GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 1 June 2023, 9.30am to 12.45pm
Kennet Room, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ

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** Kevin McNamara, Felicity Taylor-Drewe	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 4 May 2023	1 - 14	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	15	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	-	-	-
6.	**Care Reflection (Patient Story) – Services to support and facilitate improved pathways of care for patients** To be presented by Sarah Knight, Head of Patient Flow and Tania Currie, Head of Patient Experience & Engagement	16 - 19	SK/TC	Assurance	9.45
7.	**Chair's Report** Liam Coleman, Chair	20 - 22	LC	Note	10.15
8.	**Chief Executive's Report** Simon Wade, Chief Financial Officer	23 - 31	SW	Note	10.25
9.	**Integrated Performance Report** • Performance, Population & Place Committee Board Assurance Report (May) – Peter Hill, Non-Executive Director & Committee Chair • Quality & Safety Committee Board Assurance Report (May) – Claudia Paoloni, Non-Executive Director & Committee Chair • Finance, Infrastructure & Digital Committee Board Assurance Report (May – Faried Chopdat, Non-Executive Director & Committee Chair	32 - 34 35 - 40 41 - 43	PH CP FC	Assurance	10.45

	• People & Culture Committee Assurance Report (April) – Paul Lewis, Non-Executive Director & Committee Chair	44 - 45	PL		
	• Integrated Performance Report	46 - 90	All		
10.	**Charitable Funds Committee Assurance Report (May)** Paul Lewis, Non-Executive Director & Committee Chair	91 - 92	PL	Assurance	11.30
BREAK (10 minutes)					
11.	**Safe Staffing 6-month review for Nursing & Midwifery** Lisa Cheek, Chief Nurse (received at Quality & Safety Committee 18 May 2023)	93 - 113	LCh	Note	11.40
12.	**Annual Report & Accounts 2022-23** Caroline Coles, Company Secretary To delegate authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts before deadline of 30 June 2023	114 - 115	CC	Approve	11.50
13.	**Annual Quality Account 2022-23** Lisa Cheek, Chief Nurse To delegate authority to the Quality & Safety Committee to approve the Quality Accounts for 2022-23 for publication on the Trust's website	116 - 117	LCh	Approve	11.55
14.	**Digital Strategic Plan** Naginder Dhanoa, Chief Digital Officer & Jon Burwell, Chief Information Officer (received at Trust Management Committee 20 April 2023 and Finance, Infrastructure & Digital Committee 22 May 2023)	118 - 151	ND/JB	Approve	12.00
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
15.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	Verbal	CC	Note	12.30
16.	**Research & Innovation Annual Report** Jon Westbrook, Chief Medical Officer (received at Trust Management Committee 20 April 2023 and Quality & Safety Committee 18 May 2023)	152 - 168	JW	Note	12.35
17.	**Terms of Reference Annual Review** Caroline Coles, Company Secretary	169 - 191	CC	Approve	12.40
18.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
19.	**Date and Time of next meeting** Thursday 3 August 2023 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-

20.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	12.45

Board Meeting Timetable

2023											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Board	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
			Workforce, Culture & EDI			Patient Voice/Patient Safety Framework			Strategy		

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC JAMES YOUNG SIMPSON ROOM, VYGON, PIERRE SIMONET BUILDING, SWINDON AND VIA MS TEAMS 4 MAY 2023 AT 9.30 AM

Present:

Voting Directors

Peter Hill (PH)	Deputy Chair/Non-Executive Director
Lizzie Abderrahim (EKA)	Non-Executive Director
Nick Bishop (NLB)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Paul Lewis (PL)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Claudia Paoloni (CP)	Non-Executive Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Chief Medical Officer

In attendance:

Emily Beardshall (EB)	Deputy Director – Improvement & Partnership (agenda item 13/23 only)
Caroline Coles (CC)	Company Secretary
Naginder Dhanoa (ND)	Chief Digital Officer
Julian Duxfield (JD)	Non-Executive Director *(arrived 12noon)*
Alex Harrington (AH)	Head of Integrated Podiatry (agenda item 13/23 only)
Lisa Marshall (LM)	Director of Midwifery & Neonatal Services (agenda item 14/23 only)
Bernie Morley (BM)	Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director
Kat Simpson (KS)	Head of Midwifery & Neonatal Services (agenda item 14/23 only)
Claire Warner (CW)	Deputy Chief People Officer (Observer)

Apologies:

Liam Coleman (LC)	Trust Chair
Claire Lehman (CL)	Associate Non-Executive Director

Number of members of the Public: 5 members of public* (included 4 Governors: Pauline Cooke, Judith Furse, Chris Shepherd and Mufid Sukkar, and 1 member of staff)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
8/23	**Apologies for Absence and Chair's Welcome** The Deputy Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public	

Minute	Description	Action

Apologies were received as above.

9/23 **Declarations of Interest**
There were no declarations of interest.

10/23 **Minutes**
The minutes of the meeting of the Board held on 2 March 2023 were adopted and signed as a correct record.

11/23 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

The Board **noted** the outstanding actions.

12/23 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

13/23 **Improving Together Staff Stories**
Emily Beardshall, Deputy Director – Improvement & Partnership, and Alex Harrington, Head of Integrated Podiatry, joined the meeting for this agenda item.

The Board received a reflection from Alex Harrington on being part of Cohort 3 of the Improving Together training. She considered that the Improving Together journey was about developing a quality change culture within the organisation and embedding leadership behaviours, mindset and values throughout the organisation, together with motivational development which had been welcomed by staff.

Alex also outlined how this training had been applied and adapted to address some of the challenges within the Unscheduled Care Division to implement Improving Together methodology. The opportunity to allow staff within that division to attend Improving Together training, despite conflicting pressures and increased productivity, had enabled staff to feel empowered and involved to develop a real culture of leadership at all levels. Any identified gaps in training were being addressed with the rescheduled training dates to allow for site pressures, particularly during the Winter period.

Emily Beardshall presented the reflections from Hayley Moore, Ward Sister on Beech Ward, and the key leadership role that Hayley had played in the team training during Cohort 3. It was noted that the Improving Together approach had helped the team to have space for daily improvements huddles and had encouraged all staff to get involved in discussions and feel empowered to implement change with chosen performance drivers to focus on three areas.

In response to a question asked by Peter Hill, Non-Executive Director, on how the three areas for Beech Ward were chosen, Emily explained that this was an important part in the early stages of the training process and that areas of focus had been formed by the strategic pillars and breakthrough objectives, and that falls had been chosen as one area to reduce harm. Alex also outlined how this approach had also been applied to her team.

In response to a question raised by Rommel Ravanan, Associate Non-Executive Director, Alex confirmed that daily huddles by community teams were held virtually and that the methodology had been adapted to support this; noting that the community teams had originally undertaken Improving Together training in person as a group.

Minute	Description	Action

Peter Hill, Deputy Chair, asked about the challenges of sustainability of the model and Claire Thompson, Chief Officer of Improvement & Partnerships, outlined the actions being undertaken by the Coach House to embed the new process into operational management systems which was essential for sustainability.

In response to a question raised by Faried Chopdat, Non-Executive Director, on the support being provided to teams in this change management process, Claire Thompson, Chief Officer of Improvement & Partnerships, replied that a number of tools and training had been provided to support staff and that the Trust was still on a journey to embed this golden thread of improvement throughout the organisation.

Faried Chopdat, Non-Executive Director, also asked about medical engagement and Emily Beardshall outlined some the of tactical interventions being applied to encourage increased medical engagement, which included the introduction of Champions, networks created through training and support from the Coach House to engage with specialties using improvement tools.

Emily Beardshall also outlined the work being undertaken within the Acute Hospital Alliance to learn collectively and that GWH had been selected as an early innovator site nationally as it had a common improvement methodology in place which had been adopted by both Bath and Salisbury acute hospitals.

Kevin McNamara, Chief Executive, reported to the Board on the national launch of NHS Impact, which was the new single, shared NHS improvement approach to 'improving patient care together'. Kevin welcomed the leadership behaviours being embedded at GWH which would underpin the sustainability of Improving Together within the organisation going forward.

The Chair and Chief Executive both thanked Emily and Alex for sharing this improvement approach for a strategic framework and organisational management system to embed improvement using the Improving Together methodology.

The Board **noted** the Improving Together staff story.

14/23 **Ockenden Report – GWH Update**

Lisa Marshall, Director of Midwifery & Neonatal Services, and Kat Simpson, Head of Midwifery & Neonatal Services, joined the meeting for this item.

The Board received a paper which provided an update on the Immediate & Essential Actions (IEAs) outlined in the full Ockenden Report including key highlights for celebration and key risks. A SWOT analysis undertaken on GWH Ockenden 'red' Immediate & Essential Actions was noted.

The GWH Ockenden progress summary was noted as:

- Significant increase in 'green' Immediate & Essential Actions following a deep dive into the 'amber' actions. This has been influenced by associated progress achieved against the Clinical Incentive Scheme for Trusts (CNST) and compliance with local audits initiated following publication of the Ockenden report in March 2022.
- Funding secured to support expansion of bereavement services, consultant job planning to support the patient safety agenda and support worker development.

Minute **Description** **Action**

Kat Simpson outlined the actions being undertaken to mitigate against the remaining 'red' actions and the next steps for progression. Three of the remaining red actions related to the anticipated publication of national standards and three of the actions were anticipated to move to 'amber' within the next couple of months,

Lizzie Abderrahim, Non-Executive Director, commented that the EDI box on the front sheet of the report stated that no issues had been identified and disagreed that none of the issues were relevant as women from BAME backgrounds were four times more likely to die in childbirth and that as a Board the context within which the work was being undertaken should be recognised. Lisa Marshall agreed and would amend this accordingly.

In response to a question from Jon Westbrook, Chief Medical Officer, on this Trust benchmarks against other equivalent organisations, Lisa Marshall replied that currently there was limited benchmarking however the Trust had started to share the IPR slides with the Local Maternity & Neonatal System (LMNS) Board and that evidence from other organisations would also be shared. Lisa added that this Trust was in a favourable position.

In response to a question asked by Faried Chopdat, Non-Executive Director, on any gaps from a strategic level following the risk assessment against the Ockenden Report, Lisa Marshall was able to provide assurance that this report and CNST would be reviewed alongside CQC local reports to encompass all aspects of maternity services to ensure that safe services were being provided and would meet the needs of the Trust's population.

In response to a question raised by Will Smart, Non-Executive Director on evidence of improvements in outcomes from the actions being taken, Lisa Marshall replied that the review against the Ockenden report had provided an opportunity for national learning to be shared and also across the system to enable collaborative working. The Board also noted the positive impact of improvements for staff with regards to the recruitment perspective and also staff morale and wellbeing.

Paul Lewis, Non-Executive Director, provided his views as Maternity Services Champion and outlined the positive feedback from Mothers and their families and also the staff. He commended on the considerable work that had been undertaken and the transformation in terms of the leadership capability in this area and the recruitment and retention of staff. Paul considered that the Trust had the confidence and capability to influence change more locally and nationally, particularly around succession planning development. Nick Bishop, Non-Executive Director, added that as Chair of the Quality & Safety Committee, assurance against the Ockenden report actions had been reported to the committee on a monthly basis and was confident that good progress would be sustained.

Peter Hill, Deputy Chair/Non-Executive Director, thanked Lisa Marshall and Kat Simpson for their leadership and assurance against the Ockenden Report.

15/23 **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 and the following was noted:-

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- In March 2023, NHS England had launched the new NHS provider licence, which formed part of the oversight framework for all NHS providers, such as this Trust. The appointment of the new Non-Executive and Associate Non-Executive Directors was noted.
- Claudia Paoloni, Non-Executive Director, had taken over as Chair of the Quality & Safety Committee from Nick Bishop, whose tenure comes to an end at the end of June 2023.

The Board **noted** the report.

16/23 **Chief Executive's Report**

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

British Medical Association industrial action – An update on the recent strike action undertaken in April by the BMA was noted. More than 1,000 outpatient appointments and a number of operations were cancelled and rescheduled at short notice during the two strikes, and the operational and financial impact would continue to be monitored together with the significant impact on patients and the delivery of the Trust's annual plan.

Royal College of Nursing industrial action – It was noted that the Royal College of Nursing was due to hold a 48-hour strike over the May bank holiday. However, following a challenge by the Government in the High Court, this had been curtailed by a day and as a result the impact had been lessened. The strike would be without derogations and as such would include areas such as emergency and critical care for the first time. Kevin McNamara, Chief Executive, wished to thank the nursing medical operational leads and HR in supporting the Trust through that strike period.

The Board noted the pay deal that had been approved for Agenda for Change staff. The majority of the unions had taken this proposal to its members, with the exception of the RCN and Unite as these unions were remaining in dispute. However the Government can impose to progress the pay deal, however ballots were expected to be held on further strike action.

Lizzie Abderrahim, Non-Executive Director, asked about what actions had been taken to minimise the impact of the strike action on vulnerable patients. Felicity Taylor-Drewe, Chief Operating Officer, outlined the actions that were being taken in relation to rebooking day case inpatient activity and the management of those patients and any learning from the impact of the strike action was to be considered for any future industrial action.

Infection Prevention and Control changes – Following updated national guidance from the Government, the Trust had made changes to the way in which Covid-19 would be managed in relation to testing and wearing of masks for both patients and staff, with exceptions for cancer and haematology.

NHS England Maternity Plan – NHS England had approved a three-year delivery plan for maternity and neonatal services. The plan had identified 12 objectives across four themes, bringing together actions from recent national reports into maternity (including the Ockenden and Kirkup reports) as well as the NHS long-term plan and maternity transformation programme. The themes and objectives were listening to and working

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with women and families with compassion, supporting the workforce, development and sustaining a culture of safety, and meeting and improving standards and structures.

Hewitt review – An outline of the key recommendations from the report into integrated care systems was noted and next steps on implementation of those recommendations was awaited. It was noted that this placed additional pressure on the Trust on how to use short term funding and the impact to sustain a strategic approach to service delivery and review of the NHS capital regime. Nick Bishop, Non-Executive Director, asked about the outcome of this report and if there was to be an implementation programme. Kevin McNamara, Chief Executive, responded that there was no further detail available as yet and added that more relevant was the early innovator programme for funding and influencing policy.

Disability Confident Level 3 Leader award – The Trust had been awarded the Disability Confident Level 3 Leader award, which provided assurance that the Trust was committed to ensuring that individuals with disabilities had opportunities to fulfil their potential and realise their aspirations within the Trust and was also a further step towards creating a truly inclusive culture.

The Board **noted** the report.

17/23 **Integrated Performance Report**

Integrated Performance Report – Pillar Metric deep dive and refresh
The Board received a report which outlined a recommended change for the Improving Together Pillar Metrics and Breakthrough Objectives for 2023/24.

It was noted that the Trust Management Committee had reviewed the metrics and agreed that the measures for pillars 3 (Waiting List – RTT), 8 (EDI) and 12 (System Control Total/Improvement & Efficiency) be refined, the measure for ED breakthrough objective be changed, productivity be added as a new breakthrough objective, and that Non-Criteria To Reside be removed as a breakthrough objective (pillar metric would remain) and replaced with productivity. An outline of measures and the actions to be taken to provide assurance was provided to the Board.

Lizzie Abderrahim, Non-Executive Director, welcomed the proposed changes and asked what the frequency would be to present data to the Board to provide evidence of improvement for EDI and Claire Warner, Deputy Chief People Officer, responded that this could also be measured through the Quarterly Pulse Survey as well as the Annual Staff Survey.

Helen Spice, Non-Executive Director, also welcomed the changes but asked for further clarification on pillar metric 1 on Reducing Harm and how this was going to be measured in the future. Lisa Cheek, Chief Nurse, confirmed that pressure harms in both acute and community would continue as a breakthrough objective for this year. However, she considered that the methodology had not been fully applied until recently and that there had been a disparity between the overarching, divisional and frontline A3 Improving Together methodology. The overarching A3 had now been reviewed as a whole team to work towards a common aim. A root cause analysis had also been undertaken into four key areas and the counter measures had been revised for the next 12 months, in relation to safer staffing and the impact on harm levels including induction and education, and leadership and oversight of matrons and ward managers, roles and

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responsibilities of wider support team, and processes and implementation of the skin bundle which was being piloted in two ward areas.

In response to a question from Claudia Paoloni, Non-Executive Director, on the timeframe to measure objectives to reach zero harm, Lisa Cheek, Chief Nurse, replied that the ambitious target was to aim towards a 30% reduction in a year and that a realistic stretch target had been set and consideration would be given on how the goals would be reflected in the IPR.

Paul Lewis, Non-Executive Director, reflected on the success the actions taken in the Trust in relation to Non-Criteria to Reside and the work by the Coordination Centre, and formally document the learning and to share it within the organisation from an engagement perspective around Improving Together but also to celebrate success.

In response to a question asked by Faried Chopdat, Non-Executive Director, on the impact of the care coordination system on waiting lists, Felicity Taylor-Drewe, Chief Operating Officer, explained that this was currently unclear but validation requirements had been enhanced from an administrative point of view and that the quality metrics were being worked through. Felicity added that the Trust's theatre utilisation currently stood at 80% and that this Trust was top in the South West for theatre utilisation.

Jude Gray, Chief People Officer, outlined the actions to be taken for the Breakthrough Objectives to maintain the successes from the staff survey results and drive further improvement. Jude particularly reported on the increased results which related to staff feeling empowered make improvements in their work and recommending the Trust as a place to work. She acknowledged the need to sustain these increases but that all indicators evidenced a systematic move in the right direction. Nick Bishop, Non-Executive Director, encouraged the continued need to share these improved results with staff.

Kevin McNamara, Chief Executive, reflected on the improved leadership behaviours of the organisation enhanced by Improving Together methodology being applied and that this would continue to be evidenced through improved Staff Survey and Pulse Survey results. Learning from other organisations would also help to drive further improvement and increase staff empowerment and morale.

Simon Wade, Chief Financial Officer, reported that the BSW system would achieve the planned position and that all targets had been reached which should provide some flexibility into next year's capital. However, he added that to deliver the position, there had been an element of non-recurring funding across the system and issues with the delivery of efficiency programmes, together with an increase in agency staff usage and loss of productivity experienced over recent years and added that these problems were consistent across organisations within the system. Simon reported on the evidence within the organisation moving towards a longer term recovery plan and development of schemes to improve the position, but acknowledged that further challenges for the year would continue.

Kevin McNamara, Chief Executive, added that some investments in the plan may require system level approval and oversight by the System Recovery Board, of which this Trust was a member. Kevin also commented that the revision of the Trust Strategy would help to narrative the Trust's financial position alongside sustaining the staff survey results as a great place to work.

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Integrated Performance Report Review
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 March 2023.

The Board **noted** the update.

18/23 **Board Committee Assurance Reports**
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) at its meetings on 29 March and 26 April 2023 and following was highlighted:-

Emergency Access – The Trust continued to perform relatively well against the 4-hour standard and had seen a reduction in mean waiting times. Industrial action and a decrease in the number of non-criteria to reside patients in the Trust was considered to have contributed to this improved performance.

Referral to Treatment Time (RTT) – Positive news in terms of end of year compared to March. Management of the 78 week cohort continued, with patient-by-patient reviews continuing and extending to patients who will be waiting over 78 weeks to ensure next steps were in place and being expedited, and any complexities of pathways understood so these can be mitigated.

Diagnostics (DMO1) – DM01 performance was the highest it had been in two years at 56% with MRI/CT scans continuing to see good progress, in line with the performance delivery plan.

Cancer Performance - Cancer performance had shown no decrease in 62-day waiting performance, however there was an increase in the number of patients waiting and predicted a decline in March. This was a similar position reflected nationally however the Trust was performing better than all national performance. There was to be continued focus with the plan within Colorectal, Urology, Dermatology and Plastics.

Non-Criteria to Reside – In March, it was reported that for a fourth consecutive month there had been a reduction in the number of bed days lost through non-criteria to reside. GWH had taken part in a Peer Trauma Network exercise which had shown positive results in how it responds to trauma and the part GWH plays within the trauma network.

Theatres Programme Assurance Report – Assurance had been gained on the Theatre Improvement Programme along with national benchmarking exercises, regional theatre projects and actions resulting from those. The significant improvements within the service had been acknowledged by the Performance, Population & Place Committee.

Quality & Safety Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Safety Committee (Q&SC) at the meetings held on 23 March and 20 April 2023 and the following highlighted:-

Hospital Acquired Infections – In March, MSSA remained above trajectory almost wholly due to poor cannula practice. Efforts were concentrating on reducing the current 30% use of ante cubital fossa (at the elbow) for cannula replacement.

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In response to a question raised by Rommel Ravanan, Associate Non-Executive Director, Lisa Cheek, Chief Nurse, confirmed that the programme for the installation of permanent air scrubbers was still ongoing, with portable air scrubbers in place where required.

IPR : Pillar Metrics - Total number of harms had increased from 218 to 302. Significant factors were an increase in hospital acquired pressure harms, falls and *C.diff* numbers.

The Trust would no longer be testing for Covid routinely, which would impact our total harms numbers and so consideration was needed on how to manage this in the future.

Friends and Family Test positive responses had reduced in March but still remained within the internal target of 86%.

There had been an increase in C.diff rates in March from 39 to 49 and this was currently under review to identify a cause.

Perinatal Mortality Review Tool Q3 – 100% compliance across all measures was reported and the system remains embedded.

Getting It Right First Time (GIRFT) – There has been a renewed focus on GIRFT activity within GWH. A centralised support had now been identified to help coordinate and support services, with a new overarching governance process in place to ensure better oversight around recommendations and improvements that may be required following scheduled GIRFT visits or deep dives.

Update on CQC Preparedness - There had been further progress. An action plan was in place to address the Safeguarding Children Level 3 Training, all spaces had been filled and therefore an increase in compliance was expected.

Finance, Infrastructure & Digital Committee Chair Overview
The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at the meeting held 23 January 2023 and the following was highlighted:-

Faried Chopdat, Non-Executive Director, congratulated the Executive Directors and their teams to enable the Trust to reach the breakeven position and the assurance provided by the risk management processes in place.

Month 12 Finance position – The Committee was satisfied with the mitigation actions to address the risks, which included audit challenges on provisions.

Capital Plan – Increased governance with Procurement and capital scheme leads to manage slippage in the capital spending and bring forward other items of spending was in place to support the effective delivery of care in a safer, more robust environment

IT & Digital Risks – There was assurance that the risk management process and reporting for IT and Digital was adequate and effective, however further work was required to improve the maturity of the risk management process as a whole.

Shared EPR Risks – The Shared EPR Procurement was progressing on track with a preferred bidder identified and notified. Contract finalisation negotiation was now underway and funding yet to be received.

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The Board **noted** the reports.

Year End 2022/23 Update
Simon Wade, Chief Financial Officer, provided an update on the end of year position. The audit of the annual accounts had now been submitted to the External Auditors and that the audit had commenced, and that no issues have been highlighted as yet.

Simon Wade also reported that the interim report from the Infrastructure Projects Authority on the Trust's PFI contract had been received which provided a good level of confidence to prepare the Trust for the handover in 2029.

People & Culture Committee Chair Overview
The Board received an overview of the detailed discussions held at the People & Culture Committee at the meeting held on 28 April 2023 and the following was highlighted:-

IPR Metric – Staff Survey (recommended place to work) – This was agreed as the main focus for staff survey action plans as the breakthrough objective and the approach for 2023 was currently under review and the way forward would be agreed at the next meeting. The question was to also be added to Pulse Surveys to gain further insight and understanding.

IPR Metric – Staff Survey (I am able to make improvements happen in my area of work) – It was agreed that Divisions would return on rotation going forward to provide regular updates and assurance about the implementation of their action plans to enable progress to be monitored. The first review would be received from the Surgery, Women's & Children's Division to provide insightful analysis and engagement.

IPR Metric – Voluntary Staff Turnover Rate – The Trust target is 11%. The voluntary turnover rates have been on a positive, downward trend since July 2022, but are still above target. The 6 monthly Retention Progress Report provided further insight and assurance about our position, plans and key priorities for improvement.

The Board **noted** the report.

19/23 **Mental Health Governance Committee Board Assurance Report**
The Board received an overview of the detailed discussions held at the Mental Health Governance Committee (MHGC) at the meeting held on 21 April 2023 and the following highlighted:-

Report on the use of Deprivation of Liberty Safeguards (DoLS) – There had been an increase in the number of applications and it was recognised that this had reflected an increase awareness resulting from the MCA upskilling programme. However, it remained the case that the supervisory bodies lacked the capacity to complete the statutory assessments and a number of patients therefore continued to be cared for outside the legal framework. This would continue to be monitored as this remained a significant risk to the Trust in terms of implementation of those safeguards due to legal implications.

Emergency Department/Mental Health Liaison Team Update and Children's Services/Child & Adolescent Mental Health Service Update – Concern was expressed that the Trust was not a provider of mental health services but we provided care to people who are experiencing mental ill health whilst in our care. This meant it was

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important to have processes and structures in place to support them through that. Both ED and the Children's Services received support through a liaison team (AWP for adults and Oxford for both CAMHS and children); however both organisations had significant challenges that have impacted on their ability to provide the liaison service expected of them. The Committee had assurance that in both units the working relationships with those liaison teams were good. Of note, AWP was reporting a much better performance against the expectations of the service provided to the Trust within ED, however the liaison service provided to the Children's remained challenged by workforce issues and remains a concern.

Felicity Taylor-Drewe, Chief Operating Officer, provided assurance that conversations were underway with system partners and at ICA level to try to address the provision of an appropriate environment to accommodate patients whilst they were waiting for an acute mental health bed and to further build on the good working relationships with local teams.

The Board **noted** the report.

20/23 **Staff Survey Results 2022**

The Board received a report on the results of the National Staff Survey 2022.

It was noted that the Trust Pillar Metric "Recommending my Organisation as a Place to Work" had remained.

The Trust breakthrough objective *"I can make improvement happen in my area of work"* had improved significantly when compared to last year's result but remained below the national average and slightly below the Trust Target of 55%.

There had been an improvement in the Staff Morale theme. However, the associated sub themes of advocacy and work pressures/burnout showed a decline in the survey, and was also reflected in the free text comments.

The national average scores for staff agreeing with the statement *"I think that my organisation respects individual differences (e.g., cultures, working styles, backgrounds, ideas, etc.)"* had improved and, although below national average, our BME staff had reported that they had experienced reduced levels of bullying and harassment from patients, service users, colleagues, and managers compared to 2021.

The Trust also reported better than the national average for the statement "*My organisation takes positive action on health and well-being"* for the second year in a row.

It was noted that the results had been discussed by both the Trust Management Committee and People & Culture Committee.

Jude Gray, Chief People Officer, reported that in terms of the national context, there had been a high response rate to the survey and this had resulted in the Trust being ranked 8th nationally and first in the South West for our response rates. Jude thanked her team for the considerable efforts made to ensure an improved response rate by staff.

The Board noted the areas to celebrate success related to flexible working, compassionate leadership and improvements in staff being understanding and kind to

Minute **Description** **Action**

each other. Priorities identified for further work related to advocacy and work pressures and that work to address these areas would continue.

In response to a question raised by Julian Duxfield, Non-Executive Director, Claire Warner, Deputy Chief People Officer, confirmed that the data was broken down by division and staff group and also by departmental level to enable it to be stratified and analysed by staff, group and department.

Helen Spice, Non-Executive Director, commented on the commendable progress being shown by the survey results and the need to celebrate success and asked how the free text data would be analysed. Peter Hill, Deputy Chair/, provided assurance that this disparity had been discussed by the Performance, Population & Place Committee and free text had been absorbed and analysed by the Executives.

Lizzie Abderrahim, Non-Executive Director, asked a question regarding the free text for Morale & Feeling Valued, and the work being undertaken to understand this data, as morale might be particular to this organisation or much more generalised morale about the NHS. Assurance was provided that Divisions were undertaking detailed analysis by teams to engage with those with the lowest scores through listening sessions and apply learning. Lisa Cheek, Chief Nurse, added that the free text had also been analysed for nursing and midwifery which mainly related to nursing ratios and workload, and was pleased to note that the score for questions under morale had not deteriorated from the previous year's scores.

The Board encouraged analysis of free text to be undertaken for corporate support functions, as this had been recognised by the leadership team that more visibility in those areas was required to make staff feel more valued.

The Board **noted** the report.

21/23 **Committee Effectiveness Review 2022/23**

The Board received a paper to consider the annual review for the Board Committee structure and the terms of reference for Board Committees Audit, Risk & Assurance, Quality & Safety Committee, Finance, Infrastructure & Digital Committee, Mental Health Governance Committee, Performance, Population & Health Committee and Trust Management Committee. The following was noted:-

- Each Board Committee had undertaken an open discussion to consider their effectiveness, including terms of reference.
- There were no issues or concerns to draw to the attention of the Board.
- The terms of reference of the Committees were circulated showing minor amendments.

The Board **agreed**:

(a) that there are no changes proposed to the Board Committee structure;
(b) that the Terms of Reference for each Committee as circulated separately with the agenda be approved.

22/23 **Annual Review of Trust Constitution**

The Board received a paper that provided a proposal to amend the Trust's Constitution following an annual review which reflected the following:-

Minute **Description** **Action**

- the establishment of Joint Committees/Committees-in-Common
- the appointments of Associate Non-Executive Directors
- the revised National Health Service Act 2006
- the changes to the Trust's Partner organisations on the Council of Governors
- holding virtual/hybrid meetings
- various 'tidying up' i.e. change of job title and gender-neutral language.

Following consideration of the number of changes the Board supported the amendment. The next stage was to seek approval from the Council of Governors.

RESOLVED

to approve the amendments to the Trust's Constitution as outlined in 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.

23/23 **Ratification of Decisions made via Board Circular**
None.

24/23 **Annual Self Certification – G6/FT4/CoS7**
The Board received a number of self-certifications for Board approval prior to publication. The self-certifications were:-

- Condition G6 - effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution;
- Condition FT4 - complied with governance arrangements; and
- Condition CoS7 - the required resources available if providing commissioner requested services (CRS).

The Audit, Risk & Assurance Committee had reviewed and agreed compliance with the Provider Licence at its meeting held in March 2023 and the Council of Governors reviewed and agreed that the training received by governors during 2022/23 met the requirements of the S151(5) of the Health & Social Care Act 2012.

RESOLVED

to approve the annual self-certifications G6, FT4 & CoS7.

25/23 **New Code of Governance for Provider Trusts**
The Board received a paper that provided an overview of the Code of Governance for NHS Provider Trusts that had been issued by NHS England.

The report set out the key headlines from the Code, implications for the Trust, proposal for monitoring compliance and next steps.

Minute	Description	Action

It was proposed that a formal report, detailing the 'comply and explain' position against the provisions of the Code would be provided in April, on an annual basis, as is the current practice. The report would be considered by the Audit, Risk & Assurance Committee.

In recognition that 2023/24 was the first year of the new code it is proposed that in September the Audit, Risk & Assurance Committee receive a mid-year 'comply and explain' report providing details of the position against the provisions of the Code.

Kevin McNamara, Chief Executive, added that a governance review of the Acute Hospital Alliance had been undertaken which would drive further conversations about the level of delegated authority into a committee in common or potential future joint committee.

The Board **noted** the update and next steps.

26/23 **Register of Interests and Declaration of Interests at Meetings**

The Board received a paper that provided an annual reminder to members of the Board of their obligation to register any relevant and material interests as soon as they arise or within 7 clear days of becoming aware of the existence of the interest and to also make amendments to their registered interests as appropriate. It also provided a copy of the Register of Interests of the Board of Directors for review, which best practice suggested should be undertaken on at least an annual basis.

The Board **agreed**:

(a) that the requirement of directors to register their relevant and material interests as they arise or within 7 clear days of becoming aware of the existence of an interest be noted;
(b) that the requirement to keep the register up to date by making amendments to any registered interests as appropriate be noted;

(c) that the requirement to declare the existence of registered interests or any other relevant and material interests at meetings be noted including the requirement to leave the meeting room whilst the matter is discussed;
(d) that the Director's Register of Interests be received and it be agreed that the Board is assured that the requirements of the Constitution to maintain a register of interest of Board Directors are being met.

27/23 **Urgent Public Business (if any)**

None.

28/23 **Date and Time of next meeting**

It was noted that the next meeting of the Board would be held on 1 June 2023 at 9.30 am, at the Double Tree by Hilton, Swindon.

29/23 **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.

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – June 2023				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
2-Feb-23	231/22	**Chief Executive's Report : Improving Together** 'One-year on' reflection report on Improving Together to include next steps	Chief Officer for Improvement & Partnerships	On agenda
2-Feb-23	232/22	**IPR : Board Assurance Reports** Relook at format of Board Assurance Reports to ensure consistency of rag ratings across all committees	Company Secretary	On agenda

Future Actions				
None				

Report Title	**Care Reflection (Patient Story)**				
Meeting	**Trust Board**				
Date	**1st June 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek – Chief Nurse				
Report Author	Tania Currie – Head of Patient Experience and Engagement				
Appendices	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 film identifies the work of two new services set up to support and facilitate improved pathways of care for patients.

Home First is a new service where patients are facilitated to return home with appropriate support and then receive an assessment from the relevant social worker or community support services in order to assess their ongoing needs. By undertaking the assessment in the patient's own home this can provide a more accurate review of the patients and family's needs.

The Urgent Community Response Service aims to quickly assess patients in their own home in order to ensure that they are triaged and streamed to the most appropriate pathway of care for their presenting condition. The service facilitates assessment by registered practitioners in the patient's own home within a 2-hour time frame and then provides onward signposting or referral.

The film shares the experiences of two patients who have benefitted from these services along with staff providing an explanation of the pathways, how these are facilitated and the benefits that have been delivered.

Report

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

The Care Reflection film

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 will be 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: Not formally assessed			

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ To receive the presentation as assurance of the developments and improvements in patient pathways of care identified in the Care Reflection film.	
Accountable Lead Signature	Lisa Sheek
Date	25th May 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Care Reflection

Community services

Trust Board – June 2023

Care Reflection

Community Services

Home First and Urgent Community Response Services

- The film identifies the work of two new services set up to support and facilitate improved pathways of care for patients into the community
- The Home First service facilitates patients to return home to be assessed for ongoing care needs in their own home
- The Urgent Community Response Service aims to quickly assess patients in their own home in order to ensure that they are triaged and streamed to the most appropriate pathway of care
- The film shares the experiences of two patients who have benefitted from these services along with staff providing an explanation of the pathways, how these are facilitated and the benefits that have been delivered

Watch film here: https://youtu.be/s47Ii4xc2t0

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

Purpose

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

Assurance Level

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

Process

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

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

Report

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

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

The report provides information in respect of:-

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

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	25 May 2023

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 May 2023.

1. Council of Governors

2.1 Governors - Councillor Caryl Sydney-Smith has had to step down as appointed Governor for Swindon Borough Council due to the recent election results. The Board wishes to thank Caryl for her time and commitment during her term of office as a governor.

2.2 Council of Governors Meeting – A Council of Governors was held on 10 May 2023 which included governor briefings on Business Planning, ICS Update and Staff Survey.

2.3 Public Health Talk – A very successful health talk, hosted by the governors, was held on 24 May 2023 Research & Activity of GWH, and we thank Suzannah Pegler, Clinical Research Delivery Lead for taking the time to present this well attended talk.

2.4 Monthly Meeting with Lead Governors - The regular monthly meetings were held with the Lead Governors.

3. Non-Executive Directors

3.1 Farewell - This is the last meeting for Nick Bishop, Non-Executive Director as his term of office comes to an end on 30 June 2023. The Board wishes to thank Nick for his significant contribution and commitment over the past 7 years and wish him well in the future.

4 Strengthening Board Oversight

4.1 Safety Visits - There was one Board safety visit during the period covered by this report as follows:-

Date	Area	Board Member
24 May 2023	Jupiter Ward	Simon Wade, Chief Financial Officer and Paul Lewis, Non-Executive Director

4. Key Meetings during May 2023

To note the Chair was on annual leave in May.

Meetings	Purpose
1-2-1 meeting with Chief Executive	Regular meeting
EPR Update	Monthly update meeting
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
BSW Chairs catch up	Regular meeting bringing together healthcare providers within the BSW ICS
Finance, Infrastructure & Digital Committee	Attended Board Committee as observer
Performance, Population & Place Committee	Attended Board Committee as observer
Remuneration Committee	Attended as member
WHC Members' Board meeting	Attended as member

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

Purpose

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

Assurance Level

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

Board members are asked to note the report.

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

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

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

Report

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

This report includes updates on:

- Industrial action
- Robotic surgery
- Patient Safety Incident Response Framework
- Launch of NHS England's National Provider Collaborative Scheme
- The NHS@75 project and our plans to mark the 75th anniversary of the NHS
- How we are addressing the issues raised in the Staff Survey

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 provides an update on our staff networks which give a voice to staff and provide opportunities to positively influence change within our organisation.

The report mentions our Staff Excellence Awards which recognise high-performing staff and teams and the awards include a category on recognising staff who have gone out of their way to champion equality, diversity and inclusion in the workplace.

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

1. Operational updates

1.1. Industrial action

The national Staff Council agreed to the pay deal offered by the Government and staff on Agenda for Change last month.

This means that all staff who are employed under Agenda for Change will receive:

- A non-consolidated award of 2% of an individual's salary for 2022/23
- A one-off 'NHS Backlog Bonus' equivalent to 4% of the Agenda for Change pay bill. The bonus will be worth at least £1,250 per person and will be determined by pay band and position within the band
- For 2023/24, the government has offered Agenda for Change staff a 5% consolidated increase in pay, worth at least £1,065.

This will be paid in June to staff who were employed by the Trust on 31 March 2023.

Although an agreement has been reached, this does not necessarily mean the end of strikes. The Royal College of Nursing, which voted against the pay offer, has said that it intends to ballot members again for a new mandate for industrial action.

The Society of Radiographers, which also voted against offer, will ballot its members for strike action as well.

Junior Doctors and Consultants are not on Agenda for Change terms and conditions and so the Government pay deal does not impact upon them.

British Medical Association (BMA) Junior Doctors remain in dispute with the Government and their next strike will take place for 72 hours from 14-17 June. Our response planning for this has begun.

BMA consultants are currently being balloted for industrial action.

The Trust will continue to plan and prepare for any future strike action and we hope for a resolution to the dispute as quickly as possible in the interests of reducing the clinical impact upon our patients.

2. Quality

2.1. Robotic surgery

Last month we carried out our first robotic surgery at Great Western Hospital, following our purchase of a surgical robot earlier in the year.

The robot was used by a surgical team for a resection of part of an intestine. It can be used across our General Surgery, Urology and Gynaecology departments and over time

with the development of technology we will be able to apply its use to more specialties and more patients.

This is an important moment in ensuring we deliver the best possible care to all of our patients. The new surgical robot allows our surgeons to carry out operations in a less invasive way, meaning our patients should spend less time in hospital and have a decreased chance of complications.

Until now, patients have had to travel longer distances to neighbouring hospitals for this type of treatment. Now, they will be able to have this surgery closer to home while also hopefully experiencing shorter recovery times.

Our surgical teams have undergone extensive training in recent months to allow them to use this new technology. In the coming weeks, they will begin using the robotic technology more frequently delivering improvements in care to the patients we look after.

2.2. Patient Safety Incident Response Framework

When an incident occurs, it is really important that we learn lessons about what has happened and spread this learning to prevent similar incidents taking place. This is key to our work to create a Just and Learning Culture.

The Patient Safety Incident Response Framework (PSIRF) was published by NHS England in August and outlines how providers should respond to patient safety incidents in order to learn from them.

The framework will replace the current Serious Incident Response Framework by Autumn this year and represents a significant shift in the way the NHS responds to patient safety incidents.

It is focussed on compassion and involving those affected; system-based approaches to learning and improvement; considered and proportionate responses; and supportive oversight.

PSIRF is a major step towards improving safety management across the healthcare system and will support the NHS to embed the key principles of a patient safety culture. It will ensure the NHS focusses on understanding how incidents happen, rather than apportioning blame on individuals; allowing for more effective learning and improvement, and ultimately making care safer for patients.

PSIRF removes the requirement that only incidents meeting the criteria of a ‘serious incident’ are investigated, allowing for other incidents to be investigated and for learning to focus on areas with the greatest potential for patient safety improvement.

Staff are currently in the process of completing training on using the new system.

2.3. New Carer Support Passport

To help provide the best possible service for carers and those they care for, we have introduced a new Carer Support Passport.

Designed with the input of staff, patients, carers and our external partners, the passport is available to all unpaid carers that are helping patients through their time in hospital.

While in hospital, there is no expectation for any unpaid carer to continue their role. However, as a Trust we are committed to supporting carers and enabling them to be involved in care as much as they, and the patient, want them to be.

The Carer Support Passport has been designed to enable hospital staff to recognise carers more quickly, allowing them to be involved in discussions about the patient's care where appropriate.

The passport provides an opportunity to document the agreed involvement in the care that will continue to be provided by the carer during the patient's hospital stay.

The passport also makes clear the support and benefits available to unpaid carers such as flexible visiting, being able to stay overnight, concessions on parking, food, and beverages.

2.4. Digital Recommended Summary Plan for Emergency Care and Treatment

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) was introduced 18 months ago and is used to record difficult decisions about treatments that would, or would not, offer benefit and be wanted by a patient in a crisis.

Until now, it has only been possible to fill out paper versions of ReSPECT forms, but these are now available digitally to allow instantaneous sharing of any updates to patient plans to everyone who can access the Integrated Care Record across the integrated care system.

It is important that technology does not prevent important conversations around end-of-life care taking place, so paper versions are not being phased out at this point.

3. Systems and Strategy

3.1. Decant begins for Integrated Front Door.

Construction work on our urgent and emergency care expansion is underway, and the concrete slab has recently been poured for the new Emergency Department (ED) as part of our Way Forward Programme.

Over the coming months, as construction continues, some of our front door teams will need to move their service location so that reconfiguration works can take place within part of the existing building.

There will also be some changes to patient pathways. For example, some paediatric Emergency Department patients will be transferred to the Paediatric Assessment Unit on the second floor earlier in their care.

Last week Paediatric ED moved in to the children's area in the Urgent Treatment Centre (UTC). Paediatric ED staff will also be moving, to continue their management of their patients in this new location. Children who would routinely be seen in the children's area of the UTC will be seen and treated in designated cubicles in the adult area of UTC during this phase of temporary service location.

A number of desk moves have also taken place and modification work will start next week in the former Paediatric ED to prepare for temporary service relocations, with the ED Observation Unit moving to this area shortly.

Any patients needing urgent or emergency care as a walk-in will continue to arrive at the Urgent Treatment Centre and be signposted to the right place for their care needs by the Clinical Navigator.

3.2. NHS@75 and marking the NHS' 75th birthday

The NHS Assembly brings together a range of individuals from across the health and care sectors at regular intervals to provide independent advice to the board of NHS England.

Its members include NHS clinical and operational leaders, frontline staff, patients, and representatives from several charities and community organisations.

The Assembly's NHS@75 project aims to seek consensus on the future development of the NHS, asking three questions:

1. How far has the NHS come in 75 years?
2. Where is it now?
3. What would we like from it in the future?

This engagement has now closed – we asked any of our staff completing the questions to share their responses with us to help inform our work on refreshing our Trust's strategy.

A number of celebrations are taking place nationally and at our Trust to celebrate the 75th anniversary of the NHS.

Among the celebrations, an exhibition of photographs of some of the staff who make up our Trust will be displayed, we will take part in the NHS Big Tea for patients, and we will be involved in helping to tell the story of the NHS' links to the railways in Swindon and the birth of healthcare locally.

We have also re-launched our Great to Talk podcast, which will be sharing staff stories in the lead up to the anniversary. The podcast can be accessed from the Trust's website along with providers such as Apple, Google, Amazon and Spotify.

3.3. NHS England National Provider Collaborative Innovators Scheme launch

I attended the national launch of NHS England's Provider Collaborative Innovators Scheme in London last week, alongside the Integrated Care Board and our Acute Hospital Alliance partners Salisbury NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust, and also clinical leaders.

This follows our Acute Hospital Alliance being selected as the only South West representative in the first wave of the scheme.

The event reinforced the national expectation and local need to collaborate to address the shared challenges we face. It also highlighted the role of clinical leadership across professions to change mindsets and fundamentally shift from competition to collaboration.

3.4. Climate-friendly pain relief

Our Trust recently became only the second NHS organisation in the country, and first in the South West, to install a Central Destruction Unit (CDU) to make entonox - also known as gas and air - carbon neutral.

In the process, entonox is sent to the CDU, which is designed to 'crack' any nitrous oxide into oxygen and nitrogen, natural components of air.

This is a significant first for the Trust in our move to reduce our carbon footprint, as anaesthetic gases make up two per cent of the total NHS England footprint.

The CDU is currently connected to four of the Trust's maternity delivery rooms, with plans to connect all 12 rooms in the near future.

Earlier this year, we also decommissioned the piped supply of nitrous oxide, a gas medically distinct from entonox but a contributing factor to our carbon footprint. This project was made possible by obtaining funding from the Healthier Futures Action Fund via Greener NHS and we were one of 14 successful applicants out of 109 across the South West. The Trust now only uses a small number of nitrous oxide gas cylinders and will save hundreds of thousands of litres of gas usage every year.

4. Workforce, wellbeing and recognition

4.1. Staff Networks

We marked National Day for Staff Networks last month, which had the theme of 'Staying Strong' to remind staff that standing together as allies equals power.

All our networks meet regularly, either in person or virtually, and welcome all staff, regardless of characteristics or lived experience.

Our networks are safe, supportive and professional spaces, offering staff an opportunity to connect with others, make friends, share experiences, challenge organisational practices and influence policy.

Following a launch event in March, the Women's Network held its first meeting last month, which was an opportunity for all staff to feedback on what the network should focus its activities on in the coming months.

Along with the Women's Network our networks include Black, Asian and Minority Ethnic, Differently Abled, and LGBTQ+. We also have other networks which focus on issues outside of the characteristics protected by the Equality Act 2010, including an Armed Forces Network and a Carers Network.

4.2. Staff Survey 2022

Following the results of the 2022 NHS Staff Survey, a number of Trust-wide actions have been identified to help us respond to what staff told us could be improved.

Just over nine per cent of staff told us they had experienced discrimination from a manager or colleague in the last 12 months. We will make it a focus to support departments where there is higher incidence of reporting and identify good practice in other areas. Equity Data Walks will take place to enable us to learn more about the experiences behind the data, and professional conversation support forums will take place for international staff.

Fifty-three per cent of staff said they would recommend the Trust as a place to work. This year we will be launching our new leadership behaviours framework, refreshing our induction programme for new starters, and launching a new campaign highlighting some of the things that staff enjoy most about working for us.

Just 22.7% staff said they felt there were enough staff at the organisation to be able to do their jobs properly. This is despite a 20% increase in whole time equivalent staff since before the pandemic. We have invested £2.2m in safer staffing, and will continue to do so to increase our patient to staff ratio on wards. We are also investing significantly in robotics, theatres, stroke and diagnostics.

In addition to our Trust-wide plan, divisions have been asked to put together local plans to address the issues raised by staff.

4.3. Pulse Staff Survey results

Along with the national NHS staff survey, shorter surveys of how staff are feeling take place quarterly. More staff than ever before say they feel able to make improvements in their area of work, reflecting the growing confidence of teams to adopt the principles of our Improving Together way of working.

The latest Pulse Staff Survey results show 57 per cent of staff now feel able to make improvements happen in their area, a significant increase from the same period last year

when 50 per cent responded positively to the question “Do you feel able to make improvements happen in your area of work?”

The survey is shared with all staff every three months, providing important feedback on what staff are thinking and feeling throughout the year.

4.4. Staff Excellence Awards

Tickets have now sold out for our Staff Excellence Awards which will take place on Friday 9 June, at the Steam Museum in Swindon.

The evening will include a three-course dinner, raffle, music, performers and the prestigious awards which recognise the work of the incredible staff and teams who were nominated this year.

4.5. Star of the Month

Lucy Stark, Dietetic Assistant Practitioner, won our most recent STAR of the Month Award. Lucy was recognised for always putting her patients first, often going above and beyond to call with updates or to arrange collection of emergency supplies. She is a much-valued member of the team, and is passionate about research and innovation – making real change to improve the service she provides to her patients and their families.

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Paul Lewis		24th May 2023
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	R	A	There has been four months of improvement in the Mean Length of Stay (MLOS) for some of our patients although this remains below the national standard. Flow in ED has remained challenging which has contributed to ambulance handover delays. Patients have not been delayed within the Urgent Treatment Centre which demonstrates a good flow through the service.	Monitor Actions	June 2023
Integrated Performance Report – Elective Access - RTT	R	A	The number of patients waiting over 65 weeks has increased in the month by 59 patients to 443, however this is ahead of the submitted trajectory. There has been good progress with the longest waits (over 65 weeks) and this is ahead of the national expectation for March 2024.	Monitor Actions	June 2023

Integrated Performance Report – Elective Access – DM01	R	A	Overall, the service is continuing to show steady progress (in line with recovery trajectory) being made which the committee felt is a sustainable improvement and there has been good progress in terms of activity, especially given the challenges and impacts of industrial action.	Monitor Actions	June 2023
Integrated Performance Report – Cancer	R	A	Committee members received the quarterly report and update on cancer performance which highlighted progress is slower than planned. Although there is a similar position reflected across the whole of England (where GWH are performing better than the overall England performance level) there continue to be hot spots within Colorectal, Urology, Dermatology and Plastics. The Committee asked for a more detailed action plan (covering 'what by when') to be included in the next quarterly report to provide a greater level of assurance. **The Risk Assurance Level was changed from Amber to Red.**	Monitor Actions	June 2023
Integrated Performance Report – Non-Criteria to Reside (NCTR)	A	G	The Committee acknowledged the significant progress made with NCTR and were keen to show their appreciation for this achievement. The further 21% reduction since March has delivered a saving of 652 bed days. In recognition of this, **the Assurance Level for Actions was changed from Amber to Green.**	Monitor Actions	June 2023
Outpatients Performance Update (6 Monthly)	A	G	Committee members received the 6 monthly report which included details about Referral Assessment Service; Patient Initiated Follow ups; advice and Guidance and the learning taken from the 'outpatient imperfect week' approach which took place between the 17th and 23rd April. This included a detailed summary which provided a high level of assurance about the actions which are now being planned and implemented.	Monitor Actions	June 2023
Emergency Preparedness Resilience & Response Assurance Report (EPRR)	R	A	The Committee were fully supportive of the approach taken by the EPRR Steering group to change our internal risk ratings from Amber to Red for the core standards for 'Shelter & Evacuation' and 'Lockdown Plans' as there has been no progress since the last assurance report and they are dependent on work from Health & Safety and the external contractor SAFE who oversee our security. This generated a detailed debate and it was agreed to take a cautious approach with our risk appetite on this. Even though our externally assessed position remains positive, we agreed to a Risk Assurance Level of Red until we are confident that we are not breaching any core standards.	Monitor Actions	June 2023

Cancer Services Quarterly Assurance Report	R	A	See services above.	Monitor Actions	June 2023
Community Update inc. Virtual Ward (6 Monthly)			The Community Update was received and noted and it was agreed that agreeing a Risk Assurance Level rating would be inappropriate because of the broad range of services covered. The main area of discussion and concern is with Virtual Ward – now called NHS@Home – where our position is not where we need to be and the Committee requested a more detailed action plan as part of the next update to provide greater clarity and assurance about what, when and how performance will improve to meet national expectation.	Monitor Actions	June 2023

Issues Referred to another Committee –	
Topic:	**Committee:**

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Claudia Paoloni	Dr Claudia Paoloni		18 May 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

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Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR Pillar Metric: Total Harms	A	A	There has been a reduction in total harms from 302 to 249 but this is mostly attributed to a reduction in Covid infections. We have revised our 2022/23 breakthrough objectives around pressure harms. There had been six serious incidents declared this month, which are being investigated appropriately and as yet no themes have been identified.		
IPR Pillar Metric: Friends & Family Test	A	A	We have an increase in positive responses to just below 90% which is above our internal target of 86%.		
IPR Breakthrough Objective: Pressure Harms	A	A	There has been a slight reduction in the number of hospital acquired pressure harms but an increase in community acquired pressure harms. Further investigation demonstrates a complexity of causation and impacting		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			patients on complex care packages and end of life care pathways most significantly. The new objective metric will be: • a reduction in the number of pressure harms by 20% across the organisation in 2023/24 compared to 2022/23 • zero category 4 pressure ulcers across the organisation • zero category 3 pressure ulcers in the acute setting Some wards have been showing marked improvement with no pressure ulcers and continued teaching and training and focused driver meetings will mitigate instances in other areas. The Committee was assured that progress was being made.		
IPR Alerting Watch Metric: Hospital Acquired Infections	R	A	We have noticed a marked improvement in the trajectory of MSSA infections, especially cardiac services following work and improvement around cannula care. *E.Coli* has shown improvement following focused catheter care work. It has been the lowest rate of *E.Coli* bloodstreams infections in April for some time. Towards the end of the last financial year there was an increased incidence of *C.diff* which was identified predominantly to a surgical ward, and there was a period of increased scrutiny in that area and a peer review from an external organisation which resulted in some feedback regarding environment factors and infection control behaviours. We still await the formal report but following focused measures taken, there have been now no new cases for 28 days.		
IPR Non Alerting Watch Metric: Falls	A	A	There has been a slight reduction in falls noted this month.		
Maternity Performance Report	A	G	The Committee was assured by the metrics in this report. There has been a review within the community teams of antenatal community care. We await an update around this. We have maintained full compliance for CNST.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			The Ockenden report was presented to the public Trust Board showing significant improvement. A new action group has been created to focus on the remaining 6 red and 43 amber outstanding actions. Whilst in April, there were 2 intrauterine deaths over a 2-day period and 1 one fetal death following a rupture uterus. Immediate and in depth action has been taken to investigate. Two are under local investigation and one has been referred to HSIB. It is worth noting, there has been a national increase in stillbirths which is being investigated by the NHSE/I with potential association to the recent pandemic. Progress has been made regarding expansion of the perinatal support service team and a succession planning strategy to support staff with career progression.		
Board Assurance Framework – BAF 1 Q4 2022/23	Not Rated	Not Rated	We received the latest Board Assurance Framework for strategic risk 1 (quality) and the Committee approved the risk score and strategic objective and priorities aligned to outstanding patient care and quality improvement and that they are being managed effectively. However, there is some review in the wording of the proposed strategic risk for 2023.		
Trust Mortality & Morbidity Q4 2022-23 & Annual Report	R	A	The Committee received the annual report and quarterly report which demonstrated that our HSMR and SHMI are within the expected range compared to hospital trusts nationally; but this data has to be viewed with caution as it is impacted by clinical coding delays. Whilst local actions have been put in place to address the clinical coding delays with extra resource and external organisational assistance, our data is still incomplete. There have also been 5 new CUSUM alerts. These again are impacted by coding delays and need to be considered with that in mind. The pandemic and industrial actions have also impacted the number of mortality and morbidity meetings that have been held. The Committee are assured that the Chief Medical Officer is aware and addressing the areas of development and actions that need to be		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			implemented to address both timely M&M reviews and clinical coding; but is worth noting that our crude mortality data shows a similar trend compared to our peers nationally. The position of Mortality & Morbidity Lead has been advertised and responded to.		
Clinical Audit & Effectiveness Q4 2022-23 Report	A	G	Good progress has been made, finishing the end of the year with all audits on track except for the National Asthma Audit, with 99.5% national audit rate, 100% delivered data on time on those. A business case has been put together around funding to support undertaking the National Asthma Audit. Local governance around audit reports are progressing well. Focused areas are Paediatrics and Urology. No exceptions to report.		
Research & Innovation Annual Report	A	A	This is a new report to the Quality & Safety Committee. It demonstrated that the Covid-19 pandemic negatively impacted the ability for GWH to participate and develop its research and innovation work. This was a national problem with a substantial reduction in the ability to recruit effectively on time. There has been a slight increase in the number of patients recruited to commercial research and there are numerous opportunities as we enter 2023/23 to grow our research capabilities. A £20,000 award from the Brighter Futures charity will be invested in supporting aspiring researchers to develop their research projects. The Trust Research Group will now routinely report into the Patient Quality Sub-Committee, its purpose to create ambition for research as core business and to improve the quality of care for patients. Space has been identified within GWH which it is hoped to be refurbished through a bid for capital funding to NIHR.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Annual Quality Account 2022/23	Not Rated	Not Rated	Update on the progress of the Annual Quality Account was given and the final document will be brought to the June meeting for approval.		
Safe Staffing 6-month review for Nursing & Midwifery	A	G	The Committee was assured that we are providing safe staffing levels through a robust system of daily, weekly and monthly meetings and there is a robust control around agency spend. Reviewing the establishment reports, following last year's investment we are now meeting the national standard of 1:8 for HCSW and the focus for this year will be to bring registered nursing in line with the same ratio and to ensure a 30% Band 6/7 presence in ED. Where theatres have historically had staffing vacancies, focused work to address this means we can anticipate a zero vacancy rate this year. Further areas requiring extra focus are within Children's Services and the Critical Care Unit. We have been utilising international recruits and developing our career support throughout. Maternity staffing meets the required midwife to birth ratios and all recruitment campaigns have been successful.		
Update of CQC preparedness	Not Rated	Not Rated	The Committee received a report outlining a new structure in which the CQC will undertake future inspections and our response in preparation for this. The CQC are going through a significant transformation programme again, moving to new multi-disciplinary teams requiring a new Operations Manager and a team of inspectors who we will work openly and transparently with. There is now a single assessment work with 5 domains and a portal for receiving evidence continuously from our organisation and not just around inspections. This may result in more frequent inspections triggered by data submitted but they are more likely to be focused in those areas. This may lead to more fluidity in the data ratings. There has been significant work on improving compliance with Level 3 Children's Safeguarding and a plan is in place for all non-compliant staff to attend training, although this may be impacted by any ongoing industrial action.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			In April, we ran a series of mock inspections lead by corporate and divisional teams which showed noticeable improvement in several clinical areas but also identified some common areas of focus and improvement.		

Issues Referred to another Committee	
Topic	Committee

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Finance, Infrastructure and Digital Committee – 22 May 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**22 May 2023**
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			
FINANCE					
Board Assurance Framework	G	G	We reviewed the Board Assurance Report for strategic risks 6 (Use of Resources – Funding) and 7 (Use of Resources – IT & Estates), and the Committee was satisfied that the report appropriately noted the strategic risks and provided all relevant assurances. Overall, we were satisfied with the process and reporting of the strategic risks in the BAF.	Monitor quarterly through FIDC.	FIDC Meetings 2023
Finance Risks & Way Forward Programme Risks	A	G	The Committee noted that Finance's risk management process and reporting, including that of the Way Forward Program, is adequate and effective. Whilst we were reassured that the scoring of risks aligned with the Risk Management Policy, we requested management to reflect on the scoring of risk 872 as the delivery of the savings plan of £16.8m is the most significant risk of the financial position in FY23/24. We noted several risks relating to the Way Forward Program that were adequately mitigated and removed from the risk register, resulting in the Committee's assurance evaluation as A/G.	Monitor Risk 872 monthly through FIDC.	FIDC Meetings 2023
Month 1 Finance position	R	A	The Trust started FY23/24 with a £2.2m deficit, or £0.9m, adverse to budget. The negative variance driver is non-pay, precisely £1.3m of unidentified efficiency savings. The Trust must deliver £16.8m of cash-releasing savings, of which a gap of £6m unspecified savings exists.	Monitor monthly through FIDC	FIDC Meetings 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Risks & Mitigations within the Financial Plan	R	A	The Committee received a verbal update on critical risks identified in the delivery of the financial plan and mitigation actions, including enhanced monitoring and grip and control activities.	Monitor through FIDC	FIDC Meetings 2023
Improvement and Efficiency Plan Update	R	A	The Trust commenced the year with a £16.67m cash-releasing efficiency plan, including £2.98m carried forward from FY22/23. In collaboration with Support Services, divisions have been working to identify locally sourced and cross-cutting efficiency schemes to address the target. The critical risk is that the Trust does not yet have a fully identified plan, and 41% of the £10.6m identified schemes were flagged as Amber or Red. Teams are requested to convert identified schemes to green-rated projects. Enhanced Governance arrangements are implemented to focus on this crucial risk.	Monitor monthly through FIDC	FIDC Meetings 2023
Overseas Visitors	A	G	The report provided the Committee with an overview of the activity for the year, including income received and outstanding debt. We were assured that management is taking critical steps to recover debt, albeit there has been an increase in debt in the last year.	Monitor through FIDC	FIDC meetings 2023
PFI Financial Update	A	G	An update paper was presented to the Committee on PFI charges for 2023/24, including crucial issues relating to inflation and financial model changes, lifecycle, and benchmarking. The Committee acknowledged that appropriate actions were taken regarding the PFI financial position however was mindful of the operational risk associated with the PFI contract, hence rating the report A/G.	Monitor through FIDC	FIDC meetings 2023
Winter Plans	A	G	The Committee received a paper outlining management's vision to change the winter planning process to a seasonal plan which will include bank holidays and winter planning and to develop a strategic, organised, and coordinated approach. We were assured on the ongoing plans to maintain and improve performance in line with standing financial instructions.	Monitor through FIDC	FIDC meetings 2023
IT & DIGITAL					
Digital Strategy Plan	-	-	We received the Trust's Digital Plan for approval. The plan outlines the Trust's digital vision, underlying principles, and vital strategic programmes over seven years. The Committee approved the Digital Plan and recommended that comments highlighted by members are reflected as this plan is aligned with the overall Trust's strategy.	Monitor through FIDC	FIDC meetings 2023
EPR Programme Update	R	A	The Committee is assured that EPR Programme Risks are identified, managed, and actioned within the Shared EPR Programme Governance structure. Procurement activities are on track, with Oracle Health (previously Cerner) noted as the preferred bidder. Overall, the inherent programme risk is Red due to the lack of benefits to support the FBC, including estimated increased costs, resourcing challenges, and the risk that the FBC needs to be approved.	Monitor through FIDC	FIDC meetings 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Update – Actions to Update Key IT Operational Issues	A	A	An update report outlining salient operational concerns raised with the IT team was presented. Many of the issues raised through the helpdesk form part of more comprehensive programs, and governance-related matters are addressed via the Digital Steering Group monthly and via FIDC quarterly.	Monitor through FIDC	FIDC meetings 2023
ESTATES & FACILITIES					
ERIC – Benchmarking data comparison Update	A	A	Following the approval of the Estates Return Information Collection (ERIC) submission in July 2022, FIDC requested further insight to illustrate where GWH sits across peers in the region. Several key metrics compare GWH with other acutes across the Southwest region, including benchmarking to Model Hospital Data. The Committee was satisfied with the actions taken by management, and we look forward to receiving the ERIC submission for approval in July.	Review the Eric Submission for approval in July.	FIDC meetings 2023

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

Board Committee Assurance Report

People & Culture Committee – April 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	**Paul Lewis**		**28th April 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?			

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Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR – Staff Survey (Recommend Place To Work)	A	A	The Trust aims to improve our Staff Survey response rates year on year and increase the number of staff "recommending the Trust as a place to work''. In 2022 it was agreed that the main focus for staff survey action plans would be on the breakthrough objective of "I am able to make improvements happen in my area of work" (see below) and our approach for 2023 is currently under review so this will be discussed again at the next meeting to agree the way forward. The question (recommend place to work) has also been added to the Pulse Surveys to gain further insight and understanding.	Review progress at the next meeting.	June 2023
IPR – Staff Survey (I am able to make improvements happen in my area of work)	G	A	The Trust Breakthrough objective is to achieve a 5% improvement in this question in the Staff Survey. The latest survey showed positive progress and the Divisions presented their action plans at this meeting for further improvement. It was agreed that the Divisions will return on rotation going forward to provide regular updates and assurance about the implementation of their actions plans so the Committee can monitor progress. The first regular review will be at the next meeting with Surgery, Women & Children.	Review progress at the next meeting.	June 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR – Voluntary Staff Turnover Rate	A	A	The Trust target is 11%. Voluntary Turnover Rates have been on a positive, downward trend since July 2022, but are still above target. The 6 Monthly Retention Progress Report was also presented to the Committee at this meeting to provide further insight and assurance about our position, plans and priorities. (please see below)	Review progress at the next meeting.	June 2023
IPR – EDI Disparity Ratio			The EDI Measure is currently under review and so an Assurance Rating was not discussed at this meeting	Review progress at the next meeting.	June 2023
6 Monthly Retention Report	A	A	The 6 Monthly Retention Progress Report was well received and the key priorities for improvement will be the Health & Wellbeing conversation training refresh and evaluation, the launch of a Trust-wide Retention Working Group with operational and clinical stakeholders, the publication of GWH Leadership Behaviours by the OD team and the publication & launch of the Trust Resourcing Strategy.	Review progress in 6 months.	October 2023

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

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

Purpose

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

Assurance Level

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

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

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

Report

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

Our Performance

Key highlights from the report this month are:

OPERATIONAL PILLAR METRICS

Of the 6 Operational Pillar Metrics, improvements have been seen in 5 during the month of March 2023.

Cancer 62 day - Cancer 62 day waiting times remain below standard.

RTT 65 Week Waiters – April performance shows the total number of patients waiting over 65 weeks at 458. The trust is on trajectory for the number of patients over 65 weeks YTD. There were no patients >104 weeks. 1 Patient >78 weeks (Plastics) who was the same patient reported in March.

Emergency Care, Emergency Department Mean Stay – In the month of April 2023 there has been a fourth month of improvement in the Mean Length of Stay (MLOS) for Type 1 & Type 3 patients.

Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. February saw a decrease in ED attendances. The number of attendances has returned to the levels seen in August & September 2022.

Inpatient Spells, Number of Non-Criteria to reside (NC2R) days. The number of patients who remain in an Acute Hospital bed without a Criteria to Reside (NC2R) has seen a significant decrease in April 23. The Trust remains on track to see a month-on-month reduction against the 2023/24 operational requirement of 79.

OPERATIONAL BREAKTHROUGH OBJECTIVES

Clinically Ready to Proceed (CRTP) This month we see a change to several breakthrough objectives. The breakthrough objective relates to Clinically Ready to Proceed (CRTP). The patient group only include Type 1 (not UTC). There has been an improvement based on retrospective data for patients from arrival to being CRTP and those who go on to be admitted.

Alerting Watch Metrics

The 25 Alerting Watch Metrics show improvements in 15 measures across the range of RTT, DM01, Cancer, ED & Flow. Has been no change in one of the alerting measures. There has been deterioration in 9 measures.

Our Care

Strategic Pillar Targets

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

There has been a significant decrease in the total number of harms from 302 to 249 in month. This downward trajectory can be directly attributed to a significant drop in the number of hospital acquired infections (Klebsiella and Clostridium difficile). The number of Family and Friends positive responses have increased in April and is now at 90% and well above the internal target.

Breakthrough Objectives

Pressure harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. For 2022-23 the following new targets have been agreed

- Reduction in the number of pressure harms by 20% across the organisation in 2023/24 compared to 2022/23.
- Zero category 4 pressure ulcers across the organisation.
- Zero category 3 pressure ulcers in the acute setting.

April has seen an increase in community acquired pressure harms, but slight decrease in hospital acquired pressure harms of 12.5% compared to the previous month.

Senior Nurse leaders continue to provide close support, focus and challenge to ensure ongoing embedding of actions and improvements in line with Improving Together methodology.

Alerting Watch Metrics

The Trust complaint response rate has remained similar in month at 75%.

There has been a good start to the year regarding Methicillin-resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA) and Escherichia coli (E. coli), with the data showing zero, one and five respectively for April.

The rate for E. coli bloodstream infections in April was the lowest we have seen for some time. We await the national trajectory setting for 2023/24 but the Trust is currently below the 2022/23 trajectory.

Non-alerting Watch Metrics

Significant points to note relating to non- alerting watch metrics include

- The total number of falls and rate per 1000 bed days has decreased slightly in month.
- Six Serious Incidents have been declared in month, with one being identified as a Never Event. All will be investigated under the Serious Incident Framework
- There has been a considerable decrease in the number of concerns and complaints in month.
- Using last year's thresholds as a basis (since this year's have not yet been published) the Trust is over trajectory for C. diff, Klebsiella and Pseudomonas. There were additional cases of C. diff on Ampney Ward, with the period of increased incidence on that ward continuing to prompt additional scrutiny.
- FFT overall response rate has seen a significantly increased in month, now at 30.6% (25.5%)
- The emergency department has seen a slight increase in both the overall response rate and positive response rates.

Our People

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

Strategic Pillar Target from A3 goals:

To aim to be in the top 20% of trusts for staff survey results and in the lower quartile for turnover within Model Hospital.

The Trust aims to improve our Staff Survey response rates year on year and increase the number of staff "recommending Trust as a place to work"

Breakthrough Objectives

The Trust Breakthrough objective is to achieve a 5% improvement in the question "*I am able to make improvements happen in my area of work*" in the Staff Survey.

Divisions presented their staff survey results 2022 to People & Culture Committee on the 28th April, outlining the areas achieving and requiring improvement further to the annual analysis, including Q3F performance year to date and the Divisional priorities plan for year-end 2023.

Positive Quarter 1 Pulse survey results are available at the time of reporting, indicating improvement to 57% from 52% for the Q3F impact.

Alerting Watch Metrics
Sickness absence continues to alert above KPI, however has increased insignificantly in month from 4.5% to 4.59% of which 1.92% is long term absence and 2.67% is short term absence. Further to gap analysis identification, the Trust 'Improving Attendance' working group has developed and communicated a series of absence management training workshops, targeting support to Band / 7 team leaders.
The Trust remains in the 2nd lowest quartile and through the working group aims to reduce this to the lower quartile.

Non-Alerting Watch Metrics
Staff survey responses and my immediate manager take a positive interest in my wellbeing are above the national average.
Leavers in the last 12 months has remained stable and below target.

HR Scorecard

Vacancy rate has increased by 2% due to investments of 112wte post which include Theatre investment, Safer Staffing and additional admin and clerical post in Divisional and Corporate roles. Contracted staff has only reduced by 4wte.

The in-month time to hire has decreased slightly in April to 52.9 days for substantive staff. Bank Recruitment pipeline has undergone a 'data cleanse' and is being recorded monthly with focus on streamlining the pipeline to ensure timely process and reduced overall TTH from June 2023.
The Trust has an ambitous £3m agency reduction plan for 23/24 and month 1 target has been achieved. Month 1 was £402K below target and 3.4% against total workforce spend, GWH target is 4.5% and national target is 3.7%.

Use of Resources

To be completed when data available.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review /	TMC & PPPC				

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

Workforce

The IPR report identifies issues where minoritized protected groups experience is less favourable than other groups. This is specifically around the staff survey question 16B and experience of discrimination from colleague or manager. The staff survey provides this data by ethnicity, and it is likely that other groups both protected and non-protected have reported discrimination. The report identifies a number of countermeasures and actions are underway and planned to reduce discrimination for all staff and specifically those in protected groups. The report references workforce indicators such as sickness, retention and vacancy rate which are likely to be affected by the disparities between the working life experience of majority group staff and minoritized staff. National analysis of the NHS staff survey studies, results indicate that exclusionary behaviour correlates with staff intention to leave the NHS and other research indicates the link between discrimination and physiological, psychological, and behavioural consequences. By addressing the disparity we will be:

- Helping to reduce the Trust Disparity Ratio (probability white staff being promoted from lower to upper bands compared to BAME staff) over time
- Helping to reduce the impact of conscious and unconscious bias, thereby increasing opportunities for marginalised candidates to join the Trust – this will positively impact the shortlisting-to-appointment ratio (WRES and WDES)
- Supporting retention and engagement by improving perceptions and experience of equal opportunities
- Improve our employee value proposition
- Sharing good practice so that they can continue to apply good practice beyond the boundaries of the programme

https://www.hee.nhs.uk/sites/default/files/documents/Pan-LondonDiscrimination%26RacismPrimaryCareSurvey_Final.pdf
https://lcp.uk.com/our-viewpoint/2023/04/burnt-out-or-something-more-examining-the-real-root-cause-of-nhs-workforce-challenges/
Workforce race inequalities and inlcusion in NHS providers (kingsfund.org.uk)

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	**Felicity Taylor-Drewe**
Date	25th May 2023

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

May 2023

March 2023 & April 2023 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

Section & purpose	Slides
Key indicators This is the NHS Oversight Framework indicators for 2022/23 and provides a summary of our performance against national standards	3-4
Executive summary This provides an overview of the targets, performance and countermeasures (remedial actions) for each of our pillar metrics	5-11
Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: patients developing pressure ulcers; over 12 hour waits in the Emergency Department; patients awaiting discharge (NCTR) and staff survey results	12-15
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	16-19
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	20-22
Use of Resources This includes key indicators and watch metrics for finance as assured by the Finance, Digital & Infrastructure Committee, and is also subject to a separate board report	23
Our People This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee	24-28
Explaining the IPR This section explains how the work of front line teams to drive improvement connects from 'ward to board' through our operational management system, and the business rules we apply to support that.	29-41

Key Indicators

NHS
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Measure Name	Mean/Thres.	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Total patients waiting more than 52 weeks	1773 (Avg)	852	1028	1215	1568	1926	2164	2281	2188	1817	1,833	2,163	2,240
Total patients waiting more than 78weeks	41 (Avg)	50	52	34	35	44	40	45	68	62	56	2	1
Total patients waiting more than 104 weeks	0 (Nat)	0	1	0	0	0	0	1	0	0	0	0	0
Total elective activity undertaken compared with 2019/20 baseline	104% (Nat)	95.5%	97.1%	87.3%	100.3%	94.2%	86.1%	97.1%	82.1%	100.1%	99.3%	108.1%	65.3%
Total diagnostic activity undertaken compared with 2019/20 baseline	120% (Nat)	94.6%	92.4%	87.9%	94.5%	88.8%	79.7%	97.0%	98.4%	100.2%	97.0%	138.6%	Reported one month behind
Total Cancer patients waiting over 62 days	211 (Avg)	168	209	268	326	284	258	223	178	150	110	145	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	78.9%	79.3%	75.8%	73.7%	67.1%	64.7%	73.2%	78.2%	70.8%	77.8%	76.5%	Reported one month behind
Total patients treated for cancer compared with the same point in 2019/20 (first and	100% (Nat)	150.5%	85.5%	58.6%	107.1%	106.2%	85.4%	123.3%	141.0%	118.8%	115.6%	80.4%	Reported one month behind
Outpatient follow-up activity levels compared with 2019/20 baseline	75% (Nat)	89.5%	85.9%	73.9%	94.5%	88.8%	79.7%	97.0%	86.9%	89.3%	91.8%	86.6%	57.3%
Proportion of ambulance arrivals delayed over 30 minutes	44.1% (Avg)	38.9%	26.9%	31.0%	42.9%	46.3%	49.9%	47.2%	60.1%	44.6%	47.8%	47.2%	46.1%
Proportion of Patients spending more that 12 Hours in an Emergency Department (Type 1 & 3)	2% (Nat)	7.4%	6.4%	6.5%	8.2%	8.4%	8.5%	8.2%	9.4%	8.9%	8.0%	8.0%	7.1%
Proportion of patients discharged from hospital to their usual place of residence	94.1% (Avg)	94.1%	93.8%	94.2%	93.9%	94.3%	94.2%	94.0%	93.8%	94.2%	94.6%	94.3%	94.4%
GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	24.4% (Avg)	24.8%	25.4%	24.5%	24.0%	26.1%	26.7%	25.6%	24.6%	22.6%	22.7%	24.2%	21.9%
National Patient Safety Alerts not completed by deadline	0 (Int)	0	0	0	1	0	0	0	0	0	0	0	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (Per 100,000	0 (Nat)	0	0	0	0	0	6	0	0	6	6.4	Waiting for data	Reported one month behind
Clostridium difficile infection rate (Per 100,000 bed days)	19.7 (Avg)	11.7	12.9	11.7	17.3	41.7	17.3	41.3	5.7	5.7	31.9	Waiting for data	Reported one month behind
E. coli bloodstream infection rate (Per 100,000 bed days)	51.6 (Avg)	29.3	60.5	52.7	75.0	35.8	11.5	35.4	51.4	68.6	95.8	Waiting for data	Reported one month behind

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Proportion of staff in senior leadership roles who are from BME background	12% (Nat)	4.5%	4.5%	4.7%	5.9%	6.0%	6.5%	6.8%	6.8%	6.8%	6.6%	6.6%	Reported one month behind
Proportion of staff in senior leadership roles who are women	62% (Nat)	69.1%	68.9%	69.1%	67.0%	66.3%	67.3%	67.5%	67.5%	68.2%	68.4%	67.5%	Reported one month behind
Average hours lost to ambulance handover delays per day	50 (Avg)	48	34	30	51	61	66	60	49	67	53	47	32
Adult general and acute bed occupancy	95.9% (Avg)	96.5%	95.8%	95.3%	97.9%	95.9%	96.5%	95.9%	95.7%	96.0%	95.8%	95.5%	94.1%
Summary Hospital-level Mortality Indicator	1.00	0.86	0.88	0.90	0.93	0.95	0.98	1.00	1.02	1.04	1.06	1.08	Waiting for data
Financial efficiency - variance from efficiency plan (£'000)	+/-	-424	-209	-289	-268	-247	190	-378	-338	-400	-238	281	-377
Financial stability - variance from break-even (£'000)	+/-	-2006	-888	-2068	-1848	-1938	-363	-1672	-1502	-1579	-1469	-1482	-2157
Financial stability - variance from PLAN (£'000)	+/-	-335	-517	-326	-268	-408	1154	389	164	106	214	-18	-893

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	6.7
Staff survey engagement theme score	6.9	6.9	6.9	7	7	6.7	6.7
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%	56.4%

Executive Summary

NHS
Great Western Hospitals
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Total Harms

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

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

Pressure ulcers/harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough Objective.

The other harms are all presented as watch metrics later in the report.

Patient Experience (FFT)

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

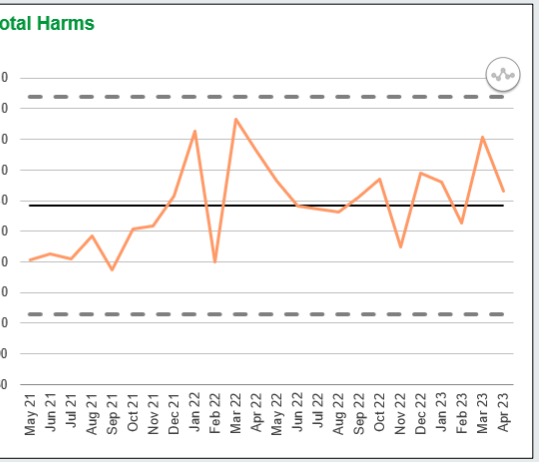
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

We have set ourselves a target of 86% for the combined positive response rate, this is based on the mean from 2021-22 plus 2%.

Total Harms

To achieve and sustain zero avoidable harm.

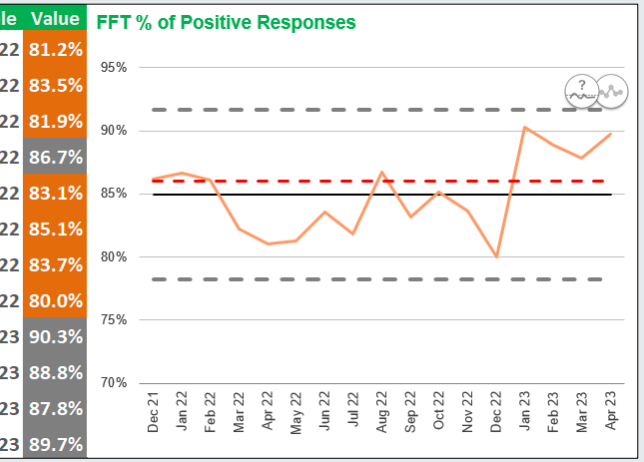
Timescale	Value
May 22	259
Jun 22	235
Jul 22	232
Aug 22	229
Sep 22	243
Oct 22	261
Nov 22	195
Dec 22	267
Jan 23	258
Feb 23	218
Mar 23	302
Apr 23	249



Patient Experience (Friends & Family Test)

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

Timescale	Value
May 22	81.2%
Jun 22	83.5%
Jul 22	81.9%
Aug 22	86.7%
Sep 22	83.1%
Oct 22	85.1%
Nov 22	83.7%
Dec 22	80.0%
Jan 23	90.3%
Feb 23	88.8%
Mar 23	87.8%
Apr 23	89.7%



Counter Measures

The number of harms has decreased in month, with number of falls and hospital-acquired infections contributing to this, pressure harms have increased in month.

The number of hospital-acquired COVID cases has also dropped, although a direct comparison with 2022/23 is not possible due to changes in testing protocols implemented nationally in April (almost all asymptomatic testing has ceased)

Focus for addressing hospital-acquired pressure harm, with dedicated training on mucosal membrane harms related to urinary catheter care training.

For April, the number of Family and Friends positive responses rate has risen and is just below the 90% rate and well above the internal target of 86%.

- New Deputy Head of PALs role will focus on supporting divisions with understanding themes from Family and Friends reports and identifying areas for learning and improvement.
- New ward information boards/posters developed to ensure public are clear on how to raise a concern.
- Proposal developed to include patient information leaflets via trust webpage in line with CQC requirements.
- New process implemented to ensure all Out-patient departments complaints are escalated appropriately within divisions following rise in number of concerns related to waiting times. Report also being produced for Elective care sub-committee.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Trust Access Standards - Referral to Treatment (RTT) & Cancer Standards
It is poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

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

Cancer 62 Day
In March, there were 31.5 breaches in total, with 23.5 of these attributed to the Urology, Skin and Colorectal pathway. Skin and Colorectal have increased demand resulting in capacity challenges. We continue to see greater than normal breaches in Urology. Over half the breaches can be attributed to our capacity for TRUS Biopsies. & LATP along with patients needing time to consider which choice of treatment they would prefer.

RTT: Number of patients waiting over 65 weeks

The number of patients waiting over 65 weeks increased in month by 59 patients, to 443. This was driven by increases in General Surgery (+29), Pain Management (+14) and ENT (+7). However, despite the increase, this is ahead of the submitted trajectory.

Internally, a stretch trajectory has been set for all patients who would be waiting over 65 weeks at the end of March 2024 (the '65 week cohort') to be treated or discharged by the end of December 2023. This is ahead of the national expectation of March 2024. To support this, a weekly speciality level trajectory is in place for the required reduction in this cohort each week to meet the end of December internal target. This will support early identification of any specialities not on track to achieve in order that remedial action can be planned well ahead of the end of the year, and is currently on track.

1x 78 week breach was reported in April 2023 in Plastics Surgery, a decrease of 1 in month. Treatment is booked for 24th May.

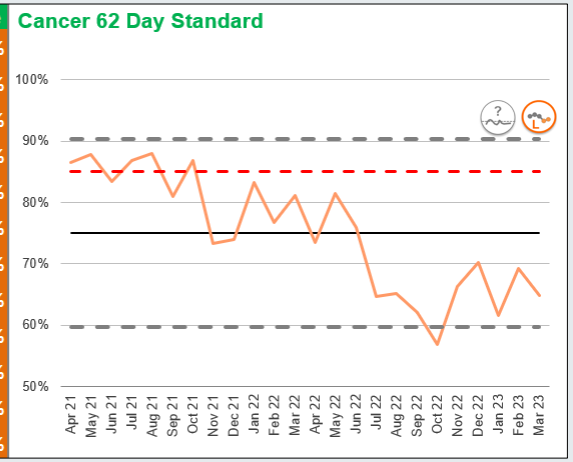
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

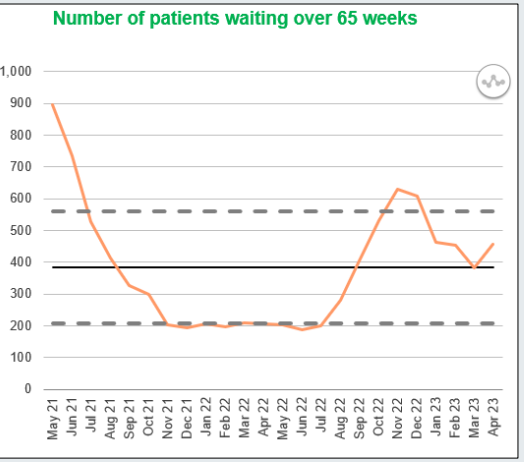
Timescale	Value
Apr 22	73.5%
May 22	81.5%
Jun 22	76.0%
Jul 22	64.7%
Aug 22	65.1%
Sep 22	62.0%
Oct 22	56.9%
Nov 22	66.4%
Dec 22	70.2%
Jan 23	61.6%
Feb 23	69.3%
Mar 23	64.8%



RTT: Number of patients waiting over 65 weeks

To eliminate over 65-week waiters by March 2024 supporting reduction in average waiting times.

Timescale	Value
May 22	203
Jun 22	187
Jul 22	201
Aug 22	280
Sep 22	404
Oct 22	531
Nov 22	631
Dec 22	610
Jan 23	463
Feb 23	455
Mar 23	384
Apr 23	458



Counter Measures

Risk: Capacity in Dermatology & Plastics is insufficient to see and treat patients.
Mitigation:
Plastics - Seeking further Mutual aid from OUH. Plastic Consultants have agreed to see additional patients on a pay per patient basis. The challenge is that this is ad-hoc and we do not always have MOP & Theatre space available when the Consutants are free.
Dermatology – A Locum Consultant is due back from long term leave in June, which will create greater capacity. We are using CSP for BCC patients that will reduce the number of patients being referred to the Plastics team.

Risk: Urology Pathway are often complex requiring multiple diagnostics, with multiple treatment options needing to be discussed at Tertiary centres before treatments can be planned. Patients requiring additional treatment following an incomplete TURBT procedure will breach due to recovery and planning time.
Mitigation: Pathway improvement manager is working with service to implement the best practice timed pathway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team are undertaking LATP biopsy training with a view to reducing the demand on TRUS biopsies, this will start to have an impact from Q2..

Risk: Colorectal 2ww triage & Appointment post MDT.
Mitigation Service has direct oversight of the registrar rotas with Consultant input to allow triage to happen. Registrar clinics in place to aid outpatient capacity for first appointment and MDT slots are allocated to clinics

Risk: Insufficient capacity to recover 65 week + breach position by March 2024
Mitigation:
- Patient level details/plans updated on weekly basis in line with recovery trajectory.
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Additional clinical capacity being provided across services for patients at risk of breaching the 65 week standard.

Risk: Impact on Elective capacity due to the proposed industrial action across multiple staff groups.
Mitigation:
- All elective activity on proposed strike days reviewed. Maximum clinical sessions running where staffing allows.
- Patient impact assessed and alternative sessions to be provided. Long waiting and cancer patients prioritised.

Pillar Metrics

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime in April ’23 was 440 minutes against the national standard of 240 minutes, continued improvement for four months. This has been despite increased LOS (rise in 21+ days LOS bed occupancy). Flow in ED remained challenging, contributing to ambulance handover delays, although total time lost (<1 hour) was again improved coupled with 50% better performance against BSW peer RUH.

Emergency Care – Urgent Treatment Centre - Mean Stay

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

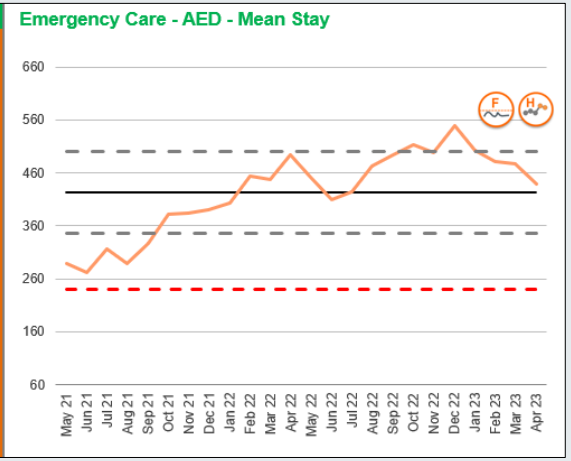
The total meantime wait for a patient in April 2023 was 146 minutes against the national standard of 240 minutes, and an improvement on March, demonstrating good flow through the service.

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.

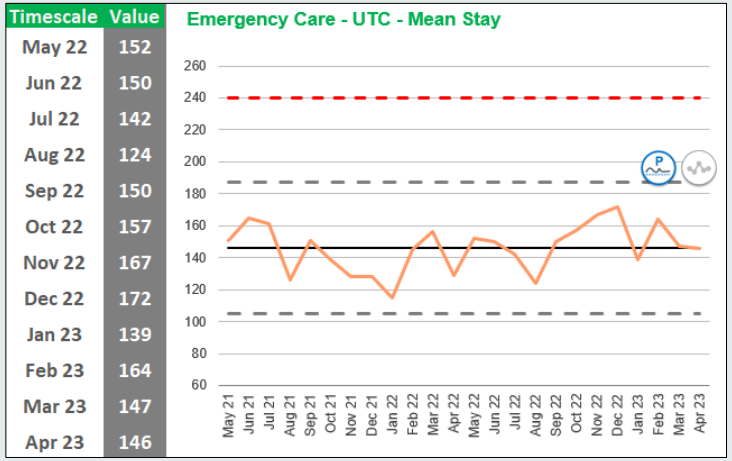
Timescale	Value
May 22	450
Jun 22	409
Jul 22	425
Aug 22	473
Sep 22	494
Oct 22	514
Nov 22	499
Dec 22	550
Jan 23	503
Feb 23	482
Mar 23	477
Apr 23	440



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
May 22	152
Jun 22	150
Jul 22	142
Aug 22	124
Sep 22	150
Oct 22	157
Nov 22	167
Dec 22	172
Jan 23	139
Feb 23	164
Mar 23	147
Apr 23	146



Counter Measures

- Weekend ED Paeds Consultant to be maintained with vacancy monies; improve quality of care and waiting times for children, whilst also supporting main ED staffing
- Pit-stop nursing maintained (challenging as now within 'normal' staffing numbers); provides clinical oversight of queue, starts assessments early & potential for simple treatments
- Support services input for admission avoidance & improved discharge - Co-ordination Centre, Flow and Community Teams
- Increased capacity for Triage of self-presenting patients (Triage cubicles x2), assessment of 'ED Majors' patients (6 bays) and provision for early ambulance assessment (Pitstop x1)

- Metric routinely meeting standard
- Roster change trial implemented for staff to increase staffing model mapped to key times of patient arrival – extension continues.
- Review of ACP staffing model and operational hours commencing to provide more reactive service.
- Single front door pathways between the Emergency Department and the Urgent Treatment Center are now in place alongside front door building work and new patient entrances.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Department & Urgent Treatment Centre - Emergency Attendances

Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). April has seen a slight decrease in attendances to both ED & UTC. Improved support services likely help with reduced numbers, external factors such as strike action may also have contributed to the decrease in month.

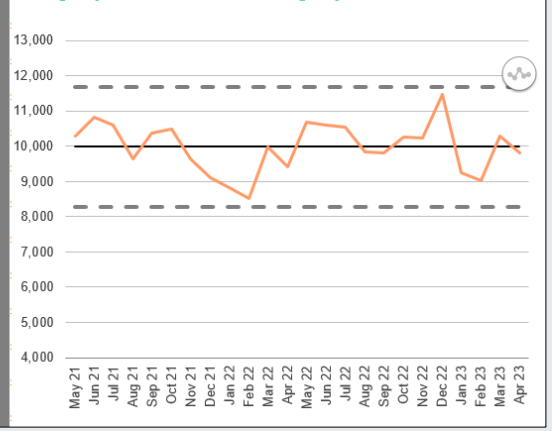
Attendances are up by over 700 compared to the same time in 2022 and up by 4,710 compared to 2021.

ED & UTC combined saw 9,802 patients in April(ED 4810, UTC 4992). There was a corresponding increase in the number of long stay patients >21 days with a levelling of NCTR bed days.

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

To ensure patients are cared for in the appropriate setting

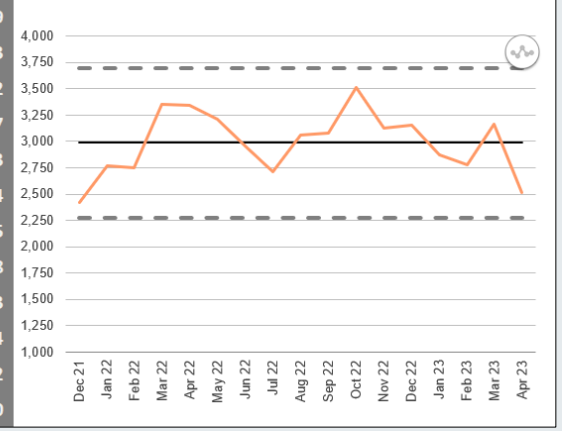
Timescale	Value
May 22	10,684
Jun 22	10,596
Jul 22	10,554
Aug 22	9,846
Sep 22	9,803
Oct 22	10,272
Nov 22	10,240
Dec 22	11,474
Jan 23	9,252
Feb 23	9,018
Mar 23	10,302
Apr 23	9,801



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
May 22	3,209
Jun 22	2,953
Jul 22	2,712
Aug 22	3,057
Sep 22	3,083
Oct 22	3,514
Nov 22	3,125
Dec 22	3,158
Jan 23	2,873
Feb 23	2,774
Mar 23	3,162
Apr 23	2,510



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

Predicted improvement in NCTR from last month as all IPC concerns resolved. 21% deduction from March saving 652 beds days.

Counter Measures

- Co-ordination Centre and Navigation Hub processing referrals from community teams and ambulance service.
- SWAST reviewing processes and conveyance requirements. HALO support in ED.
- Assessment and pathway changes to support direct access from ED & UTC to most appropriate admission areas.

Continued battle rhythm around discharges during Easter and Bank Holiday weekends.
Focus on reducing extra beds and reduction in medical outliers as part of flow preparation leading into challenging weekends.
Patients that require reablement were discharged with Home First and did not have to wait in hospital for availability.
37% of patients discharged with Home First went on to require no further support in the community and thus freeing up more capacity to deliver more on the day PW 1 discharges.

Felicity Taylor-Drewe
Chief Operating Officer

Executive Summary

NHS
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NHS Foundation Trust

Voluntary Staff Turnover (rate)

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

The NHS People Plan highlights the support and action needed to create an organisational culture where everyone feels they belong.

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.

The Trust has seen an improvement in the trend since July 2022. The voluntary turnover rate for March 2023 is now in line with the figure for 12 months ago, driven by ongoing initiatives in the Trust Retention Plan 2022-25.

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 Quarterly Pulse Survey.

Willingness to recommend the organisation as a place to work is a strong indicative measure of overall staff engagement. There is also an evidenced link between this measure and the quality of patient care that is delivered.

The staff engagement score is seen as a key priority for the Trust. The Kings Fund reports there is now overwhelming evidence to show that engaged staff really do deliver better health care and higher levels of staff engagement (measured through the staff survey) have lower levels of patient mortality, make better use of resources and deliver better financial performance.

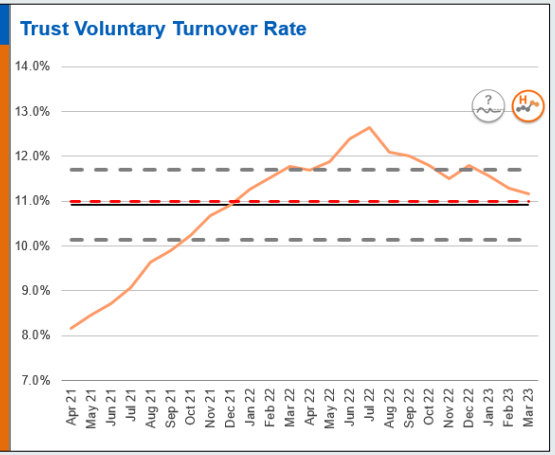
Q1 Pulse Survey results (58.4%) show a 5.1% improvement from the annual staff survey figure result.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

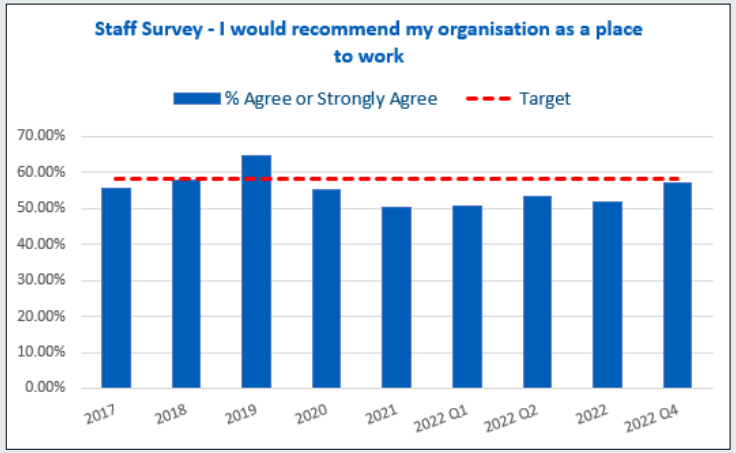
To achieve and maintain a maximum voluntary turnover rate of 11%.

Timescale	Value
Apr 22	11.7%
May 22	11.9%
Jun 22	12.4%
Jul 22	12.6%
Aug 22	12.1%
Sep 22	12.0%
Oct 22	11.8%
Nov 22	11.5%
Dec 22	11.8%
Jan 23	11.6%
Feb 23	11.3%
Mar 23	11.2%



Staff % recommend the organisation as a place to work

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



Counter Measures

- Further to collective learning from the South-West regional retention conference, the Trust will sustain focus on embedding the 'stay and thrive' initiative for international colleagues, increasing the impact of the 'stay conversation', and expanding flexible working options for staff.
- 'Stay Conversations' are being relaunched in May 2023, offering 45-minute appointments for staff with subject matter experts to help staff rethink the decision to leave, including refreshed guidance for managers. The success of this initiative is underpinned by manager engagement through regular 1 to 1 / appraisal conversations to identify areas of frustration or development.
- The Trust-wide Retention Workshop is scheduled to take place in May 2023 with representation from operational leads.
- Divisional leads presented staff survey results to P&C Committee on Friday 28th April outlining movement in the annual results along with updated countermeasures. Momentum will be driven through the monthly staff survey working group and by divisional teams maintaining commitment through application of the Improving Together methodology. Progress will be evaluated through quarterly presentation at P&C.
- Further to feedback from the national staff survey network group, the Trust will be rolling out a "What is my favourite thing about working here campaign"
- The comprehensive Health & Wellbeing plan continues with a range of support including the launch of the new 'VR Headset' trial for relaxation taking place within the ICU team and being extended to ED, SWICC, and the Orbital.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

EDI - Staff Survey Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?

The trust's ED&I Strategy 2020-24 recognises that a 'represented and supported workforce' is an essential component of creating an inclusive workplace where staff have a sense of belonging, have equity of opportunities and feel they can contribute to the success of the organisation. Our ambitious ED&I Strategy and Action Plan responds to this – it supports our ambition to reduce these inequalities by leveraging the benefits that come from Equality, Diversity and Inclusion.

Discrimination has been a longstanding issue in the NHS, the GWH NHS Staff Survey results highlights highlight that 19.8% of Ethnic and Minoritized staff have experience discrimination compared to 6.3% of white staff. Staff can also experience discrimination based on other grounds including disability, sex, sexual orientation, age, religion and other protected and non-protected characteristics

This is an important measure for the Trust as it is the right thing to do for our staff; furthermore, we have a legal duty and there is a strong correlation between workforce inclusion and wellbeing and patient outcomes. Discrimination also affects our workforce retention, studies have indicated that a lack of inclusion is the most influential factor in contributing to staff intention to leave.

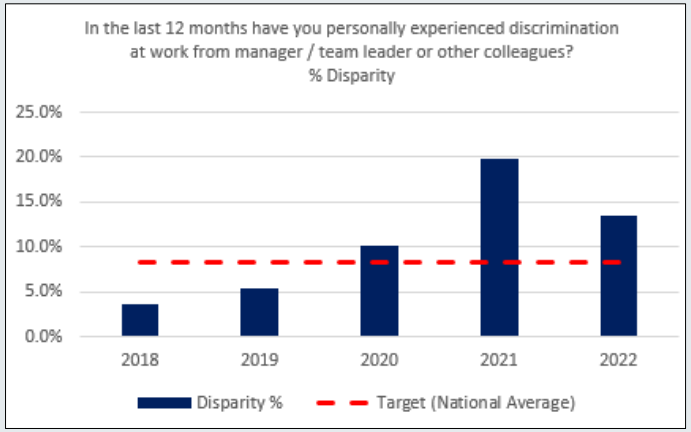
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing discrimination will take us one step further towards our aims of building an inclusive workplace.

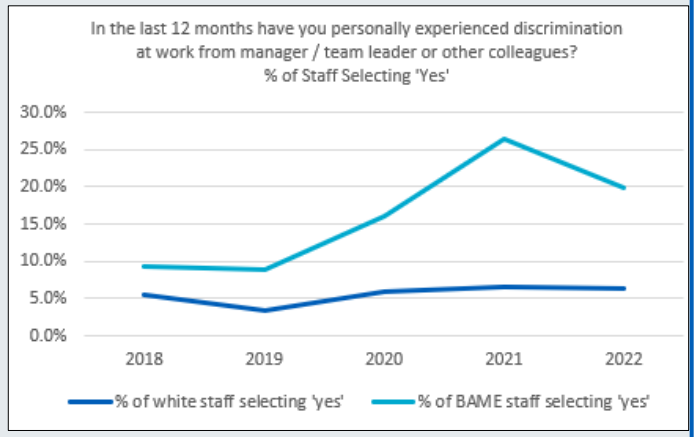
The Trust ambition is to reduce the disparity between white staff and BAME staff from 13.5% to 8.3% in line with the national average and be below the national average for all staff.

Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

% Disparity – Staff Survey Q16b - In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?.





Counter Measures

- The Trust has planned a number of Equity Data Walks during May 23. An Equity Data Walk will enable staff across the organisation to engage with the disaggregated data, share their experiences and inform the initiatives that will drive change.
- Trust Management Committee were invited to be part of the development of the A3 and at a recent away day shared ideas for countermeasures and actions to support positive action against discrimination.
- Divisional and Departmental data has been shared with Divisional Tri's and will be presented at Divisional Board in May to discuss supporting local driver metrics in areas of low performance.
- Unconscious bias training and HR panel membership has been included for senior management recruitment.
- Inclusion Recruitment Champions paper has been shared with Trust Management Committee and Equality Inclusion and Diversity Gorup for feedback and planned implementation scheduled for June/July.
- Overhauling recruitment process is part of the new recruitment plan 24 –27 which is scheduled for June and will include standardised values-based interview question and mandatory EDI question.
- Professional conversation support forum for international staff has been launched with dates between May and October

Executive Summary

Great Western Hospitals NHS Foundation Trust

GWH Control Total / I & E (Improvement & Efficiency)

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.

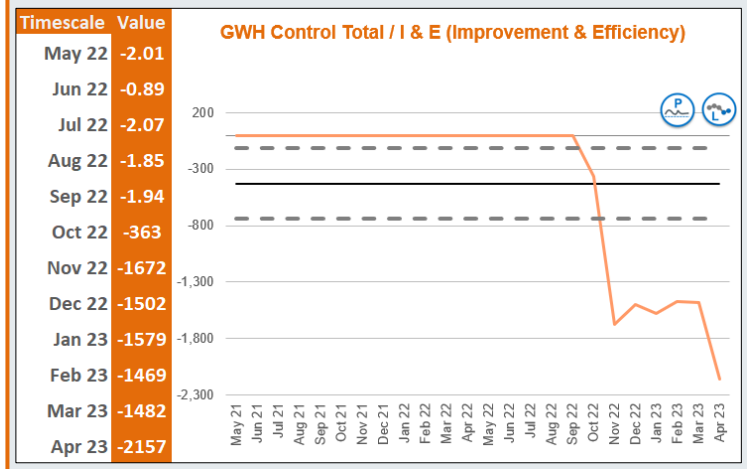
Over the coming years we will be focusing on the delivery of our Green Plan and ICS Green Plan which will be formally reported on annually and refreshed every 3 years.

Simon Wade
Chief Financial Officer

GWH Control Total / I & E (Improvement & Efficiency)

To achieve and sustain a break even financial position.

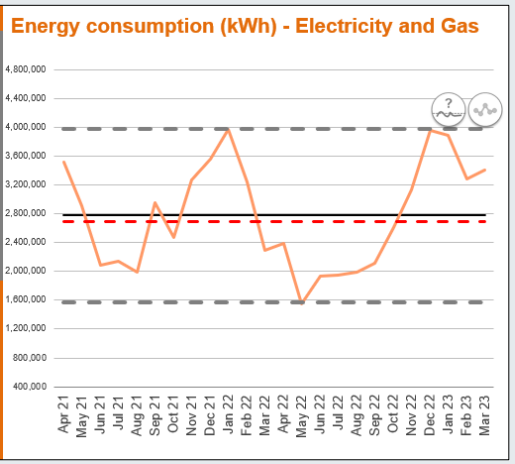
Timescale	Value
May 22	-2.01
Jun 22	-0.89
Jul 22	-2.07
Aug 22	-1.85
Sep 22	-1.94
Oct 22	-363
Nov 22	-1672
Dec 22	-1502
Jan 23	-1579
Feb 23	-1469
Mar 23	-1482
Apr 23	-2157



Energy consumption (kWh) – Electricity & Gas

To achieve an organisational carbon neutral footprint.

Timescale	Value
Apr 22	2,388,534
May 22	1,543,874
Jun 22	1,940,413
Jul 22	1,953,493
Aug 22	1,983,344
Sep 22	2,115,111
Oct 22	2,613,274
Nov 22	3,136,178
Dec 22	3,961,047
Jan 23	3,883,373
Feb 23	3,284,505
Mar 23	3,405,549



Counter Measures

- At M1 the Trust is reporting a £2.2m deficit, and a £0.9m adverse variance to budget, driven by unidentified efficiency savings (currently in non-pay). Income was £0.2m higher than plan in M1, driven by patient care (commissioning income). Commissioning income has been devolved to the clinical divisions in M1 to ensure income (and specifically variable elective recovery income) is matched against the costs incurred to deliver it. Pay was broadly in line with budget for M1, however pay budgets in the clinical divisions, in particular Unscheduled Care, are adverse to budget due to the high use of temporary staffing to cover vacancies, mental health patients and industrial action. Agency spend in M1 was £0.9m and is above the ceiling of 2.7% of total pay budget
- Countermeasures have been put in place through the efficiency programme, including:
  - Focus on actions to reduce run rate
  - Cross-divisional schemes such as Better Buying and Medicines Optimisation
  - Enhanced workforce controls
  - Agency control measures

•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.

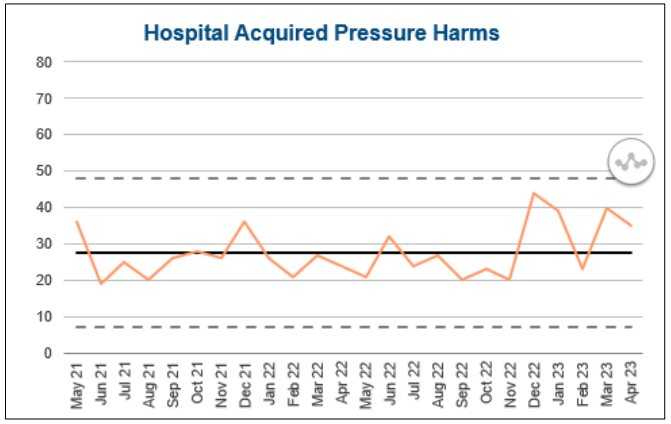
2023/24 Breakthrough Objectives

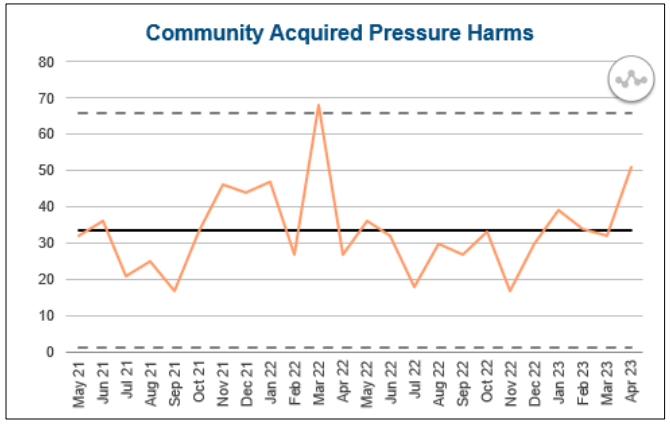
Reduction of Pressure Harms

Great Western Hospitals NHS Foundation Trust

Total Pressure Harms

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
57	64	42	57	47	56	37	74	78	57	72	86





Common cause – no significant change

Understanding the Data

The number in the charts above represents the number of pressure harms 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 harms.

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

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

We are driving this measure because...

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

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

Performance

Overall, there has been a rise in the number of pressure harms reported, there have been no category 3 or 4 harms reported.

There were 35 hospital-acquired pressure harms during April.

- This is a decrease of 12.5% compared to last month (30).
- Further training on the hybrid mattresses has been arranged, as well as an evaluation of the roll-out to identify issues before they become embedded.
- A structured evaluation process in nursing documentation (known as SSKIN) is being trialed on 3 wards. This is widely used in other Trusts with good results.
- Divisional quality meetings focusing on pressure ulcer prevention are now occurring monthly, with attendance from Tissue Viability to ensure a collaborative approach.

In the community setting there were 51 pressure harms acquired during April.

- This is an increase and at its highest point since March 2022.
- Education delivered in March might have increased staff awareness, and therefore contributed slightly to the increase.
- Partnership working with therapy to review risk assessment and skin inspection at therapy visits to ensure 'every contact counts'.
- Caseload seems to be a contributory factor and to address this, the work with caseload reviews continues, with the implementation of a cap in the number of visits per staff starting with the North Locality (top contributor).
- Community Nursing Safer Staffing Tool exercise completed beginning of May. This will enable a better understanding of the staffing requirements (workforce modelling) following analysis of the data

The continuing high caseloads for Tissue Viability and Community Nursing in addition to the difficulties in recruiting to establishment in the Community Nursing services can impact the ability to provide high quality pressure ulcer prevention management, specialist review and assessment and as a result pressure ulcer rates may increase.
The Acute Team were unable to recruit to their Band 7 vacancy. The vacancy is being covered by Band 5 and Band 2 bank, so there is a gap in expertise.

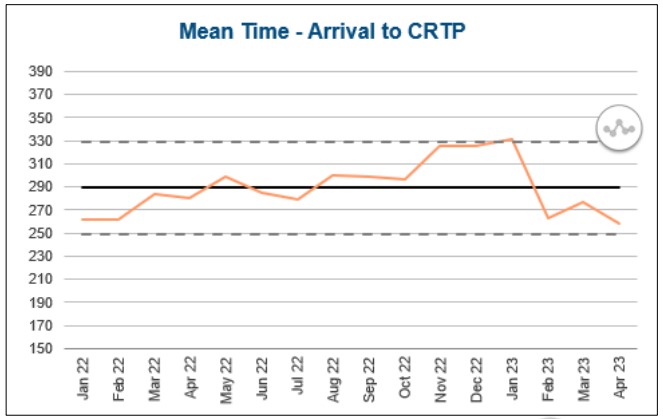
2023/24 Breakthrough Objectives

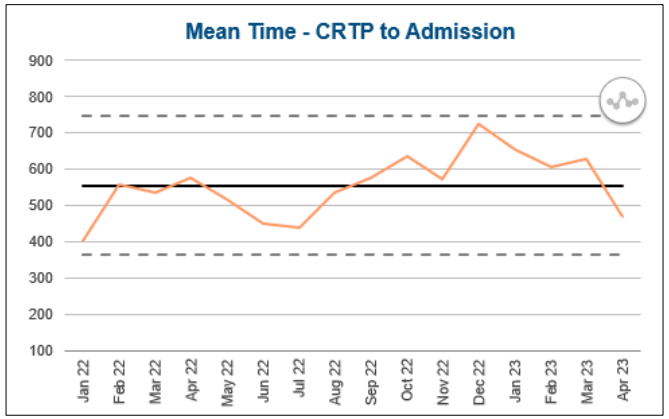
Emergency Attendances - Clinically Ready to Proceed (Admitted)

NHS Great Western Hospitals NHS Foundation Trust

Mean time in ED (Minutes)

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Pre CRTP	286	279	300	299	297	326	326	332	263	277	259	258
Post CRTP	517	450	438	536	575	636	572	725	654	608	629	467





Common cause – no significant change

Understanding the Data

The patient cohort for the data is only type 1 patients who are admitted into the Trust (excludes type 3 patients or any patients discharged). More work to be done to include discharged patients with CRTP.

The graphs show the mean time waiting from arrival to clinically ready to proceed and post clinically ready to proceed.

On average 65-70% (mean time) of the patients in ED who are 'clinically ready to proceed' are awaiting beds within the hospital. This figure has remained consistent for many months.

April data highlights that on average patients are waiting less time in for a bed in ED compared to previous month.

We are driving this measure because...

The metric Clinically Ready to Proceed is part of the UEC Bundle that is part of the proposed Clinically Led Review of NHS Access Standards.

CRTP is a milestone that separates out the overall Pillar Metric of 'mean time in ED'. Pre CRTP shows the time taken for patients to be triaged, seen and diagnosed. Post CRTP would indicate the time taken for patients to wait for a bed to be available.

Performance

- Mean time in ED from arrival to clinically ready to proceed (CRTP) reduced in month to 258 in April (from 259) showing patients facing less wait to be triaged, seen and diagnosed.
- Mean time in ED from CRTP to admission also reduced in month from 629 to 467 in April indicating patients spending less time in ED awaiting admission.
- With the exception of March 2023, mean time in ED (CRTP to Admission) has continued to decrease since January 2023.

Risks

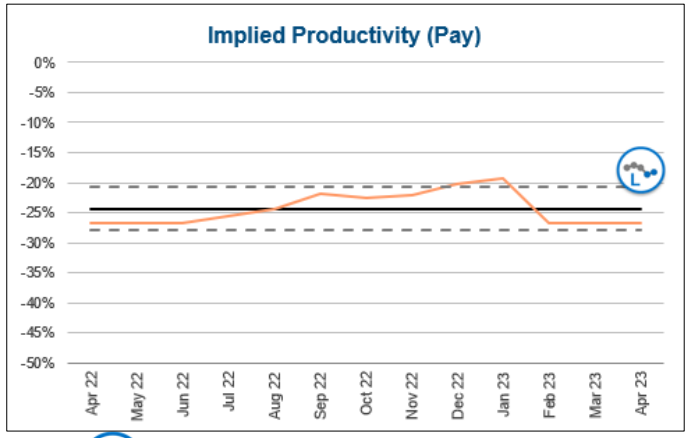
Physical and pathway reconfiguration required for WFP programme will see slightly reduced bed numbers across the ED footprint.

2023/24 Breakthrough Objectives

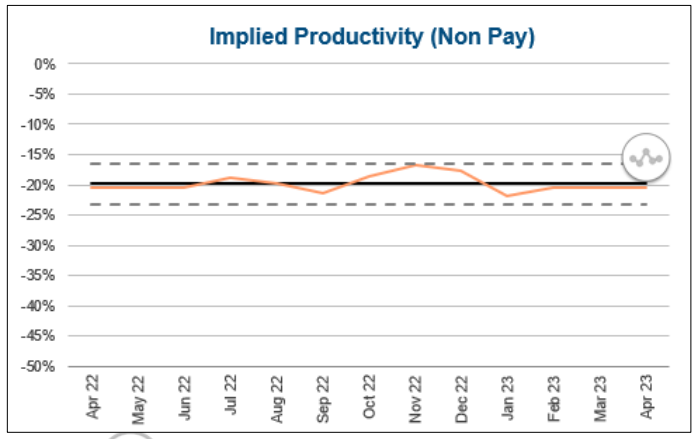
Great Western Hospitals NHS Foundation Trust

Productivity

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Pay	-27%	-27%	-25%	-24%	-22%	-23%	-22%	-20%	-19%	-15%	-14%	-19%
Non Pay	-20%	-20%	-19%	-20%	-21%	-19%	-17%	-18%	-22%	-22%	-24%	-15%



Specil cause of improving nature due to higher values



Common cause – no significant change

Understanding the Data

The graphs show a metric made up of weighted activity growth and cost (adjusted for inflation) as a change from 2019/20 levels to give implied productivity. This is currently negative meaning we are less productive than 2019/20 levels - so either weighted activity being delivered is lower or the costs of delivering that activity are higher than in 2019/20. This is shown for pay and non-pay.

We are driving this measure because…

Productivity is reduced when compared to 2019/20 levels leading to longer delays in treatment (activity) and increase in costs. Elective recovery rates are lower than planned and the 2023/24 plan has been set with a target level of activity and productivity stretch

Risks

There have been several risks outlined as part of the A3 for productivity (refer to fishbone diagram)
These included risks such as Divisions lacking capacity to engage in data/findings and sickness and work pressures impacting workforce to deliver on increased productivity stretch in the Trust activity plans.

Performance & Countermeasure

Implied Productivity is stable overall at total **–17%** for Month1 (this is a 1% improvement from the 18% at the end of 2022/23).

As part of this pay productivity has dropped for April to reflect lower pay costs in 2019/20 at the start of that year. As this measure continues to be against 2019/20 cost change this is just a profiling impact as pay costs then increased as 2019/20 progressed. The pay productivity will return to –14% at the end of the 2023/24 plan if planned activity levels this year are also delivered.

The Non-Pay productivity movement is due to 2022/23 costs increasing following receipt of risk share funding in Month 7 to offset our planned deficit last year of c£19m. This has then increased the rolling quarterly profile but has reset itself for April in line with the new financial year.

These factors could be smoothed out but we are replicating the NHSE implied productivity model so we are currently providing narrative to explain.

The CIVICA project has been implemented to allow the full range of outputs to be realised – full project deliverables are by August 2023 with Aurum opportunities being presented before that. Data quality tolerance needs to be reviewed for areas such as coding and information breakdown

The outputs will allow more key divisional stratified data to also be presented and for key questions to be asked around activity, workforce and quality.

The aim is to produce productivity data, trends and information that can enable intelligence and action plans across divisions in areas such as variation in treatment cost. A Division engagement plan will be put in place when outcomes are fully available, embedding into improvement groups etc. as standing items for review and updates.

2023/24 Breakthrough Objectives

NHS
Great Western Hospitals
NHS Foundation Trust

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

2018	2019	2020	2021	2022 Q1	2022 Q2	2022 Q4	2022	2024 Q1
49.40%	56.70%	54.50%	49.30%	50.31%	51.10%	52.72%	51.90%	57.20%

Domain	Our Leadership
Metric Focus	Driver
Threshold	
Value	Percentage
Improvement Direction	Higher is Better

Understanding the Data

The data shows the percentage of staff positively responding that they feel able to make improvements happen in their area of work.

These results are predominantly a measure of engagement and service improvement. It is important to know if staff feel able to provide the care and service they aspire to give.

We are driving this measure because...

This staff survey feedback is an important measure of staff's engagement with both the organisation and the rollout of Improving Together.

The result of this survey could help how staff feel about making improvements happen in their workplace.

Performance

- The Quarter 1 Pulse Survey results show an impressive increase in staff feeling able to make improvements happen in their area of work, moving to 57% in Q1 from 52% in Q4.
- Alongside the continued rollout of Improving Together by the internal coach house team, a Corporate Support Plan has been developed by the Transformation & Improvement hub to drive an increase in performance for question 3F. Progress against the support plan is being monitored through the monthly staff survey working group.
- Monthly progress via the Staff Survey Working Group to share learning and update on progress.
- Divisional Lead will be presenting 6 monthly at People and Culture Committee on progress and plans
- This month results to be shared via Trust Communication with a focus on what has been achieved and what is planned

Risks

- Whilst continuing the 'inch wide, mile deep' focus on question 3F, there are broader opportunities for improvement which are outlined in the divisional Staff Survey presentations which require focus.

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

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23	Trend
RTT	No. of >=18 weeks waiters		H	15539	15363	16051	16723	
	No. of >=52 weeks waiters		H	1817	1833	2159	2240	
DM01	No. of patients on DM01 waitlist		H	10329	11111	11441	One month behind	
	DM01 performance %	99% (Nat)	H	48.5%	54.2%	56.1%	One month behind	
	DM01 6 week wait breaches		H	5316	5090	5018	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	L	61.6%	69.3%	64.8%	One month behind	
	% Cancer 31 day performance	96% (Nat)	L	83.5%	87.7%	85.5%	One month behind	

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

Performance & Counter Measure

April DM01 performance has not been validated but looks to be showing a slight decrease from the 56.1% performance in March. The number of patients on the waiting list has increased slightly to 12,077 and the number of 6 week breach has increase to 6192. 2 Pads in Radiology continue to be fully utilised with one now supporting the CDC and activity numbers continue to remain high although Easter did see a reduction in month. The teams continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Progress in activity in Ultrasound and DEXA has also decreased the waits although Ultrasound still remains the largest issue. ERF Funding is being used for mobile MRI for 6 months, and CT 3 days a week for 6 months will be funded by the TVCA. Activity is also ongoing to bring mobile Endoscopy on site with a target date of June, supporting the CDC project.

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathway with 78% of the breaches being accounted for by this service. WLI activity is being used to help manage demand. A locum returns in June, providing additional capacity. Additional capacity in Plastics is being sourced through private partner (CSP in Wootton Bassett) and through any available mutual aid from OUH.

74.6% of the 62-day breaches were with the Skin, Urology & Colorectal Pathway.

Counter Measure - Work is underway with the TVCA to implement the Best Practice Timed Pathways across all 5 (Lower GI, Urology, Gynae, Upper GI & Head & Neck) of these Pathways.

We continue to work with the OUH Plastics team for extra capacity, however, there is a clear deficit in capacity within Plastics that will impact the cancer pathway is unable to be mitigated further without significant staffing and / or investment. This is subject to a strategic service review.

The weekly Elective Access Meetings continues to 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.

Additional capacity for LATP biopsy within the Prostate pathway will come on-line from June 23 when further consultants complete their training. This will help alleviate some of the capacity issues within Radiology for TRUS biopsy (LATP is gold standard procedure for biopsy, and should be used in place of TRUS)

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	L	75.8%	74.3%	77.2%	75.7%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	L	55.2%	55.2%	58.4%	54.9%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	H	18.1%	16.0%	16.0%	14.5%	
	A&E Arrival to Departure Percentage over 12 Hours (Type 1 & Type 3)	2% (Nat)	H	8.9%	8.0%	8.0%	7.1%	
	A&E Arrival to Departure over 12 Hours (Admitted Patients)	2% (Nat)	H	35.3%	33.6%	33.6%	27.7%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		2086.60	1491.63	1443.00	951.30	
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1111	1121	1097	1051	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	68.0%	70.2%	71.5%	66.9%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	729	763	725	590	

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

Performance & Counter Measure

ED performance has demonstrated continued improvement across most areas compared to previous months, despite increased attendances. This is an indicator of the implemented measures across the 'Front Door' and support across the organisation.

Relevant teams are looking at improvement measures across the 'Front Door' , pre-hospital and post discharge with measures to improve flow & discharge rates.

Work continues with various data streams internal and external, identifying which is not accurate and looking to improve and streamline all reporting

- Triage times have dropped slightly to 68% from 70%.
- Total % over 12 hours has reduced from 16% to the same at 14.5%.
- % over 12 hours admitted, significantly improved; 32.% compared to 40% last month.
- % over 12 hours non admitted has reduced from 5.67 % to 5.49%
- % of patients admitted increased from 30 to 33%

Counter measures remain in place within the Breakthrough objective slides.

Risks

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23	Trend
ED	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	44.6%	47.8%	47.2%	37.6%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		488	487	475	304	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	29.9%	30.5%	30.9%	19.4%	
Flow	Admitted - Average Length of Stay in Department (mins)	SPC	H	915	885	887	725	
	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	293	296	302	299	
	Community Average Length of Stay (Days)	SPC	H	23	19	18	19	
	Number of Stranded Patients (over 14 days)	SPC	H	134	134	136	136	
	Number of Super Stranded Patients (over 21 days)	SPC	H	79	77	81	80	
	GWH Acute Adult Bed Occupancy (%)	SPC	H	96.0%	95.8%	95.5%	94.1%	

Performance & Counter Measure

ED performance has demonstrated continued improvement across most areas compared to previous months, despite increased attendances. This is an indicator of the implemented measures across the 'Front Door' and support across the organisation.

Relevant teams are looking at improvement measures across the 'Front Door' , pre-hospital and post discharge with measures to improve flow & discharge rates.

Work continues with various data streams internal and external, identifying which is not accurate and looking to improve and streamline all reporting

- Triage times have dropped slightly to 68% from 70%.
- Total % over 12 hours has reduced from 16% to the same at 14.5%.
- % over 12 hours admitted, significantly improved; 32.% compared to 40% last month.
- % over 12 hours non admitted has reduced from 5.67 % to 5.49%
- % of patients admitted increased from 30 to 33%

Counter measures remain in place within the Breakthrough objective slides.

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

Risks

Pressure to maintain flow and bed availability with increasing demand, thereby with a potential to impact elective activity. This is mitigated by our ongoing Seasonal Planning and work with system partners.

Physical and pathway reconfiguration required for WFP programme works creating IFD project. Working with key stakeholders to mitigate potential Impact on capacity

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23
RTT	No. of >=78 weeks waiters	SPC	L	62	56	2	1
Cancer	% Cancer 2 week wait	93% (Nat)		92.0%	88.5%	89.2%	One month behind
	No. of referrals received	SPC		1834	1723	1979	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		95.9%	93.1%	95.6%	95.7%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)		0.0%	0.0%	0.1%	0.0%
	Total ED Type 1 Attendances (all arrival methods)			5312	5903	5104	4809
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	75.1%	71.0%	69.6%	66.8%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		54.4%	49.9%	47.3%	50.2%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		53.0%	39.4%	44.6%	44.2%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)		175	197	178	180
	Total Number of Ambulance Handovers	SPC	L	1634	1597	1535	1571
Flow	Elective Patients Average Length of Stay (Days)	SPC		3.9	3.6	3.0	3.0
	Non-Elective Patients Average Length of Stay (Days)			5.6	5.3	5.0	5.0
	GWH Discharges by Noon (%)	SPC		17.7%	17.9%	16.2%	18.0%

Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

Cancer waiting times remain below standard with an increase in demand and a lack of capacity. The Colorectal Pathway is having the greatest impact on all of the 2ww standard with 38.2% of all of the breaches.

In March, 71% (292) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, Gynae & Breast)

Risks

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

Our Care

Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		75%	77%	75%	75%	
IP&C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		2	3	3	0	
IP&C	Escherichia coli (E. coli) infections (cumulative)	5.75 (Nat)		81	96	108	5	
	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative	1.8 (Int)		29	31	32	1	
	Maternity Response Rate	19% (Int)		16%	18%	18%	17%	
	Maternity Positive Responses	94% (Int)		92%	90%	91%	93%	

Common cause - no significant change.

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

Performance & Counter Measure

The complaint response rate has remained similar in month.

The rate for MSSA has been declining for several months, perhaps linked to the scrutiny given to these cases to identify the learning. If this rate can be maintained (or improved on further) we will see a significant decrease in overall numbers in 2023/24.

The rate for *E. coli* bloodstream infections in April was the lowest we have seen for some time. We await the national trajectory setting for 2023/24 but the Trust is currently below the 2022/23 trajectory. The CAUTI Group has switched to monthly meetings to maintain progress and continues to be well supported by the divisions.

Maternity response rates and positive responses continue to remain slightly lower than target, although the positive response rate is now at 93%, the highest point over the last four months.

Risks

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23
Harm	No. of serious incidents reported in month	SPC		3	3	6	6
	Falls rate per 1000 bed days	SPC		6.6	5.3	6.4	6.0
	No. of Falls in month	SPC		134	96	127	116
	No. falls with moderate harm or above	SPC		2	2	7	2
	Medication incidents with moderate harm	SPC		2	2	2	2
Concerns and Complaints	No. of concerns received	SPC		151	173	190	109
	No. of complaints received	SPC		37	50	46	29
	Number of reopened complaints	SPC		2	4	3	2
IP&C	Clostridium difficile (C. diff) infections (cumulative)	4 (Nat)		34	39	49	6
	Pseudomonas infections (cumulative)	1.58 (Nat)		12	12	15	5
	Klebsiella infections (cumulative)	1.92 (Nat)		20	22	26	4
	Covid – no. of hospital acquired	SPC		22	36	63	17

Common cause - no significant change.

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

Performance & Counter Measure

There are a total of 19 on-going Serious Incidents (SI), with six reported in month, including one never event. The total overdue SI's is five, which is an unchanged picture from the previous month.

There is been a significant fall in the number of concerns and complaints received in month, nearly 50 percent compared to the previous months data. The number of re-opened complaints remains stable.

The numbers of falls in month has decreased slightly to 116. To support training a new aging simulation suit and vision impairment simulation glasses have been received. The Clinical Practice Educator for Falls and Enhanced Care has delivered training to 69 members of nursing and Allied Health Professional (AHP) staff. This face-to-face training in clinical areas has included topics such as multi factorial falls assessment, sensor mats usage, vision impairment, and the new falls assessment in therapy.

Using last year's thresholds as a basis (since this year's have not yet been published) the Trust is over trajectory for C. diff, Klebsiella and Pseudomonas. There were additional cases of C. diff on Ampney Ward, with the period of increased incidence on that ward continuing to prompt additional scrutiny.

There have been marked improvements in cleanliness and other elements of IPC practice and there have now been no cases for >28 days. The noticeable increase in Pseudomonas cases has coincided with increased numbers of positive water samples. IPC and Estates are working closely with Serco to understand if these are linked and to mitigate the risks with additional testing and remedial work to pipework. The reasons for the increase in Klebsiella cases are not yet known, though numbers are low, and it is possible this may be a statistical anomaly.

Risks

Our Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)		98.3%	94.4%	96.6%	96.7%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	H	114.3%	111.7%	109.8%	111.1%
FFT	Overall response rate (%)	27% (Int)		29.8%	30.2%	25.5%	30.6%
	Positive response (%)	87% (Int)		90%	89%	88%	90%
	ED & UTC Response Rate	20% (Int)	H	22%	20%	20%	22%
	ED & UTC Positive Responses	78% (Int)		84%	78%	81%	82%
	Inpatients Response Rate	25% (Int)	H	26%	31%	26%	34%
	Inpatients Positive Responses	85% (Int)		86%	88%	86%	89%
	Daycases Response Rate	25% (Int)		30%	25%	26%	26%
	Daycases Positive Responses	96% (Int)	H	96%	97%	95%	96%
	Outpatients Positive Responses	98% (Int)	H	98%	98%	96%	98%

Common cause - no significant change.

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

Performance & Counter Measures

Safe Staffing fill rates remain consistent with previous months.

There has been an increase or stability of all FFT response rates and positive response rates in month. With FFT data showing an increase in response rates for the inpatient areas, now 34%, with positive responses up at 89%.

Improvement actions implemented include:

- Bespoke complaint training for managers has been established
- Carers awareness training is now in place
- The New Carers passport is due to be released in May
- Proposal developed to include patient information leaflets via trust webpage in line with CQC requirements.

Risks

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23
Use of Resources	Capital Expenditure (£'000)	SPC		652	2270	12940	Waiting for data
	Pay (£'000)	SPC		22868	21772	46425	Waiting for data
	Non Pay (£'000)	SPC		15521	17019	14984	Waiting for data

Performance & Counter Measure

Note that capital expenditure for M1 and M2 will form part of M2 reporting.

Pay costs are c£22.5m lower than M12 22/23. There were a number of one-off items in M12 22/23. The pay award accrual totalled £11.8m and notional pension costs offset income at £11.2m. Temporary staffing spend, notably nursing, has reduced by £0.4m from M12. Reducing agency spend is a priority for the efficiency programme

Non-Pay costs have increased by £0.6m from M12 22/23 due to the release of provisions in M12 offset by an increase in depreciation costs

Risks

The Trust started the year with a £16.67m cash releasing efficiency plan, which includes a £2.98m carry over from 22/23. Divisions, in collaboration with support services such as Procurement and Pharmacy, have been working to identify both locally sourced and cross-cutting efficiency schemes to hit the target. The focus is on delivering recurrent cash releasing schemes, which currently stands at 71%. As at M1 of 23/24 a total of £10.6m of schemes are included in the programme, however the BRAG status graph shows that many are schemes are flagging as amber or red risk to delivery.

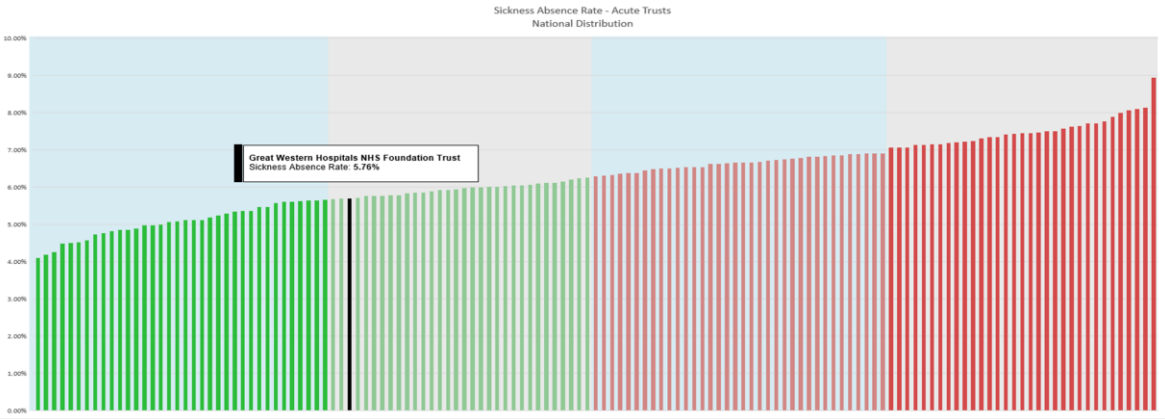
 Common cause - no significant change.

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.9%	4.5%	4.6%	One month behind	



Common cause - no significant change.	Variation indicates consistently failing the target.

Performance & Counter Measure

- Sickness increased marginally in month to 4.6%, driven by an increase in short term sickness to 2.7%. Long term sickness has reduced slightly in month however, decreasing to 1.9%.
- National benchmarking data for December 2022 (NHS Digital) shows an increase in the national sickness level, rising from 5.4% to 6.3%. Comparatively, the sickness level for the South West is 6.5%, and for GWH is 5.8% leaving us in the top 40% nationally and in the 2nd quartile. - See chart
- The Trust 'Improving Attendance' working group is currently focussing on upskilling managers on completing robust return to work meetings to better manage short term sickness absences.

Risks

- Increase sickness rate as per national trend during winter.

Our People

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-23	Feb-23	Mar-23	Apr-23	Trend
Workforce	% of leavers within 1st year of employment	31.2% (Int)		23.6%	28.6%	24.7%	One month behind	

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023 Q1
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	22.8%
	My immediate manager takes a positive interest in my health and well-being	67.4% (Nat)	68.8%	67.5%	74.8%	69.2%	64.4%	67.6%	Not in Quarterly Survey

Performance & Counter Measure

- The % of leavers within 1st year of employment has reduced in March 2023 to 24.7%. 'Work/Life Balance' continues as the top reason for leaving, and countermeasures are being explored through the Trust Retention Working Group.
- The 2022 Annual Staff Survey saw an increase in both response rates and the positive response on staff feeling their manager takes a positive interest in their health and wellbeing.
- A review of the watch metric will take place In May

Risks

A review of the watch metric will take place In May as staff survey metrics can only be measured annually.

Common cause - no significant change.

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend Vs Last Month	Trend Vs Apr-22
	Vacancy																	
W	Vacancy Rate	%	7.00%	8.03%	7.31%	6.94%	7.48%	6.70%	6.31%	6.56%	5.97%	6.23%	7.43%	6.40%	5.30%	7.52%	↑	↓
W	Vacancy Rate	WTE	-	415.32	377.16	358.52	386.57	347.09	328.65	343.04	313.11	329.52	392.94	335.02	276.66	401.58		
W	All Nursing Vacancy	%	7.00%	7.40%	6.44%	5.27%	5.62%	4.88%	5.58%	5.95%	5.27%	5.62%	6.51%	5.20%	3.65%	4.50%	↑	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	184.68	160.51	131.68	140.23	122.71	141.28	151.92	135.61	146.64	170.25	135.53	94.47	117.71		
W	All Registered Nursing Vacancy	WTE	-	109.82	112.98	119.04	130.70	121.67	113.32	102.85	87.51	91.41	92.65	77.18	43.38	84.20		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	33.55	52.23	53.91	63.29	55.96	50.49	51.28	43.73	54.94	47.18	36.73	27.43	27.90		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	74.86	47.53	12.64	9.53	1.04	27.96	49.07	48.10	55.23	77.60	58.35	51.09	33.51		
W	Medical Vacancy	%	7.00%	9.00%	8.68%	8.94%	9.57%	6.53%	3.64%	5.73%	5.80%	5.43%	5.61%	8.49%	6.86%	9.35%	↑	↑
W	Medical Vacancy	WTE	-	63.55	60.96	62.75	67.19	45.84	25.59	40.26	40.74	38.33	39.16	59.19	47.86	67.29		
W	STT/AHP Vacancy	%	7.00%	7.84%	7.11%	7.44%	8.94%	8.25%	7.57%	6.89%	6.09%	6.54%	6.97%	6.29%	7.66%	11.10%	↑	↑
W	STT/AHP Vacancy	WTE	-	64.89	58.82	61.57	74.04	68.37	62.72	57.10	50.49	54.28	57.85	51.64	63.84	94.86		
W	SMA Vacancy	%	7.00%	8.97%	8.50%	8.98%	9.21%	9.66%	8.68%	8.21%	7.55%	7.88%	10.97%	7.96%	6.37%	10.62%	↑	↑
W	SMA Vacancy	WTE	-	102.20	96.87	102.52	105.11	110.17	99.06	93.76	86.27	90.27	125.68	88.66	70.50	121.73		
W	Recruitment Time to Hire - Trust Sub	Days	46.00	61.20	67.70	67.90	62.00	61.10	74.70	63.70	74.30	72.30	91.30	50.90	54.50	52.90	↓	↓
W	Recruitment Time to Hire - Trust Bank	Days	46.00	-	-	-	-	-	-	-	-	-	-	117.90	127.80	118.00	↓	↓
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,169.51	5,162.20	5,168.30	5,167.69	5,183.80	5,204.80	5,226.19	5,248.35	5,289.43	5,289.16	5,236.02	5,224.47	5,337.41		
W	Budgeted vs Worked WTE Variance	WTE	-	58.44	89.92	91.14	138.16	191.33	121.30	71.71	184.20	87.52	51.09	109.88	237.86	31.62		
W	Actual Worked vs Budgeted %	%	-	1.13%	1.74%	1.76%	2.67%	3.69%	2.33%	1.37%	3.51%	1.65%	0.97%	2.10%	4.55%	0.59%		
W	Total Workforce Cost £	£	-	£23.15M	£22.93M	£23.22M	£21.61M	£22.66M	£26.58M	£23.35M	£23.45M	£23.54M	£22.87M	£21.77M	£46.43M	£23.86M		
W	Agency Spend as % of Total Spend	%	4.50%	6.88%	6.57%	6.36%	4.18%	6.23%	5.65%	6.53%	6.17%	5.97%	5.60%	4.98%	5.35%	3.41%	↓	↓
W	Agency Spend £	£	-	£1.51M	£1.44M	£1.42M	£0.91M	£1.37M	£1.55M	£1.53M	£1.48M	£1.41M	£1.28M	£1.23M	£1.27M	£0.81M		
W	Agency Target £	£	-	-	-	-	-	-	-	-	-	-	-	-	-	£1.16M		
W	Agency Spend vs Target £	£	-	-	-	-	-	-	-	-	-	-	-	-	-	-£0.35M		
W	Agency WTE	WTE	-	113.88	124.59	117.85	121.32	134.43	137.51	127.69	113.12	109.26	102.88	90.00	106.82	90.76		
W	Bank WTE	WTE	-	316.65	311.77	304.96	377.97	375.45	285.71	258.31	354.47	278.67	310.93	323.25	377.11	303.84		
W	Registered Nursing Bank Fill	%	45.00%	45.28%	44.86%	47.09%	44.52%	37.70%	46.59%	48.32%	53.80%	43.60%	52.86%	55.30%	54.71%	57.70%	↑	↑
W	Unregistered Nursing Bank Fill	%	70.00%	63.53%	69.76%	75.59%	72.53%	69.81%	72.94%	66.26%	70.85%	62.98%	74.32%	71.78%	77.63%	83.58%	↑	↑

Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend Vs Last Month	Trend Vs Apr-22
	Retention																	
W	All Turnover %	%	13.00%	14.89%	14.82%	15.46%	15.90%	15.00%	14.87%	14.69%	14.52%	14.90%	14.84%	14.42%	14.48%	-	↑	↓
W	Voluntary Turnover %	%	11.00%	11.89%	11.88%	12.38%	12.64%	12.07%	12.00%	11.78%	11.54%	11.84%	11.57%	11.25%	11.16%	-	↓	↓
W	Number of Leavers	Headcount	-	68	55	80	78	49	65	57	54	69	74	42	77	-		
W	Number of RN Leavers	Headcount	-	21.00	18.00	17.00	16.00	12.00	15.00	8.00	6.00	14.00	16.00	8.00	17.00	-		
W	Registered Nursing Vol Turnover	%	-	10.37%	10.48%	10.47%	10.48%	10.11%	10.02%	9.61%	8.92%	8.79%	8.58%	7.99%	7.84%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	10.00	12.00	22.00	13.00	15.00	16.00	17.00	17.00	19.00	15.00	12.00	12.00	-		
W	Unregistered Nursing Vol Turnover	%	-	14.35%	14.23%	15.39%	15.69%	15.02%	15.29%	15.72%	15.62%	16.37%	16.73%	16.57%	15.95%	-		
W	Leavers within 1st Year of Employment	%	-	25.00%	34.55%	28.75%	29.49%	24.49%	20.00%	28.07%	29.63%	21.74%	24.32%	28.57%	24.68%	-		
W	Number of starters	Headcount	-	93	89	70	56	99	103	103	84	56	107	71	77	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	6.37%	5.80%	5.63%	5.71%	5.54%	5.43%	5.42%	5.36%	5.40%	5.36%	5.29%	5.12%	-	↓	↓
D	Sickness Absence %	%	3.50%	6.08%	4.68%	5.13%	6.01%	4.73%	4.77%	5.34%	4.87%	5.79%	4.90%	4.50%	4.59%	-	↑	↓
W	Long Term Sickness %	%	2.00%	2.60%	2.60%	2.70%	2.67%	2.70%	2.52%	2.36%	2.36%	2.48%	2.51%	2.20%	1.92%	-	↓	↓
W	Short Term Sickness %	%	1.50%	3.47%	2.09%	2.43%	3.34%	2.03%	2.24%	2.99%	2.51%	3.30%	2.39%	2.31%	2.67%	-	↑	↓
W	Sickness Absence Cost £	£	-	£806.7k	£642.2k	£678.0k	£842.5k	£648.5k	£638.9k	£767.6k	£650.4k	£749.9k	£687.4k	£575.4k	£675.3k	-		
W	WTE Days Lost	WTE	-	8,559.9	6,926.0	7,280.7	8,728.5	6,887.2	6,780.7	7,952.9	7,096.4	8,768.5	7,364.2	6,109.2	6,960.2	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	87.36%	87.75%	87.87%	87.74%	86.70%	87.22%	85.79%	86.39%	86.40%	86.61%	86.79%	87.69%	89.19%	↑	↑
W	Role Essential MT %	%	85.00%	89.05%	89.33%	89.62%	89.64%	88.56%	89.28%	87.99%	88.75%	88.94%	89.06%	89.03%	89.66%	90.91%	↑	↑
W	CQC Safe MT %	%	85.00%	85.73%	86.22%	86.17%	85.91%	84.90%	85.22%	83.65%	84.10%	83.93%	84.18%	84.54%	85.71%	87.47%	↑	↑
W	Appraisal Compliance %	%	85.00%	70.05%	73.03%	74.55%	75.56%	75.75%	75.04%	76.32%	79.31%	81.43%	81.16%	83.33%	82.25%	83.11%	↑	↑
W	Non Medical Appraisal Compliance %	%	85.00%	71.44%	74.99%	77.85%	77.91%	78.12%	78.03%	77.94%	78.88%	81.08%	80.60%	82.33%	80.68%	82.46%	↑	↑
W	Medical Appraisal Compliance %	%	85.00%	60.29%	58.82%	50.37%	58.38%	58.41%	53.44%	64.63%	82.84%	84.13%	85.44%	91.07%	93.90%	87.90%	↓	↑
	Demographics																	
W	Staff in Leadership Roles %	%	-	3.37%	3.43%	3.34%	3.32%	3.17%	3.24%	3.32%	3.21%	3.17%	3.20%	3.26%	3.26%	3.45%		
W	Staff in Leadership Roles WTE	WTE	-	197.00	202.00	197.00	195.00	188.00	194.00	199.00	194.00	193.00	192.00	196.00	197.00	207.00		
W	% of Leadership Roles who are Female	%	-	66.50%	65.84%	65.48%	65.64%	67.02%	66.49%	67.34%	68.04%	67.88%	68.23%	68.37%	67.51%	68.12%		
W	% of Leadership Roles who from BME	%	-	5.58%	5.45%	5.58%	5.64%	5.85%	6.19%	6.53%	5.67%	5.70%	6.77%	6.63%	6.60%	6.28%		
W	Male % of Workforce	%	-	17.45%	17.51%	17.66%	17.57%	17.43%	17.62%	17.45%	17.36%	17.38%	17.55%	17.50%	17.72%	17.68%		
W	Female % of Workforce	%	-	82.55%	82.49%	82.34%	82.43%	82.57%	82.38%	82.55%	82.64%	82.62%	82.45%	82.50%	82.28%	82.32%		
W	BME % of Workforce	%	-	20.16%	20.39%	20.65%	20.81%	21.05%	21.24%	21.48%	21.83%	21.94%	22.54%	22.75%	23.25%	23.66%		
W	White % of Workforce	%	-	70.59%	70.31%	70.17%	70.21%	69.99%	69.71%	69.60%	69.33%	69.16%	68.74%	68.71%	68.24%	67.99%		

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

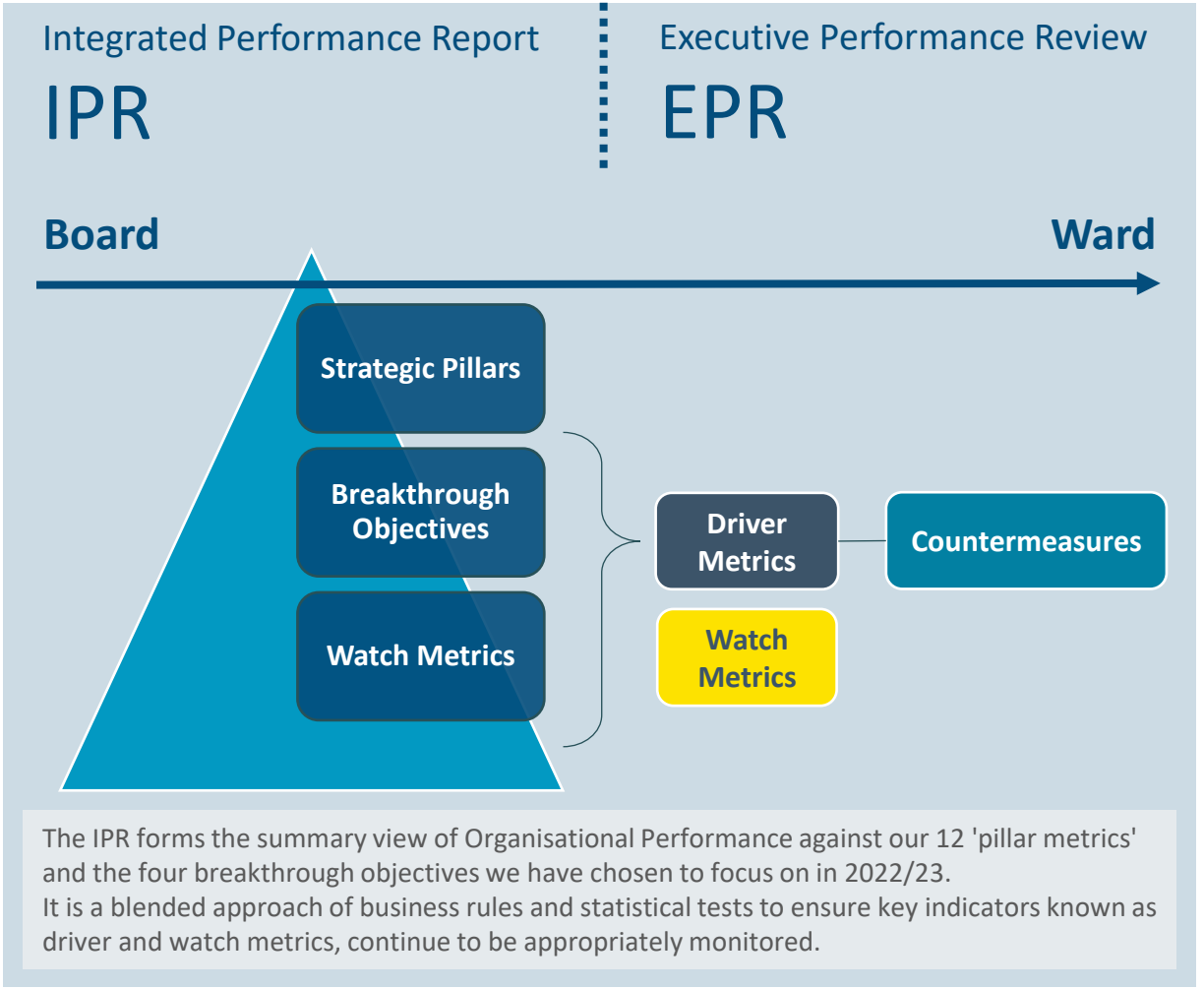
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- 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 four 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.

Our vision & strategic focus

NHS
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

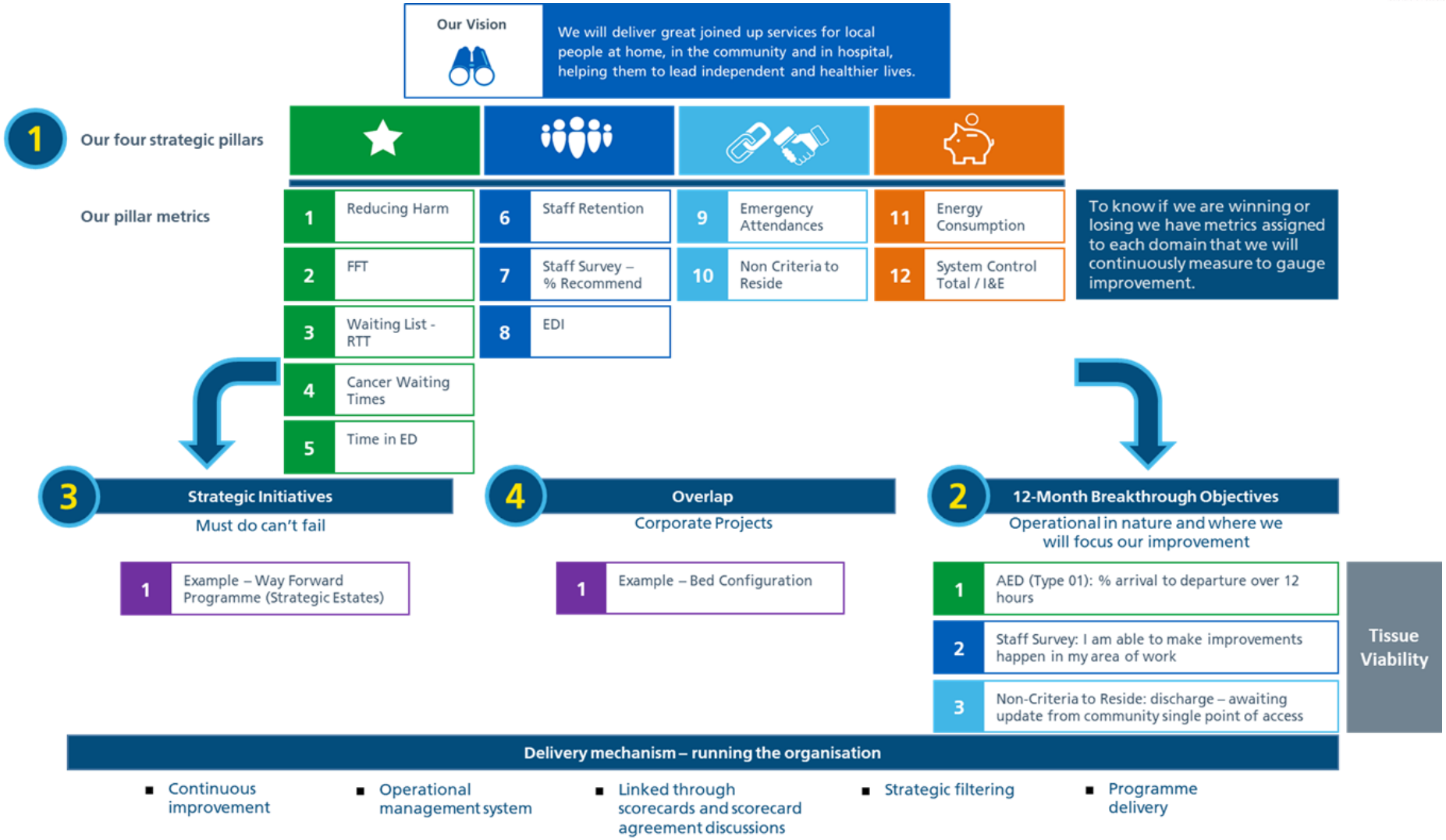
Staff and volunteers feeling valued and involved in helping improve quality of care for patients

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

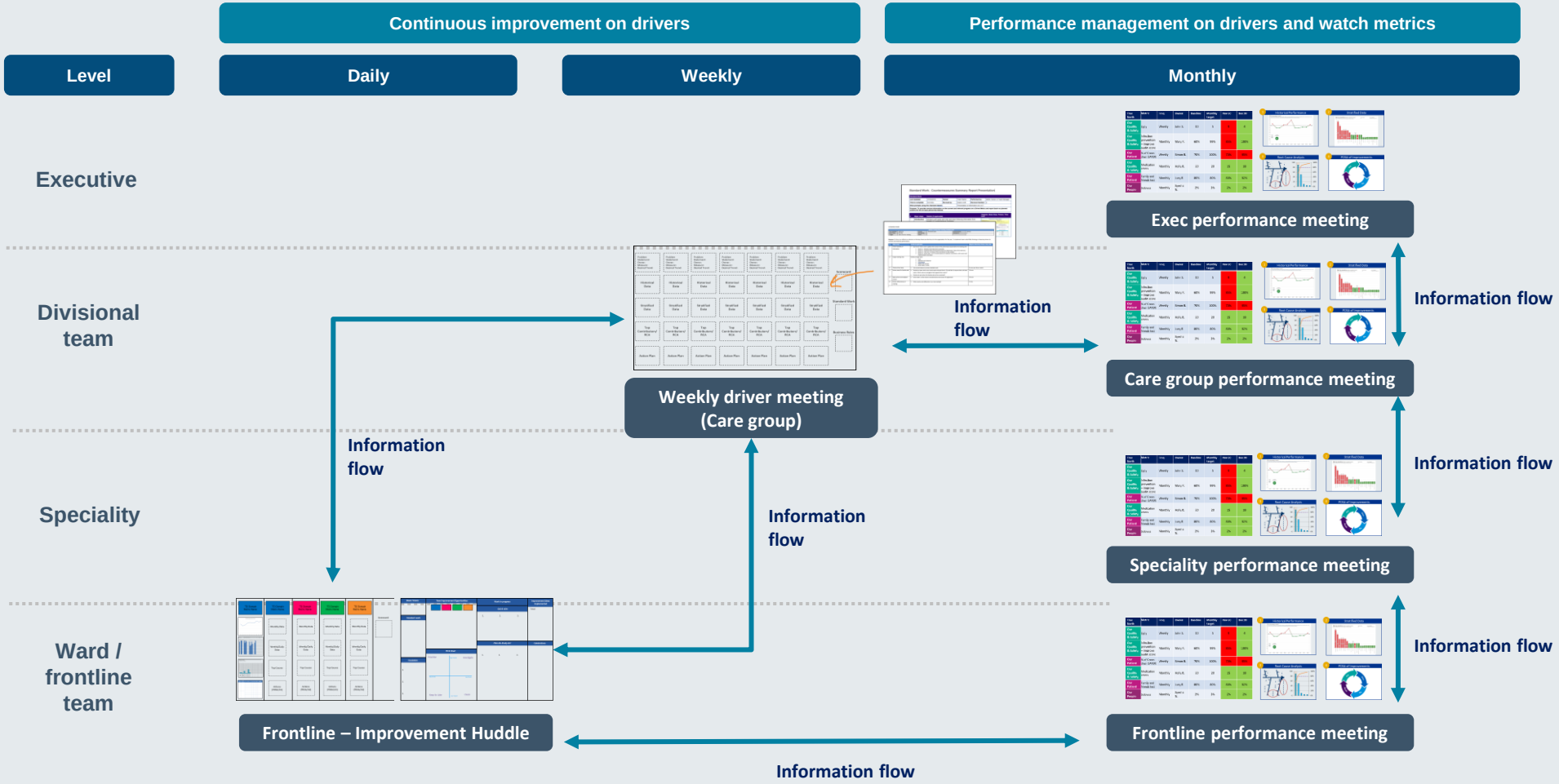
Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust



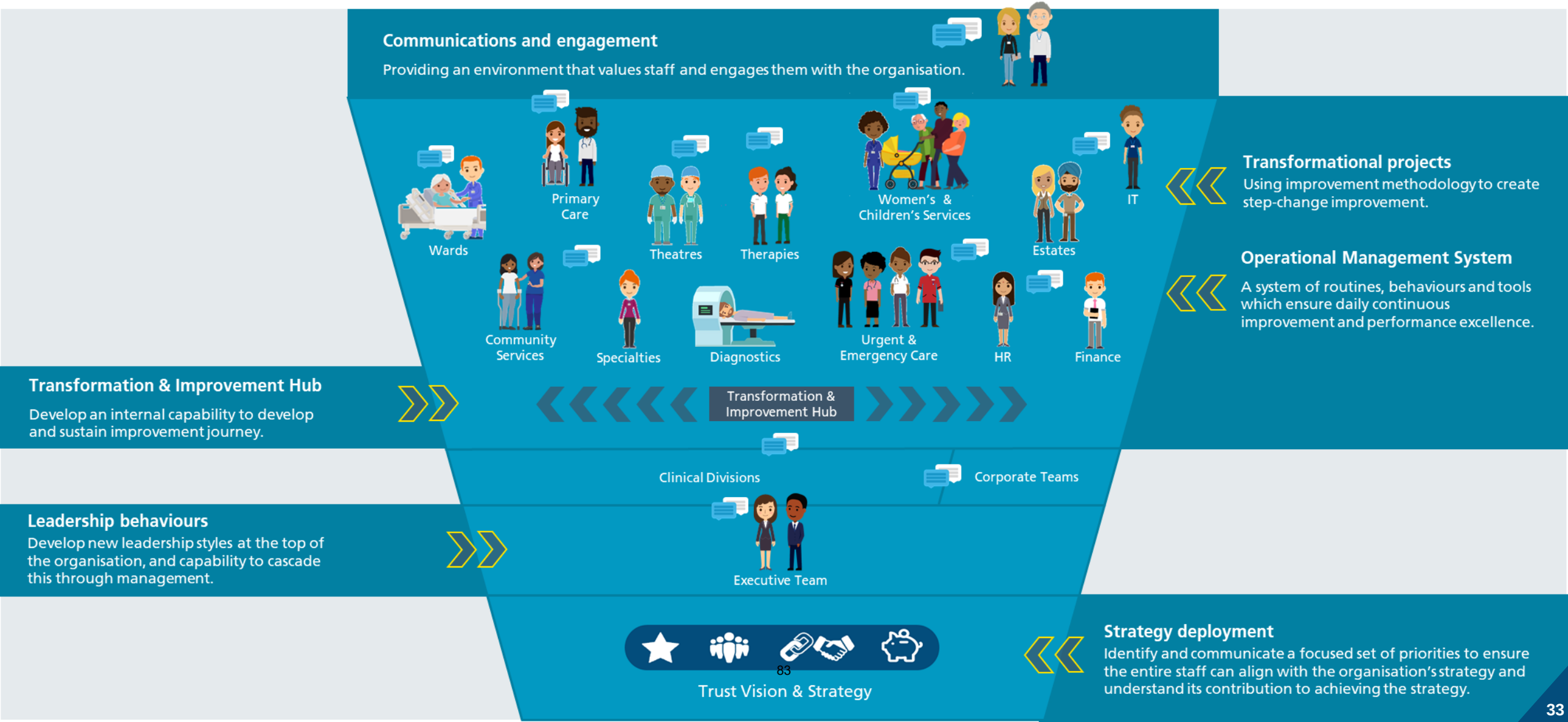
Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

The 'Improving Together' 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.

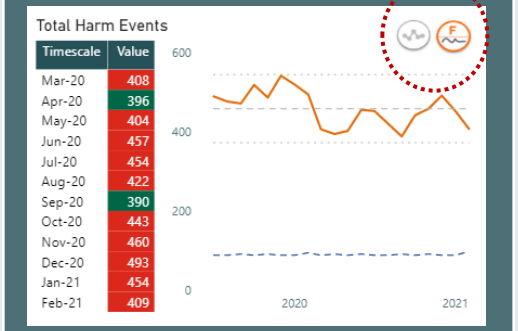
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

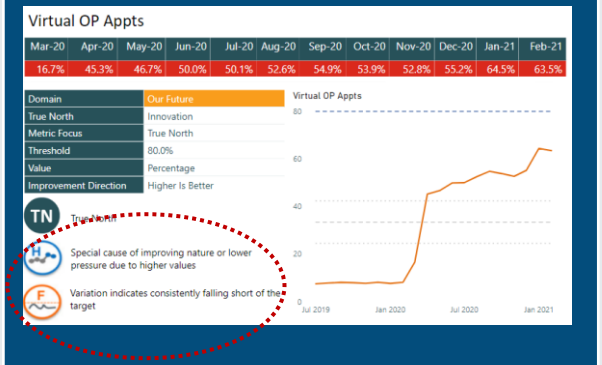
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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



Performance business rules

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
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NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Board Committee Assurance Report

Charitable Funds Committee – May 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	**Paul Lews**		**10 May 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	N/A		

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Fundraising	R	A	The Risk Assurance Level remains Red due to the continued risks and uncertainty with cost-of-living implications. We have actions in place to mitigate this, but the external risk factors remain very concerning. The assurance level was changed from Green to Amber due to the level of capacity and stretch within the team at present.	Review progress at the next meeting.	August 2023
Financial Position	A	G	The Finance position continues to be well controlled. We agreed that the proposal to set a minimum threshold level for the General Fund will be presented and agreed at the next meeting in August. We also agreed we will review and agree our Investment Strategy at the meeting in November and agree our plans for Funds Rationalisation at the meeting in February 2024. The 6 monthly General Fund Forecast was noted with no concerns raised.	Review progress at the next meeting.	August 2023
Cases of Need	A	A	The Cases of Need process continues to work well. The external review of Charitable Funds has highlighted some areas for further improvement (in particular with the prioritisation of needs and with the impact of the grants) and this will form part of the action plan which will be presented for agreement at the meeting in November.	Review progress at the next meeting.	August 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Charitable Funds	A	A	The Divisions presented their spending plans for this year using a common template and structure which helped provide far more assurance and confidence that needs and priorities have been reviewed (from a patient, environment, equipment and staff perspective) and this has resulted in a significant increase in planned spend over coming months. It was agreed to invite the Divisions to provide regular updates at future meetings, on a rotation basis, starting from the next meeting beginning with Integrated & Community Care.	Review progress at the next meeting.	August 2023

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

Great Western Hospitals NHS Foundation Trust

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

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

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

Report

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

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

The last report to the Board of Directors was in January 2023.

This report details assurance around our key risks and governance of safe staffing and reports on Nursing, Midwifery and AHP workforce. Community Nursing will be the focus for future reports once the current review using the safer nursing care tool is complete.

Governance of Safe Staffing

The report describes how Trust's safe staffing process is monitored through daily, weekly, monthly and annual actions. Planning for data collection across the Trust using the Safer Nursing Care tool is underway and will be presented in the next report. The Safer Nursing Care Tool helps informs nursing establishments against patient needs in terms of acuity and dependency.

Maternity Safe Staffing

The report covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report. It is recognised that Midwifery staffing is challenged nationally with high

numbers of vacancies. The Trust's midwifery staffing has improved over the last six months by identifying different staffing models, recruitment locally and internationally, alongside recruitment of band 5 nurses to work in specific areas within maternity. The key metrics of Supernumerary status of the Delivery Suite Coordinator, One-to-one care in Labour and Midwife to ratio and midwife to birth ratio are all presented and discussed. Although there is ongoing work to ensure compliance there are no specific areas of immediate concern.

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for are those who require short term intensive care (ITU), up to 48 hours, high dependency (HDU) care and low dependency care. The report describes the position against the British Association of Perinatal Medicine standards (2010). To meet the standards there is a focus on increasing the number of band 5 registered nurses that hold the qualified in Speciality course. External funding has enabled the further development of Advanced Neonatal Practitioner roles.

AHP report
The AHP report gives detail to the 427wte AHPS in the Trust and the challenges of recruiting to some professional groups such as podiatry. The international recruitment of AHPS is proving to be successful and work is ongoing to increase the pipeline and ensure the recruits are supported when they arrive.

Nursing report
The current vacancies for band 5 registered nurses is 42 wte and the average turnover is between 8-10 a month.

The Registered Nurse recruitment trajectory is described, with the international recruitment pipeline of 10 recruits per month and national / local recruitment projections, it is expected to reach a 0 vacancy position for band 5 registered nurses at the end of the year.

Establishment Reviews
The acute wards now have funded establishments for a 1:8 ratio for HCSW. 4 wards have moved to 1:8 for registered nursing and with the aim to ensure that all wards will be working on a 1:8 ratio as part of the business planning for 2023/24.

In addition, the aim to invest in facilities management in 2023/24 will ensure that non clinical tasks such as drinks rounds and cleaning duties are undertaken by housekeeping staff. These tasks are currently being undertaken by HCSWs and have added to the high workload which is reflective in the in-patient and staff surveys.

Neptune (respiratory medicine) and the Acute Medical Unit are requiring further review and analysis to ensure the high acuity of patients in these areas, especially those requiring non invasive ventilation, are managed appropriately. Both areas are high users of temporary staff during times of high demand or acuity.

The report highlights the benchmarking against national safe staffing standards for the specialist areas, Theatres, Critical Care Unit and the Children's wards and highlights areas of concern.

Conclusion
Maintaining safe staffing for Nursing and Midwifery remains a key challenge for the NHS and the Trust. There is a monthly nursing and midwifery workforce group that reviews risks and challenges and helps inform workforce planning. A detailed monthly report is presented to the Quality and Safety Committee.

The report makes the following recommendations:

Continue to implement the 1:8 nurse to patient ratio following investment in 2023/24 and report on the benefits realisation with support from the improvement team.

Ensure the SNCT data collection is completed in time to inform this year's establishment reviews with the Chief Nurse. Consider benchmarking areas specialist areas using SNCT across the Acute Hospital Alliance.

The Trust should continue to invest in the Internationally Recruited Nurses programme supported to help maintain safe staffing levels.

Retention and reducing turnover in hot spot areas should be a continual focus and driven through the Nursing and Midwifery Workforce Group.

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ The Board is asked to note the contents of the paper.	
Accountable Lead Signature	Lisa S Arch
Date	3rd May 2023

1. Introduction

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

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

These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.

- Publish information with the planned and actual registered and unregistered nurse staffing for each shift
- Provide a six-monthly report on nurse and midwifery staffing to the Board of Directors.

This report serves as the six-monthly safe staffing review at Great Western NHS Foundation Trust. The Board of Directors last received a Safe Staffing Paper in January 2023.

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

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

The report covers:
Governance of Nursing and Midwifery safe staffing
Nursing report
Midwifery report
Allied Health Professionals report

2. Governance of safe staffing

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

The Trust continues to have a Trust wide three times a day safe staffing meetings and a 'duty matron' role providing support out of hours.

The weekly 'look ahead' review to ensure any gaps are mitigated has been strengthened by the Divisional Directors of Nursing as part of the Nursing and Midwifery Agency reduction work.

The Nursing and Midwifery Workforce group meets monthly reviewing the Trust position, divisional reports and areas of risk as well as strategic developments. There is also the nationally recommended monthly fill rate report that is reported to the Quality and Safety Committee.

The yearly Establishment reviews were completed in December 2023 and main areas to highlight are presented in the nursing report below. These reviews allow for 'ward to board' oversight of safe staffing and the Ward/ Unit Managers an opportunity to discuss staffing and any concerns with the Chief Nurse. The reviews cover registered nurse / unregistered nurse to patient ratio, care hours per patient day, model hospital comparators, national or royal college guidance as well as current vacancies, roster metrics and quality metrics / nurse sensitive indicators. A summary is included below.

Safer Nursing Care tool
Acuity and Dependency is currently measured daily through the 'Safe Care Live' electronic system on the electronic roster. The Safer Nursing Care Tool (SNCT) is an evidence based tool that is endorsed by National Institute of Clinical Excellence that calculates clinical staffing requirements based patients acuity and dependency. It is recommended that data for the tool is collected twice yearly to inform establishment reviews along with professional judgment. The Emergency Department data was presented in the last report and further data collection is planned for April 2023. The new Community Nursing SNCT is being rolled out nationally and plan for local data collection is being developed. The Divisional Directors of Nursing are ensuring that the general wards complete the tool prior to the establishment reviews for 2023 starting in September.

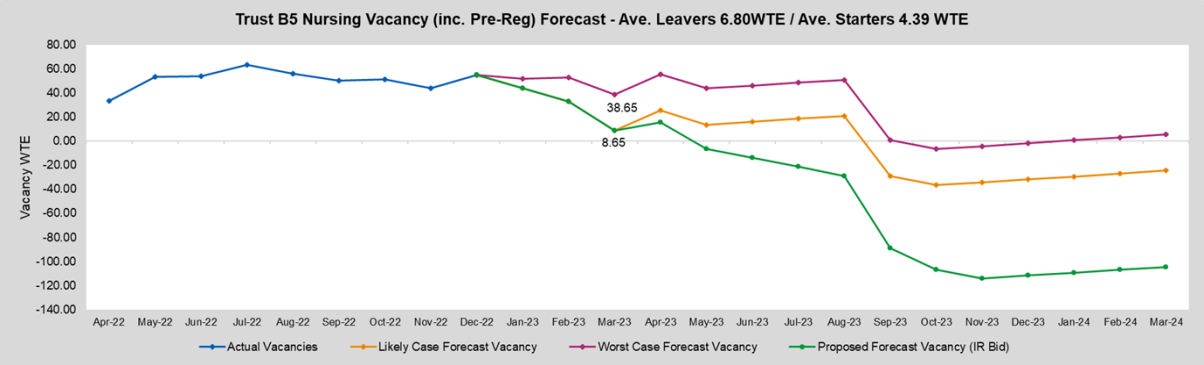
3. Nursing Report

3.1 Vacancies and turnover

The current vacancies for band 5 registered nurses is 27.4 wte (March 23) and the average turnover is 13%.

The Registered Nurse recruitment trajectory is described below with the international recruitment pipeline of 10 recruits per month and national / local recruitment projections. This trajectory also includes the uplift in registered nurse numbers for 2023/24 in line with the safer staffing business case.

Table 1 Registered Nurse Recruitment trajectory April 2022 – March 2024



Health Care Support Worker (HCSW) vacancies continue to be monitored through a weekly report and a programme of rolling weekly adverts and interviews. In March 2023 there were 28wte vacancies for HCSWs with a pipeline in place of over 60wte. This includes all ward areas having now recruited to the new HCSW ratios to meet the nationally recommended ratio of 1:8.

Turnover for HCSW is still between 10-15 wte per month but higher is some areas. Analysis of leavers for HCSWs shows that the majority leave within a year of starting.

Work led by the deputy Divisional Director of Nursing for Unscheduled Care is looking at improved on boarding and retention initiatives including trial of a 'training ward', improved induction programmes, developing HCSW leads in each clinical area and recognition events such as Care Certificate celebrations.

Table 2. Leavers by length of employment for Registered and Unregistered Nurses.

Registered Nursing & Midwifery	
Staff Group	Registered Nursing and Midwifery
Row Labels	**Count of Employee**
less than 1 year	8
1-1.99 years	20
2-4.99 years	26
5-9.99 years	17
10+ years	17
Grand Total	**88**

Unregistered Nursing & Midwifery	
Staff Group	Unregistered Nursing and Midwifery
Row Labels	**Count of Employee**
less than 1 year	34
1-1.99 years	10
2-4.99 years	13
5-9.99 years	9
10+ years	6
Grand Total	**72**

The top reason for leaving remains as improving work life balance, further work is planned to understand this further to enable actions targeted to reduce turnover.

3.2 Establishment Reviews

The full report on the 2022 Chief Nurse establishment reviews will be presented in Nursing and Midwifery Workforce Group and the Ward Managers forum.

The main points to note are:

- National guidance is to have ratios of 1:8 or less, ratios above this are recognised as increasing the potential for harm. 4 wards have uplifted the registered nurses to a 1:8 ratio with the remaining wards moving to a 1:8 ratio from the 1st April 2023.
- Implementation of the 1:8 ratio for HCSW is now complete and recruitment to the new establishments is nearly finished.
- The Improvement team are supporting the benefits realisation report for this investment and will be presented in future reports.
- The Ward Managers are supervisory in the establishment but frequently working clinically to support.
- The quality dashboard and roster metrics were reviewed in detail in the establishment reviews. The Ward Managers had good oversight of their data and were taking actions to drive improvement.

3.3 Areas of note from the Establishment reviews

3.3.1 Acute and General Wards

The acute wards now have funded establishments for a 1:8 ratio for HCSW. 4 wards have moved to 1:8 for registered nursing and with the aim to ensure that all wards will be working on a 1:8 ratio as part of the business planning for 2023/24.

In addition, the aim to invest in facilities management in 2023/24 will ensure that non clinical tasks such as drinks rounds and cleaning duties are undertaken by housekeeping staff. These tasks are currently being undertaken by HCSWs and have added to the high workload which is reflective in the in-patient and staff surveys.

Neptune (respiratory medicine) and the Acute Medical Unit are requiring further review and analysis to ensure the high acuity of patients in these areas, especially those requiring non invasive ventilation, are managed appropriately. Both areas are high users of temporary staff during times of high demand or acuity.

3.3.2 Theatres

Theatre staffing was reviewed in detail for the first time as part of the establishment review. The review considered national staffing guidance from the Association of Perioperative Practice.

The new matron has made improvements in the team structure, support for specialist scrub teams and management of sickness in theatres which has been higher than expected.

Theatres has been significantly challenged by vacancies for some time, but a detailed recruitment plan is in place and being effective. There is now a pipeline of new recruits which will reduce the vacancy to 2.54wte. However, the start dates for the new recruits will be over the next 4-5 months. To support activity whilst the recruitment is ongoing, theatres currently has approx. 10.5wte agency staff working within the department with a plan for a staggered reduction over the next 5 months.

Cover for staffing gaps is now being managed using the Standard Operating Procedure, developed to support safe staffing in theatre. This SOP includes a requirement to review existing staffing first alongside scheduled activity, before escalation to bank, agency and premium agency. This has supported a significant reduction in the number of ad hoc agency requests as well as operating list cancellations. Theatres does not anticipate at this stage, needing to formally implement block booked agency arrangements after September 2023, however, this is dependent on the recruitment pipeline and success in getting candidates into post in line with the expectation.

The establishment review also highlighted the historic use of Band 3 theatre support workers who had received inhouse training to perform an assistant surgical role. These roles are being phased out and replaced with national recognised ‘First Assistant’ role which is a registered role at Band 6 with a funded and recognised training programme. This issue is recorded on the risk register with a current score of 12.

3.3.3 Children’s Ward

The Children’s Ward follows the Royal College of Nursing guidance for registered Children’s Nursing of a 1:4 ratio for age 2 or over and a 1:3 ratio for under 2 years old. Children requiring high dependency should be nursed on a ratio no higher than 1:2.

The current funded establishment is set on a 1:4 ratio and does not accommodate the ratio needed to manage children under the age of 2 or those children requiring high dependency care (a 1:2 ratio). A recent audit demonstrated that over a 3 month period in 2022 the children’s ward was:

- 29 Days over bed capacity
- 54 Days of children requiring HDU level care
- 12 Days of more than 2 children requiring HDU care on ward

It is of note that the Trust and RUH are the only hospitals in South West region without a funded HDU for Children. This will be reviewed as the next stage of the Acute Hospital Alliance establishment reviews led by the Chief Nurses. The Trust has one of the highest number of children transferred to PICU in the South West. For example, the number is higher than Gloucester Hospital which has 1.5 times greater population served.

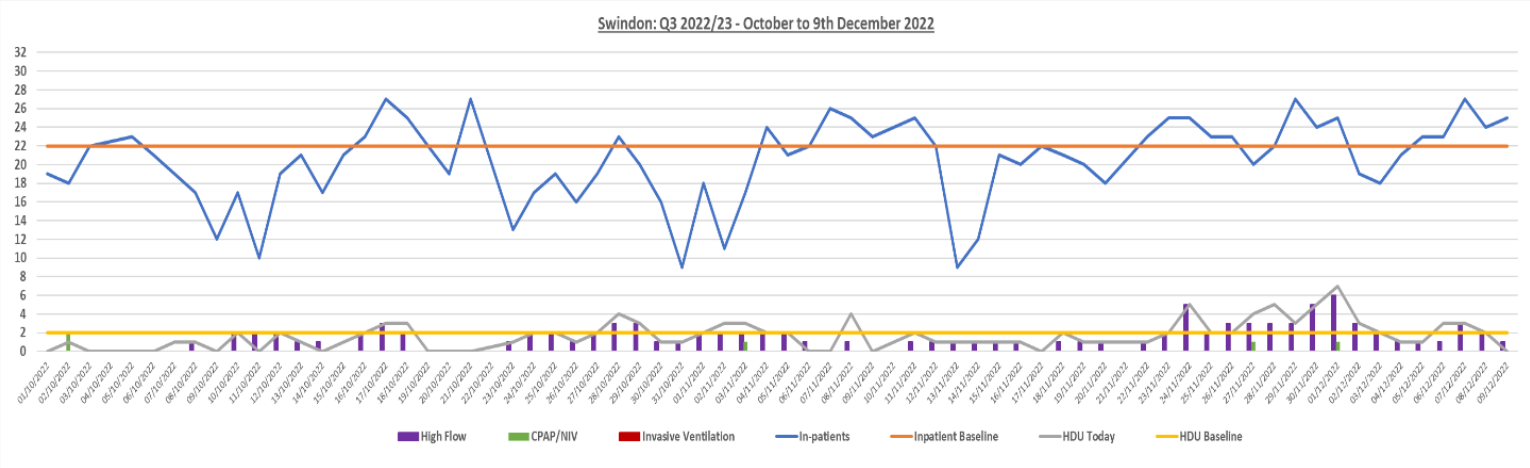
Further the Children's ward has a lower bed base in comparison to other Trusts of a similar size.

A review of incidents and quality data demonstrates that the children are receiving safe care when requiring high dependency care but it is an area that requires further review and focus.

Figure 3. Bed capacity and high dependency numbers for the Children's Ward at GWH.

The blue line is bed occupancy against the funded beds available

The green line is high dependency children



Another consideration and area of non compliance with guidance is the Children's ward does not currently have a practice development nurse. There is a gap in training for children's nursing with the GWH academy being predominately adult focused and a lack of children's specialist trainers. Training is provided by the senior staff on the ward but without dedicated time to deliver this.

3.3.4 Critical Care Unit (CCU)

The CCU nurse staffing was reviewed in detail with the Matron and a benchmarking exercise against the standards laid out in the 'Guidelines for the Provision of Intensive Care Services' (GPIC 2022) was completed. The CCU has 2 standards rated as RED and 1 rated as AMBER.

Figure 4 GWH CCU Nursing Workforce Gap Analysis compared to GPICS v2

Standard/ Recommendation	RAG	Comment	Actions
STANDARD: Additional nurse to be rostered (not to deliver direct patient care) for units>10beds or less depending on the size and layout of the unit (e.g. multiple pods/bays, single rooms).	RED	This is not within the current workforce model based on 12beds (8L3 and 4L2). Recent consultation held with staff regarding the threshold for this based on unit geography: 12 single side rooms and segregated glass pods built during covid impact upon nursing workflow and patient safety. Consensus being tested currently is ~8patients in department/ 3 'zones'	To incorporate this within the next workforce planning round and for next budget setting priorities. To incorporate this additional nurse within daily staffing risk assessment when occupancy <12 beds and the current model should therefore allow.
STANDARD: There must be a supernumerary (i.e. not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides the supervisory clinical coordinator role on duty 24/7 in critical care units.	AMBER	This is supported within the current workforce model. However there are occasions when the coordinating nurse is the admitting nurse. This is more often on a night shift when other non clinical roles are unavailable to mitigate.	Recruitment into vacant posts Reduction in sickness. Timely discharge from ACC to ward. Staffed to expect an emergency admission approx. every 12hours (based on current data)
RECOMMENDATION: The Best Practice Principles to Apply When Considering Moving Critical Care Nursing Staff to a Different and Unfamiliar Clinical Care Area should be followed at all times to enable staff to achieve and maintain competence in intensive care nursing.	RED	The potential adverse effects not only on patient safety but also staff morale, recruitment and retention should be considered, particularly when this is recurrent. April = 18 occurrences of staff movement May = 4 occurrences of staff movement	Support for this risk assessment discussed with Chief Nurse, DDON, Site Matron, and a version is being trialled by ITU staff following consultation on this. Feedback being gathered by end of June to inform full document. Full proposed document to be shared in July for comment and to move through governance and ratification process.

A strengths, weakness, opportunities and threats (SWOT) analysis was also presented. The main themes include:

- Current uplift not in line with 22% minimum recommendation in GPICS v2
- Currently unable to achieve a 24/7 band 7 clinical presence.
- The unit is compliant with the requirement to have 50% of the establishment with a post graduate certificate in critical care and 25% with a children's critical care module. Working is ongoing to ensure this is maintained with turnover of staff.
- Lead role funded and recruited to for the ongoing management of the electronic system
- Introduction of staffing risk assessment as per GPIC recommendation.
- Deep dive into staff survey with HR and a local forum to gather further details and the creation of an action plan
- Bank enhanced rates has improved fill rate and reduced high-cost agency compared to last year.
- The development of the Advanced Critical Care Practitioner role is planned for this year.

4.0 Maternity staffing

4.1 National / regional context

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

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

include as a minimum NHSE, RCOG, RCM, RCPCH.' The Trust will continue to utilise the BR+ methodology pending the findings of the national review.

Trusts are expected to commission a BR+ report every 2-3 years, and a revised report was received by GWH's report in May 2022, which was funded by the Local Maternity and Neonatal System (LMNS). This report identified a registered midwife gap of 3.33wte. The BR+ report is reflective of a 20% uplift in maternity services. Following the Ockenden report there is a requirement to reflect a workforce that can accommodate increased levels of training. This requires a 28% uplift (including maternity leave) to achieve this training requirement. A business case has been written to support a 4% uplift, utilising the CNST rebate for 2022/23.

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

4.2 Skill mix review and on call planning

The maternity department concluded a staff consultation for an acute unit on call model in February 2023, which will strengthen the staffing model at times of high acuity, without relying on the community on call system. The on-call rota will commence on April 10th, 2023.

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

The successful recruitment plan to date, will continue as a rolling planned model of recruitment to ensure that there is a constant pipeline of new starters.

The inpatient services have been successful with recruitment with the current vacancy sitting within the community midwifery workforce.

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

The below table illustrates the level of staff turnover across departments, monthly between February 2022 and January 2023. This data informs the focus of the retention plan for maternity services.

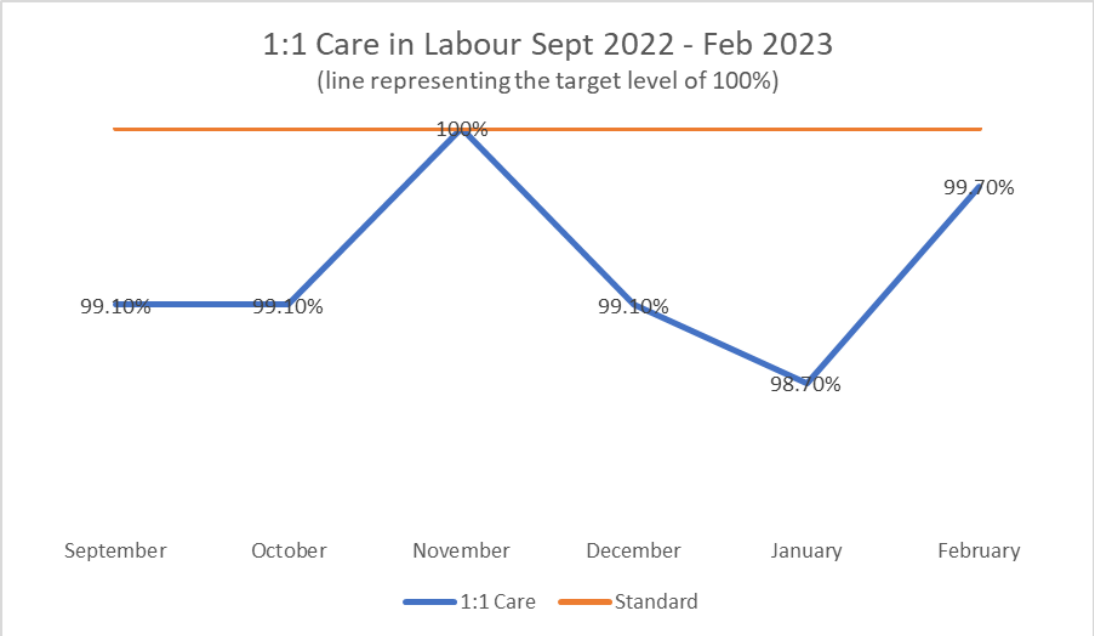
Division	Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Surgery, Women's & Children's Division	Ante-Natal Screening - J65919	5	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Birthing Centre - J65921	7	1	14.29%	1	14.29%
Surgery, Women's & Children's Division	Community Midwifery - J65918	51	7	13.86%	4	7.92%
Surgery, Women's & Children's Division	Continuity of Carer - Midwives - J65922	14	1	7.41%	1	7.41%
Surgery, Women's & Children's Division	Day Assessment Unit - J65910	24	2	8.33%	1	4.17%
Surgery, Women's & Children's Division	Hazel & Delivery Staff - J65914	150	32	21.33%	26	17.33%
Surgery, Women's & Children's Division	Specialist Midwives - J65920	17	3	17.65%	2	11.76%

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

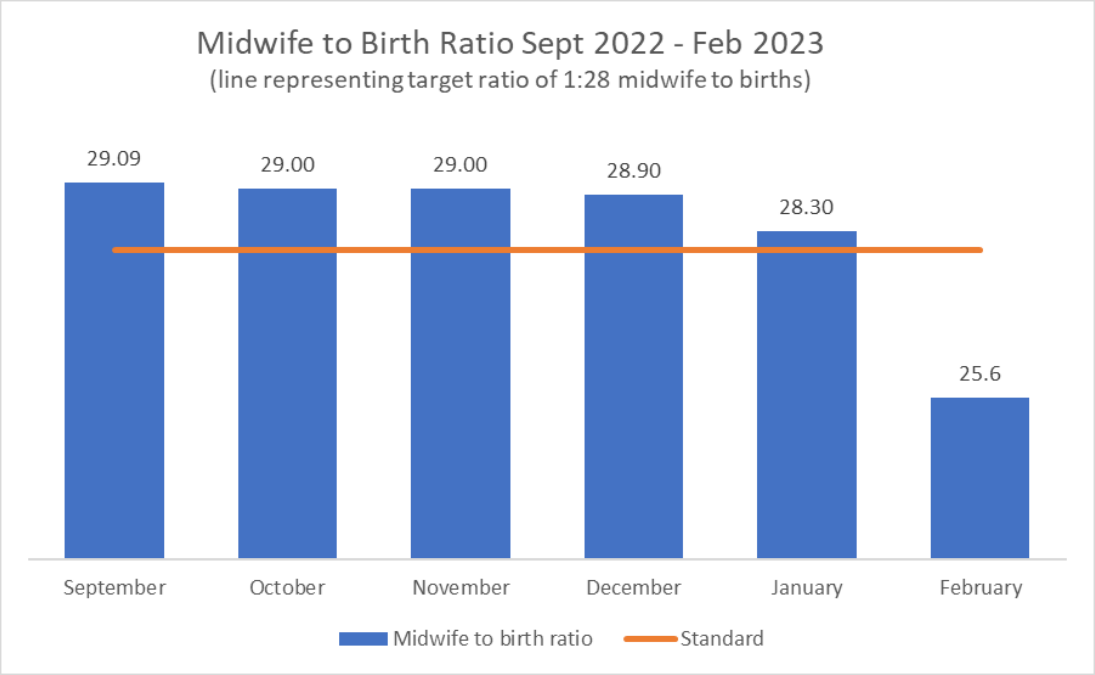
Sickness Rates as of Jan 2023				
Department	Professional Group	ST	LT	% Sick
Ante-Natal Screening - J65919	Registered Nursing and Midwifery	25.81%	0.00%	25.81%
Birthing Centre - J65921	Registered Nursing and Midwifery	2.15%	2.93%	5.09%
Community Midwifery - J65918	Registered Nursing and Midwifery	2.00%	3.73%	5.73%
Continuity of Carer - Midwives - J65922	Registered Nursing and Midwifery	0.81%	0.00%	0.81%
Day Assessment Unit - J65910	Registered Nursing and Midwifery	1.55%	4.23%	5.78%
Hazel & Delivery Staff - J65914	Registered Nursing and Midwifery	4.67%	5.83%	10.51%
Specialist Midwives - J65920	Registered Nursing and Midwifery	6.63%	0.22%	6.85%

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

The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the graph below demonstrates that it fluctuates between 98.7 % and 100% compliance over the 6-month period. The Team continues to work on ways to achieve 100% 1:1 care in labour, with focussed recruitment it is anticipated that there will be a consistent 100 % one to one care in labour ratio.

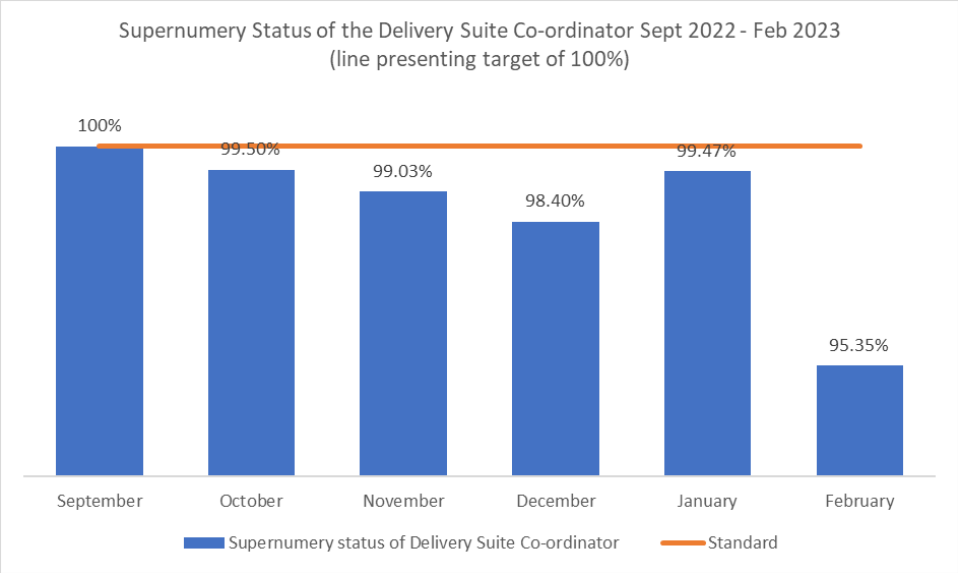


The Maternity Service monitors and reports the Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer Childbirth (2007). The midwife to birth ratio is calculated using the planned establishment rather than the actual staffing numbers in line with national guidance. The table below demonstrates the improvement in midwife to birth ratio in February 2023.



4.5 Supernumerary status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status to ensure there is an oversight of all birth activity within the service. This is defined as having no caseload of their own during their shift. Over the period September 2022 – February 2023 a mean compliance rate of 98.6% was achieved. The focus is on achieving 100% compliance and identifying measures to achieve this with the team within the current staffing model. Where compliance is below expected each episode of care is reviewed by the governance team.

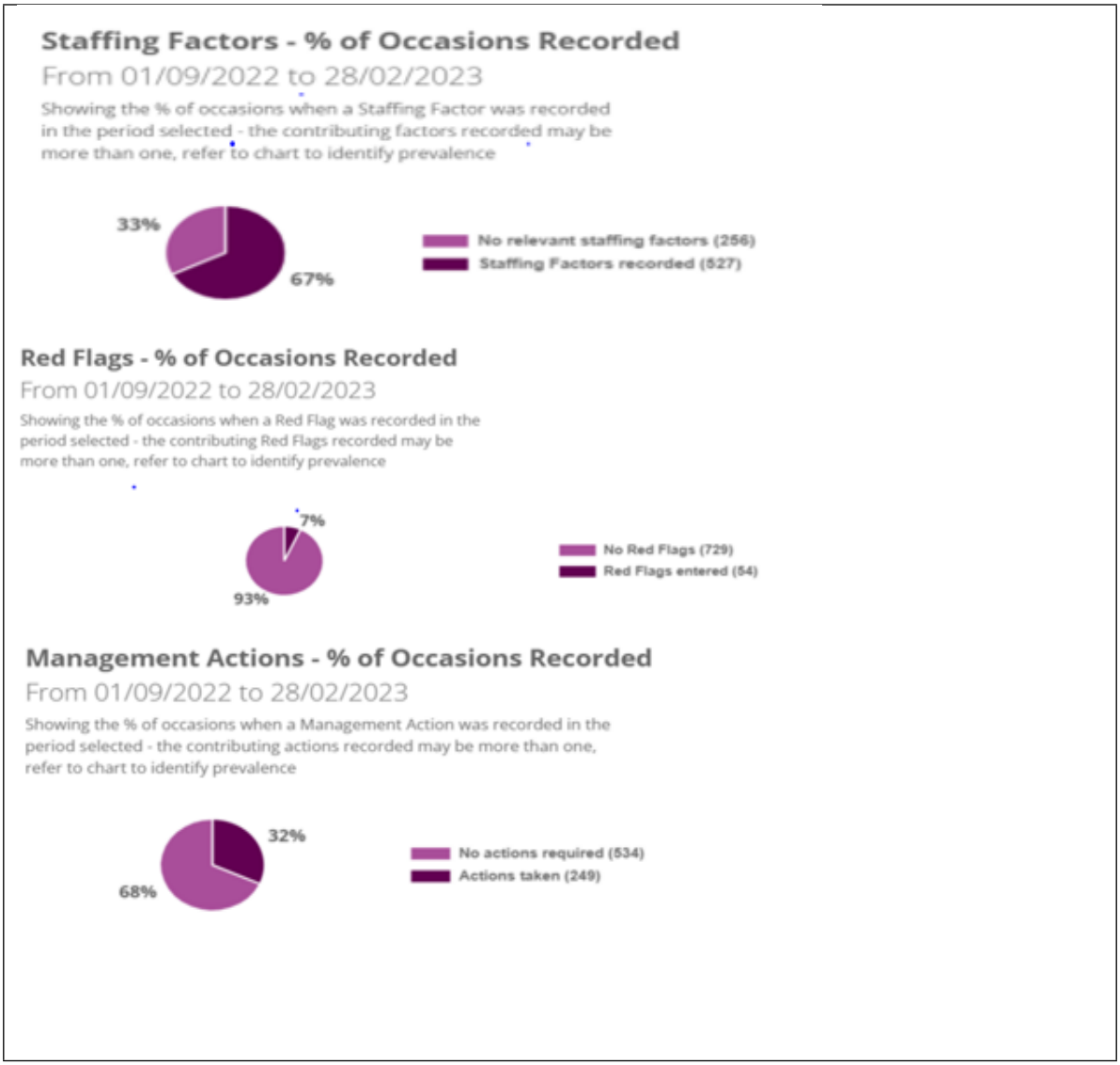


4.6 Red Flags

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

The 10 red flags are as follows:

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



Analysis of the data shows that there was a slight increase in the number of occasions red flags were recorded compared to the previous Safer Staffing paper. There were no changes in the number of occasions where management actions were required to escalate staffing concerns but there was an increase in the number of occasions were staffing factors were recorded as a concern requiring escalation. Several initiatives have been put in place to strengthen midwifery staffing as part of the recruitment and retention plan set out below. We are now fully recruited to establishment for inpatient services, with the introduction of Registered Nurses on Hazel ward.

4.7 Recruitment and retention

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

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

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

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

- 4 Places secured with the University of Worcester to deliver two-year midwifery programme. Three nurses have commenced training in February 2023 with the fourth starting in 2024.
- Successful Maternity funding bid of £67,720 to support Obstetric leadership, bereavement provision and educational development for maternity support staff.
- Successful funding bid of £129,300 funding for recruitment, workforce growth, pastoral care, and educational support
- In September 2022 we re-started enhanced bank rates for bands 2,3,4,5, 6 and 7. Bank fill rates are reviewed against agency usage weekly. Payments are in line with other Trusts within the LMNS, bank fill rate has seen a significant improvement. The enhanced bank rates have been continued following executive approval in February 2023.

4.8 Continuity of carer

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

Following these national recommendations, a review of the provision of care under the Maternity Continuity of Carer (MCoC) model was undertaken in April 2022 with a full update provided to Quality and Safety Committee. The decision was made to reduce the two existing teams to one team, to facilitate safe staffing levels across the service. The Maternity Service is currently supporting 10%- 13% of total bookings within the one Continuity of Care team, with the team focussing care in areas of deprivation.

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

5.0 Neonatal staffing

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for are those who require short term intensive care (ITU), up to 48 hours, high dependency (HDU) care and low dependency care. The unit comprises of 8 HDU/ITU cots plus 10 low dependency cots. Neonatal units have an unpredictable and fluctuating activity level, and so should aim to operate at 80% capacity to allow for times of high acuity. National standards for neonatal nursing care, and medical provision have been developed to safeguard patient safety, and we have a duty to comply with these standards. The neonatal unit at GWH works within the South West Neonatal Network to provide the right level of high-quality care to each baby as close to home as possible.

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

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

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

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

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

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

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

The requirement is for 1 registered nurse that is qualified in speciality (QIS) course to 4 intensive care babies. Data for quarter 3 2022/23 shows the Trust was compliant for 87% on days and 71% on nights. There are currently 20 WTE nurses who have completed the qualified in speciality (QIS) course and a further 3 nurses currently undertaking the QIS course. There is a plan to increase the number of band 5 registered nurses with the qualification.

Turnover Rates			
Department	Average Head Count	All leavers	All Turnover
Neonatal Unit - J65931	47	6	12.90%

Sickness Rates			
Department	Short Term Sickness	Long term Sickness	Total % Sickness
Neonatal Unit - J65931	5.20%	10.79%	15.99%

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

External funding from the neonatal network has enabled the Division to develop 2 further Advanced Neonatal Practitioner role (ANNPs). There are two trainee ANNPs who commenced their program in September 2022 with a view to 2 further trainees starting in September 2023. A Lead ANNP at Band 8B is starting in April 2023, and a qualified 8a

ANNP is joining the team in June 2023. This will support both the development of the service provision locally, provide educational and peer support and mentorship to the trainees and facilitate enhanced service development work. These roles will also support career development opportunities within the workforce.

A 0.64 wte Practice Development Nurse has been appointed to support the neonatal workforce in developing a skilled workforce and support stability within the team. Recruitment to the LNU has gradually improved in the last six months.

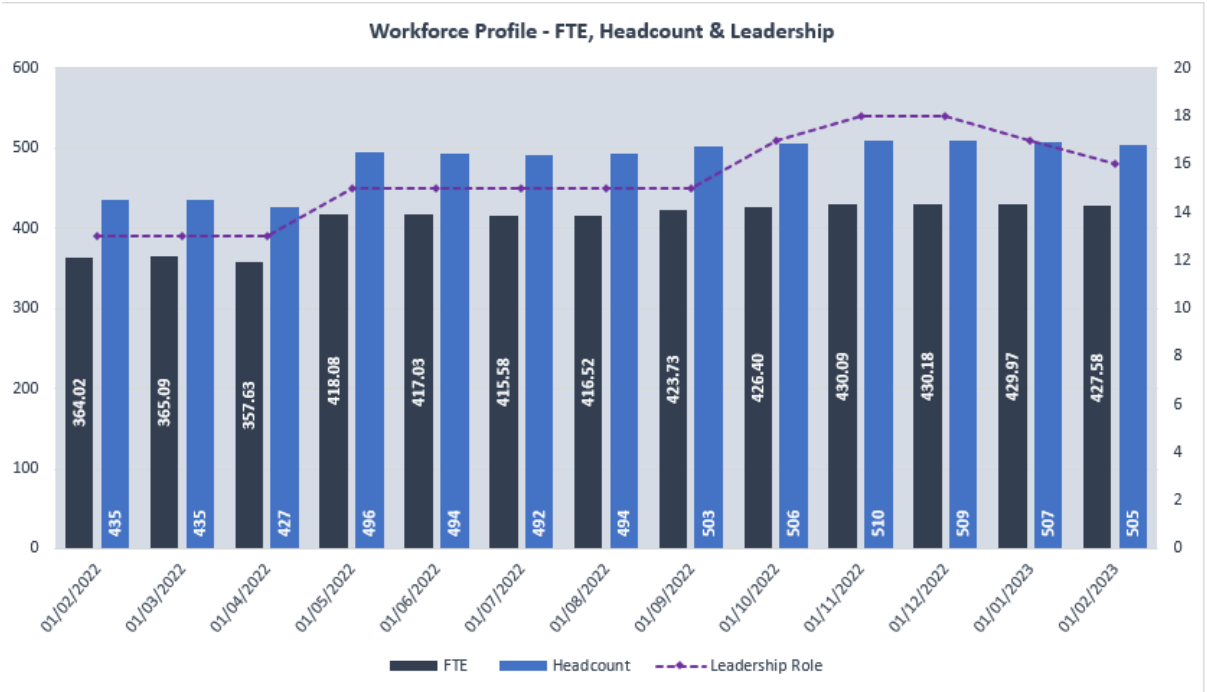
6.0 AHP report

6.1 Introduction

AHP is an umbrella term for a range of professions and includes registered Health and Care Professions Council (HCPC) practitioners and support staff. AHPs are a diverse group of professionals supporting people of all ages to live healthy, active and independent lives.

Our AHPs are a distinct group of practitioners who apply their expertise to diagnose, treat and rehabilitate people of all ages across our divisions. Within Great Western Hospitals we have 9 AHP staff groups that include Dietitians, Diagnostic Radiography, Orthoptists, Physiotherapy, Occupational Therapy, Operating Department Practitioner (ODP) Paramedics, Podiatrists and Speech and Language Therapists.

The Trust is beginning to have a better understanding of the current AHP workforce through monthly work force data and metrics. The combined AHP workforce, registered and un-registered has a headcount of 505 staff or 427 WTE.



The Trust's AHP workforce metrics shows there is work to do to ensure an inclusive and diverse workforce; the majority of the workforce is female, and there is underrepresentation of staff from ethnic minority backgrounds. The Trust follows the national picture of AHPs ethnicity being predominately white (79%) (NHSE 2022). Work is planned to develop a more representative workforce including supporting the international recruits to grow their career at GWH.

Figure 2 Breakdown of AHP workforce by gender and ethnicity at GWH.

Sex

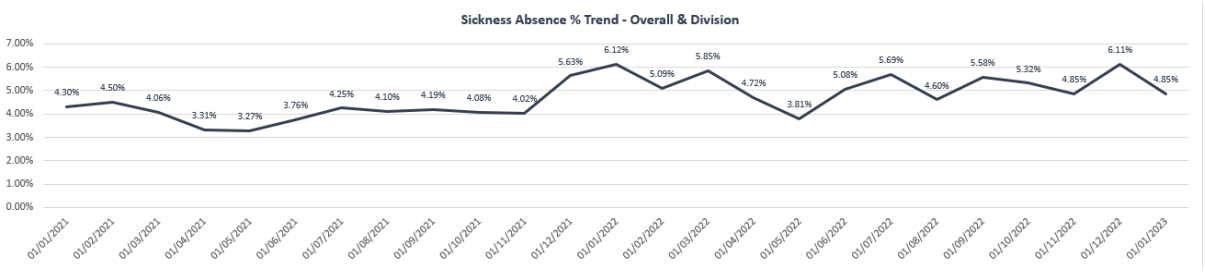
Sex	HC	HC %	FTE	FTE %
Female	412	81.58%	341.30	79.82%
Male	93	18.42%	86.28	20.18%
Grand Total	505	100.00%	427.58	100.00%

Ethnicity

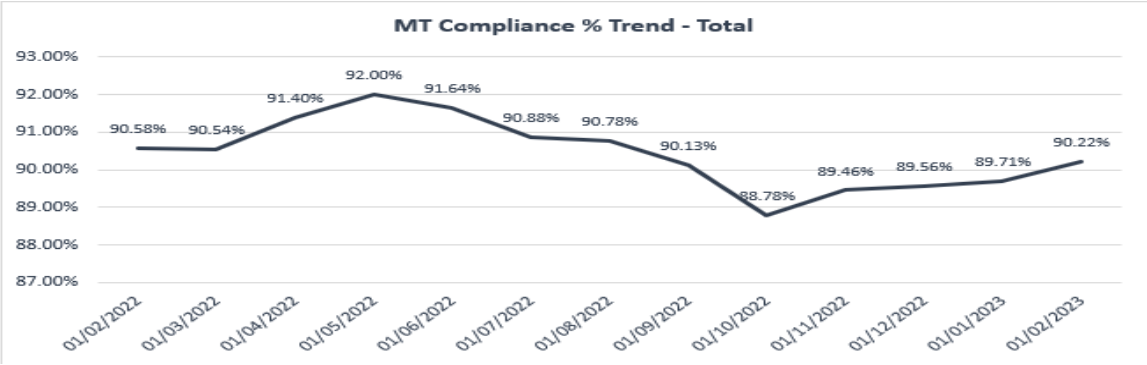
Ethnicity	HC	HC %	FTE	FTE %
Asian	33	6.53%	31.03	7.26%
Black	12	2.38%	11.56	2.70%
Mixed	5	0.99%	4.40	1.03%
Other	5	0.99%	5.00	1.17%
Undefined	34	6.73%	27.35	6.40%
White	416	82.38%	348.24	81.44%
Grand Total	505	100.00%	427.58	100.00%

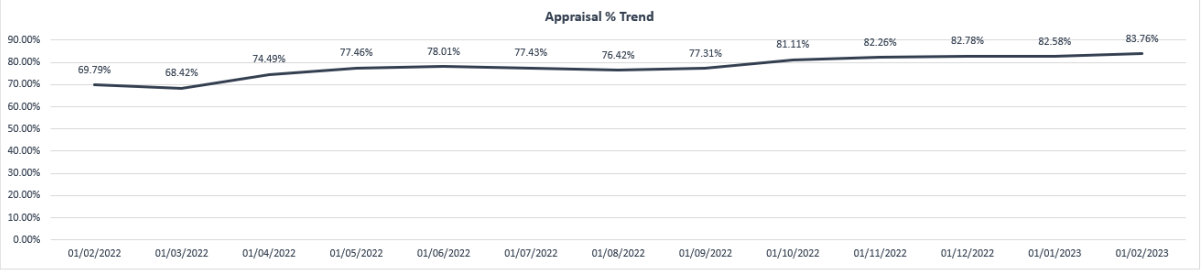
6.2 Sickness

Sickness absence is monitored within professions and individual teams and AHP teams are supported from the HR business partners, looking at hot spots and short and long term sickness absence.

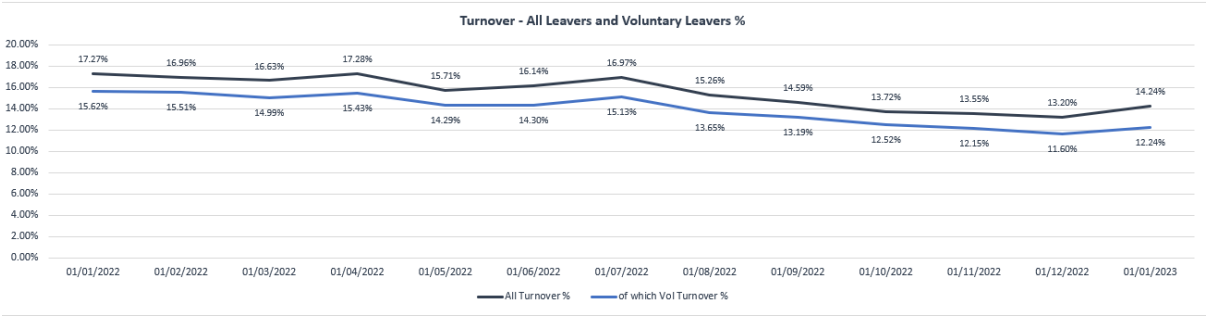


There is good compliance with mandatory training and appraisal.





AHP turnover is around 14%, this will be looked at further within the AHP workforce plan which will start to gather data later in April 2023.



Of the staff that leave, there is no obvious theme within the reasons to leave collected, many leave for the following reasons; highest numbers are retirement, promotion and to undertake further education (this would include AHP Support workers leaving to start degree programmes).

6.3 Safer staffing

There is currently limited national benchmarking standard of AHP specialty and no safer staffing tool, this is made more complex by the diversity of clinical specialisms across all acute and community divisions. Job planning for AHP is in its infancy and has yet to be rolled out for GWH AHP teams.

Limited safer staffing and benchmarking data can make developing consistent staffing models a challenge.

There are mixed funding models and no consistent approach for 7 day working across all professions. The AHP Acute Hospital Alliance have agreed to work on some shared programmes which include consideration of headroom to be applied to the AHP workforce and an objective to deliver standardised 7-day services.

The AHP Leads from the Providers across BSW have been meeting to benchmark AHP staffing and develop core staffing principles and system conversations on our AHP workforce and challenges. This work has been supported through HEE funding into the AHP faculty (which ended on 31st March 2023).

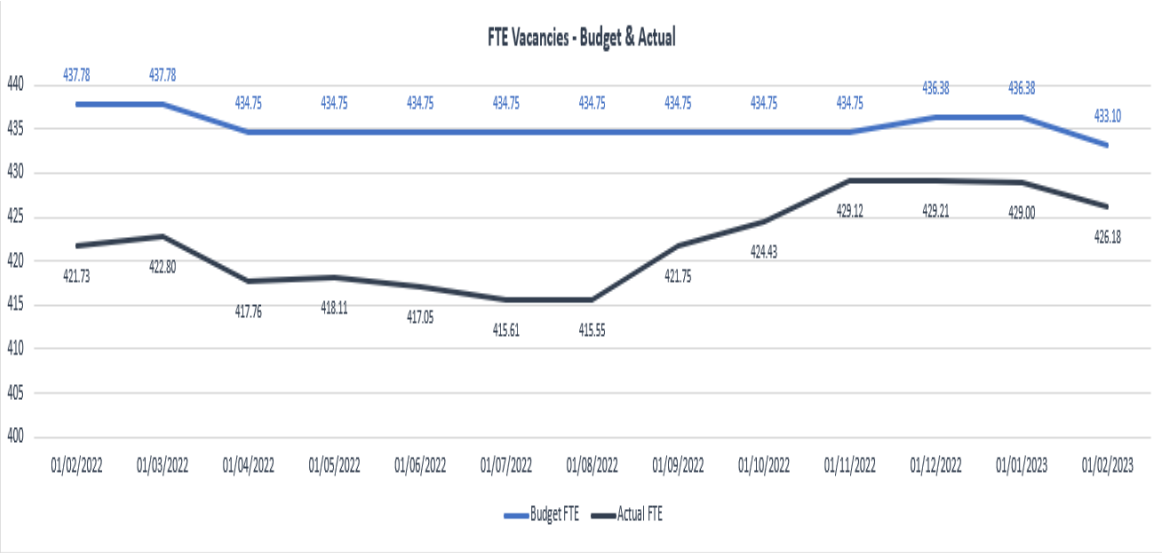
There is currently no funded AHP Professional lead in the Trust, this is something that needs further exploration and benchmarking.

6.4 AHP workforce

Recruitment and retention of the AHP workforce remains a challenge. There have been significant drops in applications to study in many AHP careers over the past few years. Some professions such as podiatry are seen as '*professions at risk'*. This is on the risk register.

The Trust is developing a robust workforce plan for the AHP workforce. This follows a BSW approach to workforce review and analysis of pipelines into the professions.

The graph below demonstrates the AHP vacancies for all professions.



6.5 International Recruitment

Targeted recruitment, supported through HEE funds for Podiatry, Diagnostic Radiography and Occupational Therapy is in place. These posts have been difficult to source as many other trusts are running similar projects.

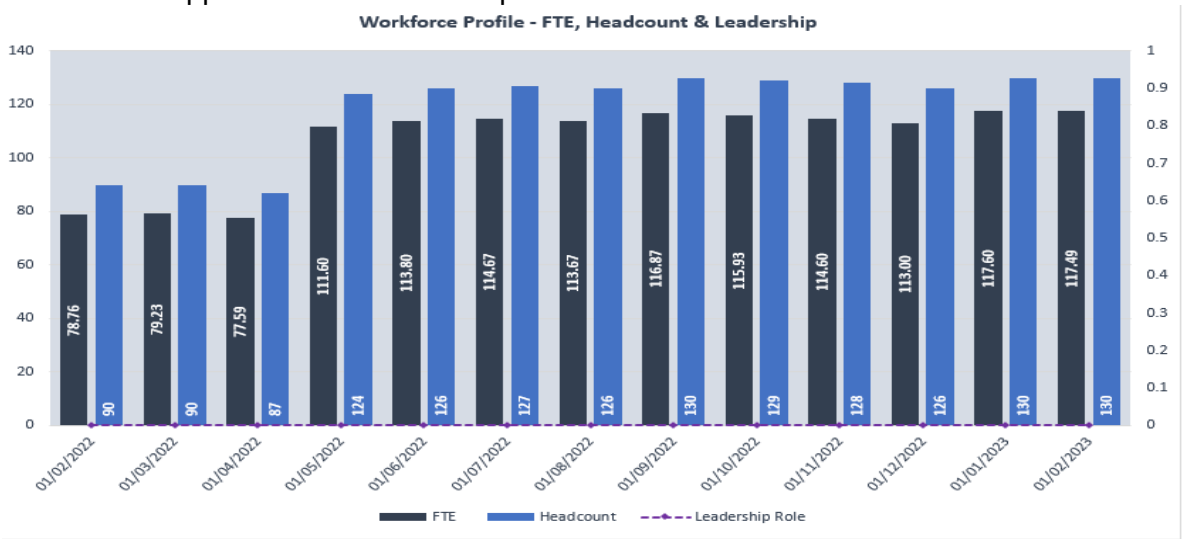
The AHP Education and Development lead is working with the recruitment team, on the international recruitment programme and support for International Recruits when they arrive. In March 2023 there are 16 AHP international recruits with a further 6 in the pipeline.

6.6 Skill mix

There are opportunities to improve the skill mix within AHP, this is shown below in the increase of AHP support worker profiles since 2022.

The AHP support worker framework produced by HEE provides a structure framework to support the development and retention. Work is ongoing to develop career mapping for support workers and the AHP education and Development lead is working on individual career pathways for the AHP professions. Work is ongoing to further develop apprenticeship pathways for AHP and AHP support workers to progress their careers.

GWH AHP Support Worker workforce profile is shown below.



6.7 Advanced clinical practice

There are increasing numbers of AHPs developing into Advanced Clinical Practitioner (ACP) roles. This currently includes AHP colleagues from a physiotherapy/paramedic/podiatry and dietician background.

Embedding ACP with teams helps support the clinical career development and aims to support the recruitment and retention of experienced clinical practitioners. In 2022 37% of those working as ACPs or trainee ACP were AHP's.

7. Trust Risk Register

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

8. Conclusion

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

9. Recommendations

Continue to implement the 1:8 nurse to patient ratio following investment in 2023/24 and report on the benefits realisation with support from the improvement team.

Ensure the SNCT data collection is completed in time to inform this years establishment reviews with the Chief Nurse. Consider benchmarking areas specialist areas using SNCT across the Acute Hospital Alliance.

The Trust should continue to invest in the Internationally Recruited Nurses programme supported to help maintain safe staffing levels.

Retention and reducing turnover in hot spot areas should be a continual focus and driven through the Nursing and Midwifery Workforce Group.

Report Title	**Delegation of Authority for approval of Annual Accounts 2022/23**				
Meeting	**Trust Board**				
Date	**1 June 2023**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

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							
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 Foundation Trust is required to comply with the guidance in the Annual Reporting Manual for Foundation Trusts for 2022-23 and submit a set of audited annual accounts including an Annual Report by the national deadline of 30 June 2023. The process for the completion of Foundation Trust Annual Accounts is set out in the attached summary paper. These are in line with the updated guidance from NHS England for the NHS accounts timetable and year-end arrangements.

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	5 May 2022 - External Auditors w/c 8 May 2022 – Executive Committee 22 May 2022 –Board members				
Next Steps	Approval of Annual Report and Accounts				

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to delegate authority to the Audit, Risk & Assurance Committee to approve the Annual Report & Accounts 2022/23.

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	17 May 2023

Delegation of Authority for approval of Annual Accounts 2022/23

1. The Foundation Trust is required to comply with the guidance in the Annual Reporting Manual for Foundation Trusts for 2022/23 and submit a set of audited annual accounts including an Annual Report by the national deadline of 30 June 2023.

2. The process for the completion of Foundation Trust (FT) Annual Accounts is set out below. These are in line with the updated guidance from NHS England for the NHS accounts timetable and year-end arrangements.

Date	Action
1 June 2023	Trust Board delegates authority to Audit, Risk & Assurance Committee to approve accounts and the Annual Report.
23 June 2023	Audit, Risk & Assurance Committee receives annual report, audited accounts, certificates and audit opinion and approves accounts and annual report
30 June 2023 (12 noon)	NHS FTs submit (electronically) audited accounts, the external auditors ISA 260 report, the external audit opinion on the accounts, and the Annual Report to NHSE.
Date to be confirmed	Laying NHS foundation trust annual report and accounts before Parliament

Conclusion

3. The Trust requires the delegation of authority to approve its Annual Accounts to the Audit, Risk & Assurance Committee in order to ensure the delivery of accounts in line with the national timetable.

Recommendation

4. The Trust Board is asked to approve the request to delegate authority to the Audit, Risk & Assurance Committee to sign-off the Foundation Trust Annual Accounts and Annual Report for 2022/23

Report Title	**Annual Quality Account 2022/23**				
Meeting	**Trust Board**				
Date	**1st June 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Rayna McDonald, Deputy Chief Nurse				
Appendices	n/a				

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

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 Trust is required under the Health & Social Care Acts 2009 & 2012 to produce an annual Quality Account. Changes introduced in the last two years mean.

1. NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. NHS foundation trusts will continue to produce a separate Quality Account for 2022-23.
2. There is no national requirement to obtain external auditor assurance on the Quality Account approval from within the Trust's own governance procedures sufficient.
3. The deadline for uploading the final Quality Report to the Trust's website is 30 June 2023.

In order to meet the deadline, the Board is asked to delegate authority to the Quality and Safety Committee to approve the Quality Report for 2022/23 at its meeting scheduled for 22nd June 2023. The final draft will be presented as a consent item for at the Trust Board in July 2023.

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	
Next Steps	

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to delegate authority to the Quality & Safety Committee to approve the Quality Accounts for 2022/23.

Accountable Lead Signature	
Date	22 May 2023

Great Western Hospitals NHS Foundation Trust

Report Title	**Digital Strategic Plan**				
Meeting	**Trust Board**				
Date	**1st June 2023**	Part 1 (Public) [Added after submission]		Part 2 (Private) [Added after submission]	
Accountable Lead	Naginder Dhanoa, Chief Digital Officer				
Report Author	Jon Burwell, Chief Information Officer				
Appendices	None				

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 presents the Trust's new Digital Strategic Plan which builds on the work undertaken over the last five years of the IT Plan 2017-2022.

The Strategic Plan outlines a clear vision that will be achieved through delivery of a range of programmes summaries under five priority areas: Access & Mobility, Infrastructure & Security, Applications, Use of Information and Digital Literacy, Support & Training. Where appropriate, the Trust will work closely with key partners including Acute Hospital Alliance peers and the wider ICS to reduce duplication, improve the services we deliver and the experience of both our population and staff.

The document provides a summary of how the Strategic Plan responds to the Trust Strategy, with each programme of work seeking to improve four outcomes, these being Quality and Safety, Efficiency and Productivity, Resilience and Business Continuity and User Experience.

In recent years there has been significant investment in IT Infrastructure, reducing the risks associated with ageing equipment, however there is more work to undertake to support our future initiatives. Core to the next phase of improving the Trust's digital maturity is the programme of procurement, implementation, and exploitation of capabilities of a new shared Electronic Patient Record (EPR). This will replace a range of disparate and legacy systems across the Trust. Importantly it will require us to think differently as to how we deliver care to our population, reducing variation and having pathways that maximise the potential of the digital technology available.

There is a clear need to invest in training and education across our digital team, our clinical leadership, wider staff groups, our partners, and our population. By focusing on education and engagement, we will look to create a strong movement towards digital ways of working, aligned with our continuous improvement approach of 'Improving Together'.

Whilst the Strategic Plan covers the years 2023 to 2030, aligning it with the future planned update of the Trust Strategy, the exact programmes from 2027 onwards will heavily depend on the areas that Digital can help transform and potential emerging technologies.

The Strategic Plan highlights the actions to help ensure the expected outcomes and deliverables are achieved. Key risks have been identified, those around funding, staff capacity, engagement and leadership; noting the mitigations highlighted in the Plan.

Finance, Investment and Digital Committee (FIDC) approved the Strategic Plan with the following reflections:

- The Digital Strategic Plan should be reviewed alongside the refresh of the Trust Strategy, ensuring it accurately reflects any agreed future priorities and is in line with the structures of wider enabling strategic plans.
- Given the rapid changes of technology and the need for responding to any emerging risks and changes in national/local priority, it is difficult to undertake detailed planning more than a few years in advance. Therefore it will be important to use the annual business planning process to ensure our digital investment priorities and programs remain relevant.
- Whilst there is a strategic risk relating to a potential lack of funding highlighted, a detailed breakdown of the potential investment needed to achieve the priorities set out within the Strategic Plan has not been provided. An indicative financial plan will be developed over the next three months and refreshed annually as part of annual business planning going forwards.
- The Strategic Plan outlines the importance of strong clinical ownership and leadership. FIDC emphasised this dependency on successful delivery including how we will increase the level and consistency of digital literacy for both staff and our population. There was acknowledgement that we must ensure there remains an option for those people which will also find technology to be a challenge.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X		X	X	X
Key Risks 12 and above Risk number & description (Link to BAF / Risk Register)					**Risk Score**
	382: IT Infrastructure - Aging Equipment - Impact for Patient Care and Service Delivery				12
	487: Cyber Security – Internal Website Risk of cyber attack via unsecure internal web links				12
	496: Cyber Security – Penetration Attack – Internal Risk of cyber-attack due to internal vulnerabilities				12
	497: Cyber Security – Phishing Attack Risk of cyber-attack via phishing emails				12
	626: Deteriorating patient escalation Risk of insufficient risk alerting				12
	630: There is a risk due to the lack of search function on the EDRMS system				12
	792: Inconsistent Wi-Fi and wired network connection within ICU				12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps					

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			X

Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			X
Explanation of above analysis:			

Recommendation / Action Required The Committee is requested to:	
- Approve the Digital Strategic Plan.	
Accountable Lead Signature	Naginder Dhanoa 
Date	24th May 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Digital Strategic Plan

2023 – 2030

Contents

1) Executive Summary

Our Digital Strategic Plan builds on the work undertaken over the last five years of the IT Plan 2017-2022. It recognises that the digital world has moved on significantly since 2017, with new technologies, higher expectations on digital ways of working similar to how someone might live their every-day life. Now, national, regional and local strategies have digital at their heart as a key enabler.

By putting in place a cohesive Digital Strategic Plan with a clear vision, a set of underlying principles and key strategic programmes to achieve the vision and activities to enable successful delivery; we will have the right focus to improve our digital maturity. This will reduce the risk of investment in systems and technology that will not meet future high standards and prioritise emerging technologies where they respond to our four expected outcomes highlighted within this plan.

Our approach to digital aims to support the four outcomes, these being Quality and Safety, Efficiency and Productivity, Resilience and Business Continuity and User Experience.

Although developed to address the digital requirements of the Trust and ensure it enables wider initiatives such as the Way Forward Programme; the Strategic Plan needs to remain aligned to the wider Integrated Care System (ICS) and Acute Hospital Alliance (AHA) strategies and priorities.

This Strategic Plan is not just about IT systems, it responds to the growing requirement for responsive business intelligence and analytics in areas such as predictive modelling. This is a key area where we will work closely with ICS partners to reduce duplication and exploit the collective skills and capacity we have.

We recognise the positive impact that a strong digital offer can have on patient care and user experience. In recent years there has been significant investment in IT Infrastructure, reducing the risks associated with ageing equipment, however there is more work to undertake to support our future initiatives. Core to the next phase of improving the Trust's digital maturity is the programme of procurement, implementation and exploitation of capabilities of a new shared Electronic Patient Record (EPR). This will replace a range of disparate and legacy systems across the Trust. Importantly it will require us to think differently as to how we deliver care to our population, reducing variation and having pathways that maximise the potential of the digital technology available.

There is a clear need to invest in training and education across our digital team, our clinical leadership, wider staff groups, our partners, and our population. By focusing on education and engagement, we will look to create a strong movement towards digital ways of working, aligned with our continuous improvement approach of 'Improving Together'.

On our digital journey, we need to routinely reassess our environment and think not in a siloed approach, but envision a whole-system, population focused approach. We need to recognise that what we do locally at the level of our organisation should be interoperable within our Integrated Care System as well as with our partners across multiple clinical networks.

Naginder Dhanoa, Chief Digital Officer

2) Digital Strategic Plan on a page

Vision & Key Outcomes

Vision

To maximise and expand the improvements available from the use of technology and information, enabling joined up services for our local people across care settings and organisational boundaries, improving people's experience of using our systems.

Outcomes

Our approach to digital aims to help support one or more of the following four outcomes:

- Quality and Safety
- Efficiency and Productivity
- Resilience and Business Continuity
- User Experience

Underlying principles

- User centric design
- Collaboration and Partnership working
- High Data Quality
- Do Once Share Many
- Intelligent use of Information
- Maximising System Functionality
- Emergent Technology Opportunities
- System and Data Security

Key Risks

- Insufficient commitment and capacity across the organisation to own the delivery of the digital agenda and associated benefits
- Insufficient reconciliation and alignment of goals and priorities across ICS partners to deliver collaboration across the digital agenda to achieve potential benefits
- Insufficient funding available to deliver the Digital Plan
- Increased revenue costs associated with movement to cloud based technologies
- Skill set and capacity within IT insufficient to deliver programmes in the Digital Plan
- Insufficient funding and capacity to take opportunities to introduce and maximise potential of emerging technology
- Insufficient capacity within key third party suppliers, leading to potential delays and erosion of benefits
- Insufficient staff capacity and bandwidth to effectively engage with digital transformation

What Success Looks Like

1) Access & Mobility
- Improved speed of application access through appropriate use of Single Sign On and virtual desktop capabilities.
- Resilience, consistent and fast access to applications from any location.
- Staff have access to fit for purpose unified comms solutions with clear guidance on their use.

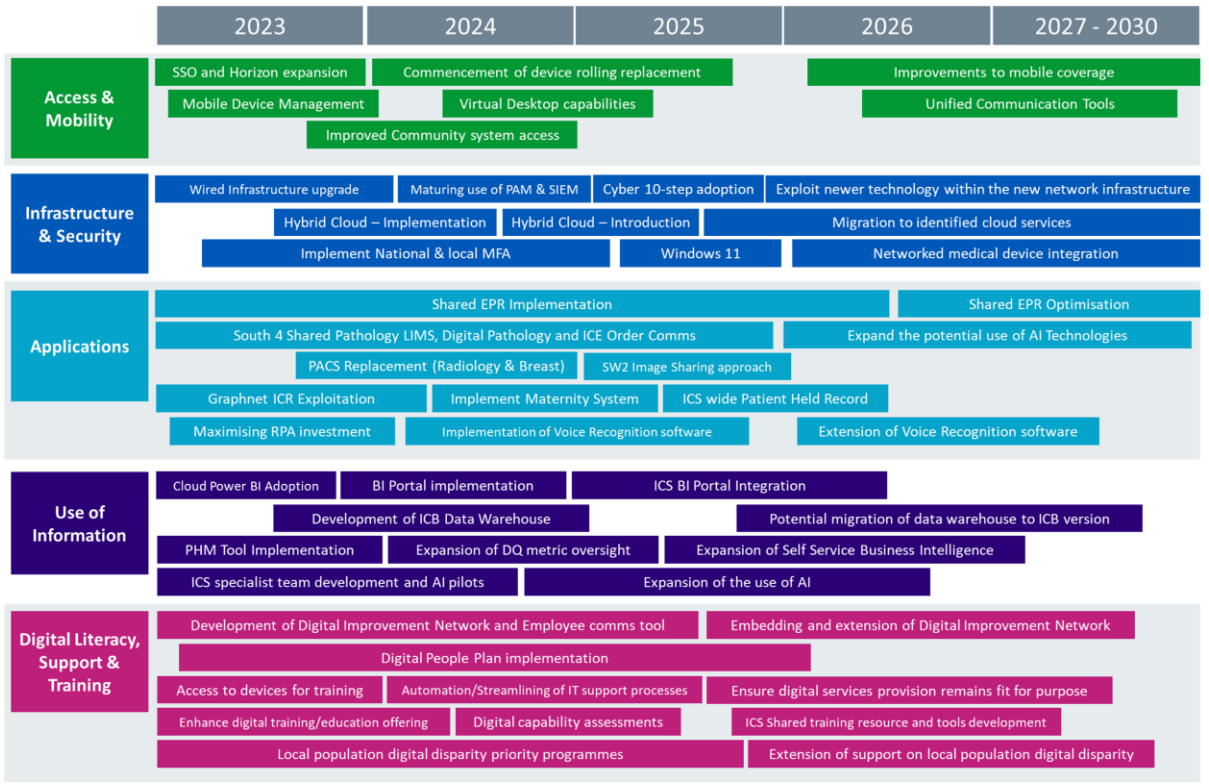
2) Infrastructure & Security
- Upgraded infrastructure that is capable of supporting emerging technologies.
- All devices across the Trusts windows 11 compatible.
- All unsupported technologies removed wherever possible.
- Adoption of the cyber 10-step framework.
- Introduction of Multi-Factor Authentication.

3) Applications
- Implementation of a new Shared EPR, with pathways and workflows optimised in line with EPR capabilities.
- Image sharing available across both clinician networks' peer organisations.
- Maximisation of investments in RPA and AI with clear benefits realisation achieved.
- Achieve a core level of digital maturity (minimum HIMSS Level 5).
- Improvement in User Experience evidenced by improved staff survey results.

4) Use of Information
- Implementation of a single place to find all data for business, information and analysis.
- Divisions have access to expertise on areas such as modelling and predictive analytics.
- Data quality metrics such as ADT timeliness achieves expected performance targets.

5) Digital Literacy, Support & Training
- Our population and staff have the access, training and support to use the systems they require.
- Mature Digital Improvement Network in place across the Trust.
- All staff have completed and passed a basic digital skills competency assessment.

Timeline 2023 - 2030



3) Strategic Alignment and Vision

The Trust Strategy has a vision of 'delivering joined up services for local people at home, in the community and in hospital helping them to lead independent and healthier lives.' The Digital Strategic Plan will enable this vision and its four strategic pillars in a variety of ways, with examples given below:

Outstanding patient care and a focus on quality improvement in all that we do	▪ Implementation of a new Shared EPR, reducing unwarranted variation, increasing a proactive user experience and streamlining pathways across the ICS. ▪ Integration of systems across care settings to enhance the sharing of information, improving clinical decision making an ultimate patient outcomes. ▪ Enable the digital people plan activities to help recruit, upskill and retain staff for the services we deliver. ▪ Providing our population with the tools and support required to improve personal ownership of care close to home.
Staff and volunteers feeling valued and involved in helping improve quality of care for patients	▪ Delivery of a patient portal to improve patient ownership of their care and engagement with clinical teams. ▪ Provide future proofed, modern, safe and resilient infrastructure and equipment devices, supporting staff to effectively undertake their roles. ▪ Implementation of the Digital Improvement Network and development of improved training and education offerings for staff and our population.
Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers	▪ Expansion of the ICS Shared Care Record. ▪ Implementation of image sharing across providers in the ICS and local region. ▪ Introduction of a new Pathology Laboratory Information Management System (LIMS) across the South 4 Pathology Network.
Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care	▪ Development of joint business intelligence approaches including population health management analysis and extension of self service BI. ▪ Introduction of AI where appropriate in areas such as radiology, digital pathology and decision support. ▪ Ensure the Trust is cyber secure to reduce the risk of ransomware attacks.

Any investment in digital technologies is expected to respond to four key outcomes, these being improvements in:

Quality & Safety	Efficiency & Productivity	Resilience & Business Continuity	User Experience

Our Digital Strategic Plan's vision is aimed at delivering the Trust Strategy and vision. Our digital vision is:

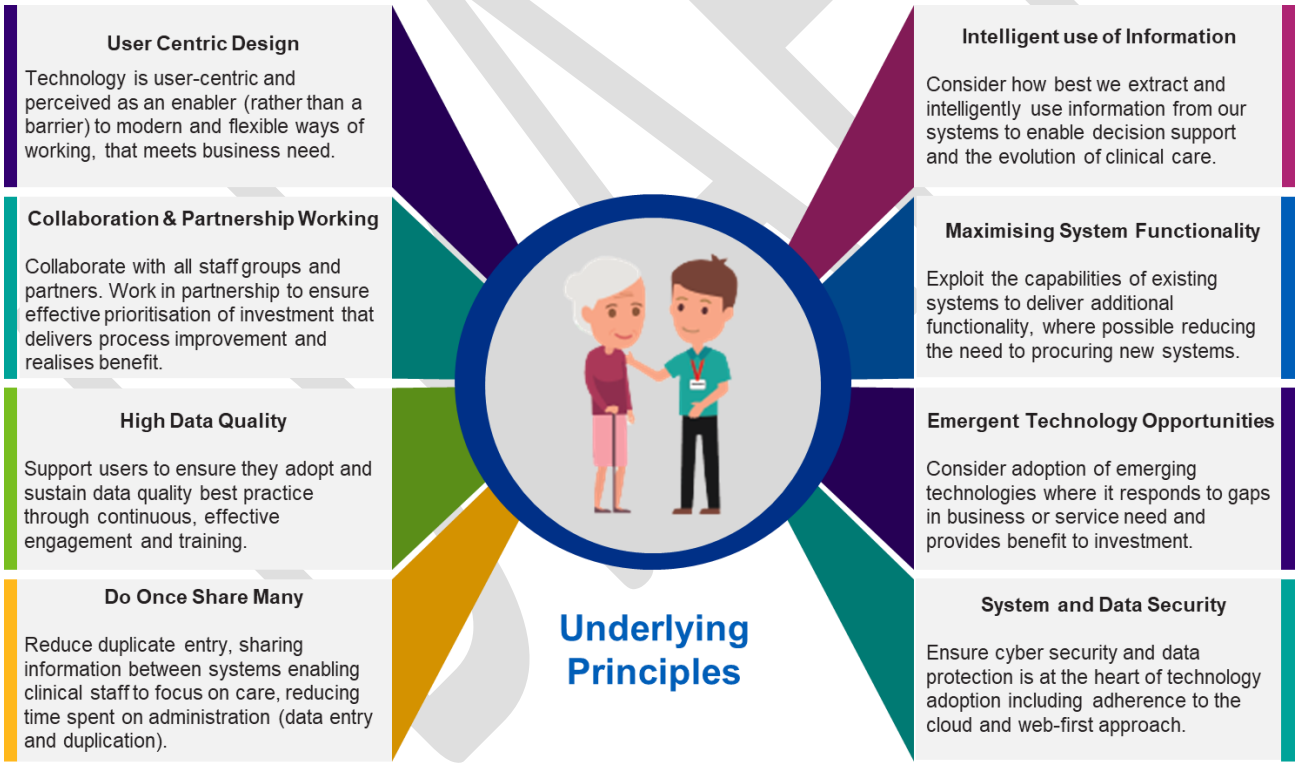
To maximise and expand the improvements available from the use of technology and information, enabling joined up services for our local people across care settings and organisational boundaries, improving people's experience of using our systems.

National and Local Context

Digital will respond to wider national strategies, such as the NHS People Plan to improve the experience of people that work in the NHS and our responsibilities within the Green Plan 2022-26. Progress against initiatives within the Digital Strategic Plan will need to link back to the seven success measures within the 'What Good Looks Like' framework (WGLL) published in August 2021 by NHS England.

4) Digital Underlying Principles

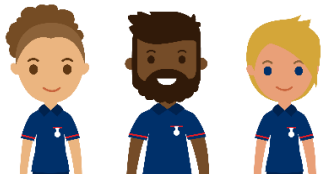
All activities undertaken to deliver the digital vision must comply with eight digital underlying principles. These principles are used to challenge our thinking when developing, implementing, or optimising systems and processes. Adherence to the principles through our work will ensure our systems work together to streamline working practices, we spend money on tools we truly need and that fit into our overall systems plan and everyone understands the importance of timely and high-quality data entry.



5) What will the future look like?

The high-level aspiration of the Digital Strategic Plan is to move the Trust to a position whereby it achieves the national expectations of digital maturity. This translates into providing technology and business information responding to the four key outcomes above. This is what the people we serve tell us that delivering the Digital Strategic Plan will mean to them:

Community Teams



Integration of systems across pathways and care settings will enable me to follow a patient's journey across our services, ensuring I have the relevant information I need about the patient and any carers at my fingertips. This will enable me to assist patients to remain at home being the best they can be and provide continuity of care. My productivity will be improved through being able to update the patient's record in real time and interact with other care professionals using standardised communication tools.

I will be able to give complex nursing and /or therapy interventions safely, either in the patient's home or in a local clinic, utilising alternative technologies such as remote patient monitoring to gain individualised clinical specialist advice which supports the patient's care where appropriate to do so.

Admin and Management

I will have the skills and confidence to use the systems that my role requires. I will have more time to proactively support clinical teams with modern technologies automating and reducing repetitive and manual tasks. I will have access to all correspondence electronically in an easy to use format, enabling me to communicate with patient and clinical queries more quickly. This will help make quicker and more informed decisions.

Nursing/AHPs

I will be able to more effectively care for patients as all relevant information about them will be available in a single system which is available to me anywhere, at any time. The information I record electronically is used by the IT systems to provide me with real time advanced alerting to help reduce risk. I have access to reports and analysis that provide me with insights into areas where the quality of care can be improved, allowing me to track the impact of improvement activities I undertake.

Patients and Carers

Having control of my own health and care records, monitoring my health issues using apps at home and speaking to clinical professions about my care without the need for face-to-face appointments will help me manage my health concerns more effectively. Supporting me to use technology and understand my health information will help me make better decisions about myself.

Doctors

By having access to a comprehensive digital record about my patients including access to information, imaging and results from outside of our organisation boundaries, means I can deliver better, more up-to-date care to my patients on a continuous proactive basis. Having decision support underpinned by proven artificial intelligence advances will make me safer and more effective as a doctor and enable me to support and empower my patients in their own care.

6) Where we are today in developing our Strategic Plan

The Digital Maturity self-Assessment (DMA) undertaken in 2019 identified the Trust as having low digital maturity using the internationally recognised HIMSS EMRAM scoring methodology, the Trust scoring below HIMMS level 2 (HIMSS is scored from level 0 to level 7).

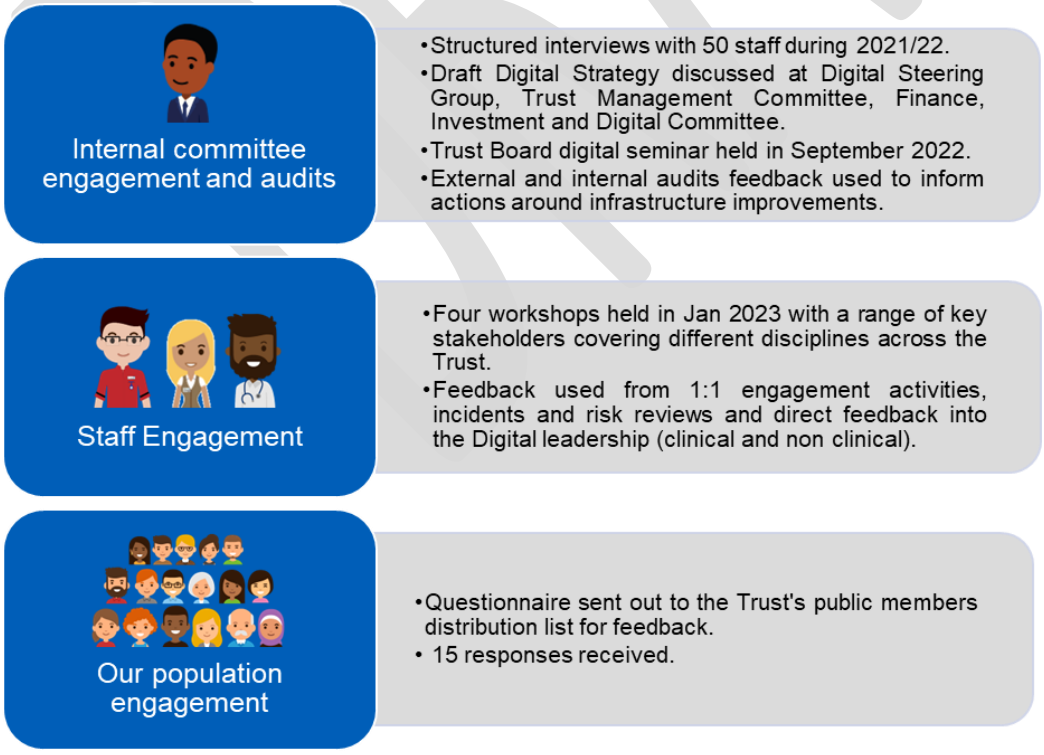
Over the last three years a range of programmes and improvements in digital maturity have been either delivered or have commenced. The significant investment in our underlying technical infrastructure over the last two years provides a resilient platform to build upon in future years. It will provide opportunities to bring in emerging technologies, ensure our shared EPR functions effectively and create a safe and secure environment for people to use their devices.

Whilst good progress has been made, there is recognition our plan needs to go further. Feedback from users of the Trust digital applications and information highlight several key areas where improvement is needed. Examples include numerous separate IT systems which are not fully interacting with one another, variability in the speed and quality of devices in use, multiple system log ins and limited proactive specialist analysis to support decision making.

Wider examples of our progress and areas for improvement can be seen in Appendix 1.

Developing the Strategic Plan

It is vital that the Digital Strategic Plan responds to both areas of weakness and/or poor user experience from both staff and our local population, as well as consider the requirements to enable future innovation and service development. To understand this a series of activities were undertaken to both socialise the emerging Digital Strategic Plan and listen to key stakeholders. These activities are shown below with feedback themes seen in Appendix 2.



7) The Priorities of the Digital Strategic Plan

The expectation is that all Acute Trusts will reach HIMMS level 5 by March 2025 with an aspiration to progress to HIMSS level 7. To achieve this, investment in both a new shared EPR and underpinning infrastructure is required. This will only get us so far, with a fundamental cultural shift required of how our organisation approaches the use of digital as a tool to truly enable and facilitate how we work.

There are five priority areas to support the delivery of the vision.

1) Access & Mobility

Expected deliverables:

- Improved speed of application access through appropriate use of Single Sign On and virtual desktop capabilities.
- Resilient, consistent and fast access to applications from any location.
- Staff have access to fit for purpose unified communications solutions with clear guidance on their use.

2) Infrastructure & Security

Expected deliverables:

- Upgraded infrastructure that is capable of supporting emerging technologies.
- All devices across the Trust are Windows 11 compatible.
- All unsupported technologies removed wherever possible
- Adoption of the cyber 10-step framework.
- Introduction of Multi-Factor Authentication.

3) Applications

Expected deliverables:

- Implementation of a new shared EPR, with pathways and workflows optimised in line with EPR capabilities.
- Image sharing available across both clinician networks' peer organisations.
- Maximisation of investments in RPA and AI with clear benefits realisation achieved
- Achieve a core level of digital maturity (minimum HIMSS Level 5).
- Improvement in User Experience evidenced by improved staff survey results.

4) Use of Information

Expected deliverables:

- Implementation of a single place to find all data for business, information and analysis.
- Divisions have access to expertise on areas such as modelling and predictive analytics.
- Data quality metrics such as ADT timeliness achieves expected performance targets.

5) Digital Literacy, Support & Training

Expected deliverables:

- Our population and staff have the access, training and support to use the systems they require.
- Mature Digital Improvement Network in place across the Trust.
- All staff have completed and passed a basic digital skills competency assessment.

The key programmes to achieve the above priorities are in Appendix 3.

8) Emerging Digital Opportunities

The Digital Strategic Plan looks to introduce a range of new technologies and systems, building on what we have now. However, there will always be solutions not articulated in the Plan that could have the potential of progressing our digital maturity, reducing emerging risks or delivering improvement for our four stated outcomes. We will consider whether it is appropriate to investment in these solutions on a case by case basis, aligned with Trust future strategies and priorities. The table below outlines some areas which we know are evolving but are not currently in our Strategic Plan to give a flavour of potential future considerations:

Theme	Opportunity	How evolved is the market?	Benefits	Capital or Revenue
Infrastructure	Artificial Intelligence and Automation in IT infrastructure	Growing	Prevention of downtime through early prediction and remediation of risks/failures • Increased cyber threat detection • faster deployment of new infrastructure	Capital & Revenue
	Use of drones	Immature	Swift transportation of organ transplants, small medical devices, medicines and vaccines and time sensitive diagnostic samples.	Capital & Revenue
Data and Insights	Artificial Intelligence supported advanced analytics	Growing	Undertake analytics or large datasets, providing insight and predicative analytics • Proactive scenario modeling based on trends/insights through machine learning	Revenue
Clinical Solutions	Secure Clinical Messaging	Growing	Significant time savings • Cessation of legacy bleep systems • Expedited communications enabling earlier discharge • UK GDPR compliance	Revenue
	Virtual Reality	Immature	Improving medical education • Delivering Chronic Pain Management • Supporting mental health therapy	Revenue
Patient Engagement	Remote Patient Monitoring	Growing	Improve quality of care • Timely interventions, reducing cost further down	Revenue
	Digital therapeutics	Immature	Prevent, manage, or treat behaviour-modifiable conditions such as diabetes, obesity and Alzheimer's disease.	Capital & Revenue
Other Areas	Artificial Intelligence use in various services	Growing	Early detection of diseases such as cancer • Augments clinicians in their diagnosis process • Staff productivity • 24/7 productivity	Capital & Revenue
	IoT Wearables	Growing	Accurate diagnoses at the point of care • More data collected for analytics purposes • Timely interventions	Revenue

9) Delivering our Strategic Plan

To realise the priorities and outcomes outlined in the Digital Strategic Plan, there are three main dependencies which the Trust will need to make progress in, some of which have already started. These dependencies are outlined below with some of the key focus areas to achieve success.

There is an overarching need to ensure there is sufficient funding to respond to both the priority areas within the Digital Strategic Plan as well as any emerging investment needs based on changing risk profiles, national NHS policy changes or local partnership working. The digital team plays an active part in annual business planning, with assurance of proposed rolling investment plans through Digital Steering Group to ensure it aligns with the principles in this Digital Strategic Plan. The actions to mitigate the potential lack of funding is picked up in the risk section later in the document.

Engagement and Leadership

The Digital Strategic Plan outlines a range of priorities to help improve the engagement around digital. This is not just about delivering new technologies successfully but about the day to day interactions between the Digital Team and the people they serve.

Actions to include:

a. Ensure there is a voice of all staff groups within the Digital senior leadership team through maintaining and expanding the dedicated clinical resources as necessary.

b. Development and implementation of digital improvement network to identify and upskill digital champions and superusers across the Trust.

c. Wider clinical engagement, where possible using our existing governance structures led by the CCIOs, CNIOs and other digitally focused clinicians.

d. Introduction of a 'service level agreement' and relevant key performance indicators to enable staff to understand what to expect from the digital teams (for example turnaround times for application access requests, new BI dashboards or new device provisioning).

e. Implementation of a digital communication plan, aligned with the three acute Trusts in the AHA, bringing together key programmes such as the shared EPR programme.

f. Leadership across the Trust champion and empowering staff to engage with the key programmes within "Digital Literacy, Support and Training" priority, to improve staff digital capability.

g. Introduction of a patient/carer engagement forum to improve interaction and feedback on programmes that impact their experience and care.

Digital team capability and capacity	It is recognised that the Trust must look at building productive relationships with both NHS and non-NHS partners to help supplement our highly skilled internal capabilities.

Actions to include:

a. Annual training needs analysis will be implemented within the digital team, ensuring there is a clear understanding of skills required to support the future digital agenda, with space and funding provided (often as part of new technology implementation) for staff to undertake the necessary training.

a. Build upon existing and develop key partnerships with third party suppliers in areas where capability or capacity gaps exist including networking, cloud, infrastructure and telephony.

a. The Trust has been working with ICS partners for a number of years, seeking to reduce duplication and co-develop core capabilities. Areas of success include joint procurements, shared cyber lead for the ICS, alignment of documented used in Information Governance and having a single team of experts on SharePoint. The shared EPR programme will see a fundamental review of many digital teams to consider how we should work differently going forward as a joint team for core activities such as EPR configuration and training. Another key area of focus is the alignment and co-design of business intelligence and data warehousing, creating single ICS teams for predictive analytics and modelling to better support our customers.

Strong Governance and Programme Management	The Digital agenda continues to grow and often there are competing requirements and insufficient capacity to deliver everything within the ideal timeframes. Therefore it is imperative that structures and processes are in place to ensure there is robust and realistic planning and management of expectations, aligned to our Improving Together methodologies.

Actions to include:

a. Successful programme delivery and benefits realisation relies on having the right people identified to help support this both in championing and technical delivery. No programme will be commenced without confirmation the resources needed for it to be a success are available at the outset and for the likely lifetime of the programme.

b. The recent changes in digital governance is designed to help improve the oversight and assurance of all aspects of the digital agenda. Digital Steering Group remains the key executive led assurance forum for programme delivery and consideration of how emerging technologies/programs align with this Digital Strategic Plan.

c. Programme and Improving Together governance will be aligned, creating a single entry point for requests for programme and change resources, prioritising these with existing commitments.

10)Strategic risks to delivery

The following have been identified as potential risks to delivery of the Digital Strategic Plan with proposed mitigating actions.

Risk	Rating	Mitigating Actions to be taken
Insufficient reconciliation and alignment of goals and priorities across ICS and AHA partners to deliver collaboration across the digital agenda to achieve potential benefits.	Medium	Engagement on digital through ICS governance by CDO. CDO representation at Board, AHA, ICS and ICB level. Clinical pathway transformation agenda to support prioritisation of digital programmes, digital representation through ICS governance to support discussions. Joint procurements of systems/technology across the ICS. Alignment of strategic priorities between ICS partners.
Insufficient funding available to deliver the Digital Strategic Plan.	High	Plan structured to be as realistic as possible. Bids to be put in for any available external funding where appropriate. Consideration of further funding options should external funding not be available for large programmes. Full Business Case for the EPR Programme to clearly articulate the full resource needs for successful implementation to limit financial "surprises".
Increased revenue costs associated with movement to cloud based technologies.	Medium	Maximise nationally procured cloud-based products (e.g. Microsoft 365). National guidance around use of capital for cloud-based system purchases available (where Trust has a preferred appetite for capital purchase).
Skill set and capacity within IT insufficient to deliver programmes in the Digital Strategic Plan.	Medium	Work to align and/or converge key teams across GWH and SFT. Some restructures will be formed as part of shared EPR procurement. 3rd party partnerships with key suppliers in place for Infrastructure and networking contracts to be reviewed and bolstered where necessary. Upskilling of existing staff through professional development. Where appropriate seek partners to provide managed support. Shared EPR programme developing joint resource plan across the three Trusts (SFT, GWH, RUH) for coming years including seating arrangements to ensure there is an effective approach to resourcing the programme successfully.
Insufficient engagement, commitment and capacity across the organisation to own the delivery of the digital agenda and associated benefits.	High	Agreement from Board, executive team and senior management, including clinical leaders, to champion the use of technology and adhere to consistent message. Improved engagement with staff on digital agenda with revised governance structures to help ensure benefits identified are owned. Clinical ownership needs identified at the outset of all projects to ensure effective change management and benefits realisation.

		Proactive engagement with people in their place of work to better understand concerns, demonstrate benefits, provide training and support uptake of digital technologies.
Insufficient funding and capacity to take opportunities to introduce and maximise potential of emerging technology	Medium	Trust prioritisation process to be finalised for possible future investments from external funding streams and/or potential opportunities of funding for pilots. Proactive horizon scanning to support understanding of emerging technologies and the possible benefits, consider the merits of developing an internal business case for funding.
Insufficient capacity within key third party suppliers, leading to potential delays and erosion of benefits.	Medium	Jointly agree programme plans with suppliers to ensure there are realistic business cases accurately reflecting expected benefits. Ensure contracts are of a sufficient strength to hold third party suppliers to account for delivery within agree timeframes. Strong governance to maintain oversight of programmes and emerging capacity/delivery risks, enabling the development of relevant mitigation plans.
Insufficient staff capacity and bandwidth to effectively engage with digital transformation	Medium	Effective prioritisation of programmes aligned to Improving Together methodologies, helping to maintain a realistic level of transformation activities (both digital and non-digital). Escalation processes through divisional management teams to highlight where different approaches are required to better support staff to interact with digital transformation programmes.

Appendix 1 – Examples of progress to date and areas requiring improvement

Examples of progress made during the last IT Strategy 2017-2022:

• Implementation of an electronic ICU solution	• Implementation of Digital Nursing Handovers and Assessments (e.g. Sepsis, AKI, Smoking & Alcohol, Fluid Balance)
• Extension of the use of Electronic Prescribing & Medicines Administration	• Introduction of Video Consultations for outpatient appointments
• Introduction of new Patient Portal for the delivery of digital correspondence and appointment information, linked to the NHSApp.	• Implementation of a RPA tool with a number of manual processes now automated (specifically within Outpatients)
• Introduction of Patient Flow/Bed Management interactive views from Ward to Board	• Implementation of a decision support tool for Radiology requesting
• Implementation of Medical photography Image capture via Mobile Technology	• Deployment of an Integrated Care Record as part of the ICS shared solution
• Extension of IP Telephony across the organisation	• Extension of digitisation to paper Medical records for Outpatient appointments
• Introduction of shared Wi-Fi networks across Swindon Healthcare locations enabling staff to use the GWH Wi-Fi in more locations	• A complete refresh of the Trust's wireless network infrastructure with the replacement of the wired network underway
• Upgrade to external lines and associated Firewalls and Security products	• Commencement of a Shared EPR Programme to replace the current EPR and disparate systems
• Commencement of a programme to expand the use of Single Sign-on and functionality	• Commencement of Digital Pathology Imaging implementation
• Commencement of a Shared Pathology LIMS implementation across the S4 Network	

Examples of areas requiring improvement include:

• There continues to be over 100 separate IT systems with many not interacting with one another creating risk and duplication of data entry	• There is no single point of access to good business intelligence and reporting to support management of the organisation and decision making.
• The speed of using some applications remains slower than expected, particularly from remote locations at time of high usage	• There is variability around the use of Horizon and the speed/quality of devices across the Acute site
• Limited predictive analytics, population health information and modelling to support decision making	• Users still need to log in to multiple systems to get a view of a patient
• History of rolling out IT systems without sufficient change management to embed pathway/workflow changes ensuring benefits are realised.	• The current maternity IT solution does not meet the requirements laid out in Better Births
• There is some variation across the Trust for access to Trust IT systems, devices and training/education.	• Local population disparity in the ability to use and have access to technologies, equipment and information to support self care

Appendix 2 – Digital Strategic Plan engagement sessions feedback

Feedback Theme	Digital Strategic Plan Response
- Ensure we have a clear order to migrate from paper to digital, looking at the dependency between different workflows - System agnostic in regard to EPR – work towards digital maturity regardless of application in use	The Digital Strategic Plan has been ordered with the aim to ensure that improvement in digital maturity occurs without increasing the risk of unintended creation of paper silos. The shared EPR programme will be the key programme for digitisation with dependencies fully considered in planning. The new shared EPR will be expected to integrate with key systems seamlessly and be agnostic of supplier as per national guidance.
- Ensure the approved digital maternity strategy features in the Digital Strategic Plan	This has been noted in the Digital Strategic Plan with key elements such as moving core IT systems in the plan itself.
- Digital competencies of workforce and maintaining skills - Inclusivity considerations both patient and workforce	Priority 5 – Digital Literacy, Support & Training – responds to these areas.
- System wide considerations with the different clinical networks and interfaces - Information follows the patient regardless - Ensuring there are strong interfaces with Primary, Community and Acute pathways	Priority 3 – Applications – seeks to ensure that integration and the flow of information across care settings is fully considered as part of future procurements and work on key programmes such as the Patient Health Records and Maternity.
- Key programmes that need to be reflected including Single Sign On, Virtual Desktop Infrastructure (VDI), Picture Archiving and Communication System (PACS), Improvement in Electronic Document and Records Management System (EDRMS), Single place for information, Patient Portal, Bi-directional feedback with patients, Remote monitoring	All of these programmes feature in the Digital Strategic Plan. Some programmes are already in progress and actively monitored through programme governance. Others are planned in but subject to the annual prioritisation process as per normal Trust governance arrangements.
- Ensure there is a strong communication plan of the vision, achievements and plans - Ensure programmes have the right resources and testing with end users - Ensure there is a framework of how the Digital Strategic Plan will be delivered - Digital workforce skills to match future demands and technologies	The 'Delivering our Strategic Plan' section outlines intended actions on communication, ensuring appropriate programme resourcing
- Alignment of data and process across the three acute providers - Empower the workforce to make effective decisions	Priority 4 – Use of Information – responds to these areas with the development of Applications (priority 3) also looking to ensure data flows between clinical systems, facilitating intelligent decision support solutions
- Reduce variation and double entry, Ease of use paramount - Consistency of interaction and common platforms	The Digital Strategic Plan's underlying principles are designed to ensure all activities in the digital agenda focus on areas such as reducing variation, duplication and user centric design.
- Ensure there is alignment with the needs of the Trust Strategy so that the plan enables the priorities within this	The Digital Strategic Plan outlines examples of how it responds to the priorities within the Trust Strategy. The plan also outlines the expected thematic outcomes any programme is expected to achieve which mirrors the expectations in the Trust Strategy.

Appendix 3 – Associated programmes for the five priorities

1) Access & Mobility

Objective:
We aim to ensure we provide a good user experience for either our staff, when accessing the technology to undertake their roles, or the people we serve when interacting with our services from any location. By providing reliable and fast access staff will have improved productivity on a day-to-day basis.

Key Programmes

First 2-3 years:

- Extend a consistent GWH identity and authorisation experience to the network and to the cloud using industry leading technology like card or biometric network authentication
- Assessment and remediation of any identified connectivity issues across existing and future planned locations for GWH community services
- Complete roll out of single sign-on solution across the organisation where appropriate.
- Mobile devices using the right software and the right applications
- Complete review of clinical areas to ensure appropriate use of Trust virtual desktops
- Add functionality and security to all GWH-managed devices

Longer term:

- Offer multiple tiers of authenticated access based on staff GWH identity and managed device
- Further exploit pervasive, seamless use of unified communications tools: integrated voicemail, email, text messaging, chat, phones, and video conferencing
- Consider opportunities to broaden 4G/5G mobile device coverage
- Further extend wi-fi integration across partner organisations

Expected deliverables:

- Improved speed of application access through appropriate use of Single Sign On and virtual desktop capabilities
- Resilient, consistent and fast access to applications from any location
- Staff have access to fit for purpose unified communications solutions with clear guidance on their use.

2) Infrastructure & Security

Objective:

Build on our existing infrastructure improvement work and cyber security activities, bolstering resilience, proactively responding to emerging cyber risks and minimising down time; increasing safety and improving the experience of people when they interact with our services supported by our underpinning infrastructure.

Key Programmes

First 2-3 years:

- Complete the programme of work to refurbish the organisation's core IT network infrastructure, laying the firm foundations for improved services.
- Continue migration to cloud-based collaboration tools, integrating new tools for use by the GWH community.
- Continue to consolidate and virtualise computing equipment to realise energy savings and reduce operating expenses.
- Combine data centre and cloud solutions to improve business continuity and resilience
- Put in place controls to improve oversight through internal governance of plans relating to resolve cyber security weaknesses as identified.
- Enable SIEM (Security Information and Event Management) integration in collaboration with BSW to collect & correlate data.
- Further progress with PAM (privileged access management) enforcement for all admin roles across the infrastructure.
- Implement in line with national and regional requirements MFA (multi-factor authentication)
- Conditional Access & device posturing in place to access company resources (Windows, iOS, Web)
- Full adoption of the 10-step framework promoted by the UK National Cyber Security Centre (NCSC).
- Removal of unsupported software, end user devices and servers, including application upgrades/replacement as appropriate.
- Maintain and enhance cyber monitoring tools

Longer term:

- Continue to migrate towards cloud services.
- Adopt and implement emerging technologies where appropriate.
- Continue to integrate medical devices.
- Ensure our cyber security measures go hand-in-hand with physical security and personnel and people security
- Expand on our near-term cyber security control actions with local, regional and national peers, increasing our oversight of emerging cyber risks and providing flexible yet secure access to technology and information.

Expected deliverables:

- Upgraded infrastructure that is capable of supporting emerging technologies
- All devices across the Trust are Windows 11 compatible
- All unsupported technologies removed wherever possible
- Adoption of the cyber 10-step framework
- Introduction of Multi-Factor Authentication

3) Applications

Objective:

To provide modern, fit for purpose applications and other systems that enable our staff to work productively, removing duplicate data entry, reducing clinical risk and having integration across care settings. Empower our population to have access to the tools to manage their own health and access their holistic health and care records cover cross organisation board information.

Key Programmes

First 2-3 years:

- Implementation of a shared EPR solution.
- Implementation of a new shared pathology LIMS and digital pathology across S4 Pathology Partnership.
- Migration to a shared order communications shared solution with S4 Pathology Partnership.
- Undertake the replacement of the Radiology and Breast PACS.
- Align with the image sharing approach agreed with the West of England Imaging Network.
- Expansion of the integrated care record functionality and use across ICS.
- Work with ICS partners to implement an agreed Patient Held Record (PHR).
- Enable additional functionality within the Microsoft 365 offering.
- Maximise the potential of the investment in Robotic Process Automation (RPA) technology.
- Introduction of voice recognition in areas to support the collection of data and reduce administration overhead.
- Continue upgrades of applications to ensure they remain within version support and meet the required standards for security and data returns.
- Implementation of a new maternity system with integration to the future EPR as part of the wider approved digital maternity strategy implementation.
- Improvement in electronic document management software functionality and usability.

Longer term:

- Exploit the full functionality of the shared EPR.
- Realisation of benefits in line with the shared EPR full business case.
- Increased use of patient self-management and monitoring apps.
- Expansion of voice recognition use with shared EPR.
- Consider the appropriate use of AI technologies to complement clinical and non-clinical practices.

Expected deliverables:

- Implementation of a new shared EPR, with pathways and workflows optimised in line with EPR capabilities
- Image sharing available across both clinician networks' peer organisations.
- Maximisation of investments in RPA and AI with clear benefits realisation achieved
- Achieve a core level of digital maturity (minimum HIMSS Level 5)
- Improvement in User Experience evidenced by improved staff survey results

4) Use of Information

Objective:

To ensure timely business information and analytics are available at the fingertips of those who require it; whether in acute, community, managerial, clinical or research settings. To work with partner organisations to increase skills and resilience across the business intelligence function, streamline reporting and data management, reduce duplication and improve data quality. To help staff to analyse performance and activities trends to help drive improvement and reduce inefficiencies.

Key Programmes

First 2-3 years:

- Adoption of cloud Power BI using the national shared tenant in line with ICS partners.
- Co-design Power BI dashboards and value add business intelligence with staff, helping to deliver self-service ways of working.
- Implementation of BI Portal for single access point to business intelligence.
- In conjunction with ICS Partners, lead on the piloting, benefits analysis and introduction of Artificial Intelligence products for data analytics and modelling.
- Adoption of population health management tools analysis tools
- Development of ICS wide virtual teams for specialist areas such as modelling and predictive analytics
- Support the development of an ICB data warehousing solution so that it has the potential of extended across the ICS including the GWH.
- Introduce oversight of data quality as part of performance management framework (for example within executive performance reviews).

Longer term:

- Expansion of self-service business intelligence
- Integration with ICS wide BI portal
- Migration of data warehouse to the ICS warehouse solution should there be sufficient benefits of doing so, in line with ICS BI Strategy.
- Expansion in the use of intelligent automation to improve data quality, real time analysis and decision support.

Expected deliverables:

- Implementation of a single place to find all data for business, information and analysis.
- Divisions have access to expertise on areas such as modelling and predictive analytics.
- Data quality metrics such as ADT timeliness achieves expected performance targets.

5) Digital Literacy, Support & Training

Objective:

Create an environment where staff and people using our systems and data have the necessary training and confidence to effectively use them, having parity of access to equipment and training materials. For people who require an alternative to digital methods, provide a conduit for access to appropriate care and information. Develop a network of likeminded people to help proactively drive and encourage the use of technology.

Key Programmes

First 2-3 years:

- Development of Digital Improvement Network across GWH, linking in with wider ICS peer groups
- Build upon existing core digital learning resources/training programmes, making this available through appropriate mediums.
- In tandem with the shared EPR programme, provide staff with digital capability self-assessments to help inform areas for professional and personal development as part of appraisals and job planning
- In conjunction with ICS peer organisations, implement key priority areas to improve digital disparity in local population, including options where digital is not suitable.
- Improve customer experience of using IT support services through streamlining and automating workflows.
- Work with divisions to ensure staff have appropriate access to devices for education and training, including dedicated time to undertake these activities.
- Digital tools in place to improve methods of communication during incidents and planned works.
- Agree and implement the immediate priorities from the Digital People Plan

Longer term:

- Further evolution and embedding of Digital Improvement Network with digital champions and superusers identified. Alignment with Improving Together ethos and inclusion of local population champions.
- In conjunction with ICS peer organisations, expand the support to our population in the use of technology, maximising the digital interactions with the Trust.
- Ensure the Digital services provision remains fit for purpose, aligned with wider ICS peers to provide the support emerging technology and service models.
- shared training resources and tools across the ICS.
- Continued delivery of priorities of the Digital People Plan.
- Continued evaluation of the potential benefits of introducing emerging digital innovations

Expected deliverables:

- Our population and staff have the access, training and support to use the systems they require
- Mature Digital Improvement Network in place across the Trust
- All staff have completed and passed a basic digital skills competency assessment

Appendix 4 – Glossary of Terms

Term Description	Definition
Way Forward Programme	The Way Forward Programme is a series of site developments with support from £45 million of government funding. The programme will expand and improve services for the growing population of Swindon and Wiltshire. Examples of successful projects include our new Urgent Treatment Centre and Radiotherapy Centre, in partnership with Oxford University Hospitals NHS Foundation Trust.
Improving Together	Improving Together is our approach to continuous improvement, empowering all staff to make improvements in their own area, making a real difference to the experience of patients and the working lives of staff.
BSW AHA	The Bath and North East Somerset, Swindon and Wiltshire (BSW) Acute Hospitals Alliance (AHA) was formed in 2018. It sees hospitals in Bath, Swindon and Salisbury working together, actively looking at opportunities to build on individual and collective strengths to the benefit of our population. The joint projects including joint procurements and the shared EPR programme will ensure our hospitals are organised around what our populations need rather than what we as individual hospitals determine needs to be done.
ICS	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
ICB	An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
Power BI	Power BI is data visualisation software that enables stronger interaction with business intelligence.
HIMSS (EMRAM)	Healthcare Information and Management Systems Society (HIMSS) is a global advisory company who among other areas, specialise in assessing digital maturity. Their Electronic Medical Record Adoption Model (EMRAM) is an outcome driven approach of assessment for healthcare.
ADT	Admission, Discharge and Transfer (ADT)
PHM	Population health management (PHM) brings together health-related data to identify a specific population that health and care systems may then prioritise for particular services.
DQ	Data Quality (DQ)
AI	Artificial intelligence (AI) is intelligence demonstrated by machines, often mimicking the problem-solving and decision-making capabilities of the human mind.
ICU	Intensive Care Unit (ICU) provides critical care and life support for acutely unwell patients.
S4 Pathology Partnership	South 4 (S4) Pathology Partnership covers Buckinghamshire Healthcare, Milton Keynes University Hospital, Oxford University Hospitals, and Great Western Hospitals NHS trusts with the purpose of improving pathology services across the region.

Digital Strategic Plan 2022-30 Overview

Our Vision and Building the Digital Strategic Plan

Great Western Hospitals NHS
NHS Foundation Trust

Our Digital Strategic Plan's vision is aimed at delivering the Trust Strategy and vision. Our digital vision is:

To maximise and expand the improvements available from the use of technology and information, enabling joined up services for our local people across care settings and organisational boundaries, improving people's experience of using our systems.

Engagement undertaken in developing the Strategic Plan:

Internal committee engagement and audits

- Structured interviews with 50 staff during 2021/22.
- Draft Digital Strategy discussed at Digital Steering Group, Trust Management Committee, Finance, Investment and Digital Committee.
- Trust Board digital seminar held in September 2022.
- External and internal audits feedback used to inform actions around infrastructure improvements.

Staff Engagement

- Four workshops held in Jan 2023 with a range of key stakeholders covering different disciplines across the Trust.
- Feedback used from 1:1 engagement activities, incidents and risk reviews and direct feedback into the Digital leadership (clinical and non clinical).

Our population engagement

- Questionnaire sent out to the Trust's public members distribution list for feedback.
- 15 responses received.

Underlying Principles

Great Western Hospitals NHS
NHS Foundation Trust

User Centric Design

Technology is user-centric and perceived as an enabler (rather than a barrier) to modern and flexible ways of working, that meets business need.

Collaboration & Partnership Working

Collaborate with all staff groups and partners. Work in partnership to ensure effective prioritisation of investment that delivers process improvement and realises benefit.

High Data Quality

Support users to ensure they adopt and sustain data quality best practice through continuous, effective engagement and training.

Do Once Share Many

Reduce duplicate entry, sharing information between systems enabling clinical staff to focus on care, reducing time spent on administration (data entry and duplication).

Underlying Principles

Intelligent use of Information

Consider how best we extract and intelligently use information from our systems to enable decision support and the evolution of clinical care.

Maximising System Functionality

Exploit the capabilities of existing systems to deliver additional functionality, where possible reducing the need to procuring new systems.

Emergent Technology Opportunities

Consider adoption of emerging technologies where it responds to gaps in business or service need and provides benefit to investment.

System and Data Security

Ensure cyber security and data protection is at the heart of technology adoption including adherence to the cloud and web-first approach.

National context

- The national strategy has a series of policies and guidance covering aspects such as using the NHS App the front door for NHS services, standardising on good practice activities to empower citizens and using data to inform care planning.
- Some of the key documents are listed below

- In August 2021 NHSX published the 'What Good Looks Like' framework (WGLL). The WGLL programme is intended to build "on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely.
- It describes 7 success factors which the Digital Strategic Plan will help deliver against.

1. Well Led
2. Health Population
3. Ensure Smart Foundations
4. Safe Practice
5. Support People
6. Empower Citizens
7. Improve Care

- HIMSS EMRAM is an internationally recognised scoring methodology for inpatient settings, the Trust scoring below HIMMS level 2 (HIMSS is scored from level 0 to level 7). The national aspiration is for NHS Trusts to achieve HIMSS level 5 by March 2025 – The last assessment in 2019 score the Trust at 1.11.

Overall Programme Approach

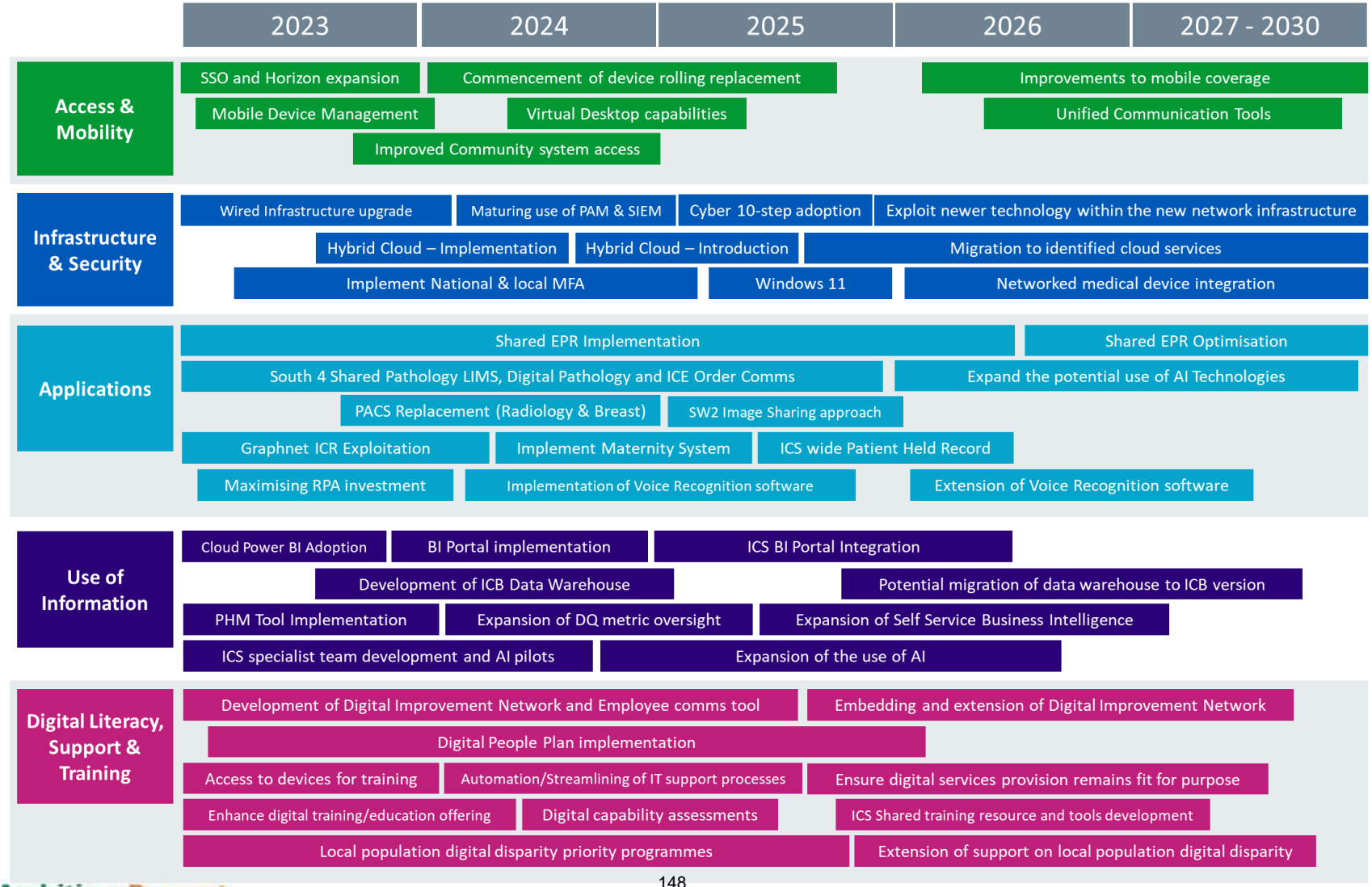
Great Western Hospitals NHS
NHS Foundation Trust

Priority Areas	Key Deliverables
Access & Mobility	• Improved speed of application access through appropriate use of Single Sign On and virtual desktop capabilities. • Resilient, consistent and fast access to applications from any location. • Staff have access to fit for purpose unified communications solutions with clear guidance on their use.
Infrastructure & Security	• Upgraded infrastructure that is capable of supporting emerging technologies. • All devices across the Trust are Windows 11 compatible. • All unsupported technologies removed wherever possible. • Adoption of the cyber 10-step framework. • Introduction of Multi-Factor Authentication.
Applications	• Implementation of a new shared EPR, with pathways and workflows optimised in line with EPR capabilities. • Image sharing available across both clinician networks' peer organisations. • Maximisation of investments in RPA and AI with clear benefits realisation achieved. • Achieve a core level of digital maturity (minimum HIMSS Level 5). • Improvement in User Experience evidenced by improved staff survey results.
Use of Information	• Implementation of a single place to find all data for business, information and analysis. • Divisions have access to expertise on areas such as modelling and predictive analytics. • Data quality metrics such as ADT timeliness achieves expected performance targets.
Digital Literacy, Support & Training	• Our population and staff have the access, training and support to use the systems they require. • Mature Digital Improvement Network in place across the Trust. • All staff have completed and passed a basic digital skills competency assessment.

Outcomes

Roadmap

Great Western Hospitals NHS
NHS Foundation Trust



Emerging Digital Opportunities

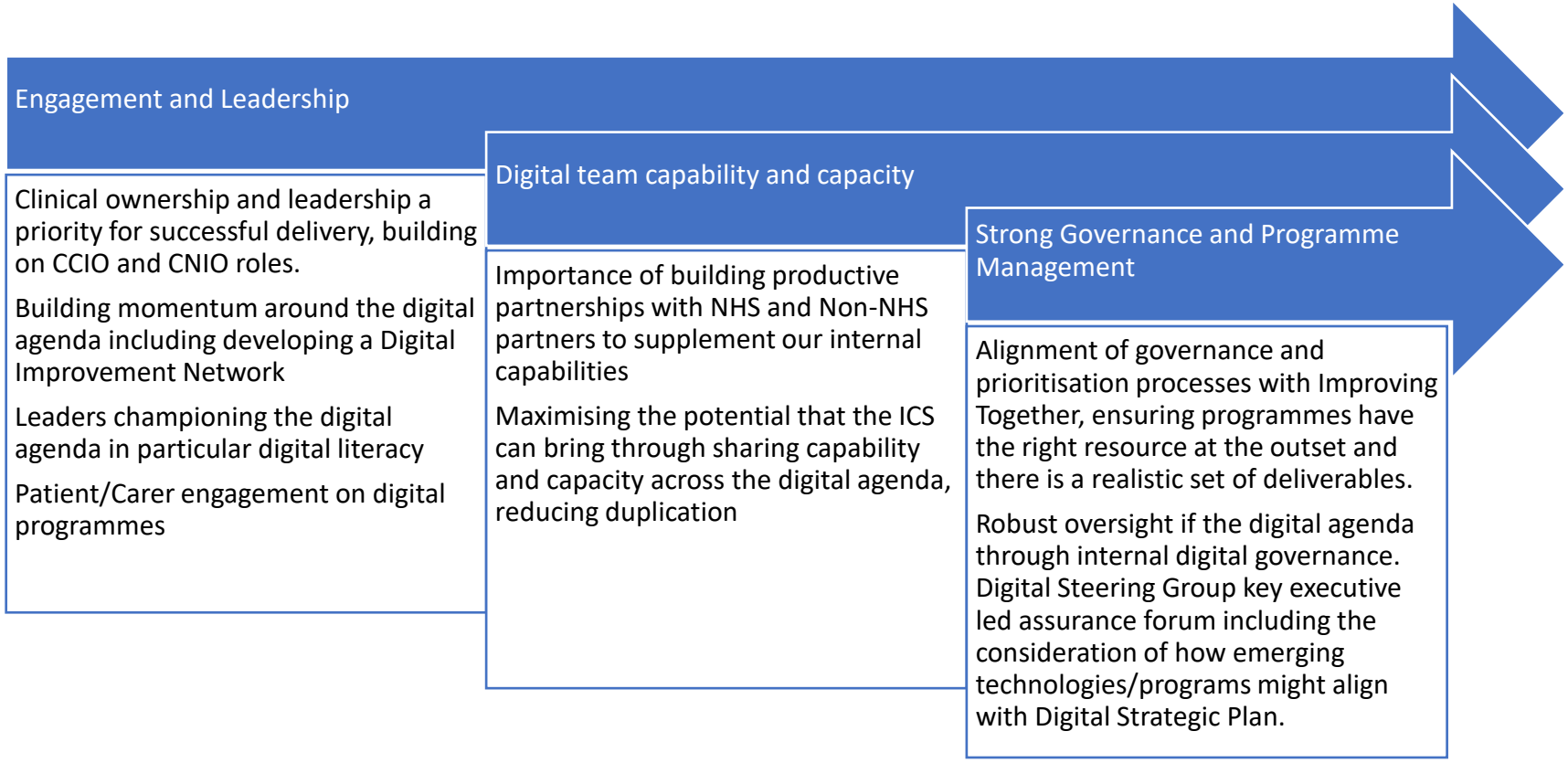
Great Western Hospitals NHS
NHS Foundation Trust

The Digital Strategic Plan looks to introduce a range of new technologies and systems, building on what we have now. However, there will always be solutions not articulated in the Plan that could have the potential of progressing our digital maturity, reducing emerging risks or delivering improvement for our four stated outcomes. We will consider whether it is appropriate to investment in these solutions on a case by case basis, aligned with Trust future strategies and priorities

Theme	Opportunity	How evolved is the market?	Benefits	Capital or Revenue
Infrastructure	Artificial Intelligence and Automation in IT infrastructure	Growing	Prevention of downtime through early prediction and remediation of risks/failures • Increased cyber threat detection • faster deployment of new infrastructure	Capital & Revenue
	Use of drones	Immature	Swift transportation of organ transplants, small medical devices, medicines and vaccines and time sensitive diagnostic samples.	Capital & Revenue
Data and Insights	Artificial Intelligence supported advanced analytics	Growing	Undertake analytics or large datasets, providing insight and predicative analytics • Proactive scenario modeling based on trends/insights through machine learning	Revenue
Clinical Solutions	Secure Clinical Messaging	Growing	Significant time savings • Cessation of legacy bleep systems • Expedited communications enabling earlier discharge • UK GDPR compliance	Revenue
	Virtual Reality	Immature	Improving medical education • Delivering Chronic Pain Management • Supporting mental health therapy	Revenue
Patient Engagement	Remote Patient Monitoring	Growing	Improve quality of care • Timely interventions, reducing cost further down	Revenue
	Digital therapeutics	Immature	Prevent, manage, or treat behaviour-modifiable conditions such as diabetes, obesity and Alzheimer's disease.	Capital & Revenue
Other Areas	Artificial Intelligence use in various services	Growing	Early detection of diseases such as cancer • Augments clinicians in their diagnosis process • Staff productivity • 24/7 productivity	Capital & Revenue
	IoT Wearables	Growing	Accurate diagnoses at the point of care • More data collected for analytics purposes • Timely interventions	Revenue

Delivering the Strategic Plan

Great Western Hospitals NHS
NHS Foundation Trust



Strategic risks

- The following have been identified as potential risks with proposed mitigating actions

Risk	Mitigating Actions
Insufficient funding available to deliver the Digital Strategic Plan.	Plan structured to be as realistic as possible. Bids to be put in for any available external funding where appropriate. Consideration of further funding options should external funding not be available for large programmes. Full Business Case for the EPR Programme to clearly articulate the full resource needs for successful implementation to limit financial "surprises".
Insufficient staff capacity and bandwidth to effectively engage with digital transformation	Effective prioritisation of programmes aligned to Improving Together methodologies to ensure i, helping to maintain a realistic level of transformation activities (both digital and non-digital). Escalation processes through divisional management teams to highlight where different approaches are required to better support staff to interact with digital transformation programmes.
Insufficient engagement, commitment and capacity across the organisation to own the delivery of the digital agenda and associated benefits.	Agreement from Board, executive team and senior management, including clinical leaders, to champion the use of technology and adhere to consistent message. Improved engagement with staff on digital agenda with revised governance structures to help ensure benefits identified are owned. Clinical ownership needs identified at the outset of all projects to ensure effective change management and benefits realisation. Proactive engagement with people in their place of work to better understand concerns, demonstrate benefits, provide training and support uptake of digital technologies.
Insufficient reconciliation and alignment of goals and priorities across ICS and AHA partners to deliver collaboration across the digital agenda to achieve potential benefits.	Engagement on digital through ICS governance by CDO. CDO representation at Board, AHA, ICS and ICB level. Clinical pathway transformation agenda to support prioritisation of digital programmes, digital representation through ICS governance to support discussions. Joint procurements of systems/technology across the ICS. Alignment of strategic priorities between ICS partners.
Insufficient funding and capacity to take opportunities to introduce and maximise potential of emerging technology	Trust prioritisation process to be finalised for possible future investments from external funding streams and/or potential opportunities of funding for pilots. Proactive horizon scanning to support understanding of emerging technologies and the possible benefits, consider the merits of developing an internal business case for funding.

Report Title	**Research & Innovation Annual Report**				
Meeting	**Board of Directors**				
Date	**1 June 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Jon Westbrook				
Report Author	Dr Donna Noonan Dr Badri Chandrasekaran				
Appendices	Appendix 1: departmental organogram				

Purpose							
Approve		**Receive**		**Note**	Y	**Assurance**	Y
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):							
Research & Innovation Performance							
Significant	Y	**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

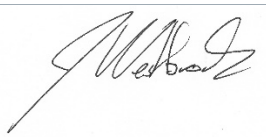
Executive Summary – Key messages / issues of the report (inc. threats and opportunities / resource implications):

- Reduction in participant recruitment to non-commercial research relative to 2021/22, reflecting national pressures on research as the NHS recovers from the Covid-19 pandemic.
- A slight increase in the number of patients recruited to commercial research.
- Continued growth in the volume of patient appointments taking place for research.
- The Brighter Futures Charity has invested in research, to allow for pump-priming locally developed research ideas.
- Numerous opportunities are identified for developing research capabilities in 2023/24.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
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**		
Explanation of above analysis: Research aims to provide improvements to care accessible to all. R&I have recently received funding from the NIHR CRN to ensure research visibility and accessibility for communities currently underserved within Swindon.			

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪	
Accountable Lead Signature	
Date	11-4-23

1. Introduction

1.1. Research in the NHS

Research and Innovation are integral parts of the NHS constitution and key enablers in driving improvements in clinical care. This was highlighted by the central role that research played in the COVID-19 pandemic.

Clinical research has the potential to transform lives, and Trusts that are more research active have been shown to provide a better care experience and deliver improved outcomes for patients.

Research also helps to build organisational reputation, attract investment, and makes it easier to recruit and retain staff. The Care Quality Commission now recognises research as a key activity in a 'Well Led' NHS Trust and indicators for research are embedded in its Well Led Inspection Framework (Trusts).

A policy paper *'The future of UK clinical research delivery'* was issued by the Department of Health & Social Care on 23 March 2021. This details the vision of the government to unleash the full potential of clinical research delivery to tackle health inequalities, bolster economic recovery and to improve the lives of people across the UK. In June 2021, The National Institute for Health Research (NIHR) also set out forward-looking areas of strategic focus to enable research to become practically and meaningfully embedded as part of the experience of patients and service users, regardless of where they live or whether the health and social care professionals who care for them are traditionally 'research active'.

It is therefore essential that research becomes part of the standard care we deliver at Great Western Hospital NHS Foundation Trust. The last few years has seen research become part of the Trust Board's vision, and 2022/23 has seen the Trust approve the establishment of a formally constituted Research Group of the Patient Quality Sub-Committee. The purpose of this group is to create ambition for research as part of core business, as well as to oversee, coordinate, and guide the strategic direction of research at GWH. This group is due to convene for the first of its quarterly meetings in Q1 of 2023/24.

The successful performance of the Trust in COVID-19 studies was a key driver in reviewing the presence of research within the Trust by demonstrating the financial and prospective health benefits for Great Western Hospital of being able to deliver a strong and varied research portfolio.

However, as the UK has emerged from the COVID-19 pandemic, clinical research delivery nationwide has faced unprecedented challenges, resulting in a substantial reduction in the number of studies able to recruit effectively and on time. This is due to continued pressure in the NHS from workload/workforce issues, elective backlogs, and the need to complete existing COVID-19 urgent public health research. These challenges are reflected in research performance

at Great Western Hospital, where we have seen a general reduction in clinical research activity in 2022/23, as outlined in Section 2 of this report. Despite this however, 2022/23 has been seen an increase in the number of patients recruited to commercial research and a continued growth in the number of research appointments taking place.

Since 2020, a national focus for the Department of Health and Social Care (DHSC) has been on clinical research recovery, resilience and growth. Work is also underway nationally to revitalise the NHS research portfolio and to free up capacity in the research system by reducing the number of non-viable studies. It is hoped that this will help to ensure clinical research delivery is achievable and sustainable as we move forward in recovering from the pandemic.

In 2022/23, GWH was awarded over £87,000 of NIHR funding aimed specifically at sustaining and developing research capabilities at the Trust, which was invested in pump-priming our non-COVID research portfolio as we emerge from the pandemic, and raising awareness of research across the organisation (see Section 2.4). Further such funding is also confirmed for 2023/24 to enable continued re-growth of our local research portfolio.

1.2. National Institute for Health Research

The National Institute for Health Research (NIHR) is funded through the Department of Health to improve the health and wealth of the nation through research. It is a large, multi–faceted and nationally distributed organisation.

The Health and Social Care Act 2012 places a statutory duty to promote research. The powers to support it fall upon on the Secretary of state and on all levels of the NHS, including the NHS commissioning Board and Clinical Commissioning Groups. The NIHR provides a key means through which the Secretary of State discharges this duty. The NIHR plays a key role in the Government strategy for economic growth, attracting investment by the life-sciences industries through its world-class infrastructure for health research.

The NIHR Clinical Research Network (NIHR CRN) is the clinical research delivery arm of the NHS in England, tasked with supporting the rapid set-up and effective conduct of studies, so that researchers can gather the robust evidence needed to improve treatments for NHS patients.

The NIHR Clinical Research Network is led by a national Co-ordinating Centre, and operates through 15 Local clinical Research Networks (LCRNs) that drive clinical research delivery performance.

The Great Western Hospitals NHS Foundation Trust forms part of the West of England Local Clinical Research Network (WoE LCRN).

1.3.Research & Innovation Department, Great Western Hospital

Research & Innovation is a dedicated, centrally managed research management & delivery team. The department funds 19.32 FTE who support activity across a wide and varied research portfolio and clinical departments. This includes financial support for 1.48 FTE Pharmacy and 0.8FTE Pathology staff members. R&I also fund 0.5 SPA for the Deputy Director of Research & Innovation. See Appendix 1 for organisational chart.

In 2022/23, there were 60 active Principal Investigators at GWH, and a multitude of other research-active staff, including nurses, midwives and allied healthcare professionals who contribute to the delivery of research at the Trust.

2. Research Activity[1]

2.1. Recruitment

During 2022/2023 GWH recruited a total of 638 participants to 51 studies (see Table 1). Recruitment by Specialty to both non-commercial and commercial research is shown in Figures 1 and 2. While the number of patients recruited to non-commercial research has fallen, 2022/23 has seen a slight increase in recruitment to commercial research.

Table 1: Recruitment numbers to commercial and non-commercial trials

Year	Number of Commercial Studies	Commercial Recruits	Number of Non-Commercial Studies	Non-commercial Recruits	Total Recruitment
2022-2023	7	38	44	600	**638**
2021-2022	6	21	46	1,225	**1,246**
2020-2021	4	16	38	1,817	**1,833**
2019-2020	4	13	41	1,082	**1,095**
2018-2019	9	25	51	1,602	**1,627**

[1] 2022/23 recruitment figures are subject to upwards change as the final verified end of year data is not available from NHIR until the end of April.

Figure 1: The number of non-commercial recruits by NIHR specialty

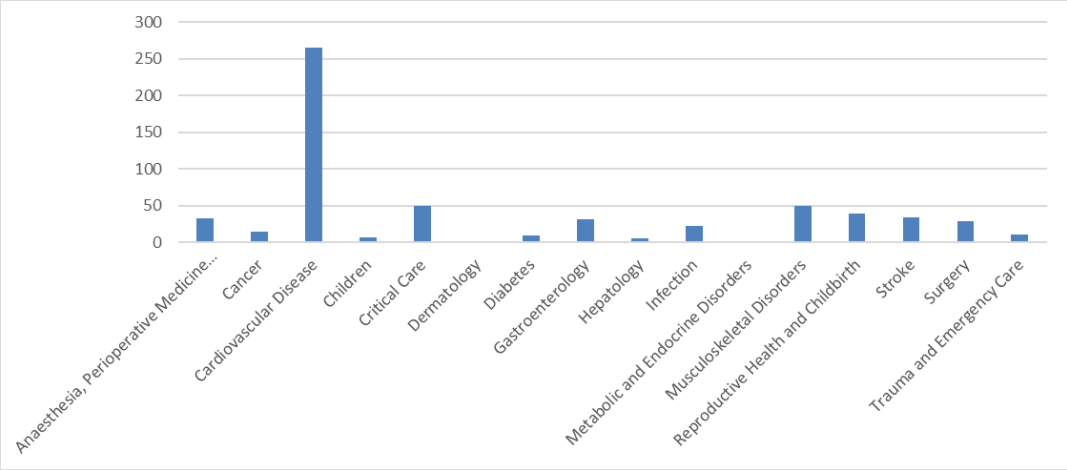
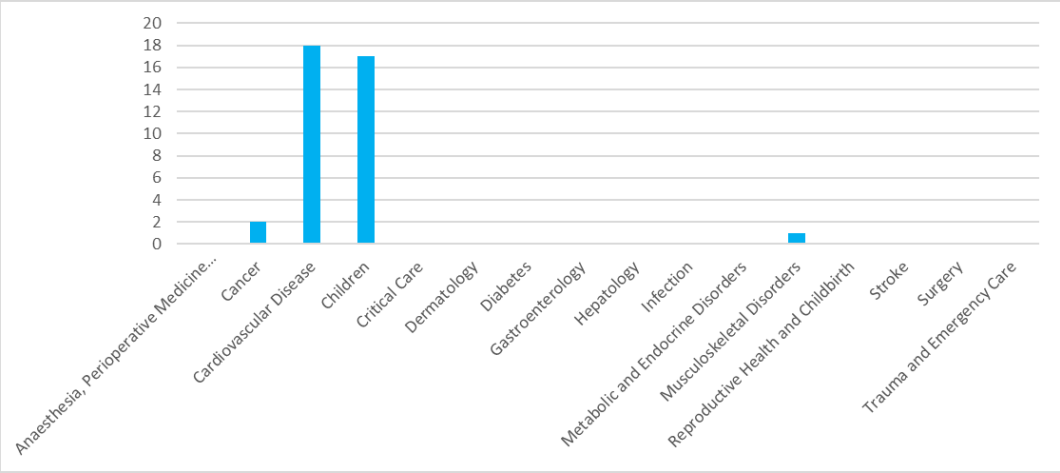


Figure 2: The number of commercial recruits by NIHR specialty

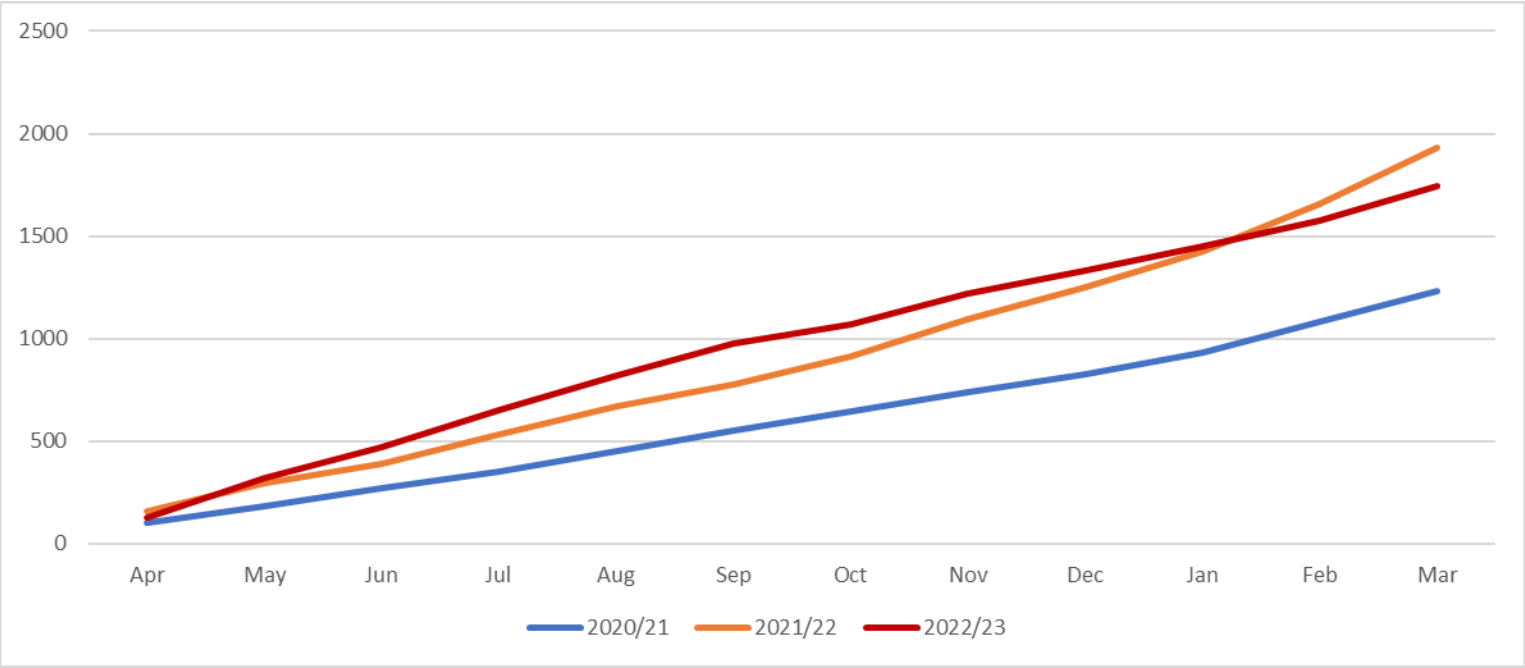


2.2. Follow-up

Once a participant is recruited into a research study, research protocols often require ongoing treatment, follow-up, and data collection. In 2022/23, a total of 88 research studies required participant follow-up, and Research & Innovation carried out 1,745 research appointments, both face-to-face and virtual. Figure 3 displays the cumulative number of research appointments that have taken place over the last 3 business years.

Figure 3: The cumulative volume of patient research appointments (of all types) for the last 3 financial years.

Please note that the figure for 2021/22 excludes data from one large COVID-19 study involving a high volume of NHS staff appointments, which otherwise distorts the figures.



2.3. Patient Satisfaction

Each year, Research & Innovation takes part in the NIHR's Participant in Research Experience Survey (PRES) which aims to put participant experience at the heart of research delivery - helping to improve the way research studies are designed and delivered. The survey this year ran from August 2022 to March 2023. In 2022/23 the number of NIHR Portfolio study participants responding to the PRES was an NIHR High Level Objective. GWH achieved the highest proportional response rate (23.3%) of all Trusts in the West of England region.

Final verified response data is not published until next financial year, but provisional data indicates that 94% of patients who have taken part in research at GWH would consider doing so again.

2.4. Sponsored Research

NIHR research capability funding (RCF) is allocated to NHS organisations that undertake NIHR research, to help them maintain research capacity and capability. GWH meet the criteria to receive an RCF allocation of £20,000 (see Section 3 for more detail).

A permitted use of RCF includes salary costs associated with preparing grant applications. The sum of RCF awarded is proportional to the total amount of other NIHR income received by that organisation. Therefore, in 2022/23 we have strategically invested this resource in building capabilities to successfully support the development of successful NIHR research grant funding applications, which in turn will enhance our RCF allocation.

Specifically, we have brought in an expert advisor from a regional partner NHS organisation which hosts a multi-million research grant portfolio develop plans for how GWH can achieve success at gaining NIHR grant funding. A recently appointed a Research Manager at GWH will take forward these plans as we move into 2023/24.

Key to achieving successful research grant funding is enabling researchers to undertake pilot work and to develop robust applications. In 2022/23 we applied to the GWH Brighter Futures Charity for funding to invest in pump-priming quality research proposals. A £20,000 award from the Charity has recently been confirmed, and in 2023/24 R&I will therefore launch a process for allocating this award in order to support aspiring researchers at GWH.

2.5 Research Impact

The examples below highlight the impact this research taking place at GWH has on patient outcomes. This demonstrates the valuable role our hospital, staff and patients play in helping to improve health and social care.

GenOMICC

GenOMICC has been open to recruitment at GWH since April 2020 and has recruited 74 participants at time of writing. This research study aims to engage and unite clinicians and scientists from all over the world to understand the genetic factors that determine susceptibility to and outcome from critical illness. The study has had significant impact in the care of critically ill patients, for example:

- discovered the TYK2 association with critical Covid-19 that led directly to a new effective drug treatment, baricitinib. This is the first time that host genetics has led to a new drug treatment for infectious disease or critical illness
- discovered a total of 49 genetic variants associated with Covid19, some of which may have broad implications for ARDS and other types of viral pneumonitis.
- recruited over 20,000 critically ill patients, with many ICUs consistently recruiting >50% of eligible cases

EMPA-KIDNEY

This research study recruited 6,609 participants in eight countries, half of whom were assigned a 10mg daily dose of empagliflozin and half who were assigned a placebo. The study was open to recruitment at GWH between March 2020 and April 2021 and is now in follow-up. We recruited our full allocated cohort and also participated in an MRI sub-study.

The research has found that empagliflozin reduced the risk of the primary outcome of kidney disease progression or cardiovascular death by 28%. These results are important because slowing down loss of kidney function in those with chronic kidney disease progression and avoiding the need for dialysis or a kidney transplant is highly desirable due to the adverse effects on quality of life, and the increased risk of cardiovascular disease. Those involved in the care of kidney disease, heart disease and diabetes now look forward to the changes to clinical practice that are expected from this important research finding.

IRONMAN

This study was looking at patients with heart failure, reduced left ventricular ejection fraction and iron deficiency anaemia. GWH were one of the top UK recruiting sites, with 103 patients recruited GWH between September 2016 and September 2021. Patients were randomly assigned to receive intravenous ferric derisomaltose or usual care.

The study has found that for a broad range of patients with heart failure, reduced left ventricular ejection fraction and iron deficiency, intravenous ferric derisomaltose administration was associated with a lower risk of hospital admissions for heart failure and cardiovascular death, further supporting the benefit of iron repletion in this population. European Society of Cardiology guidelines suggest consideration of intravenous ferric carboxymaltose for symptomatic patients with recent hospital admission for heart failure to reduce further heart failure admissions, with data from IRONMAN providing further evidence to support the use of intravenous iron in these patients.

3. Finance

3.1. Funding Streams

Research Income is multifaceted. Table 2 highlights the various income streams received in 2022/23, as well as the amount of each income stream subsequently allocated within GWH.

Table 2: Income streams received by GWH R&I, showing percentage of each income stream allocated within GWH.

Income Stream	Description	GWH Income 2022/23	Allocated within GWH 2022/23 *(% of funding stream)*	Comments
Core NIHR CRN Budget	Annual NIHR CRN budget that is subject to change each year.	£570,373.00	£43,560.76 *(7.6%)*	Core NIHR CRN budget includes a fixed overhead. This fixed overhead was allocated to Trust overheads.
			£111,754.43 *(19.6%)*	The pay element of the Core NIHR CRN budget funded 3 embedded posts within Support Services (2.28 FTE), aimed at enhancing capacity to support research. This funding is transferred to the relevant Division as a recurrent salary cost.
NIHR CRN development/contingency awards	NIHR CRN funding that is awarded competitively to develop and maintain research capabilities.	£93,234.50	£5,470.62 *(5.9%)*	Development awards include a fixed overhead. This fixed overhead was allocated to Trust overheads.
			£23,306.75 *(25%)*	The pay element of NIHR CRN development/contingency awards provided funding to enhance research capabilities within Divisions.
NIHR CRN Specialty Leads	NIHR CRN Gastroenterology Specialty Lead based at GWH.	£6,803.28	£6,803.28 *(100%)*	Transferred to the Specialty Lead's Division as a recurrent salary cost.
Other NIHR CRN funding awards	Other non-recurrent funding received via the NIHR CRN.	£5,027.00	£0.00 *(0%)*	Funding for additional support for vaccine trials, utilised within R&I.
Non-commercial research costs	The costs of research activity charged to non-commercial sponsors.	£85,749.74	£457.50 *(0.5%)*	Costs payable to departments outside R&I were transferred to relevant department.
Commercial costs (including overheads/capacity build uplift)	The costs of research activity charged to commercial sponsors. Includes a 90% overhead on all pay costs (20% on investigation costs).	£161,252.01	£11,842.25 *(7.3%)*	A proportion of the overheads on all costs was allocated to Trust overheads.
			£3,518.45 *(2.2%)*	Costs payable to Pharmacy were transferred to the Pharmacy department.
			£21,081.44 *(13.1%)*	Costs payable to departments outside R&I were transferred to relevant department.
			£19,308.87 (12%)	Available for strategic reinvestment by research investigators
			£1,261.48 *(0.8%)*	Available for strategic reinvestment by Pharmacy
Research Capability Funding	The sum of RCF awarded is proportional to the total	£20,000	£0.00 *(0%)*	Utilised by R&I to maintain and develop research capacity and capability

	amount of other NIHR income received by that organisation			
Excess Treatment Costs	GWH only receive funding where excess treatment costs incurred surpass a local threshold, which in 2022/23 was £3,175 As of Q3 2022/23, no funding has been received. Q4 data is yet to be released.	TBC	TBC	Where funding for excess treatment costs is received, this will be transferred to Divisions.
TOTAL		**£942,439.53**	**248,365.83** ***(26.4%)***	

3.2. R&I Expenditure

Table 3 displays expenditure incurred by R&I. Please note that the pay costs outlined in this Table include the salary costs for embedded posts and Specialty Lead position that are explained in Table 2, above.

Table 3: 2022/23 Income and Expenditure*

Expenditure: Pay	£743,113.86
Expenditure: Non-Pay	£21,881.25
Deferred Income**	£685,343

** M12 accounts not finalised at time of writing. Expenditure based on projections from M11.*

*** This deferred income consists funding carried forward from previous years to invest in the development of future research capabilities within the Trust. Of this, £51,012.87 was generated via commercial research and is ring-fenced for strategic use by research investigators/pharmacy.*

3.3. Treatment cost savings

In addition to the visible income from Research there is an added benefit of treatment cost savings, where standard care may be replaced by experimental study interventions (saving NHS spend), or where the standard care therapy is funded by Sponsors in addition to provision of the experimental arm.

For example, Table 4 shows pharmacy cost savings related to research. There has been a significant decline in cost savings in recent years. Whilst we await delivery of the upcoming Pharmacy Manufacturing Unit (PMU), we haven't been able to run chemotherapy studies where the highest savings are possible. However, we plan to invest in developing the oncology research portfolio throughout 2023/24 in order to build capacity and capability to deliver these trials once the PMU is operational.

Table 4: Pharmacy treatment cost savings

Year	Annual Saving
2017/18	£11,936
2018/19	£13,581
2019/20	£3,569
2020/21	£1,696
2021/22	£1,283
2022/23	£1,289

4. Financial Year 2023/24

4.1 Opportunities

Research Integration	The Trust have refreshed the Sub-Committee Structure and a Trust Research Group will now routinely report into the Patient Quality Sub-Committee. The purpose of this Group is to create ambition for research as part of core business, as well as to oversee, coordinate, and guide the strategic direction of research at GWH.
Physical Resources	Space has been identified within GWH, providing the R&I department with clinical resource to support research delivery. A bid for capital funding has been submitted to the NIHR to meet the costs of refurbishment of part of this space.
Research Awareness	R&I are currently exploring opportunities to enhance awareness with all stakeholders that GWH is a research active Trust.
Life Sciences Industry	The NIHR are driving forward initiatives to support the life-sciences industry, which enhances opportunity for GWH to contribute to bringing healthcare innovations to the market. This also provides opportunity for GWH to generate additional commercial income to reinvest strategically in research.
Oncology Research	The upcoming Pharmacy Manufacturing Unit (PMU) provides opportunity to develop the existing GWH portfolio of oncology research. An NIHR CRN development bid has been awarded for 2023/24 to provide dedicated research resource for oncology trials, and a bid for capital funding has been submitted to the NIHR to obtain equipment that will support chemotherapy research, and a
Pump Priming Research	A £20,000 award from the Brighter Futures Charity will allow GWH to invest in enabling aspiring researchers to develop research projects, and to support them in submitting for additional funding to implement these projects.

Supporting New Portfolios	An NIHR CRN development bid has been awarded for 2023/24 to provide dedicated research resource for Audiology/ENT trials, allowing GWH to support research in previously underserved areas.
System-wide Working	A development bid has been awarded from the NIHR CRN to provide capacity to work regionally with Primary Care and other regional stakeholders to enhance research opportunities for Swindon communities currently underserved by research.

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4.2 Objectives

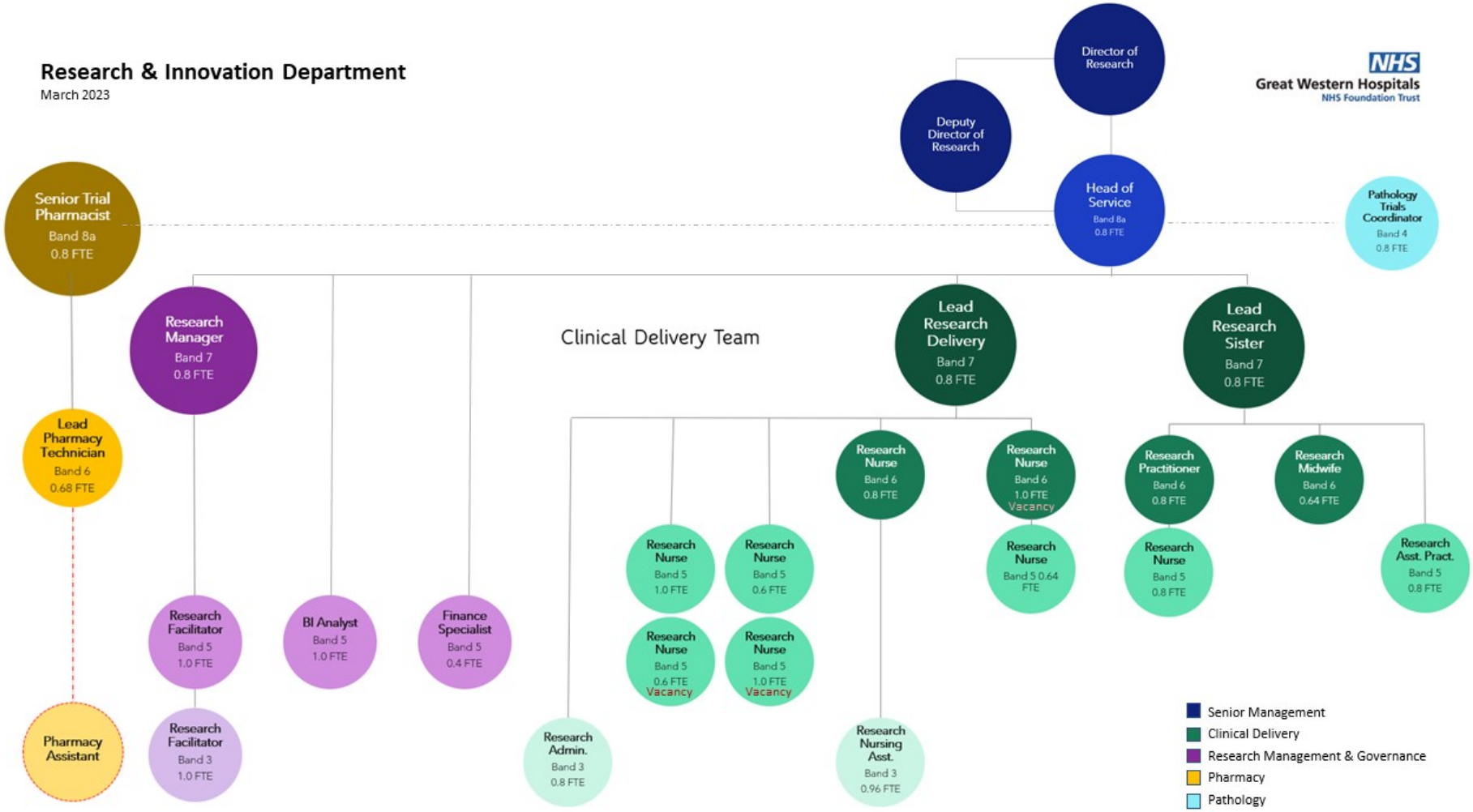
Strategy	Working with the Trust Director of Strategy, develop strategic aims for the R&I department that feed into Trust strategy.
Policy	Ensure relevant R&I policies are reviewed and agreed with the Trust Research Group, and ratified for Trust-wide use.
Finance	Continue to work with finance to enhance transparency of research budgets.
Communication	Working with the Trust Communications Department, identify opportunities to enhance visibility of research at GWH.

8. Conclusion and recommendations

As we have emerged from the Covid-19 pandemic and the NHS are facing unprecedented clinical pressures, Research & Innovation has experienced a decline in the number of patients being offered the opportunity to take part in research. However, there are numerous opportunities as we enter 2023/24 to grow our research capabilities, to enhance research opportunities for Swindon's population, and to generate research income that can be reinvested in supporting this continued cycle of growth.

We thank the Board for its continued support for Research and Innovation across the whole organisation. We hope that continuing to work with the Board to enhance research capabilities will enable research to continue to develop as part of the institutional fabric of Great Western NHS Foundation Trust.

Appendix A


Research & Innovation Department
March 2023
NHS
Great Western Hospitals
NHS Foundation Trust
Director of Research
Deputy Director of Research
Head of Service
Band 8a
0.8 FTE
Pathology Trials Coordinator
Band 4
0.8 FTE
Senior Trial Pharmacist
Band 8a
0.8 FTE
Research Manager
Band 7
0.8 FTE
Clinical Delivery Team
Lead Research Delivery
Band 7
0.8 FTE
Lead Research Sister
Band 7
0.8 FTE
Lead Pharmacy Technician
Band 6
0.68 FTE
Research Nurse
Band 6
0.8 FTE
Research Nurse
Band 6
1.0 FTE
Vacancy
Research Practitioner
Band 6
0.8 FTE
Research Midwife
Band 6
0.64 FTE
Research Nurse
Band 5
1.0 FTE
Research Nurse
Band 5
0.6 FTE
Research Nurse
Band 5
0.6 FTE
Vacancy
Research Nurse
Band 5
1.0 FTE
Vacancy
Research Nurse
Band 5 0.64 FTE
Research Nurse
Band 5
0.8 FTE
Research Asst. Pract.
Band 5
0.8 FTE
Research Facilitator
Band 5
1.0 FTE
BI Analyst
Band 5
1.0 FTE
Finance Specialist
Band 5
0.4 FTE
Pharmacy Assistant
Research Facilitator
Band 3
1.0 FTE
Research Admin.
Band 3
0.8 FTE
Research Nursing Asst.
Band 3
0.96 FTE
Senior Management
Clinical Delivery
Research Management & Governance
Pharmacy
Pathology

Report Title	**Committee Effectiveness Review 2022/23**				
Meeting	**Trust Board**				
Date	**1 June 2023**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – People & Culture Committee Appendix 2 – Charitable Funds Committee Appendix 3 – Remuneration Committee				

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	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):

A series of committee effectiveness reviews took place in February / March 2023. This was in line with year-end close down work, good governance practices, & requirements of the NHS Code of Governance. The reviews gave meeting members the opportunity to reflect on past practice & performance over the last year and consider any changes that should be enacted the following year.

This report invites the Board to refresh the Terms of Reference of the Board Committees as attached.

There were no issues or concerns to draw to the attention of the Board about the effectiveness of the committees, the committee structure generally or the terms of reference for each committee. Each 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	People & Culture Committee Charitable Funds Committee				

	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

The Board/Committee/Group is requested to:

The Board is requested to approve the terms of reference for the following Board committees:-

- People & Culture Committee
- Charitable Funds Committee
- Remuneration Committee

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	25 May 2023

PEOPLE & CULTURE COMMITTEE
TERMS OF REFERENCE
2023/24

Purpose
The purpose of People & Culture Committee is to support the Trust in achieving all its strategic objectives with particular reference to: ***"Staff and volunteers feeling valued and involved in helping improve quality of care for patients"***.

1. AUTHORITY

1.1 The People and Culture Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors. 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.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. ROLE

2.1 To monitor, review and report to the Board on the cultural and organisational development of the Trust, and to receive and provide the Board with assurance with regard to:

- the organisation's understanding of strategic workforce needs (including wellbeing, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them.

- the implementation of key HR controls, including recruitment and retention, and performance management including appraisal systems.

- the commitments of the NHS Constitution and the stated values of the Trust and standards of behaviour are being practiced at all levels of the organisation, based on evidence.

- the achievement of key deliverables in relation to the equality, diversity and inclusion (EDI) plan, and to monitor key metrics in relation to EDI.

- the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements.

- ensure engagement and consultation processes with staff reflect the ambition and values of the Trust and also meet statutory requirements

2.2 To seek assurance on behalf of the Board that the strategic risks linked to the strategic pillar (2) *"Staff and volunteers feeling valued and involved in helping improve quality of care for patients",* and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.3 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 of the People and Culture Committee shall consist of:

- Four Non-Executive Directors
- Three Executive Directors - the ~~Director of HR & Organisational Development~~Chief People Officer, Chief Nurse and ~~Medical Director~~ Chief Medical Officer.

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

4.1 Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

4.4 *Substitutes/Deputies* - Any Non-Executive Director of the Trust, (excluding the Chair), may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Lead, the ~~Director of HR~~ Chief People Officer.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet on a bi-monthly basis with additional meetings called where necessary. However, meetings that are not required will be cancelled.

7. DUTIES

7.1 People

7.1.1. Review the development and delivery of the Trust's sustainable workforce strategy, including, to the extent necessary and relevant considering the wider BSW system's strategies, focusing on:

- Strategic workforce information and planning.
- Recruitment and retention.
- Staff experience and engagement, reward, recognition, health and wellbeing
- Education, learning and organisational and leadership development.
- Equality, diversity and inclusivity

7.1.2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies.

7.1.3 Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities.

7.2 Culture and Values

7.2.1 The role of the committee would be to oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback.

7.2.2. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board.

7.2.3. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area.

7.3 Organisational Capacity

7.3.1 The role of the Committee would be to oversee the development and delivery of a strategy regarding a sustainable workforce (more generally), including, to the extent necessary and relevant considering the wider BSW system's strategies. That would include development of new roles, recruitment and retention etc.

7.3.2. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management.

7.4 Education and Training

7.4.1 Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system.

7.4.2. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff.

7.5 Staff Health & Wellbeing

7.5.1 Oversee the development and delivery of a Trust Staff Health and Well-being Strategy

7.5.2. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics.

7.6 Other Duties

7.6.1 To refer to the Trust Board or other Board committee and/or the Executive Team any identified unresolved risks arising within the scope of these terms of reference that require Executive action or that pose significant threats to the operation, resources or reputation of the Trust.

7.6.2 To identify, assess and manage strategic risks in relation to the Committee's area of focus via the Board Assurance Framework. Review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Trust Board with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function.

7.6.3 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the

Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

7.6.4 To receive and monitor workforce indicators including recruitment, retention/turnover, sickness, appraisals and training in the IPR and Oversight Framework.

7.6.5 To receive and review relevant reports of or relating to the BSW integrated care system and provider collaborative.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. 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. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Employee Partnership Forum
- Joint Liaison Negotiation Committee
- Medical Staffing Support Group
- Nursing, Midwifery and AHP Workforce Committee
- Equality, Diversity & Inclusion Group
- HWB Oversight Committee

10.2 The Committee will consider the key assurance reports as outlined in appendix 1.

10.3 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 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.

11.2. The terms of reference of the Committee shall be reviewed annually by the and approved Board of Directors.

Version Control

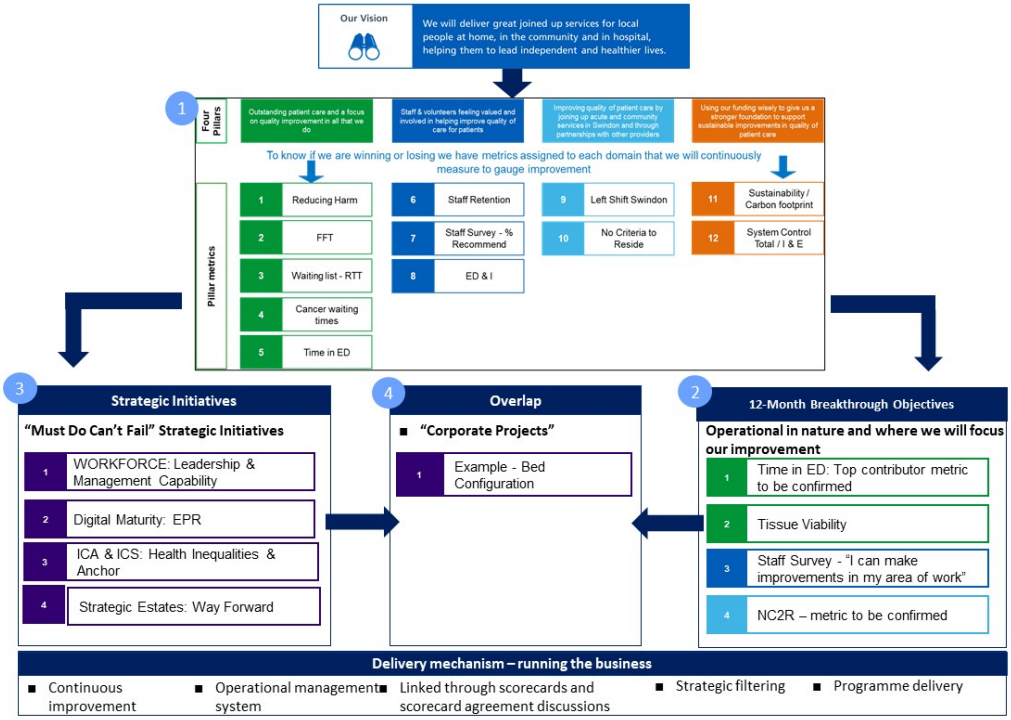
Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1	For review	March 2022	Company Secretary	New committee
V1.1	For approval	June 2022	Chair and Director of HR	For approval at first P&CC
V2.0	Annual Review	March 2023	Company Secretary	• Job title changes • Strengthen reference to partnership working • Reference Oversight Framework

Appendix 1 - Summary

Committee	People & Culture
Chair Lead ED	Paul Lewis, Non-Executive Director Jude Gray, ~~Director of HR~~ Chief People Officer
Frequency	Bi-monthly
Membership	4 x NEDs 3 x ED (~~Director of HR~~ Chief People Officer, Chief Nurse & ~~Medical Director)~~ Chief Medical Officer)
Quorum	3 x members (2 Non-Executive Directors and 1 Executive Director).
Assurance	People Strategy Workforce performance ~~–~~IPR / Oversight Framework Equality, Diversity & Inclusion Nursing skill mix Medical revalidation inc. appraisal/MHPS report/GMC Guardian of Safe Working Staff survey and engagement Job planning compliance Education and Training Gender pay gap WRES performance data WDES performance data Organisational Development Clinical Excellence Awards Voluntary services Compliance with employment legislation Recruitment and retention Workforce digital solutions – e-roster, job planning etc.
Strategic Risk	Workforce (S2)

Appendix 2

GWH - Strategic Planning Framework



CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE
2023/24

Purpose
On behalf of the Corporate Trustee, the purpose of the Committee is to manage the routine affairs of the charity, in accordance with the Scheme of Delegation.

1. AUTHORITY

1.1 Great Western Hospitals NHS Foundation Trust Board, acting as a Corporate Trustee for Great Western Hospital (GWH) Charitable Fund (Charity Registration Number 1050892) has established a Charitable Funds Committee (the Committee).

1.2 The Committee is administered and managed by the Trustees who are responsible for the overall management of the Charitable Funds. This is a non-statutory Committee that reports to the Trust Board and has no powers other than those specifically delegated in these terms of reference.

2. ROLE

2.1 The purpose of this Committee is to oversee the management of Charitable Funds.

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 of the Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the ~~Director of Finance & Strategy~~ Chief Financial Officer and the ~~Director of Improvement & Partnerships~~ Chief Officer for Improvement & Partnerships.

3.2 One of the Non-Executive members will be appointed Chair of the Committee by the Board

3.3 In the absence of the Chair, a Non-Executive Committee member will perform this role.

3.4 *Voting* – For voting purposes there must be a majority of Non-Executive Directors

4. ATTENDANCE

4.1 Other attendees will include but are not limited to:

Chief Executive
Associate Director of Fundraising

Head of Financial Control
Financial Accountant (or nominated Deputy)
Divisional Directors
Executive Assistant to ~~Director of Finance~~ Chief Financial Officer (administrative support)

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 *Substitutes/Deputies* - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 The Trust Chair may attend meetings of the Committee (but not if specifically excluded by the Chair of the Committee), but may not chair meetings nor contribute to the quorum.

4.6 *Advisors* – External advisors may attend as necessary at the request of members to include any departments who have an interest in the current meeting, i.e. fundraising, finance, and any department submitting a case of need or external investment advisors.

4.7 *Administration of Committee* – The Executive Assistant to the ~~Director of Finance & Strategy~~ Chief Financial Officer shall provide appropriate administrative support and guidance to the Chair and Committee members.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be two members to include one Non-Executive Director and one Executive or Non-Voting Board Director.

6. FREQUENCY OF MEETINGS

6.1 The Trustees shall normally meet four times per year and at such other times as the Trust shall require.

7. DUTIES

7.1 Ensure that best practice is followed in terms of guidance from the Charity Commission, Audit Commission, National Audit Office, Department of Health and other relevant organisations.

7.2 Ensure that the appropriate policies and procedures are in place to support the Charitable Funds Strategy and to advise Fund Managers on income and expenditure and that this is reviewed at regular intervals.

7.3 Ensure that fund objectives and spending plans are in line with Charitable objectives, spending criteria and priorities set by donors.

7.4 Ensure that all funds are correctly allocated as restricted or unrestricted and are accounted for accordingly. The number of funds should be reviewed on an annual basis to identify whether a programme of rationalisation is required.

7.5 Develop and review the Trust's Charitable Funds Strategy and Trustees' terms of reference on an annual basis and agree changes where appropriate.

7.6 Develop and review the Scheme of Delegation for charitable funds on a regular basis and recommend changes where appropriate.

7.7 Ensure that a separate register of interests is compiled for both Trustees and Fund Managers, and that this is reviewed and updated on a regular basis.

7.8 Review and approve fundraising policies in conjunction with the Director of Finance, ensuring that statutory requirements are complied with.

7.9 On an annual basis, review and approve summary level income and expenditure plans from Fund Managers, ensuring that they complement the strategy.

7.10 Ensure an effective mechanism exists whereby equipment needs are identified and satisfied (within resource constraints) through an equitable bidding process underpinned by business plans. (All equipment purchased by charitable funds will be recorded in a separate register.)

7.11 Oversee the management of investments. Where an investment broker is used, the Trustees will ensure the investment strategy has been appropriately communicated, the information required is specified and received in a timely manner, and that the service is market tested at regular intervals.

7.12 Ensure that all research monies paid into charitable funds meet the criteria for charitable status as specified by the Charity Commission.

7.13 Review and discuss all Audit Reports on Charitable Funds and recommend action to Trustees.

7.14 Review the Charity Annual Accounts and Trustee Annual Report and comment/recommend approval to the Trustees as appropriate.

7.15 Approve any request to set up new funds and cost centres (Charitable Funds only).

7.16 Agree and approve the bases of apportionment for investment income and administration costs, respectively.

7.17 Recommend to the Board any major fund raising appeals and plans, including any material changes to those plans already approved by the Board.

7.18 The charity also holds funds on behalf of Wiltshire Health & Care LLP who have their own approval process, which is then ratified by the GWH Charitable Funds Committee subject to funds being available

8. REPORTING RESPONSIBILITIES

8.1 The Trustees are accountable to the Charity Commission for the proper use of the charitable funds and to the public as a beneficiary of those funds.

8.2. Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee and others as necessary. Once the Committee has approved the full minutes, a copy will be available, for information, to the Board at its next meeting.

8.3 The key issues of the Committee will be included in the Board of Directors agenda and papers as directed by the Chair of the Charitable Funds Committee and accepted by the Chairman of the Trust.

8.4 The Chair of the Committee shall draw to the attention of Trust Board any issues that require disclosure to the full Board, or require Executive action.

8.5 The Committee will report to the Trust Board annually on the matters of business it has carried out.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. 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.

9.5 A forward planner of agenda items shall be determined by the Chair.

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.

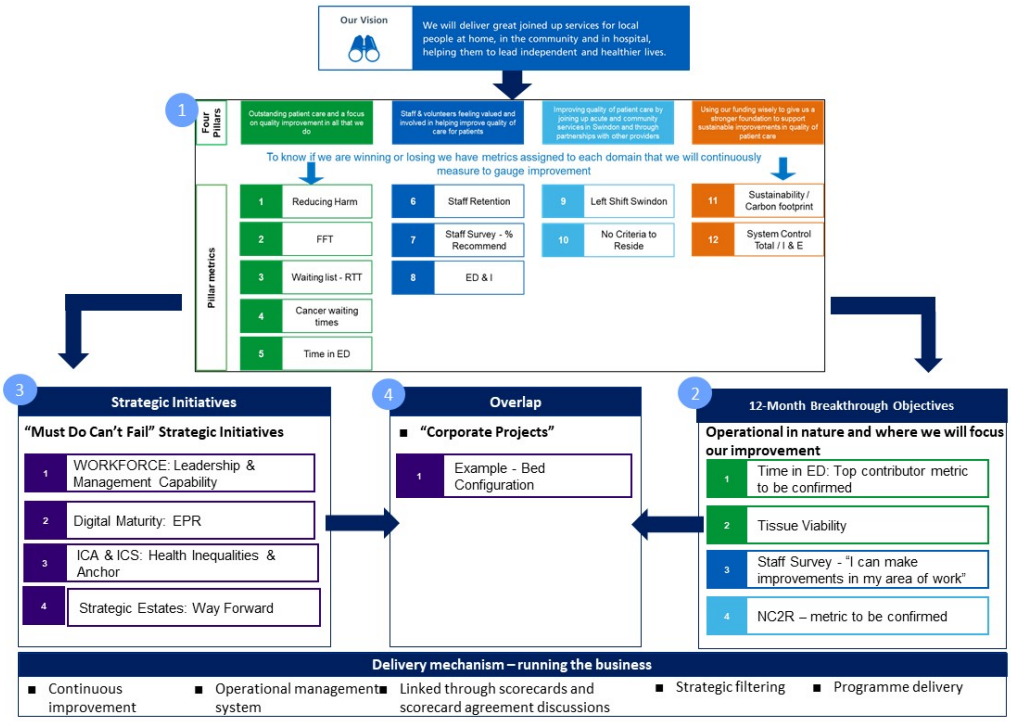
Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1	For review	Nov-21	Charitable Funds Committee	- Membership to reflect NED to be in majority - Divisional Directors to be included in the attendee list
V1.1	For review	Apr-22	Committee Effectiveness Review	- Include Wiltshire Health & Care in duties. Other amendments include:- - New format - Added deputies for Executive Directors - Link to the Strategic Framework - Summary table of meeting remit
V2.0	For annual review	May-23	Company Secretary	- Change of job titles

Appendix 1 - Summary

Committee	Charitable Funds Committee
Chair Lead EDs	Paul Lewis, Non-Executive Director Simon Wade, ~~Director of Finance & Strategy~~Chief Financial Officer Claire Thompson, ~~Director~~ Chief Officer of Improvement and Partnerships
Frequency	At least 4 times per year
Membership	3 x NEDs 2 x EDs
Quorum	1 x NED 1 x ED
Remit	Charitable Funds Performance Charitable Funds Strategy Funding Policies Management of Funds

Appendix 2 – GWH – Strategic Planning Framework

GWH - Strategic Planning Framework



REMUNERATION COMMITTEE
TERMS OF REFERENCE

Purpose
To fulfil the Committee's statutory role in the appointment and removal of Executive Directors including the Chief Executive in line with the NHS Act 2006 and code of governance, and, to determine levels of remuneration and terms of conditions of service for Executive Directors.

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~~ Chief People Officer 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 To approve the appointment of Executive Directors, including the Chief Executive

7.4 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.

7.5 To consider and agree any matter relating to the continuation in office of any Board Executive Director including removal from office, suspension or termination of employment by the Trust.

7.6 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.

7.7 To set on an annual basis individual remuneration arrangements for the Chief Executive, other Executive Directors in accordance with policy and having regard to individual performance.

7.8 To ensure that in the event of loss of office and/or termination of employment of the Chief Executive or any Executive Director the contractual terms and any payments made, are appropriate and consistent with all relevant Government guidelines.

7.9 To monitor and evaluate the performance of individual Executive Directors.

7.10 To engage the services of or take advice from any suitably qualified third party or advisers to assist with any aspects of its responsibilities provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Chief Executive.

~~7.10 To provide a view to the Chief Executive / Director of Finance~~ Chief Financial Officer ~~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~~ Chief People Officer (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.

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
V2.0	Annual Review	May 2023	Company Secretary	Amendments to job titles Added 7.3 Deleted 7.10

Appendix 1 - Summary

Committee	Remuneration Committee
Chair Lead EDs	Nick Bishop, Senior Independent Director Jude Gray, ~~Director of HR~~Chief People Officer
Frequency	At least twice a year
Membership	All Non-Executive Directors
Quorum	3 x NEDs
Remit	Recruitment and appointment of Executive Directors Develop, maintain and implement Remuneration Policy Ensure orderly succession plans Receive reports on Chief Executive and other Executive Directors performance against objectives To agree annual remuneration of Chief Executive and other Executive Directors

Appendix 2

GWH - Strategic Planning Framework