GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

# BOARD OF DIRECTORS

## Thursday 6th October 2022, 9.30am to 1.00pm
## By MS 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**<br>Jon Westbrook, Paul Lewis | Verbal | LC | - | 9.30 |
| **2.** | **Declarations of Interest**<br>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)**<br>Liam Coleman, Chair<br>• 4 August 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 (pages 12 – 15)** | ✓ | LC | Note | |
| **6.** | **Care Reflections – Patient Story – EDI Complaint (pages 16 – 22)**<br>Peter Coutts, Deputy Divisional Director Outpatients, and Chris Bumford, Matron Outpatients, to present | Presentation | PC/CB | Note | 9.40 |
| **7.** | **Chair's Report (pages 23 – 25)**<br>Liam Coleman, Chair | ✓ | LC | Note | 10.10 |
| **8.** | **Chief Executive's Report (pages 26 – 33)**<br>Kevin McNamara, Chief Executive | ✓ | KM | Note | 10.20 |
| **9.** | **Integrated Performance Report (pages 34 – 109)** | | | Assurance | 10.40 |
| | • Performance, Population & Place Committee Board Assurance Report (August & September) – Peter Hill, Non-Executive Director & Committee Chair | ✓ | PH | | |
| | • Quality & Safety Committee Board Assurance Report (August & September) – Nick Bishop, Non-Executive Director & Committee Chair | ✓ | NLB | | |
| | • Finance, Infrastructure & Digital Committee Board Assurance Report (August & September) – Faried Chopdat, Non-Executive Director & Committee Chair | ✓ | FC | | |

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|---|---|---|---|---|---|
| | • People & Culture Committee Assurance Report (August) – Faried Chopdat, Non-Executive Director & Deputy Committee Chair | ✓ | FC | | |
| | • Integrated Performance Report (new version) | ✓ | Execs | | |
| ***BREAK (10 minutes)*** | | | | | |
| **10.** | **Charitable Funds Committee Board Assurance Report (pages 110 - 111)**<br>Peter Hill, Non-Executive Director & Deputy Committee Chair | ✓ | PH | Assurance | 12.20 |
| **11.** | **Audit, Risk & Assurance Committee Board Assurance Report (pages 112 – 114)**<br>Helen Spice, Non-Executive Director & Committee Chair | ✓ | HS | Assurance | 12.30 |
| **12.** | **Equality, Diversity and Inclusion (EDI) Annual Report 2021-2022 (pages 115 – 167)**<br>Jude Gray, Chief People Officer<br>Patrick Ismond, Lead for Equality, Diversity & Inclusion to present | ✓ | JG/PI | Note | 12.40 |
| **13.** | **Workforce Race Equality Standard (WRES) Annual Report 2021-2022 (pages 168 – 206)**<br>Jude Gray, Chief People Officer<br>Patrick Ismond, Lead for Equality, Diversity & Inclusion to present | ✓ | JG/PI | Note | - |
| **14.** | **Workforce Disability Equality Standard (WDES) Annual Report 2021-2022 (pages 207 – 246)**<br>Jude Gray, Chief People Officer<br>Patrick Ismond, Lead for Equality, Diversity & Inclusion to present | ✓ | JG/PI | Note | - |
| **CONSENT ITEMS**<br>**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.** | | | | | |
| **15.** | **Responsible Officer Annual Report (pages 247 – 262)**<br>Steve Haig, Deputy Medical Director | ✓ | SH | Approve | 12.55 |
| **16.** | **Ratification of Decisions made via Board Circular/Board Workshop**<br>Caroline Coles, Company Secretary | Verbal | CC | Note | - |
| **17.** | **Terms of Reference – Remuneration Committee (pages 263 – 271)**<br>Caroline Coles, Company Secretary | ✓ | CC | Approve | - |
| **18.** | **Urgent Public Business (if any)**<br>To consider any business which the Chair has agreed should be considered as an item of urgent business | Verbal | LC | Note | - |
| **19.** | **Date and Time of next meeting**<br>Thursday 3rd November 2022 at 9.30am, DoubleTree by Hilton Hotel (hybrid meeting) | Verbal | LC | Note | - |
| **20.** | **Exclusion of the Public and Press**<br>The Board is asked to resolve:-<br>*"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"*

**Board Meeting Timetable**

| 2022 | | 2023 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct |
| Board | Seminar | Board | Board | Seminar | Board | Board | Seminar | Board | Board | Seminar | Board |
| | Financial Sustainability | | | Workforce, Culture & EDI | | | Patient Voice | | | *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 4 AUGUST 2022 AT 9.30 AM

**Present:**

**Voting Directors**

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

**In attendance**

| | |
|---|---|
| Johanna Bogle | Deputy Director of Finance |
| Caroline Coles | Company Secretary |
| Naginder Dhanoa | Chief Digital Officer |
| Madeline Goodwin* | Communications Officer |
| Steve Haig | Deputy Medical Director |
| Dr Patricia Monteiro* | ED Consultant (agenda item 105/22 only) |
| Claudia Paoloni | Associate Non-Executive Director |
| Dr Bushra Sohail* | ED Consultant (agenda item 105/22 only) |

**Apologies**

| | |
|---|---|
| Sanjeen Payne-Kumar | Associate Non-Executive Director |
| Simon Wade | Director of Finance & Strategy |
| Jon Westbrook | Medical Director |

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

*Indicates those members attending virtually by MS Teams.

**Matters Open to the Public and Press**

| Minute | Description | Action |
|---|---|---|
| 100/22 | **Apologies for Absence and Chair's Welcome**<br>The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public.<br><br>Apologies were received as above. | |

| Minute | Description | Action |
|---|---|---|

101/22 **Declarations of Interest**
There were no declarations of interest.

102/22 **Minutes**
The minutes of the meeting of the Board held on 7 July 2022 were adopted and signed as a correct record with the following amendments:-

72/22 : Chief Executive's Report : Staff Excellence Awards - Add to sentence *"…*Admiral Nurses, Tim Allen and Hannah Rogers have won the South West and National Parliamentary Awards*. It was noted at the meeting that since the report was written Tim and Hannah had gone on to win the National Parliamentary Award*."

73/22 : Integrated Performance Report : Use of Resource – Add to last paragraph "…the completion of the Urgent Treatment Centre *in July 2022…".*

103/22 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

104/22 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public for the Board.

105/22 **Care Reflections – Staff Story**
*Dr Patricia Monteiro, ED Consultant & Dr Bushra Sohail, ED Consultant joined the meeting for this agenda item.*

The Board received a reflection of care that highlighted the work of the Covid Medicine's Delivery Unit. This service was set up by all acute trusts at the beginning of the pandemic to treat those patients who were considered high risk of developing complications of covid in the community. This care reflection demonstrated how the staff had established the service within 2 weeks but also highlighted the barriers that had to be overcome, including setting up a service alongside their substantive posts.

This successful service, together with winning the Excellence in Integration Award at this year's Staff Excellence Awards, was a testament to Patricia and Bushra's tenacity and commitment to both hospital and patients but also for their strong clinical leadership.

The story prompted a discussion which included staff wellbeing, sustainability of service, future provider, ways of working, IT system, data and the clinical excellence awards.

The Board thanked Patricia and Bushra for sharing their story and for all that they had achieved and continued to do for the Trust and for patients.

The Board **noted** the care reflection.

106/22 **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. Of particular note was the Acute Hospital Alliance (AHA) Away Day in July 2022 which had focussed on the development of a clear set of priorities to focus on across the three acute trusts in the Integrated Care System (ICS) with a further session arranged for October 2022.

| Minute | Description | Action |
|---|---|---|

Clarification was sought on whether the Acute Hospital Alliance Committee-in-Common (CiC) was a sub committee of the Board. The Chief Executive confirmed that it was a formal part of our governance structure and partnership working however no statutory functions had been delegated to the committee. The responsibility of the CiC was to lead on the development of the AHA Programme and workstreams and to set the overall strategic direction in order to deliver the AHA Programme.

Helen Spice, Non-Executive Director asked what the next steps were now that the two appointed governors had stepped down due to the closure of the Bath & North East Somerset, Swindon & Wiltshire (BSW) Clinical Commissioning Group (CCG). Caroline Coles, Company Secretary replied that this provided an opportune time to review partner organisations to ensure that the these organisations were relevant to the current partnership relationships and this would take place over the next few weeks.

It was noted that the bi-monthly Non-Executive Directors meeting had been delayed in July 2022.

The Board **noted** the report.

107/22 **Chief Executive's Report**

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

Covid-19 - The number of covid patients had significantly reduced since last month and had peaked part way through July 2022. There was also a marked reduction in the number of staff off sick, however this had been compounded by school holidays and leave which was a challenge over and above covid sickness.

Covid Booster Vaccinations – The autumn booster vaccination was expected to start in September 2022 for all hospital staff. Vaccinations for the wider population would be available within the community.

National Covid Inquiry - The National Covid-19 Inquiry had been set up to examine the UK's response, the impact of the Covid-19 pandemic and to learn lessons for the future. Caroline Coles, Company Secretary had been appointed lead and a report on the Trust's preparations would be provided at the next Board meeting.

**Action : Company Secretary** CC

Operational Pressures – Patients with no criteria to reside in hospital and delays in ambulance handovers continued to cause operational challenges however there were early signs of impact from the Navigation Hub set up as part of the Swindon Integrated Care Alliance Co-ordination Centre which would formally launch In September 2022.

Endoscopy Service - The endoscopy service had been re-accredited with the he Royal College of Physicians Joint Advisory Group (JAG) and congratulations were extended to the team who had worked hard to make improvements since last year's annual visit.

Agency Spend - Nationally all systems had been asked to significantly reduce spend on agency staffing, with a control total set for Integrated Care Boards.

Faried Chopdat, Non-Executive Director asked what initiatives the Trust were taking to reduce agency spend. Jude Gray, Director of HR replied that as medical spend was the key driver initiatives had commenced which included tighter controls on locum sign off

| Minute | Description | Action |
|---|---|---|

and a 6 week sprint programme within ED. Kevin McNamara, Chief Executive added that alongside this was the work at system level which would include a single bank, incentive schemes, and nursing and medical establishment reviews however these were long term workstreams.

Urgent Treatment Centre - The new Urgent Treatment Centre opened on 27 July 2022 to treat its first patient. This was one of the biggest milestones for the Trust in recent years with good facilities for the population the hospital served.

Improving Together – Improving Together, the Trust's new approach to change, innovation and continuous improvement, continued to be rolled out with the first improvement huddle in SwICC and was a good demonstration of how to translate the theory into conversations on the ground.

Pay Award - The Government had announced the annual pay award for NHS staff which was variable across the staffing groups and causing concern for staff, as a result this had been added to the Trust's risk register.

Nick Bishop, Non-Executive Director asked if there was any further update on the IT incident that occurred in July 2022. Naginder Dhanoa, Chief Digital Officer replied that the Trust were awaiting a response from the service provider however mitigating actions had been put in place to ensure no further failures occurred. It was noted that this was not a weather related incident and the investigation outcomes would go through the normal governance route once completed.

Faried Chopdat, Non-Executive Director asked if 4 hours was acceptable for a critical incident to be stood down. Naginder Dhanoa, Chief Digital Officer replied that a solution had been found much quicker however the long gap was due to waiting for clinical colleagues to complete morning drug rounds.

The Board **noted** the report.

108/22 **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 May/June 2022.

**Part 1 : 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 27 July 2022 and the following highlighted:-

Emergency Access - Performance against the 4-hour standard remained at 76% making it the best performing Trust in BSW and above average performance against the region and nationally. The service remained under extreme pressure however of significant note was the improvement in ambulance handover delays.

Referral to Treatment Time - The Trust continued to have no patients waiting over 2 years and ahead of trajectory for the over 78 week waiters. However, an increase in the over 52 week waiters was noted and this was subject to weekly scrutiny.

| Minute | Description | Action |
|---|---|---|

Diagnostics - This was at a similar position as last month and improvements were expected in Q3/4.

Cancer Service - The Committee received the annual Cancer Performance Report which demonstrated good performance across most services and KPIs. A significant increase in referrals year on year coupled with patient-initiated cancellations and pressure on diagnostic facilities meant that some targets were missed.

Stroke Service - The performance remained good at a level B.

Community and Primary Care – A remedial action plan was taking place in response to the Primary Care CQC warning notice and the team were confident to meet the requirements withn the timescale. Community services continued to be under pressure but delivering a good service.

Theatres Programme - Good working progress had been made on a number of fronts however day cases required further improvement.

In addition, it was noted that in terms of the Committee's new remit around population and health inequalities, although no assurances provided yet, there had been a good and lengthy discussion at the meeting around examples of work being undertaken which included approving the terms of reference for the GWH Health Inequalities Steering Group, the draft health inequalities action plan for the Trust, reflections from a graduate trainee who had been supported on this work and future agenda items which included in-house data and the Swindon Joint Strategic Assessment Needs which had recently been updated.

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

- A published case study on the Trust's cancer personalised care service. The link would be circulated post meeting.
  **Action : Chief Operating Officer** FTD
- With regard to capacity issues in Plastics this had impacted the 62-day performance for July/August 2022 and possibility September however mitigating actions were in place which included mutal aid and the Performance, Population and Place Committee were fully sighted on the issue.
- Reduced ED and UTC pathway attendances had been achieved through the Navigation Hub set up in July 2022 with partners working together however it was recognised that there was still a lot to do in terms of non-criteria to reside patients.

Liam Coleman, Chair asked in terms of winter planning if there were plans in place to meet waiting lists if there was a resurgent of Covid. Felicity Taylor-Drewe, Chief Operating Officer replied that back up plans were in place through the emergency preparedness, resilience response programme and added that the potential risk would be more on staffing than lack of beds. Kevin McNamara, Chief Executive added that following capacity work across the system it had been highlighted that there was a 351 bed gap therefore there was still a material risk around bed capacity particularly in Swindon, however organisations were looking at other ways to sustain elective activity.

**Minute** **Description** **Action**

Faried Chopdat, Non-Executive Director commented that the Trust were now relying on Model Hospital data instead of Public View data which had a considerable time lag and asked what value this had and whether the Trust were doing anything else for benchmarking. Felicity Taylor-Drewe, Chief Operating Officer replied that both Public View and Model Hospital data had significant time lag which was not under the Trust's control. However with the introduction of a new IPR format the aim was to address this issue with better in-house data although this would take time to embed.

**Part 2 : Our Care**
**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 21 July 2022 and the following highlighted:-

Infection Prevention & Control – C.difficile had reduced and remained below the set target however MSSA had risen and work was focussed in this area with further training.

Pressure Ulcers - Numbers had increased in Acute but there had been an increase in the number of high risk patients admitted. Work had begun to focus on special mattress availability and involvement of the ambulance service in assessment and recognition of pressure harm. Community numbers were stable.

Maternity – Good news in that the midwife to birth ratio had improved and further progress on Ockenden had been made however it was recognised that this was a long term project. The Perinatal Mortality Review Tool once again recorded all scores at green rating and therefore the Committee were assured that good practices had been embedded and therefore the Committee gave a 'blue' rating for full assurance in this area.

Mortality Report - Figures showed that the Trust were among the best performing in the south west for mortality. However it was noted that patients dying of Covid were excluded from the HSMR & SHMI data and the Trust had a higher number than most and as a result the Medical Director was undertaking an investigation to ascertain whether correct reporting had been undertaken.

Infection Prevention & Control Annual Report - A good report with a new Lead which reflected a lot of improvement work carried out over the past few months.

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

- The key approach this year within infection prevention and control area was to roll out a different initiative each month. This new approach had already seen an impact with the reduction in C-difficile cases.
- The roll out programme to replace the ventilation systems within the hospital had commenced with an immediate impact seen in the reduction in the rate of nosocomial infection.
- The CNSTstandard submission had been delayed to January 2023. Good progress had been made but the Trust continued to be non compliant around carbon dioxide montoring however there was a plan in place to achieve the trajectory of 80%, currently at mid-70%.
- It had been a challenging few months within the staffing establishment due to

sickness and annual leave however with the safer staffing investment and drive in recruitment and retention the Trust had seen good progress in recruitment particularly around Healthcare Assistants and newly qualified students

Paul Lewis, Non-Executive Director asked if there was a reason for the significant increase in clinical care complaints. Lisa Cheek, Chief Nurse replied the key areas were ED and Surgerical Assessment Unit and a deep dive had been undertaken and as a result enhanced monitoring introduced. It was also noted that clinical care captured concerns around discharge and this was also a theme currently being worked through.

**Part 3 : Our People**
**People & Culture Committee Chair Overview**
There was no Board Committee Assurance Report for this month as the People & Culture Committee (P&CC) met bi-monthly.

The Board received and considered the Workforce performance element of the report and the Director of HR highlighted that although there had been very few changes in the HR matrix since last month's report there were significant risks around industrial action and pay increase campaigns by the trade unions and as a result had been placed on the Trust's risk register.

There followed a discussion on pay awards and the differing amounts. It was noted that there was also a wider issue around funding as any pay settlements came from NHSE not the Treasury and therefore had the potential to impact on services and flow.

Lizzie Abderrahim, Non-Executive Director highlighted the good initiative from the Health & Wellbeing team on making arrangements for UWE training psychologists which was an added bonus for the workforce accessing counselling and would also reduce the reliance in the past on agency psychologists.

**Part 4 : Use of Resource**
**Finance, Infrastructure & Digital Committee Overview**
The Board received an overview of the detailed discussions held at the Finance, Infrastruture & Digital Committee around the use of resource element of the IPR at the meeting held 25 July 2022 and the following was highlighted:-

- The various ratings reflected the risk profile around financial sustainability.
- The central theme of the Committee discussions concerned the action plans and deliverability of the CIP programme.
- The Committee looked at the risks for infrastructure, IT and digital for the first time and although were assured around the process of risk management further work was required around the quality of mitigations and a consistency in reporting across the 3 reports.
- The overall financial position for month 3 was not positive and adverse to plan with a high level forecast of a widening deficit gap projected against plan. Although it was acknowledged that the finance team and divisions were working hard towards mitigating plans the Committee were concerned that the trend was going towards a red/red risk.
- The Committee were appraised of plans to address gaps in best practice as identified following the self assessment exercise recommended in the HFMA briefing 'Improving Financial Sustainability' It was also noted that a mandatory internal audit of financial controls would take place in August/September 2022.

**Minute** **Description** **Action**

- The full business case for the Integrated Front Door project was considered with a recommendadtion for Board approval.

The Board received and considered the use of resource element of the report and the Deputy Director of Finance highlighted the work being undertaken around reducing the run rate, holding to the budget position, reduction in agency spend, job planning, and the funding gap for the pay awards.

Liam Coleman, Chair asked if their was a concern with cash as it was £7m lower than anticipated. Johanna Bogle, Deputy Director of Finance replied that this was a timing issue and there were no current concerns however highlighted the potential cash issue later in the year if the requested loan to the Department of Health was not granted.

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

109/22 **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 8 July 2022 and the following highlighted:-

- There was not a copy of the minutes due to annual leave. It was agreed that as the next Board meeting was in October 2022 the minutes would be circulated outside the meeting.
- Assurance ratings remained consistent.
- The Trust had responded to the consultation on the Libby Protection Safeguards (LPS) Code of Practice and whilst there would be significant training and workforce issues associated with the introduction of LPS the Committee were satisfied that work continued to prepare for implementation.
- The Trust continued to see pressures in ED and children services due to the pressures in partner organisations. This would be monitored closely by the Committee.
- The Chief Nurse for the BSW ICB attended the meeting to discuss the approach to a regional Mental Health Strategy and how the Trust would input.

There followed a discussion around displacement particularly the impact on patients as well as the financial pressures to provide specialist care, and the system Mental Health Strategy.

The Board **noted** the report.

110/22 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Audit, Risk and Assurance Committee (ARAC) meeting on 14 July 2022 and the following highlighted:-

Surgery, Women & Children Division Risk Review – A good report and assurance of managing risk and controls robustly but noted that some old risks required review.

Risk Register – Datix was now fully operational and congratulated the team of this achievement. The Committee noted progress in some areas but were disappointed that overall the overdue actions and risks with no actions continued to increase and requested further updates on progress at the next meeting.

External Audit - Deloitte, the external auditors, confirmed that the Annual Report and

| Minute | Description | Action |
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Accounts for the year ended 31 March 2022 had been submitted in line with the delayed timeline. A joint report from the Trust Finance team and Deloitte would be provided to the next meeting of the Committee on the lessons learned during the audit process.

Internal Audit - The Committee received the updated plans and progress for the current year. Plans were progressing but were a little delayed and a query was raised by the Committee that due to the addition of the required HFMA Financial Sustainability Audit whether there was adequate coverage of all four pillars of the strategy, particularly around patient care.

Losses and Compensations Q1 2022/23 - The Committee approved the write offs for quarter 1 2022/23 and noted the losses for the quarter. The Committee asked for further assurance that overseas debts were being managed for review on a timely basis and noted the actions taken to review the losses which had increased from prior periods.

Jude Gray, Director of HR queried the referral to Performance, Population and Place Committee (PPPC) with regard to consultant surgeon job plans. Felicity Taylor-Drewe, Chief Operating Officer replied that this had been discussed at the last PPPC meeting and was around recruiting surgeons with no capacity within the theatre timetable. It was confirmed that this does not happen at the Trust however work was ongoing to improve threatre efficiency by reviewing the timetable and job planning.

The Board **noted** the report.

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

111/22 **Ratification of Decisions made via Board Circular/Board Workshop**
There was one Board circular in July 2022 to approve a Non-Executive Director's request to work for another healthcare provider outside the region. It was confirmed that as per the constitution over 75% of votes were received to approve this request.

***RESOLVED***

***the Board ratified the request for a Non-Executive Director to work for another healthcare provider as well as working as a Non-Executive Director for Great Western Hospitals NHS FT.***

112/22 **Terms of Reference of Board Committees – Audit, Risk & Assurance Committee**
The Board received and considered a paper that contained the outcome of the annual review of the Audit, Risk and Assurance Committee terms of reference.

***RESOLVED***

***the Board approved the Audit, Risk & Assurance Committee's terms of reference for 2022/23.***

113/22 **Urgent Public Business (if any)**

| Minute | Description | Action |
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None.

114/22 **Date and Time of next meeting**

It was noted that the next meeting of the Board would be held on 6 October 2022 at the Double Tree by Hilton Hotel (MS Teams facility would also be available).

115/22 **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.***

The meeting ended at 1630 hrs.

| ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – October 2022 | | | | |
|---|---|---|---|---|
| PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee | | | | |
| **Date Raised** | **Ref** | **Action** | **Lead** | **Comments/Progress** |
| 03-Mar-22 | 329/21 | **IPR : Our Care : New Infection Prevention & Control Lead**<br>Invitation to present to Board once new IP&C Lead at an appropriate time. | Chief Nurse | The new IPC Lead presented the Annual Infection Prevention & Control Report to the Quality & Safety Committee in July-22 and Committee were assured that the report reflected the amount of work that had been carried out in the last few months. |
| 04-Aug-22 | 107/22 | **Chief Executive's Report : National Covid Inquiry**<br>Report on the Trust's preparations for the National Covid Inquiry. | Company Secretary | This is on the agenda in the private session of the Board meeting for consideration. |
| 04-Aug-22 | 108/22 | **Integrated Performance Report : Our Performance**<br>Link to the case study on the Trust's cancer personalised care service to be circulated to Board members | Chief Operating Officer | The link has been circulated to Board members. Completed. |

| **Future Actions** | | | | |
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| None | | | | |

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| **Report Title** | **Questions for the Board** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **6 October 2022** | Part 1 (Public) | X | Part 2 (Private)] | |
| **Accountable Lead** | Caroline Coles, Company Secretary | | | | |
| **Report Author** | Caroline Coles, Company Secretary | | | | |
| **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**<br>Assurance in respect of: process/outcome/other (please detail): | | | | | | | |
|---|---|---|---|---|---|---|---|
| Process & outcome | | | | | | | |
| **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: | | | | | | | |
| Assurance in respect of the process of obtaining and gaining response to questions to the Board from the public. | | | | | | | |

**Report**

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

This paper reports the questions and responses asked of the Board by governors and members of the public.

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

| | | | | | |
|---|---|---|---|---|---|
| **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 | |
| **Key Risks** – risk number & description (Link to BAF / Risk Register) | n/a | | | | **Risk Score** |
| | BAF S2 & S4 | | | | |
| **Consultation / Other Committee Review / Scrutiny / Public & Patient involvement** | Clinical Led for Staff Health & Wellbeing, Director of HR, Deputy Recovery Director, Chief Operating Officer | | | | |
| **Next Steps** | To be submitted to next Council of Governors meeting. | | | | |

| **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**<br>The Board/Committee/Group is requested to: | |
|---|---|
| ***that the questions and responses be considered with the Board invited to consider if further action is required.*** | |
| **Accountable Lead Signature** | Caroline Coles |
| **Date** | 2 August 2022 |

| Questions to the Board | | | | |
|---|---|---|---|---|
| **Topic** | **Questioner** | **Question** | **Responder** | **Board Response** |
| Staff Wellbeing | Pauline Cooke, Lead Governor | Has Wellbeing/HR considered helping staff in the current climate with the cost of living by providing a food bank or similar – could we get local business to help out like during the pandemic. | Jude Gray, Director of HR | The Health & Wellbeing team are in the process of drafting a leaflet outlining various services that can help with financial wellbeing. It will outline the following areas / service that can provide support in:<br><br>- help with childcare costs<br>- uniform tax rebate<br>- help with travelling to work (e.g. fuel prices, MOTs, cycle to work schedules, car share schemes, public transport options)<br>- help with feeding the family (e.g. places where children can eat free)<br>- free food apps (e.g. Too Good to Go app, Olio app)<br>- cooking on a budget websites<br>- getting grants<br>- energy costs advice and grants<br>- organisations dedicated to helping healthcare staff<br>- help with pet health care costs<br>- how best to find NHS staff deals and discounts<br><br>The issue with promoting foodbanks is contentious, and our approach is to signpost staff to areas/organisations which provide support which include signposting to Foodbanks. |

| | | | | |
|---|---|---|---|---|
| Waiting List Communication | Pauline Cooke, Lead Governor | How often does the Trust communicate with the patients to keep them updated on the position with regard to waiting lists? | Felicity Taylor-Drewe, Chief Operating Officer | In terms of direct communication with patients, after each appointment written communication will be sent, and often at this point an indication of waiting times can be given. Once a patient is on a waiting list for surgery, they will be contacted by letter periodically so we ensure we are aware of any unavailability they may have coming up. We do recognise there are further improvements we can make to keep patients updated on waiting times; earlier in the year we piloted communicating with patients via text message with the purpose of both sharing waiting time updates and ascertaining if the patient wished to remain on the waiting list, which we are hoping to expand upon. We are also contributing to the newly launched national 'My Planned Care' website, which publishes average waiting times for specialities. My Planned Care NHS.<br><br>Waiting times can be difficult to predict given current Covid waves and impact on recovery and we recognise we have more to do to ensure that patients are informed of their stage on their journey. |

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Care Reflection (Patient Story)** | | | | |
| **Meeting** | **Board of Directors** | | | | |
| **Date** | **6th October 2022** | 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** | Powerpoint Presentation including 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 | | 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:

The presentation identifies significant work being undertaken to address the concerns raised in this Care Reflection

**Report**

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

The Care Reflection film recounts the story of a patient with extensive physical accessibility needs who experienced cancellation of their Outpatient appointment at very short notice. The service user had made significant arrangements in preparation for the appointment, including changing her personal carer support service for the day. The reason given by the clinician was that the appointment would have made the clinic run behind as there was not sufficient time allocated to support the use of a hoist for the patient. The action significantly impacted both the patient and her carer and provided an extremely poor experience.

The presentation details the findings from the departmental investigations along with associated actions that have been taken to ensure that the situation does not arise again. The learning and improvements made were shared widely within the division and across all outpatient areas. Staff were also supported to reflect on the patient experience and how they might manage a similar situation moving forward.

A full apology and explanation along with assurance regarding the actions, learning and improvements taken was shared with the patient.

| **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 | | | | |

| **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 |
| **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 presentation as assurance of actions being taken to address areas of concern raised in the Care Reflection.

| | |
|---|---|
| **Accountable Lead Signature** | Lisa Cheek |
| **Date** | 30 September 2022 |

# Care Reflection – Michelle's story

Peter Coutts, Deputy Divisional Director Outpatients
Chris Bumford, Matron of Outpatients and Sexual Health

# Background

Great Western Hospitals NHS Foundation Trust

- A patient with extensive physical Accessibility needs had an Outpatient appointment cancelled upon very short notice (1 hour prior)
- The reason given by the clinician was that the appointment would have made the clinic run behind as there was not sufficient time allocated to support the use of a hoist
- The service user had made extensive arrangements including carer support for the appointment.
- They had also been in contact with hospital days prior to confirm the necessary arrangements

# Investigation Findings

Great Western Hospitals NHS Foundation Trust

- The National referral system booked directly into pre-provided appointment slots with the facility not allowing for appointment duration changes

- Outpatients identified a lack of a robust process to support Nurse escalation when Clinicians consider not being able to facilitate patient appointments

- The decision making and lack of escalation has been addressed with relevant teams

# Michelle's Story

Film : https://youtu.be/9GebrgPPKJI

# Learning Points & Plan

Great Western Hospitals NHS Foundation Trust

- New automated system to review and flag hoist requirements
- Where the appointment slot has not been extended the system will prompt the bookings team to combine appointment slots, essentially doubling the time allocated
- Staff in Outpatient departments will undergo additional training
- The Accessible Information Standards (AIS) project modular training went live in April 2022.
- Plans are to also develop role specific training for cohorts of staff who are patient facing
- Where a decision is made by a clinician to cancel a patient; this will be escalated internally to the Matron or Senior Sister so that resolution can be found
- This will be outlined in the form of a Standard Operating Procedure (SOP)
- This escalation process will be agreed and communicated across the entire Outpatients nursing team

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Chair's Board Report** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **6 October 2022** | 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**<br>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<br>The Board/Committee/Group is requested to: | |
|---|---|
| **The Board is requested to note the contents.** | |
| **Accountable Lead Signature** | Liam Coleman, Chair |
| **Date** | 6 September 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 August and September 2022.

### Council of Governors

Governors - It is with regret to receive three governor resignations.

Dr Badri Chandrasekan an appointed staff governor who represented the doctors and dentists within the Trust. Dr Chandrasekan has stepped down due to work commitments in that he has taken on the appointment of clinical lead for the Cardiology department. We wish Badri well in his new role and to also thank him for his time and commitment whilst a governor.

Maurice Alston and Pam Kemp elected public governors for Wiltshire Central & Southern and Wiltshire Northern Constituency. Both Maurice and Pam have resigned due to personal reasons and we wish them well in the future and thank them both for their time and commitment whilst a governor.

Governor Elections - We are currently holding governor elections across 6 of the Trust's constituencies. Nominations for elections are now closed and we are especially pleased that our members have a contested election in 4 constituencies. Thank you all to those who nominated themselves and attended our election events.

Elections will take place in the following categories; Swindon for public governors, and Allied Health Professional, Doctors & Dentists and Administrators, Maintenance & Auxiliary for staff governors. Results will be known on 11 November 2022.

Public Health Talks - A public health talk, hosted by the governors, was held on 20 September 2022 on Dietetics at GWH by Louise Goulding and was very well attended.

### Non-Executive Directors

Annual Appraisal Review - The annual appraisal review for Non-Executive Directors, including the Chair, has been completed for this year. A summary of the outcomes was presented to the Council of Governors' sub working group, the Nominations & Remunerations Committee, and a report will be submitted to the next Council of Governors meeting in November 2022.

**Strengthening Board Oversight**

Board Seminar - The second Board Seminar session, in line with the agreed new Board timetable, was held in September 2022 and the focus was on the Trust's digital agenda and the outcomes would inform the development of a Digital Strategy.

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

| Date | Area | Board Member |
|---|---|---|
| 11 August 2022 | Teal Ward | Jon Westbrook, Medical Director<br>Lizzie Abderrahim, Non-Executive Director |
| 11 August | ICU / CCU<br>(unannounced) | Lisa Cheek, Chief Nurse<br>Liam Coleman, Trust Chair |
| 7 September 2022 | Trauma Unit | Jude Gray, Chief People Officer<br>Peter Hill, Non-Executive Director |
| 27 September 2022 | Meldon Ward<br>(unannounced) | Simon Wade, Chief Financial Officer<br>Liam Coleman, Trust Chair |

**Local Update**

Annual Report & Accounts 2022/23 - The Trust's Annual Report & Accounts 2022/23 was laid to Parliament week commencing 5 September 2022 and was presented to members at its Annual Members Meeting held on 26 September 2022.

**Key Meetings during August – September 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. |
| Primary Care Future | To discuss the future of primary care with the Executive Directors. |
| Nomination & Remuneration Committee | Review appraisals for Chair and Non-Executive Directors. |
| HWB Oversight Committee | Quarterly meeting to discuss health and wellbeing issues. |
| Chairs & CEO ICS Health Meeting | Regular meeting bringing together healthcare providers within the BSW ICS. |
| 1-2-1 meeting with Chief Executive | Regular meeting. |
| Annual Members' Meeting | Annual meeting with the Members and public |
| Remuneration Committee | To review the Executive Directors annual appraisal process |
| EPR Update | Monthly update meeting |
| Board safety visit | Regular planned and unannounced visits to areas of the trust by Board members |

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Chief Executive's Report** | | | | |
| **Meeting** | Trust Board | | | | |
| **Date** | 6 September 2022 | **Part 1 (Public) [Added after submission]** | **X** | **Part 2 (Private) [Added after submission]** | |
| **Accountable Lead** | Chief Executive Officer | | | | |
| **Report Author** | Kevin McNamara, Chief Executive Officer | | | | |
| **Appendices** | 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 covers August and September 2022 and 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:

- The Trust's operational response on the Bank Holiday, 19 September
- Covid-19
- Vaccination campaigns
- Current operational pressures
- The new Swindon Integrated Care Alliance Coordination Centre
- Our primary care network
- Patient Safety Day
- PERIPrem
- Improving our IT infrastructure
- Improving Together
- Staff Survey
- Great West Fest
- Potential industrial action
- Governor elections

| | | | | | |
|---|---|---|---|---|---|
| **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 the Covid and flu vaccination programmes. We know that Covid has a disproportionate impact on some ethnic groups, and also that there is reluctance within some groups to have the vaccine. We will be working directly with staff within these protected groups to support them.

The report includes an update on the Staff Survey. This survey is designed to highlight a range of issues, and recent surveys have highlighted issues from staff who are from protected groups and how they feel about working for the Trust. We will use this information to continue to try to make improvements.

Additionally, the report touches on the cost of living crisis. We know that the crisis is likely to disproportionally impact on some groups within our community, and will also exacerbate existing health inequalities.

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

- **Note the report**

| | |
|---|---|
| **Accountable Lead Signature** | Kevin McNamara, Chief Executive |
| **Date** | 30 September 2022 |

# 1. Operational updates

## 1.1. Bank Holiday, 19 September

Following the death of Her Majesty The Queen, the Government announced that the day of her funeral, 19 September, would be a Bank Holiday.

We took the decision to continue with as much of our activity on this day as possible and were able to continue with the majority of appointments for those patients already booked in for Bank Holiday Monday.

Teams involved worked very hard to plan and prepare for the day, calling every one of the 1,400+ patients originally booked in to check they were still able to attend. Just over 10% made the personal decision not to attend.

We saw around 1,250 patients and were able to run 76% of our activity on the day – ensuring these patients were treated as planned and minimising future operational disruption.

Primary care staff continued to run nurse-led appointments, despite national directive allowing GP practices to close, and community staff carried out home visits.

Given the short notice of the Bank Holiday it was not an easy decision to take to run services on this day, but it was the right choice to put patients first as many needed urgent care or have been waiting a very long time.

The feedback we have received from the public was overwhelmingly positive, reflecting the desire from people to be treated as quickly as possible.

## 1.2. Covid-19

Nationally, data from the Office for National Statistics indicates that infection rates have begun to rise once again.

At the time of writing we had seen numbers of inpatients testing positive for Covid rise quite quickly in a short space of time. Latest patient numbers will be provided at the Board meeting.

We have introduced a Covid escalation framework, ranging from Green to Black, with various infection prevention and control measures in place for visiting, testing and mask-wearing depending on a series of triggers. The latest level is clearly displayed on the intranet and changes to requirements are clearly communicated to staff and patients as required.

## 1.3. Covid booster and flu vaccine

Vaccination continues to offer the best protection against Covid, and we are offering the jab to all our staff – along with the flu vaccine – and strongly encouraging everyone to take this up.

This is likely to be the first winter in which both Covid and flu are in full circulation.

A large, early wave of flu is expected this year (reflecting the experience in the southern hemisphere) and there is likely to be little local immunity to the virus following a break from the disease during the earlier stages of the pandemic when people were mixing much less.

Covid vaccinations are currently being offered to frontline health and care workers, along with people aged over 65 and those who are potentially at higher risk.

Our staff covid and flu vaccination programme launched this month and within three days we had 28% of staff booked on.

This year, Occupational Health will be administering both vaccines to staff at the same time, with jabs being delivered in our Commonhead vaccination hub along with Moredon Medical Centre.

Last year we were the best in the South West for uptake of the flu vaccine and eighth in the country, and the importance of a strong vaccination programme for both viruses as part of our winter preparations cannot be underestimated.

For the public, vaccinations are available from a range of locations across the region, including the Steam Museum in Swindon, Bath Racecourse, and Salisbury City Hall, along with many smaller venues in the community.

People can find their nearest vaccination centre, as well as book their vaccine appointment, by visiting www.nhs.uk

### 1.4. Managing current pressures

The whole health and social care system is extremely busy.

At GWH this has been felt with high front door attendances, and high numbers of patients with no criteria to reside in hospital.

Like many Trusts, we are frequently unable to discharge a significant proportion of medically fit patients for a range of reasons, including capacity in care homes, capacity in the community or internal process issues. In the context of the current cost of living crisis this winter we are facing a more complex set of challenges which creates risk for us as an organisation and ultimately patient care. For example, the increased risk of admission due to cost of living factors, such as frail elderly not heating their homes or the impact on social care providers which face significant utility cost increases which may impact on the delivery of the services we rely on to maintain flow. Whilst outside of our control, they do create greater risk operationally and therefore we will be paying close attention to these issues and working closely with system partners on any practical solutions which may be open to us.

One area of development which will help this winter is the Virtual Ward and the Two-Hour Urgent Care Response service supporting people with complex medical needs at home, as well as preventing people from being admitted to hospital by providing them with urgent care at home.

We know that times of high demand have an impact on delays caused to ambulance crews working to hand over their patients to us. A number of initiatives are in place to support this, including the Swindon Integrated Care Alliance Coordination Centre, a liaison officer, new escalation area and admissions lounge, increased opening hours for Same Day Emergency Care, and an ED Majors Clinical Navigator to ensure patients are treated in the right place, first time.

### 1.5. Swindon Integrated Care Alliance Coordination Centre

The new Swindon Integrated Care Alliance Coordination Centre officially launched on 1 September in the Liden Centre at GWH with full staffing due early October.

The centre is home to clinical call assessors, the SAFER and navigation hubs, Integrated Care Alliance and community services representatives, voluntary services, transport, ambulance service, therapists, end of life, health and social care, locality leads, mental health workers and many more.

Along with being a real milestone in partnership working and a joined up approach to tackling demand in the health and care system, it is a significant and different way of trying to tackle the pressure on beds this winter. With no extra beds available to us – as other parts of the system

may have this winter – we are reliant on working with partners to divert patients to somewhere more appropriate than hospital for them to be cared for.

The centre will help to remove organisational boundaries to enable the system to provide the right care in the right place as quickly as possible.

We were pleased to welcome Minister for Health and Social Care Will Quince MP to the coordination centre at the end of September. The Minister was given a tour of the centre and spent some time speaking to staff involved in the day-to-day running.

We also recently hosted the BBC in the centre to find out more about the approach we are taking this winter.

## 2. Quality

### 2.1. Our Primary Care Network – Care Quality Commission

The Care Quality Commission's inspection of our GP practices took place in May and was published in August.

Inspectors recognised that significant progress had been made and I'm pleased to report that the CQC has indicated it will be lifting warning notices it issued at the time, following good work from the team to address areas for improvement including coding of patient correspondence, summarising records, the security within the buildings, pre-diabetes diagnosis and how we highlight medicine safety alerts.

This puts the practices in a better place as we work closely with the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board to explore the opportunities to enhance the improvement journey of our practices.

We believe the practices are now in a secure enough position to begin the next phase of their improvement outside of the Trust, where they can benefit from the experience, knowledge, and scale of another established primary care network.

We will continue to support our staff as we navigate through this process of potentially moving this service, and their employment, to a new provider.

### 2.2. Patient Safety Day

We marked Patient Safety Day last month and this year we focused in particular on medicines management.

This was one of the few events we continued with during the period of national mourning as it was a really important opportunity for teams to learn about the importance of medicines safety which is critical to providing good patient care.

### 2.3. PERIPrem

Our work pioneering PERIPrem, evidence-based bundle of interventions for premature babies, continues to go from strength to strength.

PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) is delivered by doctors, nurses and midwives, joining forces to consistently provide the very best care, before, during and after birth.

It has elevated the South West as a region of excellence in perinatal care.

A new evaluation, conducted independently by the South West Academic Health Science

Network and published last month in the British Medical Journal, shows how the uptake of the PERIPrem care interventions has increased in 12 NHS trusts across the South West, alongside improving the perinatal team culture.

By the end of the evaluation period, 26 per cent more mothers and babies born prematurely in the South West, received the care interventions they were eligible for, compared to before PERIPrem started.

Congratulations go to Kate Giles, Practice Development Midwife, who has won the national Midwife Education Trailblazer Award. Kate developed training for the whole perinatal team, ensuring the Trust meets required national standards. She is currently leading on the maternity transformation project and apprenticeships.

## 3. Systems and Strategy

### 3.1. Cost of living

The cost of living crisis has been widely publicised and there has been particular focus on the impact of rising energy bills.

As a Trust we are working to better understand the impact upon our organisation of increased energy costs, and the work we have already done to make our organisation more sustainable has already helped in this area.

Around 95% of lighting has been converted to LED lighting and all of our electricity contracts are now on 100% renewable tariffs.

The CHP go live next year should save us £1m in energy costs – but we need to consider the financial implication if it doesn't do this.

The rising cost of living has far-reaching impact – not least on our own staff – and is likely to have an increased impact on the mental health of our local population, exacerbate health inequalities, along with potentially impacting upon service delivery and capital projects.

We are aware that, nationally, government departments will not see their budgets increased in line with inflation and must be prepared for the financial situation to become even more challenging.

### 3.2. Improving our IT infrastructure

Through our work to improve our IT infrastructure, the WiFi across GWH, the new Urgent Treatment Centre and Brunel Treatment Centre buildings was upgraded last month.

This work will provide increased resilience, and capacity, and help to provide more reliable coverage on the site, following feedback from staff about intermittent WiFi coverage in some parts of our buildings. We will be closely monitoring the impact of this to ensure it alleviates the concerns raised.

Although coincidental, the timing of this upgrade work benefitted patients who wished to watch Her Majesty the Queen's funeral on 19 September.

### 3.3. Improving Together

As part of our ongoing roll-out of Improving Together, we held a week-long roadshow across the hospital and community sites.

This was an opportunity for staff from the Transformation and Improvement Hub to visit a number of teams as part of the tea trolley round.

We used this focussed week as an opportunity to launch Workspace, our new shared space for staff to use on the 2nd floor of GWH, along from Trust HQ, and we held a number of improvement surgeries.

### 3.4. Appointment of Intregrated Care Partnership Chair

Richard Clewer, Leader of Wiltshire Council, has been appointed as the Chair of the Integrated Care Partnership (ICP).

The BSW ICP is a statutory committee formed by the Integrated Care Board.

It will develop an Integrated Care Strategy for local health and care services and advocate for innovation, new approaches and improvement to the way services are provided and run. Trust representation at the ICP will be agreed in due course.

## 4. Workforce, wellbeing and recognition

### 4.1. Staff Survey

The 2022 Staff Survey launched in late September.

We have asked managers to encourage their staff to complete the survey, and support them by ensuring they are given the opportunity to fill it in.

Last year we heard from more than 2,400 staff from all areas of the Trust, giving us really valuable insight into how our teams are feeling.

Hearing people's views – whether they are positive, negative, or indifferent is essential to help us to understand the issues affecting our staff and enable us to make improvements where possible.

### 4.2. Great West Fest

Our second Great West Fest was held on Saturday 3 September in Town Gardens, Old Town, Swindon.

Tickets went within days and 2,000 staff members and their families and friends joined us on the day. Feedback from staff has been extremely positive.

We are probably the only Trust in the country to run a family festival and this will be an annual event in our calendar as an opportunity to thank staff, and also those who support them. My thanks go to the support provided by our charity Brighter Futures to fund events of this nature and we will be seeking ongoing support for next year's activities.

### 4.3. STAR of the Month

Our latest STAR of the Month winner is Lisa Thorogood, ward sister on Saturn.

Lisa was described as a real team player and an advocate for her patients.

She is also a great advocate for good palliative care and ensuring patients at the end of their lives receive the care and dignity they deserve

### 4.4. NHS Communicate Awards

We have been shortlisted in three categories of the NHS Communicate Awards, the winners of which will be announced on 11 October.

The Communications and Engagement Team is shortlisted in the Best use of digital communications category, and also the Health and wellbeing category. Brighter Futures has also been shortlisted in the Best charity campaign category for their work on the Radiotherapy Centre.

### 4.5. National Inclusion Week

Last week we celebrated National Inclusion Week, which had the theme of 'Time to Act: The Power of Now' and as part of this we're encouraging staff to join one of our Staff Networks.

An Executive Director will champion each of our staff networks:

- BAME (Black, Asian, and Minority Ethnic)
- Differently Abled
- LGBTQ+
- Veterans Network
- We will soon be launching a Women's Staff Network.

### 4.6. Potential industrial action

The Royal College of Nursing has sent us a formal letter setting out the timescale for balloting their members on taking industrial action.

Although both the British Medical Association and Unison have indicated they will also be balloting their members, we have not yet received formal notification of this.

In the event of any industrial action, it will be essential that we run as many of our services as possible. We need to be able to run an urgent and emergency care service, and are conscious that any action could impact on our elective recovery programme at a time when we know many of our patients have been waiting much longer for treatment than we would like.

We have therefore set up a working group made up of representatives from across the Trust to consider the risks involved and what mitigation might be possible.

### 4.7. Governor elections

We have had a good response to our call for nominations from both staff and members of the public to become a governor at our Trust.

In the Allied Health, Doctors and Dentists, Nursing and Therapy, and Administrators, Maintenance, Auxiliary and Volunteers staff categories, there will be elections held as at least two nominations were received. There was one nomination for the Nursing and Therapy group.

We received 10 public nominations for the Swindon constituency.

A notice of poll will be published on 12 October, the election will close on 7 November, and the results will be announced on 8 November.

Great Western Hospitals NHS Foundation Trust

# Board Committee Assurance Report

| Performance, People & Place Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| Peter Hill | Peter Hill | | 24th August 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 | | | The service remains under enormous pressure. The committee were, therefore, pleased to note that ED performance is firmly within the top quartile compared against other Trusts nationally. The ambulance handover trend continues to see overall improvement despite an increase in ambulance conveyance. The non-criteria to reside figures have unfortunately increased. | Monitor Actions | September |
| Integrated Performance Report – Elective Access - RTT | | | The Trust is meeting its KPI's in terms of long waiters with no 104+. It remains on target for the 78 week waiters but the committee noted a concerning trend in terms of the over 52 week waiters. The committee received assurances regarding the amount of management attention this was receiving. Also some concern regarding the increase in total numbers on the waiting list. | Monitor Actions | September |

| | | | | | |
|---|---|---|---|---|---|
| Integrated Performance Report – Elective Access – DM01 | | | The committee remains concerned regarding the current level of performance, however, it was reminded of the improvement planned for the second half of 22/23. | Monitor Actions | September |
| Integrated Performance Report - Cancer | | | The standard in June was still not met in terms of 2 Week Wait mainly due to Skin, Colorectal & Upper GI. Patient choice continues to be the major factor in 2ww breaches. The 28 day diagnostic target was met, however, the 62 day performance is 76% against a target of 85%. | Monitor Actions | September |
| Integrated Performance Report - Stroke | | | Still performing but some concerning trends that the committee will monitor over the next month or two. | Monitor Actions | September |
| IT Performance | | | Performance of the service is the focus at this committee.<br>Presentation and report received on key developments in relation to the IT planned activity. Availability of resource and the speed of change required remains a key risk. Improvements expected in automation and self-service options. The service will develop a user-satisfaction feedback tool. | Monitor Actions | November |
| EPRR (Emergency Preparedness Resilience & Response) | | | Suitably assured and continued improvements were noted. | Monitor Actions | November |

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

Great Western Hospitals NHS Foundation Trust

# Board Committee Assurance Report

| Performance, People & Place Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| Peter Hill | Peter Hill | | 28th September 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 | | | The service is performing relatively well in terms of the 4-hour target in relation to other Trusts and national average waiting time. However, the mean waiting time has now reached 8 hours during August with a significant number of patients waiting over 12 hours (15%). Reasons for this are multi-factorial including a high number of patients unable to be discharged for reasons outside of GWH's control (non-criteria to reside) effecting flow from ED to the wards. High levels of delayed ambulance handovers also noted. Work ongoing to improve "clinically ready to proceed" processes. | Monitor Actions | October 22 |
| Integrated Performance Report – Elective Access - RTT | | | Performing well in terms of no 104 week waiters and reduction in 78 week waiters. There are concerns over the increase in over 52 week waiters. The Trust achieved 93% of it's Elective August plan (103% for Elective in-patients & 92% for outpatients). The Committee has an expectation to look at 52/78/104 week profile predictions going forward. | Monitor Actions | October 22 |

| | | | | | |
|---|---|---|---|---|---|
| Integrated Performance Report – Elective Access – DM01 | | | Not much movement, however, good news being CT & MRI showing early signs of improvement as planned. The positive trajectory for improvement for CT/MRI would need to be mirrored by Endoscopy to impact on overall position. | Monitor Actions | October 22 |
| Integrated Performance Report - Cancer | | | Not delivering on any counts of national standard for Cancer. Moved to Red/Amber as 2 week waits still impacted by patient choice and capacity in skin. The Trust received Mutual Aid with regards to Plastic surgery service from Oxford. | Monitor Actions | October 22 |
| Integrated Performance Report - Stroke | | | The service achieved SSNAP level B. To be removed from monthly monitoring unless deterioration in performance is noted. | N/A | N/A |
| Health Inequalities Trust Action Plan | | | The committee noted good early progress on it's action plan along with it's close ties to the Swindon ICA group. Good early work with regards to ensuring patients with learning disability or no fixed abode are accorded appropriate clinical priority and further work to do on systematising the management of elective lists in line with patients' health equity risk profile. The committee recognised the priority is for us to be able to present our waiting list data by deprivation and protected characteristic. | Monitor Actions | January 23 |

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|---|---|
| **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 | | 18 August 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 |
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| 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 | | | |
| IPR:Overall | Amber | Green | The IPR was rated as shown this month with the following comments to note. | | |
| Integrated Performance Report: Medicines Safety | Green | Green | No significant change. Slight decrease in number of reported medication incidents. National Medicines Safety day is September 1st. | | |
| IPR:Infection Control | Amber | Amber | C.diff remains below the set trajectory. We are slightly above for E.coli and Klebsiella. MSSA has flattened but remains above trajectory. Work is concentrating on this area with further training relating to cannula insertion and care. | | Monthly monitoring. |
| IPR: Pressure Ulcer Harms | Amber | Amber | Some improvements in this area in both acute and community. Evidence of Improving Together leading to beneficial change. | | |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Integrated Performance Report: Falls | Amber | Amber | Falls rates have declined slightly this month and the trend is favourable. If this continues we expect a rating of A/G next month. | | |
| Serious Incidents Monthly Report | Amber | Amber | Numbers remain within control limits. Continued efforts to reduce outstanding investigations which are having some effect. | | |
| Integrated Performance Report: Staffing | Amber | Amber | Staffing levels and fill rates have improved slightly but a mixed picture remains. Although maternity staffing level remain a concern the outlook is better with new recruits in the pipeline. | | |
| IPR:Perinatal Quality Surveillance Tool | Amber | Green | Midwife to birth ratio is back to1:29, on target (1:29). There were an additional 30 deliveries in the month of July. Progress has been made in meeting the CNST 10 Safety criteria with the expectation that the CO monitoring (smoking) at 26 weeks will be compliant. | | |
| IPR:Ockenden update | Amber | Amber | Further progress has been made but this remains a long term project. | | |
| Serious Incidents Monthly Update | Amber | Green | Good Progress. Further reduction in outstanding investigations such that GWH is now best in SW Region for overdue investigations. | | |
| Freedom to Speak Up Annual Report | Red | Amber | Whilst this report showed many positive aspects, (including the recent appointment of 4 more Guardians), when compared to the included National Report, the main concerns related to the failure to replace the Lead Guardian, due to lack of funding. (The previous lead was voluntary). This has led to a number of issues the main ones being a lack of coordination between our 7 Guardians coupled with an inability to submit our FTSU data nationally. The Chief Nurse agreed to take the outcome of this discussion to the Execs. | Chief Nurse to take this discussion to Execs. | |
| Biannual Safeguarding Report: Adults | Amber | Green | This service was recently subjected to audit in Q4 by BDO, our internal auditors. This revealed a 'well designed and robust control environment in place'. Two main themes remain relating to discharge processes and tissue viability. | | |
| Biannual Safeguarding Report: Children | Amber | Amber | Continued impact of the pandemic in terms of increased demand and complexity of cases. Levels of Safeguarding training remain a concern at Level 3. This is complex to manage but a plan is in place to separate what is required for compliance as opposed to what is desirable for best practice. It was agreed that as this was the main outstanding "Must do" for CQC, it was important to have a detailed plan in place with evidence of improvement. | | |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Clinical Audit and Effectiveness. | Amber | Green | There has been continued progress in reducing the number of outstanding reports awaiting sign-off. The recent report on standards of care for children within the ED has been and continues to be, subject to detailed scrutiny at department level in order to address potential safeguarding issues. | | |
| Update on CQC Preparedness | Not Rated | Not Rated | There has been further progress. The two remaining “Must dos” relate to Level 3 Children’s Safeguarding training and the WHO safety checklist. The former has an action plan in place to improve compliance (see above) and the latter is on the point of closure. Analysis of recent CQC inspections elsewhere is taking place to allow a self check against those action points raised by CQC. Overall there has been a significant reduction in the number of remaining Must do (2) & Should do (5) actions which is a creditable performance by the team. | | |

| 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 September 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 |
|---|---|
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| 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 | | | |
| Guardian of Safe Working 6 month report | Amber | Amber | Data quality is not always reliable. Committee requested a less confusing presentation in future with a summary, clearer statements of position, risks to safety and potential actions. Main breaches are in Surgery, General Medicine and ED. We have limited ability to understand where we are compared to other trusts. There is no available national benchmarking but the Guardian and CMO have referenced reports from peer hospitals. Prospects over the next 3 years are better with > 30 more trainee doctors to be appointed. | | |
| IPR:Overall | Amber | Green | The IPR was rated as shown this month with the following comments to note. | | |
| Integrated Performance | Green | Green | No significant change. | | |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Report: Medicines Safety | | | | | |
| IPR:Infection Control | Amber | Amber | C.diff remains below the set trajectory. There has been a further rise above for E.coli and MSSA. Focus now on catheter care to reduce E coli bacteraemias. MSSA rates expected to fall following improvements in cardiology cannula processes. | | Monthly monitoring. |
| IPR: Pressure Ulcer Harms | Amber | Amber | A small but insignificant rise in cases. Work on Teal ward under Improving Together has led to significant falls in number of pressure harms. | | |
| Integrated Performance Report: Falls | Amber | Amber | Falls rates have increased slightly this month but remain only just above average rate.. | | |
| Serious Incidents Monthly Report | Amber | Amber | Numbers remain within control limits. Continued efforts to reduce outstanding investigations which are having some effect. | | |
| Integrated Performance Report: Staffing | Amber | Green ↑ | Staffing levels and fill rates have improved with HCA vacancies now low but many recent recruits require training as they are new to health care. Midwife recruitment has improved. | | |
| IPR:Perinatal Quality Surveillance Tool | Amber | Green | Midwife to birth ratio was 1:27, (target 1:29). However 1:1 care in labour failed briefly for 3 women dropping the rate to 99%. Progress has been made in meeting the CNST 10 Safety criteria with the expectation that the CO monitoring (smoking) at 26 weeks will be compliant by the target date. However this assumes that the targets will not be changed just before submission. | | |
| IPR:Ockenden update | Amber | Amber | Further progress has been made but this remains a long-term project. PROMPT and Fetal Surveillance training are ahead of target and are expected to exceed the 90% target by submission date. | | |
| Serious Incidents Monthly Update | Amber | Green | Good Progress. Further reduction in outstanding investigations such that GWH is now best in SW Region for overdue investigations. The committee decided that this report was no longer needed at the monthly Q&S meetings and we could rely on the quarterly report with any intervening major issues brought to the committee's attention if necessary. | | |
| Board Safety Walkarounds | N/R | N/R | This report was noted by the committee. The current process had been welcomed by staff and there was good engagement with the Exec & Non Exec visitors to the departments. Most were announced but some have been unannounced. Main themes arising from these visits varied | | |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| | | | between departments but tended to be about Staffing, Equipment and Space. | | |
| Patient Experience Report Q1. | Amber | Amber | There have been improvements in some areas but many remain stable and could improve. Further improvement actions are planned but the outcomes from these are awaited. Paradoxically when maternity services introduced MSM text responses, the rates fell. This is probably because the cards were no longer issued so this practice has been reintroduced. | | |
| Responsible OfficerAnnual Report | N/R | N/R | A new software program (SARD) has been introduced which links entries by consultants directly to the GMC for revalidation purposes. This has made collection of data for appraisal easier. Appraisal rates are currently good with those completed + those with appraisal dates totalling 98%. More appraisers have been appointed with the expectation that each will carry out at least 10. A Deputy Chief Medical Officer has completed RO training and delegated responsibility for medical appraisal in the Trust will be applied for. The committee was content that the Trust is compliant with the regulations relating to appraisal. | | |
| Update on CQC Preparedness | Not Rated | Not Rated | There has been further progress. The Improvement Notices in primary Care have been closed with CQC applauding the Trust and the teams involved for their prompt actions. Level 3 safeguarding training remains a challenge but continues to improve its rates. The WHO related action has been closed as this is now compliant. | | |

| Issues Referred to another Committee | |
|---|---|
| **Topic** | **Committee** |

# Board Committee Assurance Report

| Finance, Infrastructure and Digital Committee – 22 August 2022 | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Faried Chopdat** | **Faried Chopdat** | | **22 August 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:

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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** | | | | | |
| Board Assurance Framework | A | A | The Committee discussed and deliberated the assurance provided by the BAF Strategic Risks Report. We are comfortable that the scoring of strategic risks is appropriate regarding the sources of assurance from the 3 LOD, and that risks are managed in the context of current challenges. We remain concerned regarding the delivery of the 2022/23 Financial Plan and the Improvement and Efficiency Plans - the rating of the Finance Risk below reflects this. | Monitor through FIDC & Board | FIDC Meetings 2022/23 |
| Finance Risks | R | A | We are assured that the risk management process and reporting of financial risks are adequate and effective. However, we continue to raise a concern about the robustness and sustainability of management action plans to address the following significant risks: (1) The Trust does not meet its control total of £19.3m deficit; and (2) The Trust does not deliver its efficiency target recurrently in 2022/23. | Monitor monthly through FIDC and (significant risks to be reviewed quarterly at Board). | FIDC Meetings 2022/23 |
| Infrastructure Risks | A | A | Estates & Facilities risks were presented to the Committee and assured that the risk management process and reporting are operating effectively. A new risk was identified, one was closed, and no risk scores were adjusted. | Monitor through FIDC | FIDC Meetings 2022/23 |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| IT and Digital Risks | A | A | IT & Digital risks were presented to the Committee. We were assured that the IT & Digital Risk Register is reviewed and updated through the IT Governance Meeting, including oversight of IT Clinical Risks identified by other departments. However, further work is progressing to align and identify all IT-related clinical risks, including ownership and onward management. | Monitor through FIDC | FIDC Meetings 2022/23 |
| **OPERATIONAL** | | | | | |
| Month 4 Finance position | R | A | The overall position for month 4 is £2.1m against a planned deficit of £1.7m (£0.4 adverse to plan). Pay costs for temporary Medical and Nursing staff remain above plan within Unscheduled Care, the critical driver of overspending year to date. A forecast highlights a projected deficit of £24m against a planned deficit of £19.4m. The Committee continues to raise a concern about the progress to bringing the run rate in line with the plan highlighting that this risk may trend higher should the mitigations be considered ineffective. | Monitor through FIDC | FIDC meetings 2022/23 |
| Winter Plan | A | G | The Winter Plan was presented to the Committee for approval. The plan included the priority schemes, recommendations and the funding required. We were delighted that the program started earlier this year, covering 30 weeks from 1 September to 30 March, addressing the risk of recruitment. The Committee noted the paper and approved the funding for the Winter Plan. | Monitor through FIDC | FIDC meetings 2022/23 |
| **BUSINESS CASES & UPDATES – for noting** | | | | | |
| PFI – Financial Update | A | G | We received a good paper providing an update of the PFI charges for 2022/23 for noting. A key consideration is the financial implications of high inflation levels that must be considered carefully for 2023/24 Business Planning. | FIDC to review periodically | FIDC meetings 2022/23 |
| IT Infrastructure Update | A | G | Based on project progress reports, the Committee was appraised of the crucial developments concerning IT planned activities for the previous quarter. Overall good progress is noted on all programmes, although mindful that a critical risk that could impact delivery remains the availability of resources and the scope and speed of change required. | FIDC to review quarterly | FIC meetings 2022/23 |
| EPR Programme Update | A | A | A paper on the status of the EPR program was presented for noting. Good progress is made to streamline governance to ensure key stakeholders, including the Committees and Boards of all three Trusts, are considered part of the decision and approval processes. An update on the procurement process was also noted, with three suppliers opting in and issued with the complete tender documentation. | FIDC to monitor progress. | FIC meetings 2022/23 |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Cyber Security Update | A | G | The Committee received a paper outlining the state of the Trust's Cyber Security for noting. We were reassured that key activities are undertaken to bolster the Trust's cyber defences and maintain the integrity of GHW's network and systems from Cyber-attacks. A comprehensive action plan outlining steps taken to address Cyber risk was presented. | | FIDC meetings 2022/23 |

| Issues Referred to another Committee | |
|---|---|
| **Topic** | **Committee** |
| None | n/a |

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

| Finance, Infrastructure & Digital Committee – 26 September 2022 | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Faried Chopdat** | **Faried Chopdat** | | **26 September 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, Infrastructure & Digital are adequate and effective. However, we continue to raise concerns about the £4m gaps to address the critical risk: The Trust does not deliver its 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** | | | | | |
| **Month 5 Finance position** | R | A | The overall position for Month 5 is £1.85m against a planned deficit of £1.58m (£0.3 adverse to plan). Pay costs remain above plan within both Unscheduled Care and Integrated Care & Community, together with the growing pressure of high-cost drugs are critical drivers of overspending year to date. The Committee continues to raise concerns about the progress in bringing the run rate in line with the plan. | Monitor through FIDC | FIDC meetings 2022/23 |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| **Improvement and Efficiency Plan – Update** | R | A | The focus for efficiencies is on reducing the run rate to budget and driving up productivity. A good paper was presented to the Committee outlining management actions and reporting on an increased forecast and achievement of efficiencies; 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 £4m yet to identify. | Monitor through FIDC and monthly update to the Board | FIDC meetings 2022/23 |
| **Capital Plan** | R | A | Capital expenditure on all schemes is £1.3m, which is £3.8m below plan as at Month 5. The Capital Management Group is taking action to ensure that the Capital plan is delivered in 2022/23 as reserve schemes brought forward from future years have been drawn up by Estates, Equipment, and IT leads, in conjunction with Divisions, to offset slippage of current projects. The Committee has requested a further update in October as it remains concerned about the slow progress of Capital spending. | Monitor through FIDC | FIDC meetings 2022/23 |
| **Divisional Year on Year WTE Analysis** | R | A | The Committee received a well-informed presentation on the analysis of the Whole Time Equivalents changes from 2020 to 2022. Key themes identified include:<br>• Quality related staffing requirements (non-activity generating).<br>• Post covid schemes, job planning.<br>• Theatre and outpatient productivity.<br>• Recruitment and retention; and<br>• Realising digital benefits.<br><br>The Committee noted partial assurance due to the actions taken to date and the following steps to be taken to enhance the workforce productivity, stabilise community spend and WTE increases and deliver elective activity. | Monitor through FIDC | FIDC meetings 2022/23 |
| **Financial Planning Process** | A | A | The Committee was briefed on the methodology and timelines for the 2023/24 budget-setting process, including the alignment of finance with activity, efficiency, and operational workforce planning. The budget setting and workforce methodology are comprehensive, and the Committee looks forward to the outputs and future updates. | Monitor through FIDC and key updates to the Board | FIDC meetings 2022/23 |
| **Premises Assurance Model Submission** | - | - | The Premises Assurance Model (PAM) is an Estates & Facilities self-assessment compliance tool now mandated for submission to NHSI Estates. The Committee was appraised of the process followed, the proposed recommendation, findings, and next steps. The Committee acknowledged the results of the self-assessment and requested a future review of results either by a peer-to-peer review or by an independent party. | Monitor through FIDC and refer to ARAC for an independent review | FIDC meetings 2022/23 |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| **BUSINESS CASES & UPDATES – for noting** | | | | | |
| **Maternity Digital Strategy** | - | - | A good paper on the Maternity Digital Strategy was presented, which was developed in line with the Trust Values, What Good Looks Like Framework, National Maternity Drivers, and the Trust Digital Strategy. The Committee well received the paper; however, we chose not to risk-rate the strategy as we would like to review this in the context of the more comprehensive Trust Digital Strategy. | FIDC to review in context of the Digital Strategy of the Trust as whole | FIDC meetings 2022/23 |
| **Integrated Front Door FBC update** | - | - | The Integrated Front Door FBC was submitted to NHSE/I on 17/08/22. The Southwest Region Capital team confirmed that due to the high volume of submissions nationally, there is a lack of capacity to review all Business Cases. The target date for the FBC review/approval is pushed back to Jan 2023 though the WFP team are in regular dialogue with the regional team to expedite this. The Committee will monitor this closely and determine the impact of the delays should this position worsen. | Monitor through FIDC | FIDC meetings 2022/23 |
| **Update on PFI Soft FM Benchmarking** | G | G | The Committee received an update on the PFI Soft FM benchmarking offer and assurance on monitoring and auditing the service provision. | Monitor through FIDC | FIDC meetings 2022/23 |
| **Update on Procurement** | A | G | The procurement overview paper provided acceptable assurance of the status of procurement Workplan projects, service development initiatives, a look forward to high-value projects, and savings performance to date. | Monitor procurement activity through FIDC | FIDC meetings 2022/23 |

| **Issues Referred to another Committee** | |
|---|---|
| **Topic** | **Committee** |
| Consider Independent Review by 3rd party assurance provider of the Premises Assurance Model for the 2023 submission. | ARAC |

# Board Committee Assurance Report

| People & Culture Committee – August 2022 | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Paul Lewis** | **Paul Lewis** | | **23rd August 2022** |
| **Assurance:** Does this report provide assurance in respect of the Board Assurance Framework strategic risks? | | | |

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 | | | |
| Workforce Planning | R | A | The main on-going concern is with WTE levels being above plan, mainly due to Temporary Staffing. Improved check & balance controls are now in place with both the Divisional Directors of Nursing Meetings and Medical Staffing Meetings, so further improvement is expected over the coming weeks.<br><br>Recruitment gaps are still an ongoing issue and plans are being developed to further improve the position.<br><br>The risk of industrial action is also a key concern in how this may affect workforce planning. | Review progress at the next meeting. | October 2022 |
| Great Opportunities | A | A | There have been positive improvements with talent management and internal appointments and promotions.<br><br>Although the 'Stay & Thrive' approach has been well received, turnover levels are still a concern and plans are being reviewed and developed to address this to improve the quality of career conversations to deploy and retain our staff more effectively. | Review progress at the next meeting. | October 2022 |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Employee Experience | A | A | Our Staff Survey/Breakthrough objective has had a small improvement, towards our breakthrough objective target (30% improvement over a 12-18month period). Safety Visits and 'Walkabouts' are taking place and more are planned, so this should also provide us with greater insight. We continue to make good progress with the roll-out and embedding of<br><br>The roadmap for culture development was reviewed in detail and embedding the STAR Values (with clarity about the behaviours we do – and don't – want to see will be another key part of how this is developed across the Trust.<br><br>The EDI strategy and position was reviewed and although there is a mixed picture on improvement from last year it was noted that we are making positive progress with our Networks. | Review progress at the next meeting. | October 2022 |
| Employee Development | A | A | There have been positive improvements with learning & development, talent management and internal appointments and promotions. There are plans for Admin Careers events in September and there remains a need to further improve the quality of appraisals to support employee development. | Review progress at the next meeting. | October 2022 |
| Great Leadership | A | A | The Committee were very complimentary about the documented review of our position in relation to the Messenger Report and noted that we already have plans in place to make further improvements across the 7 recommendation areas. We will await further clarity and guidance before initiating further actions (especially where additional funding will be required) particularly within the key recommendation area of 'management standards and accredited training'. | Review progress at the next meeting. | October 2022 |

| Issues Referred to another Committee | |
|---|---|
| **Topic** | **Committee** |
| None | N/A |

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Integrated Performance Report (IPR)** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **6th October 2022** | Part 1 (Public) [Added after submission] | x | Part 2 (Private) [Added after submission] | |
| **Accountable Lead** | Felicity Taylor-Drewe, Chief Operating Officer<br>Simon Wade Chief Finance Officer<br>Jude Gray, Chief People Officer<br>Lisa Cheek, Chief Nurse<br>Claire Thompson, Chief Officer, Improvement & Partnership | | | | |
| **Report Author** | Al Sheward – Deputy Chief Operating Officer<br>Rayna McDonald – Deputy Chief Nurse<br>Claire Warner – Associate Director of HR Operations<br>Elizabeth Hills – Head of Financial Management | | | | |
| **Appendices** | Use of Resources:<br>• Statement of Financial Position<br>• Working Capital<br>• Income & Expenditure – Variance Run Rate<br>• SPC Chart – Pay | | | | |

**Purpose**

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

**Assurance Level**

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

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

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

**Report**

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

The September Integrated Performance Report (IPR) is the first Integrated report of the Trusts position using the Improving Together approach, building a culture of continuous improvement. The content of the report is built against the strategic planning framework. It provides oversight against the Trusts 12 Pillar Metrics supported by the breakthrough objectives. The conditions in which the IPR operates is set around the Performance Business rules which show areas of deterioration, improvement and the actions being taken to address performance issues.

Each Pillar Metric is supported with an Executive Summary with corresponding Executive Lead and therefore the coversheet doesn't repeat this.

The report is structured into:

- Pillar metrics: a small number (12) of critical performance indicators that will determine whether we are 'winning or losing' in delivering our vision and strategy.
- Breakthrough objectives: 'top contributors' to our pillar metrics – i.e those things that drive the performance and on which we are aiming to make an improvement of 30% or more in a 12 month period.
- Watch metrics: those performance indicators which are important in delivering our strategy or for assuring our public and regulators, but which we do not focus on driving improvement in, in the short term.
- Alerting watch metrics: those 'watch metrics' that have deviated from the threshold and which therefore require attention according to business rules
- Key indicators: those performance indicators that are none of the above but which are important for oversight due to regulatory or other purposes.

The reporting aligns watch metrics and key indicators to performance, care, people and finance to align with committee accountabilities.

We are continuing to work on the collation of and narrative action (countermeasures) in relation to these and welcome Board members feedback.

Key highlights from the report this month are:

**Our Performance**

**Unfortunately, due to issues with data availability in Model Hospital, the comparison against BSW and CQC 'Good' peers is not available this month. This will be reintroduced in future months as this data becomes available again.**

**Key highlights from the report this month are:**

**CANCER 62 DAY PILLAR METRIC** - Cancer waiting times remain below standard with an increasing number of referrals. 62 Day performance for July was 66.9% a reduction from June 2022. 31-day performance was 93.5% a slight improvement on June performance. Cancer 2 week waits performed at 76.4%, a reduction from the June position of 89.1%.

**RTT 18 WEEK COMPLIANCE PILLAR METRIC –** The Trust reported an RTT Incomplete Performance of 57.84% July and 57.43 in August. The total number of patients waiting over 18 weeks in July was 13,961 & August 14,609 an increase of 648. The Trust reported a waiting list size of 33,122 for July & 34,315 for August. 32,579 (an increase of 1,193). There were 1215, 52-week breaches in July and 1568 52-week breaches for August 2022. In July 2022 there were 102 patients waiting more than 70 with 118 patients waiting over 70 weeks in August.

The Trust reports a 104+ week clock stops In August but no 104+ weeks waiters in July and August.

**EMERGENCY CARE AED & UTC MEAN STAY PILLAR METRIC -** Total Meantime in ED was 473 minutes in August against a national standard of 240 mins. Mean time in UTC continues to perform well. ED attendances have shown a slight improvement in August 2022 with reductions seen in June and July also.

**EMERGENCY CARE EMERGENCY ATTENDANCES PILLAR METRIC –** The number of attendances to ED and UTC has grown year on year. However, in the past 3 months there has been an overall reduction in the number of patients who attend the ED and UTC.

**INPATIENT SPELLS WITH NO CRITERIA TORESIDE PILLAR METRIC -** The number of In-patient spells where the patient is delayed pending the outcome from a referral made to social care. This initially reduced following some data cleansing and therefore reduced in July 2022 however, there has been a growing trend in August.

**Other key Statutory Performance Measures - Updated at PPPC**

**CANCER WATCH METRICS** - Cancer waiting times remain below standard with an increasing number of referrals. 62 Day performance for July was 66.9% a reduction from June 2022. 31-day performance was 93.5% a slight improvement on June performance. Cancer 2 week waits performed at 76.4%, a reduction from the June position of 89.1%.

**DIAGNOSTICS (DM01) -** In July DM01 performance was 46.9%. The number of patients on a Wait List reduced in July from 12,819 to 12,398

**EMERENCY DEPARTMENT** – The number of patients who are seen, treated and discharged from ED continues to perform and track above 70%

**HOSPITAL HANDOVER DELAYS Watch Metric –** Marked deterioration in August with an average of 51 hours in month from an average of 30 hours in the previous month.

**Our Care**

**Medicines Safety**

The number of reported medication incidents has decreased in July 22, but there is no increase in incidents associated with moderate harm or above. The proportion of incidents resulting in any level of harm reduced in July but remained consistent over the reporting period.

The overall reduction in reported medicines incidents is likely associated with a change in trust incident reporting system. This will be monitored closely in future months.

**Infection Control**

In August 2022 there were three reportable C. difficile infections. One was a Community Onset, Healthcare Associated (COHA) cases, identified in the Emergency Department and two were Hospital Onset – Healthcare Associated (HOHA), both identified on Neptune Ward.

The Trust has been set a threshold of 48 C.difficile infections for 2022/23, which means that at the end of August 2022, we are under the trajectory for that threshold.

The Trust has been set thresholds of 69 E.coli, 23 Klebsiella and 19 Pseudomonas aeruginosa bacteraemias for 2022/23. In August 2022, 11 E.coli, one Klebsiella and one Pseudomonas aeruginosa bacteraemia were identified, placing the Trust over trajectory for E.coli but under for Klebsiella and Pseudomonas aeruginosa.

**Pressure Ulcer Reduction**

There were a total number of 229 incidents reported for pressure ulcer related harms during the month of August. 27 (24 the previous month) of these incidents were hospital acquired and the remaining 202 incidents were a combination of PU harms which were present on admission and not pressure ulcer damage.

Through the Improving together work stream on Trauma Unit the following causes of harm have been identified; delayed skin inspection on admission, pressure mattresses are not readily available when required. Repose air mattresses overlay's have been purchased by the department for all standard foam mattresses, with evaluation planned for September.

Teal Ward have only had one Category 2 pressure ulcer reported in August compared to five the previous month. Through identification of patients at risk and offering a toilet break within the first 20 minutes of admission the staff are performing a skin check and mobility assessment. This has been achieved by identifying the need through the wards Improving Together workstream and the staff working together to identify a solution to prevent harm.

**Safer Mobility**
There were 128 reported inpatient falls reported in August 2022, resulting in 6.4 per 1000 bed days, this remains within normal variance. On average each month 30.3% of falls involve patients who have fallen twice or more as an inpatient. During August 2022 there were two inpatient falls resulting in harm.

There has been a small trial for Front Door Team and Safe and Well Advisors at the fire service to refer members of the public for a multi-factorial falls risk assessment with a Live Well Advisor at Swindon Borough Council (trained by the Integrated Falls Lead). Personalised Falls Risks have been identified and individuals given proactive, preventative advice and signposted to appropriate physical activity opportunities. As the proof of concept has been successful, six months additional funding to extend the pilot and expand capacity of the service has been agreed, in order to provide evidence to build a business case for long term funding.

**Patient Experience**
63 complaints received (previous month 48) and 159 concerns (previous month 118) were received in August 2022. Out of a total of 204 cases received from Complaints and Concerns in August, the overall top three themes were communication, clinical care and waiting times.

For August, 87% of the Friends and Family Test (FFT) responses were positive, an increase of 5% on last month. This is based on the % of responses rated as 'very good' and 'good'. The negative responses at 8% are lower than last few months being in the low teens, based on responses rated as 'poor' and 'very poor'.

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

**Exceptions in August:**
The Trust vacancy KPI has decreased in-month from 7.48% to 6.70%, a decrease of 39.48WTE. The Trust HCA vacancy is in an overrecruited position of 21.66wte compared to approx. 100wte vacancies earlier in the year. (Excluding safer staffing investment).

Sickness absence increased in-month from 5.1% to 5.94%, of which 1.96% is Covid related absence and 3.98% is non-Covid related.

The in-month agency spend as a percentage of the total pay bill has increased from 4.18% to 6.22% which is above Trust target (6%). The increased demand on services continues

as evidenced by the use of 180.75WTE in excess of Trust workforce budget in August. Temporary staff utilisation above the Trust vacancy position continued in month, with 345WTE of Registered & Unregistered Nursing staff being used against a vacancy of 123WTE and 65WTE Medical staff used against a vacancy of 46WTE.

Electronic Rostering project implementation continues with Acute and General Medicine and anticipated go-live for complete delivery is end November 2022.

Time to hire in August was 61.1 days and exceeding the Trust target of 46 days, attributable to delays with shortlisting and issue of offer letters.

Trust appraisal compliance is reported at 75.75% in August. The SARD system is implemented for medical staff enabling access to conduct online appraisal. There is evidence to support improved compliance rates and work is underway to align the ESR system with SARD to enable more accurate and detailed reporting.

The workforce priorities for the month ahead include annual Staff Survey 2022/23 launch on 26th September, supporting reduction of staff absence and implementing the 'Locums Nest' App to enable medical locums to book temporary shifts and inform a regional collaborative Bank workforce.

**Use of Resources**

The Trust is reporting a deficit of £1.85m against a planned deficit of £1.58m in Month 5 (£0.3m adverse to plan). Year to date the position is £1.8m adverse to plan. Within Unscheduled Care (USC) there has been a reduction in Medical staff costs in month, however pay costs overall continue to be above plan due to additional RMN use within the division. Trust-wide YTD, we are seeing growing pressures on high-cost drugs that are covered by a block income contract (£0.4m), and ESRF costs above guaranteed income (£0.4m). These combine with the USC overspend as keys driver of the overspend year to date.

Additional efficiency plans have been reported in month however a gap of £4.0m remains to find to deliver the full year plan. The Trust forecast is £4.1m adverse to plan, the detailed forecast is being refreshed and will be reported for Quarter 2.

The cash position at the end of July was £24.7m, ich is £5.0m below plan. Capital expenditure is £1.3m to the end of Month 5, which is £3.8m below plan.

| **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 – r**isk number & description (Link to BAF / Risk Register) | | | | | **Risk Score** |
| | | | | | |
| **Consultation / Other Committee Review / Scrutiny / Public & Patient involvement** | PPPC & Trust Management 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<br>The Board/Committee/Group is requested to: | |
|---|---|
| ***The Board/Committee/Group is requested to:***<br>▪ ***Review and support the continued development of the IPR***<br>▪ ***Review and support the ongoing plans to maintain and improve performance*** | |
| **Accountable Lead Signature** |  |
| **Date** | 29th September 2022 |

NHS
Great Western Hospitals
NHS Foundation Trust

# Integrated Performance Report

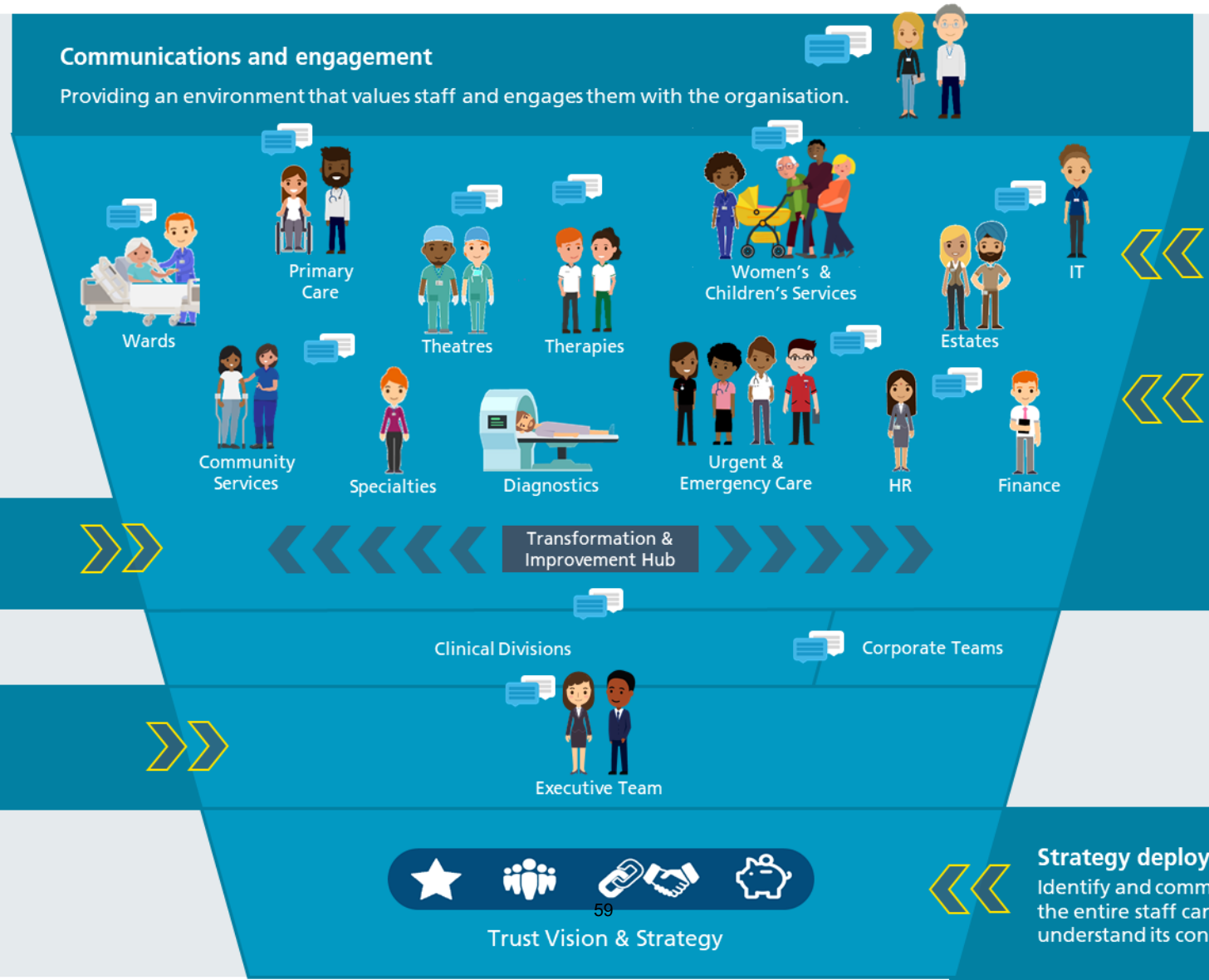
September 2022

July & August 2022 data period

Improving together

# Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust




**Transformational projects**
Using improvement methodology to create step-change improvement.

**Operational Management System**
A system of routines, behaviours and tools which ensure daily continuous improvement and performance excellence.

**Transformation & Improvement Hub**
Develop an internal capability to develop and sustain improvement journey.

**Leadership behaviours**
Develop new leadership styles at the top of the organisation, and capability to cascade this through management.

**Strategy deployment**
Identify and communicate a focused set of priorities to ensure the entire staff can align with the organisation's strategy and understand its contribution to achieving the strategy.

# Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

**Our Vision**

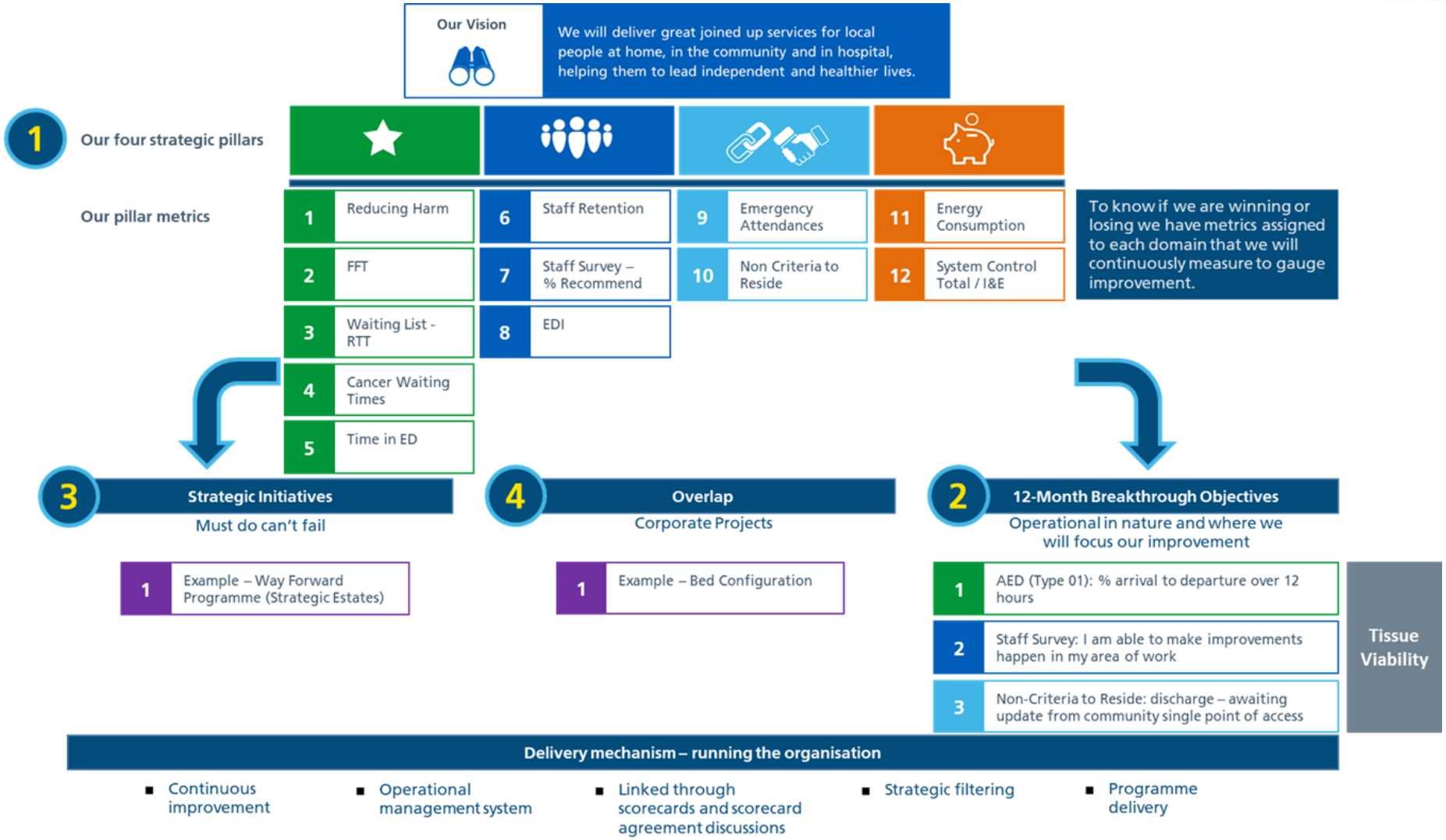
We will deliver great joined up services for local people at home, in the community and in hospital, helping them to lead independent and healthier lives.

## 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



# Executive Summary

Great Western Hospitals NHS Foundation Trust

**Total Harms**

The Strategic Pillar target is to achieve zero avoidable harm within 5-10 years.

We have identified the most significant avoidable harm as pressure damage acquired in our care (either as an inpatient or in the community), in response the Breakthrough objective for Tissue viability has been developed. We are currently reviewing the most appropriate way to report total avoidable harms to ensure we develop a meaningful metric that allows us to monitor progress and improvements effectively. We have not included an SPC chart in this report until this has been agreed.

**Lisa Cheek** Chief Nurse **Jon Westbrook** Medical Director

**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 recommended score together, we have therefore added completion rates as watch metrics to our overall scorecard.

**Lisa Cheek**
Chief Nurse

Service | Teamwork | Ambition | Respect

## Total Harms

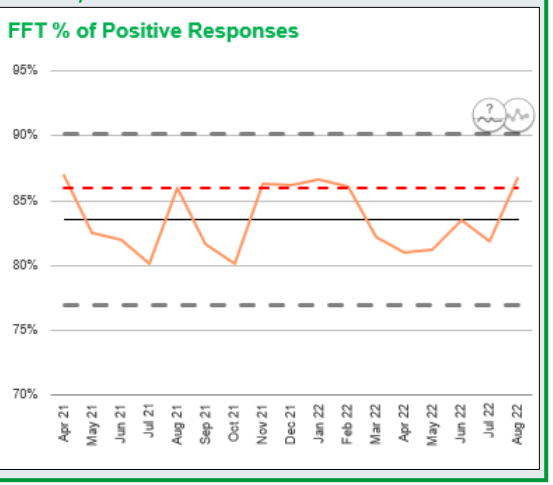
To achieve and sustain zero avoidable harm.

To be updated in October 2022

## Patient Experience (Friends & Family Test)

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

| Timescale | Value |
|---|---|
| Sep 21 | 81.6% |
| Oct 21 | 80.2% |
| Nov 21 | 86.3% |
| 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% |




## Counter Measures

- The Manual Handling Risk Assessment Tool has been reviewed, updated, and transferred onto Nerve Centre ready to go live in September 2022
- Teal Ward have reduced Category 2 pressure ulcers from five to one in month following a new intervention of offering new at-risk patients a toilet break within the first 20 minutes of admission to allow staff to perform a skin check and mobility assessment.
- *C. difficile* rates remain under trajectory since June, senior IPC staff continue to attend all case review meetings and ward rounds, working closely with the IPC team, Infection Control Doctor and Antimicrobial Pharmacists to maintain scrutiny and ensure continued reduction.
- To target E.coli infections there was a focus on catheter care in August , this highlighted several areas where practice could be improved, which will feed into the work of the Catheter - Associated Urinary Tract Infection group.
- Initial external review of new Carers Accreditation scheme for OPD. Full assessment October 2022.
- Patient Care Reflection filmed to demonstrate the importance of mouth care.
- Bespoke managers complaint training sourced for November 2022 with focus on early resolution, improved communication and managing concerns at source.
- Customer care training sourced for front line admin/reception teams to be rolled out from October 2022.
- New Nerve centre property form being trialled. For roll out Oct 2022
- Carers Charter launched.
- Addition to Signlive added to enable direct calls to PALs team with BSL. Will be advertised widely to deaf community.
- Actions agreed as in response to National inpatient survey focussed around – discharge, nutrition, first impressions and hygiene

# Executive Summary

Great Western Hospitals NHS Foundation Trust

**Trust Access Standards (Cancer, RTT & ED)**

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.

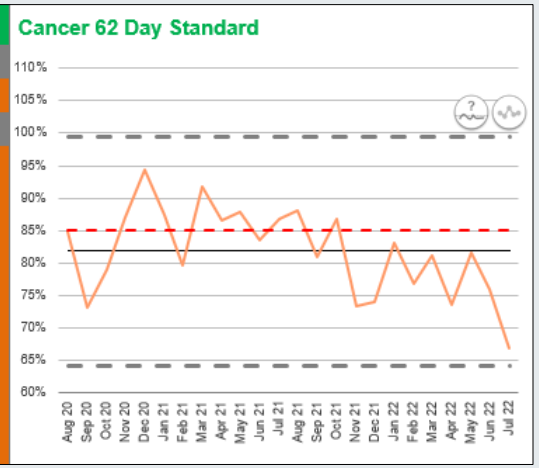
In common with many other providers, the Trust has not consistently achieved the national access standards for ED and RTT, and nationally expectations are being reset around targets. Countermeasures for the deteriorations seen here are listed below

**Felicity Taylor-Drewe**
Chief Operating Officer

## Cancer 62 Day

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

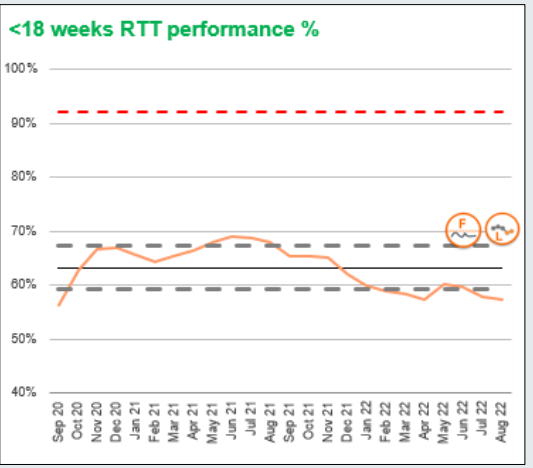
| Timescale | Value |
|---|---|
| Aug 21 | 88.0% |
| Sep 21 | 81.0% |
| Oct 21 | 86.8% |
| Nov 21 | 73.3% |
| Dec 21 | 74.0% |
| Jan 22 | 83.2% |
| Feb 22 | 76.8% |
| Mar 22 | 81.2% |
| Apr 22 | 73.5% |
| May 22 | 81.5% |
| Jun 22 | 76.0% |
| Jul 22 | 66.9% |




## RTT: 18 Week Compliance

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

| Timescale | Value |
|---|---|
| Sep 21 | 65.4% |
| Oct 21 | 65.4% |
| Nov 21 | 65.2% |
| Dec 21 | 62.0% |
| Jan 22 | 60.1% |
| Feb 22 | 59.0% |
| Mar 22 | 58.5% |
| Apr 22 | 57.4% |
| May 22 | 60.2% |
| Jun 22 | 59.7% |
| Jul 22 | 57.8% |
| Aug 22 | 57.4% |




## Counter Measures

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

Mitigation: Mutual aid at Oxford agreed for 100 patients sent for treatment. Dermatology are planning to hold clinics at Wootton Bassett from late September to help free up surgical space at GWH for Plastics to utilise. The Pathway has been mapped with the milestones assessed, potential improvements in both pathway and processes are being implemented. Concerns with capacity & operational processes have been raised and discussed with the divisional management team. The risk within capacity has been raised with the Cancer Alliance and NHSI SW team.

- Risk: For All Cancer Tumour Sites, capacity in outpatients to stage WLI activity is restricted by staff issues and space issues.

Mitigation: All services liaise with Outpatients to review any gaps in clinic utilisation on a weekly basis.

- Risk: Outpatient capacity issues in both the upper and lower GI pathways continue to delay follow up activity.

Mitigation: Registrar activity in lower GI is being used to free up clinic time for consultants to see their cancer patients.

- Risk: Staffing challenges in radiology due to vacancy and absence is placing increasing strain on capacity. Additional funding for external CT van in place until Mar 2023. Current waiting time for a CT Colon is 12 days.

Mitigation: Weekly meetings are held to escalate PTL concerns and booking times data is shared weekly. Radiology are actively managing and prioritising cancer referrals.

- Risk: Insufficient staffed theatre capacity to meet activity plan due to anesthetic and theatre staff absence and staffing of additional maternity elective list

Mitigation: Business proposal in development to staff all theatres 50 weeks per annum. Theatre timetable review to extend to all day lists and right size theatre schedule to demand on-going. Job planning to commence with new AMD to optimize funded resources. Weekend insourcing contract extended to December 2022.

- Risk: Theatre and Outpatient Utilization below expectations

Mitigation: Projects focusing on utilisation of both outpatient and theatre capacity. Demand management pathways in progress where appropriate. Skill mix reviews underway to increase nurse / AHP led elective activity

- Risk: Insufficient capacity to meet Activity plan.

Mitigation: Weekend payment per case activity planning underway for surgical specialties who do not undertake any insourcing activity. Additional capacity (including diagnostic) being provided in Endoscopy, Dermatology, Cardiology and Rheumatology in September and October 2022

# Executive Summary

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.

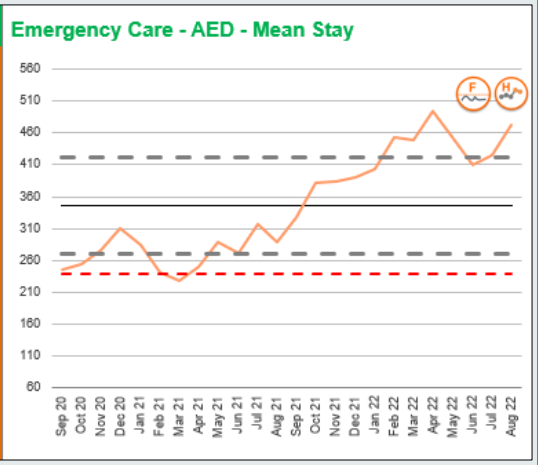
The total meantime wait for a patient in August 2022 was 473 minutes against the national standard of 240 minutes. Poor flow resulting from increases in length of stay (for both Criteria to Reside and Non criteria to reside patients) and COVID inpatients increasing has contributed to deterioration.

**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 |
|---|---|
| Sep 21 | 327 |
| Oct 21 | 381 |
| Nov 21 | 383 |
| 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 |




## Emergency Care – Urgent Treatment Centre - Mean Stay

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

| Timescale | Value |
|---|---|
| Sep 21 | 151 |
| Oct 21 | 139 |
| Nov 21 | 128 |
| 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 |


## Counter Measures

- An increase in Criteria To Reside (CTR) through August with a corresponding increase in Length of Stay has contributed to a deterioration in flow out of the department and an increase in ambulance handover delays. Bed occupancy of 98% further highlights pressure on flow out of the department.
- Review of ED breaches highlights an improvement in internal ED process with time to first assessment reduced through August. 75% of ED breaches now attributed to bed availability.
- Clinically ready to proceed (CrTP) update planned with an opt out process to increase completion expected in September.
- Data warehouse and informatics development underway for complete ED pathway mapping to highlight areas of delay.
- Introduction of a 2nd triage space in ED Major chairs to increase the capacity for triage.
- New triage space allows increased privacy and dignity for triage
- Review of nursing numbers in Triage space to increase capacity and reduce wait time for triage.

- Metric routinely meeting standard
- Roster change implemented for staff to increase staffing model mapped to key times of patient arrival.
- Availability on late shifts and address poor fill rate and staff support. Monitoring in place for implications on performance.
- New clinical navigator role in place but requires embedding into the model of care.
- Pathways between the emergency department and the urgent treatment center are being reviewed.

# Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

**Emergency Care**
Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC)

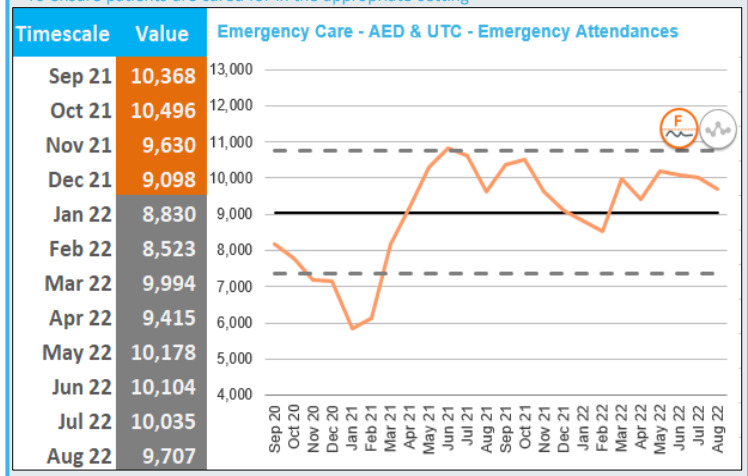
**Inpatient Spells - GWH - Number Non Criteria to Reside (NCTR) Days**
This is when a referral for health and social care is made to partners and we are waiting the outcome from the social worker assessment or Single Point of Contact. re discharge pathway and planning.

**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

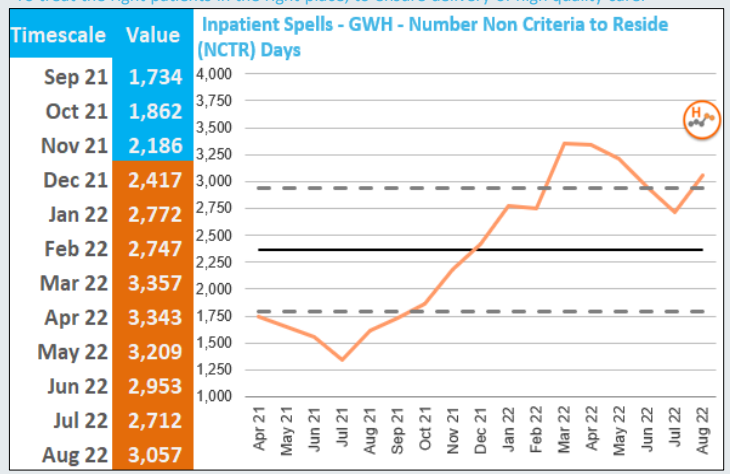
| Timescale | Value |
|---|---|
| Sep 21 | 10,368 |
| Oct 21 | 10,496 |
| Nov 21 | 9,630 |
| Dec 21 | 9,098 |
| Jan 22 | 8,830 |
| Feb 22 | 8,523 |
| Mar 22 | 9,994 |
| Apr 22 | 9,415 |
| May 22 | 10,178 |
| Jun 22 | 10,104 |
| Jul 22 | 10,035 |
| Aug 22 | 9,707 |




## 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 |
|---|---|
| Sep 21 | 1,734 |
| Oct 21 | 1,862 |
| Nov 21 | 2,186 |
| 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 |




## Counter Measures

**- Pre-Hospital**
- Determination of correct response through the Navigation Hub working from the ICA Coordination Centre.
- Coordinate the person who needs to come going to the right place

**- Intra Hospital**
- Internal ED flow improvement plan reported to Urgent Care and Flow Sub- committee
- Clinical Navigator lead at UTC front door and increased Triage Nurses at ED Front door
- Move to Singe Front door in 6-8 weeks (unheralded patients)
- Internal Same Day Care Pathway work for Medical and Surgical Patients
- Medical Getting it Right First Time (GIRFT) and Same Day Emergency Care Opportunity Work
- Direct access Pathways
- Acute floor review & weekend working

- Implemented a weekly battle rhythm for the Coordination Centre that supports a system wide approach to reducing LOS by clear actions.
- The Coordination Centre role cards developed to support teams around roles and responsibilities against specific patient groups e.g. > stranded patients >50 days , EOL. Care home
- 100-day challenge work continues to bridge gaps identified as positive flow markers.
- Review of pre and post 5pm discharges- deep dive into the 60:40 ratio
- Recruitment of Flow Navigator Senior Nurse 8a supporting pathway development with GP's & community teams
- Senior Discharge Support B5 supporting surveillance of Front Door referrals and Front doors to expedite quick win cases to social care
- Home First model now more embedded and can move from 1 to 2 patients per weekday. By Christmas, the plan is to increase this to 5 per day.

# Executive Summary

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.

Without staff retention, we can be overly reliant on our temporary staffing, see a reduction in staff morale and a detrimental impact on our finances.

**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.

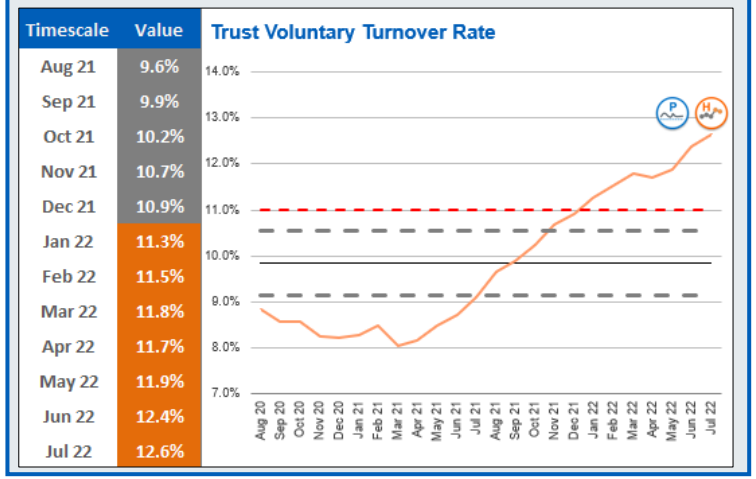
If staff currently felt more positive about their working experience at GWH this will translate positively in improvement in our patient's experience.

**Jude Gray**
Director of Human Resources (HR)

## Trust Voluntary Turnover Rate

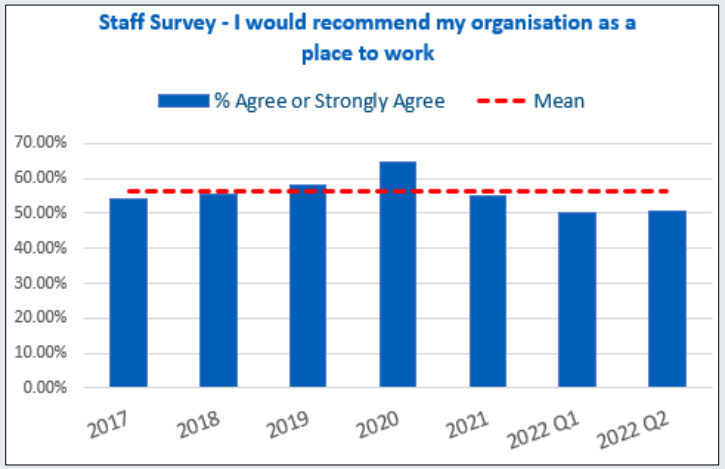
To achieve and maintain a maximum voluntary turnover rate of 11%.

| Timescale | Value |
|---|---|
| Aug 21 | 9.6% |
| Sep 21 | 9.9% |
| Oct 21 | 10.2% |
| 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% |




## Staff % recommend the organisation as a place to work

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




## Counter Measures

•The Trust 'Stay & Thrive' programme marks key success in 2022 with introduction of comprehensive induction including community orientation, OSCE duration extension to 6-8 weeks, and quarterly surveys of international cohort. The Deputy Chief Nurse is extending the reach of this group to wider international colleague representation to sustain Trust focus and align with BSW retention project.

•The Trust is completing the national Nursing and Midwifery retention self-assessment tool against the seven elements of the NHS People Promise. The tool assesses factors which are influencing Nursing and Midwifery retention and will inform evidence-based retention improvement plans for Winter 2022/23.

•The Trust are engaging with the BSW retention project, attending the first task and finish group in September to explore the appetite for career navigator roles and development of the Employee Value Proposition (EVP) for the Integrated Care Board.

•The divisions are progressing with "go and see" sessions at identified departments to understand progress against the Trust breakthrough objective – "I am able to make improvements happen in my area of work" to understand staff perception on empowerment and their working experience.

•The Trust held the second annual Great West Fest on Saturday 3rd September to recognise and thank staff for their hard work and commitment. The family focus of this event included live music, children's funfair, and a CEO personal message of thanks.

•In response to the cost-of-living crisis a Trust Corporate working group has produced a "Financial Wellbeing" signposting guide. Subject to final approval this will be communicated and available to staff on the intranet. Pension seminars arranged for September to December and to be conducted by the Money and Pension service.

# 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 ca n 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 ca n be static at certain levels, resulting in under -representation of certain groups.

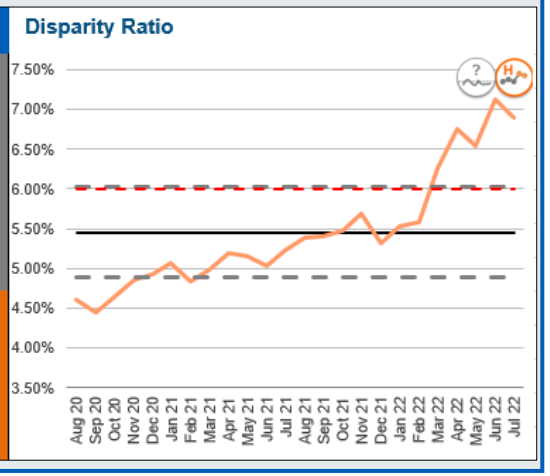
The complexities of addressing ED&I make it a challenge for the trust, however GWH are keen to have a representative workforce across all levels of the trust.

**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 |
|---|---|
| Aug 21 | 5.4% |
| Sep 21 | 5.4% |
| Oct 21 | 5.5% |
| Nov 21 | 5.7% |
| 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 | 6.9% |




## Counter Measures

- Evaluation of the Reciprocal Mentoring scheme designed to address disparity across the Trust is planned for September. Evaluation will assess success of the Phase One Mentor Experience, and interest in formalising a database of Trust mentors with mentoring qualification.

- WRES and WDES reports approved at TMC and P&C and will be submitted to board for noting in October.

- The Trust celebrated South Asian Heritage month with video outlining contribution of South Asian staff which has been well received by Trust and System colleagues and forms a BSW system wide resource under the EDI pillar.

- EDI lead developing the principles of an allyship program to be reviewed by staff networks to positively influence equality and retention. 50% of places on the next Aspiring Leaders programme will be for BAME staff.

# Executive Summary

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.

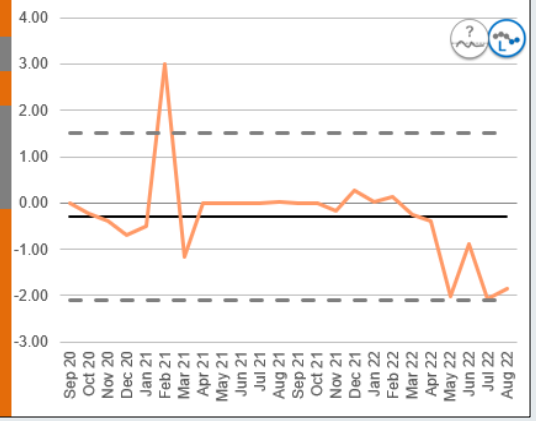
Over the coming years we will be focusing on the delivery of our Green Plan and ICS Green Plan which will be formally reported on annually and refreshed every 3 years.

**Simon Wade**
Chief Financial Officer

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

To achieve and sustain a break even financial position.

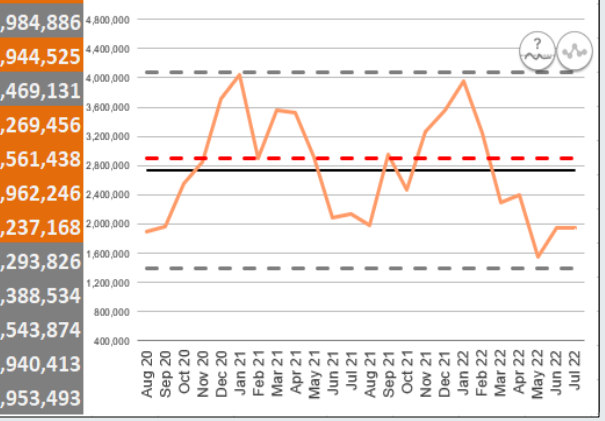
| Timescale | Value |
|---|---|
| Sep 21 | -0.01 |
| Oct 21 | 0.01 |
| Nov 21 | -0.17 |
| Dec 21 | 0.28 |
| Jan 22 | 0.03 |
| Feb 22 | 0.14 |
| Mar 22 | -0.26 |
| Apr 22 | -0.39 |
| May 22 | -2.01 |
| Jun 22 | -0.89 |
| Jul 22 | -2.07 |
| Aug 22 | -1.85 |




## Energy consumption (kWh) – Electricity & Gas

To achieve an organisational carbon neutral footprint.

| Timescale | Value |
|---|---|
| Aug 21 | 1,984,886 |
| Sep 21 | 2,944,525 |
| Oct 21 | 2,469,131 |
| 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 |




## Counter Measures

- At Month 5 the year-to-date position is a surplus of £5.0m for the ICB which is £1.8m behind the planned position of £6.8m. The forecast has deteriorated by £3.4m and stands at a surplus of £47.7m to support the planned ICS deficit of £51.1m
- At Month 5 GWH year-to-date position is a deficit of £9.3m which is £1.8m 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

NHS Great Western Hospitals NHS Foundation Trust

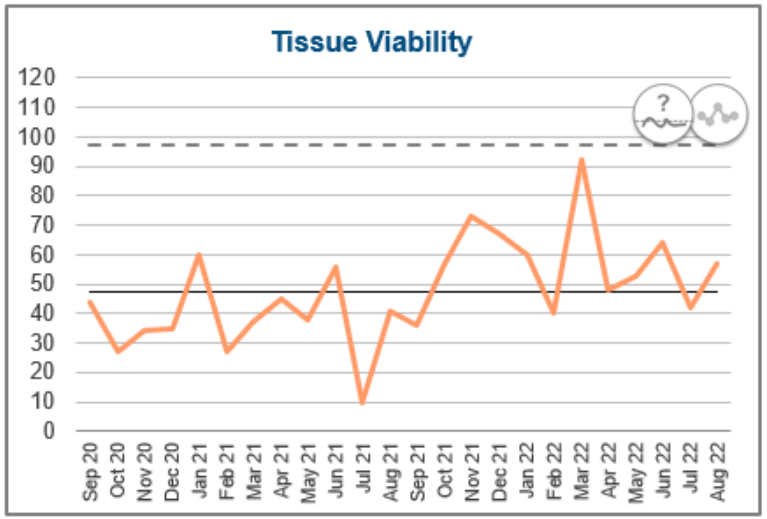
## Tissue Viability

| Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 36 | 57 | 73 | 67 | 60 | 40 | 92 | 48 | 53 | 64 | 42 | 57 |

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

Common cause – no significant change

Variation indicates inconsistently hitting passing and falling short of the target




### Understanding the Data

The number in the chart 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 are hospital acquired.

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

- In the hospital setting a total number of 229 incidents reported for pressure ulcer related harms during the month of August . All of these were validated by the Tissue Viability Nurses.
  - 27 of these incidents were hospital acquired and the remaining 202 incidents were a combination of PU harms which were present on admission.
  - This is an increase of 3 harms, following the 24 reported hospital acquired harms the previous month.
  - There were a total number of 27 harms on 25 patients.
  - There were 6 medical device pressure related harms this month.
  - Areas reporting high numbers include Trauma Unit (x 5) and Forest ward (x 5)

•In the community a total of 83 pressure ulcer related harm incidents were reported in August following validation 30 were deemed to be Community acquired pressure ulcers.

  - This represents an increase of 5 when compared to last month
  - 23 patients have pressure ulcers identified and reported. Of these 19 patients either receive a care package, reside in a residential home, or their care is being delivered by either Prospect or the Select team, for end-of-life care.

### Risks

- In the hospital setting reduced capacity within the tissue viability service due to sickness and annual leave. Causing limited availability and review of referrals into the department. This will improve during September.
- 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.

# 2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

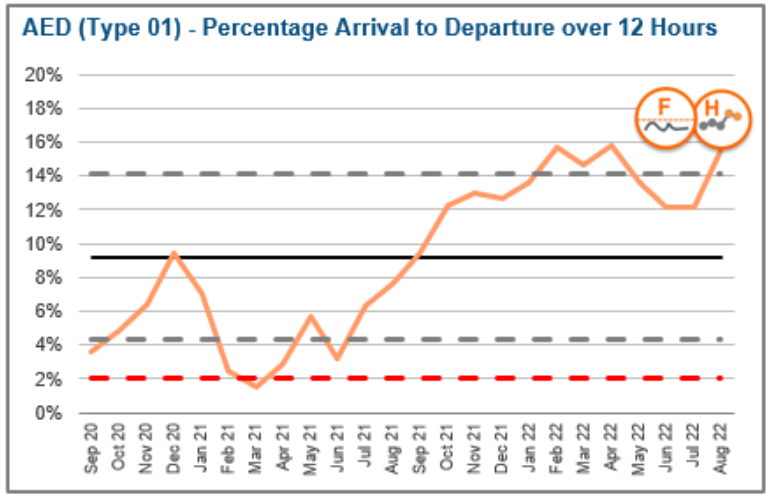
## Emergency Department (Type 1) - Percentage Arrival to Departure over 12 Hours

| Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 9.4% | 12.2% | 13.0% | 12.7% | 13.6% | 15.7% | 14.7% | 15.8% | 13.6% | 12.2% | 12.1% | 15.4% |

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

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

F – Variation indicates consistently (F)alling short of the target




### 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 A&E. The target is to achieve is to not have more than 2% of all patients who attended ED waiting over 12 hours.

### Performance

%>12 hour waits in ED – increase through August associated with increase in mean ED time.

54 x 12-hour reportable Decisions to Admit (DTA) breaches – reduction of 13 (Old criteria)

Clinically ready to proceed 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

### Risks

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

Increases in LOS 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.

# 2022/23 Breakthrough Objectives

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

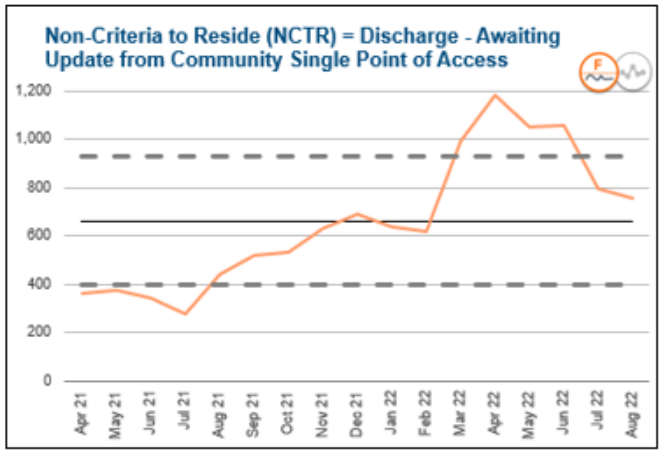
Great Western Hospitals NHS Foundation Trust

| Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 521 | 531 | 633 | 690 | 636 | 618 | 993 | 1185 | 1053 | 1060 | 795 | 760 |

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

Variation indicates consistently (F)alling short of the target

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

- Smart Objectives set against time from NCTR to referral, improvement trajectory at 3, 6 & 9 months
- Overall improvement in updates from Single Point of Access

**Counter Measure**

- Improved communication through co-location of services in the Swindon ICA Coordination Centre covering areas of ;
  - Wiltshire Flow Hub
  - Gloucester Transfer of Care Bureau (not co located in the SICA CC)
  - Swindon Borough Council

Internally the Trust is reviewing our approach to referral(s) and weekend working

### Risks

The risk is 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

•Divisions continue to embed 'Go & See' sessions, collating feedback and key themes for shared success and improvement learning in the Go & See Log. A session was conducted with the Speech & Language Therapy Team who have been identified as an area of outstanding practice and a case study is being prepared to share learning and success.

•QR Code surveys are conducted monthly within the divisions to seek regular feedback on staff's engagement with making improvements happen. USC have had 5 responses with an 80% positive score, SWC have received 88 responses with a 43% positive score, and ICC have had 53 responses with a 62% positive score.

•The Corporate function are being trained on the Improving Together methodology in September to extend implementation Trust-wide. The annual staff survey opens early October, supported by the launch of Trust "Improvement Week" (26th – 30th September) promoting the principles and benefits of Improving Together for front line teams with access to the T&I team for training and support.

### Risks

•Limited time until next staff survey to impact on 2022 positivity rate, work over the next 12 months will aim to improve 2023 staff survey positivity response %.

•Go & See sessions have highlighted continued risk of perception that hierarchy restricts empowering and effective communication.

# Our Performance

Great Western Hospitals NHS Foundation Trust

## Alerting Watch Metrics

| Plan Area | Measure Name | Mean/Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| RTT | No. of >=18 weeks waiters | | 12,634 | 13,145 | 13,961 | 14,609 |
| | No. of >=52 weeks waiters | | 852 | 1,028 | 1,215 | 1,568 |
| DM01 | No. of patients on DM01 waitlist | 12342 | 11,810 | 12,819 | 12,398 | One month behind |
| | DM01 performance % | 92% | 49.9% | 48.2% | 46.9% | One month behind |
| | DM01 6 week wait breaches | 6,383 | 5,922 | 6,640 | 6,588 | One month behind |
| Cancer | % Cancer 62 day performance | 85% | 81.5% | 76.0% | 66.9% | One month behind |
| | % Cancer 31 day performance | 96% | 93.6% | 93.4% | 93.5% | One month behind |
| | % Cancer 2 week wait | 93% | 91.7% | 89.1% | 76.4% | One month behind |
| ED | AED (Type 01) - Percentage Arrival to Departure within Four Hours | 95% | 54.8% | 58.7% | 54.6% | 54.9% |
| | AED (Type 01) - Percentage Arrival to Departure over Twelve Hours | 2% | 13.6% | 12.2% | 12.1% | 15.4% |
| | Total ED Type 1 Attendances (all arrival methods) | 5,555 | 5,799 | 5,600 | 5,597 | 5,225 |
| | Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival) | 38.4% | 32.6% | 29.9% | 33.3% | 57.8% |
| | A&E (ED & UTC) Emergency Care 4 Hour Performance % | 95.0% | 73.9% | 76.6% | 74.5% | 75.0% |
| Flow | Community Average Length of Stay (Days) | 18.8 | 19.4 | 17.6 | 19.1 | 18.9 |

### Performance & Counter Measure

DM01 performance deteriorated in Jul 22 to 46.9% with significant staff sickness in Radiology across Radiologist, Radiographers and admin teams. The Radiology waiting list in month has seen a small decrease >26 weeks. The two new Pads have come on-line now and we are starting to see an increase in our activity for routine MRI and CT (offset significantly in Jul 22 due to substantive staff sickness). We continue to deliver scans within 2 weeks for cancer referrals and anticipate a recovering picture in Aug 22. Progress in activity in Ultra-sound has also decreased the waits in this modality. CT and MR activity are delivering above plan following investment earlier in the Summer.

ED arrival to departure over 12 hours has seen an increase in August which alongside the increase in mean time in ED highlights an increase in % admission conversion rate, patient LOS>21 days and Criteria to Reside.

Cancer waiting times remain below standard with an increasing number of referrals.

**Counter Measure -** 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.

Community length of stay benchmarks positively in comparison to other local providers.

### Risks

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.

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

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| RTT | No. of >=70 weeks waiters | | 129 | 107 | 102 | 112 |
| | No. of referrals received | 1,782 | 1,868 | 1,735 | 1,743 | One month behind |
| | % 28 day faster diagnosis | 75% | 78.9% | 79.8% | 75.5% | One month behind |
| ED | UTC (Type 03) - Percentage Arrival to Departure within Four Hours | 95% | 96.5% | 96.6% | 96.7% | 97.7% |
| | UTC (Type 03) - Percentage Arrival to Departure over Twelve Hours | 2% | 0.0% | 0.0% | 0.1% | 0.0% |
| | Total Number of Ambulance Handovers | 1,927 | 1,896 | 1,937 | 1,995 | 1,879 |
| | Total Hours Ambulance Handover Waits (over 15mins) | 52 | 62 | 42 | 39 | 66 |
| | A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance | 48.5% | 44.1% | 52.9% | 54.3% | 42.8% |
| | A&E (ED & UTC) Median Arrival to Departure in Minutes | 193 | 200 | 191 | 194 | 185 |
| | Number of Ambulance Handover Over 15 Minute Waits | 1124 | 1,179 | 1,019 | 1,096 | 1,202 |

### Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

The Access Meeting weekly, reviews patient by patient within each speciality and questions the next steps for that patient pathway. Alongside this the activity forward look identifies any positive next activity increases and / or any risks to support mitigations.

A full theatre improvement plan supports the improvement of elective activity.

28 day previously delivered & will be reviewed as a non-alerting watch metric.

A unscheduled improvement plan supports a reduction in Handover Delays within the context of wider system pressures.

### 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

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| ED | Number of Ambulance Handover 30 Minute Waits | 672 | 738 | 522 | 619 | 807 |
| | Number of Ambulance Handover Over 60 Minutes Waits | 429 | 518 | 290 | 345 | 563 |
| | Percentage of Ambulance Handover Over 15 Minute Waits | 58.4% | 62.2% | 52.6% | 54.9% | 64.0% |
| | Percentage of Ambulance Handover s Over 30 Minutes | 34.9% | 38.9% | 26.9% | 31.0% | 42.9% |
| | Percentage of Ambulance Handovers Over 60 Minutes | 22.4% | 27.3% | 15.0% | 17.3% | 30.0% |
| | Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival) | 40.6% | 36.4% | 41.1% | 42.9% | 42.0% |
| | Admitted - Average Length of Stay in Department (mins) | 775 | 803 | 727 | 737 | 833 |
| | A&E Arrival to Departure Percentage over 12 Hours (All Patients) | 7.1% | 7.4% | 6.4% | 6.5% | 8.2% |
| | A&E Arrival to Departure over 12 Hours (Admitted Patients) | 7.1% | 7.4% | 6.4% | 6.5% | 8.2% |
| Flow | Non - Admitted - Average Length of Stay in Department (mins) | 291 | 295 | 278 | 291 | 298 |
| | Non-Elective Patients Average Length of Stay (Days) | 5.6 | 5.7 | 5.6 | 5.4 | 5.7 |
| | Number of Super Stranded Patients (over 21 days) | 74 | 79 | 74 | 64 | 79 |
| | GWH Acute Adult Bed Occupancy (%) | 96.3% | 96.5% | 95.8% | 95.3% | 97.9% |
| | GWH Discharges by Noon (%) | 16.2% | 16.2% | 16.9% | 15.5% | 16.1% |
| | Elective Patients Average Length of Stay (Days) | 3.6 | 4.1 | 3.5 | 3.2 | 3.5 |
| | Number of Stranded Patients (over 14 days) | 128 | 136 | 127 | 117 | 134 |

### Performance & Counter Measure

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

- Outlier model ward configuration
- Acute floor review (are we using our space in the optimum way)
- Weekend working
- Processing speed of empty beds
- Board round processes
- Surgical pathways
- 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

This all forms part of the improvement plan for ED and the winter plan, where we have focused our resources on key areas.

### Risks

NCTR numbers and Covid peak for a sustained period of time and do not enable bed availability and therefore flow.

# Our Performance

Great Western Hospitals NHS Foundation Trust

## Key Indicators

| Measure Name | Mean/Thres. | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total patients waiting more than 52 weeks | 824 | 680 | 664 | 593 | 639 | 626 | 612 | 664 | 744 | 852 | 1,028 | 1,215 | 1,568 |
| Total patients waiting more than 78weeks | 70 | 201 | 131 | 70 | 56 | 65 | 52 | 47 | 49 | 50 | 52 | 34 | 35 |
| Total patients waiting more than 104 weeks | 0.2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | - | - |
| Total elective activity undertaken compared with 2019/20 baseline | 100.0% | 94.2% | 77.6% | 88.2% | 91.6% | 87.1% | 98.6% | 127.0% | 90.5% | 95.5% | 97.1% | 86.1% | 88.7% |
| Total diagnostic activity undertaken compared with 2019/20 baseline | 100.0% | 90.2% | 78.9% | 93.2% | 95.3% | 79.5% | 89.0% | 83.3% | 88.7% | 94.6% | 92.4% | 87.9% | Reported one month behind |
| Total Cancer patients waiting over 62 days | 191 | 105 | 109 | 156 | 170 | 169 | 170 | 154 | 181 | 216 | 247 | 310 | 310 |
| Proportion of patients meeting the faster cancer diagnosis standard | 75% | 75.5% | 80.7% | 75.3% | 77.3% | 68.0% | 79.3% | 80.8% | 81.6% | 78.9% | 79.4% | 75.5% | 73.3% |
| Total patients treated for cancer compared with the same point in 2019/20 (first and | 100.0% | 126.0% | 89.8% | 138.3% | 156.0% | 126.0% | 114.2% | 100.5% | 71.7% | 150.5% | 85.5% | 58.6% | Reported one month behind |
| Outpatient follow-up activity levels compared with 2019/20 baseline | 100.0% | 89.3% | 76.4% | 92.2% | 92.8% | 81.8% | 84.3% | 108.5% | 85.6% | 89.5% | 85.9% | 69.8% | 80.6% |
| Proportion of ambulance arrivals delayed over 30 minutes | 32.9% | 13.3% | 27.9% | 25.0% | 26.7% | 29.6% | 44.9% | 39.5% | 48.4% | 38.9% | 26.9% | 31.0% | 42.9% |
| Proportion of patients spending more than 12 hours in an emergency department | 2.0% | 5.4% | 7.0% | 7.2% | 7.3% | 7.5% | 8.6% | 8.0% | 8.4% | 7.4% | 6.4% | 6.5% | 8.2% |
| Ambulance average response times - Category 1 | 0:10:21 | 0:10:10 | 0:11:11 | 0:09:55 | 0:11:13 | 0:09:32 | 0:11:12 | 0:11:14 | 0:10:13 | 0:09:23 | 0:09:51 | 0:10:02 | Waiting for data |
| Proportion of patients discharged from hospital to their usual place of residence | 94.1% | 94.1% | 94.5% | 94.3% | 93.7% | 94.5% | 94.4% | 94.3% | 93.8% | 94.1% | 93.8% | 94.2% | 93.9% |
| GWH - Percent Non-Criteria to Reside (NCtR) Bed Days | 22.1% | 11.5% | 14.7% | 19.5% | 20.6% | 23.5% | 23.5% | 26.6% | 26.4% | 24.8% | 25.4% | 24.5% | 24.0% |
| Average hours lost to ambulance handover delays per day | 37.1 | 13.5 | 22.5 | 17.5 | 25.7 | 30.1 | 62.0 | 44.1 | 66.7 | 48.3 | 33.8 | 30.0 | 51.0 |
| Adult general and acute bed occupancy | 95.6% | 94.8% | 95.8% | 96.1% | 94.8% | 94.1% | 94.7% | 95.4% | 95.7% | 96.5% | 95.8% | 95.3% | 97.9% |

# Our Care

## Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| Harm | Number of Falls in month | 123 | 147 | 125 | 92 | 128 |
| FFT | Maternity Positive Responses | 91% | 94% | 90% | 88% | 90% |
| Complaint | Trust overall complaint response rate | 80% | 67% | 64% | 64% | 58% |

## Performance & Counter Measure

Note on falls – see subsequent page

Maternity positive FFT threshold may need adjustment

Out of a total of 204 cases received from Complaints and Concerns in August, the overall top three themes were:

| Theme | Complaint | Concerns | % |
|---|---|---|---|
| Communication | 9 | 43 | 22% |
| Clinical Care | 12 | 15 | 12% |
| Waiting Times | 2 | 28 | 11% |

Complaint response rate has declined , PALs team are supporting and meeting regularly with divisional teams to escalate any delays.
Countermeasures:
Offers of support has been provided to divisions. A new process to agree extensions is being developed.
Bespoke managers complaint training has been sourced and an initial training day is being planned for November 2022. This will focus on early resolution, improved communication and managing concerns at source to try to avoid protracted complaints process and reassure people early.
A new Nerve centre property form is being trialled on Falcon ward, following any adjustments it will then be rolled out from Oct 22. This will ensure all patients have improved documentation of their property and valuables with the hope of reducing losses.
In August we launched our new Carers Charter which was developed in conjunction with GWH staff, community partners and Carers.

## Risks

Complaints response rate - Divisions are reporting high workload causing challenges in responding within agreed timeframes. Response rate within agreed timeframe is declining.

# Our Care

Great Western Hospitals NHS Foundation Trust

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| Harm | Falls rate per 1000 bed days | 6.3 | 7.4 | 6.6 | 4.7 | 6.4 |
| | No. falls with moderate harm or above | 3 | 6 | 3 | 1 | 2 |
| | Access, Admission, Xfer, Discharge | 8 | 8 | 9 | 8 | 7 |
| | Treatment/procedure harm events | 15 | 11 | 24 | 19 | 7 |
| | Other Accident/incident | 6 | 9 | 10 | 5 | 0 |
| | Infection Control Incidents | 3 | 5 | 1 | 5 | 0 |
| | Infrastructure (Incl. Staffing) | 8 | 12 | 11 | 7 | 0 |
| | Maternity Incidents | 3 | 2 | 8 | 1 | 2 |
| | Consent, Communication, Confidentiality | 5 | 5 | 7 | 6 | 2 |
| | Documentation (Inc Records, ID) | 7 | 4 | 13 | 12 | 0 |
| | Clinical Assessment (Diag, Scans,tests) | 6 | 6 | 7 | 8 | 4 |
| | Medical Device, Equipment | 4 | 8 | 7 | 2 | 0 |
| | Verbal Abuse | 1 | 1 | 4 | 0 | 0 |
| | Physical Abuse | 1 | 4 | 0 | 1 | 0 |
| | Implementation Of Care/ongoing Monitor | 3 | 2 | 8 | 1 | 0 |
| | Security | 4 | 3 | 6 | 4 | 1 |

## Performance & Counter Measure

128 inpatient falls reported in August 2022, resulting in 6.4 per 1000 bed days, this remains within normal variance. One fall resulted in a fractured Neck of Femur and one in a fractured wrist.

## Risks

# Our Care

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| Harm | Self-Harming Behaviour | 1 | 2 | 0 | 1 | 0 |
| | Manual Handling | 1 | 1 | 2 | 0 | 0 |
| | Sexual Abuse | 0 | 0 | 0 | 0 | 0 |
| | Fire | 1 | 1 | 0 | 1 | 0 |
| | Racial Abuse | 0 | 0 | 0 | 0 | 0 |
| | Total no. of Near miss events | 106 | 65 | 92 | 139 | 127 |
| | Medication Errors | 9 | 8 | 5 | 17 | 6 |
| | No. of serious incidents reported in month | 4 | 5 | 5 | 1 | 4 |
| Complaint | No. of concerns received | 116 | 88 | 99 | 118 | 159 |
| | No. of complaints received | 53 | 48 | 52 | 48 | 63 |
| | Number of reopened complaints | 2 | 0 | 0 | 2 | 5 |
| IP&C | Clostridium difficile (C. diff) infections in month | 2 | 2 | 2 | 2 | 3 |
| | Escherichia coli (E. coli) infections in month | 8 | 5 | 8 | 9 | 11 |
| | Methicillin-resistant Staphylococcus Aureus (MRSA) infections in month | 0 | 0 | 0 | 0 | 0 |
| | Meticillin Sensitive Staphylococcus Aureus (MSSA) infections in month | 2 | 2 | 5 | 1 | 3 |
| | Covid – no. of hospital acquired | 33 | 33 | 18 | 72 | 9 |
| | Covid – no. detected in patients | 179 | 154 | 159 | 304 | 99 |
| | Pseudomonas infections in month | 1 | 0 | 1 | 1 | 1 |
| | Klebsiella infections in month | 2 | 3 | 2 | 2 | 1 |

## Performance & Counter Measure

Complaints and concerns have increased in month, no specific themes identified to cause the increase – see previous slide for counter measures.

Gram negative bacteraemias -The Trust has been set thresholds of 69 E.coli, 23 Klebsiella and 19 Pseudomonas aeruginosa bacteraemias for 2022/23. In August 2022, 11 E.coli, 1 Klebsiella and 1 Pseudomonas aeruginosa bacteraemia were identified, placing the Trust over trajectory for E.coli but under for Klebsiella and Pseudomonas aeruginosa.

**Counter measure**

*E.coli* is commonly found in the gut, so infections are often associated with catheter/continence care. *E.coli* rates are rising nationally, with the increase in the BSW region appearing to be community-driven, but GWH rates remain high compared with local Trusts. In addition to existing collaborative work across BSW and that of our Catheter-Associated Urinary Tract Infection (CAUTI) Group there was a focus on catheter care in August as part of the IPC Improvement Plan.

## Risks

Complaints - Divisions are reporting high workload causing challenges in responding within agreed timeframes.

Availability of academy room to support complaints training has been escalated to academy manager to source off site resource.

# Our Care

Great Western Hospitals NHS Foundation Trust

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| Safer Staffing | Safer Staffing – average fill rate RN (%) | 95% | 98.1% | 95.1% | 96.3% | 98.2% |
| | Safer Staffing – average fill rate HCA (%) | 95% | 100.3% | 104.4% | 103.6% | 102.6% |
| FFT | Overall response rate (%) | 25% | 22% | 27% | 23% | 27% |
| | Positive response (%) | 83% | 81.2% | 83.5% | 81.9% | 86.7% |
| | ED & UTC Response Rate | 17% | 17% | 15% | 17% | 20% |
| | ED & UTC Positive Responses | 73% | 71% | 73% | 71% | 77% |
| | Inpatients Response Rate | 20% | 21% | 17% | 20% | 22% |
| | Inpatients Positive Responses | 84% | 82% | 86% | 79% | 88% |
| | Daycases Response Rate | 21% | 22% | 20% | 20% | 23% |
| | Daycases Positive Responses | 93% | 92% | 92% | 93% | 95% |
| | Outpatients Positive Responses | 96% | 96% | 96% | 95% | 98% |
| | Maternity Response Rate | 19% | 20% | 17% | 21% | 18% |

Performance & Counter Measure

Risks

# Our Care

## Key Indicators

| Measure Name | Mean/Thres. | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National Patient Safety Alerts not completed by deadline | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Overall CQC rating | | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | Requires improvement | Requires improvement |
| Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Waiting for data |
| Clostridium difficile infection rate | 24.2 | 19.1 | 43.2 | 25.5 | 43.2 | 18.5 | 13.7 | 18.5 | 36.3 | 11.7 | 12.9 | Waiting for data | Waiting for data |
| E. coli bloodstream infection rate | 34.6 | 31.9 | 30.8 | 19.1 | 18.5 | 49.3 | 34.1 | 18.5 | 54.4 | 29.3 | 60.5 | Waiting for data | Waiting for data |
| CQC well-led rating | | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | No Data Available | Good | Good |
| Summary Hospital-level Mortality Indicator | 0.89 | 0.91 | 0.90 | 0.89 | 0.89 | 0.89 | 0.88 | 0.88 | 0.87 | 0.86 | 0.88 | 0.90 | 0.93 |

# Use of Resources

Great Western Hospitals NHS Foundation Trust

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| Use of Resources | Capital Expenditure (£'000) | 323 | 524 | 410 | 131 | 225 |
| | Pay (£'000) | 22,323 | 22,732 | 23,054 | 21,512 | 21,995 |
| | Non Pay (£'000) | 14,431 | 14,568 | 13,903 | 14,153 | 15,101 |

Performance & Counter Measure

Risks

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# Use of Resources

## Key Indicators

| Measure Name | Mean/Thres. | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Financial efficiency - variance from efficiency plan (£'000) | +/- | 44 | -4 | 121 | -54 | -51 | 6 | 46 | -34 | -424 | -209 | -289 | -268 |
| Financial stability - variance from break-even (£'000) | +/- | -6 | 5 | -173 | 279 | 28 | 141 | -386 | -2506 | -2006 | -888 | -2068 | -1848 |
| Financial stability - variance from PLAN (£'000) | +/- | -6 | 5 | 331 | 783 | 533 | 645 | 3552 | -387 | -335 | -517 | -326 | -268 |

# Our People

Great Western Hospitals NHS Foundation Trust

## Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| Workforce | Trust sickness absence rate | 3.5% | 4.7% | 5.1% | 5.9% | One month behind |

### Performance & Counter Measure

Sickness absence increased again in-month to 5.9% of which 1.88% is COVID related absence and 4.06% is non-COVID related. The HR team are working on-site in departments where KPI compliance is low, and providing close support intervention with HR policy and guidance to managers.

### Risks

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# Our People

Great Western Hospitals NHS Foundation Trust

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Mean/ Thres. | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|
| Workforce | % of leavers within 1st year of employment | 31.2% | 31.5% | 29.1% | 32.9% | 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

The % of leavers within 1st year of employment has increased month on month. The key theme of reason for leaving remains as work/life balance.

Quarterly staff survey response rates have increased in Q2, additional data will be available following the next staff survey in Q3

Promotion of Health and Wellbeing conversations will continue ahead of the 2022 annual staff survey.

### Risks

# Our People

## Key Indicators

| Measure Name | Mean/Thres. | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of staff in senior leadership roles who are from BME background | 4.8% | 4.8% | 4.8% | 4.8% | 5.1% | 5.1% | 5.1% | 4.7% | 4.7% | 4.5% | 4.5% | 4.7% | Reported one month behind |
| Proportion of staff in senior leadership roles who are women | 70.2% | 70.5% | 70.2% | 69.6% | 70.8% | 71.2% | 71.3% | 70.9% | 70.3% | 69.1% | 68.9% | 69.1% | 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 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Vacancy | | | | | | | | | | | | | | |
| W | Vacancy Rate % | % | 7.63% | 5.18% | 6.52% | 6.06% | 6.55% | 6.91% | 6.77% | 6.33% | 8.03% | 7.31% | 6.94% | 7.48% | 6.70% |
| W | Trust Vacancy WTE | WTE | - | 259.13 | 330.01 | 306.31 | 332.42 | 350.82 | 343.65 | 321.55 | 415.32 | 377.16 | 358.52 | 386.57 | 347.09 |
| W | Nursing Vacancy % | % | 7.63% | 3.96% | 5.13% | 4.50% | 5.20% | 5.60% | 5.31% | 4.59% | 7.40% | 6.44% | 5.27% | 5.62% | 4.88% |
| W | Nursing Vacancy WTE | WTE | - | 94.13 | 123.31 | 108.03 | 125.70 | 135.51 | 128.45 | 110.90 | 184.68 | 160.51 | 131.68 | 140.23 | 122.71 |
| W | Medical Vacancy % | % | 7.63% | 6.36% | 7.44% | 7.14% | 6.93% | 7.01% | 8.08% | 6.89% | 9.00% | 8.68% | 8.94% | 9.57% | 6.53% |
| W | Medical Vacancy WTE | WTE | - | 42.72 | 50.68 | 48.60 | 47.44 | 47.99 | 55.32 | 47.14 | 63.55 | 60.96 | 62.75 | 67.19 | 45.84 |
| W | STT/AHP Vacancy | % | 7.63% | 4.65% | 6.68% | 6.68% | 7.41% | 7.92% | 7.45% | 7.36% | 7.84% | 7.11% | 7.44% | 8.94% | 8.25% |
| W | STT/AHP Vacancy | WTE | - | 37.90 | 55.43 | 55.42 | 61.53 | 65.57 | 61.71 | 60.99 | 64.89 | 58.82 | 61.57 | 74.04 | 68.37 |
| W | SMA Vacancy | % | 7.63% | 7.43% | 8.80% | 8.24% | 8.54% | 8.88% | 8.57% | 8.95% | 8.97% | 8.50% | 8.98% | 9.21% | 9.66% |
| W | SMA Vacancy | WTE | - | 84.38 | 100.59 | 94.26 | 97.75 | 101.75 | 98.17 | 102.52 | 102.20 | 96.87 | 102.52 | 105.11 | 110.17 |
| W | Recruitment Time to Hire | Days | 46.00 | 50.10 | 47.10 | 43.00 | 45.40 | 50.60 | 52.20 | 56.90 | 61.20 | 67.70 | 67.90 | 62.00 | 61.10 |
| | Workforce Utilisation | | | | | | | | | | | | | | |
| W | Budgeted vs Worked WTE Variance | WTE | - | 174.46 | 118.95 | 149.10 | 129.81 | 149.44 | 129.31 | 240.44 | 57.48 | 89.92 | 91.14 | 138.16 | 180.75 |
| W | Actual Worked vs Budgeted % | % | - | 3.49% | 2.35% | 2.95% | 2.56% | 2.94% | 2.55% | 4.74% | 1.11% | 1.74% | 1.76% | 2.67% | 3.49% |
| W | Total Workforce Cost £ | £ | - | £25.82M | £21.33M | £21.52M | £21.81M | £22.06M | £22.00M | £19.99M | £23.34M | £22.93M | £23.22M | £21.61M | £22.70M |
| W | Agency Spend as % of Total Spend | % | 6.00% | 5.86% | 6.38% | 6.62% | 6.86% | 7.13% | 7.74% | 7.60% | 6.82% | 6.57% | 6.36% | 4.18% | 6.22% |
| W | Agency Spend £ | £ | - | £1.39M | £1.36M | £1.42M | £1.48M | £1.58M | £1.71M | £1.77M | £1.51M | £1.44M | £1.42M | £0.91M | £1.37M |
| W | Agency WTE | WTE | - | 109.30 | 110.22 | 115.23 | 124.53 | 124.18 | 120.02 | 139.35 | 113.88 | 124.59 | 117.85 | 121.32 | 123.85 |
| W | Bank WTE | WTE | - | 293.16 | 308.47 | 307.07 | 305.88 | 350.76 | 320.03 | 386.55 | 315.69 | 311.77 | 304.96 | 377.97 | 375.45 |
| W | Registered Nursing Bank Fill | % | 55.00% | 48.98% | 47.43% | 47.16% | 46.74% | 46.48% | 48.71% | 47.78% | 45.28% | 44.86% | 47.09% | 44.52% | 37.70% |
| W | Unregistered Nursing Bank Fill | % | 70.00% | 63.06% | 61.58% | 68.01% | 62.64% | 62.61% | 62.23% | 62.47% | 63.53% | 69.76% | 75.59% | 72.53% | 69.81% |
| | Retention | | | | | | | | | | | | | | |
| W | All Turnover % | % | 13.00% | 13.72% | 13.97% | 14.32% | 14.51% | 14.96% | 15.26% | 15.59% | 14.89% | 14.82% | 15.46% | 15.90% | 0.00% |
| W | Voluntary Turnover % | % | 11.00% | 9.79% | 10.16% | 10.58% | 10.77% | 11.24% | 11.40% | 11.66% | 11.89% | 11.88% | 12.38% | 12.64% | 0.00% |
| W | Number of RN Leavers | Headcount | - | 16.00 | 16.00 | 21.00 | 17.00 | 17.00 | 22.00 | 25.00 | 21.00 | 18.00 | 17.00 | 16.00 | 0.00 |
| W | Registered Nursing Vol Turnover | % | - | 8.04% | 8.06% | 8.62% | 8.84% | 9.12% | 9.56% | 9.86% | 42.12% | 10.43% | 10.41% | 10.43% | 0.00% |
| W | Number of Unreg Nursing Leavers | Headcount | - | 14.00 | 11.00 | 12.00 | 12.00 | 6.00 | 11.00 | 14.00 | 10.00 | 12.00 | 22.00 | 13.00 | 0.00 |
| W | Unregistered Nursing Vol Turnover | % | - | 12.57% | 14.22% | 14.73% | 14.64% | 14.29% | 14.10% | 14.19% | 68.40% | 14.12% | 15.28% | 15.58% | 0.00% |
| W | Leavers within 1st Year of Employment | % | - | 26.39% | 21.13% | 21.43% | 23.44% | 26.67% | 30.95% | 29.87% | 24.29% | 33.33% | 29.27% | 32.91% | 0.00% |
| W | Number of Trust starters | Headcount | - | 97 | 50 | 79 | 27 | 97 | 61 | 85 | 92 | 88 | 70 | 55 | 0 |

# Our People

## Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

| Type | Metric | Unit/Measure | Target | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Absence | | | | | | | | | | | | | | |
| D | Sickness Absence % | % | 3.50% | 5.08% | 5.36% | 5.37% | 5.78% | 6.50% | 6.07% | 6.60% | 6.06% | 4.67% | 5.10% | 5.94% | 0.00% |
| W | Long Term Sickness % | % | 2.00% | 2.28% | 2.52% | 2.46% | 2.87% | 3.97% | 3.36% | 3.85% | 3.45% | 2.08% | 2.46% | 3.58% | 0.00% |
| W | Short Term Sickness % | % | 1.50% | 2.80% | 2.84% | 2.91% | 2.91% | 2.53% | 2.72% | 2.75% | 2.60% | 2.59% | 2.65% | 2.35% | 0.00% |
| W | Sickness Absence Cost £ | £ | - | £652k | £749k | £706k | £794k | £879k | £753k | £936k | £807k | £642k | £678k | £843k | £k |
| W | WTE Days Lost | WTE | - | 7,197.3 | 7,867.9 | 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 | 0.0 |
| | Learning & Development | | | | | | | | | | | | | | |
| W | Mandatory Training Compliance % | % | 85.00% | 85.04% | 87.18% | 88.13% | 88.85% | 88.33% | 87.60% | 87.38% | 87.36% | 87.75% | 87.87% | 87.74% | 87.74% |
| W | Role Essential MT % | % | 85.00% | 86.85% | 88.95% | 89.50% | 90.16% | 90.00% | 86.06% | 89.17% | 89.05% | 89.33% | 89.62% | 89.64% | 89.64% |
| W | CQC Safe MT % | % | 85.00% | 83.29% | 85.47% | 86.80% | 87.59% | 86.72% | 89.20% | 85.64% | 85.73% | 86.22% | 86.17% | 85.91% | 85.91% |
| W | Appraisal Compliance % | % | 85.00% | 73.85% | 71.79% | 73.78% | 74.17% | 73.27% | 68.61% | 68.85% | 70.05% | 73.03% | 74.55% | 75.56% | 75.75% |
| W | Non Medical Appraisal Compliance % | % | 85.00% | 73.03% | 72.24% | 75.08% | 77.42% | 74.84% | 70.16% | 69.66% | 71.44% | 74.99% | 77.85% | 77.91% | 78.12% |
| W | Medical Appraisal Compliance % | % | 85.00% | 79.70% | 68.52% | 64.55% | 51.18% | 62.18% | 57.66% | 63.13% | 60.29% | 58.82% | 50.37% | 58.38% | 58.41% |
| | | | | | | | | | | | | | | | |
| W | Staff in Leadership Roles % | % | - | 3.26% | 3.23% | 3.24% | 3.26% | 3.39% | 3.39% | 3.37% | 3.37% | 3.43% | 3.34% | 3.32% | 3.17% |
| W | Staff in Leadership Roles WTE | WTE | - | 190.00 | 188.00 | 189.00 | 190.00 | 197.00 | 197.00 | 197.00 | 197.00 | 202.00 | 197.00 | 195.00 | 188.00 |
| W | % of Leadership Roles who are Female | % | - | 67.37% | 67.02% | 66.67% | 67.37% | 68.02% | 67.51% | 67.51% | 66.50% | 65.84% | 65.48% | 65.64% | 67.02% |
| W | % of Leadership Roles who from BME | % | - | 8.95% | 5.85% | 4.76% | 5.26% | 5.08% | 5.08% | 5.08% | 5.58% | 5.45% | 5.58% | 5.64% | 5.85% |
| W | Male % of Workforce | % | - | 19.27% | 19.19% | 19.13% | 19.17% | 19.20% | 19.23% | 19.24% | 19.31% | 19.37% | 19.47% | 19.44% | 19.23% |
| W | Female % of Workforce | % | - | 80.73% | 80.81% | 80.87% | 80.83% | 80.80% | 80.77% | 80.76% | 80.69% | 80.63% | 80.53% | 80.56% | 80.77% |
| W | BME % of Workforce | % | - | 24.45% | 19.43% | 19.37% | 19.36% | 19.49% | 19.75% | 20.03% | 20.38% | 20.63% | 20.87% | 20.97% | 21.18% |
| W | White % of Workforce | % | - | 71.59% | 71.37% | 71.37% | 71.01% | 70.62% | 70.72% | 70.52% | 70.17% | 69.80% | 69.65% | 69.70% | 69.51% |

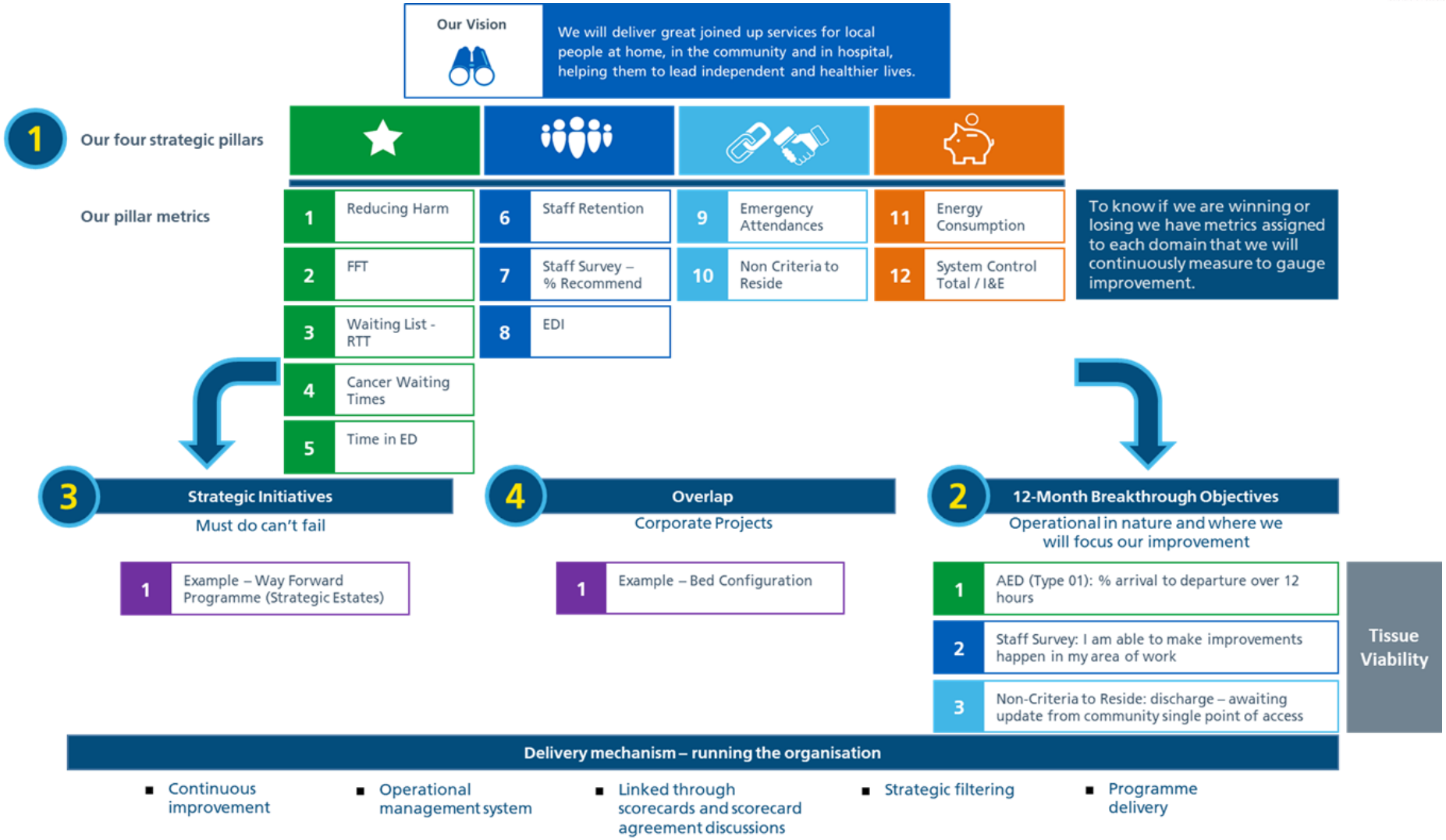
# Appendices

*Explaining the IPR*

Improving
together

# Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust



# Explaining the IPR

Great Western Hospitals NHS Foundation Trust

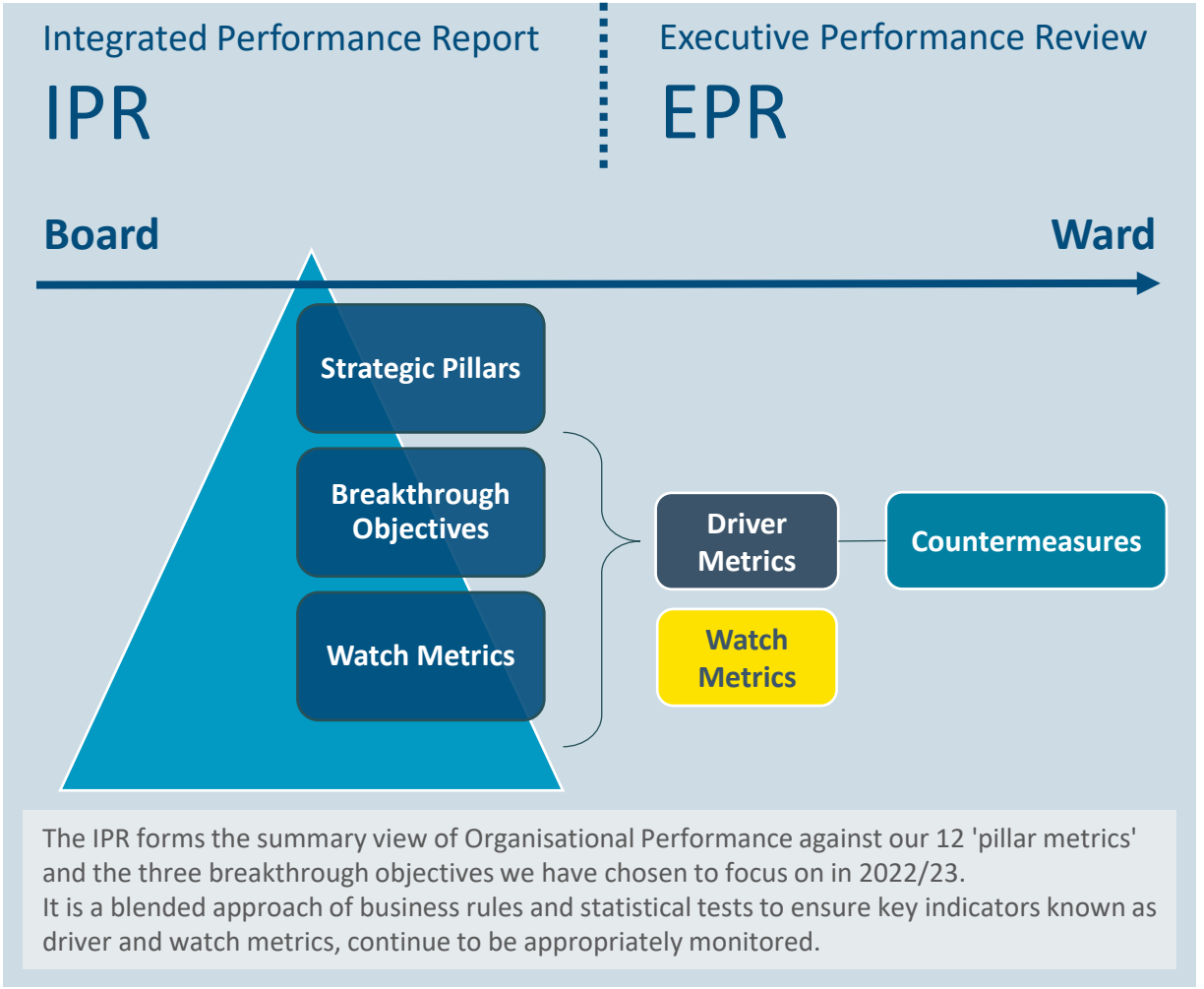
To turn our strategic themes into real improvements, we're focusing on three key objectives that contribute to these themes for the next year.

- 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.

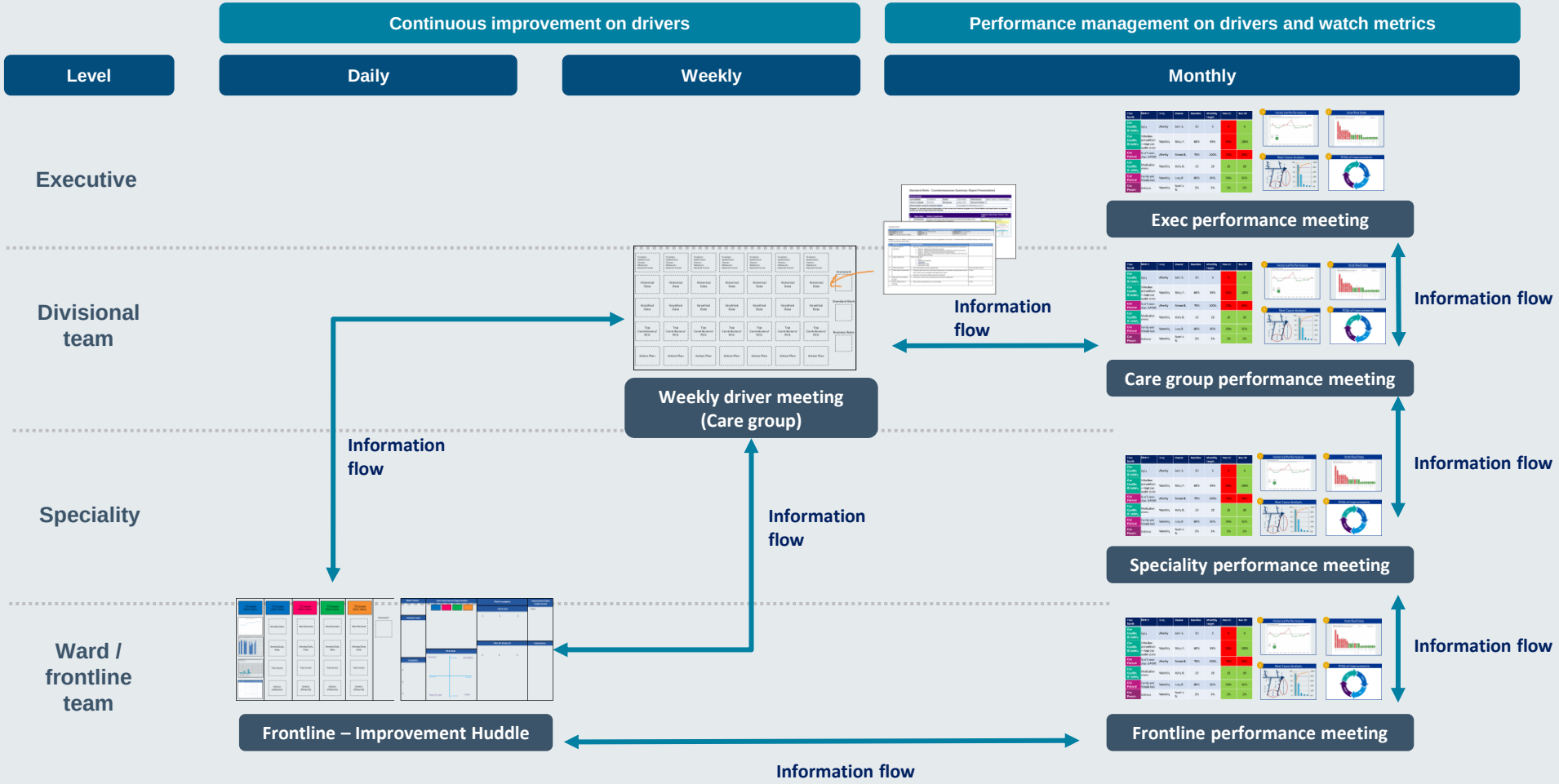
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our 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:<br>1. Switch to watch metric<br>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<br>Discussion:<br>1. Switch to driver metric (replace driver metric into watch metric)<br>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.

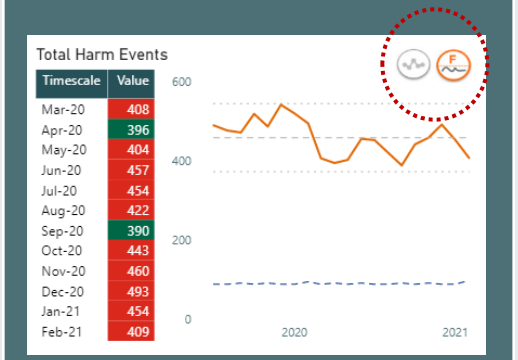
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

### NHS Improvement SPC icons:

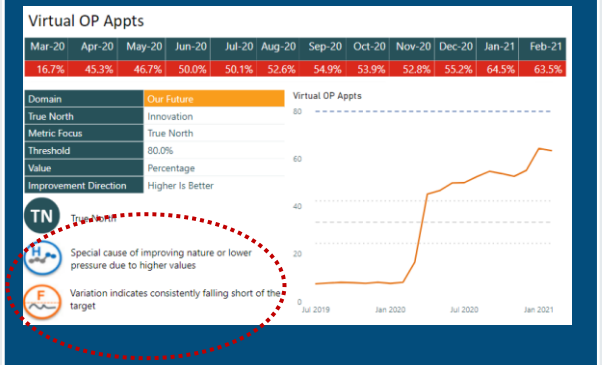
| Variation | | | Assurance | | |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| Common cause – no significant change | Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values | Special cause of improving nature or lower pressure due to (H)igher or (L)ower values | Variation 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

NHS
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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.<br>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.<br>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.<br>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.<br>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.<br>It is presented at monthly Performance Review Meetings. |

# Agreed Terms

Great Western Hospitals 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).<br>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.<br>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.<br>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.<br>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.<br>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.<br>They aim to encourage conversation, involvement and team working.<br>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.<br>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.<br>This new way of working will help us to achieve our vision and the four pillars we want to be known for.<br>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.<br>Key elements of the system are:<br>- To cascade the organisational priorities to Divisions and then frontline teams, ensuring everyone understands their contribution<br>- Embedding a new performance framework<br>- A focus on problem-solving at Divisions and team level, rather than waiting for solutions to be imposed from above<br>- 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:<br>- A focus on problem-solving at a team, ward, or department level, rather than waiting for solutions to be imposed from above<br>- Concentration on the Four Pillars and vision and ensuring everyone understands their contribution<br>- 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.<br>The PDSA cycle is a series of steps for gaining learning and knowledge for the improvement of a product or process.<br>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.<br>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).<br>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.<br>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.<br>The purposes of a Scorecard is to:<br>- Make strategy a continual process that involves everyone<br>- Promote key measurements<br>- Make clear the team's goals in relation to the Trust's four pillars<br>- 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.<br>The aim being to:<br>- Understand how each Division contributes to achieving the organisational priorities<br>- 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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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. |

NHS
Great Western Hospitals
NHS Foundation Trust

# Integrated Performance Report

## August 2022 (M5 data)

Service Teamwork Ambition Respect

# Part 4: Use of Resources

## Our Priorities

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

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

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

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

## How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

**Use of Resources**

# Financial Overview

Use of Resources

| For Period Ended - 31st August 2022 | In Month Plan £000 | In Month Actual £000 | In Month Variance £000 | | YTD Plan £000 | YTD Actual £000 | YTD Variance £000 | | Ful Year Plan £000 | Forecast Outturn £000 | Forecast Variance £000 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Operating Income | 34,967 | 35,233 | 266 | | 176,285 | 175,486 | (799) | | 420,872 | 424,041 | 3,169 | |
| Total Operating Expenditure | (36,547) | (37,081) | (534) | | (183,768) | (184,802) | (1,034) | | (440,392) | (447,616) | (7,224) | |
| Total Surplus/(Deficit) *excl donated assets* | (1,580) | (1,848) | (268) | | (7,483) | (9,316) | (1,834) | | (19,520) | (23,575) | (4,055) | |
| Capital | 965 | 225 | (740) | | 5,081 | 1,290 | (3,791) | | 17,246 | 17,246 | 0 | |
| Cash & Cash Equivalents | 29,700 | 24,659 | (5,041) | | | | | | | | | |
| Efficiencies | 1,043 | 855 | (188) | | 3,808 | 2,811 | (997) | | 11,109 | 7,085 | (4,024) | |

**Overview**

**Income & Expenditure:** The Trust is reporting a deficit of £1.85m against a planned deficit of £1.58m in Month 4 (£0.3m adverse to plan). Year to date the position is £1.83m adverse to plan.

Within Unscheduled Care (USC) there has been a reduction in Medical staff costs in month, however pay costs overall continue to be above plan due to additional RMN use within the division.

Trust-wide YTD, we are seeing growing pressures on high-cost drugs that are covered by a block income contract (£0.4m), and ESRF costs above guaranteed income (£0.4m). These combine with the USC overspend as keys driver of the overspend year to date.

**Cash** – the cash balance at the end of August 2022 was £24.7m, £5.0m below the plan of £29.7m. This reduction in cash compared to plan is primarily due to contract receivables being higher than plan, as well as the adverse impact on cash of the income & expenditure variance. Outstanding contract income is expected to be paid in September.

**Capital** – Capital expenditure is £1.3m as at the end of Month 5, £3.8m below plan. In the submitted plan we expected spend to be spread evenly across the year. Slippage is addressed at the monthly Capital Management Group and is being actively managed to ensure we deliver our capital plan by year end.

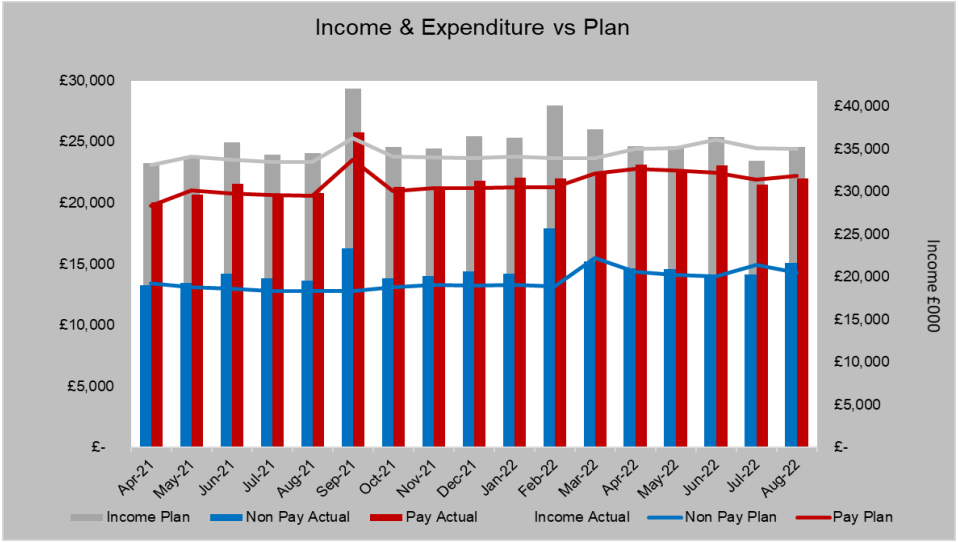
**Efficiencies** – In month £0.9m has been delivered against a plan of £1.0m. Year to date the efficiency plan is £1m off plan. There has been an increase in identified efficiency in month, the remaining forecast gap is now £4.0m.



**Forecast –** the forecast is based on Quarter 1 actuals and assumptions. An adjustment has been made to reflect additional efficiency schemes identified in month, improving the forecast by £0.5m. The detailed forecast is being reviewed and updated for Quarter 2.

# Income and Expenditure - Run Rate

Use of Resources



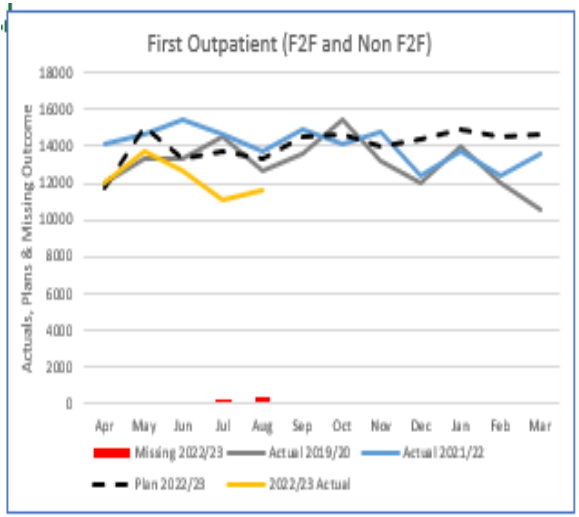

**Background**

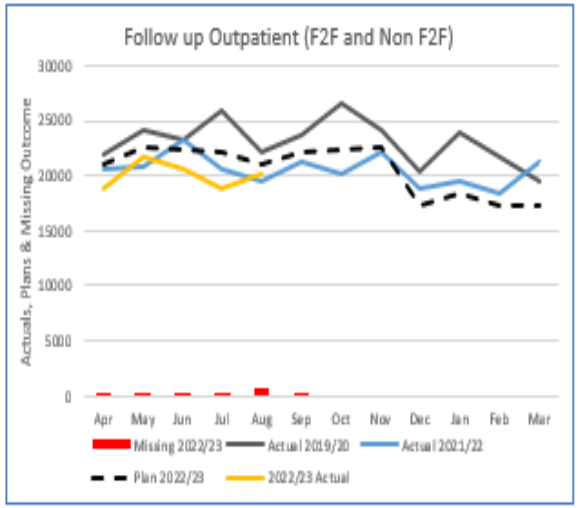
In month the I&E position is £1.8m deficit against a planned deficit of £1.6m.

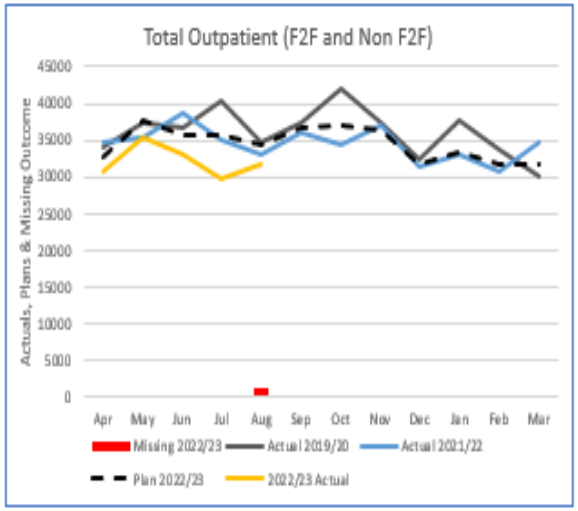
- Income run rate has increased by £1.6m in August and is £0.3m above plan in month (£0.5m adverse to plan year to date). In July there was a one-off reduction of £1.3m for RTA income. There has been an increase in Private Patient income in August (£0.1m relating to backdated drugs charges), an increase in Education income (£0.2m offset by increased costs) and other smaller movements in month. ESRF income in Month 5 is based on pro rata 25% ICB and 100% NHSE allocations (£1.3m YTD compared to a plan of £2.2m).
- The Pay run rate has increased by £0.5m in month however Month 4 was low due to a release of ESRF costs to match income. Pay is £0.2m below plan in month (£0.4m above plan year to date).
    - Increased requirements for enhanced care have seen agency costs within divisions increase in month, particularly within Unscheduled Care.
    - Vacancies within Surgery, Women's and Children's are being recruited to reducing the benefit seen in the position in previous months.
    - Vacancies continue to be captured within the Corporate division and will contribute to the non recurrent delivery of efficiencies.
- Non Pay run rate has increased by £0.9m from July and is £0.7m above plan year to date. The year-to-date variance is mainly driven by increased drugs costs, which are predominantly offset by income.

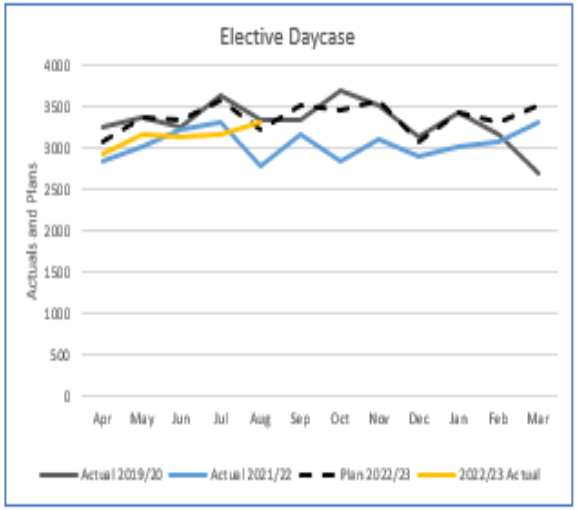
# Point of Delivery – Activity Trendline

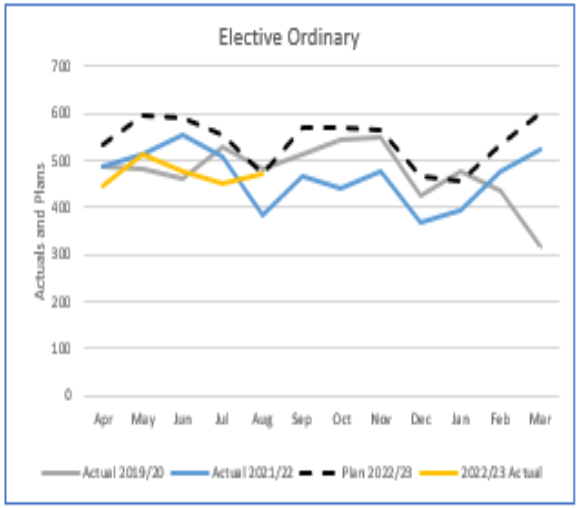
Use of Resources

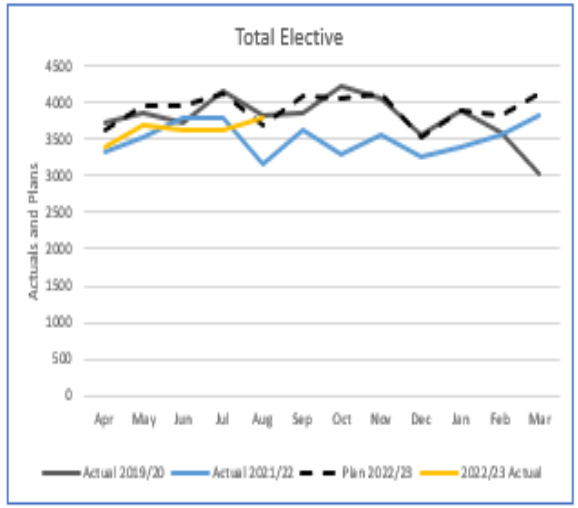


# Income by Point of Delivery

Use of Resources

| Acute activity type | August 2022 Year to date 19/20 | 21/22 | 22/23 | 22/23 v 19/20 Note 1 | |
|---|---|---|---|---|---|
| Main ED (excl UTC) | 6,228,200 | 5,039,479 | 4,976,930 | 76% | Omits shift to UTC since 19/20 |
| Non Elective | 39,837,743 | 43,421,686 | 41,193,415 | 99% | August 102% |
| Outpatient | 17,983,034 | 15,640,173 | 15,884,029 | 84% | August 92% |
| Day case | 9,916,092 | 9,180,912 | 8,722,988 | 84% | August 86% |
| Elective inpatient | 7,205,934 | 6,903,468 | 6,632,985 | 88% | August 89% |
| **Total** | **32,485,714** | **32,018,922** | **30,011,139** | **92%** | August 95% |

Note 1: Between 19/20 and 22/23 tariffs have been uplifted by 4.8% 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.

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.

It gives a feel for the impact of Covid-19 and the scale of income recovery back to 19/20 levels.

**Focus on actuals:**

For August, actual income on a PbR basis has been shown v prior year and the pre-Covid base of 19/20.

**Issues:**

Non-elective activity is running at c.102% of 19/20 levels in financial terms although fewer more complex cases are being seen.
Outpatients are running at 92% of 19/20 levels.
Elective and day case are c.86-89%, which is behind 2019/20 levels. Increases are expected later in the year.

**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.

# Efficiency – Better Care at Lower Cost

Use of Resources

**Background**

The Trust started the year with a £10m cash releasing efficiency plan. In June, the Trust agreed to reduce its deficit plan, as part of this the efficiency target was increased non-re currently by £1.1m to £11.1m. The additional target sits within Trust Wide.

Identified efficiency has increased by £0.5m in month however there is still a shortfall against the target. Divisions and Directorates are asked to work to their budget, which is a proxy (non-recurrent) delivery of CIP for this year.

| Cash Releasing - Division M05 | Plan £000 | Identified £000 | Unidentified £000 |
|---|---|---|---|
| Corporate | 1,100 | 389 | 711 |
| Integrated Care & Community | 1,000 | 884 | 116 |
| Surgery, Women & Children | 3,209 | 1,957 | 1,252 |
| Unscheduled Care | 3,600 | 3,600 | - |
| Trust Wide | 2,200 | 247 | 1,953 |
| **Total** | **11,109** | **7,077** | **4,032** |

| Cash Releasing - Division M05 | In Month Plan £000 | In Month Delivery £000 | In Month Variance £000 | YTD Plan £000 | YTD Delivery £000 | YTD Variance £000 | Full Year Plan £000 | Recurrent Forecast £000 | Non Recurrent Forecast £000 | Forecast Variance £000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 103 | 30 | 73 | 378 | 113 | 266 | 1,100 | 104 | 293 | 703 |
| Integrated Care & Community | 91 | 94 | (3) | 362 | 277 | 85 | 1,000 | 487 | 397 | 116 |
| Surgery, Women & Children | 301 | 311 | (10) | 1,103 | 934 | 169 | 3,209 | 1,284 | 673 | 1,252 |
| Unscheduled Care | 328 | 399 | (71) | 1,304 | 1,385 | (81) | 3,600 | 1,194 | 2,406 | 0 |
| Trust Wide | 220 | 21 | 199 | 660 | 103 | 557 | 2,200 | 247 | - | 1,953 |
| **Total** | **1,043** | **855** | **188** | **3,808** | **2,811** | **996** | **11,109** | **3,316** | **3,769** | **4,024** |

**Improvement actions planned**

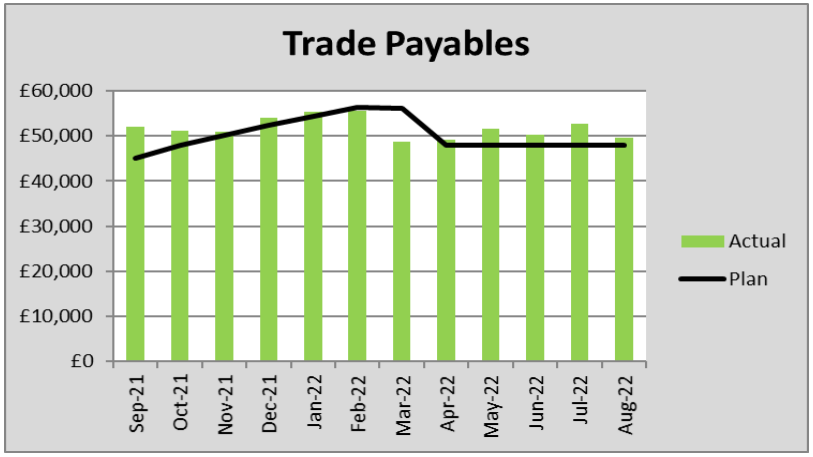
In month £0.9m efficiency has been delivered against a plan of £1.0m. Year to date reports £1.0m off plan. With additional efficiency identified in month, the forecast year end position is a gap of £4.0m. Within the forecast, a large amount is expected to be delivered non recurrently. Divisional platforms continue to address the unidentified plan and monitor delivery in year. A cross divisional working group has also been established. A detailed report on efficiency is presented at Finance and Infrastructure Committee monthly.

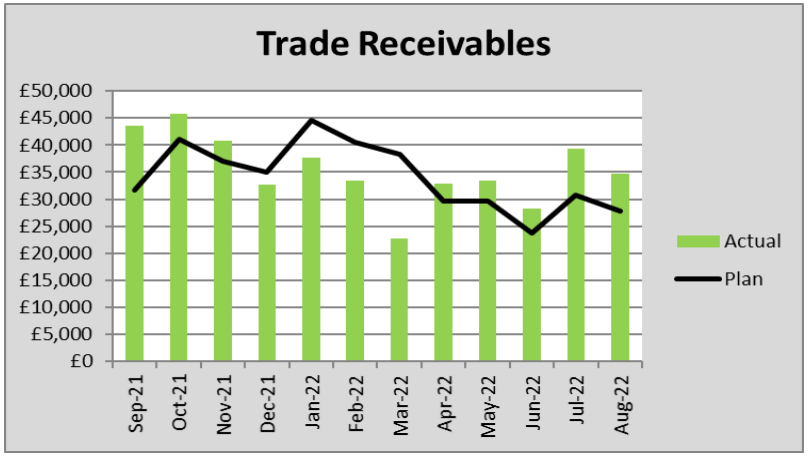
**Risks to delivery and mitigations**

The Trust does not yet have a fully identified efficiency plan – this is being addressed through Divisional platforms as well as cross Divisional workshops to mitigate the risk to in year delivery.

# Statement of Financial Position: Key movements

Use of Resources




**Background**

- Trade payables are £1.7m above plan due to an increase in Non-PO Accrued Expenditure and delays in payment due to ongoing SBS issues
- Receivables are £6.8m above plan due to an increase in Accrued and Invoiced income.
- A full Statement of Financial Position is included in the appendices.

**Risks to delivery and mitigations**

- The Trust submitted an application for Emergency Capital funding in May 2022. The application is with national capital team for review
- The Trust is monitoring SBS actions around reducing processing times and working closely with Divisions and Procurement to ensure suppliers are paid as soon as possible.

# Cash

Use of Resources

| | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | 22/23 Total | Rolling 12 Mths Aug 22 to Jul 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Opening Balance** | **25,829** | **24,694** | **20,885** | **12,106** | **11,545** | **11,054** | **2,765** | **2,188** | **17,545** | **1,036** | **1,036** | **4,013** | **1,095** | **52,898** | 24,694 |
| **Income** | | | | | | | | | | | | | | | |
| Clinical Income | 32,809 | 33,960 | 32,860 | 32,860 | 32,860 | 32,860 | 32,860 | 32,857 | 32,857 | 32,857 | 32,857 | 32,857 | 32,809 | 395,234 | 395,354 |
| Other Income | 2,667 | 1,225 | 6,892 | 1,225 | 1,225 | 6,292 | 725 | 1,228 | 1,228 | 1,228 | 1,228 | 1,228 | 2,667 | 36,103 | 26,391 |
| Revenue Financing Loan / PDC | | | | | | | | 17,000 | 4,200 | 2,856 | 2,856 | 10,300 | 1,200 | 17,000 | 38,412 |
| Capital Financing Loan / PDC | | 437 | | 1,100 | 1,370 | 1,804 | 1,804 | 8,895 | | | | | | 15,410 | 15,410 |
| **Total Income** | **35,477** | **35,622** | **39,752** | **35,185** | **35,455** | **40,956** | **35,389** | **59,980** | **38,285** | **36,941** | **36,941** | **44,385** | **36,677** | **463,748** | **475,568** |
| **Expenditure** | | | | | | | | | | | | | | | |
| Pay | 20,858 | 24,161 | 22,570 | 22,824 | 22,764 | 22,783 | 22,783 | 23,583 | 20,348 | 21,307 | 20,812 | 20,724 | 20,858 | 265,516 | 265,516 |
| Revenue Creditors | 15,033 | 11,382 | 11,642 | 11,269 | 11,187 | 11,472 | 11,187 | 11,190 | 15,124 | 13,517 | 11,284 | 13,512 | 15,033 | 147,799 | 147,799 |
| Capital Creditors | 721 | 1,325 | 1,325 | 1,595 | 1,996 | 1,996 | 1,996 | 7,288 | 6,327 | 2,059 | 1,868 | 131 | 721 | 28,627 | 28,627 |
| PFI | | | 12,994 | | | 12,994 | | | 12,994 | | | 12,937 | | 51,919 | 51,919 |
| PDC Interest | | 2,563 | | | | | | 2,562 | | | | | | 5,125 | 5,125 |
| Financing | | | | 58 | | | | | | 58 | | | | 116 | 116 |
| **Total Expenditure** | **36,612** | **39,431** | **48,530** | **35,746** | **35,947** | **49,245** | **35,966** | **44,623** | **54,793** | **36,941** | **33,964** | **47,303** | **36,612** | **499,101** | **499,101** |
| **Closing Balance** | **24,694** | **20,885** | **12,106** | **11,545** | **11,054** | **2,765** | **2,188** | **17,545** | **1,036** | **1,036** | **4,013** | **1,095** | **1,160** | **17,545** | **1,160** |

## Background

- Cash at the end of August was £25m. This was £5m below the planned level of £30m.
- This was due to:
  - Clinical income £1.7m lower than plan, loan draw down delay of £4.3m and an increase in invoiced receivables.
  - Revenue Creditor payments are above plan and Capital Creditors £3.8m below plan

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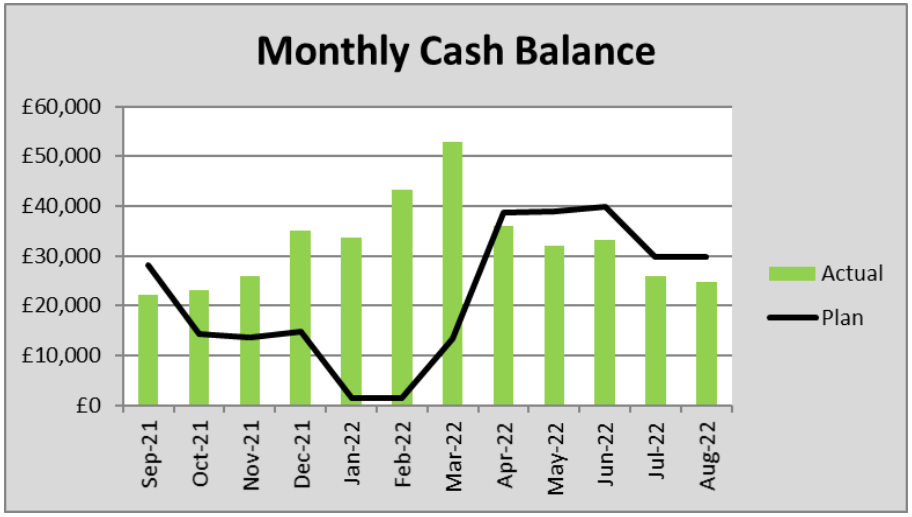
The forecast has been revised to reflect expected clinical income and payment of pay increases (backdated to April) in September. Capital financing has also been adjusted to reflect IFD drawdown and delay in the approval of our emergency capital application



# Capital Programme

Use of Resources

| Capital Scheme | Capital Group | 2022-23 Full Year Plan £000 | Month 5 Plan £000 | Month 5 Actual £000 | Month 5 Variance £000 | Month 5 YTD Plan £000 | YTD Actual £000 | Month 5 Accrual £000 | YTD Total (Actual & Accruals) £000 | YTD Variance £000 | M12 Forecast £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Estates Replacement Schemes | Estates | 1,000 | 83 | 12 | (71) | 265 | 72 | - | 72 | (193) | 1,000 |
| Service Development & Expansion - Aseptic Unit | Estates | 2,166 | - | - | | 370 | - | - | - | (370) | 2,166 |
| Service Development & Expansion - Other works | Estates | 1,239 | 200 | - | (200) | 603 | 176 | - | 176 | (427) | 1,519 |
| Service Development & Expansion - EPR & Path LIMs | IT | 1,156 | - | - | | 200 | - | - | - | (200) | 1,156 |
| IT Emergency Infrastructure | IT | 1,000 | 83 | - | (83) | 265 | - | - | - | (265) | 1,000 |
| IT Replacement Schemes | IT | 2,000 | 167 | 175 | 8 | 535 | 594 | - | 594 | 59 | 2,000 |
| PACS - environment/replacement solution (Nov21) | IT | 1,500 | 125 | - | (125) | 400 | - | - | - | (400) | 1,500 |
| Equipment Replacement Schemes | Equipment | 2,055 | 167 | 38 | (129) | 733 | 38 | - | 38 | (695) | 1,775 |
| Contingency | CMG | 379 | - | - | - | - | - | - | - | - | 379 |
| **Total Trust CDEL** | | **12,495** | **825** | **225** | **(600)** | **3,371** | **880** | **-** | **880** | **(2,491)** | **12,495** |
| Way Forward Programme | | 4,610 | 140 | - | (140) | 1,710 | - | 410 | 410 | (1,300) | 4,610 |
| Finance Leases | | 141 | - | - | - | - | - | - | - | - | 141 |
| **Total Capital Plan (Excl PFI)** | | **17,246** | **965** | **225** | **(740)** | **5,081** | **880** | **410** | **1,290** | **(3,791)** | **17,246** |

**Risks to delivery and mitigations**

Expenditure on schemes has been slow to commence but is expected to pick as we move into Q3.

Any slippage is reported to and managed by CMG

**Background**

- The Trust's CDEL plan for 2022/23 is £12.5m.
- Service Development Allocation includes Aseptic Suite (£2.2m), Pathology LIMS (£0.4m), EPR (£0.8m), Electrical Upgrade (£0.2m) and Co-ordination Centre (£0.3m).
- Total Capital Expenditure at Month 5 is £3.8m below plan. Of this, £2.5m relates to Trust CDEL schemes, with the remaining £1.3m slippage on externally funded schemes.
- During September the Capital team will be following up with Procurement & Project Leads to ensure expenditure is being committed or slippage flagged so that funds can be re-prioritised.
- Slippage is reported to Capital Management Group and action agreed by CMG to ensure schemes can be brought forward from 2023/24 to ensure CDEL can be spent. Changes to the Capital plan are reported to Trust Management Committee.
- The Trust's application for Emergency Capital funding for £9.9m has been reviewed by NHSE South West Capital Team. The Trust has provided feedback and the claim is now with the National Team for review.

# Board Committee Assurance Report

| Charitable Funds Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Paul Lewis** | **Paul Lews** | | **3 August 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 | A | G | We reviewed the Fundraising Report and agreed to adjust our Risk Assurance Level from Green to Amber due to the developing situation with cost-of-living implications which could have a detrimental impact on our Fundraising plan for this year. We received assurance that we have actions in place to mitigate this, but the external risk factors are becoming increasingly concerning. | Review progress at the next meeting. | November 2022 meeting |
| Financial Position | G | G | The Finance position is well controlled and no concerns were raised. | Review progress at the next meeting. | November 2022 meeting |
| Cases of Need | A | A | The changes made to improve the Cases of Need process have had a positive impact. There is still scope to further improve the Divisional Director's levels of understanding and ownership, but additional actions are in place to address this. | Review progress at the next meeting. | November 2022 meeting |
| 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. A detailed plan for this is being developed including a key focus on communications to ensure there is appropriate staff engagement before the specific changes are implemented. | Review progress at the next meeting. | November 2022 meeting |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Finance Strategy | A | A | The Finance Strategy paper was reviewed in detail and further actions were agreed to further develop our thinking and approach. We agreed the need for a 'low risk' investment approach alongside further scope to maximise shorter term interest rates where appropriate. The agreed actions will be reviewed again at the next meeting. | Review progress at the next meeting. | November 2022 meeting |

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

# Board Committee Assurance Report

| Audit, Risk & Assurance Committee | | | |
|---|---|---|---|
| **Accountable Non-Executive Director** | **Presented by** | | **Meeting Date** |
| **Helen Spice** | Helen Spice | | 15 September 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 | | | |
| Annual Accounts 2021/22 – Lessons Learned | A | A | The challenges through the 2021/22 audit process were recognised by the Finance Team and Deloitte and a detailed action plan is in place to ensure that the process is robust for 2022/23. The Committee challenged some aspects of the plan and in addition to some specific actions, requested improved communication with the Audit Committee and speedy escalation of issues. The Committee also requested a more detailed review of the key financial systems in the Internal Audit planned for later in the year. | | |
| External audit | | | All elements of the year end process including the final External Auditor's Year End Report and the inclusion of the completion certificate in the Annual Report and Accounts have been completed. | | |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Divisional Risk Review – Integrated Care and Community | A | A | Integrated Care and Community Division updated the Committee on their processes to manage risk and their actions to mitigate the risks as well as the work they are doing to review risks in conjunction with incidents to ensure their mitigations are reducing the likelihood of incidents. The Committee were pleased to note the actions being taken to mitigate the 15+ risks but as some of these actions are not fully embedded as long term solutions the assurance on actions was rated Amber rather than Green. | | |
| Risk Register Report | A | A | The Committee continue to be assured that the processes for managing risk in the trust are effective and the completion of the Datix roll-out is providing the ability to improve the management of risk across the Trust. There has been a significant reduction in the number of overdue risk reviews since the last report. However the Committee continue to be concerned on the number of overdue action and risks with no actions and asked for this to be escalated to the Executive Committee for review and action. | | |
| Internal Audit – HFMA Financial Sustainability Audit | G | A | The Committee received the terms of reference and timeline for the completion of this audit which NHSE/I has required all trusts to commission. The Committee is content with the plan but raised some concern that the outcome may not provide the assurance that the actions required to improve financial sustainability are completed. | | |
| BDO Internal Audit Progress Report | G | G | BDO confirmed that work is progressing well against the 2022/23 internal audit plan and they do not see any challenges in completion of all the work planned for the year. | | |
| Internal Audit – Divisional Governance Structure x | A | A | The Divisional Governance Structure Report was rated substantial assurance for design and moderate assurance for operational effectiveness. Concerns were raised by the committee on the lack of clinical staff engagement in Divisional Board meetings. It was agreed that this should be escalated to the Quality and Safety Committee for review by the Chief Medical officer. Clinical input is critical not only here but for example clinical input will be vital for the EPR project. | | |
| Internal Audit – Workforce and Finance Management | R | A | The Workforce and Finance Management Report was rated moderate for both design and operational effectiveness. The Committee raised concerns on the potentially significant impact of the lack of operational control at a time when the Trust has a very challenging financial situation thus the red rating for Risk. It was agreed that it was vital that this was recognised and acted on by the Executive as soon as possible. | | |

| Key Issue | Assurance Level | | Committee Update | Next Action (s) | Timescale |
|---|---|---|---|---|---|
| | Risk | Actions | | | |
| Internal Audit – follow up of recommendations | A | A | There has been good progress since the last meeting with 8 outstanding recommendations completed, including the implementation of actions to address the high rated recommendation on the WHO checklist. The Committee however raised concerns on the long term outstanding recommendations and asked the Executive to review and report back at the next meeting. | | |
| Counter Fraud Progress Report | G | G | The Committee noted the progress and the two allegations that had been received which have been closed with no action required. | | |
| Annual Report of Security Management | G | G | The Committee received the Annual Report on Security Management and were pleased to note the significant reduction on incidents of violence and aggression against staff. The Committee noted the plan for 2022/23 and were content with the actions being taken but recognised that there are some important risks currently rated red and amber that need to be completed this year. | | |

| Issues Referred to another Committee | |
|---|---|
| **Topic** | **Committee** |
| Internal Audit Report – Divisional Governance Structure | Quality and Safety Committee |

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Equality, Diversity and Inclusion (EDI) Annual Report, 2021-2022** | | | | |
| **Meeting** | Trust Board | | | | |
| **Date** | 06 Oct. 2022 | Part 1 (Public) [Added after submission] | x | Part 2 (Private) [Added after submission] | |
| **Accountable Lead** | Jude Gray | | | | |
| **Report Author** | Patrick Ismond | | | | |
| **Appendices** | Included with report | | | | |

**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 EDI Annual Report for 2021/2022 provides evidence of progress and achievements during the period, and the commitment to equality, diversity and inclusion. Specifically, the focus is on:

- Evidence of EDI progress and achievements during the period for our workforce, and our patients;
- A demographic profile picture of our staff and patients, through data on their personal protected characteristics (mainly age, ethnicity, disability and gender);
- An outline of the range of staff and patient services we have developed to improve patient care (including the creation of a new staff network), and better support our workforce.
- An outline of Trust performance in relation to the national context of statutory, mandatory and regulatory requirements.

The annual report is informed by our EDI Strategy, 2020-2024. A key message of our Strategy is the commitment to move beyond compliance. This means providing evidence that we are being proactive, heading in the right direction, and that equality and inclusion for all is inherent in everything that we do.

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

| | | |
|---|---|---|
| – risk number & description (Link to BAF / Risk Register) | | |
| **Consultation / Other Committee Review / Scrutiny / Public & Patient involvement** | This report has been to both TMC and P&C in August | |
| **Next Steps** | | |

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

Explanation of above analysis:
The report identifies where those in protected groups are treated less favourable. The report provide assurance on progress against the EDI strategy and actions for continuous improvements.

**Recommendation / Action Required**

The Board/Committee/Group is requested to:

- **The Board to note the finding and support the future actions**

| | |
|---|---|
| **Accountable Lead Signature** | Jude Gray |
| **Date** | 06 September 2022 |

NHS
Great Western Hospitals
NHS Foundation Trust

# Equality, Diversity and Inclusion (EDI) Annual Report
## 2021-2022

Equality, Diversity & Inclusion

# EDI Annual Report (2021-2022)

## Contents

# Our Commitment

**Kevin McNamara**
Chief Executive

Over the last year, we have been working hard to embed the objectives we set out in our Equality, Diversity and Inclusion strategy across the organisation.

We promised to be vocal advocates and allies for all the people we serve - including our staff, patients, visitors and our local communities - by challenging all forms of discrimination and supporting thriving networks to give our staff a stronger voice.

All of this is so we can keep celebrating and championing diversity, across an organisation that is open and transparent, but we know we can't achieve our ambitions alone. We're stronger working with others, and together we can make a real difference to people's lives.

One of our biggest steps forward in this approach is by becoming an Anchor organisation. This means bettering the lives of the people in our communities, by working collaboratively to share what we have and providing opportunities for people to improve their health and life chances, for example through expanded employment opportunities – all of which benefit the whole of Swindon and the surrounding areas.

We are now working closer with patients, families, carers, local faith leaders and community groups to listen, understand and share ideas that will make all of our organisations more inclusive, supporting and in touch with our communities.

Internally, we've established a new staff network, the Differently Abled Network, to run alongside our existing BAME and LGBQT+ Networks and all three are active, vocal, and proactive in championing change at every level of the organisation.

We are also accredited as a Veteran Aware organisation, offering dedicated support and guidance to staff and patients who have linked to the Armed Forces; including our veterans, reservists and spouses.

Our Trust Board and senior staff management are more representative of the population it serves, and we are focusing on providing all applicants with equal opportunities to not only join our NHS Trust, but to thrive as a valued member of our NHS Trust family.

Despite this good work, we know there is much more we need to do. Evidence suggests that some people in our community – our friends, relatives, and neighbours – having poorer health outcomes because of their financial position, ethnicity, sexuality, or a disability. This is simply wrong.

We will be exploring how we can maximise the contribution we make to local communities in terms of reducing health inequalities, supporting employment, and promoting overall health.

The NHS is the greatest symbol of what it means to live in a compassionate society and diversity, and inclusion is central to that and in how we serve our local community and our staff better.

# EDI Annual Report Summary

The Equality, Diversity and Inclusion (EDI) Annual Report for 2021-2022 seeks to present an 'holistic portrait' of our staff and patients, through data on their personal protected characteristics (mainly age, disability, ethnicity, and gender). Alongside this, the report outlines the range of services we have developed to improve patient care, and better support our workforce.

The supporting efforts have assumed an added importance when we reflect on the long-term impact of the Covid-19 pandemic, which continues to place our staff under increased levels of pressure, and calls for monumental levels of resilience.

A summary of our progress against national reporting requirements is also included, focusing on the gender pay gap, and workforce improvement standards for 'race' and disability.

Over the last year, our workforce has remained relatively stable, with a small net increase in the numbers of Whole Time Equivalent staff. As per last year, the highest staff numbers are in the area of Registered Nursing and Midwifery. Our workforce continues to be predominantly female, aged between 26 and 60 years, and identifies as White British. This profile also reflects the national picture. Alongside this small net increase, our Black, Asian and Minority Ethnic (BAME) workforce has grown by around 21% since last year, and data collection on ethnicity reveals an increasingly wide range of backgrounds, and countries of origin (see *A Note on the use of the acronym BAME*, page 34).

The picture for staff and patients appears less certain when we consider other protected personal characteristics – specifically religion and belief, sexuality and disability. We recognise that our data collection in these areas is uneven, inconsistent, and therefore not necessarily reflective of the organisation as a whole. We adopted a new data collection system in September 2021 that will help to standardise and improve consistency levels when it comes to data collection. Alongside this, we continue to work with staff to understand and address their fears about data safety, and to re-emphasise the importance of data collection, as a way to improve services. For the first time, we are also collecting data on the trans status of our patients and workforce, to better support this group.

We're seeking more ways to ensure that our patients' voices are heard, and learn from their experience. In 2021, we launched our Patient Experience and Engagement Framework, to facilitate that process, and are working more closely with Swindon's BAME groups to better provide for their health needs.

Where possible, we have compared our position with that of our local partners in the **Bath and North East Somerset, Swindon and Wiltshire Integrated Care System**. The significance of partnership working is vital to combat long standing health inequalities and to create a compassionate, equitable and inclusive workplace. Datasets extracted from the South West Workforce Planning and Intelligence Systems Information Pack were used to create a quarterly report for the BSW/South West Region, and any compatible metrics have been taken from the report released in December 2021.

Our overall ambition for EDI within the Trust is to empower our diversity networks to be able to implement the actions prioritised by the ED&I Group, and for the networks to drive the agenda going forward. The forewords to our national reports have been provided by our network leads, reflecting this commitment.



**Dr Patrick Ismond**
Lead for Equality, Diversity & Inclusion

# Our Patients

# Our Patients

Tania Currie

Tania Currie (left), Head of Patient Experience and Engagement continues to strive to ensure that we are engaging with our patients, their families, carers and the wider public, including with some of the seldom heard and minority groups. Over the last year we have increased this feedback and engagement which is vitally important to ensure that the patients voice is heard and that our development work includes their views.

Moving forward we want to expand the opportunities for public members to work with us as joint partners in-order to influence improvements and we will ensure that this engagement work is central to our new Improving Together programme. Patient, Carer and family representation bring important views, perspectives and challenge to the work that we are doing. We have advertised opportunities for public members to become involved in three key areas of work:

- The Way Forward Programme
- Quality Improvement
- Recruitment

We continue to work closely with system partners including:- Healthwatch, Voluntary Action Swindon, Bath & North East Somerset, Swindon and Wiltshire CCG, Swindon Equality Coalition, Maternity Voices Partnership, Learning Disability Partnership Board, Disability Experts and Swindon Children's and Young Peoples Participation network.

**Some Collaborative Working Partners**

Voluntary Action Swindon

healthwatch Swindon

NHS
Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group

SWINDON EQUALITY COALITION

Bath & North East Somerset, Swindon and Wiltshire
Maternity Voices Partnership Plus
Working in partnership to improve maternity services


## Patient Experience and Engagement Framework

In 2021 Tania Currie launched our new Patient Experience and Engagement Framework. The document, that was jointly created with staff and patients, articulates our commitment to increase opportunities for patients, families and cares to provide feedback and to become involved in our work.

We are working to provide more opportunities for people across Swindon and Wiltshire to get involved in improving their local healthcare services, and the Framework provides the chance to directly feed into our improvement and development plans with a specific focus on better engagement with some of the seldom heard and minority groups.

# Our Patients

## Care Reflections

We are developing a suite of 'Care Reflections' with a dedicated intranet site that closely links to our Learning Zone. These reflections recount real life patient and family stories and provide an excellent resource for staff to reflect and learn from their experiences. The stories articulate relevant learning and improvements but also feedback from staff about receiving this feedback. One particular story reflects on the experience of a patient who is a wheelchair user and her planned attendance at an outpatient's appointment. Her experience was very poor but learning, actions and improvements have been made as a result and are reflected in the short Care Reflection film that is available online. The film can be viewed here.

## Accessible Information Standards

Work to further embed the national Accessible Information Standard (AIS) is ongoing and we are working to ensure that information can be read, received and understood by the individual or group for which it is intended. We also provide individualised communication support when it is needed to enable effective, accurate dialogue between a professional and a service user.

The trust webpage now contains links to the 'My Needs' form for patients to electronically submit AIS requirements. Family, friends and carers are able to submit the form on behalf of patients or any requests can also be raised on attendance at the hospital or with their GP. We are continuing to promote awareness through a Trust Communications campaign, both internally and externally which includes through our Social Media channels as well as hospital wide signage/posters and business cards in patient facing departments.

Through new IT software, Prism Synertec, we are now able to ensure that hospital letters are sent to patients in the applicable format identified by them. This may include for instance; large print, easy read, a language other than English or Braille. We have implemented specific AIS staff Training and are also working closely with the specialities who have large cohorts of patients with AIS requirements.

# Our Patients


## Carers

The Head of Patient Experience and Engagement has become the new Carers lead for the trust. Following COVID the focus on Carers requires some review and awareness raising once again to ensure appropriate provision and support is in place across the trust.

Our Carers café, Information service, Carers passport and Staff carers support are all being relaunched. We are also working towards achieving a Carers Accreditation Standard for out outpatients areas.

## Volunteers Patient Experience Forum

A new Volunteers Patient Experience Forum has been set up in order for the Head of Patient Experience and Engagement to meet regularly with volunteers and the team managers. The forum provides the opportunity to ensure that the Volunteers are sighted on any key challenges for the clinical teams so that their resource can be appropriately directed. A recent focus was directed towards loneliness and isolation, with volunteers working to provide meaningful engagement and support virtual visiting and telephone calls to family and friends, particularly for some of our most vulnerable patients.

**Bath and North East Somerset, Swindon, and Wiltshire (BSW) Collaborative working**

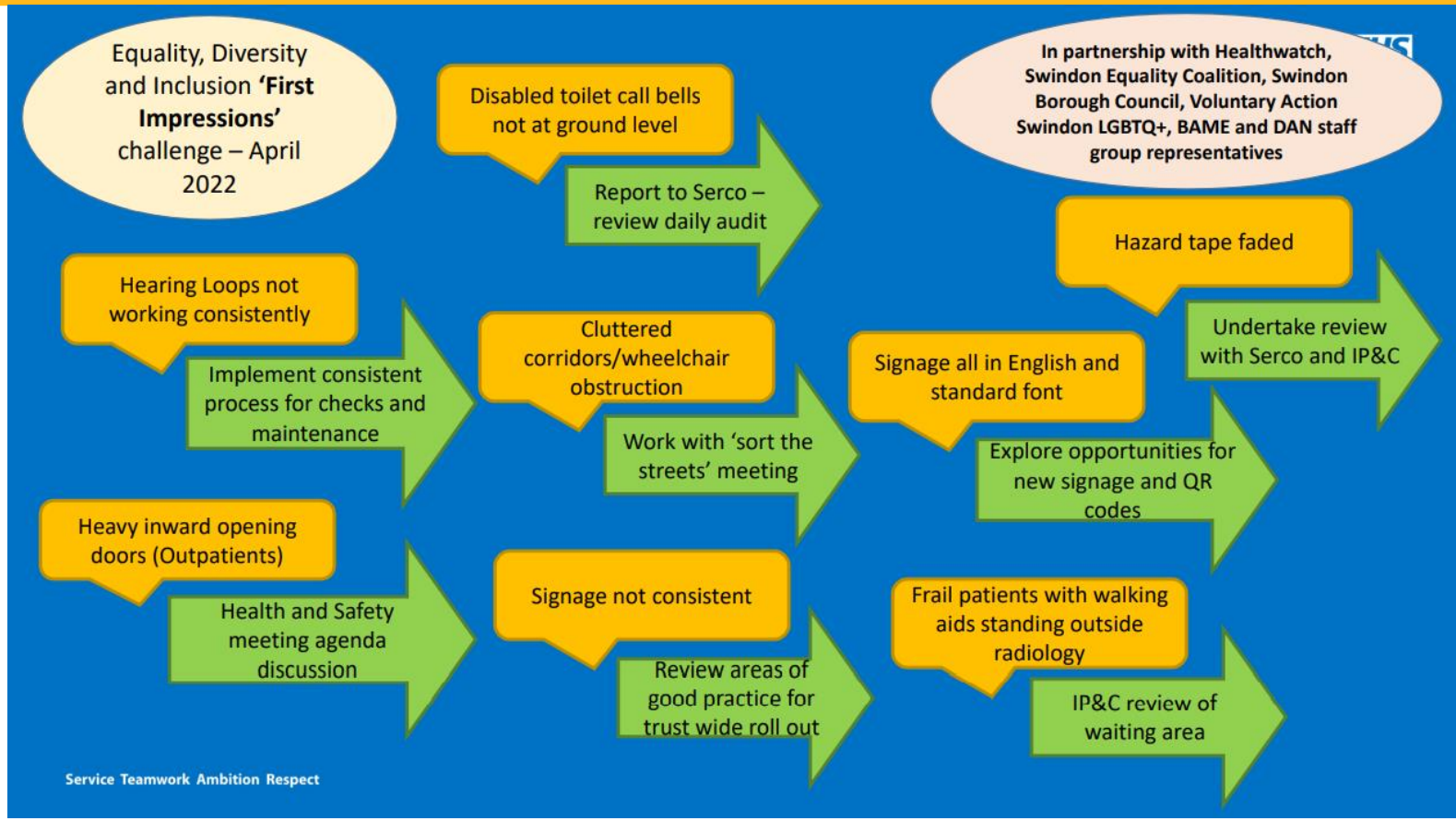
We are working closely with BSW colleagues including with the new BSW Academy which is enabling collaboration across health and care services for the benefit of staff and patients. The academy provides five core pillars of focus: Leadership, Learning, Inclusion, Innovation and Improvement.

As part of the BSW EDI strategy group we are linking with the Academy to introduce standardised training aimed at ensuring our staff better understand health inequalities and social injustice.

# Our Patients

## EDI First Impressions Challenge

In April we undertook our first ever EDI focussed 'first impressions challenge'. The process was based on a previous national 15 step challenge programme but specifically reviewed how accessible and inclusive areas across the Trust were. We were joined by staff from our BAME, LGBTQ+ and DAN groups along with public members from Healthwatch, Swindon Borough Council and Swindon Equality Coalition. Small teams visited and reviewed some of our inpatient wards, outpatients departments and communal areas across the Trust. Feedback and actions are outlined in the graphic (opposite).




## Trans Toolkit

A toolkit to support caring for patients from our Trans community is currently in production. The toolkit will help to raise awareness and understanding and provide guidance and advice for staff caring for patients, in order to ensure that the care is individualised, sensitive and appropriate. The toolkit is being devised in conjunction with members of our Trans community and advice from the West of England Specialist Gender Identity Service.

# Our Patients

## Interpreting and Translation Services

Our interpreting and translation services continue to grow in use. The main languages that we are asked to translate are Urdu, Polish and Konkani (the official language of Goa). We continue to offer face to face, telephone, Skype and Sign Live (British Sign Language, BSL) services to ensure effective communication. There are around 360 interpreting requests each quarter, including for face-to-face interpreters, and these services can be booked in advance if the patient has a planned attendance, or on the day for urgent and emergency attendances.

We also have an Eye Care Liaison Officer in place at the hospital to provide additional support in our Ophthalmology department.

We plan to undertake a Trust wide audit in summer 2022 to review all communication devices across the Trust and ensure that the necessary provision is in place, along with staff training and awareness.

Our Patient Information Leaflets are available in all languages, formats, and easy read and many of these leaflets are available via the Trust website for patients to access themselves.

## Changing Places

Our new Urgent Treatment Centre opened this Summer, and includes a specially designed accessible bathroom facility. We also have a similar facility in our Children's unit.

These facilities will meet the Changing Places accreditation standard to ensure that both children and adults accessing our service have access to appropriate facilities.

# Our Patients

## Swindon Participation Network

We have recently joined Swindon Participation Network who are a multidisciplinary, multi-organisation group of interested parties working closely with vulnerable children and their families. The Network links closely with Wiltshire and Swindon Youth Commission in- order to engage and gather specific feedback from Children and Young people whilst also supporting joined up training across the partners.

## Next Steps

In the coming months further work will be focussed on hearing more feedback from seldom heard groups. This will include a series of workshops/drop in opportunities in the community with the aim of:

- Us demonstrating our commitment to the EDI agenda and explaining the work that we are doing
- Understanding what is important to that particular community from a patient experience point of view, what adjustments are needed if any
- Understanding any health inequalities for the community, why they may not access health care and explaining how outcomes could be improved

We are also working closely with the Maternity Voices Partnership to target feedback opportunities with some of the groups who often do not respond to our traditional survey methods including young mums and families whose first language is not English.

# Our Patients

## The Learning Disability (LD) Service

For a long time, people with learning disabilities and their advocates have been fighting for equality with the rest of the population. While progress has been made, there is still some way to go. People with learning disabilities still suffer inequality of treatment in healthcare settings and can face barriers to accessing healthcare that people without learning disabilities do not. The Covid-19 Pandemic has accentuated these difficulties. The LD agenda remains a priority for our Trust, and there is a wide range of activities to support people with learning disabilities in our locality. Principal among these is the **Learning Disability Forum**, which:

- Delivers an annual work plan, to reduce inequality of access to healthcare. The Trust has an established patient feedback programme to ensure the patient is at the heart of all our service delivery and planning (although this was paused during the Covid-19 Pandemic).
- Is chaired by the Associate Director for Safeguarding and has a collaborative working model with multi-professional engagement from the acute site, community, service users, carers, community care providers, advocacy groups and the Primary Care Network (or PCN).

## Key Achievements 2021-2022

- Employment and development of two LD Liaison Nurses (1.0wte/Job share) to ensure staff are supported to provide reasonably adjusted, high quality care to patients with LD.
- Delivery of the annual workplan reflecting learning from National Report recommendations (Learning Disabilities Mortality Review, or LeDeR), local need (Swindon JNSA) and local intelligence data.
- Development of the Learning Disability (LD) Liaison Nurse role at the Trust.
- Learning Disability liaison oversight of quality of care and auditing of care experiences for inpatients and day case admissions.
- Development of an ‘easy read’ patient feedback form for use on the Trust intranet.
- Design, development, creation, and Implementation of a new ‘Enhanced Care’ process (including documentation) to support appropriate delegation of 1-1 care provision.
- Development of a Complex Care admissions care pathway for day case admissions.
- System/partner agency collaboration: Trust attendance and contribution at the following Boards: Learning Disability Partnership Board (LDPB), Autism partnership board, Suicide Prevention Group and Domestic Abuse forum (DA and WAGV).
- Through the Associate Director of Safeguarding, practice is monitored, and risk identified and acted on through established internal systems and processes‘. Learning from incidents in relation to LD practice is a standing agenda item at the following meetings: MACS Forum, LD Forum, and Mental Health Governance Committee (MHGG).

## Learning Disability Support in the Trust

Jade Pearce

Sue Ellingham

The Trust has two Learning Disability Liaison Nurses, Sue Ellingham and Jade Pearce (both above).

Their main role is to improve health outcomes, inequalities, and experiences for patients with a learning disability accessing our services, including inpatients, and planning for admissions/ attendances, in addition to supporting patients with Autism that do not have a learning disability.

# Our Patients

## Changes Places Bathroom

‘Mums on a Mission’ group viewing the facility (above).

Changing Places Bathrooms are for people who need accessible toilets and changing areas who are unable to use the standard accessible toilets. Equipment is provided in these areas to help support people and their carers to use these facilities.

The Trust has a changing place bathroom in the new onsite Radiology Centre and Changing Places bathrooms in the Urgent Treatment Centre and the Children’s Unit. This means people with disabilities have a safe, clean place with everything they need on site and protects their dignity.

Changing Places Facility (top, left)

## Primary Care Network

LD Annual Health Checks are currently provided one day per week. The Annual Health Check includes putting a health action plan in place that includes early cancer screening. The service is moving along well and seeing good progress. Four care homes link into the Primary Care Network and are aligned to GP Practice’s. All residents in the care homes have received an annual health check. This is tremendous work by the team.

## Learning Disability (LD) Education

The use of the LD education toolkit is now established in the HCA Academy curriculum and has been well evaluated to date. Over the year training was provided to ED doctors (all grades), theatre staff, foundation doctors and to newly recruited Health Care Assistants in relation to LD practice.

## Children’s Services

Children’s LD/Autism has been added as a separate item to the LD Forum meeting agenda. The LD work plan for 2022/23 will include Children Services.

Our Trust was an early pioneer of children’s Hidden Disabilities Lanyards.
Any child arriving to hospital for an appointment, who has a hidden disability, can collect a lanyard from reception and staff know to tailor their care to meet the needs of the patient.
Above, children’s ward staff and children in their lanyards.

## Dementia Care

The LD Liaison Nurses are linking in with Admiral Nurses at GWH to identify areas of work where processes/ pathways cross over/ can be shared.

Admiral Nurses, above

**NHS England & NHS Improvement Learning Disabilities Year 4 Improvement Standards for NHS Trusts – Audit**
The audit allows the Trust to monitor its progress as to how well we meet the needs of people with Learning Disabilities.

The Trust was requested to submit data for the audit. 100 x Patient Service User questionnaires were sent out by GWH to patients as per the NHSI request. A Staff Survey link was circulated to key areas in GWH, 50 surveys required and completed. Trust data uploaded and submitted. The Trust are currently awaiting the report from the NHSI team.

# Our Patients

## The People We Serve

During the financial year 2021/22, Great Western Hospitals NHS Foundation Trust cared for 149,858 patients, from new born babies to people aged 90 and over. Information on these patients can be seen in the infographic below, which contains basic demographic data for all individual patients who had contact with the Trust during the aforementioned 2021/22 period.

At present, we do not have access to the level of data that would indicate sexual orientation or disability. However, ethnicity, religion, gender and age range are recorded. We have reviewed the way equality data is recorded in the Trust, and we hope to have a more detailed picture in our next report.

**149,858 Patients**

### By Sex

- 68,008 Male
- 81,809 Female
- 41 not specified

### By Ethnicity

- 85% (126,777) – White
- 9% (14,182) – BAME
- 6% (8,899) – not Stated

### By Religion and Belief:

- 33,887 – Church of England
- 23,106 – Not Known
- 14,981 – Other Religion
- 9,650 – Catholic
- 50,824 – Not Religious
- 1,852 – Muslim
- 456 – Sikh
- 282 - Agnostic
- 1,220 – Hindu
- 98 – Spiritualist
- 85 – Jewish
- 77 – Pagan

### By age:

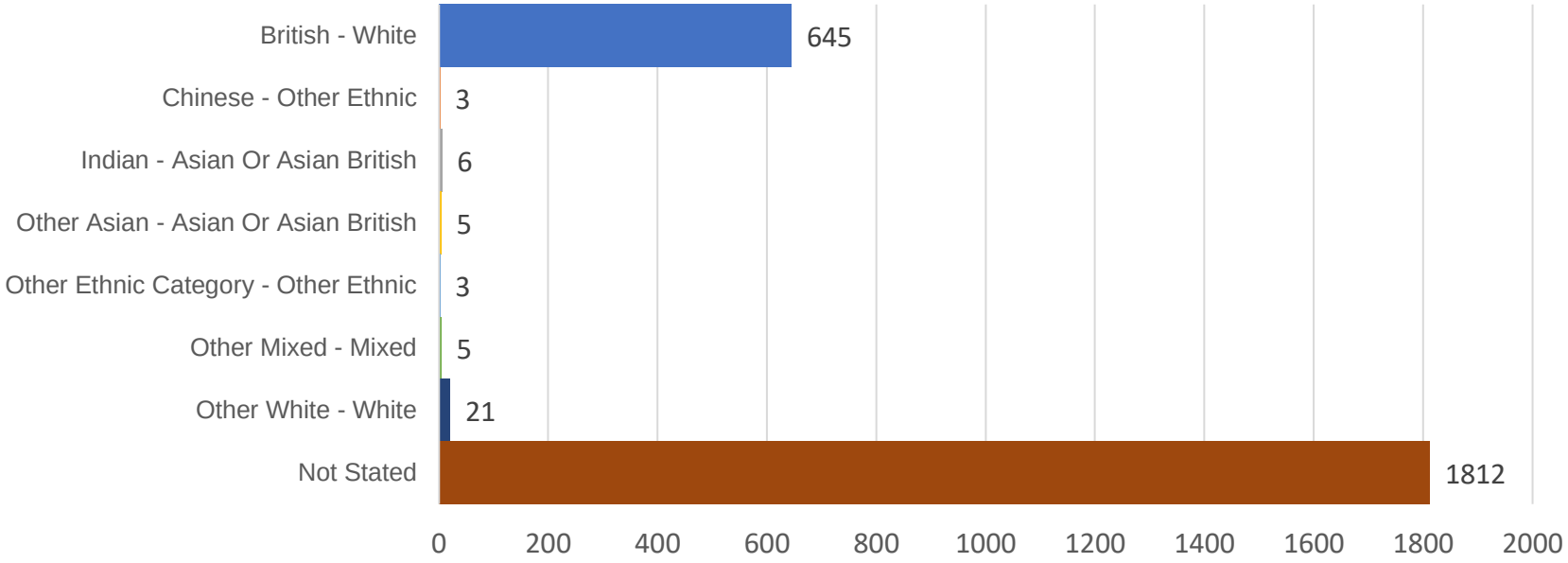
- 0-9 yrs – 15,900
- 10-19 yrs – 11,276
- 20-29 yrs – 14,615
- 30-39 yrs – 18,529
- 40-49 yrs – 16,696
- 50-59 yrs – 20,562
- 60-69 yrs – 18,562
- 70-79 yrs – 18,563
- 80-89 yrs – 11,857
- 90+ yrs – 3,298

**Note**:

The data sets include all patients who have had either an outpatient appointment; an Accident and Emergency (A&E) attendance; an inpatient admissions visit, and any contact by the community nursing team. The data set only counts individual patients once, so even if they had multiple A&E or Outpatient attendances (for instance) they would only appear once in the data. Also excluded are missed/cancelled appointments and a community home visit. Data sets also include all patients seen at our GP Surgeries.

# Our Patients

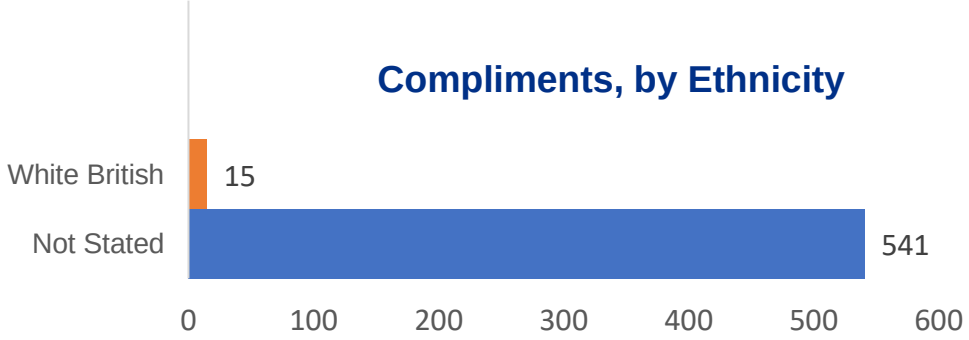
## Complaints and Concerns, by Ethnicity




Data on complaints and concerns (opposite) is aggregated, data on compliments appears below. All data is for the period April 2021 to March 2022.

Our new data system has enabled us to gather more detailed information on ethnicity, than in previous years.

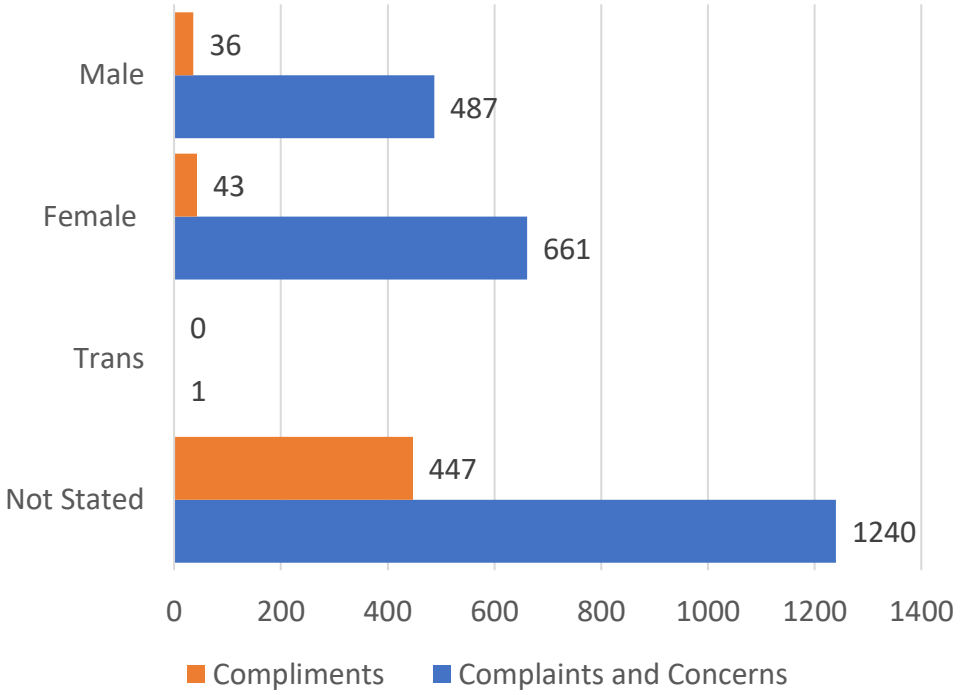
## Compliments, by Ethnicity



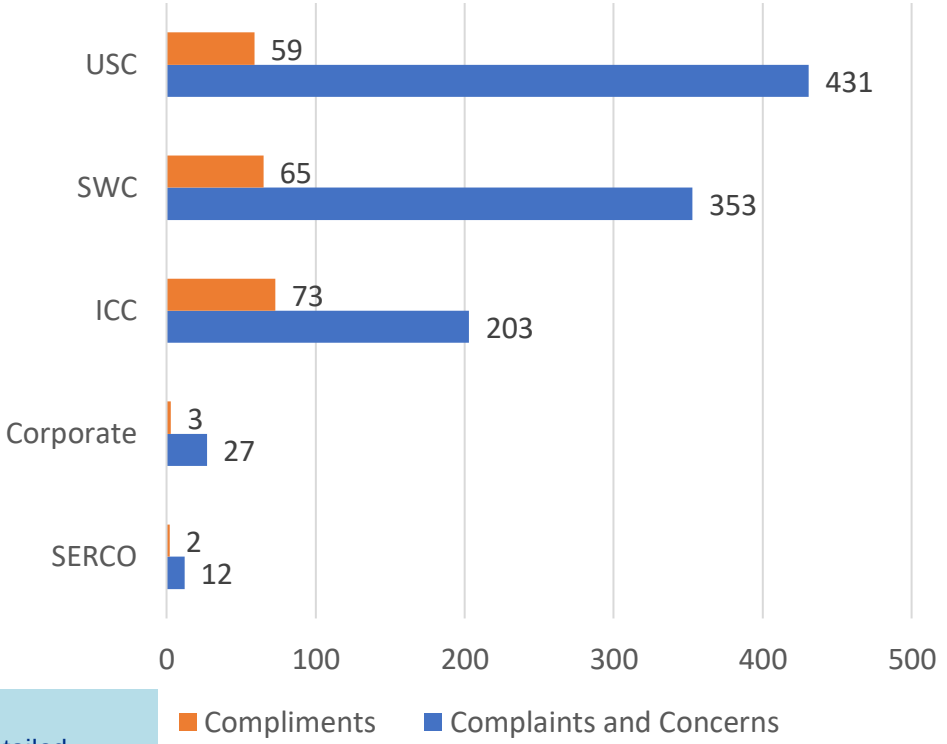

**Note**
No compliments were received, apart from 'White British' and 'Not Stated', so the other categories have been removed

# Our Patients

## Complaints and Concerns / Compliments By Gender




## Complaints and Concerns / Compliments By Service




**Notes**

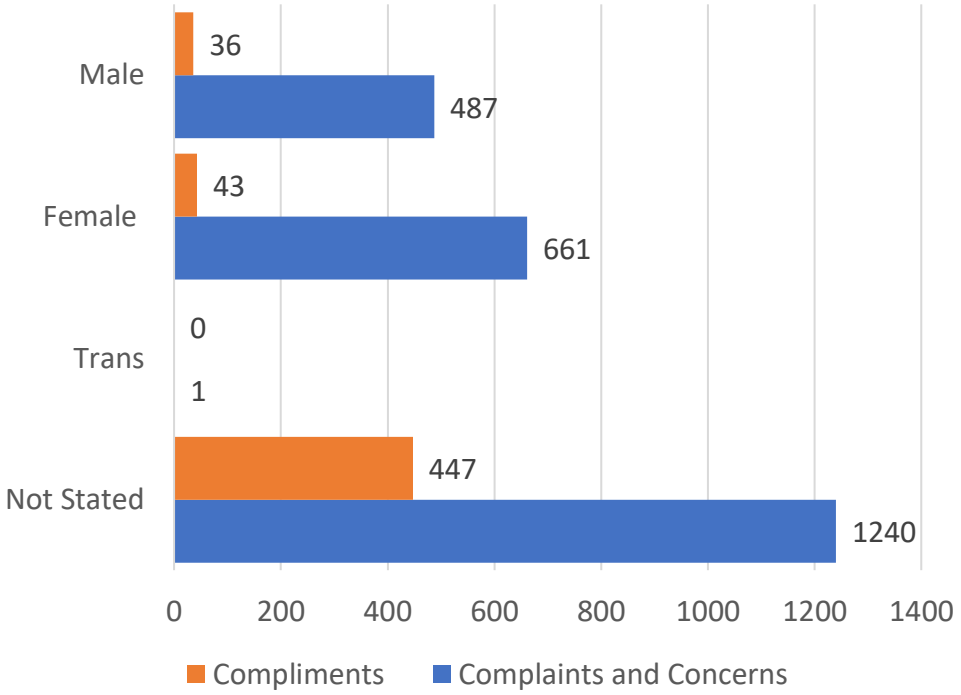
Following a change to our data systems in September 2021, we are able to gather more detailed information on personal protected characteristics. For the first time, our recording system has included people who identify as *Trans* (see elsewhere in this report also). The recorded data shows we received one complaint from a Trans patient.

The recorded data shows that our Unscheduled and Planned Care divisions receive the most concerns and complaints. These are also the areas that record the highest patient numbers. ICC recorded the most compliments.

Following the above mentioned system change, data from last year is not directly comparable, but our USC received 20 fewer concerns and complaints, and 83 fewer compliments, than last year; whilst our Corporate Services received 47 fewer complaints and 14 fewer compliments than last year.

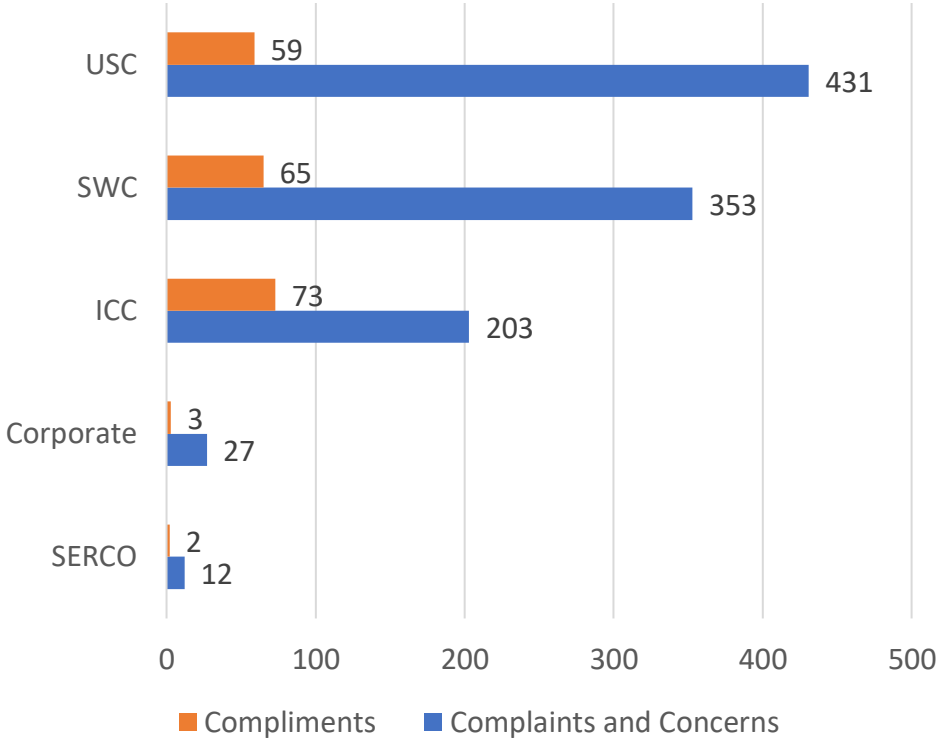
# Our Patients

## Complaints and Concerns / Compliments By Gender




Following a change to our data systems in September 2021, we are able to gather more detailed information on personal protected characteristics. For the first time, our recording system has included people who identify as *Trans* (see elsewhere in this report also).

## Complaints and Concerns / Compliments By Service




The recorded data shows that our Unscheduled and Planned Care divisions receive the most concerns and complaints. These are also the areas that record the highest patient numbers. ICC recorded the most compliments.

# Our Patients

## The Chaplaincy Service

The Chaplaincy Service is religion-non-specific, denominationally neutral, and thus able to offer generic spiritual and pastoral care to all patients and their carers, family and friends, staff and volunteers to help deal with the experiences of illness and injury, life and death and to process issues of personal meaning and purpose. Chaplains are trained and experienced in listening to and supporting people in difficult situations and offer a sensitive and discreet support. The team can also help with cultural and religious routines and rites of passage.

Rev Christopher Mattock
Chaplaincy Team Leader

**"Chaplains are trained and experienced in listening to and supporting people in difficult situations and offer a sensitive and discreet support. The team can also help with cultural and religious routines and rites of passage."**

Rev George Mireku-Yeboah

Rev Jean Brown

We have one whole time Lead and two part time Chaplains supported by 33 chaplaincy volunteers from a range of social and religious backgrounds. Chris Mattock our chaplaincy team leader is a Baptist Minister, George Mireku-Yeboah a part time chaplain is an Assemblies of God Minister and Jean Brown also a part time chaplain is a Church of England Priest. We currently have one honorary Chaplain, Jacob Frimpong a charismatic Pentecostal Christian Pastor who is studying for a Masters Degree in Healthcare chaplaincy. During the next 12 months our aim is to have 4 more honorary Chaplains from Muslim, Sikh, Hindu and Pagan religious backgrounds.

Our Roman Catholic Chaplaincy is provided by the Swindon RC Deanery with a Priest on call 24/7 via a dedicated mobile and the Roman Catholic Diocese have provided prayer booklets for staff and families to use with end-of-life patients. We have reinforced links with the Thamesdown Islamic Association, Swindon Hindu Temple and the Pagan Federation Hospital Ministry.

The Chaplaincy Centre and multi-faith room is on the First Floor of the hospital, near Main Theatres and the Daisy Unit. It is open at all times for reflection, quietude and if wished, prayer.

Local religious communities and faith groups supply the chaplaincy with a range of religious texts from the major world religions to be available for staff and patients.

Within the multi-faith room are artefacts from the Christian, Muslim, Sikh, Hindu, Buddhist and Jewish religions kept in bespoke cabinets which can be opened, or closed, as appropriate.



**Reverend Christopher Mattock**
Chaplaincy Team Leader

# Our Patients

## The Chaplaincy Service

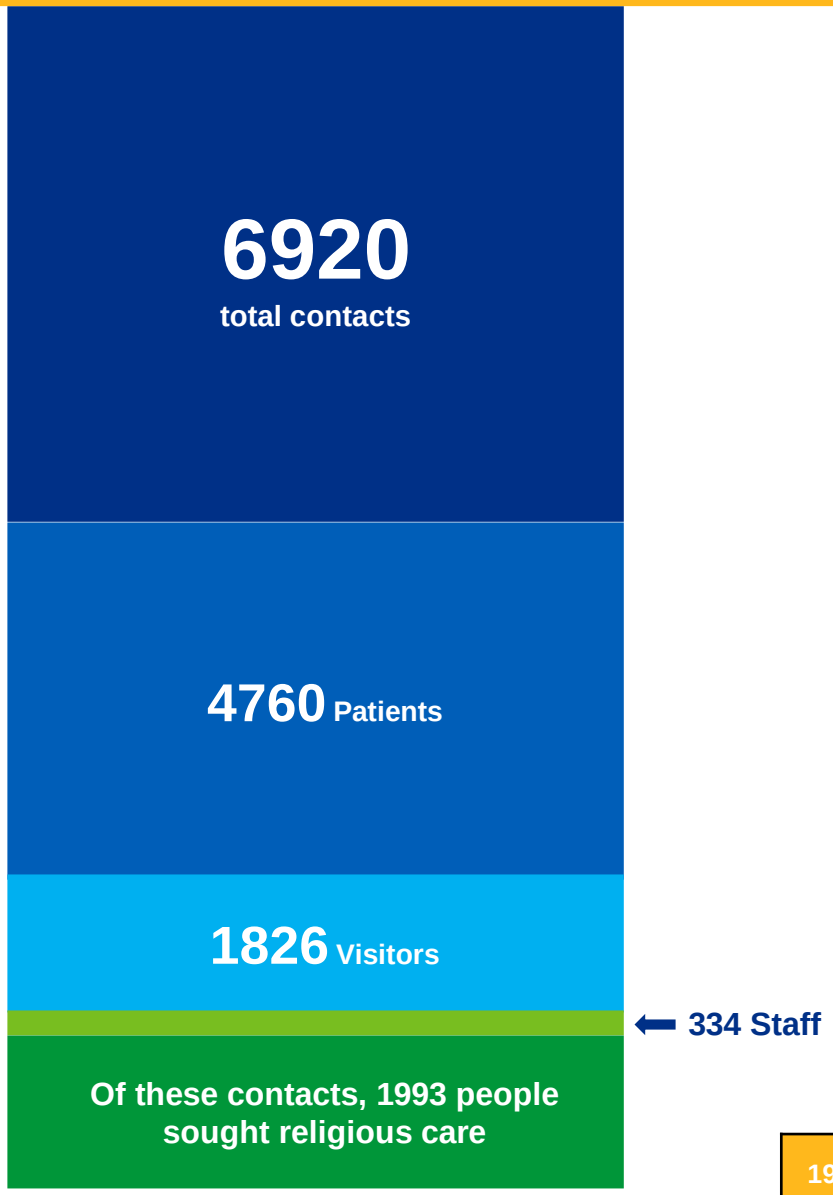
As the Pandemic reduces our chaplaincy volunteers are making a gradual return and our regular teaching and training is beginning to increase. In 2020 we were early adopters of virtual visiting technology using iPads and mobiles phones to assist families of patients unable to visit the hospital. We were also able to use the same technology to enable local religious leaders connect with patients for prayers and other religious rituals, and this has proved to be so successful that it will continue

From the beginning of the pandemic, we have been able to keep the multi-faith room open 24/7 for private prayer and reflection, particularly as a space for staff to take time out of an intense working day or as a place for decompression following a difficult shift. We maintain frequent cleaning and sanitation and the use of disposable prayer mats to keep infection risk low.

Emergency religious contacts list has again been approved by Swindon Interfaith Group and is available to all staff on the Chaplaincy intranet page. Our lead Chaplain has been appointed to the organising committee of the Swindon Interfaith Group

Gideons International have ceased operation in the UK and Bibles and New Testaments and Psalms for patients and staff are now provided by the organisation Good News for Everyone.

The last set of meaningful statistics are from 2019 (opposite) and we look forward to returning to this level of activity in 2022/3.



# Our Staff

# Our Staff

## By Staff Group

At the time the snapshot was taken (to 31 March 2022), the Trust had 5,502 staff (by headcount). The following infographic shows the breakdown of our staff by occupational group, and where data is recorded for their personal protected characteristics. This shows that Registered Nursing and Midwifery staff group makes up the largest proportion of our workforce, whilst Non-Clinical Support is our smallest proportion.

**5,502**
**total staff**

- **1800** Registered Nursing and Midwifery staff
- **1100** Admin and Clerical staff
- **884** Unregistered Nursing and Midwifery staff
- **683** Medical and Dental staff
- **390** Scientific, Therapeutic and Technical staff
- **497** Allied Health Professionals
- **146** Non-clinical Support staff

## By Sex

The majority of our staff are female, and our figure of 83% is above the national average, according to a **recent study from NHS England,** which found that around 77% of all NHS staff are female.

**83% (4546) Female Staff**

**17% (956) Male Staff**

**Note**

These staff groups are recognised by the Trust. They differ from those used by national teams, or when data is extracted manually from the Electronic Staff Record (ESR).

Two employees on a career break have been removed from these figures, which explains the slight discrepancy when compared with our national reporting data.

# Our Staff

## By Age

The majority of our staff (15%) are aged between 31 and 35. This varies slightly from the national picture. According to **research from NHS Digital**, the largest age group employed is staff between 35-39 years.

| Our workforce by age | | | |
|---|---|---|---|
| < 20 years | 55 | 46-50 years | 655 |
| 21-25 years | 376 | 51-55 years | 655 |
| 26-30 years | 729 | 56-60 years | 536 |
| 31-35 years | 821 | 61-65 years | 306 |
| 36-40 years | 677 | 66-70 years | 70 |
| 41-45 years | 592 | >71 years | 29 |

Our Trust also has a younger workforce than the average within the BSW ICS.

| Workforce aged 55 and over | |
|---|---|
| BSW ICS Average 21.1% | GWH NHS FT 17% |

## By Sexual Orientation

| 62% (3,408) Heterosexual/ straight | 36% (1,969) Not stated/ Response declined | 0% (1) Undecided | 1% (72) Gay / Lesbian | 1% (43) Bisexual |
|---|---|---|---|---|

Modern data collection processes are safe, secure, and the results yielded are key to service improvement. Nonetheless, a sizeable proportion of our staff (36%) chose not to declare their sexual orientation. This abstention reflects a national trend, and mirrors findings from the Equality and Human Rights Commission. **Their study** found that staff felt uncomfortable disclosing their sexual orientation in a monitoring form if the reasons for being asked, how the data would be used, and whether it would remain anonymous and confidential, were not fully explained. In addition, the evidence shows that some individuals, employers and service providers still consider sexual orientation to be more 'private' than other characteristics for monitoring purposes.

138

| LGBTQ+ Workforce Declaration | |
|---|---|
| BSW ICS Average 2.4% | GWH NHS FT 2% |

This low reporting trend is also mirrored in the BSW ICS data.

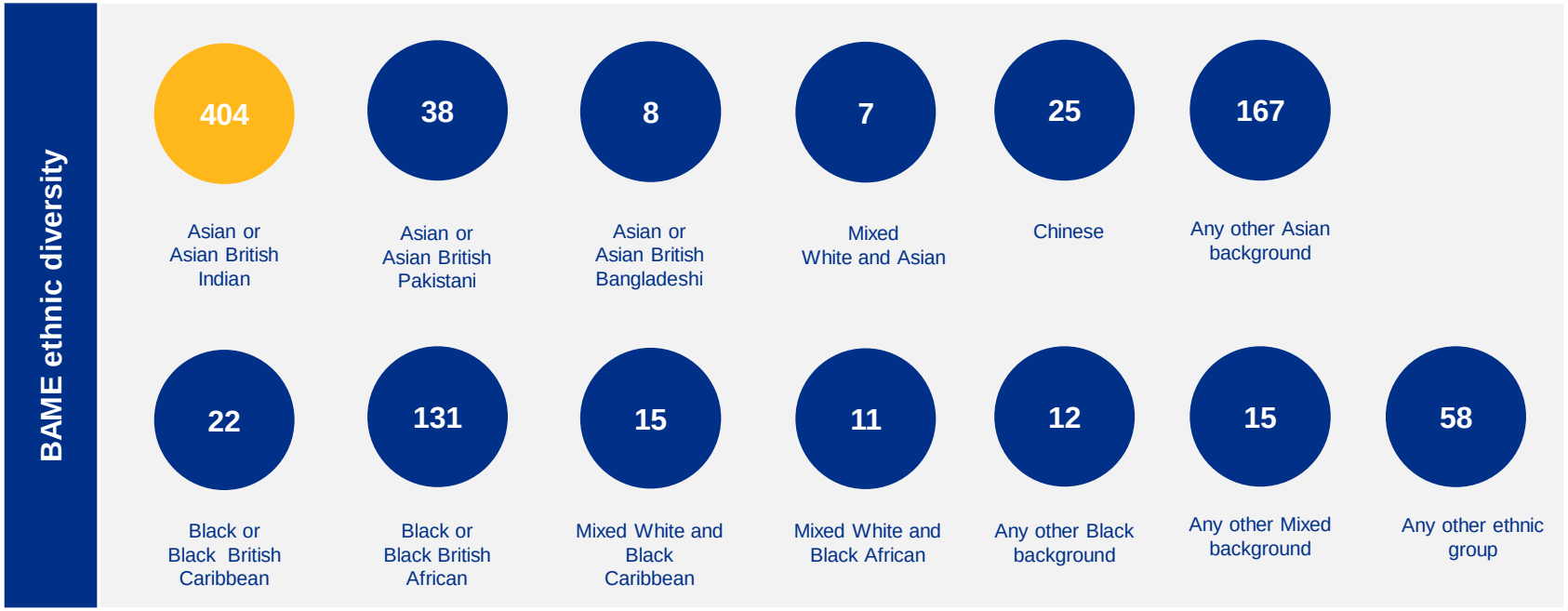
# Our Staff

## By Ethnicity


'Any other ethnic group', 'not stated' and 'Other Specified'

Whilst the majority of our staff (3598, 65%) identify as White British, there is also an additional level of White ethnic diversity to be seen when we look at data for staff with 'any other White Background'. This encompasses a range of White identities, such as White Irish, White Polish and White Greek.

In 2021/22, when this snapshot was taken, our Black, Asian and Minority Ethnic (BAME) workforce increased by 21% (193) on the previous year, and now makes up around 21% of our total workforce (headcount 1131).

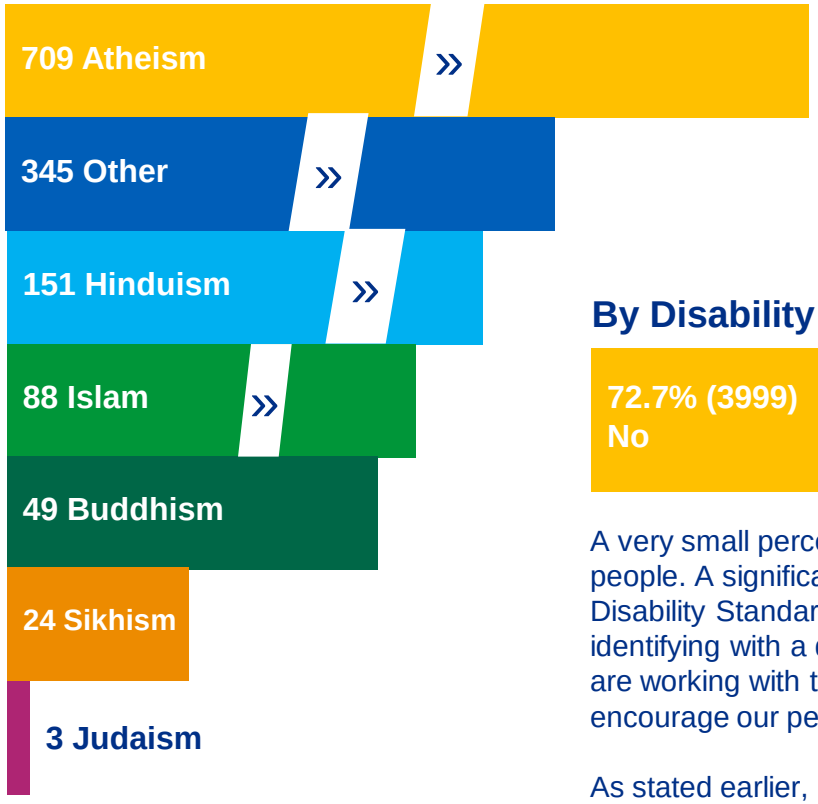



The chart opposite shows the diversity of our workforce, by BAME categories in the 2001 census.

As we have only included census categories, the total is smaller than our actual BAME staff number, which includes other BAME categories. We can see that the largest BAME minority is Asian or Asian British – Indian.

# Our Staff

## By Religion and Belief




A proportion of our staff (40%, 2203 headcount) follow the Christian faith; whilst a smaller proportion (35%, headcount 1930) did not wish to disclose their religion/ belief. The religious preferences of the other staff can be seen in the chart opposite, which shows that the majority of these staff (13%, headcount 709) identify as atheist.

**Note:**
35% of staff (1930) chose not to disclose their religion or belief

## By Disability


A very small percentage of our staff (2.4%) have indicated that they have a disability, equating to 133 people. A significant number of staff (1238) reported not know or prefer not to say. The Workforce Disability Standard (WDES) Report, findings summarised later, shows that the number of our people identifying with a disability in the NHS Staff Survey is much higher, and does not reflect this number. We are working with the Differently Abled Network (formerly called the Disability Equality Network) to encourage our people to feel confident to disclose their relevant disabilities.

As stated earlier, our Trust emphasises that data collection is safe, secure, and a vital way to improve services. Nonetheless, small numbers of staff have declared a disability. This reflects a national trend, and mirrors findings from the Equality and Human Rights Commission. The evidence shows that some individuals, employers and service providers still consider disability to be more 'private' than other characteristics for monitoring purposes.

**Note**
All numeric and percentage charts on pages 22 to 28 are approximate pictorial representations only, and not to scale.

# Our Staff

## Starters and Leavers

| + 71 Staff Headcount | + 1,113 staff joined |
|---|---|
| | - 1042 staff left |

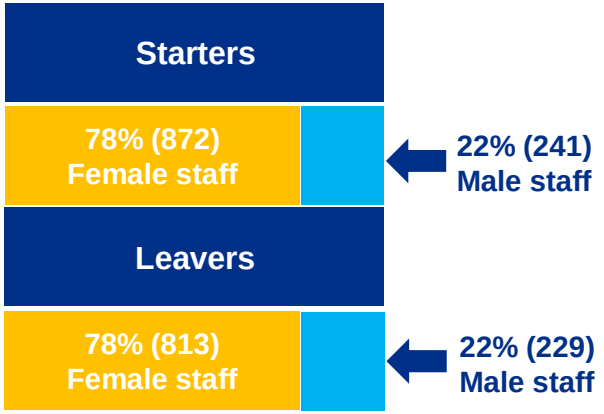
In the year 2021/22, a total of 1113 staff joined the Trust and 1042 left, giving a net increase of 71. Demographic information on our starters and leavers is shown in the charts below.

### By Age

| Starters | | | |
|---|---|---|---|
| < 20 years | 59 | 46-50 years | 62 |
| 21-25 years | 233 | 51-55 years | 61 |
| 26-30 years | 249 | 56-60 years | 37 |
| 31-35 years | 213 | 61-65 years | 10 |
| 36-40 years | 121 | 70+ years | 1 |
| 41-45 years | 67 | | |

| Leavers | | | |
|---|---|---|---|
| < 20 years | 24 | 46-50 years | 68 |
| 21-25 years | 129 | 51-55 years | 58 |
| 26-30 years | 219 | 56-60 years | 86 |
| 31-35 years | 163 | 61-65 years | 67 |
| 36-40 years | 125 | 66-70 years | 26 |
| 41-45 years | 65 | 70+ years | 12 |

### By Sex




The age profiles of our starters and leavers also broadly reflects the profile of our pre-existing (recruited and in post before 2022) workforce.

# Our Staff: Starters and Leavers

## By Sexual Orientation

| | Starters | Leavers |
|---|---|---|
| Heterosexual/ straight | 749 | 664 |
| Not stated/ response declined | 326 | 335 |
| Gay/ Lesbian | 13 | 14 |
| Bisexual | 20 | 8 |

A significant proportion of both our starters and leavers (29% of starters; 34% of leavers) chose not to declare their sexual orientation. It is likely that this is for the reasons already discussed, and is consistent with findings for our pre-existing workforce.

## By Disability

| Response | Starters | Leavers |
|---|---|---|
| No | 926 | 791 |
| Yes | 28 | 14 |
| Prefer not to answer | 159 | 237 |

In common with our pre-existing and retained workforce, the vast majority of our starters and leavers have declared that they do not have a disability. Starters and leavers sharing information that they have a disability has increased from last year, but we also recognise that sharing rates are low.

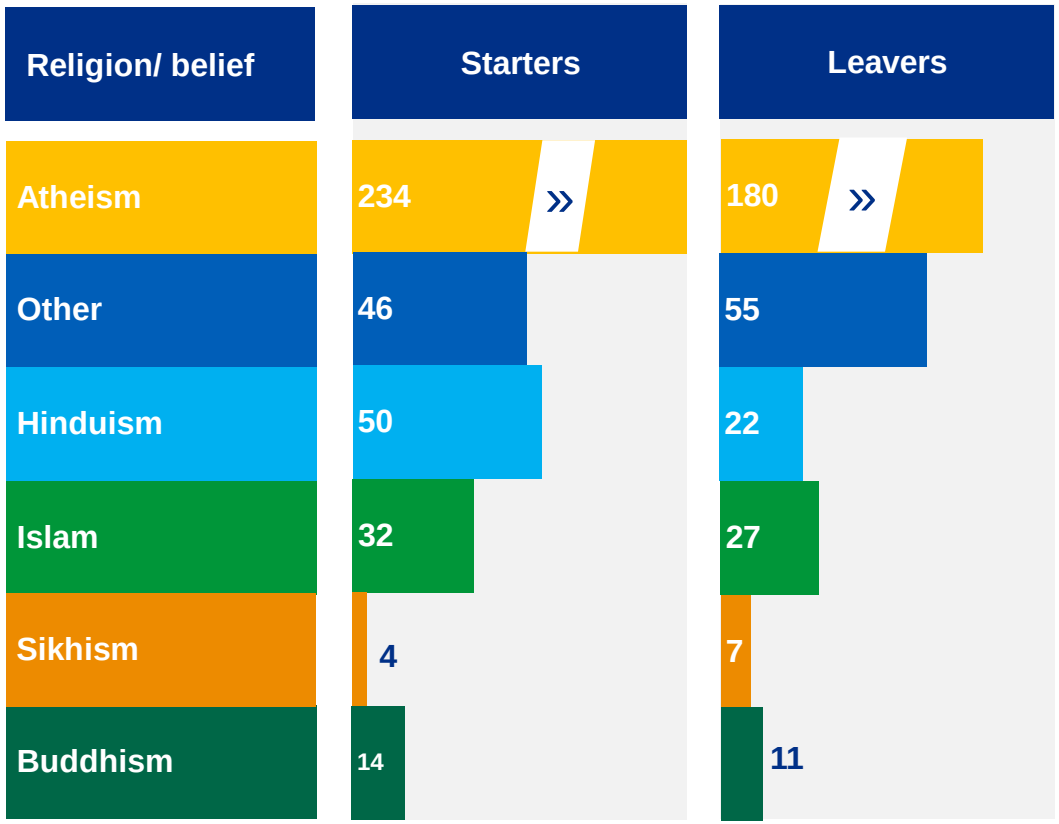
## By Ethnicity

| Starters | | Leavers | |
|---|---|---|---|
| White: 665 | | White: 729 | |
| 286 | BAME | 149 | BAME |
| 162 | Unknown | 164 | Unknown |

**Unknown** is ‘any other ethnic group’, ‘not stated’ and ‘other specified categories’. The majority of our starters and leavers are White British and this is consistent with our pre-existing workforce.

# Our Staff: Starters and Leavers

## By Religion and Belief




The majority of our starters and leavers follow the Christian faith; whilst a similar total (around 35%) did not wish to disclose their religion/belief. A sizeable number of starters (337) left the data form blank. The religious preferences of the other starters and leavers can be seen in the pictorial representations opposite (not to scale).

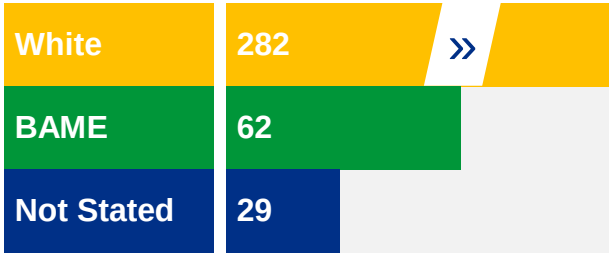
**Note**:

This data includes:

- Maternity leave, but excludes those on career breaks;
- Substantive staff only;
- Staff in post, based on the official data from our Electronic staff Records.

# Our Staff: Volunteers


## By Ethnicity

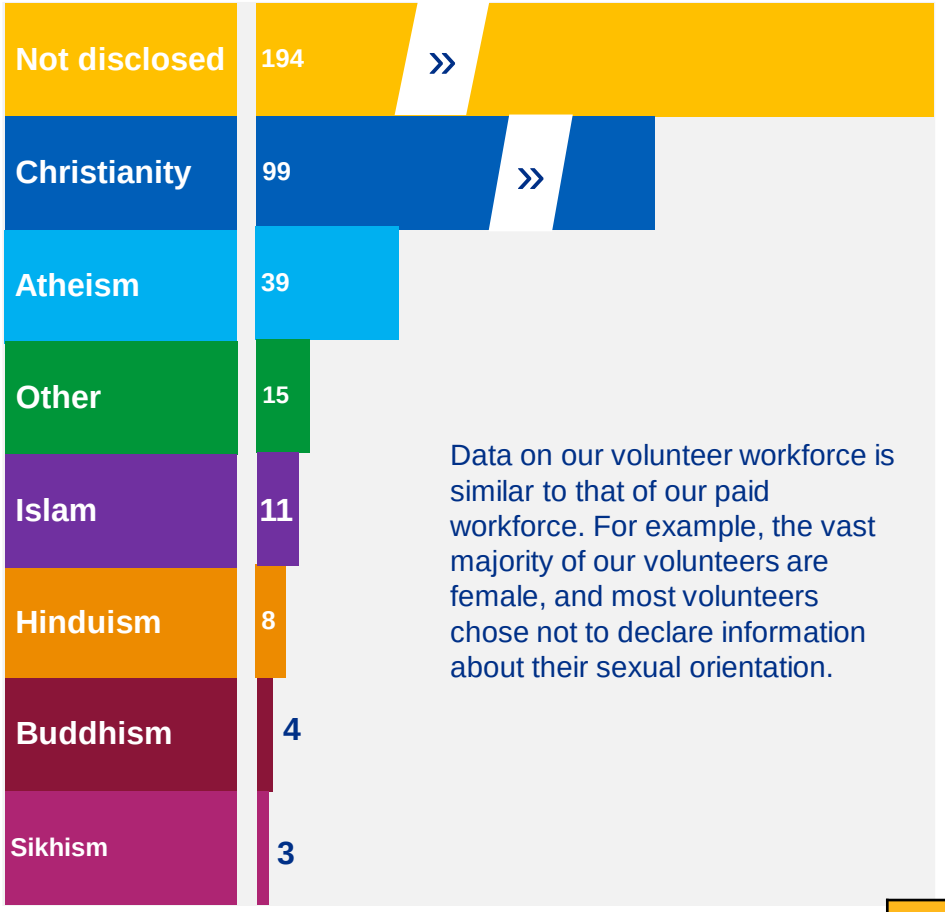



**Note**

During the Covid-19 pandemic, the majority of volunteers did not attend the hospital site. As we slowly returned our volunteers back to their roles, we requested that they complete new equality information. As a result, we have a much more complete picture of the volunteers on site. The following graphs show the equality data relating to our current team of 373 volunteers.

## By Sex


## By Religious Beliefs




Data on our volunteer workforce is similar to that of our paid workforce. For example, the vast majority of our volunteers are female, and most volunteers chose not to declare information about their sexual orientation.

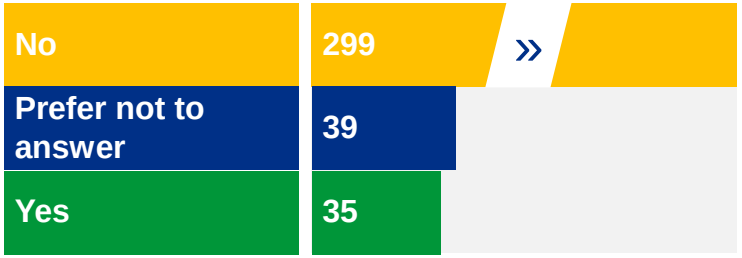
# Our Staff: Volunteers

## By Age

| | | | |
|---|---|---|---|
| < 20 years | 87 | 46-50 years | 18 |
| 21-25 years | 8 | 51-55 years | 24 |
| 26-30 years | 12 | 56-60 years | 31 |
| 31-35 years | 12 | 61-65 years | 34 |
| 36-40 years | 12 | 70+ years | 78 |
| 41-45 years | 11 | | |

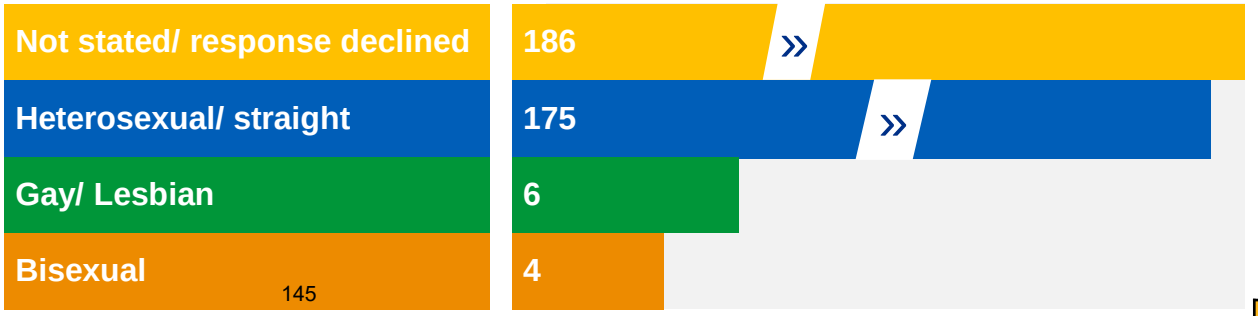
The age profile of the majority of our volunteers shows that they are likely to be both the oldest and youngest members of staff

## By Disability




In common with our pre-existing workforce, the vast majority of our volunteers have declared that they do not have a disability.

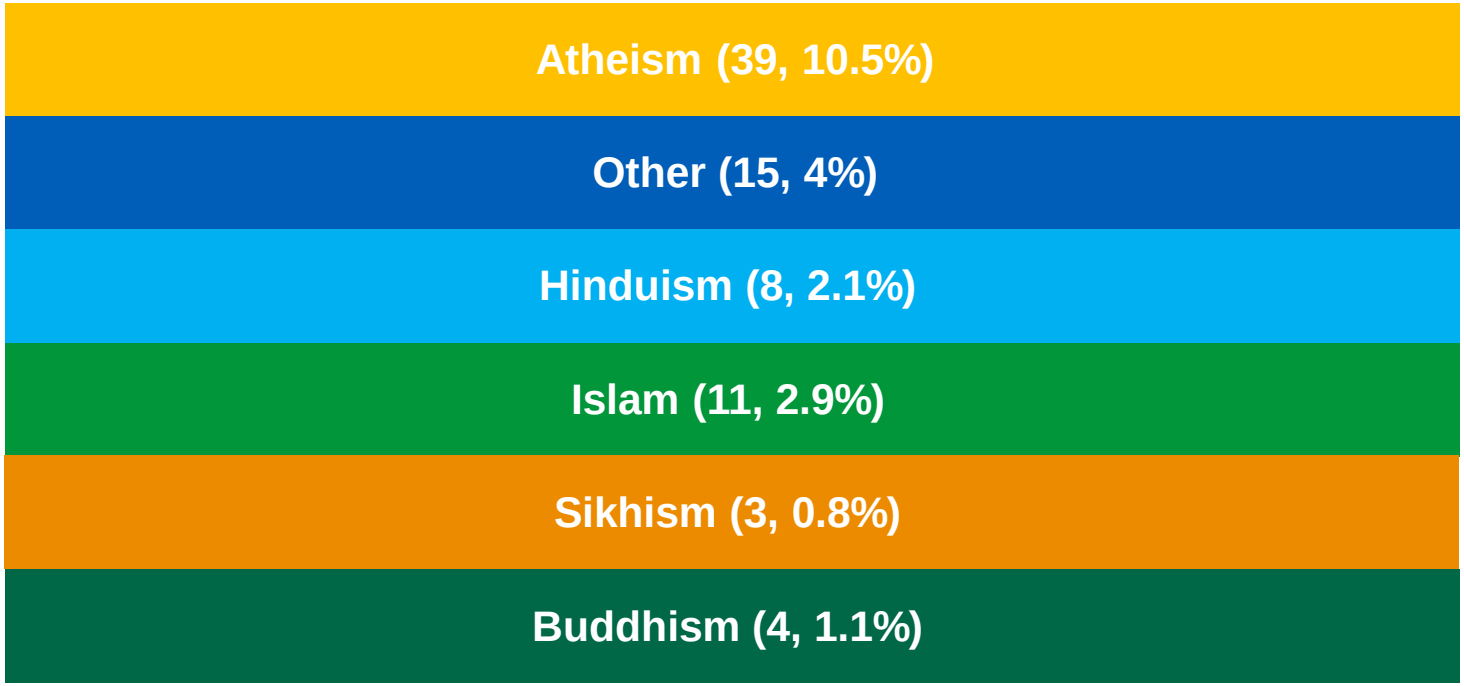
## By Sexual Orientation



# Our Staff: Volunteers

The majority of our volunteers (26.5%) follow the Christian faith; whilst a sizeable total (52%) did not wish to disclose their religion/belief. The religious preferences of the other volunteers can be seen in the pictorial representation opposite.

## By Religion and Belief



# Training and Development

Effective leadership is crucial to ensure the smooth operational running of the Trust, develop and gain the best from each member of staff, and provide all of our staff with an equal opportunity to contribute. Our training and development continues to be affected by the Covid-19 pandemic, with some programmes and plans delayed. Despite this, the Trust has continued to develop its leadership offer, and below shows the progression and plans for 2021 and 2022. We will continue to review our leadership programs to ensure that diversity and inclusion is contained throughout our Talent Management and Leadership Development Programmes.

## Leadership Programmes

We have continued to offer a mandatory EDI training module within our internal Leadership Development Programme (Bands 7 and 8a) and now incorporate this within our internal Aspiring Leaders programme (Bands 4-6). Both programmes focus on the inclusion of everyone within a diverse team, enabling them to feel more empowered, share ideas and promote innovative thinking with an emphasis on ensuring those in under-represented groups have a voice. This providers leaders and aspiring leaders the opportunity to identify how ED&I will fit into their development as a leader, rather than viewing it in isolation.

We also support leaders to undertake accredited training either with the NHS Leadership Academy which includes programmes specifically aimed at Black, Asian and minority ethnic colleagues. These include:

**Stepping Up Programme:** which is designed to bridge the gap between where applicants are and where they need to be, to progress into more senior roles, empowering them to drive forward the inclusion agenda and develop their skills and abilities to grow and progress. Applications are expected to reopen in Summer 2022 and were paused during the Covid-19 Pandemic, so there were no participants in 2021/22.

**Ready Now Programme:** supports senior BAME leaders to move into board level positions and significantly more senior roles, contributing to a more inclusive leadership culture within the Trust and wider system. The program is yet to restart, following the Covid-19 Pandemic.

An alternative accredited training route is via leadership apprenticeships which provides opportunities ranging from levels three to seven (Masters level). The Apprenticeship Diversity Champions Network (ADCN) champions apprenticeships and diversity amongst employers and encourages more people from underrepresented groups to consider apprenticeships. We have enrolled three staff members at Level 7, and one staff member at Level 5.

# Training and Development

## Talent Management and Succession Planning

In 2021/22, the Trust has been successful in securing approval to pilot the national Scope for Growth project (official launch date July 2022), which focuses on career conversations and will support delivery of the People Plan and the People Promise by fostering a culture of inclusion and belonging. It defines potential in terms of a person's ability to make a positive difference to the NHS now and, in the longer-term-people who have the ambition, motivation and desire for growth, development and to stretch themselves.

### Scope for Growth Timetable

- Facilitators were accepted on to the pilot project in January 2022, and started their training in May 2022.
- We started offering the training sessions to individuals and managers / ambassadors in July 2022.
- Once both the individual and line manager / ambassador have completed their training then they can start the career conversations.

The first phase will include Black, Asian and Minority Ethnic colleagues and International Nurses. The provision of a framework for more person-centred development conversations, will:

- Support aspirations
- Improve diversity
- Support health and wellbeing

## Improving Together-and a new Leadership framework

Leadership behaviours have been identified as critical in supporting the 'Improving Together' methodology currently being rolled out across the Trust. A new leadership framework has been developed with an emphasis on the fundamental and re-enforcing behaviours required to lead within a culture of continuous improvement.

This approach has provided an opportunity to work with staff across the organisation, delivering an OD module to develop energetic, enthusiastic, and passionate leadership behaviours in readiness for this new way of working, inspiring positive changes in those who follow. The whole emphasis is on the inclusion of all team members in improvement-harnessing their knowledge, skills and creativity in the service of our patients.

## Coaching and Mentoring

The Trust has invested in developing staff to undertake the level five and level seven ILM accredited training in Coaching and Mentoring. Developing an employee coaching and mentoring register will supports leaders and future leaders to develop knowledge and skills, to become better able to affect diversity and inclusion in an authentic way. The unique nature of coaching can help support those from under-represented groups, who often experience unique challenges in the workplace. We had seven Level 5 and four Level 7 trainees at GWH, and no qualified coaches on the register.

# Training and Development

Jackie Fawcett

## Training data

Over the last year (to 31 March 2022) compliance data across our mandatory EDI training was 90.32% which is an increase of 10.32% on the previous year (to 31 March 2021).

## Widening Participation

As an anchor institution (one whose long-term sustainability is tied to the wellbeing of our local community), we seek to improve and increase entry routes for staff from diverse backgrounds, to facilitate better access to development and career opportunities. Current projects include:

- Scoping and creating opportunities to raise the aspirations of children and young people through work experience, informed presentations, and outreach activities by creating a strong network within schools, colleges and other providers within our local community.
- Supporting Local Authorities in their role as corporate guardians, to secure the best outcomes for looked after and young people.
- Supporting and exploring projects that examine routes into employment and training, making a positive impact on local communities. For example, the NHS Cadet Scheme, supporting schools with ASDAN students' programmes, and colleges with T-Level placements.

## Early Years Careers Service

Jackie Fawcett (pictured, above) is our Early Years Careers Advisor. The Early Years Careers Service (EYCS) aims to attract a wide diversity of students through multiple routes, such as the school careers advisory service, local council careers hubs and social media outlets.
Our data shows that 20% of our programme intake identify as Black, Asian, and Minority Ethnic (BAME), and our programmes are tailored more widely to meet diverse student interests, needs and academic abilities.

# EDI Activity

Our Equality, Diversity and Inclusion (EDI) Strategy was developed and published in February 2021. The strategy identified priority work areas over a four year period, to improve equality, diversity and inclusion at the Trust. The Trust's Equality, Diversity and Inclusion Lead and Head of Patient Experience and Engagement support the delivery of the Strategy, which has benefited from the input of our network staff. EDI highlights have included:

DFN Project | SEARCH

We committed to a job creation scheme that encourages people with learning disabilities and autism into the workplace. You can read about **Project SEARCH** here.

## Celebrating South Asian Heritage Month

We celebrated South Asian Heritage Month for the first time, recognising the hugely important and lasting contributions that South Asian staff have made to our modern NHS.

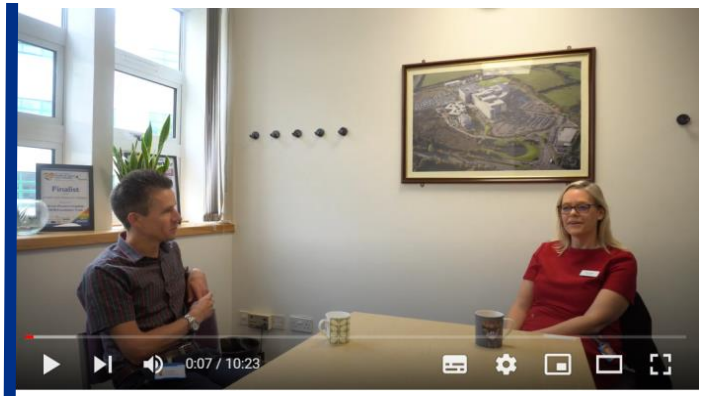
**Click here to see our short celebratory video**

## Podcast Series


A series of Podcasts, providing a platform for more intimate and authentic, deep dive discussions on topics relevant to health and social care staff. There were four episodes in the series, focusing on Neurodivergence, the effects of the menopause, becoming a good Ally, and the importance of Role Models.

**All the recordings can be accessed here.**

## Reciprocal Mentoring Programme




Following a successful pilot, Phase One of a Trust-wide reciprocal mentoring programme has been rolled out to all staff.

**Click here to see what participants learned; Click here to see what worked well**

## Black History Month

The Trust helped to fund the South West Black History Month event, held on 11 October 2021. The event was an overwhelming success, with over 2,200 registrations, and attendees from the UK and world wide. The speakers David Olusoga OBE, June Sarpong OBE, Hon Stuart Lawrence and Anton Ferdinand were all amazing, as was expected! This was followed by a Trust-wide event, adopting the national theme: 'Proud to be', held on 14 October. Events and resources included educational videos, information stands, merchandising, educational podcasts, national flags; food, music, and more!

# Staff Support Networks and Services

## The BAME Network

Our BAME* Network (Black, Asian and Minority Ethnic. Please also see Note overleaf) continues to support and celebrate the contributions and ethnic diversity of staff who work and study at the Great Western Hospitals NHS Foundation Trust. We support staff towards improving and progressing in their chosen career paths with the support of the Trust for all of our BAME staff.

Over the last year we have been growing as a network and involving more staff in the Trust. We continue to hold Black History Month in October with the addition of South Asian Month and Diwali this year. We continue to make strong connections both in and outside of GWH. We have asked more allies to join the network and see and hear from our staff about their experiences and what we can do to support all staff.

Members of our Board (Executive and Non-Executive Directors) have met staff to more fully understand what's happening 'on the ground', and the day-to-day running of the Trust. Going forward, we are planning to work with Pride, develop a BAME leadership event, and celebrate dates such as Diwali and Windrush day. We have been working with the GWH international nurses and encouraging staff to develop through the NHS wide leadership programmes.

"We are having more challenging conversations within the BAME network and more staff have understood different points of view. We've heard those people at the top listening to our Network. Hearing real stories in real time about experiences from staff and how we go forward with staff needs and experiences."

**Alicia Messiah**
Chair, BAME Network

The Network meetings remain monthly, although we are flexible about this, to try and reach staff who can't attend a meeting and also to sustain momentum. We will also add in extra dates where we can to accommodate some events and speakers who would like to join the conversations we have. Meetings can have anything from five to 30 people attending and have been held virtually due to the pandemic. At present we remain on a virtual platform but will hold some face to face events going forward.

Across all the Networks we work together as themes will relate to staff. We will be having a network relaunch day across the Trust to showcase what we can do to support and how we can all work together. We are having more challenging conversations within the BAME network and more staff have understood different points of view. We've heard those people at the top listening to our Network. Hearing real stories in real time about experiences from staff and how we go forward with staff needs and experiences.

# Staff Support Networks and Services

## The BAME Network

Our Chief Executive made a pledge to support the BAME Network and EDI and so far he has delivered. He's spoken to the BAME Network and is happy to support what we do. We have an EDI lead that can also bring forward the work the BAME Network does and the feelings we have and support any actions that the WRES needs to implement. We have seen more concerns and complaints and more openness in the organisation and more actions being taken.

Covid-19 highlighted inequalities in health, how different our bodies and minds are. The inequalities with poorer and richer areas and accessibility to health care. We hear, about what different cultures think about health care and vaccines. It highlighted that as a country, government, NHS, we have a lot of work to do to educate and change people's mindsets. Its celebrated cultures and what they bring to the table. BLM started a movement which has been around for a long time to the forefront of our minds again. This network isn't to focus on negativity but to hear the points of view and celebrate what we do. We are all different colours and lets embrace and acknowledge this, not hide this. We are not all races but one human race.

***A Note on our use of the acronym 'BAME'**

A number of terms have been used to collectively refer to Britain's ethnic minority populations. These include "Black and Minority Ethnic" (BME), and "Black and Ethnic Minority" (BEM). The terms have been challenged on a number of grounds: for example, for excluding national minorities such as the Cornish, Welsh, Scottish and Northern Irish from the definition of ethnic minorities; and for suggesting that black people (and Asian people, specifically South Asians with regards to BAME) are racially separate from the minority ethnic population.

Our Trust network has decided to retain the term BAME. We recognise the changing, cyclical nature of language in the area; that one label will not encompass the entirety of experiences and identities in a way that we all agree; and that the most important consideration is to disaggregate data within the label, to get an accurate picture of health inequalities, and staff progression. It is important to then use the monitoring data to understand where the gaps are, and develop strategies and action plans to close them.

We have therefore used our staff network's BAME acronym throughout this report, for consistency and ease.

A similar conclusion was reached by The National Centre for Diversity. Their article can be accessed here.

# Staff Support Networks and Services

## The LGBTQ+ Network

Our LGBTQ+ Staff Network was established to increase awareness of issues specifically faced by LGBTQ+ staff, actively influence Trust Policies and strategies that impact on LGBTQ+ staff, and to build a safe space for all. The Network exists to provide first-level support to LGBTQ+ staff who feel they are being bullied or harassed on the grounds of sexual orientation or sexual identity. The Trust places great importance on, and is committed to, equality for all staff and the network gives staff a voice to face inequalities at all levels. In December, the LGBTQ+ Network said goodbye to outgoing Chair Ryan Jary. The Trust thanked Ryan for his efforts to grow the Network. The new Network Chair is Ashley Boyd, with Howard Chitty as vice Chair. Ashley combines this role with being the Trust's first ever Trans (see below) liaison nurse.

### Notable highlights have been:

- Supported the Swindon Pride event, held on 07 August 2021.
- A Q&A/information led session with Stonewall, to address myths and misinformation around support for trans staff.
- Collaborating with Brighter Futures to implement a Rainbow bench in our new garden.
- Developed the Trust's first policy to support Trans staff.
- Currently developing the Trust's first patient guidance to support Trans patients.
- Part of an EDI 'First Impressions' challenge with the Patient Experience Team to give us an insight into looking at GWH through an inclusion lens.



**Ashley describes his role as a Trans liaison nurse:**

"Much of [it] involves simply listening to patients. I start the conversation and listen to their experiences, worries and anxieties, and try my best to offer compassionate advice, support, and guidance.

"I am constantly learning, through patient experiences, advocacy organisations like Stonewall and even listening to people on YouTube. I also signpost patients and families to local charities and other services when I think they need further support.

**Ashley Boyd**
Chair, LGBTQ+ Network

Note

Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer (GQ), gender-fluid, non-binary, gender-variant, cross-dresser, genderless, agender, non-gender, third gender, bi-gender, trans man, trans woman, trans masculine, and trans feminine. Our incoming Trans staff and service user policies will help us to better meet the needs of this group.

# Staff Support Networks and Services

## The Differently Abled Network

The Differently Abled Network - DAN (formerly called the Disability Equality Network) is a space for staff to connect, share experiences and information, and support each other.
Our aim is to raise awareness and visibility of disability issues, to help promote an inclusive culture that improves the work experience for staff with visible and hidden disabilities and be a safe point of contact for differently abled staff.
The network aims to actively influence policies that may impact on differently abled staff and support the recruitment of people with disabilities.
Throughout 2021/2022 the network has met regularly to discuss a range of topics and offer support to its members.
The DAN group are also delighted to continue to add new members to the group, and welcome anyone who would like to join.

### Notable highlights have been:

- Building up a library of knowledge accessed via the DAN Intranet site, with the aim of growing this into an information 'portal', filled with information and support.
- Continued to build on the Neurodiversity toolkit. The toolkit not only helps raise awareness, but can also be used by managers to support staff.
- Working with the Health and Wellbeing Team about the use of a 'Health Passport'. This is a valuable tool to help facilitate 1 to 1 conversations about any reasonable adjustments that staff may need.
- Working with Salim Suleman (Head of Service, Audiology) to promote the use of clear face masks in the Audiology Department.
- Part of an EDI 'First Impressions' challenge with the Patient Experience Team to give us an insight into looking at GWH through an inclusion lens.


"I have been the chair for our Differently Abled Network for about a year now and continue to be enthused by the passion and energy of our group to make a real difference to our staff and our patient's experience in the Trust. I would like to thank all the members of the Differently Abled Network for their contributions in the past year and look forward to continuing to make a difference with them"

**Justin Sysum**
Chair, Differently Abled Network

**Note**

The Differently Abled Network (or DAN) was formed in February 2021, and had its first meeting in March. Following discussion at that meeting, the Disability Equality Network has changed its name, and will now be called the Differently Abled Network. We are aware that other Trusts and organisations do not use this term, so 'disability' may be also be used when liaising with other outside networks, for ease and familiarity.

# Staff Support Networks and Services

## Freedom To Speak Up (FTSU)

Freedom to Speak Up Guardians (FTSUGs) help to make raising concerns the norm in NHS organisations, and standardise how NHS organisations support staff when concerns are raised.

**We have taken several steps to embed and normalise a culture of raising concerns when necessary. For example:**

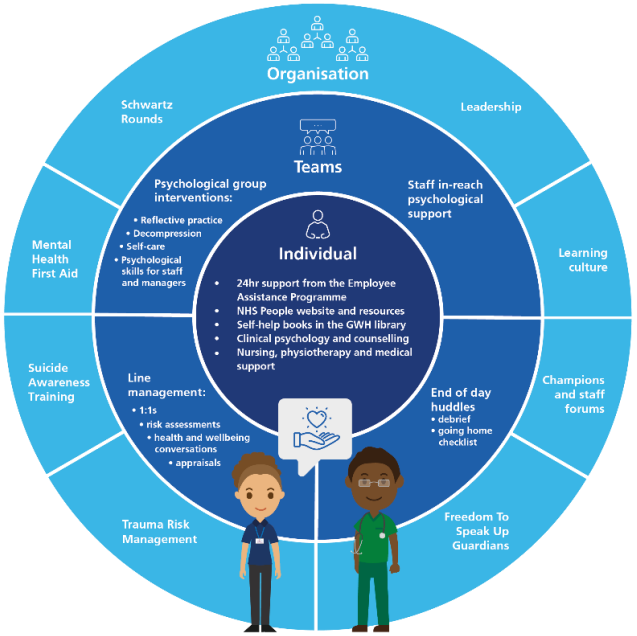
- Providing information on Trust intranet pages about our FTSUG, including Guardian contact details and biographies;
- Increasing FTSUG visibility by issuing Guardian business cards, badges and FTSU lanyards;
- Sharing green FTSU ribbons across the Trust, so that our Guardians were instantly recognisable;
- Ensuring our Trust induction program for new staff makes reference to the role of our FTUSGs and the importance of the service generally.
- Guardians got out and about, either together or individually to meet people and spread the message that speaking up is a positive step. Ward tea trolley rounds provided a great opportunity to do this;
- Hosting several drop-in sessions to meet Guardians in the acute, community and primary care settings.
- FTSU training is now available to all staff.

**The Trust vision on speaking up incorporates:**

- Promoting an open and transparent culture across the organisation
- Ensuring that all members of staff feel safe and confident to speak out
- Continuing to develop a culture of speaking up so that it is instilled throughout the organisation
- Modelling behaviours which promote a positive culture in the organisation
- Senior leaders readily articulating the Trust's FTSU vision and key learning issues that workers have spoken up about, as well as regularly communicating the value of speaking up.

# Staff Support Networks and Services

## Staff Health and Wellbeing




Our Circles of Support (pictured left) is the umbrella term for our Health and Wellbeing Plan. It highlights all of the health and wellbeing interventions and strategy in place within the organisation.


Read our
**Health and Wellbeing Plan**

‘It’s been a busy yet satisfying year in Staff Health and Wellbeing. Being able to support so many colleagues to keep well and to overcome difficulties they are experiencing is a real privilege. This support not only benefits us as a GWH family, but also our patients. Seeing the numbers of staff trained in Mental Health First Aid and also Suicide First Aid grow, as well as the numbers accessing our in-reach wellbeing groups, is a great achievement and reflects the cultural shift in how we think about and access health and wellbeing support.’

**Dr Jon Freeman**
**Clinical Lead for Staff Health and Wellbeing**

156

The Health and Wellbeing Team have submitted a separate annual report detailing in full developments over the last year. The report can be accessed **here**.

## Mental Health Provision in Numbers

- **137 staff trained in Mental Health First Aid**
- **47 staff trained to be Suicide First Aiders**
- **90 psychological in-reach group-based sessions for departments**
- **372 staff attended mental health bite-sized sessions**

**Training delivered by Sarah Webb (above)**

**Sessions led by Dr Sarah Masson (above)**

# National Report Summaries

# National Report Summaries

## The Gender Pay Gap Report 2020-2021

Our organisation shows a slight reduction in the mean gender pay gap for hourly pay, from 29.66% to 29.10%. This amounts to a 0.56% narrowing of the gap, and shows that we are moving in the right direction. Despite mechanisms in place to harmonise pay scales and career progression arrangements, some elements of our gender pay gap have a historical /national context which will take a period of time to resolve. This partly explains why males continue to be paid more than females. The overall picture, therefore, is mixed.

**We have made progress, because:**

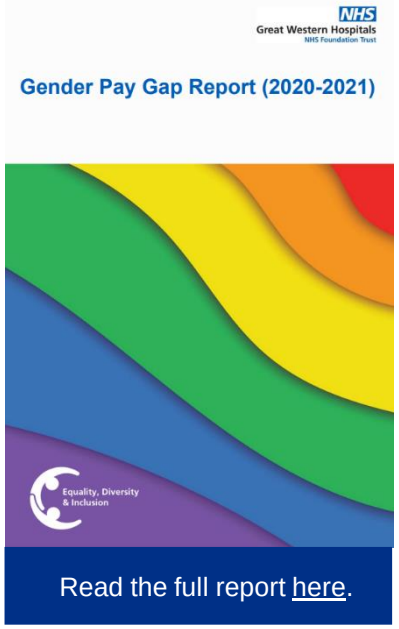
- When excluding medical and dental staff from the calculations, the mean pay gap as mentioned above narrows significantly, from 29.10% to 6.47%.
- The median gender pay gap has been reduced for staff in Bands 3,4,6,7,8b, and Medical; and, with the exception of Medical grades, these Bands are also where we have achieved parity between males and females.

**There are areas where our progress is less marked:**

- Some pay gaps have widened or remained constant. For example, the median gender pay gap has increased for women at Bands 8c and 8d.

As stated above, removing medical and dental staff from calculations significantly lowers the gender pay gap. For this reason, our 2021 action plan focuses on the Medical grades that most affect the pay gap, and any barriers to progression.

The gender pay audit obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. As an organisation that employs more than 250 people and listed in Schedule 2 to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 we must publish and report specific information about our gender pay gap.




**Note**
A national independent review looking at gender pay gaps in medicine can be accessed here.

# Gender Pay: Calculations and Findings

01

## Mean gender pay gap in hourly pay

Adding together the hourly pay rates of all male or female full-pay and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.

29.10%

6.47%

02

## Median gender pay gap in hourly pay

Arranging the hourly pay rates of all male or female employees from highest to lowest and finding the point that is in the middle of the range.

19.81%

3.05%

03

## Mean bonus gender pay gap

Adding together bonus payments for all male or female employees and dividing by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.

79.37%

-2.41%

04

## Median bonus gender pay gap

Arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.

79.76%

-20.00%

**Notes:**
Figures in yellow squares (below) are our results when medical and dental staff are excluded from calculations.

We are adopting the standard convention when looking at pay differences between males and females. A negative measure (for example, -2.41 as shown), indicates the extent to which females earn more per hour, on average, than their male counterparts.

# National Report Summaries

## The Workforce Race Equality Standard (WRES) Report 2021-2022

The Workforce Race Equality Standard (WRES) was launched and mandated for all NHS Trusts in 2015/16, with the first report published in June 2016. It was introduced to ensure employees from Black, Asian and Minority Ethnic (BAME) backgrounds have equal access to career opportunities, and receive fair treatment in the workplace.

There are nine WRES indicators, including four relating to the workplace covering recruitment, promotion, career progression and staff development, as well as one which specifically measures BAME representation at Board level. The remaining four indicators cover harassment, bullying or abuse from managers, colleagues, patients, relatives or the public.

The aim is for results to be published annually in order to support organisations, particularly those with lower scores, to continuously improve standards. Trusts can compare their performance with others in the same region or providing similar services.


### Key areas of change from our 2021/22 WRES report are:

- A 21% (193) overall increase in BME staff numbers since 2019;
- The greatest movement for BME (clinical and non-clinical) staff into Band 5 (from 32.8% to 42.3% of clinical staff);
- Noticeable increases in the proportions of BME clinical trainee grade staff (from 16.1% to 25%);
- The number of Very Senior Managers (VSMs – which includes Non Executive Directors and Associate Non-Executive Directors) in the Trust has risen from zero to three, which represents a 16.7% increase.);
- BME staff are less likely than White staff to enter the formal disciplinary process. This bucks the national trend, but the gap between the proportion of BME and the proportion of White staff entering the formal disciplinary process has grown smaller, since 2020/21.

### There are areas where our progress is less marked. Namely:

- White applicants are more likely to be appointed to job roles from shortlisting than BME applicants, with the ratio similar to the previous year;
- All harassment and bullying indicators have shown a deterioration for staff, which is particularly marked for BME staff. In particular, harassment, bullying or abuse from patients, relatives or members of the public has increased from 22.8% to 32.8% for BME staff;
- Fewer staff believe the Trust provides equal opportunities for career progression or promotion, with the decline particularly marked for BME staff. The figure for BME staff has declined from 71% to 39%, since last year;
- The Disparity Ratio has been developed as a metric by the national WRES team to help set trajectories and monitor them. It is the difference in proportion of BME staff at various Agenda for Change (AfC) bands in a Trust, compared to the proportion of White staff at those bands. Our overall disparity ratio is 5.59. This means that White staff are 5.59 times more likely to progress from a lower band (1-5) to the upper employment bands (8a and above) as BME staff. Looking more closely at our figures, this disparity is greater from the middle bands (6,7) to the upper bands, although the disparity has decreased since last year. National findings also indicate that BME Band 5 clinical staff continue to struggle to attain promotions to higher grades and bands.

# National Report Summaries

## The Workforce Disability Equality Standard (WDES) Report 2021-2022

The NHS Workforce Disability Equality Standard (WDES) launched on 1 April 2019. The overall aim is to make the NHS an exemplar employer for disabled people and to address the issues they face.

There are nine WDES indicators. Key areas covered include representation across pay Bands, recruitment, involvement in formal capability processes, and experiences of bullying and harassment. The aim is for results to be published annually in order to support organisations, particularly those with lower scores, to continuously improve standards. Trusts can compare their performance with others in the same region or providing similar services.

Our data presents a mixed picture regarding career progression and improved work experiences for staff with disabilities. Whilst some WDES indicators show an improvement on scores from previous years, and when viewed against the national averages, others have deteriorated or remained the same.


**Our disabled staff are:**

- More likely to share their disability status;
- Equally likely as non-disabled applicants to be appointed to roles once shortlisted;
- Less likely to enter the formal capability process;
- Part of a growing network, increasing awareness of member's issues. For example, raising awareness of and providing support for neurodiverse staff.

**When compared with the national average for benchmark Trusts, we also know that:**

- Our disabled staff believe there are more opportunities for career progression and promotion;
- Fewer disabled staff feel pressured to come to work when ill.

**There are areas where our progress is less marked. Namely:**

- We have yet to have any members of our Executive team or Board with a declared disability;
- Very few staff (133, or 2.4%) have self-declared a disability;
- There is a large disparity between the number of staff declaring a disability through the ESR, and the number of staff declaring a disability when completing the National NHS Staff Survey.
- More likely to experience abuse, than in previous years;
- Less likely to be satisfied with adjustments made to the workplace, compared with previous years;
- Less likely to feel valued by the organisation, compared with previous years.

**Note**

With such low numbers declaring a disability, and with a large disparity between the ESR and NHS staff survey, it is difficult to draw firm conclusions. However, our Differently Abled Network continues to build on the work being done to improve experiences for disabled staff.

# National Report Summaries

## Future influencing factors

The following initiatives will influence and effect our approach to EDI over the coming months:

- The NHS People Plan
- The NHS Long Term Plan
- Annual contributions to the WRES and WDES programmes
- Annual reporting against the Gender Pay Gap
- A Model Employer – NHS England

Work continues across the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System to identify EDI resources and opportunities to promote the inclusion agenda. An active EDI Leads Network continues to identify areas of joint working to create an inclusive and fair culture.

## Conclusions

This report presents progress made during 2021/22 to improve equality, diversity and inclusion for staff and patients. With this in mind, our EDI Strategy identified areas of priority to work on over a four year period, and that work is well underway. The work is being supported by our Lead for Equality, Diversity and Inclusion, and our Lead for Patient Experience and Engagement.

### Examples of ongoing work include:

- A developed Patient Experience and Engagement Plan;
- Patient feedback systems extended to improve patient services;
- A Reciprocal Mentoring Programme for Network staff and senior leaders;
- Stronger links developed with community groups and services to reduce any inequalities identified through their feedback;
- A Program to retain, develop and support our staff recruited from overseas;
- A project partnership to increase employment rates for people with disabilities;
- EDI training to ensure diverse and representative Board and leaders;
- Several ongoing initiatives to help people from more diverse backgrounds to access development and career opportunities;
- A talent management programme rolled out across the organisation.

# Since Last Year

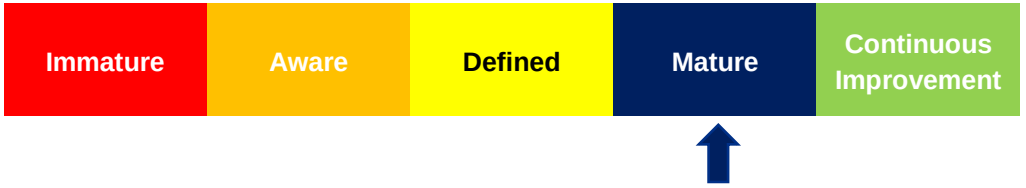
# Since Last Year

Further to the priorities identified for 2021/22 in the WRES, WDES and the five-year Equality, Diversity and Inclusion Strategy, the Trust is committed to improve both staff and patient experiences through increased awareness, and to continue to take practical steps to develop and embrace a culture of equality, diversity and inclusion.

Since last year, we have taken the following actions as we continue our equality, diversity and inclusion journey:

- Introduced a new system to record staff data and patient records. The system includes a broader set of questions on protected characteristics. At the moment we do not record all the protected characteristics, but we are moving towards this.
- The Lead for Equality, Diversity and Inclusion continues to ensure EDI is embedded in all training provided by the Trust.
- The EDI Group is developing a mechanism for identifying and collecting EDI related work across all directorates.
- The Trust continues to provide appropriate resources to ensure the development of efficient and effective staff support networks.
- As part of BSW, and our commitment to delivering the People Plan, we will continue to work with our regional partners to develop a joined up approach to EDI for the future (see the WRES and WDES reports for examples of how we are doing this).
- We undertook an EDI self-assessment audit of our current position, in October 2021. The audit's purpose was to help ensure that an effective approach to Equality, Diversity and Inclusion becomes embedded across the Trust, by highlighting areas where processes could be improved. Overall, we were assessed as 'Mature' (the second highest measure on a five-point scale, measuring from scale of categories ranging from 'Immature' to 'Continuous Improvement'. We will continue to build on the audit findings, to develop our Trust into a position of Continuous Improvement overall.

**Internal Auditor EDI Assessment Categories**




**Our Trust's Overall Assessment**

**Author and Sponsor**

Author: Dr Patrick Ismond
Sponsor: Jude Gray

# Appendices

# Appendix 1

## The Public Sector Equality duty

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. The Act replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it's unlawful to treat someone.

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the general duty, and all public authorities must pay 'due regard' to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general duty is underpinned by a set of actions and assurances termed the specific duties. These serve as guidance on how the general duty can be met, through a range of actions and the provision of evidence in varied formats. The specific duties are to:

- Publish Information outlining how they will comply with the general duty by 31/1/2012 (Annually thereafter).
- Formulate at least one Equality objective

All information published on how they will meet the equality duty must be presented in such a manner that it is accessible to the public.

This EDI Annual Report is one way in which we seek to discharge the PSED.

**P**ublic
**S**ector
**E**quality
**D**uty

Equality Act 2010

# Appendix 2

## A Snapshot of Swindon

**Notes:**

The data we used to create the snapshot of Swindon has been provided by Swindon's Joint Strategic Needs Assessment (JSNA). The JSNA has not updated that data since 2019, due to the continued impact of the Covid-19 pandemic.

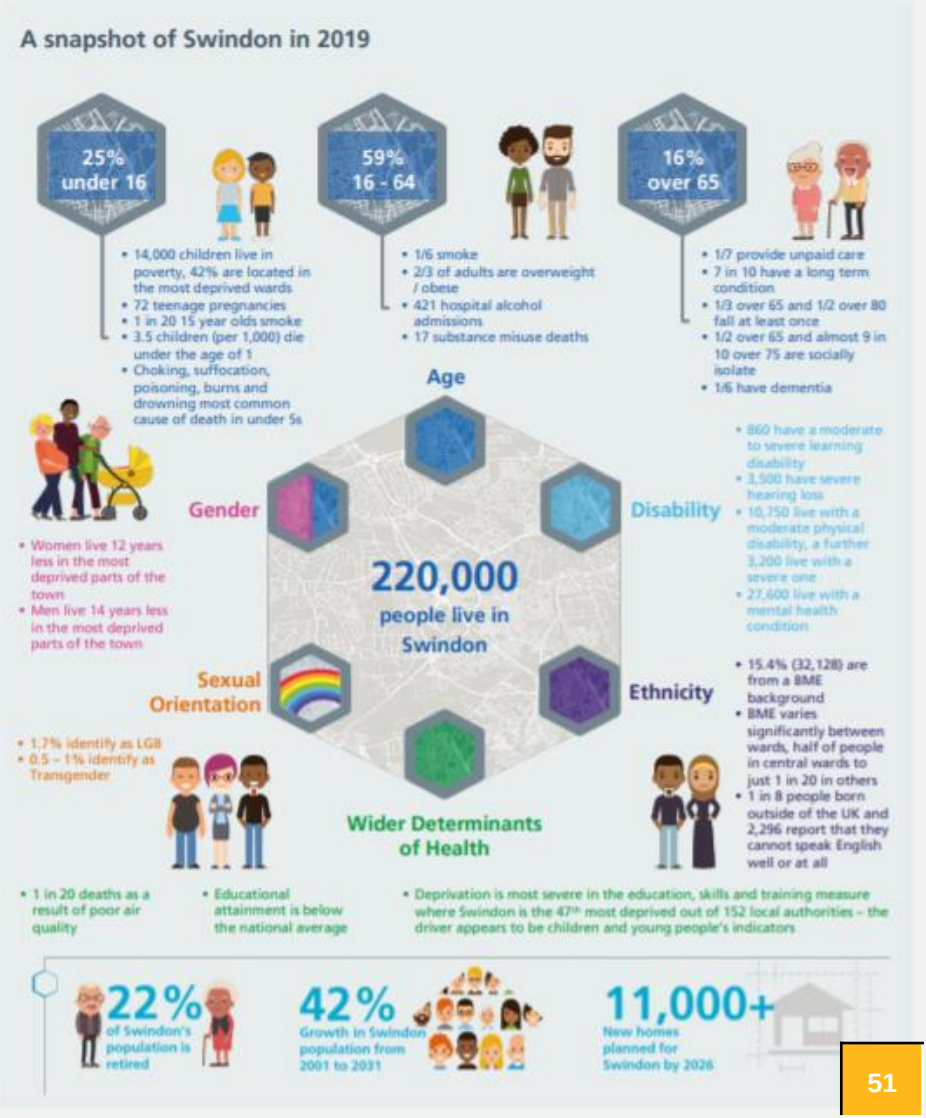
We wanted to present an equivalent data set for North Wiltshire. However, this has been researched, and only data for the whole of Wiltshire is available.





## Understanding our community

The information below sets out broadly what we know about the profile of different groups of people in Swindon, and helps us to understand better the equality, diversity and inclusion issues which may impact on the people who may use our services. We know that many people, outside of Swindon, in North Wiltshire also access our care. There are many similarities in these communities with those in Swindon but we will be working closely with Wiltshire Council and local community groups in the coming years to better understand this part of the county and any specific needs they may have.



| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Workforce Race Equality Standard (WRES) Annual Report, 2021-2022** | | | | |
| **Meeting** | Trust Board | | | | |
| **Date** | 06 Oct. 2022 | Part 1 (Public) [Added after submission] | x | Part 2 (Private) [Added after submission] | |
| **Accountable Lead** | Jude Gray | | | | |
| **Report Author** | Patrick Ismond | | | | |
| **Appendices** | Included with report | | | | |

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

**Assurance Level**

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

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

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

**Report**

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

This paper contains a summary of the Trust results for this year's Workforce Race Equality Standard (WRES) reporting.

**Key areas of change and/or progress from our 2021-22 WRES report are:**

- A 21% (193) overall increase in BME staff numbers since 2019;
- The greatest movement for BME (clinical and non-clinical) staff into Band 5;
- Noticeable increases in the proportions of BME clinical trainee grade staff;
- A 16.7% rise in the number of BME Very Senior Managers;
- BME staff less likely than White staff to enter the formal disciplinary process and the gap between the proportion of BME and the proportion of White staff entering the formal disciplinary process has grown smaller, since 2020/21.

**There are areas where our progress is less marked. Namely:**

- White applicants are more likely to be appointed to job roles from shortlisting than BME applicants, with the ratio similar to the previous year;
- All harassment and bullying indicators have shown a deterioration for staff, which is particularly marked for BME staff. In particular, harassment, bullying or abuse from patients, relatives or members of the public has increased from 22.8% to 32.8% for BME staff;
- Fewer staff believe the Trust provides equal opportunities for career progression or promotion, with the decline particularly marked for BME staff. The figure for BME staff has declined from 71% to 39%, since last year;
- The Disparity Ratio shows that White staff are 5.59 times more likely to progress from a

lower band (1-5) to the upper employment bands (8a and above) as BME staff, with this disparity greater from the middle bands (6,7) to the upper bands. National findings also indicate that BME Band 5 clinical staff continue to struggle to attain promotions to higher grades and bands.

| | | | | | |
|---|---|---|---|---|---|
| **Link to CQC Domain** – select one or more | **Safe** | **Caring** | **Effective** | **Responsive** | **Well Led** |
| | | 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** | This report has been to both TMC and P&C in August | | | | |
| **Next Steps** | | | | | |

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

Explanation of above analysis:
The report identifies where staff in protected groups (BAME) are treated less favourable. The report provides information regarding areas of improvement and makes recommendation for action against those areas where BAME staff are treated less favourably.

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

- **The Board to note the finding and support the future actions**

| | |
|---|---|
| **Accountable Lead Signature** | Jude Gray |
| **Date** | 06 September 2022 |

Great Western Hospitals
NHS Foundation Trust

# Workforce Race Equality Standard (WRES) Report
## 2021-2022

Equality, Diversity & Inclusion

# WRES Report (2021-2022)

## Contents

# Foreword


Click the image (above) to see Alicia discussing the WRES

## What does the WRES mean to me?

It means evidence for change and improvement. It helps provide the data to improve the experience of ethnic minorities in the NHS.

## Why is the WRES important?

It gives the NHS in our case the GWH, the evidence of what we do well and what we need to improve on. It looks at areas of change and development.

## If I could take one detail away from the WRES, what would it be?

Talent-we have so many talented staff across the NHS but they are not recognised due to the colour of their skin or their name. We only have to look at the GWH to see how things have improved and the good work we continue to do. We need to find ways to support out colleagues and showcase the skills they have to provide a great service.

**Alicia Messiah**
Chair, BAME Network

# Report Summary

The NHS Workforce Race Equality Standard (WRES) is an important mechanism to achieve workplace equality, and has several key functions. Firstly, to help NHS commissioners and NHS healthcare providers (including independent organisations) review their data against nine WRES equality indicators. Second, to produce action plans to close the gaps in workplace experience between White, and Black and Minority Ethnic staff (BME. But see also note on page 5). Third, to improve BME representation at the Board level of their organisation.

A WRES return is completed annually. It requires comparative information on workforce indicators for White and BME staff, and also compares national NHS Staff Survey data for these groups.

Our WRES Report is composed of several elements that together help us to plan and develop an approach to improve the work experiences of our BME staff. Progress is measured against the nine WRES indicators and we compare our present position with results from previous years.

Our findings show that there are a number of areas where we are demonstrating progress, and some areas that present a more mixed picture. For example, we have either exceeded or matched our mandated BME recruitment targets to more senior positions (as set out by NHS England). In the last year, the number of Very Senior Managers (VSMs – which includes Non Executive Directors and Associate Non-Executive Directors) in the Trust has risen from zero to three, which represents a 17.6% increase. However, our BME staff at Bands 5 and 6, who make up the largest proportion of our BME workforce, still do not progress at the same rate and in the same numbers as their White colleagues. BME staff are also less likely to enter formal disciplinary processes. This counters the national trend, and at Trust level, the gap between the proportion of BME and White staff entering the formal disciplinary process has grown smaller, since 2020/21.

A clearer picture can be seen with our rates of appointment from shortlisting for White and BME staff. We are far closer to a figure of 'parity' (that is to say, an equal likelihood of appointment for White and BME applicants) than the national figure, and we are closer to parity now, than we were in our benchmark year (2018-2019). We are working closely with our local partners and developing a system-wide approach to overhauling recruitment and promotion practices.

Rising rates of bullying and harassment faced by all staff (from managers, team leaders or colleagues) is an area where we need to focus attention, and we are seeking to address this through staff training, improved awareness of and access to our Trust policies, our wellbeing service, and more accurate data collection. It is difficult to gauge whether the increase is due to added pressures imposed by the Covid19 pandemic, and/or greater staff confidence in raising issues.

To improve the work experience for our BME staff, we will continue to engage with EDI Leads and Staff Networks across the BSW Integrated Care System. For the first time, our action plan has been agreed with and is jointly owned by our neighbouring acute Trusts. The range of issues are consistent across our organisations, and we are seeking to share best practice and resources, and develop a co-ordinated approach.

**Listen to an audio recording of this report summary**

**Dr Patrick Ismond**
Lead for Equality, Diversity & Inclusion

# What is the WRES?

The Workforce Race Equality Standard (WRES) was launched and mandated for all NHS Trusts in 2015/16, with the first report published in June 2016. It was introduced to ensure employees from Black and Minority Ethnic (or BME. Also see note below) backgrounds have equal access to career opportunities, and receive fair treatment in the workplace.

There are nine WRES indicators, including four relating to the workplace covering recruitment, promotion, career progression and staff development, as well as one which specifically measures BME representation at Board level. The remaining four indicators cover harassment, bullying or abuse from managers, colleagues, patients, relatives or the public.

The aim is for results to be published annually in order to support organisations, particularly those with lower scores, to continuously improve standards. Trusts can compare their performance with others in the same region or providing similar services.

**This workforce data is reporting against the period 1 April 2021 to 31 March 2022**

**Our WRES Report for 2021/22 contains a number of elements.**

- Comparison with latest national findings for all participating NHS organisations;
- Comparison with findings from previous GWH NHS FT WRES reports;
- Comparison with latest average NHS Staff Survey findings, for the benchmark group assigned by NHS England. In our case, the benchmark group is 'Acute and Acute and Community Trusts'.
- A Summary of key findings;
- The GWH Model Employer – 10 year plan;
- The NHS Employers Disparity Ratios.
- An updated action plan, 2022-2023.

The definitions of BME (Black and Minority Ethnic) and White as used in the WRES have followed the national reporting requirements of ethnic categories in the NHS data model and dictionary and are used in NHS Digital data. At the time of publication of this guidance, these definitions were based upon the 2001 ONS Census categories for ethnicity. WRES definitions, in line with the categories taken from the 2001 Census, are as follows:

**White**
A - White – British
B - White – Irish
C - Any other White background

**BME**
D - Mixed White and black Caribbean
E - Mixed White and black African
F - Mixed White and Asian
G - Any other mixed background
H - Asian or Asian British – Indian
J - Asian or Asian British – Pakistani
K - Asian or Asian British – Bangladeshi
L - Any other Asian background
M - Black or black British – Caribbean
N - Black or black British – African
P - Any other black background
R – Chinese
S - Any other ethnic group

**Not known**
Z - not stated
NULL
Unknown

## A Note on the use of BAME / BME Acronyms

Although BME is used throughout this report (for reasons of national consistency), our staff network has continued to use the acronym BAME (Black, Asian and Minority Ethnic). This is because the network recognises the changing, cyclical nature of language in the area; that one label will not encompass the entirety of experiences and identities in a way that we all agree; and that the most important consideration is to disaggregate data within the label, to get an accurate picture of health inequalities, and staff progression. It is important to then use the monitoring data to understand where the gaps are, and develop strategies and action plans to close them. A recent study, by the NHS Race and Health Observatory (RHO), reached the same conclusions. The RHO study can be accessed **here**.

# What is the WRES?

## WRES data sources include:

- The Electronic Staff Record (ESR); TRAC recruitment system; Annual Staff Survey (Autumn 2021).
- To evaluate our position and see what action we need to take, we have compared our data this year with the national WRES results, and have also compared our current position with our previous position in 2020/21.
- Where possible, we have also compared our position with that of local partners in the Bath, Swindon and Wiltshire Integrated Care System (BSW ICS). Datasets extracted from the South West Workforce Planning and Intelligence Systems Information Pack were used to create a quarterly report for the BSW/South West Region, and any compatible metrics have been taken from the latest report, released in December 2021.

| Overall Workforce increase | | BME Workforce increase | |
|---|---|---|---|
| +40 | From 2021 to 2022 our overall workforce has increased by 0.73%. | Over that same period, our BME workforce increased by 20.6% | +193 |

## Overall Picture

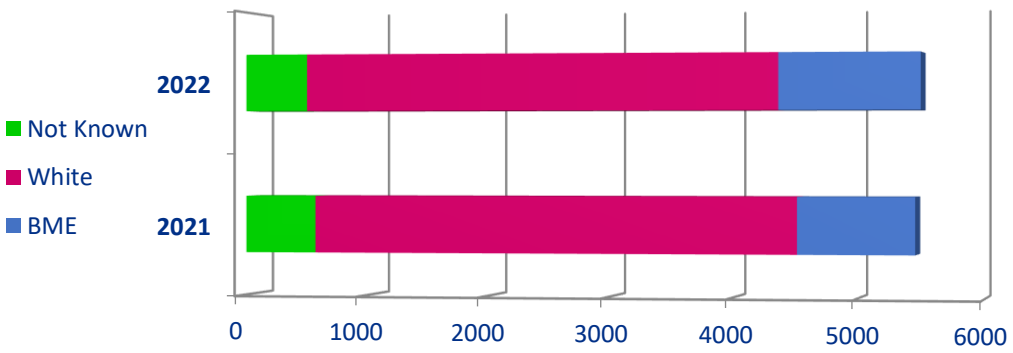
The total number of staff as at 31 March 2022 is shown below, and compared with previous years.

| | 2020/21 | 2021/22 |
|---|---|---|
| Total Number of Staff (Headcount) | 5462 | 5502 |

| BME WTE NHS Staff | |
|---|---|
| BSW ICS Average 15.9% | GWH NHS FT 20.6% |

Our Trust has a higher proportion of BME WTE NHS staff in its overall workforce than the BSW workforce average, as shown by the figures opposite.

**The changing proportions of staff, by ethnicity, for reporting years 2020/21 and 2021/22.**




175

# WRES: The National Picture

**The national NHS 2021 WRES report was published in March 2022, and refers to data from the 2020-2021 reporting year. Its key findings are reproduced below.**

**The national results demonstrate positive change in a range of areas including an overall increase in BME staff across the NHS compared with the previous year; an increase in BME representation at very senior management (VSM) and executive board level;**

## + 3.3%

As at 31 March 2021, **22.4%** (309,532) of staff working in NHS trusts in England were from a black and minority ethnic (BME) background. This is an **increase from 19.1%** in 2018. There were 74,174 more BME staff and 71,296 more white staff in 2020 compared to 2018.

## +48.3%

The total number of BME staff at very senior manager level has **increased by 48.3%** since 2018 from 201 to 298.

## x1.61

White applicants were 1.61 times more likely to be appointed from shortlisting compared to BME applicants; this is the same as 2020. There has been year-on-year fluctuation but no overall improvement over the past six years.

## x1.14

BME staff were 1.14 times more likely to enter the formal disciplinary process compared to white staff. This reflects little change from 2020 (1.16) and a significant improvement from 2016 when it was **1.56**. BME staff were more than 1.25 times more likely to enter the formal disciplinary process at 50.0% of trusts.

## 16.7%

**16.7%** of BME staff had personally experienced discrimination at work from a manager, team leader or other colleagues in 2020; the highest level since 2015 (14%).

## +12.6%

12.6% of board members in NHS trusts were from a BME background. This is an improvement from **10.0%** in 2020.

## +25.6%

The number of BME board members in NHS trusts **increased by 86 (25.6%)** between 2020 and 2021.

## 43.5%

**43.5%** of staff from a Gypsy or Irish Traveller background experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

## 36.2%

**36.2%** of staff from an "other" Asian background (i.e., other than Bangladeshi, Chinese, Indian, or Pakistani) experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

## 35.3%

**35.3%** of staff from an "other" black background (i.e., other than African or Caribbean) experienced harassment, bullying or abuse from other staff in the last 12 months. This has **increased from 32.8%** in 2016.

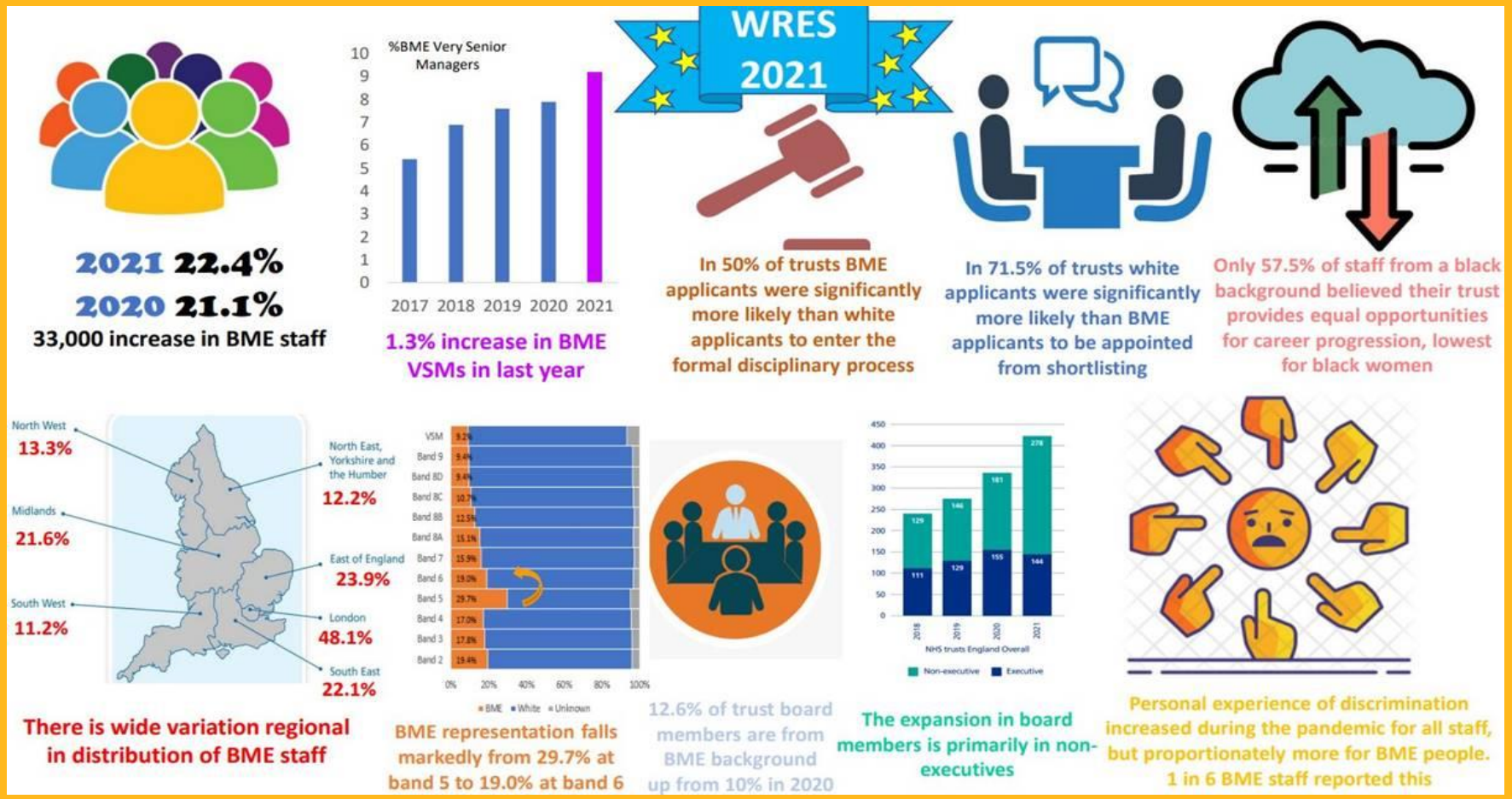
**and an increase in BME nurses, midwives and health visitors at Bands 6 and above. While these increases are welcome, there is still work to be done. The national report also showed an increase in discrimination against BME staff, and a much lower percentage of BME staff who believe their organisation provides equal opportunities for promotion. The full report can be accessed here.**

# WRES: The South West Position

**The graphic below shows the most recent position in the South West**

**Our region's results demonstrate positive change in a range of areas including an overall increase in BME staff across the NHS compared with the previous year; and an overall increase in BME representation both at very senior management (VSM) and executive board level.**

**However, the SW position also showed that BME staff are more likely than their White colleagues to enter the formal disciplinary process, and experience a disproportionate increase in levels of personal discrimination The full report can be accessed here.**



# Data on Ethnicity

The following table compares our current data on ethnicity with that of previous years. The total staff number for 2020/21 differs slightly from the Workforce Disability Equality Standard (WRES) data, because last year's data snapshots were taken at different points in time.

| | 2020/21 | | 2021/22 | |
|---|---|---|---|---|
| | Headcount | % of Staff | Headcount | % of Staff |
| Ethnicity Declared | 4881 | 89.4% | 4994 | 90.8% |
| Ethnicity Not Declared | 581 | 10.6% | 508 | 9.2% |
| Total Number of Staff | 5462 | 100.0% | 5502 | 100.0% |

**What we know**
We need to improve the way we collect data on personal protected characteristics such as ethnic background, sexuality and disability.

**What action we are taking**
Please see **Appendix 2** for further information.

## The Annual Staff Survey – Trust Completion Rates

**- 6.0%**

- The decreased percentage of staff completing the NHS Staff Survey in 2021, when compared with 2020;
- It was completed by **2,428** Great Western Hospital NHS FT staff in 2021;
- We achieved an **overall response rate** of 47.1% from all eligible respondents;
- An increase from **81 to 371** BME staff completed the survey in 2021.

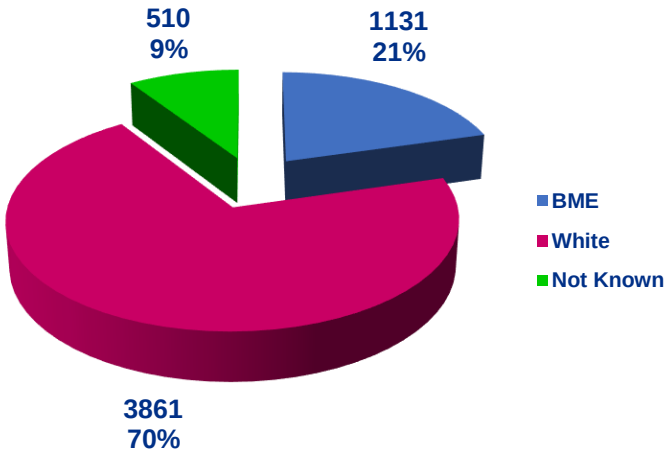
# NHS WRES Indicators

# Indicator 1: BME Workforce as at 31 March 2022

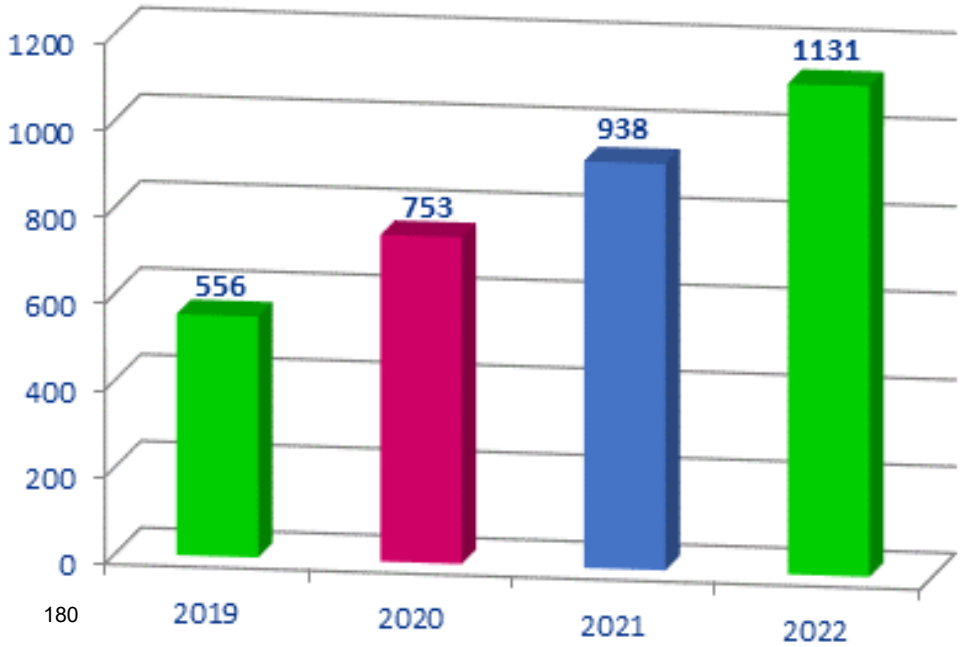
This indicator looks at the percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM.
When compared with our results from 2020/21, our Trust has, in general, changed. Scores are either shown as percentages or as a decimal number (see Indicators 2,3 and 4 below).

**+ 20.6% (193)** — **The percentage (and numerical) increase in BME Trust staff since 2021**

- As at 31 March 2022, 20.5% (1131) of staff working for The Great Western Hospitals NHS Foundation Trust were from a Black and Minority Ethnic (BME) background.
- There was a 2% (82) decrease in White staff in the corresponding period.

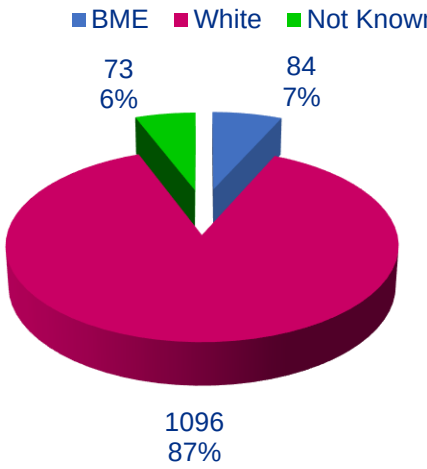



There has been a steady increase in the number of people from BME backgrounds employed by the Trust, as can be seen in the graph below. This increase has been boosted by the recruitment of international nurses.

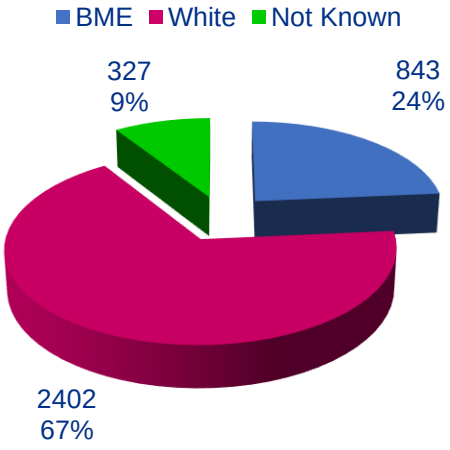


# Indicator 1: BME Workforce as at 31 March 2022

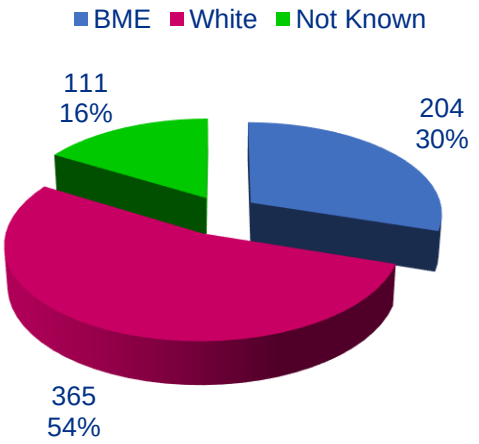
## Non-clinical




## Clinical




## Medical and Dental




The pie charts (above and opposite) show the percentage of BME staff in clinical and non-clinical roles compared with White staff. 4,252 (77.2%) of our staff are clinical, compared to 1,253 (22.8%) non-clinical.

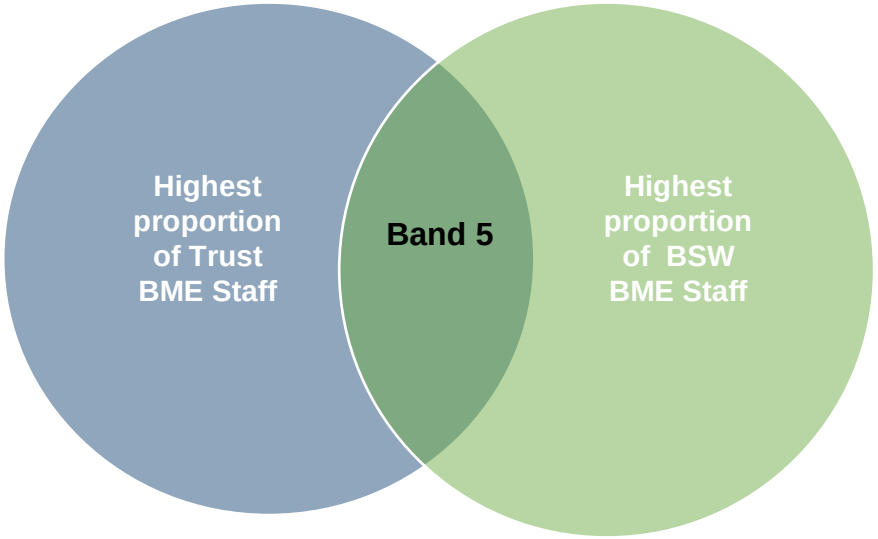
# Indicator 1: BME Workforce as at 31 March 2022

## A breakdown of the workforce by pay band and ethnicity – clinical and non-clinical roles

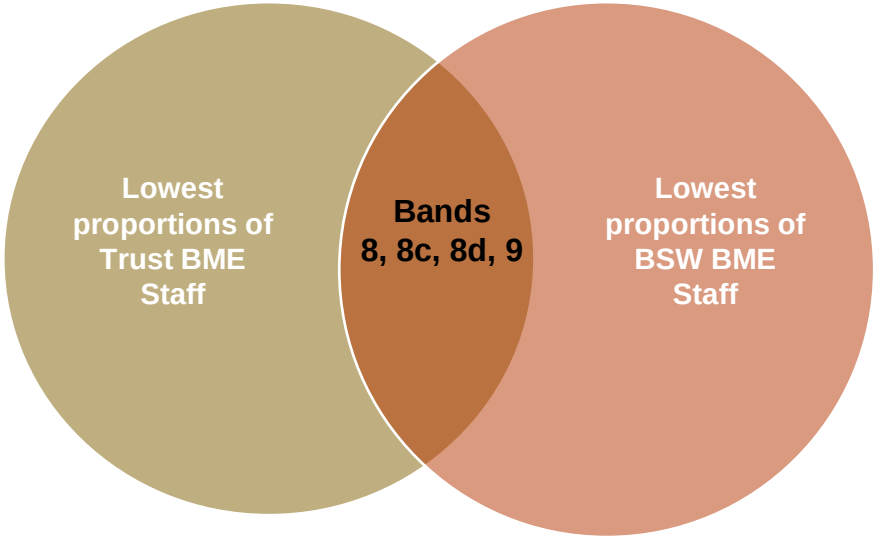
| | Non Clinical | | | | | | Clinical, Medical and Dental | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2022** | **WHITE** | **BME** | **Not Known** | **Total** | **White %** | **BME %** | **WHITE** | **BME** | **Not Known** | **Total** | **White %** | **BME %** |
| Under Band 1 | 16 | 1 | 0 | 17 | 94.1 | 5.9 | 4 | 0 | 0 | 4 | 100.0 | 0.0 |
| Band 1 | 1 | 0 | 0 | 1 | 100.0 | 0.0 | 2 | 0 | 0 | 2 | 100.0 | 0.0 |
| Band 2 | 360 | 30 | 23 | 413 | 87.0 | 7.2 | 418 | 169 | 55 | 642 | 65.1 | 26.3 |
| Band 3 | 302 | 16 | 22 | 340 | 88.6 | 4.7 | 240 | 40 | 15 | 295 | 81.4 | 13.6 |
| Band 4 | 129 | 4 | 12 | 145 | 88.4 | 2.7 | 169 | 40 | 10 | 219 | 77.2 | 18.3 |
| Band 5 | 71 | 11 | 3 | 85 | 83.5 | 12.9 | 440 | 422 | 135 | 997 | 44.1 | 42.3 |
| Band 6 | 51 | 11 | 5 | 67 | 76.1 | 16.4 | 636 | 133 | 67 | 836 | 76.1 | 15.9 |
| Band 7 | 56 | 4 | 2 | 62 | 90.3 | 6.5 | 357 | 31 | 33 | 421 | 84.8 | 7.4 |
| Band 8A | 48 | 3 | 2 | 53 | 90.6 | 5.7 | 105 | 4 | 9 | 118 | 89.0 | 3.4 |
| Band 8B | 16 | 0 | 1 | 17 | 94.1 | 0.0 | 15 | 2 | 2 | 19 | 78.9 | 10.5 |
| Band 8C | 20 | 0 | 0 | 20 | 100.0 | 0.0 | 5 | 1 | 1 | 7 | 71.4 | 14.3 |
| Band 8D | 3 | 0 | 0 | 3 | 100.0 | 0.0 | 10 | 0 | 0 | 10 | 100.0 | 0.0 |
| Band 9 | 8 | 1 | 0 | 9 | 88.9 | 11.1 | 1 | 1 | 0 | 2 | 50.0 | 50.0 |
| VSM | 15 | 3 | 0 | 18 | 83.3 | 16.7 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| Consultants | | | | | | | 143 | 54 | 38 | 235 | 60.9 | 23.0 |
| Non-consultants career grade | | | | | | | 44 | 26 | 12 | 82 | 53.7 | 31.7 |
| Trainee grades | | | | | | | 171 | 121 | 55 | 347 | 49.3 | 34.9 |
| Other | | | | | | | 7 | 3 | 6 | 16 | 43.8 | 18.8 |
| Total | **1096** | **84** | **70** | **1250** | **87.5%** | **6.7%** | **2767** | **1047** | **438** | **4252** | **65.1%** | **24.6%** |

# Indicator 1: BME Workforce as at 31 March 2022

## Comparing our Trust with the Overall BSW Workforce…




The employment levels of BME staff working for the Trust and our system are comparable, as shown by the Venn diagrams

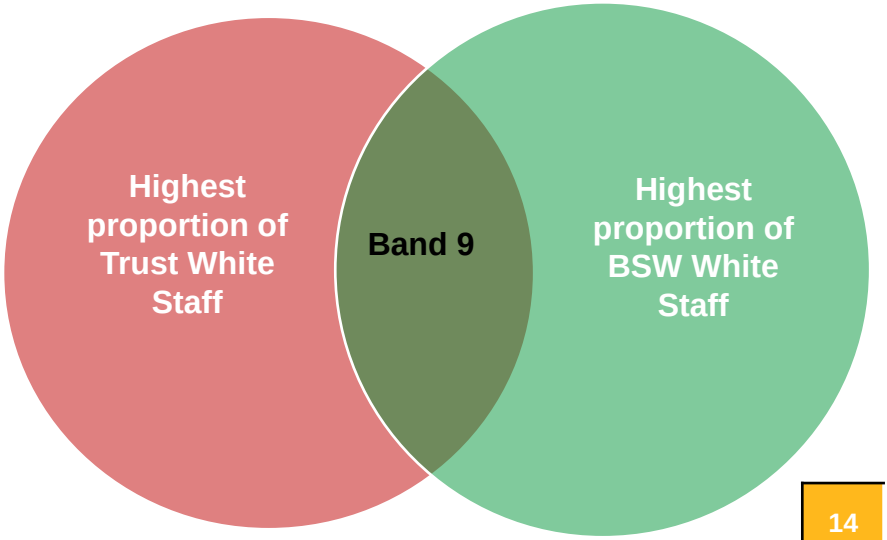



### What we know

The 2020 and 2021 National WRES reports identified that BME staff in Bands 5 and 6 do not progress at the same rate and in the same numbers as their White colleagues in their respective organisations.

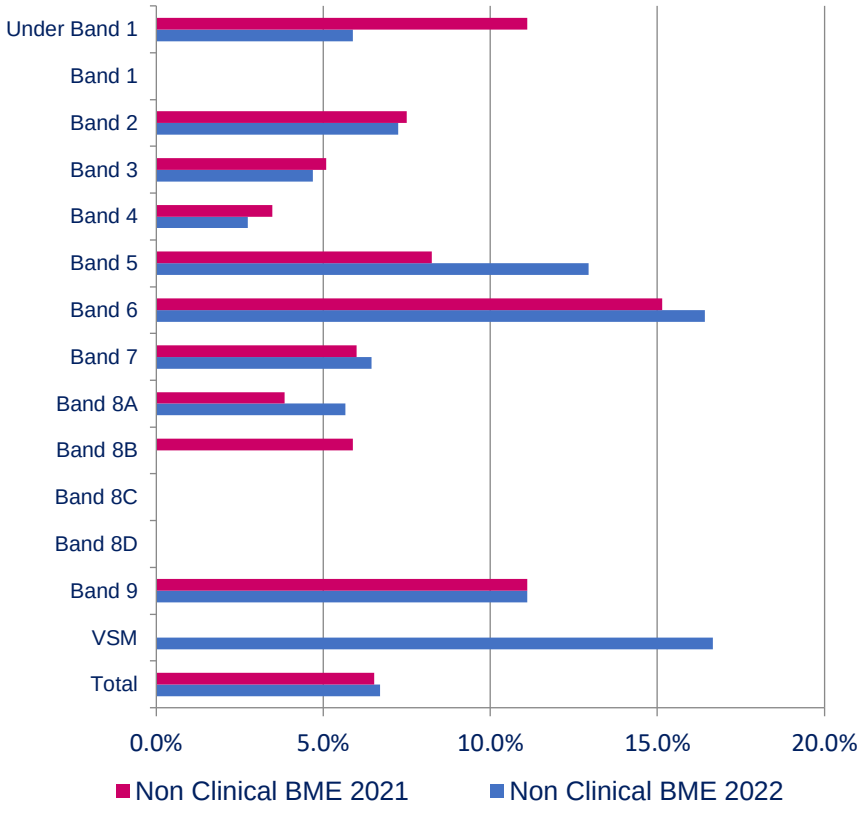
### What action we will take

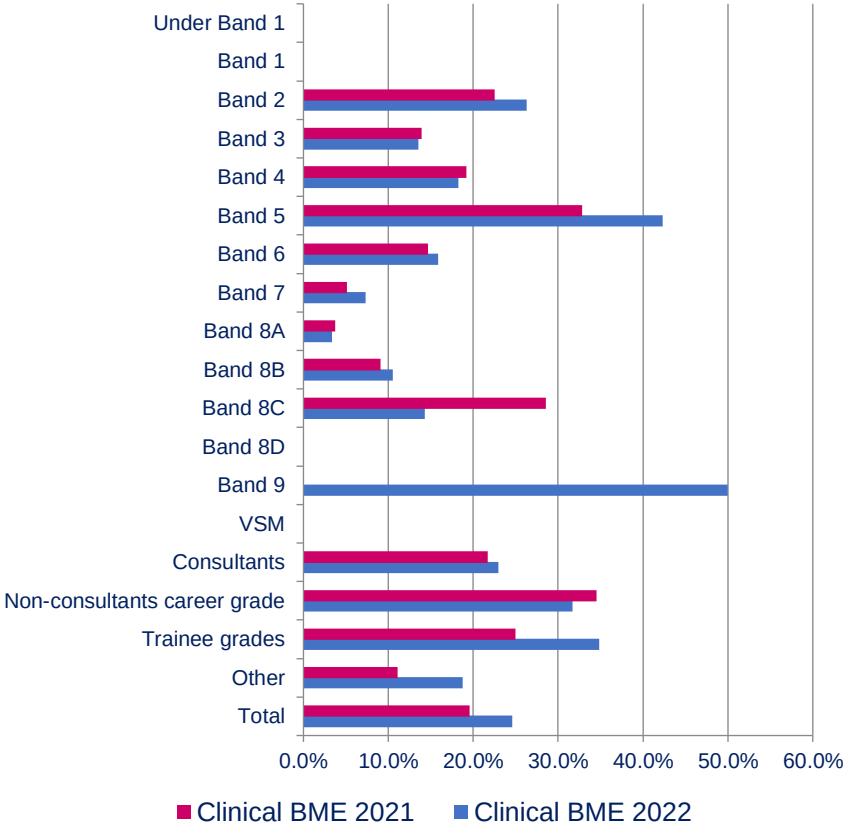
Identify the issues affecting career progression for BME staff at Bands 5,6. Please see the action plan in **Appendix 2** for further information.



# Indicator 1: BME Workforce as at 31 March 2022

The following graphs show the changing proportions of BME staff in movement between pay bands over the last 2 years, for clinical and non-clinical staff.




**When we compare our findings from 2020-2021 to our findings from 2021-2022:**

- Band 5 represents the level of greatest movement (into) for both clinical and non-clinical staff, and is also the band where most BME staff are concentrated.
- There are noticeable increases in trainee grade and Band 5 BME clinical staff.
- There is a percentage drop for BME clinical staff at Band 8c level. This appears more marked, given the small numbers of BME staff at that level.

# Indicators 1,9: BME Staff in Senior Management Positions

| 3* | The number of BME staff at Very Senior Manager (VSM) Level in 2022 |
|---|---|

Indicator 9 looks at the percentage difference between the organisations' Board voting membership and its overall workforce, for White and BME staff (see also note overleaf).

| | Overall Workforce | | Board Voting Membership | | |
|---|---|---|---|---|---|
| | No. in Workforce | % in Workforce | No. on Board | % on Board | % Difference |
| **BME** | 1131 | 20.6% | 1 | 7.1% | -13.5% |
| **White** | 3863 | 70.2% | 13 | 92.9% | 22.7% |
| **Not Known** | 508 | 9.2% | 0 | 0.00% | -9.2% |
| **Total** | 5502 | 100.0% | 14 | 100.00% | |

**BME Workforce Aim**

The Trust exceeded its aim to have one BME member of staff at this level by 2024, which is an improvement from it's last reported position.

**The WRES 'Model Employer' Leadership Strategy**

In 2019 NHS England produced a plan for each Trust across the country, titled the **WRES 'Model Employer' leadership strategy**. The plan sets out an example of a commitment to meet the aspiration to improve BME representation across the workforce and at leadership positions in the NHS, as set out in the **NHS Long Term Plan**.

Each Trust received a **bespoke plan** setting out the suggested goal setting trajectory for Bands 8a to VSM BME recruiting. The following table contains the suggested trajectory based on Great Western Hospitals NHS Foundation Trust 2018 staff demographics.

# Indicators 1, 9: BME Staff in Senior Management Positions

***Note**
This number includes two Associate Non-Executive Directors (NED). The Associate NED role is used in the NHS to support Board succession strategy and achieve a balance of Board level skills. The role is aimed at attracting potential Non-Executive Director candidates who do not yet have (sufficient) Board-level experience, or currently do not have the required availability – but have the ability and potential to succeed in a Trust Board-level role. This is a developmental post for someone looking to take the next step in their career in utilising skills associated with strategic business management; and together with others, governing and leading as part of a Board. It also serves to attract individuals to areas where there is under-representation. Associate Non-Executive Directors are not Directors of the Trust or Board members and do not have the associated rights or liabilities, instead what they have is the ability to learn and influence as they do, so that they operate as a full member of the team but without the same degree of accountability.

## The WRES 'Model Employer' Leadership Strategy

In 2019 NHS England produced a plan for each Trust across the country, titled the **WRES 'Model Employer' leadership strategy**. The plan sets out an example of a commitment to meet the aspiration to improve BME representation across the workforce and at leadership positions in the NHS, as set out in the **NHS Long Term Plan**.

Each Trust received a **bespoke plan** setting out the suggested goal setting trajectory for Bands 6 to VSM BME recruiting. The following table contains the suggested trajectory based on Great Western Hospitals NHS Foundation Trust 2021/22 staff demographics. The target does not include Medical & Dental staff, where the proportions are generally already above our target.

| 2022 | Total Staff | BME Staff (Actual) | BME Target 16% by 2025 | Gap | % (Actual) |
|---|---|---|---|---|---|
| **Band 6** | 903 | 144 | **144** | 0 | 16% |
| **Band 7** | 483 | 35 | **70** | -35 | 7% |
| **Band 8a** | 171 | 7 | **25** | -18 | 4% |
| **Band 8B** | 36 | 2 | **6** | -4 | 6% |
| **Band 8C** | 27 | 1 | **4** | -3 | 4% |
| **Band 8D** | 13 | 0 | **2** | -2 | 0% |
| **Band 9** | 11 | 2 | **2** | 0 | 18% |
| **VSM** | 18 | 3* | **2** | 1 | 16.7% |
| **Total** | 1662 | 194 | **255** | -61 | 12% |

**The above target will be reviewed every four years, and is currently linked to the percentage of BME staff as at the 2020-2021 level.**

# Indicators 1, 9: BME Staff in Senior Management Positions

**The 'Race Disparity Ratio'**

The 'Disparity Ratio' has been developed as a metric by the national WRES team to help set trajectories and monitor them. It is the difference in proportion of BME staff at various AfC bands in a Trust compared to proportion of White staff at those bands. It is presented at three tiers:

- Bands 5 and below ('lower');
- Bands 6 and 7 ('middle')
- Bands 8a and above ('upper')

| Bandings | White - Current Year | BME - Current Year | Unknown - Current Year |
|---|---|---|---|
| 1 to 5 | 2,152 | 733 | 278 |
| 6 and 7 | 1,100 | 179 | 107 |
| Band 8a+ | 246 | 15 | 15 |
| **Grand Total** | **3,498** | **927** | **400** |

| | White | BME |
|---|---|---|
| **Lower to middle** | **1.96** | **4.09** |
| **Middle to upper** | **4.47** | **11.93** |
| **Lower to upper** | **8.75** | **48.87** |

**PROGRESSION RATIOS**
**This** is the probability of White staff versus BME staff being promoted through the lower, middle and higher bands. The data submitted by organisations as part of the WRES 2021 survey has been used to calculate the disparity ratio.

| | |
|---|---|
| **Disparity ratio - lower to middle** | **2.09** |
| **Disparity ratio - middle to upper** | **2.67** |
| **Disparity ratio - lower to upper** | **5.59** |

**DISPARITY RATIO**
Our **disparity ratio is 5.59**. This means that White staff are 5.59 times more likely to progress from lower to the upper employment bands as BME staff.

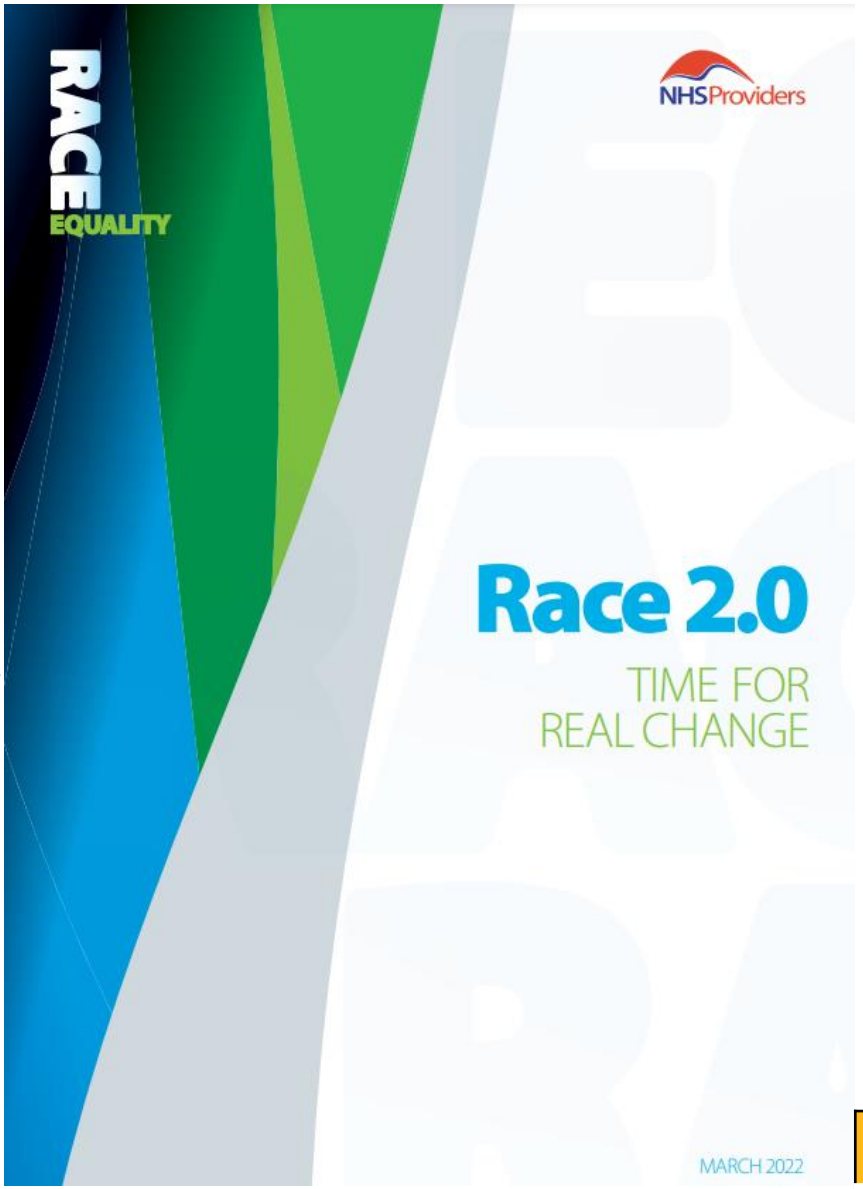
# BME Staff in Senior Management Positions: The Bigger Picture

A report from *NHS Providers* outlines members' views on the progress they feel their Trust boards are making towards racial equality. Despite areas of progress, only 4% of respondents – chairs, CEOs and NEDs – felt that race equality was fully embedded as a core part of their board's business.

The report highlights trust leaders' views on what constitutes good practice. Ten key priorities were identified, including: building closer engagement with staff and community networks, fostering safe spaces, better education, focusing on personal values and behaviours, and openly challenging discrimination.

The full report from NHS Providers, titled *Race 2.0*, can clicking on the image (opposite).

Our action plan aligns with a key finding of this study. See **Appendix 2**



# Indicator 2: BME appointments from shortlisting

This measure looks at the rate at which White applicants were more likely to be appointed than BME applicants…

| | |
|---|---|
| x 1.13 | Our Trust in 2020/21 |
| x 1.61 | Latest national result (2020/21) |
| x 1.37 | Our Trust in 2021/22 |

We are in a more equitable position compared to the national picture. However, our current position is less equitable than last year, when we were closer to parity.

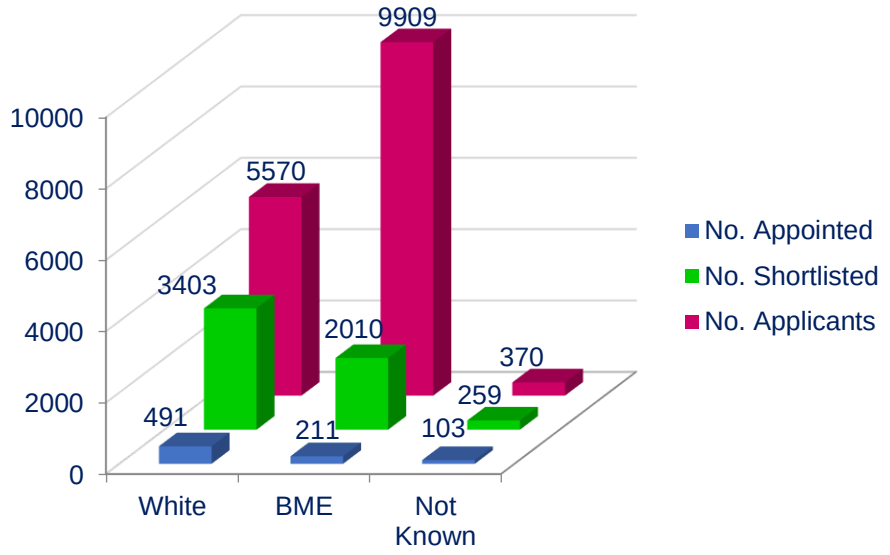
Also:

- When we look at the national picture, we find that White applicants are 1.61 times more likely to be appointed than BME applicants.
- The issue of inclusive recruitment is in the process of being reviewed nationally and locally to redress the balance.
- There is a commitment within the NHS People Plan to overhaul the recruitment and promotion processes.
- A six point action plan has been developed and is aimed at system wide improvement in this area.
- Over the coming months, Great Western Hospitals NHS Foundation Trust will continue to work on the plan with partner organisations across the BSW ICS.

**What action we are taking** Continue work at wider system level to redress issues with recruitment. See Appendix 4.

189

**Applications, shortlisting and appointments, for BME and White staff**




- During 2021/22, a total of 9909 BME people applied for jobs at GWH;
- 2010 were shortlisted and interviewed, and 211 were appointed;
- If BME staff were equally as likely to be appointed from shortlisting as White candidates, then the rate for White staff (**x1.37**) would be 1.
- Although this ratio is further from parity than it was in 2020/21, it is not significantly worse.

# Indicator 3: BME staff entering the formal disciplinary process

This measure looks at the rate at which BME staff were likely to enter the formal disciplinary process, compared with their White colleagues

| | |
|---|---|
| x 0.72 | Our Trust in 2020/21 |
| x 1.14 | Latest national result (2020/21) |
| x 0.81 | Our Trust in 2021/22 |

- Our most recent Trust figure is 0.81 for BME staff, which shows that BME staff were less likely than White staff to enter the formal disciplinary process.
- If BME staff were equally as likely to enter the formal disciplinary process as White staff, then the figure for BME staff would be 1.
- The figure is closer to parity than last year, and also shows a slightly higher likelihood of BME staff entering the formal disciplinary process.
- We have bettered the national picture which, as can be seen above, shows that BME staff are more likely than White staff to enter the formal disciplinary process.

**Notes**:

- A disciplinary process is a formal way for an employer to deal with an employee's 'unacceptable or improper behaviour' ('misconduct'); and/or performance ('capability').
- Before starting a disciplinary process, it is recommended that an employer first see whether the problem can be resolved in an informal way. This can often be the quickest and easiest solution.

# Indicator 4: BME staff accessing non-mandatory/CPD training

This indicator looks at the rate at which White staff are likely to access non-mandatory/CPD training, compared with their BME colleagues.

| | |
|---|---|
| x 0.92 | Our Trust in 2020/21 |
| x 1.14 | Latest national result (2020/21) |
| x 1.01 | Our Trust in 2021/22 |

- White staff are slightly more likely to access non-mandatory/CPD training than BME staff.
- This is a stable position, although in our previous year, data showed that White staff were slightly less likely to access non-mandatory/CPD training.
- If all staff were equally as likely to access training, then the figure for BME staff would be 1.

**Reminder Note on indicators 2,3,4**

A score of one, or 'parity', means that the measure affects both BME and White staff equally.

# Latest NHS Staff Survey Data (2021)

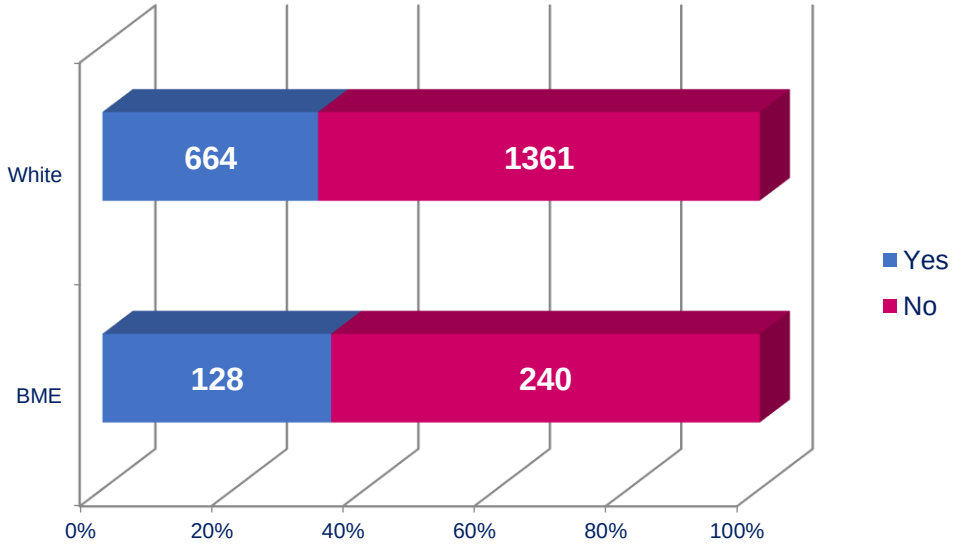
# Indicators 5, 6: BME Staff experiencing harassment, bullying or abuse

## 34.8%

The percentage of BME staff who reported experiencing harassment, bullying or abuse from patients / service users, relatives or the public.

- This is a much higher rate (+12.3%) for BME staff, when compared to data from 2020.
- The rate for White staff is also higher (+2.8%) than last year, but less markedly than for BME staff.
- GWH figures are higher when compared to the latest national benchmark average (2021), which records figures of 28.8% for BME staff and 26.5% for White staff.

**BME and White staff who reported experiencing harassment, bullying or abuse from patients, relatives or the public.**

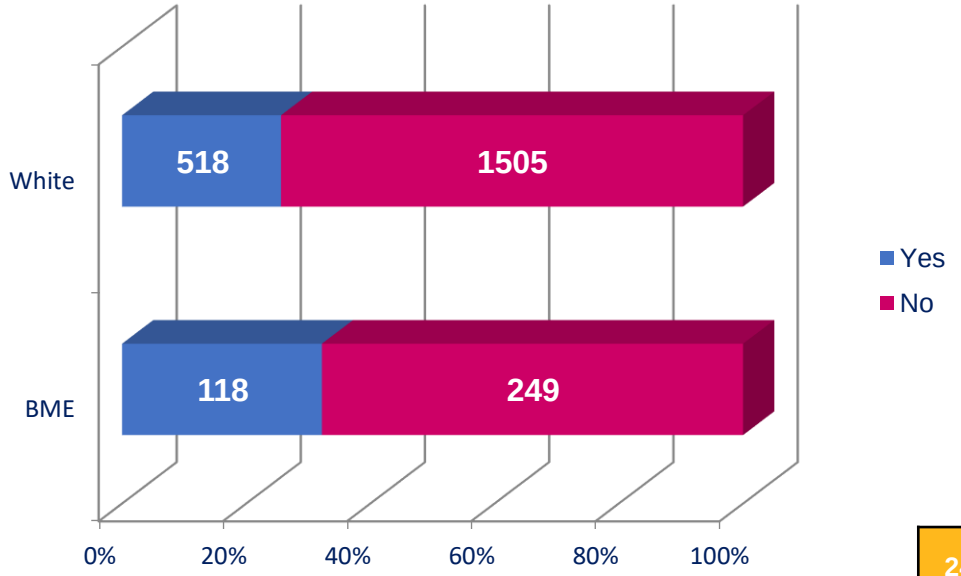



## 32.2%

The percentage of BME staff who reported experiencing harassment, bullying or abuse from other members of staff.

- This is a significant increase (over 10%) for BME staff, since last year.
- **25.6%** of White staff also reported experiencing harassment, bullying or abuse from other members of staff.
- GWH figures are higher when compared to the latest national benchmark average (2021), which records figures of 28.5% for BME staff and 23.6% for White staff.

**BME and White staff who reported experiencing harassment, bullying or abuse from other members of staff.**



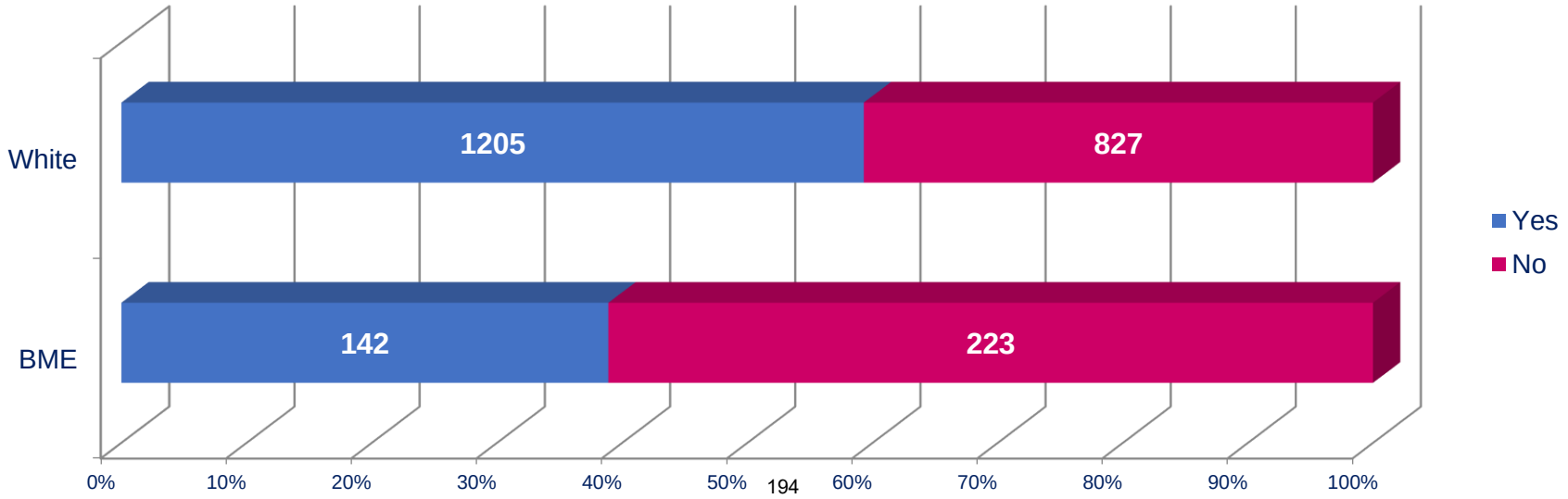
# Indicator 7:
# BME Staff believing the Trust provides equal opportunities for career progression or promotion

This indicator looks at the rate at percentage of BME staff who believe Great Western Hospitals NHS FT provides equal opportunities for career progression or promotion.

| | |
|---|---|
| **44.6%** | **Benchmark Organisations Average in 2021** |
| **38.9%** | **Our Trust Average in 2021** |

- The finding for Trust BME staff is worse than the previous year (by -6.8%), whilst the finding for White staff is an improvement (by +1.3%) on last year's figures.
- Whilst the finding for Trust BME staff is below the benchmark national average (ibid), the finding for White staff has remained relatively constant (-0.7%).

**BME and White staff who believe that Great Western Hospitals NHS FT Provides equal opportunities for career progression or promotion.**



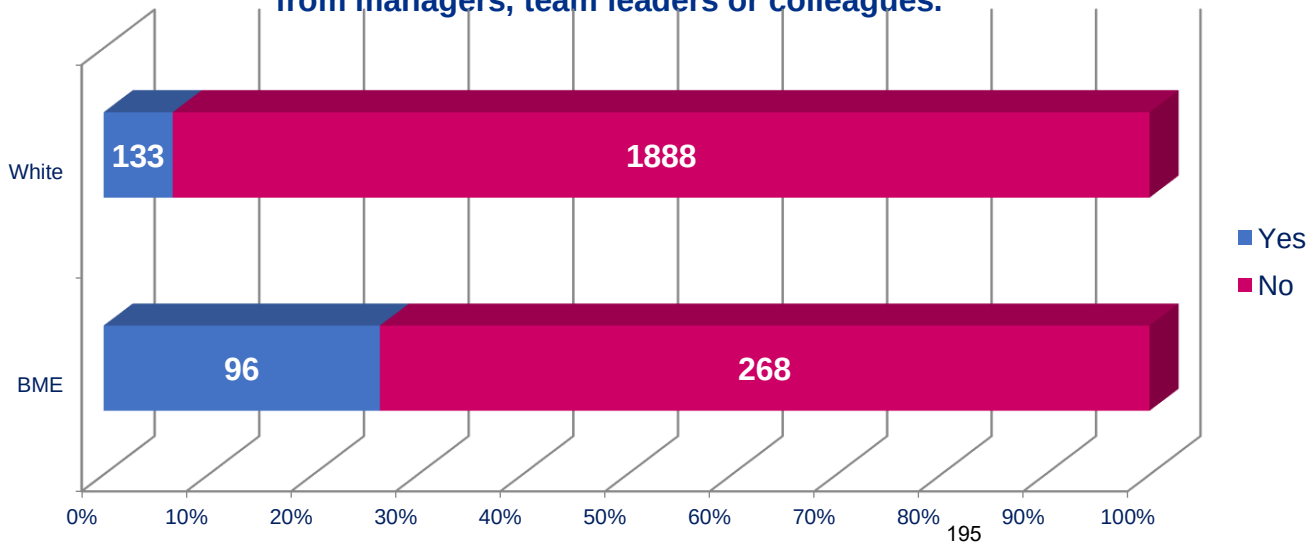
# Indicator 8: BME staff experiencing harassment bullying or abuse

This indicator looks at the rate at the percentage of BME staff who reported experiencing discrimination from manager / team leader or other colleagues.

| | |
|---|---|
| 17.3% | Benchmark Organisations Average in 2021 |
| 26.4% | Our Trust Average in 2021 |

- There has been an increase in the number of BME staff experiencing discrimination when compared with the 2020 figures. In 2020, 16% of BME staff reported experiencing discrimination. In the corresponding period, the figure for White staff was 5.9%.
- Most recent Trust figures for White staff (6.6%) are comparable with the national average; but, as shown above, figures for Trust BME staff are almost 10% worse.

**BME and White staff who reported experiencing discrimination from managers, team leaders or colleagues.**




**What we know**

Although our figures are marginally better than the national averages for White staff, this is still a general concern across all staff groups

**What action we are taking**

We operate a zero tolerance policy to all forms of discrimination, and are seeking to make that more visible (through clear reporting channels, management training and coaching, and promoting our Freedom to Speak Up and Wellbeing services, for example); as well as providing clear routes to reporting.

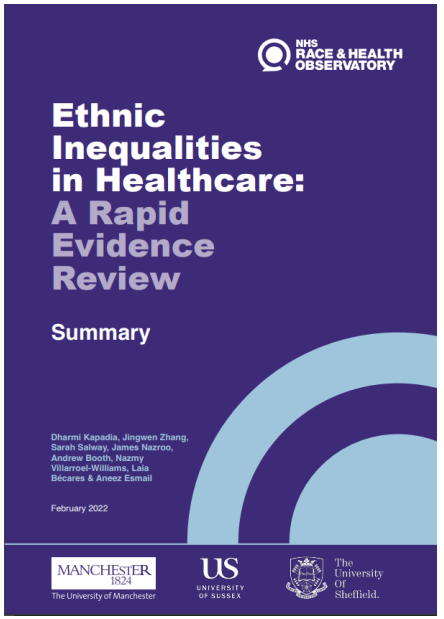
# Staff Survey Findings – The Bigger Picture

## Ethnic Inequalities in Healthcare

A study by the NHS Race and Health Observatory, reviewing ethnic inequalities in healthcare and within the NHS workforce, contained several findings that align closely with the NHS national staff survey results. Most notably, the review found:

- NHS ethnic minority staff enduring racist abuse from other staff and patients and this was particularly stark for Black groups. Most of the qualitative studies on experiences of racist abuse in the NHS workforce have been undertaken with nurses (and particularly Black African nurses or those that have been internationally recruited), indicating a lack of research on the experiences of other ethnic minority groups working in the NHS.
- Limited and mixed evidence on ethnic inequalities in NHS staff mental health and wellbeing. Notably, there was very limited evidence connecting the racist experiences endured by staff and their mental health, wellbeing and likelihood of burnout, and indeed other health outcomes. The studies on career progression were largely qualitative and conducted mainly with women; these studies showed how racism played out in the workplace to hamper ethnic minority staff's career progression and professional development. There was also evidence for an ethnic pay gap in most staff sectors in the NHS and which was evident for Black, Asian, Mixed and Other groups, but less so for Chinese groups.

Click on the image (below) to access the full study




Our action plan aligns with the findings of these studies. See **Appendix 3**

## BMA Racism in Medicine Survey

(launched in October 2021, published March 2022)

Interim findings…

- Just over 90% of Black and Asian respondents, 73% of Mixed respondents, and 64% of White respondents said racism in the medical profession is an issue
- 76% of the doctors surveyed experienced racism at least once in the last two years, with 17% experiencing these racist incidents on a regular basis.
- Low-level of reporting for racist incidents - 71% of doctors who experienced racism chose not to report
- Experiences of racism had a negative impact on wellbeing, staff retention, and career progression.

Click on the image (below) to access the full study

# Summary of Key Findings for 2021-2022

**Key areas of progress from our 2021/22 WRES report are:**

- A 20.6% (193) overall increase in BME staff numbers since 2020/21;
- The greatest movement for BME (clinical and non-clinical) staff is into Band 5 (from 32.8% to 42.3% of clinical staff);
- Noticeable increases in the proportions of BME clinical trainee grade (from 25% to 34.9%) and non-clinical VSMs (from 0% to 16.7%);
- BME staff were less likely than White staff to enter the formal disciplinary process. This bucks the national trend, but the gap between the proportion of BME and the proportion of White staff entering the formal disciplinary process has grown smaller, since 2020/21.

**There are areas where our progress is less marked. Namely:**

- White applicants are more likely to be appointed to job roles from shortlisting than BME applicants, with the ratio similar to the previous year;
- All harassment and bullying indicators have shown a deterioration, and this is more marked for BME staff. In particular, harassment, bullying or abuse from patients, relatives or members of the public has increased from 22.8% to 32.8% for BME staff.
- Fewer staff believe the Trust provides equal opportunities for career progression or promotion, with the decline marked for BME staff. The figure for BME staff has declined from 45.7% to 38.9%, since last year;
- The Disparity Ratio has been developed as a metric by the national WRES team to help set trajectories and monitor them. It is the difference in proportion of BME staff at various AfC bands in a Trust compared to proportion of White staff at those bands. Our disparity ratio is 5.59. This means that white staff are 5.59 times more likely to progress from lower to the upper employment bands as BME staff;
- The national WRES findings indicate that BME Band 5 clinical staff continue to struggle to attain promotions to higher grades and bands.

# About Our Action Plans

NHS
Royal United Hospitals Bath
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

## Joint ownership of our action plans

To improve the work experience for our BME staff, we will continue to engage with EDI Leads and Staff Networks across the BSW Integrated Care System, to share best practice and resources. With this wider engagement in mind, our Trust action plan has been agreed with and is jointly owned by our neighbouring acute Trusts. The range of issues are consistent across our organisations (although our key steps to achieve the actions and completion dates may differ).

## Our Action Plans

Following the results of the Trust WRES, our action plan has been simplified and updated (see Appendix 3). Principally, our focus is to provide a safe space for our colleagues, reduce forms of discrimination, and ensure equal opportunities for recruitment and progression within the workforce (as reflected by lower disparity ratios).

**Alongside the above action plans, we will:**

- Develop and publish progress against the Model Employer goals in line with the NHS People Plan, to ensure that at every level the workforce is representative of the overall workforce;
- Work to reduce levels of harassment, bullying or abuse from manager or colleagues
- Work to reduce levels of discrimination at work by manager/team leader or colleague
- Work to reduce levels of harassment, bullying and abuse from patients, relatives or the public
- Continue our work as part of the BSW ICS, and our commitment to delivering the People Plan, which includes a strong commitment to overhauling recruitment practices (the NHS People Plan, inclusive recruitment paper can be read here). We will work with our regional partners to develop a joined-up approach to EDI for the future.

# Appendices

# Appendix 1: Summary of WRES Indicator Scores

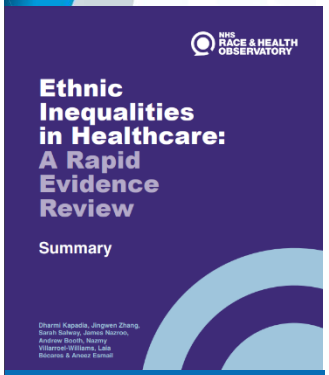
Below is a summary of the WRES indicator scores for our Trust over the last four years, shown as either a percentage or as an indicator (with an indicator score of one, or 'parity', being the overall aim). Comparisons are between figures from 2020 and 2021, to rate our 'direction of travel', with an assessment of positive or negative referring to the indicator's impact on BME staff.

| | WRES Indicator | 2018-2019 (Benchmark Year) | 2019-2020 | 2020-2021 | 2021-2022 | Direction of Travel |
|---|---|---|---|---|---|---|
| 1 | Increased representation across **some** staff grades and bands | 11.7% | 14.5% | 17.2% | 20.6% | ↑ |
| 2 | Likelihood of White staff being appointed from shortlisting | x1.59 | x1.27 | x1.13 | x1.37 | ↔ |
| 3 | Likelihood of BME staff entering the formal disciplinary process | x0.57 | x0.83 | x0.72 | x0.81 | ↔ |
| 4 | Likelihood of BME staff accessing non-mandatory training and CPD | x0.97 | x0.91 | x0.92 | x1.01 | ↑ |
| 5 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public | 22.8% BME<br>26.5% White | 22.8% BME<br>29.6% White | 22.5% BME<br>29.0% White | 34.8% BME<br>32.8% White | ↓ |
| 6 | Percentage of staff experiencing harassment, bullying or abuse from staff | 29.6% BME<br>24.5% | 22.8% BME<br>21.6% White | 21.0% BME<br>22.9% White | 32.2% BME<br>25.6% White | ↓ |
| 7 | Percentage believing Trust provides equal opportunities for career progression or promotion | 38.9% BME<br>55.7% White | 50.0% BME<br>61.1% White | 45.7% BME<br>58.0% White | 38.9% BME<br>59.3% White | ↓ |
| 8 | Percentage experiencing discrimination from Manager/team leader or other colleagues | 9.3% BME<br>5.6% White | 8.8% BME<br>3.4% White | 16.0% BME<br>5.9% White | 26.4% BME<br>6.6% White | ↓ |
| 9 | BME percentage difference/change between the organisations' Board voting membership (BME) and its overall workforce percentage (BME) | -10.05% | -11.69% | -17.2% | -13.5% | ↑ |

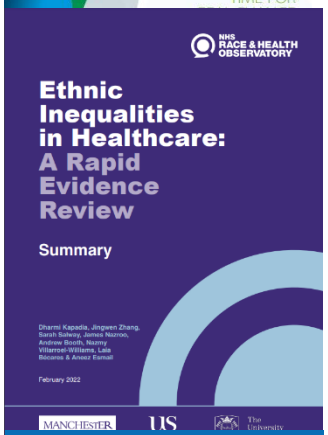
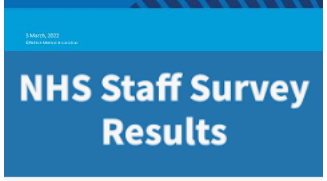
**Key**

- Improvement for BME staff
- Similar findings
- Deterioration for BME staff

# Appendix 2: Trust Action Plan, 2022-2023

| Key Problem Area(s) and Action(s) | Source(s) | Key Steps to Achieve Actions | Completed | Desired outcome(s) |
|---|---|---|---|---|
| **Reducing Disparity & Progression Ratios** |  <br>  <br>  | Actively encourage applications from BME staff (at Bands 4-7), for the Trust Aspiring Leaders programme (the programme includes interview practice, and other communications skills training).<br><br>Develop an Allyship programme<br><br>Review of appraisal system as part of BSW system-wide 'Overhauling Recruitment' Processes<br><br>Career coaching as integral to annual appraisal process (staff at Bands 2-7)<br><br>Develop a Reciprocal Mentoring programme<br><br>Leadership Development programme (aimed at all staff in Bands 7, 8a)<br><br>All recruiting managers to complete the License to Recruit training to promote good practise (training includes EDI, unconscious bias and safeguarding). This is monitored and reported to the EDI Group.<br><br>Recruit BME staff for the 'Scope for Growth' Career conversations. | Feb. 2023<br><br>Dec. 2022<br><br>Sept. 2022<br><br>Sept. 2022<br><br>Sept. 2022<br><br>Ongoing<br><br>Aug. 2022<br><br>Ongoing | Equal likelihood of White and BME being promoted through the lower, middle and higher bands<br>■<br>More BME staff in roles at Bands 7 and above<br>■<br>Reduced disparity ratio<br>■<br>Reduced progression ratio |

# Appendix 2: Trust Action Plan, 2022-2023

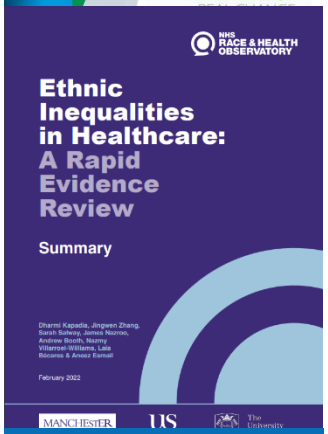
| Key Problem Area(s) and Action(s) | Source(s) | Key Steps to Achieve Actions | Completed | Desired outcome(s) |
|---|---|---|---|---|
| **Reducing Overt & Covert Discrimination**<br>**Areas of focus include…**<br>▪ Identifying and tackling forms of racism<br>▪ Ways to increase confidence in complaints processes<br>▪ Understand the role of the Trust in tackling the issue<br>▪ Ensuring we listen to the experiences of minority communities<br>▪ Supporting ALL staff to stand up to unacceptable behaviour from patients - yellow carding demonstrations that abuse won't be tolerated.<br>▪ Creating spaces for honest conversations.<br>▪ Ensuring conversations are confidential.<br>▪ Considering external coaching, particularly for chairs, to build confidence and capability to lead on race |  <br>  <br>  <br>  | Disseminate case study material through focused group work that looks at emotional impact and practical measures to redress | **Feb. 2023** | Improved staff satisfaction scores<br>■<br>Lower rates of bullying and harassment<br>■<br>Improved rates of staff retention and engagement<br>■<br>The Trust as a more desirable place to work<br>■<br>Increased confidence in complaint systems and processes |
| | | Develop a public EDI Q+A forum to address areas of confusion, outline measures and Trust support, and convey emotional impact of discrimination | **Dec. 2022** | |
| | | ▪ Analyse findings from incident reports into bullying and harassment of staff;<br>▪ Organise focus groups to discuss and review current measures<br>▪ Refine approach and change content as required | **Nov. 2022** | |
| | | Career coaching as integral to annual appraisal process (staff at Bands 2-7) | **Sept. 2022** | |
| | | ▪ Regular Board Stories of staff and patient experiences | **Current** | |

# Appendix 2: Trust Action Plan, 2022-2023

## Fostering Safe Spaces

### Areas of focus include…

- Linking Board executives with members of staff networks to help foster trust between staff and the board.
- Co-designing programmes with board members and the minority ethnic network

| Key Problem Area(s) and Action(s) | Source(s) | Key Steps to Achieve Actions | Completed | Desired outcome(s) |
|---|---|---|---|---|
| |  | Develop and embed an Allyship programme | Dec. 2022 | Additional channel to present ideas for improvement and to raise awareness<br>■<br>Individual board member ownership of parts of the EDI agenda<br>■<br>Measurable increase in trust between Board and BME network |
| |  | Develop and embed a Reciprocal Mentoring programme | Sept. 2022 | |
| |  | Develop an interactive, time-sensitive EDI dashboard that registers and monitors network concerns and outlines levels of Board level accountability | April 2023 | |
| |  | | | |

# Appendix 3: Trust and BSW ICS Action Plan, 2021-2022

| Key action | Steps to achieve action | Status/ due by | Desired outcomes |
|---|---|---|---|
| Ensure Executive and Very Senior Managers (ES&VM) own the agenda, as part of culture changes in organisations, with improvements in Black Asian and Minority Ethnic representation (and other under-represented groups) as part of objectives and appraisal by:<br>a) Setting specific KPIs and targets linked to recruitment.<br>b) KPIs and targets must be time limited, specific and linked to incentives for which ES&VMs are accountable | 1. Executive Lead appointed to EDI Agenda<br>2. Ensure an inclusive and responsive approach based on staff feedback through new starter survey.<br>3. Increase diversity of applications from under-represented groups. Monitor and report our EDI data from candidate application to appointment.<br>4. Continued development of staff networks (LGBQT, DAN, BME) | 1. Completed<br>2. Ongoing<br>3. Ongoing<br>4. Completed | 1. Executive Lead is Kevin McNamara.<br>2. A 'fresh eyes' survey continues to be undertaken for new starters. The data collated from this is shared with Resourcing, HR and our Academy. Dependent on outcomes necessary actions are implemented.<br>3. Recruitment EDI data capturing ethnicity of candidates from application, shortlisted and appointment continues to be reviewed monthly and shared in the Trust's performance report.<br>4. All staff networks meet monthly and represent at the Trust EDI meeting. The EDI recruitment data is shared and discussed with the networks. The Chairs of Networks attend each of the meeting to understand each others' networks. |

Note
The Trust and BSW ICS Action Plan was developed and has been updated for 2021/22, and contains measures developed with our local partners as part of a system wide approach. These were the areas under discussion during 2021-22, some of which are still under discussion.

**BSW (system wide themes/ actions)**

System wide oversight of KPIs and progress to identify and share areas of best progress via OPDG dashboard presented quarterly

| | | | |
|---|---|---|---|
| **Introduce a system of constructive and critical challenge to ensure fairness during interviews.**<br><br>**This system includes requirements for diverse Interview panels, and the presence of an equality representative who has authority to stop the selection process before offer is made, if it is deemed unfair and compliments the need for accountability** | 1. Adopting diverse interview panels for Exec and VSM OR across the Trust where possible<br>2. Explore the inclusion of patients on focus groups.<br>3. Recruiting managers to undertake 'License to Recruit' mandatory training which includes EDI and unconscious bias training<br>4. Pilot the introduction of a 'critical friend', to observe and review consistency across interview panels (target areas based on experience feedback, ensuring different roles and banding are included). | 1. Executive Recruitment (Completed) / VSM (Ongoing)<br>2. Completed<br>3. Completed<br>4. Ongoing | 1. All Executive Recruitment has adopted a diverse interview panel / stakeholder discussion groups. Work on implementing this for all VSM recruitment continues.<br>2. The Trust has created a process to enable the public/patients where appropriate the opportunity to partake on focus groups.<br>3. Mandatory for all recruiting managers to have completed the Trust Licence to Recruit mandatory training module.<br>4. Inconsistencies across interviews removed, and additional oversight regarding the interview process. |

# Appendix 3: Trust and BSW ICS Action Plan, 2021-2022

| | Key action | Steps to achieve action | Status/ due by | Desired outcomes |
|---|---|---|---|---|
| | Enhance EDI support available to:<br>a) Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies<br>b) Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews. | 1. Incorporate questions for bands 8a level roles that enable candidates to demonstrate their EDI experience, commitment and engagement<br>2. Internal communications to promote the importance of completing effective Equality Impact Assessments and the governance process on monitoring EIA's. | **1. Completed**<br>**2. Ongoing** | 1. The recruiting manager paperwork includes a selection of EDI questions designed to enable candidates the ability to demonstrate EDI work/ legacy. It is mandatory one question from the section is asked at interview.<br>2. Greater awareness and understanding of the importance of EIAs, and how to complete them. EIA completion rates and quality monitored and increased. |
| | Overhaul interview processes to incorporate:<br><br>a) Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used.<br>b) Ensure adoption of values based shortlisting and interview approach.<br>c) Consider skills-based assessment such as using scenarios | 1. Compulsory for all recruiting managers to complete the License to Recruit training to promote good practise (training includes EDI, unconscious bias and safeguarding). This will be monitored and reported.<br>2. Create best practise document that can be distributed to recruiting managers across the Trust.<br>3. Values based recruitment to be explored and implemented across the system (BSW RRS Objective) | 1. Completed<br>2. Ongoing<br>3. Ongoing | 1. Mandatory for all recruiting managers to have completed the Trust Licence to Recruit mandatory training module.<br>2. Best practice consistent and disseminated across partner organisations.<br>3. Whilst the ICS Values based recruitment work continues, the Trust is utilising Leadership Framework behaviours and Trust Values behaviours to design a portfolio of competency questions linked to these. |

# Appendix 3: Trust and BSW ICS Action Plan, 2021-2022

| | Key action | Trust steps to achieve action | Status/ due by | Desired outcomes |
|---|---|---|---|---|
| | Overhaul interview processes to incorporate:<br><br>a) Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used.<br>b) Ensure adoption of values based shortlisting and interview approach.<br>c) Consider skills-based assessment such as using scenarios | 1. Compulsory for all recruiting managers to complete the License to Recruit training to promote good practise (training includes EDI, unconscious bias and safeguarding). This will be monitored and reported.<br>2. Create best practise document that can be distributed to recruiting managers across the Trust.<br>3. Values based recruitment to be explored and implemented across the system (BSW RRS Objective) | 1. Completed<br>2. Ongoing<br>3. Ongoing | 1. Mandatory for all recruiting managers to have completed the Trust Licence to Recruit mandatory training module.<br>2. Best practice consistent and disseminated across partner organisations.<br>3. Whilst the ICS Values based recruitment work continues, the Trust is utilising Leadership Framework behaviours and Trust Values behaviours to design a portfolio of competency questions linked to these. |

**BSW (system wide themes/ actions)**

| | | | |
|---|---|---|---|
| Adopt resources, guides and tools to help leaders and individuals have productive conversations about race | Developing a range of teaching resources that focus on intersectionality (audio visual, newsletter, fresh eyes, feedback from all networks – BME, DAN, LGBQT…) | **Completed** | AV resource focused on recognising and tackling forms of discrimination now available; EDI newsletter produced quarterly; Network groups provide updates at other respective meetings; all training and development opportunities cascaded to all networks. |

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Workforce Disability Equality Standard (WDES) Annual Report, 2021-2022** | | | | |
| **Meeting** | Trust Board | | | | |
| **Date** | 06 Oct. 2022 | Part 1 (Public) [Added after submission] | x | Part 2 (Private) [Added after submission] | |
| **Accountable Lead** | Jude Gray | | | | |
| **Report Author** | Patrick Ismond | | | | |
| **Appendices** | Included with report | | | | |

**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):

This paper contains a summary of the Trust results for this year's Workforce Disability Equality Standard (WDES) reporting.

When compared with previous years, our staff are:

- More likely to share their disability status;
- Equally likely as non-disabled applicants to be appointed to roles once shortlisted;
- Less likely to enter the formal capability process;
- Part of a growing network, increasing awareness of member's issues. For example, raising awareness of and providing support for neurodiverse staff.

When compared with the national average for benchmark Trusts, we also know that:

- Our disabled staff believe there are more opportunities for career progression and promotion;
- Fewer disabled staff feel pressured to come to work when ill.

There are areas where our progress is less marked. Namely:

- We have yet to have any members of our Executive team or Board with a declared disability;
- Very few staff (133, or 2.4%) have self-declared a disability;

- There is a large disparity between the number of staff declaring a disability through the ESR, and the number of staff declaring a disability when completing the National NHS Staff Survey.
- More likely to experience abuse, than in previous years;
- Less likely to be satisfied with adjustments made to the workplace, compared with previous years;
- Less likely to feel valued by the organisation, compared with previous years.

With such low numbers declaring a disability, and with a large disparity the ESR and NHS staff survey, it is difficult to draw firm conclusions. However, our Differently Abled Network (created in March 2021), continues to build on the work being done to improve experiences for disabled staff.

| | | | | | |
|---|---|---|---|---|---|
| **Link to CQC Domain** – select one or more | **Safe** | **Caring** | **Effective** | **Responsive** | **Well Led** |
| | | 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** | This report has been to both TMC and P&C in August | | | | |
| **Next Steps** | | | | | |

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

Explanation of above analysis:
The report identifies where staff in protected groups (disability) are treated less favourable. The report provides information regarding areas of improvement and makes recommendation for action against those areas where disable staff are treated less favourably.

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

- **The Board to note the finding and support the future actions**

| | |
|---|---|
| **Accountable Lead Signature** | Jude Gray |
| **Date** | 06 September 2022 |

NHS
Great Western Hospitals
NHS Foundation Trust

# Workforce Disability Equality Standard (WDES) Report

## 2021-2022

Equality, Diversity & Inclusion

# WDES Report (2021-2022)

## Contents

# Foreword


**Click the image (above) to see Justin discussing the WDES**

My name is Justin Sysum, I am the Clinical Audit and Effectiveness Facilitator for the Trust and the Chair of our Differently Abled Network. Our network is open to all staff who have a passion for an inclusive culture.

I always wait on the results of the latest WDES (Workforce Disability Equality Standard) report with interest, as I believe this gives us a real temperature check against not only the previous years results, but also our peer trusts and our EDI Strategy. But more importantly, it gives us an important insight into our organisational culture, and as they say, "*Organisational culture will eat strategy for breakfast, lunch and dinner*."

**"Disability need not be an obstacle to success"**

***Steven Hawking***

I have always believed that for us to be an inclusive place to work, we should not just judge our inclusivity by the reported percentage of disabled, BAME or LGBTQ+ staff that work for us or are recruited by us. A truly inclusive culture is an organisation that embraces equality and is a place where disabled, BAME and LGBTQ+ people are able and proud to be themselves, and in turn, is an attractive place for all people to work.

As you will see in the report, we have made important strides and we are traveling in the right direction for some metrics, but there is still much to be done in others. You will also see in this report what our action plan is going forward, and my call to arms is that it is all our responsibility to continue the good work we have started.

Thank you.

**'…My call to arms is that it is all our responsibility to continue the good work we have started.'**

**Justin Sysum**
Chair, Differently Abled Network

# Report Summary

In essence, the NHS Workforce Disability Equality Standard (WDES) helps NHS commissioners and NHS healthcare providers (including independent organisations) achieve workplace parity between their disabled (see Equality Act definition below) and non-disabled staff. It aims to achieve this by reviewing data against a number of key performance indicators, and obliges organisations to produce action plans to close identified gaps in career and workplace experiences.

A WDES return is completed annually. As well as requiring comparative information on workforce indicators for disabled and non-disabled staff, it also compares national NHS Staff Survey data for these groups. Progress is measured against the WDES indicators, and we compare our present position with results from previous years.

Our findings present a fairly mixed picture regarding career progression and improved work experiences for staff with disabilities. For instance, when viewed against the benchmark Trusts' national averages, our disabled staff believe there are more opportunities for career progression and promotion, feel under less pressure to come to work when unwell, and are more likely to be appointed to roles once shortlisted. By contrast, they are more likely to experience abuse at work, and less likely to be satisfied with the value placed on their work, than in previous years.

Crucially, we cannot be wholly confident about our findings due to the disparity in number between our staff who self-declare a disability on our recording system, and our staff who declare a disability via the NHS Staff Survey.

We have developed an action plan that builds on work we have done in previous years, and responds to the areas where we currently need to improve. We also continue to engage with Equality, Diversity and Inclusion (EDI) leads and staff networks across the Bath, Swindon and Wiltshire Integrated Care System, to share best practice and resources. With this wider engagement in mind, our action plan has been agreed with and is jointly owned by our neighbouring acute Trusts. The range of issues are consistent across our organisations (although key steps to achieve the actions and completion dates may differ). Finally, our network for staff with disabilities continues to act as an important source of advice, support and awareness-raising for staff in the Trust.

**The Equality Act 2010 defines disability as:**

A physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.

**Listen to an audio recording of this report summary**

**Dr Patrick Ismond**
Lead for Equality, Diversity & Inclusion

# What is the WDES?

The NHS Workforce Disability Equality Standard (WDES) launched on 1 April 2019. There are ten metrics, taken from a variety of data sources and they are used to compare the experiences of staff who have a disability with those who do not.

The aim is for results to be published annually in order to support organisations, particularly those with lower scores, to continuously improve standards. Trusts can compare their performance with others in the same region or providing similar services.

**Our WDES Report for 2021/2022 contains a number of elements:**

- Comparison with findings from previous GWH NHS FT WDES reports;
- Comparison with latest national findings for all participating NHS organisations (report for 2020-2021 released in March 2022). For indicators 2 and 3;
- Comparison with latest average NHS Staff Survey findings, for the benchmark group assigned by NHS England. In our case, the benchmark group is 'Acute and Acute and Community Trusts'. For indicators 4-8;
- A Summary of key findings;
- An updated action plan, 2022-2023.

**WDES data sources include:**

- The Electronic Staff Record (ESR) (Indicators 1, 3 & 10)
- The TRAC recruitment system (Indicator 2)
- The Annual Staff Survey (Autumn 2021) (Indicators 4 to 9)

**This workforce data is reporting against the period 1 April 2021 to 31 March 2022**

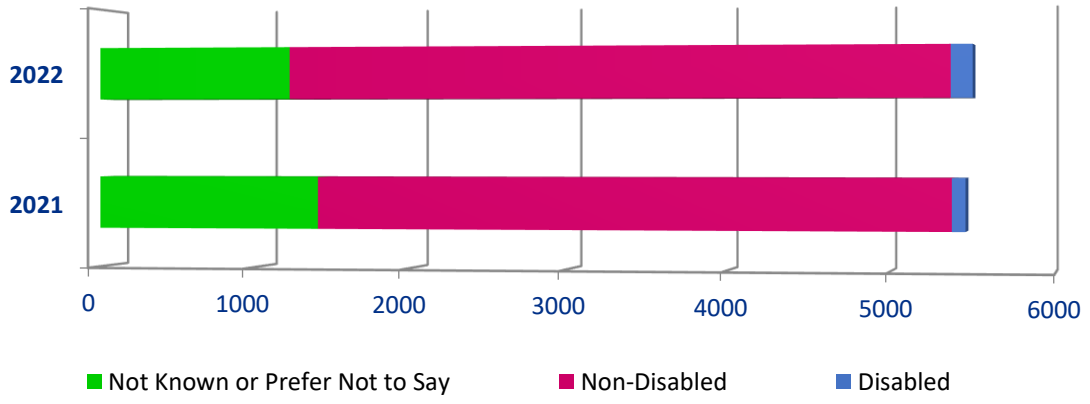
Where possible, we have compared our position with that of our local partners in the Bath, Swindon and Wiltshire Integrated Care System (BSW ICS). Datasets extracted from the South West Workforce Planning and Intelligence Systems Information Pack were used to create a quarterly report for the BSW/South West Region, and any compatible metrics have been taken from the report released in December 2021.

# Overall Trust Picture

## Overall Picture

The total number of staff employed at our Trust as at 31 March 2022 is 5502. The table and chart below show the proportion of our workforce, by disability status. The total staff number for 2020/21 differs slightly from the Workforce Race Equality Standard (WRES) data, because last year's data snapshots were taken at different points in time.

| | | 2020/21 | | 2021/22 | |
|---|---|---|---|---|---|
| | | Headcount | % of Staff | Headcount | % of Staff |
| Disability Declared | Disabled | 83 | 1.5% | 133 | 2.4% |
| | Non-Disabled | 3999 | 72.7% | 4133 | 75.1% |
| Total Disability Declared | | 4082 | 74.2 | 4266 | 77.5% |
| Not Known or Prefer Not to Say | | 1421 | 25.8% | 1236 | 22.5% |
| Total Number of Staff (Headcount) | | 5503 | 100.0% | 5502 | 100.0% |




## Since last year:

A greater proportion of staff are choosing to share their disability status on the ESR system, and by extension, the proportion of staff for whom this information is not known, or who 'prefer not to say' has decreased.

The improved findings suggest an increased staff awareness about the importance of accurate data collection for service improvement, and a gradual easing of staff fears regarding job security and data safety

# Comparing the ESR and Annual Staff Survey

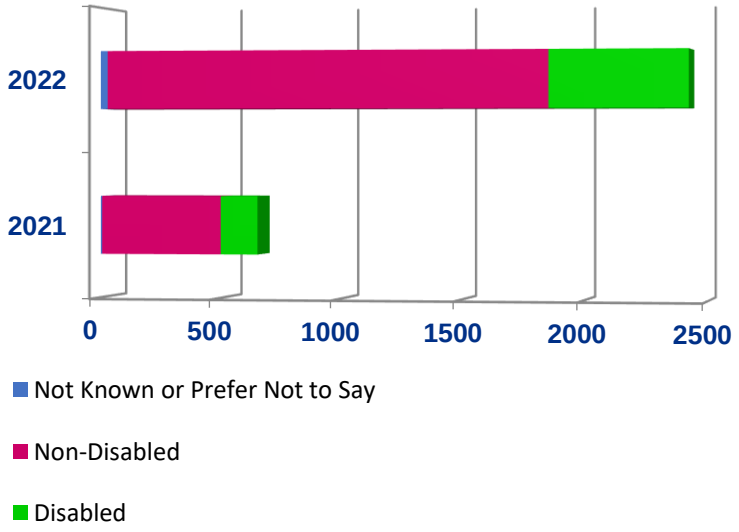
## The Annual NHS Staff Survey (2021)

**- 6.0%**

- The percentage decrease in eligible staff who completed the Annual NHS Staff Survey, since 2020;
- It was completed by **2428** Great Western Hospital NHS FT staff in 2021;
- We achieved an **overall response rate** of **47.1%** from all eligible respondents;
- **568** staff who completed the NHS Staff Survey declared a disability.

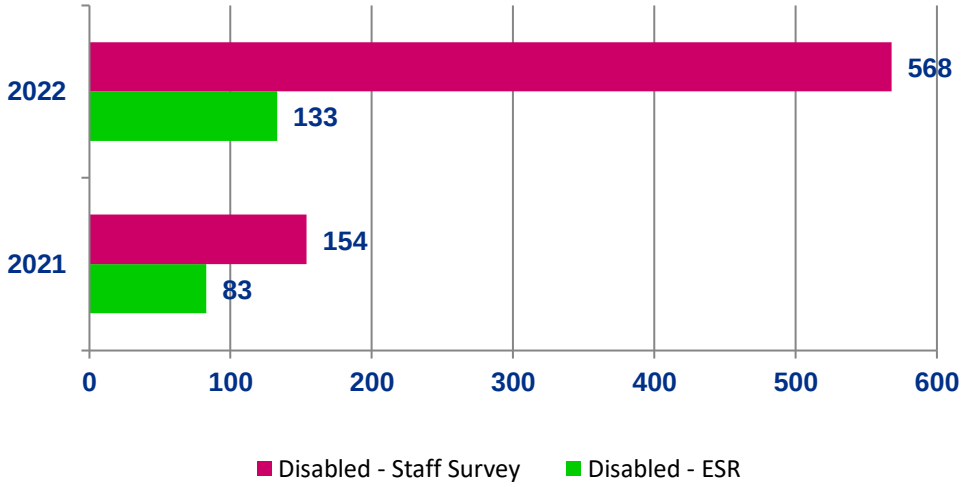
In 2020, a sample of our staff (around 22%) were invited to complete the NHS Staff Survey, whereas in 2021, it was open to all eligible staff. As a result, 2428 completed the survey in 2021, up from 660 the previous year. This significant increase has affected the disability declaration ratio, between the ESR and NHS Staff Survey.

**Total number of Trust staff eligible to complete the latest Annual NHS Staff Survey in 2021, and 2022, by disability status**




We have traditionally seen that more staff declare a disability in the annual staff survey, than they do on ESR. However, the disparity has increased significantly since 2021, as can be shown by the graph below.
This suggests that despite the improvements identified with an increase in sharing rates on ESR, there is a note of caution about the extent of progress made in this area.

**Declaration of disability status, for ESR (2022), and the latest NHS Staff Survey (2021)**



# WDES: The National Picture

**The NHS 2021 WDES report was published in March 2022, and refers to data from the 2020-2021 reporting year. Its key findings are reproduced below.**

**Workforce Representation**

2021 data shows an **increase of 0.3** percentage points to **3.7%** of the total workforce.

**59%** of trusts have five or fewer Disabled staff in senior positions (bands 8c and above, including medical consultants and Board members).

**Capability**

Disabled staff are nearly **twice as likely** to enter the formal capability process as their non-disabled colleagues.

**Board Representation**

Disabled board member numbers have increased by **more than 20**.

The proportion has **increased by 0.7** percentage points to **3.7%**.

**Staff Engagement**

All but six trusts facilitate the voices of Disabled staff to be heard.

**CQC well-led domain**

Trusts that are rated outstanding in the CQC well-led domain show evidence of **being better employers** for Disabled staff.

**Reasonable Adjustments**

**76.6%** of Disabled staff report that they have the adjustments necessary to perform their duties effectively, an **increase of 2.8** percentage points from 2020.

**The national results demonstrate positive change in a range of areas including an overall increase in disabled staff at board level across the NHS compared with the previous year; and an increase in the proportion of disabled staff reporting that adjustments made to the workplace enable them to perform their roles effectively. While these increases are welcome, the national report also showed that disabled staff are more likely to enter the formal capability process, and we know that nationally, numbers of staff declaring disability status are artificially low. The full report can be accessed here.**

# Electronic Staff Records (ESR) Indicators

# Indicator 1: Workforce by disability, as at March 31 2022

This indicator looks at the numbers of disabled staff, as a proportion of the entire workforce.

**+0.9%** — **The percentage increase in Trust staff who declared a disability, since last year**

**When our latest results are compared with our results from 2020/21:**

- 2.4% (133) of staff working at The Great Western Hospitals NHS Foundation Trust declared they had a disability.
- This is an increase of 50 staff since last year, as illustrated in the bar chart opposite.
- There were 3.35% (132) more non-disabled staff in 2022, compared with 2021.

**Staff declaring a disability**

| BSW ICS Average | GWH NHS FT Average |
|---|---|
| 3.4% | 2.4% |

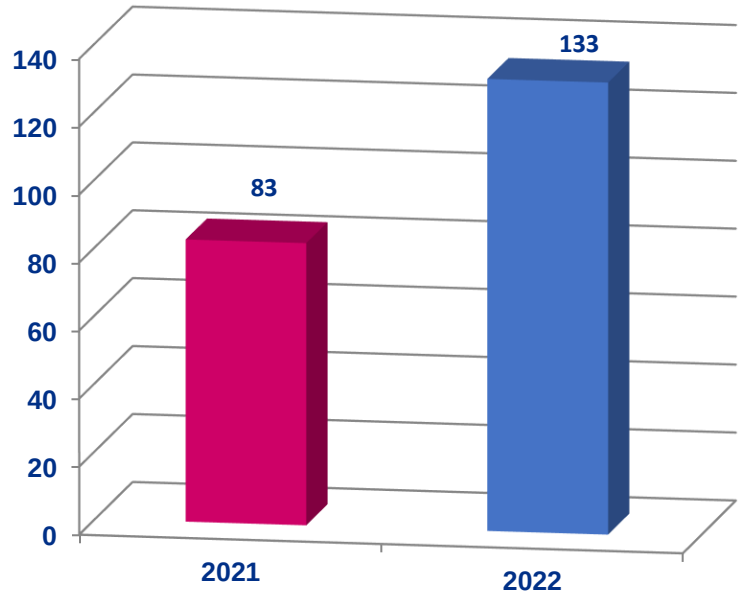
**What we know**

- Our declaring rate is lower than the overall average for other Trusts in BSW ICS.
- This is a persistent, long-standing issue that will not have a 'quick fix'.
- There is a 'clear and growing need' to more accurately capture diversity at Board level.

**What action we will take**

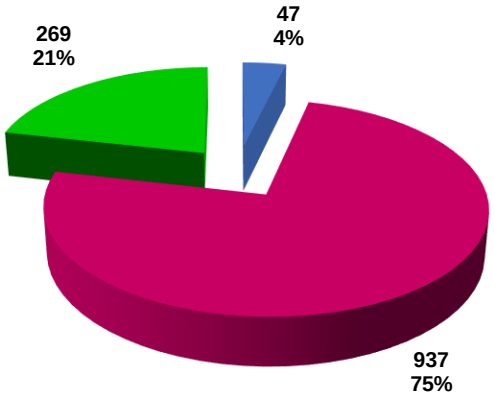
- Continue with regular stories from staff and patients with disabilities heard at Board Level;
- Use our Differently Abled Network to introduce and review resources to aid our staff with disabilities;
- Increase awareness about the range and scope of disabilities and remove the stigma sometimes associated with them. See **Appendix 1** for more detail

**Number of staff declaring a disability, 2021 and 2022**



# Indicator 1: Workforce by disability, as at March 31 2022

## Non-clinical

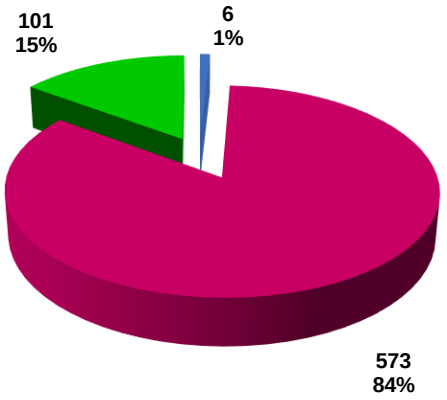



Disabled

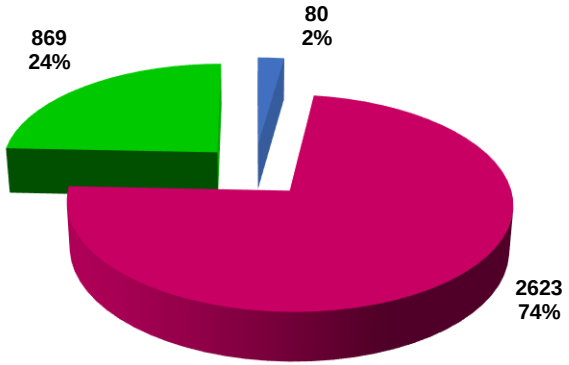
Non- Disabled

No known or Prefer not to say

## Medical and Dental




## Clinical




The pie charts show the percentage of disabled staff in clinical and non-clinical roles compared with non-disabled staff. 4,252 (77.2%) of our staff are clinical, compared with 1,253 (22.8%) non-clinical.

**The majority of our known disabled workforce are employed as…**

**Bands 5 & 6 Clinical Staff**

**Our 43 disabled Band 5 & 6 clinical staff represent 2.3% of the total number of Band 5 & 6 Clinical staff (1833).**

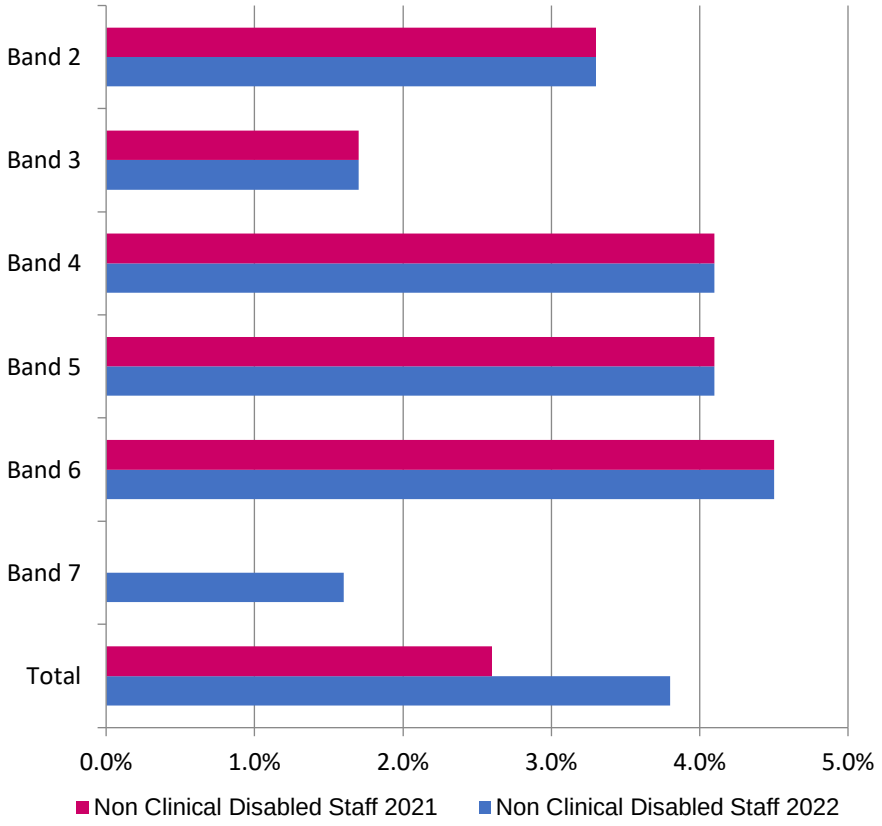
# Indicator 1: Workforce by disability, as at March 31 2022

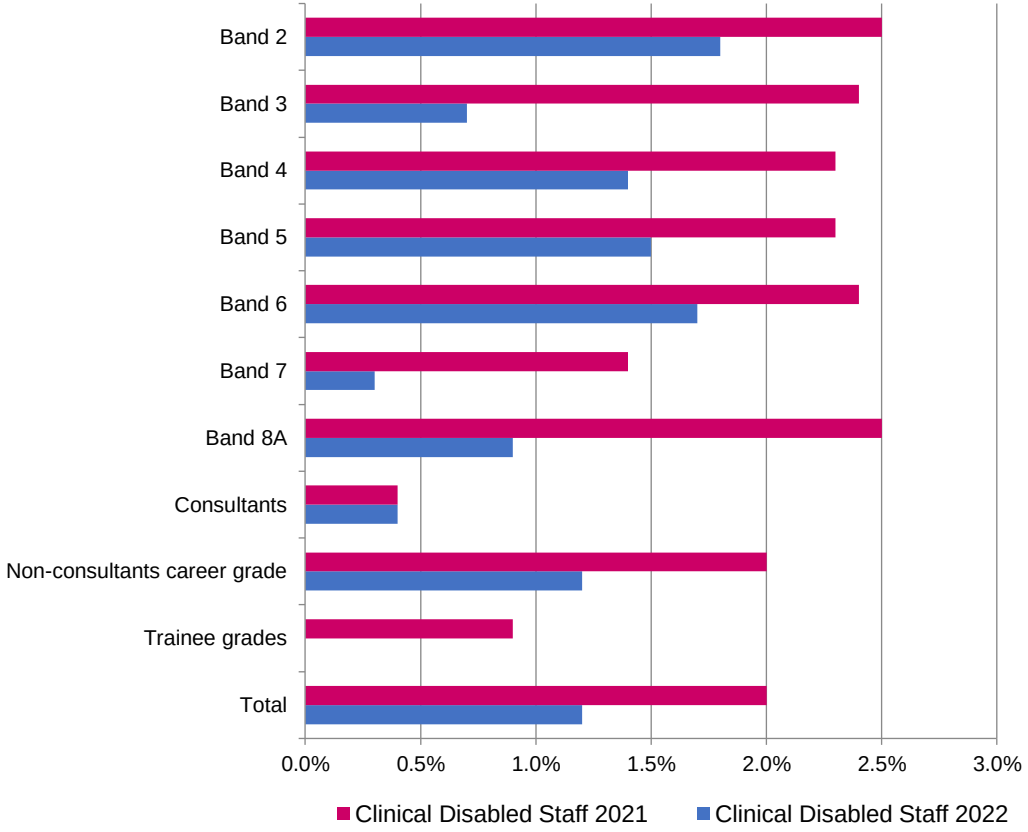
| | Non Clinical | | | | | | Clinical, Medical and Dental | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2022 | Disabled | Non-Disabled | Prefer Not to Say | Total | Disabled % | Non-Disabled % | Disabled | Non-Disabled | Prefer Not to Say | Total | Disabled % | Non-Disabled % |
| Under Band 1 | 1 | 13 | 3 | 17 | 5.9 | 76.5 | 0 | 4 | 0 | 4 | 0.0 | 100.0 |
| Band 1 | 0 | 1 | 0 | 1 | 0.0 | 100.0 | 0 | 2 | 0 | 2 | 0.0 | 100.0 |
| Band 2 | 18 | 316 | 79 | 414 | 4.3 | 76.3 | 16 | 487 | 139 | 642 | 2.5 | 75.9 |
| Band 3 | 11 | 256 | 73 | 341 | 3.2 | 75.1 | 7 | 233 | 55 | 295 | 2.4 | 79.0 |
| Band 4 | 7 | 92 | 46 | 146 | 4.8 | 63.0 | 5 | 142 | 72 | 219 | 2.3 | 64.8 |
| Band 5 | 4 | 67 | 14 | 85 | 4.7 | 78.8 | 23 | 728 | 246 | 997 | 2.3 | 73.0 |
| Band 6 | 5 | 46 | 16 | 67 | 7.5 | 68.7 | 20 | 615 | 201 | 836 | 2.4 | 73.6 |
| Band 7 | 1 | 45 | 16 | 62 | 1.6 | 72.6 | 6 | 298 | 117 | 421 | 1.4 | 70.8 |
| Band 8A | 0 | 43 | 10 | 53 | 0.0 | 81.1 | 3 | 81 | 34 | 118 | 2.5 | 68.6 |
| Band 8B | 0 | 17 | 0 | 17 | 0.0 | 100.0 | 0 | 15 | 4 | 19 | 0.0 | 78.9 |
| Band 8C | 0 | 14 | 6 | 20 | 0.0 | 70.0 | 0 | 7 | 0 | 7 | 0.0 | 100.0 |
| Band 8D | 0 | 2 | 1 | 3 | 0.0 | 66.7 | 0 | 9 | 1 | 10 | 0.0 | 90.0 |
| Band 9 | 0 | 7 | 2 | 9 | 0.0 | 77.8 | 0 | 2 | 0 | 2 | 0.0 | 100.0 |
| VSM | 0 | 18 | 0 | 18 | 0.0 | 100.0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| Consultants | | | | | | | 1 | 190 | 44 | 235 | 0.4 | 80.9 |
| Non-consultants career grade | | | | | | | 2 | 76 | 20 | 98 | 2.0 | 77.6 |
| Trainee grades | | | | | | | 3 | 307 | 37 | 347 | 0.9 | 88.5 |
| Other | | | | | | | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| Total | 47 | 937 | 266 | 1250 | 3.8% | 74.8% | 86 | 3196 | 970 | 4252 | 2.0% | 75.2% |

220

# Movement between pay bands

**The following chart shows the changing proportions of disabled staff in movement between pay-bands over the last 2 years, for clinical and non-clinical staff.**




**Notes:**

- There are only non-clinical staff who declared a disability between Band 2 and Band 7, for both 2021 and 2022, so all other bands have been removed from the chart.
- There are no clinical staff with a declared disability below Band 2, or between Bands 8B, VSM level and Other, for 2021 and 2022, so those bands have been removed from the chart.

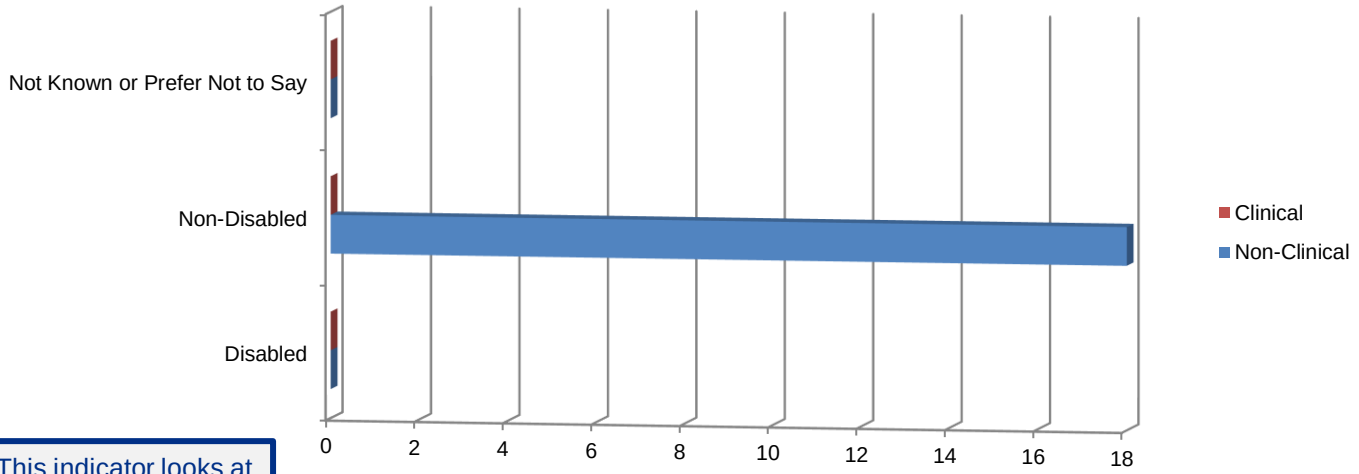
- The number of Trainees with a declared disability has reduced to zero for 2022, and this will affect future WDES data, as Trainees form an important part of the NHS future workforce
- The overall number of non-clinical staff declaring a disability has increased and the number of clinical staff declaring a disability has reduced.

# Indicators 1, 10: Disabled staff in senior management positions

**0**

## The Number of Disabled Staff at Very Senior Manager (VSM) Level in 2021

### Declared disability status, clinical and non-clinical staff




This indicator looks at the percentage difference between the organisation's board voting membership and the organisation's overall workforce.

| | Overall Workforce | | Executive Board Voting Membership | | % Difference |
|---|---|---|---|---|---|
| | No. in Workforce | % in Workforce | No. on Board | % on Board | |
| Disabled | 133 | 2.4% | 0 | 0.00% | -2.4% |
| Non-Disabled | 4133 | 75.1% | 14 | 100.00% | 24.9% |
| Not Known or Prefer Not to Say | 1236 | 22.5% | 0 | 0.00% | -22.5% |
| Total | 5502 | 100.00% | 14 | 100.00% | |

**What we know**

- There is a 'clear and growing need' to more accurately capture diversity at Board level.

**What action we will take**

- Continue with regular stories from staff and patients with disabilities heard at Board Level;
- Use our Differently Abled Network to introduce and review resources to aid our staff with disabilities;
- Increase awareness about the range and scope of disabilities and remove the stigma sometimes associated with them.

See **Appendix 1** for more detail

# Indicator 3: Disabled staff and the formal capability process

This indicator looks at the rate at which disabled staff were likely to enter the formal capability process, compared with their non-disabled colleagues.

| | |
|---|---|
| x 1.94 | National Average in 2021 |
| x 0.00 | Our Trust Average in 2021 |
| x 0.00 | Our Trust Average in 2022 |

- Our Trust figure is 0.00, which shows that no disabled staff entered the formal capability process during this period.
- If disabled staff were equally as likely as non-disabled staff to enter the formal capability process, then the figure for disabled staff would be 1.
- By contrast, figures from 2020 showed disabled staff were more likely to enter the formal capability process than non-disabled staff.

**Notes**

- This metric looks at capability on the grounds of performance, rather than ill health.
- A capability process is a formal way for an employer to address the circumstances surrounding an employee's 'under performance'. This may involve, for example, reviewing an employee's personnel file, appraisals, and gathering any relevant documents.
- Before starting a capability process, it is recommended that an employer first see whether the problem can be resolved in an informal way. This can often be the quickest and easiest solution.

# Declaration rates: the national picture, since March 2015

| | |
|---|---|
| +1.44% (30,977) | Percentage (and numerical) increase in numbers of staff declaring a disability |
| -11% | Percentage decrease in number of staff records where disability question is left unanswered |
| -6.6% | Percentage decrease in number of staff records where 'not declared' is recorded |

## Note

Over recent years, there has been a push at national level to improve data collection on all personal protected characteristics. Partly as a result, we have seen improvements in the overall return rates for all these data sets. In the case of disability, the progress is less marked than, say, data on ethnicity, but it does suggest that employees now feel more comfortable sharing their disability status.

Declared rates of disability are low, relative to the size of the working population, and this means we cannot be assured about the experiences of staff with disabilities, including their reasons for not sharing disability status. Improving data collection is central to our action plan (see **Appendix 2**).


# Why neurodiversity?

We know from national studies (and from members of our Trust Disability network) that a sizeable number of staff are neurodivergent, and are reluctant to talk about their condition, for fear of stigma. Our action plan aligns with the findings of these studies.
See Appendix 2.

## Neurodiversity at Work: The Power of Difference

The research summary study found that:

- Around 1 in 7 people (more than 15% of people in the UK) have neurodivergent conditions, meaning that the brain functions, learns and processes information differently;
- 50% of people would not employ someone from one of the neuro-minorities;
- Most organisations do not include neurodiversity within policy and procedures, or provide training on inclusion;
- People who have neurodivergent conditions have worse experiences than their neurotypical peers perceive.

**Click on the image (right) to access the full study**


THE INSTITUTE OF LEADERSHIP & MANAGEMENT

Neurodiversity at work
Research Summary

Our research: why now?

It is estimated that around 1 in 7 people (more than 15% of people in the UK) have neurodivergent conditions, meaning that the brain functions, learns and processes information differently; this includes Attention Deficit Disorders, Autism, Dyslexia and Dyspraxia (ACAS, 2019). Although often characterised by a set of "deficits" which are used to identify ways they differ from the majority of the neurotypical population, neurodivergents often have unique attributes and there is a strong business case for employing people from neurominorities for their creativity, problem solving skills and other capabilities (Bawley & George, 2016, CIPD, 2018; Faragher, 2018; GMB, 2018; Silberman, 2015).

Despite the opportunities presented by employing neurodivergents, false stereotypes persist which limit opportunities available to both neurodivergents and to organisations who are not accessing this untapped talent. Furthermore, many neurodivergents report mental health issues arising as a result of active discrimination, exclusion and bullying due to their differences, or as a result of the efforts of hiding their differences (ACAS, 2019; CIPD,2018; GMB,2018)

Highlights

The Institute of Leadership & Management found that neurominorities have far worse experiences in the workplace than their neurotypical colleagues believe they do; with autistics, dyscalculics and people with ADHD reporting the worst experiences. Half of all leaders and managers reported that they would not employ someone who had one or more neurodivergent condition with many providing statements making assumptions of incapability, the need for additional supervision and other negative and false stereotypes.

225

## Empowering Dyslexic Thinking in the Workplace

A guide aimed at helping organisation to understand and empower dyslexic thinking in the workplace, and to help dyslexic employees, and their colleagues, to understand and value dyslexic strengths – and the vital contribution they make.

The guide refers to four key steps to achieve it's vision, namely:

- Define dyslexia as a valuable thinking skill set;
- Offer adjustments to help every dyslexic thrive;
- Tailor recruitment processes to spot dyslexics;
- Start affinity groups for support and openness.


**Click on the image (above) to access the full study**

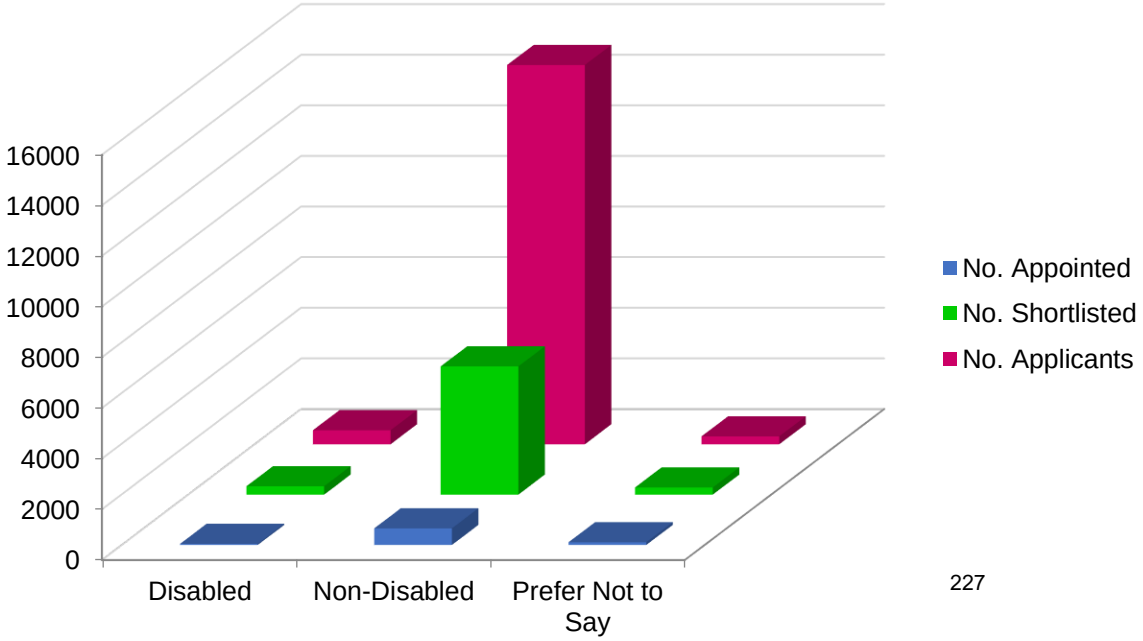
# TRAC Recruitment Indicator

# Indicator 2: Disabled Appointments from Shortlisting

This indicator looks at the rate at which non-disabled applicants were more likely to be appointed than disabled applicants

| | |
|---|---|
| x 1.11 | National Average in 2021 |
| x 1.12 | Our Trust Average in 2021 |
| x 0.98 | Our Trust Average in 2022 |

- During 2021/22, a total of 554 applicants who declared a disability applied for job roles at GWH;
- 332 were shortlisted for interview, and 44 were appointed;
- If disabled staff were equally as likely to be appointed from shortlisting as non-disabled candidates, then the above figure would be 1.
- Our ratio is closer to one in 2022 than it was in 2021. We are therefore showing an Improvement in our position, relative to the previous year.




**What we know**

Although wee are closer to parity, our data shows that a relatively low number of applicants who declare a disability apply for roles in the Trust.

**What action we will take**

Continue work at a wider system level to redress issues with recruitment.

See **Appendix 2** for more detail

# Latest NHS Staff Survey Data (2021)

# Indicator 4: Disabled Staff experiencing Harassment, Bullying or Abuse*

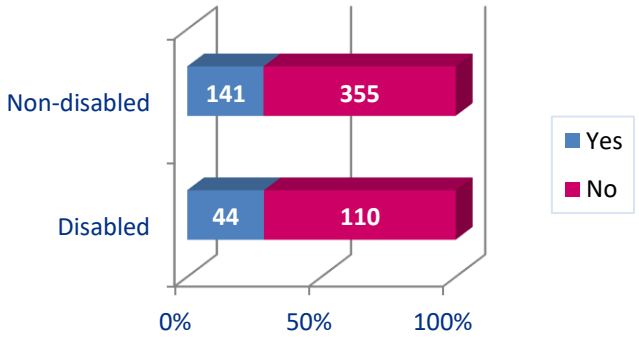
This indicator looks at the percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

a) Patients/service users, their relatives or other members of the public
b) Managers
c) Other colleagues

Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

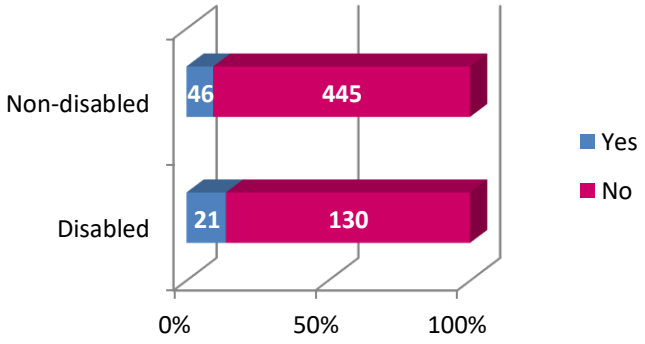
## a) 37.7%

- This is an increase for disabled staff, when compared to data from both 2019 and 2020.
- 31.7% of non-disabled staff also reported experiencing harassment, bullying or abuse from patients, relatives or the public.
- GWH figures are higher when compared to the latest national benchmark average (2021), which records figures of 32.4% for disabled staff (and 25.2% for non-disabled staff).



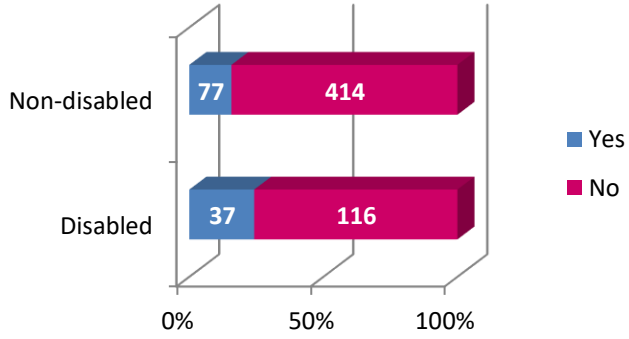

## b) 16.90%

- This is an increase for disabled staff, when compared to data from both 2019 and 2020.
- **9.6%** of non-disabled staff also reported experiencing harassment, bullying or abuse from patients, relatives or the public.
- GWH figures are lower when compared to the latest national benchmark average (2021), which recorded figures of 18.0% for disabled staff (and 9.8% for non-disabled staff).




## c) 27.50%

- This is an increase for disabled staff, when compared to data from both 2019 and 2020.
- **20.1%** of non-disabled staff also reported experiencing harassment, bullying or abuse from patients, relatives or the public.
- GWH figures are higher when compared to the latest national benchmark average (2021), which recorded figures of 26.6% for disabled staff (and 17.1% for non-disabled staff).





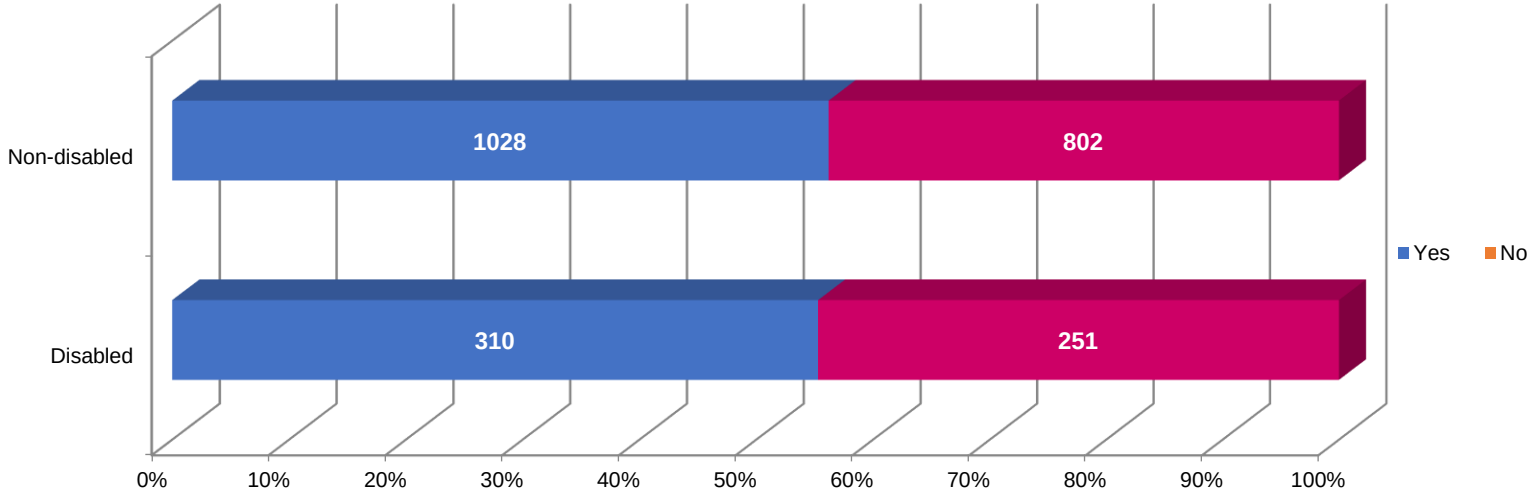

*See 'What We Will Continue to Do'. Indicator 6

# Indicator 5: Disabled Staff believing the Trust provides equal opportunities for career progression or promotion

This indicator looks at the percentage of disabled staff who believe Great Western Hospitals NHS FT provides equal opportunities for career progression or promotion.

| | |
|---|---|
| 51.4% | Benchmark Organisations Average in 2021 |
| 55.3% | Our Trust Average in 2021 |

**Disabled and non-disabled staff who believe Great Western Hospitals NHS FT provides equal opportunities for career progression or promotion**




230

**Note**:
This is a similar position to the previous year, for both disabled and non-disabled staff groups (50% for disabled staff in 2020, 58.4% for non-disabled staff).

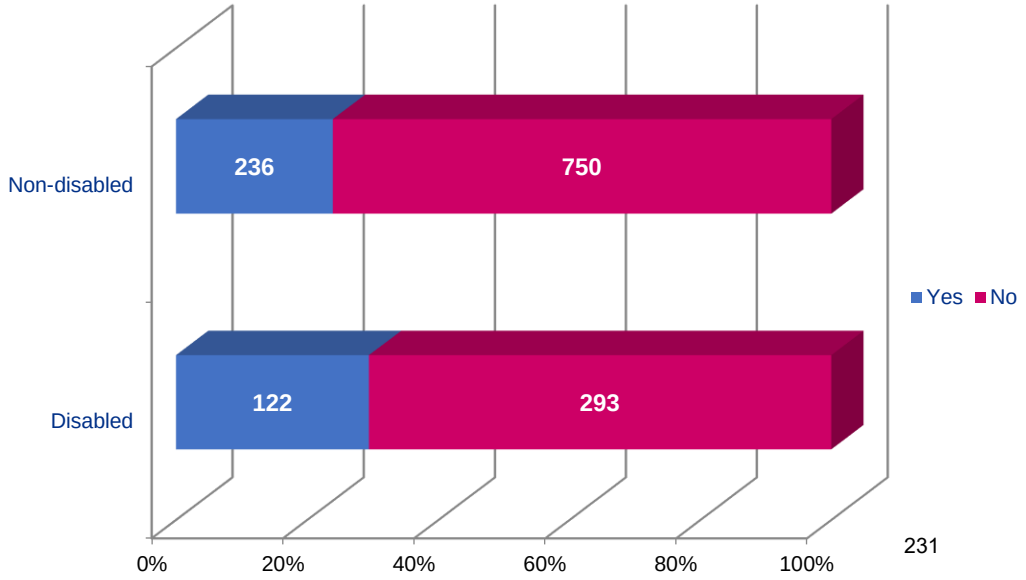
# Indicator 6: Disabled staff feeling pressurised to come to work

This indicator looks at the percentage of disabled staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

| | |
|---|---|
| **32.2%** | **Benchmark Organisations Average in 2021** |
| **29.4%** | **Our Trust Average in 2021** |

- When compared with last year, there has been a decrease in the proportion of disabled staff feeling pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- Our Trust figures are slightly better than the national average.

**Disabled and non-disabled staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties**




**What we will continue to do**

- Work to reduce levels of harassment, bullying or abuse from manager or colleagues;
- Work to reduce levels of discrimination at work by manager/ team leader or colleague;
- Work to reduce levels of harassment, bullying and abuse from patients, relatives or the public;
- Continue our work as part of the BSW ICS, and our commitment to delivering the People Plan. We will work with our regional partners to develop a joined-up approach to EDI for the future.
- Increase awareness about the range and scope of staff Wellbeing support services, alongside staff and management training.

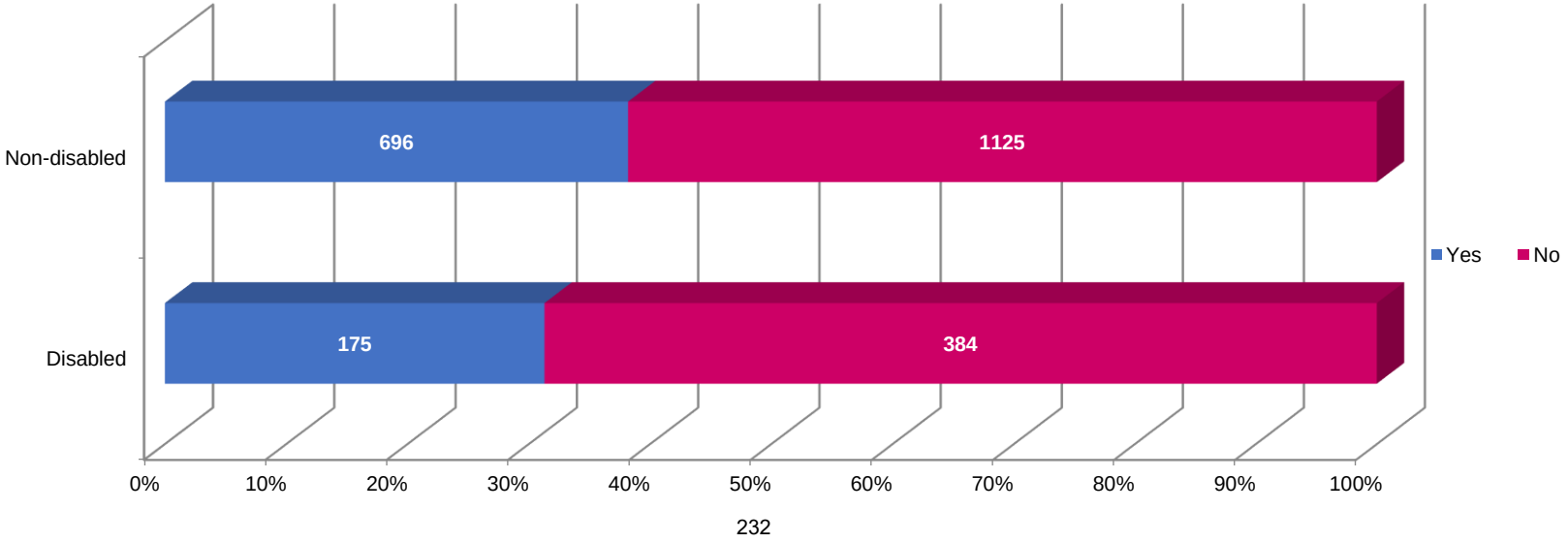
# Indicator 7: Disabled staff satisfied with the value placed on their work

This indicator looks at the percentage of disabled staff who are satisfied with the extent to which their organisation values their work

| | |
|---|---|
| 32.6% | Benchmark Organisations Average in 2021 |
| 31.3% | Our Trust Average in 2021 |

- Our findings for 2021 show a significant deterioration for disabled staff, when compared with our findings for 2020 (41.8%)
- Our findings for 2021 also show a deterioration for non-disabled staff groups, when compared to the benchmark figure for 2021 (38.2% for non-disabled staff in 2021, with the benchmark average being 43.3%).

**Disabled and non-disabled staff who are satisfied with the extent to which the organisation values their work**



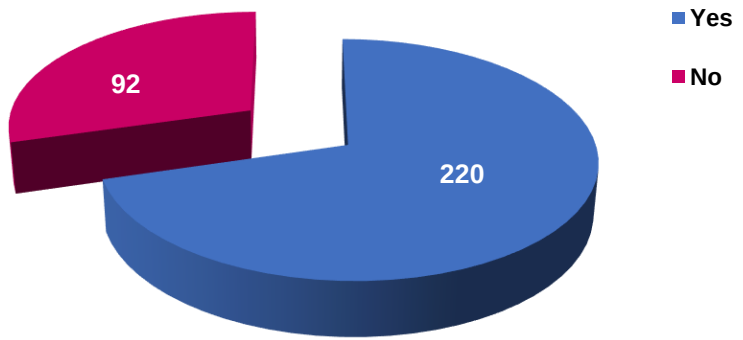
# Indicator 8: Disabled staff satisfied that adequate adjustments are made

This indicator looks at the percentage of disabled staff who are satisfied that their employer has made adequate adjustment(s) to enable them to carry out their work.

| | |
|---|---|
| 70.9% | Benchmark Organisations Average in 2021 |
| 70.5% | Our Trust Average in 2021 |

- The staff survey data for this metric only collects responses of disabled staff.
- Our latest result is a deterioration in our position from the previous year, when we recorded a figure of 81.4%.
- Our latest result is the closest we have been to the benchmark average, since 2018.

**Disabled staff who are satisfied that the trust has made adequate adjustment(s) to enable them to carry out their work**




233

# Indicator 9: Disabled Staff Engagement Score

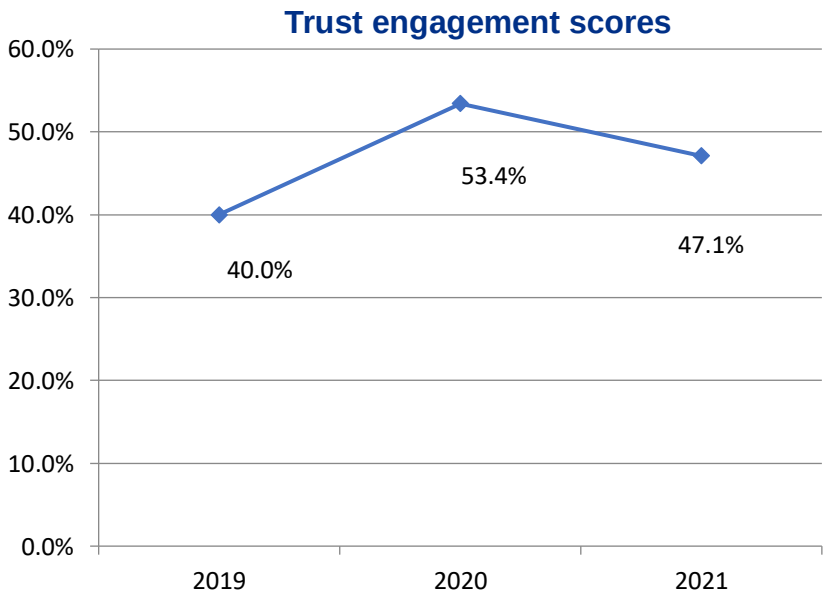
| | |
|---|---|
| 53.4% | Our Trust in 2020 |
| 41.7% | Our Trust in 2021 |

- The overall response rate (from all eligible respondents) in 2021 is 47.1%. This is a deterioration on the previous year, and represents an engagement score of 6.3 for disabled staff.
- In 2020, we achieved an overall response rate of 53.4% from all eligible respondents, representing an engagement score of 7.0.
- Our latest engagement scores are similar for both our disabled and non-disabled staff groups. They are also similar to the latest national scores.

**The staff engagement score is a composite score calculated using the responses to nine individual questions. See here for more information.**


| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Organisation average | 6.9 | 7.0 | 7.0 | 6.6 |
| Staff with a LTC or illness: Your org | 6.4 | 6.6 | 6.7 | 6.3 |
| Staff without a LTC or illness: Your org | 7.0 | 7.0 | 7.0 | 6.7 |
| Staff with a LTC or illness: Average | 6.6 | 6.7 | 6.7 | 6.4 |
| Staff without a LTC or illness: Average | 7.1 | 7.1 | 7.1 | 7.0 |
| Organisation Responses | 529 | 495 | 659 | 2,425 |
| Staff with a LTC or illness: Responses | 80 | 93 | 154 | 563 |
| Staff without a LTC or illness: Responses | 417 | 380 | 500 | 1,696 |

Average calculated as the median for the benchmark group



# Indicator 9: Taking action to facilitate the voices of disabled staff

In 2021, the Trust created a Disability Equality Network, as a space for staff with visible and non-visible disabilities and impairments to connect, share experience and information, and support each other. The Network also raises and promotes awareness of disability issues, and shares best practice.

## Differently Abled Network

NHS
Great Western Hospitals
NHS Foundation Trust

### Upskill the DAN

- We would like the DAN Group to be the point of contact for support and advice.
- Our aim is to ensure we have the necessary skills and information withing the network to support any staff member who may need it.
- Continue to build a library of resource available via our Intranet Site. (Added useful ADHD resource recently)
- Currently using 4-D Model to envisage what we as a group could do in the future.

# Summary of Key Findings

Our data presents a mixed picture regarding career progression and improved work experiences for staff with disabilities. Whilst some WDES indicators show an improvement on scores from previous years, and when viewed against the national averages, others have deteriorated or remained the same.

**Our disabled staff are:**

- More likely to share their disability status;
- Equally likely as non-disabled applicants to be appointed to roles once shortlisted;
- Less likely to enter the formal capability process;
- Part of a growing network, increasing awareness of member's issues. For example, raising awareness of and providing support for neurodiverse staff.

**When compared with the national average for benchmark Trusts, we also know that:**

- Our disabled staff believe there are more opportunities for career progression and promotion;
- Fewer disabled staff feel pressured to come to work when ill.

**There are areas where our progress is less marked. Namely:**

- We have yet to have any members of our Executive team or Board with a declared disability;
- Very few staff (133, or 2.4%) have self-declared a disability;
- There is a large disparity between the number of staff declaring a disability through the ESR, and the number of staff declaring a disability when completing the National NHS Staff Survey.
- More likely to experience abuse, than in previous years;
- Less likely to be satisfied with adjustments made to the workplace, compared with previous years;
- Less likely to feel valued by the organisation, compared with previous years.

With such low numbers declaring a disability, and with a large disparity the ESR and NHS staff survey, it is difficult to draw firm conclusions. However, our Differently Abled Network (created in March 2021), continues to build on the work being done to improve experiences for disabled staff.

# About Our Action Plans

NHS
Royal United Hospitals Bath
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

## Joint ownership of our action plans

To improve the work experience for our staff, we will continue to engage with EDI Leads and Staff Networks across the BSW Integrated Care System, to share best practice and resources. With this wider engagement in mind, our action plan has been agreed with and is jointly owned by our neighbouring acute Trusts. The range of issues are consistent across our organisations (although our key steps to achieve the actions and completion dates may differ).

## Our Action Plans

Following the results of the Trust WDES, our action plan has been simplified and updated (see Appendix 2). Principally, our focus is to increase diversity at senior levels in the organisation, improve the physical workplace and improve data collection for our disabled staff. It aligns closely with the BSW system plan.

**Alongside the action plan, we will:**

- Work to reduce levels of harassment, bullying or abuse from manager or colleagues
- Work to reduce levels of discrimination at work by manager/team leader or colleague
- Work to reduce levels of harassment, bullying and abuse from patients, relatives or the public
- Continue our work as part of the BSW ICS, and our commitment to delivering the People Plan. We will work with our regional partners to develop a joined-up approach to EDI for the future.

# Appendices

## Appendix 1: Summary of WDES Indicator Scores

Below is a summary of the WDES indicator scores for our Trust over the last three years, shown as either a percentage or as an indicator (an indicator score of one, or 'parity', being the overall aim). Comparisons are between figures from 2020 and 2021, to rate our direction of travel, with an assessment of positive or negative referring to the indicator's impact on disabled staff.

**Direction Key**
Improvement
No noticeable change
Deterioration

| | WDES Indicator | 2019-2020 | 2020-2021 | 2021-2022 | Direction of Travel |
|---|---|---|---|---|---|
| 1 | Disabled representation across all pay bands | 1% | 2% | 2.4% | |
| 2 | Relative likelihood of appointment from shortlisting. | x1.52 | x1.12 | x0.98 | |
| 3 | Relative likelihood of entering the formal capability process | x2.83 | 0 | 0 | |
| 4 | a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: | | | | |
| | i. Patients/Service users, their relatives or other members of the public | 35.3% disabled<br>26.4% not disabled | 28.6% disabled<br>28.4% not disabled | 37.7% disabled<br>31.7% not disabled | |
| | ii. Managers | 15.1% disabled<br>6.7% not disabled | 13.9% disabled<br>9.4% not disabled | 16.9% disabled<br>9.6% not disabled | |
| | iii. Other colleagues | 24.4% disabled<br>16.4% not disabled | 24.2% disabled<br>15.7% not disabled | 27.5% disabled<br>20.1% not disabled | |
| 5 | Believing that the Trust provides equal opportunities for career progression or promotion. | 52.7% disabled<br>51.6% not disabled | 50.0% disabled<br>58.4% White | 55.3% disabled<br>56.2% not disabled | |
| 6 | Relative percentage saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. | 27.4% disabled<br>18.4% not disabled | 32.7% disabled<br>23.0% not disabled | 29.4% disabled<br>23.9% not disabled | |
| 7 | Relative satisfaction with their organisation valuing their work | 30.8% disabled<br>43.4% not disabled | 41.8% disabled<br>46.2% not disabled | 31.3% disabled<br>38.2% not disabled | |
| 8 | Adequate adjustments made, to enable disabled staff to carry out their work | 82.4% | 81.4% | 70.5% | |
| 9 | a) Staff engagement score (10 = highest score) | 6.6 disabled<br>7.0 not disabled | 6.7 disabled<br>7.0 not disabled | 6.3% disabled<br>6.6% not disabled | |
| | b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) | No | Yes | Yes<br>(see indicator 9) | |
| 10 | Percentage difference between the organisation's Board voting membership and the proportion of the organisation's overall workforce. | -1.3% / -1.4% | -2.5% | -2.4% | |

# Appendix 2: Trust Action Plan, 2022-2023

| Key Problem Area(s) and Action(s) | Source(s) | Key Steps to Achieve Actions | Completed | Desired outcome(s) |
|---|---|---|---|---|
| **Improving the Physical Workplace**<br>■<br>**Increasing diversity at senior levels**<br>■<br>**Improving Data Collection** |  <br>  | Continue to grow and develop the Differently Abled Network | Currently Ongoing | Increased awareness and understanding of hidden and visible disabilities<br>■<br>Improved workplace adjustments<br>■<br>More staff sharing disability as a personal protected characteristic<br>■<br>Smaller disparity between staff sharing disability status on ESR, and staff sharing on the NHS Staff Survey<br>■<br>Achieve Disability Confident Level III |
| | | Regular Board Stories about experiences of disabled staff | Currently Ongoing | |
| | | Actively encourage applications from disabled staff for the Trust Aspiring Leaders programme | Feb. 2023 | |
| | | Develop an Allyship programme | Dec. 2022 | |
| | | All recruiting managers to complete the License to Recruit training to promote good practise (training includes EDI, unconscious bias and safeguarding). This is monitored and reported to the EDI Group. | Aug. 2022 | |
| | | Continue to grow existing library of neurodiversity toolkits | Currently Ongoing | |
| | | Develop and embed a Reciprocal Mentoring programme | Sept. 2022 | |

# Appendix 2: Trust Action Plan, 2022-2023

| Key Problem Area(s) and Action(s) | Source(s) | Key Steps to Achieve Actions | Completed | Desired outcome(s) |
|---|---|---|---|---|
| **Improving the Physical Workplace**<br>■<br>**Increasing diversity at senior levels**<br>■<br>**Improving Data Collection** |  <br>  <br>  | Develop a public EDI Q+A forum to address areas of confusion, outline measures and Trust support, and emphasise importance and safety of data collection | **Dec. 2022** | Increased awareness and understanding of hidden and visible disabilities<br>■<br>Improved workplace adjustments<br>■<br>More staff sharing disability as a personal protected characteristic<br>■<br>More staff sharing disability status on ESR, with smaller disparity between this figure, and sharing on the NHS Staff Survey<br>■<br>Achieve Disability Confident Level III |
| | | Work with DAN network to develop narrative for EDI Q+A forum, around safety and confidentiality of data sharing | Currently Ongoing | |
| | | Review and complete the Disability Confident Assessment with the DAN; Work with the Resource team and the DAN to collect the necessary data for the assessment. | Currently Ongoing | |
| | | Review how the Trust collects data on the progress of individuals from application to appointment. This to include the comparison between applicants who identify with a disability and those who do not. | Currently Ongoing | |

# Appendix 3: Action plan for 2021-22, with areas developed with our system partners

Following the results of the Trust WDES, the following action plan was developed and has been updated for 2021/22. The table cells coloured blue below contain measures developed with our local partners as part of a system wide approach to overhaul recruitment processes. These were the areas under discussion during 2021-22, some of which are still under discussion.

| Key Action | Steps to achieve action | Due by | Desired Outcomes |
|---|---|---|---|
| **Achieve Disability Confident Leader Level III** | ▪ Improved recruitment processes to ensure attraction of diverse candidates;<br>▪ Promote best practice standards in line with the level 3 requirements;<br>▪ Validate self assessment by recognised validator organisations;<br>▪ Encourage other employers to make the journey to become Disability Confident;<br>▪ Report using the Voluntary Reporting Framework. | End of 2022 to achieve Level 3 status | More candidates with disabilities attracted to roles and appointed to post from shortlisting. |
| **Increase uptake of recorded personal protected charac-teristics on ESR** | ▪ Continue with campaign to encourage staff to update personal information on ESR;<br>▪ Run quarterly ESR reports to see rates of data submission on ESR;<br>▪ Publicise importance of data collection via Trust Comms and EDI newsletter, and EDI Podcasts;<br>▪ Use targeted emails to contact staff showing as “Not Known” in any of the protected characteristic monitoring information fields on ESR and ask if they are prepared to discuss concerns about declaring this information.<br>▪ EDI Lead to work with **Head of Quality** to ensure that a standard set of equality data is recorded across all directorates in the Trust. | Done<br>Ongoing<br>Done<br>Done<br>Done | More targeted interventions to improve services and experiences for staff.<br>More staff self-declaring personal protected characteristics.<br>Decrease unknown/ null figures by 5% (currently 26%) |
| **Raise the profile and awareness of disability issues** | ▪ Continue with regular stories at Board Level,<br>▪<br>▪ The Differently Abled Network to introduce and review resources to aid our staff with disabilities, that also recognise the diversity of mental and physical health issues included under this term.<br>▪ To continue to embed Equality, Diversity and Inclusion into strategic decision making committees and forums;<br>▪ Increase membership of DAN and diversity of voices. | Done<br>Done<br>Ongoing<br>Ongoing | Greater awareness throughout organisation of the range and scale of disability issues in the Trust;<br>Greater awareness to Trust Board and Senior Leaders around equality issues and information included in monthly Workforce Report<br>Increased visibility of ED&I at Trust Board and Senior Leaders with ED&I topics on agenda quarterly. |

Note
The Trust and BSW ICS Action Plan was developed and has been updated for 2021/22, and contains measures developed with our local partners as part of a system wide approach. These were the areas under discussion during 2021-22, some of which are still under discussion.

# Appendix 3: Action plan for 2021-22, with areas developed with our system partners

| Key Action | Steps to achieve action | Due by | Desired Outcomes |
|---|---|---|---|
| **Improved recruitment processes to ensure attraction of diverse candidates**<br><br>**Introduce a system of constructive and critical challenge to ensure fairness during interviews.**<br><br>**This system includes requirements for diverse Interview panels, and the presence of an equality representative who has authority to stop the selection process before offer is made, if it is deemed unfair and complements the need for accountability** | ▪ Adopting diverse interview panels for Exec and VSM **OR** across the Trust where possible;<br>▪ Explore the inclusion of patients on focus groups;<br>▪ Recruiting managers to undertake 'License to Recruit' mandatory training which includes EDI and unconscious bias training;<br>▪ Pilot the introduction of a 'critical friend', to observe and review consistency across interview panels (target areas based on experience feedback, ensuring different roles and banding are included). | 31 December 2022<br><br>Ongoing<br><br>Done<br><br>December 2022 | Training to be included as role essential<br><br>At least 1 member of the recruitment panel has completed the "License to Recruit" training<br><br>Monitoring of training compliance |
| **Organise talent panels to:**<br>**a) Create a 'database' of individuals by system who are eligible for promotion and development opportunities such as Stretch and Acting Up assignments must be advertised to all staff**<br>**b) Agree positive action approaches to filling roles for under-represented groups**<br>**c) Set transparent minimum criteria for candidate selection into talent pools** | ▪ Standardise adverts to include applicants welcomed from under-represented groups;<br>▪ Use CPD/Appraisals to support Divisions creating a database of individuals who are eligible for promotion. Ensure this succession planning data is captured in Divisional workforce planning;<br>▪ Collate feedback from wider community groups to reach candidates (areas to include; where we advertise, type of advertisement, language used…) | Done<br><br>December 2022<br><br>Done | Monitoring of progress through relevant governance routes |
| **Enhance EDI support available to:**<br>**a) Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies**<br>**b) Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews** | ▪ Incorporate questions for bands 8a level roles that enable candidates to demonstrate their EDI experience, commitment and engagement.<br>▪ Internal communications to promote the importance of completing effective Equality Impact Assessments and the governance process on monitoring EIA's. | Done<br><br>Done | Monitoring of progress through relevant governance routes |

# Appendix 3: Action plan for 2021-22, with areas developed with our system partners

| Key Action | Steps to achieve action | Due by | Desired Outcomes |
|---|---|---|---|
| **Overhaul interview processes to incorporate:**<br>▪ **a) Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used.**<br>▪ **b) Ensure adoption of values based shortlisting and interview approach.**<br>▪ **c) Consider skills-based assessment such as using scenarios** | ▪ Compulsory for all recruiting managers to complete the License to Recruit training to promote good practise (training includes EDI, unconscious bias and safeguarding). This will be monitored and reported.<br>▪ Create best practise document that can be distributed to recruiting managers across the Trust.<br>▪ Values based recruitment to be explored and implemented across the system (BSW RRS Objective) | 31 Dec 2022<br>Done<br>October 2022 | Monitoring of progress through relevant governance routes |
| **Raise the profile and awareness of disability issues** | ▪ Continue with regular stories at Board Level,<br>▪ The Differently Abled Network to introduce and review resources to aid our staff with disabilities, that also recognise the diversity of mental and physical health issues included under this term.<br>▪ To continue to embed Equality, Diversity and Inclusion into strategic decision making committees and forums;<br>▪ Increase membership of DAN and diversity of voices. | Ongoing<br>Ongoing<br>Ongoing<br>Ongoing | Greater awareness throughout organisation of the range and scale of disability issues in the Trust;<br>Greater awareness to Trust Board and Senior Leaders around equality issues and information included in monthly Workforce Report<br>Increased visibility of ED&I at Trust Board and Senior Leaders with ED&I topics on agenda quarterly. |
| **Adopt resources, guides and tools to help leaders and individuals have productive conversations about race** | ▪ Developing a range of teaching resources that focus on intersectionality (audio visual, newsletter, fresh eyes, feedback from all networks – BAME, DAN, LGBQT…) | Ongoing | Monitoring of progress through relevant governance routes |

| Workforce Metrics | |
|---|---|
| For the following three workforce metrics, compare the data for both Disabled and non-disabled staff. | |
| **Metric 1** | **Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.**<br>Organisations should undertake this calculation separately for non-clinical and for clinical staff.<br><br>Cluster 1: AfC Band 1, 2, 3 and 4<br>Cluster 2: AfC Band 5, 6 and 7<br>Cluster 3: AfC Band 8a and 8b<br>Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)<br>Cluster 5: Medical and Dental staff, Consultants<br>Cluster 6: Medical and Dental staff, Non-consultant career grade<br>Cluster 7: Medical and Dental staff, Medical and dental trainee grades<br><br>**Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes |
| **Metric 2** | **Relative likelihood of non-disabled staff compared to Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.**<br>**Note:**<br>i) This refers to both external and internal posts<br>ii) If your trust implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations. |
| **Metric 3** | **Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.**<br>**Note:**<br>i) This metric will be based on data from a two-year rolling average of the current year and the previous year<br>ii) This metric applies to capability on the **grounds of performance and not ill health**. |
| **National NHS Staff Survey Metrics** | |
| For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff | |
| **Metric 4**<br>Staff Survey Q13a-d | **a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:**<br>i. Patients/Service users, their relatives or other members of the public<br>ii. Managers<br>iii. Other colleagues<br>**b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it** |





# Appendix 4

# WDES Indicators

| | |
|---|---|
| **Metric 5**<br>Staff Survey Q14 | **Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.** |
| **Metric 6**<br>Staff Survey Q11e | **Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** |
| **Metric 7**<br>Staff Survey Q5f | **Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.** |
| **The following NHS Staff Survey metric only includes the responses of Disabled staff** | |
| **Metric 8**<br>Staff Survey Q26b | **Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.** |
| **NHS Staff Survey and the engagement of Disabled staff**<br>For part a) of the following metric, compare the staff engagement scores for Disabled and non-disabled staff<br><br>For part b) add evidence to the Trust's WDES Annual Report | |
| **Metric 9** | **a) The staff engagement score for Disabled staff, compared to non-disabled staff.**<br><br>**b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)**<br><br>**Note: For your Trust's response to b)**<br>**If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no**, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the national WDES 2019 Annual Report. |
| **Board representation metric**<br>For this Metric, compare the difference for Disabled and non-disabled staff. | |
| **Metric 10** | Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:<br><br>• By voting membership of the Board.<br>• By Executive membership of the Board. |

246



# Appendix 4

# WDES Indicators

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Responsible Officer Annual Report** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **6th October 2022** | Part 1 (Public) [Added after submission] | x | Part 2 (Private) [Added after submission] | |
| **Accountable Lead** | Dr Jon Westbrook - Chief Medical Officer | | | | |
| **Report Author** | Dr Jon Westbrook | | | | |
| **Appendices** | A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance. | | | | |

**Purpose**

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

**Assurance Level**

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

| Significant | | Acceptable | | 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 Responsible Officer annual report outlines the issues and actions that have taken place during 2021/2022.

Oversight of the appraisal process and quality is through the monthly Medical Staff Support Group (Professional Standards) where any need for support, intervention, concerns or failure to engage are identified.

GWH recently upgraded its online appraisal and revalidation system to SARD in July 2022, this will reduce the manual inputting of data and link to the GMC connect website to give timely and accurate information.

| **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 |
| **Key Risks** – risk number & description (Link to BAF / Risk Register) | | | | | **Risk Score** |
| | | | | | |
| **Consultation / Other Committee Review / Scrutiny / Public & Patient involvement** | Appraisals and revalidations are reviewed monthly at the Medical Staff Support Group (Professional Standards). | | | | |
| **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<br>The Board/Committee/Group is requested to: | |
|---|---|
| ▪ The Committee is asked to note and accept this summary. | |
| **Accountable Lead Signature** |  |
| **Date** | 13 September 2022 |

# A Framework of Quality Assurance for Responsible Officers and Revalidation

# Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

# Contents

# Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) Help the designated body in its pursuit of quality improvement,

b) Provide the necessary assurance to the higher-level responsible officer, and

c) Act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

# Designated Body Annual Board Report

## Section 1 – General:

The board of Great Western Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

   Date of AOA submission: 28th September 2021

   Action from last year: Submit report as per national requirements

   Comments: Appraisals were suspended in 2020 due to COVID and all revalidation dates were deferred by 1 year. Appraisals recommenced at GWH in July 2020.

   Action for next year: Continue with current oversight for submission of AOA.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: A new post has been created as Deputy Chief Medical Officer for Medical Workforce with responsibility for oversight of job-planning and appraisal (Dr Steve Haig). He will soon complete the requisite RO training.

   Comments: The Chief Medical Officer (Dr Jon Westbrook) was appointed as RO for GWH from 1st September 2021. He is up to date with RO training.

   Action for next year: To ensure the Deputy CMO completes the appropriate CPD training for the role.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Action from last year: Continue to provide these resources and provide enough time for Study and Professional leave for all involved in the Appraisal and Revalidation process. This will be monitored at the appraisal of the Clinical Lead and Responsible Officer.

   Comments: A Clinical Lead for Appraisals receives 1 PA. A new post of Medical Job Planning and Revalidation Specialist has been created to strengthen revalidation oversight. The post holder took up the role in July 2022. They are supported by new dedicated role of Medical Job Planning and Revalidation Administrator. The Trust has now purchased the SARD software system for Job Planning and Revalidation to improve oversight of all activity and better support doctors in this process.

   Action for next year: Continue to work within the resources available to deliver the service. Transfer of appraisals to the new system is now complete and the new job plans will continue to be uploaded to SARD.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to maintain the record.

Comments: A live list of all medical practitioners with a connection to the Trust can be viewed via the GMC connect website. Automatic emails are sent to the revalidation inbox when a doctor adds or removes their connection to GWH so all other records can be kept up to date. The new SARD system (see above) links directly to GMC Connect and updates every day providing an accurate and up to date record of the revalidation position for all doctors for whom GWH is the designated body. This replaces a previous manual system.

Action for next year: Bed in new system and support medical staff in the transition. Update the MAG form based on the new national template when available.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Upload the new policy to the T drive when finalised. Ensure that the changes that have been made to the policy are embedded into the appraisal process. This will be monitored at the monthly Revalidation meeting.

Comments: The Medical and Dental Registration and Revalidation Policy was approved by both the JLNC & Medical Staffing Group Committee. It was approved on 27th January 2021 and is due for review on 27th January 2024.

Action for next year: Continue to ensure that the changes made in the policy are fully embedded.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None

Comments: Due to COVID no external peer review has been undertaken. However, the appraisal process has been reviewed regularly at the Revalidation meeting. The Revalidation meeting is now part of the new Medical Staff Support Group MSSG which oversees all appraisal activity and supports any doctor requiring additional help.

Doctors are now allocated an appraiser when they have completed 3 appraisals with the same appraiser. This allows for a better distribution of appraisals across the appraisers and ensures that they are all completing a satisfactory number to maintain their appraisal skills.

Action for next year: Facilitate an external peer review for 2023..

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: There has always been an induction for all locum staff when they start with the Trust. Following learning from the COVID pandemic, changes have been made to the induction of locums into GWH. The booking length that identifies a locum as long term has been reduced from 3 months to 6 weeks. At 6 weeks they will now have access to a trust IT account. This will give them access to emails and Site Comms which will support their professional development.

Report to be taken to PPPC to confirm that the changes have been made and that induction process if compliant.

Comments: The new process of identifying locums as long term from 6 weeks is now embedded and a report was taken through PPPC. Transfer of information forms are completed if requested.

Action for next year: Continue to support locum and short-term placement doctors while they are working at GWH.

## Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Strengthened Medial Appraisal team (see above) and implementation of SARD software systems. Increased SPA tariff for doctors undertaking at least 10 appraisals.

Comments: Agreement with Ridgeway hospital executive that concerns about conduct or performance in either organisation will be communicated to ensure the entire scope of a clinician's practice is included in the appraisal process.

All doctors that are connected to GWH are reminded by the Medical Job Planning and Revalidation Specialist when their appraisal is due. In addition to automatic notifications by SARD system. Doctors that work in other organisations, this is predominantly the Ridgeway Hospital, are required to complete an 'other practice form. This allows for evidence of any complaints or incidents to be shared with GWH. This also occurs with the doctors from the Prospect Hospice.

Action for next year: Continue to monitor the information that is included on 'other practice forms' to ensure that there is a robust transfer of data.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue monitoring the appraisal process.

Comments: At the monthly MSSG all overdue appraisals are discussed. If there are mitigating reasons these are documented. If not, a plan is developed to support the doctor to achieve their appraisal. If there is continuing non-engagement with the appraisal process the doctor is discussed with the GMC ELA and if appropriate a Non-Engagement Referral is made. There have been no Failure to Engage notices in the year 2021/22.

Action for next year: Continue to monitor the appraisal process.

**3.** There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Ensure current policy is reviewed and in date.

Comments: The Medical and Dental Registration and Revalidation Policy was approved by both the JLNC & Medical Staffing Group Committee. It was approved on 27th January 2021 and is due for review on 27th January 2024.

Action for next year: Monitor implementation of the updated policy.

**4.** The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Appraiser training and refresher training will be provided on a yearly basis. A course was accessed April 2022 in Bristol but further access is to be put in place to increase attendees.

Comments: The trust currently has 110 trained appraisers although not all are currently undertaking appraisals. The job planning guidance has been revised to identify specific SPA recognition for colleagues provide 10 appraisals. The expectation is that this will increase the pool of trained appraisers.

Action for next year: Refresher training being planned to include update on SARD utilisation. Along with the recognised remuneration for appraisers there will be a new job description to clarify roles and responsibilities and objectives.

**5.** Medical appraisers participate in on going performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action from last year: Ensure each Appraiser receives a copy of their evaluation to include in their own appraisal so this can be reflected on and improvements can be made. Continue to keep appraisal system up to date reflecting the latest GMC guidance. SARD system generates request for appraiser feedback.

Comments: On-going

Each appraisal is appraised by the appraisee and the appraisals are quality checked by either the Clinical Lead for Appraisal or the RO before final sign off.

Action for next year: Appraisers are required to reflect on feedback as part of their own appraisal process. Appraiser feedback is monitored to identify areas where additional training/support may be required.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Quality assurance is maintained by monthly MSSG meetings. These are attended by the Chief Medical Officer, Appraisal Lead, Head of Medical Workforce, Medical Job Planning and Revalidation Specialist and the Medical Job Planning and Revalidation Administrator and the Deputy CMO for Medical Workforce. The committee regularly review quality assurance and create actions on an ad hoc basis as required.

Comments: Quality assurance is maintained by monthly MSSG meetings.

Action for next year: The MSSG is a new group with the strengthening of appraisal processes in its remit and will be reviewed at 12 months.

## Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: The GMC ELA has been supportive in speaking to the consultant workforce about Revalidation from the perspective of the GMC.

Comments: None

The RO has monthly meetings with the GMC ELA to discuss all investigations that are on-going and any concerns about engagement in the appraisal process. The GMC ELA is involved in any conversations about deferrals or Failures to Engage and this has helped to avoid the need to reach formal process.

Action for next year: Continue to engage with the GMC ELA and invite them to present to consultant groups so that the medical staff are aware of changes in GMC registration and revalidation process.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue with the current policy.

Comments: Where a deferral has been made the RO will write to the doctor involved to explain the reasoning behind the decision. If appropriate the Clinical Lead for Appraisal and Revalidation HR Business Partner are included so that they are able to support the doctor. The most common reason this year has been the lack of evidence of colleague or patient feedback. However the new SARD system with its automated prompts and integrated 360 modules should significantly reduce this risk.

Action for next year: Continue with the current policy and monitor impact of SARD.

## Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: A job planning review for senior doctors is underway that will ascertain if staff are achieving their SPA time. These are now being uploaded to a central system which did not previously exist improving transparency and oversight across specialties.

Comments: The new SARD system was implemented in July 2022 and job plans are being uploaded and reviewed by Clinical Leads and Associate Medical Directors.

Action for next year: Progress towards full job plan compliance being monitored and reported to Trust Board.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

There will be further training for Case Investigators and for Medical Workforce who support investigations. A small number of staff will also be trained in becoming Case Managers. Next training program scheduled for November 2022 with NHS Resolution. The MSSG is set up to better triangulate disparate areas of medical performance so that concerns around performance, conduct, health complaints etc can be seen as one offering the

opportunity to better support doctors in difficulty and for earlier intervention if concerns are evolving.

Comments: Significant events (IR1's), complaints, mandatory training, national audits are all provided with the appraisal reminder paperwork.

The Trust has also increased the number of consultants who have completed their Case Investigator and Case Manager training. This allows for a more robust system when concerns are raised about conducts or capability.

Action for next year: Continue training and feedback for the new cohort of Case Investigators and Case Managers.

**3.** There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Review investigations to ensure that the investigation followed policy and if there is any learning for change

Comments: Correct. This is covered in the Medical and Dental Revalidation and Appraisal Policy.

Action for next year: To continue to review investigations when they are completed to ensure that the correct process was followed and illicit any learning from the investigation process. For MHPS level investigations a NED is appointed to provide oversight of the process and ensure progress is in line with policy.

**4.** The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: The MSSG improves the governance of concerns management with the relevant stakeholders to support process and decision making. The group has been set up to ensure good Inclusion and Diversity to minimise and bias in decision making.

Comments: The Chief Medical Officer and Medical HR Business Partner meet regularly to discuss any on-going investigations or concerns. The Chief Medical Officer meets monthly with the nominated Non-Executive Director to discuss on-going investigations to ensure that the correct process is being

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

followed. A monthly report is presented to Board with anonymous data on current investigations and exclusions or restrictions in practice.

Action for next year: Medical Workforce HR team report to the MSSG on progress with any on-going investigation. The reporting of these information is strictly confidential and reporting stored in a secure folder.

**5.** There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None.

Comments: The RO communicates with any other RO relevant to the practice of an individual doctor.

The GPs working in the GWH Primary Care Network are not connected to GWH but to NHS England. This relationship has strengthened over the past 12 months with a more robust system for raising and discussing concerns.

The RO is in direct communication with the counterpart at the local private hospital to ensure concerns are shared between the two organisations should these arise.

Action for next year: Continue to build a clear structure for notifying NHS England of concerns about GPs, if issues arise.

**6.** Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: The MSSG is diverse and includes the trust lead for Inclusion and Diversity to minimise the risk of unconscious bias impacting on case management and decision making.

Comments: All members of MSSG are up to date with Equality and Diversity training.

Action for next year: Continue to develop the MSSG meeting to ensure robust oversight.

## Section 5 – Employment Checks

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

| |
|---|
| Action from last year: None.<br><br>Comments: Following the introduction of the TRAC recruitment system, all processes and checks are monitored throughout the year in conjunction with the general recruitment team to standardise processes.<br><br>Pre-employment checks include: GMC check, national insurance number, right to work checks (Passport/Visa), DBS check, an occupational health check, forms including Confidentiality, Data Protection & Caldicott Statement and Self Declaration.<br><br>Action for next year: Continue to monitor the pre-employment checks. |

## Section 6 – Summary of comments, and overall conclusion

| |
|---|
| Systems for appraisal and revalidation have been significantly updated and strengthened in the past 12-months and have already improved oversight for the organisation and support for doctors in this process. |

## Section 7 – Statement of Compliance:

The Board of Great Western Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Great Western Hospitals

Name: Dr Jon Westbrook Signed:

Role: Chief Medical Officer and Responsible Officer

Date: 12/9/2022

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Terms of Reference of Board Committees** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **6 October 2022** | Part 1 (Public) | X | Part 2 (Private)] | |
| **Accountable Lead** | Caroline Coles, Company Secretary | | | | |
| **Report Author** | Caroline Coles, Company Secretary | | | | |
| **Appendices** | Appendix 1 – Remuneration Committee Terms of Reference | | | | |

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

| **Assurance Level** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Assurance in respect of: process/outcome/other (please detail): | | | | | | | |
| Process and outcome | | | | | | | |
| **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 Board approved a number of changes to the Board committee structure in April 2022. As a result the terms of reference for each of the committees have been updated to reflect the changes. The Remuneration Committee terms of reference are attached for Board approval. The amendments are as follows:-

- 2.1 & 7.11 Reference to succession planning and diversity

The Remuneration Committee has reviewed and agreed their terms of reference.

| | | | | | |
|---|---|---|---|---|---|
| **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 | ★ | | | | |
| | | | | | |
| **Key Risks** – risk number & description (Link to BAF / Risk Register) | n/a | | | | **Risk Score** |
| | | | | | |
| **Consultation / Other Committee Review / Scrutiny / Public & Patient involvement** | Remuneration Committee | | | | |
| **Next Steps** | To align annual work plans to the terms of reference | | | | |

| **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<br>The Board/Committee/Group is requested to: | |
|---|---|
| **The Board is requested to approve the terms of reference for Remuneration Committee**. | |
| **Accountable Lead Signature** | Caroline Coles, Company Secretary |
| **Date** | 6 September 2022 |

# REMUNERATION COMMITTEE TERMS OF REFERENCE

| | |
|---|---|
| **Review Date** | **May 2023** |
| **Board Approval** | |

| Version | Status | Date | Issues/Amended | Summary of Change |
|---|---|---|---|---|
| **V1.0** | For annual review | June 2022 | Remuneration Committee | 2.1 & 7.12 reference to succession planning and diversity |

## 1. AUTHORITY

1.1 The Remuneration Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors (Trust Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2. The Committee is authorised by the Board of Directors to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

## ROLE / PURPOSE

2.1 The Committee is required to put in place formal, rigorous and transparent procedure for the appointment of the Chief Executive and other Executive Directors , ensure plans are in place for orderly succession to the board and oversee the development of a diverse pipeline for succession, and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates.

2.2 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

## 3. MEMBERSHIP

3.1 The membership will comprise all Non-Executive Directors including the Chair of the Trust.

3.2 The Chief Executive shall be a voting member of the Committee for the appointments or removal of Executive Directors only.

3.3 The Committee will be chaired by the Senior Independent Director of the Trust. In the absence of the Chair of the Committee, the remaining members present shall elect one of their number to chair the meeting.

## 4. ATTENDANCE

4.1 The Chief Executive will normally attend meetings, withdrawing as appropriate when matters relating to their own performance and remuneration are discussed.

4.2 The Director of HR will support the Committee with appropriate papers and proposals for consideration and be in attendance as and when appropriate and necessary.

4.3 *Substitutes / deputies* – There is no provision for substitutes on this Committee.

4.4 *External advisors* - The Committee may invite external advisors to attend for all or part of any meeting.

## 5. QUORUM

5.1 The quorum for meetings of the Committee shall be three members (3 Non-Executive Directors).

## 6. FREQUENCY OF MEETINGS

6.1 The Committee will meet at least twice a year with additional meetings being called at such other times as may be required.

## 7. DUTIES

7.1 To keep under review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.

7.2 To approve the procedure and documentation for the appointment of Executive Directors and Chief Executive posts.

7.3 Additionally, for the appointment of the Chief Executive the Committee will keep the Council of Governors informed of progress of a campaign and report the appointment of the Chief Executive to the Council of Governors for approval.

7.4 To consider and agree any matter relating to the continuation in office of any Board Executive Director including removal from office, suspension or termination of employment by the Trust.

7.5 The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract and retain Executive Directors.

7.6 To set on an annual basis individual remuneration arrangements for the Chief Executive, other Executive Directors in accordance with policy and having regard to individual performance.

7.7 To ensure that in the event of loss of office and/or termination of employment of the Chief Executive or any Executive Director the contractual terms and any payments made, are appropriate and consistent with all relevant Government guidelines.

7.8 To monitor and evaluate the performance of individual Executive Directors.

7.9 To engage the services of or take advice from any suitably qualified third party or advisers to assist with any aspects of its responsibilities provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Chief Executive.

7.10 To provide a view to the Chief Executive / Director of Finance on interim appointments above £50k.

7.11 Ensure plans are in place for orderly succession to the Board and oversee the development of a diverse pipeline for succession, taking into account the challenges

and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.

## 8. REPORTING RESPONSIBILITIES

8.1 This Committee is accountable to the Trust Board. The Chair of the Committee will provide a brief verbal summary after each meeting to the Board on the work of the Committee.

8.2. Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee. Minutes will be retained by the Company Secretary.

8.3 Minutes of meetings of this Committee will not be made available to Executive Directors, with the exception of the Chief Executive and Director of HR (on a need to know basis).

8.4 The Committee shall make a statement in the annual report as required.

## 9. MEETING ADMINISTRATION

9.1 The Company Secretary will provide administrative support to the Committee.

9.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

## 10. REVIEW

10.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

10.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

## Appendix 1 - Summary

| Committee | Remuneration Committee |
|---|---|
| Chair<br>Lead EDs | Nick Bishop, Senior Independent Director<br>Jude Gray, Director of HR |
| Frequency | At least twice a year |
| Membership | All Non-Executive Directors |
| Quorum | 3 x NEDs |
| Remit | Recruitment of Executive Director & other Executive Directors<br>Develop, maintain and implement Remuneration Policy<br>Ensure orderly succession plans<br>Receive reports on Chief Executive and other Executive Directors performance against objectives<br>To agree annual remuneration of Chief Executive and other Executive Directors |

**Appendix 2**

# GWH - Strategic Planning Framework