Great Western Hospitals NHS Foundation Trust

Agenda Board of Directors

Date	1 April 2021
Time	9:30 - 14:40
Location	Teams
Chair	Liam Coleman
Description	

1 9:30	**Agenda**
2	**Apologies for Absence and Chairman's Welcome**
3	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust.
4	**Minutes (pages 1 – 10)** Liam Coleman, Chairman • 4 March 2021 (public minutes)
5	**Outstanding actions of the Board (public) (page 11)**
6	**Questions from the public to the Board relating to the work of the Trust (pages 12 – 13)**
7 9:45	**Chairman's Report, Feedback from the Council of Governors** Liam Coleman, Chairman
8 9:55	**Chief Executive's Report (pages 14 – 18)** Kevin McNamara, Chief Executive
9 10:15	**Staff Story - Shielding clinical staff and support in place (pages 19 – 24)** Linda Clements, Assistant Practitioner
10 10:35	**Integrated Performance Report (pages 25 – 100)** • Performance, People & Place Committee Chair Overview - Peter Hill, Non-Executive Director & Committee Chair Part 1: Operational Performance - Jim O'Connell, Chief Operating Officer • Quality & Governance Committee Chair Overview - Nick Bishop, Non-Executive Director & Committee Chair Part 2: Our Care - Lisa Cheek, Chief Nurse & Charlotte Forsyth, Medical Director

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

- Finance & Investment Committee Chair Overview - Andy Copestake, Non-Executive Director & Committee Chair

  Part 4: Use of Resources - Simon Wade, Director of Finance

11 **Chair of Audit, Risk & Assurance Committee Overview (pages 101 – 102)**

11:50 Julie Soutter, Non-Executive Director - Committee Chair

12 **GWH Performance & Public View Data (pages 103 – 104)**

12:00 Jim O'Connell, Chief Operating Officer

13 **Theatres and Outpatients Transformation (pages 105 – 128)**

12:10 Jim O'Connell, Chief Operating Officer

14 **Ratification of Decisions made via Board Circular/Board Workshop**

12:30 Caroline Coles, Company Secretary

15 **Terms of References of Committees – for approval (pages 129 – 149)**

Caroline Coles, Company Secretary

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

17 **Date and Time of next meeting**

Thursday 6 May 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 4 MARCH 2021 AT 9.30 AM, BY MS TEAMS

Present:

Voting Directors

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

In attendance

Helen Brown	Lead Palliative Care & End of Life Nurse (agenda item 392/20 only)
Caroline Coles	Company Secretary
Tim Edmonds	Head of Communications and Engagement
Amanda Fox	Deputy Chief Operating Officer
Louise Simmons	Junior Sister, Beech Ward (agenda item 392/20 only)
Helen Winter	Head of Quality (agenda item 392/20 only)

Apologies for Absence

Jim O'Connell (JO)	Chief Operating Officer

Number of members of the Public: 7 members of public (including 6 Governors; Arthur Beltrami, Chris Shepherd, Roger Stroud, Maggie Jordan, Janet Jarmin and Ashish Channawar)

Matters Open to the Public and Press

Minute	Description	Action
385/20	**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.	
386/20	**Declarations of Interest** There were no declarations of interest.	
387/20	**Minutes** The minutes of the meeting of the Board held on 4 February 2021 were adopted and signed as a correct record with the following amendments:-	

Minute	Description	Action

357/20 : Chair's Report / Governor Development - Change work 'interrupting' to 'interpreting'.

358/20 / Chief Executive's Report - Add to the last paragraph "*In relation to the item concerning staff support Lizzie Abderrahim, Non-Executive Director advised that she had attended the NHSE/I launch event for the Wellbeing Guardian role at which Boards were urged to take a more preventative approach to the matter of staff wellbeing.* There followed a discussion…..*".*

360/20 / Use of Resources – Change 10th paragraph 1st bullet point to "The *year-to-date* position was £130k *better than* plan", and the 2nd bullet point "The Trust's in month position was £71k *better than* plan".

388/20 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list and noted that:-

359/20 / Board Well-being Guardian - This action would be discussed at the next Non-Executive Director (NED) meeting on 17 March 2021.

389/20 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

390/20 **Chair's Report, Feedback from the Council of Governors**
The Board received a verbal update which included:-

Public Health Talks - A successful virtual public health talk was held in February 2021 on the Menopause with well over 100 attendees. Dr Griffiths was thanked for presenting at this event.

Council of Governors - A meeting of the Council of Governors was held on 18 February 2021 which included a presentation on Equality, Diversity and Inclusion together with approval of the recruitment and re-appointment of Non-Executive Director roles.

The Chair added that it was with great sadness to advise the untimely death of one of our governors, Enam Chowdhury who had been enormously supportive over a number of years both to the Trust and to the wider community. He was particularly a strong supporter during the Pandemic in supplying meals from his restaurant to staff and on behalf of the Board and Governors wished to record our condolences and recognition of his contribution to his family.

The Board **noted** the report**.**

391/20 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report and the following was highlighted:-

- The updated position with regard to Covid, which indicated a significant reduction in bed occupancy due to Covid since the last Board meeting. The focus would now shift to recovery.
- Thanks and praise was given to the small Infection, Protection and Control team

who had been incredible over a long period of time in managing any outbreaks as well as supporting flow through the hospital.

- On 11 March 2021 was the 1 year anniversary of the first covid patient and the Trust would mark this by a number of events in particular a memorial service to remember those lost.
- CQC had carried out a full inspection of our Primary Care services. Although no formal feedback had been received as yet the Trust were hopeful that the CQC would recognise the significant improvements made since the Trust agreed to take on these services in November 2019.
- The vaccination programme was still on-going and the Trust's great achievement in reaching 27,000 jabs.
- The progress in terms of the Way Forward Programme with regard to the approval of the land purchase which would accommodate new services. It was recognised that despite the restrictions caused by the pandemic over the last year staff, construction teams and partners continued to work across this challenging period to allow service development projects to continue and progress which was a positive step for Swindon and the surrounding area.

The Board **noted** the report**.**

392/20 **Patient Story**

Helen Brown, Lead Palliative Care & End of Life Nurse, Louise Simmons, Junior Sister, Beech Ward and Helen Winter Head of Quality joined the meeting for this item.

The Board received a presentation which centred on end of life and a patient's wishes to be at home with their family. The story highlighted the commitment from staff in order to make this happen, the processes involved which were turned around at a fast pace, within 4 hours, and multidisciplinary team working across the health community

The Board reflected on the story and recognised the importance not only to the patient but also to family members and this was a fantastic testament to the compassion and empathy of the staff involved.

There followed a discussion on how any learning could be applied and what additional support the Board could give so that more patients experienced this choice. It was recognised that training was key for all staff together with and support for end of life care in the community.

The Board thanked Helen and the team for such an inspiring and powerful story.

The Board **noted** the patient story.

393/20 **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 December 2020/January 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 around the IPR at its meeting on 24 February 2021 and

highlighted the following:-

Emergency Access – Assurance rating green. It was recognised that performance was not achieving the national standard, in line with other trusts, however the Trust now ranked 14th in terms of performance in the country despite the challenges being faced.

Cancer - Assurance rating amber. This was mainly due to the challenges within the breast service due to increased demand, COVID restrictions, consultant sickness together with some challenges with the Tertiary centre. It was recognised that improvement would be seen over the next 2-3 months.

Vaccination Programme - Assurance rating green. The Trust was leading and delivering an excellent and highly regarded programme.

Equality, Diversity and Inclusion (EDI) Priorities - Assurance rating green. The Committee were suitably assured from a presentation from the new EDI Lead on the priorities for 2021/22.

IT - Assurance rating green. There were a number of key developments presented to the Committee which were positively received.

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

Emergency Department/ 4 Hour Access - Performance against the 4 Hour Access standard had improved from 81.5% to 86.14%, however continued to be below the 95% standard. Daily 'Criteria to Reside' calls continued to focus on unblocking any delays to discharges and provided support to wards to identify earlier 'Golden Patients'. Covid-19 admissions to the Trust increased significantly in January 2021 and on 13 January 2021, the Trust declared a critical incident.

Cancer Performance - Plans were in place to address the challenges experienced within the breast service due to increased demand, COVID restrictions, and consultant sickness, together with some challenges with the Tertiary centre.

Referral to Treatment Time (RTT) - Overall, the Trust's RTT Incomplete Performance for December 2020 was 67.04%, which was an improvement of 0.34% in month. December saw referrals at 92% of the prior year. For the first time in 3 months, the Patient Treatment List (PTL) had increased in size (196).

Diagnostics - The diagnostic waiting times, DM01 performance, saw a slight decline to 61.5% in December compared to 62.5% in November 2020.

Stroke - The Trust continued to maintain SSNAP Level B performance. Q2 improved further on Q1 performance (73.1% v 77.9%) and Q3 was predicted to continue within Level B performance despite increasing pressure on stroke beds in December 2020.

The Chair asked how confident was the operational team in being able to take back control of the elements of the hospital which had seen a number of changes to the way the Trust normally operated during the pandemic, in order to cope with conditions other than covid. Amanda Fox, Deputy Chief Operating Officer replied that the team were very aware of what actions were required and robust and clear plans were in place for

Minute	Description	Action

recovery, including different ways of working and learning from the pandemic.

Paul Lewis, Non-Executive Director wished to thank the team for adding the data quality rating to all the matrix within the Board pack and also acknowledged the work that was being undertaken behind the scenes to progress the data quality agenda.

Peter Hill, Non-Executive Director added that the Trust was well placed for recovery and lessons learnt however a word of caution to manage expectations of both the Board and Council of Governors in that there was a long road to recovery from this Pandemic and to be patient.

A discussion followed on embedding the new ways of working to improve patient discharges which were key to elective recovery not only within the hospital but with external partners for out of hospital issues.

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 18 February 2021 and the following highlighted:-

Patient Advice & Liaison Service (PALS) - Assurance rating green. Response times to complaints had improved. The Friends & Family Test (FFT) had seen significant progress in responses in those areas where texting has been implemented.

Sharps Injuries - Assurance rating amber. The total number of reported sharps injuries had remained static since 2017. This disproportionately involved medical staff with commonest reasons related to syringe/needle combination and IV cannulae. A ten-point action plan was being implemented, targeting those most at risk.

Andy Copestake, Non-Executive Director asked if there was a real concern with regard to sharp injuries. It was noted that sharps were used safety however the real concern was that the expectation was for continual improvement and this had plateaued over the past 3 years. Further data was also required in the differences between 'dirty' sharp injuries and 'clean' ones

Infection Prevention & Control Board Assurance Framework (BAF) - Assurance rating green. The Committee were assured by the Trust's performance and the assessments against standards. These were almost all green with some amber and no red. It was noted that the amber ratings did not imply non-compliance.

Ockenden Review - Assurance rating green. In the main the report showed RAG ratings as green or amber with good compliance. Some red ratings were the result of requirements that would need substantial funding and resources to be complaint. Notable was the need to recruit more midwives and obstetricians, which was a national issue due to insufficient numbers of trained staff available to recruit.

Julie Soutter, Non-Executive Director asked if there was any update in terms of a system wide approach to address the 7-day working and staff shortages as referred to in the Ockenden report. Julie Marshman, Chief Nurse replied that these challenges were being looked at by the Local Maternity System (LMS) who were pulling together a

regional response to go to the national chief midwife.

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

Pressure Ulcers - A Pressure Ulcer Improvement Programme launch day was held on 4 March 2021, with all divisions and professions represented. This was in response to the deteriorating position in the number of reported pressure ulcers.

Falls - The Quality Improvement Programme to improve falls was progressing well with the anticipation of moving from an amber assurance rating to green in the near future.

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

Julie Soutter, Non-Executive expressed concern in the reporting of 12 incidents due to the failure to follow procedure especially given some discussions in the past around this failure, and asked what was planned to address this. Julie Marshman, Chief Nurse replied that lots of work was being undertaken by the Deputy Chief Nurse and a full report would be presented at the next meeting of Quality & Governance Committee

Action : Chief Nurse JMa

Part 3 : Our People

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

- The report was similar to previous months except for the backdrop of a critical incident pressure which put significant pressure on the workforce.
- The vacancy rate was stable however agency spend, back fill rates and sickness created significant pressures in certain areas.
- In April 2021 the Nurse Agency contractual arrangement would move from a Master Vend to a Preferred Supplier List increasing opportunities to fill nurse agency at a lower rate.
- Divisions continued to review and monitor their Mandatory Training compliance monthly and highlight any areas of concern regarding reporting to the Academy. The Academy continued to work on the project to move Mandatory Training modules from training tracker to ESR to improve accuracy of compliance.
- The indicator score continued to be 1 for January 2021, driven by the appraisal rates for the Trust of 70.43% against a KPI of 85%. A paper proposing a simplified appraisal process was considered by Performance, People and Place Committee in January 2021 and would be rolled out in the coming months.
- The Leadership Development Programme (cohort 1) would restart on the 24 February 2021 after a short pause, with cohort 2 commencing in April 2021.

Charlotte Forsyth, Medical Director highlighted an error in the chart representing the medical appraisal compliance which looked worse than it should as medical appraisals were now up and running and were closely monitored.

Part 4 - Use of Resources

Finance & Investment Committee Overview

The Board received an overview of the detailed discussions held at the Finance & Investment Committee around the financial element of the IPR at the meeting held on 22 February 2021 and the following highlighted:-

Impact of Bank Incentive Scheme - Assurance rating green. A very good paper was received on the impact of the incentive scheme introduced to raise bank fill rates and therefore reduce reliance on Agency nurses. The Committee agreed with the recommendations, including the proposal to end the scheme from the end of February 2021 and to introduce a more targeted scheme in the future.

Forecast Capital Expenditure position - Assurance rating amber. There was still a significant challenge to increase the rate of Capital expenditure and meet the forecast, however the Committee was assured that every effort was being made to do this or to retain funding into 2021/22 where it is not possible to spend the money this financial year.

Exit run rates and business planning - Assurance rating red. There was still no central guidance on the finance regime that would be in place after Q1 2021/22. Work had been on-going to understand pay and non-pay run rates as the Trust exits 2020/21. These, combined with non-achievement of CIP this year, had resulted in a significant increase in the Trust's underlying deficit. In addition, there would be a significant challenge to reduce the cost base associated with Covid in 2022. The Executive team was on top of the issues but the lack of central guidance for the remainder of 2021/22 represented a significant problem.

Procurement update – Assurance rating amber. The Committee noted the quarterly report on procurement. Whilst the performance of the procurement team remaine strong, the amber rating related to the Committee's request for a review of the procurement process to learn lessons from recent procurements, to differentiate between strategic procurements and others, and to see whether local procurement could be reflected in the criteria for future procurements.

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

- Cash support for Q1 had been confirmed from NHSE/I.
- In terms of business planning national guidance would be published mid-March 2021 however it had been indicated that the financial framework would see a block contract extension to that currently in place for the 1st half of the year 2021/22.
- The Trust in month position was £508k deficit against a plan of £882k deficit which was £374k favourable variance.
- The year-to-date (YTD) position was £1,812k deficit against a plan of £2,316k which was £504k favourable variance.
- Income variance was £1,183k above plan in month and £2,411k above plan YTD. The majority of this was NHS Clinical income matched by costs and related to in month income for Hospital Discharge Programme, Lateral Flow Testing and specialist high cost drug adjustments.
- The Elective Incentive Scheme had been suspended and would only apply to the last 5 months of the year.

Minute	Description	Action

- Increase in pay was due to the vaccination programme incurred staffing costs which were not budgeted however the costs would be recovered through central funding.
- Non pay was overspent in-month due to additional charges from the PFI provider.
- It is anticipated that the Trust would achieve the year end forecast.
- A significant amount of work was being undertaken in February/March 2021 to achieve the capital plan; however there would be some retained funding into 2021/22 where it was not possible to spend the money this financial year which mainly related to the Way Forward Programme.

Nick Bishop, Non-Executive Director asked if any extra charges were being applied at delivery as a result of Brexit. Simon Wade, Director of Finance confirmed that the Trust had not seen any additional charges as a result of Brexit.

Kevin McNamara, Chief Executive highlighted the progress the Trust had made over the past year in respect to Public View data. Overall the Trust's performance had been very strong as in March 2020 the Trust were ranked 87th out of 123 trusts, and in March 2021 had moved to 48th out of 123 trusts. This was the first time the Trust had moved into the top 50. We were also one of the 8 most improved trusts. Paul Lewis, Non-Executive Director added that a one-page summary would be useful to compare, track and learn progress.

Action : Chief Operating Officer — JO

RESOLVED

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

394/20 **Chair of Charitable Funds Committee Overview**

The Board received an overview of the discussions held at the Charitable Funds Committee at the meeting held on 10 February 2021 and the following highlighted:-

- Covid had impacted on the ability to hold physical events and therefore difficult to promote Brighter Futures.
- Income was similar to last year however this was due to monies from "NHS Charities Together".
- There was one concern raised around Brighter Futures paying the whole salary of the Director of Fundraising & Voluntary Services. The restructure had been agreed by both Performance, People and Place Committee and Charitable Funds Committee in November 2020, but not the division of costs.

Action : Director of HR — JG

The Board **noted** the report.

395/20 **Chair of Mental Health Governance Committee Overview**

The Board received an overview of the discussions held at the Mental Health Governance Committee at the meeting held on 22 January 2021.

There followed a discussion with regard to the chronic lack of specialist CAMHS beds which was a gap in assurance however it was recognised this issue was one the Trust had no control over. It was also recognised this was not an isolated Swindon issue and was part of a wider concern around children's mental health and should be addressed

through the BSW system. In light of this, it was agreed that the Chief Executive and Chair would raise this through the relevant BSW committees to ensure a system wide approach.

The Board **noted** the report.

396/20 **Armed Services Community Covenant Agreement**

The Board received and considered a paper that outlined the refreshed approach to support veteran and reservist Armed Forces communities with a recommendation to commit to a refreshed agreement with regard to the Armed Services Community Covenant Agreement and further exploration of becoming a member of the Veteran Covenant Health Care Alliance.

The Board were fully supportive of the refreshed approach with the following agreed:-

- Feedback to Swindon Borough Council around the signatory page.
- Monitoring and oversight to be undertaken through the Performance, People and Place Committee.
- Guidance to be produced for users.
- Indicate support across a wider patch to incorporate Wiltshire.

RESOLVED

to support the recommendation to sign the Swindon Armed Forces Community Covenant agreement and the associated actions as recommended.

397/20 **Ratification of Decisions made via Board Circular/Board Workshop**

The Board was asked to ratify two Board Circulars which had been approved since the last Board meeting:-

- The contract for the provision of Linen & Laundry Services
- PDC Drawdown – Expansion Land Purchase.

The Board was also asked to approve one Board Circular which had been circulated prior to the Board meeting:-

- Contract for the Capital Purchase of Radiology equipment - Single-Photon Emission Computed Tomography / Computed Tomography.

RESOLVED

(a) to ratify the contract for the provision of the linen and laundry services;

(b) to ratify the PDC drawdown for the expansion land purchase; and,

(c) to approve the contract for the purchase of Single-Photon Emission Computed Tomography / Computed Tomography.

Minute	Description	Action
398/20	**Urgent Public Business (if any)** **Chief Nurse** The Chair wished to formally thank, on behalf of the Board and Governors, Julie Marshman, Chief Nurse for her incredible support, commitment and dedication over the past 38 years of service to the NHS. Julie was retiring at the end of the month.	
399/20	**Date and Time of next meeting** It was noted that the next virtual meeting of the Board would be held on 1 April 2021 at 9:30am via MS Teams.	
400/20	**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 1643 hrs.

Chair …… Date……

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – March 2021				
JG – Jude Gray, JMa - Julie Marsham, KM - Kevin McNamara, CF – Charlotte Forsyth, TC – Tracey Cotterill, JO - Jim O'Connell, SW – Simon Wade, CC – Caroline Coles PPPC - Performance, People and Place Committee, Q&GC - Quality & Governance Committee, RemCom - Remuneration Committee, FIC – Finance & Investment Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
4-Mar-21	393/20	**IPR / Our Care** A full report on Serious incidents and plans to address those reported as failure to follow procedure to be presented at the next Quality & Governance Committee.	JMa	For Q&GC
4-Mar-21	393/20	**IPR / Use of Resources** A one-page summary to be produced in terms of Public View in order to compare, track and learn progress.	JO	For Board sub committees
4-Mar-21	394/20	**Charitable Funds Committee** Review division of costs around the salary of the Director of Fundraising & Voluntary Services.	JG	For PPPC

Future Actions				
None				

Great Western Hospitals NHS Foundation Trust

Questions for the Board

Meeting	Trust Board	**Date**	1 April 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.

The Board is invited to consider the questions raised, the responses given and agree if any further action is required.

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		Responsive		Well Led	x

Link to relevant Trust Commitment	n/a

Consultations / other committee views

Recommendations / Decision Required

that the questions and responses be considered with the Board invited to consider if further action is required.

Questions to the Board			
Topic	**Questioner**	**Question**	**Board Response**
Integrated Performance Report (IPR)	Ashish Channawar, Public governor, Swindon	In IPR section for performance summary (and other similar tables) the rankings for Bath and Salisbury are mentioned for each KPI. Please could you help me understand what does "National Ranking" mean? Also why we do not have a "Swindon Ranking" similar to Bath & Salisbury?	Public View is a provider of benchmarking services to the NHS. The 'National Ranking' column in our IPR indicates where GWH is ranked, alongside RUH, Bath and Salisbury hospital. Overall our performance has been very strong over the past year as in March 2020 we were ranked 87th out of 123 trusts, and in March 2021 we moved to 48th out of 123 trusts. This is the first time the Trust had moved into the top 50. We are also one of the 8 most improved trusts.
Covid Vaccinations	Ashish Channawar, Public governor, Swindon	Regarding the vaccination uptake there has been lots of efforts put by the Trust and the SBC to increase it in BAME community. Please can we have statistics based on race/ethnicity so that the attention can be given to the groups need? Also can we have stats based on geographical areas where the uptake is very low? For example I understand that the uptake is concerning in Manchester Road (Swindon Town Centre) and Salisbury.	Unfortunately, the Trust does not hold this information and therefore is unable to provide it, however please find a link to the NHS webpage which provides national information:- Statistics » COVID-19 Vaccinations (england.nhs.uk) The link within this page COVID-19 weekly announced vaccinations 11 March 2021 is probably the most helpful document although it does only provide a breakdown of ethnicity by STP area.

Great Western Hospitals NHS Foundation Trust

Chief Executive's Report

Meeting	Trust Board	**Date**	1 April 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. Coronavirus

1.1 Current position

The number of patients we have in Great Western Hospital has now fallen to single figures – a significantly improved position from January and February.

This has meant that we have been able to return back to a normal theatres schedule, with the number of theatre and anaesthetic staff needed to support ITU reduced. It is our expectation that this will help increase the number of elective patients we can now see helping begin the gradual recovery that is required following the significant disruption that patients waiting for operations have experienced.

1.2 Marking one year of the pandemic

On 11 March, one year after we treated our first patient with COVID-19 we held a virtual memorial service internally to remember those members of our staff and volunteers who died during the year.

The service made particular mention of Dr Edmond Adedeji and Dr Thaung Htaik, our two doctors who died of Covid-19 while working for the Trust, but we remembered everyone we lost during the year, not just those who had coronavirus.

This was in recognition that staff have not been given the traditional opportunity to grieve and reflect upon their colleagues owing to the restrictions in place on funerals and memorial services.

11 March is an important date in our Trust calendar, and from now on we will hold a similar service on this date each year.

Given the experiences we have collectively faced, we know it is important to give staff the opportunity to reflect on what they have been through over the last 12 months.

Over the course of the anniversary week we also publicised video diaries from staff from teams across the Trust looking back on the past year. Together these form a powerful narrative of the impact of the pandemic on our organisation and our staff.

For those who need support, we continue to have in place a wide range of mental health support, including two clinical psychologists, which is available to any member of staff who needs it.

As part of our thank you to staff for their incredible efforts, we have given them an extra day's leave to be taken on their birthday or anniversary in 2021/22, and all staff were given a thank you card and Trust badge.

1.3 Our recovery programme

Although coronavirus remains present, the decline in patient numbers in recent weeks has meant that we are now in a position to step up our recovery programme which aims to begin tackling the significant waiting time challenges the pandemic has caused. This remains a very significant quality, operational, financial and workforce challenge for all Trusts. As the country looks forward to some form of return to normal post-lockdown, the impact of the pandemic on our services and our staff will be felt for some time to come as we work through significant patient backlogs.

We know patients have been waiting much longer for treatment than we would ever have wanted and I am sorry for this.

Recovering our activity must also be set in the context of reduced capacity with less beds and space available to see patients. We must also remember that our staff are tired following a very intense winter and an intense 12 months and we need to ensure we support their wellbeing through this next phase.

The recovery plan has the following workstreams:

1. Activity planning
2. Managing the backlog

3. Empowering change
4. Demand management
5. Validation
6. Independent Sector
7. Pooled waiting lists
8. Tackling inequalities

At the time of writing this report the national expectations for next year have not yet been issued to Trusts. This is expected towards the end of the month and therefore a verbal update on these expectations and what it will mean for our recovery will be provided at the meeting.

2. Our focus in 2021/22

Whilst we await the national planning guidance, it is self-evident that as we move in to 2021/22 a different set of challenges awaits us, which is broadly grouped around the following headings which I believe we must maintain our focus on:

- Reset on quality – we need to focus on improving the quality of care we provide which we hope will result in the Care Quality Commission recognising us as being 'Good'. This also requires us to play a bigger role in reducing the health inequalities exposed by Covid.
- Restore our elective activity – we need to focus on seeing patients as quickly and safely as we can, but recognising that it will take some considerable time to get back to our pre-pandemic position.
- Regroup as a team and replenish our wellbeing – our staff have worked incredibly hard for a very long period of time and we need to ensure we are providing the necessary support going forward.
- Recover our finances – we start the year with a significant underlying deficit and although after a year where finances have not been a priority for obvious reasons, there is a significant task ahead of us to refocus on this agenda to bring costs down.

All of this will be in the context of a pandemic that is far from over and so our ability to flex and respond as needs arise to Covid will be central to our planning.

2.1 Vaccination programme

Our vaccination programme will continue to be a key priority and we will maintain focus on vaccinating those in the national priority groups. At the time of writing c 33,000 people have received the jab.

One of these groups is of course our own staff and although we have had good take up so far, with around 87 per cent of our substantive workforce having the jab, we know that some staff are reluctant to have the vaccine for a number of different reasons.

Managers have been holding one-to-one discussions with those staff who have not yet had the vaccine to better understand their concerns in order to help them make an informed decision.

2.2 Supporting our staff

From 1 April we welcome back a number of staff who have been shielding, following a change in the Government's advice.

Staff who we previously assessed as being at most risk have been asked to complete a new assessment and we will of course take whatever action is needed to keep them safe.

Health and wellbeing remains a real focus for us in 2021/22 and our nationally-recognised programme will continue to be developed on an ongoing basis. It is expected that a health and wellbeing 121 will be required for all staff to be completed within the first six months of 2021/22 and annually thereafter so that we maintain a focus on staff wellbeing across our Trust.

It is also important that we recognise the efforts our staff have made, and continue to make, and along with our regular monthly awards, we plan to hold a staff awards ceremony this year, along with a summer event for staff and their families – all of course subject to national rules.

3. NHS staff survey

Last month we received the results back from the NHS staff survey carried out between September and December at the Trust.

I'm really pleased that we had our best ever response rate (53%) meaning that we have a really good indication of how our staff are feeling. The results are really significant in providing a better understanding of how COVID-19 has impacted upon us.

In last year's survey there were 20 questions where our results were below average; this time there are four. This shows a clear improvement, but also indicates that there is much more we need to do in certain areas.

Areas such as health and wellbeing and quality of care show good improvement, which is really encouraging and we need to build on this. There have also been improvements in questions related to the openness of the organisation, but we know there is still more we need to do here.

There are several areas where we need to pay more attention to and work is already underway in some of these, for example equality, diversity and inclusion (EDI). While we have made some good progress – with a new strategy approved, and a new lead for EDI appointed – there is still a long way to go.

The data from the survey, and comments made, will be analysed and we will agree Trust-wide actions to ensure we act upon what we've been told. I've also asked for teams to discuss the results and consider how they can support targeted improvements in those areas where we would like to make positive progress.

4. Research and Innovation

During the course of the pandemic we have taken part in a number of clinical trials, which has been a really important part of the overall response to coronavirus.

I'm really pleased that we recently recruited our 400th patient to the Covid-19 RECOVERY trial – this puts us in the top 15 recruiting sites based on the number of patients and the percentage of Covid admissions recruited to the trial.

5. Primary care

Our Primary Care Network has made considerable progress over the last 12 months and one of its aims is to engage with patients and incorporate the patient voice in to the way this service is run and develops.

Last month the network held a patient participation group meeting – although attendance was small, feedback was positive and provides a good basis to build from and the group will meet again in a couple of months' time.

At the time of writing we await the written report from the recent CQC inspection of these practices.

6. Leadership

Given the challenges we face over the next few months, ensuring we find time for leaders to grow and develop is really important.

Last week our Leadership Forum met for the first time this year and the theme of this session was equality, diversity and inclusion. Patrick Ismond, our EDI Lead, spoke to the group about the work he is doing internally and externally to help the Trust take forward this agenda and how it is everybody's responsibility to take action.

7. Recruitment to senior roles

I would like to formally welcome Lisa Cheek as our new Chief Nurse. Lisa is an experienced Chief Nurse and joins us from the RUH in Bath.

We are also currently in the process of recruiting to two roles on our Executive team – Medical Director and Chief Operating Officer. These positions are integral to our recovery from coronavirus and the challenges we will face over the forthcoming months and year. The roles are being advertised nationally and we look forward to making appointments to these roles in due course. Interviews will take place at the end of May.

The story of a shielding staff member

Linda Clements | April 2021

Clinically Extremely Vulnerable

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- Joined in 2010 (Urgent Care)
- Assistant Practitioner, Integrated Community Care, IV therapy Services
- CEV since March 2020 – 12 months with adjustment and working from home
- Rare lung condition
- When CEV paused continued to WFH due to health condition
- Support from OH regarding adjustment, support from the GP and the BLF to help manage my lung condition

Working from home

What it's been like

- Initially was difficult
- Never had a desk job
- Always been hands on nurse
- Missed the team
- Felt disconnected from the team
- Had to organise IT and learn systems
- Set up an office at home

New ways of working

- Structured working, having a routine is important
- Clinical assessment/pre assessment over the phone
- Building strong relationships with patients
- Regular contact with patients who are receiving Chemo
- Ordering equipment in advance
- Regular contact with colleagues
- Meetings with teams regularly virtually
- PPE support for nursing team
- End of Life support for patients
- Working with other teams

Making it work

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- **For myself:**

Adjustments (physical and mental), learning new systems and ways of working

- **My colleagues/team:**

What's app group, Teams, phone calls, supporting each other

- **The Trust:**

Supported WFH, health and wellbeing pack, letter from CEO, gifts, equipment, regular contact OH, WFH CEV group meeting Via team weekly, EAP service (telephone counselling) immediate support

- **My Family:**

Support from family who even supported with PPE packs and setting up the office

Any questions?

Integrated Performance Report (IPR)

Meeting	Trust Board	Date	1st April 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

Over the last several months, we have seen a significant improvement in our Hospital Combined Performance score on Public View – we have achieved 48th position out of 123 Trusts (in March 2020 our ranking was 87th). In addition, we are currently one of the most improved Trusts in England (8th). The trend chart below reflects our aggregate position improving against CQC measures and our performance is tracking 'Good'.

Turning to February 2021, performance against the 4 Hour Access standard has improved from 86.14% to 87.79% in month; however this continues to be below the 95% standard. Daily 'Criteria to Reside' calls are continuing and are chaired by the Head of Clinical Operations and robust processes (Ambulance Handover SOP and Flow Action Cards) have been implemented for managing the flow of patients through the system. There is still inconsistency in discharging Golden Patients every day and this is now part of the Flow Transformation Project, led by the Chief Nurse.

Covid-19 admissions to the Trust have reduced significantly throughout late January and February from a peak of 163 patients to 32 on 9th March.

Overall, the Trust's RTT Incomplete Performance for January 2021 was 65.57%, which was a deterioration of 1.47% in month. January saw referrals at 76% of the prior year. The PTL has decreased by 293 in month. In terms of diagnostic waiting times, the DM01 performance saw a slight decline to 60.7% in January compared to 61.5% in December.

December's 62 day performance was 87.5% with the Trust achieving the national 62 day standard for the last

three months. Prior to this, performance was heavily impacted by Covid-19 and the diagnostic/treatment delays.

The Trust has achieved level B SSNAP performance (74%) for Q3, and have now maintained level B for the last 12 months.

Our Care

In line with the national picture numbers of patients diagnosed with COVID-19 have decreased significantly in February 2021, 154 compared to 438 in January 2021. A total of 7 of these cases were deemed to be hospital acquired.

Tissue viability reporting of harms in the acute setting remains high; however, there has been a decrease in the reported levels of harm. This suggests earlier detection and intervention of hospital acquired harm i.e. improved skin inspections and quick implementation of pressure reliving equipment. The community have reported a reduction in tissue viability harm levels when compared to compared to January 2021, this may be due to a number of factors – appropriate investigation, frequent delivery of education sessions and improved Bank and Agency processes and knowledge and skills check.

A Pressure Ulcer Improvement Programme launch day was held on the 4th March 2021, all divisions and professions will be represented. The event was enthusiastically received with 102 people attending bite size learning sessions were held discussing, skin inspections and 'react to red', SSKIN care bundle, reducing device related harm, investigation and learning, training and education.

There is an increasing trend in falls from January 2020, resulting in an increase in the average number of falls per 1000 bed days from 5.7 to 7.5. Anecdotally falls leads across the South West Falls Network are seeing a similar rise. Progress with the falls improvement plan continues, with a number of key activities and projects underway during March and April.

There have been 61 complaints and 104 concerns reported in month an increase on January, but continues to demonstrate a downward trend.

In February 4,925 Friends and Family Test (FFT) text messages were sent, the overall response rate was 17%, in response to the question "How likely are you to recommend our services to your friends and family" a score of 91% was achieved. It is planned to introduce text messaging to outpatient areas and maternity by 1st April 2021.

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

Our People

This section of the report presents workforce performance measured against the pillars of the 'People Strategy' – Great workforce planning, opportunities, experience, employee development and leadership. Each area is measured with a KPI indicator achievement score and self-assessment score based on progress in month. Exceptions for February are high agency spend, high bank usage in specified areas, an increase in sickness absence to 4.38% and no decrease in the recruitment time to hire KPI of 51 days due to volume of activity with Health Care Assistant and International nurse recruitment.

Overall agency spend in February was 6.09% of the total spend and £558K over plan (£4M above target year to date). Increased Trust activity includes escalation due to winter pressures and continued activity relating to Covid-19 requirements. Bank usage is highest across community nursing to meet the increase in demand for Community services and Rapid Response due to hospital discharge rates and in line with normal winter pressures; the second highest use of Bank resource is allocated to the Covid-19 vaccination team.

The Trust vacancy position has improved in February to 6.3% from 7.4% with a significant reduction in the all nursing vacancy position to 4.6% further to the recruitment of 44 aspirant nurses on Fixed Term Contracts on the 3rd February and the successful recruitment of international nurses on track to increase to 16 monthly recruits. Vacancy in AHP has increased to 13%, Scientific to 7%, Medical & Dental to 4% and Senior Managers & Admin has reduced marginally to 8.5%. There have been no overall budget changes applied to

February and 90 new starters in-month (82.07 WTE) commenced employment at the Trust and the time to hire for February was 51 days (outside of KPI target) from advert live to start date confirmed.

Sickness absence continues to report above the 3.5% increasing in January 2021 at 4.38%. Currently performance can be expected to vary between 3.3% and 4.6% attributable to the winter period and continued implications of the COVID pandemic.

There has been improvement in overall mandatory training performance from 83.85% to 84.93% and remains just below target of 85%. Medical & Dental mandatory training has improved to 73% compliance from 67% further to in-month focussed intervention. Appraisal rate has improved to 77.72% although remaining below the 85% target. The Divisions compliance trajectories are being implemented with expectation that managers achieve realistic improvement across departments during the critical pressures of the pandemic.

The Trust continues to invest in the health and wellbeing plan during the period March 2020 to February 2021 - £117,970. Key areas of spend included - Tea trolley (£2620), Hampers (£2890), Tea Trolley bags (£966), Massage Chairs (£1159), MHFA (£4,700), TRiM training (£8051), Christmas Thank You (£9965), Winter Refreshments (£2597), EDI lead pilot role (£50K)

The mapping exercise to identify location of volunteer HWB Champions has concluded and further communication in March will seek further volunteers for these non-represented areas. HWB leads have assessed the Trust health and well-being provision using the NHS England diagnostic framework and have shared outcomes with the wellbeing NED lead. This review will inform the development of a HWB strategy for 2021/22.

The EDI lead continues to successfully embed the role with achievements outlined in the report and in addition to these highlights, the EDI lead is developing the first Trust Transgender policy, benchmarking with Nationwide and region to understand successful reverse mentoring programmes and forming the Disability Equality Network.

Following feedback there has been a review of the parameters, the scoring used has been adjusted for Agency spend, Time to Hire and Mandatory Training for the HR section of IPR this month. As this is a new approach, the scoring system will continually be monitored with another review scheduled for June 2021.

Use of Resources

The Trust plan is £3,829k deficit. The Trust in month position is £3,008k surplus against a plan of £648k deficit which is £3,656k favourable variance. The YTD position is £1,195k surplus against a plan of £2,964k deficit which is £4,160k favourable variance.

Trust income is above plan by £7,469k year to date due to funding received to cover additional costs and lost income. The Trust has received Lost Income funding to cover the shortfall of private patient income, car parking income and other non patient care income caused by the Covid-19 pandemic. The funding is £4,224k for 20/21 of which £3,520k is included in the Month 11 position. The Trust has also received income to cover costs of Hospital Discharge Programme (HDP), Lateral Flow Testing, Thames Valley Cancer Alliance (TVCA), Carbon Energy Fund, high cost drugs and estates dilapidation work in Primary Care sites.

Pay is £1,776k overspent due to costs of Covid-19 Vaccination Programme, HDP, aspirant nurses, incentive payments, lateral flow testing staff and additional staffing required to meet Covid-19 surges. Non -pay expenditure is overspent by £1,776k due to costs of Covid-19 vaccination programme, HDP, TVCA, estates dilapidation costs and carbon energy costs which are funded by additional income. Non-pay also includes International Recruitment fees linked to NHSE/I funding, IT equipment and screens to support agile working. Clinical supplies and drugs are underspent due to reduction in elective activity during Covid-19 surges.

The forecast for 20/21 is £357k deficit which is £3,472k better than plan. The forecast includes the additional Lost Income funding of £4,224k and an increase in the annual leave accrual of £752k.

The Trust capital plan for 20/21 is £39,467k. This has increased by £1,593k in month relating to funding agreed for Pathology LIMs, IT Audio-visual and Remote Monitoring.

For Information	x	Assurance	x	Discussion & input		Decision / approval	

Executive Lead	
Author	Jim O'Connell, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Julie Marshman, Chief Nurse

Author contact details	jim.o'connell@nhs.net jude.gray@nhs.net julie.marshman1@nhs.net simon.wade5@nhs.mail

Risk Implications - Link to Assurance Framework or Trust Risk Register

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

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

Link to relevant CQC Domain

Safe		Effective		Caring		Responsive		Well Led	
	x		x		x		x		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.

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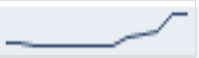
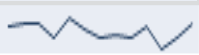
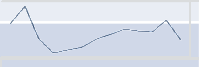
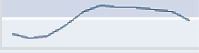
Integrated Performance Report

March 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	5672 (Mar)		48	31(6088)	21(6747)	Mar 21
ED 4 Hour Access Standard (combined Types 1 & 3)	87.79% (Feb)		30	82(77.57%)	29(87.87%)	Feb 21
Total Time in ED (Type 1) in Minutes (Median)	218 (Feb)		17 (145)	87 (201)	78(196)	Jan 21
RTT Incomplete Pathways	65.59% (Jan)		61	60 (67.07)	40(71.07)	Jan 21
Cancer 62 Day Standard	87.5% (Jan)		07	51(75.20%)	16(84.85%)	Jan 21
6 Weeks Diagnostics (DM01)	60.7% (Jan)		83	85(60.08%)	21(86.13%)	Jan 21
Stroke – Spent>90% of Stay on Stroke Unit	88.8%(Q2 20/21)		43	26 (91.5%)	75(83.3%)	Q2 20/21
Family & Friends (staff) – Percentage recommending GWH as a great place to work	66% (Q4)		87	51	1	Q2 19/20
YTD Surplus/Deficit	-4.3% (Oct)		82	8	37	Q2 19/20
Quarterly Complaint Rates (Written Complaints per 1000 wte)	39.79 (Q4 20/21)		112	32	47	Q2 20/21
Sickness Absence Rate	4.17% (Aug)		57	42	25	Oct 20
MRSA	0 (Feb)		46	105	41	Dec 20
Elective Patients Average Length of Stay- (Days)	3.42 (Feb)					
Non-Elective Patients Average Length of Stay (Days)	3.71 (Feb)					
Community Average Length of Stay - Days	16.1 (Jan)					
Number of Stranded Patients (over 14 days)	72 (Feb)					
Number of Super Stranded Patients (over 21 days)	33 (Feb)					

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Board Committee Assurance Report

PPPC Meeting			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		24th March 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 - Overarching combined performance		Green	8th most improved Trust in the last year moving from 87th to 48th out of 145.		
Integrated Performance Report – Emergency Access	Amber	Green	Solid performance in challenging times. Good staff attitude towards this performance target.	To monitor actions.	Ongoing
Integrated Performance Report - RTT	Red	Red	The Committee received a verbal update on the Trust plans moving forward and expected to receive the full Recovery Plan at the April 2021 meeting.	Full report to April meeting	April 2021

Integrated Performance Report – Diagnostic Wait Times	Amber	Amber	There were encouraging figures for February showing improvement which the Committee was happy to see and will receive more details at its April meeting.	To monitor actions	April 2021
Integrated Performance Report – Stroke	Green	Green	Good performance SNNAP score continues as a B.	To monitor actions	Ongoing
Cancer Performance Update	Amber	Green	There continues to be significant challenges within the Breast Service, however, a plan is in place to get back to where we need to be.	To monitor actions.	Ongoing
Re-admissions	Amber	Amber	This was a working progress and the Committee expect to see a good worked up plan of improvement in June 2021.	To monitor actions.	June 2021
Community & Primary Care	Amber	Green	Some services under enormous pressure with increased demand, however, generally performing well with a recent approval for additional staff. Excellent leadership demonstrated.	Next deep dive in July	July 2021
Integrated Performance Report – Sickness Absence	Amber	Green	A plan is in place which is expected to improve staff absence including the vaccination programme and staff returning to work after shielding.	To monitor actions.	Ongoing
Integrated Performance Report – Overall agency spend	Red	Amber	Agency spend continues to be high. The Trust moves over to the PSL contract on 1st April 2021.	To monitor actions.	Ongoing
Integrated Performance Report – Mandatory Training	Amber	Amber	There had been some notable improvement although there is still work to be done.	To monitor actions.	Ongoing
Integrated Performance Report -	Amber	Amber	Significant improvement has been made but there were still pockets of concern in patient facing areas which were being addressed.	To monitor actions.	Ongoing

Appraisal Proposal					

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?

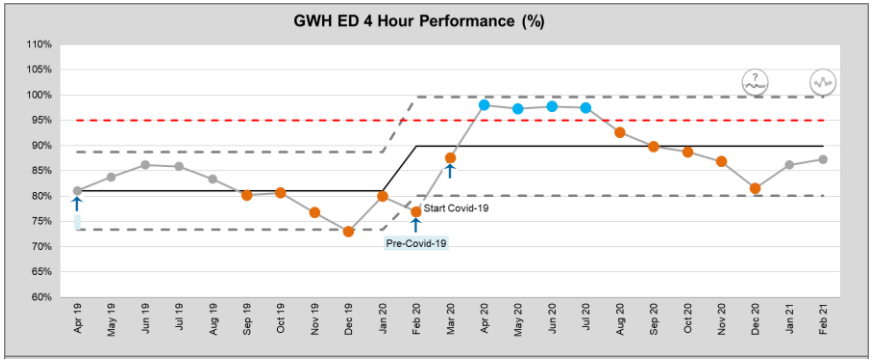
Are We Well Led?

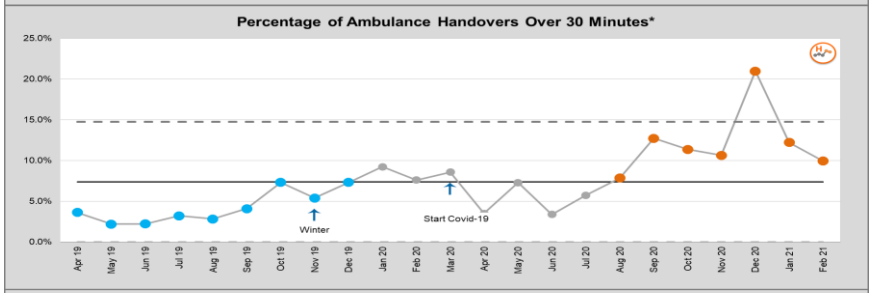
Use of Resources

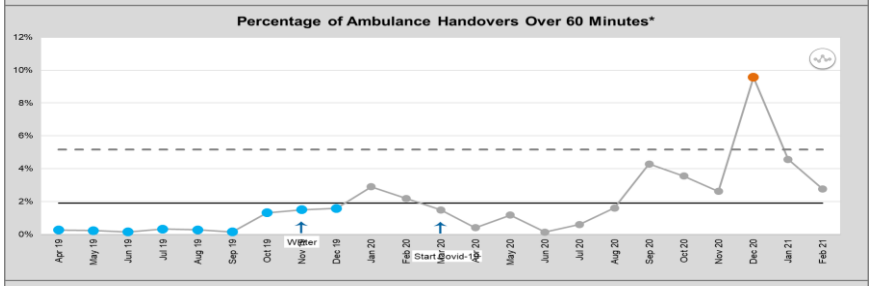
1. Emergency Access (4hr) Standard Target 95%

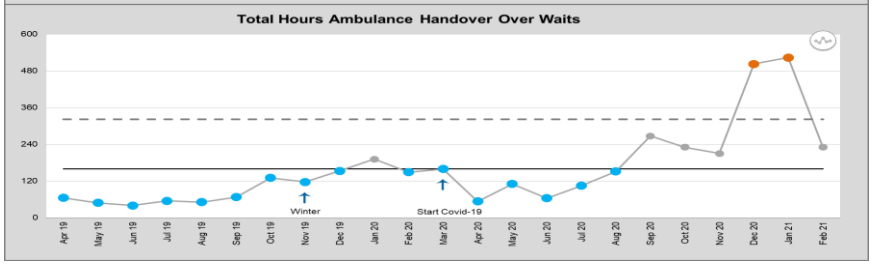
Data Quality Rating:

National Key Performance Indicators





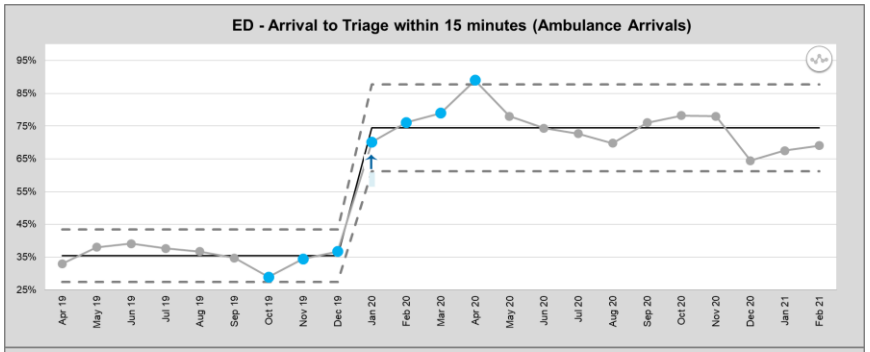


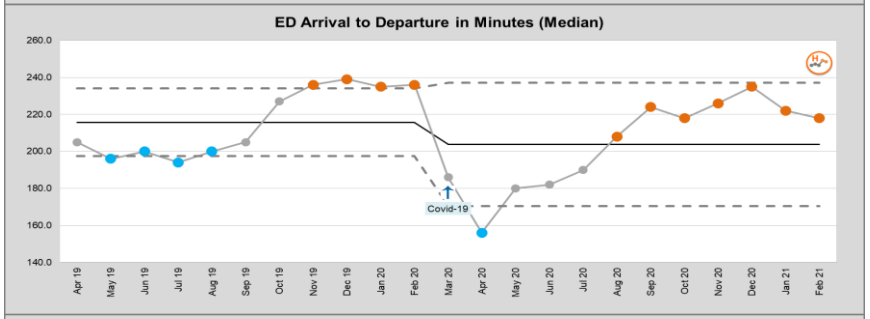


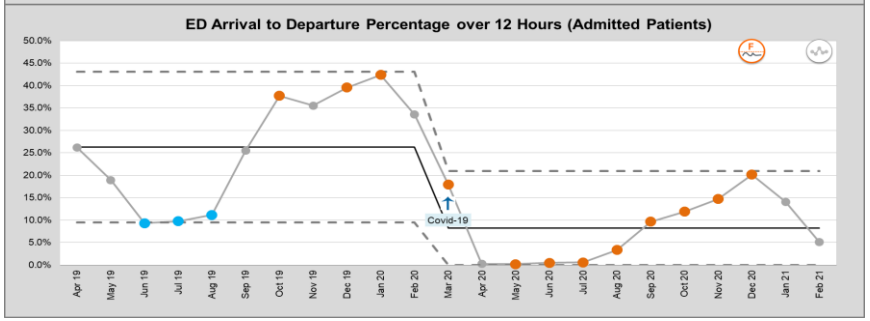
Performance Latest Month: 87.79% (Feb)

Attendances:
Type 1 79.74%
Type 3 99.77%

12 Hour Breaches (from decision to admit) 0







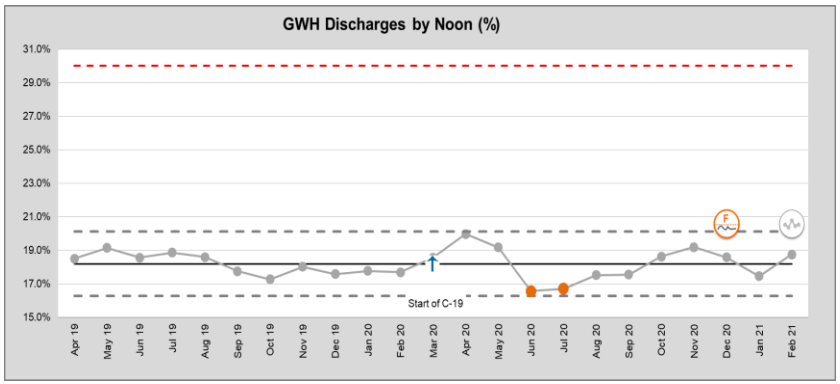
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

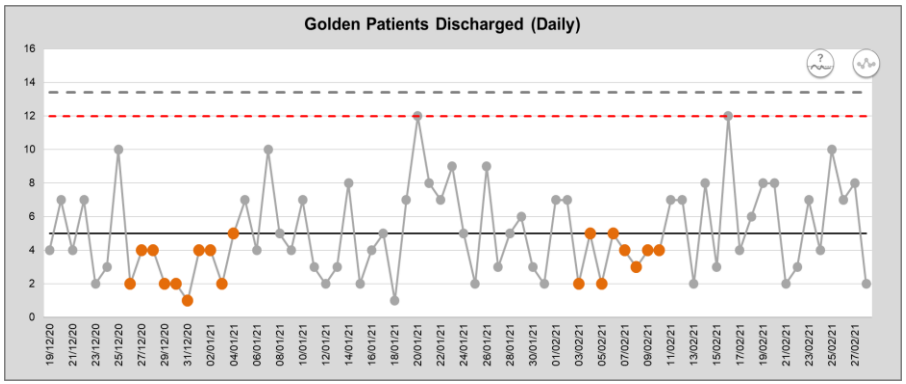
* Data from SWAST – 1 month lag

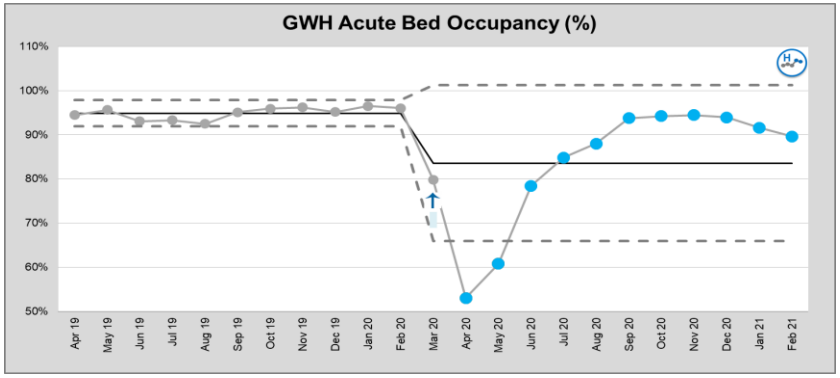
1. Emergency Access (4hr) - Patient Flow and Discharge

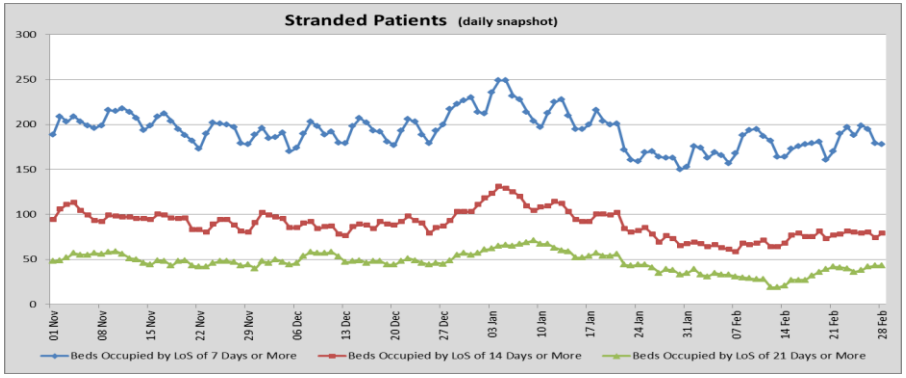
Data Quality Rating:

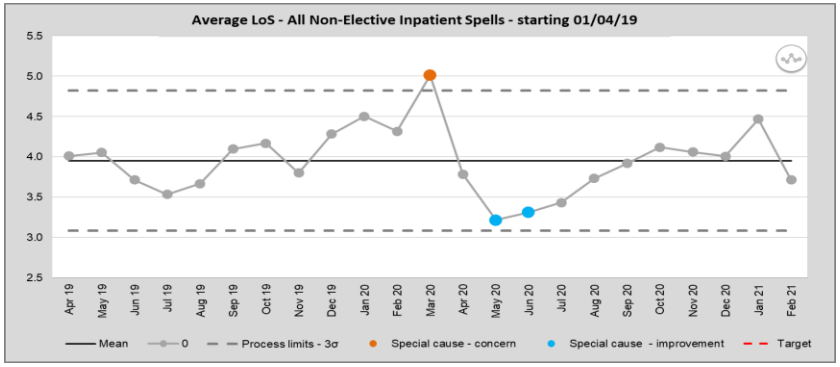
Are We Effective?

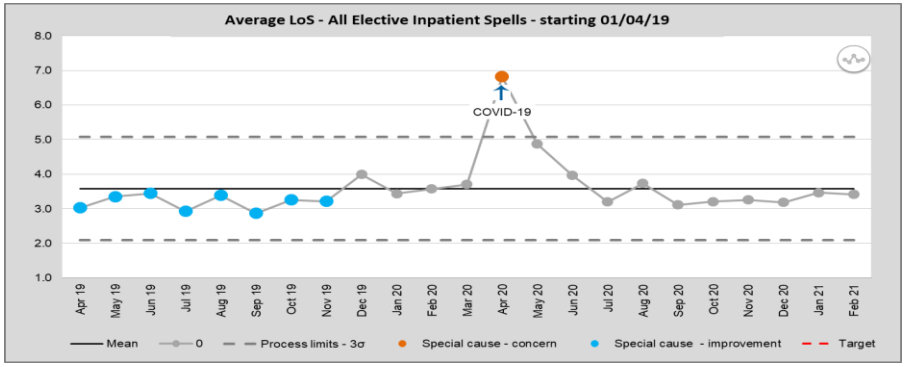












Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

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 an improvement of 1.62% in 4 hour breaches to 87.79% in February. There were 0 x 12 hour decision to admit breaches in February (decreased by 25 from January). Attendances have increased in February by 265 patients across both Type 1 (179) and Type 3 (85). However they remain lower than the same period last (-2257) across type 1 and 3 departments. This has been mainly in response to the continued national lockdown, with a communication drive to avoid unnecessary attendance to hospital.
Breaches due to 'waits to be seen' in ED have continued to remain under 10% from a high of 44% in August. Non admitted performance accounts for just 7% of breaches.

Key Impacts on Performance
Flow from to ED to base wards continues to be compromised resulting in 77.2% of breaches related to waits for inpatient beds. 94.8% of the bed breaches relate to waits for a medical bed.
There has been an improvement in the number of patients waiting over 12 hours in the department, from a peak of over 20% in December reducing to 5% in February. One of the factors in this reduction is the creation of the Clinical Decision Unit (CDU.) This is for patients to wait in a ward environment for diagnostics and treatments, Front Door Team (FDT) review and transport home.
Whilst Length of stay has improved and discharges before 12:00 have increased, moves out of the department are happening into the evening and overnight. The movement from assessment areas to inpatient beds is still not aligned to the demand profile in ED, resulting in late flow out of the department. As a result, this can impact on ambulance handover times and triage within 15 minutes.
Ambulance handovers delays over 60 and 30 minutes have decreased in February, with 60 minute handovers reducing below 3 %, from a high of 10% in December. A BSW ambulance handover improvement event is planned on 18th March to discuss system wide actions.

What will make the Service green?

- Improvement in flow into inpatient beds, patients to move within an hour of referral.
- Flow to meet the demand of ED attendances to reduce probability of overcrowding or ambulance handover delays.
- Development of the 'Think 111 First' programme to include access to SDEC and the change in culture of the local population's use of emergency and urgent care services
- Trust wide escalation plans to support the timely flow and discharge of patients
- The 'Way Forward' programme

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

1. 'Ambulance Delay Escalation Handover' SOP which sets out trigger points, actions and escalation needed has been implemented. ECSIST KLOES are now being implemented for improving handover times. Front door manager role in place until 31 March 2021 to support On-Call Teams. **Completed**
2. Lateral flow testing remains live in ED and CAU. The additional 400 Cepheid swabs have enabled faster swab turnaround reducing bottlenecks due to unknown Covid status. However the supply is being reviewed by NHS England. **March 2021**
3. The 'Think 111 First' programme went live on 1 December 2020. Activity was high but is now starting to reduce through February due to National lock down. A soft audit has shown that when asked patients are reporting interactions with 111 this hasn't resulted in a booked appointment. Examples to be shared with Vocare (111 provider and NHS digital) to understand cause and utilise more appointment slots. **April 2021**
4. A review of Majors Step-down is being undertaken to ensure pathways remain effective in reducing admissions to inpatient beds. This will also study length of stay and focus on front door review and community opportunities for joint working. **April 2021**
5. Daily 'Criteria to Reside' calls continue and are chaired by the Head of Clinical Operations. These meetings expedite and unlock delays to discharges; support wards to identify 'Golden Patients' earlier and ensure their timely move to the Discharge Lounge and enables partners to speak directly to the wards to review and unblock medically fit patients over 7 days. **On-going**
6. Flow Action Cards implemented across the Trust to provide clear roles and responsibilities at all escalation levels **March 2021**

Risks to delivery and mitigations

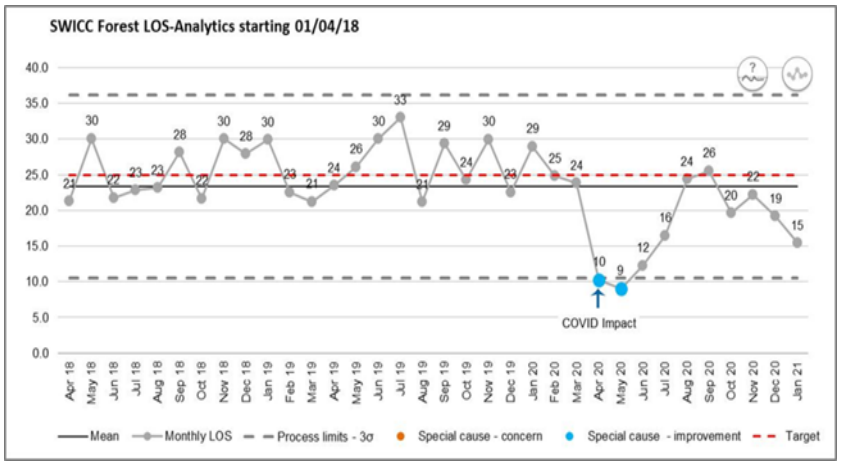
There is a risk that if Covid numbers remain as they are, or increase, the number Cepheid swabs will not be sufficient to prevent bottle necks in flow. which in turn will put increased pressure on flow from ED. **Mitigation:** The split of blue and green beds across the Trust are reviewed 7 days a week in the 1pm Control Room meeting. Case submitted to NHS England for further supply of Cepheid swabs

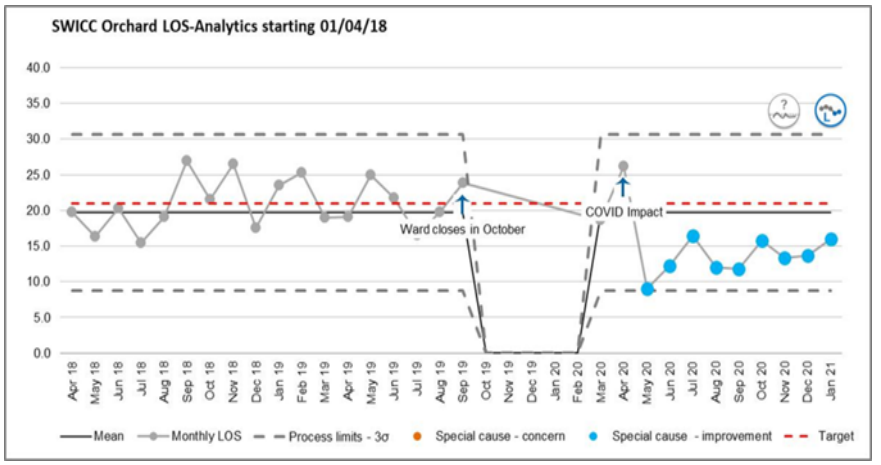
There is a risk that reduced nursing and medical staff, due to sickness and isolation, will impact on our capacity to manage flow. **Mitigation:** Daily review of staffing across the front door to ensure safety and timely assessment of patients.

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

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

Are We Effective?





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

LoS remains below target for Forest Ward at 15 days however, the ward has been well below normal bed occupancy due to a Covid outbreak and subsequent ward closure. During January there was also a concerted effort to discharge patients because of the anticipated peak in hospital Covid admissions which created enormous pressure for beds .

Orchard has seen a small increase in length of stay plus low bed occupancy, as it has remained a 'blue' ward and closed to admissions at one point. Some Out of Area patients (Gloucester in particular) have pushed up length of stay for OOA patients with poor flow to their bed bases and care services.

Sunflower has maintained a steady flow of discharges for most of the month but did become a Blue ward on the 23rd Jan with a Covid outbreak which reduced its bed base to 17 .

Improvement actions planned, timescales when improvements will be seen

The use of Sunflower to support patients requiring slower stream rehab has been impacted by the Covid outbreaks in all 3 wards and due to IP&C concerns patient movement has been minimally restricted. It is expected this will continue well into February before this pathway can be re established. Medical resourcing has started to improve and will support the increasing acuity of Orchard patients. Recruitment plans are in place to offer longer term posts for 2 junior doctors to support the permanent GPs . The number of unregistered nursing vacancies will improve over February and March as staff start in post from the recent recruitment activity .

Bed occupancy for Forest should show improvement in February as the ward has become 'green'.

Risks to delivery and mitigations

Admissions to Orchard remain challenging- Covid patients appear to be more acutely unwell and are taking longer to become medically stable enough to transfer to Orchard which is impacting on the ability to fill Orchard beds . Depending on the progress on the pandemic ,this position could continue.

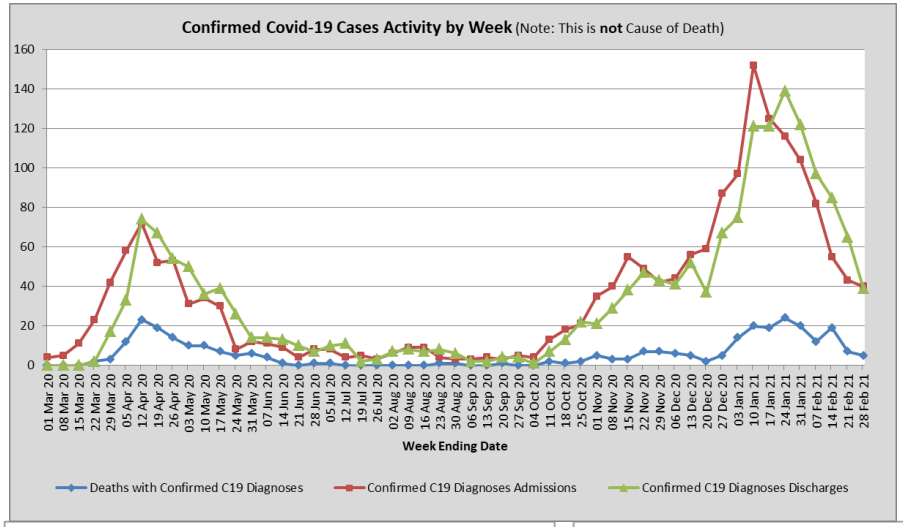
Mitigation: When Orchard becomes a ''Green ward ''in February the flow of admissions will increase

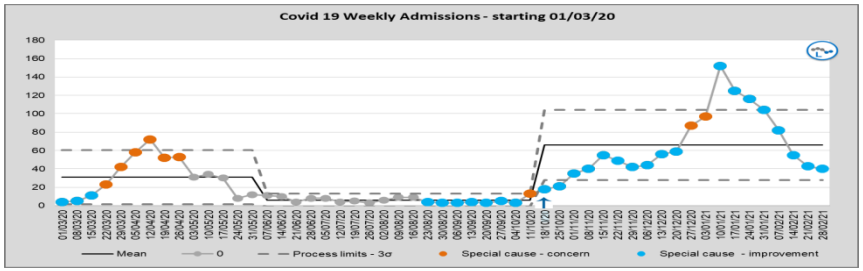
Registered nursing resources continues to be challenging with the number of vacancies and Covid related sickness both causing significant impact.

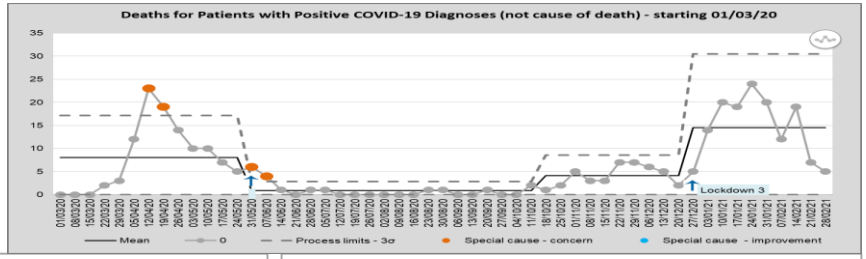
Mitigation: Recruitment of Nurse Associates is underway to mitigate this risk as well as International nurses.

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

Are We Effective?







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

The graph above shows a continued decrease in Covid-19 admissions from January through February.

As a result, the Covid Assessment Unit (CAU) reverted back to 11 beds w/c 8 February. The Medical Assessment Unit (MAU) then returned to a 'Green' area and the mini Defense Watch at the Front Door ceased.

CAU continues to use point of care testing (POCT) for Covid-19. As of March, the 400 extra 'fast-track' (Cephid) samples have been used and CAU has returned to allocated capacity of 10 fast-track swabs a day. Staff are managing this limited capacity, balancing clinical need versus flow, whilst ensuring samples are available overnight when there is no Pathology processing.

Pending laboratory results are still delaying patient movement during the day. CAU will not routinely use Cephid swabs when lab results are pending unless risk at the Front Door deems this may be required.

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 ambulance delays in February outside of CAU.

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

1. Prospective further delivery of 400 Cephid tests. POCT machine in Linnet Ward can be utilised to further support flow. Confirmation pending. **March 21**

2. Review of MAU/CAU current Medical model with potential 'Physician of the Day' role replacing need for Consultant based in CAU. **April 21**

3. On-going review of data to plan potential incorporation of CAU into total MAU bed base **August 21**

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

Risks to delivery and mitigations

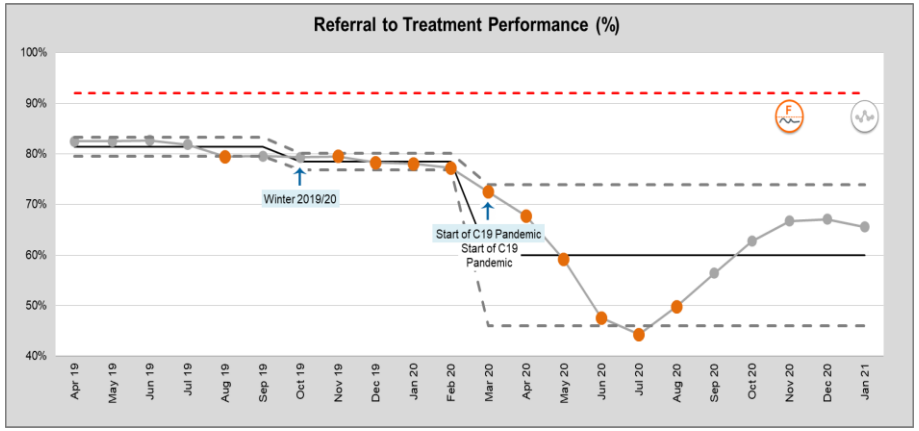
- There is a risk of delayed ambulance handovers in CAU due to delay in swab results limiting movement from CAU. **Mitigation** – Use of POCT/Cephid swabs and patients with high suspicion of COVID are managed with lateral flow testing at times of high escalation.

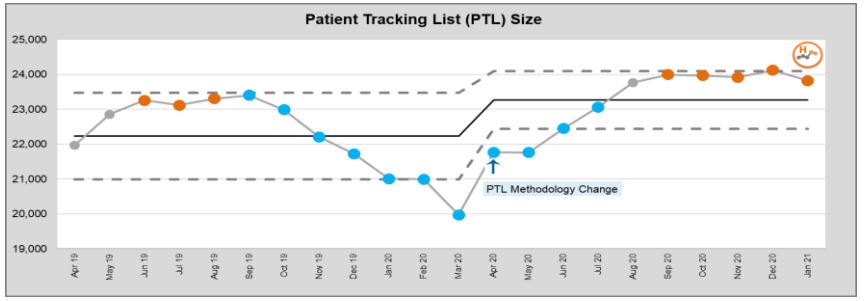
- There is a risk of reduced flow from CAU due to allocation of Blue/Green beds. **Mitigation** – Flow and bed availability monitored throughout day. Green/Blue bed split in the hospital reviewed 7 days a week on the COVID control call.

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

Data Quality Rating:

National Key Performance Indicators





January Performance:	65.57%
PTL Volume:	23,820
52 Week Breaches:	R – 1,642, IM - 178

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

Overall, the Trust's RTT Incomplete Performance for January 2021 was 65.57%, which was a deterioration of 1.47% in month. January saw referrals at 76% of the prior year.

The PTL decreased by 293 in month, which puts us 573 adrift of our pre-Covid end of year trajectory. However, our current PTL is 3,208 below our Phase 3 Trajectory of 27,028 for January, primarily due to the fact that this forecast assumed a return to prior year referral levels which we are yet to realise.

In January, we reported 1,642 x 52 week reportable breaches against a trajectory of 1,477. This was an increase of 330 from December and of the 1,642 breaches, 338 (20.58%) of them are P5 and have opted to defer treatment until post-Covid. There were 178 in month 52 week breaches cleared in January, which is considerable decrease over the rolling 3 month average of 402 per month. This reduction is due to the reduction in Elective Theatres following ICU escalation into Recovery 1.

Of the 1,642 reportable breaches, 1,388 are Admitted, 176 are Non-Admitted and 78 are Diagnostic.

Our Phase 3 trajectory for 52 week breaches puts us at 2,269 reportable breaches at the end of March 2021, with a waiting list size of 28,995. Within our current PTL, we have around 3,230 patients who have breached or are due to breach 52 weeks between now and the end of the year, highlighting the amount of work that is required to meet our 52 week breach trajectory. Given recent levels of escalation and the reduction in elective theatres there is a significant risk that these trajectories will not be achieved.

What will make the Service amber?

- NHSE/I funding to use the Independent Sector (IS); either national contract or locally commissioned.
- Improving Theatre Utilisation (limited gains given the scale of the backlog).
- Improving Outpatient Utilisation.
- STP approach to RTT recovery.
- Wave 2 Recovery Plan delivery.

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

RTT performance is being measured at the Weekly Access Meeting and reported against the previous year's activity as part of the Phase 3 Recovery Programme. Underperforming services are escalated and discussed at RTT Oversight to identify support and recovery actions.

The Trust is now utilising 4 Independent Sector organisations to maximise the number of patients that can be treated from February 2021 onwards. This includes Inter Provider Transfers for surgical patients who will be removed from our PTL following transfer. Pre-Assessment Clinic (PAC) and Elective Admission Team Recovery Plans are now in place to map and improve current processes to enable improved levels of efficiency and Theatre Utilisation.

Initial KPI improvements are anticipated to be achieved in March 2021, when we return to 8-12 x Elective operating Theatres.

Risks to delivery and mitigations

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

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

There is a risk that PAC capacity continues to be a challenge. Pre Covid-19 we were assessing 1,300 patients per month. In January we assessed 804 patients compared to a 6 month rolling average of 730. **Mitigation:** A weekly Recovery Meeting has been established and PAC staff are being ring-fenced to protect PAC activity.

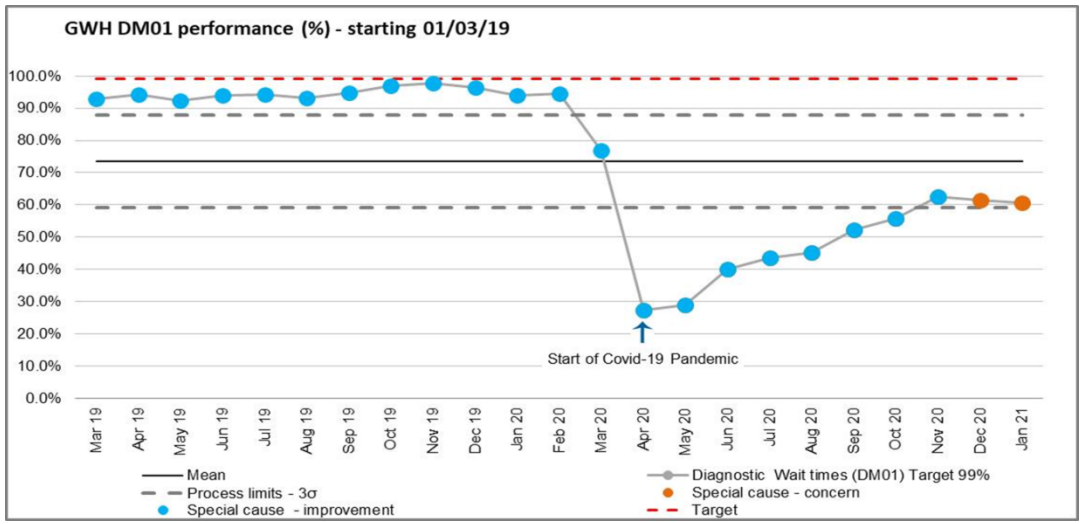
Although the new IS framework contracts / activity plans are in place, there is a risk that we cannot secure the same level of IS capacity that we previously had access to. There is also a risk that IS capacity will be needed to support a Covid surge. **Mitigation**: This is being managed with support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

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

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

Data Quality Rating:

National Key Performance Indicators



Waiting	< 6 Weeks	> 6 Weeks	Total WL	Performance %
Magnetic Resonance Imaging	615	388	**1003**	61.32%
Computed Tomography	369	144	**513**	71.93%
Non-obstetric ultrasound	1740	640	**2380**	73.11%
Barium Enema	0	0	**0**	N/A
DEXA Scan	129	5	**134**	96.27%
Audiology - Audiology Assessments	207	61	**268**	77.24%
Cardiology - echocardiography	56	23	**79**	70.89%
Cardiology - electrophysiology	0	0	**0**	N/A
Neurophysiology - peripheral neurophysiology	46	0	**46**	100.00%
Respiratory physiology - sleep studies	17	4	**21**	80.95%
Urodynamics - pressures & flows	1	0	**1**	100.00%
Colonoscopy	170	488	**658**	25.84%
Flexi sigmoidoscopy	79	222	**301**	26.25%
Cystoscopy	5	8	41 **13**	38.46%
Gastroscopy	99	304	**403**	24.57%
Total	**3533**	**2287**	**5820**	**60.70%**

January 2020

Performance Latest	60.70%
Waiting List Volume:	5820
6 Week Breaches	2287

Background

Performance in January 2020 reduced to 60.7% compared to 61.5% in December, with Endoscopy the primary driver of reduced DM01 performance in month. Overall, the total waitlist size reduced from 6769 in December to 5820 in January (-949). This reduction in the waiting list size, whilst positive, will impact the overall DM01 % performance. The number of breaches has reduced from 2605 in December to 2287 in January (-318). Covid continues to impede performance, however focused actions remain in place to stabilise and improve performance from February 2021 onwards (un-validated position 70.2%).

Improvement Actions

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

- 11 CT van days in February.
- Additional MRI van capacity for Q4 2021 within forecasted budget (15 in February and 16 in March).
- Additional Payment Sessions are in place to support delivery of a further 300 slots for Ultrasound backlog clearance.
- The Independent Sector continued to support Echo cardiology, and Non Obstetric Ultrasound with additional capacity during February.
- 12 point OGD lists starting from 6 March 2021
- Fifth room build commencing in March 2021. Awaiting timeframe for completion

Risks (Risk1855= 20) Failure to deliver DM01 for Imaging (risk remains the same). Insufficient capacity to recover the backlog remains the greatest risk to recovery. There was limited MRI van availability in 2020, however bookings have being confirmed for Q4, January, February and March 2021. **Further mitigations for this risk can be found as part of the more detailed Radiology update on the following 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 26% performance in January which is a reduction from December. The number of referrals received in January has greatly reduced (506) compared to previous months (972 in December) which means the denominator for DM01 performance has been impacted. There are 75 P5/P6 patients on the wait list. 40% of the wait list over 6 weeks are surveillance patients which remain a challenging cohort to book. Discussions started in relation to whether patients who DNA their swab can be managed in line with Trust Policy. GWH continue to provide more Endoscopy activity then SFT and RUH.

Radiology: Combined DM01 performance improved 68.6% in December to 70.8% in January with a further reduction in waiting list size to 4000. There was an decrease in patients waiting over 6 weeks (193) with a total of 1177 breaches (predominantly MRI and Ultrasound capacity). Dexa is close to achieving the 99% target in February.

Echo: Performance dropped from 72.83% in December to 70.89% in January. January saw a significant drop in the overall wait list from 173 in December to 79 in January, with Aerosol generating procedures such as Trans Oesophageal Echo (TOE); Exercise Stress Echo (ESE) and Bubbles solely comprising the booked and unbooked breach list of 23 referrals. Routine Echo is now being booked <6 weeks. Echo wait list activity reduced slightly from 636 procedures in December to 590 in January

Audiology: There was a total of 61 breaches in January (138 in December) that improved performance to 77% (67% in December) with 268 on the waiting list. That was an improvement of 77patient breaches and 10% performance in month. The main patient cohort that are breaching in December are specialist areas including paediatrics and specialist adult diagnostics rather than routine adults. Audiology has been supporting ENT as per pre-Covid levels, but the expectation for Audiology is that February will show further improvements above trajectory and possibly fully recover

What will make the Service Amber?

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

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

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

Endoscopy: Paper discussed at Investment Committee in January which focused on activity and revenue options for Endoscopy in FY21/22 (including an increase in current levels). Awaiting confirmation on revenue spend for FY21/22. 12 point OGD lists starting from 6th March 2021. Fifth room build will commence in March although awaiting final build timeframe to know completion date. Discussions started in relation to whether patients who DNA their swab can be managed in line with Trust Policy.

Radiology: MRI van capacity has been secured from January 2021 with 800 slots available in Q4. A further 27 days (540 slots) have been secured during April and May 2021 with recovery predicted for April 2021. Static CT cardiac applications were undertaken in January to increase CT cardiac slots. Cardiac slots have also been increased on CT1 and booking in progress. An additional US machine has been agreed via capital and the order has been placed to receive in March. 2 WTE Sonographer recruitment in progress (1 WTE mat cover) following reallocation of budget.

Echo: Waiting List Initiative (WLI) activity remains high and February offers from Cardiac Physiologists will ensure that the current levels of activity are sustained. WLI will be minimal in March due to the recovery of routine new patient echo <6 weeks. A new Echo Qualified Cardiac Physiologist starts on 22 February with an additional 1 x Band 6 Physiologist starting in April. An advert has been placed for an additional Band 7 following the withdrawal of the 3rd potential candidate .

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

Risks to delivery and mitigations

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

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

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

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

Audiology: There is a risk that ENT RTT recovery may reduce the rate of recovery if additional Audiology capacity is needed to support ENT. To mitigate, Audiology will continue to offer overtime to the team and utilise additional capacity when ENT reduce clinics with appropriate notice (this has worked well in January). There is a risk that priority clinical patients on the planned activity waiting list will need to be booked/seen alongside of routine DMO1 diagnostics (currently 57% overdue). **Mitigation**: overtime will continue to be offered to staff

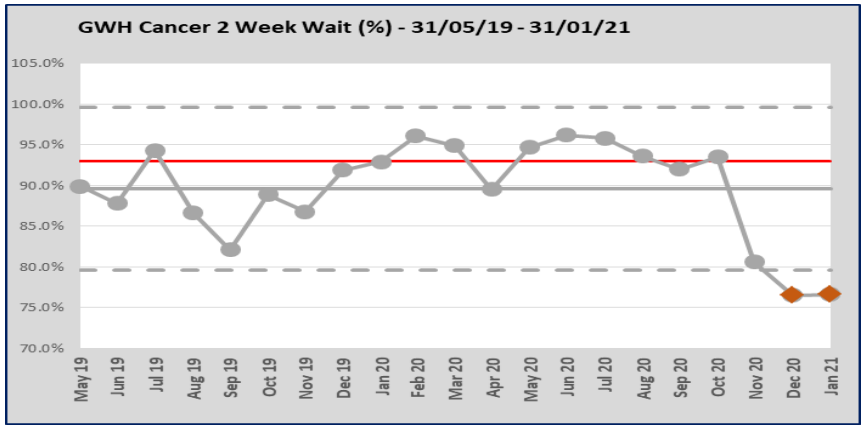
Cancer 2 Week Wait Performance Target 93%

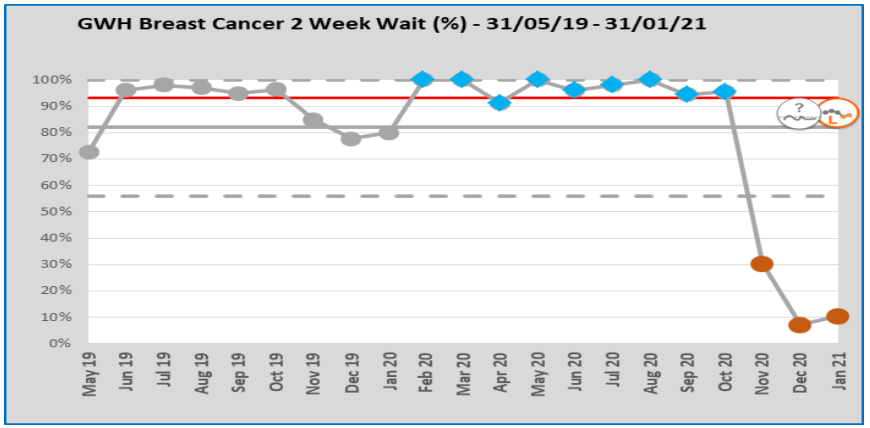
National Key Performance Indicators

Performance Latest Month: **January**

Data Quality Rating:

Two Week Wait Standard: 76.6% Two Week Wait Breast Standard: 10.5%





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 during breast cancer awareness month (October). From this point the breast service have been unable to maintain 2ww performance due to physical distancing requirements in the breast unit as a result of COVID restrictions. In January the service has run very few wait list initiative (WLI) clinics due to staffing (imaging assistants). No WLIs have been undertaken in February. Due to the physical distancing requirements, one additional WLI clinic each week is required to maintain usual capacity for the unit. Work on demand and capacity is being undertaken by the service to predict future recovery. This is dependent on breast build and staffing for additional WLIs. Breast build completion has moved from end of March to end of April.

Straight to Test (STT) Colorectal pathway resumed 28th Sept 2020 improving colorectal 2ww performance although the standard was not achieved (86.7%) in January. Clinic capacity and staff sickness impacted performance. Further improvement through February is anticipated.

Gynae-oncology did not achieve the 2ww standard mainly due to patient choice with appointments and covid isolation.

Urology service was similar with patient choice, patient fitness and comorbidities as reasons for delay.

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

1. Breast 2ww demand and capacity work by service to support recovery now due in March. Imaging assistant support is required; radiology working with bank office to increase staff pool. Breast Unit building work was due for completion by March 2021, discussions between estates and SERCO are now anticipate at the end of April.

2. An incentive payment paper for imaging assistants to undertake WLI clinics has been submitted to Executives for agreement in short term until building works completed.

3. Review of breast 2ww pathway at Thames Valley Cancer Alliance (TVCA) breast clinical advisory group (CAG) 9th February to consider alliance wide strategy/mutual aid. Further TVCA GP training event in April. Mutual aid declined within BSW due to similar service pressures.

4. Consideration of clinical triage of breast referrals and under 25 year olds accessing rapid access "light" clinic. Under 25 clinic piloted through February with some success, though numbers in this cohort may not support regular provision.

5. Endoscopy delivering procedures within 2 weeks. TVCA request to protect Endoscopy services and Gastroenterologists not to be working on Trust medical rota. Endoscopy Service have recovery plan and maintained cancer activity.

6. 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). 45% of referrals had Qfit completed in February. Navigators to work with primary care to increase completion.

Risks to delivery and mitigations

1. Risk: Delay implementing breast wait list initiative clinics (WLI) due to incentive payment request by imaging assistants.

Mitigation: Radiology team working with Human Resources and bank team to recruit additional staff to support clinics. Executive sign off for incentive payment expected to support clinics from mid March.

2. Risk: Delays to breast build will impact recovery trajectories.

Mitigation: This has been escalated for Estate Executive to support imminent start to building work.

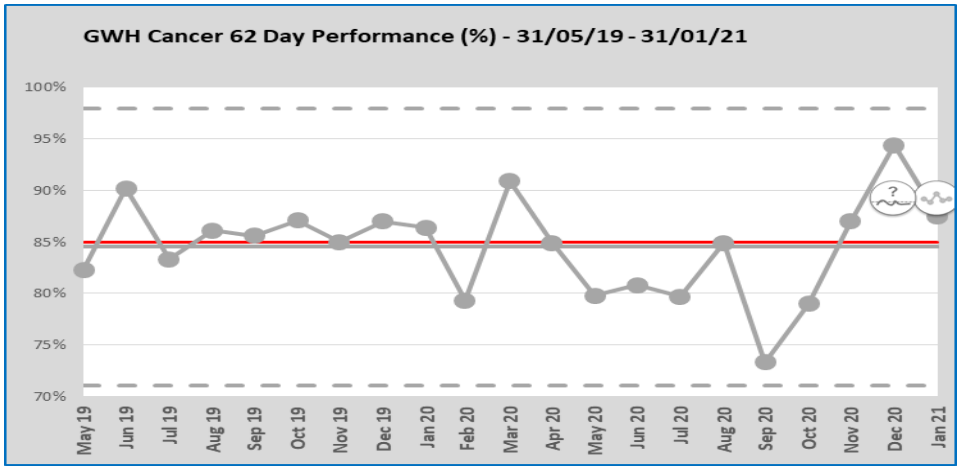
3. Risk: Patient reluctance to attend during lockdown.

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.

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

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: **January**

62 Day Standard (Target 85%):	87.5%
62 Day Screening (Target 90%):	94.6%
62 Day Upgrade (local standard 85%):	100.0%
Q3 (Target 85%):	86.3%

Background

January 62 day performance was 87.5% with the Trust achieving the national 62 day standard for the last three months. Prior to this performance was heavily impacted by the COVID 19 pandemic and diagnostic/treatment delays .

In January, patient pathways were delayed due to appointments, errors in requesting diagnostics, repeat diagnostics and clinical capacity. Three patients had pathways with additional diagnostics due to the complex nature of their cancer. One of these had a high grade prostatic cancer with all options offered as treatment. Discussions with Oxford and Bristol were needed before the treatment could be planned.

8 pathways were referred to Oxford for treatment within 38 days and have not resulted in a breach to GWH. 6 of these were on a Head & Neck pathway.

In January the screening standard was met. A colorectal screening pathway breached as a result of surgical capacity.

The upgrade standard was met in January. A patient treated out of timeframe had been sent to OUH within 38 days resulting in no breach being recorded against GWH

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

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

2. Thames Valley Cancer Alliance (TVCA) transformation work continues with focus on lung and colorectal pathways and scoping for rapid diagnostic services in November. Following a covid pause, the Rapid Diagnostic Service meeting with TVCA 10th March will discuss funding to support this improvement work.

3. TVCA dashboard completed for reporting Alliance and Trust cancer performance and is now live with drop in training events booked.

4. TVCA mutual aid plan (P2 patients) in place with support brokered by COOs. Mutual aid discussed weekly at secondary care clinician call which recommenced in December.

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

Risk to Performance Delivery

Risk: February cancer performance is anticipated not to achieve with four breaches due to complex pathways in January with tertiary providers. Pressures were seen within theatres, pre-assessment clinic, outpatients and diagnostics. There were a number of complex pathways requiring additional diagnostics and changes to treatment plans. Performance is expected to be in the region of 81.0%.

March performance is also expected to be challenged with a number of patients being treated outside timeframes yet to have a formal diagnosis. Current forecast based on only diagnosed patients is showing the standard performance being met, however the undiagnosed risks could see performance of approximately 83.0%.

Mitigation: Continue twice weekly PTL meetings and fortnightly cancer recovery meetings to progress pathways and improvement work.

Gynae pathology delays are impacting patient pathways. This has been escalated with Oxford University Hospital (OUH)pathology services.

Plastics outpatient capacity continues to be challenged due to OUH consultant availability . The service manager has met with the OUH plastics manager to discuss further support and dating of OUH surgery, with weekly catch ups now in place to progress pathways.

Outpatient capacity issues in both the Upper and Lower GI pathways result in delays to follow up activity. Registrar clinics commencing in March.

Oncology capacity is challenged due to significant workforce gaps. Workforce modelling underway with discussions with Oxford University Hospitals and TVCA..

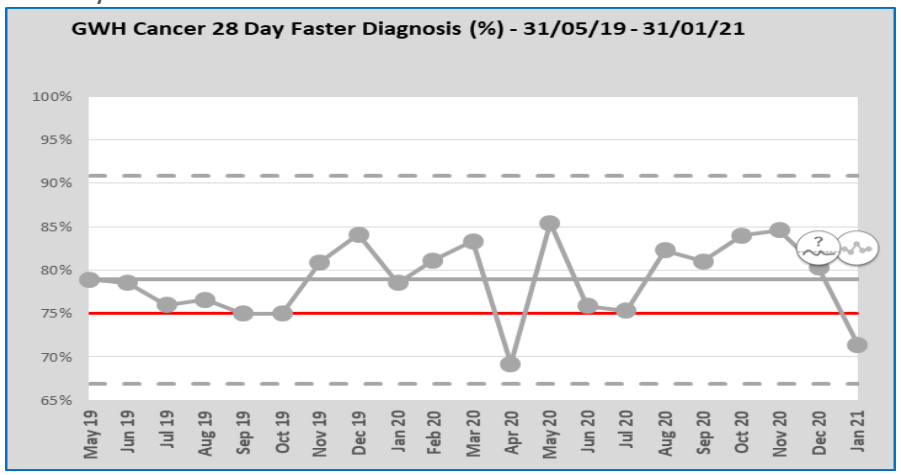
Cancer 28 Day Diagnosis Target 75%

Are We Effective?

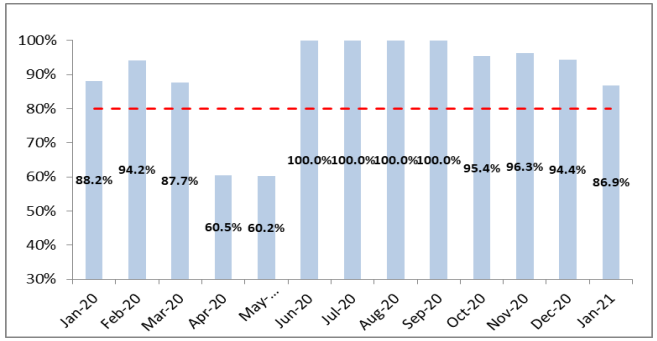
Performance Latest Month: **January**

Data Quality Rating:

28 Day FDS 71.4%



Cancer 28 FDS Completeness



Background

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

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

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

In January a number of colorectal patients were communicated their diagnosis beyond 28 days due to limited capacity to provide follow up activity due to continued ward support during the pandemic. Registrar recruitment will provide additional capacity in clinics.

Gynae pathways that involve pathology are being affected by delays in Oxford pathology reporting and in follow up reviews.

February is forecast to return to compliance with the standard.

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

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

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 place this standard under pressure . Lower GI, Upper GI & Urology all use the suite for early pathway diagnostics

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

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

Mitigation: Incentive payment to imaging assistants to undertake wait list initiative clinics.

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

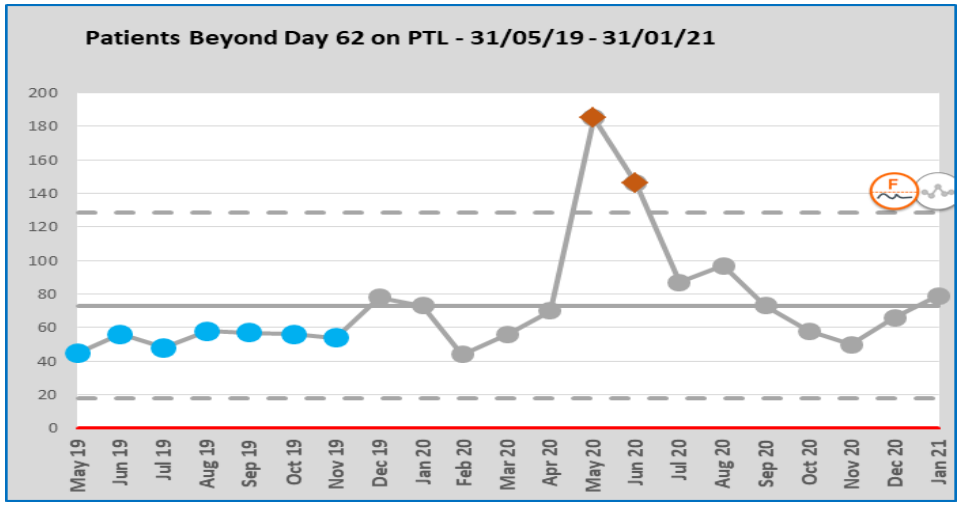
Mitigation: Escalated with OUH and pathology monitoring of key performance indicators working with clinical lead where deviations

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

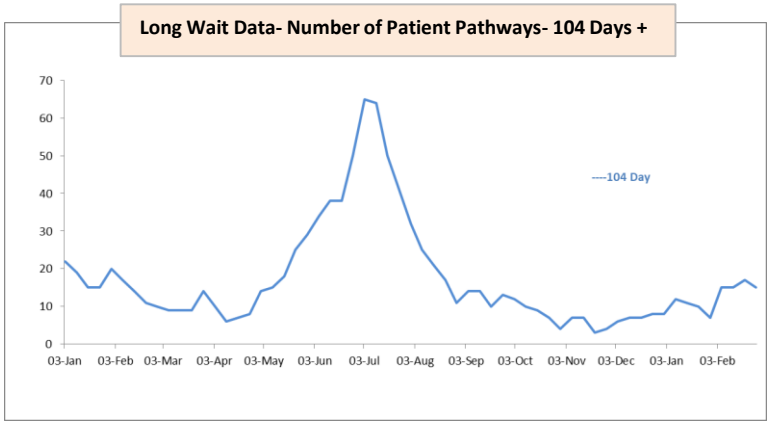
Mitigation: Colorectal service has recruited two registrars to support clinics commencing in March.

62 day + longer waiters including > 104 day

National Key Performance Indicators



Data Quality Rating:



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

104 Day Breaches: January: 3 Patients; 2.5 breaches

Treated at GWH

Colorectal: 1 patient-1.0 breach: The pathway was slowed by the requesting of a CT Scan as urgent rather than as a potential cancer case. There was a delay to follow up post MDT. The patient tested positive for Covid at pre assessment leading to postponement of surgery due to isolation and need for vaccine. An infusion was also needed ahead of surgery

Haematology: 1 patient-1.0 breach: A complex pathway that was transferred from Head & Neck on day 53 following a repeated biopsy due in inconclusive pathology.

Treated at OUH

Upper GI: 1 patient-0.5 breach : Patient had a concurrent Lower GI cancer under investigation and treatment making this a complex case. This resulted in additional MDT discussions and a late transfer of care to Oxford. Oxford needed to repeat sigmoidoscopy and await pathology before treatment could be agreed and completed.

February is likely to see 4 patients breach 104 days on their pathway resulting in 1.5 breaches. 2 patients were referred to OUH for treatment within 38 days and will therefore not result in breaches for GWH.

The high number of 104day+ pathways on the PTL is largely due to a high number of patients (8 out of 15) 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. Additionally 3 of the patients do not have cancer and are awaiting confirmation of their diagnosis.

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

1. The "Managing Long waiting cancer patients (72 day+)" Standard Operating Procedure (SOP) proactively monitors all patients over 72 days on the Patient Tracking List (PTL) and is business as usual for teams and has resulted in the number of patients over 104 days reduce to pre-Covid levels.
2. This report continues to be shared with the Medical Director for executive clinical oversight fortnightly.
3. Review of 62 day breach reports and long waiting patients with a pilot currently being run with MDT coordinators producing the breach reports contemporaneously with review by CNS and Heads of Service.

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 recovery.

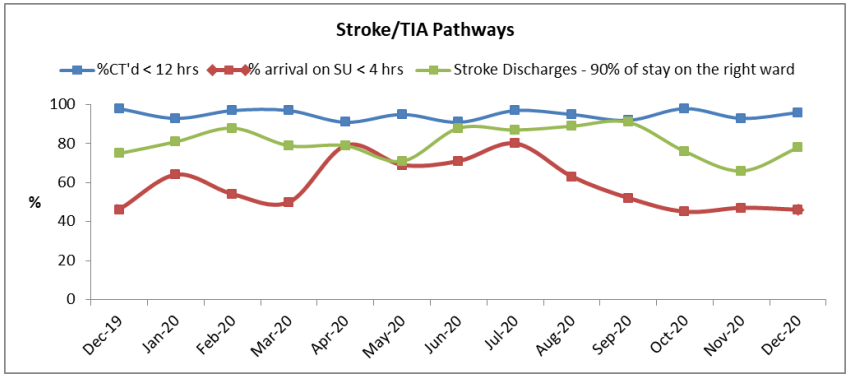
Mitigation: TVCA monitoring long waiting patients with discussion of mutual aid where appropriate out of region.

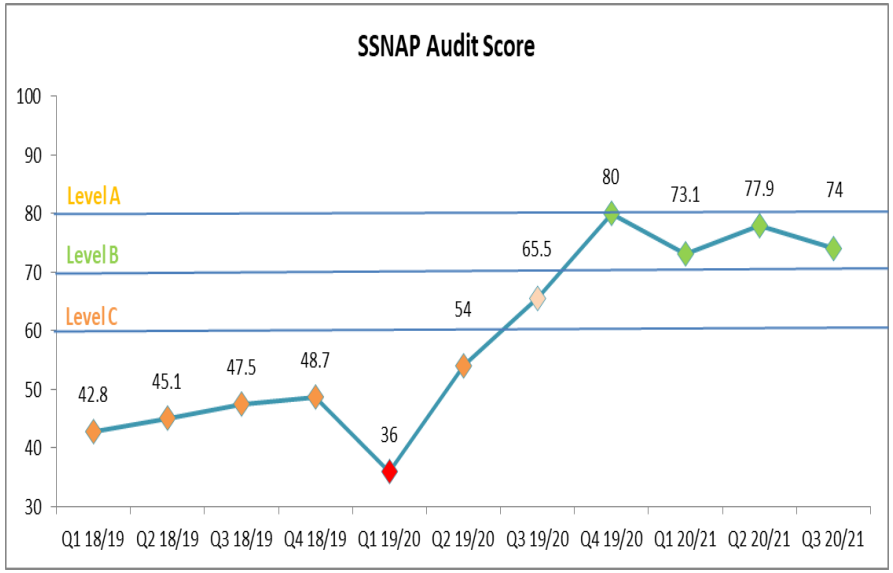
Stroke Pathways

Are We Effective?

GWH SSNAP Audit Score:

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





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

The Trust continues to comfortably maintain SSNAP Level performance, with Q3 confirmed performance of Level B.

Analysis of data for December 20 has shown that the Xmas and New Year bank holiday periods have been a contributory factor to the monthly performance of a C, due reduced specialist nursing and therapist cover over this time. Despite December's performance, Q3 is predicted to be a Level B performance.

Sickness absence of SSNAP data administrator has highlighted a single point of failure in data capture and allowed for introduction of resilience measures to mitigate this going forward.

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

1. Contact other well performing hospitals with good ASU admission performance to identify learning opportunities to improve OOH referrals. **Apr 21**
2. 24/7 Stroke Specialist Nurses to be included in Service Reviews and Nursing Skills Mix. **Apr 21**
3. ED nurses to shadow stroke specialist nurses on ASU to gain knowledge and confidence with thrombolysis. **Apr 21**
4. Introduce mitigation and resilience around any planned or unplanned absence of stroke data administrator. **Mar 21**
5. Locum Stroke Consultant taking April and May off. Replacement required and advert out. **Mar 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 provides DD with weekly update on performance. Stroke Consultants to deliver stroke training to ED doctors.

There is a risk that we are unable to find cover for the Stroke Consultant during April and May.

Mitigation Medical workforce are actively contacting agencies and one CV is within the Clinical Lead to review. If we are unable to find cover, the Neurologists would need to be released from OP to support the Stroke ward.

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

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

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

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

Key Issue	Assurance Level	Committee Update	Next Action(s)	Timescale
Quarterly Mortality Report		This report was due this month but had to be delayed until April for administrative reasons.		
BDO Internal Audit Mortality Review	Amber	This report was a referral from ARAC as the committee felt there were actions required that fell under the remit of Q&G. There was detailed discussion with the Trust's lead for mortality and the Deputy Medical Director and the committee heard how the various actions would be implemented. Key to this are the Medical Examiners who will be fully up and running during April. This will mean that every patient who dies within the Trust will be discussed by an ME with a doctor from the relevant clinical team. This will reduce the need for Structured Judgement Reviews (other than where otherwise required) and will improve the accuracy of the death certificate and learning by trainee doctors.	Roll out the ME process and address the recommendations within the BDO report as agreed. Future Audit reports on mortality will be reviewed by the Executive Team prior to ARAC.	
Board Assurance Framework - Refresh	Green	A much more concise draft was presented as a pilot dealing only with the Care aspect of the BAF. This was approved by the committee and the Company Secretary was congratulated on a meaningful paper that was easy to read.	Roll out to other areas prior to Board approval.	
Integrated Performance Report	Green	This was rated Green because of the actions put in place. It was acknowledged that some of these will take a while to show effect but the signs were good. A	Continue improvement efforts to reduce falls and the	

Key Issue	Assurance Level	Committee Update	Next Action(s)	Timescale
		recent on line workshop on Pressure Ulcers was attended by 102 people. Neptune ward had had no PUs in the past month.	number of complaints received.	
Getting It Right First Time (GIRFT)	Red	The pandemic had had a negative impact on the introduction of some of the recommended practices but it had to be acknowledged that many predated Covid by a long time. Effort is being made on this but more action is needed to move ahead with this. As noted previously by this committee, some improvements are still possible without large capital investment. The list of about 90 actions needs to be reviewed to make it more relevant and timely, removing those that are inappropriate.	Medical Director to continue to lead progress on this.	June Q&G
Patient Engagement and Experience	Green	Good progress has been made on this with a detailed plan in place.		
Inpatient Survey	Amber	The trust was ranked in the lower 20% in many of these responses to the survey carried out in 2019. The recently appointed Head of Patient Experience and Engagement has developed a plan to deal with the lowest ranked scores which included personal care, noise at night and communication.	Action plan to be delivered.	Q&G to monitor progress in July
Guardian of Safe working	Green	This report concerned Rota Gaps and Shift working by trainee doctors. Overall the results were good with few gaps. Some specialties still had vacancies requiring locum cover.		
Freedom to speak up Biannual Report	Green	The Trust continues to perform well in this area but actions are in place for further improvement.		

Other Comments	
Topic	**Comment**

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Part 2: Our Care

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

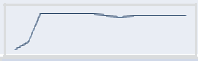
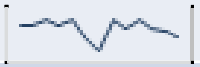
Are We Caring?

Are We Well Led?

Use of Resources

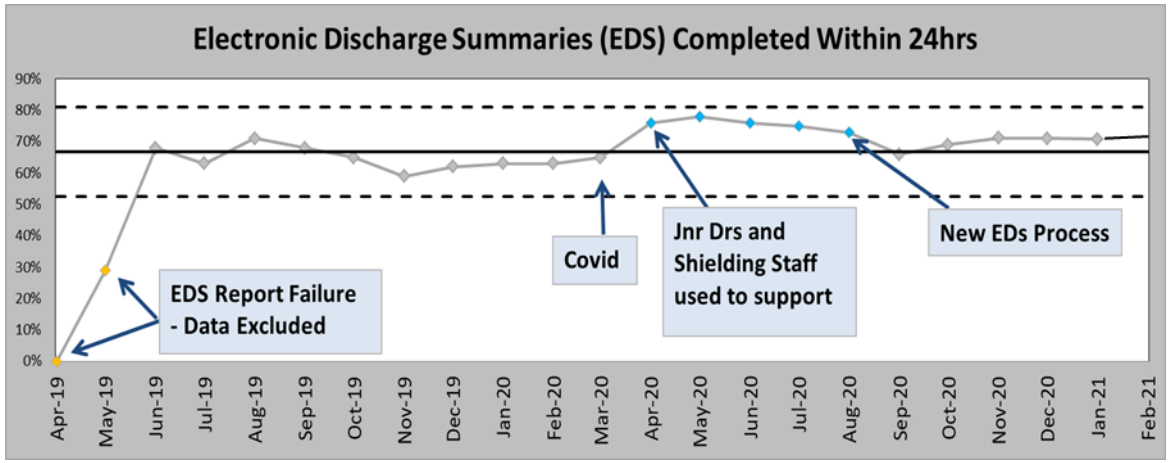
Our Care Summary

Great Western Hospitals NHS Foundation Trust

KPI	Latest Performance	Trend (last 13 months)	Public View (Latest Published Data)			
			National Ranking	Bath Ranking	Salisbury Ranking	Month
Dementia Assessment (Public View)	86.1% (Feb 21)		61	1	1	Feb 20
C. Difficile (Hospital onset) per 1000 bed days	10.34 (Feb 21)		21	47	33	Dec 20
VTE Assessment	98.9% (Feb 21)		18	114	1	Dec 19
Patient Safety Reporting Culture (Percentage of Incidents Recorded as Severe or Death)	0.7% (Feb 21)		121	116	76	Dec 20
Hip Fracture Best Practice Tariff – 12 Month Rolling	68.2% (Jan 21)		35	81	4	Jan 21
Complaints Rates	39.79 (Q4 20/21)		112	32	47	Q2 20/21
Family and Friends Score – Percentage of Positive Responses - Inpatients	87.12% (Feb21)		103	19	7	Feb 20
Falls per 1000 bed days	8.2 (Jan 21)					
Pressure Ulcers – Acute	34 (Feb 21)					
Pressure Ulcers – Community	18 (Feb 21)					
Hand Hygiene Audits	98.9% (Feb 21)					
Never Events 20/21	3					
Serious Incidents	5 (Feb 21)					

2. Patient Outcomes – Electronic Discharge Summaries (EDS)

Are We Safe?



	24 hours	48 hours	72 hours.
Apr-20	76.28%	82.68%	85.92%
May-20	78.26%	83.98%	86.77%
Jun-20	76.44%	82.96%	85.81%
Jul-20	75.36%	81%	84.64%
Aug-20	73.07%	78.3%	81.75%
Sep-20	66.47%	71.24%	74.65%
Oct-20	69.05%	73.49%	76.99%
Nov-20	71.14%	75.67%	78.62%
Dec-20	71.08%	75.59%	79.81%
Jan-21	70.81%	75.43%	78.50%
Feb-21	71.52%	74.84%	77.55%

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

Over the past four months the completion rate of EDs compliance has shown minimal change, but there is an improvement on the same months when compared to last year.

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

Table 1 below shows the current EDs backlog over the last 5 months and table 2 below shows the top 5 hotspots from January which have considerably reduced their backlog.

Table 1

Month	Ed's Backlog (as of 10/03/2021)
Oct 20	100
Nov 20	105
Dec 20	84
Jan 21	93
Feb 21	95

Table 2

Top 5 areas for January		February Results
DCL	132	9
Orchard	114	4
SAW	106	22
Meldon	99	5
PAU	83	21

53

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

The EDs process is under review by the IT department with potential actions including procurement of a new system.

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

Following the second month of reporting the top 5 areas with the highest numbers of outstanding EDS we continue to see a positive response and improvements within these areas.

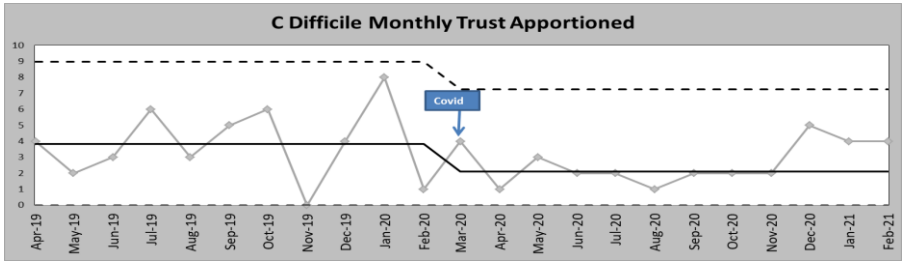
Risks to delivery and mitigations

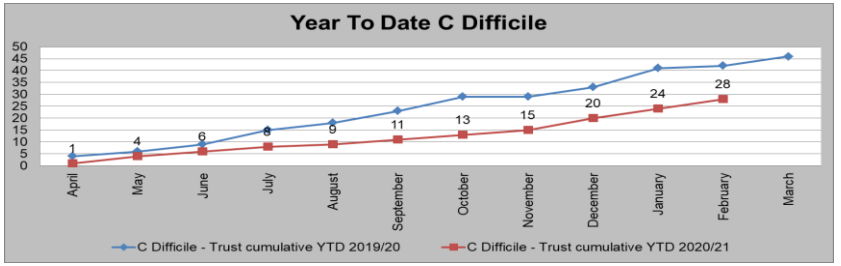
Risk to delivery include changeover of doctors in February and lack of familiarity with the system.

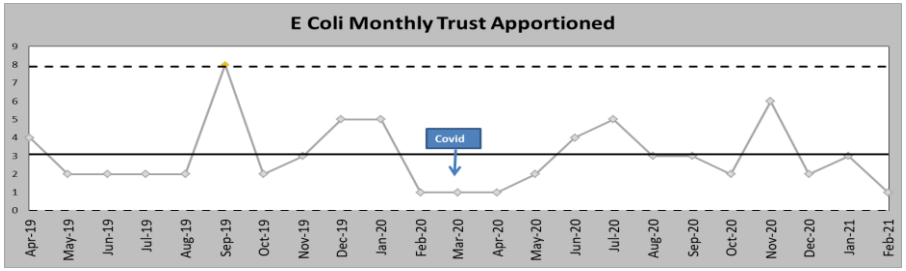
Winter pressures and Covid- 19, redeployment of staff to cover areas that have gaps in their staffing model may also have an impact.

2. Patient Safety - Infection Control

Are We Safe?







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

Hand Hygiene	January
Audit Results	98.9%

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

C. difficile – 28 infections have been reported to date in 2020/21. Four cases were identified during February 2021. Two were identified as a hospital onset and two community onset (within 28 days of hospital admission).

A trajectory was not set for 2020/21 therefore adoption of 2019/20 trajectory of 47 has been used as a guide, current reported cases are under this level.

Flu – No flu cases have been identified so far in winter 2020/21. This reflects the national picture.

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

C. difficile - All four patients had a short inpatient spell prior to C.diff being identified. A period of increased Incidence was instigated for Teal ward, as 2 or more cases had been identified on one ward. Ribotyping has been requested.

E.Coli – RCA's undertaken for all hospital acquired infections. There have been some delays in identifying the root case for these infections occurring this has been due to the prioritisation of COVID post infection reviews. The delay in the RCA being completed will not impact on patient care and treatment

Risks to delivery and mitigations

Teal ward was the only Green DOME Ward during February, increasing the probability of infections being identified in one area.

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

2. Patient Safety – Coronavirus

Are We Safe?

Covid 19	Feb-21	Jan-21
Number of detected Inpatients	154	438
Number of Deaths in Hospital	46	91
Hospital Acquired Covid-19 Cases*	7	54

Covid-19 (Apr 20 – Feb 21)	
Number of detected Inpatients	1385
Number of Deaths	318
Hospital Acquired Covid-19 Cases*	139

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

A total of 154 patients were diagnosed with COVID-19 during February 2021, compared to 438 in January 2021.

A total of 7 of these cases were deemed to be hospital acquired.

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

Daily monitoring and reporting of results continues with contact tracing of hospital acquired COVID-19 undertaken for nosocomial infections, all bays/wards are then closed as necessary. Isolation is proactively managed by staff and the patients are informed of their status.

A full cross trust audit has been completed by IP&C and there is a clear improvement in practice. This will be repeated on a bi-monthly basis. Wards have been tasked with completing self audits as part of Safety Day, to allow the Trust to have a consistent view of any challenges. The importance of PPE and social distancing within the wards and corridors of the Trust is being promoted and challenged when standards can be improved upon.

The increasing number of infections that had been seen across January has started to settle within February and with the sustained collaborations with ward staff the prevalence of the number of nosocomial infections has reduced significantly. The outbreaks have been impacted by the increase in the prevalence within the community, and increased risk of infection transmission rates.

The effect and impact of the vaccine on the COVID-19 infection rate is starting to demonstrate a change in demographic, which has reduced the vulnerable group who are being admitted/attending the Trust. The 30-60 year old age group is currently the largest age group requiring a hospital admission.

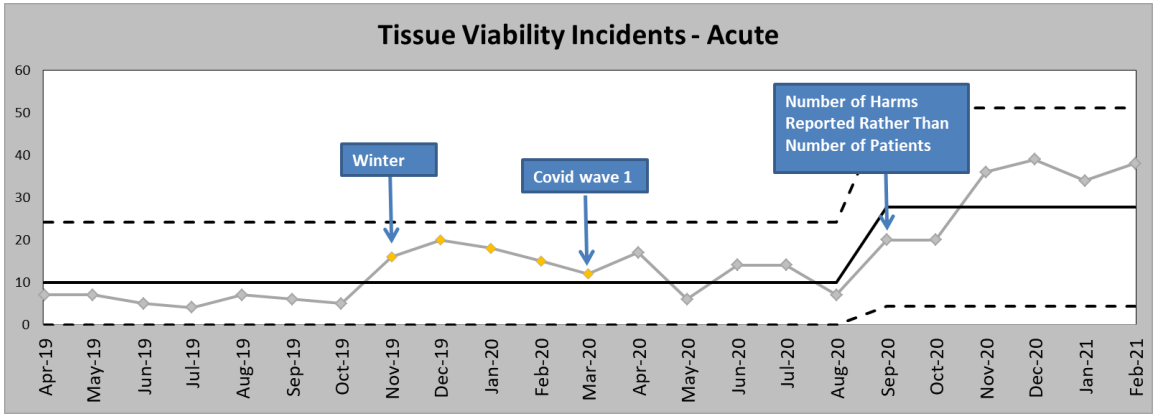
Risks to delivery and mitigations

Operational pressures have created additional patient moves during February. This has increased the risk of patients with undetected COVID being moved between wards and creating COVID-19 outbreaks. (This would be after their admission screen but before their day 3 and or day 6 swab).

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

2. Patient Safety - Pressure Ulcers- Acute

Are We Safe?



Incidents of harms by Category for February 2021:

Category 2 PU	Category 3 PU	DTI	Device related PU	Total Incident of Harms
20	0	10	4	34

Number of Patients	Harms per Patient
1	3
7	2

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

Total incident reporting remains high, however, there has been an increase in Category 2 Pressure Ulcers this month but a reduction in the higher levels of harm (Cat 3 and above). This suggests earlier detection and intervention of hospital acquired harm i.e. improved skin inspections and quick implementation of pressure relieving equipment.

The Tissue Viability improvement plan includes education and training with an updated version of the Pressure Ulcer Training Tracker going live for the Safer Skin campaign on the 4th March.

Lack of referrals to Tissue Viability following identification to harm is a continual theme however there is an improvement from last month of 13.5%.

Image taking still requires improvement. There is a risk that PU's may not be able to be validated by level of harm or origin prior to discharge or transfer.

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

Information sharing of levels of harms occurred within each department so that this leaning can be disseminated through to all staff within the department.

Each department to send out a safety brief to remind/educate staff on the correct referral process to Tissue Viability and Image taking process.

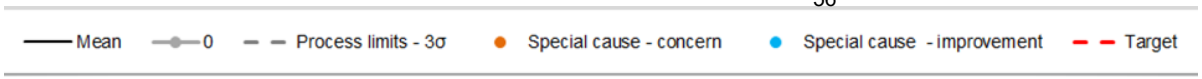
Focus on ensuring improved compliance with the Pressure Ulcer training tracker.

The Tissue Viability improvement lead is currently working in partnership with RUH and Salisbury Hospitals, work includes benchmarking the data collection of incidences of harm and reviewing reporting processes.

Risks to delivery and mitigations

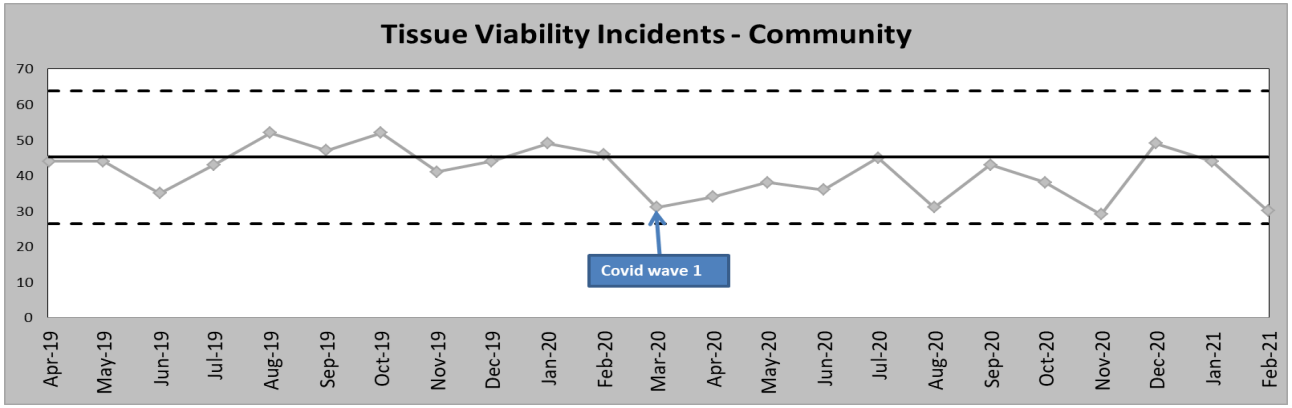
The pressures upon staff from the pandemic have reduced the levels of resources and capacity of the wards and departments in enabling staff to uptake training.

Engagement from staff has improved but needs to continue to attend training sessions, Safer Skin Event and uptake Training tracker module



2. Patient Safety - Pressure Ulcers- Community

Are We Safe?



February 2021				
Locality	**Cat 3**	**Cat 4**	**DTI**	**Totals**
North	2	2	2	7
South	1	1	2	4
West	2	0	0	2
Central	3	0	2	3
CICT	0	0	1	1
S/Flower	1	0	0	1
Totals	**9**	**3**	**7**	**18**

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

A reduction in harm levels has been recorded compared to January 2021, this may be due to a number of factors – appropriate investigation, frequent delivery of education sessions and improved Bank and Agency processes and knowledge and skills check.

Suspected Deep Tissue Injury's (DTI) require further investigation from 72 hours onwards by TVN to determine if they evolve or resolve. An audit of the DTIs recorded in February demonstrated that 6 out of the 7 SCHS acquired DTI's had resolved so would change classification to category 2.

Incident numbers continue to be the result of the COVID Spike in Dec/January and the increase in acuity and admissions and rapid discharges.

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

Category 2 pressure ulcers are now validated by SCHS TV service, and origin determined so able to clarify numbers acquired in SCHS.

Risk assessment paperwork adapted for ease of completion by bank and agency staff.

Improved process for feedback following visits from bank and agency staff and rapid scanning implemented for patient's hard copy notes from agency /bank to expedite validation and management plan

Bi weekly training: pressure injury prevention, 'react to red' and incontinence.

Development of carer information and education package to be discussed at bi-weekly Pressure Ulcer Action Group.

Risks to delivery and mitigations

Staffing challenges continue resulting in high levels of bank and agency staff and subsequent lack of familiarity with documentation and processes.

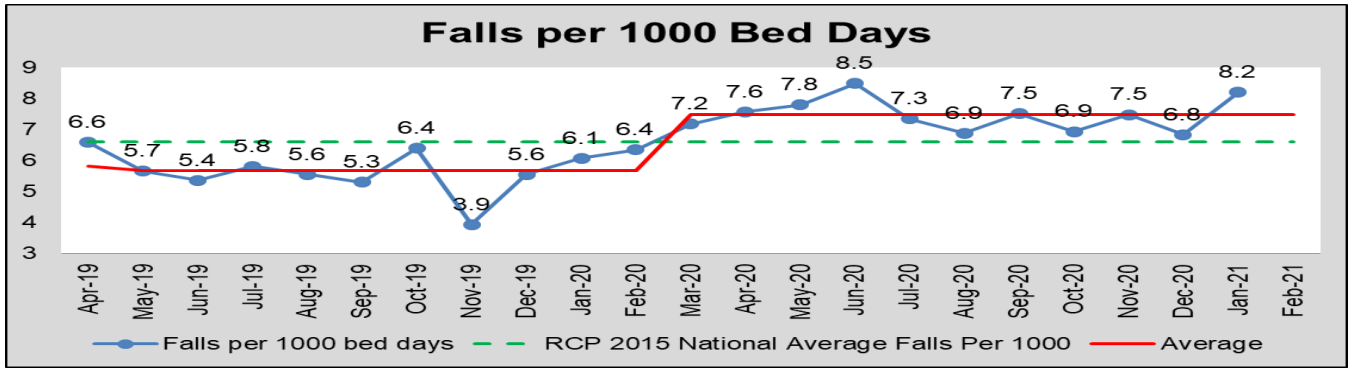
Evidence in reduction in early escalation from family and carers leading to higher levels of harm.

Significant Increase in referrals and in patient acuity and complexity, requiring increased requirement for TV team to validate levels of harm and support Tissue Viability Education.

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

2. Patient Safety - Patient Falls

Are We Safe?



February 2021	
Falls Resulting in No Harm	129
Falls Resulting in moderate Harm or above	2

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

The chart evidences an increasing trend in falls from January 2020 and a shift in the average from 5.7 to 7.5 falls per 1000 bed days.

There has been a sustained increase in the number of falls reported from September 2020, leading to a shift in the average number of falls reported from 110 to 129 per month.

Falls Leads across the South West Falls Network are reporting seeing a similar rise.

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

Progress with the falls improvement plan continues, with the following key activities underway during March and April.

Falls assessment and care planning documentation workstream – Project agreed to commence on six wards planned to take falls documentation off Nervecentre and onto paper to undertake PDSA testing and amend content of documentation, this allows for rapid changes to the documentation in response to outcomes from the testing phase. Once content of falls documentation has been agreed and tested, an options appraisal will be drafted, considering benefits and risks of remaining on paper or moving documentation back onto Nerve centre.

Safe use of Bedrails - Baseline data collection on Mercury completed. Training of all staff members in progress to be completed by end March 21. On-going data collection with real time feedback commenced. Bedrail assessment tool amended and in use on Mercury – to be sent to printing for PCP booklet by end March 21.

Post falls SWARM/hot debrief – Royal College of Physicians has now published the pilot post fall process 'Hot debrief' and 'After Action review'. This is being piloted nationally, testing will commence on Teal once falls assessment and care planning workstream has been progressed. This is a high priority project, due to high number of patients falling multiple times and it is critical to review interventions in place to reduce the risk of a patient falling again.

Risks to delivery and mitigations

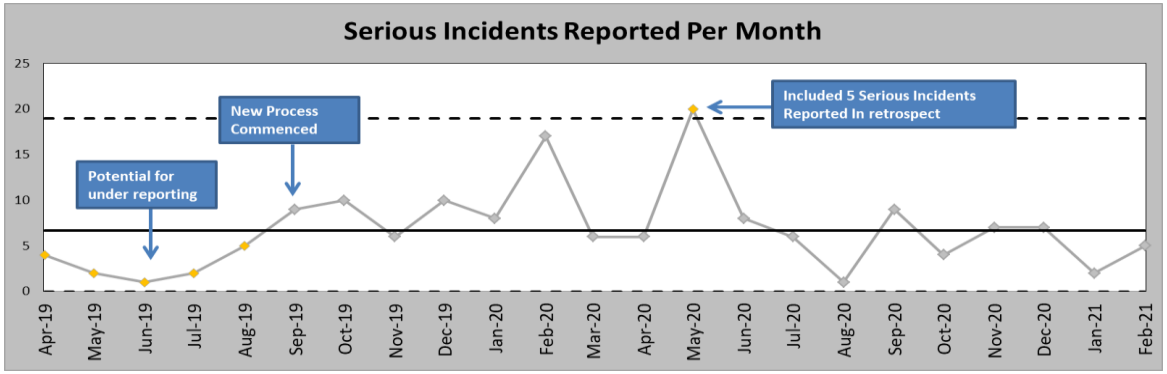
Team and ward based capacity to sustain the QI work.

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

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

2. Patient Safety - Incidents

Are We Safe?



Serious Incidents Reported			Comparison
Dec	Jan-21	Feb-21	Feb-20
7	2	5	17

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 39 on-going Serious Incident (SI) investigations, with 5 reported in February.

The number of SI's reported has increased compared with January 2021, however, remains below the Trusts average per month..

There continues to be good levels of incident reporting with a total of 839 patient safety incidents being reported in February. The top 3 themes consisted of

1. Tissue viability incidents - 210
2. Slips Trips and Falls - 131
3. Medication incidents - 95

Improvement update on working groups

Progress with Working Groups

Access to SPINE Task and Finish Group:

- >120 staff have registered for a smart card, which will improve ease of access to NHS systems
- there are on-going plans between IT and HR for the new doctors to be registered on the system at induction

Discharge Improvement Group: (Following a number of potentially unsafe discharges).

- Set up to communication and patient experience
- Initial focus will be on improving discharges from hospital to patient homes and external care providers for End of Life patients
- Expansion to other patient groups in the future.
- Working in tandem with the #helping you to get home works stream.

WHO working group:

- A cultural survey will be disseminated in March
- A snap shot audit of Lumbar Puncture's and Chest Drains has commenced, with an aims to identify compliance with the use of a WHO checklist.

Risks to delivery and mitigations

Due to the ongoing increased pressures on services during the pandemic there is a potential risk of under reporting of incidents and a further risk that SI investigations may become overdue.

In order to mitigate this risk the Clinical Risk Team have continue to provide support in terms of:

- Ensuring staff can report incidents via the incident management system, via telephone or paper form (where required)
- Undertaking SI in a day methodology
- Supporting the Implementation of a new Pressure Ulcer and Falls Investigation process which aim to reduce the time spent investigating whilst ensure the root cause of these incidents are identified and appropriate mitigating actions are undertaken

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

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

Are We Safe?

Background and underlying issues

Safe Staffing process;

all shifts safe, effective use of resources, shared understanding of risk, compliance with national guidance.

Professional judgment is added to wards that are red and short of care hours per patient day.

Wards are using tasks for patients who require specific care in addition to the prescribed care hours.

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

ICU are benchmarking with other Trust in BSW to understand the best use of Care Hours per Patient Day and the acuity and dependency of this group of patients. Additional Tasks are being reviewed ready for launch in April.

Children's unit acuity and dependency to be added to SafeCare.

Roster review process starting this week to check and challenge and provide assurance that rosters are within agreed KPIs. Terms of Reference produced to provide continuity of the review process.

New preferred supplier list for agencies from 1st April, opportunity to reset and reduce high cost agency.

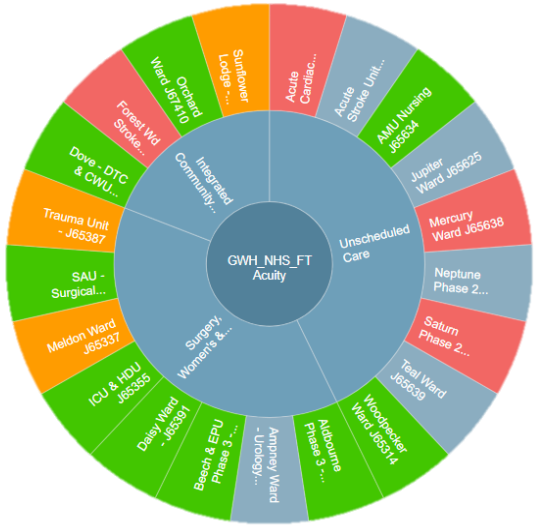
Plan to achieve zero Registered Nurse vacancies by December 2021. A further 80 Overseas Nurses joining in next 6 months.

NHSE/I funding to fill HCA vacancies by 1 April (current gap 55wte).

41 Oxford Brookes University 3rd Year students on paid placements for 12 weeks from 2 February until 26 April. They are included in the Care Hours.

Divisional Directors of Nursing to chair the SafeCare meetings going forward and will continue to monitor agency usage.

Ward Clerk review as part of Transformation and Improvement Workforce and OD work stream. The aim being to further strengthen their role in the process of admission, transfer and discharging patients freeing up clinical time.



Sundial indicating wards that are adequately staffed (green) versus wards short of care hours (CHPPD).

**Example above shows 3rd of March – All day*

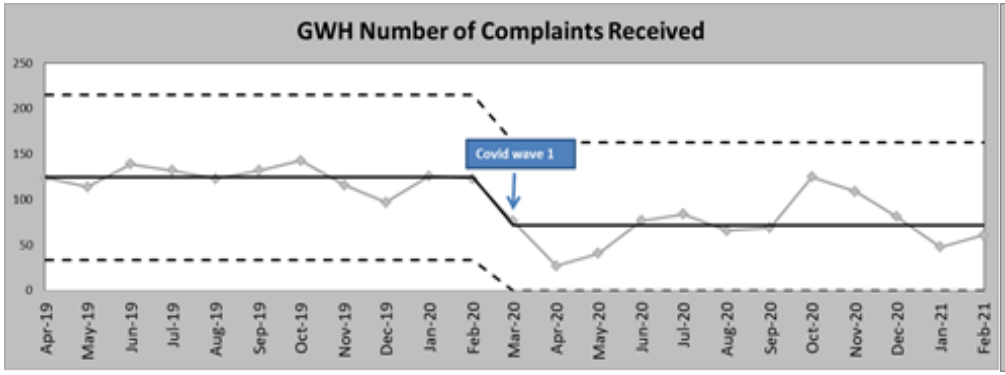
Risks to delivery and mitigations

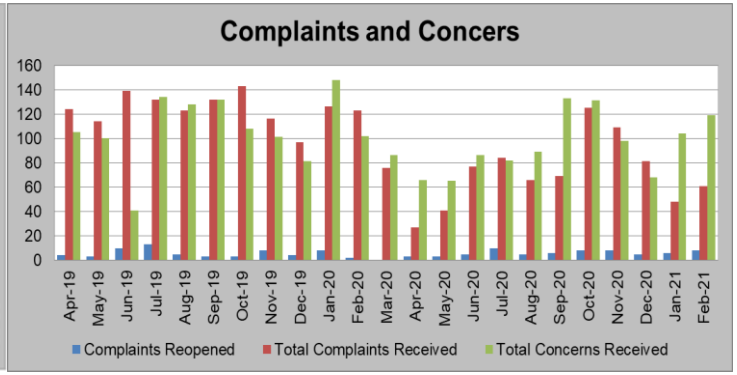
Risk of increased vacancies / turnover in registered nursing needs to be mitigated by focus on recruitment and retention.

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

2. Patient Experience - Complaints and Concerns

Are We Caring?





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

61 complaints (previous month 48) and **119** concerns (previous month 104) were received in February 2021.

Out of a total of **180** cases received from Complaints and Concerns in February, the overall top three themes were:

- **Clinical Care:** 27 (15%) – 17 complaints, 10 concerns.
- **Waiting Time:** 24 (13%) – 0 complaints, 24 concerns.
- **Telecommunications:** 24 (13%) – 3 complaint, 21 concerns.

Complaints: 61 complaints were received, 59 were rated as (Low – Medium), 2 (High to Extreme).

Cases rated as High for February related to complex cases including:-

- Case 1 (H-E) : Potential misdiagnosis, initial review has identified appropriate medical intervention was taken at the time. However further scans after the event identified differential diagnoses and this is being investigated inline with the incident investigation policy.
- Case 2: (H-E) This relates to an end of life patient. Delays with pain relief given, lost patient property and complex needs of the patient required to be taken into consideration with discharge planning.

Response rates: 90% L-M Complaints, 50% H-E complaints. (KPI 80%), 73% concerns were resolved within 24 hours (KPI 80%).

61

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

Telecommunications/Communication - Task and Finish group set up to review key aspects – Telephony, web information, Internal directory, systems and support at ward level. This group will include service user involvement

Waiting Times

- Reopening of Aldbourne Ward week commencing 1st March.
- Restarting of reduced elective orthopaedic lists week commencing 1st March.
- Plan to have all theatres back online by the end of March.
- Support from independent sector to provide additional capacity
- Extended and increased theatre lists for Orthopaedics

Risks to delivery and mitigations

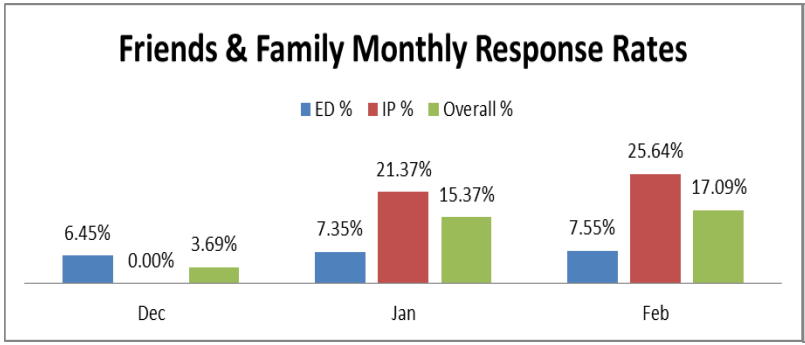
The contract for Datix complaints management system is progressing via procurement.

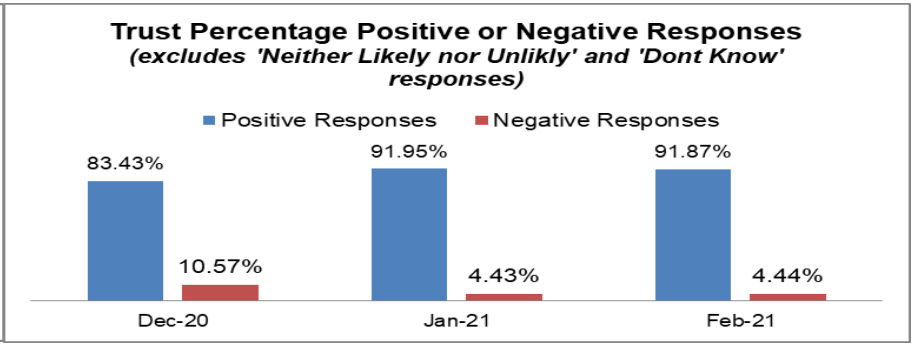
The risk of the current provider giving notice before a new system is in place remains.

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

2. Patient Experience – Friends and Family Test

Are We Caring?





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

In February the Trust achieved a likelihood to recommend score of 91% with a response rate of 17%.

This was achieved by

	No. text	No. responses	Overall Likelihood to Recommend Score
ED	1,172	314	89.49%
Inpatients	2,001	623	87.8%
Day Case	1,752	569	95.25%

(correct as of 10th March)

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

Further roll out of the text messaging format for FFT collection is underway with a 'go live date' for Outpatients of April. Maternity services are also a priority, however due to further complexities will roll out following Outpatients. Scoping for implementation to community services and primary care is also underway. Additional opportunities for obtaining feedback are now in place including via our webpage and with the support of volunteers throughout the organisation.

Working closely with the Accessible Information Standards group (AIS) we will be introducing a message in the FFT text, which will highlight the support available to patients who required (AIS) additional support. The advice will guide patients where they can register, this will ensure that additional support will be put in place for them for future attendances and preferred methods of communication.

Risks to delivery and mitigations

2. Patient Safety - Perinatal Quality Surveillance Tool February 2021

Are We Safe?

Measures	Comments
CQC ratings	Overall Good in the 5 domains (2020)
Maternity Safety Support Programme	Not required as CQC ratings overall 'Good'
Findings of review of all perinatal deaths using the real time data monitoring tool	1 eligible case in February for review which is a case of an intrauterine death at 32 weeks of pregnancy. A multi-disciplinary team consisting of midwives, obstetricians and neonatologists, currently meet weekly to review all cases using the real time data monitoring tool. This is a national tool, which evaluates and rates the care provided.
Referrals and findings of HSIB reports	1 case currently under review by HSIB for a baby born in October 2020. The draft report has been received from HSIB and circulated to the wider MDT for comments prior to final report being published and shared with the family. The safety recommendations will be implemented following receipt of the final report, which is also shared with the family.
Number of incidences graded moderate or above and actions taken	2 incidents were graded at moderate harm. Case one required no further investigation as it related to a known complication of surgery. Case two will be investigated in line with the Trust risk processes. The themes identified as part of the initial review include a loss of situational awareness and analysis of the fetal heart rate monitoring. There are currently 4 Serious Incidents under investigation which are outlined on the next slide..
Minimum safe staffing in maternity to include Obstetric cover on delivery suite	Midwifery Staffing monitored via roster any shortfalls covered as required via bank office. 60 hours Consultant presence on the delivery suite. Any shortfalls in Obstetric staffing is addressed by acting down or use of locums
Service user feedback	Feedback is received in a variety of ways and the Trust has a valuable collaboration with the Maternity voices partnership (MVP). Posters are being created by MVP for the clinical areas to inform women of how they can be involved in generating feedback for maternity services. Plans for FFT to be delivered via text message to include maternity cohort of service users, however this is not currently in place.
Coroner's Regulation 28	Nil
Concerns or requests for actions from national bodies	Ockenden assurance report has been submitted to the National team on 15/02/2021. Public Health England (PHE) have oversight of a Serious Incident relating to reviewing babies that did not receive routine hip screening based on their individual risk factors. This forms part of the National Screening Program.
CNST 10 Maternity standards (NHSR)	Submission due: 15/7/21. The Maternity Data set has now been successfully submitted to NHS England. Training compliance is being addressed and is outlined on a separate slide.
Staff feedback from frontline	Discussed at Maternity Safety Champion meeting, reviewing feedback process.

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

2. Patient Safety - Maternity – Update on Maternity Incentive Scheme

Are We Safe?

	Maternity Safety Action Detail:	RAG
1.	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	Standard Met
2.	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Standard Met
3.	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units programme?	Standard Met
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Further Action Required
5.	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Further Action Required
6.	Can you demonstrate compliance with all five elements of the Saving Babies Lives care bundle Version 2?	Further Action Required
7.	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Further Action Required
8.	Can you evidence that at least 90% of each maternity unit staff group have attended an "in-house" multi-professional maternity emergencies training session within the last training year?	Further Action Required
9.	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate local identified issues?	Further Action Required
10.	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolutions Early Notification (EN) scheme?	Standard Met

2. Patient Safety - Maternity – Update on Maternity Incentive Scheme

Are We Safe?

Safety Standard	Maternity Safety Action Detail:	Outstanding Action	Action Lead	Target Date for Completion
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Update the business case which meets the BAPM recommendations for Neonatal staffing (both nursing and medical) for Board sign off. Audit against ACSA standards, including elective and emergency C section requirements, and devise action plan if there are any shortfalls.	Sarah Bates Emma Churchill	31.03.2021
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Implement Birth-rate Plus recommendations. Complete audit to demonstrate supernumery status of Delivery Suite Coordinator and 1:1 care in labour. Action plan to be developed if shortfalls are identified.	Christina Rattigan Chris Bull	30.06.2021
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Implementation of text messaging service to gain feedback.	Tania Currie Deborah Tapley	31.05.2021
8	Can you evidence that at least 90% of each maternity unit staff group have attended an "in-house" multi-professional maternity emergencies training session within the last training year?	Training plan and trajectory in place for each professional group. Need to ensure staff are released to attend training.	Adam Brooks Kat Simpson	30.06.2021
9	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate local identified issues?	Revised Continuity of Carer action plan for Board oversight on a quarterly basis.	Christina Rattigan Chris Bull	30.04.2021

Background and underlying issues:

Since the February update, we have now progressed to no red RAG rated actions, i.e., significant concerns for the achievement of the Maternity Safety Standards.

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

Focus is now on the amber actions and the collation of evidence to ensure compliance with standards. Audit and initial action plans are required for sign off by Trust Board in June 2021. 65

Risks to delivery and mitigations:

Key concerns for achieving all 10 safety criteria are:

Release of staff to ensure 90% of each professional group completing in house MDT training is compliant. There is a compliance trajectory in place and currently on track.

Failure to provide a robust action plan if there are unexpected findings following a variety of audits. Plans are in place to complete timely audits to aid decision making.

2. Patient Safety – Summary of On-going Serious Incident Investigations

Are We Safe?

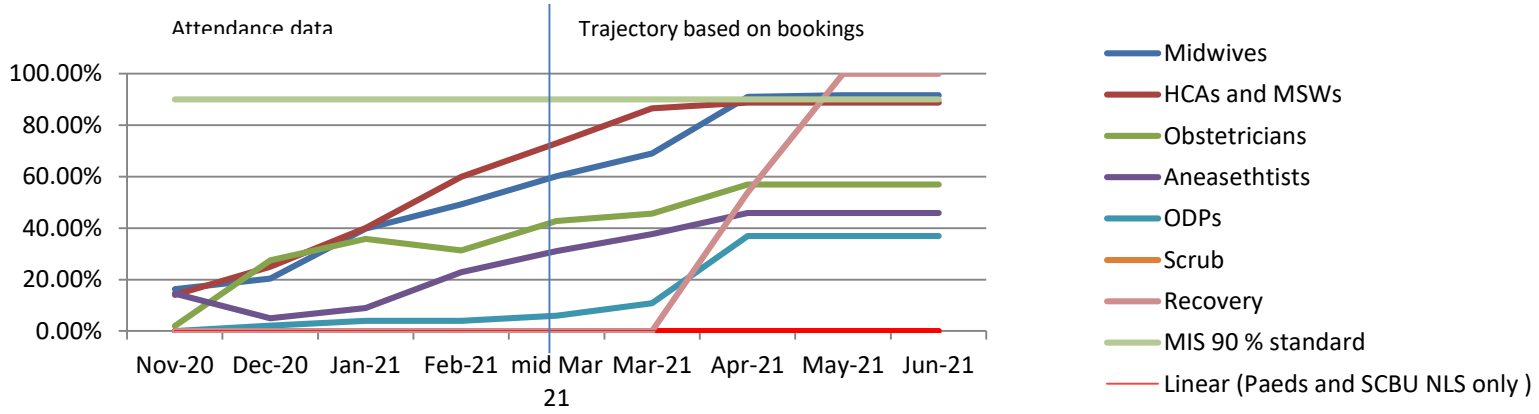
Case ref	Overview	Date due	Case update
1	28/40 neonatal death on SCBU	01-Feb-21	Case undertaken by external investigator and with Coroners office. Delayed due to clinical demands of the external investigator. Post Mortem report not yet received from the Coroner's office.
2	Birth injuries following forceps birth and shoulder dystocia	19-April-21	Round table review scheduled for 29/03/2021. The meeting with be chaired by the Risk and Governance Lead Midwife and Lead Obstetrician for Risk The invited attendees include midwives, obstetricians, neonatologists and anaesthetists, and we have invited an obstetrician from another Trust to attend and contribute.
3	Baby underwent a second unnecessary lumbar puncture	Submitted	Report complete. Awaiting sign off by CCG The learning and recommended actions from the case include reducing duplication of patient information and implementation of a Local Safety Standard for Invasive Procedure (LocSSIPs) for lumbar punctures
4	Babies identified that should have received USS to screen for developmental dysplasia of the hips who were not identified and referred	13/04/2021	During an initial review of this incident the process was mapped and immediate actions were identified and implemented, including improving staff training and accessibility of the IT system so that the baby's details can recorded at the point of care. The case has oversight by Public Health England as it concerns a national screening requirement. The Serious Incident investigation is being carried out by a Trauma and Orthopaedic Consultant in order to ensure objectivity is maintained, and a Senior Midwife.

Following recommendations made in the Ockenden Report the following system will be adopted for all cases meeting criteria for review by HSIB:

- The Trust will undertake an immediate review (48-hour report) to identify urgent safety concerns
- After this review, where an incident meets the HSIB criteria for investigation, this should be undertaken only by HSIB. Trusts should not be duplicating the investigation
- Report all HSIB investigations as Serious Incidents (SIs) – this will ensure CCGs and NHSE/I remain fully informed of on-going investigations, this may be reflected in an increased number of on-going SI reports in subsequent months.

2. Patient Safety – Maternity Training Compliance

Are We Responsive?



Background and underlying issues

- Maternity Incentive Scheme (MIS) Safety Action 8 requires 90% of each Maternity Unit staff group have attended an in house multi professional maternity emergencies training session within the last training year. In July 2019 we achieved 90 percent compliance for all staff groups attending face to face multi-disciplinary teams skills and drills training (PROMPT) day.
- FtF 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.
- Maternity Incentive Scheme extension to meet the same target by July 2021

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

Compliance in some groups will not meet deadline based on trajectory of bookings that are currently made. Practice Development team have explored alternative ways of achieving compliance. Training team have moved 2 dates to support theatre staff attendance. Awaiting bookings and predict that trajectory will greatly improve over next few weeks.

Paediatric doctors and SCBU nurses required to attend NLS session on PROMPT day. PDM team are attending paediatric meetings to improve compliance, and the paediatric leads are exploring how they can support this.

Risks to delivery and mitigations

- The graph shows the trajectory that we will not meet MIS safety action 8 by the end of June 2021 for 7 of the 8 staff groups. However, this is expected to improve over next few weeks as theatre managers are confident they can release staff now we have moved days to support them with this.
- One date in February was cancelled due to shortage of facilitators.
- Staff shielding may pose a problem for some staff groups. There are many HCAs shielding with no IT access at home therefore cannot train them until return from shielding.

Great Western Hospitals NHS Foundation Trust

Part 3: Our People

Our Priorities

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

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

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

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

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Resources

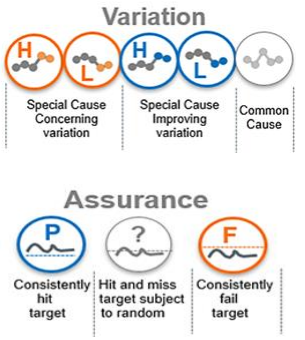
Trust Overview: Summary

Great Western Hospitals NHS Foundation Trust

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

Summary Dashboard - Workforce Performance

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Overall Agency Spend as a % of Total Spend			6.09%	6.00%	3.93%	7.31%	5.62%
2	RN Bank Fill Rates			56.3%	70.0%	34.5%	59.8%	47.1%
3	Vacancy Rate			6.30%	7.63%	5.92%	8.72%	7.32%
4	Recruitment Time To Hire (Days)			50.5	46.0	27.6	58.5	43.0
5	All Turnover			13.35%	13.00%	12.15%	13.54%	12.84%
6	Voluntary Turnover			8.23%	11.00%	9.14%	10.11%	9.62%
7	All Sickness Absence			4.38%	3.50%	3.29%	4.59%	3.94%
8	Statutory Mandatory Training Compliance			84.93%	85.00%	84.32%	89.19%	86.75%
9	Appraisal Compliance			77.72%	85.00%	71.28%	81.77%	76.53%



Trust Overview: Narrative

Great Western Hospitals NHS Foundation Trust

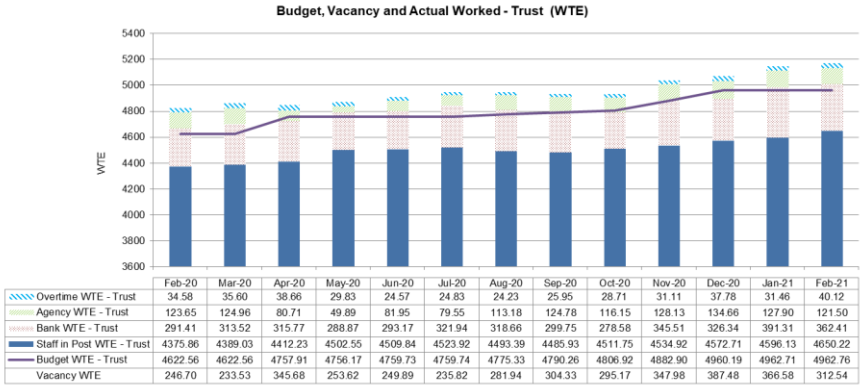
"Great" Scoring	Indicator Score (1-4)	Self Assessment Score	Headline
1 – Underperforming / Inadequate | 2 – Requires Improvement |3 – Good | 4 – Outstanding			
Great Workforce Planning	**2**	**3**	The Indicator and Self Assessment Score in February is 2, on account of the proportion of the Trust's total workforce spend being attributed to agency improving to 6.09% (vs. 6.0% KPI); the Trust vacancy rate improving noticeably to 6.30% (vs 7.63% KPI), and, the Registered Nurse bank fill rate in February improving to 56.34%, albeit against a stretching 70% KPI target. February saw a reduction in temporary workforce utilisation, whilst the improvements in Medical and Nurse agency spend seen in January continued in to February, particularly on the Nursing front. Alongside improved Divisional controls the opportunity to improve nurse agency performance still further will emerge in April '21, with agency contract arrangements moving from a Master Vend to a Preferred Supplier List, increasing opportunities to fill nurse agency shifts at a lower rate.
Great Opportunities	**2**	**3**	The indicator score and self assessment score has increased to 2 in February due to the decrease in vacancy position (54wte Trust wide) and the consistency with all turnover. Recruitment time to hire metric remains a concern at 51 days from advert live to start date confirmed. An additional £36k funding has been received to support the Trust achieving a zero HCSW vacancy position. In addition to this, the Trust was successful in securing an additional £600k funding for international recruitment (Strand B plus) to support bringing in a further 80 overseas nurses into the UK by 31st December 2021.
Great Experience	**2**	**2**	Sickness absence in-month is 4.38% remaining above the 3.5% target with staff seeking support for work and personal related matters driving a KPI score of 2. The self assessment score is also reported again as 2 this month as the OH department continue to manage resource to meet demand as outlined in the report. Staff Support services continue to provide a range of departmental group therapy sessions and the report this month includes a spotlight on the staff uptake of the Employee Advisory Service (EAP) since March 2020. The EDI lead role is embedding successfully holding in-month communication forums sharing the EDI strategy and role objectives, launching the EDI newsletter, annual calendar of national diversity celebrations and commencing key issue community engagement.
Great Employee Development	**2**	**2**	The Academy continues to focus on maximizing the use of the both the Trust and HEE CPD funds and will continue to do so until 31st March 2021.The ability to accrue the HEE CPD funding will ensure it can be used. Mandatory Training (CQC) compliance has improved in month due to continuing work on data accuracy and work within the Divisions. The mandatory Training project which will move training from Training Tracker into ESR has been brought forward with a completion date of 31st May 2021
Great Leadership	**1**	**2**	There has been a significant improvement in appraisal rates in February rising by 7% to 77.72%, which whilst lower than the KPI target of 85% is encouraging. The revised appraisal paperwork was discussed at EPF on 1 March and some changes were agreed. The second cohort of the Leadership Development programme will start in April 2021. The first session of the AMD development programme took place in February and was well received-attended by Associate Medical Directors from GWH, Salisbury NHS FT and Royal United Hospital in Bath.

Workforce

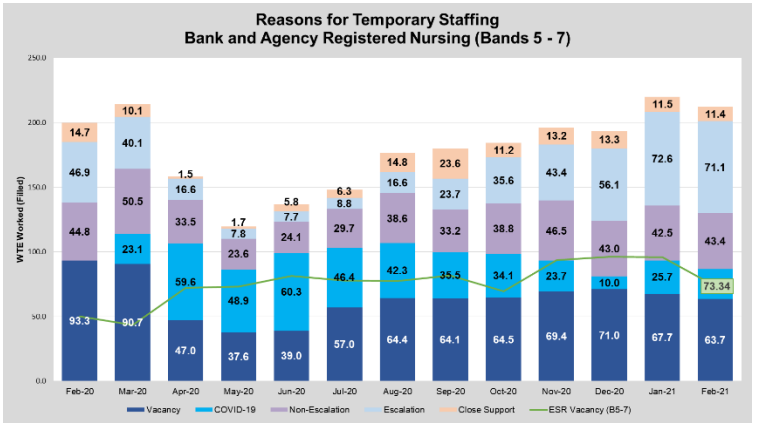
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
2	3



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Overtime WTE - Trust	34.58	35.60	38.66	29.83	24.57	24.83	24.23	25.95	28.71	31.11	37.78	31.46	40.12
Agency WTE - Trust	123.65	124.96	80.71	49.89	81.95	79.55	113.18	124.78	116.15	128.13	134.66	127.90	121.50
Bank WTE - Trust	291.41	313.52	315.77	288.87	293.17	321.94	318.66	299.75	278.58	345.51	326.34	391.31	362.41
Staff in Post WTE - Trust	4375.86	4389.03	4412.23	4502.55	4509.84	4523.92	4493.39	4485.93	4511.75	4534.92	4572.71	4596.13	4650.22
Budget WTE - Trust	4622.56	4622.56	4757.91	4756.17	4759.73	4759.74	4775.33	4790.26	4806.92	4882.90	4960.19	4962.71	4962.76
Vacancy WTE	246.70	233.53	345.68	253.62	249.89	235.82	281.94	304.33	295.17	347.98	387.48	366.58	312.54



Background

The Trust utilised 5174WTE staff to deliver its services in February '21, an increase of 27WTE on the previous month and 212WTE in excess of budget. February did, however, see a noticeable improvement in the type or workforce utilised, with a reduced reliance on bank and agency reflected by a net gain of 54WTE substantive posts in month delivered through recruitment.

Bank and agency utilisation decreased by 35WTE compared to the previous month, with escalation remaining the primary reason for temporary staffing utilisation, alongside the on-going need to supply registered nursing staff to deliver the Covid vaccination programme.

Community Nursing continues to have the greatest demand for temporary staffing resource, which is supported by the approval to secure up to an additional 25 registered nurses per day until the end of March. ED, Neptune and Trauma are the remaining areas of high demand, though for a variety of reasons including mental health support and escalation.

General Medicine vacancies, ED medical cover and GP vacancy cover in Primary Care, continue to drive medical agency spend.

Improvement actions

1. A monthly initiative reviewing the top 10 Locum and Agency medical workforce spend is in place, aimed at targeting priority areas with a view to migrating Agency resource to Locum (GWH bank) and thus reduce cost
2. A new Consultant job description has been developed and awaiting approval from the Medical Staffing Group. Its purpose is to offer greater appeal and focus on aspects of professional interest to candidates
3. A salary benchmark exercise is underway in respect of GP's in Primary Care and is intended to provide salary insights to inform the Trust's financial competitiveness
4. On-going recruitment in Unscheduled Care, leading to the appointment of 25 Aspirant Nurses on short term contracts to support with Covid19 related demand
5. Recruitment and retention initiatives are in place in Imaging and Pathology, aimed at stabilising existing workforce and enhancing attraction from a limited local/national supply pool. This has proved particularly effective in Pathology and from Apr '21 will result in a 50% reduction in agency usage
6. ACP mobilisation from PCN to Sunflower, mitigating GP cover shortfall and supporting improved flow

Risk to performance and mitigations

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

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

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

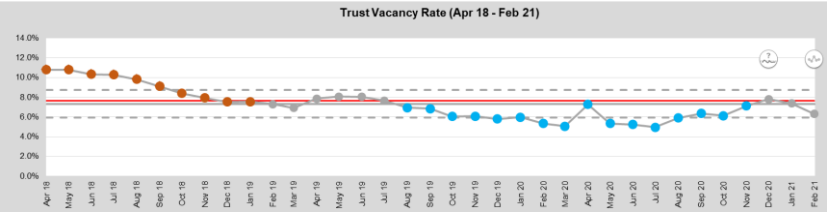
Mean 0 Process limits - 3σ Special cause - concern Special cause - improvement Target

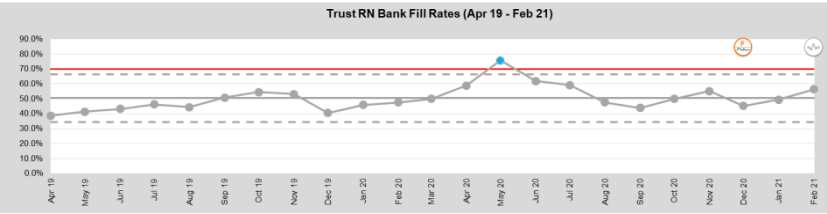
Workforce

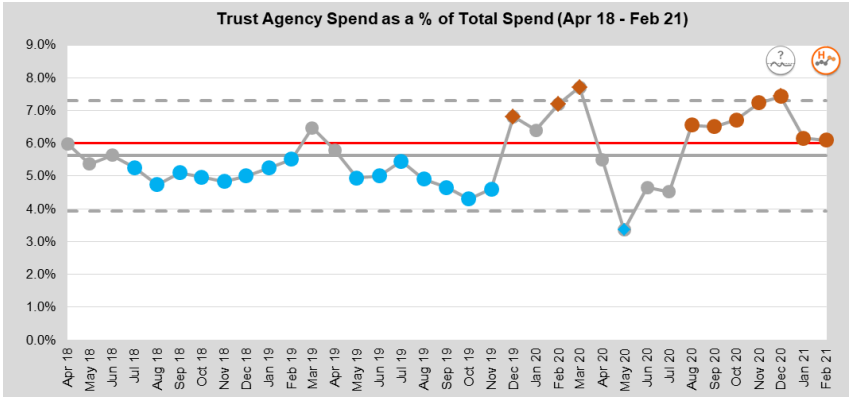
Use of Resources

Great Workforce Planning

Indicator Score	Self Assessment Score
2	3







Background

The Trust vacancy position improved to 6.30% in February, compared to 7.39% in January and equates to 312WTE vacant posts. The Medical and Nursing vacancy rates are low at 4.02% and 4.61% respectively. The AHP staff group continues to represent the greatest vacancy challenge to the Trust, with February's vacancy figure of 12.96% equating to 49WTE vacancies, with this being marginally worse than January's 12.46%/47WTE vacancy gap.

Registered Nursing bank fill rates achieved improvement for the third successive month, with February's fill rate of 56% comparing favourably to the 49% fill rate achieved in January and mean performance overall, to some extent accounting for the reduction in agency usage.

Agency spend as a proportion of total pay spend in February (6.09%) reduced relative to the previous month (6.15%), continuing the trend of improvement and in fact reaching its lowest point in seven months. Agency spend was driven mainly by Medical Workforce at £658k (vs. £629k Jan), followed by Nursing spend of £554k (vs £556k Jan).

Improvement actions

1. Long-line agency booking, securing challenged areas with staffing continuity and a preferable agency rate owing to the longer term commitment
2. Expanded use of 'daily staffing' roster functionality and SafeCare by Matrons, with additional functionality being used to allow departments to accurately forecast the number of additional hours required per department by factoring both volume and acuity. This is providing improved oversight at both ward and in turn Trust level, with greater visibility enhancing the ability to mobilise staff
3. Bank recruitment is taking place for registered and un-registered roles, to provide greater depth to bank staffing resource
4. Roster review underway in Primary Care, intended to re-align roster and ESR information in a way that allows improved oversight and understanding of workforce deployment
5. A Preferred Supplier List (PSL) project led jointly by Nursing and HR is underway and on track for implementation from April '21. This is intended to improve cap rate compliance and reduce the Trust's reliance on one provider
6. E-roster for medical staffing launched in early March with an implementation road map established and criteria based priority services identified

Risk to performance and mitigations

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

Incentives for Bank workers ended on the 28th of February '21 without a replacing additional or modified incentive scheme, posing a risk to bank shift uptake.

The adoption of Preferred Supplier List (PSL) has the potential to result in reduced agency cover in the short term, with transition and familiarity likely factors.

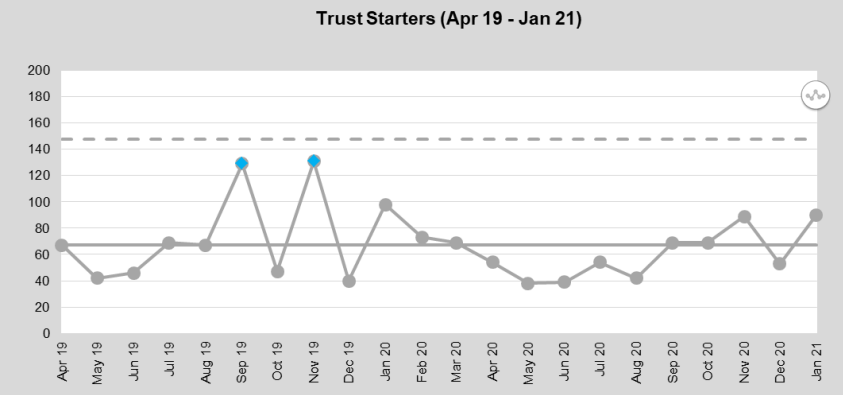
Continued Covid-19 related absence, whether through sickness, lateral flow tests that return a positive result or self isolation, inevitably creates a need for backfill and thus a reliance on temporary staffing

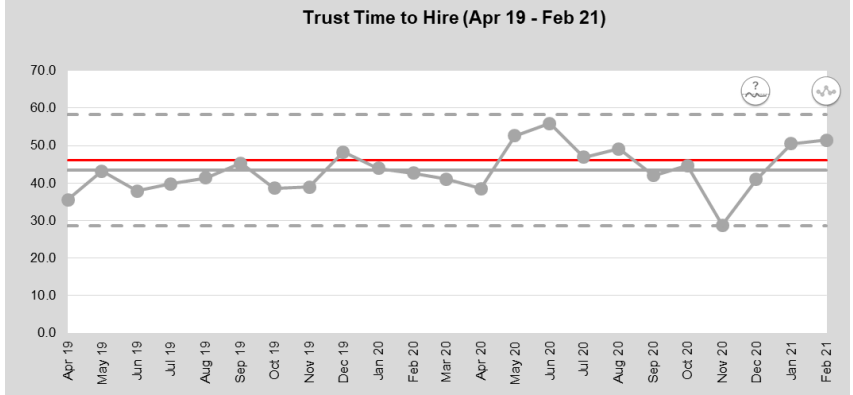
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Opportunities	Indicator Score	Self Assessment Score
	2	3





Background

The vacancy position declined in February to 6.30% from 7.39% (a decrease of 54.04 WTE vacancies Trustwide). Negligible increase of 0.05 WTE additional establishment from M10 to M11.

During January 2021, 90 new starters (82.07 WTE) commenced employment at the Trust. There has been no significant change in the number of new starters to the Trust.

The Trust has 86 candidates to date due to commence employment in March with additional weekend inductions being planned to support the increased HCSW pipeline.

The recruitment time to hire has had no significant change and remains at 51 days in February.

Improvement actions

1. An additional £36,850 funding received to support the Trust achieving zero HCSW vacancy position. This funding will be added to the previous funding to support on-boarding arrangements, training, mentoring and pastoral support.

2. Following Strand B plus bid the Trust was successful in receiving an additional £600k funding for International Recruitment. This will support the Trust to bring a further 80 overseas nurses into the UK by 31st December 2021.

3. Due to recent unsuccessful recruitment a Recruitment Retention Permia has been approved for Critical Care Therapists to support with attracting candidates.

4. Maternity services have continued to see a reduction in the number and quality of applicants for midwifery posts compared to the usual market. A new and refreshed recruitment campaign is now being designed and will focus on continuity of care model.

Risk to performance and mitigations

Launch of the recruitment microsite continues to be postponed, the Trust currently continues to utilise social media platform to support advertising vacancies. It is anticipated this will launch in April 2021.

Due to the continued increase in recruitment activity the KPI metrics have remained high, through NHSI funding an additional fixed term administrator has been recruited to support the increased activity in HCSW.

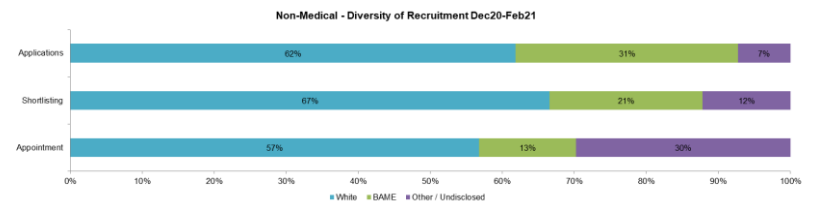
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

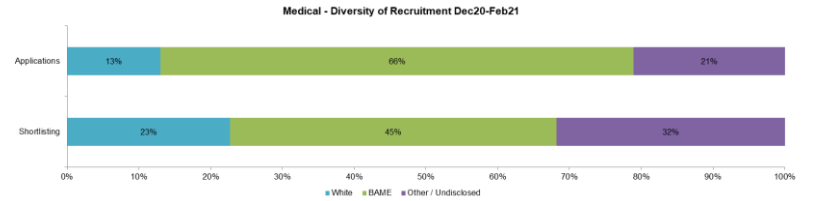
Workforce

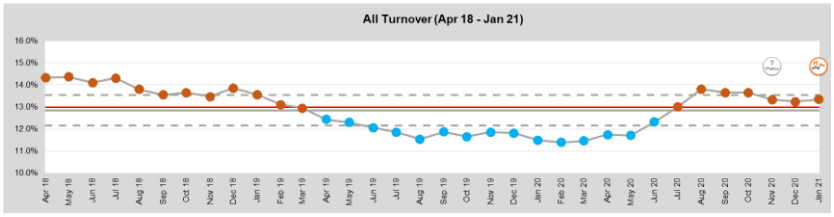
Use of Resources

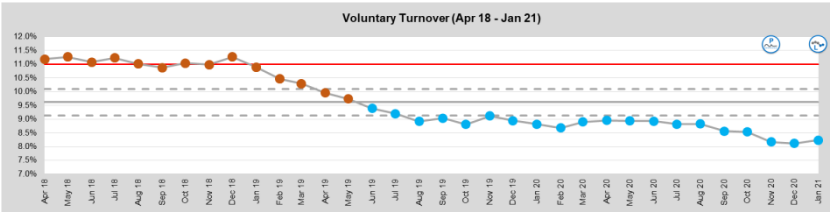
Great Opportunities

Indicator Score	Self Assessment Score
2	3









Background

Within the period Dec 20 – Feb 21, in medical recruitment of a possible 66% BAME applicants, 45% were taken forward at the shortlisting stage. Appointments are not reported here due to start dates not yet agreed. For non-medical 43% of staff that were appointed were either from a BAME (13%) or Other (30%) background.

Performance for all turnover has remained stable and is between the expected standards of 12.1% and 13.5%.

Voluntary turnover has remained stable and continues to be consistently below the 11% target.

Improvement actions

1. Hotspot turnover departments will be conducting new starter questionnaires to ensure that they feel supported in post and managers will be coached to undertake 'stay' interviews. There departments include the Children's Unit and HSDU.

2. License to recruit training has been approved from leads and is being converted onto training tracker. We are working towards the training being available for recruiting managers to undertake from 1st April 2021.

3. Review of turnover for USC has taken place. Improvement areas identified include encouraging completion of exit questionnaires and interviews, a one page guide will be populated for managers to easily access when processing resignations. Monthly discussions with managers to ensure all leavers are recording correctly to avoid 'other unknown' category being used.

Risk to performance and mitigations

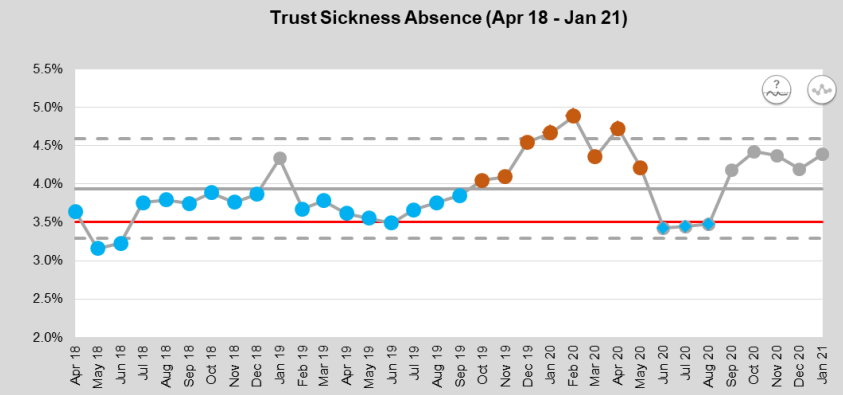
Due to Covid-19 and increase in clinical activity there have been delays in the creation of bespoke recruitment video's for high vacancy roles/areas that can be utilised to attract candidates during recruitment campaigns. Working with departments and Communications teams to agree a revised timetable.

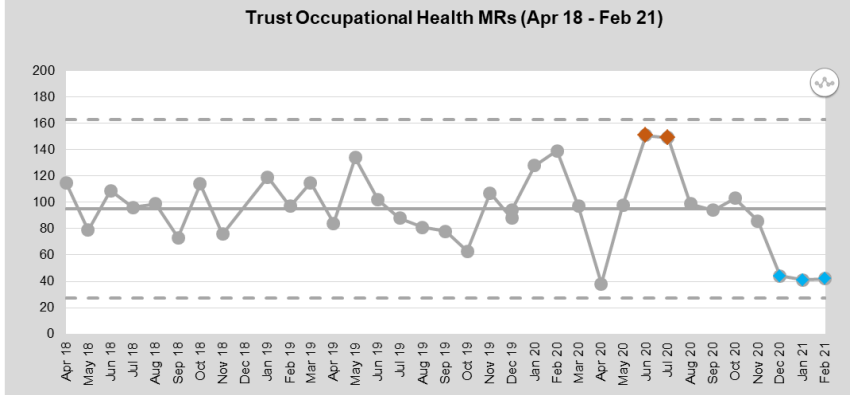
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Employee Experience	Indicator Score	Self Assessment Score
	2	2





Background

Sickness absence continues to report above the 3.5% increasing in January 2021 at 4.38%. Currently performance can be expected to vary between 3.3% and 4.6% attributable to the winter period and continued implications of the COVID pandemic.

In February 2021, 51 client Managament Referrals were made to OH comprising 46 for GWH staff, 3 for SERCO, 1 for Wiltshire Health and Care and 1 for Swindon CCG. This was a slight increase from 41 in January 2021. Key themes for MRs are MSK – back and shoulder pain, mental health, reasonable adjustments for long term and chronic medical conditions and advisory support for sickness absence.

Improvement actions

1. The Occupational Health department has temporarily relocated to a dedicated area in the Commonhead offices and whilst clinical virtual service continues, this space will restore mandated professional confidentiality and collaboration. Work is underway with the Estates team to create two clinical rooms in this area to increase the nurse and physiotherapy clinics and meet client demand.

2. Further to a consultative period of engagement with service users in February, the outsourcing of the pre-employment questionnaire activity is on track to be introduced in March. This will increase capacity of the OH nurses to focus on management referral triage, clinics and other essential OH services.

3. Advertising for a Band 5 OH nurse has received encouraging interest from high calibre applicants as part of the mitigating actions to improve resource levels. Mentoring for OH student nurse has been agreed with University providers to ensure high professional support during this challenging period. Additional OH Physician clinics have been arranged to respond to the increase in shielding and management referrals.

4. The mapping exercise to identify location of volunteer HWB Champions has concluded and further communication in March will seek further volunteers for these non-represented areas. HWB leads have assessed the Trust health and well being provision using the NHS England diagnostic framework and have shared outcomes with the wellbeing NED lead. This review will inform the development of a HWB strategy for 2021/22.

Risk to performance and mitigations

The number of OH management referrals has increased in month and further to the national shielding letter distribution there has been an increased requirement to assess clinical risk factors for staff.

The OH team are assessing demand and resource risk and improvement actions this month identify the interventions in place.

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	2

Employee Recognition

Long Service Awards	1	Hidden Heroes	2
Retirement Awards	2	STAR awards	1

Diversity/Inclusivity

The EDI lead continues to successfully embed the role with following achievements in February:

- Launch of the first Trust EDI newsletter and publication of the annual calendar of notable events and celebrations on the EDI agenda;
- Introduction of a series of social media videos (Facebook / Twitter) promoting the role, remit and objectives for next 12 months;
- Interview with local radio Gloucestershire about the Covid-19 vaccine to dispel myths and misinformation;
- Engagement work with Colposcopy service to encourage communication with hard to reach groups;
- Presenting the EDI Strategy to main Trust governance committees – PPPC, COG and sharing information as part of CQC inspection;
- Supporting the community nursing teams to discuss best ways to attract and retain international nurses.

In addition to these highlights, the EDI lead is developing the first Trust Transgender policy, benchmarking with Nationwide and region to understand successful reverse mentoring programmes and forming the Disability Equality Network.

Wellbeing Initiatives

The Trust Tea Trolley: Due for relaunch on 3rd March 2021, with 23 volunteers from the 'Project Wingman' initiative returning to the Trust to run the service. Covid-19 blue wards will continue to receive DIY tea trolley in a bag. Soft drink deliveries are also being made to ICU, Woodpecker and Neptune until the end of March.

Massage Chairs: Beech ward, Pathology and Shalbourne Medical Assessment Unit continue to have massage chairs as part of the rotation cycle. One massage chair has rotated from SwiCC to the Mortuary department.

Yoga Class Referral Sessions: This pilot is planned for March with the 80 online session available for members of staff referred by the Occupational Health physiotherapy and mental health triage.

Background

In-month staff support uptake was offered to 16 clients and included 25 sessions offered with 99% attendance. 12 group / department intervention sessions.

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

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

In-reach activity for February:

- Workload & transition to new role workshop, Neptune;
- Skills group for HUB call handlers;
- Relationship counselling, Sunflower Ward
- Selfcare group for Managers, Radiology
- Coping with Bereavement, Breast Centre
- Theatres staff, wellbeing talk
- ICU physio wellbeing talk

Improvement actions

1. In February there were 19 new first time contacts made to the EAP service, of this; 3 online counselling, 12 telephone counsellor and 7 telephone information specialist. The total number of clients in February was 38 including new and existing clients. The total contacts made during the period March 2020 to February 2021 is 204; 55 face to face / virtual counselling sessions, 118 telephone counselling, 31 information specialist.
2. Plan roll out on track for TRiM training for 16 further practitioners, 4 managers and 128 Mental Health First Aiders during 2021.
3. Successful recruitment to 0.6wte Clinical Psychologist in February.
4. Wobble Rooms – an additional staff wobble room opened in the Oral Surgery Department.
5. Investment in the Health and Wellbeing plan during the period March 2020 to February 2021 - £117,970. Key areas of spend included - Tea trolley (£2620), Hampers (£2890), Tea Trolley bags (£966), Massage Chairs (£1159), MHFA (£4,700), TRiM training (£8051), Christmas Thank You (£9965), Winter Refreshments (£2597), EDI lead pilot role (£50K)

Risk to performance and mitigations

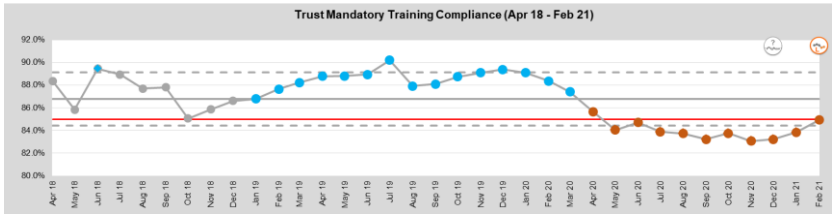
Sickness absence rates indicate that staff continue to be impacted and exhausted by Covid-19 wave 2 and winter pressure. There is the risk of staff perception that to seek support is a weakness and this may be discouraging them from seeking further support and guidance.

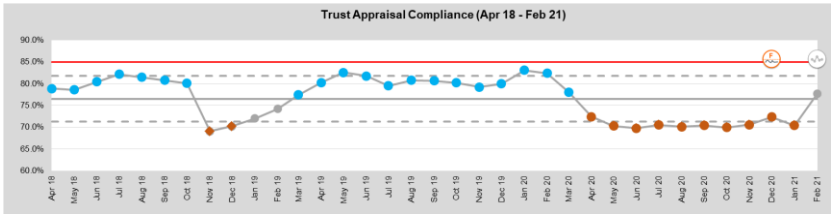
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

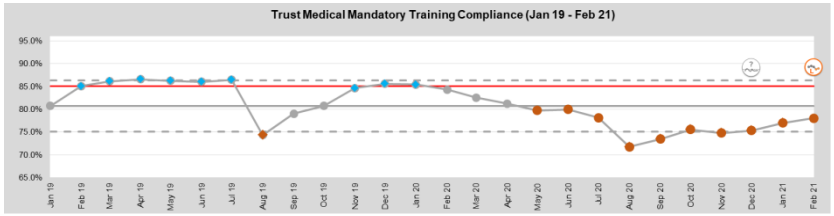
Workforce

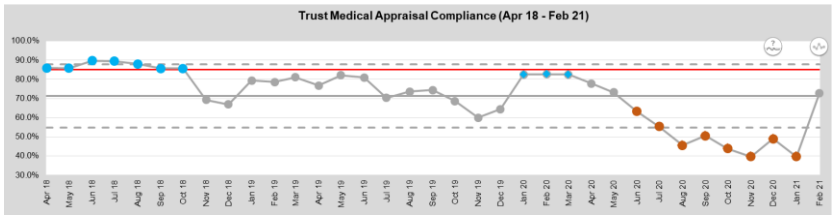
Use of Resources

Great Employee Development	Indicator Score	Self Assessment Score
	2	2









Background

Mandatory Training compliance remains under target overall. However, there has been an improvement in CQC MT form 81.93% in January to 83.73 %in February.

The Academy team has been working to improve data accuracy and this , alongside the focus Divisions are giving this issue, appears to be reflected in the figures.

Role essential training compliance remains stable (85.89% in January and 86.2% In February).

Appraisal compliance has improved significantly in February –from 70.43% to 77.72%.

Improvement actions

1. A report will be submitted to weekly Execs on 8th March 2021 with details of all of the actions taken to date to improve data accuracy and the plan to move mandatory training to ESR.
2. Further training has taken place with the HR BPs to support then in maximizing the use of the MT report. A guidance document has also been produced to help managers navigate this comprehensive report.
3. The risk register is reviewed on a monthly basis.
4. The move from Training Tracker to ESR continues with a project completion date being brought forward to 30th May.

Risk to performance and mitigations

The continued reduction of capacity at courses due to social distancing.

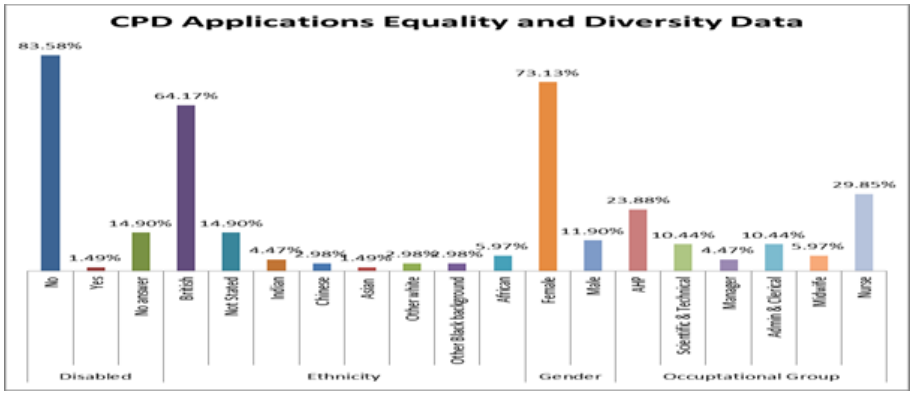
Additional courses for Mandatory Training are being made available to help drive up compliance e.g. ABLS/PBLS

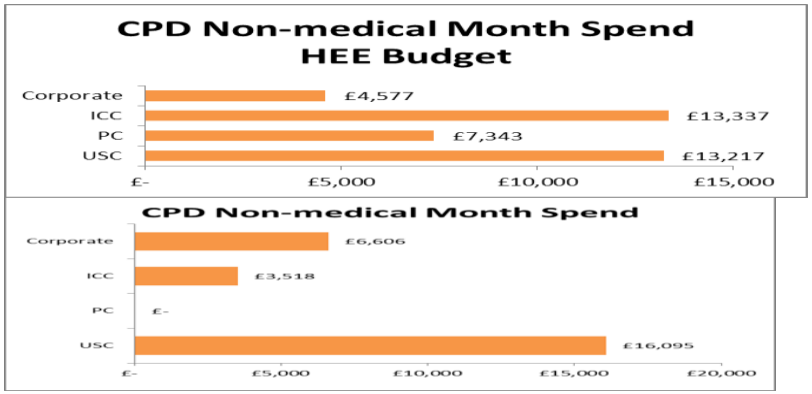
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Workforce

Use of Resources

Great Employee Development	Indicator Score	Self Assessment Score
	2	2





Background

HEE Funding for Clinical Staff:
HEE budget spend to date is £187,454.
Divisions have been submitting CPD requests and continue to do so.
HEE will require a final account of how the money has ben spent by 30th April 2021

The graph top right highlights spends /committed within February.

The Trust CPD allocation is underspent year to date £35,000 against allocated budget of £240,000.

There were 67 non medical CPD Applications in February for up-skilling and leadership courses.

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

Improvement actions

1. The Academy continues to work with the divisions to maximise the use of the Trust Non–medical CPD fund and HEE CPD funds.
2. Work will shortly begin on a systematic training needs analysis process to ensure that there are detailed plans in place for CPD spending.
3. The head of learning and development continues to work with the EDI lead to understand what additional steps can be taken to increase uptake of CPD applications across all those staff with protected characteristics. The data above does show an in month improvement in CPD applications received from a wider staff group than previous.

Risk to performance and mitigations

Accessibility of courses, whilst still ,is proving with course providers starting to develop more on lone learning opportunities

The Head of learning and development will be retiring and returning to a different post at the end of April.

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

Workforce

Use of Resources

Great Leadership	Indicator Score	Self Assessment Score
	1	2
Leadership Roles at the Trust	**4.27% of staff**	**Equating to 172.19 WTE**
Leadership Development Programme *(cohort 1)*	**22 leaders**	**Undergoing Training**
Leadership Development Programme *(cohort 2)*	**19 leaders**	**Identified for next Iteration**
Leadership Forum Members	**300 managers**	**Members Engaged**
Latest Leadership Forum *(24 Nov)*	**76 managers**	**Actively Attending**
Ward Accreditation	**24 of 24 departments**	**using the Perfect Ward App**

Background

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

Leadership Forum had to be cancelled in January, but the next session in March will focus on Equality, Diversity and Inclusion.

The revised appraisal documentation was discussed at Employee Partnership Forum on 1 March 2021 and some changes were agreed.

The Head of Leadership, Talent Management and Succession Planning has now taken up post. Her initial focus is on the design of the Aspiring Leaders programme and the updating of the Leadership section on the intranet.

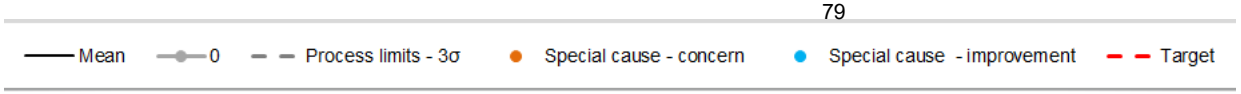
Ward accreditation is on hold at present as the current deputy chief nurse has requested a review to ensure we are incorporating other forms of intelligence into the ward accreditation process. The review will be completed by the end of the month and a new plan will be implemented to re start the process.

Improvement actions

1. The first session of the development programme for Associate Medical Directors across the acute Trusts in BSW took place on the 26 February. This was attended by AMDs from all 3 Trusts and was well received.
2. Phase 2A of the Talent Management programme will conclude with a Talent Review Board on 16 March . Phase 2B has been launched and will conclude with a Talent Review Board in May.
3. The Head of Leadership, Talent Management and Succession Planning is reviewing the leadership content on the intranet to ensure it is relevant and user friendly. The aim is to work towards a 'virtual leadership hub' which will gather together the different elements of the leadership offer
4. The Head of Leadership, Talent Management and Succession Planning will continue to develop the leadership offer for Aspiring Leaders.

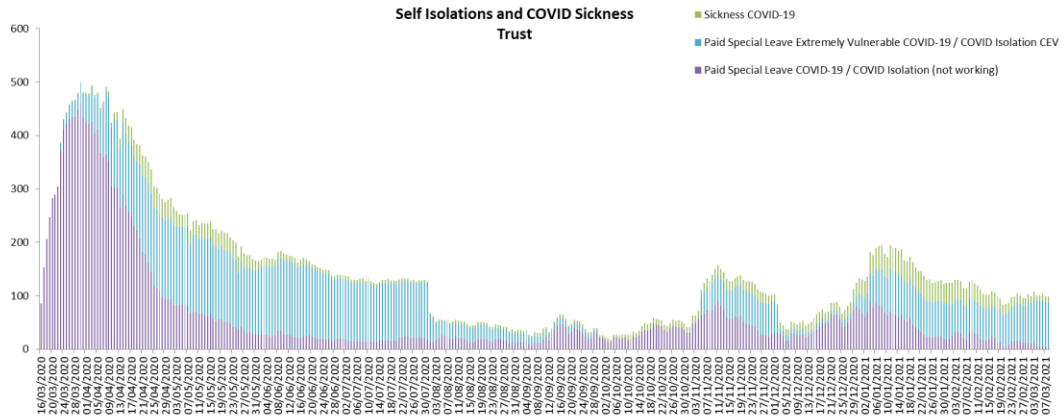
Risk to performance and mitigations

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



Covid-19 and Risk Assessments

Exception Report



Risk Assessment Compliance	97.23%		
	Category B	Category C	Category D
% done Mgmt Discussion	91.58%	82.91%	70.80%
Mgmt Discussion Compliance	82.88%		

Background

Following new guidance from the Government in February, the status of Clinically Extremely Vulnerable remains until the end of March at the Trust. At present there are 109 staff recorded as “CEV” and therefore working from home or awaiting redeployment to a home based role. These staff continue to be backfilled where possible in addition to those with confirmed exposure or recommended isolation periods (circa 70-90 absences per day).

Asymptomatic Testing continues to help mitigate spread between staff and to patients with a decrease in positive tests declared reported for February and the last two weeks of national submissions report *zero* asymptomatic staff cases.

Improvement actions

1. Roster Managers are encouraged to enter Covid-19 absence in real time which has been supported by an additional Covid-19 line. To date this extra measure has provided assurance of the quality of data for clinical staff in particular.

2. To reduce the numbers on special leave, redeployment options continue to be offered to staff who are both Clinically Extremely Vulnerable and Clinically Vulnerable.

3. The Wellbeing Project lead maintains regular contact with CEV staff who are shielding or WFH. In addition, Team Brief and a weekly update on Trust communications is shared with staff to keep them engaged and working from home activities are centrally organised.

Risk to performance and mitigations

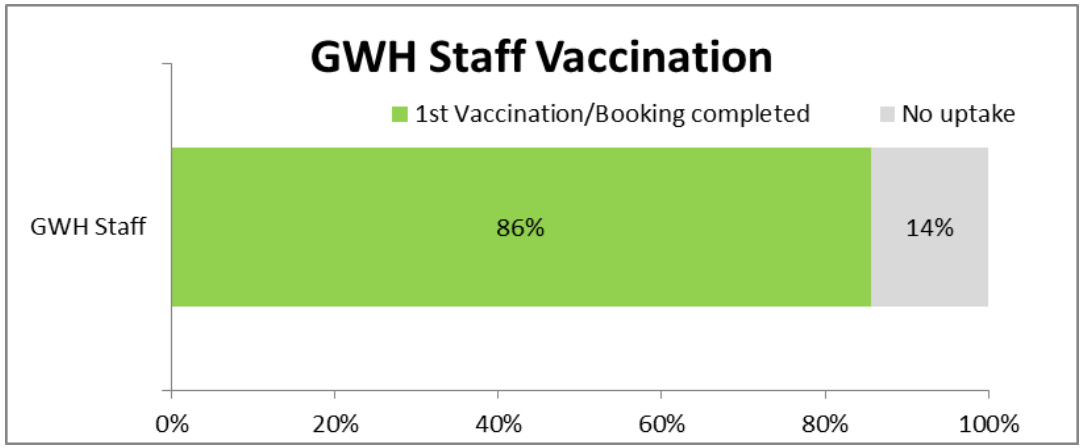
At present daily information pertaining to Covid-19 absence is as accurate as can be with a small number of retrospective absences added after the fact. The data is refreshed retrospectively daily to ensure the most accurate picture is available at all times.

Asymptomatic testing and lateral flow testing remains a small risk to increasing the number of staff who need to self isolate though of late the numbers of positive declarations have decreased. Lateral Flow testing of patients within some services has positively impacted the service’s ability to remain safe and Covid-19 free whilst maintaining Business As Usual.

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

Vaccination Programme

Exception Report



BME	Total Staff	Vaccinated Dose 1	% Vaccinated
BME	978	716	73%
Not Stated	757	53	70%
White	4350	3706	85%
TOTAL	**6085**	**4955**	**81%**

Background

The Mass Vaccination programme for Covid-19 launched Early December 2020 for priority categories: Vulnerable Staff, Out-Patients over 70's and Care Home Staff within 32 Care Homes across Swindon. This has since been extended to include all Staff with patient facing staff remaining the top priority. To date 87% of the current substantive staff have engaged with the programme positively receiving at least their first vaccination or currently booked to receive it within the coming weeks.

Over 28,000 vaccine have been given to staff and on track for 30,000 vaccines by mid-march. In addition to the staff vaccination campaign, the focus during February has been vaccination for Tier 7 i(over 60) individuals and invitations now open to Tier 8 (over 55).

A dedicated clinical and operational team, Workforce Intelligence , volunteers and OH continue to supporting the implementation.

Improvement actions

1. The vaccination programme is being coordinated by a dedicated clinical lead, and successfully recruited operational and booking managers.
2. Introduction of the Astra Zenica vaccine is being planned for March and the removal of requirement for the15 minute waiting time post vaccine allows space to be clearly separated between AZ and Pfizer vaccine delivery.
3. To ensure clear dilineation between AZ and Pfizer vaccine there will be clear signage and a colour coded system. All first doses will become AZ vaccine identified by orange signage and administered in identified clinic rooms; Pfizer will remain for second doses only and be identified by purple signage and dedicated clinic rooms.
4. Volunteers are being provided with support training to ensure they are confident with this new way of working and in preparation for a potential increase to 600 daily vaccinations.
5. The clinical lead is developing high risk clinics for individuals with allergies. Additionally in January 56 in patients were vaccinated as a trial and the learning is being reviewed with potential to develop an inpatient vaccination programme.
6. The Trust EDI lead gave an interview to Radio Gloucestershire about the Covid-19 vaccine to dispel myths and misinformation and support available at the Trust to encourage staff to come forward to have the vaccine.

Risk to performance and mitigations

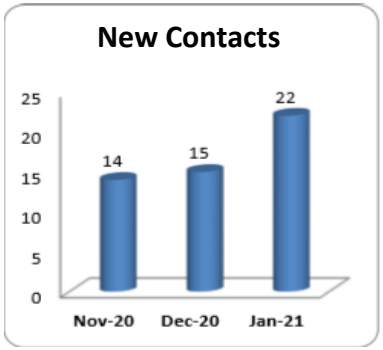
The vaccine programme is being conducted from the Occupational Health department.

Introduction of the Astra Zenica vaccine is being planned for March and this presents the complexity of a dual vaccine programme (AZ and Pfizer).

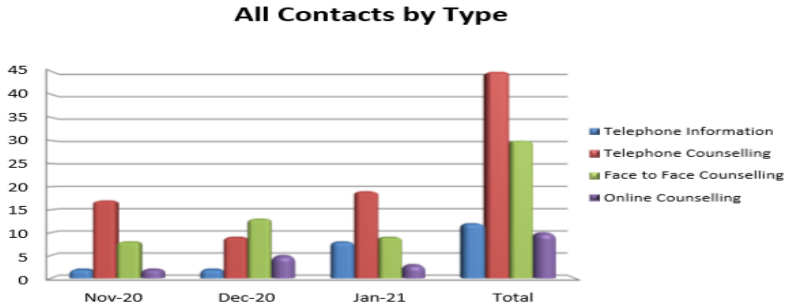
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Employee Advisory Programme (EAP)

Exception Report



Service Details	
Description	Total
Employee Headcount	6580
Service Commencement Date	1st November 2020
Annual Contacts	97
Annual Usage	1.47%
Annual New Cases	51



Service Knowledge (Top 3)	
Description	Total
Recommendation	46%
Leaflet and Card	37%
Intranet	7%

All Contacts by Type	Nov 2020	Dec 2020	Jan 2021	Qtr.		YTD	
Telephone Information	2	2	8	12	12%	12	12%
Telephone Counselling	17	9	19	45	46%	45	46%
Face to Face Counselling	8	13	9	30	31%	30	31%
Online Counselling	2	5	3	10	10%	10	10%
TOTAL	29	29	39	97		97	

Background

The EAP service was introduced in March 2020 at the outset of the Covid-19 pandemic and further to successful trial, was contractually extended with effect from 1st November 2020.

Reporting is tracked against 'contacts' from members of staff accessing range of services and there have been 97 contacts and 51 new cases since November 2020. The represents an increase of 68 more contacts compared to the previous quarter. Of the new contacts made 78% were female and 16% were male. 98% were self referral and 2% were management referral.

Total utilisation for the EAP service in the period 1st November 2020 to 31st January 2021 was 1.47% uptake from the workforce. Web usage and open cases are not recorded in this percentage.

Service provision includes virtual / telephone counselling, information telephone advice, webinars and online support.

Of the 128 pages on the Lifestyle website available to staff 61% were views to home section and 39% were views to work section and presenting an encouraging awareness of the site resource.

Improvement actions

1. Actively promote the EAP service to encourage this service to staff as their first port of call for a personal and confidential 24/7 advisory and support service. This is enabling the Trust staff support team capacity to support teams and departments with group education and counselling initiatives.

2. Promote the breadth of services available through the EAP service – consumer, financial, legal, childcare practical advice and guidance in addition to the emotional wellbeing support.

Risk to performance and mitigations

There is no risk to performance presented by the EAP as a service.

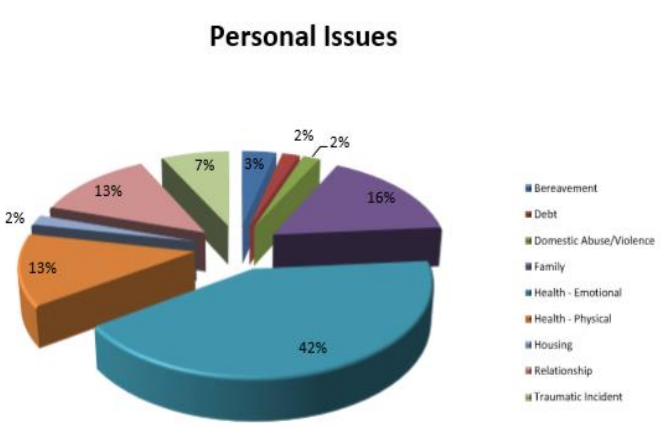
The challenge for the Trust is to increase the uptake of the service from the current 1.47% utilisation for the 3 month period through Trust-wide promotion and support.

The 1.47% benchmarks as an encouraging uptake for an EAP service in its first 12 months and the target is to achieve 4% uptake in the first 2 years.

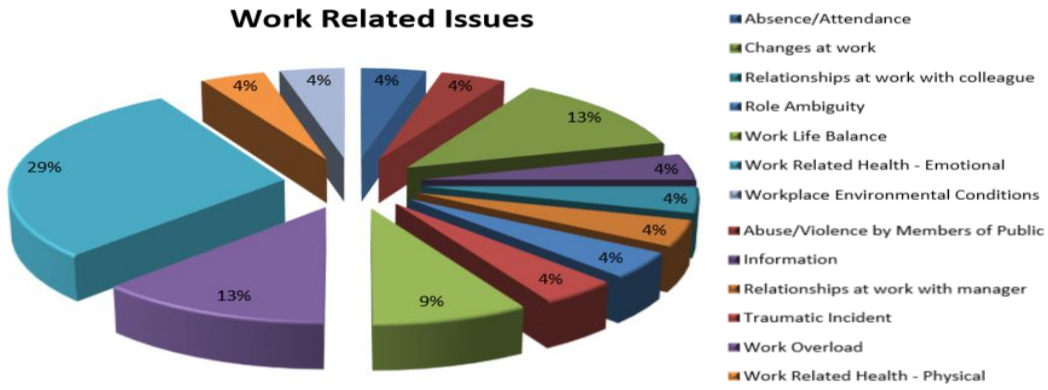
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Employee Advisory Programme (EAP)

Exception Report



Personal Issues (Top 3)	
Description	Total
Health - Emotional	42%
Family	16%
Health - Physical	13%



Work Related Issues (Top 3)	
Description	Total
Work Related Health - Emotional	29%
Work Overload	13%
Changes at Work	13%

Background

The monthly IPR report consistently reports the wellbeing of our staff and the reasons they seek help in relation to work and personal related stress.

The EAP report presents further clarity on specific areas of support staff are seeking;

Top 3 personal issues – 42% of contacts made have been for emotional health, 16% for family concerns and 13% for physical health.

Top 3 work related issues – 29% of contacts made are emotional work related queries, 13% are work overload concerns and 13% for changes at work queries.

Improvement actions

1. The EAP records that only 2% of the contacts made were referred by an individual's manager – this highlights the need to promote the service more widely with managers to encourage and improve signposting of the service to their teams for support with work and personal concerns.

2. Information specialist – The EAP provides a range of practical information support and promotion essential to ensure that staff are aware that this is not just a counselling advisory service. During this period, there were 12 information specialist issues presented by staff to the EAP information team. The most common issues were housing (12%), other information (17%), childcare (8%), divorce and separation (8%).

Risk to performance and mitigations

The health and wellbeing of staff is essential for good organisational performance.

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

Board Committee Assurance Report

Finance & Investment Committee 22 March 2021			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Andy Copestake	Andy Copestake		22 March 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			
Month 11 Income and Expenditure position	G	G	Strong in-month performance at £3,656k over budget. Evidence of good controls over Covid costs and related funding. Finance report explains all key variances.	Continue to monitor through FIC	26 April 21
Forecast Income and Expenditure Position	G	G	Breakeven position now assumed, taking into account additional central funding support.	Continue to monitor through FIC	26 April 21
Month 11 and forecast cash position	G	G	Strong cash balance of £41.2m at end of M11 - £6.9m higher than previous month. Additional central cash support received in March to compensate for unwinding of block payments and to pay PFI charges in early April.	Continue to monitor through FIC	26 April 21
Forecast Capital Expenditure position	G	G	On track to spend £30.8m of £33.6m plan, as predicted. Committee noted tremendous performance to reach this level of spend over the last few months of the year.	Continue to monitor through FIC	26 April 21

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Business Planning and Budget Setting	R	A	The budget setting process is progressing, despite the lack of guidance from the centre on the finance regime being put in place for the remainder of 2021/22. The amber rating on actions reflects the fact that the Committee has only seen a high level summary of the key numbers and that a detailed budget won't be signed off until May Board.	April FIC	26 April 21
Supply of Orthopaedic Prostheses – Hips and Knees	G	A	A good paper from the procurement team setting out the process for reviewing the supply of Hip & Knee implants across the BSW ICS. The Committee agreed to recommend the award of the £4.2m contract to the full Board. The amber rating on actions reflects the Committee's view that the decision is being made very close to the end of the existing contract (although contingency plans are in place).	Board	1 April 21
Additional Clover funding paper	G	G	Additional funding of £1.1m has been made available late in March to spend on the Clover project. The Executive team has proposed spending a large proportion of this on extending the lease life for decant facilities. The projects being proposed fall within the delegation limits for CEO and DOF approval so the Committee was simply asked to note the proposal.	Monitor through Way Forward Project Board	Monthly

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

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

Income and Expenditure

Use of Resources

Income & Expenditure		IN MONTH (February) Budget £'000	Actual £'000	Variance £'000	YTD (February) Budget £'000	Actual £'000	Variance £'000	FULL YEAR FORECAST Annual Budget £'000	Forecast £'000	Variance £'000
Income	NHS Clinical Income - System Block Allocation	25,861	25,861	-	281,153	281,153	-	307,914	307,914	-
	NHS Clinical Income - Block Top Up	1,981	1,981	-	24,707	24,707	-	26,688	26,688	-
	NHS Clinical Income - Cancer Drug Fund	232	232	-	1,160	1,160	-	1,392	1,392	-
	NHS Clinical Income - Original Covid Top Up	1,141	1,141	-	12,866	12,866	-	14,007	14,007	-
	NHS Clinical Income - Additional Covid Top Up	540	540	-	2,700	2,700	-	3,240	3,240	-
	NHS Clinical Income - Growth Funding	367	367	-	1,835	1,835	-	2,202	2,202	-
	NHS Clinical Income - System Envelope Planning Adj	238	238	-	1,190	1,190		1,428	1,428	-
	NHS Clinical Income - Lost Operating Income Funding	-	3,520	3,520	-	3,520	3,520	-	4,224	4,224
	NHS Clinical Income - Other	365	1,930	1,565	4,784	8,212	3,428	4,248	9,176	4,928
	Sub-Total NHS Clinical Income	30,725	35,810	5,085	330,395	337,343	6,948	361,119	370,271	9,152
	Private Patients	40	69	29	702	876	174	742	945	204
	Other Non Mandatory/Non Protected Revenue	64	58	(6)	650	700	50	715	758	44
	Research & Development Income	55	60	5	607	660	53	684	720	35
	Education and Training Income	969	976	7	10,680	10,846	166	11,644	11,821	178
	Misc Other Operating Income	680	617	(63)	7,749	7,828	78	8,438	8,444	6
		32,532	**37,589**	**5,057**	**350,784**	**358,253**	**7,469**	**383,341**	**392,960**	**9,619**
Expenditure	Pay Costs	(20,138)	(21,163)	(1,025)	(217,874)	(219,650)	(1,776)	(238,039)	(242,018)	(3,979)
	Non Pay	(7,830)	(8,291)	(460)	(80,690)	(82,895)	(2,204)	(88,534)	(91,659)	(3,125)
	Drugs Costs	(2,872)	(2,819)	53	(30,576)	(30,076)	500	(33,606)	(32,894)	712
		(30,840)	**(32,272)**	**(1,433)**	**(329,140)**	**(332,620)**	**(3,480)**	**(360,179)**	**(366,572)**	**(6,392)**
EBITDA		**1,692**	**5,317**	**3,625**	**21,644**	**25,632**	**3,988**	**23,162**	**26,388**	**3,226**
EBITDA as % of Total Income		**5.2%**	**14.1%**	**8.9%**	**6.2%**	**7.2%**	**1.0%**	**6.0%**	**6.7%**	**0.7%**
	Depreciation	(823)	(823)	(0)	(8,077)	(8,077)	0	(8,899)	(8,901)	(2)
	Net Interest	(1,248)	(1,217)	31	(13,578)	(13,407)	171	(14,827)	(14,625)	202
	PDC Dividend	(268)	(268)	-	(2,952)	(2,952)	-	(3,221)	(3,221)	-
	Pension Unwinding	-	-	-	-	-	-	(45)	-	45
Total Surplus/(Deficit)		**(648)**	**3,008**	**3,656**	**(2,964)**	**1,195**	**4,160**	**(3,829)**	**(357)**	**3,472**
Total Surplus/(Deficit) Excluding Lost Income Funding		**(648)**	**(512)**	**136**	**(2,964)**	**(2,325)**	**640**	**(3,829)**	**(4,581)**	**(752)**

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

Income and Expenditure – Variance from Plan

Use of Resources

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

The Trust in month position is £3,008k surplus in month against a plan of £648k deficit which is £3,656k favourable variance. The YTD position is £1,195k surplus against a plan of £2,964k deficit which is £4,160k favourable variance. The M11 position includes £3,520k funding for Lost Operating Income (£4,224k for Months 7-12) which was not planned and is driving the favourable variance.

Income variance is £5,057k above plan in month and £7,469k above plan YTD. The majority of the variance is NHS Clinical income which is explained in more detail on the next slide.

Misc Other Operating Income is £63k below plan in month and includes credit of aged invoices £469k. The position also contains £170k landlord income contribution for Primary Care dilapidation costs (matched by YTD costs) and £150k income expected from Health Education England (HEE) to cover Aspirant Nursing costs.

There has been an increase in Private Patient income which is £29k higher than plan in month (£174k above plan YTD).

Pay variance is £1,025k overspend in month and £1,776k overspend YTD. The variance includes Covid-19 Vaccination Programme staffing costs £149k (£359k YTD) and HDP overspend £250k (£409k YTD), both of which are matched by income.

The nursing overspend is £647k in month (£1,507k YTD) which is an increase of £228k from prior month. The overspend has increased for permanent staff and is partially offset by a reduction in temporary spend as vacancies are filled Overspends include £200k HDP and £84k vaccination programme costs. In addition, 39 Aspirant nurses joined the Trust in February at a cost of £150k (offset by expected income). Temporary nursing continues to be used on ICU, Neptune, Linnet, Jupiter and Woodpecker wards due to staffing additional beds, covering absences and providing care to high acuity patients with a combined overspend of £197k.

The medical staffing overspend is £400k in month (£657k YTD). The overspend includes medical costs of HDP schemes 50k and Vaccination Programme prescribers £22k (£83k YTD). The position also includes backdated WLI costs £47k (£204k YTD), central locum provision £100k and an accrual for medical staffing TOIL £120k. Further pay analysis is provided on the following slides.

Non Pay (including ITDA) variance is £376k overspend in month and £1,776k overspend YTD. Drugs and Supplies costs are underspent by £193k (£1,291k) which reflects the reduction in elective activity across the hospital. Other Non Pay costs include £240k International Recruitment fees linked to NHSE/I funding. IT hardware and licence costs of £104k have been incurred in month across Corporate and Community and an additional £305k has been incurred for essential divisional non-pay spend including screens for Outpatients & Ophthalmology and IT equipment to support agile working.

Forecast for 20/21 is £355k deficit which is an improvement of £5,024k due to the additional Lost Operating Income funding of £4,224k and removal of the anticipated £1,000k Elective Incentive Scheme penalty which will no longer impact the Trust. The forecast has also been adjusted for an increase in annual leave accrual to £752k (forecast was £552k).

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

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

Risks to delivery and mitigations

The forecast overall has improved in Month 11 due to additional income but underlying costs have worsened due to an increase in the value of the expected change in annual leave accrual to £752k. A risk still remains that this value is not high enough particularly following the recent surge of Covid-19 when staff will have postponed their annual leave to provide patient care.

NHS Clinical Income – Variance from Plan

Use of Resources

NHS CLINICAL INCOME	IN MONTH (FEBRUARY) Budget	Actual	Variance	Value of Cost Offset	YTD (FEBRUARY Budget	Actual	Variance	Value of Cost Offset
	£000	£000	£000	£000	£000	£000	£000	£000
Block NHS Clinical Income	30,360	30,360	-	-	325,611	325,611	-	-
Additional NHS Clinical Income								
Lost Operating Income funding	-	3,520	3,520	-	-	3,520	3,520	-
Hospital Discharge Programme (HDP)	-	1,073	1,073	(622)	-	1,932	1,932	(1,932)
Vaccination Costs	-	443	443	(138)	-	443	443	(443)
Lateral Flow income	-	23	23	(23)	-	62	62	(62)
Covid income for PCN	-	60	60	(60)	-	60	60	(60)
Primary Care Dilapidations	-	-	-	-	-	280	280	(280)
Thames Valley Cancer Alliance	-	-	-	-	-	266	266	(266)
Other	365	331	(34)	-	4,784	5,169	385	-
Additional Total NHS Clinical Income	365	5,450	5,085	(843)	4,784	11,732	6,948	(3,043)
TOTAL	30,725	35,810	5,085	(843)	330,395	337,343	6,948	(3,043)

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

The Trust has received £11,732k YTD NHS Clinical Income in 20/21 in addition to block payments of which £6,984k is not included in the budget. The majority of the additional income is offsetting costs that have been incurred either in month or in prior months. An exception to this is the funding for Lost Operating Income. In Month 11 the Trust received £4,224k (£3,520k for months 7-11) additional funding from NHSE/I to recognise the income that has been lost during the Covid-19 pandemic. The funding covers M7-12 and recognises the reduction in private patient, car parking and other income.

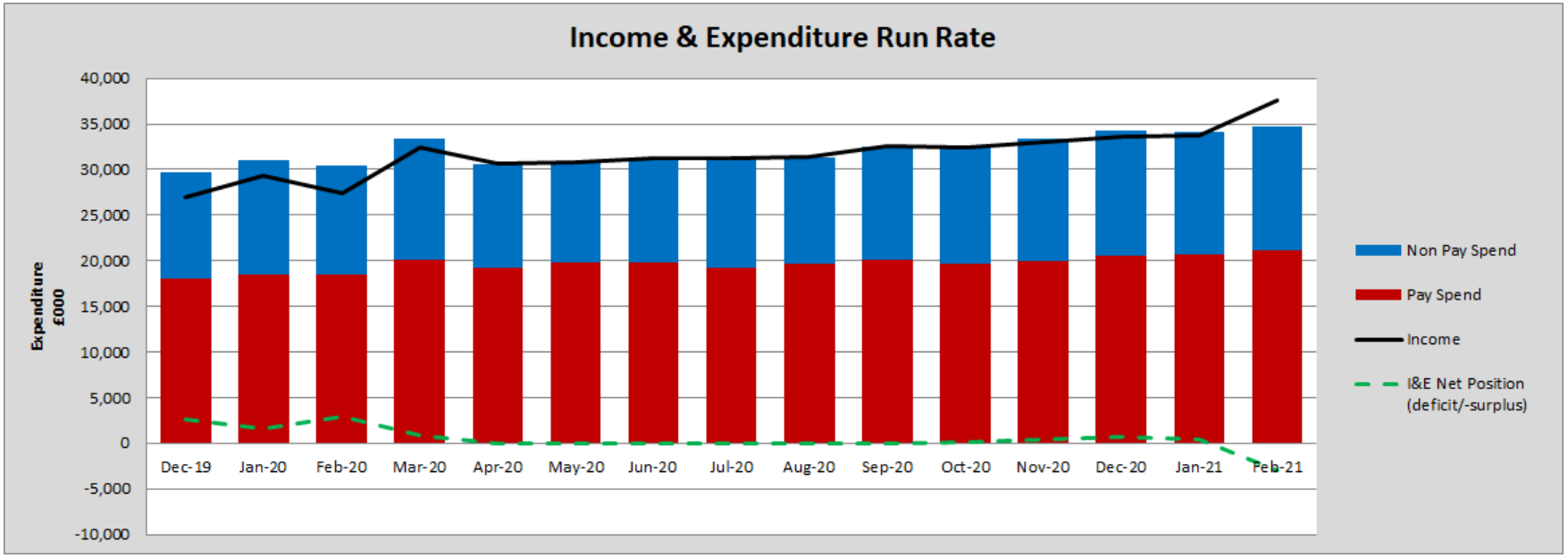
The funding for Lost Operating Income was received in Month 11 and is driving the variance from plan for NHS Clinical Income variance which is £5,085k above plan in month and £6,948k above plan YTD. The funding for Lost Operating Income was £3,520k and was not included in the budget (£4,224k full year). This is not offset by additional costs.

The NHS Clinical Income variance also includes income for Hospital Discharge Programme (HDP). The income was not confirmed when the plan was set and is not budgeted for, which has created a favourable variance of £1,073k in month (£1,932k year to date). The £1,073k Month 11 income includes £451k that relates to prior months costs although the year to date income is fully matched by costs.

Clinical Income also includes Vaccination Income of £443k of which £138k relates to costs incurred in Month 11 and £305k relates to prior months. Year to date income is fully matched by costs. Income has also been received to cover the costs of Lateral Flow testing and GP Covid-19 work. Other NHS Clinical Income includes Local Authority, Maternity Pathway and Foundation Trust income.

Income and Expenditure - Run Rate

Use of Resources



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

The Trust net expenditure run rate has reduced by £3,516k in Month 10 which is £3,656k more than plan.

Income run rate – has increased by £3,908k from last month. The February position includes £3,520k Lost Operating Income funding and £443k Covid-19 Vaccination Programme income. Other income includes credit of aged RUH soft FM invoices, Primary Care income from landlord for dilapidation works and Aspirant Nurse income to cover costs incurred.

Pay run rate – has increased by £499k in month which is £1,025k higher than plan. The pay run rate movement is explained in more detail on the Pay Spend by Workforce slide within this pack.

Non Pay run rate has reduced by £107k in month which is £376k higher than plan.

Spend on Supplies has increased by £441k due to stock adjustment of £400k and increase in pacemaker spend of £161k. Spend on general supplies has reduced by £250k reflecting the reduced level of elective activity during February.

Other non pay costs have reduced by £538k due to one-off adjustments made last month for charges expected from PFI provider (THC) for gas £269k, Aseptic Unit revenue costs £120k and PFI £240k. There have been additional costs incurred in Month 11 for International Recruitment fees £240k and Primary Care dilapidation works £80k which are matched by income.

Income and Expenditure - Divisional Positions (Devolved Income)

Use of Resources

April 2020 - Feb 2021		IN MONTH (FEBRUARY)						YEAR TO DATE (FEBRUARY)					
Income & Expenditure	Annual Budget	Budget v Actuals			Variances			Budget v Actuals			Variances		
		Budget	Actual	Variance	Income	Pay	Non Pay	Budget	Actual	Variance	Income	Pay	Non Pay
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Unscheduled Care	(5,511)	51	(671)	(722)	(478)	(500)	256	(6,617)	(13,231)	(6,614)	(5,664)	(1,503)	553
Planned Care	16,115	1,851	(542)	(2,393)	(2,315)	(310)	232	12,937	3,861	(9,076)	(9,323)	(278)	525
Integrated & Community Health	(8,275)	(800)	44	844	999	(198)	43	(7,640)	(6,867)	773	1,305	(104)	(428)
CLINICAL DIVISIONS	**2,329**	**1,102**	**(1,170)**	**(2,271)**	**(1,794)**	**(1,008)**	**530**	**(1,320)**	**(16,237)**	**(14,917)**	**(13,683)**	**(1,884)**	**650**
Corporate	(18,414)	(1,576)	1,224	2,800	3,184	11	(395)	(16,851)	(12,688)	4,163	5,713	44	(1,593)
DIRECTORATES	**(18,414)**	**(1,576)**	**1,224**	**2,800**	**3,184**	**11**	**(395)**	**(16,851)**	**(12,688)**	**4,163**	**5,713**	**44**	**(1,593)**
Non-Divisional	(1,908)	(169)	(587)	(417)	150	(29)	(539)	(1,739)	(2,337)	(598)	61	65	(724)
Trust Income	41,155	2,335	5,849	3,513	3,517	-	(4)	41,553	56,894	15,340	15,377	-	(37)
EBITDA	**23,162**	**1,692**	**5,317**	**3,625**	**5,057**	**(1,025)**	**(407)**	**21,644**	**25,632**	**3,988**	**7,469**	**(1,776)**	**(1,704)**
EBITDA as % of Total Income	**6.1%**	**5.2%**	**14.1%**	**8.9%**				**6.2%**	**7.2%**	**1.0%**			
Depreciation	(8,899)	(823)	(823)	(0)	-	-	-	(8,077)	(8,077)	0	-	-	-
Net Interest	(14,827)	(1,248)	(1,217)	31	-	-	-	(13,578)	(13,407)	171	-	-	-
PDC Dividend	(3,221)	(268)	(268)	-	-	-	-	(2,952)	(2,952)	-	-	-	-
Pension Unwinding	(45)	-	-	-	-	-	-	-	-	-	-	-	-
Total Surplus/(Deficit)	**(3,829)**	**(648)**	**3,008**	**3,656**				**(2,964)**	**1,195**	**4,160**			

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

Income and Expenditure - Divisional Positions (Devolved Income)

Use of Resources

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

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

Unscheduled Care income variance is due to activity being below plan, the preliminary activity data reports February's activity is averaging 16% less performance than that of Q3. Year to date income for the Vaccination Programme of (£454k) is a benefit to the in month position of (£305k)

Pay is £500k overspent in month, £149k of which is the cost of the Covid-19 Vaccination Programme. The nursing spend is £262k above budget (excl. Vaccination costs); this is a combination of £50k for Aspirant Nurse placements, £49k RMN spend for close support, £55k for incentive payments, £41k for supernumery cover & £74k for escalation across LAMU (CAU), Neptune & Woodpecker.

Medical overspend is £145k due to a combination of cover for continued restricted duties & an increase in fill rate for the outlier team and the pressure of compliance with the new weekend rota.

Non Pay is (£256k) underspent of which (£100k) relates to prior year benefit from cardiology supplies. Reduced activity in month has impacted the drug spend across specialties (£63k). CT Van Days continue to be provided by NHS-E, (£35k benefit), the billing pathway for Genetic Testing has changed (£31k benefit) and the HBS dermatology contract was not extended for Q4 (£29k benefit).

Surgery, Women & Childrens Income is above plan due to Private Patient (PP) income. PP activity remained low in February, when compared with Q3, due to continued restrictions on theatre activity as a result of converting recovery for critical care use due to the Covid-19 surge.

Pay costs are overspent by £310k, this includes £172k cost for additional sessions owed to Anaesthetic, ICU and T&O medical staff for extra PAs worked over the course of the pandemic. ICU nursing costs were £74k above plan for Covid-19 escalation, £23k above plan for additional bed capacity on Trauma and a further £18k agency cost was incurred for Close Support on the Childrens Unit

Reduced activity levels resulted in non-pay being £232k below plan. Preliminary data suggests day-case and elective activity was 15% below the average for the year so far and the supplies spend is in-line with this (£350k below budget). This includes orthopaedic implant costs £249k underspent against plan in month. Offset against this were increased drugs costs in ICU of £137k due to Covid-19 pressures

Integrated & Community Care income is £999k above plan in month due to Hospital Discharge Programme (HDP) income, Primary Care Covid-19 income £60k and landlord surgery dilapidations contribution of £172k. The balance is Cancer additional income of £48k.

Pay is £198k above plan due to additional recruitment in Cancer £28k (offset by income) and Outpatients of £7k. Sexual Health £21k is over plan in month due to additional activity to cover backlog at overtime rates. Palliative Care is £9k overspent due to TUPE of staff to GWH (offset by an underspend in non pay). Community HDP is £250k above plan made up of £200k nursing in the community and Orchard and Sunflower wards, £32k medical staffing and £18k support staff. The services below plan are Primary Care (£43k across all staff groups) as staff are working together better; Acute therapy £28k vacancies due to difficulties recruiting to HDP roles and management and admin savings of £46k.

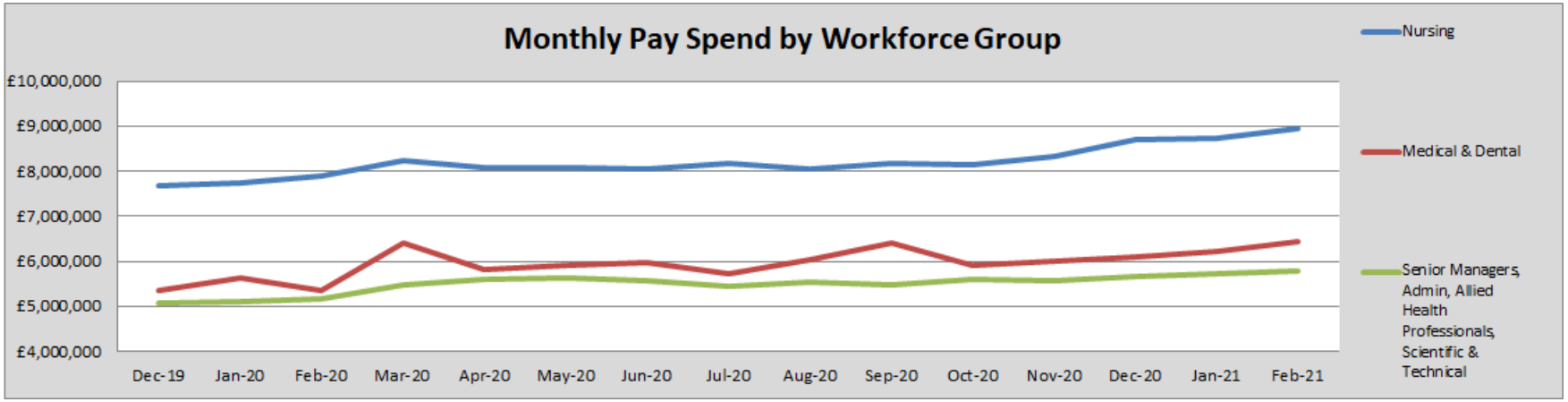
Non pay is £42k below plan overall. Services above plan are HDP £31k (Sunflower rent) and Primary Care £105k building works. Cancer is £94k and Sexual Health £63k below plan due to reduced activity.

Corporate income is below plan by £431k mainly due to credit notes issued to RUH for aged invoices Pay is below plan £11k due to movement of expenditure to SCHS, who had accrued this expenditure, internal recharge income from Primary Care, and vacancies.

Non pay is above plan by £395k due to additional costs for increased international nursing recruitment £240k, chief nurse recruitment costs and Board development £58k, expenditure on computer hardware £41k and Carbon Energy Fund additional costs of £40k.

Pay Spend by Workforce Group

Use of Resources



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

Pay run rate has increased by £499k in month which is £1,025k higher than plan. The increase is driven by increases across most staff groups.

Nursing run rate has increased by £228k and is £647k overspent. Permanent nursing costs have increased by £315k from last month and include £150k for 39 Aspirant Nurses who joined the Trust in February. These costs will be reimbursed by central funding. HDP nursing costs have increased by £134k which is matched by income. A further 16 International Nurses joined the Trust in February to fill existing vacancies and reduce use of temporary staff.

The increase in permanent nursing costs is partially offset by a £87k reduction in temporary nursing spend due to a reduction in shift fill requests. This is due to easing of Covid-19 pressures which was exceptionally high last month and recruitment of international nurses. Despite the reduction in month, temporary staffing spend remains high, particularly for Neptune, Linnet, Jupiter and Woodpecker which continue to incur increased costs of staffing additional beds, covering absences and providing care to high acuity patients.

Medical spend has increased by £209k including backdated WLI payments of £41k to permanent staff in Ophthalmology (£14k) and Trauma & Orthopaedics (£27k).

Temporary locum staffing costs have increased by £162k due to a central provision made for anticipated costs of the recent Covid-19 wave and expected cost of covering TOIL for anaesthetic and ICU medical staff.

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

Allied Health Professional spend has increased by £17k due to Covid-19 vaccination programme costs

Scientific and Technical Staff spend has reduced by £4k.

Senior Managers and Admin spend has increased by £50k due to new starters in clinical divisions covering vacancies.

Income and Activity Delivered by Point of Delivery

Use of Resources

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

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

Non Elective -24% (-12,157 spells) below year to date (YTD) activity plan and -9% (-£8.2m) below YTD income plan
Activity has been relatively stable since the initial Covid-19 peak, but has been consistently lower than both plan and prior year run rate. The number of Covid-19 spells reduced from 350 in January, to 174 in February. Activity is further behind plan than PbR income would have been which indicates that activity reductions are in the lower complex areas.

Acute A&E -33% (-23,735) attendances) below YTD activity plan and -26% (-£3m) below YTD income plan
Footfall through the emergency department is lower than plan almost certainly due to Covid-19. The largest reduction has been within the lower tariff, less complex activity. Although still below plan, activity in February increased from January when the critical incident was declared.

Elective Inpatients -45% (-1,999 spells) below YTD activity plan and -45% (-£9.3m) below YTD income plan
Prior to January, activity levels had been steadily increasing since the first wave with the best month of December being 21% lower than the pre-Covid-19 plan. February saw activity drop to it's lowest level since May, due to the impact of Covid-19. Trauma and Orthopaedics (T&O) is the main driver, accounting for c70% of the underperformance.

Day-cases -36% (-14,280 day cases) below YTD activity plan and -39% (-£14m) below YTD income plan
Performance was markedly affected in the early part of the year with recovery from July but still consistently behind plan on a monthly basis. Activity dropped in January compared to Q3 and the same low levels continued into February. Multiple specialties are behind plan with the largest in financial terms being T&O, General Surgery and Gastroenterology. Urology, ENT, Cardiology, Respiratory and Ophthalmology are operating at 50% or below, against pre Covid-19 plan levels.

Outpatients (Cons Led F2F & non F2F – Below YTD plan for consultant led activity (-22%/-66.1k attendances) and behind YTD plan for income (-43%/-£18,909k)
Outpatient activity has been below plan all year in particular in Q1. Switching activity to non face to face consultations has allowed the trust to reach closer to prior year activity levels since Q1, but not across all specialties. Both T&O and Cardiology are significantly behind pre-Covid-19 plan levels. The price of NF2F activity is based on pre-Covid-19 tariffs and undervalues where full consultations are given. There are also some counting changes within Cardiology which may account for a significant proportion of the activity drop.

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

The Trust, as part of the STP, has submitted its forecast activity trajectory per the national collection requirements which asked us to achieve 90% of elective activity by October and 100% of Outpatient attendances by September, compared to prior year levels, and sustain performance at these levels.

Some tolerances in final NHSI guidance meant that GWH had enough activity in Sep and Oct not to trigger any penalties under the Elective Incentive scheme, and the Covid-19 surge since December has led to the performance management of activity levels under this scheme being dropped for the rest of 2020/21.

Risks to delivery and mitigations

The Elective Incentive Scheme (EIS) guidance is now confirmed.

(i) There is zero charge for September/October due to a 10% tolerance in those months.

(ii) The scheme has been suspended from November due to the levels of Covid-19 in the system.

Statement of Financial Position

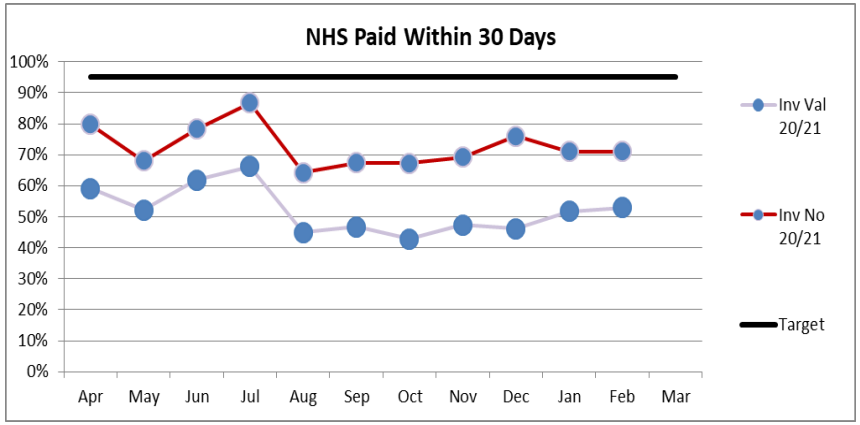
Use of Resources

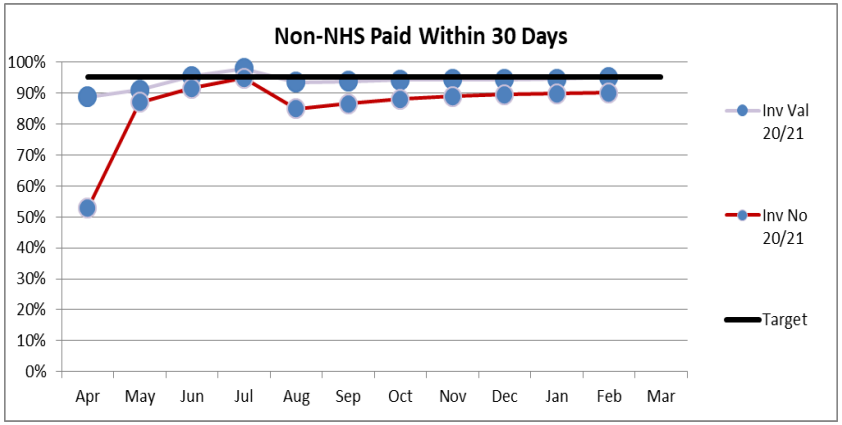
	2020-2021 Plan £'000	Previous Month Jan-21 (£'000)	Current Month Feb-21 (£'000)	Movement (£'000) From Prior Mth	As at year-end Mar-20 (£'000)
Non-Current Assets					
Intangible assets	1,831	3,447	3,447	-	3,447
Property, plant and equipment	207,698	210,420	211,408	988	206,058
Investments in associates & joint ventures	-	10	10	-	10
Receivables - non-current	-	612	612	-	612
Total Non-Current Assets	209,529	214,489	215,477	988	210,127
Current Assets					
Inventories	5,511	5,436	4,538	(898)	5,554
Receivables: invoiced	9,628	5,405	4,737	(667)	8,947
Receivables: not invoiced	21,545	36,598	33,911	(2,687)	23,043
Cash and cash equivalents.	13,913	34,305	41,213	6,908	9,140
Total Current Assets	50,597	81,743	84,399	2,656	46,684
Total Assets	260,126	296,233	299,876	3,643	256,811
Current Liabilities					
Other liabilities: deferred income	2,602	34,326	35,514	1,188	2,710
Trade and other payables: invoiced	5,931	6,488	6,564	76	12,165
Trade and other payables: not invoiced	9,305	31,470	30,208	(1,262)	21,082
Provisions - current	150	71	71	0	155
Trade and other payables: capital	2,594	10,920	12,114	1,194	5,058
Borrowings: PFI, loans & finance leases	14,587	1,235	675	(560)	69,944
Total Current Liabilities	35,169	84,509	85,145	635	111,114
Non current Liabilities					
Other liabilities: deferred income	1,123	790	790	-	904
Provisions - non-current	1,018	1,389	1,389	-	1,431
Borrowings: loans & finance leases	56,233	1,392	1,392	-	5,679
PFI obligations	86,538	95,448	95,448	-	95,447
Total Non-Current Liabilities	144,911	99,019	99,019	-	103,461
Total Assets Employed	80,046	112,704	115,712	3,008	42,236
		OK			OK
Taxpayer's and Others Equity					
Public dividend capital	76,710	106,837	106,837	-	34,556
Income and expenditure reserve	(33,601)	(32,829)	(29,821)	3,008	(31,017)
Revaluation reserve	36,937	38,697	38,697	-	38,697
Total Assets Employed	80,046	112,704	115,712	3,008	42,236

Working Capital

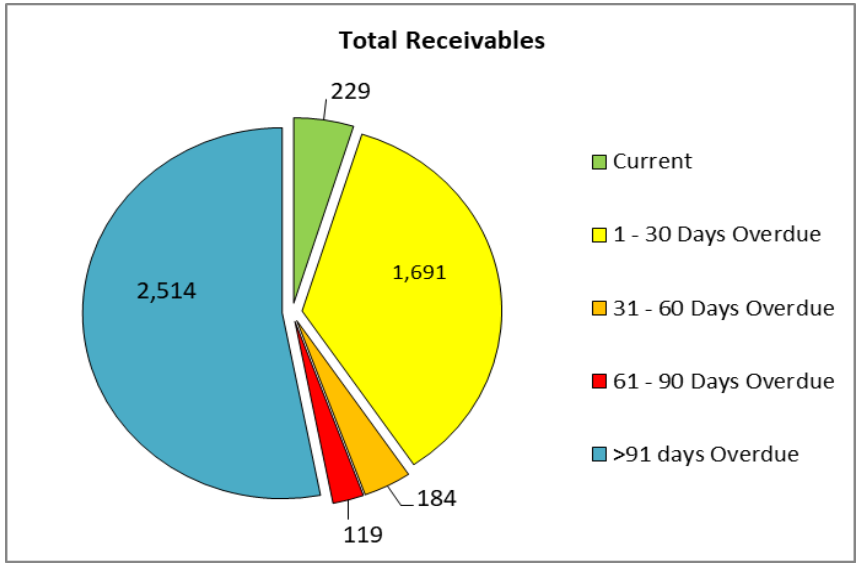
Use of Resources

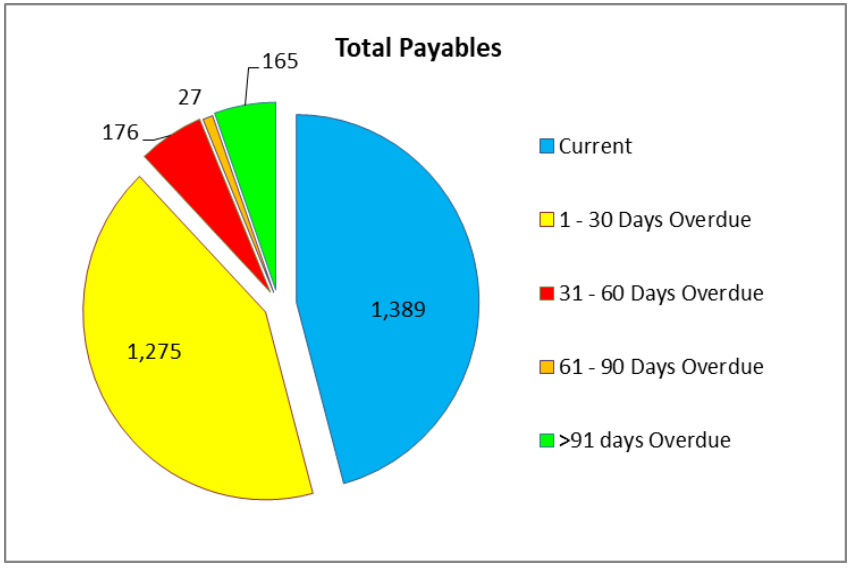
Payments to Suppliers





Outstanding Receivable and Payable Balances





Statement of Financial Position

Use of Resources

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

Non-Current Assets

- The £612k receivable relates to a clinician tax reimbursement provision recognised at year-end.
- The in month movement in property, plant & equipment relates to depreciation of £823k offset by expenditure of £1,811k.

Total Current Assets are higher than the previous month by £3,701k.

- Stock levels have decreased by £898k due to drug purchases in month and adjustment to theatre stock (identified as part of Implementing the theatre stock system).
- Current receivables are £3,354k lower than last month. Receivables not invoiced main movement relates to the decrease in PFI prepayments.
- Cash is £6,908k higher than last month

- **Total Current Liabilities** have increased by £635k from last month.
- The deferred income increase of £1,188 relates to a monthly increase in the quarterly Health Education England payment
- Invoiced trade payables have increased by £76k. This relates to invoices that have been received but are not yet approved for payment . Non-invoiced payables have decreased by £1,262k due to movements in accruals
- Capital payables have increased by £1,194k compared to last month due to payment of prior year creditors offset by in-month accruals for equipment.
- Borrowings decreased due to the monthly £546k PFI repayment, £14k finance lease payment.

Risks to delivery and mitigations

Creditors - We have a objective to pay creditors within 30 days and Budget holders are actively chase by system emails and the AP team to minimise delay in coding and approval. Overall our BPPC rate is for number of invoices paid with target is now 89.4%. Up from 88.2% last month.

Cash – The Trust has received additional cash from NHS E/I in February and has received confirmation of approval for Revenue Borrowing in March. This mitigates the pressure created from the unwinding of 2 months in advance NHS Clinical Block contract payments in March.

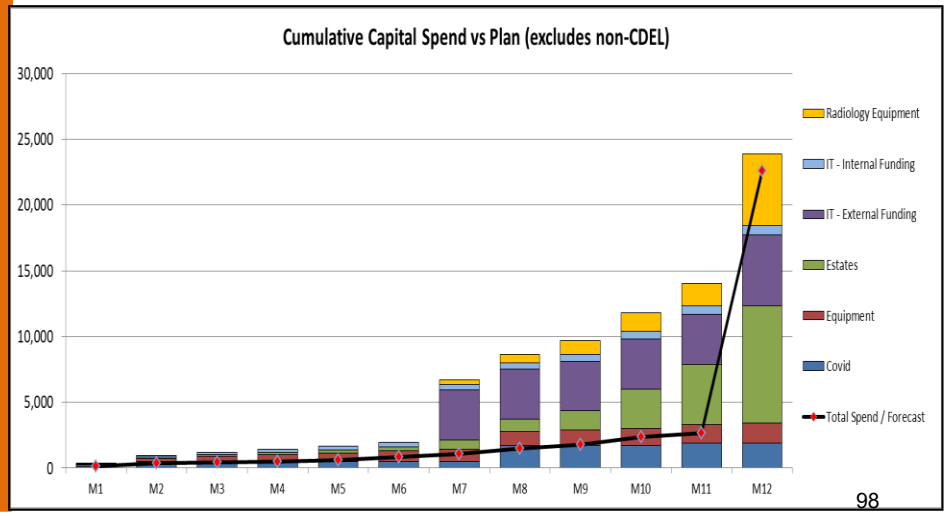
Debtors – Debtors have increased due to the increase in the PFI Prepayments and adjustment in income accruals.

Rolling 12 Month Cashflow, Capital Programme

Use of Resources

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	20/21 Total	Rolling 12 Mths Mar 21 to Feb 22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000
Opening Balance	**34,306**	**41,193**	**17,426**	**7,544**	**10,648**	**11,861**	**10,545**	**13,708**	**13,322**	**6,545**	**7,704**	**8,917**	**4,837**	**9,140**	34,306
Income															
Clinical Income	37,605	5,037	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	27,517	386,018	307,727
Other Income	759	2,970	4,730	3,962	2,012	4,730	3,962	2,012	2,012	2,012	2,012	2,012	2,012	29,752	34,438
Revenue Financing Loan / PDC		3,865				6,638						6,592	6,592	70,997	23,687
Capital Financing Loan / PDC		25,525	4,591	4,591	4,591	4,591	4,591	4,591	8,487	4,591	4,591	4,591	4,591	30,675	79,922
Total Income	**38,364**	**37,397**	**36,838**	**36,070**	**34,120**	**43,476**	**36,070**	**34,120**	**38,016**	**34,120**	**34,120**	**40,712**	**40,712**	**517,442**	**445,773**
Expenditure															
Pay	19,776	20,494	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	20,138	233,510	242,012
Revenue Creditors	11,171	12,456	10,230	8,307	8,302	8,302	8,302	8,302	8,302	8,302	8,302	8,302	8,302	125,928	105,706
Capital Creditors	529	22,792	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	4,467	29,746	71,931
Prepayments		2,200													
PFI			11,886			11,886			11,886			11,886		46,616	47,544
PDC Interest		3,222						1,600						3,914	4,822
Financing				55						55				67,242	110
Total Expenditure	**31,476**	**61,164**	**46,721**	**32,967**	**32,907**	**44,793**	**32,907**	**34,507**	**44,793**	**32,962**	**32,907**	**44,793**	**32,907**	**506,956**	**472,125**
Closing Balance	**41,193**	**17,426**	**7,544**	**10,648**	**11,861**	**10,545**	**13,708**	**13,322**	**6,545**	**7,704**	**8,917**	**4,837**	**12,642**	**19,626**	**7,954**

Capital Programme



	Feb-21			YTD			FOT		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
PFI capital	-	-	-	-	-	-	3,544	3,544	-
Medical Equipment General	125	412	287	1,425	1,585	160	1,550	1,707	157
Radiology Equipment	353	94	(259)	1,745	2,217	472	5,420	5,526	106
Building / Estates General	50	47	(3)	550	177	(373)	600	644	44
Aseptic Suite	-	-	-	-	198	198	198	198	-
IM&T General	58	-	(58)	638	-	(638)	700	342	(358)
IT Infrastructure	-	106	106	3,800	1,047	(2,753)	3,800	3,800	-
IT LIMs Pathology	-	-	-	-	-	-	1,530	1,530	-
IT Remote Monitoring	-	-	-	-	-	-	43	43	-
IT Covid Response Audiovisu	-	-	-	-	-	-	20	20	-
Way Forward	273	139	(134)	5,581	161	(5,420)	6,032	3,217	(2,815)
Way Forward (CDEL)	-	-	-	-	1,687	1,687	1,687	1,687	-
Covid	219	254	35	721	772	51	721	772	51
Oxygen scheme	-	36	36	-	129	129	492	492	-
UTC Clover	1,589	619	(970)	3,658	4,207	549	4,915	4,915	-
Commonhead design	-	(2)	(2)	-	68	68	115	115	-
Critical Infrastructure	-	-	-	-	-	-	195	195	-
Critical Infrastructure 2							200	200	-
Critical Care Resilience	-	171	171	1,234	1,063	(171)	1,234	1,234	-
GWH Clinic room	-	-	-	300	17	(283)	300	300	-
CT Enabling Infrastructure	-	-	-	200	188	(12)	200	200	-
Order Comms	-	-	-	-	-	-	99	99	-
Other	-	-	-	11	11	-	11	11	-
Total	**2,667**	**1,876**	**(791)**	**19,863**	**13,527**	**(6,336)**	**33,606**	**30,791**	**(2,815)**

Cash Position & Capital Programme

Use of Resources

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

The Cash Position in February continues to be good with £4,224k additional cash received from NHSE/I. The receipt of block payments 2 months in advance supports the balance of payments, particularly with Trust's PFI arrangements. This is expected to unwind in M12 before the start of the new financial year, requiring additional funding.

The total capital programme 20/21 is £39,467k, excluding prior year brought forward accrual this is £33,605k. This has increased by £1,593k in month relating to funding agreed for Pathology LIMs, IT Audio-visual and Remote Monitoring.

Capital Plan 2021	10,270
IT Infrastructure Bid 1920	3,800
Brought Forward 1920	5,862
Additional Funding 2021	9,959
Way Forward Programme 2021	6,032
PFI capital adjustment 2021	3,544
	39,467

The Trust has been granted emergency funding to support the 20/21 capital plan and the majority of PFI capital, in total £12,794k. £4,519k of this was drawn down in January. The remaining £25,525k of schemes will be drawn down in March 2021 to match expected spend. This is in addition to £3,865k revenue borrowing.

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

The Capital Programme is managed via the capital groups:

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

Spending to plan is being very closely monitored in M12 to ensure that all schemes are ordered and delivered to plan.

92% of the £39,467k has been committed, with spend expected by end March 2021. The balance is:

- £2,815k – Way Forward c/f 21/22
- £304k - relates to prior year

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

Risks to delivery and mitigations

Total expenditure including accruals at Month 11 is £13,527k.

In year expenditure excluding accruals and brought forward from 19/20, is £2,849k resulting in a substantial risk to in year delivery. The accrual, £10,678k, includes items ordered not yet delivered. There is a big push in March to get items delivered, invoiced and paid before the end of the Financial Year.

YTD Spend by category:

- Equipment £5,338k
- Estates £7,117k
- IT £1,072k

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

Capital Risks:

1. Radiology Equipment 2xCT machines (£2,500k) are being ordered in March to be delivered to be fitted in May/June. Certificates of ownership are being arranged.

2. Estates projects have been delayed with the recent increase in Covid-19 patients and Vaccination Programme making access to areas difficult. Works are expected to start before the end of the year and finish Q1 21/22.

Cost Improvement Plans – Better Care at Lower Cost

Use of Resources

Division	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	FY Plan £'000	FY Fcast £'000	FY Variance £'000
Integrated and Community Care	132	12	(120)	1,338	293	(1,045)	1,480	305	(1,175)
Surgery, Womens & Childrens	205	31	(174)	2,089	312	(1,777)	2,311	343	(1,968)
Unscheduled Care	229	62	(167)	2,331	699	(1,631)	2,578	763	(1,816)
Corporate	142	18	(124)	1,444	210	(1,234)	1,598	228	(1,370)
Trust Wide	92	0	(92)	933	0	(933)	1,032	0	(1,032)
Total	**800**	**123**	**(677)**	**8,135**	**1,514**	**(6,621)**	**9,000**	**1,639**	**(7,361)**
Percentage		**15%**			**19%**			**18%**	

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

The Cost Improvement Programme (CIP) delivery plan for February is £800k (£8,135k YTD).

CIPs delivered in month were £123k (£1,514k YTD) which is £677k below plan (£6,621k YTD). In month delivery is slightly higher than prior month which was £119k.

The 20/21 forecast delivery is £1,639k (18% of plan). There is no movement from M10.

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

The Trust Improvement Plan has been launched and provides a structured approach to managing and delivering schemes in 2021/22.

Risks to delivery and mitigations

Management efforts have been focused on Covid-19 response and restarting services which has reduced the CIP opportunities that have been progressed.

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Audit, Risk and Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Julie Soutter	**Julie Soutter**		**11th March 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			
Divisional Risk Register – USC	Red	Green	Comprehensive report on risks, improvements and governance. Controls strengthening as division restructure continues to bed in. Check and challenge and plans to work more across divisions at tri level. Good grip and control demonstrated.	Progress report at next cycle	TBC
BAF - refresh		Green	New format presented using Quality as example. Positive feedback on approach, format and content with suggestions for further refining. Submission to Q&G for more discussion as lead committee. Finance BAF to be developed next with others to follow iteratively.	Verbal update to Board	April 2021
15+ Risk Register	Red	Amber	Good report and discussion on top risks. Nature and number of Corporate risks to be further analysed. Risk management processes continue to improve, with Risk Committee to meet in April and cross divisional work to spread learning. New risk system approved – implementation plan required.	System implementation plan to ARAC Report on Corporate Risks	July 2021 July 2021
External Audit – progress report,		Green	No significant matters to report. Updates on additional reporting and disclosures for year-end accounts including VFM (significant work done),	External audit report	June 2021

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
benchmarklng and annual reporting timetable			going concern opinion, anti-fraud measures and equality, diversity and inclusion policies. Assurance on testing of year end balances processes. Year-end timetable on track.		
Internal Audit and Counter Fraud progress Report		Green	Following delays caused by Covid19, work for 20/21 nearing completion with some outstanding reports due. On track for issuing of year end opinion. New CF standards published, with review of risk register to check in line with new requirements. No fraud allegations since last report	Outstanding IA reports to be circulated before June meeting	May 2021
Internal Audit Report – Mortality Review			To be discussed at March Q&G with clinical representation	Q&G to discuss with ARAC members attending	Mar 2021
Counter Fraud – new Functional Standards		Amber	Current practice mapped to new requirements with 21/22 plan addressing new requirements. Transition year. 3-5 yr strategy to be linked to annual plan. Specific requirements from NHSCFA still awaited to finalise both.	Strategy and Annual Plan	June/July 2021
Counter Fraud Report – Pre-employment review		Amber	Reviewed longer term employee records (employed 20 years+) for evidence of pre-employment checks (pre current requirements). Current practices comply. Risk-based approach to achieve compliance as necessary	Director of HR update	July 2021
Internal Audit – Follow up Report		Green	Overdue recommendations discussed. Strong assurance from BDO on recommendations and actions being monitored and progressed with some agreed delays. Phasing of work on Consultant Job Planning to be agreed.	Update report	June 2021
Internal Audit Plan 2021/22		Green	Final plan agreed with Execs and approved. Key risk areas covered and statutory requirements met.	n/a	
Counter Fraud – National Procurement Review feedback		Green	National exercise based on 18/19 data (19/20 collection cancelled due to Covid). Trust performed in top 20 for adherence to procurement controls on disaggregate spend ('contract splitting') and average performance on controls over Non-PO spend (affected by PFI spend)	n/a	
Overseas Debt Recovery		Amber	Recovery of aged debt raised at FIC. Processes in place with SBS and external debt recovery discussed – review of processes continues	Update on process review and write offs	Sep 2021
ARAC Terms of Reference		Green	Amended for FTSU reporting. Some wording to be amended by circular	Minor amendments	By circular

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

GWH Performance & Public View Data

Meeting	Trust Board	**Date**	1st April 2021

Summary of Report

In March 2020, we were ranked 87th out of 123 Trusts. A year later, we were ranked 48th out of 123 Trusts which is the first time we have moved in to the top 50. The attached presentation sets out our performance against key standards in March 2020 and now.

For Information	x	Assurance	x	Discussion & input		Decision / approval	

Executive Lead	Jim O'Connell
Author	Vanda Clarke, Recovery Director
Author contact details	vanda.clarke@nhs.net ext: 5660

Risk Implications - Link to Assurance Framework or Trust Risk Register

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

Legal / Regulatory / Reputation Implications	CQC 'Must' and 'Should' dos form part of the CQC and Quality Workkstream.

Link to relevant CQC Domain

Safe	x	Effective	x	Caring	x	Responsive	x	Well Led	x

Link to relevant Trust Commitment	Trust Strategy 2019 -2024

Consultations / other committee views

Recommendations / Decision Required

- The Board is informed of the performance against key standards in March 2020 and now.

Performance Standards

Great Western Hospitals NHS Foundation Trust

In March 2020, we were ranked 87th out of 123 Trusts. A year later, we were ranked 48th out of 123 Trusts which is the first time we have moved in to the top 50. The table below sets out our performance against key standards in March 2020 and now.

	March 2020	Latest 2021 Data
Hospital Combined Performance Score	87th (5192)	48th (5672)
ED 4 Hours	44th (87.4%)	30th (87.79%)
Total time in ED	27th (147 mins)	17th (145)
Cancer 62 Day Standard	9th (90.9%)	7th (87.5%)
RTT Incomplete Pathways	106th (73.0%)	61st (65.5%)
52 Week Breeches	56th (114)	63rd (1,642)
DM01	118th (77.01%)	50th (74.94%)
Stroke Q3 SSNAP	68th (level C)	43rd (level B)

Great Western Hospitals NHS Foundation Trust

Theatres Transformation

Meeting	Trust Board	**Date**	1st April 2021

Summary of Report

The attached presentation provides an overview of the Theatre Transformation Project which formally relaunched within the Surgery, Women's and Children's Division on 4th March 2021.

The presentation highlights the use of The Productive Operating Theatre (TPOT) principles to underpin the Transformation programme, along with the key work streams.

For Information	x	Assurance	x	Discussion & input		Decision / approval	

Executive Lead	Amanda Fox
Author	Emma Churchill, Deputy Divisional Director
Author contact details	emma.churchill1@nhs.net ext: 7065

Risk Implications - Link to Assurance Framework or Trust Risk Register

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

Legal / Regulatory / Reputation Implications	CQC 'Must' and 'Should' dos form part of the CQC and Quality Workkstream.

Link to relevant CQC Domain

Safe	x	Effective	x	Caring	x	Responsive	x	Well Led	x

Link to relevant Trust Commitment	Trust Strategy 2019 -2024

Consultations / other committee views

4th March 2021: Divisional relaunch

Recommendations / Decision Required

- The Board is informed of the relaunch of the Theatres Transformation project, along with the associated work streams.
- The Board supports the Division to achieve the deliverables associated with this transformation project.

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Theatres Transformation

March 2021

Theatre Transformation Improvement Framework

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Working collaboratively with our ICS partners at Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Improving theatre utilisation which will reduce waiting times and cancellations and will provide a more consistent and improved patient experience. Digital solutions will efficiently capture patient information and reduce risk of error or non-input.

Theatre Transformation Improvement Programme

Breakthrough Projects	Bluespier Theatre System *(led by I.T.)*	PAC & EB Processes	Workforce Development	CQC & Quality Governance	Theatre Inventory Management *(led by Procurement)*	Sustainable Theatres
Constraints & Dependencies	Engaged clinical workforce		Our existing digital systems		Daily Line-Side Controls	
	We will use the TPOT methodology , guides and framework to act as our foundations for improvement					
Foundations	Our KPI's & Metrics		Defined projects		Project documentation complete and loaded into Aspyre	

Our other Improvement Programmes

- GIRFT & Model Hospital
- Outpatients Transformation
- SLR, Coding & Counting
- Estates, Digital & Corporate
- Clinical Support
- Better Buying
- Shift Left & LoS
- Flow
- Workforce & OD

CareQuality Commission

Ideas Programme

Model Hospital

GIRFT
GETTING IT RIGHT FIRST TIME

BRITISH ASSOCIATION OF DAY SURGERY
Excellence in short stay surgery

Why is this approach different?

Great Western Hospitals NHS Foundation Trust

There is recognition that we need to galvanise the approach to Theatre Utilisation and associated projects.

There are key differences to previous approaches that will help us to achieve this:

- **The implementation of Line-Side Controls.** These have not been in-place and ensures a robust daily performance review, by specialty. Terms of reference will be in-place ensuring a higher degree of accountability.
- **Project Framework and methodology.** The implementation of a project management back-office system is a new concept to the organisation and allows standardised documentation that is transparent and accessible whilst focussed upon output and delivery. We are also following a recognised Theatre Transformation methodology by using TPOT principles to underpin the programme.
- **Implementation of the Bluespier Theatre System** resulting in an integrated system and subsequent step-change for the Department and supporting functions such as elective booking. We will be able to review performance at consultant-level on a 'live' basis.
- **Engaging our Staff.** We have a dedicated project focussed upon developing our staff and increasing morale and other staff survey factors.

By Spring 2021

Line-side Controls will be BAU within the department and all theatre projects will have a project framework in-place

By Summer 2021

We will have developed a plan that focusses upon leadership development for our theatres and supporting function staff.

By Autumn 2021

The Bluespier theatre system will be implemented and electronic pre assessment scoping will have commenced

Project Framework

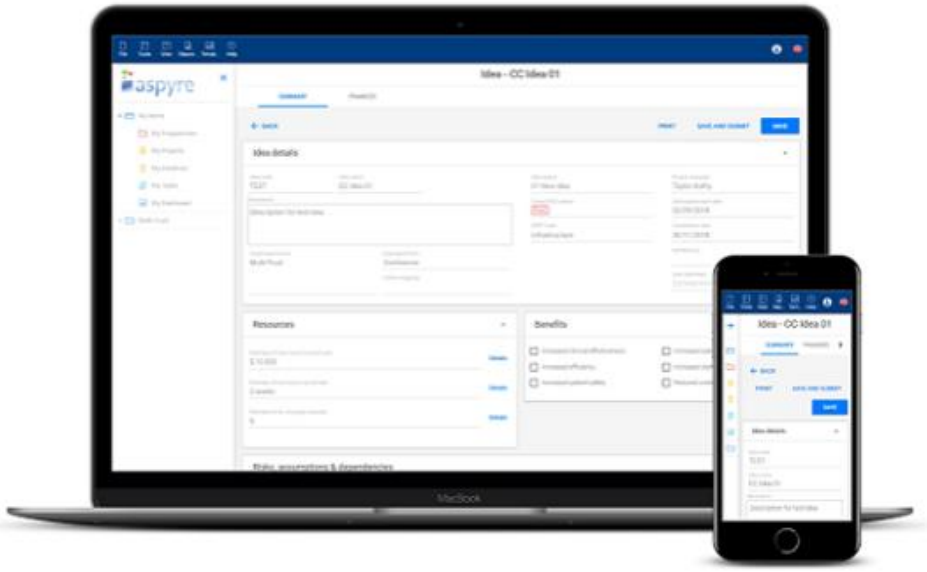
Great Western Hospitals NHS Foundation Trust

Delivery of our improvement programme and associated projects will be tracked and managed through a project management back-office system, owned by the Transformation & Improvement Hub, that will be implemented in Q4 2020/21 . This system will also support transparent reporting through the governance process and will also include financial savings.

aspyre

Key Features

- Risks & issues
- Milestones & dependencies
- Finances (costs and savings)
- Objectives, KPIs and targets
- Initiatives & ideas
- Resource planning & tracking
- Lessons learned
- Live dashboards & reports
- Meeting minutes & agendas



1. **Feasibility** — An idea is generated and a decision is made to confirm whether it is feasible to proceed with the idea.
2. **Analysis** — The idea is feasible and is further analysed through acquiring background information.
3. **Redesign** — The need for the improvement has been proven and the idea is actively moving towards its' implementation and delivery phase.
4. **Implementation and success** — The improvement is now implemented and benefits are realised.
5. **Continuous Improvement** — The improvement is monitored regularly and further improvements are identified.

All project templates will be standardised ensuring consistency and a greater degree of emphasis placed upon delivery and output.

Project Workstreams

Great Western Hospitals NHS Foundation Trust

1

Workforce Development

To ensure theatres and enabling support functions are an exemplar in leadership, employee relations and job design

2

CQC and Quality Governance

To ensure the quality and safety of a patient's journey and to safeguard our patients from harm

3

Digital and Processes

To ensure theatres is an exemplar in its data, information and IT by maximising our digital transformation

4

Theatre System Implementation

To implement an integrated theatre system that enhances our data quality and increases our efficiency and productivity gains

5

Theatre Utilisation

To have exemplar theatre utilisation in all specialties and to embed a culture of continuous improvement in our theatres

6

System Integration

To maximise benefits for our patients across the BSW system and beyond

7

Inventory Management

To ensure a robust inventory management system with supply chain visibility and traceability across our theatres

8

Well Organised Theatre

To maximise productivity and efficiencies in our Theatres

9

Sustainable Theatre

To ensure the sustainability of our theatres by reducing single-use plastics and limit our carbon footprint

Our KPI's and Metrics

Great Western Hospitals NHS Foundation Trust

The Theatre KPI Report is refreshed on a monthly basis on the 5th of each month, or next working day, subject to when the agreed data quality checks and validation has been completed by the services.

Work has recently been undertaken to update the Report to reflect necessary KPI's and metrics within theatre utilisation.

Note that further alignment is scheduled between Informatics and the Transformation & Improvement Hub to ensure all metrics are captured in one-place.

Theatres Utilisation – Draft Monthly Dashboard

Great Western Hospitals NHS
NHS Foundation Trust

Theatre Specialty Performance Dashboard | **Month:** | **Jun-18** | AMBER

Measure	Overall Theatre Target	ENT	Gen Surg	Gynae	Ophthal	Oral Max-Fax	Ortho & Pod	Urology	Other Theatre Users	Overall Theatres in June 18		Overall Theatres in Mar 18	Overall Theatres in Apr 18	Overall Theatres in May 18
Scheduled lists at week 4	**90%**	89%	94%	96%	85%	90%	91%	88%	97%	91%	↑	77%	87%	88%
Booked lists at week 2	**80%**	102%	54%	78%	48%	71%	70%	93%	0%	74%	↑	87%	70%	68%
Theatre list utilisation	**85%**	84%	90%	87%	85%	70%	90%	70%	99%	85%	↓	86%	86%	88%
Late starts %age lists (≥10mins from start)	**20%**	40%	39%	30%	25%	85%	20%	35%	0%	33%	↑	39%	29%	27%
Average start time mins (AM / PM)	**09:00**	9:07 / 14:09	9:10 / 14:09	9:01 / 14:10	8:53 / 14:10	9:22 / 15:09	9:03 / 14:12	9:09 / 14:15	9:05 / 13:50	9:06 / 14:12	↑	9:00 / 14:12	9:04 / 14:10	9:05 / 14:08
Over-runs (>12:30 or 18:00)	**20%**	17%	33%	32%	17%	30%	30%	9%	20%	25%	↓	28%	29%	30%
Under-runs percentage lists (<20mins)	**20%**	48%	50%	33%	48%	46%	5[illegible]	62%	37%	48%	↑	42%	44%	41%
Under-runs in time (total per mth)	**55:00**	13:47	26:09	10:21	16:43	06:11	5[illegible]37	17:57	00:00	147:45	↑	NA	134:52	146:44
Percentage all day lists / mth	**25%**	38%	48%	10%	0%	31%	34[illegible]	19%	35%	27%	↑	40%	25%	22%
Av Turnaround time	**14.00**	20.01	23.26	13.45	3.80	17.69	21.09	15.61	15.40	16.22	↑	16.05	15.25	14.15
DNAs	**18**	4	1	0	4	3	3	3	0	18	↓	16	22	19
Total Pt Cancellations on Day	**36**	14	11	6	13	6	23	8	0	81	↓	126	74	82
Canx Pts on Day (reportable)	**10**	1	2	3	[illegible]	[illegible]	9	0	0	20	↓	30	25	21
Cancelled Sessions on the Day	**0**	0	0	0	[illegible]	0	0	0	0	0	↓	14	1	8
Elective Cases done	**1200**	119	197	125	[illegible]217	71	301	121	8	1159	↑	975	1013	1125
Elective Sessions complete	**450**	43	99	45	[illegible]1	19	167	38	12	464	↓	415	436	482
Ave Case per Session	**3**	2.767	1.990	2.778	5[illegible]93	3.737	1.802	3.184	0.667	2.498	↑	**2.349**	**2.323**	**2.334**

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Non Elective Activity

Year to date:

April	274	Oct
May	335	Nov
June	331	Dec
July		Jan
Aug		Feb
Sep		Mar

JUNE PERFORMANCE HEADLINES.

- **Scheduled lists:** On target**.** Improvement in utilised lists in month from 88% to 91%
- **Booked lists**: Improved in month as staffing levels recovered and booking KPIs daily and weekly reporting set up.
- **Utilisation**: On target. Oral & Urology utilisation impacted by DNAs and Canx on day at 12% and 9% of activity respectively. This skewed the overall position, which would have achieved 89% otherwise.
- **Under-runs**: Time under used remained static to previous month, but as a percentage of all activity, increased. Main drivers were in orthopaedics and general surgery, in part due to case mix and complexity where there are fewer 'short' cases to book to lists with available time, but also impacted by high cancellations on the day @ 5% and 7% respectively.
- **Late Starts**: increased in month by 5%; however, Oral Surgery's high number of late starts (on smaller activity levels) has skewed the overall position which would have been 27%. This is a recurring theme of delays for consenting (either anaesthetist or surgeon) and the service has been asked to produce an action plan to improve. July so far looking better.
- **Average Case per session**: improved again in month, driven by improvement in ENT, General Surgery, Gynae and Ophthal performance.
- **DNAs and Canx on Day**: slight reduction in month. Weekly RCA of canx on day being implemented in July

Theatres Utilisation Draft Monthly Dashboard by Specialty

Great Western Hospitals NHS
NHS Foundation Trust

Inputs

Measure	Target	Performance
Scheduled lists at 6 weeks	75%	
Scheduled lists at 4 weeks	90%	
Scheduled lists at 2 weeks	100%	
Theatre List Utilisation	90%	
Late Starts	10%	
Over Runs	10%	
Under Runs	10%	
% All Day Lists	100%	
Average Turn Around Time	10 minutes	
DNAs	0	
Cancellations on the Day	0	
Elective Cases Target	TBC	
Elective Cases Actual		
Average Case Per Session	4	

Performance Summary:

The monthly target cases for ENT was x. The actual delivery of cases was y.

Reasons for deviation from Plan:

Recovery Actions:

1.
2
3.

Outputs

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Totals
1 Planned								
1 Actual								
2 Planned								
2 Actual								
3 Planned								
3 Actual								
4 Planned								
4 Actual								
Total								

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Performance Summary:

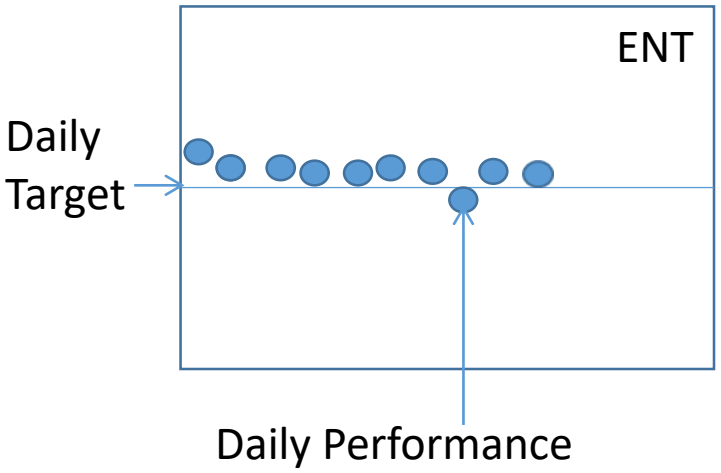
The monthly target cases for ENT was x. The actual delivery of cases was y.

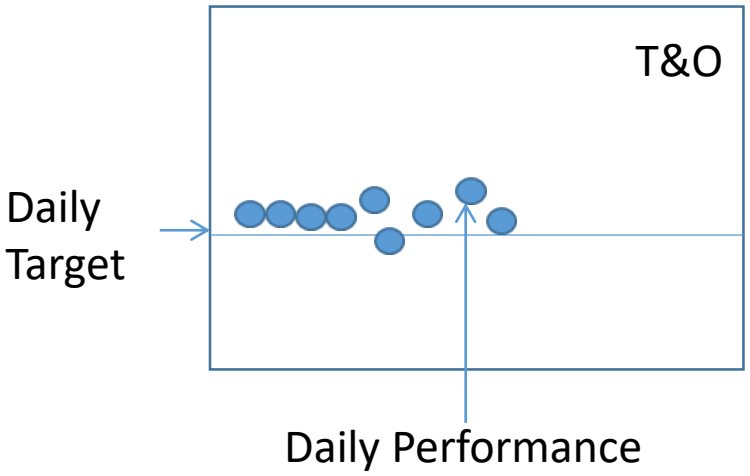
Reasons for deviation from Plan:

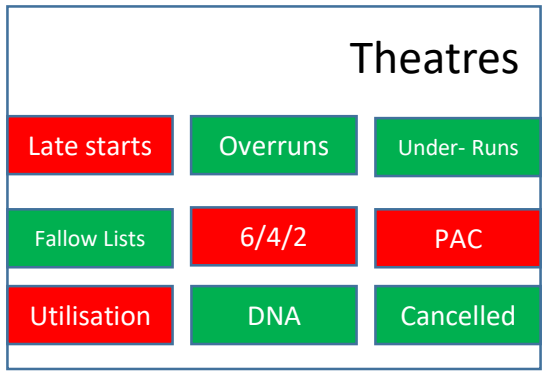
Recovery Actions:

1.
2
3.

Line Side Controls – introducing daily performance governance







Head of Service Narrative	Theatre Manager Narrative
My daily performance target yesterday was X	My daily performance target yesterday was X
Yesterday I had Y patients on the table	Yesterday I had Y patients on the table
My bookings for the next few days show that I should/should not hit my weekly target	My bookings for the next few days show that I should/should not hit my weekly target

Programme Governance

Our monthly Theatres Performance Board will feed into the Improvement Board.

Each project has a monthly working group in-place with key stakeholders

Theatre Transformation Performance Board	
Month	**Time**
February 2021	Wednesday 3rd, 14.00-15.30
March 2021	Wednesday 3rd, 14.00-15.30
2021/22	
April 2021	Wednesday 7th, 14.00-15.30
May 2021	Wednesday 5th, 14.00-15.30
June 2021	Wednesday 9th, 14.00-15.30
July 2021	Wednesday 7th, 14.00-15.30
August 2021	Wednesday 4th, 14.00-15.30
September 2021	Wednesday 8th, 14.00-15.30
October 2021	Wednesday 6th, 14.00-15.30
November 2021	Wednesday 3rd, 14.00-15.30
December 2021	Wednesday 8th, 14.00-15.30
January 2022	Wednesday 5th, 14.00-15.30
February 2022	Wednesday 9th, 14.00-15.30
March 2022	Wednesday 9th, 14.00-15.30

Great Western Hospitals NHS Foundation Trust

Outpatients Transformation

Meeting	Trust Board	**Date**	1st April 2021

Summary of Report

The attached presentation provides a high level overview of the transformation that has been delivered in 2020-21 within Outpatients. This includes a performance update, a briefing on automation and a review of the roadmap for 2021-22.

For Information	x	Assurance	x	Discussion & input		Decision / approval	

Executive Lead	Amanda Fox
Author	Peter Coutts, Deputy Divisional Director
Author contact details	peter.coutts@nhs.net ext: 4940

Risk Implications - Link to Assurance Framework or Trust Risk Register

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

Legal / Regulatory / Reputation Implications	CQC 'Must' and 'Should' dos form part of the CQC and Quality Workkstream.

Link to relevant CQC Domain

Safe	x	Effective	x	Caring	x	Responsive	x	Well Led	x

Link to relevant Trust Commitment	Trust Strategy 2019 -2024

Consultations / other committee views

Recommendations / Decision Required

- The Board is updated on the transformation work within Outpatients and has a good awareness of the transformation plans for the new financial year.
- The Board supports the Division to achieve the deliverables associated with this transformation project.

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Outpatients update

Service review – Peter Coutts April 2021

Introduction

The following slides are intended to give a high level overview of some of the transformation that has been delivered in 2020-21. This will include a performance update, briefing on automation and review of the roadmap for 2021-22. There is a Q&A section at the end but please raise your hand if you'd like to pause on a particular slide.

- KPI Review

1. ASI – Available slot issues

2. Missing Outcomes

3. 6 week Appointment cancellations

4. Hold file – Follow up patient wait list

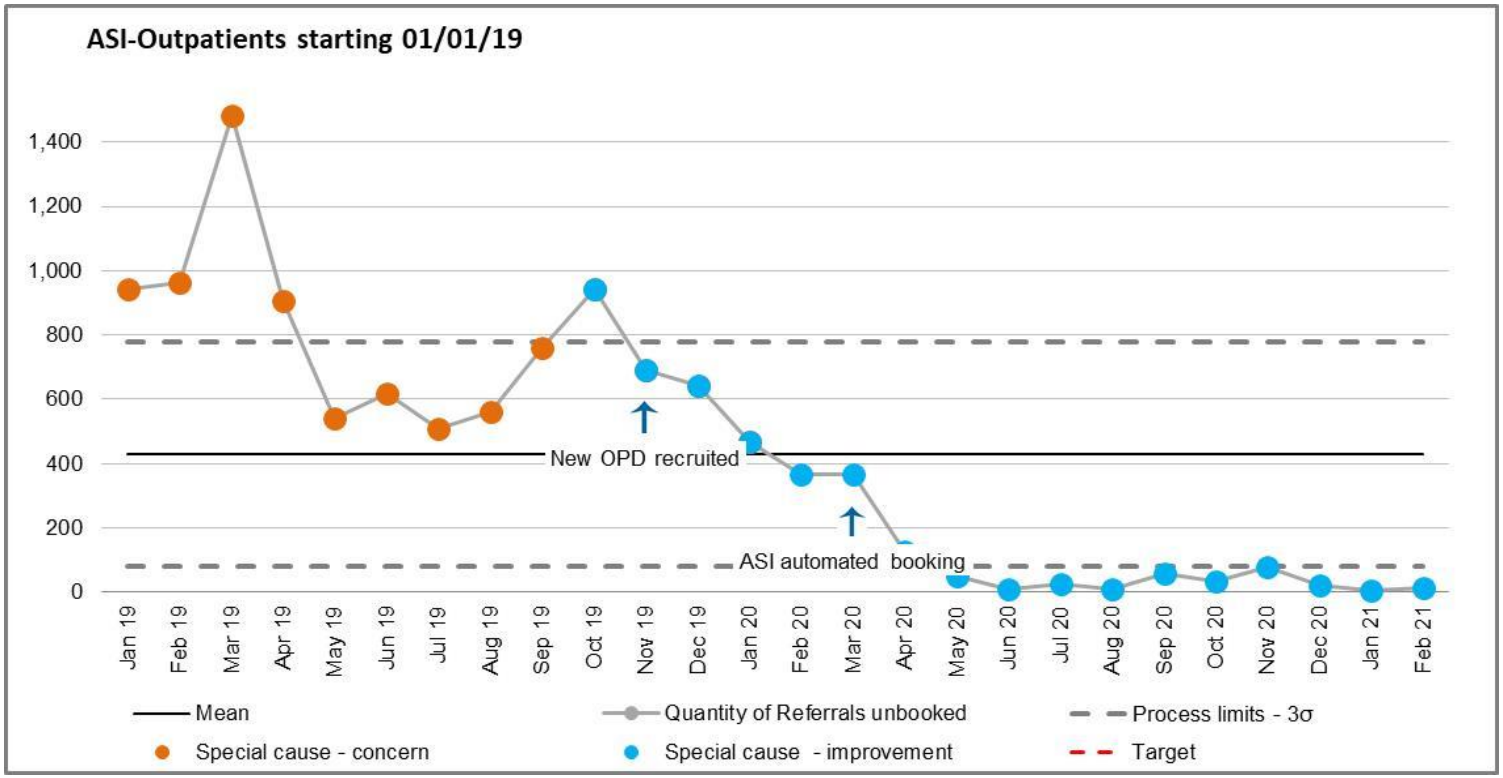
- New ways of working (Automation via Thoughtonomy)

- New look Outpatients at GWH

- What's next for Transformation (next steps)

KPI - ASI – Available Slot Issues

Great Western Hospitals NHS Foundation Trust



What is an ASI?

ASI are Appointment Slot Issues and indicate where a referral is held in the national ERS (Electronic Referral System) as there is no available directly bookable appointment for a GP to book a patient into.

ERS is the system used for all new patients to be referred into the trust and for most services allows GPs to select a suitable appointment time and date for a patient. Where there are no appointments available the GP can only refer in by creating an ASI.

High ASI is an indicator that there are capacity issues or poor admin controls in place.

What is the data showing us?

In Outpatients we strive to never have ASI referrals that are in excess of 24hrs. In February there was a run rate of 14 referrals that had exceeded our standard.

These un-bookable referrals have largely been as a result of limited 2 week wait capacity – we have worked with service to clear these as soon as is practical.

There have been significant improvements with ASI and we now control this process through automation. This means that slots which can't be booked by a GP are picked from the National system and booked into the trusts waiting clinics automatically through the use of Automation via Thoughtonomy. This is no longer a human task.

What's next?

The national referral system has a 6 month expiry attached to all referrals. This means that if a referral is held without being booked for longer than 6 months, it will disappear from the trust's systems.

The trust previously had an issue with these "drop offs" and automation will continue to be utilized as an assurance mechanism to guarantee that patient referrals are never missed again.

KPI - Missing Outcomes

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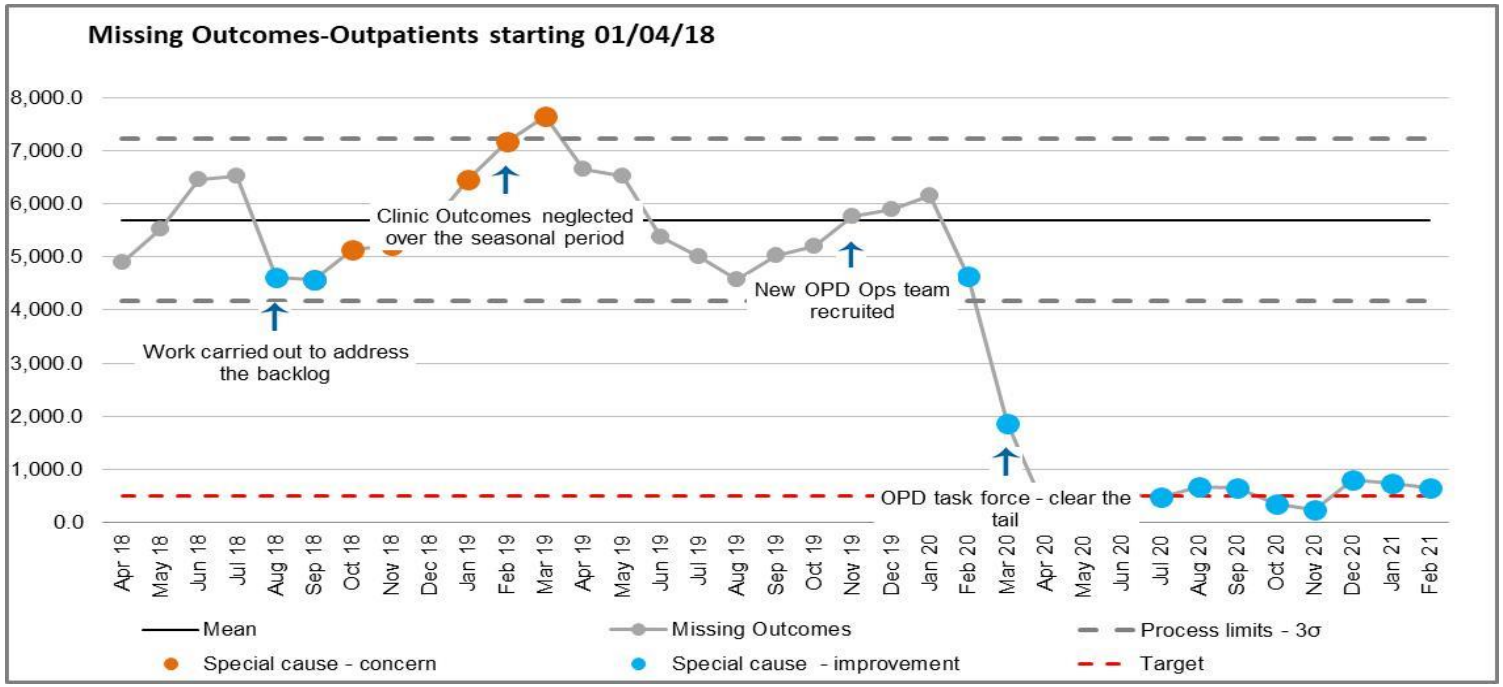


What are missing Outcomes?

Missing outcomes are appointments that have not yet been concluded within our PAS (Patient administration system). Missing outcomes do not necessarily mean that the appointment can't be concluded in the system because the outcome form is lost.

It does indicate where there is a delay in the process of concluding a patient attendance. There are multiple reasons as to why an outcome being completed may be delayed. These can include – No direction received from the clinician, Clinic did not occur, delay in admin processes or delay in receiving clinician outcome (such as clinic held off site).

What is the data showing us?

The February position saw 652 missing outcomes recorded. Predominantly these outcomes were not completed across 6 services. These delays were a combination of off site clinics (198 Tele-med or community based appointments), Admin delays following higher than normal absence levels (221) and no response received by clinician (233).

The trust has had a poor history of completing patient attendances and this has previously exceeded 7000. The last year has in comparison been more controlled but the need to grow our Tele-medicine appointments has impacted efficiency.

What's next?

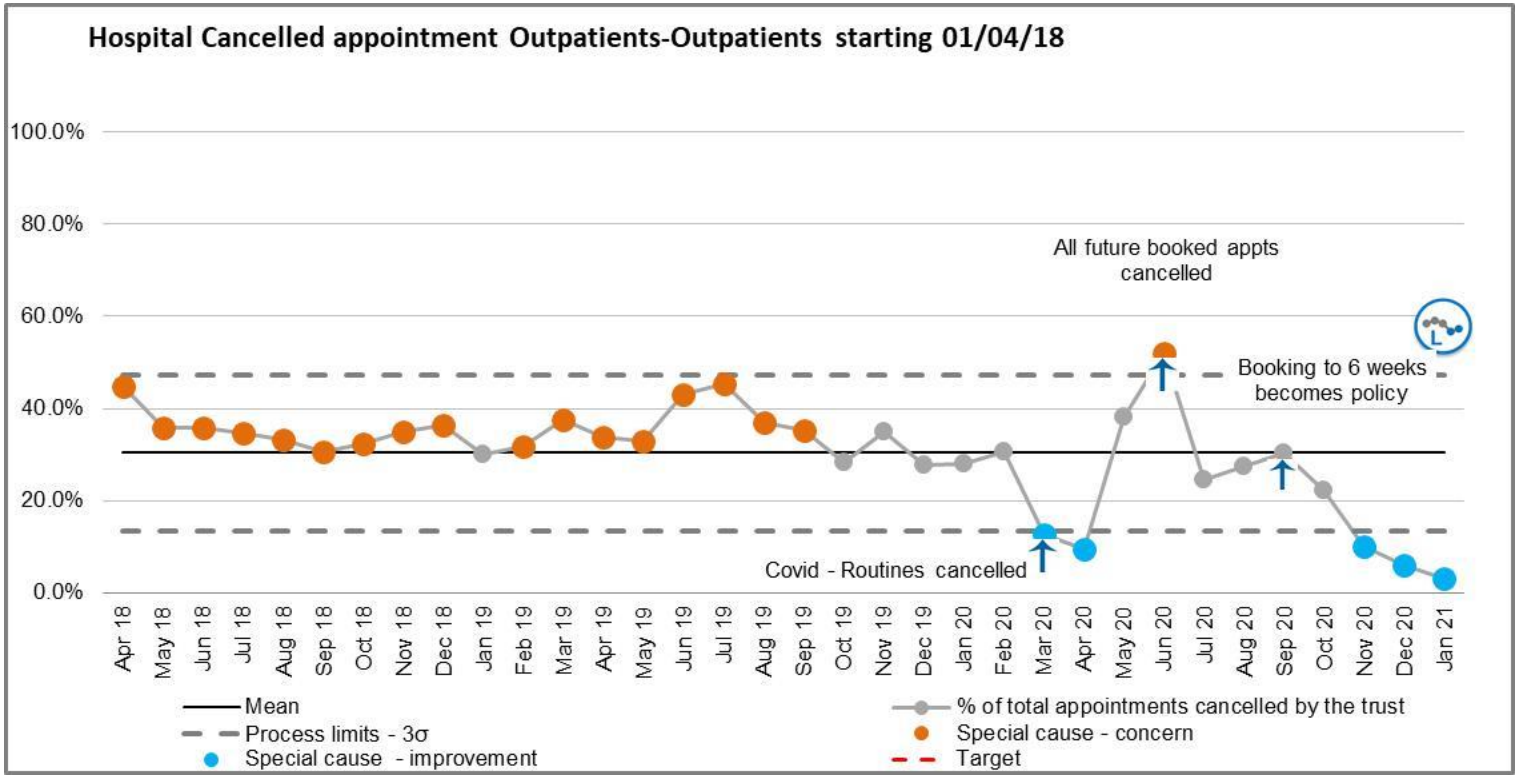
Outpatients is looking to adapt the way that it concludes appointments. The current method involves the clinician completing a paper form and the admin team uploading this information into the PAS. This is very inefficient and is also open to human error.

With the commencement of Tele-med we have had to adapt to a new way of working and have introduced "Partial Outcoming". This process allows the clinician to partially conclude the attendance directly onto the system in clinic.

This approach has not been widely adopted and needs to form part of a larger culture/process change in the trust. To that end the Outpatients department aims to introduce "Partial booking" as change project in 2021/22.

KPI – Appointment Cancellations

Great Western Hospitals NHS Foundation Trust



What is defined as an appointment cancellation?

This chart shows the quantity of **hospital** cancelled appointments within 6 weeks of the patients scheduled attendance.

There are multiple reasons that the hospital may need to cancel a patients appointment. These can include administration changes (move patient from this date to an alternate date) and Clinician on annual leave or sick.

What is the data showing us?

Before the Covid-19 pandemic the hospital cancelled **34%** of all booked appointments. This means that 1 in 3 patients would have their appointment cancelled by the hospital before they successfully attended an appointment. In some instances patients were cancelled more than once.

The decision was made to cancel all future appointments and with Trust approval we implemented a 6 week rule on clinic bookings. This means that Outpatients will not book appointments in excess of 6 weeks. Where patients require an appointment and there is no space to book in this 6 week window, we "hold" the referral. We then book in date order as each day passes.

This has resulted in **3%** of patient appointments being cancelled by the hospital in January. An improvement of 1000% and a better experience for our patients.

What's next?

There is a nervousness with clinicians that when a referral is held it can become forgotten or lost. This is not systemically possible. A campaign of communication with our clinical colleagues is set to begin in April. This "Outpatient Forum" is intended to advertise, educate and listen to concerns that clinicians may have.

As mentioned previously we are looking to begin partial booking. This process allows a clinician to "pencil in" a future patient appointment date – it is believed that this change will both assure our clinical colleagues patients will not be missed as well as delivering the cultural change required to deliver on Missing Outcomes.

KPI - Overdue Hold file (follow up patient wait list)

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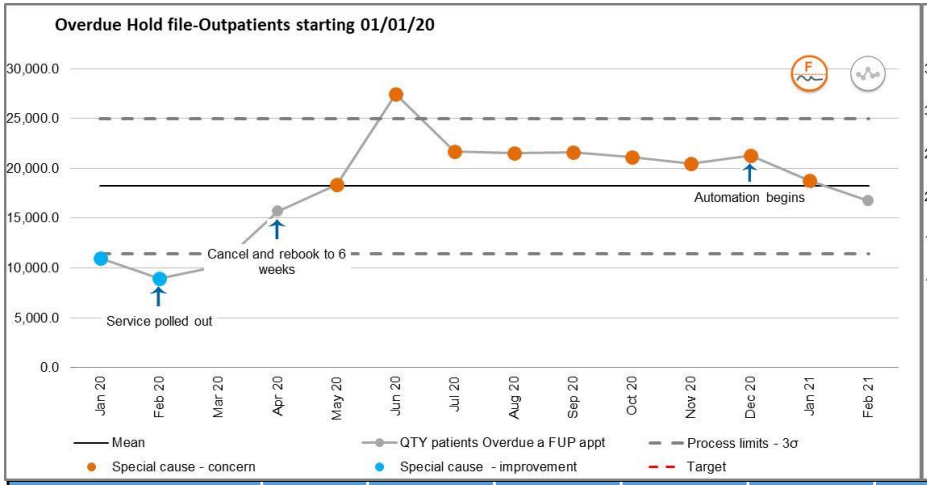

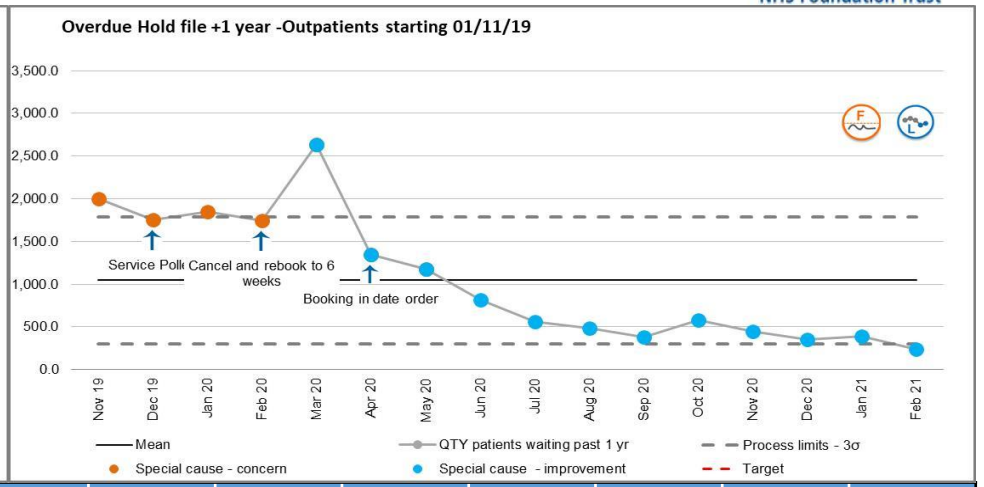

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Total Overdue patients	8,973	10,135	15,689	18,394	27,480	21,696	21,544	21,614	21,109	20,479	21,313	18,793	16,717
Total Overdue +1yr	1,741	2,630	1,346	1,180	813	564	481	382	581	445	357	389	242

What is the Holdfile?

The hold file is a computer database where any patients that have been identified as requiring a follow up appointment are "held" if they do not have said appointment booked within the Trust's PAS.

Where patient demand has exceeded capacity an element of the patient list is past the date that the clinician instructed that they wanted to see the patient by. We call this cohort of patient "Overdue".

The hold file is a systemic database that is linked to the PAS. If a patient is not booked into an appointment but the pathway is still live, the patient is automatically added to holdfile.

What is the data showing us?

Prior to the pandemic and the cessation of routine appointments on March 23rd the trust allowed follow up appointments to be booked up to 18 months into the future. When patients are booked into appointments they no longer appear on the hold file. This may lead to an unclear understanding of how many patients the trust has that are waiting for a follow up appointment. In June it was decided to cancel all future appointments that were booked in the future. This allowed the true size of the follow up wait list to be exposed. There were 27000+ patients. A campaign of booking in date order began and the 6 week booking process controlled the accuracy of the data.

In December Semi-Automation was launched to increase the utilization (fill) of our clinics. The increased efficiency that this has delivered has reduced the holdfile consistently since launch. The current trajectory places the hold file below 9000 by December 2021.

What's next?

Automation will continue to be refined to highlight where appointment slots are being created but are not used.

In addition a demand report from the automation highlights where additional clinics are required. This real time demand and capacity modeling will dynamically support the recovery of the Follow up wait list.

Thoughtonomy

Processes to date

Great Western Hospitals NHS Foundation Trust

Phase 1:

Automate appointment bookings – both new and follow up.

Predicted cost saving £229,000 per annum.

Complete

Phase 2:

Partial booking/appointment outcoming

Predicted cost saving £38,889 per annum

In progress

Phase 3:

Patient kiosk “self service” (& Outpatients Service Ambassador role implementation)

Predicted cost saving of £45,000 Medway module cost

Phase 4:

Patient choice – appointment re-booking through patient portal (via automation).

Due this year

Thoughtonomy via blueprism

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Automation – what is it and how are we implementing it?

Automation is a robotic process automation (RPA) solution that mimics the human user in performing various tasks, such as clicks, navigations, typing or any meaningful activities that may involve multiple systems or applications.

The virtual workers work 24/7 and are able to significantly reduce the average handling time of administrative tasks.

The overall aim of automation is to:

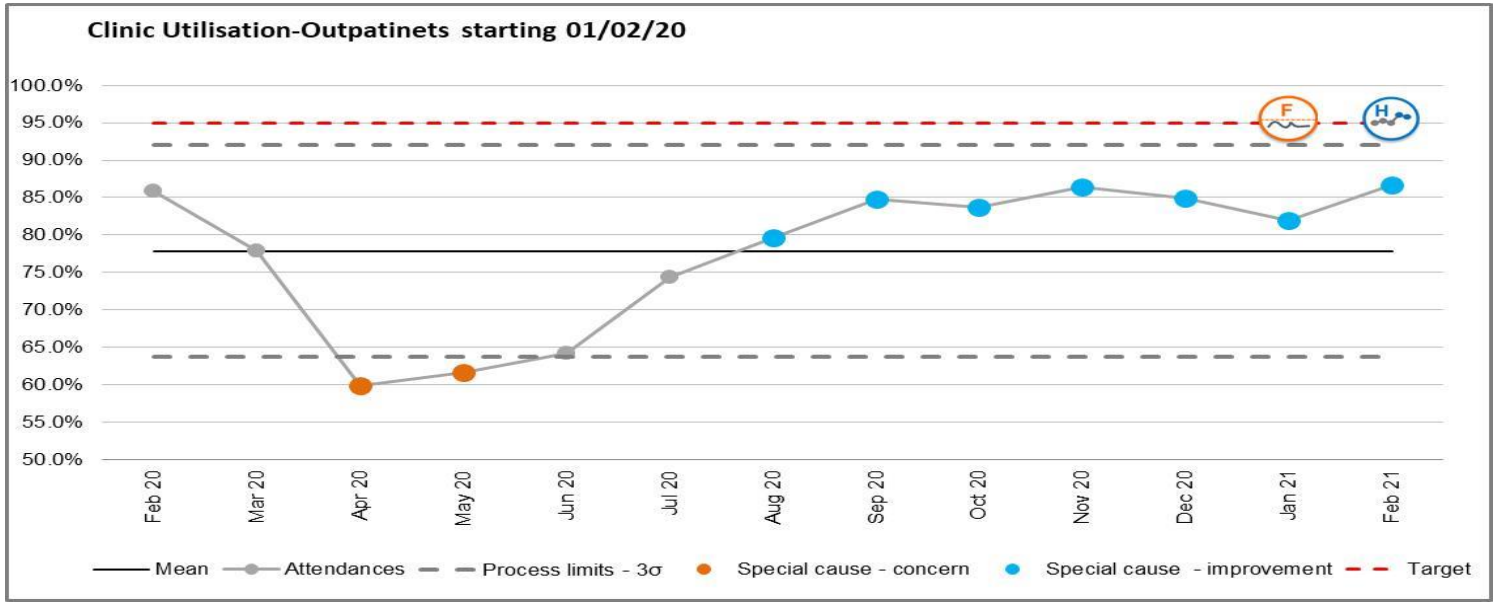
- Increase efficiency and productivity while reducing costs
- Remove errors
- Improve staff morale and employee engagement
- Enhance patient outcomes and improve services

Currently we have been building automations for the last 9 months as part of transforming Outpatients. To date we have automated:

1. 2WW referrals – when a referral arrives it is automatically emailed to the relevant services and clinicians.
2. Upload referral letters – the automation uploads 2ww referrals into Medway for clinicians to immediately access.
3. Check cancer register – the automation compares patients that have been referred against referrals that have been registered with cancer services. A further automation emails the cancer team to let them know when no cancer has been found so they can update the GPs.
4. Patient cancelations – When a patient cancels their appointment via text message, the automation cancels the patient in our booking system and offers the appointment to the next waiting patient.
5. ASI bookings – when there is no appointment visible to the GP in ERS, the automation books the ASI referral into a holding clinic.
6. New patient appointment bookings – when a new patient appointment becomes available, the automation selects the next longest waiting patient for that clinic and books them from the holding clinic.
7. Follow up appointment bookings – the clerks are provided with a report of all patients that are due/overdue their follow up appointments. The clerks indicate the names of clinics that the patients are waiting for. Armed with this information the automation fills the clinics and refills appropriately when patients cancel.

Output of Automation - Clinic Utilization

Great Western Hospitals NHS Foundation Trust



Amended Utilisation	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Utilisation %	85.9%	77.9%	59.9%	61.7%	64.3%	74.4%	79.6%	84.8%	83.7%	86.4%	84.9%	82.0%	86.7%
Total Slots	21,153	20,896	9,520	10,572	16,670	16,414	13,849	17,205	17,527	17,166	16,239	14,669	14,721
Booked + Cancelled Slots	18,165	16,286	5,698	6,526	10,712	12,207	11,018	14,585	14,666	14,835	13,788	12,031	12,758

What is the Clinic Utilization?

Clinic Utilization is a measure of how full a clinic is. It is largely measured as a percentage of fill.

There are a few reasons why a clinic would not be 100% utilized. These include –

- Patient cancelled appointment and the appointment was not refilled.
- There is no demand for the appointment , no patients waiting.
- Outpatients did not fill the clinic.

What is the data showing us?

The average clinic utilization from April 2018 is 81%. New patient booking has been automated from May 2020 and this has resulted in 97% clinic fill. Semi-automation began in December 2020 for follow up patients and this is now delivering a combined fill of 85%. This has generated an additional 1,800 attendances in 3 months. This increased efficiency is set to support the recovery of both new and follow up patient wait lists without any additional spend adding more clinics.

Automation works by replacing a human administrator with a cloud based automaton. The motions that a human operator would follow when booking are repeated continuously 24 hours a day, 7 days a week. We currently employ 4 automatons within the outpatient department. The relentless actions of filling a clinic mean that when a patient cancels, the appointment slot is offered to the next waiting patients without any human intervention.

New appointment booking is relatively simple, as it only involves the use of 2 hospital systems. The pathway is significantly easier to follow. Follow up patient booking is significantly more complex. This is why at present, this process is semi-automated. Human intervention is still currently required to identify which clinics are suitable for which patients waiting.

New look Outpatients

Great Western Hospitals NHS Foundation Trust

Present day

- Currently our clerks sit behind a desk appearing inaccessible.
- There is no patient service training.
- The team have a “functional” uniform made from 100% polyester.
- The team have additional task to complete while welcoming our patients so their attention is often divided.
- Patients have no choice but to wait to let us know they have arrived.
- Feedback from patients is limited to friend and family paper forms.
- Clerks need to juggle task such as email, answering the phone and booking clinics… and welcoming patients

2021-22

- We will remove the desks and issue our colleagues with a live tablet.
- Automation will remove task. This will be combined with centralised telephony support to reduce inbound calls.
- Customer service training will be provided with an emphasis on putting the patient first and making them feel welcome and valued. This will be underpinned by a redefined job description – the service ambassador rather than admin clerk.
- We have redefined the uniform for both men and women. The professional look will help the team to feel comfortable and confident.
- Self check in will be offered as an option for patients that don’t need or may not want to interact with the service ambassador.
- The patient portal will survey patient experience and provide on the hour feedback for Unit managers to improve service.

Next steps

Great Western Hospitals NHS Foundation Trust

Outpatients transformation 2021-22

- Complete phase 2 – partial booking by the **end of quarter 1**
- Implement phases 3 (self check in) and phase 4 (Patient choice) by the **end of quarter 3**
- Launch the Thoughtonomy Innovation Hub across the trust in **quarter 3** to identify further opportunities to unlock efficiencies and save cost.
- Further innovate to modernise the patient pathway via the patient portal DrDoctor with more Video/Telemedicine features and improved patient communication via digital letters – **Complete in Q1**
- Work with the system to decrease referrals and reduce the need for Follow up waiting list via A&G (advice and guidance) and PIFU (patient initiated follow up). **Date to be established.**
- Digitise the patient's medical records through the EDRMS (electronic data record management system) and enable a paper light approach within the Outpatient setting – **Bulk scanning commences in Q1.**

Any Questions?

Great Western Hospitals NHS Foundation Trust

Terms of Reference of Committees

Meeting	Trust Board	Date	1 April 2021

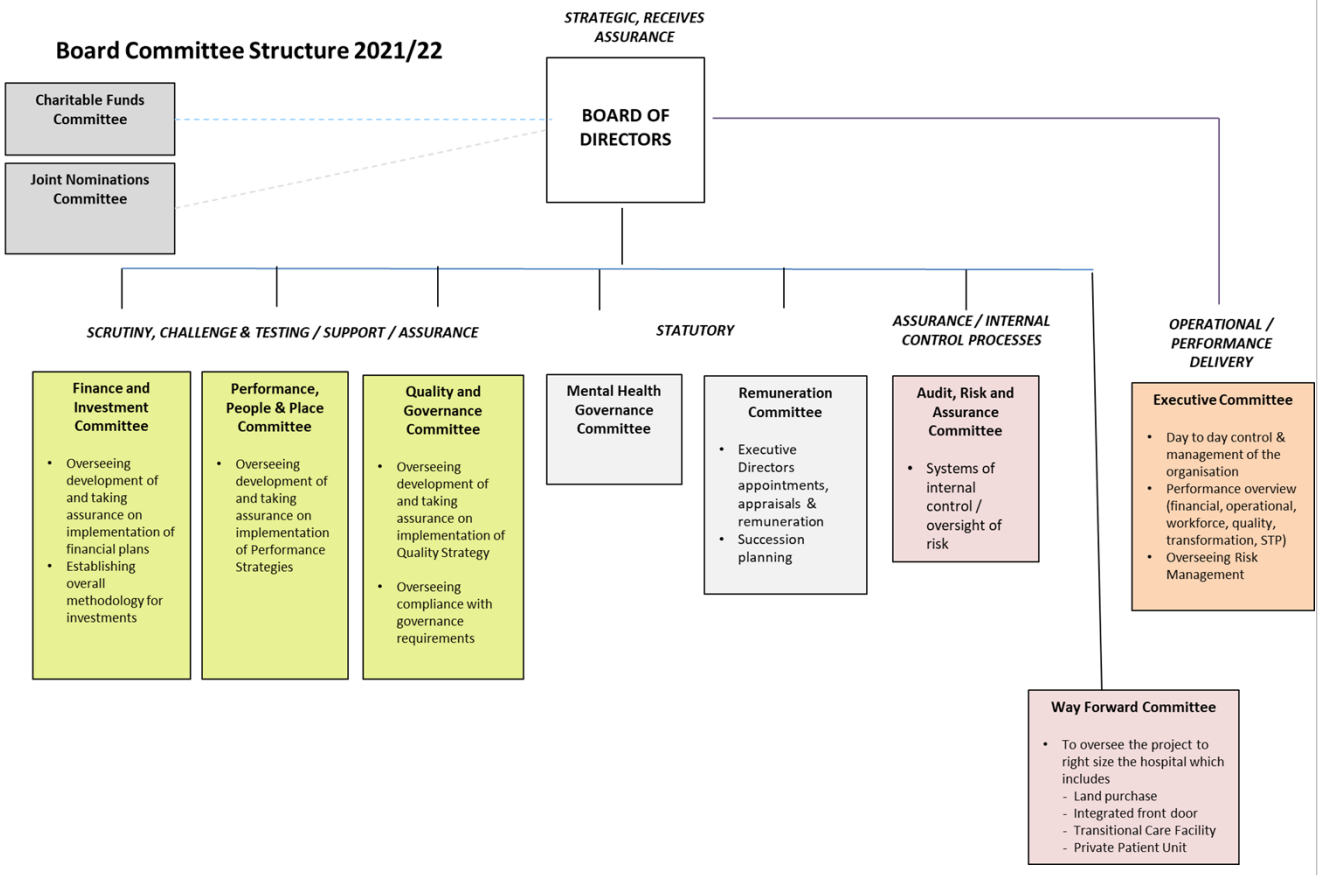
Summary of Report

This report invites the Board to refresh the Terms of Reference of the Board Committees as attached. Minor amendments only have been made to reflect feedback from Directors.

The Board is advised that each of the Board Committees through open discussion have considered their effectiveness through their terms of reference at their relevant meetings.

There were no issues or concerns to draw to the attention of the Board about the effectiveness of the committees, the committee structure generally or the terms of reference for each committee.

Current Committee Structure 2021/22



Note 1 : that the Terms of Reference for the Joint Nominations Committee is set out in the Constitution and no amendments are proposed.

Note 2 : that the Terms of Reference for the Mental Health Governance Committee, Executive Committee and Performance, People & Place Committee will follow once reviewed and agreed at the relevant committee.

Appendix 1 : Audit, Risk & Assurance Committee
Appendix 2 : Quality & Governance Committee
Appendix 3 : Finance & Investment Committee
Appendix 4 : Charitable Funds Committee
Appendix 5 : Remuneration Committee

For Information		Assurance		Discussion & input		Decision / approval	x		
Executive Lead	Kevin McNamara, Chief Executive								
Author	Caroline Coles, Company Secretary								
Author contact details	Caroline.coles3@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	n/a								
Link to relevant CQC Domain									
Safe		Effective		Caring		Responsive		Well Led	x
Link to relevant Trust Commitment									
Consultations / other committee views									
All Board Directors / Committees / Chairs of Committees									

Recommendations / Decision Required

(a) that it be agreed that there are no changes proposed to the Board Committee structure as set;; and,

(b) that the Terms of Reference for each Committee as attached be approved.

Great Western Hospitals NHS Foundation Trust

AUDIT, RISK AND ASSURANCE COMMITTEE TERMS OF REFERENCE 2020-21- 2021-22

Established by Trust Board
Reports and accountable to the Trust Board
(Statutory)

Overview
The Audit, Risk and Assurance Committee (the Committee) is a formally constituted Committee of the Board of Directors (Trust Board).
This is a statutory non-executive Committee.

Summary of purpose and objectives

This Committee shall provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

In addition this Committee shall

- provide assurance of independence for external and internal audits;
- ensure that appropriate standards are set and compliance with them monitored, in non-financial, non-clinical areas that fall within the remit of this Committee; and
- monitor corporate governance (e.g. compliance with terms of authorisation, Constitution, Codes of Conduct, Standing Orders, Standing Financial Instructions, maintenance of registers of interest).

Role and duties

1.	To oversee the establishment and maintenance of an effective system of internal control, and management reporting.
2.	To ensure that there are robust processes in place for the effective management of clinical and corporate risk to underpin the delivery of the Trust's principal objectives.
3.	To oversee the effective operation and use of Internal Audit.
4.	To encourage and enhance the effectiveness of the relationship with External Audit.
5.	To oversee the corporate governance aspects that cover the public service values of accountability, probity and openness.
6.	To review and sign off prior to formal approval by the Board, the annual report, statutory accounts and quality accounts as well as receiving the draft audit letter.
7.	To receive input from the Quality & Governance Committee as required on its work in ensuring reliability and robustness in the preparation, assessment and data integrity of the Quality Accounts or Clinical Risk reporting, to facilitate the assurances necessary for this Committee to validate the Trust's Quality Accounting and overall risk review process.

Responsibility / delegated authority	
1.	**Internal Control and Risk Management** The Committee will review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the Trust's principal objectives. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (including the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board. • The structures, processes and responsibilities for identifying and managing key risks facing the organisation, and controlling the same. This includes the underlying assurance processes. • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Annual Governance Statement and other relevant guidance. • Any significant audit adjustments and changes in accounting policies and practices. • The operational effectiveness of policies and procedures. • Systems and processes for ensuring effective compliance with health & safety legislation and Standards for Better Health. • Systems and processes for ensuring compliance with NHS Improvement, CQC and other relevant regulators. • Arrangements for ensuring compliance with Local Security Management Directions. • Arrangements for ensuring compliance with Emergency Planning Policy. • Arrangements for ensuring compliance with counter fraud standards and requirements. The Committee will receive the 15+ Risk Register and Board Assurance Framework at least 3 times a year to take assurance that the processes for managing risks are effective.
2.	**Internal Audit** The Committee will ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit, Risk & Assurance Committee, Chief Executive and Trust Board, by the: • Consideration of the provision of the internal audit service and associated costs, ensuring it has adequate resource and appropriate standing. • Review and approval of the internal audit plan, ensuring that there is consistency with the audit needs of the organisation as identified in the Assurance Framework and co-ordination with the work of external audit. • Consideration of the major findings of internal audit work and management responses and ensuring the co-ordination between internal and external audit to optimise use of audit resources. • Monitor and review of the effectiveness of the internal audit function.
3.	**External Audit** • The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process, including the review of the work, findings and management responses to the work. This will be achieved by: • Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external auditor. • Reporting to the Trust Board and the Council of Governors identifying any matters where action or improvement is needed and making recommendations for action. • Reviewing and monitoring ~~of~~ the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements. • Discussing and agreeing with external auditors before the audit commences, the nature and scope of the audit for the Annual Audit. This includes the evaluation of audit risk, assessment of the organisation and impact on the audit work and fee. • Approving the remuneration and terms of engagement of the external auditor, supplying information as necessary to support statutory function of the Board of Governors to appoint, or remove, the auditor. • Reviewing all external audit reports, including those charged with governance, before submission to the Board, together with the appropriateness of management responses. The Committee will: • Develop and agree with the Council of Governors, the criteria for the appointment, re-appointment and removal of the external auditors. • Make recommendations to the Council of Governors in relation to the above.

4.	**Financial Reporting** • Monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing any significant financial reporting judgements. • Ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to the completeness and accuracy of the information provided. • Review of the annual report and financial statements before submission to the Board focussing on - Wording in the annual governance statement and other disclosures relevant to these terms of reference - Changes in, and compliance with, accounting policies, practice and estimation techniques - Unadjusted mis-statement in the financial statements - Significant adjustments resulting from the audit - Letters of representation - Explanations for significant variances
5.	**Quality** • Monitor the integrity of quality statements and reporting relating to quality performance, reviewing any significant quality reporting judgements. • Review of all quality management systems.
6.	**Freedom to Speak Up** • Review annually the effectiveness of the arrangements by which staff may raise, in confidence, concerns about possible inappropriateness in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that there is proportionate and independent investigation and follow-up action.
7.	**Governance & Regulatory Frameworks** • Keep under review the systems and processes of governance, assurance and their operational effectiveness and impact for the Trust. • Oversight of systems, processes, controls and governance (compliance with Regulations, Single Oversight Framework, GIRFT & Model Hospital)
8.	**System Working, Managing Change & Transformation** • Oversight of system working, managing change and transformation, notably our role in the ~~Sustainability Transformation Programme (STP)~~ Integrated Care System (ICS), partnership working (Wiltshire Health & Care LLP), new projects and transformation schemes.
9.	The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
10.	The Committee is authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, provided that the financial implications of seeking outside advisers have been agreed by the Director of Finance and/or Chief Executive in accordance with the Scheme of Delegation.

Agendas
The content of the agenda will be agreed by the Chair of the Committee.

Standing Agenda Items
(List of items which shall normally appear on the agenda for this Committee unless otherwise agreed by the Chair)
The Audit, Risk and Assurance Committee will receive reports on activity under the following headings:

- Assurance, Risk / Information Governance
- External Auditor
- Internal Auditor
- Counter Fraud
- Governance & Regulatory Frameworks
- Managing Change & Transformation
- Operational Matters
- Allocated slots for internal auditor, external auditor and Trust Management

One meeting should include a discussion of the external audit letter between the External Auditors and the Non-Executive Directors.

A forward planner of agenda items shall be agreed by the Chair of the Committee at least annually.

Accountability / reporting requirements	
1.	This Committee is accountable to the Trust Board.
2.	Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee and others as necessary. Minutes of the meeting will be reported to the Board.
3.	The Chair of the Committee will submit ~~a written report~~ to the Board, in public session a written Chair's Report outlining the key issues discussed by the Committee ~~which it is considered should be drawn~~ and drawing to the attention of the Board ~~in public session~~ any issues that require disclosure to the Board, or require Executive action. The report should focus on the view taken by Non-Executive Directors~~'s view of the issues in terms of challenge and scrutiny.~~
~~4.~~	~~The Chair of the Committee shall draw to the attention of Trust Board (via the Chair of Committee's report) any issues that require disclosure to the Board, or require Executive action.~~ Duplication 3 above
5.	The Chair of the Committee shall draw to the Governors attention any high risk or criminal issue concerning the control or operation of the Trust which has not been adequately communicated to them by the Board Chairman or Chief Executive. Such issues would be those of a serious nature, such as any deliberate neglect or failure to act in the best interests of the Trust by the Board Chairman or Chief Executive. The Chairman or Chief Executive shall engage with the Chair of the Audit, Risk & Assurance Committee in such an event.
6.	The Chair of the Committee will report to the Council of Governors on the work of the Committee on an annual basis.
7.	The Committee will report to Trust Board annually on its work in support of the Annual Governance Statement, specifically commenting on: - - The fitness for purpose of the assurance framework - The completeness and "embeddedness" of risk management in the organisation - The integration of governance arrangements - The appropriateness of the evidence that shows the Trust is fulfilling regulatory requirements relating to its existence as a functioning business - The robustness of the processes behind the quality account The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
8.	The Committee will draw to the attention of the Executive Committee (and any other Committees as necessary) any issues which it believes requires that committee's consideration.
Membership Members – The membership will comprise at least 3 Non-Executive Directors excluding the Chairman of the Trust who shall not be a member, one of whom shall have recent relevant financial experience. One Member shall also be the Chair of the Quality & Governance Committee. Chair – The Trust Board will appoint the Chair of the Committee.	
Meeting requirements	
(a)	Quorum – The quorum for meetings of the Committee shall be 2 of the 3 non-executive members.
(b)	Voting – Only the Non-Executive Directors who are members of the Committee or in their absence their substitute may vote.
(d)	Substitutes/Deputies - Any Non-Executive Director of the Trust, excluding the Chairman, may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.
(e)	Invitees - Executive Directors will be invited to attend, especially when the Committee is discussing areas of risk or assurance relating to a Director's portfolio. Any member of Trust Board may attend meetings of the Committee. Other persons may be invited to attend with the specific invitation of the Chair of the Committee.
(f)	Compulsory Attendees – The Director of Finance (or in their absence their deputy and another Executive Director) is expected to attend regularly. The External and Internal Auditors shall normally attend as agreed by

	the Chair of the Committee. The Counter Fraud Specialist shall attend at least 2 meetings each year as agreed by the Chair of the Committee. The Chief Executive, as Accounting Officer, shall be invited to attend meetings and should discuss at least annually with the Committee, the process for assurance that supports the annual governance statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts. Other Executive Directors and Non-Voting Board Directors shall be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director.
(g)	Support – The work of this Committee will be supported by the Director of Finance who will normally attend and ensure appropriate attendance from other directors and officers.
(h)	Frequency of Meetings – The Committee will meet as a minimum five times per year with additional meetings being called where necessary.
(i)	Additional meetings – The External Auditor, the Head of Internal Audit and Counter Fraud Specialist have a right of direct access to the Chair. The Accounting Officer, external auditors, or Head of Internal Audit may request a meeting of the Committee if they consider that this is necessary. At least once each year the Committee will meet privately with the internal and external auditors.
(j)	Administration of Committee – The Secretariat shall provide appropriate administrative support, guidance and advice to the Chair and Committee members.
Lead contacts for this Committee Director of Finance ~~/ Director of Governance & Assurance~~	
Monitoring Effectiveness and review of Terms of Reference The Committee should consider its effectiveness and refresh its terms of reference annually.	

Great Western Hospitals NHS Foundation Trust

QUALITY & GOVERNANCE COMMITTEE TERMS OF REFERENCE 2020-21 2021-22

Appointed by Trust Board
Reports and accountable to the Trust Board
(Non-Statutory)

Overview
The Quality & Governance Committee (the Committee) is a formally constituted committee of the Board of Directors (Trust Board).
This is a non-statutory Committee.

Summary of purpose and objectives

To obtain assurance on behalf of the Board that the Trust has in place the necessary structures and processes for the effective direction and control of the organisation so that it can meet its objectives, in particular, the provision of safe high quality patient care and that it complies with all relevant legislation, regulations and guidance that may from time to time be in place.

To seek assurance on behalf of the Board that strategic risks linked to strategic pillar (1) "outstanding patient care and focus on quality improvement in all that we do", identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

Role and duties

1.	To ensure the Trust is at all times compliant with the terms of its Authorisation, Provider Licence and Registrations and with CQC Regulations and NHSI's Governance Framework.
2.	To ensure that the Trust's objective to deliver outstanding patient care and a focus on quality improvement in all that we do is embedded in the organisation and to promote a culture of open and honest reporting of any situation that may threaten the quality of patient care.
3.	To review the Quality Strategy and make recommendations to the Board.
4.	To agree the framework of the Quality Accounts to ensure they meet Regulators' requirements and best practice, to monitor performance against agreed indicators and to oversee the preparation of the Annual Quality Accounts for approval by the Board via the Audit, Risk and Assurance Committee.
5.	To ensure that processes are in place for the management of significant clinical and quality risks arising out of claims, complaints, incidents, serious incidents, never events and contract and compliance inspections and that any necessary changes or improvements to practice or procedures are implemented.
6.	To scrutinise trends in patient satisfaction and identify areas for improvement identified in National Patient Surveys, Trust Surveys and PALS reports and to review the actions taken.
7.	To investigate any risk identified and referred to it by the Audit, Risk and Assurance Committee arising from its reviews of the Trust's risk register and to report to the Audit, Risk and Assurance Committee any significant risks identified by the Committee itself.

Responsibility / delegated authority	
1.	To seek assurance of behalf of the Board that activities and services within the remit of the Committee are being effectively managed to include an overview of internal audit service reviews (linking in with the work of the Audit, Risk and Assurance Committee).
2.	To approve any policy or procedural document relating to any clinical, safeguarding or patient care matter where there is not a specific requirement for Board approval.
3.	To consider any strategy, policy or procedural document relating to any governance matter prior to formal ratification by the Board.
4.	On behalf of the Board to receive six monthly reports on Adult and Children's Safeguarding.
5.	On behalf of the Board to receive the Report of Hospital Based Programme Co-Ordinator (HBPC) for the Cervical Screening Programme at GWH.
6.	The Committee may carry out or request ad-hoc reviews of specific issues of concern.
7.	The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
8.	The Committee is authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, provided that the financial implications of seeking outside advisers have been agreed in accordance with the Scheme of Delegation.

Agendas

The content of the agenda will be determined by the Chair of the Committee.

Standing Agenda Items

(List of items which shall normally appear on the agenda for this Committee unless otherwise agreed by the Chair)

The Quality & Governance Committee will normally receive reports for each meeting as follows:-

- ~~Quality Report~~
- ~~Safer Staffing Report~~
- Intergrated Performance Report

The Committee will also consider as required: -

- Strategic risks aligned to the committee
- Quality Improvement Strategy Delivery
- ~~Corporate Governance Report~~
- Clinical Audit Plan
- Quality Account
- Medicines management / prescribing arrangements
- Medical records management
- ~~Powers Reserved to Board~~
- ~~Scheme of Delegation~~
- ~~Equality & Diversity Update~~
- Safeguarding Report
- Provider Licence Compliance
- Code of Governance Compliance
- Internal audit reviews
- Oversight of GIRFT
- Patient Experience and PALS
- Mortality Updates
- ED Quality Report
- Compliance with national maternity standards/reviews
- ICP annual report
- FTSU

- Guardian of safe working
- Clinical Governance Overview
-

Minutes / reports of the following will be presented to the Committee: -

- Patient Quality Committee
- Improvement Committee
- ~~Equality & Diversity Group~~

A forward planner of agenda items shall be determined by the Chair.

Accountability / reporting requirements	
1.	This Committee is accountable to the Trust Board.
2.	Minutes will be prepared after each meeting and circulated to members of the Committee and others as necessary. Minutes of the Committee will be reported to the Board.
3.	The Chair of the Committee will submit to the Board, in public session a written Chair's Report outlining the key issues discussed by the Committee and drawing to the attention of Trust Board any issues that require disclosure to the Board, or require Executive action. The report should focus on the view taken by Non-Executive Directors.
4.	The Chair of the Committee shall draw to the Audit, Risk and Assurance Committee's attention any concerns he/she has as a result of this committee's activities which may warrant formal review by the internal auditors or other professional review under the direction of the Audit, Risk & Assurance Committee.
5.	The Chair of the Committee will report to the Council of Governors on the work of the Committee.
Membership	
Members - The membership will comprise at least 3 Non-Executive Directors and 2 Executive Directors. Chair – The Trust Board will appoint the Chair of the Committee who shall be a Non-Executive Director. The Chair of this Committee shall also be a member of the Audit, Risk and Assurance Committee.	
Meeting requirements	
(a)	Quorum – The quorum for meetings of the Committee shall be 3 members (2 Non-Executive Directors and 1 Executive Director).
(b)	Voting – For voting purposes there must always be a majority of Non-Executive Directors.
(c)	Attendance – The ~~Director of Governance & Assurance~~ Company Secretary is expected to attend. The Chief Operating Officer should attend meetings of the Committee for any quality discussions. Any Non-Executive Director may attend. Associate Medical Directors are invited to attend meetings of the Committee.
(d)	Substitutes/Deputies - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum. Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.
(e)	Invitees – Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

	The Committee may call other officers of the Trust to attend as appropriate. No other party may attend without the specific invitation of the Chair of the Committee.
(f)	Support – The work of this Committee is be supported by the Chief Nurse and Medical Director ~~and the Director of Governance & Assurance.~~
(g)	Frequency of Meetings – The Committee will normally meet on a monthly basis with additional meetings being called where necessary. However, meetings that are not required will be cancelled.
(h)	Administration of Committee – The Secretariat shall provide appropriate administrative support, guidance and advice to the Chair and Committee members.
Lead contacts for this Meeting Chief Nurse & ~~Director of Governance & Assurance~~ Medical Director.	
Monitoring effectiveness and review of Terms of Reference The Committee should consider its effectiveness and refresh its terms of reference annually.	

FINANCE AND INVESTMENT COMMITTEE
TERMS OF REFERENCE
~~2020-21~~2021-22

Established by Trust Board
Reports and accountable to the Trust Board
(Non-Statutory)

Overview
The Finance and Investment Committee (the Committee) is a formally constituted Committee of the Board of Directors (Trust Board).
This is a non-statutory Committee.

Summary of purpose and objectives

To oversee the development, implementation and delivery of
- Long Term Financial Plan
- Sustainability and Transformation Plan
- Plans for changes in the financial regime
- Annual business planning / Divisional overviews

To oversee, scrutinise and review
- key financial plans (capital and revenue)
- capital and revenue business cases
- proposed business partnering arrangements
- transformation (CIPs)
- procurement
- pfi arrangements
- private patients income

To ensure that any material, long term financial or business risks identified are brought to the attention of Audit, Risk and Assurance Committee to ensure they are reflected within the Trust's Risk register and Risk management process and to advise the Audit, Risk and Assurance Committee on the adequacy of any mitigation planning and recommend any areas requiring Audit scrutiny.

To seek assurance on behalf of the Board that strategic risks linked to strategic pillar (4) "using our funding wisely to give us a stronger foundation to support sustainable improvement in quality of patient care", identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

Role, duties, responsibility and delegated authority

1.	**To oversee the development, implementation and delivery of the Trust's Strategy, Operational Plan, Sustainability and Transformation Plan, other plans and annual business planning with particular focus on key financial issues. Specifically:** • To consider and agree the Operational Plan) for Board approval, ensuring that the plan is consistent with the Trust's Five-Year Strategy. • To consider and agree the proposed Sustainability and Transformation Plan, for Board approval, ensuring as far as is possible that the plan is aligned with the Trust's Five-Year Strategy and Operational Plan. • To consider and agree for Board approval, the Trust's Business Plan, Directorate Plans and the Annual Plan. • To consider and advise the Board on the impact of any proposed business/marketing opportunities. • To performance manage the delivery of specified projects against project proposals.

2.	**To oversee, scrutinise and review the development and implementation of the key Financial and Operational Plan to meet statutory and regulatory obligations** • To provide assurance that the Trust, as a Foundation Trust, is financially solvent, including current and forecast compliance with financial covenants, and to meet statutory and regulatory obligations through oversight of strong financial management. • To ensure strong linkages exist between financial and service planning as identified in the Integrated Business Plan. • To ensure financial and operational planning is forward looking and that scenario planning is undertaken to fully understand the future financial risks. • To provide further analysis and challenge to the Trust's financial performance and decision-making. • To ensure responsive financial management achieves effectiveness and efficiency in the economic use of resources. • To provide challenge and in-depth scrutiny of Transformation (Cost Improvement Plans) and its implementation. • To provide assurance to the Board that the Trust is complying with best practice in terms of balance sheet management, principally around working capital and treasury management. • To review benchmarking information to challenge whether the Trust is ensuring best value in corporate and service areas. • To scrutinise the financial performance of the Trust.
3.	**To oversee the Trust plans for changes in the financial regime** • To account to the Board for the development of financial processes and reporting systems within the Trust. • To oversee the implementation of Service Line Reporting (and Service Line Management as appropriate) across the Trust. • To consider and advise the Board on the impact of changes to the financial regime such as Payment by Results and to monitor robust plans to manage the change. • To account to the Board regarding arrangements for the management of the procurement. To account to the Board regarding arrangements for the management of the pfi.
4.	**To scrutinise capital, revenue and operational business cases in accordance with the Scheme of Delegation** • To establish the overall methodology, processes and controls which govern investments, ensuring that robust processes are followed. • Evaluate, scrutinise and monitor investments. • To scrutinise preliminary business cases in accordance with the Trust Investment Policy and Scheme of Delegation. • To scrutinise detailed business cases in accordance with the Trust Investment Policy and Scheme of Delegation. • To review Outline Business Cases, and Full Business Cases prior to submission to the Board in line with financial limits within the Scheme of Delegation. • To ensure the financial impact of business cases on the overall financial position of the Trust is fully understood. • To undertake post implementation review of business cases.
5.	**To scrutinise proposed business partnering arrangements where there is a significant financial aspect indication** • To consider forms of delivering business partnering arrangements. • To provide assurance that Trust interests will be safeguarded from proposed partnering arrangements. • To review the legal, financial and risk implications of proposed partnering arrangements.
6.	To seek assurance on behalf of the Board that activities and services within the remit of the Committee are being effectively managed to include an overview of internal audit service reviews of financial controls and systems (linking in with the work of the Audit, Risk and Assurance Committee).
7.	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
8.	To review and approve any financial / procurement policies, procedures or other documents relating to its terms of reference.

Agendas
The content of the agenda will be determined by the Chair of the Committee.

Standing Agenda Items
(List of items which shall normally appear on the agenda for this Committee unless otherwise agreed by the Chair)
The Finance & Investment Committee will receive reports for each meeting covering:

- the financial position
- an overview of Transformation – Cost Improvement Programme
- the Sustainability and Transformation Plan (funding)
- presentations from Divisions

The Committee will also consider as required: -

- Strategic risks
- Pay bill management
- NHS Improvement submission
- Service Line Reporting
- Procurement
- Reference Costs
- Overseas visitors income
- Annual Plan
- Annual Accounts
- Scheme of Delegation
- Standing Financial Instructions (every 2 years)
- Service reviews

Minutes / reports of the following will be presented to the Committee: -

- Capital Planning Group Minutes

A forward planner of agenda items shall be determined by the Chair.

Accountability / reporting requirements

1.	This Committee is accountable to the Trust Board.
2.	Minutes will be prepared after each meeting of the Committee and circulated to members of the Committee and others as necessary. Minutes of the Committee will be reported to the Board.
3.	The Chair of the Committee will submit to the Board, in public session, a written Chair's Report outlining the key issues discussed by the Committee and drawing to the attention of the Trust Board any issues that require disclosure to the Board, or that require Executive action. The Non-Executive Director view should be the focus of the report.
4.	The Chair of the Committee shall draw to the Audit, Risk and Assurance Committee's attention any concerns he/she has as a result of this committee's activities which may warrant, under the direction of the Audit, Risk & Assurance Committee, formal review by the internal auditors or other professional review.
5.	The Chair of the Committee will report to the Council of Governors on the work of the Committee.

Membership
Members – The membership will comprise at least 3 Non-Executive Directors not including the Chairman of the Trust who shall not be a member and 2 Executive Directors who shall be the Chief Executive and the Director of Finance.

Chair – The Trust Board will appoint the Chair of the Committee who shall be a Non-Executive Director.

Meeting requirements	
(a)	Quorum – The quorum for meetings of the Committee shall be three members (2 Non-Executive Directors and 1 Executive Director).
(b)	Voting – For voting purposes there must always be a majority of Non-Executive Directors.
(c)	Attendance – The Deputy Director of Finance is expected to attend. Any Non-Executive Director may attend.
(d)	Substitutes/Deputies - Any Non-Executive Director of the Trust, (excluding the Chairman ~~and the Chair of the Audit, Risk and Assurance Committee~~), may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum. Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.
(e)	Invitees – Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee. The Committee may call other officers of the Trust to attend as appropriate. No other party may attend without the specific invitation of the Chair of the Committee.
(f)	Support – The work of this Committee will be supported by the Director of Finance.
(g)	Frequency of Meetings – The Committee will normally meet on a monthly basis with additional meetings being called where necessary. However, meetings that are not required will be cancelled.
(h)	Administration of Committee – The Secretariat shall provide appropriate administrative support, guidance and advice to the Chair and Committee members.
Lead contact for this Committee Director of Finance	
Monitoring effectiveness and review of Terms of Reference The Committee should consider its effectiveness and refresh its terms of reference annually.	

Great Western Hospitals NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE
~~2020-21~~ 2021-22

Established by Trust Board
Reports to and is accountable to the Trust Board
(Non-Statutory)

Overview

The Great Western Hospital NHS Foundation Trust Charitable Fund (Charity Registration Number 1050892) is governed by the Trust Deed which was approved by the Board on behalf of Great Western Hospitals NHS Foundation Trust (previously Swindon and Marlborough NHS Trust).

Under the terms of the deed the Charitable Fund is administered and managed by Great Western Hospitals NHS Foundation Trust, which is a Corporate Trustee.

The Trust Board have delegated operational responsibility to the Charitable Funds Committee for the overall management of the Charitable Funds.

This is a non-statutory Committee.

Summary of role

The purpose of this Committee is to oversee the management of Charitable Funds.
The Committee reports to the Trust Board.

Role, duties, responsibility and delegated authority

The Charitable Funds Committee are responsible for the overall management of the Charitable Funds. They are required:-

1.	To ensure that best practice is followed in terms of guidance from the Charity Commission, Audit Commission, National Audit Office, Department of Health and other relevant organisations.
2.	To ensure that the appropriate policies and procedures are in place to support the Charitable Funds Strategy and to advise Fund Managers on income and expenditure and that this is reviewed at regular intervals.
3.	To develop and review the Trust's Charitable Funds Strategy and Charitable Funds Committee terms of reference on an annual basis and agree changes where appropriate.
4.	To develop and review the Scheme of Delegation for charitable funds on a regular basis and recommend changes where appropriate.
5.	To ensure that a separate register of interests is compiled for both Board members and Fund Managers, and that this is reviewed and updated on a regular basis.
6.	To review and approve fundraising policies in conjunction with the Director of Finance, ensuring that statutory requirements are complied with.
7.	On an annual basis, to review and approve summary level income and expenditure plans from Fund Managers, ensuring that they complement the strategy.
8.	To ensure an effective mechanism exists whereby equipment needs are identified and satisfied (within resource constraints) through an equitable bidding process underpinned by business plans. (All equipment purchased by charitable funds will be recorded in a separate register.)

9.	To oversee the management of investments. Where an investment broker is used, the Committee will ensure the investment strategy has been appropriately communicated, the information required is specified and received in a timely manner, and that the service is market tested at regular intervals.
10.	To ensure that all research monies paid into charitable funds meet the criteria for charitable status as specified by the Charity Commission.
11.	To review the number of funds on an annual basis and undertake a programme of rationalisation, where appropriate.
12.	To approve any request to set up new funds and cost centres (Charitable Funds only).
13.	To decide the bases of apportionment for investment income and administration costs, respectively.
14.	To recommend to the Board any major fund raising appeals and plans, including any material changes to those plans already approved by the Board.
15.	To manage Charitable Funds.

Agendas
The content of the agenda will be determined by the Chair of the Committee.

Standing Agenda Items
(List of items which shall normally appear on the agenda for this Committee unless otherwise agreed by the Chair)
The Charitable Funds Committee will normally receive reports for each meeting as follows: -

- Fundraising Report
- Financial Report
- ~~CCLA Report (quarterly)~~

Accountability / reporting requirements

1.	The Charitable Funds Committee are accountable to the Board of Directors on behalf of the Corporate Trustee (The Trust). The Corporate Trustee is accountable to the Charity Commission for the proper use of the charitable funds and to the public as a beneficiary of those funds.
2.	Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee and others as necessary. Once the Committee has approved the full minutes, a copy will be available, for information, to the Board at its next meeting.
3.	The key issues of the Committee will be included in the Board of Directors agenda and papers as directed by the Chair of the Charitable Funds Committee and accepted by the Chairman of the Trust.
4.	The Chair of the Committee shall draw to the attention of Trust Board any issues that require disclosure to the full Board, or require Executive action.
5.	The Committee will report to the Trust Board on the matters of business it has carried out.

Membership
Members – The membership of the Committee will comprise at least 2 Non-Executive Directors and 1 Executive Director.

Chair - The Trust Board will appoint the Chair of the Committee who shall be a Non-Executive Director.

Meeting requirements	
(a)	Quorum – The quorum for meetings of the Committee shall be two members to include one Non-Executive Director and one Executive or Non-Voting Board Director.
(b)	Voting – For voting purposes there must be a majority of Non-Executive Directors.
(c)	Attendance – Members are invited to all meetings of the Committee but are expected to attend three quarters of meetings in any one financial year.
(d)	Substitutes/Deputies - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum. Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum. The Trust Chairman may attend meetings of the Committee (but not if specifically excluded by the Chair of the Committee), but may not chair meetings nor contribute to the quorum.
(e)	Advisors – External advisors may attend as necessary at the request of members to include any departments who have an interest in the current meeting, i.e. fundraising, finance, and any department submitting a case of need or external investment advisors.
(f)	Support – The work of the Committee will be supported by the ~~Director of Strategy & Community Services~~ Director of Improvement & Partnership who will ensure the attendance of other Executive Directors and officers as appropriate.
(g)	Frequency of Meetings – The Trustees shall normally meet at least four times per year and at such other times as the Trust shall require.
(h)	Administration of Committee – The Secretariat shall provide appropriate administrative support, guidance and advice to the Chair and Committee members.
Lead contact for this Committee Chief Executive	
Monitoring Effectiveness and review of Terms of Reference The Committee should consider its effectiveness and refresh its terms of reference annually.	

Great Western Hospitals NHS Foundation Trust

REMUNERATION COMMITTEE TERMS OF REFERENCE 2020-21 2021-22

Established by Trust Board
Reports and accountable to the Trust Board
(Statutory)

Overview
The Remuneration Committee (the Committee) is a formally constituted Committee of the Board of Directors (Trust Board).
This is a statutory Committee.

Summary of purpose and objectives

The Committee is required to put in place formal, rigorous and transparent procedure for the appointment of a new Chief Executive and other Executive Directors and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates

Role and duties, responsibilities and delegated authority

1.	To keep under review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.
2.	To consider and recommend to the Board plans for orderly succession for appointment to the Board and to senior management, so as to maintain an appropriate balance of skills and experience within the Trust and on the Board.
3.	~~To identify, select and appoint new Executive Directors as and when the need arises.~~ To approve the procedure and documentation for the appointment of Executive Directors and Chief Executive posts.
4.	~~To consider nominations from the Joint Nominations Committee on suitable candidates to fill the position of Chief Executive and thereafter the Remuneration Committee will identify and approve for appointment a candidate to fill the position of Chief Executive, subject to approval by the Council of Governors.~~ Additionally, for the appointment of the Chief Executive the Committee will keep the Council of Governors informed of progress of a campaign and report the appointment of the Chief Executive to the Council of Governors for approval.
5.	To consider and agree any matter relating to the continuation in office of any Board Executive Director including removal from office, suspension or termination of employment by the Trust.
6.	~~To develop a policy for the employment and remuneration of the Chief Executive and other Executive Directors including but not limited to salary, including variable pay, pension, and other allowances. The objective of such policy shall be to ensure that the Trust will be able to attract and retain individuals with the skills, qualifications and experience required by the Trust and to ensure that members of the executive management of the Trust are provided with appropriate incentives to encourage enhanced performance and are, fairly rewarded for their individual contributions to the success of the Trust.~~ The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract and retain Executive Directors.
7.	To set on an annual basis individual remuneration arrangements for the Chief Executive, other Executive Directors in accordance with policy and having regard to individual performance.
8.	To ensure that in the event of loss of office and/or termination of employment of the Chief Executive or any Executive Director the contractual terms and any payments made, are appropriate and consistent with all relevant Government guidelines.
9.	To monitor and evaluate the performance of individual Executive Directors.
10.	To engage the services of or take advice from any suitably qualified third party or advisers to assist with any

	aspects of its responsibilities provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Chief Executive.
11.	To provide a view to the Chief Executive / Director of Finance on interim appointments above £50k.

Standing Agenda Items

(List of items which shall normally appear on the agenda for this Committee unless otherwise agreed by the Chair)

The Remuneration Committee will normally receive reports for each meeting on the following: -

- Executive Director Remuneration (annually)
- Executive Director Performance (annually)
- Succession Planning (annually)

Accountability / reporting requirements

1.	This Committee is accountable to the Trust Board. The Chair of the Committee will provide a brief verbal summary after each meeting to the Board on the work of the Committee.
2.	Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee. Minutes will be retained by the Company Secretary.
3.	Minutes of meetings of this Committee will not be made available to Executive Directors, with the exception of the Chief Executive and Director of HR (on a need to know basis).
4.	The Committee shall make a statement in the annual report as required.

Membership

~~Members –~~ The membership will comprise all Non-Executive Directors including the Chair~~man~~ of the Trust.

The Chief Executive shall be a voting member of the Committee for the appointments or removal of Executive Directors only

In Attendance

The Chief Executive will normally attend meetings, withdrawing as appropriate when matters relating to their own performance and remuneration are discussed. ~~is also a member of the Committee with the exception of when the Committee is considering the Chief Executive Director appointment and remuneration (legal requirement that this should be a committee comprised on NEDs only). Note the Trust does not have a separate committee for Executive Director nominations.~~

The Director of HR will support the Committee with appropriate papers and proposals for consideration and be in attendance as and when appropriate and necessary.

Chair

~~–~~ The Committee will be chaired by the Senior Independent Director of the Trust. In the absence of the Chair of the Committee, the remaining members present shall elect one of their number to chair the meeting.

Administrative Support

~~– The work of the Committee will be supported by the Director of HR and the~~ The Company Secretary will provide ~~secretarial~~ administrative support to the Committee.~~.~~

Meeting requirements

(a)	Quorum – The quorum for meetings of the Committee shall be three members (3 Non-Executive Directors).
(b)	Attendance – Members should make every effort to attend all meetings of the Committee each year. Attendance will be reported in the Annual Report.
(c)	Substitutes / deputies – There is no provision for substitutes on this Committee.
(d)	Invitees - The Director of HR will attend meetings of the Committee and other Executive Directors of the Board may be invited to attend as appropriate and agreed by the Chair of the Committee.
(e)	External advisors - The Committee may invite external advisors to attend for all or part of any meeting.
(f)	Frequency of Meetings – The Committee will meet at least twice a year with additional meetings being called at

	such other times as may be required.
Lead contact for this Committee Senior Independent Director	
Monitoring Effectiveness and review of Terms of Reference The Committee should consider its effectiveness and refresh its terms of reference annually.	