Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 7 November 2024, 9.30am to 1.00pm

By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome**	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 • 5 September 2024 (draft)	7 – 16	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	17	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Patient Story (Care Reflection) – Negative impact of deconditioning on frail patients** Rachel Taylor, Falls Specialist Nurse and Annie Morse, Head of Acute Therapies & Professional Lead for Physiotherapy	18 – 19	RT/AM	Assurance	9.35
7.	**Chair's Report** Liam Coleman, Chair	20 – 27	LC	Note	10.05
8.	**Managing Director's Report** Jon Westbrook, Interim Managing Director	28 – 34	JW	Note	10.15
9.	**Integrated Performance Report**				10.30
	• Performance, Population & Place Committee Board Assurance Report (September & October) – Bernie Morley, Non-Executive Director & Committee Chair	35 – 38	BM	Assurance	
	• Quality & Safety Committee Board Assurance Report (September & October) – Claudia Paoloni, Non-Executive Director & Deputy Committee Chair	39 – 46	EKA	Assurance	-
	• Finance, Infrastructure & Digital Committee Board Assurance Report (September & October) – Faried Chopdat, Non-Executive Director & Committee Chair	47 – 59	FC	Assurance	-

		PAGES	BY	ACTION	TIME
	• People & Culture Committee Board Assurance Report (October) – Julian Duxfield, Non-Executive Director & Committee Chair	60 – 61	JD	Assurance	-
	• Integrated Performance Report	62 – 112	All	Assurance	-
BREAK (10 minutes) at 11.30 to 11.40am					
10.	**Audit, Risk & Assurance Committee Board Assurance Report (September)** Helen Spice, Non-Executive Director & Committee Chair	113 – 114	HS	Assurance	11.40
11.	**Learning from Deaths Report** Steve Haig, Acting Chief Medical Officer	115 – 120	SH	Assurance	11.50
12.	**Perinatal Services 6 month summary** Lisa Marshall, Director of Midwifery and Neonatal Services and Kat Simpson, Head of Midwifery and Neonatal Services	121 – 132	LM/KS	Receive	12.05
13.	**Freedom to Speak Up Annual Report 2024** Lisa Cheek, Chief Nurse Chris Mattock, Lead Guardian	133 – 142	LCh/CM	Note	12.20
14.	**Health & Safety Annual Report 2023/24** Simon Wade, Chief Financial Officer	143 – 166	SW	Approve	12.35
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
15.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	-	CC	Approve	12.50
16.	**Review of Trust Constitution** Caroline Coles, Company Secretary	167 – 171	CC	Approve	
17.	**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	-	-
18.	**Date and Time of next meeting** Thursday 5 December 2024 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
19.	**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"*	-	-	-	13.00

Great Western Hospitals NHS Foundation Trust

Board Meeting Timetable

2024											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Board	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
			Risk Management & Way Forward Plan			GWH Strategy Risk Appetite & Tolerance			• Power Outage • Cyber Security Training • 24+ Trust Strategy • Clever Together		

Great Western Hospitals NHS Foundation Trust

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

Present:

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Julian Duxfield (JD)	Non-Executive Director
Bernie Morley (BM)	Non-Executive Director
Will Smart (WS)	Non-Executive Director
Claudia Paoloni (CP)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Acting Chief Executive

In attendance:

Anushka Chaudhry	Deputy Chief Medical Officer (deputising for Steve Haig)
Caroline Coles (CC)	Company Secretary
Rommel Ravanan (RR)	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Claire Warner (CW)	Deputy Chief People Officer (deputising for Jude Gray)
Shelly Knight	Student Placement Manager (agenda item 109/24)
Hannah Langford-Wood	Paediatric Consultant (agenda item 109/24)
Sharon Woma	Lead for Equality, Diversity & Inclusion (agenda item 115/24)

Apologies

Jon Burwell (JB)	Acting Chief Digital Officer
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Claire Lehman (CL)	Associate Non-Executive Director

Number of members of the Public: No members of the public were in attendance

Matters Open to the Public and Press

Minute	Description	Action
104/24	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above. Liam Coleman, Chair acknowledged that this was the last meeting for Felicity Taylor-Drewe, Chief Operating Officer before she leaves the Trust in mid-October and thanked Felicity for her considerable commitment and contribution to the Executive role and Board.	
105/24	**Declarations of Interest** There were no declarations of interest.	
106/24	**Minutes of the previous meeting (public)** The minutes of the Board meetings held in public on 22 July 2024 and 1 August 2024 were adopted and agreed as a correct record.	

Minute	Description	Action

107/24 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list and the following noted:

043/24 : Charitable Funds Committee Board Assurance Report : Staff Lottery – It was noted that the governance process would be for a bi-annual report to Trust Management Committee and a light touch internal audit review would be undertaken feeding back into Audit, Risk & Assurance Committee.

082/24 : Quality & Safety Committee Board Assurance Report : Electronic Discharge Summaries (EDS) – It was confirmed that the installation date of the interim solution would be in November 2024.

108/24 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

109/24 **Improving Together Staff Stories**
Hannah Langford-Wood, Paediatric Consultant with special interest in Neonatology and Shelly Knight, Student Placement Manager joined the meeting to present this item.

The Board received a presentation which provided an overview of the Improving Together deployment and reflections from staff on recent Improving Together training. Both Hannah and Shelly shared their experiences around some of the challenges faced to undertake the training and outlined some of the early benefits to empower staff to contribute to drive continued improvement.

The Board discussed the challenges for medical staff to attend Improving Together training due to time constraints but was assured that those staff would continue to be supported through huddles on wards to maintain good engagement. Actions had been taken to adapt fast track training alongside more in-depth cohort training and that this would continue to be monitored to ensure its effectiveness for medical input. Connection was also being made with the Post Graduate Medical Education to link into existing Improving Together projects for junior doctors.

The Board thanked Hannah and Shelly for their presentation and was encouraged by the improvements being driven through the implementation of Improving Together methodology.

The Board **noted** the staff story.

110/24 **Chair's Report**
The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally.

It was noted that a meeting with local MPs and the Leader of Swindon Borough Council was due to take place on 6 September 2024 which would update stakeholders of new developments at the Trust, together with a tour of the new Emergency Department.

A summary report of Board Safety Walks for January to May 2024 was also noted.

The Board **noted** the report.

111/24 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report, and the following was highlighted:

Minute	Description	Action

National disorder
Following national violence and disorder seen in other parts of the country, assurance was provided to the Board that staff were being actively encouraged to report any incidents of abuse from patients or visitors using Trust policy and that support actions were being followed through. Processes were also to be strengthened to enable members of the public to report any witnessed incidences of abuse towards staff.

Integrated Front Door development
The new Emergency Department (ED) building was expected to open on 18 September 2024 and a plan was in place to safely care for patients during the transition from the old department to the new department. There would be no change to how patients would access services and that walk-in patients would continue to arrive via the Urgent Treatment Centre and triaged at the door.

Industrial action
Junior Doctors had been offered a pay deal by the Government. The British Medical Association has put this offer to its members and a decision was awaited.

A number of GPs were to take collective action after the BMA rejected changes to the 2024/25 General Medical Service contract. Any reduction in certain areas of work would be monitored for impact on patients.

UNISON members who work for Serco at GWH had voted for strike action. This would primarily affect housekeeping and portering staff and Serco have advised that the impact on our services should be minimal.

Adult Inpatient Survey
The results of the 2023 CQC Adult Inpatient Survey were recently published and the Trust's response rate was 42.4%. There had been improvement in 20 questions which included good staffing levels and attention from staff when needed, privacy and dignity and the overall patient experience. However, there had also been a decline in some areas which related predominantly to the discharge process. A number of actions had been agreed following a review of the findings of the survey.

Financial situation
As at month 4, the Trust was in a £6.2m deficit position, which was £3.3m worse than plan. Savings targets this year were £21.9m, of which £3.9m had been delivered to date, with 59% of those savings recurrent. Work continued by divisions and services on the delivery of savings, together with tight controls to reduce the pay spend.

Veteran aware
The Trust had been re-accredited as a Veteran Aware organisation which demonstrated its commitment to high standards of care for the Armed Forces community.

Senior appointments
Benny Goodman had been appointed as the Trust's new Chief Operating Officer and Ana Gardete had been appointed as Deputy Chief Nurse.

Great West Fest
The 4th Great West Fest for staff and their families will take place on 14 September.

Launch of e-cards staff recognition scheme
In response to feedback from last year's staff survey, a peer-to-peer e-card system had been launched for staff to recognise and celebrate their colleagues' hard work.

Minute	Description	Action

South Asian Heritage Month
South Asian Heritage Month was marked which followed the theme of 'Free to be Me' and celebrated the stories that make up our diverse and vibrant community.

Pride
Some of GWH staff joined the Swindon and Wiltshire Pride festival last month and shared some of the great work happening across the Trust for an inclusive and equal organisation, including some of the initiatives underway to develop its diverse workforce.

Emergency Care Performance
A visit was expected by the Emergency Care Improvement Support Team (ECIST) and GIRFT to review and support areas of good practice. The Trust was now in a better position following the work of its operational teams, with the 4-hour performance target now at 80% and a reduction in ambulance handover times.

The Board discussed the support from ECIST and the improvements made in SDEC with developed pathways. It was noted that performance around frailty services remained a challenge and that ECIST would be asked to support the improvement work in this area. This would be monitored through the Performance, Population & Place Committee to gain further assurance.

The Board **noted** the report.

112/23 **Integrated Performance Report**
The Board received the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in July 2024.

Quarterly Pillar Metric deep dive
The quarterly deep dive of breakthrough objectives and pillar metrics were presented, with a particular focus on the past 12 months trends.

Our Care
Lisa Chief, Chief Nurse reported that there were two strategic pillar targets for Our Care. These were to achieve zero avoidable harm within 5-10 years and to achieve consistent positive response rates in excess of 90% from patient Family and Friends Test (F&FT).

In terms of F&FT for Q4 2023 and Q1 2024, the average score for the Emergency Department and Urgent Treatment Centre was 79%, for the inpatient areas an average of 85% and overall Trust average score of 88%. Data comparison had shown that the score remained fairly static, although there had been a very slight decrease in the number of negative free text comments overall. The top negative themes were staff attitude, environment and waiting times and the top positive themes were staff attitude, environment and waiting times and the top positive themes related to staff attitude, implementation of care and environment, which had remained the same when comparing the two quarters. There had been increased focus on driving improvement using this feedback and free text comments and examples of that work was outlined and noted.

Total harms for this period in comparison to the previous six months had shown a slight reduction in overall total harms and the three top contributor areas to total harms were pressure damage, falls and infections.

Falls remained the current breakthrough objective with the aim to reduce total falls by 20%, reduce the number of patients who had experienced moderate harm and above by 20% and reduce the number of patients who had fallen more than once by 20%. In relation to total falls and multiple falls, there had been an improvement this year with lower numbers than last year. However, there had been an increase in falls with moderate harm and above and this continued to be an area of focus. Several improvement projects had been

Minute	Description	Action

implemented which related to the new level of supervision assessment tool, an enhanced care policy, and new mobility assessment tool to support staff.

Community pressure harm continued to show improvements. However, further actions continued to be implemented in the acute setting to drive further improvement and improvement could be evidenced in the reduction of reported category 3, 4 or unstageable pressure harm from the previous year. An increase in reporting category 1 or 2 pressure harm was an indication of harm being detected earlier and preventative measures being implemented. Pressure harm continues to be a driver metric and actions continued to drive improvements and to promptly identify decreases in performance to allow the right interventions and support to be put in place.

Comparisons to the previous year and also for Q1 for this year against the South West, had shown improvements in MRSA, MSSA and *C.diff* and also positive comparison to the SW rates. Two areas that required further work related to *E.coli* and *Klebsiella* and improvement actions were outlined and noted.

The Board acknowledged the targeted focus in relation to pressure harms and that the impact from the measures being implemented to drive improvement were encouraging.

Our Performance

Felicity Taylor-Drewe, Chief Operating Officer reported that the strategic pillar target for Our Performance related to Ambulance Handover Delays which had been chosen as the 2024/25 breakthrough objective.

July performance data had shown the total number of patients waiting over 52 weeks had increased from the previous month and 371 patients worse than the operating plan trajectory for July. Focus for the operating plan was to achieve the end of year target of zero breaches and the Trust remained ahead of trajectory in this area across all specialties, with the largest volume of unbooked patients in General Surgery, Gastroenterology and Gynaecology. The Trust also remained committed to reducing the size of the waiting list tail by eliminating 65 week wait breaches by the end of September.

The PTL continued to be managed within nationally set thresholds and the Trust remained below the national target of 6.8%. The Trust exceeded the operating plan trajectory for both the 28-day Faster Diagnosis Standard (FDS) and 62-day referral to treatment standard in June at 70.2% and 69.4% respectively.

The Trust remained in Tier 2 for cancer as part of the performance management regime and robust evidence of sustaining an improved position was required for the next assessment.

Performance data for ambulance handover delays showed that the average hours lost per day had reduced by 40% from 118 hours in June to 71 in July. This was just above the breakthrough target of under 70 hours of hours lost per day and actions were in place to continue to sustain improvements. The Trust had initiated a SAFER Summer rapid improvement event throughout July with support across the Trust and system partners and the learning from this event would be carried forward into the Urgent and Emergency Care transformation programme.

Our People

Claire Warner, Deputy Chief People Officer provided an update on the actions against the strategic pillar targets which related to Staff Survey – Recommend a Place to Work, Staff Voluntary Turnover and EDI disparity.

A marked improvement to the score for “Recommend as a Place to Work” had been seen in the 2023 Annual Survey results; however, the recent Pulse Survey had shown a decline

Minute	Description	Action

in this question in Q2. In Q2 there had been a slight decline to the number of staff who would recommend the organisation as a place to work, driven by a noticeable decrease in the number of Healthcare Support Workers who had agreed with this statement. The Board noted that analysis of this data was to be undertaken to further understand the reasons behind this decline and that this would inform a targeted focus by Divisional Directors of Nursing.

Following a review of staff survey performance, the Trust-A3 had been updated and 'Teamwork' had been identified as an area of opportunity to drive performance against the pillar metric of 'Recommending as a place of work' and therefore the breakthrough objective had moved to question 7C ('I receive the respect I deserve from my colleagues at work') to drive further improvement in 2024/25. The Q2 Pulse Survey had also included free text questions to allow staff to share their expectations around respect in the workplace and key themes had been identified which related to communication, listening, equality and fairness, understanding and empathy, and support and teamwork. Workstreams had been developed to drive improvement in these areas.

The Trust continued to improve and stabilise the voluntary turnover rate and in July this had reduced to 8.0%. Performance below the 11% target had been sustained for 12 months and performance would continue to be maintained through the Trust Retention Working Group, with high impact actions to further reduce the turnover rate driven by the People Promise Manager. A visit was scheduled for early October from national and regional team to show case work underway which would focus on onboarding experience, digitalisation of appraisals, exit interviews and flexible working.

Discrimination disparity had significantly increased this month due to an increase in BAME staff reporting discrimination from manager/team leader or colleague. To address this the EDI Lead will put in place mitigating actions which include continue to recruit, train and deploy EDI Champions, offer Cultural Competence and working with staff networks and divisional leads.

Use of Resources

Simon Wade, Chief Financial Officer reported on the breakthrough objective for productivity. The financial breakthrough objective was to remain within the Trust's overall deficit plan by month for 2024/25, having improved the underlying financial deficit position by the financial year and through delivery of recurrent CIP.

As at Month 4, the Trust had a year-to-date adjusted deficit position of £6.2m, which represented a £3.3m adverse variance to plan. Income was £1.3m favourable to plan driven by Elective Recovery Fund (ERF) (£0.4m) and an overperformance on NHSE commissioned drugs (£0.9m).

The performance behind plan on the efficiency programme of £1.8m demonstrated that the Trust's run-rate reductions did not sufficiently impact the financial position to extent required to meet the full-year plan. Various recovery workstreams were in progress, particularly around run-rates. Activity was being scrutinised around the non-delivery of volume, or value of the relevant volume, against plan.

Pay remained £0.5m under plan due to centrally-held reserves which would be used to support divisional pay positions throughout the year.

Non-Pay was £5.8m over plan which included a £3.8m variance in clinical supplies. A proportion of the cost related to the delivery of additional ERF activity and would be partially offset by income. A working group, which included procurement, was to analyse the drivers of clinical supply spend with a view to achieving savings. Non-Pay would continue to be an area of key focus for the Finance, Infrastructure & Digital Committee to further explore headline numbers.

Minute	Description	Action

Board Assurance Reports

Our Performance
Performance, Population and Place Committee Chair Overview
The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meetings on 26 June 2024 and 24 July 2024 and the following was highlighted:

- Diagnostic performance continued to deliver above plan for activity and for performance at 70.72% for July 2024, which was the best performance since July 2021. Work continued to ensure all modalities were supported to achieve performance recovery. Good recovery in NOUS (non-obstetric ultrasound scan) and CT modalities was reported.
- An update was received on the work of the Swindon Integrated Care Alliance, Swindon Borough Council Health & Wellbeing Board and the Acute Hospital Alliance work to strengthen collaboration across the three trusts.

The Board **noted** the report.

Our Care
Quality & Safety Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meetings on 20 June 2024 and 18 July 2024 and the following was highlighted:

- A team had been established to review the Trust status in the implementation of current NICE guidelines. A new database had been created to be mapped against the national NICE database and that data cleansing was ongoing to ensure that accurate data was available to divisional quality teams to drive improvements to ensure that all relevant NICE guidelines were being implemented.
- A robust discussion had been held around the lack of assurance for interim measures for electronic discharge summaries to be implemented through the Careflow integration adjustments, with no control around the third-party activity. Further options were required in relation to interim non-electronic measures and costings and any additional resource investment requirements. It was noted that the development of a new discharge summary production platform was anticipated to be completed by late November 2024.

Liam Coleman, Chair reflected on the limited assurance rating by QSC which related to wider issues of engagement by clinicians in the mortality review process and that it was to be more directly addressed through the Medical Director team. It was requested that an update be provided to the Board on the proposed strategy to improve attendance at the Learning From Deaths Group and clinical engagement with structured judgement reviews.
Action: Acting Chief Medical Officer **SH**

The Board **noted** the report.

Our People
People & Culture Committee Chair Overview
The Board received a verbal, due to timing of the meeting, overview of the discussions held at the People & Culture Committee (PCC) at its meeting on 25 June 2024 and the following was highlighted:

- An update on the leadership development work provided assurance that a good range of initiatives were being deployed, but there was a need to ensure that the

Minute	Description	Action

approach continued to be simplified, and that evidence of impact was tracked in the future.
- The emerging work on career development plans and the implementation of the 'scope for growth' model for career conversations with staff was received. Succession Planning Moderation Board meetings were to be held in October and November.
- Minor changes to the current Board Assurance Framework were that strategic risk 3 (health and wellbeing) would be incorporated into strategic risk 2 (culture) for Q2 and that workforce appetite and tolerance statements would be available for review at the next PCC meeting, together with any changes to the risk descriptions.

The Board **noted** the report.

Use of Resources

Finance, Infrastructure & Digital Committee Chair Overview

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meetings on 24 June 2024 and 22 July 2024 and the following was highlighted:

- The Trust's financial position and the broader BSW system remained a challenge in 2024/25. There was a requirement for more mature governance processes, greater transparency, consistent criteria and uniform forecasting methodology at system level to gain greater assurance and better viewing comparable data points. FIDC remained unsure about the alignment of the Trust governance processes to that of the system and the actions to be taken. Assurance was provided that regular meetings were taking place at system level to address this and move plans into the delivery phase. Liam Coleman, Chair reflected that governance processes would also need to be mapped out for the proposed Group Model and the actions needed to address the projected year-end system deficit of £30m in line with the plan.

The Board **noted** the report.

113/24 **Mental Health Governance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Mental Health Governance Committee (MHGC) at its meeting on 19 July 2024 and highlighted the following:

- The challenge remained significant in the Emergency Department and Children's Services. Good assurance had been provided on the work done, in partnership with AWP and CAMHS, to ensure that the mental health needs of patients were being met. Steps were being taken by ED to support the safe management of patients presenting to ED with mental health issues given the reduction in the bed base associated with the development of the Integrated Front Door. In relation to Children's Services, the development of Mental Health Champions and the introduction of the Barnardo's Youth Workers were noted.
- A review of internal missing persons procedures had demonstrated that these were fit for the phase 2 implementation of the Right Care Right Person operational model and that positive feedback had been received from Wiltshire Police as an organisational peer.
- Assurance was also received on the processes and procedures applied at the Trust on the use of the Mental Capacity Act and Deprivation of Liberty Safeguards.

The Board **noted** the report.

Minute	Description	Action

114/24 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 14 August 2024 and highlighted the following:

- A new Charitable Funds Impact Report was agreed which would provide a way of analysing and measuring the impact of charitable funding and would also provide confidence to donors on the use of donated monies.
- The process and documentation for cases of needs was to be revised to drive further improvement.
- There had been good progress on the dialogue with divisions to ensure that clear plans exist to use the funds available. Divisions would continue to attend future CFC meetings to present a further deep dive into plans.

Lizzie Abderrahim, Non-Executive Director commented on the significant charitable funds held by Wiltshire Health & Care. It was confirmed that they were being encouraged to develop clear plans for those funds.

The Board **noted** the report.

115/24 **Inclusion & Health Inequalities Annual Report 2023/24**

Sharon Woma, Lead for Equality, Diversity & Inclusion joined the meeting to present this item.

The Board received and considered the Inclusion & Health Inequalities Annual Report 2023-24 which provided an overview of the progress against the EDI Strategic Objectives and 2023-24 Priorities for the Trust. This included improvements in the two key performance frameworks – Workforce Disability Equality Standard and Workforce Race Equality Standard, and progress on the Gender Pay Gap, Equality Delivery System and the NHS EDI Improvement Plan which the Trust implemented this year.

It was noted that the EDI Strategy 2020-2024 was currently being refreshed and a new Strategic EDI Plan would be published towards the end of 2025 which would provide direction for the next four years. The EDI Plan published in this year's annual report for the year ahead represented the foundation work underway to support the 2024-2028 Strategic Plan.

Bernie Morley, Non-Executive Director reflected on the reference to the statistical data gathered to inform tackling health inequalities and if there were any further studies available to help the Trust make further improvements to patient care for the local population. Sharon Woma agreed to explore this further to drive improvement.

Lizzie Abderrahim, Non-Executive Director commented that the report and introduction to the report should be strengthened to further reference health inequalities. Sharon Woma responded that actions were to be taken to include a more robust reference to health inequalities within the workforce in future reports and that Improving Together initiatives would also help to build on this work.

The Board thanked Sharon Woma for the considerable work undertaken to produce a concise and informative report.

RESOLUTION

The Board

(a) ***approves*** *the Inclusion & Health Inequalities Annual Report 2023-2024 for publication, subject to the addition of strengthened reference to health inequalities in the report introduction; and*

(b) ***delegates authority*** *to the Chair and Chief Executive to have final sign off before publication.*

Minute	Description	Action

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

116/24 **Ratification of Decisions made via Board Circular**
None.

117/24 **Annual Review of Scheme of Delegation (including Powers Reserved to the Board)**
The Board received and considered the annual review of the Scheme of Delegation (SofD) (including Powers Reserved to the Board). Two amendments were proposed in Powers Reserved to the Board (highlighted in italics below) as follows:

- Council of Governors : To represent the interests of members of the NHS Foundation Trust as a whole and the public *"at large".*
- Delete - *Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.*

RESOLUTION
*The Board **approves** the proposed revisions to the Scheme of Delegation as above*.

118/24 **Urgent Public Business (if any)**
None.

119/24 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 7 November 2024 at the DoubleTree by Hilton Hotel, Swindon.

120/24 **Exclusion of the Public and Press**
The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.

The meeting finished at 13:00hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – November 2024				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
5 September 2024	112/23	**Quality & Safety Committee Chair Overview** Update to be provided on the proposed strategy to improve attendance at the Learning From Deaths Group and clinical engagement with structured judgement reviews.	Acting Chief Medical Officer	
5 September 2024	115/24	**Inclusion & Health Inequalities Annual Report 2023/24** Report to be amended before final sign off and publication.	Chief People Officer	Additional text has been signed off by Chair and Acting Chief Executive. Final version to be published on Trust website by 31 October 2024.

Future Actions				
None				

Report Title	**Care Reflection – Negative impact of deconditioning on frail patients**				
Meeting	**Board of Directors**				
Date	**7th November 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement				
Appendices					

Purpose

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

Assurance Level

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

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

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

The Care Reflection highlights areas for improvement in care, staff awareness and training. The staff leading this work provide information about ongoing projects to ensure we learn from this experience of care.

Report

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

This care reflection shares the experience of an elderly patient and her daughter following a hip fracture. It demonstrates the importance of early and continued mobilisation for patients in order to ensure that they have the best opportunity to return to their baseline functional ability.

The experience explains the negative impact that deconditioning can have on frail patients, how this can occur very quickly and how it can lead to poorer outcomes and negative patient experience. There are positives identified but the experience has also identified some areas where care could be further improved and the need to raise awareness and knowledge with our staff.

The video will be used as part of staff training connected to our falls prevention and 'Get up, Get Dressed, Get Moving' campaign.

Staff leading this project will provide further detail about ongoing improvement work and how the experience is being shared.

The film can be viewed at: Deconditioning - Trust Board (youtube.com)

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps	The learning from this care reflection will be shared widely via the departmental and divisional governance structures and more widely across the trust as part of staff training.				

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 patient and family experience along with the developments and improvements identified from this Care Reflection.	
Accountable Lead Signature	Lisa Heath
Date	10th November 2024

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**7 November 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Strategic Risk Mapping to Board agenda 23/24				

Purpose

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

Assurance Level

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

Process

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

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

Report

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

This report outlines a summary of the Chair's activity and key areas of focus since the previous Board of Directors meeting, including:

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

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk 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	28 October 2024

Chair's Board Report

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

1. Council of Governors

1.1 The Trust 's Annual Members Meeting took place on 25 September 2024. At this meeting the Trust's Annual Report & Accounts were formally presented together with the opportunity to hear about the Trust's progress and achievements.

The 2023/24 annual report and accounts is available on the Trust's website: annual-report-and-accounts-2023-24.pdf

1.2 The results of the Governor elections (uncontested) that were held over the summer period are as follows:

- Wiltshire Northern (public) 2 seats – Sarah Marshall, 1x vacancy remains
- Wiltshire Central (public) 2 seats – Chris Callow (re-elected), 1x vacancy remains
- West Berkshire & Oxfordshire (public) 1 seat – Stephen Baldwin
- Allied Health Professionals (staff) 1 seat – Caroline Olukemi

Congratulations to our new governors and to Chris for being re-elected and we welcome them all to the next Council of Governors meeting on 27 November 2024.

1.3 A huge thank you goes to Pauline Cooke who has been a governor representing Northern Wiltshire for the past 9 years and steps down at the end of November. It has been a pleasure to work with Pauline and she will be sorely missed.

1.4 The following table outlines the key meetings, training and events during September & October 2024 which governors participated:-

September 2024		
Date	**Event**	**Purpose**
16 Sept	Nominations & Remuneration Committee	To consider the annual review of the Chair and Non-Executive Directors and to recommend to the Council of Governors that there has been a robust appraisal process.
24 Sept	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
25 Sept	Annual Members Meeting	Presentation of Annual Report & Accounts to Trust members
October 2024		
10 Oct	Extraordinary Council of Governors meeting	To approve the appointment of the Group Chief Executive
15 Oct	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
21 Oct	Outpatient Membership Recruitment	Governor stand to promote membership
24 Oct	Hospital Radio	Governor guest on hospital radio to promote membership
30 Oct	People's Experience & Quality Working Group	To identify key issues in relation to service users and staff experience and the quality of the work of the Trust. The Group received updates on the AHP recruitment & retention, safeguarding training in maternity and patient experience update, as well as the relevant Board Assurance Committee reports.

2. Strengthening Board Oversight & Development

2.1 Safety Visits - There were 3 Board safety visits during the period covered by this report as follows:-

Date	Area	Board Member
9 September 2024	Orchard Ward	Lisa Cheek, Chief Nurse Will Smart, Non-Executive Director
23 September 2024	Gynae Outpatients	Steve Haig, Acting Chief Medical Officer Helen Spice, Non-Executive Director Claudia Paoloni, Non-Executive Director
30 October 2024	Pharmacy	Jude Gray, Chief People Officer Julian Duxfield, Non-Executive Director

2.2 The strategic risk mapping to Board agenda exercise as requested in the September meeting is attached as appendix 1.

The table below summarises the strategic risks in terms of percentage of items on the board agenda over a 12 month period. This demonstrates that there is a fairly equal distribution for each strategic risk theme and that quality is the highest in all except one across the period.

	2023				2024							
Month ⇨	S	O	N	D	J	F	M	A	M	J	J	A
Themed Strategic Risk ⇩	% of agenda items mapped to strategic risk											
Quality	24%		31%	31%	39%	39%	30%		29%	35%		29%
Workforce	23%		20%	26%	22%	17%	24%		24%	21%		25%
Joined Up Care	23%		23%	22%	11%	22%	22%		21%	21%		24%
Use of Resource	30%		26%	20%	28%	22%	24%		26%	23%		20%

2.3 A Board Seminar was held on 3 October 2024 which focussed on cyber security, Trust Strategy and Speaking up and Listening, which included a report from the external review undertaken by Clever Together.

3. Trust Chair Key Meetings during September and October 2024

Meeting	Purpose
Monthly meeting with Non-Executive Directors & Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Performance, Population & Place Committee	To attend as an observer
Remuneration Committee	Board sub-committee meeting
Nominations & Remuneration Committee	NED Appraisal review
HWB Champions Forum	Network meeting
Wiltshire Health & Care Members' monthly meeting	Regular meeting
BSW Chairs' meeting	Regular meeting
AHA Transition Planning	Regular meeting of Chairs
Annual Members' Meeting	Annual statutory meeting
Meeting with Swindon MPs	To update and discuss any topical issues
Meeting with Berkeley Partnership re shared EPR Programme	To discuss EPR Project
BSW Acutes Group CEO Interview Panel	To appoint Group CEO
Extraordinary Council of Governors' Meeting	Approve the appointment of Group CEO
Big Coffee Break Roundtable Discussion – Speak Up, Listen Up	To listen to staff experience on EDI
Visit to Aseptic Unit	To visit unit prior to opening

Appendix 1 : Strategic Risk Mapping to Board agenda items – Sept-23 to Aug-24

KEY	
	Quality
	Workforce
	Partnership
	Use of Resources

Sept-23	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Patient Story – Complex Needs	1			
WDES & WRES Annual Report 2022-23		2		
IPR	All	→	→	
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – P&CC		2/3/4		
BAR – MHGC	1		6	
BAR – CFC				7
WDES & WRES Annual Report 2022-23		2		
Private	**Q**	**W**	**P**	**R**
Seasonal Plan	1	4	5	7
BAF Q1	All	→	→	
Risk Register Report	All	→	→	
Financial outlook - short to medium term				7
BSW Three Year Financial Recovery Plan				7
Partnership Update			6	
WFP: Expansion Land –				8
Total %	**24%**	**23%**	**23%**	**30%**

OCT-23
Seminar
– Trust Strategy

Nov-23	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Staff Story – Improving Together	1			7
IPR	All	→	→	
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – P&CC		2/3/4		
BAR – ARAC	All	→	→	
BAR – MHGC	1		6	
Saving Babies Lives v3	1			
Ockenden Report	1			
Equality Diversity Inclusion Annual Report		2		
Freedom to Speak Up Annual Report		2		
PSIR Framework	1			
Health & Safety Annual Report				8
IT Cyber Security				10
Risk Management Policy	All	→	→	
Private	**Q**	**W**	**P**	**R**
Expansion Land				8
Procurement of Community Services	1	4	6	8
Mortality Review	1			
Delivery of Financial Regime				7
Partnership Update			6	
Total %	**31%**	**20%**	**23%**	**26%**

Appendix 1 : Strategic Risk Mapping to Board agenda items – Sept-23 to Aug-24

KEY
Quality
Workforce
Joined up Care
Use of Resources

Dec-23	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Patient Story – Impaired hearing	1			
IPR	All →			
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – P&CC		2/3/4		
BAR – ARAC	All →			
BAR – CFC				7
EPRR Annual Statement	1	3/3/4	5	
SFIs Limits				7
Private	**Q**	**W**	**P**	**R**
CQC Improvement Notice	1			
Board Assurance Framework	All →			
Risk Register Report	All →			
Financial Plan				7
Partnership Update – Community Services Contract	1	2/3/4	6	
External Well Led Review	All →			
EDI Board Commitment	1	2/3/4		
Total %	**31%**	**26%**	**23%**	**20%**

Jan-24	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Staff Story – Improving Together	1	2/3/4		7
IPR	All →			
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
CNST Submission	1			7
Safe Staffing 6 mth review	1	2/3/4		
Private	**Q**	**W**	**P**	**R**
Appointment Process SID	1			
Charitable Funds AR&A				7
EDI Board Commitment	1	2/3/4		
Total %	**39%**	**22%**	**11%**	**28%**

Feb-24	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Patient story	1			
IPR	All →			
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – P&CC		2/3 →		
BAR – ARAC	All →			
BAR – MHGC	1		6	
Private	**Q**	**W**	**P**	**R**
Maternity, Adults & Children Safeguarding Report	1			
SID Appointment	1			
Cash Support Application				7
Total %	**39%**	**17%**	**22%**	**22%**

Appendix 1 : Strategic Risk Mapping to Board agenda items – Sept-23 to Aug-24

KEY	
	Quality
	Workforce
	Joined up Care
	Use of Resources

Mar-24	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Staff story – IPC & sustainability	1			8
IPR	All	→	→	
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – P&CC		2/3/4		
BAR – CFC				7
Learning from Deaths	1			
Gender Pay Gap		2/3/4		
Fit & Proper Person Test Policy	1			
Private	**Q**	**W**	**P**	**R**
EDI Board Commitment	1	2/3/4		
Board Assurance Framework	All	→	→	
Risk Register	All	→	→	
Wiltshire Health & Care			6	7
Partnership – Community Services	All	→	→	
Partnership – Trust Strategy	All	→	→	
Cash Requirement				7
WFP – Commercial Developer partner	All	→	→	
Total %	**30%**	**24%**	**22%**	**24%**

Apr-24
Seminar –
Risk Management / WFP

May-24	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Patient story – Parkinson's Disease	1			
IPR	All	→		
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – P&CC		2/3/4		
BAR – ARAC	All	→		
Ockenden Report	1			
Saving Babies Lives	1			
Staff Survey Results		2/3/4		
Register of DofI	1	2/3/4		7
Private	**Q**	**W**	**P**	**R**
Case for Change	All	→		
Partnership – AHA Briefing	All	→		
Partnership – Community Contract	All	→		
Partnership – WH&C			5/6	7
Partnership – EPR	All	→		All
Planning Update			5/6	7
Total %	**29%**	**24%**	**21%**	**26%**

Appendix 1 : Strategic Risk Mapping to Board agenda items – Sept-23 to Aug-24

KEY	
	Quality
	Workforce
	Joined up Care
	Use of Resources

Jun-24	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Staff story – breast cancer pathway	1			
CQC Unannounced Inspection	1			
IPR	All	→	→	
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – MHGC	1		6	
BAR – CFC				7
Safe Staffing 6 mth review	1	2/3/4		7
EDI Pillar Metric Review	1	2/3/4		
Committee Effectiveness	All	→	→	
AR&A Delegation	1			
Annual Self Certs	1			
Quality Accounts	1			
Private	**Q**	**W**	**P**	**R**
Partnership – AHA Briefing	All	→	→	
Partnership – Community Contract	All	→	→	
Partnership – Trust Strategy	All	→	→	
Board Assurance Framework	All	→	→	
Risk Register	All	→	→	
Board Disclosure Obligations and Lessons learn	All	→	→	
Total %	**35%**	**21%**	**21%**	**23%**

July-24
Seminar –
Risk Management & Trust Strategy

Aug-24	Strategic Objective/BAF			
Public	**Q**	**W**	**P**	**R**
Patient story - neonatal	1			
BAR – PPPC			5/6	
BAR – Q&SC	1			
BAR – FDIC				7/8/9/10
BAR – PCC		2/3/4		
BAR – ARAC	All	→	→	
Improving Together Yr2	All	→	→	
Committee Effectiveness	All	→	→	
F&PPT Annual Assurance	All	→	→	
Responsible Officer Annual Report	1	2/3/4		
Use of MH Act Annual Review	1		6	
Private	**Q**	**W**	**P**	**R**
Electrical Incident	All	→	→	
224/25 Capital Planning	All	→	→	
Partnership – Community Contract	All	→	→	
CDC Contract	All	→	→	
Total %	**29%**	**25%**	**24%**	**20%**

Report Title	**Managing Director's Report**				
Meeting	Trust Board				
Date	7 November	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jon Westbrook, Interim Managing Director				
Report Author	Jon Westbrook, Interim Managing Director				
Appendices	N/A				

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

Assurance Level

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

Board members are asked to note the report

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

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

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

Report

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

The report includes updates on:

- Appointment of Joint Chief Executive Officer
- Opening of our Integrated Front Door and Children's Emergency Unit
- Reducing noise at night
- Engagement on the Government's 10 year plan and Lord Darzi's report
- Outcome of community services procurement
- Recognition for our staff
- Staff survey

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

Links to Strategic Pillars & Strategic Risks – select one or more	★			
	x	x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)				**Risk Score**
	N/A			
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	N/A			
Next Steps	none			

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

Explanation of above analysis:

The report covers the opening of our Integrated Front Door and Children's Emergency Unit. Both of these developments involved engagement with individuals, groups, charities and support networks to ensure they best met the needs of our population.
This included representatives from the learning disability and autism community, the dementia community, wheelchair users, along with children and adolescent mental health services and many others.

The report also mentions the graduation of our first cohort of equality, diversity and inclusion champions, who work across the Trust to advocate for EDI.

Recommendation / Action Required The Board/Committee/Group is requested to:	
To note the report	
Accountable Lead Signature	Jon Westbrook, Interim Managing Director
Date	30 October 2024

1. Appointment of Joint Chief Executive Officer

On 1 November Cara Charles-Barks officially started as Joint Chief Executive Officer of our Trust, the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust.

She spent her first day in the new role at Great Western Hospital.

Cara has worked in our system for eight years, with CEO roles in Salisbury and Bath.
She is now the accountable officer at our Trust, the RUH and SFT.

Her appointment follows a decision by the three Trust Boards to establish a group model which will deliver better outcomes for the population we serve.

The group will be a collaboration between the three existing Trusts; each of which remain separate organisations and will maintain a dedicated Executive team and Board. This decision is not a merger of the Trusts.

Managing Directors will provide day-to-day leadership at each Trust. Jon Westbrook will be the interim Managing Director until a substantive appointment has been made through an open recruitment process.

2. Operational updates

2.1. Integrated Front Door opening

On 18 September we welcomed our first patient in to our new Emergency Department – a real milestone in our journey as a Trust.

The £33.5million urgent and emergency care expansion is the biggest ever investment to the hospital site and follows the opening of the Urgent Treatment Centre and OUH Radiotherapy @ Swindon Centre in 2022.

With a 60 per cent bigger footprint, the new Emergency Department will ensure unplanned healthcare provision is fit for the increasing demand and growing population of the town and surrounding areas.

In the first five weeks of being open, clinical teams have seen more than 8,000 patients in the new department.

2.2. Children’s Emergency Unit

We celebrated the completion of building work on our new Children's Emergency Unit (CEU), with children from Shaw Ridge Primary School cutting the ribbon on the new development at the end of September.

The CEU provides the capacity for the integration of our Children’s Emergency Department with our Paediatric Assessment Unit.

The new unit has 13 cubicles, two high acuity bays and one resuscitation bay, a baby and breastfeeding room, a sensory play room for children with neurodiversities and a wellbeing room for younger patients arriving in mental health crisis.

The team worked with young people across Swindon to understand how the new Children’s Emergency Unit should best meet their needs, and held design workshops at local primary schools and youth clubs.

The CEU was due to become operational yesterday.

2.3. Improving care for our surgical and medical patients

Currently, there are a number of clinical areas that care for both surgical and medical patients in the same area which we know does not enable us to deliver the best patient care possible.

Later this month a series of bed moves and reconfiguration of spaces will be taking place around the hospital, kick-started by the opening of the new Medical Assessment Unit which will run from the old Emergency Department, which has been refurbished.

The aim of this work is to help consolidate the care of medical outlying patients onto a dedicated ward to improve their care, in turn also reducing length of stay and the number of times a patient is moved during their stay.

3. Quality

3.1. Reducing noise at night

Recent feedback from the inpatient survey highlighted key issues that are affecting our patients' ability to rest and recover during the night.

Disruptions such as bright lights left on, excessive noise, and the unnecessary movement of patients late at night are impacting the quality of sleep across our wards.

A new project underway at the hospital aims to address these concerns by focusing on improving the night-time environment through better planning and heightened awareness of basic care principles.

One key goal is to ensure that patients are settled in their beds by 11pm, with minimal disruptions during key sleep hours.

3.2. Health Innovation West of England award

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

This service empowers women at high risk of hypertension during pregnancy to keep healthy and well at home using an automated text messaging system.

The pathway has other benefits for patients by reducing the financial cost and physical impact of travelling into hospital for frequent appointments.

Every year the outpatient service saves 1,248 face-to-face appointments, 312 clinical hours and 118 acute unit appointments.

The team’s achievement was also recognised with a STAR of the Month award internally.

3.3. World Patient Safety Day

We marked World Patient Safety Day in September with an online seminar featuring a number of guest speakers, including a focus on HIV testing which featured a powerful patient story. Staff at all levels were encouraged to attend.

3.4. New heart monitoring technology

Our Cardiac Physiology team recently completed the first ever implant of a new heart monitoring technology in the UK.

The Biomonitor IV is a substantial upgrade, and features cloud-based artificial intelligence technology to reduce the impact of ongoing remote monitoring for patients and to help clinicians achieve timely and accurate diagnosis.

The implant was performed by Kyra Sullivan, Specialist Physiologist, with support from the Cath Lab nursing team and representatives from Biotronik.

3.5. Anaesthesia Clinical Services Accreditation

Our Anaesthetic Department has been awarded the Anaesthesia Clinical Services Accreditation.

Throughout their journey to get to this point, the team have implemented significant improvements to their service, leading to enhanced safety, streamlined processes, and better outcomes for our patients.

A number of colleagues contributed to this achievement, including the pre-assessment team, anaesthetic theatre practitioners, recovery nurses, and anaesthetic doctors.

4. Systems and Strategy

4.1. 10 year plan

The Department of Health and Social Care and NHS England have launched a programme of engagement on a new 10-year plan which will be published in the spring.

The plan will set out how an NHS fit for the future will be delivered, creating a truly modern health service designed to meet the changing needs of the changing population, both here in Swindon and Wiltshire and right across the country.

The plan will be co-developed with the public, staff and patients through a thorough and detailed engagement exercise – which is the first of its kind ever conducted on this scale.

There are two key ways people can get involved:

- Submitting ideas and feedback through the online platform at change.nhs.uk
- Joining events taking place across the country and online which will be focussed on the three big shifts in healthcare to make the NHS fit for the future, moving it from analogue to digital, from hospital to community, and from sickness to prevention.

4.2. Lord Darzi report

The launch of the engagement follows the publication of a Government-commissioned report on the state of the NHS led by Lord Ara Darzi, a former health minister and surgeon.

The ‘Independent Investigation of the National Health Service in England’ focused on long waits in emergency departments, patient flow through hospitals, the UK’s higher cancer mortality rates, and capital investment in to the NHS.

The report details the current performance of the NHS, and builds a picture of a system where long waits are the norm, quality of care is mixed, productivity is low, and too great a share of the budget is spent in the acute sector.

It also highlights how the health of the nation has deteriorated.

Health Secretary Wes Streeting said three 'big shifts' were now needed: a move from hospital to community care; from analogue to digital; and from treating sickness to preventing it.

4.3. Outcome of procurement of community services

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

The consortium our Trust is a part of, BSW Communities Together, was not chosen to lead community-based care, however we are committed to work with HCRG and other partners to join up and improve care.

Our focus now is on supporting our staff through this change. Staff working in services affected will be protected by Transfer of Undertakings Protection of Employment (TUPE) regulations.

4.4. Financial situation

We have a year-to-date deficit of £7.6m, which is £2.9m worse than our plan.

Of the £6.8m savings delivered so far year to date, 52% is recurrent.

Our savings target is £21.9m, and we have considerable work to do to reduce the amount we spend and work to deliver recurrent savings if we are to achieve this.

Tighter controls around the approval of bank shifts, overtime and waiting list initiatives will contribute to this, as will ongoing work in reducing temporary staffing.

5. Workforce, wellbeing and recognition

5.1. Senior appointments

James Curtis has been appointed as Divisional Director for our Surgery, Women and Children's Division.

5.2. STARS of the Month

Recent STAR of the Month winners include Teresa Sorrenti and Stacey Chilton-Pearce, from the Sexual Health Results Team, who worked hard to manually input test results for over 500 patients, ensuring that the results are received in a timely manner, following an electrical outage.

5.3. Staff survey

The national 2024 Staff Survey runs until 22 November and we have encouraged all staff to complete the survey as it is really important that we hear the views of as many colleagues as possible.

To support those working in clinical areas, we have mobile computers rotating around, providing an opportunity for everyone to have their say.

5.4. Sustainability award

Our sustainability team were recently highly commended at the BBC Wiltshire Make a Difference Awards.

The team were recognised for their contributions to reducing our carbon footprint across all Trust sites, through projects including:

- The installation of solar and other renewable energy
- Introduction of Sustainability Champions
- Improvements to the staff cycle hub and other public transport options
- A green app for staff which encourages healthy competition by rewarding staff who log sustainable actions in the workplace and at home.

5.5. Green accreditation

Our Emergency Department team became one of the first in the country to be given Silver 'Green ED' accreditation.

This award recognises their contribution and hard work to reduce the carbon footprint in urgent and emergency care.

The team have worked hard to recycle more, reduce paper use by switching to QR codes, reduce single use equipment, and introducing a donation station for old clothes for patients to wear, among many other initiatives

5.6. British Association of Physicians of Indian Origin awards

Dr Satinder Mann won the Award for Professional Excellence in Service Design and Innovation at the recent British Association of Physicians of Indian Origin awards.

Satinder was instrumental in the development of new clinical pathways for our urgent and emergency care expansion.

5.7. EDI Champions

We celebrated the graduation of our first cohort of EDI Champions, who work right across the Trust to advocate for equality, diversity and inclusion.

They are helping to make sure our organisation is a more supportive place to work for all colleagues, and that all patients have fair and equal access to healthcare.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	25th September 2024	
Committee Chair	Bernie Morley Non-Executive Director	
Link to Strategic Objective	Pillar 3: Joining up acute and community services in Swindon	
Link to Board Assurance Framework	BAF 3: SR 5 – Performance and SR6 - Partnerships	
Improving Together Pillar Metrics	Emergency Attendances	Waiting List – over 65-week waiters
	Diagnostic Waiting Times	Cancer Waiting Times
Improving Together Breakthrough Objective	Reduction in ambulance handover delays	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Partnership Update	N/A	xx
2. Operational Highlight Report	N/A	xx
3. IPR - DM01	Good	xx
4. IPR - RTT	Partial	xx
5. IPR - Cancer	Partial	xx
6. IPR – ED / 4 hours	Good	xx
7. IPR – Ambulance Handover	Partial	xx
8. Care Coordination and Navigation hub	Note	xx
9. Annual Review Appeal	Note	xx
10. 15+ Risk Report	Good	xx

POINTS OF ESCALATION	No items to escalate to Trust Board.
KEY AREAS TO NOTE	Partnership report presented including NHS providers briefing on Darzi review. Medium term financial plan BSW presented and reviewed. DMO1 improved performance and therefore assurance to good. Cancer sustained performance and therefore assurance remains partial, Trust remains in tier 2 regime though has met the exit criteria required so this is under review with National & regional teams (28 FDS at 75.2% & 62 day 68.1%). Key specialties colorectal, urology and plastics. RTT work continues to address the longest waiting patients; 291 v 145(plan) for 65ww so adverse to plan, controls and mitigations in place. Benchmarking on elective position will be shared in October PPPC. Ambulance handovers have improved alongside movement into the new Integrated Front Door in September, and this was noted.
BOARD ASSURANCE FRAMEWORK & RISKS	Further review of risk 455 Pall Care was noted to be underway and would be reviewed in the next quarterly update. JAG risk (1160) in process of review with Medicine Division on the basis of accreditation until November being confirmed. This will be reviewed in the next quarterly update (risk is combined with DM01).
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Improvements noted in the 4 hour performance, combined performance at 79.5% top quartile performance (SW). Average hours lost reduced from 71 to 45 per day showing improvement in handover delays. 6hr breaches down to 2 from 18. Diagnostics above % improvement in plan and above % activity, on track to deliver for March 2025, 6 weeks increased to 75.05% from 70.72%.

REFERRALS TO OTHER BOARD COMMITTEES	Q&S legal risk (1230) referral.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	30th October 2024	
Committee Chair	Bernie Morley Non-Executive Director	
Link to Strategic Objective	Pillar 3: Joining up acute and community services in Swindon	
Link to Board Assurance Framework	BAF 3: SR 5 – Performance and SR6 - Partnerships	
Improving Together Pillar Metrics	Emergency Attendances	Waiting List – over 65-week waiters
	Diagnostic Waiting Times	Cancer Waiting Times
Improving Together Breakthrough Objective	Reduction in ambulance handover delays	

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
1. Partnership Update		
2. Operational Highlight Report	See below	
3. IPR - DM01	Good	
4. IPR - RTT	Limited	
5. IPR - Cancer	Good	
6. IPR – ED / 4 hours	Good	
7. IPR – Ambulance Handover	Partial	
8. Cancer Services Quarterly Update	See above	
9. Community Update	N/a	
10. Elective Waitlist Position and Referral to Treat Times	See above	
11. Major Incident – Power Outage	Partial	
12. Bed Configuration	N/a	
13. TES NHSE Letter / RAG Rating	N/a	

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	The HCRG contract was discussed and the importance of reassuring staff as far as possible and the risk to be managed relating to continuity of service until end of March. Board sub committee reporting of community services negotiations was raised Power outage learning received and significant activities underway to ensure a repeat is not possible. Testing of new processes still needs to take place to provide good assurance. Response to NHSE letter was positively received with a query around patient safety visits. RTT 65 week waits 75 end September, down from 291 in August. 78 week 6 patients (5 choice). 1,924 52 week waits remaining on PTL, though down by 148. Targets for end of December for 65 wk and end March for 52 wk are challenging Ambulance handovers performance remains subject to fluctuation and to note 4 patient safety incidents. Combined 4 hour performance at 77.4% and mean length of stay still remains good despite increase in attendances.
BOARD ASSURANCE FRAMEWORK & RISKS	N/A

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Cancer faster diagnosis (81.8% Aug), 62 day (70.3% August) remain better than national average. Additional funding from TVCA and SW will support additional improvements. Diagnostics performance remains strong (80.28% September). Trust has exited regional tiering. Community services update received and positive improvements to waiting lists, nursing referrals, rehab team referrals and hospital at home, though hospital at home still below target. Clinical services review received indicated reallocation of beds so that Medical patients are located together. Positive impact on improving efficiency and patient experience.
REFERRALS TO OTHER BOARD COMMITTEES	None

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	19.09.24
Committee Chair	Claudia Paoloni, Non-Executive Director
Link to Strategic Objective	Pillar 1 : Outstanding Patient Care
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality
Improving Together Pillar Metrics	Reducing Harms
	Friends & Family Test
Improving Together Breakthrough Objective	Reducing Falls with Harm

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Falls (IPR breakthrough objective). Falls	**Partial**	
2. IP&C (IPR breakthrough objective)	**Good**	
3. IPR concerns and complaints (Non-Alerting Metric)	**Partial**	
4. IPR Maternity	**Good**	
5. Patient Experience Report 6 monthly	**Good**	
6. Safeguarding Maternity, Adults, Children & Young People/ Safeguarding Annual Report 2023-2024	**Good**	
7. Electronic Discharge summaries	**Note**	
8. Safe staffing monthly report	**Note**	
9. Minutes Patient Quality Sub Committee August 2024	**Note**	
10. Minutes Maternity & neonatal Safety Champion Meeting June 2024	**Note**	

POINTS OF ESCALATION

IPR: Reduction Total Harms:

- Steady progress in reduction in total harms, reduction in falls contributing to this.

IPR: continued monitoring Pressure Harms:

- Increasing numbers of vulnerable patients are attending Emergency Department with pre-existing pressure harm, 77 were identified on admission. With the early identification and intervention there was no further extension.
- There has been no change in total incidences of acute or community Pressure harms, staff are still being supported but a noted increase in category 3, further interrogation of these cases identified 2 areas where there were some lapses in care and remedial support and retraining has been implemented immediately.
- There has been introduction of the “Dressing Club” for community clinicians.

IPR: Infection Control:

- Following the release of the NHSE trajectories for infections 2024/25, GWH are closer to target trajectories than previously expected. However, whilst Clostridium Difficile infection rate is below the national trajectory, our gram-negative infection rates are still outlying.
- An external audit on catheter care identified areas requiring focussed work and a further audit on deconditioning has also identified areas for improvement work.

IPR: Breakthrough Objective: Falls

- There has been a reduction in total falls and falls with harm in the month.
- Enhanced care group meet twice a week to embed actions.
- 250-300 patients attend the Emergency Department with a primary diagnosis of falls which puts at increased of further falls, better initial assessment and examination is in place but a theme for improvement has been identified on night patient moves and handovers.
- ‘Steady on your feet Swindon’ website launched in September, GWH is working with Swindon Borough Council and Barnes on on-line resource for guidance and a video, directing patients where they can get support.
- The Committee now has assurance around the information presentation, that will enable them to have assurance around monitoring progress around the set Breakthrough objectives:
    1. To reduce the number of patients that have more than 1 inpatient fall by 30%
    2. To reduce total number of inpatient falls by 30%

	• Monthly audit of A3 collated around falls improvement work, including policy review, and progress against this will be submitted with IPR going forwards. • Good community partnership working: 'Steady on your Feet', 'Dressing Club'. • Good patient involvement: 'Get Up, Get Dressed, Keep Moving'.
	Complaints and Concerns • Improvement work has commenced on reducing formal complaints by ensuring staff are responsive to any concerns raised and respond in a timely manner.
	Maternity Integrated Performance Report • Staffing levels have not quite met the required QIS staffing level target, influenced by an increase in patient occupancy and complexity, the Committee was assured that despite this there has been no negative impact on patient safety or experience. There has been a regional increase in acuity of patients but a robust system is in place to ensure safety is maintained. • Significant progress has been made against the CQC action plan including increased compliance with adult safeguarding Level 3 training and enhanced women/birthing triage rates within 15 minutes of arrival. • There has been significant of work around ensuring appropriate level safeguarding training for both children and adults is achieved to a 90% compliance target. • 88% has now been achieved with 90% being expected by the end of November. • The Committee were reassured that safeguarding is given a high priority within maternity and neonate unit. • Surgical Site Infection rates have shown a small decrease since the introduction of various preventative measures including changing the type of dressings used in higher BMI ladies.
	Patient Experience 6 monthly Report: • The Patient Advice and Liaison Service (PALS). Team have experienced a much higher number of cases in this period at the same time as PALS staffing has been under pressure due to vacancies, resulting in reduced response rates in this 6-month period. Despite the staffing level difficulties, the PALS team are still supporting Divisions. In all aspects of complaint management. • Top themes remain unchanged including waiting times and communication. • Trust-wide, the Family Friends Test has achieved 80%. Recommendation vs a target of 90%. • Patients, families and carers are continually being involved in improvement work across the Trust and these opportunities are used to promote health advice. Groups such as Motor Neurone Disease Workshop Group, Cancer Support Groups and Spinal Cord Injury Co-production Group are all examples of such interactive groups. • Improving Together is also being used to look at how to improve our complaints response rates with benchmarking against BANES and Wiltshire activity.
	Safeguarding Maternity, Adults, Children & Young People/ Safeguarding Annual Report 2023-2024 • The Committee were impressed by the very comprehensive annual report which gave assurance around the high standard of governance and risk management being delivered by GWH in its statutory and ICB contract safeguarding responsibilities. • Safeguarding activity in relation to the number of referrals shows a slight decline across both paediatric and maternity safeguarding, despite an increasing number of children under the age of 13 presenting with mental illness. • Safeguarding training compliance rates remain a priority for Divisions with in-house training being prioritised. • The safeguarding team are working within an environment of increasing complexity and requests for assistance. • A lot of work is being done around system partnership working and strategic meeting attendance. • An extensive programme of training activity, risk management, review assessments and partnership workshops have been completed in 2023-2024. • The Mental Health Governance Committee robustly overview GWH safeguarding activity around MHCA Deprivation of Liberty.
BOARD ASSURANCE FRAMEWORK & RISKS	

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	24.10.24
Committee Chair	Claudia Paoloni, Non-Executive Director
Link to Strategic Objective	Pillar 1 : Outstanding Patient Care
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality
Improving Together Pillar Metrics	Reducing Harms
	Friends & Family Test
Improving Together Breakthrough Objective	Reducing Falls with Harm

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
1. Falls (IPR breakthrough objective). Falls	**Partial**	
2. IP&C (IPR breakthrough objective)	**Partial**	
3. IPR concerns and complaints(. Non-Alerting Metric)	**Partial**	
4. IPR Maternity	**Good**	
5. Quarter 2 2024/25 Maternity and Neonatal Quality and Safety Report	**Good**	
6. Perinatal Mortality Review Tool Report Q2 2024-25	**Substantial**	
7. Saving Babies Lives v3 (Q1 Assessment-July 24)	**Good**	
8. Trust Quarterly Learning From Deaths	**Partial**	
9. National Inpatient Survey 2023	**Note**	
10. Freedom to Speak Up Q1 2024-25	**Good**	
11. Getting it Right First Time (GIRFT) update	**Good**	
12. Risk Register Report	**Good**	
13. Electronic Discharge summaries October 24 Update	**Partial**	
14. Safe staffing monthly report 15. Minutes Maternity & neonatal Safety Champion Meeting June 24 16. Minutes patient Quality Sub Committee Aug 2024	**Note** **Note** **note**	

POINTS OF ESCALATION	
	IPR: Reduction Total Harms • Slight increase in harms in month related to slight increase in Clostridium Difficile infections and an increase on falls. **IPR: continued monitoring Pressure Harms** • Shows a reduction in acute and community acquired pressure harms. • Weekly tri divisional meetings continue to share learnings. • Second cohort of the specialist interest course for tissue viability is about to start, which is proving to be a popular course. **IPR: Infection Control** • GWH are doing well with respect to managing certain infection rates within the organisation and maintaining trajectories below the local, regional or national trajectories. However, whilst local *Clostridium Difficile* infection rate is below the national trajectory, our other gram-negative infection rates are still outlying. • An external audit on catheter care identified areas requiring focussed work including additional disinfection, new standards for managing catheter equipment and other measures which will help control all gram negative infections. We have rated our assurance level as partial as we await the outcomes following the introduction of the new measures. **IPR: Breakthrough Objective: Falls** • There have been 2 falls with moderate or above harm in the month of August and 12 multiple falls cases, both. Metrics are higher than the previous month.

	• It is important to note that the number of attendances to ED with a fall are much higher than previously. ED are managing many of these attendances and returning to the community for supportive care, working closely with system partners. • Approximately 339 patients present to ED with a fall per month, but only 181 are admitted. These are patients more likely to experience further falls and may have multiple risk factors. • The Committee received a detailed report on the A3 being used to manage our breakthrough Objective around Falls. • Reassurance was achieved around the depth of interrogation and understanding of the current scale of the issue, the underlying risk factors, better assessment and identification of those patients more likely to have falls or further falls and a good plan of actions as countermeasures across enhanced care, Falls Debriefing, Footwear, Postural Hypotension and Policy, Deconditioning and medication management. • A table of completed actions also reflected the work being done. • Work is being done with System partners to enable patients to stay in the community following a fall and not need to attend ED, which impacts ambulance delays and ED congestion, e.g. the use of mobile X-Ray cars.
	Complaints and Concerns • Improvement work has commenced on reducing formal complaints by ensuring staff are responsive to any concerns raised and respond in a timely manner. • Overall numbers of complaints received has slightly reduced in month. • The Friends and Family Test overall response rate has increased but the positive response rate remains below target.
	Maternity Integrated Performance Report • High admissions, high acuity and recent new recruitment of nurses, continue to result in us not meeting the required QIS staffing level target, the Committee were assured that despite this there continues to be no negative impact on patient safety or experience and a robust system is in place to ensure safety is maintained, whilst newly recruited staff are trained to QIS standard. • Training compliance for all staff groups in maternity remain on trajectory to meet the 90% required target. For child protection 3 level training compliance, whilst target achievement is delayed due to newly recruited staff requiring training, a programme is in place to complete training. • Surgical Site Infection Precision feedback is that GWH maternity unit are demonstrating good engagement and commitment to improving rates of surgical site infections. • Early indication is that PICO dressing use in high BMI patients is having an improvement effect.
	Patient Experience 6 monthly Report • The Patient Advice and Liaison Service (PALS) Team have experienced a much higher number of cases in this period at the same time as PALS staffing has been under pressure due to vacancies, resulting in reduced response rates in this 6 month period. Despite the staffing level difficulties, the PALS team are still supporting Divisions in all aspects of complaint management. • Top themes remain unchanged including: Waiting Times and Communication. • Trustwide the Family Friends Test has achieved 80% recommendation versus a target of 90%. • Patients, families and carers are continually being involved in improvement work across the Trust and these opportunities are used to promote health advice. Groups such as Motor Neurone Disease Workshop group, Cancer Support Groups and Spinal Cord Injury Co-production Group are all examples of such interactive groups. • Improving Together is also being used to look at how to improve our complaints response rates with benchmarking against BANES and Wiltshire activity.
	Quarter 2 2024/25 Maternity and Neonatal Quality and Safety Report • The report received gave an overview of safety initiatives and their alignment with National Guidance, serious incidents under review and risks in relation to maternity and neonatal services. • The Committee had assurance around 4 serious incidents closed and that identified learnings had been put into robust action plans. • The two main points of learning around triage times and managing a deteriorating patient have already been managed and improved ahead of this report, the cases of which relate to incidents prior to the introduction of the new mitigating measures. • A local training strategy has been developed to achieve all elements of the Core Competency Framework version 2 by the end of 2025/26.

	• Fetal monitoring training and Fetal Surveillance training compliance rates of over 90% necessary for Maternity Incentive Scheme Year 6, are anticipated by the end of November 2024. This has been hampered by rotational posts and industrial action. • Extra focused work around Datix reports has resulted in significant increased closure rates, the reports of overdue Datix are shared with the senior team to provide oversight of improvements and insight into where delays are occurring. • Pipeline of newly qualified midwives remains consistently high but those with experience much lower, impacting ability to supply to community. Agency staffing spend has been successfully reduced through the recent recruitment of Band 5 nurses onto the neonatal unit. • Focus on the improvement actions from Ockendon report remained a priority in Q2 and no operational risks have been identified with the now remaining amber actions. • Continued implementation of improvement plans will further embed and result in conversion of RAG ratings going forwards to green throughout 2024/25
	Perinatal Mortality Review Tool Report Q2 • 100% compliance has again been achieved for all aspects of mandatory requirements for mortality reporting.
	Saving Babies Lives v3 (Q1 Assessment-July 24) • The Committee were assured by the Local Maternity and Neonatal System commenting on the progress noted in GWH working towards full compliance of all aspects of the Saving Babies Lives Care Bundle. • There has been improved compliance rates with 2 elements out of the 6 and maintained compliance with the other 4. • 100% compliance has been met in 2 elements. • Anticipated full compliance is anticipated by end November.
	Trust Quarterly Learning From Deaths • The Committee were assured by the report that a lot of work had been ongoing and which has been successful in ensuring that data accuracy around SHMI and Telstra Health HSMR data, both of which look at whether our actual death rates match with expected death rates when take into consideration co-morbidities and individual characteristics are correct. All measures identify our actual death rates match our expected rates. • Internal data analysis also concurred. • A robust structure is now in place with regular weekly, monthly and quarterly review meetings although attendance remains a problem as this structure embeds. • Structured Judgement Review completion remains low but this is impacted by the complex and time consuming data collection required for these to be completed, work is being done to focus on the mandatory categories and to create an alternative learning/action outcome process for others.
	Freedom to Speak Up Q1 2024-25 • The committee were assured by the good progress in this area as the new system embeds. More concerns are arriving indicating an uptake in the level of engagement. • There has been good progress with mandatory training compliance rates, although overall still low. • Recruitment drive has resulted in good interest in application to be Ambassadors and Champions. • 4 new Guardians have been appointed. • A robust action plan for 2024/25 will be focussed on for next 6 months around linking FTSU to the patient safety agenda, training compliance throughout the Trust and possible areas to work in collaboration at system level. • 13 concerns have been received in Q1 compared to 10 overall 2023/24. • Review of data has identified areas of attitudes and behaviours, policies and procedures being the main themes. • The Committee wished to express their thanks for the hard work and commitment that Chris Mattock has applied to the development of the FTSU service, but who sadly will be retiring in January.

	Getting It Right First Time (GIRFT) update • The Committee was assured that there has been significant traction around GIRFT governance throughout the organisation with respect to deep dives, reviews and data submission and sharing of the recommendations. • Where projects have stalled or require support, a transformation and support hub has been created. • Further plans are being developed to improve overall awareness of GIRFT by aligning workstreams including financial recovery and improvement and efficiency opportunities. • Outcomes from Deep Dives/Visits include commendation for engagement, levels of work, good communication and Improving Together Team Commitment • Adult Orthopaedic Trauma Surgery was commended for collaborative cross team work, patient involvement and excellent quality assurance programme. • Successes were also noted through the ICB Deep Dive reviews in Diabetes Gateway, Gynaecology Gateway, Anaesthesia and Perioperative Assessment, Pancreatic Cancer and Spoke and Hub review. • Areas for development were suggested in all reviews and action plans in progress for all areas. • Good clinical engagement has resulted in 229 historical recommendations being completed (from previous 68) and a further 390 being found to be now no longer required due to system and external body work progressing. • 58 recommendations remain outstanding and a further 44 stalled and in requirement of support.
	Electronic Discharge Summaries October 2024 Update • The benchmark to complete EDS within 24 hours of discharge sits at 80%. • 7 areas now meet this benchmark threshold, however overall the compliance still remains at 74% with episodes of non completion. • There has been significant improvements in certain areas e.g. Respiratory Medicine but still below 80%. • Alternative options for improving performance have been explored and costed including to mandate EDS prior to discharge, additional shift provision and team based performance improvement. • But following consideration of financial cost of providing additional shifts to make some improvement at being between £332,000-£416,000 and which would negatively impact our overall commitment to reduce additional hours work and may disincentivise completion under normal circumstances, and whilst implementation of new electronic EDS remains on trajectory for end of November, the Committee concurred this was not a viable option. • With respect to mandating no discharge without EDS, this had to be balance against flow through the hospital and impact on ED. • Year to date performance remains stable, with slight improvement overall.
BOARD ASSURANCE FRAMEWORK & RISKS	**Risk Register Report** • The Committee were assured that there had been no escalation from the 15+ risks. • 3 risks remain unable to reduce due to risks being impacted through increasing demand and acuity in ED, recruitment into Medical Consultant Team and delayed discharge information whilst new EPR being introduced.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

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

Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	23 September 2024	
Committee Chair	Helen Spice, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Partial	x
2. Month 5 Finance Position	Good	x
3. Non-Pay Review	Partial	x
4. Grip & Control audit	Note	x
5. Improvement & Efficiency Program	Partial	x
6. Estate & Facilities – PFI Lifecyle – Risk Mitigation	Good	x
7. Health, Safety Fire and Security – Quarterly Report	Good	x
8. Procurement - Quarterly Report	Good	x
9. Procurement – Annual Review and Lessons Learnt	Note	x
10. Letter of Indemnity – 5th Generator	Approved	x

POINTS OF ESCALATION	**BSW Financial Update** – The Committee received a verbal update outlining the System's challenges in delivering its financial plan, particularly given the scale of the collective deficit. The BSW position at month five is £8.m adverse to plan. The continued view across the ICB and in alignment with each of the trust forecasts and intervention actions that the ICB forecast will to be achieve plan – but with a number of challenges within that. The Committee continues to rate this update as partial as the Committee is not in a position to assure itself on the controls that are in place across the ICS. The Committee recognises that there are improved plans across the ICB and the Trusts are all working together to address the overall systems challenge. Useful benchmarking information is now being provided at a high level from BSW on the delivery of financial performance which identifies that each of the trusts is in a similar position on performance although the challenges are different – this will be shared with the Committee each quarter as soon as it is available. A positive point of note for BSW is that in month 5 BSW had the highest productivity improvement in the South West Region. **Letter of Indemnity – 5th Generator** The Committee reviewed and approved the Letter of Indemnity to enable the work to progress with the installation of a 5th Standy Generator. The Committee requested that due to the significance of the decision that the authority for finalising the Letter of Indemnity should be delegated jointly to the Chief Financial Officer and Chief Executive with referral to the Chair of FIDC at the time of signature.
	Month 5 Financial Position: The Trust's adjusted deficit position is £6.8m, representing a £2.7m adverse variance from the plan. Income is favourable to plan by £3.2m in M05 driven by an overperformance on NHSE Commissioned Drugs (£1.4m), pay award income (£0.7m), industrial action costs (£0.5m) and private patient income/education and training (£0.6m). Pay is £0.2m above plan, with centrally held reserves offsetting divisional pay positions. Non-Pay continues over plan by £6.3m – see considerations further below. Capital spend is £6m behind year to date but continues to be forecast to be fully spent by the end of the year, following a reprioritisation process. ERF is ahead of the 108% original plan but behind the stretch target of 112%. There is still a considerable amount of work to be done on total headcount which is budgeted to reduce by the end of the year in comparison to March 2023 so improved controls have been implemented for approvals on temporary staffing.
	Improvement and Efficiency Plan: The efficiency target for 2024/25 is £21.9m. As of M05, the actual delivery was £4.9m, which is £2.6m under the plan. 57% of the £4.9m delivered is recurrent. There has been an improvement in the savings identified this month – but the challenge continues on delivery. The Trust is doing well on delivery of ERF but this is not always flowing through to the savings. There is good governance in place but the Committee asked if a review could be taken of other Trust Financial Recovery Boards to see if there are other approaches we could learn from. The partial assurance rating relates to the continued challenge of delivering the efficiency programme for 2024/25. The Trust set a very challenging target and this is recognised by the Committee. The Committee is assured that the divisions have a good grip of their financial position but there is still a lot of work to be done to achieve the delivery of the savings identified.
	Non-Pay Review: As identified above there is a challenge on non-pay in the current year so a deep dive was conducted to identify the issues in order for actions to be taken to improve the position. There is clearly still more work to be done to understand the drivers and the challenges around this spend but also to ensure that existing controls need to be improved and embedded particularly in the procurement area. The Committee asked for this to be done and reported back to the next Committee. There is also learning that will be taken into next year's budget process and methodology to ensure that all contracts and non-pay is budgeted clearly in line with activity.
	Grip and Control Audit at GWH: The Committee received an update on the review being undertaken by the ICB on grip and controls. The internal audit plan for this year will remove the financial controls audit and replace it with a workforce and controls audit reporting to ARAC. If there are any actions arising from this review they will be referred back to FIDC.
	Health, Safety, Fire and Security Quarterly Update: The quarterly update covered the incidents in the last quarter and the actions that are being taken to ensure that the Trust is compliant across all areas. Actions have been taken to ensure that the trust has the appropriate resources in place for fire safety and has improved the manual handling training for staff. A review is being undertaken to ensure that the Trust is only issuing Unacceptable Behaviour Letters in both the best interests of staff and patients and ensuring that staff have access to appropriate training to de-escalate unacceptable behaviour wherever possible.
	Procurement Quarterly Update: The Committee reviewed the quarterly procurement update. Good progress is being made on the annual plan and the team are hoping to exceed the original plan for their Cost Improvement for the year. The Procurement Act implementation date has been delayed until February 2025 but this does not have an impact on any of the work the procurement team is currently undertaking. **Procurement Annual Review:** The Committee also received the 2023/24 annual review of procurement including a survey of

	stakeholders. It was a good report and demonstrated progress in the team. There is further work to be done in improving the engagement with stakeholders and ensuring that they understand their role and responsibilities in the procurement process.
BOARD ASSURANCE FRAMEWORK & RISKS	**PFI Lifecycle – Risk Mitigation:** The Committee had requested a detailed review of the Trust's actions to mitigate the risk of not completing all the work prior to the expiry of the PFI contract, specifically with the lack of funding available for the ward decant project. The Committee were pleased to note that the Trust's progression with completion of tasks related to Lifecycle work benchmarks well against other Trusts but that should not make us complacent. The Committee requested that all options are actively pursued including negotiation on funding if we do not achieve 100% with a clear preference for all the work being completed if at all possible.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	None noted.
REFERRALS TO OTHER BOARD COMMITTEES	None noted.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Great Western Hospitals NHS Foundation Trust

Report Title	**GWH 2023/24 PAM Submission**				
Meeting	**Finance, Infrastructure & Digital Committee**				
Date	**27 August 2024**	Part 1 (Public)		Part 2 (Private)]	
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Mark Chapple, Associate Director of Estates & Facilities				
Appendices	none				

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

Assurance Level

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

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

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

A strong understand of the assessment tool and a process EFM has followed for a number of years.

Report

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

The 2023/24 PAM assessment shows several small gains in scoring compared to the previous year.
The Estates & Facilities Dept secured capital funding to progress some of the heatwave actions, however, due to budget pressures the funding was returned.

EFM has recently recruited into an Information Officer role, and this will play a key part leading and progressing the PAM reviews this year.
0 domains scored as "inadequate".

There is an identified £490k revenue requirements, along with a £5.75M capital requirement identified. £5M of this is allocated for ventilation improvements.

The helipad domain is a new domain this year (last year it was optional), and there is lots of work already ongoing to ensure compliance against the new Civil Aviation Authroty CAP 1264 guidance.
The FM maturity domain is a new domain this year, although scored separately and differently to the other question sets.

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
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	n/a				n/a
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	EFM Board				
Next Steps	To embed the task & finish review groups, ensuring regular review and progress towards a "good" score for each domain.				

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 Finance, Digital & Infrastructure Committee are asked to note and gain assurance from the continued improvement in domain scores, including:

FIDC committee is asked to note the process adopted compiling the Trust Premises Assurance Model data, and to approve the 2023/24 submission using its delegated authority from Trust Board.

To note the ongoing multi-disciplinary working group review and update of PAM, developing costed actions plans for each domain (where applicable), and working though the actions towards achieving a "good" rating subject to available funding/resource.

To note the previous 2022/23 PAM assessment scores, and updated 2023/24 scores.

To note the ongoing revenue and capital funding requirements for each domain.

Accountable Lead Signature	
Date	20 August 2024

1.0 Introduction

1.1 The Premises Assurance Model (PAM) is an assurance tool that Trusts have been able to complete voluntarily for many years. It has evolved over time to become a comprehensive assurance tool and this year all domains of PAM have become mandatory within the NHS Standard Contract (SC17 Services Environment and Equipment - 17.9).

1.2 PAM has been developed to provide a nationally consistent basis for Trust Board assurance on regulatory and statutory requirements relating to their estate and related services, and the NHS constitution right: "**To be cared for in a clean, safe, secure and suitable environment**."

The assurance gained can then be used more widely and be provided to commissioners, regulators, the public and other interested stakeholders.

The PAM tool bridges the space between NHS boards and the operational detail of its day-to-day Estates and Facilities operations. The model can be used as a prompt for further investigation, and to stimulate better-informed dialogue as to how the premises can be more efficiently used, more effectively managed and contribute to the overall strategic objectives of the organisation.

1.3 PAM data is held and maintained by the NHS E/I Estates team. A user group made up of NHS Trusts, regional colleagues, the Care Quality Commission and other users oversee changes to the PAM tool. Changes and updates to PAM are approved by this group and implemented such that they minimise ongoing problems for the NHS.

1.4 The PAM tool self-assessment questions (SAQs) are grouped into Seven "domains", these are further broken down into 367 questions known as 'prompt' questions. The model is completed by scoring the prompt questions under each question. The seven domains are:

- Safety Hard
- Safety Soft
- Patient Experience
- Efficiency
- Effectiveness
- Organisational Governance
- Helipads
- *FM Maturity* this is reported but not scored like the above domains, and a new domain*

2.0 Timescales

2.1 The deadline for submission is 13th September 2024.

2.2 Presuming FIDC approve the submission, it will be presented to the 11th September at the Estates & Facilities Board meeting, ahead of formal submission to the NHS Improvement online portal. It was not possible to collate all the responses and to draft the report, ahead of the August E&F Board meeting.

3.0 Self-Assessment Questions (SAQS)

3.1 Each self-assessment questionnaire section has been completed by the relevant Trust service lead. It has not undergone a peer review and the PAM guidance notes this is a significant time burden upon any Trust and should be considered carefully.

The Trust regularly consult with their RUH Bath and Salisbury Trust colleagues, and discuss PLACE PAM, ERIC and other assessment and scoring regularly, and benchmark each other informally. Each domain includes a list of the SAQs and against each SAQ are the prompt questions that need to be rated against:

- **Not applicable** - this prompt question does not apply to an organisation/site
- **Outstanding** - compliant with no action required, plus evidence of high-quality services and innovation
- **Good** - compliant no action required
- **Requires minimal improvement** - the impact on people who use services, visitors or staff is low
- **Requires moderate improvement** - the impact on people who use services, visitors or staff is medium
- **Inadequate** - action is required quickly — the impact on people who use services, visitors or staff is high.

3.3 The service leads involved in each domain/SAQ response are summarised in table 01.

Domain	Service lead
Hard FM	Rupert Turk / Mark Chapple / Sue Morgan Stewart Thomson / Sarah Orr
Soft FM	Dan Purdy / Sue Morgan / Richard Cornish / Glyn Rowe
Patient Experience	Dan Purdy / Tania Currie
Efficiency	Rupert Turk / Will Moran / Ken Mclean
Effectiveness	Rupert Turk / Ken Mclean / Caroline Railston-Brown
Organisational Governance	Rupert Turk / Mark Chapple
Helipad	Mark Chapple

Table 1. PAM domain response service leads

3.3 The Trust submission to NHS Improvement is limited to the score and any capital or revenue costs to achieve compliance and a “good” rating. Our collated information will incorporate where appropriate, evidence to support each self-assessed score and any further actions required, together with supporting commentary.

3.4 The PAM collection was uploaded into the NHS E/I online portal, with completion of the spreadsheets an onerous process, and it remains difficult to create meaningful reports from a spreadsheet.

The summary provides an overview of the key findings across each of the five reportable domains. Once submitted and validated, the results are released approx. Oct 2024, a more detailed report and update on progress will be issued. 2024 results summary:

Safety Hard FM (156 in total)
6 domains scored “outstanding”. This is 2 more than last year.
109 domains scored “good”. This is 7 more than last year.
40 domains scored “require minimal improvement”. This is 2 more than last year.
1 domain scored “requires moderate improvement”. This is the same score as last year.
0 domains scores “inadequate”.

Safety Soft FM (97 in total)
11 domains scored “outstanding”. This is 1 more than last year.
66 domains scored “good”. This is 5 more than last year.
15 domains scored “require minimal improvement”. This is the same score as last year.
5 domains scored “requires moderate improvement”. This is 1 more than last year.
0 domains scores “inadequate”.

Patient Experience (24 in total)
0 domains scored “outstanding”. This is the same score as last year.
13 domains scored “good”. This is 1 more than last year.
11 domains scored “require minimal improvement”. This is 4 less than last year.
0 domains scored “require moderate improvement”. This is the same score as last year.
0 domains scored “inadequate”.

Efficiency (30 in total)
0 domains scored “outstanding”. This is the same score as last year.
20 domains scored “good”. This is 2 more than last year.
9 domains scored as “require minimal improvement”. This is the ae score as last year.
1 domain scored “require moderate improvement”. This is 1 more than last year.
0 domains scored “inadequate”.

Effectiveness (25 in total)
3 domains scored “outstanding”. This is 2 more than last year.
8 domains scored “good”. This is the same score as last year.
13 domains scored “require minimal improvement”. This is the same score as last year.
1 domain scored “require moderate improvement”. This is 1 less than last year.
0 domains scored “inadequate”.

Governance (26 in total)
0 domains scored "outstanding". This is the same score as last year.
23 domains scored "good". This is 1 more than last year.
3 domains scored "require minimal improvement". This is 1 less than last year.
0 domains scored "require moderate improvement". This is the same score as last year.
0 domains scored "inadequate".

Helipad (9 in total). This is a new question set.
0 domains scored "outstanding".
3 domains scored as "good".
6 domains scored "requires minimal improvement".
0 domains scored "require moderate improvement".
0 domains scored "inadequate".

FM Maturity (52 in total). This is a new question set.
52 questions scored "?", while 1 scored as a "4".
The remaining 48 scoring as a 3.
This is a new domain requirement of the Cabinet Office, and despite an NHS Improvement and Cabinet Office training sessions, many Trusts remain unclear how to complete the assessment, or to its benefit to the NHS.
These are scored in a different manner to the usual PAM domains i.e. 1 to 5, but across the 52 questions the scoring was very high. The scoring was undertaken by the Serco National Health Asset Director, and subsequently reviewed by the author and Asset Director jointly.

4.0 Summary

4.1 Figure 1 below shows the 2023/24 domain scores. Helipad was a new domain this year.

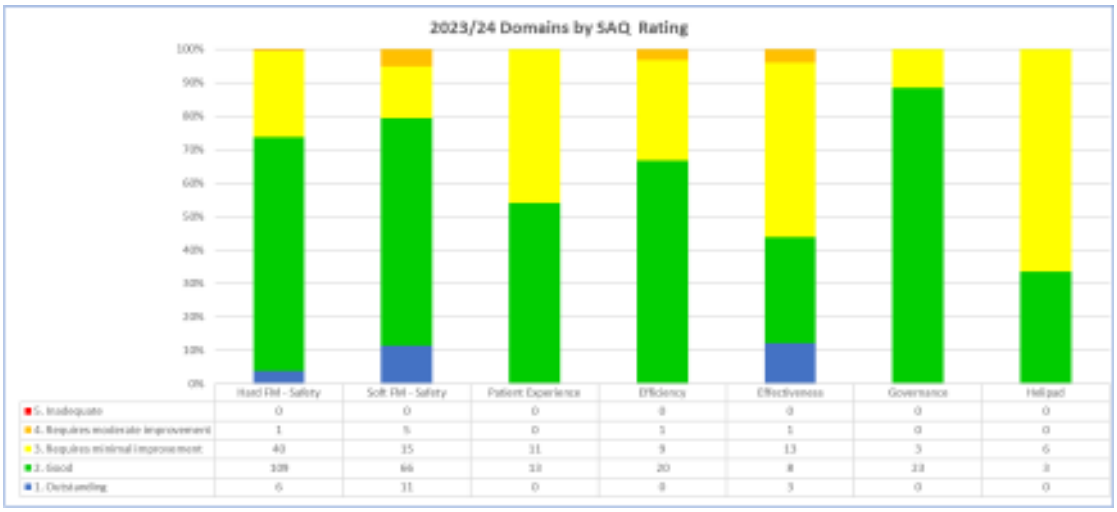

Figure 1. 2023/24 domain scores

4.2 Figure 2 below shows the 2022/23 domain scores as a comparison.

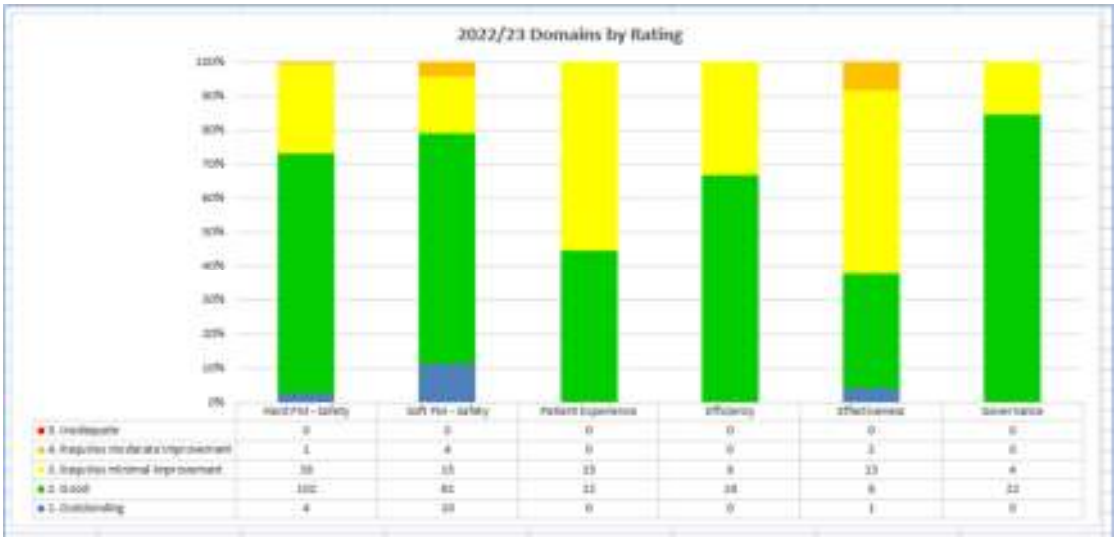

Figure 2. 2022/23 domain scores

4.3 Table 2 below shows the 2023/24 domain score, totalled by subject.

2023/24						
Domain x 7	**1. Outstanding**	**2. Good**	**3. Requires minimal improvement**	**4. Requires moderate improvement**	**5. Inadequate**	**Total No.**
Hard FM - Safety	6	109	40	1	0	156
Soft FM - Safety	11	66	15	5	0	97
Patient Experience	0	13	11	0	0	24
Efficiency	0	20	9	1	0	30
Effectiveness	3	8	13	1	0	25
Governance	0	23	3	0	0	26
Helipad	0	3	6	0	0	9
Total	**20**	**242**	**97**	**8**	**0**	**367**

Table 2. 2022/23 domain scores

4.4 Table 3 below shows the 2022/23 domain score, totalled by subject as a comparison.

2022/23						
Domain x 7	**1. Outstanding**	**2. Good**	**3. Requires minimal improvement**	**4. Requires moderate improvement**	**5. Inadequate**	**Total No.**
Hard FM - Safety	4	102	38	1	0	145
Soft FM - Safety	10	61	15	4	0	90
Patient Experience	0	12	15	0	0	27
Efficiency	0	18	9	0	0	27
Effectiveness	1	8	13	2	0	24
Governance	0	22	4	0	0	26
Helipad	0	1	7	0	0	8
Total	**15**	**224**	**101**	**7**	**0**	**347**

Table 3. 2022/23 domain scores

5.0 Costs

5.1 Each domain requires a costed action plan to achieve a "good" rating if it has been assessed as "requires minimal improvement," or "requires moderate improvement", or "inadequate". There is ongoing work with service leads to develop action plans and to agree ongoing capital or revenue funding requirements. The funding identified within the 2023/24 PAM return will be challenged at quarterly review groups and updated as appropriate.

5.2 The assessment shows additional funding is required for several domains, and this is summarised in table 4.

Domain	Capital	Revenue
Hard FM Safety	5,125,000	385,000
Soft FM Safety	580,000	0
Patient Experience	0	0
Efficiency	0	0
Effectiveness	0	0
Governance	0	80,000
Helipad	50,000	25,000
Total	**5,755,000**	**490,000**

Table 4. 2023/23 domain funding requirement

5.3 The assessment will be discussed at FIDC then EFM Board before a funding request is submitted to CMG/TIG and other appropriate funding routes.

5.4 The headline figures to achieve compliance are below, and any previous year's values have been uplifted with RPI inflation.

- Capital £5.75M + vat. £5M is allocated for ventilation improvements.
- Revenue £490k + vat. £100k less than last year.

6.0 Next Steps (actions to be monitored through the Estates & Facilities Group)

Ref	Action	Target Completion
1	Secure FID Committee approval	27th August 2024
2	Secure Estates & Facilities Board approval	11th September 2024
3	Submit data to NHS Improvement PAM online portal	12th September 2024
4	Capture lessons learnt from the PAM exercise this year to improve the process for next year	By 31st October 2024
3	Establish a multi-disciplinary working group to review PAM returns and action plans	By 31st October 2024

4	Develop risk assessed/costed action plans to achieve a "Good" or "Outstanding" standard across all domains/SAQs	29th November 2024
5	Convene PAM review group sessions	Quarterly as required
6	Work with THC/Serco in readiness for next year's response	Quarterly as required

Table 5. Next steps

7.0 Recommendations

Committee members are asked to:

- Note the process adopted compiling the Trust Premises Assurance Model data
- Approve the 2023/24 submission using its delegated authority from Trust Board.
- Note the ongoing multi-disciplinary working group review and update of PAM, developing costed actions plans for each domain (where applicable), and working though the actions towards achieving a "good" rating subject to available funding/resource.
- Note the previous 2022/23 PAM assessment scores, and updated 2023/24 scores.
- Note the ongoing revenue and capital funding requirements for each domain.

Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	28 October 2024	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Partial	x
2. Month 6 Finance Position	Good	x
3. Improvement & Efficiency Program	Partial	x
4. Digital Risk Register	Good	x
5. Data Protection, IT Resilience & Cyber Security Quarterly Update	Partial	x
6. Digital Strategic Plan – Quarterly Update	Good	x
7. Procurement Recommendation Reports: (1) Linen & Laundry; and (2) Replacement Theatre Stacks	Approve	x
8. Information Governance Annual Report	Good	x
9. BAF Strategic Risks – Emerging Risks	Note	X

POINTS OF ESCALATION	**BSW Financial Update:** The finance position at M6 is a YTD adverse variance of £11.6m. This position is after recognising the pro-rata share of £30m deficit funding. The adverse variance to plan at M5 has worsened at M6 by £3.4m, which is £3m behind the system's revised target profile. The positions by organisation are as follows: GWH £2.9m off plan; RUH £1.8m off plan; SFT £6.9m off plan; and ICB on plan. For all providers, issues remain with the delivery of efficiency and improvement programmes, leading to run rates exceeding the required levels. Mitigating actions have been identified to address some of these challenges, but the outlook for 2024/25 remains extremely challenging, and delivery of the £30m deficit plan is at risk. The Committee notes that the financial risk for the system is escalating and is high. However, Trust leadership assured us that regular meetings are taking place at the system level to address this. Based on these management representations, we agreed to a partial assurance rating.
POINTS TO NOTE	**Month 4 Financial Position:** The Trust's adjusted deficit position is £7.6m, representing a £2.9m adverse variance from the plan. Income increased by £5.8m in M6, driven by ERF (£2.7m) and an overperformance on NHSE Commissioned Drugs (£2.1m). Overall, Pay is £0.4m over the plan, with Medical & Dental pressures in the front door areas offset by centrally held reserves (e.g. maternity/ paternity leave), which will be used to support divisional Pay positions throughout the year. Non-Pay is £8.3m over the plan, including a £4.2m variance in clinical supplies and a £0.5m variance against outsourcing, particularly in Medicine and Surgery, Women's & Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. A working group, including Procurement, is analysing the drivers of clinical supply spending to achieve savings.
	Improvement and Efficiency Plan: The Trust started the year with a £21.90m cash releasing efficiency target with no carry forward of undelivered/non-recurrent efficiency from 2023/24. We are now at the mid-point of delivery of the programme. As at M6, the programme has delivered £6.820m year to date (76% of year-to-date plan) and is £2.203m under plan, with 52% of this being delivered recurrently. This significant improvement on the M5 position where 65% of the year-to-date plan had been delivered, shows that we are progressing towards our efficiency targets. Tighter controls around approving bank shifts, overtime, and Waiting List Initiative payments will contribute to this while continuing with the excellent work already in place, resulting in run rate reductions in temporary staffing, specifically in Nursing. This commitment to reducing temporary staffing costs demonstrates our dedication to effective cost management. Non-pay, most notably clinical supplies, will be the focus of cross-team/divisional support to maximise savings opportunities in this area. The partial assurance rating relates to the risk of delivering the efficiency programme for 2024/25. Although systems and controls identifying and tracking savings provide good/substantial assurance, the challenge of the scale of efficiencies and current delivery means there can only be partial assurance.
	Cyber Security, Resilience & Data Protection Report: The Trust is reporting strong performance for the Data Security and Protection Toolkit (DSPT), with solid evidence provided. Cybersecurity is a crucial priority for the Trust, with investment in various controls and risk mitigations. Risk is well understood and routinely reviewed; however, there remains a range of actions to improve overall control as risk management controls improve over the next six months.
BOARD ASSURANCE FRAMEWORK & RISKS	**Digital Risk Register:** The Committee noted that the risk management process and reporting are adequate and effective and is assured that risks are identified, appropriately rated, and mitigation actions are in place. The Committee is assured that the review process for risk oversight by the IT & Digital team is embedded, with monthly meetings and mitigation actions allocated to risk owners. When funding is required, this is bid for through regular routes. Actions are prioritised based on the speed of delivery, anticipated impact and available capacity.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	None noted.
REFERRALS TO OTHER BOARD COMMITTEES	None noted.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

BOARD COMMITTEE ASSURANCE REPORT

Committee	**People & Culture Committee**	
Date of Meeting	29th October 2024	
Committee Chair	Julian Duxfield, Non-Executive Director	
Link to Strategic Objective	Pillar 2: Workforce	
Link to Board Assurance Framework	BAF: SR 2 (Culture) & SR 4 (Workforce Planning)	
Improving Together Pillar Metrics	Voluntary Turnover	Staff Recommendation as a place to work
	Equality, Diversity & Inclusion (EDI)	
Improving Together Breakthrough Objective	Improving Staff Survey – Q7c I receive the respect I deserve from my colleagues at work	

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
People Promise and Retention Progress update	Substantial	No
Medicine Division, staff survey progress update	Good	No
Undergraduate Medical Education Annual Report	Substantial	No
AHP 'reason for leaving' concerns	Good	No

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	The substantial assurance level agreed for the progress on the 'people promise' work reflects the clearly identified priorities and progress against these agreed initiatives. An external visit from NHSE who have funded this work was also complimentary about the work which has been delivered. However, as the government introduces new employment legislation we will need to re-visit additional priorities. There has been some good work done across Medicine Division to focus improvement actions following the last staff survey and small but steady improvements have been seen across some areas in recent pulse surveys. These improvements have also been against the backdrop of over changes, e.g. bed reconfiguration and IFD. It was also recognised that appropriate action should be deployed when individual and team behaviour and conduct falls short of expectations. Substantial assurance was provided by an impressive report on the Trust's undergraduate medical education. The scale and quality of our work in this area is a real credit to the Trust. Reports and presentations were received on a range of other initiatives, including: the roll out and first Safe Learning Environment Charter and initial evaluation of the AHP group against this framework; the roll out of on-line appraisals via use of ESR; the continued development of the 'scope for

	growth' framework to support staff career development; some changes to mandatory training requirements; a new training course for managers to outline the people management expectations which the Trust has of them; and a re-launch of the 'fresh eyes survey' to obtain feedback from staff after their first three months working in the Trust. Finally, the committee re-visited the work which has been done for the AHP workforce following the referral of concerns from Quality and Safety committee about the reasons why some of these staff were leaving. The committee were provided with a good level of assurance about the work done to address retention, career development and long-term recruitment for this group, for whom retention is close to being the best in the SW having reduced from 100 to 30wte over the last 12 months.
BOARD ASSURANCE FRAMEWORK & RISKS	There is a concern that we may be understating the risk attached to Trust is able to deliver the WTE reduction plan by the year end. Although we are currently on trajectory things will get more difficult during the second half of the year. The workforce recovery group will re-assess the risk level and manage the progress against this plan. At the previous meeting the committee agreed that one (SR3: Risk of not prioritising wellbeing & engagement of staff we compromise delivery of safe quality care) of the three people strategic risks should be discontinued and issues folded into one of the two remaining strategic risk areas, culture ('There is a risk that if the conditions for shaping leadership and organisational culture are suboptimal, we will not develop the culture which improves patient care') and workforce planning (There is a risk that without a clear 5-year workforce plan, we continue to respond to urgent, immediate workforce gaps and do not plan for our future workforce models. This results in significant pressures on recruitment) At the next P&C meeting the format and definition of these risks will be fully reviewed and revised as appropriate.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
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LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**7th November 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Robert Presland – Deputy Chief Operating Officer Luisa Goddard – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

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

Assurance Level

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

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

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

Report

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

Our Performance

Key highlights from our operational performance for September (August for Cancer) are as follows:

Strategic Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

September performance shows the total number of patients waiting over 52 weeks at 1,924, a decrease of 148 patients. As a trust we set an ambitious target to book all patient's first appointment by the end

of September, who would turn 52 weeks by March 2025. As of the 6th October, there remains 9,941 patients without their first appointment booked. The largest un-booked cohorts at risk are General Surgery, Gastroenterology and Gynaecology. Engagement across specialties & corporate teams is under way to highlight this risk and to ensure this cohort of patients can be prioritised. This builds on the work in September from non-delivery of 65 ww and the lessons learned.

The Trust exceeded our anticipated high-risk cohort of 65-week breaches at the end of September, reporting 75 breaches in total. Nearly half of these were the result of patient choice, with both capacity and complexity reasons included. Assurance review meetings threw up new challenges in the final weeks of September with specialties reliant on external diagnostics to close pathways, this was particularly evident for Gastroenterology. The trust also reported 6 x 78-week breaches (5 in medicine division and 1 in Surgery, Womens and children). 90% of these were breaches by patient choice and therefore the teams are taking forward specific actions to inform patients of their place on the waiting list and asking patients to confirm if they still wish to be seen.

As we move forward, both corporate and divisional teams are working collaboratively to outline challenges faced which caused breaches for the September cohort and form plans to mitigate this moving forward. Plans are further developing to define how we can clear our backlog of patients who will breach 65 weeks by December 2024. Main risks to delivery across the divisions of Medicine and Surgery, Women and Children are; Gastroenterology, Neurology, General Surgery and Urology.

- Cancer waiting times

At the end of August there were 112 patients waiting >62 days on the PTL, which was 6.4% of the overall PTL size and therefore remaining below the national target of 6.8%. The PTL continues to be managed within nationally set thresholds.

The Trust exceeded the operating plan trajectory for both the 28-day Faster Diagnosis (FDS) standard and 62-day referral to treatment standard in August at 81.8% and 70.3% respectively. In September we forecast that we will meet the 28-day FDS trajectory but miss the 62-day trajectory due to the continuing issue with Urology pathways impacted by waits for LATP biopsy and capacity issues in Plastics. We are not expecting to see improvement through October due to ongoing issues within the Urology, Dermatology, Plastics & Colorectal pathways. However, we remain on track to deliver the end of year operating plan trajectories across both cancer metrics.

Validated August performance against the 31-day decision to treatment standard continues to improve and was 96%, which was the national standard. Performance is improving for decision to treatment and illustrates the importance of recovering the diagnostic stage of our cancer pathways.
GWH remains in discussion with the regional team about exiting tiering arrangements having met the required criteria over the last three months. We understand the recommendation from the SW team would be we have met the exit tiering criteria and whilst we need to deliver sustainability we have demonstrated the required improvement.

- Emergency Department (ED) and Urgent Treatment Centre (UTC) Mean Stay and Attendances

ED and UTC attendances increased by 2.7% in September compared to the previous month, with year to date activity at 1.8% above plan. Mean stay in ED and the UTC remains within control limits, with ED time in department currently 83 minutes above the national 4 hour target. Improvements in UTC have been supported by changes to streaming of patients and reconfiguration of triage capacity to meet demand at peak periods. Type 1, 4 hour performance has improved following whole hospital flow improvement initiatives and focused work on non-admitted pathway performance in areas such as ambulatory majors, although there was a 5% reduction in performance in September compared to August.

Combined 4 hour performance was 77.4% and above operating plan trajectory of 76.2%.

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

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

- Inpatient spells - No Criteria to Reside Bed Days

The number of bed days lost for patients with no criteria to reside (NCTR) continued to show special cause variation in the month of September with an average of 64 patients occupying a bed where the criteria to reside was not met. There were 13.4% of beds occupied against the operating plan trajectory of 13%.

There remains a data quality issue with reporting of no criteria to reside following nationally mandated changes implemented in August. This will improve once medically fit for discharge has been retired across the Trust, but there remain issues to resolve in terms of implementing this in parts of SWICC, especially where it affects GP led areas such as Orchard ward. These issues are being resolved in October but the data should continue to be treated with caution in the meantime.

Current priorities for improvement with partners remain in terms of reviewing processes through the Transfer of Care Hub (with a focus on Pathway 1 home first), enhancing escalation processes for out of area referrals, improving the timeliness and completeness of recording and daily touchpoint calls with partners to review discharge plans for complex and stranded patients..

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

Operational Breakthrough Objective

- Ambulance handover delays

The Trust Breakthrough objective to reduce the average daily hours lost in ambulance handover delays was achieved for the second consecutive month in September, with performance at 65 hours compared to the target of 70 hours.

On the 25th and 26th September the whole of the BSW system experienced significant flow challenges leading to reported incidents in the community where patients may have come to harm as a result of delayed ambulance response times. These incidents are being investigated by BSW and in the meantime the Trust has reinstated internal escalation processes for handover delays with trialling of safety and decompression huddles for the ambulance queue starting in October.

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

The Trust will be receiving support from Emergency Care Intensive Support Team (ECIST) in October and November to help realise the benefits of the Integrated Front Door, with the relocation of MEU and SDEC scheduled for November. The UEC transformation programme remains focused on delivering sustainable improvements to flow that will be in place before winter and that also support the effective operating of the new department.

Findings from the ECIST rapid improvement offer will be incorporated into a review of requirements to be delivered for Phase 2 of the transformation programme later in the winter.

Alerting Watch Metrics

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

- Diagnostics – September validated performance against the 6 weeks wait standard improved to 80.28%, which was above operating plan trajectory. Recovery towards the 99% constitutional standard (above our operating plan) remains dependent on reducing the size of the NOUS backlog and also sustaining the improvements made in endoscopy which is now performing better than plan.

Our Care

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

Strategic Pillar Targets

1. To achieve zero avoidable harm within 5-10 years.
2. To achieve consistent positive response rates in excess of 90% from patient friends and family test.

There has been a slight increase in the overall harms in September, 176 from 167 in August. This is driven by a slight increase in infection (C. difficile) and an increase in total number of falls.

The number of Family and Friends (FFT) positive responses for September has remained at 89.8%, no change from the previous month, remaining just below the 90% target.

Breakthrough Objectives

The Breakthrough Objective for 2024/25 is related to reducing harm from inpatient falls.

Aim for 2024/25

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

In September two patients had moderate harm or above following an inpatient fall, which is the same as August 2024.

Alerting Watch Metrics

The complaint response rate has increased from 68% in August to 72% in September.

The numbers of patients with two or more falls were 12 in month, compared to 7 for August.

The overall Family and Friends positive response rate target was reviewed and increased in April to 90% and as a result now sits within an alerting watch metric. The response rate for September is 89.8%, no change from the previous month and just below the internal target.

Non-alerting Watch Metrics

C.*diff* numbers have increased this month to eight (two in August), however the Trust remains below its target trajectory and one of the best performing Trusts in region. Methicillin-sensitive Staphylococcus aureus (MSSA) numbers have reduced in month to one and now are more in line with previous months. Indicating that last month's increase appears to have been a statistical fluctuation.

There has been targeted work on catheter management since an external audit at the start of August and this may have contributed in the overall reductions seen in *E. coli* and *Klebsiella.*

Pseudomonas numbers remain lower than last year; however, we anticipate that the catheter work may impact on these too.

The number of hospital-acquired pressure ulcers has reduced in month to 14 (25 in August). All cases are discussed weekly at a tri-divisional meeting to identify and share learning in a timely way.

The number of Community acquired pressure harms have also decreased in month (17 compared to 20 August).

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

- Safer staffing fill rates remain above the National target of 85%.
- Two Patient Safety Incident Investigations have been declared in September, one a Never Event involving a wrong site Occipital Nerve Block. All previous Serious Incident investigations are now closed. Patient Safety Incident Investigations are now being reviewed under the new patient safety framework.

Our People

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

Strategic Pillar Target from A3 goals:

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

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

- **Staff Survey – Recommend a Place to Work**
  Stretched Target 63%: achieving 59.6% (2023 Annual Survey), 55.9% Q1 Pulse Survey, and 55.5% Q2 Pulse Survey (steady decline since the annual survey)
- **Staff Voluntary Turnover**
  Target 11% achieving 8.7% (August data)
- **EDI disparity (reducing discrimination disparity)**
  Target 9.4% achieving 12.7% (2023 Annual Survey), and 13.1% Q1 Pulse Survey and 17.5% Q2 Pulse Survey

The annual Staff Survey launched on 9th September 2024 and will run until 22nd November 2024. A communications plan is in place to promote the survey during this period and encourage a high response rate. The Trust achieved a 69% response last year ranking second nationally, and aims to achieve a similar or higher response rate this year. At week 5 of the Survey period the Trust has achieved a 55% response rate, higher than our position at this time last year (53%) and the average for Trusts using our survey provider (24%).

Breakthrough Objectives

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

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

Alongside the annual staff survey we are continuing with promotion of the newly launched e-recognition scheme allowing staff an opportunity to show thanks and respects to colleagues. To date 416 staff are registered on the platform and have sent 508 cards. Further options within the platform are being explored to increase the range of recognition options available including drawing on positive patient feedback and experience to thank staff for the impact they make to patient care.

Alerting Watch Metrics

In-month sickness absence decreased in August from 5.2% to 4.6%. This is back in line with position in June although above the position in 2023 (4.1%). Whilst still above our KPI of 3.5%, we are seeing

promising reduction in both short and long-term absence levels and countermeasures identified at the Trust Improving Attendance working group are being initiated to further reduce sickness. The Trust continues to perform in the second-lowest quartile for Acute Trusts (42nd out of 133).

HR Scorecard

Vacancy Rate
Our vacancy rate in September is 191WTE (3.5%), a reduction compared to August where our medical contract position has been adjusted following the correction of assignments in ESR set during August changeover.

All Nursing vacancy at month 6 has reduced to 17TWE, and within this our Band 5 Nursing vacancy excluding pre-registration nurses is over established at +47.8WTE. Medical & Dental vacancy in September is 67.2WTE with resident doctor vacancy reducing in September, following changeover, from 30WTE to 22WTE.

Workforce Utilisation

Agency
In-month agency spend was £0.26M in September, it's lowest amount in the 12-month reporting period and below target by £0.2M. Agency spend as a percentage of all pay-bill spend was 1.01%, significantly below the KPI of 4.5% and planned threshold in the workforce plan of 3.7%.

Bank
Bank usage and spend decreased in September to £1.88M which was £70K above the in-month target. Overall bank levels have increased since April, in part due to the transfer of overtime usage into more cost-effective bank cover, although usage remains broadly in line with planned levels.

Workforce Recovery
5,591WTE was used in September to deliver our services which was -30WTE less than the planned total of 5,621WTE. Our substantive WTE position is -11WTE less than plan in month 6 due to later impact of CDC/EPR compared to the phased workforce plan. Agency WTE is significantly overperforming to plan at -20WTE in September.

Current Divisional forecasting presented at FRSC in October is showing a year-end position of +124WTE to plan. A review of current workforce including vacancies and fixed-term contracts is being undertaken through the Workforce Recovery meeting, where divisions will outline corrective actions to return to plan.

Use of Resources

As at M06 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £7.6m, which represents a £2.9m adverse variance to plan.

Income is £5.8m favourable to plan. ERF performance has improved significantly in M06, driven by Cardiology pacer alert coding, and is £2.7m higher than plan. The Trust is hitting its 112% ERF target and is 14.5% above its 2019/20 baseline, with Medicine division the key contributor. There is a £2.1m overperformance on NHSE-commissioned drugs and a further £1.0m relating to pay award funding and allocations above the fixed baseline. Note also that the income position includes £4.7m of non-recurrent deficit funding and target.

The pay position includes c.£0.5m of junior doctor industrial action costs incurred over June/July, which are offset by income. Overall, pay is £0.4m over plan with Medical & Dental pressures in the front door areas offset by centrally-held reserves (e.g. maternity / paternity leave).

Non-Pay is £8.3m over plan, which includes a £4.2m variance in clinical supplies and a £0.5m variance against outsourcing, particularly within Medicine and Surgery, Women's and Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income.

Work with Procurement is ongoing to understand the underlying drivers. Drugs spend is £1.0m over plan, all of which is passthrough related and offset by income. Estates and PFI related costs account for the remaining variance.

The £2.9m adverse variance to plan includes a £2.4m underperformance against the efficiency target, which is £9.7m as at M06 and £21.9m for the full year. 52% of the £6.8m delivered YTD is recurrent, which is in line with M05. The forecast delivery is £15.8m which will represent a £6.2m gap to the £21.9m target. The focus of divisions and directorates must remain on increasing the 52% delivery of savings on a recurrent basis to reduce the underlying deficit. Pay is a key area for savings with a target to reduce the number of headcount working in the Trust by 263 compared to March 2022 by the end of the year. Tighter controls around the approval of bank shifts, overtime and WLIs are already contributing to this, as is ongoing work in reducing temporary staffing. Clinical supplies spend should be scrutinised at the point of order, to ensure that we are practicing good governance with the choice and amount of stock being purchased.

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

We remain c.£2.9m off plan in Month 6. Our performance behind plan on the efficiency programme of £2.4m demonstrates that our run-rate reductions are not going far enough to impact our financial position to the extent that it is needed to meet our full-year plan. There are various recovery workstreams in progress, particularly around pay run rates. Activity is being scrutinised for where we are not delivering volume, or value of the relevant volume, against plan.

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

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

Actions continue to be progressed in relation to improving requisitioning controls and developing the training offer. An Improving Together working group has been set up in Finance to focus on financial training throughout the Trust, including a mandatory training course on ESR and staff group specific training. There is a task & finish group focussing on the drivers of non-pay spend which includes Finance, Procurement & divisional leads. Work is ongoing around requisitioning controls. Divisions have submitted a list of users for revocation. Focussed training for the remaining requisitioners around best practice is a key next step.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	PPPC (Performance, Population & Place Committee) & Trust Management Committee				
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 IPR report identifies issues where minoritized protected groups experience is less favourable than other groups. This is specifically around the staff survey question 16B and experience of discrimination from colleague or manager. The staff survey provides this data by ethnicity, and it is likely that other groups both protected and non-protected have reported discrimination. The report identifies a number of countermeasures and actions are underway and planned to reduce discrimination for all staff and specifically those in protected groups.

The report references workforce indicators such as sickness, retention and vacancy rate which are likely to be affected by the disparities between the working life experience of majority group staff and minoritized staff. National analysis of the NHS (National Health Service) staff survey studies, results indicate that exclusionary behavior correlates with staff intention to leave the NHS and other research indicates the link between discrimination and physiological, psychological, and behavioral consequences. By addressing the disparity, we will be:

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board/Committee/Group is requested to: ▪ ***Review and support the continued development of the IPR*** ▪ ***Review and support the ongoing plans to maintain and improve performance***	
Accountable Lead Signature	
Date	16.10.24

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

October 2024

September 2024 & August 2024 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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

Key Indicators

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Measure Name	Mean/Thres.	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total 104 week waits	0	0	0	0	0	0	0	0	0	0	1	1	0
Total 78 week waits	0	1	2	4	5	10	4	3	4	3	3	12	6
65 weeks wait performance vs plan (size adjusted)	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	70.0%	117.9%	148.4%	154.6%	200.7%	0.0%
Proportion of PTL over 65 week waits (size adjusted)	0.0%	1.2%	1.1%	0.9%	0.9%	0.7%	0.2%	0.4%	0.6%	0.7%	0.6%	0.7%	0.2%
Under 18 elective activity rate vs baseline	100%	115.7%	117.5%	116.3%	122.5%	128.8%	119.1%	123.9%	119.0%	114.4%	117.0%	131.8%	218.6%
Faster diagnosis rate	75% (Nat)	58.2%	59.7%	60.4%	60.2%	70.5%	71.3%	59.2%	66.7%	70.2%	75.2%	81.8%	Reported one month behind
62-day performance	85% (Nat)	61.1%	67.2%	65.0%	62.2%	68.6%	66.7%	63.1%	64.3%	69.4%	68.1%	70.3%	Reported one month behind
Proportion of patients seen within 4 hours	95% (Nat)	71.5%	71.4%	74.7%	73.5%	71.1%	74.4%	75.9%	75.3%	75.0%	77.1%	79.5%	77.4%
Number of mental health patients spending >12 hours in an emergency dept	8	10	9	5	12	5	5	14	9	6	6	7	3
Readmission rate	15.3%	17.2%	15.9%	16.4%	11.2%	16.1%	15.7%	14.0%	15.9%	15.1%	14.7%	16.0%	14.8%
Summary Hospital-level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
CQC safe rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Sickness rate	3.5% (Int)	4.7%	4.7%	5.0%	4.9%	4.4%	4.1%	4.2%	4.2%	4.6%	5.2%	4.5%	Reported one month behind
Leaver rate	11.0% (Int)	9.2%	9.2%	8.9%	8.6%	8.6%	8.4%	8.6%	9.7%	11.0%	9.6%	11.0%	Reported one month behind
Implied productivity	0	-17%	-15%	-14%	-16%	-13%	-12%	-13%	-17%	-15%	-17%	-15%	-13%
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	5.3%	5.4%	5.4%	3.5%	3.5%	3.5%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
Proportion of staff in senior leadership roles who are women	64% (Nat)	56.1%	56.9%	57.1%	56.1%	56.1%	56.1%	56.7%	56.7%	56.7%	57.4%	58.3%	56.7%
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	1.8%	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%	1.7%	1.7%	1.6%	1.7%	1.7%

Key Indicators

Great Western Hospitals NHS Foundation Trust

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

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

Executive Summary

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Total Harms

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

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

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

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

Patient Experience (FFT)

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

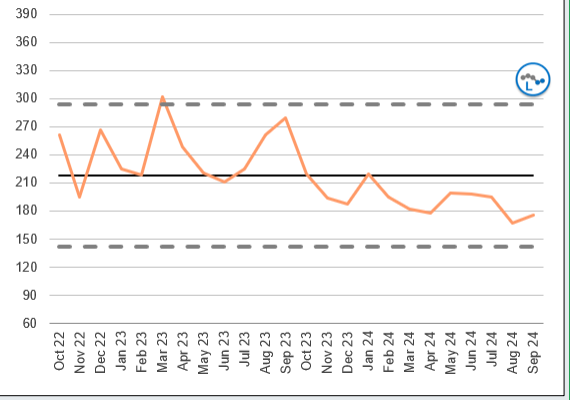
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

We have set ourselves a target of 90% for the combined positive response rate, this is based on an increased of 4% from last year's target of 86%.

Total Harms

To achieve and sustain zero avoidable harm.

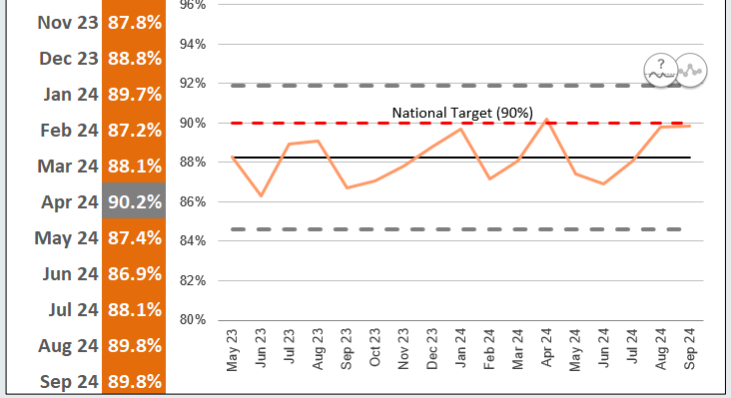
Timescale	Value
Oct 23	219
Nov 23	194
Dec 23	187
Jan 24	219
Feb 24	195
Mar 24	182
Apr 24	178
May 24	199
Jun 24	198
Jul 24	195
Aug 24	167
Sep 24	176



Patient Experience (Friends & Family Test)

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

Timescale	Value
Oct 23	87.1%
Nov 23	87.8%
Dec 23	88.8%
Jan 24	89.7%
Feb 24	87.2%
Mar 24	88.1%
Apr 24	90.2%
May 24	87.4%
Jun 24	86.9%
Jul 24	88.1%
Aug 24	89.8%
Sep 24	89.8%



Counter Measures

The total number of harms has increased in September to 176, up from 167 in August, but remains a downward trend when compared to the last 12 months data.

The increase in harms this month is being driven by an increase in falls and C. difficile. There continues to be a reduction in pressure harms both in the Community and Acute services.

There has been two patient safety incident investigations, one relating to a never event of wrong site Occipital Nerve Block.

For September, the Trust wide positive Family and Friends (FFT) score has remained relatively static. The target for 2024 /25 has been increased to 90% to ensure there is stretch. Work is underway to increase completion of FFT with volunteers, QR codes and posters.

Improvement work is continuing focusing on reducing formal complaints and ensuring robust and timely responses.

Key themes identified are waiting times and communication. Various improvement workstreams are underway to address.

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NHS Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance
Cancer 62-day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In August, there were 58.0 breaches in total, with 36.5 of these attributed to the Urology, Plastic, Colorectal pathways. These pathways are seeing issues with capacity for appointments and diagnostics.

We continue to see greater than normal breaches in Urology where number of breaches relate to patients requiring a biopsy after their initial MRI. Template biopsy in Theatres has replaced TRUS biopsy in Radiology, capacity for which is currently insufficient to meet demand.
Patient thinking time in respect of treatment options in the Prostate pathway and the need for capacity limited tertiary consultations impacts performance too.

RTT: Number of patients waiting over 52 weeks
September performance shows the total number of patients waiting over 52 weeks at 1,924 a decrease of –148. Patients reported waiting over 65 weeks was 75, a decrease of 216 from last month. As of 10th of October out total PTL cohort size was 43,133.

6 x 78 weeks breaches were reported in September 2024. 90% of these were choice breaches.
- 4 x Gastroenterology
- 1 x General Surgery
- 1 x Cardiology

We did not meet our ambition to clear all 65 week waits by end of September, however in light of service challenges and the number of choice breaches included, specialties did exceptionally well to keep breaches to a minimum.
The Elective team, both corporate and divisional, have met to review the performance and further understand challenges and areas where change is required to achieve future RTT performance success. There remains a zero tolerance for 78-week breaches and specialities who have outstanding long waiters are working to clear these as soon as possible.

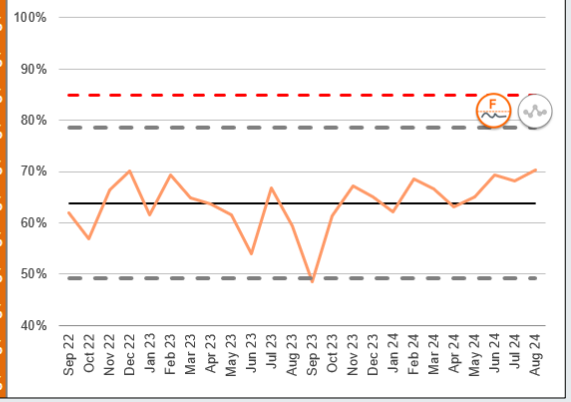
Felicity Taylor-Drewe | Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

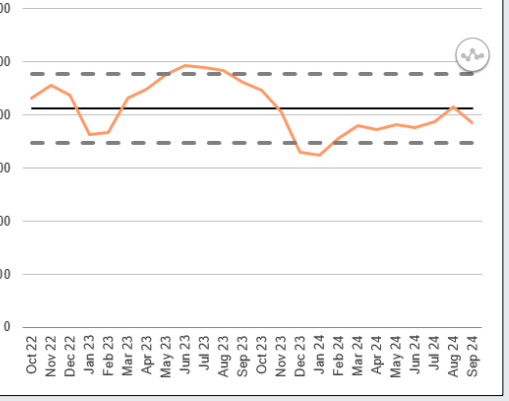
Timescale	Value
Sep 23	48.5%
Oct 23	61.3%
Nov 23	67.2%
Dec 23	65.0%
Jan 24	62.2%
Feb 24	68.6%
Mar 24	66.7%
Apr 24	63.1%
May 24	65.1%
Jun 24	69.4%
Jul 24	68.1%
Aug 24	70.3%



RTT: Number of patients waiting over 52 weeks

To eliminate over 52-week waiters as soon as possible and by March 2025 at the latest.

Timescale	Value
Oct 23	2,238
Nov 23	2,031
Dec 23	1,653
Jan 24	1,625
Feb 24	1,777
Mar 24	1,900
Apr 24	1,859
May 24	1,909
Jun 24	1,885
Jul 24	1,941
Aug 24	2,072
Sep 24	1,924



Counter Measures

Risk: Urology Pathways are impacted by delays in Radiology & Theatres (capacity & vacancies)
Mitigation:
-Funding approved for mobile LATP by TVCA, funds to be used to assist with flexible cystoscopy capacity too. This went live on 7 September with weekend clinics to clear backlog and provide the necessary additional capacity. Improvements in the 62D performance are expected from November onwards
Risk: Capacity issues for **Colorectal** 2ww triage, post diagnostic reviews and appointments after MDT are an issue.
Mitigation:
-Close management of Registrar rota's with Consultant input to allow triage to happen. Registrar clinics in place to aid outpatient capacity for first appointment and MDT slots are allocated to clinics
Risk: Capacity issues in **Plastics** for appointments and minor op clinics impacting pathway
Mitigation
-Suitable patients are sent to a private third party provider (CSP) where necessary
-Revised SLA with Oxford approved, though insufficient support from Oxford being provided due to consultant availability

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

Risk: Delay in achieving targets due to Industrial action/major incident.
Mitigation:
- All elective activity on strike/major incident days reviewed. Maximised clinical sessions running where staffing allows.
- Patient impact assessed and alternative sessions to be provided. Long waiting and cancer patients prioritised.
- Long waiting and cancer patients brought forward to reduce the risk of cancellation.

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Emergency Care – Emergency Department - Mean Stay

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

The total meantime in Sept 24 was 324 minutes against the national standard of 240 minutes. This is the first month where mean time in ED has increased following a downward trend throughout 2024. However Sept is still is the second lowest mean time in ED performance.

Emergency Care – Urgent Treatment Centre - Mean Stay

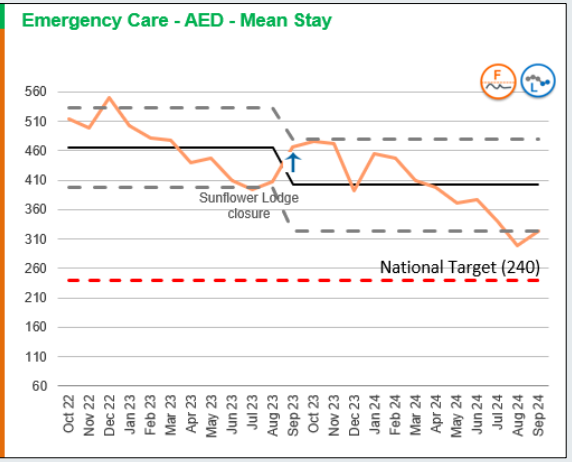
The total meantime wait for a patient in September 24 was 149 minutes against the national standard of 240 minutes. This has increased from 138 mins in August where the department experienced a drop in demand. 149 minutes is still one of the better performances since Oct 23 and below mean.

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.

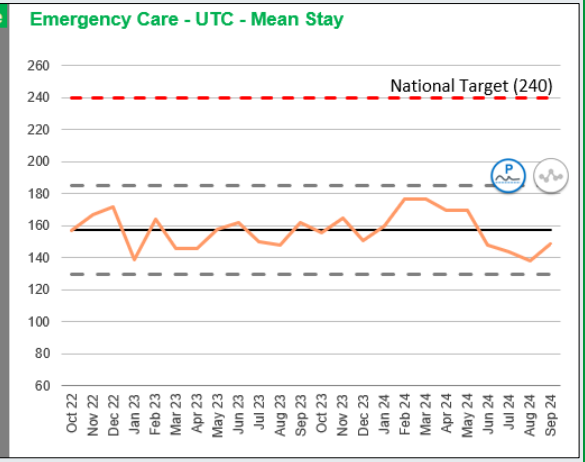
Timescale	Value
Oct 23	475
Nov 23	471
Dec 23	391
Jan 24	455
Feb 24	447
Mar 24	410
Apr 24	398
May 24	371
Jun 24	377
Jul 24	340
Aug 24	299
Sep 24	324



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Oct 23	156
Nov 23	165
Dec 23	151
Jan 24	160
Feb 24	177
Mar 24	177
Apr 24	170
May 24	170
Jun 24	148
Jul 24	144
Aug 24	138
Sep 24	149



Counter Measures

- Recruitment drive initiated via Medical Control Weekly Meeting to reduce agency and increase substantive body. This will improve the financial sustainability of department but also improve quality of care across the 24/7 running of the department.
- Medicine Emergency flow programme

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

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).

There were 11,066 patients seen in ED/UTC in September, which is a 2.7% increase from August. This increase has been driven entirely from ED attendances (6% increase) with UTC demand remaining static.

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

In September, we observed a further decrease in NCTR averaging 66. The new codes are now fully functioning in Nerve Centre and feature on the site report for divisional intelligence.
Discharges were 25% over predicted for the month. Over a 21-day LoS, the average length of stay (LoS) was 15 patients which is lower than last month, marking the lowest average since we began collecting this data in 2022.

Discharges before midday decreased slightly to 17%, Utilisation of the Discharge Lounge was at an all-time high of 319, just for medical patients. The Discharge Lounge was used for 15 patients overnight on 3 separate occasions – as this didn't go above the 6 patients full use of DCL the next day was possible.

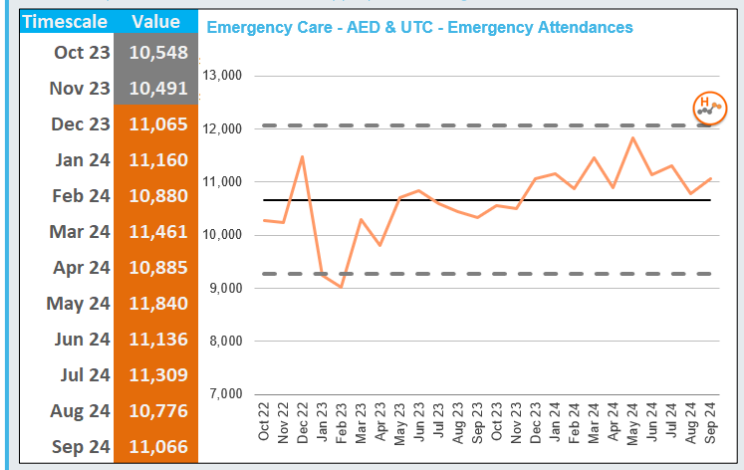
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

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

To ensure patients are cared for in the appropriate setting

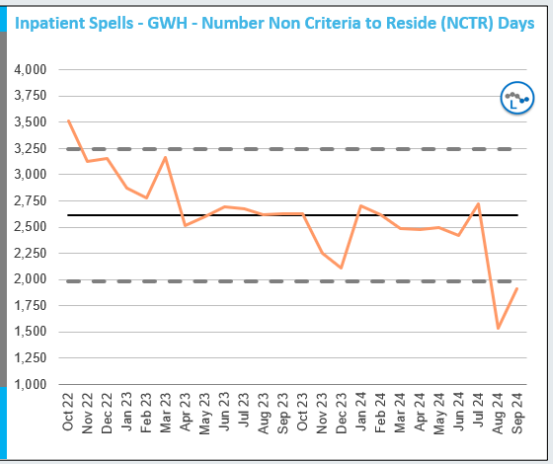
Timescale	Value
Oct 23	10,548
Nov 23	10,491
Dec 23	11,065
Jan 24	11,160
Feb 24	10,880
Mar 24	11,461
Apr 24	10,885
May 24	11,840
Jun 24	11,136
Jul 24	11,309
Aug 24	10,776
Sep 24	11,066



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
Oct 23	2,625
Nov 23	2,251
Dec 23	2,106
Jan 24	2,703
Feb 24	2,615
Mar 24	2,484
Apr 24	2,474
May 24	2,500
Jun 24	2,425
Jul 24	2,726
Aug 24	1,534
Sep 24	1,913



Counter Measures

- Co-ordination Centre and Navigation Hub processing referrals from Care Homes, community teams, ambulance service and partner referrals via the discharge hub. However, from the 17th June all care home calls will be dealt with via GP in hours and Medvio out of hours.
- Call before convey message to SWAST crews through BSW care co-ordination.
- Assessment and pathway changes to support direct access from ED & UTC to most appropriate admission areas.
- Specialist Direct to the right bed initiative underway during end of August – with positive results
- Hospital at Home (across BSW) working to one model and full occupancy.

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

Opportunities:

- Review of escalation approach for patients with no criteria to reside including out of area patients – this is showing improvement and twice weekly calls in place.
- To review the approach to criteria led discharge for patients and maximise opportunities for earlier in the day discharge including to discharge lounge. - continuing with positive outcomes
- Review wards that have opportunities for higher discharges prior to midday - underway
- Pre-empting discharges 24 hours in advance & preparing TTAs in advance.

Reflections:

- Standardising discharge processes including discharge summaries and medicine to take away.
- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Reserve Boarding needs to be investigated as a continuous flow and enacted daily to proactively manage ambulance surges and prevent bed surges. A meeting has happened with DDON's to agree formula at ward level.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

The Trust has seen a downward trend seen in its voluntary turnover rate from July 2022, with performance below the 11% target being sustained for over 12 months. Voluntary turnover increased slightly in August to 8.7% however remains under the Trust target of 11%.

Staff Recommendation as a Place to Work
The Trust recommend a place to work target is 58% which is in line with the National Average for 2022 staff survey results. In 2023 the Trust achieved 60% performance, and the national results also improved to 61%. Therefore, the new stretch target is 63% to be achieved in the 2025 staff survey.

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

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

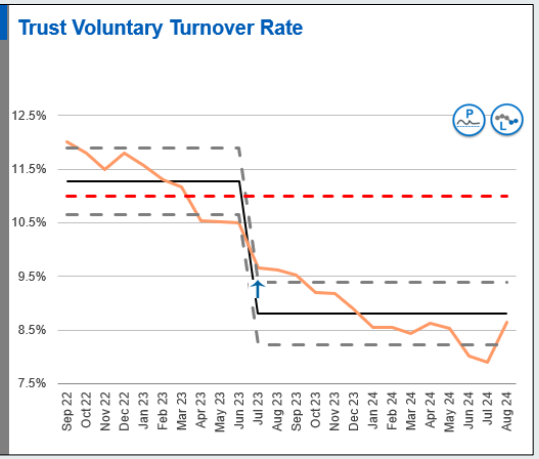
The number of staff who would recommend the organisation as a place to work increase from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey. Pulse survey result has shown a slight decline in results since the annual survey, deteriorating to 55.9% in Q1 and to 55.5% in the latest Q2 survey.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

Timescale	Value
Sep 23	9.5%
Oct 23	9.2%
Nov 23	9.2%
Dec 23	8.9%
Jan 24	8.6%
Feb 24	8.6%
Mar 24	8.4%
Apr 24	8.6%
May 24	8.5%
Jun 24	8.0%
Jul 24	7.9%
Aug 24	8.7%



Staff % recommend the organisation as a place to work

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

Counter Measures

- There has been a slight increase to Voluntary Turnover in August, rising to 8.66%. (from 8% in July)
- NHS England held a visit in October, allowing the Trust an opportunity to showcase our work to date on the People Promise retention project plan. The People Promise manager outlined the following deliverables which were well received by the group:
  - Digitalisation of Exit Conversations on ESR – delivered in October
  - Sexual Safety Policy – delivered in October for Agenda For Change staff and scheduled in November for Medical & Dental staff
  - Launch of 90-day induction booklet in November
  - Digitalisation of Flexible Working process in November
  - Expectations of Line Managers Programme in November

- The annual flu campaign launched on 3rd October, allowing all of our staff the opportunity to protect themselves and others against winter illness. In the first week of the campaign we have vaccinated 25% of our staff, compared to 18% at this time last year. A Covid vaccination programme is due to launch for staff on 28th October.
- A 'tea trolley in a box' is being launched in October, with deliveries being made to all community sites every 3 months.
- The Occupational Health & Wellbeing team celebrated Occupational Health Awareness week in September, showcasing the large offering available to staff in promoting and managing their wellbeing at work.
- Mental Health Skills for Managers and First Aid training continues in October, alongside the Psychological Wellbeing course.

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

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

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

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

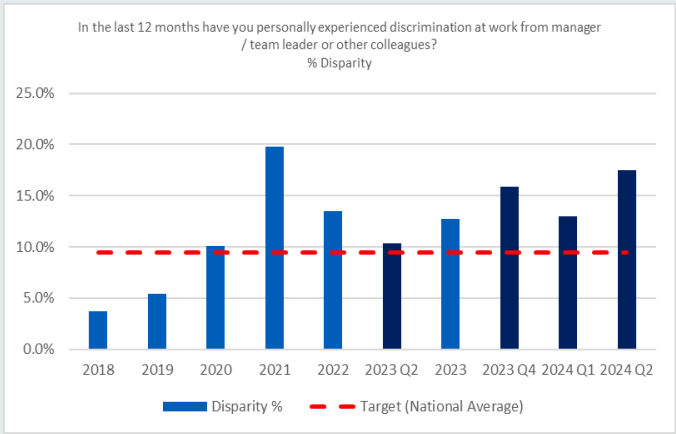
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

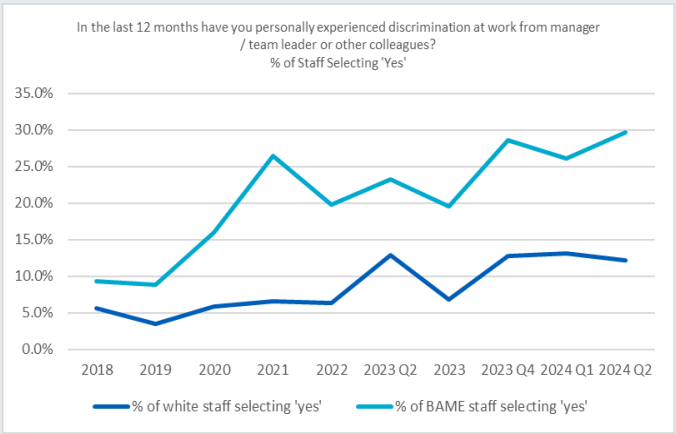
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

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

Jude Gray
Director of Human Resources (HR)

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





Counter Measures

- The Staff Networks continue to plan joint working arrangements, and their first meeting is scheduled for January 2025, when ToR will be agreed. The networks have agreed priorities for the next twelve months including adopting the EDI Pillar Metric to address discrimination.
- The EDI and HI Annual Report 23-24 has been approved by the Board on Thursday 5 September, with some small amendments. The report will be published on or before 31 October 2024. A 4-year strategic plan is currently being written following engagement with the Trust Board and IHISC; a draft will be presented at subcommittees from November.
- Four Slice of Life events have taken place to date. Representatives from the Trust Board have met with staff from ethnic minority backgrounds, women and two sessions have taken place which were open to all staff. The remaining sessions are scheduled for November and December. The Board will meet in the new year to explore learning and consider any actions.
- Engagement with the wider workforce continues, following the EDI and Inclusion Champions Graduation Ceremony in September, the Race Equality Network are planning Black History Month Celebrations on 15 October, when the new chairs will be introduced. The Trust will also take part in system-wide celebrations with our provider partners and ICB on the 30 October. Training in November will include a workshop for EDI Champions and Cultural Competence and the EDI conference will now take place on November 5.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

As at M06 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £7.6m, which represents a £2.9m adverse variance to plan. Income is £5.8m favourable to plan. ERF performance has improved significantly in M6, driven by Cardiology pacer alert coding, and is £2.7m higher than plan. The Trust is hitting its 112% ERF target and is 14.5% above its 2019/20 baseline, with Medicine division the key contributor. There is a £2.1m overperformance on NHSE-commissioned drugs and a further £1.0m relating to pay award funding and allocations above the fixed baseline. Note also that the income position includes £4.7m of non-recurrent deficit funding and target. The pay position includes c.£0.5m of junior doctor industrial action costs incurred over June/July, which are offset by income. Overall, pay is £0.4m over plan with Medical & Dental pressures in the front door areas offset by centrally-held reserves (e.g. maternity / paternity leave). Non-Pay is £8.3m over plan, which includes a £4.2m variance in clinical supplies and a £0.5m variance against outsourcing, particularly within Medicine and Surgery, Women's and Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. Work with Procurement is ongoing to understand the underlying drivers. Drug spend is £1.0m over plan, all of which is passthrough related and offset by income. Estates and PFI related costs account for the remaining variance.

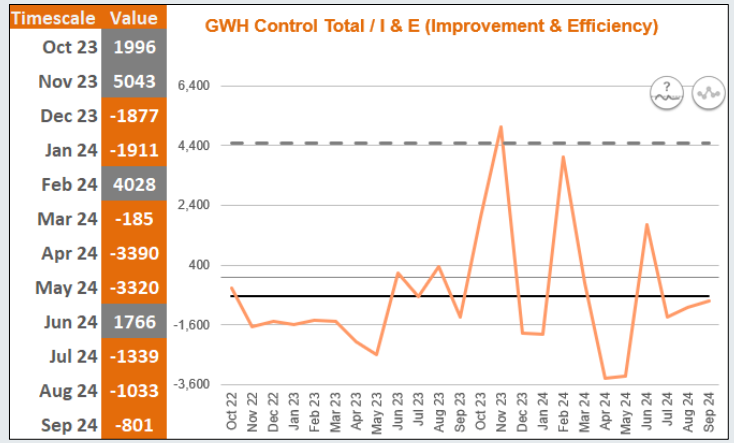
The £2.9m adverse variance to plan includes a £2.4m underperformance against the efficiency target, which is £9.7m as at M06 and £21.9m for the full year. 52% of the £6.8m delivered YTD is recurrent, which is in line with M05. The forecast delivery is £15.8m which will represent a £6.2m gap to the £21.9m target. The focus of divisions and directorates must remain on increasing the 52% delivery of savings on a recurrent basis to reduce the underlying deficit. Pay is a key area for savings with a target to reduce the number of headcount working in the Trust by 263 compared to March 2022 by the end of the year. Tighter controls around the approval of bank shifts, overtime and WLIs will contribute to this, as will ongoing work in reducing temporary staffing. Clinical supplies spend should be scrutinised at the point of order, to ensure that we are practicing good governance with the choice and amount of stock being purchased.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Oct 23	1996
Nov 23	5043
Dec 23	-1877
Jan 24	-1911
Feb 24	4028
Mar 24	-185
Apr 24	-3390
May 24	-3320
Jun 24	1766
Jul 24	-1339
Aug 24	-1033
Sep 24	-801



Counter Measures

- Efficiency savings were £0.4m ahead target in month with income schemes in Medicine the key contributor. Year-to-date the efficiency programme is £2.4m behind plan with pay accounting for £1.3m, income £0.3m and non-pay £0.8m. Of the £6.8m of savings delivered year-to-date, 52% is recurrent.
- The Trust has a £21.9m target for 24/25 with a heavy focus on workforce related reduction schemes (£12m) and specifically reducing the number of funded posts. As mentioned, divisions and services will need to undertake a thorough review of their resources and processes to identify schemes for recurrent delivery. Increasing productivity by meeting the Trust's activity targets and associated ERF income is also a key objective in 24/25

Executive Summary

Great Western Hospitals NHS Foundation Trust

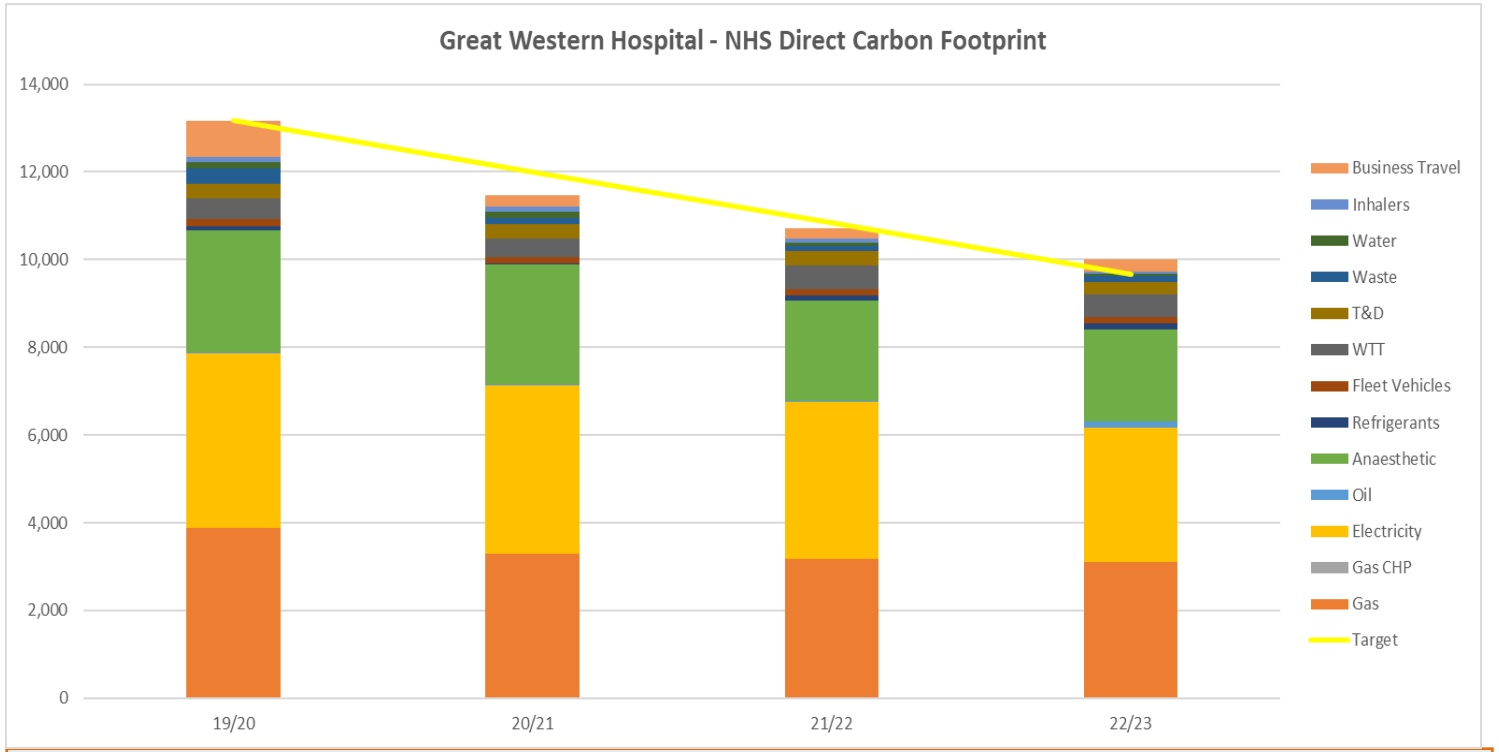
Carbon Footprint / Sustainability

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

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

The Department for Energy Security and Net Zero's (previously known as DEFRA) carbon conversion factor for grid electricity has increased by 7% for year 23/24 due to an increase in natural gas use in electricity generation and a decrease in renewables.

Note: Awaiting carbon data for 23/24 to provide an update for the latest financial year.



Counter Measures

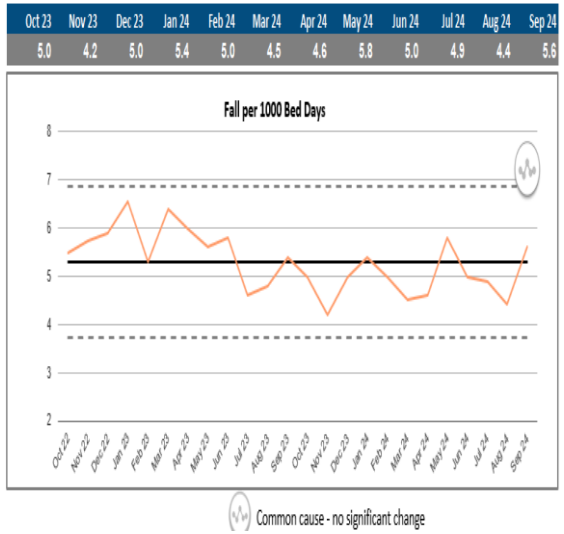
1. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and for indirect emissions by 2045.
2. The Sustainability Team have a full detail heat decarbonisation plan which was funded by Salix. The team are currently awaiting to hear if they have been successful with Salix phase 5 bid which starts looking at the design phase.
3. Capital projects for reducing emissions from medical gasses have taken place with a further improvement project this capital year to expand the AGSS in labour delivery.
4. Current capital projects includes the electrification of fleet vehicles.
5. Sustainability Champions launched in GWH and an expansion of sustainability working groups in departments who have larger carbon footprints e.g. Theaters, ED and Endoscopy.

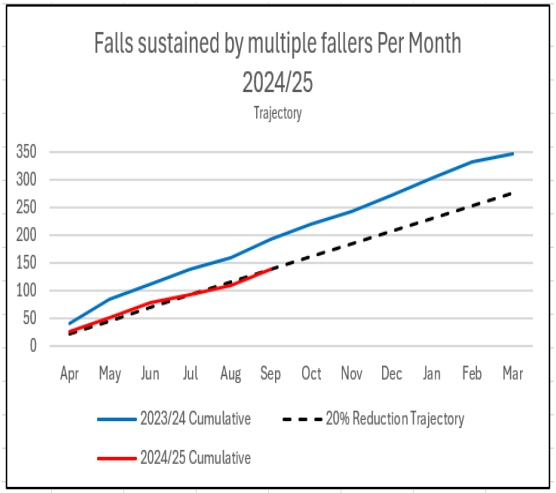
Simon Wade
Chief Financial Officer

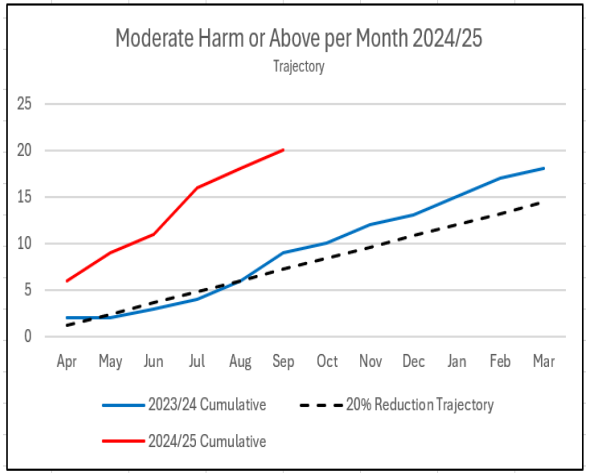
2024/25 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust







Understanding the Data

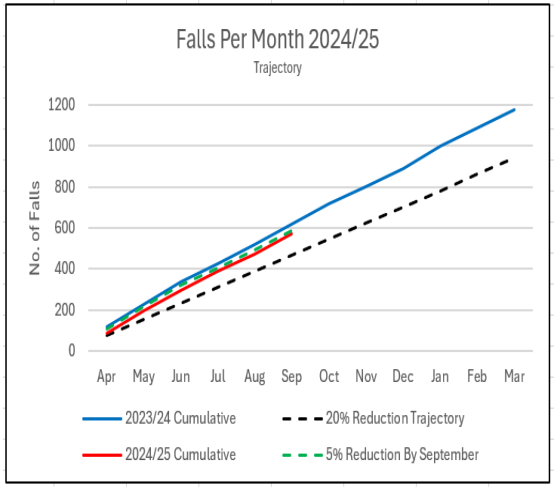
Falls per 1000 bed days will be monitored quarterly to provide benchmarking data. In September, the rate had increased to 5.6 when compared to 4.4 in August.

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

We are driving this measure because..

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

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



Performance

Inpatient falls has increased from 90 in August to 102 in September. This increase may be within natural variation but analysis of themes is ongoing. The number of falls with moderate harm or above has remained the same as last month (two patients), one experiencing moderate harm and one experiencing severe harm.
It is noted that the number of patients attending and being admitted with a fall has risen in month, driving an increase demand.

The Countermeasures include:
Ensuring patients have appropriate footwear
Identifying and treating postural hypotension.
Patients are being assessed for the level of supervision they require.
Prevention of hospital acquired deconditioning.

The monthly Enhanced care sessions are being updated to reflected the changes within the new policy and work is ongoing to ensure good attendance at the training.

Work continues to support the identification and management of postural hypotension. This includes a new escalation process being trialled on two wards and sharing of the Banes, Swindon Wiltshire postural hypotension guidelines on the microguide system to enhance better consistent and management.

The new falls policy is being audited monthly, with the initial findings expected to be published in November.

BT

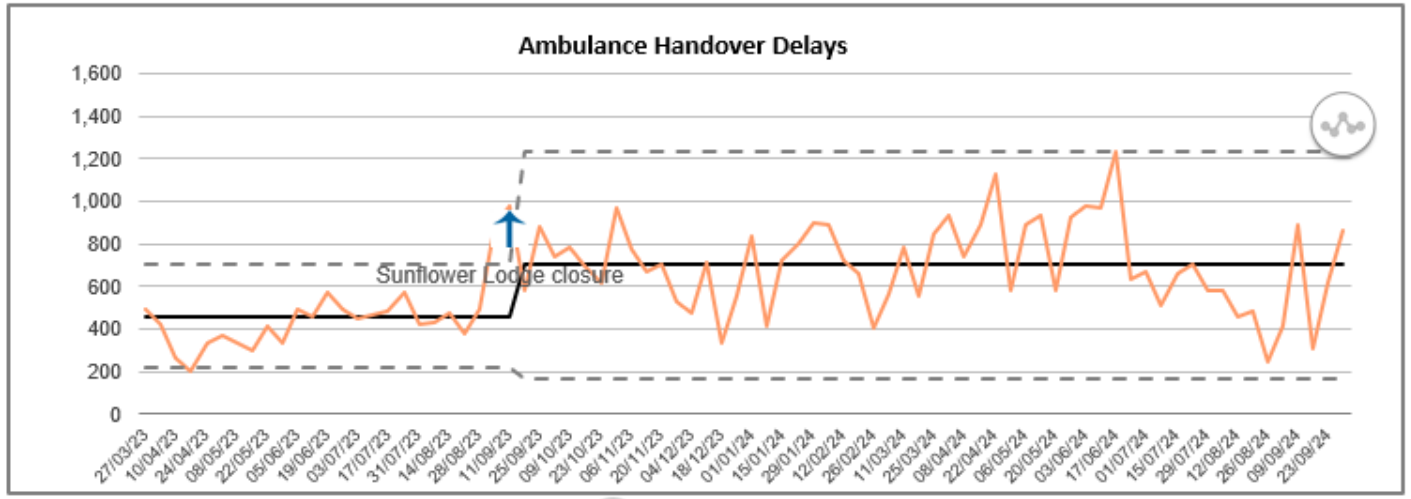
Breakthrough Objectives

2024/25 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Ambulance Handover Delays

15/07/24	22/07/24	29/07/24	05/08/24	12/08/24	19/08/24	26/08/24	02/09/24	09/09/24	16/09/24	23/09/24	30/09/24
658.0	708.0	583.0	583.0	457.0	483.0	248.0	413.0	892.0	309.0	619.0	867.0



Common cause - no significant change

Understanding the Data

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

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

We are driving this measure because...

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

Performance

The Trust Breakthrough objective to reduce the average daily hours lost in ambulance handover delays was achieved for the second consecutive month in September, with performance at 65 hours compared to the target of 70 hours.
Eight weeks of special cause improvement is shown up to the week commencing 16th September, although performance deteriorated for the final two weeks of the month which resulted in the first reported 6 hour ambulance offload breaches since July.

On the 25th and 26th September the whole of the BSW system experienced significant flow challenges leading to reported incidents in the community where patients may have come to harm as a result of delayed ambulance response times. These incidents are being investigated by BSW and in the meantime the Trust has reinstated internal escalation processes for handover delays with trialling of safety and decompression huddles for the ambulance queue starting in October. Whilst performance is significantly improved from the position reported in Quarter 1 of this year (and in comparison to the same period last year), there remains a significant risk to patient safety and care for patients who require emergency treatment due to the inability to offload ambulances at the point of arrival. This is due to critical capacity of the Trust, Emergency Department, and MAU, & flow throughout the Hospital and to system partners (including out of area patients) (Risk ID 731 and 1085).

The Trust will be receiving support from Emergency Care Intensive Support Team (ECIST) in October and November to help realise the benefits of the Integrated Front Door, with the relocation of MEU and SDEC scheduled for November. The UEC transformation programme remains focused on delivering sustainable improvements to flow that will be in place before winter and that also support the effective operating of the new department.

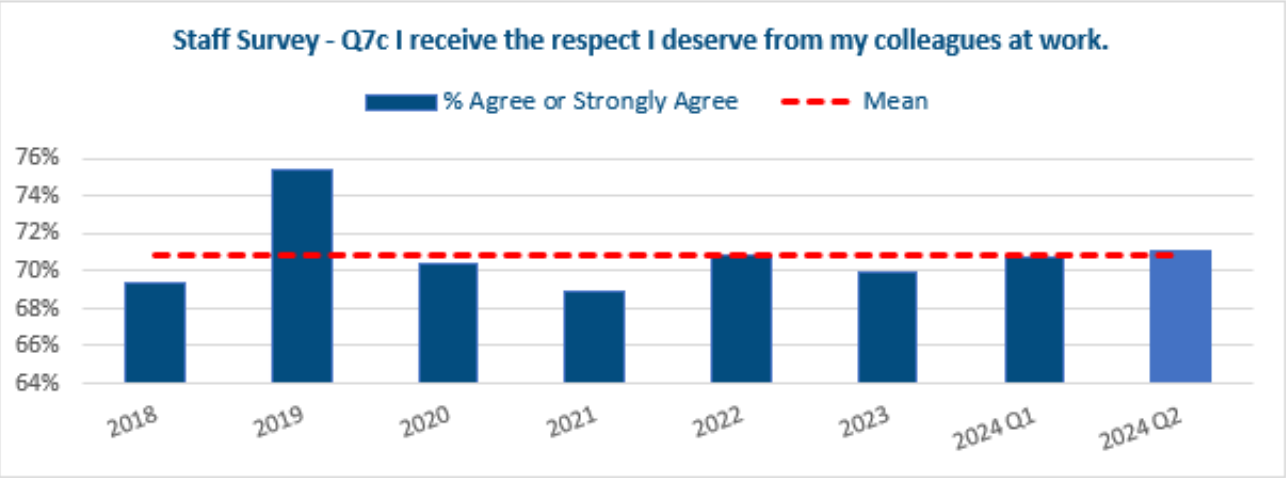
Findings from the ECIST rapid improvement offer will be incorporated into a review of requirements to be delivered for Phase 2 of the transformation programme later in the winter.

2024/25 Breakthrough Objectives

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

Great Western Hospitals NHS Foundation Trust

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



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- The annual NHS Staff Survey launched on 9th September and runs to 22nd November. At week 5 of the Survey we are achieving a response rate of 55% (3,254 responses), compared to 53% this time in 2023. To ensure representativeness of this year's sample, the People Operations team are conducting ward and community visits to encourage completion and engagement with the Survey.

- The e-card recognition platform launched in August continues to impact positively with 416 staff registered on the platform and 508 cards sent to date. Further options within the platform are being explored to increase the range of recognition options available including drawing on positive patient feedback and experience to thank staff for the impact they make to patient care.

Risks

- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change.

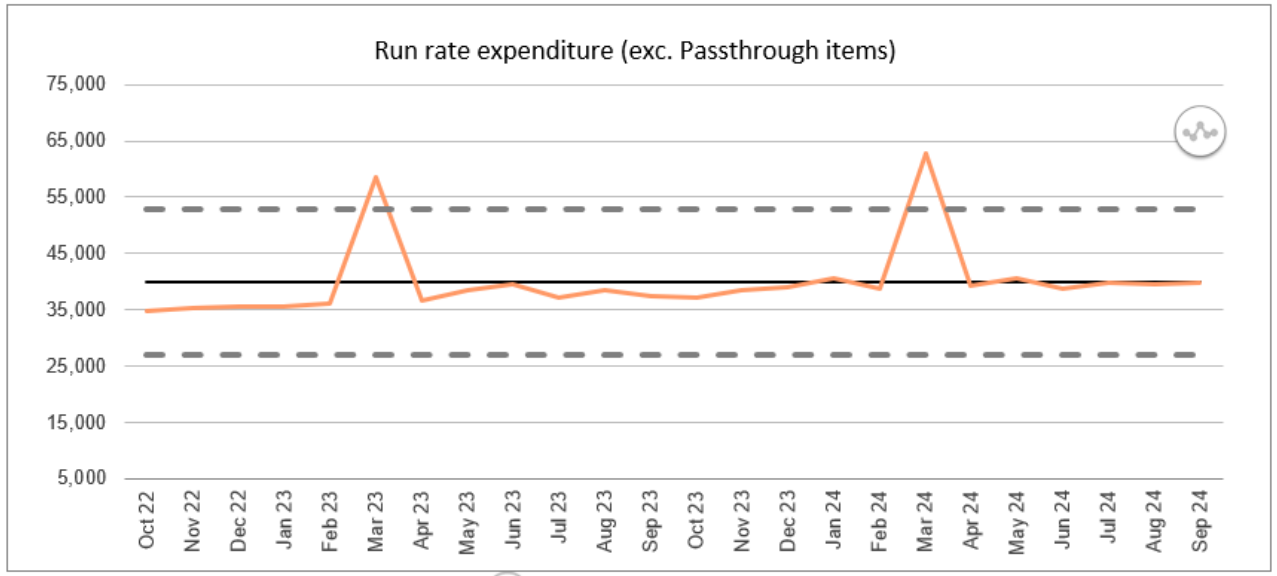
- Clinical division's breakthrough objectives whilst aligned to our strategic pillar are not the same as the Trust breakthrough objective, therefore strategic focus is not aligned.

2024/25 Breakthrough Objectives

NHS Great Western Hospitals NHS Foundation Trust

Financial Recovery

Expenditure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total expenditure (excl. passthrough items)	37,118	38,412	38,973	40,519	38,664	62,891	39,339	40,664	38,705	39,705	39,538	39,904
Medicine	11,445	12,851	12,636	13,454	12,028	13,002	12,248	12,820	12,457	12,931	11,862	12,206
SWC	10,368	10,496	10,777	10,498	10,513	11,111	10,484	10,848	10,666	10,633	10,818	10,628
ICC	5,599	5,687	5,674	5,715	5,447	5,805	5,397	5,420	5,057	5,578	5,685	5,620
Corp	8,334	7,517	7,595	7,391	7,484	8,361	7,947	8,022	8,014	8,169	8,348	7,971



Common cause – no significant change

Understanding the Data

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

We are driving this measure because...

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

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

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

Performance

- As at M05 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £7.6m, which represents a £2.9m adverse variance to plan.
- We are currently £2.4m behind our YTD efficiency plan.
- Non-pay spend analysis for the last year is being completed to provide top contributors for review, and any further drip and control measures.
- Actions focussing on the Countermeasures include:
  - Training offer to be developed for the whole Trust for general financial acumen.
  - Financial Data accessible through SBS Business Intelligence System may not be as user-friendly as needed.
  - Agree ideal number of requisitioners with Div Tri and reduce down as appropriate.
  - Validate training offered by SFT Procurement Team and enhance where needed.
  - Ensure TMC message shared consistently throughout Div Board / specialty boards / team meetings etc.

Risks

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		62%	62%	68%	72%	
	No. of complaints received	SPC	H	54	70	79	64	
	Number of reopened complaints	SPC	H	2	0	1	1	
FFT	Overall response rate (%)	28% (Int)		23.7%	25.8%	26.1%	32.0%	
	Positive response (%)	90% (Int)		86.9%	88.1%	89.8%	89.8%	
	ED & UTC Response Rate	16% (Int)		14.7%	15.1%	15.7%	15.3%	
	Inpatients Response Rate	22% (Int)		18.9%	21.0%	19.5%	23.7%	
	Daycases Response Rate	22% (Int)		18.9%	21.1%	20.5%	24.5%	

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

Performance & Counter Measure

There is a further improvement in the complaint response rate at 72%. A multi professional meeting using the Improving Together methodology are working to make improvements to the complaint process, reduce the backlog of overdue complaints and ensure robust empathetic responses moving forward.

The overall number of complaints received in month has reduced to 64 from previous month of 79. There is work ongoing to try to reduce the number of formal complaints received including better communication on waiting times and ensuring staff are addressing concerns immediately at ward/department level. The number of re-opened complaints is one in month, reassuring that the quality of complaints is a high standard.

The FFT overall response has increased and is above target but, the positive response rates remains just below target. Emergency Department (ED) and Urgent Treatment Centre (UTC) response has stayed static.

Risks

- Vacancies within PALS (Patient Advice and Liaison Service) now fully recruited to.
- Rise in backlog of complaints and failure to response in a timely manner is negatively impacting on patient experience. Additional resource provided to Division of Medicine to clear backlog.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24
Harm	Patient safety incident investigation	SPC		4	0	2	2
	Falls rate per 1000 bed days	SPC		5	4.9	4.4	5.6
	No. of Falls in month	SPC		98	93	81	102
	No. falls with moderate harm or above	SPC		2	5	2	2
	Medication incidents with moderate harm	SPC		5	1	5	7
	Pressure Ulcer (Hospital Acquired)	SPC		35	25	25	14
	Pressure Ulcer (Community Acquired)	SPC		16	25	20	17
Concerns and Complaints	No. of concerns received	SPC		334	441	365	294
IP & C	C.Diff	6.42		7	4	2	8
	MRSA	0		0	0	0	0
	MSSA	2.00		1	2	4	1
	E.coli	8.33		10	10	5	6
	Klebsiella	2.92		2	3	3	1
	Pseudomonas	2.50		1	5	2	2
	COVID (hospital acquired)	SPC		15	29	19	16

Performance & Counter Measure

There are seven Patient Safety Incident Investigations (PSII) in progress. There were Two PSII's reported in month of September one a Never Event related to a wrong side Occipital Never block, the other was the over-arching PSII in relation to the power outage in July.

The number of falls has increased in month to 102 (81 in August). There has been two falls with moderate harm or above this month.

Hospital-acquired category 2-4 pressure ulcers have dropped to their lowest level for at least two years. Of the 14 reported, one was category 3 and there were zero category 4 ulcers. The Tissue Viability Nurse (TVN) team continue to work with top contributing wards to drive further improvements.

There were 17 community pressure ulcer harms in September (20 in August) involving 17 patients. Seven of these harms were associated with patients on an end-of-life pathway and eight occurred in patient with other complex needs. The majority of harms were reported at Category 2 (11) with zero category four harms identified. Following a review of the current product used for management for moisture associated skin damage (MASD), there has been an agreed change to use an alternative that offers better protection as well as being a cost saving.

Although *C.diff* numbers have increased this month, the Trust remains below its target trajectory and one of the best performing Trusts in region. Methicillin-sensitive Staphylococcus aureus (MSSA) numbers have returned to normal after last month's increase which appears to have been a statistical fluctuation. Targeted work on catheter management since an external audit at the start of August may be contributing to the overall reductions seen in *E. coli* and *Klebsiella,* although a slight increase in E.coli in month five compared to six in August. P*seudomonas* numbers remain lower than last year; however, we anticipate that the catheter work may impact on these too.

The number of concerns and complaints received remains high at 294 but we are seeing a drop on the previous 2 months. The main themes continue around waiting times and communication.

Risks

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

Patient and staff concerns regarding lack of disability access within GWH in line with Equality Act requirements. The Estates team are working on the plan including assessment of heavy doors with relevant specialists such as the fire officer. Blue lights in toilets has been implemented.

Our Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	94.1%	94.7%	93.0%	93.1%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	107.6%	108.0%	103.5%	102.9%
	ED & UTC Positive Responses	79% (Int)	?	79.1%	78.9%	84.1%	78%
	Inpatients Positive Responses	88% (Int)	?	89.8%	91.4%	89.8%	92.3%
	Daycases Positive Responses	95% (Int)	?	95.2%	95.2%	95.0%	96.6%
	Outpatients Positive Responses	97% (Int)	?	98.2%	97.5%	98.4%	97.9%
	Maternity Response Rate	20% (Int)	?	25.9%	25.3%	22.2%	21.8%
	Maternity Positive Responses	92% (Int)	?	92.5%	92.9%	92.5%	91%

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

Performance & Counter Measures

Safe Staffing fill rates remain above the National target and are within safe parameters.

The inpatient positive response rate has increased and remains above the target of 88%.

The maternity response rate has decreased slightly to 21.8% (22% August). The positive response rate has also decreased slightly 91% and has dip just below the internal target.

Review of the complaint process using Improving Together has been completed, using A3 methodology to understand where improvements can be made to ensure timely and robust responses and learning.

New carer referral email implemented so that wards and departments can contact the carer support service for advice and proactively visit any carers. This is prompted via a mandatory carer assessment on Nervecentre.

Engagement event held (25th September) with patients who have undergone total knee replacement (TKR) surgery to understand their lived experience of the TKR pathway and where improvements can be made.

Reaccreditation as Veteran Aware organisation achieved and highly commended on an exemplar application.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24	Trend
RTT	No. of >=18 weeks waiters		H	19892	20650	21130	20968	
	No. of >=52 weeks waiters		H	1885	1941	2072	1924	
DM01	No. of patients on DM01 waitlist			9064	8819	7392	One month behind	
	DM01 performance %	99% (Nat)	F	70.6%	70.7%	75.8%	One month behind	
	DM01 6 week wait breaches		H	2669	2582	1789	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	69.4%	68.1%	70.3%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	89.5%	94.9%	96.0%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	40.7%	45.2%	68.1%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	70.2%	75.2%	81.8%	One month behind	

Performance & Counter Measure

Diagnostics

Septembers validated DM01 performance is showing an increase in performance variance from the 75.80% performance in July to 80.28% - this is the highest DM01 since July 2021. The number of patients on the waiting list has decreased by 487 to 6,907 driven by the by the continued work to improve NOUS.

Counter measures: Radiology now have a specialist CT outsourcing provider to support on the mobile pads with complex scans which make up the majority of the long waiters (Cardiacs and Colons). Activity for the imaging vans on the CDC site is now achieving 90% utilisation for MRI and CT.. Endoscopy usage remains lower than planned and ended on 30th September. Ultrasound still remains the largest issue with 1,807 on the waiting list and 404 over 6 week. Medicare continue to support US activity on site with levels increasing as they increase support to the team. A locum sonographer is also being sourced to help with the more complex long waiters.

Cancer

62.9% of the 62-day breaches were with the Plastics, Colorectal & Urology pathways.

Cancer waiting times for first appointment remain below standard. Colorectal and Dermatology are the largest contributors with 65.9% of all breaches. Capacity for outpatients were the main factors in these breaches (81.8%).

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Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	75.0%	77.1%	79.5%	77.4%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	6.9%	5.2%	2.7%	3.7%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	54.2%	58.2%	60.7%	57.7%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	14.2%	10.7%	5.6%	7.5%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	3667.81	2296.43	1452.14	2000.45	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1647	1691	1660	1740	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	91%	89%	82%	86%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1260	1213	940	1118	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	70.0%	64.1%	46.6%	55.5%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	916	781	499	664	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	50.9%	41.3%	24.8%	33.0%	
Flow	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	378	340	299	324	
	Community Average Length of Stay (Days)	SPC	H	21	22	18	18	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4 hour performance (type 1 and 3) decreased from 79.5% to 77.4%. This is 0.6% below the 23/24 national target. This performance places the Trust 26th in the country out of 122 acute providers. The reduction in performance relates to type 1 performance reducing from 60.7% to 57.7%.

Total % over 12 hours has risen from 5.6% to 7.5% however this is still an improved position compared to June/July 24.

Ambulance handover delays over 15 minutes increased from 1452 hours to 2000 hours (phase 1 breakthrough objective = 2100 hours) showing growing pressure on the Emergency Department.

Number of ambulance handovers over 30 minutes has increased from 940 to 1118.

Number of ambulance handovers over 60 minutes increased from 24.8% to 33%

Counter measures remain in place within the Breakthrough objective slides.

Risks

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

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

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24
RTT	No. of >=78 weeks waiters	SPC	L	3	3	12	6
Cancer	No. of referrals received	SPC		1858	2035	1756	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	94.7%	95.1%	97.2%	97.1%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.0%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5415	5525	5235	5531
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	80.0%	82.6%	78.8%	80.9%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		60.6%	60.8%	64.5%	61.6%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		55.2%	52.6%	57.9%	58.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	189	183	175	196
	Emergency Care - AED - Median Stay	240 (Int)	?	239	237	237	238
	Emergency Care - UTC - Median Stay	240 (Int)	P	145	140	131	153
	Total Number of Ambulance Handovers	SPC	L	1801	1891	2016	2014
	Average hours lost to ambulance handover delays per day	SPC		118	71	45	65

Performance & Counter Measure

ED

Number of ambulance conveyances remained static but at a high level of 2014 down from 2016 in previous month. Average hours lost increased in September from 45 to 65 which is 5 hours below breakthrough objective target. The performance

Triage performance for ED has decreased rising from 64.5% to 61.6%. ED team continuing to embed in to new department. Significant improvement in Type 3 triage performance now that additional capacity is in place (58.6%).

Median stay has remained static at 238 mins in ED and a in median stay seen in UTC (140 down to 131).

Cancer referrals remain above pre covid levels (27%), resulting in capacity issues in a number of sites. The services are providing WLI activity to support where possible, though cancer performance is adversely affected where this is insufficient.

Risks

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		594	524	407	444
	Elective Patients Average Length of Stay (Days)	SPC		3	3	3	3
	Non-Elective Patients Average Length of Stay (Days)	SPC		5	5	4	5
	GWH Discharges by Noon (%)	SPC		16.8%	17.2%	17.5%	15.6%
	Number of Stranded Patients (over 14 days)	SPC		122	130	95	94
	Number of Super Stranded Patients (over 21 days)	SPC		67	78	54	49
	Adult general and acute type 1 bed occupancy	SPC		95.7%	94.5%	91.2%	92.4%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC		18.2%	20.1%	10.7%	13.4%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.4%	95.7%	95.5%	95.6%

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Performance & Counter Measure

Patient Flow

- Discharges prior to Midday at 17% not the recorded 15.5% on data set.
- Data set reports significant decrease in stranded patients over 14 days and 21 days - mitigations in place: NCTR daily calls, BSW senior flow calls coupled with IFD – LoS bed audit with ECIST

***** No concerns as not in amber/red for measures ******

Risks

There is a risk of ongoing ambulance handover delays if overall bed occupancy and no criteria to reside does not reduce further, however it is heading in a downward trajectory. Trust focus remains on improvements that can be made to earlier discharge in the day and escalating the completion of next steps for discharge which will reduce length of stay and positivity impact on NCTR reduction.

Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24
Use of Resources	Capital Expenditure (£'000)	SPC		1793	2325	3463	1474
	Pay (£'000)	SPC		24562	25158	26170	25648
	Non Pay (£'000)	SPC		17264	17712	16549	17727

Performance & Counter Measure

Year-to-date capital spend at M6 is £12.0m against a plan of £20.2m, giving an underspend against plan of £8.2m. Key drivers are EPR, CDC and PFI lifecycle.

Pay costs are £0.5m lower than M5 due to SAS doctor pay award and bank holiday payments in prior month.

Non-Pay is £1.2m higher than M5 driven by lower clinical supply costs (£0.6m) in Medicine in prior month due to accrual estimates being lower than actuals, and higher passthrough drug costs (£0.4m) offset with income. PFI related costs were £0.2m higher.

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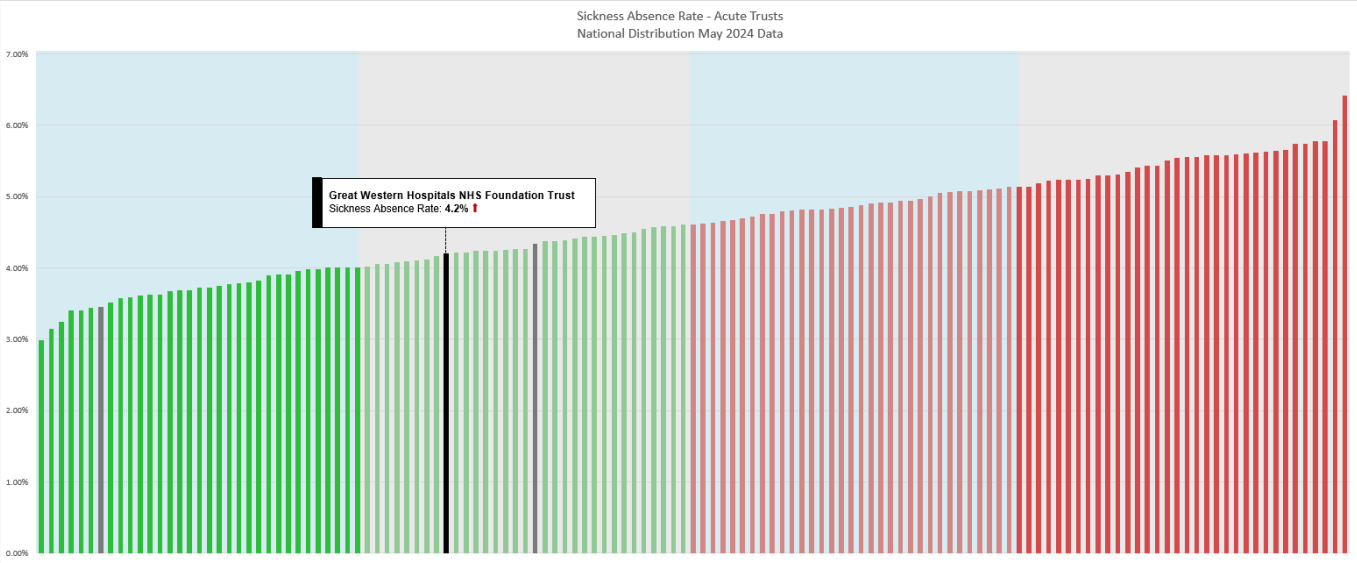
Risks

The Trust started the year with a £21.9m cash releasing efficiency plan. As at M6 delivery is £2.4m behind plan with 52% of the £6.8m delivered being recurrent. The risk is that any unmet or non-recurrent delivery adds to the underlying deficit of the Trust. Divisions and services must work to develop recurrent cash releasing schemes. There is a key focus on workforce savings in 24/25, with pay schemes accounting for £12m of the £21.9m plan.

Our People

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-24	Jul-24	Aug-24	Sep-24	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.6%	5.2%	4.5%	One month behind	



Performance & Counter Measure

- Sickness absence decreased in August from 5.2% to 4.5%. Short term absence decreased to 1.98%, and long term absence to 2.6%. Short-term absence increased to 2.7% and long-term absence to 2.5%. Anxiety/Stress persists as our top reason for absence in-month and levels of this absence reason have increased in August (24% of absence). MSK problems remain our second most prevalent reason at 10% of absence.

- The Trust Improving Attendance working group met on 10th October with representation from Clinical Teams across divisions in hotspot areas for sickness absence. The following proposed countermeasures were reviewed by the group and an A3 will be presented at the next meeting (7th November) by each team outlining their current situation and countermeasures:
    - Development of departmental A3s on improving attendance
    - Development and implementation of Trust-wide sickness call guidance
    - Review of all staff on absence markers/policy conducted by People Operations

- Benchmarking data for May 2024 (NHS Digital) shows a marginal decrease to the National absence rate, dropping from 4.76% in April to 4.71% in May. Absence for our ICS decreased slightly in May, reducing from 4.24% to 4.21%. At Trust level, we saw a small increase to absence in May, increasing to 4.2%. This moved us up into the second-lowest quartile for Acute Trusts, ranking 42nd out of 133 Organisations.

Risks

- Increased sickness rate as per national trend during winter.

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

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Our People

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

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

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	69.0%
	My immediate manager takes a positive interest in my health and well-being	67.4% (Nat)	68.8%	67.5%	74.8%	69.2%	64.4%	67.6%	Not in Quarterly Survey
	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.5% (Avg)	59.6%	54.1%	60.4%	57.1%	56.1%	56.4%	56.5%

Performance & Counter Measure

- Leavers within their 1st year of employment increased in August to 11%, in line with the overall trend of an increase to turnover. This metric remains below the target of 14.8%.
- The annual Staff Survey launched on 9th September and a final response rate will be available at the end of November. The Trust is aiming to improve on the response rate of 69% last year and remain in the top 5 Acute/Acute & Community Trusts nationally. As at week 5 of the 2024 survey, we have achieved a response rate of 55% which is +2% compared to this time last year.

Risks

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

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Our People

Workforce Scorecard

NHS Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Trend Vs Last Month	Trend Vs Sep-23
	Vacancy																	
W	Vacancy Rate	%	7.00%	4.87%	4.33%	3.93%	3.74%	4.12%	4.11%	3.93%	4.19%	4.04%	3.98%	3.44%	3.82%	3.53%	↓	↓
W	Vacancy Rate	WTE	-	262.33	232.95	211.39	201.47	223.67	223.82	213.76	227.43	219.66	216.12	186.71	207.11	191.29		
W	All Nursing Vacancy	%	7.00%	1.96%	1.30%	1.94%	1.43%	2.75%	2.39%	2.21%	2.20%	1.73%	1.73%	0.96%	1.30%	0.64%	↓	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	51.43	34.17	51.03	37.87	73.60	63.97	59.14	58.90	46.13	46.07	25.61	34.47	17.00		
W	All Registered Nursing Vacancy	WTE	-	47.47	18.62	26.55	9.50	28.02	14.37	9.70	4.67	4.75	14.57	5.24	0.02	-27.25		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	23.20	3.60	8.44	-3.79	5.29	-3.91	-7.35	-19.60	-12.95	-3.59	-11.35	-23.55	-47.80		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	3.96	15.55	24.48	28.37	45.58	49.60	49.44	54.23	41.38	31.50	20.37	34.45	44.25		
W	Medical Vacancy	%	7.00%	5.22%	5.66%	5.26%	5.89%	7.07%	7.96%	7.47%	8.30%	6.78%	6.67%	7.82%	10.39%	8.99%	↓	↑
W	Medical Vacancy	WTE	-	38.22	41.48	38.61	43.30	53.08	59.82	56.06	62.23	50.71	49.94	58.44	77.65	67.20		
W	STT/AHP Vacancy	%	7.00%	10.41%	9.20%	6.88%	6.44%	4.87%	4.78%	3.74%	3.39%	3.67%	3.63%	3.00%	2.30%	3.92%	↑	↓
W	STT/AHP Vacancy	WTE	-	90.28	79.85	58.89	54.92	41.53	40.83	31.72	28.78	31.27	30.91	25.62	19.64	33.48		
W	SMA Vacancy	%	7.00%	7.12%	6.70%	5.44%	5.66%	4.80%	5.09%	5.76%	6.68%	7.77%	7.58%	6.57%	6.44%	6.30%	↓	↓
W	SMA Vacancy	WTE	-	82.40	77.45	62.86	65.38	55.46	59.20	66.84	77.52	91.55	89.20	77.04	75.35	73.61		
W	Recruitment Time to Hire - AFC	Days	46.00	41.70	42.70	41.80	43.50	44.40	42.70	38.40	39.50	39.40	43.20	40.40	43.80	44.10	↑	↑
W	Recruitment Time to Hire - Bank	Days	46.00	43.50	37.00	39.90	45.20	42.00	50.30	39.30	43.30	33.30	44.00	22.90	-	30.30	↓	↓
W	Recruitment Time to Hire - Medical	Days	46.00	-	-	-	-	64.30	66.10	32.60	39.00	39.44	35.30	44.20	57.40	37.25	↓	↓
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,381.76	5,379.33	5,382.66	5,382.34	5,431.15	5,446.50	5,433.90	5,433.90	5,437.81	5,434.79	5,430.70	5,427.80	5,424.66		
W	Substantive WTE	WTE	-	5,119.43	5,146.38	5,171.27	5,180.87	5,207.48	5,222.68	5,220.14	5,206.47	5,218.15	5,218.67	5,243.99	5,220.69	5,233.37		
W	Additional Substantive WTE	WTE	-	22.95	26.89	24.63	25.22	21.90	22.51	24.78	20.17	5.53	8.24	9.23	6.30	7.64		
W	Bank WTE	WTE	-	277.29	280.45	260.02	246.43	295.57	294.32	380.50	286.32	301.97	326.11	333.04	333.94	318.99		
W	Agency WTE	WTE	-	80.48	66.71	60.65	55.12	61.82	69.47	60.09	49.52	43.70	38.63	45.95	44.39	30.74		
W	Budgeted vs Worked WTE Variance	WTE	-	118.39	141.10	133.91	125.30	155.62	162.48	251.61	128.59	131.54	156.87	201.51	177.52	166.07		
W	Actual Worked vs Budgeted %	%	-	102.20%	102.62%	102.49%	102.33%	102.87%	102.98%	104.63%	102.37%	102.42%	102.89%	103.71%	103.27%	103.06%		
W	Total Workforce Cost £	£	-	£26.42M	£25.47M	£24.85M	£25.09M	£25.67M	£25.39M	£25.92M	£25.13M	£25.50M	£25.21M	£25.57M	£25.87M	£25.27M		
W	Agency Spend as % of Total Spend	%	4.50%	3.11%	4.56%	3.56%	1.22%	2.83%	2.83%	2.04%	1.83%	1.30%	2.01%	1.94%	1.58%	1.01%	↓	↓
W	Agency Spend £	£	-	£0.82M	£1.16M	£0.89M	£0.30M	£0.73M	£0.72M	£0.53M	£0.46M	£0.33M	£0.51M	£0.50M	£0.41M	£0.26M		
W	Agency Target £	£		£1.17M	£1.07M	£0.91M	£1.10M	£0.91M	£0.86M	£0.96M	£0.54M	£0.52M	£0.51M	£0.49M	£0.47M	£0.46M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-£0.35M	£0.09M	-£0.03M	-£0.79M	-£0.18M	-£0.14M	-£0.44M	-£0.08M	-£0.19M	£0.00M	£0.01M	-£0.06M	-£0.20M	↓	↑
W	Bank Spend £	£	-	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	£1.89M	£2.02M	£2.23M	£2.32M	£2.04M	£1.88M		
W	Bank Target £	£		£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£2.19M	£2.12M	£2.04M	£1.96M	£1.88M	£1.81M		
W	Bank Spend vs Target £	£ Diff	£0.00M	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	-£0.31M	-£0.10M	£0.19M	£0.36M	£0.15M	£0.07M	↓	↓
W	Registered Nursing Bank Fill	%	45.00%	81.62%	84.87%	86.80%	87.74%	90.73%	90.69%	90.40%	90.86%	94.13%	90.81%	85.23%	82.25%	85.50%	↑	↑
W	Unregistered Nursing Bank Fill	%	70.00%	81.35%	79.99%	84.45%	81.80%	80.12%	79.46%	78.92%	81.89%	87.18%	86.23%	79.50%	77.63%	78.67%	↑	↓

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Trend Vs Last Month	Trend Vs Sep-23
	Retention																	
W	All Turnover %	%	13.00%	12.56%	12.20%	12.00%	11.49%	10.98%	10.90%	10.72%	10.85%	10.57%	10.24%	10.47%	10.91%	-	↑	↓
W	Voluntary Turnover %	%	11.00%	9.52%	9.20%	9.19%	8.89%	8.55%	8.56%	8.45%	8.62%	8.53%	8.02%	7.90%	8.66%	-	↑	↓
W	Number of Leavers	Headcount	-	63	41	44	42	44	40	62	44	46	58	45	71	-		
W	Number of RN Leavers	Headcount	-	18	11	14	11	21	10	15	12	17	20	14	15	-		
W	Registered Nursing Vol Turnover	%	-	6.50%	6.57%	6.95%	6.99%	7.07%	7.16%	7.19%	7.33%	7.52%	7.17%	7.36%	7.70%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	21	10	8	15	7	11	13	11	10	13	6	13	-		
W	Unregistered Nursing Vol Turnover	%	-	13.35%	12.65%	12.34%	11.86%	12.01%	11.21%	10.87%	11.16%	11.00%	10.91%	10.69%	11.10%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	14.74%	14.44%	13.35%	13.96%	12.14%	11.86%	11.72%	10.68%	9.74%	10.98%	9.57%	11.00%	-		
W	Number of starters	Headcount	-	115	65	72	39	86	38	52	62	44	64	60	69	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	4.12%	4.33%	4.42%	4.54%	4.60%	4.57%	4.52%	4.48%	4.45%	4.47%	4.53%	4.57%	-	↑	↑
D	Sickness Absence %	%	3.50%	4.21%	4.74%	4.70%	4.98%	4.91%	4.36%	4.16%	4.21%	4.20%	4.62%	5.20%	4.55%	-	↓	↑
W	Long Term Sickness %	%	2.00%	2.10%	2.41%	2.40%	2.65%	2.63%	2.40%	2.24%	2.24%	2.32%	2.44%	2.88%	2.57%	-	↓	↑
W	Short Term Sickness %	%	1.50%	2.11%	2.33%	2.31%	2.33%	2.28%	1.96%	1.92%	1.97%	1.88%	2.18%	2.32%	1.98%	-	↓	↓
W	Sickness Absence Cost £	£	-	£614.8k	£738.9k	£726.5k	£794.0k	£777.2k	£647.1k	£669.2k	£675.4k	£708.3k	£748.9k	£.0k	£755.3k	-		
W	WTE Days Lost	WTE	-	6,401.2	7,487.3	7,187.9	7,922.9	7,774.7	6,566.1	6,618.1	6,482.7	6,662.1	7,157.7	8,351.6	7,372.3	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	90.36%	90.75%	91.38%	91.88%	91.49%	91.72%	92.31%	92.46%	91.37%	91.59%	92.42%	89.84%	89.85%	↑	↓
W	Role Essential MT %	%	85.00%	91.93%	92.20%	92.77%	93.14%	92.92%	93.28%	93.79%	94.03%	91.84%	92.30%	94.14%	89.00%	89.52%	↑	↓
W	CQC Safe MT %	%	85.00%	88.78%	89.32%	90.01%	90.64%	90.07%	90.16%	90.85%	90.90%	90.86%	90.84%	90.71%	90.88%	90.25%	↓	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	82.14%	83.26%	83.85%	85.24%	86.22%	85.23%	86.51%	84.26%	83.54%	82.60%	84.77%	86.96%	82.88%	↓	↑
W	Appraisal Compliance %	%	85.00%	84.88%	84.92%	83.62%	85.63%	84.32%	84.85%	85.26%	84.18%	84.39%	84.74%	84.88%	84.67%	84.09%	↓	↓
W	Non Medical Appraisal Compliance %	%	85.00%	84.89%	84.91%	83.81%	85.37%	84.06%	84.37%	84.59%	84.40%	83.99%	84.87%	84.95%	84.71%	84.37%	↓	↓
W	Medical Appraisal Compliance %	%	85.00%	84.84%	85.04%	82.25%	87.59%	86.32%	88.38%	90.10%	82.58%	87.32%	83.81%	84.40%	84.38%	82.07%	↓	↓

Our People

Workforce Scorecard

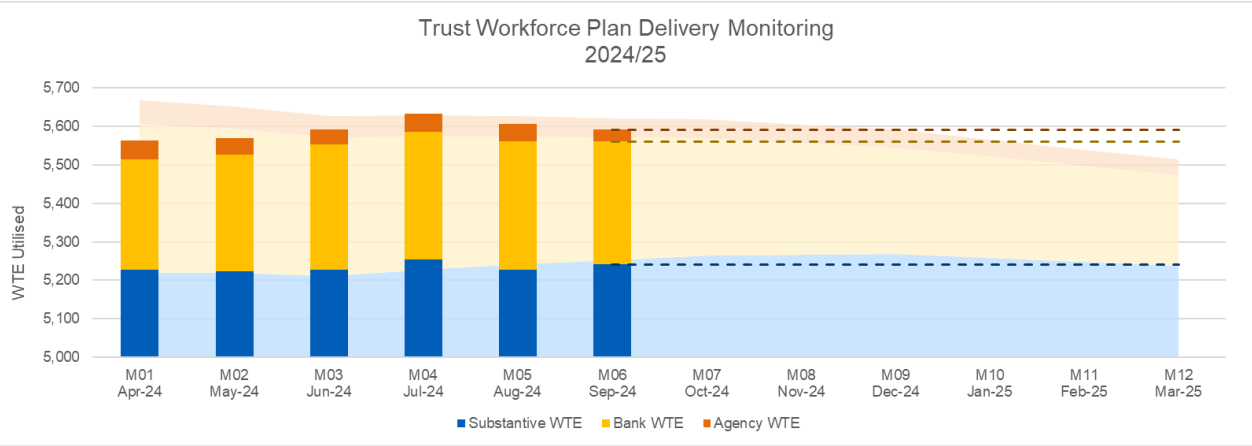
Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Trend Vs	
																	Last Month	Sep-23
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.18%	4.12%	4.21%	4.19%	4.23%	4.26%	4.28%	4.28%	4.23%	4.26%	4.29%	4.25%	4.21%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	260.00	258.00	265.00	264.00	268.00	271.00	272.00	272.00	269.00	271.00	273.00	273.00	271.00		
W	% of Leadership Roles who are Female (B8a+)	%	-	71.15%	70.93%	71.32%	71.59%	71.27%	71.22%	70.59%	70.59%	69.89%	70.11%	70.33%	70.70%	70.11%		
W	% of Leadership Roles who from BME (B8a+)	%	-	6.54%	6.20%	6.79%	6.82%	6.34%	6.64%	6.25%	6.25%	6.32%	6.64%	6.59%	6.23%	6.27%		
W	Staff in Leadership Roles % (B8c+)	%	-	0.92%	0.91%	0.92%	0.89%	0.90%	0.90%	0.90%	0.94%	0.94%	0.94%	0.96%	0.93%	0.93%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	57.00	57.00	58.00	56.00	57.00	57.00	57.00	60.00	60.00	60.00	61.00	60.00	60.00		
W	% of Leadership Roles who are Female (B8c+)	%	-	56.14%	56.14%	56.90%	57.14%	56.14%	56.14%	56.14%	56.67%	56.67%	56.67%	57.38%	58.33%	56.67%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.26%	5.26%	5.17%	5.36%	3.51%	3.51%	3.51%	3.33%	3.33%	3.33%	3.28%	3.33%	3.33%		
W	% of Leadership Roles who are disabled (B8c+)	%	-	1.75%	1.75%	1.72%	1.79%	1.75%	1.75%	1.75%	1.67%	1.67%	1.67%	1.64%	1.67%	1.67%		
W	Male % of Workforce	%	-	18.16%	18.36%	18.40%	18.29%	18.33%	18.32%	18.36%	18.39%	18.52%	18.51%	18.56%	18.48%	18.32%		
W	Female % of Workforce	%	-	81.84%	81.64%	81.60%	81.71%	81.67%	81.68%	81.64%	81.61%	81.48%	81.49%	81.44%	81.52%	81.68%		
W	BME % of Workforce	%	-	25.18%	25.47%	25.68%	25.98%	26.08%	26.12%	26.36%	26.56%	26.76%	27.05%	27.31%	27.53%	27.99%		
W	White % of Workforce	%	-	66.86%	66.58%	66.32%	66.19%	65.84%	65.76%	65.61%	65.36%	65.09%	64.99%	64.84%	65.00%	64.54%		
W	ER Cases Closed	Number	-	35	30	28	40	42	45	24	19	57	44	50	43	32		

Our People

Great Western Hospitals NHS Foundation Trust

Workforce Scorecard - Workforce Planning



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

Performance & Counter Measure

- In September we utilised 5,591WTE to deliver our service compared to a planned figure of 5,621WTE. This was -30WTE below plan and driven by an overperformance of Contract and Agency WTE compared to the workforce plan.
- The position at month 5 has been adjusted following the correction of assignments not marked as honorary in ESR during August changeover, meaning the position in August also reported below plan (-21WTE).
- Temporary staffing usage decreased by 28WTE in September compared to August. Bank utilisation remains marginally above plan (+1WTE), whilst agency utilisation is -20WTE compared to plan. Higher than planned sickness absence levels are impacting on temporary staffing usage, along with enhanced care requirements for HCSWs.

Impact on Workforce

- Increased restrictions on overtime usage continue to positively impact our substantive WTE position, with usage decreasing from an average 35WTE per month to 7WTE per month in 2024/25. Usage has been transferred largely to bank WTE, which whilst not impacting overall workforce levels is positively influencing cost.
- Escalations outlined in the Workforce Recovery project plan, beyond overtime restrictions, have not been initiated. Despite a positive position against plan at the end of Q2, divisional forecasting is showing a potential year-end variance to plan of +124WTE and so options to managed vacancies and fixed-term contracts are being reviewed at the Workforce Recovery Meeting in October.

Risks & Mitigations

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

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

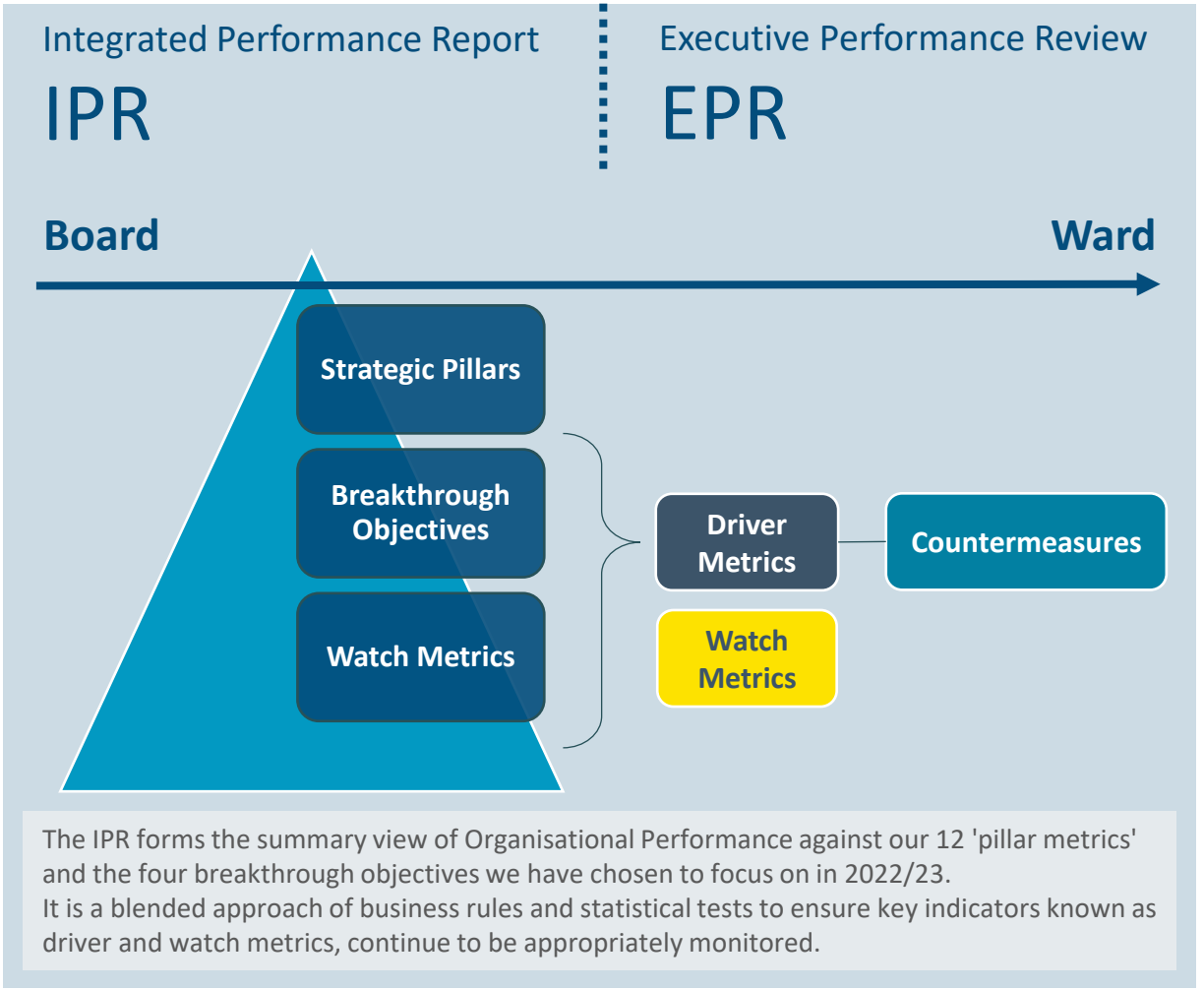
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

NHS
Great Western Hospitals
NHS Foundation Trust

Our Vision

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

Our four strategic pillars

Outstanding patient care and a focus on quality improvement in all that we do

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

Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers

Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

24/25 Strategic Planning Framework

NHS Great Western Hospitals NHS Foundation Trust

Our Vision

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

1 Our four strategic pillars

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

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

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust

Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

Level	Daily	Weekly	Monthly
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

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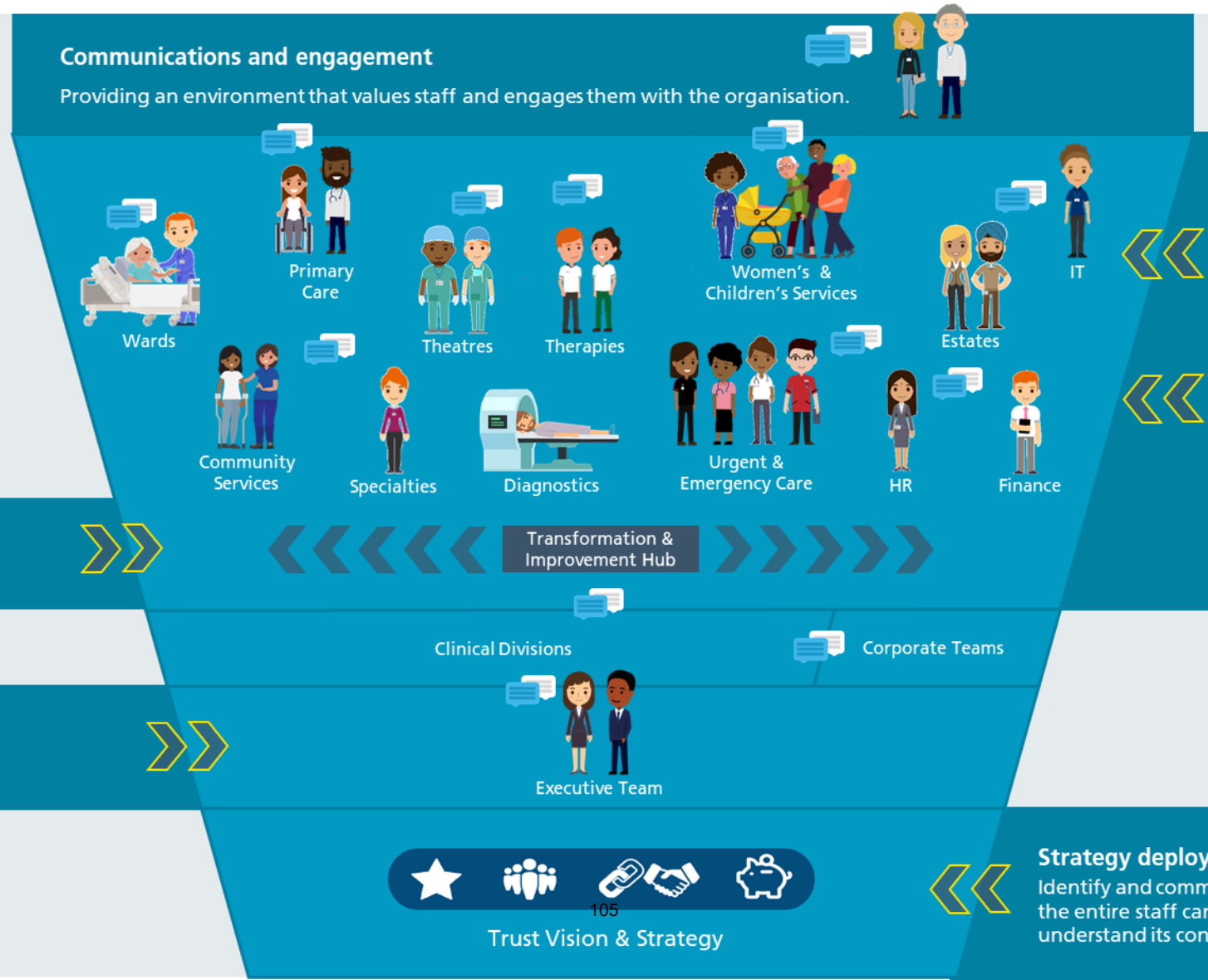


Transformational projects
Using improvement methodology to create step-change improvement.

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

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

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

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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

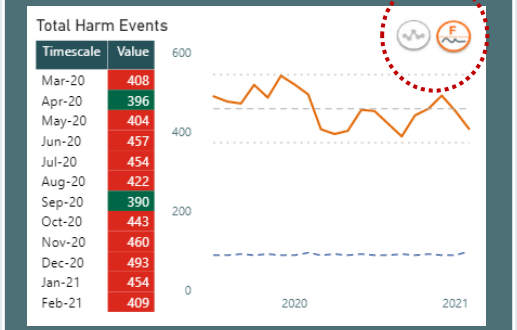
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

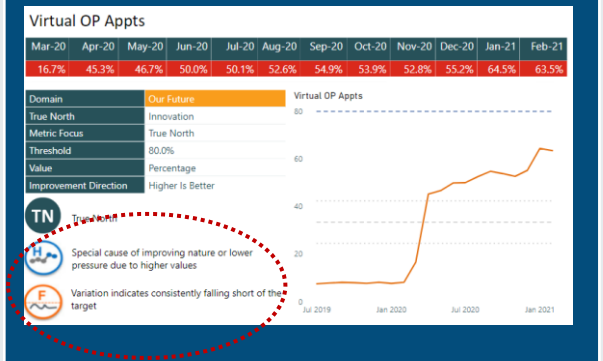
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
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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.

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Audit, Risk & Assurance Committee**
Meeting Date	12 September 2024
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Divisional Risk Review Surgery, Women's and Children's	Good Assurance	x
2. GWH Electrical Incident Risk Review	Partial Assurance	x
3. Cyber Security Annual Report	Partial Assurance	x
4. SAFE Annual Report 2023/24	Substantial Assurance	x
5. External Audit – Auditor's Annual Report 2023/24	Noted	x
6. Internal Audit - Progress Report and Action Tracking	Good Assurance	x
7. Internal Audit – Cyber Security Final Report	Good Assurance	x
8. Local Counter Fraud Progress Report	Noted	x
9. National Cost Collection 2023/24 post-submission assurance	Substantial Assurance	x
10. Single Tender Actions	Good Assurance	x
11. Losses and Compensation Report Q1 2024/25	Noted	x
12. Documents Signed under Trust Seal	Noted	x

POINTS OF ESCALATION	
KEY AREAS TO NOTE	The Committee received an update on the 9 July Electrical Incident from the perspective of the risks associated with the incident and the way they are being managed. It was agreed that once the review of the incident is completed that there should be a full reflection on the related risks registered and the processes to identify risks and how we manage those risks on an ongoing basis. The Committee reviewed the Cyber Security Annual Report and the outstanding actions related to that report. The main actions required are assured by FIDC but the Committee agreed that ARAC needed to continue to gain assurance that all the appropriate controls are in place and appropriately managed across the Board Committees. This will be reflected on at a future meeting. Following both this and the electrical incident it was agreed that there should also be a reflection on whether there should be oversight of EPRR at ARAC. Deloitte provided their Auditor's Annual Report for 2023/24 which was submitted in July. The Trust year end accounts have now been laid before Parliament and can be published. The Committee reviewed the final internal audit report on Cyber Security from KPMG. The review was rated Significant Assurance with minor improvement opportunities. This was the first review conducted in tandem with Salisbury and the Committee appreciated the benchmarking feedback this provided. The internal audit plan for the year is progressing well. An additional review on the application of Grip and Control on workforce controls has been requested by NHSE/SW region and the plan will be adapted to incorporate this. The Committee received a report on the progress of the Local Counter Fraud Plan for 24/25 which is progressing well. The Committee were pleased to note the timely submission of the data for National Cost Collection. A detailed benchmarking report will be provided to FIDC following publication of the national data. The Committee reviewed the single tender actions approved in the six months to 31 May 2024. The use of waivers remains low. The Committee noted that some of the waivers categorised as Urgent but unavoidable could have been avoided if the teams had planned appropriately and asked for the teams to be notified of the concerns from ARAC.
BOARD ASSURANCE FRAMEWORK & RISKS	The Surgery Women's and Children's Division updated the Committee on their process to manage risk and their actions to mitigate the risks. The Division has achieved a significant reduction in their longstanding risks and at the time of the meeting had no overdue reviews or risks with no actions. There is an ongoing challenge to reduce the risk in theatres due to the requirement for capital investment.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	The Committee received the SAFE annual report on the Trust's security management services covering policies and procedures, incidents and assurance on various security assessments and reviews. The Committee were assured on the quality of the report and the management of security but raised a question on whether people were appropriately raising and recording incidents of verbal abuse as the number of incidents seemed low. It was agreed to refer this to the People and Culture Committee on whether our people are appropriately recognising and reporting verbal abuse.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Report Title	**Trust Quarterly Learning from Deaths Report October 2024**				
Meeting	**Board of Directors**				
Date	**7 November 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Dr Stephen Haig, Acting Chief Medical Officer				
Report Author	Dr Laurie Powell, Trust Mortality Lead				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

SHMI remains "as expected".

Telstra report shows HSMR and weekday/weekend mortality to be "as expected", however ratio is expected to rise with imminent changes to Telstra methodology and introduction of their "HSMR+" platform.

SJR completion rate remains low, but the Learning from Deaths team are optimistic that this will improve with increased uptake for the "Mortality Review Programme" due to start for quarter 4 (Oct).

Internal data regarding mortality rates demonstrates that trend is following 2023/2024 pattern, though is higher than trust average.

Ongoing development of Learning from Deaths processes, including:

- Quarterly Trust "Learning from Deaths" meetings.
- Monthly "Learning from Deaths sub-group meetings".

- Weekly Learning from Deaths team meetings.
- Mortality reviews for pneumonia, inpatient falls and hip fracture (ongoing work following outlier status for mortality following hip fracture identified).
- Ongoing development of System Mortality Group, working towards a system approach for pathways relating to mortality.

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

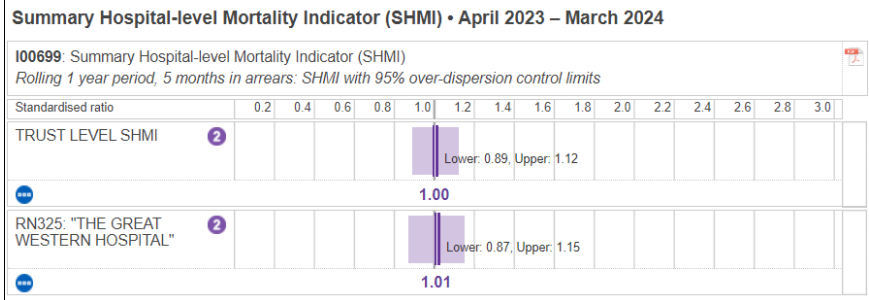
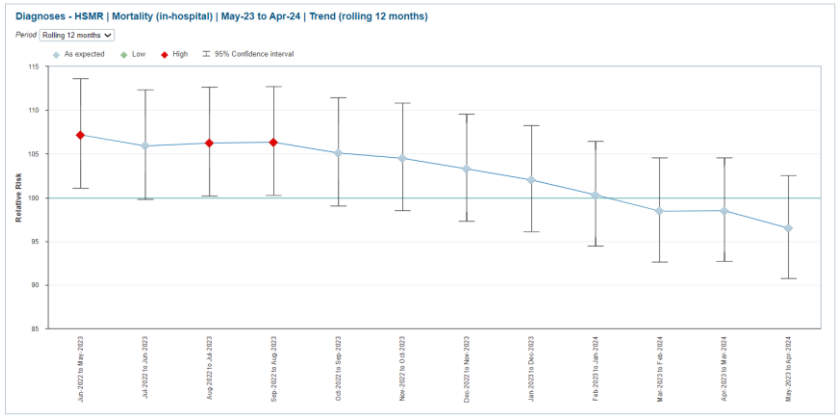
Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			x
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation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

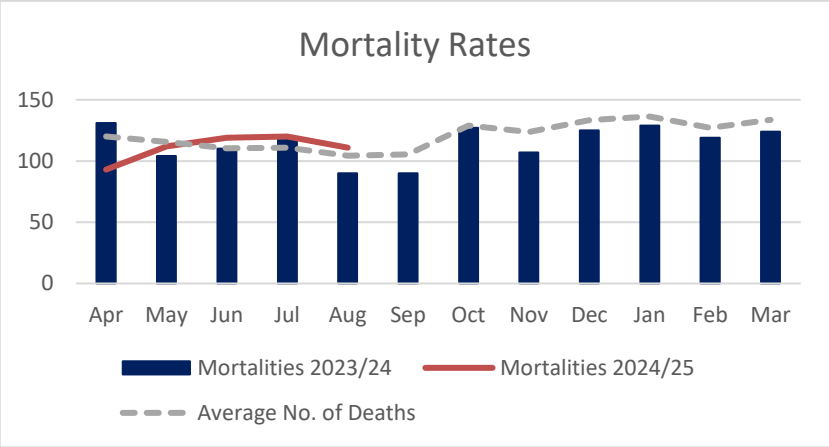
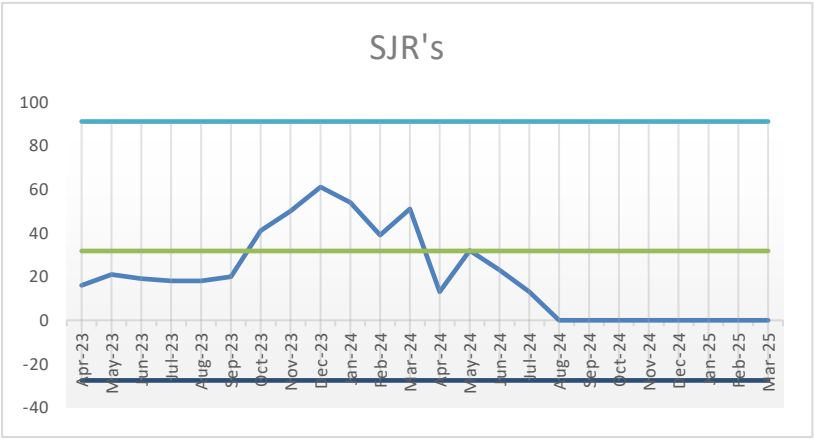
Recommendation / Action Required The Board/Committee/Group is requested to:	
Accountable Lead Signature	
Date	21/10/2024

Trust-wide Quarterly Learning from Deaths Report

MONTH/YEAR: October 2024 (Q2 Data)

The Trust-wide Quarterly Learning from Deaths Report is produced using a combination of external data sources (Telstra health, NHS Digital), internal information gathered from specific internal Coding and Clinical Case note reviews, analysis and outcomes from Structured Judgements Reviews (SJR's) and any other mortality-related activity or data.

SHMI (*External Data*)	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	The latest SHMI data publication covers the period April 2023-March 2024. This shows the Trust to be 'As Expected'. A review of the diagnostic indicators shows the Trust to have marginally higher than expected figures for Pneumonia showing 305 observed deaths during the period, vs 267 expected deaths, and also aspiration Pneumonia (inc. food vomitus) at 68 observed deaths vs 57 expected deaths. There are currently no alerts around these indicators and the numbers remain 'As expected'.	Data for both pneumonia and septicaemia indicators continue to be higher than expected. As a precaution, a review of clinical coding has been undertaken for the pneumonia observed deaths; although no concerns have been identified, there were themes arising gaps in documentation which did not correlate with discharge summaries in relation to the diagnosis of pneumonia. For additional assurances, a clinical review of local mortality data is scheduled to be undertaken. (See Coding/Clinical Reviews below). There are plans to discuss the excess deaths in the "septicaemia" dataset with the new trust sepsis lead.
TELSTRA HEALTH (*External Data*)	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	The **HSMR** for the same reporting 12-month period is 96.5 (90.7 – 102.5), this **is within the expected range**. However, Telstra apply a 2-month lag due to a coding delay for discharges which heavily affects the ratio; therefore the 2 most recent months of data available, May 2024 and June 2024 are currently not reported here, but will be available in future reports). Weekend (97.3) and Weekday (96.0) HSMR figures are also reported to be **within expected ranges**.	The HSMR continues to be monitored with the support of Telstra Health UK who are about to launch their new reporting model HSMR+. This model uses updated indices to improve the accuracy and depth of the data, however it may change our HSMR and the trust is expecting to see an increase in the figures for relative risks of mortality. These changes are expected to affect other trusts as well. The LfD team continue to work with Telstra Health to review and report on externally received data, and to act on concerns or alerts identified.

Trust Activity *(Internal Data)*	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	Internal data demonstrates the Trust mortality to be higher than average since May 2024, however the trend since has followed similar pattern to that of 2023/2024 and will continue to be monitored. On review of admissions data, this also shows to be higher than 2023/2024; reassuringly the mortality rate has remained constant at 1.2% of overall admissions. ED data shows an increase in the number of attendances, however, deaths in the ED department during Q1 and Q2 in 2024/2025 are significantly lower than 2023/2024 (28 vs 51 respectively).	No further actions required; continue to monitor.
STRUCTURED JUDGEMENT REVIEWS *(Internal Data)*	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	SJR completion rate continues to be poor despite attempts to improve this by the LfD team. A review of the SJR's during this reporting period identified overall Good/Excellent care delivered with evidence of timely investigations, resuscitation, IV fluids, Snr reviews and good involvement of specialist teams. Themes arising and areas for improvement include documentation around sepsis (completion of sepsis proformas) and delays with radiology requests (timely requests for scans or scans undertaken). There is a theme around poor documentation particularly around decision making.	In view of the poor SJR completion rate (approx. 30 month), a meeting was held with the Medical Director and the Associate Medical Directors of each division to request their support in improving this. AMDs are in supportive of a nominated individual from each speciality to contribute to the Mortality Review Programme (MRP); a structured programme whereby case note reviewers complete a minimum number of SJR's a week over a 12-week period. Participation is recognised and awarded with a Bronze/Silver/Gold Certificate which individuals can use towards appraisal/revalidation. This is supported by the new SJR training which has been launched and will encourage a consistent approach to SJR reviews and completion. Recruitment to the programme is underway and aims to commence during Qtr 4 which also allows for relevant training to be provided.

CODING/CLINICAL REVIEWS *(Internal Data)*	CURRENT POSITION	FORWARD ACTION PLAN
1. Pneumonia & Aspiration Pneumonia (identified via SHMI)	A review of internal Mortality data identified a peak in figures during Q4 2023 for pneumonia and although the data for aspiration pneumonia identifies a reduction, observed rates remain higher than expected. Both indicators were also reviewed by the Clinical Coding Manager using a small sample of case notes to ensure excess mortality was not due to coding inaccuracies. Asp. pneumonia identified a few coding amendments required, in relation to missing comorbidities. There was greater confidence with the coding for the pneumonia documentation, however this identified concerns around discharge summaries not always reflecting patient case notes.	Local findings were discussed at the LfD Sub-group meeting on 25/09/2024 and it was agreed to proceed to a limited clinical notes review. A patient list has been identified and recruitment of case note reviewers is underway. Progress/findings from this review will be scheduled at the next Trust wide LfD Group meeting scheduled in November.
2. Hip Fracture Review	In view of the recent mortality outlier alert for patients with Hip fracture, a Trust wide multidisciplinary review of a sample of patient case notes is scheduled for the 14th October 2024. This review will assess adherence to key standards in the Hip fracture pathway and previous recommendations from the BOA inspection in 2016.	Progress/findings from the review will be shared at the next Trust wide LfD Group meeting scheduled in November.
3. Inpatient Falls Review	The Inpatient Falls Review is now complete; key learning identified a wide variation in practice in recording patient's clinical care and risk assessments. Patients received adequate to good levels of care on admission although there were gaps in the completion of a full multifactorial risk assessment. Care during admission was largely rated as adequate; there was evidence of inconsistent recording of the patients' falls and delirium status. Post fall debriefs, and documentation is inconsistent with some wards appearing to be able to do this more reliably than others. It was agreed there was a requirement to have a structured approach to falls care, particularly around the recording/ documentation across the trust, education around clinical care (particularly where there are prescribed care requirements to maintain safe care), including clarification around the	The report has been finalised is available to present at the next Trust wide LfD Group meeting scheduled in November.

	specificity in definition of ACVPU status (Alert, Confusion, Voice, Pain, and Unresponsive) which was used inconsistently for confused patients.	

Learning from Deaths – Subgroup Meetings *(Monthly review of collated data and identification of actions. Attendance from Medical Examiner, legal team, patient safety, clinical coding, LfD team)*

Attendance at the LfD sub-group meetings this quarter has been poor and have therefore not met quoracy, however this may represent a change in the day of the meeting and annual leave.

There continues to be a weekly meeting between the LfD leads to review external and internal data and assessment of actions required and workplan objectives to deliver. This includes the completion of the internal trust wide reviews (Hip fracture, Pneumonia and Inpatient Falls) and the support around the implementation of the trust framework for the Mortality Review Programme with support from the Divisional Leads. Additional work plan priorities include a review of the Medical Examiner referral pathway for SJR's, the Trust's Learning from Deaths Policy, and attendance/support to the BSW wide mortality meetings, and learning identified that may improve local care.

Next Scheduled Meeting: 28/10/2024

Trust-wide Learning from Deaths Meetings *(Quarterly review of data summaries & actions, shared learning of review outcomes and speciality M&M Meetings. Attendance expected from departmental M&M leads, Medical Examiner, Learning Disability team)*

The Quarterly meeting scheduled for July 2024 was cancelled due to quoracy not being met.

Next Scheduled Meeting: 04/11/2024

BSW System mortality group *(Monthly meeting with mortality teams from Bath and Salisbury, ICB Chief Medical Office, Swindon Borough Council to identify and improve mortality across the system)*

Recent meetings include updates regarding:

- Suicide prevention
- Data analysis (Telstra, SHMI)
- Public health data
- Falls learning from external trusts

Next scheduled meeting: 25/11/2024

SHMI (Summary Hospital Level Mortality Index)
Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS England Digital

Report Title	**Perinatal Services 6 month summary**				
Meeting	**Trust Board**				
Date	**7th November 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek				
Report Author	Kat Simpson, Head of Midwifery and Neonatal Services Laura Little, Project Coordinator				
Appendices	NA				

Purpose

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

Assurance Level

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

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

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

Report

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

This six-month update on perinatal services provides a comprehensive overview of progress mapped against key priorities, including CQC must-do and should-do actions, the Three-year Plan for Maternity and Neonatal Services, and the recommendations from the Ockenden Report. This review demonstrates the commitment to strengthening perinatal care through improved staffing, addressing health inequalities, and fostering a positive culture within our workforce.

Key Highlights

1. Improved Staffing: Significant progress been made to address staffing gaps and support team resilience. We have successfully increased the recruitment of midwives and neonatal care staff, aligning with CQC requirements to enhance patient safety and care standards. The onboarding of new staff is complemented by additional training and preceptorship, ensuring readiness to deliver high-quality perinatal care.

2. Reducing Health Inequalities: Focused initiatives are in place to address health disparities, with particular attention to digital poverty, ensuring equitable access to services. Through targeted community engagement and partnerships, we've expanded access to digital resources and services for under represented populations. These efforts align with the national agenda to close health inequality gaps, creating an inclusive environment for all mothers and families.

3. Engagement with NHSE Perinatal Culture and Leadership Program: Participation in the NHSE Perinatal Culture and Leadership Program underpins the commitment to building a positive and cohesive workplace culture. Through structured engagement and feedback mechanisms, our team is developing leadership behaviours that promote accountability, collaboration, and patient-centred care across the perinatal services.

The progress is mapped directly against established CQC actions, ensuring that "must-do" and "should-do" recommendations are systematically prioritised. Compliance with the Ockenden Report immediate and essential actions remains a key priority, especially in areas such as patient safety, family engagement, and transparent communication.

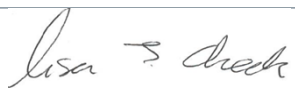
Our roadmap for the coming months includes further improvements in staffing levels, implementation of the BadgerNET electronic patient record system and ongoing collaboration with the NHSE Perinatal Culture and Leadership Program to strengthen our culture of safety and quality, with the continued aim to provide safe, inclusive, and high-quality perinatal services for all families.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	593 - There is a risk that patient safety will be compromised across Maternity Services because of insufficient midwifery staff to fill roster requirements				**Risk Score** 9
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:

Note the progress within the service against the Three Year Maternity & Neonatal Delivery Plan and the impact on the development of the perinatal services to make care safer, more personalised and more equitable.

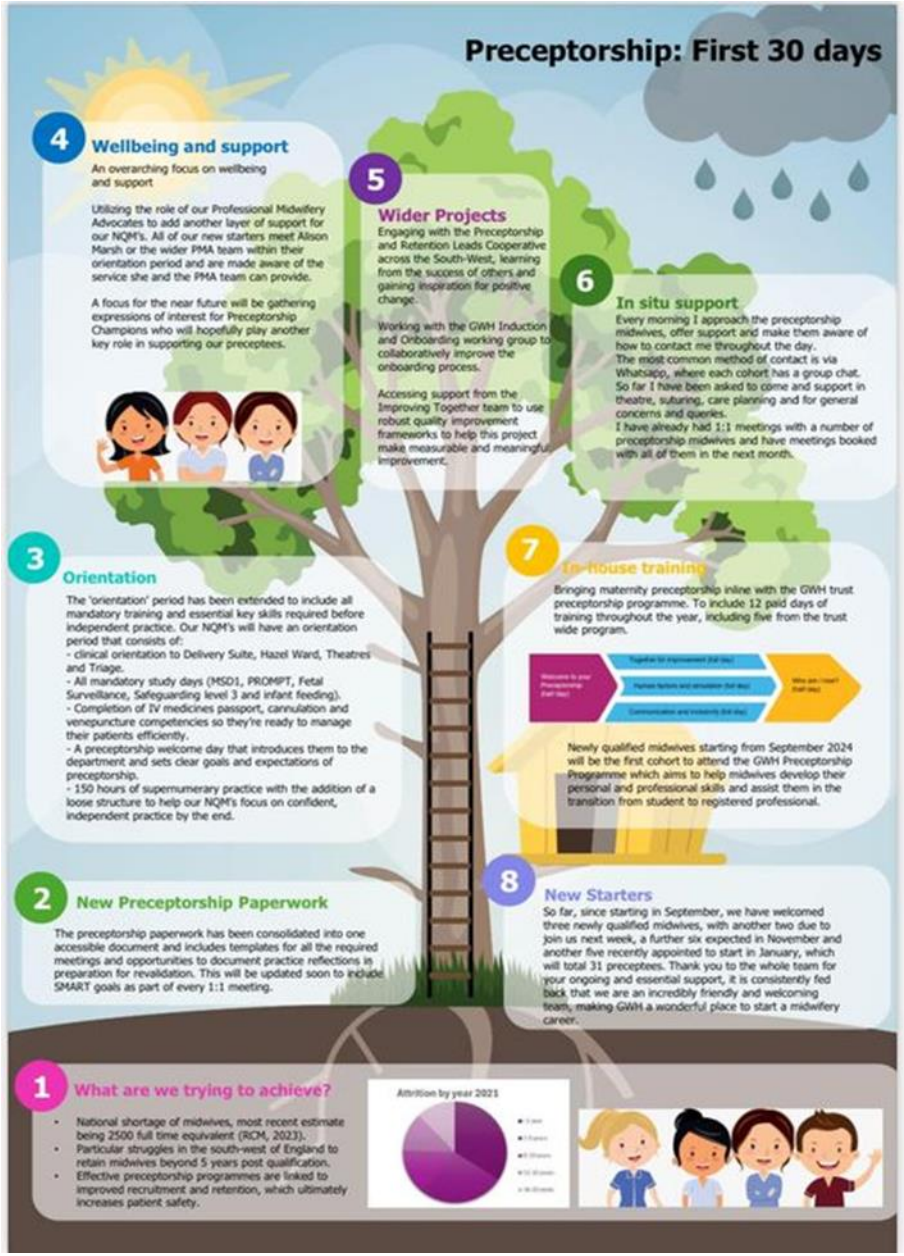
Accountable Lead Signature	
Date	29 October 2024

Perinatal Service Summary

April – September 2024 (Q1 & Q2)

Workforce & Training

- The Perinatal service is embedding a refreshed preceptorship programme supported by NHSE funding which is anticipated to positively impact retention of staff both locally and to the profession.
- Consistent pipeline of newly qualified midwives from both local students and the wider region.
- Business planning has directed investment to Neonatal workforce to enable split rota between Neonatal and Paediatric services with ongoing recruitment
- Consistent reduction in nursing vacancies in Neonatal nursing unit
- Midwifery degree apprenticeship pathway in place with Winchester University with 4 apprentices in post
- Great Western Hospital are the host Trust for the NHSE Maternity support worker competency, education and career development framework which aims to realise the potential within the band 2, 3 and 4 workforce and enable delivery confident and capable care
- Midwifery led tongue tie service fully established



Three Year Delivery Plan for Maternity & Neonatal Services

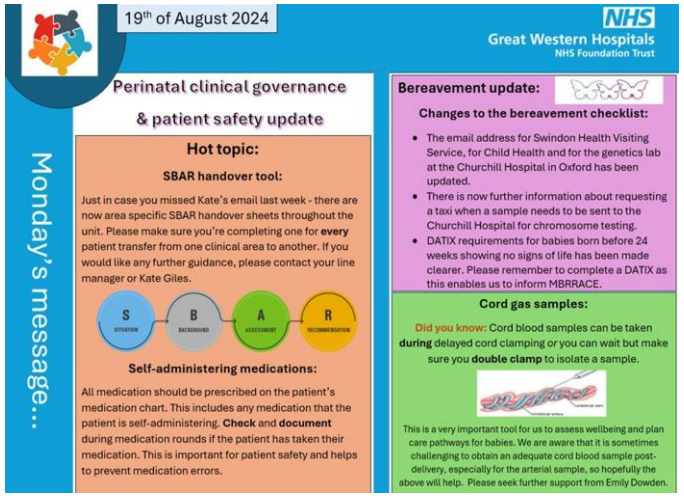
Objective 4 Grow Our Workforce

Objective 5 Value & Retain Our Workforce

Objective 6 Invest In Skills

Quality & Safety

- Continued Trust roll-out of Patient Safety Incident Review Framework (PSIRF) & Patient Safety Incident Review Plan (PSIRP) to align perinatal response to patient safety incidents with national guidance.
- Patient Safety Incident Investigation (PSII) process embedded within perinatal services to replace Serious Incident (SI) framework.
- Early family engagement following Patient Safety Incidents to ensure family concerns inform the incident learning responses, which utilise a system and human factors using a Just and Learning culture.
- Sharing of investigation reports with the families involved, and for learning amongst internal teams including perinatal services and more widely with the Local Maternity and Neonatal System.
- Thematic analysis being embedded in patient safety reviews to identify opportunities for service development and improvement.
- A 'Monday Message' is utilised to ensure all staff remain up to date on current patient safety learning.
- Continued focus on improvement actions to achieve full accreditation with UNICEF UK Baby Friendly Initiative (BFI) in 2025
- Triangulation of multiple data sources, including service user feedback, patient safety data and NHS Resolution data, have been used to strengthen the approach to enable continuous development of the Trusts patient safety incident response plans.



Three Year Delivery Plan for Maternity & Neonatal Services

- **Objective 1** Care that is Personalised
- **Objective 3** Work with Service Users to Improve Care
- **Objective 7** Develop A Positive Safety Culture
- **Objective 8** Learning & Improving
- **Objective 9** Support & Oversight
- **Objective 10** Standards to Ensure Best Practice

Digitalisation of Services

- BadgerNET implementation in progress in line with the Digital Roadmap for the service, supported by comprehensive testing to ensure localisation of the system and a robust staff training and support program.
- The maternity team have joined the 'Good Things Foundation' to become a data hub which will provide free sim cards with unlimited internet access for people accessing maternity care for 12 months. This will ensure all women can access the app that supports BadgerNET.
- Outpatient hypertension pathway for women and birthing people at high risk of developing hypertension in pregnancy, developed by Great Western Hospitals NHS Foundation Trust has been selected to be rolled out across the South-west. This pathway has benefits for patients by reducing the financial cost and physical impact of travelling into hospital for frequent appointments

- Additional scanning equipment purchased to enable improved ultrasound equipment across scanning services at GWH.
- Reinvestment of funding to purchase ultrasound information technology platform to facilitate improved fundal height and fetal growth risk assessments and enable detailed risk stratification in line with Saving Babies Lives version 3.

Three Year Delivery Plan for Maternity & Neonatal Services

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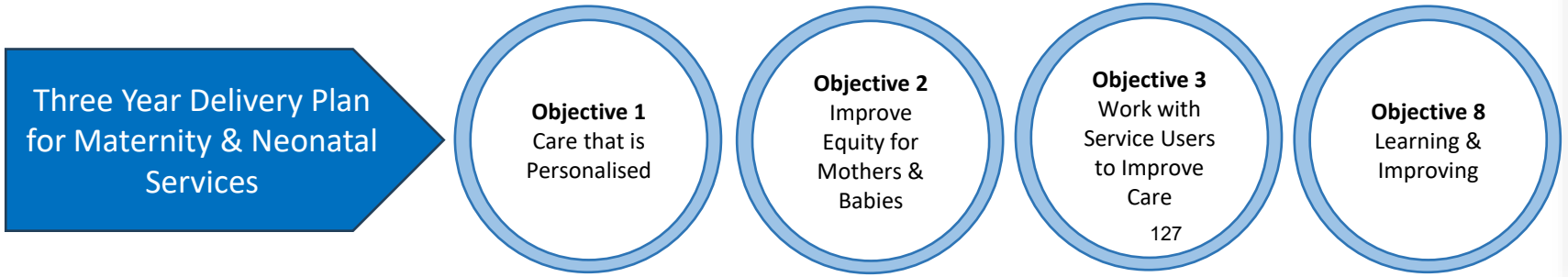
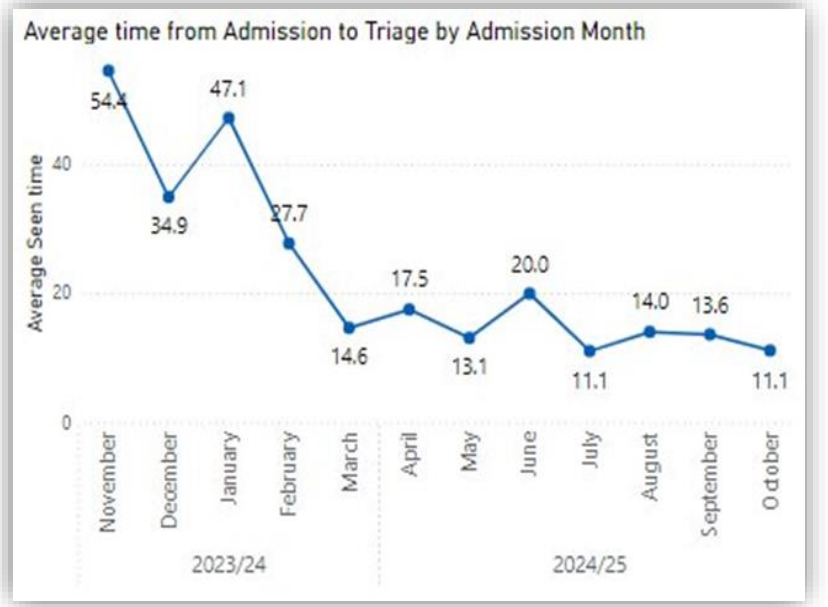
- **Objective 2** Improve Equity for Mothers & Babies
- **Objective 10** Standards to Ensure Best Practice
- **Objective 11** Data To Inform Learning
- **Objective 12** Make better use of digital technology

Triage

- In February 2024 Maternity Triage was relocated to a stand-alone dedicated area of service with a separate staffing model available Monday to Sunday 07:30-20:15 hours.
- This has resulted in a significant and sustained improvement in ensuring women are seen within 15-30 minutes of arrival using the Birmingham Symptom Specific Obstetric Triage System (BSOTS) model of care
- Quality improvement model of care to ensure we are providing safe and timely care for the women using the services and to ensure staff feel confident in the pathway of care
- Continuous engagement with Maternity & Neonatal Voice Partnership (MNVP) to ensure service user feedback shapes future development of the service

- Data analysis reviews undertaken to understand attendance activity peaks to ensure suitable workforce model in place with countermeasures developed to ensure risks are mitigated.
- Long term workforce and business planning options appraised to develop robust models of care to further develop the single point of access for service users





Healthcare Equity & Equality

- A detailed review of ethnicity representation in reported incidents within Maternity and Neonatal services at GWH was undertaken, the outcome demonstrated that service user complaints during this period indicated a significant under-representation of people of non-white ethnicity.
- The Perinatal Quality, Safety and Assurance (PQSA) team are working with the Patient Advice and Liaison Service (PALS) to ensure that feedback from all ethnicities can be heard.

- Black Maternity Matters continues to provide targeted education for service level and leadership roles within the perinatal service with the aim to reduce the inequitable maternity outcomes faced by Black mothers. Participants take part in an innovative six-month education experience, examining a range of topics including unconscious biases and the role of the individual in perpetuating unsafe systems of care for Black women.
- Maternity & Neonatal Voices Partnership (MNVP) membership embedded across Perinatal governance, learning and safety meetings to ensure the service user voice is represented.
- Maternity & Neonatal Independent Senior Advocate (MNISA) for BaNES ICB pilot role underway to provide valuable support to families and act as conduit for their voices to be heard throughout maternity and neonatal investigations.

Three Year Delivery Plan for Maternity & Neonatal Services

Objective 1 Care that is Personalised

Objective 2 Improve Equity for Mothers & Babies

Objective 3 Work with Service Users to Improve Care

Objective 5 Value & Retain Our Workforce

Objective 8 Learning & Improving

Objective 11 Data to Inform Learning

Perinatal Culture & Leadership Programme

- The aims of Perinatal Culture and Leadership Programme are:
  - Improve the quality of care by enabling leaders to drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.
  - Support perinatal leadership teams to create and craft the conditions for a positive culture of safety and continuous improvement, enabling a more psychologically safe, collaborative, and supportive workplace

- A perinatal quadrumvirate have attended the national programme and have undertaken a comprehensive education program and engaged in coaching sessions facilitated by an external provider endorsed by NHS England.
- A culture survey and staff listening sessions have been undertaken with areas for focus identified.

Three Year Delivery Plan for Maternity & Neonatal Services

Objective 5 Value & Retain Our Workforce

Objective 7 Develop A Positive Safety Culture

Objective 9 Support & Oversight

- The perinatal quadrumvirate have developed a vision for all staff to feel a valued member of the perinatal team by:
  - Staff being empowered to make positive change
  - Staff feeling they have been listened to
  - Teams will be acting with kindness and civility
  - Have right staff in right place with manageable workload

Ockenden Report GWH Progress Summary

- Continued progress against identified improvements for Immediate and Essential actions following focussed engagement with clinical teams for the ‘amber’ actions.
- Trust continues to have no ‘red’ actions within the Immediate and Essential Actions.
- Sustained engagement with national bodies for acuity tool review with current tool, associated processes & reporting embedded locally.
- Data collation underway for updated BirthRate Plus report to be issued in Spring 2025 which will enable future workforce planning
- Continued triangulation of themes and trends with a collaborative approach to service user responses between the Trust, Local Maternity & Neonatal System (LMNS) and Maternity & Neonatal Voice Partnership (MNVP)
- Patient Experience Coordinator now in role with significant positive impact on response rate from service users across Friends and Family feedback survey
- Engagement in system wide work across our BSW to review Induction of Labour pathways
- Mandatory attendance at Perinatal training & education programme to enable clinicians to work within intrapartum care settings.
- No operational risks identified within the remaining amber actions.
- Continued consideration of Ockenden improvement actions was given during the 2024/25 business planning cycle.
- Currently no identified actions that require additional investment.

Ockenden Ongoing Improvement Actions

IEA				Ongoing Improvement Actions
1	0	6	5	• Engagement with workforce planning across Local Maternity & Neonatal System (LMNS) • Development of in-house training provision for High Dependency maternity care • Development of Perinatal succession planning strategy in line with GWH Scope for Growth programme
2	0	2	8	• Continued review of Escalation Policy underway • Review of opportunities for supernumerary clinical skills facilitator roles within funded establishment
3	0	2	3	• Review ongoing opportunities for Obstetrics and Gynaecology workforce with consideration of Ockenden requirements
4	0	0	7	• No continued improvement actions identified
5	0	1	6	• Embedding assurance process for local action plans from serious incidents meet Ockenden criteria for completion within six months
6	0	0	3	• No continued improvement actions identified
7	0	0	7	• No continued improvement actions identified
8	0	2	3	• Ratification of local audit program with associated improvement plans where indicated • Engagement with national agencies to understand the requirements for a specialist midwifery team for multifetal pregnancies

IEA				Ongoing Improvement Actions
9	0	0	4	• No continued improvement actions identified
10	0	3	3	• Audit of newly introduced pathway for women birthing in the community to ensure practice and documentation embedded • Operational review of escalation policy for Induction of Labour pathway in progress
11	0	5	3	• Continued engagement with anaesthetic national bodies to understand next steps with implementation of Ockenden recommendations
12	0	3	1	• Implementation of improvement actions identified for consultant review of post-natal readmissions
13	0	1	3	• Enhanced training and education for midwives undertaking post-mortem consent supported by the Ockenden funded bereavement role
14	0	3	5	• Continued engagement with our Operation Delivery Network for Neonatal Care (ODN) to promote access to shared learning and experiences. • Development of a model for rotation with the ODN • Business planning has directed investment to Neonatal workforce to enable split rota between Neonatal and Paediatric services with ongoing recruitment
15	0	3	0	• Embedding practice of the OCEANS psychological support service • Delivery of specialist training sessions throughout the three-year education programme

Any questions?

Report Title	**Freedom to Speak Up Annual Report 2024**				
Meeting	Board Report				
Date	7th November 2024	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek, Chief Nurse.				
Report Author	Chris Mattock, Lead Guardian				
Appendices	Nil				

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):

Assurance given around the process by which safe care is delivered across the organisation.

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

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

Report

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

The purpose of this paper is to provide an overview of the work of the Freedom To Speak Up (FTSU) Guardians, updates from the National Guardian office and the FTSU service activity over the twelve-month period related to this report. The report will also cover trends and themes that will be used to guide future developments and actions.

There have continued to be challenges with recruitment of new guardians and support for existing guardians with time to fulfil their commitment. This is being addressed through the roll out of the guardian and manager pledge, which supports the guardian and manager to mutually agree the level of time commitment to FTSU, equating to a minimum of four hours per month.

There continues to be a focus on staff communication and awareness through the development of new initiatives and publicity campaigns supported by the communication team.

A robust action plan has been developed and this is used to ensure traction with actions and initiatives, providing executive and non-executive director oversight through a three-monthly review process.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	X	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		X		x
					Risk Score
Key Risks – risk number & description (Link to BAF / Risk Register)	332 - Risk that staff feel unable to speak up and therefore the opportunity for learning and improvement is missed.				6
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 quality matters within the report and the actions taken to support improvement.	
Accountable Lead Signature	Lisa J Creek
Date	29 October 2024

1. Introduction

This paper provides an overview of the concerns raised through the Freedom To Speak Up (FTSU) Guardians for the period April 2023 to March 2024. For ease of reporting and to bring the annual report and quarterly updates in line with the data being submitted to the National Guardians office, the data presented is for the whole year April 2023 to March 2024 and not one calendar year from the last report. The report describes the FTSU service and its performance over the year.

The Trust's approach to developing and supporting a 'speaking up' culture is an important component of the Care Quality Commissions (CQC)'s well-led framework. Staff who feel empowered to raise concerns and have a positive experience of their concerns being addressed will positively impact patient safety, allow the trust to learn lessons from incidents and promote good practice. Leadership and support are provided by the Trust Board and Senior Leadership team to ensure an open and transparent speaking up culture.

The FTSU service is a significant component for supporting a culture of speaking up across the trust. The service sits within a wider system of speaking up which includes, but is not limited to, many options for speaking up including FTSU Guardians, line managers, Chaplaincy, Staff Networks, Professional Nurse and Midwifery Advocates and People Operations

2. Freedom to Speak Up Service

The FTSU service is led by a Lead Guardian whose post has been established since January 2023, providing dedicated time to lead and develop the service. This dedicated role has been instrumental in identifying areas of improvement with the Senior Leadership team and developing an action plan to drive the service forward (appendix one).

We are committed to listen to our staff, learn lessons and improve patient care by using the eight principles set out by the National Guardian's Office:

1. Value speaking up
2. Role-model speaking up and set a healthy Freedom to Speak up culture
3. Make sure workers know how to speak up and feel safe and are encouraged to do so.
4. When someone speaks up, they are thanked, listened to and their concerns are followed up.
5. Use speaking up as an opportunity to learn and improve
6. Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements
7. Identify and tackle barriers to speaking up
8. Continually improve our speaking up culture

3. Key developments and challenges

The speaking up culture continues to be developed through key workstreams that are monitored through a close working relationship between the accountable Executive Director Lead, Non-Executive Director and Lead Guardian.

The oversight is driven through regular Lead Guardian meetings, FTSU guardians catch up meetings and Guardians case review meetings when Guardians review closed cases after six months to ensure resolutions and improvements are being sustained.

Raising the profile

Several actions are in progress to raise the profile of FTSU and improve the service including:

- Continued development of a communication plan to promote the service Trust wide. This commenced with the promotion of the service through FTSU Month 2023 (October) which was successful, with an increase in concerns raised and offers to become Guardians and FTSU Ambassadors.
- Guardians have continued to promote the service by speaking at numerous staff meetings, particularly a regular training and information session to the leadership development forum.
- A FTSU information and training session is now included in corporate induction.
- A request for the National Guardians Office and NHS Egland FTSU eLearning to be made mandatory – Speak Up for all staff; Listen Up for managers; Follow Up for leaders.

- Identify potential groups that face barriers to speaking up, and work towards addressing those barriers through being an active member of the Inclusion & Health Inequalities Sub Committee
- Support the guardians to maintain their roles through completion of the National Guardian Office dedicated training
- A systematic review of cases from other Trusts and consider national Guardian Office publications and guidance via a standing agenda item at the quarterly FTSU meetings
- Development of standing agenda items at the monthly Guardians meeting to include hints and tips of issues to consider and points of reflection and the closed case six-month review
- Guardian attendance at regional and national events, sharing best practice relating to issues of confidentiality in small teams and staff groups, and in creating safe spaces and processes for staff to raise concerns
- The National FTSU policy was adopted in January 2024.
- Encourage speaking up relating to service improvements via the Transformation & Improvement Hub

Expanding the service and involvement
Barriers to speaking up remain where the response of recipients to FTSU concerns raised has been negative and defensive, still asking “who” rather than “what & why”. We have begun to process of closing this gap with the Guardians educating managers to ensure that they have a positive attitude to receiving and responding to FTSU alerts. Most notably training sessions in the Developing Leaders programme and New Consultants programme. Our aim is to give managers confidence to listen up and follow up, but also to continuously support a culture of learning and responding, defined by the National Guardians Office (NGO) as Speak Up, Listen Up, Follow Up.

The service has continued to face some challenges, mainly with recruitment and retention of guardians. Three Guardians have stepped down and we are seeking to recruit three FTSU Guardians from a range of staff groups.

Staff commit to be a guardian as part of their normal role and this poses some challenges, especially with time commitments and the ability to be released from their usual duties. To help support guardians in their commitment the service has introduced a pledge. This will help to facilitate a conversation at the start of the process, which will include both the guardian and line manager pledging a minimum of four hours per month to support the service. It is hoped that the addition of manager pledge will help new guardians to feel supported and will encourage more people to consider the role of guardian.

In addition to the guardian’s pledge, the service supports guardians with a health and wellbeing support package and team developments, with increased senior input and oversight.

A new Freedom To Speak Up Ambassador role and network is being established. This role will assist the team of FTSU Guardians in three areas:

- Awareness raising through ensuring staff understand the importance of speaking up, listening up and following up
- Signposting and discussing concerns with staff and providing details of the available speaking up routes as stated in our Freedom to Speak Up Policy
- Promoting a positive speaking up culture, by supporting the Trust to welcome and celebrate speaking up

The FTSU service has considered other options for staff that cannot committee to being either a Guardian or an Ambassador but who still want to be involved. These options include support for single day events, committing to help as a one off or supporting the FTSU month with support from a few hours to a whole day on a day of raising awareness through trolley dashes or other engagement activities.

Recent Cases

In addition to providing the FTSU service it is essential that there is a robust system for the collection of mandated data and that the data is reviewed and analysed to support the development of the service.

Anonymised data is shared with the National Guardian's Office quarterly as follows:

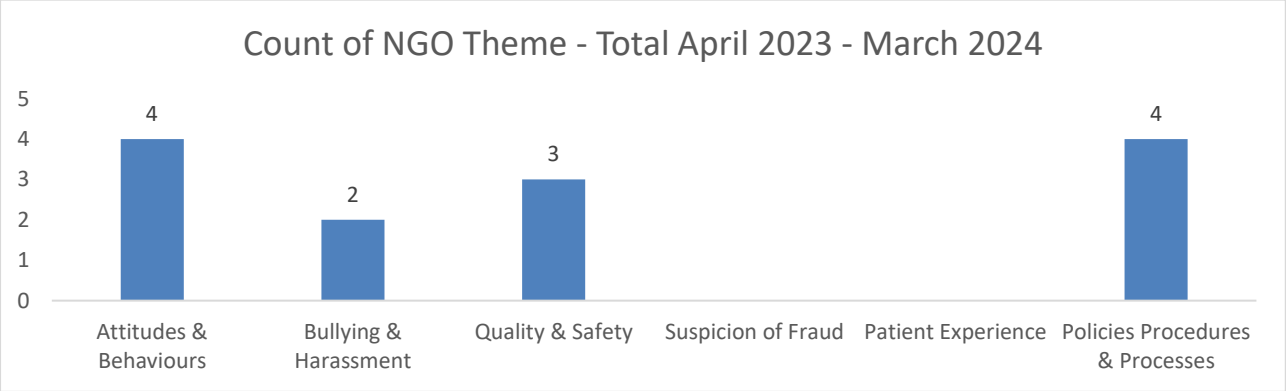
- The number of cases received.
- The number of cases raised anonymously
- The number of cases with an element of:
    - patient safety/quality concern
    - worker safety or wellbeing
    - bullying or harassment
    - other inappropriate attitudes or behaviours
    - where people indicate that they are suffering disadvantageous and/or demeaning treatment as a result of speaking up
- Concerns brought by professional/worker groups
- Concerns where there was a response to the feedback question: 'Would you recommend staff to use the FTSU service' (and the answer).

There have been fourteen cases received by the Freedom to Speak Up Guardians April 2023 to March 2024. When comparing to other Trusts this is a low reporting figure. Therefore, more work is being done to raise awareness of FTSU and encourage staff to use the service. To align reporting with the submissions to the National Guardians office the reporting dates (appendix two) have been aligned to a financial year.

A review of the data has identified attitudes and behaviours and policies, procedures and processes as being the top themes (figure one). There were no cases categorised as suspicion of fraud or patient experience, although there could be indirect links to other cases for example quality and safety. For reporting purposes only one category can be provided to the National Guardians Office.

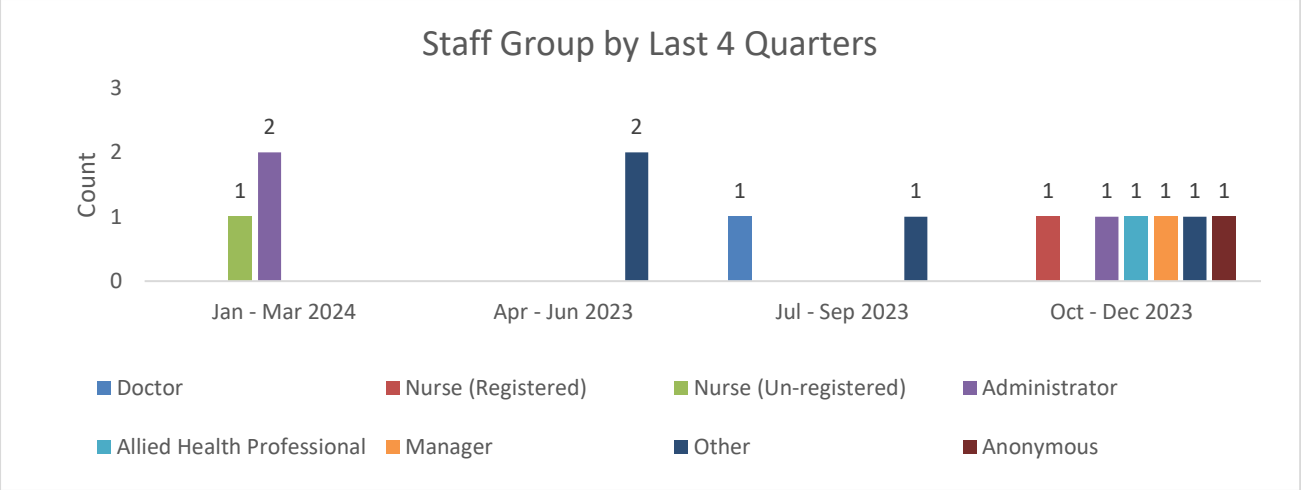
There were no cases reported where individuals indicated that they were suffering detriment as a result of speaking up.

Figure one – theme identified.



It is important to review the spread of staff groups involved in bring forward FTSU cases. Figure two provides this data and it is noted that the majority of cases have been raised by administrators, although the spread is fairly even across all staffing groups.

Figure two – staff groups.



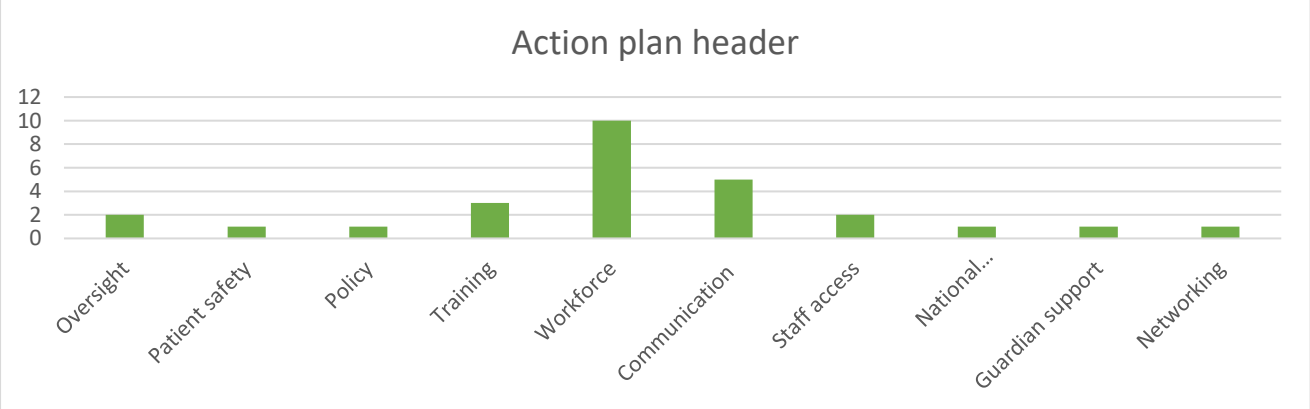
There have been seven feedback responses in relation to the service and all have been positive. The service will continue to explore feedback as it is important to understand both the experience of the staff member but also to identify any areas of improvement.

4. Next Steps

The Freedom to Speak Up Lead Guardian will continue to work towards delivering the actions identified and recorded in the action plan (appendix one). To map the actions identified through the completion of the reflection and planning tool are logged. The reflection and planning tool is national provided and aimed at supporting the Executive Director and Non-Executive Director to understand the Trust compliance with national requirements and to guide the actions for the year ahead. The initial reflection and planning tool has been completed and will be discussed in detail with the Lead Executive and lead Non-Executive Director. The actions agreed will then be included in the ongoing action planner.

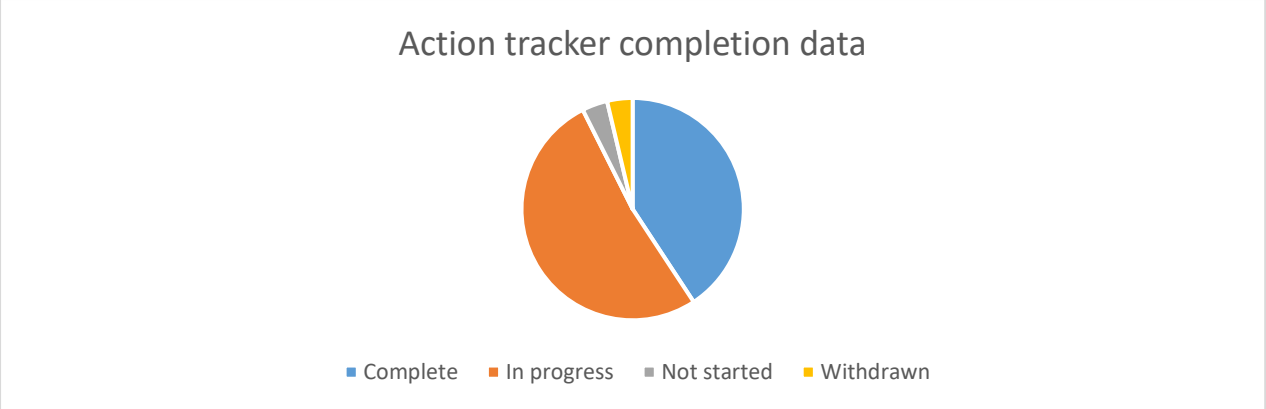
Each action is grouped under a driver header (figure three), this shows that the main focus is on workforce and communication.

Figure three action plan driver heading.



Tracking the completion of actions is essential to maintain traction. Figure four shows the compliance data with regards to action tracker completion. This shows good progress with over 50% of actions in progress and 39% of actions already completed.

Figure four – action tracker completion data.



The following is a list of ongoing and planned actions that will be focused on for the first six months in 2024:

- Develop annual plan for event and general awareness
- Refresh of posters with names, pictures etc
- Linking FTSU back to Patient Safety agenda
- Training across the Trust in FTSU, review to consider mandated training at what levels
- Develop plans for learning to be shared more widely
- Continue discussions at a system level to look at a more sustainable model for the longer term FTSU
- Develop opportunity for Guardians to reflect on learning and effectiveness of management of cases
- Look at options for team development
- Review capacity of Guardians to deliver and maintain role
- Review resources dedicated to FTSU to ensure the service is robust and resilient
- Begin to review the FTSU policy ready for September 2024 completion
- New guardian commitment and pledge to be rolled out
- Levels of FTSU training and compliance linking with the policy/guidance
- Develop a suit of opportunities for people to support FTSU that includes guardians, ambassadors and FTSU month support

5. Conclusion

The FTSU service has continued to develop and strengthen the provision available to support staff. There have been challenges with recruitment and retention of guardians, but it is hoped that the increased support for guardians, the recognition of the importance of the role they play through a guardian and manager pledge and the introduction of the ambassador role, will help address some of the issues the guardians have faced.

Appendix one – Action tracker.

Action No.	Action - Heading	Action Description	Target completion Date	Status
2	Communication	Develop annual plan for event and general awareness building	Jan-24	In progress
3	Communication	Refresh of posters with names, pictures etc	Nov-23	In progress
4	Staff access	Develop safe space as an alternative way to access FTSU	Oct-23	Complete
5	Training	Training ensure Guardians are accessing and completing training	Oct-23	Complete
6	Patient safety	Find ways of linking FTSU back to Patient Safety agenda	Jun-24	In progress
7a	Training	Training across the Trust in FTSU, review to consider mandated training at what levels	Jun-24	In progress
8	Oversight	Review current reporting schedule and assess if effective to ensure visibility and awareness across the Trust	Dec-23	Complete
9	Staff access	Identify potential groups that face barriers to speaking up, and work towards addressing those barriers	Nov-23	Complete
10	National compliance	Ensure data is uploaded to NGO Portal on time	Sep-23	Complete
11	Guardian support	Develop Meeting schedule, that describes meeting and plans date for 23-24	Sep-23	Complete
12	Communication	Develop plans to develop how learning can be shared more widely	Jan-24	In progress
14	Networking	Develop external links with other Guardians and engage with Southwest Regional Network of Guardians and sharing learning.	On going	Complete
15	Workforce	Continue discussions at a system level to look at a more sustainable model for the longer term.	On going	In progress
16	Workforce	Develop opportunity for Guardians to reflect on learning and effectiveness of management of cases	On going, case review meeting 21/12/23	In progress
17	Workforce	Look at options for Team development	Mar-24	In progress
18	Workforce	Review capacity of Guardians to deliver and maintain role	Jul-24	In progress
19	Workforce	Develop Health and Wellbeing support package for Guardians	Jan-24	Complete
21	Communication	Develop Ambassador role and promote	Mar-24	Complete

22	Workforce	Review resources dedicated to FTSU to ensure the service is robust and resilient.	TBC	In progress
23	Policy	Begin to review the FTSU policy ready for September 2024 completion	On going	In progress
24	Workforce	New guardian commitment and pledge.	Feb-24	In progress
27	Training	Levels of FTSU training and compliance linking with the policy/guidance	Mar-24	In progress
28	Oversight.	TMC oversight of report for all speaking Up - Annual report.	Jun-24	In progress
29	Workforce	Develop a suit of opportunities for people to support FTSU that includes guardians, ambassadors and FTSU month support. The plan is to develop and share these opportunities as part of the communication plan. For now the focus has been on the recruitment of Guardians and Ambassadors.	Jun-24	Not started.
30	Workforce	Develop a pledge for ambassadors	Jul-24	Complete
31	Workforce	Get the phone number changed to the pastoral care line	Apr-24	Withdrawn

Appendix two – National Guardians office data submission dates 2024 – 2025.

Upcoming dates for data submissions

Q1 (2024/25): Opens Monday 8th July and closes on Friday 2nd August 2024
Q2 (2024/25): Opens Monday 7th October and closes on Friday 1st November 2024
Q3 (2024/25): Opens Monday 6th January and closes on Friday 31st January 2025
Q4 (2024/25): Opens Monday 7th April and closes on Friday 9th May 2025

Report Title	**Great Western Hospitals Health & Safety Annual Report 2023/24**				
Meeting	Trust Board				
Date	7th November 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Rupert Turk, Director of Estates & Facilities				
Appendices	Appendix A, Equality Impact Assessment Appendix B, Health and Safety Policy, Statement of Commitment Appendix C, 2023/24 Annual Business Plan Appendix D, draft 2024/25 Annual Business Plan				

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

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

There is a corporate Health and Safety team in place to monitor H&S compliance through policies and procedures, managers self-assessment audit reports and accident and incident data. Departments are supported with health, safety, fire and security advice and training. A three-year strategy is being developed in 2024/25 along with reportable Key Performance Indicators (KPI's).

Report

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

The Trust prepares an annual Health & Safety report, which provides an overview of events & performance of the Health & Safety, Fire & Security disciplines. The report for 2023/24 is included below.

This paper also outlines the proposed headline objectives for the H&S Team for 2024/25. These objectives have already secured approval through the Health & Safety Group.

The Trust publishes an annual H&S Statement of Commitment which can also be found in appendix two below.

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

Key Risks – risk number & description (Link to BAF / Risk Register)		Risk Score
	As described within the report.	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Business Objectives approved by Health & Safety Group 22Apr24 Full report approved at Health & Safety Group (24Jun24) Full report approved at TMC 18.07.24 Full report approved at FIDC 22.07.24	
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:

- approve the Health & Safety annual report 2023/24.
- approve the H&S Statement of Commitment for inclusion in the Trust Health & Safety policy.
- approve the Health & Safety Plan for 2024/25.

Accountable Lead Signature	
Date	31 October 2024

NHS
Great Western Hospitals
NHS Foundation Trust

Health & Safety, Fire and Security Annual Report 2023/24

Contents

1. Purpose

This annual report has been prepared to inform the Trust of the current status of Health, Safety, Fire and Security management during the period 1 April 2023 to 31 March 2024. The report summarises progress and issues identified over the past year in nine key areas.

2. Executive Summary

Health & Safety

There were no prosecutions or improvement notices from the CQC or Dorset & Wiltshire Fire & Rescue Service during 2023/2024, This status has now been maintained for many years and is a direct result of the 'good Safety Culture' and the high standards throughout the Trust with health & safety compliance.

Incidents reported during the year constitute a 13% increase on the figures from the previous year. This may be explained by the change in the Trust's incident reporting system for staff (from Safeguard to Datix), with the new Datix system becoming more established in this last reporting year. 2,664 of the incidents reported required further action / follow-up from the Health & Safety team.

During the year there were seventeen RIDDOR reportable accidents reported to the HSE, compared with ten in 2021/22 and five in 2022/23. The main reporting categories consisted of eleven over seven day injuries and six specified injuries (fractures) including one patient fall. Six of the RIDDORS were reported to the HSE outside of the statutory reporting timescale and to avoid this going forward there have been repeated reminders to managers about meeting the timescales. RIDDOR training is on the Business Plan for 2024/25 and a reminder has been added to the team's email signature.

The H&S 2-day bespoke training for Safety Reps with our external provider, has seen an increase in participants in 2023/24 and the feedback from staff regarding this course continues to be positive. This course is also available for all managers in the Trust to support them with a better understanding of how to influence a positive health and safety culture within the organisation.

The Annual Health & Safety audit of all departments with five or more employees took place in June 2023. There were 164 departments identified and 157 audits were returned. 3 departments achieved 100% and they were presented with certificates to acknowledge their achievements. There were 35 departments that scored less than 70% (approximately half were new to audit) and these departments were contacted by H&S officers who provided them with support and guidance moving forward.

In July 2022 we carried out workplace air monitoring in our high-risk areas. In August 2023 workplace air monitoring was also carried out Endoscopy and during this visit the company were asked to check the actions from July 2022 had all been suitably completed. This was completed and further actions identified, this action plan is monitored in the Trust Health and Safety Group.

Fire

On-going fire safety improvements continue to be identified and progressed according to plan within the GWH & BTC buildings regarding fire and smoke damper improvements.

The Fire Advisors have carried out a detailed survey of the spaces designed within the hospital to be safe refuges for evacuation purposes. New fire evacuation plans have delivered to the Trust and these are in the process of being installed.

The Trust's ability to keep our main hospital streets free of equipment remains a challenge. A small working group was tasked with addressing this issue, this group was temporarily suspended due to gaps in resource and will recommence in 2024/25.

Ski sheets were purchased to safely assist with the vertical evacuation of patients in an emergency within the GWH, BTC and SWICC buildings. Training on how to use these commenced in 2023/24 and will continue into 2024/25

Fire Warden training has been attended well with our external bespoke training for fire wardens which is a half-day session. This is bespoke due to being developed specifically for our Trust in line with Trust policies. We have received positive feedback from attendees.

Since 2020 we have been unable to comply with HTM05_01 where it is stated that all patient facing employees must have face to face fire safety training. The fire safety team have commenced fire training on wards and clinical areas, this has been added to the draft 2024/25 business plan to ensure that training is in line with legislation and guidance.

Security

The Trust's Security Management Specialist [SMS] remains committed to reducing acts of violence and aggression against our staff and is there to support managers and staff when required. There has been an increase in the Trust issuing unacceptable behaviour letters (UBL's) from 3 in 2022/23 to 19 (84%) in 2023/24 to persons acting in an unacceptable way towards Trust staff both at the acute site and in the community. The Security Management Client Engagement Lead continues to work with partner agencies to hold perpetrators to account for their actions on Trust sites to secure prosecutions.

During April 2023, in accordance with the Trust's contractual obligations, our Accredited Security Management Specialist completed the NHS self-review tool (SRT) on our behalf. The SRT has been reviewed against the new Violence Prevention and Reduction indicators.

The Trust reported 939 security related incidents via Datix during the year 2023/24. This shows an increase of 25 from the previous year. This can be seen as a positive safety culture in that staff are raising Datix forms for security issues.

The team are working with SAFE on how lockdown can be achieved on the GWH site should the Trust need to use this method to ensure areas can be controlled and measures due to a threat to site. There is now a lockdown policy in draft format. This continues to be an ongoing project with joint working with the Emergency Planning team.

In July 2023 the Trust commissioned SAFE to prepare a report assessing the current location and size of the security control room to establish if it was fit for purpose or if a move to a larger more suitable location was required. This risk was added to the Trust risk register and the control room is now scheduled to move in 2024/25.

In September 2023 the Trust commissioned SAFE to provide a Child Abduction Exercise Report. The objective of this exercise was to carry out a threat and vulnerability assessment to test physical security arrangements and staff engagement in response to the attempted abduction of a child and penetration of the Ward by a hostile actor.

3. Risk Register review process

The following table highlights the year end risk register entries relating to H&S, Fire and Security which have been monitored and discussed by the Health & Safety Group throughout the year with each change to score or status highlighted and explained to the group.

Risk Number	Description	Risk Value	Status
	Fire		
763	There is a risk that equipment, furniture, supplies stored within the GWH streets could create an obstruction in a fire / emergency situation preventing a timely evacuation.	12	Open
1013	Staff not trained in some areas Fire training within the TRUST. On a fire activation a lack of absence of trained staff The training program has been extended. Continuous Communications to be sent out to ask for volunteers and the EPRR group are asking for HOD to promote the release of staff to attend the course	9	Open
	Safety		
1123	There is a risk that the Security Team may not respond effectively to a security incident, because the location of the Control Room and the surveillance capabilities of the systems is not optimal, leading to delays in their response times. This risk will be greater when the IFD building comes on line in Summer 2024. The risk has been scored with this factored in.	12	Open

4. Incident reporting

The Trust moved across to a new incident reporting system called Datix Cloud IQ from July 2022, ceasing the use of the previous reporting system Ulysses Risk Management System (Safeguard). All incidents received continue to be read daily by the Health & Safety team.

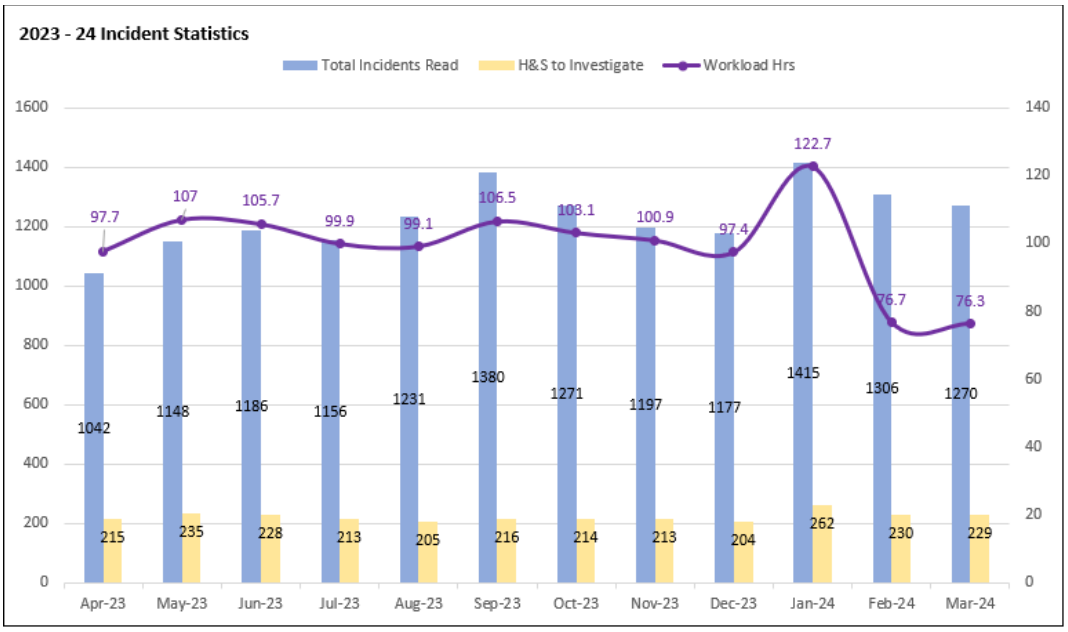
Each incident is assessed to determine if it requires action and / or investigation. Examples of these are Staff Falls, Staff Injuries, Environmental, Fire, Muscular Skeletal issues, Manual Handling, Contact with Sharps, Burns and Scalds, Contact or Collision with moving / stationary objects, Exposure to Radiation, Biological or Hazardous substances, Car Park, and all Security related incidents.

The team also review all patient falls to ensure there are no Health & Safety environmental hazards that contributed towards the fall and whether they are RIDDOR reportable. This is done through the checking of Careflow results for fractures / injuries and falls questionnaires being scrutinised. Each incident is managed

appropriately through correspondence with managers and staff, ensuring the correct areas have been notified and manager outcomes show incidents have been fully investigated.

Year	Total number of incidents reported
April 2020 to Mar 2021	12,847
April 2021 to Mar 2022	14,288
April 2022 to Mar 2023	13,115
April 2023 to Mar 2024	14,779

Incidents reported during the year constitute a 13% increase on the figures from the previous year. This may be explained by the change in the Trust's incident reporting system for staff (from Safeguard to Datix), with the new Datix system becoming more established in this last reporting year. 2,664 of the incidents reported required further action / follow-up from the Health & Safety team.



5. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

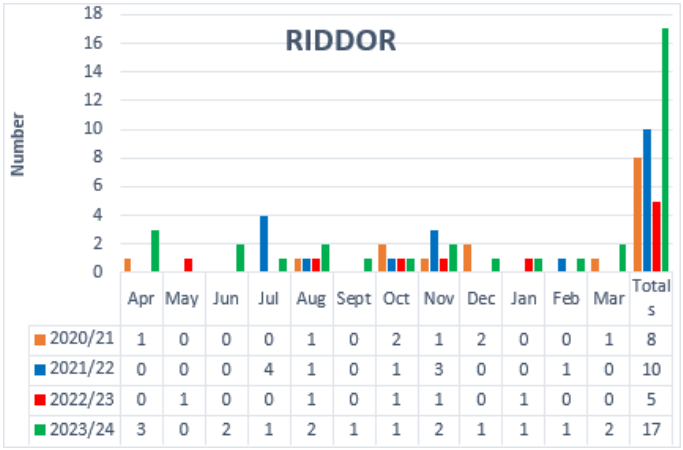
RIDDOR requires all organisations to report work-related incidents to the Health & Safety Executive (HSE) in certain circumstances. Incidents are only reportable if they arise 'out of or in connection with' work which can include incidents involving visitors, patients, and contractors in our workplaces.

Managers and staff must ensure that all incidents, accidents and near misses are reported as soon as possible after it occurs. The Health and Safety Department should be notified directly of any specified injuries to staff or visitors and patients - or if staff are absent from work following an incident at work - at the earliest opportunity.

The Health & Safety team follow a process where questionnaires and full reports are completed to determine if an incident is RIDDOR reportable. If appropriate, accident analysis forms are also completed. The Heath and Safety team will submit all RIDDOR reportable incidents to the HSE once an initial investigation is completed.

During the year there were seventeen RIDDOR reportable accidents reported to the HSE compared to five in 2022/23 and ten in 2021/22. Root cause analysis investigations are completed in all cases and the learning is built back into the relevant processes and procedures.

Breakdown of reportable incidents by year / month



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Totals
2020/21	1	0	0	0	1	0	2	1	2	0	0	1	8
2021/22	0	0	0	4	1	0	1	3	0	0	1	0	10
2022/23	0	1	0	0	1	0	1	1	0	1	0	0	5
2023/24	3	0	2	1	2	1	1	2	1	1	1	2	17

2023 /2024 Summary of RIDDOR reportable incidents

Orbital Offices, North Swindon District Centre		Staff	>7 days - Contusions and bruising
Delivery Maternity Theatre 1		Staff	>7 days - Strains/Sprain - upper limbs
Delivery Maternity Theatre 2		Staff	>7 days - Strains/Sprain - neck injury
Residential Care Home		Staff	Fracture Foot
Atrium		Staff	Fracture Foot
BTC Carpark		Staff	Fracture Wrist
Maternity Theatre		Staff	>7 days - Superficial injuries to parts of face
Aldbourne Ward		Staff	>7 days Strains/Sprain - back
Boots Picnic Table area		Staff	>7 days Strains/Sprain - ankle
Linnet Ward		Staff	>7 days - Physical assault
Car Park		Staff	>7 days - Slip/trip/falls
Orchard Ward		Staff	>7 days Strains/Sprain - Wrist
Car Park		Staff	Fracture
Jupiter Ward		Staff	>7 days - Superficial injuries to parts of face
Mercury Ward		Patient	Fracture NOF
Car Park		Staff	Upper limb fracture
Theatres		Staff	>7 days - Contusions and bruising

Six of the RIDDORS were reported to the HSE late and to avoid this going forward there have been reminders sent to managers about meeting the timescales. The H&S team have also added information to their email signature about understanding the requirements of RIDDOR and specific training will be offered in 2024/25

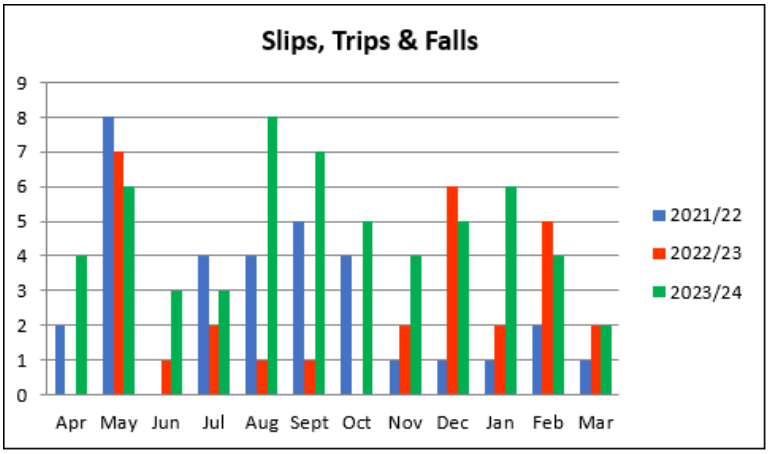
Lost time accidents that were not reported as RIDDOR's

The RIDDOR regulations continue to require that incidents of over three-day incapacitation (and under seven days) must be recorded although not reported to the HSE. These 'Lost Time' incident days are equally as important in understanding the root causes after a thorough investigation and help reinforce our safety culture.

Year	Days
April 2020 to March 2021	53
April 2021 to March 2022	51
April 2022 to March 2023	52
April 2023 to March 2024	39

6. Slips, Trips and Falls

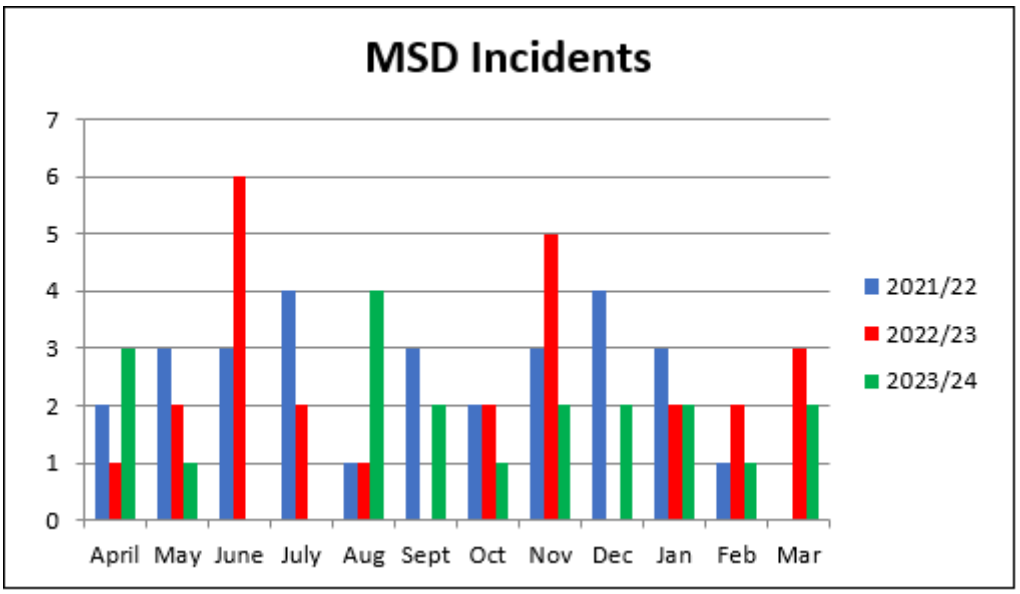
Slips, trips, and falls are monitored through the incident reporting system. All incidents will lead to the Health & Safety Team making contact with the person, staff member, line manager to ascertain whether an injury has been sustained and/or required time off work. If this is the case, then the manager is sent a form to complete so that we have a more in depth understanding of the incident and if there is a requirement to report to any external government bodies.



Year	Number of Slips / Trips
2020/21	38
2021/22	33
2022/23	29
2023/24	57

7. Manual Handling

Each manual handling incident is looked at by the Manual Handling Advisor. The member of staff involved, and their manager are contacted to find out more details about the incident if required. The Manager is asked to investigate as appropriate and report back to the advisor. The advisor offers support and checks risk assessments and safe systems of work are in place and updated as required.



Year	Number of MSD Incidents
April 2020 to March 2021	34
April 2021 to March 2022	29
April 2022 to March 2023	26
April 2023 to March 2024	20

Work-related Manual Handling incidents, resulting in a staff injury, remain very low in comparison to the total Musculoskeletal Disorder [MSD] cases reported. Each of these incidents were investigated for learning and to prevent recurrence by the Manual Handling advisor.

8. Training

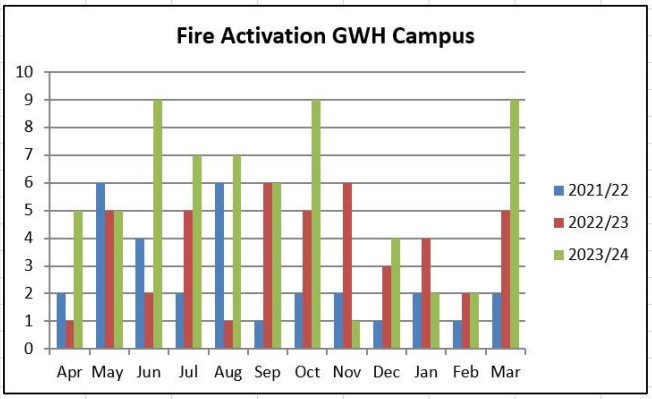
	2020/21	2021/22	2022/23	2023/24
Fire Warden Training	34 (2 sessions cancelled due to Covid)	110 staff trained – note reduced delegate numbers for May, July & August sessions due to Covid restrictions and distancing	111 Staff trained	155 staff trained
Manual Handling Link Training	Face to face sessions cancelled due to Covid. Regular contact maintained via email	2 sessions due to Covid restrictions for most part of reporting year. Regular contact maintained via Email	11 Staff trained. 4 sessions were planned. 2 sessions cancelled due to resources.	35 staff trained, 4 sessions completed
Managers Health & Safety Training – GWH in house	3 sessions	3 sessions through academy	14 attendees	14 attendees (2 sessions)
2-day bespoke H&S training – external provider	Not applicable	40 staff trained – note reduced delegate numbers for June, July & August sessions due to Covid restrictions and distancing	47 Staff trained	58 staff trained

9. Fire

The Trust Fire Advisors investigate all notified fire alarm incidents that occur within the GWH Hospital, BTC, SWICC and the wider Trust community estate. All incidents are monitored for performance and actions taken by Serco fire response teams and Trust staff. Recommendations are made based on the findings of the investigation.

Fire Incidents

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Apr	1	1	3	2	1	5
May	2	1	1	6	5	5
Jun	6	3	4	4	2	9
Jul	8	3	3	2	5	7
Aug	7	4		6	1	7
Sep	2	1	4	1	6	6
Oct	1	2	4	2	5	9
Nov	0	2	1	2	6	1
Dec	1	2	4	1	3	4
Jan	3			2	4	2
Feb	2	2		1	2	2
Mar	2	2	4	2	5	9
Totals	35	23	28	31	45	66



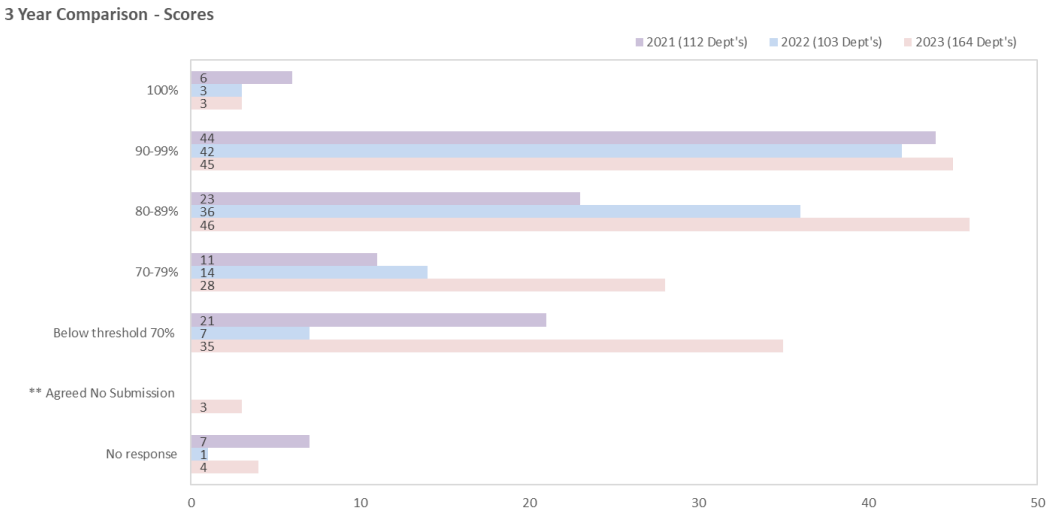
The majority of the fire alarm activations were false alarms or patients activating manual call points. There were no actual fires in GWH during this reporting period.

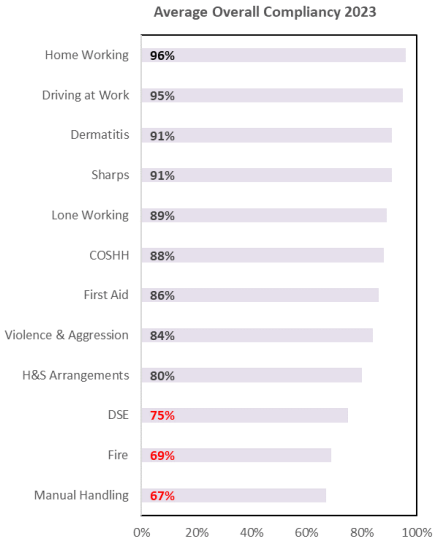
Training is now in place for vertical evacuation using 'ski-sheets' and these have been placed in fire boxes in the main stair wells. The fire safety team are in discussions with the Academy in regards to reinstating in-person training and department specific training events have been planned with a recent training event taking place in Theatres.

New fire evacuation plans have been delivered for both GWH and BTC and the team are in the process of having these installed. These give significantly more detail for ward and department fire evacuation and clearer definition of fire rating zones. There is an ongoing programme to identify all fire hazard rooms within the hospital which will continue into 2024/25. The lifts in the BTC are being upgraded this year with the intention of one of the lifts to be made a firefighting lift with a firefighter switch and key.

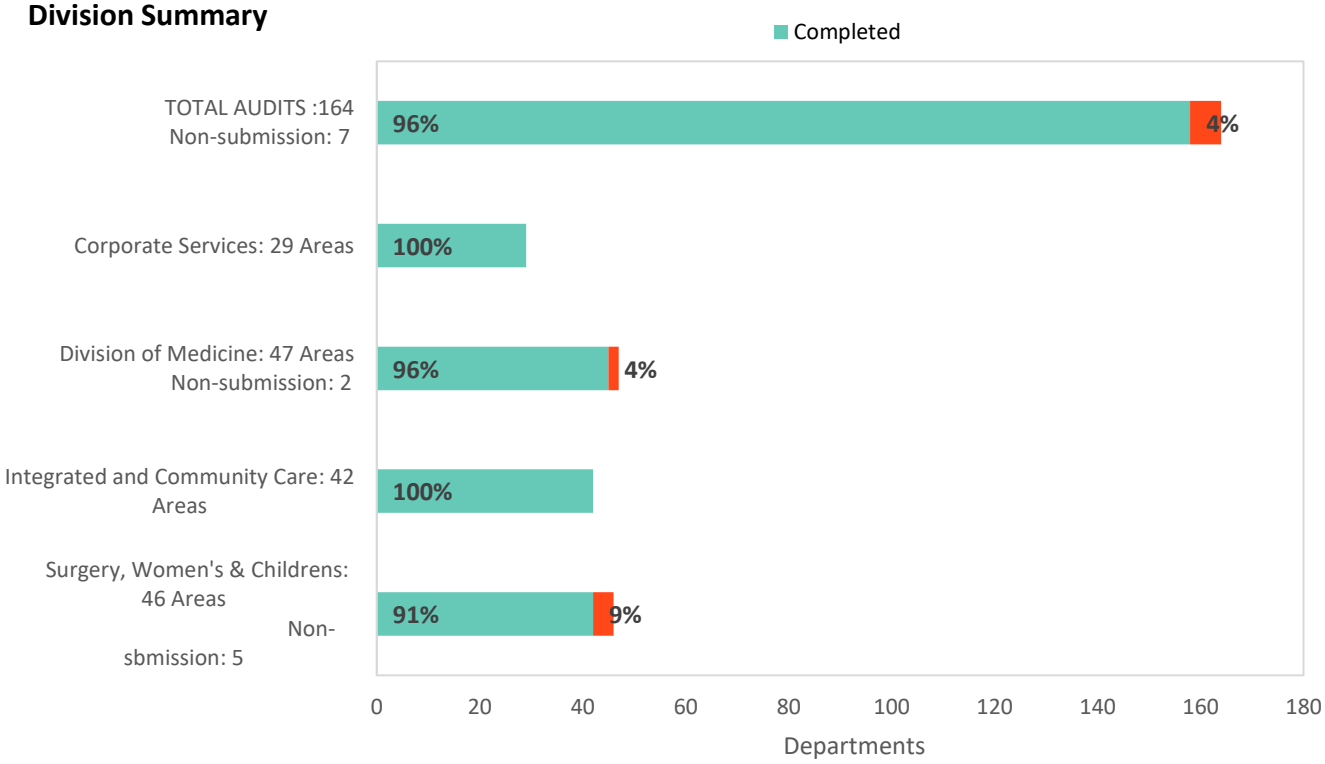
10. H&S Audit Programme

The Annual Health and Safety audit of all departments with five or more employees took place in June 2023. There were 164 departments identified and 157 audits were returned. Three departments achieved 100% and they were presented with certificates to acknowledge their achievements. There were 35 departments that scored less than 70% (approximately half were new to audit) and these departments were contacted by H&S officers who provided them with support and guidance moving forward. The three areas that are noted as 'agreed no submission' were new to the audit process and support has been provided to ensure they are ready for audit in 2024/ 25.





Division Summary



11. Security

The Trust reported 939 security related incidents via the Incident Reporting System [Datix] during the year 2023/24. This shows an increase of 35 incidents from the previous year.

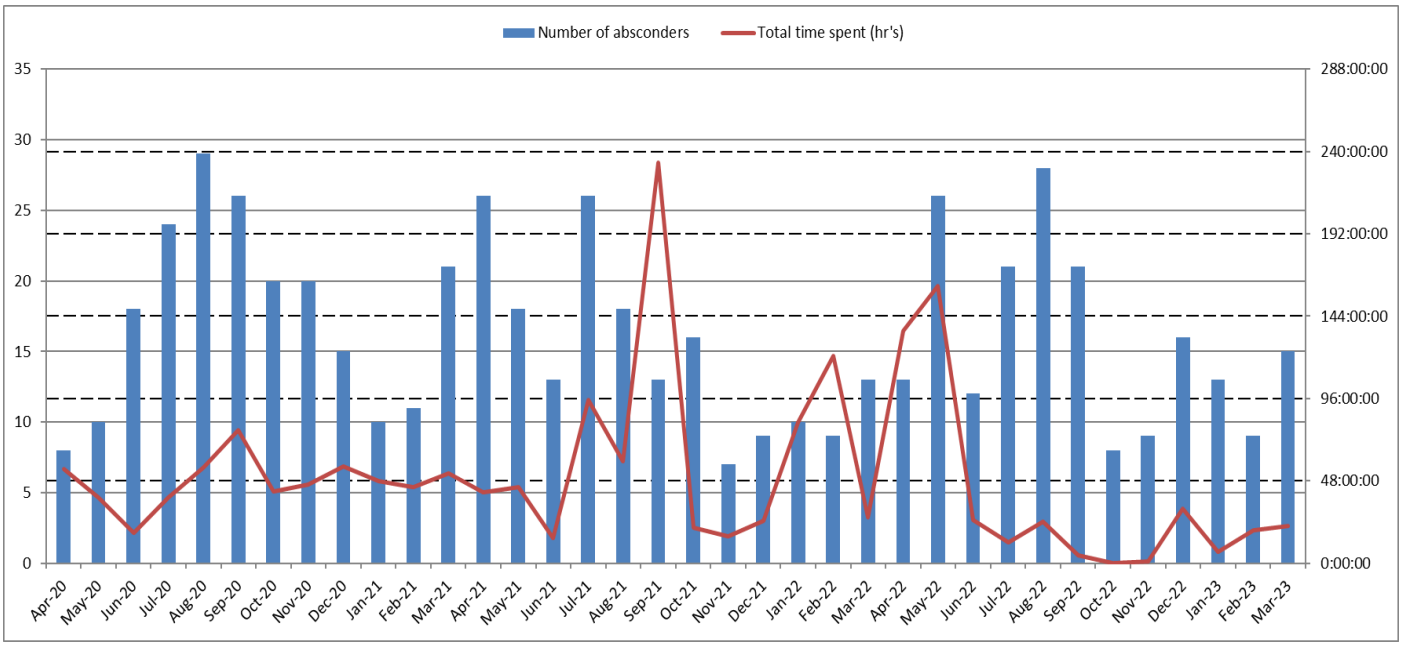
Total Incidents Reported

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Number of incidents 01.04.2023 to 31.03.2024
862	904	939
There has been a slight increase in incidents reported during the 2023/24 financial year compared to 2022-23.		

Absconder/Missing Patient

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Number of incidents 01.04.2023 to 31.03.2024
178	177	250

Time associated with absconders / missing patients



Physical Abuse (injury) Patient on Staff

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Number of incidents 01.04.2023 to 31.03.2024
44	98	I21

Physical Abuse (no injury) Patient on Staff

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Number of incidents 01.04.2023 to 31.03.2024
36	30	28

Verbal Abuse Staff on Staff (includes Agency Staff on Staff)

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Number of incidents 01.04.2023 to 31.03.2024
39	41	37

Verbal Abuse Pt on St & Verbal Abuse other on staff/other

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Number of incidents 01.04.2023 to 31.03.2024
134	86	77
46	25	40

Sanctions issued 2023/2024

Internal
19 x Unacceptable Behaviour Letters (UBL)
1 x Exclusion Notice submitted currently under review.

External
2 x Referrals to Youth Justice System:
- Possession Offensive Weapon (bladed article)
- Possession Drugs

3 x Community Resolutions:
- Sexual Assault
- Common Assault
- Causing a Disturbance on NHS Premises

1 x Police Caution for Causing a Disturbance on NHS Premises.
5 x Court convictions
- Drunk & Disorderly (fined + costs)
- Assault / Racial Offences (Pleaded guilty awaiting sentencing)
- Assault / Racial Offences (Charged to court awaiting outcome)
- Assault (Pleaded guilty awaiting sentencing)
- Assault + Public Order Offence (Charged to court awaiting outcome)

Summary
There has been an increase in the Trust issuing UBL's from 3 in 2022/23 to 19 (84%) in 2023/24 to persons for using unacceptable behaviour towards Trust staff both in the acute site and in the community. The Security Management Client Engagement Lead continues to work with partner agencies to hold perpetrators to account for their actions on Trust sites to secure prosecutions.

During this reporting period there was an increase in suspected criminal activity involving the misuse / supply of illegal substances on GWH premises and grounds. A strategy was developed and implemented with Wiltshire Police to reduce the risk to patients, visitors, and staff from criminal activity on site. Intelligence sharing in-conjunction with pro-active Security patrols on the GWH site identified a series of vehicles used in crime and criminals visiting the site for no other purpose than to facilitate the supply of illegal substances to inpatients and / or other persons. This joint operation directly led to the arrest of four persons involved in the misuse / supply of illegal substances at GWH. In addition as a result of the pro-active Security patrols on the GWH site two further persons were arrested by Police for possession of illegal substances and possession of an offensive weapon namely a 'machete' style knife. Both persons presented a significant risk due to their criminal activity on site and the wider community.

The Datix team have recently re-instated the SIR's page so we can record clinical / non-clinical Physical Assaults and police attendance / outcomes etc. it needs fine tuning but will hopefully provide more accurate records.

Appendix A – Equality Impact Assessment

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.

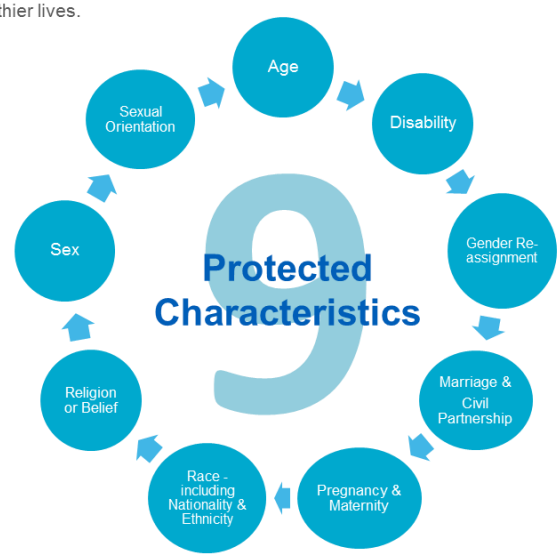
If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

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

Trust Equality and Diversity Objectives			
Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

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.



Appendix B, Statement of Commitment for Health & Safety

NHS
Great Western Hospitals
NHS Foundation Trust

Health & Safety Policy

Statement of Commitment

The health, safety, and security of everyone who may be affected by the Great Western Hospitals NHS Foundation Trust's activities including staff, patients, visitors, and carers is of paramount importance to us all.

The Chief Executive and Board are committed to providing and maintaining a safe and healthy working environment providing and maintaining safe plant and equipment and ensuring safe manual handling practices as well as safe use of hazardous substances so far as is reasonably practicable.

The Trust will strive for continual improvement in all aspects of risk management and aim to prevent accidents and cases of work-related ill health whilst recognising its requirements to comply with all relevant health & safety legislation as a minimum requirement. In pursuing these aims, Trust employees are empowered to take all reasonable steps to ensure the highest standards of health, safety and welfare for staff, patients, visitors, and any other persons that may be affected by the Trust's activities.

The Trust will provide adequate control of the occupational health and safety risks arising from our work activities and will provide the necessary information, instruction, training, and supervision for our staff in order to ensure they are competent to conduct their tasks.

The Trust recognises that good risk management awareness and use of risk assessment practice at all levels is a critical success factor for our organisation

Policies will be reviewed regularly in line with changes in legislation, approved codes of practice or official guidance as recommended by recognised national bodies as advised by the Health and Safety Department.

The Trust encourages staff at all levels of the organisation to give consideration to and take a responsible approach to the assessment and management of all risks when planning and organising work activities or changes to the workplace. In order to promote active participation and consultation at all levels within the organisation, the Trust encourages staff to take on health and safety responsibilities particularly as accredited Safety Representatives.

Full co-operation on the part of staff is vital to the successful delivery of this Policy and in achieving the safety aims of the Trust. The Trust expects all staff to fully comply with all matters of health and safety and in return offers full commitment to the well-being of employees Each employee shall recognise their personal involvement and responsibility for observing all Trust policies and procedures.

Chairman, ... **Date:** 27.10.23

Chief Executive, KMcNamara..... **Date:** 30.10.23

Service Teamwork Ambition Respect

Appendix C, Closed Business Plan 2023/24

Health & Safety, Fire and Security Business Plan Objectives & Targets 2023/24

ACTION: *(*) Carried forward from previous year*	**DESIRED OUTCOME:**	**ACTION BY WHOM:**	**ACTION BY WHEN** *RAG RATING* ***Red:** Significant delay/stopped* ***Amber:** On target/Minor delays* ***Green:** Completed*	**COMMENTS AND UPDATES**
MANAGEMENT				
To conduct a review of the current H&S team structure to ensure resilience due to only 1.6 WTE H&S officers sharing other roles	Review to be completed and recommendations accepted by H&S lead Exec.	BS & SH	**Q1**	The new AD for Health, Safety and Security started in post 02.04.24 providing an additional full time resource and roles across the team are being clarified
HEALTH & SAFETY				
To conduct a specific Trust wide H&S review of the process for ordering bariatric patient equipment. To confirm a process is in place. Carried forward from 22/23	To confirm consistent process in place across the Trust	SB	**Q2**	Call the Equipment Library on Ext 4446 (out of hours requesting details on EL answerphone) State the requesting department and equipment required. Equipment details on the Intranet under Trust Equipment.

				If no Bariatric bed, we will advise the ward to go for a rental. Rental details have been provided to all wards, but we can supply contact number at that point if require. Rental company will provide equipment advice & costs. Delivery time around four hours max.
Re introduce the Exec RIDDOR tours to understand how RIDDOR incidents have been managed and closed within departments.	To ensure RIDDOR incidents are followed up for assurance that they have been closed and any support can be offered from the H&S Team	SH	**Q3**	A new RIDDOR process has been put in place (April 2024) so this action can now be closed
Review non-clinical manual handling link coordinator training	To understand if clinical and non-clinical can be merged	SB SH	**Q2**	Manual Handling link training inc DSE Training: 8th Nov 23 - fully booked 24th Jan 24 - fully booked 23rd March 24 - 3 booked DSE training: 27th Oct 23 - 4 booked 23rd Feb 24 - 2 booked 26th Apr 24 - 0 booked 24th Jun 24 – 1 booked

Carry out face to face audits on High-risk departments to ensure good HSE compliance	To give in depth assurance compliancy from HSE perspective	BS SH	**Q3**	General face to face audits ready but specialised audits still ongoing – June 2023 template has been formulated and looking at plan to role out throughout Q3 & Q4 08/02/24 Interim HOS was looking at this and has now left the trust
FIRE SAFETY				
To carry out a formal Ski Sheet training exercise within GWH in the north, west and SWICC building and also to include the Liden department.	To ensure all staff are aware how to use equipment and patients can be evacuated safely	NH/SH	**Q3**	Constant reminders to all staff via Comms and Posters and Video now online. Q2 training took place 168 staff now trained and plans for bigger rollout throughout Trust with discussion provided by the Academy
• To carry out toolbox fire talks withing the GWH organisation so that staff gain further knowledge in the event of an evacuation.	To engage staff in departments and understand how to safely evacuate patients	SH/NH	**Q4**	On-going but backlog of other Fire issues remains priority. Still in place but hopefully Q3
• The Fire team will produce a video training aid to go online for new starters and temp staff that have not had the practical training.	To support new staff and also current staff in advice around a safe fire safety culture	SH/NH	**Q2**	Planned but staff shortage is an issue now we have two Fire Advisors this should assist us. Ski Sheet Training video has been completed. Other Fire Videos will follow. Focused on Signage. Also videos have been completed however format is incorrect.

To understand how the team can incorporate the 2 iPad's that we have to assist with fire risk assessments audits.	To improve efficiency within the team and streamline processes.	SH/BS	**Q4**	We need to purchase the Audit program once that is actioned it will make the task easier sourcing program Oct 23 IT have been contacted they will look at software as there may be a conflict with the software.
SECURITY				
To create a 'Staff Physical Safety' Action Plan with actions to improve staff safety and security confidence whilst at work. Carried over from 22/23	Action Plan progress monitored and reported regularly to the Security Assurance Group [SAG].		**Q4**	On going with talks with new SAFE Security Manager COMMs to be sent out W/C 16th Oct on Morning dark / nights when car parking 08/02/24 Interim Head of Service was looking at this and will now be passed to new AD of Service.
*To conduct a formal 'Lockdown Exercise' of the Emergency Department at GWH to test Keri system functionality and the Security I-Respond deployment plans. Carried over from 22/23	To complete a site lockdown capability exercise	H&S, Serco Security, EPRR	**Q4**	Lockdown is planned once the doors have been modified on the ground floor which is now approved awaiting SERCO to start the work Jan 24. Once completed Lockdown will be planned for Feb or Mar 24
Infiltration Exercise - To test and challenge the security culture of staff by systematically attempting to access Keri locked areas across the Trust by tailgating and other means. Carried over from 22/23 .	Infiltration exercise carried out and report of findings issued with recommendations for improvement presented to H&S working group	SAFE team members	**Q3**	This was carried out by SAFE. Maternity exercise successful

To ensure that all active cards on Keri are relevant and that any cards that have been inactive for more than 90 days are removed except for some cards that will be identified by H&S team. To provide assurance that the Keri card system is being continuously monitored and managed. Ongoing from 22/23	To provide assurance that the Keri card system is being continuously monitored and managed.	SERCO/Keri-Co-ordinator	**Q3**	May 2023 Keri co-ordinator sends monthly report to Serco helpdesk for removal of cards from system when there has been no activity in 90 days. Review underway 11/10 to understand why figure has increased. 11,000 on the system 12 Oct 23 TF has been in contact with ASG to clarify removal 7/12/23. 11/12/23 ASG advised this will be undertaken as part of upgrade.
Rolling bite size programme over 12 months to undertake the replacement of PXL to NXT controllers in identified high risk/sensitive areas.	To confidentially provide assurance that there is a proactive replacement programme for aged PXL controllers (monitoring of this via quarterly SAG meeting).	H&S/Keri Co-ordinator SMS & EPRR	**Q4**	August 2023 – 3-year plan provided by ASG to bring system up to date. If existing PXL's fail these will be replaced by new NXT. This is being brought forward asap due to issues with the KERI System 3 Year program now in place and quotes received, however work will not start until possibly April 24 7/12/23 08/02/24 Capital agreed for phase 1 (A&B) to commence this financial year.

Appendix D, draft Business Plan 2024/25

Health & Safety, Fire and Security Business Plan Objectives & Targets 2024/25

ACTION: *(*) Carried forward from previous year*	**DESIRED OUTCOME:**	**ACTION BY WHOM:**	**ACTION BY WHEN** *RAG RATING* ***Red:** Significant delay/stopped* ***Amber:** On target/Minor delays* ***Green:** Completed*	**COMMENTS AND UPDATES**
MANAGEMENT				
To conduct a review of the current H&S team structure to ensure resilience due to only 1.6 WTE H&S officers sharing other roles	Review to be completed and recommendations accepted by H&S lead Exec.	SM & SH	**Q1**	A review of work priorities is being undertaken. The post for the new AD for Health, Safety, Fire and Security has been recruited to and commenced in post 01.04.24 giving another WTE in the team.
HEALTH & SAFETY				
To introduce new network sessions for manual handling for drop in sessions Link Coordinators.	To improve links relationship to work with each other for problem solving	SB	**Q2**	
To improve the information on DSE to all staff in the trust and create a video for user regarding how to set a chair up to support staff within the trust.	To support staff to set their chairs up and improve posture	SB	**Q3**	
Complete a training needs analysis to ensure the health, safety, fire and security training is appropriate	To ensure appropriate training courses are available for all staff. To include short courses on RIDDOR and risk assessment	SM	**Q2**	
FIRE SAFETY				
To carry out a large fire exercise in Theatres which will include the Fire and Rescue service	To engage staff and assure the trust and fire service if the need	SHe/NH	**Q3**	

	arises for a large evacuation from Fire,			
The Fire team will produce a video training aid to go online for new starters and temp staff that have not had the practical training. Carry over from 23/24	To support new staff and also current staff in advice around a safe fire safety culture	SHe/NH	**Q2**	
To understand how the team can incorporate the 2 iPad's that we have to assist with fire risk assessments audits. Carry over from 23/24	To improve efficiency within the team and streamline processes.	SHe/ NH	**Q2**	We need to purchase the Audit program to enable this task to progress
SECURITY				
To create a 'Staff Physical Safety' Action Plan with actions to improve staff safety and security confidence whilst at work. Carried over from 23/24	Action Plan progress monitored and reported regularly to the Security Assurance Group [SAG].		**Q4**	
*To conduct a formal 'Lockdown Exercise' of the Emergency Department at GWH to test Keri system functionality and the Security I-Respond deployment plans. Carried over from 23/24	To complete a site lockdown capability exercise	H&S, Serco Security, EPRR	**Q4**	
Infiltration Exercise - To test and challenge the security culture of staff by systematically attempting to access Keri locked areas across the Trust by tailgating and other means. .	Infiltration exercise carried out and report of findings issued with recommendations for improvement presented to H&S working group	SAFE team members Trust	**Q3**	
To ensure that all active cards on Keri are relevant and that any cards that have been inactive for more than 90 days are removed. To provide assurance that the Keri card system is being continuously monitored and managed. Ongoing from 23/24	To provide assurance that the Keri card system is being continuously monitored and managed.	SERCO/Keri-Co-ordinator	**Q3**	

Report Title	**Review of Trust Constitution**				
Meeting	**Trust Board**				
Date	**7 November 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Proposed changes to Great Western Hospitals NHS FT Constitution				

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):

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

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

All due governance process has been followed.

Report

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

Following the appointment of the Group Chief Executive Officer/ Accountable Officer (voting Board member), at Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust, together with a newly created role of Managing Director (voting Board member) for each trust, the Trust's Constitution in terms of the composition of the Board requires amendment.

The proposed amendment is in appendix 1 (red text indicates the change). This is in alignment with Royal United Hospitals Bath NHS FT and Salisbury NHS FT.

Any change to the Constitution requires both the Board and Council of Governor's approval.

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

Key Risks – risk number & description (Link to BAF / Risk Register)	-	**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement		
Next Steps	• Approval from the Council of Governors on 29 November 2024. • Advise NHSE. • Publish revised Constitution on the Trust's website.	

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to approve the changes to the Constitution to reflect the change in the Board composition with the appointment of a Group Chief Executive and Managing Director.	
Accountable Lead Signature	Caroline Coles, Company Secretary
Date	23 October 2024

Proposed amendments to the Trust's Constitution

1. Background

1.1 Following the appointment of the Group Chief Executive Officer/Accountable Officer, at Great Western Hospitals NHS FT, Royal United Hospitals Bath NHS FT and Salisbury NHS FT, together with a newly created role of Managing Director for each trust, the Trust's Constitution in terms of the composition of the Board requires amendment.

2. Statutory Context

2.1 Current Trust Constitution - Board of Directors – composition

19.1 The Trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

19.2 The Board of Directors is to comprise:

19.2.1 a Non-Executive Director Chair; and

19.2.2 a minimum of 4 (four) and a maximum of 8 (eight) other Non-Executive Directors; and

19.2.3 a minimum of 4 (four) and a maximum of 7 (seven) Executive Directors,

PROVIDED THAT the number of Non-Executive Directors plus the Chair shall exceed the number of Executive Directors.

19.3 One of the Executive Directors shall be the Chief Executive.

19.4 The Chief Executive shall be the Accounting Officer.

19.5 One of the Executive Directors shall be the Chief Financial Director.

19.6 One of the Executive Directors is to be a registered medical practitioner (within the meaning of the Medical Act 1983) or a registered dentist (within the meaning of the Dentists Act 1984).

19.7 One of the Executive Directors is to be a registered nurse or a registered midwife (within the meanings of the Nurse and Midwifery Order 2001 (SI 2002/253)).

19.8 In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his absence, the Deputy Chair), shall have a second or casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors attached at Annex 7.

3. Current GWH Board Composition

- The total number of voting NEDs (including Chair) is eight (8).
- The total number of voting EDs is seven (7)
- Following the appointment of a Group CEO the Trust would be in line with the Constitution.

4. Appointment of a 'Managing Director (MD)'

- For a further voting Executive Director (in the form of a MD) this would make our Board composition a ratio of 8 to 8 - this is acceptable as per the model constitution[1]. **However, this would increase the number of Executive Directors to 8 and therefore our Constitution would need to be amended to cover the increase in numbers of voting EDs (current maximum of 7 EDs)**
- The proposed amendments are contained within appendix 1, which will see a minimum number of Non-Executive Directors and Executive Directors which reflects the statutory roles required.

4. Future Considerations

4.1 Further consideration could be an appointment of an additional NED to be in line with the principles of good governance; the constitution provide that at least half of the Board of Directors, excluding the Chair, should be non-executive directors.

[1] *In accordance with the principles of good corporate governance, it is recommended that the constitution provide that at least half of the Board of Directors, excluding the Chair, should be non-executive directors. Alternatively, in the event that the constitution provides for parity on the Board of Directors between executive and non-executive directors, the Chair should have a casting vote (Gov.UK model constitution for Foundation Trusts April 2013)*

Appendix 1 : Proposed changes to Great Western Hospitals NHS FT – November 2024

INTRODUCTION

19 Board of Directors – composition

19.1 The Trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

19.2 The Board of Directors is to comprise:

19.2.1 a Non-Executive Director Chair; and

19.2.2 a minimum of ~~4 (four) and a maximum of 8 (eight)~~ 5 (five) other Non-Executive Directors; and

19.2.3 a minimum of ~~4 (four) and a maximum of 7 (seven)~~ 5 (five) Executive Directors,

PROVIDED THAT the number of Non-Executive Directors plus the Chair shall exceed the number of Executive Directors.

19.3 One of the Executive Directors shall be the Chief Executive.

19.4 The Chief Executive shall be the Accounting Officer.

19.5 One of the Executive Directors shall be the Chief Financial ~~Director~~ Officer.

19.6 One of the Executive Directors is to be a registered medical practitioner (within the meaning of the Medical Act 1983) or a registered dentist (within the meaning of the Dentists Act 1984).

19.7 One of the Executive Directors is to be a registered nurse or a registered midwife (within the meanings of the Nurse and Midwifery Order 2001 (SI 2002/253)).

19.8 In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his absence, the Deputy Chair), shall have a second or casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors attached at Annex 7.

19.9 The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director.

19.10 ~~Subject to the provisions of paragraphs 19.3 to 19.7 above, the Board of Directors shall determine any change in the number of Directors, PROVIDED THAT any change in the number of Directors is within the range set out in paragraph 19.2 above.~~

19A Board of Directors – general duty

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole, and for the public.

Annex 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

2.7 Composition of the Board of Directors

2.7.1 In accordance with the paragraph 19 of the Constitution, the Board of Directors is to comprise:

2.7.1.1 The following Non-Executive Directors:

2.7.1.2 the Chair, and a minimum of ~~four~~ 5 (five) ~~and a maximum of eight other Non-Executive Directors;~~ and

2.7.2 a minimum of ~~four~~ 5 (five) ~~and a maximum of seven~~ Executive Directors, including:

2.7.2.1 the Chief Executive who shall be the Accounting Officer;

2.7.2.2 the Chief Financial Officer;

2.7.2.3 a registered medical practitioner (within the meaning of the Medical Act 1983) or a registered dentist (within the meaning of the Dentists Act 1984); and

2.7.2.4 a registered nurse or midwife (within the meaning of the Nursing and Midwifery Order (SI 2002/253).

2.7.3 In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his absence Deputy Chair) shall have a second or casting vote at meetings of the Board of Directors.