Great Western Hospitals NHS Foundation Trust

Agenda Board of Directors

Date	1 July 2021
Time	9:30 - 14:20
Location	Microsoft Teams
Chair	Liam Coleman

Agenda

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

2 **Declarations of Interest**

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

3 **Minutes (pages 1 – 9)**

Liam Coleman, Chairman

- 3 June 2021 (public minutes)

4 **Outstanding actions of the Board (public) (page 10)**

5 **Questions from the public to the Board relating to the work of the Trust (pages 11 – 14)**

6 9:40 **Chairman's Report, Feedback from the Council of Governors**

Liam Coleman, Chairman

7 9:50 **Chief Executive's Report (pages 15 – 18)**

Kevin McNamara, Chief Executive

8 10:10 **Patient Story (pages 19 – 21)**

Podiatry - supporting vulnerable patients, an integrated approach to managing appointments

Jill Kick, Head of Integrated Services & Community Therapy, and

Alex Harrington, Head of Podiatry Swindon Community Services, to present

9 10:30 **Integrated Performance Report (pages 22 – 90)**

- Performance, People & Place Committee Board Assurance Report - Peter Hill, Non-Executive Director & Committee Chair
  Part 1: Operational Performance - Jim O'Connell, Chief Operating Officer

- Quality & Governance Committee Board Assurance Report - Peter Hill, Non-Executive Director & Deputy Committee Chair
  Part 2: Our Care - Lisa Cheek, Chief Nurse & Charlotte Forsyth, Medical Director

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

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

10 **Safer Staffing - Six Monthly Skill Mix Review (pages 91 – 107)**
11:30 Lisa Cheek, Chief Nurse

11 **Ockenden Quarterly Report (pages 108 – 116)**
11:45
- Update summary introduction (verbal) - Paul Lewis, Non-Executive Director
- Quarterly report - Lisa Cheek, Chief Nurse

12 **Maternity Incentive Scheme - NHS Resolution 10 Criteria**
12:00 Lisa Cheek, Chief Nurse
(paper to follow)

13 **Audit, Risk & Assurance Committee Board Assurance Report (pages 117 – 119)**
12:15
Julie Soutter, Non-Executive Director & Committee Chair

14 **Integrated Care System (ICS) Development Update (pages 120 – 128)**
12:20 Claire Thompson, Director of Improvement & Partnerships

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

15 **Ratification of Decisions made via Board Circular/Board Workshop**
12:35 Caroline Coles, Company Secretary

16 **Urgent Public Business (if any)**
To consider any business which the Chairman has agreed should be considered as an item of urgent business

17 **Date and Time of next meeting**
Thursday 5 August 2021 at 9.30am (MS Teams)

18 **Exclusion of the Public and Press**
The Board is asked to resolve:-
"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD VIRTUALLY IN PUBLIC ON 3 JUNE 2021 AT 9.30 AM, BY MS TEAMS

Present:

Voting Directors

Liam Coleman (LC) (Chair)	Trust Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Nick Bishop (NB)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Andy Copestake (AC)	Non-Executive Director
Charlotte Forsyth (CF)	Medical Director
Jude Gray (JG)	Director of HR
Peter Hill (PH)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Jim O'Connell (JO)	Chief Operating Officer
Sanjeen Payne-Kumar (SP-K)	Associate Non-Executive Director
Julie Soutter (JS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Claire Thompson (CT)	Director of Improvement & Partnerships
Simon Wade (SW)	Director of Finance & Strategy

In attendance

Caroline Coles	Company Secretary
Charmaine Durant	Occupational Health Nurse (agenda item 79/21 only)
Kirsty Hart	Quality Governance Facilitator (agenda item 79/21 only)

Apologies

Paul Lewis (PL)	Non-Executive Director
Claudia Paoloni (CP)	Associate Non-Executive Director

Number of members of the Public: 6 members of public (6 Governors; Chris Shepherd, Roger Stroud, Pauline Cooke, Ashish Channawar, Judith Furse and Janet Jarmin).

Matters Open to the Public and Press

Minute	Description	Action
72/21	**Apologies for Absence and Chairman's Welcome** The Chair welcomed all to the virtual Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
73/21	**Declarations of Interest** There were no declarations of interest.	
74/21	**Minutes** The minutes of the meeting of the Board held on 6 May 2021 were adopted and signed as a correct record with the following amendments:-	

40/21 : Our Care : Summary Hospital Level Mortality Indicator (SHMI) Data Review Report - Change the word 'journey' to 'data' in the 2nd paragraph, 2nd line.

43/21 : Gender Pay Gap - Add title of report at end of 1st paragraph "(*Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England).*

43/21 : Gender Pay Gap - Change the last paragraph to *"The Board were assured that there had been a comprehensive analysis of the gender pay gaps as at 31 March 2020 and an appropriate action plan was in place."*

75/21 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list and noted that:-

05/21 : Covid vaccinations hesitancy - Included in the Council of Governors discussions around vaccination hesitancy was the wider risk within the Swindon population. There were a range of vaccine delivery models which included the hospital hub however the Trust were responsible for the uptake of hospital staff only and supported Swindon Borough Council through Public Health and Primary Care with the wider Swindon population.

76/21 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

77/21 **Chair's Report, Feedback from the Council of Governors**
The Board received a verbal update which included:-

- The Board had been holding virtual meetings since the onset of the pandemic but were now exploring the most viable and safe options to move to hybrid meetings (a mixture of online and face-to-face participation). It was hoped that this would be from July 2021 however would be dependent on a number of factors including government advice. Any change would be published on our website.
- A Council of Governors meeting was held on 20 May 2021. The governors were presented with the Trust's Efficiency and Improvement Plan as well as the local priorities for the Quality Accounts. The Chair wished to record his thanks to the Governors for their understanding of the challenges the Trust faced in terms of the governance process and tight timescales with regard to the production of the Quality Accounts this year.
- The Trust had received the resignation of David Halik, appointed governor for Wiltshire Council caused by the change in his elective position.
- The governors held a virtual visit with the Orthopaedics and Fracture clinic team on 17 May 2021 which gave the governors some insight into the opportunities and concerns within the service.

The Board **noted** the report.

78/21 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report and the following was highlighted:-

- There were a number of staff that were recognised for their hard work and dedication in the Newsquest Swindon and Wiltshire Health and Social Care Awards

2021.

- Recent media had brought attention to the significant pressure primary care was under. Of note was the Trust's concern around the challenges that our primary care colleagues faced around abuse and criticism. Contrary to media reports our GP practices were open and staff were working extremely hard to accommodate people, however the public should be mindful that services were part of the Trust's recovery plan.

- The numbers of patients with confirmed covid-19 within the Trust were low; however coronavirus was still present and remained a concern. At the time of writing the Swindon case rate was lower than the England average but higher than that of the South West.

- The Trust had now administered more than 62,000 first and second doses as part of the vaccination programme.

- A new Great Care campaign had been launched which would seek to align all initiatives, schemes, quality improvement project and other good work around improving the patient experience under one umbrella.

- The demolition of the old Clover building was completed last week marking an important milestone in the programme to build our new Urgent Treatment Centre.

- In addition to the report it was noted that the Royal United Hospitals Bath NHS Foundation Trust had announced that it had bought Circle Bath – an independent hospital which would secure capacity for NHS patients at a critical time of recovery for NHS waiting lists nationally.

Peter Hill, Non-Executive Director congratulated all the staff award winners but particularly Abbey Meads and Moredon for the GP Practice of the Year award which was testament to the commitment of staff to turn around the practices in such a short space of time. Kevin McNamara, Chief Executive agreed however the staff recognised that there was still work to be undertaken to build on this progress.

Andy Copestake, Non-Executive Director asked if there were any implications to the Trust with regard to the acquisition of a hospital in Bath in terms of diverting resources. Simon Wade, Director of Finance & Strategy confirmed that there would be no impact on capital funding.

The Board **noted** the report.

79/21 **Staff Story**

Charmaine Durant Occupational Health Nurse and Katie Hart, Quality Governance Facilitator joined the meeting for this agenda item.

The Board received a presentation which centred on a member of staff's experience working through the pandemic and who had to readjust to working in different roles and locations within the organisation, ending up in the vaccination hub. The challenges faced from the staff member's perspective were described together with the personal development that had resulted.

The Board thanked Charmaine for sharing her story as it added value to the Board in terms of what the organisation had learnt through the pandemic and to take those

changes and make the future better for its staff. The main lesson learnt was the importance of communication and support from both a personal and professional aspect.

The Board also thanked the vaccination team for their incredible work and significant achievement in rolling out the vaccination.

The Board **noted** the staff story.

80/21 **Integrated Performance Report**

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

Part 1 : Our Performance

Performance, People and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, People and Place Committee (PPPC) around the IPR at its meeting on 26 May 2021 and highlighted the following:-

Emergency Access - There was significant increase in demand whilst still maintaining Covid safe measures. The Trust was performing well relative to other Emergency Departments in the country and the appropriate actions were being taken to make further improvements.

Referral to Treatment Time (RTT) - As like other trusts an incredibly challenging position however there had been a reduction in 52 week waiters and a better than expected recovery in month 1 (April).

Diagnostic Wait Time - A slight downturn had been seen partly due to the fact the mobile CT van was no longer available.

Cancer Performance - There continued to be significant challenges within the Breast Service, however, actions against the improvement plan were looking positive and an improvement in performance was expected by the summer. Good performance continued across most cancer services against the various targets.

Stroke Performance - Continued to perform well.

IT Performance Report - A well-received report on positive work however further work was required to understand the risks around the benefit realisation for many of the schemes.

Research & Innovation (R&I) Annual Report - The Committee received very positive assurance with regards to R&I at the Trust.

Workforce Report - Continued improvements in performance.

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

52 Week Breach Standard - Early estimates for April showed a large reduction in 52-week reportable breaches due to a downturn in referrals during April 2021. However performance was expected to move up and down as patient referrals increased post-Covid.

4 hr Standard - ED performance remained a key concern for the Trust due to the significant increase in ED attendances month on month. The challenges remained around capacity and social distancing constraints. Action plans were in place which included 'Safer Week' a national initiative where the Trust puts additional support into services to improve the flow of patients through the hospital to enhance patient safety, experience and performance across emergency care.

Liam Coleman, Chair commented that the Trust were making all efforts to try and balance between re-establishing elective capacity, dealing with the surge in demand and hospital constraints and asked what support from the Board was required in terms of decision-making or influencing. Peter Hill, Chair of Performance, People and Place Committee replied that the ask was one of tolerance and assured the Board that the Committee considered the recovery plan every month and were holding the team to account who were doing a good job in very difficult situation. Jim O'Connell, Chief Operating Officer agreed with understanding and tolerance as the Trust emerged from a pandemic.

Part 2 : Our Care

Quality & Governance Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Governance Committee around the quality element of the IPR at the meeting held on 20 May 2021 and the following highlighted:-

- All risks were rated an assurance level of amber in terms of risk however all actions were rated green which reflected the effort of the management team.
- The Mortality Audit Report was referred from the Audit, Risk & Assurance Committee as a result of an Internal Audit. The Committee were satisfied that actions had been put in place to address the recommendations from the internal audit report and would continue to monitor progress through the quarterly mortality updates.
- The Perinatal Quality Surveillance tool showed the Trust remained just short of compliance however this was expected to be resolved in the coming months.
- Compliance with the Shine Checklist was green throughout. However since March five additional standards had been added to the list by the department. These related to skin assessment and progress was already being made though not yet green. This would assist the reduction in Pressure Ulcers.

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

Medicine Safety - An additional slide on Medicine Safety had been introduced this month due to a theme coming out of incident reporting. There were 2 key areas of focus; administration in ED and allergies and documentation Focussed improvement work was underway in both areas. It was noted that the numbers of unintended omitted medicines remained consistently low and well below national levels.

Patient Safety - There had been a slight reduction in both pressure ulcers and falls however it was recognised that further improvement work was required.

Maternity and Neonatal Safety - A new quality surveillance tool would provide consistent oversight of maternity and neonatal services with the measures reported to Board on a monthly basis. The on-going learning and insight would help to inform improvements in the provision of perinatal services, together with the establishment of a Maternity and Neonatal Safety Champions meeting led by the Lisa Cheek, Chief Nurse and Paul Lewis, Non-Executive Director maternity champion.

Andy Copestake, Non-Executive Director commented that there was a lot of investment in meeting the CNST maternity standards and asked what confidence was there was in achieving this standard. Lisa Cheek, Chief Nurse replied that the Trust were making good progress and there was no anticipation of any significant risk due to a robust action plan.

Quality Accounts - Due to reduced time scales this year there was a limited consultation compared to previous years with regard to the priorities. Data and information were used from the past year to determine what would make a difference with the following priorities proposed; listening and engaging with our patients, their families and carers; reducing the incidence of hospital acquired pressure ulcers and achieving smooth and effective flow across the hospital and community.

Mortality - The focus on mortality was now around learning particularly with the introduction of the Medical Examiner service which would provide better oversight of all deaths.

Faried Chopdat, Non-Executive Director asked how the learning from the Great Care Campaign would be documented and what were the measures of success. Lisa Cheek, Chief Nurse responded that a framework had been built with priorities and outcomes and the intention was to produce a key performance dashboard which would include other key metrics to show progress. In terms of learning there were a number of ideas which included a learning zone, quality forums and webinars, together with plans to ensure actions had been embedded.

CF

Liam Coleman, Chair asked the Chair of Quality & Governance Committee whether there were any areas of focus to be brought to the Board's attention. Nick Bishop replied that there were no other areas other than as mentioned in respect of the recognition of dying patients which was linked to the mortality report. Charlotte Forsyth, Medical Director confirmed that this would be an agenda item for Quality & Governance Committee next month.

Action : Medical Director

Part 3 : Our People

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

- There had been a better performance this month in terms of workforce planning. Overall headcount was down nevertheless there continued to be reliance on temporary workforce. However the trend was encouraging supported by positive

feedback following the introduction of the preferred supplier list.
- Vacancy rate was low and sickness absence was below target.
- There continued to be significant areas with disproportionate vacancies. Work was underway to explore a number of ways to market the Trust particularly in respect of the unique position of having secondary, primary care and community services.
- Mandatory training and appraisal rates were close to their targets. The move to a different system, ESR, had been implemented and this may see a dip as staff acclimatised to change.
- There was potential impact on overseas nurse's intake due to an immediate pause on all nurse international travel from India as a result of the Red Country status due to the Covid-19 pandemic. Alternative arrangements were being explored to keep the gap to a minimum.
- Roll out of e-roster to the medical workforce had commenced in Obstetrics & Gynecology with a plan to rollout across the rest of the medical departments.
- Planning for the annual flu campaign had commenced this month with the requirement to align with the on-going Covid-19 vaccination programme.
- Further funding had been secured to develop the nursing workforce.
- In July a new Head of Learning would join the Academy.

Liam Coleman, Chair asked how the funding to develop the nursing workforce would be deployed. Jude Gray, Director of HR replied that there was strict criteria to use this money. This was year 2 funding over a 3 year period and the Trust would build on the plans produced last year. Lisa Cheek, Chief Nurse added that the Trust were exploring the option of employing a small team of practice educators within the clinical setting.

Kevin McNamara, Chief Executive updated on the Executive team in that following a Remuneration Committee on 26 May 2021 new appointments had been made for a Medical Director, Jon Westbrook currently at Oxford University Hospitals NHS FT and a Chief Operating Officer, Tracey Taylor-Drew at Gloucester Hospitals NHS FT. Both would start at the end of summer.

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 24 May 2021 and the following highlighted:-

Income and Expenditure - Month 1 was only a £2k deficit against a breakeven budget. However, the amber rating reflected concerns from the Committee on the shortfall in the Cost Improvement Programmes (CIPs) achieved in the month. Also, pay costs were above plan, which was a cause for concern this early in the financial year.

Financial Planning : 1st Half of Year - The financial regime for the first 6 months of 2021/22 would broadly follow the pattern from 2020/21 with enhanced monthly block payments. The Committee approved the H1 revenue budget on behalf of the Board, however the amber rating on actions reflected concerns over CIP delivery and Pay control within the agreed plan.

Financial Planning : 2nd Half of Year - The second half of the year would probably be much more challenging from a finance perspective. Central guidance had still not been recieved and if the regime reverted to the pre-Covid regime the Trust would, again, be facing a substantial operating deficit.

Capital Expenditure - The capital expenditure for the year had been approved. There were a number of unfunded projects in the new financial year. Phasing of the budget would be picked up at the next meeting to ensure there were no undue pressure to spend in the latter part of the year.

Debtors in depth review - Good progress had been made in resolving a number of long-standing issues in this area and reducing debt levels.

Business Cases - One business case was approved for automated endoscope washer/dryer.

Contracts - Three contracts were approved; replacement and maintenance of automated endoscopy washer, novation of 6 pathology contracts and maintenance of Siemens equipment.

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

- The in month and year to date position was a deficit of £2k against a plan of breakeven, an adverse variance of £2k.
- The Trust income was above plan by £293k year to date due to Education & Training funding received from HEE and Carbon Energy Fund, both of which are matched by costs.
- Pay was £145k overspent in month and year to date. The in month position included nursing overspend of £299k and medical overspend of £48k which were offset by underspends within scientific, technical and admin staff.
- Non -pay expenditure was overspent by £150k in month and year to date. The in month position included a savings target of £169k of which £34k had been achieved.
- The Trust capital plan for 2021/22 was £33,493k including the UEC Clover project and Way Forward Programme. A contingency of £541k (CDEL) was being held centrally to mitigate any potential risks arising in year.

Liam Coleman, Chair noted a reference from Performance, People and Place Committee with regard to an update on Research & Innovation (R&I) and asked in respect of income and expenditure how much income was brought in via R&I and what were the costs associated to this. Simon Wade, Director of Finance & Strategy replied that this was being monitored and would be brought into future financial reports.

Liam Coleman, Chair asked if there were any indications on when the guidance for H2 would be published. Simon Wade, Director of Finance & Strategy replied that possibly late August/September however the Trust continued with internal planning processes.

RESOLVED

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

Minute	Description	Action

81/21 **Chair of Charitable Funds Committee Board Assurance Report**

The Board **noted** the report.

Consent Items

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

82/21 **Ratification of Decisions made via Board Circular/Board Workshop**
None.

83/21 **Urgent Public Business (if any)**
None.

84/21 **Date and Time of next meeting**
It was noted that the next virtual meeting of the Board would be held on 1 July 2021 at 9:30am via MS Teams.

85/21 **Exclusion of the Public and Press**

RESOLVED

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

The meeting ended at 1520 hrs.

Chair …… Date……

Great Western Hospitals NHS Foundation Trust

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – July 2021				
PPPC - Performance, People and Place Committee, Q&GC - Quality & Governance Committee, RemCom - Remuneration Committee, FIC – Finance & Investment Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
3-Jun-21	80/21	**Integrated Performance Report : Our Care** A report on actions around recognition of dying patients to be presented at Q&GC in July 2021.	Medical Director	For Q&GC

Future Actions				
None				

Great Western Hospitals NHS Foundation Trust

Questions for the Board

Meeting	Trust Board	**Date**	1 July 2021

Summary of Report

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

For Information		Assurance		Discussion & input	x	Decision / approval	

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

Risk Implications - Link to Assurance Framework or Trust Risk Register

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

Legal / Regulatory / Reputation Implications	n/a

Link to relevant CQC Domain

Safe		Effective		Caring	x	Responsive		Well Led	

Link to relevant Trust Commitment	n/a

Consultations / other committee views

Recommendations / Decision Required

that the questions and responses be considered by the Board.

Questions to the Board				
Topic	**Questioner**	**Question**	**Responder**	**Board Response**
SwICC Staffing	Pauline Cooke, Governor	It has been brought to the governors attention that their maybe an issue with the level of staffing and the split between agency and permanent staff in SwICC. We would like the situation looked into and that patients have the best possible care to help them become well and leave hospital as soon as possible, but also the staff are being supported if there is an issue.	Lisa Cheek, Chief Nurse	SwICC was a hotspot for recruitment but with the centralised recruitment the following actions are in progress to improve the situation:- • All the band 2 vacancies have been filled however some staff training is required before they can work on the wards; • Band 5 nurse vacancies are almost fully recruited once our overseas nurses pass their OSCE exams and receive their PIN • There are also some staff who are about to qualify as Nursing Associates who will form part of our Nursing team. Until such time as the above actions are complete the Trust will still need to use bank and agency staff in SwICC and at Sunflower Lodge. However, there are staffing meetings three times a day and staff are moved to ensure there are no 'critical' or red shifts and there is good oversight of staffing and safety. A practice educator role has also been employed which is making a significant difference. The level of vacancies is closely monitored to ensure appropriate timely action is taken.
Waiting Lists	Pauline Cooke, Governor	1. Can you please ascertain what process we are using to validate our waiting lists to ensure that priority is given to the right people. How we are ensuing that people on our waiting lists still require the requested treatment or if their circumstances have changed how are we feeding this information into this process.	Jim O'Connell, Chief Operating Officer	1. We are using NHSE's Surgical Prioritisation guidance which is supported by the National Royal Medical & Nursing Colleges. All patients waiting for elective surgery are given a surgical prioritisation code which dictates the timeframes they must be treated within based on clinical priority. These range from P1 (the most urgent) to P4 (patients who would not be classed as urgent) There is also a P5 & P6 category where the patient or clinician agree surgery can wait. This was in place due to the Covid Pandemic. We have no P5 & P6 patients currently waiting. All patients who are placed on a waiting list will have

		2. How are we keeping the patients on our waiting lists informed of the delay (or expected time frame for an appointment)		been clinically validated to make sure the patients initial code is matched to P1-P4. If there is a change in the patient's condition the code is changed. For non-clinically urgent cases, where we have capacity, we are treating the longest waiting patients first. All patients on our waiting list were validated at the end of 2020 beginning of 2021, where we explained the long waits and ascertained if their personal circumstances had changed. In addition, as part of the pre-assessment process and consent process, this is also discussed. In addition, we are currently in the early stages of planning to expand our administrative and clinical validation programme for all waiting lists, taking learning from other Organisations who have already developed this. This is planned to utilise a digital solution (with paper version for patients where this isn't possible) to understand whether patients still wish to attend an appointment or whether their needs have changed. 2. Patients have been made aware of the timeframes they are likely to be treated within at the time of listing for a procedure for some time now. This is normally agreed between the patient and the clinician from the outset. Expectations are aligned with surgical prioritisation (P1-P4), or current length of waits for routine activity. as above, all patients were validated at the end of 2020 beginning of 2021. In addition, services are continually validating their waiting lists, and we are currently in the process of validating all P2 patients. Once this is complete, we will validate P3 patients. Our long waiting patients are either being progressed by GWH or are being triaged by the Independent Sector organisations we are working with, who are providing some capacity for our longest waiting patients. At the end of April 2021 there were 5479 patients waiting on the in-patient waiting list.

				Those on the waiting list pre Jan has been written to. We have kept patients updated regularly when they have been validated.

Great Western Hospitals NHS Foundation Trust

Chief Executive's Report

Meeting	Trust Board	**Date**	1 July 2021

Summary of Report

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

For Information	x	Assurance		Discussion & input		Decision / approval	

Executive Lead	Kevin McNamara, Chief Executive Officer
Author	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	x	Effective	x	Caring	x	Responsive	x	Well Led	x

Link to relevant Trust Commitment	

Consultations / other committee views

N/A

Recommendations / Decision Required

This report is for information only.

1. Pressure on the local health system

We continue to see very high numbers of people booking appointments at our GP surgeries and arriving for urgent and emergency treatment at the Great Western Hospital.

The pressure we are currently experiencing - which is not from Covid patients - exceeds the level of demand we would usually expect to see at this time of year.

In March we saw well over 8,000 attendances in our urgent and emergency care services; in April this figure was over 9,000, and in May it was over 10,000. During this time we have seen some of our busiest days on record.

Increases like this are clearly unsustainable, particularly when social distancing means our available space and beds, which have always been a challenge, are under more pressure. High demand has been seen right across the health system and we continue to work closely with our partners.

However, this level of demand is difficult to manage and the situation is exacerbated by our need to reduce the waiting times of patients whose treatment has been delayed because of the pandemic. It is really important that we manage urgent and emergency demand to keep our elective beds for patients on the waiting list.

At the end of March, there were around 2,000 people who had been waiting for more than a year for treatment. I'm pleased that this has now reduced to around 1,200 but this progress will potentially be put at risk if this level of demand is sustained.

It shouldn't be forgotten that we continue to rely on the dedication of our staff who have worked exceptionally hard over the last 14 months during the pandemic, which itself followed a really difficult winter, and we will continue to offer a very wide range of support 24/7 to our workforce.

2. Our performance

Although we are currently under a considerable amount of pressure and we are struggling to see patients as quickly as we would like, it is important to remember that our overall performance remains very good, and we are out-performing many Trusts rated as Good or Outstanding by the Care Quality Commission.

National data indicates that our combined performance across a range of metrics means that we are currently the 10th most improved Trust in the country and the 47th best performing Trust out of 123 Trusts.

3. Coronavirus

3.1 Current position

We have seen a slight rise in the number of patients with confirmed Covid-19 within Great Western Hospital over the last few weeks, although numbers remain low in comparison to both the first and second waves.

We remain ready to escalate our incident response as needed although our modelling indicates that the next wave of the pandemic will not be as severe as the first two waves.

In addition to Covid, we are also planning for a potential increase in cases of respiratory syncytial virus (RSV). RSV is a very common virus, which predominantly affects children aged 0 to 2 years but does also affect older children and the elderly who have decreased immunity. RSV is often

present simultaneously with other viruses such as influenza, rhinovirus and adenovirus and can be difficult to distinguish without testing.

It is normally seen in the winter however we are preparing for an increase in cases and for these to be seen earlier than usual, following the experience in Australia which has seen a significant rise. Due to Covid, we will have seen almost two seasons of children who may have no immunity due to decreased social interaction.

3.2 Vaccination programme

I'm really proud that we have administered more than 70,000 first and second doses as part of our vaccination programme at GWH and vaccinations are now available to every person aged 18 and over at our Commonhead clinic.

GWH is now classified as a 'hospital hub plus' as new appointments are now booked via the national booking system. This is a really positive step forward as it means our appointments are open to all and has meant all of our slots have been fully booked.

As part of our wider work on the vaccination programme we have helped the system to deliver well over 1 million vaccines. This is an incredible effort by colleagues in primary care, hospital hubs, large scale vaccination centres and more. My thanks go to all the staff and volunteers right across the system who have worked so hard to make this happen.

4. Care Quality Commission

Last month we held the first of our quarterly engagement meetings with the Care Quality Commission's new relationship manager. The Executive team collectively briefed the CQC's team on the significant improvements we have made since our last inspection and programmes of work such as our Great Care campaign.

The CQC has also published its new strategy, which has four themes: People and communities; Smarter regulation; Safety through learning; and Accelerating improvement. The strategy places a real focus on relationship-building and indicates a move away from scheduled inspections to a more flexible and targeted approach.

5. Armed Forces Covenant

We are working to become 'Veteran Aware' and accredited through signing a commitment to the Armed Forces Covenant. The Covenant is a promise by the nation ensuring that those who serve, or have served in the Armed Forces, and their families, are treated fairly.

For our Trust, this means:

- Ensuring members of the Armed Forces and veterans, along with their families, have appropriate access to relevant health and care services.
- Supporting veterans through our recruitment process, should they apply to work for us.
- Supporting our staff who are, or considering becoming, an Armed Forces Reservist; enabling fulfilment of reservist training commitments and provision of advice and support for any staff who are mobilised.

We are establishing a new policy to provide a framework for all of this, and will also be setting up an Armed Forces Champion Network, which will meet quarterly to support and review implementation of the new policy and share ideas and expertise on how the Armed Forces can help to shape our on-going pledge to support the Covenant.

We are also working to ensure that we meet the standards to become a 'Veteran Aware' organisation by supporting our patients and their families. This involves identifying patients,

assessing any specific needs and then referring them onto external organisations who may be able to offer additional support, advice and services so that they are not disadvantaged and have access to fair and appropriate healthcare.

6. Staff support and recognition

6.1 Wellbeing Garden

The health and wellbeing of our staff has always been important but this has really been highlighted during the pandemic when they have gone above and beyond to care for our patients. Last month initial work started to create a Wellbeing Garden which will become a legacy where families and colleagues can remember their loved ones for years to come.

The garden will be located around the pond on the hospital site, and will be landscaped with modern perennial planting, colourful borders, and new trees. The existing walkway will be widened for greater accessibility for wheelchair users. Along with providing space for staff to reflect, it will also include interactive areas with sensory features, as well as a trail incorporating wellbeing messages.

Brighter Futures will shortly be launching an appeal to raise additional funds for the project.

6.2 Great West Fest

Our first ever ‘Great West Fest’ will be taking place at the Old Town Bowl in Swindon on Saturday 4 September – and all staff and their families are invited to attend for free.

There is a strong line up of local musicians and bands, and two headliners who have recently risen to fame on TV – Phoebe Maddison from 'The Voice' and Billy and Louie from 'Little Mix: The Search'.

There will also be circus performances, face painting, fairground rides, local food vendors and more. It promises to be a great afternoon and my thanks go to the small team which is working really hard to organise this event to enable the Trust to say thank you not just to our staff for all they have done, but also to their families who have supported them.

6.3 Staff Excellence Awards

Sadly we were unable to hold our annual staff awards ceremony last year due to the pandemic but we are determined to go ahead and hold a safe event later this year.

We will be recognising individual staff members and teams for their incredible contributions to our patients and the work of the Trust in a number of different categories.

Nominations opened last month for staff to choose which of their colleagues should be recognised in this way at the ceremony which will take place on 5 November.

Podiatry -Patient Story- supporting vulnerable patients, an integrated approach to managing appointments

Integrated and Community Care

Great Western Hospitals NHS Foundation Trust

Patient story

Background

- A vulnerable adult with Downs Syndrome and Autistic Spectrum Disorder was referred to Community Podiatry; they had on-going problems with their feet and were reluctant for anyone to review. Family and close carers struggle to help with any hands on care.

- Multiple appointments in Community Podiatry were attempted to slowly build a relationship to allow a clinician to examine his feet but the patient found this too stressful.

- Bespoke insoles and footwear were organised as these did not require hands on treatment

MDT Case Review/Best Interest Meetings

- Established patient was having dental issues and at a previous best interest meeting

- Podiatry team liaised with the dental team and completed a further best interest meeting with patient, his family, his carers and the GP. (A best interest meeting is carried out with professionals/advocate when the person lacks capacity to make a particular decision at the time that decision needs to be made)

- Agreed that when patient was next under a GA, podiatry would attend to complete necessary assessments and treatments as required.

- A risk assessment was carried out and plan put in place

Great Western Hospitals NHS Foundation Trust

Patient story

Risk assessment and Planning

- Initially delayed and impacted by COVID
- Team worked with care home and family to make sure patients favourite carers and family accompanied patient to provide the appropriate support

Joining with dental/ working in theatre- outcome for patient

- Discussed from a Podiatric/Dentistry before consenting so we could assure the best treatment could be delivered for the patient and his family.
- As patient was unable to communicate verbally; time was taken to ensure the patient was at ease.
- Under a general anaesthetic, simultaneously the Dentistry and Podiatry treatment was conducted and provided a positive outcome for the patient, it may benefit many more complex cases in the future.
- Opened the opportunity for an integrated approach to managing complex and vulnerable patients as the Dentistry team have a surgical list for complex cases every month.
- Referral pathway and processes to be reviewed, establish relationships with LD Liaison Nurse

Integrated Performance Report (IPR)

Meeting	Trust Board	Date	1st July 2021

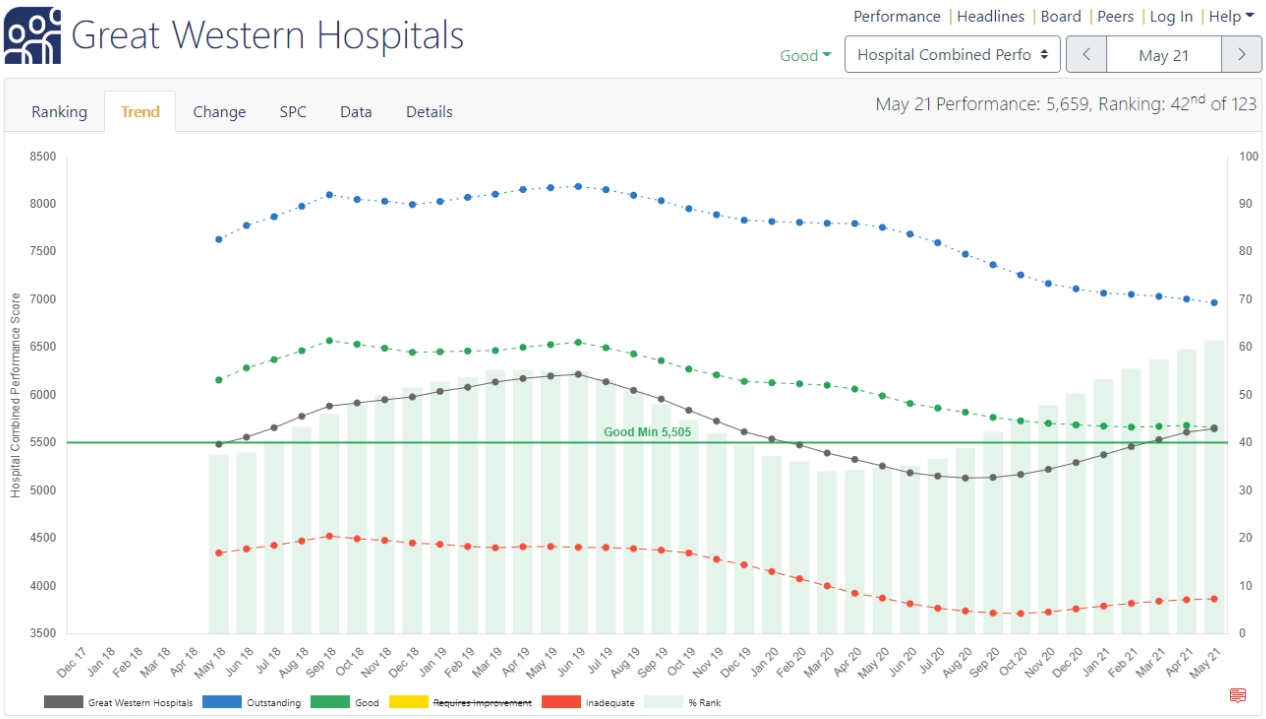
Summary of Report

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

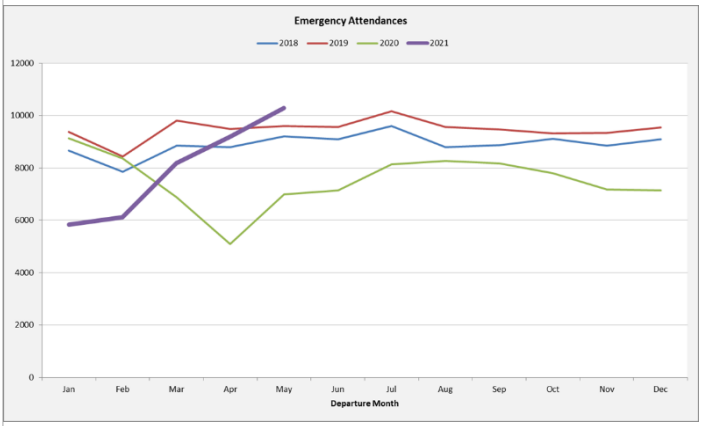
Key highlights from the report this month are:

Our Performance

The improvement we have seen over several months in our Hospital Combined Performance score on Public View continues despite very challenging times. We are now ranked 42nd (up from 44th) out of 123 Trusts. In May we were the 5th most improved Trust in England compared to 12 months ago. The trend chart below reflects our aggregate position improving against CQC measures and our performance is tracking as 'Good'.

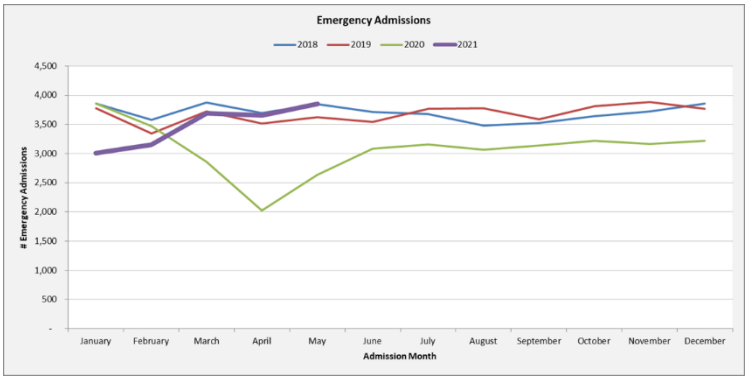


Turning to May 2021, performance against the 4 Hour Emergency Care Standard (ECS) deteriorated from 82.59% to 80.63%. Revised *Transformation of Urgent and Emergency Care Standards* are expected in Q1 2021 which will see the removal of the 4-hour Emergency Care Standard. Measures will include pre-hospital measures. They also include a system measure of the number of patients in ED who wait more than 12 hours. There is a greater degree of focus on patients being clinically ready to proceed. Shadow reporting of the revised datasets has commenced.



ED Emergency attendances have increased in May by 1,091 (12%) patients across both Type 1 (482) and Type 3 (609).
Attendance to the Majors Department have increased in month by 8.5% (5593). The Urgent Treatment Centre (UTC) saw a 13% increase (4699) in May compared to April 2021.
4-hour breaches within the UCC increased in May by 24 (10).

Emergency Admissions have increased by 6% (1,091) in May 2021.



Covid 19 admissions, to the Trust, continue to reduce form the peak of 163 in Jan 2021. During April we assessed 74 suspected patients with 27 patients testing positive. In May we assessed 96 patients of which 3 tested positive. There has been 5 attendances by 4 patients from the Swindon Covid Quarantine Hotel. There has been little impact from the Hotel on the Trust. Plans are currently being worked up to close the formal Covid Assessment Unit moving this facility to the Medical Assessment Unit.

Overall, the Trust's RTT Incomplete Performance for May 2021 was 68.02% which was an improvement of 1.64% in month. May saw an increase in the overall PTL of 229 (25,434). The Trust received 9415 referrals in May 2021 compared to 9853 in April 2021 (438). Pre Covid average referrals totalled 10,002 suggesting a near return to pre pandemic levels. The National Elective Recovery Fund threshold for May was 75%. We achieved a validated April position of 84%. May's position is currently being validated. It is expected the May Elective Recovery Fund (ERF) income to be realised.
There were 342 in month 52-week breaches cleared in May which is a considerable improvement over the rolling 3-month average of 280 per month.

Diagnostic Wait (DMO1) Performance in April was 76.2% a decrease from 81.57% in March driven primarily by increases in Ultrasound breaches (+391).

62 Day Cancer performance in April was 86.6% against a National and Local target of 85%.

Stoke performance unexpectedly reduced to a Level C for Quarter 4 (67.5%). This was not inline with the Bournemouth production tool for the first time. Recovery actions are being put in place.

Our Care

The Care Section of the Integrated Performance Report provides commentary and progress on activity associated with key safety and quality indicators.

Medicines administration error trends are being discussed at a number of professional and quality groups with the aim of exploring and capturing key areas to systematically reduce errors. Community insulin administration, transfer of care and additional training for insulin administration are all areas of focus. Medicines incident reporting is taking a priority in the introduction of the Datix system. This will ensure that the system supports accurate data collection on incidents to generate effective actions to improve practice.

June's Safe Skin messages will focus on preventing heel damage, off-loading and using the new 'repose wedges'. This follows on from educational sessions in May that covered equipment guidance, categorisation of Pressure Ulcers and mattress inspection, supported by a Pressure Relieving Equipment users guide on the intranet. There is a 10% duplication of documented harm with pressure ulcers and therefore there is a drive to improve data collection and reduce duplication to ensure accurate data to drive improvement.

Falls per 1000 bed days is now at the lowest point that it has been since November 2019, at 5.5, with stability of falls resulting in moderate harm or above. Patients are presenting with higher levels of de-conditioning in relation to mobility and falls due to the recent national 'lock down'.

Patient Safety continues to concentrate in-house staff training and education that has focused on Duty of Candour and Just Culture, but following the release of the NHS Patient Safety Syllabus in May 2021 National training, supported by Patient Safety Academy, has been shared across the organisation and is available to all staff.

There is conclusive evidence, despite evidence of terminal cleans (cleaning undertaken when a patient is discharged) being carried out, of cross infection between two cases on one ward in March 2021. Therefore, we will develop a more robust process to provide assurance that clinical staff follow a consistent approach to terminal cleans. There has been no Flu identified over the previous winter, there is concern that Respiratory Syncytial Virus (RSV) in children may be increasing nationally, although the Trust has none detected to date.

Our People

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

Exceptions in May: Minimal changes to report for workforce KPI's. Hours worked remain above budgeted (84wte) however there has been a reduction in usage over the last 2 months. Vacancy, Trust Agency Spend as a % of Total spend, time to hire, voluntary turnover, sickness and appraisal rates all remain in target.

Workforce planning - May saw a small increase in the Trust vacancy rate. The increase in vacancy rate is due mainly to additional budgeted WTE, though despite this the vacancy rate remains inside of Trust target. May also saw a small increase in the proportion of total pay spent on agency, though the increase was marginal and spend encountered fell within target. There was a total of 35WTE less temporary workforce resource was actually utilised in May compared to April. Performance in May is therefore on a par with the previous month and for the second successive month rated as "good" overall.

Opportunities - In M2 the recruitment time to hire metric continued to improve and is achieving below the Trust target at 44 days from vacancy advertised to contract of employment. Appointment for Medical Director and Chief Operating Officer successfully completed. There continues to be a sustained improvement in voluntary turnover reliably achieving below the 11% target. In May the Trust vacancy position slightly increased 6.70% (337.16 WTE) and performance for all turnover increased to 14% above target and review to be undertaken in June to understand the drivers of this level of turnover.

Experience - Sickness reported in April 2021 is 3.45% just below the target of 3.5% for the Trust. As evident from the SPC chart this is also below the average performance for the Trust (just below 4%) since April 2018, demonstrating a good level of sickness absence for the organisation. The variation in month is not significant (3.48% for March) as seen by the SPC chart symbols and comparatively is lower to the previous year (4.72%) when COVID sickness absence began to emerge across the Trust (April 2020).

Preparation for the annual flu campaign commenced in May, and plans are being formulated to manage this in conjunction with the requirements for a possible COVID booster vaccination. Planned confirmation anticipated for July.

This is an important time of year in the EDI agenda with the preparation of the EDI Annual Report, WRES (Workforce Race Equality Standard) report to include Model Employer data and information on 'disparity ratios' and WDES (Workforce Disability Equality Standard) report due for Executive review by end of June. The scope for an internal audit has also been agreed to understand organisational maturity of the EDI agenda.

Employee Development - HEE CPD funding for nurses, midwives and AHPs for 2021/2 has been confirmed as £632,000 and will be distributed in 2 payments over the financial year, the first in Q2 of this financial year. Detailed work already underway to ensure the Trust is ready to submit our 21/22 CPD investment plans to HEE by 31st July 2021. The mandatory training project has successfully completed, achieving the transfer from Training Tracker to ESR by 31 May 2021. The new system went live on the 1st June and will improve the timeliness and accuracy of reporting. A communications plan for staff has been implemented to ensure a smooth transfer to the system and includes a user guide and contact details for support.

Leadership - There has been a slight decrease in mandatory training rates-but this was expected due to the system change over which required some down time. Appraisal rates remain broadly stable. The HEE CPD investment for 2021/22 is significant (£632,000) The in-house provision of leadership activity is now more comprehensive than it is ever been, with provision in place for Bands 4-8a. The Trust continues to work with the Leadership Academy to track the reintroduction of programmes for more senior staff and with BSW to scope opportunities for collaborative leadership development activity.

Use of Resources

The Trust plan is breakeven. The in month position is £11k surplus and year to date position is £10k surplus which is a favourable variance of £10k.

Trust income is above plan by £19k in month and £161k year to date. Car parking income has increased in month. In addition Education & Training funding received from HEE and Carbon Energy Fund are above budget, both of which are matched by costs.

Pay is £306k underspent in month and £22k underspent year to date. The underspend is primarily due to community budgets which are now benefitting from HDP funding. Pay budget in the prior month was lower due to divisional recruitment lag targets.

Non -pay expenditure is overspent by £314k in month and £172k year to date. Costs of clinical supplies have increased in month which reflects additional elective activity.

The Trust capital plan for 21/22 is £33,493k. Spend is £6,229k as at the end of Month 2 against a plan of £3,375k.

For Information	x	Assurance		Discussion & input		Decision / approval	

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

Risk Implications - Link to Assurance Framework or Trust Risk Register		
Risk(s) Ref	Risk(s) Description	Risk(s) Score
792 1357 1917	1. 4 Hour Standard 2. 2.RTT Standard 3. Cancer	
Legal / Regulatory / Reputation Implications	Regulatory Implications for some indicators – NHSi, CQC and Commissioners	

Link to relevant CQC Domain									
Safe	x	Effective	x	Caring	x	Responsive	x	Well Led	x
Link to relevant Trust Commitment									
Consultations / other committee views									

Recommendations / Decision Required

The Trust Board is asked to review and support:

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

NHS
Great Western Hospitals
NHS Foundation Trust

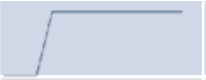
Integrated Performance Report

June 2021

Service Teamwork Ambition Respect

Performance Summary

Great Western Hospitals NHS
NHS Foundation Trust

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
Hospital Combined Performance Score	5505 (May)		42(5505)	27(6031)	21(6341)	Jun 21
A&E 4 Hour Access Standard (combined ED & UTC)	80.63% (May)		94(82.6)	106(79.7%)	80(84.98%)	Apr 21
A&E Median Arrival to Departure in Minutes (combined ED & UTC)	191 (May)		54(160)	98 (183)	67 (167)	Mar 21
RTT Incomplete Pathways	68.02% (May)		101(65)	86(68.01)	100(65.5)	Mar 21
Cancer 62 Day Standard	86.6% (Apr)		8 (91.82)	96 (70.55)	62 (77.08)	Mar 21
6 Weeks Diagnostics (DM01)	76.24% (Apr)		83(81.6)	111(70.9%)	43(92.9%)	Mar 21
Stroke – Spent>90% of Stay on Stroke Unit	72.3% (Q420/21)		73(77.1)	33 (87.8)	9 (92.3)	Q3 20/21
Family & Friends (staff) – Percentage recommending GWH as a great place to work	69.89% (Q3)		85(70.0)	22(82.0%)	33(79.0%)	Q3 20/21
YTD Surplus/Deficit*	-4.3% (Oct)		82(-4.3)	8(1.3)	37(-1.4)	Q2 19/20
Quarterly Complaint Rates (Written Complaints per 1000 wte)	39.79 (Q4 20/21)		112(33.5)	32(12.8)	47((15.3)	Q2 20/21
Sickness Absence Rate	4.37% (Jan)		27(4.37)	71 (5.25%)	83 (4.50%)	Jan 21
MRSA	0 (May)		48(1.74)	95(3.38)	69(2.24)	Feb 21
Elective Patients Average Length of Stay- (Days)	3.01 (May)					
Non-Elective Patients Average Length of Stay (Days)	3.88 (May)					
Community Average Length of Stay (Days)	12.7 (May)					
Number of Stranded Patients (over 14 days)	82 (May)					
Number of Super Stranded Patients (over 21 days)	39 (May)					

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

Board Committee Assurance Report

PPPC Meeting				
Accountable Non-Executive Director	**Presented by**			**Meeting Date**
Peter Hill	Peter Hill			23rd June 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?		Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Cancer Update	Amber	Green	The Committee were assured that based on the current trajectory and management plan improvement would be seen in the Breast Service by August. Short term access issues experienced in G.I. due to 2 doctors needing to quarantine on their return from India.	To monitor actions	August meeting
Integrated Performance Report – Emergency Access	Amber	Green	Demand for the service continues to increase with significant numbers trying to access. This mirrors the national situation.	To monitor actions.	July meeting
Integrated Performance Report - RTT	Amber	Green	Solid progress made with this very challenging target. Committee were particularly heartened to see the reduction in the over 52 week waiters.	To monitor actions	July meeting
Integrated Performance Report –	Amber	Green	Steady progress made.	To monitor actions	July meeting

Diagnostic Wait Times (DM01)					
Integrated Performance Report – Stroke	Amber	Amber	There had been an unexpected dropped in the SNNAP score to a C partly as a result of the breaches getting onto the Stroke Unit. The Committee will scrutinise this in the deep dive that will be on the agenda for the July meeting.	Deep dive	July meeting
Integrated Performance Report – Workforce	Green	Green	The Committee feels that the current position is incredibly positive and the quality of reporting from the Workforce Team gives a significant amount of assurance. While appreciating the substantial progress that has been made it is acknowledged by the team that there is still room for improvement. The ongoing issues are being addressed and the Committee is comfortable with the work being done to monitor and improve these.	Continue to monitor	July meeting
Integrated Performance Report – Staff Engagement	Amber	Green	The Committee has seen significant effort by the Leadership Team to promote staff engagement over recent months. Several indicators (including Public View) suggest this is having a positive effect.	Continue to monitor	July meeting
Safer Staffing	Amber	Green	The Committee received the review from Deputy Director of Nursing (Acute) and Chief Nurse demonstrating good control systems for safer staffing a daily basis, coupled with good recruitment overall, although the national position with regards to Midwife recruitment and Community Nursing is proving challenging.	Continue to monitor	July meeting

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Part 1: Operational Performance

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

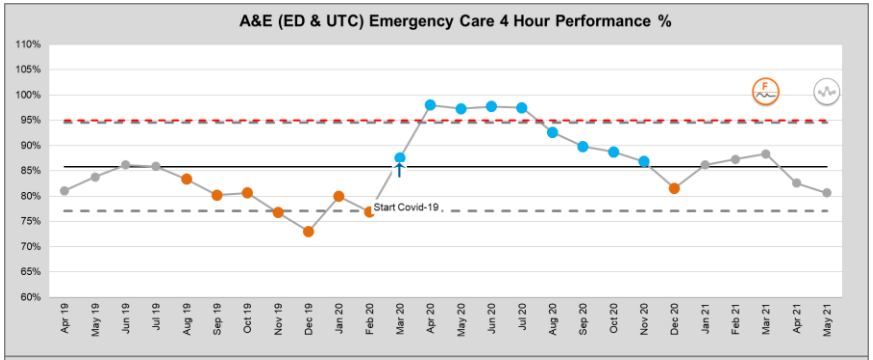
Are We Well Led?

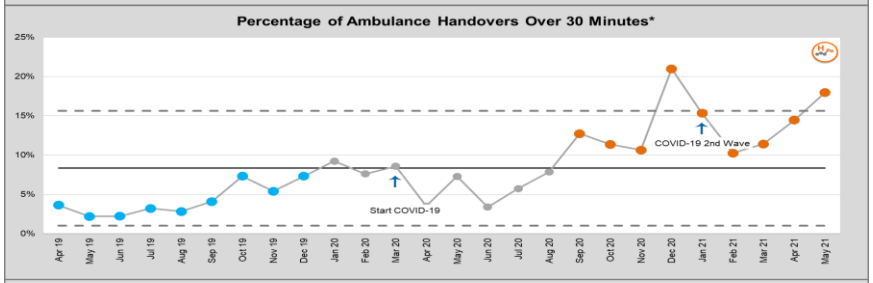
Use of Resources

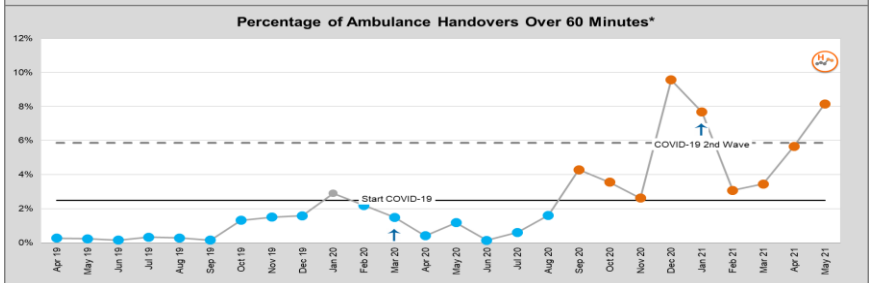
1. Emergency Access (4hr) Standard Target 95%

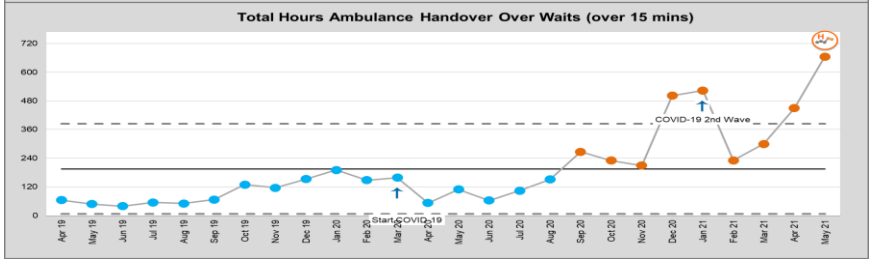
Data Quality Rating:

National Key Performance Indicators





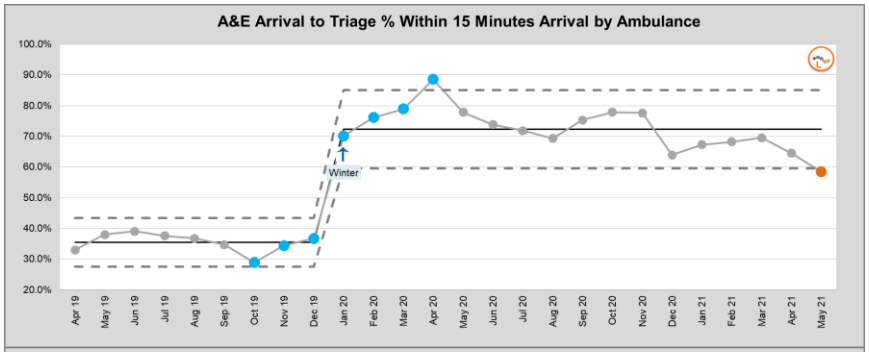


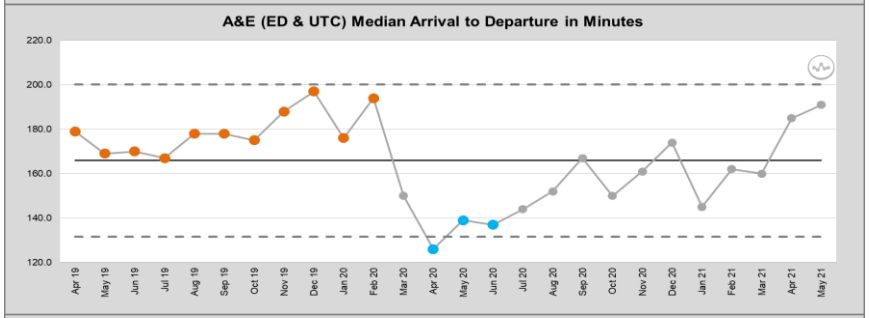


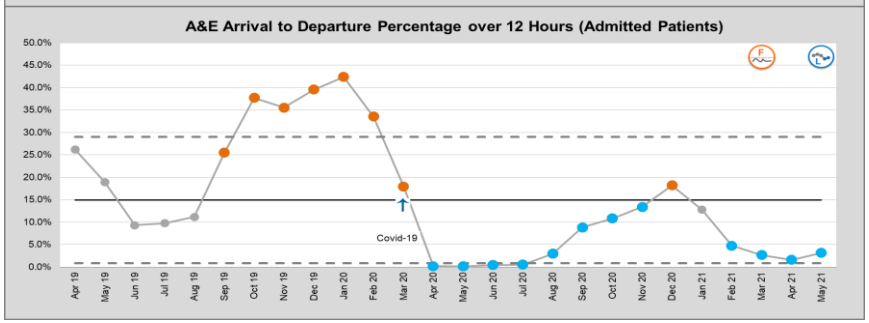
Performance Latest Month: 79.95% (May)

Attendances:
Type 1 ED 68.71%
Type 3 UTC 94.81%
Total – 80.63%

12 Hour Breaches (from decision to admit) 7







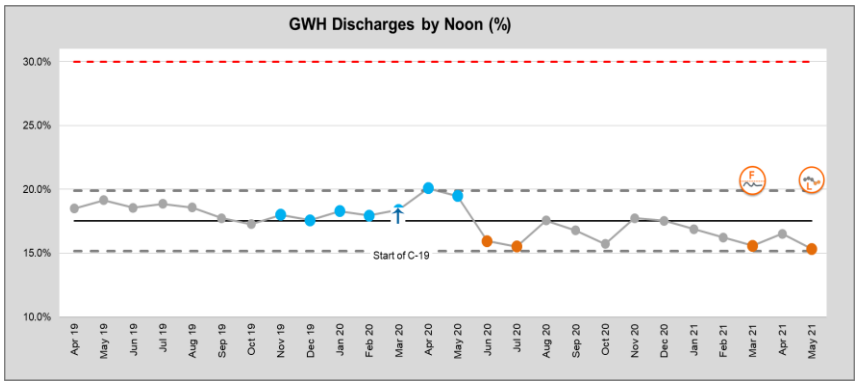
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

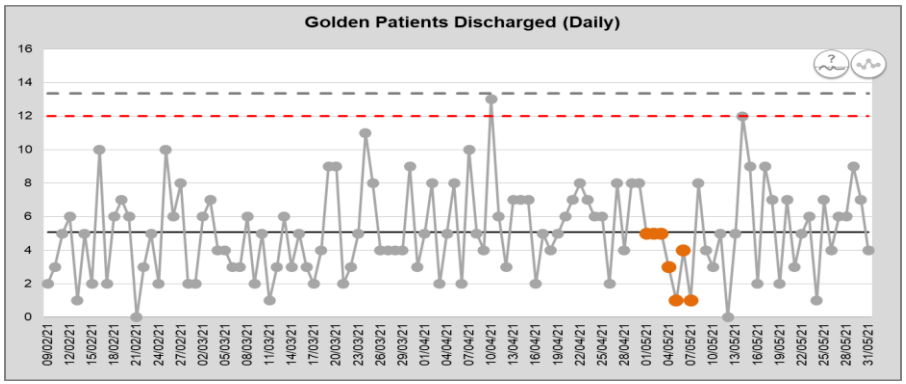
* Data from SWAST – 1 month lag

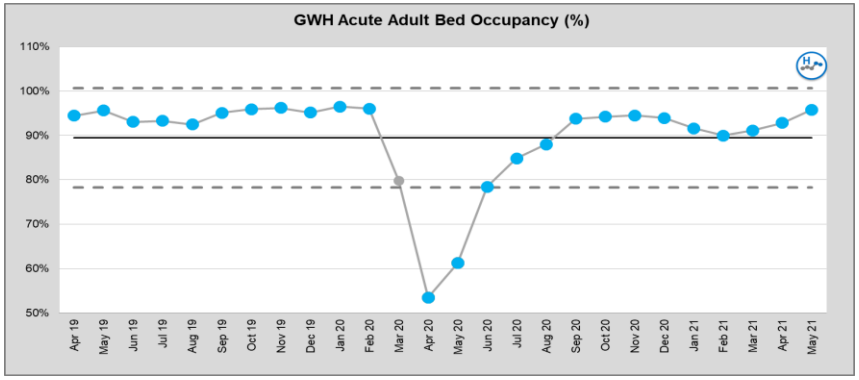
1. Emergency Access (4hr) - Patient Flow and Discharge

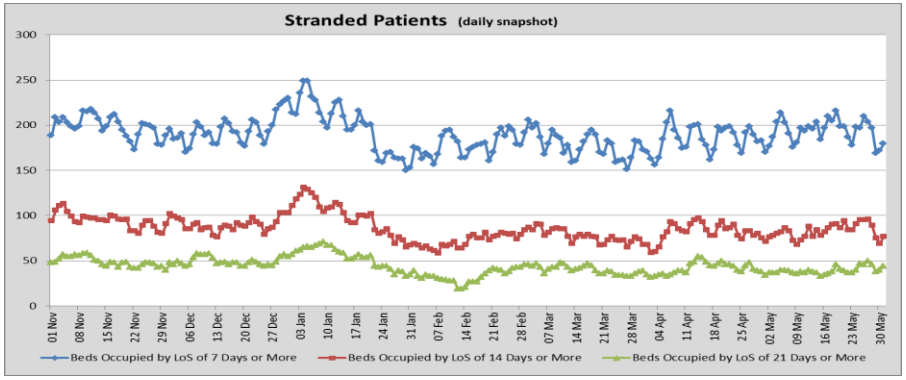
Data Quality Rating:

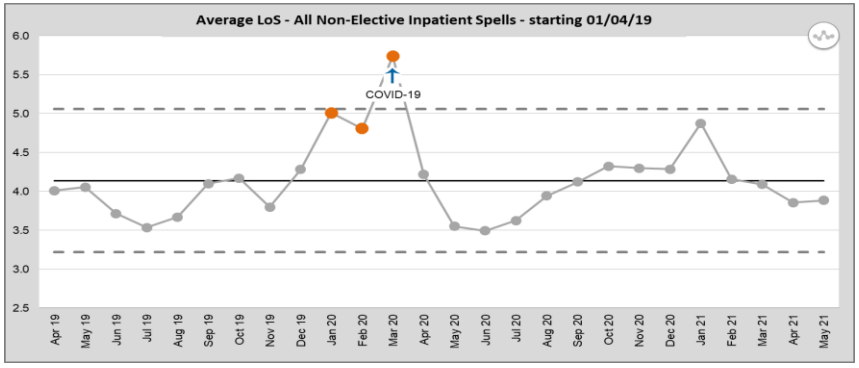
Are We Effective?

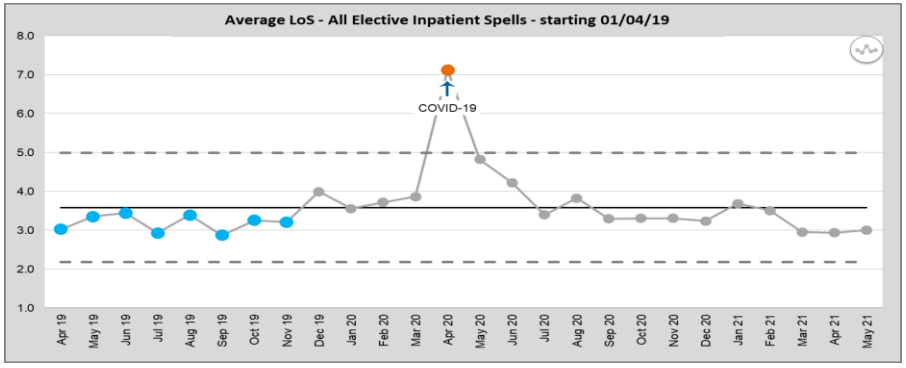












Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

1. Emergency Access (4hr)

Data Quality Rating:

Are We Effective?

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

The ED 4 Hour Performance chart shows that performance in month continues to remain below the 95% standard. There has been a decline of 1.96% in 4 hour breaches to 80.63% There were 7 x 12 hour reportable decision to admit (DTA) breaches in May which is an increase to the 0 reported in April. The process for validating 12hr DTA's is currently underway.
Attendances have increased in May (from April) by 1,091 (12%) patients across both Type 1 (482) and Type 3 (609). 4 hour breaches within the UTC increased in May by 59 (215 reported in April and 274 in May.) Breaches due to 'waits to be seen' in ED have risen to 47% the highest recorded since August 2020. Non admitted performance accounts for 38% of breaches, an increase of 8% on last month.

Key Impacts on Performance

Flow into ED from SWAST causing surges in arrivals especially in the afternoon with high numbers of Hospital Handover Delays. Hospital Handovers Delays over 60 and 30 minutes have increased in May, with 60 minute handovers increasing to 8% unvalidated by SWAST, (from 6%) but remaining below the high of 10% in December.

Delays to be seen by clinicians contributes to worsening performance. The ability for clinicians to assess patients is compromised due to ED overcrowding at times.

Flow from to ED to base wards continues to be compromised resulting in 37% of breaches related to waits for inpatient beds. This is an improvement on last month (38%) and is a reflection of the decrease in ambulance handover performance resulting in more wait to be seen breaches.

There has been a slight decrease in performance in May relating to the number of patients waiting over 12 hours in the department, increasing to 4% from 0% in April. This is still a continued improved performance from the peak of 20% in December 20. One of the factors in this reduction is the creation of the Clinical Decision Unit (CDU) for patients to wait in a ward environment for diagnostics and treatments, Front Door Team (FDT) review and transport home.

What will make the Service green?

- Ability to offer SWAST alternatives to front door attendance. Including direct access to SDEC.
- Internal department review of delays to first clinical assessment to identify workforce availability to meet demand times.
- 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: increasing size and capacity of front door areas.

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

1. NHS England are about to publish revised access standards for emergency and urgent care including Same Day Emergency Care (SDEC) . Standards suggested are currently being developed in shadow form as part of the Emergency Care Data Set (ECDS) **July 2021**
2. Complete **SAFER** Week which has identified several improvements that need to be made related to flow across the Trust. August's SAFER Week planning in place.
3. A review of Majors Step-down is being undertaken to ensure pathways remain effective in reducing admissions to inpatient beds. Community rapid in reaching on Mon, Tues, Fri and leaflets being distributed for staff to be made aware of 2-hour response time. **Completed**
4. ECIST visited ED on Wed 12th May to undertake an observation review of ambulance handovers and ambulance delays. All recommendations from the visit have been captured within the Front Door Action Plan.
5. Amendment to 'wait to be seen' validation to include a second 'ambulance delay, wait to be seen' option. This will help identify whether the wait to be seen performance is improving once the patient is within the department. **Completed**
6. Commissioned review of the UTC to focus on; staffing profile, attendance profile (whether the current patient attendance is reflective of the current function and ability of the UTC)and opportunities to work with primary care to drive alternative community options. **July 2021**
7. Review of direct access pathways to SDEC and community services for SWAST and the Front Door. **June 2021**
8. Business Case to move SDEC to a seven-day service underway. First draft to be with Divisional Tri w/c 7 June. **June 2021**
9. Focus on reducing 15 to 30 minute ambulance handover delays. Ensure that handover process is embedded so that 'clock stops' at the point ED receive patient. **June 2021**
10. Maria Purse, ECIST UEC lead will be on site on the 11th June within ED all day**. June 2021**
11. Weekly Front Door Improvement meetings in place as well as bi weekly calls with NHSEI. **Completed**

Risks to delivery and mitigations

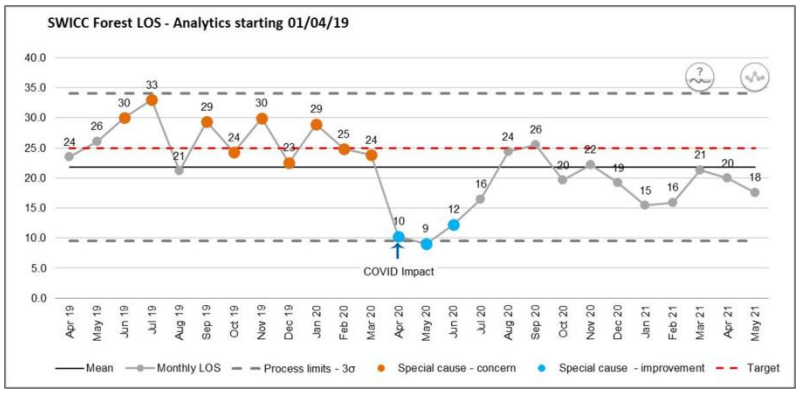
There is a risk that ambulance handover delays will continue to be seen due to a high demand and lack of flow out of ED. **Mitigation:** The ED Team are working closely with SWAST to identify opportunities to both support the crews delayed and identify and implement actions that reduce holding. Urgent review underway of any direct pathways to SDEC or Community services to reduce the pressure at ED. Greater emphasis needs to be placed on planning for SWAST surges.

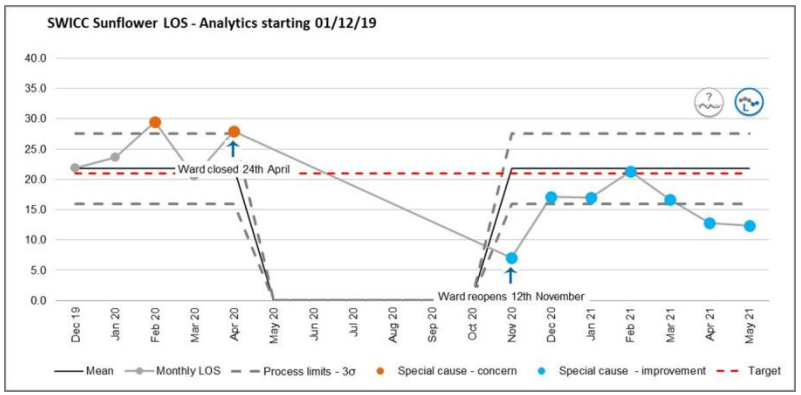
There is a risk that performance will be compromised given the significant increase in ED/UTC attendances**.**

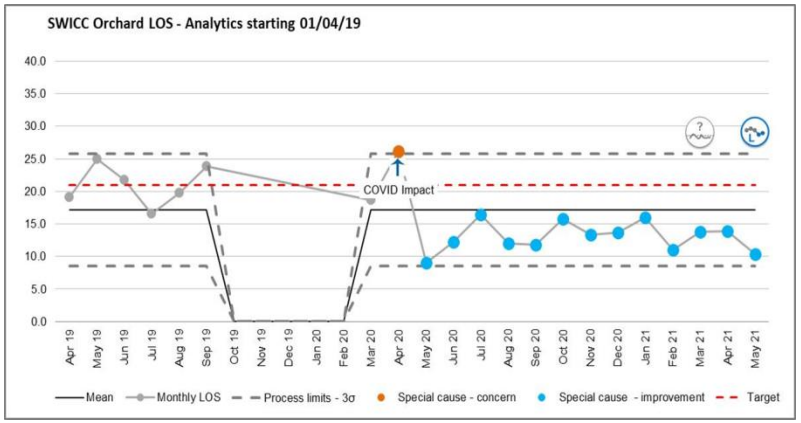
Mitigation: Work is underway with Primary Care to understand measures they can take to help reduce attendances i.e. re-establishment of community wound care service at Moredon (staff had been redeployed from this service to support with pandemic response.) Commissioned review of the UTC to focus on; staffing profile, attendance profile (whether the current patient attendance is reflective of the current function and ability of the UTC)and opportunities to work with primary care to drive alternative community options. Urgent review underway of any direct pathways to SDEC or Community services to reduce the pressure at ED.

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

Are We Effective?







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

In May the average length of stay fell in all three wards. Patient flow continues to increase with 177 discharges in May. Pre covid the monthly average to 2 wards was 80. The additional 24 beds in Sunflower and the inclusion of Out of Area and Wiltshire patients would appear to have significantly improved step-down flow. In **Forest Ward**, the average length of stay was 18 days.. There are currently 6 stranded patients, the longest having been on the ward for 63 days. The ward has a 99% occupancy figure this month. In **Orchard Ward**, the average length of stay was 10 days, a continued trend of low ward stays and a high number of admissions and discharges (76). 6 Patients are still stranded (spending over 21 days in the ward). There was a rise in bed occupancy this month to 96%. **Sunflower Lodge** occupancy levels have increased to 97% in May. The average length of stay for the 58 discharged patients was 12.34, with 2 patients still on the ward for over 21 days.

Swindon and Wiltshire residents have lower than average length of stay with Gloucestershire residents remaining on Sunflower and Orchard ward for an average of 24days.

Improvement actions planned, timescales when improvements will be seen

Specialist Rehabilitation Pathway:

The task and finish group has identified improvements to the funding authorisation process to minimise delays. Investigation into access to specialist facilities in Swindon have been initiated to facilitate timely transfer and local service provision. At month end only 2 patients were waiting transfer for 13 days and 2 days respectively.

Discharge Management:

The use of nerve centre to record Criteria to Reside (CtR) is being implemented but not yet embedded. Future reports will include CTR data. Discharge pathway to Gloucestershire requires more robust management and NCTR data will inform the improvement actions.

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Risks to delivery and mitigations

Risk: Delayed transfer and admissions to SwICC. caused by internal transport delays and the requirement for 24hour covid swab tests .

In May, most delays were due to a delay in Swab results (11%) followed by transport failures (8%).

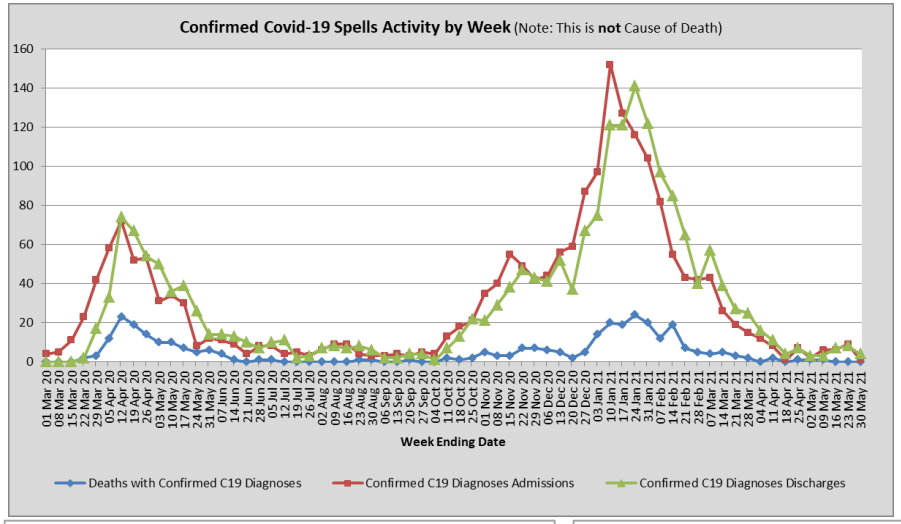
Mitigation

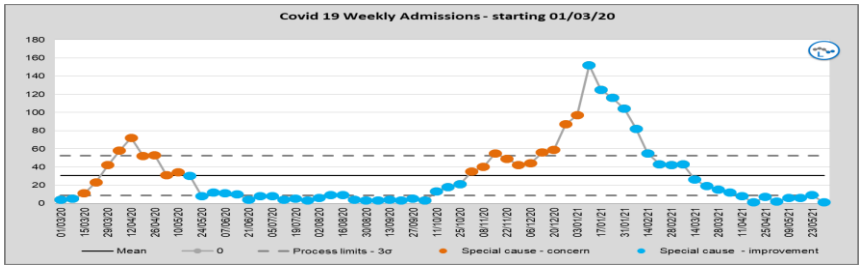
Despite these delays' occupancy levels are in excess of 95% in all areas. However, the May data has established a baseline against which improvement actions will be monitored. A review of the Ambulance Contract is currently underway.

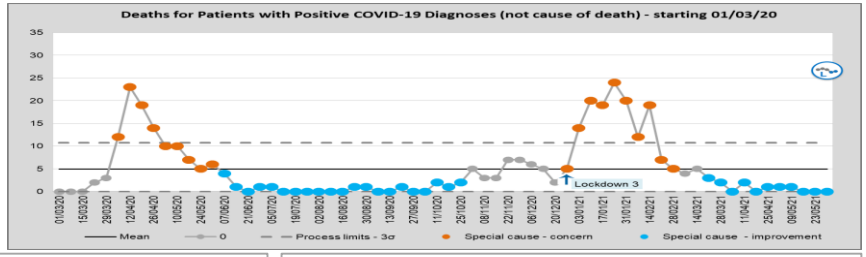
1. Emergency Access (4 Hours) Covid 19 Weekly Admissions

Data Quality Rating:

Are We Effective?







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

The graph above shows that attendances to the Covid Assessment Unit (CAU) have remained low through May, with an increased number of days with maximum occupancy with most patients assessed onto green pathways.

CAU continues to use point of care testing (POCT) for Covid-19 with allocated capacity of 20 fast-track swabs a day. Staff are managing this capacity, balancing clinical need versus flow, ensuring samples are available overnight.

Referrals are ongoing to 'Covid Oximetry @ Home' and the 'Covid Virtual Ward' facilitating admission avoidance and allowing for earlier discharges. Escalation and Ambulance SOPs are in place and there were no reportable ambulance delays in May for CAU.

The team are currently working up plans to close CAU in mid-June, subject to outcome of relaxation in lockdown rules / increased attendances and IP&C guidance.

During May there have been 5 attendances to the Trusts Covid Assessment Unit by 4 patients from the Swindon Covid Quarantine Hotel. There has been little impact on the Trust from the Hotel.

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

1. Review of CAU requirement and bed capacity. Likely need to maintain facility, and potential to re-open Shalbourne 6 bedded area. **June 21**

2. Review of CAU admission criteria (CS/EB) – this will apply to CAU as current set up or revise to enable patient admission through ED, dependant on #1. **Completed**

3. Increasing 'Covid Virtual Ward' catchment to include younger age group (50+) and Obstetric patients. **June 21**

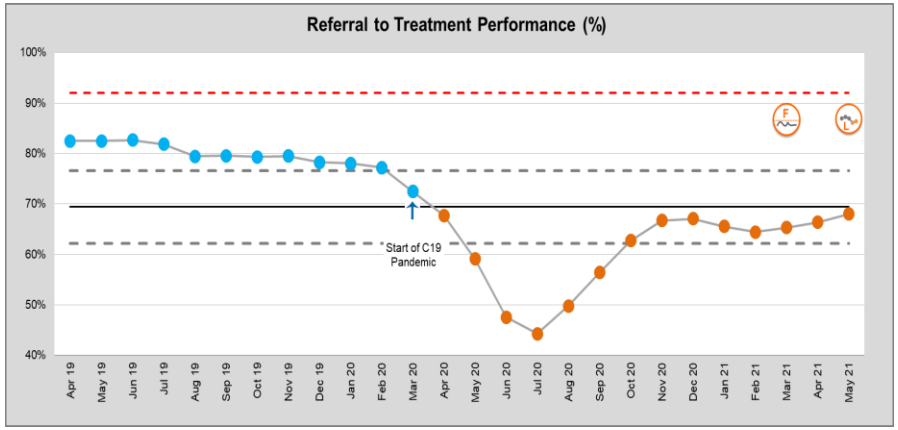
Risks to delivery and mitigations

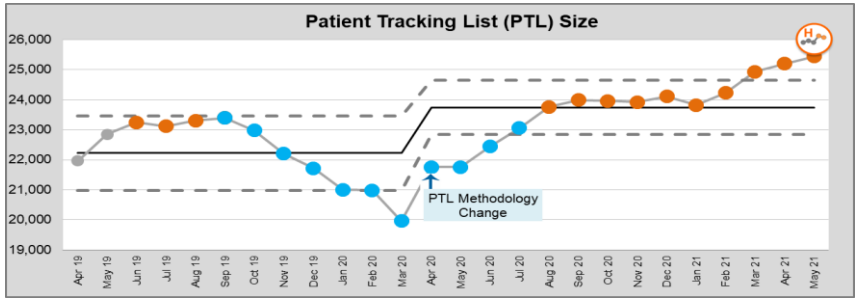
- There is a risk of delayed ambulance handovers in CAU due to delay in swab results limiting movement from CAU. **Mitigation** – Use of POCT/Cephid swabs and patients with high suspicion of COVID are managed with lateral flow testing at times of high escalation. Prioritisation of patient movement from CAU to free capacity.
- There is a risk of reduced flow from CAU due to allocation of Blue/Green beds. **Mitigation** – Flow and bed availability monitored throughout day. Green/Blue bed split in the hospital reviewed 3 days a week on the COVID control call.
- There is a risk of increased Covid Blue pathway attendances from mid-May due to provision of the 'Quarantine Hotel'
  Mitigation – Review attendances and act on trigger levels. Plan to extend Blue bed capacity into Shalbourne 6 beds (1), extend into MAU (2) and review if numbers continue to increase.

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

Data Quality Rating:

National Key Performance Indicators





	April	May
RTT Performance:	66.38%	68.02%
PTL Volume:	25,205	25,434
Reportable 52 Week Breaches:	1,609	1,267
In Month 52 Week Breaches:	468	438

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

The Trust's RTT Incomplete Performance has been updated to include the most recent complete calendar month. For May 2021 RTT performance was 68.02%, which was an improvement of 1.64% in month on April performance (66.38%). The PTL increased by 229 (0.9%) in month. A GWH WL trajectory has been submitted to BSW for May – September 2021 as part of our Elective Recovery Fund trajectory.

Referrals have seen a 6% increase of the Pre-Covid 19 average (May19-Feb20). The Trust received 9415 referrals in May 2021 compared to 9853 in April 2021.Pre Covid we were averaging 10,002 referrals.

In May, we reported 1,267 x 52-week reportable breaches. This was a decrease of 342 (21.2%) from April and of the 1,267 breaches, 141 (11.0%) of them are P5 and have opted to defer treatment until post-Covid. This reduction is primarily driven by minimal patients who were due to breach 52 weeks in May, as a direct result of reduced referral levels in April-20. Of the 1,267 reportable breaches, 1,089 are Admitted, 178 are Non-Admitted and 45 are Diagnostic. ,

There were 438 in month 52-week breaches cleared in May which is a considerable increase over the rolling 3-month average of 280 per month. Of the 438, 252 were admitted clock stops and 186 were non-admitted clock stops.

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

- Elective Recovery Fund weekend lists to commence Saturday 12th June, prioritising T&O and Urology. We are aiming to run 2 x All Day Saturday Lists and 2 x All Day Sunday Lists. These lists will help tackle our long waiting patients, and where clinically appropriate, we will be looking to book 78 week + patients.
- The Trust will continue utilising 3-4 Independent Sector organisations for part/all of 2021/22. T&O capacity secured from Horton Treatment Centre and Circle Reading. Ad Hoc capacity agreed with BMI Bath Clinic. So far in 21/22 we have transferred 102 patients to the IS, and currently have an additional 309 patients in our Triage Pipeline.
- Daily Theatre Line Side Control meetings in place w/c 15/03/21, to monitor performance against required activity levels to deliver RTT performance. Key themes identified impacting utilisation. Utilisation in May improved by 4.0%.
- Ongoing focus on clearing our 78 week + patients, with all P5 & P6 patients being contacted and clinically validated. As it currently stands, we have 0 P5 patients and 1 P6 patient waiting 78 weeks +. This is down from 108 P5 and 38 P6 on 23rd April.
- Overall number of 78 week + patients as at the end of April was 330, which has reduced to 312 at the end of May.

Risks to delivery and mitigations

There is a risk that we lose core Elective Theatre capacity, due to supporting the Anaesthetic 3rd On Call Rota.

Mitigation: Recruitment due to be completed by end of June, with successful candidates in post from August.

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

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

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

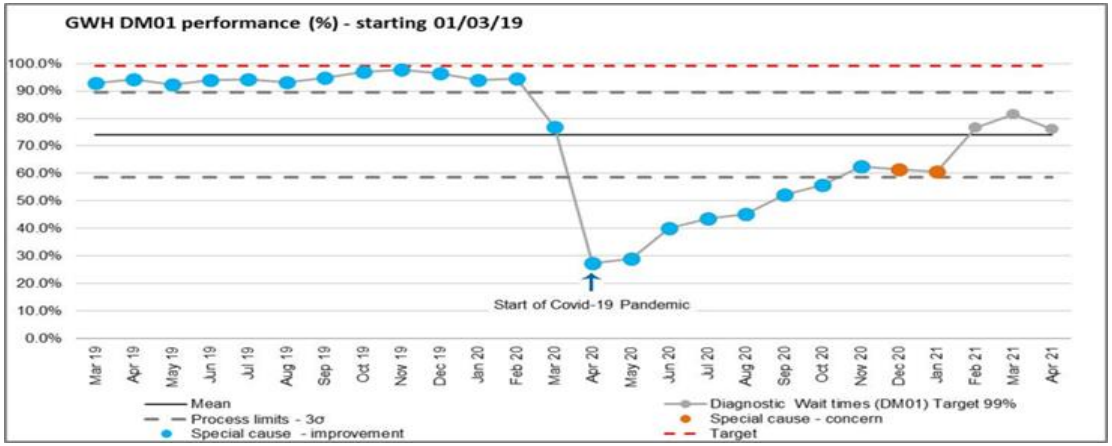
Mitigation: Ensure patient communication clearly explains the current challenges and waiting times and is being done at the appropriate level.

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

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

Data Quality Rating:

National Key Performance Indicators



April 2021

Performance Latest	76.2%
Waiting List Volume:	6283
6 Week Breaches	1493

Waiting	< 6 Weeks	> 6 Weeks	Total WL	Performance %	Total tests / procedures
Magnetic Resonance Imaging	528	2	**530**	99.62%	**1081**
Computed Tomography	830	132	**962**	86.28%	**2885**
Non-obstetric ultrasound	2102	595	**2697**	77.94%	**1935**
Barium Enema	0	0	**0**	N/A	**0**
DEXA Scan	141	2	**143**	98.60%	**136**
Audiology - Audiology Assessments	290	1	**291**	99.66%	**1123**
Cardiology - echocardiography	192	53	**245**	78.37%	**461**
Neurophysiology - peripheral neurophysiology	67	0	**67**	100.00%	**42**
Respiratory physiology - sleep studies	49	8	**57**	85.96%	**106**
Urodynamics - pressures & flows	2	0	**2**	100.00%	**0**
Colonoscopy	266	348	**614**	43.32%	**322**
Flexi sigmoidoscopy	108	198	**306**	35.29%	**123**
Cystoscopy	39	7	**46**	84.78%	**179**
Gastroscopy	176	147	**323**	54.49%	**248**
Total	**4790**	**1493**	**6283**	**76.2%**	**8877**

Background

Performance in April was 76.2% a decrease from 81.57% in March driven primarily by increases in Ultrasound breaches (+391) with smaller increases in CT (+20) and Cardiology (+16) breaches. Endoscopy remained adverse to trajectory which resulted in a further 98 patients breaches. Overall, the total waitlist size increased from 6217 in March to 6283 in April (+66). Due to lack of CT van capacity during the month and Ultrasound backlog, we are predicting a drop in performance in Radiology to around 82% for May with an overall Trust DM01 of circa 77%. It is currently predicted from May onwards that CT will continue to impact the overall Trust DM01 performance.

Improvement Actions

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

- 6 Adhoc CT van days have been allocated in May and 4 in June.
- Exploration of Mutual Aid opportunity from ICS partners
- Discussion with Ridgeway re reducing private patients referrals for CT
- Additional MRI van capacity for May and June within forecasted budget extra 220 slots.
- Bank sonographer recruited into vacancy and 750 slots supported through Additional staff payments to sonographers to support delivery of Ultrasound. New Ultrasound room available for use W/C 7th June.
- Planned expansion of WCC into Oral health to accommodate echo. Review of Job plans to increase consultant specialist Echo list.
- Weekends lists are being booked to 12 points (both OGD and Colonoscopy) where case mix allows so that social distancing can be maintained. Fifth room build expected to be completed by the end of August

Risks (Risk1855= 15) Failure to deliver DM01 for Imaging (risk remains reduced). Insufficient capacity to recover the backlog remains the greatest risk to recovery. CT van availability has been relocated regionally by NHSE and now remains in limited supply. CT replacement may further impact recovery. Mitigations remain in place above to support risk, detailed on next slide.

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

Data Quality Rating:

National Key Performance Indicators

Background, actions being taken and issues

Endoscopy: Combined, Endoscopy achieved 45% performance in April which is an increase of 1% from March and 3% below trajectory. Pre Covid, Endoscopy received 849 referrals per month on average. In March 915 were received and in April 1045. This 130 increase from March to April mainly driven by 2ww (80.) Due to the increase in 2ww referrals, capacity was amended to meet the cancer demand. There are 33 P5/P6 patients on the wait list (reduced from 58 in March). Lists are now being booked to 12 points at weekends. Text initiative commenced to remind patients they are on the wait list so to contact to book an appointment with a 30% response rate to date. DNA's continue to be a concern with 10% of Covid swabs being DNA'd on average a month. DNAs combined with cancellations have seen an average of 15% of slots not being utilised in 3 of the last 5 months. Awaiting approval options submitted as part of the Endoscopy recovery business case.

Radiology: Combined DM01 performance reduced to 83.1% in April from 92.43% in March with an increase in waiting list size to 4332 from 4228 in March(+104). The total number of patients waiting over 6 weeks increased in April to 731 (+228). Dexa achieved the 99% target in April . NHSE have reallocated CT van capacity across the South West, which will impede the CT recovery trajectory from May onwards due to the loss of between 230 and 360 slots per month. It is predicted that this will lead to rises in both Waiting list and breaches delivering reductions in CT DM01 (70%- 75%) performance during this period. Ultrasound performance was compromised due to capacity constraints. These are being addressed.

Echo: Performance dropped from 83.98% in Mar to 78.37% in April. April saw a slight increase in the overall wait list from 231 in Mar to 245 in April with Aerosol generating procedures Trans Oesophageal Echo (TOE) and Stress Echo (DSE/ESE) solely comprising the wait list breach list of 53 referrals. Routine Echo is now being booked <6 weeks. Echo wait list activity decreased from 571 procedures in Mar to 461 in April. This was due to the cessation of WLI activity on 31 Mar 21.

What will make the Service Green?

Endoscopy: Completion of the fifth Endoscopy room which will increase capacity M to F and can increase overall activity if we also maintain weekend WLIs as they are now.

Radiology: Recruitment to further Cardiac Radiologist (1WTE) and 2 International Radiographers commenced at the beginning of May.

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

Endoscopy:

1. Revenue and activity options submitted via Investment Committee in February. Awaiting feedback as to whether Endoscopy can increase their activity once the fifth room is built through maintaining current WLI levels**. June 2021.**
2. Review of whether the service can provide two evening weekday sessions a week with current staff and the cost associated for review**. June 2021.**
3. Initial conversations underway with TVCA in relation to becoming a pilot site for Capsule Endoscopy. If successful, would see a reduction in the number of Colonoscopies required. Further discussions re: pilot happening in May with initial training in June. **June 2021**
4. Audit of patients who DNA/Cancel for 7 days to understand reason causes**. May 2021.Completed-** HoS now reviewing findings**.**

Radiology:

1. **CT**: Adhoc CT van capacity is being sought from NHSE (6 in May and 4 in June) with a range of actions being implemented to mitigate the loss of van days (see risk column). Cardiac slots have been increased on CT1 and booking in progress (oldest date for cardiac is 7th December 20). Additional hours have been offered to run extra CT lists. **June 2021**
2. **U/S** Room now has an earlier completion date (**June 21**). Additional US machine arrived in April. Recruitment of 1.6WTE Sonographer's is completed, 1 WTE commenced in June with 0.6 WTE start date in August. 750 Sonographer APS have been approved, with 300 diarised for **June 2021**.
3. **MRI**: A further 17 van days of MRI van capacity has been secured in May and June 2021 (220 slots) with recovery expected to continue to deliver MRI DM01 performance.

Echo: Waiting List Initiative (WLI) ceased as of 31 March 2021. An Echo flexi list has been introduced to take advantage of ECG/Treadmill Room when not in use. Where Echo takes place in 2 bays in the same room, patients have been staggered to support social distancing measures without reducing output on both clinics. Phase 1 Redesign Work has been endorsed and funded to divide the TOEs room into 2 separate Echo Rooms. This will increase weekly capacity. In addition, Phase 2 Redesign Work has been submitted for consideration to Divisional board in May. This phase will convert the WCC admin room into 2 Echo rooms, again increasing capacity.

Risks to delivery and mitigations

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

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

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

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

- NHSE approached weekly for further CT van capacity with 6 ad-hoc van days in May.
- Post code review of referrals underway to determine opportunity for mutual aid from SFT.
- Approach IS to discuss/ reduce private patients.
- Additional Cardiac and CT sessions offered to staff
- Approached NHSE to provide CT van cover during CT replacement in August.
- Additional US machine delivered. U/S room completion due early June and escalated to complete sooner.
- Additional sonographer recruited (1 WTE) , with 0.6 WTE due to commence in August.
- Shielding staff member now returned to work
- Additional MRI van slots booked as per plan.

Echo: There is a risk that there is insufficient space to deliver echo cardiology within in the Wiltshire Cardiac Centre (WCC) which will increase wait times. Work to conduct the splitting of room 042 has been approved to double its capacity and will commence May 21. A bid has been submitted to convert admin rooms 001/002 into 2 x Echo Bays while relocating the Diagnostic Reporting Team and Booking Team to offered rooms within Oral Surgery. Work will continue to identify low-cost external venues capable of meeting BSE specification for the delivery of Echo.

Cancer 2 Week Wait Performance Target 93%

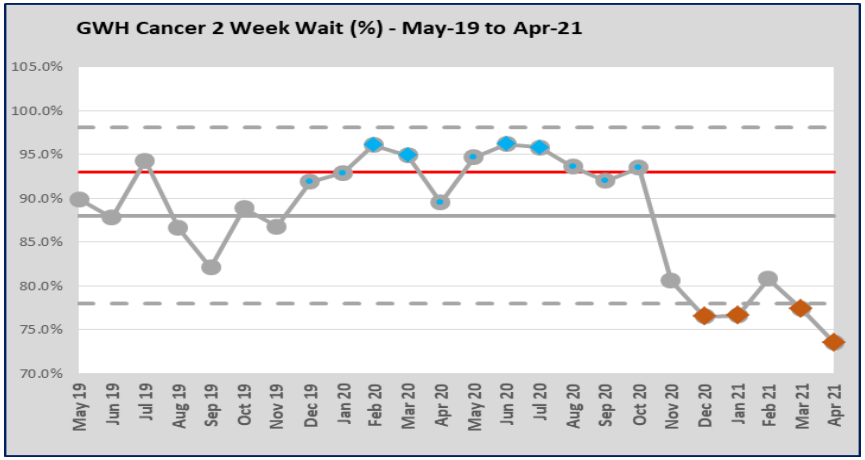
Data Quality Rating:

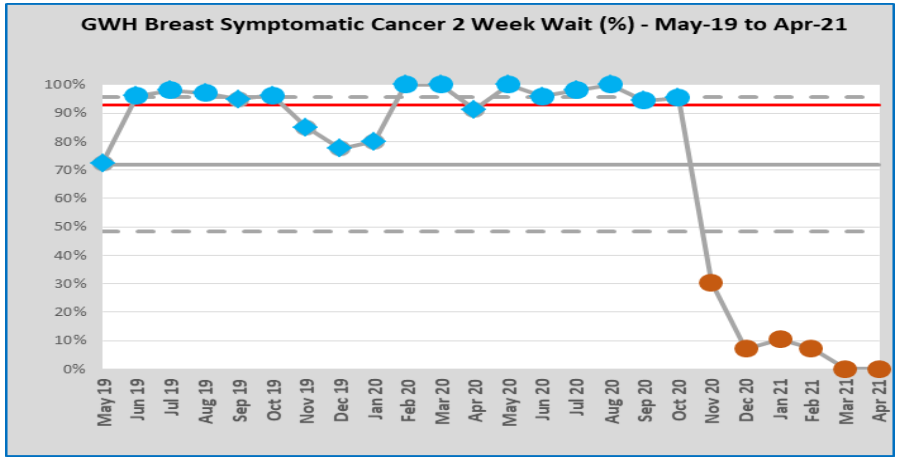
National Key Performance Indicators

Performance Latest Month: **April**

Two Week Wait Standard: 73.6%

Symptomatic Breast Standard: 0%





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

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

Referrals into the breast service increased following breast cancer awareness month (October 2020) as anticipated. From this point the breast service have been unable to maintain 2ww performance due to capacity and physical distancing requirements in the breast unit as a result of COVID restrictions. To maintain usual capacity the team needs to deliver 1 wait list initiative (WLI) clinic each week. This had not been possible due to staff fatigue and request for incentive payment. This resulted in an increasing backlog. The same team also support the breast screening recovery work.

In April there were 5 WLI evening clinics and 4 Saturday WLI clinics resulting in 108 additional patients being seen. The breast team confirmed the breast trajectory will deliver recovery in August. Current booking time is 22 days.

The standard was not met in upper GI as a result of limited outpatient capacity, an increase in referral numbers and due to 3 clinics cancelled due to inpatient outlier support. Patient choice and the reluctance of patients to attend the hospital as a result of COVID remains a challenge within endoscopy.

GWH will be a pilot site for Colon Capsule Endoscopy (CCE). Training will commence in June.

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

1. Breast 2ww recovery plan is now in place with WLIs and weekend clinics through May (3) & June(4) to help recover position. The forecast and trajectories show that the additional WLI clinics are required to recover and maintain 2ww performance. The service audited the updated 2ww referral form to guide if triage is required.

2. The reconfigured breast clinic room was available from 17 May, this will help the number of patients who can be accommodated safely within current social distancing guidelines.

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

4. qFIT (faecal testing) was introduced in primary care for LGI 2ww pathway. The number of 2ww referrals including qFIT results are shared monthly with the Primary Care Network (PCN). 48.9% of all Lower GI referrals had Qfit completed in May. Swindon PCN is proactively managing non-compliance, 50.7% of referrals from Swindon GPs included a qFIT result.

5. The teledermatology trial in Dermatology continues with 301 referrals to date. In total 140 referrals have been returned to GP with advice or routed to non 2ww pathway since January, equating to 47% of those sent.

6. Task and Finish group in Urology has been set up to support progress of Urology service strategy and was presented to the COO on 20th May 2021 for progression to Executive committee.

Risks to delivery and mitigations

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

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

2. Risk: UGI clinic capacity

Mitigation: Locum recruited to support activity and Saturday lists for Endoscopy.

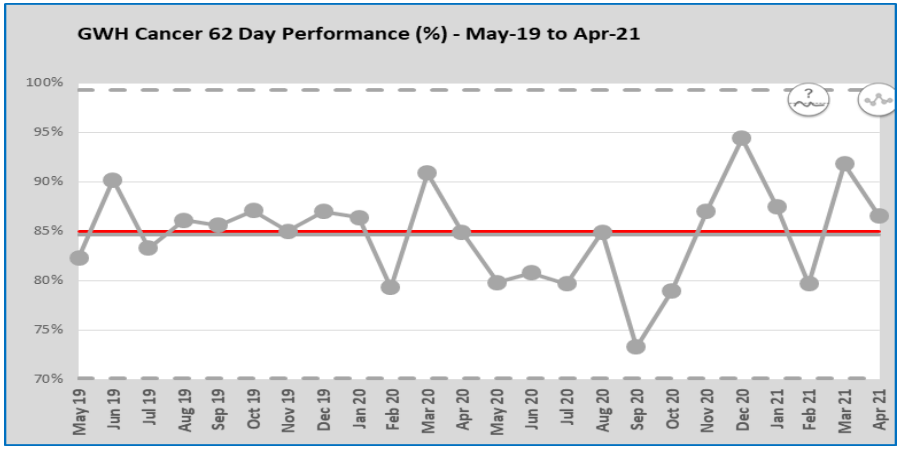
3. Risk: Patient reluctance to attend during easing of national lockdown.

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

Cancer 62 Day Standards Performance Target 85%

Data Quality Rating

National Key Performance Indicators



Performance Latest Month: **April**

62 Day Standard (Target 85%):	86.6%
62 Day Screening (Target 90%):	94.4%
62 Day Upgrade (local standard 85%):	100.0%

Background

April 62 day performance is anticipated to be 86.6% with the Trust achieving the national 62-day standard. Performance in the last year has been heavily impacted by the COVID 19 pandemic with diagnostic/treatment delays since March 2020 .

The performance for April had been predicted to be challenged. Two diagnosed pathways rolled to May due to capacity with the tertiary provider(colorectal) and the other related to patient fitness (Skin). Some predicted suspicious patients did not have a cancer diagnosis.

April breach reasons included several complex pathways (9)that required additional diagnostics or were difficult to diagnose. These were in Colorectal, Gynae (2), Haem, Lung(2), skin and Urology (2). Two pathways were impacted by patient choice, in the case of a skin patient by a DNA of a follow up appointment delaying transfer of care to OUH and a colorectal pathway was delayed by patient anxiety about his investigations and treatments. Four pathways (2 Head & Neck, 1 Gynae and 1 Lung) were delayed at the tertiary treating centre with the transfer of care being made before day 38 and will not result in a breach being recorded against GWH. The remaining pathways (3 colorectal) were due to surgical capacity (2) and delays to requesting investigations.

In April, the screening standard was met. There was, however, 1 breach; a colorectal pathway experienced delays to follow-up and surgery. Poor PTL management also contributed to the delays, more robust measures are being put in place to ensure screening pathways are monitored.

The upgrade standard was also met in April. A breached pathway in Head and Neck was referred for treatment before day 38, resulting in no breach being recorded against GWH

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

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

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

3. TVCA dashboard is now live for reporting Alliance and Trust cancer performance. The next step is embedding the dashboard into performance reporting and PTL management practice.

4. TVCA continue to monitor priority 2 (P2) patients to ensure patients are offered treatment in a timely manner across alliance. Intensive care capacity is improving in Oxford to support complex surgeries particularly for Head and Neck and Upper gastro-intestinal patients.

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

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

Risk to Performance Delivery

Risk: May performance is not expected to achieve 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 approximately 83%.

May breaches are heavily impacted by capacity issues at OUH in oncology and surgery with 6 pathways effected (2 Head & Neck, 2 Gynae, & 2 Colorectal). A further colorectal pathway was delayed in transfer to Oxford due to oncology capacity at GWH. A plastics pathway was delayed by the need for a biopsy in dermatology before the patient was transferred. Other pathways have involved complex cases (2 in Urology) and pathways where patient choice has played a role.

Fewer CT van sessions are impacting on the service being able to offer earlier scans to help bring pathway forward. Radiology are actively managing and prioritising cancer referrals. PET CT van would assist capacity.

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

Outpatient capacity issues in both the upper and lower GI pathways continue to delay follow up activity. Lower GI registrar clinic streams in May have helped create 112 additional slots for consultant outpatient activity. Two Upper GI consultants are currently away, locum support in place.

Straight to Test Nurse posts have been filled, the role will help with the triage of colorectal patients to their first appointment or diagnostic and engage with the patient on the cancer pathway. This will support the communication of diagnosis.

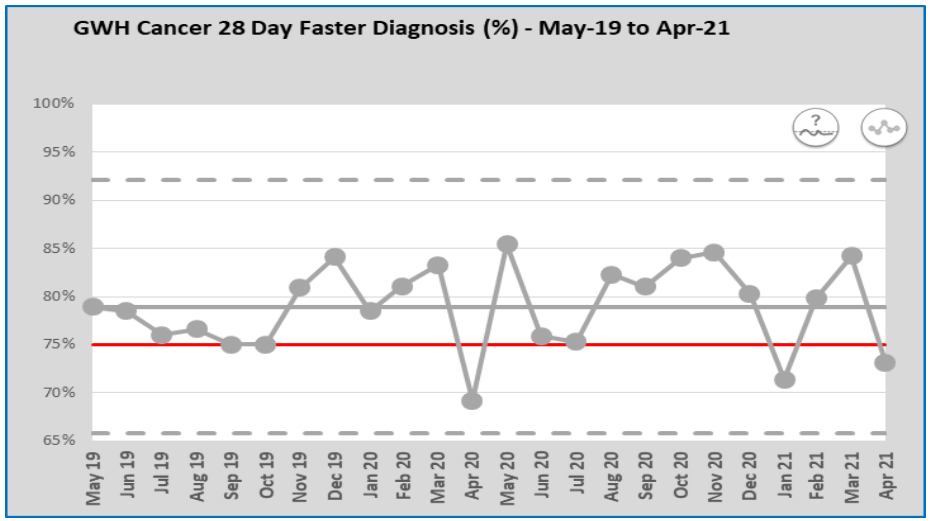
Oncology capacity remains challenged due to significant workforce gaps. Workforce modelling is underway with discussions with Oxford University Hospitals (OUH). GWH will recruit locally for clinical oncologists with the satellite unit expected early 2022. These posts will be GWH based and include some OUH activity (2 days).

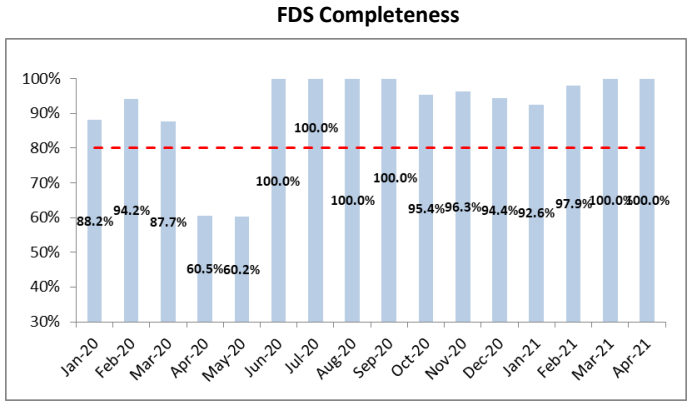
Cancer 28 Day Diagnosis Target 75%

Data Quality Rating:

Are We Effective?

Performance Latest Month: **April – 74.5%**





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 is likely to remain suspended until September 2021 and in the interim, we will continue to shadow report.

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

Gynae pathways are being affected by delays with Oxford pathology reporting and with follow up reviews due to clinical capacity (consultant maternity leave).

Colorectal performance is being adversely effected by the delays to follow up appointments following first diagnostic tests with pathology results and following MDT. The additional registrar clinics will improve capacity.

April is forecast not to be compliant with the standard. A return to compliance with the shadow standard is expected in May.

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

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

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

Review of process for the recording of the communication of diagnosis completed. Patients will remain on the Cancer PTL until they have had their diagnosis communicated. A process for noting these in the PTL and for notifying the heads of service was implemented in February and monitored via cancer delivery meetings.

FDS improvement work with each service to support sustainable model for communicating diagnosis within 28 days to be undertaken Q1.

TVCA funded colorectal straight to test nurses commenced in May 2021.

Cancer services liaising with Bournemouth to establish best practice and sharing of processes.

Pathway mapping in Urology and Lower GI to establish potential improvements continues.

FDS discussed fortnightly at cancer delivery meeting as part of standard reporting metrics

Risk to Performance Delivery

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

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

2. Risk: Breast 2ww pathway delays will result in delays to faster diagnosis standard.

Mitigation: Incentive payment to imaging assistants to undertake wait list initiative clinics and training of additional staff to support future clinics. Clinics planned for April. May and June. Job plan reviews being undertaken to assess ability to continue this activity as business as usual.

3. Risk: OUH pathology delays will impact gynaecology pathways predominantly.

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

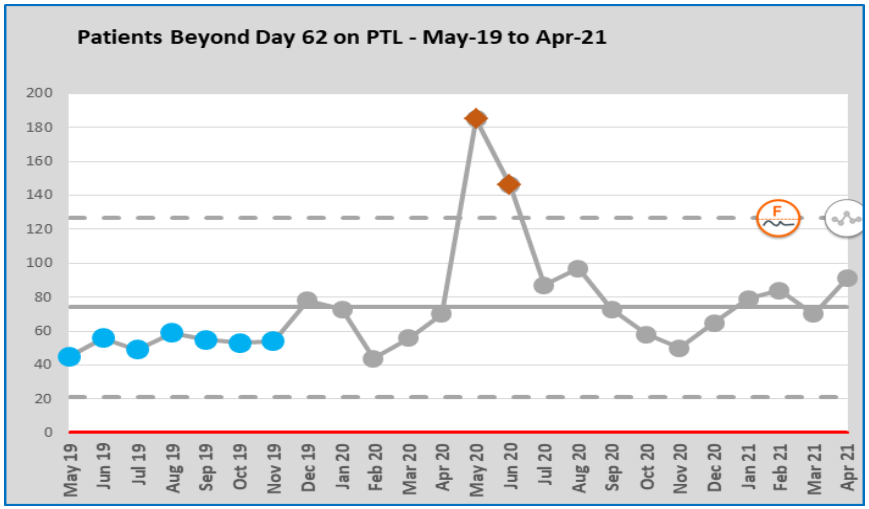
4. Risk: Delays to follow up appointments in colorectal and upper GI, as a result of consultant capacity, will impact on the delivery of diagnosis.

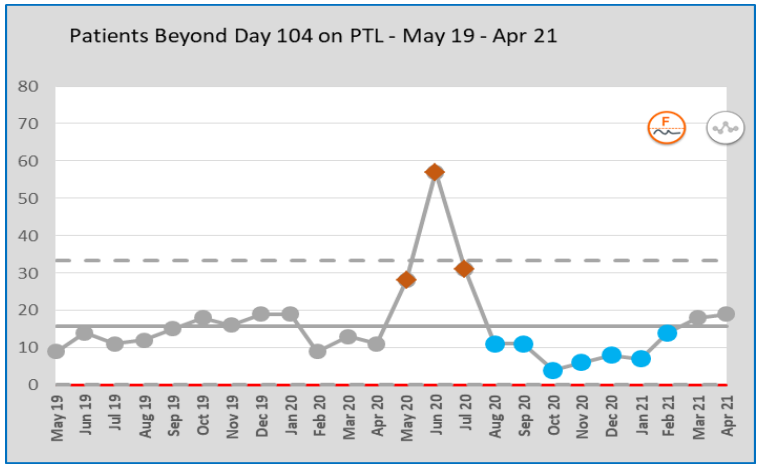
Mitigation: Colorectal service has recruited two registrars to support clinics commenced in March. Additional slots for consultant clinics have been created.

Cancer 62 day + longer waiters including > 104 day

Data Quality Rating:

National Key Performance Indicators





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

104 Day Breaches: April: 2 Patients; 1.5 breaches (IPT)

Treated at OUH

Urology: 1 patient-0.5 breach: significant capacity issues at the time of the TURBT led to longer wait (31 days) than normal. The procedure was reported as incomplete, requiring a referral to Oxford for additional treatment. There were also delays in Oxford for their radiotherapy post ITR due to capacity issues.

Treated at GWH

Colorectal: 1 patient- 1.0 breach: pathway was delayed due to CT Scan not being requested after an outpatient appointment in a timely way and patient choice/thinking time.

May is likely to see 5 patients breach 104 days on their pathway resulting in 3.5 breaches. (IPT)

The high number of 104day+ pathways on the PTL is in part due to a high number of patients (6 out of 19) that do not have cancer and are awaiting confirmation of their non cancer diagnosis. Additionally, there are 2 patients on a Plastic pathway at OUH awaiting pathology from procedures completed or dates for procedures. OUH provide weekly updates on GWH patients under their care.

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

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

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

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

Risks to delivery and mitigations

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

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

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

4. Risk: Delays to pathway communication from tertiary centres resulting in patients being on PTL longer than necessary.
Mitigation: weekly PTL updates from OUH, heads of service regular contact with counterparts where necessary.

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

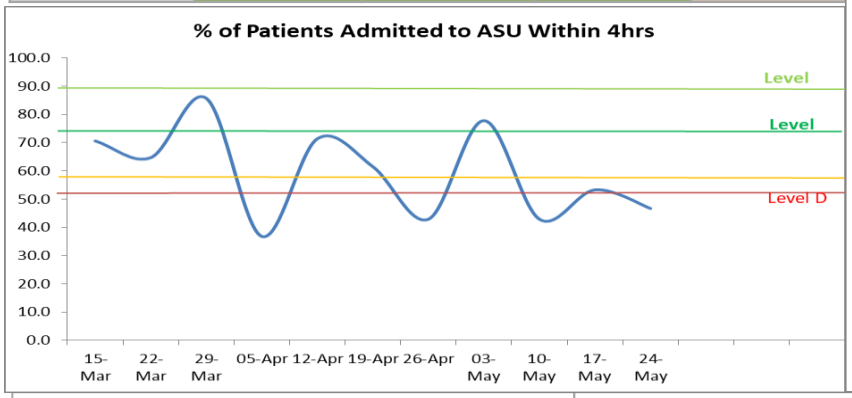
Stroke Pathways

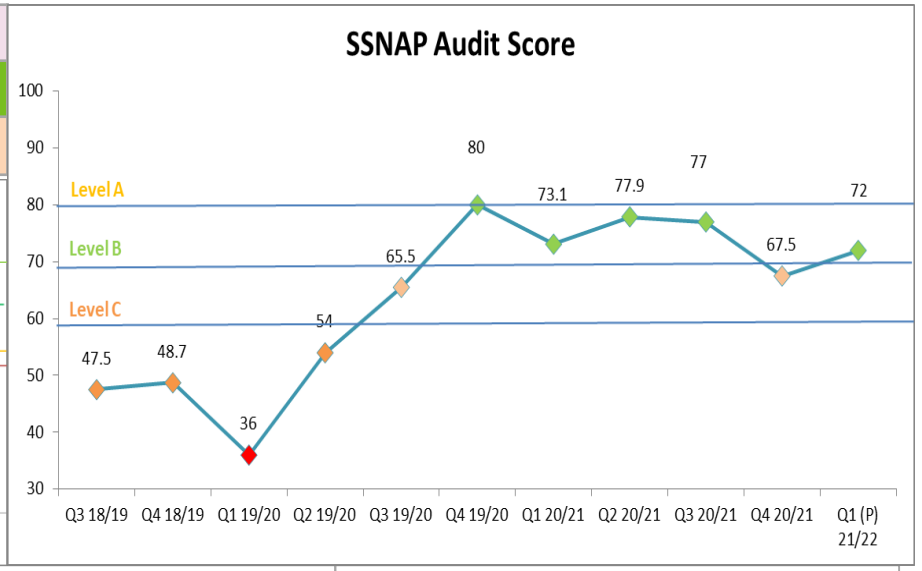
Data Quality Rating:

National Key Performance Indicators

GWH SSNAP Audit Score:

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





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

The Q4 SSNAP score has been received and is at Level C/67.5. The predictor tool was forecasting Level B/70.3 and historically actual SSNAP score has always been in excess of the prediction. The key area where we have seen a drop in performance is across the Physiotherapy/Occupational Therapy (PT/OT) teams , who are carrying 3 vacancies across the Acute and Rehab team, although these have now been recruited into.

Admission to Acute Stroke Unit within 4hrs has also been challenging during Q4, with delays in admission to ASU impacting other SSNAP domains, such as Thrombolysis and Specialist Assessments. Time Spent>90% of Stay on Stroke Unit was 72.3% (Q420/21)

Audit compliance performance also dipped in Q4, and this is attributed to a period of sickness of the Stroke Data Administrator, which created a backlog in data entry, which has since been recovered.

May has proved to be particularly challenging in maintaining direct admission to the stroke unit, with 31 breaches out of 67 admissions up to 31st May 21.

Q1 21/22 is currently predicted at Level B/72.

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

1. PT/OT Team recruited to 3 x therapists due to start in Aug 21. **Aug 21**
2. Stroke patients to be identified and discussed at daily Site Meetings to improve admission times and support flow. **Jun 21**
3. Development of business case to support increased OOH stroke cover. **Jun 21**
4. ED Nurses to shadow Stroke Specialist Nurses to improve knowledge and confidence with Thrombolysis. **Jul 21**
5. Therapy SOP to be written with clear actions for the therapists to instigate during peaks in demand across the system. **Jun 21**
6. Review of Bournemouth Predictor Tool to understand Q4 performance over prediction. **Jun 21**
7. Understand whether the amendments made by SSNAP as to how they have scored Q4 impacted our outcome. **June 21**

Risks to delivery and mitigations

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

Mitigation - Stroke Matron monitors admissions to the ASU on a weekly basis and feeds back to Divisional Director on performance. IR1s are completed for any breaches of SOP to drive improvement performance. Overall site pressures through May have influenced further SOP breaches and a marked decline in direct admission performance.

There is a risk that the PT/OT team vacancies will continue to impact the overall performance of Stroke until filled in Aug 21.

Mitigation – Recruitment has been made to vacancies with start dates to be confirmed. Redeployment of staff across the Stroke pathway to minimise impact.

Board Assurance Report

Quality & Governance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		17 June 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report	Green	Green	This is an overall rating. Pressure Ulcer numbers have risen slightly since last month. This was discussed in detail. Early skin assessment in ED may help reduce this rate. Actions put in place have been externally assessed as being the right ones. Data quality remains Amber but work is in hand to improve this. Falls have reduced to their lowest level since Nov.'19. Serious Incident reports have reduced. Owing to changes in process, the number of Concerns has increased but number of Complaints has reduced. This follows asking people how they wish their issue to be addressed. Concerns tend to be resolved much quicker bringing earlier resolution. Friends and Family response rates continue to increase and now exceed those of other acute trusts within BSW. The positive to negative ratio is about 8:1. For April the consultant presence in the Delivery Suite increased to the target of 60 hours/week	Continue monthly monitoring	

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Patient complaints and Conduct Policy.	Green	Green	In response to questions raised in April, this report from Claire Warner, Assoc Dir HR, outlined the trust's approach. This focused on a Just and Learning Culture. The committee was assured that the Conduct policy would be implemented when necessary and that any trends that emerged via the complaints process would be addressed appropriately.	Executives to remain sighted	
Mortality & Morbidity	Green	Green	The report from the Trust Mortality Lead showed the Trust to continue to lie with in the "as expected" range for the HSMR and SHMI. Increasing numbers of Structured Judgement Reviews (SJR) have been carried out and learning points arising from these have been disseminated.		
Medical Examiner Service	Green	Green	This report from the Lead Medical Examiner outlined the role of the ME and how it will develop. By August all GWH deaths will be scrutinised as we expect to have a full complement of MEs by then. From Dec '21 non-GWH deaths will begin to be scrutinised and from April '22, all catchment area deaths.		
Ockenden Report Update	Amber	Green*	Good progress is being made. One criterion requires the Head of Midwifery (HoM) to report directly to an Executive Director. The Chief Nurse (CN) explained that in most Trusts our size, this did not happen because of the Divisional accountability structure. However since the Red rating in March by NHSE/I it has been made clear that there is professional accountability by the HoM to the CN and they meet on a regular basis. * This rating is subject to successful receipt of funding from our bid to NHSE/I for additional staffing costs to cover shortfalls, as outlined in the report. This bid was felt to be barely adequate to fund requirements but any higher bid would not have been successful.		
Maternity Incentive Scheme.	Green	Green	This report showed only one Amber rating in the ten Safety criteria needed to achieve compliance and therefore financial reward from CNST. The Committee heard that the team were confident this would be rated green by the due date. Evidence for this is awaited from an external body.		
GIRFT Update	Amber	Green	Many outstanding actions have now been safely closed on the basis that they were out of date or evidence had changed. This has resulted in a tidier plan. There is still some work to be done to achieve full GIRFT Compliance.	Continue to monitor via quarterly reports to Q&G.	

Issues Referred to another Committee	
Topic	**Committee**

NHS
Great Western Hospitals
NHS Foundation Trust

Part 2: Our Care

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Our Care Summary

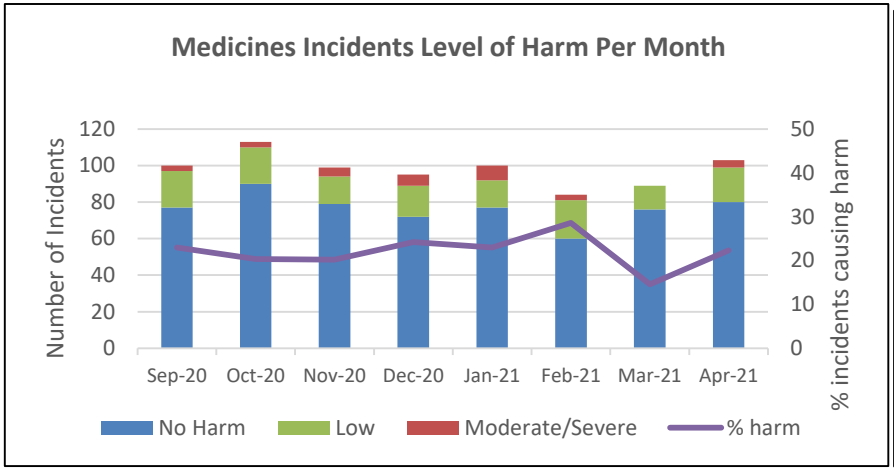
Great Western Hospitals NHS Foundation Trust

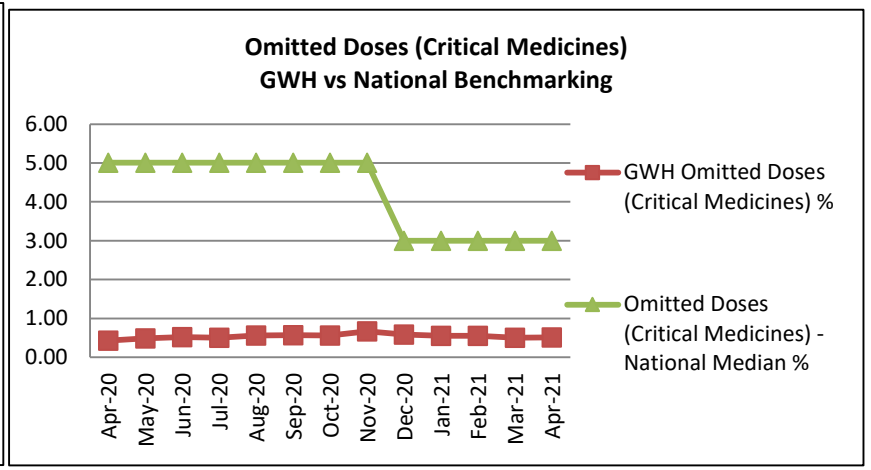
KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
Dementia Assessment (Public View)	86.1% (Feb 21)		61	1	1	Feb 20
C. Difficile (Hospital onset) per 1000 bed days	11.2 (Feb 21)		22	51	37	Feb 21
VTE Assessment	97.3% (May 21)		18	114	1	Dec 19
Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death)	1.3% (May 21)		121	116	76	Dec 20
Hip Fracture Best Practice Tariff – 12 Month Rolling	71.1% (Apr 21)		26	74	3	April 21
Complaints Rates	25.7 (Q4 20/21)		112	32	47	Q2 20/21
Family and Friends Score – Percentage of Positive Responses - Inpatients	79.6% (May 21)		107	49	13	Feb 21
Complaints Response Backlog	0.1 (Q2 20/21)		2	90	59	Q2 20/21
MRSA all cases	0 (May 21)		48	95	69	Feb 21
Falls per 1000 bed days	5.5 (May 21)					
Pressure Ulcers – Acute	34 (May 21)					
Pressure Ulcers – Community	32 (May 21)					
Never Events 20/21	3					
Serious Incidents	2 (May 21)					

2. Medicines Safety

Data Quality Rating:

Are We Safe?





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

Medication Incidents

- The rate of medication incidents and the proportion causing harm remains stable across the year with a small increase in the number of incidents reported in April. This indicates a consistent reporting culture and systems in place that prevents harm to patients.
- Trends Identified in April:
- Incidents related to administration of medicines identified as main theme of incidents in April. This theme has continued from previous month
- 3 incidents leading to moderate harm involving insulin administration in the community

Omitted Critical Medicines

- Percentage of unintended omitted critical medicines (all administrations of medicines) remains consistently low
- Compared to the national median of acute hospital trusts (2020 national benchmarking*), GWH has a lower rate of unintended omitted critical medicines.
*Benchmarking value updated Dec 2020

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

Medication Incidents

- Theme of medicines administration incidents being discussed at a number of professional and quality groups, including Matrons and Senior nurse forums as part of working group development. Intention to explore and capture key areas to systematically reduce errors as part of medicines safety arm of the Great Care Campaign.
- Actions identified to improve the community insulin incidents. The focus of the actions will look at transfer of care issues for patients on insulin, as well as insulin administration training for community staff.
- Medicines incident reporting is taking a priority in the introduction of the Datix system. This will ensure that the system supports accurate data collection on incidents to generate effective actions to improve practice.

Omitted Critical Medicines

- The process for omitted medicines are audited as part of Perfect Ward App. The information has recently been updated and circulated to ward areas which details how to securely order medication out of hours.

Risks to delivery and mitigations

Medication Incidents

No specific risks to delivery identified at this stage.

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

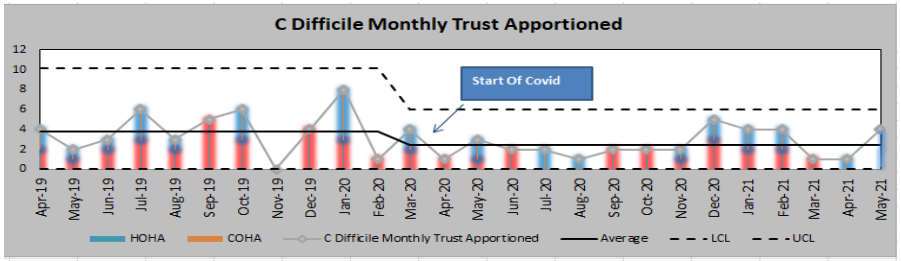
Omitted Critical Medicines

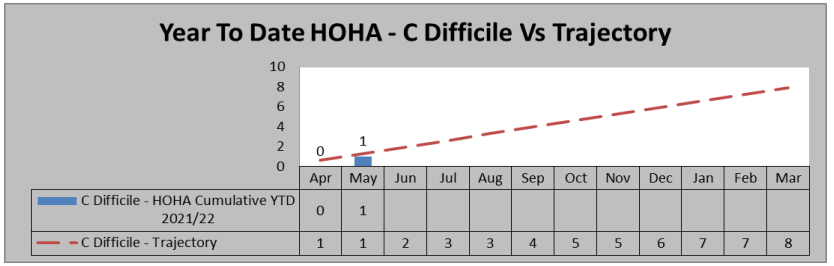
No specific risks to delivery identified at this stage.

2. Patient Safety - Infection Control

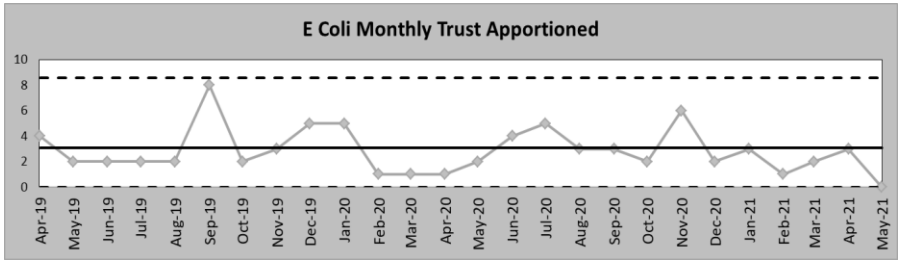
Data Quality Rating:

Are We Safe?





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
C Difficile - HOHA Cumulative YTD 2021/22	0	1										
C Difficile - Trajectory	1	1	2	3	3	4	5	5	6	7	7	8



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

Hand Hygiene	May
Audit Results	98.10%

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

C. difficile – In May there was one Hospital Onset Healthcare Associated infection identified on Mercury Ward.

The Trust reports all *C.Difficile* that we detect as inpatients this includes all those acquired outside of the hospital (community) setting and those within the acute setting.

We have set ourselves and internal trajectory of no more than 2 per quarter for Hospital Onset Hospital Acquired *C.Difficile*.

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

C. difficile - Ribotyping has been requested on all cases of C. Difficile Infection (CDI) within the Trust to give assurance around any cross contamination.

There is conclusive evidence of cross infection between 2 cases on one ward in March 2021 which will be investigated further by IP&C, focussing on cleanliness practices with the ward and Serco. Despite evidence of terminal cleans (cleaning undertaken following patient discharge) being carried out, we plan to instigate an audit process to review quality and compliance with cleaning standards.

There has been no Flu identified over the previous winter, there is concern that Respiratory Syncytial Virus (RSV) in children may be increasing. To date the Trust has not detected any RSV. However, The influenza national reporting system will be kept open this year to assist with on-going surveillance.

Risks to delivery and mitigations

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

This will include developing a terminal clean sign off sheet for clinical staff which sets the standards that are expected to be achieved.

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

52

I Community Onset I Healthcare Onset

2. Patient Safety – Coronavirus

Data Quality Rating:

Are We Safe?

Covid 19	May-21	Apr-21
Number of detected Inpatients	24	22
Number of Deaths in Hospital	1	4
Hospital Acquired Covid-19 Cases*	1	0

Covid-19 (Apr 21 – Mar 22)		(April 20- Mar 21)
Number of detected Inpatients	46	1458
Number of Deaths	5	324
Hospital Acquired Covid-19 Cases*	1	139

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

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

There has been one hospital acquired Covid-19 case during May 2021 identified on day 12 of admission.

The Swindon case rate is currently 14 per 100,000. The South West is 9.3 per 100,000. The England Average has risen to 30.6 per 100,000.

Increased sequencing has now been implemented for all positive COVID tests, which will help provide more detail of variant of interest and concern spread.

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

Continued progress is being made on the Post Infection Reviews (PIR) for the hospital acquired COVID-19 cases. Each of the reviews will feed into the individual ward outbreak reports.

2 metre social distancing and PPE usage remains in place for staff and visitors. Visitors are being supported to have longer stays with their relatives and increased numbers within bays. Guidance is being issued via social media and the Trust website.

Risks to delivery and mitigations

The impact of overseas travel on the current COVID-19 figures may increase admissions of patients with a variant of concern.

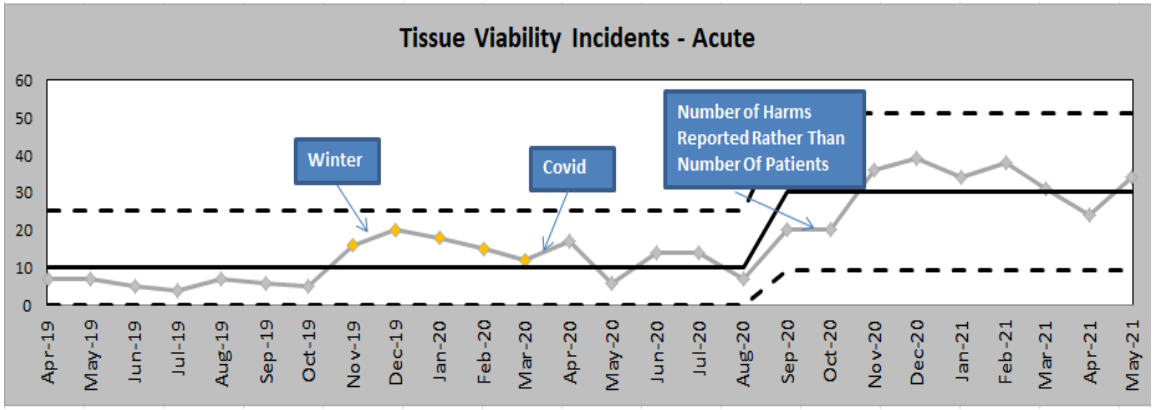
The IP&C Team is reviewing the impact of variants as lockdown restrictions decrease.

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

2. Patient Safety – Acute Pressure Ulcers

Data Quality Rating:

Are We Safe?



Incidents of harms by Category for May 2021:

Category 2 PU	Category 3 PU	DTI	Device related PU	Unstagable	Total Incident of Harms
20	0	6	3	5	34

Number of Patients	Harms per Patient
30	1
2	2

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

Disappointing increase in number of pressure ulcer harms in May 21.

Majority of harm is at Category 2 with a significant increase in number of pressure ulcers to heels (13 incidents in 9 patients).

9 harms relate to ED or Assessment areas which may be due to poor initial skin inspections and/ or documentation on admission.

There were 3 Device related harms due to oxygen / catheter tubing and TED stocking.

Hot spots this month include Woodpecker and Teal.

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

Improved investigation process will be launched in June for all grade 2 pressure ulcers.

June's Safe Skin messages will focus on preventing heel damage / off loading and using the new 'repose wedges'.

Follow up on patients with Deep Tissue Injuries on discharge has been improved in May with bi weekly meeting with community TV team.

Educational training session held May for all ward staff for new Pressure relieving Equipment guidance/ categorisation of Pressure ulcers and mattress inspection. Approx. 60 people attended.

Pressure Relieving Equipment users guides on TV Intranet site –May 21.

Collaborative working with Meldon and Trauma to improve learning outcomes identified from themes. Pressure Ulcer Training booked for Meldon during June.

Areas identified as Hot Spots will have enhanced support with weekly visits and deep dive into themes for improvement.

A deep dive into reporting demonstrated about 10% duplication of harms. Work is on going to improve data collection and reduce duplication to ensure accurate data to drive improvement.

Risks to delivery and mitigations

Incomplete documentation (IR1) and investigation of harm from wards /departments.

This will be addressed by launching the new SWARM investigation process.

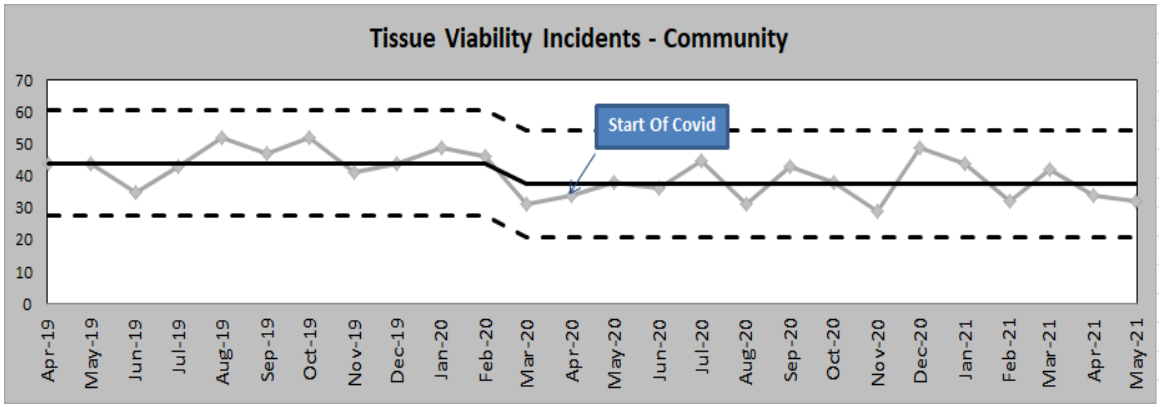
Duplication of IR1 reporting across the patient journey, work is ongoing to address this.

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

2. Patient Safety – Community Pressure Ulcers

Data Quality Rating:

Are We Safe?



Incidents of harms by Category for May 2021:

Category 2 PU	Category 3 PU	Category 4 PU	DTI	Device related PU	Unstagable	Total Incident of Harms
16	10	0	0	0	6	32

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

Numbers broadly consistent with last month.

The lower levels of harm e.g. Category 2 continue to be higher for the second month running representing a faster escalation and reporting of harm with appropriate intervention.

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

Identification of new or deteriorating harm or equipment failure included within Rapid Response Team 2 hour window to improve effective and timely intervention implementing in June 21.

Additional pressure ulcer and equipment training being delivered during June 21 using MS teams.

New equipment ordering process will be completed by July 21 simplifying and embedding process for effective and timely ordering of Pressure Relieving equipment.

Additional training delivered to inductees re the importance of /documentation/wound assessment and image taking - June /July 21

All staff have been asked to complete the new Electronic learning package and compliance is being monitored through the division.

Risks to delivery and mitigations

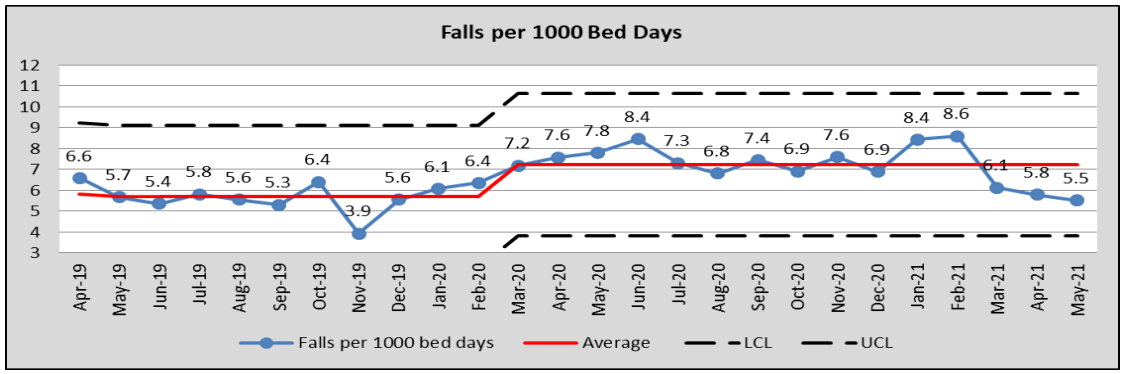
High Bank and Agency staff usage in community nursing increases the risk of incomplete documentation assessment and escalation and inappropriate management of specific pressure ulcers. This is mitigated by the additional training available which temporary staff can attend.

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

2. Patient Safety – Safer Mobility (Falls Reduction)

Data Quality Rating:

Are We Safe?



	Jan 2021	Feb 2021	Mar 2021	April 2021	May 2021
Falls Resulting in No Harm	141	129	104	99	101
Falls Resulting in moderate Harm or above	2	2	2	2	3

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

Over the last three months we have seen a month on month decrease in falls per 1000 bed days, reducing from 8.6 in February 2021 to 5.5 in May 2021.

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

- The 6 project wards are continuing to use the new paper based falls assessment document. Documentation of falls interventions on these wards has improved from 0% in March 2021, prior to implementation of the new documentation, to 84% in June 2021. Further work is being completed with therapy leads to review the functional assessment documentation in relation to falls. Final formatted falls assessment document to be sent to Nervecentre for costing by 18th June.
- Extending work to Linnet to start review of falls assessment and post fall review process.
- The inpatient falls information leaflet has been reviewed and sent for comment to staff, patients, and carers. Feedback has been collated and the leaflet will now be sent for ratification.
- Orchard, Forest and Sunflower identified as the first pilot areas for Royal College of Physicians (RCP)post fall 'hot debrief'. A process where the multi disciplinary team review causes of a patients falls and ensure the appropriate interventions are in place to reduce the risk of further falls. The first PDSA of falls debrief with was completed on 12th May. Process mapping session completed with MDT on 1st June. Anticipated start date 14th June.
- Safer Mobility – falls reduction master class scheduled for 2nd July 09:00 – 12:30

Risks to delivery and mitigations

Patients are presenting with higher levels of de-conditioning in relation to mobility and falls due to the recent national 'lock down'. Increasing demand on the service.

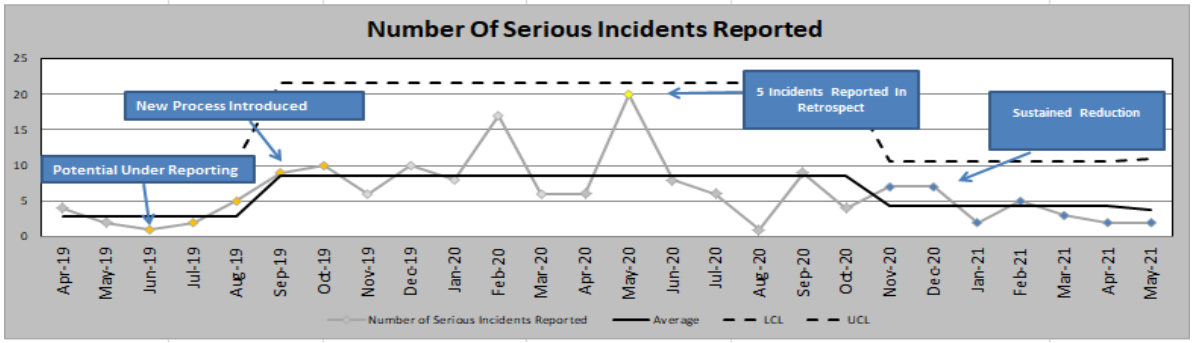
Any delay in transferring the new multifactorial falls assessment onto Nervecentre will delay roll out to remaining wards.

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

2. Patient Safety - Incidents

Data Quality Rating:

Are We Safe?



Serious Incidents Reported			Comparison
Mar	Apr	May-21	May-20
3	2	2	20

Never Events	
2019-20	2020-21
2	3

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

At the time of reporting there is a total of 30 on-going Serious Incident (SI) investigations. However, good progress is being made.

The number of SI's reported has decreased significantly

The overall level of incident reporting has remained consistent.

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

Patient Safety Training and Education

Training and education sessions continue to be delivered including:

- 85 staff receiving Duty of Candour and Just Culture training
- 33 staff received Incident Reporting & Management training
- Participant feedback was positive ranging from 'good' to 'excellent'
- The NHS patient safety syllabus has been released and the Patient Safety Academy (PSA) has been commissioned to provide a Patient Safety Programme to organisations across England & Wales with staff at GWH invited to attend.

Central Alerting System (CAS) Alerts

The CAS disseminates important public health messages and other safety critical information and guidance to the NHS and others. Below is a summary of actions taken against recent alerts

- **Deterioration due to rapid offload of pleural effusion fluid from chest drains** - The Trust WHO Pleural Procedure checklist and Bedside observation chart have both been updated to comply with the actions and guidance.

- **Steroid Management** - relates to all patients with primary adrenal insufficiency, such as those with Addison's disease. A number of actions have been completed including Trust wide communications, Grand Round education sessions, teaching sessions to pharmacy staff, development of guidelines and provision of steroid emergency cards.

Think Allergy, Think Wristband Campaign

The Trust has recently launched the Think Allergy, Think Wristband campaign which aims to increase awareness of incidents relating to allergies and promote best practice across the trust.

Risks to delivery and mitigations

Clinical Risk & Patient Safety Manager has now been appointed, start date end of June. While the post holder receives induction the Lead Quality Governance Facilitator continues to provide support to the incident management process.

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

Data Quality Rating:

Are We Safe?

Apr 2021	Day		Night		Actual Ratio of RN to Care Staff			
					Day		Night	
Ward name	Average Fill Rate - Registered Nurses/ Midwives (%)	Average Fill Rate - Non-registered Nurses/ Midwives (%)	Average Fill Rate - Registered Nurses/ Midwives (%)	Average Fill Rate - Non-registered Nurses/ Midwives (%)	RN	Care Staff	RN	Care Staff
Dove	100.2%	101.7%	99.8%	-	80.2%	19.8%	100.0%	0.0%
Aldbourne	112.1%	60.0%	109.2%	98.6%	65.1%	34.9%	68.9%	31.1%
Ampney	100.0%	79.7%	98.9%	106.7%	54.6%	45.4%	73.6%	26.4%
ITU	91.0%	55.6%	93.6%	124.0%	90.0%	10.0%	89.3%	10.7%
Meldon	103.3%	133.8%	100.8%	102.4%	56.3%	43.7%	56.8%	43.2%
Kingfisher SAU/SAW	97.7%	82.4%	98.5%	95.0%	54.2%	45.8%	56.4%	43.6%
Trauma Unit	97.8%	110.1%	98.5%	120.3%	47.0%	53.0%	45.0%	55.0%
ACU	95.4%	143.9%	99.1%	162.8%	72.6%	27.4%	64.6%	35.4%
Falcon	115.6%	134.1%	115.8%	106.7%	56.4%	43.6%	76.5%	23.5%
Jupiter	104.5%	105.6%	103.3%	105.1%	49.7%	50.3%	49.6%	50.4%
LAMU & Shal MEU	98.1%	90.7%	104.8%	109.1%	58.9%	41.1%	62.7%	37.3%
Mercury	94.0%	114.4%	99.1%	118.4%	50.7%	49.3%	52.7%	47.3%
Neptune	96.1%	91.9%	95.0%	117.9%	54.9%	45.1%	49.2%	50.8%
Saturn	105.0%	124.1%	106.7%	100.8%	53.0%	47.0%	51.4%	48.6%
Teal Wards	98.9%	75.4%	102.6%	153.6%	56.7%	43.3%	47.7%	52.3%
Woodpecker	96.2%	107.3%	107.8%	117.2%	47.3%	52.7%	47.9%	52.1%
Beech & EPU	99.7%	101.0%	100.0%	127.5%	59.7%	40.3%	43.9%	56.1%
Childrens	109.6%	28.4%	302.2%	73.2%	82.8%	17.2%	87.0%	13.0%
Hazel, Delivery & WHBC	83.4%	69.1%	86.3%	84.9%	72.5%	27.5%	76.5%	23.5%
SCBU	93.2%	70.0%	84.2%	76.8%	86.9%	13.1%	84.6%	15.4%
Forest Ward SWICC	94.9%	113.5%	93.9%	151.8%	33.9%	66.1%	38.2%	61.8%
Orchard Ward SWICC	89.7%	126.5%	100.0%	160.2%	43.6%	56.4%	38.4%	61.6%
Sunflower	121.4%	100.2%	120.0%	110.0%	37.7%	62.3%	42.1%	57.9%
Overall Total	97.0%	94.4%	101.3%	114.5%	59.3%	40.7%	60.3%	39.7%

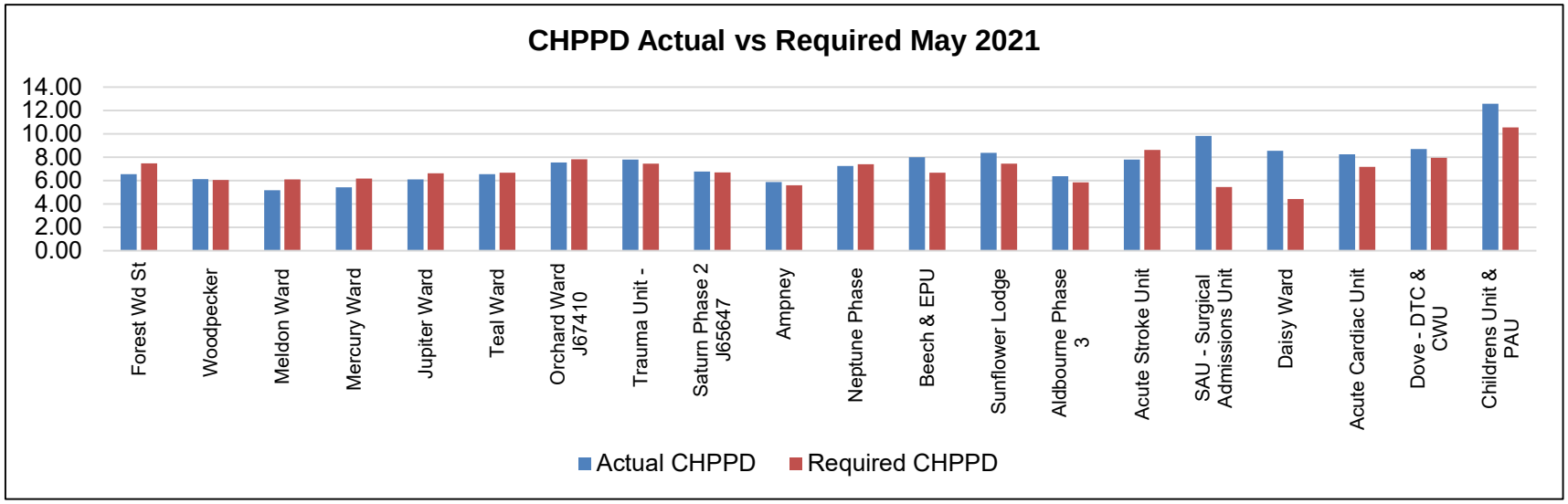
It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board. High level figures are provided here. The data is reported against Registered Nurse (RN) and Unregistered Nursing Assistant (NA) shifts

- Work has been completed to improve the accuracy of this reporting with robust sign off process. This data is uploaded on UNIFY for NHS Choices and is publically available.
- The combined figures for GWH show a Registered Nurse fill rate of 97% for day shifts and 101.3% for night shifts and for Unregistered Nursing 94.4% for day shifts and 114.5% for night shifts.
- Areas flagging red or over establishment are reviewed by the DDONs and narrative is included in submission. No care or quality concerns have been raised. Areas are monitored through the daily staffing process and supplemented where required. Ampney, Albourne, and Kingfisher average fill for unregistered staff during the day shift is due to intermittent reduced occupancy or acuity. ICU only have 1 HCA per shift and will not routinely replace short term gaps such as sickness / annual leave due to specialist skills required.
- Health Care Assistant recruitment has been successful and these fill rates should improve next month.
- Midwifery staffing is 83.4% fill rate for registered staff during the day shift due to vacancy, an active recruitment plan and mitigations are in place.
- Areas showing over 100% are related to enhanced care or RMN usage. This is an area of focus for improvement, including the RMN reduction plan.
- The Registered to unregistered ratios are within national guidance.

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

Data Quality Rating:

Are We Safe?

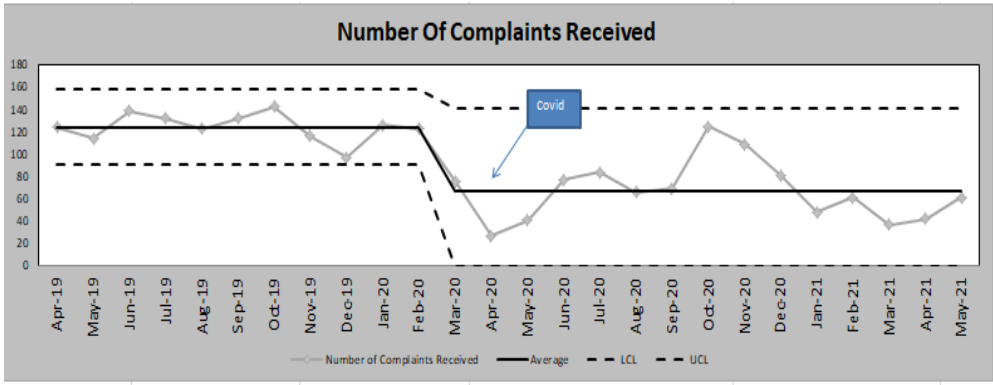


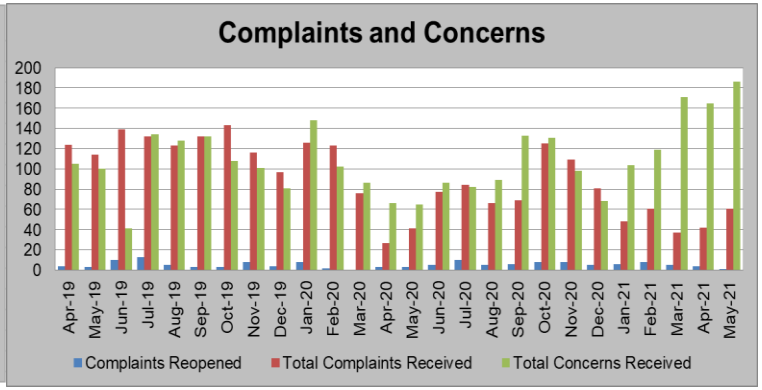
- This chart shows the Care Hours per Patient Day by Area for May 2021 actual vs required
- All areas above or below required hours are reviewed by DDON and Deputy Chief Nurse,
- Work is ongoing to review the accuracy of the data when patients require RMMs e.g. the children's unit which then flag as excess CHPPD.
- The acuity of patients is measured three times daily at ward level. The Safe Care data is triangulated with numbers of staff on shift and professional judgement to determine whether the required hours available for safe care in a ward/unit aligns with the rostered hours available. Staff will be redeployed between clinical areas and Divisions following daily staffing meetings involving all Divisions, to ensure safety is maintained in wards/areas where a significant shortfall in required hours is identified, to maintain patient safety
- The data on AMU and ICU is not included as further analysis is required.
- There has been successful recruitment , currently have 56 band 5 vacancies with 26 in the Trust about to gain their NMC registration and a pipeline of 96 with start dates (including the students expecting to start Sept / Oct). This is a very positive position to enable the Trust to recruit to turnover and meet the trajectory of 0 Band 5 vacancies by December 2021.
- Recruitment from Red Countries, such as India, has currently paused but the Trust is working with the agencies to ensure recruitment from other countries as well as supporting staff already in the UK to pass the OSCE and gain NMC registration.
- The intensive Health Care Assistant recruitment has been successful to significantly reduced vacancies and there is now a on-going recruitment plan to cover turnover and maintain a 0 vacancy position.

2. Patient Experience - Complaints and Concerns

Data Quality Rating:

Are We Safe?





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

61 complaints (previous month 42) and **186** concerns (previous month 165) were received in May 2021.

Out of a total of **247** cases received from Complaints and Concerns in May, the overall top three themes were:

Themes	Total	Complaints	Concerns
Behaviour/ Attitude	35 (15%)	13	22
Clinical Care:	31 (12%)	14	17
Communication	31 (12%)	2	29

Complaints: **61** complaints were received, 61 were rated as (Low – Medium), there were no cases which had been rated as High to Extreme.

Response rates: Response rate of **84**%. **62**% of concerns were resolved within 24 hours, **86**% were resolved within 7 working days (KPI 80%).

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

Behaviour/Attitude

Following the successful "Friendly February" focus on civility in ED, the team are supporting and sharing their experience across the organisation to help spread the learning. The focus of this work is staff civility, professional behaviours and manners. This is linked with the development of a "Just Culture" related to professionalism and a culture where "disruptive behaviours" are unacceptable. The Senior leadership Forum had a presentation from an external expert in the field as part of this programme of work.

Clinical Care

On reviewing the Clinical Care theme, many of the issues identified relate to relatives being unhappy with the care of a family member as an inpatient. There are various work streams underway which will identify and realise improvements:

- Telephony improvement project – to improve communication with relatives. Extremely positive feedback received following dedicated phone line trial on Teal ward. Assessment underway to identify requirements for roll out to other wards.
- Great Care Campaign was launched in May and will focus on improving several key areas of patient centred care. This work will link into the Personalised Care work stream focusing on hydration/nutrition and patient hygiene.
- Further real time and peer review auditing has been introduced by the Matron team to identify and address any issues at the time .
- A Volunteer is supporting real time 'Care Conversations' which covers 8 of the Trusts worst performing questions from the Inpatient Survey and includes questions such as did you get enough help to wash?, how clean would you say the ward is? and how would you rate the hospital food? providing valuable qualitative feedback.
- New resources have been purchased to support patients with Dementia on our department of medicine for the elderly wards.

Risks to delivery and mitigations

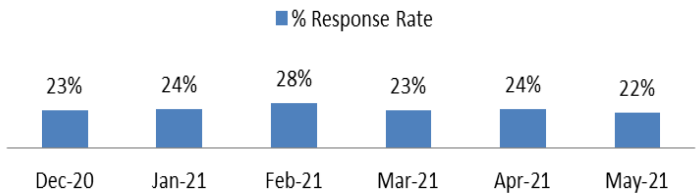
The risk of current provider giving notice has been eliminated as the Icasework contract has been extended until September 2021. The planning is in place for the Datix complaints module to be in place by September.

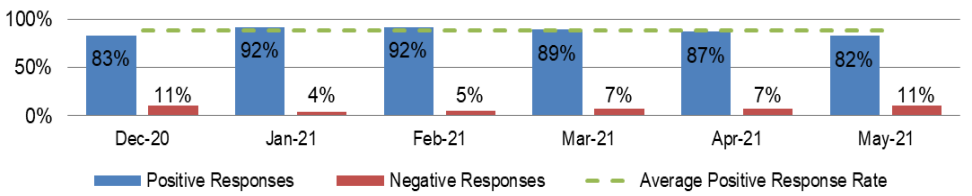
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

2. Patient Experience – Friends and Family Test

Data Quality Rating:

Are We Caring?





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

For May, 82.42% of the Friends and Family Test responses were positive, (previous month 87.1%). This is based on the % of responses rated as 'very good' and 'good'.

This was achieved by:

	Number of Text sent	Number of Responses	Positive Responses
ED	4008	846	73.88%
Inpatients	2686	748	79.68%
Day Cases	2103	674	94.96%

(correct as of 2th June)

The Friends and Family card has now been reintroduced into all areas, complemented by text messaging in ED, Inpatient and Day case areas.

Collection of cards by the PALS team has been reinstated ensuring that cards are sent to the FTT service provider for scanning in a timely manner. This allows for monthly divisional/individual service area reports to be produced. Results will be displayed on patient FFT noticeboards throughout the trust.

Roll out to maternity is planned for July. Outpatient testing complete and will be rolled out once financial sign off agreed.

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

Overall Positive themes for May :

- **Staff Attitude** 1021 comments (previous month 909).
- **Implementation of Care** 689 comments (previous month 637).
- **The Environment** 525 comments (previous month 459).

Overall Negative themes for May :

- **Staff attitude** 210 comments (previous month 126 comments).
- **The Environment** 180 comments (previous month 111 comments).
- **Waiting Time** 165 comments (previous month 100)

With a designated FFT Coordinator now in post the following work will be carried out throughout June:

- Improvements to the Trust website feedback pages making it clearer for patients to leave real time FFT feedback.
- Promotional material in the form of posters and display banners are being produced. These will be distributed to all areas throughout June/July, raising awareness on how patients can leave feedback together with the promotion of the importance of responding to FFT texts when received.

Risks to delivery and mitigations

Text messaging for Outpatient areas has been delayed due to additional funds required outside of the agreed contract.

Testing has taken place and a "go live" date will be agreed with the provider once financial sign off has been granted.

2. Patient Safety - Perinatal Quality Surveillance Tool April 2021

Data Quality Rating:

Are We Safe?

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

<table>
<tr><th>Measures</th><th>Comments</th></tr>
<tr><td>Minimum safe staffing in maternity to include Obstetric cover on delivery suite</td><td>
<table>
<tr><th>Measure</th><th>Aim / Target</th><th>March 2021</th><th>April 2021</th></tr>
<tr><td>Midwife to birth ratio</td><td>1:29</td><td>1:27</td><td>1.28</td></tr>
<tr><td>1:1 Care</td><td>100%</td><td>97.7%</td><td>98.3%</td></tr>
<tr><td>Consultant presence in Delivery suite (Hours per week)</td><td>60 (Hrs.)</td><td>57 (Hrs.)</td><td>60 (Hrs.)</td></tr>
</table>
</td></tr>
<tr><td>Service User feedback</td><td>To strengthen our feedback opportunities a QR code with a link to the friends and family section on the Trust website is in progress with the PALS department. In addition, the link will be added to the monthly birth info graphics on the Trust social media site requesting users to complete. Two written complaints have been received via PALS this month concerning delay/postponement of planned C-sections. Investigation into reasons why is in progress.
The Trust continues to have a valuable collaboration with the Maternity voices partnership (MVP). MVP representatives has been invited to attend the Maternity Clinical Forum to ensure that service user feedback can be heard effectively to guide developments in the service. Maternity text message for Friends and Family Test is planned waiting for confirmation of date to go live from the company /PALS</td></tr>
<tr><td>Concerns or requests for actions from national bodies</td><td>Ockenden action plan has been produced and is monitored through both Maternity and Divisional Governance meetings. All evidence against the 7IE standards must be submitted via the national portal by 30th of June. We are on target to comply with this timeframe.</td></tr>
<tr><td>CNST 10 Maternity standards (NHSR)</td><td>CNST progress update will be provided at Executive Committee on 15nth June .Final evidence against all 10 standards will be presented at the weekly Executive and Trust Board prior to final sign off by the Chief Executive and submission on the 15/7/21. An action plan for compliance with Safety Standard 6 is required as this requires implementation of a mandatory annual study day focussing on fetal surveillance in labour, to include a competency based assessment.</td></tr>
<tr><td>Staff feedback from frontline</td><td>Concerns being addressed by Senior Team and regular meetings set up to provide an effective voice for staff. Staff have been updated on actions taken to mitigate staffing shortfall issue which was raised by staff. A meeting is arranged with staff on 16th June to discuss further. Chief Nurse in her role as Exec Maternity safety champion attended the perinatal safety huddle on the 27/5/21 which gave staff the opportunity to raise any issues staff may have.</td></tr>
<tr><td>CQC ratings</td><td>Overall Good in the 5 domains (2020)</td></tr>
<tr><td>Maternity Safety Support Programme</td><td>Not required as CQC ratings overall ‘Good’</td></tr>
<tr><td>Findings of review of all perinatal deaths using the real time data monitoring tool</td><td>None</td></tr>
<tr><td>Coroner’s Regulation 28</td><td>Nil</td></tr>
</table>

2. Patient Safety – Summary of Incident Investigations

Data Quality Rating:

Are We Safe?

Moderate Harm Incidents	
Measure	**Comments**
Number of incidences graded moderate or above and actions taken	Unexpected birth of baby at 23/40. Baby stabilised and transferred to local neonatal unit for retrieval by Newborn Emergency Stabilisation and Transport Team. During siting of umbilical venous catheter baby suffered chemical skin damage. Immediate learning identified: • Inappropriate concentration of cleaning solution used from bottled source, that may have resulted in an excess being used and pooling under the baby. • All bottles of solution removed immediately. • 2 concentrations of solution appropriate for gestation now in use in sachets/wands to limit the volume. These are contained in lidded boxed with safety warnings • Case to be investigated via Trust Risk Management Strategy
	Patient swab result not followed up, which required treatment and may have contributed to the onset of preterm labour 6 days later. Immediate learning identified: • Process map of current system has identified weaknesses with current system • SOP planned to provide an effective system to follow up results, with failsafe measures

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

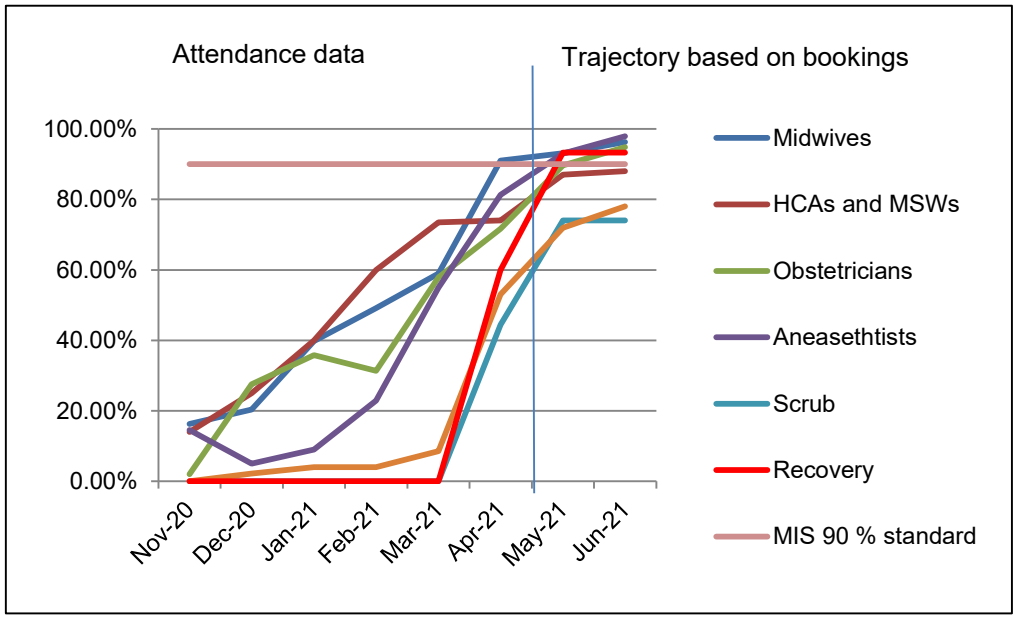
Serious Incidents (SI) Reported In Month			
Case ref	**Overview**	**Date**	**Case update**
156997	Chemical skin damage described above	**06/05/2021**	**Under investigation**

On-going SI investigation update			
Stage of investigation	**March 2021**	**April 2021**	**May 2021**
Referred to HSIB awaiting decision	1	1	1
Under local investigation	3	2	1
Under HSIB investigation	0	1	0
Report complete awaiting Serious Incident Review Learning Group (SIRLG)	0	1	1
Submitted to CCG	2	5	5

Maternity – Prompt Training Update Including a Trajectory

Data Quality Rating:

Are We Responsive?



Staff group	Total number	Trajectory number to complete training	Number of additional people required
Midwives	190	183	NA
Obstetrician	39	37	NA
Anaesthetist	43	42	NA
Scrub staff	27	20	5
ODPs	47	37	6
Recovery	15	14	NA
HCAs and MSWs	54	48	2

Background and underlying issues

Background and underlying issues

In July 2019 we achieved Action 8 of the Clinical Negligence Scheme for Trusts safety actions (CNST)– 90% compliance for all staff groups attending face to face multi-disciplinary skills and drills training (PROMPT) day.

Face to face MDT training cancelled Feb 2020 onwards due to COVID restrictions. All training time revoked.

From December 2020 weekly online PROMPT training offered to all staff groups.

90% compliance target removed from CNST standards for 2020/2021 compliance

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

Compliance in three groups will not meet deadline based on trajectory of bookings. Escalated by Divisional Director of Nursing and Midwifery and overtime offered. Training team have moved 2 dates to help theatre staff attendance. Practice Development Midwifery team will inform leads of those not booked on to follow up to improve compliance.

Paediatric doctors and neonatal nurses required to attend NLS update, 1 session provided by Practice Development Midwifery team was sufficient to meet this.

Maternity staff are required to complete additional maternity specific training which at present is not captured on electronic staff record (ESR).

Risks to delivery and mitigations

Staff not being released for training due to staffing pressures and high levels of shortages, some staff have been rebooked twice due to this. Some HCAs need to be rebooked following shielding as had no IT access, managers to chase.

Midwives are given 12hours paid training time versus 80 hours required to complete all training requirements.

Whilst 90% compliance is not mandatory for CNST compliance this financial year and therefore does not have a financial implication, it is anticipated this will be required for compliance in the next financial year.

Great Western Hospitals NHS Foundation Trust

Part 3: Our People

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Resources

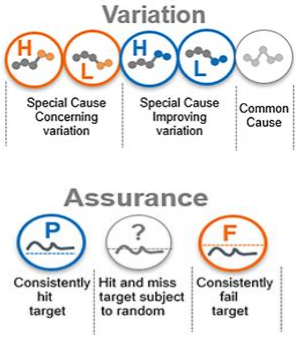
Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

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

Summary Dashboard - Workforce Performance

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Overall Agency Spend as a % of Total Spend			5.39%	6.00%	3.92%	7.33%	5.63%
2	Trust RN Bank Fill Rates			61.00%	70.00%	36.27%	60.10%	48.19%
3	Vacancy Rate*			6.80%	7.63%	5.76%	8.66%	7.21%
4	Recruitment Time To Hire (Days)			44.50	46.00	30.00	57.62	43.81
5	All Turnover			14.41%	13.00%	12.18%	13.56%	12.87%
6	Voluntary Turnover			8.10%	11.00%	9.04%	10.04%	9.54%
7	All Sickness Absence			3.45%	3.50%	2.95%	4.80%	3.88%
8	Statutory Mandatory Training Compliance			83.81%	85.00%	84.23%	88.92%	86.58%
9	Appraisal Compliance			82.25%	85.00%	71.77%	82.13%	76.95%



Trust Overview: Narrative

Great Western Hospitals NHS Foundation Trust

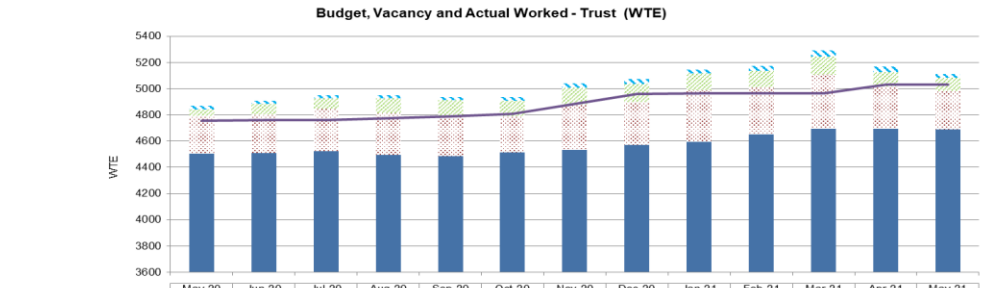
"Great" Scoring	Indicator Score (1-4)	Self Assessment Score	Headline
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding			
Great Workforce Planning	3	3	May saw an increase in the Trust vacancy rate, maintenance of an improved overall bank fill rate and a slight increase in the proportion of total workforce spend on agency. The increase in vacancy rate is due mainly to the injection of additional budgeted WTE, though despite this the vacancy rate remains inside of Trust target. May also saw a small increase in the proportion of total pay spent on agency, though the increase was marginal and the spend encountered fell within target, whilst a total of 35WTE less temporary workforce resource was actually utilised in May compared to April. Performance in May is therefore on a par with the previous month and for the second successive month rated as "good" overall.
Great Opportunities	2	3	In M2 the recruitment time to hire metric continued to improve and is achieving below the Trust target at 44 days from vacancy advertised to contract of employment. Appointment for Medical Director and Chief Operating Officer completed. There continues to be a sustained improvement in voluntary turnover reliably achieving below the 11% target. In May the Trust vacancy position slightly increased 6.70% (337.16 WTE) and performance for all turnover increased to 14% above target.
Great Experience	2	3	Sickness reported in April 2021 is 3.45% just below the target of 3.5% for the Trust. As evident from the SPC chart this is also below the average performance for the Trust (just below 4%) since April 2018, demonstrating a good level of sickness absence for the organisation. The variation in month is not significant (3.48% for March) as seen by the SPC chart symbols and comparatively is lower to the previous year (4.72%) when COVID sickness absence began to emerge across the Trust (April 2020). Of note the highest rate of sickness across the Divisions is in Surgery, Women's and Children's at 3.94% and the lowest within Corporate Services at 1.96%.
Great Employee Development	2	3	HEE CPD funding for nurses, midwives and AHPs for 2021/2 has been confirmed as £632,000 – and will be distributed in 2 payments over the financial year, the first in Q2 of this financial year. Detailed work already underway to ensure the trust is ready to submit our 21/22 CPD investment plans to HEE by 31th July 2021. The mandatory training project has successfully completed, achieving the transfer from Training Tracker to ESR by 31 May 2021. The new system went live on the 1 June and will improve the timeliness and accuracy of reporting.
Great Leadership	2	2	There has been a slight decrease in mandatory training rates-but this was expected due to the system change over which required some down time. Appraisal rates remain broadly stable. The HEE CPD investment for 2021/22 is significant . The in house provision of leadership activity is now more comprehensive, with provision in place for Bands 4-8a. The Trust continues to work with the Leadership Academy to track the reintroduction of programmes for more senior staff and with BSW to scope opportunities for collaborative leadership development activity.

Workforce

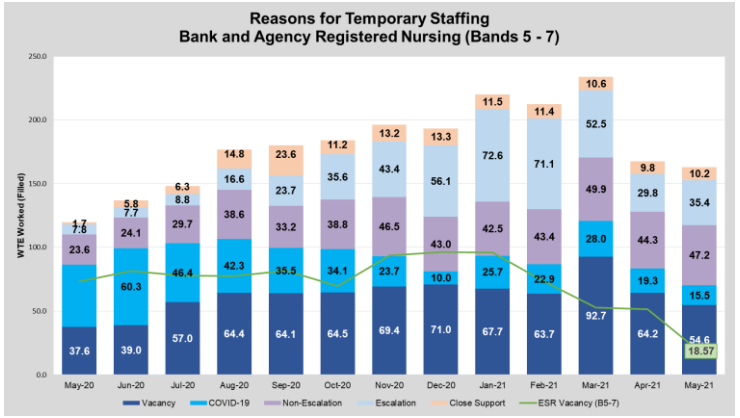
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
3	3



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Overtime WTE - Trust	29.83	24.57	24.83	24.23	25.95	28.71	31.11	37.78	31.46	40.12	45.04	44.43	31.18
Agency WTE - Trust	49.89	81.95	79.55	113.18	124.78	116.15	128.13	134.66	127.90	121.50	140.44	106.52	97.74
Bank WTE - Trust	288.87	293.17	321.94	318.66	299.75	278.58	345.51	326.34	391.31	362.41	413.49	323.09	296.99
Staff in Post WTE - Trust	4502.55	4509.84	4523.92	4493.39	4485.93	4511.75	4534.92	4572.71	4596.13	4650.22	4692.14	4694.94	4686.97
Budget WTE - Trust	4756.17	4759.73	4759.74	4775.33	4790.26	4806.92	4882.90	4960.19	4962.71	4962.76	4962.76	5028.93	5028.93
Vacancy WTE	253.62	249.89	235.82	281.94	304.33	295.17	347.98	387.48	366.58	312.54	270.62	333.99	341.96



Background

The Trust utilised 5112WTE staff to deliver its services in May '21, a decrease of 56WTE on the previous month though still 84WTE in excess of budgeted WTE. Notably there was a reduction in both bank and agency utilisation in May, with both reaching their lowest levels since Oct '20.

The Trust vacancy rate increased to 6.80% (341WTE) in May, due in part to a net 8WTE reduction of staff in post. May also saw the addition of 66WTE to the budgeted establishment (rolled back to M1 data), with this additional budgeted WTE most evident across Nursing and Medical workforce in Surgery, Women's & Children's and the Scientific and Nursing workforce in Unscheduled Care.

Community Nursing continues to be the highest exponent of temporary workforce resource, due to the on-going approval to secure up to an additional 20 registered nurses per day, as a measure to cope with additional community nursing demand and avoid hospital admissions. Funding for this additional activity has been agreed until September 2021. Remaining departments of high temporary workforce use include General Medicine and ED where vacancy gaps remain key drivers.

Improvement actions

1. A detailed review of medical workforce vacancies has emerged as an initiative arising from the recently established Unscheduled Care Improvement Board, resulting in scrutiny and subsequent development of plans for every vacancy. The plans include refreshed approach to recruitment and alternative workforce transformation such as the introduction of ACPs to replace Junior Doctor gaps. The latter initiative is based on the established and successful deployment of ACPs in Trauma and Orthopaedics and leading the 'Hospital at Night' support. The improvement board is reviewing this as a resource option for Acute Medicine.

2. Divisions are leading on clinical strategies and HR Business Partners are working alongside this work to develop workforce plan.

3. With a lack of system capacity evident in respect of paediatric mental health demand, work is underway with system partners to improve pathways, create system capacity and mitigate Trust paediatric mental health related spend

4. To address long term recruitment difficulties in Podiatry, a rotational post has been introduced stretching across both podiatry and community nursing, creating the ability to develop podiatry expertise from within and the versatility to straddle both domains

Risk to performance and mitigations

As the Trust moves into recovery phase and the development of the operational plan 21/22, increase (unfunded) activity to deliver recovery is likely to impact workforce costs through the use of temporary resource.

An ageing workforce risk has been identified in Maternity, which may be compounded by the need to work with significantly greater flexibly due to implementation of 'Continuity of Care. The latter is mitigated by phased implementation, whilst a recruitment and retention plan is under development to mitigate the retirement risk itself.

Hard to recruit Consultant medical roles are recognized nationally and whilst a project approach is being adopted to target this, there is a possibility that a relative dearth in workforce supply will result in only a marginal impact.

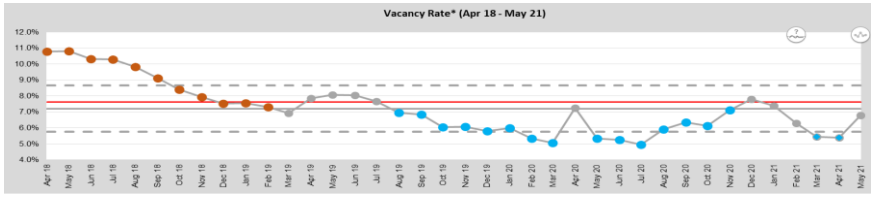
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

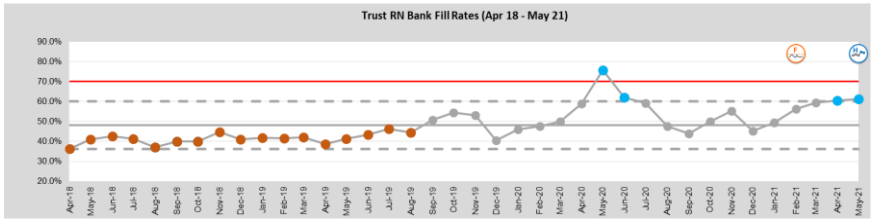
Workforce

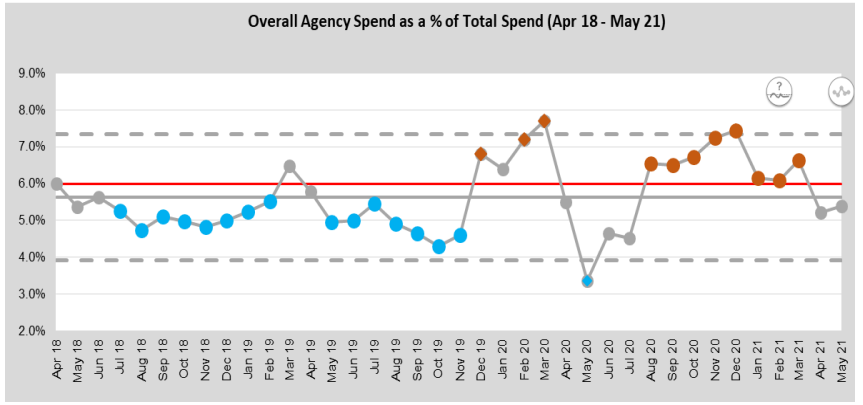
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
3	3







Background

The Trust vacancy rate increased to 6.80% from 5.45% in May, due mainly to the 66WTE increase in budgeted establishment. The vacancy rate equates to 341WTE vacant posts, with Unscheduled Care (9.95%/163WTE) holding a large proportion of this. The Nursing vacancy rate remains low overall (2.81%/64.83WTE), whilst Medical & Dental (6.43%/43.58WTE) and Scientific, Technical & Therapeutic (13.09%/61.44WTE) vacancy levels have increased, due to additional budgeted WTE.

Registered Nursing bank fill rates in May were 61% virtually mirroring April's performance and maintaining the positive trend overall, relative to the 13 month average of 55%.

Agency spend as a proportion of total pay in May was 5.39%, which was slightly higher than April's 5.23%, though within target and continuing the recent trend of improvement. Agency spend was driven mainly by Medical Workforce at £747k (12.20% of staff group total spend vs. 11.53% previous month) and Nursing £295k (3.38% of staff group total spend vs. 4.06% previous month).

Improvement actions

1. Increasing temporary staffing resource remains a priority and in-month successful recruitment has included 7 Registered Nurses (acute and community) and 22 Health Care Assistants. In addition, temporary workforce supply has significantly increased since 1st April with the addition of 429 bank assignments for existing staff, including 138 Registered Nursing and 123 Registered Midwifery.

2. Further to the introduction of the Preferred Supplier List (PSL) in April '21, dashboard information has now been standardised for use at Senior Nursing Team and PSL meetings, creating an improved level of scrutiny and ability to identify improvement opportunities.

3. Obs & Gynae medical staffing migration to E-Roster is now complete and through improved and much earlier sight of staffing gaps, has created the ability to flex workforce cover and avoid temporary workforce spend. ED are the next department scheduled for implementation in July 2021.

Risk to performance and mitigations

The availability of temporary staffing resource across both bank and agency is limited dependent on speciality and demand. The Temporary Staffing team monitor the fill rate with Senior Leads to ensure appropriate escalation for cover is in place where necessary, whilst bank recruitment remains ongoing.

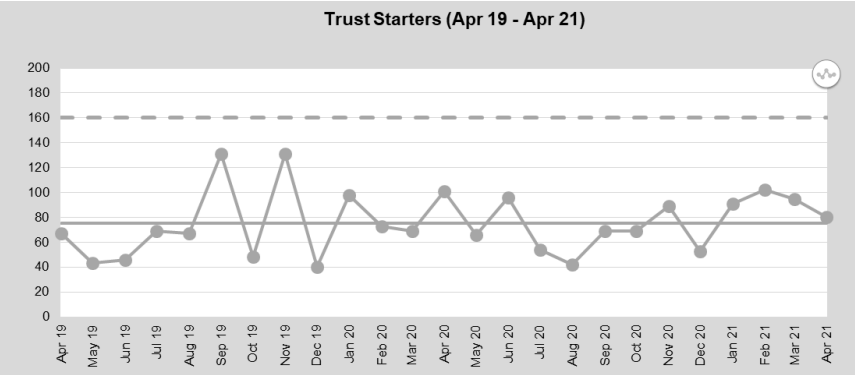
There is a risk that despite improvements in the vacancy position that temporary workforce spend continues above establishment. Avoidance of this is reliant on effective divisional roster based controls being in place. In the absence of an E-roster system for medical staff, control of the risk is dependent on non-automated excel spreadsheets for managing planned activity which provides limited oversight of utilisation. Some degree of mitigation is provided by a web-based locum resource system with timesheet platform.

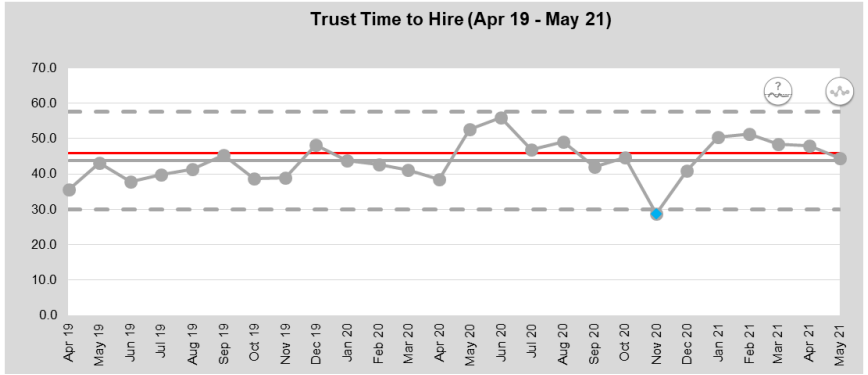
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	3





Background

The number of Trust new starters in April was 80, as shown on the SPC chart and this is above the Trust average of 75.

The Trust has 64 candidates to date across all staffing groups due to commence employment in June.

The recruitment time to hire in May was 44.5 which as shown on the SPC chart is now below the Trust target of 46. Comparatively this is also lower than the previous year (52.6) and demonstrates continuous improvement from February to May 2021.

Improvement actions

1. Maternity Services have seen a high withdrawal of candidates post offer / close to starting. A recruitment and retention plan is being developed in June which will include interventions to reduce turnover and maximize the retention of new recruits. In addition to this international recruitment for midwives will also be explored.
2. Surgery, Women's and Children's division is exploring short, medium and long term workforce interventions to support the theatre recovery plan, these include; introduction of B4 Scrub Practitioners (unregistered), international recruitment campaign for ODP and Anesthetics Nurses, apprenticeships schemes for Theatre Support Workers and offering a return to practice programme.
3. The Podiatry department have extended their scope to support students from Brighton, this new initiative will increase the pool of graduates entering the Trust and support the process of an integrated community podiatry service working across community nursing and podiatry.
4. Integrated Community Care are implementing the 2 hours Urgent Community Response (UCR). The workforce plans are being developed with a recruitment campaign to be created to support the appointment of the required new posts.
5. A new Clinical Coding Apprenticeship role has been created and will be launched in September.
6. Appointment for Medical Director and Chief Operating Officer completed. Chief Digital Officer (shared role with Salisbury) will commence in June.

Risk to performance and mitigations

The pause on international recruitment of nurses from India remains in place. We haven't seen an immediate impact on pipeline and are working with our agencies to increase to 20 recruits per month to utilise the part funding for government accommodation.

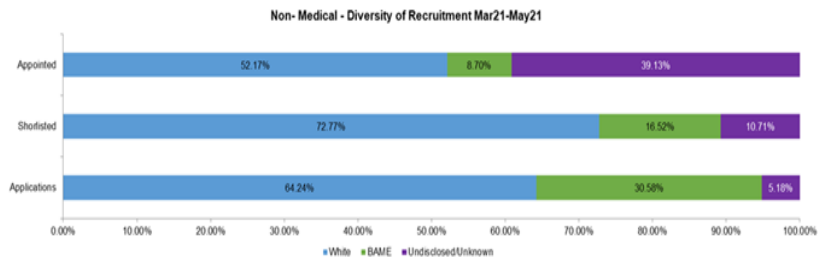
Due to the National increase in overseas nurse recruitment there has been a delay on the time taken for nurses who have passed OSCE to receive their NMC Pin. This has been escalated to the NHSE/I National team and it has been confirmed that the NMC will ensure all candidates receive there pin with 10 days. Should staff receive delays over this time period an escalation route has been provided for Trusts to use.

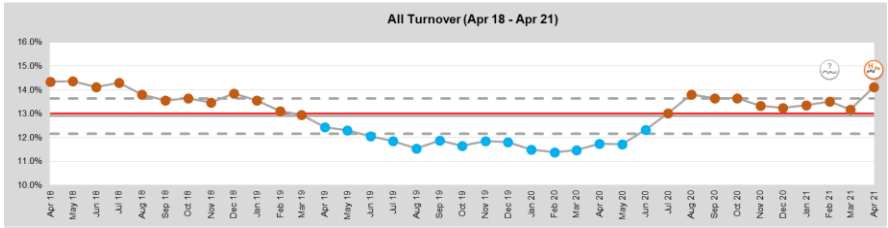
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

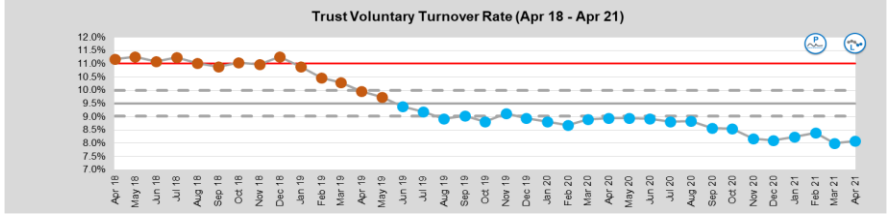
Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	3







Background

EDI continues to be monitored throughout the recruitment process. For Non-Medical recruitment within the period March – May 2021, of a possible 16% BAME applicants shortlisted, 30% of staff were appointed and of a possible 10% other/undisclosed applicants shortlisted, 5% of staff were appointed.

Performance for all turnover has increased in April to 14.11%, above Trust KPI of 13%.

There has been a sustained significant improvement in voluntary turnover since 2019, as shown by the SPC chart icons. The SPC chart icons also identify that the Trust will reliably achieve the 11% target each month.

Improvement actions

1. Managers from across the divisions attended the BSW Flexibility Workshop held on 12th May where participants discussed workforce flexibility including maximizing benefits, overcoming barriers and agreeing system wide actions to take forward. Participants will be feeding back to each of the divisions at Divisional Board and take forward local actions.

2. Following USC review into the divisions leaver data it has highlighted there is a significant gap of leavers completing leaver questionnaire or exit interviews. The HR team are working on a one-pager document to support managers with the leaver process to ensure that staff are encouraged to complete to allow the Division to assess the reason/trends for leavers.

3. The Trust will be attending the following recruitment events;
   - Swindon Pride 6th – 8th August 2021
   - Adult Transitions Roadshow, 22nd September 2021

4. The annual Prague Recruitment event has taken place virtually in May 2021, this year there were over 100 individuals that attended our talk about the Trust and the opportunities we offer to F1 level doctors. This resulted in over 40 applications being received for just 11 posts, of this 20 candidates have been shortlisted with interviews scheduled to occur in mid June. This recruitment event will enable the Trust to fill all F1 level roles for August 2021. This successful yearly event continues to see a number of candidates staying on for further years in the Trust which is where the real benefit is seen by maximising the vacancy fill rate at SHO level.

Risk to performance and mitigations

EDI reporting remains inaccurate for Medical appointed candidates. An overhaul of the recruitment process for inputting on TRAC and additional training was provided to the team in May and June. A review of candidates appointed between March – May 21 is underway to ensure the data is accurate going forward. The EDI for non-medical staff will be corrected and reported for June data.

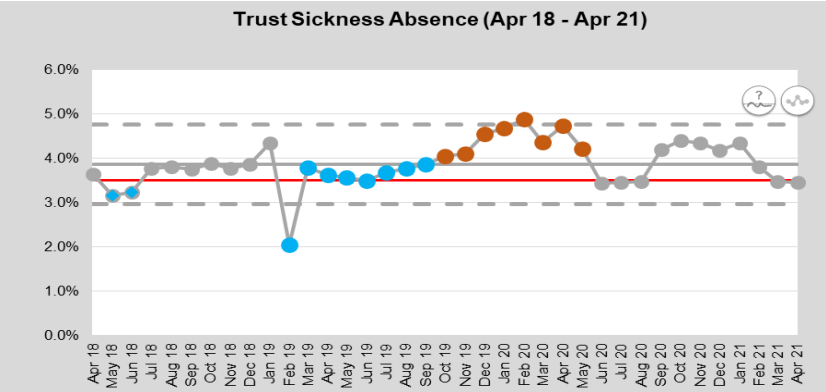
Close monitoring of turnover as we move into recovery. The NHS is expecting an increase in turnover levels post pandemic.

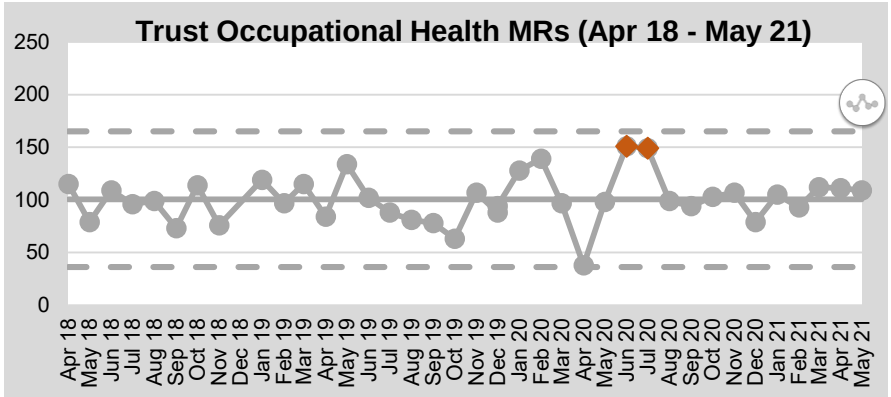
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	2	3





Background

For April 2021, sickness absence is reported at 3.45% which is below the Trust average of 3.9%, following seasonal trend for this time of year and Trust target of 3.5%.

OH received 109 management referrals in May. Main reasons for referral were regarding mental health, musculoskeletal and skin-related difficulties, in addition to sickness absence management.

COVID -related referrals have significantly reduced.

Improvement actions

1. The new band 5 nurse started at the beginning of the month and is trained to run the OH clinics. The physiotherapy vacancy was advertised and shortlisted applicants will be invited for interview in June. An additional weekly clinic has been provided in May by one of the mental health practitioners.
2. Meetings across departments regarding the annual flu campaign started in May, and plans are being formulated to manage this (i.e. Plan A if this will be a separate vaccine or Plan B if this will be in combination with a COVID booster) – clarity regarding this is expected in July.
3. The conversion of a Commonhead room into an OH clinic room will now start on 14th June, and is expected to be completed within the week. Alternative clinic room space is being looked into so that OH clinics can continue to run in the interim.
4. Refresh of Health and Wellbeing KPI's are underway and will be implemented in July.

Risk to performance and mitigations

As a result of limited access to clinic space and reduced staffing, there is a backlog of appointments for those needing post induction assessments or booster/serology appointments. Now that the new nurse is providing clinics and a clinic room it is expected this will be cleared by the end of July.

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

Workforce

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	2	3

Employee Recognition

Long Service Awards	17	Hidden Heroes	17
Retirement Awards	4	STAR awards	11 Nominations

Diversity/Inclusivity

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

- Reciprocal mentoring pilot started in May, 13 Board Executives and members of Executive team paired with equal number of colleagues from our three staff networks, to share career and life experience.
- Educational resource developed for staff to understand more prevalent forms of discrimination in the workplace and colleagues have 'lent their voice' to this initiative to develop case study recordings. Three 15 minute Youtube videos produced, content currently being edited.
- Preparing EDI Annual Report, WRES report (which will include Model Employer data and information on 'disparity ratios') and WDES report, for review by end of June/first week of July.
- The LGBTQ+ Network next meets on 08 July, and has attracted several LGBTQ+ champions from staff. BAME network next meets on 10 June 2021.
- Disability Network now called Differently Abled Network. Next meeting on 24 June.
- Trust will recognise LGBTQ month, Learning Disability Week, UK Windrush Day and Armed Forces Day (all June).
- ICC and USC divisions committed to three EDI areas of action. Action plans developed.

Wellbeing Initiatives

Massage Chairs – rotated to Mortuary, Mercury & Physiotherapy during May, with an additional chair provided in Cherwell

Staff Room Refurbishment – phase 1 of this programme started on 25th May – decorating & adding relaxing wall art to staff areas, & providing new furniture items to areas as needed

The Trust Tea Trolley: c900 drinks & snacks were given out this month. Luisa Goddard, Deputy Chief Nurse joined the trolley on the 12th for Nurses Day, visiting various wards & depts, during which c250 drinks & snacks were given to staff

Yoga Class Referral Sessions – 4 clients from Occupational Health were referred to this supplementary health and wellbeing initiative in May

Background

In May, 31 staff were seen for 1:1 counselling / psychology support. 6 are currently waiting for an appointment. In addition, 36 contacts were made with the EAP service.

The most common reasons for referral were:
- work-related : overload / stress (44%)
- personal: overload / stress (63%), low mood (56%), anxiety (50%), relationship difficulties (44%), bereavement (44%)

In-reach activity for the month included:
- 22 'bite size' virtual wellbeing sessions covering various topics – examples included 'managing the mind' (attended by 6) and 'compassionate conversations' (attended by 5)
- a reflective practice group session was facilitated for 8 ICU nurses
- supporting the Medical Records staff through the consultation process, including providing a talk on hwb support (attended by 22 staff) and providing the first of 4 planned drop-in clinics within the dept. (the one in May was attended by 4 staff)

Improvement actions

- A new clinical psychologist joined the team this month.
- In May, a further 11 staff members were trained in Mental Health First Aid , bringing the total within GWH to 125 and 11 planned for June.
- An additional 7 members of staff were trained this month in Trauma Risk Management (TRiM), from various departments with a mix of clinical and non-clinical staff. This now brings our total of TRiM trained practitioners to 47, of which 8 are trained as TRiM managers. From June, awareness of trauma and the TRiM process will be rolled out in a staged approach within departments, commencing in ICU and Maternity.
- CORE-10 (a standardised counselling questionnaire) is now routinely used before and after 1:1 appointments and this data will inform the quarterly wellbeing dashboard to help measure wellbeing improvement quantitative outcomes.
- Menopause Talk – the team arranged this virtual talk on 24th May led by our Women's Health colleagues, which was attended by 47 members of staff – the slides from the talk have been uploaded on our intranet page
- An updated evaluation form is now being used eliciting feedback from staff who have accessed psychology / counselling appointments – feedback received in May: 'I cannot thank (the counsellor) enough for her kindness and understanding throughout my sessions…. I am now trying to be kind to myself and thinking of myself as a friend. I make time for reading as relaxation and for yoga which I find very beneficial for my mind and my body….The support has enabled me to remain at work and cope with the situation at the present time….I cannot praise the support given by (the counsellor) enough…. I now have strategies to help me deal with tricky and challenging situations which I hope will help situations from escalating out of control

Risk to performance and mitigations

The wait for 1:1 counselling / psychology/counselling appointments has recently increased to 2 weeks due to demand and capacity. This wait will reduce within the next month by creating more capacity within the substantive members of the team and deployment of the Bank counselling support.

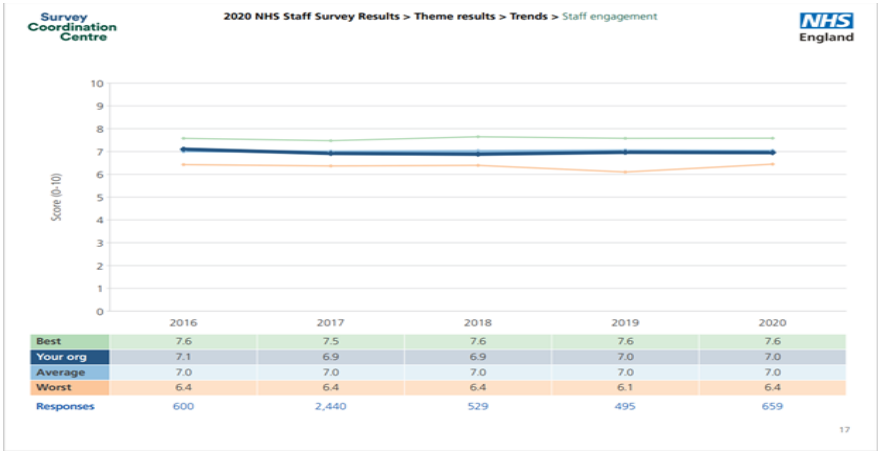
Wellbeing remains on the risk register as we monitor post COVID impact or the possibility of another wave impact.

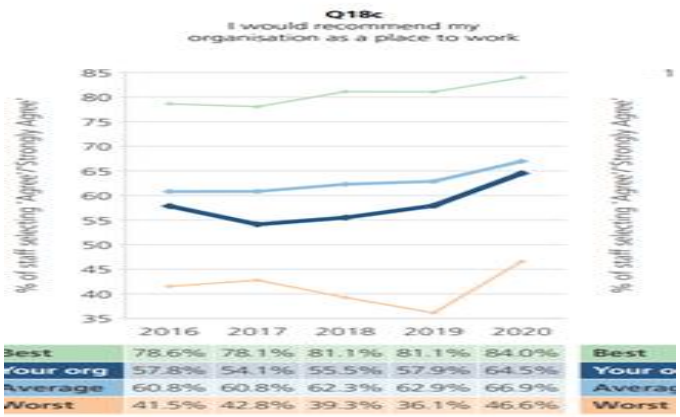
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	2	3





Background

- Staff engagement, as measured by the staff survey, has remained stable since 2016
- The Trust's ambition is to be equal to the "best" score for staff engagement.
- Staff friends and family was put on hold during COVID, this will be reinstated in July to enable us to do quarterly measurements throughout the year
- Staff friends and family test are the highest contributory factors to the staff survey staff engagement measure and whilst there has been a 10% improvement over the last 3 years, this still remains slightly below average.

Improvement actions

- MacLeod review summaries 4 enablers of employee engagement: Leadership/Line management/Employee voice/Organisation integrity (values and organizational culture). The Trust is taking action in all four areas.Board development, executive development, Tri Development and targeted areas: E.g Ophthalmology
- OD programme with KPMG
- EPF partnership agreement development with Staff side
- Staff Open Forums
- Leadership forum this month focused on civility; this is closely aligned to the work underway by the "Our GWH working group" which is looking at the GWH culture and how we want to take forward: a Just and Learning culture, Health and Wellbeing, EDI and Civility Matters.
- Bi-weekly senior management briefings continue to have strong attendance
- The development of the clinical strategy is underway, facilitated by an external OD practitioner for the Executive Committee members, 2nd away day scheduled for the 8th June. Communication has been shared with staff and feedback will be gathered shortly.
- Increased engagement in the monthly STAR award as demonstrated by increased nominations from 1-2 a month to over 10 per month.
- Staff excellence award categories have been refreshed and will be launched on the 21st June and event is scheduled for the 5th November
- Great West Fest is scheduled for the 4th September to thank staff and their families for their contribution during COVID. Festival/circus theme event

Risk to performance and mitigations

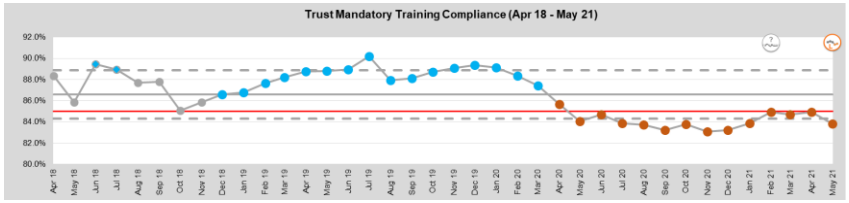
- Staff engagement is a continuous process, requires long term culture change and sustained effort before significant improvement will be measurable.
- Commitment and buy-in from Board to ward to embrace a change to our culture – how we do things around here.
- Managing any further waves with business as usual may have an impact on staff engagement.

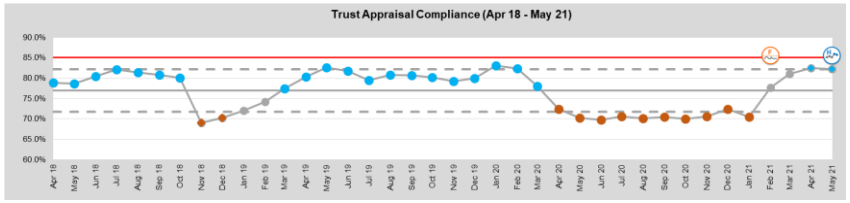
Workforce

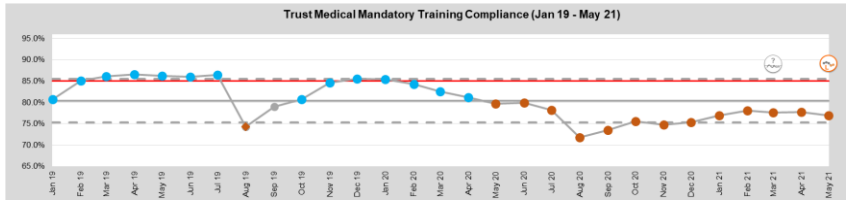
Use of Resources

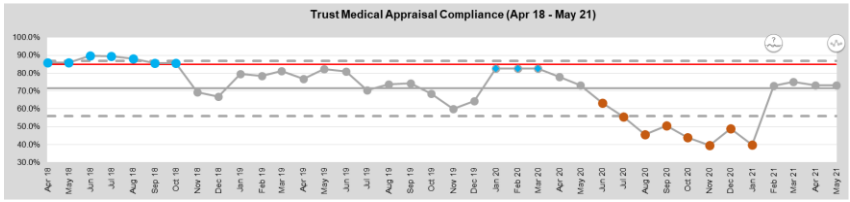
Great Employee Development

Indicator Score	Self Assessment Score
2	3









Background

Trust mandatory training compliance performance remains slightly below the 85% target, reported at 83.81%. This is a slight decrease on April's performance of 84.91%, however this was anticipated due to the planned transfer of Training Tracker to ESR, resulting in a loss of training activity for 1 week.

Role essential training is also just below the target, reported at 84.93%.

Trust appraisal compliance is reported at 82.25% in May and remains broadly stable (the April figure was 82.47%).

Improvement actions

1. The risk register is reviewed on a monthly basis.
2. The mandatory training project has been successfully completed, achieving the transfer from Training Tracker to ESR by 31 May 2021. The new system went live on the 1 June and will improve the timeliness and accuracy of reporting.
3. All mandatory training modules were uploaded by 31st May and are available for staff to complete. The remaining non mandatory training modules have been largely uploaded, with some lesser used modules due to be uploaded by 3rd June.
4. A communications plan for staff has been implemented to ensure a smooth transfer to the system and includes a user guide and contact details for support.

Risk to performance and mitigations

Capacity continues to be a challenge for some courses due to the requirements of social distancing.

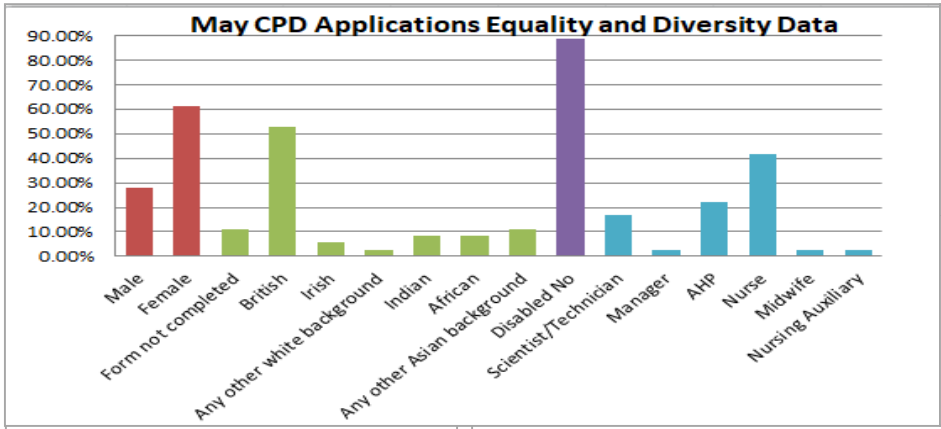
Additional courses for Mandatory Training will continue to support increased compliance.

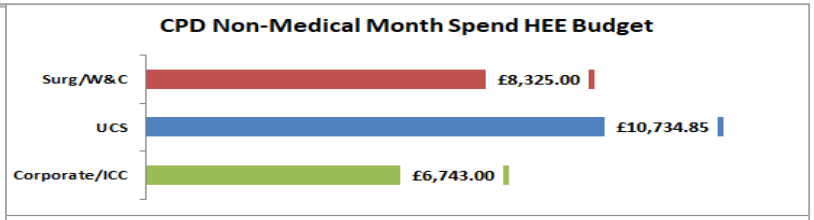
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

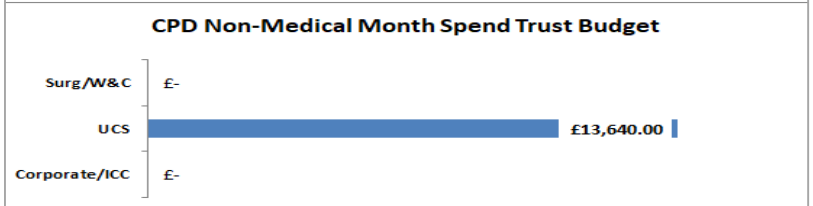
Workforce

Use of Resources

Great Employee Development	Indicator Score	Self Assessment Score
	2	3







Background

HEE Funding for Non-medical Clinical Staff: Nursing, Midwives and AHP

HEE budget spend to date is £400,044 (with an accrual of the remainder of the money) of £516,000 In addition to the monthly course applications we have also purchased further frequently applied for modules from University West England for the current financial year totaling £15,044.

There were a total of 36 non-medical CPD Applications in May for up-skilling and leadership courses.

Improvement actions

1. The Interim Head of Learning and Development has commenced in post and will be covering until the substantive candidate joins the Trust in late July. A handover period of 2 weeks is planned to ensure continuity for both the service and team.

2. HEE CPD funding for nurses, midwives and AHPs for 2021/2 has been confirmed as £632,000 – and will be distributed in 2 payments over the financial year, the first in Q2 of this financial year.

3. Detailed work already underway to ensure the trust is ready to submit our 21/22 CPD investment plans to HEE by 30th July 2021. Subject to the submission and acceptance of plans, the financial allocation will be paid in full (remaining 50%).

Risk to performance and mitigations

The transition from the Interim Head of Learning and Development and the substantive recruit could lead to a period of instability within the Academy. However, there is a 2 week period of handover to ensure this is minimised. This risk will be mitigated by the oversight of the Associate Director of OD and Learning.

Detailed plans for the CPD HEE funding will be required for the submission on 31th July 2021, planning with the services/divisions is in place to deliver on time and to maximise funding.

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

Workforce

Use of Resources

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

Background

Applications have been invited from staff in Bands 4-6 for the Aspiring Leaders Programme with an excellent response, application numbers have already exceeded places for the first cohort in June. A second cohort will be available in October to provide an opportunity to all those who have applied.

An introductory session with the University of South Wales for coaching training at levels 5 and 7 was attended by thirty employees from across the Trust including medical, clinical and nonclinical staff. During their training they will provide coaching to staff on both the Leadership Development Programme and Aspiring Leaders Programme and once accredited will join the internal coaching register to support the development of staff where coaching has been identified as an appropriate intervention .

Improvement actions

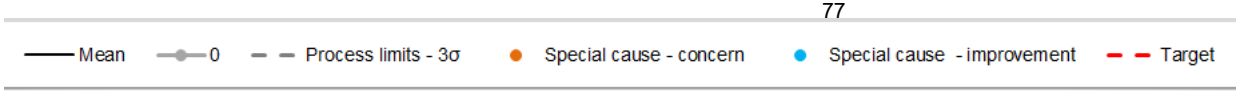
1. The Trust will continue to contribute to new initiatives across BSW as part of the new leadership development community of practice. This will scope opportunities to deliver and commission leadership development programmes and support via the BSW Academy.
2. The Leadership team is monitoring the take up of leadership programmes/initiatives. This will allow identification of any under - represented groups and facilitate a targeted approach for future cohorts of the Leadership Development Programme.
3. The Trust will continue to support senior leaders by providing apprenticeship levy funded places on the Senior Leaders Masters Degree Apprenticeship due to commence in September.
4. The Leadership Team will work with senior medical staff to design and facilitate a leadership programme for new to role consultants
5. The BSW Acute Alliance programme was reviewed on the 28 May and participants have confirmed they find it useful. It will continue on half day bi-monthly basis. AWP NHS Trust has expressed an interest in joining the programme.
6. The focus of the Leadership Forum on 27 May was civility and respect and showcased the work of the ED department in this area, with input From Chris Turner, Consultant in Emergency Medicine University Hospitals Coventry and Warwickshire NHS Trust.
7. Phase 2A of the Talent Management programme is complete. The final Talent Board for Phase 2B is due to take place at the end of June/early July.

Risk to performance and mitigations

The attendance at Leadership Forum remains lower than might be expected. However, the timing of this session is under review. (It currently starts at 6pm)

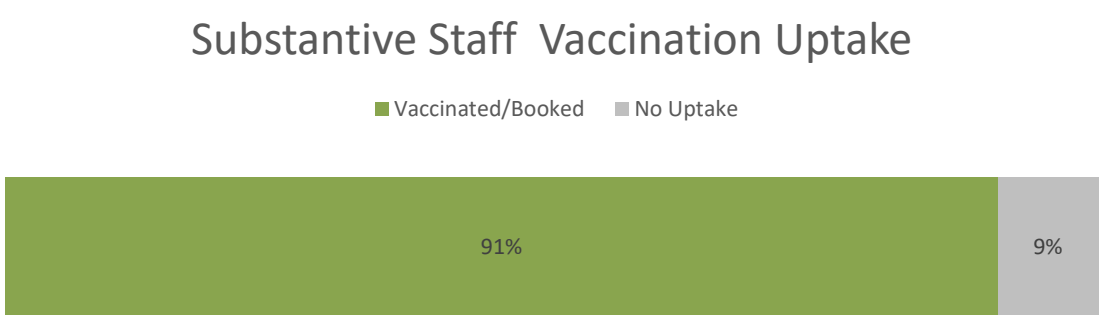
Time will need to be invested in the AMD programme to adapt it to meet AWP's needs. There is currently no funding for this programme, and there is now a move to at least some face to face sessions.

The Associate Director of OD and Learning is investigating avenues for funding.



Exception 1 of 2: Vaccination Programme

Exception Report



BME (excluding bank staff)	Total Staff	Vaccinated Dose 1	% Vaccinated
BME	942	800	85%
Not Stated	558	489	88%
White	3870	3602	93%
TOTAL	**5370**	**4891**	**91%**

Background

Ninety-one per cent of substantive staff have been vaccinated or are due to be vaccinated at the end of May 2021 with now only one of the four divisions being below 90% (89%). The highest percentage achieved remains within Surgery Women's and Chldren's Division at 91% of their substantive staff.

Vaccination uptake compliance has now been achieved in 150 departments to date. Analysis continues to show that the majority of those declining vaccinations (55%) and one to one meetings (26%) are due to pregnancy or breast-feeding concerns. Overall 2.5% of total staff have declined.

Improvement actions

1. Root Cause Analysis (RCA) of the clinical incident where incorrect type of second dose was inadvertently administered to a recipient is now complete. This will be shared on the 11th June at the Operational Delivery Group..
2. National policy has changed which means that the site can become a Hospital Hub+. This will entail migrating from a local booking system to the National Booking System. This is planned for the 10th June and will align the booking process with all other sites across BSW and provide easier and greater access for the local population.

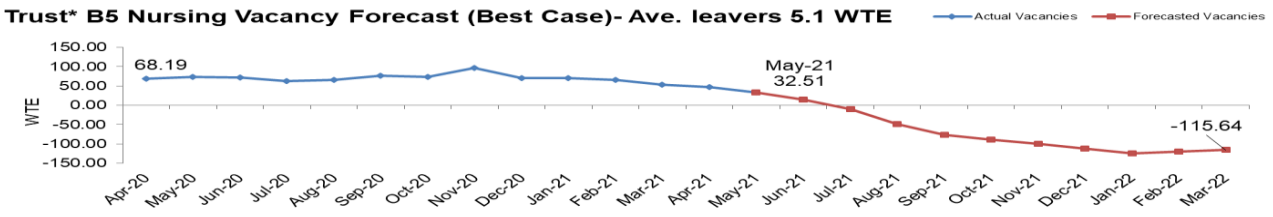
Risk to performance and mitigations

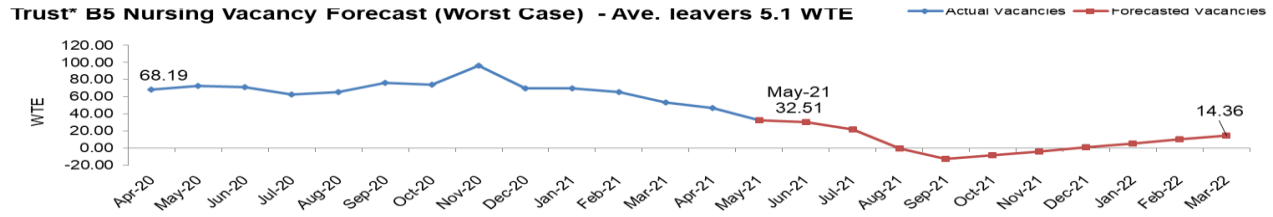
The Covid-19 vaccine programme is being conducted from the Occupational Health department and resourced by substantive / bank workforce and volunteers.

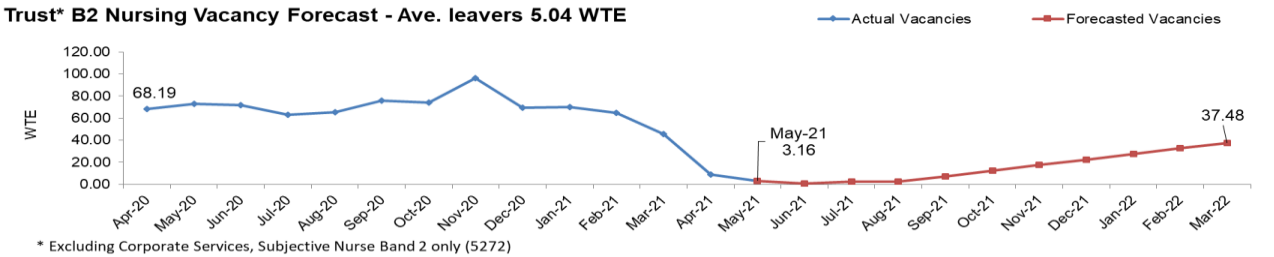
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

Exception 2 of 2: Recruitment Trajectory

Exception Report







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

Assumptions:

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

Background

In M2 the Trusts vacancy position for B5 Nursing is 32.51 WTE and Healthcare Support Workers is 3.16 WTE.

There are 54.20 WTE B5 Student nurses due to join the Trust between July/September.

Through NHSE/I Strand B/B+ funding 130 WTE nurses are due to arrive between now and December 2021.

Improvement actions

1. To ensure the B2 Healthcare Support Worker vacancy position remains close to zero vacancies the recruitment team continue to hold centralised recruitment events monthly. Any candidates offered through this route are allocated across the Trust via the Divisional Directors of Nursing.

2. Due to the COVID pandemic situation in India there has been an immediate pause on all international travel from India to take up employment with the NHS until further notice. Due to this we have been working with our agencies to review our pipeline and source overseas nurses from alternative locations to ensure we are able to meet the required funded numbers through the NHSI/E Strand B/B+ bids.

Risk to performance and mitigations

Previously, NHSI reimbursed the Trust full cost (£1,750) for overseas nurses that were entering from a red list requiring hotel quarantine. From April NHSI will now reimburse £1,000 per nurse and Trust are required to pay the remaining £750 per nurse. This currently only applies until 30th September 2021. This will continue to be an additional cost pressure as our international nurses are predominately from red list countries.

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

Board Committee Assurance Report

Meeting – Date			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Andy Copestake	Andy Copestake		21 June 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Business Planning & Budget Setting process	R	G	The Committee discussed a helpful paper commissioned by the CEO and produced by the DoF which highlighted a number of business planning and budget setting issues emerging from the production of the H1 budget, including the need for more robust workforce and activity/capacity planning. The Committee applauded the honest appraisal but was concerned to see a number of issues that needed to be addressed ahead of the production of the H2 budget later this year. The paper included a clear set of actions which the Committee welcomed (hence the green rating). Divisions will be invited to future FIC meetings (dates to be agreed) to give the Committee assurance that the key issues are being addressed.	In depth FIC review with divisions before signing off the H2 budget	TBA (probably September)
Month 2 Finance Position	G	A	All the main indicators are green – a favourable I & E variance to date of £11k; Cash of £27.4m at the end of May; good performance re: the Elective Recovery Fund and good progress in spending the Capital budget. Also, for the first time, the Trust achieved the 95% target for paying creditors within 30 days. The amber rating on management actions reflects concerns over escalating pay costs, especially close support, and a shortfall in CIP achievement.	Continue to monitor monthly through FIC	FIC meetings 2021/22

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Finance Risk Register	A	G	A good update report on Finance risks, which now includes a new table setting out the possible £ value associated with each key risk and an assessment of the Primary Care funding risk which may emerge at the end of 2022.	Monitor through FIC	FIC meetings 2021/22
Improvement Plan update	R	A	The Committee received a short update on the financial savings opportunities associated with each of the key workstreams under the Improvement Plan. The Committee acknowledged that the numbers in the report were subject to validation but was concerned on 2 points – firstly that the savings opportunities appeared to be lower than in the original plan and, secondly, that a number of savings opportunities and initiatives were not included in the report. The Committee asked that all the relevant work was brought together and reported in one place and that the gap was identified between the original savings target included in the Efficiency & Improvement Plan and the new total, so any necessary action can be taken to plug the gap.	Monitor through FIC	FIC meetings 2021/22
Summary of Model Hospital data	A	R	The Committee received a report setting out the Top 10 financial opportunity areas produced by Model Hospital based on 2019/20 data. The red rating reflects the Committee's view that there could be better linkage between Model Hospital and GIRFT data and that the apparent savings opportunities needed to be validated.	Should form part of the benchmarking data that is reviewed (including GIRFT) in business planning and CIP development for H2.	FIC meetings 2021/22
Procurement Service Business Case	G	G	The Committee noted the considerable amount of work that had gone into the negotiation and production of the proposal by the Director of Procurement and his team and approved the Business Case for the establishment of a single procurement service across the 3 Acute hospitals from 1 October 2021.	Review as part of the quarterly FIC procurement review	FIC August 2021
Novation of 5 further Pathology contracts	G	G	The Committee approved the novation of 5 further Pathology contracts into the Beckman Coulter Managed Service Contract, resulting in significant VAT savings as well as other benefits. This followed the novation of 6 Pathology contracts last month.	None	

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

NHS
Great Western Hospitals
NHS Foundation Trust

Part 4: Use of Resources

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Financial Overview

Use of Resources

For Period Ended - 31st May 2021								
	In Month Plan £000	In Month Actual £000	In Month Variance £000		YTD Plan £000	YTD Actual £000	YTD Variance £000	
Total Operating Income	34,120	34,139	19		67,275	67,435	161	
Total Operating Expenditure	(34,119)	(34,128)	(8)		(67,275)	(67,425)	(151)	
Total Surplus/(Deficit)	0	11	11		0	10	10	
Capital	1,772	3,605	(1,833)		3,375	6,229	(2,854)	
Cash & Cash Equivalents	27,373	27,373	0					
Efficiencies	165	156	(9)		330	190	(140)	

Overview

Income & Expenditure: The Trust in month position is £11k surplus against a plan of breakeven. Operating Income is £19k favourable against plan and Operating Expenses are £8k adverse against plan. This includes Pay costs that are £306k favourable against plan and Non-Pay costs that are £314k adverse against plan.

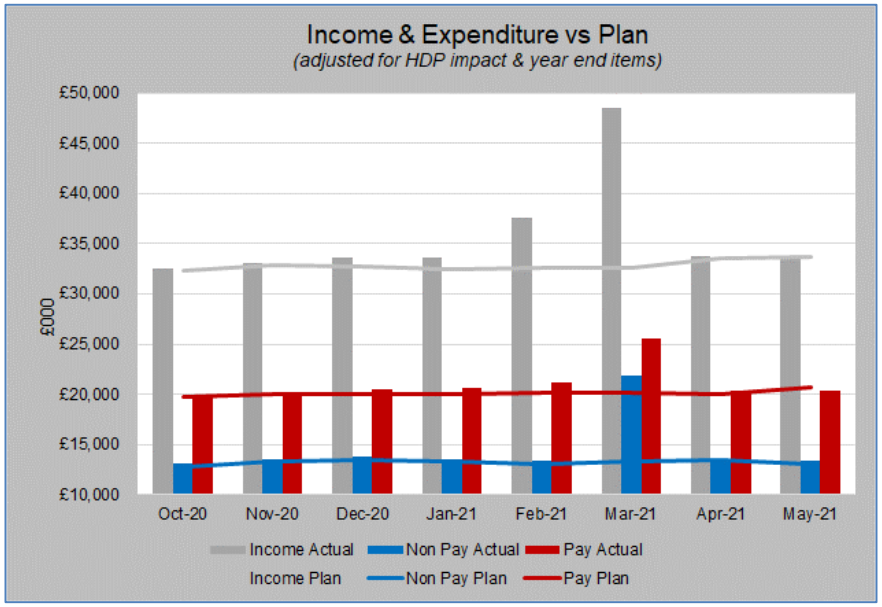
Cash – the cash balance at the end of May was £23,373k, the plan has been updated for the remainder of the financial year.

Capital – Capital expenditure is £6,229k as at the end of Month 2. The plan profile is under review and will be updated for Month 3 reporting.

Efficiencies – £190k YTD, below plan by £140k. A greater focus on capturing cash releasing efficiencies is needed to ensure that the H1 efficiency requirement is met by the end of the first half of the year.

Income and Expenditure - Run Rate

Use of Resources



Background

The May position has improved from April to a £11k surplus.

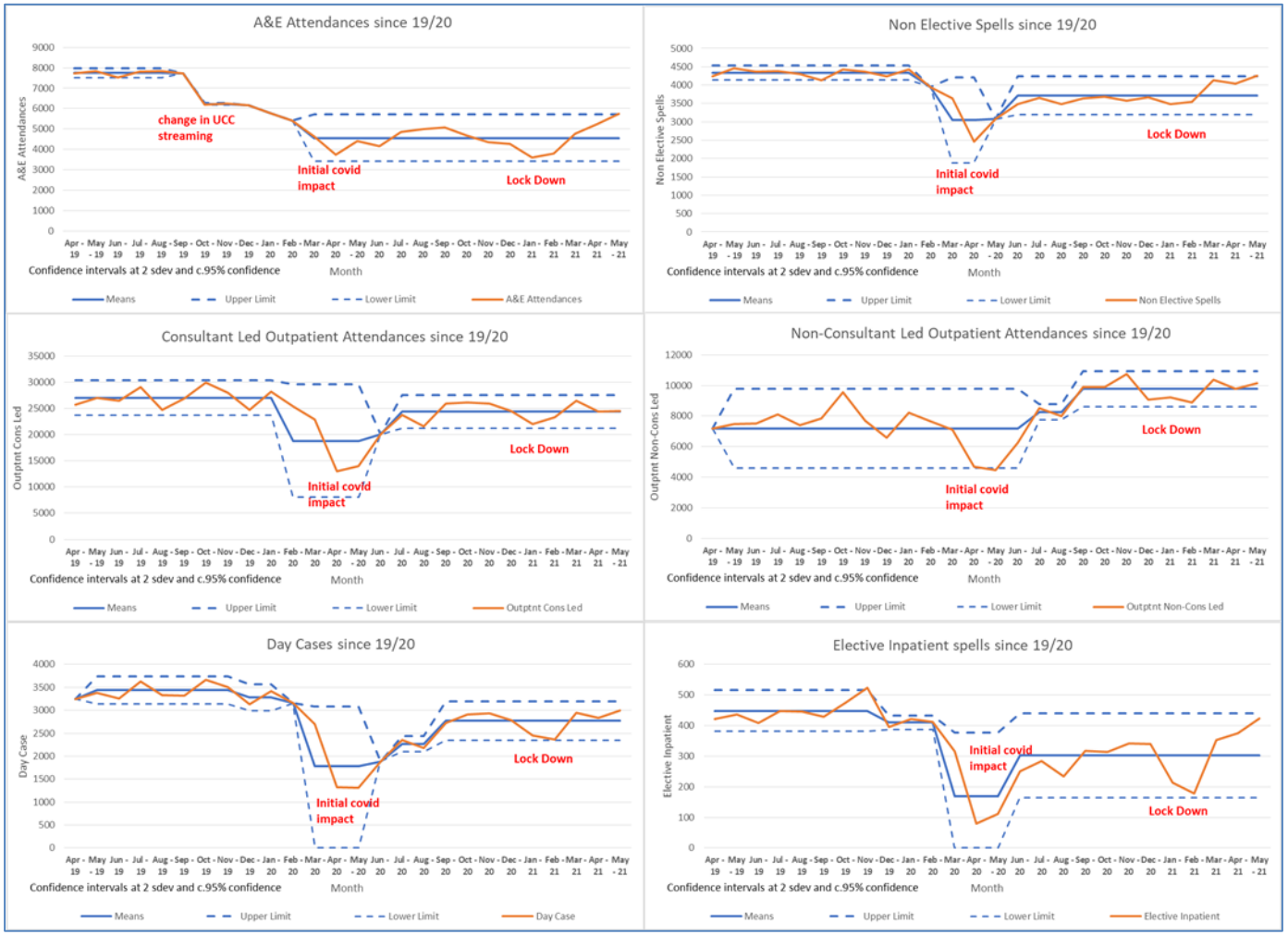
- Pay run rate has reduced by £11k from prior month. Nursing agency has reduced by £32k due to lower vacancy cover although there was a requirement for additional shifts to cover escalation in month due to non-elective pressures. The position includes additional £80k WLI costs for elective recovery, which will be funded through ERF income achieved.
- Although the run rate has reduced marginally, pay is underspent by £306k in month due to community budgets which are now benefitting from HDP funding. Pay budget in the prior month was lower due to divisional recruitment lag targets.
- Non Pay run rate has reduced by £58k but is overspent in month by £314k. Unachieved non-pay CIPs are £27k in month (£157k YTD). Clinical Supplies have increased by £290k (12%) and are £277k above plan in month (£116k below plan year to date). The increase is on prostheses, medical & surgical equipment and lab tests which is reflects the higher elective activity delivered in month. This is partially offset by sleep consumables and cardiology devices. Drugs have reduced by £209k, particularly Sexual Health and Ophthalmology. It is expected that drugs spend will increase next month in line with the timing of clinics and prescribing.

Note: HDP funding was agreed in M2. For reporting purposes, the financial impact has been smoothed over M1 & M2 in this slide.

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

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

Use of Resources



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

Income and Activity Delivered by Point of Delivery

Use of Resources

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

Activity Type	Activity Variance	19/20 Income	21/22 Income	Income Variance	Income Variance	Comment (comparing income and activity variances)
	%	£'000	£'000	£'000	%	
A&E	-29.4%	2,490	1,966	-524	-21.0%	Minor activity affected more than major
NEL	-4.7%	15,592	16,696	1,104	7.1%	Minor activity affected more than major
Outpatient (All)	-2.9%	7,043	6,096	-946	-13.4%	Due to switching to Non face to Face
Day Case	-11.9%	3,819	3,640	-178	-4.7%	Various drivers
Elective Inpatient	-7.0%	3,029	2,872	-156	-5.2%	Volume related

Context

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

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

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

Issues:

Income that would be earned under PbR is well below the costs of the Trust due to Covid-19 reducing throughput. Notional PbR income has moved in line with activity trends except for A&E and Emergency where income has held up better than activity as minor casework has been affected more than majors and outpatients, where a larger proportion is delivered through non face to face means.

Risks:

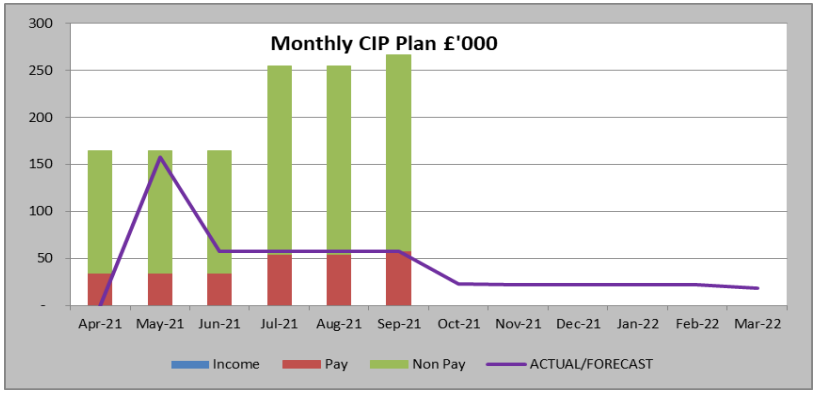
- If the previous cost and volume funding approach was reintroduced by NHSE/I, with current GWH run rates, it would lead to a deficit in the region of £4.2m per annum

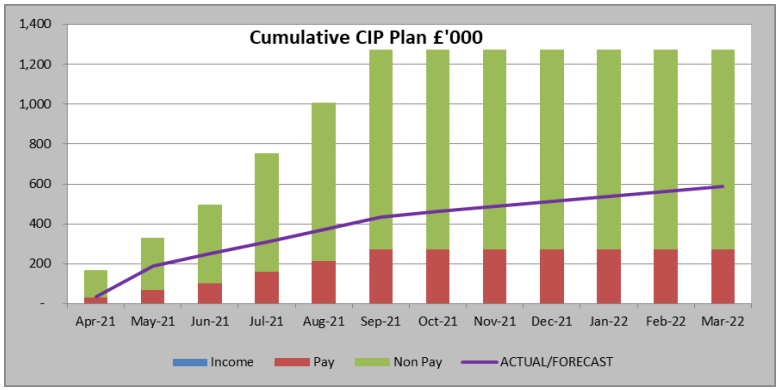
Actions & mitigation:

- Finance are keeping in close contact with NHSE/I to clarify future funding arrangements as soon as there is further intelligence.
- The current view, but not confirmed, is that PbR is not likely to be reintroduced in 21/22.

Cost Improvement Plans – Better Care at Lower Cost

Use of Resources





Background

- The Cost Improvement Programme (CIP) delivery plan for May is £165k.
- The total for H1 of the year is £1,272k, c. 0.7% of total budgets.
- CIPs identified and delivered in month were £156k (£190k full year) which is £9k below plan (£140k full year).
- Delivery year to date is currently 58% of plan and needs to be a focus of Trust improvement going forward.

Improvement actions planned

Clarification of the Operational and Executive Leads is anticipated for the improvement programmes during June and this will enable further progression of financial validation of projects aligned to those programmes.

Work is continuing to identify efficiency projects driven by opportunity identified in the improvement programme through divisional initiatives and ideas programmes.

The efficiency requirement for the second half of the year is still to be quantified as it will depend on the financial settlement for the second half of the year. The cumulative chart above therefore plateaus at present for the second half of the year.

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Risks to delivery and mitigations

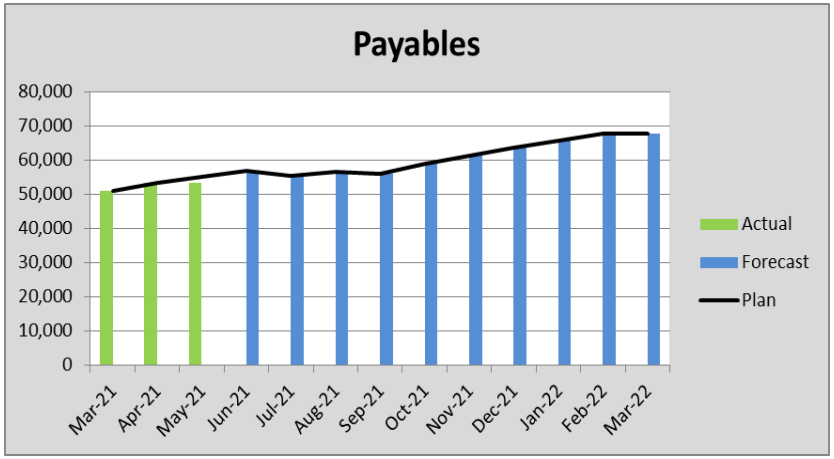
The key risk to delivery is delay in actions taken to deliver efficiencies to date and the pace at which schemes are being developed and implemented across the Trust. In addition while schemes are progressing under the improvement initiatives identified, identifying cashable savings arising from projects is proving challenging as a number of the schemes are cost avoidance and mitigating existing cost pressures.

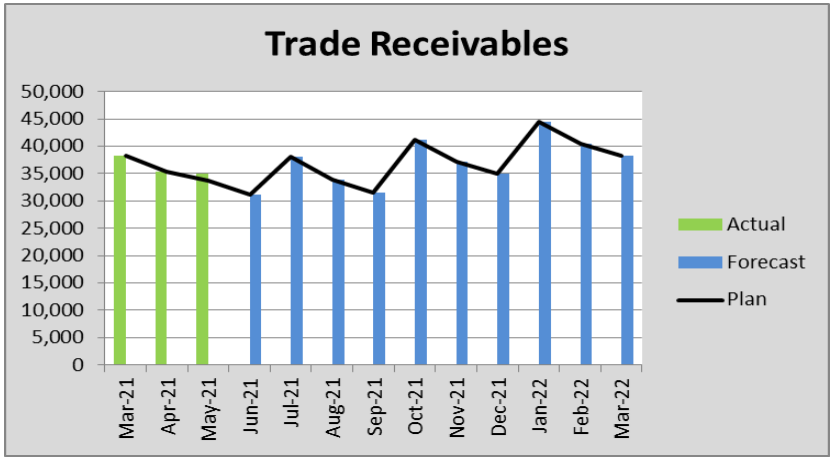
This is partially addressed through the profiling of the target, which is lighter in Q1 to reflect that projects are still requiring work up and commencement.

Prioritisation of improvement opportunities is to progress in the coming month to enable focus on those areas with the biggest potential, both operationally and financially.

Statement of Financial Position: Key movements

Use of Resources





Background

- The monthly plan has been updated to reflect the H1 and H2 I&E plans signed off by Trust Board
- Payables are broadly in line with plan in month, an analysis of Trade and Capital Payables has been done in month to ensure correct reporting split in the detailed balance sheet (see appendices)

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- Receivables remain on plan, £1.2m of current receivables relates to a prepayment to Swindon Borough Council for rates. NHS Property Services remain our largest longer term debtor (£0.5m) and this continues to be pursued.
- A full Statement of Financial Position is included in the appendices.

Risks to delivery and mitigations

- Capital Payables will continue to be reviewed to ensure payments for prior year capital are made as invoices are received.
- A review of Aged Debt was present to FIC in May and the process is being reviewed to ensure any risks to the receivables balance is identified.

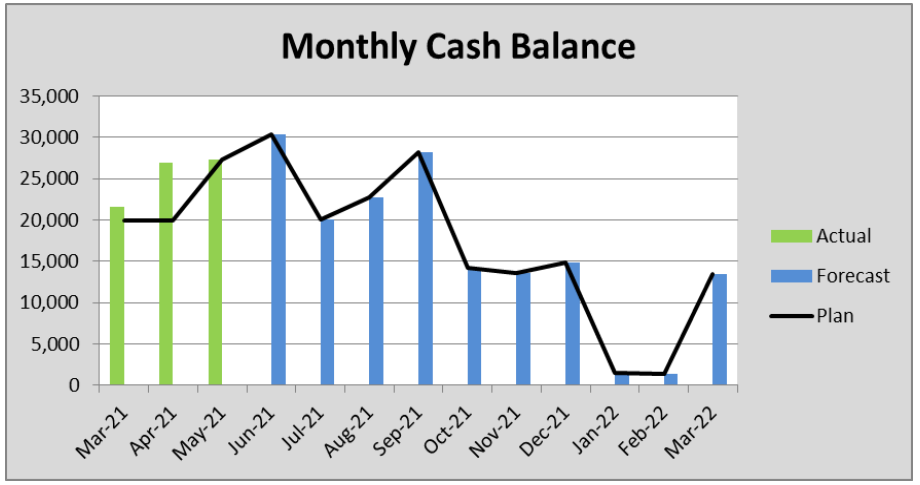
Cash

Use of Resources

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	21/22 Total	Rolling 12 Mths June 21 to May 22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Balance	**26,880**	**27,373**	**30,344**	**20,098**	**22,741**	**28,241**	**14,269**	**13,629**	**14,857**	**1,424**	**1,336**	**13,454**	**2,567**	**21,553**	27,373
Income															
Clinical Income	30,760	31,084	31,084	31,084	31,086	27,500	27,435	27,435	27,435	27,435	27,435	27,517	27,517	350,441	344,047
Other Income	1,349	1,744	4,174	3,230	1,287	1,900	3,568	1,624	1,960	3,563	1,619	1,619	1,619	35,326	27,905
Revenue Financing Loan / PDC									1,000		13,500			14,500	14,500
Capital Financing Loan / PDC		3,728	1,120	1,121	8,071	1,929	1,929	5,594	1,614	1,614	4,537	4,537	4,537	31,257	40,331
Total Income	**32,109**	**36,556**	**36,378**	**35,435**	**40,444**	**31,329**	**32,932**	**34,653**	**32,009**	**32,612**	**47,091**	**33,673**	**33,673**	**431,524**	**426,784**
Expenditure															
Pay	19,266	20,218	20,198	20,181	20,194	20,130	20,105	20,105	20,099	20,098	20,044	20,138	20,138	239,330	241,648
Revenue Creditors	11,343	9,594	9,802	9,425	9,387	10,102	9,907	9,880	10,224	9,889	10,219	8,302	8,302	122,729	115,032
Capital Creditors	953	3,772	4,884	3,186	3,233	3,417	3,505	3,440	3,465	2,713	2,585	4,467	4,467	38,154	43,134
PFI			11,740			11,653			11,653			11,653		35,046	46,699
PDC Interest					2,130						2,125			4,255	4,255
Financing	55						55							110	55
Total Expenditure	**31,617**	**33,584**	**46,624**	**32,792**	**34,944**	**45,302**	**33,572**	**33,425**	**45,441**	**32,700**	**34,973**	**44,560**	**32,907**	**439,624**	**450,823**
Closing Balance	**27,373**	**30,344**	**20,098**	**22,741**	**28,241**	**14,269**	**13,629**	**14,857**	**1,424**	**1,336**	**13,454**	**2,567**	**3,333**	**13,454**	**3,333**

Background

- The cash plan and forecast has been updated to reflect the H1 and H2 plan signed off by Trust Board.
- It is anticipated that revenue PDC will be required in January (£1m) and March (£13,5m) to support PFI payments and maintain a working cash balance.
- There has been a delay to receiving the monthly VAT refund in May (£0.5m) due to process delays, this will be received in June and is reflected in the forecast.



Capital Programme

Use of Resources

Capital Scheme	Capital Group	2021/22 Full Year Plan £000	2021/22 YTD Plan £000	2021/22 YTD Actual £000	2021/22 YTD Variance £000
Aseptic Suite	Estates	1,903	42	17	(25)
Oxygen	Estates	500		503	503
Estates Replacement Schemes	Estates	750			-
Utilities (LV & Heating) Project	Estates	2,300	150	287	137
Site Reconfigurations Urology/R&D etc	Estates	300			-
Pathlake (national funds requires matching)	IT	260	14		(14)
Pathology LIMS (network procurement)	IT	510			-
IT Emergency Infrastructure	IT	3,000	31	2,669	2,638
IT Replacement Schemes	IT	1,404		66	66
PACS - environment/replacement solution (Nov21)	IT	800			-
Equipment Replacement Schemes	Equipment	1,450			-
Contingency	Equipment	541	90		(90)
Way Forward Programme		9,690	808	1,249	441
Clover UEC		10,085	2,240	1,438	(802)
Total Capital Plan (Excl PFI)		**33,493**	**3,375**	**6,229**	**2,854**

Background

- The plan above is in line with the Capital Plan submitted to NHSI/E in April 2021. The profile is under review and a revised final profile will be included in the Month 3 report.
- The Finance team are working on the process to ensure Capital Expenditure reflects committed spend to date, not just invoices received and orders placed) This will also be completed for Month 3 reporting.
- IT and Equipment Replacement Schemes have been prioritised and approved for in year spend. Estates Replacement Schemes are due to be signed off the E&F Board in June.
- The in month position shows capital expenditure is above plan, this primarily relates to the Hybrid Cloud order placed in Month 1.
- Variances on the Oxygen, Way Forward Programme and Clover are due to profiling of the plan which will be updated for future months reporting.

Risks to delivery and mitigations

The Trust currently anticipates to deliver capital in line with the planned value by year end. This will continue to be monitored on a monthly basis at the relevant capital groups.

Safer Staffing – Six Monthly Skill Mix Review

Meeting	Board of Directors	**Date**	1st July 2021

Summary of Report

The purpose of this paper is to provide assurance to the Board of Directors that nursing and midwifery clinical areas have been safely staffed over the last 6 months.

The paper outlines:
Any significant changes that have occurred in nursing and midwifery staffing establishments and skill mix in the last six months.
Any risks on the Trust Risk Register relating to nursing / midwifery staffing levels.
Knowledge on how the Trust knows the wards and departments have been safely staffed over the last 6 months, including Care Hours Per Patient Per Day.

This report aims to provide the Trust Board with the assurance that staffing has been managed during this time in line with national recommendations, including during the COVID-19 pandemic.

Key points to note:

- The Trust has been experiencing unprecedented challenges on its workforce due to COVID-19 pandemic.
- The indicators suggest that overall the standard of patient care was managed as safely as possible.
- The Trust has recognised the importance of staff wellbeing and support throughout the pandemic.
- The overseas recruitment initiative has seen 75 successfully arriving in the last 6 months. A funding bid from NHSE/I to support international recruitment was successfully secured.
- The Trust continues to see a decrease in band 5 registered nurse vacancy with a projection to have zero Band 5 registered nurse vacancy by December 2021.
- The Trust had a successful health care assistant recruitment campaign supported by the additional investment from NHSE&I's Health Care Support Worker Programme, which aimed to have as close to zero vacancies by March 2021 as operationally possible.
- The successful move to the Preferred Supplier List (PSL) for Nurse Agency has resulted in the Trust being complaint with NHS Cap Rates for the first time.
- Safe staffing reviews led by the Chief Nurse are planned to take place from May to August 2021.
- Care Hours per Patient Day analysis is reassuring that there is sufficient staffing and we benchmark with comparable organisations.
- This paper can assure the Trust Board that GWH had sufficient processes and oversight of its staffing arrangements in place to ensure safe nursing and midwifery staffing levels.

For Information		Assurance	x	Discussion & input		Decision / approval	

Executive Lead	Lisa Cheek, Chief Nurse
Author	Luisa Goddard, Deputy Chief Nurse
Author contact details	luisa.goddard@nhs.net

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score
1956	Shortfall in nurse staffing compared to NHSE Service Specification for Neonatal Critical Care Nursing staff model not previously benchmarked against national standards in BAPM 2010 framework.	8
2259	Non-compliance with Intensive Care Society staffing standard. Unit should not utilise >20% of registered nurses from agency on any shift.	9
1773	Patients in the community at risk of harm or of experiencing delay in receiving care and treatment due to community nursing unable to meet demand.	20
1619	Significant financial risk associated with the use of agency staff due to gaps in trained staff in medical and nursing and AHPs/Scientific.	12
2771	Women will not have a named midwife responsible for their care due to vacancies.	12
2698	Potential for patient safety to be compromised due to insufficient midwifery staff to fill roster requirements.	9

Legal / Regulatory / Reputation Implications	CQC Regulation 18 – Staffing – Significant human resource continues to be required to establish reliable and robust systems and processes for the collation and validation of Safer Staffing data. Safe staffing is a key determinant of high quality care. NHSE/1 Developing Workforce Standards
Link to relevant CQC Domain	
Safe [x] Effective [ ] Caring [x] Responsive [ ] Well Led [x]	
Link to relevant Trust Commitment	
Consultations / other committee views	
Senior Nursing and Midwifery Group	

Recommendations / Decision Required

That the Board notes the contents of this report.

- ***Note the actions being taken to ensure nurse staffing levels are safe.***
- ***Note this as assurance of compliance against the expectations of the National Quality Board 2016.***

1. Introduction

Following publication of the Francis Report (2013) and the subsequent "Hard Truths" (2014) document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels.

These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift
- Provide a 6 monthly report on nurse staffing to the Board of Directors.

The National Quality Board (NQB) guidelines and recommendations (2016) are highlighted in table 1.

Table 1- NQB: Safe, Sustainable and Productive Staffing

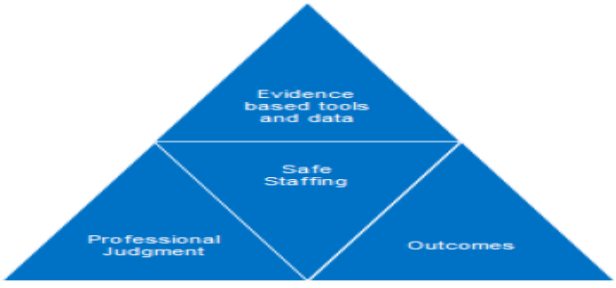
Right Staff	Right Skills	Right Place and Time
Evidence based workforce planning	Mandatory training, development and education	Productive working and eliminating waste
Professional Judgement	Working as a multiprofessional team	Efficient deployment and flexibility
Benchmarking speciality at a national level	Recruitment and Retention	Efficient employment and minimising agency

The NHS Improvement "Developing Workforce Safeguards" (October 2018) made further recommendations to ensure that Trust report on safe staffing information including all areas, departments and clinical services.

The Guidance highlights that Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes:

- evidence-based tools
- professional judgement
- outcomes

Figure 1 Principles of Safe staffing



Demonstrating sufficient staffing is one of the essential quality and safety standards required to comply with the Care Quality Commission (CQC) regulation.

The Board of Directors last received a Safe Staffing Paper in March 2020 but there is now a robust plan to ensure that the 6 monthly updates are presented.

The report aims to provide the Board of Directors with assurance that staffing has been managed in line with national recommendations and with close oversight from the Trust's senior nurses, over the last 6 months and throughout the COVID-19 pandemic.

National reporting on Safer Staffing (planned and actual) was suspended for short period in 2020 due to the impact of COVID-19 pandemic but has now resumed. Work has been completed to improve the accuracy of the GWH reporting following the reconfiguration of ward areas and associated staffing models during the pandemic and a more robust governance around the 'sign off' of the data has been implemented.

Future reports may wish to include The NHS Improvement "Developing Workforce Safeguards" (October 2018), that recommendations Trust reports include safe staffing information for Allied Healthcare Professionals (AHPs), Medical staff as well as nursing and midwifery staff.

The document suggests that best practice on the following areas at board level should be included. "*Any workforce review and assessment and the safeguards reported should cover all clinical groups, areas and teams. Nursing/midwifery is the most often represented group at board level, but a focus on medical staff, AHPs, healthcare scientists and the wider workforce is needed too. Reports need to cover all areas, departments and clinical services*".

2. National Context

The NHS and the political landscape within the UK continues to go through an unprecedented period of change. There continues to be a number of factors which may affect our ability to recruit and retain our Nursing and Midwifery workforce at Great Western NHS Foundation Trust.

The main factors are outlined below:

- EU Exit – There are no immediate changes in place in terms of immigration, however, the issue of supply of nurses from within EU countries remains uncertain and will depend on the immigration rules.
- The number of Nursing and Midwifery vacancies nationally remains high but improving with the national Overseas Recruitment campaign. However, recruitment from 'red' countries is currently ceased.
- The Government has committed to training significant numbers of nurses. Universities are seeing high levels of student nurses enrolling and Trusts are being asked for additional placements.
- Effect of Covid 19 pandemic – the effect is currently unknown but may affect retention of staff.
- The Nursing Associate role has now been recognised as a registered profession in law and needs further development.
- Changes in other parts of the NHS clinical workforce also continue to impact the profession; predominantly the reduction in junior doctors, requiring a greater number of nurses to work at an advanced and specialist level.
- The ambition in the NHS People Plan to eliminate off framework agency use by 2022
- The NHS People Plan highlights the need for an inclusive culture and strong evidence that where the workforce is representative of the community it serves patient experience is improved. Staff from ethnic minority backgrounds remain underrepresented at senior level.

- The NHS People Plan (2020), has specific commitments

    - Looking after our people – with quality health and wellbeing support for everyone
    - Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
    - New ways of working and delivering care – making effective use of the full range of our people's skills and experience
    - Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return

3. COVID-19 Response

In Wave 1 a central staffing resource hub was set up in March 2020 in order to provide full oversight and coordinate the changes to nurse staffing required to manage the Covid-19 situation. Significant numbers of staff from non-ward based areas: - outpatients, specialist nursing, corporate roles etc were successfully deployed across the organisation to support ward areas. This involved approximately 170 registered nurses and 68 unregistered nurses.

In Wave 2 and 3 normal services were maintained as much as possible and staffing was successfully managed through the new Safe Staffing meetings.

In addition, the Trust had 42 student nurses on paid placement from January to April 2021 in line with the NMC Emergency Standards, which was a significant support to the clinical areas.

A 'Safest' staffing SOP was developed for use in the pandemic but wasn't activated as staffing was able to be managed within the existing Trust's Safe Staffing SOP. Risk was mitigated through the staffing meetings led by the Divisional Directors of Nursing and cross divisional working. Neptune (the respiratory ward) was particularly challenged during this time but support was achieved through moving staff from less acute areas.

The ICU skill mix and nurse / patient ratio was reduced in line with the ICU Network and NHSE&I recommendations. Staff were redeployed from across the Trust to support but especially from Theatres who had lower levels of activity.

The quality metrics during Wave 2 and 3 were reviewed in view of the challenged staffing. Inpatient falls were higher than previous months and there was significant rise of pressure damage in ICU. Inpatient falls have subsequently improved and whilst the number of pressure ulcer in the Trust remain of concern, there has been improvement in pressure ulcer damage caused in ICU.

4. Review of the Nursing and Midwifery Workforce

Surgical, Women & Children's
The below table shows the changes during phase 3 of COVID

Table 2 Establishment changes in Surgery, Women and Children's During Covid-19

Increase to WTEs	Band 7	Band 6	Band 5	Band 3/4	Band 2	Total	RN increase	Average Agency Use
Trauma 39	0.00	0.81	4.61	3.97	8.64	**18.03**	**5.42**	**1.30**
Meldon	0.00	0.77	4.61	1.49	6.48	**13.35**	**5.38**	**0.44**
Kingfisher/SAU	0.00	1.24	8.44	3.36	10.63	**23.67**	**9.68**	**0.32**
Patient Testing	0.00	0.00	1.45	0.00	5.82	**7.27**	**1.45**	**0.00**
Dorcan	0.00	0.00	-5.38	0.00	-6.05	**-11.43**	**-5.38**	**0.00**
Shalbourne	-1.00	-6.21	-12.83	-4.99	-13.86	**-38.89**	**-20.04**	**0.00**
Aldbourne	1.00	-0.72	-3.28	-0.08	1.24	**-1.84**	**-3.00**	**0.00**
ICU	0.00	5.38	5.38	0.00	2.69	**13.45**	**10.76**	**7.80**
	0.00	**1.27**	**3.00**	**3.75**	**15.59**	**23.61**	**4.27**	**9.86**

Trauma Unit – To support the back log of Orthopaedic Elective activity and the significant risk to long waiting list waits, it is planned for Aldbourne and the Trauma Unit to revert back to pre COVID bed models in May 2021.

Meldon – has reverted back to baseline establishment (pre Covid19).

Kingfisher/ SAU – The Front Door project is in progress, which includes a joint assessment unit with AMU. This will impact the future staffing model but timescales are still to be confirmed. As part of budget setting the Division has requested to fund Phase 3 model for 6 months.

Shalbourne (Private Patients) – Front door project also includes a small Private Patient Unit, no timeframes for plans to open. The existing Private Patients staff are currently deployed across the division and into USC /ICC.

ICU – The pre COVID-19 establishment was funded to a dependency of 8, however the unit was frequently working at a higher dependency and using high cost temporary staff to accommodate pre Covid 19 demand The Phase 3 model supports a dependency of 10 and is part of budget setting the division has requested.

Patient Testing – The service was developed to support COVID-19 PCR testing for all elective patients in the organisation and has expanded to support lateral flow testing in maternity services. There are on average 120-135 PCRs per morning. Lateral Flow Tests are on average 40-60 patients with partners (to support visiting) this becomes 80-120 in total Monday – Friday. This is being reviewed to develop a different model going forward.

Maternity Services:
Birthrate Plus is a nationally recognised tool to calculate Midwifery staffing levels. The methodology underpinning the tool is: the total Midwifery Time required to care for women on a one to one basis, throughout established labour. The principles underpinning BR+ methodology are consistent with the recommendations in the NICE Safe staffing guidelines for Maternity settings and have been endorsed by the Royal College of Midwives and the Royal College of Obstetrics and Gynaecologists.

The Maternity Incentive Scheme also requires Trusts to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year. It should be submitted in the maternity incentive scheme year three reporting period (December 2019 – July 2021) and cover key safety issues.

Trusts have previously commissioned BR+ report every 2-3 years, GHW's last report was 2019, which highlighted a registered midwife gap of 9.8wte. The funding for these posts have now been agreed and recruitment is underway.

Maternity Acuity and Dependency
The Maternity Acuity and Dependency is captured live on the BirthRate Plus acuity tool which was implemented at GWH in 2020. The tool is able to model and calculate midwifery staffing numbers and will trigger escalation to the Maternity and Divisional Triumvirate if required. Further work in ongoing in its development and ensuring the escalation processes are in parallel to the acute wards processes.

Current vacancy
In addition to the BR+ gap, the current Midwifery vacancy level is 12.8 WTE registered midwives, this is further compounded by high level of Maternity Leave and Long Term sickness.

Table 3 Vacancies in Maternity in May 2021

Area	Vacancy Level
Delivery Suite /Hazel ward/ White Horse Birth Centre	2.11 WTE (+7.56 WTE in CoC teams)
Day Assessment Unit/Antenatal Clinic	4.49 WTE
Community Midwifery	6.20 WTE
Total	**12.80 WTE**

To mitigate this there is a robust recruitment and retention plan with short, medium and long term actions in place and regular workforce meetings with senior representation.

Continuity of Carer
The provision of care by a known midwife throughout the pregnancy, labour, birth and postnatal period can be associated with improved health outcomes for the mother and baby, and also greater satisfaction levels. It is being implemented throughout England by NHSE&I through the Maternity Transformation programme. Continuity of Care for 2 teams was commenced in April 2021, this has had an impact of 7.56 WTE midwives transferring from the acute inpatient services to join the Continuity of Carer teams. During the transition period the benefit of Midwives coming in to support the women in their teams in Delivery Suite has not yet been fully realised.

1 to 1 care in labour

The Maternity Service monitors and reports its Midwife to Birth ratio on a monthly basis. This is the ratio as recommended by the Royal Collage of Midwives and Safer Childbirth (2007).

The midwife to birth ratio is calculated and reported on using the funded establishment rather than the actual staffing numbers. The use of RAG ratings clearly demonstrates when ratios are outside the accepted standard of 1:28 midwife to birth ratio as follows:

- Red 1:40 or above,
- Amber 1:30 < 1:39 inclusive
- Green 1:28 or below

Table 4 illustrates that over the 12 months period there has been some fluctuations in ratios as a result of increasing birth numbers. In nine months out of 12 the midwife to birth ratio was within the accepted standard the remaining 3 months showed a slightly higher caseload for midwives in the amber category. Any increase in status would result in escalation so mitigation to cover any shortfalls would be actioned.

Table 4 Midwife to Birth Ratio

	Births	Funded WTE	Ratio
Apr-20	**351**	135.68	**01:25**
May-20	**356**	135.68	**01:28**
June-20	**330**	135.68	**01:27**
Jul-20	**349**	135.68	**01:31**
Aug -20	**352**	135.68	**01:28**
Sept-20	**375**	135.68	**01:30**
Oct -20	**334**	135.68	**01:30**
Nov-20	**332**	135.68	**01:27**
Dec-20	**322**	135.68	**01:28**
Jan-21	**337**	135.68	**01:28**
Feb-21	**334**	135.68	**01:28**
Mar -21	**320**	135.68	**01:28**

The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service

For the first six months 01/04/20 - 31/01/20 71% compliance was achieved with the labour ward co-ordinator maintaining supernumerary status during their shift.

The remaining six months 01/11/20 - 31/03/21 showed a small increase in compliance to 73.5%

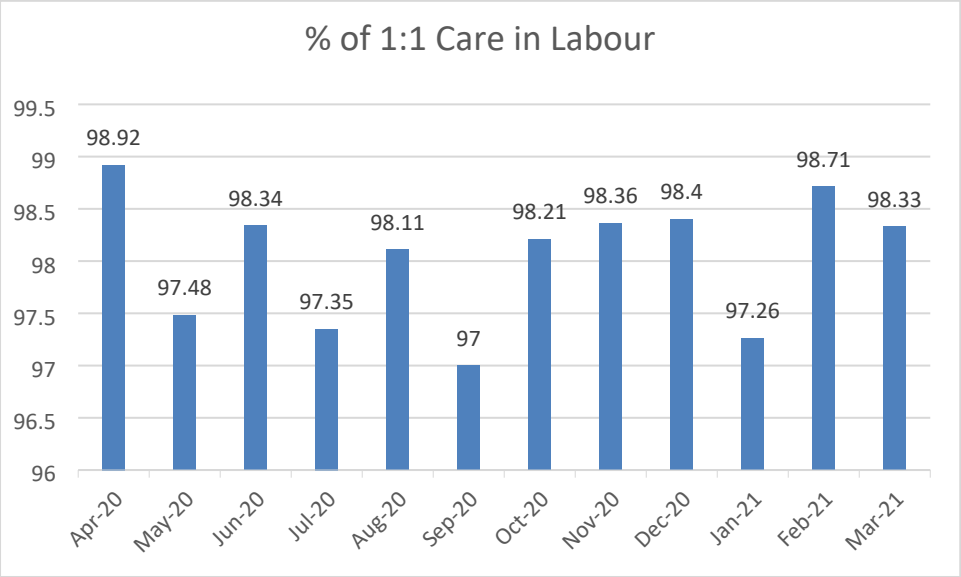
The focus is on achieving 100% compliance and identifying measures to achieve this with the team.

All women in active labour receive one-to-one midwifery care

The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision.

This is audited monthly and Graph below demonstrates an average of 95% compliance over the 12 month period. September which showed the highest number of births for this period showed the lowest compliance of 1to1 in labour. It remains a priority to achieve 100% compliance in this standard.

Graph 1 1to1 Care during Active Labour



Red flags

The Maternity unit uses a 'Red Flag' indicators for identifying critical shifts and have identified 10 red flags which trigger escalation and follows the procedure to mitigate, taking an overview of staffing across Maternity and relocating staff to the most in need area as required and outlining both clinical and management actions

The 10 red flags are as follows

- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes for suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example diabetes medication)
- Delay of more than 30 minutes in providing pain relief
- Delay of more than 30 minutes between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delay recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
- Supernumerary status of Delivery Suit coordinator not achieved

The charts below demonstrate the last years data on the red flags.

Staffing Factors - % of Occasions Recorded

Red Flags - % of Occasions Recorded

Clinical Actions - % of Occasions Recorded

Management Actions - % of Occasions Recorded

Unscheduled Care

The table below shows the changes in USC in the response to COVID19. Currently this has been reduced and there is no longer an increase in registered nurse staffing in ED and Mercury.

Table 5 Unscheduled Care changes to establishments during Covid-19

USC Phase 2 staffing requirements	Current Cost	Current WTE	Proposed Cost	Proposed WTE	Total Cost Increase	Total WTE Increase
Emergency Department (20 RNs + 1)	£ 6,144,508	145.12	£ 7,297,376	174.50	£ 1,152,868	29.38
AMU	£ 4,659,973	122.57	£ 4,868,552	127.18	£ 208,579	4.61
Mercury	£ 1,645,688	41.32	£ 1,862,986	46.70	£ 217,298	5.38
Saturn phase 2	£ 1,657,393	44.01	£ 1,370,074	35.95	-£ 287,319	-8.06
Neptune phase 2 (8 RNs)	£ 1,788,889	46.70	£ 2,739,206	68.21	£ 950,316	21.51
Substantive Model	**£15,896,451**	**399.72**	**£18,138,193**	**452.54**	**£ 2,241,742**	**52.82**
Agency costs	£ -		£ 529,285		£ 529,285	
Total funding required	**£15,896,451**	**399.72**	**£18,667,478**	**452.54**	**£ 2,771,026**	**52.82**
Cost pressure funding	£ 760,731	19.92			-£ 760,731	-19.92
Increase required	**£16,657,182**	**419.64**	**£18,667,478**	**452.54**	**£ 2,010,295**	**32.90**

Acute medicine - increase in current establishment to support the COVID Assessment Unit (CAU) it is planned to revert back to pre COVID establishment in June 2021 providing we can close CAU.

Saturn – reduction in establishment due to reconfiguration of the bed base to support respiratory with extra capacity throughout the pandemic. The WTE workforce was moved into Neptune's establishment due to increase in their bed base.

Neptune – increase in current establishment to open a high care respiratory unit and extra bed capacity as part of our response to COVID19. This has been recruited into substantively as agreed through COVID Board. There is a plan to reduce the bed base on Neptune and the staff moved from Saturn to Neptune at the start of the pandemic will return. There will still be an increase in current establishment to manage the high care respiratory unit.

ED – an extra HCA (6th HCA) was agreed February 2020 to support privacy, dignity, hydration and nutrition to patients in a crowded ED. As part of the response to COVID 19 ED expanded to what was the Surgical Assessment Unit to increase the capacity to care for patients to avoid any crowding in the main department. The 6th HCA was utilised to care for the patients in this area which is now called majors step down.

Mercury Ward – this is a 35 bedded ward with an establishment of 2 x HCA's at night. Following a review of quality indicators e.g. amount of falls and call bell response times at night it was agreed to increase to 3 x HCA at night to support quality and safety of patients.

Trainee Advanced Nurse Practitioners (ACP's) – currently our trainee ACP's are Band 7's with no budget to support an increase to 8a when they complete their masters in advanced practice and are competent against the competency framework. Years of training and support to get to this level is needed and without the budget to support the increase in banding there is a risk that they will leave to work for another provider who offers Band 8a. This is part of our cost pressure for budget setting this year as this role is pivotal to many of the services we deliver.

Community Staffing
Community Nurse staffing continues to be challenged over the last 6 months associated with significant increases in demand and activity. This is described on the risk register.

There continues to be temporary funding from the CCG for 20 wte additional posts, which are being filled with temporary staff (bank and agency). The fill rates through bank and agency staff for these posts are relatively low and there is a daily call with the Temporary workforce team to determine if shifts should be released to high cost / off framework agencies. The division is working up a plan to substantively recruit to these posts as funding allows.

In May 2021, the Trust signed up to a NHSE&I Community Nursing Staffing Tool project, which will help develop acuity and dependency data and a safe staffing tool similar to the model used for acute wards. The initial planning meeting with NHSE&I has occurred.

Nursing and Midwifery Staffing Review
A detailed nursing and midwifery staffing review of every ward is planned with the Chief Nurse between May and August, this will ensure that the establishments are aligned with the principles for staffing on general inpatient wards. Inpatients areas should be based on a 60:40 registered to unregistered nurse, although it is recognised that some specialist areas will have a higher ratio due to complex drug regimes / high acuity.

The principle of the ratio of the numbers of patients per nurse should be one registered nurse to eight patients day and night.

The staffing reviews will help determine which areas are compliant with these principles and a risk assessment will be completed if not. This process will help inform budget and financial planning in future.

5. How does the Trust know its been safely staffed over the last 6 months

Safe staffing process
A new safe staffing SOP was implemented in January 2021 along with implementation of Trust wide staffing meetings and the more robust use of the 'Safe Care Live' electronic system that reviews staffing with acuity and dependency. The Divisional Directors of Nursing are leading the staffing meetings and moving staff appropriately across the Trust to ensure all areas are safely staffed as well as ensuring effective use of resources.

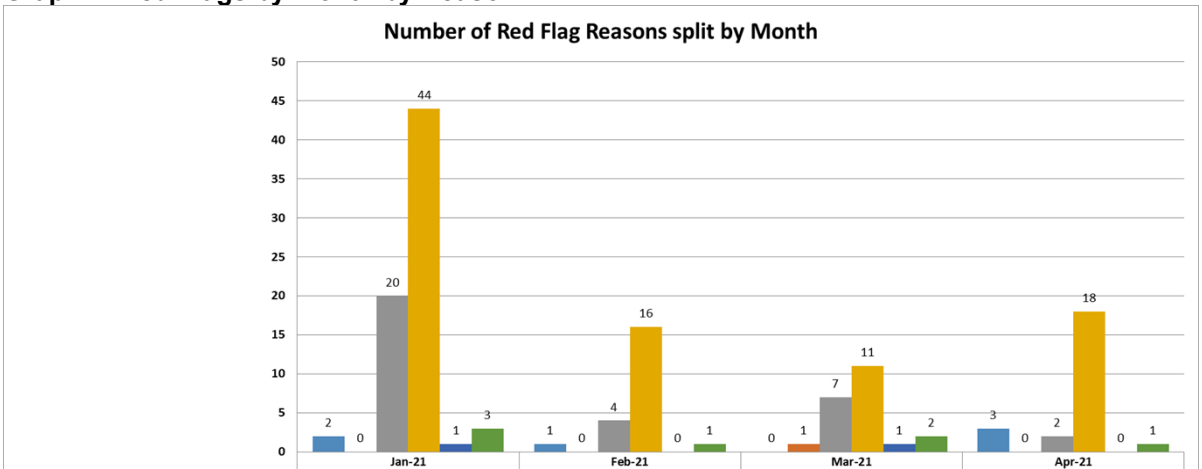
Red Flags
The Acute Wards in the Trust uses a 'Red Flag' for identifying critical shifts and follows the procedure to mitigate, moving staff from 'green' areas, utilising non clinical time etc. This is part of the Safe Staffing process and implemented in line with national guidance.

- A "shortfall" of more than 8 hours or 25% (whichever is lower) of registered nurse time available compared with the actual requirement for that shift. This assumes that the area has no empty beds and patient acuity and dependency is within the average for that area.
- Less than 2 registered nurses present on a ward during a shift

In addition, Red Flag Incidents can be added to the Safe Care Live System for some staffing indicators: missed intentional rounding; delays in providing pain relief, unplanned omission of providing medications, vital signs not assessed or reported.

Further work is required to ensure that these validated, not reported in error or mitigated but not removed. However, it does portray the staffing challenge in January with the increased activity relating to Covid 19 and winter pressures.

Graph 2: Red Flags by month by Reason



	Jan-21	Feb-21	Mar-21	Apr-21
Delay in providing pain relief	2	1	0	3
Less than 2 RNs on shift	0	0	1	0
Missed 'intentional rounding'	20	4	7	2
Shortfall in RN time	44	16	11	18
Unplanned omission in providing medications	1	0	1	0
Vital signs not assessed or recorded	3	1	2	1

Fill rates

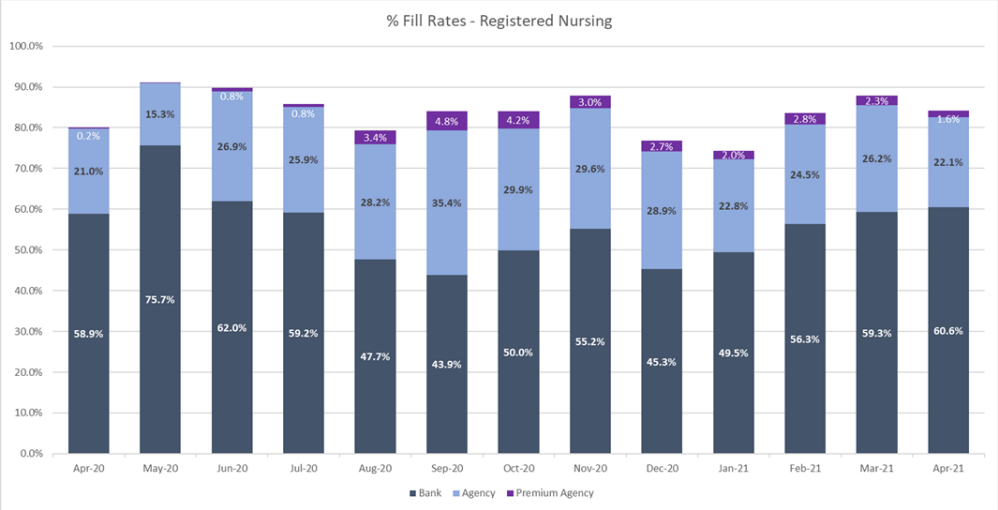
The Trust should be submitting monthly returns to the Department of Health via the NHS National Staffing return. This return details the overall Trust position on actual hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN) and Health care assistants for day and night shifts, together with the overall Trust percentage fill rate.

With the changes in ward establishments and additional capacity this data hasn't been accurate so work has been completed to improve the accuracy and formal reporting will resume in May 2021.

However, fill rates have been monitored daily through the Safe Care Live process and staffing meetings and no shift has been left as 'red' (or unsafe staffing levels) throughout this time.

Agency and Bank fill rates are below (table X), prior to moving to the PSL work was completed to ensure that only 'critical' shifts were released to agency. Currently shifts are released to nurse agencies (at NHS Cap Rates) 2 weeks ahead of the shift, work is on going to 'turn off' automatic escalation to agency when wards reach substantive recruitment of over 70%.

Graph 3 Fill rates for bank and agency nursing



Staffing incidents

Staffing incidents will be reviewed at the Senior Nurse workforce meeting going forward for themes and actions to improve.

The overall number of staffing incidents is relatively low, further work is required to determine if this is under reporting. There are no reports of actual harm from any reporting staffing incident.

Nurse Vacancy Data for Jan, Feb and March 2021

Table 6 Vacancy Data for Jan, Feb and March 2021

		Budgeted WTE			Contracted WTE			Vacancies WTE			Vacancies %		
		Jan 21	Feb 21	Mar 21	Jan 21	Feb 21	Mar 21	Jan 21	Feb 21	Mar 21	Jan 21	Feb 21	Mar 21
Nursing Breakdowns (inc. Midwifery and Corporate Services)	Bands 2-4	752.10	752.10	752.10	679.55	730.14	735.93	72.55	21.96	16.17	9.65%	2.92%	2.15%
	Bands 5-7	1483.86	1483.91	1483.91	1387.92	1410.57	1431.20	95.94	73.34	52.71	6.47%	4.94%	3.55%
	Band 2	515.94	515.94	515.94	434.39	448.00	451.59	81.55	67.94	64.35	15.81%	13.17%	12.47%
	Bands 3-4	236.16	236.16	236.16	245.16	282.14	284.34	-9.00	-45.98	-48.18	-3.81%	-19.47%	-20.40%
	Band 5	773.94	773.94	773.94	703.99	709.81	719.79	69.95	64.13	54.15	9.04%	8.29%	7.00%
	Bands 6-7	709.92	709.97	709.97	683.93	700.76	711.41	25.99	9.21	-1.44	3.66%	1.30%	-0.20%

Hot spot areas for vacancy are

- Emergency Department (8wte) successfully recruited to posts and waiting employment checks.
- Acute Medical Unit (16.4wte) recruited to 50% of the posts and supporting Overseas Nurses recruitment, projected to be fully recruited by October 2021.
- Forest and Orchard (8wte) additional Overseas Recruitment programme in place.

HealthCare Assistant Vacancy
The Trust had a successful health care assistant recruitment campaign supported by the additional investment from NHSE&I's Health Care Support Worker Programme, this programme aimed to have as close to zero vacancies by March 2021 as operationally possible. In March 2021 the Trust had 16.41 wte vacancies at band 2-4 with a pipeline of 24.8wte.

There continues to be significant vacancies for Health Care Assistants in Sunflower Lodge due to the uncertainty of future funding and model for the unit. It is currently being staffed with regular bank Health Care Assistants and any shortfalls escalated through the Trust's safe staffing meeting.

There is now a focus on retention and development of the unregistered workforce with on going recruitment to turnover.

Turnover
Turnover remains steady throughout the last 6 months despite the pandemic. There is a continual focus on retention and there are a number of Trust wide and local initiatives to support staff in their health and well being.

The unregistered workforce is slightly higher and further work is ongoing to look at retention initiatives and development opportunities and pathways specifically for this group.

Table 7 Turnover by Registered and Unregistered Nursing (voluntary)

Month	Division	Staff Group	Vol Turnover
Oct-20	Trust	Registered Nursing and Midwifery	7.73%
Nov-20	Trust	Registered Nursing and Midwifery	7.57%
Dec-20	Trust	Registered Nursing and Midwifery	7.13%
Jan-21	Trust	Registered Nursing and Midwifery	7.52%
Feb-21	Trust	Registered Nursing and Midwifery	7.70%
Mar-21	Trust	Registered Nursing and Midwifery	7.28%
Oct-20	Trust	Unregistered Nursing and Midwifery	9.22%
Nov-20	Trust	Unregistered Nursing and Midwifery	8.96%
Dec-20	Trust	Unregistered Nursing and Midwifery	9.84%
Jan-21	Trust	Unregistered Nursing and Midwifery	10.02%
Feb-21	Trust	Unregistered Nursing and Midwifery	9.82%
Mar-21	Trust	Unregistered Nursing and Midwifery	10.02%

Sickness
Sickness absence has remained steady in Registered and Unregistered Nursing, ranging from 3.63 – 4.49% in registered and from 5-8.05% in unregistered.

Table 8 % Sickness by Staff Group

Month	Staff Group	Sick %
Oct-20	Registered Nursing and Midwifery	4.06%
Nov-20	Registered Nursing and Midwifery	3.97%
Dec-20	Registered Nursing and Midwifery	3.99%
Jan-21	Registered Nursing and Midwifery	4.49%
Feb-21	Registered Nursing and Midwifery	3.74%
Mar-21	Registered Nursing and Midwifery	3.63%

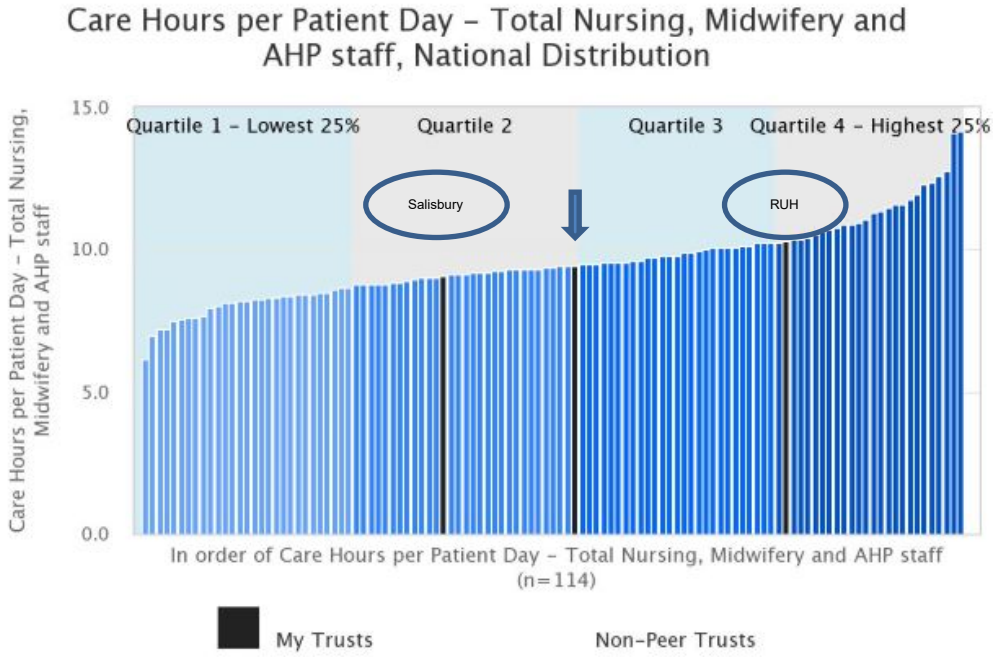
Oct-20	Unregistered Nursing and Midwifery	8.05%
Nov-20	Unregistered Nursing and Midwifery	7.98%
Dec-20	Unregistered Nursing and Midwifery	7.57%
Jan-21	Unregistered Nursing and Midwifery	6.80%
Feb-21	Unregistered Nursing and Midwifery	5.74%
Mar-21	Unregistered Nursing and Midwifery	5.00%

Acuity and Dependency / Care Hours Per Patient Day (CHPPD)
CHPPD was developed, tested and adopted by the NHS to provide a single consistent way of recording and reporting deployment of staff on inpatient wards/units.

The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone. The data gives a picture of how staff are deployed and how productively they are used. It is possible to compare a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. If a wide variation between similar wards is found it is possible to drill down and explore this in more detail. Every month the hours worked during day shifts and night shifts by registered nurses and by health care assistants are added together. Each day the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate the average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

The care hours per patient day required to deliver safer care can vary in response to local conditions, for example the layout of wards or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. Lower levels of CHPPD may also reflect organisational efficiencies or innovative staffing deployment models or patient pathways.

Graph 4 National comparator of Care Hours Per Patient Day (from Model Hospital).



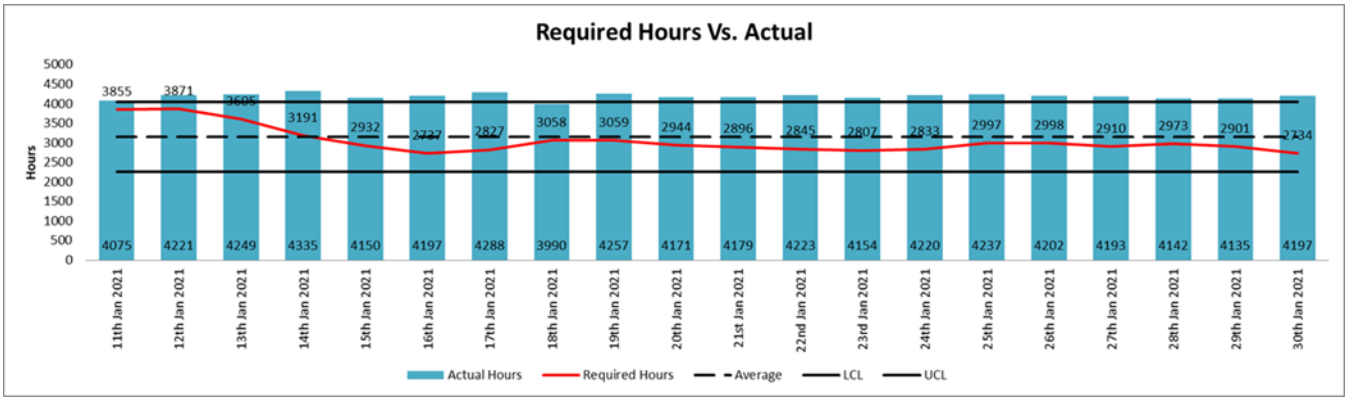
In line with national recommendations, 20 days of acuity and dependency data was collected and analysed in January 2021. The acuity and dependency data was then compared with the 'actual' staffing available.

This demonstrated that staffing levels were within safe parameters safe, there were no wards that had 'required' more nursing hours than 'actual' staff numbers over the 20 days.

Ward by ward analysis has also been completed with no immediate concerns although Trauma and Orchard / Forest Ward all require further analysis.

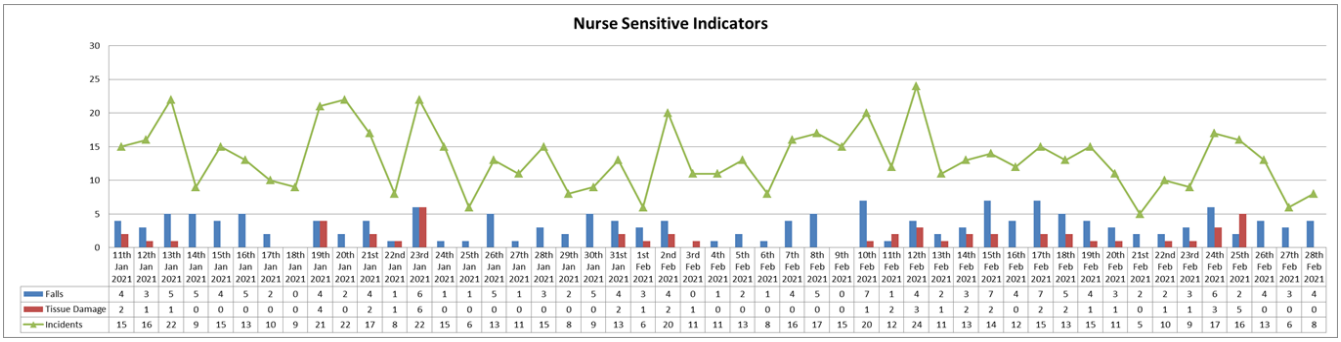
To note this data does not include, admitting / transferring / discharging patients so will not give an accurate reflection of workload in high patient turnover areas. Registered Mental Health Nurses or health care assistants providing enhanced care will also be included in the CHPPD.

Graph 5 Results of the 20 day collection of Acuity and Dependency Data in January 2021



Nurse sensitive indicators were also completed for the same time period and no direct link to staffing levels were observed.

Graph 6 Nurse sensitive indictors for 20 day data collection period.



E roster Metrics

Good rostering management is essential for staff well being and effective use of resources. Roster reviews have been completed for all inpatient wards by the Lead Nurse for Transformation, a summary is below.

Actions following the review process include further training on good roster management especially around the headroom data. The standards for supernumerary time have also been implemented. This exercise will be completed regularly to improve the KPIs and ensure ongoing compliance.

Table 9 Outcomes of E Roster KPIs reviews

KPI	Dove Compliance	Forest Compliance	ACU Compliance	AMU Compliance	ASU Compliance	ED Compliance	Jupiter Compliance	Mercury Compliance	Teal Compliance	Wood Pecker Compliance	Ampney Compliance	Meldon Compliance	Orchard Compliance
1. Annual Leave target – 14.58% (within headroom), with a tolerance of 14.00%- 16.00% on each roster, (for both Registered and Unregistered employees on the rosters).	Yes	No	Yes	No	Yes	No	No	Yes	No	No	No	No	No
2. 25% of staff members leave entitlement taken per quarter.	Yes	No	Yes	Yes	No	No	Yes	No	No	No	No	No	No
3. Sign off roster by scheduled deadline for Partial Approval	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No
4. Sign off roster by scheduled deadline for Full Approval	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No
5. Unused contracted hours - Time Balance. The net time balance should not exceed 12 hours.		No	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	No	No
6. Ward/department managers, and senior managers, should also request their AL via Employee on Line (EOL), to be approved by their line manager.	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No
7. All study leave needs to meet Trust headroom parameters and needs to be approved by the Ward/Departmental Lead/Matron. Requests must be made via EOL, stating where study is mandatory, and the Ward/Departmental Lead/Matron should prioritise such requests when approving, to meet headroom target.	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A				N/A
8. Assess the amount of time that staff are rostered as supernumerary aligned to below (ref. Staffing controls protocol Many 2018).	Yes	No	N/A	No	Yes	No		N/A	Yes				N/A
	75.0%	0.0%	75.0%	62.5%	75.0%	0.0%	50.0%	62.5%	12.5%	50.0%	50.0%	12.5%	0.0%

Colour Key		
Yes	2	0%-60%
N/A	1	60%-90%
No	0	90%-100%

Observations

8 KPIs are defined to monitor the performance of **Electronic Roster** from different perspectives for wards listed above. Forest, ED, Teal, Meldon and Orchard wards are areas of core concern and the DDONs are ensuring that these areas are supported with the improvements needed.

Other areas also require very close monitoring to improve their compliance level to the maximum (100%)

6. Workforce planning for the future

Agency reduction

In 2020/21 the Trust spent £5,599,258.23 agency nursing, including £750K on Registered Mental Health Nurses. Sustained reduction in nurse agency is part of the OD and Workforce Transformation Plan. Actions undertaken in 2021 include:

- Recruitment and retention of substantive workforce including Overseas Nurses Recruitment Programme
- Health Care Assistant recruitment
- Implementation of the Preferred Supplier List to improve fill at NHS Cap rates
- Agency RMN Reduction plan

Workforce redesign

There is a project on the Trauma Unit led by the Lead Nurse for Workforce Transformation and Improvement. The aim of the project is to:

- Increase the confidence of staff caring for patients on the Trauma unit.
- Review of the Band 4 Nurse Associates, to maximise the potential of the role and how we can use them effectively within the nursing establishment.
- Establish the opportunity of 'blended' roles specifically Therapy Assistants / Health Care Assistants / use of pharmacy technicians to support medication administration.
- Strengthen integration of Therapists / Nurses as part of the ward team, for example 50% of therapists basing themselves on the ward at 8am to support patients mobilising / getting dressed etc

Nursing Associates

The introduction of the Nursing Associates aims to bridge the gap between health care support workers and registered nurses. The role is a registered role with the NMC and is focused on supporting Registered Nurses to spend more time using their skills and knowledge to focus on complex clinical duties and leading decisions in the management of patient care.

The role is under utilised at GWH and work is underway to ensure that we maximise the potential of the role and build the role into ward establishments.

RMN Reduction
An improvement plan is underway to reduce the reliance on agency RMNs and increase the skills of our substantive staff. This plan includes training up unregistered staff with enhanced skills in behaviour / mental health skills.

International Recruitment
The Trust has welcomed 75 International Recruits in the last 6 months. There were 2 successful bids for NHS England monies to support the programme, the funding included educational support for Objective Structured Clinical Examination, pastoral care and the management of the recruitment process in HR.

International Recruits bring an immense opportunity to the nursing workforce and work is underway to strengthen the support they have in practice to ensure they have a valuable experience and we maximise their potential.

Representation of BAME staff in Nursing and Midwifery
The NHS Workforce Race Equality Standard report 2019 highlighted the need for Trusts to review career progression of Nursing and Midwifery staff from an ethic minority background.

When looking at Clinical (non medical) workforce at Band 7 or above, GWH have 22 staff from an ethic minority background compared to 417 who identify as White. The Trust Lead for Equality and Diversity has been invited to the Nursing and Midwifery Workforce Group to discuss this further.

Summary
This report has captured the work to ensure safe staffing within the Nursing and Midwifery workforce. The priority continues to build a workforce for the future, building our substantive staff and focusing on retention and professional development. There has been good progress reducing the band 5 and health care assistant vacancies and better utilisation of existing resources through the safe staffing meetings and use of Safe Care Live.

Ockenden Quarterly Report

Meeting	Board of Directors	Date	1st July 2021

Summary of Report

This report provides the Board of Directors with an update on progress with recommendations laid out in the Ockenden Report (written following an independent review of maternity and neonatal services at Shrewsbury and Telford Hospital NHS Trust) and the Trust's actions to achieve full compliance. It also describes the investment that will be required in the Maternity Workforce and the plan to meet Midwifery staffing standards.

A detailed report was submitted to the Board of Directors in February 2021 that highlighted the Trust's position against the 7 Immediate and Essential Actions (IEAs) and the 10 Maternity Incentive Scheme Safety Actions laid out in the NHSE&I Assurance Assessment Tool. This assurance tool was subsequently submitted and assessed by NHSE&I. The NHSE&I assessment was favourable to the GWH position, reducing 4 'Red' actions to Amber. However, they highlighted the concerns about the leadership accountability structure, which is now being addressed.

There is a robust action plan in place to ensure the Trust is fully compliant, which is monitored through Maternity Governance and Divisional Management Board, and evidence is being collated to provide assurance. There is also a Maternity Safety Champions Group to provide additional governance and Executive / Non Executive Oversight.

Following a letter from the Chief Nursing Officer on the 8th April 2021 describing the investment in Maternity Workforce and Training, the Trust has submitted a bid for £**533,570**.

The report also highlights the progress to meet the BirthRate Plus (BR+) standard and plans to support Midwife recruitment.

For Information		Assurance	x	Discussion & input		Decision / approval	

Executive Lead	Lisa Cheek, Chief Nurse
Author	Luisa Goddard, Deputy Chief Nurse and Christina Rattigan, Head of Midwifery
Author contact details	Luisa.goddard@nhs.net Christina.rattigan@nhs.net

Risk Implications - Link to Assurance Framework or Trust Risk Register

Risk(s) Ref	Risk(s) Description	Risk(s) Score
2819	Due to the Ockenden Report published in December 2020 - mothers and babies are at risk of potential harm in the event of not achieving all 7 immediate and essential actions as outlined in the Ockenden Report.	9

Legal / Regulatory / Reputation Implications	The Ockenden Report and implementation of actions has the potential to impact on The Trust's reputation, regulatory framework and legal cases.

Link to relevant CQC Domain

Safe	X	Effective		Caring		Responsive		Well Led	

Link to relevant Trust Commitment	

Consultations / other committee views

Executive Directors

Recommendations / Decision Required

The Board is asked to
(a) note the progress to meet the recommendations outlined in the Ockenden Report and the on-going work to ensure full compliance.

Introduction

The Ockenden report was written following an independent review of maternity and neonatal services at Shrewsbury and Telford Hospital NHS Trust. The report outlines the emerging findings and recommendations from the independent maternity review on the first 250 reported cases of maternal and neonatal harm. Although the investigation is not complete, it has identified immediate and essential actions for those that lead maternity services.

NHSE&I accepted all the recommendations and in a letter to Trust CEO's 14th December 2020 identified 12 urgent clinical priorities within 7 overarching actions for Trusts to meet Immediate and Essential Actions (IEA's). The Assurance Assessment Tool assesses Trust's against these IEAs and the 10 Maternity Incentive Scheme Safety Actions. GWH submitted the Assurance and Assessment Tool to NHSE&I on the 15th February 2021 and the Regional NHSE&I team subsequently assessed and independently rated GWH's evidence.

Progress with the Assurance Assessment Tool
There is some difference in the assessment by NHSE&I, detailed below, however of note they have reduced the 4 IEA's rated as non-complaint to partial compliance.

- GWH identified 4 IEAs as 'Red' (non-compliant, requires funding and resources) and 14 areas as 'Amber' (non-compliant, however have resources and funding).
- The Regional NHSE&I team assessed GWH as having 1 'Red', relating to accountability of the Head of Midwifery (which GWH had rated as green), reduced the other 'Red' EIAs and rated 15 as 'Amber'.
- One action the Trust had rated as green NHSE&I rated as amber '*External clinical specialist opinion from outside the Trust must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death'*

There have been additional audits added to the Maternity Audit Programme to ensure compliance and provide assurance that the changes in practice as a result of the Ockenden Report and action plan are sustained.

A summary of the GWH and Regional position against the Assurance data and the Amber and Red actions are described below:

Immediate and Safety Action (IEAs)	Assessments			Action to get to compliance
	GWH Feb 2021	NHSE&I March 2021	GWH May 2021	
IEA Action 1: Enhanced Safety Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.				Monthly Maternity Quality Metrics including the Perinatal Quality Surveillance report is submitted to Trust board as part of the Care section of the IPR. A structured safety report will be shared with LMNS quarterly.
External clinical specialist opinion from outside the Trust (but from within the region must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death				Maternal Death policy completed and available on intranet. Neonatal brain injury and neonatal death and intrapartum death pathways to be completed by 30th June 2021. This will then become compliant.
Maternity Safety Action 2 (CNST): Are you submitting data to the Maternity Services Dataset to the required standard				Fully compliant with the required standard after successful submission of the MSDS data in May 21.
IEA Action 3 : Staff training and working together Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.				MDT training trajectory is in place demonstrating 90% compliance by 31/06/21. This is monitored via the Divisional Board IPR and quarterly training validation by the LMS.
Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and				In progress, job plans are being reviewed by Clinical Lead and AMD. Additional funding submitted as part of NHSE&I bid.

present multidisciplinary ward rounds on the labour ward				
Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)				Maternity training budget has been ring fenced with statement from Director of Finance.
Maternity Safety Action 8 (CNST): Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?				Training trajectory in place to ensure compliance by July 2021.
IEA Action 4: Managing Complex Pregnancy All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.				System now in place and audit in April 2021 demonstrated 100% of women with complex pregnancy have a named consultant.
Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team				Early specialist involvement takes place with pathway to Oxford and women being involved in their management / care plan. Audit added to Maternity yearly audit programme.
Maternity Safety Action 6 (CNST): Can you demonstrate compliance with all five elements of the Saving Babies Lives care bundle Version 2?				February 2021 submission demonstrates partial compliance against this action. The next quarter survey will demonstrate full compliance.
IEA Action 5: Risk assessment throughout All women must be formally risk assesses at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional				Risk assessment undertaken at every contact

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.				Digital Midwife is exploring with other maternity Medway system users to share their electronic risk assessment data. Current risk assessment include place of birth
Links to urgent clinical priorities: A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.				As part of Better Births the roll out of Personalised care plans are in development across the LMNS. HOM is in liaison with LMNS to plan roll out.
IEA Action 7 Informed consent All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care				Working to ensure all service users have a voice including those women with vulnerabilities or those whose don't have English as a first language. MVP are working with the Trust to update the Maternity section of the website.
All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care - - Please could you state what information is available to those women who do not have access to the internet or cannot speak or read English				There is a plan in place to update the website by September 2021 and to include access to different languages.
Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care				Audits and feedback from Service Users being used to ensure that women are enabled to participate

				equally in all decision-making processes and to make informed choices about their care.
Women's choices following a shared and informed decision-making process must be respected				Work in progress with the MVP to ensure system in place to seek feedback from the BAME community and women with vulnerabilities.
Section Two: **Workforce planning** *Maternity Safety actions4 (CNST):* Can you demonstrate an effective system of clinical workforce planning to the required standard.				Robust system of clinical workforce planning and rota compliance confirmed but some gaps identified.
Maternity Safety action 5 (CNST): Can you demonstrate an effective system of midwifery workforce planning to the required standard?				The Trust has BirthRate Plus report in 2019 and uses the Acuity and dependency tool to determine staffing status. Recruitment to vacancies and additional posts underway.
Midwifery Leadership Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director				Structure has been changed so the Head of Midwifery is professionally accountable to the Chief Nurse and managerial accountable to Divisional Director of Nursing and Midwifery. The Head of Midwifery meets with Chief Nurse regularly. The structure is under review with the Regional Head of Midwifery to ensure alignment across BSW.
Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:				All requirements met with the exception of having a consultant midwife

Action plan to achieve all recommendations in the Ockenden Report

GWH has a robust action plan to achieve full compliance with all the IEAs and 10 Maternity Incentive Scheme Safety Actions. These actions are monitored through the monthly Maternity Governance and Divisional Board meetings. Any action not on track to achieve full compliance is then escalated through the Divisional Management Team to the relevant person and the Maternity Safety Champions are alerted.

A regular meeting with the Maternity Safety Champions has been set up with a standard agenda. The agenda will cover new Serious Incidents, the Assurance Assessment Tool, user feedback and reports from the Maternity Voices Partnership and the action tracker. A score card is being developed to help reporting and ensure these key metrics are clearly visible.

The Division is also ensuring that there is an Operational Head of Service for Maternity to support this transformational work.

The NHSE&I Portal to submit evidence of compliance is now live and all evidence is due to be submitted by 30th June. Evidence is currently being collated and we are on track to meet the submission deadline. All spot check audits and larger audits on the changes in practice that were detailed in the Assurance Assessment Tool have been added to the Maternity Audit Programme and will be uploaded to the portal as evidence.

Given the complexity of this action plan and evidence, collection support has been provided through the Trust's Transformation team.

Investment in Maternity Workforce and Training

In a letter of the 8th April 2021, the Chief Nursing Officer for England explained that to reduce variation in experience and outcomes for women and their families across England, NHSE&I is investing an additional £95.9m in 2021/22 to support the system to address all 7 IEAs consistently and to bring sustained improvements across all Maternity services. The funding is focused on 3 key areas highlighted in the Ockenden report; Midwifery Workforce, Obstetric Workforce and MDT Training.

GWH have submitted a bid on the 6th May 2021 for:

Midwifery Workforce (including MDT)		370,637
Consultant Obstetrician Time (including MDT)		70,211
MDT Training (other than midwives and consultants)		92,722
Total Funding Requirement		**533,570**
Contribution from Trust or System (+ve for contribution)		
Total Funding Request		**533,570**

The costing have been phased for 2021/2 (shown above) but recurrent funding was included in the bid. The costs shown include headroom costs for annual leave, sickness etc.

The Midwifery workforce gap is for 9.8 wte Midwives which will ensure that the Trust meets BirthRate Plus+ requirements, and 1wte Fetal Surveillance Midwife.

Medical staffing is 0.9wte consultant time to ensure compliance with the recommendation that there is Consultant led ward rounds 7 days a week.

Midwifery staffing

Birth Rate Plus+

Birthrate Plus is the national tool available for calculating midwifery staffing levels that is endorsed by the Royal College of Midwives and is incorporated within CNST standards issued by the NHS Litigation Authority. The use of Birthrate Plus has been recommended in all recent DH maternity policy and as part of the response to the Ockenden Report.

The last BirthRate Plus+ report for GWH was completed in 2019 and highlighted a gap of 9.84 wte.

BrthRate Plus+ is usually done every 3 years and is planned to be repeated December 2022.

There is currently a review of an element in Birthrate Plus+ to do with Continuity of Carer. This has been funded by the LMNS across the 3 maternity units and is due to start in GWH in June 2021.

In addition, there is currently a 12.80 wte vacancy gap for Registered Midwives across GWH, this is further compounded by some maternity leave and long term sickness.

To address these gaps a bespoke recruitment plan is in place with short, medium and longer term actions. However, it is recognised that all Midwifery Units nationally will be looking to recruit additional Midwives as a response to Ockenden and GWH is working closely with the LMNS to explore alternative recruitment routes.

The Trust currently supports Student Midwives from University of Western England, however explorative work is underway to see if the Trust can accommodate students from Oxford Brookes University as this may serve GWH's local community more.

Midwifery Leadership

Strengthening midwifery leadership: a manifesto for better maternity care (RCM 2019) describes the seven steps to strengthen midwifery leadership.

- A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service
- A lead midwife at a senior level in all parts of the NHS, both nationally and regionally
- More consultant midwives
- Specialist midwives in every trust and health board
- Strengthening and supporting sustainable midwifery leadership in education and research
- A commitment to fund ongoing midwifery leadership development
- Professional input into the appointment of midwife leaders

NHSE&I raised concerns that the previous structure was that the Head of Midwifery reported to the Divisional Director of Nursing and Midwifery. This has been addressed by having the Head of Midwifery professionally accountability to the Chief Nurse and managerial accountable to the

Divisional Director of Nursing and Midwifery. There are regular meetings with the Head of Midwifery and the Chief Nurse.

There is work on going to review the Midwifery Leadership structure in alignment across the Banes, Swindon and Wiltshire STP (BSW).

The Trust is also not compliant with this guidance as there isn't a Consultant Midwife in post and there is work ongoing within the workforce plan to scope this role for GWH / across BSW.

Next steps

- Submission of the evidence to the portal to be completed by the 30th June 2021.
- Continue to monitor the Action Plan through Maternity Governance and Divisional Board.
- Midwifery recruitment to be monitored through the Senior Nurse Work Force Group.

Conclusion

GWH NHS FT has the ambition to be one of the safest places to have a baby and are committed to focusing on excellence and ensuring the learning from the Ockenden report is fully embedded.
Work to achieve full compliance is on track and will be supported by the additional national funding bid.
There is significant focus on the current workforce gap in Midwifery with robust actions to mitigate in the short, medium and longer term.

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Board Assurance Report

Audit, Risk & Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Julie Soutter	Julie Soutter		1 July 2021
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Mortality Reviews - Update	A	A	Risk remains amber due to remaining actions for assurance arising from the report. Action plan in place and broad progress reported. Q&G to continue to review mortality on quarterly basis and IA audit follow up at ARAC.	Reports to Q&G IA follow up reports	Quarterly Bi monthly
Risk Tolerance and Appetite	A	A	Robust discussion on statement and usage including applicability, decision making, clarity and consistency. Exec Co work reflected in latest draft. Possible inclusion in Board workshop on risk management	Board workshop	TBC
National Cost Collection 20/21	G	G	Learning on process and controls embedded from previous submissions. Estimates and assumptions mostly set nationally with prescribed methodology. Risks arising due to staff changes and continuity mitigated.	Update	Sep 21
DBS Renewal Process	G	A	Alignment of approach with ICS partners. Trust now to bear cost of renewals where required. Exec Co to approve final process and implement.	N/A	

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Annual Report and Accounts	G	G	Year ended with Trust in surplus of £2.2m (£28k after technical adjustments – reconciliation to be added to notes to accounts). Underlying recurring deficit known and reflected in annual external audit report. Some minor changes to text. Recommend to the Board subject to agreed changes.	N/A	
KPMG Year End Report Annual Report 20/21 Draft Audit Opinion Draft Management Representation Letter	G	G	Audit reported to have progressed well this year. Some audit completion work was outstanding but nothing significant expected. Audit risks stable or reduced. No unadjusted audit differences. One adjusted audit difference corrected with nil impact on trust results. No subsequent events identified. Going concern confirmed on basis of revised definition (continuation of services principal) Unqualified audit opinion to be issued No significant weaknesses in VFM arrangements – noted system financial sustainability risk and management actions underway at system level. One informal improvement area noted – accruals process documentation. Two audit recommendations – Income uploads done via the system require review of approvals processes, coding quality checks to be reviewed. Testing extended but no issues reported. Other areas for potential improvement (informal) – ICS financial strategy and H2 plan impact assessment; scenarios in financial reporting to underpin risk assessment; more timely scheduling and/or completion of internal audit points (some improvements already); review/removal of old risks on system Audit recommendations to be scheduled in for action and review via ARAC No issues in Management Representations Letter.	N/A	
BDO Internal Audit Annual Report 20/21 and Statement of Assurance Follow-up of Recommendations Report	A	G	Overall moderate assurance that there is sound system of internal control. Good assurance/confidence on managements positive approach and actions to address areas for improvement. All audits were either significant or moderate for design, moderate for effectiveness, with only 1 Limited Assurance for effectiveness which was an area known to management and being addressed. Robust discussion on significance of some findings. Closure of old items where possible or rescheduled.	IA updates	Bi monthly

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Data Quality IA Report	A	R	Discussed data quality impact across organisation. Actions required to improve data access, awareness, training, support and resources - as well as understanding of responsibilities - across all teams. Understanding, communication and use of policies discussed. Policy approval process to be reported to ARAC for further discussion.	Policy approval process to ARAC	TBC
Risk management Advisory Review	A	R	Advisory review requested in anticipation of new system and impact of recent changes to divisional structures and management. Discussion centred around achieving good risk identification and description; consistency of risk management and reporting; governance. Opportunity for new system to enable better quality risk management across Trust. Agreed to recommend Board workshop on risk management.	IA follow up reports Board workshop	Bi monthly TBC
Data Security and Protection Toolkit	A	A	Some gaps in compliance with new and tougher Toolkit requirements. Plan to address for June submission. GWH in top quartile of Trusts audited.	Report back to ARAC	July
Counter Fraud Annual Report 20/21 Self Review Toolkit	G	G	No significant weaknesses or risks identified during the year. Assurance based on return for Standards for Providers 20/21. Work to do for compliance with new standards for 21/22 and plan in place to address new requirements	CF Updates	Bi monthly
Counter Fraud Strategy and Annual Plan	G	G	No known areas of high risk. Areas to address to meet new standards for 21/22 submission. Work progressing. Strategy and Annual Plan in place.	CF Updates	Bi monthly
Losses and Compensations Payments Q4 and 20/21	A	G	Review of aged debtors to be progressed with increased focus on NHS Property Services and actions from agreement of balances at year end.	Agenda item	Quarterly

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

ICS Development Update

Meeting	Trust Board	**Date**	1 July 2021

Summary of Report

This presentation summarises the latest guidance relating to ICS development from the Design Framework published on 16 June 2021.
Report template - NHSI website (england.nhs.uk)

The Board's attention is drawn to:

- The respective roles of the ICS Partnership and ICS Body
- The membership of the ICS NHS Board
- Options for place-based leadership and delivery
- Requirements for provider collaboration

For Information	x	Assurance		Discussion & input	x	Decision / approval	

Executive Lead	
Author	Claire Thompson, Director of Improvement & Partnership
Author contact details	claire.thompson10@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	There are legal implications in relation to future organisational form and provider collaboratives which are not covered in this update and would be subject to future more detailed board discussion. There is a positive opportunity in relation to place-based leadership and integration of services for GWH.

Link to relevant CQC Domain

Safe		Effective		Caring		Responsive		Well Led	x

Link to relevant Trust Commitment	N/A

Consultations / other committee views

Not applicable due to timing of release

Recommendations / Decision Required

The Board is recommended to note the contents of this update

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ICS Development Update

Trust Board Update – July 2021

ICS Design Framework Overview

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- The ICS Design Framework was published on 16th June and sets out the next level of detail on expectations and ambitions for ICSs from April 2022.
- It builds on the White Paper and, where relevant, will be subject to legislation
- There is a focus on expectations for the NHS specifically, and the functions, governance and role of the ICS NHS Body, in the context of the wider ICS Partnership.
- There is a re-commitment to the principles of subsidiarity, collaboration and flexibility, in the context of consistent national standards and common core components of integrated care systems.
- There is a recognition that the ongoing role – and accountabilities – of individual organisations within each ICS footprint; the role of the ICS to make these greater than the sum of its parts
- The Design Framework will be followed by further resources and materials to support transition over the course of this year, including draft statutory guidance where relevant.

DESIGN FRAMEWORK: CONTENTS

- The ICS Partnership
- The ICS NHS body
- People and culture
- Governance and management arrangements
- The role of providers
- Clinical and professional leadership
- Working with people and communities
- Accountability and oversight
- Financial allocations and funding flows
- Digital and data standards and requirements
- Managing the transition to statutory ICSs

The ICS Partnership

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Each ICS will have a Partnership at system level, formed by the NHS and local government as equal partners – it will be a committee, not a body.

Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be widely drawn from all partners working to improve health, care and wellbeing in the area, to be agreed locally.

There is an expectation that the ICS Partnership will have a specific responsibility to develop an "integrated care strategy" for their whole population.

The chair of the partnership can also be the chair of the ICS NHS body but doesn't have to be – for local determination.

DHSC will issue further guidance, which is expected to be permissive

The ICS NHS body

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The functions of the ICS NHS body will include:

- **Developing a plan** to meet the health needs of the population
- **Allocating resources** to deliver the plan across the system (revenue and capital)
- Establishing **joint working** and **governance** arrangements between partners
- Arranging for the provision of health services including through contracts and agreements with providers, and **major service transformation programmes** across the ICS
- **People Plan** implementation with employers
- Leading system-wide action on **digital and data**
- Joint work on **estates**, **procurement**, **community development**, etc.
- Leading **emergency planning and response**

The ICS NHS bodies will take on all functions of CCGs as well as direct commissioning functions NHSE may delegate including commissioning of primary care and appropriate specialised services

There is an expectation that the ICS NHS body will have a unitary board – members of the ICS NHS Board will have shared corporate accountability for delivery of the functions and duties of the ICS and the performance of the organisation.

ICS NHS Board membership

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ICS NHS Boards will be different to traditional NHS boards, owned by the partners across the ICS

The minimum requirements for Board membership will be set out in legislation. In order to carry out its functions effectively there is an expectation for every ICS NHS body to establish Board roles above this minimum level, so that in most cases each Board will include the following roles:

Independent non-executives: Chair plus a minimum of two other independent non-executive directors.

Executive roles: Chief Executive, Finance Director, Director of Nursing and Medical Director.

Partner members: a minimum of three additional board members

- one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
- one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS Body
- one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS Body.

ICS NHS bodies will be able to supplement these minimum expectations as they develop their own constitution.

ICS Place-based leadership

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Place arrangements and leadership are for local determination – partners within each ICS will want to decide how best to bring together the parties to address the needs of the place, building from understanding at the level of neighbourhoods and primary care networks. Further supporting material will be shared in due course.

An ICS NHS body could establish any of the following place-based governance arrangements with local authorities and other partners:

- **Consultative forum**, *informing* decisions by the ICS NHS body, local authorities and other partners
- **Committee of the ICS NHS body** with delegated authority to take decisions about the use of ICS NHS body resources
- **Joint committee of the ICS NHS body** and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee
- **Individual directors of the ICS NHS body** having delegated authority, which they may choose to exercise through a committee
- **Lead provider** managing resources and delivery at place-level under a contract with the ICS NHS body

Providers and provider collaboratives

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Organisations providing health and care services are the frontline of each ICS. The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care

Providers will continue to retain their statutory duties and meet requirements under the NHS standard contract or relevant primary care contract, but with new relationships between commissioners and providers embodied in the composition of the ICS NHS board and ways of working across the ICS

It is expected that providers will increasingly lead service transformation, potentially via delegation of functions from the ICS NHS body

Primary Care Networks will play a central role in Place Based Partnerships

In addition to their partnerships at place level, trusts/FTs are expected to join provider collaborative arrangements from April 2022. (Ambulance trusts, community trusts, and non-statutory providers, are not required to join provider collaboratives but should where it makes sense). Each Provider Collaborative will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the Collaborative will agree together how this contribution will be achieved.

Transition timeline

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Current ICS and CCG leadership are accountable for managing transition, with increasing involvement of the new leaders (e.g. Chair, Chief Executive) who may be appointed on a designate basis, pending the legislation.

Each ICS should make initial arrangements to manage the transition and ensure that there is capacity in place ready for implementation of the new ICS body. Plans should be agreed with regional NHSEI teams.

The Transition timeline is set out in the Design Framework.

Key actions expected by the end of Q2 include:

- Carry out the agreed national recruitment and selection processes for the ICS NHS body Chair and Chief Executive – subject to/after the 2nd reading of the Bill these roles will be confirmed as designate roles.
- Draft proposed new ICS NHS body MoU arrangements for 2022/23, including ICS operating model and governance arrangements, in line with NHSEI model constitution and guidance.
- In Q3 the recruitment and selection processes for designate Finance Director, Medical Director, Nursing Director and other board level roles in the NHS ICS body via a local filling of posts processes.