TRUST BOARD

Thursday 5 December 2024, 9.30am to 12.45pm

By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Liam Coleman, Cara Charles-Barks, Claire Lehman	Verbal	FC	-	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	FC	-	-
3.	**Minutes of the previous meeting (public)** Faried Chopdat, Deputy Chair • 7 November 2024 (draft)	6 – 17	FC	Approve	-
4.	**Outstanding actions of the Board (public)**	18	FC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Staff Story – Learning from staff representing GWH at an employment tribunal** Angela Morris, Senior People Partner; Kathryn Owen, Matron; and Kevin Jenner, Deputy Divisional Director of Nursing	19 – 27	AM/KO/ KJ	Receive	9.35
7.	**Chair's Report** Faried Chopdat, Deputy Chair	28 – 30	FC	Note	10.05
8.	**Chief Executive's Report** Jon Westbrook, Interim Managing Director	31 – 43	JW	Note	10.15
9.	**Integrated Performance Report** • Integrated Performance Report – Breakthrough Objective and Pillar Metric deep dive	44 – 94	FC/ Executive Directors	Assurance	10.35
BREAK (10 minutes) at 11.30 to 11.40am					
	• Performance, Population & Place Committee Board Assurance Report (November) – Bernie Morley, Non-Executive Director & Committee Chair	95 – 96	BM	Assurance	11.40

		PAGES	BY	ACTION	TIME
	• Quality & Safety Committee Board Assurance Report (November) – Claudia Paoloni, Non-Executive Director & Deputy Committee Chair	97 – 100	CP	Assurance	-
	• Finance, Infrastructure & Digital Committee Board Assurance Report (November) – Faried Chopdat, Non-Executive Director & Committee Chair	101 – 102	FC	Assurance	-
10.	**Charitable Funds Committee Board Assurance Report (November)** Julian Duxfield, Non-Executive Director & Committee Chair	103 – 104	JD	Assurance	11.55
11.	**Audit, Risk & Assurance Committee Board Assurance Report (November)** Helen Spice, Non-Executive Director & Committee Chair	105 – 106	HS	Assurance	12.05
12.	**Safe Staffing 6-month Report for Nursing, Midwifery & AHP** Luisa Goddard, Chief Nurse *(received by Quality & Safety Committee 21 November 2024)*	107 – 136	LG	Note	12.15
13.	**Directors Code of Conduct 2024-2027** Caroline Coles, Company Secretary	137 – 142	CC	Approve	12.30
14.	**Committee Effectiveness Review 2023/24 – Trust Management Committee** Caroline Coles, Company Secretary	143 – 152	CC	Approve	12.35
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
15.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	-	CC	Approve	12.40
16.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	FC	-	-
17.	**Date and Time of next meeting** Thursday 9 January 2025 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	FC	Note	-
18.	**Exclusion of the Public and Press** The Board is asked to resolve:- *“that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest”*	-	-	-	12.45

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ AND VIA MS TEAMS 7 NOVEMBER 2024 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Jon Burwell (JB)	Acting Chief Digital Officer
Cara Charles-Barks (CCB)	Chief Executive
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Julian Duxfield (JD)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Bernie Morley (BM)	Non-Executive Director
Rob Presland (RP)	Acting Chief Operating Officer
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Interim Managing Director

In attendance:

Caroline Coles (CC)	Company Secretary
Deborah Rawlings (DR)	Board Secretary
Tim Edmonds (TE)*	Associate Director of Communications & Engagement
Rachel Taylor	Falls Specialist Nurse (agenda item 138/24)
Juliette Sherrington	Associate Director of AHP (agenda item 138/24)
Lisa Marshall	Director of Midwifery & Neonatal Services (agenda item 144/24)
Kat Simpson	Head of Midwifery & Neonatal Services (agenda item 144/24)
Helen Winter	Associate Director of Nursing – Insights and Learning (agenda item 145/24)

Apologies

Claire Lehman (CL)	Associate Non-Executive Director
Claudia Paoloni (CP)	Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director

Number of members of the Public: There were 5 members of public in attendance (Chris Shepherd, Governor; Pauline Cooke, Governor; Natalie Wong, CQC; Jessica Hughes, CQC; John Dixon, Healthcare Business Solutions UK)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

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133/24	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above. Liam Coleman, Chair welcomed Cara Charles-Barks, newly appointed joint Chief Executive for Great Western Hospitals Foundation Trust (GWH); Royal United Hospitals Bath NHS Foundation Trust (RUH) and Salisbury NHS Foundation Trust (SFT) and Rob Presland, Acting Chief Operating Officer to the Board meeting. Cara Charles-Barks provided an	

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	overview of the future vision and strategic objectives for the Group Model and local health populations.	
134/24	**Declarations of Interest** There were no declarations of interest.	
135/24	**Minutes of the previous meeting (public)** The minutes of the Board meeting held in public on 5 September 2024 were adopted and agreed as a correct record, subject to the following amendment: Minute No. 111/24 – Chief Executive's Report – Industrial Action Deletion of the word "Junior" and replaced with "Resident".	
136/24	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list.	
137/24	**Questions from the public to the Board relating to the work of the Trust** There were no questions from the public to the Board.	
138/24	**Patient Story (Care Reflection) – Negative impact of deconditioning on frail patients** *Rachel Taylor, Falls Specialist Nurse and Juliette Sherrington, Associate Director of AHP joined the meeting to present this item.* The Board received a presentation on the negative impact that deconditioning could have on frail patients and the importance of early and continued mobilisation opportunities for patients to return to their baseline functional ability. Positives had been identified from a patient's experience shared with the Board, but areas had also been identified where care could be further improved and the need to raise awareness and knowledge with our staff. Rachel and Juliette provided further detail about the ongoing improvement work, training and baseline audits and how the experience was to be shared within the organisation for learning. The actions were also supported by Lisa Cheek, Chief Nurse and that improvement work metrics being introduced could already demonstrate improvements in falls prevention. It was noted that the video would also be used as part of staff training connected to the Trust's falls prevention and 'Get Up, Get Dressed, Get Moving' campaign. The National Audit of Inpatient Falls dataset starting in January 2025 also required that every patient should have a multifactorial assessment for safe activity rather than for prevention and would be supported by this campaign. A bedside mobility assessment tool was also being introduced to support nursing staff confidence around mobility decisions. Work was also underway within the system in relation to vulnerable elderly patients within the community who were admitted with a primary diagnosis of a fall, together with the need to ensure that patients who were already in hospital were not deconditioning. Assurance was provided to the Board around the fractured neck of femur pathway and that data was being captured using the patient safety incident response framework (PSIRF) methodology to enable learning and themes to be identified to inform improvement plan workstreams. Oversight would be maintained through the Quality & Safety Committee. The Board also reflected on how the EPR implementation would help to align and monitor standardisation of pathways to provide good data across all areas, and to also provide benchmarking data with system partners. Lisa Cheek, Chief Nurse provided further assurance to the Board around the oversight and management of complex patients with multi-disciplinary input to broaden the confidence	

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	and capability amongst all parts of the caring team to provide the best possible patient experience. The Board was also asked to consider the risk appetite around the ongoing funding for staff training and support for these workstreams in the next financial year and how this could now be delivered in-house.	

The Board acknowledged and thanked the team and recognised that patient stories can include both positive and negative experiences, and are a valuable tool for improving healthcare services and a way to capture the patient voice and identify areas for improvement.

The Board **noted** the patient story.

139/24 **Chair's Report**

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

- The results of the Governor elections (uncontested) in relation to the seats for Wiltshire Northern (public), Wiltshire Central (public), West Berkshire & Oxfordshire (public) and Allied Health Professionals (staff).
- The Board acknowledged that Pauline Cooke would be stepping down from her Governor role representing Northern Wiltshire at the end of November 2024. Pauline was thanked for her time and commitment to the Trust over the past nine years.
- The strategic risk mapping exercise paper which had been appended to the report which summarised the strategic risks in terms of percentage of items on the board agenda over a 12-month period. The paper demonstrated that there was a fairly equal distribution for each strategic risk theme and that quality was the highest in all except one across the period.

Liam Coleman, Chair also reflected on this recent visit to the Aseptic Unit prior to its official opening mid-December 2024 and was impressed by the involvement of the Pharmacy Team in its design and planning.

It was noted that the Board Safety Visit on 30 October 2024 was to Day Surgery/Daisy and not Pharmacy as stated in the report.

The Board **noted** the report.

140/24 **Managing Director's Report**

The Board received and considered the Managing Director's Report, and the following was highlighted:

Critical Incident at Great Western Hospital

A critical incident was declared at the Great Western Hospital on 1 November 2024 due to operational pressures on the front door and long ambulance handover waits. Considerable work was undertaken to respond to the critical incident which resulted operations being stepped down to business continuity by the following Monday. Preliminary investigation work had been undertaken to understand the triggers and the ability to respond and manage surges in attendances, which included further improvements for Hospital at Home. Further work was also needed to improve system support and develop dynamic conveyancing by the ambulance service in response to pressures.

It was noted that there had also been additional impact from the number of patients who had presented with mental health issues over that period and the complex nature of the need to treat those patients within the resources and space available, together with the

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need to increase the mental health assessment by external providers to enable discharge or to access the right facilities. The Mental Health Governance Committee would review the mental health assessment service provision by external providers.

Cara Charles-Barks, Chief Executive added that each of the Managing Directors had been asked to take a leadership role across the group around urgent care and elective care perspective and dynamic conveyancing, together with broader opportunities around mental health services provision.

Integrated Front Door
The new Emergency Department had opened on 18 September 2024 and would ensure unplanned healthcare provision was fit for the increasing demand and growing population of the town and surrounding areas.

Children's Emergency Unit
The building work for the new Children's Emergency Unit (CEU) was completed at the end of September and would provide capacity for the integration of the CEU with the Paediatric Assessment Unit. The unit became operational to receive its first patients on 6 November 2024.

Improving care for our surgical and medical patients
In November a series of bed moves and reconfiguration of spaces would take place around the hospital to help consolidate the care of medical outlying patients onto a dedicated ward to improve their care, in turn to also reduce length of stay and the number of times a patient would be moved during their stay.

Reducing noise at night
In response to recent feedback from the inpatient survey which highlighted key issues in relation to disruption and noise at night, a new project was underway at the hospital to address those concerns by focusing on improving the nighttime environment through better planning and heightened awareness of basic care principles.

Health Innovation West of England award
The outpatient hypertension pathway for those at high risk of developing hypertension in pregnancy had been selected from 20 applications by Health Innovation West of England to be rolled out across the West.

New heart monitoring technology
The Cardiac Physiology team recently completed the first ever implant of a new heart monitoring technology in the UK, using the Biomonitor IV cloud-based artificial intelligence technology to reduce the impact of ongoing remote monitoring for patients and to help clinicians achieve timely and accurate diagnosis.

Anaesthesia Clinical Services Accreditation
The Anaesthetic Department had been awarded the Anaesthesia Clinical Services Accreditation in recognition of the significant service improvements implemented to enhance safety, streamline processes, and better outcomes for patients.

10-year plan
The Department of Health and Social Care and NHS England had launched a programme of engagement on a new 10-year plan which would be published in Spring 2025. The plan would be co-developed with the public, staff and patients through an engagement exercise and the involvement was being encouraged.

In response to a question asked by Faried Chopdat, Non-Executive Director and the resources required to review the output from the 10-year plan, together with the alignment with this Trust's strategy and optimisation planning with both Salisbury NHS Foundation

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Trust and Bath Royal United Hospitals NHS Foundation Trust, Claire Thompson, Chief Officer of Improvement & Partnerships replied that the broad consensus was around the requirement for trusts to left shift and redesign models of care to have a more flexible and multi-skilled workforce and that there would be increased focus on delivery. In relation to strategies to be aligned across all three trusts in the Group Model would require board engagement and discussion to align vision for both population and staff.

Cara Charles-Barks, Chief Executive also outlined the key recommendations from the Darzi Report to address public confidence levels around improved performance for local health population needs, together with leadership management programmes to improve management capability. Improving Together methodology would create commonality and continuous improvement and sharing of best practice. There would also be further opportunity around how to work with the integrated care system as a group which would reduce duplication to create a strong ambition for BSW.

Outcome of procurement of community services
Meetings continue with community staff following the ICB's decision to award the single contract for community services across BSW to HCRG Care Group from April 2025. Focus was now on the support of staff through this significant change and to ensure that the ability to deliver integrated services to the community was not impacted.

Financial situation
The year-to-date deficit was at £7.6m, which was £2.9m worse than plan, although this was an improvement on last month's position. Savings continued to be identified to deliver financial benefits, together with work to better understand pay costs within the system and opportunities for savings around procurement.

Senior appointments
James Curtis had been appointed as Divisional Director for the Surgery, Women's & Children's Division.

Staff survey
Good progress continued to be made on completion of the staff survey and that this data would provide important and rich information as an organisation to learn how to better support its staff.

Sustainability award
The Trust's sustainability team were recently highly commended at the BBC Wiltshire Make a Difference Awards and recognition received for the reduction of our carbon footprint across all Trust sites. The Emergency Department had also been recognised as the first ED in the country to achieve sustainability accreditation.

EDI Champions
The graduation of the first cohort of EDI Champions was recently celebrated, who would work right across the Trust to advocate for equality, diversity and inclusion.

A GWH EDI Conference Allyship for Unlocking Inclusive Leadership was held on 5 November 2024 at which stimulating talks and challenging discussion had taken place. The conference reflected good representation across the organisation to address issues for our workforce and patients.

Story in Swindon Advertiser
An outline of a recent story published in the Swindon Advertiser was noted around supporting patients with carers in the hospital. The story published was inaccurate and the issue was more about companies not providing continuity of care for patients whilst an inpatient in hospitals. The Swindon Advertiser had since updated the story.

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	The Board **noted** the report.	

141/23 **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 September 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 meetings on 25 September 2024 and 30 October 2024 and the following was highlighted:

- Cancer diagnosis performance reported similar data for both September and October and remained better than the national average. Additional funding from the Thames Valley Cancer Alliance and the South West would continue to support additional improvements.
- Diagnostics performance remained strong and it was reported that the Trust had now exited regional tiering for cancer. The Board acknowledged the considerable work undertaken to drive this improvement.
- Ambulance handovers performance remained subject to fluctuation and there had been four patient safety incidents. Combined 4-hour performance and mean length of stay remained good despite an increase in attendances.
- Referral to Treatment (RTT) figures continued to reduce, however challenges remained to meet targets for the end of December for 65 weeks and end of March for 52 weeks and that focused work around flow was underway to help achieve these targets.
- The HCRG community contract was discussed and the importance of reassuring staff as far as possible. It was also agreed that the governance around the sub-contract reporting would be received by PPPC in future.
- An NHSE letter regarding urgent and emergency care in which patient safety visits are referenced had been reviewed and it was considered that this required further discussion by the Non-Executive Directors on how this would be enacted at future visits in response to the letter. Lisa Cheek, Chief Nurse agreed to review the recommendations in the NHSE letter to gain further clarification around the level of assurance and oversight by NEDs mapping out the approach to hear the voice of patients across the Trust as this is not done solely through Board safety visits.
- Mortality data was to be further reviewed to gain rich information on local health population to inform actions on how to drive improvements.

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 meetings on 19 September 2024 and 24 October 2024 and the following was highlighted:

- Acute and community acquired pressure harms continued to show a reduction in reported data and this achievement was acknowledged by the Board.
- Whilst local *Clostridium difficile* infection rates were below the national trajectory, it was noted that other gram-negative infections rates were outlying. Assurance was provided to the Board that Improving Together methodology would continue to drive improvement in *Klebsiella* and *E.coli* infection rates. An action plan from the recent

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external audit into urinary catheter care had started to deliver a reduction in the number of reported infection rates and that this would continue to be monitored. Work undertaken by the Estates and IPC Teams had delivered a positive impact on Pseudomonas rates.

- Further assurance was provided on the required QIS staffing level targets in the Maternity Unit that oversight and robust processes were in place to ensure safe staffing levels were maintained and that an internal training development programme was underway for newly recruited staff whilst QIS standard was being attained.
- The benchmark to complete EDS within 24 hours of discharge stood at 80%, however the overall compliance still remained at 74% with episodes of non completion. The financial option of providing additional shifts to complete EDS was not a viable option for investment versus output. Assurance was provided that the new EDS production platform was on track to go live at the beginning of December 2024 which would improve the EDS completion trajectory.

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 meetings on 23 September 2024 and 28 October 2024 and the following was highlighted:

- The Letter of Indemnity for the installation of the 5th Generator was reviewed and approved. Due to the significance of the decision, the authority for finalising the Letter of Indemnity would be delegated jointly to the Chief Financial Officer with referral to the Chair of FIDC at the time of signature.
- There had been a review of the Trust's actions to mitigate the risk of not completing all the work prior to the expiry of the PFI contract, specifically with the lack of funding available for the ward decant project. The Trust's progression with completion of tasks related to lifecycle work benchmarked against other trusts.
- The Trust's financial position and the broader BSW system remained a challenge in 2024/25 and the delivery of the £30m deficit plan was at risk. However, assurance was gained that regular meetings were being held at system level to address this and that robust management actions and controls were in place at GWH.
- The Trust reported strong performance for the Data Security and Protection Toolkit (DSPT) with solid evidence provided. Cyber security remained a crucial priority for the Trust, with investment in various controls and risk mitigations. Further assurance would continue to be sought on the delivery to improve overall risk management controls around incident management response.
- The Trust's 2023/24 PAM assessment was noted and attached to share with the Board for information.

The Board received an outline of the work being undertaken by the Regional Finance Team looking at all three organisations to identify savings within existing programmes to improve the collective deficit position. It was noted that the three Chief Financial Officers, Chairs of Finance and Audit Committees would be meeting regularly to develop an Improving Together framework with identified breakthrough objectives to address the financial issues. The Regional representative had also attended GWH financial recovery meetings to provide further assurance on the actions being taken internally.

Simon Wade, Chief Financial Officer also provided an update on the productivity data and reported that the BSW was the highest in the region for ERF performance in the current year. National validation was awaited which may result in a higher position. Simon Wade

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outlined the main drivers for the productivity improvement; however it was acknowledged that the planned reduction in whole-time equivalent numbers had still not been achieved.

Simon Wade, Chief Financial Officer also reported that the GWH Finance Team had won the HFMA South West Team of the Year and that Johanna Bogle, Deputy Chief Financial Officer had also been awarded Deputy of the year.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received a verbal update due to timing of the meeting on the discussions held at the People & Culture Committee (PCC) at its meeting on 29 October 2024 and the following was highlighted:

- The substantial assurance level agreed for the progress on the 'people promise' work reflected the clearly identified priorities and progress against the agreed initiatives. Validation on the work delivered to date had been received following an external visit by NHSE.
- There had been good work demonstrated across the Medicine Division to focus improvement actions following the last staff survey and there had been some improvements against areas identified in recent pulse surveys.
- Substantial assurance had been received from a report on the Trust's undergraduate medical education and had recognised the scale and quality of the work in the area.
- AHP turnover continued to reduce as a result of initiatives to address retention, career development and long-term recruitment for this group.

The Board **noted** the report.

142/24 **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 12 September 2024 and highlighted the following:

- An update on the risks for the Surgery, Women's & Children's Division had been received which provided good assurance on processes to manage risk and actions to mitigate risks. The Division had achieved a significant reduction in their longstanding risks and there were no overdue reviews or risks with no actions. There was an ongoing challenge to reduce the risk in theatres due to the requirement for capital investment.
- The Cyber Security Annual Report had been reviewed, along with the outstanding actions related to that report. ARAC would continue to gain assurance that all the appropriate processes and controls were in place and appropriately managed across the Board committees.

Cara Charles-Barks, Chief Executive reflected on the alignment around internal audit programmes to gain a view across all three organisations around specific issues to then create an opportunity for shared learning and shared best practice. Helen Spice, Non-Executive Director welcomed benchmarking feedback that had already been received through internal audits, noting that some areas would remain specific to a particular trust.

The Board **noted** the report.

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143/24 **Learning from Deaths Report**

The Board received and considered the quarterly report on Learning from Deaths for the Trust.

Steve Haig, Acting Chief Medical Officer reported that that the SHMI and HSMR data for the period April 2023 to March 2024 had both remained within the expected range. Both pneumonia and septicaemia indicators continued to be higher than expected and that additional assurance was to be sought from an ongoing coding workstream within SHMI. The ratio for HSMR was expected to rise with imminent changes to Telstra Health methodology and the introduction of their "HSMR+" platform.

It was noted that structured judgement review (SJR) completion remained low and this had been impacted by the increased number of reviews to be completed and also the complex and time-consuming data collection required for completion. Work was underway to develop a plan to support Divisions with the completion of SJRs and a structured mortality review programme was to receive oversight and monitoring by the Trust Mortality Group.

An overview of the specific issues for this Trust related to Pneumonia and Aspiration Pneumonia (identified via SHMI), Hip Fracture Review, and Inpatient Falls Review and a forward action plan for each issue was outlined and would continue to be monitored by the Trust-wide Learning From Deaths Group.

Steve Haig, Acting Chief Medical Officer added that additional roles within each specialty were being explored to include SJR completion within job plans.

The Board welcomed the increased engagement with completion of SJRs across the Trust and that learning opportunities had been identified and shared, but that this would remain an area for monitoring by the Board to seek assurance on further improvements.

The Board **noted** the report.

144/24 **Perinatal Services 6 month summary**

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

The Board received and considered the six-month update on perinatal services which provided a comprehensive overview of progress mapped against key priorities, including CQC Must Do and Should Do actions, the Three-Year Plan for Maternity and Neonatal Services, and the recommendations from the Ockenden Report. The review also demonstrated the commitment to strengthen perinatal care through improved staffing, addressing health inequalities, and fostering a positive culture within the Trust's workforce.

An overview of the key highlights from the presentation was received which related to:

- Workforce and training and improved staffing, with significant progress made to address staffing gaps and support team resilience.
- Preceptorship programme supported by NHSE funding to positively impact retention of both staff locally and to the profession.
- The continued Trust roll-out of Patient Safety Incident Review Framework (PSIRF) and Patient Safety Incident Review Plan (PSIRP) to align perinatal response to patient safety incidents with national guidance.
- Early family engagement following patient safety incidents.
- Progress of BadgerNET implementation in line with the Digital Roadmap for the service. The 'Good Things Foundation' data hub to ensure that all women could access maternity care for 12 months.

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- The development by GWH of an outpatient hypertension pathway for women and birthing people at high risk of developing hypertension in pregnancy which had been selected to be rolled out across the South West.
- The Maternity Triage had been relocated to a standalone dedicated area of service with a separate staffing model and this had resulted in a significant and sustained improvement for women. Long term workforce and business planning options had been appraised to develop robust models of care to further develop the single point of access for service users.
- Reducing health inequalities with focused initiatives in place to address health disparities, with particular attention to digital poverty to ensure equitable access to services through targeted community engagement and partnerships.
- Engagement with the NHSE Perinatal Culture and Leadership Programme to build a positive and cohesive workplace culture. Through structured engagement and feedback mechanisms, leadership behaviours were being developed to promote accountability, collaboration, and patient-centred care across perinatal services.
- Progress mapped directly against established CQC actions to ensure that Must Do and Should Do recommendations were systematically prioritised. Compliance with the Ockenden immediate and essential actions remained a key priority, especially in areas such as patient safety, family engagement, and transparent communication. Further assurance was provided on ongoing improvement actions to move to full compliance.

The Board was reminded that the Quality & Safety Committee had oversight and scrutiny of a full range of metrics for maternity and neonatal services through a monthly performance report, together with a quarterly quality and safety report.

It was noted that a detailed review of ethnicity representation in reported incidents within maternity and neonatal services at GWH had been undertaken; the outcome of which had demonstrated that service user complaints during this period had indicated a significant under-representation of people of non-white ethnicity. Assurance was provided that findings were to be further investigated, particularly into areas such as postpartum haemorrhage and serious investigations where there had been some over-representation.

The Board **noted** the report.

145/24 **Freedom To Speak Up Annual Report 2024**

Helen Winter, Associate Director of Nursing – Insights and Learning joined the meeting to present this item.

The Board received and considered a report which provided an overview of the work of the Freedom To Speak Up (FTSU) Guardians, updates from the National Guardian Office and the FTSU service activity in 2023/24. The report also covered trends and themes that would be used to guide future developments and actions.

Helen Winter reported that the speaking up culture continued to be developed through key workstreams and the actions that were in progress to raise the profile of FTSU and improve the service were outlined. This included work undertaken to raise the profile of Guardians to ensure there was protected time within their roles at the Trust and this action had also helped to improve retention. It was noted that the role of the Lead Guardian was also to be enhanced to help make the service more sustainable and this role was currently out to advert.

The next steps for the FTSU Lead Guardian were noted which would continue to work towards delivering the actions identified and recorded in the action plan and identified actions would be mapped through the completion of the reflection and planning tool. This tool would support the Executive Director and Non-Executive Director aligned to FTSU to

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understand Trust compliance with national requirements and to guide the actions for the year ahead.

Jude Gray, Chief People Officer added that the FTSU service was a key part of a much broader question about the Trust's speaking up culture in general and that the Board had committed to the commissioning of an external review to drive further improvement. The Board was to receive a future update which would outline four key actions for focus.

In response to question from Faried Chopdat, Non-Executive Director around benchmarking against other trusts, Helen Winter acknowledged that numbers for this Trust appeared low which could be attributed to the available capacity by FTSU Guardians who had undertaken the role voluntarily alongside their own roles, but provided assurance that improvement was anticipated with the appointment of a new Lead Guardian in the near future. The Board acknowledged the work undertaken by Chris Mattock, who was due to retire from the role in January 2025.

The Board was also informed of the actions that were being taken to signpost psychological safety for those staff who wished to raise a concern. However, it was acknowledged that there was a number of under-represented people with prior experience of raising a concern and that actions were underway to provide assurance of a safe place. The Clever Together project would also drive further improvement around empowerment and safe environment to increase a speaking up culture and how this data would be captured and measured in future.

The Board **noted** the report.

146/24 **Health & Safety Annual Report 2023/24**

The Board received and considered the GWH Health & Safety Annual Report for 2023/24 which provided an overview of events and performance of the health and safety, fire and security disciplines. The paper also outlined the proposed headline objectives for the Health & Safety Team for 2024/25.

Simon Wade, Chief Financial Officer highlighted that there had been no prosecutions or improvement notices from the CQC or Dorset & Wiltshire Fire & Rescue Service during 2023/24. This status had been maintained from previous years and was a direct result of the good safety culture and high standards throughout the Trust with health and safety compliance.

Incidents reported during the year constituted a 13% increase on the figures from the previous year and could be due to the change in the Trust's incident reporting system for staff.

There had been 17 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable accidents reported to the HSE, which was an increase in comparison to previous years. The main reporting categories were noted and the actions to drive improvement were outlined.

The Board reflected on the reports of physical abuse (injury) by patients on staff which had increased significantly year on year. Simon Wade, Chief Financial Officer provided an overview of the actions being taken to improve security within the Trust, and particularly in the Emergency Department. Actions were being implemented around de-escalation training to support staff in ED and also ward areas to address an increase in behaviours by some patients and that this had been well received by staff.

RESOLUTION

- The Board **approved** the Health & Safety Annual Report for 2023/24.

DRAFT

Minute	Description	Action

- The Board **approved** the H&S Statement of Commitment for inclusion in the Trust Health & Safety policy.
- The Board **approved** the Health & Safety Plan for 2024/25.

Consent Items

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

147/24 **Ratification of Decisions made via Board Circular**

None.

148/24 **Review of Trust Constitution**

The Board received and considered the proposed amendment to the Trust Constitution in terms of the composition of the Board, following the appointment of the Group Chief Executive Officer/Accountable Officer (voting Board member) at Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust, together with a newly created role of Managing Director (voting Board member) for each trust. The proposed amendment was in alignment with Royal United Hospitals Bath NHS FT and Salisbury NHS FT.

There followed a discussion on the composition of the Board, in particular adding the newly created Managing Director role into the Constitution. Although it was acknowledged that not all voting Executive Director roles were included, it was agreed that for this particular role it was essential to be a voting director and therefore to be included in the composition of the Board. It was noted that this would be approved by the Council of Governors at its November meeting.

RESOLUTION

- The Board **approved** the changes to the Constitution to reflect the change in the Board composition with the appointment of a Chief Executive and Managing Director for the BSW Hospitals Group.
- The Board **approved** that the Managing Director would be a mandated voting Executive Director member in the Board composition within the Constitution.

149/24 **Urgent Public Business (if any)**

Liam Coleman, Chair acknowledged that this was the last meeting for Lisa Cheek, Chief Nurse before she retired in mid-November and thanked Lisa for her considerable commitment and contribution to the Trust and the Board, and also her long and successful career in nursing.

150/24 **Date and Time of next meeting**

It was noted that the next meeting of the Board would be held on 9 January 2025 at the DoubleTree by Hilton Hotel, Swindon.

151/24 **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 13:10hrs

DRAFT

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – December 2024				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
None				

Future Actions				
None				

Report Title	Staff Story			
Meeting	Trust Board			
Date	5th December 2024	Part 1 (Public)	x	Part 2 (Private)]
Accountable Lead	Jude Gray, Chief People Officer			
Report Author	Angela Morris, Senior People Partner Kathryn Owen, Matron Kevin Jenner, Deputy Divisional Director of Nursing			
Appendices				

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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, 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 staff story on representing GWH at an employment tribunal.

	Safe	Caring	Effective	Responsive	Well Led
Link to CQC Domain – select one or more	X	X	X	X	X

	Pillar 1	Pillar 2	Pillar 3	Pillar 4
Links to Strategic Pillars & Strategic Risks – select one or more	X	X	X	X

		Risk Score
Key Risks – risk number & description (Link to BAF / Risk Register)		
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:

Claimant submitted a claim to an employment tribunal based on grounds of discrimination and harassment arising from her disability.

Assurance is provided by:-

a) The tribunal judge found that reasonable adjustments had been made and that Trust policy, practice, and procedure, did not give rise to a substantial disadvantage. The claim was dismissed, therefore providing assurance that the Trust follows fair process and policy.
b) The judge found that the factual basis of harassment allegations were not proved and this claim was also dismissed.

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board to note staff story.

Accountable Lead Signature	Jude Gray
Date	22/11/24

Tribunal Feedback

Background

Overview of the case and journey to tribunal

- **Internal Procedure**
  An employee was dismissed on 28th February 2023 under the Trust Conduct Policy on grounds of gross misconduct for:
  1. withholding prescribed medication (cyclizine) from a patient who had requested it.
  2. administering intravenous saline to a patient without informing them, and which was not prescribed.

  The dismissal decision was upheld on appeal.

- **External steps - progression to employment tribunal**

July 2023	GWH notified by Bristol Employment Tribunal of the claimants claim for: unfair dismissal, wrongful dismissal, discrimination arising in consequence of a disability, failure to make reasonable adjustments, and harassment related to a disability.
Aug 23-Sept 24	Preparation of GWH response, witness statements, 700 page bundle, and preliminary hearings with judge.
Oct 2024	Employment tribunal hearing.
Nov 2024	Judgement decision received.

Tribunal process

Format of the tribunal

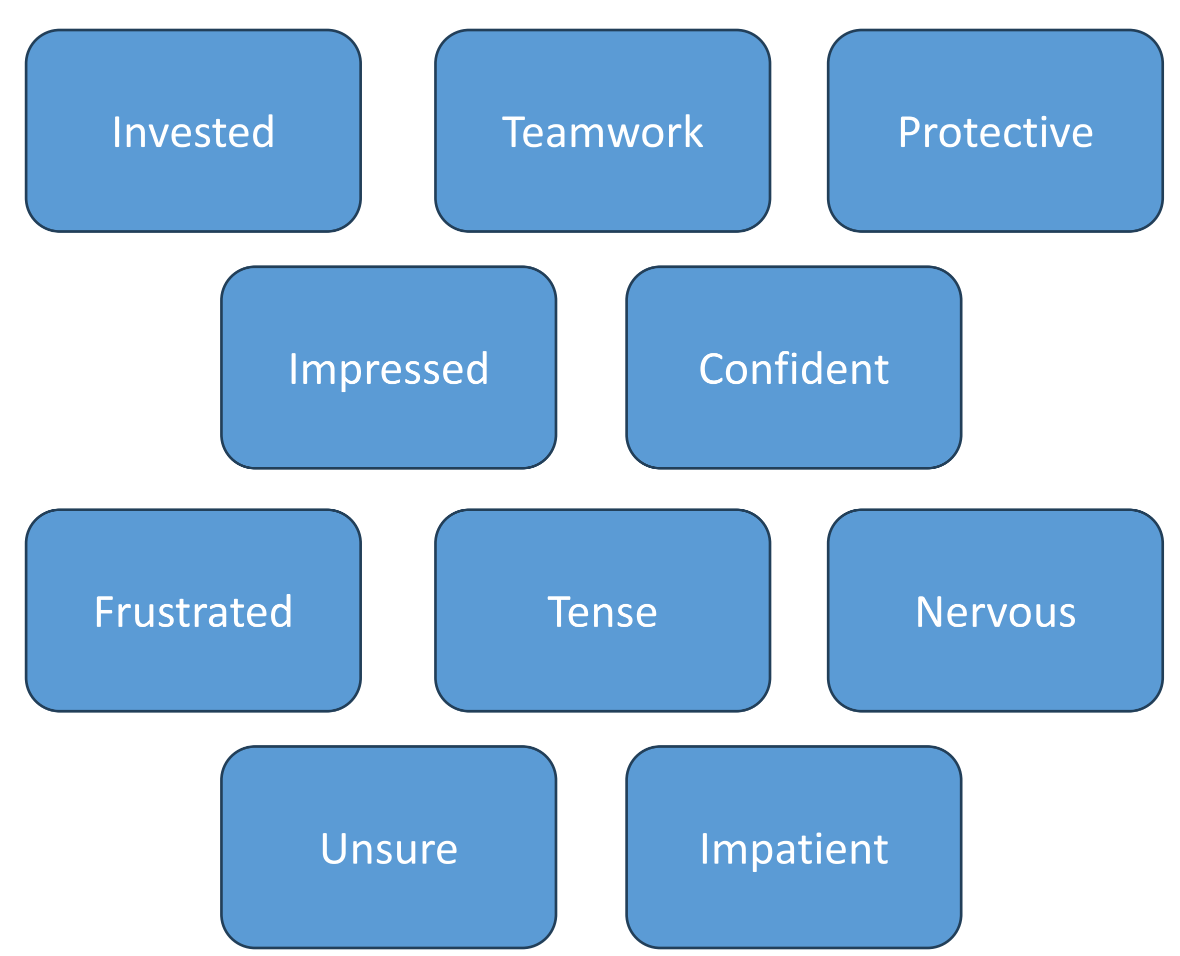
- Hearing held on Teams, 6 days allocated, Judge plus 2 lay members
- Format:

Day 1	Preliminary matters and claimant evidence with cross examination by Barrister
Day 2	Claimant evidence with cross examination
Day 3	Claimant evidence plus witness evidence with cross examination
Day 4	Claimant witness evidence followed by 3 GWH witnesses' evidence with cross examination by claimant legal advisor
Day 5	1 GWH witness evidence, final submissions by both parties
Day 6	Tribunal deliberations

- Plans made to observe the hearing together and adjourn to confidential space when giving evidence. It network issue meant returning home, deciding to go in pairs, before reconvening back on site once network connection resolved.

Angela's story

- Was SWC HRBP and led ET case preparation.
- Almost 2 years of work.
- Numerous legal deadlines along the way.
- Repeated requests for additional disclosures and delays to exchange of documents.
- Increasing significance over time.
- Learning: script update, notice forfeit on gross misconduct, documentation importance and update to People Ops wider team.
- Personal reflections:
  - seeing it through lens of the employment lawyer
  - value of preparation
  - creeping doubt, debriefs
  - decision ownership of appointed managers
  - professional learning and procedure improvements



Kathryn's Story

- Appointed as hearing manager
- Very challenging due to some behaviors and lack of insight and compassion of the employee.
- Am experienced in undertaking hearings.
- Nearly 2 years of involvement in this case (NMC, Tribunal)
- Personal reflections:
  - A lot of self-doubt despite outcome clear in my mind
  - Significant amount of learning to share – Policies/processes must be used. Any written evidence must be shared.
  - Advice and support from other witnesses, HR, Solicitor and Lawyer – invaluable.
  - Prepare and if you do not know the answer to a question , do not try

Kevin's Story

- Appeal manager.
- Joint decision to uphold decision.
- Struggled receiving the paperwork pre-trial.
- Last to give evidence on the day.
- Personal Reflections:
  - Professional Learning.
  - Support for colleagues.
  - Understanding of Tribunal process.
  - Transparency is key.
  - Work on cases individually.

Outcome of Hearing

Judgment

- **Judgment received in November, 1 month after the hearing:-**

1. Wrongful dismissal – claimant withdrew claim

2. Discrimination arising from disability – claims dismissed

3. Harassment related to a disability – claims dismissed

4. Unfair dismissal – upheld based on a procedural technicality however finding that dismissal would have resulted in any event. GWH finding that claimant was culpable upheld, and that her contribution to the dismissal was 100%. All awards therefore reduced by 100% to zero.

Report Title	Chair's Board Report				
Meeting	Trust Board				
Date	5 December 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

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

Assurance Level							
Assurance ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).							
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 identified assurance rating (whether substantial, good, partial or limited). *If 'Partial' or 'Limited' assurance has been indicated, 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 outlines a summary of the Chair's activity and key areas of focus since the previous Board of Directors meeting, including:

- Council of Governors – Key Meeting Dates
- 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 Score

– risk number & description (Link to BAF / Risk Register)	-	
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	26 November 2024

Chair's Board Report

This report outlines a summary of the Chair's activity and key areas of focus since the previous Board of Directors meeting during November 2024.

1. Council of Governors

1.1 The following table outlines the key meetings, training and events during November 2024 which governors participated:-

November 2024		
Date	**Event**	**Purpose**
12 Nov	Business & Planning Working Group	To identify key issues in relation to address in relation to Trust finances and business planning. The Group received reports on finance, digital, estates and performance.
13 Nov	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
13 Nov	Public Health Talk – HRT & Menopause	Governors host to promote membership. A successful talk with over 100 participants.
27 Nov	Council of Governors meeting	Meeting of the whole group quarterly to gain assurance, on behalf of the membership and the public, on the organisation's performance, with a particular focus on service quality. The Council received updates on the Trust strategy, community services contract, group model and the staff survey results.

2. Strengthening Board Oversight & Development

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

Date	Area	Board Member
14 November 2024	Saturn Ward	Steve Haig, Acting Chief Medical Officer Helen Spice, Non-Executive Director

3. Trust Chair Key Meetings during November 2024

Meeting	Purpose
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
1-2-1 meeting with Managing Director	Regular meeting
Meeting with ICB Chief Executive	To discuss system issues
Performance, Population & Place Committee	To attend as an observer
Remuneration Committee	Board sub-committee meeting
HWB Champions Forum	Network meeting
BSW Chairs' meeting	Regular meeting
Meeting with Berkeley Partnership re shared EPR Programme	To discuss EPR Project
Council of Governors	Meeting with Governors
AHA Committees in Common	Regular system meeting
Wiltshire Health & Care Members' Board	Regular system meeting
EPR Joint Committee	System meeting
GWH EDI Conference – Allyship Unlocking Inclusive Programme	Attendee to discuss EDI at the Trust

Report Title	Chief Executive's Report				
Meeting	Trust Board				
Date	5 December 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, 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):

The Chief Executive's report covers:

1. National updates
2. System
3. Group
4. Operational updates – including pressure on services at Great Western Hospital, bed reconfiguration, Children's Emergency Unit, improving our power resilience, and Serco industrial action
5. Quality – including supporting our patients' nutrition needs, and improvements being made to coincide with Disability History Month
6. Systems and strategy – including our financial position, Improving Together week, and community services
7. Workforce, wellbeing and recognition – staff survey, our Equality, Diversity and Inclusion conference, flu campaign, and Armistice Day

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
Links to Strategic Pillars & Strategic Risks – select one or more					
Key Risks – risk number & description (Link to BAF / Risk Register)	N/A				Risk Score
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		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	x		

Explanation of above analysis:

The report mentions the opening of our new Children's Emergency Unit, and highlights the sensory play room for children with neurodiversities and a wellbeing room for younger patients arriving in mental health crisis.

The report includes work carried out during Disability History Month to show our support for the local Ask Danny campaign which aims to raise greater awareness of the needs of people in hospital with learning disabilities.

Our first ever Equality, Diversity and Inclusion Conference, which had a focus on Allyship: Unlocking Inclusive Leadership, is mentioned. EDI is a key theme of our new Expectations of a Line Manager programme which is also mentioned in the report

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	28.11.24

1. National

1.1 Evolution of NHS Operating Model

The Chief Executive received a letter on 13 November 2024 from NHS England Chief Delivery Officer and National Director for System Development outlining plans to evolve the operating model to ensure that the way the NHS works supports delivery of the priorities as well as deliver the neighbourhood health model that will underpin the health and care system that is fit for the future.

Four actions will guide a refresh of the current operating framework which are outlined below:

i) Simplify and reduce duplication, clarifying roles and responsibilities and being clear on the place of performance management.
ii) Shift resources, time and energy to neighbourhood health, creating momentum that makes clear the role of the provider sector in neighbourhood health and how to work with local partners.
iii) Devolve decision-making to those best placed to make changes, clarifying the role of integrated care partnerships (ICPs) and health and wellbeing boards.
iv) Enable leaders to manage complexity at a local level, supporting leaders with new strategic commissioning frameworks to include national best practice.

Achieving this will require everyone in the NHS to work together, alongside its partners in the wider system, to fully leverage the potential of integrated care systems, aligned around a clear purpose and each with a distinct role to play.

1.2 NHS Providers Conference 2024: Secretary of State for Health and Social Care Speech - Key Messages

The Secretary of State for Health and Social Care, Wes Streeting, spoke at the NHS Providers conference on 13 November 2024 where he outlined the Government's ambition to reform the NHS.

The key messages from the speech were:

a) Important to lay down some directions.
b) The NHS is not meeting its promises to patients.
c) Performance of the NHS has deteriorated, which in turn is deteriorating the health of the nation.
d) Biggest barrier - long waiting times.
e) Need to deliver better outcomes and better value for taxpayers.
f) Values and standards should be the same nationally.
g) Five key tasks:
    I. Living within money
    II. Embedding improvement
    III. Maintaining quality and safety
    IV. Working with primary care
    V. Optimising Efficiency

1.3 NHS Management and Leadership Programme

a) Leadership Management Programme

The NHS is one of the largest employers in the world and delivers care and treatment to more than a million people every 24 hours. It impacts everyone's lives and employs over 1.3 million people across more than 350 different careers. The NHS delivers amazing care to patients every single day, but there are times when it falls short, and services aren't what we want them to be, which has to change.

Excellent leadership and management are key to delivering that change. We need our colleagues to have the right skills, the right support and the right accountabilities.

The NHS Chief Executive, Amanda Pritchard, has announced a programme to transform NHS leadership and management over the next two years as leaders and managers shape the culture, experience and outcomes across the service for patients and staff.

The aims of the NHS Management and Leadership Programme are to make sure:

- NHS leaders and managers at all levels meet the standards and competencies our staff and patients expect of them
- All leaders and managers have access to professional development and support to meet the expected standards and competencies
- The NHS attracts, develops and retains the best talent
- The public has increased confidence in NHS leaders and managers, who feel a continued sense of pride in their profession.

The programme will have three workstreams which will set the right standards, improve its development offer, and nurture and deploy talent across the NHS.

- Workstream 1: Set the right standards for our leaders and managers
- Workstream 2: Develop our leadership and management
- Workstream 3: Talent support and career development

Further information can be found via https://www.england.nhs.uk/leaders/

b) Insightful Board

NHS England has published the Insightful Board for Integrated Care Boards and Provider Boards which will help Boards to consider their approach to handling and acting on the information they receive.

It considers the leadership behaviours and culture of the Board and how these can affect the information it receives and the actions it takes, as well as metrics that can support the Board to better understand the organisation's performance.

Further information can be found via https://www.england.nhs.uk/leaders/insightful-board-guidance/

1.4 NHS managers' regulations proposal

A public consultation was launched on 26 November 2024 seeking views on government proposals to regulate health service managers, ensuring they follow professional standards:

https://www.gov.uk/government/consultations/leading-the-nhs-proposals-to-regulate-nhs-managers/leading-the-nhs-proposals-to-regulate-nhs-managers

The Department of Health and Social Care also launched a consultation on 26 November 2024 considering whether to introduce a new professional duty of candour on managers, and in addition to make managers accountable for responding to patient safety concerns.

Amanda Pritchard, Chief Executive of NHS England, stated:

"It is right that NHS managers have the same level of accountability as other NHS professionals, but it is critical that it comes alongside the necessary support and development to enable all managers to meet the high-quality standards that we expect.

"We welcome this consultation and already have a range of work underway to boost support for managers in the NHS and to help set them up to succeed – this includes creating a single code of practice, a new induction process and a new set of professional standards, which will ultimately help drive improvements in productivity and patient care."

BSW Hospitals Group is well-placed to be at the forefront of developments. Our Chief Executive Cara Charles-Barks sits on the national CEO working group.

1.5 NHS Launches Major New Stroke Campaign

Tens of thousands of people who have a stroke could be diagnosed and treated sooner as new data found that the average time between onset of first symptoms and a 999 call being made was nearly an hour-and-a-half.

New analysis of NHS data shows that for 2023/24 of 41,327 patients with a recorded time of symptom onset, the average time between first symptom and a 999 call being made was 88 minutes.

The figures come as the NHS launched the first major update to the 'Act FAST' campaign since 2009. As part of the campaign launch, a powerful new film has also been released which features stroke survivors listening back to audio recordings of the real 999 calls that saved their lives.

For further information please follow this link: https://www.england.nhs.uk/2024/11/nhs-launches-major-new-stroke-campaign-as-thousands-delay-calling-999-by-nearly-90-minutes/

1.6 Covid Inquiry:

Module 3 of 10 of the UK Covid 19 Inquiry opened on Tuesday 8 November 2022 with the impact of Covid-19 Pandemic on Healthcare Systems in the four nations of the UK Public Hearings taking place between 9 September – 28 November 2024. It continues to look into the governmental and societal response to Covid-19 as well as dissecting the impact that the pandemic had on healthcare systems, patients and health care workers. This includes healthcare governance, primary care, NHS backlogs, the effects on healthcare provision by vaccination programmes as well as long covid diagnosis and support.

The preceding modules looked at UK's resilience and preparedness for the pandemic (Module 1) and core political and administrative governance and decision-making for the UK (Module 2).

1.7 Lampard Inquiry

The Lampard Inquiry is a statutory inquiry investigating mental health inpatient deaths in Essex. It is chaired by Baroness Kate Lampard CBE. The Lampard Inquiry will investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023.

The Lampard Inquiry was preceded by a non-statutory inquiry that was set up to investigate the deaths of mental health inpatients in Essex between 2000 and 2020, launching in November 2021.

In June 2023 the then Secretary of State for Health and Social Care, Steve Barclay, announced that the Inquiry would be granted statutory status under the Inquiries Act 2005.

Following a consultation period and development of the Terms of Reference, the Lampard Inquiry commenced in September 2024.

The Lampard Inquiry is expected to conclude in 2026.

1.8 Uniting Health Data Report

Professor Cathie Sudlow's independent review of the UK health data landscape, titled 'Uniting the UK's Health Data: A Huge Opportunity for Society', was published on Friday 8 November 2024.

The review's findings set out a bold vision for overcoming the barriers and inefficiencies that currently delay the safe and secure use of health data to improve lives. It also sets out how that can be achieved, with five key recommendations to transform the national health data ecosystem.

1. Major national public bodies with responsibility for or interest in health data should agree a coordinated joint strategy to make England's health data a critical national infrastructure
2. Leading government health and research bodies should establish a national health data service for England with accountable senior leadership
3. The Department for Health and Social Care should oversee and commission a strategy for ongoing, coordinated engagement with patients, public, health professionals, policymakers and politicians
4. The health and social care departments in the four UK nations should set a UK-wide approach for data access processes and proportionate data governance
5. National organisations in the four UK nations should develop a UK-wide system for standards and accreditation of SDEs holding data from the health and care system.

Further information can be found via https://www.hdruk.ac.uk/helping-with-health-data/the-sudlow-review/

2. System

2.1 BSW Review of System meeting (H2 – second half of the year):

In November, a meeting was held with the ICB and Regional Team to discuss the performance and financial position in the BSW system.

Three key priority areas were agreed for the remainder of 2024/2025 as:

- Year-end financial position
- 65 week waits
- Urgent and emergency care with a key focus on ambulance turnaround

2.2 South West Region Managing Ambulance Handover Delays in Extremis Standard Operating Procedure update

An updated Standard Operating Procedure for Managing Handovers in Extremis was implemented on 18 November 2024 in response to the deteriorating position across the Region in relation to delayed ambulance handovers and consequently response times.

It is nationally recognised that unassessed patients in the community (those awaiting an ambulance to attend) pose the greatest level of clinical risk in a system. As such, every effort is being made to prevent any ambulance handover delays.

The new SOP strengthens the response to delays, including how and when handover delays are escalated in the system and Region, ensuring that senior support and input is available.

3. Group

3.1 BSW Hospitals Group Development:

Activities & Achievements:
As new Chief Executive of the BSW Hospitals Group, the first month in-post has seen focus on getting to know the organisations, meeting teams and visiting departments across Great Western, Salisbury and RUH Bath Foundation Trusts. In these first few weeks it has been striking to see the opportunities we have to share excellent practice more widely across BSW Hospitals Group.

We have established a new rhythm of work with the Chairs and interim Managing Directors. We meet locally in each Trust considering local priorities, and also come together weekly to plan the development of BSW Hospitals Group. Jon Westbrook, Lisa Thomas, Andrew Hollowood, and I have arranged a series of monthly development days, designed to support our group development work and most importantly to establish the behaviours, principles and culture we will aspire to together.

The Trusts have developed a Strategic Planning Framework which outlines the key issues we need to work on collectively. We have been working with the SW Regional team to identify budget required to support our Group development.

Priorities:
While work is beginning to establish a governance structure and operating model for our Group, there are a number of issues which need our immediate focus in each Trust. Emphasised in recent announcements from NHS Chief Executive and the Secretary of State, these include:

- Urgent and Emergency Care, particularly improving access for our population across BSW.
- Financial sustainability, including our 2024-25 year-end position.

- Digital environment. We will implement a new shared Electronic Patient Record, maximising the opportunity this gives us, using Improving Together, to drive clinical transformation and improvement.

We will work together to develop our responses to these challenges.

Great Western Hospitals NHS Foundation Trust update

4. Operational update

4.1 Pressures on services

Great Western Hospital has been extremely busy in recent weeks.

To help us manage the demand upon us, we declared an internal critical incident on 26 November which was later downgraded to a business continuity incident.

The declaration reflected the extreme pressure being felt in all services and the need to generate bed capacity to support the safe care of patients.

In particular we asked operational teams to focus on discharging patients who can continue their care outside of the hospital.

We continue to encourage clinicians to use the NHS at Home Service – on this virtual ward patients can continue their care outside of a hospital environment.

As we move further into the busy winter period we continue to ask the public to try to access the most appropriate healthcare, and call 111 or visit www.111.nhs.uk if they are unsure what to do.

4.2 Bed reconfiguration

Last month teams across the organisation successfully undertook a significant programme of work to align a number of clinical departments, in one of the biggest moves of hospital services since the Great Western Hospital first opened 22 years ago.

The changes to the way we configure our medical and surgical bed spaces will enable us to provide better care for patients by ensuring they are in the right place.

This was an incredible achievement, with months of detailed planning and coordination in advance, and hundreds of staff involved in the physical moves.

The work involved successfully aligning a number of clinical services, moving around 100 patients from one location to another.

Around 350 staff were supported to start working in new areas. These staff have now joined new teams and will continue to be supported whilst they settle into their new working environments. The disruption for patients was minimal, and staff on the wards made sure everything was explained clearly to patients who were impacted.

4.3 Children's Emergency Unit, Same Day Emergency Care, and Medical Assessment Unit

Our new Children's Emergency Unit saw its first patient as it became operational on 6 November. Staff treated more than 200 patients in the first week in the new unit which has 13 cubicles, two high acuity bays and one resuscitation bay, a baby and breastfeeding room, a sensory play room for children with neurodiversities and a wellbeing room for younger patients arriving in mental health crisis.

We held a small ribbon-cutting ceremony to mark the completion of the refurbishment work on our old Emergency Department, which has reopened as a new Medical Assessment Unit (MAU).

The MAU brings together our existing Same Day Emergency Care (SDEC) service and the Medical Expected Unit (MEU).

This new department will see patients who have been referred by their GPs, paramedics, the Emergency Department or the Urgent Treatment Centre.

Providing care from one MAU will improve the experience for patients, giving them the care they need in the right place, first time.

4.4 Installation of additional generator

Last month we tested and installed a new electrical generator on the Great Western Hospital site.

Our fifth generator has significantly increased our resilience in the event of an interruption to the power supply at the hospital.

4.5 Serco industrial action

We saw the second strike at the hospital involving Serco staff last month.

Just over 30 Serco staff went on strike. There was no impact to any service with all areas covered with other staff, and some additional volunteers around the site to help with portering.

The dispute is not with our Trust – Serco staff are in dispute with unions over not receiving the non-consolidated Covid bonus payment.

5. Quality

5.1 Safeguarding adults week

We marked Safeguarding Adults Week last month, which had the theme of Working in Partnership.

During the week, the Trust's Adult Safeguarding Team offered some learning and development opportunities, alongside Wiltshire Safeguarding Vulnerable People Partnership, and met with staff during walkabout sessions around the hospital.

5.2 Supporting our patients' nutrition needs

Eight of our wards have now introduced a Ward Host role, employed by Serco, who will provide a fully catered service to all patients.

Saturn, Jupiter, Mercury, Neptune, Kingfisher, Teal, Woodpecker and Linnet will be supported every day by their Ward Host, who will have overall responsibility for all catering requirements, including meal ordering, mid-morning and mid-afternoon snack delivery, delivery of all drinks including ensuring water jugs are topped up and delivery of breakfast, lunch and dinner.

As part of these changes to catering, the lunch and dinner service will also be swapped, meaning patients will have their main hot meal in the evening and a light lunch during the day. This will ensure the patients are more full, less likely to be interrupted whilst eating and have an overall improved experience when in hospital.

Earlier this year, the Trust introduced a new role – Dining Companions – for staff working in the corporate division. This is an opportunity for corporate staff to support ward teams and patients during mealtimes.

It also gives corporate staff chance to spend time in clinical settings, network with other colleagues and interact with patients in ways they may not normally get to experience.

After a successful pilot, the scheme is now being rolled our wider across the organisation. Each corporate staff member who signs up to become a Dining Companion will be link with a specific ward, will meet initially with the ward manager as part of an induction and will receive role modelling from two volunteers who can provide basic training.

5.3 Ask Danny

We marked Disability History Month by showing our support for the local Ask Danny campaign which aims to raise greater awareness of the needs of people in hospital with learning disabilities.

Danny Lynch died unexpectedly at the age of 40 last year following complications during surgery in Bristol.

His family believes that healthcare professionals could have done more to understand his needs, and formed the charity Ask Danny which aims to raise awareness of people with complex learning disabilities in hospital and ensure that patients and families get support from specialist learning disability nurses.

Danny's mum Maria visited Great Western Hospital to meet staff and talk about the resources available to help support for patients with learning disabilities.

6. Systems and strategy

6.1 Finance

We continue to work hard to manage our budget and make savings.

Our year-to-date financial deficit is £7.8m – which is £2.9m worse than the position we had planned for.

This position is mainly due to over-spending on clinical supplies, the cost of medical and dental temporary staffing, and not yet making the savings we have planned to.

Our target this year is to save £21.9m; so far we have delivered £8.6m of these savings.

6.2 Improving Together week

We held a week dedicated to celebrating Improving Together, our Trust-wide approach to improvement.

Colleagues from our Transformation and Improvement Hub shared how Improving Together is helping teams to solve problems, explore ideas and make improvements in their area.

Improving Together is used across our Trust as well as in Salisbury and the Royal United Hospital in Bath, bringing teams together, giving all staff a voice and empowering people to make positive changes.

We celebrated the sixth group of staff to have completed Improving Together training, which includes colleagues from Falcon, Jupiter and Aldbourne Wards and the Children's Unit.

The specialist training includes whole-day training sessions and weekly coaching, over a five-month period.

Different training options are available, including a five-month programme with coaching, a three-day bootcamp and a fast-track offer.

To date, almost 1,000 staff have taken part in some form of Improving Together training, with many more embracing the principles of the approach.

6.3 Community services

We have been meeting with community staff following the Integrated Care Board's decision to award the single contract for community services across BSW from April 2025 to HCRG Care Group.

We are still working closely with HCRG to understand which services will be transferring and which services will not and want to complete this work as soon as possible.

Our focus is on supporting our staff through this change. Staff working in services affected will be protected by Transfer of Undertakings Protection of Employment (TUPE) regulations. As we go forward, we are committed to working with HCRG and other partners to join up and improve care

7. Workforce, wellbeing and recognition

7.1 Staff survey

We have exceeded last year's response rate for our staff survey.

Last year 69 per cent of our staff completed the survey, but this year more than 70 per cent have filled in the questionnaire which makes us one of the top performing Trusts in the country for this measure.

Importantly, it means we will have a really rich set of information giving us a broad range of views of staff from across the organisation.

The survey will be published nationally in March next year.

7.2 Equality, Diversity and Inclusion conference

We held our first ever Equality, Diversity and Inclusion Conference which focused on Allyship: Unlocking Inclusive Leadership.

Speakers included the Associate Director of Inclusion at Barts Health NHS Trust, Swindon Borough Council's Director of Public Health, and Roger Kline, who has written several reports on race equality in the NHS.

7.3 'Count me in' funding

Staff are invited to apply for dedicated funding for projects which will help to create a more inclusive, welcoming and accessible workplace or healthcare service.

This amazing opportunity is open to all staff and aims to support the great work already taking place across the Trust to ensure patients, carers and staff have equal access, opportunities and support, regardless of their characteristics or circumstances.

Teams or individuals can bid for either £2,500, £1,000 or £500 to support their project which should focus on promoting equality, diversity and inclusion for staff or patients, or reducing health inequalities by improving access to healthcare for local communities.

7.4 Flu and Covid jabs

We continue to offer staff the flu jab and our Occupational Health teams are aiming to vaccinate 80 per cent of our workforce.

Being vaccinated helps to protect staff against flu, along with their patients and the wider community.

We are also offering Covid vaccinations for those staff and volunteers who would like to have one.

7.5 Expectations of a line manager

More than 50 staff attended our new Expectations of a Line Manager programme which launched last month.

Those attending discussed issues including: equality, diversity and inclusion, induction and onboarding, developing employees, supporting attendance, and workforce planning and rostering. The one-day course is aimed at Band 6 and 7 line managers

7.6 Healthcare scientists

We held a Healthcare Science Event to celebrate the work of our healthcare scientists. The event focused on teaching and learning in healthcare science, including how we can inspire the next generation of healthcare scientists in Swindon.

We had several guest speakers offering talks on silent coaching, reflection and associate fellowship, workforce growth through education and the future of physiological sciences and apprenticeships.

7.7 Occupational Therapy Week

We marked Occupational Therapy Week with 'Oaties from the OTs' – delivering oat biscuits to staff, patients and relatives around the hospital to raise awareness of their important work.

7.8 Armistice Day

Around 300 staff, volunteers, patients and visitors joined our Armistice Day service outside the Atrium, as we remembered members of our armed forces who lost their lives in the line of duty.

Report Title	Integrated Performance Report (IPR)				
Meeting	Trust Board				
Date	5th December 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Rob Presland, Acting Chief Operating Officer Lisa Cheek, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Aimi Armitage – Associate Director of Performance Luisa Goddard – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • 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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, 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 our operational performance for September (August for Cancer) are as follows:

Strategic Pillar Metrics

RTT (Referral to Treatment) 52 Week Waiters

October's performance shows the total number of patients waiting over 52 weeks at 1,637, a decrease of 287 patients.

As a trust we set an ambitious target to book all patient's first appointment by the end of September, who would turn 52 weeks by March 2025. As of the 8th November there remains 6,725 patients without their first appointment booked. The largest un-booked cohorts at risk are General Surgery, Neurology, Gastroenterology and Gynaecology. Divisions have been tasked to view these cohorts alongside their available capacity and prioritise long waiters during booking.

With regards to our over 65 cohort, there remain specialty risks which have impacted on our aspirations to reduce the end of month breaches in this cohort. Loss of weekend list initiatives and an increase of 2-week waits has impacted the ability to clear these patients at pace. Specialties with the biggest level of risk include; Gastroenterology, General surgery, Neurology and Gynaecology. At the end of October, we reported 79 breaches, of which 5 were over 78 week waits.

Assurance review meetings have been increased with ambitious actions to mitigate risks and provide a point of escalation. The RTT team is reporting weekly submissions to NHS England and the Trust has been included in BSW "shadow tiering" with the regional team to support recovery plans.

Main risks to delivery across the divisions of Medicine and Surgery, Women and Children are; Gastroenterology, Neurology, General Surgery and Gynaecology.

Cancer waiting times
Cancer performance has steadily improved month on month since April 2024, across both the 28-day FDS and 62 Day performance. Great Western Hospital has now officially come out of tiering for cancer services and will need to maintain rigor around performance to maintain this position and provide system assurance. There is work occurring at AHA level across tumor sites to review future state of services, where radical change is required to meet demand e.g. Lower GI.

At the end of September there were 104 patients waiting >62 days on the PTL, which was 6.6% of the overall PTL size and therefore remaining below the national target of 6.8%. The PTL continues to be managed within nationally set thresholds.

The Trust exceeded the operating plan trajectory for both the 28-day Faster Diagnosis (FDS) standard and 62-day referral to treatment standard in September at 78.8% and 70.8% respectively. September 28-FDS performance target was met due to increased capacity in breast and external funding of first appointments and MOPs in Dermatology. Urology has been showing signs of improvement following changes to triage and removing post MRI face to face appointments ahead of booking a biopsy.

Our 31-day decision performance remains variable, with the national standard not being met in September – 87.8%. 24 pathways breached the standard. Unvalidated October performance shows improvement at 92.2% with 12 breaches.

Emergency Department (ED) and Urgent Treatment Centre (UTC) Mean Stay and Attendances
ED and UTC attendances increased by 2.1% in October, with 11,300 patients seen. This was driven primarily from Type 1 ED attendances, with a 4% increase on top of the 6% rise in September. The total mean wait time for a patient in October was 158 minutes in UTC, this is against the national standard of 240 minutes. In comparison to September's performance this shows an increase from 149 minutes where the department experienced a drop in demand.

Total type 1 ED attendances increased to 5742, from 5531 in September, with Type 1 triage (seen within 15 minutes) falling from 61.6% to 60.9%.

Combined 4- hour performance was 72.6%, a reduction in September's figure of 77.4%. This sits 5.4% below national target.

Work continues with support from the Emergency Care Intensive Support Team (ECIST) to review alternative admission pathways and the reconfiguration of the Medical Assessment Unit and SDEC

area in November will also facilitate improvements to accessing same day emergency care pathways and increasing zero day length of stay activity.

Inpatient spells - No Criteria to Reside Bed Days
In October, we observed a significant increase in NCTR averaging 81 – this is reflecting a similar picture with the trend from last October. Medically fit was removed from Nerve Centre towards the end of October with divisional sign off to do so, to be in line with national direction. Discharges were 21% over predicted for the month. Over a 21-day Length of stay (LOS), the average LOS was 10 patients which is showing a downward trajectory month on month. Homefirst (PW1) for Swindon was an all time high at 118 patients being discharged – which would be reflected in the over 21 days LoS.

Support from the Emergency Care Intensive Support Team (ECIST) remains in place to support improvements to the case management of patients in hospital greater than 10 days and awaiting discharge. A GWH task and finish group has also been set up with leadership from community services to help with reviewing recovery trajectories and associated activities to ensure the required bed day equivalent savings are realised between now and March 2025 through reductions in no criteria to reside. This is an important contributor towards the delivery of the Trust winter bed plan.

Operational Breakthrough Objective

Ambulance handover delays
An average of 81 hours were lost per day from ambulance handover delays in October compared to the Trust Breakthrough objective of 70 hours. This follows two consecutive months during which the breakthrough objective was met.

There were 19 six hour breaches reported in October, 5 of which breached 8 hours. Data shows that there is currently no evidence of special cause deterioration in handover delays since the opening of the new Emergency Department. However, time in department has increased and 4 hour performance has deteriorated during a month in which Trust bed occupancy increased to 97.1%, with P1-P3 no criteria to reside showing special cause deterioration in the Swindon locality driven by Pathway 2 and Pathway 3 delays.

The Trust has been receiving support from Emergency Care Intensive Support Team (ECIST) since October with a work plan to support the realisation of benefits from the Integrated Front Door, with the relocation of MEU and SDEC offering opportunities to support improved flow.

The EICST support package will support Trust objectives by December to improve rapid assessment and handover processes, increase SDEC volumes and case mix of patients, embed early discharge to the discharge lounge before midday and shape future design of the UEC and flow programme based on findings including but not limited to an ECIST led criteria to admit audit.

The Trust is also part of regional and system conversations to implement the South West Rapid Ambulance Handover approach. This will require a whole hospital and system approach to implement as it proposes a 75 to 90 minute rapid offload for the South West Ambulance to improve Category 2 response times, and is in response to the growing risk of undifferentiated patients not receiving timely access to emergency care in the community.

Alerting Watch Metrics
Key alerting measures in September across RTT, Diagnostics (DM01), Cancer, ED and Flow, and not already covered in strategic pillar metrics or the breakthrough objective are:

- Diagnostics - Octobers validated DM01 performance is showing an increase in performance variance from the 80.28% performance in September to 88.45% - this is the highest DM01 since February 2020. The number of patients on the waiting list has decreased by 268 to 6,639 driven by the by the continued work to improve NOUS. There are now only 767 patients waiting over 6 weeks vs. 8,301 in October 2023.

Our Care
The Integrated Performance report (IPR) for Care presents 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 90% from patient friends and family test.

There has been a slight decrease in the overall harms in month 168 in October compared to 171 in September. The has been a reduction in the number of falls and pressure harms in the acute, but a slight increase in pressure harms in Community Services and a slight rise in the number of patients with C. difficile, E. coli and Klebsiella.

The number of Family and Friends (FFT) positive responses for October has fallen slightly to 87.8% and remains just below the 90% target.

Breakthrough Objectives
The Breakthrough Objective for 2024/25 has changed from reducing harm associated with pressure ulcers to reducing harm from inpatient falls.

Aim for 2024/25
- Reduction in the number of Total Falls by 20%
- Reduction in the number of patients experiencing moderate harm or above by 20%
- Reduction in the number of patients that fall more than once by 20%

In October there has been no moderate harm or above following an inpatient falls.

Alerting Watch Metrics
The complaint response rate has decreased in October to 58% when compared to 72% in September.

The numbers of patients with two or more falls were 11 in month, compared to 12 in September.

The overall Family and Friends positive response rate target was reviewed and increased in April to 90% and as a result now sits within an alerting watch metric. The response rate for October is 87.8% and remains just below the internal target.

Non-alerting Watch Metrics
C*.diff* numbers have increased this month to ten (eight in September), however the Trust continues to remain below its target trajectory. Enhanced investigation and supportive best practice measures have been put in place as a result of two cases on one ward within 28 days, triggering a Period of Increased Incident being declared.

Methicillin-sensitive Staphylococcus aureus (MSSA) numbers remain low (two in month) Methicillin-resistant Staphylococcus aureus (MRSA) remained zero for the eighth consecutive month.

The targeted work on catheter management continues and although there has been an increase in *E. coli* and *Klebsiella,* the number associated with urinary infections has decreased. *Pseudomonas* numbers continue to remain lower than last year.

The number of hospital-acquired pressure ulcers has reduced further in month to 11 (14 in September). However there has been an increase in the level of harm with 7 category 3 pressure ulcers reported. All cases are discussed weekly at a tri-divisional meeting to identify and share learning in a timely way.

The number of Community acquired pressure harms has increased in month to 25 (17 in September). The majority of harms were reported at Category 2 (10) with zero category 4 harms identified.

Further points to note relating to non-alerting watch metrics include:

- Safer staffing fill rates remain above the National target of 85%.

Four Patient Safety Incident Investigations have been declared in September, including two Never Events wrong site surgery and retained foreign object.

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**
  Stretched Target 63%: achieving 59.6% (2023 Annual Survey), 55.9% Q1 Pulse Survey, and 55.5% Q2 Pulse Survey (steady decline since the annual survey)
- **Staff Voluntary Turnover**
  Target 11% achieving 8.5% (September data)
- **EDI disparity (reducing discrimination disparity)**
  Target 9.4% achieving 12.7% (2023 Annual Survey), and 13.1% Q1 Pulse Survey and 17.5% Q2 Pulse Survey

The annual Staff Survey launched on 9th September 2024 and will run until 22nd November 2024. A communications plan is in place to promote the survey during this period and encourage a high response rate. The Trust achieved a 69% response last year ranking second nationally and aims to achieve a similar or higher response rate this year. Uptake in the 2024 survey is ahead of last year, with the response rate at week 9 of the survey period reporting at 68% / 4,064 responses (compared to 66% last year). The People Operations team continue to target areas of poorer response through departmental visits to encourage further engagement with the survey ensuring we have a representative sample and staff are able to share their views.

Breakthrough Objectives

Following a review of staff survey performance, the Trust-A3 has been updated and it has identified 'Teamwork' as an area of opportunity to drive performance against our Pillar Metric of 'Recommending as a place to work' and therefore the breakthrough objective has moved to question 7C ("I receive the respect I deserve from my colleagues at work") to drive further improvement in 2024/25.

The national average for this question is 71% in the 2023 Staff Survey, against which a stretch target of 73% has been set. Currently, The Trust performance is 70% (2023 Staff Survey results) and 71.1% in the Q2 Pulse Survey.

Alerting Watch Metrics

In-month sickness absence decreased further in September from 4.5% to 4.3%, in line with our position 12 months ago. Short term absence increased in month to 2.1% however there was a promising decrease to long-term sickness absence rates, dropping from 2.8% to 2.1%. Whilst our position remains above the Trust KPI of 3.5%, the most recent benchmarking data shows we are below both regional and national sickness levels and currently benchmarking in the second-lowest quartile for Acute Trusts (55th out of 133 organisations).

HR Scorecard

Vacancy Rate

Our vacancy rate in October has further decreased to 180WTE (3.3%), despite an increase to our budgeted establishment of 18WTE (due to CDC budget being added into the establishment). Our

contract WTE increased by 29.51WTE, supported by a sustained time-to-hire of 43 days and further reduction to our turnover rate.

Workforce Utilisation
Agency
In-month agency spend increased in October to £0.45M, above target by £0.1M. Agency spend as a percentage of all pay-bill remains under our KPI target of 4.5%, reporting as 1.23% in October.

Bank
Bank spend increased in October to £2.29M, above the in-month target by £0.56M. Whilst partly attributable to backpay for the 2024/25 pay award for our bank workforce, an increase in usage across Medical and Unregistered Nursing has also impacted usage in October.

Workforce Recovery
5,638WTE was used to deliver our services in October which was +20WTE above planned levels of 5,618WTE. The above-plan position is predominantly driven by an increase in our contract WTE without subsequent reductions in temporary staffing usage. Our contracted WTE grew by 30WTE in October, with 20WTE of this being attributable to planned growth in CDC, Imaging, and EPR.

Temporary staffing remains an area of focus for reduction. Agency usage increased in month 7 due to high levels of RMN usage although remains favourable to plan by -10WTE. Bank usage continues to report above planned levels, with a further increase in October attributable to additional Consultant cover and an increased Healthcare Support Worker vacancy position.

Current WTE forecasting shows a year-end position of 5,672WTE, which is above plan by +159WTE. The ICB have asked the group to increase workforce controls to ensure WTE returns to WTE workforce plan.

Use of Resources

As at M07 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £7.8m, which represents a £2.9m adverse variance to plan.

Income is £7.6m favourable to plan driven by overperformances on ERF (£3.4m) and NHSE commissioned drugs (£2.5m). ERF performance is currently 3.1% above the 112% stretch target and is 15.1% above its 2019/20 baseline. The remaining £1.8m of excess income over plan is due to industrial action funding of £0.5m offsetting costs incurred, private patient income of £0.4m and £0.9m of additional education & training/other funding.

Pay is £2.6m over plan. The position includes c.£0.5m of junior doctor industrial action costs offset by income and a £1.5m under delivery of pay efficiencies. Ongoing Medical & Dental pressures in the front door areas account for the rest of the pay variance, partially offset by centrally-held reserves (e.g. maternity / paternity leave).

Non-Pay is £8.0m over plan, which includes £4.8m of overspends in clinical supplies and outsourcing, particularly within Medicine and Surgery, Women's and Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. Work is ongoing with Procurement and the services to understand the underlying drivers. The non-pay variance also includes £0.8m of undelivered efficiencies, while drug spend is £1.5m over plan, all of which is passthrough related and offset by income. Estates and PFI related costs account for the remaining variance.

The efficiency plan is £2.5m under target at M07 with total savings delivered year to date of £8.6m. The forecast is to deliver £16.3m of savings, which would represent a £5.6m under delivery against the £21.9m target. Of the £8.6m savings delivered year-to-date, 52% is recurrent, which is in line with M06. The focus of divisions and directorates must remain on increasing the 52% delivery of savings on a recurrent basis to reduce the underlying deficit. Pay is a key area for savings with a target to reduce the number of headcount working in the Trust by 263 compared to March 2022 by the end of

the year. Tighter controls around the approval of bank shifts, overtime and WLIs are contributing to this, as is ongoing work in reducing temporary staffing. Non-pay, and specifically clinical supplies spend, is the focus of detailed work between Finance, Procurement and divisional teams to understand the key drivers. The analysis has already highlighted some areas where immediate action can be taken to reduce spend, while benchmarking against other system Trusts has flagged further areas for investigation.

Breakthrough Objectives
The financial breakthrough objective is to remain within our overall deficit plan by month for 24/25, having improved the underlying financial deficit position by the end of the financial year through delivery of recurrent CIP.

We remain c.£2.9m off plan in Month 7. Our performance behind plan on the efficiency programme of £2.5m demonstrates that our run-rate reductions are not going far enough to impact our financial position to the extent that it is needed to meet our full-year plan. There are various recovery workstreams in progress, particularly around pay run rates. Activity is being scrutinised for where we are not delivering volume, or value of the relevant volume, against plan.

The wider cultural and capability-based requirements to deliver this BTO are detailed in the countermeasures, which have action plans associated with them. These are summarised below:

1) Is financial capability adequately supported in core roles?
2) Do those charged with financial management have the right information available for decision making?
3) The non pay run rate is increasing year on year.
4) Does everyone understand the underlying financial position of the Trust?

Actions continue to be progressed in relation to improving requisitioning controls and developing the training offer. An Improving Together working group has been set up in Finance to focus on financial training throughout the Trust, including a mandatory training course on ESR and staff group specific training. Task & finish groups including Finance, Procurement and Specialty leads have been set up to focus on the drivers of non-pay spend. The analysis has already highlighted some areas where immediate action can be taken to reduce spend, while benchmarking against other system Trusts has flagged further areas for investigation. Work is also ongoing around requisitioning controls. Divisions have submitted a list of users for revocation which is being checked by SBS. Focussed training for the remaining requisitioners around best practice is a key next step.

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 (TMC)				
Next Steps					

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

Explanation of above analysis:

The 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.

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	Rob Presland
Date	13.11.24

Integrated Performance Report

November 2024

October 2024 & September 2024 data period

Improving together

Service Teamwork Ambition Respect

Content & introduction

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

Measure Name	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Total 104 week waits	0	0	0	0	0	0	0	1	1	0	0
Total 78 week waits	4	5	10	4	3	4	3	3	12	6	5
65 weeks wait performance vs plan (size adjusted)	0.0%	0.0%	0.0%	0.0%	70.0%	117.9%	148.4%	154.6%	200.7%	0.0%	0.0%
Proportion of PTL over 65 week waits (size adjusted)	0.9%	0.9%	0.7%	0.2%	0.4%	0.6%	0.7%	0.6%	0.7%	0.2%	0.2%
Under 18 elective activity rate vs baseline	116.3%	122.5%	128.8%	119.1%	123.9%	119.0%	114.4%	117.0%	131.8%	124.8%	Reported one month behind
Faster diagnosis rate	60.4%	60.2%	70.5%	71.3%	59.2%	66.7%	70.2%	75.2%	81.8%	78.8%	Reported one month behind
62-day performance	65.0%	62.2%	68.6%	66.7%	63.1%	64.3%	69.4%	68.1%	70.3%	70.8%	Reported one month behind
Proportion of patients seen within 4 hours	74.7%	73.5%	71.1%	74.4%	75.9%	75.3%	75.0%	77.1%	79.5%	77.4%	72.6%
Number of mental health patients spending >12 hours in an emergency dept	5	12	5	5	14	9	6	6	7	3	9
Readmission rate	16.4%	11.2%	16.1%	15.7%	14.0%	15.9%	15.1%	14.7%	16.0%	14.8%	13.7%
Summary Hospital-level Mortality Indicator	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
CQC safe rating	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Sickness rate	5.0%	4.9%	4.4%	4.1%	4.2%	4.2%	4.6%	5.2%	4.5%	4.3%	Reported one month behind
Leaver rate	8.9%	8.6%	8.6%	8.4%	8.6%	9.7%	11.0%	9.6%	11.0%	10.6%	Reported one month behind
Implied productivity	-14%	-16%	-13%	-12%	-13%	-17%	-15%	-17%	-15%	-13%	Waiting for data
Proportion of staff in senior leadership roles who are from BME background	5.4%	3.5%	3.5%	3.5%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.4%
Proportion of staff in senior leadership roles who are women	57.1%	56.1%	56.1%	56.1%	56.7%	56.7%	56.7%	57.4%	58.3%	56.7%	56.9%
Proportion of staff in senior leadership roles who are disabled	1.8%	1.8%	1.8%	1.8%	1.7%	1.7%	1.7%	1.6%	1.7%	1.7%	3.5%

Key Indicators

The below metrics are also included in the 24/25 SOF Measures. However, publication of the final guidance documentation for the 2024/25 NHS Oversight Metrics is required to clarify the definitions to ensure aligned reporting with the National Metrics.

Metrics
65 week waits as a % of total patient tracking list (PTL) (size adjusted)
65 weeks wait reduction against trajectory
Number of emergency admissions for ambulatory care sensitive conditions
Proportion of Category 4 calls resulting in ambulance response
Midwifery fill rate in line with Birthrate Plus
Number of emergency admissions for people with multiple long term conditions
HCW proportion of Covid-19 and influenza vaccinations
NHS staff survey safety culture sub-score
Inpatient satisfaction NET survey
MI admission rate deprivation gap
Provider stability score
Provider efficiency score
Progress against trust sustainability plan
Proportion of Apprenticeship Levy spent
Compliance with 10% social value weighting across contracts

Executive Summary

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

The Breakthrough Objective for 2024/25 has changed from reducing harm associated with pressure ulcers to reducing harm from inpatient falls.

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

Patient Experience (FFT)

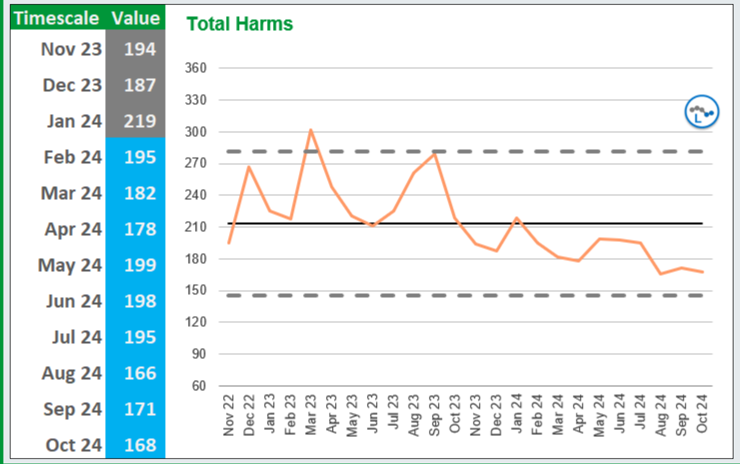
The Friends and Family Test is a national scheme which encourages patients to provide feedback about their experience of using our services. Patients are asked the question, Overall, how was your experience of our service? and have six options ranging from very good to very poor and don't know, there 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 90% for the combined positive response rate, this is based on an increased of 4% from last year's target of 86%.

Total Harms

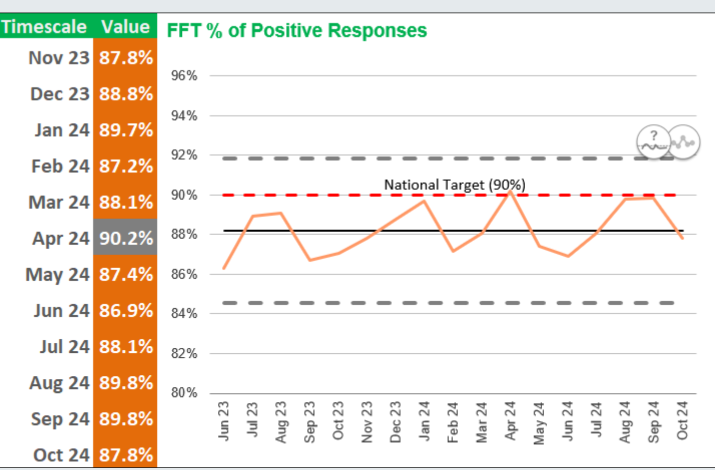
To achieve and sustain zero avoidable harm.



Timescale	Value
Nov 23	194
Dec 23	187
Jan 24	219
Feb 24	195
Mar 24	182
Apr 24	178
May 24	199
Jun 24	198
Jul 24	195
Aug 24	166
Sep 24	171
Oct 24	168

Patient Experience (Friends & Family Test)

To achieve consistent positive response rates in excess of 90% from patient friends and family test.



Timescale	Value
Nov 23	87.8%
Dec 23	88.8%
Jan 24	89.7%
Feb 24	87.2%
Mar 24	88.1%
Apr 24	90.2%
May 24	87.4%
Jun 24	86.9%
Jul 24	88.1%
Aug 24	89.8%
Sep 24	89.8%
Oct 24	87.8%

Counter Measures

The total number of harms has decreased in October to 168 from 171 in September, the overall downward trend continues when compared to the last 12 months data.

The decrease has been driven by a reduction in the number of falls and pressure ulcers in the acute hospital. Pressure harms in the Community Services have increased slightly. There has also been an increase in C. difficile, E. coli and Klebsiella this month.

There has been four patient safety incident investigations, two declared as Never Events, one relating to wrong site surgery and the other a retained foreign object.

For October, the Trust wide positive Family and Friends (FFT) score has decreased slightly to 87.8%. The target for 2024/25 has been increased to 90% to ensure there is stretch.

Work has commenced with the FFT provider to review the provision of the service, with the aim to complete by early 2025.

Pillar Metrics

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 62-day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In September, there were 50.5 breaches in total, with 31.0 of these attributed to the Urology, Plastic, Colorectal pathways. These pathways are seeing issues with capacity for appointments and diagnostics.

We continue to see greater than normal breaches in Urology where number of breaches relate to patients requiring a biopsy after their initial MRI. Template biopsy in Theatres has replaced TRUS biopsy in Radiology, capacity for which had been insufficient to meet demand. This has now been addressed and it is expected that we will see fewer breaches from November.

RTT: Number of patients waiting over 52 weeks

October performance shows the total number of patients waiting over 52 weeks at 1,637 a decrease of –287. Patients reported waiting over 65 weeks at the end of October was 79 , an increase of 4 from last month. The PTL size at the end of the month was 41,686.

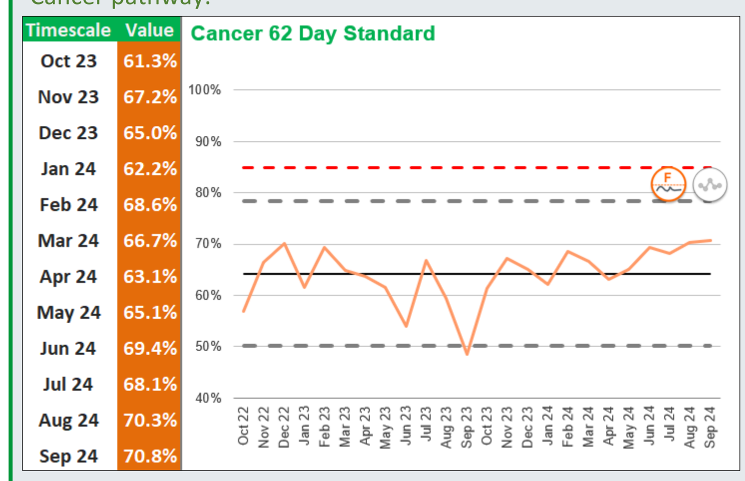
5 x 78 weeks breaches were reported in October 2024. 60% of these were choice breaches.

- 1 x Gastroenterology
- 2 x General Surgery
- 1 x Cardiology
- 1 x Gynaecology

Ambitions to clear our 65-week cohort remain challenged due to speciality risks with capacity. This is particularly evident for Gastroenterology, Neurology, General Surgery and Gynaecology. System conversations have commenced to review the need of mutual aid.

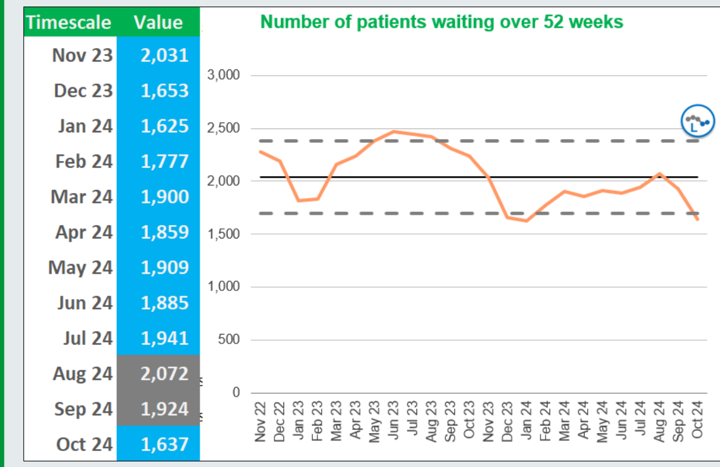
Robert Presland | Interim Chief Operating Officer

Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.



Timescale	Value
Oct 23	61.3%
Nov 23	67.2%
Dec 23	65.0%
Jan 24	62.2%
Feb 24	68.6%
Mar 24	66.7%
Apr 24	63.1%
May 24	65.1%
Jun 24	69.4%
Jul 24	68.1%
Aug 24	70.3%
Sep 24	70.8%

RTT: Number of patients waiting over 52 weeks
To eliminate over 52-week waiters as soon as possible and by March 2025 at the latest.



Timescale	Value
Nov 23	2,031
Dec 23	1,653
Jan 24	1,625
Feb 24	1,777
Mar 24	1,900
Apr 24	1,859
May 24	1,909
Jun 24	1,885
Jul 24	1,941
Aug 24	2,072
Sep 24	1,924
Oct 24	1,637

Counter Measures

Risk: Urology Pathways are impacted by delays in Radiology & Theatres (capacity & vacancies)
Mitigation:
-Funding approved for mobile LATP by TVCA. This went live on 7 September with weekend clinics to clear backlog and provide the necessary additional capacity. Improvements in the 62D performance are expected from November onwards
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: Capacity issues in **Plastics** for appointments and minor op clinics impacting pathway
Mitigation
-Suitable patients are sent to a private third party provider (CSP) where necessary
-Revised SLA with Oxford approved, though insufficient support from Oxford being provided due to consultant availability

Risk: Insufficient capacity to eliminate waits over 65 weeks as soon as possible and by December 2024 by the latest
Mitigation:
- Patient level details/plans updated on a daily basis. Booking in order practice being reviewed.
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Improved clinical review processes introduced with emphasis placed on the use of PIFU if a patient cannot be discharged.
- Booking to DNA rates has commenced in key specialties, along with additional WLI sessions being focused on long waiting patients.
- Validation of waiting lists (Project Verify) being embedded, along with cohorts of patients waiting over 40 weeks being offered alternative health care providers.
- Access team led intensive validation to work through cohort and increase clock stop run rate. Team now commenced extended patient treatment list review sessions.

Risk: Delay in achieving targets due to Industrial action/major incident.
Mitigation:
- All elective activity on strike/major incident days reviewed. Maximised 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 brought forward to reduce the risk of cancellation.

Executive Summary

Emergency Care – Emergency Department - Mean Stay

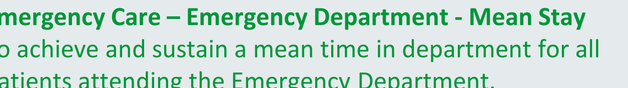
Patients are delayed within the Emergency Department (ED). This is a marker of a crowded system resulting in delays in assessment, investigation, treatment and discharge.

The total meantime in Oct 24 was 365 minutes against the national standard of 240 minutes. This is the second month where mean time in ED has increased following a downward trend throughout 2024. However October is still is the fourth lowest mean time in ED performance.

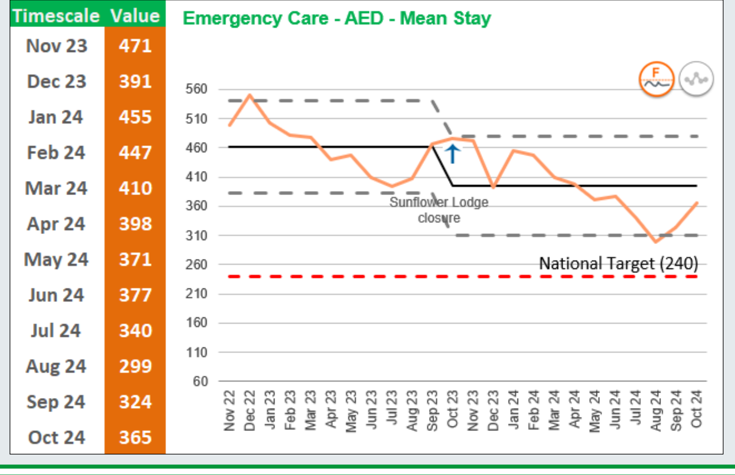
Emergency Care – Urgent Treatment Centre - Mean Stay

The total meantime wait for a patient in October 24 was 158 minutes against the national standard of 240 minutes. This has increased from 149 mins in September where the department experienced a drop in demand.

Robert Presland
Interim Chief Operating Officer

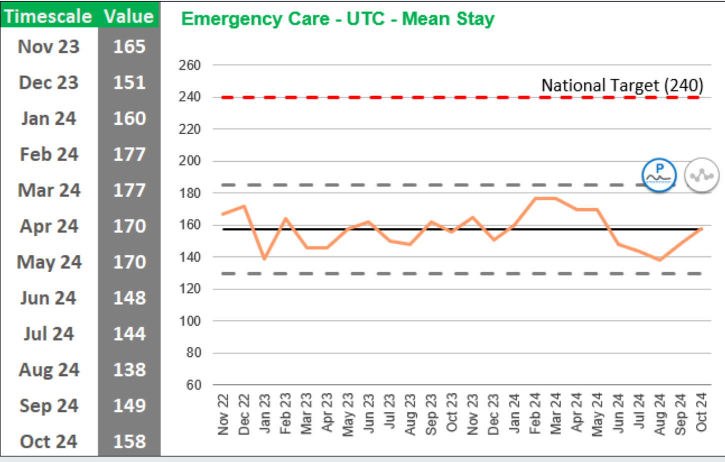


Emergency Care – Emergency Department - Mean Stay
To achieve and sustain a mean time in department for all patients attending the Emergency Department.



Timescale	Value
Nov 23	471
Dec 23	391
Jan 24	455
Feb 24	447
Mar 24	410
Apr 24	398
May 24	371
Jun 24	377
Jul 24	340
Aug 24	299
Sep 24	324
Oct 24	365

Emergency Care – Urgent Treatment Centre - Mean Stay
To achieve and sustain a mean time in department for all patients attending UTC.



Timescale	Value
Nov 23	165
Dec 23	151
Jan 24	160
Feb 24	177
Mar 24	177
Apr 24	170
May 24	170
Jun 24	148
Jul 24	144
Aug 24	138
Sep 24	149
Oct 24	158

Counter Measures

- 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.
- New ED performance dashboard
- Medicine Emergency flow programme

- 7-day rota review and implementation
- Data capture around our surge days (Sunday – Tuesday predominantly) and patients access to primary care
- Data capture around trends in presenting condition – anecdotal evidence shows rise in sickness related conditions.
- Discussions with ICB and Locality around support to reduce attendances to UTC
- Short term additional medical cover to mitigate surges and impact on ED
- Additional triage capacity now implemented with improved triage performance seen in June.

Pillar Metrics

Executive Summary

Emergency Department & Urgent Treatment Centre - Emergency Attendances

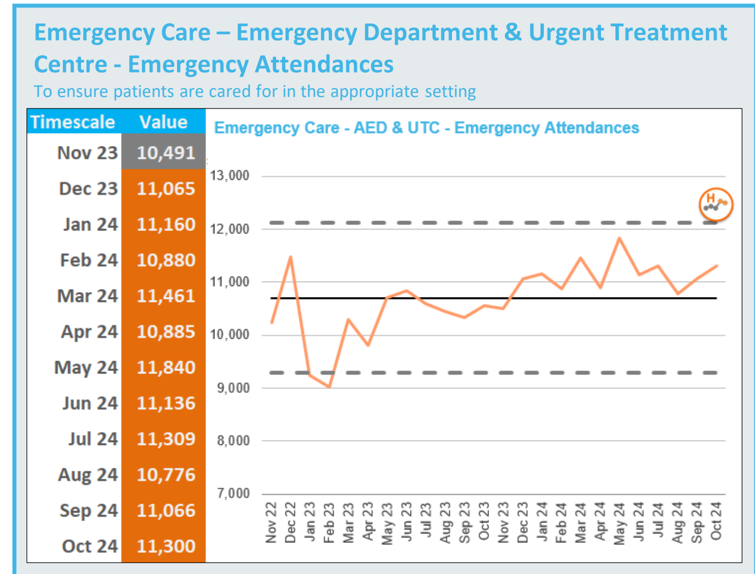
Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC).

There were 11,300 patients seen in ED/UTC in October, which is a 2.1% rise from September on top of the 2.7% increase from August. This increase has been driven entirely from ED attendances (4% increase on top of the 6% rise in September) with UTC demand remaining static.

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

In October, we observed a significant increase in NCTR averaging 81 – this is reflecting a similar picture with the trend from last October. Medically fit was removed from the Trust electronic patient record towards the end of October which means data quality is now improving. Discharges were 21% over predicted for the month. Patients over a 21-day length of stay was **10 patients** on average which is showing a downward trajectory month on month. Homefirst discharges for the Swindon locality was at an all time high at **118** patients being discharged – which would be reflected in the over 21 days length of stay improvement.

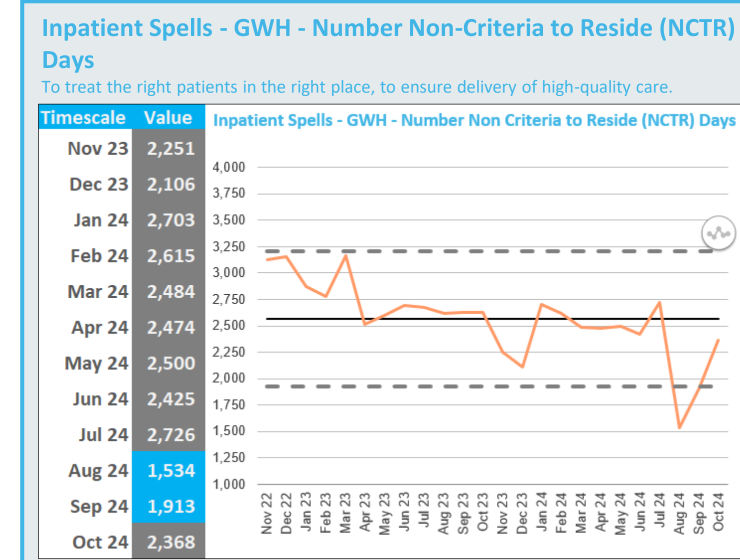
Robert Presland
Interim Chief Operating Officer



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

To ensure patients are cared for in the appropriate setting

Timescale	Value
Nov 23	10,491
Dec 23	11,065
Jan 24	11,160
Feb 24	10,880
Mar 24	11,461
Apr 24	10,885
May 24	11,840
Jun 24	11,136
Jul 24	11,309
Aug 24	10,776
Sep 24	11,066
Oct 24	11,300



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
Nov 23	2,251
Dec 23	2,106
Jan 24	2,703
Feb 24	2,615
Mar 24	2,484
Apr 24	2,474
May 24	2,500
Jun 24	2,425
Jul 24	2,726
Aug 24	1,534
Sep 24	1,913
Oct 24	2,368

Counter Measures

- Transfer team introduced towards the end of October – being monitored – objectives to increase before midday discharges and impact on decrease in Ambulance hand over delays.
- 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.
- Specialist Direct to the right bed initiative ongoing since end of August with plans to develop at scale to support new Medical Assessment Unit and Same Day Emergency care function at the front door from mid November.
- Hospital at Home (across BSW) working to one model and full occupancy.

Actions within the Hospital Flow/Admitted Flow work streams for Urgent and Emergency Care transformation include:

Opportunities:

- Review of escalation approach for patients with no criteria to reside including out of area patients – this is showing improvement and twice weekly calls in place.
- To review the approach to criteria led discharge for patients and maximise opportunities for earlier in the day discharge including to discharge lounge. - continuing with positive outcomes
- Review wards that have opportunities for higher discharges prior to midday and over weekends – ongoing.
- 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.
- Reserve Boarding needs to be investigated as a continuous flow and enacted daily to proactively manage ambulance surges and prevent bed surges.

Pillar Metrics

Executive Summary

Voluntary Staff Turnover (rate)
The annual voluntary turnover rate provides us with a high-level overview of Trust health.

The NHS People Plan highlights the support and action needed to create an organisational culture where everyone feels they belong. Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

The Trust has seen a downward trend seen in its voluntary turnover rate from July 2022, with performance below the 11% target being sustained for over 12 months. Voluntary turnover decreased slightly in September to 8.5% however remains under the Trust target of 11%.

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 2022 staff survey results. In 2023 the Trust achieved 60% performance, and the national results also improved to 61%. Therefore, the new stretch target is 63% to be achieved in the 2025 staff 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.

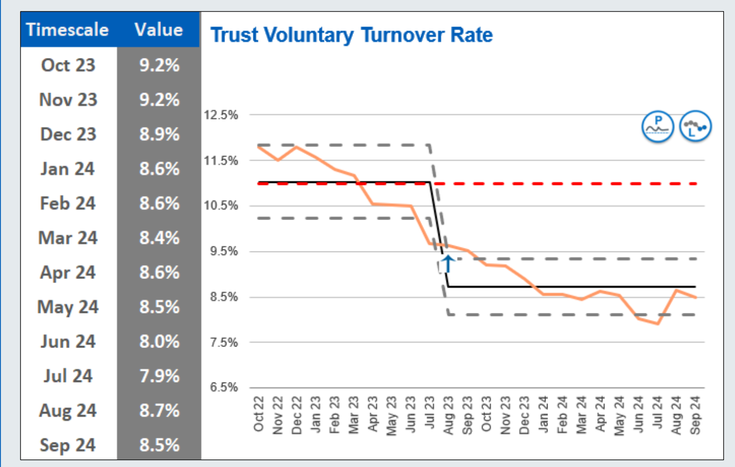
The number of staff who would recommend the organisation as a place to work increase from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey. Pulse survey result has shown a slight decline in results since the annual survey, deteriorating to 55.9% in Q1 and to 55.5% in the latest Q2 survey.

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
Oct 23	9.2%
Nov 23	9.2%
Dec 23	8.9%
Jan 24	8.6%
Feb 24	8.6%
Mar 24	8.4%
Apr 24	8.6%
May 24	8.5%
Jun 24	8.0%
Jul 24	7.9%
Aug 24	8.7%
Sep 24	8.5%

Staff % recommend the organisation as a place to work

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

Counter Measures

- There has been a slight decrease to Voluntary Turnover in September to 8.5% (8.7% in August).
- The People Promise Manager continues to deliver on the key objectives of the People Promise Plan and will be embedding new processes and systems over the coming months. This month the 90-day local induction booklet will be launched.
- Expectation of line managers launched on the 12th November, a successful day with over 40 managers in attendance. Feedback from the first event will be collated and appropriate changes to the programme made.
- A bid for a Safe Learning Charter Lead has been submitted to improve experience and retention of learners. The outcome of the bid will be known by the end of November.

- The Trust annual survey has launched, therefore Q2 results of the pulse survey have not changed. Recommend a place to work has slightly deteriorated since the annual Staff Survey in 2023. There are a number changes could be impacting staff engagement which include:
  - Community bid
  - Bed reconfiguration
  - IFD changes
  - Executive changes/Senior management changes
  - Financial controls – impacting pay
- The annual flu campaign launched on 3rd October and to date 44% of staff have been vaccinated, 5% behind last year.
- COVID vaccine has launched to staff on the 28th October at a cost pressure for the Trust.
- The Health and Wellbeing Team recognised world mental health day with a stall in Academy, and led on a Schwartz round (51 attendees).

Pillar Metrics

Executive Summary

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.

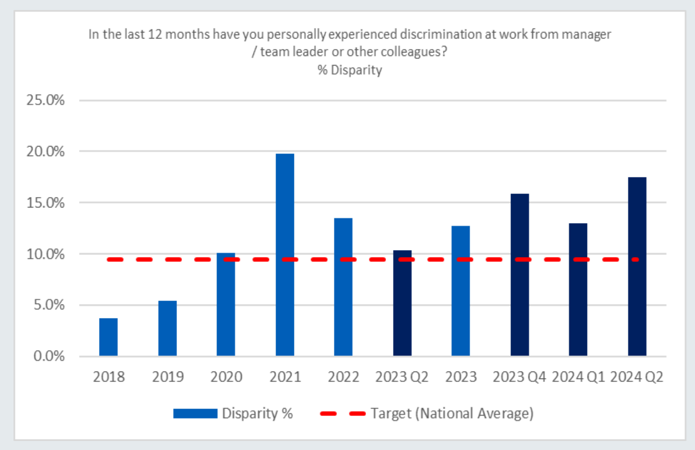
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

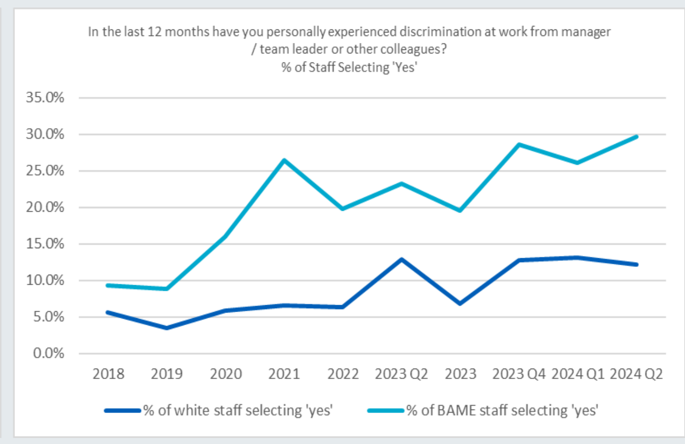
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

Disparity has increased to 17.5% in Q2 (13.1% in Q1). Both white staff and BAME staff are reporting discrimination, white staff has decreased in Q2 from 13.1% to 12.2% and BAME has increased from 26.1% to 29.7%.

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

- The first joint staff network meeting is scheduled for January 2025, when ToR will be agreed. The meeting will also be used to judge entries for the new Trust initiative 'Count Me In'. This is an internal 'grant' that will be used to enable teams to deliver EDI and health inequalities related projects. Communications will be issued week commencing 11.11.24 to promote the project.
- The EDI and HI Annual Report 23-24, WRES, WDES and Gender Pay Gap (GPG) reports were published on 31 October 2024 on our website, fulfilling our statutory duty and NHS mandated duty to publish equalities information.
- The Trust will launch mentoring in November 2024, this will be open to all staff, following a short recruitment period for mentors. An online platform will enable the Trust to make this opportunity available widely because of the use of artificial intelligence (A.I.) which will match mentors and mentees thus reducing the administrative burden; self-paced training can also be accessed via the platform and the reporting function will also identify trends that can support decisions around OD and training and development needs.
- An immersive training pilot programme will be launched in December/January. Three hundred places will be made available to staff over a six-month period. The short workshops (20-30 minutes) support staff to develop soft skills (human capabilities – the human side of work) ranging from inclusion to handling difficult conversations and interview skills. This provides a range of opportunities that align with EDI/HI objectives including helping staff to recognise and address poor behaviour and improving skills that can support career advancement. Training can be undertaken using a desktop PC or laptop, mobile phone, tablet or VR headsets (which can be borrowed from the Academy). The immersive learning opportunity leverages augmented and virtual reality and artificial intelligence (AI) which leads to greater engagement and offers the opportunity for staff to role play in a safe environment and receive constructive feedback to enhance their skills.

Executive Summary

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

There has been a significant and growing financial deficit over the last 4 years at the Trust. Large financial deficits undermine the public trust in the NHS and put the financial viability of the organisation at risk.

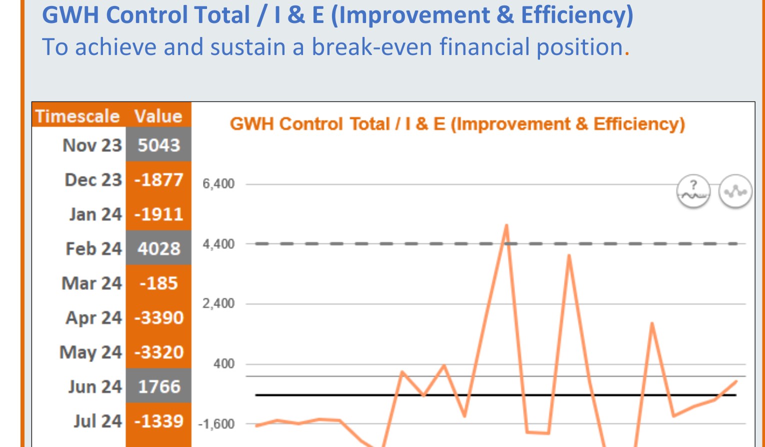
As at M07 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £7.8m, which represents a £2.9m adverse variance to plan. Income is £7.6m favourable to plan driven by overperformances on ERF (£3.4m) and NHSE commissioned drugs (£2.5m). ERF performance is currently 3.1% above the 112% stretch target and is 15.1% above its 2019/20 baseline. The remaining £1.8m of excess income over plan is due to industrial action funding of £0.5m offsetting costs incurred, private patient income of £0.4m and £0.9m of additional education & training/other funding. Pay is £2.6m over plan. The position includes c.£0.5m of junior doctor industrial action costs offset by income and a £1.5m under delivery of pay efficiencies. Ongoing Medical & Dental pressures in the front door areas account for the rest of the pay variance, partially offset by centrally-held reserves (e.g. maternity / paternity leave). Non-Pay is £8.0m over plan, which includes £4.8m of overspends in clinical supplies and outsourcing, particularly within Medicine and Surgery, Women's and Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. Work is ongoing with Procurement and the services to understand the underlying drivers. The non-pay variance also includes £0.8m of undelivered efficiencies, while drug spend is £1.5m over plan, all of which is passthrough related and offset by income. Estates and PFI related costs account for the remaining variance.

The efficiency plan is £2.5m under target at M07 with total savings delivered year to date of £8.6m. The forecast is to deliver £16.3m of savings, which would represent a £5.6m under delivery against the £21.9m target. Of the £8.6m savings delivered year-to-date, 52% is recurrent, which is in line with M06. The focus of divisions and directorates must remain on increasing the 52% delivery of savings on a recurrent basis to reduce the underlying deficit. Pay is a key area for savings with a target to reduce the number of headcount working in the Trust by 263 compared to March 2022 by the end of the year. Tighter controls around the approval of bank shifts, overtime and WLIs are contributing to this, as is ongoing work in reducing temporary staffing. Non-pay, and specifically clinical supplies spend, is the focus of detailed work between Finance, Procurement and divisional teams to understand the key drivers. The analysis has already highlighted some areas where immediate action can be taken to reduce spend, while benchmarking against other system Trusts has flagged further areas for investigation.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.



Timescale	Value
Nov 23	5043
Dec 23	-1877
Jan 24	-1911
Feb 24	4028
Mar 24	-185
Apr 24	-3390
May 24	-3320
Jun 24	1766
Jul 24	-1339
Aug 24	-1033
Sep 24	-801
Oct 24	-200

Counter Measures

- Efficiency savings were £0.1m ahead target in month. Year-to-date the efficiency programme is £2.5m behind plan with pay accounting for £1.5m, income £0.2m and non-pay £0.8m. Of the £8.6m of savings delivered year-to-date, 52% is recurrent.
- The Trust has a £21.9m target for 24/25 with a heavy focus on workforce related reduction schemes (£12m) and specifically reducing the number of funded posts. As mentioned, divisions and services will need to undertake a thorough review of their resources and processes to identify schemes for recurrent delivery. Increasing productivity by meeting the Trust's activity targets and associated ERF income is also a key objective in 24/25

Pillar Metrics

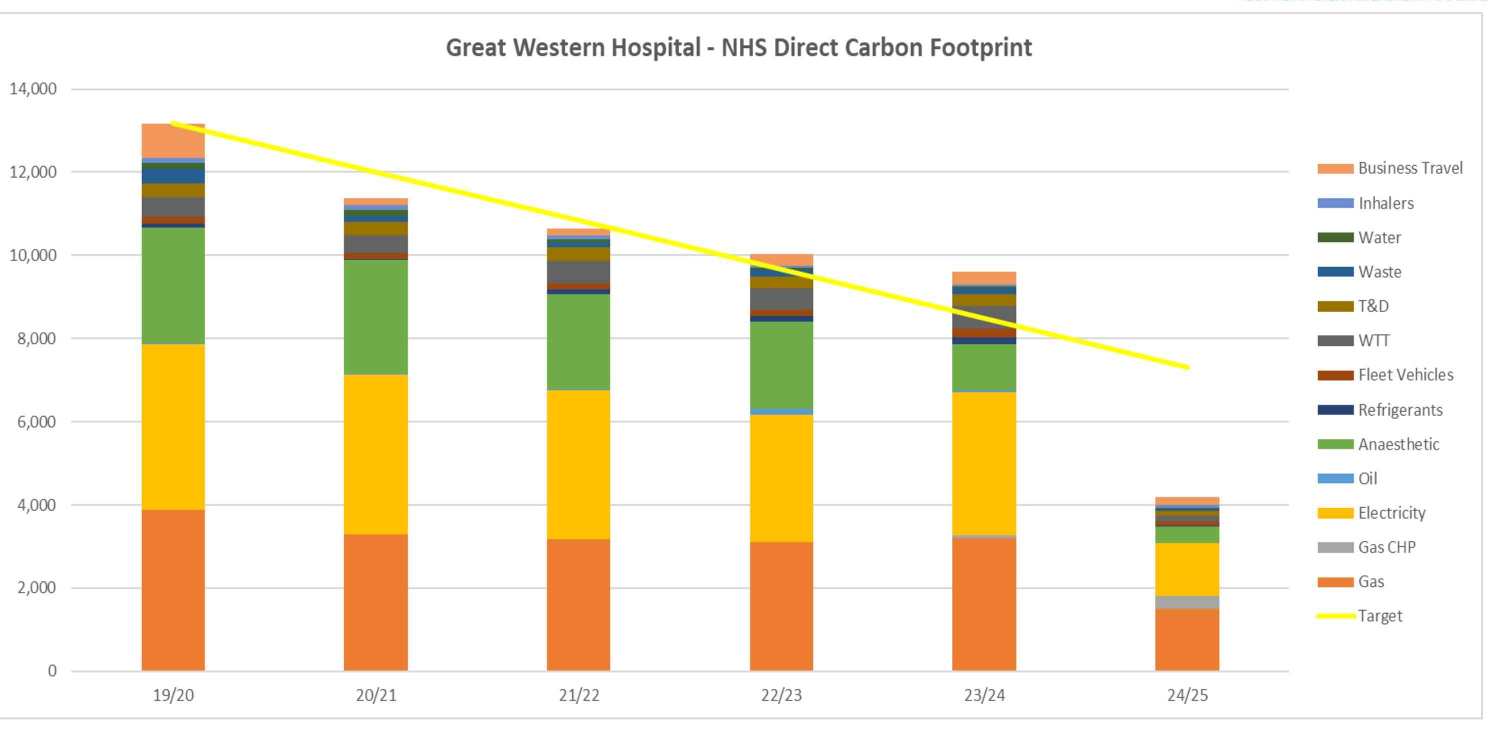
Executive Summary

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.

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.

Note: Data for the current financial year is for half-way through the year heading into the winter months. Some utility billing and reading issues therefore utilities have been estimated for the purpose of reporting.



Counter Measures

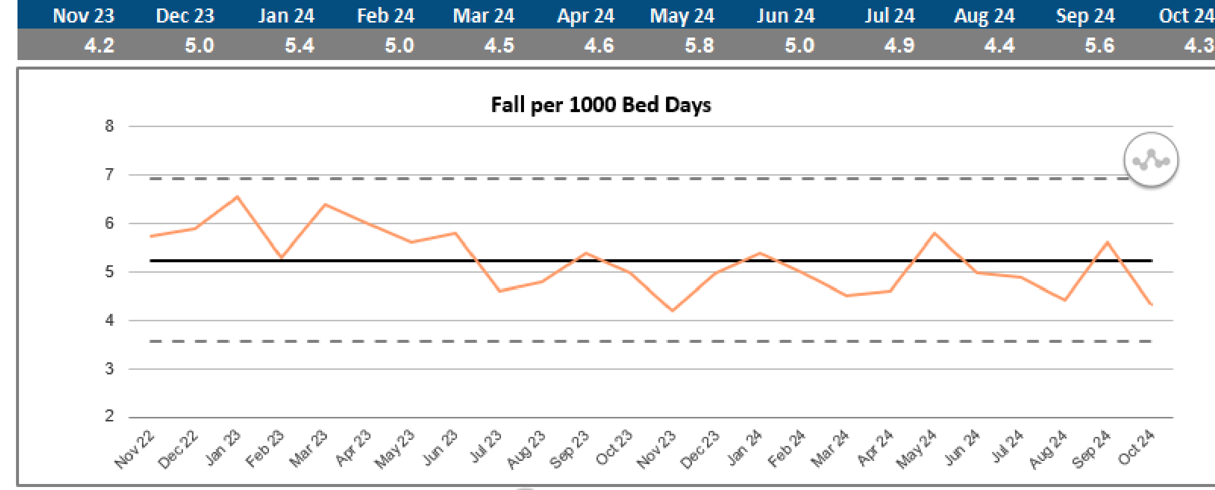
1. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be Net Zero Carbon for direct emissions by 2040 and for indirect emissions by 2045.
2. A heat decarbonisation plan has been completed following a successful Salix funding bid. Unfortunately our bid for phase 5 funding was not reviewed in the lottery style assessment so no funding has been awarded to further this plan.
3. Sustainability Champions launched in GWH and an expansion of sustainability working groups in departments who have larger carbon footprints e.g. Theaters, ED, Endoscopy and a group for Pharmacy is proposed.

Simon Wade
Chief Financial Officer

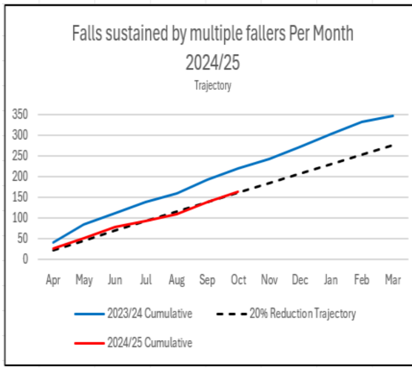
2024/25 Breakthrough Objectives

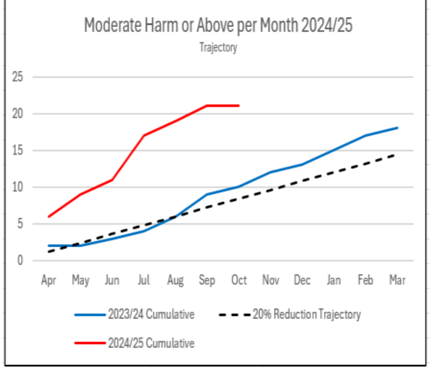
Reducing Falls & Falls With Harm

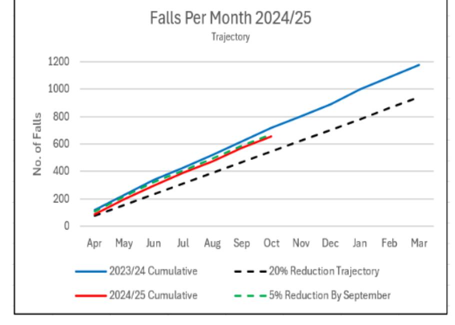
Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
4.2	5.0	5.4	5.0	4.5	4.6	5.8	5.0	4.9	4.4	5.6	4.3



Common cause - no significant change







Understanding the Data

Falls per 1000 bed days will be monitored quarterly to provide benchmarking data. In October, the rate had decreased to 4.3 compared to 5.6 in September.

Aim for 2024/25

Reduction in the number of Total Falls by 20%
Reduction in the number of patients experiencing moderate harm or above by 20%
Reduction in the number of patients that fall more than once by 20%

We are driving this measure because..

Analysis shows that inpatient falls are a top cause of moderate and above harm in the Trust. Between Jan 23-Dec 23, 1274, were reported, nine resulted in moderate harm, five resulted in severe harm, and eight resulted in death. Even when a fall has resulted in no apparent harm, falls can cause psychological distress, prolonged hospital stay and delayed functional recovery.

Reducing inpatient falls will help the Trust to reduce harm, improve experience and reduce the financial burden of increased length of stay, costs of additional surgery/ treatment.

Performance

Inpatient falls has decreased from 102 in September to 83 in October.

The number of falls with moderate harm or above is zero in month. The first time in the past 12 months. Falls sustained in patients who have fallen more than once has decreased to 11 in month (12 in September).

Improvement actions remain focusing on embedding the enhanced care assessment and work, ensuring patients have appropriate footwear Identifying and treating postural hypotension.

Prevention of hospital acquired deconditioning continues with a deconditioning patient story filmed for use in training.

Ward based guidelines for treating postural hypotension have been developed, and first draft shared has been shared with medical team for review and feedback.

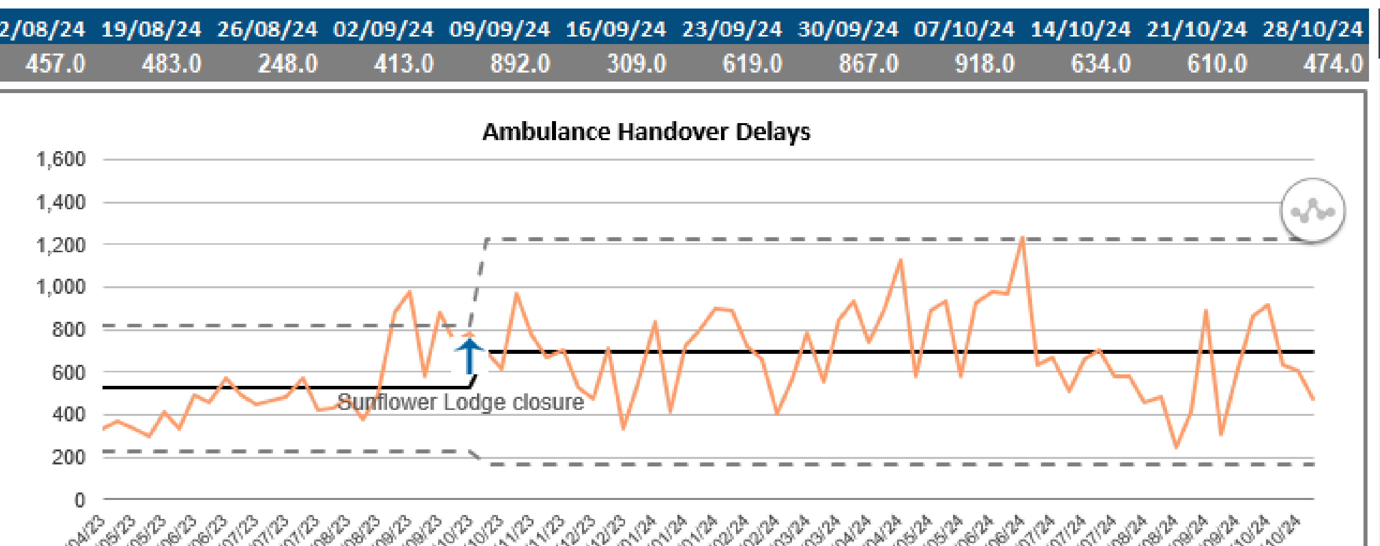
A decaffeinated drinks projected will be commencing on Trauma and Jupiter wards from 1st November and will run for 6 months. The project aims to identify whether switching to decaf drinks reduces fall and urinary related symptoms.

2024/25 Breakthrough Objectives

NHS
Great Western Hospitals
NHS Foundation Trust

Ambulance Handover Delays

12/08/24	19/08/24	26/08/24	02/09/24	09/09/24	16/09/24	23/09/24	30/09/24	07/10/24	14/10/24	21/10/24	28/10/24
457.0	483.0	248.0	413.0	892.0	309.0	619.0	867.0	918.0	634.0	610.0	474.0



Common cause - no significant change

Understanding the Data

This data shows the weekly hours of ambulance resources lost by the South Western ambulance service due to total handover delays reported at the Great Western Hospital.

The data is provided daily by the South Western ambulance service. Work is ongoing to improve data quality and data completeness, as some Ambulance providers may not be included in reporting. September 2024 audits have showed potential discrepancies in SWAST handover data and GWH which is also being reviewed as part of counter-measure actions.

We are driving this measure because...

Ambulance handover delays impact the provision of outstanding care for our patients because patients are more likely to come to harm as result of delays in diagnosis and treatment and access to ongoing care in the hospital. There is also an increased risk of harm to patients in the community because of reduced ambulance resources to respond due to time spent queuing. This in turn is worsening ambulance response times to patients with life threatening emergencies, with national NHS standards not being met.

Performance

An average of 81 hours were lost per day from ambulance handover delays in October compared to the Trust Breakthrough objective of 70 hours. This follows two consecutive months during which the breakthrough objective was met.

There were 19 six hour breaches reported in October, 5 of which breached 8 hours. Data shows that there is currently no evidence of special cause deterioration in handover delays since the opening of the new Emergency Department. However, time in department has increased and 4 hour performance has deteriorated during a month in which Trust bed occupancy increased to 97.1%, with P1-P3 no criteria to reside showing special cause deterioration in the Swindon locality driven by Pathway 2 and Pathway 3 delays.

Whilst performance is significantly improved from the position reported in Quarter 1 of this year (and in comparison to the same period last year), there remains a significant risk to patient safety and care for patients who require emergency treatment due to the inability to offload ambulances at the point of arrival. This is due to critical capacity of the Trust, Emergency Department, and MAU, & flow throughout the Hospital and to system partners (including out of area patients) (Risk ID 731 and 1085).

The Trust has been receiving support from Emergency Care Intensive Support Team (ECIST) since October with a work plan to support the realisation of benefits from the Integrated Front Door, with the relocation of MEU and SDEC scheduled for November.

The EICST support package will support Trust objectives by December to improve rapid assessment and handover processes, increase SDEC volumes and case mix of patients, embed early discharge to the discharge lounge before midday and shape future design of the UEC and flow programme based on findings including but not limited to an ECIST led criteria to admit audit.

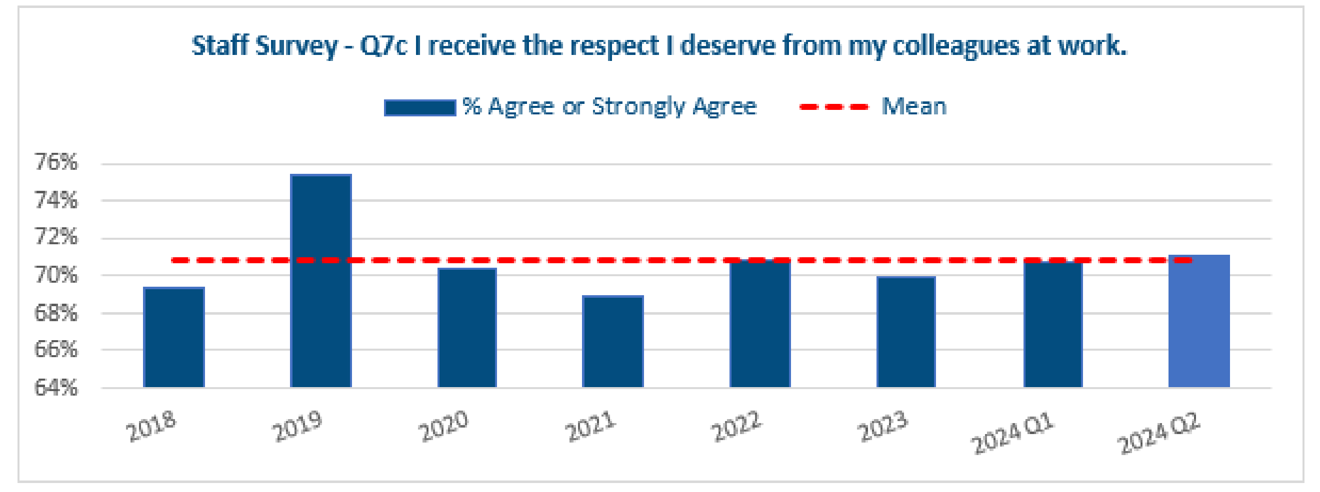
The UEC transformation programme remains focused on delivering sustainable improvements to flow that will be in place before winter and that also support the effective operating of the new department. Findings from the ECIST rapid improvement offer will be incorporated into a review of requirements to be delivered for Phase 2 of the transformation programme later in the winter.

2024/25 Breakthrough Objectives

Great Western Hospitals
NHS Foundation Trust

Staff Survey - Q7c I receive the respect I deserve from my colleagues at work

2018	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024	2024 Q4	2024
69.40%	75.44%	70.37%	68.85%	70.80%	69.96%	70.70%	71.10%			



Understanding the Data

The data shows the percentage of staff positively responding that they receive the respect they deserve from their colleagues at work.

These results are predominantly a measure of engagement and sense of team working. It is important to know if staff feel respected and supported by their immediate teams as there is an intrinsic link to recommending the organisation as a place to work.

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.

Creating an environment where all staff feel they receive the respect they deserve from colleagues at work will help drive overall engagement alongside recommending the organisation as a place to work. There is also a link to absence rates and team working.

Performance

- I receive the respect I deserve from my colleagues at work has seen a small improvement since the annual survey in 2023. Q2 is the most recent data as the current annual survey (Q3 data) is under way.
- The annual NHS Staff Survey launched on 9th September and runs to 22nd November. At week 9 of the Survey, we are achieving a response rate of 68% (4,064 responses), compared to 66% this time in 2023. The People Operations team are conducting ward and community visits, including evening visits to encourage completion and engagement with the Survey.
- The Trust is celebrating world kindness day on the 13th November, encouraging staff to celebrate successes through thank you cards, and promotion in the staff canteen with a stall supported by the People Operations, Health and Wellbeing and Learning and development teams.

Risks

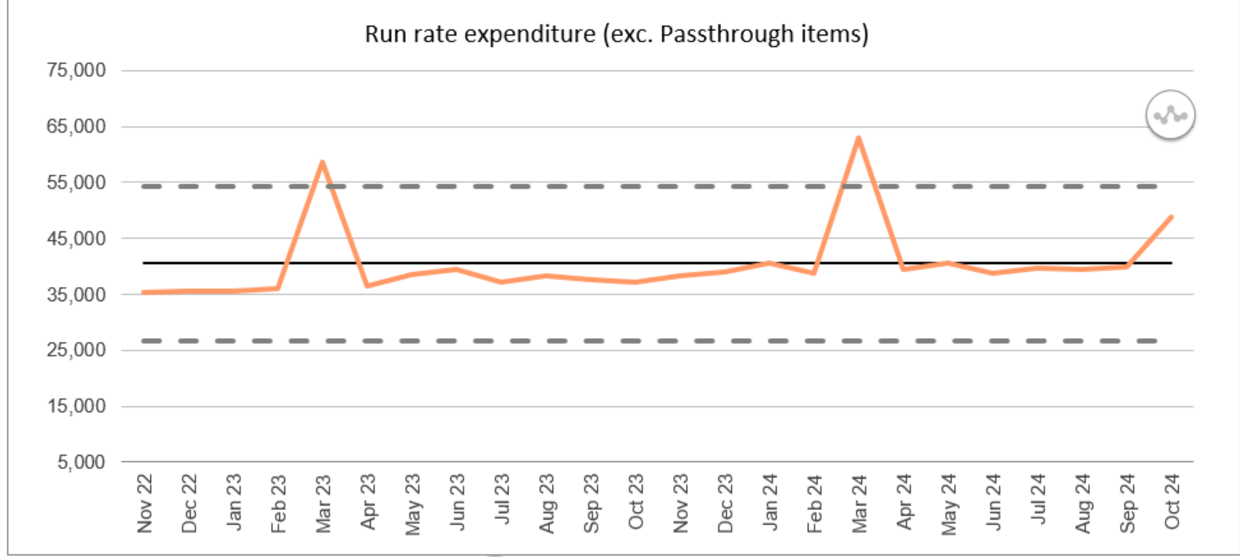
- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change.
- Clinical division's breakthrough objectives whilst aligned to our strategic pillar are not the same as the Trust breakthrough objective, therefore strategic focus is not aligned.

2024/25 Breakthrough Objectives

Great Western Hospitals
NHS Foundation Trust

Financial Recovery

Expenditure	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Total expenditure (excl. passthrough items)	38,412	38,973	40,519	38,664	62,891	39,339	40,664	38,705	39,705	39,538	39,904	48,729
Medicine	12,851	12,636	13,454	12,028	13,002	12,248	12,820	12,457	12,931	11,862	12,206	16,193
SWC	10,496	10,777	10,498	10,513	11,111	10,484	10,848	10,666	10,633	10,818	10,628	15,049
ICC	5,687	5,674	5,715	5,447	5,805	5,397	5,420	5,057	5,578	5,685	5,620	7,188
Corp	7,517	7,595	7,391	7,484	8,361	7,947	8,022	8,014	8,169	8,348	7,971	8,915



Common cause – no significant change

Understanding the Data

The data shows that, if we continue at the current run rate of income and expenditure, we are likely to be c.£15m deficit by year end, compared to a c£10.2m planned deficit. We are also likely to fall short of our CIP target, with a material amount of non-recurrent CIP needing to be found recurrently again next year.

We are driving this measure because…

It is important that we remain within our overall deficit plan for 24/25, having improved the underlying financial deficit position by the financial year end through delivery of recurrent CIP.

The run rate needs to be brought under control, in order to ensure that we do not run out of cash to pay for our daily expenses, or for our capital programme. It also needs to reduce on a recurrent basis, so that we deliver our CIP programme recurrently.

Any non-recurrent CIP delivery will need to be found next year, in addition to efficiency savings expected as part of a normal planning round.

Performance

- As at M05 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £7.6m, which represents a £2.9m adverse variance to plan.
- We are currently £2.5m behind our YTD efficiency plan.
- Non-pay spend analysis for the last year is being completed to provide top contributors for review, and any further grip and control measures.
- Actions focussing on the Countermeasures include:
  - Training offer to be developed for the whole Trust for general financial acumen, using combination of methods of delivery.
  - Financial Data accessible through SBS Business Intelligence System may not be as user-friendly as needed, so we are developing Power BI dashboards.
  - Agreeing the ideal number of requisitioners with Div Tri's and reducing current requisitioners, as appropriate.
  - Validating training offered by SFT Procurement Team and enhancing where needed.
  - Ensuring financial position updates are shared consistently throughout Div Board / specialty boards / team meetings etc.

Risks

- Significant risk to staff morale and engagement due to current financial challenges and requirement to reduce our workforce to deliver recurrent savings (pay is c70% of our cost base).
- Competing demands on reduced workforce in Finance

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)	?	62%	68%	72%	58%	
	No. of complaints received	SPC	H	70	79	64	56	
	Number of reopened complaints	SPC	H	0	1	1	5	
FFT	Overall response rate (%)	28% (Int)	?	25.8%	26.1%	32.0%	26.2%	
	Positive response (%)	90% (Int)	?	88.1%	89.8%	89.8%	87.8%	
	ED & UTC Response Rate	15% (Int)	?	15.1%	15.7%	15.3%	14.2%	
	Inpatients Response Rate	21% (Int)	?	21.0%	19.5%	23.7%	20.8%	
	Daycases Response Rate	22% (Int)	?	21.1%	20.5%	24.5%	20.9%	

	H / L	H / L	?	P	F
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 October complaint response rate fell to 58%
A3 meetings using the Improving Together methodology are continuing with the focus to reduce the backlog of overdue complaints before larger scale improvements. A new Complaints Policy has been drafted in line with improvement work. Complaint writing training, co-delivered with a legal firm was well attended and well received.

The overall number of complaints received in month has reduced to 56 from previous month of 64. However, there remains between 100 and 120 cases open at any given time. Benchmarking with BSW also underway to look at standards and key performance indicators.

The FFT overall response has decreased and is below the internal target of 28%. The positive response rates remains just below target. The Emergency Department (ED) and Urgent Treatment Centre (UTC) and Day Case response rates have all decreased and are all now below the internal target.

Risks

- Rise in backlog of complaints and failure to respond in a timely manner is negatively impacting on patient experience. Additional resource is being provided to Division of Medicine to clear backlog.

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24
Harm	Patient safety incident investigation	SPC		0	2	2	4
	Falls rate per 1000 bed days	SPC	L	4.9	4.4	5.6	4.3
	No. of Falls in month	SPC	L	93	81	102	83
	No. falls with moderate harm or above	SPC		5	2	2	0
	Medication incidents with moderate harm	SPC		1	3	2	2
	Pressure Ulcer (Hospital Acquired)	SPC		25	25	14	11
	Pressure Ulcer (Community Acquired)	SPC		25	20	17	25
Concerns and Complaints	No. of concerns received	SPC		441	365	294	316
IP & C	C.Diff	6.42		4	2	8	10
	MRSA	0		0	0	0	0
	MSSA	2.00		2	4	1	2
	E.coli	8.33		10	5	7	9
	Klebsiella	2.92		3	3	1	4
	Pseudomonas	2.50		5	2	2	1
	COVID (hospital acquired)	SPC		29	19	16	15

Performance & Counter Measure

There are 12 Patient Safety Incident Investigations (PSII) in progress. There were four PSII's reported in month of October, two have been declared as Never Events, wrong site surgery and retained foreign object. In addition to the individual PSII's an overarching investigational review of the recent cluster of never Events has been commissioned.

The number of falls has decreased in month to 83 (102 in September). There has been no falls with moder harm or above in month. This is the first month in the last rolling 12 months.

Hospital-acquired category 2-4 pressure ulcers have continued to decrease. Of the 11 reported, seven were category 3 and 4 were category 2. With an increase in the level of harm seen the Tissue Viability Nurse (TVN) team are working with top contributing wards to drive further improvements and ensure early reporting and actions are being taken.
There were 25 community pressure ulcer harms in October (17 in September) involving 15 patients. Six of these harms were associated with patients on an end-of-life pathway. The majority of harms were reported at Category 2 (10) with zero category four harms identified. All deep tissue injuries occurred in patients receiving End-of-Life Care. The improvement actions include face to face training sessions and a training video that has been shared widely.

Although *C.diff* numbers have increased again this month, the Trust remains below its target trajectory and below last year's numbers. Two cases on Meldon Ward within 28 days means that a Period of Increased Incidence has been declared, thus the cases will be investigated in detail and various measures will be implemented to confirm best practice and to mitigate risk. Methicillin-sensitive Staphylococcus aureus (MSSA) numbers remain historically low and there have been zero Methicillin-resistant Staphylococcus aureus (MRSA) cases so far this year. There has been a slight rise in *E. coli* and *Klebsiella* cases however the number attributed to urinary infections continues to decrease each month, which may be related to the continued focus on catheter care. *Pseudomonas* numbers remain well below last year's.

The number of concerns received remains high at 316, a slight increase from September.

Risks

Work is ongoing to address the requirement of the Accessible Information Standard and Equality Act. This includes a communication toolkit in al clinical areas and ongoing work with the implementation of EPR.

There continues to be concerns raised by patients and staff regarding the lack of disability access within GWH in line with Equality Act requirements. This is to be discussed at the next Inclusion and Health Inequalities meeting.

Our Care

Non-Alerting Watch Metrics

NHS
Great Western Hospitals
NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	94.7%	93.0%	93.1%	95.6%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	108.0%	103.5%	102.9%	101.6%
FFT	ED & UTC Positive Responses	79% (Int)	?	78.9%	84.1%	78%	76%
	Inpatients Positive Responses	89% (Int)	?	91.4%	89.8%	92.3%	91.0%
	Daycases Positive Responses	95% (Int)	?	95.2%	95.0%	96.6%	95.2%
	Outpatients Positive Responses	97% (Int)	?	97.5%	98.4%	97.9%	97.7%
	Maternity Response Rate	21% (Int)	?	25.3%	22.2%	21.8%	25.9%
	Maternity Positive Responses	92% (Int)	?	92.9%	92.5%	91.4%	92.7%

Common cause	H / L (concerning)	H / L (improving)	?	P	F
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 remain above the National target and are within safe parameters.

The inpatient positive response rate has decreased slight but remains above the target of 88%.

The maternity response rates have increased in October and are now above the internal target of 92%.

The review of the complaint process using Improving Together has been completed, using A3 methodology. Initial themes and actions have been identified to streamline the process and reduce delays.

Further complaints training sessions have been held for complaint managers. There was good multidisciplinary engagement and positive feedback received regarding supporting the approach and investigations.

A Trust board ‘Change the narrative’ public engagement session aimed at hearing lived experience of the challenges of accessing our services has been held.

A public engagement session held to gain feedback into how the Trust publishes our maternity/birth statistics. A large amount of feedback was received with review of dashboard and information underway as a result.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24	Trend
RTT	No. of >=18 weeks waiters		H	20650	21130	20968	19986	
	No. of >=52 weeks waiters		H	1941	2072	1924	1637	
DM01	No. of patients on DM01 waitlist			8819	7392	6907	One month behind	
	DM01 performance %	99% (Nat)	F	70.7%	75.8%	80.3%	One month behind	
	DM01 6 week wait breaches		H	2582	1789	1362	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	68.1%	70.3%	70.8%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	94.9%	96.0%	87.8%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	45.2%	68.1%	87.2%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	75.2%	81.8%	78.8%	One month behind	

	H	L	H	L	?	P	F
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

Diagnostics

Octobers validated DM01 performance is showing an increase in performance variance from the 80.28% performance in September to 88.45% - this is the highest DM01 since February 2020. The number of patients on the waiting list has decreased by 268 to 6,639 driven by the by the continued work to improve NOUS. There are now only 767 patients waiting over 6 weeks Vs 8301 in October 2023

Counter measures: Radiology now have a specialist CT outsourcing provider to support on the mobile pads with complex scans which make up the majority of the long waiters (Cardiacs and Colons). Activity for the imaging vans on the CDC site is now achieving 90% utilisation for MRI and CT. Ultrasound still remains the largest issue with 1,783 on the waiting list but now only 183 over 6 week. Medicare continue to support US activity. A locum sonographer is also being sourced to help with the more complex long waiters.

Cancer

61.4% of the 62-day breaches were with the Plastics, Colorectal & Urology pathways.

31D performance fell in September due to outpatient capacity in the Skin pathways, accounting for 58.3% of the 24 pathway breaches. Elective capacity in Gynae, Colorectal, Urology & Breast accounted for 20.8%.

Cancer waiting times for first appointment remain below standard. Colorectal and Urology are the largest contributors with 60.9% of all breaches. Capacity for outpatients were the main factors in these breaches (62.8%).

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	77.1%	79.5%	77.4%	72.6%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	5.2%	2.7%	3.7%	5.7%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	58.2%	60.7%	57.7%	52.9%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	10.7%	5.6%	7.5%	11.1%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2296.43	1452.14	2000.45	2583.35	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1691	1660	1740	1742	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	89%	82%	86%	91%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1213	940	1118	1257	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	64.1%	46.6%	55.5%	65.7%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	781	499	664	837	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	41.3%	24.8%	33.0%	43.8%	
Flow	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	340	299	324	365	
	Community Average Length of Stay (Days)	SPC	H	22	18	18	15	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4 hour performance (type 1 and 3) decreased from 77.4% to 72.6%. This is 5.4% below the 23/24 national target. The reduction in performance relates to type 1 performance reducing across admitted and non admitted from 57.7% to 52.9%.

Total % over 12 hours has risen from 7.5% to 11.1% indicating an increase in overcrowding of the department.

Ambulance handover delays over 15 minutes increased from 2000 hours to 2583 hours (phase 1 breakthrough objective = 2100 hours) showing growing pressure on the Emergency Department.

Number of ambulance handovers over 30 minutes has increased from 1118 to 1257.

Number of ambulance handovers over 60 minutes increased from 33% to 43.8%

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

Icon	Meaning
(grey)	Common cause - no significant change.
H / L (orange)	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.
H / L (blue)	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.
P	Variation indicates consistently (P)assing the target.
F	Variation indicates consistently (F)alling the target.

Our Performance

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24
RTT	No. of >=78 weeks waiters	SPC		3	12	6	5
Cancer	No. of referrals received	SPC		2035	1756	1831	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		95.1%	97.2%	97.1%	92.9%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)		0.0%	0.0%	0.0%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5525	5235	5531	5742
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		82.6%	78.8%	80.9%	84.7%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		60.8%	64.5%	61.6%	60.9%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		52.6%	57.9%	58.6%	55.8%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)		183	175	196	208
	Emergency Care - AED - Median Stay	240 (Int)		237	237	238	240
	Emergency Care - UTC - Median Stay	240 (Int)		140	131	153	156
	Total Number of Ambulance Handovers	SPC		1891	2016	2014	1912
	Average hours lost to ambulance handover delays per day	SPC		71	45	65	81

Performance & Counter Measure

ED

Number of ambulance conveyances have reduced to 1912 from a high of 2016 in August, and down from 2014 in previous month. Average hours lost increased in October from 65 to 81.

Triage performance for ED has remained static at 60.9%. Significant improvement in Type 3 triage performance now that additional capacity is in place (55.8%).

Median stay has remained static at 240 mins in ED and a in median stay seen in UTC has risen to 156 mins.

Risks

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

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		524	407	444	530
	Elective Patients Average Length of Stay (Days)	SPC	L	3	3	3	2
	Non-Elective Patients Average Length of Stay (Days)	SPC	L	5	4	5	4
	GWH Discharges by Noon (%)	SPC		17.2%	17.5%	15.6%	16.8%
	Number of Stranded Patients (over 14 days)	SPC		130	95	94	104
	Number of Super Stranded Patients (over 21 days)	SPC		78	54	49	54
	Adult general and acute type 1 bed occupancy	SPC		94.5%	91.2%	95.8%	97.3%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	L	20.1%	10.7%	13.4%	15.7%
	Proportion of patients discharged from hospital to their usual place of residence	SPC	H	95.7%	95.5%	95.6%	95.8%

	H	L	H	L	?	P	F
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

Patient Flow

- 86 minute deterioration in average time in department during October comparted to previous month. New ED processes being embedded with specific work to reduce time in rapid assessment cubicles and reduce the number of patients experiencing 12 hour delays from decision to admit.
- Bed occupancy increased in month and Trust wide no criteria to reside also correlating with deterioration in ambulance handover delays and 4 hour performance.
- NHS England emergency care intensive support in place with focus on clinical criteria for admission, ED handover processes and benefits realisation for Medical Assessment Unit and Same Day Emergency Care Flow in November and December.
- Trust wide UEC Flow and Transformation programme phase 2 being scoped for Spring.
- Rapid Ambulance Handover Standard Operating procedure being reviewed to reduce delays over 75 minutes with anticipated launch during November.

Risks

There is a risk of ongoing ambulance handover delays if overall bed occupancy and no criteria to reside does not reduce further, however it is heading in a downward trajectory. 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 positivity impact on NCTR reduction.

Use of Resources

Watch Metrics

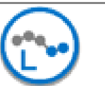
Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24
Use of Resources	Capital Expenditure (£'000)	SPC		2325	3463	1474	Waiting for data
	Pay (£'000)	SPC		25158	26170	25648	34801
	Non Pay (£'000)	SPC		17712	16549	17727	17381

Performance & Counter Measure

Year-to-date capital spend at M7 is £14.5m against a plan of £23.1m, giving an underspend against plan of £8.6m. Key drivers are EPR, CDC and Way Forward Programme.

Pay costs are £9.2m higher than M6 due to AfC and medical pay awards paid in M7.

Non-Pay is £0.3m lower than M6 driven by outsourcing costs in Dermatology being lower than prior month and CDC actual costs being lower than accruals.

					
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.

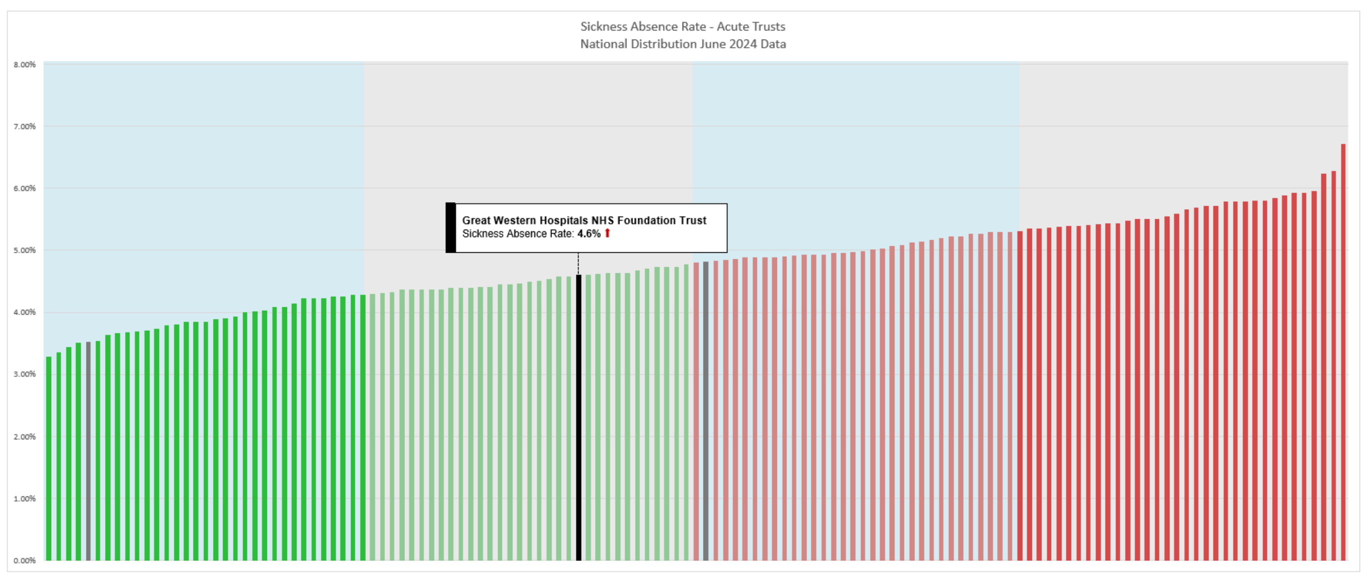
Risks

The Trust started the year with a £21.9m cash releasing efficiency plan. As at M7 delivery is £2.5m behind plan with 52% of the £8.6m delivered being recurrent. The risk is that any unmet or non-recurrent delivery adds to the underlying deficit of the Trust. Divisions and services must work to develop recurrent cash releasing schemes. There is a key focus on workforce savings in 24/25, with pay schemes accounting for £12m of the £21.9m plan.

Our People

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	5.2%	4.5%	4.3%	One month behind	



Performance & Counter Measure

- Sickness absence decreased further in September from 4.5% to 4.3%, broadly in line with the position this time last year. Short term absence increased in month to 2.14%, however long term absence decreased significantly from 2.8% to 2.12%. Absence relating to Stress/Anxiety/Depression continues to drive the majority of absence, however levels have decreased slightly in September from 24% to 22% of all absence. There has been a slight increase to Gastrointestinal related absence which accounts for 10% of absence however remains in line with the reasons for sickness this time last year and usual winter illness.

- The Trust Improving Attendance working group are focusing on reviewing the Trust Policy as requested by the Trust working group. Benchmarking has been completed and the national team progressing with a national policy with consideration of removing triggers. The impact of removing triggers needs to be assessed before the Trust can adopt this approach. Timescales for review and implementation is January 2025.

- Current benchmarking data (NHS Digital – June 2024) shows an increase to both National and Regional absence rates in June. National absence increased from 4.71% to 4.87%, and South-West sickness from 4.56% to 4.69%. As a provider we remain below both these comparators, although saw a similar trend with an increase to absence in June, increasing from 4.2% to 4.6%. We remained in the second-lowest quartile for Acute Trusts in this period, ranking 55th out of 133 Organisations.

Risks

- Increased sickness rate as per national trend during winter.

- Vacancy and frozen roles in People Services could impact line management support to reduce sickness.

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

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-24	Aug-24	Sep-24	Oct-24
Workforce	% of leavers within 1st year of employment	14.8% (Int)		9.6%	11.0%	10.6%	One month behind

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	69.0%
	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
	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%	56.5%

Performance & Counter Measure

- Leavers within their 1st year of employment decreased marginally in September to 10.6%, remaining below the target of 14.8%.
- The annual Staff Survey launched on 9th September and a final response rate will be available at the end of November. The Trust is aiming to improve on the response rate of 69% last year and remain in the top 5 Acute/Acute & Community Trusts nationally. As at week 9 of the 2024 survey, we have achieved a response rate of 68%.

Risks

- Turnover has remained stable for 12 months, changes at senior level and the impact of financial recovery workstreams 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

Type	Metric	Unit/Measure	Target	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Trend Vs	
																	Last Month	Oct-23
	Vacancy																	
W	Vacancy Rate	%	7.00%	4.33%	3.93%	3.74%	4.12%	4.11%	3.93%	4.19%	4.04%	3.98%	3.44%	3.82%	3.53%	3.31%	↓	↓
W	Vacancy Rate	WTE	-	232.95	211.39	201.47	223.67	223.82	213.76	227.43	219.66	216.12	186.71	207.11	191.29	179.89		
W	All Nursing Vacancy	%	7.00%	1.30%	1.94%	1.43%	2.75%	2.39%	2.21%	2.20%	1.73%	1.73%	0.96%	1.30%	0.64%	0.72%	↑	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	34.17	51.03	37.87	73.60	63.97	59.14	58.90	46.13	46.07	25.61	34.47	17.00	19.26		
W	All Registered Nursing Vacancy	WTE	-	18.62	26.55	9.50	28.02	14.37	9.70	4.67	4.75	14.57	5.24	0.02	-27.25	-36.48		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg	WTE	-	3.60	8.44	-3.79	5.29	-3.91	-7.35	-19.60	-12.95	-3.59	-11.35	-23.55	-47.80	-49.08		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	15.55	24.48	28.37	45.58	49.60	49.44	54.23	41.38	31.50	20.37	34.45	44.25	55.74		
W	Medical Vacancy	%	7.00%	5.66%	5.26%	5.89%	7.07%	7.96%	7.47%	8.30%	6.78%	6.67%	7.82%	10.39%	8.99%	7.84%	↓	↑
W	Medical Vacancy	WTE	-	41.48	38.61	43.30	53.08	59.82	56.06	62.23	50.71	49.94	58.44	77.65	67.20	58.64		
W	STT/AHP Vacancy	%	7.00%	9.20%	6.88%	6.44%	4.87%	4.78%	3.74%	3.39%	3.67%	3.63%	3.00%	2.30%	3.92%	4.31%	↑	↓
W	STT/AHP Vacancy	WTE	-	79.85	58.89	54.92	41.53	40.83	31.72	28.78	31.27	30.91	25.62	19.64	33.48	37.01		
W	SMA Vacancy	%	7.00%	6.70%	5.44%	5.66%	4.80%	5.09%	5.76%	6.68%	7.77%	7.58%	6.57%	6.44%	6.30%	5.55%	↓	↓
W	SMA Vacancy	WTE	-	77.45	62.86	65.38	55.46	59.20	66.84	77.52	91.55	89.20	77.04	75.35	73.61	64.98		
W	Recruitment Time to Hire - AFC	Days	46.00	42.70	41.80	43.50	44.40	42.70	38.40	39.50	39.40	43.20	40.40	43.80	44.10	42.80	↓	↑
W	Recruitment Time to Hire - Bank	Days	46.00	37.00	39.90	45.20	42.00	50.30	39.30	43.30	33.30	44.00	22.90	-	30.30	26.70	↓	↓
W	Recruitment Time to Hire - Medical	Days	46.00	-	-	-	64.30	66.10	32.60	39.00	39.44	35.30	44.20	57.40	37.25	38.40	↑	↓
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,379.33	5,382.66	5,382.34	5,431.15	5,446.50	5,433.90	5,433.90	5,437.81	5,434.79	5,430.70	5,427.80	5,424.66	5,442.77		
W	Substantive WTE	WTE	-	5,146.38	5,171.27	5,180.87	5,207.48	5,222.68	5,220.14	5,206.47	5,218.15	5,218.67	5,243.99	5,220.69	5,233.37	5,262.88		
W	Additional Substantive WTE	WTE	-	26.89	24.63	25.22	21.90	22.51	24.78	20.17	5.53	8.24	9.23	6.30	7.64	9.62		
W	Bank WTE	WTE	-	280.45	260.02	246.43	295.57	294.32	380.50	286.32	301.97	326.11	333.04	333.94	318.99	325.94		
W	Agency WTE	WTE	-	66.71	60.65	55.12	61.82	69.47	60.09	49.52	43.70	38.63	45.95	44.39	30.74	39.41		
W	Budgeted vs Worked WTE Variance	WTE	-	141.10	133.91	125.30	155.62	162.48	251.61	128.59	131.54	156.87	201.51	177.52	166.07	195.08		
W	Actual Worked vs Budgeted %	%	-	102.62%	102.49%	102.33%	102.87%	102.98%	104.63%	102.37%	102.42%	102.89%	103.71%	103.27%	103.06%	103.58%		
W	Total Workforce Cost £	£	-	£25.47M	£24.85M	£25.09M	£25.67M	£25.39M	£25.92M	£25.13M	£25.50M	£25.21M	£25.57M	£25.87M	£25.27M	£36.50M		
W	Agency Spend as % of Total Spend	%	4.50%	4.56%	3.56%	1.22%	2.83%	2.83%	2.04%	1.83%	1.30%	2.01%	1.94%	1.58%	1.01%	1.23%	↑	↓
W	Agency Spend £	£	-	£1.16M	£0.89M	£0.30M	£0.73M	£0.72M	£0.53M	£0.46M	£0.33M	£0.51M	£0.50M	£0.41M	£0.26M	£0.45M		
W	Agency Target £	£		£1.07M	£0.91M	£1.10M	£0.91M	£0.86M	£0.96M	£0.54M	£0.52M	£0.51M	£0.49M	£0.47M	£0.46M	£0.44M		
W	Agency Spend vs Target £	£ Diff	£0.00M	£0.09M	-£0.03M	-£0.79M	-£0.18M	-£0.14M	-£0.44M	-£0.08M	-£0.19M	£0.00M	£0.01M	-£0.06M	-£0.20M	£0.01M	↑	↓
W	Bank Spend £	£	-	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	£1.89M	£2.02M	£2.23M	£2.32M	£2.04M	£1.88M	£2.29M		
W	Bank Target £	£		£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£2.19M	£2.12M	£2.04M	£1.96M	£1.88M	£1.81M	£1.73M		
W	Bank Spend vs Target £	£ Diff	£0.00M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	-£0.31M	-£0.10M	£0.19M	£0.36M	£0.15M	£0.07M	£0.56M	↑	↓
W	Registered Nursing Bank Fill	%	45.00%	84.87%	86.80%	87.74%	90.73%	90.69%	90.40%	90.86%	94.13%	90.81%	85.23%	82.25%	85.50%	83.28%	↓	↓
W	Unregistered Nursing Bank Fill	%	70.00%	79.99%	84.45%	81.80%	80.12%	79.46%	78.92%	81.89%	87.18%	86.23%	79.50%	77.63%	78.67%	71.95%	↓	↓

Our People

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Trend Vs	
																	Last Month	Oct-23
	Retention																	
W	All Turnover %	%	13.00%	12.20%	12.00%	11.49%	10.98%	10.90%	10.72%	10.85%	10.57%	10.24%	10.47%	10.91%	10.70%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	9.20%	9.19%	8.89%	8.55%	8.56%	8.45%	8.62%	8.53%	8.02%	7.90%	8.66%	8.50%	-	↓	↓
W	Number of Leavers	Headcount	-	41	44	42	44	40	62	44	46	58	45	70	57	-		
W	Number of RN Leavers	Headcount	-	11	14	11	21	10	15	12	17	20	14	15	10	-		
W	Registered Nursing Vol Turnover	%	-	6.57%	6.95%	6.99%	7.07%	7.16%	7.19%	7.33%	7.52%	7.17%	7.36%	7.70%	7.30%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	10	8	15	7	11	13	11	10	13	6	12	14	-		
W	Unregistered Nursing Vol Turnover	%	-	12.65%	12.34%	11.86%	12.01%	11.21%	10.87%	11.16%	11.00%	10.91%	10.69%	11.10%	10.34%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	14.44%	13.35%	13.96%	12.14%	11.86%	11.72%	10.68%	9.74%	10.98%	9.57%	11.00%	10.62%	-		
W	Number of starters	Headcount	-	65	73	39	86	38	52	62	44	64	60	69	102	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	4.48%	4.56%	4.67%	4.72%	4.67%	4.59%	4.55%	4.51%	4.52%	4.58%	4.58%	4.58%	-	↑	↑
D	Sickness Absence %	%	3.50%	4.74%	4.72%	5.00%	4.92%	4.37%	4.16%	4.21%	4.20%	4.61%	5.20%	4.58%	4.26%	-	↓	↓
W	Long Term Sickness %	%	2.00%	2.42%	2.41%	2.67%	2.64%	2.41%	2.24%	2.24%	2.32%	2.44%	2.90%	2.80%	2.12%	-	↓	↓
W	Short Term Sickness %	%	1.50%	2.32%	2.31%	2.33%	2.28%	1.96%	1.92%	1.97%	1.88%	2.17%	2.30%	1.78%	2.14%	-	↑	↓
W	Sickness Absence Cost £	£	-	£738.9k	£726.5k	£794.0k	£777.2k	£647.1k	£669.2k	£675.4k	£708.3k	£748.9k	£.0k	£755.3k	£727.5k	-		
W	WTE Days Lost	WTE	-	7,487.3	7,187.9	7,922.9	7,774.7	6,566.1	6,618.1	6,482.7	6,662.1	7,157.7	8,351.6	7,372.3	6,700.5	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	90.75%	91.38%	91.88%	91.49%	91.72%	92.31%	92.46%	91.37%	91.59%	92.42%	89.84%	89.85%	90.58%	↑	↓
W	Role Essential MT %	%	85.00%	92.20%	92.77%	93.14%	92.92%	93.28%	93.79%	94.03%	91.84%	92.30%	94.14%	89.00%	89.52%	90.57%	↑	↓
W	CQC Safe MT %	%	85.00%	89.32%	90.01%	90.64%	90.07%	90.16%	90.85%	90.90%	90.86%	90.84%	90.71%	90.88%	90.25%	90.58%	↑	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	83.26%	83.85%	85.24%	86.22%	85.23%	86.51%	84.26%	83.54%	82.60%	84.77%	86.96%	82.88%	82.42%	↓	↓
W	Appraisal Compliance %	%	85.00%	84.92%	83.62%	85.63%	84.32%	84.85%	85.26%	84.18%	84.39%	84.74%	84.88%	84.67%	84.09%	84.90%	↑	↓
W	Non Medical Appraisal Compliance %	%	85.00%	84.91%	83.81%	85.37%	84.06%	84.37%	84.59%	84.40%	83.99%	84.87%	84.95%	84.71%	84.37%	84.94%	↑	↑
W	Medical Appraisal Compliance %	%	85.00%	85.04%	82.25%	87.59%	86.32%	88.38%	90.10%	82.58%	87.32%	83.81%	84.40%	84.38%	82.07%	84.58%	↑	↓

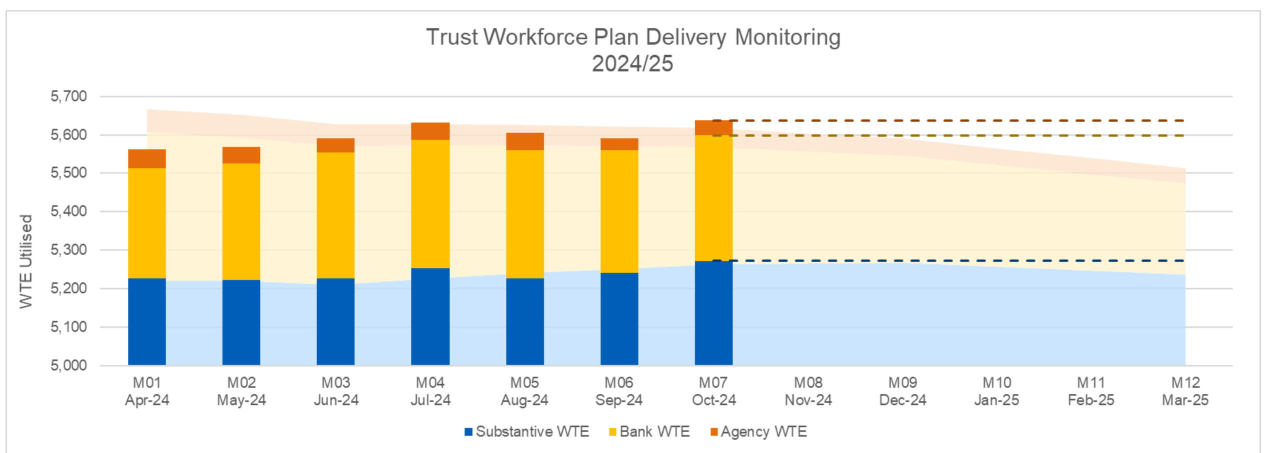
Our People

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Trend Vs	
																	Last Month	Oct-23
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.12%	4.21%	4.19%	4.23%	4.26%	4.28%	4.28%	4.23%	4.26%	4.29%	4.25%	4.21%	4.28%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	258.00	265.00	264.00	268.00	271.00	272.00	272.00	269.00	271.00	273.00	273.00	271.00	276.00		
W	% of Leadership Roles who are Female (B8a+)	%	-	70.93%	71.32%	71.59%	71.27%	71.22%	70.59%	70.59%	69.89%	70.11%	70.33%	70.70%	70.11%	70.29%		
W	% of Leadership Roles who from BME (B8a+)	%	-	6.20%	6.79%	6.82%	6.34%	6.64%	6.25%	6.25%	6.32%	6.64%	6.59%	6.23%	6.27%	6.16%		
W	Staff in Leadership Roles % (B8c+)	%	-	0.91%	0.92%	0.89%	0.90%	0.90%	0.90%	0.94%	0.94%	0.94%	0.96%	0.93%	0.93%	0.90%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	57.00	58.00	56.00	57.00	57.00	57.00	60.00	60.00	60.00	61.00	60.00	60.00	58.00		
W	% of Leadership Roles who are Female (B8c+)	%	-	56.14%	56.90%	57.14%	56.14%	56.14%	56.14%	56.67%	56.67%	56.67%	57.38%	58.33%	56.67%	56.90%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.26%	5.17%	5.36%	3.51%	3.51%	3.51%	3.33%	3.33%	3.33%	3.28%	3.33%	3.33%	3.45%		
W	% of Leadership Roles who are disabled (B8c+	%	-	1.75%	1.72%	1.79%	1.75%	1.75%	1.75%	1.67%	1.67%	1.67%	1.64%	1.67%	1.67%	3.45%		
W	Male % of Workforce	%	-	18.36%	18.40%	18.29%	18.33%	18.32%	18.36%	18.39%	18.52%	18.51%	18.56%	18.48%	18.32%	18.40%		
W	Female % of Workforce	%	-	81.64%	81.60%	81.71%	81.67%	81.68%	81.64%	81.61%	81.48%	81.49%	81.44%	81.52%	81.68%	81.60%		
W	BME % of Workforce	%	-	25.47%	25.68%	25.98%	26.08%	26.12%	26.36%	26.56%	26.76%	27.05%	27.31%	27.53%	27.99%	28.30%		
W	White % of Workforce	%	-	66.58%	66.32%	66.19%	65.84%	65.76%	65.61%	65.36%	65.09%	64.99%	64.84%	65.00%	64.54%	64.41%		
W	ER Cases Closed	Number	-	30	28	40	42	45	24	19	57	44	53	46	39	41		

Our People

Workforce Scorecard - Workforce Planning



		M01 Apr-24	M02 May-24	M03 Jun-24	M04 Jul-24	M05 Aug-24	M06 Sep-24	M07 Oct-24	M08 Nov-24	M09 Dec-24	M10 Jan-25	M11 Feb-25	M12 Mar-25
Total Workforce	Plan	5,667	5,651	5,627	5,627	5,626	5,621	5,618	5,604	5,591	5,565	5,539	5,514
	Actual	**5,562**	**5,569**	**5,592**	**5,632**	**5,605**	**5,591**	**5,638**	0	0	0	0	0
	Variance	-104	-82	-35	5	-21	-30	20	-	-	-	-	-
Substantive	Plan	5,220	5,220	5,211	5,227	5,241	5,252	5,264	5,266	5,268	5,258	5,247	5,237
	Actual	**5,227**	**5,224**	**5,227**	**5,253**	**5,227**	**5,241**	**5,272**	0	0	0	0	0
	of which Overtime	**20**	**6**	**8**	**9**	**6**	**8**	**10**	0	0	0	0	0
	Variance	6	4	16	26	-14	-11	8	-	-	-	-	-
Bank	Plan	387	373	359	346	332	318	305	291	277	264	250	237
	Actual	**286**	**302**	**326**	**333**	**334**	**319**	**326**	0	0	0	0	0
	Variance	-100	-71	-33	-13	2	1	21	-	-	-	-	-
Agency	Plan	60	58	56	55	53	51	49	47	45	44	42	40
	Actual	**50**	**44**	**39**	**46**	**44**	**31**	**39**	0	0	0	0	0
	Variance	-10	-14	-18	-9	-8	-20	-10	-	-	-	-	-
Trust All Turnover	Plan	10.90%	10.90%	11.19%	11.19%	11.19%	11.19%	11.68%	11.88%	12.07%	12.26%	12.45%	12.65%
	Actual	**10.85%**	**10.57%**	**10.24%**	**10.47%**	**10.91%**	**10.70%**						
	Variance	-0.05%	-0.33%	-0.95%	-0.72%	-0.28%	-0.49%	-	-	-	-	-	-
Trust 12-Month Sickness	Plan	4.35%	4.33%	4.31%	4.29%	4.29%	4.29%	4.22%	4.20%	4.18%	4.16%	4.14%	4.12%
	Actual	**4.35%**	**4.39%**	**4.47%**	**4.53%**	**4.57%**	**4.58%**						
	Variance	0.00%	0.06%	0.16%	0.25%	0.29%	0.30%	-	-	-	-	-	-

Performance & Counter Measure

- In October we used 5,638WTE to deliver our service against a planned figure of 5,618WTE, a variance of +20WTE to plan. Contract WTE has increased in October by 30WTE, of which 20WTE is attributable to planned growth in CDC, Imaging, and for the EPR Programme.
- Despite positive movement in our contracted WTE position, we have not seen corresponding decreases to our temporary staffing usage which increased overall in October by 15WTE. Bank usage remains over plan in M7, with increases due to additional Consultant cover (additional demand/ad-hoc cover) and Healthcare Support Workers (enhanced care/increased vacancy level). Although still under plan by 10WTE, agency usage has also increased largely due to heavy mental health nursing usage in DOPs.

Impact on Workforce

- Increased restrictions on overtime usage continue to positively impact our substantive WTE position, with usage decreasing from an average 35WTE per month to 7WTE per month in 2024/25. Usage has been transferred largely to bank WTE, which whilst not impacting overall workforce levels is positively influencing cost.
- Current WTE forecasting suggests a year-end position of 5,672WTE which is above plan by +159WTE. Whilst further escalation of planned interventions has not yet been initiated, Divisional teams are currently reviewing vacant posts and fixed-term contracts within their Divisions to review any potential to mitigate this year-end position.

Risks & Mitigations

- Total workforce levels (substantive and temporary staff) remain above our establishment figure. The establishment WTE is being rationalised to bring it in line with the planned worked WTE levels for 2024/25 to enable easier monitoring for budget holders.
- There is risk that workforce levels continue above plan in 2024/25 worsening our financial position. The Workforce Recovery Meeting has been established to drive reduction throughout the coming financial year.

Appendices

Explaining the IPR

Improving together

Explaining the IPR

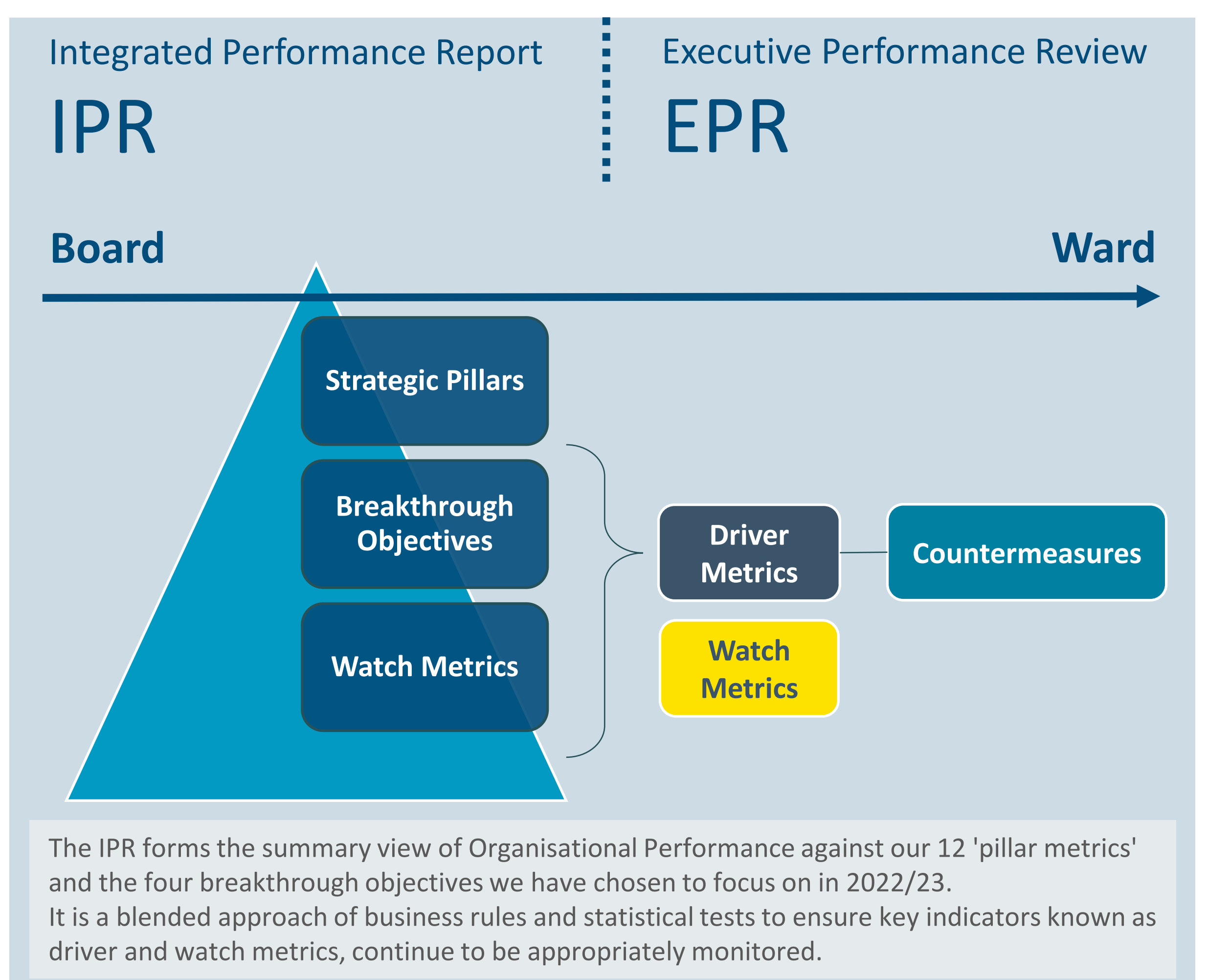
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- 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.



Our vision & strategic focus

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

24/25 Strategic Planning Framework

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

#	Metric
1	Reducing Harm
2	FFT (Friends & Family Test)
3	Waiting list – over 52 week waiters
4	Cancer waiting times
5	Time in ED (Emergency Department)
6	Staff Retention
7	Staff Survey - % Recommend
8	ED & I (Equality, Diversity, and Inclusion)
9	Emergency Attendances
10	No Criteria to Reside
11	Sustainability / Carbon footprint
12	Trust Control Total / I & E (Improvement & Efficiency)

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

#	Initiative
1	Leadership & Management Capability
2	The Way Forward Programme
3	Digital First
4	System & Place
5	Improving Together

4 Overlap

Corporate Projects

	Project
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

	Objective
BTO	Ambulance Handover Delays
BTO	Falls harm prevention
BTO	Staff Survey = respect from colleagues
BTO	Financial Recovery

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

Level	Continuous Improvement on Drivers: Daily	Continuous Improvement on Drivers: Weekly	Performance Management on Driver & Watch Metrics: Monthly
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

Communications and engagement

Providing an environment that values staff and engages them with the organisation.

Wards
Primary Care
Theatres
Therapies
Women's & Children's Services
Estates
IT
Community Services
Specialties
Diagnostics
Urgent & Emergency Care
HR
Finance

Transformational projects

Using improvement methodology to create step-change improvement.

Operational Management System

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

Transformation & Improvement Hub

Develop an internal capability to develop and sustain improvement journey.

Transformation & Improvement Hub

Clinical Divisions

Corporate Teams

Leadership behaviours

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

Executive Team

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Trust Vision & Strategy

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

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

Total Harm Events

Timescale	Value
Mar-20	408
Apr-20	396
May-20	404
Jun-20	457
Jul-20	454
Aug-20	422
Sep-20	390
Oct-20	443
Nov-20	460
Dec-20	493
Jan-21	454
Feb-21	409

Breakthrough Objectives

Virtual OP Appts

Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
16.7%	45.3%	46.7%	50.0%	50.1%	52.6%	54.9%	53.9%	52.8%	55.2%	64.5%	63.5%

Domain	Our Future
True North	Innovation
Metric Focus	True North
Threshold	80.0%
Value	Percentage
Improvement Direction	Higher Is Better

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

Variation indicates consistently falling short of the target

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

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

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

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

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

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.

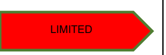
Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	27th November 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 Attendances	Waiting List – over 65-week waiters
	Diagnostic Waiting Times	Cancer Waiting Times
Improving Together Breakthrough Objective	Reduction in ambulance handover delays	

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
Operational Highlight Report (see below)		
1. IPR - DM01	GOOD	X
2. IPR - RTT	LIMITED	Y
3. IPR - Cancer	GOOD	X
4. IPR – ED / 4 hours	PARTIAL	X
5. IPR – Ambulance Handover	PARTIAL	X
6. Theatres Update	GOOD	X
7. EPRR Quarterly Update and Annual Assurance	GOOD	X
8. Partnership Report	NOTE	X
9. Quarterly Health Inequalities	NOTE	X
10. Board Assurance Framework	SUBSTANTIAL	X

POINTS OF ESCALATION	RTT: Unlikely to reach zero 65-week breaches by Dec 2024, likely to be 70. Reducing 52-week breaches to zero by March is also unlikely.
KEY AREAS TO NOTE	1637 patients waiting greater than 52 weeks at end Oct. Main areas of concern: General Surgery, Neurology, Gastro, Gynaecology 79 breaches of 65 weeks at end Oct, of which 5 greater than 78 weeks. ED attendances up 2.1% and combined 4-hour performance fell from 77.4% to 72.6%. Total mean wait has risen to 158 minutes from 149 minutes. NCTR has risen to 81 patients, but home first discharges at all time high of 118. Support provided from ECIST (Emergency Care Intensive Support Team) Ambulance handovers: 81 hours lost per day, with 19 x 6-hour breaches and 5 of those over 8 hours. “Drop and go” at 75 minutes introduced as of 27 Nov, reliant on a new cohort area (to be reported further in Jan). EPRR: Work required on business impact analysis and business continuity plans. Partnership report: the Committee noted a verbal update on the H2 ICS meeting with NHS South West and written reports on the work of the Health & Wellbeing Board and Integrated Care Alliance. The recent positive peer review of SBC and opportunities for joint work were also noted. Health Inequalities report: the Committee received a deep dive into the impact of health inequalities in Swindon and shared actions by ICA partners to address these. Members requested better understanding of our mortality data on the

	basis of deprivation and insights to improve this, as well as a focus on a specific area for improvement (cancer and maternity were discussed)
BOARD ASSURANCE FRAMEWORK & RISKS	Discussion around future risk tolerance and minor changes to initial recommendations.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Diagnostics. 6-Week standard up to 88.5% from 80.3%. Only 767 patients now waiting more than 6 weeks. Cancer performance remains better than the national 62-day target at 6.6% of the overall PTL size, and we are continuing to perform well against the other measures. Theatre utilisation is the highest it has been in the last 2 years.
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?	
 	Substantial Assurance: 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.
 	Good Assurance. 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.
 	**Partial Assurance**: 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.
LIMITED	**Limited Assurance**: 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.

Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	21.11.24
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	Reducing Falls with Harm

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
1. Falls (IPR breakthrough objective). Falls	Partial	
2. IP&C (IPR breakthrough objective)	Partial	
3. IPR : Concerns and complaints (Non-Alerting Metric)	Limited	
4. IPR Maternity	Good	
5. Board Assurance Framework BAF1 Outstanding Patient care & Risk Appetite and Tolerance Review 2024/25		
6. Quality Oversight of the Integrated Front Door, Emergency Dept, Urgent Treatment Centre and Medical Expected Unit	Partial	
7. Estates & Facilities water Pseudomonas Update Report	Substantial	
8. GWH Electrical Incident Update		
9. Clinical Audit and Effectiveness Q2 2024-25 Update and Annual Report 2023/24	Good	
10. Matrons Quarterly Audit	Good	
11. Safe Staffing 6-month Report for Nursing, Midwifery & AHP	Good	
12. Safe staffing monthly Report		
13. Electronic Discharge summaries October 24 Update	Partial	
14. CQC preparedness and progress report	Good	

POINTS OF ESCALATION

IPR: Reduction Total Harms

- Slight decrease in the overall harms in month related to a reduction in in number of falls and pressure harms in the acute setting, although there has been a slight increase in *Clostridium Difficile, E.Coli* and *Klebsiella* infections and an increase in community pressure harms.

IPR: continued monitoring Pressure Harms

- Shows a reduction in acute acquired pressure harms, however there was a slight increase in the severity.
- Weekly tri divisional meetings continue to share learnings to address this and maintain enhanced early identification and management and the dedication of the ward managers around managing their qualitative data was noted.

IPR: Infection Control

- GWH remains below target trajectory for *C.difficile* infection numbers despite a slight in month rise.
- Methicillin-Sensitive Staphylococcus (MSSA) numbers remain low and Methicillin resistant Staphylococus aureus (MRSA) have remained at zero for the 8th consecutive month.
- Targeted work on urinary catheter care has resulted in a reduction in associated infections.

IPR: Breakthrough Objective: Falls

- There have been no falls with moderate or above harm in the month of October but whilst slightly reduced, 11 multiple falls cases were recorded.
- >300 patients present to A&E with a fall per month and over half are admitted. These are patients more likely to experience further falls and may have multiple risk factors.

	• Following A3 work towards this Breakthrough Objective, focussed work around postural hypotension has progressed. Now confident in the ability to identify patients susceptible to postural hypotension. Work is being focussed on 'so what if'.
	Complaints and Concerns • The October complaint response rate has fallen to 58%, the Committee reduced its assurance rating in this area as this is a further deterioration despite the focussed work being done around this.
	Maternity Integrated Performance Report • High admissions, high acuity and recent new recruitment of nurses, continue to result in not meeting the required QIS staffing level target, however a plan Is in place to have full QIS trained by end January 2025. • Training compliance for all staff groups in maternity to meet the Clinical Negligence Scheme for Trusts (CNST) 2022-24 is now fully compliant. For child protection 3 level training compliance, whilst target achievement is delayed due to newly recruited staff requiring training, a programme is in place to complete training and required target. • Significant compliments received for the maternity services around the environment and staff attitude towards patients. Of note was specific thanks for the compassion and care provided by staff to a woman admitted with a mental health crisis. • As the end of the reporting period for the Maternity Incentive Scheme (CNST) Year 6 approaches, compliance on all 10 standards is expected.
	Quality Oversight of the Integrated Front Door (Emergency Dept, Urgent Treatment Centre and Medical Expected Unit) • This report covered the period before the move into the new accommodation, where new methods within a new environment are being applied. • Challenges around ambulance offloading, overcrowding and flow in complex location likely contributed to the metrics of the report. • There has been some improvement around length of stay and triage times but this is in the context of variable attendance rates. • With the move into the new location, the first two weeks have demonstrated a notable difference in triage times which has been positively impacted by all children now being cared for in one environment. • Shine data showed weakness. in timeliness of ECG, vital sign and pressure assessment recording. The Committee noted the decline in these metrics align with ambulance delay times. • Interim measures are being put in place to focus on these areas.
	Estates & Facilities Water Pseudomonas Update Report • The Committee received an update on the progress on the pseudomonas sampling activity and ongoing management and remediation for the elevated pseudomonas rates. • Flexible hosework replacement has made good progress with only a small number outstanding and a plan for completion of those. • Dove Ward work is now complete and October was the first month that had full negative samples. • The pseudomonas risk assessment is complete. • Sampling rates have shown significant improvement through augmented and non-augmented care areas. • An Independent Trust Water Management Audit of Serco Staff and their governance process demonstrated high legislation compliance. • The Committee were assured by the level on management oversight and effective action and the team were commended for the effective work that has been done and maintained over the past 18 months.

	Clinical Audit & Effectiveness Q2 2024-25 Update and Annual Report 2023/24
	• There have been 15 new national audits released of which 10 are relevant to the Trust to participate – there are a total 226 national audits registered on the audit programme.
	• The Trust did not participate in the following 3 national audits, bringing participation rate to 99%:
	    o NRAP – Secondary Care Adult Asthma 2024/2025
	    o NDA – National Diabetes Audit 2023/2024
	    o Chron's and Colitis (IQICC) (previously National IBD Audit)

	• Data submission has been recorded at 100% for the remaining 223 audits. • For the year, the number of audits registered appears to be returning to average levels. • Governance sign off process has improved. • Average level of compliance has increased by 4%. • Overall audit results show an increase in. level of assurance. • Documentation and capacity remain the areas for improvement.
	Matrons Audit Quarterly Report • The matrons audit provides the organisation with a level of assurance that care delivery is being delivered safely and effectively across our wards, departments and specialist areas. • Themes and trends from the audit are discussed at the Matron group and contribute to the improvement plan. • And the creation of standard operating procedures (SOPs). • All interventions are monitored the audit framework. • The Committee was assured by the level of commitment and individual accountability around the improvement measures and audits demonstrated by the ward leadership and individuals. • Themes have centred around medication management, cleaning inspection, uniform and badges, performance boards, storage of confidential information and staff feeling supported and valued.
	Safe Staffing 6-month Report for Nursing, Midwifery & AHP • The Committee was assured that the Trust makes good progress around delivery of safe staffing across Acute, Community, Midwifery and AHP safe staffing. • Good governance processes are in place. • Escalation processes are effectively utilised. • Actions that need to be undertaken revolve around robust recruitment and retention in light of the reduced international recruitment and reduced numbers entering nursing training. • Where ratios of 1:10, outside the recommended 1:8, occur and result in redeployment of staff across the site, an audit is being undertaken to see the impact and need for this process to cover sickness absence. • The impact of the next birth rate and report recommendations will also inform the recruitment needs of the future midwifery workforce. • Patient acuity data according to location is also being used to influence staffing plans. • Following the safer staffing investment over the past 3 years, all wards except Orchard and Forest are now in line with the ratio standard of 1:8.
	CQC preparedness and progress report • The Committee were assured that the Trust continues to review compliance against key quality standards expected by CQC, ensuring robust learning and effective actions from previous assessments. • It has also been acknowledged that the CQC is undergoing significant change which is making this more challenging but the Trust remains committed to working closely with the regulators to build effective relationships. • Following the Medical Inpatients assessment in May 2024, an action plan was created to address the verbal report received. The majority of actions have been closed or are on track. • The draft report has now been received which reads well delivers a "Good" rating and is currently going through a factual accuracy track.
	Electronic Discharge summaries November 24 Update • The benchmark to complete EDS within 24 hours of discharge sits at 80%. The current status is 72.1% but where 6.3% still required sending. • Since the last report there has been an interruption of the EDS platform which impacted EDS production, but which was resolved. • A coronial inquest where handover discharge was identified as a learning point was undertaken, related to an incident involving GWH. • The Chief Digital Officer has committed to a go live date for the electronic EDS of 3rd December 2024. • The Committee remained with limited assurance but acknowledged that in the interim all measures that can be taken cost effectively and with current capacity is being undertaken.

BOARD ASSURANCE FRAMEWORK & RISKS	**BAF1 Outstanding Patient Care-Q2 2024/25 risk. Appetite and Tolerance review 2024/25** • The risk levels and description were reviewed and agreed.
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?	
SUBSTANTIAL	**Substantial Assurance**: 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.
GOOD	**Good Assurance**. 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.
PARTIAL	**Partial Assurance**: 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.
LIMITED	**Limited Assurance**: 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.

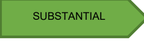
Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	26 November 2024	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Partial	x
2. Month 7 Finance Position	Good	x
3. Improvement & Efficiency Program	Partial	x
4. Finance Risk Register (including Way Forward Program)	Substantial	x
5. 2025/26 Planning Update	Partial	x
6. Debtors Report	Good	x
7. Coding & Mortality Status Report	Partial	x
8. BAF Strategic Risks (including Strategic Risks and Appetite & Tolerance Review	Substantial	x

POINTS OF ESCALATION	**BSW Financial Update:** The finance position at M7 is a YTD adverse variance of £11.3m. This position is after recognising the pro-rata share of £30m deficit funding. The individual positions by organisation are as follows: GWH £2.9m off plan; RUH £2.1m off plan; SFT £7.2m off plan; and ICB is £1m ahead of plan. These positions are deteriorating at RUH and SFT, with GWH staying the same and the ICB improving. For all providers, issues remain with the delivery of efficiency and improvement programmes, leading to run rates exceeding the required levels. Mitigating actions have been identified to address some of these challenges, but the outlook for 2024/25 remains exceptionally challenging and delivery of the £30m deficit plan is at risk. The Committee notes that the financial risk for the system is escalating and is high; however, Trust leadership assured us that regular meetings are taking place at the system level to address this. Based on these management representations, we agreed to a partial assurance rating.
POINTS TO NOTE	**Month 7 Financial Position:** The Trust's adjusted deficit position is £7.8m, representing a £2.9m adverse variance from the plan. Income is £7.6m favourable to the plan, driven by ERF (£3.4m) and an overperformance on NHSE Commissioned Drugs (£2.5m). Overall, Pay is £2.6m over the plan, which includes £0.5m of Junior Doctor's industrial action costs offset by income and a £1.5m under delivery of Pay efficiencies. Non-Pay is £8m over the plan, including a £4.8m variance in clinical supplies and outsourcing, particularly in Medicine, Surgery, Women's ^ Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. A working group, including Procurement, is analysing the drivers of clinical supply spending to achieve savings.
	Improvement & Efficiency Plan: The Trust started the year with a £21.90m cash-releasing efficiency target with no carry forward of undelivered/non-recurrently delivered efficiency from 2023/24. As of Month 7, the programme has delivered £8.6m year to date, with 52% of this being delivered recurrently. Pay is a crucial area for savings, with a target to reduce the headcount working in the Trust by 263 compared to March 2022 by the year-end. Tighter controls around approving bank shifts, overtime, and Waiting List Initiative payments will contribute to this while continuing with the excellent work already in place, resulting in run rate reductions in temporary staffing, specifically in Nursing. This commitment to reducing temporary staffing costs demonstrates our dedication to effective cost management. Non-Pay, most notably clinical supplies, will be the focus of cross-team/divisional support to maximise savings opportunities in this area. The partial assurance rating relates to the risk of delivering the efficiency programme for 2024/25. Although systems and controls identifying and tracking savings provide good/substantial assurance, the challenge of the scale of efficiencies and current delivery means there can only be partial assurance.
	2025/26 Planning: The Committee was presented with the details of the approach to develop the 2025/26 plan, which focuses on creating an optimal system plan that will require all organisations within the Group to work together with a consistent set of assumptions, using the same methodology and a template that can be aggregated to form one plan. This will enable peer review, check, challenge, and report our planning story externally as one team, maximising the likelihood of the system plan being approved nationally. Due to the high ambiguity of requirements from a national level and the challenging timelines to develop the plan, this was assessed as partial assurance.
	Coding & Mortality Status Update Report: The Coding performance at the Trust has been impacted by several factors in 2024/25 to date, which have led to a deterioration in the backlog position. These include a significant rise in the volumes of Inpatient episodes that require coding compared to prior years (11,144 average in 2024/25 vs 10,301 average in 2023/24) and the loss of third-party coding support due to lack of available funding, leading to a drop of 3,500 episodes of coding capacity per month. While recruitment activity to fill the remaining vacancies within the Clinical Coding team is now complete, due to the difficulties in recruiting experienced staff there remains a significant number of trainee coders within the Clinical Coding team due to the scarcity of skilled coders in the local market, which continues to impact on overall coding capacity. Clinical Coding capacity and backlog volumes are still not acceptable, and until sustainable improvement is seen this report will remain partial assurance.
BOARD ASSURANCE FRAMEWORK & RISKS	**Board Assurance Framework, including Risk Appetite and Tolerance:** The Committee reviewed and challenged the risk appetite approach, definitions, and risk appetite for Finance-related strategic risks and agreed with Executive Management's proposal. We suggested adjusting to two risk categories, namely Health & Safety Risk and Supply Chain Management Risk, to reflect a more prudent risk appetite for these risks. **Finance Risk Register, including the Way Forward Program:** The Committee noted that the risk management process and reporting are adequate and effective and is assured that risks are identified, appropriately rated, and mitigation actions are in place. The Committee is assured that the review process for risk oversight by the Finance and Way Forward teams is embedded, with monthly meetings and mitigation actions allocated to risk owners.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The Executives and their teams continue to provide high-quality and insightful papers followed by constructive challenge and debate at the monthly FIDC meetings. The Committee acknowledges that continuous improvements are made in the control environment, risk mitigation strategies, and culture to drive accountability across all colleagues within the Trust. This dedication to continuous improvement instils optimism about the Trust's future.
REFERRALS TO OTHER BOARD COMMITTEES	None noted.

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?	
	**Substantial Assurance**: 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.
	Good Assurance. 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.
	Partial Assurance: 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.
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Board Committee Assurance Report

Committee	Charitable Funds Committee
Meeting Date	13 November 2024
Committee Chair	Julian Duxfield, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Fundraising	Partial	
2. Financial reporting	Good	
3. Cases of need	Good	
4. Charitable funds	Good	
5. External review action plan	Partial	

POINTS OF ESCALATION	None at present.
KEY AREAS TO NOTE	Immediately prior to this meeting the General Fund's available uncommitted balance stood at £34k, excluding our agreed minimum threshold of £57k. The Trust's overall Charity funds balance as at 30 September 2024 is £1,079k of which £793k is Restricted and £286k is Unrestricted. The meeting reviewed the 'cases of need' and it was agreed to fund the refurbishment and initial re-stocking of the mobile trolley shop which the RVS ran until Covid. This will now be run by the GWH Voluntary Services Team for patients who are unable to visit the Atrium. Funding for the prescription collection lockers is deferred until sufficient funds are available. The Committee agreed to defer a decision on the Penicillin de-labelling service pilot until there is more clarity on longer-term funding from the Trust via the business planning and budgeting process. Surgery, Women & Children's Division presented their Charity funds allocations. Of their current £110k balance approx. £63k of charitable funds have been allocated, leaving approximately £48k as a Divisional total available. The Division's highest value fund, Critical Care, will fully utilise all of their fund (£45k). The Committee approved three items proposed of charitable spend by the Wiltshire Health & Care Executive Committee. It was noted that the award to HCRG of the tender to provide Adult and Children's Community Services from 1 April 2025 means that work will need to be done to identify how this will affect the charitable funds currently held by WH&C. Progress was made with the planning to rationalise the 98 charitable funds across GWH, this fragmentation prevents the most effective use of funds. It was agreed that all the previous planning and thinking would be brought together to clearly articulate a proposed end point, a consultation and communication plan with stakeholders would be developed and additional resource to support this project would be brought in.

	The proposal to move all charitable funds to an Investment Manager will be paused during the funds rationalisation process. This option, for funds which will not be spent for some time, will be communicated during the rationalisation process. The costs of generating funds, where these cannot be directly attributed to a specific fund, are currently apportioned to all funds on the basis of the income received in the period, excluding legacies. The Committee agreed that the previously agreed (November 2021) method to apportion charges to funds on the basis of all income, including legacies, should be adhered to.
BOARD ASSURANCE FRAMEWORK & RISKS	Assurance ratings remained as at the last meeting in August. Although good progress has been made with the External Review Action Plan a key outstanding action is the rationalisation of funds.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Whilst total charitable income is lower than at this point last year, when legacy income (which is more erratic and unplanned) is removed income has increased by £30k.
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?	
	Substantial Assurance: 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.
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LIMITED	**Limited Assurance**: 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.

Board Committee Assurance Report

Committee	Audit, Risk & Assurance Committee
Meeting Date	14 November 2024
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Divisional Risk Review - Medicine	Good Assurance	x
2. Board Assurance Framework	Significant Assurance	x
3. Risk Register Report	Good Assurance	x
4. DSPT Compliance 2023/24	Good Assurance	x
5. External Audit – Update Report	Noted	x
6. Internal Audit - Progress Report and Action Tracking	Good Assurance	x
7. Internal Audit – Procurement Final Report	Partial Assurance	✓
8. Internal Audit – Admissions Final Report	Partial Assurance	✓
9. Local Counter Fraud Progress Report	Noted	x
10. Losses and Compensation Report Q2 2024/25	Noted	x

POINTS OF ESCALATION	The Committee received the final report on the Internal Audit on Admissions which was rated as partial assurance with improvements required. There were 10 medium priority and 3 low priority actions raised – mainly related to the quality, ownership and completion of data related to admissions and readmissions. The Committee asked for all the actions to be completed by 31 March 2025 to ensure that an improved process is in place for the beginning of next year. The Committee were concerned by the issues raised and escalated the full report to PPPC for their review and input as it mainly impacts the data received by that Committee and the ownership and completion of data from an operational perspective. The Committee also asked for it to be reviewed and acknowledged by the Trust Management Committee for oversight of completion of the actions. The Committee received the final report on the Internal Audit on Procurement which was rated as partial assurance with improvements required. The main issue driving the rating is the lack of evidence on the completion of declarations of interest in the procurement process, including the requirement in single tender waivers. The Committee were assured that this is recognised by the Trust and new processes have been put in place to ensure that is completed going forward. However, it is not possible to know if there are any outstanding issues for already completed procurement. The Committee therefore asked for a review to be undertaken for any significant contracts over the last few years to ensure that the conflicts of interest process had been followed and documented.
KEY AREAS TO NOTE	The Committee received a short update from Deloitte on the good progress and outcomes of the charity audit. The External Audit plan for 2024/25 will be reviewed at the next meeting. The internal audit programme is continuing to time for the year. A number of actions from the HFMA follow up audit have been delayed but the Committee was assured that all should be completed to the new timelines. The process of approval for agreeing revised completion dates had been followed and the delay had received the appropriate approvals.
BOARD ASSURANCE FRAMEWORK & RISKS	The Medicine Division updated the Committee on their process to manage risk and their actions to mitigate the risks. There has been quite a number of changes in risks, both number and scoring over the period since Medicine last presented to the Committee. The team talked the Committee through the processes followed and the Committee were assured that a good process is in place and escalations are taking place appropriately. The new IFD has prompted a number of changes to the risk profile and good reflection on likelihood vs consequence to achieve a more accurate scoring. The team are regularly reviewing their old risks with a good plan to reduce and mitigate – and currently have no risks with no actions. There is now also good recognition of the risk with respect to finance in the division. The Committee reviewed the overall Trust risk register to gain assurance on the overall trust risk processes. The Committee were assured on the process overall but highlighted the need for ongoing management of the risks with no actions. The team confirmed that Datix has now settled in well. It was also noted that the risks related to the transfer of the Community services are being treated as a separate programme, similar to the Way Forward programme, and risks will be managed and escalated so that the highest rated risks will be reviewed appropriately both through TMC and the PPPC Committee. The Committee received an update on the process for the Board Assurance Framework and were assured that the process for the systematic updating and review of the BAF is working well. It is appropriately discussed at each of the Board Committees and is very effective. Continued refinements on reporting are underway and work is also being done to

	align the GWH BAF with the BAF at Salisbury. Although this is not yet co-ordinated with RUH, who have recently updated their process, it is understood that there is a high level of consistency in the approach. The Committee received a short update on the completion of the actions from the DSPT compliance audit for 2023/24 and were assured that the actions are being dealt with appropriately. A question was raised on the monitoring of IG training for bank staff and the challenges with ensuring bank staff are up to date with all training requirements across the trust. This is being addressed by the temporary staffing team.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The Local Counter Fraud Team have recently completed a number of activities for Fraud Awareness month. .
REFERRALS TO OTHER BOARD COMMITTEES	The Committee referred the internal audit report on Admissions data to PPPC Committee and escalated it to TMC for acknowledgement and review.

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?	
SUBSTANTIAL	**Substantial Assurance**: 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.
GOOD	**Good Assurance**. 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.
PARTIAL	**Partial Assurance**: 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.
LIMITED	**Limited Assurance**: 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.

Report Title	Safe Staffing 6 month review for Nursing, Midwifery and AHP				
Meeting	Trust Board				
Date	5 December 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek Chief Nurse				
Report Author	Luisa Goddard Deputy Chief Nurse, Ana Gardete Divisional Director of Nursing, Kat Simpson Head of Midwifery				
Appendices	None				

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):							
The report gives the Board assurance of safe staffing processes for Nursing, Midwifery and AHP within the Trust and highlights areas of concern.							
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 service**s. Outcomes are generally achieved but with **inconsistencies i**n 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 aims to provide the Board with assurance that staffing has been managed over the past 6 months in line with the National Quality Board guidance and Developing Workforce standards.

It makes recommendations for maintaining a safe sustainable nursing, midwifery and allied health professional (AHP) workforce through the triangulation of professional judgment and professional evidenced based acuity tools.

The Trust Board last received a Safe Staffing Paper in April 2024.

This report covers:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations,
- Safe staffing related to AHP
- Community Nursing safe staffing
- Nurse staffing compliance with national guidance

The Acute Nursing report highlights the compliance against the National Quality Board Safe, Sustainable and Productive staffing recommendations of Right Staff, Right Skills and Right Place and Time. the Trust remains in Quartile 3 against the national benchmarking on Model Hospital. The Trust has a value of 9.1 (peer median is 9.0) for total nursing staff and 5.1 (peer median 5.5) for registered nursing staff. Health care support workers is 3.8 with a provider median of 3.0.

The report also highlights that the majority of wards are now funded to be compliant with the 1 nurse to 8 patient ratios with the exception of the SWICC wards. However further work in under way to determine the frequency of areas working above that due to short term absence.

Community Nursing

Community Nursing is presented in detail highlighting the findings from the implementation of the community safer nursing care tool which will inform the establishment requirements using a recognised methodology. It also updates on progress with vacancies and other workforce metrics.

Maternity and Neonatal Safe Staffing

The report covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report. It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has continued to improve over the last six months by identifying different staffing models, and recruitment locally and internationally. The key metrics of Supernumerary status of the Delivery Suite Coordinator, one-to-one care in Labour and midwife to birth ratio are all presented and discussed. Although there is ongoing work to ensure compliance there are no specific areas of immediate concern.

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

Allied Health Professionals

The AHP workforce is in a stronger position than six months ago, but continued efforts are required to address retention challenges and national shortages. A clear long-term workforce plan, informed by capacity and demand modelling, will be crucial to building a sustainable AHP workforce at GWH.

Conclusion
The Trust continues to make good progress in delivering safe staffing across Acute, Community, Midwifery and AHP safe staffing. The work on recruitment and retention is demonstrated in improvements in the workforce metrics and is supporting the drive to improve patient care.

There is good governance and oversight of staffing and escalation processes in place for any concerns.

The report will make recommendations to the committee regarding actions required to achieve a sustainable and effective nursing, midwifery and AHP workforce.

- Ensure robust recruitment and retention plans for registered nursing in light of the reduction of the international recruitment pipeline and reduced student nurse applications.
- Develop improved monitoring for when wards / clinical units are working above the 1:10 ratios.
- Complete the Community CNSST audit in October 2024 and ensure establishment recommendations are considered.
- Ensure the next Birth Rate + report recommendations inform future workforce planning to achieve safe staffing.

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 500 There is a risk of poor-quality metrics and reduced staff morale/high turnover due to inpatient wards working at a ratio of 1:10 for registered and unregistered staff. This is against the national guidance of 1:8 or below.				**Risk Score**: 9
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Nursing, Midwifery and AHP workforce group, Trust Management Committee, Quality & Safety 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: the paper describes the governance of safe staffing across the Trust.			

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is asked to note the recommendations of the report	
Accountable Lead Signature	Lisa Cheek
Date	13th November 2024

1. Introduction

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

These include:

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

The Royal College of Nursing (RCN) Workforce Standards (2021) report has also been fully reviewed and compliance continues to improve with actions in place to support best practice.

The Board of Directors is expected to confirm their staffing governance processes are safe and sustainable. This report aims to provide the committee with assurance that staffing has been managed over the past 6 months in line with national recommendations and to highlight areas that are not compliant or need further work to improve compliance. The report will make recommendations to the committee regarding actions required to achieve a sustainable and effective nursing and midwifery workforce.

The Board last received a Safe Staffing Paper in November 2023.

The report covers:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations,
- Safe staffing related to AHP
- Community Nursing safe staffing
- Acute Wards compliance with national guidance and the Emergency Department Safer Nursing care Tool review.

1.1 Background

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) supports Trusts to use best practice in effective staff deployment and workforce planning utilising evidence-based tools and professional judgement to ensure the right staff, with the right skills are in the right place at the right time. Using this approach will ensure that safe staffing levels are determined on patient needs, acuity and risks and can be monitored from 'ward to board'. This triangulated approach to staffing decisions is also supported by the CQC.

Table 1- NQB: Safe, Sustainable and Productive Staffing

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

For the acute inpatient wards, this report will focus the updates in the structure of Right Staff, Right skills and Right place and time

2.0 Right Staff

To support professional judgement, evidence-based workforce planning includes Care Hours per Patient Day, Safer Nursing Care Tool, Fill rates (planned vs actual staffing) and Model Hospital benchmarking.

2.1 Fill Rates – Nursing staff planned vs Actual (in-patient beds)

The Trust submits monthly returns to the Department of Health via the NHS National return. This return details the overall Trust position with actual hours worked versus hours expected for all inpatient areas. The percentage fill rate for registered nurses and health care support workers for day and night shifts together with the overall Trust percentage fill rate. This return also includes CHPPD.

The fill rates report is presented monthly to Quality and Safety Committee, highlighting areas for improvement.

The fill rates have remained above the expected benchmark of 85% for the months reported. It should be noted that there remains a level of fluctuation in the fill rates related to recruitment, the need for enhanced care and additional patients on wards due to operational pressure. It should also be noted that the new safer staffing models will affect the fill rate as they are fully implemented as the planned numbers will increase.

Table 2 Trust wide Fill Rates

	Safer Staffing – average fill rate RN (%)	Safer Staffing – average fill rate HCA (%)
Apr-24	93.75%	104.38%
May-24	92.78%	107.82%
Jun-24	94.14%	107.65%
Jul-24	94.74%	108.04%
Aug-24	92.96%	103.51%
Sep-24	93.07%	102.92%

2.2 Care Hours Per Patient Day (CHPPD)

The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone.

Every month the hours worked during day shifts and night shifts by registered nurses and by health care assistants are added together. Each day the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate the average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

The Model Health System is a digital tool provided by NHSE which provides national benchmarking on productivity and quality. CHPPD is available as a benchmark against other Trusts, it is produced from actual whole time equivalents worked i.e. not funded establishments.

The latest data is July 2024 and shows that for nursing staff, the Trust remains in Quartile 3. The Trust has a value of 9.1 (peer median is 9.0) for total nursing staff and 5.1 (peer median 5.5) for registered nursing staff. Health care support workers is 3.8 with a provider median of 3.0.

This demonstrates that the Trust is comparing within a safe benchmark to peers and national benchmarking.

2.3 Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is a nationally recommended, evidence-based tool that enables nurses to assess patient acuity and dependency and by incorporating a staffing multiplier ensures that nursing establishments reflect patient needs in acuity / dependency terms.

It is recommended that it is used at least once a year to inform establishments and facilitate consistent nurse-to-patient ratios in line with agreed standards.

The acute wards completed a 2 week data collection in September 2024. This will allow a comparison against the 3 data point recommendations and current funded establishment in more detail. This analysis will be presented in more detail in future reports.

However the results are shown below, which demonstrates the increasing number of patients that are dependent on nursing care to meet most or all of their nursing needs. The number of Level 2 acute patients is also increasing and seen across a variety of wards with a concentration on Neptune Ward (respiratory).

Results of patient acuity and dependency audit Sept 24

Level Descriptors
Level 0 – needs met by normal ward care
Level 1a – acutely ill patients requiring intervention
Level 1b – dependent on nursing care to meet most of all their needs
Level 2 – acutely ill requiring intervention, normally in Level 2 designated beds.

Unit	Level 0	Level 1a	Level 1b	Level 2
Dove Inpatient Roster - J65027	2.5	5	2	0
Forest Ward SWICC - J67409	6.5	0.1	21.8	0
Orchard Ward SWICC - J67410	0.4	2.7	24.6	0
Acute Cardiac Unit - J65621	3.8	5.8	2.5	1.1
Acute Stroke Unit - J65624	4.2	2.4	7.9	0.5
Jupiter Ward - J65625	6.9	1.5	26.6	0.3
LAMU Nursing - J65634	5.7	4.7	6.1	0.2
MAU Nursing - J67565	13.7	3.4	12.8	0
Mercury Ward - J65638	19.8	3.6	11.5	0
Neptune Phase 2 - J65637	11.2	5.5	15.7	2.5
Saturn Phase 2 - J65647	10.3	14.2	10.6	0
Teal Ward - J65639	7.3	4	22.7	0.1
Woodpecker Ward - J65314	5.3	7.8	21.6	0.3
Aldbourne - J65313	5.3	0	4.3	0
Ampney Ward - Urology - J65331	7.9	0.6	8.9	0
Beech & EPU - J65917	7.2	0.3	8.8	0
Daisy/DSU - J65351	7.3	0	0.1	0
Meldon Ward - J65337	11.2	1.5	22.9	0
SAU - Surgical Admissions Unit - J65380	14.6	0.6	1.4	0
Trauma Unit - J65387	0.9	0.2	34.9	0

This data will be compared to the 2 previous audits to help determine average acuity and dependency and then analysed against the funded the establishment. This will help give assurance that the funded establishments are set to meet patient need.

The audit for September 2024 shows an increasing picture of dependency across all the inpatient areas. This is in line with the narrative from the Ward managers and the increase in patients that require Enhanced Care. There are slightly less patients requiring Level 2 care outside of areas with designated high dependency beds (Neptune and ACU) however this may reflect seasonal pressures.

The new SNCT tool has 2 new categories 1C and 1D will be included in the next data collection. These are patients that are stable but need additional intervention to maintain safety and this information will be helpful to review the enhanced care activity on wards.

2.4 Nurse to Patient Ratios

National guidance since the Francis Report (2015), including NICE guidance, states that nurse to patient ratios should not be greater than 1:8. There is an increasing body of evidence that links ratios greater than 1:8 to higher mortality as well as poor nurse sensitive indicators and poorer patient experience.

Following the agreed 3 year safer staffing investment, all wards except for Orchard and Forest are now in line with guidance. The establishment reviews with the Chief Nurse will be providing assurance that the wards are working at the 1:8 ratio that is funded. However, it should be noted that the wards are still working at higher ratios when covering last minute absence. A process is being developed to capture the frequency of this, however it is being managed through the 3 times a day safer staffing meeting and review of safety is considered during those conversations.

<u>Emergency Department</u>
The benchmarking of the Emergency Department (ED) with the other EDs in BSW and the results of the SNCT audit was presented in the previous report. However, the SNCT audit will be repeated in the next quarter as well as a review to understand the impact of new ways of working and a larger physical environment in the new ED. Currently there has been no changes to the ED staffing establishment.

3.0 Right Skills

3.1 Recruitment and Retention

3.1.1 Vacancies and turnover for nurses

The reduction in Registered Nursing and Health Care support worker vacancies has been maintained. The nursing vacancy rate for registered and unregistered was between 2.2% and 0.96% in the last 6 months (April to Sept 24).

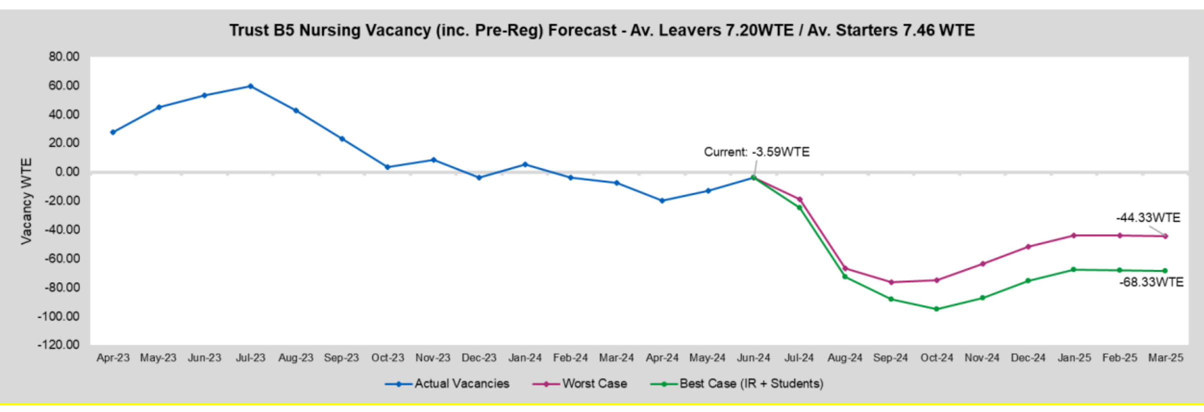
Registered Nurse turnover has remained stable between 7.33% and 7.55% with between 7-10 wte nurses leaving per month. Benchmarking on Model Hospital for July 2024 has the 12-month rolling turnover at 8.8% with the national average as 9.8%, this places the Trust in Quartile 2.

Unregistered nursing turnover has also remained stable between 10.91% and 11%.

The recruitment trajectory remains in a postitive position as detailed below. However it should be noted that there is a risk that this position will deterioate but it should be noted that there is a significant risk looking forward to 2025/26 with the lack of an international recruitment

pipeline and significantly reduced numbers of studnets applying for nurse training, for example the Trust normally recruits 65-70 newly qualified nurses from Oxford Brookes University, this year there are only 50 student nurses commencing their 3 year course.

Band 5 Registered Nurse trajectory to March 2025



Current Recruitment initiatives include; supporting local students to have a positive placement experience at the Trust and student recruitment events to support them into the Trust, continuing the 'SIFE' process which supports HCSW who have an overseas registration to gain NMC registration and complete a 'return to acute' course, and regular bespoke open days / recruitment events for clinical areas.

3.1.2 Areas with highest vacancies

Vacancies and turnover are discussed by division at the Nursing, Midwifery and AHP workforce group. Areas with high vacancies or turnover are discussed in detail and the recruitment and retention plans are presented. The Acute Medical Unit and the Childrens ward are the areas with the highest vacancies and active recruitment is ongoing to address this.

4.0 Right Place and Time

4.1 Safe staffing process

The Trust continues to have 3 times a day safe staffing meetings chaired by a divisional directors of nursing or deputy. This ensures that no ward is left on a 'red shift' and there is effective deployment of staff.

There is a monthly Nursing, Midwifery and AHP workforce group that reviews the workforce metrics including compliance with roster metrics and any recruitment and retention plans.
A monthly report to the Quality and Safety Committee details areas of concern as well as reporting the fill rates.

A yearly establishment review takes place with the Chief Nurse and Ward Managers to ensure that there is 'ward to board' reporting and understanding of how safe staffing feels in the clinical area.

5.0 Community Nursing

5.1 Context

In line with the National Quality Board (NQB) (2017), the Trust should have assurance that the workforce establishment is able to meet both patient needs and quality outcomes within Community (District) Nursing Services (CNS). The Queens Nursing Institute (QNI) (2022) and NQB (2017), articulates the need to quantify unmet need within CNS, as they have no means of limiting their caseload and must therefore have markers and metrics to indicate sufficient workforce numbers. This report summarises progress to date with the implementation of Community Nursing Safer Staffing Tool (CNSST) to understand safe establishment, evidence-based work management processes (fair and manageable workload) and its triangulation with patient safety & quality metrics.

5.2 Community Nursing Safer Staffing Tool (CNSST)

Both QNI (2022) and Royal College of Nursing (2021) set out workforce standards based on modelling and activity. These outline the need for CNS to deliver the required nursing care for a defined community through safe staffing establishments and skill mix that are reflective of the demand placed upon them by their population needs.

Safe staffing regulations and recommendations are set out through:

- Care Quality Commission (CQC) through regulation 18 of the Health and Social Care Act (2008)
- National Quality Board – Safe, sustainable and productive staffing - An Improvement resource for the district nursing service (2017)
- Queens Nursing Institute – International Community Nursing Observatory Workforce Standards for the District Nursing Service (2022)

The community Nursing Safer Staffing tool was developed and licenced by NHS England, with Swindon Community Nursing service participating in the first implementation cohort in 2023. This facilitates a twice-yearly formal review of patient dependency and aims to capture the ‘unseen patient care needs’ to ensure that there are sufficient staff within the service that can provide optimal care.

The community Nursing Safer Staffing tool was developed and licenced by NHS England with Swindon Community Nursing service participating in the first cohort. This facilitates a formal review of patient dependency twice a year and aims to capture the ‘unseen patient care needs’ to ensure sufficient staff within the service that can provide optimal care. The third data collection (census) for the CNSST was undertaken in March 24. This follows two earlier census periods when data was collected 30th October 2023 and 24th April 2023. Each census period lasts for a period of seven days. To ensure a standardised approach to assessment a decision matrix is used by nurses to assign patient dependencies (1-4) based on care provided during the visit and identify any unmet needs. Additional hours of community nursing visits were collected in period 2 by including work undertaken by clinical leads.

5.3 Exception report

The census data collected over the three census periods does demonstrate significantly different outcomes in safe staffing establishment requirement (see table 1).

Table 1

	Census 1 April 23	Census 2 October 23	Census 24 March 24
Budgeted establishment	**94.5 WTE**	**94.5 WTE**	**94.5 WTE**
Total recommended CNSST establishment (20% headroom)	**66.19 WTE**	**105.2 WTE**	**118.32**
Total number of additional staff required to meet CNSST	**- 30.31 WTE**	**10.7 WTE**	**23.82 WTE**

Census period 1 identifies a safe staffing establishment less than that budgeted, this is despite the fact that during this census, demand appeared to outstrip capacity. It is recognised that the data collection for census period 1 was far less reliable due to data collection challenges, magnified by the fact that this was a new process not implemented previously. The findings of both censuses 2 and 3, however, demonstrate that current community nursing establishment of 94.5 WTE (excluding B8a and B8b) fails to meet the recommendations of the CNSST for both census 2 of 105.2 WTE and census 3 of 118.3 WTE (band 8a and B8b excluded) see Table 1.

The census periods 2 & 3 are a more realistic and accurate reflection of staffing requirement. Census 3 however, reflects the increased workload due to the transfer of 2–48-hour work from Urgent Community Response to Community Nursing. The data collection differences are described in A-C below.

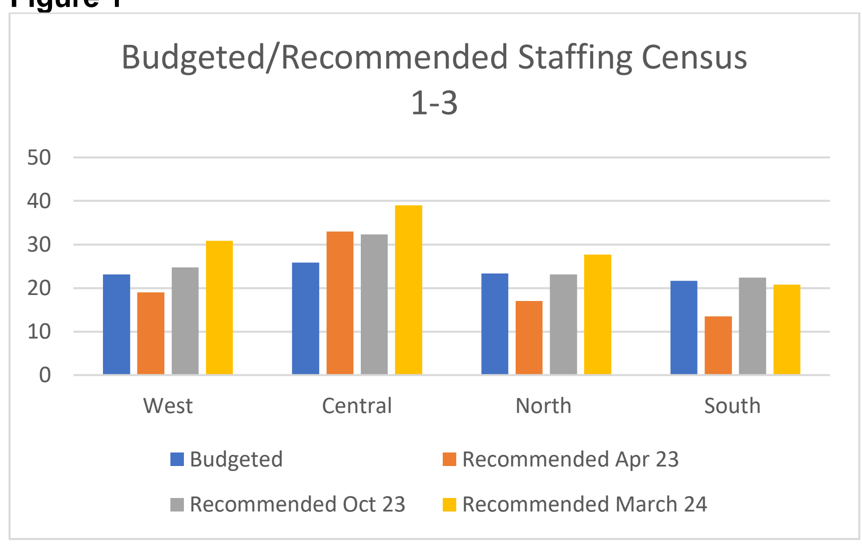
A) Data collection census 1 (April 2023):
- Community nursing visits 08.00- 16.30
- Not including all bank and agency visits
- No deferred doppler/continence included
- No 2-48 hour work included

B) Data collection census 2 (October 2023)
- Community nursing visits 08:00-22.00 (additional twilight visits for community nursing included)
- Deferred visits for doppler and continence assessments
- All bank and agency visits that were completed.

C) Data collection census 3 (March 2024)
- Community nursing visits 08:00-22.00 (additional twilight visits for community nursing included)
- Deferred visits for doppler and continence assessments
- All bank and agency visits that were completed
- 2–48-hour work that transferred from Urgent Community Response in January 2024 (200-300 additional visits per month)

The chart below identifies the budgeted staffing and recommended staffing by locality in each census period and demonstrate that the only locality with safe staffing is currently South locality.

Figure 1



In October 2023 Community Nursing was fully recruited for both registered and unregistered nurses. During the census period, an additional 17 WTE temporary staff were used (bank/agency) over the budgeted establishment. This additional use of temporary staffing appears to have bridged the recognised establishment/recommendation deficit but there were still visits being deferred on a daily basis due to capacity and demand.

Demand and capacity modelling undertaken during the census week in March that is based on care plan quantity and default duration of care settings, demonstrates a daily establishment deficit as per table 2 which equates to a requirement of around 12 additional WTE, however, this does not account for work not done such as deferred continence and lower leg doppler assessments.

Table 2

Day of week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	11/03/2024	12/03/2024	13/03/2024	14/03/2024	15/03/2024	16/03/2024	17/03/2024
Mins of care needed	20494.5	21208.5	18737.5	18616	19406	12838.5	10374
Hours of care needed	341.6	353.475	312.291667	310.266667	323.433333	213.975	172.9
Total staff needed to achieve care plans (based on Sept average)	59.28	61.34	54.2	53.85	56.13	37.13	30.01
Hours care minus twilight/co-ordinators - 30%	267	249	239	238	277	162	153
WTE balance	-10	-14	-10	-10	-4.4	-7	-2.7

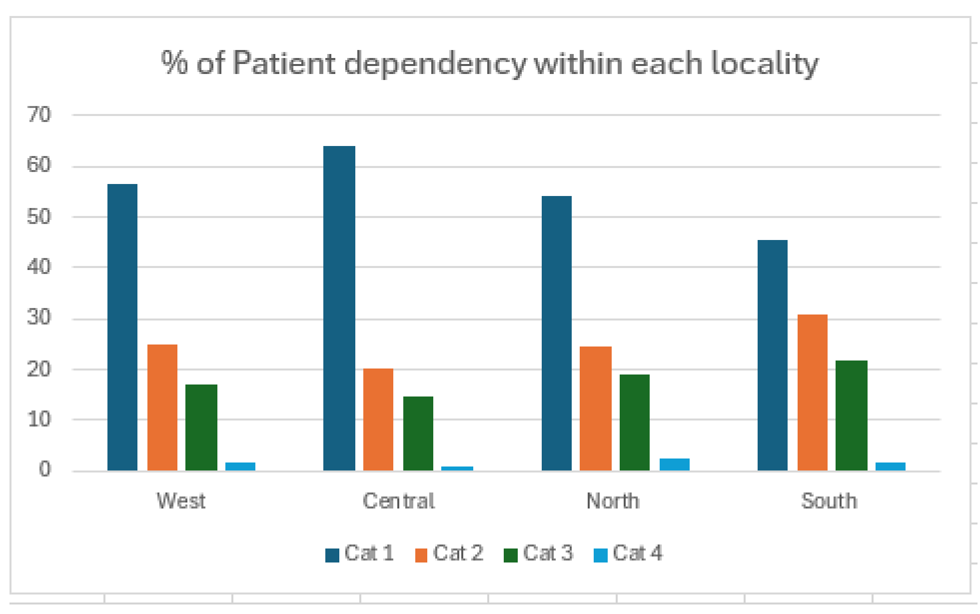
QNI (2022) outlined red flags for safety concerns including deferring high priority work (for example end of life care, blocked catheters) or high numbers of deferrals on a regular basis. There are no identified standards for maximum caseload size or number of visits per day however it was noted that evidence identifies that >10 visits per nurse per day were tipping points for patient harm. Fair and manageable workload was implemented to ensure nurses were not being overloaded and the data (table 3) strongly suggests that nurse workload is within safe limits. The data is caveated as the average number of daily visits will be reduced as the co-ordinator role was included in the October data collection.

Table 3 Average daily caseload per nurse per day

Average number of patients per nurse per day	West	Central	North	South
Oct 23	6.54	7.68	6.51	6.89
Mar 24	8.78	9.01	6.87	8.22

The data also identifes that the majority of patients that are seen, sit within the lowest level of dependency, category 1 (see figure 3). These are often for insulin administration/medication administration which require high frequency visits. The most complex patients category 4 still constitute a low percentage of the caseload.

Figure 3 Caseload by patient dependency – March 24



Next Steps Plan

- Undertake census October 24 – improve data collection efficiency.

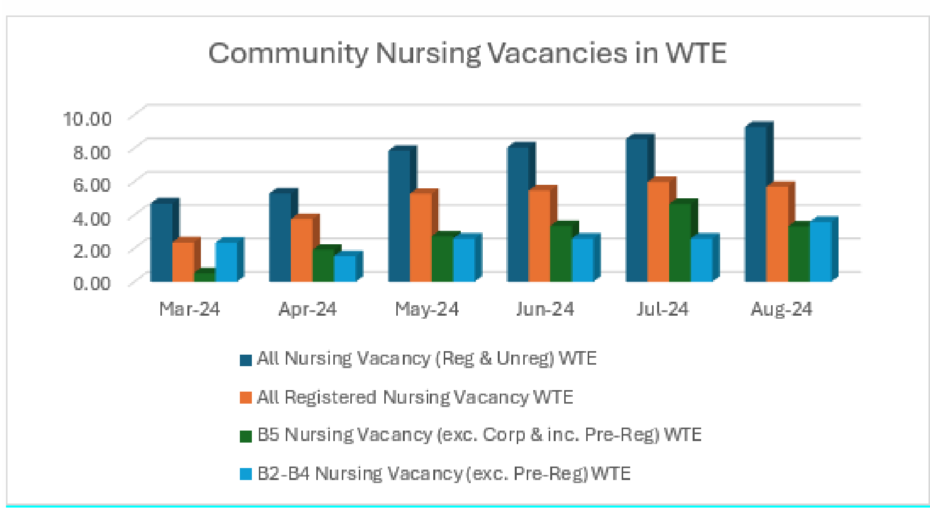
- Community Nursing Matrons to review locality establishments and skill mix within the localities in Integrated Neighbourhood Teams context.
- Review safe staffing establishment and make recommendations for business planning. Continue to monitor demand and capacity through weekly staffing.
- Review Community Nursing OPEL status reporting.
- Skill mix review of other Community services resulted in the transfer of 2.6 WTE B6 to Community Nursing

5.5 Vacancies, turnover and sickness absence in Community Nursing

Staff retention continues to be an area of focus and there are clear career pathways for registered and unregistered staff. Apprenticeships (band 5 and ACP) and the Nurse Associate roles have been well received and we continue to support these pathways, which results in retaining our staff through the different stages of their careers. Community Nursing also continues to work directly with NHS England to secure funding streams for the specialist Community Nursing qualification, with an average of 4 registered nurses being supported each year.

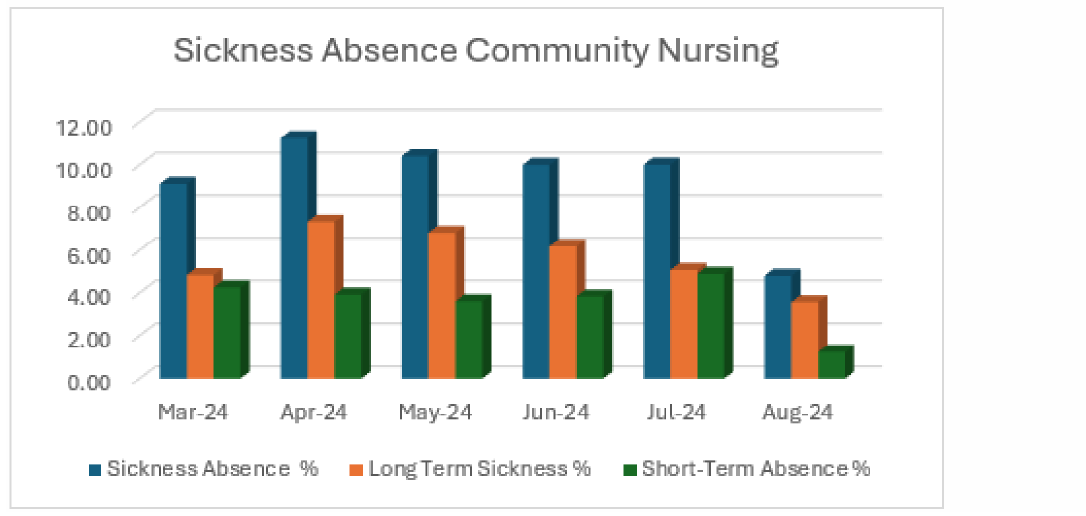
In August 2024, the vacancies for band 5 registered nurses were 3.31 wte, but the team currently have no vacancies with the new intake of newly qualified nurses in September. The budget has recently been reviewed and following a number of staff successfully qualifying as band 4 Nursing Associates the team is currently recruiting 5 wte Health Care Support Workers.

Table 6 Community Nursing vacancies



Sickness absence is monitored within the individual teams with support from HR colleagues, looking at short and long term sickness absence. In August 2024, the overall sickness was 4.82%.

Table 7 Community nursing sickness absence



6.0 Maternity staffing

6.1 National / regional context

This paper covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board on a six-monthly basis, (Maternity and Perinatal Incentive Scheme Year Six).

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

Trusts are expected to commission a BR+ report every 2-3 years, and a revised report was received by GWH's report in May 2022, which was funded by the Local Maternity and Neonatal System (LMNS). This report identified a registered midwife gap of 3.33wte. The BR+ report is reflective of a 20% uplift in maternity services. Following the Ockenden report there is a requirement to reflect a workforce that can accommodate increased levels of training. This requires a 28% uplift (including maternity leave) to achieve this training requirement. A temporary uplift of 24% has been approved utilising the CNST rebate from year 4 of the maternity incentive scheme. Further analysis of the workforce across the LMNS is in progress to develop a system wide approach to a sustainable headroom uplift.

The next BR+ review has been commissioned and funded by the LMNS, with data capture in progress to inform the review. The full review is expected to be undertaken within 2024/25 which will inform future workforce modelling.

It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has improved over the last six months by identifying different staffing models, recruitment locally and through engagement with the NHS England international recruitment program.

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

The embedded recruitment plan continues to ensure a rolling planned model of recruitment to ensure that there is a constant pipeline of new starters.

The inpatient services have been successful with recruitment with the ongoing vacancy sitting within the community midwifery workforce. A rolling recruitment program is in place which supports new staff to join the Trust and offers the opportunity for staff rotation to community services and the recruitment strategy has been reviewed to allocated staff to their area of service on appointment, which enables the areas of the greatest service need to be prioritised.

There is now a plan to further focus on retention of staff, utilising the NHS England Education and Training funding for the retention which has been continued into 2024/25. A recruitment and retention lead is in place utilising this funding to provide a robust orientation and preceptorship program with an aim to improve retention in the first year after qualification and reduce the time taken to consolidate the enhanced skills to support them working in other areas of the service, which include community services.

The below table illustrates the level of staff turnover across departments, monthly between March and September 2024. The turnover within the inpatient teams has stabilised. The increased turnover in the Specialist Midwife group reflects career progression opportunities and secondments and this is not expected to continue. There have been successful appointments into vacant posts which indicates that the succession planning achieved through the appraisal process is providing staff with the skills and abilities to progress within the wider team. The turnover within the community teams remains an outlier despite adaptations to working patterns to include a longer working day. The next steps will focus on a shift based homebirth model which may influence the retention of staff who would prefer not to work in an on call model.

Division	Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Surgery, Women's & Children's Division	Ante-Natal Screening - J65919	5	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Birthing Centre - J65921	17	2	12.12%	2	12.12%
Surgery, Women's & Children's Division	Community Midwifery - J65918	49	10	20.62%	8	16.49%
Surgery, Women's & Children's Division	Continuity of Carer - Midwives - J65922	8	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Day Assessment Unit - J65910	24	2	8.33%	2	8.33%
Surgery, Women's & Children's Division	Hazel & Delivery Staff - J65914	143	19	13.33%	19	13.33%
Surgery, Women's & Children's Division	Specialist Midwives - J65920	27	4	15.09%	4	15.09%

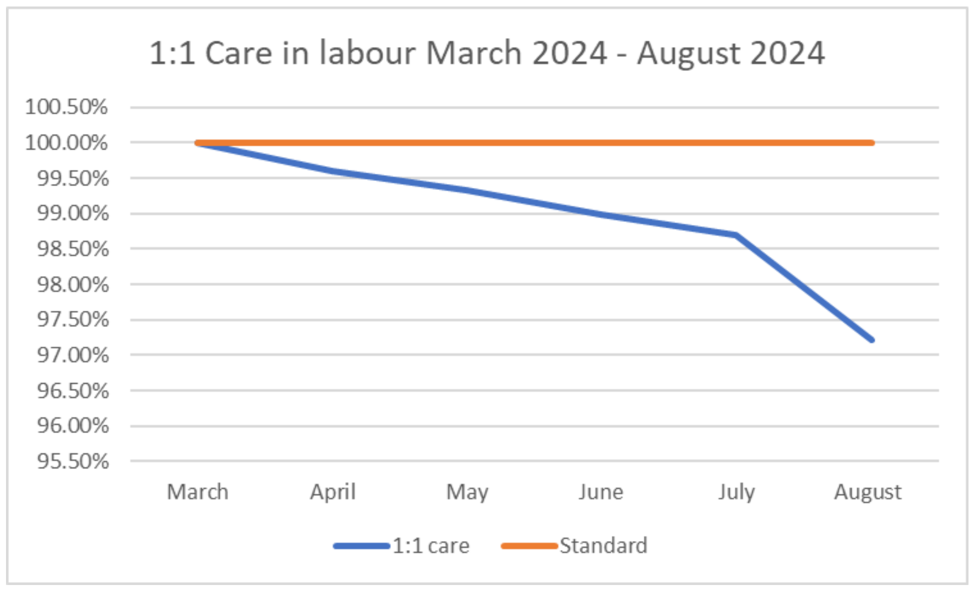
There is an increased sickness rate within both community services and the Hazel and Delivery groups. The matron team are developing an A3 to support reducing sickness in conjunction with the wider Trust. This has been supported by a focus on supportive 'Welcome Back to Work' meetings and HR guidance. The increased sickness within the community staff relates to long term sickness with mitigations in place including staff support to return to work.

Sickness Rates as of August 2024				
Department	**Professional Group**	**ST**	**LT**	**% Sick**
Ante-Natal Screening - J65919	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Birthing Centre - J65921	Registered Nursing and Midwifery	0.63%	0.00%	0.63%
Community Midwifery - J65918	Registered Nursing and Midwifery	2.66%	7.49%	10.15%
Continuity of Carer - Midwives - J65922	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Day Assessment Unit - J65910	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Hazel & Delivery Staff - J65914	Registered Nursing and Midwifery	3.48%	3.75%	7.23%
Specialist Midwives - J65920	Registered Nursing and Midwifery	0.64%	2.99%	3.63%

The recruitment of Internationally Educated Midwives (IEM) has been in place at GWH since June 2022. 10 midwives have joined the midwifery team and completed the OSCE program to obtain their NMC PIN, supported by a dedicated practice educator. Due to the reduced vacancy, loss of NHS England funding supporting the Practice Educator role and high level of support required to stay and thrive, the pipeline for IEM has been paused at present.

6.3 One-to-one care in Labour and Midwife to birth ratio

The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the data demonstrates that there is fluctuation between 97.72% and 100% compliance over the 6-month period. Each case where 1:1 care is not fully achieved is reviewed to ensure that escalation processes have been utilised to minimise the impact on the family, and to provide opportunities to develop escalation pathways to prioritise labour care in line with the Maternity Incentive Scheme (CNST) safety action 5, with a detailed action plan in place to support achieving 100% compliance. There have been no patient safety concerns associated with occasions where the 1:1 care was not achieved.



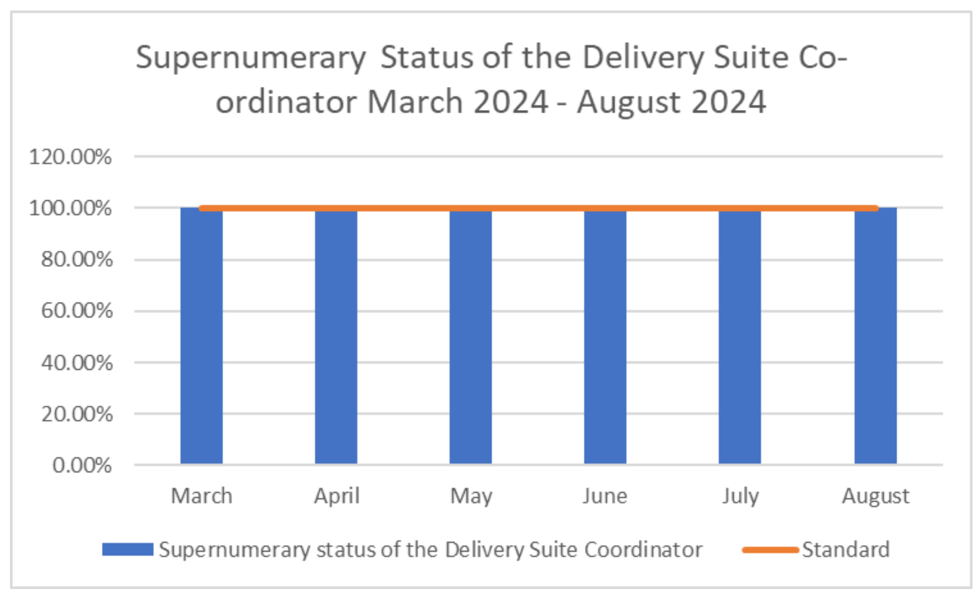
The Maternity Service monitors and reports the Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer Childbirth (2007). The midwife to birth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

fluctuation in the midwife to birth ratio which is impacted by variable birth numbers month on month and the vacancy factor in the community midwifery team.

Trust	May 2024	June 2024	July 2024
Great Western Hospital	1:28	1:26	1:27
Royal United Hospital Bath	1:27	1:27	1:28
Salisbury Foundation Trust	1:28	1:25	Data not available

6.4 Supernumerary status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status to ensure there is an oversight of all birth activity within the service. This is defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service, which is specified within the maternity Incentive Scheme (MIS). Over the period March 2024 – August 2024 100% compliance was achieved. The focus is now on maintaining 100% compliance.



6.5 Red Flags

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

The red flags are defined as:

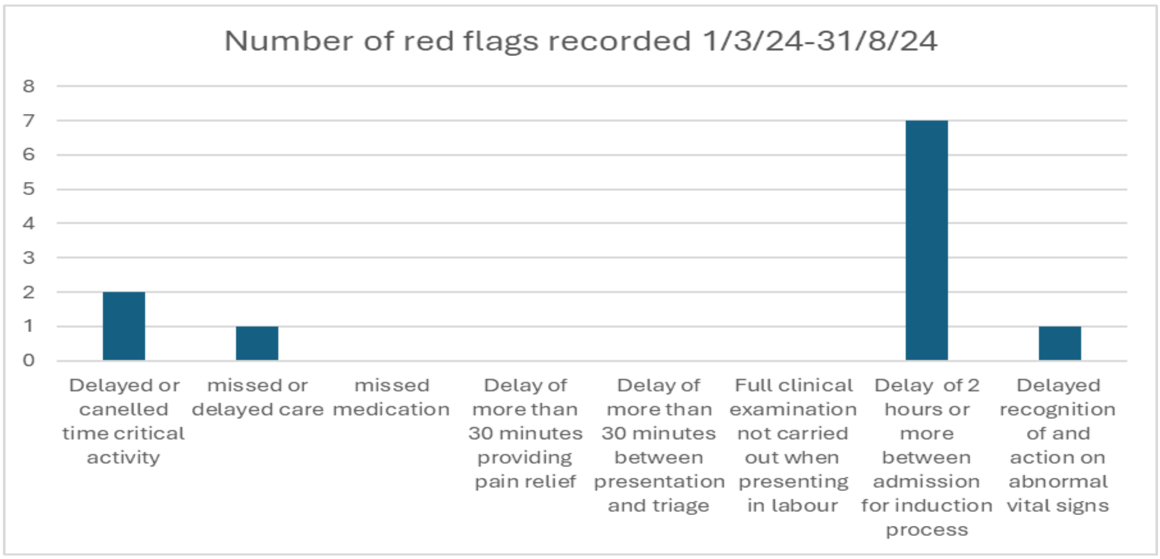
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes for suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example diabetes medication)

- Delay of more than 30 minutes in providing pain relief
- Delay of more than 30 minutes between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delay recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour (see graph 6.3)

Other clinical and management actions are captured to represent to activity within the service including redeployment of staff to other services/sites/wards based on acuity.

The data below shows the periods of March 2024 to August 2024 when 11 red flags were recorded. We can see the significant impact that the relocation of Triage services has had on patient safety as there were no red flags reported during the reporting period time, for "The delay of more than 30 minutes between presentation and triage".

We have seen increase in red flags related to "Delay of 2 hours or more between admission for induction and beginning of process", which was reported on 7 occasions, which was due to acuity and flow, no harm occurred as a result. This will feed into A3 around reducing the length of stay which will consequently improve the flow through Maternity services.



The Acute Unit Midwifery on call system is now embedded in the service to minimise the impact of red flag triggers on service delivery. During the reporting period, the Acute Midwife On call has been utilised on 4 occasions.

The acute unit on call system has had a further impact on reducing the need to call the community teams into the unit; this has impacted positively on recruitment to the community teams.

6.6 Recruitment and retention

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

- Introduction of the Midwifery Degree Apprenticeship Program (MDAP). Four members of the existing midwifery support worker team have initiated the MDAP with Winchester University.
- The retention funding via NHS England has been confirmed to be continuing for a further 12-month period.
- An extended supernumerary period for newly qualified midwives is in place, utilising nationally available funding
- Scheduled meet and greets with divisional staff, new starters and students
- Review and refresh of preceptorship package
- Blended learning programme with University of West England
- Working with Universities to increase student midwife places
- Return to practice programme
- Successful completion of the education program for Internationally Educated Midwives
- Health Education England funding for nurses to undertake 2-year Midwifery course
- Close working with Swindon College, supporting T level student placements
- Health and well-being programme
- Apprenticeship and Nurse Associate model to 'grow our own'.

Funding was secured to provide an enhanced Professional Midwifery/Nurse Advocate model for restorative supervision. This is being used alongside 2 funded places for newly appointed professional midwifery advocate training places to expand the offer of the advocacy service to support staff in line with the national framework.

6.7 Continuity of carer

One of the key areas of focus were identified in the Better Births report (2016) to improve outcomes of maternity services was identified as continuity of carer. Two teams were initiated at Great Western Hospital (GWH) in 2022 with an aim to deliver the model of care to the most vulnerable families. The CORE20PLUS5 approach identified these families to include women or birthing people from Black, Asian and minority ethnic communities and the most deprived groups defined by the national index of deprivation.

The commitment in terms of work/life balance required for a CoCr model has not been found to be sustainable locally and despite financial remuneration to staff GWH has not been able to continue this model of care at present and following challenges in recruitment the CoCr model at GWH was paused in December 2023 with actions in place to mitigate the impact of this change on women and birthing people.

7.0 Neonatal staffing

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

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

Maternity Incentive Scheme with Trusts required to evidence that the neonatal unit meets the BAPM neonatal nursing standards. Where this is not achieved a local action plan must be in place which should be shared with the LMNS and Neonatal ODN.

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

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

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

These care levels are defined in specific detail by nationally set criteria. To meet BAPM/NHSE standards with the unit at full cot capacity staffing levels on each shift should be:

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

Staffing requirements will fluctuate with acuity and therefore staffing to an average cot occupancy result in staffing being set at 7.0 wte per shift. Staffing data is reported on a monthly basis to demonstrate both the skill mix on a shift to shift basis and amongst the whole neonatal nursing workforce.

The budgeted establishment meets the BAPM neonatal nursing standard. The proportion of staff who are QIS trained has reduced to 60.6-63.3% since January 2024 against the target of 70%. This is due to an increase in new staff who are not QIS trained, and not due to attrition. Despite several targeted rounds of recruitment, the team have been unable to appoint any staff new to Trust who hold the QIS qualification. Benchmarking across the region demonstrates that other Trusts are reporting this metric below 50%.

Two nurses have completed the QIS program at Birmingham University course which started in Dec 2023 and ended July 2024. Both have provisionally passed the course and are awaiting confirmation of this through the university board in October. Three further nurses commenced the Birmingham course in October 2024 to complete in April 2025, and a further three will commence the course in December and finish in July 2025.

This will be the first time the service has run two cohorts of nurses attending due to the availability of courses and the operational impact of ensuring safe staffing whilst releasing staff due to the covering clinical shifts on LNU.

There is a pilot QIS programme commencing Jan 2025 which will run in Plymouth and be led by the SW Neonatal Operational Delivery Network (ODN). The expectation is that from Sep 2025, the course will be delivered by the Network in Bristol. This will follow directly on from

the Foundation programme that the ODN have been running for the past 18 months and that all new registered nurses are enrolled on when they join the Trust.

	Target	Threshold		April 24	May 24	June 24	July 24	Aug 24	Sept 24
Percentage of shifts staffed to BAPM QIS recommendations	90 %	≥90%	<90%	96.6%	96.6%	90.0%	70.9%	66.1%	66.6%
Percentage of Registered Nurse or Midwifery staff who hold Qualified in Speciality (QIS)	70 %	≥70%	<70%	63.3%	63.6%	63.8%	63.8%	62.7%	60.6%

The reduction of agency staff has been sustained and has not impacted the skill mix on a shift-to-shift basis.

The funded establishment meets the BAPM standards for neonatal nursing staff based on the cot capacity and activity. This has been reviewed and approved in collaboration with the Operation Delivery Network (ODN).

7.1 Recruitment and Turnover in The Neonatal Unit

Turnover Rates			
Department	Average Head Count	All leavers	All Turnover
Neonatal Unit – J65931	45	0	0%

Sickness Rates			
Department	Short Term Sickness	Long term Sickness	Total % Sickness
Neonatal Unit - J65931	2.29%	3.42%	5.71%

The sickness has reduced from 7.01% in the previous reporting period to 5.71% in the current period and has demonstrated a sustained downward trend over the last 12 months. A refreshed approach to the 'Welcome Back to Work' introduced by the new ward managers process has positively impacted on supporting staff wellbeing. Furthermore, the lack of staff turnover is a positive indication of the orientation and welcome to the team for new staff, and the leadership by the ward manger team to ensure that each member of the team feels valued.

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

Recruitment into Band 5 posts for nurses who are not yet QIS has been successful, with the recruitment and retention focus on supporting those nurses through a preceptorship program and with educational support to increase the annual intake of nurses onto the QIS education pathway. This program of education was commenced in January 2024, which is being led by our Neonatal Practice Educator, has been positively evaluated by staff, which has positively impact on the turnover rate in the last 6 months.

The Lead Advanced Neonatal Nurse Practitioner (ANNP) is now embedded within the team with one further ANNP in role. There has been limited applicants for the remaining post despite a focused recruitment campaign. The 4 apprenticeship ANNPs have entered the second year of the 3 year program. The qualified posts support both the development of the service provision locally, provide educational, peer support and mentorship to the trainees and nursing workforce, alongside facilitating enhanced service development work and supporting the medical workforce. These roles support career development opportunities within the workforce. With the pipeline of apprentices, a fully staffed rota will be in place from 2026 of all of the team take up full time posts.

7.2 Temporary staffing

There has been considerable focus on reducing agency use on the neonatal unit. A consistent and robust strategy was implemented in November 2023 with increased controls has demonstrated a sustained reduction in agency staff bookings.

8.0 Allied Health Professionals report

8.1 Workforce Overview

Allied Health Professionals (AHPs) are degree-level professionals who work across health and social care, playing a key role in assessment, diagnostics, treatment, discharge, and rehabilitation. AHPs represent the third-largest clinical workforce within the sector. Great Western Hospital (GWH) employs professionals from 9 out of the 14 recognised AHP disciplines, which include:

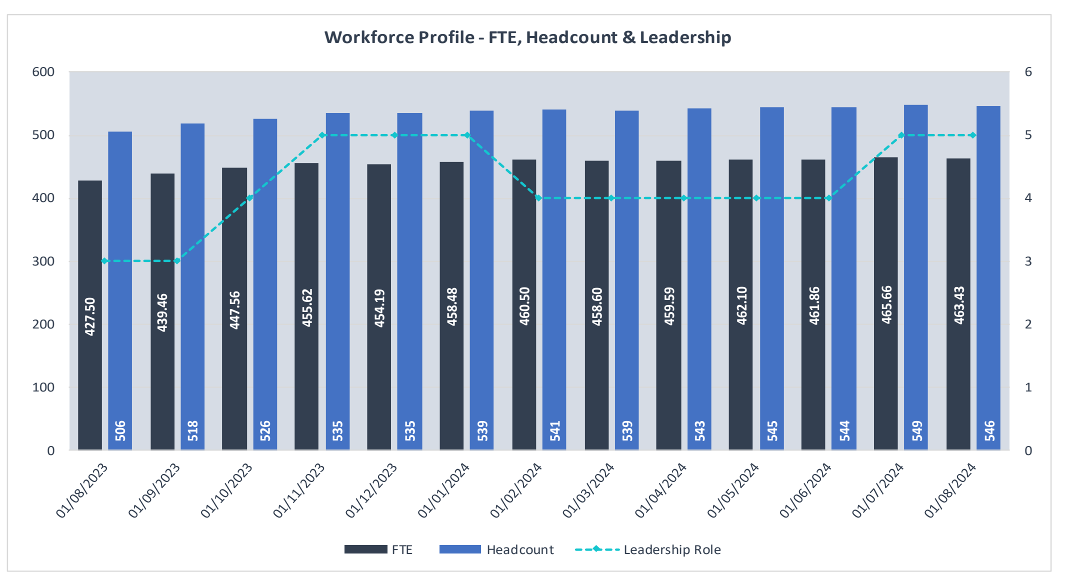
- Dietitians
- Occupational Therapists
- Operating Department Technicians
- Orthoptists
- Paramedics
- Physiotherapists
- Podiatrists
- Radiographers
- Speech and Language Therapists

AHPs are regulated by the Health and Care Professions Council (HCPC) and are supported by a workforce of both registered and unregistered staff, with a ratio of 3:1.

GWH currently employs 463.66 Whole Time Equivalent (WTE) AHPs, representing 546 individuals. While most AHPs are concentrated in the IC&C division, radiographers are housed

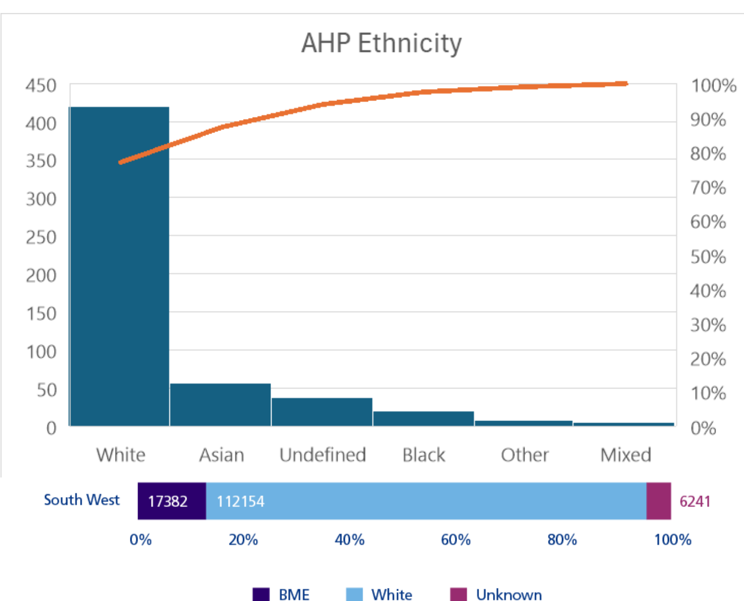
in the Medical division and orthoptists in SW&C. However, clinical work often spans across divisions, making governance and activity tracking challenging.

Some AHPs hold extended roles beyond traditional clinical practice, such as leadership positions or working in areas like urgent treatment centres (UTC). The Associate Director of AHPs maintains regular contact with all registered staff.



8.2 Workforce Diversity

The AHP workforce at GWH is predominantly female, with a continuing underrepresentation of individuals from global majority backgrounds. This trend mirrors the Southwest region but is less representative of the local Swindon population. GWH is actively promoting early career pathways to address this disparity by developing carer entry routes from the local population.

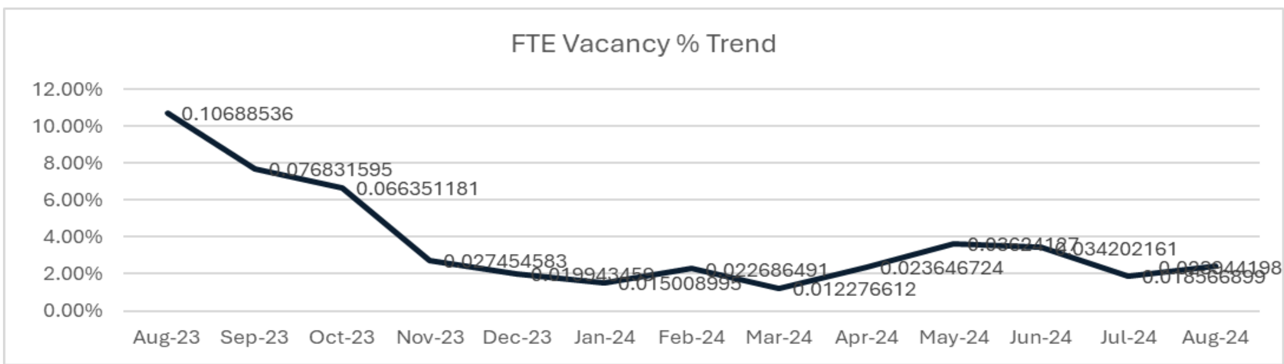


There has been an increase in the number of staff reporting their sexual orientation, particularly among bisexual and gay or lesbian employees. This suggests improved comfort and trust in the organisation regarding diversity and inclusion.

8.3 Workforce Supply

8.3.1 Vacancies

Vacancies in the AHP workforce saw an increase starting in March, but recent efforts have prevented a return to the peak vacancy rates of over 10% seen in 2023.



Orthoptics has made significant progress, reaching full staffing for the first time in a year following a successful recruitment campaign and service restructure.

However, challenges persist in diagnostic radiotherapy, occupational therapy (OT), and entry-level podiatry.

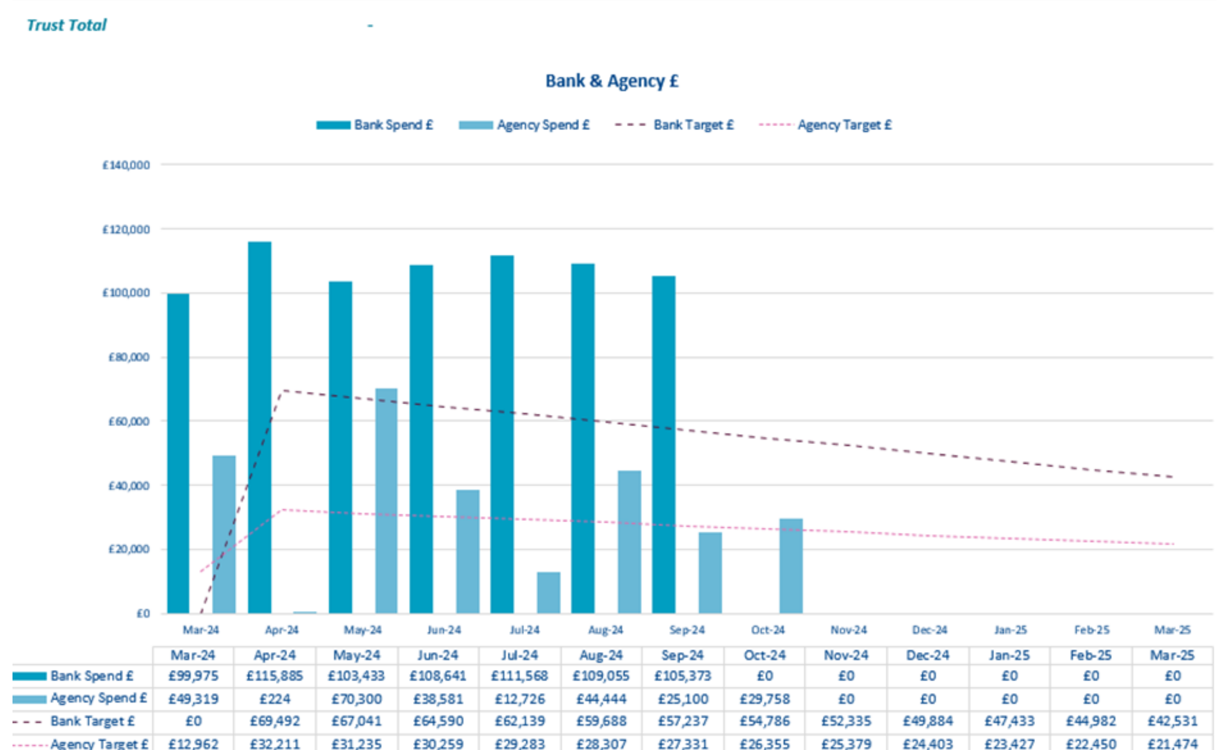
National shortages in podiatry, linked to gaps in university cohorts, are expected to be addressed through the introduction of work-based learning within the next decade. GWH has focusing on higher-level apprenticeships and extended scope roles to date to attract talent. The focus now needs to be on securing band 5 podiatrists via the apprenticeship route.

OT have implemented the improving together methodology realising improvement in recruitment with 9 new members of staff being onboarded and further reform to be implemented.

Diagnostic radiography continues to face challenges, especially in breast imaging and ultrasound. Efforts to improve staff retention and training opportunities, such as bringing in clinical practice educators, have begun to show positive results.

8.3.2 Bank and Agency Spend

Agency spend remains above target, particularly within the medical division, where diagnostic radiography is the main driver. Issues contributing to these costs include workforce shortages, recruitment and retention challenges, and unfunded services. Governance improvements have been introduced to better manage temporary staffing costs, with the AHP leadership and divisional team working together to reform workforce practices and build a long-term staffing model.

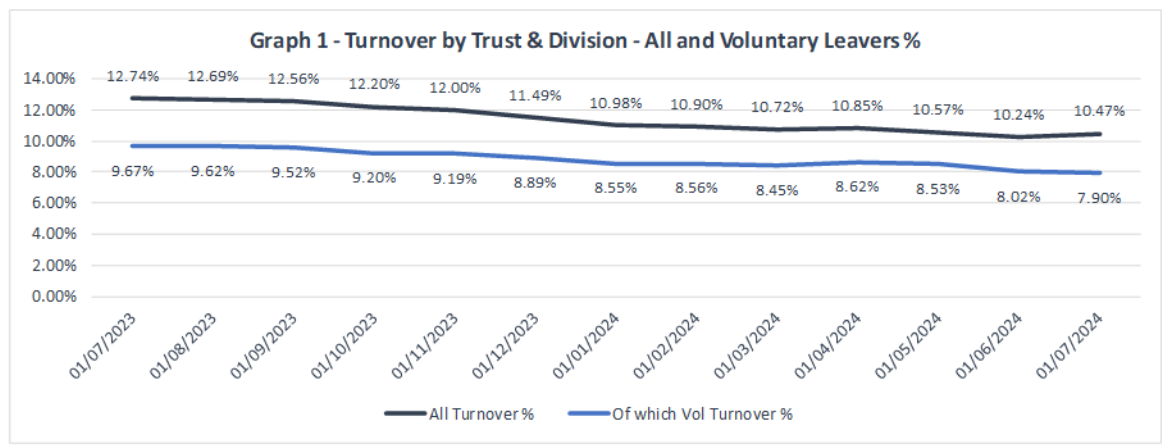


	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Bank Spend £	£99,975	£115,885	£103,433	£108,641	£111,568	£109,055	£105,373	£0	£0	£0	£0	£0	£0
Agency Spend £	£49,319	£224	£70,300	£38,581	£12,726	£44,444	£25,100	£29,758	£0	£0	£0	£0	£0
Bank Target £	£0	£69,492	£67,041	£64,590	£62,139	£59,688	£57,237	£54,786	£52,335	£49,884	£47,433	£44,982	£42,531
Agency Target £	£12,962	£32,211	£31,235	£30,259	£29,283	£28,307	£27,331	£26,355	£25,379	£24,403	£23,427	£22,450	£21,474

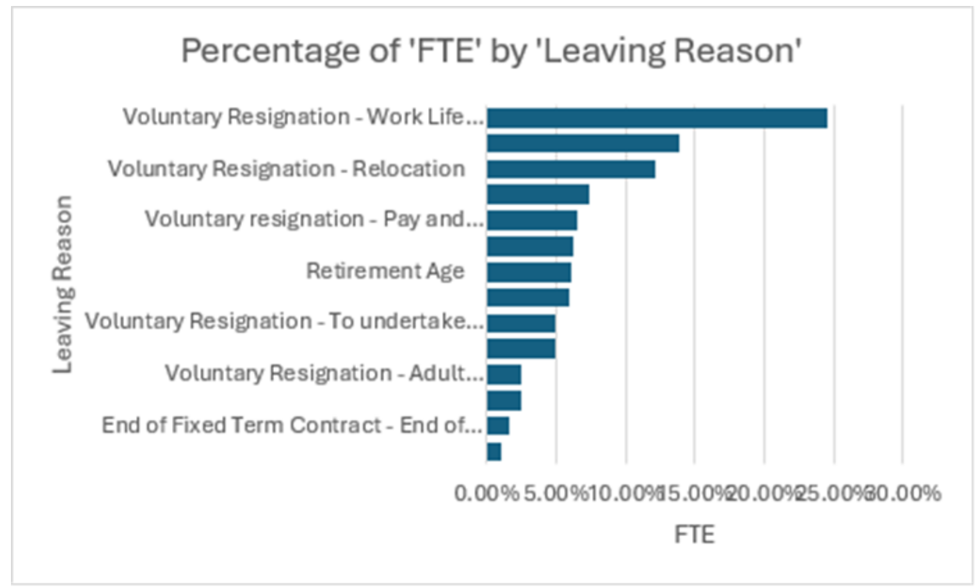
Bank spend remains higher than expected. AHP's are staffed on headcount without budget headroom. Additional controls and scrutiny is now in place to ensure that there is improved oversight and reduction in costs.

8.3.3 Recruitment and Retention

Recruitment and retention efforts have shown improvement since the last report, with turnover rates dropping from 11.5% all turnover and 9.8% voluntary to 10.4% all and 7.9% voluntary.



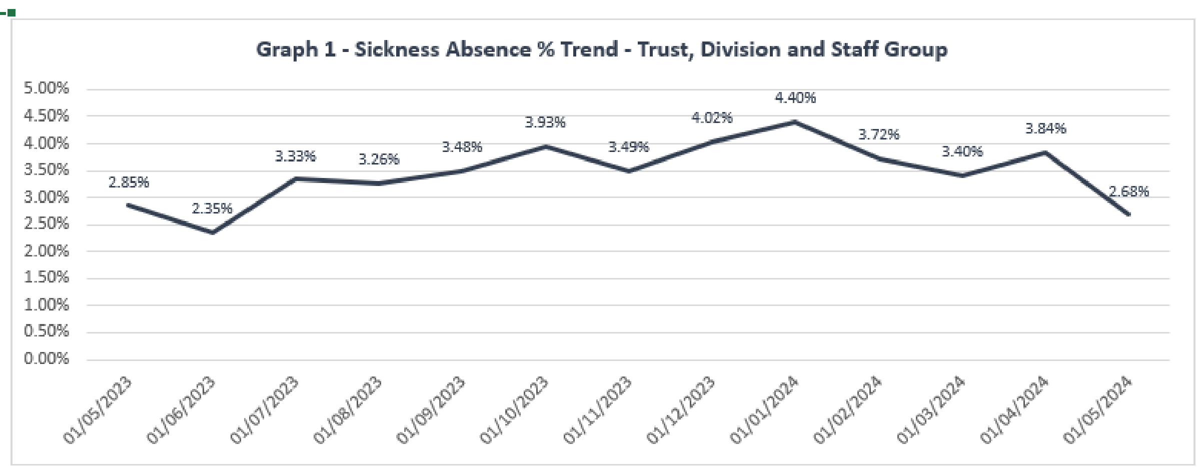
Retention remains a concern; particularly as surrounding organisations offer more flexible working arrangements.



To address this, AHP "Stay Clinics" are rolling out to provide staff with an opportunity to discuss their career development and potential concerns in a confidential setting. Exit interviews are also being introduced to gather feedback and reduce future turnover.

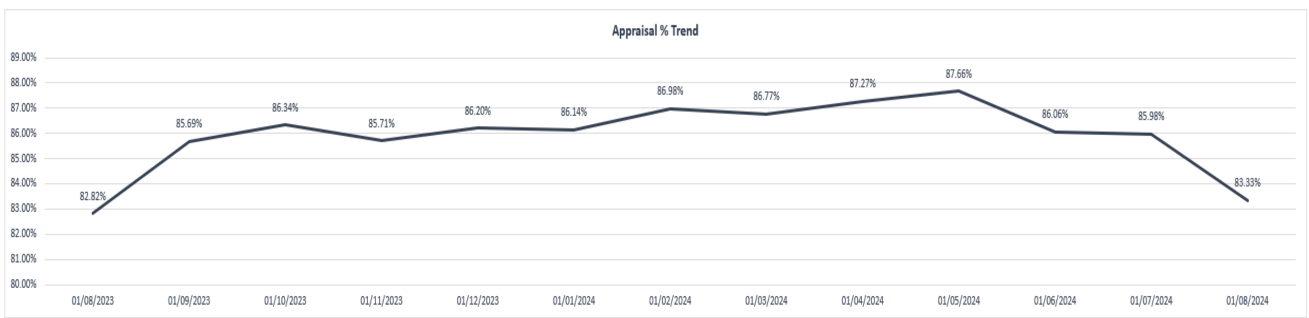
8.3.4 Sickness

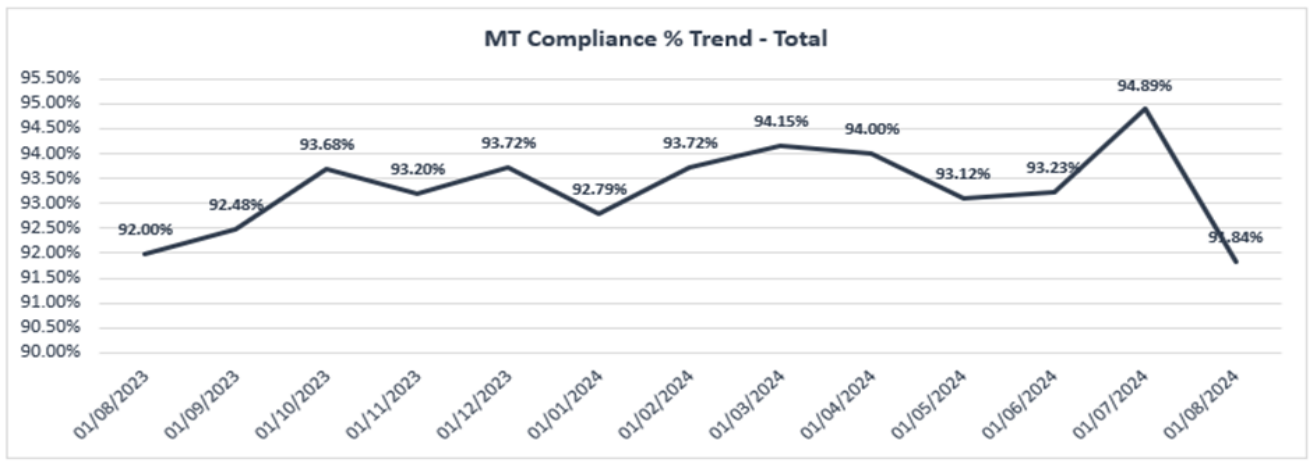
Sickness rates remain low among AHPs, though certain areas, such as acute therapies and community podiatry, have seen higher rates due to workforce shortages. Long-term sickness in some areas, such as dietetics administration, is being managed.

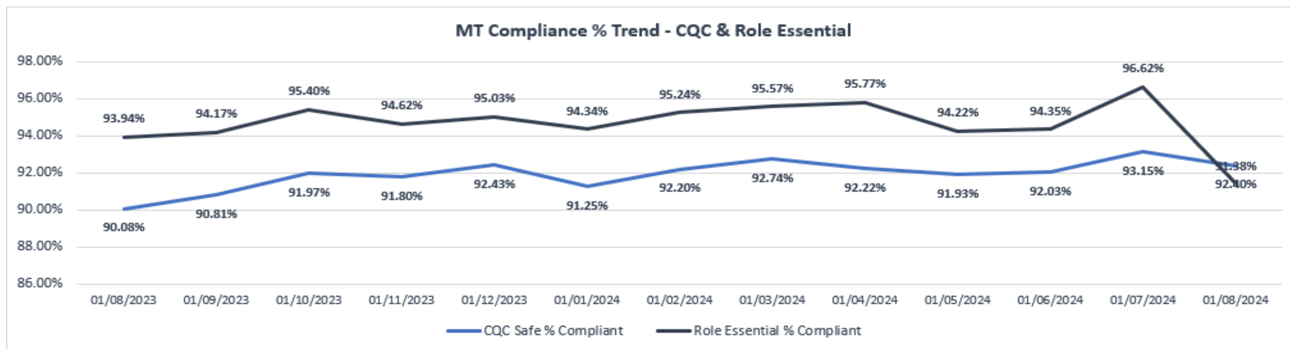


8.3.5 Appraisal and Mandatory Training

Both appraisal and mandatory training compliance have declined in the past six months. Appraisal compliance has dropped to 83%, below the trust target of 85%. Mandatory training compliance is at 91%, which is within the trust target but lower than expected for achieving CQC recommendations.







These trends will be addressed through divisional and AHP leadership meetings to ensure recovery in the next six months.

8.4 Safer Staffing

There are no national safer staffing levels for AHPs, making it difficult to benchmark service delivery. GWH AHP services are participating in a national benchmarking project, with results expected in mid-October.

Outpatient physiotherapy have implemented paper job planning, which has improved staff satisfaction and activity levels. This approach is being explored in other areas of unplanned care.

A clear target driven long term workforce plan requires capacity and demand modelling to be completed before staffing trajectories can be fully presented. NHS England has led capacity and demand modelling amongst some AHP staff groups nationally, including acute therapies and imaging to provide solutions for the lack of AHP safer staffing models. Opportunities to

learn and adopt these models are being explored. Support from IT is required to implement this. This will increase understanding of the AHP workforce, and risks associated with non-delivery based on staffing numbers.

Progression of this is being monitored via the AHP governance structure. Progress is limited due to the lack of project management support to fully mobilise programmes.

8.5 Pipeline Supply

GWH has been proactive in developing its AHP workforce through apprenticeships, with 60% of AHP areas utilising level 6 apprenticeships to build pipeline supply. The first GWH AHP apprentices are now transitioning into registered roles.

However, educational fatigue among staff due to increased demands from learners is a challenge. Clinical practice educators have been introduced in key areas to address this and reduce staff turnover.

GWH recently hosted a "Dare to AHP" event aimed at promoting AHP careers among local school-age children. The event was well attended and highlighted a need for more early-career opportunities within the organisation. The nursing model is well established, and work is being done with the apprenticeship team to streamline this for AHP's. A SOP is required and consideration in investment of lower-level support workers to provide traction to this model is required, as detailed in the long-term workforce report.

8.6 Key Risks and Work in Progress

8.6.1 Risks

- Operational delivery is at risk if future workforce planning is not proactive.
- Financial planning is at risk if workforce demands continue to rely on temporary staffing.

8.6.2 Ongoing Work

- Promoting early-career entry to increase workforce diversity.
- Developing a standardised apprenticeship pathway from entry-level to consultant roles.
- Implementing capacity and demand tools in each service line to better align workforce with key performance indicators.
- Launching stay clinics and exit interviews to reduce turnover.
- Ongoing monitoring of sickness, mandatory training and appraisal.
- Reviewing bank and agency spend targets as part of ongoing workforce reform.

8.7 Conclusion

The AHP workforce is in a stronger position than six months ago, but continued efforts are required to address retention challenges and national shortages. A clear long-term workforce plan, informed by capacity and demand modelling, will be crucial to building a sustainable AHP workforce at GWH.

9. Trust Risk Register

As per NQB guidance, the Nursing and Midwifery staffing risks are on the Trust Risk Register. There are 2 of note.

Risk 500 - Nurse to patient ratios - safe nurse staffing - Score 9
There is a risk of poor quality metrics and reduced staff morale / high turnover due to the inpatient wards working at a ratio of 1:10 for registered and unregistered staff. The SWICC wards are funded to 1:10 in their establishment. Other wards work to 1:10 when short notice gaps. This is against the national guidance of 1:8 or below.

Risk 1132 Financial affordability of high quality patient care if nursing and midwifery temporary staffing costs are not reduced - Score 9

There is a risk to the financial affordability of high quality patient care if nursing and midwifery temporary staffing costs are not reduced, this would impact on ability to maintain safer staffing levels and the Trust's financial recovery plan.

10. Conclusion

This report has outlined the safe staffing processes and assurance on delivery of safe staffing across Acute nursing, community nursing, Midwifery and AHPs.

11. Recommendations

The report makes the following recommendations:

- Ensure robust recruitment and retention plans for registered nursing in light of the reduction of the international recruitment pipeline and reduced student nurse applications.
- Develop improved monitoring for when wards / clinical units are working above the 1:10 ratios.
- Complete the Community CNSST audit in October 2024 and ensure establishment recommendations are considered.
- Ensure the next Birth Rate + report recommendations inform future workforce planning to achieve safe staffing.

Report Title	Directors Code of Conduct 2024-2027				
Meeting	Trust Board				
Date	5 December 2024	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Directors Code of Conduct – for approval				

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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Review undertaken within timeframe.

Report

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

It is a requirement of the Constitution that "*Directors and (where relevant) Nominated Officers should comply with the Directors Code of Conduct and any guidance or best practice advice issued by NHS England. This section of SOs should be read in conjunction with these documents*". For the purposes of the Constitution, the "Directors Code of Conduct" means the Code of Conduct for Directors of the Trust, as adopted by the Trust and as amended from time to time by the Board of Directors, which all Directors must subscribe to.

The current Code of Conduct was approved by the Board in December 2022 and is therefore due for its two year review.

The changes to the code are highlighted in yellow in appendix 1 and mainly reflect the revised Fit & Proper Person Framework.

The document has been revised in line with Royal United Hospitals NHS FT and Salisbury NHS FT.						
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	Trust Chair				
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 adopt the Directors Code of Conduct 2025 – 2027.	
Accountable Lead Signature	Caroline Coles, Company Secretary
Date	28 November 2024

Code of Conduct for the Board of Directors 2025-2027

1. Introduction

High standards of corporate and personal conduct are an essential component of public services. As an NHS Foundation Trust, the Great Western Hospitals NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all directors. This is in addition to the Trust's STAR Values (Service, Teamwork, Ambition, Respect).

This Code, and the Code of Conduct for Governors and the NHS Constitution, form part of the framework designed to promote the highest possible standards of conduct and behaviour within the NHS Foundation Trust. The Code is intended to operate in conjunction with ~~NHS Improvement's Code of Governance~~ The Code of Governance for NHS Provider Trusts, The NHS Trust's Provider Licence, the NHS Foundation Trust's Constitution and Standing Orders and with the Care Quality Commission's Regulations relating to Fit and Proper Persons.

~~The Code applies at all times when Directors are carrying out the business of the Trust or representing the Trust.~~

2. Application of the Code

This Code applies to Directors when they are acting in the capacity of a Trust Director and outlines the behaviour expected of persons holding such office within the Trust.

This Code also applies to Directors when acting in other capacities (including a personal capacity) in the event that there are concerns about a Director's conduct when they are acting in such other capacity and those concerns are relevant to the person's role as a Director. The Trust will act proportionately and reasonably when applying this Code in any such circumstances.

3. Principles of Public Life

All Directors are expected to abide by the Nolan principles of selflessness, integrity, objectivity, accountability, honesty, transparency and leadership.

- **Selflessness**
  Directors should act solely in the public interest; they should not act so as to gain financial or other benefits for themselves, their family or their friends.

- **Integrity**
  Directors should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

- **Objectivity**
  In carrying out public business including making public appointments, awarding contracts or recommending individuals for rewards and benefits, directors should make choices based on merit alone.

- **Accountability**
  Directors are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness**
  Directors should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty**
  Directors have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts of interests so that the public interest is protected.

- **Leadership**
  Directors should promote and support these principles by leadership and example.

4. General Principles

Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from public funds to which they are entrusted and to demonstrate high ethical standards of personal conduct.

The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and to the wider public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of ethical conduct. The Board of Directors will lead in ensuring the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying Scheme of Delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this Code of Conduct will inform and govern the decisions and conduct of all directors.

5. Confidentiality and Access to Information

Directors must comply with the Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances.

Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Trust has adopted policies and procedures to protect the confidentiality of personal information and to ensure compliance with the Data Protection Act, the freedom of information act and other relevant legislation which will be followed at all times by the Directors.

6. Bribery and Corruption

Directors should be aware that under the Bribery Act 2010 it is an offence to accept any inducement or reward for doing or refraining from doing anything in an official capacity or corruptly showing favour or disfavour in the handling of contracts. Breaches of these provisions will be reported to the Local Counter Fraud Specialist and could give rise to liability to criminal prosecution and may lead to loss of employment and superannuation rights.

7. **Register of Interests**

Directors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the Constitution. It is the responsibility of each director to update register entries where their interests change. A pro forma is available from the Company Secretary. Failure to register an interest when it comes to light within a reasonable time may constitute a breach of this Code. Any declarations will be transposed onto the Trust's register which will be available on the Trust's website.

8. Fit and Proper Person

It is a condition of the Trust's NHS Provider Licence that every director serving on the Board of Directors is a 'fit and proper person' as defined in the Trust's NHS Provider Licence, by the Care Quality Commission and NHS England's Fit & Proper Person Test Framework for Board members. Directors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Director can no

longer be regarded as a fit and proper person or if it comes to light that a Director is not a fit and proper person, their Board membership will be terminated pending confirmation and the outcome of any appeals process.

9. Conflicts of Interest

Directors have a statutory duty to avoid situations where they have direct or indirect interests that conflict or may conflict with those of the Trust. Directors must not accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust the Director must declare the nature and extent of that interest to the other directors. If such a declaration proves to be or becomes inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

The Trust Chair will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Company Secretary will provide advice on declaring interests between meetings.

10. Duty of Candour

Directors are required to comply with the Duty of Candour in terms of complying with statutory requirements to inform and apologise to patients if there have been mistakes in their care that have led to significant harm noting that the aim of the Duty of Candour is to help patients receive accurate, truthful information from health providers.

11. Gifts and Hospitality

The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Trust for hospitality and entertainment, including hospitality at conferences or seminars will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector.

The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Trust in the eyes of the community. Directors must not accept gifts or hospitality other than in compliance with the Management of Conflicts of Interests ~~in the NHS~~ Policy.

12. Raising Matters of Concern (Freedom to Speak Up ~~or Whistle-Blowing~~)

The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing concerns or complaints about maladministration; malpractice breaches of this Code and other concerns of an ethical nature. The Trust has adopted a Freedom to Speak Up ~~/ Whistle-Blowing~~ Policy on raising matters of concern which will be followed at all times by Directors.

13. Personal Conduct

Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specific provisions are included in the Constitution which are reflected below: -

- Act in the best interests of the Trust and adhere to its values and this Code of Conduct;
- Respect others and treat them with dignity and fairness;
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- Be honest and act with integrity and probity;
- Contribute to the workings of the Board of Directors in order for it to fulfil its role and functions;

- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the NHS Foundation Trust;
- Raise concerns and provide appropriate challenge regarding the running of the NHS Foundation Trust or a proposed action where appropriate;
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Executive Directors, Non-Voting Directors and Non-Executive Directors;
- Make every effort to attend meetings where practicable;
- Adhere to good practice in respect of the conduct of meetings and respect the views of others;
- Take and consider advice on issues where appropriate;
- Acknowledge the responsibility of the Council of Governors to represent the interests of the NHS Foundation Trust's members and partner organisations in the governance and performance of the NHS Foundation Trust, and to hold Non-Executive Directors to account for the performance of the Board of Directors, and to have regard to the views of the Council of Governors;
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person;
- Accept responsibility for their performance, learning and development.

14. Compliance

Directors will satisfy themselves that the actions of the Board and individual Directors in conducting business fully reflects the values, general principles and provisions in this Code and as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Directors will be required to give an undertaking to abide by the provisions of this code of conduct in their capacity as a Board Director for this Trust.

Any Director who requires advice on the provisions or application of this Code should obtain it from the Company Secretary.

All Directors are required to comply with this Code. Each Director must confirm this within 7 days of their appointment by signing and returning to the Company Secretary a copy of this Code.

Any suspected or actual non-compliance with this Code will be addressed in accordance with the Constitution.

15. Approval and review of this Code

This Code was approved by the Trust Board on XXXXX.

This Code will be subject to review, led by the Chair and Company Secretary, not more than two years from its date of approval.

Declaration

I (insert name) ……………………………………………………………… have read, understood and agree to comply with this Code of Conduct for the Trust Board of Great Western Hospitals NHS Foundation Trust.

Signature Date

……………………………………………………………….. ……………………………………………………

Report Title	Committee Effectiveness Review 2023/24 – Trust Management Committee			
Meeting	Trust Board			
Date	5 December 2024	Part 1 (Public)	X	Part 2 (Private)]
Accountable Lead	Caroline Coles, Company Secretary			
Report Author	Caroline Coles, Company Secretary			
Appendices	Appendix 1 – Trust Management Committee Terms of Reference			

Purpose

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

Assurance Level

Assurance ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Annual Committee Effectiveness review completed, and outputs informed amendments to the terms of reference.

Report

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

The Trust Management Committee has completed an annual review and self-assessment of performance using a standardised approach.

This report invites the Board to note a committee effectives review has been undertaken and to consider the terms of reference of the Trust Management Committee as attached. The amendments are highlighted in yellow with the main changes around membership and reference to group model.

There were no issues or concerns to draw to the attention of the Board about the effectiveness of the committee.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
					x

Links to Strategic Pillars & Strategic Risks – select one or more				

Key Risks – risk number & description (Link to BAF / Risk Register)	n/a	Risk Score

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Trust Management Committee
Next Steps	To align annual work plans to the terms of reference

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to approve the terms of reference for Trust Management Committee

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	22 November 2024

TRUST MANAGEMENT COMMITTEE
TERMS OF REFERENCE
2024/25

Purpose
The purpose of the Committee is to support the Trust in achieving all its strategic objective.

1. AUTHORITY

1.1 The Trust Management Committee (the Committee) is constituted as a standing committee of the Great Western Hospitals NHS Foundation Trust's Board of Directors (Trust Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings. It is a non-statutory Committee.

1.2. The Committee is authorised by the Board of Directors to consider any activity within its terms of reference. All colleagues who work at the Trust are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to exercise its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 The Committee ~~has been constituted as the first tier~~ is the executive decision-making group of the Trust. ~~As such it is considered a strategic group which~~ It receives assurance and accepts escalation from a number of tactical sub-groups, which themselves receive assurance and escalation from a number of operational groups across the Trust.

2. ROLE / PURPOSE

2.1 The purpose of the Committee is to provide a mechanism for the Executive Directors to provide assurance to the Board concerning all aspects of delivering the Trust's strategy and supporting strategic plans, including the day to day operational management of the Trust. The Committee brings together the most senior leaders to role model our values, working in an integrated way to deliver conditions that support our colleagues to deliver our strategic objectives.

2.2 In carrying out their duties members of the TMC and any attendees must ensure that they act in accordance with the leadership framework of the Trust, which includes:

- Leadership behaviours
- Clarity about expectations and actions
- Exhibiting trust STAR values

The Committee will create a culture of collective leadership. It will provide a safe space to explore issues, provide solutions, and share learning.

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH and BSW Hospitals Group's Strategic Planning Framework in doing so. The key driver metrics will be reported at every meeting (see section 10).

2.4 Duties include:-

- To support the Trust Board in developing and implementing the vision and strategic direction for the Trust as part of the BSW Hospitals Group, Swindon Integrated Care Alliance (ICA) and BANES, Swindon and Wiltshire Integrated Care System (ICS).
- To develop ideas and formulate proposals that will inform the Trust Board's discussions on the future strategy of the Trust and BSW Hospitals Group.
- To implement the strategy to the key milestones using our Improving Together approach of strategy deployment and the use of a strategic filter.
- To have oversight of/gain assurance on the overall performance of the Trust ensuring all key quality, safety and performance indicators are achieved and early corrective action is taken to prevent variation from plan.
- To drive the annual business planning processes, ensuring the Board is presented with the correct information on which to take sound decisions.
- To provide staff with clear leadership and short-, medium- and long-term direction and vision.
- To lead on the maintenance of effective processes to manage risk by triangulating management information across the Trust that enables a whole organisational view of risks and actions.

3. MEMBERSHIP AND ATTENDANCE

3.1 The membership of the TMC shall consist of:

Managing Director (GWH)
Chief Financial Officer
Chief Operating Officer
Chief People Officer
Chief Digital Officer
Chief Nurse
Chief Medical Officer
Chief Officer of Improvement & Partnerships
Divisional Directors
Associate Medical Directors
Divisional Directors of Nursing
Director of Midwifery & Neonatal Services
Director of Estates & Facilities

3.2 The following participants are required to attend meetings of the Trust Management Committee (mandatory participants):

Deputy Chief Nurse~~(s)~~ (One only unless deputising for CNO)
Deputy Chief Medical Officer~~(s)~~ (One only unless deputising for CMO)
Deputy Chief Operating Officer
Deputy Chief Financial Officer
~~Associate Director of OD and Learning~~
~~Director of Pharmacy & Medicines Optimisation~~
~~Chief Information Officer unless deputising for CDO~~
Deputy Chief Officer of Improvement and Partnerships
Deputy Chief People Officer
Associate Director of Communications & Engagement
Company Secretary

3.2 **Chair** – The Chair of the Committee is the Managing Director. In the absence of the Chair, any other Executive Director shall Chair the meeting.

4. ATTENDANCE

4.1 Non-Executive Directors will not attend meetings of the Trust Management Committee (unless otherwise agreed by the Managing Director for a specific purpose).

4.2 *Substitutes/Deputies* - Each member of the Committee is permitted to send a substitute / deputy to attend in their absence but this will not count towards the quorum. The participants (3.2) should not send a deputy in their absence unless by specific request to the chair.

4.3 *Invitees* - Other persons may be invited to attend meetings of the Committee as required and agreed by the Chair of the Committee. Staff will be invited to present reports as considered appropriate.

4.4 *Compulsory Attendees* – Persons (or in their absence their representative) writing papers for this Committee are expected to attend meetings of the Committee to present their paper.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be:-

- 3 Executive Directors; and,
- representation from each Division – at least one of whom will be a ~~practicing~~ registered clinician.

6. FREQUENCY OF MEETINGS

6.1 The Committee will normally meet on a monthly basis with additional meetings being called where necessary. However, meetings that are not required will be cancelled.

7. RESPONSIBILITIES

The Committee will provide a forum in which to discuss and consider strategic issues which affect operational and corporate services. It will have executive-led tactical sub-groups that will ensure that the Committee is a point of escalation for any risks or issues that need wider operational or corporate consideration, decision, or dissemination. The main responsibilities of the Committee are to:-

7.1 To ensure the implementation of the strategic vision and direction (once agreed by the Board of Directors) in line with the timescales set out by the Board and with due consideration for the needs of the BSW Hospitals Group, ICA/ICS.

7.2 To actively monitor achievement of the annual plan.

7.3 To carry out periodic strategic reviews of the environment and landscape to inform business planning.

7.4 To direct managers, via sub-committees and working groups, to undertake specific areas of work on its behalf.

7.5 To ensure implementation throughout the Trust of key policy actions.

7.6 To assure the Board that a quality, safety and performance management culture is embedded throughout the organisation and the external and internal targets are achieved, and where not, to implement and monitor achievement through action planning.

7.7 To develop, formulate and present ideas and proposals for the Board's consideration and approval.

7.8 To drive the annual business planning and clinical and service development cycle within the Trust.

7.9 To review and recommend business cases for onward approval to relevant committee, including business cases arising through the BSW Hospitals Group, ICA/ICS taking into account financial, quality, workforce and operational performance considerations in line with scheme of delegation.

7.10 To authorise capital and revenue funding in line with scheme of delegation.

7.11 To provide leadership and management of the risk framework ensuring that the Assurance Framework is scrutinised and challenged and an overview is taken to check that the risks remain relevant; controls are adequate and that arrangements are in place to achieve the organisation's objectives and management of risks are effective and operating as intended and to regularly review, scrutinise and challenge risks; actions required to address those risks; and progress against actions as detailed in the Corporate risk register (15+ risks) and Divisional and Corporate Department risk registers. The Committee will:-

- recommend risks for escalation to the Board Assurance Framework where it is felt they have potential to materially impact upon delivery of the trust's strategy

- satisfy itself that risks scoring 15+ are being effectively managed and mitigated
- ensure that new risks scoring 15+ are accurately identified and scored and
- ensure that risks are being consistently reviewed, with timely action taken in mitigation by each Division or corporate department.

7.12 To review and approve estates, facilities management, equality and diversity and any other operational policies, procedures or other documents.

7.13 To receive minutes, notes or reports from sub-committees and groups convened to address particular issues relating to the day-to-day control and management of the organisation.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

8.3. The Committee chair will report to the Chief Executive of the BSW Hospitals Group on the decisions of TMC material to the operation of the Group. This will include elements impacting on the Strategic Planning Framework of the Group.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary of the meeting shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest. Minuting will be supported by a recording +/- transcription.

9.5. Meetings will be held in the GWH Academy Lecture Room unless otherwise stated and all members are required to attend in person. There will be no Teams facility to join the meeting. In the event that the Academy or alternative suitable venue cannot be secured the meeting will be held entirely on Teams.

10. Agendas

The content of the agenda will be agreed by the Chair of the Committee.

Standing Agenda Items
(List of items which shall normally appear on the agenda for this Committee)

The Trust Management Committee will normally receive reports for each meeting on activity under the following headings which reflect the Improving Together approach to drive quality improvement within the Trust:-

- **Strategic Initiatives** - Strategy Delivery, Commitments & Priorities
- **Pillar metrics** - Financial Management, Patient Safety and Quality of Care, Operational Performance, Workforce
- **Breakthrough objectives performance**
- **Strategic filter** – projects & programmes
- **Risk**

11. REPORTING/PROVIDING ASSURANCE

11.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

Minutes / reports from the following for **information only**: -

- Investment Committee, TRIGG (monthly)
- Divisional Operational Performance Review Board (monthly)
- Improvement Board
- Employee Partnership Forum (monthly)
- ~~Equality & Diversity Group~~ Inclusion & Health Inequalities Sub-Committee
- (quarterly)
- Patient Quality Committee (monthly)
- Risk Committee (monthly)

11.2 Working groups will be tasked to prepare supporting reports for the Committee.

11.3 The committee will have regular Away Day sessions to inform planning and key decision making.

11.4 A forward planner of agenda items shall be determined by the Chair.

11.5 The Committee will also consider key assurance reports as outlined in appendix 1.

12. REVIEW

12.1 The Committee should consider its effectiveness and refresh its terms of reference annually.

12.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Version Control

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	May 2022	Company Secretary / Director of Improvement & Partnerships	Revised TofR due to the introduction to new ways of working in the form of 'Improving Together' approach

				and to refocus the work programme to strengthen oversight of key strategic area.
V1.1	For review	17 May 2022	Executive Committee	Comments/feedback received TofR
V1.2	Approved	23 June 2022	Trust Management Committee	Comments/feedback received TofR amended for ratification by Board
V1.3	For review	Dec-22	Trust Management Committee	It was agreed in June-22 to review in 6 months' time especially the membership. Changes agreed:- • Split membership into membership and attendees • Reference TMC Away Days • Strengthened Improving Together reference (No 10)
V2.0	Annual Review	May-23	Company Secretary	• Job title changes • More explicit reference to Improving Together
V2.0	Approved	May-23	Board	As above
V3.0	For Review	Nov 2024	TMC/Board	• Reduced the size of Membership • Change job titles and meeting title • Added reference to BSW Group Hospital • Added meeting with take place face-to-face

Appendix 1

Committee	Trust Management Committee
Chair	Managing Director
Frequency	Monthly
Membership	Senior Management Team
Quorum	3 Executive Directors; and, 1 x representation from each Division – at least one of whom will be a clinician
Remit	Trust Strategies Business & operational plans Corporate policies & procedures Major service developments Trust wide business cases Operational, clinical, quality and financial performance Strategic filter Improving Together ICA/ICS Strategy and Plans Risk Management Board Assurance Framework
Strategic Risks	All
Key Assurance Reports	IPR – highlight report Operational Reports Workforce reports National surveys Business Planning reports Quality Reports IT Performance Reports IG Reports Benchmarking Reports Sub committee escalation reports Estates & Facilities / H&S Report Board Assurance Framework & Risk Report