GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Friday 13 January 2023, 9.30am to 1.00pm
By Teams

AGENDA

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

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome**	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public) (pages 1 – 10)** Liam Coleman, Chair • 3 November 2022	✓	LC	Approve	-
4.	**Outstanding actions of the Board (public) (page 11)**	✓	LC	Approve	-
5.	**Questions from the public to the Board relating to the work of the Trust**	-	-	-	
6.	**Care Reflections (Patient Story) – Daisy Unit (pages 12 – 13)** Tania Currie, Head of Patient Experience & Engagement, and Susan Price, Junior Sister, to present	Video	TC/SP	Note	9.40
7.	**Chair's Report (pages 14 – 16)** Liam Coleman, Chair	✓	LC	Note	10.10
8.	**Chief Executive's Report (17 – 22)** Kevin McNamara, Chief Executive	✓	KM	Note	10.20
9.	**Integrated Performance Report (pages 23 – 94)**			Assurance	10.40
	• Performance, Population & Place Committee Board Assurance Report (November & December) – Peter Hill, Non-Executive Director & Committee Chair	✓	PH		
	• Quality & Safety Committee Board Assurance Report (November & December) – Nick Bishop, Non-Executive Director & Committee Chair	✓	NLB		
	• Finance, Infrastructure & Digital Committee Board Assurance Report (November & December) – Faried Chopdat, Non-Executive Director & Committee Chair	✓	FC		
	• Integrated Performance Report	-	All		

10.	**Audit, Risk & Assurance Committee Board Assurance Report (pages 95 – 97)** Helen Spice, Non-Executive Director & Deputy Committee Chair	✓	EKA	Assurance	12.10
11.	**Charitable Funds Committee Board Assurance Report (pages 98 – 99)** Paul Lewis, Non-Executive Director & Deputy Committee Chair	✓	PL	Assurance	12.20
12.	**CNST Year 4 Submission – GWH Compliance Report (pages 100 – 106)** Lisa Cheek, Chief Nurse Lisa Marshall, Director of Midwifery & Neonatal Services, and Kat Simpson, Head of Midwifery & Neonatal Services, to present	✓	LG/LM	Approve	12.30
13.	**Safe Staffing 6 month review for Nursing and Midwifery (pages 107 – 125)** Lisa Cheek, Chief Nurse (received at Quality & Safety Committee on 22 December 2022)	✓	LCh	Assurance	12.40
	CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**				
14.	**Ratification of Decisions made via Board Circular/Board Workshop** Caroline Coles, Company Secretary	Verbal	CC	Note	12.50
15.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	Note	-
16.	**Date and Time of next meeting** Thursday 2nd February 2023 at 9.30am, venue to be confirmed (hybrid meeting)	Verbal	LC	Note	-
17.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	13.00

Board Meeting Timetable

2023											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar
		Workforce, Culture & EDI			Patient Voice			*To be confirmed*			*To be confirmed*

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLE TREE BY HILTON, SWINDON AND VIA MS TEAMS 3 NOVEMBER 2022 AT 9.30 AM

Present:

Voting Directors

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

In attendance

Rachel Almond (RA)	Matron for Clinical Operations & Patient Flow (agenda item 164/22 only)
Caroline Coles (CC)	Company Secretary
Luisa Goddard (LG)	Deputy Chief Nurse
Lisa Marshall (LM)	Director of Midwifery & Neonatal Services (agenda item 167/22 & 169/22)
Claudia Paoloni (CP)	Associate Non-Executive Director

Apologies

Lisa Cheek	Chief Nurse
Naginder Dhanoa	Chief Digital Officer
Peter Hill	Non-Executive Director

Number of members of the Public: 3 members of public* (included 3 Governors: Pauline Cooke, Chris Shepherd and Mufid Sukkar)

*Indicates those members attending virtually by MS Teams.

Matters Open to the Public and Press

Minute	Description	Action
159/22	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public and in particular Luisa Goddard, Deputy Chief Nurse who was representing Lisa Cheek, Chief Nurse in her absence. It was also noted that both the Chair (in part) and Chief Executive would be absence from the private session of Board due to a visit from the Shadow Health Minister to the Trust. Apologies were received as above.	
160/22	**Declarations of Interest** There were no declarations of interest.	

Minute	Description	Action

161/22 **Minutes**

The minutes of the meeting of the Board held on 6 October 2022 were adopted and signed as a correct record with the following amendments:-

132/22 : Care Reflection – Add to last paragraph "*Claudia Paoloni, Associate Non-Executive Director, also stated that there was a need to understand why some clinics started late or overran which could also affect the patient experience. Chris Bumford responded that the reason for this was not always clear, however all patients booked into clinics would still be seen."*

137/22 : Audit, Risk & Assurance Board Report : Workforce and Finance Management – Add to the end of the paragraph "….*and People & Culture Committee with each defining which aspects to focus on to ensure no overlap*".

162/22 **Outstanding actions of the Board (public)**

The Board received and considered the outstanding action list and the following noted:-

135/22: Freedom to Speak Up (FTSU) Annual Report – Following a question from Nick Bishop, Non-Executive Director and Chair of the Quality & Safety Committee it was confirmed that 2 days per week had been secured for a FTSU Lead Guardian which would include uploading data to the national portal.

135/22 : Integrated Performance Report (IPR) – It was noted that benchmarking was only one element of the feedback into the new IPR which linked to the new Improving Together process and was an iterative process to the final version.

163/22 **Questions from the public to the Board relating to the work of the Trust**

The Board received a verbal update on one question received since the publication of the papers. This was in connection with the impact on appointment letters due to the postal strike. The Chief Operating Officer responded that there were a number of ways that the Trust contacted patients and the postal strike would only marginally impact the notification period of 'routine appointments'.

The Board **noted** the questions.

164/22 **Care Reflections – Staff Story**

Rachel Almond, Matron for Clinical Operations and Patient Flow joined the meeting for this agenda item.

The Board received a reflection of care that highlighted Rachel's progression and journey from Ward Manager to Clinical Site Manager to Matron for Clinical Operations and Patient Flow. Rachel described her current role and responsibilities as a Clinical Site Manager and Flow Matron, a role that leads and coordinates capacity which supports effective clinical flow.

There followed a discussion that included wellbeing, the challenges and the unique insight of this role particularly for cross site learning.

The Chair thanked Rachel for sharing her story and the invaluable insight into a key area of the Trust.

The Board **noted** the care reflection.

Minute	Description	Action

165/22 **Chair's Report**

The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally. The following was noted:-

Council of Governors : The Trust welcomed two new governors: Mufid Sukkar representing Wiltshire Northern Constituency and Caryl Sydney-Smith as representative for Swindon Borough Council.

Public Health Talks - A public health talk, hosted by the governors, was held on 1 November 2022 on Health Inequalities by Claire Thompson, Chief Officer of Improvement & Partnerships.

Strengthening Board Oversight Safety Visits - There was one Board safety visit during the period covered by this report on 12 October 2022 in ICU by Simon Wade, Chief Financial Officer and Lizzie Abderrahim, Non-Executive Director.

In addition, the Chair also briefed verbally on the following:-

Non-Executive Directors – Sanjeen Payne-Kumar, Associate Non-Executive Director had resigned due to other work commitments. The Chair, on behalf of the Board, thanked Sanjeen for his time and commitment and wished him well for the future. It was noted that in anticipation of a number of departures in the near future the Trust had entered into advert for the recruitment of Non-Executive Directors and an Associate Non-Executive Director. The Trust had decided on a different approach and were not using a head-hunter but utilising a variety of other portals which included the use of networks and encouraged those present to spread the word.

Peter Hill, Non-Executive Director asked if there were any other candidates from the last recruitment round to follow up and whether there were any unique skills required. The Chair replied that there were no follow up candidates, and the 3 key skills and experience were digital, clinical background and generalist NHS knowledge.

Lizzie Abderrahim, Non-Executive Director supported the use of networking however cautioned that members of the Board had very similar backgrounds and therefore the portals used would be similar and asked how the wider diversity question would be addressed. The Chair confirmed that the Trust were committed to improving inclusivity into the recruitment process to help increase diversity into the Board membership and had learnt lessons from the last recruitment process.

Meetings - In addition to those meetings outlined in the report, it was noted that the first meeting of the BSW Integrated Care Partnership (ICP) had been held which was chaired by Wiltshire Council.

The Board **noted** the report.

166/22 **Chief Executive's Report**

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

Maternity – East Kent Report – The East Kent Report 'Reading the Signals', an independent investigation into maternity and neonatal services in East Kent Hospitals NHS FT, was published on 19 October 2022. This would also be covered in an agenda

Minute	Description	Action

item later in the meeting however wanted to highlight a key message on culture and behaviour and that the Trust would take an in-depth review at what lessons could be learnt from the East Kent Report not just for our maternity services but for the Trust as a whole.

Faried Chopdat, Non-Executive Director asked what mechanisms were in place to ensure that this sort of behaviour was not taking place in other parts of the Trust. The Chief Executive responded that positive progress had taken place in maternity and the next step was to reflect how to take the OD part across the whole organisation. The Chief People Officer added that there were several mechanisms in place which included Freedom to Speak Up, staff networks and areas of concern highlighted at Divisional Executive Reviews. The Trust would also use the Improving Together methodology to identify any missing countermeasures.

Covid Position – There had been a decline in covid patients however there were further waves anticipated this winter with the added risk of a wave of flu.

Vaccination Programme – The current position on staff take up of the vaccination programme was reported as 52% for covid and 55% flu. The challenge was increasing the public uptake and the BSW were working together to improve this rate.

Current Pressures – The Trust's Winter Plan was in place to help manage demand which included working closely with partners in recognition that the whole health and social care system was stretched. The challenge continued to be on improving flow and a number of actions had taken place which included looking at the North Bristol Trust model to identify areas that could safely be adopted within the Trust, as well as the previously mentioned, Swindon Integrated Care Alliance Coordination Centre. The Quality & Safety Committee would be kept up to date on any changes and would monitor progress. A further risk that could impact on flow was the Local Authorities financial position and although there was no detail as to the full implications this would be picked up through the risk management and planning round processes.

NHS England had also written to Trusts and System Leaders setting out further preparations for winter and a gap analysis would be undertaken and scrutinised through the Performance, Population and Place Committee. FTD

Action : Chief Operating Officer

Claudia Paoloni, Associate Non-Executive Director asked if the ambulance service was involved in managing demand within the ICS response. The Chief Operating Officer replied that the Southwest Ambulance Services were involved and engaged at both local and system level.

Primary Care – The Trust had requested the ICS to expediate the procurement process due to staff sickness. The timescale for transition was 9 January 2023 and a preferred bidder had been identified, who was offering mutual aid support to manage the risk of staff absence.

Andy Copestake, Non-Executive Director asked if the primary care indemnity came to an end this month. The Chief Financial Officer confirmed this was correct and provisions had been made to cover the financial gap.

Power Supplies – The Trust had responded positively to a national return for assurance on power supplies. The Trust had replaced its generator recently due to a black out a

Minute	Description	Action

few years ago. Full oversight and monitoring in this area was undertaken at the Finance, Infrastructure & Digital Committee.

Claudia Paoloni, Associate Non-Executive Director asked if there was a power failure were torches and other practical tools available. The Chief Executive confirmed that they were and this was all covered in learning from real incidents and oversight was through the Board committees.

Lizzie Abderrahim, Non-Executive Director highlighted the event which celebrated Black History month and wished to thank all those involved for such a successful and inspirational event.

The Board noted the report.

167/22 **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 Aug/Sept 2022.

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) around the IPR at its meeting on 26 October 2022 and the following highlighted:-

Cancer Performance – The RAG rating had moved to red/red due to a further deterioration in performance with no discernible improvement expected. The service was being supported by the Trust's improvement planning process.

Emergency Access - The Emergency Department / Urgent Treatment Centre performed relatively well against 4-hour target (74%) compared to other trusts and national average. However, the average waiting time now exceeded 8 hours. Ambulance handover waits continued to be a concern, and specific improvement work was planned with the ambulance service week beginning 12 December 2022. Non-Criteria to Reside (NCTR) patients (i.e those who do not need to be in hospital) remained very high.

Elective Access – Referral to Treatment Time (RTT) - The Trust continued to have no patients waiting in excess of 104 weeks (1 of only 4 trusts in the southwest). There had been continued improvement in the reduction of 78-week waiters, with a forecast of achieving zero waiters by February/March 2023, although dermatology and neurology remained a significant challenge as did the number of 52-week waiters.

The Board received and considered the Operational element of the report and the Chief Operating Officer highlighted the following:-

Cancer Performance – The Trust overall were nationally in a slightly better position in October 2022 except for the skin and plastics pathway which was provided by Oxford University Hospitals who were experiencing capacity issues. Mitigating actions were in place seeking mutual aid from a number of partner providers as well as support from Southwest and Thames Valley Cancer Alliances. The Performance, Population and Place Committee were fully sighted on the issue.

Minute **Description** **Action**

Claudia Paoloni, Associate Non-Executive Director commented that day cases were not reliant on beds and asked if day case surgery was being fully optimised. The Chief of Improvement & Partnerships responded that although good progress had been made in the theatres improvement programme this was still an area to optimise opportunities and was a focus at the Performance, Population & Place Committee.

Our Care

Lisa Marshall, Director of Midwifery & Neonatal Services attended for this agenda item.

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (Q&SC) around the quality element of the IPR at the meeting held on 20 October 2022 and the following highlighted:-

Pillar Metrics - The two pillar metrics for this Committee were 'Total Harms' and 'Friends and Family Test (FFT) Positive Responses'. The overall score for Total Harms included the Breakthrough Objective of Pressure Harms plus Watch Metrics of Falls, Hospital Acquired Infections, Medication Incidents, Serious Incidents and Never Events.

Breakthrough Objectives : Pressure Ulcers Harms - The total number of pressure harms reduced slightly in both Acute and Community, but numbers remained higher than September 2021. Work continued under 'Improving Together' to reduce these numbers.

Non-Alerting Watch Metrics : Hospital Acquired Infections - Hospital acquired Covid infection increased significantly in September 2022 in line with the national trend. Imminent installation of air filtration units on wards and units at highest risk, should reduce this. The Trust remained below trajectory for C.diff, MRSA and Pseudomonas and in line for Klebsiella. E.coli and MSSA rates remained a concern and further work was underway to address this.

Maternity - A recent visit from the NHS Insight Team found no safety issues and reported a dedicated and proud staff with a culture of openness.

Emergency Department Dashboard - The RAG rating for risk was red due to increase in attendance and resultant drop in triage times reflecting high pressure. The SHINE checklist had remained mainly green however some numbers had fallen in part due to new scores in relation to ambulance delays.

CQC Preparedness - There had been further progress. Robust plans were in place to address the Safeguarding Children Level 3 Training which remained below target.

The Board received and considered the quality element of the report and the Deputy Chief Nurse and Chief Medical Officer highlighted the following:-

- The high numbers of hospital acquired covid infections had been reducing and the Trust were managing outbreaks well. Good progress had been made with the installation of air scrubbers and additional capital funding had been allocated for further areas.
- Safeguarding Level 2 training process had been mapped out and improvements made at all stages with trajectory targets and additional space allocated for training.
- Complaint responses flagged this month due to a number of factors, however this figure had significantly improved since this report due to process improvements.

Minute **Description** **Action**

Nick Bishop, Non-Executive Director asked if there was a revenue stream to replace the air scrubber filters. The Chief Financial Officer confirmed that revenue had been allocated to replace filters.

Andy Copestake, Non-Executive Director asked if there had been any reported never events. The Deputy Chief Nurse replied that there had been none reported in recent months.

The Board received and considered the maternity element of the report and the Director of Midwifery & Neonatal Services highlighted the following:-

Continuity of Care Performance – Recognising the continued workforce challenges faced in maternity services an NHS England letter received in September 2022 removed all target dates for the implementation of midwifery continuity of care. Following a risk assessment, the Trust continued with 1 team instead of 2 however as a result the service would not achieve the target of 75% as stated in the Core20PLUS5, however it was noted that the Trust were performing better than partners in the Acute Hospital Alliance (AHA) in relation to minority/ethnic population.

CNST Performance – The current position was that the Trust were on track for full compliance however was dependent on the final criteria for submission in January 2023 which had not been published yet.

Use of Resource
Finance, Infrastructure & Digital Committee Overview
The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee around the Use of Resource element of the IPR at the meeting held 24 October 2022 and the following was highlighted:-

Risk Management Process – The Committee were assured that the risk management process and reporting risks for Finance, Infrastructure and Digital were adequate and effective. However, greater emphasis and direction were required in identifying mitigating actions and ensuring ownership of the risk mitigation activities.

BSW Consolidate Report - The Committee received an update on the overall financial position of the BSW ICB at Month 5, including key risks, mitigations, and delivery of efficiencies.

Mth 6 Position – A red risk rating due to run rate, efficiencies shortfall and capital slippage.

Improvement and Efficiency Plan – Update - The CIP target was 64% achieved at month 6 with £0.8m efficiency delivered against existing schemes rather than determining new schemes. The limited increase in identified savings from the previous month constituted a significant risk to our financial plan.

Financial Planning Process – The Committee were assured that a proactive and comprehensive approach across the organisation was in place.

Business Case – Additional Theatre Sessions - The Committee considered the Theatre Capacity Proposal and agreed to a phased investment approach: Phase 1: Agency and Locum staffing uplift; Phase 2: Engagement of Substantive workforce; and Phase 3: Full

Minute **Description** **Action**

establishment to optimise Theatre Capacity. This investment supported mutual aid for the broader system and the reinvigoration of private practice services, which was forecasted to improve the income stream for the Trust. The Committee would monitor each phase and update the Board.

Shared EPR Programme Update - The EPR programme was tracking to plan. A key risk noted was that pre-implementation activities were delayed due to a lack of resources.

Consult Connect – Lessons Learnt - The Committee received a paper on lessons learnt from the consult connect procurement legal challenge. Actions had been taken to address the issues to strengthen the existing process.

Lizzie Abderrahim, Non-Executive Director asked if there were any conclusions on the Trust's approach in the Consult Connect procurement. The Chief Executive responded that this was not solely a trust issue but was a much wider one on how commissioning was conducted at that time. Helen Spice, Chair of Audit, Risk and Assurance Committee added that in terms of the conflicts of interest element this was unusual in that in this case it was not financial and more a disclosure of knowing the company.

Our People
People & Culture Committee Chair Overview
The Board received an overview of the detailed discussions held at People & Culture Committee around the workforce element of the IPR at the meeting held 25 October 2022 and the following was highlighted:-

- Assurance ratings remained unchanged to the previous report.
- There was one red assurance around workforce planning due to industrial action and the Committee had been assured that robust actions were in place.
- A detailed review had been undertaken of progress against the People Strategy. At the next meeting the Committee would complete a RAG rating on progress made.

The Board received and considered the Workforce performance element of the report and the Chief People Officer highlighted that initial response rate to the staff survey had been encouraging at 46% and a focus area would be around improvement in time to hire.

Helen Spice, Non-Executive Director commented that both the statistics around sickness absence and medical vacancies had improved and wished to recognise this positive move and thank the staff for their efforts.

It was noted that a health & wellbeing dashboard had been requested to inform CQC preparedness.

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

168/22 **Mental Health Governance Committee Board Assurance Report**
The Board received an overview of the detailed discussions held at the Mental Health Governance Committee (MHGC) meeting on 21 October 2022 and the following highlighted:-

- An audit had been conducted in A&E and the findings reflected the ongoing challenges presented by the lack of acute mental health beds and the recruitment challenges experienced within the Mental Health Liaison Team (MHLT). In these

Minute	Description	Action

circumstances the risk rating remained at red. However, the Committee was assured by the collaborative work being done with AWP and BSW to mitigate the risks, in particular the work that had been done in response to the audit.

- The committee had the opportunity to provide feedback on AWPs draft Mental Health Strategy and heard from the AWP CEO about how the draft had been developed and what the next steps were.

  The Chief Officer of Improvement & Partnerships added that the AWP's draft Mental Health Strategy had been circulated to all Board members for comment.

- The above audit did not include children services but would have had a similar result although a bigger challenge. The Trust were working closely with CAMHS and had put in a range of measures to manage this risk and work had begun on a joint action plan to address the challenges.

  There followed a discussion around the impact on staff wellbeing in these circumstances and the support provided which included over 25 mental health first aiders.

  The Chair added that the Trust had raised these issues at the ICP meetings and the next meeting would be developing the ICP strategy at which the Chief Officer of Improvement & Partnerships and Chief Nurse would be present to further influence this priority.

  The Board **noted** the report.

169/22 **Ockenden Report – GWH Update**

Lisa Marshall, Director of Midwifery & Neonatal Services attended for this agenda item.

The Board received and considered a paper which provided an update on the progress on the Immediate and Essential Actions (I&EA) in the full Ockenden Report together with a brief overview of the newly released East Kent Report and subsequent recommendations.

It was noted that the Trust had received a Regional Insight visit on 17 October 2022 and received a positive assurance of local implementation and embedding of the 7 Ockenden recommendations with some further recommended improvements.

The key recommendations from the East Kent Report were highlighted particularly of note was for the requirement for trusts to review their approach to reputation management and to ensure there was proper representation of maternity care on Boards.

There followed a discussion on the appropriate level of oversight and assurance at Board level and whether further reporting or data was required. It was also recognised that other forms of assurance were gained from visits and staff forums where there was opportunity to ask staff directly. The Executive Team were tasked to reflect on what visibility was required in this space.

Action : Chief Nurse LC

The Board **noted** the report.

Minute	Description	Action

Consent Items

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

170/22 **Ratification of Decisions made via Board Circular/Board Workshop**
None.

171/22 **Urgent Public Business (if any)**
None.

172/22 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 13 January 2023 at 9.30 am, venue to be confirmed.

173/22 **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.

Great Western Hospitals NHS Foundation Trust

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – January 2023				
PPPC - Performance, Population and Place Committee, PCC – People & Culture Committee, QSC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
03-Nov-22	169/22	**Ockenden Report : GWH Update** A review on reporting and data required at Board level	Chief Nurse	The Director of Midwifery & Neonatal Services and Chief Nurse would determine the appropriate level of reporting to Board.
03-Nov-22	166/22	**Chief Executive's Report : Current Pressures** A gap analysis to be undertaken against the NHS letter setting out further preparations for winter.	Chief Operating Officer	For Performance, Population & Place Committee

Future Actions				
None				

NHS
Great Western Hospitals
NHS Foundation Trust

Report Title	**Care Reflection (Patient Story)**				
Meeting	**Trust Board**				
Date	**13 January 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek – Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement				
Appendices	Film				

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

Assurance Level							
Assurance in respect of: process/outcome/other (please detail):							
Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

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

The film demonstrates positive feedback received from a patient and how the staff have reflected on this feedback in order to share the learning and approach.

Report

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

The film recounts the experience of one patient, Alan, who was cared for in the Daisy unit. Alan approached us asking to provide feedback and wanted to share his story as a thank you to the staff.

Alan shares his experience and explains why his stay on the unit was so positive. He specifically mentions individual members of staff for the way in which they cared for him and how this positively affected his experience.

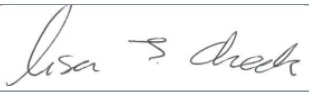
We then asked the staff how the feedback had made them feel, how they had reflected on this and how they can share their approach with colleagues in order to widen the learning and foster the same approach within the team.

The film has been shared at departmental and divisional meetings and is available on the trust intranet for all staff to access.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	NA				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The Care Reflection has been shared widely with staff and is available on the trust intranet				

	for future learning Care Reflection Films & Messages
Next Steps	

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ To receive the film as evidence of positive patient experience and staff reflection	
Accountable Lead Signature	
Date	19 December 2023

Link to Care Reflection film: -

https://youtu.be/7cizzU34yhI

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**13 January 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Process							
Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally.

The report provides information in respect of:-

- Council of Governors
- Non-Executive Directors
- Strengthening Board Oversight
- Local Update
- Key Meeting Dates.

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	21 December 2022

Chair's Board Report

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally during November and December 2022.

Council of Governors

Council of Governors meeting – A Council of Governors meeting was held on 8 November 2022 when the governors received presentations on both Business Planning and Equality, Diversity & Inclusion Annual Report. There was also an update on the process to appoint the External Audit service, together with confirmation on the appointment of the Lead Governor role. Congratulations were extended to Chris Callow for successfully being appointed to the Lead Governor role and thank you to Pauline Cooke for undertaking this role for the past 2 years. It was a constructive and informative meeting with the Trust sharing key updates and the governors seeking assurance on current challenges and risks.

My thanks to governors who attended, Non-Executive Directors who provided important briefings and Executives and Senior Managers who shared key updates and were available to answer any questions.

Elections **–** The elections for staff governor representing Administration, Auxiliary & Volunteers concluded in December 2022 and congratulations goes to Chris Shepperd for being re-appointed.

We also welcome a new appointed governors Jane Davis from Wiltshire County Council. Our thanks go to both Nick Holder the former Wiltshire County Council representative for his support and commitment during his time in this role.

Induction **-** A governor induction facilitated by GovernWell for our new governors as well as a refresher for our existing governors took place on 6 January 2023.

Non-Executive Directors

Non-Executive Director Recruitment - The recruitment process for 2 NEDs and 1 ANED is well underway with interviews taking place in January/February 2023.

Strengthening Board Oversight

Board Seminar - A Board Seminar session was held in December 2022 and the focus was on Financial Sustainability and the outcomes would inform the development of a Finance Strategy.

Safety Visits - There were 2 Board safety visits during the period covered by this report as follows:-

Date	Area	Board Member
9 November 2022	SDEC	Claudia Paoloni, Associate NED and Felicity Taylor-Drewe, Chief Operating Officer
8 December 2022	Emergency Department	Lizzie Abderrahim, NED and Lisa Cheek, Chief Nurse

Key Meetings during December 2022

Meetings	Purpose
Monthly Chair/ Lead Governors Meeting	Regular meeting to update and discuss any topical issues.
Bi-monthly NED meeting	Regular meeting to update and discuss any topical issues.
Bi-monthly meeting with Chair/Deputy Chair/ Senior Independent Director	Regular meeting to update and discuss any topical issues.
Chairs ICS Health Meeting	Regular meeting bringing together healthcare providers within the BSW ICS.
1-2-1 meeting with Chief Executive	Regular meeting.
Remuneration Committee	To review the Executive Directors annual appraisal process
EPR Update	Monthly update meeting
Chair and Chief Executive meeting with ICP Chair	To connect
Council of Governors	Quarterly meeting
Wiltshire Health & Care Board	Quarterly meeting of the WHC Members Board
Shadowing day	Shadowing an ED Consultant in the Emergency Department
Meeting with RUH Bath Chief Executive	To discuss the AHA Programme 2023-24
Acute Hospital Alliance Committee in Common meetings and Away Day	Three organisations working together on equity, sustainability and improvement
Strategic Exchange between BSW ICS Chairs, Chief Executives and Non-Executive Directors	Setting the context for BSW ICB e.g. winter plans
BSW Integrated Care Strategy Stakeholder Engagement Event	Engage and involve key stakeholders with BSW Together Partnership with emerging themes and priorities within our Integrated Care Strategy

Report Title	**Chief Executive's Report**				
Meeting	**Trust Board**				
Date	13 January 2023	**Part 1 (Public) [Added after submission]**	**X**	**Part 2 (Private) [Added after submission]**	
Accountable Lead	Chief Executive Officer				
Report Author	Kevin McNamara, Chief Executive Officer				
Appendices	N/A				

Purpose

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

Assurance Level

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

Board members are asked to note the report.

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

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

The Chief Executive's report provides an overview of a broad range of current issues at the Trust themed around operations, quality, systems and strategy, and workforce, wellbeing and recognition.

Report

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

This report includes updates on:

- Current pressures, including an internal critical incident being declared
- Industrial action affecting the Trust
- An update on our Primary Care Network
- New guidance from NHS England on priorities for 2023/24
- The 20th anniversary of Great Western Hospital.

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

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	X		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	X		
The report includes an update on our internationally educated nurses, and a celebration of the contribution this group of staff makes to our Trust.			

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Note the report**	
Accountable Lead Signature	K. McNamara.
Date	5.1.23

1. Operational updates

1.1. Current pressures

We declared an internal critical incident on 30 December and again on 3 January, due to all areas of the hospital being at full capacity with patients waiting for a long time in the Emergency Department, Urgent Treatment Centre, and in queuing ambulances.

Declaring a critical incident is a reflection that we have reached our maximum operational capacity and need to take extraordinary measures to help manage the high numbers of patients we are seeing combined with a high level of acuity of patients.

Unfortunately, some planned activity had to be cancelled so more clinical staff were able to focus on assessing and caring for patients.

Operational teams worked hard to focus efforts on discharging patients, and we worked with local authorities and other partners to support with discharges home or to care providers as quickly as possible.

Similar pressures were experienced in other parts of BSW and across the South West, and South West Ambulance Service also declared a critical incident due to severe pressure.

The whole system remains extremely challenged in to January with continued issues with ambulance handover delays and high numbers of patients with no criteria to reside in hospital, of which we are regularly caring for up to 100 patients.

We have seen an increase in numbers of patients with Covid and Flu, and high numbers of paediatric attendances to urgent and emergency care.

Public messaging has focussed on signposting people to NHS 111 online, local children's clinics, and local prescribing pharmacies.

Given the pressures being felt across the NHS, it's clear that we are likely to meet the criteria for a critical incident on more occasions over the coming months.

A fuller update will be provided at the meeting.

1.2. Industrial Action

The Royal College of Nursing (RCN) held strikes on 15 and 20 December.

Ahead of these dates we asked patients to continue to attend all appointments unless advised otherwise.

Considerable planning went in to mitigating the impact of the strike and we were grateful that many staff gave us notice that they intended to strike, which helped with our preparation.

Working closely with the RCN enabled us to provide safe levels of staffing, and where we were not able to provide safe staffing, we cancelled activity.

On strike days all urgent and emergency care, maternity services and some cancer services remained operational. Other essential services were derogated, meaning they continued to run as normal.

On 15 December, around 130 staff were on strike and we cancelled 33 outpatient appointments and 24 operations.

On 20 December, around 120 staff were on strike, and we cancelled 29 outpatient appointments and 24 operations.

The RCN has announced two further days of industrial action, on 18 and 19 January, although these dates will not affect our hospital or the RUH. SFT will be affected on these dates.

SWASFT staff were on strike on 21 December, and we are planning for the impact of further action by ambulance workers on 11 January.

A number of other unions have balloted, or plan to ballot their members, on industrial action.

The Royal College of Midwives announced last month that the threshold for taking strike action had not been met.

The Chartered Society of Physiotherapy announced last month that while the threshold for taking strike action had not been met, the threshold for taking action short of a strike had been met.

The British Medical Association are balloting its junior doctor members this month on taking strike action and the results are expected at the end of February.

2. Quality

2.1. Primary Care Network

The transfer of our GP practices to a new provider to take them through the next stage of their improvement journey will take place on 9 January.

This follows approval by the Integrated Care Board's Primary Care Commissioning Committee to approve the bid by partners of Victoria Cross Surgery, Westrop Medical Practice and North Swindon Practice to run the services.

A full consultation has taken place with staff who will transfer to the new providers.

2.2. Emergency care pathway

A new entrance is now in place for all patients arriving at the Great Western Hospital for urgent or emergency care as a walk-in.

All patients must now enter through the Urgent Treatment Centre, where they will be triaged at the door by a Clinical Navigator who will signpost them to the Emergency Department, Urgent Treatment Centre, or an assessment unit.

This means patients will be seen in the clinical area best suited to their needs and can easily be moved around if their condition worsens.

Any patient who is arriving at the hospital in an ambulance will be taken straight to the Emergency Department via the current ambulance route at the back of the hospital.

3. Systems and Strategy

3.1. NHS England guidance

On 23 December, NHS England published the 2023/24 priorities and operational planning guidance.

This sets out the priorities for the next financial year including recovering core services, improving productivity and renewing focus on delivering the long-term plan.

The guidance recognises that 2023/24 will be a challenging year for the NHS with ongoing Covid pressures, rising demand and capacity issues.

It sets out actions to increase capacity and improve patient flow to ease pressures in urgent and emergency care.

It also sets out ambitions to improve access to mental health services, tackling health inequalities and improving care for people with a learning disability and/or autism.

NHSE also published its guidance for integrated care boards (ICBs) and their partner trusts and foundation trusts on the development of five-year joint forward plans (JFPs).

This guidance covers specific statutory requirements that the plans must meet, such as setting out how an ICB and its partner trusts will meet the health needs of its population. It also sets out how JFPs should be produced, including conducting consultations, involving health and wellbeing boards, and the role of NHSE.

NHSE has set out three principles describing the nature and function of the JFP: alignment with the wider system partnership's ambitions; addressing local strategies and priorities as well as the wider NHS commitments; and being delivery-focused, including specific objectives, trajectories and milestones.

ICBs and their partner trusts have a duty to prepare a first JFP before the beginning of 2023/24. However for this first year of the process, NHSE has said it expects systems to produce a version by 31 March, but consultation on further versions can continue beyond that date, in time for a final plan by 30 June.

3.2. Visit of NHS England Regional Director

We were pleased to welcome NHS England Regional Director Elizabeth O'Mahoney to the Trust in November.

We discussed with her our current challenges, opportunities and successes including PeriPREM, Improving Together, our site developments, coordination centre, and community services.

4. Workforce, wellbeing, and recognition

4.1. Staff Survey

The national staff survey closed in late November and we achieved a 59% response rate – 12% more than the previous year, and 16% higher than the response rate for other trusts using the same staff survey provider.

The large number of responses means that we will have a much better understanding of how our staff feel about working for the Trust, and will enable us to make improvements.

The results of the survey will be published in March.

4.2. STAR of the Month

Our latest STAR of the Month is Nicola Daisley, Paediatric Diabetes Nurse Specialist. Nicola was recognised for having gone above and beyond for a young patient with a complex social background, going out of her way to ensure the patient's medical needs were met, even buying a cake and present so she could celebrate her birthday with her family.

4.3. Internationally Educated Nurses Development Day

We marked Internationally Educated Nurses Development Day, celebrating our 400 nurses and their development. Part of the day, held at Oxford Brooke University Campus in Swindon, focussed on Stay and Thrive, which is helping support this group of staff to thrive and grow and be the best version of themselves.

4.4. 20th anniversary of Great Western Hospital

Last month we recognised the 20th anniversary of Great Western Hospital with a range of celebrations, including 100 staff members, volunteers, retired colleagues and staff from Princess Margaret Hospital coming together to spell out the letters 'GWH' on our expansion land.

We produced a video looking back on the last 20 years, and there was also media coverage on BBC Wiltshire, BBC Points West and BBC Politics West which focussed on the size of the hospital and the PFI legacy.

There was also a staff birthday cake competition and the Chairman and Executives joined the tea trolley making hot drinks for staff in different parts of the hospital.

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		23rd November 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access			ED/UTC still performing relatively well against targets compared to other trusts and national average. However, the average waiting time now at 8.5 hours with 17% waiting 12+ hours. Ambulance handovers remain a concern with over a third in delayed by an hour or more. Further improvement work planned with SWAST in December. High levels of NCTR patients, however, there are signs of improvement with patient numbers reducing from c. 130 during the reporting period to 1.05 at time of meeting.	Monitor Actions	December 22
Integrated Performance Report – Elective Access - RTT			Trust continues to have no patients waiting in excess of 104 and remains on track to have no over 78 week waiters by February/March 2023. There are still concerns around the 52 week waiters with numbers increasing by 1,500 since March 22.	Monitor Actions	December 22

Integrated Performance Report – Elective Access – DM01			The committee noted a continued improvement in wait times in Radiology (MRI/CT/Echo). Further work planned to improve waiting times for Endoscopy patients and PPPC will receive a presentation on this at it's December meeting.	Monitor Actions	December 22
Integrated Performance Report - Cancer			The committee received a presentation from the Deputy Divisional Director responsible for Cancer Services. Performance is similar or better than the South West and National averages. Over-reporting of low-grade skin cancers (not expected to be reported nationally) was noted resulting in GWH reporting a higher figure of long waiters than required ie more patients reported waiting longer than the 2 week access time than should have been. The revised figures will show an improvement in performance although the number of patients requiring consultation and possible treatment remains the same. The committee noted good development work and the Deputy DD anticipated an improved performance going forward.	Monitor Actions	December 22
UTC Improvement Plan			Presentation from UTC Matron highlighting some of the improvements over recent weeks including the move into purpose designed building, recruitment of GPs and other members of the team including the new Matron and a Clinical Navigator. Evidence of improved staff engagement along with a rise in the number of compliments and positive media coverage was also noted.	Monitor actions	December 22
Emergency Preparedness, Resilience & Response Assurance Report (EPRR)			Described as "substantially compliant" but with a few amber areas that have an action plan against the self-assessment.	Monitor actions	February 2023

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

Board Committee Assurance Report

Performance, Population & Place Commitee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		23rd December 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access	R	A	The committee noted some minor improvements with ED performance across some metrics compared to October. However, the mean waiting time remained in excess of 8 hours. Non-criteria to reside occupied bed days remained high in November creating difficulties with flow from ED, this has reportedly improved at the time of the meeting. UTC seems to be performing well.	Monitor Actions	January 2023
Integrated Performance Report – Elective Access - RTT	R	A	The combination of increased referrals (5%) and reduced clock stops has resulted in an increased waiting list size in year, with a corresponding increase in the number of patients waiting over 52 weeks. However, patients waiting over 78 weeks has been maintained, with good progress being made against the target of zero patients waiting over 78 weeks by March 2023 and with consistently high performance in this area regionally.	Monitor Actions	January 2023

Integrated Performance Report – Elective Access – DM01	R	A	Trust performance improved by a further 4% in October with the number of patients waiting over 6 weeks reducing by 424 and the total waiting list decreasing by 412 showing a continued improvement.	Monitor Actions	January 2023
Integrated Performance Report - Cancer	A	A	The committee received a presentation from the Deputy Divisional Director responsible for Cancer Services. At Trust total level, there has been an increase in referrals in comparison to 2019/20 of 16.9% across all tumour sites. This has particularly impacted the ability to achieve the 2ww standard for patients on Lung, Lower GI and Skin pathways. However, despite these increases, of the 6 largest tumour sites (Breast, Lower GI, Gynae, Upper GI, Skin, Urology), 5 have remained consistently better than the national average percentage of patients waiting over 62 days and at Trust level the 28 Day Faster Diagnosis standard has been achieved for 4 out of 8 months. The Skin pathway remains the most challenged area with a significant demand and capacity gap within Plastic Surgery and remains a priority to address. The committee noted good development work and the Deputy DD anticipated an improved performance going forward.	Monitor Actions	January 2023
Winter Plan Update	R	A	The committee received an update on the various programmes in place such as Home First and the co-ordination hub where the teams are trying to evidence whether focusing on flow rather than beds has a material difference in operational pressures.	Monitor actions	January 2023
IT Performance	A	A	The report submitted shows significant improvement in terms of the response times and the consequent reduction in abandoned calls for all front of service issues. There remains continued issues with Wi-Fi onsite. The committee were keen to monitor progress with Wi-Fi issues along with a meaningful user survey report.	Monitor actions	March 2023

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

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		17 November 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

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

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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			
Q2 BAF			The BAF for Strategic risk 1 deals with 'Safe' and 'Effective'. Safe remains at 15 although some slight improvements have been made in some areas. The score for Effective remains at 8.		
Integrated Performance Report: **Pillar Metrics**	Amber	Amber	*The two pillar metrics for this Subcommittee are 'Total Harms' and 'FFT Positive Responses'. The overall score for Total Harms includes the Breakthrough Objective of Pressure Harms plus Watch Metrics of Falls, Hospital Acquired Infections, Medication Incidents, Serious Incidents and Never Events.* There has been a slight increase in total number of harms mainly due to nosocomial Covid during October.	UV Air 'scrubbers' should be installed in two more wards during November and this will reduce this risk.	

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Friends and Family			A mixed report with a slight improvement in positive responses but also a continued rise in negative responses that now stands at 13%. Overall response rate has increased to 28%. See below.		
IPR: Pressure Harms Pressure Ulcer Harms	Amber	Amber	The total number of Pressure Harms increased slightly by single figures in both Acute and Community. Work continues under 'Improving Together' to continue to reduce these numbers. New mattress overlays are now in use together with focused teaching and introduction of early assessments. After establishing a small trust wide group to develop a mattress replacement programme, new mattresses have been purchased which will allow faster access for those who need them.		
IPR: Hospital Acquired Infections	Amber	Amber	Hospital acquired Covid infection increased in October in line with the national trend. The Trust remains below trajectory for C.diff, MRSA and Pseudomonas and in line for Klebsiella. One MRSA bacteraemia occurred in October and this is under investigation as a Serious Incident. E.coli and MSSA rates remain a concern and further work is underway to address this.		
Falls:			Falls rates remain within normal variance this month.		
Friends and Family Test (FFT) + Complaints			A mixed report with a slight improvement in positive responses but also a continued rise in negative responses that now stands at 13%. Overall response rate has increased to 28%. Staff attitude and the environment remain the top issues. Complaints, concerns and PALS activity remain high and this is affecting the ability to respond within the deadline.	Divisions are being supported by PALS	
Integrated Performance Report: Staffing			Safe Staffing now appears as a separate Monthly Report. See below.		
Perinatal Quality Surveillance Tool	Amber	Green	Midwife to birth remains at 1:29, (target 1:29). 1:1 care in labour is at 100%. Progress has been made in meeting the CNST 10 Safety criteria with the expectation that all measures will now be compliant at submission.		
Ockenden update	Amber	Amber	Further progress has been made but this remains a long-term project.		
Midwifery continuity of care update	Amber	Amber	GWH has one MCoC team whose aim is to prioritise those mothers who are most likely to benefit from personalised care during their pregnancy. This includes BAME women and those with a high index of multiple deprivation. Last month 31% of the former and 48% of the		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			latter received MCoC against a target of 80%. This is no longer a national requirement but as the service is established and can be delivered within available resources, the decision was taken to continue.		
Mortality Quarterly Update	Amber	Amber	The latest Dr Foster data is from July. The trust HSMR is well below the national average at 91.2. However the SMR, which is a measure of total deaths, is at 107.1. These figures may be amended in future as GWH is behind in coding. This is due to a shortage of coders resulting in a backlog. Steps have been taken to address this including recruitment of more coders back to establishment. A business case has been made to recruit some temporary coding time to manage the backlog. Poor engagement by consultants in monitoring mortality with poor attendance at mortality meetings is being addressed by the Chief Medical Officer via Job Plan Reviews. Plans have been completed to establish a Trust Mortality Team, funding is agreed and recruitment has commenced. This will address the criticisms levelled by our internal auditors.		
National Inpatient Survey.	Amber	Amber	This report is based on questionnaires completed by inpatients in November 2021. Results are disappointing with only one Q being improved and 10 deteriorated. Worst scores related to disturbed sleep due to lighting or staff noise, help with personal care, consideration of home situation on discharge and ability to discuss care without being overheard.	An improvement plan is being addressed by the Dep Chief Nurse with Div Dirs of Nursing.	As the 2022 survey is currently happening the improvement plan initiated will not have been fully implemented in time for next year's report.
Primary Care Network Action Plan	Amber	Green	This plan sets out to address the issues raised by CQC in their report on our two general practices. The inspection was in May '22. Nine improvement notices were issued but after improvements a further inspection in September resulted in the removal of these warning notices. Currently 20 actions have been closed and 10 are on track.		
Clinical Audit and Effectiveness	Amber	Green	GWH remains on track for most audits with a 9% increase in audits overall. However the trust did not participate in 8 national audits, the		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Annual Report '21/'22 and Q2 '22/'23			highest level of non-participation ever. These will be carried forward so that they undergo local assessment of results when national results are published.		
Monthly Safe Staffing	Amber	Amber	Fill rates have been satisfactory overall. Averag fill rates for nurses and midwives were 97% and for HCAs 102%. There are local variations within this. In the community it has not been possible to visit all planned patients so some have been deferred to the following day. Work in in progress to determine the causes of these deferments.		
Update on CQC Preparedness	Not Rated	Not Rated	There has been further progress. There is a plan in place to address the Safeguarding Children Level 3 Training which remains at 50-60% instead of 90%.		
Quality Accounts	N/R	N/R	An update on progress developing the QA was received showing aims to be generally on track or achieved.		

Issues Referred to another Committee	
Topic	**Committee**

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		22 December 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	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: **Pillar Metrics**	Amber	Amber	*The two pillar metrics for this Subcommittee are 'Total Harms' and 'FFT Positive Responses'. The overall score for Total Harms includes the Breakthrough Objective of Pressure Harms plus Watch Metrics of Falls, Hospital Acquired Infections, Medication Incidents, Serious Incidents and Never Events.* Total Harms have decreased from 261 to 201, mainly due to reduced nosocomial Covid infections. Slight increase in medication incidents from three to seven. FFT positive responses remain at 84%, the target being a consistent 86%,	UV Air 'scrubbers' have still not been installed due to sickness in staff due to do so. We are told they are on site and should be installed in January. This is the responsibility of THC.	
Friends and Family			Negative responses now fell from 13% to 11% but in August they were at 8%. Overall response rate has increased to 28%. See below.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR: Pressure Harms Pressure Ulcer Harms	Amber	Amber	Pressure harms continue to fall in both acute and community.		
IPR: Hospital Acquired Infections	Amber	Amber	Hospital acquired Covid infection fell in November in line with the national trend. The Trust remains below trajectory for C.diff, though numbers increased by seven. E.coli and MSSA rates are stable but work continues especially in catheter management, to reduce E.coli.		
IPR: Falls:	Amber	Amber	Falls rates remain within normal variance this month but have reduced slightly.		
IPR: Friends and Family Test (FFT) + Complaints	Amber	Amber	See above. Complaints and concerns plus PALS contacts continue at a high level with a 95% increase on last year's contacts. The number of concerns has reduced since last month.	Divisions are being supported by PALS	
Integrated Performance Report: Staffing			Safe Staffing now appears as a separate Monthly Report. See below.		
Perinatal Quality Surveillance Tool	Amber	Green	Midwife to birth remains at 1:28.9, (target 1:29). 1:1 care in labour is at 99.1%. Progress has been made in meeting the CNST 10 Safety criteria with the expectation that all measures will now be compliant at submission. This will come to the Trust Board in January prior to submission later in January. Peer review suggests we shall be complaint on submission.		
Ockenden update	Amber	Amber	Further progress has been made but this remains a long-term project.		
Quarterly Report on Patient Experience	Amber	Green	Steady improvement in many areas covered by this report including Great Care, communication following Care of the Dying audit and launch of Carers-Hospital Liaison Service to support effective discharge. Following discussion it was agreed that this report would in future be received twice a year with the option to add an extraordinary report should the need arise.		
Update on Electronic Discharge Summaries (EDS).	Red	Amber	Little further to report regarding performance. However there is a possibility that the EPMA prescribing system could be used to produce a limited EDS. This is being pursued with a view to a cost benefit analysis, pending the acquisition of a full EPR.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Monthly Safe Staffing	Amber	Green	Fill rates are below 85% in some areas but overall the average fill rate is >90% for Nurses/Midwives and HCAs. Work is continuing to move towards a 1:8 nurse to patient ration from the current 1:10.		
Safe Staffing 6 month review for Nursing & Midwifery.	Amber	Green	Gradual improvement in recruitment of midwives which is commendable in the face of national trends. Sickness absence remains an issue but this is currently more short term sickness related to viral infections.		
Update on CQC Preparedness	Not Rated	Not Rated	There has been further progress. There is a plan in place to address the Safeguarding Children Level 3 Training which remains at 50-60% instead of 90%.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Finance, Infrastructure & Digital Committee – 21 November 2022			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**21 November 2022**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
RISK MANAGEMENT & REPORTING					
BAF Strategic Risks	G	G	The latest summary of the Board Assurance Framework for Finance and Infrastructure risks were presented to the Committee for review. Significant levels of assurance were received around the process to support the completion of the BAF, enabling effective scrutiny and challenge.	Monitor periodically through FIDC and Board.	FIDC Meetings 2022/23
Finance, Infrastructure and Digital Risk Management	A	A	We are assured that the risk management process and reporting risks for Finance, Infrastructure and Digital are adequate and effective. However, we continue to raise challenges in mitigating salient risks such as, for example, the £3m gaps in delivering the efficiency target recurrently in 2022/23. Overall, we are pleased with the focus and attention to the risk management process, reporting of identified risks, and governance; however, greater emphasis is on ensuring ownership of the risk mitigation activities.	Monitor monthly through FIDC and (significant risks to be reviewed quarterly at Board).	FIDC Meetings 2022/23
OPERATIONAL					
BSW Financial Position	R	R	The Committee received an update on the overall financial position of the BSW ICB financial position at Month 6, including key risks, mitigations, and delivery of efficiencies. The Committee challenged the overall finance governance at BSW. Further, we raised concerns about the need for more clarity, the workings of the new model and structure, and its impact on GWH.	Monitor through FIDC	FIDC meetings 2022/23

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Month 7 Finance position	A	A	The overall position for Month 7 has improved compared to previous months. Income is received from the ICB to fund the planned deficit (£19.4m); £11.3m of this is reported in the Month 7 position. The Trust is reporting a deficit of £0.4m in Month 7, which is £1.2m favourable to plan. The year-to-date position is £11.6m deficit, £1.1m adverse to plan.	Monitor through FIDC	FIDC meetings 2022/23
Improvement and Efficiency Plan – Update	R	A	£1.2m of efficiency is reported against a plan of £1m in Month 7. This improvement reflects non-recurrent delivery in the Corporate Division and Divisional enhancements. The forecast to year-end has also improved because of this work; however, as noted in the risk section above, we remain concerned that we are unlikely to achieve the full CIP of £11.1m by year-end as we have a substantial gap of £3m yet to identify.	Monitor through FIDC and monthly update to the Board	FIDC meetings 2022/23
2023/24 Financial Planning Process	A	G	The Committee was updated on the business planning for 2023/24 and was delighted with the progress. The Committee looks forward to the outputs of the planning process and future updates.	Monitor through FIDC and key updates to the Board	FIDC meetings 2022/23
BUSINESS CASES & UPDATES – for noting					
Surgical Robot Business Case	-	-	A paper outlining the business case for rapid development of a robotics surgery programme was presented for approval. Following the Committee's review and challenge, this was approved by the Trust Board in December 2022.	-	-
Shared EPR Programme Update	R	A	An update on the EPR procurement process and key achievements were presented. Overall, we raised concerns about the risks associated with the approval by multiple parties of the FBC, including the risk of receiving funds to commence the project.	Monitor through FIDC	FIDC meetings 2022/23
IT & Infrastructure Update	A	G	A summary of the key developments about IT planned activities for the previous quarter was presented to the Committee, with overall good progress noted in several areas. The essential risk to the comprehensive digital plan is the availability of resources and the scope and speed required for effective and sustainable change.	Monitor through FIDC	FIDC meetings 2022/23
Cyber Security Update	A	G	An update on salient Cyber Security developments to further enhance the Trust's cyber defences was presented to the Committee. No reported incidents were noted.	Monitor through FIDC	FIDC meetings 2022/23

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

Board Committee Assurance Report

Finance, Infrastructure & Digital Committee – 21 December 2022			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**21 December 2022**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

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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			
RISK MANAGEMENT & REPORTING					
Finance, Infrastructure & Digital Risk Management	A	A	We are assured that the risk management process and reporting risks for Finance (A/G), Infrastructure (A/A) and Digital (A/A) are adequate and effective. However, the Committee continues to challenge the adequacy, effectiveness, and ownership of mitigation actions, particularly regarding Infrastructure and IT & Digital Risks.	Monitor monthly through FIDC (and significant risks to be reviewed quarterly at Board).	FIDC Meetings 2023
OPERATIONAL					
Month 8 Finance position	A	G	The overall position for Month 8 has improved compared to previous months. Income is received from the ICB to fund the planned deficit (£19.4m); £12.9m of this is reported in the Month 8 position. The Trust is reporting a deficit of £1.7m in Month 8, which is £0.4m favourable to plan. The year-to-date position is £13.3m deficit, £0.7m adverse to plan. The latest forecast position is £1m worse than the plan, which is an improvement on the previously reported £1.8m due to the ICB agreement to fund ESRF costs.	Monitor through FIDC	FIDC meetings 2023
Capital Plan	A	A	The total Capex at Month 8 is £6.4 m below plan. Of this, £4.8m relates to Trust CDEL schemes, with the remaining £1.6m slippage on externally funded schemes. The slippage is managed to expedite the reprioritisation of the Capital plan and bring forward other items of spend to use the Capital allocation.	Monitor through FIDC	FIDC meetings 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Improvement and Efficiency Plan – Update	A	A	£0.67m of efficiency is reported against a plan of £1.05m in Month 8, resulting in an under-achievement of £0.38m. The forecasted position is that 74% of the plan will be achieved at year-end however, there is reliance on non-recurrent schemes with both the year-to-date and forecasted position.	Monitor through FIDC and monthly update to the Board	FIDC meetings 2023
2023/24 Financial Planning Process	R	G	An update was noted on the business planning for 2023/24, summarising the National Update, Progress to Date, and Anticipated Outcomes. The Committee notes that the planning methodology is comprehensive and robust and looks forward to the outputs of the planning process and future updates. The Committee continues to raise concerns about the clarity of the financial planning and governance processes at the ICS level and therefore have rated the inherent risk as Red.	Monitor through FIDC and key updates to the Board	FIDC meetings 2023
BUSINESS CASES & UPDATES – for noting					
BSW Financial Strategy	-	-	A paper outlining the Financial Strategy for BSW ICB setting up a high-level road map by which the BSW system seeks to achieve long-term financial sustainability over five years. The challenge is significant given that there is an estimated underlying position of £125m across the BSW with the focus on how turnaround support could be provided, and positions challenged across all organisations.	-	-
Shared EPR Programme Update	R	A	An update on the EPR procurement process and key achievements was presented. Overall, the programme inherent risk is Red due to the lack of benefits to support the FBC, including estimated increased costs and the challenges around resourcing.	Monitor through FIDC	FIDC meetings 2023
Update on Procurement	A	G	An update was received providing an overview of crucial work plan projects, status and service development initiatives, a look forward to high-value contracts coming up for renewal in the next 12 months, and savings performance to date. The Committee was delighted with the proactive actions management has taken to address significant challenges to procurement activities in the current climate.	Monitor through FIDC	FIDC meetings 2023

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

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**13th January 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Simon Wade Director of Finance Jude Gray, Director of HR Lisa Cheek, Chief Nurse				
Report Author	Al Sheward – Deputy Chief Operating Officer Rayna McDonald – Deputy Chief Nurse Claire Warner – Associate Director of HR Operations Elizabeth Hills – Head of Financial Management				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC Chart – Pay				

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

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

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

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

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

Our Performance

Key highlights from the report this month are:

OPERATIONAL PILLAR METRICS
Of the 6 Operational Pillar Metrics, 5 continue to deteriorate in month. The mean time in the Emergency Department UTC being the only Pillar Metrics delivering to plan. There has been some improvement in Emergency Department mean stay non-criteria to reside days in month, but these remain adverse to plan.

Cancer 62 day - Cancer waiting times remain below standard. In October 2022 performance of 56.9% was recorded against an 85% target.

RTT 18 Week Compliance – November performance of 54.6% against a target of 92%.

Emergency Care, Emergency Department Mean Stay – November mean time in ED reduced to 499 from 514 mins in October 2022.

Emergency Care, Urgent Treatment Centre Mean Stay – November mean time continues to deliver well within the scope of the National standard of 240 mins.

Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. These remained relatively static in month, with 10,240 attendances in November compared with 10,272 in October resulting in sustained pressure on Urgent and Emergency Care services.

Inpatient Spells, Number of Non-Criteria to reside (NC2R) days. The number of patients who remain in an Acute Hospital bed without a Criteria to Reside decreased for the first time since June, reducing from 3,514 spells in October to 3,125 in November.

OPERATIONAL BREAKTHROUGH OBJECTIVES
Both breakthrough objectives have shown an improved position in November. The percentage of patients waiting over 12 hours in the emergency department reduced slightly from 16.9% in October to 16.1% in November, and the number of of patients awaiting an update from the Community Single point of Access reduced from 1309 in October to 723 in November.

Our Care

Strategic Pillar Targets

1. To achieve zero avoidable harm within 5-10 years
2. To achieve consistent positive response rates in excess of 86% from patient friends and family test.

There has been a decrease in the total number of harms from 261 to 201, this mainly relates to a reduction in hospital acquired COVID infections. All areas have reported a decrease in harms except medication incidents with moderate harm which saw an increase from three to seven.

For November, the number of Family and Friends positive response remains consistent with previous months at 84%, This is based on the % of responses rated as ‘very good’ and ‘good’.

Breakthrough Objectives
Pressure ulcers/harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. In November we have seen a reduction in the number of harms in both the hospital and community setting.

The new digitalised Pressure Ulcer Risk Assessment Tool has been launched trust wide, following a successful trial. Dashboards are in place that will show ward compliance with various assessments including the PURAT. This will allow divisions to monitor performance and ensure outstanding assessments are completed. This is the first time this data has been available in real time.

In the community the Improving Together programme continues with a focus on reduction in Category 2 pressure ulcers.

Alerting Watch Metrics
Complaints, concerns and PALs activity continues at a high level, despite this here has been an improvement in November, in meeting complaint response deadlines. This has been particularly evident in USC and ICC due to increased oversight from the senior team and with additional support being provided by the PALs team.

MSSA remains a concern, with a theme related to IV cannula management. An IV Forum has been set up to mirror the successful impact the CAUTI Group has had on catheter practice. The IV Forum's first meeting will take place in December. Every MSSA case is subject to a detailed post infection review to support the identification of themes and areas for learning and/or improvement.

Non-alerting Watch Metrics
Significant points to note relating to non- alerting watch metrics include

- Complaints, concerns and PALs activity continues at a high level, with a 95% increase on last year's number of contacts, this includes queries, concerns, complaints and compliments. The number of concerns has reduced when compared to last month.
- The number of falls remains consistent with previous months.
- The Trust remains below its trajectory *Pseudomonas* infections and in line for *Klebsiella and C. difficile*. C. difficile rates have increased in month, investigations have not identified deficits in care or areas for improvement or learning.
- E. *coli rates* remain over trajectory however rates are now are reducing due to the focused improvement work on catheter care.
- FFT negative responses have continued to be in the early teens, at 11%, compared to 8% for August, 11% in September and 9% for October, retaining the trends for this year. This is based on responses rated as ‘poor’ and ‘very poor’.
- Staff attitude and the environment remain the top themes in terms of both positive and negative responses, waiting times feature strongly as a negative theme and implementation of care as a positive theme.
- ED and UTC have maintained their score of 72% despite significant operational pressures.
- Outpatients continue to maintain a high positive score of 98%

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.

Strategic Pillar Targets
To aim to be in the top 25% of trusts for lowest staff turnover within Model Hospital.
Improve our Staff Survey response rates and increase the number of staff recommending Trust as a place to work.

Having a workforce representative of the population we serve across all roles, with a 16% BAME representation by 2025.

Breakthrough Objectives
“I am able to make improvements happen in my area of work” will also be reported in the Staff Survey full data set in January 2023.

Response rates for 2022 staff survey were 59% which is 12% higher then last year and ranked 4th when comparing those Trust who completed via Quality Health (49 Trusts).

Alerting Watch Metrics
Sickness absence increased slightly in-month (October) from 4.70% to 5.3%, of which 0.75% remains Covid related absence and 4.55% is non-Covid related. October has seen a static rate of COVID cases which continues to impact the sickness KPI, particularly levels of short-term sickness. To mitigate the increase in absence levels, targeted HR support to managers with sickness management. The Trust is also working with the NHS sickness national team to roll out a Trust Wide toolkit to improve sickness rates (January 2023).

The in-month agency spend as a percentage of the total pay bill has decreased slightly in month from 6.53% to 6.17%, although remains above the Trust target of 6%. Weekly monitoring by the divisional teams continues to support agency spend reduction.

Recruitment time to hire is alerting, reporting at 74.3 days in November against the KPI of 46 days. An analysis of recruitment stages within the TRAC system shows an increase in the pre-offer stages of employment, specifically within the gap between vacancies closing and shortlisting happening. The Recruitment team are working with managers to confirm these dates ahead of time to reduce the delay from this part of the process.

Non-Alerting Watch Metrics
Improvement in voluntary turnover has been achieved for a second month.

Significant planning is underway to respond to strike action on the 15th and 20th December.

Use of Resources
Income has been received from the ICB to fund the planned deficit (£19.4m), £12.9m (8/12) of this is reported in the Month 8 position. Excluding this income, the Trust is reporting a deficit of £1.7m in month which is £0.4m favourable to plan. In month, the ICB have also agreed to fund a further shortfall on ESRF costs vs income (£0.6m) which results in an improved forecast position. Year to date position is £13.3m deficit, £0.7m adverse to plan.

The latest forecast position is c.£1m worse than plan, this is an improvement of the previously reported c£1.8m gap due to agreement from ICB to fund further ESRF at the planned level. Forecast costs remain in excess of income (£7.8m costs, £6.9m income) which is the main driver of the forecast variance.

Efficiency delivery has not kept pace with plan this month and is £1.4m behind plan year to date. The forecast to year end remains at £3.0m unidentified. However, in expecting to deliver an overall position close to plan, by proxy we could expect to deliver close to the CIP target, albeit non-recurrently.

The cash balance at the end of Month 08 is £18.7m above plan, This is due to the receipt last month of £19.4m of deficit funding from the ICB, partially offset by a delay in drawdown of loans.

Capital expenditure is £6.4m below plan to date due to profiling and slippage. The capital team have met with all the divisions, project leads and procurement to monitor progress fortnightly to ensure the funding will be spent by the end of the financial year. There has also been purchase orders raised in November (£3.1m) and December (£0.25m) that will increase the level of spend, once goods are on site / services are received, and they are receipted.

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

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

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

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	
Date	5th January 2023

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

Our Performance

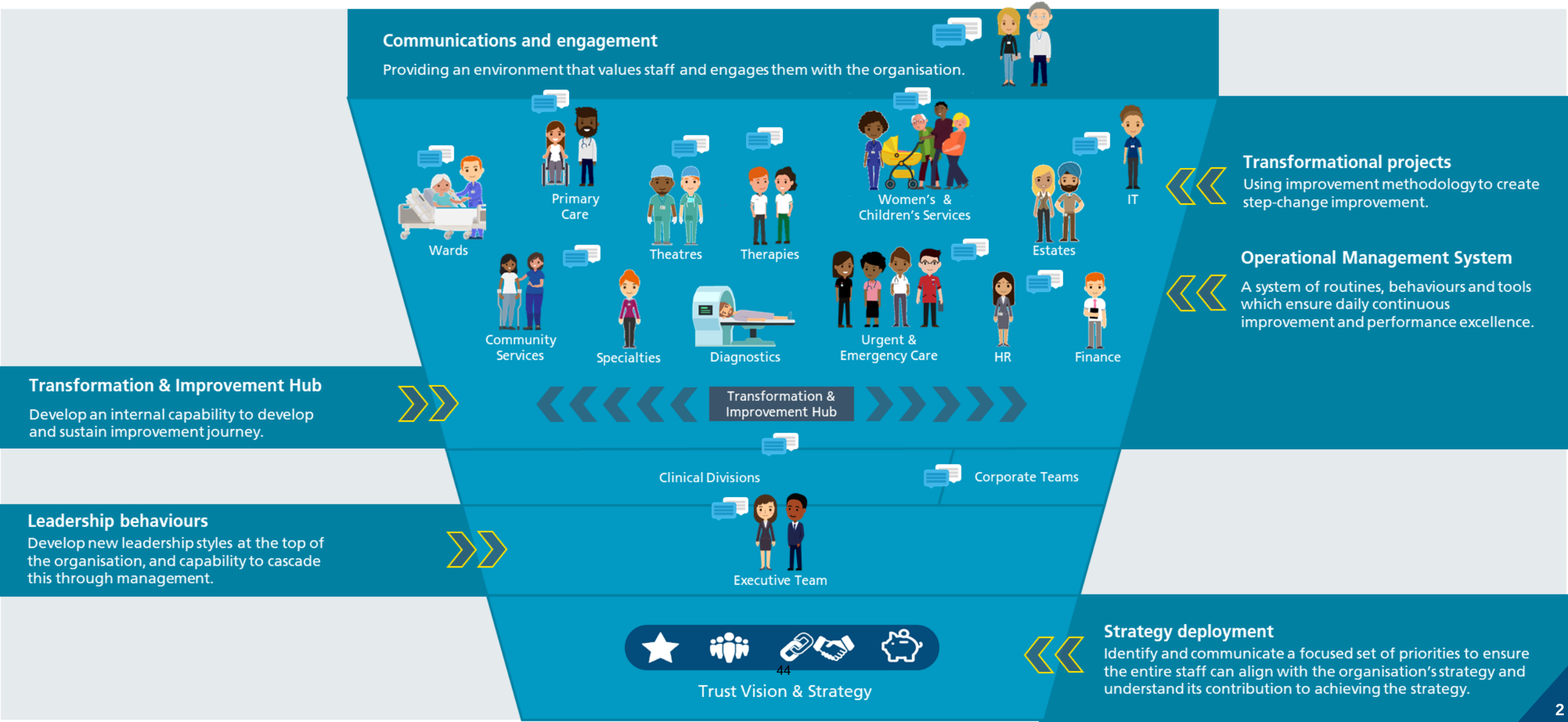
December 2022

October & November 2022 data period

Improving
together

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

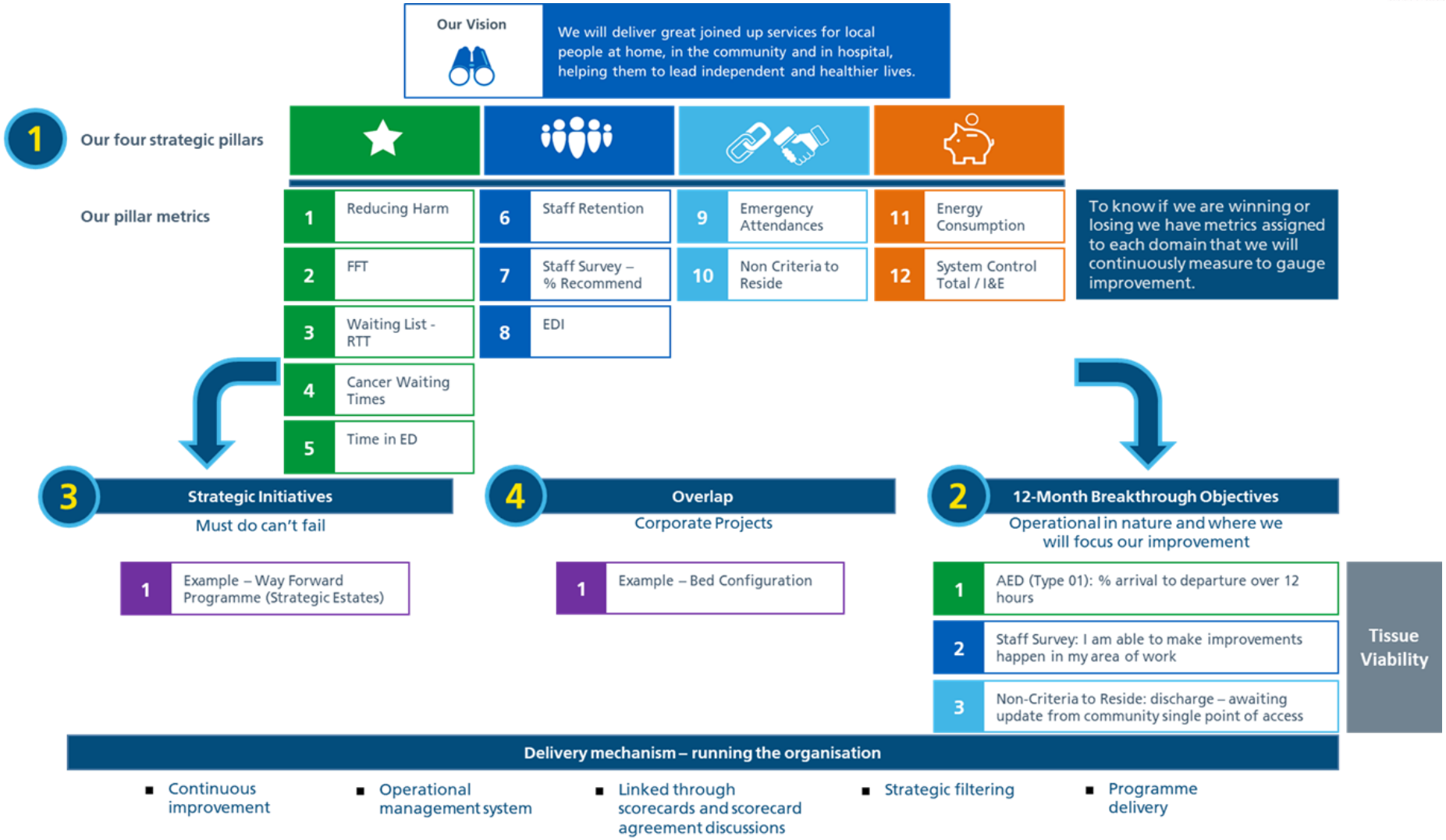
We will deliver great joined up services for local people at home, in the community and in hospital, helping them to lead independent and healthier lives.

Our four strategic pillars

- Outstanding patient care and a focus on quality improvement in all that we do
- Staff and volunteers feeling valued and involved in helping improve quality of care for patients
- Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers
- Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust



SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

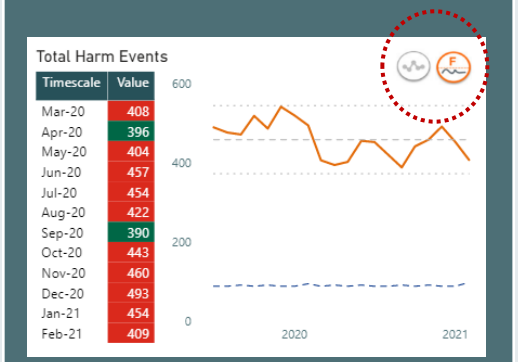
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

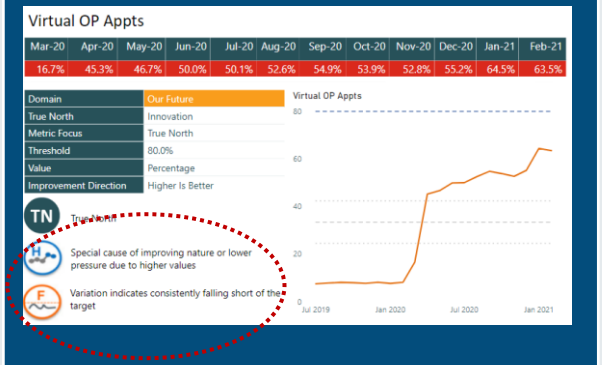
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them:

Strategic Pillars



Breakthrough Objectives



Executive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

The Strategic Pillar target is to achieve zero avoidable harm within 5-10 years. Our calculation for total avoidable harms aggregates incidences of the following in each month;

- Pressure ulcers/harms
- Falls
- Hospital acquired infections (including Covid-19)
- Medication incidents
- Serious incidents
- Never Events

Pressure ulcers/harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. The other harms are all presented as watch metrics later in the report.

Patient Experience (FFT)

The Friends and Family Test is a national scheme which encourages patients to provide feedback about their experience of using our services. Patients are asked the question, Overall, how was your experience of our service? and have six options ranging from very good to very poor and don't know, there is also an area for free text comments, results are collated monthly.

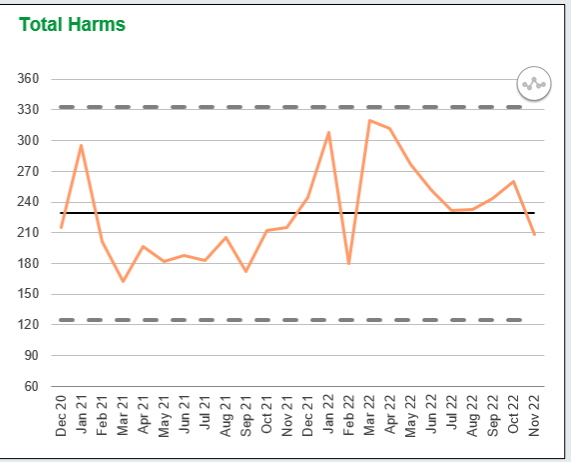
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall scorecard.

We have set ourselves a target for 2022-23 of 86% for the combined positive response rate, this is based on the mean for last year plus 2%.

Total Harms

To achieve and sustain zero avoidable harm.

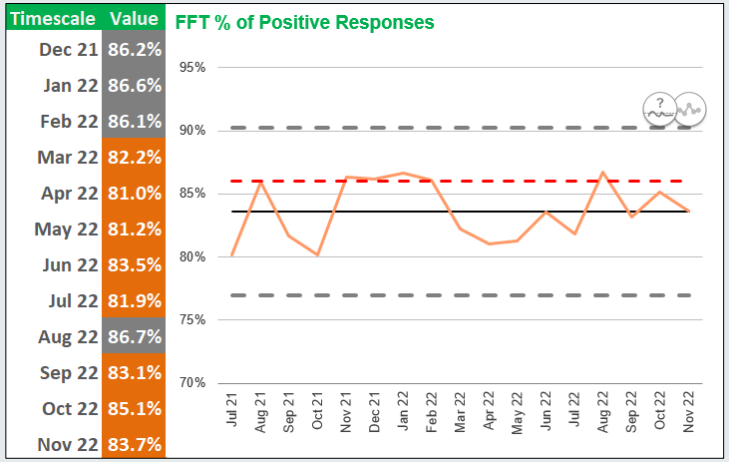
Timescale	Value
Dec 21	244
Jan 22	308
Feb 22	180
Mar 22	320
Apr 22	312
May 22	277
Jun 22	251
Jul 22	232
Aug 22	233
Sep 22	243
Oct 22	260
Nov 22	208



Patient Experience (Friends & Family Test)

To achieve consistent positive response rates in excess of 86% from patient friends and family test.

Timescale	Value
Dec 21	86.2%
Jan 22	86.6%
Feb 22	86.1%
Mar 22	82.2%
Apr 22	81.0%
May 22	81.2%
Jun 22	83.5%
Jul 22	81.9%
Aug 22	86.7%
Sep 22	83.1%
Oct 22	85.1%
Nov 22	83.7%



Counter Measures

The number of avoidable harms has reduced in November by 60, the reduction has been seen across all areas apart from a small increase in medication incidents.

- Hospital acquired Covid- 19 rates have reduced through November, matching the national and regional picture. Installation of ceiling-mounted UV air cleaners is scheduled to commence before Christmas and should reduce rates.
- The Learning Zone resources available continue to grow. There is now an icon on all iPods and iPads for direct access at ward/service level.

For November, the number of Family and Friends positive response remains consistent with previous months at 84%, This is based on the % of responses rated as 'very good' and 'good'.

A number of workstreams are underway to improve the patient experience and the environment including;

- New Carers Passport in draft and out for public and partner consultation
- Collaborative working with the Defence medical welfare service and recruitment of a liaison officers who will support with admission avoidance and timely discharge

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Trust Access Standards - Referral to Treatment (RTT) & Cancer Standards

It is poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

In common with many other providers, the Trust has not consistently achieved the National Cancer Standards or Access standard for RTT. Nationally expectations are being reset around targets. Countermeasures for the deteriorations seen here are listed below

Cancer 62 Day

In October, there were 40.5 breaches in total, with 19.5 of these attributed to the Skin pathway that we have not historically seen. This is due to the capacity challenges we have seen along with the unprecedented level of demand. We have also seen greater than normal breaches in Urology with 10.5. over half the breaches can be attributed to our capacity for TRUS Biopsies.

Without the Skin breaches we would have achieved 77.7%

RTT: 18 Week Compliance

In November, the RTT 18 Week Compliance deteriorated by 0.47% in month along with a Patient Tracking List (PTL) decrease of 230 (0.6%). This has been driven by an 10% increase in referrals into the Trust.

52 week breaches increased in month by 117, with the largest deteriorations in Respiratory Neurology and Gastroenterology. There was a detriaroation in the 78 week position, with the number of patients waiting over 78 weeks increasing by 5 in month.

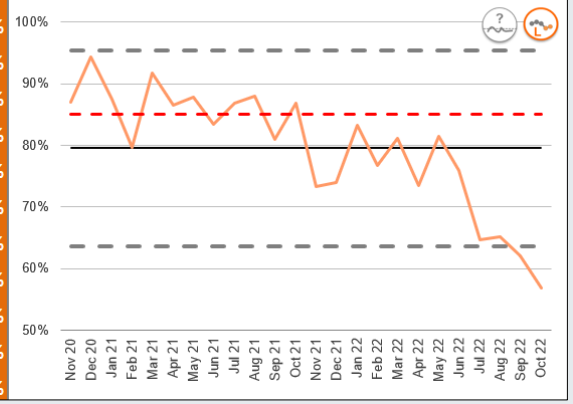
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

To achieve and sustain 85% performance for patients on a Cancer pathway.

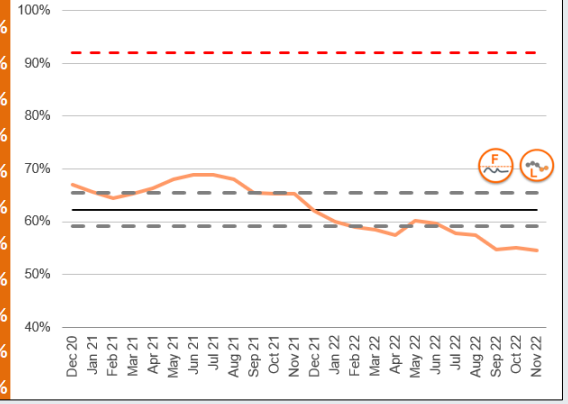
Timescale	Value
Nov 21	73.3%
Dec 21	74.0%
Jan 22	83.2%
Feb 22	76.8%
Mar 22	81.2%
Apr 22	73.5%
May 22	81.5%
Jun 22	76.0%
Jul 22	64.7%
Aug 22	65.1%
Sep 22	62.0%
Oct 22	56.9%



RTT: 18 Week Compliance

To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.

Timescale	Value
Dec 21	62.01%
Jan 22	60.05%
Feb 22	58.98%
Mar 22	58.45%
Apr 22	57.39%
May 22	60.15%
Jun 22	59.65%
Jul 22	57.85%
Aug 22	57.43%
Sep 22	54.74%
Oct 22	55.03%
Nov 22	54.60%



Counter Measures

Risk: Capacity in Dermatology & Plastics is insufficient to see and treat patients.

Mitigation:
Plastics - Seeking further Mutual aid from OUH. Plastic Consultants have agreed to see additional patients on a pay per patient basis. The challenge is that this is ad-hoc and we do not always have MOP & Theatre space available when the Consutants are free.

Dermatology – A Locum Consultant stated in October which has created greater capacity. We are using CSP for BCC patients that will reduce the number of patients being referred to the Plastics team.

Dermatology performance should recover by December 22.

Risk: TRUS Biopsy Capacity for Prostrate Patients.

Mitigation:
The prostrate best practice timed pathway review is underway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team are undertaking LATP biopsy training with a view to reducing the demand on TRUS biopsies.

Risk: Insufficient theatre capacity to meet activity plan due to anaesthetic and theatre staffing.
Mitigation:
•Locum Anaesthetist secured whilst substantive recruitment underway.
•Block booking of Theatre stafff whilst substantive recruitment under way.
•Weekend insourcing contract extended to March 2023.

Risk: Insufficient clinic capacity to meet activity plan.
Mitigation:
•Additional outpatient capacity (including diagnostic) being provided across medicine and surgical specialties throughout December2022.

Risk: Insufficient capacity to recover 52 week + breach position resulting in poor RTT 18 Week compliance.
Mitigation:
•Additional capacity in Dermatology and Neurology, to address the growing trend. Additional Minor Ops capacity provided by ENT and Oral Surgeons to manage long waiting patients in Plastics.

Risk: Impact on Elective capacity due to the proposed industrial action.
Mitigation:
•All elective activity on proposed strike days reviewed. Maximum clinical sessions running where staffing allows.
•Patient impact being assessed and alternative sessions to be provided.

Pillar Metrics

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

Patients are delayed within the Emergency Department (ED). This is a marker of a crowded system resulting in delays in assessment, investigation, treatment and discharge.

The total meantime wait for a patient in November 2022 was 500 minutes against the national standard of 240 minutes an improvement since last month. Poor flow resulting from increases in length of stay (for both Criteria to Reside and Non criteria to reside patients) and COVID inpatients has contributed to deterioration alongside an increase in attendances. Beds occupied by long stay patients is still high and has increased in November and is 35% higher than Nov 21.

Emergency Care – Urgent Treatment Centre - Mean Stay

Patients are not delayed within the Urgent Treatment Centre (UTC). This is a marker of a service that is functioning as expected

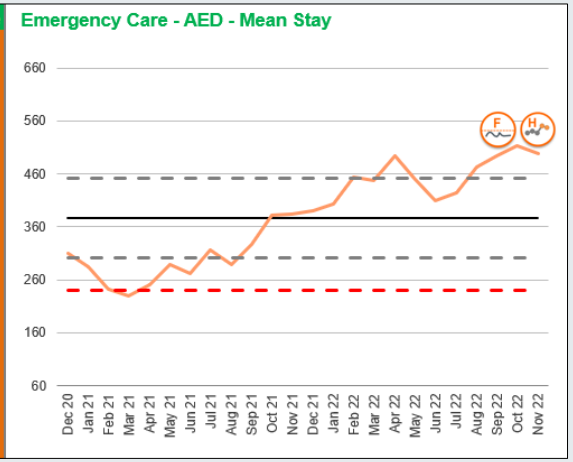
The total meantime wait for a patient in November 2022 was 168 minutes against the national standard of 240 minutes demonstrates good flow through the service despite a continuing rise in attendances.

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

To achieve and sustain a mean time in department for all patients attending the Emergency Department.

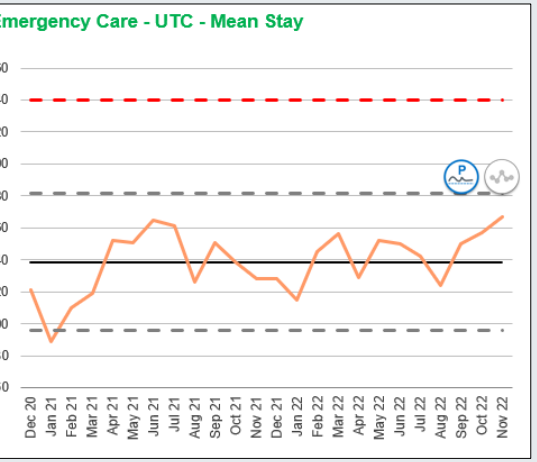
Timescale	Value
Dec 21	391
Jan 22	403
Feb 22	453
Mar 22	448
Apr 22	493
May 22	450
Jun 22	409
Jul 22	425
Aug 22	473
Sep 22	494
Oct 22	514
Nov 22	499



Emergency Care – Urgent Treatment Centre - Mean Stay

To achieve and sustain a mean time in department for all patients attending UTC.

Timescale	Value
Dec 21	128
Jan 22	115
Feb 22	145
Mar 22	156
Apr 22	129
May 22	152
Jun 22	150
Jul 22	142
Aug 22	124
Sep 22	150
Oct 22	157
Nov 22	167



Counter Measures

- Significant improvement in Triage times following a focused IMT piece of work in ED Majors Chairs as part of new triage space, and robust capture of data particularly with ambulance team handover
- Winter slippage monies for Paeds ED Twighlight nurse & weekend Consultant implemented with shifts booked, will reduce impact on staffing numbers overall during peak times and improve quality of care
- Winter slippage monies for Pit-stop nursing implemented - provides clinical oversight of queue, starts assessments early & potential for simple treatments and potential for discharge from ambulance with EPIC oversight
- Winter monies for dedicated transfer porters implemented - this has really supported with reducing the amount of nursing time off the ward with prompt transfers and diagnostic moves. AMU porter has completed 807 tasks since commencement, and ED porter has completed 1387 jobs. This has released other pool porters to be getting on with other jobs across the trust, too
- Metric routinely meeting standard
- Roster change trial implemented for staff to increase staffing model mapped to key times of patient arrival – extension continues
- Single front door pathways between the emergency department and the urgent treatment center are now in place alongside front door building work and new patient entrances beginning Dec 22

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Department & Urgent Treatment Centre - Emergency Attendances

Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). November saw a continued high level of Emergency attendances to both ED & UTC.

This is a marker of the continued pressure at our front doors which is accelerating, alongside an increasing number of long stay patients >21 days however there has been a reduction in NCTR bed days.

Inpatient Spells - GWH - Number Non-Criteria to Reside (NCTR) Days

This metric highlights the total number of bed days lost on inpatient spells for patients who are deemed to be Non-Criteria to Reside.

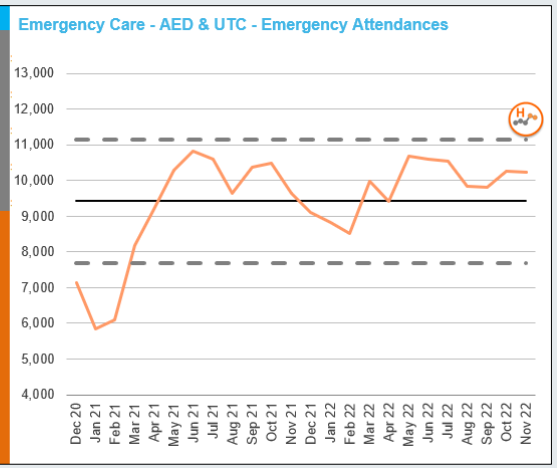
The highest numbers of discharges at 123 was achieved in November supporting recovery from GWH critical Incident. Overall, an improvement noted in the daily discharge rate compared to October. On average we have seen an increase in weekend discharges but at a cost of a reduced number on Mondays from 100 to around 80 which often leads to significant site pressures.
A decrease in 50-day LOS patients was also achieved seeing our lowest number of cases at 11, average hold around 15 patients. Our 21-day LOS patients remains high at 45 (30 sitting at 21-49 days but has reduced since October.

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department & Urgent Treatment Centre - Emergency Attendances

To ensure patients are cared for in the appropriate setting

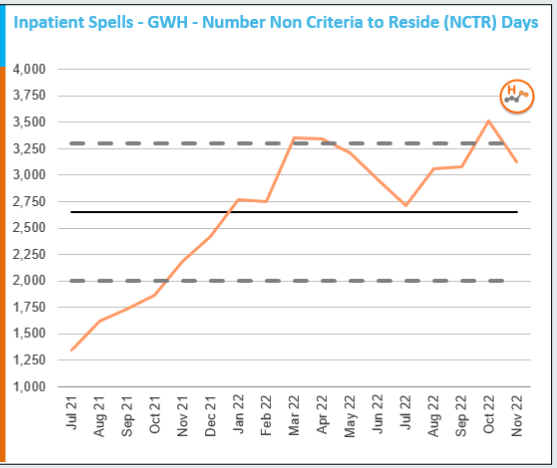
Timescale	Value
Dec 21	9,098
Jan 22	8,830
Feb 22	8,523
Mar 22	9,994
Apr 22	9,415
May 22	10,684
Jun 22	10,596
Jul 22	10,554
Aug 22	9,846
Sep 22	9,803
Oct 22	10,272
Nov 22	10,240



Inpatient Spells - GWH - Number Non-Criteria to Reside (NCTR) Days

To treat the right patients in the right place, to ensure delivery of high quality care.

Timescale	Value
Dec 21	2,417
Jan 22	2,772
Feb 22	2,747
Mar 22	3,357
Apr 22	3,343
May 22	3,209
Jun 22	2,953
Jul 22	2,712
Aug 22	3,057
Sep 22	3,083
Oct 22	3,514
Nov 22	3,125



Counter Measures

- Pre-Hospital
Clinical assessors now working 7 days a week 12 hrs and will move to a 24hr service December 19th. Discharge support team supporting signposting Home First patient over the weekends, so we have cases to review on Monday is working well.
More Navigation Hub pathways are now at a stage of being signed off to offer more streamlining of patients to RPRTRT.
Care Coordination Week at Chippenham will offer a hybrid model of working with GWH coordination center and hopefully will gain in more opportunities/learning to manage the call stack with SWAST colleagues and extended BSW services.

- Intra Hospital
Home First have maintained an improvement trajectory of patients leaving hospital on this model. An increase of a further 8 (38 total for Nov) . Waiting for confirmation from SBC on funding ring fenced care support slots to be able to increase the level of risk of patients that can be discharged with anticipated care needs.

-Post hospital
Discharge hub task and finish group a should be able to outline the structure proposed and start date this month. Conversations around social care support at front door are being explored.

We have better success with patients being supported by on virtual Ward and SAFER and Navigation supporting identifying patients, further comms work is required to medical teams.

BSW winter surge beds on Ward 4 (Bath) and South Newton (Salisbury) have not been successful with GWH patients consenting. Leaving Hospital policy and letters to patients now signed off by the ICB quality board and have started circulation for its use this week.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Voluntary Staff Turnover (rate)

The annual turnover rate provides us with a high-level overview of Trust health.

Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Staff turnover has been stable over the last 3 years until Feb/March 2021. Since Feb/March 2021 we have started to see a steady increase in turnover levels.

The last two months have seen an improved position on Turnover.

Staff Recommendation as a Place to Work

The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

In the South West we are no. 17th as an organisation. We want to see an overall improvement in our staff survey results and our position in the South West. Our current performance could have an impact on our reputation as an employer, staff retention and staff morale.

If staff currently felt more positive about their working experience at GWH this will translate positively in improvement in our patient's experience.

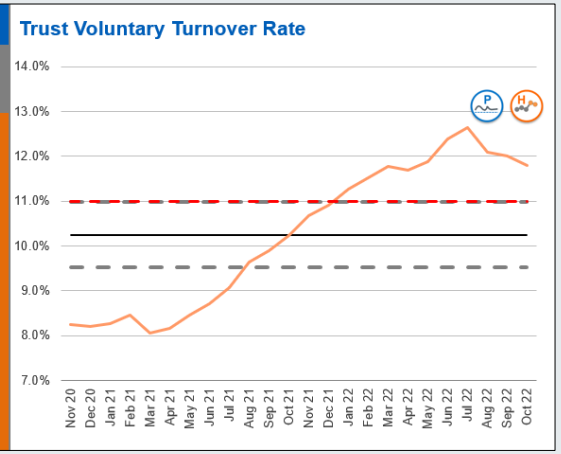
Quarter 2 shows that we remain stable, we await the annual staff survey results to see if there has been an improvement in this question.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

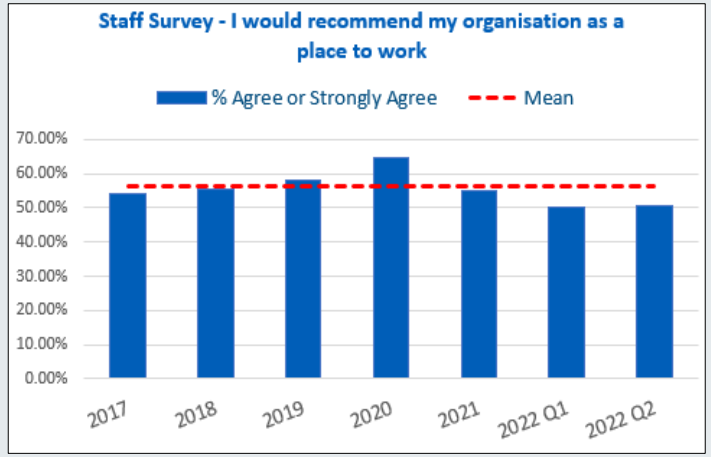
To achieve and maintain a maximum voluntary turnover rate of 11%.

Timescale	Value
Nov 21	10.7%
Dec 21	10.9%
Jan 22	11.3%
Feb 22	11.5%
Mar 22	11.8%
Apr 22	11.7%
May 22	11.9%
Jun 22	12.4%
Jul 22	12.6%
Aug 22	12.1%
Sep 22	12.0%
Oct 22	11.8%



Staff % recommend the organisation as a place to work

To improve our staff engagement score as demonstrated in the annual staff survey.



Counter Measures

• GWH Mediation service is launching on the 28th November to support resolution of dispute / conflict with intervention of trained cohort of mediators. Trust wide and divisional comms are being shared and intranet page will be live for Managers and staff to explain process and principles. Resources include referral guide, referral forms and process map.

• Following the launch of Stay Conversations in June 2022, 10 conversations with staff have taken place. Discussion and support to retain staff has focussed around promotion opportunities, further training, flexible working, and internal vacancies. Sustained promotion planned to increase positive impact of initiative.

•New Internationally Educated Lead Nurse role to lead on retention initiatives for our BAME staff including further support with pastoral care and career development.

•As a thank you to all staff for their hard work this winter, the Trust has agreed with Aramark, the company that provides catering services, that staff will get 50% off in the Refresh restaurant or Bookends during the winter, for the next three months.

•Gold application for Armed Forces Employer Recognition Scheme underway, workshop in December and application window January 2023 for 9 weeks. Focus in this application will be on 'advocacy' and its impact on HR and Procurement policies. 36 Staff across the Trust have identified themselves as armed forces veterans, 16 have family members/spouses/partners within the armed forces, 9 are reservist, and 1 Cadet armed forces volunteer.

•Christmas trolley starting 1st December with support from Executives, Health & Wellbeing Team, and volunteers. Visits planned for departments around the Trust bringing refreshments and minced pies.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Disparity Ratio %

The trust has launched an ED&I strategy having identified this as an essential component to a satisfied and productive workforce and a inclusive workplace.

The trust has a focus on addressing health inequalities within the local population and an effective ED&I strategy and successful implementation of this within the trust can model this approach and more effectively leverage internal expertise in this area, as well as making GWH a strong anchor institution.

We want to measure ED&I across all areas and this is currently a work in progress to identify the right metric—workforce by ethnicity can be used as a proxy measure for now.

At GWH, some staff are unevenly represented through different levels, broadly with over representation at junior levels and under representation in senior leadership positions. The nature of some roles within the trust can be static at certain levels, resulting in under -representation of certain groups.

The complexities of addressing ED&I make it a challenge for the trust, however GWH are keen to have a representative workforce across all levels of the trust.

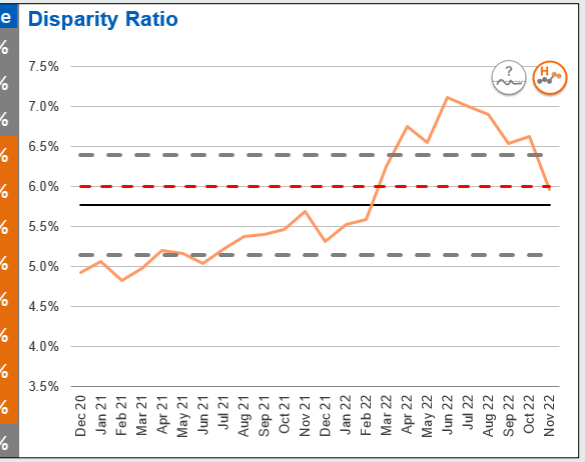
This data measures the difference in the proportion of BAME staff at lower bands (1-5) to higher bands (8a-9) compared to the proportion of White staff at those bands and tells us that our BAME staff are less likely to access progression to higher pay bands. We have seen a reduction in this disparity over the last two months.

Jude Gray
Director of Human Resources (HR)

Disparity Ratio

To ensure a broad and diverse workforce to best represent the community we serve.

Timescale	Value
Dec 21	5.3%
Jan 22	5.5%
Feb 22	5.6%
Mar 22	6.3%
Apr 22	6.8%
May 22	6.6%
Jun 22	7.1%
Jul 22	7.0%
Aug 22	6.9%
Sep 22	6.5%
Oct 22	6.6%
Nov 22	6.0%



Counter Measures

- Equality Lead Nurse developing a monthly CPD newsletter to promote and encourage access to training opportunities for our BAME/International colleagues.

- Disability history month celebrated 16th November to 16th December, creating a disability positive NHS. The theme of Disability History Month is 'Creating a disability positive NHS' and one of the first steps is encouraging staff to share their disability on their personal NHS Electronic Staff Record. Push from networks on staff updating their equality information on ESR to assist with local and national reporting and awareness of issues for staff.

- Working group established to explore themes of inequality and incivility through the development of an A3, with representation from the staff networks and stay to thrive programme.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Financial Position (I&E Margin)

There has been a significant and growing financial deficit over the last 3 years at the Trust. Large financial deficits undermine the public trust in the NHS and put the financial viability of the organisation at risk.

Carbon Footprint / Sustainability

Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and also for indirect emissions by 2045. In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032.

In lieu of our carbon footprint data from Greener NHS (anticipated for early Q3) this report focus is on electricity and gas consumption which forms a significant part of our direct carbon footprint.

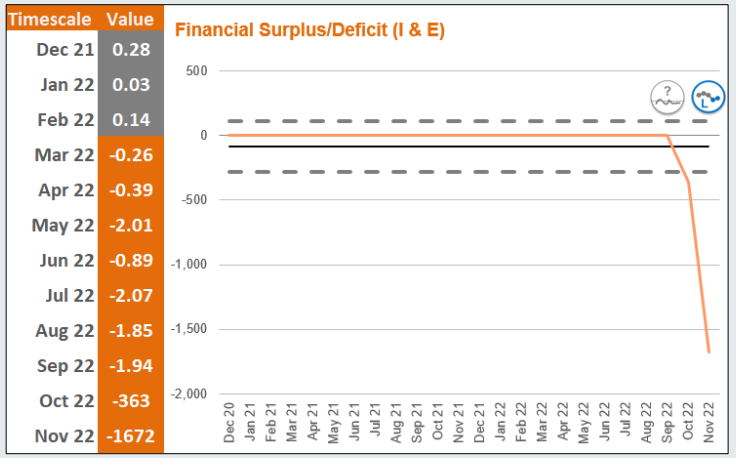
Over the coming years we will be focusing on the delivery of our Green Plan and ICS Green Plan which will be formally reported on annually and refreshed every 3 years.

Simon Wade
Chief Financial Officer

System financial performance - surplus / deficit (I & E)

To achieve and sustain a break even financial position.

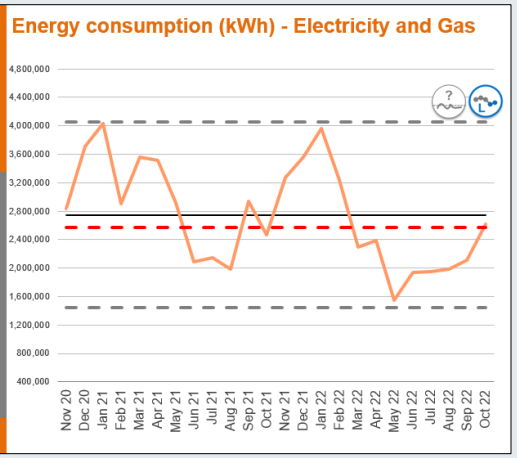
Timescale	Value
Dec 21	0.28
Jan 22	0.03
Feb 22	0.14
Mar 22	-0.26
Apr 22	-0.39
May 22	-2.01
Jun 22	-0.89
Jul 22	-2.07
Aug 22	-1.85
Sep 22	-1.94
Oct 22	-363
Nov 22	-1672



Energy consumption (kWh) – Electricity & Gas

To achieve an organisational carbon neutral footprint.

Timescale	Value
Nov 21	3,269,456
Dec 21	3,561,438
Jan 22	3,962,246
Feb 22	3,237,168
Mar 22	2,293,826
Apr 22	2,388,534
May 22	1,543,874
Jun 22	1,940,413
Jul 22	1,953,493
Aug 22	1,983,344
Sep 22	2,115,111
Oct 22	2,613,274



Counter Measures

- At M8 there is a YTD deficit of £5.7m for the ICB (which is £45m behind plan). The ICB has a deficit YTD as the risk share expense has been recognised as 8/12 of £51m whereas the planned surplus YTD was only 5/9 of £51m. The ICB is forecasting to deliver a position where actual income will match actual expenditure but this will ultimately be a deficit vs plan
- At Month 8 GWH year-to-date position is a deficit of £13.3m which is £0.7m worse than plan.
- Countermeasures have been put in place
  - Relevant divisions in enhanced support
  - Focus on actions to reduce run rate
  - Enhanced workforce controls
  - Targeted work on efficiencies including driving out benchmarked opportunities
  - Drive on productivity including theatre rescheduling

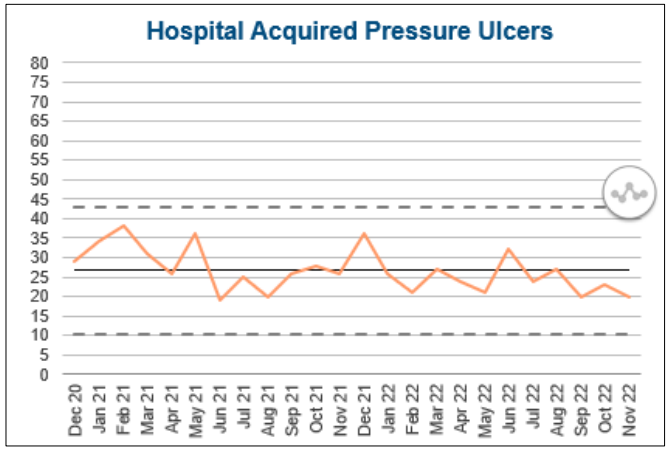
•The board approved Green Plan has been published with targets and action plan agreed.
•Capital funding for sustainability projects has been agreed and work is underway on reducing emissions from nitrous oxide and entonox at GWH.
•GWH is the ICS Green Plan chapter lead for reducing emissions from Medical Gases.

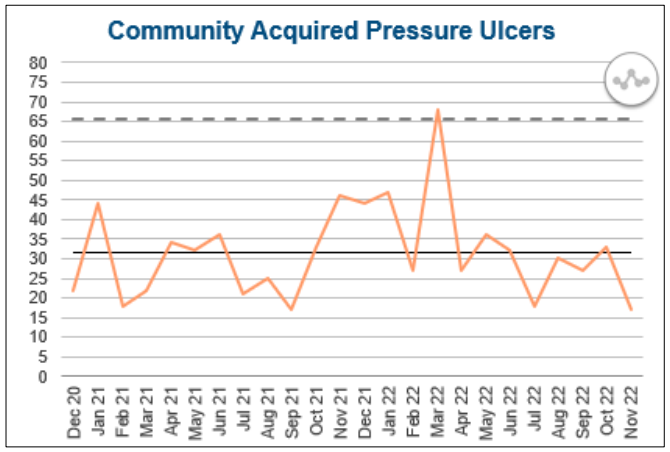
2022/23 Breakthrough Objectives

Reduction of Pressure Ulcer/Harms

Great Western Hospitals NHS Foundation Trust

Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
80	73	48	95	51	57	64	42	57	47	56	37





Common cause – no significant change

Understanding the Data

The number in the charts above represents the number of pressure area harms (pressure ulcers) that patients have developed whilst in hospital or under the care of a community nursing team. The number reflects the total number of harms not total number of patients i.e., one patient may have two or more pressure ulcers.

All pressure ulcer related harms are reported and then clinically validated to determine if they were acquired whilst under the care of GWH.

Tissue viability is the overarching term that describes the speciality that primarily considers all aspects of skin and soft tissue wounds.

We are driving this measure because…

We know that pressure damage is an avoidable cause of harm to patients and believe that through using the evidence-based improvement methodology we can make a significant difference to patients.

Regular measurement is required to ensure front line teams and divisions identify themes and those actions required for improvement of pressure related harms. This will help reduce the level of pressure related harm and improve staff knowledge and skills in caring for our patients.

Performance

There were a total number of 20 hospital acquired pressure harms during the month of November in the hospital setting.

- This is a small decrease of 3 harms, from the previous month, with a total number of 20 harms.
- The new digitalised Pressure Ulcer Risk Assessment Tool has been launched trust wide, following a successful trial.
- Evaluation of hybrids mattresses is taking place in mid-December to determine preferred supplier.

In the community setting there were a total number of 17 pressure harms acquired during the month of November

- This is a significant reduction compared to last month (reduction of 14). We will need to identify whether this is a trend, and this reduction is sustained.
- There have been two successful, Stop the Pressure educational events one in the community and one in the Academy at GWH. There were a total of over 200 attendees, across both events. The events focused on awareness of posture management, risks of pressure damage, equipment and products were on display, interactive stands and tasks to complete.
- Improving Together programme continues with a focus on reduction in Category 2 pressure ulcers.

Risks

In the Community the continuing high case load and difficulties in recruiting to establishment in the Community Nursing services and Tissue Viability services can impact the ability to provide high quality pressure ulcer prevention management, specialist review and assessment. This is being mitigated by:

- Ongoing recruitment of community staff
- Case load reviews with Tissue Viability and other specialist services.
- Increased use of temporary staffing
- Education for temporary staff

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

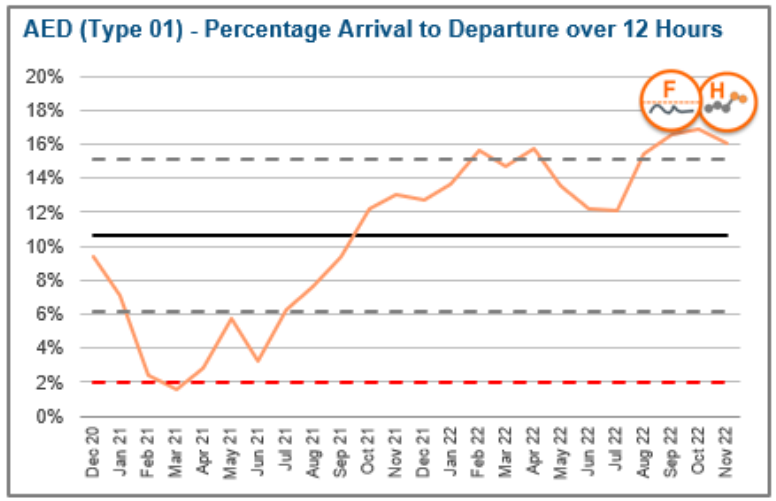
Emergency Department (Type 1) - Percentage Arrival to Departure over 12 Hours

Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
12.7%	13.6%	15.7%	14.7%	15.8%	13.6%	12.2%	12.1%	15.4%	16.6%	16.9%	16.1%

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	2%
Value	Percentage
Improvement Direction	Lower is Better

Variation indicates consistently (F)alling short of the target

Special cause of concerning nature or higher pressure due to (H)igher values



Understanding the Data

Total number of patients who have a total time in ED (Type 1) over 12 hours from
arrival to admission, transfer or discharge.

The clock starts from the time that the patient arrives in ED and it stops when the
patient leaves the department on admission, transfer from the hospital or discharge is completed

We are driving this measure because...

To reduce the number of patients who have waited over 12 hours in ED. The target is to not have more than 2% of all patients who attended ED waiting over 12 hours.

Performance

- %>12 hour waits in ED – decrease through November associated with reduced mean ED time but static number of attendances
- x96 12-hour reportable Decisions to Admit (DTA) breaches – reduction of 7 from last month (previous criteria)
- Clinically ready to proceed option in Careflow is in place, uptake and completion challenging. Review on opt out process underway following specialty referral. This is a change from our current recording and referral processes and will make a difference as we know we are an outlier
- An increase in the LOS >21 days and bed availability at the right time have contributed to stays beyond 12 hours and % beds occupied by long stayers has increased again in November; 35% > than Nov 21
- Additional Managerial Support to ED now recruited fixed term to support progress chasing of referrals and internal delays

Risks

Increases in COVID positive patients and processes for co-horting may impact on flow out of ED and contribute to increases in 12 hour waits.

LOS and % of longest stayers will impact on bed availability and flow out of ED resulting in increased time in ED and likelihood of 12 hour waits.

Increased surges of ED attendances, particularly out of hours, alongside bed availability could contribute to increases in 12 hours waits in ED.

Paediatric surge in attendances is contributing to a crowded ED & UTC increasing wait times and likely to impact on quality of care

2022/23 Breakthrough Objectives

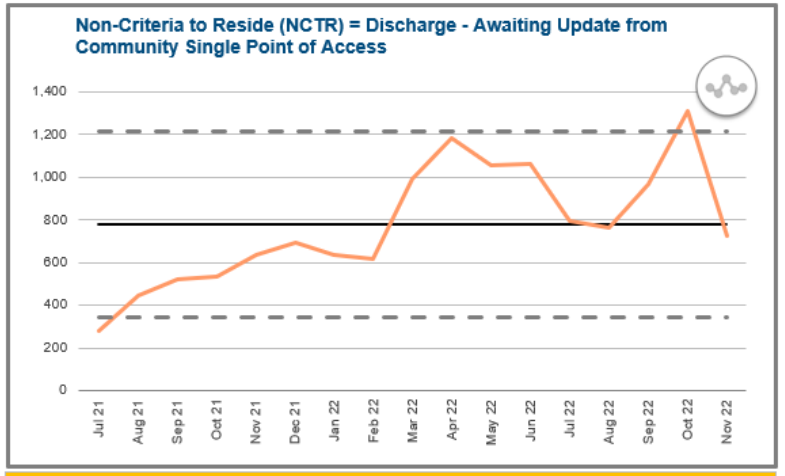
Great Western Hospitals NHS Foundation Trust

Non-Criteria to Reside (NCTR) - Partner Supported Discharge

Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
690	636	618	993	1185	1053	1060	795	760	968	1309	723

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	
Value	Number
Improvement Direction	Lower is Better

Common cause - no significant change



Understanding the Data

This Breakthrough objective will primarily capture PW1,PW2,PW3 patients as by definition PW0 are simple ward led discharges. A small number of patients on PW0 may require social care support outside of healthcare needs and this group will be inclusive within this modelling.

This is linked closely to the BSW improvement work of reducing NC2R patients by 30% from a Dec 2022 baseline.

The data surrounding updates from Single Point of Access is directly related to lost bed days and therefore the time patients wait to leave the Acute Trust.

We are driving this measure because...

In a 12-month period more than 10,000 bed days were lost within the discharge criteria 'Awaiting update from Community Single Point of Access'.

Internally the aim is to refer patients that require social care support for discharge as soon as this has been identified as a discharge care need. Different referral approaches from localities can be a barrier to being proactive with discharge planning from admission.

One of the aims of this breakthrough objective to use the data to demonstrate the value of being able to refer patients to partners before they a medically safe to leave hospital, building on a collaborative uniform ICA approach.

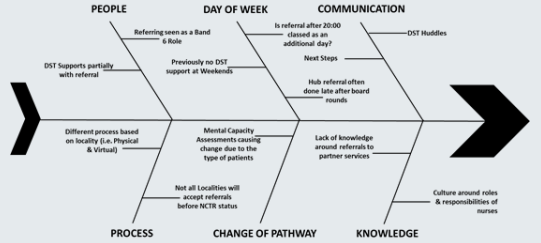
Further delays to patients' discharges can be increased waiting for social care assessment, outcomes and inventions required to proceed with that discharge. Patients with complex care needs can experience significant lengths of stay which increases further risk of harm to the patient. Improvements through internal professional standards set by time metrics, and implementation of assessments in the community using the D2A model will support reduction in the total bed days lost.

Performance

- Significant improvement noted against this discharge criteria.

Counter Measure

- Through some of the actions from a focus group and A3 modelling work with the test ward Saturn and SWicc we have seen a reduction in bed days lost to waiting update from SPOA. This learning will be prompted through SAFER and to other wards that have been identified as 'top contributors'



We concluded that the four main areas for our initial focus would be:
1.Day of week
2.Time of day
3.Change of Pathway
Education

Risks

The ongoing risk unchanged -maintaining good internal professional standards from time patient is fit to referral through constant surveillance. This is required throughout the day and not just from board round decisions.

There is an unknown risk against social worker demand and capacity caseloads when there is a current average of 50 patients on amber hold/watch list. This means a number of patients are referred to social care who wait in excess of 3 bed days to be assessed by the social work team.

There is a risk to batching of referrals on the day patients become fit increasing the potential for further bed days lost waiting for social worker allocation. This is in part to the Trusts approach to 5 day working.

Unable to deliver a 7 day service that is truly supported by localities working on patient case loads over weekends

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Staff Survey - I am able to make improvements happen in my area of work

2017	2018	2019	2020	2021	2022 Q1	2022 Q2
54.20%	55.60%	58.00%	64.50%	55.06%	50.31%	51.10%

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	
Value	Percentage
Improvement Direction	Higher is Better

Understanding the Data

The Staff Survey results are predominantly aimed at service improvement. It is important to know if staff could provide the care and service they aspired to give.

We are driving this measure because...

This staff survey feedback is extremely important. The result of this survey could help how staff feel about making improvements happen in their workplace.

Performance

•Annual staff survey cycle has closed with a 59% response rate. Initial summary data will be available in December, with embargoed data being available end of January and a presentation to the Executive Team planned for February. This data will give us feedback on retention and staff recommending as a place to work.

•Future approach of the staff survey working group has been realigned in November. The group are now considering improvement actions that are having the greatest impact and can be scaled up across divisions. This will form part of working group agenda in future.

•Examples of divisional improvements include daily huddles, monthly newsletter, ideas meetings, subject matter expert by department and process mapping.

•Corporate bootcamp to take place in March with representatives meeting 21/12 to align department improvements to divisional wide actions, and T&I training the estates department in December.

Risks

•Divisions need to ensure that countermeasures are demonstrating a positive impact prior to rolling out across the whole division and align with the Trust breakthrough objective.

•Divisional teams are going through improving together training in different timescales, therefore the risk is that less improvement actions could be made in areas who are yet to go through training.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
RTT	No. of >=18 weeks waiters		H	14609	15794	16191	16257
	No. of >=52 weeks waiters		H	1568	1926	2164	2281
DM01	No. of patients on DM01 waitlist		H	12388	12229	11725	One month behind
	DM01 performance %	99% (Nat)	H	43.9%	46.5%	50.4%	One month behind
	DM01 6 week wait breaches		H	6951	6544	5818	One month behind
Cancer	% Cancer 62 day performance	85% (Nat)	L	65.1%	62.9%	56.4%	One month behind
	% Cancer 2 week wait	93% (Nat)	L	68.0%	72.2%	65.4%	One month behind
	% 28 day faster diagnosis	75% (Nat)	L	73.3%	66.0%	64.5%	One month behind
	No. of referrals received		H	1848	1872	1762	One month behind

Common cause - no significant change.	Special cause of concerning nature or higher pressure due to higher or lower values.	Special cause of improving nature or lower pressure due to higher or lower values.	Variation indicates inconsistently hitting passing and falling short of the target.	Variation indicates consistently (P)assing the target.	Variation indicates consistently (F)assing the target.

Performance & Counter Measure

DM01 performance has improved in October to 50.38% from 46.49% in September. The number of patients on the waiting list decreased and the overall waiting time has reduced in Radiology. The 2 Pads in Radiology continue to be fully utilised and activity numbers continue to exceed any previous levels. We continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Progress in activity in Ultra-sound and DEXA has also decreased the waits.

Cancer waiting times remain below standard with an increase in demand and a lack of capacity. The Skin Pathway is having the greatest impact on all of the standards. Skin accounted for 75% of the 2ww breaches and 47% of the 62-day breaches.

Counter Measure - A Locum started in the Dermatology team in October which should see the 2ww performance recover by the end of December 22. We continue to work with the OUH Plastics team for extra capacity, however, there is a clear deficit in capacity within Plastics that will impact the cancer pathway is unable to be mitigated further without significant staffing and / or investment. This is subject to a strategic service review.

The weekly Elective Access Meetings will support improvement work through monitoring of counter measures, identifying support and mutual aid options and review of individual patients within pathways to move on in pathway if required.

Risks

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)		75.0%	73.9%	72.5%	73.1%
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		54.9%	51.5%	51.8%	53.4%
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)		15.4%	16.6%	16.9%	16.1%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5225	5164	5409	5393
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		42.8%	44.4%	44.2%	38.1%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)		183	197	202	212
	A&E Arrival to Departure Percentage over 12 Hours (All Patients)	2% (Nat)		8.2%	8.4%	8.4%	8.2%
	A&E Arrival to Departure over 12 Hours (Admitted Patients)	2% (Nat)		32.9%	34.5%	36.8%	34.8%
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		1579:59	1829:45	2056:34	2048:59
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		64.0%	64.8%	69.2%	69.4%

Common cause - no significant change.	Special cause of concerning nature or higher pressure due to higher or lower values.	Special cause of improving nature or lower pressure due to higher or lower values.	Variation indicates inconsistently hitting passing and falling short of the target.	Variation indicates consistently (P)assing the target.	Variation indicates consistently (F)assing the target.

Performance & Counter Measure

ED performance has seen some improvement across most metrics compared to October, with triage time seeing a significant improvement following focused IMT work; focus on ED Majors Chairs as part of new triage space, and robust capture of data particularly with ambulance team handovers

Ambulance handover audits now completed by team with data showing prompt handover and ambulance waits linked directly to capacity in department and flow to IP beds

- Triage times have improved significantly; 68% within 15 mins compared to 38% prior month
- Total % over 12 hours has improved; 16% compared to 16.8% prior month
- % over 12 hours Admitted improved; 39.8% compared to 42.9% prior month
- % over 12 hours Non-Admission improved; 0.052% compared to 0.057% prior month
- % of patients admitted increased; 31% compared to 30% prior month

Counter measures remain in place within the Breakthrough objective slides 7 and 8

Risks

Pressure to maintain flow and bed availability as we proceed into the winter months ahead, thereby with a potential to impact elective activity. This is mitigated by our Winter plan and work with system partners.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
ED	Number of Ambulance Handover 30 Minute Waits	SPC		807	819	904	848
	Percentage of Ambulance Handover s Over 30 Minutes	SPC		42.9%	46.3%	49.9%	47.2%
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		563	558	648	604
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		30.0%	31.5%	35.8%	33.6%
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		833	868	960	895
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		298	312	322	319
	Non-Elective Patients Average Length of Stay (Days)	SPC		5.7	5.4	5.3	5.4
	Number of Stranded Patients (over 14 days)	SPC		134	138	150	142
	Number of Super Stranded Patients (over 21 days)	SPC		79	82	89	86
	GWH Acute Adult Bed Occupancy (%)	SPC		97.9%	95.9%	96.5%	95.9%

Common cause - no significant change.	Special cause of concerning nature or higher pressure due to higher or lower values.	Special cause of improving nature or lower pressure due to higher or lower values.	Variation indicates inconsistently hitting passing and falling short of the target.	Variation indicates consistently (P)assing the target.	Variation indicates consistently (F)assing the target.

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Risks

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Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
RTT	No. of >=78 weeks waiters		L	39	44	40	45
Cancer	% Cancer 31 day performance	96% (Nat)		85.6%	79.6%	85.6%	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		97.7%	96.8%	93.8%	93.5%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)		0.0%	0.0%	0.0%	0.0%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)			42.0%	41.0%	41.0%	37.7%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)			57.8%	48.5%	48.5%	51.5%
	Total Number of Ambulance Handovers		L	1879	1769	1810	1797
	Number of Ambulance Handover Over 15 Minute Waits			1202	1147	1252	1248
Flow	Elective Patients Average Length of Stay (Days)			3.5	3.4	3.5	3.0
	Community Average Length of Stay (Days)		H	19	20	22	21
	GWH Discharges by Noon (%)			16.1%	15.2%	17.3%	16.8%

Common cause - no significant change.	Special cause of concerning nature or higher pressure due to higher or lower values.	Special cause of improving nature or lower pressure due to higher or lower values.	Variation indicates inconsistently hitting passing and falling short of the target.	Variation indicates consistently (P)assing the target.	Variation indicates consistently (F)assing the target.

62

Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

An unscheduled care improvement plan and BSW system group is supporting actions to reduce Handover Delays across the system with audits of handovers now completed.

28 day previously delivered & will be reviewed as a non-alerting watch metric.
In October, 82% (444) of the breaches were for across 4 tumour sites. Work is underway with the TVCA to implement the Best Practice Timed Pathways across 3 of these (Colorectal, Gynae & Urology) by the end of December 22.
In October, a Locum started in Dermatology (25% breaches) which should see this service achieve the 28 day standard by December 22.

There are several workstreams as part of the Improvement plan for Flow and the Emergency Department that support the non- alerting watch metrics.
These include

- Patient Care & Experience – Medical Care & Workforce transformation
- Acute floor review (are we using our space in the optimum way) Nov 22
- Weekend working review (postponed from Nov 22)
- Processing speed of empty beds
- Board round processes
- Surgical pathways – Phase 1 General Surgery & SAU pathways completed Nov 22
- The ICA co-ordination Centre
- Home First
- ED 'pit stop' for patients – rapid review and transfer
- Acceleration of the Virtual ward model
- Acceleration of the Urgent Care response
- Review of CTR and NCTR pts over 21 days daily internally and with partners

Risks

Increased pressure on our longest waiting patients, as the waiting list size is disproportionate to the capacity to support recovery.

Activity plans are below target, whilst this is being addressed, failure to deliver will result in increased pressure on our delivery of no patient waiting over 75 weeks by March 2023.

Our Performance

Great Western Hospitals NHS Foundation Trust

Key Indicators

Measure Name	Mean/Thres.	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Total patients waiting more than 52 weeks	1193	639	626	612	664	744	852	1028	1215	1568	1,926	2,164	2,281
Total patients waiting more than 78weeks	47	56	65	52	47	49	50	52	34	35	44	40	45
Total patients waiting more than 104 weeks	0.2	0	0	0	0	0	0	1	0	0	0	0	1
Total elective activity undertaken compared with 2019/20 baseline	100.0%	91.6%	87.1%	98.6%	127.0%	90.5%	95.5%	97.1%	87.3%	100.3%	94.2%	81.6%	74.4%
Total diagnostic activity undertaken compared with 2019/20 baseline	100.0%	95.3%	79.5%	89.0%	83.3%	88.7%	94.6%	92.4%	87.9%	90.5%	101.9%	95.6%	Reported one month behind
Total Cancer patients waiting over 62 days	233	170	169	170	154	181	216	247	310	310	331	306	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75%	77.3%	68.0%	79.3%	80.8%	81.6%	78.9%	79.4%	75.5%	73.3%	66.0%	64.5%	Reported one month behind
Total patients treated for cancer compared with the same point in 2019/20 (first and	100.0%	156.0%	126.0%	114.2%	100.5%	71.7%	150.5%	85.5%	58.6%	107.1%	106.2%	85.4%	Reported one month behind
Outpatient follow-up activity levels compared with 2019/20 baseline	100.0%	92.8%	81.8%	84.3%	108.5%	85.6%	89.5%	85.9%	73.9%	94.5%	88.8%	77.5%	79.9%
Proportion of ambulance arrivals delayed over 30 minutes	39.4%	26.7%	29.6%	44.9%	39.5%	48.4%	38.9%	26.9%	31.0%	42.9%	46.3%	49.9%	47.2%
Proportion of patients spending more than 12 hours in an emergency department	2.0%	7.3%	7.5%	8.6%	8.0%	8.4%	7.4%	6.4%	6.5%	8.2%	8.4%	8.5%	8.2%
Ambulance average response times - Category 1	00:10:17	00:11:13	00:09:32	00:11:12	00:11:14	00:10:14	00:09:21	00:09:52	00:10:02	00:10:13	00:09:54	00:10:16	Waiting for data
Proportion of patients discharged from hospital to their usual place of residence	94.1%	93.7%	94.5%	94.4%	94.3%	93.8%	94.1%	93.8%	94.2%	93.9%	94.3%	94.2%	94.0%
GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	24.8%	20.6%	23.5%	23.5%	26.6%	26.4%	24.8%	25.4%	24.5%	24.0%	26.1%	26.7%	25.6%
Average hours lost to ambulance handover delays per day	48.2	25.7	30.1	62.0	44.1	66.7	48.3	33.8	30.0	51.0	61.0	66.3	59.9
Adult general and acute bed occupancy	95.7%	94.8%	94.1%	94.7%	95.4%	95.7%	96.5%	95.8%	95.3%	97.9%	95.9%	96.5%	95.9%

Our Care

Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		58%	61%	64%	73%
IP&C	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections in month	14.67 (Int)		17	20	22	25
FFT	Inpatients Positive Responses	82% (Int)		81%	77%	81%	80%
	Maternity Response Rate	24% (Int)		18%	17%	18%	19%

Special cause of concerning nature or higher pressure due to higher or lower values.

Performance & Counter Measure

The high level of activity is impacting on the ability to meet complaint response deadlines, there has been an improvement in November, this is particularly evident in USC and ICC due increased oversight from senior team and additional support being provided by the PALs team.

The PALs teams from the acute trusts across BSW have met to share good practice, the RUH and SFT both report they are struggling to respond to complaints within designated timeframes.

New complaints management training with a focus a on early resolution and delivering a thorough high quality response was delivered by external company in November. It is planned to repeat the training in January and later in the year. Future sessions will be jointly delivered by the Head of PALs and Complaints and external company to ensure internal processes are covered.

MSSA remains a concern, with theme related to IV cannula management. An IV Forum has been set up to mirror the successful impact the CAUTI Group has had on catheter practice. The IV Forum's first meeting will take place in December. Every MSSA case is subject to a detailed post infection review to support the identification of themes and areas for learning and/or improvement.

Risks

Divisions are reporting high workload causing challenges in responding within agreed timeframes. Response rate within agreed timeframe is declining. PALS team are supporting to help ensure response times are maintained. Weekly meetings in place to monitor and provide support with oversight from Deputy Chief Nurse.

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
Harm	No. of serious incidents reported in month	SPC		4	4	1	0
	Falls rate per 1000 bed days	SPC		6.4	5.8	5.5	5.7
	No. of Falls in month	SPC		128	113	112	113
	No. falls with moderate harm or above	SPC		2	2	5	1
	Medication incidents with moderate harm	SPC		7	5	3	7
	No. of concerns received	SPC		159	205	206	183
	No. of complaints received	SPC		63	50	50	54
	Number of reopened complaints	SPC		5	6	3	7
IP&C	Methicillin-resistant Staphylococcus Aureus (MRSA) infections in mor	0 (Int)		0	0	1	1
	Clostridium difficile (C. diff) infections in month	32 (Int)		15	22	25	32
	Escherichia coli (E. coli) infections in month	46 (Int)		46	52	54	60
	Pseudomonas infections in month	12.67 (Int)		4	5	6	9
	Klebsiella infections in month	15.3 (Int)		10	14	15	16
	Covid – no. of hospital acquired	SPC		9	53	78	31

Performance & Counter Measure

The numbers of Falls remains consistent with previous months and within normal variance. The new Clinical Practice Educator for Falls and Enhanced Care has commenced in post, providing training and face to face clinical support for falls assessment and interventions, complex or multiple falls, enhanced care, meaningful activity and exercise.

A Meaningful activity project to help reduce falls commenced in SWICC and Sunflower Lodge at the beginning of December with support from voluntary services and health and social care students

Activity through PALS remains high, although there has been a reduction in concerns this month. The number of compliments has increased, with Unscheduled care receiving 55 their highest number on record. Themes for concerns continue to be Waiting times, communication and day to day care on the ward, complaints tend to be focuses on care and treatment.

We are continue to support and encourage managers to offer meetings early in the process of complicated complaint to ensure a thorough understanding issues, this should lead to a comprehensive response and reduce the likelihood on reinvestigation.

E.coli rates are falling since the focus on catheter care began in August and the Trust could come back under trajectory if this continues.

The Trust remains below its trajectory *Pseudomonas* infections and in line for *Klebsiella and C. difficile*. C. difficile rates have increased in month, investigations have not identified deficits in care or areas for improvement or learning.

Risks

Significant operational pressures means that training and capacity to respond to complaints can be compromised. Support to operational and clinical teams from corporate teams is in place.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)		98.2%	99.0%	96.6%	97.3%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	H	102.6%	103.1%	102.4%	104.2%
FFT	Overall response rate (%)	26% (Int)		27.4%	27.4%	27.2%	25.7%
	Positive response (%)	86% (Int)		87%	83%	85%	84%
	ED & UTC Response Rate	18% (Int)	H	20%	20%	19%	20%
	ED & UTC Positive Responses	77% (Int)		77%	74%	73%	72%
	Inpatients Response Rate	22% (Int)		22%	20%	24%	23%
	Daycases Response Rate	24% (Int)		23%	22%	24%	22%
	Daycases Positive Responses	96% (Int)		95%	92%	94%	95%
	Outpatients Positive Responses	96% (Int)	H	98%	99%	98%	98%
	Maternity Positive Responses	95% (Int)		90%	91%	92%	92%

Common cause - no significant change.

Special cause of improving nature or lower pressure due to higher values.

Performance & Counter Measures

For November, the number of Family and Friends positive response remains consistent with previous months at 84%, This is based on the % of responses rated as ‘very good’ and ‘good’.

Negative responses have continued to be in the early teens, at 11%. Compared to 8% for August, 11% in September and 9% for October, retaining the trends for this year. This is based on responses rated as ‘poor’ and ‘very poor’.

ED & UTC combined positive score at 72% is maintained from last month. Inpatients show a 80% positive score slightly up on prior months. Outpatients show a return to a positive score of 98%, above the prior months range of 93% to 95%. For the combined areas of maternity services, the positive score of 91% is maintained.

Staff attitude received the highest positive (1567) and highest negative (275) theme, the environment and implementation of care remain the other top positive themes and waiting times was a top negative theme.

Improvement actions in place include

- Implementation of a specific feedback survey for ladies undergoing Caesarean section
- Patient led involvement in hydration campaign including hydrations poster, patient case study and care reflection film

Risks

Our Care

Great Western Hospitals NHS Foundation Trust

Key Indicators

Measure Name	Mean/Thres.	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
National Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	1	0	0	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (Per 100,000	1	0	0	0	0	0	0	0	0	0	0	5.8	One month behind
Clostridium difficile infection rate (Per 100,000 bed days)	22.1	43.2	18.5	13.7	18.5	36.3	11.7	12.9	11.7	17.3	41.7	17.3	One month behind
E. coli bloodstream infection rate (Per 100,000 bed days)	40.0	18.5	49.3	34.1	18.5	54.4	29.3	60.5	52.7	75.0	35.8	11.5	One month behind
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Summary Hospital-level Mortality Indicator	0.91	0.89	0.89	0.88	0.88	0.87	0.86	0.88	0.90	0.93	0.95	0.98	1.00

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
Use of Resources	Capital Expenditure (£'000)	SPC		225	225	289	597
	Pay (£'000)	SPC		21995	26581	23353	23452
	Non Pay (£'000)	SPC		15101	14274	14218	14816

Performance & Counter Measure

The Trust has capital expenditure of £597k in November against the CDEL programme in total for 2022/23 of £12.5m. Total Capital Expenditure at Month 8 year to date is £6.4m below plan. Of this, £4.8m relates to Trust CDEL schemes, with the remaining £1.6m slippage on externally funded schemes.

Through the Year capital expenditure is low, the capital team have been meeting with divisions, project leads, and procurement to monitor progress and ensure the allocated funding is spent. Purchase orders to the value of £3.1m (Nov) and £0.25m (to date in Dec) have been raised which will lead to an increase in spend.

Pay costs are £99k higher than the previous months costs so there has been little change. This includes agency and bank costs. Pay is however our biggest cost and a key contributor of our variances. The spike in September 2022 £ is due to back pay of the AFC pay award.

Non Pay costs have increased significantly from 2019/20, with the 2022/23 run rate relatively static in year. Increased costs this month vs. Previous month of £0.6m are predominantly driven by some increases in drugs and estates costs.

Risks

.

Common cause - no significant change.

Use of Resources

Great Western Hospitals NHS Foundation Trust

Key Indicators

Measure Name	Mean/Thres.	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Financial efficiency - variance from efficiency plan (£'000)	+/-	-54	-51	6	46	-34	-424	-209	-289	-268	-247	190	-378
Financial stability - variance from break-even (£'000)	+/-	279	28	141	-386	-2506	-2006	-888	-2068	-1848	-1938	-363	-1672
Financial stability - variance from PLAN (£'000)	+/-	783	533	645	3552	-387	-335	-517	-326	-268	-408	1154	389

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-22	Sep-22	Oct-22	Nov-22
Workforce	Trust sickness absence rate	3.5% (Int)		4.6%	4.7%	5.3%	One month behind
	% of leavers within 1st year of employment	31.2% (Int)		13.8%	18.0%	23.8%	One month behind

Plan Area	Metric	2017	2018	2019	2020	2021	2022 Q1	2022 Q2
Staff Survey	Staff Survey response rates	46.5%	43.6%	40.0%	53.4%	39.5%	21.4%	23.6%
	My immediate manager takes a positive interest in my health and well-being	68.8%	67.5%	74.8%	69.2%	64.4%	Not in Quarterly Survey	Not in Quarterly Survey

Performance & Counter Measure

Sickness absence increased slightly to 5.3% in month, of which 3.2% is short term and 2.1% is long term. Of total sickness absence, 0.75% is Covid-19 related. Absence in October is in line with the previous year, and the increase in absence over the previous 3 months matches the seasonal variation experienced in 2021.

The % of leavers within 1st year of employment has increased again in month. Key themes for staff leaving are 'Work/Life Balance' and 'Undertaking Further Education/Training'

Staff survey response rates are 59% which is a 20% increase compared to last year .

Risks

Sickness trends during winter months are historically higher and include the continued management of legacy cases of long-Covid related absence.

Common cause - no significant change.

Our People

Key Indicators

Measure Name	Mean/Thres.	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Proportion of staff in senior leadership roles who are from BME background	5.2%	5.1%	5.1%	5.1%	4.7%	4.7%	4.5%	4.5%	4.7%	5.9%	6.0%	6.5%	Reported one month behind
Proportion of staff in senior leadership roles who are women	69.3%	70.8%	71.2%	71.3%	70.9%	70.3%	69.1%	68.9%	69.1%	67.0%	66.3%	67.3%	Reported one month behind

Measure Name	Mean	2017	2018	2019	2020	2021	2022
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	Reported annually
Staff survey engagement theme score	6.9	6.9	6.9	7	7	6.7	Reported annually
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	0.6	59.6%	54.1%	60.4%	57.1%	56.1%	Reported annually

Our People

Workforce Scorecard

Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
	Vacancy															
W	Vacancy Rate %	%	7.00%	6.06%	6.55%	6.91%	6.77%	6.33%	8.03%	7.31%	6.94%	7.48%	6.70%	6.31%	6.56%	5.97%
W	Trust Vacancy WTE	WTE	-	306.31	332.42	350.82	343.65	321.55	415.32	377.16	358.52	386.57	347.09	328.65	343.04	313.11
W	Nursing Vacancy %	%	7.00%	4.50%	5.20%	5.60%	5.31%	4.59%	7.40%	6.44%	5.27%	5.62%	4.88%	5.58%	5.95%	5.27%
W	Nursing Vacancy WTE	WTE	-	108.03	125.70	135.51	128.45	110.90	184.68	160.51	131.68	140.23	122.71	141.28	151.92	135.61
W	Medical Vacancy %	%	7.00%	7.14%	6.93%	7.01%	8.08%	6.89%	9.00%	8.68%	8.94%	9.57%	6.53%	3.64%	5.73%	5.80%
W	Medical Vacancy WTE	WTE	-	48.60	47.44	47.99	55.32	47.14	63.55	60.96	62.75	67.19	45.84	25.59	40.26	40.74
W	STT/AHP Vacancy	%	7.00%	6.68%	7.41%	7.92%	7.45%	7.36%	7.84%	7.11%	7.44%	8.94%	8.25%	7.57%	6.89%	6.09%
W	STT/AHP Vacancy	WTE	-	55.42	61.53	65.57	61.71	60.99	64.89	58.82	61.57	74.04	68.37	62.72	57.10	50.49
W	SMA Vacancy	%	7.00%	8.24%	8.54%	8.88%	8.57%	8.95%	8.97%	8.50%	8.98%	9.21%	9.66%	8.68%	8.21%	7.55%
W	SMA Vacancy	WTE	-	94.26	97.75	101.75	98.17	102.52	102.20	96.87	102.52	105.11	110.17	99.06	93.76	86.27
W	Recruitment Time to Hire	Days	46.00	43.00	45.40	50.60	52.20	56.90	61.20	67.70	67.90	62.00	61.10	74.70	63.70	74.30
	Workforce Utilisation															
W	Budgeted vs Worked WTE Variance	WTE	-	149.10	129.81	149.44	129.31	240.44	25.11	89.92	91.14	138.16	156.56	121.30	71.71	184.20
W	Actual Worked vs Budgeted %	%	-	2.95%	2.56%	2.94%	2.55%	4.74%	0.49%	1.74%	1.76%	2.67%	3.02%	2.33%	1.37%	3.51%
W	Total Workforce Cost £	£	-	£21.52M	£21.81M	£22.06M	£22.00M	£19.99M	£23.15M	£22.93M	£23.22M	£21.61M	£22.66M	£26.58M	£23.35M	£23.45M
W	Agency Spend as % of Total Spend	%	6.00%	6.62%	6.86%	7.13%	7.74%	7.60%	6.88%	6.57%	6.36%	4.18%	6.23%	5.65%	6.53%	6.17%
W	Agency Spend £	£	-	£1.42M	£1.48M	£1.58M	£1.71M	£1.77M	£1.51M	£1.44M	£1.42M	£0.91M	£1.37M	£1.55M	£1.53M	£1.48M
W	Agency WTE	WTE	-	115.23	124.53	124.18	120.02	139.35	113.88	124.59	117.85	121.32	134.43	137.51	127.69	113.12
W	Bank WTE	WTE	-	307.07	305.88	350.76	320.03	386.55	283.32	311.77	304.96	377.97	340.68	285.71	258.31	354.47
W	Registered Nursing Bank Fill	%	45.00%	47.16%	46.74%	46.48%	48.71%	47.78%	45.28%	44.86%	47.09%	44.52%	37.70%	46.57%	48.32%	53.80%
W	Unregistered Nursing Bank Fill	%	70.00%	68.01%	62.64%	62.61%	62.23%	62.47%	63.53%	69.76%	75.59%	72.53%	69.81%	72.94%	66.26%	70.85%
	Retention															
W	All Turnover %	%	13.00%	14.32%	14.51%	14.96%	15.26%	15.59%	14.89%	14.82%	15.46%	15.90%	15.00%	14.87%	14.69%	-
W	Voluntary Turnover %	%	11.00%	10.58%	10.77%	11.24%	11.40%	11.66%	11.89%	11.88%	12.38%	12.64%	12.07%	12.00%	11.78%	-
W	Number of RN Leavers	Headcount	-	21.00	17.00	17.00	22.00	25.00	21.00	18.00	17.00	16.00	12.00	15.00	7.00	-
W	Registered Nursing Vol Turnover	%	-	8.62%	8.84%	9.12%	9.56%	9.86%	10.31%	10.43%	10.41%	10.43%	10.06%	9.90%	9.50%	-
W	Number of Unreg Nursing Leavers	Headcount	-	12.00	12.00	6.00	11.00	14.00	10.00	12.00	22.00	13.00	15.00	16.00	17.00	-
W	Unregistered Nursing Vol Turnover	%	-	14.73%	14.64%	14.29%	14.10%	14.19%	14.24%	14.12%	15.28%	15.58%	14.80%	15.07%	15.50%	-
W	Leavers within 1st Year of Employment	%	-	21.43%	23.44%	26.67%	30.95%	29.87%	24.29%	33.33%	29.27%	32.14%	13.61%	17.95%	23.81%	-
W	Number of Trust starters	Headcount	-	79	27	97	61	85	92	88	70	56	99	103	101	-

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
	Absence															
D	Sickness Absence %	%	3.50%	5.36%	5.79%	6.52%	6.10%	6.65%	6.08%	4.68%	5.12%	5.98%	4.71%	4.73%	5.30%	-
W	Long Term Sickness %	%	2.00%	2.45%	2.88%	3.99%	3.37%	3.86%	3.47%	2.09%	2.43%	3.35%	2.02%	2.24%	3.20%	-
W	Short Term Sickness %	%	1.50%	2.91%	2.91%	2.53%	2.74%	2.79%	2.60%	2.59%	2.68%	2.63%	2.69%	2.48%	2.09%	-
W	Sickness Absence Cost £	£	-	£706k	£794k	£879k	£753k	£936k	£807k	£642k	£678k	£843k	£649k	£639k	£768k	-
W	WTE Days Lost	WTE	-	7,458.7	8,325.3	9,385.5	8,030.5	9,661.7	8,559.9	6,926.0	7,280.7	8,728.5	6,887.2	6,780.7	7,952.9	-
	Learning & Development															
W	Mandatory Training Compliance %	%	85.00%	88.13%	88.85%	88.33%	87.60%	87.38%	87.36%	87.75%	87.87%	87.74%	86.70%	87.22%	85.78%	86.39%
W	Role Essential MT %	%	85.00%	89.50%	90.16%	90.00%	86.06%	89.17%	89.05%	89.33%	89.62%	89.64%	88.56%	89.28%	87.95%	88.75%
W	CQC Safe MT %	%	85.00%	86.80%	87.59%	86.72%	89.20%	85.64%	85.73%	86.22%	86.17%	85.91%	84.90%	85.22%	83.66%	84.10%
W	Appraisal Compliance %	%	85.00%	73.78%	74.17%	73.27%	68.61%	68.85%	70.05%	73.03%	74.55%	75.56%	75.75%	75.04%	76.32%	79.31%
W	Non Medical Appraisal Compliance %	%	85.00%	75.08%	77.42%	74.84%	70.16%	69.66%	71.44%	74.99%	77.85%	77.91%	78.12%	78.03%	77.94%	78.88%
W	Medical Appraisal Compliance %	%	85.00%	64.55%	51.18%	62.18%	57.66%	63.13%	60.29%	58.82%	50.37%	58.38%	58.41%	53.44%	64.63%	82.84%
	Demographics															
W	Staff in Leadership Roles %	%	-	3.24%	3.26%	3.39%	3.39%	3.37%	3.37%	3.43%	3.34%	3.32%	3.17%	3.08%	3.32%	3.40%
W	Staff in Leadership Roles WTE	WTE	-	189.00	190.00	197.00	197.00	197.00	197.00	202.00	197.00	195.00	188.00	184.00	199.00	206.00
W	% of Leadership Roles who are Female	%	-	66.67%	67.37%	68.02%	67.51%	67.51%	66.50%	65.84%	65.48%	65.64%	67.02%	66.30%	67.34%	67.48%
W	% of Leadership Roles who from BME	%	-	4.76%	5.26%	5.08%	5.08%	5.08%	5.58%	5.45%	5.58%	5.64%	5.85%	5.98%	6.53%	6.80%
W	Male % of Workforce	%	-	19.13%	19.17%	19.20%	19.23%	19.24%	19.31%	19.37%	19.47%	19.44%	19.23%	19.42%	19.25%	19.12%
W	Female % of Workforce	%	-	80.87%	80.83%	80.80%	80.77%	80.76%	80.69%	80.63%	80.53%	80.56%	80.77%	80.58%	80.75%	80.88%
W	BME % of Workforce	%	-	19.37%	19.36%	19.49%	19.75%	20.03%	20.38%	20.63%	20.87%	20.97%	21.18%	21.41%	21.65%	21.97%
W	White % of Workforce	%	-	71.37%	71.01%	70.62%	70.72%	70.52%	70.17%	69.80%	69.65%	69.70%	69.51%	69.26%	69.18%	68.93%

Appendices

Explaining the IPR

Improving
together

Strategic Planning Framework

NHS
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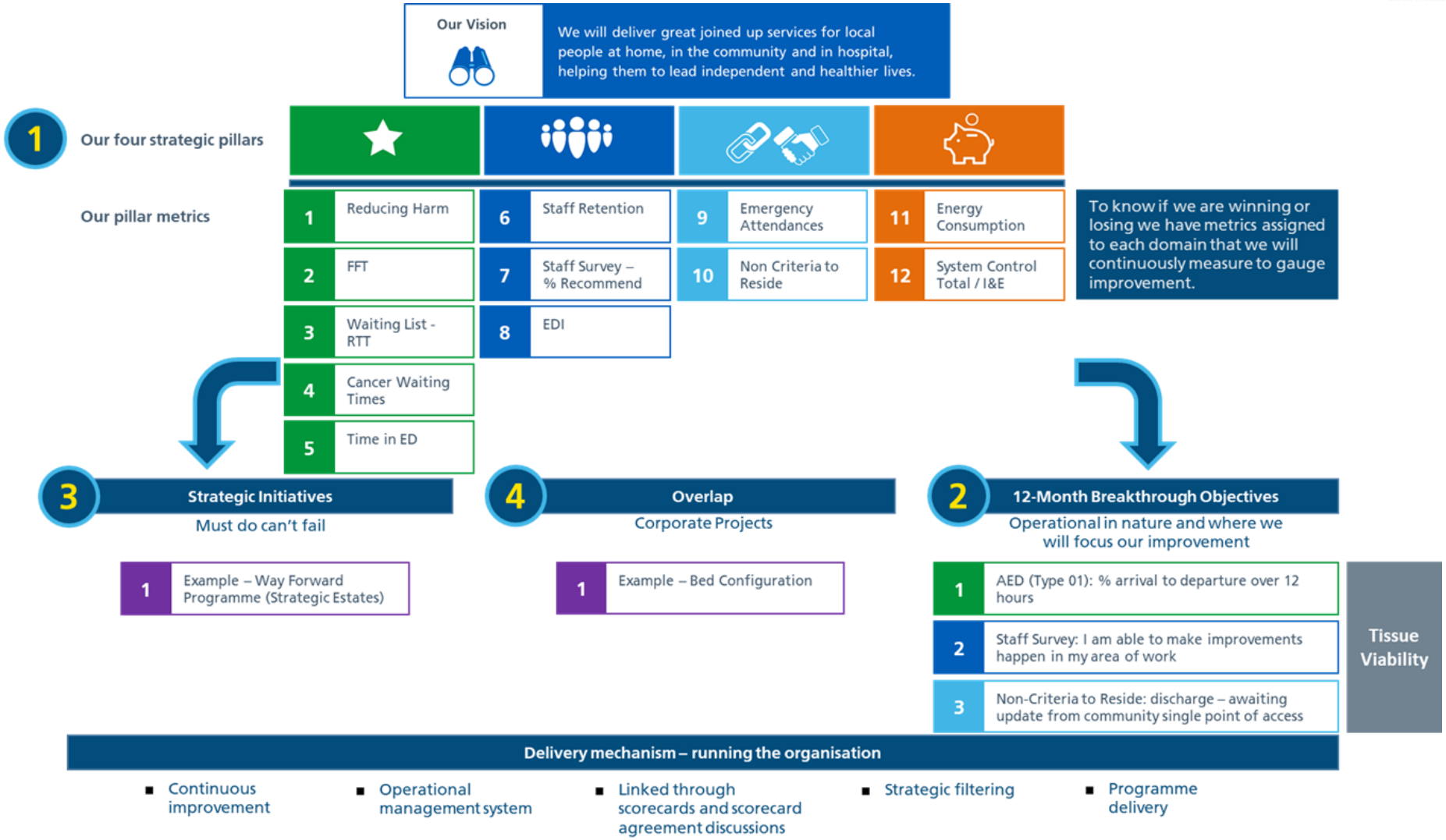


Explaining the IPR

Great Western Hospitals NHS Foundation Trust

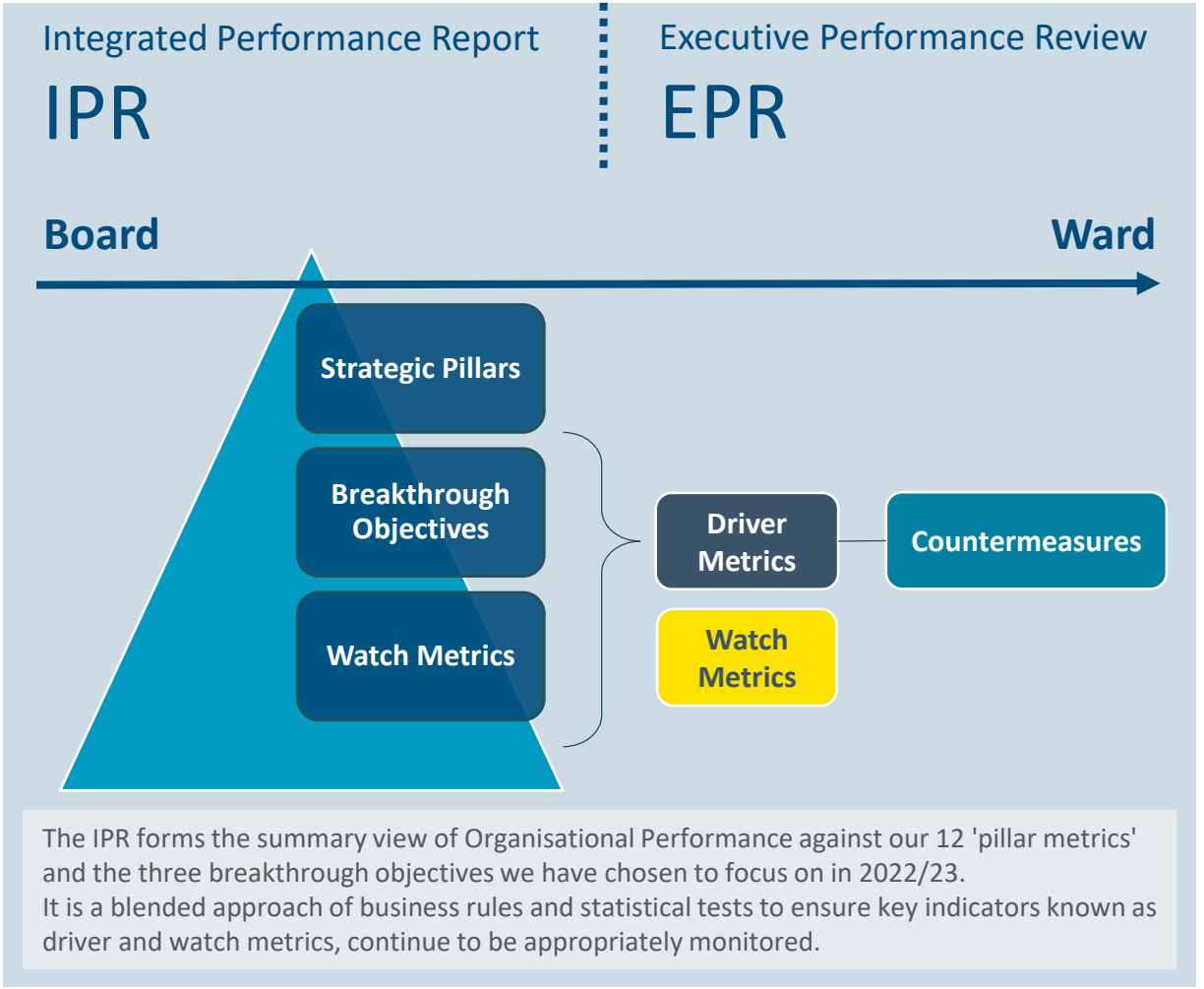
To turn our strategic themes into real improvements, we're focusing on three key objectives that contribute to these themes for the next year.

- Tissue viability – reducing pressure ulcers
- A&E arrival to departure over 12 hours
- Staff survey – I am able to make improvements happen in my area of work
- Non-criteria to reside – reducing patients waiting in hospital

We have chosen these four objectives using data to see where we can make the most significant improvements by focusing our efforts. We'll also use data to measure how much we're making a difference.

Frontline teams will lead improvements in these areas of focus. They will be supported by our Transformation and Improvement Hub, which will help give teams the training and tools they need, and our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

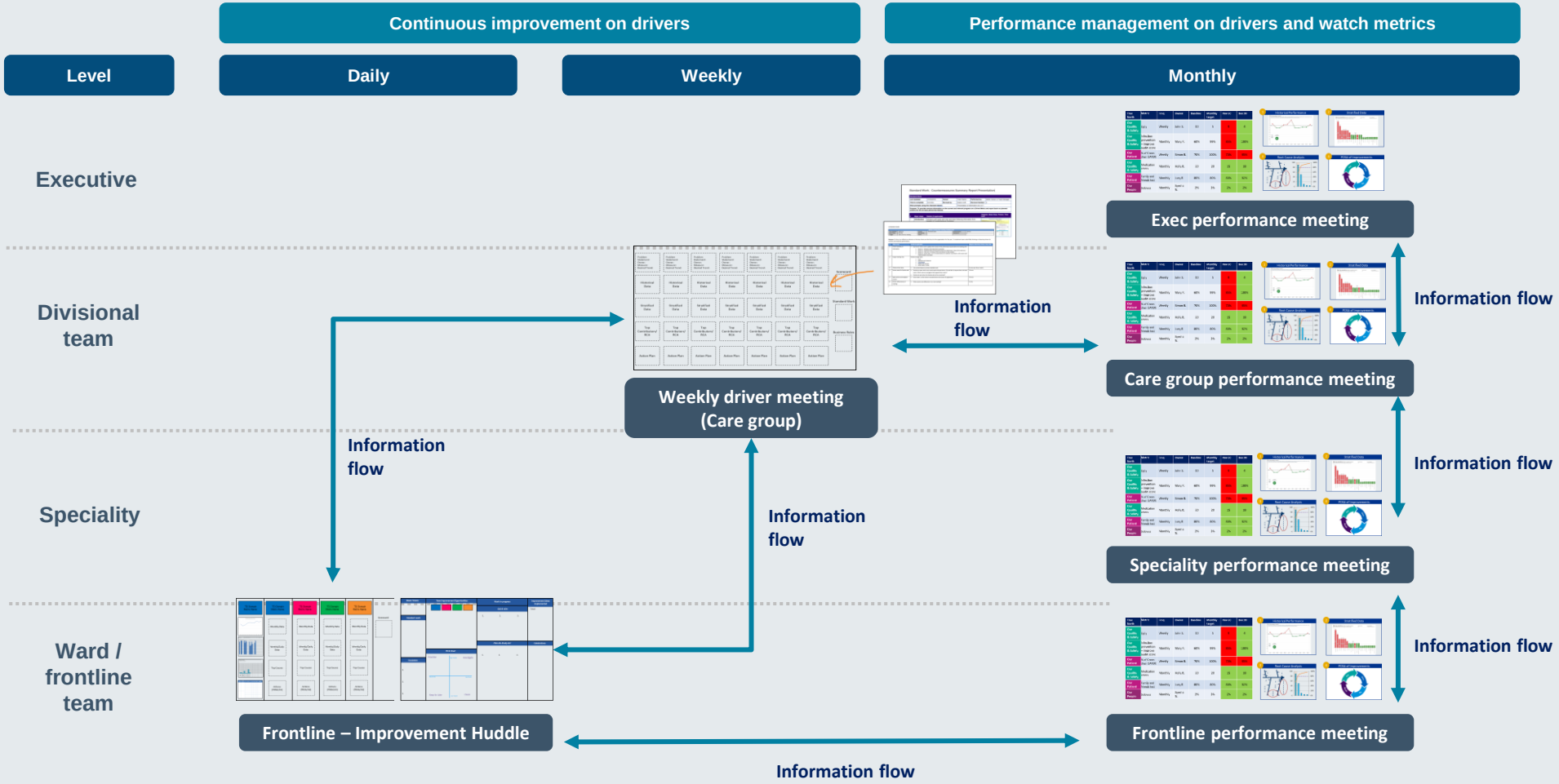
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.



The IPR forms the summary view of Organisational Performance against our 12 'pillar metrics' and the three breakthrough objectives we have chosen to focus on in 2022/23.
It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Performance business rules

		Alignment with Making data count	Rule	Actions
1		N/A	Driver is **Blue** for reporting period	Share success and move on
2	●	Blue dots – showing sustained improvement	Metric is positively outside SPC control limits for seven consecutive reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	●	**Orange** dot	Metric is negatively outside SPC control limits for 1 reporting period (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	●	**Orange** dot	Metric is negatively outside SPC control limits for 2 consecutive reporting periods (e.g. 2 months)	Produce Countermeasure summary performance report
5	●	**Orange** dot	Watch is **Orange** for 3 of the last 4 months (above / below the mean)	Move from Non alerting to Alerting Watch Metric Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Review thresholds
6	●	**Grey** dots	Metric is within control limits	Continue to maintain this performance

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

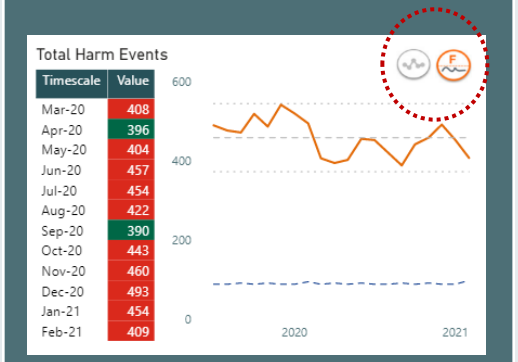
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

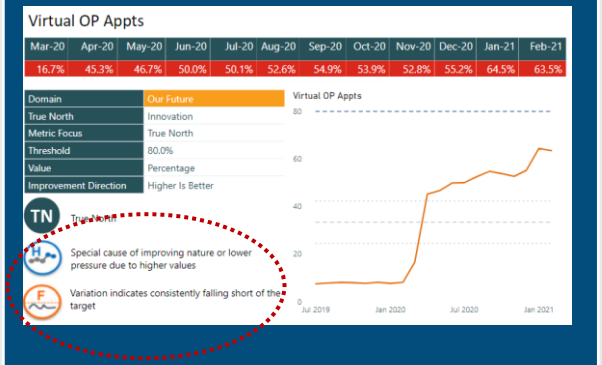
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them:

Strategic Pillars



Breakthrough Objectives



Agreed Terms

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Term	Description
A3	A methodology used as part of Improving Together to ensure that problems, ideas, and areas for improvement are all approached in the same way. A3 provides a template for thinking through a problem, so that teams gain a good understanding of the problem and causes, before reaching a solution. Coined 'A3' after the A3 sized paper used to map the process, it consists of eight steps, with questions to work through. This visual tool provides a complete picture of the problem, contributions, and solution, on one page which should be displayed for all involved to see.
Breakthrough Objectives	The few significant changes we need to meet in order to achieve our vision. Objectives should be achieved within a 12-month period and through teamwork across the organisation.
Business Rules	A set of rules used to determine how metrics are discussed in Performance Review Meetings.
Corporate Projects	Large complex projects identified as a priority by the Executive Team which require the involvement of more than one team, and/or significant capital investment.
Countermeasure	An action to prevent a problem from continuing. It's not a solution so further action may be needed in the future if performance does not improve.
Countermeasure Summary	A document that summaries the A3 information used to explore a problem or area for improvement. It is presented at monthly Performance Review Meetings.

Agreed Terms

NHS
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NHS Foundation Trust

Term	Description
Driver Lane	A visual management tool displayed on a team's Performance Board, containing driver metric information taken from A3 workings (e.g., problem statement, data, contributing factors, 3 C's or Action Plan). Driver lane information is discussed every day at Improvement Huddle boards and in more detail at driver meetings and monthly Performance Review Meetings.
Driver Meetings	Weekly meetings that update a team on progress against driver metrics. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings are also a way of checking progress to plan.
Driver Metrics	Metrics that a team chooses to focus on to help them achieve an improvement which will support one of the four pillars. Examples include, 'to reduce 30-day readmissions by 50%' or 'eliminate all avoidable surgical site infections.
Fishbone	A diagram used in the Root Cause section of the A3 template. It can be used to structure a brainstorming session to identify the potential causes of a problem.
Go and See	A visit to observe a specific problem or area for improvement and gain a better understanding of the process, engage with staff, and explore opportunities for improvement. While observing, visitors should ask open ended questions, lead with curiosity, and try to see the problem from different perspectives.
Important Project	A project that supports the four Pillars but is less of a priority than a Mission Critical Project.
Improvement Board	A visual tool to track daily improvement and operational activities. 1) Improvement activities will be identified when discussing the driver metric on the Performance Board. 2) Daily operational activities can be identified in the morning handovers/ward rounds.

Agreed Terms

Great Western Hospitals NHS Foundation Trust

Term	Description
Improvement Huddle Boards	A visual display used by teams to work through areas for improvement, track improvement work and daily operational activities. They should be used during daily improvement huddles, where staff can identify, and explore areas for improvement which align with the four pillars and vision. They aim to encourage conversation, involvement and team working. Improvement Huddle Boards need their own Standard Work document to ensure they are used effectively. Areas for improvement should be identified when discussing the Driver Metric on the Performance Board. Daily operational activities should be identified in morning handovers/ward rounds.
Improving together	Our new approach to improvement which will empower staff to make improvements in their own areas using a consistent approach to problem solving and exploring areas for improvement. This new way of working will help us to achieve our vision and the four pillars we want to be known for. It's important that every member of staff understands what our vision is, what the four pillars are, and how they can make improvements in their area to support these pillars, using the Improving Together approach.
Mission Critical Project	A critical project which may be mandatory, time sensitive, remove patient harm or form part of a wider system priority objective.
Operational Management System – Divisions	A way of working that enables the Improving Together approach to be applied routinely across the Divisions. Key elements of the system are: - To cascade the organisational priorities to Divisions and then frontline teams, ensuring everyone understands their contribution - Embedding a new performance framework - A focus on problem-solving at Divisions and team level, rather than waiting for solutions to be imposed from above - Embedding coaching behaviors to help support and develop colleagues.
Operational Management System - Frontline	A way of working that enables the Improving Together approach to be applied as part of the individual wards or departments daily work and routines. Key elements are: - A focus on problem-solving at a team, ward, or department level, rather than waiting for solutions to be imposed from above - Concentration on the Four Pillars and vision and ensuring everyone understands their contribution - The use of visual management tools that allow us to see and track improvement areas for our key priorities at a glance.
Performance Review Meeting	A monthly meeting where the scorecard is reviewed, and decisions are made to improve performance and resolve issues preventing improvement. The meeting is usually chaired by the manager and has all staff groups represented.
Plan Do Study Act (PDSA)	A four-stage problem solving model used for improving a process or carrying out change. It is particularly useful for small to medium sized ward or departmental problems. The PDSA cycle is a series of steps for gaining learning and knowledge for the improvement of a product or process. A PDSA Ticket is a proposed change which needs to be trialed. They are discussed at Improvement Huddles and can take 3-4 weeks to implement after planning, trying it out, observing the results, and acting on what is learnt.

Agreed Terms

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Term	Description
Process Observation	Observing how a process or procedure is performing compared to the agreed standard. Benefits include creating stability and reducing the risk of deviation from the agreed standard. This process also creates opportunities for coaching, highlights any training or education needs, provides a baseline for improvement and aids problem solving.
Quick Win Ticket	Used to identify simple improvements during an Improvement Huddle (which can be made within 2-5 days). A method of problem solving used to identify the root causes of problems or barriers to improvement.
Root Cause Analysis	A method of problem solving used to identify the root causes of problems or barriers to improvement. A fishbone diagram, pareto charts and 5 why's are some of the tools used to guide a root cause analysis.
Scorecard	A visual management tool that lists the measures and projects a ward or department is focusing on. The purposes of a Scorecard is to: - Make strategy a continual process that involves everyone - Promote key measurements - Make clear the team's goals in relation to the Trust's four pillars - Provide a concise picture of the team's performance.
Scorecard Objectives	A formal conversation between two different levels in the organisation (e.g., Executive Directors and Divisional Leads) held annually to agree the next financial year's objectives, and the resources needed to achieve them. The aim being to: - Understand how each Division contributes to achieving the organisational priorities - Agree what additional local priorities each Division needs to achieve.
Standard Work	A written document with step-by-step instructions for completing a task using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task. The document should be regularly reviewed and updated.
Strategic Filter	A tool used to prioritise the different projects happening across the Trust.
Strategic Initiatives	Programme of work which are our must do, can't fail priorities for the organisation to support the four pillars and achieve our vision. They normally take place over a 3–5-year period.
Strategic Pillars	The Trust has four strategic pillars which we want to be known for and which will help us to achieve our vision. They are the four areas which we should be focusing on when making improvements. It's important that every member of staff understands what our vision is, what the four pillars are, and how they can make improvements in their area to support these pillars.

Agreed Terms

Great Western Hospitals NHS Foundation Trust

Term	Description
Strategy Deployment	A planning process which gives long-term direction to a complex organisation. It identifies a small number of strategic priorities for staff to focus on so that we can do these things well, rather than spreading ourselves too thinly on lots of things.
Strategy Deployment Matrix	A resource planning tool which provides an overview of resource commitments across all teams, so no team is overloaded.
Structured 1:1	A regular structured conversation between a leader and team member that lasts between 10 and 30 minutes. Open ended questions are used to guide the conversation linked with the Four Pillars. The questions aim to promote a coaching conversation about planning and mitigating any risks. These conversations form part of a chain of conversations at different levels of the organisation. Examples include, Nurse in Charge and Ward Manager (daily), Ward Manager and Service Manager (weekly), Service Manager and the Divisional Director (fortnightly), Divisional Director and Chief Operating Officer (Monthly).
Structured Verbal Update	A verbal update that follows the Standard Work Structure laid out. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	This is used if a Watch Metric is not on track, but not far off expected performance. A Tolerance Level can be applied against the metric, meaning as long as performance does not fall below the Tolerance Level, it can remain a Watch Metric.
Transformation and Improvement Hub (T&I Hub)	Our internal team of professionals embedding our new approach to improvement 'Improving together' across the organisation. Through training, coaching and support the T&I Hub are providing teams with the tools, routines and behaviours needed to solve problems and explore areas for improvement using a consistent approach. They can help teams to identify their vision for change, whether it be through problem solving, process mapping or developing plans. They will then support through a mixture of full day training sessions, bite sized coaching and work placed support.
Vision	Vision captures the few selected organisation wide priorities and goals or the strategic aims that guide all improvement work in an organisation. It can be developed by the Trust's executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch Metrics	Measures that are monitored for adverse trends.

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Finance Report M8 2022/23

Telling the story of our financial numbers, linked to our patients, our people and sustainable performance

Trust Board
13th January 2022

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

For Period Ended - 30th November 2022												
Financial Position	In Month				YTD				Full Year Forecast			
	Plan £000	Actual £000	Variance £000		Plan £000	Actual £000	Variance £000		Plan £000	Actual £000	Variance £000	
Patient Care Income	32,996	35,422	2,426		265,520	281,543	16,022		397,113	423,277	26,164	
Private Patient Income	182	185	3		1,404	1,464	60		2,131	2,200	69	
Other Income	2,353	2,602	250		18,600	18,101	(499)		27,965	27,394	(571)	
Total Income	**35,530**	**38,209**	**2,678**		**285,524**	**301,107**	**15,583**		**427,209**	**452,872**	**25,662**	
Pay - Substantive	(22,471)	(20,320)	2,152		(177,453)	(160,896)	16,557		(268,681)	(245,028)	23,653	
Pay - Bank/Locum	(282)	(1,689)	(1,407)		(2,117)	(13,148)	(11,031)		(2,872)	(19,168)	(16,296)	
Pay - Agency	(531)	(1,442)	(911)		(3,892)	(11,779)	(7,887)		(5,254)	(16,315)	(11,061)	
Total Pay	(23,284)	(23,451)	(166)		(183,462)	(185,824)	(2,362)		(276,807)	(280,511)	**(3,704)**	
Non Pay	(14,307)	(14,817)	(510)		(114,654)	(115,672)	(1,018)		(169,753)	(173,331)	**(3,577)**	
Total Expenditure	**(37,591)**	**(38,268)**	**(676)**		**(298,115)**	**(301,495)**	**(3,380)**		**(446,560)**	**(453,842)**	**(7,282)**	
Surplus/(Deficit)	**(2,061)**	**(59)**	**2,002**		**(12,591)**	**(388)**	**12,202**		**(19,351)**	**(970)**	**18,381**	
Less Risk Share Allocation	0	(1,613)	(1,613)		0	(12,901)	(12,901)		0	(19,351)	**(19,351)**	
Surplus/(Deficit) excl Risk Share	**(2,061)**	**(1,672)**	**389**		**(12,591)**	**(13,289)**	**(698)**		**(19,351)**	**(20,321)**	**(970)**	
Capital	1,300	597	(703)		8,813	2,401	(6,412)		18,219	18,219	0	
Cash & Cash Equivalents	18,817	37,557	18,740								0	
Efficiencies	1,043	665	(378)		6,927	5,516	(1,411)		11,109	8,173	(2,936)	
Headcount (worked)	5,280	5,320	(41)									

Income has been received from the ICB to fund the planned deficit (£19.4m), £12.9m (8/12) of this is reported in the Month 8 position. Excluding this income, the Trust is reporting a deficit of £1.7m in month which is £0.4m favourable to plan. Year to date position is £13.3m deficit, £0.7m adverse to plan.

The latest forecast position is c.1m worse than plan, this is an improvement of the previously reported c1.8m gap, predominantly due to agreement from the ICB to fund a further £0.6m ESRF of our planned spend. Forecast costs remain in excess of income (£7.8m costs, £6.9m income) which is the main driver of the forecast variance; if the ICB agreed to fund full costs planned on ESRF-related activity, or if we could do the same for less cost, the year end position would be in line with plan.

The cash balance at the end of Month 08 is £18.7m above plan, This is due to the receipt last month of £19.4m of deficit funding from the ICB, partially offset by a delay in drawdown of loans.

Capital expenditure is £6.4m below plan to date due to profiling and slippage. The capital team have met with all the divisions, project leads and procurement to monitor progress fortnightly to ensure the funding will be spent by the end of the financial year. There has also been purchase orders raised in November (£3.1m) and December (£0.25m) that will increase the level of spend, once goods are on site / services are received, and they are receipted.

Efficiency delivery has not kept pace with plan this month and is £1.4m behind plan year to date. The forecast to year end remains at £3.0m unidentified. However, in expecting to deliver an overall position close to plan, by proxy we could expect to deliver close to the CIP target, albeit non-recurrently.

Income and Expenditure – Trend

Great Western Hospitals NHS Foundation Trust

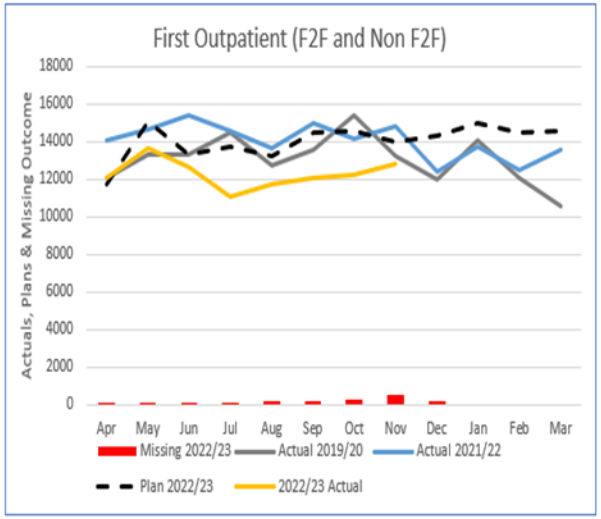
Trend Analysis	2019/20 M1-7 Average £m	2019/20 Nov-19 Actual £m	2019/20 2019/20 Average £m	2022/23 M1-7 Average £m	2022/23 Nov-22 Actual £m	2022/23 Forecast Average £m	% increase over 2019/20 M1-7 % 19/20 %	% increase over 2019/20 Nov-22 % 19/20 %	% increase over 2019/20 Forecast % 19/20 %
Income	27.7	28.9	28.2	35.7	38.2	37.7	29%	32%	34%
Pay	(17.5)	(17.7)	(17.9)	(23.2)	(23.3)	(23.4)	32%	31%	30%
Non Pay	(11.8)	(12.3)	(12.0)	(14.4)	(14.8)	(14.4)	22%	20%	20%
Surplus/(Deficit)	(1.6)	(1.1)	(1.8)	(1.9)	0.1	(0.1)			
Agency Pay	(0.9)	(0.8)	(1.0)	(1.5)	(1.3)	(1.4)	69%	60%	30%
Efficiencies	0.5	0.4	0.7	0.7	0.6	0.7	56%	47%	2%
Workforce (WTE worked)	4,519	4,610	4,591	5,180	5,320		15%	15%	

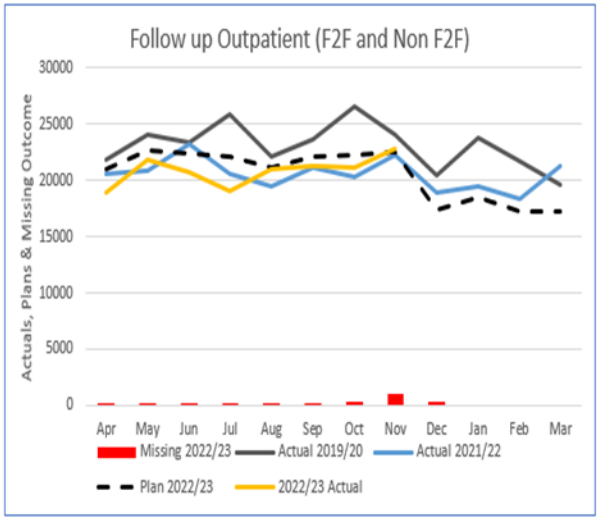
Headlines:

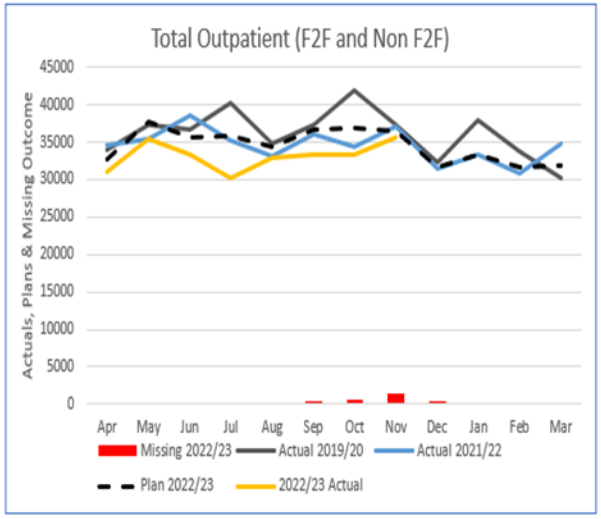
- Income, pay and non pay both average year to date and in month are consistently higher than 2019/20, despite significantly lower activity levels (see slide 15). This indicates a reduced level of productivity which poses a risk to funding levels as well as an opportunity for efficiency gains.
- Agency costs are well in excess of 2019/20 levels, both year to date and forecast. Agency use is high to cover vacancies, sickness and enhanced support. However, when triangulating workforce (for substantive, bank and agency costs in total) it is evident that as a Trust there is increased staffing levels despite lower activity levels. This is a driver of the year-to-date deficit position.
- Efficiency delivery in month and year to date is above 2019/20 achievement, however a significant proportion of 2022/23 efficiency is being delivered on a non-recurrent basis. Further detail on this is in slide 20.

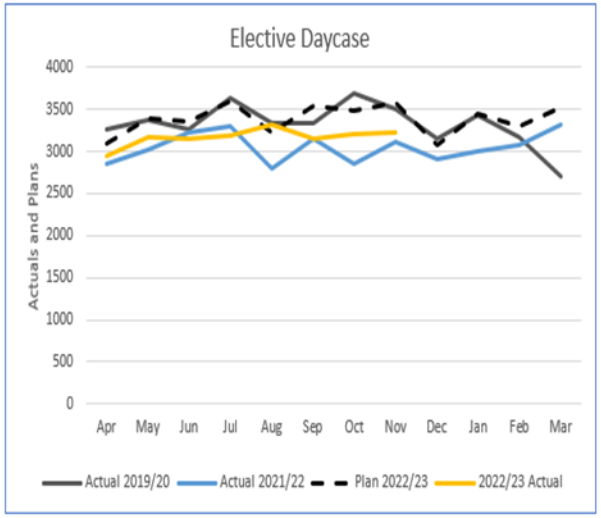
Point of Delivery – Activity Trendline

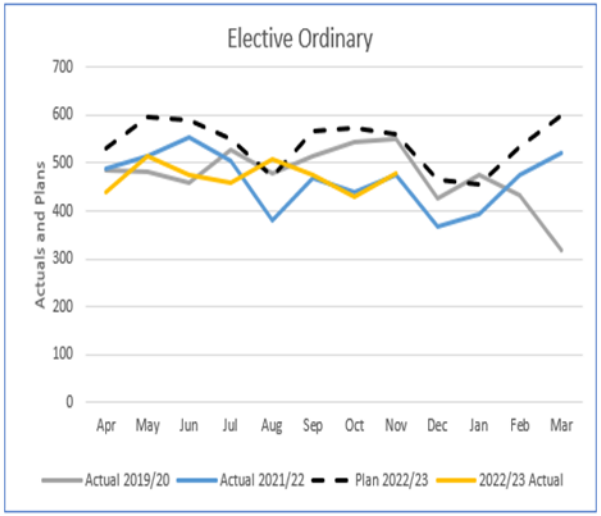
Great Western Hospitals NHS Foundation Trust

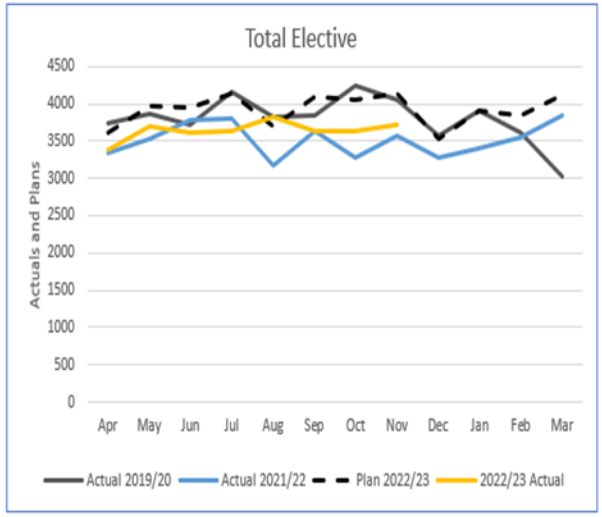












Income by Point of Delivery

Great Western Hospitals NHS Foundation Trust

Acute activity type	November 2022 Year to date £'000 19/20	21/22	22/23	22/23 v 19/20 Note 1	
Main ED (excl UTC)	9,544	8,044	9,089	89%	Omits shift to UTC since 19/20
Non Elective	63,418	70,881	67,304	99%	
Outpatient	29,401	25,504	29,128	92%	
Day case	16,133	14,684	15,477	90%	
Elective inpatient	11,998	11,206	11,423	89%	
Total	**130,494**	**130,319**	**132,420**	**95%**	

Note 1: Between 19/20 and 22/23 tariffs have been uplifted by 7.12% and this is adjusted for here

Context

Due to Covid-19, funding is still being paid on a block contract basis, with the emphasis on covering reported costs. Although there is an emerging risk of a peripheral commissioner wanting to reduce payment through activity performance being lower than previous levels.

The above table show this year's income by main activity types against the same point in 19/20, if activity-based contracting (PbR) with national tariffs was still applied. The final column then shows comparison between current year and 19/20, but taking inflationary impact into account.

Focus on actuals:

For November, actual income on a PbR basis has been shown v prior year and the pre-Covid base of 19/20. Overall 22/23 activity is c2m ahead of 2019/20 activity levels, however when taking inflation into account, activity is c£7.3m lower than an adjusted 19/20 baseline.

Issues:

Non elective activity is broadly comparable with 19/20 but Elective and outpatient activity is significantly lower. This will negatively impact on wait lists and will put pressure on ESRF performance.

Risks:

The value of GWH activity needs to return to and exceed 19/20 levels both to support the BSW system earning ESRF funds, and to prepare for the rebasing of provider funding that will occur once the need for 'special' Covid funding blocks no longer exists. A peripheral commissioner has confirmed they are looking at payment on a full PbR basis and low activity levels risks some income loss.

Improvement & Efficiency headlines

Great Western Hospitals NHS Foundation Trust

Cash Releasing - Division M08	In Month Plan £000	In Month Delivery £000	In Month Variance £000	In Month Delivery %	YTD Plan £000	YTD Delivery £000	YTD Variance £000	YTD Delivery %	Full Year Plan £000	Recurrent Forecast £000	Non Recurrent Forecast £000	Forecast Variance £000	Forecast Delivery %
Corporate	(103)	(94)	(9)	91%	(688)	(623)	(64)	91%	(1,100)	(104)	(911)	(85)	92%
Integrated Care & Community	(91)	(104)	13	114%	(633)	(595)	(39)	94%	(1,000)	(487)	(530)	17	102%
Surgery, Women & Children	(301)	(201)	(100)	67%	(2,006)	(1,489)	(516)	74%	(3,209)	(1,314)	(973)	(922)	71%
Unscheduled Care	(328)	(246)	(82)	75%	(2,281)	(2,644)	363	116%	(3,600)	(1,983)	(1,625)	8	100%
Trust Wide	(220)	(21)	(199)	9%	(1,320)	(165)	(1,155)	12%	(2,200)	(247)	0	(1,953)	11%
Total	**(1,043)**	**(665)**	**(378)**	**64%**	**(6,927)**	**(5,516)**	**(1,411)**	**80%**	**(11,109)**	**(4,134)**	**(4,039)**	**(2,936)**	**74%**

- In month £0.67m of efficiency has been reported against a plan of £1.05m – under achievement of £0.38m.
- Year to date 80% of the plan has been delivered, and by year end the forecast remains that only 74% of the plan will be achieved. However, because our plan is net of efficiency, and we are expecting to deliver on plan (subject to ESRF), we can assume 100% proxy delivery, albeit on a non-recurrent basis. There is a reliance on Non Recurrent schemes within the reported position, both year to date and forecast, and across all areas as demonstrated by the table below.

- Corporate schemes identified are heavily non recurrent (90% non recurrent forecast) which reflects the high number of vacancies across Corporate areas. Non pay underspends are also evident and will continue to be reviewed and challenged through the budget setting process as to whether any can become recurrent savings.

- Unscheduled Care efficiency is reporting below plan in month, however this is due to the profile of the plan. USC efficiency is above plan year to date and expected to be on plan by year end. Schemes include Procurement/Better Buying and a reliance on recruitment lag/vacancies, as well as a SPRINT approach across a number of areas.

- Integrated Care & Community has delivered above plan in month. In year delivery is supported by Digital transformation, EDRMS, Thoughtonomy, Medicines Management and recruitment lag.

- Surgery, Women's and Children's are below plan in month and year to date, and the forecast position is also below plan. A SPRINT approach has been undertaken within the division to identify areas of underspend, other areas of delivery include Procurement/Better Buying, private patient income and Swabbing Team redeployment. There is also a reliance on recruitment lag contributing to non recurrent delivery in year.

- Trust Wide schemes are significantly below plan year to date and forecast. Moving weekly bank payroll back in house has been captured as a scheme and work is ongoing to identify cross-divisional schemes that can mitigate this gap going forwards.

	In Month		Year to Date		Forecast	
Split of delivery	Recurrent	Non Recurrent	Recurrent	Non Recurrent	Recurrent	Non Recurrent
Corporate	12%	88%	13%	87%	10%	90%
Integrated Care & Community	46%	54%	50%	50%	48%	52%
Surgery, Women & Children	64%	36%	51%	49%	57%	43%
Unscheduled Care	41%	59%	60%	40%	55%	45%
Trust Wide	100%	0%	100%	0%	100%	0%
Total	**47%**	**53%**	**53%**	**47%**	**51%**	**49%**

Statement of Financial Position

Great Western Hospitals NHS Foundation Trust

Statement of Financial Position	31st March 2022 Actual £'000	2022-2023 Plan £'000	31st November 2022 Actual £'000	Variance to Plan £'000
Non Current Assets				
Intangible assets	6,033	6,033	6,033	-
Property, plant and equipment	248,653	285,718	259,935	25,783
Investments in associates & joint ventures	126	126	126	-
Trade & Other Receivables - non-current	843	843	843	-
Total Non-Current Assets	**255,655**	**292,720**	**266,937**	**25,783**
Current Assets				
Inventories	5,104	5,104	5,028	76
NHS Trade Receivables	4,138	4,147	3,629	518
Non NHS Trade Receivables	4,674	5,942	2,324	3,618
Prepayments & Accrued Income	10,952	18,816	29,037	(10,221)
Cash and cash equivalents.	52,909	18,817	37,557	(18,740)
Total Current Assets	77,777	52,826	77,575	(24,749)
Total Assets	**333,432**	**345,546**	**344,513**	**1,033**
Current Liabilities				
Trade Payables	45,699	42,740	51,510	(8,770)
Capital Payables	13,865	6,329	2,890	3,439
Accruals & Deferred income	8,043	4,516	9,850	(5,334)
Provisions - current	2,929	2,853	843	2,010
Capital Investment Loans	112	-	-	-
PFI Contract	7,490	2,498	2,497	1
Finance Leases	227	1,090	746	344
Total Current Liabilities	**78,365**	**60,026**	**68,336**	**(8,310)**
Non Current Liabilities (due after >1 year)				
Provisions	7,006	8,375	7,890	485
Capital Investment loans	275	275	275	-
PFI Contract	76,389	76,389	76,389	-
Finance Leases	620	29,248	19,417	9,831
Total Non-Current Liabilities	**84,290**	**114,287**	**103,971**	**10,316**
Total Assets Employed	**170,777**	**171,233**	**172,206**	**(973)**
Taxpayer's and Others Equity				
Public dividend capital	160,016	167,528	161,860	5,668
Income and expenditure reserve	(31,247)	(44,329)	(31,661)	(12,668)
Revaluation reserve	42,008	48,034	42,008	6,026
Total Assets Employed	**170,777**	**171,233**	**172,206**	**(973)**

Background

Capital

- Property, Plant & Equipment is below plan due to an adjustment to the IFRS 16 Lease additions and slippage on the Capital schemes.

Current Assets

- Invoiced Receivables are below plan due to the high level of un-invoiced income.
- Cash is £19m above plan due to the receipt of £19.4m deficit funding from the ICB offset by delay in drawdown of Capital Loan drawdown.

Current Liabilities

- Trade payables are £9m above plan due to delays in payments relating to payments issues with SBS and an increase in Non-PO Accrued Expenditure
- Finance leases below plan £0.4m due to adjustment to IFRS 16 lease additions

Non-Current Liabilities

- Finance leases below plan £9.8m due to adjustments in IFRS 16 lease additions.

Cash Flow

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Statement of Cash Flow	Actual Mar-20 £'000	Actual Mar-21 £'000	Actual Mar-22 £'000	Actual Apr-22 £'000	Actual May-22 £'000	Actual Jun-22 £'000	Actual Jul-22 £'000	Actual Aug-22 £'000	Actual Sep-22 £'000	Actual Oct-22 £'000	Actual Nov-22 £'000	Forecast Dec-22 £'000	Forecast Jan-23 £'000	Forecast Feb-23 £'000	Forecast Mar-23 £'000	Full year 2022-23 £'000
Receipts																
Clinical Income	306,038	381,533	410,662	31,505	32,204	31,387	33,874	32,144	35,594	55,253	33,593	33,228	33,228	33,228	33,225	418,463
Education & Training	10,325	12,194	14,096	3,549	-	-	3,054	1	-	5,035	-	-	3,552	-	-	15,191
Other Income	9,089	8,389	5,714	1,064	263	3,683	1,012	665	579	660	851	650	600	600	600	11,227
HMRC	10,783	11,901	11,944	983	-	-	316	1,897	2,557	18	390	352	2,467	352	352	9,684
Other Receipts	25,808	8,526	9,856	756	570	-	1,713	735	1,648	1,463	902	725	800	72	800	10,184
Working Capital Loans	26,352	5,606	10,156	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital Loans	1,791	97,176	12,577	-	-	-	-	-	-	1,844	-	2,453	1,906	3,707	6,269	16,179
Total Receipts	**390,186**	**525,325**	**475,005**	**37,857**	**33,037**	**35,070**	**39,969**	**35,442**	**40,378**	**64,273**	**35,736**	**37,408**	**42,553**	**37,959**	**41,246**	**480,928**
Payments																
Pay Costs	202,711	229,217	243,457	20,348	21,307	20,812	20,724	20,858	23,247	24,173	22,607	22,014	22,033	22,033	22,833	262,989
Trade Creditors	117,962	132,343	127,327	33,180	12,252	2,119	10,762	14,767	11,613	12,947	12,028	12,187	12,472	12,187	12,027	158,541
Capital Creditors	3,673	8,918	20,287	-	2,059	9,769	1,616	(278)	735	788		1,905	1,555	2,383	12,283	32,815
NHSLA	10,860	12,765	13,757	1,265	1,265	1,265	1,265	1,265	1,265	1,265	1,265	1,265	1,265	-	-	12,650
PDC Dividend	1,476	2,823	4,079	-	-	-	-	-	2,538	-	-	-	-	-	2,538	5,076
PFI Payments	45,451	58,512	35,598	-	-	-	12,937	-	-	12,959	-	-	12,994	-	-	38,890
Loan Repayments	4,076	67,380	117	-	58	-	-	-	-	-	58	-	-	-	-	116
Total Payments	**386,209**	**511,958**	**444,622**	**54,793**	**36,941**	**33,965**	**47,304**	**36,612**	**39,398**	**52,132**	**35,958**	**37,371**	**50,319**	**36,603**	**49,681**	**511,077**
Net Cash Flow in Period	3,977	13,367	30,383	(16,936)	(3,904)	1,105	(7,335)	(1,170)	980	12,141	(222)	37	(7,766)	1,356	(8,435)	(30,149)
Opening Cash Balance	**5,171**	**9,148**	**22,515**	**52,898**	**35,962**	**32,058**	**33,164**	**25,828**	**24,658**	**25,638**	**37,779**	**37,557**	**37,594**	**29,828**	**31,184**	**52,898**
Closing Balance	**9,148**	**22,515**	**52,898**	**35,962**	**32,058**	**33,164**	**25,828**	**24,658**	**25,638**	**37,779**	**37,557**	**37,594**	**29,828**	**31,184**	**22,749**	**22,749**

Due to the receipt of the £19.4m deficit funding from the ICB, the £17m previously in the cashflow to be requested as a Working Capital Loan has been removed from the cashflow and the March closing balance is inline with plan.

Emergency Capital PDC Drawdown	Actual Apr-22 £'000	Actual May-22 £'000	Actual Jun-22 £'000	Actual Jul-22 £'000	Actual Aug-22 £'000	Actual Sep-22 £'000	Actual Oct-22 £'000	Actual Nov-22 £'000	Forecast Dec-22 £'000	Forecast Jan-23 £'000	Forecast Feb-23 £'000	Forecast Mar-23 £'000	Forecast Total £'000
Planned Drawdown							1,844	547	1,906	1,906	3,707	6,269	16,179
Actual Drawdown							1,844						1,844
Forecast Drawdown									2,453	1,906	3,707	6,269	14,335

Working Capital

Debtors, Creditors and BPPC Achievement

Great Western Hospitals NHS Foundation Trust

	Target	YTD	YTD Var	Three month rolling averates over the last 4 months				2021/22 FY Actual
				Aug-22	Sep-22	Oct-22	Nov-22	
Debtor and Creditor Days								
Debtor days (Target=SBS Metric	30	32	(-2)	30	26	30	29	17
Creditor days (Target =Prior yr closing days)	147	124	23	144	137	124	124	147
BPPC (value %)								
NHS	95.0%	70.5%	24.5%	73.5%	72.3%	70.5%	80.9%	74.0%
Non-NHS	95.0%	93.1%	1.9%	92.7%	93.2%	93.1%	91.2%	97.4%
BPPC (volume %)								
NHS	95.0%	75.9%	19.1%	79.5%	76.9%	75.9%	74.2%	82.7%
Non-NHS	95.0%	92.7%	2.3%	93.1%	93.1%	92.7%	92.7%	94.7%

		Apr-22	Aug-22	Sep-22	Oct-22	Nov-22
No. Faster Payments Made	Salary FP	13	27	18	14	19
	Suppliers FP	24	59	72	61	51
Total Faster payments		37	86	90	75	70
Ratio of Invoice PO/Non-PO	PO	42%	39%	38%	35%	41%
	Non-PO	58%	61%	62%	65%	59%

Invoiced Receivables/Payables	Total	0-30 Days	30-60 Days	61-90 Days	over 90 Days	% over 90 Days
	£'000	£'000	£'000	£'000	£'000	£'000
Receivables						
Non-NHS Receivables	1,437	353	66	53	965	67.2%
NHS Receivables	2,192	1,232	9	0	951	43.4%
Total Receivables	3,629	1,585	75	53	1,916	24.0%
Payables						
Non-NHS Payables	6,857	3,808	675	623	1,751	25.5%
NHS Payables	3,216	1,610	320	114	1,172	36.4%
Total Payables	10,073	5,418	995	737	2,923	29.0%

	Sep-22	Oct-22	Nov-22
Receivables	£'000	£'000	£'000
Receivables: invoiced as per Aged Debt Reports	6,342	5,102	3,629
Receivables: not invoiced	23,460	31,835	31,361
Total Receivables	29,803	36,937	34,990
Payables	£'000	£'000	£'000
Trade & other payables: invoiced as per Aged Creditor Report	9,407	12,401	10,073
Trade & other payables: not invoiced	39,258	38,168	41,438
Total Payables	48,664	50,569	51,511

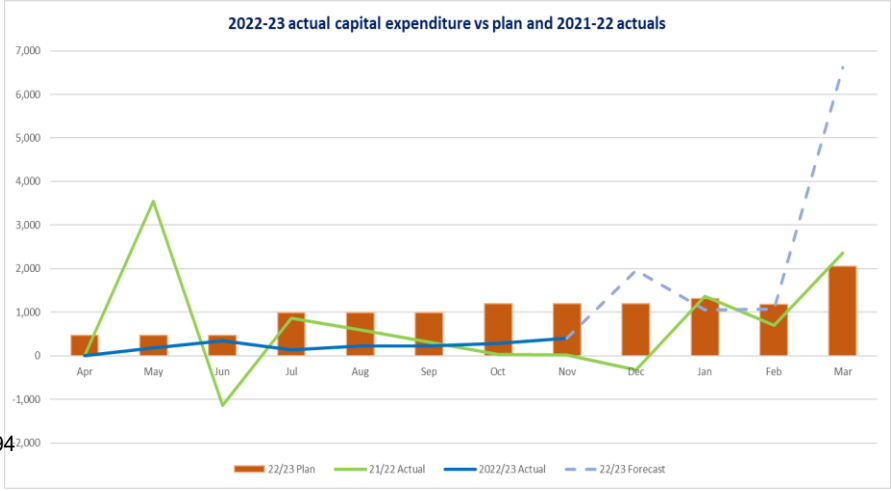
Capital Programme

Great Western Hospitals NHS Foundation Trust

Capital Scheme	Capital Group	2022-23 Revised Plan £000	Month 8 Plan £000	Month 8 Actual £000	Month 8 Accrual £000	Total (Actual & Accruals) £000	Month 8 Variance £000	Month 8 YTD Plan £000	YTD Actual £000	Month 8 Accrual £000	YTD Total (Actual & Accruals) £000	YTD Variance £000	M12 Forecast £000
Estates Replacement Schemes	Estates	1,073	100	100		100	-	548	183	-	183	(365)	1,073
Service Development & Expansion - Aseptic Unit	Estates	1,940	234	-	97	97	(137)	678	-	97	97	(581)	1,940
Service Development & Expansion - WFP IFD	Estates	452	38	8		8	(30)	264	21	-	21	(243)	452
Service Development & Expansion - Other works	Estates	2,023	169	62		62	(107)	1,079	371	-	371	(708)	2,023
Service Development & Expansion - EPR	IT	800		-		-	-	400	-	-	-	(400)	800
IT Emergency Infrastructure	IT	1,000	100	-		-	(100)	548	-	-	-	(548)	1,000
IT Replacement Schemes	IT	2,000	200	207		207	7	1,102	1,006	-	1,006	(96)	2,000
PACS - environment/replacement solution (Nov21)	IT	500	150	-		-	(150)	825	-	-	-	(825)	500
Equipment Replacement Schemes	Equipment	2,185	200	30		30	(170)	1,300	220	-	220	(1,080)	2,185
Contingency	CMG	522	-	-		-	-	-	-	-	-	-	522
Total Trust CDEL		**12,495**	**1,190**	**407**	**97**	**504**	**(686)**	**6,743**	**1,801**	**97**	**1,898**	**(4,845)**	**12,495**
Way Forward Programme		4,610	110		93	93	(17)	2,070	-	503	503	(1,567)	4,610
Mental Health - UEC		70											70
Diagnostics - Digital		687											687
Diagnostics - Imaging		85											85
Diagnostics - Mammography (mobile satalite link)		31											31
DDCP - National (MRI accelaration)		80											80
Critical Cybersecurity Infrastructure Risks		20											20
Finance Leases		141	-	-		-	-	-	-	-	-	-	141
Total Capital Plan (Excl PFI)		**18,219**	**1,300**	**407**	**190**	**597**	**(703)**	**8,813**	**1,801**	**600**	**2,401**	**(6,412)**	**18,219**

Background

- The Trust's CDEL plan for 2022/23 is £12.5m.
- Service Development – Other works includes Co-ordination Hub £0.3m, Ward Configuration £0.2m, SSE Survey & Design £0.2m, Sustainability (£0.2m) and Robotics £1.0m).
- Total Capital Expenditure at Month 8 is £6.4m below plan. Of this, £4.8m relates to Trust CDEL schemes, with the remaining £1.6m slippage on externally funded schemes.
- Though the Year to Date expenditure is low, the capital team have been meeting with divisions, project leads, and procurement to monitor progress and ensure the allocated funding is spent. **Purchase orders to the value of £3.1m (Nov) and £0.25m (to date in Dec) have been raised which will lead to an increase in spend, once receipted.**



Board Committee Assurance Report

Audit, Risk & Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Helen Spice	Helen Spice		15 November 2022
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Divisional Risk Review – Unscheduled Care	**A**	**A**	Unscheduled Care updated the Committee on their processes to manage risk and their actions to mitigate and control the risks in the division. The Committee agreed that good progress has been made since the division last presented to the Committee and their actions are tending to green. However, the division needs to include reporting on Finance risks for the division and provide assurance to the Committee that the old risks are being continuously monitored and actions are being taken to control and mitigate these risks.	Update report to Committee	July 2023
Board Assurance Framework	**G**	**G**	The Committee reviewed the Board Assurance Framework to ensure that the BAF is appropriate and fit for purpose and reviewed the process for review and development of the BAF. The Committee recommended to the Board that the BAF remains effective and were assured that the process for review and development of the BAF by the sub committees is robust.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Risk Register Report	**A**	**A**	The Committee is assured that process for managing risk in the trust are effective. The KPIs have improved and further improvement since the issuance of the reports was also recognised, however, concerns were raised that risks exist with no actions and the Committee would like to ensure that all risks have actions against them. It was noted that Unscheduled Care had achieved nearly 100% compliance.		
External Audit Report			The external auditors confirmed that their plans are in place for each phase of the audit for the year ended 31 March 2023 and that clear reporting has been agreed with the finance team. It was agreed that management and the external auditor would report back at the ARAC meeting in January on their progress on the action plan from the lessons learned process.	Updated report to ARAC	January 2023
BDO Internal Audit Progress Report	**A**	**A**	BDO confirmed that work is slightly behind but progressing and on target for completion by the end of the year. Concerns were raised by the Committee on the delays to some of the work and final issuance of reports – with a large number to be completed and reviewed at the final ARAC meetings of the year.		
Internal Audit – HFMA Financial Sustainability Report	**A**	**A**	BDO reviewed the self assessment by the Trust and confirmed that the self assessment was reasonable. The evidence provided supported the assessment. Action plans are in place to address the weak areas but are in place but are too high level. Further work will be completed by the Trust on action plans and timescales for the next meeting. It was noted by BDO that the Trust has more challenges to address than other Trust.		
Internal Audit – Key Financial Systems Terms of Reference			The Committee approved the terms of reference for the Key Financial Systems audit which has been extended to address some of the issues that arose from the external audit for the year ended 31 March 2022.		
Internal Audit – follow up of recommendations	**A**	**A**	There were no recommendations due to be completed for review, however, BDO raised a concern that the outstanding recommendation from the Mortality Review would not be completed as required by 31 December 2022. The Committee asked for this to be referred to the Quality and Safety Committee for urgent action.		
Counter Fraud Progress Report			The Committee noted the progress and the actions that are taking place during Fraud Awareness week this week. One allegation had been received from the NHSCFA but this had already been dealt with and closed previously.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Trust NHSCFA Procurement Report	R	A	The NHSCFA has issued a report to the Trust on the findings from the national exercise on Purchase Order versus non Purchase Order spend. The Trust had a very disappointing ranking and the Committee received a report on the outcome of the review and the actions that are being taken to address this. The Committee were concerned about the risks highlighted but were satisfied with the actions being taken to address the shortcomings.	Update on actions taken	March 2023

Issues Referred to another Committee	
Topic	**Committee**
Internal Audit Mortality Review – overdue recommendation.	Quality and Safety Committee

Board Committee Assurance Report

Charitable Funds Committee – November 2022			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	**Paul Lews**		**9 November 2022**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	N/A		

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			
Fundraising	R	G	We reviewed the Fundraising Report and agreed to adjust our Risk Assurance Level from Amber to Red due to the increased risks and uncertainty with cost-of-living implications, which will undoubtably have a detrimental impact on our Fundraising plan for this year. We have actions in place to mitigate this, but the external risk factors have now become very concerning.	Review progress at the next meeting.	February 2023
Financial Position	A	G	The Finance position is well controlled; however, the current financial forecast shows a £55k deficit at the end of the year. To mitigate this, we agreed to make 'agreements in principle' for Cases of Need to ensure that funds are made available only when monies are available to avoid a deficit materialising.	Review progress at the next meeting.	February 2023
Cases of Need	A	A	The changes made to improve the Cases of Need process have had a positive impact, but there is still a need to further improve the Divisional Director's levels of understanding and ownership. This was once again highlighted by another Case of Needs submission which did not have the appropriate sign-off for it to be reviewed at the meeting.	Review progress at the next meeting.	February 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Charitable Funds	A	A	There remains considerable scope to increase Divisional Spending and this will be incorporated within our plans to rationalise the 81 Charitable Funds. As the Divisions have significant sums available (without documented commitments) it was agreed that the Divisions will be asked to present their 2023 Plans at the first meeting in the new year to provide greater assurance. As part of this oversight review, the Committee members will also seek greater assurance about how the funds will be spent, with a clear focus on equipment and facilities for patients & their families and staff (whilst avoiding the risk of funds being spent on staff related costs which should be covered by the Trust)	Review progress at the next meeting.	February 2023
Finance Strategy	A	A	The Finance Strategy plan, which will be based upon a 'low risk' investment approach with the scope to maximise shorter term interest rates will be developed and presented in early 2023.	Review progress at the next meeting.	February 2023

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

Report Title	**CNST Year 4 Submission – GWH Compliance Report**				
Meeting	**Trust Board**				
Date	**13th January 2023**	Part 1 (Public) [Added after submission]	X	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek (Chief Nurse)				
Report Author	Lisa Marshall, Kat Simpson & Laura Little				
Appendices					

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Significant	X	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

The purpose is to notify Trust Board that NHS Resolution (NHSR) is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

This presentation provides a final compliance position update to the Board with supporting key commentary to demonstrate the achievement of all 10 maternity safety actions to the required standards requested by NHSR.

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:
▪ **To approve.**

Accountable Lead Signature	
Date	5th January 2023

NHS
Great Western Hospitals
NHS Foundation Trust

CNST Year 4 Submission – GWH Compliance Report

Lisa Marshall — Director of Midwifery and Neonatal Services

Kat Simpson — Head of Midwifery and Neonatal Services

Assurance of Governance Process for Compliance Against NHSR Safety Actions

Great Western Hospitals NHS Foundation Trust

- Throughout the Year 4 reporting period there has been a strong focus on embedding a visible and consistent strategy for safety in Maternity & Neonatal care.
- The implementation of consistent monitoring, guidance and visibility from ward to board has shaped our local governance framework and reporting to the wider system

1. **Maternity Governance meetings** (monthly)
2. **SWC Divisional Board**
3. **Monthly Perinatal Quality Slides** (reviewed & discussed at Maternity Governance, Quality & Safety, SWC Division Board & Patient Quality Group)
4. **Quarterly Maternity & Neonatal Safety Report** (reviewed & discussed at Quality & Safety Committee)
5. **Maternity & Neonatal Safety Champions meeting** (bi-monthly)
6. **Local Maternity & Neonatal System** (LMNS) & **Integrated Care System** (ICS) meeting

Scheduled Plan For Chief Executive Sign Off	
8th December 2022	CNST Evidence check & challenge meeting with Lisa Cheek *(Chief Nurse & Board Level Maternity & Neonatal Safety Champion)*, Paul Lewis *(Non Exec Director & Board Level Maternity & Neonatal Safety Champion)* & Gill May *(ICS Accountable Officer)*
13th January 2023	Presentation to Trust Board
25th January 2023 (4pm)	Formal sign off meeting by Kevin McNamara *(Chief Exec.)* & Gill May *(Accountable Officer)*
2nd February 2023 (Noon)	Final deadline for completed Declaration Form (signed by Chief Exec. and Accountable Officer) to be submitted to NHS Resolution

Year 4 GWH CNST Compliance Across NHSR 10 Safety Actions

Great Western Hospitals NHS Foundation Trust

	Criteria	Initial Self Assessment RAG (Sept 2021)	Submission RAG (Jan 2023)	Key Commentary
1.	Are you using the National PMRT to review perinatal deaths to the required standard?			• Consistent reporting process via Quality & Safety • Effective & robust engagement with families during review process
2.	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			• System wide visibility of local digital strategy for Maternity Services • Achievement of full Clinical Quality Improvement Metrics & associated data set
3.	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			• Consistent monitoring of local Transitional Care provision against national standards to review opportunities for further service development • Continued engagement with South West Operational Delivery Network for Neonates
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?			• Increased availability of Consultant workforce • Development and implementation of Advanced Neonatal Practitioner Service • Increased funded neonatal nursing establishment to meet British Association of Perinatal Medicine (BAPM) standards • Ongoing progress on Neonatal Medical Workforce
5.	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			• Safe and available workforce monitored via BirthRate Plus • Transparency & visibility of workforce challenges evaluated through the embedded practice of Safer Staffing Reporting process

Year 4 GWH CNST Compliance Across NHSR 10 Safety Actions (cont'd)

NHS Great Western Hospitals NHS Foundation Trust

	Criteria	Initial Self Assessment RAG (Sept 2021)	Submission RAG (Jan 2023)	Key Commentary
6.	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?			• An established audit programme to monitor progress against national standards aligned to the national ambition for maternity care • Successful reintroduction of Carbon Monoxide Screening • Introduction of local Fetal Monitoring Training education programme with competency assessment
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?			• Established links with MVP including engagement with local governance and EDI meetings • Further embedding of co-production throughout the service
8.	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?			• Established local three year training plan based on national Core Competency Framework • Full multi-disciplinary engagement with in house training programme • Achievement of 90% attendance across focussed maternity and neonatal educational training
9.	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			• Maternity Safety Champions pathway embedded and further strengthened • Continual review Maternity Continuity of Carer • Consistent engagement across Perinatal Services Improvement strategies
10.	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN)scheme from 1st April 21 - 5th December 22?			• Consistent reporting process via Quality & Safety • Effective & robust engagement with families during review process

CNST Year 4 Submission (2023)

NHS
Great Western Hospitals
NHS Foundation Trust

Enabling safer maternity care

Report Title	**Safe staffing 6-month review for Nursing and Midwifery**				
Meeting	**Trust Board**				
Date	**13 January 2023**	**Part 1 (Public) [Added after submission]**	**x**	**Part 2 (Private) [Added after submission]**	
Accountable Lead	Lisa Cheek Chief Nurse				
Report Author	Luisa Goddard Deputy Chief Nurse				
Appendices					

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Significant		**Acceptable**	**X**	**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

The purpose of this report is to provide the Board of Directors with assurance that wards and departments have been safely staffed in line with the National Quality Board guidance (2014) and Developing Workforce standards (2018). This report also gives in depth focus to Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations. The last report was in May 2022.

This report details the governance of our safer staffing processes, the key Nursing and Midwifery metrics and work on developing the workforce for the future. The report also gives a summary of themes from this year's Chief Nurse establishment reviews.

Maternity Safe Staffing

The report covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report. Key Maternity metrics are reviewed and discussed. It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has gradually improved over the last 6 months by identifying different staffing models, recruitment locally and internationally, alongside the recruitment of band 5 registered nurses to work within specific areas in Maternity.

Governance of Safe Staffing
The report describes the Trust's safe staffing process is monitored through daily, weekly, monthly, and annual actions.

Workforce metrics
Recruitment of unregistered and registered nurses continue, the international educated nurses pipeline remains strong with between 8-10 wte starting each month. The band 5 trajectory shows a 0-vacancy position by March 2023. Recruitment of health care support workers continues with a strong pipeline in place, wards are recruiting to the new safer staffing establishments to meet the 1 to 8 ratio. Focused work on retention is underway utilising the NHSE Nursing and Midwifery Retention Self-Assessment to ensure high impact actions.

Establishment Reviews
The Chief Nurse chairs yearly establishment reviews with the Ward / Unit managers to ensure 'ward to board' oversight of safe staffing. The reviews cover registered nurse / unregistered nurse to patient ratios as well as current vacancies, roster metrics and quality metrics / nurse sensitive indicators. The reviews have been carried out in September / October 2022. The Trust has agreed to investment in safe staffing to increase the health care assistant to patient ratio to a 1:8 this year and increase the registered nurse to patient ratio in 2023/24. Although the full impact of this investment has not yet taken effect, there was very positive feedback from the ward managers on the impact this is having on patient care.

- The majority of inpatient wards are still working at a 1:10 or above ratio for registered and unregistered nurses. However, good progress is being made to recruit to the new safer staffing establishments for health care assistants and for registered nurses in 4 key areas.
- The Ward Managers are supervisory in the establishment but working clinically at times to support.
- The E Roster metrics were reviewed and discussed for each clinical area, overall, there was good controls in place, but a few areas are having enhanced supervision from the Matron / Divisional Director of Nursing.
- The quality dashboard was reviewed focusing on the nurse sensitive indicators (falls, pressure ulcers, concerns, and complaints). The Ward Managers had good oversight of their quality data and were taking actions to drive improvement.
- Sickness absence, especially short term was impacting of planned staff numbers. The training session and additional support from Human Resources and the Matrons / Divisional Directors of Nursing is supporting this.
- The Surgical Assessment Unit, Theatres, Critical Care, and the Stroke Unit require further analysis and review.

The Emergency Department review included review of progress against the Royal College of Emergency Medicine Workforce standards and noted significant improvement since the last review in 2021. Results from the first data collection and analysis on the Safer Nursing Care Tool for Emergency Departments were reviewed and shared. Further data collection will take place in January 2023.

Conclusion
Maintaining safe staffing for Nursing and Midwifery remains a key challenge for the NHS and the Trust. The Trust has good governance processes to ensure that staffing risks are known, visible and mitigated as much as possible.

The report makes the following recommendations:

The Trust to support the continual investment in registered and unregistered nursing to ensure that the nurse-to-patient ratios are 1 to 8 or less.

The robust recruitment continues including the Internationally Recruited Nurses programme supported to ensure that there is a strong pipeline.

The focus on Nursing and Midwifery retention is driven through the Nursing and Midwifery Workforce Group.

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ The committee is asked to note the contents of the paper	
Accountable Lead Signature	Lisa S Heath
Date	05/01/23

1. Introduction

The purpose of this report is provide the Board of Directors with assurance that wards and departments have been safely staffed in line with the National Quality Board guidance (2014) and Developing Workforce standards (2018). This report also gives in depth focus to Maternity staffing to ensure compliance with CNST and Ockenden recommendations.

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

These include:

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

This report serves as the six-monthly safe staffing review at Great Western NHS Foundation Trust. The Board of Directors last received a Safe Staffing Paper in May 2022.

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) supports Trusts to use best practice in effective staff deployment and workforce planning utilising evidence-based tools and professional judgement to ensure the right staff, with the right skills are in the right place at the right time. The Board of Directors is expected to confirm their staffing governance processes are safe and sustainable.

In 2021 The Royal College of Nursing published 'Nursing Workforce Standards; supporting a safe and effective nursing workforce' which were designed to support safe staffing. A benchmarking exercise against these standards were previously presented and found to be compliant.

2. Governance of safe staffing

Nursing and Midwifery staffing is monitored through daily, weekly, monthly and annual actions in compliance with the guidance described above.

2.1 Daily Safe Staffing process

The Trust continues to have a Trust wide three times a day safe staffing meeting. With the implementation of the 'duty matron' role out of hours these meetings now occur 7 days a week. The 'duty matron' working a late shift also ensures better oversight of safe staffing into the night shift. The wards have a staffing board visible for patients and relatives to see.

2.2 Weekly review of staffing

The Divisional Directors of Nursing review staffing weekly with a look forward to ensure any gaps are mitigated. The Chief Nurse reviews staffing including agency usage with the Divisional Directors of Nursing / Midwifery at a weekly meeting.

2.3 Monthly Safe Staffing

From April 2014, it became a national requirement for all hospitals to publish information regarding staffing levels on each ward each month. The published information lists the number of nurses, midwifes and care staff (planned and actual) working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

The results are available through the NHS Choices website. With the changes to the Integrated Performance Report a monthly safe staffing report including highlighting any areas reported as less than 80% fill rate (the national standard) is presented to the Quality Committee.

The monthly Nursing, Midwifery and AHP workforce Group reviews divisional workforce reports including vacancies, agency spend and roster metrics.

2.4 Establishment reviews

The Chief Nurse chairs yearly establishment reviews with the Ward / Unit managers to ensure ‘ward to board’ oversight of safe staffing. This gives Ward Managers an opportunity to discuss staffing and any concerns with the Chief Nurse. The reviews cover registered nurse / unregistered nurse to patient ratio, care hours per patient day, model hospital comparators, national or royal college guidance as well as current vacancies, roster metrics and quality metrics / nurse sensitive indicators.

The reviews have been carried out in September / October 2022 and are being written up with recommendations and actions. The Trust have agreed to investment in safe staffing to increase the health care assistant to patient ratio to a 1:8 this year and increase the registered nurse to patient ratio in 2023/24. Although the full impact of this investment has not yet taken effect, there was very positive feedback from the ward managers on the impact this is having on patient care.

2.5 Acute Hospital Alliance Benchmarking for Nurse and Midwifery Safe staffing

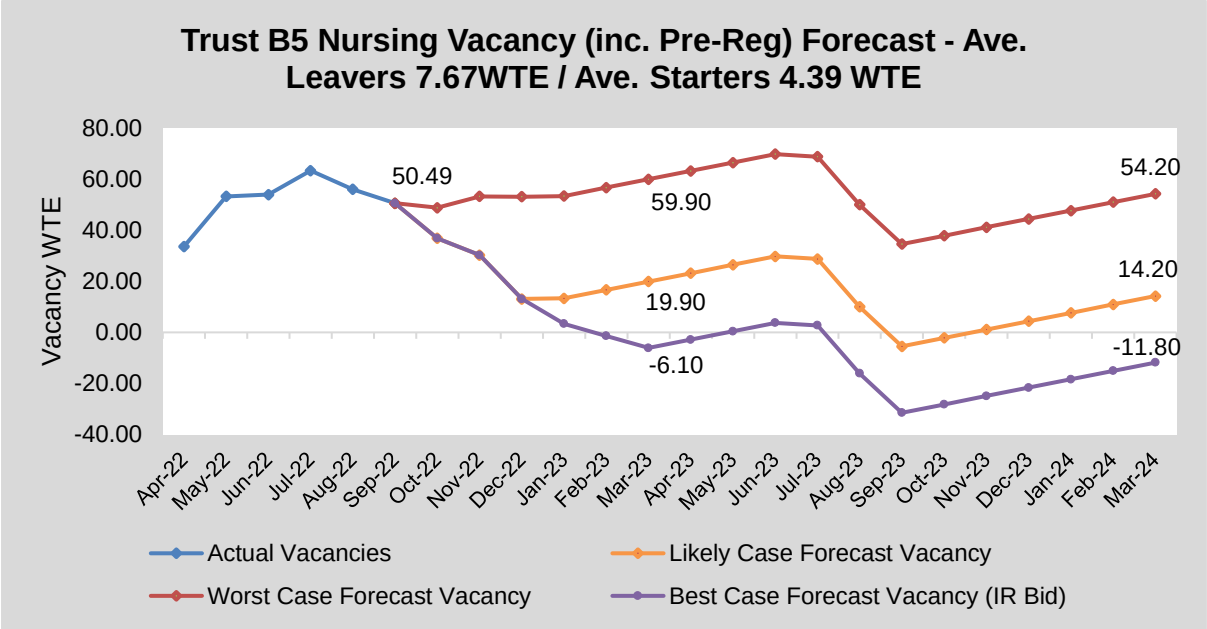
The Chief Nurses and Deputy Chief Nurses from the Acute Providers across BSW have been meeting monthly to benchmark Nurse and Midwifery staffing and develop core safe staffing principles. It is expected that this will give a helpful oversight across the Acute Hospital Alliance and help inform funding decisions. The key metrics include nurse to patient ratio, headroom and use of the nurse associate role. A paper is due to the Acute Hospital Alliance in December 2022.

3. Workforce Metrics

3.1 Vacancies

The Registered Nurse recruitment trajectory is described below. It is noted that the forecast has an average leaver per month of 7.67 wte, average starters excluding international recruitment is 4.39 wte.

Table 1 Registered Nurse Recruitment trajectory April 2022 – March 2023

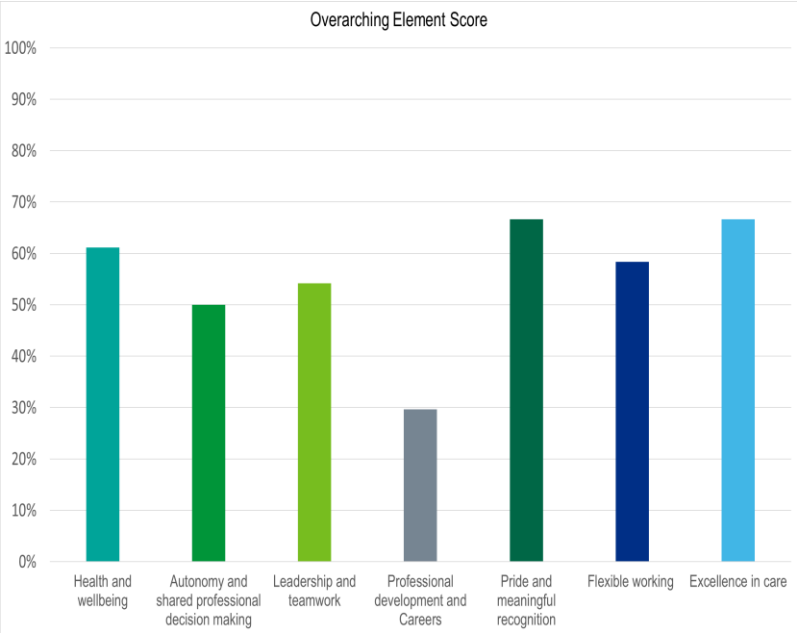


The ‘Best’ trajectory line includes international recruitment until March 2023 and demonstrates a zero vacancy if the Trust continues the international recruitment programme.

Health Care Assistant vacancies continue to be monitored through a weekly report and a programme of rolling weekly adverts and interviews. The aim is to recruit 15 Health care assistants per month which is currently being met. In October 2022 there were 2.18wte vacancies however recruitment to the additional posts (approximately 100wte) to support the new safe staffing model is ongoing.

There is focus work on retention in place, in September 2022 the Deputy Chief Nurse and HR team completed the Nursing and Midwifery Retention Self-Assessment tool from NHSE. This highlighted high impact actions and areas for continual focus such as professional development and career pathways. A summary of the self-assessment is below in table 2.

Table 2 NHSE Nursing and Midwifery Retention Self-Assessment Scores.



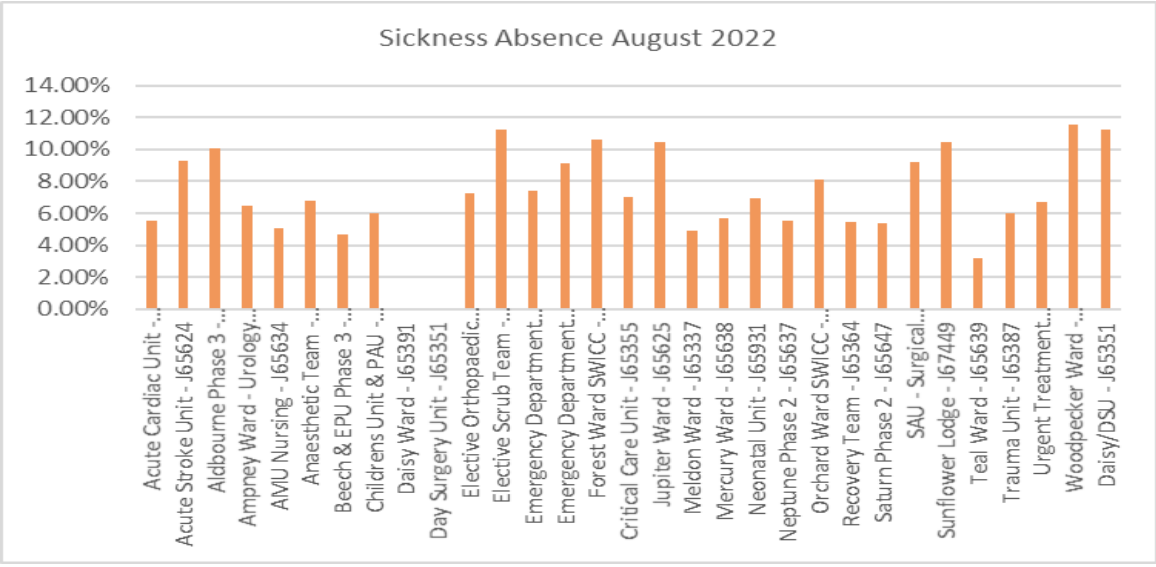
3.2 Sickness absence

Sickness absence continues to be monitored closely. Table 3 gives an example of sickness absence report by ward for August 2022.

The areas flagging as having higher than expected sickness absence have had enhanced support from the Human Resources Advisor and Business Partners.

Ward Managers attended an in-depth training session in October on the absence management policy, which was well evaluated and also produced some suggestions for improvement.

Table 3 Sickness absence report for August 2022 by ward.



4. Workforce for the future

4.1 Band 2 to 5 pathway

The senior nursing team and academy leads are developing a clear pathway for progression from a band 2 health care assistant to a registered nurse. There is also work with Swindon College to ensure that T level students are supported with placements at the Trust and to apply to the Trust once completed their studies. These pathways support recruitment of our local population and onwards development ensuring retention and a higher standard of patient care.

4.2 Registered Nurse Associates

The Trust currently has 13 registered nurse associate and 27 in training. Work is under way to increase the number of registered nurse associates in training with larger cohorts being recruited to for places in January and September 2023. Nurse Associates have gained a foundation degree level and are registered with the NMC. The role has advantages such as, provides progression route into graduate level nursing, bridging role between healthcare support workers and registered nurses, enable nurses to undertake more advanced roles, improves staff retention through career progression, 'Grow your own' nursing workforce.

4.3 Student Nurse training

Applications to university nurse training (in all disciplines) have been significantly lower than expected, locally not all places have been filled. The Universities are also reporting high attrition rates.

The Trust continues to work closely with Oxford Brookes to ensure that students have a good experience at the Trust and any feedback is acted on. The Trust and University have jointly recently set up a Student Council which will be run by the students with the Chief Nurse and Deputy Chief attending and supporting.

5. Establishment Reviews

The full report on the 2022 Chief Nurse establishment reviews will be presented in the next report. The main themes are described below:

- The majority of inpatient wards are still working at a 1:10 or above ratio for registered and unregistered nurses. National guidance is to have ratios of 1:8 or less, ratios above this are recognised as increasing the potential for harm. However, good progress is being made to recruit to the new safer staffing establishments for health care assistants and for registered nurses in 4 key areas.
- The Ward Managers are supervisory in the establishment but frequently working clinically to support.
- The E Roster metrics were reviewed and discussed for each clinical area, overall, there was good controls in place but a few areas are having enhanced supervision from the Matron / Divisional Director of Nursing.

- The quality dashboard was reviewed focusing on the nurse sensitive indicators (falls, pressure ulcers, concerns and complaints). The Ward Managers had good oversight of their quality data and were taking actions to drive improvement.
- Sickness absence, especially short term was impacting of planned staff numbers. The training session and additional support from Human Resources and the Matrons / Divisional Directors of Nursing is supporting this.
- The Surgical Assessment Unit, Theatres, Critical Care and the Stroke Unit require further analysis and review.

5.1 Emergency Department

Benchmarking against the Royal College of Emergency Medicine Workforce Standards was completed in 2021 and repeated in September 2022.

The benchmarking showed that with the recent Safe Staffing investment in the Emergency Department has made a significant difference to the Trust's compliance against these standards (appendix 1). The main changes are improving the skill mix to meet the 30% of registered nurses are band 6 or 7 from a previous baseline of 11.3% and investment in practice educator and safeguarding time.

The key remaining areas of non-compliance are no Emergency Department Nurse Consultant, Headroom uplift does not meet the minimum 27% to support training requirements, there is no non clinical time for nominated Emergency Department Charge Nurse leads for each of the cross cutting themes of the RCN Competency Framework. allocated for these.

Safer Nursing Care Tool for Emergency Departments

The national roll out of the Safer Nursing Care Tool for Emergency Departments happened in 2021 with the Trust's Emergency Department completing the data collection and analysis in June 2022 following training and validation from the national team. The data collection consists of attendances, occupancy as well as acuity and dependency.

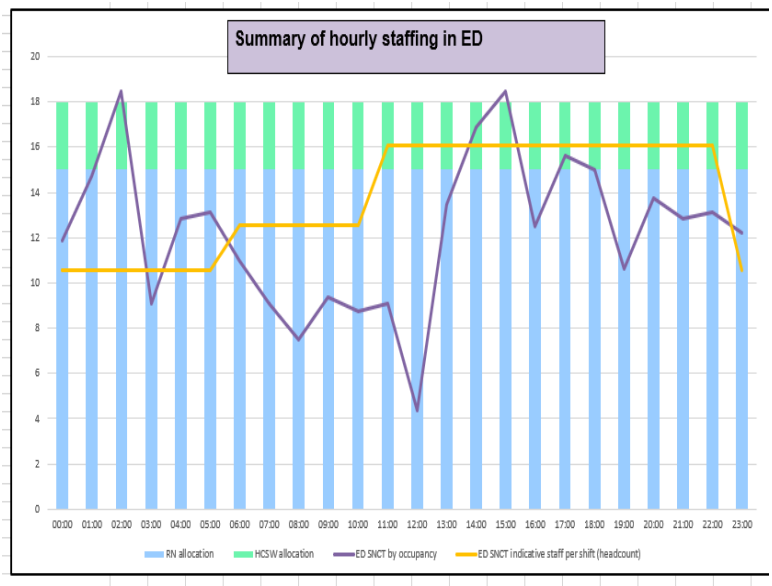
Table 4 Safer Nursing Care Tool for GWH Emergency Department data collection

Hour of day	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
RN allocation	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
HCSW allocation	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
ED SNCT by occupancy	12	15	18	9	13	13	11	9	8	9	9	9	4	13	17	18	13	16	15	11	14	13	13	12
ED SNCT indicative staff per shift (headcount)	11	11	11	11	11	11	13	13	13	13	13	16	16	16	16	16	16	16	16	16	16	16	16	11

The results were reassuring that there were sufficient overall numbers of nursing staff for the case mix during the data collection period for the majority of the day but there may be some

benefit of changing the numbers of staff available mid-afternoon. This is currently being explored by the Emergency Department Matron. The plan is to repeat the data collection twice yearly at different times of the year, the next is planned for January 2023.

Table 5 Safer Nursing Care Tool, Summary of hourly staffing in GWH ED



It is also recognised that this data does not account for operational surge or the need to manage additional patients in the Emergency Department or Ambulance queue.

5.2 Community Nurse Staffing

Community Nursing encompasses several elements of community services such as the Locality Community Nursing Teams, Urgent Community Response Team, Community Intermediate Care Team, the Virtual Ward and a range of specialist teams.

The Queen's Nursing Institute in 2021 (QNI) recommended that caseloads should be no larger than 150 patients and that a registered nurse should have no more than 9-10 visits per day nurse. The Community Matrons monitor closely the number of visits per nurse and number of visits deferred due to staffing shortage. Visits are prioritised for safety and mitigations are put in place such as the use of specialist teams to minimise any potential harm/ delay in treatment. This process is described in a standard operating procedure and the inclusion of data of number of visits referred will be presented in the monthly workforce report.

Training has commenced on the national Community Safer Nursing Care Tool which will enable greater visibility on the acuity and demand and help with workforce planning.

Community Nursing vacancies continue to be challenging, the community nurse team have 14wte (34%) vacancies for band 5 nurses in September 2022. However, the recruitment pipeline consists of 9.8 wte newly qualified nurses starting in September / October (student nurse pipeline) and 3.27 wte experienced band 5 nurses.

The success of recruiting the newly qualified nurses is a result of working closing with the university to ensure Student Nurses understand the role of the community nurse and developing bespoke community rotations in the 3rd year.

The Recruitment and Retention plan for community nursing is regularly reviewed by the Divisional Director of Nursing. The team are trialling different ways to support Health and Well Being conversations including incorporating into team meetings and sessions with the Trust Well Being team.

If a patient has a deferred visit the patient is assessed at the next visit to ensure that no harm was identified as a result of the delay. If potential harm was identified an incident report would be completed and follow the Trust incident review process. Quality metrics (pressure ulcers, falls, serious incidents) are reviewed and monitored at the Divisional Quality Governance meeting and in the Trust's Quality and Safety Committee.

6. Maternity staffing

6.1 National / regional context

This paper covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board on a six monthly basis, Maternity incentive scheme October 2022.

Birthrate Plus (BR+) is a nationally recognised tool to calculate Midwifery staffing levels. The methodology underpinning the tool is the total midwifery time required to care for women on a 1:1 basis, throughout established labour. The principles underpinning BR+ methodology is consistent with the recommendations in the NICE Safe staffing guidelines for Maternity settings and have been endorsed by the Royal College of Midwives and the Royal College of Obstetrics and Gynaecologists. Following the full Ockenden report (Ockenden) an immediate and essential action mandated that 'The feasibility and accuracy of the BirthRate Plus tool (BR+) and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.' The Trust will continue to utilise the BR+ methodology pending the findings of the national review.

Trusts are expected to commission a BR+ report every 2-3 years, and a revised report was received by GWH's report in May 2022, which was funded by the Local Maternity and Neonatal System (LMNS). This report identified a registered midwife gap of 3.33wte.

It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has gradually improved over the last six months by identifying different staffing models, recruitment locally and internationally, alongside recruitment of band 5 nurses to work in specific areas within maternity.

The Trust is monitoring the impact of actions taken when in escalation such as redirecting staff from the community teams to the labour ward for short periods. Other actions such as ceasing home birth for short periods are only implemented in consultation with the LMNS and with Trust Executive approval. An improved escalation process has been put in place to

ensure that both the Trust and LMNS are aware when there have been changes to service delivery due to acuity.

6.2 Skill mix review and on call planning

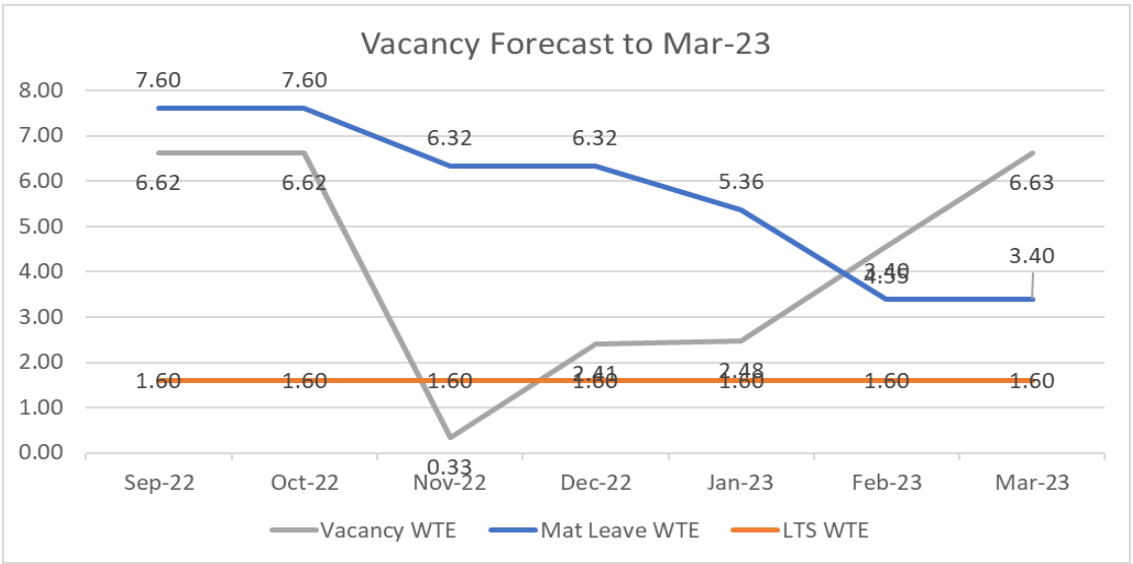
The Matron team have undertaken a skill mix review in April 2022 and have identify new roles that support clinicians. Band 5 nurses have been recruited to work in specific areas of maternity to support the wider team.

There was a staff consultation launched in March 2022 to scope a unit on-call process to enable the staffing model to be more flexible at times of high acuity. This system will reduce the impact on calling the community staff to support Delivery Suite, freeing them to support the provision of home birth, and to provide on call support to the Birth Centre. The consultation concluded in September 2022 and staff were informed in writing on October 11th, 2022 that the on-call system will commence in January 2023.

6.3 Current midwifery staffing position / vacancies / maternity leave / sickness absence

The following graph identifies current and forecast vacancy within maternity if no further recruitment is undertaken. The successful recruitment plan to date, will continue as a rolling planned model of recruitment to ensure that there is a constant pipeline of new starters.

There is now a plan to further focus on retention of staff, utilising the health education England funding for a retention lead midwife to be in post for a further 12 months, April 2023-March 2024.



Midwifery vacancy position in October 2022 is 6.62wte, with an anticipated vacancy of 0.33WTE in November 2022. This includes the additional 5.81wte posts funded through Ockenden to help meet the previous BR+ requirement. Inclusion of the further requirement for an additional 3.33WTE is part of business planning for this year.

The below table illustrates the level of staff turnover across departments, on a monthly basis between September 2021 and August 2022. This data informs the focus of the retention plan for maternity services.

All & Voluntary Turnover Sep 21-Aug 22

Division	Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Surgery, Women's & Children's Division	Ante-Natal Screening - J65919	5	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Birthing Centre - J65921	7	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Community Midwifery - J65918	49	9	18.56%	5	10.31%
Surgery, Women's & Children's Division	Continuity of Carer - Midwives - J65922	14	1	7.14%	1	7.14%
Surgery, Women's & Children's Division	Day Assessment Unit - J65910	22	2	9.30%	1	4.65%
Surgery, Women's & Children's Division	Hazel & Delivery Staff - J65914	149	32	21.55%	27	18.18%
Surgery, Women's & Children's Division	Specialist Midwives - J65920	17	2	11.76%	2	11.76%

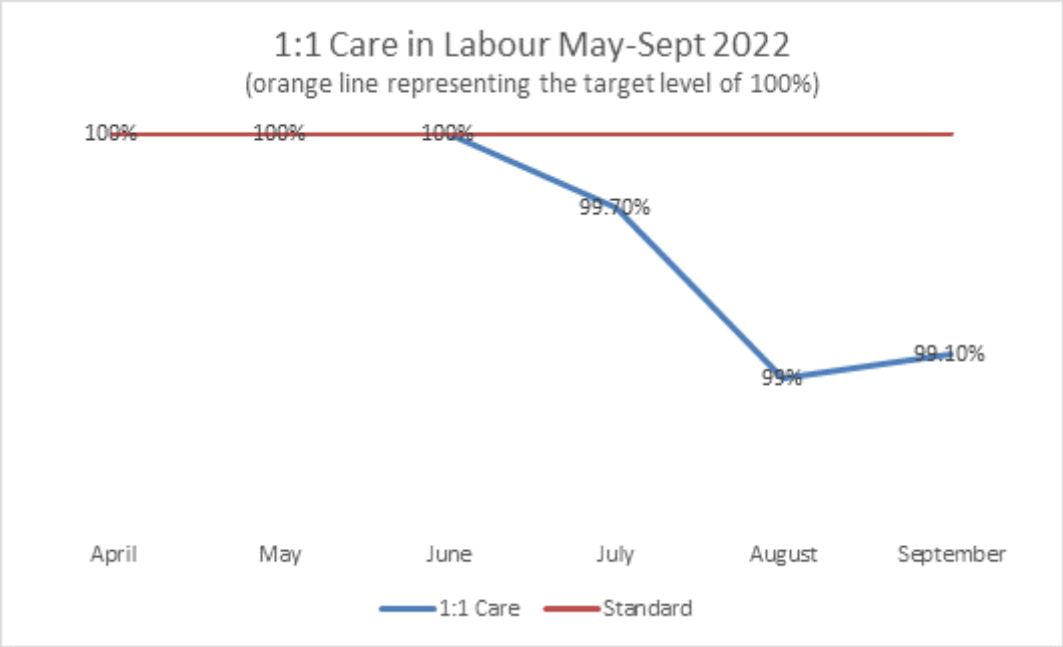
The turnover rate above is further impacted on by the sickness and retirement rates as shown in the two tables below.

Sickness rate as of Jan 2022				
Department	**Professional Group**	**ST**	**LT**	**% Sick**
Ante-Natal Screening - J65919	Registered Nursing and Midwifery	4.11%	0.00%	4.11%
Community Midwifery - J65918	Registered Nursing and Midwifery	2.17%	1.47%	3.64%
Continuity of Carer - Midwives - J65922	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Day Assessment Unit - J65910	Registered Nursing and Midwifery	1.99%	0.00%	1.99%
Hazel & Delivery Staff - J65914	Registered Nursing and Midwifery	3.25%	2.74%	5.99%
Birth Centre	Registered Nursing and Midwifery	3.92%	0.00%	3.92%
Specialist Midwives - J65920	Registered Nursing and Midwifery	2.12%	0.00%	2.12%

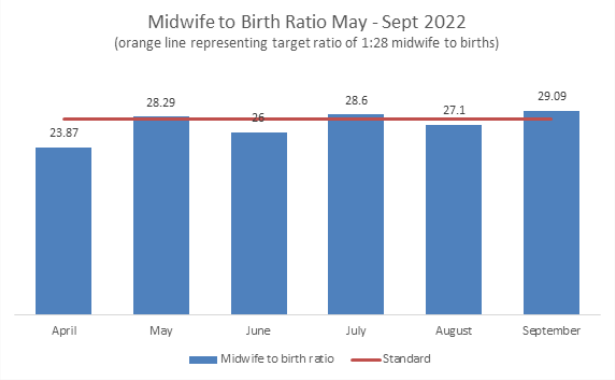
Midwives 55 or over who could retire in March 2023			
Department	Total headcount	55 or over	% who could retire in March 2022
Community Midwifery - J65918	43	7	16.28%
Day Assessment Unit - J65910	20	9	45.00%
Hazel & Delivery Staff - J65914	88	12	13.64%
Specialist Midwives - J65920	19	5	26.32%
Total	**170**	**33**	**19.41%**

6.4 One-to-one care in Labour and Midwife to ratio

The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the graph below demonstrates that it fluctuates between 98.2% and 100% compliance over the 6-month period. The Team continue to work on ways to achieve 100% 1:1 care in labour, with focussed recruitment it is anticipated that there will be a consistent improvement from 99.10 to 100%.

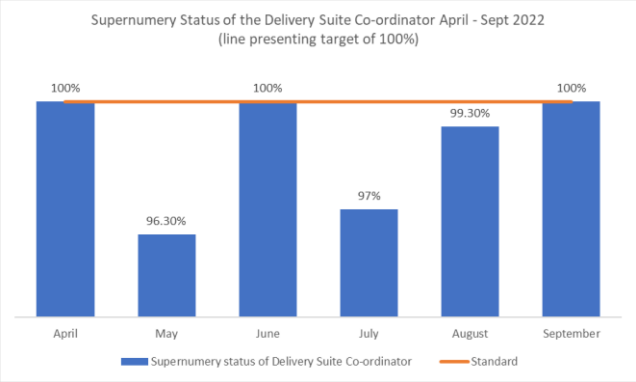


The Maternity Service monitors and reports the Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer Childbirth (2007). The midwife to birth ratio is calculated using the planned establishment rather than the actual staffing numbers in line with national guidance.



6.5 Supernumerary status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status to ensure there is an oversight of all birth activity within the service. This is defined as having no caseload of their own during their shift. Over the six-month period April-September 2022 a compliance rate of 98.8% was achieved. The focus is on achieving 100% compliance and identifying measures to achieve this with the team within the current staffing model.

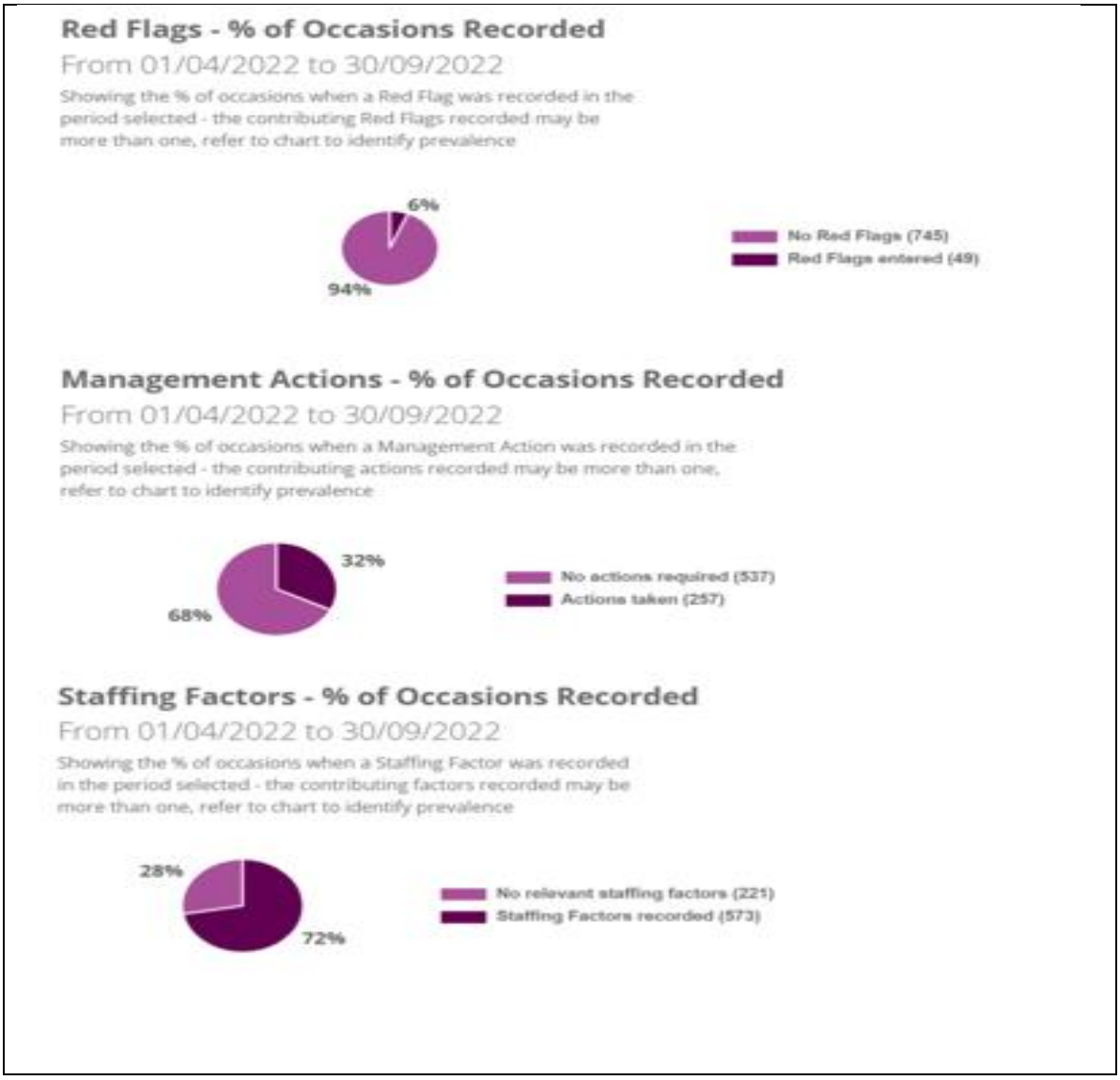


6.6 Red Flags

The Maternity unit uses a 'Red Flag' indicator system, captured via BR+, to identify critically low staffed shifts. It has identified 10 red flags which trigger escalation and follows a procedure for mitigation. This takes an overview of staffing across Maternity and relocates staff to areas of need as required, as well as outlining both clinical and management action.

The 10 red flags are as follows:

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



Analysis of the data shows that there was a reduction of the number of occasions red flags were recorded compared to the previous Safer Staffing paper. Furthermore, there was also a reduction in the number of occasions where management actions were required to escalate staffing concerns and a reduction in the number of occasions were staffing factors were recorded as a concern requiring escalation. Several initiatives have been put in place to strengthen midwifery staffing as part of the recruitment and retention plan set out below.

6.7 Recruitment and retention

There is a recruitment and retention Divisional group who meet regularly, with a plan in place including:

- Retention lead midwife and senior leaders engaging with students from day one as future employees
- Scheduled meet and greets with divisional staff, new starters and students
- Review and refresh of preceptorship package
- Blended learning programme with University of West England
- Working with Universities to increase student midwife places

- Return to practice programme
- Successful International recruitment of Midwives bid (collaborative bid across BSW)
- Band 5 Nurse role within maternity
- Health Education England funding for nurses to undertake 2-year Midwifery course
- Close working with Swindon College, supporting T level student placements
- Health and well-being programme
- Apprenticeship and Nurse Associate model to 'grow our own'.

Other action that has been taken/considered to overcome recruitment and/or retention issues:

- 4 Places secured with the University of Worcester to deliver two-year midwifery programme.
- Successful Maternity funding bid for £67,720 to support Obstetric leadership, bereavement provision and educational development for maternity support staff.
- Block booking of agency has been used during the period of focussed recruitment and will be reduced from October 2022.
- In September 2022 we re-started enhanced bank rates for bands 2,3,4,5, 6 and 7. Bank fill rates are reviewed against agency usage weekly. Payments are in line with other Trusts within the LMNS, bank fill rate has seen a significant improvement.

6.8 Continuity of carer

The model to provide a named midwife for a woman through the perinatal pathway has been a key National deliverable, however in September 2022 all national targets for full implementation were reviewed. This followed the Ockenden report published on March 30th, 2022, advising a review was undertaken by all provider Trusts of the local implementation of Continuity of Carer model to ensure safe staffing was prioritised across the maternity service.

Following these national recommendations, a review of the provision of care under the Maternity Continuity of Carer (MCoC) model was undertaken in April 2022 with a full update provided to Trust Board. The decision was made to reduce the two existing teams to one team, to facilitate safe staffing levels across the service. The Maternity Service is currently supporting 10% of total bookings within the one Continuity of Care teams with the team focussing on areas of deprivation.

This decision was re-enforced with the letter from NHS England (21st September 2022) MCoC letter supporting Trusts to only continue MCoC within a safer staffing model.

An updated MCoC paper will be presented to Trust Board in November 2022.

7. Neonatal staffing

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for are those who require short term intensive care (ITU), up to 48 hours, high dependency (HDU) care and low dependency care. The unit comprises of 8

HDU/ITU cots plus 10 low dependency cots. Neonatal units have an unpredictable and fluctuating activity level, and so should aim to operate at 80% capacity to allow for times of high acuity. National standards for neonatal nursing care, and medical provision have been developed to safeguard patient safety, and we have a duty to comply with these standards. The neonatal unit at GWH works within the South West Neonatal Network to provide the right level of high-quality care to each baby as close to home as possible.

The provision of adequate neonatal nursing staffing, including neonatal transitional care services, are core requirements for the CNST (Clinical Negligence Scheme for Trusts) Maternity Incentive Scheme.

In 2010, the British Association of Perinatal Medicine published the third edition of BAPM-Service Standards for Hospitals providing Neonatal Care.

In 2017, BAPM published Neonatal Transitional Care a Framework for Practice, these documents inform the NHS England Service Specification for Neonatal Critical Care Services, which states the **minimum** nurse to patient staffing ratios based on an average unit occupancy of 80% for neonatal services should be:

- 1:1 for Intensive Care (1 nurse to 1 patient, with no other responsibilities for that nurse)
- 1:2 for High Dependency
- 1:4 for Special Care.
- 1:4 for Transitional Care

These care levels are defined in specific detail by nationally set criteria. To meet BAPM/NHSE standards staffing levels on each shift should be:

- 2 nurses for 2 Intensive Care cots
- 2 nurses for 4 High Dependency cots
- 3 nurses for 12 Special Care cots
- 1.5 nurses for 6 Transitional Care cots
- 1 Supernumerary Shift coordinator on each shift

The planned rota is 7.0 wte as staffing requirements will fluctuate with acuity and therefore staffing to an average cot occupancy results in staffing being set at 7.0 wte per shift.

There are currently 11.86 WTE nurses who have completed the qualified in speciality (QIS) course, which enables the member of staff to provide intensive care to babies. Of these staff 2.26WTE are in the band 5 group, therefore there is a focus on increasing the number of Band 5 staff nurses who hold the qualified in speciality (QIS) course to maintain a balanced skill mix. The requirement is for there to be 1 QIS nurse to 4 patients.

Turnover Rates			
Department	Average Head Count	All leavers	All Turnover
SCBU- J65931	43	9	20.93%

Sickness Rates			
Department	Short Term Sickness	Long term Sickness	Total % Sickness
SCBU- J65931	3.38%	2.99%	6.37%

Recruitment of nursing staff continues, with the aim of staffing the neonatal unit to BAPM safe staffing standards following the operational delivery network (ODN) review of staffing against acuity.

The recurring funding secured from the Neonatal network of £143,983 has been used to support the development of the workforce and enable the Division to utilise internal funding for further development of the Advanced Neonatal practitioner role (ANNPs). There are two trainee ANNPs who commenced their program in September with a view to 2 further trainees starting in September 2023. There is an ongoing recruitment focus for the remaining ANNP roles to recruit an experienced team. This will support both the development of the service provision locally, provide educational and peer support and mentorship to the trainees and facilitate enhanced service development work. These roles will also support career development opportunities within the workforce. There has been network funding for 0.4 wte band 8b ANNP, recruitment process for this post has commenced, once in post this role will support the trainee ANNP team.

A 0.64 wte Practice Development Nurse has been appointed to support the neonatal workforce in developing a skilled workforce and support stability within the team. Recruitment to the LNU remains challenging and support from focussed Trust campaigns would be beneficial to attracting staff.

9. Trust Risk Register

As per NQB guidance, the Nursing and Midwifery staffing risks are on the Trust Risk Register. These risks are reviewed monthly at the Nursing, Midwifery and AHP Workforce Group going forward.

10. Conclusion

Maintaining safe staffing for Nursing and Midwifery remains a key challenge for the NHS and the Trust. The Trust has good governance processes to ensure that staffing risks are known, visible and mitigated as much as possible.

11. Recommendations

The Trust to support the continual investment in registered and unregistered nursing to ensure that the nurse-to-patient ratios are 1 to 8 or less.

The robust recruitment continues with the Internationally Recruited Nurses programme supported to ensure that there is a strong pipeline.

The focus on Nursing and Midwifery retention is driven through the Nursing and Midwifery workforce Group.