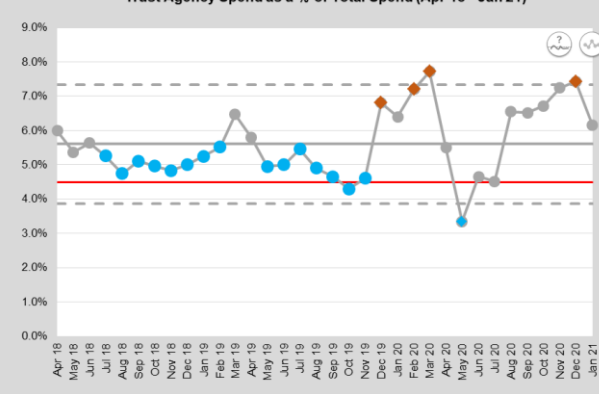
Reasons for Temporary Staffing
Bank and Agency Registered Nursing (Bands 5 - 7)



Reasons for Temporary Staffing
Bank and Agency Unregistered Nursing (Bands 2 - 4)



Trust Agency Spend as a % of Total Spend (Apr 18 - Jan 21)



Background

Registered Nursing bank utilisation in January increased noticeably by 27WTE compared to the previous month, with the majority of this driven by vacancy and escalation. Bank demand due to escalation increased dramatically relative to December. Band 2-4 temporary workforce utilisation followed the same trend overall, with significantly increased numbers of Covid-19 patients exacerbating vacancy pressure and necessitating the injection of additional staffing capacity in core areas. Bank utilisation overall was higher with January's 49.5% fill rate comparing favourably against the previous month (45%) and against mean performance.

Agency spend as a proportion of total pay spend in January (6.15%) reduced relative to the previous month (7.43%), in fact reaching its lowest point in six months. Agency spend was driven mainly by Medical Workforce at £629k, which represented 10% of total Medical workforce pay (vs. 13% Dec). This was closely followed by Nursing spend of £556k, (6.3% of all Nursing Spend vs. 7% Dec). Nursing spend is contributed to heavily by continuing use of off framework premium agency within Community Services and high cost areas (Emergency Department, Neptune, Linnet).

Improvement actions

- Long-line agency booking, securing challenged areas with staffing continuity and a preferable agency rate owing to the longer term commitment
- Expanded use of 'daily staffing' roster functionality and SafeCare by Matrons, with additional functionality being used to allow departments to accurately forecast the number of additional hours required per department by factoring both volume and acuity. This is providing improved oversight at both ward and in turn Trust level, with greater visibility enhancing the ability to mobilise staff
- Shift incentives have continued to encourage the uptake of bank shifts in the Community and particularly challenged areas such as blue ward areas, mitigating the likelihood of shifts being released to agency
- Bank recruitment is taking place for registered and un-registered roles, to provide greater depth to bank staffing resource
- Roster review underway in Primary Care with staffing resource now aligned to designated GP surgery, enabling improved oversight and understanding of workforce deployment
- PSL project underway and on plan for new contracts being in place from April, This is led jointly with nursing and HR. This should improve cap rate compliance and reduce our reliance on one provider
- Launch of e-roster for medical staffing planned for end of February to provide detailed data around usage of temporary staffing.

Risk to performance and mitigations

The availability of temporary staffing resource across both bank and agency is limited and on occasion may lead to an inability to supply, mitigated by on-going bank recruitment

Continued Covid-19 related absence, whether through sickness, lateral flow tests that return a positive result or self isolation, inevitably creates a need for backfill and thus a reliance on temporary staffing

With the focus of clinical teams on dealing with Covid-19 on the frontline, engagement with roster and SafeCare interventions could increasingly reduce meaning technological aids aren't capitalised upon

Great Opportunities

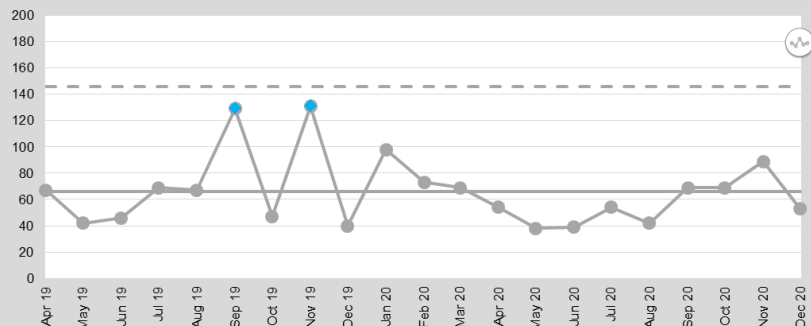
Indicator Score

1

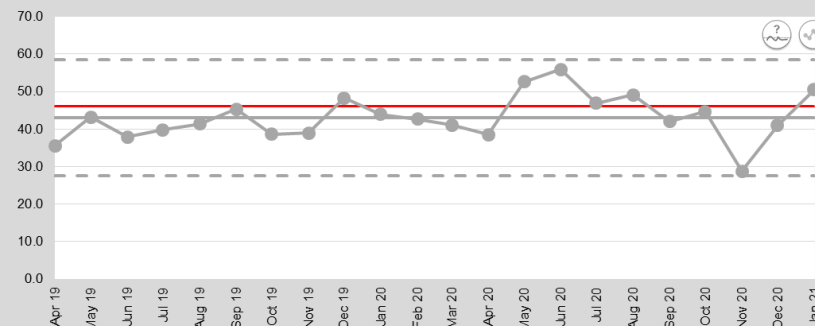
Self Assessment Score

2

Trust Starters (Apr 19 - Dec 20)



Trust Time to Hire (Apr 19 - Jan 21)



Background

The Trust vacancy position decreased in January to 7.39% from 7.81% (a decrease of 20.90 WTE vacancies Trustwide), of this AHP 12.46%, Scientific 6.66%, Medical & Dental 1.77%, All Nursing 7.52% and Senior Managers & Admin 8.87%. Small increase of 2.52WTE additional establishment from M9 to M10

During December 2020, 53 new starters (48.13 WTE) commenced employment at the Trust. There has been no significant change in the number of new starters to the Trust.

The recruitment pipeline has 74 candidates due to commence employment in February. In addition to this 44 aspirant nurses commenced on a 12 week paid placement.

There has been no significant change in the recruitment time to hire, reported at 51 days in January. Currently, monthly performance can be expected to vary between 28 and 59 days.

Improvement actions

1. £133k funding to support the recruitment and embedding of 50wte HCSW's, this funding will be used for enhanced on-boarding arrangements, training, mentoring and pastoral support.
2. The midwifery team have been providing staffing support to ICU despite their own staffing pressures which has worked well. This has also prompted a number of midwives to re-join the NMC Register as a registered nurse again which will support greatly with staffing in the future.
3. International recruitment for Radiographers has been explored and due to commence to support the on-going workforce gaps. The funding will be from the Division with a caveat on the reduction of agency staff.
4. A new apprenticeship scheme has commenced for Physiotherapists with a further apprenticeship scheme for Occupational Therapists being explored. These new roles will support the departments succession planning.

Risk to performance and mitigations

Due to international travel restrictions a number of the overseas nurses are being cancelled. Working with the Academy to support revised start dates and OSCE exams.

Launch of the recruitment microsite continues to be postponed until March 2021 due to current Covid-19 pressures

LAMU recruitment strategy remains on-going however, progress on a video has been delayed till March due to Covid-19 pressures.

Great Opportunities



Background

EDI continues to be monitored throughout the recruitment process. For Non-Medical in the period Nov 20 – Jan 21, of a possible 21% BAME applicants shortlisted, 7% of staff were appointed and of a possible 11% other/undisclosed applicants shortlisted, 35% of staff were appointed.

For Medical in the period Nov 20 – Jan 21, of a possible 66% BAME applicants, 49% were taken forward at the shortlisting stage. Appointments are not reported here due to start dates not yet agreed.

Following the significant increase in all turnover between August and October 2020, performance in December 2020 is now stable and is between the expected standards of 12.1% and 13.5%. Increase in turnover between August and October was due to a number a fixed term contracts ending following the first wave of COVID.

Voluntary turnover has remained stable and has continued to decrease.

Improvement actions

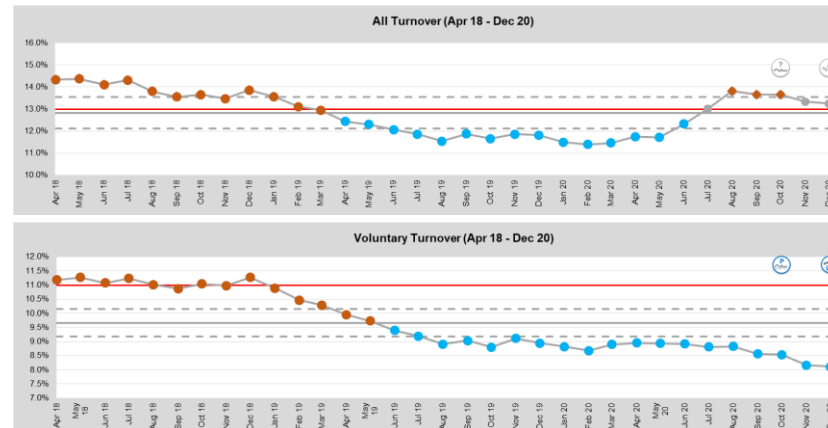
1. The Temporary Staffing master vend nurse agency contract ends in March. The Trust has commenced implementing a Preferred Suppliers List (PSL) from 1st April to ensure an efficient transition with minimal impact to the service. The PSL will consist of 8 agency's for general and 3 agency's for critical nurses, this change will allow the Trust wider access to agency staff to support workforce gaps and increase in activity.
2. 44 Aspirant nurses joined the Trust on a 3 month FTC as a paid final placement, of those 4 were allocated to paediatrics (commenced 1st February) and 40 were allocated across all other departments (commenced 2nd February).
3. Within Surgery, Women & Children's a workforce culture survey has been undertaken and a plan is currently being developed to improve the working culture.
4. A local staff survey in Endoscopy took place to understand staff perception of working in the department. 28 employees out of 44 took part in the survey which was live for 3 weeks. The survey specifically looked at feeling valued, training needs, team work, work-life balance, flexibility and the working environment. Results are currently being evaluated and an action plan will be collated.

Indicator Score

1

Self Assessment Score

2



Risk to performance and mitigations

Due to Covid-19 pressures there has been a delay in receiving the feedback from leads on the License to Recruit mandatory training module. It is anticipated this content will be finalised in February.

Great Employee Experience

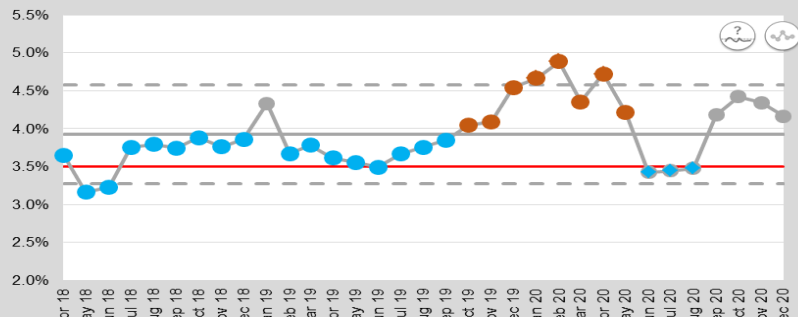
Indicator Score

2

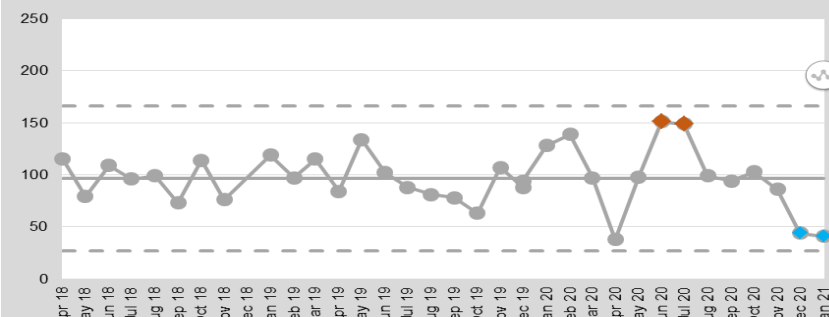
Self Assessment Score

2

Trust Sickness Absence (Apr 18 - Dec 20)



Trust Occupational Health MRs (Apr 18 - Jan 21)



Background

Sickness absence has remained consistently above the 3.5% target over the winter and during COVID wave2. Currently performance can be expected to vary between 3.3% and 4.6%, with December 2020 sickness absence reported as 4.17%.

The number of occupational health management referrals (MRs) varies considerably from month to month. There has been significantly less referrals in December and January, with 41 recorded in January 2021.

Improvement actions

1. The first HWB champions meeting was held on 2nd February with 46 attendees. Discussions on HWB initiatives and a mapping exercise is currently underway with the HWB Champions to identify areas that are well and less well represented across the Trust. Due to the number of attendees the next session in April will be run based on Divisions.
2. Outsourcing resource options have been explored for pre-employment vetting, immunisation and post-induction clinic service for candidates. A preferred supplier has been identified and work is in place to agree an implementation plan with an anticipated roll out of the new service shortly.
3. COVID vaccine has taken over the OH department. OH are seeing staff virtually and on-site clinic rooms are booked in advance if face to face meetings/clinics are required. Alternative location is being sought.
4. The main focus of OH and support teams during December to November have been to support the COVID vaccine. Over 15,000 staff and patients have received the vaccine. 80% of staff have received the vaccine, work underway to improve the uptake for BAME and Wards with low uptake.

Risk to performance and mitigations

The number of OH management referrals has decreased again in month with a backlog of referrals to be completed, this has been due to staffing capacity within OH and staff supporting the COVID vaccine programme. There is a potential risk that staff will not receive the proactive OH support they require within an adequate timeframe. Option for outsourced support underway.

Great Employee Experience				Indicator Score	Self Assessment Score
				2	2
Employee Recognition					
Long Service Awards	2	Hidden Heroes	1		
Retirement Awards	1	STAR awards	6		
Diversity/Inclusivity					
<ul style="list-style-type: none"> Chief Nurse and DDoN discussions have identified a need to prioritise an adaptation /training programme for internationally recruited nurses for Community Services. An evaluation of Occupational Support services available to the community will also be undertaken to ensure equitable access and personalisation to this staffing group. By the end of February the EDI lead will produce a draft plan to tackle forms of institutional racism based on case studies in addition to the re-launch of the EDI newsletter as a source of current information to applicable and interested parties. A visible campaign to encourage Covid-19 vaccine take up, and reduce risk of spread of virus has been completed with the video production supported by and shared through Trust Comms. The EDI calendar will also be finalised by the end of February with discussions on which event to celebrate currently underway. Gender Pay Gap reporting is currently at more advanced stage with a draft action plan due for Friday 12 February. A commitment to assist with upcoming PMS CQC inspection has been achieved. Several meetings have been held with Governance lead, GPs and Community Seniors to scrutinise plans and discuss focus of efforts. 					
Wellbeing Initiatives					
<p>The Trust Tea Trolley: Due to Covid-19 restrictions the tea trolley activity is still paused at present though Monthly tea and coffee has been provided over the winter period. January deliveries were completed to 50 wards/areas.</p> <p>Massage Chairs: Second rotation has been completed in January 2021 across Beech ward, Pathology and Shalbourne Medical Assessment Unit.</p> <p>Yoga Class Referral Sessions: a pilot within occupational health for clients seen by Physio and mental health staff is currently at the planning stage with an external company who will facilitate the sessions. It is anticipated that these sessions will be offered to staff within the next month.</p>					

Background

In-month staff support uptake included 29 staff accessing counselling services receiving immediate support, 51 sessions offered and 15 group / department intervention sessions.

Top Themes for Staff Support included;
Work related: Stress overload, and traumatic incident;
Personal related: Anxiety; Stress overload and depression & family health

A further 16 members of staff were trained as Mental Health First Aid Training during the first week of Feb. Another cohort of 16 is planned for beginning of March.

In-reach activity for January:

- self-care group to cancer service palliative care team
- promo talk about TRIM to ED Senior Team
- reflective group for Neptune
- 2 x reflective groups for Woodpecker
- drop-in for theatres staff
- 3 x reflective groups for ICU
- drop-in time in ICU
- community nursing team reflective group at the Orbital

Improvement actions

- In January there were 22 new first time contacts made to the EAP service, of this; 3 online counselling, 13 telephone counsellor and 6 telephone information specialist.
- An EAP session was held with HR, OH and HWB in January to highlight the tools available to staff. 40 staff from the HR function attended and will share this learning to promote and increase the awareness of this service to staff. We are investigating the option to apply for charitable funding to produce 2 bespoke EAP training videos for staff and managers to allow easy access for viewing at any time.
- TRiM – 16 further practitioners and 4 further managers to be trained this year, from various areas.
- Further 128 Mental Health First Aiders to get trained this year – available to all in every dept.
- Additional recruitment – position for a 0.6wte clinical psychologist in development.
- Working towards normalising in-reach offer by greater provision of staff drop-in time in depts., facilitating self-care workshops & reflective practice groups, and linking in with department to embed HBW locally.

Risk to performance and mitigations

Sickness absence rates indicate that staff continue to be impacted and exhausted by Covid-19 wave 2 and winter pressure. There is the risk of staff perception that to seek support is a weakness and this may be discouraging them from seeking further support and guidance.

Great Employee Development

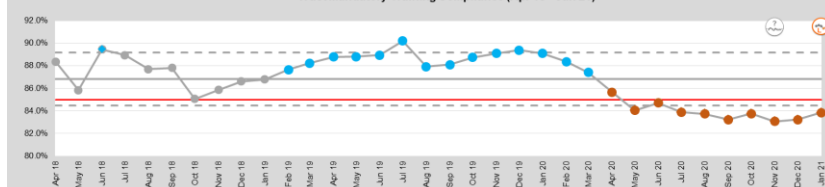
Indicator Score

2

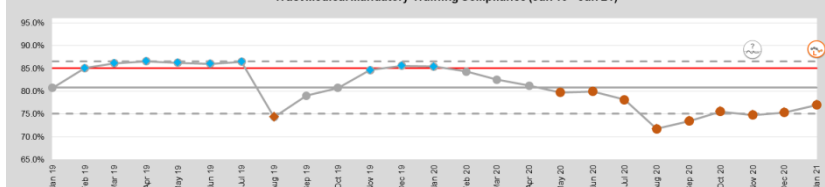
Self Assessment Score

2

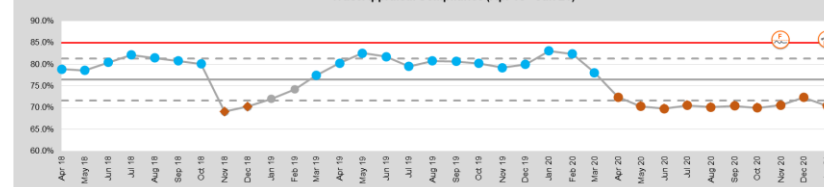
Trust Mandatory Training Compliance (Apr 18 - Jan 21)



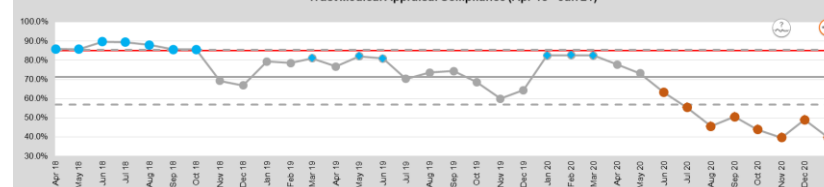
Trust Medical Mandatory Training Compliance (Jan 19 - Jan 21)



Trust Appraisal Compliance (Apr 18 - Jan 21)



Trust Medical Appraisal Compliance (Apr 18 - Jan 21)



Background

Mandatory Training compliance remains under target overall. Exception Report included in pack below.

Improvement actions

1. We continue to work with the SPOC the divisions to improve MT compliance. We are currently reviewing the training and communications around use of the new monthly MT report.
2. The risk register is reviewed on a monthly basis.
3. The move from Training Tracker to ESR continues with a project completion date of 30th June 2021.
4. MT training requirements for GPs have been reviewed and streamlined. This means some modules which are not deemed necessary will be removed.
5. The Academy is reviewing the MT modules to ensure that all those deemed mandatory/role essential remain relevant and accurate.
6. The majority of the GPS within the PCN are locum staff, engaged in a variety of ways. We have focussed on collating appraisal data for each individual long term locum (excluding agency workers). This data has now been fully collated and been recorded on ESR to help reporting accuracy. All GP appraisals have been postponed for the year by the GMC due to the pandemic, however a number have still completed this.

Risk to performance and mitigations

The continued reduction of capacity at courses due to social distancing. Additional courses for Mandatory Training are being made available to help drive up compliance. Locum staff not substantively employed. Mandatory training might be completed whilst paid at higher rates than substantive staff.

Great Employee Development

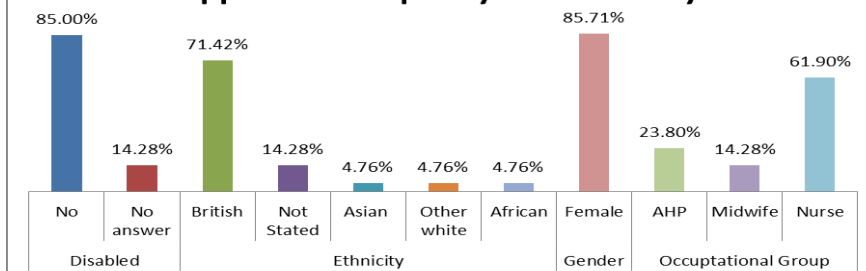
Indicator Score

2

Self Assessment Score

2

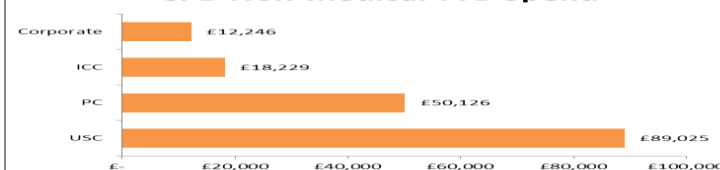
CPD Applications Equality and Diversity Data



CPD Non-medical YTD Spend HEE Budget



CPD Non-medical YTD Spend



Background

HEE Funding for Clinical Staff:

HEE budget spend to date is £149,000. There has been a review of spend and committed spend in February with HEE. The outcome of which is that the Trust will retain all the monies allocated (£516,000) and will be able to manage this amount over the year end with the use of accruals. The graph top right highlights spends /committed within January.

The Trust CPD allocation is underspent year to date £73,000 .against allocated budget of £240,000.

There were 22 non medical CPD Applications in December for up-skilling and leadership courses.

Nurse Degree Apprenticeships:

A business case is being prepared to assess the viability of employing nurse apprentices for a September cohort .

Improvement actions

1. The Academy continues to work with the divisions to maximise the use of the Trust Non –medical CPD funds.
2. The Academy is working with Divisions to ensure that the maximum amount of allocated HEE CPD funding is utilised.
3. The head of learning and development is working with the EDI lead to understand what additional steps can be taken to increase uptake of CPD applications across all those staff with protected characteristics.

Risk to performance and mitigations

Accessibility of courses is proving difficult due to provider restriction with offering face to face courses during pandemic and a level of over subscription resulting from high interest in accessing more courses with the additional HEE CPD funding.

Great Leadership		Indicator Score	Self Assessment Score
		1	2
Leadership Roles at the Trust	4.39% of staff	Equating to 173.99 WTE	
Leadership Development Programme (cohort 1)	22 leaders	Undergoing Training	
Leadership Development Programme (cohort 2)	19 leaders	Identified for next iteration	
Leadership Forum Members	300 managers	Members Engaged	
Latest Leadership Forum (24 Nov)	76 managers	Actively Attending	
Ward Accreditation	24 of 24 departments	using the Perfect Ward App	

Background

Module 2 of the Leadership programme, initially paused due to the impact of the second wave of the pandemic, will restart on the 24 February.

The second cohort is planned for April 2021.

Leadership Forum had to be cancelled. The regular promotion of NHS Elect workshops has had an impact on their uptake. 172 staff have attended these development opportunities.

A review of appraisal documentation has taken place which is designed to increase the focus on health and well being and ensure it covers the required aspects of the People Plan-but is also more user friendly. The Head of Leadership, Talent Management and Succession Planning has now taken up post.

Improvement actions

1. Salisbury NHS FT has indicated that it is keen to join the development programme for Associate Medical Directors. The first session of this new BSW Acute Alliance Associate Medical Director Development Programme will take place in February. (The session planned for the 22 January had to be cancelled due to the impact of the second wave of the pandemic)
2. An induction pack has been developed for AMDs and is currently being reviewed. It is designed to ensure that there is a comprehensive and systematic approach to identifying individual development needs and clarity about the leadership offer for this group.
3. Phase 2 of the Talent Management plan has been launched in a two parts, with corporate staff (Phase 2A) completing conversation by the end of February and senior clinical staff and Divisional Directors completing their conversations by the end of April. The timescales had to be revisited because of the impact of the pandemic.
4. The revised appraisal documentation is almost complete. A key focus to improve compliance is now on how the confirmation of completion could become electronic.

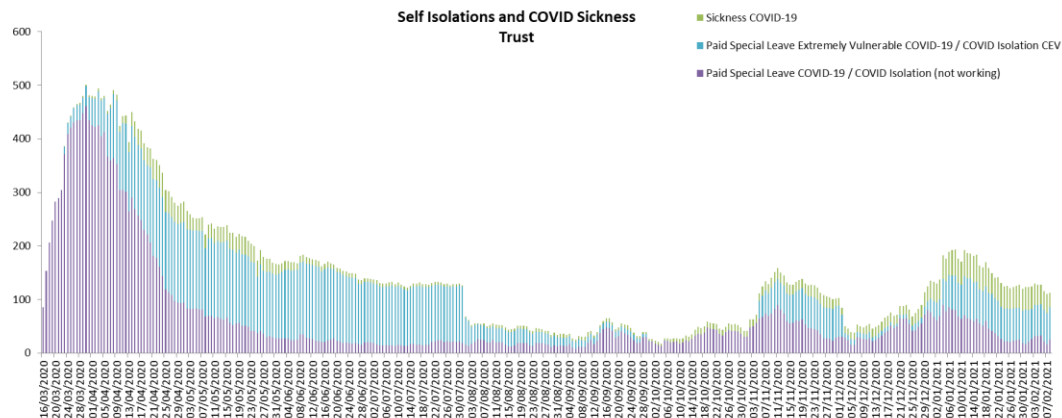
Risk to performance and mitigations

The appointment of the Head of Leadership mitigates the risk around having a single point of failure with all leadership expertise and capacity invested in one individual.

The talent management timetable has been affected by the second wave of the pandemic, but will continue if at a slower pace than originally anticipated.

The Leadership Development programme will be slightly longer in length due to the lost time. However, the option of increased frequency of sessions will be explored.

Covid-19 and Risk Assessments



Risk Assessment Compliance	96.99%		
	Category B	Category C	Category D
	172	87	84
of which done Mgmt Discussion			
Mgmt Discussion Compliance	82.25%		

Background

Clinically Extremely Vulnerable status remains to be active within our substantive and Bank Only resource at the Trust. Back fill to cover these staff members remains a sort term challenge and the numbers remain consistent over the winter period. Of note are the asymptomatic staff who contribute to these absences (100 staff to date, 17 of which were subsequently confirmed as negative). Whilst those shielding are redeployed to working from home, those tested positive from asymptomatic Lateral Flow Tests are out of the workplace for between 2 -14 days without redeployment options (treated as special leave or sickness).

At present there are 77 known category D staff members who will be eligible for CEV status and therefore subject to the redeployment and working from home, with a further 7 listed as Category D for other medical reasons.

Improvement actions

- To improve the live records of absence due to Covid-19, the control room receive phone calls for absence which are entered in to the Roster system on the same day. This has been live over the winter period and found to be necessary mainly for non rostered staff only as live COVID absence is reported on the roster simultaneously to alerting the COVID control room
- To reduce the numbers on special leave, redeployment options continue to be offered to staff who are both Clinically Extremely Vulnerable and Clinically Vulnerable.
- The Wellbeing Project lead maintain regular contact with CEV staff who are shielding or WFH. Team meeting and weekly update on Trust communication is shared with staff to keep them engaged. Working from home activities are central organised.

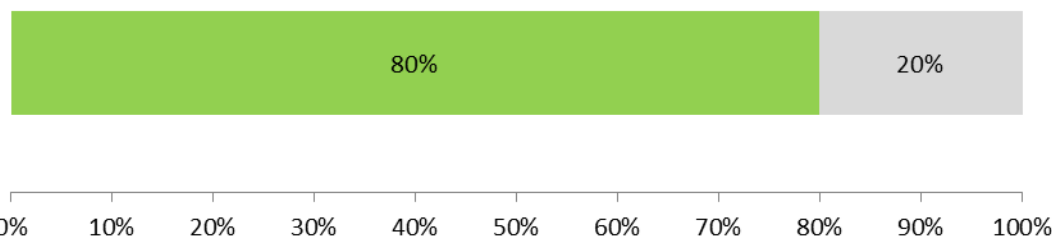
Risk to performance and mitigations

Although the COVID control room act as a base to receive notification of absence, there are a small number of absences that are reported after the fact. These are seen in weekly and retrospective reports which are more accurate than daily updated which are dependent on the quick turnaround of information. Data is refreshed retrospectively daily to ensure the most accurate picture is available.

Asymptomatic testing and lateral flow testing remains a risk to increasing the number of staff who need to self isolate. Mitigation of this will be in the form of working from home options where possible and use of Agency Pool who are not assigned to a location until the day of their shift. They are deployed to the areas of need first which are those areas with staff Isolation reported that day.

Substantive Staff Vaccination Uptake

■ Booked/First Vaccination ■ No Uptake



Bank & Substantive Staff			
BME	Total Staff	Vaccinated Dose 1	% Vaccinated
BME	965	631	65.39%
Not Stated	753	454	60.29%
White	4320	3420	79.17%
TOTAL	6038	4505	74.61%

Background

Covid-19 Vaccination launched Tuesday 8th December 2020 for priority categories: Vulnerable Staff, Out-Patients over 70's and Care Home Staff within 32 Care Homes across Swindon. This has since been extended to include all Staff with an increased target of 450 people vaccinated daily.

Over 15,000 vaccine have been given to staff, patients & healthcare workers and on track for 30,000 vaccines in mid-March.

HR, Workforce Intelligence, volunteers and OH have been supporting the implementation.

Appointment of clinical lead and operations manager has been completed who will lead the vaccination programme.

80% of substantive staff have received the vaccine, however some Department and BAME groups have lower uptake.

Improvement actions

Covid-19 Vaccination Programme:

1. Coordination of operations staff to support the programme delivery has been completed in the form of successful recruitment to these temporary posts,.
2. Bank, redeployed and voluntary workforce have been utilised to increase resilience of the resource model – to date bank fill for the Vaccination Programme has been considerably higher than other services.
3. All staff continue to be encouraged to uptake the Vaccination since it was extended to all staff in January 2021.
4. The Vaccination Database has been upgraded to a SQL back end with the support by the GWH IT team making the database more reliable for larger numbers of bookings.
5. Work will begin on web based booking for the booking team and exploring options of self book for patients (and staff)
6. It is recognized that some BAME groups and Departments have low uptake and a communication plan is in place to encourage staff take up. This includes,
 - Weekly open forum for staff to ask questions
 - Video message from EDI lead
 - Weekly email to those who have received the vaccine with information
 - Myth busters
 - Daily communications

Risk to performance and mitigations

The vaccine programme is being conducted from the Occupational Health department in the Commonhead offices which continues to pose a challenge to space.

To date there have been a decrease in management referrals to this department. It is not clear the root cause, though it should be noted that these may increase in the coming months to 'normal' performance. With the resilience in resourcing due to the new booking team, it is anticipated that the Occupational Health team will be able to retain BAU and support 'normal' numbers of Management Referrals should/when they increase.

Board Committee Assurance Report

Finance & Investment Committee			
Accountable Non-Executive Director	Presented by		Meeting Date
Andy Copestake	Andy Copestake		22 February 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level	Committee Update	Next Action (s)	Timescale
Month 10 Income and Expenditure position	Green	Continuing strong performance with M10 £374k better than budget (£504k better year to date). Pay costs and non-pay costs were over budget – but covered by additional income.	No specific actions – monitor through FIC	22 Mar FIC
Impact of Bank Incentive Scheme	Green	A very good paper from the Deputy Chief Nurse on the impact of the incentive scheme introduced to raise bank fill rates and therefore reduce reliance on Agency nurses. The Committee agreed with the recommendations, including the proposal to end the scheme from the end of February and to introduce a more targeted scheme in the future.	No specific actions except to monitor any targeted schemes through future meetings.	Future FIC meetings
Month 10 and forecast cash position	Green	Cash position continues to be strong at £34m. An application has been made to the Centre for additional Cash support needed in March, when double block contract payments unwind.	Continue to monitor and confirm that Cash support will be forthcoming in March.	22 Mar FIC
Forecast Income and Expenditure Position	Green	With just 2 months to go, and despite concerns over escalating pay and non-pay costs, the Committee was assured that the forecast should be achieved. Additional central funding has also been made available.	Continue to monitor position	FIC monthly
Forecast Capital Expenditure position	Amber	Similar to last month, there is still a significant challenge to increase the rate of Capital expenditure and meet the forecast – but the Committee is assured that every effort is being made to do this or to retain funding into 2021/22 where it is not possible to spend the money this financial year.	Continue to monitor position	FIC monthly

Key Issue	Assurance Level	Committee Update	Next Action (s)	Timescale
Exit run rates and business planning	Red	There is still no central guidance on the finance regime that will be in place after Q1 2021/22. Work has been ongoing to understand pay and non-pay run rates as we exit 2020/21. These, combined with non-achievement of CIP this year, have resulted in a significant increase in the Trust's underlying deficit. In addition, there will be a significant challenge to reduce the cost base associated with Covid in 2022. The Executive team is on top of the issues but the lack of central guidance for the remainder of 2021/22 represents a significant problem.	Extended FIC in March to sign off the 21/22 budget.	22 March FIC
Improvement and Efficiency Plan	Amber	The Plan has been updated to incorporate feedback from the Committee – it now includes much more information on the quality aspects of each programme of work and “how” the programme will be implemented. Whilst the plan itself justifies a green rating, the amber rating here reflects the considerable challenges associated with its implementation.	This will feed into the planning discussion above	22 March FIC
IT infrastructure capital bid – Full Business Case	Green	The Committee noted the improvements made to the Outline Business Case and the vital support from NHS Digital acting as a critical friend in the process. The Committee commended the hard work the team has put in to the production of the business case and is happy to recommend approval of the FBC.	Recommendation to the full Board	4 March 2021
Associated award of contract for improvements to the Cisco network and WiFi infrastructure	Green	Linked to the above Full Business Case, the Committee agreed to recommend the award of a £2.3m contract to VMB for improvements to the Cisco network and WiFi infrastructure.	Recommendation to the full Board	4 March 2021
Associated award of contract for the provision and support of Hybrid Cloud Infrastructure	Green	Linked to the above Full Business Case, the Committee agreed to recommend the award of a £3.5m contract to DELL for the provision and support of a Hybrid Cloud Infrastructure.	Recommendation to the full Board	4 March 2021
Quarterly procurement update	Amber	The Committee noted the helpful quarterly report from the Director of Procurement which covered a number of performance metrics as well as projects in the pipeline. Whilst the performance of the procurement team remains strong, the amber rating relates to the Committee's request for a review of the procurement process to learn lessons from recent procurements, to differentiate between strategic procurements and others, and to see whether local procurement can be reflected in the criteria for future procurements.	Recommendations on any changes to the procurement process to a future FIC meeting	Timing to be agreed
Aseptic Unit build – award of contract	Green	The Committee agreed to recommend the award of a £1.2m design and build contract for the Aseptic Unit to Bassaire.	Recommendation to the full Board	4 March 2021

Key Issue	Assurance Level	Committee Update	Next Action (s)	Timescale
Award of contract for the replacement of 5 radiology rooms	Green	The Committee agreed to recommend the award of a £1.9m contract to Siemens for the replacement of 5 radiology rooms.	Recommendation to the full Board	4 March 2021
Pathology S4PP LIMS business case and contract award	Amber	This project is attracting very considerable external funding (total £8.5m). Subject to clarification of a VAT issue, the Committee agreed to recommend approval of the local investment required of £509k and the award of a £3.9m contract to Clinisys for a 10 year contract via the QE Facilities Clinical IT (Software and Hardware) Solutions Framework Agreement. The amber rating reflects the VAT issue and the fact that further revenue support will be required.	Recommendation to the full Board	4 March 2021

Issues Referred to another Committee	
Topic	Committee
None	

Part 4: Use of Resources



Income and Expenditure

Income & Expenditure		IN MONTH (JANUARY)			YTD (JANUARY)			FULL YEAR FORECAST		
		Budget	Actual	Variance	Budget	Actual	Variance	Annual Budget	Forecast	Variance
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income	NHS Clinical Income - System Block Allocation	25,861	25,861	-	255,472	255,472	-	307,914	307,914	-
	NHS Clinical Income - Block Top Up	1,981	1,981	-	22,726	22,726	-	26,688	26,688	-
	NHS Clinical Income - Cancer Drug Fund	232	232	-	928	928	-	1,392	1,392	-
	NHS Clinical Income - Original Covid Top Up	1,141	1,141	-	11,725	11,725	-	14,007	14,007	-
	NHS Clinical Income - Additional Covid Top Up	540	540	-	2,160	2,160	-	3,240	3,240	-
	NHS Clinical Income - Growth Funding	367	367	-	1,468	1,468	-	2,202	2,202	-
	NHS Clinical Income - System Envelope Planning Adj	238	238	-	952	952	-			
	NHS Clinical Income - Other	365	1,324	959	4,239	6,102	1,863	5,676	5,676	-
	Sub-Total NHS Clinical Income	30,725	31,684	959	299,670	301,533	1,863	361,119	361,119	-
	Private Patients	70	59	(11)	662	807	145	742	742	-
	Other Non Mandatory/Non Protected Revenue	64	109	45	586	642	55	715	715	-
	Research & Development Income	55	85	31	553	600	48	684	684	-
	Education and Training Income	901	945	44	9,711	9,870	159	11,644	11,644	-
	Misc Other Operating Income	684	799	115	7,069	7,211	142	8,438	8,438	-
		32,498	33,681	1,183	318,252	320,663	2,411	383,341	383,341	-
Expenditure	Pay Costs	(20,060)	(20,664)	(604)	(197,736)	(198,487)	(751)	(238,039)	(238,591)	(552)
	Non Pay	(7,848)	(8,382)	(534)	(72,860)	(74,604)	(1,744)	(88,534)	(88,534)	-
	Drugs Costs	(3,133)	(2,829)	303	(27,704)	(27,257)	447	(33,606)	(33,606)	-
		(31,040)	(31,875)	(835)	(298,300)	(300,348)	(2,048)	(360,179)	(360,731)	(552)
	EBITDA	1,458	1,806	349	19,952	20,315	364	23,162	22,610	(552)
	EBITDA as % of Total Income	4.5%	5.4%	0.9%	6.3%	6.3%	0.1%	6.0%	5.9%	-0.1%
	Depreciation	(823)	(823)	0	(7,254)	(7,254)	0	(8,899)	(8,899)	(0)
	Net Interest	(1,248)	(1,223)	25	(12,330)	(12,190)	140	(14,827)	(14,827)	0
	PDC Dividend	(268)	(268)	-	(2,684)	(2,684)	-	(3,221)	(3,221)	-
	Pension Unwinding	-	-	-	-	-	-	(45)	(45)	-
	Total Surplus/(Deficit)	(882)	(508)	374	(2,316)	(1,812)	504	(3,829)	(4,381)	(552)
	Elective Incentive Scheme	-	-	-	-	-	-	-	(1,000)	(1,000)
	Total Surplus/(Deficit)	(882)	(508)	374	(2,316)	(1,812)	504	(3,829)	(5,381)	(1,552)

A revised Financial Regime was in place in for 20/21 for the first 6 months of the year enabling the Trust to balance to a break even position by retrospective top up from NHSE subject to the submitted costs being agreed. For the second 6 months of the year the Trust plan is £3,829k deficit before potential penalties arising from the Elective Incentive Scheme (EIS).

Income and Expenditure – Variance from Plan

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

The Trust in month position is £508k deficit in month against a plan of £882k deficit which is £374k favourable variance. The YTD position is £1,812k deficit against a plan of £2,316k which is £504k favourable variance.

Income variance is £1,183k above plan in month and £2,411k above plan YTD. The majority of this is NHS Clinical income (£959k in month, £1,863k YTD) matched by costs and relates to in month income for Hospital Discharge Programme (HDP £859k), Lateral Flow Testing (£38k) and specialist high cost drug adjustments (£32k). There has been a reduction in Private Patient income which is £11k lower than plan in month (£145k above plan YTD).

Pay variance is £604k overspend in month and £751k overspend YTD. The variance includes Covid-19 Vaccination Programme staffing costs £156k (£181k YTD) which are not budgeted but the costs will be recovered through central funding. The position also includes HDP costs of £386k (£959k YTD which is £159k above budget) .

The nursing overspend is £432k in month (£860k YTD). The January wave of Covid-19 admissions has resulted in increased costs of staffing additional beds, covering absences and providing care to high acuity patients. The increases are particularly high on Linnet, Intensive Care Unit, Trauma Unit and Neptune.

The medical staffing overspend is £224k in month (£258k YTD). The overspend includes medical costs of Community & HDP schemes and Vaccination Programme prescribers. The position also includes costs of covering staff who are currently on restricted duties, covering vacancies, higher seasonal pay rates for hard to fill shifts and payment of the increased hourly Covid-19 Response Rate.

Further pay analysis is provided on the following slides.

Non Pay (including ITDA) variance is £205k overspend in month and £1,157k overspend YTD. The position includes additional charges from the PFI provider which are detailed on the following slide. The position also includes HDP costs of £45k (£352k YTD which is £71k above budget). Covid-19 Vaccination Programme non-pay costs of £3k (£99k YTD) have been incurred which are not budgeted for but will be recovered.

Elective activity was reduced in month to enable the hospital to meet increased demand of Covid-19 admissions which has meant supplies costs are £597k underspent in month (£651k underspent YTD). Spend is particularly below budget on medical & surgical equipment, stents, sleep equipment and prostheses. Drugs costs are also underspent due to reduced activity.

Forecast for 20/21 has worsened due to an increase in annual leave that will be owed to staff at the end of the financial year and for which we have to accrue. This is an accounting adjustment rather than cash payment and is expected to be £552k higher than last year. The revised forecast including this adjustment is £4,381k, increasing to £5,381k if £1,000k EIS (Elective Incentive Scheme) charge is received.

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

Budgets continue to be reviewed each month with budget holders. Risks and mitigations are identified as part of this process.

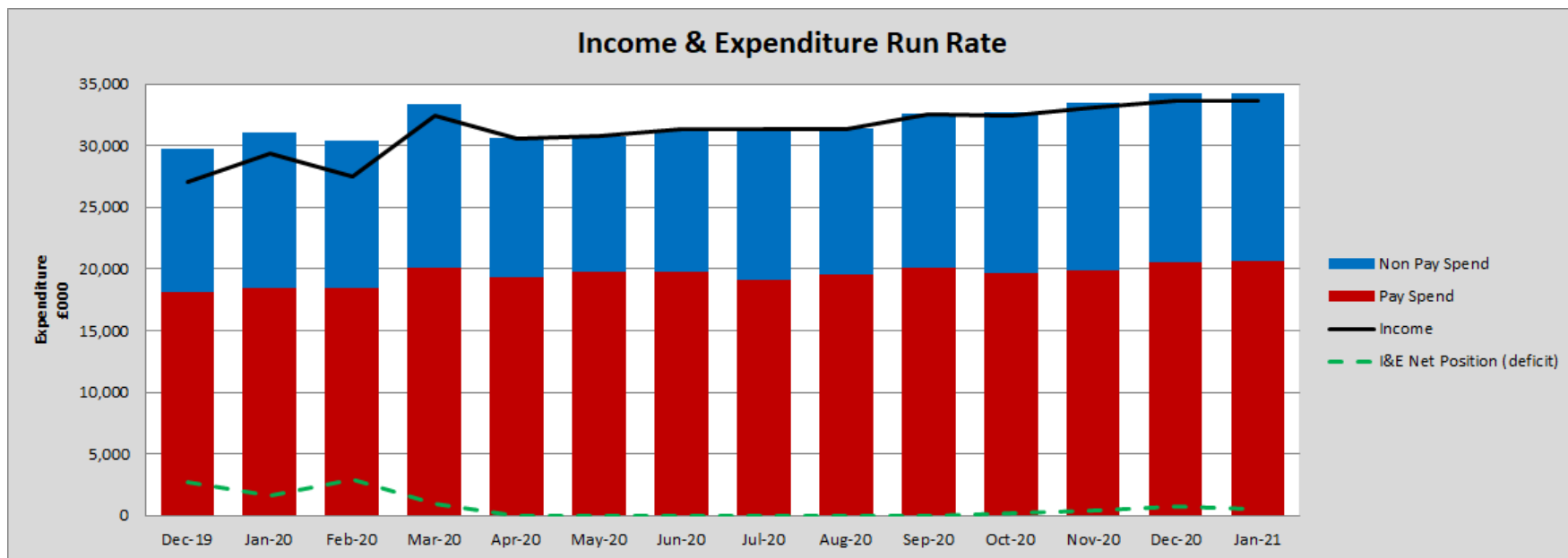
Risks to delivery and mitigations

The January wave of Covid-19 cases and hospital admissions has resulted in reduced elective activity. This activity will need to be recovered, some of which will be urgent for February and March. There is a risk that this will require temporary staffing and Waiting List Initiative (WLI) payments. This will need to be managed by redeploying staff and utilising the most cost-effective options to meet demand.

The forecast has been worsened to include the likely increase in annual leave accrual of £552k. There is a risk that the value is not high enough particularly following the recent surge of Covid-19 when staff will have postponed their annual leave to provide patient care.

A net charge to GWH is expected from the Elective Incentive Scheme (EIS). NHSE/I have shared baseline positions with systems but these are not yet finalised. The M10 reporting does not include any impact on income of the EIS.

Income and Expenditure - Run Rate



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

The Trust net expenditure run rate has reduced by £194k in Month 10 which is £374k less than plan.

Income run rate – has increased by £91k from last month. The January position includes £859k HDP income and £38k lateral flow test income. Prior month included £550k Clinical Income and £224k Education & Training income which were one-offs. The in-month position includes a reduction in Private Patient income of £82k which is £11k lower than plan due to reduced elective activity as part of the Covid-19 response in January.

Pay run rate – has increased by £172k in month which is £604k higher than plan. The pay run rate movement is explained in more detail on the Pay Spend by Workforce slide within this pack.

Non Pay run rate has reduced by £274k in month which is £205k higher than plan. Spend has reduced on drugs £235k (pass-through) and supplies £602k which reflects the reduction in elective and outpatient activity during the Covid-19 response in January. Supplies costs are lower on medical & surgical equipment £225k, prostheses £128k, stents £38k and pacemakers £126k.

Other non pay costs have increased in month due to charges expected from PFI provider (THC) for gas £269k, Aseptic Unit revenue costs £120k and PFI £240k.

Income and Expenditure - Divisional Positions (Devolved Income)

April 2020 - Jan 2021		IN MONTH (JANUARY)						YEAR TO DATE (JANUARY)					
Income & Expenditure	Annual Budget	Budget v Actuals			Variances			Budget v Actuals			Variances		
		Budget	Actual	Variance	Income	Pay	Non Pay	Budget	Actual	Variance	Income	Pay	Non Pay
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Unscheduled Care	(5,508)	995	(388)	(1,383)	(1,346)	(481)	444	(6,664)	(12,579)	(5,915)	(5,210)	(1,003)	297
Planned Care	16,108	2,114	201	(1,913)	(2,073)	(134)	294	11,078	4,204	(6,874)	(7,199)	32	293
Integrated & Community Health	(8,274)	(971)	(402)	569	681	(66)	(46)	(6,839)	(6,911)	(72)	305	94	(471)
CLINICAL DIVISIONS	2,326	2,137	(589)	(2,726)	(2,738)	(681)	693	(2,425)	(15,287)	(12,862)	(12,105)	(877)	120
Corporate	(18,414)	(1,567)	(2,027)	(460)	242	(56)	(647)	(15,275)	(15,507)	(232)	934	32	(1,198)
DIRECTORATES	(18,414)	(1,567)	(2,027)	(460)	242	(56)	(647)	(15,275)	(15,507)	(232)	934	32	(1,198)
Non-Divisional	(1,908)	(169)	(287)	(118)	1	134	(252)	(1,569)	(1,750)	(181)	(89)	93	(186)
Trust Income	41,158	1,057	4,709	3,653	3,678	-	(25)	39,221	52,859	13,638	13,671	-	(33)
EBITDA	23,162	1,458	1,806	349	1,183	(604)	(231)	19,952	20,315	364	2,411	(751)	(1,297)
EBITDA as % of Total Income	6.1%	4.5%	5.4%	0.9%				6.3%	6.3%	0.1%			
Depreciation	(8,899)	(823)	(823)	0	-	-	-	(7,254)	(7,254)	0	-	-	-
Net Interest	(14,827)	(1,248)	(1,223)	25	-	-	-	(12,330)	(12,190)	140	-	-	-
PDC Dividend	(3,221)	(268)	(268)	-	-	-	-	(2,684)	(2,684)	-	-	-	-
Pension Unwinding	(45)	-	-	-	-	-	-	-	-	-	-	-	-
Total Surplus/(Deficit)	(3,829)	(882)	(508)	374				(2,316)	(1,812)	504			

Income assigned to divisions is based on activity done, priced at the 2020/21 national tariff that was intended to be the mechanism this year prior to Covid-19. Total commissioner income received by the GWH has actually been on a block basis based on previous expenditure levels and Covid-19 costs. This amounts to more than would have been earned under the National Tariff and the balance is shown on the Trust Income line.

Income and Expenditure - Divisional Positions (Devolved Income)

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

The devolved income plan for M7-12 is currently set at pre-Covid-19 levels as it was not possible to sign off plans due to the uncertainties faced with Covid-19 pressures.

Unscheduled Care income variance is due to activity being below plan across most points of delivery due to Covid-19.

Pay is £481k overspent in month, £145k of which is the cost of the Covid-19 Vaccination Programme. Medical overspend is £164k due to a combination of cover for continued restricted duties, seasonal pay rates for hard to fill shifts and agreed change in hourly pay rate for Covid-19 Response. Nursing is £210k overspent driven by close support £61k, Covid-19 escalation beds on Linnet £74k and opening UTC overnight £51k.

Non Pay is £444k underspent of which £100k relates to prior year benefit and £183k relates to pacemaker adjustments. Reduced activity in month has also impacted the drug spend in Dermatology and Rheumatology (£90k), CT Van costs (£35k) and Genetic Testing costs (£51k).

Planned Care (from 1st Feb renamed as Surgery, Women & Childrens) clinical and private patient income is below plan as elective activity was cancelled in January due to the Covid-19 surge.

Pay costs are overspent by £134k due to increased Covid-19 escalation staffing in ICU, Covid-19 escalation beds on Trauma ward and increased bank use for maternity and midwifery services to cover vacancies and staff shielding.

Reduced activity levels resulted in non-pay being significantly lower than in prior months. In total non-pay is £294k below budget in month driven in large part by reduced Orthopaedic elective work meaning that theatres supplies spend in month is £270k overall below what was previously forecast.

Integrated & Community Care income is £681K above plan in month mainly due to Hospital Discharge Programme (HDP) income.

Pay is £66k above plan due to additional recruitment in Cancer and Outpatients of £77k (offset by income), increased Palliative Care costs of £11k due to TUPE of staff in house (offset by an underspend in non pay). Community HDP medical staffing costs are £48k above plan, but therapy is £38k below plan with recruitment very difficult. In Primary Care both medical and admin has reduced to be £19k and £14k below plan.

Non pay is £46k above plan overall, with the overspend on community rent (prior year invoice) £91k, HDP laptops £13k, medical supplies £51k, Primary Care rent (prior year invoice) £35k and further one-off building costs of £40k (above the £280k agreed income from CCG). These pressures are partially offset by underspends on diabetes pumps £18k, acute pass through drugs £126k, supplies (laboratory tests) £15k and Synertec credit of £27k.

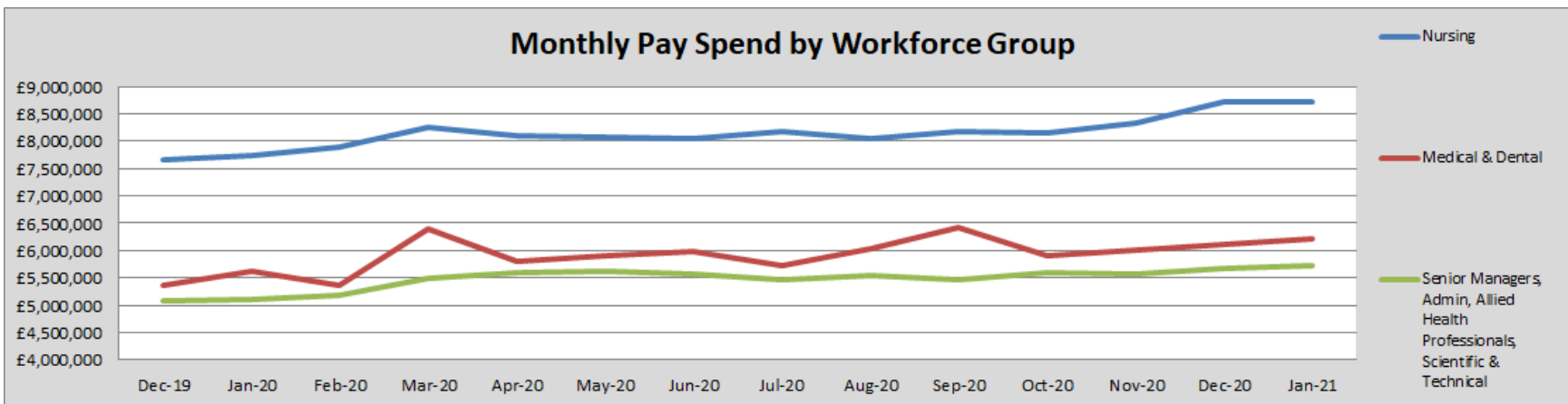
Corporate income variance is due to additional income for overseas recruitment, R&I, and Apprenticeship Benefit, this is all matched by additional expenditure on pay and non-pay.

Pay is overspent by £56k for additional Covid-19 Pay costs and R&I (covered by income).

Non pay is overspent by £647k due to additional costs for PFI, and Gas (prior years charges).

Trust Income variance is caused by the income paid through blocks being higher than income that would have been earned through PbR and relates to central funding to respond to Covid-19.

Pay Spend by Workforce Group



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

Pay run rate has increased by £172k in month which is £604k higher than plan. The increase is driven by increases across all staff groups.

Nursing run rate has increased by £9k. Permanent nursing costs have reduced by £181k from last month which included £140k enhancements for Christmas bank holidays. The reduction in elective activity has meant that WLI and overtime payments to nursing staff have reduced in January.

Temporary nursing spend has increased by £190k (bank & agency) due to 567 additional shifts booked in January which is an increase of 21% from last month. The shifts have been required to support Covid-19 pressures and HDP schemes. Included within the temporary spend is an increase in bank costs of £253k and reduction of agency costs £64k. Bank shifts were incentivised in January at a cost of £145k (cost was £150k in December).

Medical spend has increased by £113k, driven by an increase in permanent pay of £162k and reduction in temporary spend of £49k. Permanent costs includes new starters within Ophthalmology and Head & Neck, TUPE transfer of palliative care staff and radiologist sessional insourcing.

Temporary medical spend has reduced due to new permanent staff joining the trust and a movement from agency to lower cost locum spend.

Allied Health Professional spend has increased by £6k due to Covid-19 vaccination programme costs

Scientific and Technical Staff spend has increased by £11k due to increase in permanent staff and Covid-19 vaccination programme.

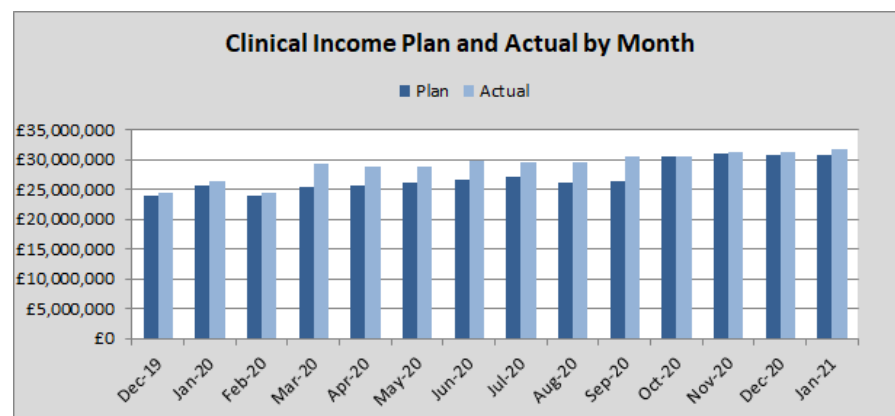
Senior Managers and Admin spend has increased by £27k due to Covid-19 vaccination programme admin support.

Income & Activity Delivered by Point of Delivery (December 20)

Income by Point of Delivery (PoD) for all commissioners	January YTD		
	Plan £'000	Actual £'000	Variance £'000
A&E	12,617	8,064	(4,552)
Non Elective	88,900	76,961	(11,939)
Outpatients (incl non cons led, non F2F & unbundled radiology)	42,383	26,703	(15,681)
Elective/Day Case	36,955	21,273	(15,682)
Drugs/Devices	28,080	26,002	(2,078)
Other	33,149	28,365	(4,784)
Truing Up	(252)	55,094	55,346
Total Acute	241,832	242,463	631
BSW Community	16,885	16,885	0
Primary Care	3,185	3,465	280
NHSE/BSW Top-up	33,428	33,466	38
Other	4,340	5,254	914
Total NHS Clinical Income	299,670	301,533	1,863

Activity Levels by Point of Delivery (PoD)	January YTD				
	20-21 Plan	20-21 Actual	20-21 Variance	19-20 Actuals	Variance vs prior year
A&E	65,723	44,198	(21,525)	70,889	(26,691)
UCC	38,784	28,896	(9,888)	28,794	102
Non Elective	45,619	34,209	(11,410)	43,341	(9,132)
Elective Inpatients	4,485	2,486	(1,999)	4,404	(1,918)
Elective Day Cases	36,072	22,836	(13,236)	33,855	(11,019)
Outpatients (cons led incl NF2F)	279,644	216,175	(63,469)	274,517	(58,342)

SLA Income Performance at commissioner level	January YTD		
	Plan £'000	Actual £'000	Variance £'000
BANES, Swindon & Wilts	185,803	186,072	268
Specialist Commissioning	26,944	27,180	237
Peripherals, NCA & LA (Acute)	26,808	26,934	125
Cancer Drug Fund	2,277	2,277	0
BSW Community	16,885	16,885	0
Primary Care	3,185	3,465	280
NHSE/BSW Top-up	33,428	33,466	38
Other (including HDP)	4,340	5,254	914
Total	299,670	301,533	1,863



Income and Activity Delivered by Point of Delivery

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

Due to the Covid-19 situation, funding is currently on a block contract basis, with the emphasis on covering costs. This approach will be in place until the end of 2020-21. The below statistics show how performance on main points of delivery would be if funded through a payment by results (PbR) tariff basis against the pre Covid-19 planned levels of activity. Covid-19 has impacted elective activity materially this month.

Non Elective -25% (-11,410 spells) below year to date (YTD) activity plan and -10% (-£8.9m) below YTD income plan

Activity has been relatively stable since the initial Covid-19 peak, but has been consistently lower than both plan and prior year run rate. The largest reduction has been within the lower tariff, less complex activity. January saw 350 Covid-19 specific spells reported, which is the highest by far of any month this year.

Acute A&E -33% (-21,525 attendances) below YTD activity plan and -25% (-£2.7m) below YTD income plan

Footfall through the emergency department has been lower than plan all year, almost certainly due to Covid-19. The largest reduction has been within the lower tariff, less complex activity. Activity was even lower in January than in any month this year at 46% behind the pre Covid-19 plan.

Elective Inpatients -45% (-1,999 spells) below YTD activity plan and -44% (-£6.9m) below YTD income plan

Prior to January, activity levels had been steadily increasing since the first wave with the best month of December being 21% lower than the pre-Covid-19 plan however January saw activity drop to it's lowest level since May, due to the impact of Covid-19. Trauma and Orthopaedics (T&O) is the main driver, accounting for c70% of the underperformance.

Day-cases -37% (-13,236 day-cases) below YTD activity plan and -40% (-£8.4m) below YTD income plan

Performance was markedly affected in the early part of the year with recovery from July but still consistently behind plan on a monthly basis. Activity dropped by c25% in January compared to Q3. Multiple specialties are behind plan with the largest in financial terms being T&O, General Surgery and Gastroenterology. Urology, ENT, Cardiology, Respiratory and Ophthalmology are operating at no more than 50% of pre Covid-19 plan levels.

Outpatients Cons Led F2F & non F2F -23% (-63.4k attendances) below YTD plan for consultant led activity and -44% (£13.5m) behind YTD income plan

Outpatient activity has been below plan all year in particular in Q1, due to switching activity to non face to face consultations (NF2F). This has allowed the trust to reach closer to prior year activity levels in the past few months, but not across all specialties. Both T&O and Cardiology are significantly behind pre-Covid-19 plan levels. The price of NF2F activity is based on pre-Covid-19 tariffs and undervalues where full consultations are given. There are also some counting changes within Cardiology which may account for a significant proportion of the activity drop.

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

The Trust, as part of the STP, has submitted its forecast activity trajectory per the national collection requirements. This will provide indicative recovery levels for the remainder of the year.

The target set by NHSI is to achieve 90% of elective activity by October and 100% of Outpatient attendances by September, compared to prior year levels, and sustain performance at these levels.

The Trust has estimated the volume of activity it can deliver over the remainder of the year, but these volumes are dependent on additional funding being available to support.

Risks to delivery and mitigations

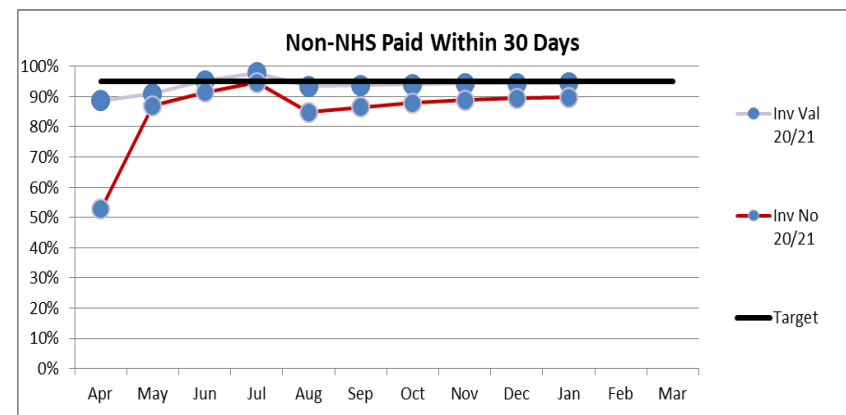
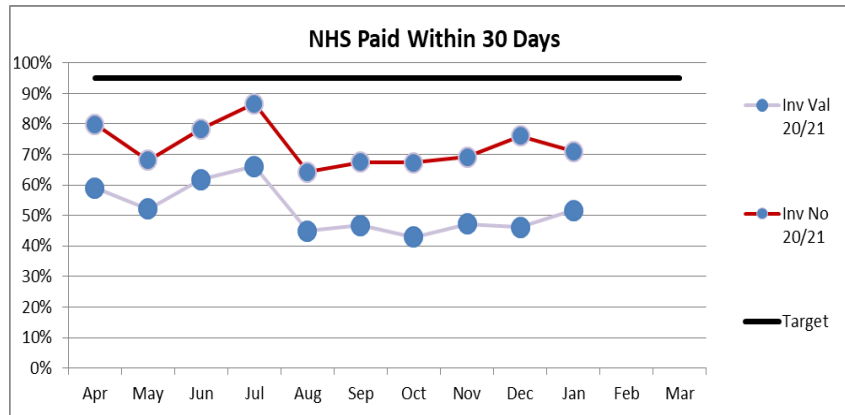
The Elective Incentive Scheme (EIS) is not final but more guidance was issued in late December. The current view is: (i) There is likely to be zero charge for September/October due to a 10% tolerance in those months. (ii) Months from November onward are likely to attract a lower EIS penalty of under £70k at pre-December activity levels. (iii) The scheme may be suspended if Covid-19 overwhelms capacity and this seems likely for at least December and January

Statement of Financial Position

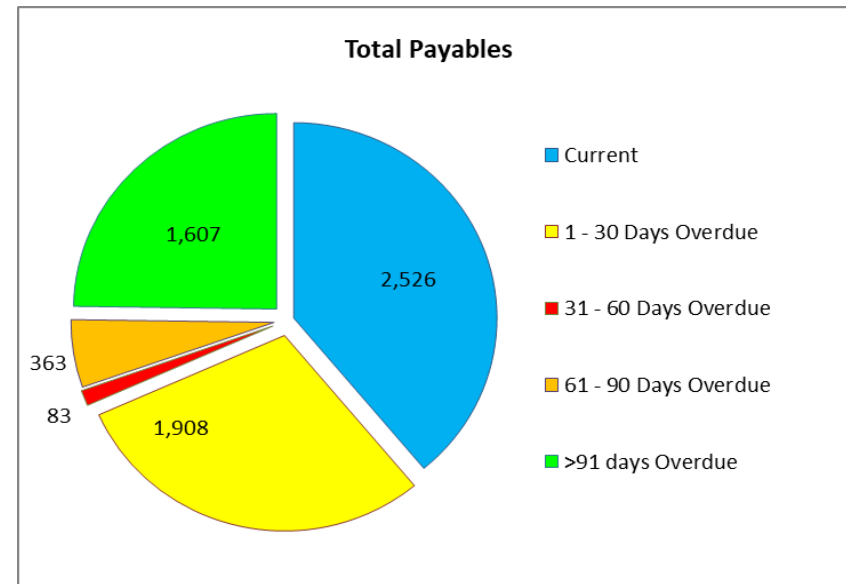
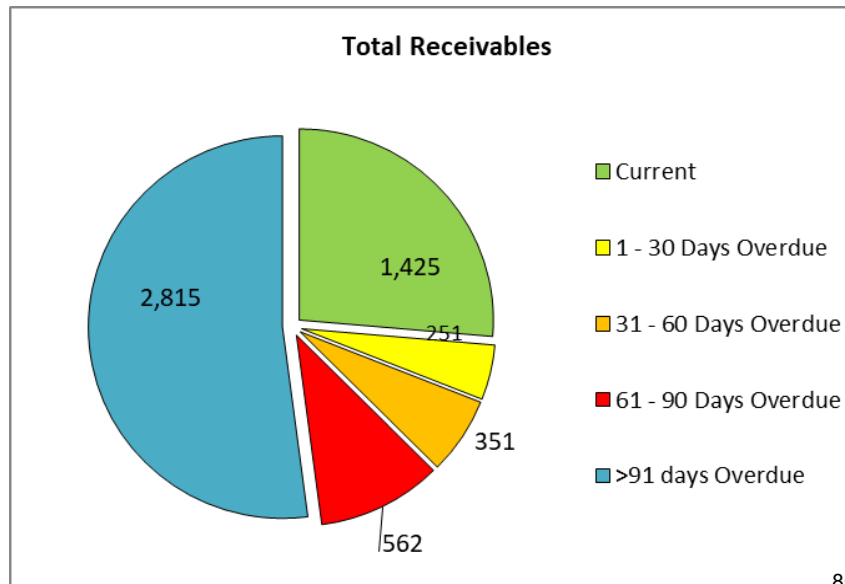
	2020-2021 Plan £'000	Previous Month Dec-20 (£'000)	Current Month Jan-21 (£'000)	Movement (£'000) From Prior Mth	As at year- end Mar-20 (£'000)
Non-Current Assets					
Intangible assets	1,881	3,447	3,447		3,447
Property, plant and equipment	207,101	207,783	210,420	2,638	206,058
Investments in associates & joint ventures		10	10	-	10
Receivables - non-current		612	612	-	612
Total Non-Current Assets	208,982	211,851	214,489	2,638	210,127
Current Assets					
Inventories	5,511	5,593	5,436	(156)	5,554
Receivables: invoiced	9,624	6,719	5,405	(1,314)	8,947
Receivables: not invoiced	26,641	27,766	36,598	8,831	23,043
Cash and cash equivalents.	11,971	36,954	34,305	(2,649)	9,140
Total Current Assets	53,747	77,032	81,743	4,711	46,684
Total Assets	262,729	288,883	296,233	7,349	256,811
Current Liabilities					
Other liabilities: deferred income	2,602	35,929	34,326	(1,603)	2,710
Trade and other payables: invoiced	5,931	7,115	6,488	(628)	12,165
Trade and other payables: not invoiced	9,933	28,017	31,470	3,453	21,082
Provisions - current	150	147	71	(76)	155
Trade and other payables: capital	2,594	8,165	10,920	2,755	5,058
Borrowings: PFI, loans & finance leases	14,379	1,798	1,235	(563)	69,944
Total Current Liabilities	35,589	81,170	84,509	3,338	111,114
Non current Liabilities					
Other liabilities: deferred income	1,123	790	790	-	904
Provisions - non-current	1,018	1,389	1,389	-	1,431
Borrowings: loans & finance leases	56,756	1,392	1,392	-	5,679
PFI obligations	86,538	95,448	95,448	-	95,447
Total Non-Current Liabilities	145,434	99,019	99,019		103,461
Total Assets Employed	81,706	108,694	112,704	4,012	42,236
		OK			OK
Taxpayer's and Others Equity					
Public dividend capital	76,710	102,318	106,837	4,520	34,556
Income and expenditure reserve	(31,941)	(32,321)	(32,829)	(508)	(31,017)
Revaluation reserve	36,937	38,697	38,697	-	38,697
Total Assets Employed	81,706	⁸⁴ 108,694	112,704	4,012	42,236

Working Capital

Payments to Suppliers



Outstanding Receivable and Payable Balances



Statement of Financial Position

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

Non-Current Assets

- The £612k receivable relates to a clinician tax reimbursement provision recognised at year-end.
- The in month movement in property, plant & equipment relates to depreciation of £823k offset by expenditure of £3,461k.

Total Current Assets are higher than the previous month by £472k.

- Stock levels have increased by £156k due to drug purchases in month.
- Current receivables are £7,517k higher than last month. Receivables not invoiced main movement relates to the increase in PFI prepayments.
- Cash is £2,649k lower than last month
- **Total Current Liabilities** have increased by £3,338k from last month.
- The deferred income decrease of £1,603k relates to a monthly decrease in the quarterly Health Education England receipt accrual
- Invoiced trade payables have decreased by £628k.
- Non-invoiced payables have increased by £3,453k due to movements in accruals
- Capital payables have increased by £2,755k compared to last month due to payment of prior year creditors offset by in-month accruals for equipment.
- Borrowings decreased due to the monthly £546k PFI repayment, £17k finance lease payment.

Risks to delivery and mitigations

Creditors - We have a directive to pay creditors within 30 days and Budget holders are actively chased by system emails and the AP team to minimise delay in coding and approval. Overall our BPPC rate is now 89.2%. Up from 88.9% last month.

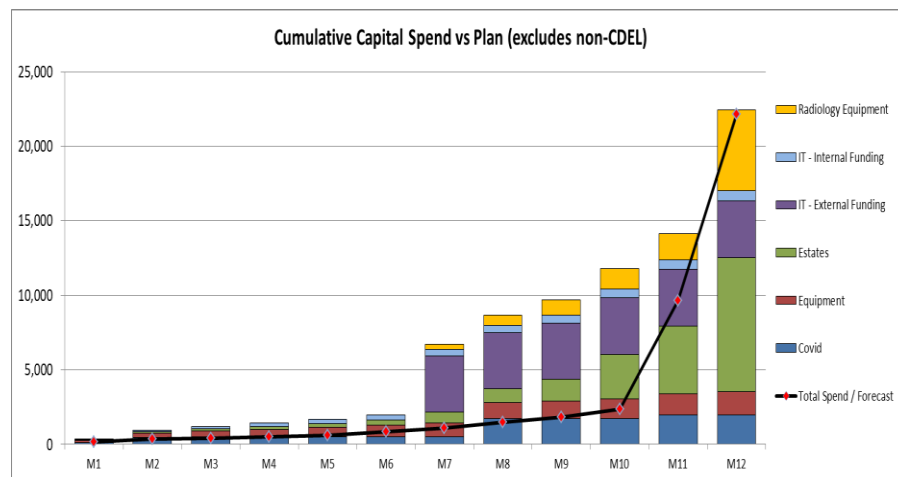
Cash – The substantial quarterly PFI payments put pressure on the cash balance, this is currently being mitigated by receiving all NHS payments in advance.

Debtors – Debtors have increased due to an increase in PFI Prepayments and adjustments in income accruals.

Rolling 12 Month Cashflow, Capital Programme

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	20/21 Total	Rolling 12 Mths Feb 21 to Jan 22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	37,045	34,396	38,992	13,590	3,708	6,811	8,025	6,709	9,872	9,486	2,709	3,867	5,081	9,140	34,396
Income															
Clinical Income	33,712	33,003	515	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	376,893	308,690
Other Income	450	2,580	250	4,730	3,962	2,012	4,730	3,962	2,012	2,012	2,012	2,012	2,012	28,853	32,286
Revenue Financing Loan / PDC			4,586				6,638						6,592	71,718	17,816
Capital Financing Loan / PDC	4,519	11,141	11,920	4,591	4,591	4,591	4,591	4,591	4,591	8,487	4,591	4,591	4,591	28,211	72,867
Total Income	38,681	46,724	17,271	36,838	36,070	34,120	43,476	36,070	34,120	38,016	34,120	34,120	40,712	505,675	431,659
Expenditure															
Pay	19,017	20,116	20,143	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	233,499	241,639
Revenue Creditors	9,992	11,672	9,846	10,230	8,307	8,302	8,302	8,302	8,302	8,302	8,302	8,302	8,302	123,727	106,466
Capital Creditors	666	10,340	9,462	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	26,227	64,474
PFI	11,654			11,886			11,886			11,886			11,886	46,616	47,544
PDC Interest			3,222						1,600					3,914	4,822
Financing					55						55			67,242	110
Total Expenditure	41,329	42,128	42,673	46,721	32,967	32,907	44,793	32,907	34,507	44,793	32,962	32,907	44,793	501,225	465,055
Closing Balance	34,396	38,992	13,590	3,708	6,811	8,025	6,709	9,872	9,486	2,709	3,867	5,081	1,000	13,590	1,000

Capital Programme



	Jan-21			YTD			FOT		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
PFI capital	-	-	-	-	-	-	3,544	3,544	-
Medical Equipment General	125	44	(81)	1,300	1,173	(127)	1,550	1,712	162
Radiology Equipment	353	793	440	1,392	2,123	731	5,420	5,420	-
Building / Estates General	50	(186)	(236)	500	130	(370)	600	639	39
Aseptic Suite	-	-	-	-	198	198	198	198	-
IM&T General	58	(599)	(657)	580	-	(580)	700	499	(201)
IT Infrastructure	-	679	679	3,800	941	(2,859)	3,800	3,800	-
Way Forward	214	(665)	(879)	5,308	22	(5,286)	6,032	3,217	(2,815)
Way Forward (CDEL)	-	1,687	1,687	-	1,687	1,687	1,687	1,687	-
Covid	-	16	16	502	518	16	721	721	-
Oxygen scheme	-	2	2	-	93	93	492	492	-
UTC Clover	1,589	522	(1,067)	2,069	3,588	1,519	4,915	4,915	-
Commonhead design	-	36	36	-	70	70	115	115	-
Critical Infrastructure	-	-	-	-	-	-	195	195	-
Critical Infrastructure 2	-	-	-	-	-	-	200	200	-
Critical Care Resilience	1,234	699	(535)	1,234	892	(342)	1,234	1,234	-
GWH Clinic room	300	-	(300)	300	17	(283)	300	300	-
CT Enabling Infrastructure	200	(87)	(287)	200	188	(12)	200	200	-
Order Comms	-	-	-	-	-	-	99	99	-
Other	-	-	-	11	11	-	11	11	-
Total	4,123	2,941	(1,182)	17,196	11,651	(5,545)	32,013	29,198	(2,815)

Cash Position & Capital Programme

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

The Cash Position in January continues to be good with back payments settled in month. The receipt of block payments 2 months in advance supports the balance of payments, particularly with Trust's PFI arrangements. This is expected to unwind in M12 before the start of the new financial year, requiring additional funding.

The total capital programme 20/21 is £37,874k, excluding prior year brought forward accrual this is £32,013k. This is up £318k vs. prior month with Order Comms. and Priority Covid-19 Projects.

Capital Plan 2021	10,270
IT Infrastructure Bid 1920	3,800
Brought Forward 1920	5,861
Additional Funding 2021	8,367
Way Forward Programme 2021	6,032
PFI capital adjustment 2021	3,544
	37,874

The Trust has been granted emergency funding to support the 20/21 capital plan and the majority of PFI capital, in total £12,794k. £4,519k of this was drawn down in January.

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

The Capital Programme is managed via the capital groups:

- Equipment Group
- Digital & IT Steering Group
- Estates and Facilities Management Group

These Groups report into the Trust Investment Committee. Schemes greater than £10k have to be agreed at these groups and over £50k at Investment Committee.

91% of the £37,874k has been committed, with spend expected by end March 2021. The balance is:

- £2,815k – Way Forward c/f 21/22
- £598k - relates to prior year

The Way Forward Programme is expecting to purchase Expansion Land in March 2021. The programme is expected to use the Trust's CDEL contribution of £1,687k and carry forward the £2,815k to 21/22.

Risks to delivery and mitigations

Total expenditure including accruals at Month 10 is £11,651k.

In year expenditure excluding accruals and brought forward from 19/20, is £2,386k resulting in a substantial risk to in year delivery. The accrual, £9,265k, includes items ordered not yet delivered. There is a big push in February to get items delivered, invoiced and paid before the end of the Financial Year.

YTD Spend by category:

Equipment £4,415k Estates £6,269k, IT £967k.

The Trust's CDEL funded is forecasted to be on plan. The previously identified risk of IT infrastructure has been managed by bringing forward schemes planned for 21/22.

Capital Risks:

1. Radiology Equipment 2xCT machines risks have been highlighted over delays in supply due to high demand. These are currently at tender stage and further conversations with radiology are underway to mitigate this (£2.5m).
2. Estates projects have been delayed with the recent increase in Covid-19 patients and Vaccination Programme making access to areas difficult. Works are expected to start before the end of the year and finish Q1 21/22.

Cost Improvement Plans – Better Care at Lower Cost

Division	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	FY Plan £'000	FY Fcast £'000	FY Variance £'000
Integrated and Community Care	125	14	(111)	1,206	281	(925)	1,480	305	(1,175)
Surgery, Womens & Childrens	195	31	(164)	1,883	280	(1,603)	2,311	343	(1,968)
Unscheduled Care	217	61	(156)	2,101	637	(1,464)	2,578	763	(1,816)
Corporate	135	14	(121)	1,302	192	(1,110)	1,598	228	(1,370)
Trust Wide	87	0	(87)	841	0	(841)	1,032	0	(1,032)
Total	759	119	(640)	7,335	1,391	(5,944)	9,000	1,639	(7,361)
Percentage	16%			19%			18%		

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

The Cost Improvement Programme (CIP) delivery plan for January is £759k (£7,335k YTD).

CIPs delivered in month were £119k (£1,391k YTD) which is £640k below plan (£5,944k YTD). In month delivery is lower than prior month, due to Procurement savings now not being realised until the following year, predominantly in Surgery, Womens & Childrens.

The 20/21 forecast delivery is £1,639k (18% of plan) which is £124k lower than last month driven by a review of Procurement schemes.

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

Planning for 2021/22 is progressing and a number of schemes that were not delivered due to Covid-19 will form part of next years plan.

Risks to delivery and mitigations

The delivery of CIP schemes in 20/21 is lower than plan due to the management focus being on responding to the Covid-19 pressures and restarting. There is a risk that the forecast delivery won't be met if pressures continue for the remainder of the financial year.

Board Committee Assurance Report

Charitable Funds Committee		
Accountable Non-Executive Director	Presented by	Meeting Date
Jemima Milton	Jemima Milton	10 February 2021

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”
Partially assured	Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives

Key Issue	Assurance Level	Committee Update	Next Action(s)	Timescale
Raising Funds while under restrictions.	AMBER	Income is similar to last year, but this is due to monies from “NHS Charities Together” (Major Tom). COVID is impacting the ability to hold physical events, and therefore promote Brighter Futures.	Continue to build corporate relationships. Plan events for the future.	Now
Brighter Futures staff - time helping with Health & Wellbeing	GREEN	Quite rightly staff have been helping across the organisation with Health & Wellbeing projects, but now need to focus on their roles within Brighter Futures.	Health & Wellbeing projects are now becoming self-sufficient.	May 2021
Salary split of key personnel between Brighter futures and the volunteer section	RED	Brighter Futures is paying the whole salary of the Director of Fundraising & Voluntary Services. This would be of a concern to the Charities Commission, as it is to the Committee. The restructure was agreed by both PPC and Charitable Funds in November 2020, but not the division of costs.	To agree a fair split between the two departments. To come back to PPC and Charitable Funds Committees at their next meetings.	May 2021
Agreement from the Executives on large projects that the Fundraising team should promote	GREEN	We have asked for the Executive team as a whole to agree the projects that they would like promoted by Brighter Futures, and to rate them.	Waiting for the Executive Team to agree which projects should be promoted.	May 2021

Other Comments	
Topic	Comment

Issues Referred to another Committee	
Topic	Committee
Salary split of Director of Fundraising and Voluntary Services	PPPC

Board Committee Assurance Report

Mental Health Governance Committee				
Accountable Non-Executive Director		Presented by		Meeting Date
Lizzie Abderrahim		Lizzie Abderrahim		22 January 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?			Yes	BAF Numbers
				1.4a ¹

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

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

Key Issue	Assurance Level	Committee Update	Next Action (s)	Timescale
Mental Health Governance workplan 2020/21 Q3	AMBER	The committee was satisfied that the Q3 report demonstrated that the workplan was progressing as expected and that where actions were incomplete or outstanding there were plans in place to ensure these were being addressed.		
Mental Health Dashboard including Risk Governance [12+ risks]	AMBER	The Q3 report provided sufficient assurance to the committee regarding the responsiveness of mental health services to adults of working age and older adults and demonstrated that risks were being managed appropriately and, with particular reference to the ligature risk, that plans were in place to address it.		
Children's Services Mental Health	RED	The Committee agreed that the reduction in the bed base in response to COVID pressures exacerbated pre-existing issues associated with the sourcing of appropriate RMN support, the significant challenge presented by the need to	WJ / VM / LG to review the risks and identify the	9 April 2021

¹ Safeguarding / Mental Health / DOLS

Key Issue	Assurance Level	Committee Update	Next Action (s)	Timescale
		care for children and young people experiencing mental ill health in the environment of a general children's ward and the delays in obtaining suitable specialist CAMHS beds that resulted from a national shortage.	potential for mitigation	
CAMHS	RED	The Committee agreed that the chronic lack of specialist CAMHS beds continued to present a significant risk for the Trust and that whilst this matter was being pursued with the Commissioners it remained the case that there was very limited provision. The rating was therefore agreed as RED until such time as the adequacy of specialist provision was addressed	CAMHS to provide regular updates on progress	Ongoing
Mental Health Liaison	AMBER	The Committee agreed that the issues associated with the overnight Intensive Team Service meant that there were gaps in assurance but that they were satisfied that there were plans to take appropriate action to address their concern.		
Emergency Department	AMBER	The Committee agreed that the issues associated with the overnight Intensive Team Service, the need for breakaway training and the need for a wider discharge pathway meant that there were gaps in assurance but that they were satisfied that there were plans to take appropriate action to address these concerns.		
Mental Capacity process and practice workstream	GREEN	The committee noted the significant amount of work that had been undertaken and that this was now at the stage of being embedded. The committee was encouraged by the extent of what had been achieved and it was agreed that there were no concerns.		
Learning Disability and Mental Health Covid Learning LeDeR report	GREEN	The committee were satisfied that a benchmarking exercise had identified no significant gaps at GWH and that the main learning points had been addressed.		

Armed Services Community Covenant Agreement

Meeting	Trust Board	Date	4 th March 2021
Summary of Report			
There are 3 recognised organisations who support current, veteran and reservist Armed Forces communities:			
<ul style="list-style-type: none">• Step into Health• Swindon Armed Services Community Covenant Agreement (Appendix 1)• Veteran Covenant Health Care Alliance (Appendix 2)			
The Trust is already committed to Step into Health and has previously signed up to Swindon Armed Services Community Covenant Agreement.			
Step into Health			
Step into Health is made up of NHS organisations which have pledged their support to the programme. Through Step into Health, members of the Armed Forces community can connect to NHS organisations to set up training opportunities, clinical and general work placements, organise insight days and receive application support. The programme provides a dedicated pathway into a career in the NHS and can be accessed at: https://www.militarystepintohealth.nhs.uk .			
Swindon Armed Services Covenant Agreement			
A joint commitment with Swindon Council and the Trust that -			
<ul style="list-style-type: none">• <i>no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizen;</i>• <i>in some circumstances special treatment may be appropriate especially for the injured or bereaved.</i>			
The commitments are focused on the provision of suitable housing, employment and terms and conditions for Armed Forces and reservists (Appendix 1)			
Veteran Covenant Health Care Alliance			
To become a member of this alliance, the Trust has to demonstrate their commitment to supporting the Armed Forces Covenant. Whilst Step into Health and Swindon Council Covenant Agreement focuses on employment, the Veteran Covenant Health Care Alliance extends to veteran patient care and treatment. There are 58 Trusts who have been accredited and local members include Oxford University Hospitals NHS Trust and Gloucestershire Hospitals NHS Foundation Trust.			
The Trust refreshed its Step into Health in May 2020 and has received recent communication from Swindon Council requesting that we refresh and reaffirm our collective local commitment to the Swindon Armed Services Covenant Agreement.			
This paper recommends a refreshed agreement with Armed Services Community Covenant Agreement and further exploration of becoming a member of the Veteran Covenant Health Care Alliance.			
For Information	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>
		Discussion & input	<input checked="" type="checkbox"/>
		Decision / approval	<input type="checkbox"/>
Executive Lead	Jude Gray		
Author	Claire Warner		
Author contact details	Claire.warner5@nhs.net		
Risk Implications - Link to Assurance Framework or Trust Risk Register			
Risk(s) Ref	Risk(s) Description		Risk(s) Score

Legal / Regulatory / Reputation Implications									
Link to relevant CQC Domain									
Safe	<input type="checkbox"/>	Effective	<input type="checkbox"/>	Caring	<input type="checkbox"/>	Responsive	<input type="checkbox"/>	Well Led	<input checked="" type="checkbox"/>
Link to relevant Trust Commitment	People Strategy Patient Experience								
Consultations / other committee views									
Recommendations / Decision Required									
<p>The Trust Board are asked to review and support:</p> <ol style="list-style-type: none"> 1. Support the recommendation to sign the Armed Forces Community Covenant agreement 2. Board to endorse that in the action outlined in section 3 									

1. Information

Further to recent communication from Council leads earlier this year, the Trust has been asked to sign a refreshed Armed Services Community Covenant and to reaffirm our collective local commitment.

The new Covenant Appendix 1 outlines the commitments made by Swindon Council with the additional and broader statement in paragraph 2.1 that demonstrates the wider commitment for the Trust as outlined below.

2. The Trust will:

- **promote the fact that we are an armed forces-friendly organisation:**
 - *promoting our work, activities and events through our own digital & social media channels as well as working with the press*
 - *publishing our Covenant pledge on a dedicated Covenant section/page on our web site*
- **aim to support the employment of veterans young and old:**
 - *welcoming applications from, and guaranteeing interviews with, Veterans who meet the criteria outlined in the job specification*
 - *recognising military skills and qualifications in our recruitment and selection process as equivalent experience*
- **strive to support the employment of Service spouses and partners:**
 - *welcoming applications from spouses/partners who meet the criteria in the job specification*
 - *endeavouring to offer a degree of flexibility in granting leave for Service spouses and partners before, during and after a partner's deployment*
- **seek to support our employees who choose to be members of the Reserve forces, including accommodating their training and deployment where possible:**

- *up to 2 weeks per year of special paid leave is available to attend annual training camps (this currently offers 1 week paid)*
- *fully supporting and accommodating mobilised deployment of Reservist employees if required*
- **offer support to our local cadet units, either in our local community or in local schools, where possible:**
 - *up to 2 weeks per year of special paid leave may be available to attend annual training camps and courses*
 - *accommodation of cadet training commitments where possible*
 - *considering sponsorship bids to support worthwhile cadet projects*
- **aim to actively participate in Armed Forces Day (AFD);**
 - *by becoming an AFD partner and:*
 - *in advance; promoting through the web, social media, membership and other networks*
 - *during; encouraging employees to take part in Reserve Forces Day, Uniform to Work Day and any Flag Raising Ceremonies; assisting with case studies and stories and working with the Wessex RFCA to get them to press*
 - *post; publishing stories on the web, social media, through our own membership and other networks as well as working with the RFCA Communications lead & the press*

The Swindon Armed Services Community Covenant wording is based on a standard used throughout local authority areas in the South West.

3. Recommendation

1. The Trust refreshes the Swindon Armed Forces Covenant Agreement and develops a Trust Wide Policy for Armed Forces and Reservists to support the implementation of the commitment. This action will enable the Trust to meet the criteria outlined in the Armed Forces Health Care Alliance by demonstrating its support for the armed forces community as an employer. Lead, Vicky Treadwell (Head of Resourcing) and Claire Warner (Associate Director of HR) supported by current reservist Julian Auckland-Lewis (Way Forward Director) by **May 2021**
2. Set up a Trust register of Veterans and current reservists – (Lead, Leianne Waller, (Workforce Intelligence Lead) by **April 2021**.
3. Clinical Lead, Rayna McDonald (Deputy Chief Nurse) to progress the Veteran Healthcare Alliance and patient experience requirement/commitment (appendix 2) and collate evidence to become accredited. Review and recommendation to be completed by **April 2021**.

4. Conclusion

Through renewed delivery of these recommendations, the Trust will strengthen and embed its objective to be a 'forces friendly employer.' This will enable the Trust to benefit from the wide range of unique skills, experiences and the diversity of talent that armed forces community members can bring to our workforce, as well as supporting our local and regional military communities.



Swindon Borough

Council

We, the undersigned,
commit to honour the

Armed Forces

Covenant

and support the Armed Forces Community.

We recognise the value Serving Personnel (Regular & Reserve), Cadets,
Veterans, and military families contribute to our business/school/charity
and our country.

Signed on behalf of:
Ministry of Defence

Signed on behalf of:
Swindon Borough Council

Signed: _____

Signed: _____

Name: _____

Name: _____

Position: _____

Position: _____

Date: _____

Date: _____


Signed on behalf of:
Ministry of Defence
Voluntary Action Swindon


Signed on behalf of:
Great Western Hospital

Signed: _____

Signed: _____

Name: Pam Webb

Name: Kevin McNamara

Position: Chief Executive

Position: Chief Executive

Date: _____

Date: _____

Commented [A1]: As this is an agreement that also includes health x2, the business community and the charitable sector we need signing boxes for each. See detail in email

Signed on behalf of:
**Bath & North East Somerset,
Swindon & Wiltshire
Clinical Commissioning Group**

Signed on behalf of:
**Swindon and Wiltshire Initiative,
Business West**

Signed:

Signed:

Name: Gill May

Name: Ian Larrad

Position: Director of Nursing

Position: Director

Date:

Date:

a

The Armed Forces Covenant

An Enduring Covenant Between

The People of the United Kingdom
Her Majesty's Government

— and —

All those who serve or have served in the Armed Forces of the Crown

And their Families

The first duty of Government is the defence of the realm. Our Armed Forces fulfil that responsibility on behalf of the Government, sacrificing some civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our Armed Forces. In return, the whole nation has a moral obligation to the members of the Naval Service, the Army and the Royal Air Force, together with their families. They deserve our respect and support, and fair treatment.

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

Section 1: Principles of The Armed Forces Covenant

1.1 We **Swindon Borough Council** will endeavour in our business dealings to uphold the key principles of the Armed Forces Covenant, which are:

- *no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizen*
- *in some circumstances special treatment may be appropriate especially for the injured or bereaved.*

Section 2: Demonstrating our Commitment

2.1 **Swindon Borough Council** recognise and remember the sacrifices made by members of the armed forces community. The Armed Forces Covenant is a promise made by Swindon Borough Council, the NHS and local businesses and charities, to support in-service personnel, ex-service personnel and their families to receive a fair and consistent service within the borough. We will seek to uphold the principles of the Armed Forces Covenant, by:

- **Supporting servicemen and ex-servicemen to secure suitable accommodation**
 - *The Council will offer suitable advice to Armed Forces applicants who present in Swindon so they are able to access affordable housing in the Borough*
 - *Accepting the UK Armed Forces Veteran ID Cards as proof of a Veteran.*
 - *The Council will offer preference for those requiring social housing who are currently in the Armed Forces or leaving the forces.*
 - *The Council will allocate a proportion of stock through local lettings plans for Armed Forces applicants.*
- **Assisting with requests for adapted homes for wounded soldiers.**
 - *Those living in a Swindon's Social Housing can be direct matched to a suitable property where there is a medical need.*
 - *The Council will offer relevant advice and support to injured veterans to help them access home improvements.*
- **promoting the fact that we are an armed forces-friendly organisation;**
 - *promoting our work, activities and events through our own digital & social media channels as well as working with the press*
 - *publishing our Covenant pledge on a dedicated Covenant section/page on our web site*
- **seeking to support the employment of veterans young and old:**
 - *welcoming applications from, and guaranteeing interviews with, Veterans who meet the criteria in the job specification*
 - *recognising military skills and qualifications in our recruitment and selection process*
- **striving to support the employment of Service spouses and partners;**
 - *welcoming applications from spouses/partners who meet the criteria in the job specification*
 - *endeavouring to offer a degree of flexibility in granting leave for Service spouses and partners before, during and after a partner's deployment*

- **seeking to support our employees who choose to be members of the Reserve forces, including accommodating their training and deployment where possible;**
 - *up to 2 weeks per year of special paid leave is available to attend annual training camps*
 - *fully supporting and accommodating mobilised deployment of Reservist employees if required*
- **offering support to our local cadet units, either in our local community or in local schools, where possible;**
 - *up to 2 weeks per year of special paid leave may be available to attend annual training camps and courses*
 - *accommodation of Cadet training commitments where possible*
 - *considering sponsorship bids to support worthwhile Cadet projects*
- **aiming to actively participate in Armed Forces Day;**
 - *by becoming an AFD partner and:*
 - *in advance; promoting through the web, social media, membership and other networks*
 - *during; encouraging employees to take part in Reserve Forces Day, Uniform to Work Day and any Flag Raising Ceremonies; assisting with case studies and stories and working with the Wessex RFCA to get them to press*
 - *post; publishing stories on the web, social media, through our own membership and other networks as well as working with the RFCA Communications lead & the press*
- **offering a discount to members of the Armed Forces Community;**
 - *registering with Defence Discount Service*
 - *offering bespoke continuing and/or limited time offers to Defence personnel*
- **additional commitments:**
 - *encourage and support employee fundraising for Service Charities*
 - *provide support and assistance to Service Families requiring school placements for their children*

2.2 We will publicise these commitments through our website and on local media, setting out how we will seek to honour them and inviting feedback from the Service community and our customers on how we are doing.

Veteran Aware Manifesto

Document purpose

This manifesto document is aimed at healthcare providers and sets out the objectives of the Veterans Covenant Healthcare Alliance, the standards expected from Veteran Aware health and care providers and commissioners and the support that can be provided to them.



The Veterans Covenant Healthcare Alliance

The Veterans Covenant Healthcare Alliance (VC HA) is a group of healthcare providers and commissioners which have volunteered to develop, share and drive the implementation of best practice that will improve UK Armed Forces veterans care, in line with the commitments set out in the Armed Forces Covenant.

The VC HA links members to the Armed Forces charities, which can provide rehabilitation services and resources for veterans. When fully utilised, these services will enhance the recovery pathway for veterans in our care.

The Veterans Covenant Healthcare Alliance steering group coordinates support to members who are implementing the standards set out in this manifesto and champions accredited veteran aware healthcare providers and commissioners.

Objectives

The Veterans Covenant Healthcare Alliance has been established to provide a mechanism for a group of volunteer healthcare providers and commissioners to:

- Identify and showcase the best standards of care for UK Armed Forces veterans
- Drive implementation of best practice in the treatment and care of veterans across the UK

The principles behind Veteran Aware care

All Alliance members will be committed to the twin underlying principles of the covenant. The Armed Forces Covenant covers the whole UK armed forces community, including those in the Armed Forces, whether regular or reserve, those who have served in the past, and their families.

- 1** The Armed Forces community should not face disadvantage compared to other citizens in the areas where they live in the provision of public and commercial services
- 2** Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved

The standards below aim to provide an interpretation of these principles specific to the NHS and set out how healthcare providers and commissioners can embody the commitments of the Armed Forces Covenant. These standards are not exhaustive, as many Alliance members will offer additional and possibly unique services for veterans that reflect locally assessed needs and priorities. Hospitals will continue to pursue their own development, in line with their commitment to the Armed Forces Covenant, and share their success with other hospitals in the Alliance.

The Veteran Aware accreditation mark

Hospitals, trusts and other healthcare providers and commissioners that are exemplars of the best care for the armed forces community will be accredited as 'Veteran Aware' and can display the 'Veteran Aware' kitemark.



Who does this manifesto apply to?

The principles set out by the Armed Forces Covenant should be applied in all healthcare settings.

The Veteran Aware kitemark was first awarded to a pilot group of acute and specialist trusts, but we are now rolling this out to other types of healthcare providers and commissioners. As new types of provider join, we will add new sections to this manifesto, setting out how these providers and commissioners can demonstrate their commitment to the Armed Forces Covenant.

The following types of organisations are already covered by this manifesto:

- Acute trusts
- Specialist trusts
- Community trusts
- Health Boards or Hospital Boards in the Devolved Administrations
- Mental health trusts
- Ambulance trusts
- Hospices
- NHS Regions
- Integrated Care Systems (ICSs) / Local Sustainability and Transformation Partnerships (STPs)

Standards for further settings may be developed.

Some types of provider are covered by other related initiatives:

- GPs are currently covered by the Veteran Friendly GP scheme
- Some hospitals that have been designated as veterans trauma centres or provide complex services for veterans are in the Veterans Trauma Network

How the Alliance can support healthcare providers to become Veteran Aware

Providing a forum

An annual workshop is held for clinicians and managers to share examples and discuss challenges. Veterans champions in different providers can contact each other for information and advice.

Linking to other services

The VC HA can help members establish links to other services provided for the armed forces community, including those provided by the NHS, charities and the MoD (including Defence Medical Services).

Education and training

The VC HA can direct members to a variety of education and training resources or potential courses, for hospitals to provide training to relevant staff

Awareness

The VC HA can provide template leaflets, posters and other materials to be used in hospitals, explaining that the trust is veteran aware and what this means.

Accreditation and recognition

The GIRFT hubs can support hospitals through the accreditation process and hospitals that demonstrate the standards in this manifesto will be awarded and encouraged to display the 'Veteran Aware' kitemark.

Background

The VC HA has been established following the work of the Getting It Right First Time programme (now part of the NHS Improvement in partnership with Royal National Orthopaedic Hospital) and the Chavasse report.

Getting It Right First Time (GIRFT) is a national programme currently centred on England, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice. Professor Tim Briggs, Chair of the Veterans Covenant Healthcare Alliance, visited over 170 NHS trusts and spoke to over 1,700 surgeons and 400 senior managers and chief executives about orthopaedic care and outcomes, including for patients are serving or have served in the Armed Forces. The programme has now been extended to reduce unwarranted variations in more than 30 clinical and medical work streams. Although the GIRFT programme does not extend beyond England, the principles it outlines are equally applicable to devolved NHS services.

To read more about GIRFT, visit the programme website at www.gettingitrightfirsttime.co.uk

The Chavasse Report built on the GIRFT report, and was inspired by the selfless heroism of Captain Noel Chavasse VC at the Battle of the Somme and the Battle of Passchendaele. The centenary of these battles, at which Chavasse was awarded two Victoria Crosses, was marked in the summer of 2017. When the wounded from these historic battles had been treated and were no longer fit to serve, they were discharged into the care of their families and in many cases relied on charity. Within today's serving population, services are provided by both Defence Medical Services (DMS) and the NHS, and the care of our serving Armed Forces is world class. When discharged, or whilst a reservist not on active operations, the NHS now commissions and provides virtually all their healthcare needs.

The full Chavasse report is available to read at www.thechavassereport.com

Professor Tim Briggs, National Director for Clinical Quality and Efficiency, is Chair of the Veterans Covenant Healthcare Alliance steering group, which includes senior representatives from the Confederation of Service Charities, Department of Health, NHS England and Improvement, NHS Improvement and Ministry of Defence. General Lord Richard Dannatt, former head of the British Army, is patron of the Alliance.

What standards will Veteran Aware healthcare providers, commissioners and organisations showcase?

This section of the Manifesto sets out specific standards for different settings or types of healthcare provider, commissioner or organisation. The setting specific standards are all aligned with the overarching principles set out in this manifesto: that the armed forces community should face no disadvantage and that special consideration is appropriate in some cases.

These standards offer more detail on what demonstrating commitment to those principles will look like in these different settings. The nominated Veterans Champions from the relevant organisations have been involved in developing these standards, alongside the members of the VCHA steering group and other stakeholders.

Setting specific standards:

<i>Setting:</i>	<i>Page reference:</i>
Hospitals, acute, specialist and community trusts, devolved administration health boards	6
Mental health providers	8
Ambulance trusts.....	10
Integrated Care Systems or Sustainable Transformation Partnerships	11
The 7 National NHS England and NHS Improvement Regions.....	14

Hospitals, acute, specialist and community trusts, devolved administration health boards

Joining the Alliance and commitment to the Armed Forces Covenant

All Alliance members will be committed to the twin underlying principles of the covenant. Alliance members will have clearly designated Veterans' Champions to lead on the implementation of this manifesto by their hospital or trust. This will consist of both a clinical champion and a management champion, who will work together in what is referred to as a 'Champion Dyad.'

- ☒ Signed and delivered on the Armed Forces Covenant
- ☒ Nominated a Veterans/Armed Forces Champion Dyad (Clinical Champion and Management Champion)
- ☒ Attend the annual workshop on Veteran Aware healthcare

Supporting the armed forces community as an employer

Veteran Aware hospitals or trusts will also be signed up to initiatives that support the employment of veterans and reservists in the NHS workforce. Through these initiatives and their own HR policies, they will support the employment of reservists in and encourage recruitment of veterans and military spouses or partners.

- ☒ Involved in an employer initiative, such as:
 - Step Into Health (www.militarystepintohealth.nhs.uk) the first access pathway from the military into the numerous career opportunities available in the NHS; and/or
 - The Defence Employer Recognition Scheme (<https://www.gov.uk/government/publications/defence-employer-recognition-scheme/defence-employer-recognition-scheme>) which recognises employer organisations that pledge, demonstrate or advocate support to defence and the UK Armed Forces community, and align their values with the Armed Forces Covenant; and/or
 - Implementing a policy to encourage the recruitment of reservists, veterans and armed forces families such as 10 days paid annual leave for reservists to undertake their training

Best practice in treatment and care in hospital

- ☒ Displaying posters in waiting rooms and wards, encouraging people to make their veteran status known, providing the definition and explaining the purpose:
'We are a veteran aware hospital and we understand the Armed Forces Covenant; please let a member of staff know if you have ever served in the UK Armed Forces, so that we can better meet your needs'
- ☒ Identify patients who are veterans and (with consent) flag them on information systems to ensure appropriate care is provided
 - Asking people, using the wording above, if they are a veteran/have ever served in the UK armed forces through electronic arrival / registration kiosks, in hospitals where such systems are in place
 - Noting where a referral letter from a GP or elsewhere has identified a patient as a veteran
 - Systems and approaches differ by trust, but normally adding a field or flag on the Patient Administration System (PAS) is a useful way to store this information
- ☒ Ensuring relevant staff receive training on the armed forces covenant and treatment and care of veterans
- ☒ Providing further specific education and training to staff as needed
- ☒ Raising awareness within the trust and sharing key information about the armed forces community with staff
- ☒ Prominently displaying the Veteran Aware accreditation kitemark on relevant communication materials

Linking in with other services

There are a wide range of services provided to veterans, including both statutory services by the NHS and MOD as well as services provided by charities. Linking in with other services, signposting and referring appropriately will improve the care offered to the armed forces community.

Veteran Aware hospitals or trusts will look into the potential for an ‘embedded’ service provided by a charity on the trust site, as well as looking into what services are available or could be made available locally, and considering the benefit of funding these services.

The Veterans Covenant Healthcare Alliance provides a map to members showing the location of different NHS, MOD and charity services for the armed forces community. It is important that Alliance hospitals build up institutional knowledge of the services available, not just the individual knowledge of a particular clinician or manager.

- ☒ Veteran Aware hospitals or trusts will have established links, where appropriate, to MOD or NHS Rehabilitation services, to ensure shared learning and the smooth transfer of patients.
 - Charity supported Personnel Recovery Centres
 - MoD’s Personnel Recovery Units
 - DMS Regional Rehabilitation Units
 - NHS Disablement Support Centres (especially those that have been enhanced from the Murrison report)
 - Primary Casualty Receiving Facilities
 - NHS hospitals employing Defence Medical Services (DMS) Personnel from the Defence Medical Group (DMG)
 - The Veterans Trauma Network
 - Specialist services provided in a smaller number of centres or trusts
- ☒ Veteran Aware hospitals or trusts will signpost or refer patients, where appropriate, to NHS Mental health services for veterans
 - NHS Veterans’ Mental Health Transition, Intervention and Liaison services (TILs)
 - NHS Veterans’ Mental Health Complex Treatment Service (CTS)
- ☒ Veteran Aware hospitals or trusts will encourage staff and patients to use the Veterans Gateway service, to identify beneficial services for patients

Resources available:

- Veteran Aware hospitals step by step guide to accreditation
- Patient leaflet template
- Poster template
- Staff leaflet template
- Examples of Patient Administration Systems
- Example Patient Access Policy
- Example Armed Forces Community Needs Assessment
- Template staff awareness slides
- Links to online training options
- ‘Buddying’ between hospitals

Mental health providers

Joining the Alliance and commitment to the Armed Forces Covenant

All Alliance members will be committed to the twin underlying principles of the covenant. Alliance members will have clearly designated Veterans' Champions to lead on the implementation of this manifesto by their trust. This will consist of both a clinical champion and a management champion, who will work together in what is referred to as a 'Champion Dyad.'

- ☒ Signed and delivered on the Armed Forces Covenant
- ☒ Nominated a Veterans / Armed Forces Champion Dyad (Clinical Champion and Management Champion)
- ☒ Attend the annual workshop on Veteran Aware healthcare

Supporting the armed forces community as an employer

Veteran Aware trusts will also be signed up to initiatives that support the employment of veterans and reservists in the NHS workforce. Through these initiatives and their own HR policies, they will support the employment of reservists in and encourage recruitment of veterans and military spouses or partners.

- ☒ Involved in an employer initiative, such as:
 - Step Into Health (www.militarystepintohealth.nhs.uk) the first access pathway from the military into the numerous career opportunities available in the NHS; and/or
 - The Defence Employer Recognition Scheme (<https://www.gov.uk/government/publications/defence-employer-recognition-scheme/defence-employer-recognition-scheme>) which recognises employer organisations that pledge, demonstrate or advocate support to defence and the UK Armed Forces community, and align their values with the Armed Forces Covenant; and/or

Best practice in treatment and care

- ☒ Ensuring relevant staff in the trust are trained and educated in the needs of veterans
- ☒ Raising awareness within the trust and sharing key information about the armed forces community with staff
- ☒ Displaying posters in public areas, encouraging people to make their veteran status known, providing the definition and explaining the purpose:
'We are a veteran aware trust and we understand the Armed Forces Covenant; please let a member of staff know if you have ever served in the UK Armed Forces, so that we can better meet your needs'
- ☒ Completing the veteran field on MHSDS and IAPT DS and stating your rate of completion
- ☒ Prominently displaying the Veteran Aware accreditation kitemark on relevant communication materials
- ☒ Consider the presence of the armed forces community in the local area. Their needs should be explicit in existing needs assessments, for example an STP or ICS population needs assessment, or a local authority 'Joint Strategic Needs Assessment'

Linking in with other services

There are a wide range of services provided to veterans, including both statutory services by the NHS and MOD as well as services provided by the Contract Group of mental health providers. Linking in with other services, signposting and referring appropriately will improve the care offered to the armed forces community.

The Veterans Covenant Healthcare Alliance provides a map to members showing the location of different NHS, MOD and charity services for the armed forces community. It is important that trusts build up institutional knowledge of the services available, not just the individual knowledge of a particular clinician or manager.

- ☑ Alliance members will signpost or refer patients, where appropriate, to NHS mental health services for veterans
 - NHS Veterans' Mental Health Transition, Intervention and Liaison services (TILs)
 - NHS Veterans' Mental Health Complex Treatment Service (CTS)
- ☑ Veteran Aware Trusts will have established links, where appropriate, to services provided by other mental health providers, including:
 - Combat Stress
 - Walking with the Wounded
 - Help for Heroes
 - Big White Wall
 - PTSD Resolution
- ☑ Alliance members will encourage staff and patients to use the Veterans Gateway service, to identify beneficial services for patients

Resources available:

- Poster template
- Example mental health needs assessment
- Mental health awareness for armed forces training and other training options
- 'Buddying' between trusts

Ambulance trusts

Joining the Alliance and commitment to the Armed Forces Covenant

All Alliance members will be committed to the twin underlying principles of the covenant. Alliance members will have clearly designated Veterans' Champions, including a Champion at board level, to lead on the implementation of this manifesto by their trust.

- ☒ Signed and delivered on the Armed Forces Covenant
- ☒ Nominated a Veterans / Armed Forces Champion Dyad (Senior Manager and Board member)
- ☒ Attend the annual workshop on Veteran Aware healthcare

Supporting the armed forces community as an employer

Veteran Aware ambulance trusts will also be signed up to initiatives that support the employment of veterans and reservists in the NHS workforce. Through these initiatives and their own HR policies, they will support the employment of reservists in and encourage recruitment of veterans and military spouses or partners.

- ☒ Involved in an employer initiative, such as:
 - Step Into Health (www.militarystepintohealth.nhs.uk) the first access pathway from the military into the numerous career opportunities available in the NHS; and/or
 - The Defence Employer Recognition Scheme (<https://www.gov.uk/government/publications/defence-employer-recognition-scheme/defence-employer-recognition-scheme>) which recognises employer organisations that pledge, demonstrate or advocate support to defence and the UK Armed Forces community, and align their values with the Armed Forces Covenant
- ☒ Taking steps to ensure that veterans and other members of the armed forces community in their work force are looked after, for example:
 - Sending staff on a mental health first aid course with a particular focus on veterans
 - Establishing a buddying system for new starters

Best practice in treatment and care

- ☒ Including the Covenant in induction training to raise basic awareness across all staff, with staff working in support, management and recruitment receiving further training or information

Linking in with other services

- ☒ Establishing links with their local reservist units
- ☒ Marking and commemorating key events for the armed forces community, for example:
 - Corporate observance of remembrance day, through an event for the whole trust
 - Displaying the poppy as appropriate
- ☒ Proactively supporting staff in their fundraising efforts for service charities

Resources available:

- ☒ Slides on the Armed Forces Covenant and being Veteran Aware for induction sessions
- ☒ Links to mental health first aid training, with veteran specific modules
- ☒ Example HR policies
- ☒ 'Buddying' between trusts

Integrated Care Systems or Sustainable Transformation Partnerships

Joining the Alliance and commitment to the Armed Forces Covenant

All Alliance members will be committed to the twin underlying principles of the covenant. Alliance members will have clearly designated Veterans' Champions to lead on the implementation of this manifesto by their organisation. This will consist of a clinical champion, a management champion, and an HR Champion, who will work together in what is referred to as a 'Champion Triad.'

- ☒ Signed and delivered on the Armed Forces Covenant
- ☒ Nominated a Veterans/Armed Forces Champion Dyad (Clinical Champion, Management Champion and HR champion)
- ☒ Attend the annual workshop on Veteran Aware healthcare

Supporting the armed forces community as an employer

Veteran Aware Health Care Organisations will also be signed up to initiatives that support the employment of veterans and reservists in the NHS workforce. Through these initiatives and their own HR policies, they will support the employment of reservists in and encourage recruitment of veterans and military spouses or partners.

- ☒ Involved in an employer initiative, such as:
 - Step Into Health (www.militarystepintohealth.nhs.uk) the first access pathway from the military into the numerous career opportunities available in the NHS; and/or
 - The Defence Employer Recognition Scheme (<https://www.gov.uk/government/publications/defence-employer-recognition-scheme/defence-employer-recognition-scheme>) which recognises employer organisations that pledge, demonstrate or advocate support to defence and the UK Armed Forces community, and align their values with the Armed Forces Covenant; and/or
 - Implementing a policy to encourage the recruitment of reservists, veterans and armed forces families such as 10 days paid annual leave for reservists to undertake their training

Ensure best practice in treatment and care in provider organisations within the ICS / STP footprint, by:

- ☒ Ensuring providers display posters in waiting rooms and wards, encouraging people to make their veteran status known, providing the definition and explaining the purpose:
'We are a veteran aware hospital and we understand the Armed Forces Covenant; please let a member of staff know if you have ever served in the UK Armed Forces, so that we can better meet your needs'
- ☒ Mandate provider organisations identify patients who are veterans and (with consent) flag them on information systems to ensure appropriate care is provided
 - Asking people, using the wording above, if they are a veteran/have ever served in the UK armed forces through electronic arrival / registration kiosks, in hospitals where such systems are in place
 - Noting where a referral letter from a GP or elsewhere has identified a patient as a veteran
 - Systems and approaches differ by trust, but normally adding a field or flag on the Patient Administration System (PAS) is a useful way to store this information
- ☒ Carry out needs assessment or plan for veterans at ICS / STP level with the local authority
 - Many healthcare organisations have completed this through their CCG, local authority or STP. A template is available from your GIRFT Regional Veterans Lead.
- ☒ Encourage all Acute, Specialist, Mental Health, Community and Ambulance Service providers within the STP / ICS are signed up to be Veteran Aware

- This will ensure that as an ICS / STP care and coordination of support between organisations of veterans is provided. It will ensure that the veterans support network within your regions is committed to identifying and supporting veterans' and their families.
- ☑ Ensuring relevant staff receive training on the armed forces covenant and treatment and care of veterans
- ☑ Providing further specific education and training to staff as needed
- ☑ Raising awareness within the ICS / STP and provider organisations and sharing key information about the armed forces community with staff
- ☑ Prominently displaying the Veteran Aware accreditation kitemark on relevant communication materials

Linking in with other services

There are a wide range of services provided to veterans, including both statutory services by the NHS and MOD as well as services provided by charities. ICSs / STPs can improve the care offered to the armed forces community by ensuring the providers and other organisations in their footprints are connecting with other services, signposting and referring appropriately.

ICSs / STPs should support Veteran Aware organisations and health care providers to look into and establish 'embedded' services provided by a charity on the trust sites, as well as looking into what services are available or could be made available locally, and encouraging organisations on the footprint to consider the benefits of funding these services.

The Veterans Covenant Healthcare Alliance provides a map to members showing the location of different NHS, MOD and charity services for the armed forces community. It is important that Alliance members build up institutional knowledge of the services available, not just knowledge held by one individual.

ICSs / STPs should support providers and other health care organisations in their footprint to:

- ☑ establish links, where appropriate, to MOD or NHS Rehabilitation services, to ensure shared learning and the smooth transfer of patients.
 - Charity supported Personnel Recovery Centres
 - MoD's Personnel Recovery Units
 - DMS Regional Rehabilitation Units
 - NHS Disablement Support Centres (especially those that have been enhanced from the Murrison report)
 - Primary Casualty Receiving Facilities
 - NHS hospitals employing Defence Medical Services (DMS) Personnel from the Defence Medical Group (DMG)
 - The Veterans Trauma Network
 - Specialist services provided in a smaller number of centres or trusts
- ☑ signpost or refer patients, where appropriate, to NHS mental health services for veterans
 - NHS Veterans' Mental Health Transition, Intervention and Liaison services (TILs)
 - NHS Veterans' Mental Health Complex Treatment Service (CTS)
- ☑ make use of the Veterans Gateway service, to identify beneficial services for patients or service users

Resources available:

- Veteran Aware ICS / STP step by step guide to accreditation
- Patient leaflet template

- Poster template
- Staff leaflet template
- Examples of Patient Administration Systems
- Example Patient Access Policy
- Example Armed Forces Community Needs Assessment
- Template staff awareness slides
- Links to online training options
- 'Buddying' between hospitals

The 7 National NHS England and NHS Improvement Regions

Joining the Alliance and commitment to the Armed Forces Covenant

All Alliance members will be committed to the twin underlying principles of the covenant. Alliance members will have clearly designated Veterans' Champions to lead on the implementation of this manifesto by their regional managing director. This will consist of both a clinical champion and a management champion, who will work together in what is referred to as a 'Champion Dyad.' They should be passionate in improving care for veterans and their families and wish to drive improvements across the NHSE/I region, by working with ICS / STPs and Local Authorities to improve care and support for all veterans and their families.

- ☒ Signed and delivered on the Armed Forces Covenant
- ☒ Nominated a Veterans/Armed Forces Champion Dyad (Clinical Champion, Management Champion and HR champion)
- ☒ Attend the annual workshop on Veteran Aware healthcare

Supporting the armed forces community as an employer

Veteran Aware NHSE/I regions will also be signed up to initiatives that support the employment of veterans and reservists in the NHS workforce. Through these initiatives and their own HR policies, they will support the employment of reservists in and encourage recruitment of veterans and military spouses or partners.

- ☒ Involved in an employer initiative, such as:
 - Step Into Health (www.militarystepintohealth.nhs.uk) the first access pathway from the military into the numerous career opportunities available in the NHS; and/or
 - The Defence Employer Recognition Scheme (<https://www.gov.uk/government/publications/defence-employer-recognition-scheme/defence-employer-recognition-scheme>) which recognises employer organisations that pledge, demonstrate or advocate support to defence and the UK Armed Forces community, and align their values with the Armed Forces Covenant; and/or
 - Implementing a policy to encourage the recruitment of reservists, veterans and armed forces families such as 10 days paid annual leave for reservists to undertake their training

Ensuring Best practice in treatment and care in provider organisations, by:

- ☒ Ensuring providers display posters in waiting rooms and wards, encouraging people to make their veteran status known, providing the definition and explaining the purpose:
'We are a veteran aware organisation and we understand the Armed Forces Covenant; please let a member of staff know if you have ever served in the UK Armed Forces, so that we can better meet your needs'
- ☒ Mandate via ICS / STPs that provider organisations identify patients who are veterans and (with consent) flag them on information systems to ensure appropriate care is provided
 - Asking people, using the wording above, if they are a veteran/have ever served in the UK armed forces through electronic arrival / registration kiosks, in hospitals where such systems are in place
 - Noting where a referral letter from a GP or elsewhere has identified a patient as a veteran
 - Systems and approaches differ by trust, but normally adding a field or flag on the Patient Administration System (PAS) is a useful way to store this information
- ☒ Support the development of a needs assessment or plan for veterans at regional ICS / STP level with local authorities
 - Many healthcare organisations have completed this through their CCG, local authority or ICS / STP. A template is available from your GIRFT Regional Veterans Lead.

- ☑ Support all ICS / STP, Acute, Specialist, Mental Health, Community and Ambulance Service providers within the NHSE/I region in signing up to be Veteran aware and the VCHA accreditation;
 - This will ensure that as an MHSE/I region, care and coordination of support between organisations of veterans is provided. It will ensure that veterans support networks within your region are committed to identifying and supporting veterans' and their families.
- ☑ Ensuring relevant staff receive training on the armed forces covenant and treatment and care of veterans
- ☑ Providing further specific education and training to staff as needed
- ☑ Raising awareness within the NHSE/I region and ICS / STP and provider organisations of veterans and their families and sharing key information about the armed forces community with staff
- ☑ Prominently displaying the Veteran Aware accreditation kitemark on relevant communication materials

Linking in with other services

There are a wide range of services provided to veterans, including both statutory services by the NHS and MOD as well as services provided by charities. Linking in with other services, signposting and referring appropriately will improve the care offered to the armed forces community.

Veteran Aware organisations and health care providers will look into the potential for an 'embedded' service provided by a charity on the trust site, as well as looking into what services are available or could be made available locally, and considering the benefit of funding these services.

The Veterans Covenant Healthcare Alliance provides a map to members showing the location of different NHS, MOD and charity services for the armed forces community. It is important that Alliance NHSE/I regions build up institutional knowledge of the services available, not just the individual knowledge of a particular clinician or manager.

- ☑ To ensure Veteran Aware organisations and health care providers will have established links, where appropriate, to MOD or NHS Rehabilitation services, to ensure shared learning and the smooth transfer of patients.
 - Charity supported Personnel Recovery Centres
 - MoD's Personnel Recovery Units
 - DMS Regional Rehabilitation Units
 - NHS Disablement Support Centres (especially those that have been enhanced from the Murrison report)
 - Primary Casualty Receiving Facilities
 - NHS hospitals employing Defence Medical Services (DMS) Personnel from the Defence Medical Group (DMG)
 - The Veterans Trauma Network
 - Specialist services provided in a smaller number of centres or trusts
- ☑ To ensure Veteran Aware organisations and health care providers will signpost or refer patients, where appropriate, to NHS Mental health services for veterans
 - NHS Veterans' Mental Health Transition, Intervention and Liaison services (TILs)
 - NHS Veterans' Mental Health Complex Treatment Service (CTS)
 - Future Mental Health High Impact Intervention (HIS) service
- ☑ Veteran Aware organisations and providers will encourage staff and patients to use the Veterans Gateway service (signposting to the new Veterans gateway App), to identify beneficial services for patients

Resources available:

- Veteran Aware NHSE/I region step by step guide to accreditation
- Patient leaflet template
- Poster template
- Staff leaflet template
- Examples of Patient Administration Systems
- Example Patient Access Policy
- Example Armed Forces Community Needs Assessment
- Template staff awareness slides
- Links to online training options
- 'Buddying' between hospitals