GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD

Thursday 1 February 2024, 9.30am to 12.30pm
By MS Teams

AGENDA

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

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome**	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 11 January 2024	1 – 8	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	9	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Care Reflection (Patient Story)** Tania Currie, Head of Patient Experience & Engagement, together with Alex Christiansen and Laura Quintin to present	10 – 16	TC	Note	9.45
7.	**Chair's Report** Liam Coleman, Chair • Committee Membership and NED Champion Roles Review	17 – 21 22 – 32	LC	Note Approve	10.30
8.	**Chief Executive's Report** Jon Westbrook, Acting Chief Executive	33 – 39	JW	Note	10.40
BREAK (10 minutes) at 11.00am					
9.	**Integrated Performance Report** • Performance, Population & Place Committee Board Assurance Report (January) – Bernie Morley, Non-Executive Director & Committee Chair • Quality & Safety Committee Board Assurance Report (January) – Claudia Paoloni, Non-Executive Director & Committee Chair	40 – 41 42 – 44	BM CP	Assurance Assurance	11.10

	• Finance, Infrastructure & Digital Committee Board Assurance Report (January) – Faried Chopdat, Non-Executive Director & Committee Chair	45 – 50	FC	Assurance	
	• People & Culture Committee Board Assurance Report (January) – Paul Lewis, Non-Executive Director & Committee Chair	51 – 52	PL	Assurance	
	• Integrated Performance Report	54 – 105	All	Assurance	
10.	**Audit, Risk & Assurance Committee Board Assurance Report** Helen Spice, Non-Executive Director & Committee Chair	106	HS	Assurance	12.10
11.	**Mental Health Governance Committee Board Assurance Report** Lizzie Abderrahim, Non-Executive Director & Committee Chair	107 – 108	HS	Assurance	12.20
	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.**				
12.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	Verbal	CC	Note	12.30
13.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
14.	**Date and Time of next meeting** Thursday 7 March 2024 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
15.	**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"*	-	-	-	12.30

Board Meeting Timetable

2024											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Board	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
			Culture & Learning			Use of Resources			Population & Health		

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ AND VIA MS TEAMS 11 JANUARY 2024 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Paul Lewis (PL)	Non-Executive Director
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)	Non-Executive Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)*	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Acting Chief Executive

In attendance:

Jon Burwell (JB)	Acting Chief Digital Officer
Caroline Coles (CC)	Company Secretary
Julian Duxfield (JD)	Non-Executive Director
Tim Edmonds (TE)*	Associate Director of Communications & Engagement
Caroline Holmes (CH)*	BSW Deputy Place Director
Claire Lehman (CL)*	Associate Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Johanna Bogle	Deputy Chief Financial Officer (agenda item 212/23 only)
Louisa Bux	Contracts Manager (agenda item 212/23 only)
Sam Cope	Management Accountant (agenda item 212/23 only)
Miles Fortune	Senior Contract Income & Planning Accountant (Trainee) (agenda item 212/23 only)
Joshua Ngeresa	Finance Business Partner – Corporate & Efficiency (agenda item 212/23 only)
Debbie Palmer	Overseas Visitors & Cashiers Manager (agenda item 212/23 only)
Jill White	Cashier (agenda item 212/23 only)
Lisa Marshall*	Director of Midwifery & Neonatal Services (agenda item 216/23 only)
Kat Simpson*	Head of Midwifery & Neonatal Services (agenda item 216/23 only)

Apologies

Faried Chopdat (FC)	Non-Executive Director
Peter Hill (PH)	Non-Executive Director

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

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action

207/23 **Apologies for Absence and Chair's Welcome**

The Chair welcomed Board members and attendees to the Great Western Hospitals NHS Foundation Trust Board meeting held in public.

The Chair welcomed Jon Westbrook, Acting Chief Executive, Steve Haig, Acting Chief Medical Officer, and Jon Burwell, Acting Chief Digital Officer, in their new roles on the Board.

Apologies were received as above.

208/23 **Declarations of Interest**

There were no declarations of interest.

209/23 **Minutes of the previous meeting (public)**

The minutes of the Board meeting held in public on 7 December 2023 were adopted and agreed as a correct record, subject to the following amendments:

Minute No. 189/23 – Emergency Preparedness Resilience Response Annual Statement

2nd paragraph to be amended to read: *"It was noted that the Trust had been assessed as fully compliant."*

Minute No. 190/23 – Amendments to Standing Financial Instructions (SFIs) Financial Limits

Amend paragraph 2 to read "*Lizzie Abderrahim, Non-Executive Director asked for confirmation that the Standing Financial Instructions (SFIs) were the appropriate documents for charitable funds".*

210/23 **Outstanding actions of the Board (public)**

The Board received and considered the outstanding action list.

211/23 **Questions from the public to the Board relating to the work of the Trust**

There were no questions from the public to the Board.

212/23 **Care Reflection (Staff Story) – The Finance Team Improving Together Journey So Far**

Johanna Bogle, Louisa Bux, Sam Cope, Miles Fortune, Joshua Ngeresa, Debbie Palmer and Jill White joined the meeting to present this item.

The Board received a staff story on how Improving Together methodology had been applied to drive continuous improvement within the GWH Finance Team, together with a culture of check and challenge. The team had been awarded Level 1 accreditation in December 2023 of the Healthcare Financial Management Association's One NHS Finance Towards Excellence Accreditation process to demonstrate improvements made, with the aim to achieve Level 2 over the next year. It was noted the Trust was the first one in the System to achieve Level 1 accreditation.

The Board welcomed the partnership work with the Swindon New College on the T Level apprenticeship scheme and that two students were due to commence working with the Finance Team next month for one day per week.

Minute	Description	Action

It was noted that the Talent Management Strategy had also been applied for succession planning and had been incorporated into appraisals.

The Finance Team was encouraged to continue with the staff newsletter and shadowing sessions across various departments.

The Board thanked the Finance Team for their inspiring presentation and congratulated them on the achievement of Level 1 accreditation and supported their aspiration towards Level 2.

The Board **noted** the staff story.

213/23 **Chair's Report**

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

It was noted that a new Governor had been appointed, Councillor Ray Ballman, who was representing the Swindon Borough Council.

The Board reflected on recent Board safety visits and a robust discussion took place on the structure, level of questions and outcome of these visits. Lisa Cheek, Chief Nurse reminded the Board that quarterly reports were received by the Quality & Safety Committee on the outcome of safety visits, in addition the Insights & Learning Team would be asked to review the previous year's visits on the issues or themes that had been identified and what changes had been made since and linked to other quality improvement workstreams. It was agreed that the safety visits continued to be well received by the departments and that it promoted good Board visibility.

The Board **noted** the report.

214/23 **Chief Executive's Report**

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

Industrial action update

Two further periods of industrial action by junior doctors had taken place in December and January with no derogations and that this had been a significantly challenging period for the organisation. Applications for five derogations had been made to the BMA but had not been granted. The significant loss of activity during the first strike period in December was noted and that any potential harm as a consequence of these cancellations was being tracked. John Westbrook, Acting Chief Executive recorded his thanks to all staff on preparation for the industrial action and the work undertaken during these periods to deliver as much patient care as possible.

Operational demand

A critical incident had been declared in January due to ambulance conveyances, high acuity of patients and pressures on bed spaces. Following considerable effort

Minute	Description	Action

to manage operational pressures, the critical incident had been downgraded to a business continuity plan throughout the duration of the January strike period. Significant work had been undertaken by the operational teams to drive improvement with ambulance handovers and that actions were in place to sustain this. There had also been a significant spike in paediatric activity and the actions taken to support this pressure were outlined.

Lisa Cheek, Chief Nurse added that preparation work before the winter period had showed a positive impact, of particular note was the work undertaken at the Trust around the management of infections through this operational period and that this was in part due to the work of the IPC Team and rollout with the Estates Team of the air scrubbers. Also, that use of the escalation policy implemented by the operational teams had resulted in risk assessments being carried out for the additional 38 patients across the organisation with less than optimum environments and that each patient said that they felt cared for.

Supporting our staff
NHS England, the Care Quality Commission, the Nursing and Midwifery Council, and the General Medical Council published a joint letter last month aimed at addressing the impact of operational pressures due to winter and industrial action. Professional codes and principles of practice were in place to guide staff and support their judgements and decision-making in all circumstances. It was acknowledged that clinical staff may need to depart from established procedures on occasion to provide the best care, and this would take into account local realities and the need to adapt practice at times of significantly increased pressure.

Improving Together
Improving Together training undertaken by staff continued to be completed across the Trust and that more than 480 staff had taken part in multiple training options, with further training opportunities planned for February. The improvements made by departments following the training were noted.

Developing our next Trust strategy
Work was underway with key stakeholders to develop the next Trust strategy for 2024 and beyond, which would build on successes to date and set the future direction for the organisation.

Financial recovery
The good work being undertaken to manage financial pressure was outlined which included the establishment of an internal Financial Recovery Board and also to tighten processes around staff recruitment the introduction of an Enhanced Vacancy Review Panel.

Working to improve sustainability
This Trust had been selected as an exemplar site by NHS England for the work being done with Sustainability and Infection Prevention Control (IPC) teams. Positive feedback had also been received from Greener NHS following a recent visit. The Board welcomed the efforts being undertaken to improve sustainability and acknowledged the work undertaken by Graham Pike, Associate Director of IPC, and his team.

Minute	Description	Action

WAY Beacons
The WAY Beacons initiative, which was a collaborative project between Swindon Borough Council and the Emergency Department and Children's Unit supporting vulnerable young adults, won the 'Connecting People' award at the South West Personalised Care Awards last month.

Inclusion Recruitment Champions
The Inclusion Recruitment Champion initiative had now been implemented and that to date six staff had received training.

The Board **noted** the report.

215/23 **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 December 2023.

Our Performance
Felicity Taylor-Drewe, Chief Operating Officer reported that despite all the challenges there were some improvements in December 2023. Emergency Care Mean stay across the Emergency Department and Urgent Treatment Centre had slightly improved alongside patients waiting times.

It was reported that the performance for RTT (Referral to Treatment) 65 Week Waiters continued to improve and that Non-Criteria To Reside (NCTR) also showed a significant decrease in November.

It was noted that of the four cancer standards, there was an improvement in the 62 day performance, 31 day performance and stabilisation in the Faster Day diagnosis (28 day) standard. Validated data was awaited for November but a slight improvement was anticipated. The Board noted that a letter had been received by the Trust from the Regional Team in relation to poor performance and Felicity Taylor-Drewe, Chief Operating Officer confirmed that an improvement plan was in place. The Performance, Population & Place Committee would continue to scrutinise and monitor Cancer performance.

Felicity Taylor-Drewe, Chief Operating Officer reflected on the ongoing extreme operational pressures on the organisation during January 2024 and the risk based decisions undertaken to keep the service as functional as possible with incremental risks to be borne by the System. Jon Westbrook, Acting Chief Executive also added that the South West Region had reported substantial improvement for all waiting times across the South West and that the GWH contribution to this improvement had been acknowledged by the Regional Chief Executive.

Claudia Paoloni, Non-Executive Director asked for further assurance around support for staff when making decisions around patient care during periods of operational pressure and Steve Haig, Acting Chief Medical Officer agreed to explore guidance or principles to provide additional help to staff.
Action: Acting Chief Medical Officer

Minute	Description	Action

Our Care

Lisa Cheek, Chief Nurse reported that in relation to the Strategic Pillar Targets, in November there had been a decrease in the total number of harms from October and that this had been linked to a reduction in pressure harms in the community, a reduction in falls and a reduction in infection harms. The number of Family and Friends Test (FFT) positive responses for November was a similar position from last month and remained above the internal target.

Our People

Jude Gray, Chief People Officer provided an update on the workforce performance measured against the pillars of the People Strategy.

The voluntary turnover was particularly highlighted which showed a continued downward trajectory and further reduction below the Trust KPI target of 11%.

Jude Gray, Chief People Officer reflected if going forward the Board should consider whether it would be meaningful to look at the pillar metrics and breakthrough objectives on a quarterly basis to look back year on year or point on point to show areas to both recognise and celebrate, and which could also help the Board to refocus around relative priorities. The Board agreed that narrative on year-on-year comparison would be included in the next quarterly deep dive of the IPR, and also how this could then be shared with the organisation to drive further staff engagement on achievements.
Action: Chief Officer of Improvement & Partnerships

Use of Resources

Simon Wade, Chief Financial Officer reported that as at Month 8 the Trust was in a breakeven position which represented a £0.3m adverse variance to plan.

The Trust had received £3.9m to fund industrial action costs incurred as well as £1.1m representing a 2% change from variable to fixed income, also for industrial action. This income, plus other non-recurrent benefits of £1.3m relating to prior year, had offset a number of in-year pressures.

Efficiency savings were £0.5m ahead of target in-month and were £1.6m behind plan on a YTD basis and the Trust remained on track for year-end.

An update was provided on work around the new Integrated Front Door project and that the timeline had moved from its original plan by a couple of months. Handover was due in July and then operational around October 2024. Work continued on the clinical and staffing models, together with final decisions on space utilisation within the new unit. The Board Members were encouraged to join a tour to see some of the initiatives being introduced around accessibility and also to reduce violence and aggression towards staff.

The Board **noted** the report.

216/23 **GWH CNST Year 5 Submission – GWH Compliance Report**

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

Minute	Description	Action

The Board received a paper which outlined the Trust position on Year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) and noted the final compliance position of achieving seven out of the ten safety actions and non-compliance against three safety actions.

It was noted that the submission had been signed off by the Chief Nurse, Non-Executive Safety Champion for Maternity and Neonates, and LMNS Accountable Officer and gone through a robust governance process.

Paul Lewis, Non-Executive Director Maternity Safety Champion provided further assurance to the Board on the robust process with evidence based review and that actions plans were in place to support the areas of non-compliance.

RESOLVED:
The Board **approved** the final CNST compliance position for GWH in preparation for the NHSR Declaration Form to be submitted on 1 February 2024.

217/23 **Safe Staffing 6-month review for Nursing, Midwives and AHP**

The Board received and considered a report which provided assurance that wards and departments were safely staffed in line with national and regulatory guidance (National Quality Board guidance 2014, Developing Workforce Standards 2018 and CQC standards).

The report covered areas of safe staffing in relation to Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations, AHP, Community Nursing, and acute wards compliance with national guidance and outputs of the Chief Nurse's establishment reviews. The themes from the establishment reviews were noted and that actions were in place to address areas on non-compliance.

It was noted that the report received governance overview and scrutiny by the Quality & Safety Committee and was assured that robust controls were in place with good oversight and assurance.

In response to a question asked around vacancies and turnover for nurses and the supernumerary period for newly qualified or new starters and the management of that cost pressure, Lisa Cheek, Chief Nurse explained that funding for internationally educated nurses (IEN) was no longer available and that this would reduce the number of IEN in future to around 40. Actions were being taken on the staff retention and also the developing of growing our own from within the existing workforce, which also included a different model for nursing associates and IEN and enhanced training support to shorten the supernumerary period.

The Board noted that the Trust had made good progress in the delivery of safe staffing across acute, community and midwifery. Significant improvements had been seen in areas with safer staffing investment and that work on recruitment and retention had continued to improve the staff experience and to support the drive to improve patient care.

The Board **noted** the report.

Minute	Description	Action
	Consent Items *Consent Items Note – these items are provided for consideration by the Board. Members were asked to read the papers prior to the meeting and, unless the Chair / Company Secretary received notification before the meeting that a member wished to debate the item or seek clarification on an issue, the items and recommendations would be approved without debate at the meeting in line with the process for Consent Items. The recommendations would then be recorded in the minutes of the meeting.*	
218/23	**Ratification of Decisions made via Board Circular** None.	
219/23	**Urgent Public Business (if any)** None.	
220/23	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 1 February 2024 at the DoubleTree by Hilton Hotel, Swindon.	
221/23	**Exclusion of the Public and Press** The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.	

The meeting finished at 12.20hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – February 2024				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
11 January 2024	215/23	**IPR : Our Performance** Guidance or principles to be explored to provide additional support to staff when making decisions around patient care during periods of operational pressure to provide further reassurance to the Board.	Acting Chief Medical Officer	Acting Chief Medical Officer to discuss with GMC ELA on 31 January 2024 and will message teams.
11 January 2024	215/23	**IPR : Our People** Narrative on year-on-year data comparison to be included in the next quarterly deep dive of the IPR, and also how this could then be shared with the organisation to drive further staff engagement on achievements.	Chief Officer of Improvement & Partnerships	Noted for the next quarterly deep dive in March 2023.

Future Actions				

Report Title	**Care Reflection (Patient Story)**				
Meeting	**Trust Board**				
Date	**1st February 2024**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement				
Appendices	Powerpoint Presentation				

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

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

Report

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

This Care Reflection shares the story of a young lady called Louise.

Louise was admitted with a traumatic spinal cord injury, she spent 6 months in our care on Forest ward. This would not normally have been the expected pathway of care for a patient with her injuries, as care would normally be provided in a specialist spinal cord injury centre. Initially Louises prognosis was poor, in terms of the likelihood of her walking and being independent again.

Louise required intensive and consistent rehabilitation and care over the many months that she spent with us. The story will share the approach taken by the ward and therapy teams which led to an amazing recovery and outcome for Louise.

Louise shares her very personal experience and reflection and how the care provided by the teams has significantly improved her life both physically and psychologically.

The therapy team will share the approach taken and the learning that they have gained from this experience.

The learning identified from this case will be shared widely across the trust along with the key themes identified that can be replicated if a similar case occurred.

	Safe	Caring	Effective	Responsive	Well Led
Link to CQC Domain – select one or more					
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x				

Key Risks – risk number & description (Link to BAF / Risk Register)		**Risk Score**
	NA	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The learning from this care reflection will be shared widely via divisional governance structures across the trust	
Next Steps		

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		**X**	
Does this report provide assurance to improve and promote equality, diversity, and inclusion / inequalities?			**X**
Explanation of above analysis: Not formally assessed			

Recommendation / Action Required	
The Board/Committee/Group is requested to:	
▪ To receive the presentation as assurance of the developments and improvements in patient pathways of care identified from this Care Reflection.	
Accountable Lead Signature	Lisa S Arch
Date	22 January 2024

Care Reflection

Trust Board

February 2024

Tania Currie, Head of Patient Experience and Engagement

Alex Christiansen, Therapy Team Lead

Laura Quintin, Physiotherapist

Care Reflection

Background

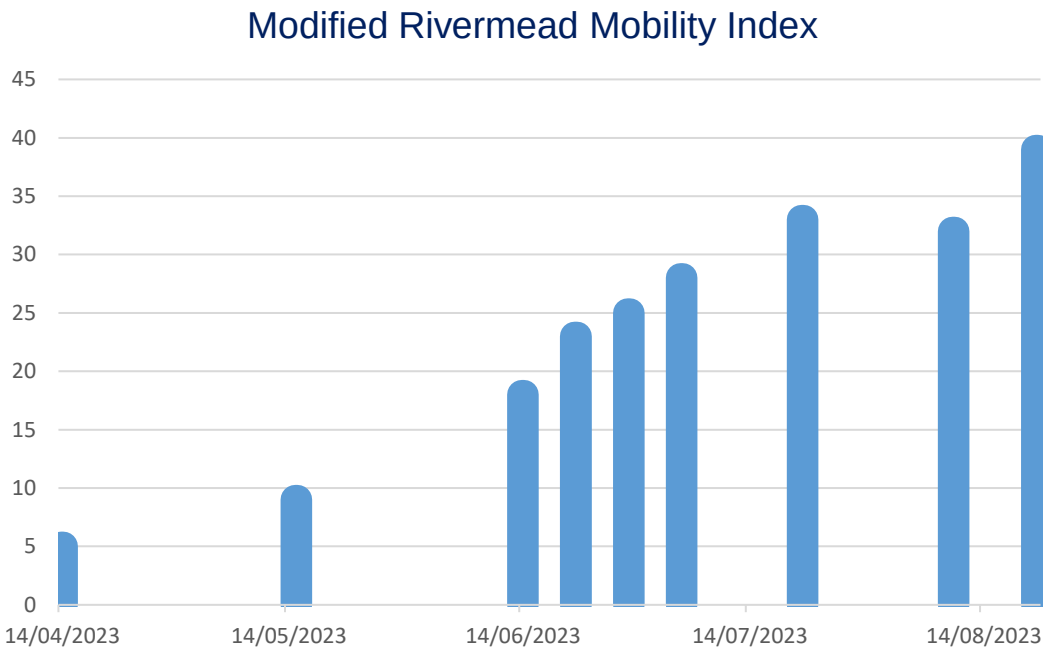
- 34-year-old mother of 2
- Previously living independently
- History of long-standing mental health, Autism.
- 4/3/23 – fall from a bridge 8m height
  - L1 burst fracture with spinal cord injury (ASIA A)
  - Multiple pelvic fractures
  - Left elbow dislocation
  - Right wrist fracture
  - Sacrococcygeal fractures

Film link: https://youtu.be/KAeDqadK6GY

Care Reflection

Outcomes

Admission	Discharge
Sitting independently 44 secs Specialist seating and sitting out regime	Independent sitting in standard chair/car. Independently using wheelchair for entire day (inside and outside).
Hoist	Independently walking without aids, or crutches outdoors, (including stairs)
Full assistance with personal care	Minimum support and an active ongoing community goal
Incontinent and with catheter	Independently managing urinary continence. Requires support for bowels
Intense phycological support 1:1 24hrs a day	Return to home with POC, and 1 visit a week from mental health team.



Care Reflection

NHS
Great Western Hospitals
NHS Foundation Trust

Learning Points

- Therapy approaches for SCI
- Value of having a treadmill
- Limited experience of SCI from MDT (OT, nursing staff, medics)
- Large service gap for supporting MH whilst an inpatient
- ↑ non-clinical time and skill for MH
- The impact of not receiving therapy had on mental health on some days
- Importance of early bladder and bowel management
- Benefit of home visits with structured phase return discharge home
- Increased emotional load on MDT team – debriefing
- Learning and Development support from Salisbury

Care Reflection

Future Plans

- Tracking outcome measures for all patients
- Level 2 rehabilitation business case to support Way Forward Programme
- Other options/pathways through discussing with regional pathway managers
- 24hr approach to therapy and independence (meals, making own bed, washing and dressing, adapted equipment).
- Active role on the wards
- More of a timetable/open gym approach would be beneficial
- Inviting wider MDT to physiotherapist SCI training and joint patient sessions

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**1 February 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Summary of Board Safety Walks				

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

Assurance Level

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

Process

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

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

Report

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

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

The report provides information in respect of:-

- Council of Governors – Key Meeting Dates
- Strengthening Board Oversight
- Trust Chair - Key Meeting Dates.

To note this report covers a 2 week period due to the timings between the January and February Board meetings.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks	★				

– select one or more	x	x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	-			**Risk Score**
	-			
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	-			
Next Steps	-			

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	24 January 2024

Chair's Board Report

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally during January 2024.

To note this report covers a 2 week period due to the timings between the January and February Board meetings.

1. Council of Governors

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

Date	Event	Purpose
11-Jan-24	Trust Board Meeting	Holding the Non-Executive to account
22 Jan-24	Informal Governor Meeting	Regular informal meeting for governors to meet the Non-Executive Directors – attending this meeting was Rommel Ravanan, Associate Non-Executive Director
26 Jan-24	Community Café Meadowcroft	An opportunity for governors to meet members of the public

2. Strengthening Board Oversight & Development

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

Date	Area	Board Member
24 January 2024	Emergency Department	Lisa Cheek, Chief Nurse Julian Duxfield, Non-Executive Director Bernie Morley, Non-Executive Director
29 January 2024	Linnet Ward	Lisa Cheek, Chief Nurse Claudia Paoloni, Non-Executive Director

3. Trust Chair Key Meetings during January 2024

Meeting	Purpose
Monthly meeting with Non-Executive Directors & Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
Bi-monthly meeting with Chair/Deputy Chair/ Senior Independent Director	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Performance, Population & Place Committee	To attend as an observer
Mental Health Governance Committee	To attend as a member
Health & Wellbeing Oversight Committee	To attend as a member
Additional Trust Board Meeting	To discuss system arrangements
Meeting with Company Secretary	To review Board Committee membership and Well Led Report
Meeting with Trust EDI Lead	To review Board EDI objectives
Introductory meeting with new Governor	To outline role of the Governor and introduction to the Trust
Wiltshire Health & Care Members' Board	To attend as a member
BSW Chairs' Catch Up	Regular meeting to update and discuss any topical issues
Meeting with BSW Chairs and CEOs with Sir David Dalton	To discuss system arrangements

Appendix 1 - Board Safety Walk Arounds Summary Report for July to December 2023

1. Introduction

The National Health Service Patient Safety Strategy 'Safer culture, safer systems, safer patients' (2019), sets out how the NHS will address the challenges required to achieve its vision to continuously improve patient safety. There are three strategic aims: Insight, Involvement, and Improvement.

The Board Safety visits are an opportunity for engagement with front line staff in respect to implementation of this vision. Providing a dedicated opportunity for staff across the Trust to engage with Board members, participate in conversations about safety, and for those board members to listen and learn about the challenges being faced regarding safety. The board safety walks provide an opportunity to embrace the National Patient Safety Strategy foundations, supporting to build a patient safety culture and a patient safety system that will continuously improve patient safety across the Trust.

Table one provides a summary of the wards/departments where visits have taken place from July to December 2023. This includes announced and unannounced visits.

Table one – visit summary

Name of site	Date of Walk Around
Woodpecker Ward	26th July 2023
Dove Ward	16th November 2023
Mercury Ward	29th June 2023
Children's Ward	23rd October 2023
Medical Expected Unit	25th October 2023
Day Surgery	27th November 2023
General Surgery Ophthalmology	14th December 2023
Orchard Ward	18th December 2023

2. Summary of feedback

The themes identified through visits are in keeping with those identified in 2022 and have been recorded under three main areas safety points, learning points and further discussion points.

Safety points raised on the visit.

The overall results for the eight visits completed July to December 2023 show that staffing remains a high area of concern, along with storage.

Safety points raised in relation to staffing included the numbers of patients with complex behaviour requiring addition of staff with specialist skills, skill mix especially ongoing challenges given the number of newly qualified nurses, junior doctors staffing, and, overnight cover in the Paediatric Assessment Unit due to relocation to ward level.

Safety Points raised in relation to space/storage included no quiet space for doctors in wards and the challenges around space, particularly with storage and lockable cabinets.

Learning points raised on the visit:
There was no overall theme identified across all visits.

Learning points raised on the visits included inconsistent communication around planned changes and bed configuration, new processes introduced that have driven improvement around tissue viability on the ward and Improving Together with mixed views on the process and engagement of all team members.

Further discussion points raised:
There was also significant positive feedback around great team relationships and morale, nursing establishment which was good and fully recruited, no recruitment issues, and staff upskilling happens quickly.

3. Outcomes

Following each board safety visit notes are made available to all those that attended the visit with an action tracker to monitor actions taken forward to completion.

4. Future Planned Visits

Future planed visits will follow the same format as previous year. Providing an opportunity for individuals and teams to guide the conversation and raise any points related to patient safety (positive or negative) with the visiting team. The current list of areas to be visited is in development and will be shared with Divisional teams as soon as possible.

5. Future unannounced visits

Future unannounced visits are also being planned for the year 2024. The departments/services to be visited will be agreed on the day by the Chief Nurse or Deputy Chief Nurse(s) and will focus on areas requiring additional support or where concern has been escalated. A crib sheet to guide the conversation will be provided as it has been noted that the unannounced visits are sometimes less natural in flow than the planned visits.

6. Governance and review

The visits have now been running well for over one year and an agreed Standard Operating Procedure (SOP) is in place to ensure consistency of approach and guide each visit. The governance of the visits is well established, including the pre visit organisation, visit ethos and after visit action(s).

Although the process is not due a formal review, a form of continual assessment will be completed and opportunity taken to improve where appropriate.

7. Summary

The feedback from the board safety visits continues to remain very positive, with excellent staff engagement before, during and after the visits. Clear actions have been agreed on the day and followed through afterwards to ensure completion. Actions are agreed during each visit and monitored until completion.

Report Title	**Committee Membership and NED Champion Roles Review**				
Meeting	**Trust Board**				
Date	**1 February 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Trust Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Committee Membership Proposals Appendix 2 – NED Champion Role Job Descriptions				

Purpose

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

Assurance Level

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

Process

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

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

Report

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

The departure of two Non-Executive Directors during March 2024 has necessitated the need to review the Board committee membership and NED roles.

It is important that the Board committees have the right membership that encompass diverse perspectives to gain the benefits of focused challenge and scrutiny and that no undue reliance is placed on particular individuals.

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)	n/a				**Risk Score**

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Executive Directors and Non-Executive Directors
Next Steps	New Committee membership effective from 1 April 2024

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:
Consideration was given to the gender balance of each Committee and adjusted accordingly where possible.

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to approve the	
Accountable Lead Signature	Liam Coleman, Trust Chair
Date	24 January 2024

Committee Membership Review and NED Champion roles Review

1. Committee Membership

1.1 The departure of two Non-Executive Directors during March 2024 has necessitated the need to review the Board committee membership and NED roles.

1.2 It is important that the Board committees have the right membership that encompass diverse perspectives to gain the benefits of focused challenge and scrutiny and that no undue reliance is placed on particular individuals.

1.3 The review includes a number of changes to the Chairs of the Board Committee as follows:-

Board Committee	New Chair
Charitable Funds Committee	Julian Duxfield
People & Culture Committee	Julian Duxfield
Remuneration Committee	Trust Chair*

*This move is based on research of other trusts' practice and the results found that the majority of Remuneration Committees are chaired by the Trust Chair.

1.4 The proposed changes are outlined in appendix 1 highlighted in yellow.

2. NED Champion Roles Review

2.1 As reported in April 2022 the Board national guidance was published on NED champion roles and the approach to these https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf

Overall, the approach is recommended and not mandatory however the Board agreed to adopt this in full to create clarity to the NED champion roles.

Five roles are defined as a recommended requirement and should be retained:

- Maternity Board Safety Champion
- Wellbeing Guardian (ED&I included)
- Freedom to Speak Up
- Doctors Disciplinary
- Security Management.

Each of these roles has a clear role description (appendix 2). In addition, the Board agreed to elevate the ED&I role into a NED champion role.

2.2 Proposed changes to the NED Champion roles are as follows:-

NED Champion Roles		
Area	**Oversight Committee**	**NED Champion – Proposed change highlighted in yellow**
Maternity Board Safety	Q&SC	Julian Duxfield
Wellbeing Guardian	P&CC	Liam Coleman
Freedom to Speak Up	Q&SC	Claudia Paoloni
Doctors Disciplinary	Board	Chair of Quality & Safety Committee assigns NED on a case-by-case basis if required
Security Management	ARAC	Helen Spice
Equality, Diversity & Inclusion	P&CC	Lizzie Abderrahim

2.3 Other roles affected are the Senior Independent Director (SID) and Deputy Chair. The SID appointment will be discussed in the private session of Board and for the Deputy Chair role, the Trust Chair will recommend a NED to the Council of Governors for consideration and approval of appointment. To note the SID nor the Deputy Chair should be chair of Audit Committee.

2.4 One of the developmental themes in the Well Led Report was around some inconsistency in how the expectations of the respective NED Champion roles have been defined, appendix 2 outlines the job descriptions for each of the retained champion roles.

	Audit, Assurance & Risk Committee	Finance & Infrastructure Committee	Performance, Population & Place Committee	Quality & Safety Committee	Mental Health Governance Committee	Remuneration Committee	Charitable Funds Committee	Nomination & Remuneration Committee (Governors)	People & Culture Committee	Trust Management Committee
Non-Executive Directors										
Liam Coleman					Member*	**CHAIR**		**CHAIR**		n/a
Lizzie Abderrahim			Member	Member*	**CHAIR**	Member			Member	n/a
Helen Spice	**CHAIR**	Member*		Member		Member		Member		n/a
Faried Chapdat	Member*	**CHAIR**				Member			Member*	n/a
Claudia Paoloni	Member			**CHAIR**	Member	Member				n/a
Will Smart	Member	Member				Member	Member			n/a
Julian Duxfield			Member			Member	**CHAIR**	Member	**CHAIR**	n/a
Bernie Morley			**CHAIR**	Member		Member	Member			n/a
Associate NED										
Rommel Ravanan				Member		Member				n/a
Claire Lehman			Member		Member	Member				n/a
Executive Directors										
Chief Executive (JW)		Attendee	Attendee	~~Attendee~~		Member		n/a	Attendee	**CHAIR**
Chief People Officer (JG)							Attendee	n/a	Member	Member
Chief Financial Officer (SW)	Attendee	Member	Attendee	Attendee			Member	n/a		Member
Chief Medical Officer (SH)				Member	Member			n/a	Attendee	Member
Chief Nurse (LC)				Member	Member			n/a	Attendee	Member
Chief Operating Officer (FT-D)		Member	Member					n/a		Member
Chief Officer of Improvement & Partnership (CT)	Attendee	Member	Member				Member	n/a		Member

Appendix 2 –NED Champion Roles

1. General – Board Director

- The essence of the Board Director role is that directors do not have portfolios in the boardroom.
- As a unitary board they are jointly and severally responsible for the entire range of the Board's work, not just part of it, and Board Executive and Non-Executive Directors share the same liability.
- If the champion role involves work outside the boardroom, then this takes NEDs away from being non-executives and therefore detracts from their independence.

2. Summary of Role of an NED Champion/Guardian

- Seeks assurance only – they do not 'do' the role for the organisation.
- Independently challenges the organisation as a 'critical friend'.
- Holds to account the senior leadership team/board, who all maintain responsibility for any specific champion/guardian role.
- Does not need to be a specialist.
- Does not need to personally collect, analyse or present data.
- Is supported to discharge their assurance duties by appropriate leaders within the organisation, for example by a director or specialist team.
- The following section provides the job descriptions for the 5 retained champion roles.

NED Champion Roles – Job Descriptions

1. Maternity Board Safety Champion

Type of Role	Assurance
Legal basis	Recommended
	In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, and in line with recommendations from the Ockenden Review
Role Descriptor:	

1.1 In line with recommendations from the Ockenden Review, the Board-level safety champion role (Executive Director) should be supported by a Non-Executive Director.

1.2 The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes. Published guidance sets these responsibilities out in detail. The Non-Executive will act as a support to the Board Safety Champion by:

- Bringing a degree of independent, supportive challenge to the oversight of maternity services agenda item
- Ensuring that they are resourced to carry out their role
- Challenging the board to reflect on the quality and safety of its maternity services
- Ensuring that the views and experiences of patients and staff are heard

1.3 Together the Non-Executive and the Board-level Safety Champion should:

- Adopt a curious approach to understanding quality and safety of services
- Jointly, with frontline safety champions, draw on a range of intelligence sources to review outcomes, including staff and user feedback to fully understand the services they champion
- Update the Trust Board on a monthly basis on issues requiring board-level action.

2. Wellbeing Guardian

Type of Role	Assurance
Legal basis	Recommended
	This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'.
Role Descriptor:	

2.1 A successful Wellbeing Guardian will be values-driven, people-focused, and willing to challenge the status quo to empower a wellbeing culture within their organisation.

2.2 The role should be that of assurance and be empowered to act strategically. Therefore, the organisation should enable the Guardian by aligning functions such as HR / OD / Occupational Health and Wellbeing to operationally support them. From an organisational perspective, the Wellbeing Guardian needs to:

- Challenge the organisation to include employee wellbeing in everything they do and actively create a 'culture of wellbeing', to care for people who care for others.
- Act as a 'critical friend' to question the impact of decisions on employee wellbeing – just as financial, performance or care quality impact are questioned. Seek assurance that how the organisation enables the wellbeing of its employees, is given as much weight as what it achieves.
- Ensure the Board holds senior leaders to account for the way employees are managed, empowered, and supported with their wellbeing.
- Seek data to show what's happening on the ground, evidencing the wellbeing needs of the diverse workforce (inputs) and that wellbeing strategy / policies / initiatives are working and impactful (outputs).
- Champion equality, diversity and inclusion, ensuring that the organisation considers the needs of the diverse groups within its workforce and adapts holistic approaches to wellbeing, appreciating peoples changing needs over time.
- Continually and strategically 'sense-check' the wellbeing agenda for the organisation and prompt improvement / developmental action if needed.
- Demonstrate that the Board takes their personal wellbeing responsibilities seriously.
- Work closely with the organisations people function (i.e. HR, OD, Occupational Health and Wellbeing etc) as enabling operational functions to

realise the wellbeing agenda for the organisation and that they are supportive to the Wellbeing Guardian to be effective in role.

2.3 From a personal perspective, the Wellbeing Guardian needs to:

- Strategically influence and shape the wellbeing agenda, speaking to the hearts and minds of the organisation's diverse workforce.
- Hold the values reflected in the role description, role modelling the values of fairness, compassion and inclusivity.
- Actively promote opportunities for the most vulnerable in the workforce to contribute and address wellbeing inequalities and the needs of diverse groups and individuals.

2.4 Although Wellbeing Guardians must be competent and confident in their ability to challenge the executive / senior leader team on behalf of the board (or equivalent senior leadership team) Wellbeing Guardians are not accountable for the entire people agenda. They do not need to be an expert in wellbeing, but they do need to be adept at understanding the breadth of wellbeing in the context of their organisation and holding the organisation to account where improvements are identified.

2.5 With this in mind, a Wellbeing Guardian does not need to:

- Be a wellbeing expert.
- Take on executive/management responsibilities for ensuring wellbeing policies are operationally actioned and delivered.
- Get involved in 'the doing', operational management, or individual staff cases.
- Personally collect, analyse or present data on wellbeing.

3. Freedom to Speak Up Champion

Type of Role	Functional
Legal basis	Recommended
	In line with the Robert Francis Freedom to Speak Up Report (2015) which sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues.
Role Descriptor:	

3.1 The Non-Executive lead is responsible for:

- role-modelling high standards of conduct around FTSU
- ensuring they are aware of the latest guidance from National Guardian's Office
- challenging the chief executive, executive lead for FTSU and the Board to reflect on whether they could do more to create a healthy and effective speaking up culture
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up matters regarding Board members – see below.

3.2 We appreciate it can be challenging to maintain confidentiality and objectivity when investigating issues raised about board members. This is why the role of the designated non-executive lead is critical. Therefore, in exceptional circumstances, we would expect the non-executive lead to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a Board member(s) and
- if so, whether an appropriate fair and impartial investigation can be conducted, is proportionate, and what the terms of reference should be for escalating matters to regulators, as appropriate.

3.3 Depending on the circumstances, it may be appropriate for the Non-Executive lead to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive lead does take the lead, they inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping. The Non-Executive lead informs NHS England and CQC that they are overseeing an investigation into a Board member (depending on the circumstances we may require you to provide the name of the board member under investigation). NHS England and CQC can then provide the non-executive with support and advice. The Trust needs to consider how to enable a Non-Executive lead to commission an external investigation (which might need an Executive Director to sign-off the costs) without compromising the confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

4. Doctors Disciplinary NED champion/independent member

Type of Role	Functional
Legal basis	Statutory
	In line with the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005
Role Descriptor:	

4.1 Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained**. There is no specific requirement that this is the same NED for each case.**

5. Security Management

Type of Role	Assurance
Legal basis	Statutory
Role Descriptor	In line with the Directions to NHS Bodies on Security Management Measures 2004

5.1 Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at Board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement. While promotion of security management in its broadest sense should be discharged through the designated NED, relevant Committees may wish to oversee specific functions related to counter fraud and violence/aggression. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

Report Title	**Chief Executive's Report**				
Meeting	**Trust Board**				
Date	1 February 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jon Westbrook, Acting Chief Executive				
Report Author	Jon Westbrook, Acting 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 in respect of: process/outcome/other (please detail):

Board members are asked to note the report

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

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

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

Report

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

The report includes updates on:

- Industrial action
- Improvements in outpatients
- Virtual reality
- Supporting our patients at mealtimes
- Integrated Front Door
- Staff recognition events

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

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

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

Explanation of above analysis:

The report mentions our Staff Excellence Awards – one of the categories of the awards is Championing Equality, Diversity and Inclusion (EDI), recognising staff who have called out inequalities that might be experienced in healthcare, either by staff or by patients and families. This could be through championing equality, challenging discriminations and prejudice, sharing and encouraging equal opportunities or ensuring inclusivity.

Our EDI newsletter, which aims to increase awareness and understanding of our work in this area, is mentioned in the report.

Recommendation / Action Required

The Board/Committee/Group is requested to:

To note the report

Accountable Lead Signature	Jon Westbrook, Acting Chief Executive
Date	23 January 2024

1. Operational updates

1.1. Industrial action

At the time of writing we had not received notification of any future industrial action but we know that British Medical Association Junior Doctors still have a mandate to strike at this time.

SAS Doctors now have a mandate for strike action but have not notified of any dates. The consultants are being balloted regarding the pay offer made by Government and the outcome of the ballot will determine the risk of further strikes by that staff group.

During the 20-23 December strike we saw 694 appointments or surgeries postponed, with 64 per cent of shifts due to be undertaken by junior doctors not filled.

During the 3-9 January strike we saw 767 appointments or surgeries postponed, with 72 per cent of shifts due to be undertaken by junior doctors not filled.

Industrial action has had a clear impact on the care we are able to provide to our patients, and we continue to hope for a resolution to the dispute between the unions and the Government.

1.2. Outpatients

Last week we ran a dedicated week for our outpatient services to review the success of measures introduced in the department.

The changes have been made in outpatients to help improve efficiency for staff, reduce our waiting times and enhance the overall patient experience.

Go and See teams visited outpatient areas to observe processes and speak with staff and patients, exploring whether efforts to reduce the number of patients not attending planned appointments and ensure as many clinic rooms are utilised as possible have been successful.

1.3. Cancer performance

Nationally, a key pillar of NHS England's oversight and support infrastructure is the tiering programme for the Elective Recovery and Cancer programmes.

Due to our 28 day faster diagnosis for cancer position being below 70 per cent during July, August and September, the Trust has been moved in to Tier 2 for our cancer performance.

This will mean a greater level of regional oversight and scrutiny with Tier 2 meetings led by the Regional Head of Cancer along with Integrated Care Board representatives, and support may be available to help our cancer performance improve.

2. Quality

2.1. Using virtual reality to improve training

Clinical Teaching Fellows are working with Goggleminds to use virtual reality headsets and immersive simulation technology to help train medical students and junior doctors on spotting the signs and symptoms of sepsis, and other conditions, such as anaphylaxis.

The headsets have been loaned to the Trust by Goggleminds and they allow students to simulate treating patients. This is also supporting work at the University of Bath which is researching how virtual reality can be used in medical education.

Our use of virtual reality was recently covered in The Times and on the BBC News website, along with BBC Points West and BBC Wiltshire.

2.2. Supporting our patients at mealtimes

Good nutrition and hydration is really important for our patients and to help with this we have introduced a new role to enable non-clinical staff to volunteer to spend time in clinical areas, supporting the ward teams and helping patients.

The Dining Companion role is available to staff working in the corporate division, who will help patients by making sure they have everything they need during their mealtime, offering companionship to those who would like it, and providing feedback to the ward manager about their experience.

3. Systems and Strategy

3.1. Shared Electronic Patient Record

At the time of writing we were awaiting a national decision on our business case to proceed with the procurement of a Shared Electronic Patient Record.

If the business case is approved, this will allow work to continue at pace to deliver the electronic patient record at our Trust, the Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust.

Oracle Health has already been chosen as our preferred supplier to deliver the new system, which will bring significant benefits to our patients and staff.

3.2. Integrated Front Door

This week marked one year to the day that the Trust successfully secured Government funding to build the £31million Integrated Front Door (IFD).

Since then, construction has developed at pace – contractors are progressing with internal wiring, ceiling grids, and roof plantroom installation, with internal door installation beginning shortly.

The new building is set to open in the summer, with the Children's Emergency Unit scheduled to open in the autumn.

This will also be followed by Same Day Emergency Care and Medical Expected Unit moving in to the current Emergency Department space, also in the autumn.

Planning is well underway for workforce and patient pathway development.

We will be continuously engaging with patient groups and other key stakeholders to ensure that the interior of the new building meets the needs of the population we serve, and we will shortly begin speaking with children and young people on our plans for the Children's Emergency Unit.

We will be undertaking staff tours of the new building during February and March to enable the wider workforce to see the work underway.

3.3. National expectations

NHS England sent all Integrated Care Boards and Trust a letter in December, and a subsequent letter in January following the conclusion of industrial action, outlining the key priorities for 2024 which include:

- Improving ambulance response and A&E wait times – all systems to deliver at least 76% four-hour performance and category 2 ambulance response times.

- Reducing elective long waits and cancer backlogs, and improving core performance standards – all systems and providers to deliver their cancer 62 day backlog reduction targets as well as achievement of the 75% faster diagnosis standard by March.

- All systems to continue to reduce long elective waits in line with the ambitions in the Elective Recovery Plan and activity levels agreed in the most recent planning exercise.

Improving access to primary care and reducing the cost of temporary staffing will also be areas of key focus.

NHS England will work with Integrated Care Boards and providers to agree a standard set of measurements for all Trusts to use to track productivity.

NHSE will invest an extra £3.3billion in both 2023/24 and 2024/25 for the NHS to respond to significant pressures.

3.4. Prescription ordering

The Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board has decided that Prescription Ordering Direct, which allows some patients to arrange medication by phone/email, will be discontinued later in year, with GP practices/care

homes offering repeat prescribing instead. Across BSW, 25 of 88 GP practices currently use Prescription Ordering Direct.

4. Workforce, wellbeing and recognition

4.1. Senior appointments

Jon Burwell has been appointed as the Acting Joint Chief Digital Officer and Senior Information Risk Owner at our Trust and Salisbury NHS Foundation Trust.

4.2. STAR of the Month

Louise Knight, Palliative Care Team Lead, is the latest winner of our STAR of the Month Award.

Louise supported a patient and their family during the patient's final moments, speaking to them sensitively and ensuring they were free from pain.

Louise also works hard to ensure every patient's wishes are met, treats everyone with care and compassion, and supports staff, patients and families to have open and honest conversations about death.

4.3. Book of Great

Our third Book of Great has been published, capturing some of the achievements of teams right across the Trust in 2023.

Hard copies have been distributed to wards and departments and it can also be found on our website.

5. Workforce

5.1. Staff recognition events

We have set the dates for our two biggest staff recognition events.

On Friday 14 June we will mark the achievements of individual members of staff and teams from across the Trust at our annual Staff Excellence Awards at the Steam Museum in Swindon.

On Saturday 14 September our fourth Great West Fest event will be held at Town Gardens in Swindon. This free event aims to recognise not just our staff but also their families who support them.

5.2. Equality, diversity and inclusion

The Trust produces a quarterly newsletter for staff focused on equality, diversity and inclusion with the aim of raising awareness of our work in this area.

The latest edition focuses on our Inclusive and Safe Workplace Award from NHS England, opportunities to train as EDI champions, the work of inclusion recruitment champions and the experiences of staff members.

5.3. Positive feedback from students

Oxford Brookes University's Celebrating Excellence in Practice Education 2023 report has been published.

It details the feedback from healthcare and social work students on their placement providers.

The feedback on our organisation is really positive, with students providing comments on areas of the Trust including the Acute Cardiac Unit, Forest Ward, Dove Ward, Mercury Ward, Day Surgery, and Community Care.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	24th January 2024	
Committee Chair	Bernie Morley, Non Executive Director	
Link to Strategic Objective	Pillar 3 : Joining up acute and community services in Swindon	
Link to Board Assurance Framework	BAF 3 : SR 5 – Performance and SR6 - Partnerships	
Improving Together Pillar Metrics	Emergency Attendance	Waiting List – over 65 week waiters
	No Criteria to Reside	Cancer Waiting Times
Improving Together Breakthrough Objective	Time in ED – Clinically Ready to Proceed	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Partnership Report	Received	X
2. Health Inequalities Quarterly Report	Approve sub committee	X
3. Provider Selection Regime	Received	X
4. NHS Oversight Framework	Received	X
5. Tiering Status for Cancer Q4	Limited	Y
6. Operational Highlights Report	Received	
7. IPR - NCTR	Partial	
8. IPR - DM01	Limited	
9. IPR - RTT	Partial	
10. Ambulance Handover Long Waits Report	Limited	**Y**
11. Integrated Front Door Update	Received	**X**
12. Feedback from NHSE Support Visits	Received	**X**
13. Quarterly 15+ Risk Report	Received	**X**

POINTS OF ESCALATION	Cancer performance is subject to 'tiering' (Tier 2) as part of the performance management regime. Board are asked to note that this has a potential impact on SOF rating. Ambulance performance (Hospital Handover Delays), long waiting times for patients was reported and notification of the system being placed in 'tiering' for urgent and emergency care on the 24/01 was noted.
KEY AREAS TO NOTE	Cancer performance showed continued improvement in the longest waiting patients (those over 62 days) & assurance was given in relation to achieving the March 2024 trajectory. Longest waiting patients have gone from 269 in October to 154 in January 2024 which shows improvement. 28-day Faster Day Diagnosis is still subject to improvement. Whilst this performance has improved because of investment in a 3rd party provider for Dermatology it was recognised that this is a short-term measure and that further work for this tumour site at AHA level for a sustainable solution. Urgent and Emergency Care performance in December was positive with a reduction in time waiting in the Emergency Department for our patients and a reduction in handover delays, despite an increase (10% of ambulance arrivals). However current performance had declined in both waiting times and handover delays. The committee agreed that the waiting times would be regularly reported to committee a month in arrears. NCTR in December continued to show a reduction however it was noted that January was challenging. Diagnostic performance (DM01) has showed that the targeted work with modalities has increased activity & reduced the number of our longest waiting patients, however the % performance has not improved. The final report from the NHSE visit has not been formally received however actions are in place to address the majority of concerns. This is on the forward plan for February 2024. The committee approved the Terms of Reference for the Inclusion and Health Inequalities sub-committee subject to minor amendments and referred to People and Culture for comments and approval. The committee were conscious this report reflected a number of areas of system working and good practice and a possible area for a future Board story.
BOARD ASSURANCE FRAMEWORK & RISKS	Risk report was reviewed, no concerns relating to process were identified.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The committee were able to see a video that illustrated the progress on the Integrated Front Door and engagement with a broad number of stakeholders. It was recognised that the Chief Improvement and Partnership Officers role as vice chair of the Swindon Integrated Care Alliance & that this would be a positive link for the organisation.
REFERRALS TO OTHER BOARD COMMITTEES	The committee approved the Terms of Reference for the Inclusion and Health Inequalities sub-committee subject to minor amendments and referred to People and Culture for comments and approval. The provider selection regime was also received by FDIC on the 21 January 2024.

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	**Quality & Safety Committee**
Meeting Date	18.01.24
Committee Chair	Claudia Paoloni, Non-Executive Director
Link to Strategic Objective	Pillar 1 : Outstanding Patient Care
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality
Improving Together Pillar Metrics	Reducing Harms
	Friends & Family Test
Improving Together Breakthrough Objective	Pressure Harms

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
1. Estates & Facilities Water Pseudomonas Update Report	**good**	x
2. Pressure Harms (IPR breakthrough objective)	**partial**	x
3. IP&C (IPR breakthrough objective)	**good**	x
4. Maternity	**good**	x
5. Q3 2023/34 Maternity and Neonatal Quality and Safety Report	**good**	x
6. Perinatal Mortality Review Tool Report Q3 2023/24	**good**	**x**
7. Quality Oversight of the integrated Front door: Emergency Department, UTC and Medical Expectant Unit	**partial**	**x**
8. Medicine Division update on National Urgent and Emergency patient care survey improvement plan 2022	**partial**	**x**
9. Regulation 28 prevention of future Deaths notice relating to Fall on Linnet		
10. Clinical Audit and Effectiveness: Annual Report 22/23 & Q2 Update	**good**	**x**
11. Safe staffing Monthly report 12. 15+ Risk Report 13. Update on CQC Preparedness	**good** **good**	**X** **x**

POINTS OF ESCALATION	
KEY AREAS TO NOTE	• **Water Pseudomonas Update** UKHSA (UK Health Security Agency satisfied with the progress to date and have reduced need for regular review meetings. They have advised that Trust tare to reduce the positive counts to one before sampling and remedial action can stop. • Flexible hose removal work has commenced with key augmented areas prioritised. Some delays whilst delivery of replacement equipment is awaited. • During black box pipe temperature monitoring it became apparent that flushing records had been falsified. Concerns were raised to Serco regarding the falsified records and increased associated risk around pseudomonas/legionella infection rates. Contractual penalties will arise and Serco have dismissed several staff as a consequence. A full action plan is in place. • Impact is being seen by a reduction in pseudomonas +ve sampling counts. • Trust continues to top table for blood stream infection rates in SW Trusts but this is expected to improve with the reducing infections. 50% of current infections are due to one patient around their wound/catheter care
	• **IPC** Gram negative infections continue to be above trajectory • 1 case of MRSA bacteraemia in a patient admitted from community with pre-existing wounds • Klebsiella rates in Swindon area appear to be highest in SW and reflected in our positive case numbers • Focussed work being undertaken IPC practice in areas of higher infection rates e.g Dove ward and oncology
	• **Pressure Ulcers** have shown a slight reduction in both community and hospital acquired for this month with few patients in corridors.
	• **Quality Oversight ED,UTC, MED** Rise in attendancies and patients requiring hospitalisation is resulting at over-crowding at the front door and impacting quality indicators for these areas. • Increased time to triage (initial assessment), extended length of stay in these areas, associated themes on patient feedback and incidents reflect the overcrowding and high demands on the service. • Delays in ambulance off loading, over past 3 months, have placed the Trust and system in bottom 8 in the country and result in delays in vital signs and pain score within an hour of admission. • Extensive work is being done to maintain patient safety related to triage times, harm reviews, pressure ulcer prevention, nutrition and hydration and communication with patients, through staffing shift changes and increased senior reviews. • Development of Same Day Emergency care Model and SDEC advanced practitioners to reduce length of stay in ED
	• **National Urgent and Emergency Care Patient Survey 2022 Improvement plan** Robust action plan to address key themes of communication, pain management and compassionate communication will be renewed in February. • Privacy in ED remains an issue with high attendances and clean clinical areas for medication preparation

	• Increased senior leadership and alternate staffing patterns are being incorporated as well as 'voices heard champion" and other supporting champions.
	• **Maternity IPR** Staffing levels have improved and a reduction in agency spend • Maternity perinatal mortality reporting times are within required time frames to meet CNST year 5 requirements • Triage time are still below the target of 15mins however there has been marked improvement following actions taken • It has been necessary to discontinue the 'Continuity of Carer Model, due to staff capacity issues, which could adversely impact health inequality accessibility and delivery of care an alternative solution is being sought suitable within the existing resource
	• **Maternity Safety Report Q3** There have been 6 serious incidents this quarter, all are being investigated and no themes identified thus far • senior leadership continue to be actively engaged and are focussing on maternity triage within 15 mins and are working to an extensive improvement plan in place • Scanning accessibility out of hours being resolved with operational changes • 80% compliance in training in core competency framework has been achieved on all staff goups. • Full action plan in place following CQC warning notice (section 29a) • Action plan in place around the 3 non-compliant safety actions for CNST year 5 -reporting time frames - business planning for medical workforce split for maternity and neonatal service -restrictions to Ultrasound scanning capacity
	• **Perinatal Mortality Review Tool Report** Q3 all standards required for mortality reporting are achieving 100% compliance
	• **Clinical Audit and Effectiveness: Annual Report 22/23** excellent levels of compliance achieved within the Trust's clinical audit process to 98% • Increased audits registered and reduced in overdue items • Only one national audit not participated due to resource capacity • Majority Audit results demonstrate reasonable or substantial assurances • Work being undertaken to support medical attendance at clinical governance meetings and undertake audit work
	• **Safer Staffing** positive impact of safer staffing investment in relation to staffing establishment ratios and patient satisfaction. • Good governance, improving sickness rates and staff retention rates reflect the extensive work and programmes achieved around this. • Each ward RAG rated for staffing levels at each shift to enable flexibility if pressures require reconfiguration of staff. • establishment ratios vs acuity of patient needs which impacts staffing distributions and this is being considered for our future staffing level needs. • From April there will be no further external funding for international nurses there is an increased focus to develop our own through apprenticeships and local recruitment
	• **Regulation 28 Report to Prevent Future Deaths** coroner highlighted concerns around ability to provide additional nursing to support patients at risk of falls and management of orthostatic hypotension. • There are Trust wide action plans wrt falls improvement and management of postural hypotension in place • Comparative tools have been tested from other centres, Northumberland and RUH and results concur • Further Trust wide work around safer staffing and baseline nursing establishment requirement is in progress • Committee is reassured that GWH falls rates are within the national normal rates
	• **Board Safety Visits** these are felt to be useful and welcomed for both the visiting team and the areas visited • Common themes relate to storage limitations, medical staffing cover and nursing staffing • Visits result in actions which are referred back to the visited areas to manage and monitored to completion
	• **CQC Preparedness Update** which gave assurance that the learnings from the recent CQC visit in maternity services could be applied throughout. The group has been revitalised and a current review into outstanding 'should do' and 'must do' actions is ongoing in light of the changes with the new style CQC reviews.
BOARD ASSURANCE FRAMEWORK & RISKS	• **15+ Risk Report** There is one risk relating to Q&S which relates to increasing demand/acuity in Majors chairs/Paeds (walk in and Ambulance) resulting in untimely triage, times to critical intervention and administration of treatments and delayed discharges • action plan in place around a review in the current triage process and the new ED Build • Anticipated improvement in score expected in Q3
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	

REFERRALS TO OTHER BOARD COMMITTEES	**To PPPC** From Safety walk rounds ,common themes around storage capacity on wards and suitable work spaces are identified which then triangulates with IPC concerns around potential infection risk associated with storage of items and lack of clean medication preparation areas

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	22 January 2024
Committee Chair	Faried Chopdat
Link to Strategic Objective	Pillar 4: Use of Resources
Link to Board Assurance Framework	BAF 4 S6 & S7
Improving Together Pillar Metrics	GWH Control Total / I&E
	Sustainability / Carbon Footprint
Improving Together Breakthrough Objective	Productivity

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial Update	Limited	x
2. Month 9 – Finance Position	Good	x
3. Efficiency Program	Good	x
4. 2024/25 Planning Update	Note	x
5. Seasonal Plan Update	Partial	x
6. Risks – Estates and Facilities	Good	x
7. Site Utility & Resilience 6 monthly Update	Good	x
8. PFI – 6 Monthly Update	Partial	x
9. Digital (including EPR) Risk Register	Good	x
10. Shared EPR Program Update	Good	x
11. Data Protection, IT Resilience & Cyber Security Quarterly Update	Partial	x
12. Digital Strategic Plan – Quarterly Update	Good	x
13. Provider Selection Regime	Note	x
14. Procurement Recommendation Reports	Approved	x
15. BAF Strategic Risks – Review of Emerging Risks	Note	x

POINTS OF ESCALATION	**BSW Financial Update** – A verbal update was provided, indicating further changes and savings may be required. The Trust faces several challenges in delivering its financial plan, and whilst management's proposed actions present a constructive way forward, the pace of delivery of these plans and the requirement for more mature governance processes at the ICS level is ever more critical to gaining greater assurance. Key challenges relating to the plan include further reductions in projected efficiency delivery, capacity restrictions impacting the delivery of Elective work, Bed reconfiguration impact, and movement in Capital charges arising from over-delivery of the Capital plan. The Committee will monitor the progress closely.
	Efficiency Programme – Efficiency savings were £0.2m below target in-month and are £1.9m behind plan on a YTD basis. The medicine division remains the key driver of the Trust's under delivery, being £2.7m under their plan at M9 due to shortfalls against temporary staff reduction schemes. Undelivered savings remain a significant risk to the Trust's inability to hit a breakeven position at year-end. The Committee is assured that enhanced governance through the Financial Recovery Board will monitor this progress to hold divisions and corporate functions accountable for their efficiency plans. The Committee also received an update on the establishment of the 2024/25 efficiency programme, where progress is being made in the identification of schemes for the coming year; £ 9.5m of opportunities have been identified, with procurement and medicines management programmes to be added to this. Whilst the assurance level of this report remains partial the risks to the 2023/24 efficiency programme have reduced since the last report.
	EPR Programme Update – The FBC is in final review with NHSE, and management is addressing any further clarification questions promptly. The Committee acknowledges the excellent progress the Programme has made to ensure an effective governance model to address the requirements of all three trusts. It has set up the program adequately to deploy EPR. Overall, the Committee is assured of the EPR programme; however, the Committee continues to reiterate the risk that the FBC is yet to be approved by NHSE and the funding received to proceed with the implementation. Management has expressed confidence that the FBC will be approved, and funding received to proceed with the EPR program. Hence, the Committee has reduced its assurance rating from Limited to Good.
KEY AREAS TO NOTE	**Month 9 Finance Position** – Whilst the Committee acknowledges that the finance risk remains high (red) and continues to escalate, we are assured of the management actions taken to stabilise the finance position with an ever-greater focus on the run rate and productivity gains. As at M9, the Trust is £1.7m deficit position year-to-date, representing a £1.2m adverse variance to plan. However, the Trust received £5m of funding for industrial action costs incurred up to M8, a further £0.5m of costs were incurred in M9. There are several other in-year pressures, namely: CDC cost over income (£0.9m), undelivered efficiency savings (£1.9m), a shortfall on ERF-related income (£2.8m), additional medical pay award costs (£0.7m) and temporary staffing pressures (£1.5m). The Trust remains reliant on non-recurrent income streams and costs budget to maintain its adverse plan position of £1.2m. Therefore, focussing on run rate savings i.e. reducing our monthly spend, particularly on temporary staffing, must be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum through strong grip & control measures, and that savings delivery is maximised to enable us to deliver as close to breakeven as possible, while retaining safe delivery of patient care. Capital expenditure is behind plan due to delays in the aseptic unit (estates-related work needed before it can complete) and lower spend on the way forward programme. All capital project leads are forecasting to spend their allocations by year end.
	Cyber Security, Resilience and Data Protection - Good performance for the Data Security and Protection Toolkit (DSPT) was noted with positive evidence provided. Cyber Security remains a key priority for the Trust with investment in a range of controls and risk mitigations. The assurance level is scored partial as there are some improvements that can be made to the Trust's preparedness for a cyber incident, highlighted in the recent desktop exercise. Risks are well understood and routinely reviewed.
	Procurement Regime - The Department of Health and Social Care recently published the Provider Selection Regime (PSR), set out in the Health Care Services (Provider Selection Regime) Regulations 2023, which came into force on the 1st of January 2024. The PSR intends to remove the procurement of health care services when procured by relevant authorities under the PSR, from the

	scope of the Public Contracts Regulations 2015 (the PCR). In doing so, the PSR seeks to give the relevant authorities to which it applies more flexibility in selecting providers for health care services, with an aim to promote greater collaboration, reduce the bureaucracy associated with the current rules, and enable the development of stable partnerships. As such, it is hoped the PSR will ensure all decisions are made with a view to securing the needs of patients, improving the quality of the services, and improving the efficiency in the provision of the services however transparency and record keeping for how decisions are made is critical to be kept compliant with these regulations. The report attached to this paper is a summary of the new Provider Selection Regime for noting by the Board.
BOARD ASSURANCE FRAMEWORK & RISKS	**Digital (incl EPR) Risk Report**: The Committee noted that the risk management process and reporting are adequate and effective; however, the Committee requested greater insight on the assurance of management actions of those risks of a clinical nature where there is a crucial dependency on the support of IT and Digital.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Agency Spend** – The Committee acknowledges the good work undertaken by management to control Agency Spend and notes the continual reduction in nursing agency spend, with medical flattening since Aug 2023. The Trust has the objective of limiting agency costs to remain within the ceiling of £14.8m for the year. For M9 total agency costs were £0.27m against an agency ceiling of £1.23m, which was £0.96m less than the maximum value permitted.
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	**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.

The Department of Health and Social Care recently published the Provider Selection Regime (PSR), set out in the Health Care Services (Provider Selection Regime) Regulations 2023, which came into force on the 1st January 2024.

The PSR intends to remove the procurement of health care services, when procured by relevant authorities under the PSR, from the scope of the Public Contracts Regulations 2015 (the PCR). In doing so, the PSR seeks to give the relevant authorities, to which it applies, more flexibility in selecting providers for health care services, with an aim to promote greater collaboration, reduce the bureaucracy associated with the current rules, and enable the development of stable partnerships. As such, it is hoped the PSR will ensure all decisions are made with a view to securing the needs of patients, improving the quality of the services, and improving the efficiency in the provision of the services.

This new regime will apply to NHS England, Integrated Care Boards, NHS Trusts, NHS Foundation Trusts, local authorities and combined authorities when they are procuring healthcare services.

NHSE carried out a number of training sessions in November and December 2023 for Contracting and income staff, ICB staff and Procurement staff across the country.

The new Healthcare Services (Provider Selection Regime) Regulations 2023 (the PSR) will play a vital role in governing the procurement of healthcare services in England from 1 January 2024, applying to relevant healthcare services (healthcare provided for individuals) procured by NHS England, Integrated care boards, NHS trusts and foundation trusts, and Local authorities or combined authorities. The Public Contracts Regulations 2015 will no longer apply to these contracts. The new Procurement Act (which replaces the current Regulations and is expected to come in late 2024) will also not apply.

The services broadly in scope are

Broadly, services **within** scope are:

- services that provide treatment, diagnosis or prevention of physical or mental health conditions to individuals or groups of individuals (i.e., patients or service users) such as hospital, community, mental health, primary health care, palliative care, ambulance, and patient transport services for which the provider requires CQC registration. This covers services contracted between NHS authorities in these areas whether ICB to Trust or NHS to NHS organisation for services classed as Healthcare services
- substance use treatment services, sexual and reproductive health, and health visitors arranged by local authorities.

Examples of procurements **not in scope** of this Regime:

- goods (i.e., medicines, medical equipment)
- social care services
- non-health care services or health-adjacent services (i.e., capital works, business consultancy, catering) that do not provide health care to an individual.

Mixed Procurement - The PSR does not apply to the procurement of goods or non-health care services (unless as part of a mixed procurement), irrespective of whether these are procured by relevant authorities. These are relevant healthcare services that also incorporate other goods or services and are procured together (for example, patient transport which includes health care services). To qualify as mixed procurement and be procured under the PSR, the

main subject-matter must be the healthcare services, and the authority must believe that the other goods or services cannot reasonably be supplied under a separate contract.

Procurement Processes: The PSR provides five distinct routes to market for procuring healthcare services, but only one which provides for competition as we know it under the current Regulations:

Direct Award Process A (one capable provider): Used when there is an existing provider for the healthcare services and there is only one capable provider. The authority awards the contract without competition and submits a notice of the award for publication. i.e. an A&E department for an area such as Swindon.

Direct Award Process B (patient choice): when patients have the freedom to choose their provider and there are no restrictions on the number of providers. The authority awards the contract without competition and submits a notice of the award for publication under the transparency rules.

Direct Award Process C (incumbent extension): Applicable when the authority assesses the existing provider's ability to satisfy the proposed contract and the proposed new contract has no considerable changes. The authority submits a notice of intention to make an award to the existing provider. After the standstill period, the contract is awarded, and a notice of the award is published.

There are five **key criteria** that must be considered when assessing providers under direct award process C, the most suitable provider process, or the competitive process. These are:

- Quality and innovation
- Value
- Integration, collaboration, and service sustainability
- Improving access, reducing health inequalities, and facilitating choice
- Social Value

Most Suitable Provider Process: The authority submits a notice of intention to follow this process and identifies potential providers, assesses them based on key criteria, and selects the most suitable provider. After the standstill period, the contract is awarded, and a notice of the award is published

Competitive Process: Utilised when the relevant authority determines criteria, invites offers from providers, assesses the offers, and makes a decision on the successful provider. After the standstill period, the contract is awarded, and a notice of the award is published.

Framework agreements can only be concluded using the competitive process.

Basic Selection Criteria and Information Management: Under routes 3-5 above, providers must meet the basic selection criteria, which may include suitability, economic and financial standing, and technical and professional ability. The authorities can impose specific requirements related to authorisations, memberships, turnover, financial capacity, and technical resources.

Record Keeping

Throughout any of these processes and awarding of agreements, Authorities must maintain acute records of contract details, decision-making processes, conflicts of interest, and more.

They are also required to publish an annual summary of contracting activity and an annual report on compliance to the rules.

These records may be requested as part of a review during the standstill period. **Records for each healthcare service award under the PSR must include:**

- the relative importance of each of the key criteria and the rationale for their relative importance and how the basic selection criteria were assessed
- name and address of the provider
- the decision-making process followed to select a provider
- the rationale for the decision
- for mixed procurements, how the procurement meets the requirements for mixed procurement
- details of the individual/individuals making the decision
- any declared or potential conflicts of interest for individuals involved in decision making and how these were managed

Transparency Requirements

The PSR provides for greater flexibility and allows relevant authorities to award contracts without using a competitive process, where appropriate. This means that other checks and balances need to be in place to ensure that the PSR is complied with and that the flexibilities are used appropriately and in the best interest of service users.

The PSR therefore requires that:

1. Transparency notices are published by GWH when contracts are awarded and in some situations before contract awards are made
2. GWH keep detailed evidence of their decisions and decision-making processes, which they may be required to share with providers (if they receive a representation).
3. An annual summary is published by GWH, which details how many contracts were awarded using the various provider selection processes.

This also covers contract modifications to healthcare services the below covers the regulation on transparency and what the Trust will need to do for any contracts awarded under healthcare services depending on the route they use to award

	decision-making processes					framework agreements		
process	direct award processes			the most suitable provider process	the competitive process	establishing a framework agreement	contracts based on a framework agreement without competition	contracts based on a framework agreement following competition
	A	B	C					
Making intentions clear in advance								
Publishing the intended approach in advance				✓				
Publishing a notice for a competitive tender					✓	✓		
Communication of the decision								
Publishing the intention to award notice			✓	✓	✓	✓		✓
Confirmation of the decision								
Publishing a confirmation of award notice	✓	✓	✓	✓	✓	✓	✓	✓
Contract modification								
Publishing a notice for contract modifications	✓	✓	✓	✓	✓	✓	✓	✓

GWH is unlikely to host framework agreements so that side of the table above can be ignored.

Standstill Period and Review

The PSR incorporates a standstill period for routes 3-5 above, of 8 working days after a notice of intention to award is published.

During this period, providers can make written representations if they believe there has been a failure to comply with the regulations. The authority reviews the representations and makes further decisions, either proceeding with the award, going back to an earlier step, or abandoning the procurement.

The standstill period will continue while the representations are reviewed by the authority until 5 working days after the authority has informed providers of its decision, following the review.

Providers have a right of appeal to a NHS England independent review panel, but there is no right to challenge potential breaches of the regulations via the courts as we see now with procurement challenges under the current Regulations. An aggrieved provider would need to consider whether to escalate matters with judicial review proceedings.

I have included a Frequently asked questions section on the PSR which can be accessed here

NHS commissioning » Provider Selection Regime frequently asked questions (england.nhs.uk)

Conclusion

The PSR is aimed at being more flexible but also more transparent on what Trusts and ICB's are awarding and why. It covers healthcare services and there is no financial value from which they apply they apply to all values of spend for services falling into healthcare

Providing the Trust has been good at complying with its requirements of Public Contract Regulations for healthcare services and provider to provider agreements and keeping these records and publishing notices then this will not be much of change however if the Trust has not had in place the level of record keeping and published notices for provider to provider agreements etc in the past consistently then it will now need to ensure these are in place.

Procurement can confirm that those agreements we are involved in we do keep this level of records and the procurement recommendation report process covers this however procurement are not involved in a large amount of Provider to provider agreements at GWH as a number pass through the contracting team in Finance and so it will be for them to confirm they are also complying with these new regulations. That said a large amount of contracting will be the ICB with the Trust so the responsibility for the award will sit with the ICB.

Board Committee Assurance Report

Committee	**People & Culture Committee**	
Date of Meeting	Tuesday 23rd January 2024	
Committee Chair	Paul Lewis, Non-Executive Director	
Link to Strategic Objective	Pillar 2 – Staff & Volunteers Feeling Valued	
Link to Board Assurance Framework	BAF 2 : SR 2 – Culture / SR 3 – Health & Wellbeing / S4 – Workforce Plan	
Improving Together Pillar Metrics	Staff Retention	Equality, Diversity & Inclusion (ED&I)
	Staff Survey - % Recommended	
Improving Together Breakthrough Objective	Staff Survey - % Improvements	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Staff Survey - Recommend	Partial	No
2. Staff Survey – Make Improvements	Partial	No
3. EDI	Partial	Yes
4. Staff retention	Good	No
5. Annual report for Education & training	Partial	No
6. Staff Survey – Corporate Division	Partial	**No**

POINTS OF ESCALATION	• None
KEY AREAS TO NOTE	• Staff Survey – awaiting latest results for both the Trust and national results. Latest staff survey response rates at 69% are very encouraging. • The Staff Survey update from Corporate Division provided assurance that further progress has been made. Again, we are awaiting the latest survey results to be published before we consider increasing the level of assurance from Partial. • EDI – Board commitments now agreed in principle and will be finalised with key actions for 2024 at the March Board Meeting. The 3 key themes will be staff & patient listening events, staff networks engagement & support and Board Meetings ED&I data and reporting. • Staff Retention – the Trust has continued to see an improving trend since July 2022 with the voluntary turnover rate being below the target (11%) for eight months. The latest position in November was 9.2%. There are still concerns with leavers within the 1st year of employment and this will feature as a key action within the 2024 staff survey actions to make the improvements required. • The Annual Report for Education & Training gave assurance with further progress being made across many areas. The key areas requiring further improvement are enabling clinical skills trainers to spend time in clinical areas on wards and departments and to improve the level of support to the Academy from Finance Division as this was highlighted as a key concern by Amanda Wylie (the Associate Director of Organisational Development & Learning).
BOARD ASSURANCE FRAMEWORK & RISKS	The key strategic risks were not reviewed at this meeting and will be assessed again at the next meeting in February 204. The agreed ratings in November were: • Culture – Adequate • Health & Wellbeing – Substantial • Workforce Plan - Adequate
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The key successes and achievements to note from the meeting were: • Staff Survey response rates • Staff Turnover/Retention rates • Sickness absence rates

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

Purpose

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

Assurance Level

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

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

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

Report

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

Our Performance

Key highlights from the report this month (November for Cancer) are:

OPERATIONAL PILLAR METRICS

Of the 5 Operational Pillar Metrics, Cancer 62 day performance improved for the second month in a row. However, due to under-performance in 62 day breaches the Trust will be

moved into Tier 2 status by the NHS England elective recovery team from the 15th January. This involve weekly meetings with the COO team and regional Head of Cancer services to support improvement to cancer performance standards.

There was improvement in RTT activity especially for patients waiting >52 & 65 weeks during December although recent industrial action presents an additional risk to Quarter 4 performance.

Emergency Care Mean stay across Emergency Department (ED) and the Urgent Treatment Centre (UTC) saw marginal change with a slight improvement for patients waiting more than 4 hours in ED and a reduction in the number of patients spending more than 12 hours in ED. There has been minimal change to the number of patients presenting overall, although ambulance conveyances increased by 10% from the previous month. The number of patients with non-criteria to reside (NCTR) remains within the SPC control limits although began to increase in the run up to Christmas.

- Cancer 62-day November performance improved for the second consecutive month to 67.2% but remains below the national target of 85%.
- RTT (Referral to Treatment) 65 Week Waiters – December performance shows the total number of patients waiting over 65 weeks at 343, an 18% reduction from the previous month. 4 patients above 78 weeks were reported in December, due to complexity of treatment.
- Emergency Care, Emergency Department Mean Stay – There has been no significant change to the time patients spend in the Emergency Department covering both the ED and UTC, with wait times within control limits.
- Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. Total attendances in December were the highest in the calendar year to date, with ambulance conveyances up 10% from the previous month. Demand increased in line with winter planning assumptions but 4 hour performance improved to 74.7%, which is just short of the national recovery ambition of 76% by March 2024.
- Number of non-criteria to reside (NCTR) days. Bed days lost due to patients in an Acute Hospital bed without a Criteria to Reside (NC2R) reduced to 2,106, which was the lowest this calendar year. This follows the implementation of a system sponsored NC2R improvement plan as part of winter planning.

It should also be noted that December junior doctor industrial action resulted in 36 elective procedures (14 related to cancer surgery) and 658 outpatients (60 relating to cancer pathway treatment).

OPERATIONAL BREAKTHROUGH OBJECTIVE

Mean time in ED from arrival to clinically ready to proceed (CRTP) has decreased to below mean levels (254 in December from 315 in November) showing patients waited less time to be off loaded, triaged, seen and diagnosed. A recovery plan to reduce ambulance handover delays remains in place which is contributing towards improvement in this area.

ALERTING WATCH METRICS

Key alerting measures include, RTT, Diagnostics (DM01), Cancer, ED and Flow.
RTT shows fewer patients over 18, 52 and 65 weeks. The number of patients over 52 weeks shows a reduction for the 6th month in a row. However, clock stops reduced in December due to industrial action and the impact of further cancellations in January presents an additional risk to waiting list recovery over the coming months.

Diagnostics – The overall waiting list continues to increase with under-performance in 6 week performance driven by non-obstetric ultrasound, endoscopy and echo. The validated position for December 2023 will be updated in due course.

Cancer – All 3-cancer metrics (faster diagnosis, 31 day decision to treatment and 62 day urgent referral to treatment) showed improvement this period compared to the previous month but remain below constitutional standard.

ED watch metrics show improvements to handover delays this period, although 4 hour performance and 12 hour trolley waits are failing against constitutional standards.
All flow measures show an improvement this period with a reduction in stranded patients waiting over 14 and 21 days.

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

Strategic Pillar Targets

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

There has been a decrease in the total number of harms down to 189 from 194 last month. The decrease is linked to a reduction in pressure harms in both the community and acute settings.

The number of Family and Friends (FFT) positive responses for December is 88.8%, a similar position from last month, and remains above the internal target.

Breakthrough Objectives
Pressure harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. For 2023-24 the following new targets have been agreed.

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

November has seen a further decrease in the number of community pressure related harms, with the fourth consecutive fall to 29 in month compared to 34 in November and 43 in October. The number of acute related pressure harms has also decreased in month to 29 compared with 39 October.

Alerting Watch Metrics
The Trust overall complaint response rate has increased in December to 73% and is just below the internal target of 80%.

The Trust remains above trajectory for all three gram-negative bloodstream infections (E. coli, Klebsiella and P. aeruginosa) and for C. difficile, however monthly rates for E. coli and P. aeruginosa have reduced over time. Klebsiella has shown a reduction for the first time in December, likely due to a reduction in cases associated with chest infections, which could

be a result of the recent focus on mouthcare. C. difficile numbers continue to be higher than expected.

The increases in community-onset and hospital-inset Klebsiella rates in Swindon were raised at the quarterly Bath and Northeast Somerset, Swindon and Wiltshire Healthcare-Associated Infections Collaborative, as the reasons for the increases are not understood. UKHSA offered to liaise with their epidemiologists to help look for causes; we have shared our data and our internal review. An extra meeting has been convened to discuss this in more detail.

There has been a decrease in the Family and Friends (FFT) Day case response rate and positive response rate and the Maternity response rate. The Emergency Department and Urgent Treatment Centre response rate has increased slightly but remains just under the internal target.

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

- Safer staffing fill rates have decreased slightly but remain well above the National target of 85%.
- Four Serious Incidents (SI's) have been declared in month, with 25 ongoing SI's, eight overdue the 60 days target. All are being investigated under the Serious Incident Framework.
- There has been a decrease in both the number of concerns and complaints in month, but the number of complaints reopened has increased.
- There has been one reported Methicillin-resistant Staphylococcus Aureus (MRSA) infection in month.
- There has been an increase in the number of falls in month to 93, from 80 in November.
- FFT overall response rate has decreased to 25% and remains below the internal target of 29%.
- There has been a decrease in the number of hospital acquired COVID cases in month (9) when compared to 15 in November.

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

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

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

- **Staff Survey – Recommend a Place to Work**
  Target 55% achieving 57% (Q2 pulse survey)
- **Staff Voluntary Turnover**
  Target 11% Achieving 9.2% (November data)
- **EDI disparity (reducing discrimination disparity)**
  Target 8.3% achieving 10.3% (Q2 pulse survey)

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

Breakthrough Objectives
The Trust Breakthrough objective is to achieve a 5% improvement from the 2022 Staff Survey in the question "*I am able to make improvements happen in my area of work*". Results from the annual staff survey are embargoed and so not available, however indicative information shows a promising increase to this question.

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

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

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

Alerting Watch Metrics
The in-month sickness absence position has been held in November at 4.7% and remains above the Trust KPI of 3.5% however is below last year's sickness rate of 4.9%. The Trust has moved from the second quartile back down to the lowest quartile and is in the top 20% of acute providers for it's absence rates (August benchmarking data).

LTS is currently 1.95 % and STS is 2.74% with an in month reduction to long-term and corresponding increase to short-term.

The COVID vaccine campaign has now concluded with 52% of our staff having received a booster. The Flu vaccine programme is continuing with 68% currently having received a vaccine. This remains 4% lower than last year, however national vaccine rates have declined, and the Trust remains the highest uptake in the BSW.

Non-Alerting Watch Metrics
Voluntary turnover remains stable at 9.2% (same as last month), and below the Trust KPI target of 11%.

Leavers within their first year of employment (rolling 12 months) have improved – current performance is 12.9% compared to 14.1% last month and a target of 14.8% (average over the last 12 months).

HR Scorecard

Vacancy Rate:
The Trust vacancy rate has further improved to 3.7% (201WTE) compared to last month 3.9% (201WTE), in line with continued improvement to our turnover rates and a stabilisation in recruitment activity (44 days' time-to-hire and 66 starters).

The new Vacancy Control Panel may impact current performance as we slow down recruitment via the process.

The new Executive Level approval process is now implemented, and approval is required for:

- All recruitment
- Increase in band
- Agency admin and clerical
- Increase in hours

This has been extended to

- Ban on Corporate bank work unless approved via EVRP

Worked Against Budget:
The Budget in WTE for M9 5,382WTE compared to a worked 5,510WTE. This is 128WTE (2.4%) above budget. This was 51WTE less than last month.

In M9 the workforce costs are a £444K overspent against budget (reduction compared to last month (£634K) £4.3M overspend YTD.

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

- Nursing +£240K
- AHP/STT +£63K
- Medical +£577K
- Admin and Clerical -£447K

Year to date as followed

- Nursing +£3.9M
- AHP/STT -£53K
- Medical +£6.5M
- Admin and Clerical -£4.0M

Included in the HR scorecard is workforce costs by Staff Group to ensure clear visibility of workforce costs by TMC.

Agency Spend against Plan
Agency spend for December was £0.3M, significantly below the in-month target of £1.1M and reporting as 1.2% as a percentage of total workforce spend.

YTD agency spend is £7.9M which is £1.3M less than plan and £3.4M less than last year – achieving our £3M reduction target set for the 23/24.

The in-month medical agency spend is significantly lower than November, this is due to financial reporting rather than actual usage. Therefore, expected to increase next month.

Use of Resources
As at M9 the Trust is in a £1.8m deficit position which represents a £1.2m adverse variance to plan. Although the Trust received £5m of funding for industrial action costs incurred up to M8, a further £0.5m of costs were incurred in M9. There are a number of other in-year pressures, namely: undelivered efficiency savings (£1.9m), a shortfall on ERF related income (£2.8m), additional medical pay award costs (£0.7m) and temporary staffing pressures (£1.5m). These are offset by prior year income and other non-recurrent income totalling £7.2m.

The Trust's forecast position is a most likely £5.6m deficit. This has increased from a £2.6m most likely forecast in M8 due to further anticipated industrial action costs of £1.5m and CDC related cost pressures of £1.5m. The Trust expects CDC to be a system risk share, but discussions are currently ongoing around this. We are working towards a best-case scenario of £3.9m which we are focusing all of our efforts on delivering over the last quarter of the year. This has moved from a best case of £0.1m in M8 due to the above pressures from industrial action and CDC plus a further £0.75m of strike impact on the delivery of efficiencies.

Efficiency savings were £0.2m below target in-month and are £1.9m behind plan on a YTD basis. Medicine division remain the key driver of the Trust's under delivery, being £2.7m under their plan at M9 due to shortfalls against temporary staff reduction schemes.

The Trust remains reliant on non-recurrent income streams and cost budget to maintain its adverse budget position of £1.2m. Therefore focussing on run rate savings i.e. reducing our monthly spend, particularly on temporary staffing, has to be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum through strong grip & control measures, and that savings delivery is maximised to enable us to deliver as close to breakeven as we can, while retaining safe delivery of patient care.

Breakthrough Objectives
Implied Productivity for the Trust in total is recovering and has improved to an overall total –14% for Month 9 unvalidated (this is a 5% improvement from the 18% at the end of 2022/23 - March 2023).

The further 1% improvement from last month (M8) reflects some recovery in activity compared to 2019/20 and the financial position being previously being compensated for industrial action and ERF activity (£5m total in M8) but this is largely not within divisions but instead held centrally. There has however been a further impact financially for industrial action in December and so current productivity has been impacted. The position does still reflect being off track with some of our activity and financial plan for 2023/24 due to higher pay pressures such as community diagnostic unit costs, pay awards, temporary staffing and behind plan CIP Delivery. The Breakthrough objective productivity measure continues to be against 2019/20 cost change as it is measuring the increased cost from 2019/20 levels.

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)				
Next Steps					

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

Explanation of above analysis:

Workforce

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

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board/Committee/Group is requested to: ▪ ***Review and support the continued development of the IPR*** ▪ ***Review and support the ongoing plans to maintain and improve performance***	
Accountable Lead Signature	
Date	24/01/24

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

January 2024

November 2023 & December 2023 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

Section & purpose	Slides
Key indicators This is the NHS Oversight Framework indicators for 2023/24 and provides a summary of our performance against national standards	3-4
Executive summary This provides an overview of the targets, performance and countermeasures (remedial actions) for each of our pillar metrics	5-12
Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: Patients Developing Pressure Ulcers; Emergency Department - Clinically Ready to Proceed; Implied Productivity and Staff Survey Results	13-16
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	17-19
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	20-23
Use of Resources This includes key indicators and watch metrics for finance as assured by the Finance, Infrastructure & Digital Committee, and is also subject to a separate board report	24
Our People This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee	25-30
Explaining the IPR This section explains how the work of front line teams to drive improvement connects from 'ward to board' through our operational management system, and the business rules we apply to support that.	32-45

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Total patients waiting more than 65 weeks	0	463	455	384	458	525	640	621	689	661	488	417	343
Percentage of patients who receive a diagnostic test within six weeks of referral	99% (Nat)	48.5%	54.2%	56.1%	50.4%	52.3%	52.2%	49.4%	44.5%	46.1%	45.0%	49.5%	Reported one month behind
62 day backlog (As % of allocated "Fair shares" position)	9.53% (Nat)	10.0%	6.3%	5.6%	157.6%	157.6%	148.4%	156.0%	180.3%	200.4%	178.6%	181.1%	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	70.8%	77.8%	76.5%	73.6%	71.3%	65.0%	67.2%	62.6%	62.0%	58.2%	59.7%	Reported one month behind
Proportion of patients seen within four hours	95% (Nat)	75.8%	74.3%	77.2%	75.7%	74.8%	73.8%	75.5%	74.2%	74.7%	71.5%	71.4%	74.7%
Ambulance average Category Two response time	00:18:00 (Nat)	00:44:55	00:46:13	00:53:23	00:37:25	00:40:02	00:51:09	00:46:15	00:56:36	02:05:05	01:48:08	01:56:41	01:11:41
Percentage of beds occupied by patients who no longer meet the criteria to reside	13.3% (Nat)	17.3%	19.0%	19.5%	16.4%	16.4%	17.8%	17.2%	14.3%	15.8%	17.4%	18.1%	17.8%
Adult general and acute type 1 bed occupancy (adjusted for void beds)	94.5% (Nat)	99.0%	98.5%	98.6%	98.0%	98.4%	98.2%	97.6%	98.2%	98.7%	98.8%	98.5%	96.3%
Virtual ward - percentage capacity occupied	64.1%	21.1%	23.8%	29.5%	23.4%	28.1%	28.5%	53.7%	44.4%	53.8%	65.1%	70.8%	78.4%
Summary Hospital-level Mortality Indicator	0 (Nat)	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	3 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
National Patient Safety Alerts not completed by deadline	0 (Nat)	0	0	0	0	0	0	0	0	0	0	0	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection	0 (Nat)	200.0%	300.0%	300.0%	300.0%	300.0%	300.0%	400.0%	400.0%	400.0%	300.0%	Reported two month behind	Reported two month behind
Clostridium difficile infection	100% (Nat)	81.3%	87.5%	102.1%	106.5%	123.9%	139.1%	152.2%	156.5%	154.4%	169.6%	Reported two month behind	Reported two month behind
E. coli bloodstream infection	100% (Nat)	129.0%	143.5%	156.5%	157.6%	169.7%	163.6%	168.2%	162.1%	165.2%	174.2%	Reported two month behind	Reported two month behind
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Leaver rate	11.0% (Nat)	11.6%	11.3%	11.2%	10.5%	10.5%	10.2%	9.7%	9.6%	9.5%	9.2%	9.2%	Reported one month behind
Sickness absence rate	3.5% (Nat)	4.9%	4.5%	4.6%	3.8%	3.7%	3.8%	4.4%	4.0%	4.2%	4.7%	4.7%	Reported one month behind

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	6.8%	6.6%	6.6%	6.3%	5.2%	6.7%	5.3%	5.3%	5.3%	5.3%	5.4%	Reported one month behind
Proportion of staff in senior leadership roles who are women	64% (Nat)	56.8%	54.9%	54.3%	55.7%	54.0%	56.0%	56.1%	56.1%	56.1%	56.1%	55.4%	Reported one month behind
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	0.0%	0.0%	0.0%	1.8%	1.7%	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%	Reported one month behind
Financial efficiency - variance from efficiency plan (£'000)	+/-	-400	-238	281	-377	-384	334	-641	-338	-504	-39	478	-224
Financial stability - variance from break-even (£'000)	+/-	-1579	-1469	-1482	-2157	-2591	-144	-659	330	-1352	1996	5043	-1877
Financial stability - variance from PLAN (£'000)	+/-	106	214	-18	-893	-2132	-223	-733	-528	-1646	1334	4489	-1204

Measure Name	Mean	2017	2018	2019	2020	2021	2022
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	6.7
Staff survey engagement theme score	6.9	6.9	6.9	7.0	7.0	6.7	6.7
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.9%	-	-	60.4%	57.1%	56.1%	56.4%
Stillbirths per 1,000 total births	2.3	-	2.4	1.9	2.1	2.8	Waiting for data
Neonatal deaths per 1,000 total live births	1.2	-	1.4	1.0	1.0	1.3	Waiting for data

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Total Harms

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

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

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

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

Patient Experience (FFT)

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

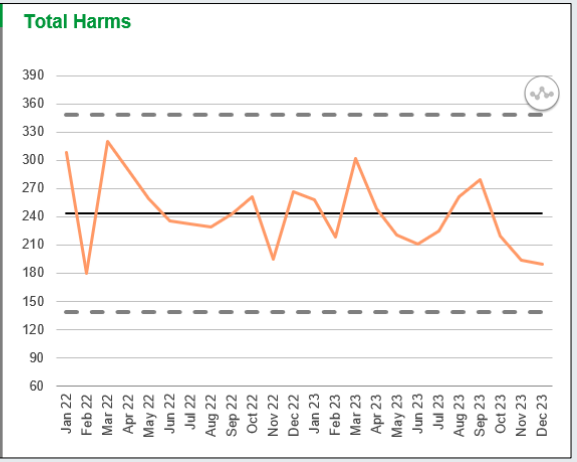
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

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

Total Harms

To achieve and sustain zero avoidable harm.

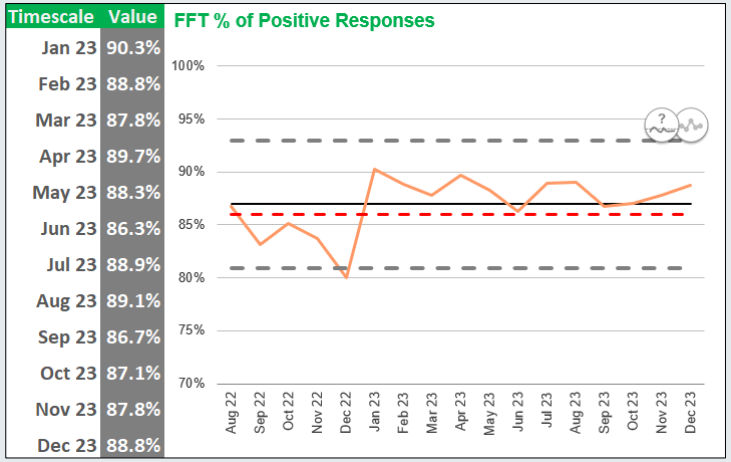
Timescale	Value
Jan 23	258
Feb 23	218
Mar 23	302
Apr 23	248
May 23	221
Jun 23	211
Jul 23	225
Aug 23	261
Sep 23	279
Oct 23	219
Nov 23	194
Dec 23	189



Patient Experience (Friends & Family Test)

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

Timescale	Value
Jan 23	90.3%
Feb 23	88.8%
Mar 23	87.8%
Apr 23	89.7%
May 23	88.3%
Jun 23	86.3%
Jul 23	88.9%
Aug 23	89.1%
Sep 23	86.7%
Oct 23	87.1%
Nov 23	87.8%
Dec 23	88.8%



Counter Measures

The number of harms has reduced in December (189), primarily driven by a reduction in pressure harms in both the acute and community setting. The number of falls has increased in month to 93 compared with 80 in November.

Whilst the Trust remains over trajectory for most infections, there are slight improvements seen, with the exception of *C. difficile* which saw an increase in December after an unusually low number of cases in November.

For December, the Trust wide positive score is 88%, a similar position from the previous month, and still above the internal target of 85%.

The maternity team have been working collaboratively with the Maternity Voices and Neonatal Partnership and PALS to develop the availability of patient information through our trust webpage. The ability for patients to access information leaflets via a direct link will soon be possible and will mean that they can also directly translate the information. This is through an extension to the Microguide system that is already used within Pharmacy. Once trialled within Maternity the PALS team will look to roll this out to other teams to ensure patient information is accessible for all.

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

Cancer 62day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In November, there were 55.0 breaches in total, with 32.0 of these attributed to the Urology, Colorectal and Skin pathways. Skin and Colorectal have seen increased demand resulting in capacity challenges. We continue to see greater than normal breaches in Urology where number of breaches relate to patients needing time to consider which choice of treatment they would prefer and pathways requiring additional treatment following an incomplete procedure.

RTT: Number of patients waiting over 65 weeks

December performance shows the total number of patients waiting over 65 weeks at 343, an 18% reduction from the previous month. 4 patients above 78 weeks were reported in December, due to complexity of treatment.

Focused monitoring and support via a weekly improvement plan is being provided to specialities that are currently predicted not to achieve the national target of eliminating 65 week waits by March 2024. High risk areas where capacity breaches are possible include Gastroenterology, General Surgery, Gynaecology and Respiratory Medicine. Trajectories for improvement and recovery plans are being reviewed following the Christmas and New Year junior doctors strikes.

4x 78 week breaches were reported at the end of December 2023: 2x non-admitted patients in Gastroenterology, 1x non-admitted patient in Paediatrics, and 1x admitted patient in General Surgery. Breach reports for these patients are underway and next events being scheduled in January.

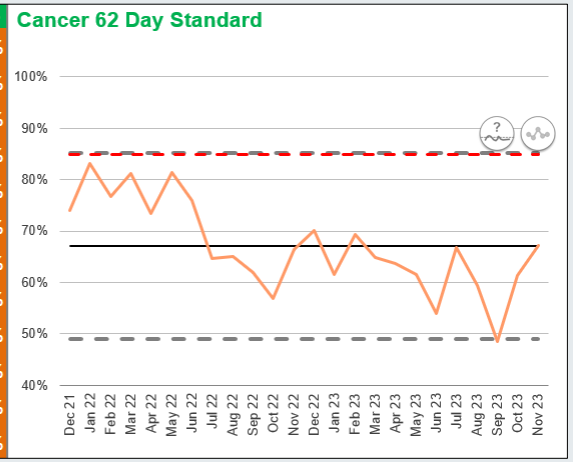
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

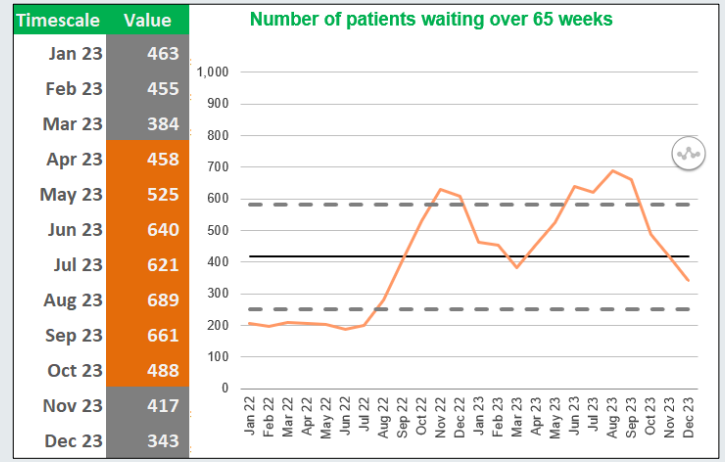
Timescale	Value
Dec 22	70.2%
Jan 23	61.6%
Feb 23	69.3%
Mar 23	64.8%
Apr 23	63.8%
May 23	61.5%
Jun 23	54.0%
Jul 23	66.9%
Aug 23	59.5%
Sep 23	48.5%
Oct 23	61.3%
Nov 23	67.2%



RTT: Number of patients waiting over 65 weeks

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

Timescale	Value
Jan 23	463
Feb 23	455
Mar 23	384
Apr 23	458
May 23	525
Jun 23	640
Jul 23	621
Aug 23	689
Sep 23	661
Oct 23	488
Nov 23	417
Dec 23	343



Counter Measures

Risk: Dermatology capacity had been impacted by vacancies and increase in referrals.
-Recruitment of substantive Consultant continues. Performance shortfalls are expected through the winter as a result of expected leave. Due to the number of referrals received this will have an impact on the overall Trust performance.
-Additional locum recruited to cover first appointments and minor ops clinics until end of December 23
-External Derm team to provide up to 400 additional slots over 2 weeks to clear ASI wait lists. Provision to include see and treat where possible. The clinics are due to commence 13 January.
Risk: Capacity in Plastics is insufficient to see and treat patients.
Mitigation: Some Plastic patients are being sent to Wootton Bassett to help free up surgical space at GWH. The Pathway has been mapped with the milestones assessed, potential improvements in both pathway and processes are being implemented. Actions to improve capacity and operational processes have been agreed with the divisional management team.
Risk: Urology Pathways are often complex requiring multiple diagnostics, with multiple treatment options needing to be discussed at Tertiary centres before treatments can be planned. Patients requiring additional treatment following an incomplete TURBT procedure will often breach due to recovery and planning time.
Mitigation: Pathway improvement manager is working with service to implement the best practice timed pathway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team have undergone LATP biopsy training with a view to reducing the demand on TRUS biopsies.

Risk: Insufficient capacity to recover 65 week + breach position by March 2024
Mitigation:

- Patient level details/plans updated on weekly basis in line with recovery trajectory. Booking in order practice being reviewed
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Additional clinical capacity being provided across services for patients at risk of breaching the 65 week standard.
- Booking to DNA rates has commenced in key specialties.
- Validation of waiting lists (Project Verify) being embedded, along with cohorts of patients waiting over 40 weeks being offered alternative health care providers.

Risk: Reduced capacity due to the proposed industrial action across multiple staff groups.
Mitigation:

- All elective activity on proposed strike days reviewed. Maximum clinical sessions running where staffing allows.
- Patient impact assessed and alternative sessions to be provided. Long waiting and cancer patients prioritised.
- Long waiting and cancer patients to be brought forward to reduce the risk of cancellation.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Department & Urgent Treatment Centre - Emergency Attendances

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

December has seen a 5.4% increase in attendances to both ED & UTC from 10,491 to 11,066 in month (ED and UTC). This is the second highest monthly attendance this year and only surpassed by attendances in Dec 22.

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

December saw a slight decrease in NCTR from **75 to 68** running on the day. Medical outliers decreased to an average of 34 patients (threshold target is <30). Average discharges per day remained the same as November at 93 patients per day. Pathway 1 discharges equated to 232 which was a **9% decrease** on November, Pathway 2 a decrease of **22% to 83** which is a positive demonstrating majority of patients are being discharged to where they reside. Home first(Swindon) was below target of 116 which was 103 discharged with home first support.

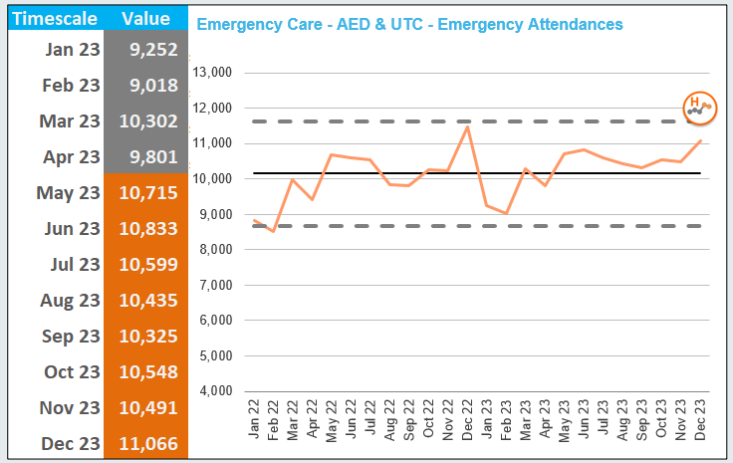
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

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

To ensure patients are cared for in the appropriate setting

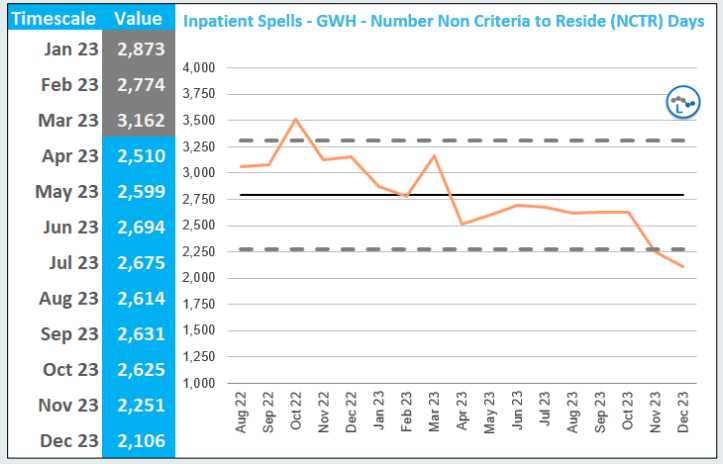
Timescale	Value
Jan 23	9,252
Feb 23	9,018
Mar 23	10,302
Apr 23	9,801
May 23	10,715
Jun 23	10,833
Jul 23	10,599
Aug 23	10,435
Sep 23	10,325
Oct 23	10,548
Nov 23	10,491
Dec 23	11,066



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
Jan 23	2,873
Feb 23	2,774
Mar 23	3,162
Apr 23	2,510
May 23	2,599
Jun 23	2,694
Jul 23	2,675
Aug 23	2,614
Sep 23	2,631
Oct 23	2,625
Nov 23	2,251
Dec 23	2,106



Counter Measures

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

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

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

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

- RESET week 4th December happened and findings to be presented at Urgent Care and Flow board – top 3 opportunities & reflections below:

Opportunities:

- To review the approach to criteria led discharge for patients and maximise opportunities for earlier in the day discharge including to discharge lounge.
- Review wards that have opportunities for higher discharges prior to midday
- Pre-empting discharges 24 hours in advance & preparing TTAs in advance.

Reflections:

- Standardising discharge processes including discharge summaries and medicine to take away.
- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Discharge Reg support has been in place for weekends during December with positive outcomes - weekends in December 2023 we exceeded an extra **32.25%** of discharges than we would usually expect over this time.. The key dates were the dates we had a discharge consultant over the weekend, averaging at **67.6** each day of the weekend, compared to **61.56** for December 2022.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime in Dec '23 was 391 minutes against the national standard of 240 minutes, this comprises a 17% reduction in mean time waits compared to November 23. This is below mean levels (460mins) and well below the mean time waits in December 2022 of 550 mins.

Emergency Care – Urgent Treatment Centre - Mean Stay

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

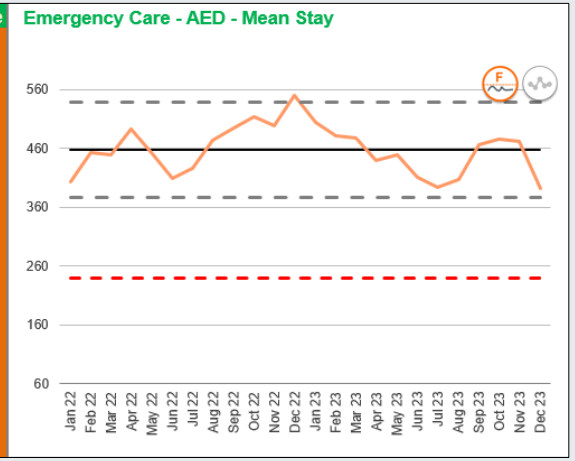
The total meantime wait for a patient in December 2023 was 151 minutes against the national standard of 240 minutes, demonstrating good flow through the service despite an increase in paediatric attendances experienced at the end of November and into December.

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

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

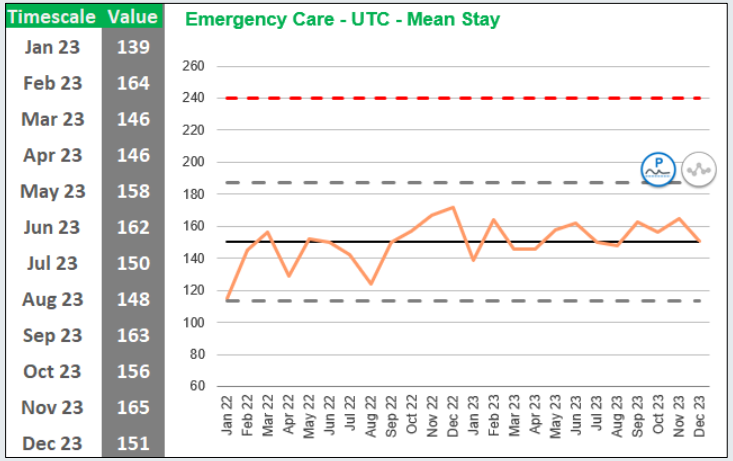
Timescale	Value
Jan 23	503
Feb 23	482
Mar 23	477
Apr 23	440
May 23	448
Jun 23	410
Jul 23	393
Aug 23	407
Sep 23	466
Oct 23	475
Nov 23	471
Dec 23	391



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Jan 23	139
Feb 23	164
Mar 23	146
Apr 23	146
May 23	158
Jun 23	162
Jul 23	150
Aug 23	148
Sep 23	163
Oct 23	156
Nov 23	165
Dec 23	151



Counter Measures

- Weekend ED Paeds Consultant to be maintained with vacancy monies; improve quality of care and waiting times for children, whilst also supporting main ED staffing
- 2nd Pit-stop implemented
- Medical Stepdown repurposing
- SDEC/Chairs in reach project
- Recruitment drive initiated via Medical Control Weekly Meeting to reduce agency and increase substantive body. This will improve the financial sustainability of department but also improve quality of care across the 24/7 running of the department.
- Internal Handover delay improvement plan in place which will be further updated following the learning from the teams who participated in reset week.
- Increase in functionality of SDEC to reduce waiting times and the volume of patients in majors chairs area.

68

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

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Voluntary Staff Turnover (rate)

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

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

The Trust has seen a continued improvement in the trend since July 2022, with the position in November being held at 9.2%, and showing sustained performance below the Trust target (11%) for eight months. Performance continues to be maintained through the Trust Retention Working Group, with countermeasures being refined to focus on leavers within the first year of employment.

Staff Recommendation as a Place to Work

The Trust recommend a place to work target is 58% which is in line with the National Average for 2021 staff survey results. Current performance is 57.1%

The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the Quarterly Pulse Survey.

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

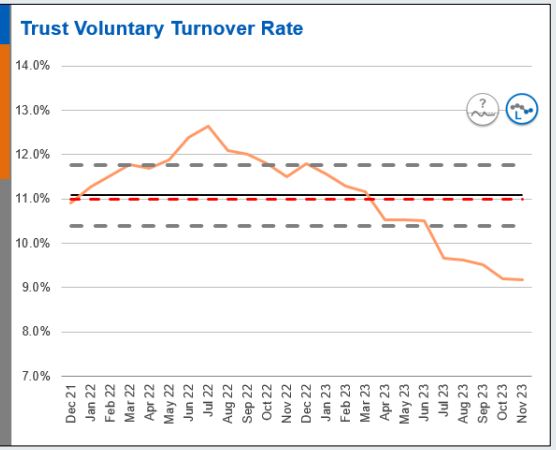
The Trust achieved a 69% response rate in the 2023 Annual Staff Survey, and initial results show promising increases to core questions. Results are currently embargoed and will be published in March, however an initial briefing has been shared with Execs and NEDs.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

Timescale	Value
Dec 22	11.8%
Jan 23	11.6%
Feb 23	11.3%
Mar 23	11.2%
Apr 23	10.5%
May 23	10.5%
Jun 23	10.5%
Jul 23	9.7%
Aug 23	9.6%
Sep 23	9.5%
Oct 23	9.2%
Nov 23	9.2%



Staff % recommend the organisation as a place to work

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

Counter Measures

A deep dive into current retention data was conducted at the December Trust Retention Working Group, reviewing departmental and professional-category hotspots and developing the following countermeasures:

- Development of the 'expectations of a line manager' toolkit
- Meaningful appraisal process
- Making good 'first impressions' with a meaningful onboarding and induction process
- Learning proactively from exit interviews, enabling automatic forms in the ESR system to capture regular and robust data on reasons for leaving
- Further promoting stay conversations across Divisions

GWH has been accepted to join cohort 2 of the BSW regional retention programme and is reviewing resourcing options alongside secured funding to deliver the NHS People Promise

There have not reported changes to this metric. The Trust staff survey results have been received however results are currently embargoed. A briefing report has been shared with the Trust Board and Trust Management Committee.

The Trust continues to promote Health & Wellbeing initiatives during the winter period:

- Happiness events planned 31st January (Orbital) and 5th February (GWH Main Site)
- Mental health skills for line manager training continuing with twice-monthly sessions
- 50% staff restaurant offer and food deliveries at the Orbital to continue to end of January
- Refresh of Health & Wellbeing champions planned to attract further interest in the role
- Successful conclusion of Covid vaccination programme and Flu campaign continues throughout February

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

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

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

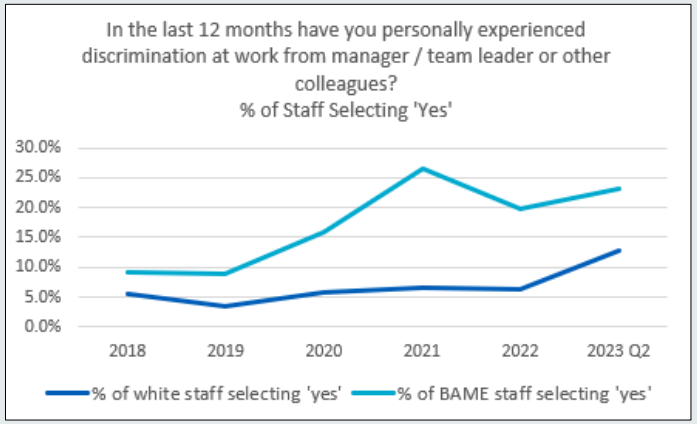
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

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

Q2 disparity has reduced to 10.3% however both white staff and BAME staff are reporting discrimination white staff from 6.3% to 12.9% and BAME 19.8% to 23.2%.

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 Trust launched its allyship programme on 26 September 2023 during National Inclusion Week. To date over 80 staff have expressed an interest in becoming an ally or EDI Champion (a more formal route for volunteering and allyship). This programme aligns with the EDI Driver Metric to reduce discrimination, particularly for our ethnic minority and disabled staff.
- Initial EDI Champion workshops will be delivered in February and March 2024 which will help volunteers to 'act in the moment' when they want to call out poor behaviour by exploring effective responses; this will include scenario-based learning to help cultivate cultural intelligence. Attendees will also understand harm caused by bullying, discrimination, incivility and microaggression to build awareness and identify potential opportunities to signpost colleagues who might need additional support. This approach has been informed by engagement with staff during the Equity Data Walk which took place early 2023.
- Improving Together, our approach to change management, has been woven into the programme and staff have been invited to help shape this work by taking part in a Benefits Mapping workshop (15.1.24) to identify how the project will deliver business benefits and identify KPIs; this supports our ambition to develop an evidence-base for EDI work. Staff are also invited to a 2-Hour Design Sprint (6.2.24) to develop a workshop prototype, the final product will be an 'addressing unprofessional behaviours (UB)' workshop (including facilitator notes and train-the-trainer workshop), the UB workshop will be rolled out across the BSW system. Note, a design sprint, which is part of the Agile methodology, is a time-based activity that brings people together with diverse skillsets to design or re-design a 'product'.

2023/24 Breakthrough Objectives

NHS Great Western Hospitals NHS Foundation Trust

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

2018	2019	2020	2021	2022 Q1	2022 Q2	2022 Q4	2022	2023 Q1	2023 Q2
49.40%	56.70%	54.50%	49.30%	50.31%	51.10%	52.72%	51.90%	57.20%	52.55%

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

Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- Divisions are currently undertaking end of year reviews to review progress against Question 3F and inform their choice breakthrough objective for next year. This decision will be further informed when full 2023 Staff Survey results are released to teams.
- On 25th January the Trust Staff Survey working group plan to review 2023 results and begin work on a refreshed A3.
- National embargo on data is due to be lifted W/C 19th February 2024, and a full presentation from our Staff Survey contractor is being scheduled for early March 2024.
- Initial analysis of results shows an improvement on last year's result for question 3F and indicates promising embedding of the Improving Together methodology across the Organisation.

Risks

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

As at M9 the Trust is in a £1.8m deficit position which represents a £1.2m adverse variance to plan.

Although the Trust received £5m of funding for industrial action costs incurred up to M8, a further £0.5m of costs were incurred in M9. There are a number of other in-year pressures, namely: undelivered efficiency savings (£1.9m), a shortfall on ERF related income (£2.8m), additional medical pay award costs (£0.7m) and temporary staffing pressures (£1.5m). These are offset by prior year income and other non-recurrent income totalling £7.2m.

The Trust's forecast position is a most likely £5.6m deficit. This has increased from a £2.6m most likely forecast in M8 due to further anticipated industrial action costs of £1.5m and CDC related cost pressures of £1.5m. The Trust expects CDC to be a system risk share, but discussions are currently ongoing around this. We are working towards a best-case scenario of £3.9m which we are focusing all of our efforts on delivering over the last quarter of the year. This has moved from a best case of £0.1m in M8 due to the above pressures from industrial action and CDC plus a further £0.75m of strike impact on the delivery of efficiencies.

Efficiency savings were £0.2m below target in-month and are £1.9m behind plan on a YTD basis. Medicine division remain the key driver of the Trust's under delivery, being £2.7m under their plan at M9 due to shortfalls against temporary staff reduction schemes.

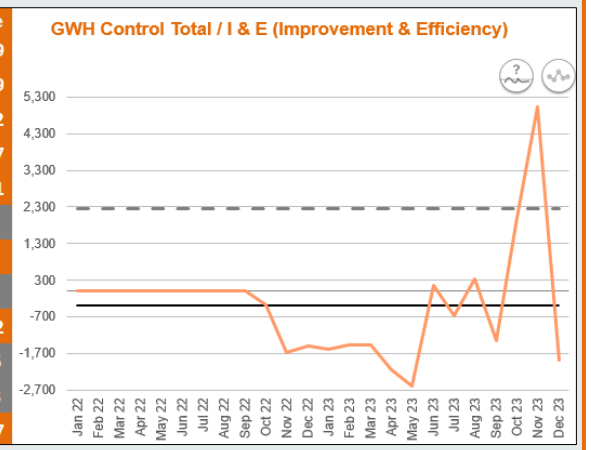
The Trust remains reliant on non-recurrent income streams and cost budget to maintain its adverse budget position of £1.2m. Therefore focussing on run rate savings i.e. reducing our monthly spend, particularly on temporary staffing, has to be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum through strong grip & control measures, and that savings delivery is maximised to enable us to deliver as close to breakeven as we can, while retaining safe delivery of patient care.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Jan 23	-1579
Feb 23	-1469
Mar 23	-1482
Apr 23	-2157
May 23	-2591
Jun 23	144
Jul 23	-659
Aug 23	330
Sep 23	-1352
Oct 23	1996
Nov 23	5043
Dec 23	-1877



Counter Measures

- Efficiency savings were £0.3m ahead of target in month and are £1.9m behind plan on a YTD basis. There are £16.9m of identified schemes but only £7.1m (42%) of this total is fully developed.
- Countermeasures continue through the efficiency programme, including:
  - Focus on actions to reduce run rate – additional sub committees focusing on green, amber and red actions
  - Cross-divisional schemes such as Better Buying and Medicines Optimisation
  - Financial Recovery workstreams including workforce controls (incl. Agency reduction), outpatients, clinical coding and elective recovery

Executive Summary

Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations.

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

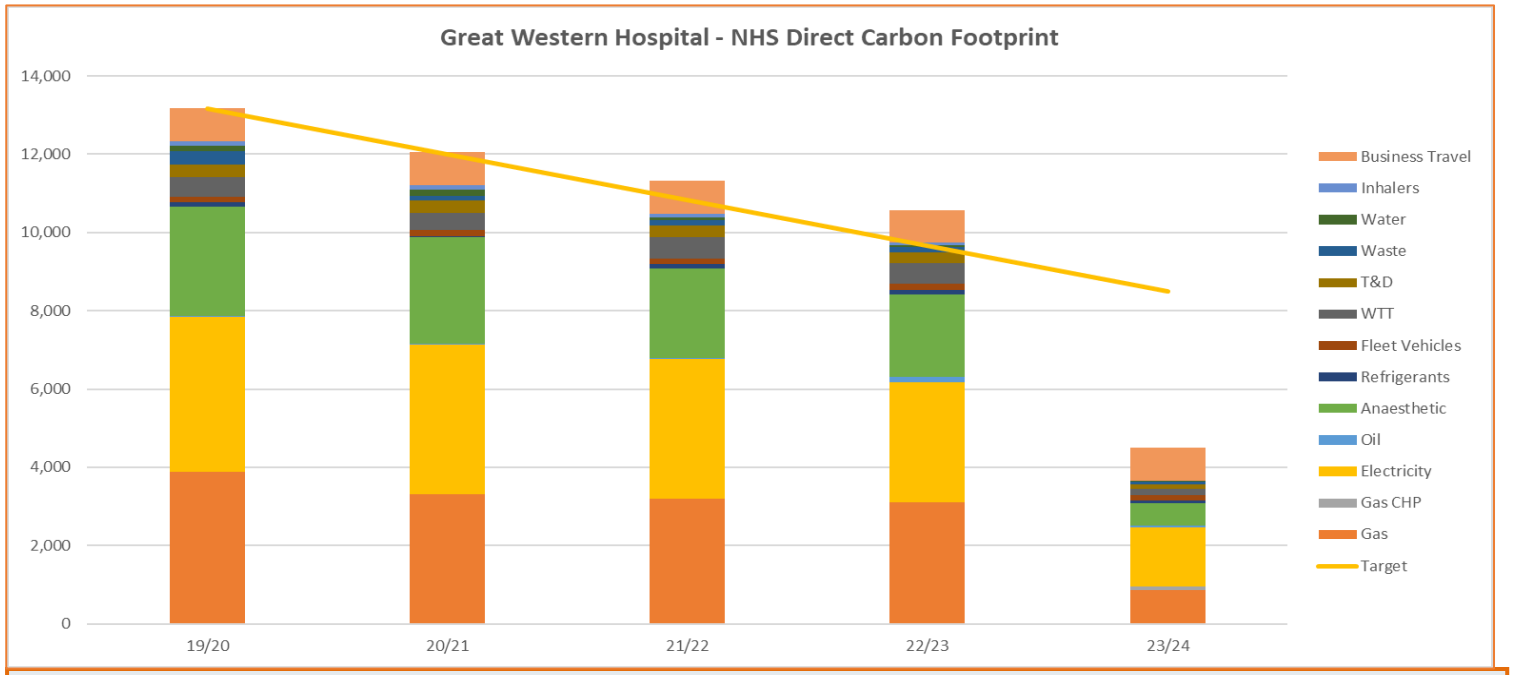
In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032 as shown with the target line on the graph from our 19/20 baseline year.

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

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

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

Simon Wade
Chief Financial Officer



Counter Measures

1. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and for indirect emissions by 2045.
2. The Sustainability Team have won Salix funding for a heat decarbonisation plan which will be completed March 2024 which will impact the wider decarbonisation graph.
3. Capital projects for reducing emissions from medical gasses have taken place with a further improvement project this capital year to expand the AGSS in labour delivery.
4. Current capital projects includes the electrification of fleet vehicles.

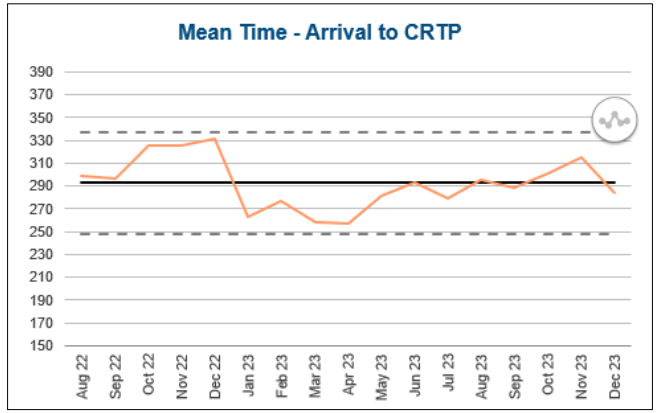
2023/24 Breakthrough Objectives

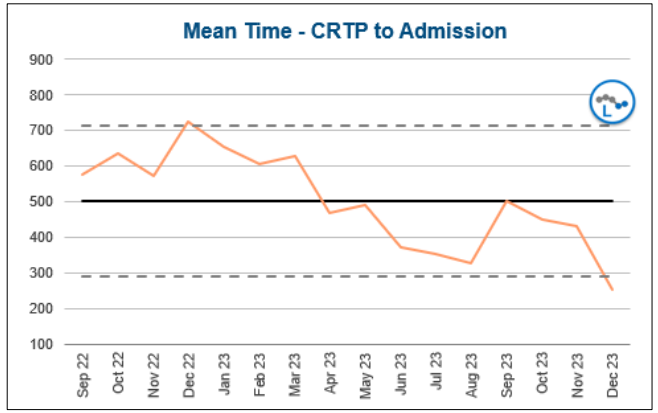
Emergency Attendances - Clinically Ready to Proceed (Admitted)

Great Western Hospitals NHS Foundation Trust

Mean time in ED (Minutes)

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Pre CRTP	263	277	259	258	281	293	280	295	289	301	315	254
Post CRTP	654	608	629	467	492	373	352	326	504	449	433	284





Common cause – no significant change

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

Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- Mean time in ED from arrival to clinically ready to proceed (CRTP) has decreased to below mean levels (254 in December from 315 in November) showing patients waited less time to be off loaded, triaged, seen and diagnosed. The decrease in ambulance handover delays has undoubtedly positively impacted this metric.
- Mean time in ED from CRTP to admission has decreased from 433 to 284 in December indicating patients spending less time in ED awaiting admission. This is the best performance recorded in ED since measuring CRtP.

Risks

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

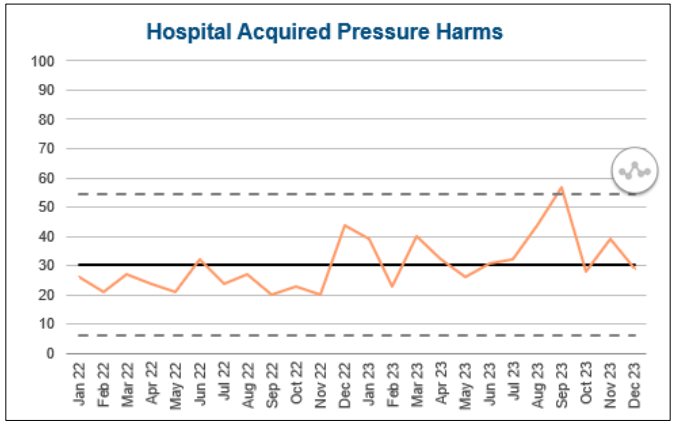
2023/24 Breakthrough Objectives

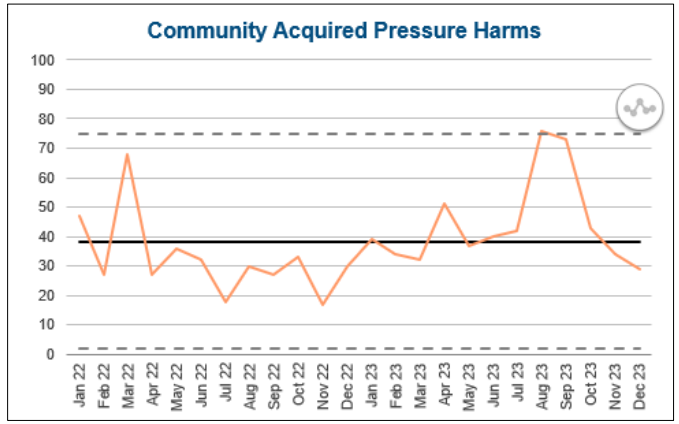
Reduction of Pressure Harms

Great Western Hospitals NHS Foundation Trust

Total Pressure Harms

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
78	57	72	83	63	71	74	120	131	71	73	58



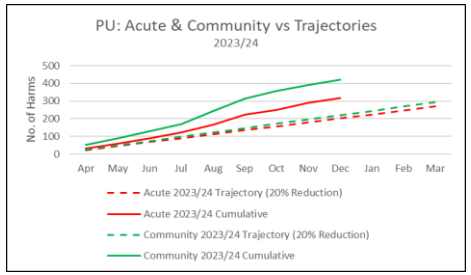


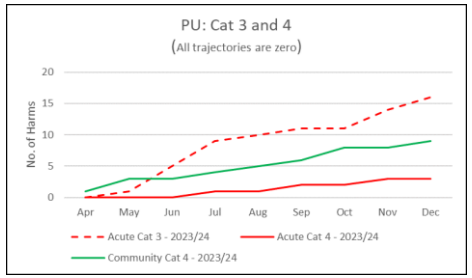
Common cause –no significant change

Understanding the Data

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

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





We are driving this measure because...

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

Performance

There has been a decrease in the number of pressure harms reported in month, across both acute and community settings, with the total from both settings (58) being the lowest for 10 months.

There were 29 (39 in November) hospital-acquired pressure harms during December.

- Wards with high numbers in recent months have reduced this significantly, including to zero on two wards.
- Previous top contributing wards have maintained their improved performance and were not top contributors this month.
- The Acute Medical Unit is one of the top contributing areas this month and is a focus for additional support.
- There were 78 category 1 harms reported this month, the majority (75) were present on admission which demonstrates improvement in early recognition.
- There were four device-related harms, which is a reduction from six last month.
- All cases are reviewed at the weekly Pressure Ulcer Panel to ensure learning is identified and acted on in a timely manner.

In the community setting there were 29 (34 in November) pressure harms acquired during December. This is a further decrease from the previous month and involved 18 patients in total.

- 48% of harms involved patient receiving end of life care (8) patients.
- One patient with a Category 4 pressure harm is declining carers and equipment and has very complex needs
- One patient experienced five harms, two patients three harms and three patients tow harms.

2023/24 Breakthrough Objectives

NHS Great Western Hospitals NHS Foundation Trust

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

2018	2019	2020	2021	2022 Q1	2022 Q2	2022 Q4	2022	2023 Q1	2023 Q2
49.40%	56.70%	54.50%	49.30%	50.31%	51.10%	52.72%	51.90%	57.20%	52.55%

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

Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- Divisions are currently undertaking end of year reviews to review progress against Question 3F and inform their choice breakthrough objective for next year. This decision will be further informed when full 2023 Staff Survey results are released to teams.
- On 25th January the Trust Staff Survey working group plan to review 2023 results and begin work on a refreshed A3.
- National embargo on data is due to be lifted W/C 19th February 2024, and a full presentation from our Staff Survey contractor is being scheduled for early March 2024.
- Initial analysis of results shows an improvement on last year's result for question 3F and indicates promising embedding of the Improving Together methodology across the Organisation.

Risks

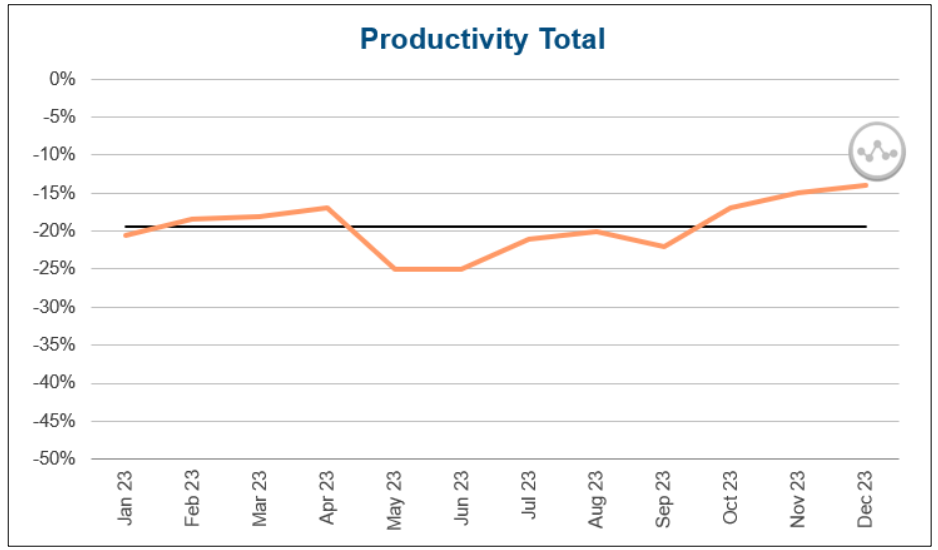
- Divisions have refreshed their breakthrough objectives and are no longer all focussing on question 3F. There is a risk that this diluted focus will impede further improvement on this question.

2023/24 Breakthrough Objectives

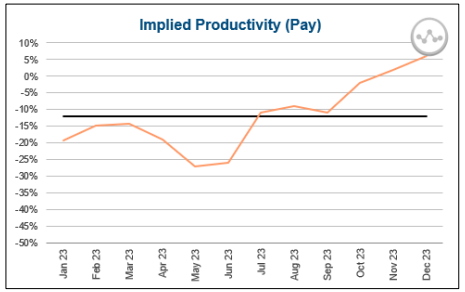
Great Western Hospitals NHS Foundation Trust

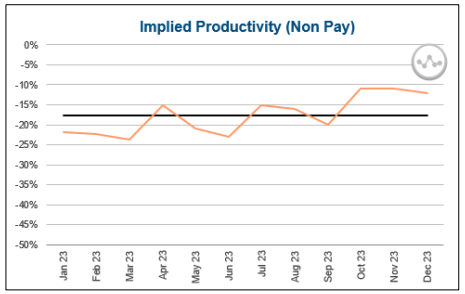
Productivity

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



Common cause – no significant change





Understanding the Data

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

We are driving this measure because…

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

Risks

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

Performance & Countermeasure

Implied Productivity for the Trust in total is recovering and has improved to an overall total **–14%** for Month 9 (this is a 4% improvement from the 18% at the end of 2022/23 - March 2023).

Productivity at end of December has only slightly improved from previous month due to financial position being £1.8m deficit year to date. This is at a -14% productivity level and but is ahead of original plan for M9.

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

Weighted activity is also running much closer to the 2023-24 plan for December in some areas as a change vs 19/20 (the measure contributing to the improvement in productivity). This includes Outpatients and Elective activity whereas non elective in medicine division is still above plan. Surgery is however behind 19/20 activity in December for outpatients. The measure continues to be against 2019/20 cost change as it is measuring the change in cost or activity relative to 2019/20 levels.

The CIVICA Aurum insight opportunities continue to be recognised as being mostly 2024/25 opportunities and have been included in the planning inputs for divisions to review and clinical engagement on these has commenced. The Top 40 represent an opportunity in clinical variation findings of c.£1.7m across divisions.

Data quality tolerance needs to be reviewed for areas such as coding and information breakdown. This is for use by divisions along with other sources of support data such as reference cost benchmarking and Model Hospital.

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		46%	69%	54%	73%	
IP & C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		1	1	1	2	
	Clostridium difficile (C. diff) infections (cumulative)	34.5 (Nat)		44	54	56	64	
	Escherichia coli (E. coli) infections (cumulative)	49.5 (Nat)		53	61	65	69	
	Pseudomonas infections (cumulative)	10.5 (Nat)		20	22	24	26	
	Klebsiella infections (cumulative)	16.5 (Nat)		21	28	34	37	
FFT	ED & UTC Response Rate	21% (Int)		21%	19%	19%	20%	
	Daycases Response Rate	25% (Int)		22%	23%	24%	22%	
	Daycases Positive Responses	98% (Int)		95%	95%	96%	95%	
	Maternity Response Rate	18% (Int)		16%	16%	16%	15%	

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

Performance & Counter Measure

The Trust overall complaint response rate has increased in December (73%) and is just below the internal target of 80%.

The Trust remains above trajectory for all three gram-negative bloodstream infections (*E. coli, Klebsiella and P. aeruginosa*) and for *C. difficile,* however monthly rates for *E. coli* and *P. aeruginosa* have reduced over time. *Klebsiella* has shown a reduction for the first time in December, likely due to a reduction in cases associated with chest infections, which could be a result of the recent focuses on mouthcare and deconditioning. *C. diff* numbers continue to be higher than expected and the ICB are working with primary care to reduce the use of broad-spectrum antibiotics.

The increases in community-onset and hospital-onset *Klebsiella* rates in Swindon were raised at the quarterly Bath and Northeast Somerset, Swindon and Wiltshire Healthcare-Associated Infections Collaborative, as the reasons for the increases are not fully understood. UKHSA offered to liaise with their epidemiologists to help look for causes; we have shared our data and our internal review. An extra meeting has been convened to discuss this in more detail.

The Division of Medicine continue to work to an A3 on *E. coli* reduction, primarily focused on catheter care, which is being supported by the IPC team and has driven improvements in practice and in the timely removal of catheters. The next steps are for the learning to be rolled out to other wards.

The rate of *Pseudomonas* infection remains lower since the additional control measures have been implemented. The Incident Management Team with UKHSA, NHS England and BSW ICB has been stood down as they are happy with our response and ongoing actions.

There has been a slight decrease in FFT day case response rate and day case positive response rate. The maternity response rate has also decreased slightly to 15% (16% in the previous two month). All remain just below the internal target.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23
	Falls rate per 1000 bed days	SPC		5.4	5	4.2	5
	No. of Falls in month	SPC		105	98	80	93
	No. falls with moderate harm or above	SPC		3	2	2	1
	Medication incidents with moderate harm	SPC		3	4	4	3
Concerns and Complaints	No. of concerns received	SPC		158	140	166	123
	No. of complaints received	SPC		59	46	62	55
	Number of reopened complaints	SPC		3	3	1	6
IP&C	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative)	31.5 (Int)		15	17	20	20
	Covid – no. of hospital acquired	SPC		20	10	15	9

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

Performance & Counter Measure

There are 25 ongoing Serious Incidents (SI), with a further four reported in month, and eight overdue the target of 60 working days. There has been no theme identified within the new SI's reported and there have been no Never Events reported in December.

There has been a decrease in both the number of complaints and concerns in month, but an increase in the number of complaints reopened. There has been no significant change to the themes, which relate to waiting times, communication, environment and staff attitude and behaviour. Enhanced complaint writing sessions have been well attended with more planned in 2024.

New nursing care planning and intentional rounding charts have been developed, with one focused on 'Get Up, Get Dressed, Keep Moving'. A test of the documents commenced on 8th January on Teal ward with continuous assessment and feedback ongoing. A bedrail working group has been set up to oversee actions to meet the recommendations from the recent Medicines and Healthcare Products Regulatory Agency alert on safe management of bedrails for all patients including children's services. The recommendations cover acute and community settings. The recommendations include a review of risk assessments, equipment, training, and policy content.

The Enhanced Care pilot continues with the development of an electronic template of the enhanced care tool developed on Nerve centre to test with the three ward areas, along with an electronic dashboard that will give greater oversight.

MSSA rates remain below last year's figures and well below our internally set threshold. COVID numbers remain low. Air scrubber installation continues and there have been no bed or ward closures due to COVID.

Risks

Lack of accessible information in line with the requirement of the Accessible Information Standard and Equality Act.
Lack of disability access within the Trust.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	92%	93%	94%	92%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	108%	107%	106%	104%
FFT	Overall response rate (%)	29% (Int)	?	31%	29%	27%	25%
	Positive response (%)	86% (Int)	?	87%	87%	88%	89%
	ED & UTC Positive Responses	82% (Int)	?	77%	78%	78%	83%
	Inpatients Response Rate	28% (Int)	?	24%	25%	25%	22%
	Inpatients Positive Responses	87% (Int)	?	80%	80%	83%	87%
	Outpatients Positive Responses	98% (Int)	?	96%	97%	98%	96%
	Maternity Positive Responses	94% (Int)	?	86%	95%	92%	94%

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

Performance & Counter Measures

Safe Staffing fill rates have decreased in month but remain well above the National target and are within safe parameters.

There has been a further slight decrease in the overall FFT response rate, which remains below the internal target, but an increase in the positive response rate that remains above the internal target.

Several initiatives have been undertaken in December to enhance the experience of patients and their families including;

- Following feedback, the 'Little Bags of Calm' that are available in the Emergency Department will be changed to allow patients to choose from a pick list rather than being provided with a standard bag.
- An engagement and codesign workshop has been held with patients with Learning Disabilities, along with other meetings with patients who have sensory/physical impairment to help inform the new Emergency Department design.

- The spinal cord injury (SCI) coproduction group is progressing well with drafts of a new patient passport and bowel care policy. This coproduction group was developed to address concerns about lack of compliance with a national patient safety alert issued in 2018 which requires the trust to have a policy and process for ensuring staff can undertake Digital Rectal Examination and Digital Removal of Faeces for SCI patients.

- A leadership behaviour master class was planned in December with 'Patient First' as the main topic, due to limited attendance the session has been moved to the new year and will also be recorded to facilitate wider engagement.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23	Trend
RTT	No. of >=18 weeks waiters		H	19161	19028	17809	17679	
	No. of >=52 weeks waiters		H	2307	2238	2031	1653	
DM01	No. of patients on DM01 waitlist		H	13843	15095	15369	One month behind	
	DM01 performance %	99% (Nat)	F	46.1%	45.0%	49.5%	One month behind	
	DM01 6 week wait breaches		H	7462	8301	7759	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	49.0%	61.1%	67.2%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	81.0%	83.6%	84.9%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	54.0%	39.0%	45.0%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	62.0%	58.2%	59.7%	One month behind	
	No. of referrals received		H	1934	1983	1902	One month behind	

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

December's DM01 UNVALIDATED performance is showing a decrease in performance variance from the 49.48% performance in November to 45.62% This is likely to improve slightly once validated. The number of patients on the waiting list has decreased significantly to 13,788 and the number of 6-week breaches has also decreased to 7,498 driven by Ultrasound, MRI and CT.

Counter measures: The 3 Pads in Radiology continue to be fully utilised with all supporting the CDC (CT, MRI and Endoscopy), and activity numbers continue to remain high for the imaging vans with Endoscopy usage improving. The teams continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Ultrasound still remains the largest issue with 6,664 on the waiting list and 4,657 over 6 week. Endoscopy continue to work with InHealth to improve the performance of the mobile Endoscopy unit. The imaging move to the CDC has been delayed now likely to be March 24.

Cancer

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Breast pathway with 38% of the breaches being accounted for by this service. WLI activity is being considered to help manage demand. 58.2% of the 62-day breaches were with the Skin, Colorectal & Urology Pathway.

Cancer waiting times for first appointment remain below standard with an increase in demand and the impact on clinic cancelations as a result of the industrial action. The Skin Pathway is having the greatest impact on all of the 2ww standard with 36.9% of all of the breaches. Breast pathways accounted for 28.2% of total breaches

In November, 77% (531) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, Skin & Gynae)

Counter Measures - Work is underway with the TVCA to implement the Best Practice Timed Pathways across all 4 (Lower GI, Urology, Gynae & Skin) of these Pathways.

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

External Derm team to provide up to 400 additional slots over 2 weeks to clear ASI wait lists. Provision to include see and treat where possible. Clinics are commencing 13 January.

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

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

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

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	74.7%	71.5%	71.4%	74.7%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	8.3%	8.5%	8.9%	6.2%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	54.7%	48.5%	48.7%	52.7%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	16.9%	17.1%	17.8%	12.6%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	93.8%	94.2%	94.1%	96.0%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2862.13	2555.40	2708.18	1592.98	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1384	1506	1447	1501	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	85%	90%	88%	84%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	989	1110	1018	847	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	61.1%	66.1%	62.2%	47.2%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	685	695	646	443	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	42.3%	41.4%	39.5%	24.7%	
Flow	Average hours lost to ambulance handover delays per day	SPC	H	95	82	90	51	
	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	307	334	325	301	
	Number of Stranded Patients (over 14 days)	SPC	H	136	129	129	107	
	Number of Super Stranded Patients (over 21 days)	SPC	H	83	77	78	63	

Performance & Counter Measure

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

4 hour performance (type 1 and 3) improved from 71.4% to 74.7% with a noticeable improvement in 4 hours performance (type 1) from 48.7% from 52.7%.

Significant action has been taken in November and December to improve ED flow which has started to impact metrics Relevant teams are looking at improvement measures across the 'Front Door' , pre-hospital and post discharge with measures to improve flow & discharge rates. This includes liaison with Co-ordination Centre, key stakeholders in & out of hospital, and utilising 'Improving Together' methodology.

- Total % over 12 hours has decreased significantly from 17.8% to 12.6% showing the trust wide work to improve flow out of the department
- Number of ambulance handovers over 30 minutes have decreased by 24% from 1118 to 847.
- Number of ambulance handovers over 60 minutes have decreased by 31.4% from 646 to 443.

Counter measures remain in place within the Breakthrough objective slides.

Risks

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

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

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23
RTT	No. of >=78 weeks waiters	SPC	L	1	1	2	4
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.1%	0.0%	0.1%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5054	5236	5236	5443
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	73.1%	73.6%	72.1%	74.6%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		48.9%	48.0%	45.2%	53.6%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		39.6%	51.2%	40.6%	50.5%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	195	202	211	192
	Emergency Care - AED - Median Stay	240 (Int)	?	238	292	300	240
	Emergency Care - UTC - Median Stay	240 (Int)	P	158	151	164	148
	Total Number of Ambulance Handovers	SPC	L	1619	1680	1637	1795

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

Performance & Counter Measure

RTT

Four 78 week breaches reported in December (2 x non-admitted patients in Gastroenterology, 1x non-admitted patient in Paediatrics, and 1x admitted patient in General Surgery). Breach reports for these patients are underway and next events are being scheduled to take place in January.

ED

Number of conveyances increased significantly from previous month (1637 to 1795) comprising a 10% increase from November levels.

Triage performance across ambulance, type 1 and type 3 have improved following improvements in pitstop capacity and Chairs capacity.

Median stay has increased showing the increased pressure on the department and flow issues experience early and mid November.

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		793	749	746	537
	Elective Patients Average Length of Stay (Days)	SPC	L	3	3	2	3
	Non-Elective Patients Average Length of Stay (Days)	SPC		6	6	6	4
	Community Average Length of Stay (Days)	SPC		16	17	14	17
	GWH Discharges by Noon (%)	SPC		16.1%	16.4%	16.0%	18.0%
	Adult general and acute type 1 bed occupancy	SPC		98.7%	94.9%	94.7%	91.7%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC		19.6%	19.3%	17.1%	16.7%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.2%	95.0%	95.2%	95.6%

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

Performance & Counter Measure

Community average LOS increased slightly but still within target of 21 days and continue to report on NCTR within the community to ensure robust monitoring.

Increase discharges before noon, Utilising Discharge Lounge for warranting earlier flow within division, highlighting 'golden' patients the day before whilst highlighting discharges for 'tomorrow' on Nerve Centre. This was picked up and tested during Rest Week 4th Dec.

A slight reduction in the NCTR Bed Days which stands at 16.7% - this has been a month on month decrease.

Risks

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23
Use of Resources	Capital Expenditure (£'000)	SPC		733	2606	2187	2641
	Pay (£'000)	SPC		25468	25350	25419	24274
	Non Pay (£'000)	SPC		15038	14750	16097	17669

Performance & Counter Measure

Capital spend in M9 was £2.6m, which is £1.4m ahead of plan in month. The overspend is driven by estates replacement schemes and the Way Forward Programme, offset by underspends against IT. All capital project leads are forecasting to spend their allocations by year end, which means that no new capital projects can be approved as we have no additional funding.

Pay costs are £1.1m lower than M8 driven by lower medical agency and prior accruals and prior year costs taken in M8.

Non-Pay is £1.6m higher than M8 due to accrued costs relating to CDC (Endoscopy)

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

Risks

The Trust started the year with a £16.67m cash releasing efficiency plan, which includes a £2.98m carry over from 22/23. As at Month 9, the programme is £1.9m under plan, a deterioration of £0.3m from M8 driven primarily by the continued underperformance of the Medicine division (specifically temporary staffing savings).

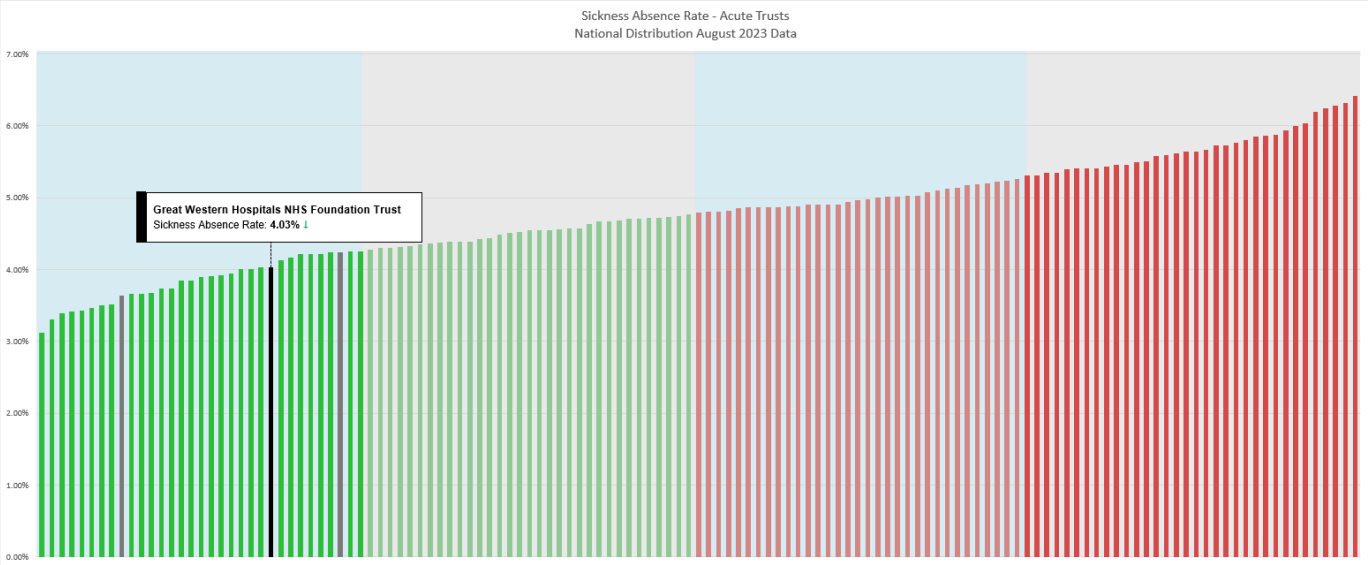
Out of the £16.67m target, £7.1m is fully developed, which is a £0.2m improvement on M8. Divisions and supporting services must work to turn the remaining schemes flagged as opportunities into deliverable savings.

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.2%	4.7%	4.7%	One month behind	



Performance & Counter Measure

- In-month sickness absence remained static in November at 4.7%, continuing to alert above the Trust KPI of 3.5%. Long term sickness has decreased in November to 2%, and short term absence has risen to 2.7%.
- The Trust Absence Working Group is exploring the following countermeasures with Medicine who have the highest absence rates, with a view to rolling out to all divisions if successful:
  - Amended 'Sick Call' guidance in line with NHS England guidance
  - People Operations to conduct attendance audit for short-term sickness management practice
  - Review trigger markers for short-term sickness absence, incorporating learnings from long-term sickness case management
- Current national benchmarking data (August 2023 - NHS Digital) shows an increase to the national and South West region sickness rates, rising to 4.88% and 4.75% respectively. As a system however we saw a decrease to our sickness rate, dropping to 4.29% and this trend was repeated for GWH. In August, we reported 4.03% sickness absence, moving us back to the first lowest quartile for Acute Trusts nationally, and in the top 20%.

Risks

- Increased sickness rate as per national trend during winter.

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

Our People

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-23	Oct-23	Nov-23	Dec-23
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	14.3%	14.1%	12.9%	One month behind

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023 Q1	2023 Q2
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	22.8%	23.8%
	My immediate manager takes a positive interest in my health and well-being	67.4% (Nat)	68.8%	67.5%	74.8%	69.2%	64.4%	67.6%	Not in Quarterly Survey	Not in Quarterly Survey
	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.5% (Avg)	59.6%	54.1%	60.4%	57.1%	56.1%	56.4%	Not in Quarterly Survey	Not in Quarterly Survey

Performance & Counter Measure

- The rolling number of leavers within the 1st year of employment has decreased in November to 12.9%, below our 12 month average and in line with the general reduction trend to our turnover rate.
- Staff survey response rates for the 2023 Annual Staff Survey was 69% which is 10% above last year and the highest response rates with the provider Picker.
- We await the annual staff survey results for comparisons on two key questions on well-being and EDI during promotions and career development.

Risks

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

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

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend Vs Last Month	Trend Vs Dec-22
	Vacancy																	
W	Vacancy Rate	%	7.00%	6.23%	7.43%	6.40%	5.30%	7.54%	8.08%	7.96%	7.82%	5.95%	4.87%	4.33%	3.93%	3.74%	↓	↓
W	Vacancy Rate	WTE	-	329.52	392.94	335.02	276.66	402.58	438.89	432.29	424.68	320.44	262.33	232.95	211.39	201.47		
W	All Nursing Vacancy	%	7.00%	5.62%	6.51%	5.20%	3.65%	4.50%	4.95%	5.38%	5.00%	2.73%	1.96%	1.30%	1.94%	1.43%	↓	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	146.64	170.25	135.53	94.47	117.71	132.11	143.74	133.58	71.58	51.43	34.17	51.03	37.87		
W	All Registered Nursing Vacancy	WTE	-	91.41	92.65	77.18	43.38	84.20	97.00	107.48	103.62	74.83	47.47	18.62	26.55	9.50		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	54.94	47.18	36.73	27.43	27.90	44.94	53.47	59.84	42.58	23.20	3.60	8.44	-3.79		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	55.23	77.60	58.35	51.09	33.51	35.11	36.26	29.96	-3.25	3.96	15.55	24.48	28.37		
W	Medical Vacancy	%	7.00%	5.43%	5.61%	8.49%	6.86%	9.35%	10.14%	9.93%	10.34%	7.28%	5.22%	5.66%	5.26%	5.89%	↑	↑
W	Medical Vacancy	WTE	-	38.33	39.16	59.19	47.86	67.29	74.56	73.05	76.03	53.43	38.22	41.48	38.61	43.30		
W	STT/AHP Vacancy	%	7.00%	6.54%	6.97%	6.29%	7.66%	11.10%	12.48%	12.69%	13.04%	13.04%	10.41%	9.20%	6.88%	6.44%	↓	↓
W	STT/AHP Vacancy	WTE	-	54.28	57.85	51.64	63.84	94.86	107.82	110.17	113.09	112.95	90.28	79.85	58.89	54.92		
W	SMA Vacancy	%	7.00%	7.88%	10.97%	7.96%	6.37%	10.71%	10.68%	9.09%	8.80%	7.13%	7.12%	6.70%	5.44%	5.66%	↑	↓
W	SMA Vacancy	WTE	-	90.27	125.68	88.66	70.50	122.73	124.41	105.33	101.98	82.48	82.40	77.45	62.86	65.38		
W	Recruitment Time to Hire - Trust Sub	Days	46.00	72.30	91.30	50.90	54.50	52.90	50.60	47.60	49.10	45.00	41.70	42.70	41.80	43.50	↑	↓
W	Recruitment Time to Hire - Trust Bank	Days	46.00	0.00	0.00	117.90	127.80	118.00	58.50	26.90	50.40	46.00	43.50	37.00	39.90	45.20	↑	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,289.43	5,289.16	5,236.02	5,224.47	5,337.41	5,434.85	5,433.60	5,433.60	5,382.13	5,381.76	5,379.33	5,382.66	5,382.34		
W	Budgeted vs Worked WTE Variance	WTE	-	87.52	51.09	109.88	237.86	30.62	44.85	50.23	3.21	131.68	70.68	132.30	203.43	152.96		
W	Actual Worked vs Budgeted %	%	-	1.65%	0.97%	2.10%	4.55%	0.57%	0.83%	0.92%	0.06%	2.45%	1.31%	2.46%	3.78%	2.84%		
W	Total Workforce Cost £	£	-	£23.64M	£22.93M	£24.66M	£23.73M	£23.85M	£23.99M	£25.72M	£24.82M	£24.44M	£26.42M	£25.68M	£24.85M	£24.88M		
W	Agency Spend as % of Total Spend	%	4.50%	5.97%	5.60%	4.98%	5.35%	3.40%	5.57%	3.39%	4.15%	2.62%	3.11%	4.52%	3.56%	1.23%	↓	↓
W	Agency Spend £	£	-	£1.41M	£1.28M	£1.23M	£1.27M	£0.81M	£1.34M	£0.87M	£1.03M	£0.64M	£0.82M	£1.16M	£0.89M	£0.30M		
W	Agency Target £	£		-	-	-	-	£1.21M	£1.04M	£0.88M	£0.76M	£1.06M	£1.17M	£1.07M	£0.91M	£1.10M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-	-	-	-	-£0.40M	£0.29M	-£0.01M	£0.27M	-£0.42M	-£0.35M	£0.09M	-£0.03M	-£0.79M	↓	↓
W	Agency WTE	WTE	-	109.26	102.88	90.00	106.82	90.76	105.02	96.40	94.71	78.85	74.91	59.88	57.41	52.29		
W	Bank WTE	WTE	-	278.67	310.93	323.25	377.11	303.84	351.68	355.36	303.23	347.55	235.16	278.50	332.80	276.94		
W	Registered Nursing Bank Fill	%	45.00%	43.60%	52.86%	55.30%	54.71%	57.70%	57.91%	54.99%	54.47%	53.30%	54.80%	62.68%	66.38%	66.31%	↓	↑
W	Unregistered Nursing Bank Fill	%	70.00%	62.98%	74.32%	71.78%	77.63%	83.58%	81.52%	80.82%	79.98%	77.52%	81.35%	79.95%	84.45%	81.80%	↓	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend Vs	
																	Last Month	Dec-22
	Retention																	
W	All Turnover %	%	13.00%	14.90%	14.84%	14.42%	14.48%	13.79%	13.88%	13.27%	12.74%	12.69%	12.56%	12.20%	12.00%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	11.84%	11.57%	11.25%	11.16%	10.54%	10.52%	10.17%	9.67%	9.62%	9.52%	9.20%	9.19%	-	↓	↓
W	Number of Leavers	Headcount	-	69	74	43	79	33	62	53	53	48	63	41	47	-		
W	Number of RN Leavers	Headcount	-	14.00	16.00	8.00	17.00	7.00	15.00	16.00	12.00	14.00	18.00	11.00	14.00	-		
W	Registered Nursing Vol Turnover	%	-	8.79%	8.58%	7.99%	7.83%	7.05%	6.82%	6.82%	6.59%	6.66%	6.55%	6.62%	7.00%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	19.00	15.00	12.00	12.00	8.00	12.00	11.00	7.00	13.00	21.00	10.00	8.00	-		
W	Unregistered Nursing Vol Turnover	%	-	16.37%	16.73%	16.57%	15.95%	15.46%	15.17%	13.99%	13.02%	12.83%	13.35%	12.65%	12.34%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	16.15%	15.51%	15.81%	15.23%	14.56%	14.29%	13.60%	15.53%	13.95%	14.33%	14.05%	12.93%	-		
W	Number of starters	Headcount	-	43	81	57	64	67	58	61	104	59	112	62	66	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	5.34%	5.19%	5.04%	4.95%	4.77%	4.61%	4.50%	4.49%	4.45%	4.43%	4.45%	4.44%	-	↓	↓
D	Sickness Absence %	%	3.50%	5.79%	4.90%	4.53%	4.63%	3.85%	3.68%	3.77%	4.43%	4.04%	4.23%	4.74%	4.69%	-	↓	↓
W	Long Term Sickness %	%	2.00%	2.50%	2.52%	2.24%	2.27%	2.13%	2.06%	2.16%	2.61%	2.21%	2.12%	2.41%	1.95%	-	↓	↓
W	Short Term Sickness %	%	1.50%	3.29%	2.38%	2.29%	2.36%	1.72%	1.61%	1.61%	1.82%	1.83%	2.11%	2.33%	2.74%	-	↑	↓
W	Sickness Absence Cost £	£	-	£749.9k	£687.4k	£575.4k	£675.3k	£546.9k	£574.4k	£550.4k	£664.8k	£626.3k	£614.8k	£738.9k	£726.5k	-		
W	WTE Days Lost	WTE	-	8,768.5	7,364.2	6,109.2	6,960.2	5,648.5	5,612.7	5,568.9	6,781.2	6,256.4	6,401.2	7,487.3	7,187.9	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	86.40%	86.61%	86.79%	87.69%	89.20%	90.27%	89.81%	89.90%	90.10%	90.36%	90.75%	91.38%	91.88%	↑	↑
W	Role Essential MT %	%	85.00%	88.94%	89.06%	89.03%	89.66%	90.92%	91.59%	91.37%	91.40%	91.64%	91.93%	92.20%	92.77%	93.14%	↑	↑
W	CQC Safe MT %	%	85.00%	83.93%	84.18%	84.54%	85.71%	87.48%	88.95%	88.25%	88.38%	88.56%	88.78%	89.32%	90.01%	90.64%	↑	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	-	-	-	-	59.32%	64.39%	73.18%	76.28%	79.91%	82.14%	83.26%	83.85%	85.24%	↑	↓
W	Appraisal Compliance %	%	85.00%	81.43%	81.16%	83.33%	82.25%	83.11%	82.18%	83.86%	83.94%	84.29%	84.88%	84.92%	83.62%	85.63%	↑	↑
W	Non Medical Appraisal Compliance %	%	85.00%	81.08%	80.60%	82.33%	80.68%	82.46%	81.38%	82.76%	83.29%	84.24%	84.89%	84.91%	83.81%	85.37%	↑	↑
W	Medical Appraisal Compliance %	%	85.00%	84.13%	85.44%	91.07%	93.90%	87.90%	88.00%	91.81%	88.64%	84.64%	84.84%	85.04%	82.25%	87.59%	↑	↑

Our People

Workforce Scorecard

Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend Vs	
																	Last Month	Dec-22
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.18%	4.17%	4.21%	4.19%	4.14%	4.12%	4.12%	4.13%	4.17%	4.18%	4.12%	4.21%	4.19%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	254.00	250.00	253.00	253.00	249.00	251.00	251.00	252.00	257.00	260.00	258.00	265.00	264.00		
W	% of Leadership Roles who are Female (B8a+)	%	-	71.26%	71.20%	71.54%	70.75%	70.68%	70.92%	70.52%	70.24%	70.82%	71.15%	70.93%	71.32%	71.59%		
W	% of Leadership Roles who from BME (B8a+)	%	-	5.12%	5.20%	5.14%	5.14%	5.22%	5.58%	5.58%	5.95%	6.61%	6.54%	6.20%	6.79%	6.82%		
W	Staff in Leadership Roles % (B8c+)	%	-	0.97%	0.92%	0.93%	0.91%	0.95%	0.95%	0.95%	0.93%	0.93%	0.92%	0.91%	0.92%	0.89%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	59.00	55.00	56.00	55.00	57.00	58.00	58.00	57.00	57.00	57.00	57.00	58.00	56.00		
W	% of Leadership Roles who are Female (B8c+)	%	-	57.63%	60.00%	60.71%	58.18%	57.89%	58.62%	56.90%	56.14%	56.14%	56.14%	56.14%	56.90%	57.14%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.08%	5.45%	5.36%	5.45%	5.26%	5.17%	5.17%	5.26%	5.26%	5.26%	5.26%	5.17%	5.36%		
W	% of Leadership Roles who are disabled (B8c+)	%	-	0.00%	0.00%	0.00%	0.00%	1.75%	1.72%	1.72%	1.75%	1.75%	1.75%	1.75%	1.72%	1.79%		
W	Male % of Workforce	%	-	17.38%	17.55%	17.50%	17.71%	17.63%	17.75%	17.83%	17.90%	18.10%	18.16%	18.36%	18.40%	18.29%		
W	Female % of Workforce	%	-	82.62%	82.45%	82.50%	82.29%	82.37%	82.25%	82.17%	82.10%	81.90%	81.84%	81.64%	81.60%	81.71%		
W	BME % of Workforce	%	-	21.94%	22.54%	22.75%	23.24%	23.60%	24.22%	24.19%	24.49%	25.06%	25.18%	25.47%	25.68%	25.98%		
W	White % of Workforce	%	-	69.16%	68.74%	68.71%	68.25%	68.07%	67.43%	67.29%	67.08%	67.03%	66.86%	66.58%	66.32%	66.19%		
W	ER Cases Closed	Number	-	44	48	57	65	43	56	54	59	20	32	25	23	2		

Our People

Great Western Hospitals NHS Foundation Trust

Workforce Scorecard - Workforce Planning

Trust Workforce Delivery Plan

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

Key

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

Performance & Counter Measure

- In M9 our establishment has remained at 5,382WTE with a nominal decrease of 0.32WTE. Actual establishment WTE remains below plan by 9WTE and within the control total of 5,4414WTE.
- The Finance and Workforce teams continue to meet fortnightly to control changes to the establishment. Planned changes in M10 which have been agreed through this group will include ED right-sizing, and correcting baseline nursing budgets for Medicine, both of which are cost-neutral exercises.
- Whilst Bank and Agency usage is below planned levels in M9, this in addition to our improved contracted position following sustained recruitment activity means we utilised an additional 128WTE to deliver our services compared to our establishment. This does represent a decrease compared to M8, reflective of further temporary staffing reductions within Nursing and Medical teams.

Risks & Mitigations

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

Our People

Workforce Costs by Staff Group

Great Western Hospitals NHS Foundation Trust

Staff Group	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD
Registered Nursing	RGN Sub £	£6,816,740	£6,873,340	£7,587,096	£7,009,523	£7,148,967	£7,089,588	£7,266,793	£7,311,337	£7,462,009	£64,565,394
	RGN Bank £	£874,747	£687,407	£704,551	£651,671	£700,835	£610,086	£593,565	£553,437	£592,494	£5,968,792
	RGN Agency £	£356,809	£390,770	£393,761	£388,506	£369,005	£387,236	£293,975	£243,990	£160,175	£2,984,227
	Budget £	£7,323,767	£7,575,268	£8,320,831	£7,708,281	£7,669,410	£7,852,551	£8,595,915	£8,366,252	£8,003,835	£71,416,110
	Actual Cost £	£8,048,296	£7,951,517	£8,685,408	£8,049,701	£8,218,807	£8,086,909	£8,154,333	£8,108,764	£8,214,678	£73,518,413
	Variance to Budget £	£724,529	£376,249	£364,577	£341,420	£549,397	£234,358	-£441,582	-£257,488	£210,843	£2,102,303
Unregistered Nursing	UR Sub £	£2,248,955	£2,401,458	£2,600,592	£2,396,310	£2,465,217	£2,395,713	£2,356,200	£2,376,329	£2,377,891	£21,618,664
	UR Bank £	£383,425	£405,741	£369,631	£400,036	£367,052	£315,117	£310,343	£283,167	£271,511	£3,106,023
	UR Agency £	£510	£0	£177	£2,721	-£1,925	£168	£2,401	-£2,220	£0	£1,831
	Budget £	£2,226,533	£2,590,428	£2,718,298	£2,514,861	£2,515,220	£2,555,518	£3,109,392	£2,080,496	£2,612,857	£22,923,603
	Actual Cost £	£2,632,891	£2,807,199	£2,970,400	£2,799,066	£2,830,343	£2,710,997	£2,668,944	£2,657,275	£2,649,402	£24,726,519
	Variance to Budget £	£406,358	£216,771	£252,102	£284,205	£315,123	£155,479	-£440,448	£576,779	£36,545	£1,802,916
Medical and Dental	M & D Sub £	£5,495,537	£5,302,186	£5,549,823	£5,640,491	£5,444,620	£7,513,085	£6,276,989	£6,036,267	£6,153,767	£53,412,765
	M & D Bank £	£863,619	£609,769	£773,185	£1,099,541	£1,036,278	£1,019,057	£655,587	£564,068	£940,237	£7,561,341
	M & D Agency £	£475,120	£786,209	£364,511	£543,650	£181,897	£474,049	£762,849	£587,026	£92,628	£4,267,938
	Budget £	£5,895,019	£6,620,055	£6,229,723	£6,263,810	£6,299,757	£8,317,388	£5,747,229	£6,689,028	£6,609,992	£58,672,001
	Actual Cost £	£6,834,275	£6,698,164	£6,687,519	£7,283,681	£6,662,795	£9,006,191	£7,695,425	£7,187,362	£7,186,632	£65,242,044
	Variance to Budget £	£939,256	£78,109	£457,796	£1,019,871	£363,038	£688,803	£1,948,196	£498,334	£576,640	£6,570,043
AHP and STT	AHP/STT Sub £	£2,805,464	£2,757,206	£3,176,461	£2,886,707	£2,889,128	£2,915,441	£2,996,760	£3,014,522	£3,052,758	£26,494,446
	AHP/STT Bank £	£68,831	£60,187	£69,503	£87,766	£79,123	£67,747	£88,723	£81,834	£82,624	£686,339
	AHP/STT Agency £	£43,181	£91,764	£63,015	£38,272	£51,346	£12,680	£42,488	£42,523	£34,377	£419,645
	Budget £	£2,900,900	£3,079,764	£3,421,223	£3,108,019	£3,097,484	£3,164,763	£2,660,831	£3,113,500	£3,106,734	£27,653,218
	Actual Cost £	£2,917,476	£2,909,157	£3,308,979	£3,012,745	£3,019,597	£2,995,867	£3,127,971	£3,138,880	£3,169,759	£27,600,431
	Variance to Budget £	£16,576	-£170,607	-£112,244	-£95,274	-£77,887	-£168,896	£467,140	£25,380	£63,025	-£52,787
Admin & Clerical	Admin Sub £	£3,348,631	£3,396,608	£3,878,898	£3,481,003	£3,515,274	£3,557,858	£3,629,334	£3,613,976	£3,722,765	£32,144,347
	Admin Bank £	£131,134	£160,120	£137,290	£135,883	£154,871	£112,014	£130,320	£132,964	£125,312	£1,219,907
	Admin Agency £	-£63,795	£68,232	£51,429	£56,454	£41,207	-£53,401	£59,554	£13,871	£17,679	£191,230
	Budget £	£3,309,618	£3,515,164	£3,967,350	£3,688,845	£3,667,961	£3,572,572	£7,134,537	£4,396,754	£4,313,396	£37,566,197
	Actual Cost £	£3,415,970	£3,624,959	£4,067,617	£3,673,340	£3,711,352	£3,616,471	£3,819,208	£3,760,812	£3,865,756	£33,555,484
	Variance to Budget £	£106,352	£109,795	£100,267	-£15,505	£43,391	£43,899	-£3,315,329	-£635,942	-£447,640	-£4,010,713
Total	Total Sub £	£20,715,329	£20,730,798	£22,792,870	£21,414,034	£21,463,206	£23,471,685	£22,526,076	£22,352,431	£22,769,189	£198,235,616
	Total Bank £	£2,321,756	£1,923,225	£2,054,160	£2,374,897	£2,338,158	£2,124,020	£1,778,538	£1,615,471	£2,012,178	£18,542,403
	Total Agency £	£811,823	£1,336,975	£872,893	£1,029,603	£641,530	£820,731	£1,161,267	£885,191	£304,859	£7,864,872
	Budget £	£21,655,837	£23,380,679	£24,657,425	£23,283,816	£23,249,832	£25,462,792	£27,247,904	£24,646,030	£24,646,814	£218,231,129
	Actual Cost £	£23,848,908	£23,990,997	£25,719,923	£24,818,534	£24,442,894	£26,416,436	£25,465,881	£24,853,092	£25,086,226	£224,642,891
	Variance to Budget £	£2,193,071	£610,318	£1,062,498	£1,534,718	£1,193,062	£953,644	-£1,782,023	£207,062	£439,412	£6,411,762

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

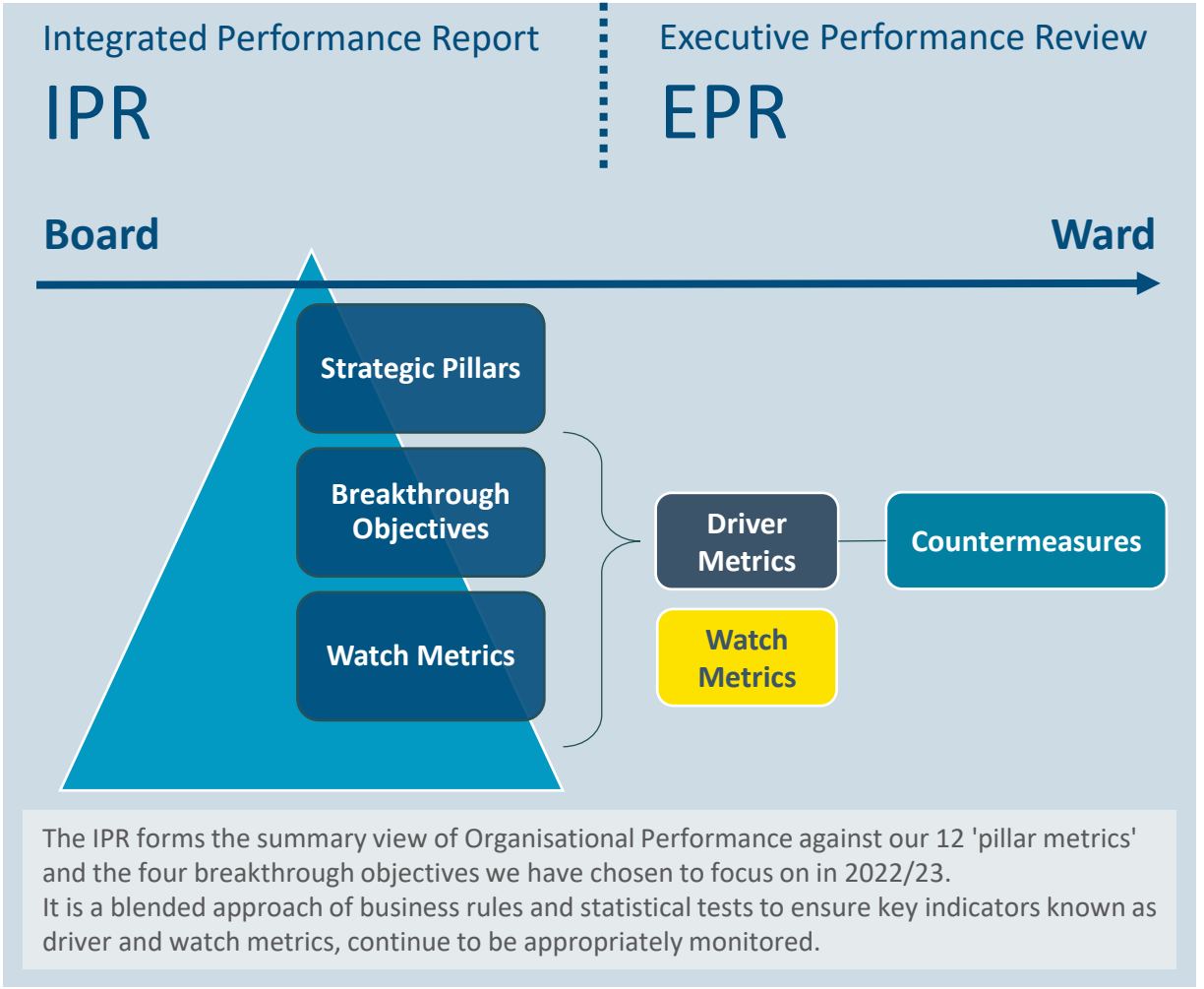
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

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

Our four strategic pillars

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

Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

Our Vision

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

1 Our four strategic pillars

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

- e.g. Electronic Patient Record
- e.g. The Great Care Campaign

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

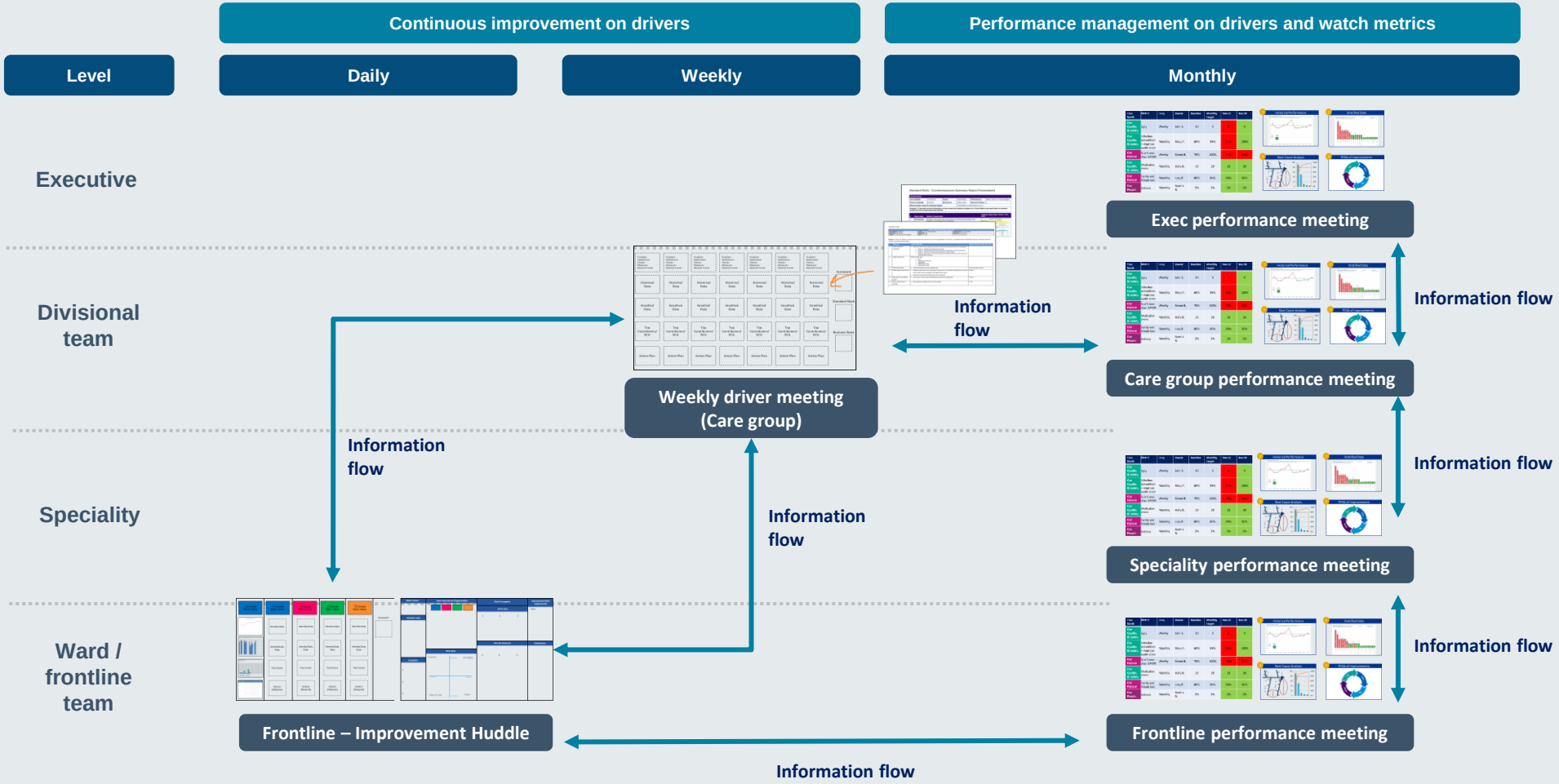
- BTO Productivity
- BTO Staff Survey = % improvements
- BTO Time to Clinically Ready to Proceed
- BTO Pressure Harms

Delivery mechanism – running the organisation

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

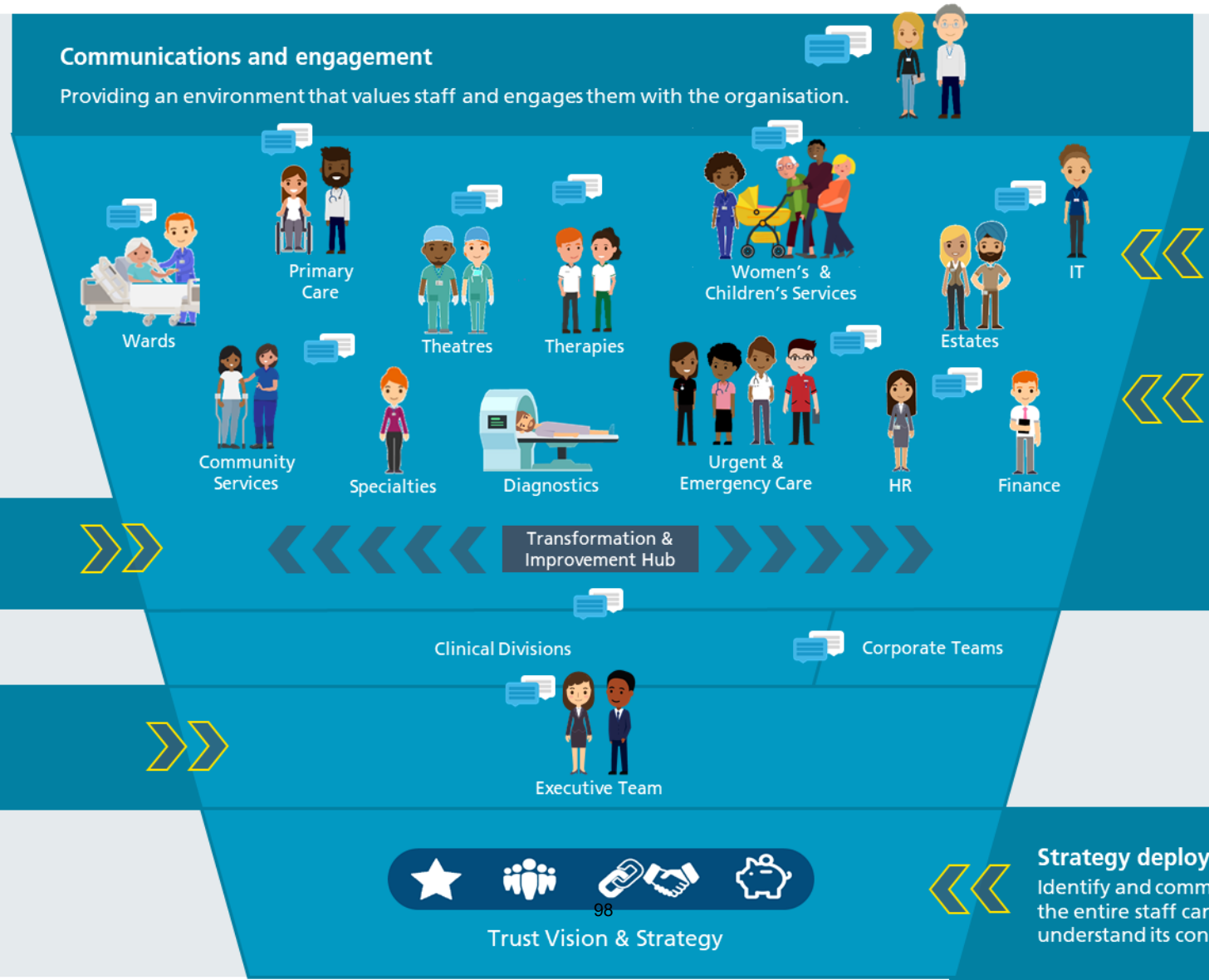
Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



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

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

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

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

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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

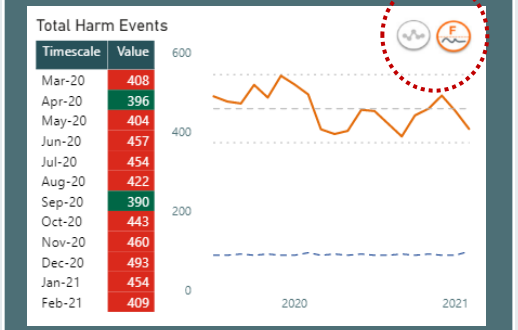
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

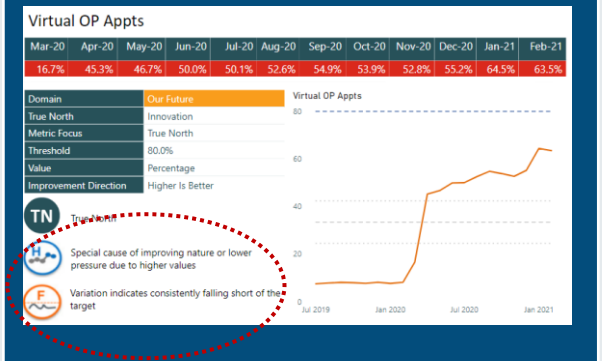
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

Great Western Hospitals NHS Foundation Trust

		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

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Audit, Risk & Assurance Committee**
Meeting Date	16 January 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 – Corporate Departments	Partial Assurance	
2. Annual Security Report	Substantial Assurance	
3. External Audit Plan 2023/24	Approved	
4. Internal Audit Progress Report and Action Tracking	Noted	
5. Internal Audit – Theatres Management Report	Good Assurance	
6. Local Counter Fraud Progress Report	Noted	
7. Local Counter Fraud – Conflicts of Interest Review	Good Assurance	
8. Single Tender Actions	Good Assurance	
9. Losses & Compensation Q3 2023/24	Noted	

POINTS OF ESCALATION	
KEY AREAS TO NOTE	The Committee were pleased to note that there continues to be a good level of referrals to the LCFS and no significant issues have been identified. The internal audit report on Theatres Management reported strong governance structures for monitoring and reporting on theatre utilisation performance and well documented policies and operational procedures.
BOARD ASSURANCE FRAMEWORK & RISKS	Just to note that it was the first time that all Corporate Risks had been brought together for ARAC. This was helpful but it was recognised that there needs to be further reflection on the structure of the Corporate Risk Register and how this is challenged across the executives in TMC prior to any further escalation by ARAC.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The LCFS review of Conflicts of Interest noted that the Trust's compliance is 100% - this is an excellent result and a high level in comparison to other NHS Trust reviews.
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	**Mental Health Governance Committee**
Meeting Date	19 January 2024
Committee Chair	Lizzie Abderrahim, Non-Executive Director
Link to Strategic Objective	Pillar 1- Outstanding Patient Care & Pillar 3 – Joining Up Acute and Community Services in Swindon
Link to Board Assurance Framework	BAF 1 : SR 1 – Quality / SR6 – Partnership Working

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Use of the Mental Health Act Q3 Report		x
2. Mental Capacity Act Q3 Report		x
3. Use of Deprivation of Liberty Safeguards Q3 Report		x
4. Mental Health Governance Workplan		x
5. Division of Medicine – ED Mental Health Report		**x**
6. Right Care Right Person Update		**x**
7. Children's Service Mental Health Update		**x**

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	1. [Use of the Mental Health Act Q3 Report] Issues associated with the detention of patients under s2 of the Mental Health Act [for assessment] at GWH pending an acute mental health bed are being considered at a task and finish group. The committee, whilst acknowledging that the detention of patients in an acute setting in circumstances where the patient has no physical health needs would not be a breach of GWH's licence conditions, expressed concern about the length of time that patients could remain in an acute hospital when the priority of the Section 2 is for them to have a mental health assessment. It was recognised that this is a system wide issue and that it was important that it had visibility across the system.
	4. [Mental Health Governance Workplan] ▪ The workplan provided further evidence of the increasing role that GWH had within the system [both as a contributor to system working and as a leader of system wide initiatives] and it was agreed that it was important that GWH understood how this was reflected across the trust and within the system. ▪ A reduced liaison service from Change Grow Live [CGL] continued to be an issue. This was a recruitment issue and it was agreed that data should be collected in relation to patients awaiting review. This would provide evidence of the impact on patients that might then be presented to the commissioners of the CGL service.
	5. [Division of Medicine – ED Mental Health Report]. ▪ There has been a reduction in RMN spend and it was notable that alongside this there had not been an increase in incidents of violence and aggression which the committee considered was an indicator of the effectiveness of the measures established within ED and the close relationship between GWH staff and the AWP Mental Health Liaison Team. ▪ The committee was pleased to note the engagement that had taken place to ensure that the needs of patients presenting with mental health concerns would be addressed in the new build.
	6. [Right Care Right Person Update] It was noted that that whilst the tactical group had been meeting and that operational issues were progressing the strategy group was yet to meet. The committee understood that whilst a phased approach to implementation had been planned it now appeared that phase one [welfare checks] and phase two [response to absconsion] were to be merged from April and agreed that, given the pace that was developing, it would be important for the strategy group to begin meeting.
	7. [Children's Service Mental Health Update] The committee welcomed the allocation of funding for the provision of a Safe Room.
BOARD ASSURANCE FRAMEWORK & RISKS	No 15+ risks were reported but a discussion was had about the management and oversight of the 12+ risks and the committee was satisfied, given the challenges across the trust in relation to the management of patients requiring care and support for their mental health, that mental health risks were being robustly managed and that appropriate mitigations were in place.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The Way Beacons is an initiative based in the emergency department that focusses on young people involved in or effected by violence/gun crime, substance misuse and risk-taking behaviour and has been running for three months. It aims to support medical staff by engaging with young people aged 11-25 with the objective of breaking the cycle of readmissions by engaging with the young person at a reachable moment and connecting them to ongoing support within the community. The and the service had been running for 3 months in the Emergency department.

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	**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.