GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 2 March 2023, 9.30am to 12.30pm
By Teams

AGENDA

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

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Peter Hill	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 • 2 February 2023	1 - 11	LC	Approve	
4.	**Outstanding actions of the Board (public)** • Comms briefing on NHS App	12- 16	LC NG	Note Note	
5.	**Questions from the public to the Board relating to the work of the Trust**	-	-	-	
6.	**Care Reflections (Patient Story) – Sophie's Legacy** Rayna McDonald, Deputy Chief Nurse, and Claire Evans, Senior Sister, Children's Services, to present	Video	RM/CE	Receive	9.45
7.	**Chair's Report** Liam Coleman, Chair	17 - 22	LC	Note	10.15
8.	**Chief Executive's Report** Kevin McNamara, Chief Executive	30 - 35	KM	Note	10.25
9.	**Integrated Performance Report**			Assurance	10.45
	• Performance, Population & Place Committee Board Assurance Report (February) – Peter Hill, Non-Executive Director & Committee Chair	36 - 37	PH		
	• Quality & Safety Committee Board Assurance Report (February) – Nick Bishop, Non-Executive Director & Committee Chair	38 - 40	NLB		
	• Finance, Infrastructure & Digital Committee Board Assurance Report (February) – Faried Chopdat, Non-Executive Director & Committee Chair	41 - 43	FC		

	• People & Culture Committee Assurance Report (February) – Paul Lewis, Non-Executive Director & Committee Chair	44 - 46	PL		
	• Integrated Performance Report	47 - 93	All		
10.	**Charitable Funds Committee Board Assurance Report** Paul Lewis, Non-Executive Director & Committee Chair	94 - 95	PL	Assurance	12.00
11.	**Gender Pay Gap Report 2021-22** Jude Gray, Chief People Officer	96 – 121	JG	Approve	12.10
	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	12.25
13.	**Fit & Proper Persons Test Policy update** Jude Gray, Chief People Officer	122 - 139	JG	Approve	-
14.	**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	Note	-
15.	**Date and Time of next meeting** Thursday 4th May 2023 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
16.	**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

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

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC IN LECTURE HALL 1, ACADEMY, GREAT WESTERN HOSPITAL SWINDON AND VIA MS TEAMS 2 FEBRUARY 2023 AT 9.30 AM

Present:

Voting Directors

Liam Coleman (LC) (Chair)	Trust Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Nick Bishop (NB)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Andy Copestake (AC)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Peter Hill (PH)*	Non-Executive Director
Paul Lewis (PL)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Chief Medical Officer

In attendance

Caroline Coles (CC)	Company Secretary
Naginder Dhanoa (ND)	Chief Digital Officer
Jackie Fawcett (JF)	Early Careers Advisor (agenda item 229/22 only)
Claudia Paoloni (CP)	Associate Non-Executive Director
Claire Warner (CW)	Deputy Chief People Officer (Observer)

Apologies

Faried Chopdat	Non-Executive Director

Number of members of the Public: 7 members of public* (included 4 Governors: Chis Callow, Chris Shepherd, Natalie Titcombe and Mufid Sukkar and 3 members of staff)

*Indicates those members attending virtually by MS Teams.

Matters Open to the Public and Press

Minute	Description	Action
224/22	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public Apologies were received as above.	
225/22	**Declarations of Interest** There were no declarations of interest.	
226/22	**Minutes** The minutes of the meeting of the Board held on 13 January 2023 were adopted and signed as a correct record with the following amendments:-	

Minute	Description	Action

198/22 : Chair's Report - Add *Faried Chopdate, Non-Executie Director* to the safety visit.

199/22 : Chief Executive's Report : Operational Pressures - amend last line of first paragraph to *'…..*in *unexpectedly* during their Christmas break.

200/22 : Our Care – On page 7, 1st paragraph amend 'Westsbrook' to *'Westbrook'* and 'had' to *'has'.*

204/22 : Safe Staffing 6 Month Review for Nursing & Midwifery - In 6th bullet point change to *'delay in the OSCE preparation programm*e of International nurses…'.

227/22 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

The Board **noted** the outstanding actions.

228/22 **Questions from the public to the Board relating to the work of the Trust**
There was one question from the Board from a member of public which was on food options in the outpatient's renal department. In response to a question from a Non-Executive Director it was clarified that this was specifically for dialysis patients and that not all outpatients were provided with food.

The Board **noted** the question.

229/22 **Care Reflections – Staff Story**
Jackie Fawcett, Early Careers Advisor joined the meeting for this agenda item.

The Board received a reflection of care through a film from Ryan who had completed the new T- Level course; a 2-year vocational course which was taken after GCSEs and equivalent to 3 A Levels. These courses offered students practical and knowledge-based learning at a school or college and on-the-job experience through an industry placement. The Trust had secured 15 placements from local colleges as a pilot scheme last year. Ryan was now a part ime staff member at the Trust.

There followed a discussion on this vocational course which included colleges involved, socio economic factors, funding and employment opportunities.

The Chair thanked both Jackie and Ryan for sharing this important activity to increase routes not only into the Trust but also into the wider health care workforce.

The Board **noted** the care reflection.

230/22 **Chair's Report**
The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally.

Of particular note was that the Trust was near completion in the recruitment process for Non-Executive Directors which had seen exceptionally high quality of candidates and thanked the HR team for their support and hard work as this was the first time the Trust had used solely in-house support to generate recruitment.

Minute **Description** **Action**

Lizzie Abderrahim, Non-Executive Director asked what was the timescale for appointment. Liam Coleman, Chair replied that subject to full Council of Governors approval the new Non-Executive Directors would join in the next 2-4 months.

Peter Hill, Non-Executive Director asked if the Trust would share any wider learning across other local NHS trusts in terms of this round of recruiting. The Chair commented that the experience would be shared with the Allied Hospital Alliance (AHA) and ICS chair conversations to work out a mechanism to share not only experience but potential suitable candidates for other vacancies within the system.

The Board **noted** the report.

231/22 **Chief Executive's Report**

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

Operational Pressures - The number of patients with Covid-19 or flu had continued to decline. One success over the past month was that the Trust was best in the south west for the reduction in nosocomial infection rates and thanked the wards and Infection Protection & Control (IP&C) teams for their more rigorous approach to IP&C.

Industrial Action - Industrial action continued to affect both health and social care services and in a number of other public sectors which had an impact upon the Trust's staff, such as education. The next wave of action to directly impact the Trust was on 6 and 7 February 2023. The Trust's priority was to minimise the disruption to patient care as much as possible, while at the same time recognising the strength of feeling on this issue, which remained a dispute between the unions and the Government over the national pay settlement.

The British Medical Association were balloting its junior doctor members this month on taking strike action and the results were expected at the end of February 2023.

Lizzie Abderrahim, Non-Executive Director asked if there had been any impact from the recent teachers' strike. Lisa Cheek, Chief Nurse replied that there had not been a huge amount of impact due to planning and flexibility of staff.

In-Patient Maternity Survey results - The results from the CQC commissioned national maternity survey had been published. The Trust scored within the top five Trusts for experiences in labour, birth and postnatal care at home in the survey, and highest in the country for feeding babies and support with breastfeeding. This was due to the focussed action and leadership in this area and thanked the maternity team for their continued commitment and progress in challenging times.

Way Forward Programme – Integrated Front Door (IFD)- The Way Forward Programme reached a significant milestone with recent approval from the Department of Health for the £32m Integrated Front Door business case. This was the biggest investment in the hospital site since it was built, and also represented a significant investment in the infrastructure of Swindon. The next steps was to finalise sequencing of this build with an expected completion in Winter 2024.

Peter Hill, Non-Executive Director asked if the Trust would seek any learning from other NHS trusts who had gone through a new build and change in terms of clinical experience and positive impacts, for example Royal Liverpool hospital. Kevin

Minute	Description	Action

McNamara, Chief Executive replied that the team had already picked up shared insight from a new Consultant who had been through a similar process in another trust however would ensure that the Liverpool experience would also be included.

Jon Westbook, Medical Director commented that it should not be underestimated the demand on leadership and clinical capacity in terms of change programmes and that the Trust were embarking on three big projects; the IFD, Electronic Patient Records and the community services tendering all at the same time. The Chair confirmed that this was an important point in terms of bandwidth capability risk during this period of significant change within the Trust.

There followed a discussion on new IT technology especially the significance of the introduction of the NHS App which included functionality, communications and engagement. The Chair requested a short briefing to the next Board particularly around the communications plan. ND

Action : Chief Digital Officer

Andy Copestake, Non-Executive Director asked for clarification on Improving Together training and the original target set for training staff. Claire Thompson, Chief Officer for Improvement & Partnerships replied that the target was to train all staff over a number of years and that the lessons learnt in phase 1 had developed speciality training at a faster pace. It was agreed that as the Trust appoached the one-year introduction of Improving Together a progress report, to include next steps, was timely for the Board.

Action : Chief Officer for Improvement & Partnerships CT

The Board **noted** the report.

232/22 **Integrated Performance Report**

Integrated Performance Report Review

In recent months the Integrated Peformance Report had undergone a change to reflect the introduction of the Improving Together methodology. Feedback had been received from Boad members on a number of occasions. The IPR forms the summary view of organisational performance against the Trust's 12 'pillar metrics' and the four breakthrough objectives chosen to focus on in 2022/23. It was a blended approach of business rules and statistical tests to ensure key indicators known as drivers and watch metrics continued to be appropriately monitored.

The Chair invited the Executive Lead of each breakthrough objective to take the Board through the context of the objective, why it was there and its importance. The following was noted:-

<u>Reduction in Pressure Ulcers</u>

- This was a top indicator that encompassed many factors on ward leadership and good patient care. It was a good signpost of good nursing across the Trust.
- The aim of a reduction by 30% had not been achieved over the past 12 months which was caused by many factors including staffing, sickness, increase patient acuity however after recently revisiting this objective it was recognised the main impact was no common thread or alignment with the 3 divisions' objectives. This would be amended going forward and the Chief Nurse was keen to keep as a breakthrough objective.

Minute	Description	Action

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

- This was a top indicator to monitor and drive down the wait times, improve flow and the standard of care for our patients.
- Improving A&E waiting times was a measure in the new 2023/24 national NHS guidance.
- Currently this target was at 18.6% vs a target of 2% which was a reflection of the national picture. However there were still changes that could be made internally around data recording and culture.
- Next steps included stratifying data and through Improving Together making improvements in departments.

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

- This indicator demonstrated the Trust's ability to use its assets to those who most needed them, improve patient experience and also the effectiveness of how this organisation was working with partners
- There had been a positive decline since January 2023 linked to the work in the discharge hub within the co-ordination centre and the home first initiative.
- There was still more to do internally in this area to continue to drive improvements.

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

- This indicator reflects culture and behaviours within the Trust and links to patient care.
- There had been a slight improvement in a short space of time but one to persevere with for further improvements.
- The next staff survey results would be available in March 2023.
- The focus going forward would be on a trust-wide basis.

There followed a discussion which included realistic targets particularly the 12hrs threshold of 2%, the improvement tools used and benchmarking.

It was agreed that this approach on updating the Board on progress with the breakthrough objectives would take place on a quarterly basis with a monthly update to note in between.
Action : Company Secretary CC

The Board **noted** the update.

233/23 **Board Committee Assurance Reports**
Performance, Population and Place Committee Chair Overview
The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meeting on 25 January 2023 and following was highlighted:-

Emergency Access – ED had record attendance in December 2022 (1,212 increase on November 2022) fuelled by high levels of covid, flu and respiratory diseases. This resulted in increased waiting times. The Urgent Treatment Centre was holding up well but further work was required to ensure the maximum number of patients benefit from the service (rather than attending ED).

Referral to Treatment Time (RTT) – RTT performance was good news despite the winter pressures. The number of 52-week waiters, which had been increasing month on month, had decreased for the first month. This month was also the first month of

Minute	Description	Action

positive day case activity during the period with more future capacity increases noted.

Diagnostics (DMO1) - DM01 performance had improved as a whole with a waiting list and long waiter reduction. The waiting list size had reduced by 2,000 since June 2022 and access time performance had improved by 8% since August 2022. There were still significant challenges in Endoscopy especially in terms of staffing turnover and sickness. The Committee noted the Endoscopy Recovery Plan & JAG accreditation and congratuled the team on this achievement. It was noted that although some of the major performance concerns of the Committee had not been highlighted through the IPR breakthrough objectives the Committee had however picked up issues through triangulation of data and had performed several deep dives and were significantly assured with more recent improvement in this area.

The Chair proposed to organise a feedback session with committee chairs outside the Board meeting to review feedback around the IPR and whether further key issue highlight reporting was required.
Action : Company Secretary CC

Cancer Performance - Cancer remained the same as the previous two months with hot spots still around Dermatology and Plastics, however, there had been an improvement particularly in Dermatology from additional outsourcing.

Virtual Ward Update - The committee received an update on the Virtual Ward (now known as NHS at Home). Members were very impressed with the progress made. The Committee noted the renewed national focus on this service model and the recruitment challenges currently being experienced.

Felicity Taylor-Drewe, Chief Operating Officer added that the Trust had been an early adoptor of Virtual Wards however recognised that the Trust had slightly lost ground. The Trust were in the process of recruiting a medical consultant to support further development and a robust action plan to progress forward.

Partnership Working - The Committee received an update on the Health Inequalities action plan. Progress had been slower in some areas than had been hoped with aspects of working on inequalities proving challenging in the current climate. However, the Committee recognised the Trust's progress relative to other local NHS Trusts. The Committee would continue to monitor the plan.

Quality & Safety Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Safety Committee (Q&SC) at the meeting held on 19 January 2023 and the following highlighted:-

IPR : Pillar Metrics - Total number of harms had increased from 195 to 267. This was across a range of associated metrics including pressure ulcers, falls resulting in harm and Covid infections.

Falls - Whilst the overall fall rate remained consistent, there was an increase in serious harm with 5 fractured neck of femurs. There had been further rollout of encouraging appropriate footwear to help address the falls rate, which included staff education and patient information.

Minute	Description	Action

Maternity - Maternity performance was positive with 100% compliance across all measures in the perinatal mortality review tool over the past few months.

The maternity slides included in the pack were noted, which had been scrutinised at the Quality & Safety Committee meetings and this in future would feed into the IPR. There were no concerns to escalate to Board.

Emergency Department Dashboard - Due to the rise in attendance in December 2022 as a result of high levels of covid, flu and respiratory diseases performance had deteriorated however improvement was expected as attendances had decreased in January 2023.

Nursing & Midwifery Audit Programme - There was evidence of good work here with the expected rollout of ward accreditation across the Trust. This links with the Improving Together programme.

Board Safety Walks - A mechanism to cascade feedback from these visits to all Board members was discussed. Lisa Cheek, Chief Nurse added that actions points were coming out of the Board safety walks and shared with the Executive and the ward teams and the Board were aware of the themes however would be happy to aggregate a summary of these visits, which were reported to Quality & Safety Committee, into a summary report and reported into Board through a relevant means.
Action : Chief Nurse LC

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

Andy Copestake, Non-Executive Director asked for clarification around the Friends and Family Test as this was achieving 80% but rated a red. Lisa Cheek, Chief Nurse explained that this was only one of a number of factors and reflected patient experience as a whole and would ensure that this was reflected in the next report.
Action : Chief Nurse. LC

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

Month 9 Position - Overall the rating showed more green partly to reflect the improved year end position as income from the ICB was received to fund the planned deficit. The latest forecast position was breakeven which was an improvement from the previously reported £1m gap due to a review of reserves and contingencies alongside the in-month cost pressures.

Cost Improvement Programme (CIP) - It was recognised that no further opportunities could be identified due to the increased focus on 2023/24 planning. As a result, there remained a crucial risk to the complete delivery of the 2022/23 plan with a projected £2.9m shortfall that would form part of the 2023/24 targets. It was anticipated that this risk would be amplified to red/red as we stepped into the next financial year.

Lizzie Aberrahim, Non-Executive Director asked for the rationale as to why CIP was rated amber and not red as forecast was to achieve only 72%. Helen Spice, Non-

Minute	Description	Action

Executive Director replied that this reflected the overall financial position to breakeven and therefore would be mitigated to enable a breakeven position.

There followed a discussion with regard to the assurance ratings and it was recognised that there was a differential approach across the committees with some contextual and some against national targets and that a relook at the governance in this area would be revisited.

Action : Company Secretary CC

Business Planning - The Committee noted that the planning methodology was comprehensive and robust however, recognised the risk as red due to the proposed deficit and the requirement for difficult decisions and trade-offs would result in a challenging budget for 2023/24.

IT and Digital Risks - The Committee was assured that the risk management process and reporting risks for IT and Digital were adequate and effective. However, further clarity and detailed action plans were required for the one risk that scored 15; engagement in using digital solutions to deliver change.

Shared Electronic Patient Record (EPR) Risks - The Committee was assured that EPR Programme risks were identified, managed, and actioned within the Shared EPR Programme governance structure. The inherent risk of the overall program remained high notwithstanding the continued efforts by the executive and the project team.

PACS Business Case - The Committee reviewed the Outline Business Case (OBC) for the Trust to invest in a single integrated Picture Archiving & Communication System (PACS) across its core radiology and breast imaging services. The Committee provided approval to commence a tender exercise to enable a Full Business Case to be developed.

Estates and Facilities Risks - The Committee was assured that the risk management process and reporting risks for Estates and Facilities, which included Health, Safety, Fire and Security risks were adequate and effective.

PFI Report - An update on the mobilisation of the Soft FM Benchmarking, including other PFI activities, was received by the Committee. No significant issues were noted, although the Committee remained interested in more detailed action plans related to the Trust's preparedness for the expiry of the PFI in 2029.

Integrated Front Door – Guaranteed Maximum Price and Stage 4 Contract - The Committee received a comprehensive paper which outlined approval for the main construction (stage 4) contract and the related Guaranteed Maximum Price (GMP). It confirmed that the proposed GMP was affordable, and that the agreement would deliver a new IFD by the Trust's requirements, as the clinically led IFD team specifies. The Committee approved the GMP and the Main Construction Contract and recommended approval to the Trust Board.

People & Culture Committee Chair Overview

The Board received an overview of the detailed discussions held at the People & Culture Committee at the meeting held on 9 January 2023 and the following was highlighted:-

Minute **Description** **Action**

- The Committee received an update from the Communications team which included progress on the research carried out by Jungle Green, a market research company looking at public views of the Trust.
- The initial response rates for the latest Staff Survey was encouraging and the Committee would receive and review the next set of results at the next meeting.
- There was one red rating which covered workforce planning predominantly due to the challenges around industrial action. Plans were in place to respond to industrial action however this remained a key concern over coming weeks and months.
- Recruitment time to hire was a concern and the new Head of Recruitment was reviewing this in detail with the Recruitment Team to make the imporvements needed.
- A review of the format of the committee assurance report would be undertaken to be more consistent with the other committees. It was recognised that it took time to establish a new committee and to find its feet.

Helen Spice, Non-Executive Director asked if there had been a discussion around the use of band and agency staff vs full time equivalents. Paul Lewis, Chair of P&CC confirmed that this was discussed but not at every meeting as the Committee tried to get a balance. It would not focus on the numbers, as this was covered in the Finance, Infrastructure & Digital Committee, only the process.

Jude Gray, Chief People Officer added that this was the first year that the staff survey had included bank staff.

The Board **noted** the reports.

233/22 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Audit, Risk & Assurance Committee at the meeting held on 19 January 2023 and the following highlighted:-

Surgery, Women & Childrens Risk Report : Good progress had been made since the division last presented to the Committee – they had reviewed and closed a lot of the old risks. As for all divisions they needed to include reporting on Finance risks for the division, which were considered but not presented in this report. A review would be undertaken with others on the reporting template.

Risk Register - The Committee continued to be assured that the processes for managing risk in the trust was effective. On the KPIs the number of risks with no actions had reduced significantly however, the other KPIs had worsened – although the operational challenges were recognised the focus on risk needed to be maintained.

External Audit Plan 2022/23 - Deloitte presented their Audit Plan for the audit for the year ending 31 March 2023. There would be a report from the interim audit at the next meeting and this would address the action plan from last year's audit to ensure that all actions had been addressed prior to the end of the financial year and the final audit.

Internal Audit - All audits were now underway and would be completed in time for an overall assurance rating by the end of the year, although there were still five reports to be finalised and presented to the Committee. There were a number of outstanding

Minute	Description	Action

actions all of which had been deferred a number of times, some since 2021. The Executive were asked to take urgent action to address these outstanding issues. There were 3 internal audit reports reviewed; Access Policy, Discharge Processes and End of Life Care.

Single Tender Actions Report - The Committee were assured on the controls that were in place to manage single tender waivers appropriately.

Counter Fraud Progress Report - The Committee were assured that this was managed well.

The Board **noted** the report.

234/22 **Mental Health Governance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Mental Health Governance Committee (MHGC) at the meeting held on 20 January 2023 and the following highlighted:-

Mental Capacity Act [MCA]: Update and Practice - The Committee received an audit of MCA practice which had identified particular gaps and work was progressing at pace to address these. In particular an MCA competency framework had been developed to support a robust upskilling programme and additional resource to improve capacity.

Use of Deprivation of Liberty Safeguards [DoLS] - Compliance with the DoLS training requirement was evidenced and the committee noted that mitigations were in place to actively address the risk in relation to patients who were cared for outside the legal framework because the supervisory bodies lacked the capacity to complete the assessments. The committee also noted a concern about the application of DoLS in relation to patients subject to long ambulance waits but received an assurance that this was being monitored.

Emergency Department [ED] / Mental Health Liaison Team [MHLT] Update - The ongoing challenge relating to the lack of acute mental health beds meant that the risk rating continued to be red. However, robust measures were in place to mitigate that risk and there was evidence of improvements in the MHLT performance in relation to referral to assessment timeframes. However emerging issues of concern were noted in the form of the loss of the observation area from April 2023 and the impact of a decision, effective from April, taken by Swindon Borough Council [SBC] to change ways of working across SBC and AWP by segregating of services.

Felicity Taylor-Drewe, Chief Operationg Officer added that mental health requirements were on the agenda for the IFD project and what the system required for paediatrics and step down beds and was also assured around the transition of the new ways of working across SBC and AWP as a potentially positive impact and how AMHPs could support the trust quicker.

Children's Services / Child and Adolescent Mental Health Service [CAMHS] Update - Ratings remained consistent. The workforce pressures that CAMHS was under continued as did the national shortage of specialist Tier 4 beds. Mitigations were in place to address the risk and further improvements in the working relationship between Children's Service and CAMHS was evident.

Minute	Description	Action

Helen Spice, Non-Executive Director commented that an issue wih Datix was referenced in the report around data reliability and asked if there was a gap in the risk management processes. Lizzie Abderrahim, Chair of the MHGC replied that this had been a long standing issue with collection and analysis of data in relation to mental health however had anticipated that this would be resolved by the next meeting in April 2023 however if not would escalate.

The Board **noted** the reports.

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.

235/22 **Ratification of Decisions made via Board Circular**
None.

236/22 **Urgent Public Business (if any)**
None.

237/22 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 3 March 2023 at 9.30 am, at the Double Tree by Hilton, Swindon.

238/22 **Exclusion of the Public and Press**

RESOLVED

that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – March 2023				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
2-Feb-23	231/22	**Chief Executive's Report : NHS App** Short briefing note on the NHS App particularly around the Communications Plan	Chief Digital Officer	Briefing attached. **Closed**
2-Feb-23	232/22	**IPR : Breakthrough Objectives** To update the forward Board cycle of business to reflect reporting timescales for the update on breakthrough objectives	Company Secretary	Completed. **Closed**
2-Feb-23	232/22	**IPR : Breakthrough Objectives** Feedback session with committee chairs outside the Board meeting to review feedback around the IPR and whether further key issue highlight reporting was required.	Company Secretary	For discussion at NED regular monthly session.
2-Feb-23	232/22	**IPR : Q&SC Chair Overview : Board Safety Walks** Consider reporting mechanism for informing Board on summary on board safety walks.	Chief Nurse	A Board safety report is presented to Q&SC on a quarterly basis. This will be attached as an appendix to the Chair's Board Report.
2-Feb-23	232/22	**IPR : Q&SC Chair Overview : CQC Preparedness** Reflections of the discussion around the Friends and Family Test and rag rating to be included in the next Q&SC Chair Board Assurance Report	Chief Nurse	Completed. **Closed**

Future Actions				
2-Feb-23	231/22	**Chief Executive's Report : Improving Together** 'One-year on' reflection report on Improving Together to include next steps	Chief Officer for Improvement & Partnerships	May-23
2-Feb-23	232/22	**IPR : Board Assurance Reports** Relook at format of Board Assurance Reports to ensure consistency of rag ratings across all committees	Company Secretary	May-23

Report Title	**NHS App**				
Meeting	**Trust Board**				
Date	2 March 2023	**Part 1 (Public)**	**x**	**Part 2 (Private)**	
Accountable Lead	Chief Digital Officer				
Report Author	Naginder Dhanoa, Chief Digital Officer				
Appendices	N/A				

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

Assurance Level

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

Board members are asked to note the report.

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

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

This report provides an update on the national development of the NHS App, and Great Western Hospital's involvement in it.

Report

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

This report includes updates on:

- The development of the NHS App
- GWH's involvement in the App
- Benefits of the App for patients and staff

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

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

The report details how patient information is moving to the NHS app, and addresses concern this may lead to digital exclusion, for those who are unable or unwilling to use this technology.

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Note the report**	
Accountable Lead Signature	
Date	23.2.23

1. The NHS App

1.1. What it is and how to access it

The NHS App is a simple and secure way to enable those living in England who have registered with a GP to access a range of NHS services on a smartphone or tablet, or via NHS.uk on a desktop computer.

The app is being developed nationally to give patients more of the information they need about their hospital appointments in one place, as it becomes positioned as the digital 'front door' to the NHS.

The development will enable patients to view and manage their hospital appointments, receive personalised information and support and have a single point of contact for each appointment.

When a patient visits the appointment pages in the NHS App, they may be provided with additional material, support and guidance related to either their appointment or ongoing care.

So far 30 million people have signed up to use the NHS App (figures correct at September 2022), and there is a national drive for 75% of adults to have registered for the NHS App by March 2024.

1.2. How the App works

The App provides users aged 16 and over with a range of services including the ability to:

- order repeat prescriptions;
- book GP appointments and online consultations;
- view their GP health record;
- get their NHS COVID pass;
- manage their first hospital or clinic appointment with a specialist when they are referred by their GP;
- View all their referrals and future secondary care appointments in one place;
- View a single point of contact for each appointment for the service currently administering their care;
- Access supporting information to help prepare for their appointments.

1.3. Trust involvement

The NHS elective care recovery programme plan aims to tackle the waiting list backlog and at the same time provide a greater level of support to those patients waiting for hospital care, and improve their experience whilst doing so.

Adding hospitals to the app gives patients more control over their hospital appointments and how and when they can access information and support.

Patients are now able to see their appointments at the Great Western Hospital in the NHS App, after the Trust was added to the platform as part of a collaboration between our patient portal (Dr Doctor) and the App.

GWH went live on the app in January and was part of one of the first waves of trusts to be visible in this way.

Our patients cannot modify their appointments directly in the app (trying to do so will redirect them back to Dr Doctor) but it is hoped that the greater visibility of appointments will support better communication with our patients and reduce wasted appointments.

Whilst the App has a number of benefits for patients in terms of being given easy access to clear information about their healthcare, there are also a number of benefits for staff.

These include:

- Clinical and administrative time being freed up as patients and their carers are now able to find more of the information they need via the NHS App rather than contacting services for an update.

- Patient-led booking is understood to help maximise clinical utilisation and reduce 'did not attend' rates for appointments.

As the app uses existing information, no new processes are being created for staff to follow.

1.4. Digital exclusion

The development reflects the increased use of apps in society, and is intended to provide the public with a modern service they expect to be able to access. It does not replace existing forms of communication – such as letters and texts to patients – but acts as an additional means of communicating.

1.5. Next steps

The Trust's communications team, supported by the national NHS communications team, will be publicising the change widely to staff and patients and working to increase awareness and usage of the app.

Report Title	**Care Reflection (Patient Story)**				
Meeting	**Board of Directors**				
Date	**2nd March 2023**	Part 1 (Public)	x	Part 2 (Private)	
Accountable Lead	Lisa Cheek – Chief Nurse				
Report Author	Tania Currie – Head of Patient Experience and Engagement				
Appendices	PowerPoint Presentation including film				

Purpose

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

Assurance Level

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

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

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

The film identifies the work undertaken by the Paediactric team to meet the wishes identified in Sophie's legacy and ensure we are providing a high standard of care for children in our services.

Report

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

The Care Reflection film is not a Great Western Hospital patient story but is one that is told by the mother of a child, cared for at another hospital, following a cancer diagnosis.

The story raises relevant concerns about aspects of care that are clearly important to many children, including those in our care. These include the wish for play specialists 7 days a week, better food for children and access to food and beverages for parents.

Sophie's legacy and wishes have been reviewed by our children's services in order for us to assess how we are meeting these and what further work is needed to raise our standards and provide services in line with her requests. The Matron for children's services will report on our work to date.

We will continue working with Sophie's mum and she will be attending the GWH Children's governance meeting in order to share hers and Sophies experience and ensure that the patient voice is central to our improvement work.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x				
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	NA				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The Care Reflection will be shared widely with staff including via the Children's services				

	clinical governance meeting and is available on the trust intranet for future learning.
Next Steps	

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ To receive the presentation as assurance of improvements in patient care identified in the Care Reflection.	
Accountable Lead Signature	Lisa Cheek, Chief Nurse
Date	22 February 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Care Reflection

Sophies Legacy – Hope

Trust Board – March 2023

Care Reflection

Sophies Legacy - Hope

- This is not a GWH Care Reflection
- This is ‘Sophies Legacy’ and we have permission from Sophies mum to share this
- We have shortened the film for todays meeting
- The story may be upsetting for you to watch

Watch film here:

Sophie's Legacy - YouTube

Care Reflection

Sophies Legacy - Hope

Great Western Hospitals NHS Foundation Trust

Sophies Legacy:

- 1. Play specialists 7 days a week – We currently have play provision 5 days a week Monday to Friday.One Band 4 Play Therapist at 0.60 WTE and a Band 5 Play Therapist 0.72 WTE. Currently have a vacancy of 0.28 WTE and exploration at using this funding to develop a Band 2 play assistant role to improve play therapy availability.

- 2. Better food for children – Work has been undertaken to provide child friendly snack bags which children can access at all times. We also have a children's menu which incorporates food that children enjoy. Snack bags, cereal and toast are available on the ward any time of day and night

- 3. Parents to be fed – We offer breakfast to all parents .Parents have access to a parents pantry where they can make and prepare food any time of the day or night. We also in the process of purchasing some more travel mugs so parents can have a hot drink without leaving the childrens bedside.

Care Reflection

Sophies Legacy - Hope

Great Western Hospitals NHS Foundation Trust

Please view the full film of Sophies Legacy at:

https://vimeo.com/730581919/e6399c86a4

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**2 March 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Summary 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							
Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

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

The report provides information in respect of:-

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

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	21 February 2023

Chair's Board Report

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally during February 2023.

1. Council of Governors

1.1 A Council of Governors meeting was held on 8 February 2023 which included governor briefings on business planning, an ICS update, and future of community services.

2. Non-Executive Directors

2.1 Andy Copestake's term of office comes to an end on 31 March 2023 after over 6 years in the role of Non-Executive Director. The Trust would like to thank Andy for his incredible support, commitment and dedication during his term of office and wishes him well in the future.

2.2 The recruitment process for 3 NEDs and 1 ANED had been completed and was now going through the appropriate governance process.

3. Strengthening Board Oversight

3.1 Attached to this report is the quarterly summary of the Board Safety Walks conducted during September to December 2022.

3.2 The Board Safety Walk in February 2023 has been rearranged to take place in March 2023.

4. Key Meetings during February 2023

Meetings	Purpose
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
EPR Update	Monthly update meeting
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
Council of Governors' Meeting	Quarterly meeting
Wellbeing Guardian and Senior Execs Community Conversations Event	NHSE event to seek peer support, share learning, challenges and successes as a Wellbeing Guardian
BSW Provider Collaborative Innovations Introductory Call	

AHA update and future plans	Call with RUH CEO and South West Regional Director
Staff Survey Presentation	Results of survey
HWB Oversight Committee	Attendee of committee
Research for new EPR bidder presentation	To receive presentation
Nomination & Remuneration Committee	NED / ANED appointments
Board Strategy	To discuss Board Strategy with CEO and External Consultant
BSW ICP Meeting	Attendee
Finance, Infrastructure & Digital Committee	Attended Board Committee as observer
Performance, Population & Place Committee	Attended Board Committee as observer

Appendix 1 - Board Safety Walk Arounds Summary Report for September to December 2022

Visit summary - announced visits

Name of site	Date of Walk Around
Trauma Unit	7th September 2022
Critical Care Unit (CCU)	12th October 2022
Same day Emergency Care (SDEC)	9th November 2022
Emergency Department	8th December 2022

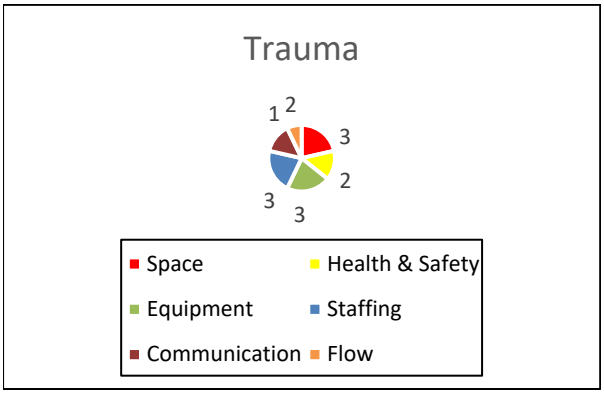
Visit summary- unannounced visits

Name of site	Date of Walk Around
Meldon Ward	27th September 2022
Saturn Ward	21st November 2022

1. Summary of feedback - announced visits

1.1 A thematic review of the notes taken during each visit has been completed. This has identified similar themes to the first visit report but with the addition of flow, which might be indicative of the areas visited.

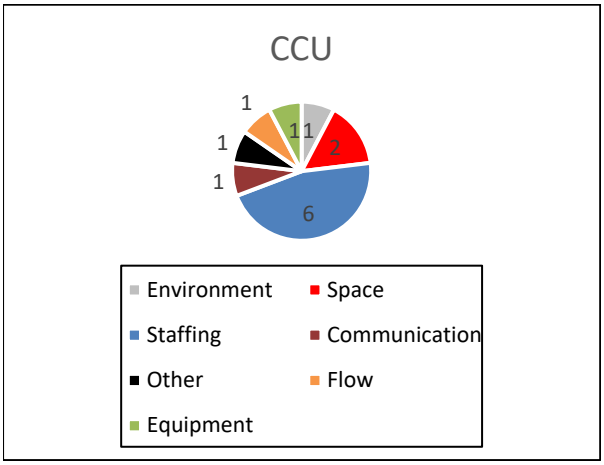
Themes identified on the Trauma Unit



The main concerns related to space, equipment and staffing were in relation to layout of the ward and the lack of visibility of patients, lack of suitable storage and the risk of falls and the trip hazard that these pose.

The new staffing model, increased work with the falls team around sensory mats, bathroom alarms and the new Datix system were all discussed as

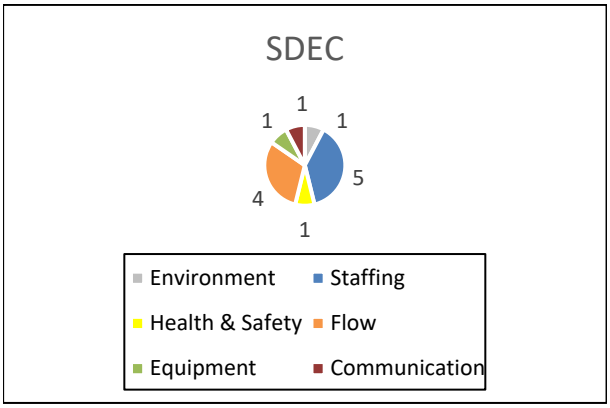
Themes identified at the Critical Care Unit



The main area of concern was related to space, this included storage in the department for equipment but also general space within the hospital to accommodate patients fit to go back to the ward and the impact delayed discharge from the unit has.

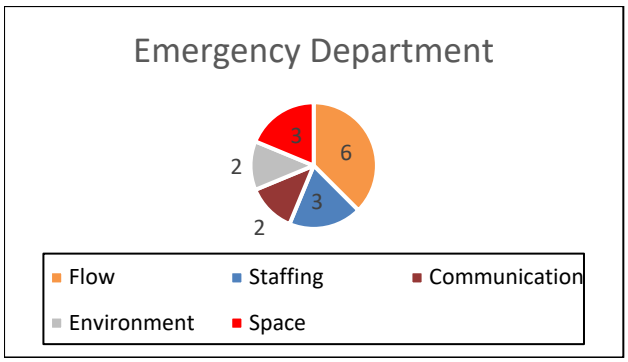
The theme of staffing was a mix of positive and negative comments. Including the development of Practice Development Leads, daily risk assessment of staffing, wider training and development and the negative impact on staffing of staff moves to Ward

Themes identified on the Same Day Emergency Care Area



The main themes and concerns were related to staffing and flow. These included the sharing of staff across areas and the impact this had on the service, the staff establishment and how areas were not visible or staff within the current establishment. The flow into the unit and expectation from some specialities/services that is outside of the scope of the unit. The positive steps the unit has already taken to improve flow, including changes to

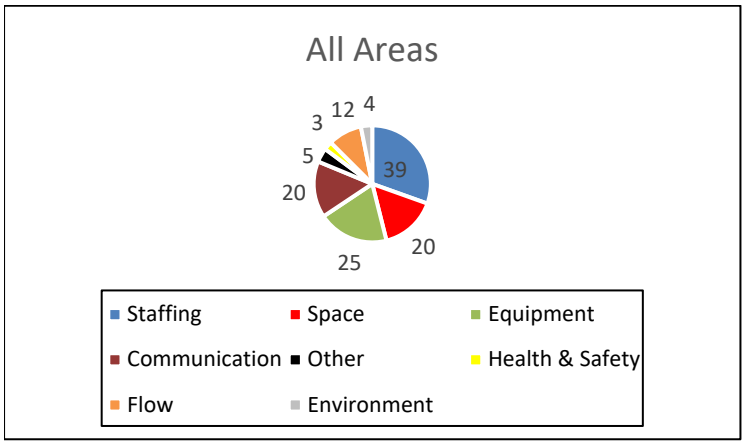
Themes identified within the Emergency Department (ED)



The main theme was related to flow of patients through the department. It was also noted that this is closely linked into staffing and space with one impacting the other.

Staff reflected on many of the changes in the department and the positive impact

Summary from all planned safety walks since the start of the year.

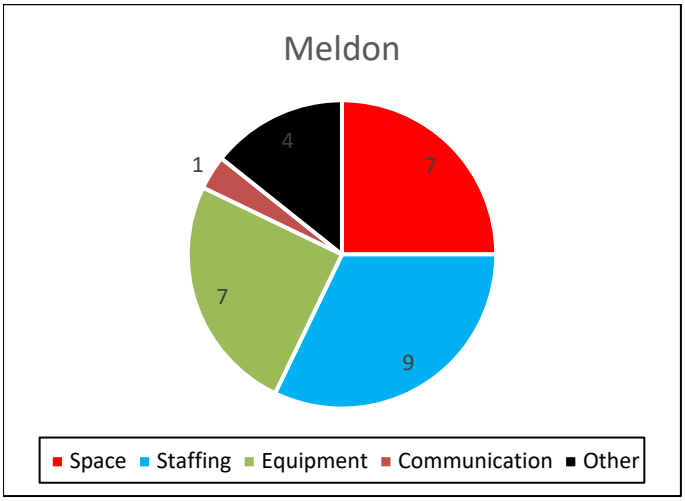


1.2 It is clear that staffing remains a significant area of concern and was the top theme for four of the nine areas visited throughout the year.

2. Summary of feedback unannounced visits

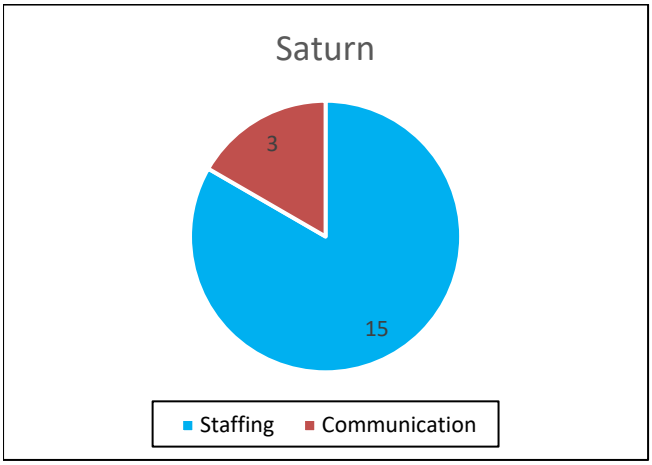
2.1 Two unannounced visits have taken place, one on Meldon Ward and one on Saturn Ward. Although staffing featured highly in both visits it was the main topic of discussion for the Saturn Ward visit.

Themes identified in the Meldon Ward



The main themes relate to staffing, space and equipment. Concerns were raised that extra bed spaces are used almost all of the time and the staffing establishment did not account for this. The new staffing establishment was welcomed, although the difficulties to recruit were recognised, along with other HR/recruitment issues. Utilisation of staff in the correct roles was discussed and has previously been escalated as an area for Trust wide improvement.

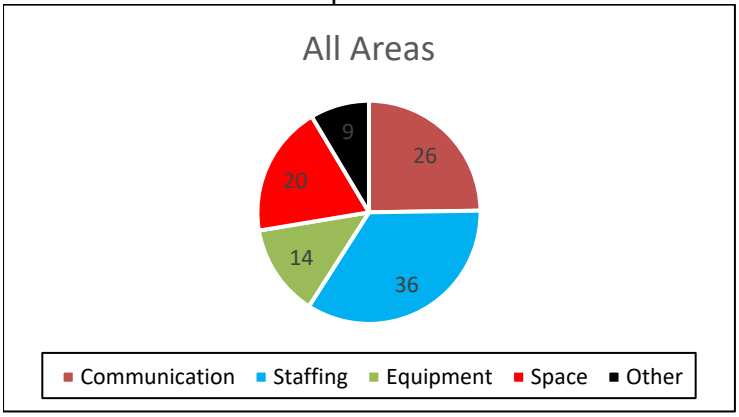
Themes identified in Saturn Ward



Staffing was the main area of focus for the whole visit. There was lots of positive feedback from the team including feeling part of a 'work family', support for everyone, good teamwork and good educational support from the Practice Educators.

The areas of focus that were negative in relation to staffing were around the expectation of workload, working with low staffing numbers, feel under valued by some colleagues, worrying about things missed on shift and impact on work life balance.

Themes identified - all unplanned area visits.



3. Summary

3.1 The feedback from the Walk Arounds has remained 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. There have been some excellent examples provided by staff during the visits of initiatives to improve patient safety as well as further areas for improvement. Feedback from patients spoken to on some of the visits was also very positive.

Report Title	Chief Executive's Report				
Meeting	Trust Board				
Date	2 March 2023	Part 1 (Public)	X	Part 2 (Private)	
Accountable Lead	Chief Executive Officer				
Report Author	Kevin McNamara, Chief Executive Officer				
Appendices	N/A				

Purpose

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

Assurance Level

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

Board members are asked to note the report.

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

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

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

Report

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

This report includes updates on:

- Current pressures
- Industrial action
- Acute Hospital Alliance – Provider Collaboratives Innovators Scheme
- Equality, diversity and inclusion
- Staff recognition
- Leadership changes

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

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

The report has a section on equality, diversity and inclusion which details some of the work we are doing in this area, specifically on race equality and marking LGBT+ History Month.

Additionally, the report covers the forthcoming launch of our new Women's Network later this month.

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Note the report**	
Accountable Lead Signature	K. McNamara.
Date	23.2.23

1. Operational updates

1.1. Current pressures

We are clearly seeing the impact of the Swindon Integrated Care Alliance Coordination Centre having oversight of our patients and front-door activity.

Whilst the number of patients with no criteria to reside in hospital remains a challenge, we continue to perform relatively well in this area when compared with other Trusts in the South West.

Latest data at the time of writing indicated we are sixth in the South West for this measure, and best-performing in our integrated care system, although we recognise that with just over 100 patients with no criteria to reside in hospital, this is still high.

We are also performing comparatively well for the number of patients occupying a bed for 21 days or more – we are currently second in the South West with 14% of patients in this category.

Our Navigation Hub helped 192 ambulance patients avoid admission to the hospital in January. Of these, 49% were provided clinical advice instead, while others were provided an alternative route, a community pathway, an appointment, or identified for the Virtual Ward.

We have seen a decrease in ambulance handover delays and continue to work closely with ambulance service colleagues to reduce the time they spend at the hospital waiting with their patients.

In terms of our recovery work, we succeeded in delivering 100% of our plan for outpatient and elective activity in January, which equates to 89% of our corresponding 2019/20 activity and 102% of our 2021/22 activity.

Last month we raised our Covid-19 alert level to red, following a rise in the number of cases in the hospital. An update on numbers will be provided verbally at the Board meeting.

1.2. Industrial Action

The Royal College of Nursing held industrial action at Great Western Hospital on 6 and 7 February. On 6 February, 96 staff were on strike, with 88 staff striking on the following day. A small number of clinics were cancelled as a result of the action.

Further planned RCN strikes on 1-3 March were suspended and, at the time of writing, the union had entered in to talks with the Government on pay.

The British Medical Association announced last month that its members had voted for strike action. It is understood to be planning a 72-hour strike in March, but no dates had been confirmed at the time of writing.

Whilst recognising the strong feelings that exist around industrial action, we know that the escalation of union disputes with the Government carries risks to the delivery of services and to our patients.

The Government has announced it is recommending a 3.5% pay increase for public sector workers in 2023/24 – this will now be considered by independent pay review bodies.

2. Quality

2.1. Care Quality Commission visit

We held our regular quarterly engagement meeting with representatives from the Care Quality Commission last week, and their team extended their visit to spend the day at the Trust looking at some of our services.

They visited the Urgent Treatment Centre, Swindon Integrated Care Alliance Coordination Centre, Radiology, and Outpatients.

We discussed with the team some of our achievements, along with our winter response and how we've worked to maintain quality and safety, updates on our Integrated Front Door, and a look ahead to some of the areas where we are focussing our efforts this year.

2.2. Accreditations

We have received a number of accreditations recently:

- Positive feedback received from Joint Accreditation Committee International Society for Cellular Therapy Europe & European Group for Blood and Marrow Transplantation (**JACIE**) inspection of haematopoietic stem cell transplantation.
- Accreditation renewed for **Blood Sciences** department by UKAS following surveillance visit.
- **Joint Advisory Group on GI Endoscopy (JAG) accreditation** following demonstration of meeting best practice quality standards.
- **Gold Accreditation from Wiltshire Carers Network** for the improvements and support provided to carers.

3. Systems and Strategy

3.1. Way Forward Programme – Integrated Front Door

Following on from the announcement of funding to progress our Integrated Front Door we held a short ground-breaking ceremony on site. Our contractors attended alongside members of the Way Forward Programme, executives, and the divisional team.

Along with a staff forum dedicated to updates and questions on the programme, we held an open meeting for the public in The Academy, providing an opportunity for local residents to find out more about our plans and the next steps in the building process.

To enable construction work to go ahead, a number of changes are underway to ambulance parking, a revised route for helipad arrival to Emergency Department, and temporary/permanent relocation of services.

These changes have been discussed and agreed with clinical, security, fire, ambulance and air ambulance colleagues.

Among the changes, physio outpatients moved to the old Urgent Treatment Centre decant building last month. Same Day Emergency Care will now move in to existing physio outpatients, freeing up Cherwell (old SDEC) for moving to start. Refurbishment of Cherwell is currently underway.

A timetable is now being agreed for the decant of Unscheduled Care management offices, the mental health pathway / Emergency Department observation areas, Paediatrics Emergency Department, and Majors Step Down.

In terms of the programme's overall timeline, with construction getting underway last month, we expect the decant to take place in April with the building being completed in Spring 2024. There will then be a period of refurbishment before the new Integrated Front Door becomes operational in Summer 2024.

3.2. BSW Acute Hospital Alliance

Bath and North East Somerset, Swindon and Wiltshire Acute Hospital Alliance is made up of our Trust working closely with the Royal United Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust.

Together, we have successfully bid to be part of the first wave of NHS England's new Provider Collaboratives Innovators Scheme.

As part of the new scheme, NHS England has chosen nine collaboratives – one from each region – to help accelerate their development, so being part of the first cohort is recognition of the work we've done so far, and our potential to do much more in the future.

We are the only collaborative chosen from the South West, with nearly 50 bids submitted across the country.

The new scheme recognises the critical role that providers play in helping systems deliver better care.

Being part of the first cohort will provide further opportunities for staff at our three organisations to collaborate more closely together.

It also means that our experience will help to improve future national policy around collaboratives and collaboration.

We are now working closely with NHS England to co-design the support and expertise we feel would provide most value to deliver our locally-agreed priorities for benefitting patients.

4. Workforce, wellbeing, and recognition

4.1. Leadership

4.1.1. Digital: Following the appointment of Naginder Dhanoa as Chief Digital Officer (joint with Salisbury NHS FT), we have now appointed Jon Burwell as joint Chief Information Officer and Tracy Farrow as deputy across both Trusts. They will lead on our digital strategy which is currently in draft.

4.1.2. Unscheduled Care Division: Some personnel changes have taken place, which means we have a new tri in place as follows:
Divisional Director: Anna Blake
Divisional Director of Nursing: Sharon Smith
Associate Medical Director: Dr Anthony Kerry

4.2. Vaccination programmes

The Covid-19 vaccine booster roll-out came to an end last month. Across the course of this winter, our vaccination team have administered Covid-19 jabs to 4,346 people, including staff, students, Serco and volunteers.

This has been a huge team effort, that has seen 66 per cent of our staff come forward for a Covid-19 booster while at work.

We continue to offer the flu vaccination to staff, and so far 81 per cent of staff have had a jab, putting us first in the South West for vaccine take-up.

4.3. Equality, diversity and inclusion

4.3.1. We supported the 2023 campaign to highlight Race Equality Week with five videos across the week from staff who were taking part in a different daily challenge. This included being mindful of pronouncing people's names correctly and addressing microaggression in the workplace.

4.3.2. We marked LGBT+ History month by encouraging our communities to think about how well they know their flags. We picked six flags that represent different LGBT+ communities and shared a digital campaign raising awareness of their meanings.

4.3.3. Our new Women's Network will be launching on 8 March, which marks International Women's Day. The launch event will have guest speakers and an opportunity to help scope the objectives of the network.

4.4. STAR of the Month

Our latest STAR of the Month winner was the Maternity team. They were recognised for their exceptional hard work during an extremely busy Christmas period, going above and beyond for every family and their baby.

4.5. Staff Excellence Awards

Nominations for the 2023 Staff Excellence Awards have opened, across 11 categories.

There will also be a STAR of the Year for 2022/23, chosen from the previous 12 winners of the STAR of the Month Award, and a Patient Choice Award winner who will be nominated by patients and families.

Shortlisted staff will be announced in April, ahead of the awards ceremony which will take place at the Steam Museum in Swindon on Friday 9 June.

4.6. Great West Fest

Our annual family festival, Great West Fest, will return for its third year on Saturday 2 September in Old Town Gardens.

All staff and their families are invited to this year's free event which will have more performers, more music and more surprises, alongside a number of food vendors, activities and funfair rides.

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Paul Lewis		22nd February 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	BAF 3

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access	R	A	January saw a significant decrease in ED attendances which coincided with Industrial Action by several Health Care unions.	Monitor Actions	March 2023
Integrated Performance Report – Elective Access - RTT	R	A	Delivery against RTT continues to show a worsening trend and has been outside of control limits since May 2022. RTT 18 week compliance for January shows a slight improvement in month. This was discussed in detail in particular in relation to the outpatient perfect week plans which were very well received. The Amber rating for assurance with the actions planned, but it was agreed to retain the current ratings and review again in March.	Monitor Actions	March 2023

Integrated Performance Report – Elective Access – DM01	R	A	DM01 performance decreased in December compared to November and there are still significant challenges in Endoscopy especially in terms of staffing turnover and sickness. The committee are aware of the plans in place to deliver further improvement and will continue to monitor this closely.	Monitor Actions	March 2023
Integrated Performance Report – Cancer & Cancer Services Assurance Report	A	A	Cancer waiting times remain below standard, however there was an improvement in January and this is the 3rd month improvements have been seen. The Committee received the latest Cancer Services Quarterly Assurance Report, which continues to focus on the hot spots with Dermatology and Plastics.	Monitor Actions	March 2023
EPRR	A	A	The annual Emergency Preparedness Resilience & Response Report (October 2021-October 2022) was presented. It was noted that 62 core standards were fully compliant and amber with further work required in 6. Of these 2 are now fully complete and also compliant. The main areas of risk are with Shelter & Evacuation and Lockdown where further work is required with collaboration and support with the H&S team. It was also confirmed that a Fire Evacuation Test will be completed later this year. Further progress will be reviewed again at the meeting in May.	Monitor Actions	May 2023

Issues Referred to another Committee – Coding Risk	
Topic: Financial Risk due to issues with Coding resource, expertise and practice.	**Committee: Finance, Infrastructure & Digital Committee**

NHS
Great Western Hospitals
NHS Foundation Trust

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		16 February 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	BAF 1

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

Assurance Level	Colour to use in 'Assurance level' column below
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Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Board Assurance Framework	Not Rated	Not Rated	The Committee received the report and thought that the scoring was reasonable.		
Integrated Performance Report: **Pillar Metrics**	R	A	Slight reduction in total harms from 267 to 258, mainly due to decreased Covid rates.		
IPR: Friends and Family Test (FFT)	R	A	FFT positive responses have improved in all areas with a more than 10% increase in positive responses within the Emergency Department and Urgent Treatment Centre. Although slight improvement in this area, the red risk rating reflected patient experience as a whole.		
IPR: Pressure Harms	R	A	Pressure harms have decreased slightly within hospital but have increased within community.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR: Hospital Acquired Infections	R	A	Concerns remain about MSSA and *E.coli*. Efforts are concentrating on cannula care and catheter care respectively. We are still awaiting delivery of a new skin preparation which has been subject to delay. The Trust remains below trajectory for *C.diff*.		
IPR: Falls:	R	A	The number of falls with harm has returned to be in line with previous months.		
Perinatal Quality Surveillance Tool	A	G	Regarding the CNST data, there will be a few months where we do not receive this data unless there is an adverse change given that we submitted 10/10 'green' ratings. The criteria for the 2023 submission will become available within the next few months when the Quality & Safety Committee will again receive compliance predictions.		
Ockenden	A	A	Work is continuing on full compliance but there has been no movement since November 2022. The Committee requested that each monthly report reflects the status that month, even if this is unchanged.		
National Maternity Survey CQC Report 2022	G	G	The Maternity Team was congratulated on behalf of the Board for a very good report. The department recorded better than average results on all metrics and compared very favourably with the South West region. The Committee received an action plan focusing on areas that can be further improved.		
Mortality	A	A	The Clinical Lead for Mortality again stated the position regarding low coding numbers which influences much of the data presented. Having said that, the results were generally reassuring with the proviso that the latest data is dated September 2022. The Structured Judgement Reviews revealed some learning points which were spread where necessary. The decision has been taken that from April 2023 presented data will be based on substantially improved coding following improvements in staffing levels. This must be taken into account when making comparisons post-April.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Clinical Audit & Effectiveness Q3	A	A	Some concern was expressed by the Committee that for the fifth year the Trust was not contributing to the National Asthma Audit. The Deputy Chief Medical Officer informed the Committee that plans were in place following the appointment of a new consultant respiratory physician to allow the asthma audit to take place. The Committee was pleased to hear that since the publication of the report, the number of national audits – overdue items had reduced to six i.e. 3% of national audits.	The Committee pressed the Deputy Chief Medical Officer to fix a time when this could be expected to begin and to work with the Chief Medical Officer on this	
Governance during operational pressures	A	G	This comprehensive but concise report was welcomed by the Committee as it outlined all the actions that had been put in place in response to unprecedented operational pressures during the Winter. This report will act as a template for future operations under similar circumstances. Although the clinical risks during this time were undoubtedly 'red' the 'amber' rating was applied for the governance of the processes.		
Monthly Safe Staffing Report	A	A	This brief report showed that fill rates had improved since December and that qualified staff and HCAs were now rated 'green'.		
Update on CQC Preparedness	Not Rated	Not Rated	The Committee was assured that the only 'Must Do' action relating to Safeguarding Children Level 3 training would be completed by the end of March 2023. The report outlined the expected direction of travel for future CQC inspections.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Finance, Infrastructure and Digital Committee – 20 February 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**20 February 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF4 SR6 & 7

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

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Significant	Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives
Full	Blue – Delivered and fully embedded

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
FINANCE					
Finance Risks & Way Forward Programme Risks	A	A	The Committee noted that Finance's risk management process and reporting, including that of the Way Forward Program is adequate and effective. Whilst the Committee was reassured of the scoring of risks for 2022/23, we noted that several Finance-related risks are likely to increase significantly as we enter the 2023/24 year.	Monitor monthly through FIDC (and significant risks to be reviewed quarterly at Board).	FIDC Meetings 2023
Board Assurance Framework	A	G	The Board Assurance Framework for Finance and Infrastructure risks' latest summary was presented to the Committee for review. Significant levels of assurance were received around the process to support the completion of the BAF, enabling effective scrutiny and challenge.	Monitor monthly through FIDC & Board	
Month 10 Finance position	G	G	The Trust received income from the ICB to fund the planned deficit (£19.4m), of which £16.1m is reported in the Month 10 position. Excluding this income, the Trust reports a shortage of £1.6m in the month, of which £0.1m is favourable to the plan. The latest forecast position is breakeven with no material movements in forecast positions.	Monitor monthly through FIDC	FIDC Meetings 2023
BSW Consolidated Finance Report	R	A	The Committee received a verbal update on the overall financial position of the BSW ICB, including key risks, mitigations, and delivery of efficiencies. Whilst the Committee was satisfied with the management engagement and response of GWH with the ICB, we challenged the overall finance governance at BSW. Further, we raised concerns about the need for more clarity, decision authority, trust and transparency, the workings of the new model and structure, and its impact on GWH.	Monitor monthly through FIDC & Board	

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Capital Plan	R	A	Capital Expenditure is £8.2m below plan due to slippage and profiling; however, the Trust's teams are managing slippage by enhancing governance outside of the Capital Management Group to monitor progress and ensure funding will be spent by year-end. Whilst the Committee is assured that actions and plans are in place to address the spending gap, we are concerned about the scale of work and the short time frame to achieve delivery by year-end.	Monitor monthly through FIDC	
CIP Programme Update	A	A	The Month 10 position is that £0.64m of efficiency is delivered against the plan of £1.05m resulting in an adverse variance of £0.4m. At year to date, 76% of the program has been delivered, with a forecast position of 72% of the plan delivered at year-end. No further opportunities are identified due to the increased focus on 2023/24 planning. As a result, there remains a significant risk to the complete delivery of the 2022/23 plan with a projected £2.9m shortfall that will form part of the 2023/24 targets. It is anticipated that this risk will be substantially amplified to R/R given that the shortfall will be carried into the next financial year.	Monitor monthly through FIDC	FIDC Meetings 2023
Business Planning Update	R	R	An updated paper was noted on the business planning for 2023/24, summarising the National Update, Progress to Date, and Anticipated Outcomes. The Committee notes that the national planning guidance has been gradually released since December, and there remain several unknowns and that an initial view of the proposed deficit and the requirement for difficult decisions and trade-offs will result in a challenging budget for 2023/24. FIDC will consider the whole plan at an Extraordinary FIDC meeting planned for the week c/o 20th March.	Monitor at FIDC + proposal to review final plan at an extraordinary FIDC scheduled for the week c/o 20th March 2023	FIDC meetings 2023
Winter Plans	A	G	The Committee noted an update on the Winter Plan for 2022/23 that was agreed upon in September 2023. The financial envelope, £1.2m, has been tracked, and where there have been underspend, monies assigned to the Winter Plan have been allocated to additional schemes. The Committee noted the initial success of the Navigation Hub initiative in managing flow and agreed that the Trust plans to move to a seasonal plan that will run throughout the year with funding identified to support over 12 months.	Monitor monthly through FIDC	
IT AND DIGITAL					
IT & Digital Risks	A	A	The Committee is assured that the risk management process and reporting risks for IT and Digital are adequate and effective; however, further work is required to improve the maturity of the risk management process as a whole – management has undertaken a review to improve the approach and oversight of risks for the division as whole, and the update will be provided to FIDC in April 2023.	Monitor through FIDC	FIDC meetings 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Shared EPR Risks	R	A	The Committee is assured that EPR Programme Risks are identified, managed, and actioned within the Shared EPR Programme Governance structure. Programme managers with reporting and escalation undertake regular reviews through appropriate channels. Work is still commencing to incorporate key risks into the Trust's corporate risk registers to enable complete visibility at the Trust level. Procurement activities are on track, with Oracle Health (previously Cerner) noted as the preferred bidder. Overall, the inherent programme risk is Red due to the lack of benefits to support the FBC, including estimated increased costs, resourcing challenges, and the risk that the FBC needs to be approved.	Monitor through FIDC	FIDC meetings 2023
IT Quarterly Update	A	A	A summary update on the key developments in the planned IT activity was provided to the Committee. Whilst positive progress has been made with the remaining phases of the IT Infrastructure programme of work, the crucial risk to the delivery remains the availability of resources and the scope and speed of change required. Funding opportunities will continue to be explored, and bids will be undertaken as necessary.	Monitor through FIDC and monthly update to the Board	FIDC meetings 2023
Cyber Security Update	A	G	An update on salient Cyber Security developments to further enhance the Trust's cyber defences was presented to the Committee. No reported incidents were noted however the further vigilance and continued control is required to mitigate the possibility of a Cyber-attack.	Monitor monthly through FIDC	FIDC meetings 2023
ESTATES & FACILITIES					
Estates and Facilities Risks	A	A	The Committee was assured that the risk management process and reporting risks for Estates and Facilities, which includes Health, Safety, Fire and Security Risks are adequate and effective. Whilst the overall risk remains amber, we were satisfied that management continues to take appropriate actions to mitigate risks.	Monitor through FIDC	FIDC meetings 2023
PAM Submission	A	A	The Committee received an update paper on the process followed to achieve compliance with the Premises Assurance Model (PAM) that the NHS National Contract mandates. We reviewed the proposed submission and findings and were satisfied with the following steps to be taken. However, we required management to consider funding and timelines to deliver the compliance program.	Monitor through FIDC	FIDC meetings 2023

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

Board Committee Assurance Report

People & Culture Committee – January 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	**Paul Lewis**		**21st February 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?		Y	BAF 2 SR2

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

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Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Workforce Planning	R	A	The level of risk remains 'red' due to the on-going position with industrial action, but the Committee were provided with further assurance about plans in place to mitigate and manage this as effectively as possible. We reviewed the workforce planning elements of the Integrated Performance Report in detail (which include voluntary turnover rate, sickess/absence rate, leavers within 1st year, vacancy rate and time to hire) and noted the on-going plans with recruitment, sickness/abence rates, 1st year attrition and 'time to hire' to further improve our position. The Committee received a detailed update about SARD implementation and this was also reviewed sepeartely from an assurance perspective (see below).	Review progress at the next meeting.	April 2023
Great Opportunities	A	A	The Committee received an excellent update about our Talent Management & Succession Strategy. There plans were well received, incuding the decision to explore the Scope For Growth model as an alternative to the 9 Box Grid for talent reviews.	Review progress at the next meeting.	April 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Employee Experience	A	A	The response rates for the latest Staff Survey are very encouraging and we will receive and review the full set of results, including details at Divisional level, at the next meeting. The Committee received a detailed update about Health & Wellbeing and reviewed the annual Gender Pay Report. These were also reviewed sepeartely from an assurance perspective (see below).	Review progress at the next meeting.	April 2023
Employee Development	A	A	As already mentioned, the Committee received an excellent update about our Talent Management & Succession Strategy and noted the contribution made by Sally Fox. The plans to improve the appraisals process and documentation (which will include personal development plans) will be covered at the next meeting and will be a key deliverable	Review progress at the next meeting.	April 2023
Great Leadership	A	A	We are still awaiting further clarity and guidance about the Messenger Report before initiating further actions within the key recommendation areas of 'management standards and accredited training'.	Review progress at the next meeting.	April 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Gender Pay Report	A	A	In order to meet obligations under the Equality Act 2010 the Trust is required to publish gender pay gap date. The Committee were presented with the 2021-2022 Report which included the latest position and plans to make further improvements next year. A detailed action plan is now being developed, with input from best practice at regional and national levels.	Review progress at the August meeting	August 2023
Health & Wellbeing	A	G	The Committee received an update about Health & Wellbeing, which covered the framework, a summary of findings and revised improvement actions. It was agreed that progress has been encouraging and it was good to see that feedback from staff forums and Networks have been taken into consideration (along with MI/data) to support the self-assessment.	Review progress at the August meeting	August 2023
SARD Implementation	G	G	The Committee received an update about the Secure Appraisal Revalidation Database (SARD) implementation which is the deployment of an electronic workforce system for medical staff covering revalidation, appraisal and job planning. It was agreed that excellent progress has been made and noted the first cycle of electronic job planning is due in July 2023 when the appraisal process will also commence to help improve the quality of appraisals.	Review progress at the December meeting.	December 2023

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

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

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

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

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

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

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

Our Performance

Key highlights from the report this month are:

OPERATIONAL PILLAR METRICS

Of the 5 Operational Pillar Metrics, improvements have been seen in 5 during the month of January 2023. Delivery against RTT continues to show a worsening trend. However, key national performance requirements (52 Weeks, 78 weeks) are delivering in line with expectation. month in 4 continued to deteriorate in month.

Cancer 62 day - Cancer waiting times remain below standard. However, saw in improvement in January to 70.2 %. This is the 3rd month improvements have been seen.

RTT 18 Week Compliance – January performance shows a 2.23% improvement in month. However, RTT performance has been outside the control limits since May 2022.

Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. January saw a significant decrease in ED attendances. This coincided with Industrial Action by several Health Care unions. Emergency Department Mean Stay – In the month of Jan 2023 there has been a small reduction in the Mean Length of Stay for patients in both the Emergency Department and Urgent Treatment Centre. This is aligned to a reduction in attendances for the same period.

Inpatient Spells, Number of Non-Criteria to reside (NC2R) days. The number of patients who remain in an Acute Hospital bed without a Criteria to Reside (NC2R) has seen a reduction for the 3rd month in a row. The achievement of this also fell during the "winter months" when we would expect to see delays increase.

OPERATIONAL BREAKTHROUGH OBJECTIVES

The breakthrough objective related to time in ED over 12 hours has seen a marginal improvement. However, remains outside of the SPC control limits. This is closely linked to the mean time in ED. The number of patients awaiting an update from the Community Single point of Access reduced from 1309 in October to 703 in December.
Partner Supported Discharges continues to show improvements.

Alerting Watch Metrics
28-day faster diagnosis, 52-week waiters, number of patients on DM01 waiting list, Cancer 62-day performance and the number of referrals received show improvement in month. However, they all remain outside the control limits with no statistical improvement over the previous 3 reporting periods.

Alerting Watch Metrics Covering the Emergent Department and Flow all show special cause for concern however, they all show areas of improvement in the month of December. The agreed counter measured appeared to have had an effect in December and Jan during the Winter Plan period.

Our Care

Strategic Pillar Targets

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

There has been a very slight decrease in the total number of harms from 267 to 258 in month. There is no specific driver, but COVID rates are slightly down and remain one of the lowest in the region.

For January the number of Family and Friends positive responses has improved in all areas. Within the Emergency Department and Urgent Treatment Centre there has been an over 10% increase in positive responses rates.

Breakthrough Objectives
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. January has seen a slight decreased in the hospital acquired pressure ulcer harms but this has not been mirrored in the Community setting, where

there has been a slight increase, specifically with those receiving end of life care as well as patients with multiple harms.

Alerting Watch Metrics
The Trust overall complaint response has remained static for the third month, however there are signs in early February of improvement across all divisions.
MSSA continues to remain an area of concern and over our internal trajectory, with a further two further cases in month. Roll-out of the licensed skin-preparation product (Hexiprep) has been delayed due to supply-chain issues and is now expected in February.

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

- Three Serious Incidents have been declared in month and continue to be investigated under the Serious Incident Framework
- This is the third consecutive month that the number of complaints received, and the number of complaints reopened has dropped.
- There has been a significant rise in the number of concerns raised in month, although the numbers have not reached to levels seen in October and November.
- The number of falls with harm has returned to be in line with previous months
- The Trust remains below trajectory for C. difficile and Pseudomonas aeruginosa
- E. *coli rates* continue over trajectory with the gap from trajectory widening in January
- FFT overall response rate has risen and is at the highest point compared to the last three months
- Emergency Department and the Urgent Care Centre has seen a significant increase in positive response rates, of over 10%, in a period of high operational pressure and challenge.

Our People

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

Strategic Pillar Target from A3 goals:
To aim to be in the top 20% of trusts for staff survey results and in the lower quartile for turnover within Model Hospital.

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

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

The Pulse Survey Q1 and Q2 shows a gradual increase from 49.3% staff survey result 2021 and Q1 50.31%and Q2 51.10%.

The Trust Staff Survey Results 2022 to be presented 8th and 15th February to Executives and senior management team and to inform the annual plan and area of A3 focus.

Alerting Watch Metrics

Sickness absence continues to alert and has increased in month from 4.9% to 5.8%, of which 2.2% is long term absence and a spike of 3.6% is short term absence. 0.8% remains COVID related absence, an increase on the previous month.

Voluntary turnover continues has seen a slight increase to 11.84% in December compared to 11.54% in November and above the 11% target.

Non-Alerting Watch Metrics
The % of leavers within 1st year of employment has decreased in month to 22.73%.

HR Scorecard
Additional slide included on TTH data and action to address performance.

Use of Resources

Income has been received from the ICB to fund the planned deficit (£19.4m), £16.1m (10/12) of this is reported in the Month 10 position. Excluding this income, the Trust is reporting a deficit of £1.6m in-month which is £0.1m favourable to plan. Year to date position is £16.4m deficit, £0.2m adverse to plan.

The latest forecast position remains breakeven, with no material movements in forecast positions across divisions since last month. Forecast ESRF costs remain in excess of income (£8.1m costs, £6.9m income); but the Trust still expects to breakeven by the end of the year. The cash balance at the end of Month 10 is £22.4m above plan, This is predominantly due to the receipt in October of £19.4m of deficit funding from the ICB, as well as a continued year to date underspend on capital.

Capital expenditure is £8.2m below plan to date due to profiling and slippage. The capital team have met with all the divisions, project leads and procurement to monitor progress fortnightly to ensure the funding will be spent by the end of the financial year. Purchase orders in the last two months total c.£4m, and this cost will show in the year-to-date actuals once goods are on site / services are received, and they are receipted.

Efficiency delivery has not kept pace with plan this month and is £2.3m behind plan year to date. The forecast to year end remains at £3.1m unidentified. However, in expecting to deliver an overall position close to plan, by proxy we could expect to deliver close to the CIP target, albeit non-recurrently.

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

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/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	23rd February 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

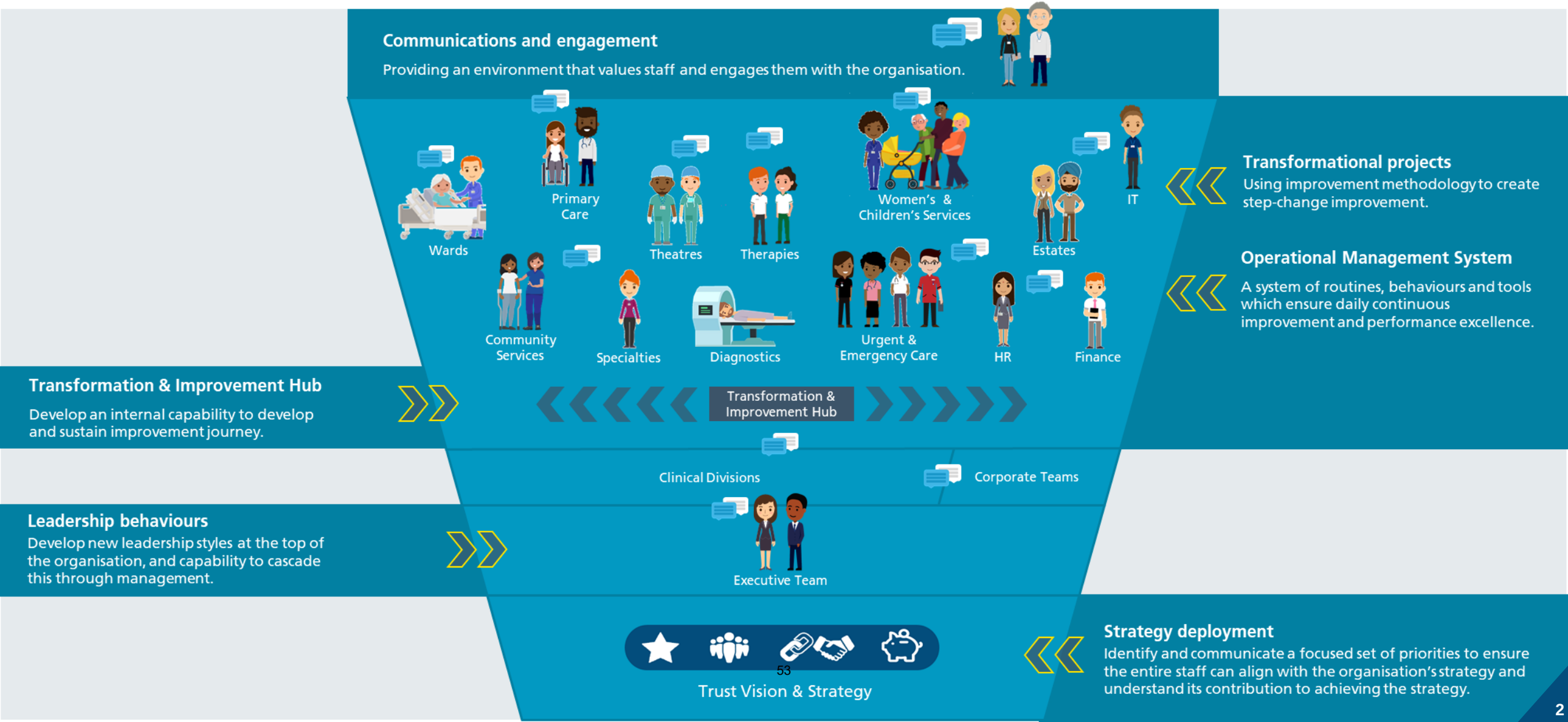
February 2023

December 2022 & January 2023 data period

Improving together

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

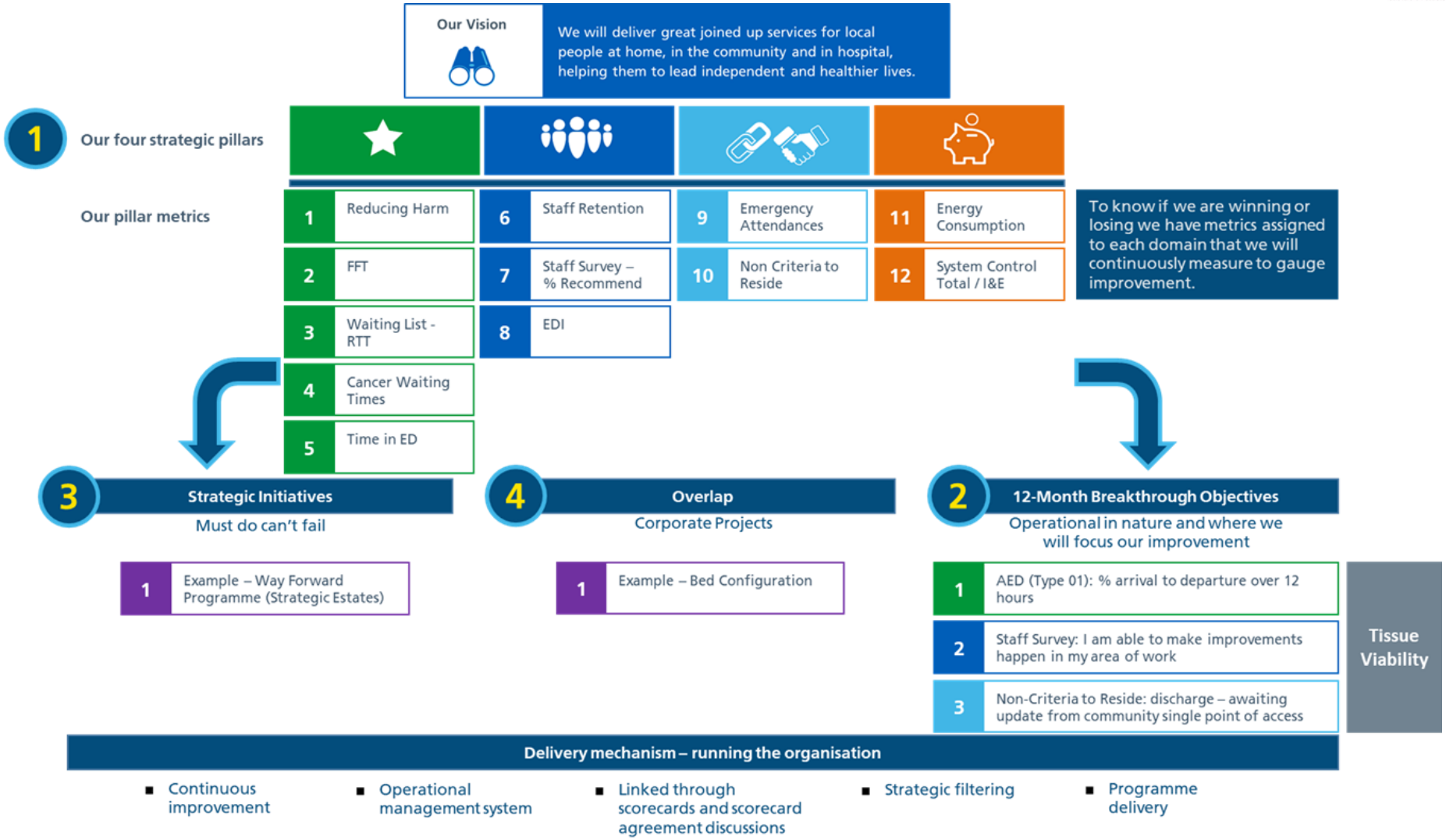
We will deliver great joined up services for local people at home, in the community and in hospital, helping them to lead independent and healthier lives.

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



SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

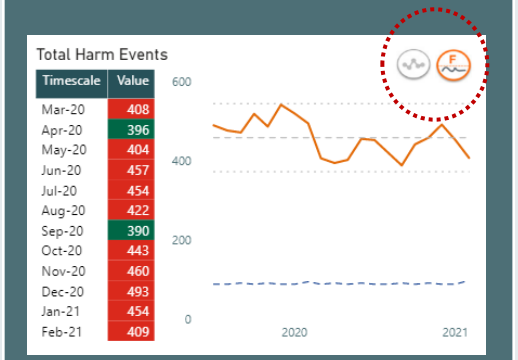
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

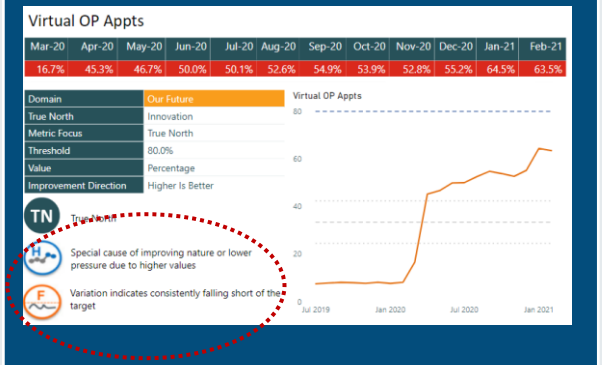
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Total patients waiting more than 52 weeks	1422 (Avg)	612	664	744	852	1028	1215	1568	1926	2164	2,281	2,188	1,817
Total patients waiting more than 78weeks	48 (Avg)	52	47	49	50	52	34	35	44	40	45	68	62
Total patients waiting more than 104 weeks	0 (Int)	0	0	0	0	1	0	0	0	0	1	0	0
Total elective activity undertaken compared with 2019/20 baseline		98.6%	127.0%	90.5%	95.5%	97.1%	87.3%	100.3%	94.2%	86.1%	97.1%	82.1%	90.5%
Total diagnostic activity undertaken compared with 2019/20 baseline		89.0%	83.3%	88.7%	94.6%	92.4%	87.9%	90.5%	101.9%	95.6%	105.2%	98.4%	Reported one month behind
Total Cancer patients waiting over 62 days	210 (Avg)	170	154	133	168	209	268	326	284	258	223	178	150
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	79.3%	80.8%	81.6%	78.9%	79.4%	75.5%	73.3%	66.0%	64.5%	73.4%	78.2%	Reported one month behind
Total patients treated for cancer compared with the same point in 2019/20 (first and		114.2%	100.5%	71.7%	150.5%	85.5%	58.6%	107.1%	106.2%	85.4%	127.1%	123.3%	Reported one month behind
Outpatient follow-up activity levels compared with 2019/20 baseline		84.3%	108.5%	85.6%	89.5%	85.9%	73.9%	94.5%	88.8%	79.7%	97.0%	86.9%	77.2%
Proportion of ambulance arrivals delayed over 30 minutes	43.4% (Avg)	44.9%	39.5%	48.4%	38.9%	26.9%	31.0%	42.9%	46.3%	49.9%	47.2%	60.1%	44.6%
Proportion of patients spending more than 12 hours in an emergency department	2% (Nat)	8.6%	8.0%	8.4%	7.4%	6.4%	6.5%	8.2%	8.4%	8.5%	8.2%	9.4%	8.9%
Ambulance average response times - Category 1	00:10:15 (Avg)	00:11:12	00:11:14	00:10:14	00:09:21	00:09:52	00:10:02	00:10:13	00:09:54	00:10:16	Waiting for data	Waiting for data	Waiting for data
Proportion of patients discharged from hospital to their usual place of residence	94.1% (Avg)	94.4%	94.3%	93.8%	94.1%	93.8%	94.2%	93.9%	94.3%	94.2%	94.0%	93.8%	94.2%
GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	25.1% (Avg)	23.5%	26.6%	26.4%	24.8%	25.4%	24.5%	24.0%	26.1%	26.7%	25.6%	24.6%	22.6%
National Patient Safety Alerts not completed by deadline	0 (Int)	0	0	0	0	0	0	1	0	0	0	0	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (Per 100,000	1 (Avg)	0	0	0	0	0	0	0	0	6	0	0	One month behind
Clostridium difficile infection rate (Per 100,000 bed days)	20.7 (Avg)	13.7	18.5	36.3	11.7	12.9	11.7	17.3	41.7	17.3	41.3	5.7	One month behind
E. coli bloodstream infection rate (Per 100,000 bed days)	41.7 (Avg)	34.1	18.5	54.4	29.3	60.5	52.7	75.0	35.8	11.5	35.4	51.4	One month behind

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Proportion of staff in senior leadership roles who are from BME background	5.5% (Avg)	5.1%	4.7%	4.7%	4.5%	4.5%	4.7%	5.9%	6.0%	6.5%	6.8%	6.8%	Reported one month behind
Proportion of staff in senior leadership roles who are women	68.7% (Avg)	71.3%	70.9%	70.3%	69.1%	68.9%	69.1%	67.0%	66.3%	67.3%	67.5%	67.5%	Reported one month behind
Average hours lost to ambulance handover delays per day	53 (Avg)	62	44	67	48	34	30	51	61	66	60	49	67
Adult general and acute bed occupancy	95.9% (Avg)	94.7%	95.4%	95.7%	96.5%	95.8%	95.3%	97.9%	95.9%	96.5%	95.9%	95.7%	96.0%
Summary Hospital-level Mortality Indicator	0.93 (Avg)	0.88	0.88	0.87	0.86	0.88	0.90	0.93	0.95	0.98	1.00	1.02	1.04
Financial efficiency - variance from efficiency plan (£'000)	+/-	6	46	-34	-424	-209	-289	-268	-247	190	-378	-338	-400
Financial stability - variance from break-even (£'000)	+/-	141	-386	-2506	-2006	-888	-2068	-1848	-1938	-363	-1672	-1502	-1579
Financial stability - variance from PLAN (£'000)	+/-	645	3552	-387	-335	-517	-326	-268	-408	1154	389	164	106

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	Waiting for data
Staff survey engagement theme score	6.9	6.9	6.9	7	7	6.7	Waiting for data
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	0.6	59.6%	54.1%	60.4%	57.1%	56.1%	Waiting for data

Executive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

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

- Pressure ulcers/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.

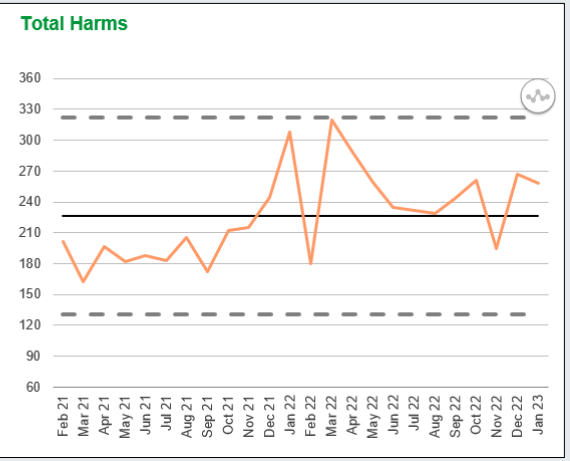
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

We have set ourselves a target for 2022-23 of 86% for the combined positive response rate, this is based on the mean for last year plus 2%.

Total Harms

To achieve and sustain zero avoidable harm.

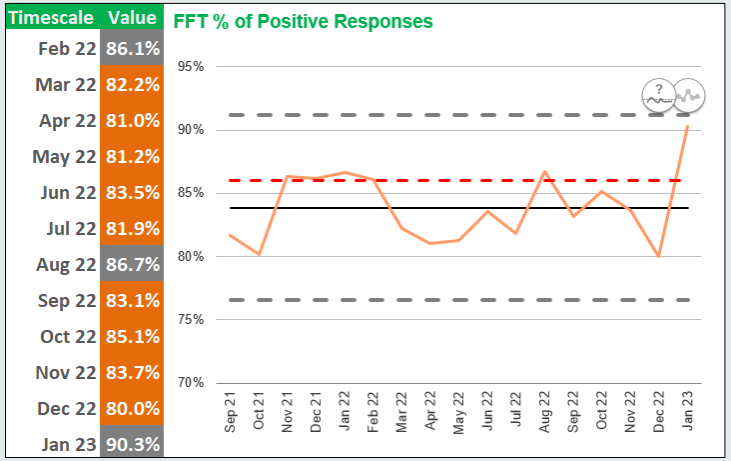
Timescale	Value
Feb 22	180
Mar 22	320
Apr 22	289
May 22	259
Jun 22	235
Jul 22	232
Aug 22	229
Sep 22	243
Oct 22	261
Nov 22	195
Dec 22	267
Jan 23	258



Patient Experience (Friends & Family Test)

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

Timescale	Value
Feb 22	86.1%
Mar 22	82.2%
Apr 22	81.0%
May 22	81.2%
Jun 22	83.5%
Jul 22	81.9%
Aug 22	86.7%
Sep 22	83.1%
Oct 22	85.1%
Nov 22	83.7%
Dec 22	80.0%
Jan 23	90.3%



Counter Measures

The number of avoidable harms has decreased slightly in month, mainly due to a reduction of hospital acquired COVID infections. There has been a small decrease in number of acute pressure harms but an increase in numbers of community pressure harms and falls.

- Hospital-acquired COVID-19 rate remains one of the lowest in the region throughout January.
- Actions required to maintain this position include installation of Air Scrubbers, staff testing when symptomatic, correct use of PPE, frequent hand hygiene, vigilance of monitoring of symptoms in staff and patients.
- Improving Together methodology being used to ensure alignment in terms of impact and effectiveness of countermeasures and use of "Go and See" visits to ensure senior oversight and scrutiny to support reduction of pressure harms.

For January the number of Family and Friends positive response has significantly increased to 90.3%.

- Staff Civility is the topic for next Schwartz round in March 23 with PALS as main contributor .
- An education video has been recorded linked to "I see you" part of the First Impression Counts improvement work which will be rolled out to all staff
- New First Impressions Count training advertised with a focus on supporting front line/reception/administration staff
- Head of Patient Experience working with switchboard team to understand main areas of challenge for members of the public contacting departments for waiting list information

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

Cancer 62 Day

In December, there were 30.5 breaches in total, with 12.0 of these attributed to the Skin pathway that we have not historically seen. This is due to the capacity challenges we have seen along with the unprecedented level of demand. We have also seen greater than normal breaches in Urology with 10.5. Over half the breaches can be attributed to our capacity for TRUS Biopsies.

Without the Skin breaches we would have achieved 82%

RTT: 18 Week Compliance

In January 2023, the RTT 18 Week Compliance improved by 2.23% in month along with a Patient Tracking List (PTL) decrease of 849 (2.4%). The improved RTT 18 week compliance has also been driven by a 11% increase in referrals into the Trust in month.

52 week breaches decreased in month by 371 (17%). Neurology, Dermatology, Gastro, General Surgery, T&O, Urology and Plastics had highest reduction in number of 52+ week waiters from last month.

There was a small improvement in the 78 week position with a decrease of 6 in month. Increases in Respiratory Medicine and Neurology were compensated by decreases in ENT and Urology.

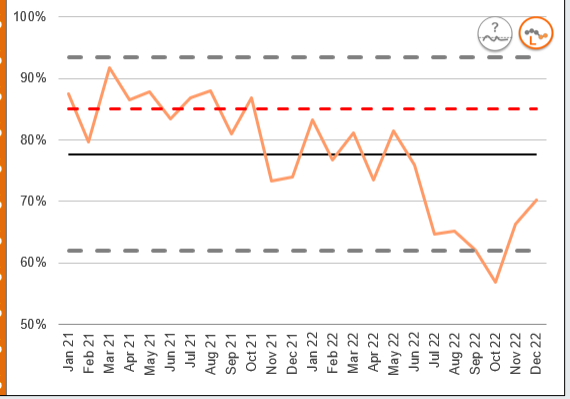
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

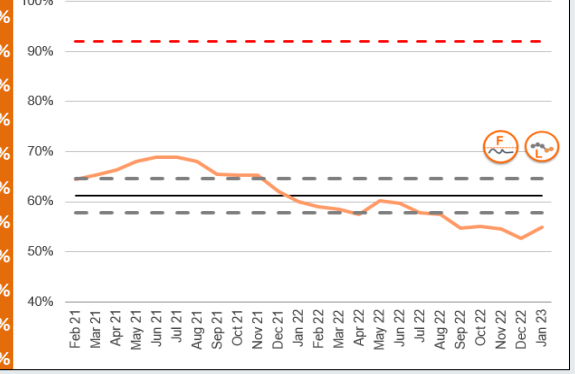
Timescale	Value
Jan 22	83.2%
Feb 22	76.8%
Mar 22	81.2%
Apr 22	73.5%
May 22	81.5%
Jun 22	76.0%
Jul 22	64.7%
Aug 22	65.1%
Sep 22	62.0%
Oct 22	56.9%
Nov 22	66.4%
Dec 22	70.2%



RTT: 18 Week Compliance

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

Timescale	Value
Feb 22	58.98%
Mar 22	58.45%
Apr 22	57.39%
May 22	60.15%
Jun 22	59.65%
Jul 22	57.85%
Aug 22	57.43%
Sep 22	54.74%
Oct 22	55.07%
Nov 22	54.60%
Dec 22	52.60%
Jan 23	54.83%



Counter Measures

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

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

Risk: Urology Pathway are often complex requiring multiple diagnostics, with multiple treatment options needing to be discussed at Tertiary centres before treatments can be planned. Patients requiring additional treatment following an incomplete TURBT procedure will breach due to recovery and planning time.

Mitigation: Pathway improvement manager is working with service to implement the best practice timed pathway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team are undertaking LATP biopsy training with a view to reducing the demand on TRUS biopsies.

Risk: Insufficient theatre capacity to meet activity plan due to anaesthetic and theatre staffing.
Mitigation:
- Phase 1 of theatre business case approved and substantive recruitment underway.
- Agency staffing secured whilst substantive recruitment underway.
- In house Fee Per Case launched for weekend operating.

Risk: Insufficient clinic capacity to meet activity plan.
Mitigation:
- Additional outpatient capacity (including diagnostic) being provided across medicine and surgical specialties throughout Q4.

Risk: Insufficient capacity to recover 78 and 52 week + breach position resulting in poor RTT 18 Week compliance.
Mitigation:
- Patient level details/plans updated on weekly basis in line with recovery trajectory.
- Insourcing activity commenced in Gastro.
- Unfit patients/patient choice being managed in line with Trust Access Policy.

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

Pillar Metrics

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime wait for a patient in January 2023 was 503 minutes against the national standard of 240 minutes, an improvement since last month. Reduced attendances in January, coupled with discharge drive resulting in reduced LOS (Drop in 21+ days LOS) contributed to this reduction. Flow in ED remained challenging despite this, contributing to ambulance handover delays, although these again were reduced.

Emergency Care – Urgent Treatment Centre - Mean Stay

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

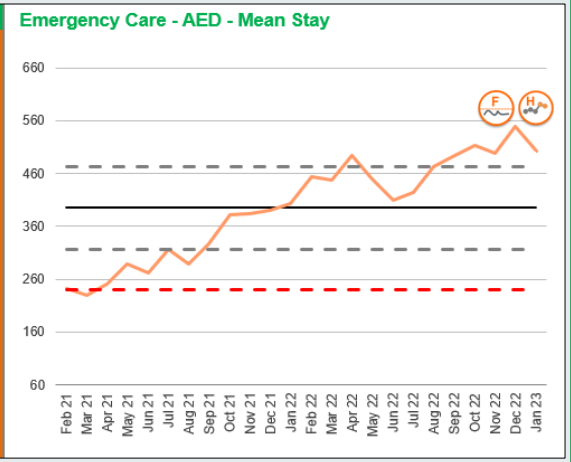
The total meantime wait for a patient in January 2023 was 151 minutes against the national standard of 240 minutes demonstrates good flow through the service. Whilst the attendance through the year has continued to increase, particularly high in December due to increased Paediatric attendances, there was a decrease of 23% in January 23 compared to December 22

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

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

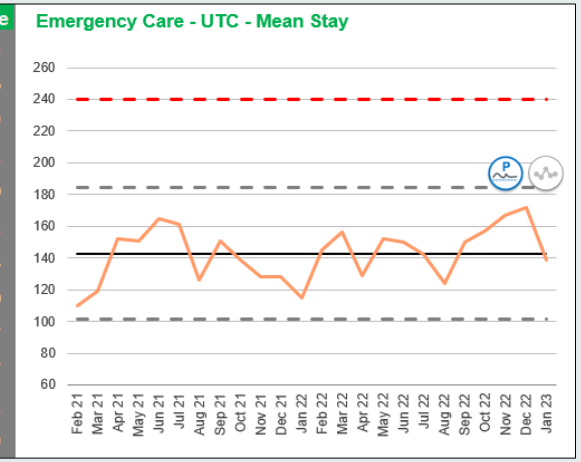
Timescale	Value
Feb 22	453
Mar 22	448
Apr 22	493
May 22	450
Jun 22	409
Jul 22	425
Aug 22	473
Sep 22	494
Oct 22	514
Nov 22	499
Dec 22	550
Jan 23	503



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Feb 22	145
Mar 22	156
Apr 22	129
May 22	152
Jun 22	150
Jul 22	142
Aug 22	124
Sep 22	150
Oct 22	157
Nov 22	167
Dec 22	172
Jan 23	139



Counter Measures

- Significant improvement in Triage times has been maintained for 3rd consecutive month
- Winter slippage monies continue to be spent on Paeds ED Twighlight nurse & weekend Consultant; will reduce impact on staffing numbers overall during peak times and improve quality of care
- Winter slippage monies continue to be spent on Pit-stop nursing; provides clinical oversight of queue, starts assessments early & potential for simple treatments
- Winter monies continue to be spent for dedicated transfer porters; supports reduced nursing time off the ward with prompt transfers and diagnostic moves
- Increased capacity for Triage of self-presenting patients (Triage cubicles x2), assessment of 'ED Majors' patients (6 bays) and provision for early ambulance assessment (Pitstop x1)

- Metric routinely meeting standard
- Roster change trial implemented for staff to increase staffing model mapped to key times of patient arrival – extension continues
- 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

Great Western Hospitals NHS Foundation Trust

Emergency Department & Urgent Treatment Centre - Emergency Attendances

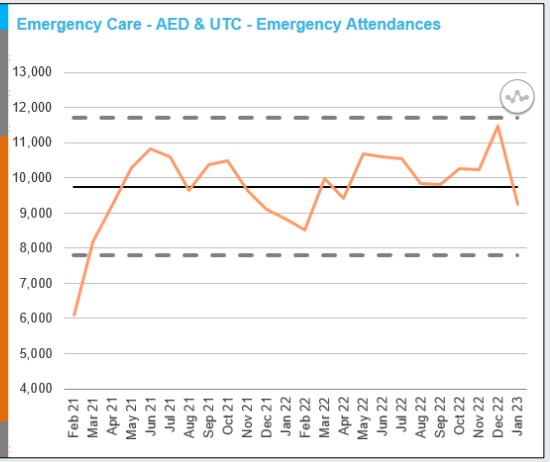
Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). November saw a continued high level of Emergency attendances to both ED & UTC, although this was significantly reduced from December. It is possible that public response to external factors such as strike action contributed to this.

Whilst this is a marker of the continued pressure at our front doors, decreased attendances likely helped with performance. **2606 fewer patients attended ED & UTC** (ED 1333, UTC 1273) compared to December 22. There was a corresponding reduction in the number of long stay patients >21 days with a levelling of NCTR bed days. This again was likely to be impacted by increased discharges for strike preparation with Critical Incident periods at the end of December into early January.

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

To ensure patients are cared for in the appropriate setting

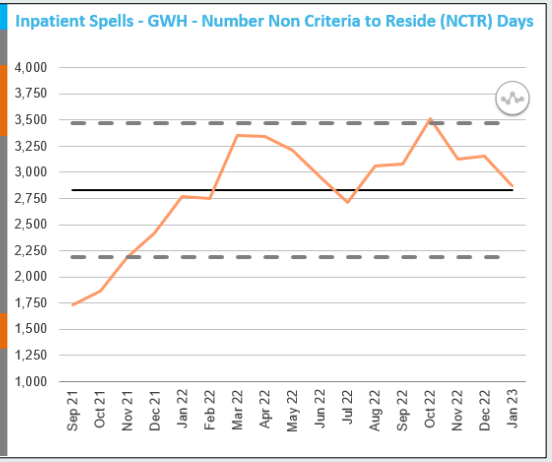
Timescale	Value
Feb 22	8,523
Mar 22	9,994
Apr 22	9,415
May 22	10,684
Jun 22	10,596
Jul 22	10,554
Aug 22	9,846
Sep 22	9,803
Oct 22	10,272
Nov 22	10,240
Dec 22	11,474
Jan 23	9,252



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

To treat the right patients in the right place, to ensure delivery of high quality care.

Timescale	Value
Feb 22	2,747
Mar 22	3,357
Apr 22	3,343
May 22	3,209
Jun 22	2,953
Jul 22	2,712
Aug 22	3,057
Sep 22	3,083
Oct 22	3,514
Nov 22	3,125
Dec 22	3,158
Jan 23	2,873



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

This metric highlights the total number of bed days lost on inpatient spells for patients who are deemed to be Non-Criteria to Reside.

Bed days lost to patients with a NCTR has made 21% reduction over the past 4 months and is currently on a good trajectory for meeting the first milestone of 30% reduction.

Counter Measures

Pre- hospital

- BSW Care Coordination centre linking with the BSW Care Co hub which offers more intelligence around potential admissions and further medical support for clinical assessors 24hrs giving better opportunities for non- conveyances with OOH GP support.
- Great engagement from care Home event which will support 7 days working with Clinical Assessors and Safety Netting building on care home confidence to 7- day admissions.

Peri hospital

- **Ov**erall reduction in Los and NCTR currently performing 2nd best trust in the Southwest which is great to see. A significant reduction noted in GWH 50 day plus NCTR currently 3 complex cases being discussed on the expert panel.
- Next priorities- A3 modelling with flow and divisions for non - bedded LOS and Longest pt' bed' waiting list to support prioritising patients at all entry points. Vision to get to one place of truth for bed request and bed allocated list.

Post hospital

- Discharge hub is showing early signs of being very successful with most simple pathway 1 patients having EDD's within 48hrs
- Home First have achieved 3 patients plus a day throughout January with some discharges over weekends. This has been one of the most improved pieces of discharge work over 4 months from 13 pts per month to over 60.
- Next priorities to review a 7-day model for Discharge hub and increase HomeFirst slots to support further SW assessments out of hospital.

Felicity Taylor-Drewe
Chief Operating Officer

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Voluntary Staff Turnover (rate)

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

Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Staff turnover has been stable over the last 3 years until Feb/March 2021. Since Feb/March 2021 we have started to see a steady increase in turnover levels.

Since July 22 there has been a steady reduction in Vol turnover however Dec there was a small increase.

Staff Recommendation as a Place to Work

The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

In the South West we are no. 17th as an organisation. We want to see an overall improvement in our staff survey results and our position in the South West. Our current performance could have an impact on our reputation as an employer, staff retention and staff morale.

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

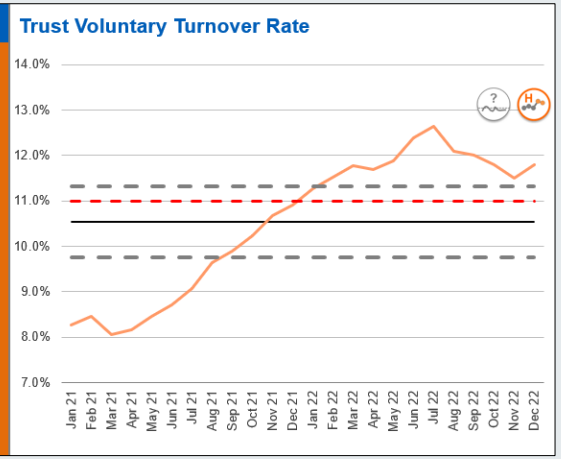
Quarter 2 shows that we remain stable, we await the annual staff survey results to see if there has been an improvement in this question.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

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



Staff % recommend the organisation as a place to work

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

Counter Measures

- Refresh of the A3 and development of a Trust wide working group underway to monitor progress and impact.
- The Trust Military Covenant – Reservist & AF Veterans Working Group Trust submitted the Armed Forces ERS Gold expression of interest on 10 January 2023 and application due 15th March 2023.
- Deputy Chief Nurse chairs weekly International Nurse 'Stay & Thrive' meetings for 2023. February launch of 6-weekly new recruit post-induction/OSCE survey and 4 monthly all cohort survey on work, pastoral care, career and professional development. Survey Monkey feedback collation anticipated April 2023.
- The Trust promotes access to the 'Stay Conversation' with department expert to advise resources, polices, opportunities available to support individual circumstances and retain staff.

- Trust Winter wellbeing events in-month include weekend yoga retreats, Psychological wellbeing sessions, Art Therapy, Tea Trolley rounds, Menopause support & Retirement sessions. Happiness events being held in the Academy and the Orbital. A new initiative 'Well-Man Drop-In' sessions launched February for our male colleagues in February to improve their access to health and wellbeing support.
- Trust working closely with the RCN in preparation for strike days on Monday 6th and Tuesday 7th February to support those staff who are participating or sustaining services, and to mitigate impact on Trust reputation and staff morale.
- Save the dates for this year's staff recognition (Staff Awards and Great West Fest) events have been promoted to staff.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Disparity Ratio %

The trust has launched an ED&I strategy having identified this as an essential component to a satisfied and productive workforce and a inclusive workplace.

The trust has a focus on addressing health inequalities within the local population and an effective ED&I strategy and successful implementation of this within the trust can model this approach and more effectively leverage internal expertise in this area, as well as making GWH a strong anchor institution.

We want to measure ED&I across all areas and this is currently a work in progress to identify the right metric—workforce by ethnicity can be used as a proxy measure for now.

At GWH, some staff are unevenly represented through different levels, broadly with over representation at junior levels and under representation in senior leadership positions. The nature of some roles within the trust can be static at certain levels, resulting in under -representation of certain groups.

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

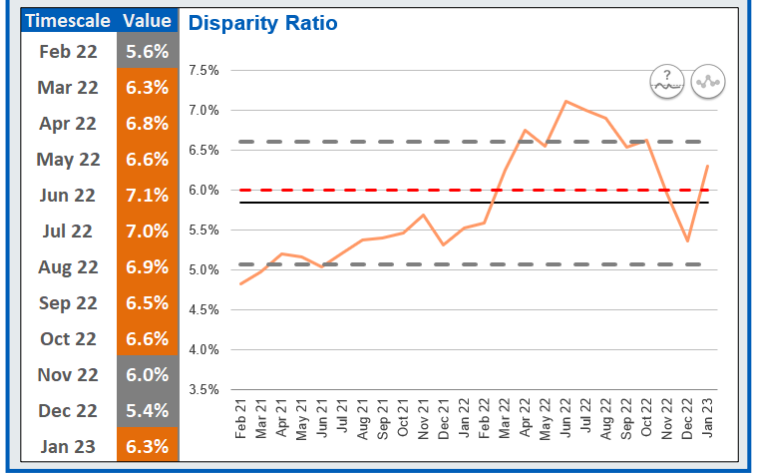
This data measures the difference in the proportion of BAME staff at lower bands (1-5) to higher bands (8a-9) compared to the proportion of White staff at those bands and tells us that our BAME staff are less likely to access progression to higher pay bands. We have seen a reduction in this disparity recently, however in January this has increased.

Jude Gray
Director of Human Resources (HR)

Disparity Ratio

To ensure a broad and diverse workforce to best represent the community we serve.

Timescale	Value
Feb 22	5.6%
Mar 22	6.3%
Apr 22	6.8%
May 22	6.6%
Jun 22	7.1%
Jul 22	7.0%
Aug 22	6.9%
Sep 22	6.5%
Oct 22	6.6%
Nov 22	6.0%
Dec 22	5.4%
Jan 23	6.3%



Counter Measures

- The EDI lead is coordinating the implementation of the Equality Delivery System (EDS 2022) – an improvement tool enabling conversations with patients, public, staff and Trade Unions to develop services, workforce and leadership and includes assessment of the physical impact of discrimination, stress and inequality.
- The BAME staff network engaging with communication team to launch Race Equality Week on the 6th February 2023 and promote race equality and develop positive working relationships across the Trust for the BAME community and the wider network of staff with protected characteristics.

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Executive Summary

Great Western Hospitals NHS Foundation Trust

Financial Position (I&E Margin)

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

Carbon Footprint / Sustainability

Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and also for indirect emissions by 2045. In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032.

In lieu of our carbon footprint data from Greener NHS (anticipated for early Q3) this report focus is on electricity and gas consumption which forms a significant part of our direct carbon footprint.

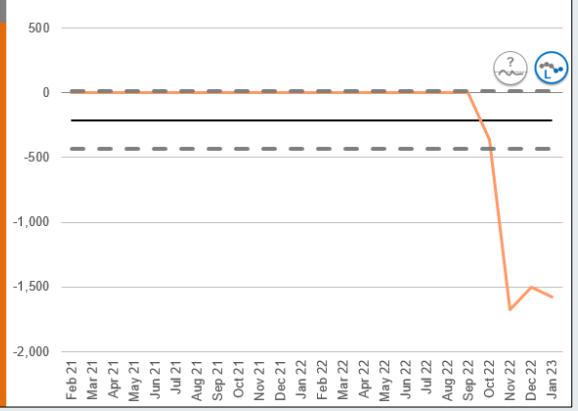
Over the coming years we will be focusing on the delivery of our Green Plan and ICS Green Plan which will be formally reported on annually and refreshed every 3 years.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break even financial position.

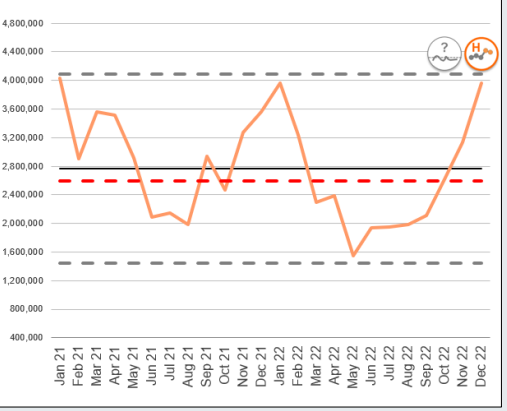
Timescale	Value
Feb 22	0.14
Mar 22	-0.26
Apr 22	-0.39
May 22	-2.01
Jun 22	-0.89
Jul 22	-2.07
Aug 22	-1.85
Sep 22	-1.94
Oct 22	-363
Nov 22	-1672
Dec 22	-1502
Jan 23	-1579



Energy consumption (kWh) – Electricity & Gas

To achieve an organisational carbon neutral footprint.

Timescale	Value
Jan 22	3,962,246
Feb 22	3,237,168
Mar 22	2,293,826
Apr 22	2,388,534
May 22	1,543,874
Jun 22	1,940,413
Jul 22	1,953,493
Aug 22	1,983,344
Sep 22	2,115,111
Oct 22	2,613,274
Nov 22	3,136,178
Dec 22	3,961,047



Counter Measures

- At M10 the ICB position has changed to retrospectively claim for an extra £200m of social care discharge funding and primary care additional roles reimbursement. This reimbursement come to (£0.9m in m10). Excluding this change the ICB is continuing to report that it's forecast income will match costs but continues to report a deficit YTD due to the phasing of the intra-system risk share. A risk of £4.4m is being reported due to the increased national pricing for CATM and NCSO drug costs in primary care. This is a national cost pressure and there may be national funding to support it but this is yet to be made available.
- At Month 10 GWH year-to-date position is a deficit of £16.4m which is £0.1m worse than plan.
- Countermeasures have been put in place:
  - Relevant divisions remaining in enhanced support
  - Focus on actions to reduce run rate
  - Enhanced workforce controls
  - Targeted work on efficiencies including driving out benchmarked opportunities
  - Drive on productivity including theatre rescheduling
  - Centralised review of utilised provisions

•The board approved Green Plan has been published with targets and action plan agreed.
•Capital funding for sustainability projects has been agreed and work is underway on reducing emissions from nitrous oxide and entonox at GWH.
•GWH is the ICS Green Plan chapter lead for reducing emissions from Medical Gases.

Pillar Metrics

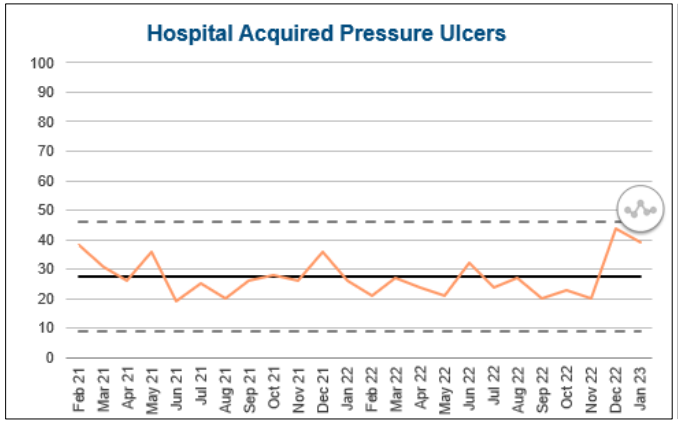
2022/23 Breakthrough Objectives

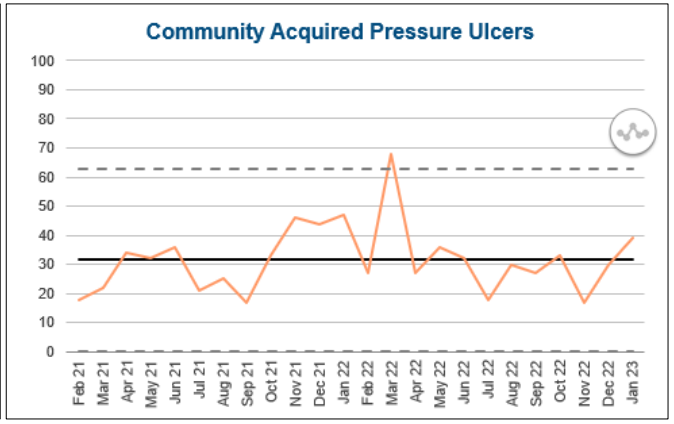
Reduction of Pressure Ulcer/Harms

Great Western Hospitals NHS Foundation Trust

Total Pressure Ulcer

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
48	95	51	57	64	42	57	47	56	37	74	78





Common cause – no significant change

Understanding the Data

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

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

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

We are driving this measure because...

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

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

Performance

There were 39 hospital-acquired pressure harms during January.

- This is a slight decrease compared to last month (44) but remains high.
- Multiple factors continue to contribute to this high level of harm, but a persistent theme is missed opportunities to detect harm (or the risk of harm) at an early stage and thus to take action to prevent deterioration.
- Wards that had a high number of pressure ulcers in January are not those that had high numbers in December; this highlights the challenge of ensuring this is a focus for all wards.
- Replacement of foam mattresses for hybrid mattresses begins in February, hybrid mattresses can provide an immediate dynamic (pressure relieving) surface ensuring at risk patients can immediately be "stepped up " to the appropriate mattress to prevent pressure harm. .
- Improvements underway to the reporting and investigation process to aid early identification of learning.

In the community setting there were 39 pressure harms acquired during January.

- The Improving Together approach continues with a focus on reduction in Category 2 pressure harms and has identified that high numbers of category 2 harms once identified are not deteriorating in significant numbers, indicating they are being managed well. Between May and October only one category 2 harm deteriorated to a category 3.
- Community teams recognise End of Life patients are at higher risk of skin damage, specific actions are being identified through a thematic analysis of the data. Immediate actions will involve a review of the documentation and information provided to patients and their families and a review of equipment available to patients.

Risks

In the Acute setting the TVN team have a 50% staffing gap due to vacancy and absence. Vacancy due to be advertised shortly and absence expected to resolve in late February.

In the Community the continuing high case load and difficulties in recruiting to establishment in the Community Nursing services and Tissue Viability services can impact the ability to provide high quality pressure ulcer prevention management, specialist review and assessment.

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

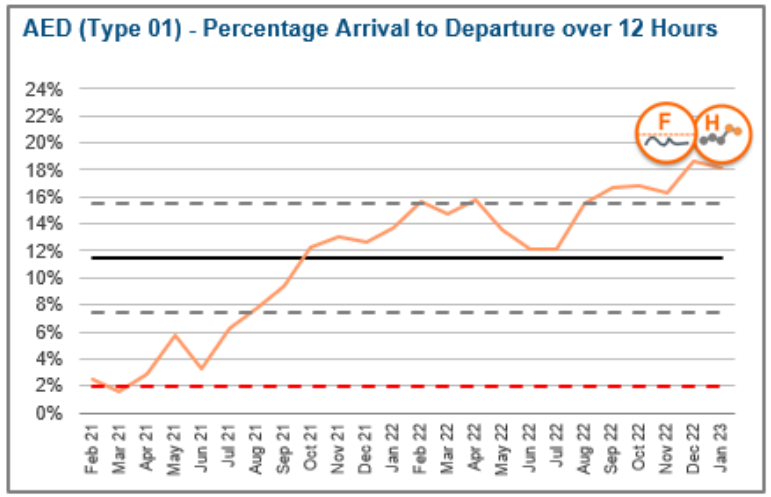
Emergency Department (Type 1) - Percentage Arrival to Departure over 12 Hours

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
15.7%	14.7%	15.8%	13.6%	12.2%	12.1%	15.4%	16.6%	16.9%	16.3%	18.7%	18.1%

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

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

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



Understanding the Data

Total number of patients who have a total time in ED (Type 1) over 12 hours from
arrival to admission, transfer or discharge.

The clock starts from the time that the patient arrives in ED and it stops when the
patient leaves the department on admission, transfer from the hospital or discharge is completed

We are driving this measure because...

To reduce the number of patients who have waited over 12 hours in ED. The target is to not have more than 2% of all patients who attended ED waiting over 12 hours.

Performance

- %>12 hour waits in ED – slight decrease through January associated with reduced mean ED time and reduced attendances
- x161 12-hour reportable Decisions to Admit (DTA) breaches – a decrease of 9 from last month (previous criteria)
- Clinically Ready to Proceed (CRTP) automatic reporting in Careflow operational. Indicates that average split CRTP/Waiting bed is 35%/65% average over the last 12 months. This indicates flow being a major contributor to delays in ED.
- Long stays did decrease in early January although timing of bed availability is still challenging contributing to stays beyond 12 hours. % beds occupied by long stayer (21+ days) is at a similar level to January 21, although has been greater than this for the intervening 12 months.

Risks

Fluctuating IP&C conditions requiring isolation/co-horting may impact on flow out of ED and contribute to increases in 12 hour waits.

LOS and % of longest stayers will impact on bed availability and flow out of ED resulting in increased time in ED and likelihood of 12 hour waits.

Increased surges of ED attendances, particularly out of hours, alongside bed availability could contribute to increases in 12 hours waits in ED.

Reconfiguration works as part of IFD, with associated capacity issues, may impact ED & UTC which may impact on 12 hour waits in ED

2022/23 Breakthrough Objectives

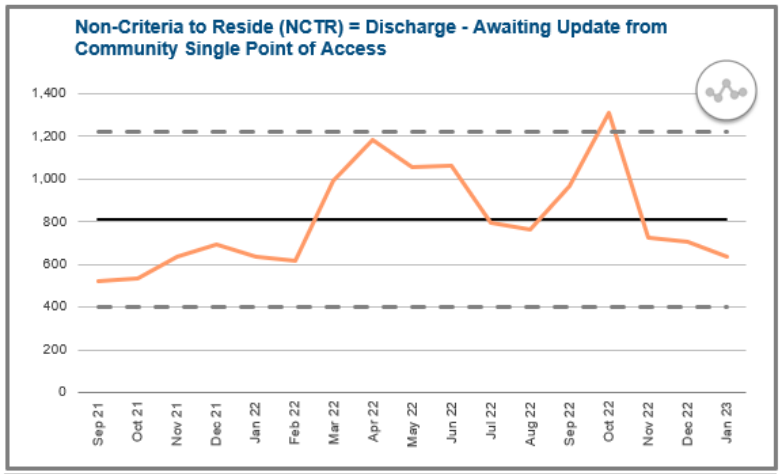
Great Western Hospitals NHS Foundation Trust

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

Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
618	993	1185	1053	1060	795	760	968	1309	723	703	635

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

Common cause - no significant change



Understanding the Data

This Breakthrough objective will primarily capture PW1,PW2,PW3 patients as by definition PW0 are simple ward led discharges. A small number of patients on PW0 may require social care support outside of healthcare needs and this group will be inclusive within this modelling.

This is linked closely to the BSW improvement work of reducing NC2R patients by 30% from a Dec 2022 baseline.

The data surrounding updates from Single Point of Access is directly related to lost bed days and therefore the time patients wait to leave the Acute Trust.

We are driving this measure because…

In a 12-month period more than 10,000 bed days were lost within the discharge criteria 'Awaiting update from Community Single Point of Access'.

Internally the aim is to refer patients that require social care support for discharge as soon as this has been identified as a discharge care need. Different referral approaches from localities can be a barrier to being proactive with discharge planning from admission.

One of the aims of this breakthrough objective to use the data to demonstrate the value of being able to refer patients to partners before they a medically safe to leave hospital, building on a collaborative uniform ICA approach.

Further delays to patients' discharges can be increased waiting for social care assessment, outcomes and inventions required to proceed with that discharge. Patients with complex care needs can experience significant lengths of stay which increases further risk of harm to the patient. Improvements through internal professional standards set by time metrics, and implementation of assessments in the community using the D2A model will support reduction in the total bed days lost.

Performance

Delighted to report further continued success in reducing bed days. From the approximately 1250 days in Oct to 620 in Jan resulting in a 48 % improvement trajectory.

Counter Measure

Business case to support a discharge hub with senior support 7 days a week.

Explore ideas around modelling the success on pathway 1 processes to the other pathways

Develop a process for supporting Medical outliers stranded CtR /NcTR clinical reviews bi- weekly.

Risks

Unable to deliver a 7-day discharge hub service that is supported with all localities working on patient caseloads over weekends and weekend Home First capacity.

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

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

2017	2018	2019	2020	2021	2022 Q1	2022 Q2	2022
52.4%	49.4%	56.7%	54.5%	49.3%	50.3%	51.1%	51.9%

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	
Value	Percentage
Improvement Direction	Higher is Better

Understanding the Data

The Staff Survey results are predominantly aimed at service improvement. It is important to know if staff could provide the care and service they aspired to give.

We are driving this measure because...

This staff survey feedback is extremely important. The result of this survey could help how staff feel about making improvements happen in their workplace.

Performance

The Trust Staff Survey Results 2022 to be presented 8th and 15th February to Executives and senior management team and to inform the annual plan and area of A3 focus. These results remain embargoed.

The monthly Staff Survey working group has identified the value of surveying a wider and less targeted cohort of staff across Divisions to include those areas who may not report as a hotspot area for improvement and who can nevertheless provide a rich source of improvement ideas. Example – Community Nursing.

Since 2021 and the launch of the improving together training, the Trust has made steady progress in improving this scored.

The Staff Survey working group have been shared the data for the Division and there are identifying areas of success and challenge and are asked to share at the next working group to identify any key Trust wide actions that can be added to the counter measures.

Risks

- Divisions need to ensure that countermeasures are demonstrating a positive impact prior to rolling out across the whole division and align with the Trust breakthrough objective.

- Divisional teams continue improving together training in different timescales, therefore the risk is that less improvement actions could be made in areas who are yet to go through training. 100 members of staff are trained as of February 2023.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
RTT	No. of >=18 weeks waiters		H	16191	16257	16710	15539
	No. of >=52 weeks waiters		H	2164	2281	2188	1817
DM01	No. of patients on DM01 waitlist		H	11725	11313	10770	One month behind
	DM01 performance %	99% (Nat)	H	50.4%	52.3%	48.0%	One month behind
	DM01 6 week wait breaches		H	5818	5394	5597	One month behind
Cancer	% Cancer 62 day performance	85% (Nat)	L	56.4%	67.6%	70.2%	One month behind
	% 28 day faster diagnosis	75% (Nat)		64.5%	72.7%	78.2%	One month behind
	No. of referrals received		H	1762	1843	1328	One month behind

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

Performance & Counter Measure

DM01 performance has decreased in December from 52.32% to 48.03 in November. The number of patients on the waiting list decreased and the overall waiting time has reduced in Radiology. The 2 Pads in Radiology continue to be fully utilised and activity numbers continue to exceed any previous levels. We continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Progress in activity in Ultra-sound and DEXA has also decreased the waits.

Cancer waiting times remain below standard with an increase in demand and a lack of capacity. The Colorectal Pathway is having the greatest impact on all of the 2ww standard with 38.5% of all of the breaches. 72.5% of the 62-day breaches were with the Skin and Urology Pathway.

In December, 80% (313) of the 28 day breaches were for across 5 tumour sites.

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

A Locum started in the Dermatology team in October which has seen the 2ww & 28 day performance recover in December 22. We continue to work with the OUH Plastics team for extra capacity, however, there is a clear deficit in capacity within Plastics that will impact the cancer pathway is unable to be mitigated further without significant staffing and / or investment. This is subject to a strategic service review.

The weekly Elective Access Meetings continues to support improvement work through monitoring of counter measures, identifying support and mutual aid options and review of individual patients within pathways to move on in pathway if required.

Risks

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	H	72.5%	73.1%	72.3%	75.8%
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	H	51.8%	53.4%	50.8%	55.2%
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	H	16.9%	16.1%	18.6%	18.1%
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	5409	5393	5409	5312
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	H	202	212	214	175
	A&E Arrival to Departure Percentage over 12 Hours (All Patients)	2% (Nat)	H	8.4%	8.2%	9.4%	8.9%
	A&E Arrival to Departure over 12 Hours (Admitted Patients)	2% (Nat)	H	36.8%	34.8%	40.9%	35.3%
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2056.34	2048.59	3384.59	2086.60
	Number of Ambulance Handover Over 15 Minute Waits		H	1252	1248	1184	1111
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		69.2%	69.4%	78.0%	68.0%
	Number of Ambulance Handover 30 Minute Waits	SPC	H	904	848	913	729

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

Performance & Counter Measure

ED performance has demonstrated improvement across most areas compared to December 22. Whilst improvement actions continue, this is also likely a reflection of reduced attendances in January.

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

- Triage times have improved for the 3rd successive month; 76% within 15 mins compared to 71% prior month
- Total % over 12 hours has decreased slightly; 18.1% compared to 18.6% prior month
- % over 12 hours Admitted improved; 42.5% compared to 47% prior month
- % over 12 hours Non-Admission reduced a little; 5.6% compared to 6.3% prior month
- % of patients admitted increased slightly; 34% compared to 30% prior month

Counter measures remain in place within the Breakthrough objective slides 10 and 11

Risks

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
ED	Percentage of Ambulance Handover s Over 30 Minutes	SPC		49.9%	47.2%	60.1%	44.6%
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		648	604	688	488
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		35.8%	33.6%	45.3%	29.9%
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		960	895	1056	915
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		322	319	331	293
	Non-Elective Patients Average Length of Stay (Days)	SPC		5.3	5.4	5.7	5.6
	Community Average Length of Stay (Days)	SPC		22	21	18	23
	Number of Stranded Patients (over 14 days)	SPC		150	142	139	134
	Number of Super Stranded Patients (over 21 days)	SPC		89	86	88	79
	GWH Acute Adult Bed Occupancy (%)	SPC		96.5%	95.9%	95.7%	96.0%

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

Performance & Counter Measure

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- % over 12 hours Non-Admission reduced a little; 5.6% compared to 6.3% prior month
- % of patients admitted increased slightly; 34% compared to 30% prior month

Counter measures remain in place within the Breakthrough objective slides 10 and 11

Risks

Pressure to maintain flow and bed availability as we proceed into the winter months ahead, thereby with a potential to impact elective activity. This is mitigated by our Winter plan and work with system partners.

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

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
RTT	No. of >=78 weeks waiters	SPC	L	40	45	68	62
Cancer	% Cancer 31 day performance	96% (Nat)		85.6%	89.7%	82.1%	One month behind
	% Cancer 2 week wait	93% (Nat)		65.4%	76.0%	89.8%	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		93.8%	93.5%	93.7%	95.9%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)		0.0%	0.0%	0.2%	0.0%
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		38.1%	67.4%	69.8%	75.1%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		41.0%	48.5%	39.2%	54.4%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		48.5%	56.4%	35.1%	53.0%
	Total Number of Ambulance Handovers	SPC	L	1810	1797	1518	1634
Flow	Elective Patients Average Length of Stay (Days)	SPC		3.5	3.0	3.3	3.9
	GWH Discharges by Noon (%)	SPC		17.3%	16.8%	17.9%	17.7%

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

Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathway with 100% of the breaches being accounted for by this service. WLI activity in Dermatology is being focused on treatments through December and January. Additional capacity in Plastics is being sourced through private partner (CSP in Wootton Bassett) and through any available mutual aid from OUH

Risks

Pressure to maintain flow and bed availability as we proceed into the winter months ahead, thereby with a potential to impact elective activity. This is mitigated by our Winter plan and work with system partners.

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

Our Care

Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		64%	73%	75%	75%
IP&C	Escherichia coli (E. coli) infections (cumulative)	57.5 (Nat)		54	60	69	81
	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative	15.83 (Nat)		22	25	27	29
FFT	Inpatients Positive Responses	81% (Int)		81%	80%	79%	86%
	Maternity Response Rate	22% (Int)	L	18%	19%	16%	16%

Common cause - no significant change.

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

Performance & Counter Measure

The complaint response rate has not demonstrated any improvement. Early indications show an improved position for February.

The Trust is over our internal trajectory for MSSA and there were two cases in January. The first case was deemed unavoidable, because the abscess that caused the bacteraemia developed before admission and was treated appropriately. The second case is still under investigation as it occurred late in the month.

Cannula practice has previously been identified as an area for improvement and the new Harm-free IV Group met for the first time in January. The roll-out of the new Trust wide licensed skin-preparation product (Hexiprep) has been delayed due to supply-chain issues and is now expected in February. Gaps in skin inspections and documentation of wounds have also been noted as a theme and the IPC team are working with the TVN team to develop a joint approach to improvement on this.

The Trust is over trajectory for *E. coli* bloodstream infections and the gap from trajectory widened in January. Four cases were deemed avoidable in January, with three of those being directly associated with a urinary catheter. IPC are working with the wards involved to ensure action plans are in place to improve practice. To ensure timely investigation and early identification of learning while it is still meaningful, the process for looking at all reportable bacteraemia cases has been revised as of late January. Wards and clinical teams are now more directly involved as soon as the result is known. A wider project around reduction of urinary tract infections across BSW is also ongoing.
There has been improvement in positive responses for family and friends, with 86% in month compared to 79% the previous month.

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
Harm	No. of serious incidents reported in month	SPC		1	0	3	3
	Falls rate per 1000 bed days	SPC		5.5	5.7	5.9	6.6
	No. of Falls in month	SPC		112	113	121	134
	No. falls with moderate harm or above	SPC		5	1	7	2
	Medication incidents with moderate harm	SPC		3	4	2	2
	No. of concerns received	SPC		206	183	116	151
	No. of complaints received	SPC		50	54	41	37
	Number of reopened complaints	SPC		3	7	3	2
IP&C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		1	1	1	2
	Clostridium difficile (C. diff) infections (cumulative)	40 (Nat)		25	32	33	34
	Pseudomonas infections (cumulative)	14.25 (Nat)		6	9	11	12
	Klebsiella infections (cumulative)	19.17 (Nat)		15	16	18	20
	Covid – no. of hospital acquired	SPC		78	31	44	22

Common cause - no significant change.

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

Performance & Counter Measure

The numbers of falls has increased slightly in month and the rate per 1000 bed days the number of falls resulting in severe harm has reduced to two this month.
Trust wide audit of patient footwear was completed in December 22 – 52% patients who were out of bed were wearing shoes or slippers. Focus on footwear during January, SWIFT (Sharing Widely Improves Future treatment) published for safety briefings and trolley rounds

There are currently 13 Serious Incidents under investigation with three reported in January. This shows good maintenance against the previous progress. The clinical risk team also meets with the Divisional quality teams on a weekly basis to provide support.

Concerns have increased in month and complaints remain at similar level to December.

The Head of PALS is doing a pilot trial comparing complaint/ concern numbers against patient activity. This data will give us more robust information about areas with high percentage of concerns/complaints.

The Trust remains below trajectory for *C. diff* infections and *Pseudomonas aeruginosa* bacteraemias and roughly in-line (1 case above trajectory) for *Klebsiella* bacteraemias. All reportable infections are now undergoing a timelier investigative process to identify learning sooner.

Risks

Falls risk are associated with a lack of a Specialist falls service in the community and a lack of Fracture Liaison Service. This increases the risk of secondary fractures for the cohort of at-risk individuals.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	H	96.6%	97.3%	95.4%	98.3%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	H	102.4%	104.2%	104.5%	114.3%
FFT	Overall response rate (%)	26% (Int)		27.2%	25.7%	19.6%	29.8%
	Positive response (%)	86% (Int)		85%	84%	80%	90%
	ED & UTC Response Rate	19% (Int)	H	19%	20%	19%	22%
	ED & UTC Positive Responses	76% (Int)		73%	72%	72%	84%
	Inpatients Response Rate	22% (Int)		24%	23%	20%	26%
	Daycases Response Rate	23% (Int)	H	24%	22%	21%	30%
	Daycases Positive Responses	96% (Int)		94%	95%	96%	96%
	Outpatients Positive Responses	97% (Int)	H	98%	98%	100%	98%
	Maternity Positive Responses	95% (Int)		92%	92%	92%	92%

Common cause - no significant change.

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

Performance & Counter Measures

FFT Data shows significant improvement in response rates in all areas, including positives responses. There is over a 10% increase in positive response rates for the Emergency Department and Urgent Treatment Centre.

Improvement actions in place include:

- PALS liaising closely with departments to ensure patients are receiving direct personal information about their waiting times and plans
- Defence Medical Welfare Service (DMWS) officers now in place to support discharge and admission avoidance
- New connections made with community organisations across Wiltshire to share information and joint working around discharge
- Weekly carers café to restart from 15th February with new volunteers in place to support carers
- Review underway of dedicated patient and family dect phone usage to ensure still in place to support contact
- There has been an improvement in the matron monthly audits related to noise at night following the actions taken to enhance a restful environment
- Work is underway to understand and avoid the number of patient moves at night to help with reducing noise and disturbance

Risks

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
Use of Resources	Capital Expenditure (£'000)	SPC		289	597	1118	652
	Pay (£'000)	SPC		23353	23452	22388	22868
	Non Pay (£'000)	SPC		14218	14816	15878	15521

Performance & Counter Measure

The Trust has capital expenditure of £652k in January against the CDEL programme in total for 2022/23 of £12.5m. Total Capital Expenditure at Month 10 year to date is £8.2m below plan. Of this, £6.4m relates to Trust CDEL schemes, with the remaining £1.8m slippage on externally funded schemes.

Though the Year capital expenditure is low, the capital team have been meeting with divisions, project leads, and procurement to monitor progress and ensure the allocated funding is spent. Purchase orders to the value of £4m since December have been raised which are leading to an increase in spend.

Pay costs are c£0.5m higher than the previous months as bank and agency costs have both increased in month (£0.5m combined). Pay overall is however our biggest cost and a key contributor of our variances.

Non-Pay costs have increased significantly from 2019/20, with the 2022/23 run rate relatively static in year but it has decreased this month vs. Previous month and this is predominantly driven by a review of its balance sheet provisions.

Risks

The Trust is expected to breakeven for this financial year but does have some financial risk relating to this year. These mainly relate to further elective recovery activity costs being above income levels received and also inflationary costs. Other risks include negotiation of financial outturns with commissioners of cost & volume vs income.

Common cause - no significant change.

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
Workforce	Trust sickness absence rate	3.5% (Int)		5.3%	4.9%	5.8%	One month behind

Performance & Counter Measure

Sickness increased in month to 5.8%, (no change from 2021) of which 3.6% is short term and 2.2% is long term. Of total sickness absence, 0.8% is Covid-19 related and the same rate for the previous year.

The national data on NHS digital is 3 months behind and in September 2022 was reporting national sickness levels of 5% compared to GWH of 4.76% in September.

The Trust first absence working group is scheduled for the 16th February which will analysis the information from the NHS absence toolkit finding and agree action to take forward. As part of this working group a A3 will be used to identify hotspots and focus areas.

Risks

Increase in seasonal flu and Covid numbers is impacting short term sickness absence compliance.

 Common cause - no significant change.

Our People

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-22	Nov-22	Dec-22	Jan-23
Workforce	% of leavers within 1st year of employment	31.2% (Int)		23.8%	29.8%	22.7%	One month behind

Plan Area	Metric	2017	2018	2019	2020	2021	2022 Q1	2022 Q2
Staff Survey	Staff Survey response rates	46.5%	43.6%	40.0%	53.4%	39.5%	21.4%	23.6%
	My immediate manager takes a positive interest in my health and well-being	68.8%	67.5%	74.8%	69.2%	64.4%	Not in Quarterly Survey	Not in Quarterly Survey

Performance & Counter Measure

The % of leavers within 1st year of employment has decreased in month to 22.73%. Key themes for staff leaving continue to be 'Work/Life Balance' and 'Relocation' choice.

30.19% of leavers are during first year of employment. Identified as hotspot amongst HCAs in the Acute Divisions of the Trust.

Risks

Common cause - no significant change.

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
	Vacancy															
W	Vacancy Rate %	%	7.00%	6.91%	6.77%	6.33%	8.03%	7.31%	6.94%	7.48%	6.70%	6.31%	6.56%	5.97%	6.23%	7.43%
W	Vacancy WTE	WTE	-	350.82	343.65	321.55	415.32	377.16	358.52	386.57	347.09	328.65	343.04	313.11	329.52	392.94
W	Nursing Vacancy %	%	7.00%	5.60%	5.31%	4.59%	7.40%	6.44%	5.27%	5.62%	4.88%	5.58%	5.95%	5.27%	5.62%	6.51%
W	Nursing Vacancy WTE	WTE	-	135.51	128.45	110.90	184.68	160.51	131.68	140.23	122.71	141.28	151.92	135.61	146.64	170.25
W	Registered Nursing Vacancy %	%	7.00%	1.33%	1.05%	1.10%	5.52%	6.23%	7.16%	7.66%	7.63%	7.28%	6.63%	6.43%	7.09%	7.69%
W	Registered Nursing Vacancy WTE	WTE	-	21.80	17.24	18.02	93.88	105.75	121.70	130.36	130.09	124.54	113.96	110.89	123.59	133.79
W	Unregistered Nursing Vacancy %	%	7.00%	14.63%	14.31%	11.95%	11.41%	6.88%	1.25%	1.24%	-0.91%	2.04%	4.54%	2.91%	2.66%	4.17%
W	Unregistered Nursing Vacancy WTE	WTE	-	113.71	111.21	92.88	90.80	54.76	9.98	9.87	-7.38	16.74	37.96	24.72	23.05	36.46
W	Medical Vacancy %	%	7.00%	7.01%	8.08%	6.89%	9.00%	8.68%	8.94%	9.57%	6.53%	3.64%	5.73%	5.80%	5.43%	5.61%
W	Medical Vacancy WTE	WTE	-	47.99	55.32	47.14	63.55	60.96	62.75	67.19	45.84	25.59	40.26	40.74	38.33	39.16
W	STT/AHP Vacancy	%	7.00%	7.92%	7.45%	7.36%	7.84%	7.11%	7.44%	8.94%	8.25%	7.57%	6.89%	6.09%	6.54%	6.97%
W	STT/AHP Vacancy	WTE	-	65.57	61.71	60.99	64.89	58.82	61.57	74.04	68.37	62.72	57.10	50.49	54.28	57.85
W	SMA Vacancy	%	7.00%	8.88%	8.57%	8.95%	8.97%	8.50%	8.98%	9.21%	9.66%	8.68%	8.21%	7.55%	7.88%	10.97%
W	SMA Vacancy	WTE	-	101.75	98.17	102.52	102.20	96.87	102.52	105.11	110.17	99.06	93.76	86.27	90.27	125.68
W	Recruitment Time to Hire	Days	46.00	50.60	52.20	56.90	61.20	67.70	67.90	62.00	61.10	74.70	63.70	74.30	72.30	91.30
	Workforce Utilisation															
W	Budgeted vs Worked WTE Variance	WTE	-	149.44	129.31	240.44	58.44	89.92	91.14	138.16	191.33	121.30	71.71	184.20	87.52	20.87
W	Actual Worked vs Budgeted %	%	-	2.94%	2.55%	4.74%	1.13%	1.74%	1.76%	2.67%	3.69%	2.33%	1.37%	3.51%	1.65%	0.39%
W	Total Workforce Cost £	£	-	£22.06M	£22.00M	£19.99M	£23.15M	£22.93M	£23.22M	£21.61M	£22.66M	£26.58M	£23.35M	£23.45M	£23.54M	£22.87M
W	Agency Spend as % of Total Spend	%	6.00%	7.13%	7.74%	7.60%	6.88%	6.57%	6.36%	4.18%	6.23%	5.65%	6.53%	6.17%	5.97%	5.60%
W	Agency Spend £	£	-	£1.58M	£1.71M	£1.77M	£1.51M	£1.44M	£1.42M	£0.91M	£1.37M	£1.55M	£1.53M	£1.48M	£1.41M	£1.28M
W	Agency WTE	WTE	-	124.18	120.02	139.35	113.88	124.59	117.85	121.32	134.43	137.51	127.69	113.12	109.26	102.88
W	Bank WTE	WTE	-	350.76	320.03	386.55	316.65	311.77	304.96	377.97	375.45	285.71	258.31	354.47	278.67	310.93
W	Registered Nursing Bank Fill	%	45.00%	46.43%	48.71%	47.77%	45.24%	44.86%	47.06%	44.47%	37.65%	46.55%	48.28%	53.79%	43.59%	55.35%
W	Unregistered Nursing Bank Fill	%	70.00%	62.61%	62.23%	62.47%	63.53%	69.74%	75.58%	72.52%	69.80%	72.93%	66.26%	70.80%	62.97%	80.03%

Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
	Retention															
W	All Turnover %	%	13.00%	13.63%	15.26%	15.59%	14.89%	14.82%	15.46%	15.90%	15.00%	14.87%	14.69%	14.52%	14.90%	-
W	Voluntary Turnover %	%	11.00%	10.01%	11.40%	11.66%	11.89%	11.88%	12.38%	12.64%	12.07%	12.00%	11.78%	11.54%	11.84%	-
W	Number of Leavers	Headcount	-	68.00	64.00	70.00	68.00	55.00	80.00	78.00	49.00	65.00	57.00	54.00	66.00	-
W	Number of RN Leavers	Headcount	-	17.00	22.00	25.00	21.00	18.00	17.00	16.00	12.00	15.00	8.00	6.00	13.00	-
W	Registered Nursing Vol Turnover	%	-	9.11%	9.62%	9.91%	10.37%	10.48%	10.47%	10.48%	10.11%	10.02%	9.61%	8.92%	8.79%	-
W	Number of Unreg Nursing Leavers	Headcount	-	6.00	11.00	14.00	10.00	12.00	22.00	13.00	15.00	16.00	17.00	17.00	19.00	-
W	Unregistered Nursing Vol Turnover	%	-	14.42%	14.21%	14.30%	14.35%	14.23%	15.39%	15.69%	15.02%	15.29%	15.72%	15.62%	16.37%	-
W	Leavers within 1st Year of Employment	%	-	22.06%	21.88%	25.71%	25.00%	34.55%	28.75%	29.49%	24.49%	20.00%	28.07%	29.63%	22.73%	-
W	Number of Trust starters	Headcount	-	97	61	85	92	88	70	56	99	103	103	84	56	-
	Absence															
D	Sickness Absence %	%	3.50%	6.52%	6.10%	6.65%	6.08%	4.68%	5.13%	6.00%	4.72%	4.76%	5.33%	4.87%	5.77%	-
W	Long Term Sickness %	%	2.00%	2.53%	2.74%	2.79%	2.60%	2.59%	2.70%	2.65%	2.70%	2.52%	2.36%	2.36%	2.14%	-
W	Short Term Sickness %	%	1.50%	3.99%	3.37%	3.86%	3.47%	2.09%	2.43%	3.35%	2.02%	2.24%	2.98%	2.52%	3.63%	-
W	Sickness Absence Cost £	£	-	£879.4k	£753.4k	£935.5k	£806.7k	£642.2k	£678.0k	£842.5k	£648.5k	£638.9k	£767.6k	£650.4k	£749.9k	-
W	WTE Days Lost	WTE	-	9,385.5	8,030.5	9,661.7	8,559.9	6,926.0	7,280.7	8,728.5	6,887.2	6,780.7	7,952.9	7,096.4	8,768.5	-
	Learning & Development															
W	Mandatory Training Compliance %	%	85.00%	87.54%	87.60%	87.38%	87.36%	87.75%	87.87%	87.74%	86.70%	87.22%	85.79%	86.39%	86.40%	86.61%
W	Role Essential MT %	%	85.00%	89.22%	89.20%	89.17%	89.05%	89.33%	89.62%	89.64%	88.56%	89.28%	87.99%	88.75%	88.94%	89.06%
W	CQC Safe MT %	%	85.00%	85.91%	86.06%	85.64%	85.73%	86.22%	86.17%	85.91%	84.90%	85.22%	83.65%	84.10%	83.93%	84.18%
W	Appraisal Compliance %	%	85.00%	73.27%	68.61%	68.85%	70.05%	73.03%	74.55%	75.56%	75.75%	75.04%	76.32%	79.31%	81.43%	81.16%
W	Non Medical Appraisal Compliance %	%	85.00%	74.84%	70.16%	69.66%	71.44%	74.99%	77.85%	77.91%	78.12%	78.03%	77.94%	78.88%	81.08%	80.60%
W	Medical Appraisal Compliance %	%	85.00%	62.18%	57.66%	63.13%	60.29%	58.82%	50.37%	58.38%	58.41%	53.44%	64.63%	82.84%	84.13%	85.44%
	Demographics															
W	Staff in Leadership Roles %	%	-	3.39%	3.39%	3.37%	3.37%	3.43%	3.34%	3.32%	3.17%	3.24%	3.32%	3.21%	3.17%	3.20%
W	Staff in Leadership Roles WTE	WTE	-	197.00	197.00	197.00	197.00	202.00	197.00	195.00	188.00	194.00	199.00	194.00	193.00	192.00
W	% of Leadership Roles who are Female	%	-	68.02%	67.51%	67.51%	66.50%	65.84%	65.48%	65.64%	67.02%	66.49%	67.34%	68.04%	67.88%	68.23%
W	% of Leadership Roles who from BME	%	-	5.08%	5.08%	5.08%	5.58%	5.45%	5.58%	5.64%	5.85%	6.19%	6.53%	5.67%	5.70%	6.77%
W	Male % of Workforce	%	-	17.26%	17.34%	17.37%	17.45%	17.51%	17.66%	17.57%	17.43%	17.62%	17.45%	17.36%	17.38%	17.55%
W	Female % of Workforce	%	-	82.74%	82.66%	82.63%	82.55%	82.49%	82.34%	82.43%	82.57%	82.38%	82.55%	82.64%	82.62%	82.45%
W	BME % of Workforce	%	-	19.22%	19.50%	19.81%	20.16%	20.39%	20.65%	20.81%	21.05%	21.24%	21.48%	21.83%	21.94%	22.54%
W	White % of Workforce	%	-	71.12%	71.19%	70.95%	70.59%	70.31%	70.17%	70.21%	69.99%	69.71%	69.60%	69.33%	69.16%	68.74%

Our People

Great Western Hospitals NHS Foundation Trust

Workforce Scorecard – Time to Hire

Key problem areas are as follows:

- Shortlisting completion time – Hiring Manager
- Updating Trac outcomes following interview – Hiring Manager
- Getting conditional offers out to successful candidates – Recruitment Team
- Emailing out for references – Recruitment Team

Actions:

- Shortlisting & Interview dates to be agreed prior to advert and made available on the advert, alongside being put into both hiring manager & co-ordinator diaries. Issues with this to be raised straight to Head of Resourcing.
- A reminder email has gone to all individuals in department to remind them of their individual responsibility of the TTH KPI's and no single KPI is less important than the next.
- There are 2 long term sicknesses in the team due to Bereavement – team to be managed to support demand (HCA/centralised recruitment)
- Weekly reporting to the Heard of Resourcing on Conditional Offers and References to ensure all are issued in the SLA
- Weekly update from Head of Resourcing to be provided to Claire Warner on progress

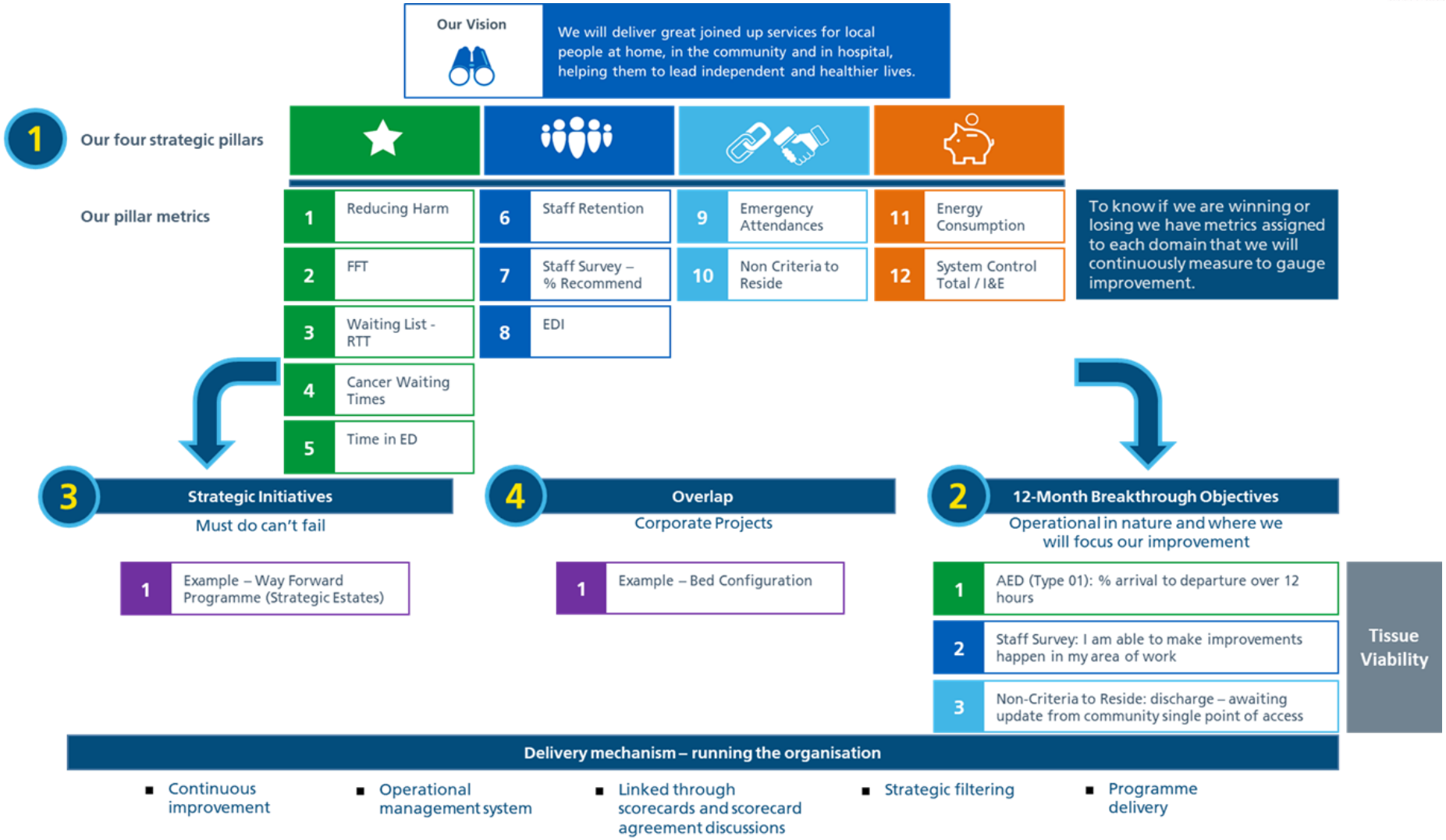
Appendices

Explaining the IPR

Improving
together

Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust



Explaining the IPR

Great Western Hospitals NHS Foundation Trust

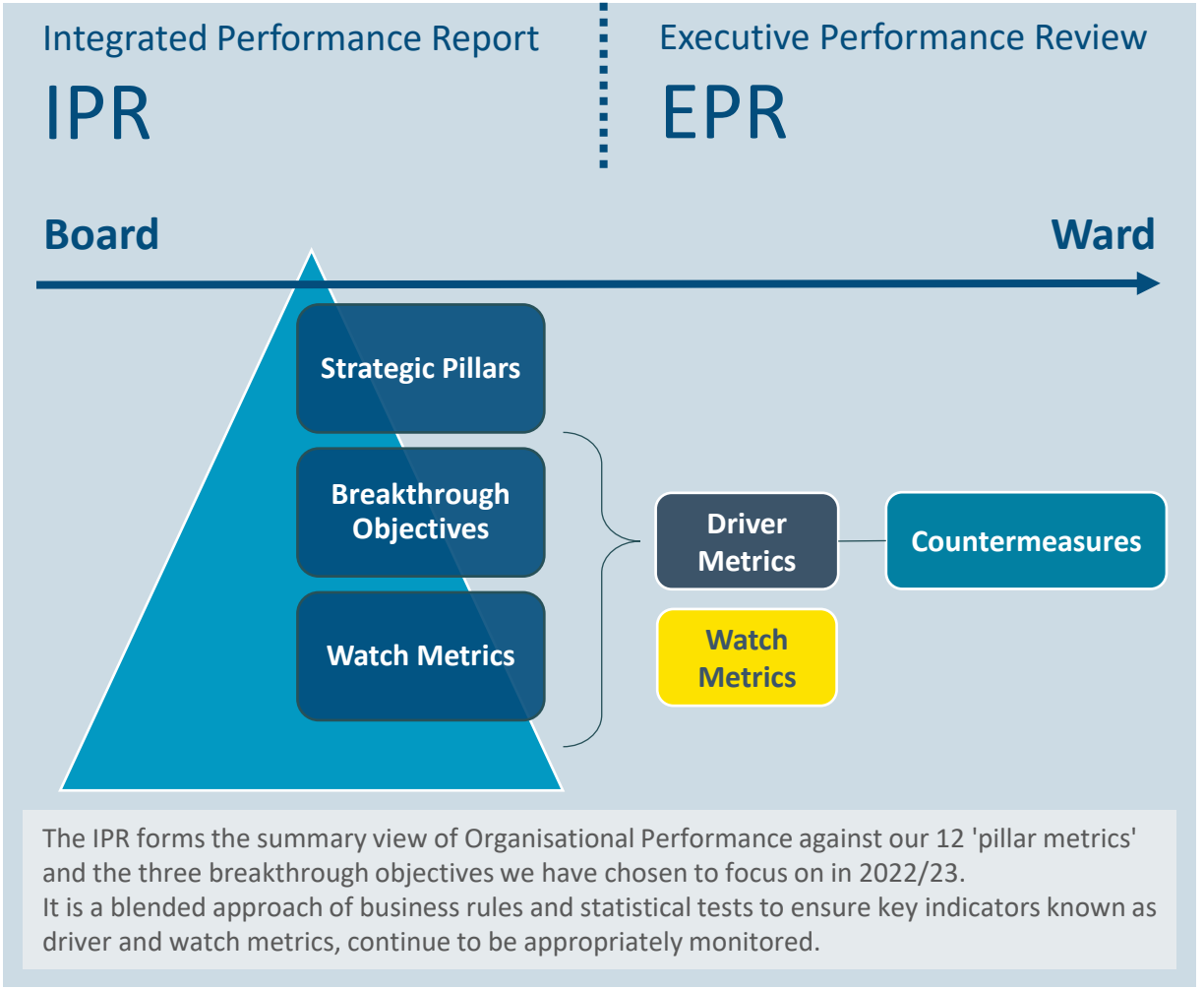
To turn our strategic themes into real improvements, we're focusing on three key objectives that contribute to these themes for the next year.

- Tissue viability – reducing pressure ulcers
- A&E arrival to departure over 12 hours
- Staff survey – I am able to make improvements happen in my area of work
- Non-criteria to reside – reducing patients waiting in hospital

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

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

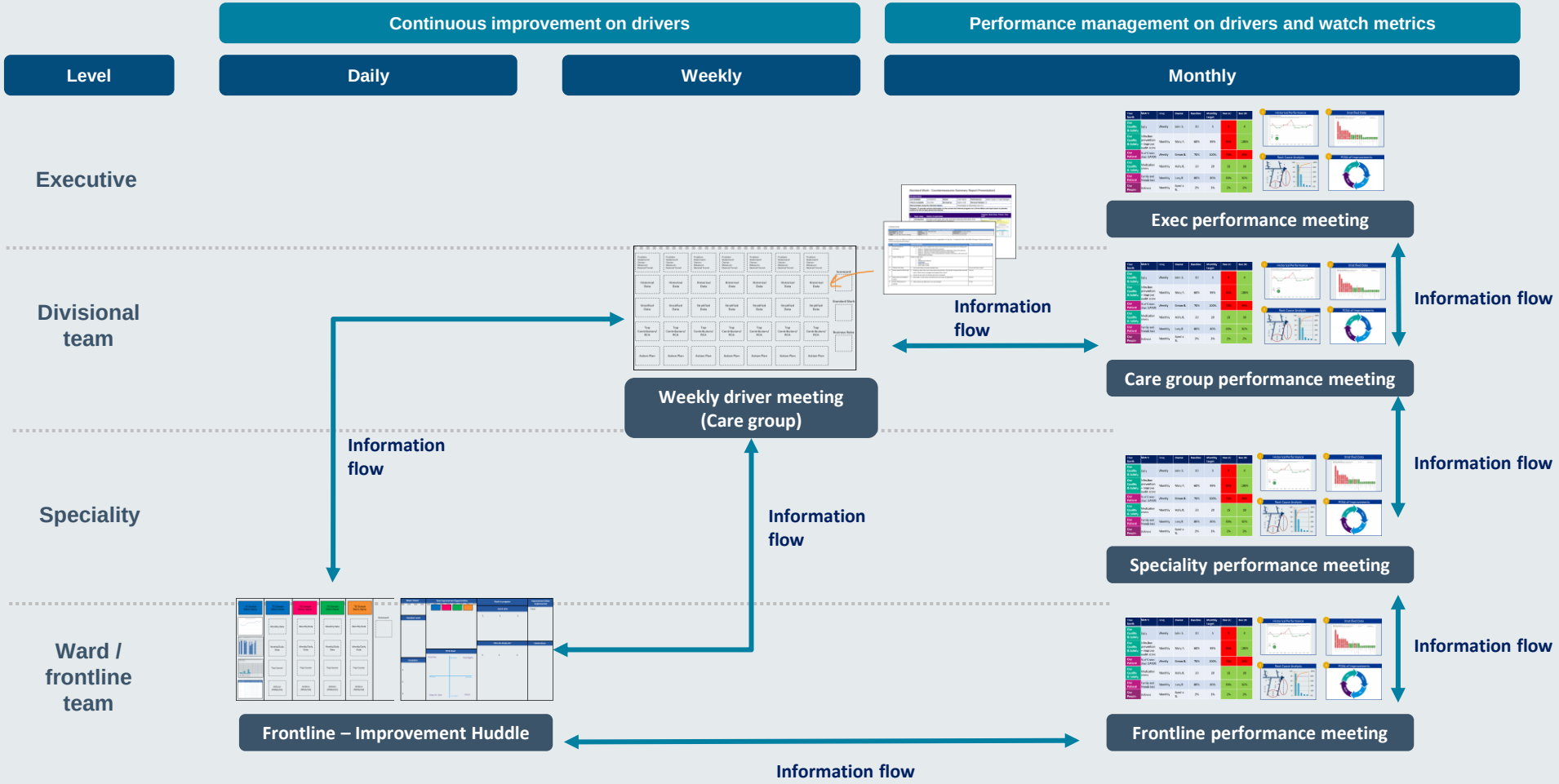
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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



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

Ward to Board
Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Performance business rules

		Alignment with Making data count	Rule	Actions
1		N/A	Driver is **Blue** for reporting period	Share success and move on
2	●	Blue dots – showing sustained improvement	Metric is positively outside SPC control limits for seven consecutive reporting periods	Discussion: 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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

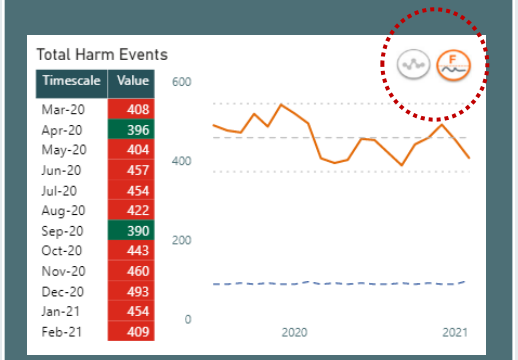
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

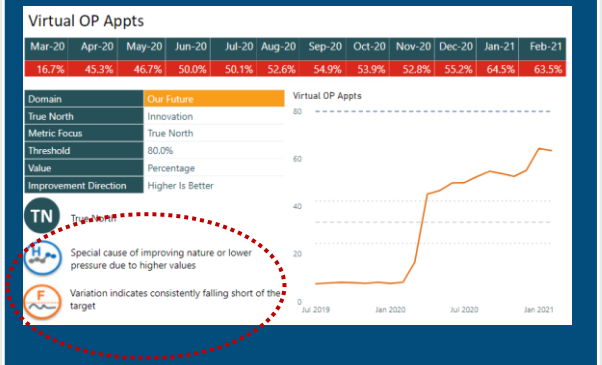
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Agreed Terms

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Term	Description
A3	A methodology used as part of Improving Together to ensure that problems, ideas, and areas for improvement are all approached in the same way. 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.

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Board Committee Assurance Report

Charitable Funds Committee – February 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	**Paul Lews**		**1 February 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	N/A		

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Fundraising	R	G	The Risk Assurance Level remains Red due to the continued risks and uncertainty with cost-of-living implications. We have actions in place to mitigate this, but the external risk factors remain very concerning.	Review progress at the next meeting.	May 2023
Financial Position	A	G	The Finance position is well controlled and there is no longer a deficit expected within our financial forecast at the end of the year due to the changes agreed to make 'agreements in principle' for Cases of Need to ensure that funds are made available only when monies are available to avoid a deficit materialising. In addition, we gave agreed to set a minimum threshold level for the General Fund which will also mitigate future risks and the amount and approach will be agreed at the next meeting in May.	Review progress at the next meeting.	May 2023
Cases of Need	A	A	The Cases of Need process is working well, but there is still a need to further improve the Divisional Director's levels of understanding and ownership. This will be reviewed again after the Divisions present their 2023 Charitable Funds plans at the next meeting in May.	Review progress at the next meeting.	May 2023

Charitable Funds	A	A	There remains considerable scope to increase Divisional Spending and this will be incorporated within our plans to rationalise the 81 Charitable Funds. As the Divisions have significant sums available (without documented commitments) it was agreed that the Divisions will be asked to present their 2023 Plans. Due to extreme pressures within the GWH, it was agreed to defer this from February to the next meeting in May. As part of this oversight review, the committee members will seek greater assurance about the key 'needs' for each Division (from both a patient & family and staff perspective) and how the funds will be spent this year in line with the agreed criteria for the use of Charitable Funds monies.	Review progress at the next meeting.	May 2023
Finance Strategy	A	A	The Finance Strategy plan, which will be based upon a 'low risk' investment approach with the scope to maximise shorter term interest rates will be presented at the next meeting in May. This was also deferred from the meeting in February due to other priorities and changes within the Finance Team.	Review progress at the next meeting.	May 2023

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

Report Title	**Gender Pay Gap Report 2021-22**				
Meeting	**Trust Board**				
Date	**2 March 2023**	Part 1 (Public)	x	Part 2 (Private)	
Accountable Lead	Jude Gray, Director of Human Resources (HR)				
Report Author	Sharon Woma, Equality, Diversity & Inclusion (EDI) Lead				
Appendices	Gender Pay Gap Report 2021-22				

Purpose

Approve	X	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):

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):

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

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

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

- The mean gender pay gap (£7.56 reduces to £1.24 excluding medical staff – in favour of males)
- The median gender pay gap (£3.83 reduces to £1.01 excluding medical staff – in favour of males)
- The mean bonus gender pay gap (£5173.35 reduces to -£52.47 excluding medical staff – in favour of females)
- The median bonus gender pay gap (£4996.00 reduces to zero (parity) excluding medical staff)
- The proportion of males and females receiving a bonus payment (males 201, 20.76%, females 1024, 22.49%)
- The proportion of males and females in each quartile pay band (lower to upper):
    - Lower – m 13.52%, f 86.48% (excluding medical m 13.48%, f 86.52)
    - Lower middle – m 12.71%, f 87.29% (excluding medical m 11.75%, f 88.25%)
    - Upper middle – m 14.32%, f 85.68% (excluding medical m 11.99%, f 88.01%
    - Upper – m 29.90%, f 70.10% (excluding m 15.96%, f 84.04%)

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

The attached report is based on a snapshot of all Trust employees on 31 March 2022. The Gender Pay Gap report must be approved by the Board and published by 30 March 2023.

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

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
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The Gender Pay Gap report will be reviewed by: EDIG; TMC; and PCC				
Next Steps	Review by People & Culture Committee and Trust Board. Publish on the Trust intranet by the end of March 2023. Deliver actions identified.				

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	X		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	X		
Explanation of above analysis: The report highlights that there is a gender pay gap in favour of male staff (rationale included in above table). The Trust will undertake several initiatives in 2023-24 to address the pay gap including reviewing equal opportunities and looking at the pay gap for other equalities groups (ethnicity, sexual orientation etc) to address any disparities that result from the intersection of two or more protected characteristics.			

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **Discuss and approve the report and action plan**

Accountable Lead Signature	J. Gray Jude Gray
Date	23rd February 2023

NHS
Great Western Hospitals
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Gender Pay Gap Report

2021-2022

Contents

Executive summary

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

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

We recognise our role and responsibility to provide equal opportunities and advance inclusion, to eliminate discrimination and to foster good relationships as an employer, provider, partner and anchor institution.

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

We regularly publish information relating to the wider diversity of our workforce in our Equality Annual Reports and our work to reduce our gender pay gap is taking us a step closer to equity for our staff.

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

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

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

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

- The mean gender pay gap has increased by 1.22%
- The median gender pay gap has decreased by 0.62%
- The mean bonus payments gap has increased by 4.28%
- The median bonus payments gap increased by 14.22%
- Proportion of males receiving bonus payments has reduced by 0.68%
- Proportion of females receiving bonus payments has reduced by 6.48%

This report fulfils the Trust's gender pay gap reporting requirements and analysis of the data and sets out what the Trust is doing to close the gender pay gap.

What is our Gender Pay Gap Report?

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

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

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

This report is based on a snapshot of all Trust employees on 31 March 2022.

The areas of focus are:

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

Elements of our Gender Pay Gap Report

Our Gender Pay Gap report contains several elements, including:

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

A Note on Terms

What do we mean by pay 'parity'?

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

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

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

What is a 'negative' data measure?

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

Gender pay reporting and equal pay

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

Gender pay gap summary – Mean Hourly

A summary of our position in 2022 using the mean data compared to 2021:

	Pay Gap	Movement from Last Year	Pay Gap % Movement
All Staff	£7.56	+£0.67	↓ +1.22%
Excluding medical and dental staff	£1.24	+£0.12	↓ +0.62%

	2021		2022	
Similar position (mean)	↔	The mean hourly rate of pay is greater for females across 5 out of 15 pay bands	↔	The mean hourly rate of pay is greater for females across 6 out of 15 pay bands
	Note: The mean gap between female and male staff slightly increased this year by £0.67 (1.22%) in favour of male staff			

Increased gender pay gap for some pay bands (mean)	↓	Overall the gender pay gap has increased for male staff by £0.67.
	↑	The gender pay gap has reduced across a number of Bands but they are still in favour of male staff (Band 4, 8A, 8C, 8D, 9, Medical Consultant and Doctors in Training.
	↑	There is a pay gap in favour of female staff at Apprentice level, which was in favour of male staff last year.

	Females		Males	
Mean hourly rates of pay	↑	Increase in mean rate of pay for females to £17.37	↑	Overall, mean rate of pay is still higher for males at £24.93
	Notes: This is due to a greater proportion of males in roles with higher pay: such as VSM, Non-Execs, Medical Consultants, Medical-Other, Band 8 to 9.			

	Females		Males	
Gender proportion at the top of the pay bands (7+)	↓	The proportion of females at the top of these pay bands is down from 41% to 39%	↓	The proportion of males at the top of these pay bands is down from 47% to 45%

Gender pay gap summary

Why do we have a mean hourly pay gender gap?	The Trust data indicates: • The Trust has recruited more males at Band 8A and above this year, resulting in a net increase of 17 compared to a net reduction of 17 for females. • More males are on the top increment at Bands 8A and above compared to female (see appendix). • AFC has widened the gap as there is no incremental pay until staff reach the top of increment and the difference between the pay points is significant: ranging between 12-16% or £6000 -£14340 per annum. • Male staff are over-represented in the highest pay quartile (30%). If staff were representative across the Trust, there would be a gender split closer to 18% male and 82% female across all quartiles. In addition, other studies highlight likely causes: • According to the 'Mend the Gap: The Independent Review into the Gender Pay Gap in Medicine' there is an unequal impact of caring responsibilities on careers; and female medical staff tend to be segregated into lower paid career paths (particular roles and specialties), this is due to the difficulties working LTFT (less-than full time), or the structure of careers in some specialities. This results in pay penalties, especially relating to non-basic pay additions, such as CEAs (clinical excellence awards). • The report also indicates that males in the profession are more likely to be older and been in practice for longer. This leads to them occupying the highest paid positions (consultants, associate specialists, GP partners, professors). • The Institute of Fiscals Study IFS Deaton review indicates that gender gaps in employment and hours increase substantially immediately upon parenthood and a higher percentage of women employed in part-time work also contributes to less wage growth and career progression.
Why do we have a bonus payments gap when we include all staff?	• More male medical staff have received a bonus (m 171, f 83), and the level of local bonuses has increased this year from £2470 to £5316 per person. • When medical staff are excluded from the calculations the mean bonus payments gap is £52.47 (-11.78%) in favour of female staff; and median pay gap is at parity (0%).

We have included a summary of initiatives we have undertaken to address the gender pay gap in the appendix.

Four-year review

Below is our gender pay gap scores for the last four years. Comparisons are from 2019 to 2022. A column has been included which indicates our direction of travel with an assessment of positive or negative referring to the indicator's impact on our staff for the measures numbered one to six in the table.

The mean gender hourly pay gap has remained relatively similar year-on-year, fluctuating between 29.10% and 31.99% (its highest in 2018/19). Likewise, the median gender pay gap has also remained at a similar percentage, fluctuating between 19.00% and 19.85% (its highest in 2019/20).

The mean bonus pay gap has worsened this year, increasing from 79.37% to 83.65%. Likewise, the median bonus pay gap has also worsened, increasing from 79.76% to 93.98%. The bonus pay gap has worsened because the CEA payment has increased from £2,470 to £5,316 and most people who get this are male.

Summary table

Gender pay gap standard measures (difference)		2018-19	2019-20	2020-21	2021-22	Comparison of male and female average earnings: Direction of travel	
1	The mean gender pay gap	31.99% £7.36	29.66% £6.80	29.10% £6.89	30.32% £7.56	Similar	← →
2	The median gender pay gap	19.00% £3.36	19.85% £3.61	19.81% £3.84	19.19% £3.83	Similar	← →
3	The mean bonus gender pay gap	88.63%	88.97%	79.37%	83.65%	Up / Negative	↓
4	The median bonus gender pay gap	84.62%	84.48%	79.76%	93.98%	Up / Negative	↓
5	The proportions of males and females receiving a bonus payment	N/A	19.05% M 21.70% F	21.44% M 28.97% F	20.76% M 22.49% F	Down / Positive	↑
6	The Gender Pay Gap Excluding medical and dental staff						
	The mean gender pay gap	2.49% £0.37	4.58% £0.71	6.47% £1.09	7.07% £1.24	Similar	← →
	The median gender pay gap	-2.80% -£0.37	0.07% £0.01	3.05% £0.47	6.26% £1.01	Up / Negative	↓
	The mean gender bonus gap	16.40% £92.26	29.24% £165.57	-2.41% -£17.09	-11.78% -£52.47	Up / Negative *(favours females)*	↓
	The median gender bonus gap	27.27% £75.00	33.33% £100.00	-20.00% -£80.00	0.00% £0	Down / Positive *(parity)*	↑
7	The proportions of males and females in each quartile pay band:						
	i. Lower Quartile	29.05% M 70.95% F	29.38% M 70.62% F	13.81% M 86.19% F	13.52% M 86.48% F		
	ii. Lower Middle Quartile	13.33% M 86.67% F	14.34% M 85.66% F	11.01% M 88.99% F	12.71% M 87.29% F		
	iii. Upper Middle Quartile	11.76% M 88.24% F	11.01% M 88.99% F	14.34% M 85.66% F	14.32% M 86.68% F		
	iv. Upper Quartile	12.84% M 87.16% F	13.64% M 86.36% F	29.38% M 70.62% F	29.90% M 70.10% F		

Gender breakdown

Gender proportions in our Trust

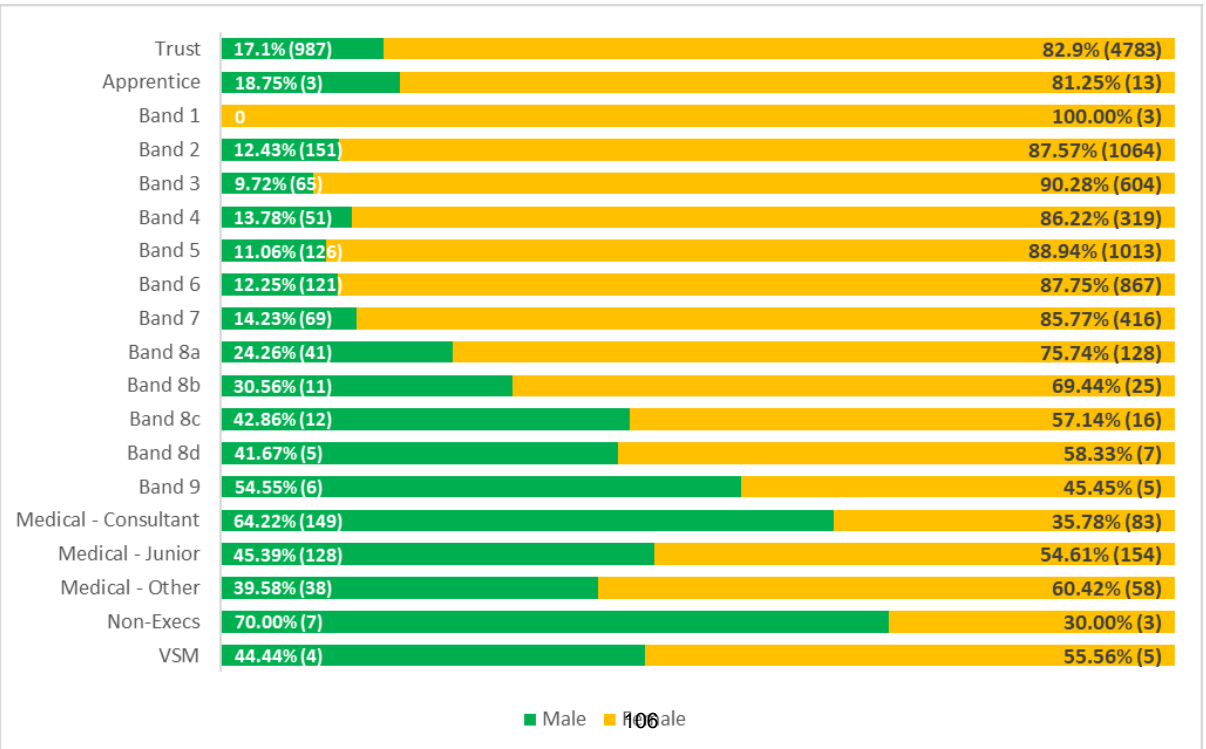
The Trust had 5445 employees/workers in the year from 01 April 2021 to 31 March 2022. The gender split of paid employees was as follows:

Gender	Headcount	Proportion of workforce
Male	959	17.61%
Female	4486	82.39%
Total	5445	100.00%

Medical and dental workforce

The medical and dental workforce comprises a large group, from trainees to those in consultant roles. This represented 609 staff, with a gender split: 316 (51.89%) males to 293 (48.11%) females. When medical staff are removed from calculations there is a total of 4836 staff – 643 (13.30%) male and 4193 (86.70%) female.

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



Gender breakdown

Medical and dental workforce cont.

There is a larger number of female staff than male staff in all bands except Band 9, non-execs and medical consultant grades, a disproportionate number of males in the higher pay band will contribute to a gender pay gap.

Mean gender pay gap in hourly pay

How is this calculated?

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

Table: Mean hourly rate including medical and dental staff

	Year to 31.3.21	Year to 31.3.22	Difference (between 2021 & 2022)
Male	£23.69	£24.93	+£1.24
Female	£16.80	£17.37	+£0.57
Difference	£6.89	£7.56	+£0.67
Pay Gap %	29.10%	30.32%	↓ +1.22%

Our mean hourly pay gap shows a slight increase (worsening position)

Table: Mean hourly rate excluding medical and dental staff

	Year to 31.3.21	Year to 31.3.22	Difference (between 2021 & 2022)
Male	£16.91	£17.53	+£0.62
Female	£15.82	£16.29	+£0.47
Difference	£1.09	£1.24	+£0.15
Pay Gap %	6.45%	7.07%	↓ +0.62%

Our mean hourly pay gap (excluding medical staff) shows a slight increase (worsening position)

Gender breakdown

What does our data tell us about this year's position, and compared with previous years?

Differential pay rates

The mean hourly pay for male staff is £7.56 (30.32%) higher than for female staff.

This would mean female staff earn 69.7p for every £1 that male staff earn when comparing mean hourly pay.

Slightly increased gap

The mean gender pay gap including medical staff has increased slightly by 1.22 percentage points (£0.67) since last year.

The impact of medical and dental staff

When the medical and dental staff were excluded from the calculation then the mean average changed significantly, resulting in a mean gender pay gap of £1.24 (7.07%) - this would mean female staff would earn 93p for every £1 a male staff earned. Although this is lower once medical staff are excluded – we have slightly worsened over the last 12 months by 0.62% (£0.15).

Table: % Mean gap ordinary hourly rate of pay

Group	Male	Female	Gap % 2020-21	Gap % 2021-22
0 - Apprentice	£4.38	£6.30	9.03%	-43.85%
1	-	£9.48	-	-
2	£11.08	£11.53	-1.57%	-4.05%
3	£11.44	£11.54	-0.89%	-0.87%
4	£12.73	£12.67	2.34%	0.45%
5	£16.11	£16.96	-7.60%	-5.26%
6	£19.83	£20.46	-5.83%	-3.19%
7	£22.83	£23.10	0.54%	-1.19%
8a	£25.72	£25.59	1.18%	0.50%
8b	£31.13	£30.13	-2.85%	3.22%
8c	£36.65	£35.96	7.57%	1.89%
8d	£44.97	£42.99	8.11%	4.41%
9	£54.11	£52.34	11.85%	3.28%
Medical - Consultant	£53.75	£51.70	5.75%	3.81%
Medical - Junior	£23.62	£23.06	8.35%	2.40%
Medical - Other	£40.05	£32.87	6.43%	17.93%
Non-Execs	£8.87	£5.76	70.79%	35.11%
VSM	£73.74	£66.17	3.28%	10.26%

Gender breakdown

What does our data tell us about this year's position, and compared with previous years?

Where have there been changes?

An overall mixed picture:

- There has been an increase in the mean pay gap in favour of females in Apprenticeship, Band 2 and Band 7. There has been an increase in the mean pay gap in favour of males at Band 8B and VSM.
- The Trust has moved closer to parity in some bands including Band 3, Band 4, Band 8A and 8C.
- The mean hourly rate of pay is greater for females across 6 out of 15 pay bands (Band 0 to 4 and 5 to 7) and greater for males across 8 of the 15 pay bands (Band 8B and above, and marginally in Band 4 and Band 8A which is close to parity).
- There are no male Band 1 staff.

Why do we have a mean gender pay gap?

Despite the mean rate of pay increasing for females in some bandings (Band 0, 2, 7), the overall result, when looking at the Trust as a whole, is the mean pay gap of £7.56 is in favour of male staff because there is a greater proportion of males with higher pay including senior managers (Band 8a and above), consultant and other medical staff, and non-executives.

The upper quartile (highest pay bracket) is made up of 29.90% male staff and 70.10% female staff (compared to the Trust wide breakdown of 82% female and 18% male).

In summary, the mean pay gap has occurred because:

- There are more male consultants.
- Consultants are on higher pay band.
- 8A and above males are more likely to be on the higher increment.
- Distribution of males on higher salary (30% in top quartile, compared to average of 13.5% lower quartiles).
- The number of staff at Band 8A and above have remained the same, but movement has resulted in a net increase in male staff (17 staff).
- National evidence suggests that male medical staff are more likely to be in practice for longer, thus occupying higher paid roles and there is a negative impact for female staff due to caring responsibilities and career breaks.

Median gender pay gap in hourly pay

How is this calculated?

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

Table: Median hourly rate **including** medical and dental staff

	Year to 31 March 2021	Year to 31 March 2022	Difference (between 2021 & 2022)
Male	£19.38	£19.96	+£0.58
Female	£15.54	£16.13	+£0.59
Difference	£3.84	£3.83	-£0.01
Pay Gap %	19.81%	19.19%	↑ -0.62%

Our median hourly pay gap shows a slight decrease (improved position)

Table: Median hourly rate **excluding** medical and dental staff

	Year to 31 March 2021	Year to 31 March 2022	Difference (between 2021 & 2022)
Male	£15.24	£16.13	+£0.89
Female	£14.77	£15.12	+£0.35
Difference	£0.47	£1.01	+£0.54
Pay Gap %	3.08%	6.26%	↓ +3.18%

Our median hourly pay gap (excluding medical staff) has doubled (worsening position)

Table: % Median gap ordinary hourly rate of pay

Group	Male	Female	Gap % 2020-21	Gap % 2021-22
0 Apprentice	£4.30	£4.30	11.95%	0.00%
1	0	£9.48	-	-
2	£10.64	£10.66	-3.48%	-0.19%
3	£11.14	£11.14	0.00%	0.00%
4	£12.72	£12.72	0.00%	0.00%
5	£16.13	£16.37	-2.20%	-1.49%
6	£19.96	£19.96	0.00%	0.00%

Median gender pay gap in hourly pay

Table: % Median gap ordinary hourly rate of pay cont.

Group	Male	Female	Gap % 2020-21	Gap % 2021-22
7	£23.14	£23.44	0.00%	-1.30%
8a	£24.65	£24.57	2.29%	0.32%
8b	£32.66	£28.01	0.00%	14.24%
8c	£38.80	£33.75	13.46%	13.03%
8d	£46.22	£39.99	6.75%	13.48%
9	£55.27	£55.27	7.11%	0.00%
Medical - Consultant	£51.18	£49.71	6.20%	2.87%
Medical - Junior	£22.98	£21.87	6.27%	4.83%
Medical - Other	£37.91	£33.68	6.18%	11.15%
Non-Execs	£7.26	£6.74	10.37%	7.16%
VSM	£74.15	£62.00	6.42%	16.39%

Differential pay rates

The median pay for male staff is £3.83 (19.19%) higher than female staff and has stayed relatively the same compared to the previous year.

When excluding medical staff, the median pay gap is significantly reduced to a gap of £1.01 (6.26%). However, the median gap excluding medical and dental staff has increased since last year when it was £0.47 (3.08%), an increase of £0.54.

Reminder – the median pay gap is usually considered to be more representative of the gender pay gap across the workforce.

Why do we have a median pay gap?

The median pay gap has occurred because:

- An increase gender pay gap (for AFC Staff) has occurred due to a higher proportion of male staff in Band 8A to Band 9 being at the top of the pay scale, when compared to the percentage of female staff at the top of the pay scale (i.e. males in senior roles earn more).
- In addition, male staff are disproportionately represented in senior roles as highlighted earlier.

Median gender pay gap in hourly pay cont.
Bonus gender pay gap as a mean average

- It should also be noted that the Agenda for Change 3 year pay deal will mean that Band 8A staff will remain on the lower salary for a longer period until they achieve the top of the pay scale, this could result in the gap widening if a higher percentage of males are at the top of the Band.

Bonus gender pay gap as a mean average

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

What is included in bonus payments?

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

Table: Bonus gender pay gap averages **including** medical and dental staff

	2020-21			2021-22		
	Male	Female	Gap %	Male	Female	Gap %
% Mean gap bonus pay	£4,592.65	£947.53	79.37%	£6,184.51	£1,011.16	83.65%
% Median gap bonus pay	£2,470.00	£500	79.76%	£5,316.00	£320.00	93.98%
% Receiving bonus	21.44%	28.97%		20.76%	22.49%	
No. of staff receiving bonus	208	1336		201	1024	

Table: Mean Bonus Gender Pay Gap averages excluding Medical and Dental Staff

	2020-21			2021-22		
	Male	Female	Gap %	Male	Female	Gap %
% Mean gap bonus pay	£710.50	£727.59	-2.41%	£445.35	£497.82	-11.78%
% Median gap bonus pay	£400.00	£480.00	-20.00%	£300.00	£300.00	0.00%
% Receiving bonus	15.18%	29.66%		10.89%	22.36%	
No of staff receiving bonus	99	1283		71	952	

Differential bonus pay

When including medical staff, 1225 staff received a bonus, 201 male (20.76% of eligible male staff) and 1024 female staff (22.49% of eligible female staff).

Bonus gender pay gap as a mean average

Differential bonus pay cont.

More medical male staff (171 staff, 33%) have received a Clinical Excellence Award than female staff (83 staff, 67%). This is split between local and national awards.

Local CEA – Due to guidance from NHS Employers, there was an increase in monies for Local Clinical Excellence Awards (LCEA) in 2021-22 as all monies unspent since 2018 were required to be spent in the 2021-22 LCEA's. Due to this, the pot of money to be spent was higher than normal and when equally split between all eligible consultants meant the payment increased from £2470 in 2020 – 2021 to £5316 in 2021-22. This resulted in a significant increase in the Median gap as there are more male (125) recipients of this award than female (69). Overall although local CEAs were 67% male, this is fairly representative of the gender split, 64% of consultants are male.

NCEA (National Clinical Excellence Award) – 60 staff received the national CEA awards – 14 female (23%) and 46 male (77%). Female consultants were under-represented in the NCEAs, 36% of consultants are female.

However, when taken as a whole (both national and local CEAs), the gender split was relatively representative, 83 female (33%) and 171 male (67%) consultants received an award – the Trust employs 83 female consultants (36%) and 149 male (64%). The financial award was also fairly representative, 68% of the award in monetary terms went to male consultants.

Fewer staff have received bonus payments this year (1225 staff in 2021/22, compared to 1544 staff in 2020/21), but there is still a higher percentage of female staff receiving a bonus, although the gap between the percentage of male and female staff receiving a bonus has decreased to 20.76% for males and 22.49% for females.

The impact of medical and dental staff

When medical and dental staff are included in the calculation, the mean bonus gender pay gap between male and female staff is £5173.35 (83.65%).

The median pay gap when including medical and dental staff is £4996.00 (93.98%).

Bonus gender pay gap as a mean average

The impact of AFC

If medical and dental staff are excluded from the calculation, the mean bonus payments gender pay gap between male and female staff is markedly reduced from £5173.35 (83.65%) in favour of male staff to £52.47 (-11.78%) in favour of female staff.

In addition, when excluding medical staff, the median value indicates there is a parity of payment.

Why do we have a bonus gap when we include all staff?

The bonus pay gap has occurred because there are more male consultants (m 149, 64% vs f 83, 36%), correspondingly a greater share of the bonus was received by male staff – financial payments were relatively proportionate (68% of the award in monetary terms went to male consultants).

Proportion of males and females in each quartile

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

The Trust continues to have a good proportion of females at Trust Board Executive and Senior Management levels, 42% of non-execs and VSMs are female. When looking at all staff, men are disproportionately represented in the upper quartile (highest paid staff) – 29.90% male and 70.10% female. This is compounded by the fact that our medical and dental staff predominantly preside in the upper quartile.

In contrast, when medical and dental staff are removed from the calculation the proportion changes to 15.96% male and 84.04% female which is more comparable with the other quartiles and representative of the gender split in the Trust (82%). Female staff are over-represented in the remaining quartiles – lower (86%), lower middle (87%) and upper middle (86%).

The tables below depict the gender split per quartiles.

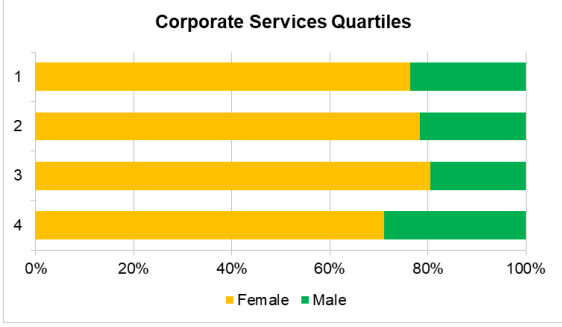
Table: Gender split for pay in each of the four quartiles – **including** medical and dental staff

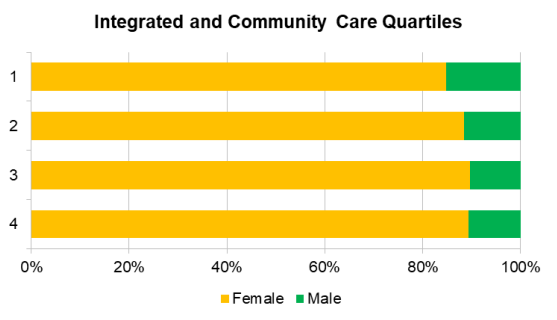
Quartile	Total staff	Male	Female	% Male	% Female
Lower	1361	184	1177	13.52	86.48
Lower Middle	1361	173	1188	12.71	87.29
Upper Middle	1362	195	1167	14.32	85.68
Upper	1361	407	954	29.90	70.10

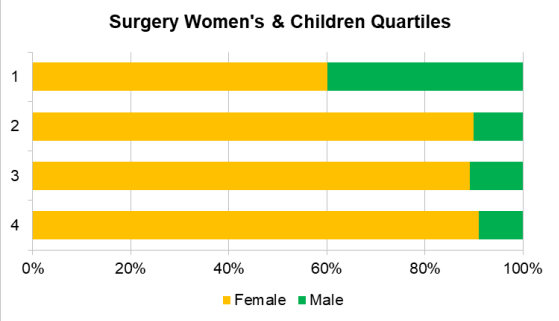
Table: Gender split for pay in each of the four quartiles – **excluding** medical and dental staff

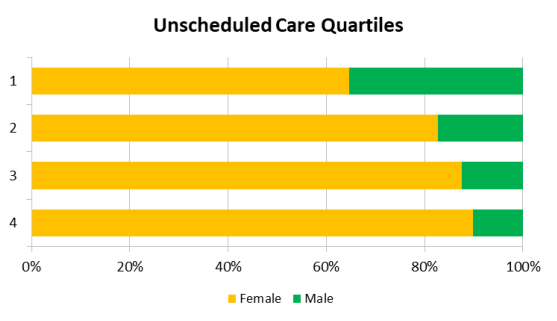
Quartile	Total staff	Male	Female	% Male	% Female
Lower	1209	163	1046	13.48	86.52
Lower Middle	1209	142	1067	11.75	88.25
Upper Middle	1209	145	1064	11.99	88.01
Upper	1209	193	1016	15.96	84.04

Proportion of males and females in each quartile









The above graphs depict the pay quartiles per division: The Surgery Women's & Children and Unscheduled Care Divisions have a larger percentage of male staff in quartile one, the upper quartile (highest pay bracket), this is reflective of the number of medical and dental male senior staff who work in these specialities. In comparison, Corporate Services and Integrated & Community Care have a relatively even spread of male staff across the quartiles.

Conclusion

We have made some progress in reducing the pay gap between males and females across a number of our Bands (Band 4, 8A, 8C, 8D, 9, Medical Consultant, Medical Junior and Non-Exec) however they are still in favour of male staff. The Trust's gender pay gap is caused by the following:

- Male staff are both disproportionately represented in the upper quartile of pay (highest earners) and are more likely to be at the top end of the pay scale across a number of those Bands.
- In 2021/22 the Trust employed additional male staff at Bands 8a and above, increasing representation of male staff in senior roles, in contrast the number of female staff in these Bands reduced.
- In addition, male staff are under-represented in the lower, lower middle and lower upper quartiles – if male staff were representative across the Trust, there would be a gender split closer to 18% male and 82% female across all quartiles.

A bonus pay gap has resulted because there are more male consultants (64%), and therefore more male staff have received an award.

The pay gap is significantly reduced when medical and dental staff are removed from calculations.

A number of initiatives were undertaken in 2020/21 to reduce the pay gap including reviewing the recruitment adverts to remove bias and gender specific terms to ensure adverts are attractive to both genders and introducing a governance process for negotiating salaries. More information about the initiatives we have undertaken can be found in the appendix and the 2021/22 action plan will build on previous work.

Notes

Agenda for Change: The NHS Pay Structure

Agenda for Change was implemented to harmonise pay scales and career progression arrangements in the NHS, to ensure that there is equity and transparency in relation to pay arrangements. This is reflected in the Trust gender pay gap reporting which identifies a 7.07% gap (excluding medical staff).

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

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

Conclusion

Notes

Agenda for Change: The NHS Pay Structure cont.

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

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

Appendix

Table: Percentage of male and female staff at the top of the pay scale across Bands 8A to Band 9

The table indicates that a higher percentage of male staff are at the top of the pay scale, compared to female staff:

Pay Scale Description	Female	Male
Band 8 - Range A	45.19%	42.22%
Band 8 - Range B	48.00%	60.00%
Band 8 - Range C	46.67%	57.14%
Band 8 - Range D	37.50%	80.00%
Band 9	50.00%	80.00%

Closing the gender pay gap

The Trust has undertaken a range of activities to close the gender pay gap including ensuring our systems and processes attract, retain and support people from all backgrounds. The following is a snapshot of the programme of work and existing policies that support getting to equity:

Recruitment – Reviewed recruitment adverts for possible unconscious bias and gender specific terms to ensure job adverts appeal to both sexes. In addition, processes have been put in place for Band 8C and 9 to ensure equality for male and female progression

Salary – Established a process to ensure there is formal governance for negotiating salaries

Flexible working – Promoted flexible working policy including work from home opportunities and part-time working

Development – Established internal and external leadership programmes across all grades from Band 4 and above including leadership programme for clinical leads. Programmes will also be developed for Band 2 and 3 staff and new consultants

Development – The Trust is piloting Scope for Growth Career Conversations which is a national talent management programme that provides a framework to support organisations in structuring career conversations around the priorities that matter to staff so we can best understand our talent, their aspirations and help shape their career-journey.

Appendix

Staff Network – The Trust has four staff networks who support the organisation to understand the needs of our diverse workforce. The networks act as a voice for the staff they represent at key strategic meetings and have the opportunity to influence policy and change.

Bonus Pay – Evaluated and promoted support to female consultants to encourage the increase in applications for local Clinical Excellence Awards.

Great Western Hospitals NHS Foundation Trust Gender Pay Gap Action Plan

We have produced an Action Plan to address the Gender Pay Gap. The plan below includes incomplete actions carried forward from 2020/21.

Action Plan

Objective	Action	Lead	Time-scale	Desired Outcome
Better promotion of our senior vacancies to women and organisations that support women, including Medical and Dental vacancies.	Equal Opportunities Review – review quantitative and qualitative evidence to assess staff experience and perceptions around equal opportunities across three domains – access to opportunities, recruitment and appointment and development	Equality Diversity Inclusion Lead	September 2023	• Improve GWH WRES and WDES metrics – shortlisting to appointment, perceptions around equal opportunities/career progression, perceptions around feeling valued • Demonstrate commitment to having a diverse workforce at every level of the organisation • Improve job candidate perceptions and experience around transparency, equal opportunities and fairness in the recruitment process • Identify and implement inclusive recruitment good practice
Identify other areas of good practice across the system	Identify good practice across the system to reduce gender pay gap and inform future action plans	Equality Diversity Inclusion Lead	July 2023	• Identify evidence-based practice • Collaborate and share resources across the health and care system

Appendix

Action Plan

Objective	Action	Lead	Time-scale	Desired Outcome
Ensure that grades contributing to the pay gap are reduced and barriers to progression removed.	Determine if other protected characteristics affect the gender pay gap. Expand review on gender pay gap to include data on religion, sexuality, disability and 'race'. Review this data across a range of occupations and directorates. As part of WRES/DES, expand on actions that may impact on gender pay.	SW, Suzie Allison-Green	September 2023	Carried forward
Reduce barriers to progression.	Evaluate and promote support to female consultants to encourage an increase in applications for local Clinical Excellence Awards. • Collaborate with partners to devise a new or review existing 'perception/reality' surveys; • Distribute survey to a sample of senior staff (male and female) who are eligible for CEAs; • Analyse results to see if these indicate a mismatch between candidates perception of their abilities, and reality, by gender; • Determine next steps/ measures to put in place depending on findings.	SW, HR Business Partner	November 2023	In progress New process in place • Next step to review national CEA and extend criteria for 2023/24 awards

Report Title	**Fit and Proper Persons Test Policy update (FPPT)**				
Meeting	**Trust Board**				
Date	**2nd March**	Part 1 (Public)	x	Part 2 (Private)	
Accountable Lead	Jude Gray – Chief People Officer				
Report Author	Claire Warner - Deputy Chief People Officer Caterina Gallo – PA Manager				
Appendices					

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

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

Report

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

The fit and proper person regulation (FPPR) came into force for all NHS trusts in November 2014 and requires organisations to seek assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role. The NHS employment check standards can support employers to have robust and effective recruitment processes in place to assess the suitability of all newly appointed directors.

The regulations have not changed since the last policy and therefore no significant changes to the policy document.

Change to governance process via the People and Culture Committee.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
					X
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
					NA
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps	Policy to be updated Annual report to update P&CC on F&PPT outcome				

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **The Board to approve the policy**
- **The Board to understand their responsibilities under this policy**

Accountable Lead Signature	Jude Gray
Date	22nd February 2023

Fit and Proper Person Test (F&PPT) Policy

Document No	HR - 00059	**Version No**	3.0
Approved by	Policy Governance Group	**Date Approved**	31/01/2020
Ratified by	Trust Board	**Date Ratified**	06/02/2020
Date implemented (made live for use)	14/06/2021	**Next Review Date**	06/02/2023
Status	LIVE		
Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.		Members of Board Directors whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all Executive Directors for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees.	
Special Cases			
Accountable Director		Chief People Officer	
Author/originator – Any Comments on this document should be addressed to the author		Deputy Director of Human Resources (HR)	
Division and Department		Trust Wide	
Implementation Lead		Deputy Director of HR	
If developed in partnership with another agency ratification details of the relevant agency		Trust Board	
Regulatory Position	Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Ref 6)		
Review period. This document will be fully reviewed every 3 years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

Contents

1 Introduction & Purpose

1.1 Introduction & Purpose

The purpose of this policy is to outline the arrangements Great Western Hospitals NHS Foundation Trust (GWH) has in place to ensure that members of the Board of Directors, together with other Trust employees identified by the Board of Directors, have been subject to the Fit and Proper Persons Test which is:

a) Outlined in Regulation 5 of The Health and Social Care Act 2008 (Ref 6) (Regulated Activities) Regulations 2014; and

b) Supported by guidance issued from time to time by the Care Quality Commission (CQC) and other appropriately designated bodies

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

CQC	Care Quality Commission
EIA	Equality Impact Assessment
GWH	Great Western Hospital
HR	Human Resources
NHS	National Health Service
FPPT	Fit and Proper Persons Test

2 Main Document Requirements

The aim of the process outlined in this document is that all members of the Board of Directors, the Executive Team and their Direct Reports have been subject to relevant the Fit and Proper Persons Test on an annual basis.

The objective of this process is to ensure:

a) Members of the Board of Directors are Fit and Proper Persons to undertake their roles on behalf of the Trust;

b) At least annually, the outcome of Fit and Proper Persons Test will be reported to the Board of Directors.

2.1 Scope

The following people are subject to the arrangements outlined in this policy:

a) The Chair of the Trust;

b) Non-Executive Directors appointed to the Board of Directors;

c) Members of the Executive Team, comprising:

i) the Chief Executive of the Trust,

ii) Executive Directors who can vote at the Board of Directors,

iii) non-voting Executive Directors who attend the Board of Directors,

iv) the Trust Secretary

v)non-voting Associate Non-Executive Directors who attend the Board of Directors

2.2 Definitions

Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations) (Ref 6) places a duty on NHS providers not to appoint a person, or allow a person to continue to be, an Executive Director or equivalent or a Non-Executive Director under given circumstances. This means 'directors' should not be appointed / continue to hold office unless they are:

a) Of good character;
b) Have the necessary qualifications, skills and experience;
c) Able to perform the work that they are employed for after reasonable adjustments are made
d) Able to supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Committee (see Appendix B).

When assessing a person being 'of good character' NHS providers are required to take account of Schedule 4 of the 2014 Regulations (Ref 6), namely:

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

The CQC's definition of good character is not the objective test of having no criminal convictions but instead rests upon a judgement as to whether the person's character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for Boards in reaching a decision and allows for the fact that people can and do change over time

The regulations list categories of persons who are prevented from holding the office and for whom there is no discretion:

a) The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986 (Ref 7);
d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006 (Ref 8), or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
f) The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment;
g) The person has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

In January 2018 the CQC issued revised guidance for providers and CQC inspectors in respect of Regulation 5 of the 2014 Regulations. Specifically the CQC has made a minor change to its guidance to make it explicit that they expect providers to undertake and "enhanced DBS check for directors to check that they are not on the children's and / or safeguarding barred list where they meet the eligibility criteria".

Directors are eligible for such an enhanced DBS check if the role that they take falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 (Ref 8).

The Trust has determined this as follows:

a) All Executive and Non Executive Director will have enhanced DBS check.

2.3 Duties

Chair – has responsibility for:

a) overseeing the outcome of Fit and Proper Person Tests where the individual is a Non Executive or Chief Executive

b) with the support of the Chief People Officer and independent legal counsel, undertaking investigations into any concerns raised about one of the above individuals, including where the individual has notified the Chair they may no longer comply with Fit and Proper Persons requirements.

Senior Independent Director (a Non Executive Director) - has responsibility for

a) overseeing the outcome of Fit and Proper Person Test for the Chair;

b) with the support of the Chief People Officer or Trust Secretary and independent legal counsel, undertaking investigations into any concerns raised about the Chair, including where the Chair has notified the Senior Independent Director they may no longer comply with Fit and Proper Persons requirements.

Chief Executive - has responsibility for:

a) overseeing the outcome of Fit and Proper Person Tests where the individual is a Direct Report

b) with the support of the Chief People Officer or Trust Secretary (if concern related to theChief People Officer), undertake investigations into any concerns raised about one of the above individuals, including where the individual has notified the Chief Executive they may no longer comply with Fit and Proper Persons requirements.

Chief People Officer as the Lead Executive Director, they have responsibility for:

a) advising the Chair and Board of Directors on the process necessary to ensure the Trust has robust systems in place which comply with Regulation 5 of the 2014 Regulations (together with any guidance issued by the CQC);

b) ensuring that any Fit and Proper Persons Tests undertaken comply with the process detailed in this policy, bringing non compliance to the attention of the Chair, Senior Independent Director or Chief Executive (as relevant);

c) designating members of the Workforce Team to undertake the Fit and Proper Persons Tests upon appointment and as part of the annual review process;

d) in respect of prospective Non Executive Directors / employees offered a position subject to the successful competition of the Fit and Proper Person Tests upon appointment, being the final arbitrator as to whether that individual meets the requirements of the Fit and Proper Persons Test

e) where an investigation is required the Chief People Officer will appoint / liaising with legal advisors in respect of the advice for the chair of the panel, the arrangements for the panel to meet, the collation of any evidence requested and liaison with the individual under investigation).

Trust Secretary – responsible for:

a)providing advice and support to the Council of Governors in respect of the administration of and compliance with the Fit and Proper Persons Test;

b)Where an investigation is required and the concern relates to the Chief People Officer , they will appoint / liaising with legal advisors in respect of the advice for the chair of the panel, the arrangements for the panel to meet, the collation of any evidence requested and liaison with the individual under investigation).

Board of Directors– are responsible for:

a) continuing to meet the requirements of being a Fit and Proper Person;

b) immediately bringing to the attention any circumstances where they may not continue to meet the requirements of being a Fit and Proper Person:

c) Providing all information necessary to complete the Fit and Proper Persons Test, the annual check or to assist the Trust in undertaking an investigation (if required) in a timely manner.

Independent Legal Counsel – are responsible once appointed for:

a)advising the Trust as to whether the individual needs to be suspended or placed on restricted duties;
b) to advise the Chief People Officer or Trust Secretary on the procedural steps necessary to investigate any Fit and Proper Person concerns raised and the evidence that will need to be collated for consideration;
Or another suitable qualified HR professional designated by the Chief Executive where the appointment relates to the Chief People Officer . Should the person under investigation be the Trust Secretary, the Chair shall seek advice from the Chief Executive and / or Director of HR as to whom shall undertake the this role.
c)at the meeting convened for the Chair, Senior Independent Director or Chief Executive (as appropriate) to consider if the concern raised affects whether an individual can continue to be regarded as a Fit and Proper Person, to advise the chair of the meeting as appropriate.

Table of Authority:

Accountable Director for F&PPT	Oversight and sign off
Chief Executive	Executive Directors (notify the Chair/SID as appropriate)
Chairman	CEO (notify SID as appropriate) NEDS (notify CEO as appropriate)
SID	Chair (notify the CEO as appropriate)

2.4 Process

2.4.1 Upon Appointment

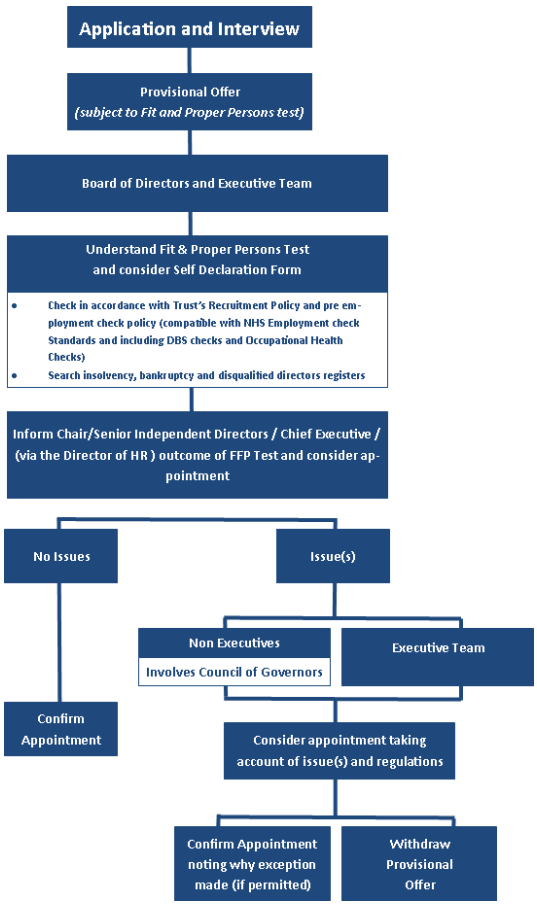
Where a post is subject to the Fit and Proper Persons Test candidates will be notified as part of the Trust's normal recruitment processes. In addition to the other requirements of the NHS Safer Employment Check Standards and the Trust's Recruitment and Selection Policy and Procedure, candidates will be required to complete the Fit and Proper Persons Self Declaration Form (see Appendix C).

The Fit and Proper Persons Test for a new starter upon appointment will comprise the following (including checking their Self-Assessment Form against the information reviewed below):

Test Element	Process Defined In
Good Character	Pre-Employment checks – see Recruitment & Selection Policy and supporting procedures (e.g., references, identify checks, right to work, qualification checked)
Physically and mental fit	Occupational health screening process - see Occupational Health Policy
Necessary qualifications	Certificates and professional registration checks - see Recruitment & Selection Policy and supporting procedures and Self-declaration
Skills and experience	Interview / assessment centre - see Recruitment & Selection Policy and supporting procedures Self-declaration
Criminal convictions	Disclosure and Barring Service - see Policy & Procedure for Disclosure & Barring Service Checks Self-declaration
Full employment history	Application form / CV - see Recruitment & Selection Policy and supporting procedures

Bankruptcy / insolvency	HR searches of relevant insolvency and bankruptcy register Self-declaration – see Appendix B
Investigations / struck off / Barring Lists	HR searches of relevant professional registers and Companies House Self Declaration see Appendix B
Fitness to practice (including safeguarding / misconduct / mismanagement)	General – see recruitment & selection Policy and supporting procedures Professional registration - see Professional Registration Policy Self-declaration – see Appendix C
Eligibility to hold office	HR searches of disqualified director register -; Employment Check Policy and Procedure Self-declaration Appendix C

Subject to the findings from completing the Fit and Proper Person Test, Figure 1 outlines the process that will be followed upon appointment.



If a person meets the Fit and Proper Persons Test then, along with the satisfactory completion of the other required pre-employment checks, an offer of employment may be confirmed. If it is unlikely the person will meet the Fit and Proper Person Tests, please refer to section 2.6 below.

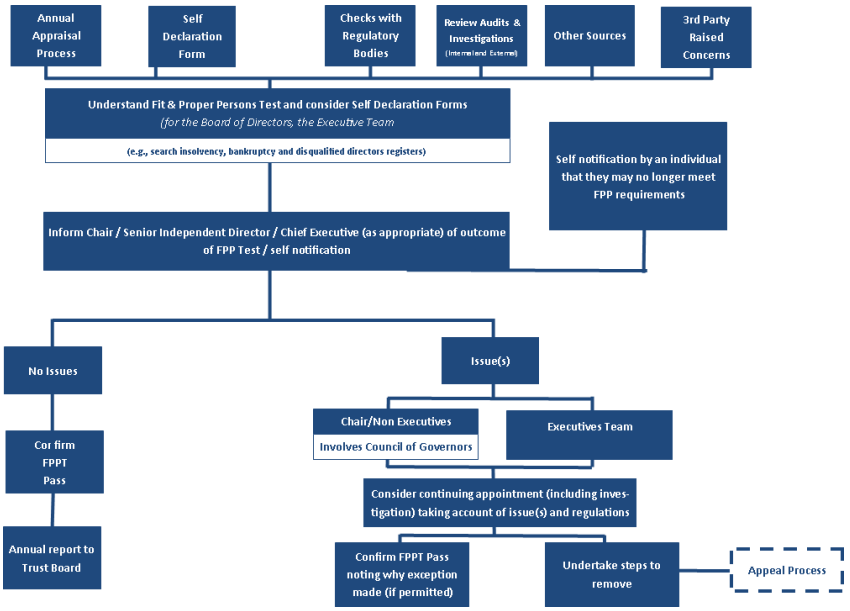
2.5 Annual and Ongoing Review

The Trust Board is responsible for ensuring the continued 'fitness' of those persons under Fit and Proper Persons Test. The Trust shall discharge this responsibility through an annual review process comprising of the following:

a) completion of the Fit and Proper Persons Self Declaration Form annually by the persons covered by this policy (see Appendix B);
b) the Workforce Team undertaking annual checks against the relevant insolvency, bankruptcy and disqualified directors registers by the end of March each year;
c) Annual declaration of interest
d) the formal appraisal process by the relevant line manager

If at any time any member of the Board fails to declare any information which could call into question them continuing to be regarded as a Fit and Proper Person, then consideration will need to be given to their suspension and potential disqualification from office and / or dismissal in line with the Trust's Disciplinary Procedure.

Subject to the findings from completing the Fit and Proper Person Test, Figure 2 outlines the process that will be followed. Please also refer to sections 2.7.



2.6 Managing an Unfit Outcome - Failure to Confirm the Appointment

If during pre-employment screening it emerges that the individual appears unlikely to meet the requirements of the Fit and Proper Person Test, then consideration should be given to withdrawing the appointment / offer of employment. The Chief People Officer with the support of their team and in line with the legislation, CQC guidance and Trust policy, may consider if requests from the individual for further information may be necessary so as to make a fully informed decision. However if the individual fails to meet the Fit and Proper Persons Test requirements, the offer for appointment / employment should be withdrawn

2.7 Managing an Unfit Outcome – Annual Review Process

If during the annual review process aspects of the annual review process have not been completed or it has been found that the Trust had not complied with this policy, then consideration should be given, based upon a risk assessment, as to whether or not the individual should be suspended and / or subject to any form of disciplinary action.

In these circumstances, the Chief People Officer will bring this matter to the attention of the Chair, Senior Independent Director or Chief Executive (as relevant). The Chief People Officer will then agree the necessary actions with the Chair, Senior Independent Director or Chief Executive (as relevant), which will then be communicated to the individual concerned. The matter and outcome should also be reported as part of the annual report to the Board of Directors.

2.8 Managing an Unfit Outcome - Upon Investigation of a Concern

Circumstances may arise that concerns are raised about the Fit and Proper Person status of an individual as a result of:

a) A self-declaration
b) Concerns raised via internal escalation processes (including the annual / ongoing review); or
c) Concerns raised externally to the Trust by an individual, an organisation or a regulator

When a concern is brought to the attention of the Trust, the following initial actions will need to be undertaken:

a) Depending on which individual a concern(s) is raised about, that the appropriate members of the Trust are informed;
b) Consideration as to whether or not the nature of the concern(s) raised will require the individual to be suspended or placed on restricted duties. As all such concern(s) will be notified to the Chief People Officer, he / she will seek appropriate and independent legal advice on this issue to inform the actions of the Trust;
c) Confirmation of the investigation officer and the process and timescale to be used for the investigation (Chief People Officer and Trust Secretary to advise the Chair, Senior Independent Director or Chief Executive as appropriate, taking account of the independent legal advice);
d) Chief People Officer (or the Trust Secretary if the concern is about the Chief People Officer to liaise with regulatory bodies such as CQC/NHSI/E as appropriate.

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
Compliance of the F&PPT policy In respect of the Board of Directors	Annual Report	People and Culture Committee	Annually	Report	As per policy
Action taken where issues or concerns are raised against a member of the Board Directors	Adhoc report	Lead Governor or the Board of Directors (as appropriate)	Adhoc	Report	As per the policy

4 Duties and Responsibilities of Individuals and Groups

4.1 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Conduct Management Policy	T:\Trust-wide Documents
2	Recruitment and Selection Policy	T:\Trust-wide Documents
3	Pre Employment Check Policy and Procedure	T:\Trust-wide Documents
4	CQC	https://www.cqc.org.uk/guidance-providers/regulations-enforcement/fit-proper-persons-directors
5	NHS Improvement	https://improvement.nhs.uk/resources/fit-and-proper-persons-requirements/
6	The Health and Social Care Act 2008	http://www.legislation.gov.uk
7	Insolvency Act 1986	http://www.legislation.gov.uk
8	Safeguarding Vulnerable Groups Act 2006	http://www.legislation.gov.uk

5.2 Consultation Process

In developing this policy, the Trust has taken account of the 2014 Regulations, guidance issued by the CQC, legal advice obtained by the Trust and discussions / correspondence with professional bodies, including NHS Employers.

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A.

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

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

Signed by the manager undertaking the assessment	Claire Warner
Date completed	07/02/2023
Job Title	Deputy Director of HR

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Appendix B - Schedule 3 of the 2014 Regulations

The CQC has the right to require the provision of information set out in Schedule 3 of the 2014 Regulations and such other information as is kept by the organisation that is relevant to the individual as follows:

1. proof of identity including a recent photograph;

2. where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(38), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(39);

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

4. satisfactory evidence of conduct in previous employment concerned with the provision of services relating to:
   - health or social care, or,
   - children or vulnerable adults;

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

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

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

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

9. for the purposes of this Schedule:
   - 'the appointed day' means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force,
   - 'satisfactory' means satisfactory in the opinion of the CQC,
   - 'suitability information relating to children or vulnerable adults' means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

Appendix C - Self-Declaration Form

To be completed by the applicant/existing member of staff

Please print the declaration form and sign using a black or blue ball point pen. In signing this declaration you are confirming that you fully understand the terms outlined within "the Regulations" and the information you have provided is accurate and correct.

Should you be aware of any pending proceedings or matters which may call such a declaration into question, please provide additional information in the space provided.

It is important to stress that our organisation aims to promote equality of opportunity and is committed to treating all individuals for positions fairly and on merit. Any information disclosed which we believe may have a bearing on your suitability for the position, will be discussed with you. If we do not raise this information with you, this is because we do not believe that it should be taken into account. In any event, you still remain free, should you wish, to discuss the matter with the recruiting manager or, where already employed, with your direct line of management.

I, the undersigned, declare that:

□ I am of good character:

□ I have not been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

□ I have not been convicted in the United Kingdom of any offence (including cautions, reprimands or final warnings) which are not "protected" (as defined by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as amended in 2013) and which are considered unspent (meaning current) under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975; or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute as an offence which is not "protected".

□ I have the necessary qualifications, competence, skills and experience for the relevant office, or position for which I am applying/or am already employed to do.

□ I do not know of any health issues, after reasonable adjustments are made, which may prevent me from properly performing tasks which are intrinsic to the position for which I am applying/or work for which I am employed to do.

□ I do not meet any of the unfit criteria as outlined below:

- I have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or in providing a service elsewhere which, if provided in England, would be a regulated activity.
- I am not an un-discharged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- I am not subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- I have not been served with a moratorium period under a debt relief order, which applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(1).
- I have not made a composition arrangement with, or been granted with a trust deed for creditors, which has not been discharged.
- I am not prohibited from holding the relevant office, or position by, or under any enactment.

This statement specifically relates to positions which, because of their activities and responsibilities, are deemed as 'regulated activity' under the Safeguarding Vulnerable Groups Act 2006 (as amended) and as such fall eligible for an enhanced check with barring information through the Disclosure and Barring Service (known as a DBS check). Where the employing organisation has identified your position as being eligible for such as check, please confirm that the following statement is correct.

- I am not included under the children's barred list or the adults' barred list which is maintained by the Disclosure and Barring Service (DBS) or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

Name:	Signed:
Position:	
Date:	
Space to include any area that you are unable to declare and/or pending proceeding	

Data Protection

The information that you provide in this declaration form will be processed in accordance with the Data Protection Act 1998. It will be used for the purpose of determining your fitness to hold a director level position under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. By signing this declaration form you consent to the information you provide in the form to be processed for this purpose. This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the organisation who are authorised to view it as a necessary part of their work.

Appendix D - Compliance Tracker

Fit and Proper Person Test - Evidence of compliance with Regulation 5		
Component of the Regulation Tested	**xxxxxxxx Director of xxxxxxxx (voting / non-voting Board member)**	**Comments**
Date of Appointment as Board Member	xx/xx/xxxx	
Further terms when fixed term appointment		
5(3)(a) good character - consider all available information		
Proof of identity		
Proof of address		
Right to work check		
2 references		
DBS check		
Insolvency & Bankruptcy Register check		
Disqualified Directors Register check		
Personnel Records (grievances, concerns, complaints, complements, awards)		
F&PP self declaration		
Third Party Confidentiality Statement		
Declared Interest Register		
Code of Conduct Declaration		
Standards for Members of NHS Boards		
5(3)(a) good character - take timely action to investigate an allegation of not good character		
5(3)(a) good character - record reasons for deeming an individual suitable when criteria not met		
5(3)(b) qualifications, competence, skill and experience - necessary for role		
Qualifications		
Professional registration		
Annual Appraisal		
5(3)(b) qualifications, competence, skill and experience - follow process & keep records		
5(3)(b) qualifications, competence, skill and experience - development of competence within specified timeframe		
5(3)(b) qualifications, competence, skill and experience - follow guidance		
5(3)(c) physically & mentally fit - ability to sustain management function		
Occupational Health clearance		
5(3)(d) serious misconduct or management - investigate and make enquiries / do not appoint		
5(3)(e) unfitness		
Other		
Information from Personnel Records relevant to F&PP Test		
Date	**Details**	**Comments**
xx/xx/xxx	xxxxxxxxxxxxx	xxxxxxxxxxxxx

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

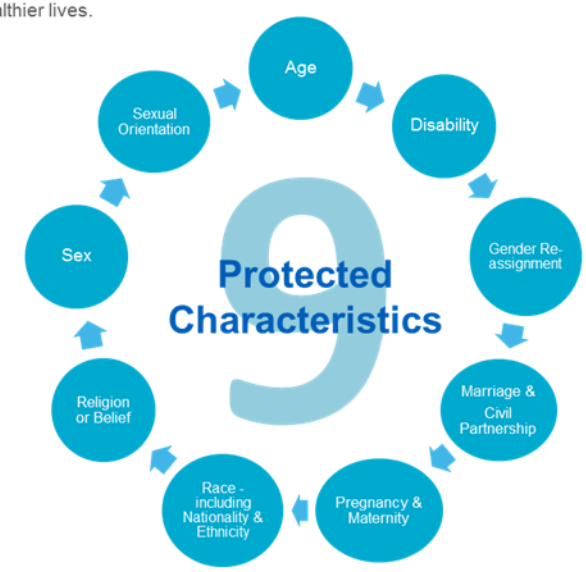
Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels