GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD

Thursday 7 March 2024, 9.30am to 12.45pm
By Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome**	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 1 February 2024 (draft)	1 – 9	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	10	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Care Reflection (Staff Story) – Personal journey to bring together infection control and sustainability to improve patient experience and care** Graham Pike, Associate Director of Nursing & IPC and Clinical Sustainability Lead	11 – 16	GP	Note	9.45
7.	**Chair's Report** Liam Coleman, Chair	17 – 19	LC	Note	10.15
8.	**Chief Executive's Report** Jon Westbrook, Acting Chief Executive	20 – 26	JW	Note	10.25
9.	**Integrated Performance Report** • Integrated Performance Report – Pillar Metric deep dive and refresh	27 – 78	LC/ Executive Directors	Assurance	10.45
BREAK (10 minutes) at 11.15 to 11.25am					
	• Performance, Population & Place Committee Board Assurance Report (February) – Bernie Morley, Non-Executive Director & Committee Chair	79 – 80	BM	Assurance	11.25

	• Quality & Safety Committee Board Assurance Report (February) – Claudia Paoloni, Non-Executive Director & Committee Chair	81 – 82	CP	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (February) – Faried Chopdat, Non-Executive Director & Committee Chair	83 – 85	FC	Assurance	
	• People & Culture Committee Board Assurance Report (February) – Paul Lewis, Non-Executive Director & Committee Chair	86 – 87	PL	Assurance	
10.	**Charitable Funds Committee Board Assurance Report** Paul Lewis, Non-Executive Director & Committee Chair	88 – 89	PL	Assurance	12.00
11.	**Learning from Deaths: Trust Mortality Report Q3 2023/24** Steve Haig, Deputy Chief Medical Officer	90 – 96	SH	Assurance	12.10
12.	**Gender Pay Gap Report** Jude Gray, Chief People Officer / Sharon Woma, EDI Lead	97 – 129	JG/SW	Assurance	12.30
	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.**				
13.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	Verbal	CC	Note	12.40
14.	**Fit & Proper Persons Test Policy** Caroline Coles, Company Secretary	130 – 163	CC	Approve	
15.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
16.	**Date and Time of next meeting** Thursday 2 May 2024 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
17.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	12.45

Board Meeting Timetable

2024											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Board	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
			Risk Management & Way Forward Plan			Use of Resources & GWH Strategy			Population & Health		

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ AND VIA MS TEAMS 1 FEBRUARY 2024 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Lisa Cheek (LCh)*	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Steve Haig (SH)	Acting Chief Medical Officer
Peter Hill (PH)	Non-Executive Director
Bernie Morley (BM)	Non-Executive Director
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)	Acting Chief Executive

In attendance:

Caroline Coles (CC)	Company Secretary
Julian Duxfield (JD)	Non-Executive Director
Tim Edmonds (TE)*	Associate Director of Communications & Engagement
Claire Lehman (CL)*	Associate Non-Executive Director
Rommel Ravanan (RR)*	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Claire Warner (CW)	Deputy Chief People Officer
Tania Currie	Head of Patient Experience & Engagement (agenda item 238/23 only)
Alex Christiansen	Therapy Team Lead (agenda item 238/23 only)
Laura Quintin	Physiotherapist (agenda item 238/23 only)
Paula Lamb	Senior Sister, Forest Ward (agenda item 238/23 only)
Luci Sawyer	Specialist Physiotherapist, Stroke Therapy Team (agenda item 238/23 only)
Sasha Webb	Maternity & Neonatal Independent Senior Advocate, BSW ICB

Apologies

Jon Burwell (JB)	Acting Chief Digital Officer
Jude Gray (JG)	Chief People Officer
Paul Lewis (PL)	Non-Executive Director

Number of members of the Public: There were 2 members of public (including 2 governors, Pauline Cooke and Chris Shepherd)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
233/23	**Apologies for Absence and Chair's Welcome** The Chair welcomed Board members and attendees to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
234/23	**Declarations of Interest** There were no declarations of interest.	

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Minute	Description	Action

235/23 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 11 January 2024 were adopted and agreed as a correct record.

236/23 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

237/23 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

238/23 **Care Reflection (Patient Story)**
Tania Currie, Alex Christiansen, Laura Quintin, Paula Lamb and Luci Sawyer joined the meeting to present this item.

The Board received a presentation and film on the pathway of care of a young lady called Louise following a traumatic spinal cord injury and the six months spent in the care of Forest Ward. The story shared the approach taken by the ward and therapy teams which had led to an amazing recovery and outcome for Louise, together with learning gained from the experience. Key learning themes identified from this case would also be shared widely across the Trust should a similar case occur.

The future plans of the service were noted, which included a Level 2 rehabilitation service business case to support the Way Forward Programme and the submission of the bid to the Commissioners was supported by the Board.

Alex Christiansen and Laura Quintin also spoke about the health and wellbeing of the staff who support patients with extensive rehabilitation and the weekly debriefs held to enable reflection and learning on challenging situations and shared between the team - together with regular wellbeing sessions hosted by staff support,

The challenge of dealing with the physical care needs of patients and also how to support their psychological mental health needs was also reflected upon, this included the importance of building relationships with the Mental Health Liaison Team in ED together with access to training support. Bernie Morley, Non-Executive Director offered to make contact with the University of Bath to ascertain if assistance around training could be provided from a clinical psychologist.

The Board thanked Alex, Laura, Paula and Luci for their inspirational presentation and also for the care provided by the Forest Ward staff.

The Board **noted** the staff story.

239/23 **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.

Of particularly note was that the Chair had recently met with Ray Ballman, newly appointed Governor for Swindon Borough Council.

Committee Membership and NED Champion Roles Review
The Board received and considered the outcome of the review of the Committee Membership and NED Champion Roles undertaken in view of the pending departure of two Non-Executive Directors during March 2024. The proposed changes to the committee membership were agreed, with effect from 1 April 2024, however noted that the NED for the Maternity Board Safety Champion role remained to be filled.
Action: Chair, Chief Executive and Chief Nurse

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Minute	Description	Action
	Lizzie Abderrahim, Non-Executive Director commented that a job description for the EDI NED Champion role had not been included in the paper and agreed to share this with the Company Secretary.	**Mar 2024**
	The Board **noted** the report.	
240/23	**Chief Executive's Report** The Board received and considered the Chief Executive's Report, and the following was highlighted: Industrial action update No further notification had been received of any future industrial action and the Board was updated on the impact of the recent strikes on the significant loss of activity during those periods. Applications for derogations during those periods had been made to the BMA but had not been granted. The NHSE have requested to receive a report from all providers on any harm identified as a result of the industrial action. Outpatients A dedicated week for outpatient services to review the success of measures introduced in the department was recently undertaken, which included changes made in outpatients to help improve efficiency for staff, reduce our waiting times and enhance the overall patient experience. Cancer performance The Trust was in Tier 2 for cancer performance which had meant increased high level scrutiny both from the Region and the ICB, however good progress had been made to improve performance and that a plan was in place to deliver target for March 2024. Risk specialties still related to GI surgery, urology and dermatology. Using virtual reality to improve training The Board was informed about the joint initiative with Bath University which was a tool called 'Gogglemінds' to develop clinical skills in virtual reality scenarios in medical student teaching to recognise conditions such as sepsis. Supporting our patients at mealtimes A new Dining Companion role had been introduced to enable non-clinical staff to volunteer to spend time in clinical areas, supporting the ward teams and helping patients. This was an important initiative to maintain good hydration and nutrition as part of patient care in the Trust. Shared Electronic Patient Record A national decision was still awaited on the business case to proceed with the procurement of a Shared Electronic Patient Record. Integrated Front Door Construction on the new Integrated Front Door continued at pace, with it set to open in the summer and the Children's Emergency Unit scheduled to open in the autumn. Lizzie Abderrahim, Non-Executive Director welcomed the ongoing engagement with service users, relatives and carers in the development of the Integrated Front Door. National expectations A letter from NHS England to all Integrated Care Boards and Trusts had been received in December, with a subsequent letter in January, following the conclusion of industrial action and outlining key priorities for 2024. This included the improvement of both ambulance response and A&E wait times, the reduction of elective long waits and cancer backlogs, and the improvement of access to primary care. The NHSE were to work with Integrated Care	

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Minute	Description	Action

Boards and providers to agree a standard set of measurements for all Trusts to use to track productivity.

Prescription ordering
The ICB had taken the decision to discontinue Prescription Ordering Direct later in the year, with GP practices/care homes offering repeat prescribing instead.

STAR of the Month
Louise Knight, Palliative Care Team Lead, was the latest winner of the STAR of the Month Award, which was in recognition of the support provided to end of life patients and their families.

Equality, diversity and inclusion
The Trust produces a quarterly newsletter for staff focussed on equality, diversity and inclusion with the aim of raising awareness of work undertaken in this area, which included the role of EDI Champions working with the allyship programme.

Positive feedback from students
Oxford Brookes University's Celebrating Excellence in Practice Education 2023 report had been published. It detailed positive feedback on this Trust from healthcare and social work students in relation to the Acute Cardiac Unit, Forest Ward, Dove Ward, Mercury Ward, Day Surgery and Community Care.

The Board **noted** the report.

241/23 **Integrated Performance Report**
The Board received the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in January 2024.

Board Assurance Reports

Our Performance
Performance, Population and Place Committee Chair Overview
The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meeting on 24 January 2024 and the following was highlighted:

Cancer performance continued to improve in the longest waiting patients (those over 62 days) and PPPC was assured on the achievement of the March 2024 trajectory. However, this was also subject to 'tiering' (Tier 2) as part of the performance management regime and the potential impact on SOF rating, which also included ambulance handover delays performance that continued to impact on long waiting times for patients.

Urgent and Emergency Care Performance in December had shown a reduction in time waiting in the Emergency Department for patients and a reduction in handover delays, despite an increase. However, current performance in January had declined in both waiting times and handover delays and Felicity Taylor-Drewe, Chief Operating Officer assured the Board that this would continue to be monitored to ensure that it was a blip in performance and not a trend.

Non-Criteria To Reside (NCTR) continued to show a reduction in December, however it was noted that January was challenging.

Diagnostic performance (DM01) had showed that targeted work with modalities had increased activity and reduced the number of the Trust's longest waiting patients, however the percentage performance had not improved. The final report from the NHSE visit had

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Minute	Description	Action

not been formally received, however actions were in place to address the majority of concerns.

Referral to Treatment (RTT) for 52 week waits had also continued to reduce for the sixth month in a row.

Medical vacancies overall continued to reduce. However, concern remained within general medicine around vacancies and that a robust plan was in place to address this within that department and further assurance was provided at a recent meeting of the Medical Staffing Control Group around trajectory.

Felicity Taylor-Drewe, Chief Operating Officer relayed the extreme stress on the organisation and neighbouring trusts during January, including community services, and added that a further Reset Week was to be undertaken to drive improvement on performance, the patient pathway and ambulance handovers. She added that conversations were also being held with system partners on the best use space in ED to continue the reduction in emergency care length of stay.

In terms of a system update it was noted that work was ongoing at ICB level on the planning round, and that the Chief Officer of Improvement and Partnerships had been nominated as vice chair of the Swindon Integrated Care Alliance which would be a positive link for the organisation.

The Board noted emerging risks which included the Swindon Borough Council's financial position, and the procurement of community services.

The Board **noted** the report.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meeting on 18 January 2024 and the following was highlighted:

- The UKHSA (UK Health Security Agency) confirmed that it was happy with the progress to date in relation to water pseudomonas infections and have now reduced the need for regular review meetings. The Trust had been advised to reduce the positive counts to one before sampling and remedial action could stop.

  The Board requested that further assurance be sought on improved processes around record keeping undertaken by Serco staff and the continued monitoring of this to ensure that no further concerns would be identified throughout the organisation. Lisa Cheek, Chief Nurse added that she was working with Serco on an action plan and that there had been good engagement to drive improvement and she was assured by the actions being taken. This would be continued to be monitored QSC.
  Action: Chief Nurse **Feb 2024**

- Gram negative infections remain above trajectory, however additional measures were in place to drive improvement.

- Klebsiella rates in the Swindon area appeared to be the highest in the South West and that support from UKHSA was being sought to help investigate the increase in community-onset and hospital-onset *Klebsiella* rates. Focused work had now shown an improvement in reported rates.

- Pressure ulcers had shown a slight reduction in both community and hospital acquired for December.

Minute	Description	Action

- A report on the Regulation 28 Prevention of Future Deaths notice received by the Trust following the inquest in a death following a fall was received by QSC Action plans were now in place with regard to falls improvement and management of at risk patients. Further Trust-wide work around safer staffing and baseline nursing establishment requirement was also in progress. The learning from this had been positively received.

  In response to a question raised by Faried Chopdat, Non-Executive Director on what actions were being taken around nursing establishment levels, Lisa Cheek, Chief Nurse responded that there was a robust system of yearly establishment reviews that considered all elements of staffing models alongside quality metrics and areas where concerns had been flagged. Whilst recruitment would be more challenging in the future, there were still a programmes of work ongoing which included international recruitment increase of trainee nursing associates, focus on the development of our own staff and also on retention.

- The CQC preparedness update had provided assurance on the recent refresh review of Must Do and Should Do improvement actions, which had been undertaken following the learnings from the recent CQC visit to Maternity Services. The Trust-wide review would ensure that the focus on improvements was robust and that there was evidence of the ongoing improvement work completed since the last inspection.

The Board **noted** the report.

Use of Resources

Finance, Infrastructure & Digital Committee Chair Overview

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meeting on 22 January 2024 and the following was highlighted:

- An update on the BSW financial plan was received. Greater assurance was being sought on governance processes at the ICS around the delivery of the plan, particularly in relation to decision making or risk share of capital allocation.

- Efficiency savings were £0.2m below target in-month and were £1.9m behind plan on a YTD basis. Undelivered savings remained a significant risk to the Trust's ability to hit a breakeven position at year end. Enhanced governance through the Financial Recovery Board would continue to monitor progress to hold divisions and corporate functions accountable for their efficiency plans. However, it was noted that there had been marked improvement from the previous year in the delivery of efficiency savings.

- A national decision on funding for the EPR business case was still awaited to proceed with procurement good work had been undertaken to date in setting up the programme and engagement with suppliers.

- Cyber security remained a key priority for the Trust with investment in a range of controls and risk mitigations. Improvements were expected to be made to the Trust's preparedness for a cyber incident and robust controls to provide further assurance of mitigations in place at the Trust.

- The new Provider Selection Regime (PSR) which came into force on 1 January 2024 was outlined. The PSR would remove the procurement of health care services when procured by relevant authorities under the PSR, from the scope of the Public Contracts Regulations 2015 (the PCR). This would give the relevant authorities to which it applies more flexibility in selecting providers for health care services, with an aim to promote greater collaboration, reduce the bureaucracy associated with current rules, and enable

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Minute	Description	Action

the development of stable partnerships. The Board considered that the Director of Procurement be invited to a future meeting to provide further clarity on the PSR.
Action: Chief Financial Officer

tbc

- Good work continued by management to control agency spend, particularly around nursing spend, however there would be further scrutiny around the controls of bank staff which had increased significantly.

Simon Wade, Chief Financial Officer also reported on recent productivity data which had shown an improvement of 4% on 2019/20 measures since month 4. Although this Trust was slightly below the regional average for 2022/23, productivity was better than the system average with an improvement of 2% at month 4, which was a reflection of the good work in place to control costs particularly in view of recent industrial action and the impact on activity. Benchmarking data was also being used to utilised to provide comparison in performance within the system and regionally.

The Board **noted** the report.

Our People
People & Culture Committee Chair Overview
The Board received a verbal, due to timing of the meeting, overview of the discussions held at the People & Culture Committee (PCC) at its meeting on 23 January 2024 and the following was highlighted:

- The retention rate continued to decrease and was currently at 9.2%. Turnover of staff within the first year of employment was to be monitored as this was 4% higher than the overall turnover rate and some work was to be undertaken to better understand this.

- Initial staff survey results had been received and that analysis of the early feedback had commenced by Divisions. A presentation on the full results would be received by the Board at a future meeting.

- The Board was reminded that the proposed themes for the Equality Diversity and Inclusion Board Commitments had been previously circulated and that an outline action plan was being developed to incorporate the 'how's' with specific measurables for agreement by the Board at its meeting in March 2024.

- A deep dive into the education and training provision at the Trust had been undertaken and that a presentation received at the P&CC which provided an outline for future enhanced focus.

The Board **noted** the report.

242/23 **Audit, Risk & Assurance Committee Board Assurance Report**
The Board received an overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meeting on 16 January 2024 and highlighted the following:

- The External Audit Plan for 2023/24 had been approved and that good progress with the audit was reported, which included progress on some of the areas highlighted in the previous year.

- An internal audit report on Theatres Management reported strong governance structures for monitoring and reporting on theatre utilisation performance and well documented policies and operational procedures.

Minute	Description	Action

- An increase in the number of referrals to Local Counter Fraud Services had been noted, which was a positive reflection of increased awareness of LCFS in the organisation and the ability to confidently report any concerns.

- The LCFS review of Conflicts of Interest noted that the Trust's compliance was 100%. This was an excellent result and compared favourably to other NHS Trust reviews.

- A benchmarking report with similar size trusts from KPMG was expected at the March 2024 ARAC meeting to provide comparative data on performance in both internal audit and counter fraud.

- Corporate risks had been received by ARAC for the first time. It was recognised that there needed to be further reflection on the structure of the Corporate Risk Register and a requirement for a more holistic view across corporate risks at the Trust Management Committee prior to any further escalation by ARAC.

  Separate organisational risk registers within the system was reflected upon, and it was agreed that alignment of scoring of risk registers across the system would be explored further, together with risk management training on scoring and the identification of system-wide risks as part of that discussion. **Mar 2024**
  Action: Chief Officer of Improvement & Partnerships

The Board **noted** the report.

243/23 **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 its meeting on 20 October 2023 and highlighted the following:

- The phased approach to the implementation of Right Care Right Person was developing at pace and the degree of risk associated with this across the different parties. The development of the strategy group being developed to oversee this implementation had increased in importance. MHGC would continue to monitor this.

- A reduction in the RMN spend, particularly on the acute site, was noted and that this had been supported by the development of a number of plans which had enabled Trust staff to work more effectively and more confidently with people who were in mental health crisis. The provision of training and development of substantive roles within acute teams to provide mental health support had resulted in less need for engagement at a RMN level. A similar approach had also been adopted by the Children's Department but this reduction in RMN usage had yet to be seen due to current need.

- The Way Beacons mentoring initiative based in the Emergency Department which focused on young people involved in or affected by violence/gun crime, substance misuse and risk-taking behaviour introduced at the end of 2023 was now underway.

- No 15+ risks had been reported but a discussion about the management and oversight of the 12+ risks was held. MHGC was satisfied that mental health risks were being robustly managed and that appropriate mitigations were in place, given the challenges across the Trust in relation to the management of patients requiring care and support for their mental health.

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

DRAFT

Minute	Description	Action
	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.	
244/23	**Ratification of Decisions made via Board Circular** None.	
245/23	**Urgent Public Business (if any)** None.	
246/23	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 7 March 2024 at the DoubleTree by Hilton Hotel, Swindon.	
247/23	**Exclusion of the Public and Press** The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.	

The meeting finished at 12.10hrs

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ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – March 2024				
PPPC - Performance, Population and Place Committee, PCC – People & Culture Committee, QSC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
1 February 2024	241/23	Quality & Safety Committee Chair Overview – Assurance on improved processes on record keeping undertaken by Serco staff to be monitored through Quality & Safety Committee.	Chief Nurse	For Quality & Safety Committee
1 February 2024	242/23	Audit, Risk & Assurance Committee Board Assurance Report – Alignment of scoring system risk registers to be explored further, together with risk management training on scoring and the identification of system-wide risks as part of that discussion.	Chief Officer of Improvement & Partnerships	Work continues to develop alignment both across the AHA and ICS.

Future Actions				
I February 2024	241/23	Finance, Infrastructure & Digital Committee Chair Overview – Director of Procurement to be invited to a future meeting to provide further clarity on the Provider Selection Regime.	To be confirmed	

Report Title	**Staff Story – Infection Control and sustainability to improve patient experience and care**				
Meeting	**Trust Board**				
Date	**7th March 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jude Gray – Chief People Officer				
Report Author	Graham Pike – Associate Director of Nursing & IPC				
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):

Substantial		Good	X	Partial		Limited	
Governance and risk management arrangements provide **substantial assurance** that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being **consistently applied** and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide **good levels of assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied** and **implemented but not across all relevant services**. Outcomes are generally achieved but with **inconsistencies** in some areas.		Governance and risk management arrangements provide **reasonable assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied but insufficient to demonstrate implementation widely across services**. Some evidence that outcomes are being achieved but this is **inconsistent across areas and / or there are identified risks to current performance**.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. **Little or no evidence** is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	

Justification for the above assurance rating. Where 'Partial' or 'Limited' assurance has been indicated above, please indicate steps to achieve 'Good' 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 personal journey to bring together infection control and sustainability to improve patient experience and care.

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 to note the staff story.	
Accountable Lead Signature	Claire Warner on behalf of Jude Gray Chief People Officer
Date	28th February 2024

Staff Story

Graham Pike

Associate Director of Nursing & IPC and Clinical Sustainability Lead

My career path

- Never wanted to be a nurse!
- Four year taught master's degree in physics, University of Oxford
  - Master's year major options in atmospheric physics and astrophysics
- Library assistant
- Three year degree in adult nursing
- General medicine, John Radcliffe Hospital
  - Staff Nurse
  - Senior Staff Nurse
  - Team Leader
- Infection Control
  - Research Nurse
  - Advanced Nurse Practitioner
- Back to the wards
  - Charge Nurse*
  - Matron, Northampton General Hospital
- COVID-19
  - Seconded back to Infection Control, March 2020
  - Applied for this post at GWH and started in April 2022

My time at GWH so far

- IPC team severely depleted in April 2022
  - Matron on long-term sick leave
  - Seconded Matron off with COVID
  - Senior IPC Nurses: one on long-term sick leave and one retired (not yet returned)
  - Vacancies
- GWH over-trajectory and/or worse than regional average for all six infections monitored by NHS England
- Opportunity to recruit, refresh and rebuild
- Moved IPC team to GWH main building
- IPC Improvement Plan
- Improvements in MSSA, COVID, *Pseudomonas* but much more to do
- Sustainability
  - Infection Prevention Society's lead on this from Dec 2022, leading to multiple presentations at conferences and events
  - Established links with NHSE CNO sustainability team through these events
  - Sustainability added to job title and job description (first nurse in UK)
  - GWH picked as the first 'exemplar site' for Sustainability in IPC

Sustainability in IPC exemplar site work

- Implementing the Intensive Care Society's *Gloves Off in Critical Care* campaign
- Supporting ED to become Green ED accredited (Royal College of Emergency Medicine) including a focus on reducing unnecessary cannulation
- Removal of couch roll
- Reducing frequency of routine sheet changing
- Stopping unnecessary use of skin prep prior to routine blood tests#
- Trial of 'bag-to-bedside' waste scheme in SWICC
- Trialling reusable gowns in Theatres
- Implementing reusable hats in Theatres
- Planning trial of more sustainable glove in Trauma
- Trail of reusable tourniquet about to start in Phlebotomy
- Stopping unnecessary use of plastic overshoes for birth partners in Maternity
- Trial of antimicrobial-coated recyclable curtains on Meldon Ward
- Trial of alcohol-free hand sanitiser on Children's and Saturn Wards
- Established the Clinical Sustainability Group to embed joint working between the Sustainability and IPC teams
- Exemplar site report to be produced by year end and will be shared nationally

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**7 March 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Process							
Substantial	x	**Good**		**Partial**		**Limited**	
Governance and risk management arrangements provide **substantial assurance** that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being **consistently applied** and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide **good levels of assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied** and **implemented but not across all relevant services**. Outcomes are generally achieved but with **inconsistencies** in some areas.		Governance and risk management arrangements provide **reasonable assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied but insufficient to demonstrate implementation widely across services**. Some evidence that outcomes are being achieved but this is **inconsistent across areas and / or there are identified risks to current performance**.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. **Little or no evidence** is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	
Justification for the above assurance rating. Where 'Partial' or 'Limited' 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 – Key Meeting Dates
- Non-Executive Directors
- Strengthening Board Oversight
- Trust Chair - 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	19 February 2024

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 February 2024.

1. Council of Governors

1.1 Key meetings, training and events during February 2024 which governors participated:-

Date	Event	Purpose
31 Jan-24	Governor Induction	To meet the Trust Chair, Company Secretary and Lead Governor
1-Feb-24	Trust Board Meeting – Observers	Holding the Non-Executive to account
6-Feb-24	Council of Governors Pre-meet	Informal meeting for governors prior to the Council of Governors meeting
6-Feb-24	Council of Governors Meeting	Meeting of the whole group quarterly
27-Feb-24	Focus Group – Equality Delivery System	Governor representatives participation as part of the Equality Delivery System process for 2023-24, evaluating PALs and complaints services

2. Non-Executive Directors

2.1 Both Peter Hill and Paul Lewis term of office comes to an end on 31 March 2024 and on behalf of the Board of Directors I would like to take this opportunity to express sincere gratitude for the many years they have dedicated to the role.

2.2 Claudia Paoloni was appointed as the Senior Independent Director approved by the Trust Board at its meeting on 1 February 2024 and supported by the Council of Governors on 6 February 2024.

3. Strengthening Board Oversight & Development

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

Date	Area	Board Member
26 February 2024	Theatres	Steve Haig, Acting Chief Medical Officer Faried Chopdat, Non-Executive Director Lizzie Abderrahim, Non-Executive Director Claire Lehman, Associate Non-Executive Director
28 February 2024	Therapy Services	Simon Wade, Chief Financial Officer Bernie Morley, Non-Executive Director

4. Trust Chair Key Meetings during February 2024

Meeting	Purpose
Monthly meeting with Non-Executive Directors & Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Quality & Safety Committee	To attend as an observer
Remuneration Committee	To attend as a member
Council of Governors	To attend as Chair of meeting
AHA Committees in Common	Regular system meeting
Wiltshire Health & Care Members' Board	To attend as a member
BSW Chairs' Catch Up	Regular meeting to update and discuss any topical issues
Follow up meeting with BSW ICB and WHC Members	System meeting
Meeting with Swindon MPs and tour of Integrated Front Door	Networking meeting
NHS ICB and Trust Chairs Event	NHS Providers Event in London

Report Title	**Chief Executive's Report**				
Meeting	Trust Board				
Date	7 March 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jon Westbrook, Acting Chief Executive Officer				
Report Author	Jon Westbrook, Acting 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

Substantial		Good		Partial		Limited	
Governance and risk management arrangements provide **substantial assurance** that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being **consistently applied** and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide **good levels of assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied** and **implemented but not across all relevant services**. Outcomes are generally achieved but with **inconsistencies** in some areas.		Governance and risk management arrangements provide **reasonable assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied but insufficient to demonstrate implementation widely across services**. Some evidence that outcomes are being achieved but this is **inconsistent across areas and / or there are identified risks to current performance**.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. **Little or no evidence** is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	

Justification for the above assurance rating. Where 'Partial' or 'Limited' assurance has been indicated above, please indicate steps to achieve 'Good' 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):

The report includes updates on:

- Industrial action
- Faster Flow February
- Care Quality Commission maternity survey
- Financial position
- Integrated Front Door
- Staff Excellence Awards

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 Score**

– risk number & description (Link to BAF / Risk Register)	N/A	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	N/A	
Next Steps	none	

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**		**X**
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	**X**		**X**

Explanation of above analysis:

The report covers our Staff Excellence Awards, which include a category on Championing Health Inequalities.

It also mentions our work to celebrate LGBT+ History Month with a short video showing staff flying the pride progress flag. This video is available to watch on the Trust's YouTube account.

Recommendation / Action Required The Board/Committee/Group is requested to:	
To note the report	
Accountable Lead Signature	Jon Westbrook, Acting Chief Executive Officer
Date	29 February 2024

1. Operational updates

1.1. Industrial action

A five-day Junior Doctors strike took place from 7am on Saturday 24 February until 11.59pm on Wednesday 28 February.

We once again asked Junior Doctors to tell us in advance if they intended to strike to enable us to minimise disruption to patients, and declared a Business Continuity Incident for the duration of the strike to help us manage its impact.

More than half the shifts due to be completed by junior doctors were affected by industrial action, with more than 700 outpatient appointments having to be postponed along with a number of surgeries.

Up until 20 March junior doctors are being balloted by the British Medical Association over a further six-month extension to their mandate for strikes, along with action short of strike.

Junior doctors are of course not the only staff group still in dispute with the Government over pay.

SAS Doctors are being asked to vote in an online referendum to accept or reject a pay offer from the Government.

Consultants have rejected the Government pay offer which means strike action could continue – but no dates have been announced yet. The BMA has asked the government to improve the pay offer, ahead of making a decision on how to respond to the ballot response.

1.2. Faster Flow February

A very busy start to the year prompted us to initiate Faster Flow through February – a whole Trust approach to improve the flow of patients through the hospital.

This enabled us to focus on monitoring barriers to achieving key performance indicators in emergency care, within the community setting and throughout the hospital.

Huddles were held each day to evaluate data and identify key learnings and opportunities for improvement.

Teams achieved our target of two bed moves out of the Emergency Department per hour.

Along with other learning, this initiative highlighted the need to continue to maximise our capacity in the Virtual Ward, NHS@Home.

1.3. Waiting time information on the NHS app

Patients are now able to view estimated waiting times for hospital treatment on the NHS App.

The app displays average waiting times for appointments and treatments at NHS trusts across the country, included ours.

This development is intended to free up clinical and administrative time as patients and their carers can find the information they need on the NHS App rather than contacting services for an update.

The NHS App can already be used by patients to view hospital referrals and appointments in one place and see a single point of contact and supporting information for appointments.

2. Quality

2.1. Care Quality Commission maternity survey

Last month the Care Quality Commission released results following a national survey it conducted on maternity services.

Our Trust scored third highest in the country for questions relating to antenatal check-ups and care on the ward after birth, and in the top five Trusts for questions relating to care at home after birth.

The Trust also performed above the national average in a number of areas, and women and birthing people said that:

- They felt listened to during antenatal check-ups, labour and birth
- They were given support for their mental health during pregnancy
- They had confidence and trust in the staff caring for them
- Those who were having an induced labour felt well supported and were provided with appropriate advice
- Personal circumstances were taken into account during the pregnancy.

2.2. National Preceptorship Quality Mark

Preceptorships provide a period of guidance and support for newly registered healthcare staff as they transition from being students to qualified professionals, aiming to provide new staff with opportunities to translate their training into everyday practice, supporting their confidence and enabling them to have the best possible start in their careers.

The Trust has been awarded the National Preceptorship Quality Mark by NHS England, in recognition of a successful preceptorship programme.

This award is a national gold standard, aimed at reducing preceptorship variation across organisations.

2.3. HIV testing

As part of a week-long campaign across the country, we highlighted our work to raise awareness of the stigma of HIV.

We are the only Trust in the South West that is currently offering opt-out HIV testing for our patients, in line with the Government's HIV Action Plan to eliminate HIV by 2030.

Our sexual health team gave 13,000 HIV tests in the last year to people across the Swindon community. Of these, 4,600 were hospital tested and 8,400 community tested (through sexual health).

They've also been supporting staff to provide the test to patients spending time in hospital, through a new testing programme that was launched at the end of 2022.

In the last year, there have been 18 new HIV diagnoses in Swindon compared to an average of 12 in previous years, with the hospital testing making a big difference in identifying patients living with HIV.

Diagnosing HIV early on means treatment can start straight away, which can help an individual with the virus to live a long and healthy life.

Most people who get an early diagnosis and effective treatments will not develop any HIV-related illnesses, and will have a normal life expectancy.

3. Systems and Strategy

3.1. Financial position

The system-wide financial position is exceptionally challenging this year, which is expected to make next year more difficult.

Across our Integrated Care System, Trusts are now subject to an extra level of decision-making on proposed investments and the vacancy controls in place.

A joint letter from the BSW Chair and Chief Executive was received last month and indicates new investments will be very difficult to make without a compelling case for spending the money, with further controls now in place.

We're performing comparatively well in a very challenging financial environment, but we are measured against our collective, system-wide position.

Our internal recovery board continues to meet fortnightly to progress a number of workstreams around cost reduction. There will be an increasing focus on using the Improving Together methodology to drive savings, achieve operational targets and reduce waste in our processes, will be key going forward.

Our current forecast position is a £5.6m deficit.

3.2. Integrated Front Door

As the construction of the Integrated Front Door continues at pace, engagement work is underway to ensure that the interiors of the new building best meet the needs of the population it will serve.

Workshops have been held with representatives from the dementia, learning disability and autism communities, as well as meetings with Healthwatch, children and adolescent mental health services, wheelchair users, spinal injury patients and local carers, amongst many more.

The Way Forward Programme team and other colleagues have also attended local community cafes and health and wellbeing groups.

In February, local borough councillors were invited for a site tour, and an online forum is being held on 20 March for members of the public to hear more about the urgent and emergency care development.

In the coming weeks, sessions will be held in primary and secondary schools, and through youth clubs for young people who are neurodiverse, to start development of the interiors for

the Children's Emergency Department. The Trust is also hosting a number of local scouts and cubs to gather their views, and will be engaging with the nursery on the hospital site.

Recently, the BBC covered the IFD development across all platforms, on TV, radio and online.

3.3. Integrated Care System tier

The whole Bath and North East Somerset Integrated Care System has moved up in to the second of NHS England's three tiers for urgent and emergency care, following a deterioration in performance with ambulance handover delays and corresponding impact upon patients.

Being in tier 2 means the system will be subject to greater national scrutiny with more support potentially available to increase performance.

3.4. Surgical robot

A small team of staff took a surgical robot to a secondary school in Malmesbury as part of a nursing, robotic surgery and engineering careers day.

During the visit, students were given the opportunity to hear from robotic surgeons, nurses and other health professionals as well as being able to use virtual reality technology and other surgical equipment.

4. Workforce, wellbeing and recognition

4.1. Staff Excellence Awards

Nominations for our Staff Excellence Awards have now opened.

There are 11 award categories this year, with a brand new award introduced for 2024: the Improving Together Award.

There will also be a STAR of the Year for 2023/24, chosen from the previous 12 winners of the STAR of the Month Award, and a Patient Choice Award winner who will be nominated by patients and families.

The awards ceremony, which will have a 1980s theme, will take place at the Steam Museum in Swindon on Friday 14 June.

4.2. STAR of the Month awards

Kola Beyioku, Clinical IT Applications Specialist, and Linda Walmsley, IT Programme Manager were recently named as STAR of the Month award winners. They were recognised for being instrumental in developing and implementing a new risk assessment tool, as recommended by NHS England, for assessing pressure ulcer risk in adult patients.

Sister Lisa Thorogood also won a STAR of the Month award, having supported a trainee member of staff to thrive on the ward. She was patient with her trainee colleague, explaining everything clearly and helping them learn on the job. Lisa always ensures her patients receive the best care, whilst showing more junior members of staff how they can get involved in delivering this care.

4.3. Healthcare support workers

Chief Nurse Lisa Cheek presented Healthcare Support Workers Amanda Pretlove and Colette Goodenough with national awards from the Chief Nursing Officer for NHS England, Dame Ruth May.

They were recognised for their commitments to quality care, with feedback from relatives stating that they always feel listened to and are grateful to both members of staff for their clinical and holistic care of loved ones.

4.4. Laura McCafferty

A member of our staff, Laura McCafferty, became one of the first Clinical Research Practitioners in our region to become formally registered through an alternative route.

Laura, who last year won the Rising Star Award at the Clinical Research Networks regional awards ceremony, joined The Academy for Health Science Clinical Research Practitioner Register, which is available to staff who do not hold a degree or equivalent level of qualification but can evidence sufficient years of experience in delivering research.

4.5. Memorial service

Our 2024 Memorial Service for staff will be held at 1.00pm on Monday 11 March in the Academy.

This service was introduced as an annual event on 11 March 2021, to mark the first anniversary of the pandemic being declared and our first Covid patient at Great Western Hospital.

The non-religious service intends to give our staff and volunteers the chance to reflect on those they have lost during the past year.

4.6. Car parking

A new and improved parking system for staff is to be introduced at the hospital.

This system will make parking on site easier, with automatic number plate vehicle recognition, improved payment machines and more payment options, which includes paying on exit at the barrier.

The new system is expected to improve traffic and reduce queueing on site, particularly at busier times of day.

With the new system, staff won’t need to top up their barrier passes in advance, but will need to apply for an e-permit with SABA, the new parking system.

Parking charges will remain the same for staff, but we are pleased to have been able to introduce free parking for students.

4.7. LGBT month

We marked LGBT+ History Month with a video showing staff flying the pride progress flag, to recognise the contributions they have made to calling out discrimination and making improvements to the working life for staff who identify as LGBTQ+.

The video is available via the Trust’s YouTube account.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**7th March 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Lisa Cheek, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Robert Presland – Deputy Chief Operating Officer Rayna McDonald – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer John Ridler – Associate Director of Finance				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose							
Approve		**Receive**	x	**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):

Substantial		**Good**	x	**Partial**		**Limited**	
Governance and risk management arrangements provide **substantial assurance** that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being **consistently applied** and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide **good levels of assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied** and **implemented but not across all relevant services**. Outcomes are generally achieved but with **inconsistencies** in some areas.		Governance and risk management arrangements provide **reasonable assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied but insufficient to demonstrate implementation widely across services**. Some evidence that outcomes are being achieved but this is **inconsistent across areas and / or there are identified risks to current performance**.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. **Little or no evidence** is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	

Justification for the above assurance rating. Where 'Partial' or 'Limited' assurance has been indicated above, please indicate steps to achieve 'Good' 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 (December for Cancer) are:

OPERATIONAL PILLAR METRICS

Of the 5 Operational Pillar Metrics, Cancer 62 day performance remained stable at 65% against the national standard of 85%. Current as at the end of December there were 174 ongoing cancer

pathways over 62 days which represents 9.13% of the PTL. The Trust has commenced tiering meetings with the NHS England regional team and at the time of writing was ahead of the recovery trajectory to meet the "fair shares" target number of breach reductions set by the regional team.

There were further improvements in the waiting list position with long waiting patients >52 & 65 weeks further reducing during January, although further industrial action taking place in February by the British Medical Association of junior doctors presents an ongoing risk to end of March delivery.

Emergency Care Mean stay across Emergency Department (ED) and the Urgent Treatment Centre (UTC) remained in line with the mean. There has been minimal change to the number of patients presenting overall, and ambulance conveyances reduced by 6% after a busier than expected December.

The number of patients with non-criteria to reside (NCTR) remains within the SPC control limits but there was a significant increase in bed days lost during January which averaged at 88 patients per day. Bed occupancy as a whole has continued to run high at greater than 98%, with Ward closures due to Infection Prevention and Control and higher acuity shown by increased utilisation of complex discharge pathways contributing towards significant flow challenges. The impact of poor flow on ambulance handover delays and increased response times to Category 1 and 2 calls has resulted in the BSW ICB moving into Tier 2 for Urgent and Emergency Care during January. Performance in other pillar metrics shows:

- Cancer 62-day December performance deteriorated from 67.5% to 65% and remains below the national target of 85%.
- RTT (Referral to Treatment) 65 Week Waiters – December performance shows the total number of patients waiting over 65 weeks at 330, a 3.8 % reduction from the previous month. 5 patients above 78 weeks were reported in January, due to complexity of treatment.
- Emergency Care, Emergency Department Mean Stay – There has been no significant change to the time patients spend in the Emergency Department covering both the ED and UTC, with wait times within control limits.
- Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. Total attendances in January were the highest in the calendar year to date, although ambulance conveyances were down 6% from the previous month. Demand increased in line with winter planning assumptions but 4 hour performance reduced to 73.5%, which is short of the national recovery ambition of 76% by March 2024.
- Number of non-criteria to reside (NCTR) days. Bed days lost due to patients in an Acute Hospital bed without a Criteria to Reside (NC2R) increased by 28% to 2,703, which is an average of 88 patients in month. A review of all complex discharge pathways is underway to improve flow out into all local authority areas in February.

OPERATIONAL BREAKTHROUGH OBJECTIVE

Mean time in ED from arrival to clinically ready to proceed (CRTP) remains below mean levels (455 in January 2024 against mean of 460 minutes in December) showing patients continue to wait longer to be off loaded, triaged, seen and diagnosed compared to national standard of 240 minutes. A recovery plan to reduce ambulance handover delays remains in place which is working towards improvement in this area, supported by the February Faster Flow initiative that is running throughout the month.

ALERTING WATCH METRICS

Key alerting measures include, RTT, Diagnostics (DM01), Cancer, ED and Flow.

- RTT shows fewer patients over 18, 52 and 65 weeks. The number of patients over 52 weeks shows a reduction for the 7th month in a row. However, industrial action in February presents an additional risk to waiting list recovery over the coming months.
- Diagnostics – The overall waiting list continues to decrease and waiting list activity in January 2024 was the highest recorded. However, performance is 49.32% against the national standard of 99% with under-performance driven by non-obstetric ultrasound, endoscopy and echo.

- Cancer – All 3-cancer metrics (faster diagnosis, 31 day decision to treatment and 62 day urgent referral to treatment) remain below constitutional standard, although 62 day performance is recovering towards the March 24 target in line with recovery plan.
- ED watch metrics show deterioration in handover delays this period and 4 hour performance and 12 hour trolley waits remain challenged against constitutional standards.

All flow measures show a deterioration this period with an increase in stranded patients waiting over 14 and 21 days. Virtual Ward occupancy however has increased to 84.8% which is the highest in this financial year.

The Integrated Performance report (IPR) for Care present our performance in key quality and patient safety indicators, reporting is based on the Improving Together methodology.

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 an increase in the total number of harms from 189 to 223 in month. The increase is being driven by a rise in Hospital Acquired (HA) COVID, falls, and pressure harms developed in the acute setting.

The number of Family and Friends (FFT) positive responses for January 2024 is 89.7%, an increase from December and remains 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 2023-24 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.

January has seen a further decrease in the number of community pressure related harms, with the fifth consecutive fall to 22 in month compared to 29 In December. The number of acute related pressure harms has increased in month to 47 compared with 30 in December.

Alerting Watch Metrics

The Trust overall complaint response rate has decreased in January 2024 to 71% and remains just below the internal target of 80%.

The Trust remains above trajectory for all three gram-negative bloodstream infections (E. coli, Klebsiella and P. aeruginosa) and for C. difficile, however there were zero Klebsiella or Pseudomonas infections in January. Some infections in previous months have been linked to intravenous long-lines, particularly in our Oncology/Haematology areas, and a working group has been set up to address this.

E. coli numbers remain high despite progress being made on catheter care. A recurring theme from investigations has been identified as issues relating to sampling (samples not sent, mislabelled or not followed up). An improvement group has been established to investigate the causes in more depth and develop appropriate actions to address where possible.

There has been an increase in the Family and Friends (FFT) Day case response rate and positive response rate and the Maternity response rate. The Emergency Department and Urgent Treatment Centre response rate has decreased slightly and remains under the internal target.

There have been no Methicillin-resistant Staphylococcus Aureus (MRSA) infections reported in month.

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

- Safer staffing fill rates have increased slightly and remain well above the National target of 85%.
- Five Serious Incidents (SI's) have been declared in month, with 25 ongoing SI's, eight overdue the 60 days target. All are being investigated under the Serious Incident Framework.
- There has been an increase in both the number of concerns and complaints in month, but the number of complaints reopened has decreased.
- There have been three Methicillin Sensitive Staphylococcus Aureus (MSSA) infections reported in month.
- There has been an increase in the number of falls in month to 106 from 93 in December.
- FFT overall response rate has increased 29% and is now above the internal target of 28%.
- There has been an increase in the number of hospital acquired COVID cases in month (25) when compared to nine in December.

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 (Key Performance Indicators) indicator achievement score and self-assessment score based on progress in month.

Strategic Pillar Target from A3 goals:
The Trust Strategic Pillar is that "*Staff and Volunteers feeling valued and involved in helping improve quality of care for patients"*

The Trust Pillar metrics to ensure performance against the Strategic Pillar are:

- **Staff Survey – Recommend a Place to Work**
  Target 55% achieving 57% (Q2 pulse survey) and 55.89% (Q4 Pulse Survey)
- **Staff Voluntary Turnover**
  Target 11% achieving 8.9% (December data)
- **EDI disparity (reducing discrimination disparity)**
  Target 8.3% achieving 15.9% (Q4 pulse survey)

The Annual Staff Survey is embargoed and therefore the results cannot be shared. However, Q4 pulse survey (22% representing 1308 staff completed the survey) data is now available. There has been a small deterioration in the results for questions "Recommend a Place to work" and "I am able to make improvement" and a significant deterioration in BME staff "experiencing discrimination from a colleague or team leader", widening the EDI disparity gap. At this stage we cannot compare it against the annual results due to the embargoed status**.**

Breakthrough Objectives
The Trust Breakthrough objective is to achieve a 5% improvement (55% target) from the 2022 Staff Survey in the question "*I am able to make improvements happen in my area of work*". Results from the annual staff survey are embargoed, however indicative information shows an improvement in this question.

The annual staff survey results are embargoed, however the results for Q4 pulse survey have shown a small deterioration in performance for this questions to 53.25% against a 55% target.

Staff Survey 2023

The 2023 Annual National Staff Survey launched on 11th September and closed on the 24th November. The Trust achieved 69% response rate which was above 59% achieved last year and above the 65% target set. The is currently the highest response rates for Trust that use Picker.

The results are currently embargoed until end of February when the national results will be shared. A separate high-level briefing has been provided to TMC and the Board. Initial analysis has been positive with an overall improvement in the majority of questions.

Division and departments have received their results and have been asked for a briefing for the Staff Survey Working group before then review their A3's.

Alerting Watch Metrics
The in-month sickness absence position increased in December to 5.0% and remains above the Trust KPI of 3.5%. LTS has seen a further decrease in month to 2.3% however STS has increased to 2.7%. Whilst alerting, this remains within usual seasonal variation and is below last year's sickness rate of 5.8%. Most recent national benchmarking data (September 2023) shows the Trust has maintained its position in the first-lowest quartile and remains within the top 20% of Acute Trusts nationally.

The Flu vaccine programme is continuing with 68% of our staff having received a vaccine. This is 5% lower than last year, however this is a trend replicated nationally and the Trust maintains its position as having the highest uptake across BSW and top 10 nationally.

Non-Alerting Watch Metrics
Voluntary turnover maintains its stability in December, reducing to 8.9% in-month and continuing below the Trust KPI of 11%.

Employees leaving within their first year of employment has experienced a slight increase from 12.9% in November to 13.6% in December, but remains below the 12-month average of 14.8%.

HR Scorecard

Vacancy Rate:
The Trust vacancy rate has increased in January to 4.1% (224WTE). This was predominantly driven by an increase to our funded establishment of 49WTE to correct budgets within Medicine Division (Nursing and Medical increases) but was offset by sustained recruitment performance (net contract growth in January of 27WTE and a 44-day time-to-hire).

Worked Against Budget:
Our funded establishment in January was 5,431WTE, and 5,578WTE was utilised in-month to deliver our services. This is 147WTE above budget (2.7%), and an increase of 19WTE from December.

In M10 the workforce costs are £4M overspent compared to budget, representing an £8.2M overspend YTD. The in-month overspend is largely driven by budget adjustments for Pay Savings targets which has been removed from budget in Admin and Clerical.

This is broken down as followed for in month variance against budget:

- Nursing -£767K
- AHP/STT -£6K
- Medical +£944K
- Admin and Clerical +£3.8M

Year to date as follows:

- Nursing +£2M
- AHP/STT -£75K
- Medical +£6.6M
- Admin and Clerical -£291K

Workforce Recovery 2024/25
For 2024/25, the Trust has a target of £11.7M paybill reduction to be delivered as a recurring efficiency – in line with the medium term financial plan. The People Services team are establishing a Workforce Recovery Group to oversee this workstream and support Divisional teams in identifying opportunities to reduce their workforce.

Current Workforce Control initiatives continue in February, with heightened approval for Corporate bank roles being introduced from 1st February. Divisional teams continue to heighten controls for their Nursing and Medical workforce, and the Executive Vacancy Review Panel is maintaining control for all vacancy requests. Whilst EVRP has been introduced to control vacancy requests, to date the panel has only declined 2 vacancies (Academy Receptionist and AHA Project Manager) and therefore a review of the added value this process brings will take place at the end of February with a view to deciding whether vacancy control can instead be driven by the Workforce Recovery Group.

Agency Spend against Plan
Agency spend for January was £0.73M, below the in-month target of £0.91M and reporting as 2.8% as a percentage of total workforce spend.

YTD agency spend is at £8.7M, which is £1.5M less than plan and £3.9M less than this time last year – over delivering the £3M reduction target set for the 23/24.

The has mainly been achieved via the reduction.

Whilst the reduction in agency compared to previous year is positive, the Trust has spent £4.8m more on bank usage and therefore the focus in 24/25 will be agency, bank and substantive workforce reduction.

Use of Resources
As at M10 the Trust is in a ytd £3.7m deficit position which represents a £3.5m adverse variance to plan. Although the Trust received £5m of funding for industrial action costs incurred up to M8, a further £1.1m has been incurred in M9 and M10. In addition, the Trust has not met efficiency savings of £0.8m as a result of industrial action. There are a number of other in-year pressures, namely: CDC cost over income (£1.8m), undelivered efficiency savings (£1.8m), a shortfall on ERF related income (£3.8m), additional medical pay award costs (£0.8m) and temporary staffing pressures (£1.5m). Some of these net costs are offset by prior year income, other non-recurrent income and underspends elsewhere totalling £8.1m.

The Trust's forecast position is a most likely £5.6m deficit, which is in line with the M8 forecast. The best case scenario is a deficit of £0.9m based on £1.7m of internal improvements (lower annual leave accrual, review of GRNI and lower annual leave accrual) and a further £3m of external funding for CDC and industrial action costs.

Efficiency savings were £0.2m above target in-month and are £1.8m behind plan on a YTD basis. However, only 42% of the YTD savings delivered are recurrent. Moving into 24/25 the focus has to be on developing recurrent savings to address the Trust's underlying deficit.

The Trust remains reliant on non-recurrent income streams and cost budget to maintain its adverse plan position of £3.6m. Therefore, focussing on run rate savings i.e. reducing our monthly spend through strong grip & control, particularly on temporary staffing, has to be the priority for operational colleagues for the remainder of the year.

Breakthrough Objectives
Implied Productivity for the Trust in total is still recovering but is slightly down to -16% for Month 10 from last month (this is a 2% improvement from the -18% at the end of 2022/23 - March 2023). The Breakthrough objective productivity measure continues to be against 2019/20 cost change as it is measuring the increased cost from 2019/20 levels.

The 1% slight deterioration from last month (M9) mostly reflects the financial position being off plan but recovery in activity still happening compared to 2019/20. The financial position overall may still end up being compensated for industrial action and ERF activity (£4.1m total) but this is largely not within divisions but instead held centrally. There has been this impact financially for industrial action in December and January and so current productivity recovery vs 19/20 is still being impacted. The position does also still reflect being off track with some of our activity and financial plan for 2023/24 due to higher pay pressures such as community diagnostic unit costs, pay awards, temporary staffing and behind plan CIP Delivery.

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

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

Explanation of above analysis:

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 (National Health Service) staff survey studies, results indicate that exclusionary behavior correlates with staff intention to leave the NHS and other research indicates the link between discrimination and physiological, psychological, and behavioral 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 (Black, Asian, and Minority Ethnic) 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 (Workforce Race Equality Standard) 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	
Date	26/02/24

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

February 2024

January 2024 & December 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 2023/24 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	5-12
Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: Patients Developing Pressure Ulcers; Emergency Department - Clinically Ready to Proceed; Implied Productivity and Staff Survey Results	13-16
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	17-19
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	20-23
Use of Resources This includes key indicators and watch metrics for finance as assured by the Finance, Infrastructure & Digital Committee, and is also subject to a separate board report	24
Our People This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee	25-30
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.	32-45

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total patients waiting more than 65 weeks	0	384	458	525	640	621	689	661	488	417	343	330
Percentage of patients who receive a diagnostic test within six weeks of referral	99% (Nat)	56.1%	50.4%	52.3%	52.2%	49.4%	44.5%	46.1%	45.0%	49.5%	46.8%	Reported one month behind
62 day backlog (As % of allocated "Fair shares" position)	9.53% (Nat)	5.6%	157.6%	157.6%	148.4%	156.0%	180.3%	200.4%	178.6%	181.1%	145.9%	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	76.5%	73.6%	71.3%	65.0%	67.2%	62.6%	62.0%	58.2%	59.7%	60.4%	Reported one month behind
Proportion of patients seen within four hours	95% (Nat)	77.2%	75.7%	74.8%	73.8%	75.5%	74.2%	74.7%	71.5%	71.4%	74.7%	73.5%
Ambulance average Category Two response time	00:18:00 (Nat)	00:53:23	00:37:25	00:40:02	00:51:09	00:46:15	00:56:36	02:05:05	01:48:08	01:56:41	01:11:41	01:49:56
Percentage of beds occupied by patients who no longer meet the criteria to reside	13.3% (Nat)	19.5%	16.4%	16.4%	17.8%	17.2%	14.3%	15.8%	17.4%	18.1%	17.8%	17.8%
Adult general and acute type 1 bed occupancy (adjusted for void beds)	94.5% (Nat)	98.6%	98.0%	98.4%	98.2%	97.6%	98.2%	98.7%	98.8%	98.5%	96.3%	98.6%
Virtual ward - percentage capacity occupied	64.1%	29.5%	23.4%	28.1%	28.5%	53.7%	44.4%	53.8%	65.1%	70.8%	78.4%	84.8%
Summary Hospital-level Mortality Indicator	0 (Nat)	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
National Patient Safety Alerts not completed by deadline	0 (Nat)	0	0	0	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
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection	0 (Nat)	3	3	3	3	4	4	4	3	3	Reported two month behind	Reported two month behind
Clostridium difficile infection	100% (Nat)	102.1%	106.5%	123.9%	117.4%	130.4%	130.4%	132.6%	147.8%	137.0%	Reported two month behind	Reported two month behind
E. coli bloodstream infection	100% (Nat)	156.5%	157.6%	169.7%	142.4%	147.0%	142.4%	147.0%	156.1%	153.0%	Reported two month behind	Reported two month behind
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Leaver rate	11.0% (Int)	11.2%	10.5%	10.5%	10.2%	9.7%	9.6%	9.5%	9.2%	9.2%	8.9%	Reported one month behind
Sickness absence rate	3.5% (Int)	4.6%	3.8%	3.7%	3.8%	4.4%	4.0%	4.2%	4.7%	4.7%	5.0%	Reported one month behind

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	6.6%	6.3%	5.2%	6.7%	5.3%	5.3%	5.3%	5.3%	5.4%	5.4%	Reported one month behind
Proportion of staff in senior leadership roles who are women	64% (Nat)	54.3%	55.7%	54.0%	56.0%	56.1%	56.1%	56.1%	56.1%	56.9%	57.1%	Reported one month behind
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	0.0%	1.8%	1.7%	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%	1.8%	1.8%
Financial efficiency - variance from efficiency plan (£'000)	+/-	281	-377	-384	334	-641	-338	-504	-39	478	-224	183
Financial stability - variance from break-even (£'000)	+/-	-1482	-2157	-2591	-144	-659	330	-1352	1996	5043	-1877	-1911
Financial stability - variance from PLAN (£'000)	+/-	-18	-893	-2132	-223	-733	-528	-1646	1334	4489	-1204	-2417

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	7.0	7.0	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	57.9%	-	-	60.4%	57.1%	56.1%	56.4%
Stillbirths per 1,000 total births	2.3	-	2.4	1.9	2.1	2.8	Waiting for data
Neonatal deaths per 1,000 total live births	1.2	-	1.4	1.0	1.0	1.3	Waiting for data

Executive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

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

- Pressure 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.

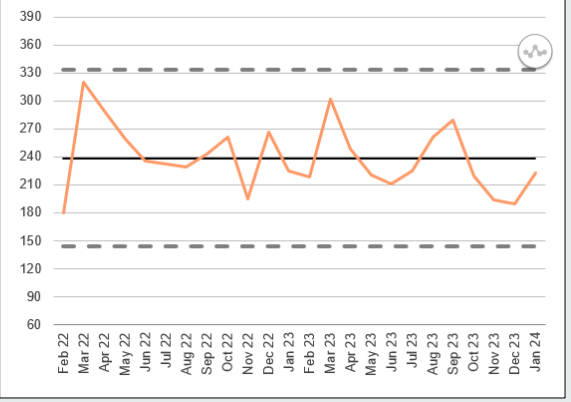
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

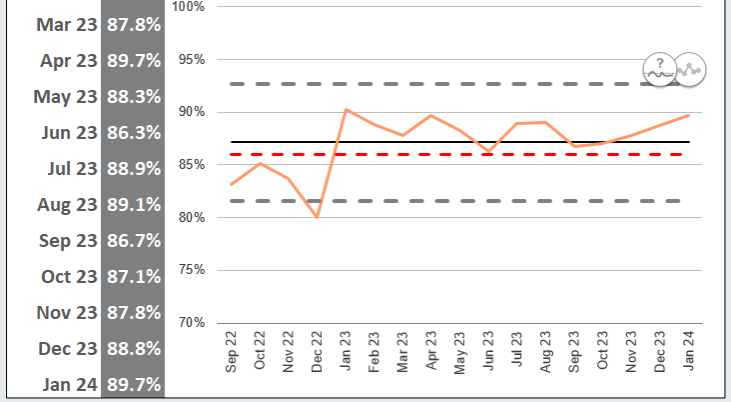
Timescale	Value
Feb 23	218
Mar 23	302
Apr 23	248
May 23	221
Jun 23	211
Jul 23	225
Aug 23	261
Sep 23	279
Oct 23	219
Nov 23	194
Dec 23	189
Jan 24	223



Patient Experience (Friends & Family Test)

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

Timescale	Value
Feb 23	88.8%
Mar 23	87.8%
Apr 23	89.7%
May 23	88.3%
Jun 23	86.3%
Jul 23	88.9%
Aug 23	89.1%
Sep 23	86.7%
Oct 23	87.1%
Nov 23	87.8%
Dec 23	88.8%
Jan 24	89.7%



Counter Measures

The number of harms has increased in January to 223, primarily driven by an increase in Hospital Acquired (HA) COVID, falls, and pressure harms developed in the acute setting. There has been a further reduction in pressure harms in the community setting.

Whilst the Trust remains over trajectory for most infections there have been further improvements seen, with zero *Klebsiella* or *Pseudomonas* infections in January.

For January 2024, the Trust wide positive Family and Friends score is 89.7%. This is the third consecutive monthly increase and remains above the internal target of 85%.

Following previous negative feedback from the deaf community, the PALS team have sourced funding for several staff to undertake a British Sign Language Level 1 course with specific modules aimed for healthcare settings. Approximately 20 staff have joined the first cohort and further funding has been secured to run a second cohort in 2024. We have already seen clear examples of staff proactively communicating with patients using their new skills.

The Cancer services team have been awarded with the Myeloma UK Clinical Service Excellence Programme accreditation. This accreditation demonstrates that as an organisation we deliver optimum treatment and care for patients with myeloma.

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.

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

Cancer 62day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In December, there were 48.5 breaches in total, with 32.0 of these attributed to the Urology, Colorectal and Skin pathways. Skin and Colorectal have seen increased demand resulting in capacity challenges. We continue to see greater than normal breaches in Urology where number of breaches relate to patients needing time to consider which choice of treatment they would prefer and pathways requiring additional treatment following an incomplete procedure.

RTT: Number of patients waiting over 65 weeks

January performance shows the total number of patients waiting over 65 weeks at 330, a 4% reduction from the previous month. 5 patients above 78 weeks were reported in January, 2 due to complexity of treatment and 3 due to capacity.

Focused monitoring and support via a weekly improvement plan is being provided to specialities that are currently at risk of not achieving the national target of eliminating 65 week waits by March 2024. High risk areas where capacity breaches are possible include Gastroenterology, General Surgery, Gynaecology and Respiratory Medicine. Trajectories for improvement and recovery plans are being reviewed along with tatctial opportunities to mitigate the loss of booked activity during the period of Industrial Action in February 2024.

5 x 78 week breaches were reported at the end of January 2023: 3x non-admitted patients in Gastroenterology, 1 x non-admitted patient in dermatology and 1x admitted patient in Oral Surgery. Breach reports for these patients are underway and next events being scheduled in February 2024.

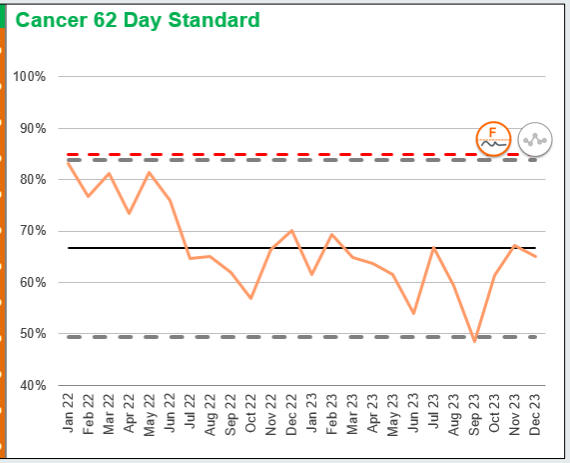
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

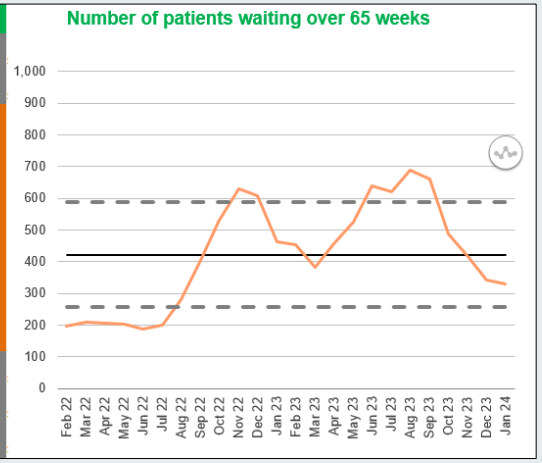
Timescale	Value
Jan 23	61.6%
Feb 23	69.3%
Mar 23	64.8%
Apr 23	63.8%
May 23	61.5%
Jun 23	54.0%
Jul 23	66.9%
Aug 23	59.5%
Sep 23	48.5%
Oct 23	61.3%
Nov 23	67.2%
Dec 23	65.0%



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
Feb 23	455
Mar 23	384
Apr 23	458
May 23	525
Jun 23	640
Jul 23	621
Aug 23	689
Sep 23	661
Oct 23	488
Nov 23	417
Dec 23	343
Jan 24	330



Counter Measures

Risk: Dermatology capacity had been impacted by vacancies and increase in referrals.
-Recruitment of substantive Consultant continues. Performance shortfalls are expected through the winter as a result of expected leave. Due to the number of referrals received this will have an impact on the overall Trust performance.
-External Derm team have provided up to 400 additional slots over 2 weeks to clear ASI wait lists through January & February.
Risk: Capacity in Plastics is insufficient to see and treat patients.
Mitigation: Some Plastic patients are being sent to Wootton Bassett to help free up surgical space at GWH. Implementation of improvements in both pathway and processes following mapping exercise are underway. Actions to improve capacity and operational processes have been agreed with the divisional management team.
Risk: Urology Pathways 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 often 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 have undergone LATP biopsy training with a view to reducing the demand on TRUS biopsies.
Risk: Capacity issues for colorectal 2ww triage, post diagnostic reviews and appointments after MDT are an issue.
Mitigation: Close management of Registrar rota's 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. Booking in order practice being reviewed
- 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.
- Booking to DNA rates has commenced in key specialties.
- Validation of waiting lists (Project Verify) being embedded, along with cohorts of patients waiting over 40 weeks being offered alternative health care providers.

Risk: Reduced 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.
- Long waiting and cancer patients to be brought forward to reduce the risk of cancellation.

Pillar Metrics

Executive Summary

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).

January has been another busy month in both ED & UTC with 11,160 patients seen in month from 11,065 in December. Whilst attendances dropped slightly in ED, there was a marked increase in UTC (2.4%).

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

January saw a significant increase in **NCTR 88 from 68** running average on the day. Medical outliers increased to an average of 45 patients (threshold target is <30). Average discharges per day remained the same as November at 93 patients per day. Pathway 1 discharges equated to 255 which was a **10% increase** on December, Pathway 2 an increase of **22% to 102** which is a direct collation of the complexity and acuity of patients. Home first(Swindon) was below target of 125 which was 110 discharged with home first support – this is due to reduced provision on the bank holidays.

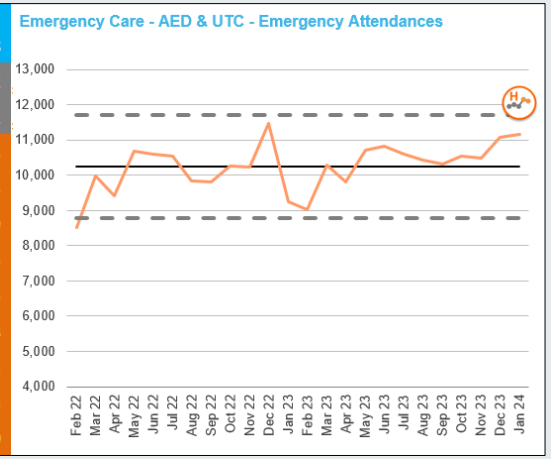
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

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

To ensure patients are cared for in the appropriate setting

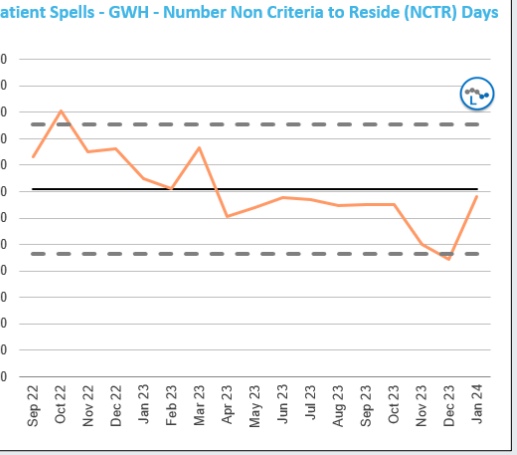
Timescale	Value
Feb 23	9,018
Mar 23	10,302
Apr 23	9,801
May 23	10,715
Jun 23	10,833
Jul 23	10,599
Aug 23	10,435
Sep 23	10,325
Oct 23	10,548
Nov 23	10,491
Dec 23	11,065
Jan 24	11,160



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
Feb 23	2,774
Mar 23	3,162
Apr 23	2,510
May 23	2,599
Jun 23	2,694
Jul 23	2,675
Aug 23	2,614
Sep 23	2,631
Oct 23	2,625
Nov 23	2,251
Dec 23	2,106
Jan 24	2,703



Counter Measures

Co-ordination Centre and Navigation Hub processing referrals from Care Homes, community teams, ambulance service and partner referrals via discharge hub.

Call before convey message to SWAST crews through BSW care co-ordination.

Assessment and pathway changes to support direct access from ED & UTC to most appropriate admission areas.

Hosptial at Home (across BSW) working to one model and full occupancy.

Trust learning from the December reset week and critical incident in early January has resulted in the implementation of a Faster Flow initiative in January carrying on throughout February. Actions within the Admitted Flow woirkstreram include:

Opportunities:

- Review of escalation approach for patients with no criteria to reside including out of area patients.
- To review the approach to criteria led discharge for patients and maximise opportunities for earlier in the day discharge including to discharge lounge.
- Review wards that have opportunities for higher discharges prior to midday
- Pre-empting discharges 24 hours in advance & preparing TTAs in advance.

Reflections:

- Standardising discharge processes including discharge summaries and medicine to take away.
- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Discharge Reg support has been in place for weekends during December and January with positive outcomes - weekends in December/Jan 2023/24 we exceeded an extra **32.25%** of discharges than we would usually expect over this time..

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 Jan'24 was 455 minutes against the national standard of 240 minutes. This is below mean levels (460mins) and well below the mean time waits in January 2023 of 503 mins.

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

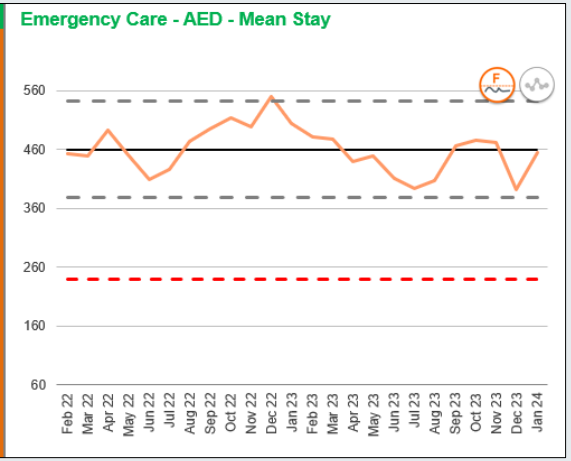
The total meantime wait for a patient in January 24 was 160 minutes against the national standard of 240 minutes, demonstrating good flow through the service despite an increase in paediatric attendances experienced at the end of November and into December.

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.

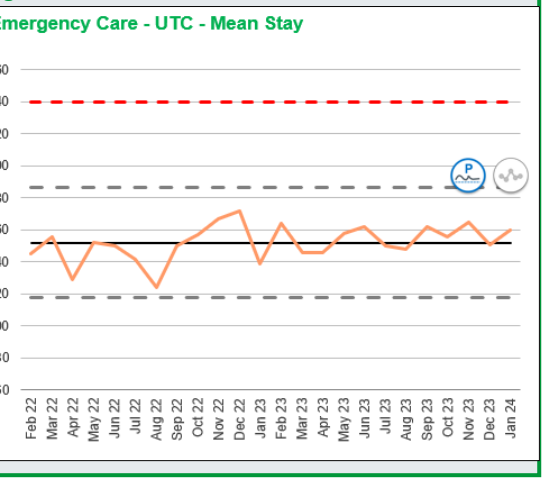
Timescale	Value
Feb 23	482
Mar 23	477
Apr 23	440
May 23	448
Jun 23	410
Jul 23	393
Aug 23	407
Sep 23	466
Oct 23	475
Nov 23	471
Dec 23	391
Jan 24	455



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Feb 23	164
Mar 23	146
Apr 23	146
May 23	158
Jun 23	162
Jul 23	150
Aug 23	148
Sep 23	162
Oct 23	156
Nov 23	165
Dec 23	151
Jan 24	160



Counter Measures

- Arc nurse trial to improve ambulance handover processes and triage / streaming in department.
- 2nd Pit-stop implemented to improve capacity for rapid assessment and triage.
- SDEC/Chairs in reach project to pull at least 10 patients from ED to SDEC per day/
- Recruitment drive initiated via Medical Control Weekly Meeting to reduce agency and increase substantive body. This will improve the financial sustainability of department but also improve quality of care across the 24/7 running of the department.
- Internal Handover delay improvement plan in place which will be further updated following the learning from the teams who participated in reset week. This has also been carried over into the February Faster Flow initiative.

- 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

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 is now sustaining the downward trend seen in its voluntary turnover rate from July 2022, with the position in December reducing further to 8.9%. The Trust has seen performance below the 11% target for 9 months and is also below the current national average of 11.1%. Performance continues to be maintained through the Trust Retention Working Group, with countermeasures being refined to focus on leavers within the first year of employment.

Staff Recommendation as a Place to Work

The Trust recommend a place to work target is 58% which is in line with the National Average for 2021 staff survey results. Current performance is 55.9% (Q4 Pulse Survey).

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 Trust achieved a 69% response rate in the 2023 Annual Staff Survey, and initial results show promising increases to core questions. Results are currently embargoed and will be published in March, however an initial briefing has been shared with Execs and NEDs.

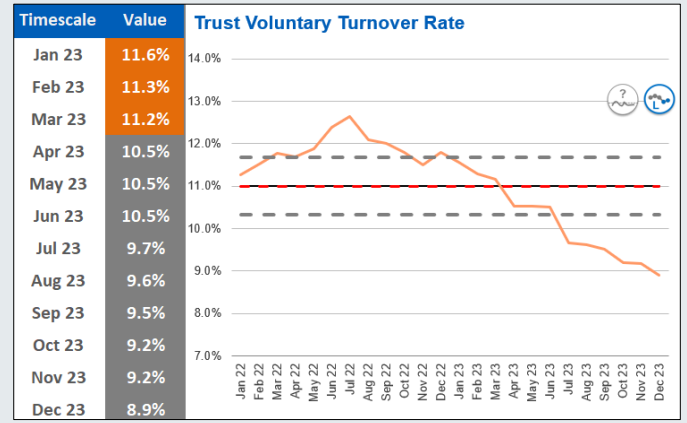
Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

Trust Voluntary Turnover Rate

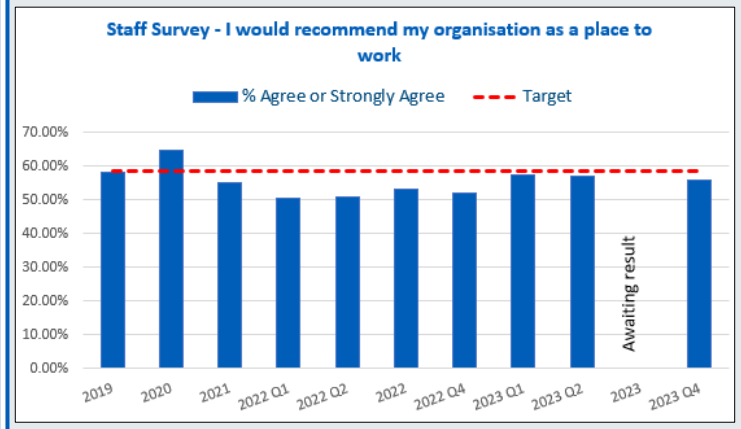
To achieve and maintain a maximum voluntary turnover rate of 11%.

Timescale	Value
Jan 23	11.6%
Feb 23	11.3%
Mar 23	11.2%
Apr 23	10.5%
May 23	10.5%
Jun 23	10.5%
Jul 23	9.7%
Aug 23	9.6%
Sep 23	9.5%
Oct 23	9.2%
Nov 23	9.2%
Dec 23	8.9%



Staff % recommend the organisation as a place to work

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



Counter Measures

- December voluntary turnover reported at 8.9%, a further reduction in-month and showing sustained performance in this metric.
- A 'People Promise Manager', focussing on retention, is being introduced in the People Operations Team from April 2024 to lead the Trust in delivering the Retention elements of the NHS People Promise.
- Current countermeasures continue to be driven by the Trust Retention Working Group. The 'expectations of a line manager' toolkit has been identified as a key component to this, and work will continue to develop this tool to empower managers to manage and prevent exits within the organisation.

- 2023 Annual Staff Survey results remain embargoed until March 2024, however the Q4 Pulse Survey results show a small decline on this metric compared to both Q2 and the 2023 Survey. Early analysis on this question shows Admin & Clerical and Unregistered Nursing Staff as potential areas of focus for countermeasures moving forward.
- Promotion of Health & Wellbeing initiatives continues in February:
  - Mental Health Skills Training for Managers planned for 15th February
  - Webinars provided by our EAP provider focusing on Care First and Random Acts of Kindness
  - Continuation of the annual Flu campaign to protect our staff

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.

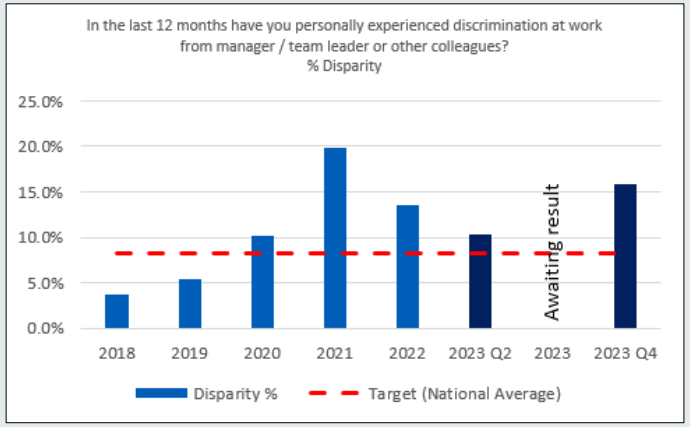
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

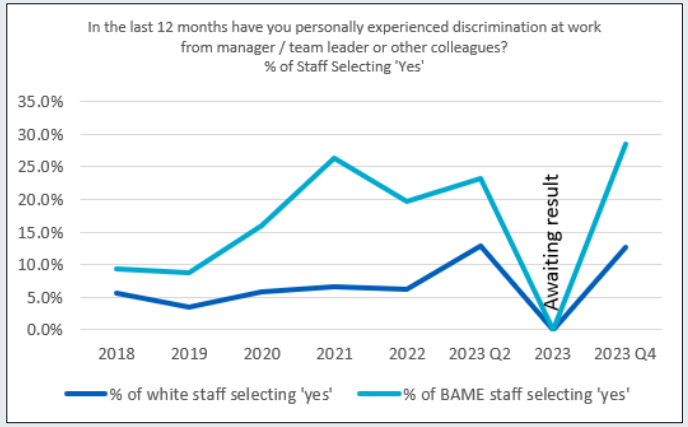
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 8.3% in line with the national average and be below the national average for all staff.

Q4 disparity has increased to 15.9%. Both white staff and BAME staff are reporting discrimination, white staff has reduced from 12.9% to 12.7% and BAME has increased from 23.2% to 28.6%.

Jude Gray
Director of Human Resources (HR)

% 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

- Inclusion Recruitment Champion Workshop – the Trust hosted its second workshop in February, there are 13 trained IRCs who are available to support interview panels for Band 8B and above roles. A further 15 are due to be trained on the 7 March.
- EDI Champions Project (EDI Improvement Award) – the Trust successfully launched the EDI Champions project, 10 staff have attended training and a further 39 have expressed an interest. There are also two workshops scheduled in March and April. The project group has delivered a Benefits Mapping session to identify KPIs and benefits and 18 staff attended the 2-hour design sprint on 6 February and the feedback from staff will be used to develop a bespoke workshop to address unprofessional behaviours.
- Equality Delivery System (2022) evaluation will take place at system level 26 February virtually, BSW will evaluate PALs and Complaints collectively under Domain 1 Commissioned & Provider Services. Domain 2 Workforce Health and Wellbeing and Domain 3 Inclusive Leadership will be scored internally. When scoring Domain 1, we will widen participation this year and include the voice of patients in this process.
- The EDI Lead, Equality Lead Nurse, Head of L&D and L&D Coordinator are designing a Cultural Competence workshop which will be rolled out in April, targeting Band 6 and 7 staff, however some spaces will be reserved for any staff.
- In the Q4 Pulse Survey, 28.6% of ethnic minority staff have said they have experienced discrimination, this has increased since the 2022 Survey when 19.8% of this group had reported the same. The EDI Lead is due to visit Divisional Boards late February to support them as they develop action plans and A3s to respond to findings in their local area.

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.

As at the Trust is in a ytd £3.7m deficit position which represents a £3.5m adverse variance to plan.

Although the Trust received £5m of funding for industrial action costs incurred up to M8, a further £1.1m has been incurred in M9 and M10. In addition, the Trust has not met efficiency savings of £0.8m as a result of industrial action. There are a number of other in-year pressures, namely: CDC cost over income (£1.8m), undelivered efficiency savings (£1.8m), a shortfall on ERF related income (£3.8m), additional medical pay award costs (£0.8m) and temporary staffing pressures (£1.5m). Some of these net costs are offset by prior year income, other non-recurrent income and underspends elsewhere totalling £8.1m.

The Trust's forecast position is a most likely £5.6m deficit, which is in line with the M8 forecast. The best case scenario is a deficit of £0.9m based on £1.7m of internal improvements (lower annual leave accrual, review of GRNI and lower annual leave accrual) and a further £3m of external funding for CDC and industrial action costs.

Efficiency savings were £0.2m above target in-month and are £1.8m behind plan on a YTD basis. However, only 42% of the YTD savings delivered are recurrent. Moving into 24/25 the focus has to be on developing recurrent savings to address the Trust's underlying deficit.

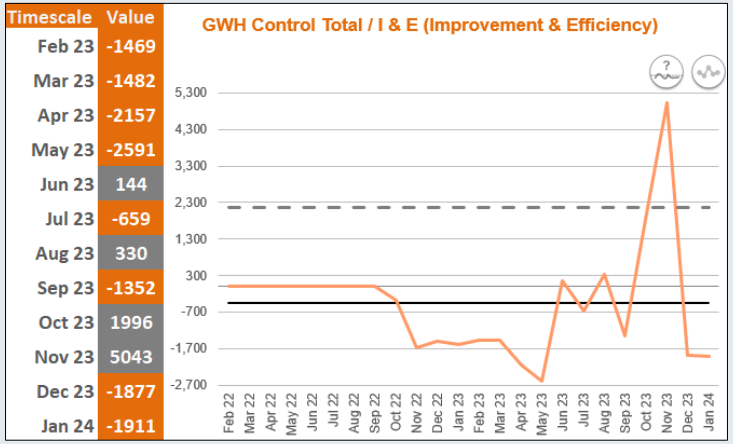
The Trust remains reliant on non-recurrent income streams and cost budget to maintain its adverse plan position of £3.6m. Therefore, focussing on run rate savings i.e. reducing our monthly spend through strong grip & control, particularly on temporary staffing, has to be the priority for operational colleagues for the remainder of the year.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Feb 23	-1469
Mar 23	-1482
Apr 23	-2157
May 23	-2591
Jun 23	144
Jul 23	-659
Aug 23	330
Sep 23	-1352
Oct 23	1996
Nov 23	5043
Dec 23	-1877
Jan 24	-1911



Counter Measures

- Efficiency savings were £0.2m ahead of target in month and are £1.8m behind plan on a YTD basis. There are £16.9m of identified schemes but only £7.1m (42%) of this total is fully developed.
- Countermeasures continue through the efficiency programme, including:
  - Focus on actions to reduce run rate – additional sub committees focusing on green, amber and red actions
  - Cross-divisional schemes such as Better Buying and Medicines Optimisation
  - Financial Recovery workstreams including workforce controls (incl. Agency reduction), outpatients, clinical coding and elective recovery

Executive Summary

Great Western Hospitals NHS Foundation Trust

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.

The graph shows the DRAFT year to date performance up until **Q2 of financial year 23/24.**

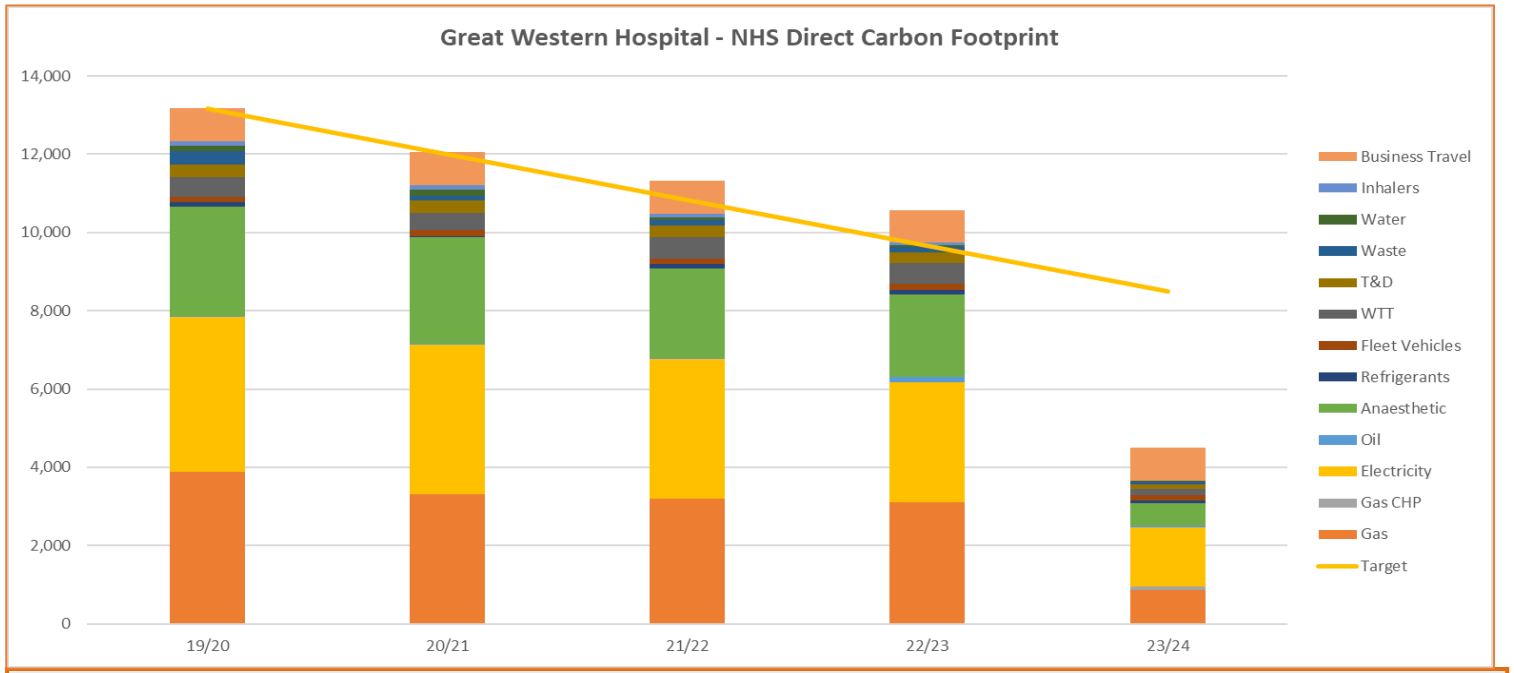
In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032 as shown with the target line on the graph from our 19/20 baseline year.

GWH are in a good position for carbon heading into the colder winter months.

The Department for Energy Security and Net Zero's (previously known as DEFRA) carbon conversion factor for grid electricity has increased by 7% this year due to an increase in natural gas use in electricity generation and a decrease in renewables.

Note: with the commissioning of our CHP the carbon footprint for this financial year is expected to increase due to a larger reliance upon natural gas. The CHP provides a cost saving but increase in our carbon footprint.

Simon Wade
Chief Financial Officer



Counter Measures

1. 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 for indirect emissions by 2045.
2. The Sustainability Team have won Salix funding for a heat decarbonisation plan which will be completed March 2024 which will impact the wider decarbonisation graph.
3. Capital projects for reducing emissions from medical gasses have taken place with a further improvement project this capital year to expand the AGSS in labour delivery.
4. Current capital projects includes the electrification of fleet vehicles.

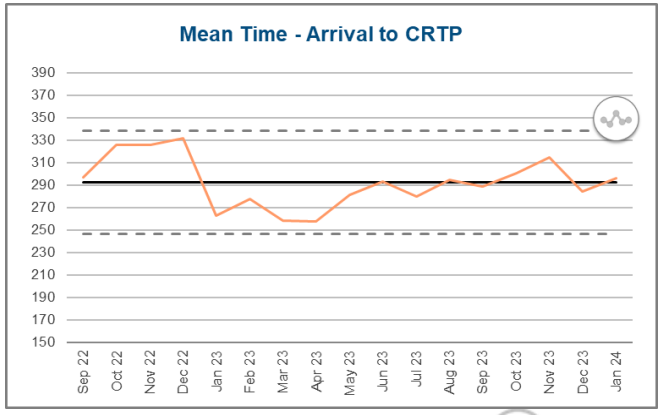
2023/24 Breakthrough Objectives

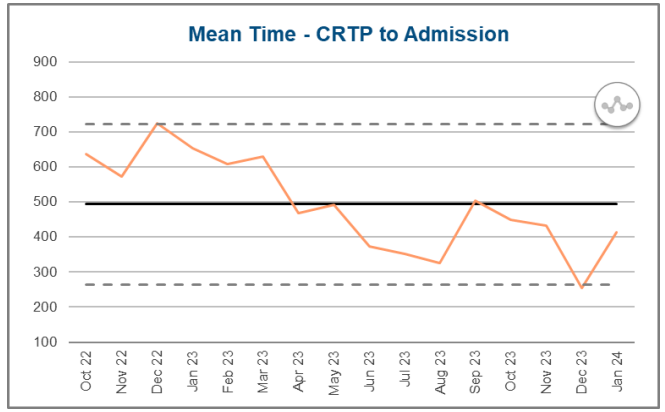
Emergency Attendances - Clinically Ready to Proceed (Admitted)

Great Western Hospitals NHS Foundation Trust

Mean time in ED (Minutes)

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Pre CRTP	277	259	258	281	293	280	295	289	301	315	284	296
Post CRTP	608	629	467	492	373	352	326	504	449	433	254	414





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.

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) remains close to median (296 in January from 284 in December) showing normal variation in the time to be off loaded, triaged, seen and diagnosed.
- Mean time in ED from CRTP to admission has increased from 254 to 414 in January indicating patients spending more time in ED awaiting admission. Flow out of ED has been significantly affected by high bed occupancy in January, which in turn has contributed towards an increase in ambulance handover delays and deteriorating ambulance response times. Whole hospital flow actions are being reviewed to improve performance in February.

Risks

Physical and pathway reconfiguration required for Way Forward Programme (WFP) will see slightly reduced cubicle space across the ED footprint.

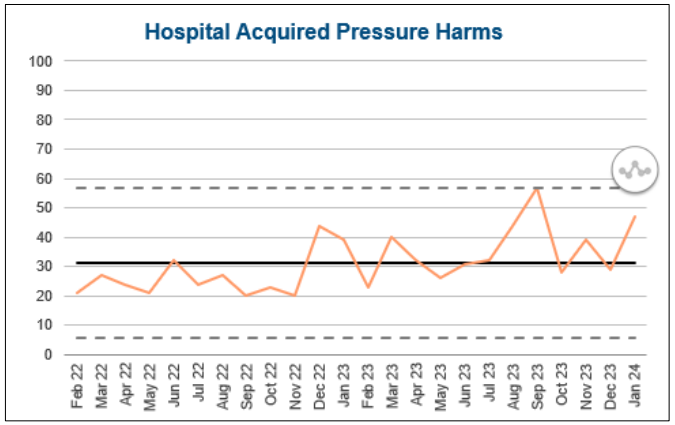
2023/24 Breakthrough Objectives

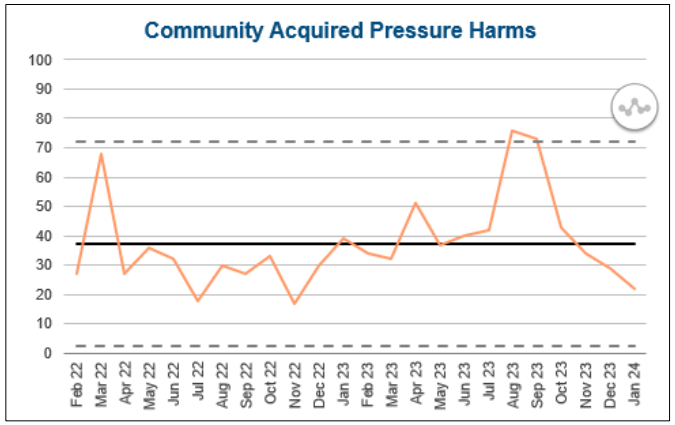
Reduction of Pressure Harms

Great Western Hospitals NHS Foundation Trust

Total Pressure Harms

Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
57	72	83	63	71	74	120	131	71	73	58	69



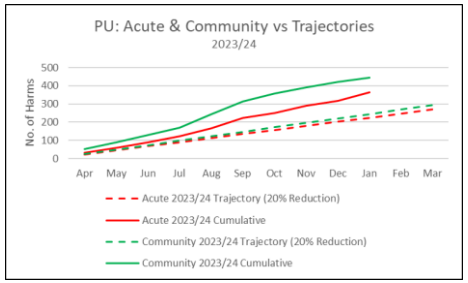


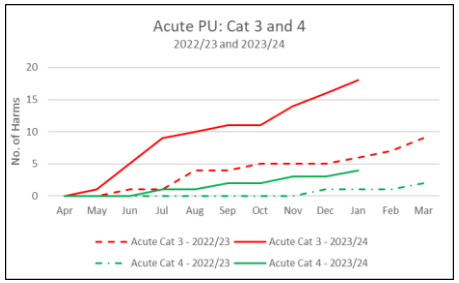
Common cause – no significant change

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.

The graphs show the cumulative number of pressure harms in both the acute and community settings and the trajectory based on the target of 20% reduction on the previous year's performance. The 1st shows overall figures while the 2nd shows only Category 3 & 4 harms and progress against the zero trajectory.





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.

Performance

There has been an increase in the number of pressure harms reported in month across the Trust. This is driven by a rise in pressure harms in the acute setting. The long waits for ambulance off loads and in assessment units may have been a contributing factor. The community setting has seen a reduction in the number of pressure harms for the fifth consecutive month.

There were 47 (29 in December) hospital-acquired pressure harms during January 2024.

- Suspected deep tissue injuries in patients near end-of-life was a strong contributing factor to this month's numbers. Focused teaching to staff is planned on the importance of repositioning such patients and discussing the need with families, in conjunction with the palliative care team.
- Inappropriate use of dressings for managing moisture-associated skin damage was another contributing factor this month. A reminder on the correct treatment pathways and products to use has been circulated to all wards.
- One category 4 harm occurred on the elbow of a patient. The TVN team are working with the ward where this occurred, highlighting improvement opportunities in the assessment and documentation of skin condition.

In the community setting there were 22 (29 in December) pressure harms acquired during January 2024. This is a further decrease from the previous month.

- 41% of harms involved patient receiving end of life care.
- One patient with a Category 4 pressure harm has significant complex needs. There was no gaps or omissions in care or provision of equipment.

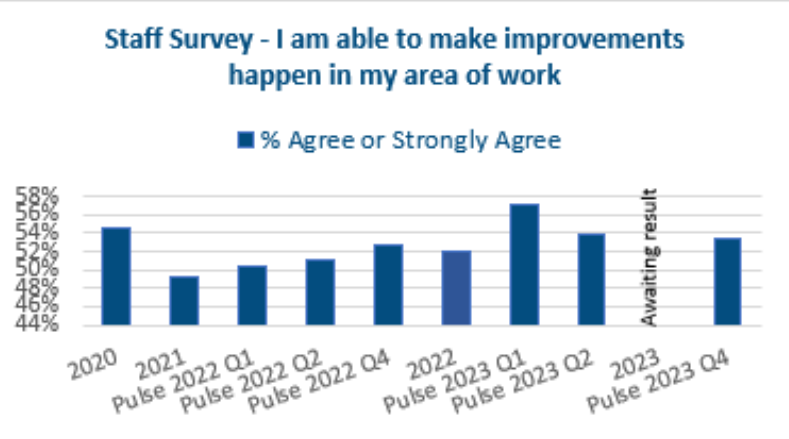
2023/24 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

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

2019	2020	2021	2022 Q1	2022 Q2	2022 Q4	2022	2023 Q1	2023 Q2	2023	2023 Q4
56.70%	54.50%	49.30%	50.31%	51.10%	52.72%	51.90%	57.20%	53.80%	Awaiting result	53.30%

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 National embargo on the 2023 Annual Survey results is still in place and full results will be shared in March, however initial data shows a positive increase in performance on this question.
- The Q4 Pulse Survey results are available and show that performance on question 3F has risen to 53.3% compared to the Q2 survey.
- Staff Survey results have been shared with Specialty/Department Tri's to review current progress on question 3F and identify future areas of focus for the Staff Survey. Divisions will be presenting updated A3s on their breakthrough questions at the next Staff Survey Working Group, along with their recommendation on their breakthrough question for 2024/25.
- An updated Trust A3 is being worked through to assess performance for question 3F and identify a future area of focus. Questions which have declined have been reviewed, and early analysis shows the theme of 'Teamwork' and as an opportunity for future improvement work.

Risks

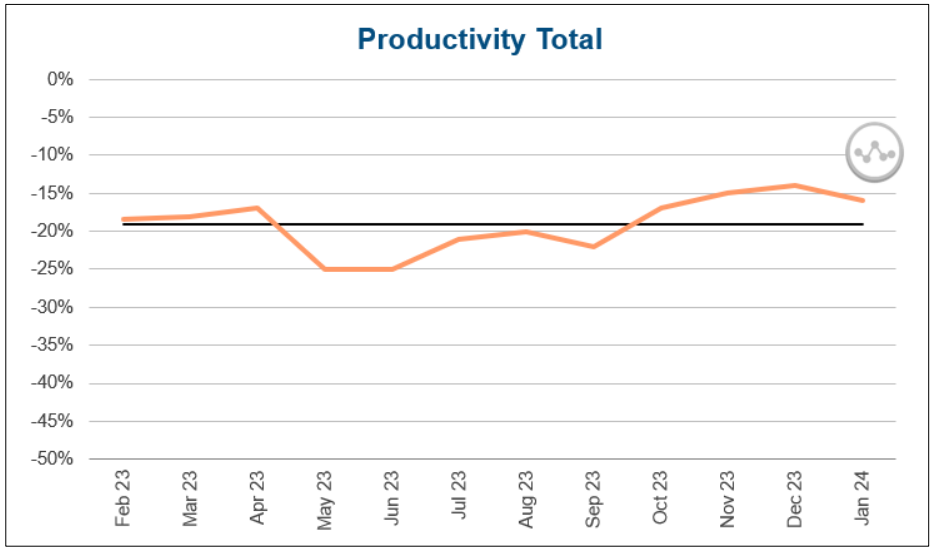
- Divisions have refreshed their breakthrough objectives and are no longer all focussing on question 3F. There is a risk that this diluted focus will impede further improvement on this question.

2023/24 Breakthrough Objectives

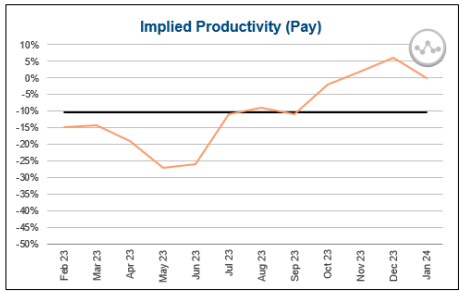
Great Western Hospitals NHS Foundation Trust

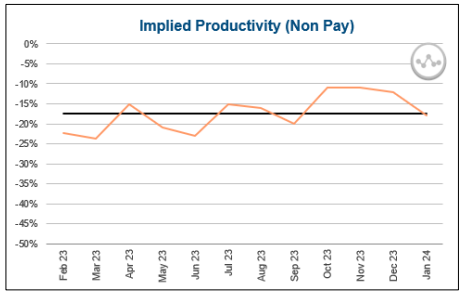
Productivity

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total	-18%	-18%	-17%	-25%	-25%	-21%	-20%	-22%	-17%	-15%	-14%	-16%
Pay	-15%	-14%	-19%	-27%	-26%	-11%	-9%	-11%	-2%	2%	6%	0%
Non Pay	-24%	-24%	-15%	-21%	-23%	-15%	-16%	-20%	-11%	-11%	-12%	-18%



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 for the Trust in total is recovering but has deteriorated slightly to an overall total **–16%** for Month 10 from last month (this is however still a 2% improvement from the 18% at the end of 2022/23 - March 2023).

Productivity at end of January has mainly deteriorated from previous month due to financial position being £3.7m deficit year to date. This is at a -14% productivity level and but is ahead of original plan for M10.

The remaining finance pressures impacting in divisions (that are being offset overall Trust wide) are related to shortfall in efficiency plans, shortfall of ERF income, medical pay award costs and temporary staffing pressures. There has also been extra pressure recognised for the excess costs of running the community diagnostic units.

Weighted activity is also running much closer to the 2023-24 plan for January in some areas and ahead as a change vs 19/20 (the measure contributing to the improvement in productivity). This includes Outpatients and Elective activity whereas non elective in medicine division is still above plan. Surgery is however slightly behind 19/20 activity for January for outpatients.

The CIVICA Aurum insight opportunities continue to be recognised as being mostly 2024/25 opportunities and have now been included in the 2024/25 efficiencies and opportunities (total value £2.5m) following initial engagement with divisions to review and with clinical leads.

Data quality tolerance and validation still needs to happen for areas such as coding and information breakdown on pathways. This is for use by divisions along with other sources of support data such as reference cost benchmarking and Model Hospital where some opportunities have also been targeted as efficiencies now.

The Divisions continue to be encouraged to develop project and resource plans to realise as many of the Aurum and Benchmarking opportunities as possible and to support the clinical and operational validation of these for productive care.

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)	?	69%	54%	73%	71%	
IP & C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		1	1	2	2	
	Clostridium difficile (C. diff) infections (cumulative)	38.33 (Nat)		54	56	64	70	
	Escherichia coli (E. coli) infections (cumulative)	55 (Nat)		61	65	69	82	
	Pseudomonas infections (cumulative)	11.67 (Nat)		22	24	26	26	
	Klebsiella infections (cumulative)	18.33 (Nat)		28	34	37	37	
FFT	ED & UTC Response Rate	20% (Int)	?	19%	19%	20%	15%	
	Inpatients Response Rate	26% (Int)	?	25%	25%	22%	21%	
	Daycases Response Rate	24% (Int)	?	23%	24%	22%	24%	
	Daycases Positive Responses	96% (Int)	?	95%	96%	95%	97%	
	Maternity Response Rate	17% (Int)	?	16%	16%	15%	16%	

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 the target.

Performance & Counter Measure

The Trust overall complaint response rate has decreased in January 2024, (71%) and remains below the internal target of 80%. Actions are being undertaken with the divisions to improve this.

The Trust remains above trajectory for all three gram-negative bloodstream infections (*E. coli, Klebsiella and P. aeruginosa*) and for *C. difficile,* however there were zero *Klebsiella* or *Pseudomonas* infections in January. Some infections in previous months have been linked to intravenous long-lines, particularly in our Oncology/Haematology areas, and a working group has been set up to address this.

E. coli numbers remain high despite progress being made on improvements in catheter care. A recurring theme from investigations has been issues related to sampling (samples not sent, mislabelled or not followed up) and we are planning a small group to investigate causes and possible solutions for this.

C. diff investigations are not showing any lapses in care which have contributed to the infections; antibiotic prescribing is generally compliant, and cases are not linked genetically, suggesting the bacteria has not been acquired in hospital. It is hoped that work being done across BSW to reduce broad-spectrum antibiotic use in primary care will eventually have an impact on our rates. Additionally, the work being done to reduce other infections is expected to have a positive impact on *C. difficile* numbers through a reduction of antibiotic usage.

There has been a slight decrease in FFT Emergency Department and in-patient response rates. The day case response rate and day case positive response rate have both increased in month, along with the maternity response rate.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24
Harm	No. of serious incidents reported in month	SPC		8	5	4	5
	Falls rate per 1000 bed days	SPC	L	5	4.2	5	5.4
	No. of Falls in month	SPC	L	98	80	93	106
	No. falls with moderate harm or above	SPC		2	2	1	3
	Medication incidents with moderate harm	SPC		4	4	2	1
Concerns and Complaints	No. of concerns received	SPC		140	166	123	234
	No. of complaints received	SPC		46	62	55	67
	Number of reopened complaints	SPC		3	1	6	3
IP&C	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative)	35 (Int)		17	20	20	23
	Covid – no. of hospital acquired	SPC	?	10	15	9	25

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 the target.

Performance & Counter Measure

There are 25 ongoing Serious Incidents (SI), with a further five reported in month, and eight overdue the target of 60 working days. There has been no theme identified within the new SI's reported. In month one SI was further escalated and reported as a Never Event.
There has been an increase in both the number of complaints and concerns in month, with the number of concerns being 234 compared to 123 in December. The themes are driven by the increased activity across the Trust with the largest theme relating to access and wait times (42%), followed by communication (13%), not being able to reach the correct department by phone/miscommunication through letter and holding dates/no response to emails.
The Enhanced Care documentation and 'stay in the bay' governance process is being agreed before rolling out across all wards, with a planned implementation date of 4th March 2024.

A quality improvement project for postural hypertension management is being developed, with the aim of commencing on one ward at the start of March.

MSSA rates remain below last year's figures and well below our internally set threshold. Hospital-acquired COVID numbers have risen, mirroring a rise in community-onset cases, however spread of COVID continues to be minimised in the wards where permanent air scrubbers have been installed. Air scrubber installation continues and there were no bed or ward closures due to COVID in January.

Risks

Lack of accessible information in line with the requirement of the Accessible Information Standard and Equality Act.
Lack of disability access within the Trust.
Inadequate provision of the Interpreting and Translation service to meet demand.

Our Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	93%	94%	92%	94%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	107%	106%	104%	107%
FFT	Overall response rate (%)	28% (Int)	?	29%	27%	25%	29%
	Positive response (%)	86% (Int)	?	87%	88%	89%	90%
	ED & UTC Positive Responses	80% (Int)	?	78%	78%	83%	81%
	Inpatients Positive Responses	86% (Int)	?	80%	83%	87%	91%
	Outpatients Positive Responses	96% (Int)	?	97%	98%	96%	96%
	Maternity Positive Responses	92% (Int)	?	95%	92%	94%	94%

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 the target.

Performance & Counter Measures

Safe Staffing fill rates have increased in month and remain above the National target and are within safe parameters. 1 ward has reported a low fill rate in January and a review is ongoing to ensure it hasn't impacted on patient care.

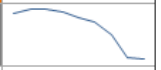
There has been an increase in the overall FFT response rate, which in now above the internal target for the first time since October 2023. There has also been an increase in the positive response rate that remains above the internal target, with Inpatient positive responses reaching 91%.

Several initiatives have been undertaken in January 2024 to enhance the experience of patients and their families including:

- A new dining companion scheme has launched with both corporate staff and volunteers supporting patients during mealtimes. The role includes preparing the patients to eat, delivery of trays, cutting up food and opening packets along with providing companionship and encouragement to eat and drink. The role is currently being trialled on two wards and following evaluation is hoped to be rolled out across the trust.
- A pilot hot clinic where patients with a clinical frailty score of six can be referred has been set up in the Department of Older Persons. This category of patients usually need help with all outside activities, and they often have problems with stairs and need help with washing and dressing. The clinic, which is run by Advanced Clinical Practitioners, is currently accepting referrals from Same Day Emergency Care and the Emergency Department as part of the trial. The aim is to identify areas of concern that can be supported to avoid further deterioration and prevent recurrent admissions to hospital.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24	Trend
RTT	No. of >=18 weeks waiters		H	19028	17809	17679	17590	
	No. of >=52 weeks waiters		H	2238	2031	1653	1625	
DM01	No. of patients on DM01 waitlist		H	15095	15369	13427	One month behind	
	DM01 performance %	99% (Nat)	F	45.0%	49.5%	46.8%	One month behind	
	DM01 6 week wait breaches		H	8301	7759	7138	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	61.1%	67.2%	65.0%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	83.6%	84.9%	88.3%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	39.0%	45.0%	48.5%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	58.2%	59.7%	60.4%	One month behind	
	No. of referrals received		H	1983	1902	1472	One month behind	

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Great Western Hospitals NHS Foundation Trust

Performance & Counter Measure

Diagnostics

January's DM01 validated performance is showing an increase in performance variance from the 46.84% performance in December to 49.32%. The number of patients on the waiting list has decreased by 1144 to 12,644 and the number of 6-week breaches has also decreased by 1090 to 6,408 with over half this reduction coming driven by Ultrasound. Ultrasound remains the biggest risk to achieving YE targets due to an increase in referrals. Activity levels are the highest the trust has ever seen at 11,144. This is an additional 2,318 YTD compared to 19/20 diagnostic test activity.

Counter measures: The 3 Pads in Radiology continue to be fully utilised with all supporting the CDC (CT, MRI and Endoscopy), and activity for the imaging vans is now achieving 100% utilisation with Endoscopy usage improving. The teams continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, however due to an increase in referrals this is now behind trajectory. Ultrasound still remains the largest issue with 6,097 on the waiting list and 4,089 over 6 week. Endoscopy continue to work with InHealth to improve the performance of the mobile Endoscopy unit. The imaging move to the CDC has been delayed now likely to be March 24.

Cancer

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathways with 71% of the breaches being accounted for by this service.

66.0% of the 62-day breaches were with the Skin, Colorectal & Urology Pathway.

Cancer waiting times for first appointment remain below standard with an increase in demand and the impact on clinic cancellations as a result of the industrial action. The Skin Pathway is having the greatest impact on all of the 2ww standard with 43.3% of all of the breaches. Breast pathways accounted for 27.8% of total breaches

In December, 80% (480) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, Skin & Gynae)

Counter Measures - Work is underway with the TVCA to implement the Best Practice Timed Pathways across all 4 (Lower GI, Urology, Gynae & Skin) 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 and is unable to be mitigated further without significant staffing and / or investment. This is subject to a strategic service review.

External Derm team to provide up to 400 additional slots over 2 weeks to clear ASI wait lists through January and February. Provision to include see and treat where possible.

Working with the 3 main challenged tumour sites (Skin, Colorectal & Urology) using the improving together methodology (A3) to ascertain key drivers in this poor performance.

Weekly PTL review meetings have been extended in time to facilitate a full review and challenge of all pathways, and delays. This will ensure patients will have next steps planned at the earliest available time.

Cancer referrals remain above pre covid levels, resulting in capacity issues in a number of sites. The services are providing WLI activity to support where possible, though cancer performance is adversely affected where this is insufficient.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	71.5%	71.4%	74.7%	73.5%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	8.5%	8.9%	6.2%	8.0%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	48.5%	48.7%	52.7%	51.1%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	17.1%	17.8%	12.6%	16.5%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	94.2%	94.1%	96.0%	94.4%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2555.40	2708.18	1592.98	2510.51	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1506	1447	1501	1473	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	90%	88%	84%	88%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1110	1018	847	969	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	66.1%	62.2%	47.2%	57.6%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	695	646	443	669	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	41.4%	39.5%	24.7%	39.8%	
Flow	Average hours lost to ambulance handover delays per day	SPC	H	82	90	51	81	
	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	334	325	301	312	
	Number of Stranded Patients (over 14 days)	SPC	H	129	129	107	124	
	Number of Super Stranded Patients (over 21 days)	SPC	H	77	78	63	70	

Performance & Counter Measure

The following narrative relates to type 1 activity only and therefore will vary when comparing against type 1 & 3 activity.

Plans renewed around improving performance across ED metrics.

4 hour performance (type 1 and 3) decreased from 74.7% to 73.5% with both type 1 and 3 seeing a reduction in numbers seen within 4 hours.

- Total % over 12 hours has increased significantly from 12.6% to 16.5% showing the congestion experienced in the department and in line with the increase seen for patients awaiting a bed.
- Number of ambulance handovers over 30 minutes have increased by 24% from 847 to 969.
- Number of ambulance handovers over 60 minutes have increased from 24.7% to 39.8%

Counter measures remain in place within the Breakthrough objective slides.

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

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 the target.

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24
RTT	No. of >=78 weeks waiters	SPC	L	1	2	4	5
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.1%	0.0%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5236	5236	5443	5402
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	73.6%	72.1%	74.6%	75.3%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		48.0%	45.2%	53.6%	51.1%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		51.2%	40.6%	50.5%	42.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	202	211	192	200
	Emergency Care - AED - Median Stay	240 (Int)	?	292	300	240	240
	Emergency Care - UTC - Median Stay	240 (Int)	P	151	164	148	156
	Total Number of Ambulance Handovers	SPC	L	1680	1637	1795	1682

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 the target.	

Performance & Counter Measure

RTT

5 x 78 week breaches were reported at the end of January 2023: 3x non-admitted patients in Gastroenterology, 1 x non-admitted patient in dermatology and 1x admitted patient in Oral Surgery. Breach reports for these patients are underway and next events being scheduled in February 2024.

ED

Number of ambullance conveyances decreased from previous month (1795 to 1682) comprising a 6% decrease from December levels.

Triage performance across ambulance, type 1 and type 3 has decreased mainly through type 3 performance showing the impact of increased demand on the service through January especially Mondays and Tuesday's. following improvements in pitstop capacity and Chairs capacity.

Median stay has stabilised at 240 mins

Median stay for both UTC and ED have decreased showing the good work focused on improving ED flow.

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		749	746	537	709
	Elective Patients Average Length of Stay (Days)	SPC	L	3	2	3	3
	Non-Elective Patients Average Length of Stay (Days)	SPC		6	6	4	5
	Community Average Length of Stay (Days)	SPC		17	14	17	23
	GWH Discharges by Noon (%)	SPC		16.4%	16.0%	18.0%	16.4%
	Adult general and acute type 1 bed occupancy	SPC		98.8%	98.5%	96.3%	95.0%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC		19.3%	17.1%	16.7%	20.4%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.0%	95.2%	95.6%	95.3%

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 the target.

Performance & Counter Measure

Community average LOS significantly increased to 23 which is over target of 21 days. This would fit with the complexity of the patients and the increase in pathway 2 numbers.

Slight decrease in discharges before noon, Utilising Discharge Lounge for warranting earlier flow within division, highlighting 'golden' patients the day before whilst highlighting discharges for 'tomorrow' on Nerve Centre. This was picked up and tested during Rest Week 4th Dec – evidence demonstartes that traction has been lost hence focus for 'Faster Flow February' to increase this number.

A significant increase in the NCTR Bed Days which stands at 20.4% - this has been impacted by complexity of patients and ward closures on the 23rd of Jan due to IPC.

Risks

There is a risk of ongoing ambulance handover delays if overall bed occupancy and no criteria to reside does not reduce further. The severity of this risk is likely to increase as we approach the end of March 2024 due to the loss of 11 ED majors spaces due to building work for the Integrated Front Door. Trust focus remains on improvements that can be made to earlier discharge in the day and escalating the completion of next steps for discharge which will reduce length of stay and provide additional headroom in the bed base to absorb the temporary loss of ED cubicles. Extension of community commissioned beds will also continue until at least July 2024 to provide additional physical capacity for complex discharge into the community.

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24
Use of Resources	Capital Expenditure (£'000)	SPC		2606	2187	2641	1365
	Pay (£'000)	SPC		25350	25419	24274	25836
	Non Pay (£'000)	SPC		14750	16097	17669	17729

Performance & Counter Measure

Capital spend in M10 was £1.4m, which is £2.0m below plan in month. The underspend is due to estates, EPR (Electronic Patient Record) and CDC (Community Diagnostic Centre), this is offset by overspend in Way Forward Programme. All capital project leads are forecasting to spend their allocations by year end.

Pay costs are £1.6m higher than M9 driven by industrial action costs, higher overall bank/agency usage due to sickness and corrections to prior period medical costs in M9.

Non-Pay is £0.1m higher than M9 due to increased drugs and supply costs.

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 the target.

Risks

The Trust started the year with a £16.67m cash releasing efficiency plan, which includes a £2.98m carry over from 22/23. As at Month 10, the programme is £1.8m under plan, an improvement of £0.2m from M9 driven by additional non-recurrent savings incurred in the Medicine division.

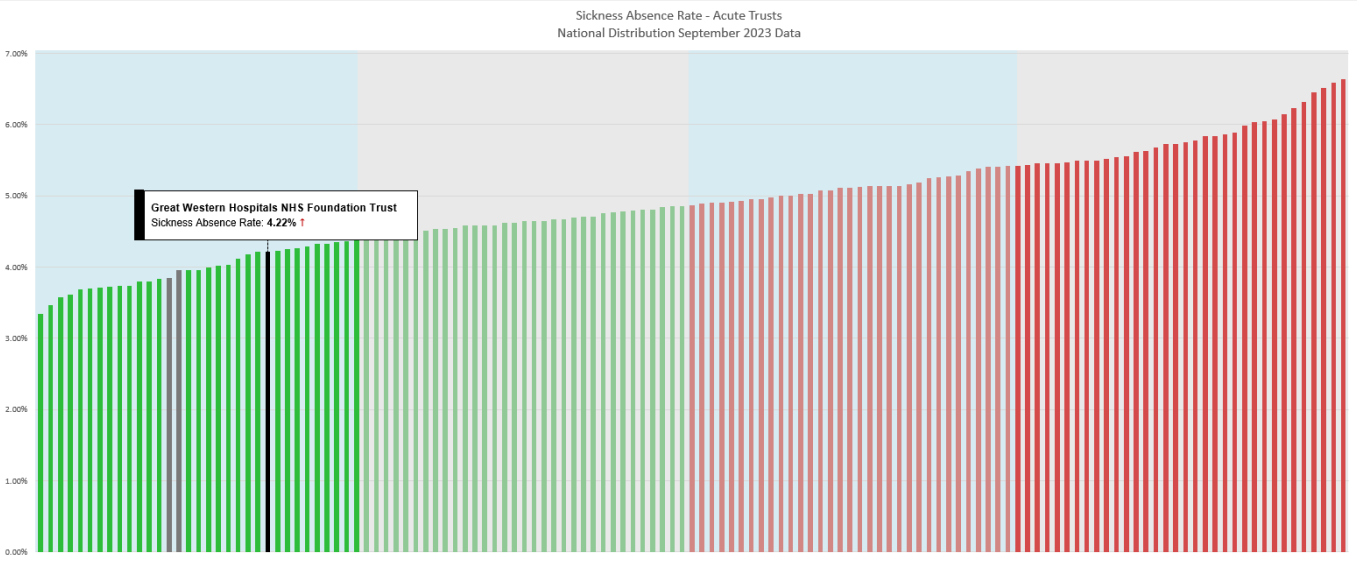
Forecast delivery for 23/24 is £14.1m representing a £2.5m under delivery to plan. It should be noted that non-recurrent savings make up £8.3m or 59% of forecast savings, which is concerning as the Trust enters 24/25. The Trust must work towards identifying recurrent cash-out savings to address the underlying financial deficit.

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.7%	4.7%	5.0%	One month behind	



Performance & Counter Measure

- In-month sickness absence increased in December to 5.0%, continuing to alert above the Trust KPI of 3.5% although significantly lower than last year (5.8%). A number of Trusts have increased the internal target in line with the national NHS sickness absence rate. The Nuffield Trust (All is not well: Sickness absence in the NHS in England) reported that sickness rates were 29% higher than in 2019 (5.3% vs 4.3%) demonstrating a national deteriorating trend.
- Short term sickness has increased in December to 2.7%, and long term absence has decreased slightly to 2.3%.
- Countermeasures identified by Medicine Division continue to be monitored at the Trust Absence Working Group to assess the impact on the top contributing departments. The following actions are being progressed in the Division, and will be adopted by Surgery, Women's & Children's:
  - Delegation of return-to-work responsibility to Band 6s on wards and introduction of a two-stage return to work process supported by People Operations and underpinned by refreshed training for Band 6s.
  - Process and guidance for rota coordinators/nurses in charge to support with managing phone calls relating to absence.
- The most recent National benchmarking data (September 2023 - NHS Digital) shows a further increase to the national and South West region sickness rates, rising to 4.98% and 4.84% respectively. Sickness for BSW also increased in September 2023, rising from 4.29% to 4.41% - a trend which was replicated for The Trust with our absence rising to 4.22%. National sickness is averaging at 5.14% over the previous three years, and the Trust is consistently below this.

Risks

- Increased sickness rate as per national trend during winter.

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 the target.

Our People

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-23	Nov-23	Dec-23	Jan-24
Workforce	% of leavers within 1st year of employment	14.8% (Int)		14.1%	12.9%	13.6%	One month behind

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023 Q1	2023 Q2
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	22.8%	23.8%
	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	Not in Quarterly Survey
	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	57.5% (Avg)	59.6%	54.1%	60.4%	57.1%	56.1%	56.4%	Not in Quarterly Survey	Not in Quarterly Survey

Performance & Counter Measure

- The rolling number of leavers within the 1st year of employment has increased in December to 13.6%, although remains below our 12 month average. Overall turnover reduced in December, suggesting higher movement in-month for 1st year leavers which will be explored by the Trust Retention Working Group.
- Staff survey response rates for the 2023 Annual Staff Survey was 69% which is 10% above last year and the highest response rates with the provider Picker.
- We await the annual staff survey results for comparisons on two key questions on well-being and EDI during promotions and career development.
- On appointment of the People Promise Retention manager this will an areas of focus.

Risks

- Turnover has remained stable for 12 months, changes at senior level may impact Trust-wide turnover rates and staff survey results.

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 the target.

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Trend Vs Last Month	Trend Vs Jan-23
	Vacancy																	
W	Vacancy Rate	%	7.00%	7.43%	6.40%	5.30%	7.54%	8.08%	7.96%	7.82%	5.95%	4.87%	4.33%	3.93%	3.74%	4.12%	↑	↓
W	Vacancy Rate	WTE	-	392.94	335.02	276.66	402.58	438.89	432.29	424.68	320.44	262.33	232.95	211.39	201.47	223.67		
W	All Nursing Vacancy	%	7.00%	6.51%	5.20%	3.65%	4.50%	4.95%	5.38%	5.00%	2.73%	1.96%	1.30%	1.94%	1.43%	2.75%	↑	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	170.25	135.53	94.47	117.71	132.11	143.74	133.58	71.58	51.43	34.17	51.03	37.87	73.60		
W	All Registered Nursing Vacancy	WTE	-	92.65	77.18	43.38	84.20	97.00	107.48	103.62	74.83	47.47	18.62	26.55	9.50	28.02		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	47.18	36.73	27.43	27.90	44.94	53.47	59.84	42.58	23.20	3.60	8.44	-3.79	5.29		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	77.60	58.35	51.09	33.51	35.11	36.26	29.96	-3.25	3.96	15.55	24.48	28.37	45.58		
W	Medical Vacancy	%	7.00%	5.61%	8.49%	6.86%	9.35%	10.14%	9.93%	10.34%	7.28%	5.22%	5.66%	5.26%	5.89%	7.07%	↑	↑
W	Medical Vacancy	WTE	-	39.16	59.19	47.86	67.29	74.56	73.05	76.03	53.43	38.22	41.48	38.61	43.30	53.08		
W	STT/AHP Vacancy	%	7.00%	6.97%	6.29%	7.66%	11.10%	12.48%	12.69%	13.04%	13.04%	10.41%	9.20%	6.88%	6.44%	4.87%	↓	↓
W	STT/AHP Vacancy	WTE	-	57.85	51.64	63.84	94.86	107.82	110.17	113.09	112.95	90.28	79.85	58.89	54.92	41.53		
W	SMA Vacancy	%	7.00%	10.97%	7.96%	6.37%	10.71%	10.68%	9.09%	8.80%	7.13%	7.12%	6.70%	5.44%	5.66%	4.80%	↓	↓
W	SMA Vacancy	WTE	-	125.68	88.66	70.50	122.73	124.41	105.33	101.98	82.48	82.40	77.45	62.86	65.38	55.46		
W	Recruitment Time to Hire - Trust Sub	Days	46.00	91.30	50.90	54.50	52.90	50.60	47.60	49.10	45.00	41.70	42.70	41.80	43.50	44.40	↑	↓
W	Recruitment Time to Hire - Trust Bank	Days	46.00	0.00	117.90	127.80	118.00	58.50	26.90	50.40	46.00	43.50	37.00	39.90	45.20	45.20	→	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,289.16	5,236.02	5,224.47	5,337.41	5,434.85	5,433.60	5,433.60	5,382.13	5,381.76	5,379.33	5,382.66	5,382.34	5,431.15		
W	Budgeted vs Worked WTE Variance	WTE	-	51.09	109.88	237.86	30.62	44.85	50.23	3.21	131.68	70.68	132.30	203.43	152.96	168.55		
W	Actual Worked vs Budgeted %	%	-	0.97%	2.10%	4.55%	0.57%	0.83%	0.92%	0.06%	2.45%	1.31%	2.46%	3.78%	2.84%	3.10%		
W	Total Workforce Cost £	£	-	£22.93M	£24.66M	£23.73M	£23.85M	£23.99M	£25.72M	£24.82M	£24.44M	£26.42M	£25.68M	£24.85M	£24.88M	£25.67M		
W	Agency Spend as % of Total Spend	%	4.50%	5.60%	4.98%	5.35%	3.40%	5.57%	3.39%	4.15%	2.62%	3.11%	4.52%	3.56%	1.23%	2.83%	↑	↓
W	Agency Spend £	£	-	£1.28M	£1.23M	£1.27M	£0.81M	£1.34M	£0.87M	£1.03M	£0.64M	£0.82M	£1.16M	£0.89M	£0.30M	£0.73M		
W	Agency Target £	£		-	-	-	£1.21M	£1.04M	£0.88M	£0.76M	£1.06M	£1.17M	£1.07M	£0.91M	£1.10M	£0.91M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-	-	-	-£0.40M	£0.29M	-£0.01M	£0.27M	-£0.42M	-£0.35M	£0.09M	-£0.03M	-£0.79M	-£0.18M	↑	↓
W	Agency WTE	WTE	-	102.88	90.00	106.82	90.76	105.02	96.40	94.71	78.85	74.91	59.88	57.41	52.29	58.93		
W	Bank WTE	WTE	-	310.93	323.25	377.11	303.84	351.68	355.36	303.23	347.55	235.16	278.50	332.80	276.94	311.41		
W	Registered Nursing Bank Fill	%	45.00%	52.86%	55.30%	54.71%	57.70%	57.91%	54.99%	54.47%	53.30%	54.80%	62.68%	66.38%	66.31%	71.94%	↑	↑
W	Unregistered Nursing Bank Fill	%	70.00%	74.32%	71.78%	77.63%	83.58%	81.52%	80.82%	79.98%	77.52%	81.35%	79.95%	84.45%	81.80%	80.12%	↓	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Trend Vs Last Month	Trend Vs Jan-23
	Retention																	
W	All Turnover %	%	13.00%	14.84%	14.42%	14.48%	13.79%	13.88%	13.27%	12.74%	12.69%	12.56%	12.20%	12.00%	11.49%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	11.57%	11.25%	11.16%	10.54%	10.52%	10.17%	9.67%	9.62%	9.52%	9.20%	9.19%	8.89%	-	↓	↓
W	Number of Leavers	Headcount	-	74	43	79	33	62	53	53	48	63	41	47	38	-		
W	Number of RN Leavers	Headcount	-	16.00	8.00	17.00	7.00	15.00	16.00	12.00	14.00	18.00	11.00	14.00	11.00	-		
W	Registered Nursing Vol Turnover	%	-	8.58%	7.99%	7.83%	7.05%	6.82%	6.82%	6.59%	6.66%	6.55%	6.62%	7.00%	7.04%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	15.00	12.00	12.00	8.00	12.00	11.00	7.00	13.00	21.00	10.00	8.00	13.00	-		
W	Unregistered Nursing Vol Turnover	%	-	16.73%	16.57%	15.95%	15.46%	15.17%	13.99%	13.02%	12.83%	13.35%	12.65%	12.34%	11.86%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	15.51%	15.81%	15.23%	14.56%	14.29%	13.60%	15.53%	13.95%	14.33%	14.05%	12.93%	13.56%	-		
W	Number of starters	Headcount	-	107	72	77	75	66	64	108	61	114	62	72	39	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	5.35%	5.09%	4.97%	4.75%	4.57%	4.45%	4.45%	4.40%	4.38%	4.41%	4.44%	4.37%	-	↓	↓
D	Sickness Absence %	%	3.50%	4.90%	4.53%	4.63%	3.85%	3.68%	3.77%	4.43%	4.03%	4.21%	4.73%	4.67%	4.99%	-	↑	↑
W	Long Term Sickness %	%	2.00%	2.52%	2.24%	2.27%	2.13%	2.06%	2.16%	2.61%	2.20%	2.10%	2.40%	2.37%	2.34%	-	↓	↓
W	Short Term Sickness %	%	1.50%	2.38%	2.29%	2.36%	1.72%	1.61%	1.61%	1.82%	1.83%	2.11%	2.33%	2.30%	2.65%	-	↑	↑
W	Sickness Absence Cost £	£	-	£687.4k	£575.4k	£675.3k	£546.9k	£574.4k	£550.4k	£664.8k	£626.3k	£614.8k	£738.9k	£726.5k	£794.0k	-		
W	WTE Days Lost	WTE	-	7,364.2	6,109.2	6,960.2	5,648.5	5,612.7	5,568.9	6,781.2	6,256.4	6,298.4	7,487.3	7,187.9	7,922.9	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	86.61%	86.79%	87.69%	89.20%	90.27%	89.81%	89.90%	90.10%	90.36%	90.75%	91.38%	91.88%	91.49%	↓	↑
W	Role Essential MT %	%	85.00%	89.06%	89.03%	89.66%	90.92%	91.59%	91.37%	91.40%	91.64%	91.93%	92.20%	92.77%	93.14%	92.92%	↓	↑
W	CQC Safe MT %	%	85.00%	84.18%	84.54%	85.71%	87.48%	88.95%	88.25%	88.38%	88.56%	88.78%	89.32%	90.01%	90.64%	90.07%	↓	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	-	-	-	59.32%	64.39%	73.18%	76.28%	79.91%	82.14%	83.26%	83.85%	85.24%	86.22%	↑	↓
W	Appraisal Compliance %	%	85.00%	81.16%	83.33%	82.25%	83.11%	82.18%	83.86%	83.94%	84.29%	84.88%	84.92%	83.62%	85.63%	84.32%	↓	↑
W	Non Medical Appraisal Compliance %	%	85.00%	80.60%	82.33%	80.68%	82.46%	81.38%	82.76%	83.29%	84.24%	84.89%	84.91%	83.81%	85.37%	84.06%	↓	↑
W	Medical Appraisal Compliance %	%	85.00%	85.44%	91.07%	93.90%	87.90%	88.00%	91.81%	88.64%	84.64%	84.84%	85.04%	82.25%	87.59%	86.32%	↓	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Trend Vs	
																	Last Month	Jan-23
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.17%	4.21%	4.19%	4.14%	4.12%	4.12%	4.13%	4.17%	4.18%	4.12%	4.21%	4.19%	4.23%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	250.00	253.00	253.00	249.00	251.00	251.00	252.00	257.00	260.00	258.00	265.00	264.00	268.00		
W	% of Leadership Roles who are Female (B8a+)	%	-	71.20%	71.54%	70.75%	70.68%	70.92%	70.52%	70.24%	70.82%	71.15%	70.93%	71.32%	71.59%	71.27%		
W	% of Leadership Roles who from BME (B8a+)	%	-	5.20%	5.14%	5.14%	5.22%	5.58%	5.58%	5.95%	6.61%	6.54%	6.20%	6.79%	6.82%	6.34%		
W	Staff in Leadership Roles % (B8c+)	%	-	0.92%	0.93%	0.91%	0.95%	0.95%	0.95%	0.93%	0.93%	0.92%	0.91%	0.92%	0.89%	0.90%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	55.00	56.00	55.00	57.00	58.00	58.00	57.00	57.00	57.00	57.00	58.00	56.00	57.00		
W	% of Leadership Roles who are Female (B8c+)	%	-	60.00%	60.71%	58.18%	57.89%	58.62%	56.90%	56.14%	56.14%	56.14%	56.14%	56.90%	57.14%	56.14%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.45%	5.36%	5.45%	5.26%	5.17%	5.17%	5.26%	5.26%	5.26%	5.26%	5.17%	5.36%	3.51%		
W	% of Leadership Roles who are disabled (B8c+)	%	-	0.00%	0.00%	0.00%	1.75%	1.72%	1.72%	1.75%	1.75%	1.75%	1.75%	1.72%	1.79%	1.75%		
W	Male % of Workforce	%	-	17.55%	17.50%	17.71%	17.63%	17.75%	17.83%	17.90%	18.10%	18.16%	18.36%	18.40%	18.29%	18.33%		
W	Female % of Workforce	%	-	82.45%	82.50%	82.29%	82.37%	82.25%	82.17%	82.10%	81.90%	81.84%	81.64%	81.60%	81.71%	81.67%		
W	BME % of Workforce	%	-	22.54%	22.75%	23.24%	23.60%	24.22%	24.19%	24.49%	25.06%	25.18%	25.47%	25.68%	25.98%	26.08%		
W	White % of Workforce	%	-	68.74%	68.71%	68.25%	68.07%	67.43%	67.29%	67.08%	67.03%	66.86%	66.58%	66.32%	66.19%	65.84%		
W	ER Cases Closed	Number	-	48	57	65	43	56	54	59	20	35	28	26	27	12		

Our People

Great Western Hospitals NHS Foundation Trust

Workforce Scorecard - Workforce Planning

Trust Workforce Delivery Plan

		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Establishment	*Plan*	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46		
	Actual	**5337.41**	**5434.85**	**5433.60**	**5433.60**	**5382.13**	**5381.76**	**5379.33**	**5382.66**	**5382.34**	**5431.15**		
	Variance	-54.05	43.39	42.14	42.14	-9.33	-9.70	-12.13	-8.80	-9.12	39.69		
Contract	*Plan*	4917.66	4942.06	4958.27	4973.06	4996.74	5018.76	5041.25	5057.46	5066.09	5064.08		
	Actual	**4934.83**	**4995.96**	**5001.31**	**5008.92**	**5061.69**	**5119.43**	**5146.38**	**5171.27**	**5180.87**	**5207.48**		
	Variance	17.17	53.90	43.04	35.86	64.95	100.68	105.13	113.81	114.78	143.40		
Bank	*Plan*	271.91	322.50	262.43	246.62	240.30	300.37	303.53	262.43	278.24	208.68		
	Actual	**303.84**	**351.68**	**355.36**	**303.23**	**347.55**	**235.16**	**278.50**	**332.80**	**276.94**	**311.41**		
	Variance	31.93	29.18	92.93	56.61	107.25	-65.21	-25.03	70.37	-1.30	102.73		
Agency	*Plan*	104.12	123.49	100.49	94.43	92.01	115.01	116.23	100.49	106.54	79.90		
	Actual	**90.76**	**105.02**	**96.40**	**94.71**	**78.85**	**74.91**	**59.88**	**57.41**	**52.29**	**58.93**		
	Variance	-13.36	-18.47	-4.09	0.28	-13.16	-40.10	-56.35	-43.08	-54.25	-20.97		
Actual vs Establishment	*Establishment*	5337.41	5434.85	5433.60	5433.60	5382.13	5381.76	5379.33	5382.66	5382.34	5431.15		
	Actual	**5329.43**	**5452.66**	**5453.07**	**5406.86**	**5488.09**	**5429.50**	**5484.76**	**5561.48**	**5510.10**	**5577.82**		
	Variance	-7.98	17.81	19.47	-26.74	105.96	47.74	105.43	178.82	127.76	146.67		

Key

Outside of tolerance
Within tolerance
in excess of plan
less than plan

Performance & Counter Measure

- Our establishment increased by 49WTE in M10 rising to 5,431WTE. This is above the planned figure by 40WTE, however remains under our control total of 5,441WTE. All in-month increases were within Medicine Division and were a 'right-sizing' of the WTE budget. These changes were cost neutral and did not represent any additional GBP budget:
  - Increase of 15WTE for Medical & Dental staff in ED Medical Staff through redistribution of Junior Doctor and Agency budgets
  - Increase of 34WTE for Nursing staff in Medicine wards to re-baseline the WTE budgets in line with previous Safer Staffing investment
- The Finance and Workforce teams are meeting weekly to control any further changes to the establishment. At present only a right-sizing of the Gen Med Junior Doctor budget is anticipated which will represent an increase to the establishment.
- 5,578WTE was utilised in M10 to deliver our services which represents an additional 147WTE compared to our establishment. Our contracted position remains positive against plan however this did not offset additional temporary staffing usage, with both Bank and Agency utilisation increasing in-month.
- A Workforce Recovery Group is being established to manage overall Workforce reduction workstreams. Key focuses will be continuing the positive control seen within the Nursing and Medical workforce, and identifying where the overall establishment can be reduced.

Risks & Mitigations

- Overall temporary staffing usage has not decreased in line with additional contracted WTE growth and there is risk that this continued over-usage will continue to push total WTE utilised above our establishment figure. Divisional agency reduction workstreams continue, and Medical/Nursing teams are exploring opportunities for bank reduction.

Our People

Workforce Costs by Staff Group

Great Western Hospitals NHS Foundation Trust

Staff Group	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD
Registered Nursing	RGN Sub £	£6,816,740	£6,873,340	£7,587,096	£7,009,523	£7,148,967	£7,089,588	£7,266,793	£7,311,337	£7,462,009	£7,472,149	£65,220,803
	RGN Bank £	£874,747	£687,407	£704,551	£651,671	£700,835	£610,086	£593,565	£553,437	£592,494	£648,452	£5,742,497
	RGN Agency £	£356,809	£390,770	£393,761	£388,506	£369,005	£387,236	£293,975	£243,990	£160,175	£218,524	£2,845,942
	Budget £	£7,726,976	£7,575,268	£8,320,831	£7,708,281	£7,669,410	£7,852,551	£8,595,915	£8,366,252	£8,003,835	£9,130,820	£73,223,163
	Actual Cost £	£8,048,296	£7,951,517	£8,685,408	£8,049,701	£8,218,807	£8,086,909	£8,154,333	£8,108,764	£8,214,678	£8,339,125	£73,809,242
	Variance to Budget £	£321,320	£376,249	£364,577	£341,420	£549,397	£234,358	-£441,582	-£257,488	+£210,843	-£791,695	£586,079
Unregistered Nursing	UR Sub £	£2,248,955	£2,401,458	£2,600,592	£2,396,310	£2,465,217	£2,395,713	£2,356,200	£2,376,329	£2,377,891	£2,379,131	£21,748,840
	UR Bank £	£383,425	£405,741	£369,631	£400,036	£367,052	£315,117	£310,343	£283,167	£271,511	£337,349	£3,059,947
	UR Agency £	£510	£0	£177	£2,721	-£1,925	£168	£2,401	-£2,220	£0	£0	£1,322
	Budget £	£2,416,017	£2,590,428	£2,718,298	£2,514,861	£2,515,220	£2,555,518	£3,109,392	£2,080,496	£2,612,857	£2,692,286	£23,389,356
	Actual Cost £	£2,632,891	£2,807,199	£2,970,400	£2,799,066	£2,830,343	£2,710,997	£2,668,944	£2,657,275	£2,649,402	£2,716,481	£24,810,108
	Variance to Budget £	£216,874	£216,771	£252,102	£284,205	£315,123	£155,479	-£440,448	£576,779	£36,545	£24,195	£1,420,752
Medical and Dental	M & D Sub £	£5,495,537	£5,302,186	£5,549,823	£5,640,491	£5,444,620	£7,513,085	£6,276,989	£6,036,267	£6,153,767	£6,158,186	£54,075,414
	M & D Bank £	£863,619	£609,769	£773,185	£1,099,541	£1,036,278	£1,019,057	£655,587	£564,068	£940,237	£1,004,952	£7,702,674
	M & D Agency £	£475,120	£786,209	£364,511	£543,650	£181,897	£474,049	£762,849	£587,026	£92,628	£445,599	£4,238,418
	Budget £	£6,259,166	£6,620,055	£6,229,723	£6,263,810	£6,299,757	£8,317,388	£5,747,229	£6,689,028	£6,609,992	£6,664,986	£59,441,968
	Actual Cost £	£6,834,275	£6,698,164	£6,687,519	£7,283,681	£6,662,795	£9,006,191	£7,695,425	£7,187,362	£7,186,632	£7,608,737	£66,016,506
	Variance to Budget £	£575,109	£78,109	£457,796	£1,019,871	£363,038	£688,803	£1,948,196	£498,334	£576,640	£943,751	£6,574,538
AHP and STT	AHP/STT Sub £	£2,805,464	£2,757,206	£3,176,461	£2,886,707	£2,889,128	£2,915,441	£2,996,760	£3,014,522	£3,052,758	£3,108,451	£26,797,433
	AHP/STT Bank £	£68,831	£60,187	£69,503	£87,766	£79,123	£67,747	£88,723	£81,834	£82,624	£97,764	£715,273
	AHP/STT Agency £	£43,181	£91,764	£63,015	£38,272	£51,346	£12,680	£42,488	£42,523	£34,377	£64,036	£440,501
	Budget £	£2,956,319	£3,079,764	£3,421,223	£3,108,019	£3,097,484	£3,164,763	£2,660,831	£3,113,500	£3,106,734	£3,276,081	£28,028,399
	Actual Cost £	£2,917,476	£2,909,157	£3,308,979	£3,012,745	£3,019,597	£2,995,867	£3,127,971	£3,138,880	£3,169,759	£3,270,251	£27,953,207
	Variance to Budget £	-£38,843	-£170,607	-£112,244	-£95,274	-£77,887	-£168,896	£467,140	£25,380	£63,025	-£5,830	-£75,192
Admin & Clerical	Admin Sub £	£3,348,631	£3,396,608	£3,878,898	£3,481,003	£3,515,274	£3,557,858	£3,629,334	£3,613,976	£3,722,765	£3,611,966	£32,407,681
	Admin Bank £	£131,134	£160,120	£137,290	£135,883	£154,871	£112,014	£130,320	£132,964	£125,312	£124,662	£1,213,436
	Admin Agency £	-£63,795	£68,232	£51,429	£56,454	£41,207	-£53,401	£59,554	£13,871	£17,679	-£1,787	£253,238
	Budget £	£3,352,314	£3,515,164	£3,967,350	£3,688,845	£3,667,961	£3,572,572	£7,134,537	£4,396,754	£4,313,396	-£91,310	£34,165,269
	Actual Cost £	£3,415,970	£3,624,959	£4,067,617	£3,673,340	£3,711,352	£3,616,471	£3,819,208	£3,760,812	£3,865,756	£3,734,841	£33,874,355
	Variance to Budget £	£63,656	£109,795	£100,267	-£15,505	£43,391	£43,899	-£3,315,329	-£635,942	-£447,640	£3,826,151	-£290,914
Total	Total Sub £	£20,715,329	£20,730,798	£22,792,870	£21,414,034	£21,463,206	£23,471,685	£22,526,076	£22,352,431	£22,769,189	£22,729,883	£200,250,171
	Total Bank £	£2,321,756	£1,923,225	£2,054,160	£2,374,897	£2,338,158	£2,124,020	£1,778,538	£1,615,471	£2,012,178	£2,213,179	£18,433,826
	Total Agency £	£811,823	£1,336,975	£872,893	£1,029,603	£641,530	£820,731	£1,161,267	£885,191	£304,859	£726,373	£7,779,422
	Budget £	£22,710,792	£23,380,679	£24,657,425	£23,283,816	£23,249,832	£25,462,792	£27,247,904	£24,646,030	£24,646,814	£21,672,863	£218,248,155
	Actual Cost £	£23,848,908	£23,990,997	£25,719,923	£24,818,534	£24,442,894	£26,416,436	£25,465,881	£24,853,092	£25,086,226	£25,669,436	£226,463,419
	Variance to Budget £	£1,138,116	£610,318	£1,062,498	£1,534,718	£1,193,062	£953,644	-£1,782,023	£207,062	£439,412	£3,996,573	£8,215,264

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

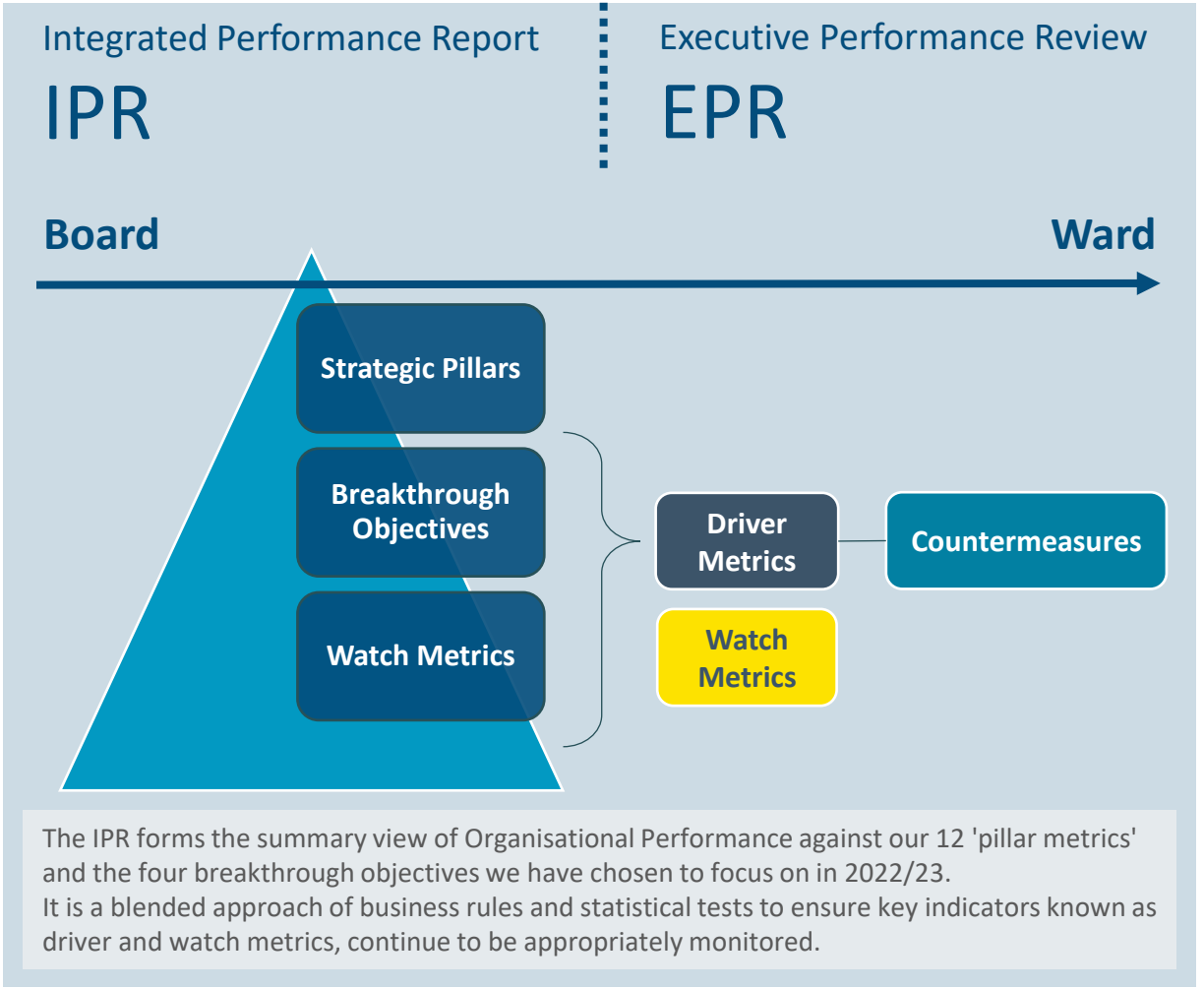
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- Tissue viability – reducing pressure ulcers
- Emergency Attendances - Clinically Ready to Proceed (Admitted)
- Implied Productivity
- Staff Survey - I am able to make improvements happen in my area of work

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

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.

1 Our four strategic pillars

Our pillar metrics

1 Reducing Harm	6 Staff Retention	9 Emergency Attendances	11 Sustainability / Carbon footprint
2 FFT (Friends & Family Test)	7 Staff Survey - % Recommend	10 No Criteria to Reside	12 Trust Control Total / I & E (Income & Expenditure)
3 Waiting list –over 65 week waiters	8 ED & I (Equality, Diversity & Inclusion)		
4 Cancer waiting times			
5 Time in ED (Emergency Department)			

To know if we are winning or losing we have metrics assigned to each domain that we will continuously measure to gauge improvement

3 Strategic Initiatives

Must do can't fail

1 Leadership & Management Capability

2 The Way Forward Programme

3 Digital First

4 System & Place

5 Improving Together

4 Overlap

Corporate Projects

e.g. Electronic Patient Record

e.g. The Great Care Campaign

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

BTO Productivity

BTO Staff Survey = % improvements

BTO Time to Clinically Ready to Proceed

BTO Pressure Harms

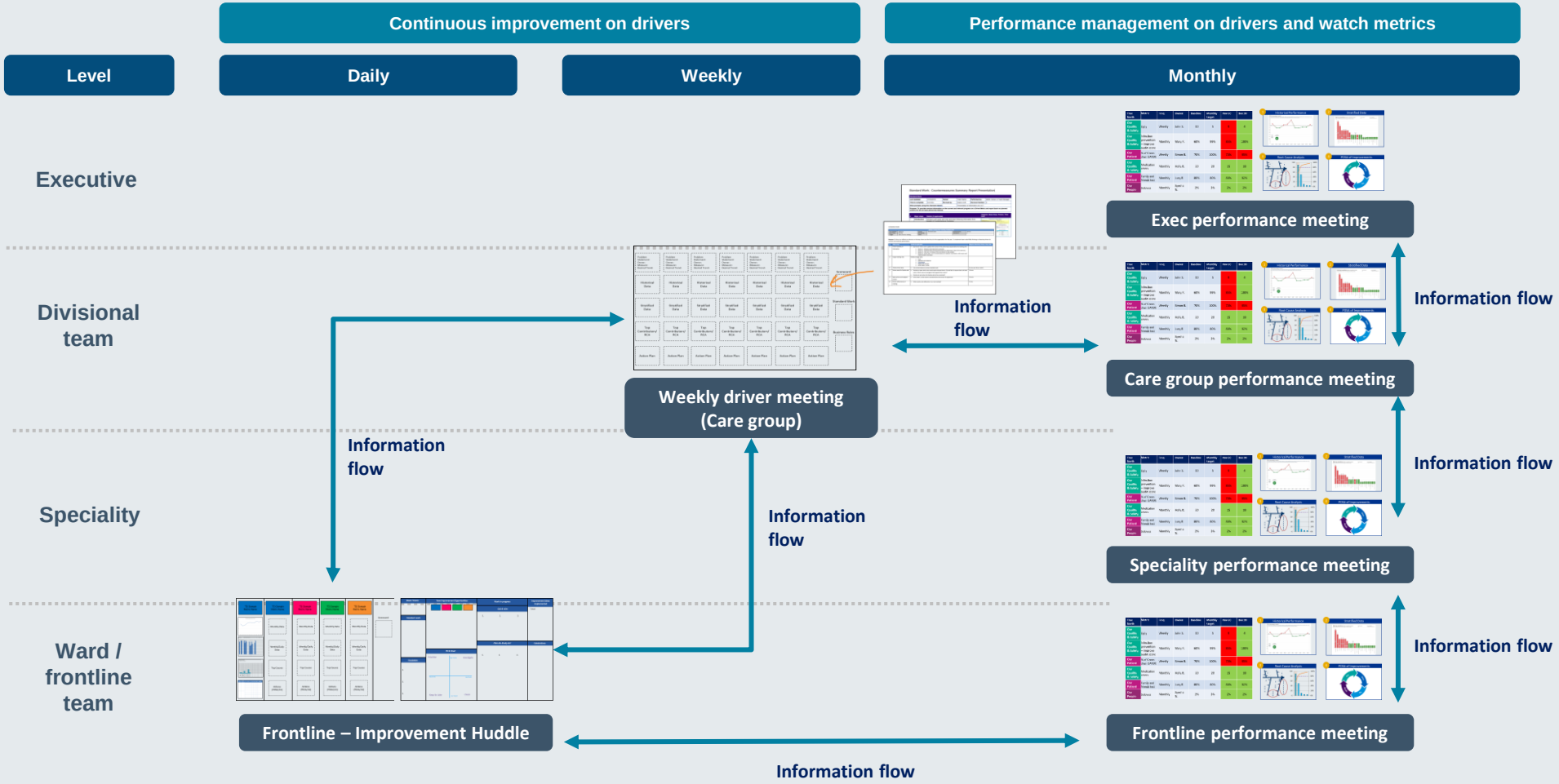
Delivery mechanism – running the organisation

- Continuous Improvement
- Operational Management System (OMS)
- Linked through scorecards & scorecard agreement
- Strategic filtering
- Programme delivery

Service | Teamwork | Ambition | Respect

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Building a culture of continuous improvement

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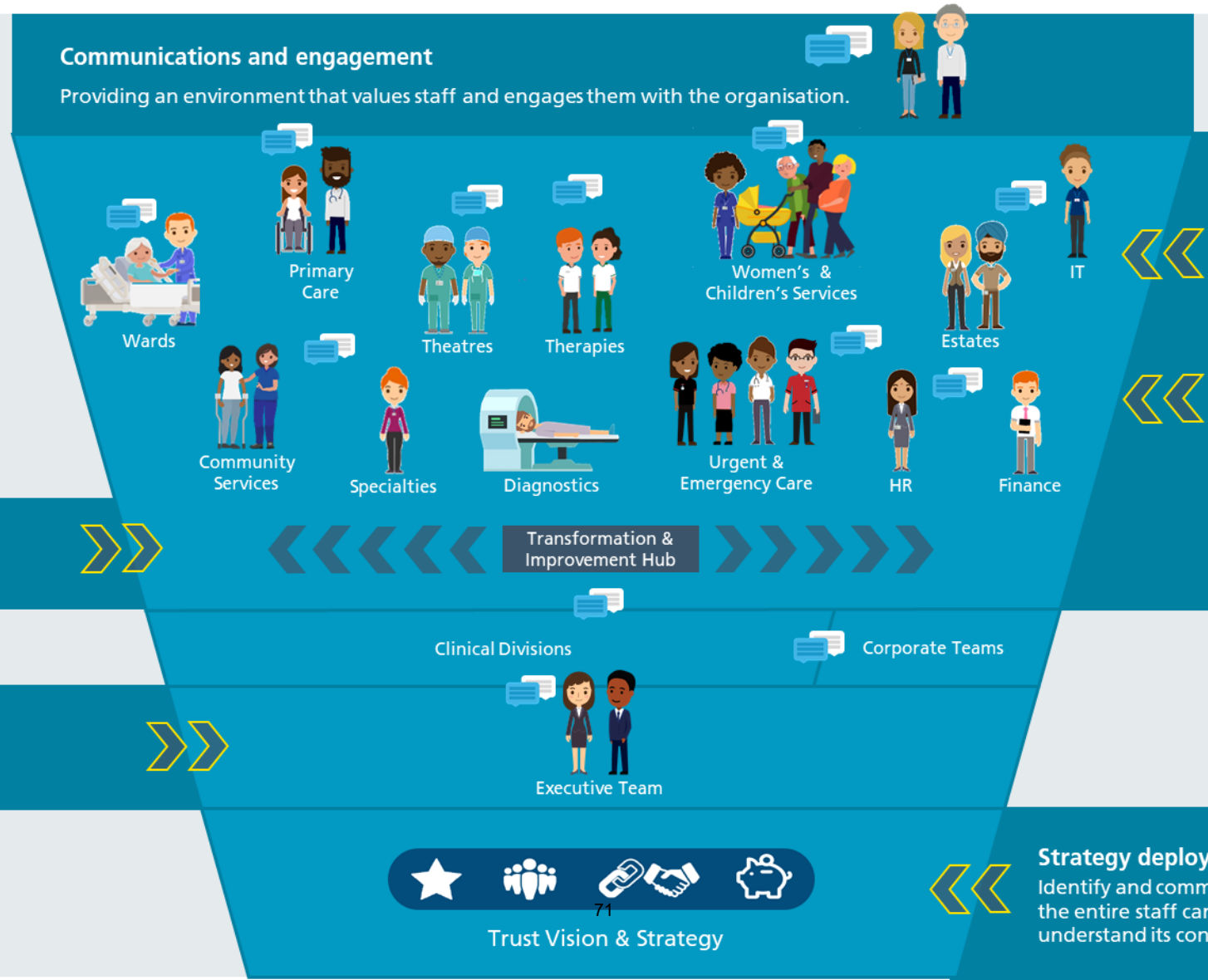


Transformation & Improvement Hub
Develop an internal capability to develop and sustain improvement journey.

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

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

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

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

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.

Note:
The Business rules are highlighting deviation from National standards (where these exist), rather than current planning targets.

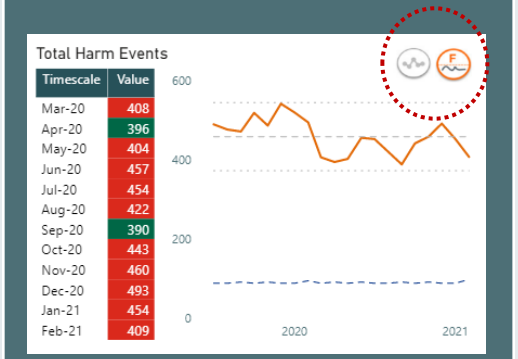
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

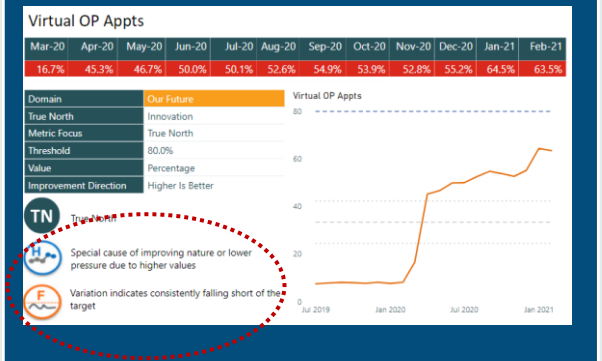
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

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

Agreed Terms

NHS
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

Committee	**Performance, Population & Place Committee**	
Meeting Date	28th February 2024	
Committee Chair	Bernie Morley, Non Executive Director	
Link to Strategic Objective	Pillar 3 : Joining up acute and community services in Swindon	
Link to Board Assurance Framework	BAF 3 : SR 5 – Performance and SR6 - Partnerships	
Improving Together Pillar Metrics	Emergency Attendance	Waiting List – over 65 week waiters
	No Criteria to Reside	Cancer Waiting Times
Improving Together Breakthrough Objective	Time in ED – Clinically Ready to Proceed	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Community Services Tender Update		
2. Lets Talk Swindon and Draft Swindon Plan		
3. NHSE Oversight Framework Q3	Partial	✓
4. Operational Highlight Report	N/A	
5. IPR - NCTR	Partial	
6. IPR - DM01	Partial	
7. IPR - RTT	Partial	
8. Trauma Peer Review	Good	
9. Cancer Services Assurance Report	Partial (tiering)	
10. Board Assurance Framework	Substantial	
11. Diagnostics Update	Partial	
12. Emergency Care	Limited	

POINTS OF ESCALATION	Note the Single Oversight Framework position & that actions are in place to mitigate the risk of deterioration to SOF 3. These relate to cancer faster diagnosis, 62 day and tiering position. Also (see referral to Q&S) in relation to improvement work in relation to mortality recording.
KEY AREAS TO NOTE	**Population and place** update consisted of 1. an update on the success of the consortium community tender through selection questionnaire stage and an update on the risks and opportunities. 2. details of the draft Swindon Plan produced by the Borough Council, our opportunity to influence this and align our developing 2024+ strategy with it. **Operational performance** BSW remain in Tier 2 for Urgent and Emergency Care Performance. Noting GWH 4 hour performance is good - supported through the Urgent Treatment Centre (UTC). GWH remains in Tier 2 for Cancer. 62day – 65% just below BSW and National, long waiting patients reducing. Faster Day diagnosis rising to 70% unvalidated for February from a low of 58%. Patients waiting decreased from 269 in December to 140 in February. RTT continues to reduce for the 7th month in a row for our longest waiting patients, 3 x 78ww breaches. DM01 longest waiting patients decreased, patients waiting over 6 weeks decreased and highest month on record for activity. Remain behind plan for ultrasound modality. Likely to be entering tiering for diagnostics, US is main driver for overall position.
BOARD ASSURANCE FRAMEWORK & RISKS	**BAF 3: Joined up services through partnership working** Strategic risk 5: this risk rating about working together to recover services has increased to 16 driven by continuing industrial action and deterioration in urgent care metrics Strategic risk 6: this risk rating about collaborating with partners to improve outcomes has decreased to 12 driven by evidence of AHA collaboration, submission of the community tender and a compact between ICB & AHA.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Collaborative working across teams during a challenging January Targeted Lung Health Checks, 44 earlier diagnoses as a result of this work across our locality.
REFERRALS TO OTHER BOARD COMMITTEES	Referral to Q&S regarding SHMI

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
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Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	22.2.24
Committee Chair	Claudia Paoloni, Non-Executive Director
Link to Strategic Objective	Pillar 1 : Outstanding Patient Care
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality
Improving Together Pillar Metrics	Reducing Harms
	Friends & Family Test
Improving Together Breakthrough Objective	Pressure Harms

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
1. Estates & Facilities Water Pseudomonas Update Report	**good**	x
2. Pressure Harms (IPR breakthrough objective)	**partial**	x
3. IP&C (IPR breakthrough objective)	**good**	x
4. Maternity	**good**	x
5. Q3 2023/34 Maternity and Neonatal Quality and Safety Report	**good**	x
6. BAF 1 outstanding patient care Q3 2023/24	**good**	**x**
7. Continuity of carer at Great Western Hospitals		**x**
8. Mortality Review Update	**partial**	**x**
9. Nice Guidel;ines Q3 2023/24 Update	**good**	**x**
10. Clinical Audit and Effectiveness: Annual Report 22/23 & Q3 Update	**good**	**x**
11. Safe staffing Monthly report	**good**	**X**
12. Update on CQC Preparedness	**good**	**x**

POINTS OF ESCALATION	
KEY AREAS TO NOTE	• **Water Pseudomonas Update** • Flexible hose removal work is well underway with key augmented areas prioritised. Some delays persist on Dove Ward to do with purchase ordering proceesess with Serco. Due to be resolved in near future so that work can begin on this ward. All due to be complete by end summer 2024. • Penalties have been agreed with Serco regarding the falsified records and increased associated risk around pseudomonas/legionella infection rates. e. • Impact is being seen by a continued reduction in pseudomonas +ve sampling counts. And a zero patient iblood stream nfection rate in January 2024 • Trust continues to top table for blood stream infection rates in SW Trusts but this is expected to improve with the reducing infections. • Assurance level such that regular reporting now reduced to 3 monthly
	• **Pressure Ulcers** have shown a reduction in community but hospital acquired for this month have risen, which is most likely due to the existing ED pressures and extended periods of ambulance handovers with patients in corridors for prolonged periods of time
	• **IP&C** whilst our infection rate remains high for gram negative blood stream infections and C Diffiicile, there were zero Klebsiella and pseudomonas.
	• Continuity carer has now ceased as the model was not sustainable. Whilst the model was well received and valued by the women involved, quantative data did not demonstrated improved outcomes in this group[. • Learnings from the model supporting individualised care for all women will , however, inform strategic service development going forwards.
	• **Maternity IPR** due to increased Birth rate, in January agency spend has increased in month. • Fetal Surveillance, PRMPT and MSD1 training compliance, has deteriorated due to industrial action impacting training, but this is being robustly managed • Triage time are still below the target of 15mins however there has been marked improvement following the introduction of a new system which should show marked improvement in next month • Following submission of robust evidence to counter the maternity CQC warning notice (section 29a) this notice has been since withdrawn • We appear to be an outlier with surgical site infection rates, as identified in a health Innovation West of ~England PreciSSion project, but the introduction of care bundles to mitigate risk are yet to be fully embedded and we are an outlier for high BMI which is being considered as an increased risk.

	• **Mortality Review** A report was received from the new Trust Mortality lead Dr Laurie Powell identifying the current position around the Mortality governance processes and activities, work undertaken to date and Forward action plan • The main issues requiring remedy are related to poor attendance and engagement at monthly Trust continued issues around coding and scanning, evidence of mortality learnings at departmental and Divisional level, difficulty in interpretation and use of HSMR and SMR data and poor performance or SJR completion. • A. robust action plan has been planned and workstreams commenced around this with an additional focus at a departmental and divisional level, introduction of local dashboards, improving together activity and process mapping.
	• **Clinical Audit and Effectiveness: Annual Report 22/23 Q3** excellent levels of compliance achieved within the Trust's clinical audit process to 99% • Increased audits registered and reduced in overdue items • Majority Audit results demonstrate reasonable or substantial assurances only 2 Suggest limited assurance around paediatric asthma and national falls and fragility, the outcome of the reviews will be used to inform ongoing work plans
	• **Safer Staffing** January has been a challenging month for staffing with additional patients on the wards and in escalation areas • Overall average fill rate for nurses/midwives and HCAs remains above 90% with exception being Hazel, Delivery and WHBC on days. • Some sickness absence has. Impacted fill rates. • It has been noted that there has been some increase in the HCSW turnover rate and this is being investigated.
	• **Nice Guidelines** All guidelines have now been assigned correctly to divisions which now require full assessment by services • Across the Trust there are 29 guidelines where the service does not fully meet the guidelines, divisions are being supported to achieve compliance through their governance processes.
	• **CQC Preparedness Update** continued monthly meetings ensuring progress against areas recognised for improvement in previous inspections. • New Medicines Safety Lead Nurse undertaking a review and audit of medicines safety • Visiting ICB quality team staff have given positive feedback and identified some areas for improvement • Further programme of mock inspections planned. • Managing Operational Surges continues to be a difficult area to demonstrate improvement.
BOARD ASSURANCE FRAMEWORK & RISKS	• Whilst work and improvements have been made in patient safety areas related to the BAF1: Outstanding Patient Care SR1, around safer staffing, pseudomonas infection rates, introduction PSIRF, Pressure harms leadership culture around management, the risk score remains at 16 due to multiple areas that remain but that have focussed work being undertaken to mitigate risk.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
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Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**
Meeting Date	26 February 2024
Committee Chair	Faried Chopdat
Link to Strategic Objective	Pillar 4: Use of Resources
Link to Board Assurance Framework	BAF 4 S6 & S7
Improving Together Pillar Metrics	GWH Control Total / I&E
	Sustainability / Carbon Footprint
Improving Together Breakthrough Objective	Productivity

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BAF Strategic Risks	Substantial	x
2. Finance Risk Register	Good	x
3. BSW Financial Update	Limited	x
4. Month 10 – Finance Position	Good	x
5. Efficiency Program	Good	x
6. 2024/25 Planning Update	Approve	x
7. Node Room Air Conditioning – Completion Report	Note	x
8. Shared EPR Program Update	Limited	✓
9. Quarterly Coding & Mortality Status Report	Note	x
10. No PO – No Payment Policy	Approve	x
11. Commercial Developer Partner – Bid Evaluation Criteria	Approve	x
12. BAF Strategic Emerging Risks noted from the meeting	Note	x

POINTS OF ESCALATION	**BSW Financial Update** – A verbal update was provided, highlighting the System's challenges in delivering its financial plan, particularly given the deficit of approx. £ 15m. Whilst management's proposed actions present a constructive way forward, the pace of delivery of these plans and the requirement for more mature governance processes and consistent criteria and measures at the ICS level is ever more critical to gaining greater assurance.
	Efficiency Programme – In-month efficiency savings exceeded the target by £0.2m, but on a year-to-date basis, they are £1.8m behind plan. After reviewing the in-year position, the Medicine division contributed £1.48m to the efficiency savings. The forecast outturn position remains unchanged at £14.15m, 86% of the £16.67m target. Good progress continues to be made in identifying schemes for the 2024/25 efficiency program, with £11.6m of opportunities identified, a £2.1m improvement from Month 9. There is a focus on multi-year transformation and system-wide collaboration, with the executive prioritising areas for corporate support. It is essential to balance the establishment of these initiatives with shorter implementation schemes in 2024/25.
	EPR Programme Update – The Committee acknowledges the excellent progress the Programme has made to ensure an effective governance model to address the requirements of all three trusts. It has set up the program adequately to deploy EPR. Overall, the Committee is assured of the progress made to establish the EPR programme; however, the Committee continues to reiterate the risk that funding is subject to the Trusts signing up to a balanced plan.
KEY AREAS TO NOTE	**Month 9 Finance Position** – The Committee recognises the high finance risk and its escalating nature. However, we assure you that management is taking action to stabilise the finance position. We are focusing on the run rate and productivity gains. As of M10, the Trust faces a deficit of £3.7m year-to-date, which is £3.5m worse than planned. We received £5m funding for industrial action costs up to M8, but an additional £1.1m has been incurred in M9 and M10. The industrial action has impacted the efficiency savings, resulting in approximately £0.8m loss. There are other in-year pressures, including CDC cost over income (£1.8m), undelivered efficiency savings (£1.8m), a shortfall on ERF-related income (£3.8m), additional medical pay award costs (£0.8m), and temporary staffing pressures (£1.5m). However, some of these costs are offset by prior year income, non-recurrent income, and underspends in other areas, totalling **£8.1m**. The Trust's forecast position is a most likely deficit of £5.6m, which aligns with the M8 forecast. The best-case scenario is a deficit of £0.9m, based on internal improvements (£1.7m) and external funding for CDC and industrial action costs (£3m).
	2024/25 Planning Update: The Committee received a full update on the 2024/25 Planning process. It acknowledged the excellent progress made by the team, notwithstanding that planning guidance from NHSE is now expected in March 2024 with no change to the date that Systems will make the first national submission on 21 March 2024. The Committee also reviewed and approved version 3 of the plan that has been used as the basis for the flash submission to the ICB, which will, in turn, be consolidated into a system position and submitted to NHSE on 29 February 2024. The Board will approve the Trust's final plan.
BOARD ASSURANCE FRAMEWORK & RISKS	**BAF Strategic Risks:** The Q3 summary Board Assurance Framework for strategic risks for Finance, Estates & Digital are attached following review by the Executive Leads. The fundamental changes for noting are: - There was no movement in the risk scores, and the aggregate assurance ratings remained the same except for (1) SR 7 - Funding, which moved from Partial to Limited, and (2) SR10 - Cyber / IT infrastructure which moved from Partial to Limited.
	Finance Risk Report: The Committee noted that the risk management process and reporting are adequate and effective; however, the Committee acknowledged that there has been some indication from other committees that divisional finance risks are not regularly seen on registers. This is being reviewed with Finance Business Partners to ensure that divisional finance risks are periodically captured and reviewed.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The Committee acknowledges and thanks management and their teams for the extensive preparation of high-quality papers and their constructive challenge of critical issues discussed at FIDC.

REFERRALS TO OTHER BOARD COMMITTEES	**None noted.**

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Board Committee Assurance Report

Committee	**People & Culture Committee**	
Date of Meeting	Thursday 27th January 2024	
Committee Chair	Paul Lewis, Non-Executive Director	
Link to Strategic Objective	Pillar 2 – Staff & Volunteers Feeling Valued	
Link to Board Assurance Framework	BAF 2 : SR 2 – Culture / SR 3 – Health & Wellbeing / S4 – Workforce Plan	
Improving Together Pillar Metrics	Staff Retention	Equality, Diversity & Inclusion (ED&I)
	Staff Survey - % Recommended	
Improving Together Breakthrough Objective	Staff Survey - % Improvements	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Staff Survey - Recommend	Partial	No
2. Staff Survey – Make Improvements	Partial	No
3. EDI	Partial	No
4. Staff Retention	Good	No
5. Gender Pay Gap Report	Good	No
6. Job Planning / SARD	Good	No
7. Health & Wellbeing Report	Good	No

POINTS OF ESCALATION	• None
KEY AREAS TO NOTE	• Staff Survey – awaiting latest results for both the Trust and national results. Latest staff survey response rates at 69% are very encouraging. We agreed to retain the assurance rating of 'partial' until the full set of results have been published. • EDI – Board commitments now agreed in principle and will be finalised with key actions for 2024 at the March Board Meeting. • Staff Retention – the Trust has continued to see an improving trend since July 2022 with the voluntary turnover rate being below the target (11%) for nine months with the position in December reducing further to 8.9%. • Gender Pay Gap Annual Report – the report has highlighted several improvements, but there remains a gender pay gap in favour of male staff. The main reason for this is because male staff are over-represented in senior roles and are less likely to occupy junior positions, particularly with consultants. The Trust will undertake several initiatives in 2024-25 to address this in relation to action areas which are within our sphere of influence. • Job Planning / SARD – Since the introduction in July 2022 the deployment of electronic workforce systems for medical staff is progressing well, especially with revalidation, appraisals and job planning. Further improvements are planned for 2024/25 with triangulating outputs from the SARD system, medical rostering and electronic staff records to allow a deeper understanding of planned vs delivered activity. • Health & Wellbeing Report – Further progress is being made with our position and KPI's and the report also highlighted areas for further improvement with clear action plans in place.
BOARD ASSURANCE FRAMEWORK & RISKS	• The risks relating to P&CC scoring 15+ were reviewed. An action was agreed to complete a wider review of the risks associated with Industrial Action to cover the remits of other sub-committees to ensure the overall risk is evaluated and scored appropriately (to include patient safety and increased financial costs in particular) • The BAF risks were reviewed with no specific issues being raised.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The key successes and achievements to note are: • Staff Survey response rates • Staff Turnover/Retention rates • Sickness absence rates
REFERRALS TO OTHER BOARD COMMITTEES	• None

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Board Committee Assurance Report

Committee	**Charitable Funds Committee**
Meeting Date	14th February 2024
Committee Chair	Paul Lewis, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Fundraising	Partial	No
2. Financial Reporting	Good	No
3. Cases of Need	Good	No
4. Chartable Funds	Partial	No
5. External Review Action Plan	Partial	No

POINTS OF ESCALATION	• None
KEY AREAS TO NOTE	• The General Fund currently stands at £71,696 which is above our agreed minimum threshold of £57,000. • The proposal for Staff Recognition Awards was reviewed and agreed in principle for this year. Funds will be released when appropriate and it was also agreed that ahead of the 2025 submission, we should clarify how this is funded across the System to ensure we have consistency of approach where appropriate going forward. • The Brighter Futures budget for 2024/25 was approved, although the Committee highlighted concerns about the ratio of costs to income and so this will be covered in more detail in the Financial Reporting element of the next meeting. • The 2022/23 Annual Accounts & Trustee Report was approved.
BOARD ASSURANCE FRAMEWORK & RISKS	• Fundraising – the continued risks and uncertainty with cost-of-living implications are still having an impact and remain a risk to our plans for 2024. • Financial Reporting – no major concerns were identified, but the ratio of costs to income was raised as an issue. This will be covered in more detail at the next meeting where Alan Millard will also present his initial insights about other potential areas for improvement following his recent appointment. • Cases of Need – the new process and documentation is robust and is being followed in an effective and consistent way. • Charitable Funds – the new approach for monitoring the spending plans for Divisions and Fund Managers is still working well, but it was agreed that our reporting should be further enhanced starting from the next meeting to include a quarterly summary so the Committee has clear oversight about the collective position and progress with all spending plans. • External Review Action Plan – good progress is still being made with the implementation of the action plan.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	• The continued improvements with the governance, structure and processes for Charitable Funds were once again highlighted. The Committee kindly recognised the contributions made by Peter Hill and Paul Lewis as they were both attending this Committee for the last time.

REFERRALS TO OTHER BOARD COMMITTEES	• None

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
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Report Title	**Learning from Deaths: Trust Mortality Report Q3**				
Meeting	**Trust Board**				
Date	**7 March 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Dr Steve Haig, Interim Chief Medical Officer Dr Tobenna Onyirioha, Deputy Chief Medical Officer				
Report Author	Dr Laurie Powell, Consultant Palliative Medicine/Trust Mortality Lead Sharon Edwards, Clinical Audit, Effectiveness & Mortality Manager				
Appendices					

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):

Substantial		Good		Partial		Limited	
Governance and risk management arrangements provide **substantial assurance** that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being **consistently applied** and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide **good levels of assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied** and **implemented but not across all relevant services**. Outcomes are generally achieved but with **inconsistencies** in some areas.		Governance and risk management arrangements provide **reasonable assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied but insufficient to demonstrate implementation widely across services**. Some evidence that outcomes are being achieved but this is **inconsistent across areas and / or there are identified risks to current performance**.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. **Little or no evidence** is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	

Justification for the above assurance rating. Where 'Partial' or 'Limited' assurance has been indicated above, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Report

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

Trustwide Mortality Data Report –

- Number of mortalities remain less than 2% of overall admissions and less than average figures in comparison to previous trends; mortalities vs admissions, and mortalities overall follow average trends for the time of year.
- Number of deaths in ED dropped to less than average numbers per month for Nov and Dec; January's figures remain in line with average trends
- Incidents are now cross-referenced on Trust Mortality Database; triangulation of this data enables easier monitoring, identification of rising themes and alerts for trust wide mortality reviews and departmental learning.
- 229 SJR's were completed during Q3; of these 95 related to actual deaths during this period. Additional SJR's completed related to deaths during Q2.

- 31% of SJR outcomes were rated as “good or excellent”, or “adequate”. 67% did not record an overall outcome, improving which is a focus of attention for the CAEMT. Only 2% recorded “poor care”, and these were reviewed and escalated accordingly.
- 8 patients were identified with >50% avoidable death; all cases were progressed through the trust mortality/SJR processes resulting with 4 deaths escalated for further investigation.
- 12 reviews identified problems in care which was predominantly around assessment, investigation or diagnosis, and treatment/management plan.
- In 9 reviews, it was felt that problems identified in care, led to harm.

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:	
Accountable Lead Signature	
Date	29 February 2024

Learning from deaths

During 2023/2024, XXXXX of Great Western Hospitals NHS Foundation Trust patients died, XXXX case record reviews and investigations have been carried out in relation to the XXXX deaths in 2023/24. XXXX of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. Data for Q1-4 2023/24 is presented below.

	Q1	Q2	Q3	Q4	Total
No. of Deaths	345	298	359	XXXX	XXXX
Case record reviews	80	141	229	XXXX	XXXX
Investigations	8	5	6	XXXX	XXXX
No. of deaths with problems identified in care	6	7	12	XXXX	XXXX
No. of deaths considered >50% avoidable	0	5	8	XXXX	XXXX

The information below is taken from the Trust Mortality Report presented to PQC and Q&S Feb 2024:

The Trust Mortality Team have taken the opportunity of having a new Trust Mortality Lead in post to review and revise current processes following a challenging few years during which the covid pandemic and industrial action have made a consistent approach to learning from deaths difficult. We have detailed the challenges faced and working solutions in the table below. It is recognised that there are considerable changes compared with the previous approach, however we are confident that these changes align with the National Guidance[1], and should enable a more accurate picture of our current mortality position, as well as an accurate rolling perspective looking forwards.

CURRENT POSITION (as of end 2023)	WORK TO DATE	LOOKING FORWARD
Poor attendance at monthly Trust Mortality Group meetings	Clarifying obligations from National Guidance on Learning from Deaths (National Quality Board 2017) and identifying purpose of TMG [1]: ngb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)	• Re-establish Terms of Reference for Trust Mortality Group • Re-establishment of regular Trust Mortality Group meeting in line with mortality reports issued to PQC and Q&S, with a new focus to share current position of SHMI, themes identified from learning from deaths work, learning and improve engagement in mortality work across the trust.
Difficulty understanding influence of coding and scanning backlog on mortality position.	Jon Burwell has been involved in Improving Together process looking at coding and scanning.	Ongoing work towards understanding and quantifying effect of coding admissions to SWICC as “elective” rather than “emergency” on SHMI.
Poor demonstration of Morbidity and Mortality learning within departments and divisions – exacerbated by industrial action, trust pressures and capacity to run and facilitate meetings.	Process mapping workshop within the Clinical Audit, Effectiveness & Mortality Team	

	Development of the Mortality Dashboard enabling a real-time view of learning from deaths within the trust (and therefore guiding workstreams)	
	Development of local dashboards to enable divisional and departmental oversight of mortality and outstanding work e.g. mandatory category SJRs, M&M meeting reports.	
Poor performance with regards to SJR completion – both in terms of timescale (current average time taken to complete SJR's at the moment is 45 days, but some not completed until >6 months after death) and uptake of completion within departments.	Process mapping workshop within the Clinical Audit, Effectiveness & Mortality Team	Active input from the CAE&MT for departments with regards to facilitation of SJRs, M&M learning.
	Work done by CAEMT to date has improved turnaround time of SJRS already.	Aim for turnaround time of 7 days for mandatory categories and 30 days for all others.
	Increase focus on mandatory category SJRs, and increase facilitation and support from CAE&MT to enable this within departments and divisions (including new time frame ensuring timely completion and action)	
	Development of SJR training tool which can be used in 1:1 sessions, group sessions or online via ESR platform (where trust mandatory training is accessed)	
	Ongoing development of the Mortality Review Programme (clinicians register to do SJRs on a quarterly basis, and are awarded a certificate which contributes to appraisal demonstrating involvement in QI work) – "Platinum award" issued Jan 2024 for the first time.	Divisional managers will be asked to engage in nominating 5 clinicians per division every quarter to ensure competitive (and motivating) process. This process will be new from 1st April 2024.
Difficulty in interpretation and use of mortality data – HSMR and SMR significantly affected by coding backlog so alerts not received (and actioned) in real time. Historic reports from TELSTRA health have been challenging to interpret and action due to lag applied.	We have sought advice from national leads in Learning from Deaths (Dr Jean MacLeod, Clinical Lead for *Better Tomorrow: Learning from deaths, learning for lives)* regarding a move towards using SHMI as the NHS-recognised mortality index.  Understanding mortality to design f	Agreeing the use of SHMI (Summary Hospital Mortality-Level Indicator) as the primary mortality index for GWH to enable more up to date understanding of mortality trends and identification of themes for learning. Using SHMI will avoid attention being focussed on trying to identify and correct differences between HSMR and SHMI, and allow a better understanding of mortality trends, alongside the identification of alerts and themes and holistic triangulation.
	Meeting with relevant teams to enable triangulation of processes contributing to holistic assessment of mortality position: a) Medical Examiner team b) Datix/PSIRF process c) Coronial process d) SJRs e) Department M&M meetings	Using data and processes from triangulation work, a weekly review of deaths will be undertaken w/c 5/2/2024; those that require further scrutiny will be identified and appropriate review facilitated. This twofold objective will initially be completed by the Trust Mortality Lead and CAE&M Manager to determine a baseline assessment of themes/trends and learning before establishing a more robust process.
Lack of joined-up working across BSW, meaning potential missed opportunities for learning, aligning processes and resources	Establishment and participation in BSW-wide mortality group looking at aligning processes and sharing learning.	Exploration of nationally-recognised tools for learning from deaths, e.g. Amat, SJRplus and whether they can be of benefit at GWH

Appendix:

1. National Guidance on Learning from Deaths A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care: nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)
2. SHMI Frequently Asked Questions: SHMI FAQs (digital.nhs.uk)
3. Final report of the steering group for the national review of HSMR, which was established on behalf of the National Quality Board (2010): http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_121327.pdf

TRUSTWIDE MORTALITY REPORT

Month/Year Ending: February 2024

Great Western Hospitals NHS
NHS Foundation Trust

The Trust Mortality Report is produced using information from the collation of local/internal data provided by the trust's information team, specific coding and clinical casenote reviews, analysis and outcomes from Structured Judgement Reviews (SJR's) extracted from the Trust's M&M database, external data sources (Telstra Health) and locally occurring mortality-related activity.

ACTIVITY

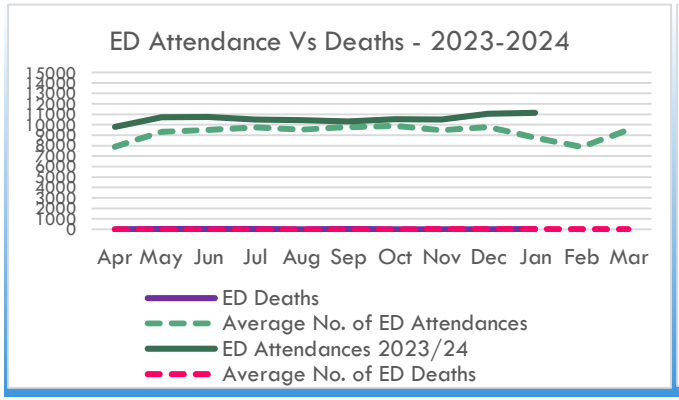


Figure 1

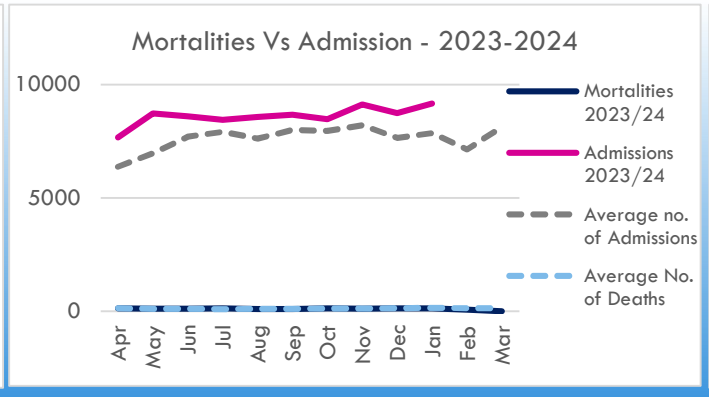


Figure 2

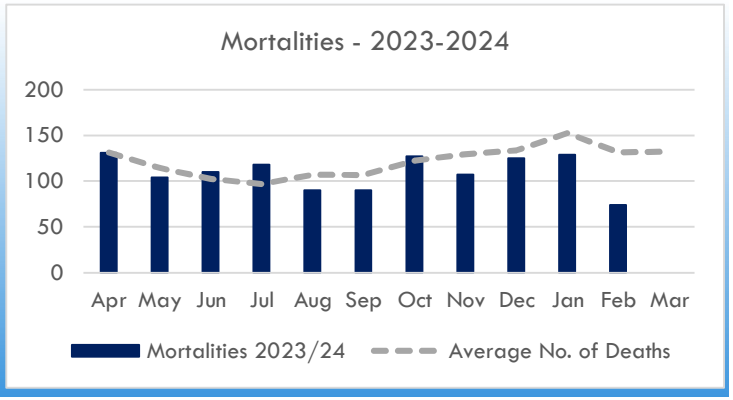
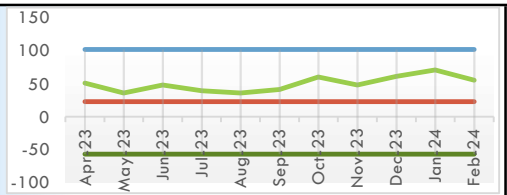
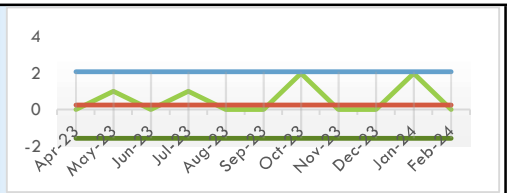
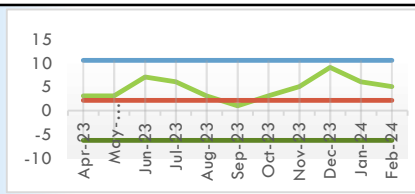
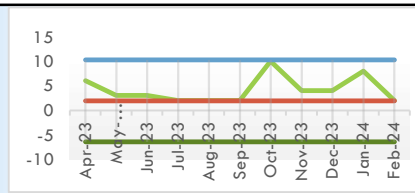


Figure 3

Internal data demonstrates ED attendances and admissions have remained above average levels (Figures 1 & 2); deaths in ED Department were reported to be lower than average with 7 and 6 deaths reported in November and December 2023, and 10 in January 2024 which is in keeping with the average. Overall the number of mortalities in the trust remains less than 2% of admissions (1.4%) and over the year we have seen fewer than average number of deaths (Figure 3).

MANDATORY CATEGORIES

Specific groups of patients are identified in the national Learning from Deaths Framework which should be prioritised for SJR; locally, the aim is to have priority reviews completed within 7 days so that the SJR can be used to inform/supplement other internal processes i.e. investigations, PSIRF, M&M learning, themed mortality reviews.

Incidents		***Incidents reported in deceased patients:*** Data is now uploaded from Datix into Trust Mortality Database. Alerts for patients needing review. Analysis shows high number of incidents relating to Falls and Pressure Ulcers; actions include themed mortality reviews, departmental review and M&M learning.
Learning Disabilities		***Learning Disabilities:*** Six patients identified with Learning Disabilities; 4 cases have SJR complete; themes include missed opportunity to refer for EoL care, prompt reviews and decision making, good documentation. 2 cases are still in progress.
Medical Examiner		***Medical Examiner:*** There was a rise in the number of ME referrals during Nov23-Jan 24 (20 in total). 17 required SJR; 8 SJR's complete, 12 SJR's in progress. 13 ME referrals also identified pts with incidents raised in relation to concerns around care.
HCAI		***HCAI:*** Internal data demonstrates a peak in the number of incidents relating to hospital acquired infection however this has subsequently fallen back to average levels; this data will continued to be monitored and themed review conducted if required.

Prepared on: 21st February 2024

TRUSTWIDE MORTALITY REPORT

Month/Year Ending: February 2024

Great Western Hospitals NHS
NHS Foundation Trust

LEARNING FROM DEATHS

Total Number of deaths during Q3	***359***	
Total number of SJR's completed during Q3	***229***	
Of which, proportion of deaths occurring in Q3 reviewed (SJR)	*95*	*41%*

Proportion of cases where death was felt to be >50% avoidable	*8*	*3%*	***Comments include:*** *lack of investigation into falls, poor documentation, delay in identification of diagnoses and appropriate onward referral, challenging cases, notes order, development of hospital acquired infection in patients declared medically fit for discharge.*
Of which,			
Proportion of cases where no further action was required	*2*	*25%*	
Proportion of cases undergoing review at speciality M&M	*3*	*38%*	
Proportion of cases undergoing 2nd speciality review	*2*	*25%*	
Proportion of cases escalated for Higher Level Review (HLR)	*5*	*63%*	
Proportion of HLR cases identified no further action	*1*	*20%*	
Proportion of HLR cases escalated for investigation	*4*	*80%*	

Proportion of cases identified with problems in care	*12*	*5%*	***Comments include:*** *good care with appropriate senior review, results not being reviewed, lack of assessment of falls, delay in assessment or review, ReSPECT form not complete, delay in treatment, poor ordering of medical notes, lack of nursing documentation, lack of documentation from private treatment.*
Of which, problems related to -	***No.***	***Felt led to harm***	
Assessment, investigation or diagnosis	*5*	*2*	
Medication/IV Fluids/Electrolytes/Oxygen	*0*	*0*	
Treatment and management plan	*6*	*3*	
Infection control	*0*	*0*	
Operation/invasive procedure	*1*	*1*	
Clinical monitoring	*2*	*1*	
Resuscitation following cardiac/respiratory arrest	*0*	*0*	
Other type not fitting the categories above	*3*	*2*	

Summary of findings from completed SJR's: *53 (23%) review identified* ***Good or Excellent*** *levels of care delivered to patients, with recorded examples of areas of good practice including timely assessments and senior reviews, early involvement of relevant specialities, appropriate sepsis management, appropriate transfers to ICU, recognition of end of life and initiated care with patient wishes being documented, RESPECT forms being completed, regular review by the palliative care team, involvement of patients families. Additionally, there were examples of excellent handling of the ethical dilemmas and documentation of relevant discussions.* ***Adequate care*** *was identified in 19 (8%) completed reviews with comments including opportunities for further investigation not taken, unclear, confusing and sometimes limited documentation meaning review of notes was difficult.* ***Poor care*** *was identified in 5 (2%) of completed reviews and comments are represented above. 152 (67%) cases did not identify/record an overall outcome which is the focus of ongoing work with the CAEMT.*

Actions going forward include *: using new data sources for real-time monitoring of internal activity and the outcomes from SJR's the will enable timely response to the identification of themes and alerts, as well as triangulation with external sources of data (e.g. Telstra). Internal data is also triangulated with incidents (datix) to inform trust-wide themed mortality reviews and in turn generate new knowledge for shared learning and improvements for patient care which will be shared at Trust Mortality Group meetings. The Trust Mortality Team have identified workplan objectives to review and streamline processes and engagement, which will support raising the Mortality profile across the Trust. This includes a relaunch in April 24 (please see report presented to PQC/Q&S Feb 24).*

Prepared on: 21st February 2024

Report Title	**Gender Pay Gap Report 2022-23**				
Meeting	**Trust Board**				
Date	**7th March 2024**	Part 1 (Public)		Part 2 (Private)]	
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Sharon Woma, Equality, Diversity & Inclusion (EDI) Lead				
Appendices	Gender Pay Gap Report 2022-23				

Purpose							
Approve		**Receive**	X	**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):

Substantial		**Good**	X	**Partial**		**Limited**	
Governance and risk management arrangements provide **substantial assurance** that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being **consistently applied** and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide **good levels of assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied** and **implemented but not across all relevant services**. Outcomes are generally achieved but with **inconsistencies** in some areas.		Governance and risk management arrangements provide **reasonable assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied but insufficient to demonstrate implementation widely across services**. Some evidence that outcomes are being achieved but this is **inconsistent across areas and / or there are identified risks to current performance**.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. **Little or no evidence** is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	

Justification for the above assurance rating. Where 'Partial' or 'Limited' assurance has been indicated above, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Report

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

In order to meet its obligations under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, the Trust is required to publish gender pay gap data on a government website and the Trust website.

This paper summarises the results of the Gender Pay Gap analysis and background information.

The gender pay gap reporting uses six different standard measures which are: -

- The mean gender pay gap is £6.88, this reduces to £0.76 excluding medical staff (in favour of males)
- The median gender pay gap is £3.92, this reduces to £0.21 excluding medical staff (in favour of males)
- The mean bonus gender payment gap is £13,478.67, this reduces to 149.76 excluding medical staff (in favour of males – this was in favour of females last year - £52.57)

- The median bonus gender pay gap is £13,922.88, this reduces to £90.00 excluding medical staff (in favour of males, this was at parity, 0% last year
- The proportion of males and females receiving a bonus payment (males 108, 11.00%, females 234, 5.26%)
- The proportion of males and females in each quartile pay band (lower to upper):
    - Lower – m 14.40%, f 85.60% (excluding medical m 14.46%, f 85.54%)
    - Lower middle – m 13.44%, f 86.56% (excluding medical m 12.66%, f 87.34%)
    - Upper middle – m 15.06%, f 84.94% (excluding medical m 12.89%, f 87.11%
    - Upper – m 29.47%, f 70.53% (excluding m 14.75%, f 85.25%)

The gender pay gap is defined as the difference between the mean or median hourly rate of pay that male and female employees receive. The mean pay gap is the difference between average hourly earnings of men and women. The median pay gap* is the difference between the midpoints in the ranges of hourly earnings of men and women.

The attached report is based on a snapshot of all Trust employees on 31 March 2023. The Gender Pay Gap report must be approved by the Board and published by 30 March 2024.

*The median is considered to better represent the gender pay gap, because the median data is not distorted by very high or low hourly pay (or bonus payments).

Gender Pay and Bonus Payment Gap key drivers:

- There are more male staff occupying senior roles and therefore receive on average a higher hourly rate of pay.
- There are more male consultants employed by the Trust and longstanding differences in terms and conditions of service has led to inequity.
- The pay gap has decreased since last year because of re-banding of some healthcare support workers and an increase in pay for specialist nurses.
- The above adjustment for specialist nurses, is a result of reclassification of what was previously classed as a bonus, thus bonus payments to female staff has reduced.
- The bonus payment gap has resulted because there are more male consultant staff and they received higher legacy bonus payments than female staff.

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	The GPG report will be reviewed by 1. People & Culture Sub Committee 2. People & Culture Committee 3. Trust Management Committee 4. Trust Board				
Next Steps	Review, approve and publish on the Trust internet by the end of March 2024. Deliver actions identified.				

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: Explanation of above analysis: The report highlights that there is a gender pay gap in favour of male staff (rationale included in above table). The Trust will undertake several initiatives in 2023-24 and 2024-25 to address the pay gap including reviewing equal opportunities and looking at the pay gap for other equalities groups (ethnicity, sexual orientation etc) to address any disparities that result from the intersection of two or more protected characteristics.

Recommendation / Action Required The Board/Committee/Group is requested to:	
Discuss and receive the Gender Pay Gap Report and action plan	
Accountable Lead Signature	Jude Gray, Chief People Officer
Date	08.02.2024

Great Western Hospitals
NHS Foundation Trust

DRAFT

Gender Pay Gap Report: 2022-2023

Draft: Version 0.8

28.02.2024

Contents

Executive Summary

Great Western Hospitals NHS Foundation Trust is committed to advancing equality, diversity and inclusion and our strategy is underpinned by the NHS Constitution's values: working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives and everyone counts.

The Trust supports a diverse workforce who have different backgrounds, with differing perspectives and different ways of working. This diversity is key to our success and helps us to provide the best possible care for our patients and population.

We recognise our role and responsibility to provide equal opportunities and advance inclusion, to eliminate discrimination and to foster good relationships as an employer, provider, partner and anchor institution. Our commitment extends to addressing our gender pay gap which is an enduring challenge in every sector. We will continue to take positive steps towards pay equity.

We want the Trust to be a great place to work, to attract the best talent and we have an ambitious Equality, Diversity & Inclusion Strategy that supports this.

We regularly publish information relating to the wider diversity of our workforce in our Equality Annual Reports.

The Trust has been required to report and publish specific details about its gender pay since 2018, including:

- Mean and median gender pay gaps
- Mean and median gender bonus payment gaps
- The proportion of males and females who received bonus payments
- The proportion of males and females in each pay quartile.

The gender pay gap measures the difference between the pay rates of all male and female staff across the Trust, irrespective of their role and seniority.

The data used in this report is taken from the NHS Workforce Electronic Staff Records (ESR) and payroll information.

- The mean gender pay gap has decreased by 3.06%
- The median gender pay gap has decreased by 0.31%
- The mean bonus payments gap has decreased by 12.94%
- The median bonus payments gap increased by 4.88%
- Proportion of males receiving bonus payments has reduced by 9.76%
- Proportion of females receiving bonus payments has reduced by 17.23%

What is our Gender Pay Gap Report?

Under the provisions of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which relate to public sector employers in England and Wales, the Trust is required by law to publish an annual gender pay gap report.

The regulations apply to all public sector employers who employ more than 250 employees and require them to publish details of the gender pay gap as of 31 March as a snapshot each year. There is a separate requirement for employers to publish gender bonus payments gap information, based on data for those employees in receipt of bonus payments during the 12 months to 31 March.

The gender pay gap is defined as the difference between the mean or median hourly rate of pay that male and female employees receive. The mean pay gap is the difference between average hourly earnings of men and women. The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women.

This report is based on a snapshot of all Trust employees on 31 March 2023.

The areas of focus are:

- The median gender pay gap in hourly pay
- The mean gender pay gap in hourly pay
- The mean gender pay gaps for any bonus payments paid out during the year
- The median gender pay gap for any bonus payments paid out during the year
- The proportion of male and female staff that received bonus payments
- The proportion of male and female staff in each quartile of the pay structure

Elements of our Gender Pay Gap Report

Our Gender Pay Gap report contains several elements, including:

- Pay information as at the snapshot date of 31 March 2023
- The report will be published on the Trust website and on the relevant government website by 30 March 2024
- A comparison with 2021 and 2022 figures
- Existing and future recommended actions to reduce the gender pay gap.

A Note on Terms

What do we mean by pay 'parity'?

In the context of gender pay, 'parity' means that males and females are being paid the same amount for work assessed as of equal value. Parity is therefore a desired outcome.

What do we mean by a 'more positive difference', or 'improvement' on a previous position?

This means that the pay of males and females for a specified measure is closer to parity (see above), than it was when we looked at the measure previously.

What is a 'negative' data measure?

We are adopting the standard convention when looking at pay differences between males and females. A negative measure (for example, a gap of -1.57 as indicated for staff at Band 2 of the pay scale), indicates the extent to which females earn more per hour, on average, than their male counterparts.

Gender pay reporting and equal pay

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between males and females who carry out the same or similar jobs or work of equal value. In the UK it is unlawful to pay people unequally because they are a man or a woman.

Gender Pay Gap Summary

A summary of our position in 2023 using the mean hourly rate of pay and mean bonus payment compared to 2022:

Mean Pay Gap	**£6.88**	**(27.26%) Reduced by £0.68 since last year from £7.56.**
Excluding medical and dental staff	**£0.76**	**(4.18%) Reduced by £0.48 since last year from £1.24.**
Mean Bonus Payment Gap	**£13,478.67**	**(70.71%) Decreased by 12.94% since last year from 83.65%.**
Excluding medical and dental staff	**£149.76**	**(47.17%) Increased by 58.95% since last year from -11.78%.**

Why do we have a mean hourly gender pay gap?	• Male staff are over-represented in senior roles (the highest pay quartile, 29%) and are less likely to occupy junior positions, they therefore have a higher hourly mean rate of pay. If staff were representative across the Trust, there would be a gender split closer to 82% female and 18% male across all quartiles. • Revision to Agenda for Change (AfC) means that there is no incremental pay until staff reach the top of their pay points and the difference between pay points is significant ranging from 12-16% or £6,000 to £14,340 per annum. • Pay increase for specialist nurses and healthcare support workers have helped to reduce the gap. • Higher proportion of male staff in senior roles who were at the top of pay scale (point) last year, have left the Trust, coupled with an increase in female staff who have moved to the top of their pay scale, resulting in a reduction in the gap. • When medical and dental staff are removed from the equation, the gender pay gap decreases from £6.88 to £0.76. This is as a result of long-standing differences in terms and conditions of service for medical staff. In addition, other studies highlight likely causes: • According to the 'Mend the Gap: The Independent Review into the Gender Pay Gap in Medicine' there is an unequal impact of caring responsibilities on careers; and female medical staff tend to be segregated into lower paid career paths (particular roles and specialties), this is due to the difficulties working LTFT (less-than full time), or the structure of careers in some specialities. This results in pay penalties, especially relating to non-basic pay additions, such as CEAs (clinical excellence awards). • The report also indicates that males in the profession are more likely to be older and been in practice for longer. This leads to them occupying the highest paid positions (consultants, associate specialists, GP partners, professors).

	• The Institute of Fiscals Study IFS Deaton review indicates that gender gaps in employment and hours increase substantially immediately upon parenthood and a higher percentage of women employed in part-time work also contributes to less wage growth and career progression.
Why do we have a bonus payments gap when we include all staff?	• When medical staff are excluded, the bonus gender pay gap for Agenda for Change (AFC) staff is 47.17% in favour of male staff, up 59%. Last year the bonus was in favour of female staff (-11.78%). Re-classification of bonuses paid to specialist nurses has meant there was an increase in average hourly rate of pay for these nurses and reduction in bonus payments, primarily affecting female staff who are more prevalent in the nursing profession. Although more AFC female staff receive a bonus, they are smaller incentive payments. • Waiting List Initiative payments for medical and nursing staff attract different rates, medical staff are on a higher rate, and given the higher proportion of males in the medical workforce (63.71%), this increases the bonus payment gap in favour of male staff. • The bonus gender pay gap for medical only staff has reduced to 13.22% (down 3.09%). • More male medical and dental staff receive bonuses (64%) than female medical and dental staff (36%), male staff have also received larger payments. What has helped to reduce the bonus pay gap for medical and dental staff is that the reduction in number of female staff who received a bonus was smaller than the reduction of male staff, 6 less compared to 38 less respectively. • In addition, female medical staff who work part-time now receive a full payment.

Note, the Trust published its last Gender Pay Gap Report (2021-22) in March 2023, the actions from this report remain in progress. We have therefore carried these actions forward to 2023-24. To support this work, during the remainder of 2023, the Trust has focussed on initiatives that will enable greater involvement of staff to drive the inclusion agenda.

Gender Breakdown

Gender proportions in our Trust

The Trust had 5,427 employees/workers in the year from 01 April 2022 to 31 March 2023. The gender split of paid employees was as follows:

Gender	Headcount	Proportion of workforce
Male	980	18.06%
Female	4,447	81.94%
Total	5,427	100.00%

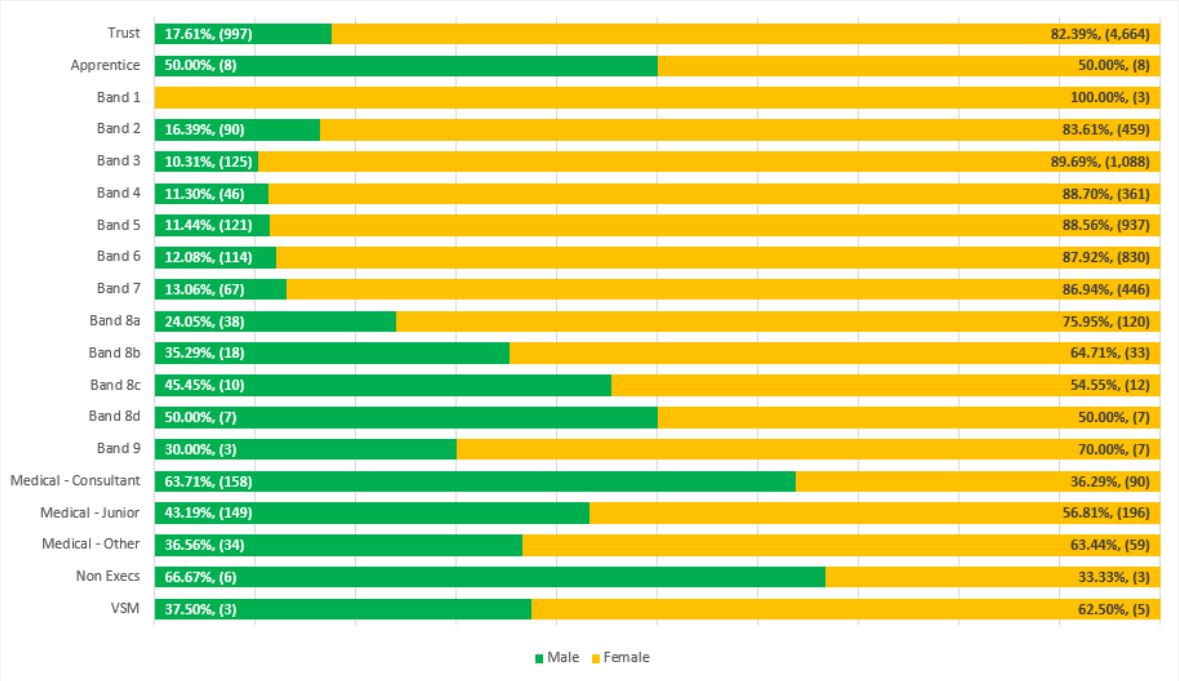
Gender	Full-Time	Part-Time
Male	800 (25%)	197 (8%)
Female	2,402 (75%)	2,262 (92%)
Total	3,202	2,459

Medical and dental workforce

The medical and dental workforce comprises of 650 staff, 330 male staff (50.77%) and 320 female staff (49.23%). This is broadly representative of the Swindon demographic and national picture – a split of 50:50. The workforce excluding medical and dental staff is 4,777 staff, 652 male staff (13.65%) and 4,125 female staff (86.35%), which reflects the greater proportion of staff working in the Nursing, Midwifery and AHP professions on Agenda for Change terms.

3,202 staff are full-time, 800 (24.98%) male and 2,402 (75.02%) female; and 2,459 staff work part-time, 197 male (8.01%) and 2,262 (91.99%) female.

The gender split of staff across all bands is as follows:



Mean Gender Pay in Hourly Pay

How is this calculated?

The mean gender pay gap is the difference between the hourly pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce. A negative measure indicates the extent to which females earn more per hour, on average, than their male counterparts.

Table: Mean hourly rate including medical and dental staff

	Year to 31.3.22	Year to 31.3.23	Difference (between 2022 & 2023)
Male	£24.93	£25.25	+£0.32
Female	£17.37	£18.37	+£1.00
Difference	£7.56	£6.88	-£0.68
Pay Gap %	30.32%	27.26%	-3.06%

Our mean hourly pay gap shows a decrease of 3.06% (an improved position)

Table: Mean hourly rate excluding medical and dental staff

	Year to 31.3.22	Year to 31.3.23	Difference (between 2022 & 2023)
Male	£17.53	£18.07	+£0.54
Female	£16.29	£17.31	+£1.02
Difference	£1.24	£0.76	-£0.48
Pay Gap %	7.07%	4.18%	-2.89%

Our mean hourly pay gap, excluding medical and dental staff shows a decrease of 2.89% (an improved position)

Differential pay rates

Female staff earn £0.73 for every £1 that male staff earn when comparing mean hourly pay. This has improved since last year, when female staff earned 70p for every £1 a male staff earned.

The impact of medical and dental staff

When medical and dental staff are removed, female staff would earn £0.96 for every £1 a male staff earned.

Table: % Mean gap ordinary hourly rate of pay

Group	Male 22-23	Female 22-23	Gap % 2020-21	Gap % 2021-22	Gap % 2022-23
0 - Apprentice	£6.73	£6.44	9.03%	-43.85%	4.37%
1	-	£10.37	-	-	-
2	£11.69	£12.35	-1.57%	-4.05%	-5.66%
3	£12.56	£12.66	-0.89%	-0.87%	-0.80%
4	£13.10	£13.22	2.34%	0.45%	-0.94%
5	£17.03	£18.27	-7.60%	-5.26%	-7.28%
6	£21.15	£21.58	-5.83%	-3.19%	-2.05%
7	£23.40	£23.67	0.54%	-1.19%	-1.19%
8a	£26.68	£26.33	1.18%	0.50%	1.29%
8b	£30.68	£30.82	-2.85%	3.22%	-0.44%
8c	£37.36	£37.43	7.57%	1.89%	-0.18%
8d	£45.90	£46.16	8.11%	4.41%	-0.56%
9	£56.25	£53.54	11.85%	3.28%	4.82%
Medical - Consultant	£53.22	£46.33	5.75%	3.81%	12.95%
Medical - Junior	£26.41	£23.70	8.35%	2.40%	10.24%
Medical - Other	£32.40	£27.12	6.43%	17.93%	16.28%
Non-Execs	£9.94	£6.02	70.79%	35.11%	39.46%
VSM	£82.21	£68.39	3.28%	10.26%	16.81%

Where have there been changes?

The picture remains mixed, however female staff are faring better. Since last year:

Existing gaps that were in favour of female staff (Bands 2 and 5) have continued to increase.

There was a significant reduction of female staff in Band 2 (reduced by 605 staff) and significant increase of female staff in Band 3 (increased by 484 staff). The Band 2 healthcare support worker roles were re-evaluated and staff had the opportunity to be re-banded to Band 3, subject to meeting criteria and these staff will have benefited from increased pay, this movement has helped to reduce the mean gender pay gap.

Some bands (Band 4, 8b, 8c, 8d) that were in favour of male staff last year, are now in favour of female staff.

Five pay bands are close to parity with a gap less than 1% (Bands 3, 4, 8b, 8c, 8d), with improvements in three of these – all higher bands (8b-d).

The gaps in favour of male staff are Band 8a, 9 and above including all medical roles and these gaps have increased since last year.

Why do we have a mean gender pay gap?

There are more male staff in the upper quartile (highest pay bracket) 29.47%, than compared in the lower quartile (14.40%), in comparison female staff are more evenly spread across the quartiles, however there is greater representation of female staff in the lower quartile (85.60%), than in the upper quartile (70.53%). Therefore, male staff on average earn more per hour.

The gap has reduced due to:

- The re-banding of female Band 2 staff, resulting in an increase in number of female staff in Band 3 roles, and therefore attracting higher pay.
- There is a small increase in the number of male staff across the lower (Band 0-5) and upper bands (8a and above), 34 and 3 respectively; with a corresponding larger increase in female staff across the lower (Band 0-5), middle (Band 6 and 7) and upper (8a and above), 42, 70 and 6 respectively.

	2021-22 Female	2021-22 Male	2022- 23 Female	2022-23 Male
Lower Band (B0-5)	2814	356	2856	390
Lower Middle Band (B6-7	1206	185	1276	181
Upper Band (Band 8a +)	526	423	532	426
			4664	997

- In addition, due to changes in how bonus payments are classified, most non-medical incentives have been replaced with ad-hoc increased hourly rates resulting in an increase in pay for specialist nurses, who are predominantly female.

National evidence suggests that male medical staff are more likely to be in practice longer, thus occupying higher paid roles and there is a negative impact for female staff due to caring responsibilities and career breaks.

Median Gender Pay Gap in Hourly Pay

How is this calculated?

The median pay gap is the difference between the pay of the middle male and the middle female when all male employees and then all female employees are listed from the highest to the lowest paid.

The median is considered to better represent the gender pay gap, it is often lower than the mean because the median data is not distorted by very high or low hourly pay (or bonus payments).

Table: Median hourly rate including medical and dental staff

	Year to 31 March 2021	Year to 31 March 2022	Year to 31 March 2023	Difference (between 2022 & 2023)
Male	£19.38	£19.96	£20.76	+£0.80
Female	£15.54	£16.13	£16.84	+£0.71

Difference	£3.84	£3.83	£3.92	+£0.09
Pay Gap %	19.81%	19.19%	18.88%	-0.31%

Our median hourly pay gap shows a slight decrease (an improvement)

Table: Median hourly rate excluding medical and dental staff

	Year to 31 March 2021	Year to 31 March 2022	Year to 31 March 2023	Difference (between 2022 & 2023)
Male	£15.24	£16.13	£16.77	+£0.64
Female	£14.77	£15.12	£16.56	+£1.44
Difference	£0.47	£1.01	£0.21	-£0.80
Pay Gap %	3.08%	6.26%	1.25%	-5.01%

Our median hourly pay gap (excluding medical staff) has decreased significantly (an improvement)

Differential pay rates

Female staff earn £0.81 for every £1 that male staff earn when comparing median hourly pay. There is no change since last year (a very slight increase of 0.31%).

When medical and dental staff are removed from the equation female staff earn £0.99 for every £1 male staff earn, an improvement from last year when female staff earned £0.94 for every £1 male staff earned.

Table: % Median gap ordinary hourly rate of pay per Banding

Group	Male 22-23	Female 22-23	Gap % 2020-21	Gap % 2021-22	Gap % 2022-23
0 Apprentice	£6.83	£4.81	11.95%	0.00%	29.58%
1	-	£10.37	-	-	-
2	£10.90	£10.90	-3.48%	-0.19%	0.00%
3	£11.85	£11.85	0.00%	0.00%	0.00%
4	£13.44	£13.44	0.00%	0.00%	0.00%
5	£16.84	£17.10	-2.20%	-1.49%	-1.51%
6	£20.76	£20.76	0.00%	0.00%	0.00%

7	£22.80	£24.38	0.00%	-1.30%	-6.93%
8a	£26.40	£25.64	2.29%	0.32%	2.86%
8b	£28.83	£29.34	0.00%	14.24%	-1.75%
8c	£39.52	£38.32	13.46%	13.03%	3.05%
8d	£46.94	£46.94	6.75%	13.48%	0.00%
Group	**Male 22-23**	**Female 22-23**	**Gap % 2020-21**	**Gap % 2021-22**	**Gap % 2022-23**
9	£56.00	£55.99	7.11%	0.00%	0.02%
Medical-Consultant	£52.45	£50.42	6.20%	2.87%	3.87%
Medical-Junior	£25.49	£22.85	6.27%	4.83%	10.36%
Medical-Other	£30.80	£25.72	6.18%	11.15%	16.49%
Non-Executives	£7.26	£7.00	10.37%	7.16%	3.58%
VSM	£84.69	£63.69	6.42%	16.39%	24.80%

Where have there been changes?

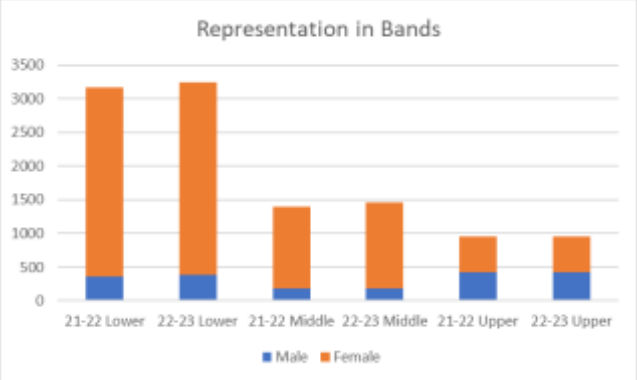
The gaps in favour of male staff have increased in seven bands (Band 0, 8a, 9 and above) and decreased in 3 bands (Band 8c, 8d and Non-Executives).

The gaps in favour of female staff have increased in two bands (Band 5 and 7); and Band 8b, the gap which was previously in favour of male staff is now in favour of female staff, a significant swing from 14.24% to -1.75% as a result of changes in the number of female staff at the top of the pay scale in Band 8a and above, and reduction in male staff at the top of the pay scale in the same bands. However, the gap has widened further in favour of male staff in Bands 9 and above.

The Trust has achieved parity in five bands (Band 2, 3, 4, 6 and 8d). We achieved parity in Bands 3 and 4 last year.

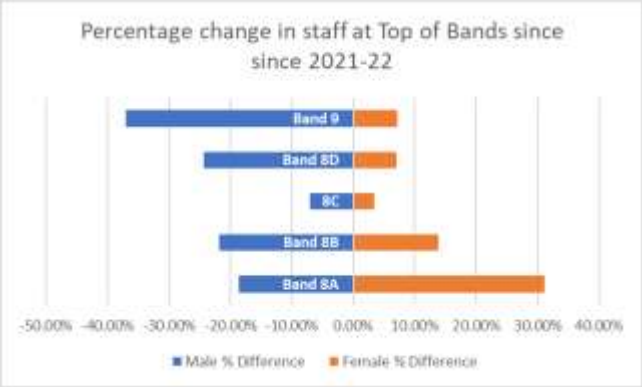
Why do we have a median pay gap?

Although we employ fewer male staff (997 male, 4664 female), male staff are disproportionately represented in senior roles, when compared to female staff and therefore earn more per hour on average and have a higher midpoint value.



39% of all male staff (390 of 997) are Band 0 to 5 compared to 61% of all female staff (2856 of 4664); and 43% of all male staff are in senior roles (426 out of 997), Band 8a and above, compared to 11% of all female staff (532 of 4664).

The levels have remained similar to 2021-22 (indicated in table above), with most growth in the middle range of roles for females (increased by 70 staff).



Last year we reported an increase in the number of male staff at the top of the pay scale in senior roles, the trend has reversed this year, contributing to an improvement in the median pay gap, particularly for non-medical staff where the median pay gap is now £0.21 (1.25%), from £1.01 (6.26%) last year, compared to £11.00 (27.65%), a slight improvement, for medical and dental staff this year (from £11.90/29.08% last year). The table above highlights the difference between the percentages of male or female staff in senior roles at the top of their pay scale last year, compared to those at the top of their pay scale this year. For example, in Band 8a, 45.19% of female staff were at the top of the pay scale last year, this has increased to 76.39% this year, a difference (increase) of 31.2%. There was a decrease in the percentages for all male groups and an increase in the percentages for all female groups.

Bonus Gender Pay Gap

The bonus gender payment gap reflects the distribution of bonus payments made to relevant male and female employees, who were paid bonus payments in the 12 months that ended on the snapshot date.

What is included in the bonus payments?

- One-off recruitment and retention payments (in place for hard to recruit to roles).
- Incentive payments (for hard to fill shifts).
- Medical and dental staff's Clinical Excellence Awards (Local and National).

Table: Mean and Median Bonus gender payment gap averages including medical and dental staff

	2020-21			2021-22			2022-23		
	Male	Female	Gap %	Male	Female	Gap %	Male	Female	Gap
% Mean gap bonus pay	£4,592.65	£947.53	79.37%	£6,184.51	£1,011.16	83.65%	£19,063.21	£5,584.54	70.71%
% Median gap bonus pay	£2,470.00	£500.00	79.76%	£5,316.00	£320.00	93.98%	£14,082.88	£160.00	98.86%
% Receiving bonus	21.44%	28.97%		20.76%	22.49%		11.00%	5.26%	

No. of staff receiving bonus	208	1,336		201	1,024		108	234	

Table: Mean and Median Bonus gender pay gap averages excluding medical and dental staff

	2020-21			2021-22			2022-23		
	Male	**Female**	**Gap %**	**Male**	**Female**	**Gap %**	**Male**	**Female**	**Gap**
% Mean gap bonus pay	£710.50	£727.59	-2.41%	£445.35	£497.82	-11.78%	£317.50	£167.74	47.17%
% Median gap bonus pay	£400.00	£480.00	-20.00%	£300.00	£300.00	0.00%	£180.00	£90.00	50.00%
% Receiving bonus	15.18%	29.66%		10.89%	22.36%		2.45%	4.07%	
No. of staff receiving bonus	99	1,283		71	952		16	168	

Differential bonus pay

When including all staff, 342 bonus payments were made to staff, 108 to male staff (11.00% of eligible male staff - 982) and 234 to female staff (5.26% of eligible female staff – 4,445).

Fewer male and female staff have received bonuses this year, however, this has had a greater impact on female staff – 201 male staff received a bonus last year compared to 108 this year and 1,024 female staff received a bonus last year compared to 234 this year.

The reduction has largely been in non-medical female staff, last year 952 female staff received a bonus compared to 168 this year (784 less), compared to 71 male staff last year and 16 this year (55 less).

Fewer awards have been granted this year due to reclassification. Most specialist nurse incentives have been replaced with ad-hoc increased hourly rates and these payments do not meet the guidance for bonus pay and have therefore been counted as allowances in ordinary pay. This has predominantly impacted nursing rates of pay, therefore there is a notable decrease in the bonuses awarded to nurses and this has impacted female staff more; there are significantly fewer male nurses.

Therefore, the mean bonus payment gap:

- For all staff has reduced from 83.65% last year to 70.71% this year and remains in favour of male staff.
- For staff excluding medical and dental, the mean has increased from -11.78% (in favour of female staff) to 47.17% (in favour of male staff).
- For medical and dental staff only, the mean has decreased from 16.31% to 13.22%

The median bonus payment gap:

- For all staff has increased from 93.98% last year to 98.86% this year.
- For non-medical staff, the median has increased from 0% last year to 50% this year in favour of male staff.
- For medical and dental staff only, the median remains at parity, 0%.

Further information about consultant awards is provided in the following paragraphs.

Clinical Excellence Awards (CEAs)

CEAs are awarded to consultants. A total of 197 award payments were made, with some consultants receiving more than one payment. More payments were made to male staff (122 payments, 61.93% and 75 to female staff, 38.07%). This is split between local and national awards.

However, fewer awards have been paid this year and this has had a greater impact on male consultant staff (down from 171 to 122 payments, 49 less). Last year 83 payments were made to female consultant staff (a reduction of 8 this year).

This has resulted in a reduction in the mean bonus pay gap for medical and dental staff mentioned in the previous section. What has also helped to reduce the gap is a change in local policy – part-time female consultants received a full award payment.

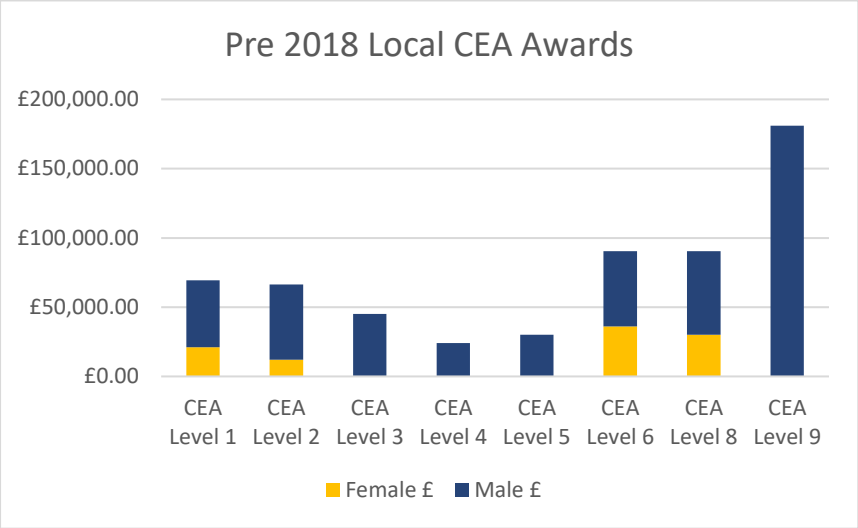
Local CEA

139 payments were made, 78 to male consultant staff (56.12%) and 61 to female consultant staff (43.88%), a gap of 12.24 percentage points. Each received a payment of £7,041.44, the award has increased as a result of national guidance to use all unspent funds since 2018. The Local CEA also increased compared to the previous year (2021-22) when it was £5,316. The gap between male and female awards has closed from 51.72 percentage points last year to 12.24 percentage points this year. Male staff are under-represented and female staff over-represented in local awards, when compared to the gender split of male and female consultants below.

Pre 2018 Local CEA award

56 pre 2018 local CEA award were paid, 44 payments to male consultants (79%) and 12 payments to female consultants (21%), resulting in male consultants receiving a larger share of the national awards – 83% of the total money paid in this category. In addition, male staff are more likely to receive the higher value awards, as highlighted in the table below, Level 1 representing the smallest value award and 9 the highest.

CEA Awards Level 1-9		Level 5	£15,080.00
Level 1	£3,016.00	Level 6	£18,096.00
Level 2	£6,032.00	Level 7	£24,128.00
Level 3	£9,048.00	Level 8	£30,160.00
Level 4	£12,064.00	Level 9	£36,192.00



Note, consultants are eligible for both local awards, the current award of £7K and the pre-2018 award. Therefore, some consultants will have received both payments.

National CEAs

Two staff received the national awards (Bronze and Silver), both staff were female, although these payments are amongst the highest monetary value awards, they represent just 5% of the total payments made.

Award	Value	Award	Value
Bronze	£36,192	Silver	£47,582
Gold	£59,477	Platinum	£77,320

Overall, male staff are over-represented in CEA awards, when compared to the gender split between male and female consultants below.

Gender split of consultants

The gender split for consultants is 158 male (65%) and 90 female (36%). When the total bonuses paid (all local and national payments) are considered, financial payments were relatively proportionate with 63% of the money going to male consultants and 37% to female consultants.

Why do we have a bonus payment gap?

The bonus payment gap is mainly driven by changes to non-medical (Agenda for Change) bonus payments:

- Marked reduction in number of non-medical awards given to female staff (748 less), compared to male staff (55 less).
- Although significantly more non-medical female staff have received bonuses (168, compared to 16 male), the bonuses are small incentives.
- In monetary terms, most of the pre-2018 bonus payments (83%) was received by male consultants and male consultants also received a larger share of local CEAs (56%).
- Male consultants are also more likely to receive the higher value awards, resulting in a higher median.
- What has had a positive impact on the gender bonus payments is the reduction in the number of payments to male consultants (a reduction of 38, compared 6 less for females), and the change in policy that has benefited part-time female consultants.

Proportion of males and females in each quartile

Quartiles are calculated by ranking all our employees from highest to lowest paid, dividing this into four equal parts (quartiles) and working out the percentage of males and females in each of the four parts.

The Trust continues to have a good proportion of females at Trust Board Executive and Senior Management levels, a third of non-executives and 62% of Very Senior Managers (VSMs) are female. When looking at all staff, male staff are disproportionately represented in the upper quartile (highest paid staff) – 29.47% male and 70.53% female, a small change from 2021-22 (29.90% male, 70.10% female). In contrast there are more female staff in the Lower, Lower Middle and Upper Middle Quartiles (80+%) than there are in the Upper Quartile (70%).

This is compounded by the fact that our medical and dental staff, who receive higher rates of pay, predominantly preside in the upper quartile. When medical and dental staff are excluded, male staff are more evenly spread across the quartiles, 14+% in Lower and Highest Quartile and 12+% in the two middle quartiles, as are female staff.

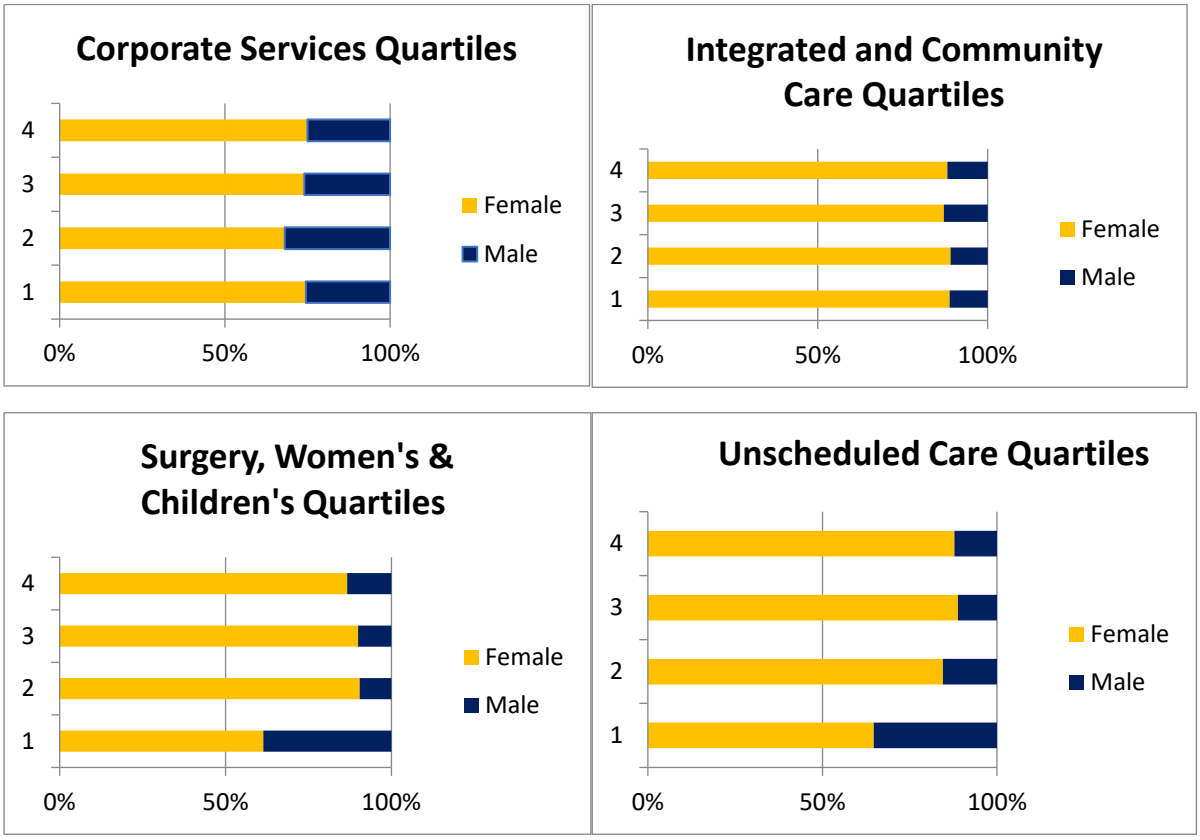
The tables below depict the gender split per quartiles.

Table: Gender split for pay in each of the four quartiles – including medical and dental staff

Quartile	Total staff	Male	Female	% Male	% Female
Lower	1354	195	1159	14.40%	85.60%
Lower Middle	1354	182	1172	13.44%	86.56%
Upper Middle	1355	204	1151	15.06%	84.94%
Upper	1354	399	955	29.47%	70.53%

Table: Gender split for pay in each of the four quartiles – excluding medical and dental staff

Quartile	Total staff	Male	Female	% Male	% Female
Lower	1196	173	1023	14.46%	85.54%
Lower Middle	1193	151	1042	12.66%	87.34%
Upper Middle	1195	154	1041	12.89%	87.11%
Upper	1193	176	1017	14.75%	85.25%



The tables above depict the pay quartiles per division.

Surgery Women's & Children (38.64%) and Unscheduled Care (35.24%) have the largest percentage of male staff in the Upper Quartile (quartile one, the highest pay bracket), and 62.96% of all male staff are based in these two divisions. This is reflective of the number of medical and dental male senior staff who work in these specialities. In comparison, Corporate Services and Integrated & Community Care have a relatively even spread of male staff across the quartiles.

Five-year review

Below is our gender pay gap scores for the last five years. Comparisons are from 2019 to 2023. A column has been included which indicates our direction of travel with an assessment of positive or negative referring to the indicator's impact on our staff for the measures numbered one to six in the table. The column is colour-coded – green is a positive change, red negative and yellow signifies little or no change.

The mean gender pay gap has reduced this year from £7.56 to £6.88, the percentage gap of 27.26% is the most favourable since we started reporting this data in 2018-19 when the gap was 29.66%. The median gender pay gap is similar to last year, with a slight reduction, from 19.19% (£3.83) last year to 18.88% (£3.92) this year, again, this is the lowest recorded percentage gap since 2018-19, albeit an incremental change.

The mean bonus payment gap has improved substantially, from 83.65% to 70.71%, a decrease of 12.94%. However, the median bonus gender payment gap has worsened, an increase from 93.98% last year to 98.86% this year.

Summary table

Gender pay gap standard measures (difference)		2018-19	2019-20	2020-21	2021-22	2022-23	Comparison of male and female average earnings: Direction of travel	
1	The mean gender pay gap	0	29.66% £6.80	29.10% £6.89	30.32% £7.56	27.26% £6.88	Down/Positive	
2	The median gender pay gap	19.00% £3.36	19.85% £3.61	19.81% £3.84	19.19% £3.83	18.88% £3.92	Similar	
3	The mean bonus gender pay gap	88.63%	88.97%	79.37%	83.65%	70.71%	Down/Positive	
4	The median bonus gender pay gap	84.62%	84.48%	79.76%	93.98%	98.86%	Up/Negative	
5	The proportions of males and females receiving a bonus payment	N/A	19.05% M 21.70% F	21.44% M 28.97% F	20.76% M 22.49% F	11.00% M 5.26% F	Down for both groups, however gap increased/ Negative	
6	The Gender Pay Gap Excluding medical and dental staff							
	The mean gender payment gap	2.49% £0.37	4.58% £0.71	6.47% £1.09	7.07% £1.24	4.18% £0.76	Down/Positive	
	The median gender payment gap	-2.80% -£0.37	0.07% £0.01	3.05% £0.47	6.26% £1.01	1.25% £0.21	Down/Positive	
	The mean gender bonus gap	16.40% £92.26	29.24% £165.57	-2.41% -£17.09	-11.78% -£52.47	47.17% £149.76	Up/Negative	
	The median gender bonus gap	27.27% £75.00	33.33% £100.00	-20.00% -£80.00	0.00% £0	50.00% £90.00	Up/Negative	
7	The proportions of males and females in each quartile pay band:							
	i. Lower Quartile	29.05% M 70.95% F	29.38% M 70.62% F	13.81% M 86.19% F	13.52% M 86.48% F	14.40% M 85.60% F		
	ii. Lower Middle Quartile	13.33% M 86.67% F	14.34% M 85.66% F	11.01% M 88.99% F	12.71% M 87.29% F	13.44% M 86.56% F		
	iii. Upper Middle Quartile	11.76% M 88.24% F	11.01% M 88.99% F	14.34% M 85.66% F	14.32% M 86.68% F	15.06% M 84.94% F		
	iv. Upper Quartile	12.84% M 87.16% F	13.64% M 86.36% F	29.38% M 70.62% F	29.90% M 70.10% F	29.47% M 70.53% F		

Conclusion

In summary, the Trust has a gender mean hourly pay gap of £6.88, and median hourly pay gap of £3.92, both in favour of male staff. We have continued to reduce our gender pay gap between male and female staff across a number of our bands, the mean pay gap is now in favour of male staff in eight out of 17 pay bands and pay gaps in favour of female staff in nine out of 17 bands; the bands where there are gaps in favour of male staff tend to be in more senior roles, thus attract higher pay. We are close to parity (<1%) in five bands.

When examining the median hourly pay gap, there is a pay gap in favour of male staff in nine bands, compared to gaps in favour of female staff in three bands; however, we have achieved parity in five pay bands (two new pay bands, Bands 2 and 8b and maintained parity in three, Band 3, 4 and 6).

The Trust's gender pay gap is caused by the following:

- Male staff are disproportionately over-represented in upper quartile of pay bands and under-represented in lower quartiles, and therefore receive on average more pay per hour.
- In contrast female staff are more evenly represented across all quartiles.

- There are more male consultants employed by the Trust than female consultants, and they receive a higher level of pay, due to longstanding differences in terms and conditions of service.
- The gap has decreased since last year because of re-banding of some healthcare support workers and an increase in pay for specialist nurses.

The mean hourly and median hourly pay gap (£0.76 and £0.21 respectively) is significantly reduced when medical and dental staff are removed from the equation.

The Trust's bonus payment gap continues to be driven by the number of male consultants (n.149, 64%), compared to female consultants (n.83, 36%) receiving payments – there are more male consultants, and male staff have received larger payments on average.

In addition, for non-medical staff (AFC), changes in the bonus classification, which has mostly affected nurses, has led to a reduction in female staff receiving bonuses (but increased hourly pay) and most non-medical bonuses tend to be incentive payments which are relatively small.

When the data is viewed over a number of years, progress is slow, we acknowledge it will take several years to change the make-up of staff across all levels of the organisation and we are taking positive steps to achieve year-on-year progress.

How have we addressed our gender pay gap and bonus payment gap?

Over the past year we have taken steps to improve our job advertising to ensure that it is appealing to candidates from diverse backgrounds and we use images in the adverts that are representative of our workforce. We now advertise roles using LinkedIn and Black Leadership Job Boards which has increased our audience and this has had a positive impact.

We have also invested in equipping our aspiring and existing leaders through internal and external leadership development and training opportunities including programmes for staff in Bands 4-6 and Bands 7-8a and we have continued to provide apprenticeship opportunities which are a route into leadership and career change. All of these efforts will help to prepare more female staff for senior positions.

In 2023-24 we will introduce leadership programmes for Consultants and junior staff in Bands 2-3. In addition, we will be supporting all staff through leadership and coaching and Scope for Growth career conversations. The Trust's Resourcing Plan for 2023-24 will implement additional measures to improve inclusive recruitment including utilising gender decoders to screen job adverts and remove gender-biased language and we will introduce Inclusion Recruitment Champions (IRCs) in November 2023. The Champions will sit on interview panels for Band 8b and above roles and they will support the interview panel to reduce the likelihood of bias and improve equity. We will also review the whole recruitment process to identify further opportunities to improve the process and equality, diversity and inclusion will be a part of this.

We continue to seek opportunities to reduce the bonus payment gap, this year payments to part-time staff match payments to full-time staff and 97% of part-time staff are female. The Trust is unable to make changes to national CEA awards policy but will continue to influence change where possible.

Finally, we have carried forward the actions from the Gender Pay Gap report that was published in March 2023 – this includes reviewing data for minoritized groups of staff to identify if the intersection of gender and other protected characteristics has an impact on the gender pay gap and to undertake engagement with female medical and dental staff in January 2024 to explore their perceptions and experience of equal opportunities.

A copy of the action plan is included in the appendix. Please note, the Trust has developed a single action plan that responds to the EDI performance frameworks that we complete during

the year and this action plan is published in the Equality Diversity Inclusion (EDI) Annual Report 2022-23, which is available on the Trust's website.

Notes

Agenda for Change: The NHS Pay Structure

Agenda for Change was implemented to harmonise pay scales and career progression arrangements in the NHS, to ensure that there is equity and transparency in relation to pay arrangements. This is reflected in the Trust gender pay gap reporting which identifies a 4.18% gap (excluding medical staff).

The majority of staff are on NHS terms and conditions. Most staff are on the national Agenda for Change Terms and Conditions of Service which uses 9 pay bands and staff are assigned to one of these on the basis of the NHS Job Evaluation Scheme. Within each band there are a number of incremental pay progression points.

The largest disparity is within medical staffing and the Trust acknowledges that there could be greater female representation in the consultant workforce and this is reflected nationally. Nationally action has been taken to increase the number of female trainees, however the impact of this will take a number of years. This discrepancy is reflected in the Trust Action Plan which focuses on closing the gap for medical staffing.

Within the NHS there are also national Medical and Dental terms and conditions of service. Depending upon seniority there are a number of pay scales for basic pay. There are separate terms and conditions for Very Senior Managers, such as Chief Executives and Directors, which is based on benchmarking information and agreed by Remuneration Committee.

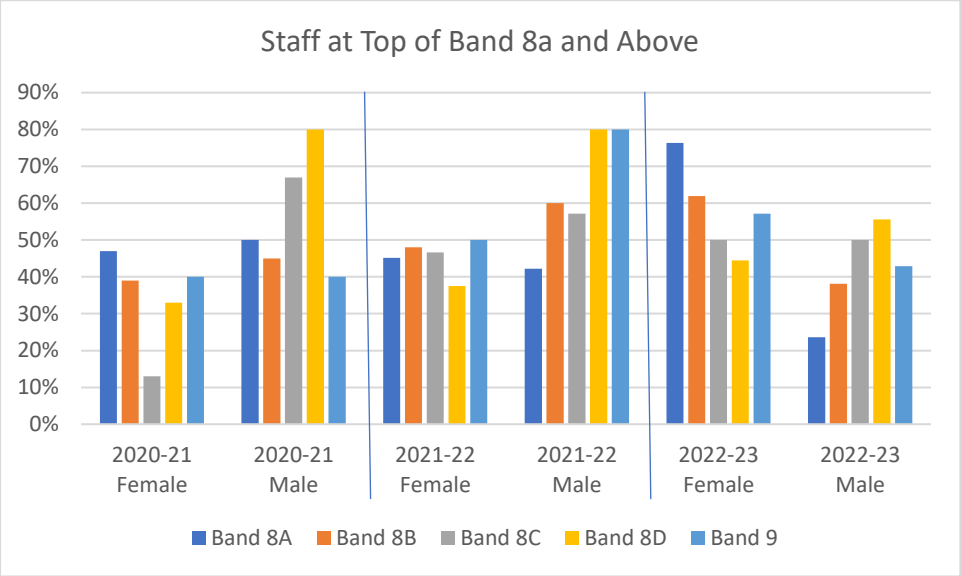
As an NHS Trust, our services are provided on a 24/7 basis, and therefore staff that work unsocial hours, participate in on-call rotas and work on general public holidays will often receive enhanced pay in addition to their basic pay. This mainly applies to clinical staff and non-clinical senior managers who undertake Senior Manager on-call duties, and non-clinical staff who provide 24/7 services such as Estates and IT.

Appendix

The Trust has fewer male staff at the top of Bands 8a and above (i.e. more senior male staff at the top of the pay scale have exited the Trust) and more female staff have reached the top of the pay scale this year compared to last year.

		2020-21	2020-21	2021-22	2021-22	2022-23	2022-23
Pay Point	Band	Female	Male	Female	Male	Female	Male
TOP	Band 8A	47%	50%	45.19%	42.22%	76.39%	23.61%
TOP	Band 8B	39%	45%	48.00%	60.00%	61.90%	38.10%
TOP	Band 8C	13%	67%	46.67%	57.14%	50.00%	50.00%
TOP	Band 8D	33%	80%	37.50%	80.00%	44.44%	55.56%
TOP	Band 9	40%	40%	50.00%	80.00%	57.14%	42.86%

This is depicted in the graph below.



All three actions have been carried forward to 2023-24 and have been incorporated into the Trust's single EDI Action Plan published in the EDI Annual Report for 2022-23.

Objective	Action	Lead	Time-scale	Desired Outcome
Better promotion of our senior vacancies to women and organisations that support women, including Medical and Dental vacancies.	Equal Opportunities Review – review quantitative and qualitative evidence to assess staff experience and perceptions around equal opportunities across three domains – access to opportunities, recruitment and appointment and development and identify good practice. (actions to engage with staff and review good practice have been amalgamated). *As a result of findings in this year's data (more senior male staff leaving the Trust), we will explore themes for Leavers during this review process.*	Equality Diversity Inclusion Lead	Revised date January 2024	Carried Forward – EDI Annual Report Action Plan To engage with female staff to understand their perceptions and experience regarding equal opportunities. January 2024
Ensure that grades contributing to the pay gap are reduced and barriers to progression removed.	Determine if other protected characteristics affect the gender pay gap. Expand review on gender pay gap to include data on religion, sexuality, disability and 'race'. Review this data across a range of occupations and directorates. As part of WRES/DES, expand on actions that may impact on gender pay.	EDI Lead and HR Business Partner (S Allison-Green)	Revised Date May 2024	Carried Forward – EDI Annual Report Action Plan Refreshed workforce data including other protected characteristics to be provided in Quarter 1/2024
Reduce barriers to progression.	Evaluate and promote support to female consultants to encourage an increase in applications for local Clinical Excellence Awards. • Collaborate with partners to devise a new or review existing 'perception/reality' surveys; • Distribute survey to a sample of senior staff (male and female) who are eligible for CEAs; • Analyse results to see if these indicate a mismatch between candidates perception of their abilities, and reality, by gender; • Determine next steps/ measures to put in place depending on findings.	HR Business Partner (S Allison-Green)	November 2023	Carried Forward – EDI Annual Report Action Plan

NHS
Great Western Hospitals
NHS Foundation Trust

Gender Pay Gap Report: 2022-23

Gender Pay Gap (GPG)
Bonus Pay Gap (BPG)

Sharon Woma, EDI Lead

Gender Pay Gap & Bonus Pay Gap Defined

NHS
Great Western Hospitals
NHS Foundation Trust

- The gender pay gap measures the difference between the pay rates of all male and female staff across the Trust

- The Trust has been required to report and publish specific details about its gender pay since 2018, including:
    - Mean (average) and median (midpoint) gender pay gaps
    - Mean and median gender bonus pay gaps
    - The proportion of males and females who received a bonus
    - The proportion of males and females in each pay quartile

- Snapshot at 31.03.2023

Gender Pay Gap Results

Great Western Hospitals NHS Foundation Trust

Mean - All workforce

	Year to 31.3.22	Year to 31.3.23	Difference (between 2022 & 2023)
Male	£24.93	£25.25	+£0.32
Female	£17.37	£18.37	+£1.00
Difference	£7.56	£6.88	-£0.68
Pay Gap %	30.32%	27.26%	-3.06% Improved

Median - All workforce

	Year to 31 March 2022	Year to 31 March 2023	Difference (between 2022 & 2023)
Male	£19.96	£20.76	+£0.80
Female	£16.13	£16.84	+£0.71
Difference	£3.83	£3.92	+£0.09
Pay Gap %	19.19%	18.88%	-0.31% Similar

Mean - Excluding Dental & Medical Staff

	Year to 31.3.22	Year to 31.3.23	Difference (between 2022 & 2023)
Male	£17.53	£18.07	+£0.54
Female	£16.29	£17.31	+£1.02
Difference	£1.24	£0.76	-£0.48
Pay Gap %	7.07%	4.18%	-2.89% Improved

Median - Excluding Dental & Medical Staff

	Year to 31 March 2022	Year to 31 March 2023	Difference (between 2022 & 2023)
Male	£16.13	£16.77	+£0.64
Female	£15.12	£16.56	+£1.44
Difference	£1.01	£0.21	-£0.80
Pay Gap %	6.26%	1.25%	-5.01% Improved

Bonus Pay Gap Results

NHS
Great Western Hospitals
NHS Foundation Trust

Mean & Median - All workforce

	2021-22				2022-23				
	Male	Female	Gap £	Gap %	Male	Female	Gap £	Gap %	
% Mean gap bonus pay	£6,184.51	£1,011.16	£5,173.35	83.65%	£19,063.21	£5,584.54	£13,478.67	70.71%	Improved
% Median gap bonus pay	£5,316.00	£320.00	£4,996.00	93.98%	£14,082.88	£160.00	£13,922.88	98.86%	Worsened
% Receiving bonus	20.76%	22.49%			11.00%	5.26%			
No. of staff receiving bonus	201	1,024			108	234			

Mean & Median - Excluding Dental & Medical Staff

	2020-22				2022-23				
	Male	Female	Gap £	Gap %	Male	Female	Gap £	Gap %	
% Mean gap bonus pay	£445.35	£497.82	-£52.52	-11.78%	£317.50	£167.74	£149.76	47.17%	Worsened
% Median gap bonus pay	£300.00	£300.00	£0	0.00%	£180.00	£90.00	£90.00	50.00%	Worsened
% Receiving bonus	10.89%	22.36%			2.45%	4.07%			
No of staff receiving bonus	71	952			16	168			

Why do we have a gender pay gap

	Summary	Cause of Gap	Actions
Gender Pay Gap	Mean Pay Gap • All staff - **£6.88 (27.26%)** – [2022 **improved** by -£0.68 (-3.06%)] • Exclude medical - **£0.76 (4.18%)** – [2022 **improved** by -£0.48 (-2.89%)] Median Pay Gap • All staff - **£3.92 (18.88%)** - [2022 **similar**, small decrease by £0.09 (-0.31%)] • Excluding medical - **£0.21 (1.25%)** – [2022 **improved** by -0.80 (-5.01%)]	• A higher proportion of male staff are employed in senior roles and therefore earn a higher hourly rate of pay on average – distribution of male staff across pay quartiles (29% in the highest pay quartile). Female staff are more evenly distributed across quartiles. • Gap has reduced because of movement healthcare support workers from B2 to B3 and increase in pay for specialist nurses (however this had an adverse effect on bonuses). Male staff no longer dominate the top of pay scale for B8A and above roles compared to last year.	Actions carried forward from 21-22 report published March 23: • Equal Opportunities Review – review quantitative and qualitative evidence to assess staff experience and perceptions around equal opportunities across three domains – access to opportunities, recruitment and appointment and development • Identify and consider good practice from across system • Intersectional view – disaggregate data to determine if other protected characteristics impact pay gap
Bonus Pay Gap	Mean Bonus Pay Gap All staff - **£13,478.67 (70.71%)** – [2022 **improved** – last year gap was £5173.34, i.e. 83.65%] Excluding medical - **£149.76 (47.17%)** – [2022 **worsened** - last year gap was in favour of females - £52.47 (-11.78%)] Median Bonus Pay Gap All staff - **£13,922.88 (98.86%)** – [2022 **worsened** – last year gap was £4,996.00 (93.98%)] Excluding medical - **£90.00 (50.00%)** – [2021 **worsened** – last year there was no gap (0 %)]	• Fewer bonus payments made (AfC & medical) • Reclassification of bonuses has meant reduction in bonuses for specialist nurse, mainly affecting AfC female staff • Waiting list initiative payments for medical staff and nurse attract different rates, higher for males • More male consultants (m 158, 64% vs f 90, 36%), thus greater share of the CEA bonus was received by males • Gap reduces when medical staff are removed • What has improved? Part-time female staff receive a full award	• Continue to review local CEA policy and take action where possible.

Any questions?

Report Title	**Fit & Proper Persons Test Policy**				
Meeting	**Trust Board**				
Date	**1 March 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Caroline Coles, Company Secretary				
Appendices	Fit & Proper Persons Test Framework Policy				

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

Substantial	x	**Good**		**Partial**		**Limited**	
Governance and risk management arrangements provide **substantial assurance** that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being **consistently applied** and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide **good levels of assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied** and **implemented but not across all relevant services**. Outcomes are generally achieved but with **inconsistencies** in some areas.		Governance and risk management arrangements provide **reasonable assurance** that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are **generally being applied but insufficient to demonstrate implementation widely across services**. Some evidence that outcomes are being achieved but this is **inconsistent across areas and / or there are identified risks to current performance**.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. **Little or no evidence** is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	

Justification for the above assurance rating. Where 'Partial' or 'Limited' assurance has been indicated above, please indicate steps to achieve 'Good' 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 revised Fit and Proper Persons Test (FPPT) Policy, following changes implemented by the new Framework.

NHSE published a new Fit and Proper Persons Test (FPPT) Framework on 2nd August 2023, which, on top of current requirements, introduces standardised board member reference, and requires FPPT checks to be part of an individual's Electronic Staff Record (ESR). Board will recall adopting this framework formally at its September meeting.

The Trust's current Fit and Proper Persons Test Policy has now been reviewed in light of this framework, and is attached at Appendix 1 for approval. As a result of this new framework the policy has had a total rewrite and therefore there are no changes to highlight.

As part of the AHA corporate governance workstream, to align and share best practice, this policy will be adopted across the three acute trusts.

To note : The publications of the Leadership Competency Framework and the Board Member Appraisal Framework have been delayed. Publication dates are now expected in Q4 2023/2024 (Leadership Competency Framework) and end of Q1 2024/2025 (Member Appraisal Framework) . The first Annual Submission returns for FPPT will now be expected in September 2024 from organisations to Regional Directors.

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	7-Sept-23 : Trust Board noting and adoption of the F&PPTF Jan-24 : Chief People Officer, Deputy Chief People Officer, HR, Head of Resourcing, Recruitment Manager				
Next Steps	Publication				

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 Trust Board is requested to approve the Fit & Proper Person Test Policy.

Accountable Lead Signature	Jude Gray, Chief People Officer
Date	28 February 2024

Trust-wide Policy

Fit and Proper Person Test Policy & Procedure

Policy number:	Do not enter anything in this box
Scope of policy:	This policy applies Board Directors, Board members and equivalents, including any other individuals who are members of the Board, irrespective of their voting rights or if in interim positions.
Ratifying committee:	Trust Board
Date ratified:	XXX
Next review date:	Do not enter anything in this box
Date implemented:	Do not enter anything in this box
Accountable lead job title:	Chief People Officer
Division and/or department:	Corporate
Lead author(s) job title:	Company Secretary
Document summary:	This policy document sets out The Great Western Hospitals NHS Foundation Trust's policy for assuring all Board Directors comply with the Fit and Proper Person Tests Framework. The policy ensures alignment with the arrangements as detailed in the Regulations; NHS Employment Check Standards; Care Quality Commission (CQC) and NHS England's guidelines.
Published by:	Corporate Governance Team, Great Western Hospitals NHS FT
To be read in conjunction with:	Trust Constitution Fraud and Corruption Policy Conflicts of Interest Policy Freedom to Speak Up Raising Concerns Policy Recruitment & Selection Policy Resolution Policy
Review period:	This document will be fully reviewed every 3 years in accordance with the Trust's agreed process for reviewing Trust-wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.

Version control history Please record brief details of the changes made alongside the next version number.	
Version	**Brief summary of changes**
V1	**Total refresh following publication of NHSE Fit & Proper Person Test Framework in August 2023 with full implementation in April 2024**

Table of Contents

1. Introduction

1.1. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 place a duty on all NHS providers not to appoint an individual as a Director, or performing the "functions of, or functions equivalent or similar to the functions of a director", or allow a person to continue in the role, if they do not meet, or cease to meet, the requirements as set out in the Regulations in relation to the Fit and Proper Person Test. A new Fit and Proper Person Test framework was published by NHS England in August 2023.

1.2. Great Western Hospitals NHS FT (the Trust) is required to ensure its Directors (as defined in 2) are 'fit and proper' to undertake the role and make every reasonable effort to assure itself by all available means.

1.3. It is the ultimate responsibility of the Trust Chair to discharge the requirement placed on the Trust to ensure that all relevant post holders (as defined in 2) meet the test.

2. Scope

2.1. This policy applies to Directors and people performing "the functions of or functions equivalent or similar to the functions" of a Director. For the purposes of this policy the positions within the Trust, the following are within the scope of this policy:

- Non-Executive Directors (including the Chair)
- Executive Directors (including the Chief Executive)
- Any other position designated by the Chair or Chief Executive as being a role that performs a function of, or functions equivalent or similar to those, of a Director. For the avoidance of doubt, this would include any Associate Non-Executive Director appointments, interim appointments, and any other individuals who are members of the board, irrespective of their voting rights.

2.2. An individual falls under the requirement of the Regulated Activity Regulations regardless of whether they undertake the role on a permanent or interim basis, if the position is likely to, or does, exceed six weeks.

3. Duties and responsibilities

Role	Responsibilities
Trust Chair	• The Chair is ultimately responsible to discharge the requirement placed upon the Trust to ensure that all directors meet the requirements of the Fit and Proper Persons Test and do not meet any of the 'unfit' criteria. The Chair is also subject to the requirements of the test. The Chair is responsible for taking the necessary action to ensure existing directors who no longer meet the regulations of the FPPR (i.e., are deemed 'unfit') do not continue in their role
Senior Independent Director (SID)	• Annually, the senior independent director (SID) will review and ensure that the Trust Chair is meeting the requirements of the FPPT. • Undertaking any investigations into any concerns raised about the Trust Chair (supported by the Chief People Officer and/or Company Secretary)

Chief Executive Officer (CEO)	• Overseeing the outcome of the FPPT for all the Executive Directors
Chief People Officer (CPO)	• Jointly overseeing the implementation of the FPPT policy • Ensuring any FPPT undertaken on appointment comply with the process detailed in this policy, bringing non-compliance to the attention of the Chair and/or Senior Independent Director [SID] (as appropriate) • Supporting the Chair and/or SID with any investigations • Ensuring that all appropriate documentation is completed, stored and available for inspection upon request
Company Secretary	• Jointly overseeing the implementation of the FPPT • Maintaining the Directors' register of interests including annual updates • Ensuring the annual FPPT declarations are undertaken, recorded and evidenced on ESR and on individual files • Ensuring annual submissions are made to NHSE • Confirming compliance with the policy in the Trust's annual report • Providing advice and support to the Trust Board and Council of Governors in respect of the administration of and compliance with the FPPT • Preparing annual reports for consideration by the appropriate Committee as part of the appraisal process • Identifying any changes to the Regulations or guidance, recommending to the Remuneration Committee and Council of Governors' Nominations & Remunerations Committee the appropriate policy amendments
Remuneration Committee	• Ensuring ongoing compliance on the application of FPPT in relation to Executive Directors (including the Chief Executive (CEO)) via annual performance appraisals.
Nominations & Remunerations Committee	• Ensuring ongoing compliance on the application of FPPT in relation to Non-Executive Directors (NEDs) including the Chair via the annual performance appraisal.
Directors (individuals who fall within the policy)	• Providing consent to the required checks as described in this policy • Signing the declaration that they are a fit and proper person on appointment and on an annual basis • Providing evidence of their qualifications, experience and identity documents on appointment or on request to confirm the competencies relevant to the position • Identifying any issues that may affect their ability to meet the statutory requirements on appointment and bringing any issues on an ongoing basis to the CEO (for Executive Directors) and the Chair (for NEDs). The Chair will raise any issues with the Lead Governor as appropriate
Staff	• Raising any concerns via appropriate Trust policies and procedures, for example through the Freedom to Speak Up – Raising Concerns Policy.
NHS Regional Director	• Oversight role covering elements of:- – appointment and initial Fit & Proper Person Test arrangements – receiving of the annual Fit & Proper Person Test submissions forms – where required, in relation to disputes and appeals.

4. Standards and Practice

4.1. Fit and Proper Person definition

4.1.1. Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulation 2014 sets out the criteria that a director must meet on appointment, and on an ongoing basis:

- be of good character
- have the qualifications, competence, skills and experience necessary for the relevant office or position or the work for which they are employed
- be able, by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed
- not have been responsible for, contributed to of facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity)
- not be 'unfit' by reason of matters set out in paragraph 4.2.2 below.

4.2. The 'Unfit Person test' and considerations relating to 'Good Character'

4.2.1. Schedule 4 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (see Appendix 2) describes the unfit person test (part 1) and matters to be considered relating to 'good character' (part 2). Its purpose is to ensure that the Trust is not managed or controlled by individuals who present an unacceptable risk to the organisation or to patients.

4.2.2. Under Schedule 4, Part 1, a director is deemed unfit if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period applies under a debt relief order, which applies under prat VIIA (debt relief orders) of the Insolvency Act 1986(1);
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children's barred list or the adults' barred list maintained under Section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.2.3. In determining whether an individual is of good character, consideration will be given to Schedule 4, Part 2:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and / or
- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health or social care work professionals.

4.2.4. The document Regulation 5: Fit and proper persons: directors released by the Care Quality Commission in 2018 provides additional guidance to help providers interpret and implement the regulation. This guidance will be taken into account by the Trust in reviewing an individual's compliance with the Fit and Proper Person Test. The document outlines:

- Definitions of misconduct and mismanagement and when proven misconduct or mismanagement should be assessed as 'serious'
- Factors to consider around concerns regarding serious misconduct or mismanagement
- Features that would normally be associated with 'good character' and factors to consider when assessing 'good character'

4.3. New Director Appointments

4.3.1. All appointments will be subject to the individual satisfactorily meeting the Fit and Proper Person Test prior to confirmation of offer of employment/office. An agreed sign-off process with all relevant checks (Appendix 3) will be carried out prior to final checking by the Trust Chair or nominated deputy and conditional offer. This will include completion, by the individual, of a self-attestation (Appendix 4). All offers must be conditional on meeting the statutory requirements.

4.3.2. Where a senior level post or interim is sourced by an agency or executive search company, the agency will be made aware of the Trust's Fit and Proper Person Test process and must confirm that they have undertaken the necessary checks; compliance will be confirmed by the Trust.

4.3.3. Disclosure & Barring Service checks - Where the position and role of the director meets the eligibility criteria, a Disclosure & Barring Service check will be undertaken in accordance with the Trust's Employment Check Policy & Procedure.

4.3.4. Disqualification - A failure or refusal by a candidate for appointment to comply with any of the procedures set out in this policy will immediately disqualify that person from the proposed appointment.

4.3.5. Ineligibility of candidates - If the candidate fails to show that they meet the Fit and Proper Person Test as outlined in 4.1 above, the Trust will withdraw the provisional offer of employment.

4.4. Joint appointments across different NHS organisations

4.4.1. For joint appointments across different NHS organisations, the full Fit and Proper Person Test would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the Chair of the other contracting NHS organisation to ensure that the Board member is fit and proper to perform both roles.

4.4.2. The host/employing NHS organisation will then provide a 'letter of confirmation' to the other contracting NHS organisation to confirm that the Board member in question has met the requirements of the Fit and Proper Person Test.

4.4.3. The Chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the Fit and Proper Person test assessment of the board member.

4.4.4. For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a Chair or Non-Executive Director) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the Fit and Proper Person Test.

4.4.5. If the Fit and Proper Person assessment at one organisation finds an individual not to be a Fit and Proper Person, the Chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not a Fit and Proper Person at the other organisation

4.5. Existing Directors: Annual Review Process

4.5.1. The Trust is responsible for ensuring that relevant individuals continue to meet the Fit and Proper Person Test. This shall be done through an annual review which will be aligned with appraisal dates to ensure that outcomes are available for reference at individual appraisals. Documentation will include:

- Completion of the self-attestation form (Appendix 4) by the individual
- Annual checks against the disqualified directors register, the bankruptcy and insolvency register, the removed charity trustees register and relevant professional registers.

4.5.2. The Chair will review and sign (Appendix 5) to confirm that the annual checks have been completed and that the person continues to meet the Fit and Proper Person Test. Confirmation of compliance will be declared in the Trust's Annual Report.

4.6. Existing Directors: Responsive Review Process

4.6.1. Circumstances may arise where concerns are raised about the Fit and Proper Person status of an individual, either by self-notification, or as a result of concerns raised by a third party. Should this occur then a review should take place outside of the normal testing schedule.

4.7. Existing Directors: Action required via Annual / Responsive Review process

4.7.1. If an individual is deemed competent but does not hold relevant qualifications, there should be a documented explanation, approved by the Chair, as to why the individual in question is deemed fit to be appointed as a Board member, or fit to continue in role if they are an existing Board member. This should be recorded in the annual return to the NHS England Regional Director.

4.7.2. If an individual is deemed unfit (they failed the Fit and Proper Person Test) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to

continue their current employment as a Board member. In such circumstances there should be a documented explanation as to why the Board member is unfit and the mitigations taken, which is approved by the Chair. This should be submitted to the relevant NHS England Regional Director for review, either as part of the annual Fit and Proper Person Test submission for the NHS organisation, or on an ad hoc basis as a case arises.

4.7.3. If an individual is deemed to no longer meet the Fit and Proper Persons Test (either through the annual review process, or via a responsive review), the Chair will be notified and is responsible for making an informed decision regarding the course of action to be followed.

4.8. Dispute Resolution

Data and information

4.8.1 Where a Board member identifies an issue with data held about them in relation to the Fit and Proper Person Test, they should request a review which should be conducted in accordance with local policies in the first instance.

4.8.2 Where this does not lead to a satisfactory resolution for the Board member, the following options are available:

- For NHS England-appointed Board members (NHS Trust Chairs and Non-Executive Directors and Integrated Care Board Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For Chairs not appointed by NHS England – a further request for review can be made to the Senior Independent Director or Deputy Chair who would establish a process proportionate to the matter being considered; for example, establishing a panel with at least one independent member.
- For all other Board members (including NHS England-appointed Board members, and Chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
    - referring the matter to the Information Commissioner's Office
    - taking the matter to an employment tribunal (for executive director roles only)
    - instigating civil proceedings.

Outcome of Fit and Proper Person Test assessment

4.8.3 Where a Board member disagrees with the outcome of the Fit and Proper Person Test assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed Board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
    - Where this results in a Board member being terminated from their appointed role, a Board Member Reference must be completed and retained by the local organisation in accordance with the Framework.

- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
    - NHS organisations may wish to take their own legal advice or seek advice from NHS England.

4.8.4 At any point, employees have the right to take the matter to an Employment Tribunal.

4.9 Personal Data

4.9.1 Personal data for Board members relating to the Fit and Proper Person Test assessment will be retained in local record systems and on the NHS Electronic Staff Record.

4.9.2 Fit and Proper Person Test outcomes must be entered onto Electronic Staff Record so that an Electronic Staff Record Fit and Proper Person Test Dashboard can reviewed by the Chair. Once satisfied, the Chair must update and sign off each Board member on Electronic Staff Record.

4.9.3 An annual submission form (Appendix 6) will be generated for Chair sign off and submitted to the NHS England Regional Director, where the NHS England Fit and Proper Person test central team will collate records from NHSE regions.

4.10 Board Member Reference Request

4.10.1 NHS organisations will need to request Board member references (Appendix 7), and store information relating to these references so that it is available for future checks; and use it to support the full Fit and Proper Person test assessment on initial appointment.

4.10.2 NHS organisations should maintain complete and accurate Board member references at the point where the Board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and Board member references should be retained locally on Electronic Staff Record.

4.10.3 Board member references will apply as part of the Fit and Proper Person test assessment when there are new Board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

- New appointments that have been promoted within an NHS organisation.
- Existing Board members at one NHS organisation who move to another NHS organisation in the role of a board member.
- Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.
- Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

5. Breaches of the Regulation

5.1 The regulation is breached if the Trust has in place someone who does not satisfy the FPPT. Evidence of this could be if:

- A Director is unfit on a 'mandatory' ground, such as a relevant un-discharged conviction or bankruptcy.
- The Trust does not have a proper process in place to enable it to make the robust assessments required by the FPPT.
- On receipt of information about a Director's fitness, a decision is reached on the fitness of the Director that is not in the range of decisions that a reasonable person would make.
- A Director has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere, which if provided in England, would be a regulated activity.

5.2 An offence contrary to the Fraud Act 2006 may be committed if an employee provides false documentation, references, or experience in relation to pre-employment checks. Any such suspected conduct will be investigated in accordance with the Trust's Resolution Policy and will also be referred to the Local Counter Fraud Specialist, potentially resulting in a full investigation, appropriate disciplinary action and/or prosecution. Where it is found non-compliance constitutes a criminal offence, it will be subject to a criminal investigation and sanction as appropriate.

If fraud is suspected in relation to this policy, please report to the Trust's Local Counter Fraud Specialist as follows:-

The Local Counter Fraud Specialist – 07392861672
Email: Isabel.Turner@kpmg.co.uk

or by calling the NHS Counter Fraud Authority (NHSCFA) FREE 24 hour confidential fraud reporting hotline on 0800 028 4060 or report via the online reporting form: https://cfa.nhs.uk/report-fraud. Please refer to the Trust's Fraud and Corruption Policy for further details.

6. Training requirements

6.1 This policy will be provided to each individual in scope electronically or on appointment whichever is applicable.

6.2 A notification of any policy revisions will be provided via the Trust intranet to promote awareness of the policy.

6.3 This policy will be regularly monitored and reviewed and will be assessed annually with the I ntention of improving its effectiveness.

7. Consultation

Below is a list of consultees who supported the formulating of this document.

Job title and department
Chief People Officer
Deputy Chief People Officer

Head of Recruitment
Recruitment Manager

8. Monitoring Compliance

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Fit and Proper Persons tests undertaken for newly appointed Directors	Chief People Officer	Audit of personal files to ensure the pre-employment checks (including FPPT) have been undertaken for all new Director appointees.	On appointment	Trust Chair / Chief Executive
Annual Fit and Proper Persons test declarations completed by existing Directors.	Company Secretary	Audit of personal files to ensure the annual fit and proper persons declarations have been completed by existing Directors.	Annually	Trust Chair / Chief Executive

9. Document Review

9.1 The policy will be reviewed after three years or earlier in view of developments which may include legislative changes, national policy instruction or Trust Board decision.

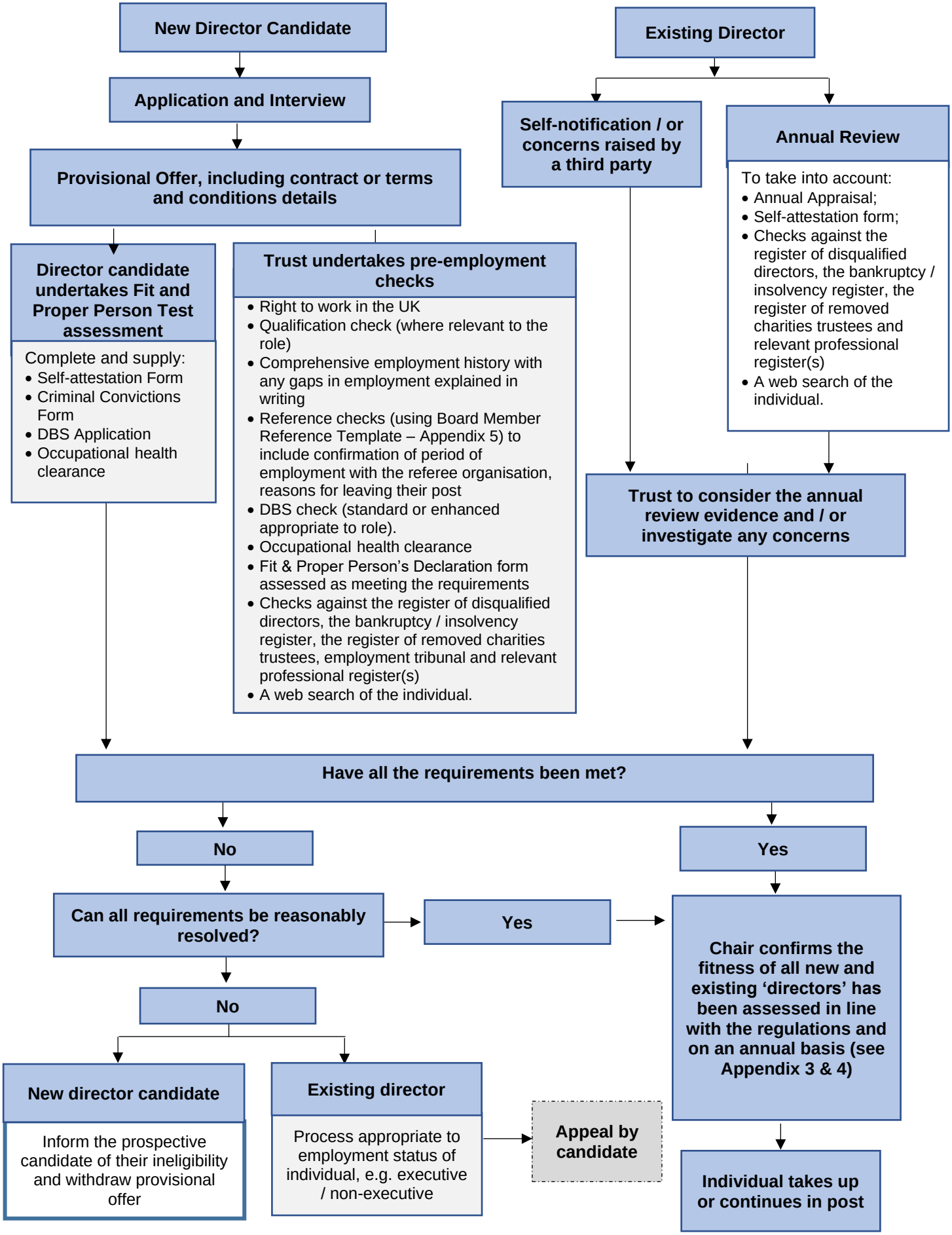
10. Associated trust documents and supporting references

- Equality Act 2010
- Safeguarding Vulnerable Groups Act 2008
- Care Quality Commission – Regulation 5: Fit and proper persons: directors (2018)
- The Health and Social Care Act (Regulated Activities) Regulations 2014
- NHS Employers Employment Check standards
- Insolvency Act 1986
- Police Act 1997
- Fit and Proper Persons Regulations in the NHS – What do providers need to know? (NHS Providers).
- NHS England Fit and Proper Person Test Framework for board members (August 2023).
- Conduct Management Policy
- Recruitment and Selection Policy
- Fraud & Corruption Policy
- Freedom to Speak Up Raising Concerns Policy
- Appraisal Policy

11. Definitions and Glossary

Term	Definition
Care Quality Commission (CQC)	The regulator for health and social care services in England
Director	For the purposes of this policy, Directors are the group of people constituted (formally or informally) as the decision-making body of the organisation. This includes interim positions as well as permanent appointments.
Fit and proper person test for directors	Aims to ensure that registered providers have individuals who are fit and proper to carry out the important role of director to make sure that providers meet the existing requirements of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014
Misconduct	Conduct that breaches a legal or contractual obligation imposed on the director.
Mismanagement	Being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management.

Appendix 1: Fit and Proper Person Test Process



Appendix 2: Regulation 5 – Schedule 3: Information required in respect of persons employed or appointed for the purposes of a regulated activity

1. Proof of identity including a recent photograph.

2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(**1**), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(**2**).

3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

4. Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to—
(a) health or social care, or
(b) children or vulnerable adults.

5. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.

6. In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

7. A full employment history, together with a satisfactory written explanation of any gaps in employment.

8. Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.

9. For the purposes of this Schedule—
(a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;
(b) "satisfactory" means satisfactory in the opinion of the Commission;
(c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

Appendix 3: Fit and Proper Person Test checklist

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate Electronic Staff Record. For NHS-to-NHS moves via Electronic Staff Record / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, e.g. clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (e.g. professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For Non-Executive Directors, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). Electronic Staff Record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to Fit and Proper Person Test. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Type of Disclosure and Barring Service disclosed	✓	✓	✓	✓	✓	✓	Electronic Staff Record and DBS response.	Frequency and level of Disclosure and Barring Service in accordance with local policy for board members. Check annually whether the Disclosure and Barring Service needs to be reapplied for. Maintain a confidential local file note on any matters applicable to Fit and Proper Person Test where a finding from the Disclosure and Barring Service needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date Disclosure and Barring Service received	✓	✓	✓	✓	✓	✓	Electronic Staff Record	
Date of medical clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (eg membership of professional bodies)	✓	x	✓	✓	✓	x	E.g. NMC, GMC, accountancy bodies.	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	
Sign-off by Chair/Chief Executive	✓	x	✓	✓	✓	✓	Electronic Staff Record	Includes free text to conclude in Electronic Staff Record fit and proper or not. Any mitigations should be evidence locally.
Other templates to be completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for Fit and Proper Person Test
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Appendix 4 - Fit and Proper Person Test annual / new starter self-attestation

GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

- I declare that I am a fit and proper person to carry out my role. I:

  am of good character

  have the qualifications, competence, skills and experience which are necessary for me to carry out my duties

  where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals

  am capable by reason of health of properly performing tasks which are intrinsic to the position

  am not prohibited from holding office (eg directors disqualification order)

  within the last five years:

  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.

  have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

- The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.
- Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix 5: Fit and Proper Persons Requirement – Annual Checklist for existing Directors

Name	
Position	

Item	Checked by (Initials)	Any relevant information to note
Fit and Proper Persons Requirement self-declaration signed and returned (appendix 4)		
Disqualified Directors Check		*(date to be noted)*
Bankruptcy & insolvency check		*(date to be noted)*
Removed Charity Trustees check		*(date to be noted)*
Financial Conduct Authority *where individual has worked for an organisation regulated by the Financial Conduct Authority (FCA)*		*(date to be noted)*
Employees Tribunal		*(date to be noted)*
Where appropriate, relevant professional registers		
Web search results		

I confirm that the above checks have been undertaken and I am satisfied the individual named above is assessed to be a "fit and proper person" to continue in their appointed role.

Trust Chair	**Name**	**Signature**	**Date**

Appendix 6 - Annual NHS Fit and Proper Person Test submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: Fit and Proper Person Test outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: Fit and Proper Person Test reviews / inspections

Use this section to record any reviews or inspections of the Fit and Proper Person Test process, including Care Quality Commission, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Care Quality Commission				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [NAME OF TRUST] [YEAR]				
For the Senior Independent Director/Deputy Chair to complete:				
Fit and Proper Person Test for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the Fit and Proper Person Test being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the Fit and Proper Person Test submission is complete, and the conclusion drawn is based on testing as detailed in the Fit and Proper Person Test framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 7 - Board Member Reference

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.	
1. Name of the applicant (1)	
2. National Insurance number or date of birth	
3. Please confirm employment start and termination dates in each previous role *A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)* *B: (As part of exit reference and all relevant information held in Electronic Staff Record under Employment History to be entered)*	
Job Title: From: To: Job Title From: To: Job Title: From: To: Job Title: From: To: Job Title: From: To:	
4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*	

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date Disclosure and Barring Service check was last completed.	Date	
Please indicate the level of Disclosure and Barring Service check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying**	Yes □	No □

• **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the Care Quality Commission definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Equality Impact Assessment Form

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? **Fit & Proper Person Test Framework Policy & Procedure**		
2.	Briefly describe the aim of the policy, strategy, project. What needs or duty is it designed to meet? **Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations ((Ref 6)**		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?	**No**	
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?	**No**	
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?	**No**	

Signed by the manager undertaking the assessment	**Caroline Coles**
Date completed	**26 January 2024**
Job Title	**Company Secretary**