GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD

Thursday 6 June 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 • 2 May 2024 (draft)	8 – 17	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	18	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Care Reflection (Staff Story) – The introduction of endocrine support clinic to improve compliance post breast cancer** Carrie Thomas, Breast Clinical Nurse Specialist	19 – 21	CTh	Note	9.40
7.	**Chair's Report** Liam Coleman, Chair	22 – 24	LC	Note	10.05
8.	**Chief Executive's Report** Jon Westbrook, Acting Chief Executive	25 – 30	JW	Note	10.15
9.	**CQC Unannounced Inspection of Medical Care** Lisa Cheek, Chief Nurse	31 – 34	LCh	Note	10.25
10.	**Integrated Performance Report** Integrated Performance Report – Breakthrough Objective and Pillar Metric deep dive and refresh	35 – 87	LC/ Executive Directors	Assurance	10.35
BREAK (10 minutes) at 11.20 to 11.30am					

	• Performance, Population & Place Committee Board Assurance Report (May) – Bernie Morley, Non-Executive Director & Committee Chair	88 – 89	BM	Assurance	11.30
	• Quality & Safety Committee Board Assurance Report (May) – Claudia Paoloni, Non-Executive Director & Committee Chair	90 – 92	CP	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (May) – Faried Chopdat, Non-Executive Director & Committee Chair	93 – 94	FC	Assurance	
11.	**Mental Health Governance Committee Board Assurance Report (April)** Lizzie Abderrahim, Non-Executive Director & Committee Chair	95 – 96	EKA	Assurance	11.45
12.	**Charitable Funds Committee Board Assurance Report (May)** Julian Duxfield, Non-Executive Director & Committee Chair	97 – 98	JD	Assurance	11.55
13.	**Safe staffing 6-month review for Nursing, Midwifery and AHP** Lisa Cheek, Chief Nurse	99 – 133	LCh	Assurance	12.05
14.	**Equality, Diversity & Inclusion Pillar Metric Review** Jude Gray, Chief People Officer Sharon Woma, Trust EDI Lead	134 – 143	JG/SW	Receive	12.15
15.	**Committee Effectiveness Review 2023/24** Caroline Coles, Company Secretary	144 – 197	CC	Approve	12.45
16.	**Delegation of authority for approval of Annual Accounts 2023/24** Caroline Coles, Company Secretary To delegate authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts before deadline of 28 June 2024	198 – 199	CC	Approve	12.50
	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.**				
17.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	-	CC	Approve	12.55
18.	**Annual Self Certification – CoS7** Caroline Coles, Company Secretary	200 – 202	CC	Approve	-
19.	**Final Annual Quality Account 2023/24** Caroline Coles, Company Secretary Approved by Quality & Safety Committee on 23 May 2024 for publication on the Trust's website	203 – 276	LCh	Ratify	-
20.	**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	-	-
21.	**Date and Time of next meeting** Thursday 1 August 2024 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-

22.	**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

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			Population & Health		

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ AND VIA MS TEAMS 2 MAY 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
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)*	Non-Executive Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Acting Chief Executive

In attendance:

Caroline Coles (CC)	Company Secretary
Claire Lehman (CL)	Associate Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director
Tim Edmonds (TE)*	Associate Director of Communications & Engagement
Deborah Rawlings (DR)	Board Secretary
Tania Currie (TC)	Head of Patient Experience & Engagement (agenda item 011/24)
Rachel Gardner (RG)*	Lead Parkinson's Disease Nurse (agenda item 011/24)
Emma Galos (EG)*	Parkinson's Disease Nurse Specialist (agenda item 011/24)
Kat Simpson (KS)*	Head of Midwifery & Neonatal Services (agenda items 016 & 017/24)
Angela Morris (AM)*	Senior People Partner (agenda item 018/24)

Apologies

Jon Burwell (JB)	Acting Chief Digital Officer

*Indicates those members attending virtually by MS Teams

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

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
006/24	**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.	
007/24	**Declarations of Interest** There were no declarations of interest.	
008/24	**Minutes of the previous meeting (public)**	

Minute	Description	Action

The minutes of the Board meeting held in public on 7 March 2024 were adopted and agreed as a correct record.

009/24 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list and the following notes:-

267/23 : IRP : Our People : Discrimination – It was noted that this had been considered in depth at the People & Culture Committee.

010/24 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

011/24 **Care Reflection (Patient Story) – Support received by Parkinson's Disease Team**
Tania Currie, Head of Patient Experience & Engagement, Rachel Gardner, Lead Parkinson's Disease Nurse, and Emma Galos, Parkinson's Disease Nurse Specialist

The Board received a film on the personal journey by Kerry that had been diagnosed with Parkinson's Disease seven years ago and the impact of the diagnosis on all aspects of her life. The film outlined how the Parkinson's Team had supported her through this in the management of her symptoms, improving her function and reducing the negative aspects of this long-term condition. The patient experience and learning identified from this case would be shared widely across the Trust which includes the approach to time critical medicines for inpatients with Parkinson's, and the establishment of a Parkinson's Champions network.

An audit against the Parkinson's UK published 10 recommendations for hospitals which had been undertaken and had demonstrated good performance and that this would continue to be repeated to ensure that standards were being met for patients.

The Board thanked Tania, Rachel and Emma for their inspirational presentation and the exceptional work being undertaken by the Parkinson's Team.

The Board **noted** the patient story.

012/24 **Chair's Report**
The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally. The following areas were highlighted for noting.

Non-Executive Directors
It was noted that Helen Spice and Faried Chopdat had commenced their second term of office from 1 April 2024. Julian Duxfield had taken over as chair of People & Culture Committee and Charitable Funds Committee from April 2024. Faried Chopdat was to step into the role of Deputy Chair as from 1 April 2024. Lizzie Abderrahim would take over the role of Maternity & Neonatal Board Safety Champion.

The Board **noted** the report.

013/24 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report, and the following was highlighted:

Industrial action
The British Medical Association (BMA) had announced that its junior doctor members had voted in favour of continuing their industrial action. A mandate for strikes remained and that specific strike dates had not yet been announced.

Minute	Description	Action

Call for Concern
In response to the first phase of 'Martha's Rule' which was to be implemented in the NHS from April 2024, GWH was to support a national campaign called 'Call 4 Concern' which would provide families with a way of speaking to the Critical Care Outreach team to receive urgent help and advice if required. Steve Haig, Chief Medical Officer, confirmed that GWH had been accepted as part of the first phase of the implementation programme.

There had been good clinical engagement at GWH around the rollout of this campaign supported by leaflets to provide further advice in accessing the service.

Fuller inquiry
Phase one of the report by the independent inquiry into the issues raised by the David Fuller case had been published. The full report was planned for publication at a later date. It was confirmed that security procedures around the GWH Mortuary had been strengthened to provide further assurance.

Car parking
A new car parking system for visitors had been launched in April 2024, with the new staff car parking system due to be launched at the end of April.

Staff Excellence Awards
The finalists for the Staff Excellence Awards had been announced ahead of the ceremony taking place at the MECA in Swindon on 14 June.

STAR of the Month awards
The recent STAR of the Month award winners was noted, which included Sue Corbett, Trust HQ Receptionist and Admin Assistant. It was noted that Sue was also due to retire from the Trust on 24 May 2024 after 22 years of service.

Celebrating neurodiversity
As part of Neurodiversity Celebration Week, an Neurodiversity Event had been held at GWH and included a talk from South Swindon MP Sir Robert Buckland. This was a well-received event by all that attended.

The Board **noted** the report.

267/23 **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 March 2024.

There followed a deep dive into the IPR pillar metrics which included a summary of year end performance and the new breakthrough objectives for 2024/25 which were Ambulance Delays, Reduction in Harms from Falls, Staff survey question around respect for colleagues, and Financial Recovery.

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 27 March 2024 and 24 April 2024 and the following was highlighted:

Cancer targets continued to improve in the longest waiting patients and performance standards were met in March. The Trust was likely to remain in Tier 2 for cancer (awaiting formal confirmation) as part of the performance management regime and the potential

Minute	Description	Action

impact on Single Oversight Framework (SOF) rating. Sustainability remained around the cancer management of skin, colorectal and urology.

Diagnostic performance (DM01) continued to improve and that there had been a significant reduction in the overall waiting list for patients.

Referral to Treatment (RTT) for the longest waiting patients continued to significantly reduce, however 4 patients breached waiting over 78 weeks.

Non-Criteria To Reside (NCTR) continued to operate above mean levels which was impacting flow across the hospitals.

Urgent and Emergency Care Performance in March showed a sustained performance despite a 6% increase in patients at the Urgent Treatment Centre. However, significant issues with delays in hospital handovers remained despite a decrease in patient waiting times in ambulances. Good oversight of arrangements were in place to deliver further improvements with additional senior registrar support in the major chairs area. Performance may reduce during July ahead of the transition to the new unit in September.

The reduction in virtual ward occupancy which impacted on flow remained a concern.

A report had been received on the NHSE oversight framework that was currently out for consultation and that the proposed changes included a focus on binding providers and ICBs together in a 'double lock' approach to performance metrics, an assessment of capability of ICBs and providers as well as performance delivery, and the continuation of NHSE's regulatory role being delivered through ICBs.

Bernie Morley, Non-Executive Director added that he had recently spoken with Claudia Paoloni, Non-Executive Director (and chair of Quality & Safety Committee) to avoid the duplication of quality issues in relation to performance issues being discussed at both meetings and that both committee chairs were satisfied with the oversight at each committee reflected by Non-Executive Director membership.

Felicity Taylor-Drewe, Chief Operating Officer highlighted the current challenges around mental health and that actions were being taken to ensure that both internal and escalation processes and support from system partners for both adults and children were in place, particularly in relation to length of stay of patients and the impact on both staff and other patients as well. This would continue to be monitored through the Mental Health Governance Committee.

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 21 March 2024 and 18 April 2024 and the following was highlighted:

There had been significant progress with infection prevention and control with robust actions in place. Improvement continued to be reported around Pseudomonas and Klebsiella rates, with *E.Coli* rates remained static.

Training around foetal monitoring and PROMPT had now become part of induction for obstetricians which had resulted in increased staff satisfaction as staff feel more prepared for their placements.

Minute	Description	Action

Pressure harms continued to reduce in the community but there had been an increase in acute for March. The Board noted that this metric was being moved away from being a breakthrough objective to an alerting watch metric for 2024/25 and that the reporting on pressure harms would now be in line with the latest national guidance reporting grades 2, 3 and 4 only. The Quality & Safety Committee was assured that the robust action plan in place would continue to monitor all pressure harms. It was particularly highlighted that the incidents of reported harms had significantly increased over the year which demonstrated an increased awareness and proactive management of pressures harms.

The Breakthrough Objective for 2024/25 had changed to reducing harm from inpatient falls, with the aim to drive improvement in the number of patients that had experienced moderate harm and above related to falls whilst in our care, especially those that have more than one fall.

Assurance around Electronic Discharge Summaries remained limited as the current system did not support EDS from June 2024. Actions were being explored to utilise Care Flow to generate EDS as an alternative solution.

Improvements in mortality reporting and actions to drive engagement with structured judgement reviews had provided assurance. It was noted that there had been an initial BSW cross system mortality meeting. Each Trust would have the opportunity to present their own data to compare data collection, systems and processes.

In relation to the quality oversight of the Integrated Front Door, Lisa Cheek, Chief Nurse also highlighted the quality metrics to provide a robust oversight on the impact of operational pressures and particularly the measures around triage time to assessment.

Lisa Cheek, Chief Nurse also reported on the Trust's ward accreditation programme and that Falcon, Beech and Teal Wards had all been presented with certificates to recognise their commitment to reaching 'good'. This programme drives forward patient safety work, by focusing on the engagement and empowerment of staff at every level to improve quality on adult inpatient wards.

Rommel Ravanan, Associate Non-Executive Director commented on the increase of patients that required additional RMNs in both the Children's Ward and ED. Lisa Cheek, Chief Nurse outlined the current challenges faced by both GWH and system partners to provide care to presenting patients with complex needs and that this would continue to be monitored by the Mental Health Governance Committee.

The Board was also requested to delegate authority to the Quality & Safety Committee to approve the Quality Account 2023/24 for publication on the Trust's website in order to meet the deadline of 30 June 2024.

RESOLVED:
The Board to delegate authority to the Quality & Safety Committee to approve the Quality Account 2023/24 for publication on the Trust's website before the deadline of 30 June 2024.

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 25 March 2024 and 22 April 2024 and the following was highlighted:

The Trust had finished the 2023/24 financial year with a £0.15m surplus. While the Trust had completed in a surplus overall, there had been several cost pressures that non-

Minute	Description	Action

recurrent income streams had covered during the financial year. This position was the result of controls in place and additional governance around the financial position with oversight by the Financial Recovery Sub-Committee meetings. It was acknowledged that financial challenges remained for the coming year and that innovations continued to be reviewed to deliver initiatives to further drive improvement. The Board thanked the Executive and Finance Teams who had contributed towards the achievement of this year-end position.

Good progress continued to be made with the EPR Programme and the Board was assured of the robust governance model that had been introduced, which included a joint committee and collaboration agreement, and the progress being made to establish the EPR programme and commence delivery.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received a verbal, due to timing of the meeting, overview of the discussions held at the People & Culture Committee (PCC) at its meeting on 23 April 2024.

The top-level results of the 2023 Annual Trust Staff Survey had been reviewed and that there had been positive progress made since the 2022 survey and also the GWH results in relation to other trusts. Each of the four Divisions had also circulated an overview of their results and presented a brief summary of the countermeasures that had been developed using the improving together methodology. Learning from the different approaches was to be shared across the Trust.

A data-based study on the correlation between discrimination and retention had been conducted at the request of the Board. Due to the limitation of the available data, there was no clear demonstrable relationship, but other evidence clearly indicated the influence of discrimination on staff turnover, and that causality was difficult to determine, however PCC was assured that there were alternative ways of identifying where there might be issues happening in different parts of the Trust, not just through survey results or other feedback. Some actions were identified to improve data on the links between these issues.

A mandatory training review report had demonstrated a robust approach to managing and monitoring the roll-out of mandatory training. A national review of mandatory training was underway and that the Trust was to undertake a continual assessment of training provided to ensure it was as effective as possible. The Board was reminded to remain compliant with its mandatory training. Jon Westbrook, Acting Chief Executive added that in response to a letter from the NHSE on improving the working lives of doctors in training received in April, Trusts were being encouraged to adopt an NHS Digital Staff Passport which was being developed to help maintain compliance with mandatory training requirements.

In response to a question asked by Claudia Paoloni, Non-Executive Director on how study leave requests by clinical fellows were supported by the Trust, it was confirmed that these particular contracts would mirror the NHS terms and conditions of service.

The Board **noted** the report.

015/24 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meeting on 14 March 2024 and highlighted the following:

The interim report on the audit of the 2023/24 annual accounts had been received from the external auditors. At this stage, there were no issues for attention but there remained work outstanding on fixed asset reconciliations that would be completed by the year-end.

Minute	Description	Action

An update from the internal auditors on the progress of scheduled audits was reviewed and there were some concerns regarding the timely completion of work. This would not impact the receipt of an overall rating for the year but improvements were needed to some internal processes to ensure that Trust management was dealing with the work and reporting on a timely basis.

An internal audit report on bank and agency staff had been rated as significant assurance with minor improvement opportunities. However, some concerns had been raised on the lack of adherence to processes and that actions to mitigate the issues identified would continue to be monitored by ARAC.

An internal audit report on the processes and controls in place to implement the actions from the June 2020 CQC inspection had been rated as partial assurance with improvements required. This was as a result of one of the actions being omitted from the action plan. The Board noted that this missed Must Do action related to monitoring of bed moves and that this had been put into the operational escalation framework and would be monitored through that process.

The Internal Audit Plan for 2024/25 and the Local Counter Fraud Plan for 2024/25 had both been approved.

Significant progress had been made by the Integrated and Community Care Division in their risk management processes, which had included a full review of all risks that had resulted in a number being downgraded due to actions in place to mitigate the risks.

The Board **noted** the report.

016/24 **Ockenden Report – GWH Update**
Kat Simpson, Head of Midwifery & Neonatal Services joined the meeting for this item.

The Board received a paper which provided an update on the Immediate and Essential Actions (IEAs) outlined in the full Ockenden Report, which included key areas of progress and ongoing improvement actions undertaken to mitigate against the conversion of the 'amber' actions to 'green' and the next steps for progression to maintain sustainability of improvements.

It was noted that the triangulation of themes and trends with a collaborative approach to service user responses between the Trust and Maternity & Neonatal Voice Partnership (MNVP) continued to gain a better understanding on partnership engagement and to help drive service improvement. Kat Simpson reported on a recent focused feedback session with MNVP representatives which was well attended and provided accessibility to seldom heard communities. Further work was to be undertaken to expand on that model to access other networks, building on the work already undertaken by the Head of Patient Experience & Engagement. Lizzie Abderrahim, Non-Executive Director/Maternity & Neonatal Board Safety Champion added that she was looking forward to gaining a better understanding on the engagement with partnership networks and welcomed this approach being taken.

The Board **noted** the report.

017/24 ***Saving Babies Lives V3 (Q4 assessment – April 2024)***
Kat Simpson, Head of Midwifery & Neonatal Services joined the meeting for this item.

The Board received a summary of the Q4 assessment outcome, review of progress to date and an overview of the improvement plan for all six elements of the Saving Babies' Lives Care Bundle (SBLCB).

Minute	Description	Action

It was noted that the action plan was on target and there had been sustained improvement with progression elements to deliver framework with confidence working with the Local Maternity & Neonatal System (LMNS). The Board was assured that the Quality & Safety Committee would continue to have oversight of the action plan and to monitor progress to reach compliance.

It was noted that GWH had declared non-compliance with SBLCB in CNST Year 5. Kat Simpson reported that CNST Year 6 guidance had been released in April 2024 and that SBLCB remained a key safety action that would require continued engagement and sustained improvement towards full compliance.

The Board reflected on the recent Council of Governors' meeting at which the CQC report on GWH Maternity Services had been discussed and the progress against trajectories to provide assurance. Lisa Cheek, Chief Nurse informed the Board that there was a plan to bring together all actions points in one quarterly report for overview by the Quality & Safety Committee to provide ongoing oversight and assurance.

In response to a question from Rommel Ravanan, Associate Non-Executive Director on obstetrician ultrasound capacity and the national shortage being experienced by other trusts, Kat Simpson outlined the local actions that had been undertaken to address this risk, together with collaborative work with stakeholders to mitigate that risk and improve the service without significant impact on capacity.

The Board **noted** the report.

018/24 **Staff Survey Results 2023**

Angela Morris, Senior People Partner joined the meeting for this item.

The Board received a report on the results of the National Staff Survey 2023. It was noted that 50% of questions scored significantly better than in 2022 and 47% of questions showed no significance in relation to the 2022 score.

The People Promise 'we work flexibly' was significantly better than sector scores, including its sub-scores of 'support for work-life balance' and 'flexible working'. It was noted that compared with 2022 scores, the theme 'Morale' was significantly better.

It was noted that the Trust pillar metric *"I recommend my organisation as a place to work"* had improved by 6.3% in comparison to the 2022 result. The Trust breakthrough objective *"I can make improvement happen in my area of work"* had improved by 3.2% in comparison to the 2022 result.

There had been a common theme of reduced satisfaction in Teamworking and there would be further focus to improve the Trust's pillar metric "*I recommend my organisation as a place to work"*. Following analysis of the results, it had been agreed that the Trust's next breakthrough objective was to be *"I receive the respect I deserve from colleagues"*.

It was noted that the results had been discussed by both the Trust Management Committee and People & Culture Committee.

As part of the survey, staff were given the opportunity to add free text comments to highlight any particular feedback to be shared and the topics mostly related to staff morale, workload stress and work pressures. This feedback was to be incorporated into the improvement action plan to demonstrate to staff that there was a link between comments made in the survey and actions being implemented to drive improvement.

The Board noted the South-West ranking for the 2023 results excluding response rate was 9th nationally in 2023 and including response rate was 2nd in 2023, which reflected the 69%

Minute	Description	Action

response level achieved. Jude Gray, Chief People Officer thanked her team for the considerable efforts made to ensure an improved response rate by staff.

Lisa Cheek, Chief Nurse reflected on the focused work to drive improvement in the pillar metrics within the organisation and that the output of that work was reflected in the positive responses made through the survey.

Julian Duxfield, Non-Executive Director reflected on the change of focus for the breakthrough objective questions and how success could be measured through a change in culture to impact the whole respect agenda. It was noted that the People & Culture Committee (PCC) had considered the appointment of an external assessor to undertake an assessment of the Trust's culture in the wider sense and that PCC would then review the output. The Board supported this approach, with oversight by PCC.

It was also noted that at the April meeting of PCC, there had been a detailed discussion on the EDI Pillar Metric in relation to the correlation between discrimination and retention and that this was to be explored further. The EDI Board Commitments was to be explored more widely at the June Board meeting and that staff network leads were to be invited to support the conversation.

The Board **noted** the report.

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.

019/24 **Ratification of Decisions made via Board Circular**

Contract recommendation report for the supply of hearing aids and consumables
The Board received a paper to ratify a decision made by the Board via a Board circular which had been circulated on 26 March 2024 to approve the recommendation to award a contract for 90%+ commitment to Oticon Ltd and up to 10% non-commitment to Phonak UK Ltd which would release benefits that included a recurring cash releasing saving of £19.509 (inc VAT). The reason for the circular was due to the expiry of the contract before the next formal Board meeting in May 2024.

A question was raised on the timing and the following response from procurement was received: *The project unexpectedly took longer to progress as originally the cost coming back for the new agreements was a big cost pressure for the Trust for 2024/25. However, it was still anticipated to meet all Board meetings in April, in line with the expiry of the contract. Unfortunately, procurement's forward look planner did not indicate that April was GWH's board development session. This has now been corrected and all board development days have been captured.*

RESOLVED:
The Board **ratified** the decision made by Board Circular on 26 March 2024 to approve the recommendation to award a contract for 90%+ commitment to Oticon Ltd and up to 10% non-commitment to Phonak UK Ltd which would release benefits that included a recurring cash releasing saving of £19.509 (inc VAT).

020/24 **Register of Board Declaration of Interests**
The Board received a copy of the Register of Interests of the Board of Directors for review, which was received on an annual basis.

Minute	Description	Action
	Amendments to the register were provided and these changes would be recorded on the register by the Company Secretary. **RESOLVED:** The Board **approved** the Register of Board Declaration of Interests, subject to the amendments made at the meeting.	
021/24	**Urgent Public Business (if any)** None.	
022/24	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 6 June 2024 at the DoubleTree by Hilton Hotel, Swindon.	
023/24	**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 12.40hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – June 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**
7 March 2024	267/23	**IPR Quarterly Pillar Metric Deep Dive – Our People** Discrimination experienced by staff to be explored further as part of the deep dive into the staff survey results.	Chief People Officer	Detailed discussion on the EDI Pillar Metric in relation to the correlation between discrimination and retention at the People & Culture Committee meeting on 23 April 2024.

Future Actions				

Report Title	**Staff Story – improving the quality of life of breast cancer patients on endocrine therapy**				
Meeting	**Trust Board**				
Date	**6th June 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Carrie Thompson, Breast Clinical Nurse Specialist				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

A staff story on improving the quality of life of breast cancer patients on endocrine therapy.

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

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A

Do any issues identified in the report affect any of the protected groups less / more favourably than any other?			x
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board to note staff story.	
Accountable Lead Signature	Jude Gray
Date	29.05.2024

IMPROVING THE QUALITY OF LIFE OF BREAST CANCER PATIENTS ON ENDOCRINE THERAPY – Virtual Workshop

Our objective is to support patients to manage the side effects of treatment for the duration of their course. To provide knowledge and expertise via a dedicated service.

Since the creation of the workshop over 150 patients have attended.

Why does this service exist?

A need or 'gap' in the current service was identified. Initially the objective was to reduce the volume of calls directed to the CNS team specifically about their endocrine treatment. It soon became apparent the objective would be to support patients to remain on treatment to reduce the risk of recurrence.

How were the delivery methods chosen?

Survey questionnaires were sent to patients asking them what they wanted the most from the service.

Research was carried out on optimum group numbers, teaching methods and the most common themes/side effects experienced.

A monthly, virtual self-help workshop has now been created with input from the Macmillan Personalised Care Team.

How has the service already evolved?

As well as the monthly workshop, patients are also able to access a 1:1 nurse led clinic appointment. This allows us to plan a more personalised support pathway for the patient.

Referrals can then be made to other appropriate services including psychology, physiotherapy, dietician, wellbeing workshops and support groups.

Patients can be seen as part of a follow up process until the service is no longer required.

Further Service Development

Internal training for CNS team.

Teaching sessions for GPs and practice nurses

NMP qualification to provide a full service to patients.

Coffee morning/support group

Creating educational social media content for the trust.

A Chatbot to answer common queries.

Patient Feedback

"Thank you for raising an unspoken issue" "excellent advice and information" "nice to feel I am not on my own."

"very informative" "I am not looking forward to starting this medication but already feel that issues are very much recognised and supported"

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**6 June 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

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

Assurance Level

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

Process

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

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

Report

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

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

The report provides information in respect of:-

- Council of Governors – Key Meeting Dates
- 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	29 May 2024

Chair's Board Report

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

1. Council of Governors

1.1 Councillor Ray Ballman has been reappointed as Swindon Borough Council governor representative.

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

Date	Event	Purpose
2 May	Trust Board Meeting – Observers	Holding the Non-Executive Directors to account
7 May	Public Health Lecture – Prostate Cancer	Governors host to promote membership
21 May	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
Various	Interviews for Associate Member for Young People	To achieve a broader representation in the Foundation Trust's membership

2. Strengthening Board Oversight & Development

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

Date	Area	Board Member
16 May 2024	Neptune Ward	Steve Haig, Acting Chief Medical Officer Rommel Ravanan, Associate Non-Executive Director
29 May 2024	Emergency Department	Felicity Taylor-Drewe, Chief Operating Officer Lizzie Abderrahim, Non-Executive Director

3. Trust Chair Key Meetings during May 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
Remuneration Committee	Board sub-committee meeting
ICB-AHA Committees in Common	Regular system meeting
AHA Acute Sustainability Workstream	System meeting
BSW Chairs' & Chief Executives' meeting	Regular meeting to update and discuss any topical issues
AHA EPR Joint Committee	System meeting
EPR Joint Committee	System meeting
Q&A Session with Carnell Farrar	System meeting
South West Leading for Improvement Conference	NHSE Event in Exeter
HWB Champions Forum	Network meeting

Report Title	**Chief Executive's Report**				
Meeting	Trust Board				
Date	6 June 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jon Westbrook, Acting Chief Executive				
Report Author	Jon Westbrook, Acting Chief Executive				
Appendices	N/A				

Purpose

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

Assurance Level

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

Board members are asked to note the report

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

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

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

Report

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

The report includes updates on:

- Industrial action
- Care Quality Commission inspection
- Ward accreditation
- Our Integrated Front Door development
- Financial situation
- Infected Blood inquiry
- 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 flexible visiting, which recognises the important role relatives and carers play in patient care. The changes introduced are in line with the Care Quality Commission standard, John's Campaign, which aims to support patients with a dementia diagnosis and NHS England plans for the implementation of Care Partners, which aims to make it clearer who the patient would like to have involved in their care.

The findings of the Infected Blood inquiry are reflected in the report. Over a two-decade period, patients were given infected blood through transfusions, plasma and other blood products, which resulted in individuals being infected with HIV and Hepatitis C.

The report includes an update on the staff survey and the actions the Trust is taking to address some of the key points made by staff. The first of these areas relates to the question 'have you personally experienced discrimination at work from a manager or other colleagues'. The organisation is focusing efforts on driving forwards the equality, diversity and inclusion agenda to provide education to all staff about the challenges being faced and what everyone can do to show support.

Recommendation / Action Required The Board/Committee/Group is requested to:	
To note the report	
Accountable Lead Signature	Jon Westbrook, Acting Chief Executive Officer
Date	30 May 2024

1. Operational updates

1.1. Industrial action

British Medical Association (BMA) junior doctors have a mandate for strike action and action short of strikes until 19 September.

They have not announced any further dates for industrial action, and are currently in talks with the Government. Given the ongoing impact on our patients of strikes, we clearly hope there will be a resolution to this dispute as soon as possible.

The BMA Speciality and Specialist (SAS) Doctors rejected the Government's pay offer. They have a mandate for strikes but have not announced any dates for industrial action yet.

BMA has launched a ballot asking its GP members whether they wish to take collective action to limit the number of patient appointments per day to 25 and refuse to carry out additional work.

A full GP strike has been ruled out as an option at this time. The ballot will open on 17 June and close on 29 July.

1.2. Preparing for the Bank Holiday weekend

We know that Bank Holiday weekends are always very busy operationally and, in the week leading up to the late May Bank Holiday, we prepared for this by holding a number of multi-disciplinary events to help prepare the organisation ahead of an anticipated increase in the number of patients.

On Wednesday 22 May, staff from the hospital joined forces once again with partner agencies from across Bath and North East Somerset, Swindon and Wiltshire, to host a multi-agency discharge event (MADE).

Separately, community services ran an initial pilot community reset week in March which enabled them to make significant improvement to the delivery of care, including:

- Community nursing caseloads reduced by 5.04% (68 patients)
- Following caseload review, 35 visits per week saved by reducing frequency of visits
- Sharing of ideas across all community services that resulted in the introduction of a number of initiatives to improve ways of working.

To further build on this work, community teams undertook 'Community Reset Two', with the aim of taking forward the learning from the first reset week.

There was a focus on multi-disciplinary team review of complex patients with multiple interventions who are known to two or more community services. There was also work to reduce the number of overdue incidents along with gaining further understanding of the pressures felt by colleagues on a daily basis.

2. Quality

2.1. Care Quality Commission inspection

Last month we received an unannounced inspection by the Care Quality Commission.

Inspectors visited a number of wards and departments within the Medicine Division.

The inspection team said how welcomed they felt, how friendly all staff were towards them and commented on the sense of teamwork and pride they saw.

Inspectors felt staff had confidence to make safe decisions in staffing and patient care. This was also reflected in good record-keeping, capacity assessments and end-of-life care.

They also recognised positive training opportunities and support from senior management.

Their key observation related to infection control, with some inappropriate glove use and inconsistent use of personal protective equipment identified.

We expect a draft report back from the CQC in a few weeks' time.

2.2. Ward accreditation

Staff on Falcon, Beech and Teal wards were presented with certificates to recognise their commitment to reaching 'good' as part of our ward accreditation programme.

This programme drives forward patient safety work, by focusing on engaging and empowering staff at every level to improve quality on adult inpatient wards.

Wards are assessed across nine standards aligned to fundamental regulations from the Care Quality Commission and Key Lines of Enquiry.

Each ward is assessed on four key areas; environment, care, leadership and staff and patient feedback.

Following inspection, the wards are then rated as 'requires support', 'good', 'great' or 'outstanding'.

2.3. Flexible visiting

Recognising the important role relatives and carers play in patient care, we have extended visiting hours from 8am-8pm on most wards.

Exceptions include the Acute Cardiac Unit, Emergency Department, Maternity and Neonatal services, the Critical Care Unit and for day case procedures

Changes are in line with the Care Quality Commission standard; John's Campaign, which aims to support patients with a dementia diagnosis; and NHS England plans for the implementation of Care Partners, which aims to make it clearer who the patient would like to have involved in their care

2.4. Open Gym

We have launched a new rehabilitation concept, the Open Gym, which is helping to improve the recovery of patients who have had a stroke.

These patients can attend the gym in the Swindon Intermediate Care Centre at any time of day. Previously, patients would have to wait to be taken for treatment by members of staff.

This initiative has helped increase the amount of time that patients are receiving with therapists, to an average of 85 minutes per day.

3. Systems and Strategy

3.1. Integrated Front Door development

We were pleased to welcome the Lord-Lieutenant of Wiltshire, Mrs Sarah Rose Troughton, and her husband to Great Western Hospital last month. They visited the new Integrated Front Door (IFD) development, along with the Integrated Care Alliance Coordination Centre.

NHS England Chief Strategy Officer Chris Hopson also visited GWH earlier this month as part of a tour of the BSW integrated care system.

Alongside a number of leaders from across our system, he was given a tour around our IFD, following a round-table discussion on the recovery from the pandemic, mental health and primary care.

3.2. Financial situation

The Trust is currently working towards delivering savings of £21.9m in 2024/25.

All divisions and services have been asked to work hard to identity and deliver these savings and try to ensure these are recurrent to reduce our underlying deficit.

One of the ways we are looking to save money is through reducing the use of agency staff, along with not using Bank staff or approving overtime unless absolutely necessary to deliver safe patient care.

Our £5m investment in Safer Staffing means we are no longer as reliant on temporary staff as we once were.

We are committed to ensuring safe levels of staffing on our wards, and we will authorise the use of Bank staff and pay overtime where this is needed. A recent media report suggesting we have banned overtime is simply not true.

Our three-times-a-day staffing meetings enable us to maintain safe staffing levels and we take a flexible approach to staffing wards so that we can fill gaps where they arise.

3.3. NHS England delivery plan

NHS England published its delivery plan for recovering urgent and emergency care in January 2023.

This put focus on improving A&E performance and Category 2 ambulance response times.

Last month NHSE sent a letter and guidance highlighting progress made in 2023/24, setting out actions to support further progress in 2024/25 and providing details of the 2024/25 capital incentive scheme.

The letter restates focus on three areas NHSE believes will deliver the ambition of the recovery plan:

- maintaining capacity expansion
- increasing productivity and improving flow
- continuing to develop out of hospital care

3.4. Infected Blood inquiry

An inquiry report that reviewed the circumstances in which men, women and children treated by national health services in 1970-1991 were given infected blood products, was published last month.

Over the two-decade period, patients were given infected blood through transfusions, plasma and other blood products, which resulted in individuals being infected with HIV and Hepatitis C.

Blood is now distributed to NHS hospitals by NHS Blood and Transplant, which was established in 2005, with all blood products undergoing extremely rigorous testing prior to being administered.

There have been no reported or confirmed cases of Hepatitis C, from any blood component since 1997, and since 2002 for HIV.

The inquiry sought to understand the failings, and the detailed recommendations published will be considered by a clinically-led NHS England task and finish group, with next steps shared as soon as possible.

A new online resource is available for patients and the public to find support services from across the NHS and the Government, and free home testing kits are also available for individuals to test for Hepatitis C. HIV testing is also free of charge on the NHS.

Following the publication of the Inquiry report, and a statement from the Prime Minister, Amanda Pritchard, Chief Executive of NHS England, also shared a statement to offer her condolences to those infected, and their families.

Our organisation was not named in the Inquiry, and has never acted as a haemophilia centre.

4. Workforce, wellbeing and recognition

4.1. Staff survey

After the results of the annual staff survey were published in March, divisional teams across the Trust have been identifying actions to make improvements to care and the working environment following the feedback from staff.

At a Trust-wide level, two key priority areas have also been identified as areas of focus for the organisation, with the two questions receiving a below national average response rate.

The first of these key areas relates to the question ‘have you personally experienced discrimination at work from a manager or other colleagues’ and the organisation is focusing efforts on driving forwards awareness and understanding of equality, diversity and inclusion to provide education to all staff about the challenges being faced and what everyone can do to show support.

The second area of focus for the Trust relates to staff feeling that they receive the respect they deserve from colleagues. A number of actions are looking to improve morale, compassion and civility between colleagues.

Report Title	**Care Quality Commission Unannounced Inspection of Medical Care in May 2024**				
Meeting	**Trust Board**				
Date	**6th June 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek Chief Nurse				
Report Author	Luisa Goddard Deputy Chief Nurse				
Appendices	CQC Assessment of Medical Care letter dated 17th May 2024				

Purpose

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

Assurance Level

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

Substantial		Good	X	Partial		Limited	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

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

Report

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

The Trust received an unannounced assessment of medical care on the 16th May 2024. The inspection was under the CQC's new single assessment framework. The assessment was triggered because of a concern or risk although the exact nature of this has not been made explicit by CQC.

The Trust received notice of the assessment at 8am on the 16th May and the inspectors were on site shortly afterwards. 3 medical ward areas were assessed and one surgical ward area in the context of assessing the care of the medical patients who are outlied there.

The assessment included 4 key questions from the single assessment framework; safe, effective, caring and responsive. Well led was not being assessed although one quality statement was included under the well led domain.

High level findings were fed back at the end of the day on the 16th and a feedback letter was received detailing the initial findings on the 21st May 2024 (dated the 17th May 2024).

An overview of the CQC Initial Feedback

- The CQC saw teams of proud, dedicated staff who spoke of supportive systems and teams within the hospital. Leaders were proud of their teams on wards, and staff spoke highly of the skill and support of ward managers.
- Records showed good practice around safeguarding and mental capacity assessments. Pain management was well recorded and reviewed often.
- All patients the CQC spoke with gave positive feedback.

- The CQC observed good end of life care and heard of staff going over and above to support the wedding of a patient on one of the wards.

Areas for improvement

- Staff did not always follow infection control principles, particularly around hand hygiene and PPE. CQC found cleaning chemicals in sluices which should either have been locked away or not stored there. This has been actioned.
- Staff knowledge of tools, skills and resources to support patients with communication needs was limited.
- Staff on surgical wards, who were supporting medical outlier patients, told CQC access to medical overview, particularly when discharge planning was difficult.
- Patient records on some wards were not always stored securely. The CQC observed cabinets which were open, broken / would not lock, and nursing notes being kept on the wall rails in the main corridors of wards.

Next Steps

The Trust has until the 31st May 2024 to submit the data requests, there are 30 requests under the key question of Safe, 1 under effective and 2 under responsive. There is a robust sign off process by the Division and Chief Nurse prior to the data being submitted.

A follow up interview has been arranged with the Lead Assessor and the Associate Director of Infection Control.

Once these elements are completed the CQC will send the Trust a draft report for factual accuracy checking, once completed the report is then published. The CQC work to an approximate timescale of 65 days from assessment to publication.

Immediate actions
Following the initial feedback an action plan has been developed to include the 4 areas of concern. In addition, the following immediate actions were undertaken.

Infection control
Immediate review of sluices to ensure no unnecessary items were stored in the sluice. Immediate action to ensure all chemicals (actichor) were stored in locked cupboards in the sluice.

As an immediate action to improve hand hygiene all clinical staff will be asked to watch a short animated video produced jointly by the Healthcare Infection Society and the Infection Prevention Society, with support from NHSE's behavioural insights team. https://youtu.be/HVr3aWs6Bas The Infection control team and the clinical practice educators will support with ward based training and using IPADS to watch the video. The Trust communications team have been asked to also support and ensure the message about effective challenge of incorrect practice. The IPC mandatory training is being updated and will include this going forward.

Other actions over the next month include asking the new hand sanitiser supplier to support with training, and other industry suppliers also supporting on site training on good hand hygiene. There are also plans to improve the internal hand hygiene audit to ensure it is using the observational data effectively.

Resources to support patients with communication needs
The Associate Director of AHPs is working with the Speech and Language Therapists to ensure ward staff know what communication aids are available and where to access them as well as ensuring patients who require complex communication support are referred appropriately.

Health care records
As an immediate action a SWIFT safety notice has been circulated to remind staff to store health care records in locked cabinets. A working group will be arranged to look at safe storage of health care records and ensure there is a consistent SOP Trust wide.

Supporting medical outlier patients
This will be partly addressed through the bed reconfiguration plan which was presented to Trust Management Committee in May 2024. However, as an immediate action surgical wards have been encouraged to escalate any delays or difficulties in accessing medical teams to the duty 'silver' manager of the day and the medical teams have been reminded of the importance of planning ahead to ensure discharge summaries are completed in a timely manner.

The upcoming changes to the electronic discharge summary will also help by making the process easier and quicker to use.

Action Plan

The CQC action plan will be monitored through the divisional governance, CQC preparedness meeting and the Patient Quality sub committee. A Trust Management Committee away day is planned for June where CQC well led will be a focus for development as well as learning from this assessment and the Maternity assessment in September 23.

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**
	2367 CQC Inspection Rating with the potential for subsequent enforcement action (special measures / service closures) for areas of noncompliance (Safety & Responsiveness) and the potential for reputational damage; financial impact (contractual and regulatory fines); loss of patient confidence; difficulty in recruiting and maintaining staff; and staff morale				12
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:	
To note the update on the CQC assessment of Medical Care.	
Accountable Lead Signature	
Date	30 May 2024

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**6th June 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Lisa Cheek, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Robert Presland – Deputy Chief Operating Officer 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 April (March for Cancer) are as follows:

Critical Incident

It should be noted that the Trust declared a critical incident running from Monday 1st April to Wednesday 3rd April, reducing to a business continuity event that ended on Thursday 4th April 2024.

The incident was declared following a surge in demand over the March Easter weekend with a corresponding loss in physical bed capacity. This was the result of building works commencing in ED majors, infection prevention and control restrictions on two Medicine wards, and scheduled building works affecting 4 x stroke beds on Falcon ward. This resulted in several extended delays in offloading ambulances during the bank holiday weekend.

An incident debrief has been completed with key learning summarised as follows:

- A review of the Trust escalation policy, including criteria for stepping up- and down- from a flow-related incident, and the temporary use of empty beds in ring-fenced elective areas during periods of surge
- A review of rotas to ensure both clinical and managerial experience for weekends and out of hours periods where flow is expected to be challenging
- Specific actions to increase resilience of the community falls service at weekends and criteria for accessing home first discharge support within ED
- A review of criteria to enable medical review of patients who have not been offloaded from ambulances for a prolonged period (> 6 hours) to improve patient safety and progress diagnostics and treatment whilst still under the care of the ambulance service.

STRATEGIC PILLAR METRICS

- RTT (Referral to Treatment) 52 Week Waiters

April performance shows the total number of patients waiting over 52 weeks at 1,859, a 2% reduction from the previous month.

Our operating plan is to focus on reducing the size of the waiting list tail by eliminating 65 week wait breaches by the end of September. At the end of April, there were 175 x 65 week wait breaches, with high-risk areas in Gastroenterology, General Surgery, Urology, T&O and Neurology. The Trust also reported 3 x 78 week wait breaches, all under the Gastroenterology specialty and within non-admitted referral to treatment pathways (2 patients due to complexity and 1 due to capacity).

Performance trajectories and delivery plans with mitigations for clock stops to meet the desired run rate are being reviewed at fortnightly Divisional escalation meetings. Part of the strategy to meet the run rate requirement will be to revisit options for removals from the wait list for reasons other than treatment. This includes extended patient tracking list (PTL) meetings for specialties at greatest risk with intensive support from the RTT validation team, implementation and training on the revised Trust Access policy to ensure RTT rules are being applied consistently and in line with national best practice. Additionally, a clinically led review of long waiting routine patients who may be appropriate to be seen through NHS commissioned activity via the independent sector or by other system partners where waiting times are better.

It should also be noted that following the release of operating planning guidance, the pillar metric for 52 weeks will be reviewed and considered being set at 65 weeks instead.

- Cancer waiting times

At the end of April there were 105 patients waiting >62 days on the PTL, which was 5.4% of the overall PTL size and below the national target of 6.8%.

However, whilst the PTL is being managed within nationally set thresholds, validated March performance for 62-day cancer dropped to 66.7%, and therefore remains well below the national standard of 85%. Skin, Colorectal and Urology cancer pathways remain most challenged, with high demand and tumour site related capacity constraints such as Breast where additional waiting list initiatives have been funded to cover consultant radiologist vacancies for one stop shop clinics.

Validated March performance against the 28-day Faster Diagnosis standard (FDS) was 71.3% and this is expected to hold at a similar level by the end of April, as the impact of outsourcing Dermatology activity continues to support the reported position. Sustainability of our FDS performance remains a significant risk going into 24/25, predominantly due to outpatient capacity constraints against a backdrop of referrals running above pre-pandemic levels.

Validated February performance against the 31-day decision to treatment standard remains below the 96% national standard, currently at 89%.

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

The mean stay in the UTC was at 170 minutes in April, which remains elevated above the mean despite a 5% reduction in attendances compared to the previous month. There were 5,673 UTC attendances against the plan of 5,508 (3% above plan). The mean stay in ED remains remained broadly in line with the mean, with attendances close to plan for the month.

4-hour performance was 75.9% against the operating plan target of 78%. This is an improvement of 1.5 percentage points from the previous month. Increases in Type 3 UTC demand and the deterioration in mean stay continue to impact on delivering the 78% target. Work continues with a whole hospital focus on 4-hour performance to improve patient experience and mitigations to stream patients away from the UTC including a post-operative wound care clinic that has proven to be successful. Further work is underway to review UTC demand and conversations have commenced with primary care to support further streaming and redirection. A priority action for Medicine is also to review staffing for the UTC to match peaks in demand, with work ongoing to embed senior decision making in ED, next day appointments in SDEC (Same Day Emergency Care) and ensure specialty support for patients in ED that are clinically ready to proceed.

- Inpatient spells - No Criteria to Reside Bed Days

The number of bed days lost for patients with no criteria to reside (NCTR) remains within control limits with April averaging 83 patients per day. There were 18.6% of beds occupied against the national standard of 13.3% and operating plan target of 10%, which is unchanged from the previous month. 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. Nationally mandated changes to recording of no criteria to reside have also been announced for implementation before the summer.

OPERATIONAL BREAKTHROUGH OBJECTIVE

- Ambulance handover delays

Urgent & Emergency Care (UEC) services have been under significant pressure during the month. This has resulted in patients facing long waits in an ambulance, in an emergency department and on wards before being discharged home and, at times of heightened pressure, being cared for in an inappropriate environment. There are several contributory issues – multiple points of entry; high bed occupancy; and variation in pathways, processes and how we manage flow. If we do not address these issues through delivery of a comprehensive and timely UEC recovery programme, our patients will continue to experience access or response delays at several points across the health system, increasing the risk of patients coming to harm or having a poor experience.

April performance showed 3,613 hours were lost due to ambulance handover delays, with 1,132 hours lost during the week ending 22nd April alone which was the highest weekly reported delay in the last 12 months.

A deep dive of April flow metrics is underway to understand the root cause of special cause variation in ambulance handover delays, and this is being included within the new ambulance handover breakthrough objective A3. Initial analysis shows that April is unlikely to be a demand led problem, with overall conveyances and general ED attendances down from the previous month. Bed days lost due to no criteria to reside also remained within control limits.

Trust average length of stay for non-elective inpatients did however increase by an additional day to 5 days in April, with bed occupancy remaining high at 98.3%. April was also the first month of operating with a combined total of 13 less majors cubicle spaces in ED. This planned closure of majors step down was to allow building works to commence for the new ED opening in July 2024, at which point there will be an additional 2 x Resus spaces and 4 x Majors cubicles available to the current ED footprint.

This suggests that our improvement actions should continue to focus on internal improvement work to reduce bed occupancy and process delays via the UEC transformation programme which is currently being mobilised in response.

ALERTING WATCH METRICS

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

- Diagnostics – Unvalidated April performance shows the overall waiting list increased by 3.7% from the previous month with activity reducing across the majority of modalities compared to the previous month. April performance against the 6 weeks wait standard deteriorated to 60.73% (unvalidated), compared to 66.37% in the previous month. Recovery towards the 99% constitutional standard (above our operating plan) remains dependent on reducing the size of the NOUS backlog (64% of 6 week breaches) and also a sustainable improvement plan for endoscopy which remains below plan.
- Virtual ward occupancy – was at 78% in April for Swindon, above the mean threshold of 64.1%. Occupancy reached over 75% in the lead up to the Easter weekend, but sustaining higher occupancy continues to be a challenge. An improvement plan is in place and is dependent upon improved referral processes, case finding across the front door and base wards, a review of virtual ward medical model and a campaign to increase referrals from primary care. Pathways are also being reconfigured across the Bath, Swindon and Wiltshire footprint to standardise processes and increase primary care utilisation.

Our Care

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

Strategic Pillar Targets

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

The total number of harms in April has dropped to 175 (from 186 in March). This is third month in a row that has seen a reduction. There has been a reduction in hospital acquired pressure ulcers (21 in April from 41 in March) and small reductions in E.coli and C.diff.

The number of Family and Friends (FFT) positive responses for April was 88.1%, an increase from February and remains above the internal target. The target for 2024 /25 has been increased to 90%.

Breakthrough Objectives

The Breakthrough Objective for 2024/25 has changed from reducing harm associated with pressure ulcers to reducing harm from inpatient falls. This is to make improvements in the number of patients that are experiencing moderate harm and above related to falls whilst in our care, especially those that have more than 1 fall.

The aims for 2024/2025

- 80% of all patients admitted to hospital have a multi factorial falls risk assessment and individualised risk reduction actions.
- Reduce the total number of inpatient falls by 10%
- Reduce the number of patients with more than 1 inpatient fall by 5%

In April 6 patients had moderate harm or above from an inpatient fall, including 1 patient that had a sub dural hemorrhage and 1 patient that had a fractured hip. Investigations are ongoing and the learning will feed into the improvement group, although initial review suggest no new themes have been identified.

Alerting Watch Metrics

There has been a slightly improvement in the complaint response rate to 70% in April (65% in March). The total number of complaints received remains high, with 79 received in April. The main themes relate to communication, waiting times and aspects of care relating to operational pressures. Remedial actions continue with the divisions and corporate teams to improve the position.

NHS England have yet to set trajectories for infections in 2024/25. Our numbers of *E. coli* infection have been declining each month since January 2024. After three months of unusually low numbers of *Klebsiella* infections (zero), four were seen in April. Four *Pseudomonas* infections were also seen; all of these were community-onset cases but counted as healthcare-associated due to the patients having been patients at GWH in the preceding 28 days. *C. diff* numbers have been lower in April than in most months of 2023/24, however this is likely to be a random fluctuation rather than an indication of reduced prevalence.

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

- Safer staffing fill rates remain above the National target of 85%.
- 1 Patient Safety Incident Investigation (previous Serious Incident or SI) has been declared in April. Ther are 19 ongoing Patient Safety Incident Investigations with 9 overdue. Work is also ongoing to ensure that actions from previous investigations are closed in a timely manner.
- There have been one Methicillin Sensitive Staphylococcus Aureus (MSSA) infection reported in month.

Harm from Pressure Ulcers
The number of hospital-acquired pressure ulcers continues on a slight downward trajectory even though there have been improvements in reporting. All cases are discussed weekly at a tri-divisional meeting to identify and share learning in a timely way.

In April there were 22 hospital acquired harms, 20 category 2, 1 category 3 and 1 category 4. Only 1 harm was noted from a patient's heel, reflecting the work on checking heels and off loading.

The main contributors were Neptune (4), Trauma (3) and Mercury (3) and additional support is in place. The Chief Nurse handed out pressure ulcer improvement awards for ED, MEU, Theatres, and Critical Care.

Community harms increased by 7 this month to 32 (25 in March) this is related to 8 patients with complex health needs. There were also 4 device related harms.

Our People

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

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

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

- **Staff Survey – Recommend a Place to Work**
  Target 55% achieving 59.6% (2023 Annual Survey) and 55.9% Q4 Pulse Survey, 55.8% Q1 Pulse Survey.
- **Staff Voluntary Turnover**
  Target 11% achieving 8.4% (January data)
- **EDI disparity (reducing discrimination disparity)**
  Target 9.4% achieving 12.7% (2023 Annual Survey) and 15.9% Q4 Pulse Survey), and 13% Q1 Pulse Survey

A marked improvement to our score for "Recommend as a Place to Work" has been seen in the 2023 Annual Survey results however recently pulse survey has shown a decline in this question.

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 Trust current performance is 70% and the national average is 71%. The stretched target the Trust has set itself of 73%.

The Trust achieved a small improvement in the question for the Pulse Survey Q1 (70.70%)

Alerting Watch Metrics
In-month sickness absence decreased again in March to 4.1%. Whilst we are still reporting above the Trust target of 3.5% absence remains below levels last year (4.6%). Short term sickness has increased slightly to 2.2% and long-term sickness has decreased to 1.9%.

The most recent national benchmarking data (December 2023) shows a similar trend with National, Regional, and ICB rates all reducing. For November 2023 we remained in the second lowest quartile for Acute trusts, 40th out of 133 Trusts.

HR Scorecard
Vacancy Rate:
Establishment in month 1 has removed stable, however due to turnover vacancy levels have increased from 213wte to 227wte. An important achievement is vacancy of less than 5wte for registered nursing, however unregistered nursing vacancy has slightly increased. The Trust is reviewing plans to improve this position before next winter.

Workforce Recovery

In M1, 5,562WTE was used to deliver our services against a planned figure of 5,667WTE. This represents an over-delivery against plan of 104WTE which was largely driven by reductions in Temporary Staffing.

A project plan has been developed to support the Workforce Recovery programme, outlining key actions which can be taken to support headcount reductions phased depending on our current variance to the planned WTE levels. Initial actions focus on overtime controls and reviewing fixed term contracts, with the review of MAR / Voluntary Redundancy schemes outlined from August if we are above plan.

Use of Resources
The Trust has started the 24/25 financial year with a £3.4m deficit position, which represents a £1.8m adverse variance to plan.

Income is £0.7m adverse to plan, driven by an underperformance on our ERF target (£0.7m). Of this, £0.4m represents a shortfall against the latest ERF activity plan, and £0.3m a further gap to our stretch target. While pay is £0.4m favourable to plan, undelivered efficiency savings are £0.4m adverse. Medical & dental costs are £0.4m overspent due to the ongoing use of temporary staffing to fill junior doctor shifts in the Emergency Department and General Medicine areas. These are offset by a favourable position in nursing. Temporary staffing costs (bank & agency) have reduced by £0.4m from M12 and are £0.3m lower than the 23/24 average. Nursing lines also hold a number of centrally-held reserves (e.g. maternity / paternity

leave), which will be used to support divisional pay positions throughout the year. Non-pay is £1.5m overspent in M1. Clinical supplies are £0.8m overspent, driven by CDC related costs. Drug costs, specifically passthrough-related costs, were £0.7m over plan, while other expenses were £0.2m adverse due to a shortfall in efficiency savings. Offsetting favourable variances totalling £0.2m were interest receivable, outsourcing and PFI operating expenses.

The efficiency target for 24/25 is £21.9m. As at M1, actual delivery was £0.7m, and therefore £0.6m under plan. 55% of the £0.7m delivered is recurrent. All divisions and services must work hard to increase overall savings to hit the £21.9m target, and more specifically to ensure the savings are recurrent to reduce the underlying deficit. Key to the delivery of savings is to become more productive by maximising activity and related ERF income. The Trust is already falling short of its ERF target by £0.7m at M1. Divisions and services must also focus on reducing pay spend throughout 24/25. The target is to reduce the number of headcount working in the Trust by 273 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, while continuing with the good work already in place which has resulted in run rate reductions on temporary staffing, specifically in nursing.

Breakthrough Objectives
While implied productivity will remain within the metrics of the financial recovery breakthrough objective, the overall A3 is being reworked and the refreshed BTO is described as "To remain within our overall deficit plan by month for 24/25, having improved the underlying financial deficit position by the financial year end through delivery of recurrent CIP."

This means that the Trust needs to meet its overall planned deficit of c.£7.1m (PFI UK GAAP adjusted deficit £13.4m) and deliver as much of its £21.9m efficiency target as possible on a recurrent basis.

The team are working through the root cause analysis and countermeasures, in order to start on additional actions not already captured through other financial recovery workstreams.

Month 1 is off-track, with £1.8m adverse to plan and £0.6m behind plan on efficiencies. To date, 55% of the efficiencies delivered are recurrent, meaning 45% will roll forward to 2025/26, increasing our underlying deficit.

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	29.05.24

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

May 2024

April 2024 & March 2024 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Total patients waiting more than 65 weeks	0	640	621	689	661	488	417	343	330	267	82	175
Percentage of patients who receive a diagnostic test within six weeks of referral	99% (Nat)	52.2%	49.4%	44.5%	46.1%	45.0%	49.5%	46.8%	49.3%	59.8%	66.4%	Reported one month behind
62 day backlog (As % of allocated "Fair shares" position)	9.53% (Nat)	148.4%	156.0%	180.3%	200.4%	178.6%	181.1%	145.9%	109.8%	120.7%	90.6%	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	65.0%	67.2%	62.6%	62.0%	58.2%	59.7%	60.4%	60.2%	70.5%	71.3%	Reported one month behind
Proportion of patients seen within four hours	95% (Nat)	73.8%	75.5%	74.2%	74.7%	71.5%	71.4%	74.7%	73.5%	71.1%	74.4%	75.9%
Ambulance average Category Two response time	00:18:00 (Nat)	00:51:09	00:47:12	00:28:22	00:57:11	01:03:52	00:52:16	00:49:02	00:49:39	00:51:11	Waiting for data	Waiting for data
Percentage of beds occupied by patients who no longer meet the criteria to reside	13.3% (Nat)	17.8%	17.2%	14.3%	15.8%	17.4%	18.1%	17.8%	17.8%	17.6%	18.6%	18.1%
Adult general and acute type 1 bed occupancy (adjusted for void beds)	94.5% (Nat)	98.2%	97.6%	98.2%	98.7%	98.8%	98.5%	96.3%	98.6%	98.8%	97.7%	98.3%
Virtual ward - percentage capacity occupied	64.1%	28.5%	53.7%	44.4%	53.8%	65.1%	70.8%	78.4%	84.8%	78.0%	61.0%	78.0%
Summary Hospital-level Mortality Indicator	0 (Nat)	2 - as expected	2 - as expected	2 - as expected	2 - as expected	3 - as expected	4 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
National Patient Safety Alerts not completed by deadline	0 (Nat)	0	0	0	0	0	0	0	0	0	0	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection	0 (Nat)	3	4	4	4	3	3	4	3	3	Reported two month behind	Reported two month behind
Clostridium difficile infection	100% (Nat)	139.1%	152.2%	156.5%	154.4%	169.6%	158.7%	173.9%	184.8%	191.3%	Reported two month behind	Reported two month behind
E. coli bloodstream infection	100% (Nat)	163.6%	168.2%	162.1%	165.2%	174.2%	171.2%	169.7%	163.6%	163.6%	Reported two month behind	Reported two month behind
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Leaver rate	11.0% (Int)	10.2%	9.7%	9.6%	9.5%	9.2%	9.2%	8.9%	8.6%	8.6%	8.4%	Reported one month behind
Sickness absence rate	3.5% (Int)	3.8%	4.4%	4.0%	4.2%	4.7%	4.7%	5.0%	4.9%	4.4%	4.1%	Reported one month behind

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	6.7%	5.3%	5.3%	5.3%	5.3%	5.4%	5.4%	3.5%	3.5%	3.5%	Reported one month behind
Proportion of staff in senior leadership roles who are women	64% (Nat)	56.0%	56.1%	56.1%	56.1%	56.1%	56.9%	57.1%	56.1%	56.1%	56.1%	Reported one month behind
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%
Financial efficiency - variance from efficiency plan (£'000)	+/-	334	-641	-338	-504	-39	478	-224	183	-415	-286	-79300.0%
Financial stability - variance from break-even (£'000)	+/-	-144	-659	330	-1352	1996	5043	-1877	-1911	4028	150	-339000.0%
Financial stability - variance from PLAN (£'000)	+/-	-223	-733	-528	-1646	1334	4489	-1204	-2417	3907	150	-234600.0%

Measure Name	Mean	2017	2018	2019	2020	2021	2022	2023
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	6.7	6.9
Staff survey engagement theme score	6.9	6.9	6.9	7.0	7.0	6.7	6.7	6.9
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.9%	-	-	60.4%	57.1%	56.1%	56.4%	56.5%
Stillbirths per 1,000 total births	2.3	-	2.4	1.9	2.1	2.8	Waiting for data	Waiting for data
Neonatal deaths per 1,000 total live births	1.2	-	1.4	1.0	1.0	1.3	Waiting for data	Waiting for data

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Total Harms

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

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

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.

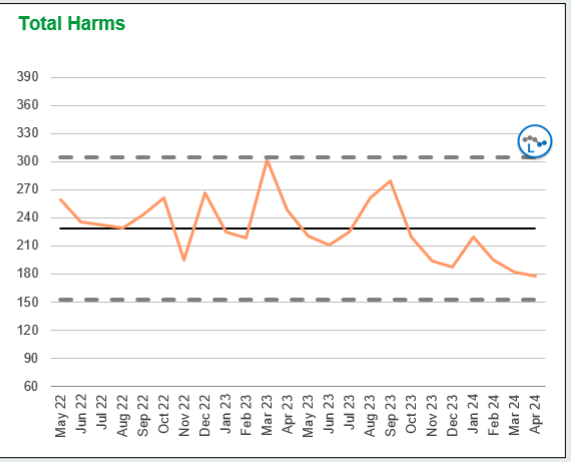
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

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

Total Harms

To achieve and sustain zero avoidable harm.

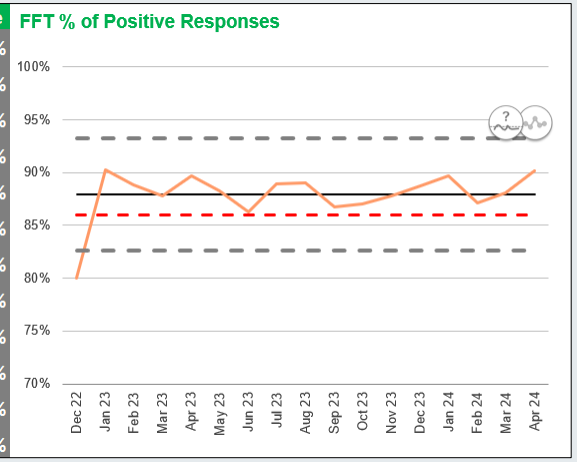
Timescale	Value
May 23	221
Jun 23	211
Jul 23	225
Aug 23	261
Sep 23	279
Oct 23	219
Nov 23	194
Dec 23	187
Jan 24	219
Feb 24	195
Mar 24	182
Apr 24	178



Patient Experience (Friends & Family Test)

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

Timescale	Value
May 23	88.3%
Jun 23	86.3%
Jul 23	88.9%
Aug 23	89.1%
Sep 23	86.7%
Oct 23	87.1%
Nov 23	87.8%
Dec 23	88.8%
Jan 24	89.7%
Feb 24	87.2%
Mar 24	88.1%
Apr 24	90.2%



Counter Measures

The total number of harms in April has dropped to 175 (from 186 in March). This is third month in a row that has seen a reduction. There has been a reduction in hospital acquired pressure ulcers (21 in April from 41 in March) and small reductions in E.coli and C.diff.

The Breakthrough Objective for 2024/25 has changed from reducing harm associated with pressure ulcers to reducing harm from inpatient falls. This is to make improvements in the number of patients that are experiencing moderate harm and above related to falls whilst in our care, especially those that have more than 1 fall in hospital.

For April, the Trust wide positive Family and Friends score was 90.2%, the first time a score over 90% has been achieved. The target for 2024 /25 is being reviewed to ensure there is a stretch target.
The new flexible visiting charter has been launched across the Trust to support friends, families and carers and in line with the new CQC standard.
A positive care reflection was presented to Trust Board following the experience of a patient with Parkinsons disease and the service they received.
In line with the national campaign 'Call for Concern' was launched seeking to empower relatives, friends and carers to speak up if they are concerns about a patient. Friends and families are more likely to notice changes in health or spot early signs of deterioration.

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

Cancer 62-day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In March, there were 56.0 breaches in total, with 33.0 of these attributed to the Urology, Colorectal and Skin pathways. There are capacity issues within a number of sites including Colorectal, Skin and Urology.

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 is due to replace TRUS biopsy in Radiology for most cases, capacity for which is currently insufficient to meet demand.
Patient thinking time in respect of treatment options in the Prostate pathway impacts performance too.

RTT: Number of patients waiting over 52 weeks

April 2024 performance shows the total number of patients waiting over 65 weeks at 175, an increase of 93 from the previous month.

3 Gastroenterology patients above 78 weeks were reported in April 2024, all non-admitted patients. 2 Of these patients breached 78 weeks due to complexity, and 1 due to capacity.

All services are focussing on eliminating waits over 65 weeks as soon as possible and by September 2024 at the latest, with zero tolerance of 78-week breaches, in line with 2024/25 priorities and operational planning guidance.

High risk areas where capacity breaches are possible include Gastroenterology, General Surgery, Urology, Trauma and Orthopaedics and Neurology. Actions required to meet the commitment of September are being shared and reviewed with corporate colleagues supporting Divisions to agree mitigations and escalate areas with stretched capacity.

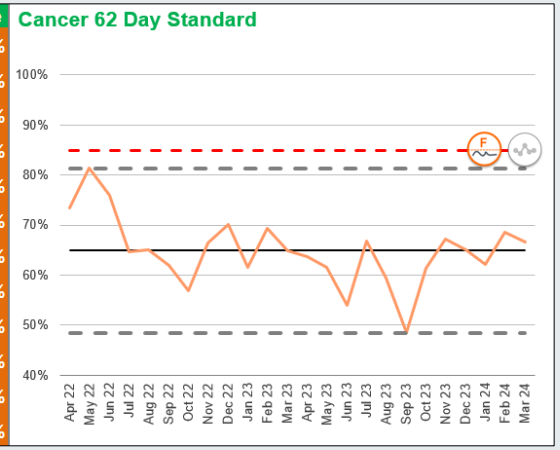
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

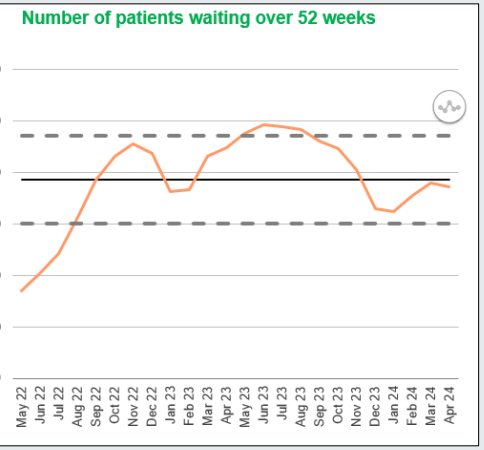
Timescale	Value
Apr 23	63.8%
May 23	61.5%
Jun 23	54.0%
Jul 23	66.9%
Aug 23	59.5%
Sep 23	48.5%
Oct 23	61.3%
Nov 23	67.2%
Dec 23	65.0%
Jan 24	62.2%
Feb 24	68.6%
Mar 24	66.7%



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
May 23	2,385
Jun 23	2,469
Jul 23	2,448
Aug 23	2,418
Sep 23	2,307
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



Counter Measures

Risk: Dermatology capacity had been impacted by vacancies and increase in referrals.
Mitigations:
-Recruitment of substantive Consultant continues.
-TVCA funding assisting with External provider for next 12 months, providing an additional 1800 first OPA and 800 MOPs
Risk: Capacity in **Plastics** is insufficient to see and treat patients (OUH unable to meet 9.5 PA clinics since Nove/Dec 23)
Mitigation:
-Eligible Plastic patients are being sent to Wootton Bassett
-OUH locum due to start 17 May for 3 PAs per week
-Increase in SLA with OUH from 9.5 to 16.5 PAs per week approved
Risk: Urology Pathways are impacted by delays in Radiology & Theatres (capacity & vacancies)
Mitigation:
-Pathway improvement manager is working with service to implement the best practice timed pathway in Prostate & Bladder
-Funding bid for mobile LATP submitted to TVCA
Risk: Capacity issues for **Colorectal** 2ww triage, post diagnostic reviews and appointments after MDT are an issue.
Mitigation:
-GP STT booking project underway
-Close management of Registrar rota's with Consultant input to allow triage to happen. Registrar clinics in place to aid outpatient capacity for first appointment and MDT slots are allocated to clinics

Risk: Insufficient capacity to eliminate waits over 65 weeks as soon as possible and by September 2024 at 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 month to work through cohort and increase clock stop run rate.

Risk: Reduced capacity due to the proposed industrial action across multiple staff groups.
Mitigation:
- All elective activity on proposed strike days reviewed. Maximum clinical sessions running where staffing allows.
- Patient impact assessed and alternative sessions to be provided. Long waiting and cancer patients prioritised.
- Long waiting and cancer patients to be brought forward to reduce the risk of cancellation.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency 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 March'24 was 398 minutes against the national standard of 240 minutes. This is a reduction from March 24, below mean levels (460mins) .

Emergency Care – Urgent Treatment Centre - Mean Stay

There has been a decline in Mean Stay in UTC following peaks in Feb/March. This is reflected in the 5% decrease rise in attendances in UTC this month compared to March.

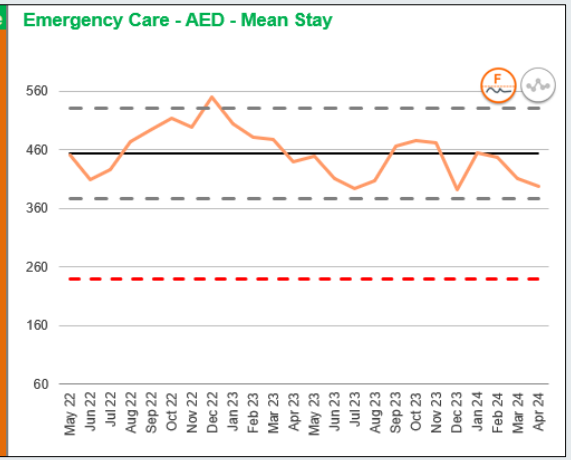
The total meantime wait for a patient in March 24 was 170 minutes against the national standard of 240 minutes. This is a clear rise in mean time which could be explained by increasing numbers of patients accessing UTC on Sunday, Monday and Tuesday.

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.

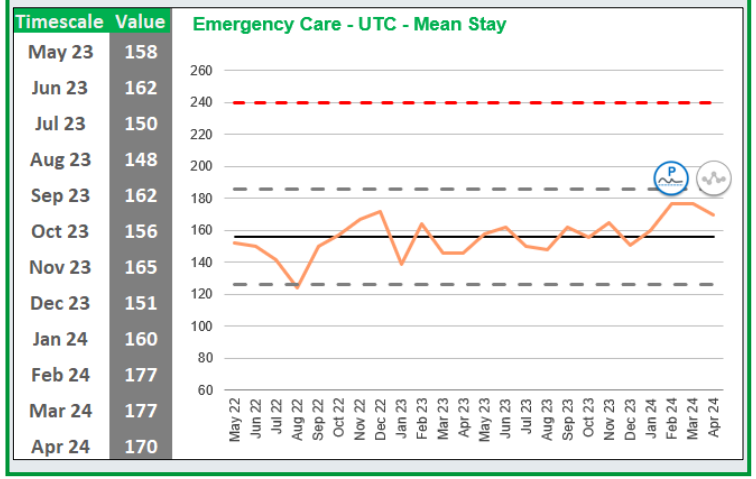
Timescale	Value
May 23	448
Jun 23	410
Jul 23	393
Aug 23	407
Sep 23	466
Oct 23	475
Nov 23	471
Dec 23	391
Jan 24	455
Feb 24	447
Mar 24	410
Apr 24	398



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
May 23	158
Jun 23	162
Jul 23	150
Aug 23	148
Sep 23	162
Oct 23	156
Nov 23	165
Dec 23	151
Jan 24	160
Feb 24	177
Mar 24	177
Apr 24	170



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.
- 4 hour Improvement Plan – focusing on breach chasing,
- 2 EPIC trial prior to IFD implementation giving great senior decision making cover across Chairs.

- 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
- Plan to increase Nursing levels to support triage/4 hour performance

Executive Summary

NHS
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).

March has seen a significant rise in attendances month in both ED & UTC with 10,885 patients seen in month down from 11,461 in March.

This is reflected in the 5% decrease in attendances in both ED and UTC this month compared to March.

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

April saw a slight increase in **NCTR from 80 to 83** running average on the day compared to March. Average discharges per day for April were 99.6 per day which is **25.8%** over the predicted discharges.
Over 21 days LoS was an average of 43 patients, which is a slight increase on March –however it dropped to 22 patients at its lowest over the month.

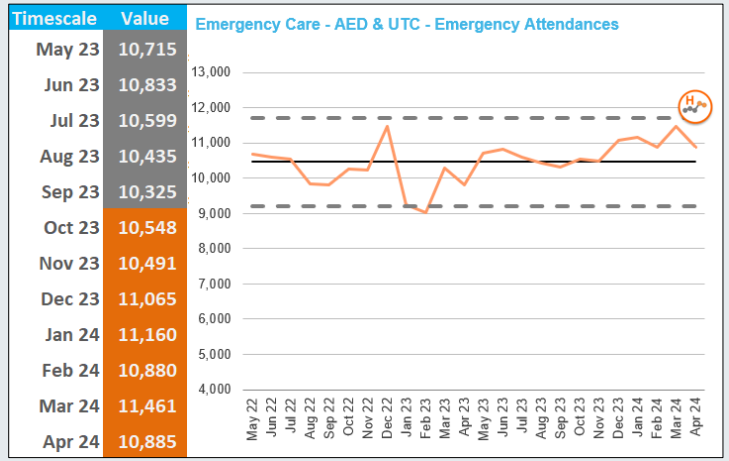
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

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

To ensure patients are cared for in the appropriate setting

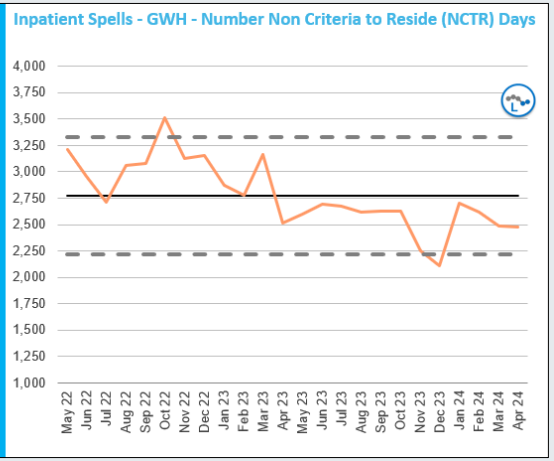
Timescale	Value
May 23	10,715
Jun 23	10,833
Jul 23	10,599
Aug 23	10,435
Sep 23	10,325
Oct 23	10,548
Nov 23	10,491
Dec 23	11,065
Jan 24	11,160
Feb 24	10,880
Mar 24	11,461
Apr 24	10,885



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
May 23	2,599
Jun 23	2,694
Jul 23	2,675
Aug 23	2,614
Sep 23	2,631
Oct 23	2,625
Nov 23	2,251
Dec 23	2,106
Jan 24	2,703
Feb 24	2,615
Mar 24	2,484
Apr 24	2,474



Counter Measures

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

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

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

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

Faster Flow initiative continued throughout February and has now been formalised in to work stream feeding into the 'Greater Flow Committee'. Actions within the Admitted Flow work stream include:

Opportunities:

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

Reflections:

- Standardising discharge processes including discharge summaries and medicine to take away.
- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Discharge Reg support was the highest on record with an increase of **39%** in weekend discharges – **this has been adhoc over April as this was winter funded.**

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

The Trust is continuing the downward trend seen in its voluntary turnover rate from July 2022, with the position in March reducing to 8.4%. Performance below the 11% target has been sustained for 12 months, with the voluntary turnover rate returning near to the level before this metric started increasing in March 2021. Performance continues to be maintained through the Trust Retention Working Group, with countermeasures being refined to focus on leavers within the first year of employment.

Staff Recommendation as a Place to Work
The Trust recommend a place to work target is 58% which is in line with the National Average for 2022 staff survey results. In 2023 the Trust achieved 60% performance and the national results also improved to 61%. Therefore, the new stretched 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 in Q4 and Q1 on recommending a place to work to 55.8% compared to Q4 which was 55.9%

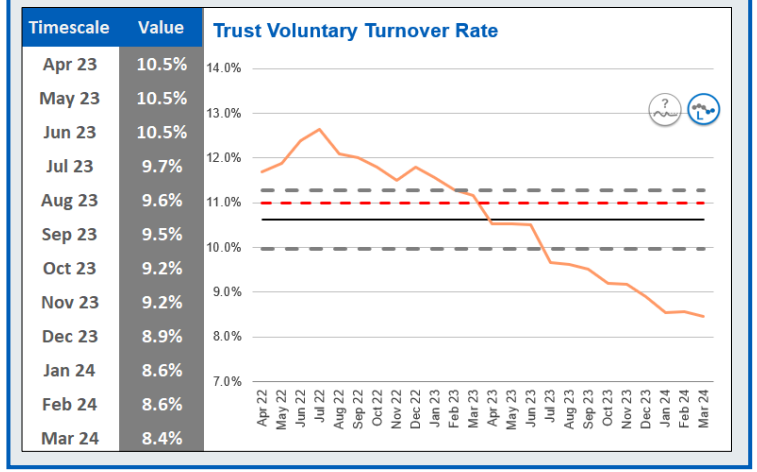
Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

Trust Voluntary Turnover Rate

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

Timescale	Value
Apr 23	10.5%
May 23	10.5%
Jun 23	10.5%
Jul 23	9.7%
Aug 23	9.6%
Sep 23	9.5%
Oct 23	9.2%
Nov 23	9.2%
Dec 23	8.9%
Jan 24	8.6%
Feb 24	8.6%
Mar 24	8.4%



Staff % recommend the organisation as a place to work

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

Counter Measures

- Voluntary turnover has decreased further in March to 8.4%. This shows sustained performance of this metric.
- The People Promise Manager post commenced from 8th April. The 30-day diagnostic has been completed and a draft report is progress. Initial findings indicate:
  - Focus on new starters in first 12 months of employment
  - Importance of the role of the line manager during the keeping walm/induction stages
  - Stronger intelligence on why people leave
  - Talent management when lack of promotion opportunities at GWH
- It should be noted that whilst we have received investment for the People Promise role, the HR team have frozen several roles as part of recovery and therefore resource to drive this agenda forward remains within the existing workforce.
- Significant risk with retention and workforce recovery.

- The Trust performance has improved from 53.3% in 2022 to 59.6% in 2023 annual staff survey, this is aligned to national results which improved from 58% to 60% average, however our Pulse Survey in Q4 and Q1 have shown a decline in staff recommending the organisation as a place to work.
- The Trust has reviewed the A3 approach and has selected a new question as the breakthrough objective, focusing on the question 7c "I receive the respect I deserve from my colleagues at work".
- There are several Trust wide countermeasure to focus on culture, line management capability and civility and respect to improve staff feeling they receive the respect they deserve from colleagues.
- It is recognised that nationally and locally Trusts the needs for Trust to stabilise their financial position and decision like increased workforce controls (overtime) will have a negative impact on engagement

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

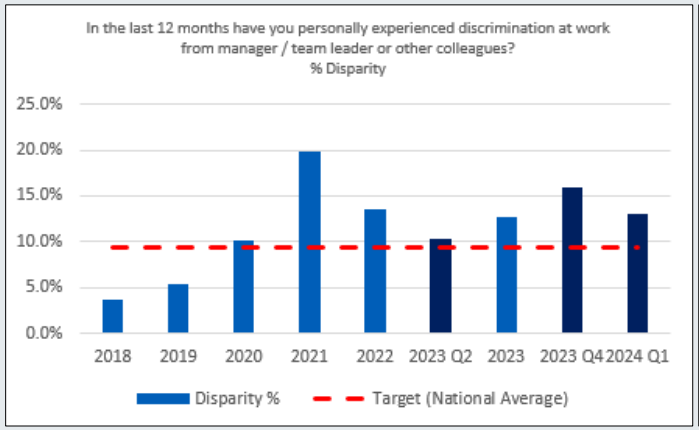
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

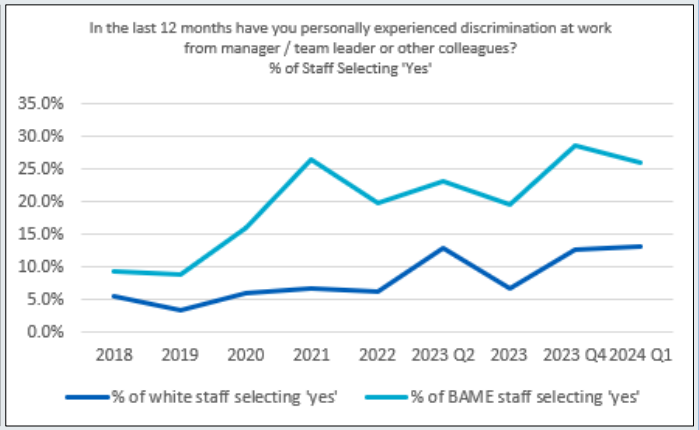
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 8.3% in line with the national average and be below the national average for all staff.

Disparity has decreased to 13.0% in Q1 (15.9% in Q4). Both white staff and BAME staff are reporting discrimination, white staff has increased marginally from 12.7% to 13.1% and BAME has decreased from 28.6% to 26.1%.

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 Cultural Competence training developed in-house launched 18th April, 20 staff attended the pilot workshop, which was well received, feedback from the evaluation was positive with an average overall rating of 5.13 out of 6. The training is open to all staff.
- The Organisation Development function are supporting EDI education with provision of additional training, a 'Compassionate Conversations' Masterclass was launched in April 2024, with additional sessions taking place 8th May, and 11th June. The interactive workshop explores the evidence for compassion in healthcare and provides practical skills. To date, 253 have attended or registered to attend the training. The OD function will also roll out Bystander training.
- The Trust received funding in November 2023 to deliver an EDI Improvement Award project, the project has ended and the Trust will submit the EDI Improvement Award project report in May; the work to recruit, train and deploy EDI champions will continue over the coming year – over 200 staff expressed an interest in the role. To date 14 champions have registered officially as EDI champions, and have logged over 50 hours of activity. The project included staff co-designing a workshop to 'address unprofessional behaviours' and this will be CPD accredited in June 2024 and rolled out across the system and made available nationally.
- Senior leaders and staff network chairs are keen to support staff networks to become sustainable and resilient. The network chairs have met in May to discuss working more collaboratively, the networks will form an overarching Inclusion Network, that will sit above all networks to facilitate a joined-up approach to lead in some areas of their work.

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.

The Trust has started the 24/25 financial year with a £3.4m deficit position, which represents a £1.8m adverse variance to plan.

Income is £0.7m adverse to plan, driven by an underperformance on our ERF target (£0.7m). Of this, £0.4m represents a shortfall against the latest ERF activity plan, and £0.3m a further gap to our stretch target. While pay is £0.4m favourable to plan, undelivered efficiency savings are £0.4m adverse. Medical & dental costs are £0.4m overspent due to the ongoing use of temporary staffing to fill junior doctor shifts in the Emergency Department and General Medicine areas. These are offset by a favourable position in nursing. Temporary staffing costs (bank & agency) have reduced by £0.4m from M12 and are £0.3m lower than the 23/24 average. Nursing lines also hold a number of centrally-held reserves (e.g. maternity / paternity leave), which will be used to support divisional pay positions throughout the year. Non-pay is £1.5m overspent in M1. Clinical supplies are £0.8m overspent, driven by CDC related costs. Drug costs, specifically passthrough-related costs, were £0.7m over plan, while other expenses were £0.2m adverse due to a shortfall in efficiency savings. Offsetting favourable variances totalling £0.2m were interest receivable, outsourcing and PFI operating expenses.

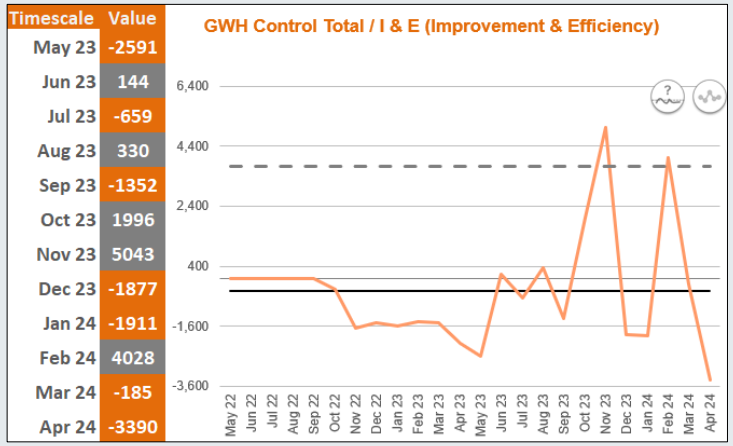
The efficiency target for 24/25 is £21.9m. As at M1, actual delivery was £0.7m, and therefore £0.6m under plan. 55% of the £0.7m delivered is recurrent. All divisions and services must work hard to increase overall savings to hit the £21.9m target, and more specifically to ensure the savings are recurrent to reduce the underlying deficit. Key to the delivery of savings is to become more productive by maximising activity and related ERF income. The Trust is already falling short of its ERF target by £0.7m at M1. Divisions and services must also focus on reducing pay spend throughout 24/25. The target is to reduce the number of headcount working in the Trust by 272 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, while continuing with the good work already in place which has resulted in run rate reductions on temporary staffing, specifically in nursing.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
May 23	-2591
Jun 23	144
Jul 23	-659
Aug 23	330
Sep 23	-1352
Oct 23	1996
Nov 23	5043
Dec 23	-1877
Jan 24	-1911
Feb 24	4028
Mar 24	-185
Apr 24	-3390



Counter Measures

- Efficiency savings were £0.6m behind target in month with pay schemes accounting for £0.4m of the under delivery.
- 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

NHS
Great Western Hospitals
NHS Foundation Trust

Carbon Footprint / Sustainability

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

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

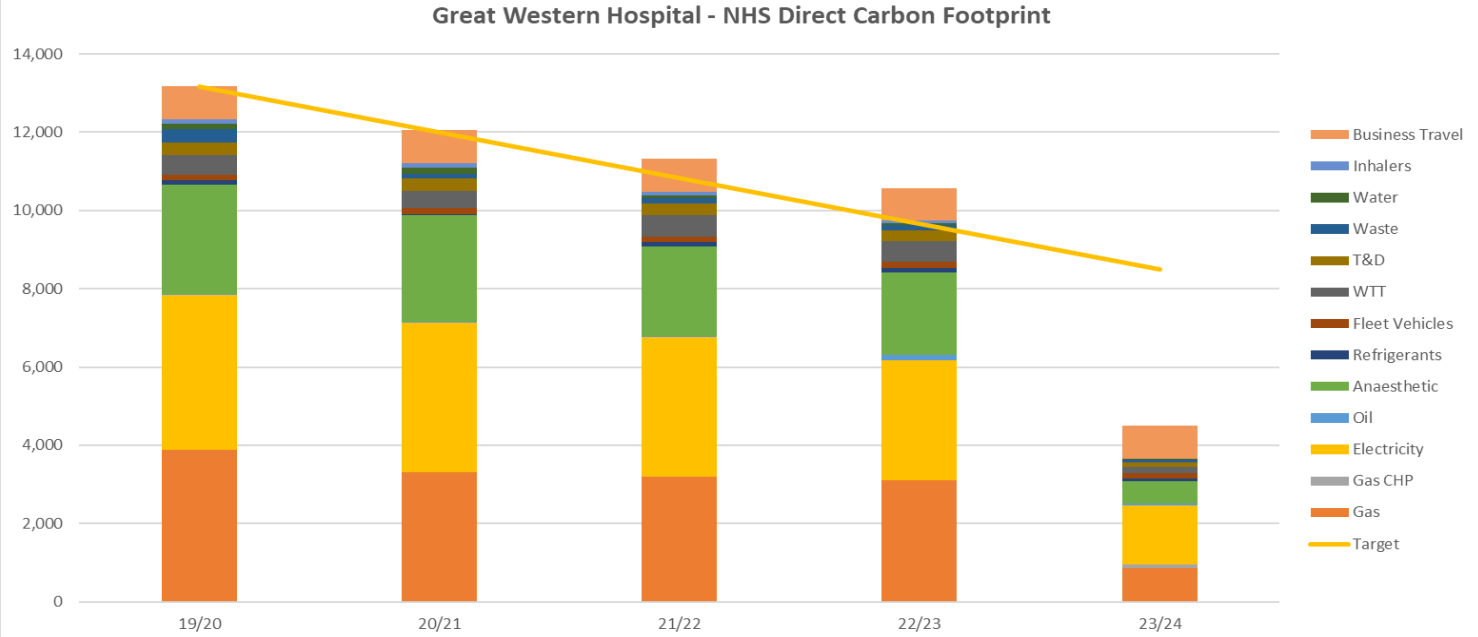
In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032 as shown with the target line on the graph from our 19/20 baseline year.

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

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

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

Simon Wade
Chief Financial Officer



Counter Measures

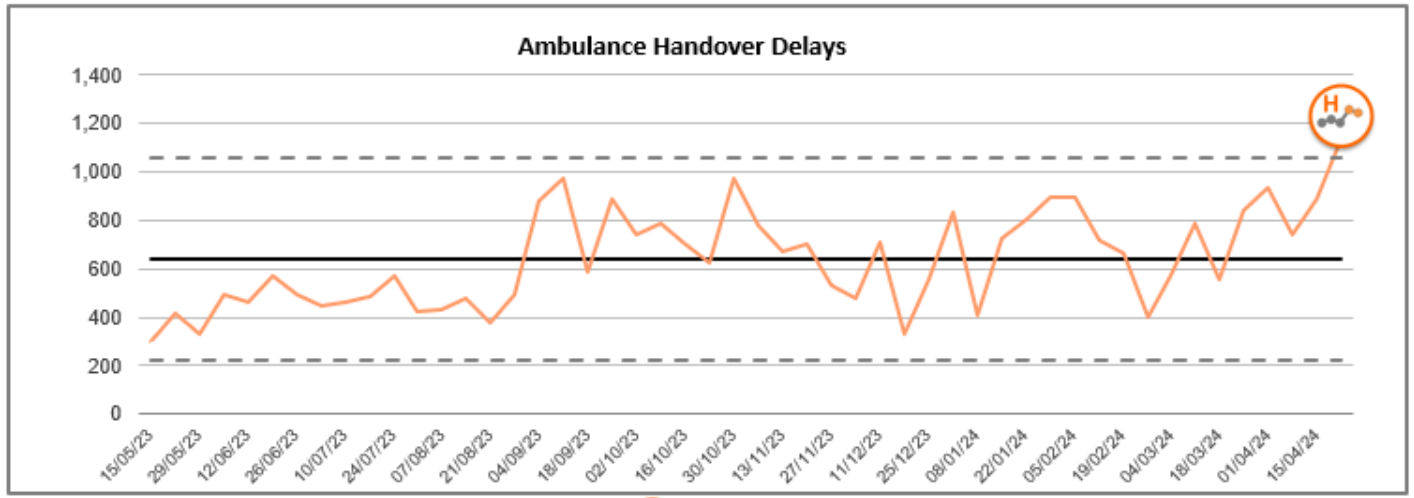
1. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and for indirect emissions by 2045.
2. The Sustainability Team have won Salix funding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

2023/24 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Ambulance Handover Delays

05/02/24	12/02/24	19/02/24	26/02/24	04/03/24	11/03/24	18/03/24	25/03/24	01/04/24	08/04/24	15/04/24	22/04/24
892.0	719.6	660.4	403.7	567.6	784.7	557.8	844.6	937.8	741.3	887.0	1132.9



Special Cause Concerning Variation

Understanding the Data

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

The data is provided daily by the ambulance service. There is a form of special cause variation in the most recent week from the SPC chart. However, the control limits are currently being reset to August 2023. This was the point at which 24 Sunflower beds were decommissioned by the Integrated Care Board which were part of the GWH community bed base. Future test of change will therefore review the period August 2023 onwards by resetting the SPC parameters.

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

April performance showed 3,613 hours were lost due to ambulance handover delays, with 1,132 hours lost during the week ending 22nd April alone which was the highest weekly reported delay in the last 12 months.

A deep dive of April flow metrics is underway to understand the root cause of special cause variation in ambulance handover delays, and this is being included within the new ambulance handover breakthrough objective A3. Initial analysis shows that April is unlikely to be a demand led problem, with overall conveyances and general ED attendances down from the previous month. Bed days lost due to no criteria to reside also remained within control limits.

Trust average length of stay for non-elective inpatients did however increase by an additional day to 5 days in April, with bed occupancy remaining high at 98.3%. April was also the first month of operating with a combined total of 13 less majors cubicle spaces in ED. This is on top of 8 spaces lost pre-Christmas. This planned closure of majors step down was to allow building works to commence for the new ED opening in July 2024, at which point there will be an additional 2 x Resus spaces and 4 x Majors cubicles available to the current ED footprint.

This suggests that our improvement actions should continue to focus on internal improvement work to reduce bed occupancy and process delays via the UEC transformation programme which is currently being mobilised in response.

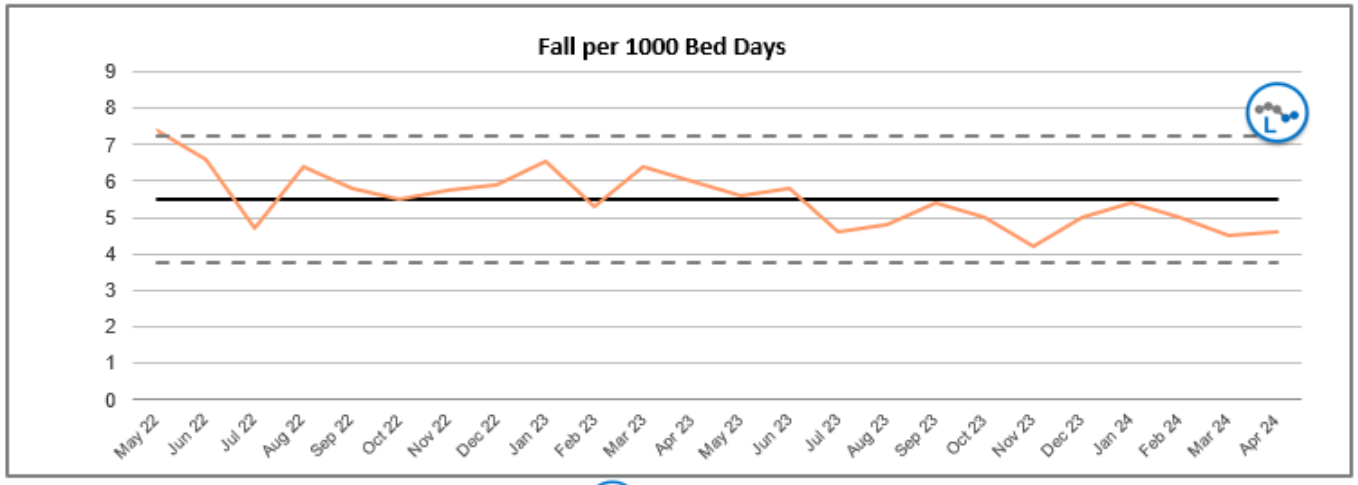
There are 4 flow workstreams (Emergency, Hospital, Admitted Patient and Out of Hospital) for the UEC Programme.

2023/24 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust

May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
5.6	5.8	4.6	4.8	5.4	5.0	4.2	5.0	5.4	5.0	4.5	4.6



Special Cause Improving Variation

Understanding the Data

Falls are reported using 3 metrics:
Falls per 1000 bed days
Number of falls per month
Number of falls with moderate harm or above

The number of falls per 1000 bed days has gradually reduced over the last 2 years as demonstrated in the chart above, although up slightly from March (4.6 in April from 4.5 in March).
However the number of falls with moderate harm or above has increased in April to 6.

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, 9 resulted in moderate harm, 5 resulted in severe harm, and 8 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

Aim for 2024/2025
- 80% of all patients admitted to hospital have a multi factorial falls risk assessment and individualised risk reduction actions.
- Reduce the total number of inpatient falls by 10%
- Reduce the number of patients with more than 1 inpatient fall by 5%

In April 6 patients had moderate harm or above from an inpatient fall, including 1 patient that had a sub dural hemorrhage and 1 patient that had a fractured hip. Investigations are ongoing and the learning will feed into the improvement group, although initial review suggest no new themes have been identified.

The A3 and countermeasures are being developed through a meeting with key stakeholders as well as review of falls data and thematic insights from previous investigations.
Once this has been completed there will be fortnightly oversight huddles to ensure there is consistent progress with the aims.

The current focus for improvement work includes:
- Ensuring patients have appropriate footwear to be able to mobilise safely
- Continued roll out of new enhanced care and 'stay in the bay' work for high risk patients
- Roll out of preventing deconditioning programme across 5 wards

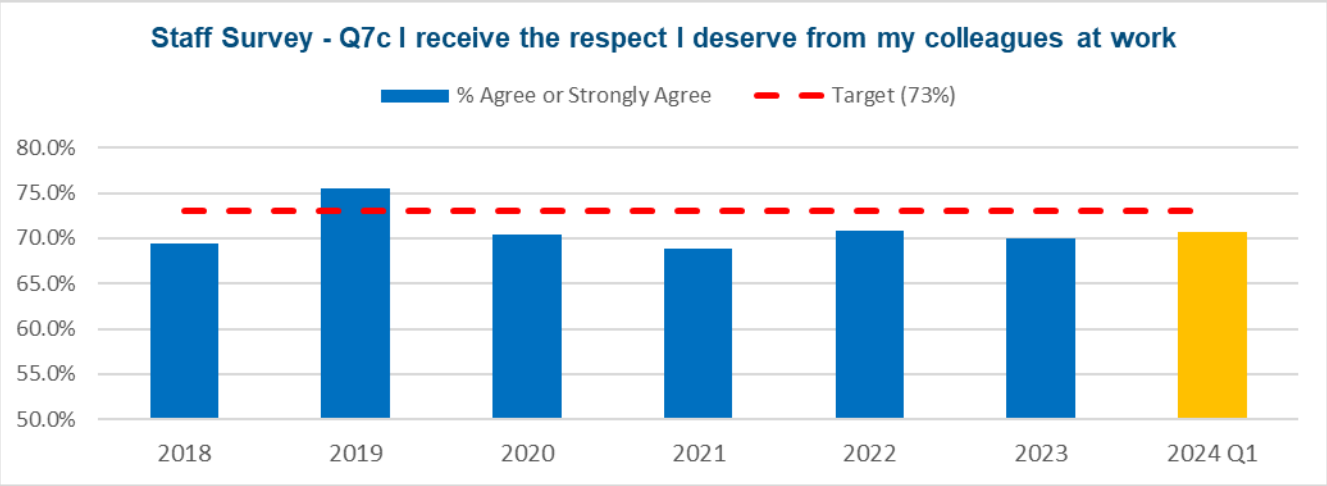
There is also work ongoing to ensure all clinical areas are aware of their data and improvement trajectory.

2023/24 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%				



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

- Quarter 1 Pulse Survey results show a slight improvement in the number of staff who feel they receive the respect they deserve from colleagues at work, increasing from 69.96% in the annual survey to 70.70%.

- Divisional breakthrough questions outlined below:
  - Medicine – Recommend a place to work, with a focus on teamwork
  - SWC – retaining I can make improvements question
  - ICC – experience discrimination in the last 12 months
  - Corporate - I receive respect I deserve with the biggest contributor being Estates.

- There are a number of Trust-wide projects that will support with driving improvement in this question:
  - Implementation of the national toolkit "role of the line manager"
  - Our compassionate way
  - Leaderships behaviours
  - Improved staff recognition and opportunities to thank staff

Risks

- Significant risk to staff morale and engagement due to current financial challenges and requirement to reduce our workforce.
- 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.
- Competing demands on reduced workforce in People Services.

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)	?	71%	72%	65%	70%	
	No. of complaints received	SPC	H	67	65	70	79	
	Number of reopened complaints	SPC	H	3	3	4	3	
IP & C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		2	3	3	0	
	Clostridium difficile (C. diff) infections (cumulative)	TBA (Nat)		70	78	82	3	
	Escherichia coli (E. coli) infections (cumulative)	TBA (Nat)		82	96	106	7	
	Pseudomonas infections (cumulative)	TBA (Nat)		26	29	32	4	
	Klebsiella infections (cumulative)	TBA (Nat)		37	37	37	4	
FFT	ED & UTC Response Rate	18% (Int)	?	15%	14%	14%	14%	
	Inpatients Response Rate	24% (Int)	?	21%	23%	21%	22%	
	Daycases Response Rate	23% (Int)	?	24%	21%	20%	22%	
	Maternity Response Rate	17% (Int)	?	16%	16%	13%	21%	

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 has been a slightly improvement in the complaint response rate to 70% in April (65% in March). The total number of complaints received remains high, with 79 received in April. The main themes relate to communication, waiting times and aspects of care relating to operational pressures. Remedial actions continue with the divisions and corporate teams to improve the position.

NHS England have yet to set trajectories for infections in 2024/25. Our numbers of *E. coli* infection have been declining each month since January 2024. After three months of unusually low numbers of *Klebsiella* infections (zero), four were seen in April. Four *Pseudomonas* infections were also seen; all of these were community-onset cases but counted as healthcare-associated due to the patients having been patients at GWH in the preceding 28 days. *C. diff* numbers have been lower in April than in most months of 2023/24, however this is likely to be a random fluctuation rather than an indication of reduced prevalence.

The FFT response rates remain slightly below targets for April, actions include increasing awareness with staff, and ensuring staff are using the patient feedback for improvement. A new partnership manager has been appointed for our FFT contract provider which will help us maximise the data and electronic system.
Day Surgery are setting up iPads for digital collection to improve response engagement. Maternity Services have a daily walk through by their patient experience coordinator to improve the response rate. This has resulted in an improved response rate of 21% (13% March).

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24
Harm	No. of serious incidents reported in month	SPC		5	3	6	1
	Falls rate per 1000 bed days	SPC	L	5.4	5	4.5	4.6
	No. of Falls in month	SPC	L	106	90	88	86
	No. falls with moderate harm or above	SPC		3	2	1	6
	Medication incidents with moderate harm	SPC		1	1	1	3
	Pressure Ulcer (Hospital Acquired)	SPC		47	25	41	21
	Pressure Ulcer (Community Acquired)	SPC		22	32	25	32
Concerns and Complaints	No. of concerns received	SPC		234	229	237	203
IP & C	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative)	TBA (Nat)		23	23	24	1
	Covid – no. of hospital acquired	SPC		25	17	7	14

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 was 1 new Patient Safety Incident Investigation (Serious Incident) reported in April. There are 19 ongoing Patient Safety Incident Investigations with 9 overdue. Work is also ongoing to ensure that actions from previous investigations are closed in a timely manner. The Trust has transitioned to Patient Safety Incident Response Framework on the 1st April 2024. The new framework promotes a culture of safety, continuous learning and quality improvement.

The number of falls has decreased in month to 86 (88 in March). There has been 6 falls with moderate harm or above this month.

The number of hospital-acquired pressure ulcers continues on a slight downward trajectory even though there have been improvements in reporting. All cases are discussed weekly at a tri-divisional meeting to identify and share learning in a timely way.
In April there were 22 hospital acquired harms, 20 category 2, 1 category 3 and 1 category 4. Only 1 harm was noted from a patient's heel, reflecting the work on checking heels and off loading.
The main contributors were Neptune (4), Trauma (3) and Mercury (3) and additional support is in place. The Chief Nurse handed out pressure ulcer improvement awards for ED, MEU, Theatres, and Critical Care.
Community harms increased by 7 this month to 32 (25 in March) this is related to 8 patients with complex health needs . There were also 4 device related harms.

MSSA and COVID numbers remain low. Two more wards (Mercury and Saturn) will see their air scrubber installations completed imminently.

Risks

- Patient concerns raised about lack of accessible information in line with the requirement of the Accessible Information Standard and Equality Act. A project group is being developed.
- Patient and staff concerns have been raised regarding lack of disability access within GWH in line with Equality Act requirements. This includes heavy doors, lack of blue badge spaces close to building, lack of lighting, blue lights in toilets. Next step actions are awaited from the Estates team.

Our Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	94%	95%	94%	94%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	107%	105%	105%	104%
FFT	Overall response rate (%)	29% (Int)	?	29%	29%	27%	33%
	Positive response (%)	86% (Int)	?	90%	87%	88%	90%
	ED & UTC Positive Responses	79% (Int)	?	81%	76%	77%	81%
	Inpatients Positive Responses	85% (Int)	?	91%	84%	86%	90%
	Daycases Positive Responses	96% (Int)	?	97%	97%	96%	95%
	Outpatients Positive Responses	97% (Int)	?	96%	97%	97%	98%
	Maternity Positive Responses	92% (Int)	?	94%	88%	92%	90%

Performance & Counter Measures

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

The FFT overall response rate is 33% this month, an improvement from March27%). The positive response rate has improved to 90%, still above target. The positive responses for ED/ UTC and inpatients have improved again from last month. Maternity response rate has increased by 6%, although positive responses are slightly down from last month.

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

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24	Trend
RTT	No. of >=18 weeks waiters		H	17590	17727	18254	18451	
	No. of >=52 weeks waiters		H	1625	1777	1900	1859	
DM01	No. of patients on DM01 waitlist		H	12644	11190	9601	One month behind	
	DM01 performance %	99% (Nat)		49.3%	59.8%	66.4%	One month behind	
	DM01 6 week wait breaches		H	6408	4500	3229	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	62.2%	68.6%	66.7%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	82.5%	90.4%	89.0%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	45.8%	62.4%	59.4%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	60.2%	70.5%	71.3%	One month behind	
	No. of referrals received		H	1881	1786	1879	One month behind	

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

Performance & Counter Measure

Diagnostics

April's DM01 unvalidated performance is showing a decrease in performance variance from the 66.4% performance in March to 60.73%. The number of patients on the waiting list has increased by 360 to 9901 Driven by the move of CT to the CDC with reduced capacity and the number of 6-week breaches have increased by 683 to 3,912 driven by US changing suppliers for the outsourcing and a delay in its procurement.

Counter measures: Radology are looking to procure a specialist CT outsouring 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 100% utilisation for MRI but CT are developing a plan to deliver contrast scans as this is impacting what can be scanned off site. Endoscopy usage remains lower than planned but work with RUH and SWC to release another Cancer stream will hopefully close the gap. Ultrasound still remains the largest issue with 4,4510 on the waiting list and 2,494 over 6 week. Medicare are now inplace as a new provider to support US activity on site with levels increasing as they increase support to the team.

Cancer

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathways with 59% of the breaches being accounted for by this service.

60.0% of the 62-day breaches were with the Skin, Colorectal & Urology pathways.

Cancer waiting times for first appointment remain below standard. Breast and Colorectal are the largest contributors with 61.4% of all breaches. Capacity for diagnostics (Breast) and outpatients (Colorectal) were the main factors in these breaches.

In March, 75% (328) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, Breast & Gynae)
Counter Measures
- Work is underway with the TVCA to implement the Best Practice Timed Pathways across 3 (Lower GI, Urology & Gynae) of these Pathways.
-OUH unable to meet Plastic Surgery SLA agreement to provide 9.5 PA/week since Nov/Dec 23. Provision in OUH SLA for additional clinic PAs in Plastics has been approved, now with OUH to assess. External provision of MOP clinics in Wootton Bassett for eligible patients ongoing. Locum from OUH to provide 3 PAs to commence May.
-External Derm team has been retained to assist with capacity through 24/25
-Working with the 3 main challenged tumour sites (Skin, Colorectal & Urology) using the improving together methodology (A3) to ascertain key drivers in this poor performance.
-Weekly PTL review meetings have been extended in time to facilitate a full review and challenge of all pathways, and delays. This will ensure patients will have next steps planned at the earliest available time.

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

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	73.5%	71.1%	74.4%	75.9%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	8.0%	7.9%	7.1%	7.5%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	51.1%	50.7%	56.1%	56.2%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	16.5%	16.3%	14.8%	15.7%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	94.4%	90.3%	91.2%	94.0%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2510.51	2507.32	2350.19	3272.00	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1473	1506	1525	1472	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	88%	91%	88%	92%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	969	1019	1050	1117	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	57.6%	61.5%	60.8%	69.6%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	669	692	699	824	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	39.8%	41.8%	40.5%	51.4%	
Flow	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	312	320	286	274	
	Number of Stranded Patients (over 14 days)	SPC	H	124	117	113	121	
	Number of Super Stranded Patients (over 21 days)	SPC	H	70	66	61	69	

Performance & Counter Measure

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

Plans renewed around improving performance across ED metrics.

4 hour performance (type 1 and 3) increased from 74.4% to 75.9% with both type 1 and 3 improving considerably.

Total % over 12 hours increased from 14.8% to 15.7% showing a slight increase in long waiters in the department.

Number of ambulance handovers over 30 minutes has increased from 1050 to 1117

Number of ambulance handovers over 60 minutes have increased from 40.5% to 51.4%

Counter measures remain in place within the Breakthrough objective slides.

Risks

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

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

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24
RTT	No. of >=78 weeks waiters	SPC	L	5	10	4	3
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.1%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5402	5275	5498	5212
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	75.3%	82.1%	77.4%	78.6%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		51.1%	54.5%	56.3%	59.3%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		42.6%	48.8%	31.4%	38.0%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	200	213	206	199
	Emergency Care - AED - Median Stay	240 (Int)	?	240	240	238	238
	Emergency Care - UTC - Median Stay	240 (Int)	P	156	177	178	170
	Total Number of Ambulance Handovers	SPC	L	1682	1656	1728	1604
	Average hours lost to ambulance handover delays per day	SPC		81	86	76	109

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

ED

Number of ambulance conveyances decreased from previous month from 1728 to 1604.

Triage performance for ED has improved from 56.3% to 59.3%. Type 3 performance has suffered due to the high level of demand in the service.

Median stay has stabilised at 238 mins in ED and in UTC (170 mins).

Risks

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		709	672	651	656
	Elective Patients Average Length of Stay (Days)	SPC	L	3	3	3	3
	Non-Elective Patients Average Length of Stay (Days)	SPC	L	5	4	4	5
	Community Average Length of Stay (Days)	SPC	H	23	25	24	22
	GWH Discharges by Noon (%)	SPC		16.4%	17.3%	18.5%	15.6%
	Adult general and acute type 1 bed occupancy	SPC	L	95.0%	95.1%	94.2%	94.9%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	L	20.4%	20.9%	18.6%	18.6%
	Proportion of patients discharged from hospital to their usual place of residence	SPC	H	95.3%	95.6%	95.9%	95.7%

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

Performance & Counter Measure

Patient Flow

Community average LOS decreased for the first time in two months to 22 which is slightly over the target of 21 days. There has been closer scrutiny of OOA referrals, which has an impact of LoS.

Changes in National NCTR guidance Jan 24 - will impact within different pathways (PW). These are further changing with guidance released on the 30th April.

PW0's – will now be inclusive of restarts and return to care homes – these were in PW3 and PW1's.
PW1 – will be any temporary/short term care provision or intermediate care
PW2 – Bed based rehab or intermediate care
PW3 – Permanent placements

This commenced the beginning of March – soft launch with Discharge Support Team. The plan is to roll out standard leader work for all of the pathways following completion for PW0. There is further work to be completed on data quality and completeness of coding for NCTR which will happen in May – due to the further changes in national guidance this will be delayed until July.

Risks

There is a risk of ongoing ambulance handover delays if overall bed occupancy and no criteria to reside does not reduce further. Trust focus remains on improvements that can be made to earlier discharge in the day and escalating the completion of next steps for discharge which will reduce length of stay and provide additional headroom in the bed base to absorb the temporary loss of ED cubicles. Extension of community commissioned beds will also continue until at least July 2024 to provide additional physical capacity for complex discharge into the community.

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24
Use of Resources	Capital Expenditure (£'000)	SPC		1365	2660	Waiting for data	Waiting for data
	Pay (£'000)	SPC		25836	25024	37412	25246
	Non Pay (£'000)	SPC		17729	16754	19462	17366

Performance & Counter Measure

Capital spend for M1 will be updated in the M2 report.

Pay costs are £12.2m lower than M12 23/24 due to the accrual of notional pension costs (standard accrual for year end) which offsets with additional income accrual. These are not replicated in M1

Non-Pay is £2.1m lower than M12 23/24 driven by additional depreciation in prior month. Clinical supplies and outsourcing costs are also lower in M1 due to higher accruals in M12.

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

Risks

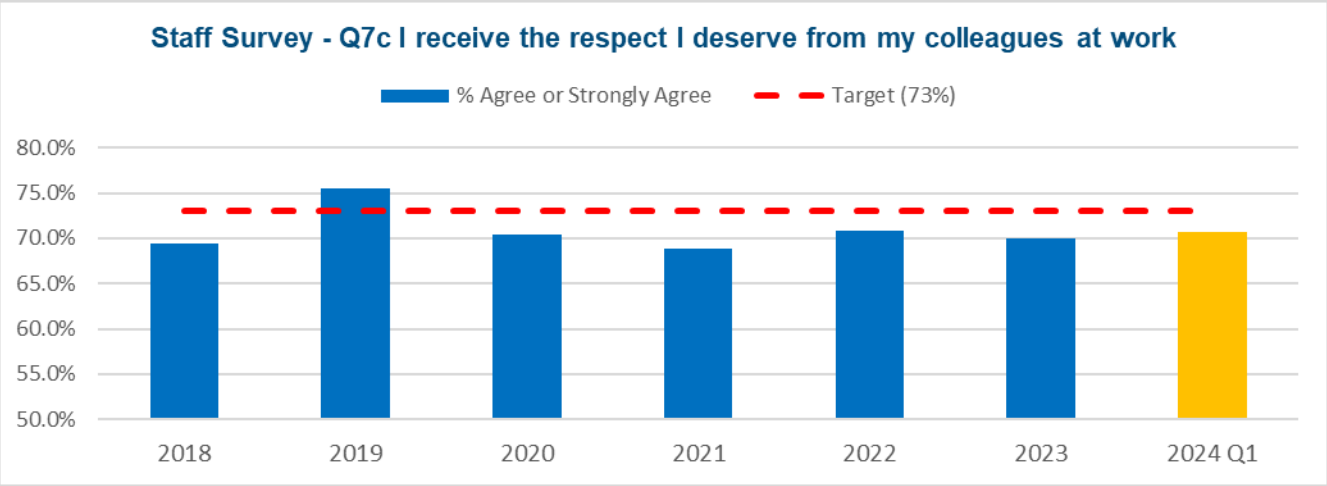
The Trust started the year with a £21.9m cash releasing efficiency plan. As at M1 delivery is £0.6m behind plan with 55% of the £0.7m delivered being recurrent. The risk is that any unmet or non-recurrent delivery adds to the underlying deficit of the Trust. Divisions and services must work to develop 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.

2023/24 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%				



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

- Quarter 1 Pulse Survey results show a slight improvement in the number of staff who feel they receive the respect they deserve from colleagues at work, increasing from 69.96% in the annual survey to 70.70%.

- Divisional breakthrough questions outlined below:
  - Medicine – Recommend a place to work, with a focus on teamwork
  - SWC – retaining I can make improvements question
  - ICC – experience discrimination in the last 12 months
  - Corporate - I receive respect I deserve with the biggest contributor being Estates.

- There are a number of Trust-wide projects that will support with driving improvement in this question:
  - Implementation of the national toolkit "role of the line manager"
  - Our compassionate way
  - Leaderships behaviours
  - Improved staff recognition and opportunities to thank staff

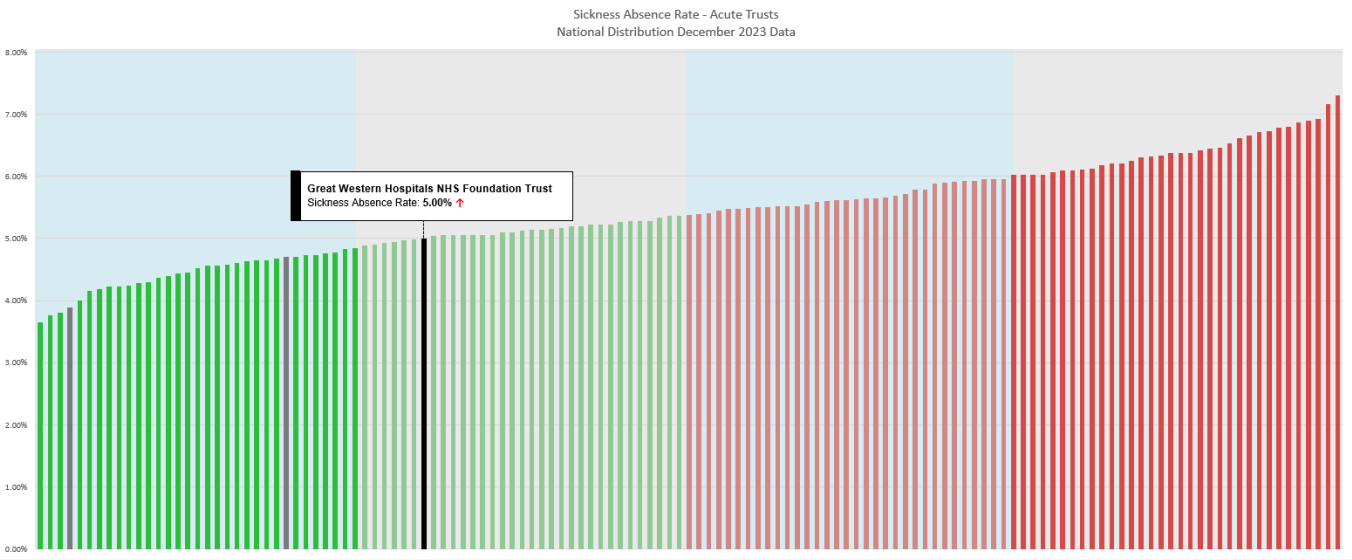
Risks

- Significant risk to staff morale and engagement due to current financial challenges and requirement to reduce our workforce.
- 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.
- Competing demands on reduced workforce in People Services.

Our People

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-24	Feb-24	Mar-24	Apr-24	Trend
	Trust sickness absence rate	3.5% (Int)	F	4.9%	4.4%	4.1%	One month behind	



Performance & Counter Measure

- In-month sickness absence decreased again in March to 4.1%. Whilst we are still reporting above the Trust target of 3.5% absence remains below levels last year (4.6%). Short term sickness has increased slightly to 2.2% and long-term sickness has decreased to 1.9%.
    - The Trust currently has 107 staff on the Long-Term Sick report with 0 staff over 12 months sickness. The DCPO receive a monthly exception report of those staff who have exceed 12 months.
    - The long-term sick report is monitored by the People Operations team.
    - The top reason for sickness is stress (22%), followed by 'other known causes' (10%) and then MSK (9%).
    - The HR team have refreshed their leads for Projects and a new HRBP has been allocated absence management.
- Current National benchmarking data (December 2023 - NHS Digital) shows an overall increase to sickness absence rates, with National sickness absence increasing from 5.3% to 5.5%, and South-West sickness from 5.1% to 5.3%. Our absence rate at this period was 5.0%, below both the National and Regional position and keeping us within the second-lowest quartile for Acute Trusts (40th out of 133).

Risks

- Increased sickness rate as per national trend during winter.
- Vacancy and frozen roles in People Services could impact line management support to reduce sickness

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

Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-24	Feb-24	Mar-24
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	11.8%	11.6%	11.5%

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

- The rolling number of leavers within the 1st year of employment has decreased again in March to 11.5%, in line with the overall trend for voluntary turnover.

Risks

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

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

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend Vs Last Month	Trend Vs Apr-23
	Vacancy																	
W	Vacancy Rate	%	7.00%	7.54%	8.08%	7.96%	7.82%	5.95%	4.87%	4.33%	3.93%	3.74%	4.12%	4.11%	3.93%	4.19%	↑	↓
W	Vacancy Rate	WTE	-	402.58	438.89	432.29	424.68	320.44	262.33	232.95	211.39	201.47	223.67	223.82	213.76	227.43		
W	All Nursing Vacancy	%	7.00%	4.50%	4.95%	5.38%	5.00%	2.73%	1.96%	1.30%	1.94%	1.43%	2.75%	2.39%	2.21%	2.20%	↓	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	117.71	132.11	143.74	133.58	71.58	51.43	34.17	51.03	37.87	73.60	63.97	59.14	58.90		
W	All Registered Nursing Vacancy	WTE	-	84.20	97.00	107.48	103.62	74.83	47.47	18.62	26.55	9.50	28.02	14.37	9.70	4.67		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	27.90	44.94	53.47	59.84	42.58	23.20	3.60	8.44	-3.79	5.29	-3.91	-7.35	-19.60		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	33.51	35.11	36.26	29.96	-3.25	3.96	15.55	24.48	28.37	45.58	49.60	49.44	54.23		
W	Medical Vacancy	%	7.00%	9.35%	10.14%	9.93%	10.34%	7.28%	5.22%	5.66%	5.26%	5.89%	7.07%	7.96%	7.47%	8.30%	↑	↓
W	Medical Vacancy	WTE	-	67.29	74.56	73.05	76.03	53.43	38.22	41.48	38.61	43.30	53.08	59.82	56.06	62.23		
W	STT/AHP Vacancy	%	7.00%	11.10%	12.48%	12.69%	13.04%	13.04%	10.41%	9.20%	6.88%	6.44%	4.87%	4.78%	3.74%	3.39%	↓	↓
W	STT/AHP Vacancy	WTE	-	94.86	107.82	110.17	113.09	112.95	90.28	79.85	58.89	54.92	41.53	40.83	31.72	28.78		
W	SMA Vacancy	%	7.00%	10.71%	10.68%	9.09%	8.80%	7.13%	7.12%	6.70%	5.44%	5.66%	4.80%	5.09%	5.76%	6.68%	↑	↓
W	SMA Vacancy	WTE	-	122.73	124.41	105.33	101.98	82.48	82.40	77.45	62.86	65.38	55.46	59.20	66.84	77.52		
W	Recruitment Time to Hire - AFC	Days	46.00	52.90	50.60	47.60	49.10	45.00	41.70	42.70	41.80	43.50	44.40	42.70	38.40	39.50	↑	↓
W	Recruitment Time to Hire - Bank	Days	46.00	118.00	58.50	26.90	50.40	46.00	43.50	37.00	39.90	45.20	42.00	50.30	39.30	43.30	↑	↓
W	Recruitment Time to Hire - Medical	Days	46.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	64.30	66.10	32.60	39.00	↑	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,337.41	5,434.85	5,433.60	5,433.60	5,382.13	5,381.76	5,379.33	5,382.66	5,382.34	5,431.15	5,446.50	5,433.90	5,433.90		
W	Substantive WTE	WTE	-	4,934.83	4,995.96	5,001.31	5,008.92	5,061.69	5,119.43	5,146.38	5,171.27	5,180.87	5,207.48	5,222.68	5,220.14	5,206.47		
W	Additional Substantive WTE	WTE	-	38.62	27.06	30.79	29.97	25.73	22.95	26.89	24.63	25.22	21.90	22.51	24.78	20.17		
W	Bank WTE	WTE	-	312.39	318.12	296.31	315.54	298.46	277.29	280.45	260.02	246.43	295.57	294.32	380.50	286.32		
W	Agency WTE	WTE	-	94.94	106.86	97.65	98.88	86.02	80.48	66.71	60.65	55.12	61.82	69.47	60.09	49.52		
W	Budgeted vs Worked WTE Variance	WTE	-	43.36	13.15	-7.54	19.71	89.77	118.39	141.10	133.91	125.30	155.62	162.48	251.61	128.59		
W	Actual Worked vs Budgeted %	%	-	100.81%	100.24%	99.86%	100.36%	101.67%	102.20%	102.62%	102.49%	102.33%	102.87%	102.98%	104.63%	102.37%		
W	Total Workforce Cost £	£	-	£23.92M	£23.99M	£25.72M	£24.82M	£24.44M	£26.42M	£25.47M	£24.85M	£25.09M	£25.67M	£25.39M	£25.92M	£25.13M		
W	Agency Spend as % of Total Spend	%	4.50%	3.71%	5.57%	3.39%	4.15%	2.62%	3.11%	4.56%	3.56%	1.22%	2.83%	2.83%	2.04%	1.83%	↓	↓
W	Agency Spend £	£	-	£0.89M	£1.34M	£0.87M	£1.03M	£0.64M	£0.82M	£1.16M	£0.89M	£0.30M	£0.73M	£0.72M	£0.53M	£0.46M		
W	Agency Target £	£		£1.21M	£1.04M	£0.88M	£0.76M	£1.06M	£1.17M	£1.07M	£0.91M	£1.10M	£0.91M	£0.86M	£0.96M	£0.54M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-£0.33M	£0.29M	-£0.01M	£0.27M	-£0.42M	-£0.35M	£0.09M	-£0.03M	-£0.79M	-£0.18M	-£0.14M	-£0.44M	-£0.08M	↑	↑
W	Bank Spend £	£	-	£2.32M	£1.92M	£2.05M	£2.37M	£2.34M	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	£1.89M		
W	Bank Target £	£		£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£2.19M		
W	Bank Spend vs Target £	£ Diff	£0.00M	£2.32M	£1.92M	£2.05M	£2.37M	£2.34M	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	-£0.31M	↓	↓
W	Registered Nursing Bank Fill	%	45.00%	83.96%	85.30%	81.03%	82.92%	81.78%	81.62%	84.87%	86.80%	87.74%	90.73%	90.69%	90.40%	90.86%	↑	↑
W	Unregistered Nursing Bank Fill	%	70.00%	83.58%	81.52%	80.86%	79.98%	77.52%	81.35%	79.99%	84.45%	81.80%	80.12%	79.46%	78.92%	81.89%	↑	↓

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend Vs	
																	Last Month	Apr-23
	Retention																	
W	All Turnover %	%	13.00%	13.79%	13.88%	13.27%	12.74%	12.69%	12.56%	12.20%	12.00%	11.49%	10.98%	10.90%	10.72%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	10.54%	10.52%	10.17%	9.67%	9.62%	9.52%	9.20%	9.19%	8.89%	8.55%	8.56%	8.45%	-	↓	↓
W	Number of Leavers	Headcount	-	33	62	53	53	48	63	41	47	42	45	40	64	-		
W	Number of RN Leavers	Headcount	-	7	15	16	12	14	18	11	14	11	22	10	15	-		
W	Registered Nursing Vol Turnover	%	-	6.95%	6.72%	6.72%	6.48%	6.61%	6.50%	6.57%	6.95%	6.99%	7.07%	7.16%	7.19%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	8	12	11	7	13	21	10	8	15	7	11	13	-		
W	Unregistered Nursing Vol Turnover	%	-	15.36%	15.08%	13.90%	12.93%	12.73%	13.35%	12.65%	12.34%	11.86%	12.01%	11.21%	10.87%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	14.56%	14.29%	13.60%	15.53%	13.95%	14.33%	14.05%	12.93%	13.56%	11.84%	11.61%	11.51%	-		
W	Number of starters	Headcount	-	64	52	56	93	57	106	60	68	37	84	38	51	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	4.25%	4.05%	3.98%	4.07%	4.07%	4.09%	4.17%	4.23%	4.31%	4.37%	4.37%	4.33%	-	↓	↑
D	Sickness Absence %	%	3.50%	3.85%	3.68%	3.77%	4.43%	4.03%	4.21%	4.74%	4.70%	5.00%	4.90%	4.36%	4.13%	-	↓	↑
W	Long Term Sickness %	%	2.00%	2.13%	2.06%	2.16%	2.61%	2.20%	2.10%	2.41%	2.41%	2.67%	2.63%	2.38%	1.90%	-	↓	↓
W	Short Term Sickness %	%	1.50%	1.72%	1.61%	1.61%	1.82%	1.83%	2.12%	2.33%	2.30%	2.34%	2.27%	1.98%	2.23%	-	↑	↑
W	Sickness Absence Cost £	£	-	£546.9k	£574.4k	£550.4k	£664.8k	£626.3k	£614.8k	£738.9k	£726.5k	£794.0k	£777.2k	£647.1k	£669.2k	-		
W	WTE Days Lost	WTE	-	5,648.5	5,612.7	5,568.9	6,781.2	6,256.4	6,401.2	7,487.3	7,187.9	7,922.9	7,774.7	6,566.1	6,618.1	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	89.20%	90.27%	89.81%	89.90%	90.10%	90.36%	90.75%	91.38%	91.88%	91.49%	91.72%	92.31%	92.46%	↑	↑
W	Role Essential MT %	%	85.00%	90.92%	91.59%	91.37%	91.40%	91.64%	91.93%	92.20%	92.77%	93.14%	92.92%	93.28%	93.79%	94.03%	↑	↑
W	CQC Safe MT %	%	85.00%	87.48%	88.95%	88.25%	88.38%	88.56%	88.78%	89.32%	90.01%	90.64%	90.07%	90.16%	90.85%	90.90%	↑	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	59.32%	64.39%	73.18%	76.28%	79.91%	82.14%	83.26%	83.85%	85.24%	86.22%	85.23%	86.51%	84.26%	↓	↑
W	Appraisal Compliance %	%	85.00%	83.11%	82.18%	83.86%	83.94%	84.29%	84.88%	84.92%	83.62%	85.63%	84.32%	84.85%	85.26%	84.18%	↓	↑
W	Non Medical Appraisal Compliance %	%	85.00%	82.46%	81.38%	82.76%	83.29%	84.24%	84.89%	84.91%	83.81%	85.37%	84.06%	84.37%	84.59%	84.40%	↓	↑
W	Medical Appraisal Compliance %	%	85.00%	87.90%	88.00%	91.81%	88.64%	84.64%	84.84%	85.04%	82.25%	87.59%	86.32%	88.38%	90.10%	82.58%	↓	↓

Our People

Workforce Scorecard

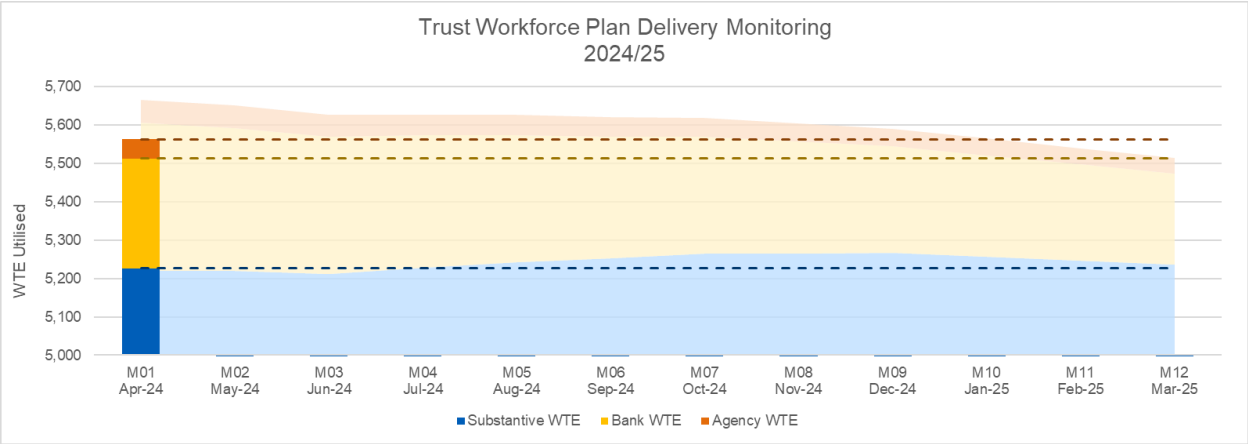
Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend Vs	
																	Last Month	Apr-23
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.14%	4.12%	4.12%	4.13%	4.17%	4.18%	4.12%	4.21%	4.19%	4.23%	4.26%	4.28%	4.28%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	249.00	251.00	251.00	252.00	257.00	260.00	258.00	265.00	264.00	268.00	271.00	272.00	272.00		
W	% of Leadership Roles who are Female (B8a+)	%	-	70.68%	70.92%	70.52%	70.24%	70.82%	71.15%	70.93%	71.32%	71.59%	71.27%	71.22%	70.59%	70.59%		
W	% of Leadership Roles who from BME (B8a+)	%	-	5.22%	5.58%	5.58%	5.95%	6.61%	6.54%	6.20%	6.79%	6.82%	6.34%	6.64%	6.25%	6.25%		
W	Staff in Leadership Roles % (B8c+)	%	-	0.95%	0.95%	0.95%	0.93%	0.93%	0.92%	0.91%	0.92%	0.89%	0.90%	0.90%	0.90%	0.94%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	57.00	58.00	58.00	57.00	57.00	57.00	57.00	58.00	56.00	57.00	57.00	57.00	60.00		
W	% of Leadership Roles who are Female (B8c+)	%	-	57.89%	58.62%	56.90%	56.14%	56.14%	56.14%	56.14%	56.90%	57.14%	56.14%	56.14%	56.14%	56.67%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.26%	5.17%	5.17%	5.26%	5.26%	5.26%	5.26%	5.17%	5.36%	3.51%	3.51%	3.51%	3.33%		
W	% of Leadership Roles who are disabled (B8c+)	%	-	1.75%	1.72%	1.72%	1.75%	1.75%	1.75%	1.75%	1.72%	1.79%	1.75%	1.75%	1.75%	1.67%		
W	Male % of Workforce	%	-	17.63%	17.75%	17.83%	17.90%	18.10%	18.16%	18.36%	18.40%	18.29%	18.33%	18.32%	18.36%	18.39%		
W	Female % of Workforce	%	-	82.37%	82.25%	82.17%	82.10%	81.90%	81.84%	81.64%	81.60%	81.71%	81.67%	81.68%	81.64%	81.61%		
W	BME % of Workforce	%	-	23.60%	24.22%	24.19%	24.49%	25.06%	25.18%	25.47%	25.68%	25.98%	26.08%	26.12%	26.36%	26.56%		
W	White % of Workforce	%	-	68.07%	67.43%	67.29%	67.08%	67.03%	66.86%	66.58%	66.32%	66.19%	65.84%	65.76%	65.61%	65.36%		
W	ER Cases Closed	Number	-	43	56	54	59	20	35	28	27	34	34	40	15	11		

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**	0	0	0	0	0	0	0	0	0	0	0
	Variance	-104	-	-	-	-	-	-	-	-	-	-	-
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**	0	0	0	0	0	0	0	0	0	0	0
	of which Overtime	**20**	0	0	0	0	0	0	0	0	0	0	0
	Variance	6	-	-	-	-	-	-	-	-	-	-	-
Bank	Plan	387	373	359	346	332	318	305	291	277	264	250	237
	Actual	**286**	0	0	0	0	0	0	0	0	0	0	0
	Variance	-100	-	-	-	-	-	-	-	-	-	-	-
Agency	Plan	60	58	56	55	53	51	49	47	45	44	42	40
	Actual	**50**	0	0	0	0	0	0	0	0	0	0	0
	Variance	-10	-	-	-	-	-	-	-	-	-	-	-

Performance & Counter Measure

- In M1, 5,562WTE was used to deliver our services against a planned figure of 5,667WTE. This represents an over-delivery against plan of 104WTE which was largely driven by reductions in Temporary Staffing.
- Substantive staffing was slightly over plan (6WTE), attributable to use of overtime in April. 20WTE was utilised in-month, although this represents a reduction of approximately 15WTE from March and is in line with the expected reduction level set through the Workforce Recovery Group.
- A project plan has been developed to support the Workforce Recovery programme, outlining key actions which can be taken to support headcount reductions phased depending on our current variance to the planned WTE levels. Initial actions focus on overtime controls and reviewing fixed term contracts, with the review of MAR / Voluntary Redundancy schemes outlined from August if we are above plan.

Impact on Workforce

- As of 1st May 2024, the Trust made the decision to restrict overtime usage on the rostering system for all areas other than exceptions agreed by Division Tri's and the Workforce Recovery Group. This decision been discussed at EPF, with an overall dissatisfaction on the communication and the decision. It was agreed that learning would be taken on board regarding communication of these difficult decisions and a standing agenda item at EPF to discuss Workforce Recovery will be instigated.

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.

Our People

Workforce Costs by Staff Group

Great Western Hospitals NHS Foundation Trust

Staff Group	Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Registered Nursing	RGN Sub £	£7,505,628	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£7,505,628
	RGN Bank £	£500,934	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£500,934
	RGN Agency £	£134,966	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£134,966
	Budget £	£8,339,881	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£8,339,881
	Actual Cost £	£8,141,528	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£8,141,528
	Variance to Budget £	-£198,353	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	-£198,353
Unregistered Nursing	UR Sub £	£2,378,175	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£2,378,175
	UR Bank £	£267,490	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£267,490
	UR Agency £	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Budget £	£2,712,503	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£2,712,503
	Actual Cost £	£2,645,665	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£2,645,665
	Variance to Budget £	-£66,838	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	-£66,838
Medical and Dental	M & D Sub £	£6,211,821	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£6,211,821
	M & D Bank £	£885,343	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£885,343
	M & D Agency £	£295,354	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£295,354
	Budget £	£6,725,770	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£6,725,770
	Actual Cost £	£7,392,518	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£7,392,518
	Variance to Budget £	£666,748	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£666,748
AHP and STT	AHP/STT Sub £	£3,109,394	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£3,109,394
	AHP/STT Bank £	£127,201	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£127,201
	AHP/STT Agency £	-£17,442	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	-£17,442
	Budget £	£3,168,989	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£3,168,989
	Actual Cost £	£3,219,154	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£3,219,154
	Variance to Budget £	£50,165	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£50,165
Admin & Clerical	Admin Sub £	£3,581,995	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£3,581,995
	Admin Bank £	£106,641	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£106,641
	Admin Agency £	£46,781	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£46,781
	Budget £	£2,830,472	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£2,830,472
	Actual Cost £	£3,735,417	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£3,735,417
	Variance to Budget £	£904,945	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£904,945
Total	Total Sub £	£22,787,013	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£22,787,013
	Total Bank £	£1,887,609	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1,887,609
	Total Agency £	£459,659	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£459,659
	Budget £	£23,777,615	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£23,777,615
	Actual Cost £	£25,134,281	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£25,134,281
	Variance to Budget £	£1,356,666	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1,356,666

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

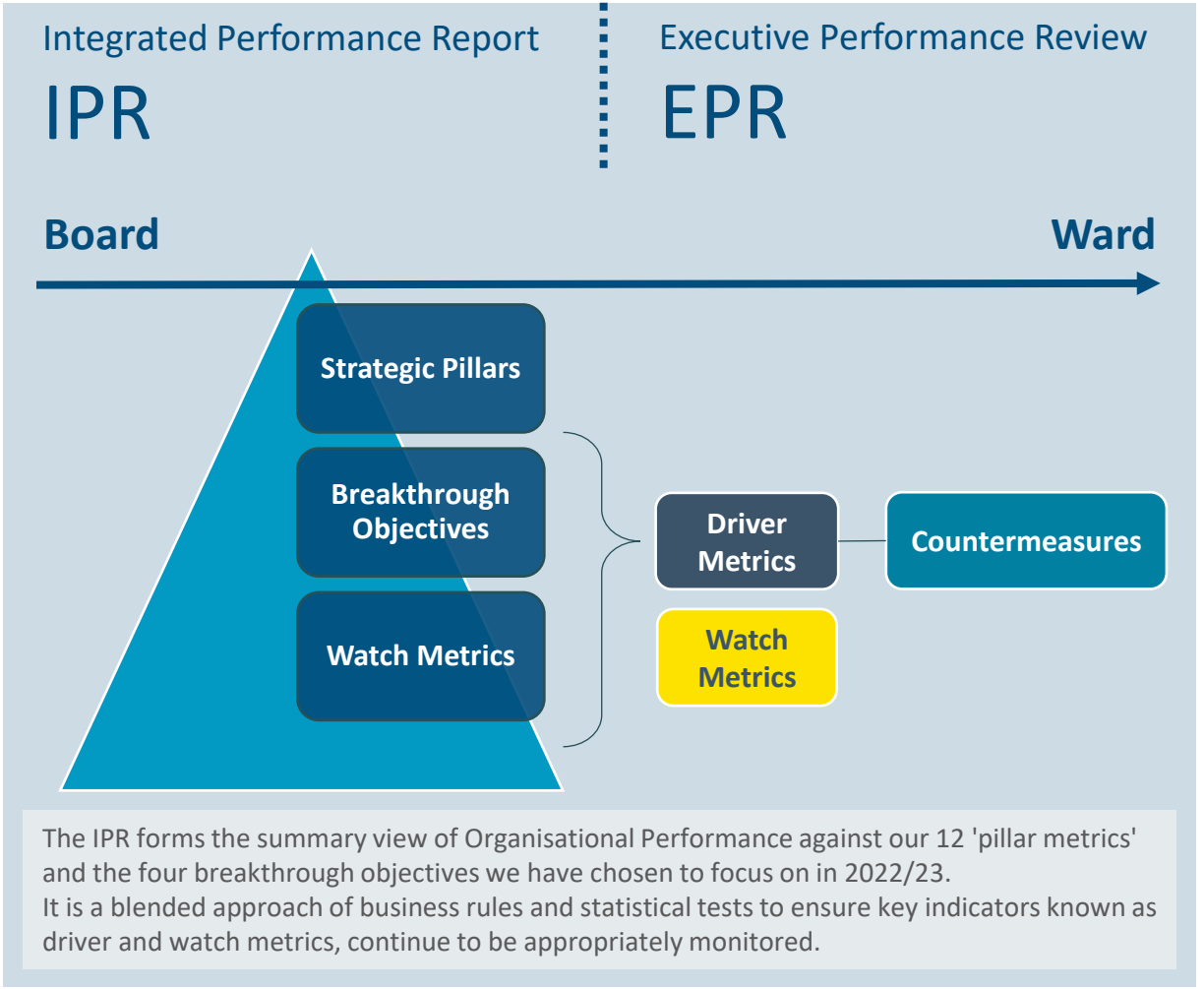
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

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

Our four strategic pillars

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

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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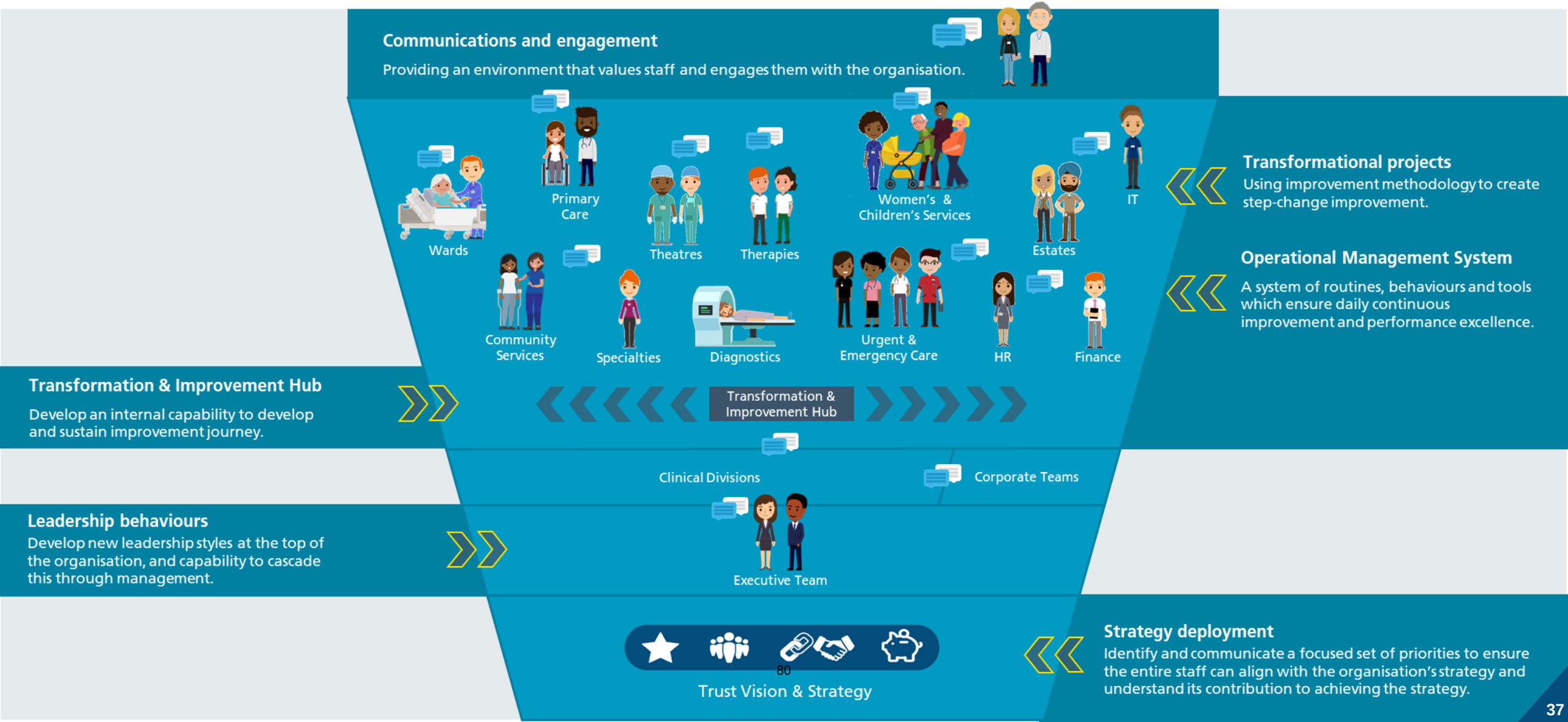


SPC supporting business rules

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.

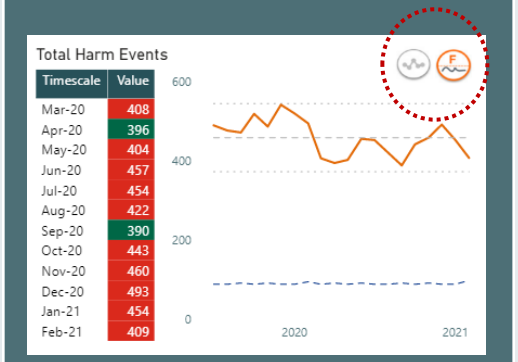
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

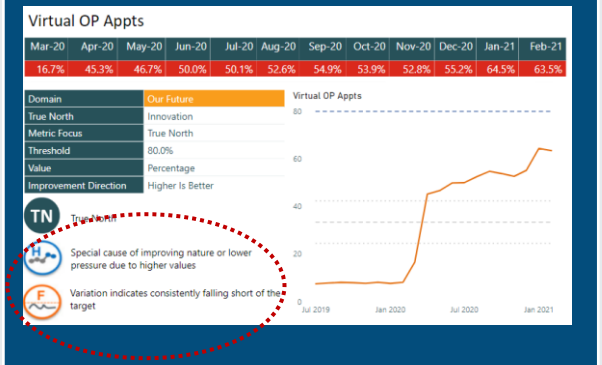
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

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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	**Performance, Population & Place Committee**	
Meeting Date	29th May 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	ED 4 hours	Waiting List – over 65 week waiters
	Ambulance Handovers	Cancer Waiting Times
Improving Together Breakthrough Objective	Time in ED – Clinically Ready to Proceed	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Partnership Update	To note	No
2. Health Inequalities Quarterly Report	To note	Yes
3. Operational Highlight Report	To note	No
4. IPR - DM01	Partial	No
5. IPR - RTT	Partial	No
6. IPR - Cancer	Partial	No
7. IPR – ED / 4 hours	Partial	No
8. IPR – Ambulance Handover	Limited	No
9. EPRR Assurance Quarterly Report	Substantial	No
10. February Faster Flow	To note	No
11. Community Update inc Virtual Ward	To note	No
12. Outpatients Performance Update	To note	No
13. Cancer Services Assurance Report	Partial	No
14. Board Assurance Framework	Substantial	No
15. Committee Effectiveness and Terms of Reference	To note	No

POINTS OF ESCALATION	Ambulance handovers remain a significant concern (3,613 hours lost due to handover), with 46 conveyances waiting more than 6 hours. Demand was noted as static in majors, so not the major issue and improvement plan across 4 key internal workstreams was described to address flow within the hospital.
KEY AREAS TO NOTE	RTT – 175 patients waiting over 65ww, this is an increase with an overall decreasing trend. 52 ww 2% reduction from the previous month. Diagnostics - % performance decrease to 60.73% though overall continues to improve / recover. Anticipated to remain circa 60% for the next month with increased performance from June. Noted that the target for March was below constitutional standards. Cancer % of PTL over 62 days at 5.4% remains within tolerance set.. FDS 71.3% and 62 day 66.7%. Skin, colorectal and urology being the key tumour sites with breaches. Further opportunity to exit from tiering was described following the exit criteria. Hospital at Home, length of stay the best in the region though overall patient volumes recognised as needing to increase at pace. Outpatient work was described in terms of the 24/25 plan which would support an overall increase in activity (supporting schemes of PFIU, increasing new activity, reducing DNA rate as examples). EPRR was rated as substantial in the annual report, training requirements & opportunities were noted. Partnerships report was noted alongside the direction of travel for the various networks e.g. imagining. The Financial framework was described as iterative with further work to deliver the required efficiencies.

	Health Inequalities report identified the need for Board to undertake a self – assessment which was agreed. The ICA schemes were noted. Committee reflected that there was still substantial work required to address inequalities within our patient population.
BOARD ASSURANCE FRAMEWORK & RISKS	BAF was rated as substantial. Corporate risks and due dates for reductions were requested to be reviewed.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Positive reduction in DNA rate comparing the previous year to now. Length of stay for Hospital at Home patients benchmarks positively. EPRR team was recognised as providing good assurance with the work they lead through teams in this subject area.
REFERRALS TO OTHER BOARD COMMITTEES	To note Board will be requested to undertake Equalities self – assessment.

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

Committee	**Quality & Safety Committee**
Meeting Date	23 May 2024
Committee Chair	Claudia Paoloni, Non-Executive Director
Link to Strategic Objective	Pillar 1 : Outstanding Patient Care
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality
Improving Together Pillar Metrics	Reducing Harms
	Friends & Family Test
Improving Together Breakthrough Objective	Pressure Harms

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Board Assurance Framework Q4 report	good	x
2. IPR Breakthrough Objective: Reduce Falls with Harm	partial	x
3. IPR: Infection, Prevention and control	good	x
4. Maternity	good	x
5. Annual Clinical Audit and Effectiveness Audit Programme 2024/25	good	x
6. Nice Guidelines Q4 2023/24	partial	**x**
7. Final Draft Quality Account 2023/24		
8. Safe Staffing 6 month review for Nursing, Midwifery and AHP	good	**x**
9. Safe staffing monthly report		
10. Electronic Discharge Summary		
11. Committee Effectiveness review		

POINTS OF ESCALATION	
KEY AREAS TO NOTE	**BAF: Q4 :** The Committee was assured that the strategic risk associated with the strategic objective and priorities were aligned to _Outstanding Patient Care (Quality Improvement) is being managed effectively, with good levels of assurance that the risks/gaps have been identified and have controls in place that are having effect. Robust discussion was had around the effectiveness and ongoing concern around Safeguarding training level 3 which remains non compliant. But effective controls are showing improving compliance and trajectory for achieving full compliance within year.
	• **IPR: Reduce Falls with Harm** this is the new objective introduced this year in response to increasing fall rate with harm and increasing coronial scrutiny. Total Fall rate has shown a continuous decline over past 2 years, however falls with harm have increased and specifically in patients experiencing more than one fall. April demonstrated a notable increase to 6 cases. A discussion was had around the metrics being used and presented to enable the committee to have assurance around improvements and status of care around fall prevention, and whilst the A3 methodology and countermeasures are still in development only partial assurance could be reached by the committee. • **IPR: Infection Prevention and Control** NHS England is yet to set trajectories for infections 2024/25 but of note are our continuing to decline *E.Coli* rates and good work around water safety with Dove Unit now having had its estates work completed and zero infection rates in the neonatal unit. Pseudomonas rates did go up in month but through community onset infection. Ongoing work continues with high scrutiny, and IPC remains one of the focus point of CQC inspections. • **IPR: Pressure Harms**: No longer a breakthrough objective but remains a watch metric. A continued decline in numbers was observed, and a clear shift in severity to lower grade. 21 Hospital acquired harms of which 20 were category 2, 1 category 3, 1 category 4 and only 1 harm (category 1) found on heels demonstrating effectiveness of the work on checking heels and offloading. Ward areas requiring additional support have been identified and improvements in ED, MEU, Theatres and critical care have been awarded improvement awards. Community showed an uptick in cases but were related to complex needs patients. • **CQC Unannounced Inspection:** the committee received a verbal report on the feedback received following the inspection of 4 medical wards, which was positive in the main part praising the staff dedication and leadership respect and demonstrated the effectiveness of the action plans in place around pain management, safeguarding, end of Life care and use of the mental capacity act. Some areas for improvement were identified and we await the final outcome report and action plan to address these areas.

	• **Maternity**: Committee assured around the progress made since the sept 2023 CQC inspection report, including improved compliance with safeguarding level 3 training and marked improvement in maternity birthing triage times. • There has been a significant reduction in need for bank usage through stricter controls without impacting safety and service delivery. • Workstream is in place to look at ethnicity as a protected characteristic relevant to pregnancy loss. • As requested by the committee, more clarity was provided around the child protection level 3 training compliance rates, such that more focus could be applied in areas showing lower compliance. • PROMPT compliance rate has been negatively impacted by anaesthesia, in part due to the fact this is not a statutory training requirement currently. The compliance is being addressed directly within Division. • Compliance Across national Guidelines has also shown marked progress with 11 actions moving from amber to green from the Ockendon report actions list, with no red outstanding actions and no operational amber actions outstanding. • The Maternity Incentive Scheme (CNST) year 6 now indicates 9 green out of the 10 safety action details, with the 10th as amber. • Three year Maternity & Neonatal Single Delivery Plan also shows progress in compliance and there are no red actions outstanding • On the back of the September 23 CQC visit and report, NHSR requested the Division to review all submission submitted over the last year for accuracy, this has been completed and accuracy confirmed. No amendments required. • NHSI visited with ICB and LMNS for a rapid review of our CQC response, the outcome of which was that there was no requirement for any amendments or extra support was required in addition to our plan in place. As a committee we have requested timelines be added to the CQC improvement actions plan.
	Annual Clinical Audit and Effectiveness Audit programme 2024/25 • The proportion of overdue items were above average at the end of the quarter despite an end of year push with some delays around the local departmental governance sign off processes, for which there is focussed action. • Of the national audits which have been signed off we are demonstrating reasonable or substantial assurance around our practice in the majority of audits.
	• **Nice Guidelines Q4 Update**: the committee could only be partially assured as with the information presented, 120 guidelines appear to remain outstanding for assessment against and response and 18 were partially implemented/in progress with a further 25 awaiting to be assigned to a Division. • There has been good progress in Division Surgery, Women and Children's with 45 completions of assessments and 19 responses completed.
	• **Final Draft Quality Account 2023/24** Board had given authority to this committee to effectively approve the final report in order to meet necessary submission deadlines. The report was reviewed and approved.
	• **Safe Staffing 6 month review for Nursing, midwifery and AHP:** Committee assured good progress made in delivering safe care through improvements in in investment and recruitment and retention of staff, there are good governance measures and oversight of staffing escalation flexibly and fluidly. • **SWICC** remains at 1:10 nursing ratios but in view of a change in complexity of patients it is recommended that there is investment to bring to national 1:8 ratios • With a reduction in international recruitment due to reduced national funding, it is clear for the need to develop our internal pipeline through apprenticeships and nurse associates. • With an increasing number of AHP employed within the Trust the Committee reflected on the observations that recruitment and retention remains a challenge, there has been a steady increase in sickness rates and an upward trajectory in turnover with a change in reasons for leaving away from non work related reasons to now poor work life balance and health reasons. It was decided that that this was of significant enough concern to raise a referral to the People Place Committee.
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	**Referral of finding in 6 monthly safe staffing review of AHP that there had been a significant change in the leaving rate and reasons for leaving for AHP**

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

Committee	**Finance, Infrastructure & Digital Committee**
Meeting Date	28 May 2024
Committee Chair	Faried Chopdat
Link to Strategic Objective	Pillar 4: Use of Resources
Link to Board Assurance Framework	BAF 4 S6 & S7
Improving Together Pillar Metrics	GWH Control Total / I&E
	Sustainability / Carbon Footprint
Improving Together Breakthrough Objective	Productivity

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BAF Strategic Risks	Substantial	x
2. Finance Risk Register (including the Way Forward Program)	Substantial	x
3. BSW Financial Update	Limited	x
4. Month 1 Finance Position	Good	x
5. Improvement and Efficiency Plan	Partial	x
6. Debtors Update	Good	x
7. PFI Financial Update	Good	x
8. Overseas Visitors Update	Good	x
9. BSW Planning Governance Structure	Partial	x
10. Seasonal Plan Update	Good	x
11. Quarterly Coding & Mortality Status Update	Limited	x
12. Review of Finance, Infrastructure and Digital Committee TOR	Approve	x
13. BAF Strategic Risks – review of emerging risks	Approve	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 deficit and the ever-increasing pressure to drive greater efficiency, productivity, and the focus on WTE at all levels. In month 1, GWH was £1.8 m off plan. It fared worse off than the other two trusts due to different phasing assumptions and approaches to delivering efficiency savings, productivity and other financial requirements. Consistent with previous months, the Committee notes that the requirement for more mature governance processes, greater transparency and consistent criteria and measures at the ICS level is ever more critical to gaining greater assurance and better viewing comparable data points.
KEY AREAS TO NOTE	**Month 1 Finance Position—** The Trust started the 2024/25 financial year with a £3.4m deficit, representing a £1.8m adverse variance from the plan. Income is £0.7m adverse to plan, driven by underperformance on the ERF target (£0.7m). While pay is £0.4m favourable to the plan, undelivered efficiency savings are £0.4m adverse. Medical & dental costs are £0.4m overspent due to the ongoing use of temporary staffing to fill junior doctor shifts in the Emergency Department and General Medicine areas—a favourable position in nursing offsets these. Temporary staffing costs (bank & agency) have reduced by £0.4m from M12 and are £0.3m lower than the 2023/24 average. Overall, the Committee is assured of frequent regular meetings and relevant workstreams to hold the most likely forecast and improve it for the best case. Further, the Committee notes good grip and control over temporary staffing costs.
	Efficiency Programme – The Trust's cash-releasing efficiency target for 2024/25 is £21.90m; the increased efficiency expectations for 2024/25 pose a significant risk to the 2024/25 position. As of Month 1, the programme has delivered £681k and is £617k under the plan, with 55% of this delivered recurrently. The focus remains on identifying and providing increased recurrent delivery in 2024/25. Procurement and corporate efficiencies are delivering well as we begin 2024/25; the main shortfall is the underachievement of benchmarking schemes. The Financial Recovery sub-committee emphasises the need for increased resources for financial recovery and must focus on actions that will reduce the run rate and deliver efficiencies. The Committee acknowledges the scale of the challenges, and whilst robust controls and governance by the Financial Recovery Sub-Committee are in place, further mitigation actions and greater control will be required to address the escalating and significant risk of delivering the scale of efficiency and productivity savings.
	Clinical Coding Update – The Committee acknowledges the progress made by the Digital team to address the coding backlog reduction activities during 2023/24 and notes the challenges around team capacity due to the scarcity of experienced coders available in the market. In 2024/25, provided the Clinical Coding business case is approved, and the capacity within the team increases, the focus will move to increase the depth of coding and improve clinical engagement, driving additional income to the Trust. The Trust's financial position makes business case approval a crucial risk. The assurance rating is 'Limited' due to the extensive work required to address the coding issue that has been prevalent for some years.
BOARD ASSURANCE FRAMEWORK & RISKS	**BAF Strategic Risks:** The Q1 BAF Strategic Risk Report was reviewed and challenged by the Committee. Overall, we were satisfied with the process and the assessment of strategic finance, infrastructure, and digital risks. Further, several emerging risks based on the meeting discussions were noted and captured as part of the BAF Strategic Risks.
	Finance Risk Report (including the Way Forward Program): The Committee noted that the risk management process and reporting are adequate and effective and is assured that risks are identified, appropriately rated, and mitigation actions are in place.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	None noted.

REFERRALS TO OTHER BOARD COMMITTEES	None noted.

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Board Committee Assurance Report

Committee	**Mental Health Governance Committee**
Meeting Date	19 April 2024
Committee Chair	Lizzie Abderrahim, Non-Executive Director
Link to Strategic Objective	Pillar 1- Outstanding Patient Care & Pillar 3 – Joining Up Acute and Community Services in Swindon
Link to Board Assurance Framework	BAF 1: SR 1 – Quality / SR6 – Partnership Working

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Annual Committee Effectiveness		✓
2. Use of the Mental Health Act Q4 Report	Substantial	x
3. Mental Capacity Act Q4 Report	Good	x
4. Use of Deprivation of Liberty Safeguards Q4 Report	Good	x
5. Mental Health Governance Workplan	Substantial	x
6. Division of Medicine – Quarterly Report	Good	**x**
7. Right Care Right Person Update	Good	**x**
8. Children's Service Quarterly Report	Good	**x**

POINTS OF ESCALATION	A longstanding under investment in mental health services has served to impact negatively on bed capacity in the mental health sector and is a direct contributor to the long waits of some patients in the ED observation unit and in children's services. Whilst GWH has robust controls over agency spend the committee noted the increased demand on agency spend in the reporting period and how this was a reflection of the need to provide RMN cover for patients whose mental health acuity was high and for whom there was no acute mental health bed available. In these circumstances GWH was effectively serving as an overflow for an overstretched mental health service and, whilst increased agency spend creates a financial risk, there is a significant risk relating to capacity and safety. These are system wide risks and not limited to GWH and there is a clear need for them to be actively addressed by the system and for system wide action to be taken.
KEY AREAS TO NOTE	*Annual Committee Effectiveness* The committee agreed the amendments to the terms of reference that had been proposed and identified further changes in relation to the oversight of learning disability. Subject to those amendments the committee recommended the terms of reference to the Board for approval.
	Use of the Mental Health Act [MHA] The substantial assurance rating reflects the proactive steps being taken to manage ongoing issues associated with the use of the MHA, in particular the management of patients detained under s2 and the numbers of patients brought to GWH under s136.
	The use of the Mental Capacity Act [MC] and of Deprivation of Liberty Safeguards [DoLS] Good assurance ratings are maintained on the basis that there is clear evidence of processes and procedures to address the legal requirements of both the MCA and DoLS but audits demonstrate that further work needs to be done to ensure that these are applied and implemented effectively across GWH.
	Division of Medicine / Children's Services – Quarterly Reports Good assurance ratings reflect the work done, in partnership with AWP and CAMHS, to ensure that the mental health needs of patients are met. However, of note was the increased agency spend in both ED and Children's Services that reflected the need for specialist RMN support for patients with high acuity and who were wating for protracted periods for an acute mental health bed. This created both a financial risk and a risk in relation to the quality of care and patient safety that is borne by GWH but which is a reflection of wider system wide risks.
	Right Care Right Person Update Previously rated as partial it was agreed that although the significant change in agency practice continued to raise as yet unknown risks there had been clear evidence of good collaborative work across the system over the reporting period supported by the cooperative approach taken by Wiltshire Constabulary which was not reflected in other parts of the country.
BOARD ASSURANCE FRAMEWORK & RISKS	The committee welcomed a review of the reporting of risk management that is to take place following a Trust Board development session and understood that changes would likely be made to future risk reports. This would be of particular significance to this committee because over several reporting periods there have been no 15+ risks to report and, as a consequence, the committee has limited opportunity to gain assurance as to the effectiveness of the risk management process.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The committee received a presentation from the physiotherapy team who described the work done with a patient on Forest ward following an injury to their spine, in particular the work they had done to address the mental health issues had arisen. The work the team did with this patient was significant and the committee noted the degree to which they had gone above and beyond what was ordinarily expected of them to ensure that the patient received the best possible service.

REFERRALS TO OTHER BOARD COMMITTEES	None identified

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Board Committee Assurance Report

Committee	**Charitable Funds Committee**
Meeting Date	8 May 2024
Committee Chair	Julian Duxfield, Non-Executive Director

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

POINTS OF ESCALATION	The Trust Board will be consulted on the investment strategy, using an external Fund Manager, for the Trust's Charitable funds.
KEY AREAS TO NOTE	Immediately prior to the meeting the General Fund's uncommitted balance stood at £208,771, above our agreed minimum threshold of £57,000. The meeting reviewed the 'Cases of Need' and it was agreed to fund the Staff Awards event in June and the End of Life Companion Coordinator. It was agreed to seek further clarification on the proposals to fund prescription collection lockers and an Armed Forces welfare service. The three Divisions all presented a summary of their plans for using the Charitable funds in their areas. There is still progress to be made in ensuring that clear plans exist to use the funds available. Each Division will be invited to attend each of the next three meetings for a further deep dive into these plans. Once the revised Trust strategy has been agreed a revised Charity strategy will be developed. The ratio of costs to funds raised (RoI) was reviewed and this will be included in quarterly finance tables and fully reviewed annually in the Charity budget paper by the Committee. A presentation on the staff lottery was received. This is operated entirely separately to the Charitable funds and it was agreed that outside the meeting it would be investigated how there could be a closer relationship between the Trust and this lottery and what links to HR (EPF) or Finance.
BOARD ASSURANCE FRAMEWORK & RISKS	Fundraising – the future fundraising plans will be further refined. The cost-of-living issues provide continued risk and uncertainty. Financial Reporting – no major concerns were identified. The Finance team will provide monthly, in place of the current quarterly, reporting to enable better management of the General Fund. Cases of Need – the process and documentation is currently good, but will be improved by providing an indication of the number of people which the proposed cases will impact and how the cases will support the least advantaged patients and those from protected groups. Charitable Funds – There is still progress to be made in ensuring that clear plans exist to use the funds available. Each Division will be invited to attend each of the next three meetings for a further deep dive into these plans. External Review Action Plan – good progress is being made with the implementation of the Action Plan. A key outstanding action is the rationalisation of funds.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Good engagement from each Division on the use of Charitable funds. A clear presentation of the ratio of costs to funds raised (RoI) providing context and historical changes. Dove and Haematology teams were praised for their staff fundraising efforts. The teams successfully raised £30k for the Dove Garden project from a variety of activities which included a team tandem skydive.

REFERRALS TO OTHER BOARD COMMITTEES	None.

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Great Western Hospitals NHS Foundation Trust

Report Title	**Safe Staffing 6 month review for Nursing, Midwifery and AHP**				
Meeting	**Board of Directors**				
Date	**6th June 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek Chief Nurse				
Report Author	Luisa Goddard Deputy Chief Nurse, Ana Gardete Divisional Director of Nursing, Lisa Marshall, Director of Midwifery				
Appendices	None				

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):

The report gives the committee assurance of safe staffing processes for Nursing, Midwifery and AHP within the Trust and highlights areas of concern.

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

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

Report

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

This report aims to provide the Trust Board with assurance that staffing has been managed over the past 6 months in line with national recommendations and to highlight areas that are not compliance or in need of further work.

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

The report covers:

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

The Acute Ward Nursing report highlights compliance against the National Quality Board Safe, Sustainable and Productive staffing recommendations of Right Staff, Right Skills and Right Place and Time.

It presents the Trust's position against national benchmarking using Care Hours per Patient Day, shift fill rates and the Safer Nursing Care Tool. The Safer Nursing care Tool audit for the Emergency Department is presented with the work to ensure the shifts patterns are being reviewed to meet peaks in demand. The report also highlights that the majority of wards are now funded to be compliant with the 1 nurse to 8 patient ratios with the exception of the SWICC wards. The report then highlights the good progress on recruitment and retention and the work to maximise efficiency and safe working through the 3 X a day staffing meetings and the success of the temporary staffing reduction plan.

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

Maternity and Neonatal Safe Staffing
The report covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report. It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has continued to improved over the last six months by identifying different staffing models, recruitment locally and internationally, alongside recruitment of band 5 nurses to work in specific areas within maternity. The key metrics of Supernumerary status of the Delivery Suite Coordinator, one-to-one care in Labour and midwife to birth ratio are all presented and discussed. Although there is ongoing work to ensure compliance there are no specific areas of immediate concern. The Midwifery Continuity of Carer team was paused in January 2024 due to challenges with recruitment and retention, with the remaining members of the team choosing to work in the community setting.

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

Allied Health Professionals
The development of the AHP workforce and leadership are described along with the workforce metrics and improvements seen in recruitment. The trust has invested in the first dedicated Associate Director for AHP and one of the Deputy Chief Nurses will take the role

of embedding a new corporate AHP Governance model to provide more robust and visible leadership, support, and oversight.

The report describes the AHP workforce and details improvements in recruitment and a reduction in turnover. A proactive approach to understanding workforce capacity and delivery, clinical education, workforce reform and understanding clinical activity is required to formulate a robust longer term workforce strategy.

Conclusion
The Trust has made good progress in delivering safe staffing across acute, community and Midwifery. There are significant improvements seen in the areas with safer staffing investment and the work on recruitment and retention is improving staff experience and is supporting the drive to improve patient care.

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

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

- Continue to ensure good recruitment and retention programmes with bespoke plans in high-risk areas and retention initiatives to support front line nursing and midwifery staff.
- Ensure that the SWICC wards working at a 1:10 ratio are included in the next business planning cycle and the impact on quality continues to be closely monitored.
- Continue to implement the fair and manageable workload in community nursing and consideration of the deficit in establishment from the SNCT audit.
- Continue to develop the Nurse Associate role and the pathway for unregistered nurses into registered nursing.
- Continue to develop the ANP workforce strategy
- Ensure continued monitoring and compliance with Maternity workforce metrics in line with CNST

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**
	Risk 500 There is a risk of poor quality metrics and reduced staff morale/high turnover due to inpatient wards working at a ratio of 1:10 for registered and unregistered staff. This is against the national guidance of 1:8 or below.				12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Nursing, Midwifery and AHP workforce group, Trust Management Committee				
Next Steps					

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

Explanation of above analysis: the paper describes the governance of safe staffing across the Trust.

Recommendation / Action Required The Board/Committee/Group is requested to:	
The committee is asked to note the recommendations of the report	
Accountable Lead Signature	
Date	22/05/24

1. Introduction

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

These include:

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

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

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

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

The report covers:

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

1.1 Background

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) supports Trusts to use best practice in effective staff deployment and workforce planning utilising evidence-based tools and professional judgement to ensure the right staff, with the right skills are in

the right place at the right time. Using this approach will ensure that safe staffing levels are determined on patient needs, acuity and risks and can be monitored from 'ward to board'. This triangulated approach to staffing decisions is also supported by the CQC.

Table 1- NQB: Safe, Sustainable and Productive Staffing

Right Staff	Right Skills	Right Place and Time
Evidence based workforce planning	Mandatory training, development and education	Productive working and eliminating waste
Professional Judgement	Working as a multiprofessional team	Efficient deployment and flexibility
Benchmarking speciality at a national level	Recruitment and Retention	Efficient employment and minimising agency

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

2.0 Right Staff

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

The definitions and Trust's position for these metrics are described below.

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

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

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

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

Table 2 Trust wide Fill Rates

	Safer Staffing – average fill rate RN (%)	Safer Staffing – average fill rate HCA (%)
Sep-23	92.3%	108.1%
Oct-23	93.2%	106.6%
Nov-23	94.0%	106.0%
Dec-23	92.4%	104.3%
Jan-24	93.6%	106.9%
Feb-24	94.6%	104.7%

2.2 Care Hours Per Patient Day (CHPPD)

CHPPD was developed, tested and adopted by the NHS to provide a single consistent way of recording and reporting deployment of staff on inpatient wards/units.

The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone. The data gives a picture of how staff are deployed and how productively they are used. It is possible to compare a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. If a wide variation between similar wards is found it is possible to drill down and explore this in more detail.

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

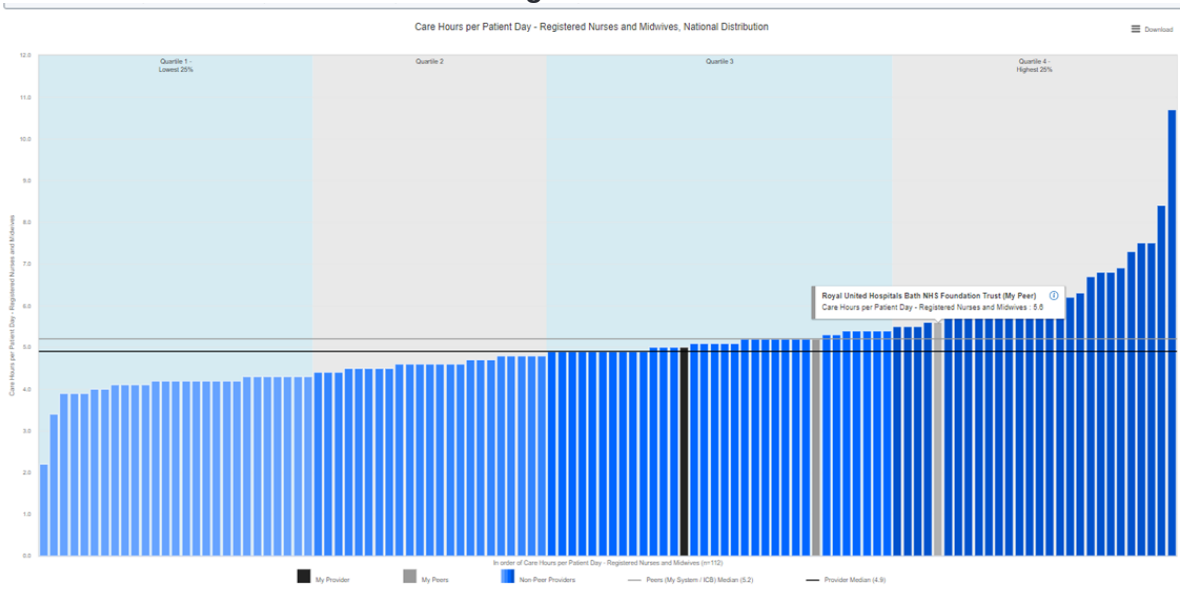
The care hours per patient day required to deliver safer care can vary in response to local conditions, for example the layout of wards or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. Lower levels of CHPPD may also reflect organisational efficiencies or innovative staffing deployment models or patient pathways.

The Model Health System is a digital tool provided by NHSE to support the NHS improve productivity, quality and efficiency. It provides national benchmarking on productivity and quality. CHPPD is available as a benchmark against other Trusts, it is produced from actual whole time equivalents worked ie not funded establishments.

The latest data is December 23 and shows that for registered nurses the Trust is in Quartile 3 for the first time. The Trust has a value of 5.0 for Registered Nurses compared with the peer median of 5.2.

Benchmarking with Salisbury Foundation Trust and Royal United Bath are shown.

Chart 1 CHPPD National benchmarking



2.3 Safer Nursing Care Tool

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

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

The acute wards completed a 2 week data collection last September and are planning to repeat the data collection in May this year. This will allow a comparison against the 2 data point recommendations and current funded establishment in more detail.

The Emergency Department (ED) has completed 3 data collections using the SNCT for EDs. The data was completed in June 2022, April 2023 and Dec 2023 and demonstrates a similar pattern re occupancy. Whilst the total occupancy numbers are lower (due to a difference in the breadth of data collection from the data above) the overall trend is largely the same, with lower occupancy seen during the earlier hours of the day. A review of shift patterns is ongoing which will take this data into consideration.

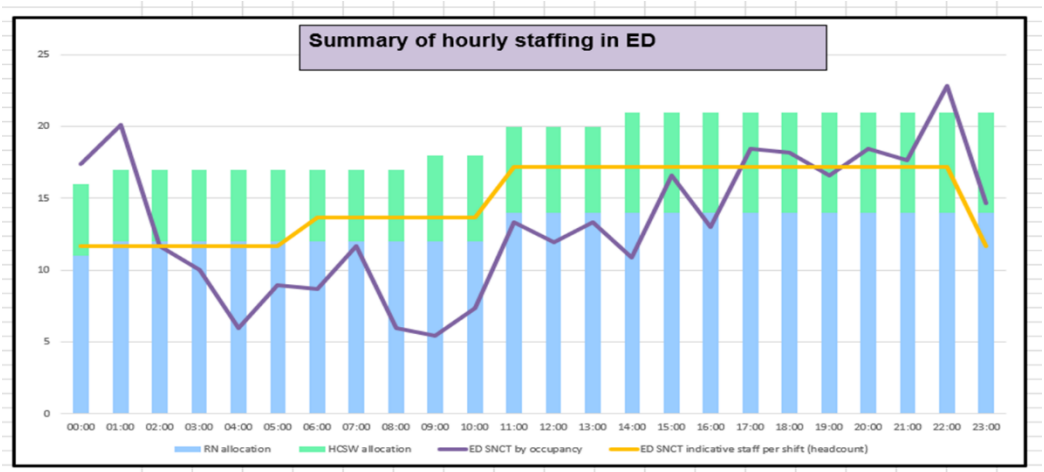
This along with the improvements in benchmarking against the Royal College of Emergency Medicine standards provides assurance that the investment in ED has made a difference and overall staffing levels are improving in ED. The area of most improvement is in the skill mix in the department, which is now meeting the standard that 30% of the registered nurse workforce is band 6 or 7. This is a crucial safety factor in ensuring that there is always an experienced nurse in each area of ED such as resus.

Evidence (Griffiths et al 2024) found that lower levels of nurse staffing are associated with adverse events that can result in delays in provision of care and serious outcomes for patients. Lower levels of nurse staffing in EDs are associated with delays in patients receiving treatments and poor quality care including an increase in leaving without being seen, delays in accessing treatments and medications and cardiac arrest.

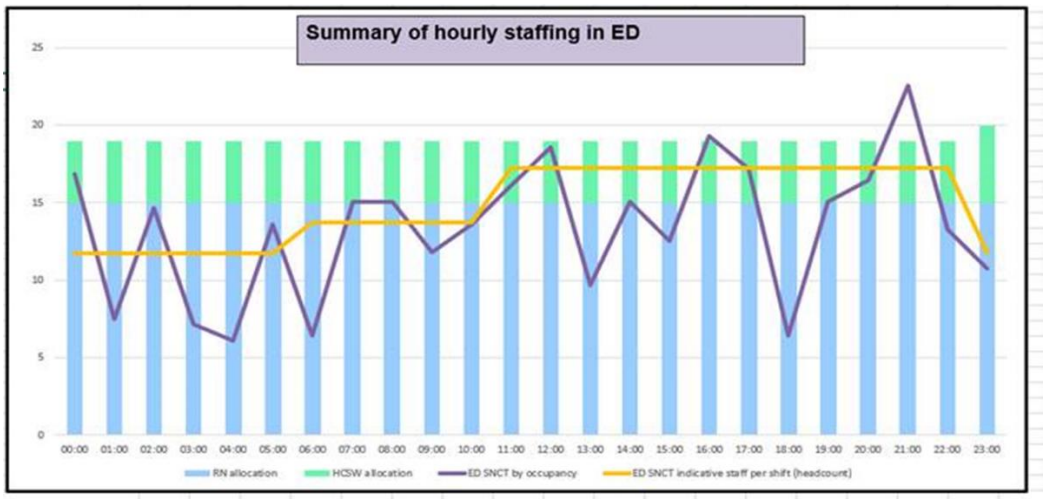
The indicative staff per shift that the audit recommends does not account for skill mix (headcount only) and does not take into consideration geographical or other internal factors that are part of the professional judgement for staffing.

Chart 3 SNCT for ED in April and December 23

April 2023



December 2023



2.4 Nurse to Patient Ratios

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

The inpatient wards at GWH prior to 2022 were working on an establishment nurse to patient ratio of 1 to 10 for registered and unregistered staff including the shift coordinator so the actual ratios were frequently 1:12/15.

Following the agreed a 3 year safer staffing investment, all wards except for Orchard and Forest are now in line with guidance. However, whilst compliant with the 1:8 ratio, it should be noted that the coordinator role on nights has not been fully implemented, particularly in the Medical Wards. This is expected to be implemented in April 2024.

As part of the temporary staffing reduction plan wards are not covering short notice absence and will be working at 'amber' levels at times, which will result in higher nurse to patient ratios. There is a Quality Impact Assessment in place however further monitoring may be required to understand the frequency this occurs.

Orchard and Forest remain at a 1:10 ratio for registered nurses, due to the increase in acuity and faster patient flow through these wards this is becoming an area of increasing concern and was a recommendation from the last Safer Staffing Reviews.

The medical ward budgets, establishments and electronic roster have been aligned to ensure that the new safer staffing ratios are fully implemented, including the supernumerary coordinator on the night shift and that the budgets are correct.

2.5 CQC Quality Statement

The CQC have implemented their new assessment framework, the quality statement relating to staffing is described below. Work is ongoing with the divisions to ensure compliance and the relevant evidence is available to meet this standard.

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

What this quality statement means
T*here are robust and safe recruitment practices to make sure that all staff, including agency staff and volunteers, are suitably experienced, competent and able to carry out their role.*

Recruitment, disciplinary and capability processes are fair and are reviewed to ensure there is no disadvantage based on any specific protected equality characteristic.

There are appropriate staffing levels and skill mix to make sure people receive consistently safe, good quality care that meets their needs.

Staff receive training appropriate and relevant to their role.

Staff receive the support they need to deliver safe care. This includes supervision, appraisal and support to develop, improve services and where needed, professional revalidation.

Staff at all levels have opportunities to learn, and poor performance is managed appropriately.

Subtopics this quality statement covers
Safe recruitment (including DBS)
Staffing levels and skills mix
Skills and qualifications/revalidation
Learning, development and competency
Support, supervision
Performance management

Volunteers and unpaid carers

Mapping the evidence against this statement is ongoing to ensure that we can meet the assessment criteria. There is work ongoing to ensure nurses can demonstrate competency for the core and extended skills.

3.0 Right Skills

3.1 Recruitment and Retention

3.1.1 Vacancies and turnover for nurses

There has continued to be good progress against the Registered Nursing and Health Care support worker vacancy position. Working in collaboration with recruitment and close monitoring of vacancies through the workforce group is proving to be successful. The nursing vacancy rate for registered and unregistered was 2.39% in February 24.

3.1.2 Health Care Support Workers (HCSW)

There continues to be a robust approach to recruitment of HCSWs, the number of starters and leavers is presented below. Vacancies have been between 20-31 wte in the last quarter and the recruitment target has been increased to 15 per month.

Although the overall turnover for HCSW has reduced, the trend of high leavers within the 1st year of employment continues and analysis of reasons for leaving is presented monthly at the Nursing and Midwifery Workforce group.

Chart 4. Example of Leavers report for Division of Medicine in March 2024

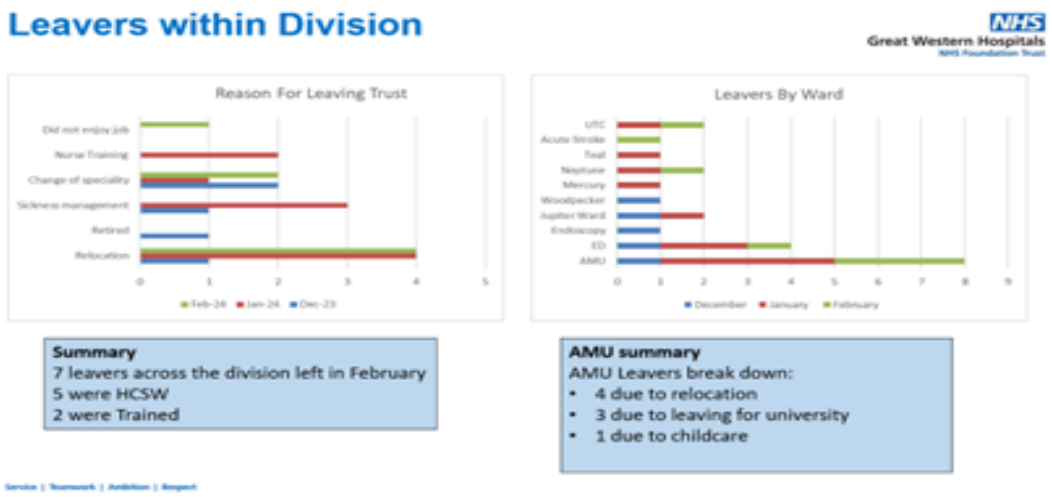


Chart 5 HCSW Leavers and Joiners report for 23-24

	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
Leavers FTE	9.29	2.30	2.96	4.00	2.28	4.31	0.00	4.88	7	6.52	11.20	5.54	9.39
Starters FTE	11.00	19.20	25.44	14.64	8.40	18.49	1.96	10.64	6.96	4	16.63	8.28	5.64

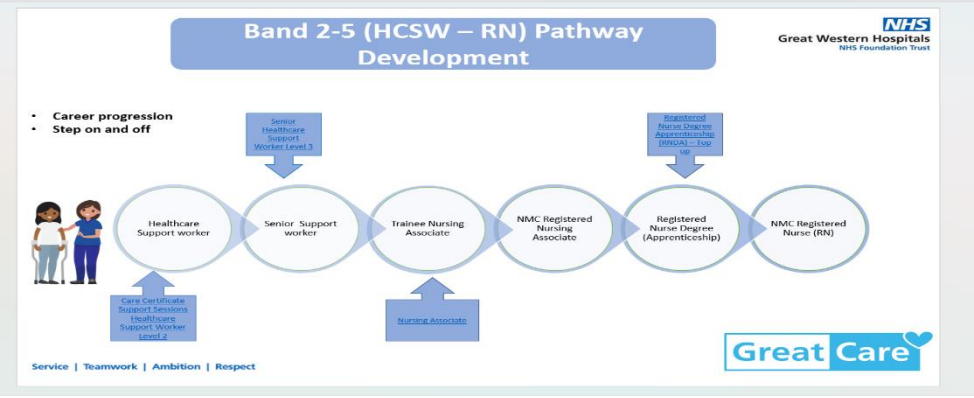
3.2 Retention activities for HCSWs

The Training Ward
A successful trial for new to care HCSW recruits has taken place and there are plans to expand the programme further. The new HCSWs spend 2 weeks on a 'training ward' working with the Clinical Practice Educators before going to their agreed ward / unit. This approach ensures that they feel supported and embed the learning from their Care Certificate / induction in a supportive manner. Feedback has been very positive including from the substantive workforce on the ward who have also benefited from this initiative.

Training days
To date 220 HCSWs have attended an off site training day including opportunity to speak to the Deputy Chief Nurse, development opportunities and updates on key quality issues such as pressure ulcers, falls and nutrition.

Progression
Offering our HCSW progression is important for retention, the development pathway is described below. So far 30 wte have completed the Nurse Associate pathway and 6 are on the degree apprenticeship.

Chart 6 HCSW development pathway



3.3 Registered Nursing

The Trust is reporting a near to zero position for registered band 5 nursing, although there are a few areas with vacancies, such as AMU, there is a good pipeline of pre registration nurses (national and international).

3.3.1 International Recruitment

The Trust continues to rely on international recruitment to maintain a near 0 vacancy level.

The Trust has recruited 57 Internationally educated Nurses in the last 6 months (Oct – Mar), of which 33 (57.9 %) have successful passed their OSCE and are working as Registered Nurses within the organisation. The remaining 24 are pending exam.

Moving into the new financial year the Trust has made the decision to focus resources towards our internal workforce and have launched the new 'OSCE Via SIFE' progression scheme which aims to upskill and promote senior HCSW staff (who were previously registered in their own country) to registered nurse within a 3 – 6 month period following OSCE and return to practice support channels.

Whilst this process is being recruited to and the internal programme is being embedded, the Trust will continue to recruit 14 IEN's from overseas via agency over the months of May and June. From July to November the focus will be on the OSCE via SIFE applicants with a view to recruit 28 Internal IEN's.

3.4 Retention initiatives for Registered Nurses

Clinical Practice Educators

The 10wte clinical practice educators are now in place and supporting all learners within the clinical environment. Initial feedback has been very positive with new staff and students feeling much more supported and having at the bedside training is very successful at translating theory into good practice.

Professional Nurse Advocates (PNAs)

PNAs are a national initiative to provide restorative supervision in practice, although the numbers of PNA are currently quite small, there is a work programme to develop regular drop in, 1 to 1 and group supervision sessions.

Legacy Mentors

The Trust had external funding for 1 Legacy mentor and was able to change a practice education role into a Legacy mentor for the second role. Legacy mentors are nurses at the end of their career who provide mentorship and guidance to newly qualified nurses. The impact of the roles are being formally evaluated and presented at Nursing and Midwifery workforce meeting. However, the legacy mentor for the acute wards is providing pastoral care as well as career advice and mentorship.

Stay and Thrive

Stay and Thrive is a bundle of actions designed to support International recruits and allow them to 'thrive' in the NHS. The Trust was awarded the national Pastoral Care Award for IENs last year and has a continued focus for support measures in place. There is a Chief Nurse Fellow for Stay and Thrive who along with our inclusion lead nurse offers practical advice and pastoral support to staff.

4.0 Right Place and Time

4.1 Safe staffing daily process

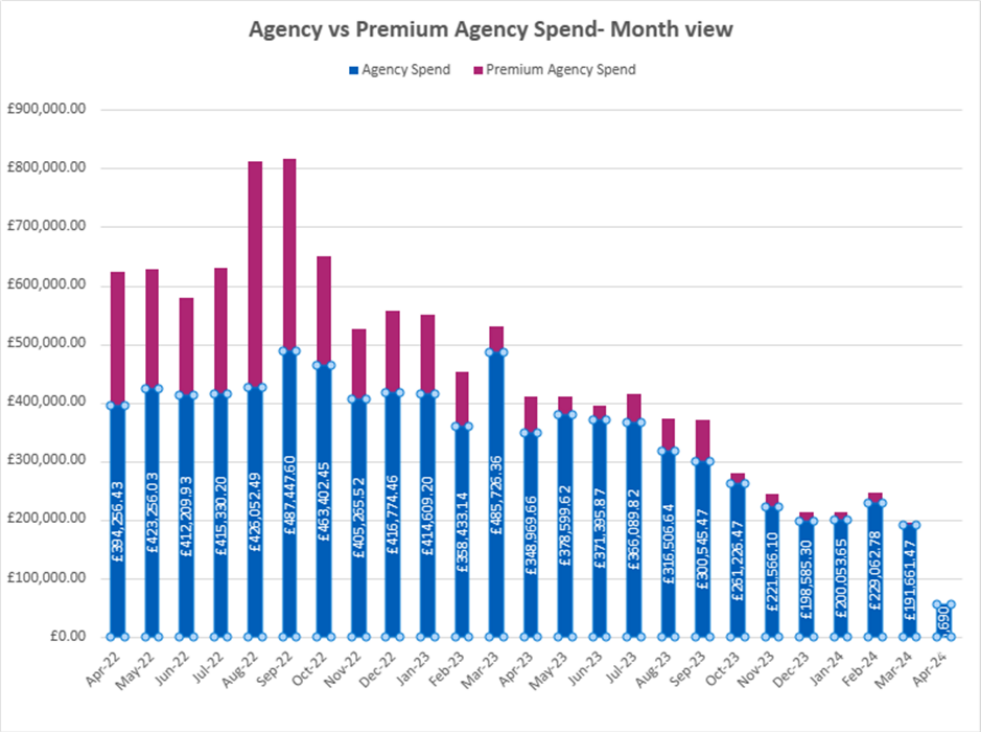
The Trust continues to have 3 times a day safe staffing meetings chaired by a divisional directors of nursing or deputy. This ensures that no ward is left on a 'red shift' and there is

effective deployment of staff. Work is starting to review the number of times shifts are working at 'Amber'.

4.2 Temporary staffing reduction plan

The Divisional Directors of Nursing and deputies continue to meet fortnightly using the A3 methodology to reduce reliance on temporary staffing. Good progress has been made with agency, especially high cost agency staff and the focus is now on reducing bank staff.

There is a Quality Impact Assessment for this work and the quality metrics are regularly reviewed to ensure the reduction is not impacting on safe staffing or quality of care.



5.0 Community Nursing

5.1 Context

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

5.2 Community Nursing Safer Staffing Tool (CNSST)

Both QNI (2022) and Royal College of Nursing (2021) set out workforce standards based on modelling and activity. These outline the need for CNS to deliver the required nursing care

for a defined community through safe staffing establishments and skill mix that are reflective of the demand placed upon them by their population needs.

Safe staffing regulations and recommendations are set out through:

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

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

The Trust's first data collection (census) was undertaken the week commencing 24th April 2023 for a period of seven consecutive days and repeated the week commencing 30th October 2023, for the same length of time. To ensure a standardised approach to assessment, a decision matrix is used by nurses to assign patient dependencies (1-4) based on care provided during the visit and identify any unmet needs. Additional hours of community nursing visits were collected in period 2, which included work undertaken from 16:30 until 22:00.

5.3 Exception report

The census data from October 2023 demonstrated a significantly different outcome to the previous census in April 2023. The findings of census 2 demonstrate that current community nursing establishment of 92.5 WTE (excludes Band 8A and Band 8B), fails to meet the recommendations of the CNSST census 2 of 105.2 WTE (band 8a and band 8b excluded). This highlights a staffing gap of 13 WTE based on 20% headroom and 16 WTE based on 22% headroom (table 1).

Table 1: Budgeted vs Recommended staffing

The difference in the outputs is thought to be due to the data collection in census 2 being a more realistic reflection of staffing requirement following on from learning from the first data collection.

Data collection census 1 (April 2023):

- Community nursing visits 08.00- 16.30
- Some bank and agency visits
- No headroom included.

Data collection census 2 (October 2023)

- Community nursing visits 08:00-22.00 (additional twilight visits for community nursing included)
- Deferred visits for doppler and continence assessments
- All bank and agency visits that were completed.
- 20% headroom was included.

Community Nursing is currently fully recruited for both registered and unregistered nurses. During the census period, an additional 17 WTE temporary staff were used (bank/agency) over this budgeted establishment. This additional use of temporary staffing appears to have bridged the recognised establishment/recommendation deficit. The recommended staffing ratio Registered Nurse (B4 NA to B7) to non-Registered Nurse is 75/25% split. The data across localities demonstrates some inequity and work continues to address a more equitable approach whilst recognising the potential under establishment.

The October 2023 census data more accurately captured the visits deferred more than seven days. These deferred visits were mainly for lower leg doppler and continence assessments. By being able to deliver this work earlier, a more proactive approach would be enabled, which would increase leg wound healing rates and reduce patient length of stay on community nursing caseload. The deferred visits equated to 1 visit per nurse per day for 3 localities, with the one locality having to defer 2 visits per nurse per day. This was in the team with the greatest deficit against recommended staffing levels (table 2).

Using prototype tools of CNSST shared by other high performing community nursing services, a prioritisation and triage tool was adapted and implemented within Swindon CNS using a RAG rating. This tool provides a framework to be used alongside professional judgement that enables nurses to safely defer visits based on a triage and a risk stratified prioritisation of work.

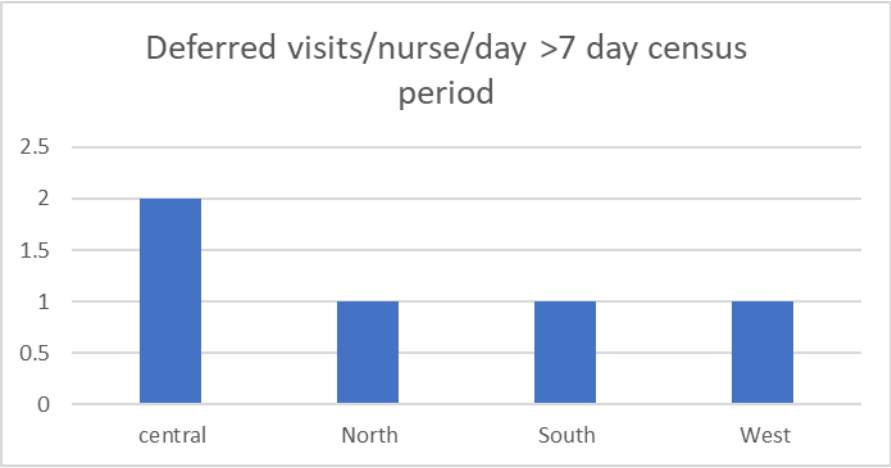


Table 2: number of deferred visits per nurse per day

In January 2024, work, previously identified as 2-48 Hour work, undertaken by Urgent Community Response transferred back to community nursing with some of the Urgent Community Response staff supporting the additional demand.

This data has not been included in CNSST to this point, however, a third data collection period is scheduled for early March 2024 to ensure this work is included and captured. NHSE recommendations are that at least 2 data sets are required before a review of permanent establishment changes can be made. This will be triangulated with professional judgment and benchmarking and will align with the Trust's business planning cycle.

QNI (2022) outlined red flags for safety concerns including deferring high priority work at all (for example end of life care, blocked catheters) or high numbers of deferrals on a regular basis. There are no identified standards for maximum caseload size or number of visits per day however, it was noted that evidence identifies that caseloads >150 and >10 visits per nurse per day, were tipping points for patient harm. Caseload size (headed by a B6 caseload holder) within Swindon Community Nursing services demonstrates significant variation from 70 patients to a maximum of 144 patients. Efforts will be made to reduce variation in caseload size.

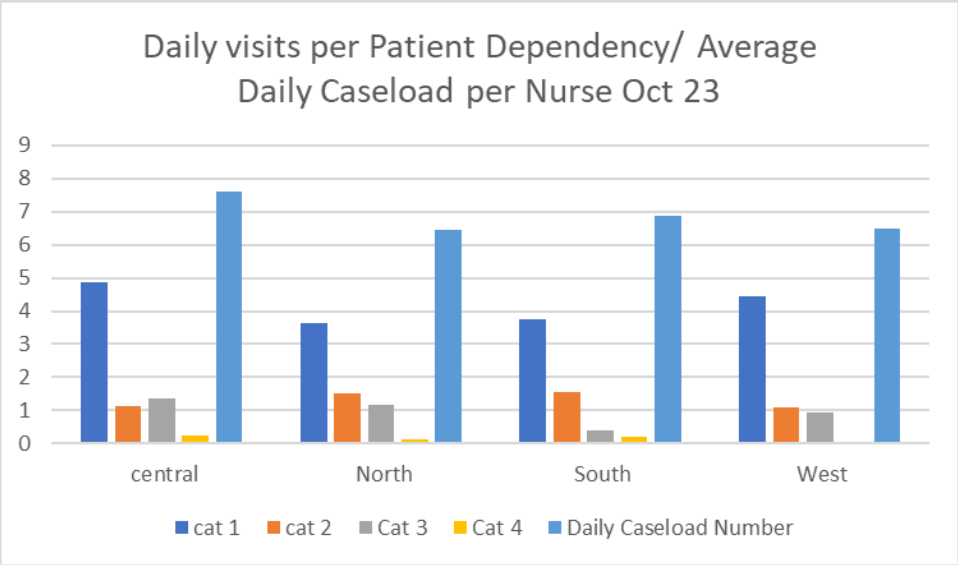


Table 3: Daily caseload per nurse & patient dependency **October**

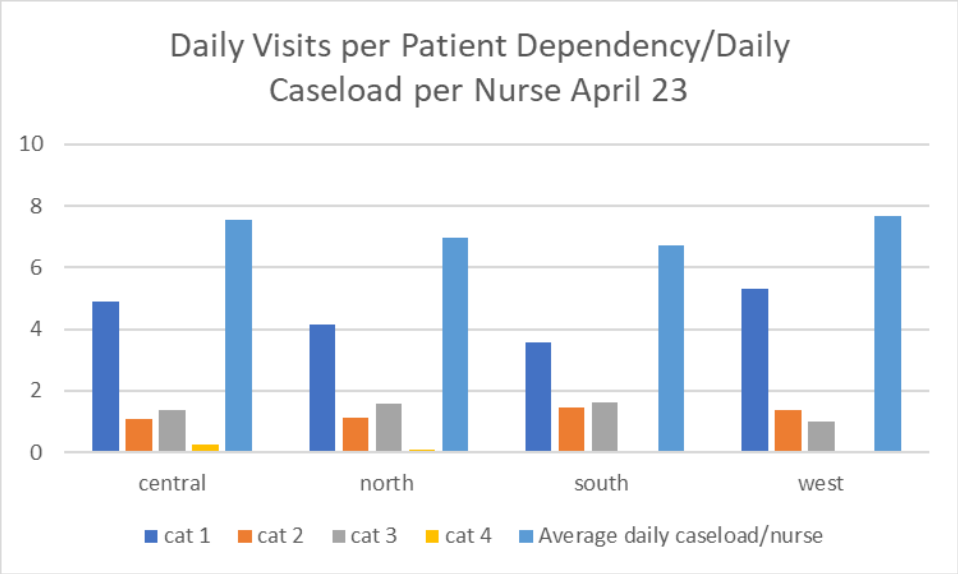


Table 4: Daily caseload per nurse & patient dependency **April**

Census data in October demonstrates that with implementation of the Fair and Manageable workload, the average number of daily visits per nurse sits between 6 & 8 and slightly less than the April data. This data census supports evidence that the Fair and Manageable workload has supported daily staff visits to meet recommendation of QNI workforce standards. The data is caveated as the average number of daily visits will be reduced as the co-ordinator role was included in the Oct data collection. The coordinator role does not undertake visits, therefore further analysis is required.

Data reveals that during the census period, the bulk of care provided within each locality was category 1, with the most complex care category 4, being a very low proportion. This data collection period does not include work undertaken by the clinical leads. The clinical leads for specialist care will be reviewing more complex patients and therefore this data needs to be included in the March census period.

The Fair and Manageable workload provides a framework, alongside professional judgment, to enable nurses to safely defer visits when demand outstrips capacity. This has continued to be used although this has been challenging at times, when rates of sickness absence have been high, where visits cannot be completed within a safe period of time these are escalated through the division to ensure adequate staff capacity is obtained and patient care not compromised. The daily demand versus capacity Opel status is monitored through the Trust site report.

5.4 Next Steps Plan

- Undertake census March 24 – improve data collection efficiency
- Include clinical lead visit data
- Consider census results in the next business planning cycle
- Implement Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS) in the Community to understand the impact of fair and manageable workload.

5.5 Vacancies, turnover and sickness absence in Community Nursing

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

The current vacancies for band 5 registered nurses are 0.31 wte (Feb 24) and the average turnover is 11.9%. The service is shows a vacancy within the HealthCare Support workers group but this is related to a number of them successfully qualifying as band 4 Nursing Associates.

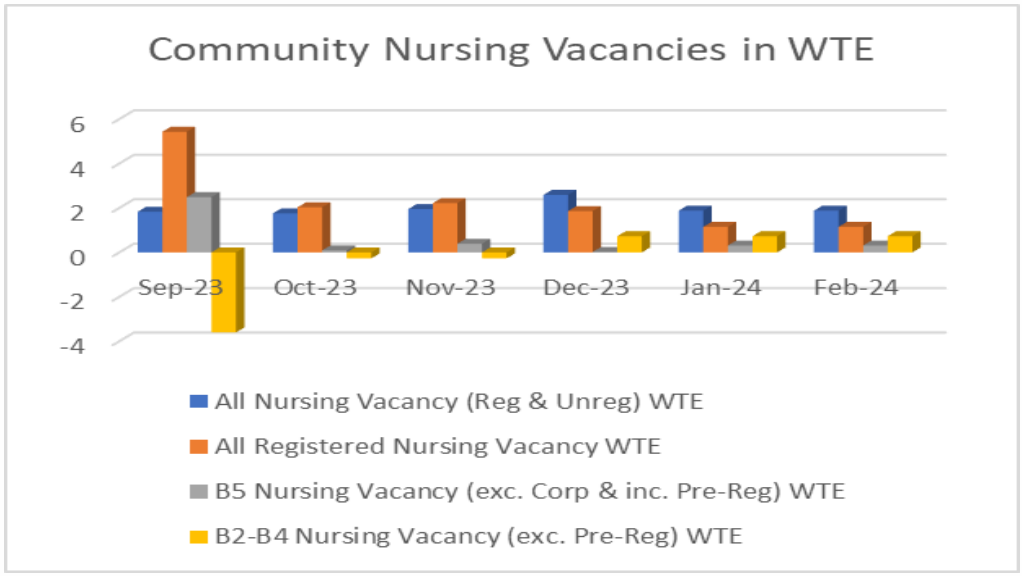


Table 6 Community Nursing vacancies

Sickness absence is monitored within the individual teams with support from HR colleagues, looking at short and long term sickness absence.

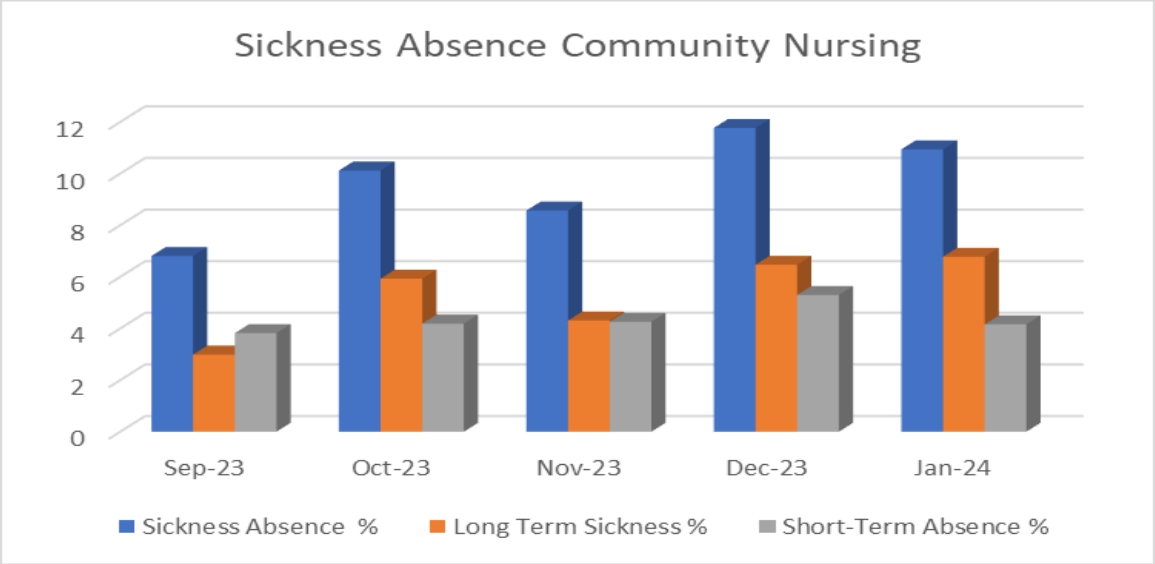


Table 7 Community nursing sickness absence

6.0 Maternity staffing

6.1 National / regional context

This paper covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board on a six-monthly basis, (Maternity incentive scheme, October 2022).

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

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

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

Midwife to birth ratio has been utilised as a measure across the system historically, however this has been recognised as not always providing a valuable quality metric. This metric will be removed from reporting across the system from April 2024, with focus on 1:1 care in labour and supernumerary status of the coordinator as quality metrics, alongside patient safety and experience data.

Trust	October 2023	November 2023	December 2023
Great Western Hospital	1:29	1:29	1:27
Royal United Hospital Bath	1:32	1:30	1:26
Salisbury Foundation Trust	1:30	1:28	1:32

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

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

The inpatient services have been successful with recruitment with the current vacancy sitting within the community midwifery workforce. A rolling recruitment program is in place which supports new staff to join the Trust and offers the opportunity for staff rotation to community services.

There is now a plan to further focus on retention of staff, utilising the NHS England Education and Training funding for the retention which has been continued into 2024/25. The below table illustrates the level of staff turnover across departments, monthly between September 2023 and March 2024. The turnover within the clinical teams has stabilised. The increased turnover in the Specialist Midwife group reflects career progression opportunities and secondments and this is not expected to continue. There have been successful appointments into vacant posts which indicates that the succession planning achieved through the appraisal process is providing staff with the skills and abilities to progress within the wider team.

Division	Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Surgery, Women's & Children's Division	Ante-Natal Screening - J65919	5	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Birthing Centre - J65921	16	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Community Midwifery - J65918	50	6	12.00%	5	10.00%
Surgery, Women's & Children's Division	Continuity of Carer - Midwives - J65922	6	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Day Assessment Unit - J65910	25	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Hazel & Delivery Staff - J65914	146	17	11.68%	15	10.31%
Surgery, Women's & Children's Division	Specialist Midwives - J65920	24	4	16.67%	4	16.67%

Alongside the reduced turnover rate, there has been a reduction in sickness in most staff group, with a reduction from 4.21% to 3.63% in the Hazel and Delivery Suite staff groups. This has been supported by a focus on supportive 'Welcome Back to Work' meetings and

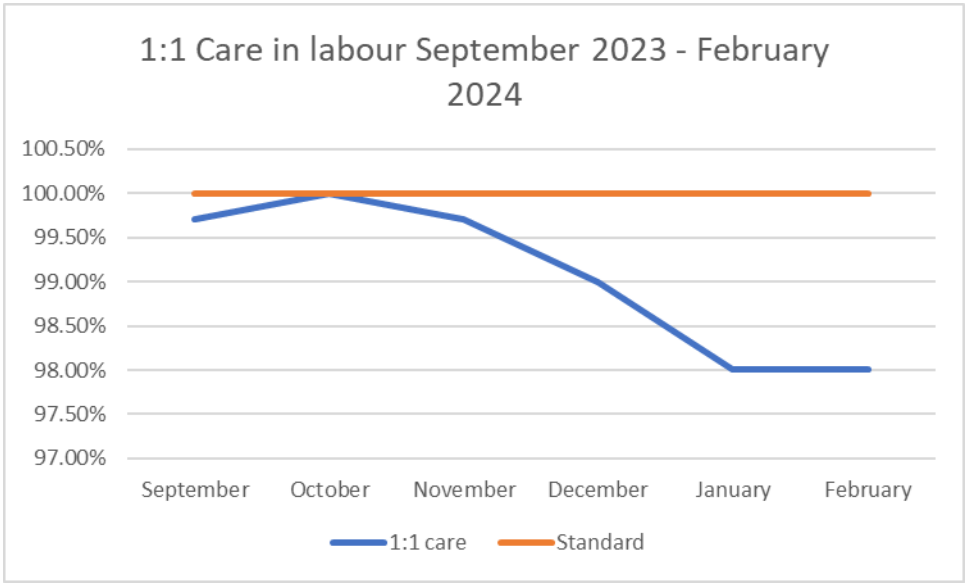
HR guidance. The increased sickness within the community staff relates to long term sickness with mitigations in place including staff support to return to work.

Sickness Rates as of February 2024				
Department	Professional Group	ST	LT	% Sick
Ante-Natal Screening - J65919	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Birthing Centre - J65921	Registered Nursing and Midwifery	3.63%	0.00%	3.63%
Community Midwifery - J65918	Registered Nursing and Midwifery	2.55%	4.18%	6.73%
Continuity of Carer - Midwives - J65922	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Day Assessment Unit - J65910	Registered Nursing and Midwifery	0.21%	0.00%	0.21%
Hazel & Delivery Staff - J65914	Registered Nursing and Midwifery	1.02%	0.14%	1.16%
Specialist Midwives - J65920	Registered Nursing and Midwifery	0.55%	0.00%	0.55%

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

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

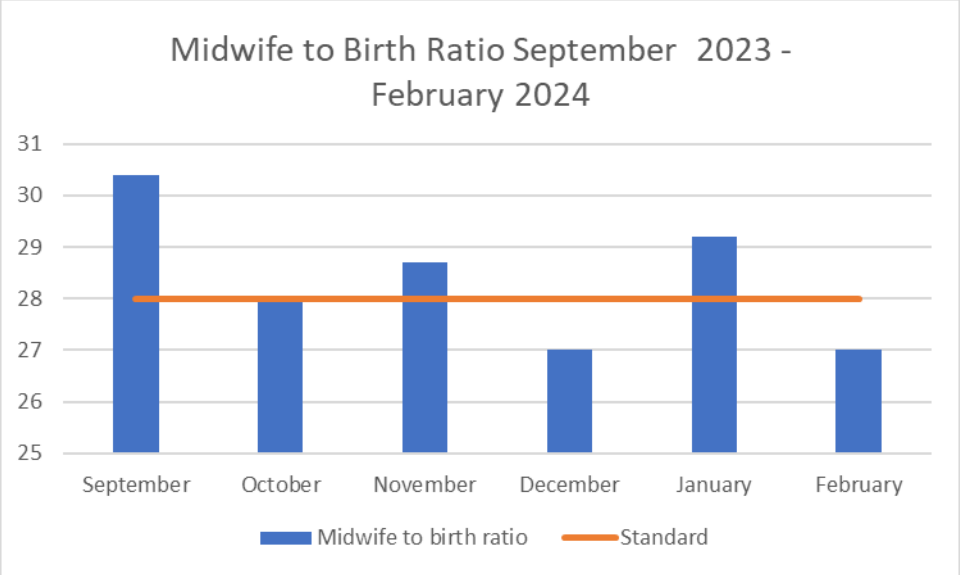
The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the data demonstrates that there is fluctuation between 98 % and 100% compliance over the 6-month period. Each case where 1:1 care is not fully achieved is reviewed to ensure that escalation processes have been utilised to minimise the impact on the family, and to provide opportunities to develop escalation pathways to prioritise labour care in line with the Maternity Incentive Scheme (CNST) safety action 5. A local action plan supports this ambition. There have been no patient safety concerns associated with occasions where the 1:1 care was not achieved.



The Maternity Service monitors and reports the Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer

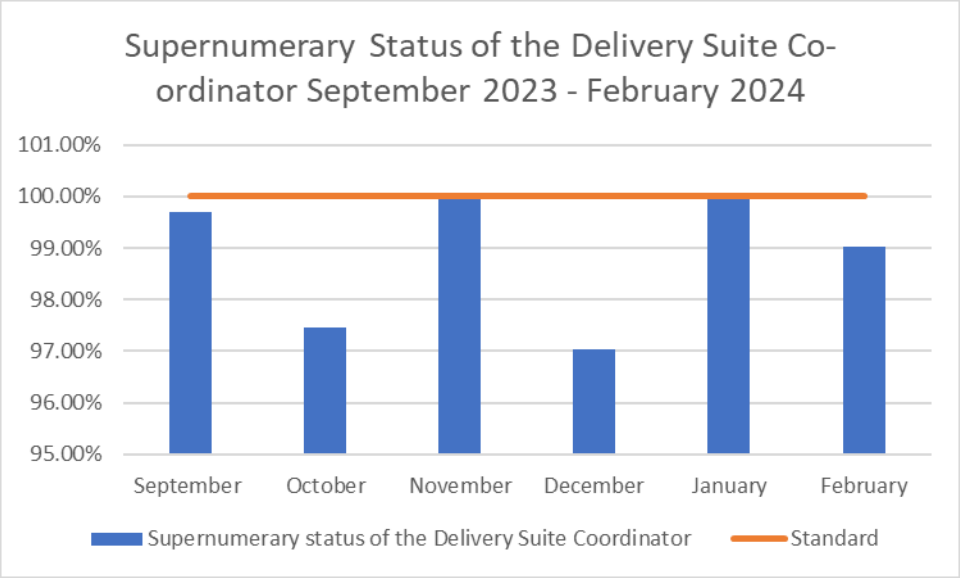
Childbirth (2007). The midwife to birth ratio is calculated using the funded establishment rather than the actual staffing numbers in line with national guidance. The table below demonstrates a fluctuation in the midwife to birth ratio which is impacted by variable birth numbers month on month and the vacancy factor in the community midwifery team.

From April 2024, we will no longer be reporting on the Midwife to Birth ratio, in line with our BSW system colleagues and will be using 1:1 care in labour as our quality measure. This has been agreed with the ICS via the Local Maternity and Neonatal System Program Board.



6.4 Supernumerary status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status to ensure there is an oversight of all birth activity within the service. This is defined as having no caseload of their own during their shift as specified within the maternity Incentive Scheme (MIS). Over the period September 2023 – February 2024 a mean compliance rate of 98.8 % was achieved. The focus is now on achieving 100% compliance and identifying measures to achieve this within the current staffing model. Where compliance is below expected each episode of care is reviewed and reported, by exception, through the monthly Maternity Governance meeting. Of note, following the release of MIS Year 6, the definition will change to as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift.



6.5 Red Flags

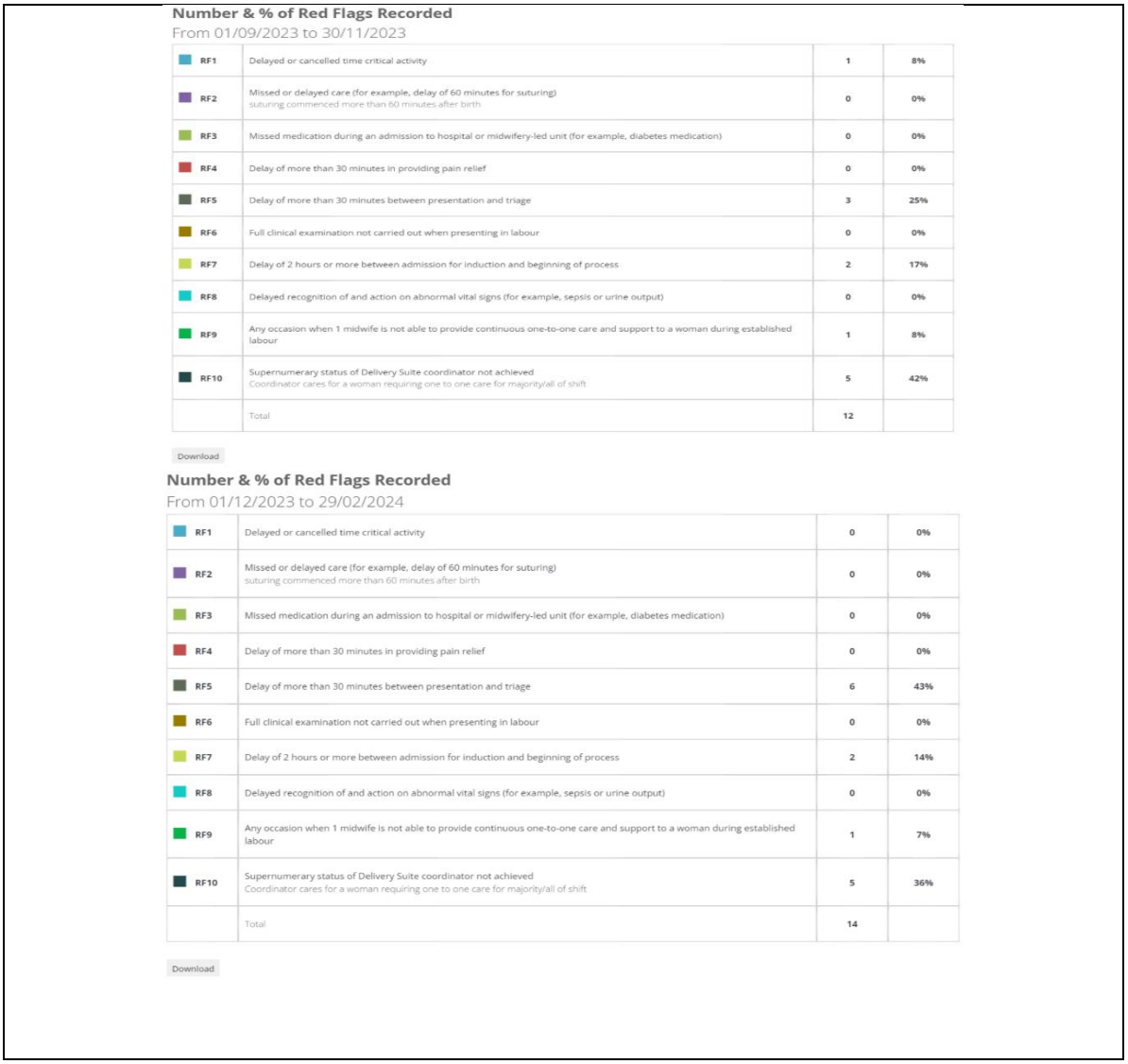
The Maternity unit uses a 'Red Flag' indicator system, captured via BR+, to identify critically low staffed shifts. It has identified 10 red flags which trigger escalation and follows a procedure for mitigation. This takes an overview of staffing across Maternity and relocates staff to areas of need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

The 10 red flags are as follows:

- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes for suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example diabetes medication)
- Delay of more than 30 minutes in providing pain relief
- Delay of more than 30 minutes between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delay recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
- Supernumerary status of Delivery Suite coordinator not achieved.

The data below shows the periods of September to November 2023 and December to February 2024 when 26 red flags were recorded. The delay of more than 30 minutes between presentation and triage was reported on 9 occasions but we expect to see a significant decrease of this number in future reports due to the relocation and ongoing improvements being made to our triage service.

Supernumerary status of Delivery Suite coordinator was recorded as not achieved on 10 occasions and was reported via Maternity Governance.



Number & % of Red Flags Recorded
From 01/09/2023 to 30/11/2023

RF1	Delayed or cancelled time critical activity	1	8%
RF2	Missed or delayed care (for example, delay of 60 minutes for suturing) suturing commenced more than 60 minutes after birth	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	0	0%
RF5	Delay of more than 30 minutes between presentation and triage	3	25%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	2	17%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	8%
RF10	Supernumerary status of Delivery Suite coordinator not achieved Coordinator cares for a woman requiring one to one care for majority/all of shift	5	42%
	Total	12	

Download

Number & % of Red Flags Recorded
From 01/12/2023 to 29/02/2024

RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes for suturing) suturing commenced more than 60 minutes after birth	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	0	0%
RF5	Delay of more than 30 minutes between presentation and triage	6	43%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	2	14%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	7%
RF10	Supernumerary status of Delivery Suite coordinator not achieved Coordinator cares for a woman requiring one to one care for majority/all of shift	5	36%
	Total	14	

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In April 2023 an Acute Unit Midwifery on call system was introduced which is now embedded in the Maternity escalation policy. This has been utilised on 15 occasions since introduction, demonstrating a low frequency of use with a high impact where the on-call system been triggered via escalation processes.

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

6.6 Recruitment and retention

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

- Introduction of the Midwifery Degree Apprenticeship Program (MDAP). Four members of the existing midwifery support worker team have initiated the MDAP with Winchester University.

- The retention funding via NHS England has been confirmed to be continuing for a further 12 month period.
- An extended supernumerary period for newly qualified midwives is in place, utilising nationally available funding
- Scheduled meet and greets with divisional staff, new starters and students
- Review and refresh of preceptorship package
- Blended learning programme with University of West England
- Working with Universities to increase student midwife places
- Return to practice programme
- Successful completion of the education program for Internationally Educated Midwives
- Band 5 Nurse role within maternity
- Health Education England funding for nurses to undertake 2-year Midwifery course
- Close working with Swindon College, supporting T level student placements
- Health and well-being programme
- Apprenticeship and Nurse Associate model to 'grow our own'.

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

6.7 Continuity of carer

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

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

To ensure that future opportunities for CoCr models of working to be re-instated the Matron for community services continues to maintain engagement with the regional continuity of carer working group to consistently review the adaptations being made nationally to address sustainability of this model of working.

7.0 Neonatal staffing

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

The neonatal unit at GWH works within the South West Neonatal Network to provide the right level of high-quality care to each baby as close to home as possible.

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

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

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

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

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

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

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

	Target	Threshold		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Percentage of shifts staffed to BAPM QIS recommendations	90%	≥90%	<90%	83.8 %	85%	95%	91.9 %	89.6 %	93.5 %
Percentage of Registered Nurse or Midwifery staff who hold Qualified in Speciality (QIS)	70%	≥70%	<70%	68.4 %	71..2 %	71.4 %	65.1 %	65%	65%

The reduction of agency staff does not appear to have negatively impacted the skill mix on a shift-to-shift basis. There is ongoing focus on a rolling pipeline of staff undertaking QIS training to increase the skill mix throughout the workforce. This is an academic module run with a limit on how many nurses can be effectively supported at any one time, therefore the percentage of staff who hold the QIS qualification can expected to improve over the next 12 months.

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

7.1 Recruitment and Turnover in The Neonatal Unit

Turnover Rates			
Department	Average Head Count	All leavers	All Turnover
Neonatal Unit – J65931	48	5	10.42%

Sickness Rates			
Department	Short Term Sickness	Long term Sickness	Total % Sickness
Neonatal Unit - J65931	4.49%	0%	4.49%

The sickness has reduced from 7.01% in the previous reporting period to 4.49% in the current period and has demonstrated a sustained downward trend over the last 12 months.

A refreshed approach to the 'Welcome Back to Work' introduced by the new ward managers process has positively impacted on supporting staff wellbeing.

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

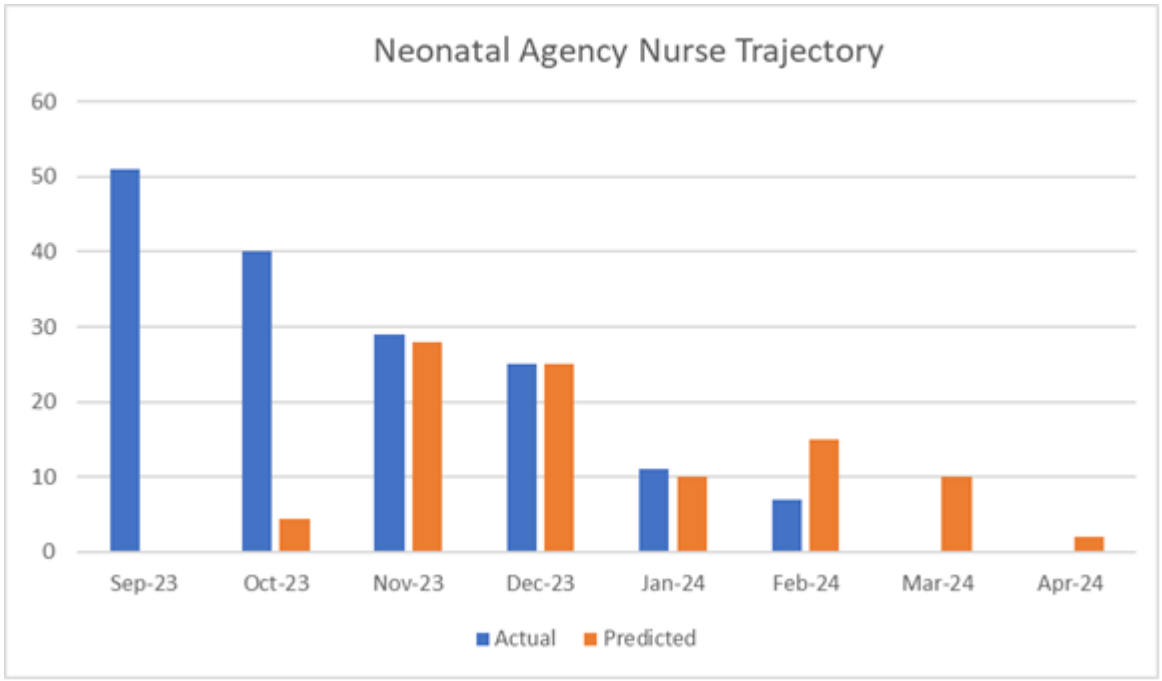
Recruiting Qualified in Speciality (QIS) has been challenging but 2 have been recruited over this reporting period and a further 3 have qualified and another 2 are the QIS course, due to complete in the summer 2024.

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

The Lead Advanced Neonatal Nurse Practitioner (ANNP) is now embedded within the team with one further ANNP in role, and one further post being recruited to. There are 4 apprenticeship ANNPs in post. The qualified posts support both the development of the service provision locally, provide educational, peer support and mentorship to the trainees and nursing workforce, alongside facilitating enhanced service development work and supporting the medical workforce. These roles support career development opportunities within the workforce. With the pipeline of apprentices a fully staffed rota will be in place from 2026.

7.2 Temporary staffing

There has been considerable focus on reducing agency use on the neonatal unit. A consistent and robust strategy was implemented in November 2023 with increased controls has demonstrated a sustained reduction in agency staff bookings with no agency bookings in March 2024.



8.0 Allied Health Professionals report

Allied Health Professionals (AHP's) are mainly degree level professionals who work across health and social care to provide system wide care. They are integral in assessment, diagnostics, treatment, discharge, and rehabilitation. AHP's are the third largest clinical workforce in health and social care. There are 14 professional groups within the AHP framework, of which Great Western Hospital (GWH) employ 9.

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

AHP's are regulated by the Health and Care Professions Council (HCPC) and work alongside support staff to provide evidence based, clinically driven care.

8.1 AHP Workforce

As of March 2024, the Trust employs 541 AHP's (460.5 WTE). This has increased in the past year from 505 (427.61 WTE). There are no safer staffing levels set for AHP's, previous benchmarking or comparisons against model hospital data prove ineffective due to nuances in service offers and structures. One of the challenges in defining workforce numbers and levels is understanding capacity and demand. The national drive from NHS England is to implement job planning to resolve this and provide transparency around service provision.

Of the 541 staff, the majority are registered staff 405 (338.3 WTE), 136 (122.1 WTE) are unregistered and work across acute and community services.

There is one associate director of AHP's (AD of AHP's) in corporate services, and one generic AHP student support team, working with AHP undergraduates and apprentices. This team are strategically guided by the AD of AHP's in conjunction with The Academy. All the other AHP services are managed by service leads and report to divisions.

Recruitment and retention of the AHP workforce remains a challenge within certain teams and professions in line with national shortage. There are specific concerns regarding occupational therapy, podiatry and radiography. AHP workforce planning will help teams to focus on solutions and opportunities and to develop profession specific action plans.

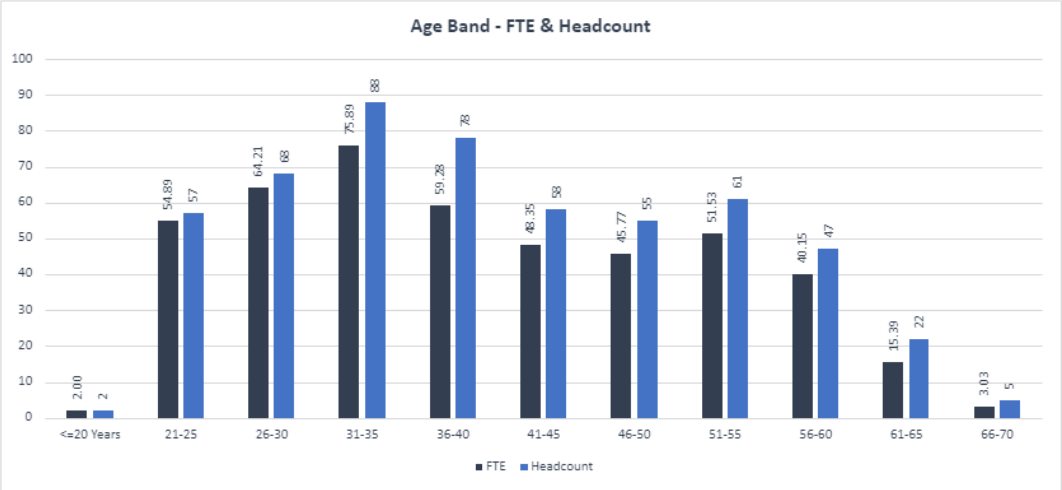
8.2 Workforce Diversity

AHP workforce metrics show the services are a challenge on presenting an ED&I workforce; most of the workforce is female, and is underrepresented from those of a global majority heritage. This is reflective of the national picture for AHPs and has remained unchanged in the past year, suggesting there is more work to be done on diversity and inclusion both nationally and locally.

Ethnicity	HC	HC %	FTE	FTE %
Asian	49	9.06%	46.08	10.01%
Black	18	3.33%	17.53	3.81%
Mixed	5	0.92%	4.40	0.96%
Other	7	1.29%	7.00	1.52%
Undefined	40	7.39%	31.31	6.80%
White	422	78.00%	354.17	76.91%
Grand Total	**541**	**100.00%**	**460.50**	**100.00%**

AHP staff declaring disability has remained at 5% for the past year, suggesting little has changed in the workforce, the figure nationally is around 24% of the population. LGBTQ+ AHP community remains static at slightly over 3% which is reflective of the population average.

The age profile remains as last year and shows an even spread. The exception being in the younger workforce. Due to the nature of degree entry, the younger workforce noted are likely to be unregistered and therefore is something to consider growing to develop the workforce pipeline.



8.3 Sickness

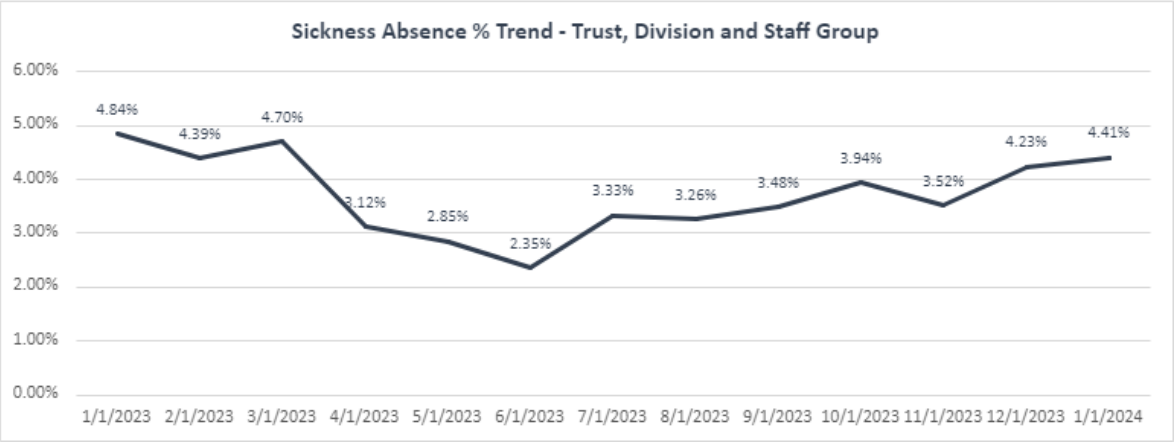
Sickness had been on a downward trajectory from its peak of over 4.7% in March 2023. However, it has been steadily rising since June 2023 and is almost in line with this peak at 4.4%, sitting 1% above trust guidelines.

Acute therapies (OT, Physio and the FDT) all have significant sickness levels. It is felt a large proportion of this is attributed to workload stress due to pressures of acute work and staff vacancies. Community podiatry also has high sickness levels which are largely attributed to one member of staff being on long term sick leave. This significantly impacts on their service delivery and requires collaboration and support with the podiatry lead and IC&C to manage.

Diagnostic radiotherapy, largely within the breast service, has a high level of sickness. They have experienced a significant staff shortage over the past year and have only recently recovered their vacancies. Sickness will require close monitoring to see whether this falls as

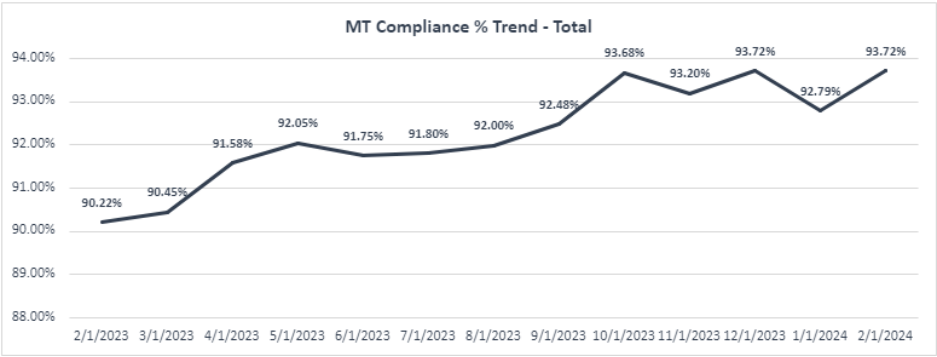
the new recruits are upskilled. This will require collaboration and support from the medical division to manage.

ODP's also have high sickness, which requires further investigation with the service leads and surgery women's and children's division.



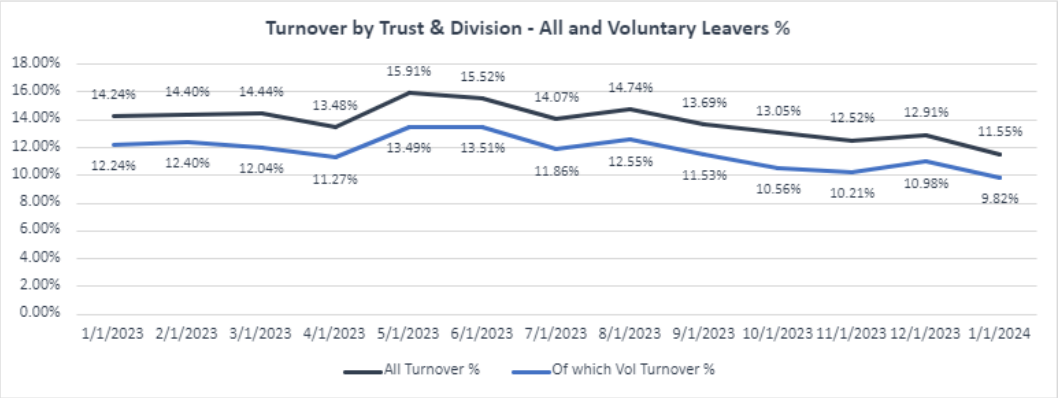
8.4 Mandatory Training

Mandatory training is generally very positive and remains consistently above 90% which is above the trust target.



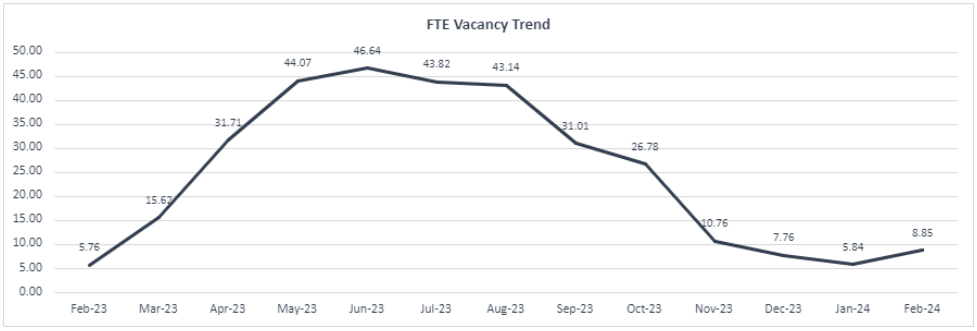
8.5 Staff Turnover

After an upward trajectory of turnover which peaked in May 2023 at 15.9 %, staff turnover has been gradually reducing and is now just over 11%. However, reasons for leaving have changed from reasons not associated with work, such as adult dependents and relocation, to more recent leavers data stating poor work life balance and health difficulties. When viewed in line with our staff survey results this is a potential area for concern and requires close monitoring.



8.6 Recruitment and Retention

From a peak of vacancies in May 2023 vacancy levels have consistently reduced. This has changed recently as demonstrated with a small upward trend which requires close monitoring and timely intervention to put proactive measures in place.



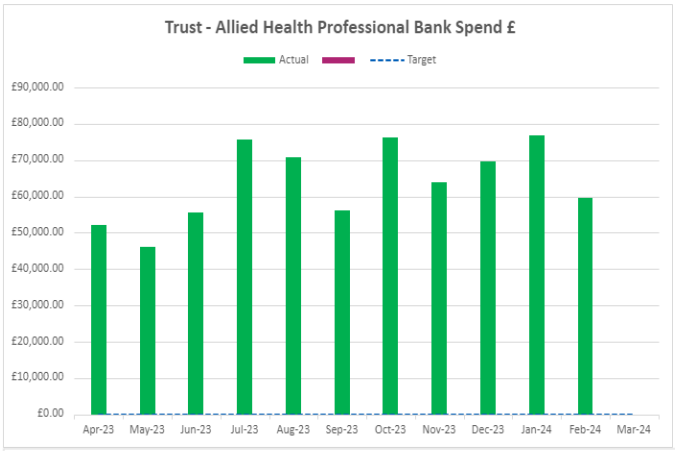
Overall, the vacancy gap is reducing which presents a positive picture, however the bank and agency spend is proportionally much higher than nursing and midwifery and further action is required to address.

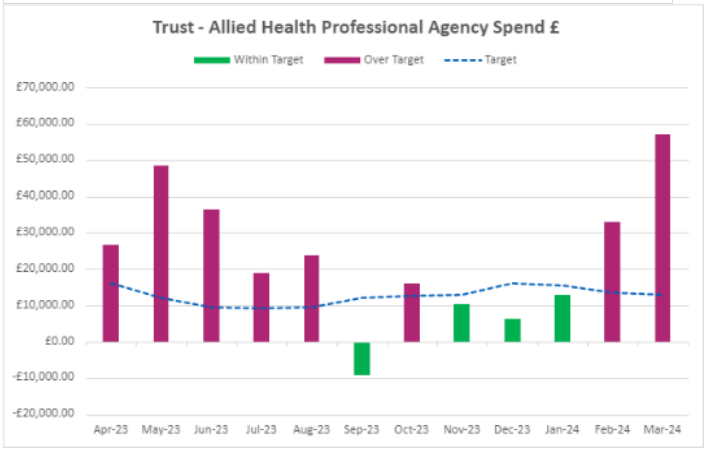
8.7 AHP Agency and Bank Spend

There are a cumulation of reasons for increased agency and bank spend, most of which is allocated to Radiotherapy and Occupational Therapy (OT), including,

- National workforce shortages in the AHP workforce with future predicted supply and demand issues particularly of concern in Radiography and speech and language therapy over the next 10 years.
- Significant issues with acute OT provision which reflects the Bath, Swindon, Wiltshire (BSW) and the national picture. The pipeline supply of OT, radiography, SALT and dietitian graduates is forecast not to supply demand. This presents an ongoing long-term risk of service delivery, particularly around flow, without proactive measures now.
- Acute trust OT's due to the nature of work is seen as an unappealing career option, leading to many acute trusts offering golden handshakes and being targeted to work abroad.

As part of the new governance structure being implemented there will be an Agency and Bank reduction group which will utilise A3 methodology to target and reduce temporary staffing spend. A summary of bank and agency spend is provided in the tables below.





8.8 AHP workforce planning

Workforce planning using A3 methodology has been completed in areas of workforce concern including diagnostic radiotherapy and acute OT. A long-term strategy for the AHP workforce, is being developed with a focus on training, retaining, and reforming.

Objective workforce planning around train, retain, reform could be assisted via electronic job planning. Considering capacity and demand, and the future needs of the local population, alongside the changing interface of NHS education to meet the growing needs of learners would assist in applying a formalised model to workforce planning.

The NHS Long Term Workforce Plan suggests future workforce shortages in podiatry, OT, Radiotherapy, SALT and dietetics. Podiatry training is moving from university to the work placed training model and this will support the ethos of ‘grow your own’ at the Trust. OT have also developed apprenticeships which will support workforce of the future.

8.9 Safer staffing and elective recovery

There are no set safer staffing levels for AHP’s, and other than the stroke SSNAP, there are no national data sets that enable the Trust to ascertain service delivery in line with standards. The acute hospital alliance (AHA) is in the process of benchmarking across BSW. Electronic job planning is the most accurate way to ascertain clinical output and enables services to assess capacity against demand.

Radiography, Physiotherapy and Dietetic services are working hard to support the elective recovery plan. These are monitored and progressed through the Improving Together performance framework within divisions. Physiotherapy have run highly successful open weekend clinics; this has enabled them to bring waiting lists down. They are also seeing more patients in a group capacity which enables a higher patient to staff ratio providing efficiency alongside positive clinical outcomes and improved patient experience.

8.10 AHP Leadership

The Trust has invested in the first dedicated Associate Director for AHP, and one of the Deputy Chief Nurses will take the role of embedding a new corporate AHP Governance model to provide more robust and visible leadership, support, and oversight. The initial scoping has identified the governance structure for AHP's requires strengthening to facilitate reform of our workforce and service provision. To ensure delivery of the AHP strategy a new governance structure for AHP's is proposed with the aim of strengthening the AHP voice at all levels to ensure they can be part of the solution to deliver against local and national strategy.

There remain gaps in professional leadership within Radiography, they have Clinical leadership of specialities (Diagnostic Radiology, Ultrasound and Mammography) but as yet no professional lead of their overall service, a general manager who is a radiographer by background is currently providing clinical leadership with positive results.

8.11 Training

There is ongoing work to establish and grow the workforce for the future with T-level and apprenticeship entry routes are now established in most areas. The introduction of the AHP student team has been successful in supporting students and ensuring a positive experience. A review of student capacity has released additional capacity and expanding to local universities including Reading and the University of Gloucestershire.

8.12 International Recruitment (IR)

28 international recruits have been supported to date, the majority of which are in the ODP and radiography workforce, followed by OT and Physiotherapy. All pastoral support is provided by the clinical teams and work is ongoing to improve the experience and ensure the international recruits have a positive experience. Funding for four IR's is in place for 24/25.

8.13 Skill mix

In GWH we have 136 AHP support workers demonstrating approximately a 3:1 ratio of registered to non-registered. The development of assistant practitioners (AP) to take on delegated duties is supported nationally as a solution to ongoing workforce issues. A review is planned to see how this can be maximised at the Trust.

8.14 Workforce Reform

There are seeing increasing numbers of AHPs developing into Advanced Care Practitioners and work is ongoing to ensure there is a robust framework for this and aligned to the clinical strategy.

Examples of AHP reforms include.

- A small AHP team working within the cancer team with a focus on supporting patients to be as well as they can prior to cancer treatment and supporting rehabilitation.
- Working to reduce length or stay and reduction in readmissions.
- A multidisciplinary AHP team that supports patients on ICU, introducing rehabilitation at the earliest part of their clinical recovery thus shortening the recovery journey.
- An open gym in stroke rehab, enabling more patients to be seen for longer periods, increasing patients experience and improving SSNAP data.
- Group musculoskeletal groups for orthopaedic post-op recovery and pain have also shown positive patient experience and a more efficient way of working. resulting in improved efficiency, waiting lists and patient experience. Some patients have been so positive they have come off surgery wait lists.
- Same day discharge trial for hip and knee patients with positive results.
- AHP at the front door, facilitating discharge and early intervention, including an ACP and paramedic handover supporting admission avoidance.
- Podiatry and podiatrist surgical teams preventing and avoiding admissions for those with complex foot disease, reducing surgical intervention, decreasing length of stay and admission avoidance.
- Student team have changed the way we support students with improved student and clinical team experience, leading to increased student offers and positive learner feedback.
- Preceptorship in place supporting new learners.

9. Trust Risk Register

As per NQB guidance, the Nursing and Midwifery staffing risks are on the Trust Risk Register. These risks are reviewed monthly at the Nursing, Midwifery and AHP Workforce Group.

10. Conclusion

The Trust has made good progress in delivering safe staffing across acute, community and Midwifery. There is significant improvements seen in the areas with safer staffing investment and the work on recruitment and retention is improving staff experience and patient care. There is good governance and oversight of staffing and escalation processes in place for any concerns.

11. Recommendations

The report makes the following recommendations:

- Continue to ensure good recruitment and retention programmes with bespoke plans in high risk areas and retention initiatives to support front line nursing and midwifery staff.
- Ensure that the SWICC wards working at a 1:10 ratio are included in the next business planning cycle and the impact on quality continues to be closely monitored.
- Continue to implement the fair and manageable workload in community nursing and consideration of the deficit in establishment from the SNCT audit.
- Continue to develop the Nurse Associate role and the pathway for unregistered nurses into registered nursing.
- Continue to develop the AHP workforce strategy

Report Title	**Equality, Diversity & Inclusion Pillar Metric Review**				
Meeting	**Trust Board**				
Date	**6 June 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Sharon Woma, Equality, Diversity & Inclusion (EDI) Lead				
Appendices	PowerPoint Slides: Board Review EDI Pillar Metric v0.2				

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):

Trust Board Action: Commitment to invite GWH staff networks to participate in a deep dive into the staff survey questions related to inclusion and discrimination.

The Trust's EDI Pillar metric is Question 16B of the staff survey: In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues. The attached presentation highlights this data, including the groups (protected characteristics) who disproportionately experience this behaviour.

A Discrimination A3 is included to support dialogue, and insights from this focussed discussion will inform the 2024-25 EDI Action Plan.

The Trust Board and staff network representatives are invited to review this information and discuss potential Counter Measures (actions).

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	• Board has previously reviewed staff survey results • A3 developed alongside engagement with workforce in 2023.			
Next Steps	Annual report action plan will respond to findings – for Board approval by October 2024.			

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

Explanation of above analysis:

There is a Trust-wide focus on addressing discrimination and other forms of unprofessional behaviours, the presentation highlights data from the staff survey results which indicates that minoritised staff, are disproportionately likely to experience discrimination, this is particularly high on the grounds of race. This data supports the need for a Trust-wide approach to addressing this issue, that not only reduces discrimination overall but also reduces the disparities between the groups who typically experience discrimination and those who do not.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Board and staff network leads to discuss contents and share feedback/ recommendations.

Accountable Lead Signature	Jude Gray, Chief People Officer
Date	30/05/2024

NHS
Great Western Hospitals
NHS Foundation Trust

GWH Staff Survey Results 2023-2024: Equality, Diversity & Inclusion Pillar Metric [Addressing Discrimination]

Trust Board

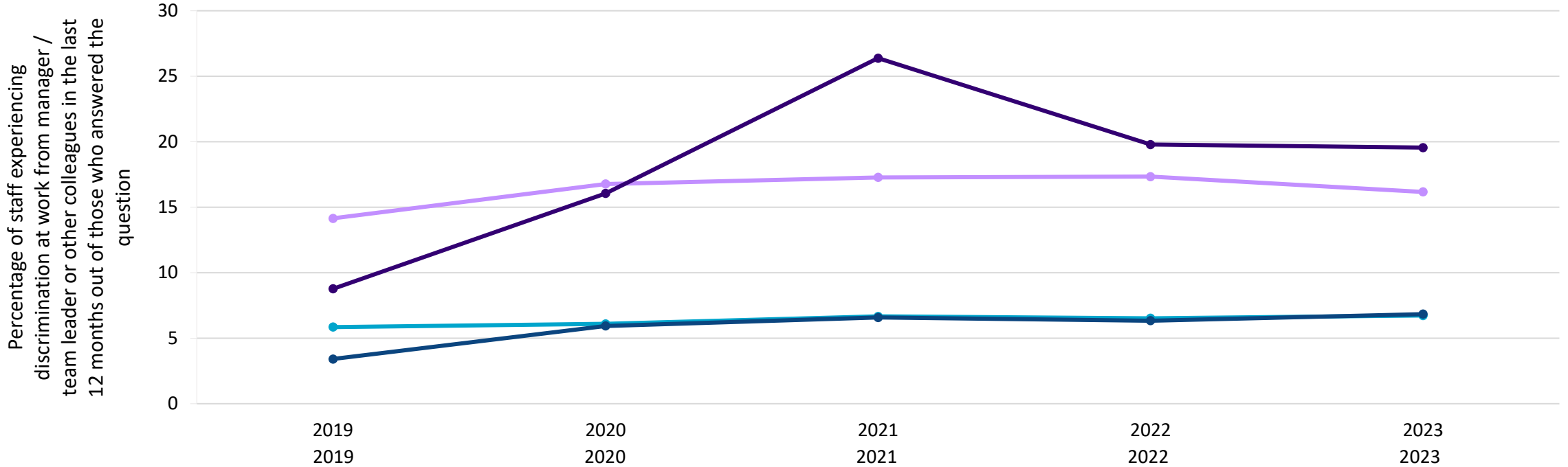
June 2024

Together we are Great

Workforce Race Equality Standard (WRES)

Great Western Hospitals NHS Foundation Trust

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



	2019 2019	2020 2020	2021 2021	2022 2022	2023 2023
White staff: Your org	3.41%	5.94%	6.58%	6.34%	6.84% ↑
All other ethnic groups*: Your org	8.77%	16.05%	26.37%	19.78%	19.55% ↓
White staff: Average	5.85%	6.09%	6.67%	6.52%	6.73%
All other ethnic groups*: Average	14.14%	16.77%	17.28%	17.33%	16.17%
GWH Disparity	**5.4%**	**10.1%**	**19.8%**	**13.5%**	**12.7%**
Benchmark: National Disparity	8.3	8.3	8.3	8.3	8.3
White staff: Responses	411	556	2021	2445	2820
All other ethnic groups*: Responses	57	81	137 364	632	1018

Experience by Staff Group

Great Western Hospitals NHS Foundation Trust

Staff Group	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (NO).	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (YES).
Estates and Ancillary (wat are demographics)	95.1%	4.9%
Administrative and Clerical	93.8%	6.2%
Add Prof Scientific and Technic	93.4%	6.6%
Allied Health Professionals	93.0%	7.0%
Healthcare Scientists	90.1%	9.9%
Medical and Dental	88.6%	11.4%
Nursing and Midwifery Registered	87.8%	12.2%
Additional Clinical Services	86.7%	13.3%
Divisions		
Corporate Services Division	93.5%	6.5%
Integrated & Community Care Division	91.5%	8.5%
Surgery Women's & Children Division	88.0%	12.0%
Medicines Division	88.5%	11.5%
Organisation	**89.8%**	**10.2%**
Comparator	**90.9%**	**9.1%**

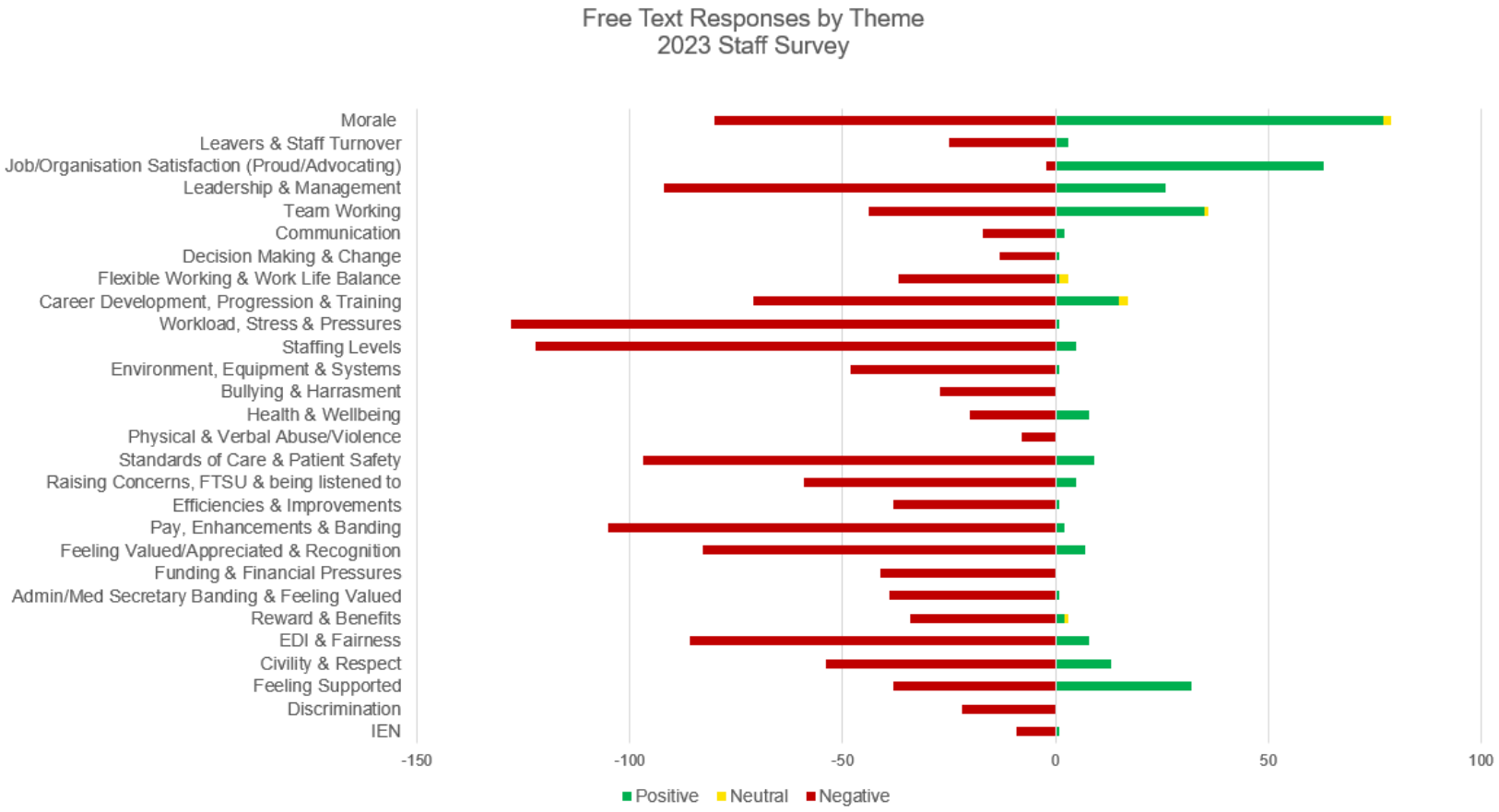
Score > 3% better than Organisation average

Score > 3% worse than Organisation average

Scores in between

Staff Survey: Free Text Analysis

2023 Staff Survey Results



The Staff Survey allows our staff to provide a free text response highlighting any other comments they wish to share. For 2023, we have analysed and grouped these responses into prevalent 'themes' and reported the number of Positive/Neutral/Negative responses associated with each.

Overall, free text sentiments are:

17% Positive	5% Neutral	78% Negative

By volume, Morale is the most prevalent theme with a balanced split between positive and negative responses.

'Workload, Stress & Pressures' is the second most prevalent theme and reported as 99% negative, and narrative links closely to 'Staffing Levels' which scores similarly.

Staff Survey: Insights from free text analysis

Great Western Hospitals NHS Foundation Trust

Theme	Insight
Perceived inequalities in workload and treatment	• Some staff feel that work is not distributed fairly and that there is favouritism in task allocation.
Career Progression and Equal Opportunities	• Limited opportunities for career progression. • Insufficient support for professional development and inconsistent pay and recognition for experienced international staff. • Need for transparent and fair processes in promotion and training opportunities. • Biased recruitment processes. • Workload pressures prevent some staff from accessing development opportunities.
Management and Leadership	• There is a perceived disconnect between management and front-line staff, with poor communication affecting morale and motivation. Managers can be seen as detached and unapproachable. • Reports of bullying and unfair treatment by colleagues and managers contribute to a toxic work environment. Staff feel that their complaints are not taken seriously or there is a lack of response, leading to a lack of trust in the system. • The values of 'equality and fairness' were not being genuinely applied.
Work life Balance	• Inconsistent shift patterns. • Poor work life balance.
Cultural sensitivity and discrimination	• Need for improved cultural sensitivity; and consideration for other cultural practices including religion. • There are concerns about covert (subtle) racism and micro-aggressions against ethnic minority ethnic staff and the way this is addressed. • While some staff appreciate the diverse and supportive environment, others report feeling psychological insecurity and unfair treatment.

Revised Improving Together | DISCRIMINATION A3

Great Western Hospitals NHS Foundation Trust

Metric Discrimination: Personal Experience of Discrimination in a 12-month period (2023)

Lead(s) Sharon Woma, EDI Lead

Step 1: Problem Statement

9.88%* of all staff at GWH have experienced discrimination (up from 8.92% last year), some protected characteristics are disproportionately represented in this data, **a disparity of 12.7%** (19.5% minus 6.8%). The Trust aspires to reduce the experience of discrimination and be ranked amongst the best performing NHS organisations in future surveys.

**GWH NHS Staff Survey 2023 - Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?*

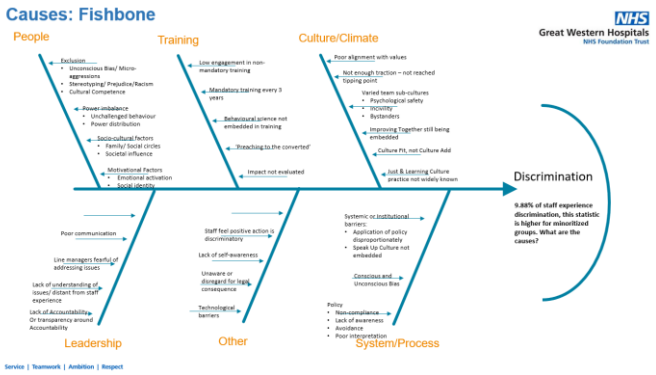
Step 3: Vision & Goals

Vision: To create an inclusive environment for all staff that is free from discrimination.

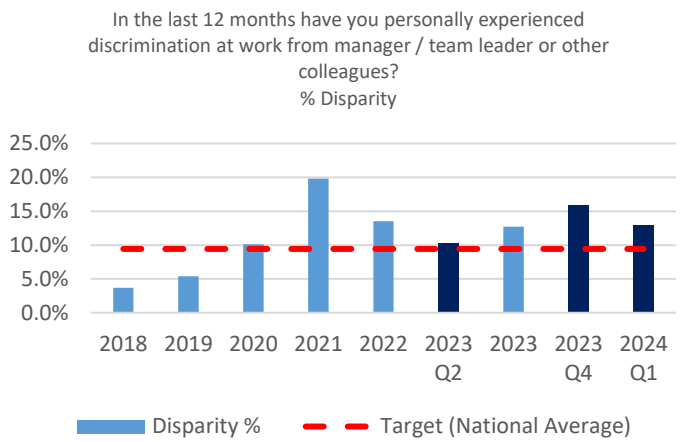
Goals:

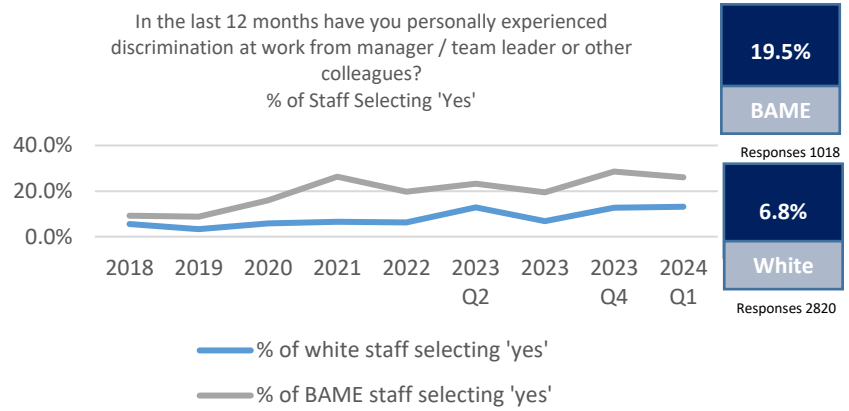
- Improve metric – **target disparity of 9.4% by 2025**, and achieve year-on-year progress (national disparity increased from 8.3 to 9.4%)
- Positively impact related metrics by addressing different forms of discrimination (e.g. opportunities to progress, bullying and harassment, feeling pressured to work)
- To influence system practice and work collectively to address findings

Step 4: Interim Root Cause / Gap Analysis (see overleaf)



Step 2: Current Situation – Percentage of Staff who Experience Discrimination





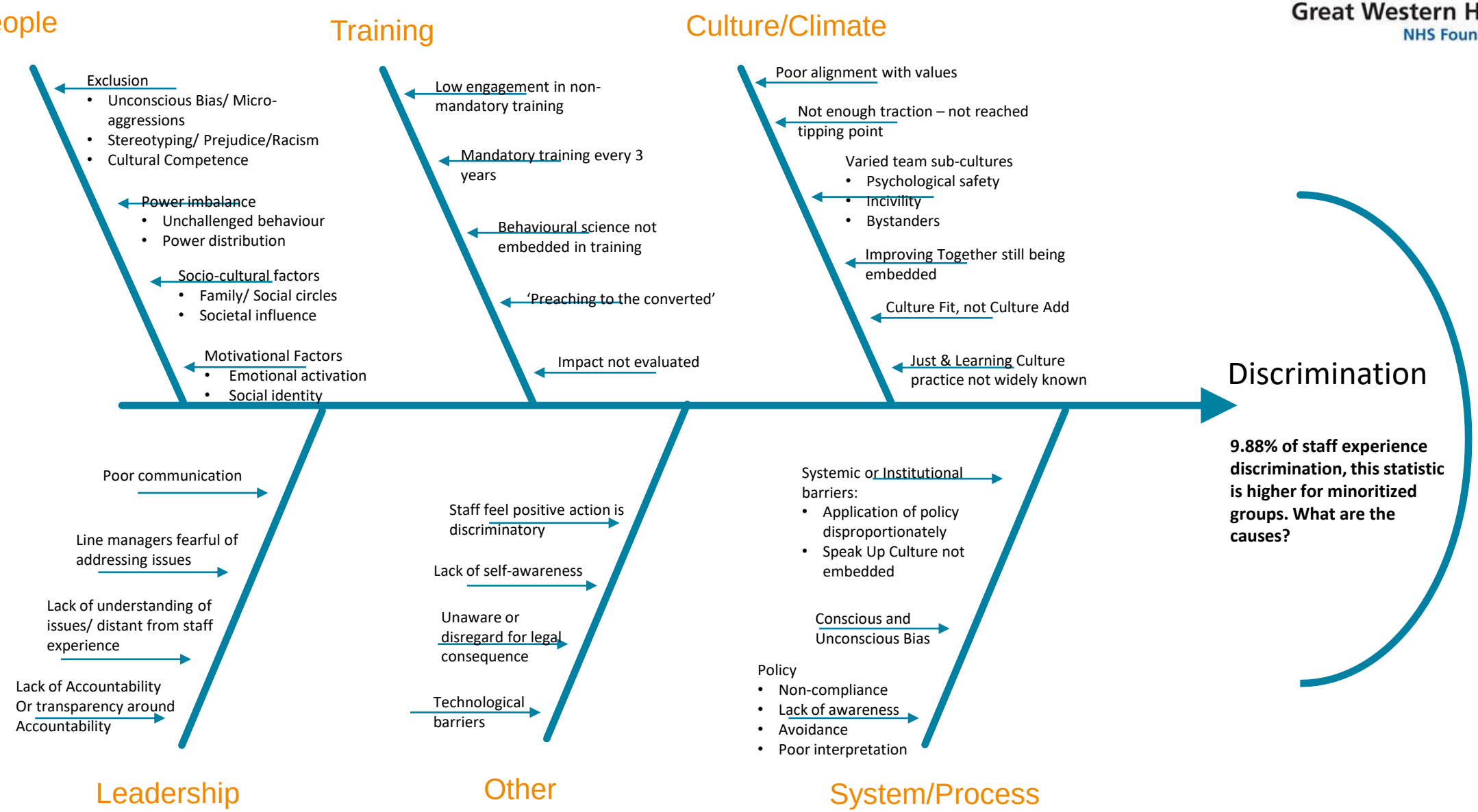
Supported by Q16C – what grounds have staff experienced discrimination (no. of responses 622)

Protected Characteristic	Ethnicity	Gender	Religion	Sexual Orientation	Disability	Age	Other
2023 GWH	57.06%	15.83%	4.12%	3.52%	9.09%	14.56%	20.19%

Step 5: Countermeasures

Board discussion: Identify Counter Measure

Causes: Fishbone



Discussion


Based on what you have learnt, discuss potential counter measures in small groups – keeping our Improving Together philosophy at the heart of the conversation (inch wide/mile deep; staff involvement)

Report Title	**Committee Effectiveness Review 2023/24**				
Meeting	**Trust Board**				
Date	**6 June 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Finance, Infrastructure & Digital Terms of Reference Appendix 2 – Quality & Safety Committee Terms of Reference Appendix 3 – Performance, Population & Place Terms of Reference Appendix 4 – People & Culture Committee Terms of Reference Appendix 5 – Mental Health Governance Committee Terms of Reference Appendix 6 - Charitable Funds Committee Terms of Reference Appendix 7 – Remuneration Committee Terms of Reference				

Purpose

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

Assurance Level

Assurance 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 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Report

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

The committees of the Board have completed an annual review and self-assessment of performance using a standardised approach.

Each committee produced an Annual Report and has reviewed their Terms of Reference as appropriate as well as an annual cycle of business.

Attendance has been generally good during 2023/24 and all committee meetings have been quorate allowing committee business to be appropriately transacted.

Each Committee has continued to meet its Terms of Reference and has delivered a comprehensive programme of work on behalf of the Board, providing timely reporting of issues via monthly Committee Chair Assurance Reports.

This report invites the Board to note a committee effectives review has been undertaken and to consider the terms of reference of the Board Committees as attached. Minor amendments have been made to reflect feedback from committee members, or where job titles have changed, these are highlighted in yellow.

There were no issues or concerns to draw to the attention of the Board about the effectiveness of the committees, the committee structure generally or the terms of reference for each committee.

The Audit, Risk & Assurance Committee and the Trust Management Committee terms of reference will come to the Board in August/September 2024.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Quality & Safety Committee Finance, Infrastructure & Digital Committee Performance, Population & Place Committee People & Culture Committee Mental Health Governance Committee Charitable Funds Committee Remuneration Committee				
Next Steps	To align annual work plans to the terms of reference				

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

Recommendation / Action Required
The Board/Committee/Group is requested to:

The Board is requested to approve the terms of reference for the following Board committees:-

Quality & Safety Committee
Finance, Infrastructure & Digital Committee
Performance, Population & Place Committee
People & Culture Committee
Mental Health Governance Committee
Charitable Funds Committee
Remuneration Committee

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	29 May 2024

FINANCE, INFRASTRUCTURE & DIGITAL COMMITTEE TERMS OF REFERENCE 2024/25

Purpose
The purpose of Finance, Infrastructure & Digital Committee is to support the Trust in achieving all its strategic objective with particular reference to: "**Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care".**

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 To support the implementation of the Board's Strategy by seeking assurance about the Trust's financial, estates and digital strategies, including, to the extent necessary and relevant considering the wider BSW system's strategies.

2.2 To ensure that any material, long term financial or business risks identified are brought to the attention of the Trust Board to ensure they are reflected within the Trust's Risk register and Risk management process and to advise the Audit, Risk and Assurance Committee on the adequacy of any mitigation plan and recommend any areas requiring Audit scrutiny.

2.3 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillar (4) *"using our funding wisely to give us a stronger foundation to support sustainable improvement in quality of patient care"*, and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.4 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.5 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Finance, Infrastructure & Digital Committee shall consist of:

- Three Non-Executive Directors (not including the Chair) – at least one of whom will have financial background
- Three Executive Directors; the Chief Financial Officer, Chief Operating Officer and the Chief Officer for Improvement & Partnerships.

3.2 The Committee may call other officers of the Trust to attend as appropriate, however the following will be invited to attend meetings of the Committee on a regular basis:

- Chief Digital Officer
- Director of Estates & Facilities
- Director of Procurement & Commercial Services
- Deputy Chief Financial Officer

3.3 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.4 One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

4. ATTENDANCE

4.1 Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

4.4 *Substitutes/Deputies* - Any Non-Executive Director of the Trust, (excluding the Chair), may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Lead, the Chief Financial Officer.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Financial Strategy and Business Planning

7.1.1 Review for recommendation to the Board the Trust annual and medium-term financial plans, assess the assumptions therein and the alignment with overall Trust objectives, including, to the extent necessary and relevant considering the wider BSW system's annual plans;

7.1.2 To review and make comment to the Board on the long term strategic financial plans of the Trust, and to the extent necessary the wider BSW system, including the level of capital investment and financial risk;

7.1.2 Review in-year performance against financial plan, particularly gaining an understanding of key assumptions and risks, and review the latest year end forecast outturn, and to the extent necessary the wider BSW system;

7.1.3 Review through 'Deep Dive Reviews' any areas requiring particular scrutiny;

7.1.4 Review levels of contingency within the Trust financial plans and the phasing of key developments and efficiency schemes, ensuring that the full impact of any developments (including depreciation and cost of capital) have been appropriately included;

7.1.5 Review and develop reporting arrangements;

7.1.6 To consider and advise the Board on the impact of changes to the financial regime, including, but not limited to, the introduction of financial and governance arrangements in support of the Integrated Care System (ICS), and to monitor robust plans to manage the change

7.2 Income and Contract Management

7.2.1 Review the Trust contracting approach with key commissioners

7.2.2 Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.

7.2.3 Consider material opportunities to grow new income streams and market share of existing services.

7.2.4 To review, approve and/or recommend to Board operational contracts in line with the financial limits within the Scheme of Delegation.

7.3 Improvement and Efficiency

7.3.1 Review the process for developing the Improvement & Efficiency Plans and for the oversight and delivery of the programme within the Trust, including the monitoring of efficiency savings;

7.3.2 Review the implementation of the Trust's strategies and plans to provide assurance on the delivery of both financial and non-financial benefits. In the case of non-financial benefits to highlight any shortfalls to the appropriate committee or to the Board;

7.3.3 Consider and recommend any major transformation programmes that the Trust should undertake;

7.3.4 Review the annual Improvement & Efficiency Plans to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable;

7.3.5 Receive assurances regarding efficient and effective resource planning, particularly with respect to staffing and the deployment of agency staff;

7.3.6 Receive benchmarking and other relevant information to assess Trust productivity and ensure targeting or efficiency programmes;

7.4 Major Capital Investment Scheme

7.4.1 The Committee has a duty to ensure that a Business Case is prepared which includes sufficient information on the business needs, benefits, risks, funding and affordability, available options, costs, clinical and quality outcome measures, project development milestones, project management and regulatory requirements for it to decide whether or not to approve the scheme or lease.

7.4.2 To review, and recommend, Outline Business Cases and Full Business Cases prior to submission to the Board in line with the financial limits within the Scheme of Delegation;

7.4.3 In respect of major capital projects of the Trust, and to the extent necessary the wider BSW system, to consider business cases in detail and where necessary advise on strengthening prior to making recommendations to the Board for its approval or

otherwise. To monitor these projects post-approval and scrutinise any cost or time variances.

7.4.3 If major capital investment schemes are approved by the Committee, and by the Board of Directors if appropriate, the Committee will be responsible for reviewing the outcomes achieved following completion.

7.5 Key Commercial Arrangements

7.5.1 The Committee will review key commercial arrangements including long-term leases, partnership arrangements and major service developments. The Committee will track the progress of such developments, as appropriate.

7.6 Procurement

7.6.1 Review the Trust Procurement Strategy, systems and arrangements for obtaining best value;

7.6.2 Monitor progress against the NHS Standards of Procurement within the Trust.

7.7 Other – Financial

7.7.1 To advise on cash management strategies and levels of cash holding;

7.7.2 Review financial systems arrangements including those used for costing, income and service level reporting where appropriate.

7.8 Infrastructure (Estates & IT/Digital)

7.8.1 To approve for recommendation to the Board the Estate and IT strategic plans to ensure that it aligns with the Trust Strategy and operational objectives, including patient care delivery, and that the necessary information governance and technology arrangements are in place to support the developing Integrated Care System (ICS);

7.8.2 To seek assurance regarding operational delivery of estates and facilities (to include equipment management, health & safety, security, Way Forward Programme operational design) and IT plans including benefits realisation, value for money and approaches to the prioritisation of resources, data quality and informatics;

7.8.3 Seek assurance about the resilience of Digital services specifically in relation to the IT operational performance, digital infrastructure, defending against, and recovery from, external threats;

7.8.4 To review key commercial partnerships as appropriate;

7.8.5 Consider the risks to the delivery of the IT programmes, Digital Services, and Estates and Facilities infrastructure in line with the review of the Board Assurance Framework and Corporate Risk Registers.

7.8.5 To work with system partners to ensure the delivery of integrated estates planning.

7.9 Other

7.9.1 To oversee Finance, Estates and Digital Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.9.2 Take responsibility for gaining appropriate levels of assurance for those items related to finance and infrastructure on the BAF for which the Committee has accepted responsibility for board assurance.

7.10 ICS

7.10.1 To receive and review financial and other relevant reports of or relating to the BSW ICS and provider collaborative.

8 Other

8.1 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

9. REPORTING RESPONSIBILITIES

9.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

9.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

10. MEETING ADMINISTRATION

10.1 The Trust Secretariat shall act as the secretary of the Committee.

10.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

10.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

10.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

11. REPORTING/PROVIDING ASSURANCE

11.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Trust Investment Group
- Infrastructure Sub-Committee
- Way Forward Programme Board
- Capital Management Group
- Information Governance Steering Group

11.2 The Committee will also consider key assurance reports as outlined in appendix 1.

11.3 A forward planner of agenda items shall be determined by the Chair.

12. REVIEW

12.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

12.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Version Control

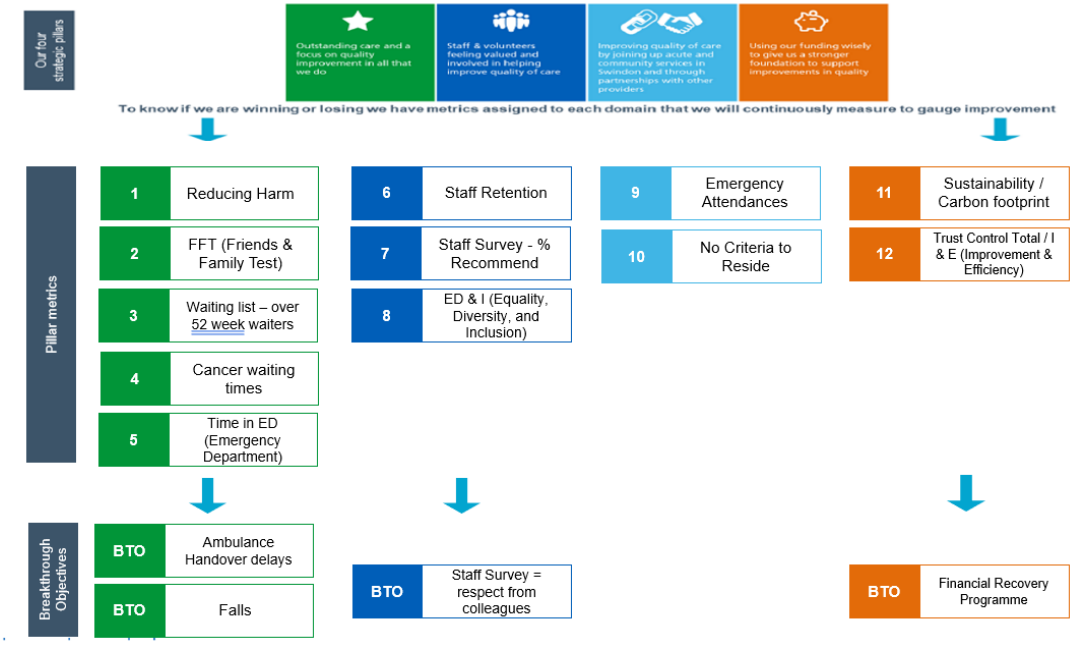
Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Finance & Investment Committee to Finance, Infrastructure & Digital Committee and expanded remit
V1.1	For review	May 2022	Finance & Investment Committee	Considered revised TofR for Finance, Infrastructure & Digital Committee. Amendments include:- • New format • Revised membership • Incorporate oversight and assurance on estates and IT/digital matters • Reference to assigned strategic risk • Added deputies for Executive Directors and voting process • Link to the Strategic Framework • Summary table of meeting remit
V1.2	Clarification	Aug-22	Company Secretary	Differentiate between the focus for IT between this committee and Performance, Population & Place Committee in the summary of meeting; this Committee focusses on systems (not performance)
V2.0	Annual Review	Mar-23	Company Secretary	• Job title changes • Reference to BSW ICS • Update sub-group reporting
V2.0	Approved	May-23	Board	As above
V2.1	Revised	Jun-23	Chairs PPPC & FIDC	Agreed to add IT service performance

				as part of remit of committee so as not to split IT elements between committees.
V3.0	Annual review	May-24	Company Secretary via PPPC	- 2.5 added '*the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make'*. - 3.3 added subject experts as regular attendees - 7.8.3 added IT operational performance - Appendix 1 undated strategic risks - Updated appendix 2

Appendix 1 - Summary

Committee	Finance, Infrastructure & Digital Committee
Chair Lead EDs	Faried Chopdat, Non-Executive Director Simon Wade, Chief Financial Officer Felicity Taylor-Drew, Chief Operating Officer Claire Thompson, Chief Officer for Improvement & Partnerships
Frequency	Monthly
Membership	3 x NEDs 3 x EDs
Quorum	2 x NEDs 1 x ED
Assurances	**Financial** Finance Report /IPR Financial strategy & policy management incl SFIs & SofD Business Planning – Operating Plans and Budget setting Reference Cost Submission Business case approval up to £500,000-£1m Improvement & Efficiency / Cost Improvement Programme Way Forward Programme Private Patients Performance data **Procurement** Contracting Report Review delivery of Procurement & Commercial services **Information Governance** SIRO Report (inc. Data Protection & Security Toolkit Performance) **IT Infrastructure** IT Infrastructure (systems) Cyber security update IT service performance **Estates & Facilities** Estates/infrastructure performance Health & Safety **Risks** Corporate risks - Finance, IT/Digital, Estates Board Assurance Framework
Strategic Risks	Use of Resources – Finance (S7) Use of Resources – Estates Infrastructure (S8) Use of Resources – Digital (S9) Use of Resources – Cyber / IT system failure (SR10)

Appendix 2 – GWH Improving Together Strategic Pillars



QUALITY & SAFETY COMMITTEE
TERMS OF REFERENCE
2024-25

Purpose
The purpose of the Committee is to support the Trust in achieving all its strategic objective with particular reference to: **"Outstanding patient care and a focus on quality improvement in all that we do".**

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 To obtain assurance on behalf of the Trust Board that the Trust has in place the necessary structures and processes for the effective direction and control of the organisation so that it can meet its objectives, in particular, the provision of safe high quality patient care and that it complies with all relevant legislation, regulations and guidance that may from time to time be in place.

2.2 To seek assurance on behalf of the Trust Board that strategic risks linked to strategic pillar (1) "outstanding patient care and focus on quality improvement in all that we do", identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.4 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Quality & Safety Committee shall consist of:

- ~~Three~~ Four Non-Executive Directors (not including the Trust Chair), at least one of whom will have a clinical background
- Two Executive Directors; Chief Nurse & Chief Medical Officer

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

4.1 Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

4.2 The Committee may call other officers of the Trust to attend as appropriate, however The following will be invited to attend meetings of the Committee on a regular basis:

- Deputy of Midwifery & Neonatal Services

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

4.4 *Substitutes/Deputies* - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Leads, the Chief Nurse and Chief Medical Officer.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Patient Safety

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems except for compliance with the Mental Health Act (MHA), Mental Capacity Act (MCA) and Human Rights Acts and associated codes of practice which is monitored at the Mental Health Governance Committee.

7.2 Patient Experience

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 Patient Outcomes

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Trust Board, and monitor its delivery.

7.3.2 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 Quality Improvement

7.4.1 The Committee will make recommendations to the Trust Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Great Care Campaign

7.4.3 The Committee will obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

7.5 Performance Monitoring

7.5.1 The Committee will advise the Trust Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review quality performance where there is ongoing non-compliance as set out in the NHS Constitution or the NHS Oversight Framework.

7.5.4 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.5 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 Other

7.6.1 To oversee quality and safety Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.6.2 Take responsibility for gaining appropriate levels of assurance for those items related to safety and quality on the BAF and the Corporate Risk Register for which the Committee has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Patient Quality Sub-Committee

10.2 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

11.2. The terms of reference of the Committee shall be reviewed annually by the and approved Board of Directors.

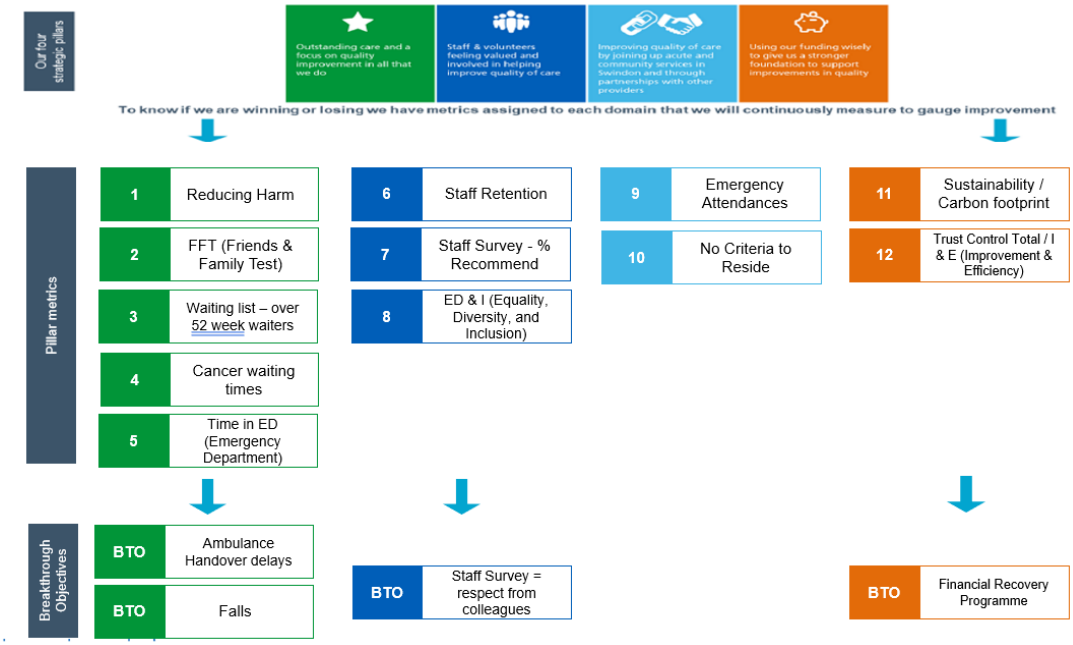
Version Control

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Quality & Governance Committee to Quality & Safety Committee and revised remit
V1.1	For review	May 2022	Quality & Governance Committee	Considered revised TofR for the Quality & Safety Committee. Amendments include: • New format • Reference to assigned strategic risk • Added deputies for Executive Directors and voting process • Clarify remit on safeguarding • Link to the Strategic Framework • Summary table of meeting remit
V2.0	Annual Review	March 2023	Company Secretary	• Job title change • Added oversight of Improving Together matrix for quality • Added reference to NHSE Oversight Framework • Added reference to corporate risk register
V2.0	Approved	May 2023	Board	As above
V3.0	Annual Review	Apr-23	Company Secretary	- Added 2.3 the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make. - Increased 3 NEDs to 4 NEDs in membership - Add Director of Midwifery & Neonatal services as regular attendee - CMO name and title change - Appendix 2 updated

Appendix 1 - Summary

Committee	Quality & Safety Committee - Summary
Chair Lead EDs	Claudia Paoloni, Non-Executive Director Lisa Cheek, Chief Nurse Steve Haig, Acting Chief Medical Officer
Frequency	Monthly
Membership	4 x NEDs 2 X EDs
Quorum	2 x NEDs 1 x ED
Assurances	Quality Performance - IPR/Oversight Framework Quality Strategy Patient experience including national and local surveys Complaints performance data Incident data / Never Events Clinical Risks Quality Report GIRFT oversight Clinical Audit Plan Clinical Effectiveness including NICE Learning from Deaths Infection Prevention & Control/DIPC Research and Development Approval of Resuscitation Policy End of Life Care Children & Young People Safeguarding Adults & Young Children Mortality and Morbidity Performance Maternity & Neonatal - Ockenden Medical device/equipment safety Medication safety Performance data Safer Staffing Freedom to Speak Report Clinical litigation Board Assurance Framework / Corporate Risk Register
Strategic Risk	Quality (SR1)

Appendix 2 – GWH Improving Together Strategic Pillars



Great Western Hospitals
NHS Foundation Trust

PERFORMANCE, POPULATION & PLACE COMMITTEE
TERMS OF REFERENCE
2024/25

Purpose
The purpose of Performance, Population & Place Committee is to support the Trust in achieving all its strategic objective with particular reference to: "**Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers"**

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 Consider and advise the Board on the impact of operational management arrangements and to monitor arrangements in place for performance management.

2.2 Consider and advise the Board on the healthcare needs of the population we serve and how these are being met.

2.3 Consider and advise the Board on the development of our role at place in the ICS/ICA, Acute Hospital Alliance, networks and other (eg academic) partnerships.

2.4 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillars (3) *"Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers*", and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.5 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.6 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Performance, Population & Place Committee shall consist of:

- ~~Four~~ Three Non-Executive Directors
- Two Executive Directors; the Chief Operating Officer and Chief Officer for Improvement & Partnerships.

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

4.1 Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 *Substitutes/Deputies* - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Leads, Chief Operating Officer and Chief Officer for Improvement & Partnerships.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Operational Performance

7.1.1 To seek assurance that the measures incorporated in the Integrated Performance Report and the Oversight Framework to the Trust Board meet both internal requirements and those of external stakeholders. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented.

7.1.2 To monitor delivery of the operational plan on at least a quarterly basis.

7.1.3 To review the operational performance from the wider BSW Integrated Care System to ensure the management of any performance challenges.

7.2 Embedding Continuous Quality Improvement & Learning

7.2.1 To oversee the delivery and embedding of Improving Together approach to continuous quality improvement and learning.

7.2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

7.3 ICS & Partnerships

7.3.1 To obtain assurance that Trust plans will positively impact on population health to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities.

7.3.2 To oversee the development of GWH as an anchor organisation.

7.4 Model of Care

7.4.1 To horizon scan for, be aware of, influence and respond to policy changes relating to models of care.

7.4.2 To ensure that changes in services at the Trust drive the outcomes required in the BSW model of care.

7.5 Other

7.5.1 To oversee Performance, Partnerships and Improvement Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.5.2 Take responsibility for gaining appropriate levels of assurance for those items related to Performance, Partnerships and Improvement on the BAF for which Committee has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. These include:-

- Divisional Board USC
- Divisional Board SW&C
- Divisional ICC
- Elective Care sub-committee
- Urgent care & Flow sub-committee
- ~~Improvement sub-committee~~ Inclusion & Health Inequalities Sub-Committee

10.2 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

11.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Version Control

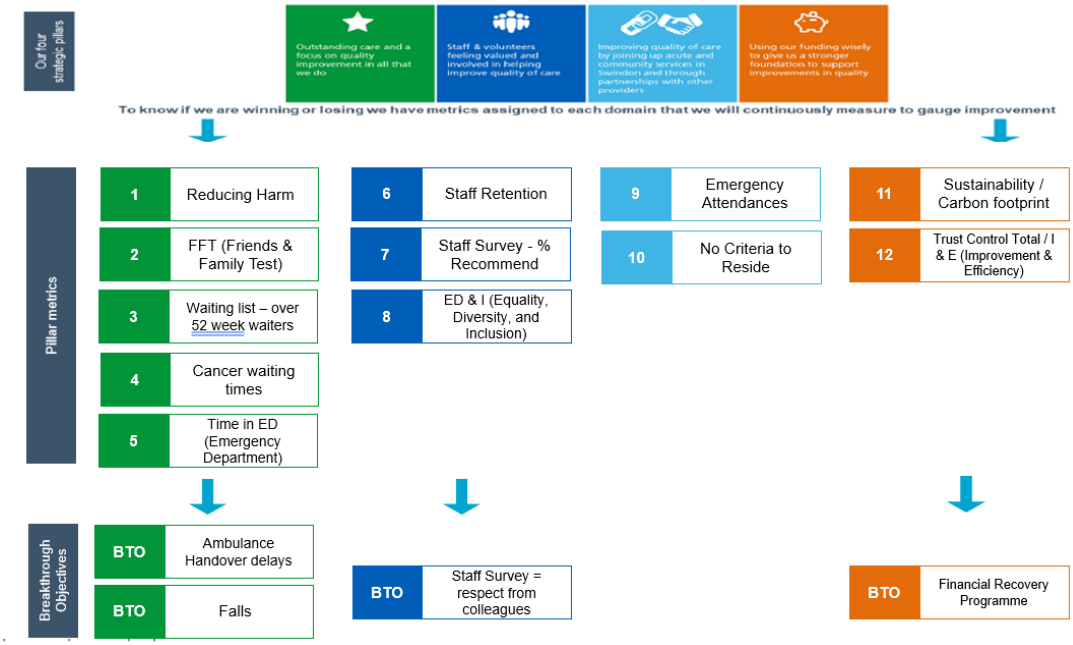
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Performance, People & Place Committee to Performance, Population & Place Committee and revised remit

V1.1	For review	June 2022	Performance, Population & Place Committee	TofR of Performance, Population & Place Committee and approved subject to the following amendments: - 2.2 add 'healthcare' before needs and change we to 'how these are being met' - 7.3.1 delete across the entire population - Add to remit; JSNA annual review, ICS work programme plan, clinical networks and EPRR
V1.2	Clarification	August 2022	Company Secretary via PPPC	Add 7.1.2 to include IT Service performance in Committee remit. To note that Finance, Infrastructure and Digital Committee to focus on Digital Strategy/Systems.
V2.0	Annual Review	March 2023	Company Secretary	• Amendment to job title • Strengthen reference to partnership working • Reference Oversight Framework • Include assurance sub committees • Transferred BSW Academy to People & Culture Committee
V2.0	Approved	May 2023	Board	As above
V2.1	Revised	Jun-23	PPPC/FISC Chairs	IT services performance to be part of FIDC
V3.0	Annual review	May-24	Company Secretary via PPPC	- 2.6 added '*the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make'*. - 10.1 amended feeder groups/forums to the committee - Appendix 1 changed name of Chair of PPPC - Appendix 1 changed strategic risks - Updated appendix 2

Appendix 1

Committee	Performance, Population & Place Committee
Chair Lead EDs	~~Peter Hill~~, Bernie Morley, Non- Executive Director Felicity Taylor- Drewe, Chief Operating Officer Claire Thompson, Chief Officer for Improvement & Partnerships
Frequency	Monthly
Membership	3 x NEDs 2 x Eds
Quorum	2 x NEDs 1 x ED
Remit	Improving Together & Oversight Framework performance data – IPR Winter Plan EPRR Community Services Benchmarking & Model Hospital Report - Impact of ICS plans on the Trust JSNA review Population Health Management ICA work programme Clinical Networks (for P&CC) Integration of Services Delivery of Improving Together PMO Performance Board Assurance Framework
Strategic Risks	~~Patient Care Through Joined Up Services – Model of Care (S3)~~ Patient Care Through Joined Up Services - Performance (S5) Patient Care Through Joined Up Services – Partnerships (S6)

Appendix 2 – GWH Improving Together Strategic Pillars



PEOPLE & CULTURE COMMITTEE
TERMS OF REFERENCE
2024/25

Purpose
The purpose of People & Culture Committee is to support the Trust in achieving all its strategic objectives with particular reference to: ***"Staff and volunteers feeling valued and involved in helping improve quality of care for patients"***.

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 To monitor, review and report to the Board on the cultural and organisational development of the Trust, and to receive and provide the Board with assurance with regard to:

- the organisation's understanding of strategic workforce needs (including wellbeing, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them.

- the implementation of key HR controls, including recruitment and retention, and performance management including appraisal systems.

- the commitments of the NHS Constitution and the stated values of the Trust and standards of behaviour are being practiced at all levels of the organisation, based on evidence.

- the achievement of key deliverables in relation to the equality, diversity and inclusion (EDI) plan, and to monitor key metrics in relation to EDI.

- the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements.

- ensure engagement and consultation processes with staff reflect the ambition and values of the Trust and also meet statutory requirements

2.2 To seek assurance on behalf of the Board that the strategic risks linked to the strategic pillar (2) *"Staff and volunteers feeling valued and involved in helping improve quality of care for patients",* and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.4 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the People and Culture Committee shall consist of:

- Three Non-Executive Directors
- One Executive Directors - the Chief People Officer

3.2 The Trust Chair may attend any or all meetings but is not designated as a member of the Committee.

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

4.1 Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

4.2 The Committee may call other officers of the Trust to attend as appropriate, in particular the Chief Nurse and Chief Medical Officer.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

4.4 *Substitutes/Deputies* - Any Non-Executive Director of the Trust, (excluding the Chair), may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Lead, the Chief People Officer.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 People

7.1.1. Review the development and delivery of the Trust's sustainable workforce strategy, including, to the extent necessary and relevant considering the wider BSW system's strategies, focusing on:

- Strategic workforce information and planning.
- Recruitment and retention.
- Staff experience and engagement, reward, recognition, health and wellbeing
- Education, learning and organisational and leadership development.
- Equality, diversity and inclusivity

7.1.2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies.

7.1.3 Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities.

7.2 Culture and Values

7.2.1 The role of the committee would be to oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback.

7.2.2. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board.

7.2.3. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area.

7.3 Organisational Capacity

7.3.1 The role of the Committee would be to oversee the development and delivery of a strategy regarding a sustainable workforce (more generally), including, to the extent necessary and relevant considering the wider BSW system's strategies. That would include development of new roles, recruitment and retention etc.

7.3.2. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management.

7.4 Education and Training

7.4.1 Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system.

7.4.2. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff.

7.5 Staff Health & Wellbeing

7.5.1 Oversee the development and delivery of a Trust Staff Health and Well-being Strategy

7.5.2. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics.

7.6 Other Duties

7.6.1 To refer to the Trust Board or other Board committee and/or the Executive Team any identified unresolved risks arising within the scope of these terms of reference that require Executive action or that pose significant threats to the operation, resources or reputation of the Trust.

7.6.2 To identify, assess and manage strategic risks in relation to the Committee's area of focus via the Board Assurance Framework. Review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Trust Board with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function.

7.6.3 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the

Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

7.6.4 To receive and monitor workforce indicators including recruitment, retention/turnover, sickness, appraisals and training in the IPR and Oversight Framework.

7.6.5 To receive and review relevant reports of or relating to the BSW integrated care system and provider collaborative.

8. REPORTING RESPONSIBILITIES

8.1 The Committee will report to the Trust board on its proceedings after each meeting through the Board Committee Assurance Report.

8.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Strategic People & Culture Sub Committee
- Employee Partnership Forum
- Joint Liaison Negotiation Committee
- Medical Staffing Support Group
- Nursing, Midwifery and AHP Workforce Committee
- Equality, Diversity & Inclusion Group
- HWB Oversight Committee

10.2 The Committee will consider the key assurance reports as outlined in appendix 1.

10.3 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

11.2. The terms of reference of the Committee shall be reviewed annually by the and approved Board of Directors.

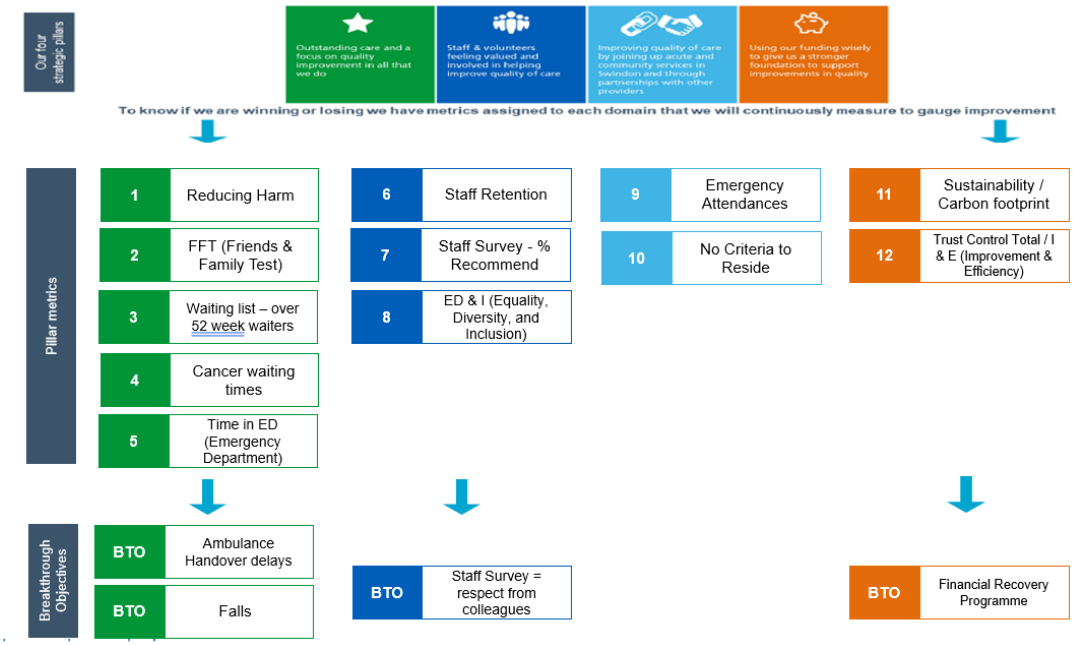
Version Control

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1	For review	March 2022	Company Secretary	New committee
V1.1	For approval	June 2022	Chair and Director of HR	For approval at first P&CC
V2.0	Annual Review	March 2023	Company Secretary	• Job title changes • Strengthen reference to partnership working • Reference Oversight Framework
V2.0	Approved	June 2023	Board	As above
V3.0	Annual Review	Apr-24	Company Secretary	- 2.3 added the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make. - 10.1 added Strategic People & Culture Sub Committee as feeder groups/forums - Appendix 1 changed name of Chair of PC&C - Appendix 1 changed strategic risks from 1 to 3

Appendix 1 - Summary

Committee	People & Culture
Chair Lead ED	Julian Duxfield, Non-Executive Director Jude Gray, Chief People Officer
Frequency	Bi-monthly
Membership	4 x NEDs 1 x ED (Chief People Officer)
Quorum	3 x members (2 Non-Executive Directors and 1 Executive Director).
Assurance	People Strategy Workforce performance IPR / Oversight Framework Equality, Diversity & Inclusion Nursing skill mix Medical revalidation inc. appraisal/MHPS report/GMC Guardian of Safe Working Staff survey and engagement Job planning compliance Education and Training Gender pay gap WRES performance data WDES performance data Organisational Development Clinical Excellence Awards Voluntary services Compliance with employment legislation Recruitment and retention Workforce digital solutions – e-roster, job planning etc.
Strategic Risk	Workforce (SR2, SE3 & SR4)

Appendix 2 – GWH – Improving Together Strategic Pillars



MENTAL HEALTH GOVERNANCE COMMITTEE
TERMS OF REFERENCE
2024/25

Purpose
The purpose of Mental Health Governance Committee is to support the Trust in achieving all its strategic objective with particular reference to: "**Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers"**

1. AUTHORITY

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

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

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

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

2. ROLE / PURPOSE

2.1 All hospitals should have governance arrangements in place to scrutinise the discharge of a range of responsibility under the Mental Health Act and the Mental Capacity Act. The Acts do not outline general requirement of governance arrangements and as such it is a matter for the Trust to determine. At GWH the Mental Health Governance Committee monitors the application of the Acts and advises the Trust Board on issues that may affect its duties under the Acts.

2.2 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.3 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the Chief Nurse and Chief Medical Officer

3.2 One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

4. ATTENDANCE

4.1 Any member of Trust Board may be in attendance at any meeting. However, they will be recorded as 'in attendance' and not as being 'present', unless they are substituting for a substantive member of the Committee.

4.2 The Committee may call other officers of the Trust to attend as appropriate. The following are expected to attend:

- Associate Director of Safeguarding
- Mental Health Act, Safeguarding Adults at Risk, Mental Capacity Act and Deprivation of Liberty Safeguards Administrator.

Additionally, the following external representatives may be in attendance at any meeting:

- Senior Representative from Child and Adolescent Mental Health Service (CAMHS) (Oxford Health)
- Senior Representative from Adult Mental Health Services and Older People's
  - Mental Health Services (Avon and Wiltshire Mental Health Partnership Trust)
- Senior representative from BSW ICB
- Senior representatives of the DoLS Supervisory Bodies

4.3 *Substitutes/Deputies* – Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.4 *Voting* - For voting purposes there must always be a majority of Non-Executive Directors.

4.5 The work of this Committee will be supported by the Executive Director Lead, the Chief Nurse.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet quarterly.

7. DUTIES

The Mental Health Governance Committee is authorised by Trust Board to:

7.1 Make policy decisions concerning the Mental Health Act 1983 (as amended by the Mental Health Act 2007) [the MHA] and the Mental Capacity Act 2005 [the MCA] on behalf of the Board.

7.2 Monitor the implementation of the MHA and the MCA and Deprivation of Liberty Safeguards [DoLS] throughout the Trust.

7.3 Oversee compliance in relation to the MHA and the MCA throughout the Trust.

7.4 Identify matters of risk relating to the Act and develop policies and procedures to manage that risk.

7.5 Identify ongoing training needs for all staff and ensure that programmes are devised and delivered and embedded.

7.6 The Mental Health Governance Committee will monitor compliance with all relevant aspects of legislation.

7.7 Instruct the Mental Health Governance Operational Group (Sub-group of this Committee) on all necessary work required to support this committee in fulfilling its objectives and functions.

7.8 Support a culture of learning through case review and ensure the learning is disseminated throughout the organisation

7.9 Support a culture of providing parity of esteem and ensuring respect and dignity for patients with mental health needs.

8. FUNCTIONS

8.1 To initiate and manage, on behalf of the Board, the development of Trust policies and procedures in respect of current legislation.

8.2 To adopt, on behalf of the Board, Trust policies and procedures in respect of current legislation

8.3 To ensure that legislation and supporting policies and procedures are understood by staff and implemented appropriately

8.4 Through an annual audit programme provide assurance to the board regarding compliance with policy and procedures

8.5 To ~~develop~~ assure that education and practice on the Acts and the Codes of Practice for all personnel involved in the application of the Acts.

8.6 To ensure that the roles and duties of Hospital Managers, as defined in the Act, are undertaken effectively and consistently throughout the Great Western Hospitals NHS Foundation Trust

8.7 To ensure that the services of Hospital Managers, as defined in the MHA are available to those detained under that Act and that those Hospital Managers exercise their duties effectively and consistently throughout the Great Western Hospitals NHS Foundation Trust.

8.8 To monitor systems in place to ensure that people who are detained under the Mental Health Act MHA in hospital are under the care of a 'responsible clinician'. (as 'approved' under section 12 of the Mental Health Act).

8.9 To monitor the use of the Acts in the Trust against national and local trends.

8.10 To prepare an Annual Report for the Trust Board and an annual work programme.

8.11 To contribute to the development of other policies and procedures as requested.

8.12 To ensure, that as required, the Department of Health returns are submitted outlining the application of the Mental Health Act.

8.13 To ensure that mental health service contracts with mental health providers meet, are robust and fulfil the requirement for an effective and efficient service.

8.14 To ensure that mental health services meet agreed quality, effectiveness and outcome measures.

9. REPORTING RESPONSIBILITIES

9.1 The Committee will report to the Trust Board on its proceedings after each meeting through the Board Committee Assurance Report.

9.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

10. MEETING ADMINISTRATION

10.1 The Trust Secretariat shall act as the secretary of the Committee.

10.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

10.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

10.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

11. REPORTING/PROVIDING ASSURANCE

11.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Mental Health Governance Operational Group
- Dementia Strategy Group

11.2 The Committee will also consider key assurance reports as outlined in appendix 1.

11.3 A forward planner of agenda items shall be determined by the Chair.

12. REVIEW

12.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

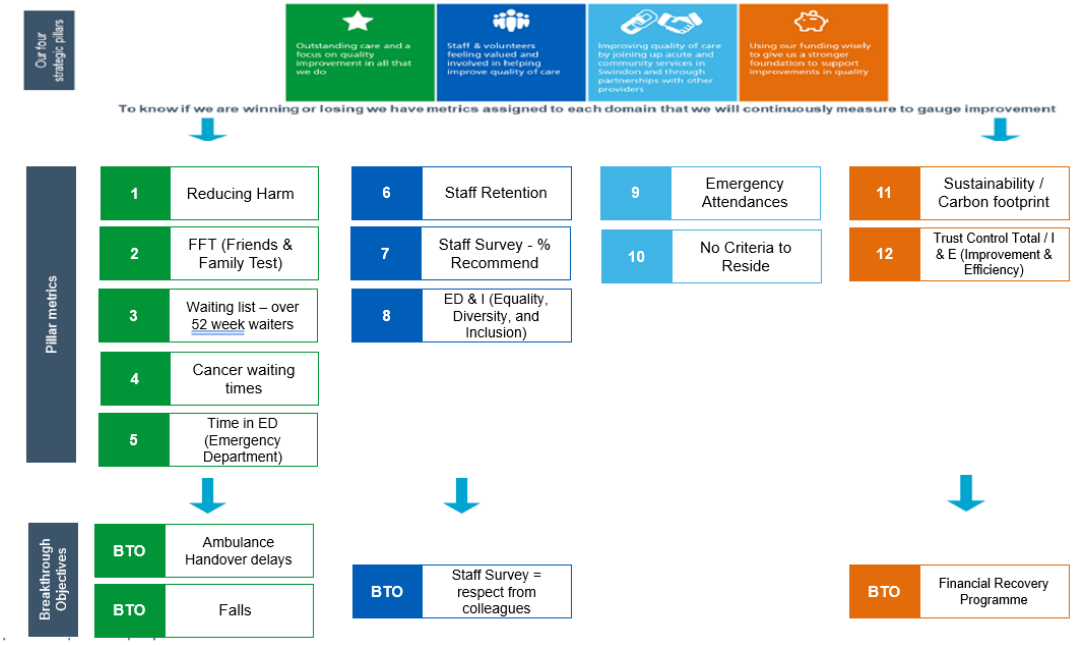
12.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For annual review	June 2022	Mental Health & Governance Committee	Amendments include:- - New format - Membership and attendance - Voting process - Deputies for NEDs and EDs - Name change of sub committee - Reword 8.7 - Delete 8.9 - Reference to strategic planning framework - Summary table of meeting remit
V2.0	Annual Review	April 2023	Company Secretary	- Change of job title - Amendment to attendee - In Summary change reporting of 12+ risks to 15+
V2.0	Approved	May 2023	Board	As above
V3.0	Annual Review	April 2023	Company Secretary	- 2/3 added the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make. - Appendix 1 - CMO name and title change - 11.1 added Dementia Strategy Group as feeder groups/forums - 8.5 change develop to assure

Appendix 1 – Summary

Committee	Mental Health Governance Committee
Chair Lead EDs	Lizzie Abderrahim, Non-Executive Director Lisa Cheek, Chief Nurse Steve Haig, Acting Chief Medical Director
Frequency	Quarterly
Membership	3 x NEDs 2 x EDs
Quorum	2 x NEDs 1 x ED
Remit	Compliance with the Mental Health Act 1983 (as amended by the Mental Health Act 2007) [the MHA] and the Mental Capacity Act 2005 [the MCA] Monitor the implementation of the MHA and the MCA and Deprivation of Liberty Safeguards [DoLS] throughout the Trust. Changes to legislation and guidance Mental Health Governance Mental Health Risks (15+) Mental Health Liaison team CAMHS Dementia Strategy

Appendix 2 – GWH Improving Together Strategic Pillars



CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE
2024/25

Purpose
On behalf of the Corporate Trustee, the purpose of the Committee is to manage the routine affairs of the charity, in accordance with the Scheme of Delegation.

1. AUTHORITY

1.1 Great Western Hospitals NHS Foundation Trust Board, acting as a Corporate Trustee for Great Western Hospital (GWH) Charitable Fund (Charity Registration Number 1050892) has established a Charitable Funds Committee (the Committee).

1.2 The Committee is administered and managed by the Trustees who are responsible for the overall management of the Charitable Funds. This is a non-statutory Committee that reports to the Trust Board and has no powers other than those specifically delegated in these terms of reference.

2. ROLE

2.1 The purpose of this Committee is to oversee the management of Charitable Funds.

2.2 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.3 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the Chief Financial Officer and the Chief Officer for Improvement & Partnerships.

3.2 One of the Non-Executive members will be appointed Chair of the Committee by the Board

3.3 In the absence of the Chair, a Non-Executive Committee member will perform this role.

3.4 *Voting* – For voting purposes there must be a majority of Non-Executive Directors

4. ATTENDANCE

4.1 Other attendees will include but are not limited to:

Chief Executive
Associate Director of Fundraising & Voluntary Services
Head of Financial Control
Financial Accountant (or nominated Deputy)
Divisional Directors
Executive Assistant to Chief Financial Officer (administrative support)

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 *Substitutes/Deputies* - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 The Trust Chair may attend meetings of the Committee (but not if specifically excluded by the Chair of the Committee), but may not chair meetings nor contribute to the quorum.

4.6 *Advisors* – External advisors may attend as necessary at the request of members to include any departments who have an interest in the current meeting, i.e. fundraising, finance, and any department submitting a case of need or external investment advisors.

4.7 *Administration of Committee* – The Executive Assistant to the Chief Financial Officer shall provide appropriate administrative support and guidance to the Chair and Committee members.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be ~~two~~ three members to include ~~one~~ two Non-Executive Director and one Executive or Non-Voting Board Director.

6. FREQUENCY OF MEETINGS

6.1 The Trustees shall normally meet four times per year and at such other times as the Trust shall require.

7. DUTIES

7.1 Ensure that best practice is followed in terms of guidance from the Charity Commission, Audit Commission, National Audit Office, Department of Health and other relevant organisations.

7.2 Ensure that the appropriate policies and procedures are in place to support the Charitable Funds Strategy and to advise Fund Managers on income and expenditure and that this is reviewed at regular intervals.

7.3 Ensure that fund objectives and spending plans are in line with Charitable objectives, spending criteria and priorities set by donors.

7.4 Ensure that all funds are correctly allocated as restricted or unrestricted and are accounted for accordingly. The number of funds should be reviewed on an annual basis to identify whether a programme of rationalisation is required.

7.5 Develop and review the Trust's Charitable Funds Strategy and Trustees' terms of reference on an annual basis and agree changes where appropriate.

7.6 Develop and review the Scheme of Delegation for charitable funds on a regular basis and recommend changes where appropriate.

7.7 Ensure that a separate register of interests is compiled for both Trustees and Fund Managers, and that this is reviewed and updated on a regular basis.

7.8 Review and approve fundraising policies in conjunction with the Director of Finance, ensuring that statutory requirements are complied with.

7.9 On an annual basis, review and approve summary level income and expenditure plans from Fund Managers, ensuring that they complement the strategy.

7.10 Ensure an effective mechanism exists whereby equipment needs are identified and satisfied (within resource constraints) through an equitable bidding process underpinned by business plans. (All equipment purchased by charitable funds will be recorded in a separate register.)

7.11 Oversee the management of investments. Where an investment broker is used, the Trustees will ensure the investment strategy has been appropriately communicated, the information required is specified and received in a timely manner, and that the service is market tested at regular intervals.

7.12 Ensure that all research monies paid into charitable funds meet the criteria for charitable status as specified by the Charity Commission.

7.13 Review and discuss all Audit Reports on Charitable Funds and recommend action to Trustees.

7.14 Review the Charity Annual Accounts and Trustee Annual Report and comment/recommend approval to the Trustees as appropriate.

7.15 Approve any request to set up new funds and cost centres (Charitable Funds only).

7.16 Agree and approve the bases of apportionment for investment income and administration costs, respectively.

7.17 Recommend to the Board any major fund raising appeals and plans, including any material changes to those plans already approved by the Board.

7.18 The charity also holds funds on behalf of Wiltshire Health & Care LLP who have their own approval process, which is then ratified by the GWH Charitable Funds Committee subject to funds being available

8. REPORTING RESPONSIBILITIES

8.1 The Trustees are accountable to the Charity Commission for the proper use of the charitable funds and to the public as a beneficiary of those funds.

8.2. Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee and others as necessary. Once the Committee has approved the full minutes, a copy will be available, for information, to the Board at its next meeting.

8.3 The key issues of the Committee will be included in the Board of Directors agenda and papers as directed by the Chair of the Charitable Funds Committee and accepted by the Chairman of the Trust.

8.4 The Chair of the Committee shall draw to the attention of Trust Board any issues that require disclosure to the full Board, or require Executive action.

8.5 The Committee will report to the Trust Board annually on the matters of business it has carried out.

9. MEETING ADMINISTRATION

9.1 The Trust Secretariat shall act as the secretary of the Committee.

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

9.5 A forward planner of agenda items shall be determined by the Chair.

10. REVIEW

10.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

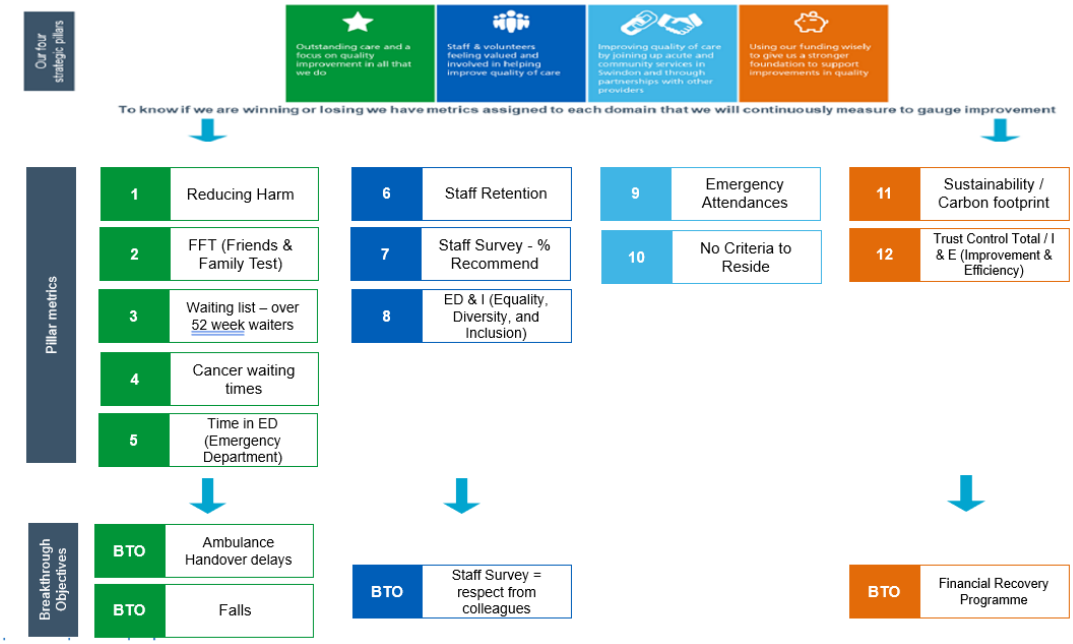
10.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1	For review	Nov-21	Charitable Funds Committee	- Membership to reflect NED to be in majority - Divisional Directors to be included in the attendee list
V1.1	For review	Apr-22	Committee Effectiveness Review	- Include Wiltshire Health & Care in duties. Other amendments include:- - New format - Added deputies for Executive Directors - Link to the Strategic Framework - Summary table of meeting remit
V2.0	For annual review	May-23	Company Secretary	- Change of job titles
V2.0	Approved	Jun-23	Board	As above
V3.0	For annual review	May-24	Charitable Funds Committee	- 2.3 added - the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make. - 4.1 job title change - Appendix 1 – Chair name change - Appendix 2 – updated - 5.1 and append 1 amended quoracy requirements for voting purposes to align with 3.4 (For voting purposes there must be a majority of Non-Executive Directors)

Appendix 1 - Summary

Committee	Charitable Funds Committee
Chair Lead EDs	~~Paul Lewis~~ Julian Duxfield, Non-Executive Director Simon Wade, Chief Financial Officer Claire Thompson, Chief Officer of Improvement and Partnerships
Frequency	At least 4 times per year
Membership	3 x NEDs 2 x EDs
Quorum	2 x NEDs 1 x ED
Remit	Charitable Funds Performance Charitable Funds Strategy Funding Policies Management of Funds

Appendix 2 – GWH – Improving Together Strategic Pillars



REMUNERATION COMMITTEE
TERMS OF REFERENCE 2024/25

Purpose
To fulfil the Committee's statutory role in the appointment and removal of Executive Directors including the Chief Executive in line with the NHS Act 2006 and code of governance, and, to determine levels of remuneration and terms of conditions of service for Executive Directors.

1. AUTHORITY

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

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

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

ROLE / PURPOSE

2.1 The Committee is required to put in place formal, rigorous and transparent procedure for the appointment of the Chief Executive and other Executive Directors , ensure plans are in place for orderly succession to the board and oversee the development of a diverse pipeline for succession, and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates.

2.2 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2).

2.3 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

2.4 The Committee will take into consideration the Trust's '*Guiding Principles for Executive Directors Remuneration*' (Sept-23) when considering Executive Director's remuneration.

3. MEMBERSHIP

3.1 The membership will comprise all Non-Executive Directors including the Chair of the Trust.

3.2 The Chief Executive shall be a voting member of the Committee for the appointments or removal of Executive Directors only.

3.3 The Committee will be chaired by the ~~Senior Independent Director of the Trust.~~ Trust Chair. In the absence of the Chair of the Committee, the remaining members present shall elect one of their number to chair the meeting.

4. ATTENDANCE

4.1 The Chief Executive will normally attend meetings, withdrawing as appropriate when matters relating to their own performance and remuneration are discussed.

4.2 The Chief People Officer will support the Committee with appropriate papers and proposals for consideration and be in attendance as and when appropriate and necessary.

4.3 *Substitutes / deputies* – There is no provision for substitutes on this Committee.

4.4 *External advisors* - The Committee may invite external advisors to attend for all or part of any meeting.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be three members (3 Non-Executive Directors).

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet at least twice a year with additional meetings being called at such other times as may be required.

7. DUTIES

7.1 To keep under review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.

7.2 To approve the procedure and documentation for the appointment of Executive Directors and Chief Executive posts.

7.3 To approve the appointment of Executive Directors, including the Chief Executive

7.4 Additionally, for the appointment of the Chief Executive the Committee will keep the Council of Governors informed of progress of a campaign and report the appointment of the Chief Executive to the Council of Governors for approval.

7.5 To consider and agree any matter relating to the continuation in office of any Board Executive Director including removal from office, suspension or termination of employment by the Trust.

7.6 The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract and retain Executive Directors.

7.7 To set on an annual basis individual remuneration arrangements for the Chief Executive, other Executive Directors in accordance with policy and having regard to individual performance.

7.8 To ensure that in the event of loss of office and/or termination of employment of the Chief Executive or any Executive Director the contractual terms and any payments made, are appropriate and consistent with all relevant Government guidelines.

7.9 To monitor and evaluate the performance of individual Executive Directors.

7.10 To engage the services of or take advice from any suitably qualified third party or advisers to assist with any aspects of its responsibilities provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Chief Executive.

7.11 Ensure plans are in place for orderly succession to the Board and oversee the development of a diverse pipeline for succession, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.

8. REPORTING RESPONSIBILITIES

8.1 This Committee is accountable to the Trust Board. The Chair of the Committee will provide a brief verbal summary after each meeting to the Board on the work of the Committee.

8.2. Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee. Minutes will be retained by the Company Secretary.

8.3 Minutes of meetings of this Committee will not be made available to Executive Directors, with the exception of the Chief Executive and Chief People Officer (on a need to know basis).

8.4 The Committee shall make a statement in the annual report as required.

9. MEETING ADMINISTRATION

9.1 The Company Secretary will provide administrative support to the Committee.

9.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REVIEW

10.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

10.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

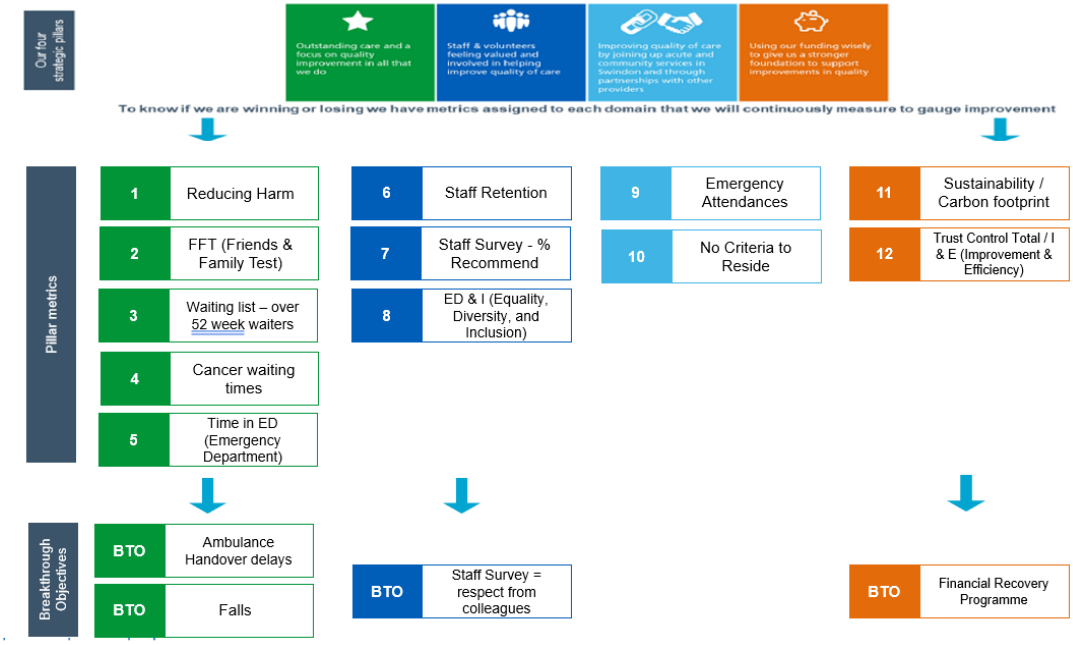
Version Control

Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For annual review	June 2022	Remuneration Committee	2.1 & 7.12 reference to succession planning and diversity
V2.0	Annual Review	May 2023	Company Secretary	Amendments to job titles Added 7.3 Deleted 7.10
V2.0	Approved	June 2023	Board	As above
V3.0	Annual Review	May-24	Remuneration Committee	Added 2.3 and 2.4 Changed Chair of meeting to Trust Chair Appendix 1 – changed name of Chair of Committee Appendix 2 – Updated

Appendix 1 - Summary

Committee	Remuneration Committee
Chair Lead EDs	Liam Coleman, Trust Chair Jude Gray, Chief People Officer
Frequency	At least twice a year
Membership	All Non-Executive Directors
Quorum	3 x NEDs
Remit	Recruitment and appointment of Executive Directors Develop, maintain and implement Remuneration Policy Ensure orderly succession plans Receive reports on Chief Executive and other Executive Directors performance against objectives To agree annual remuneration of Chief Executive and other Executive Directors

Appendix 2 – Improving Together Strategic Pillars



Report Title	**Delegation of Authority for approval of Annual Accounts 2023/24**				
Meeting	Trust Board				
Date	6 June 2024	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

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:

Report

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

The Trust is required to comply with the guidance in the Annual Reporting Manual for Foundation Trusts for 2023/24 and submit a set of audited annual accounts including an Annual Report by the national deadline of 28 June 2024.

The process for the completion of Trust's Annual Report & Accounts is outlined below and in line with guidance from NHS England for the NHS accounts timetable and year-end arrangements.

Date	Action
6 June 2024	Trust Board delegates authority to Audit, Risk & Assurance Committee to approve accounts and the Annual Report.
19 June 2024	Audit, Risk & Assurance Committee receives annual report, audited accounts, certificates and audit opinion and approves accounts and annual report
28 June 2024 (12 noon)	NHS FTs submit (electronically) audited accounts, the external auditors ISA 260 report, the external audit opinion on the accounts, and the Annual Report to NHSE.

Date to be confirmed	Laying NHS foundation trust annual report and accounts before Parliament.

In order to meet the submission deadline, the Trust requires delegation of authority to approve its Annual Report and Accounts to the Audit, Risk & Assurance Committee.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	n/a				
Next Steps	Submission of Annual Report & Accounts 2023/24				

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 delegate authority to the Audit, Risk & Assurance Committee to sign-off the Trust's Annual Accounts and Annual Report for 2023/24

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	29 May 2024

Report Title	**Annual Self Certification – CoS7**				
Meeting	**Trust Board**				
Date	**6 June 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Self Certification CoS7				

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:

Report

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

NHS providers are required to complete self-certifications for publication which provides assurance that providers are compliant with the conditions of their NHS provider licence.

With the introduction of a refreshed provider licence in 2023 the self-certification for G6 (3) and FT4 has ceased to remove duplication with the annual report. However the Trust is still required to self-assess against the following:-

Declaration	Detail
CoS7 (3)	Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services. (For NHS Foundation Trusts only)

This report invites the Board to review and confirm the attached statement in line with its provider licence CoS7.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	n/a				
Next Steps	For Chief Executive and Chief Financial Officer to sign and to publish on the website and to inform the Annual Governance Statement in the Annual Report.				

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	Caroline Coles, Company Secretary
Date	29 May 2024

Worksheet CoS7

Financial Year to which self-certification relates 2023_24

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

- The 2023/24 annual accounts are prepared on a going concern basis.
- Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the cost improvement plans are achieved.
- The year to date and the annual financial position are detailed in the following reports presented to the Trust Board and relevant Board committee and Executive Led Groups:
  - Monthly Financial Performance Report
  - Monthly Integrated Performance Report
- The Trust is working to achieve the best possible financial position for 2024/25 in agreement with the ICS and NHSE.

Signed on behalf of the board of directors:-

Signature		**Signature**	
Name		**Name**	
Capacity		**Capacity**	
Date		**Date**	

Great Western Hospitals NHS Foundation Trust

Report Title	**Final Quality Account for 2023-24**				
Meeting	**Board of Directors**				
Date	6th June 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Luisa Goddard, Deputy Chief Nurse				
Appendices	1. 2023/24 Quality Account				

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Substantial		Good	X	Partial		Limited	
Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.		Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.		Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.		Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.	
Justification for the above assurance rating. Where 'Partial' or 'Limited' assurance has been indicated above, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:							

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

Trusts are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts. The Quality Account for the 2024-25 financial year must be published by 30 June 2024. A draft is attached.

The Quality Priorities for 2023-24 mirrored the Trust's Break Through objectives:

- Time to Clinically Ready to Proceed
- Reduction in pressure harms
- Reduction in no criteria to reside.

The Quality Priorities for 2024-25;

Reducing falls and fall with harm
Improving the experience of carers by delivering responsive support and information
Improving initial assessment of pateints on front door services

The Quality priorities have been discussed with the Council of Governors and sent to partners including Health Watch and the ICB. The final draft was presented to the Quality and Safety Committee on the 24th May 2024.

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
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: The Quality Account is a national requirement by NHSE and an annual report on the quality of the services we deliver.			

Recommendation / Action Required The Board/Committee/Group is requested to:	
For the Board of Directors to approve the quality account for 2023/24.	
Accountable Lead Signature	Lisa Treadwell
Date	29/05/24

Introduction

The quality account is an important document to clinicians, service users and regulators. It allows the Trust to be held accountable by its stakeholders and it is how the Trust report on quality and evidence improvements.

Trusts are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract. The Quality Account for the 2024-25 financial year must be published by 30 June 2024. The final draft is attached.

A significant part of the Quality Account is articulating the quality priorities the Trust for the previous year and describing the priorities for the forthcoming year.

There are three priorities with at least one under the following categories.
Patient's experience
Patient safety
Clinical effectiveness

Quality priorities for 2023-24

The last years quality priorities mirrored the Trust's break through objectives. A summary is given below with more detail in the Quality Account.

Time to Clinically Ready to Proceed

Good progress made in reducing the time between clinically ready to proceed and admission.

Pressure Harms

Major focus of improvement work across ward and community areas. Severity of harms being reported has shown a positive trend, however level of harms has not made as much progress as the level expected so this remains a high priority workstream.

No Criteria to reside

Measure was stood down as a breakthrough objective given good progress was seen. Progress in this measure has been sustained and continued to see an improvement through reducing length of stay for NCTR patients.

Quality Priorities for 2024-25

Priority 1: reducing falls and fall with harm

Why is this a priority?
Falls are one of our most commonly reported patient safety incidents that happen in our care. Not all falls result in harm but can result in psychological and mobility problems, injuries from falls can have a devasting impact from cuts and bruises to fractures and brain injuries to death. As well as the impact on patients and carers, falls in hospital result in longer lengths of stay and increased costs.
Patients that fall more than once in our care are at greater risk of significant harm.

What are out aims for the coming year?
To reduce the number of patients who have more than 1 fall in hospital
To improve compliance with falls prevention actions such as identifying patients with postural hypotension and supporting those patients that require enhanced care.

Priority 2: Improving the experience of carers by delivering responsive support and information

Why is this a priority?
We know that carers play a key role in helping people to get better; they know so much about the person being cared for, and what can help them recover. We aim to improve the experience of carers to acknowledge the importance to our patients, involving them in care and recognising their contribution to care, and we are committed to finding new ways to support and empower them.

What are our aims for the coming year?
Undertake a review of the use of the GWH carers passport

Undertake a carers satisfaction survey for carers using GWH services to identify themes for improvement
Implement and evaluate 'open' visiting and the introduction of NHSE care partners
Support staff carers with promotion and evaluation of Carers UK digital resources
Achieve Carers UK carer organisation accreditation
Introduce training for ward managers to support staff carers
What will we do?
We will monitor compliance with Carers passport by producing monthly data to show how many passports are being handed out.
Roll out the new visiting guidance and associated support and conduct an evaluation at 6 months.
Reach out to community organisations to promote the carers support available at GWH.

Priority 3: Improving initial assessment of pateints on front door services

Why is this a priority?
Obtaining accurate patient assessments is essential to determining the status and needs of our patients and delivering appropriate patient care. By conducting timely and accurate patient assessments, the quality of service and patient safety can be improved.
What are our aims for the coming year?
Ensure all relevant staff have completed triage training and competency assessment
Increase compliance with initial assessment by 20% across all direct admitting specialities

What will we do?
Develop a triage working group ahead of the Integrated Front Door (IFD) to create a microguide for triage, which will be standardised across the Emergency Department and Urgent Treatment Centre.
Embed triage courses to improve compliance and ensure staff are aware of expectations and what the process involves.
Children Emergency Department: complete training needs analysis and develop a paediatric competency framework.
Ensure all maternity patients that need urgent review are seen in a timely manner in a dedicated triage service.
Ensure patients that attend the Acute Medical Unit and Surgical Assessment Unit are seen and assessed a timely manner in line with national guidance.

Quality Account Support statements

NHSE sets out in the guidance the information that is required to be reported in the Quality Account and this information is covered in detail in the account.
The account was sent to partners including Health Watch, ICB and the Council of Governors.

NHS
Great Western Hospitals
NHS Foundation Trust

Quality Account
2023-24

About the Quality Account

Our Quality Account is our annual report to the public about the quality of the services we deliver as a health care provider. The Quality Account describes our approach to quality, and provides an opportunity for scrutiny, debate and reflection by the public and also encourages us to focus and be completely open about service quality and helps us develop ways to continually improve.

Each year, our Quality Account is both retrospective and forward looking. We look back at the year just passed and present a summary of our key quality improvement achievements and challenges.

We look forward and set out our quality priorities for the year ahead, ensuring that we maintain a balanced focus on the three key domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Our quality priorities are chosen following a process of review of current services, consultation with our key stakeholders and most importantly through listening to the feedback from our service users and carers.

Some of the content of the Quality Account is mandated by NHS England and /or by The NHS (Quality Account) Amendment Regulations 2012, however other parts are determined locally and shaped by the feedback we receive.

Contents

Introduction

Priorities for improvement and statements of assurance from the Board

Further information

Introduction

Statement on quality from Acting Chief Executive Officer Jon Westbrook

I am pleased to present our Quality Account for 2023/24, which reviews the quality of care provided over the past 12 months and shares our priorities for the year ahead for improving the safety, outcomes and experience of our patients.

We have, once again, had another busy year with a range of challenges which we have risen to thanks to the hard work and commitment of our staff.

There is increasing acknowledgement that many of the issues which our patients and staff experience first-hand at the hospital – such as high attendances, delays to ambulance crews handing over their patients, and challenges discharging patients – are actually indicative of wider issues within the health and social care system.

We therefore increasingly take a system-wide approach to tackling many of these issues and work much more closely with our partners than we ever have before.

Our Acute Hospital Alliance, made up of our Trust alongside the RUH and SFT, was the only collaborative from the South West announced in the first wave of NHS England's Provider Collaborative Innovators scheme this year, and is committed to helping deliver the system's Integrated Care Strategy.

Despite the financial challenges we face as a Trust and as a system, we continue to invest in programmes of work which will benefit our patients.

Our £33.5million urgent and emergency care expansion will open in 2024/25 and will be the biggest ever investment in Swindon's healthcare infrastructure and so will be a real milestone, not just for our Trust but for the whole town.

It will enable us to make significant changes to how we provide care, and ensure that patients are treated in the right place, first time, in an environment which local people have helped us to design.

I'm pleased that we have been able to make improvements to the way we provide care to patients and this year surgeons carried out the first ever procedure using our new surgical robot. This was part of a system-wide investment in robotic surgery and will make a significant difference to outcomes and recovery times for our patients.

Our work with partners has enabled us to gain approval for our joint plans to introduce a shared Electronic Patient Record at our three Trusts, and this work will be one of our main priorities in 2024/25.

We remain focussed on delivering the NHS England priorities of recovering from the pandemic while continuing to make improvements to the quality and safety of care we provide.

Significantly, this year we have managed several periods of strikes involving our staff and, at the time of writing, industrial action has affected us for almost 18 months.

This has had a significant impact upon patient care, with many people seeing their care delayed which we know has a negative impact on outcomes.

The disruption has made our ongoing recovery from the pandemic much more complex and difficult and at the end of March 2024 our waiting list exceeded 39,000 patients. Our ongoing focus is on seeing patients as quickly as we can.

In March 2024, the Care Quality Commission (CQC) changed the rating of our maternity services from Good to Requires Improvement, which was disappointing for staff who work hard to deliver a safe level of care. Following the inspection in September 2023, we took immediate steps to begin to address some of the areas raised with us, alongside a number of

improvements that had already been implemented prior to the inspection.

The CQC identified good morale, well controlled infection risks and a positive sense of teamwork, and highlighted the maternity service working in collaboration with a university to train staff in 'Black Maternity Matters' as outstanding practice.

We were pleased that in a recent CQC survey conducted with women and birthing people who had used our maternity services, the Trust scored third highest in the country for questions relating to ante-natal check-ups and care on the ward after birth, and in the top five Trusts for questions relating to care at home after birth.

This year we have put forward the following quality priorities, further detail on these priorities is contained within this report:

1. Reducing falls and falls with harm
2. Improving the experience of carers by delivering responsive support and information
3. Improving initial assessment of patients on front door services

Improvement continues to be a cornerstone of our work and the launch of Improving Together has helped us to embed a new way of working focussed on empowering our staff to make positive change. Along with more staff saying they would recommend the Trust as a great place to work in the staff survey, and an increased number of colleagues said they felt they could make improvements in their area.

On behalf of the whole Trust Board, I would like to thank our staff for their incredible efforts to provide the highest quality patient care throughout the year.

Jon Westbrook

Acting Chief Executive Officer

About us and the service we provide

We are an integrated Trust, providing both acute and community services.

Our geographical area covers Swindon and parts of Wiltshire, Bath and North East Somerset, Hampshire, Dorset, Oxfordshire, West Berkshire and Gloucestershire, serving a population of more than 1.3m people.

Our Trust runs the Great Western Hospital, which opened in 2002 and provides emergency care, elective (planned) surgery, diagnostics, paediatrics, maternity (both midwife and consultant led), and outpatient and day case services.

At the Great Western Hospital, there is a purpose-built centre for elective surgery called the Brunel Treatment Centre, which enables us to separate emergency from elective surgery.

The Swindon Intermediate Care Centre (SwICC) is located in a separate building on the Great Western Hospital site. Patients receive therapy and further care here before being discharged to their own homes or to another community healthcare setting.

Along with running acute services we are also a provider of adult community health services across Swindon. These services are provided by community nurses and therapists, working at various GP practices, health centres and in patients' homes.

Our key achievements

April 2023 – March 2024

May 2023

- First procedure using our new surgical robot
- Awarded the NHS Pastoral Care Quality Award
- Installed a Central Destruction Unit to make Entonox carbon neutral
- Two winners at the South West Maternity & Perinatal Awards

June 2023

- Staff Excellence Awards
- First ever Leadership Conference

July 2023

- Celebrated 75 years of the NHS
- First ever Nursing and Midwifery Conference
- Awarded Gold in the Ministry of Defence's Employer Recognition Scheme
- ENT ranked best in UK in General Medical Council's annual national training survey

August 2023

- NHS Chief Executive Amanda Pritchard visited the Trust

September 2023

- Recruited our 500th internationally educated nurse
- Launched Project Search, supporting young adults with learning disabilities

November 2023

- Topping out ceremony for new Integrated Front Door
- Awarded the Inclusive and Safe Workplace Award in NHS England's Equality Diversity and Inclusion Improvement Awards

December 2023

- WAY Beacons won the 'Connecting People' award at the South West Personalised Care Awards

January 2024

- Clinical Teaching Fellows recognised for use of virtual reality headsets to help train medical students

February 2024

- Amanda Pretlove and Colette Goodenough (HSW's), presented with national awards on behalf of the Chief Nursing Officer for NHS England, Dame Ruth May

March 2024

- Second highest response rate in the country for the Staff Survey
- Mercury Ward launched a new service to develop the care for patients with heart failure
- Neurodiversity Celebration Event held

Listening to patients and families

Led by the Trust's Head of Patient Experience and Engagement, Great Western Hospitals NHS Foundation Trust strives to provide the highest quality patient-centred care across our acute and community settings.

The work includes expanding opportunities for patients, families, and carers to provide us with feedback, and developing new patient involvement and partnership processes to truly hear their voice in everything that we do. Significant progress has been made over 2023/24 to develop our approach and identify priorities. Some examples of our engagement, involvement and coproduction work are:

Community engagement

We continue to connect with local community groups, charities, and attend various groups and events across Swindon and Wiltshire. A strong network of contacts with minority ethnic groups, those living in poverty, carers, and disability groups has been developed, with feedback shared with staff or taken forward as part of our improvement work.

Speciality teams including Macmillan Personalised Care, Breast care, Community Stroke, Diabetes and Gynaecology have also joined the work to reach out to communities with joint attendance at different events.

We also have a growing number of lay members sitting on various committees across the organisation providing a valuable view and contribution to our work. These include carers audiology, podiatry, cancer services and community respiratory services.

Maternity engagement work

The maternity team continue to work with the Maternity and Neonatal Voices Partnership (MNVP), meeting with asylum seekers in Swindon to understand their needs and issues to inform maternity and other services.

The team are also working to develop an accessible e-referral form and are sourcing a supply of SIM cards and devices to be able to provide disadvantaged patients with the ability to access the internet and use the new maternity app to review their notes and personalised care plans.

Patient safety partners

The Trust has recruited patient safety partners as volunteers with a specialist interest in patient safety. These volunteers are supporting the patient voice through attendance at relevant meetings, engagement with improvements groups, and supporting various workstreams. They provide a lay member's viewpoint to ensure that learning and development related to patient safety is taken forward with the patient voice as a central driver.

The national Patient Safety Incident Response Framework (PSIRF) is driving changes to the engagement with patients and their families to ensure they are partners in the review of any patient safety event that could support Trust learning.

Changing Places

In October 2023, our new adaptive bathroom facility on the children's ward was formally registered with the Changing Places organisation. The bathroom provides a fully accessible environment with space and equipment for patients who have mobility challenges. This followed significant work with a local group, Mums on a Mission, who campaign for improvements in disability access and facilities.

Children engagement

As part of the engagement work for the new Children's Emergency Unit (CEU), we met with primary school children, joined a special educational needs and disabilities (SEND) youth group, and had feedback via a Child and Adolescent Mental Health Service (CAHMS) participation group about the new CEU mental health space. We engaged with parents of SEND children to understand how we can improve their visits to our urgent and emergency care services. We're also working with a secondary school to capture input from older groups.

Learning Disability and Autistic Spectrum Disorder

In November 2023, we held two sessions in the community to hear the views and suggestions of people with Learning Disability (LD) and Autistic Spectrum Disorder (ASD).

Working in collaboration with Swindon Borough Council, we held interactive sessions with small groups of participants, easy-read posters were shared across the community to advertise the event. The feedback received was encouraging, with the groups saying that it had made a positive impact, and they were pleased that we approached them for feedback directly.

Following these workshops, the feedback is being used by the Service User Development Lead for the new Integrated Front Door (IFD), to inform the development of a framework that will be utilised by staff to support patients with LD or ASD.

Their involvement helped shape current practice in Emergency Department (ED) through the provision of feedback on initiatives, such as the 'Little Bags of Calm', and provided future engagement opportunities with service users. There are plans to invite those that attended the sessions to visit the new department ahead of its official opening to see how their voice has directly contributed to the department.

Physical and sensory impairment

We met patients with physical and sensory impairments to discuss aspects of care and service design that impacts them specifically, and how we can improve our processes. Patients told us what is important to them, and how our teams can improve care through simple questioning and adaptations. This feedback will inform the development of the aforementioned framework to support patients with additional needs who may be presenting at our urgent and emergency care services. All patients will be asked if they have any additional or specific needs on arrival.

We have continued to develop our interpreting and translations services, raising awareness across local communities and with staff about the services we provide. This includes British Sign Language, resulting in a significant increase in requests for support.

LGBTQIA+

Collaborative work commenced with the Pride Hub in Swindon town centre. The hub provides advice, support, and information to all members of the LGBTQIA+ community and is keen to support the Trust with signposting patients who have concerns about hospital care or treatment. The group are reviewing our current guide for staff to support trans patients to ensure it meets all requirements. Promotion of services that the Trust offer will be advertised through an annual support guide including our commitment to the Pride in Veterans standard and our open welcome to all patients irrespective of their sexual identity.

Spinal Cord Injury (SCI)

A spinal cord injury coproduction group of staff and patients was set up in September 2023 with drafts of a new patient passport and bowel care policy ready to be ratified and promoted.

The group has been instrumental in developing a new passport that will be launched across the Trust and local community. Working collaboratively with Salisbury Spinal Injury Unit and the Spinal Injury Association, we will ensure there are trained staff across the Trust able to deliver specialist bowel care. In addition, staff will have access to awareness training which is currently in development, and SCI patients will share their experiences through this training.

A new Spinal Cord Injury section has been developed on our Trust website and Intranet, with specific resources for patients and staff. The group plan to launch an awareness campaign, 'We've got your back', to promote the work across the Trust and into the community.

Dining Companions

A new process has been implemented to support patients during mealtimes. Staff and volunteers share a rota to ensure patients are ready and able to eat well. The role includes preparing the patients to eat, delivering trays, cutting up food, opening packets, and providing companionship and encouragement to eat and drink. The role is currently being trialled on a couple of wards but if successful, it will be rolled out across the Trust.

Patient, family, and carer feedback

We continue to make opportunities for people to provide feedback, including the development of different formats to complete the Friends and Family Test (FFT). We are triangulating feedback from FFT, national, and local surveys, complaints and concerns, incidents, and claims, to identify key areas of focus.

Our Patient Advice and Liaison Service (PALS) are working with divisions and patient representatives to support this identification and agree the areas of concern that require attention. We are also improving our response rates, especially from our vulnerable patient groups and older population.

Learning from patient experience

We've developed more short films, 'Care Reflections', which explore lived experiences from our patients, families, and carers so that we can learn from these. These powerful reflections support staff training, individual reflection, governance meetings, and improvement work, bringing the patients voice alive and provide a unique dimension to our feedback analysis.

Employers Recognition Scheme

The Ministry of Defence (MOD), as part of their Employers Recognition Scheme, awarded the Trust with veteran's gold accreditation. This is awarded to employers that demonstrate and advocate support for armed forces and wider forces communities. Gold is the highest standard awarded and evidences the Trust's commitment through recruitment and selection, policy directive, and advocacy.

Our Quality Strategy

The Quality Strategy sets out our aims and objectives for 2022-26. It follows our overarching Trust strategy and describes the elements that drive our approach to quality. The strategy includes 'Improving Together' – an ambitious transformation programme to embed a culture of continuous improvement across the Trust.

Our strategic pillars

We'll deliver this through eight objectives

1. Improve patient and carer experience
2. Focus on continuous improvement
3. Use information to drive continuous improvement
4. Reduce health inequalities
5. Prioritise patient safety
6. Promote a positive staff and volunteer experience
7. Develop our talent and promote good leadership
8. Promote the effective use of resources

Great Care

Care with compassion, getting the fundamentals right and keeping the patient front and centre is our starting point. We want every patient to have the best possible experience when using our services. We recognise that every staff member plays a vital part in ensuring all our patients receive Great Care.

Our 'Great Care' campaign is now embedded into existing and new improvement projects and continues to generate new ideas. Our aims are to continue to:

- Deliver great care to every patient all of the time and seek to continually improve the care we provide to patients
- Receive regular feedback from patients, their families and carers
- Engage and empower staff to deliver great care.

The campaign keeps the patient at the very centre of all that we are trying to do. This means proactively collecting feedback and listening intently to our patients and their families and carers, and responding in a timely and effective way so as to ensure a positive and sustainable impact on their care experience.

Our ambition is to develop a culture and a shared language across the Trust that is synonymous with Great Care.

Improving together

Improving Together is our Trust-wide approach to change, innovation and continuous improvement, introducing a consistent methodology across the organisation so that 'improving' becomes something we all do the same way.

Two years on from Improving Together being introduced, almost 600 staff have taken part in the innovative training which is empowering teams to make improvements in their own areas.

Since 2021, this unique way of working has been embraced by multidisciplinary teams across the Trust. Staff are either using the entire Improving Together approach or using certain aspects/ key methods to deliver improvement. We have adapted our training so that there are different offers to best suit people's needs. The recently introduced fast track training supports smaller teams to tailor their learning to their services and this has been developed with teams from Wheelchair services, community rehabilitation and anticoagulation services.

Changes to our frontline team training mean that our improvement facilitators are spending more time in clinical areas supporting teams and offer a flexible approach to learning sessions; some of the teams we are working with include Orchard Ward, Delivery & Maternity, Neonatal ward and Same Day Emergency Care.

Improving Together is transforming how we bring people together, how we communicate and is helping to put improvement at the heart of everything we do.

Mirrored across our Acute Hospital Alliance with the Royal United Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust, Improving Together is becoming a golden thread of work throughout the local NHS, benefitting the working lives of staff and the experience of patients.

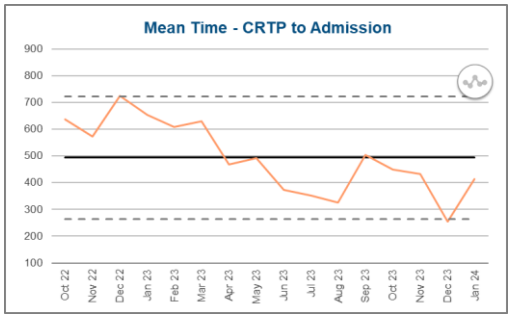
Improving together

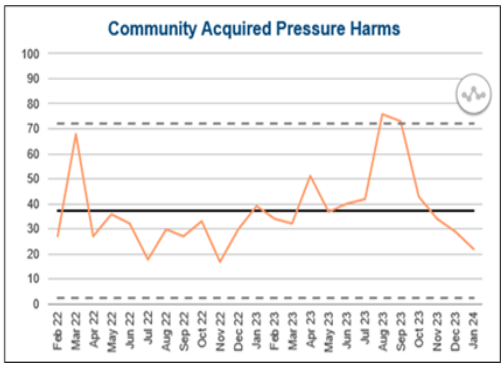
Recent staff survey results show that more than half of staff now feel able to make improvements at work and examples of both small changes and larger scale transformations are regularly celebrated.

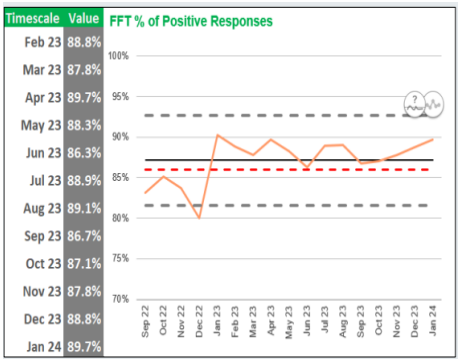
Improvement experts in the Transformation and Improvement Hub offer guidance, training and support and a dedicated area called Workspace provides staff with a place to come together. A package of resources is also available so teams can explore new ways of working at their own pace. Feedback has been very positive, with more staff saying they feel able to speak up and team communication and morale has improved.

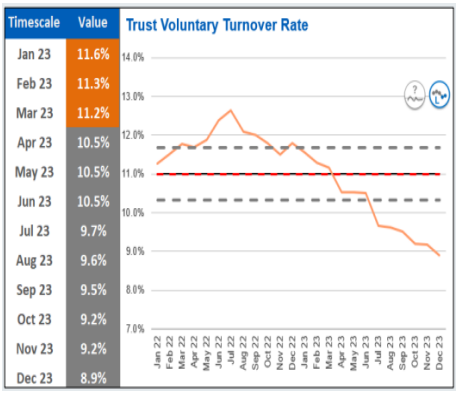
We have seen good progress in our Trust level pillar metrics* & breakthrough objectives**:

- Sustained reduction of patients waiting times from being "clinical ready to proceed" in the Emergency Department to being admitted to a bed
- Improvements in overall productivity of the organisation increasing the level of activity we undertake within our resources.
- Recent reduction in pressure harms in our community services
- Sustained reduction in voluntary turnover rate for staff
- Improvements in positive responses to our friends and family questions.









Improving together

We have also applied the Improving Together way of thinking in our outpatient improvement weeks, our recent perfect week included us speaking with around 150 patients to talk to them about the experience of not attending a booked appointment to help inform our learning and next steps. Within teams there have also been some real successes:

- Trauma team focusing on reducing pressure harms caused by medical devices
- Cancer services focusing on offering Holistic Needs Assessments to cancer patients – we achieved 100% in November-January 2024
- NHS@Home occupancy increasing to above the 80% target for the first time in January 24
- Improvements in baby cardiotocography for women who are in labour using the "fresh eyes" approach and an ongoing improvement work around our maternity triage process.
- A focus on patient pain levels in the majors area of the Emergency Department
- A focus on reducing falls in the Division of Medicine with the driver metric of less than 65 falls per month being consistently met (10 months out of 12) since February 2023
- Improvements in mandatory training compliance and appraisal rates supporting an increasing number of staff recommending our Trust as a place to work.
- Decrease in spend on agency staff across nursing and medical staff.

Looking ahead, we will continue to teach, share and support the Improving Together approach until improvement becomes an integral part of Trust culture and just the way we do things. Several of our improvement priorities for the coming year focus on the experience and care of patients in our admission areas alongside: increasing our productivity, reducing things that don't add value to staff and patients and using our resources in a more sustainable way.

*Pillar metrics – our 12 metrics tell us whether we are doing well on driving forwards our vision and strategy. These last for the duration of our strategy (3-5 years).

**Breakthrough objective – our areas for focused improvement, we should be able to see a 20–30% improvement over a 12-18 month period and they should be the focus of our improvement energy. They are likely to be top contributors to driving improvement in one of our pillar metrics.

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Results and achievements for the 2023-24 Quality Account Priorities

1. Reducing the incidents of hospital and community acquired pressure ulcers

Why was this a priority?

Whilst this has been a priority over the last few years, we know we continue to have more to do in this area because pressure damage is one of the highest causes of patient harm across the Trust. Pressure ulcers can cause physical harm, pain, and can lead to poor patient outcomes.

At our Trust, we do not want any of our patients to come to harm whilst they are in our care, to support this we have invested in increasing our nursing staff to improve our nurse-to-patient ratios.

We believe this along with the implementation of effective systems and processes, supported by education and training, is the right approach to reduce the incidence of pressure ulcers developing whilst patients are in our care.

What we said we would do

Leadership: we improved the level of leadership and oversight of pressure harms. This included increasing the level of involvement from ward managers and matrons in regular reviews of reducing risk of pressure harms with all patients in their care. We also ensured that there is a consistent approach to learning from pressure harms when they do occur.

Roles and responsibilities: we worked with ward and community teams to ensure that roles and responsibilities are clear. This included a focus on ward managers leadership with a training day for them. There were also bespoke sessions for healthcare support workers and registered nurses which included their role in preventing harm.

Process: we improved our processes to ensure that we are proactive and take early actions to prevent pressure damage. This included the embedding of the aSSKINg (Assess, Surface, Skin inspection, Keep moving, Incontinence, Nutrition and Giving information) model. This is a five-step model for pressure ulcer reduction. We embedded work to maximise the benefit of our new pressure relieving mattresses across the Trust and ensured there was a skin assessment process whenever a patient is transferred onto a new mattress. Our community teams improved their audit tool document to support more rapid assessment and action for patients.

What we did

- The ward manager's skills training day was used to discuss leadership and oversight, focusing on key roles and responsibilities of staff around pressure harm prevention.
- A weekly cross divisional pressure ulcer panel meeting was set up to review harms and share learning.
- Monthly divisional quality meetings were held with a focus on reducing pressure harms meeting to share learning and celebrate successes.
- Fortnightly review of Break Through objective's A3 on pressure harm reduction.
- Additional training sessions for Health Care Support Workers including projects to support Tissue Viability Team such as continence care.
- Combined work with the ambulance service to support the awareness and use of pressure relieving mattresses on patients in ambulances.
- Development of a Community Pressure Ulcer Improvement Group (PUIG) with the aim to create a Multidisciplinary approach to improving the prevention and management of Pressure harms. Reviews of screening panel cases are held, and themes discussed with appropriate work streams and improvements actioned to sustain change.
- Successful Implementation (Nov 2023) of new Pressure Ulcer Risk assessment tool 'Purpose T' throughout Community Nursing services to improve and standardise risk assessment and interventions to reduce harm levels.
- Implementation of End-of-Life Equipment Pathway – Clinical decision-making tool and patient leaflet to provide safety netting with appropriate equipment prior to discharge.

- Implementation of a Contractures Workstream: a multidisciplinary team approach to managing this patient cohort to prevent contractures and harm.

How will we continue to monitor and measure our progress

- Monitor number of pressure harms via pressure ulcer panel meetings with a focus on top contributing areas and themes.
- Review of Divisional and Service level action plans using the Improving Together methodology.
- Development of new working streams to respond to individualised patient need and thematic analysis.
- Continual Divisional and Executive oversight through reports and meetings.
- Ensuring learning and recognition from Wards /Units that have no harm from pressure ulcers.

2. Reducing the number of patients in hospital who are ready to be discharged to care elsewhere in the community

Why was this a priority?

We know that we have patients in hospital who are ready to be discharged to care outside of the hospital. It is important that these patients can be discharged quickly and to their own home whenever possible. Everyone should have the opportunity to recover and rehabilitate at home wherever possible. Staying in hospital for longer than is needed can increase exposure to risks such as infections, falls and loss of physical and cognitive function.

If we can reduce time in hospital, it enables people to regain or achieve maximum independence as soon as possible. It also supports hospital flow, maximising the availability of hospital beds for people requiring this level of care including urgent emergency admissions, elective surgery, and the public waiting for an ambulance response.

What we said we would do

Working together: our Co-ordination Centre brings together multi-disciplinary teams from across the health and social care system to work together on reducing admissions to hospital and improving discharge processes. We wanted to continue to make improvements by our teams working more closely together, taking a personalised approach and exchanging information more quickly.

Providing alternatives to admissions: we wanted to develop the Co-ordination Centre service to care homes to give advice and review for residents they might be concerned about. This would support getting rapid review and appropriate support in place quickly for care home residents with the aim of avoiding admission to hospital if it is possible to support people where they normally live.

Discharge support team: the development of this service helped co-ordinate and lead hospital referrals to the local authority for changes to care arrangements. Enhancing weekend co-ordination: implemented increased support for discharges over the weekend so

that we can increase the number of patients who can leave hospital over the weekend.

What we did

- The coordination centre developments have helped partnership working with primary care/community services.
- Improved coordination to ensure that patients were directed to the most appropriate service for their condition straight away.
- Since January 2024, the Care Home advice line service has been providing support to care homes in partnership with Swindon Borough Council, Medivo and the Integrated Care Alliance.
- Through better coordination there has been an overall reduction of patient stays over 21 days, we have ensured that patients have earlier access to services to support them leaving hospital.
- We have increased the number of patients able to access the 'Home First' pathway which provides support for early discharge.
- We have made improvements in the number of patients being discharged over the weekend to reduce the amount of time patients are waiting in hospital.

How will we continue to monitor and measure our progress

- There is a weekly review basis to ensure no patients are waiting unnecessarily in hospital.

3. Reducing the time patients spend in the Emergency Department before they are ready to go home or move to a hospital bed

Why was this a priority?

The Trust has continued to see an increase in attendances and admissions to our hospital, this has resulted in patients spending longer in the Emergency Department than we would want. National evidence shows that longer waiting times in Emergency Departments can lead to worse clinical outcomes and increased mortality (ref 2019, Paling et al, Emergency Medicine Journal vol 37, Issue 12).

Long waits in the Emergency Department can hamper our ability to handover with ambulance crews. Reducing the amount of time patients spend in our Emergency Department is a key priority and indicator for clinical effectiveness.

What we said we would do

We wanted to reduce the number of patients waiting more than 4 hours (240 minutes) in our Emergency Department and minimise delays over 12 hours. The average wait time was 483 minutes. We wanted to reduce this to <76% of our patients being discharged or admitted within 4 hours – whilst not fully achieved, we have made significant progress towards it.

We also wanted to reduce the percentage of patients who wait over 12 hours from arrival to departure, our current performance is shown below, we are aiming to reduce this to less than 10% of people attending our Emergency Department.

What we did

- The Trust has the amount of time patients stay in the Emergency Department as one of the Trust priorities ('Pillar metric'), this highlights its importance to the Trust.
- 2023/24 saw an improvement in the length of time patients spent in the department with an average of 437 mins compared to 481 mins in 22/23. The difference was especially marked when comparing winter months where the Trust saw patients waiting 391 minutes in December 2023 compared to 550 minutes in December 2022.

- Improving Together training was delivered to the Emergency Department and Assessment units.
- There have been improvements to the triage process for patients who arrive by ambulance.
- 2023/24 saw the start of the exciting Integrated Front Door programme start and this is still on course for delivery for July 24.

How will we continue to monitor and measure our progress

- As well as regular reporting, we have real time information in place for ambulance and Emergency Department waiting times so immediate actions can be taken as soon as a patient is ready to move on.
- We are also using patient experience feedback within the Emergency Department to ensure that the changes we make are improving the patient experience.

Choosing our priorities for 2024-25

The following priorities have been agreed by the Trust for 2024-25. These will be reported in full in the 2024-25 Quality Account with six-monthly reporting to the Governors People and Quality Group, the Patient Quality Sub-Committee and Quality and Safety Committee.

The following sources were used to identify potential improvement priorities:

- Data showing our top contributing problems for our priority areas which shows us where to focus
- Stakeholder and regulator reports and recommendations
- Clinical audit data
- Results from national in-patient surveys
- Local and national audit
- Feedback from Healthwatch through partnership working
- CQC inspection report and CQC insight reports
- Feedback from our Trust Board
- Emerging themes and trends arising from complaints, serious incidents and inquests
- Complaints, concerns and Friends and Family Test responses.

The progress against 'what will success look like' outlined against our quality priorities will be monitored by the Patient Quality Sub-Committee.

Our priorities for 2024-25

1 Reducing falls and falls with harm

Why is this a priority?

Falls are one of our most commonly reported patient safety incidents that happen in our care. Not all falls result in harm but can result in psychological and mobility problems, injuries from falls can have a devasting impact from cuts and bruises to fractures and brain injuries to death. As well as the impact on patients and carers, falls in hospital result in longer lengths of stay and increased costs. Patients that fall more than once in our care are at greater risk of significant harm.

What are our aims for the coming year?

- To reduce the number of patients who have more than one fall in hospital
- To improve compliance with falls prevention actions such as identifying patients with postural hypotension and supporting those patients that require enhanced care.

What will we do?

- Work collaboratively with clinical staff to reduce risk of falls, ensuring training is delivered to upskill staff. Training will cover falls assessments and postural hypotension as well as health issues relating to deconditioning and supporting patients with safe mobility.
- Continue the improvements in providing Enhanced Care for patients requiring increased supervision and engagement ensuring they have assessments completed and appropriate levels of support to maintain safety and meet patient needs. This is a trust wide standardised approach to “line of sight” and “within arm's reach” supervision.
- Promote links into the National Reconditioning Ambassadors Network, focusing particularly in areas caring for older adults who are at high risk of developing and sustaining harm related to deconditioning whilst they are in our care.

2 Improving the experience of carers by delivering responsive support and information

Why is this a priority?

We know that carers play a key role in helping people to get better; they know so much about the person being cared for, and what can help them recover. We aim to improve the experience of carers to acknowledge the importance to our patients, involving them in care and recognising their contribution to care, and we are committed to finding new ways to support and empower them.

What are our aims for the coming year?

- Undertake a review of the use of our carer's passport
- Undertake a carers satisfaction survey for carers using Trust services to identify themes for improvement
- Implement and evaluate 'open' visiting and the introduction of NHSE care partners
- Support staff carers with promotion and evaluation of Carers UK digital resources
- Achieve Carers UK carer organisation accreditation
- Introduce training for ward managers to support staff carers.

What will we do?

- We will monitor compliance with carers passport by producing monthly data to show how many passports are being handed out.
- Roll out the new visiting guidance and associated support and conduct an evaluation at six months.
- Reach out to community organisations to promote the carers support available across the Trust and measure the impact through carers surveys.

3 Improving initial assessment of patients on front door services

Why is this a priority?

Obtaining accurate patient assessments is essential to determining the status and needs of our patients and delivering appropriate patient care. By conducting timely and accurate patient assessments, the quality of service and patient safety can be improved.

What are our aims for the coming year?

- Ensure all relevant staff have completed triage training and competency assessment
- Increase compliance with initial assessment by 20% across all direct admitting specialities.

What will we do?

- Develop a triage working group ahead of the Integrated Front Door (IFD) to ensure a robust process for triage, which will be standardised across the Emergency Department and Urgent Treatment Centre.
- Embed triage courses to improve compliance and ensure staff are aware of expectations and what the process involves.
- Children's Emergency Department will ensure all staff have completed a training and competency framework.
- Ensure all maternity patients that need urgent review are seen in a timely manner in a dedicated triage service.
- Ensure patients that attend the Acute Medical Unit and Surgical Assessment Unit are seen and assessed a timely manner in line with national guidance.

2.2 Statements of assurance from the Board

Information on the Review of Services

During 2023/24 the Great Western Hospitals NHS Foundation Trust provided and/or subcontracted eight relevant health services. The Trust has reviewed all the data available on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2023/24.

Clinical audit and national confidential enquiries

During 2023/2024, 56 national clinical audits and two national confidential enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During that period Great Western Hospitals NHS Foundation Trust participated in 98% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2023/2024 are as follows alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1: Participation in national clinical audits and confidential enquiries

Audit Title	Participation	% Data Submission
NRAP - Secondary Care Adult COPD 2023	Yes	100%
NRAP - Secondary Care Adult Asthma 2023/24	Yes	Still in progress
National Paediatric Asthma - Secondary Care 2023/24	Yes	Still in progress
NRAP - Pulmonary Rehabilitation 2023/24	Yes	Still in progress
Sentinel Stroke National Audit Programme (SSNAP) 2023/24	Yes	Still in progress
Sentinel Stroke National Audit Programme (SSNAP) 2023/24	Yes	Still in progress
MBRRACE-UK 2023 : Maternal Morbidity confidential enquiry	Yes	Still in progress
MBRRACE-UK 2023 : Maternal Mortality confidential enquiries	Yes	Still in progress
MBRRACE-UK 2023 : Maternal Mortality surveillance	Yes	Still in progress
MBRRACE-UK 2023 : Perinatal Mortality and serious morbidity confidential enquiry	Yes	Still in progress
MBRRACE-UK 2023 : Perinatal Mortality Surveillance	Yes	Still in progress
MBRRACE-UK 2023 : Perinatal Mortality Review Tool	Yes	Still in progress
National Neonatal Intensive & Special Care Audit (NNAP) (2023 Data)	Yes	Still in progress
National Paediatric Diabetes Audit (NPDA) 2023/24	Yes	Still in progress
National Pregnancy in Diabetes 2023	Yes	100%
NCEPOD - Juvenile Idiopathic Arthritis	Yes	Still in progress
NCEPOD - Rehabilitation following critical illness	Yes	Still in progress
National Severe Trauma Audit - TARN (22/23)	Yes	Still in progress
National Elective Surgery Audit - National PROMs Programme (2023-24)	Yes	Still in progress
National Case Mix Programme 2023/24	Yes	Still in progress
National Joint Registry - NJR (2023/2024) (2023 data)	Yes	100%
National Ophthalmology Audit - Adult Cataract Surgery Audit (Data period 2023/24)	Yes	Still in progress
National Cardiac Arrest Audit NCAA 23/24	Yes	Still in progress
National Acute coronary syndrome or Acute myocardial infarction (MINAP) 2023/24	Yes	Still in progress
National Cardiac Rhythm Management (CRM) 2023/24	Yes	Still in progress
National Falls and Fragility Fractures Audit Programme (FFFAP) 2023/24 - Hip Fracture Database	Yes	100%
National Falls and Fragility Fractures Audit Programme (FFFAP) 2023 - Inpatient Falls	Yes	Still in progress
National Heart Failure Audit 2023/24	Yes	Still in progress
Improving Quality in Crohn's and Colitis (IQICC) [Previously National Inflammatory Bowel Disease (IBD) Audit] 2023/24	No	NA
RCEM Mental Health Self Harm 2023/24 (Year 2)	Yes	Still in progress
National Audit of Percutaneous Coronary Intervention (PCI) 2023/24	Yes	Still in progress
National Lung cancer Audit (NLCA) 2023/24 (2023 data)	Yes	Still in progress
National Rheumatoid and Early Inflammatory Arthritis Audit (NEIAA) 2023/24 (Year 6)	Yes	Still in progress
National Oesophago-Gastric Cancer Audit (NOGCA) 2023/24	Yes	Still in progress
National Bowel Cancer Audit Programme (NBCA) 2023/24	Yes	Still in progress
National Prostate Cancer Audit (NPCA) 2032/24 (2022/2023 data)	Yes	Still in progress
National Diabetes Foot Care Audit 2023/24	Yes	Still in progress
National Audit of Care at the End of Life 2023/24 (NACEL) - Round 5	Yes	Still in progress
Society for Acute Medicine Benchmarking Audit (SAMBA) 2023/24	Yes	100%
National Audit of Dementia: Care in general hospitals 2023/24 - Round 6	Yes	100%
National Diabetes Audit Core 2023/24	Yes	Still in progress
LeDeR Programme 2023/24	Yes	Still in progress
National Maternity and Perinatal Audit (NMPA) 2023-2024	Yes	Still in progress

Audit Title	Participation	% Data Submission
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme 2023	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) - 2023/24 - Cohort 6	Yes	Still in progress
Breast and Cosmetic Implant Registry (BCIR) 2023/24	Yes	Still in progress
National Audit of Cardiac Rehabilitation 2023	Yes	Still in progress
National Acute Kidney Injury Audit 2023/24 (UKKA)	Yes	Still in progress
National Diabetes Inpatient Safety Audit (NDISA) 2023/24	Yes	Still in progress
National Child Mortality Database 2023/24	Yes	Still in progress
RCEM Care of Old People (COP) 2023/24 (Year 2)	Yes	Still in progress
National Obesity Audit (NOA) 2023/24	Yes	Still in progress
NCABT - Audit of NICE Quality Standard QS138 2023/24	Yes	100%
NCABT - Bedside Transfusion Audit 2023/24	Planned	Not yet started
National Audit of Metastatic Breast Cancer	Yes	Still in progress
National Audit of Primary Breast Cancer	Yes	Still in progress
British Hernia Society Registry	Withdrawn	NA
BAUS Nephrostomy Audit	Yes	Still in progress

Examples of Improvement actions taken as a result of participation in national clinical audits reviewed

National COPD Audit Programme - Secondary Care: 2021

Great Western Hospitals NHS Trust performed in the upper quartile of the benchmarked Key performance indicators (KPI's) nationally with performance in the middle quartile for the remaining indicator (Respiratory review within 24 hours).

Respiratory review in 24 hours is our local most challenging indicator given workforce constraints the department has lost staff since the last in-patient audit figures (March 2022) were published and this has seen performance in this regard become more challenged. Since the last NACAP Clinical audit report was published there has been investment in a community sited lung function laboratory which has increased primary care access to lung function testing (including spirometry).

In August 2022, a re-vamped Advice and Guidance platform was commenced by the Respiratory department which allows improved access to specialist respiratory opinion for primary care and community services.

In late 2022 the Respiratory department submitted pathway designs to the Transformation hub which supported virtual ward working and the interface with Same Day Emergency Care (SDEC). There has been workforce development into nursing/medical/physiology recruitment, to safeguard performance pertaining to 24-hour review, this also supports training of non-respiratory staff to support maintenance of performance in relation KPIs and support interface with primary care/community services. A business case for increased specialist nursing support is being developed for 23/24 financial year.

There is also a Non-invasive ventilation (NIV) improvement plan which is the subject of an on-going Quality Improvement (QI) project supported/sponsored by the Academic Health

Sciences Network that started at the beginning of February 2023.

National Joint Registry – NJR (2020/2021) (2020 data)

Great Western Hospital (GWH) was listed as one of the hospitals where hip revision rates are statistically better than expected. GWHNHSFT is not listed as a negative outlier in any categories measured. Areas improved include setting up the new Amplitude Patient recorded outcome measures (PROMs) system and embedding its use within the teams involved. This includes additional option for the system to capture eligible national Joint registry (NJR) procedures to confirm that the appropriate consent forms have been completed/submitted. The team have been working with all relevant Consultants to reinforce the communication around the importance of completing a Minimum Data Set form for all eligible NJR procedures, including joint replacement performed as a result of acute trauma.

National Acute coronary syndrome or Acute myocardial infarction (MINAP)2020/21

The service has improved collaborative working with Emergency Department regarding STEMI identification and PPCI targets.

There have been maintained levels of patients seen by Cardiology Team (including referral to ACS Specialist Nurses) to ensure specialist input and encourage allocation of specialist beds to enhance patient care and continue direct admission to the Catheter Laboratory for PPCI patients wherever possible.

There is an on-going NSTEMI Improvement Programme with assistance from the Transformation Team to ensure >60% angiography within 72 hours, improve quality care and reduce length of stay for NSTEMI patients. This has resulted in a new pathway for NSTEMI, including identification of a daily 'Golden Patient' and has led to a recent marked increase in meeting the 72 hour target. The full effects of the project are yet to be established and consolidated.

The service continues to appropriately refer to the Cardiac Rehab Team (CR) to increase timely and relevant rehabilitation. Since July 2020 the offer of CR has widened to include digital/telephone support and aim soon to return to face to face group exercise/education or a hybrid approach of some digital and some face to face. The expectation is that by offering more choice it will increase uptake to rehab. There is also the aim to reduce delays for patients presenting with chest pain to the Emergency Department (ED) in order to diagnose STEMI efficiently and meet targets for PPCI.

The Cardiology team strive to ensure the right patient to right bed is in a timely manner to enhance specialist care via cardiology wards wherever possible. Although patients may be transferred to cardiology beds whilst admitted, attempt to transfer directly to speciality upon admission. (Society for Acute Medicine Benchmarking Audit (SAMBA) 2022/23)

The Acute Medical Unit has increased the number of Trainees on the medical take during the day and night, which means the Tier 1 reviews (initial assessment within 4 hours) have improved significantly. The national median is 82%. GWHNHSFT median is 91%. The unit has also demonstrated improvements with discharges without overnight admissions of 30%, with the National median reported to be 28%.

Tier 2 reviews (consultant senior reviews within 6 hours of admission in hours and within 14 hours, OOH) falls below national median of 52%. GWH 43%, however the unit is aiming to improve this by having a daily dedicated senior decision maker on the unit.

In collaboration with the Emergency Department, the Acute Medical Unit are assessing how to reduce the bed base, increase consultant numbers and identify new ways of working to minimise the overall Tier 2 waiting times; actions include all consultants working on Post take assessments for 1 hour of the morning between 8.00-9.00am together with the night take team before hand over, to enable Tier 2 reviews especially outside of Acute Medical Unit bed base, is done in a timely manner.

National Audit of Dementia: Prescription of 'Psychotropic Medication' to people with dementia 2019/20

GWH prescribing sequences throughout admission are very similar to National prescribing sequences and therefore not identified as an outlier for stopping or starting psychotropic medications in this group of patients. GWH already has a separate section on the Electronic Discharge Summary (EDS) in which review plans for psychotropic medications can be communicated to GPs.

The Trust already has a Dementia Care Pathway & has recently developed Clinical Guidelines - 'Management of Clinically Challenging Behaviour in Adult Inpatients' which promote and provide guidance on non-pharmacological ways to manage BPSD.

However, the service plan to introduce systems to document 'target symptoms' when prescribing psychotropic medications and introduce a process to ensure psychotropic medications are reviewed at the point of discharge.

The service also plan to continue education & training for junior doctors, ward teams and non-medical prescribers regarding the importance of using non-pharmacological methods as first line management for BPSD as well as how to safely prescribe psychotropic medications when necessary.

Further actions include collaborating with pharmacy & IT/EPMA team to devise process to ensure psychotropic medications are reviewed by medical team when TTAs screened are for discharge.

National Acute coronary syndrome or Acute myocardial infarction (MINAP)2020/21

8 annual care processes in Swindon are above national average with ranges for National being 44.7%, Swindon recorded as 50.8%. De-intensification of treatment in moderately frail and severely frail population is better in Swindon when compared to national average. However, HbA1c target is below national average of 62.4%, with GWHNHSFT recorded at 60.1%.

COVID-19 affected care processes for Diabetes patients nationally and although post COVID situation is improving, the service has identified the importance of detecting frail patients and de-intensify treatment as appropriate. Actions include working in collaboration with Primary Care Network to improve the treatment targets in Diabetes population.

CQC Registration and statement on CQC Reviews or investigations

The Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC). Our current registration status is "Requires Improvement". The Trust does not have any conditions on registration. The Care Quality Commission has not taken any enforcement action against the Trust.

Current CQC rating 2024:

Overall rating	Safe	Effective	Caring	Responsive	Well-led
Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Maternity Services were inspected in September 2023 as part of the national Maternity Inspection programme. The Maternity Service rating was downgraded to Requires Improvement with some improvement actions in relation to compliance with mandatory training and ensuring triage services are safe and timely. The service is making good progress on these actions and is hoping to achieve full compliance in Quarter 1 of 2024/25.

The Trust overall rating for Safe was Requires Improvement and for Well Led as Requires Improvement. This did not change the Trust's overall rating.

Our last Trust wide CQC inspection was between 11 and 13 February 2020, when the CQC inspected urgent and emergency care, medical care, surgery and maternity services. The Trust has delivered a comprehensive action plan in response to the feedback received from the CQC. The CQC will assess how well improvements have been sustained as part of future inspection activity.

The Trust has had regular engagement meetings with CQC throughout 2023/24 to ensure we keep them informed of our service delivery and of any changes, these include:

- Quarterly engagement meetings with Executive team
- Monthly oversight meetings with Chief Nurse team
- Monthly Insight meetings.

With the implementation of the new CQC single assessment framework the engagement framework for 2024/25 will change to quarterly with CQC operational manager for our area and a deputy director of the CQC attending at least yearly. The majority of information updates will be submitted through the portal when it becomes operational later in the year.

Research and development

Health research is vital to generate knowledge and evidence to improve the health and care of patients, service users, carers, and the public as well as improving our health and social care systems. Our Research & Innovation (R&I) team is comprised of nurses, practitioners, support workers, administrators, and governance staff who work to deliver safe and effective health research. The department is also supported by research posts in both Pharmacy and Pathology, enabling us to offer our patients access to new and cutting-edge treatment options. In 2023/24, more than 900 patients have been recruited to at least 40 studies across over 22 specialties.

In 2023/24, the Trust invested significantly in identifying avenues through which to develop research capabilities. By bringing together key stakeholders within the Trust, we are exploring opportunities to grow our research portfolio within the organisation. Further, through regional collaboration with multiple partners, we are looking to ensure research is made available to local populations who are currently under-served by research, and where the burden of need is the greatest.

In 2023/24, the organisation's first Clinical Research Practitioner receiving their accreditation. In celebration of their commitment to research, they also won the 'Rising Star' award at the NIHR Clinical Research Network regional research annual awards. A team member was also awarded the 'Continuous Improvement' award, in acknowledgement of the work being undertaken at the Trust to further develop research. Our collaborative contribution to regional research was acknowledged as part of the 'Collaboration in Research' award, recognising the valuable role the Trust plays in bringing research to our regional population.

Another major success was the launch of a new Research Enablement Scheme. With support from Brighter Futures, R&I held a competitive process to allocate small research grants to local investigators. Two departments within the Trust were successfully awarded this funding, allowing them to undertake research that directly addresses the needs of our patients and services.

Learning from deaths

During 2023/2024, 1374 of Great Western Hospitals NHS Foundation Trust patients died, 694 case record reviews and investigations have been carried out in relation to the 694 deaths in 2023/24. 50 of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.

Data for Q1-4 2023/24 is presented below.

	Q1	Q2	Q3	Q4	Total
No. of deaths	345	298	359	372	1374
Case record reviews	80	141	229	244	694
Investigations (SJRs related to incidents)	8	5	6	7	26
No. of deaths with problems identified in care	6	7	12	25	50
No. of deaths >50% avoidable	0	5	8	16	29

Medical Examiner

The Medical Examiner Service in Swindon has been scrutinising all hospital deaths since 2020. The aim of this service is to improve the accuracy of completion of the Medical Certificate of Cause of Death, advise on deaths that need coroner referral and establish pathways to alert Trust Mortality and Clinical Governance of any potential learning or need for structured judgement review. The Medical Examiners support families following a bereavement by discussing and explaining the death of their loved ones.

Seven day service programme

The Trust continues to work towards achieving the standards for seven day service. The Trust meets three of these standards and therefore our focus continues to be on the following key standard: All emergency admissions must be seen and have thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. Previous audits have shown the Trust is not consistently meeting this standard.

The Trust is working with leadership teams on job planning of doctors to enable more consistent coverage, as well as reviewing how services are provided.

The work will be continued in 2024/25 with an embedded electronic job planning system and electronic rostering system. This will be subject to re-audit in the coming year.

Commissioning for Quality and Innovation (CQUIN) framework

In 2023-24 the CQUIN framework has been in operation. The Trust has agreed with Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) five schemes that form part of the Trust contract against which performance will be assessed. In order to avoid the destabilisation impact arising from under performance on CQUIN resulting in a financial penalty, the Trust and commissioners have agreed that under performance will be reinvested back into the Trust.

As well as the five contractual CQUIN schemes, the Trust is required to report on all relevant CQUIN schemes that are applicable to the Trust as part of national CQUIN benchmarking. CQUIN for 24/25 is expected to be 'paused' following national consultation meaning that the Trust will not be required contractually to report on CQUIN nor will there be any financial incentive/risk associated with CQUIN reporting.

Records submission

The percentage of records in the published data:

- Which included the patient's valid NHS number was: 99.7% for admitted patient care 99.9% for outpatient care and 98.5% for accident and emergency care.
- Which included the patient's valid General Medical Practice Code was: 99.9% for admitted patient care; 99.8% for outpatient care; and 97.9% for accident and emergency care.

Payment by Results

The Trust was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

Data quality

The Trust will be taking action to continue to improve data quality. Monitoring reports will be reviewed monthly by the Trust's Data Quality Steering Group (DQSG) and quarterly by the Trust's Information Governance Steering Group (IGSG).

These reports include data items which have been identified as causing concern. For example, coding completeness and validity, coverage of NHS numbers and ethnic groups, outpatient outcomes, review of external audit reports etc. The reports are used to allow management to improve processes, training, documentation, and computer systems.

The importance of good Data Quality has been recognised at Trust Board level. An annual awareness campaign supports members of staff to understand what good Data quality is and how everyone is responsible for achieving it.

Information Governance

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Digital Data Security & Protection (DSP) Toolkit. To maintain integrity, the Trust's DSP Toolkit is subject to an independent internal audit against the standards set by NHS Digital, on an annual basis.

In 2020/21, the DSP Toolkit submission deadline was pushed back from 31 March to 30 June due to the Covid-19 pandemic. This change has now become permanent. Great Western Hospitals NHS Foundation Trust DSP Toolkit Assessment for 2022/23 was graded as 'Standards Met', with 113 out of 113 mandatory evidence items provided. The 2023/24 assessment is in progress and has been subject to an audit. The final DSPT submission is June 2024.

2.3 Reporting against core indicators

The following set of national performance core indicators are required to be reported in the Quality Account using data made available to the trust by NHS Digital.

Summary Hospital-Level Mortality Indicator (SHMI)

The Summary Hospital-Level Mortality Indicator (SHMI) is the NHS' standard measure of the proportion of patients who die while under hospital care and within 30 days of discharge. It takes the basic number of deaths, and then adjusts the figure to account for variations in factors such as the age of patients and complexity of their conditions, so the final rates can be compared. The resulting SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the expected number based on average England figures, given the characteristics of patients treated at the Trust. The expected SHMI is one, though there is a margin for error to account for statistical issues. Summary Hospital-Level Mortality Indicator (SHMI) – deaths associated with hospitalisation, England (NHS Digital national benchmarking):

Table 1: Summary Hospital Level Mortality Indicator

Period	Value	SHMI banding
2023/24	Data not available on NHS Digital	
2022/23	1.01	As expected
2021/22	1.05	As expected
2020/21	0.89	3 (lower than expected)
2019/20	0.99	2 (as expected)

The data displayed is for the last reported period via NHS Digital.

The number of patients who died after being coded as under palliative care – relief of symptoms only – is collated nationally. This can affect mortality ratios, as palliative care is applied for patients when there is no cure for their condition and they are expected to die. (NHS Digital national benchmarking):

Table 2: Palliative Care

Period	Value
2023/24	Data not available on NHS Digital
2022/23	2.10
2021/22	1.04
2020/21	0.89
2019/20	0.99

The data displayed is for the last reported period via NHS Digital.

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective, information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Patient-reported outcome measures (PROMs) are based on patients' own experiences. People are asked about their health status and quality of life both before and after four types of surgery – hip replacement, knee replacement, varicose vein and groin hernia.

The scale runs from zero (poor health) to one (full health). The 'health gain' as a result of surgery can then be worked out by adjusting for case-mix issues, such as complexity and age, and subtracting the pre-operative score from the post-operative score.

In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data.

Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

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Period	Procedure	Adjusted average health gain - EQ-5D index TRUST	Adjusted average health gain - EQ-5D index ENGLAND	Adjusted average health gain - EQ-VAS index TRUST	Adjusted average health gain - EQ-VAS index ENGLAND	Adjusted average health gain - Oxford Knee Score index TRUST	Adjusted average health gain - Oxford Knee Score index ENGLAND
2021/22	Knee replacement revision	Not available on NHS Digital	0.30	Not available on NHS Digital	7.30	Not available on NHS Digital	Not available on NHS Digital 16.90 16.70
	Knee replacement primary		0.30		8.50		
	Knee replacement		0.30		8.00		
2021/22	Hip replacement revision		0.30		8.50		14.70
	Hip replacement primary		0.50		15.00		22.90
	Hip replacement		0.50		14.70		22.50

Re-admissions

Readmissions can occur for a variety of reasons, including being discharged too early, large numbers of readmissions to hospital after treatment might suggest patients had been discharged too early. Rates are therefore monitored nationally. The published 28 day readmission rate for the Trust is:

Period	Patients aged 0 - 15 (GWH)	Patients aged 0 – 15 (England)	Patients aged 16+ (GWH)	Patients aged 16+ (England)
2023/24	Data not available on NHS Digital			
2022/23	13.1	12.8	15.3	14.4
2021/22	12.4	12.5	15.4	14.7
2020/21	12.9	11.9	16.1	15.9
2019/20	11.7	12.5	14.9	14.7
2018/19	11.4	12.5	15.4	14.6

Responsiveness to the personal needs of patients

The Trust collects information on its responsiveness to patients' personal needs, augmenting the feedback collected as part of the national inpatient survey and Friends and Family Test. Patients are asked five questions in order to compile an overview:

- Were you as involved as you wanted to be?
- Did you find someone to talk to about worries and fears?
- Were you given enough privacy?
- Were you told about medication side-effects to watch for?
- Were you told who to contact if you were worried?

Period	Indicator value (GWH)	Indicator value (England)
2023/24	Data not available on NHS Digital	
2022/23	Data not available on NHS Digital	
2021/22	Data not available on NHS Digital	
2020/21	71.90%	74.50%
2019/20	63.40%	67.10%
2018/19	65.60%	67.20%

The data displayed is for the last reported period via NHS Digital.

Staff who would recommend the Trust to their family or friends

The care question from the staff survey asks how likely staff are to recommended the NHS services they work in to friends and family who need similar treatment or care. The Great Care campaign, has focussed on supporting existing and developing new improvement projects targeted to address areas of concern identified in the staff and inpatient survey.

Period	Agree (GWH)	Strongly agree (GWH)
2023	46%	14%
2022	45%	12%
2021	48%	13%
2020	54%	16%

Patients admitted to hospital who were risk assessed for venous thromboembolism

Venous thromboembolism (VTE) is a clot in the deep veins of the leg, which can break off and clog the main artery to the lungs. Known as a pulmonary embolism, this can be serious, or even fatal. It is therefore particularly important to make sure patients do not develop VTE in hospital, where the risk is often greater because people tend not to move around as much, making blood in the veins of the legs more vulnerable to clotting. Patients therefore need to have their VTE assessed, so drugs or stockings can be used to reduce the risks. The target is for at least 95% of patients to be assessed.

Period	Agree (GWH)	Strongly agree (GWH)
Q3 2023/24	TBC	Data not available on NHS Digital
Q2 2023/24	97.30%	
Q1 2023/24	94.60%	
Q4 2022/23	Incomplete	
Q3 2022/23	95.96%	
Q2 2022/23	97.18%	
Q1 2022/23	95.04%	
Q4 2021/22	Incomplete	
Q3 2021/22	Incomplete	
Q2 2021/22	52.3%	
Q1 2021/22	95.15%	

Clostridium difficile infection

Clostridium difficile (C.difficile) is an infection, which can cause serious symptoms and potentially death. Although naturally present in some people, it can spread quickly in a confined environment like a hospital. The Trust has been working hard to combat this infection using different infection control techniques to keep patients safe.

Table: Clostridium difficile infection data

Period	Rate - Total cases per 1000 bed days (GWH)	Rate - Total cases per 1000 bed days (England)
2023/24	Data not available on NHS Digital	
2022/23	15.36	20.28
2021/22	17.20	18.30
2020/21	10.40	17.70
2019/20	13.57	15.46
2018/19	13.49	14.09

The data displayed is for the last reported period via NHS Digital.

Further information

Patient safety incidents

An incident may be defined as an event that has given rise to actual or possible harm such as injury, patient dissatisfaction, property loss or damage.

The Trust actively encourages staff to report all such incidents, a high number of reported incidents may not be a bad thing, it conveys a culture that is honest and open, so lessons can be learned and shared. Only a very small minority of incidents are at the top end of the scale, causing severe harm or death. These trigger the most rigorous of investigations.

The Great Western Hospitals NHS Foundation Trust is committed to delivering quality patient care, ensuring high standards of health and safety, by providing a system of incident reporting which allows all staff to record any incident which causes harm, damage or loss or has the potential to do so. Incident reporting presents an important opportunity to learn from past events and ensure steps are taken to minimise recurrences. There is overwhelming evidence that NHS organisations with a high level of incident reporting are more likely to learn and subsequently increase safety for patients, staff, and visitors.

The Trust ensures the right level of investigation is implemented whenever an incident is reported. The report into the investigation will ensure that local and organisational learning is taken and fed back to the relevant staff to ensure mitigation actions are put in place to prevent any recurrence.

Table 1: Overview of Patient safety incidents

Period	Patient Safety Incidents 2021/22	Patient Safety Incidents 2022/23	Severe /Death 2021/22	Severe /Death 2022/23	Rate of patient safety incidents per 1000 bed days 21/22	Rate of patient safety incidents per 1000 bed days 22/23	Rate of incidents resulting in severe harm or death (per 1000 bed days) 21/22	Rate of incidents resulting in severe harm or death (per 1000 bed days) 22/23
Apr – Jun	3013	3125	18	20	64.28	62.20	0.38	0.40
Jul – Sep	2896	2534	21	25	59.39	49.48	0.43	0.49
Oct – Dec	3141	2590	26	35	61.76	49.00	0.51	0.66
Jan – Mar	3299	2912	28	29	67.10	57.01	0.57	0.57

3.1 Creating a patient safety culture

Focus for 2024 – 2025:

- Continue to embed the patient safety incident response framework
- Continue to embed the patient safety training strategy
- Develop further the triangulation processes for all patient safety incidents regardless of their route into the organisation
- To continue to develop the Board safety visits
- Continue to recruit to the role of Patient Safety Volunteers
- To develop further learning opportunities and ways to embed new learning across the Trust
- To continue to work collaboratively with partners to share good practice and learning across the network to ensure one system learning approach.

Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS' approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety (NHS England, 2022). The framework represents a significant shift in the way the NHS responds to patient safety incidents, from the current Serious Incident Response Framework to a framework that is focused on compassion, engagement and involvement, utilising a range of system-based approaches to identify learning from patient safety incidents. Developing processes to ensure the approach is considered and proportionate in response and using a supportive oversight process that focusses on strengthening the system and improvement.

Implementation is a key part of the NHS patient safety strategy with the expectation that all National Health Services providers will have systems and processes in place to support the launch by the end of summer 2023. The Trust has commenced a project that is organisation wide and works in-line with the guidance from NHSE following early adopter success. A timeline to success has been developed and will be monitored through the Patient Quality Sub-committee.

Actions for 2024/25

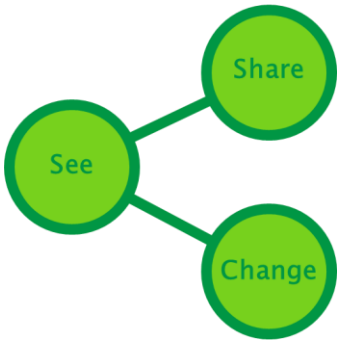
- Transition fully to the patient safety incident response framework by end of March 2024. Following this time all patient safety incidents will be managed under the new patient safety framework.
- To develop triangulation processes for all patient safety incidents regardless of their route into the organisation. This is set to commence with the first report in May. The focus of the triangulation will be litigation and complaints, pulling in learning for all other aspects of patient safety.
- To continue to support the Board safety visits and reflect on the learning / feedback from them.
- To appoint more Patient Safety Volunteers (partners).
- To develop collaborative working relationship to use opportunities to streamline effort, reduce replication and work with colleagues across the Network to ensure one system learning approach. The Trust led on some of the initiative and is now in talks re collaborative training opportunities.

Patient safety

The safety of our patients is at the heart of our approach and culture at the Trust. Patient safety incidents that are reported by our staff provide us with key insights into the safety of our patients.

Freedom to Speak Up

Freedom to Speak Up (FTSU) is an initiative resulting from the Francis Report recommendations (Mid Staffordshire NHS Foundation Trust public inquiry) to give staff the opportunity to raise issues or concerns in a supportive forum. Effective speaking up arrangements help to protect patients and improve the experience of NHS staff.



Staff who speak out have a number of channels available to them to speak up about issues or concerns they have, particularly those relating to quality of care, patient safety, and bullying or harassment. The Trust actively invites staff to speak up and contribute to discussions and activities to improve both patient and staff experience.

The Trust has a Lead Guardian and four Freedom to Speak Up Guardians who work with individuals, teams and groups to promote speaking up including, for example, attending events such as: staff inductions; staff training and development events; local staff conferences and diversity and inclusion events.

NHSE Learning Disability (LD) and Autistic Spectrum (AS) Improvement Standards Review

The Trust employs two LD nurse who job shares one role. Over 2023 the LD nurses have supported staff in delivery of high quality, adjusted care for in and out-patients. Much of the activity has been the provision of day-to-day advice and support and direct ward care planning for people with complex needs and leading on complex discharge management. The work also includes supporting the wards with Mental Capacity Act process and pathway planning for day-case admissions for patients who require a general anaesthetic (GA).

The Trust continues to take part in the annual National NHSE LD and AS Improvement standards audit programme and receives annual outcome reports. The most recent report for the Trust was received in the Autumn of 2023.

The audit benefits from a triangulated data collection method, organisational data, staff survey and patient survey data and practice and the patient experience is reviewed under three headings: Respecting and protecting rights, inclusion, engagement, and workforce. Learning from the findings of the report are used to form the basis of the content of the annual Learning Disability Forum workplan thus ensuring the voice of patients and staff, alongside operational data inform the direction of quality and safety improvement projects.

The current focus is on projects to ensure that systems and processes are better able to identify vulnerability which enables staff to understand and provide personalised reasonable adjustments to care. The current projects are also focussed on ensuring equal access to diagnostic tests and services.

In 2023 the Trust held workshops with people with LD to help with design elements of the Emergency Department build project and members of the Trust regularly visit day service providers in Swindon in support of getting direct feedback regarding our service from those who use it.

Consolidated annual report on rota gap for medical staffing including internal factors

The Trust currently has a total of 53.08 WTE vacancies across all grades and specialties of medical staff, this figure also includes doctors appointed pending start dates and candidates that are filling roles on a fixed term basis.

Internal factors:
Over the last 12 months the Trust has focused on enhancing its social media advertisement of vacancies, reviewing job descriptions and adverts to ensure they are comparable with local organisations.

The Trust continues to hold a British Medical Journal subscription and have a lead account manager supporting the advertisement of our roles. This subscription enables national and international advertising of all medical vacancies via their online portal and the advertising of Consultant vacancies in the BMJ printed journal. The Trust social media networks are also used for the advertising and promotion of medical opportunities.

Vacancies are reviewed during the Weekly and Monthly Medical Control Meetings and a regular review is in place for the use of long-term agency being used to backfill vacancies within departments.

In line with workforce systems development and the prescribed levels of attainment the Trust procured SARD (Secure Appraisal Revalidation Database) as a new software solution to manage both medical revalidation and medical e-job planning which launched in July 2022. A full job planning cycle 23/24 was loaded onto SARD for all specialities which highlighted and subsequently initiated workforce planning discussions in some areas to ensure appropriate alignment of tasks and remuneration.

In addition, the medical roster role out has taken place with an aim to be fully live from April 2024 onwards. In conjunction with the roster specialities are working towards identifying minimum staffing numbers to allow management of leave requests appropriately as well as visibility and streamlined access for all workers. Medical Roster Administrators are now in place within the Medicine and Surgery Divisions to support with the maintenance of the roster and processing leave requests. Monthly oversight takes place with reports of progress/learning discussed at the Medical Rostering Oversight group.

3.2 Performance against key national priorities

An overview of performance in 2023 - 24 against the key national priorities. Performance against the relevant indicators and performance thresholds are provided.

Measure	National Target	Local Target 2022/23	Performance 2023/24
ED 4 hours Q1	95%	76%	75%
ED 4 hours Q2	95%	76%	75%
ED 4 hours Q3	95%	76%	73%
ED 4 hours Q4	95%	76%	73% * Q4 not yet complete
Stroke	N/A	C	B (Jul – Sept 23 Score)
RTT Waiting List	WL at Jan 2021	35,012 (Feb 24 Plan)	WL at Feb 2024 38,379
RTT 52 Weeks	0	1,687 (Feb 24 Plan)	Feb 2024 1,777
DM01 performance Q1	99%	99%	51.6%
DM01 performance Q2	99%	99%	46.7%
DM01 performance Q3	99%	99%	4731%
DM01 performance Q4	99%	99%	54.6% * Q4 not yet complete.
Cancer performance (62 days) Q1	85%	85%	65.4%
Cancer performance (62 days) Q2	85%	85%	66.2%
Cancer performance (62 days) Q3	85%	85%	64.6%
Cancer performance (62 days) Q4	85%	85%	66.2% * Q4 not yet complete
Cancer performance (2WW) Q1	93%	85%	70.6%
Cancer performance (2WW) Q2	93%	93%	55.9%
Cancer performance (2WW) Q3	93%	93%	43.9%
Cancer performance (2WW) Q4	93%	93%	54.8% *Q4 not yet complete

3.3 Statements from Integrated Health Boards, local Healthwatch organisations, and scrutiny committees

Statement from Healthwatch West Berkshire

Healthwatch West Berkshire is pleased to confirm our ongoing and collaborative relationship with Great Western Hospital. (GWH). We value the transparency demonstrated by Great Western Hospital in sharing performance data, patient feedback, and improvement plans. We also recognise and appreciate the commitment of Great Western Hospital to patient centred care and continuous improvement. This partnership is built on mutual respect and a shared dedication to enhancing healthcare services for the benefit of our community.

We look forward to continuing our collaborative efforts and achieving even greater successes in improving healthcare services for all.

Sincerely,

Fiona Worby
Lead Officer
Healthwatch West Berkshire

Statement from the Council of Governors

The governors are of the opinion that the Quality Account presented is a realistic representation of the Trust's performance in 2023/2024. This, like the previous year, has been a very challenging year recovering from the Covid-19 pandemic and with various strikes impacting. The Council of Governors support this document and endorse the tremendous dedication that members of staff have and will continue to show.

Access to the hospital for governors has greatly improved post-Covid-19, but we are continuing with some of our meetings held virtually. This new way has allowed us to gain assurance on the running of the Trust and enabled us to have good oversight of the priorities of the Trust.

The Trust's priorities for quality improvement last year were:

- Reducing the incidence of hospital and community acquired pressure ulcers
- Reducing the number of patients in the hospital who are ready to be discharged to care elsewhere in the community
- Reducing the amount of time patients spend in the Emergency Department before they are ready to go home or move on into a hospital bed.

The Trust established a weekly cross-divisional pressure ulcer panel concentrating in several areas along with various enhanced monitoring processes to reduce the incidents of pressure ulcers. The co-ordination centre brought together several multi-disciplinary teams from the health and social care arenas together to improve discharge processes, alternatives to admission where appropriate were also investigated. The Trust focussed on the amount of time patients waited in the Emergency Department and improvements in the triage process when they arrive.

The governing body throughout the year continued to seek assurances from the Non-Executive Directors (NED's) that the quality agenda was being addressed and outcomes were being monitored.

The report focuses on its main priorities for the coming year. The governing body will be monitoring these and challenging to ensure we see real change.

These areas are:

- Reducing falls and falls with harm
- Improving the experience of carers by delivering responsive support and information
- Improving initial assessment of patients on front door services.

The governing body were consulted about these priorities and are fully supportive of these as the lead quality markers for the coming year.

Chris Callow
Lead Governor on behalf of the Council of Governors

Statement from Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) welcome the opportunity to review and comment on the Great Western Hospital Quality Account for 2023/ 2024. In so far as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the ICB via contractual monitoring and quality visits and is presented in the format required by NHSE/I presentation guidance.

It is the view of the ICB that the Quality Account reflects the Great Western Hospital on-going commitment to quality improvement and addressing key issues in a focused and innovative way. Great Western Hospital has been able to make achievements against a number of their priorities for 2023/24 including:

1. Reducing the incidents of hospital and community acquired pressure ulcers.
2. Reducing the number of patients in hospital who are ready to be discharged to care elsewhere in the community. Through approaches to quality improvement and improved coordination there has been an overall reduction of patient stays over 21 days.
3. Reducing the amount of time patients spend in the Emergency Department before they are ready to go home or move on to a hospital bed. The outcome of this was to reduce the number of patients waiting more than 4 hours in the Emergency Department and minimise delays over 12 hours. The average waiting time in the Emergency Department was 483 minutes and the aspiration was to reduce this for at least 76% of patients being discharged or admitted within 4 hours / 240 minutes. Although this was not fully achieved there was significant progress made towards this.
4. Maternity engagement work. The Maternity team are continuing to work with the Maternity and Neonatal Voices Partnership (MNVP) to support Asylum seekers in the hotels in Swindon, with presence of a translator to help understand needs and issues to inform maternity and other services. The team are also working to develop an accessible

e-referral form and are sourcing a supply of SIM cards and devices to be able to provide those that are disadvantaged with the ability to access the internet and use the new maternity app to review their maternity notes and personalised care plans.

The ICB supports Great Western Hospital NHS Foundation Trust's identified Quality Priorities for 2024/2025. It is recognised that several of the priorities described in this Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance with a crucial focus on reducing inequalities. The ICB welcomes continued engagement in the agreed service improvement plan and its focus on:

1. Reducing falls and falls with harm. The aim is to reduce the number of patients with more than one fall by 20% by ensuring training is delivered for assessments, improvements in Enhanced Care for patients and also promoting links to the National Reconditioning Ambassadors Network.
2. Improving the experience of carers by delivering responsive support and information. There will be a review of the use of carers passports, evaluation of the new 'open' visiting times and also to raise awareness and support staff that are also carers.
3. Improving initial assessment of patients within front door services. The aim of this is to increase compliance with initial assessment by 20% across all direct admitting specialities and to improve training and competencies to enable this.
4. Continuously improving maternity services following the Care Quality Commission (CQC) inspection and subsequent change in rating of maternity services from Good to Requires Improvement. The ICB welcomes the immediate steps taken to address some of the areas raised, alongside the evidence of ongoing improvements that had already been implemented prior to the inspection. The ICB notes a recent CQC survey conducted with women and birthing people who had used the maternity services, with the Trust scoring third highest in the country for questions relating to ante-natal check-ups and care on the ward after birth, and in the top five Trusts for questions relating to care at home after birth.

We look forward to seeing progress with quality priorities identified in this Quality Account in conjunction with the continued transition to PSIRF and the implementation of the organisation's Patient Safety Incident Response Plans (PSIRPs).

NHS Bath and North East Somerset, Swindon and Wiltshire ICB are committed to sustaining strong working relationships with the Great Western Hospital, and together with wider stakeholders, will continue to work collaboratively to achieve our shared priorities as the Integrated Care System further develops in 2024/25.

Yours sincerely

Gill May
Chief Nurse Officer
BSW ICB

Statement from Healthwatch Swindon, Healthwatch Wiltshire and Healthwatch West Berkshire

Healthwatch welcomes the opportunity to comment on the Great Western Hospitals NHS Foundation Trust quality accounts 2023/24.

As the independent champion for people using health and care services, we welcome the work to ensure the voices of patients and service users are heard. Healthwatch continues to work closely with the Head of Patient Experience and Engagement ensuring the patient voice is captured throughout the patient's journey, the trust should remain focused on listening to patients and families, service users and carers' experiences and their involvement.

We commend the hard work in making significant progress over 2023/24 to develop their approach to identify priorities and engagement, involvement and coproduction work, and the ongoing work being carried out by the Maternity team to create an accessible e-referral form. Sourcing a supply of SIM cards and devices to allow disadvantaged patients to access the Internet and use the new maternity app to review their maternity notes and personalised care plans is welcomed.

On 19th February 2024, Healthwatch Swindon visited the Maternity Services at Great Western Hospital. Our Enter and View visits are a way we can gather information about services and collect views of service users, staff and volunteers. Following our visit, we have made some recommendations to the service provider based on the feedback we have received and our observations.

We welcome the trust approach to involving children and people with a Learning Disability (LD) and Autistic Spectrum Disorder (ASD), members from the LGBTQIA+ community to help shape service provisions, and their involvement to help shape current practice in the Emergency Department (ED).

Priority 2.3 - Reducing the amount of time patients spend in the Emergency Department before they are ready to go home or move on to a hospital bed.

Although Healthwatch is aware that many trusts throughout the UK have faced the same challenges, we welcome the strong focus and ongoing commitment the Great Western Hospital has shown to reduce the amount of time patients spend in the Emergency Department as national evidence shows that longer wait times can lead to worse clinical outcomes. The Quality accounts effectively demonstrate the measures taken by the Trust to reduce waiting times.

Healthwatch recognises the hard work undertaken by colleagues at the Great Western Hospital during 2023/24. Healthwatch will continue to work collaboratively with the Trust to share information and support patients, families and carers.

"We look forward to working alongside the trust in 2024/25 ensuring that the voices of those who share their views and experiences with Healthwatch are heard and that their feedback leads to meaningful improvements and continuous good standards of care being delivered at all times with a patient-centred approach delivered with compassion."

Amritpal kaur

Amritpal Kaur
Healthwatch Swindon Projects Portfolio Manager

Term	Definition
Autistic Spectrum Disorder (ASD)	A developmental disability caused by differences in the brain. People with ASD often have problems with social communication and interaction, and restricted or repetitive behaviours or interests
Breakthrough objective	These are the areas for focused trust-wide improvement, we should be able to see a 20 – 30% improvement over a 12-18 month period and they should be the focus of our Trust-wide improvement energy. They are likely to be top contributors to driving improvement in one of our pillar metrics.
Brighter Future Charity	Brighter Futures is the charity for Great Western Hospitals NHS Foundation Trust which includes Great Western Hospital and community health sites in Swindon
Cardiotocography (CTG)	Cardiotocography (CTG) is a continuous recording of the fetal heart rate obtained via an ultrasound transducer placed on the mother's abdomen. CTG is widely used in pregnancy as a method of assessing fetal well-being, predominantly in pregnancies with increased risk of complications
Care Quality Committee (CQC	The independent regulator of health and adult social care in England
Carers UK	Carers UK is there to listen, to give expert information and guidance, to champion individuals rights and support in finding new ways to manage at home, at work.
Changing places	Changing Places are toilet facilities for people with profound or multiple disabilities
Clinical Audit	Clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients
Clinical Governance	Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care
Clinical Quality Indicators	Metrics used to assess the clinical effectiveness, safety, and patient experience of healthcare services. Clinical quality indicators may include mortality rates, infection rates, waiting times, and patient satisfaction scores
Clostridium difficile infection	Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea
Commissioners	Responsible for assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes
Dining Companions	Assist ward staff and patients during mealtimes, which includes feeding some patients who need extra help
Elective Surgery	Means that the surgery isn't an emergency and can be scheduled in advance. It may be a surgery you choose to have for a better quality of life, but not for a life-threatening condition
Emergency Care	Emergency care involves life-threatening illnesses or accidents which require immediate treatment
Fresh Eyes	The Fresh Eyes approach is regular reviews of Cardiotocography interpretation, with a protocol for escalation if concerns are raised. All staff to be trained in the review system and escalation protocol.
Friends and Family Test (FFT)	Feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience
GP	General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment
Healthwatch	Obtain the views of people about their needs and experience of local health and social care services
Hospital Episode Statistics (HES)	Hospital Episode Statistics (HES) is a curated data product containing details about admissions, outpatient appointments and historical accident and emergency attendances at NHS hospitals in England

Term	Definition
Information Governance (IG)	Information Governance (IG) is the framework for handling information in a secure and confidential manner that allows organisations and individuals to manage patient, personal and sensitive information legally, securely, efficiently and effectively in order to deliver the best possible healthcare and services
Integrated care boards (ICB	Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities
Integrated Front Door (IFD),	The point of contact for enquiries and referrals relating to children and young people made by professionals, families and the public
Interpreting and Translation services	Interpreting services are those where a professional interpreter will convert spoken words from one language to another in real-time
Learning Disability (LD)	Learning disabilities are disorders that affect the ability to: Understand or use spoken or written language
LGBTQIA	Lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual/aromantic/agender
Maternity and Neonatal Voices Partnership (MNVP),	The (MNVP) listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity
Medical Examiner	Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties.
Mums on a mission	Mums on a mission is a not-for-profit organisation that aims to create healthy, happy and fruitful families within our community.
National Institute for Health and Care Excellence (NICE)	An executive non-departmental public body in the United Kingdom responsible for providing national guidance and standards for healthcare practice and interventions. NICE guidelines inform clinical decision-making and quality improvement efforts across the NHS
NHS	The NHS stands for the National Health Service. It refers to the Government-funded medical and health care services
NHS Digital Data Security & Protection (DSP) Toolkit.	Data Security and Protection Toolkit. The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards
NHS England	NHS England leads the National Health Service (NHS) in England
NHS England	Ensures that the healthcare workforce has the right numbers, skills, values and behaviours to support the delivery of excellent healthcare and health improvement to patients and the public
'NHS@Home'	The 'NHS@Home' service is a joint initiative by local NHS organisations that offers hospital-level care and remote monitoring in an individual's home, providing an alternative to hospital admission, or helping them to return home promptly following an inpatient stay
Paediatrics	Paediatrics is the branch of medicine dealing with the health and medical care of infants, children, and adolescents from birth up to the age of 18
Patient Advice and Liaison Service)	The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. You can find PALS officers in your local hospital
Patient passport	The aim of the Hospital Passport is to provide our staff with information about yourself and your carers during a hospital visit
Patient Reported Outcome Measures (PROMS)	Patient Reported Outcome Measures
Patient Safety Incident Review Framework (PSIRF)	A new approach to responding to patient safety incidents · Compassionate engagement and involvement of those affected by patient safety incidents
Patient Surveys	Surveys conducted to gather feedback from patients about their experiences with healthcare services. Patient experience surveys assess various aspects of care delivery, including communication, accessibility, and responsiveness to patient needs

Term	Definition
Performance Metrics	Quantitative measures used to evaluate the performance and effectiveness of healthcare providers. Performance metrics may include clinical outcomes, financial indicators, and compliance with regulatory requirements.
Pressure Ulcers	Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as "bedsores" or "pressure sores
Pillar metrics	These are our 12 metrics that tell us whether we are doing well on driving forwards our vision and strategy. These last for the duration of our strategy (3-5 years).
Salisbury Spinal Unit (SCI)	The Spinal Treatment Centre focuses on the care and rehabilitation of persons with Spinal Cord Injury
Spinal cord injury (SCI)	Spinal cord injury (SCI) is a serious medical condition, which often results in severe morbidity and permanent disability
Summary Hospital-level Mortality Indicator (SHMI)	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation
Surgery	The branch of medical practice that treats injuries, diseases, and deformities by the physical removal, repair, or readjustment of organs and tissues
Swindon Borough Council (SBC)	Swindon Borough Council is the local authority of the Borough of Swindon in Wiltshire, England. It is a unitary authority, having the powers of a non-metropolitan county and district council combined
The Commissioning for Quality and Innovation (CQUIN)	The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.
The National Joint Registry (NJR)	The National Joint Registry (NJR) was set up by the Department of Health and Welsh Government in 2002 to collect information in England and Wales on joint replacement operations and to monitor the performance of implants, hospitals and surgeons
The NIHR Clinical Research Network (CRN)	The NIHR Clinical Research Network (CRN) supports patients, the public and health and care organisations across England to participate in high-quality research, thereby advancing knowledge and improving care
The Pride in Veterans Standard (PiVS)	The Pride in Veterans Standard (PiVS)is a programme developed by Fighting with Pride. It is open to any organisation that wishes to demonstrate its commitment to being inclusive and welcoming to LGBT+ Veterans, serving personnel, and their families
The Swindon Intermediate Care Centre (SwICC)	The Swindon Intermediate Care Centre (SwICC) is located in a separate building on the Great Western Hospital site. Patients receive therapy and further care here before being discharged to their own homes or to another community healthcare setting.
Tissue Viability	Tissue viability is a growing speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration
Triage	To decide the order of treatment of patients
Trust Volunteers	Volunteers support the staff by undertaking simple activities and tasks on the wards or within hospital teams
Venous thromboembolism (VTE)	Venous thromboembolism (VTE) is a condition that occurs when a blood clot forms in a vein. VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE).