GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 2 November 2023, 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

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome**	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 7 September 2023	1 – 10	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	11	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	12 – 14	CC	Receive	9.45
6.	**Care Reflection (Staff Story) – Improving Together** Emily Beardshall, Deputy Director – Improvement & Partnership	15 – 17	EB	Receive	9.50
7.	**Chair's Report** Liam Coleman, Chair	18 – 21	LC	Note	10.15
8.	**Chief Executive's Report** Kevin McNamara, Chief Executive	22 – 31	KM	Note	10.25
9.	**Integrated Performance Report**				10.40
	• Performance, Population & Place Committee Board Assurance Report (September & October) – Peter Hill, Non-Executive Director & Committee Chair	33 – 34	PH	Assurance	
	• Quality & Safety Committee Board Assurance Report (September & October) – Claudia Paoloni & Lizzie Abderrahim, Non-Executive Directors & Committee Chairs	35 – 44	CP/EKA	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (September & October) – Faried Chopdat, Non-Executive Director & Committee Chair	45 – 48	FC	Assurance	
	• People & Culture Committee – Paul Lewis, Non-Executive Director & Committee Chair	Verbal	PL	Assurance	

	• Integrated Performance Report	49 – 96	All	Assurance	
BREAK (10 minutes) at 11.20am					
10.	**Audit, Risk & Assurance Committee Board Assurance Report** Helen Spice, Non-Executive Director & Committee Chair	97 – 100	HS	Assurance	11.30
11.	**Mental Health Governance Committee Board Assurance Report** Lizzie Abderrahim, Non-Executive Director & Committee Chair	101 – 102	EKA	Assurance	11.40
12.	**Saving Babies Lives v3 – GWH First Assessment (Oct 2023)** Lisa Cheek, Chief Nurse Kat Simpson, Head of Midwifery & Neonatal Services	103 – 110	LCh/KS	Assurance	11.50
13.	**Ockenden Report – GWH Update** Lisa Cheek, Chief Nurse Kat Simpson, Head of Midwifery & Neonatal Services	111 – 116	LCh/KS	Assurance	12.00
14.	**Equality Diversity Inclusion Annual Report 2022-23** Jude Gray, Chief People Officer Sharon Woma, Lead for Equality, Diversity & Inclusion	117 – 171	JG	Approve	12.10
15.	**Freedom to Speak Up Annual Report 2022-23** Lisa Cheek, Chief Nurse (received at Quality & Safety Committee 21 September 2023)	172 – 176	LCh	Note	12.20
16.	**Patient Safety Incident Response Framework Implementation Plan and Policy** Lisa Cheek, Chief Nurse (received at Quality & Safety Committee 19 October 2023)	177 – 241	LCh	Approve	12.30
17.	**GWH Health & Safety Annual Report 2022-23** Simon Wade, Chief Financial Officer (received at Finance, Infrastructure & Digital Committee 23 October 2023)	242 – 266	SW	Approve	12.40
18.	**IT Cyber Security – Annual Summary Report** Naginder Dhanoa, Chief Digital Officer (received at Audit, Risk & Assurance Committee 14 September 2023)	267 – 277	ND	Assurance	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.**					
19.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	Verbal	CC	Note	13.00
20.	**Risk Management Policy** Rayna McDonald, Deputy Chief Nurse (approved by Trust Management Committee 21 September 2023)	278 – 312		Ratification	-
21.	**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	-	-

22.	**Date and Time of next meeting** Thursday 7 December 2023 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
23.	**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

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

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ AND VIA MS TEAMS 7 SEPTEMBER 2023 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Naginder Dhanoa (ND)	Chief Digital Officer
Peter Hill (PH)*	Non-Executive Director
Claire Lehman (CL)*	Associate Non-Executive Director
Kevin McNamara (KM)	Chief Executive
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)	Chief Medical Officer

In attendance:

Caroline Coles (CC)	Company Secretary
Tim Edmonds (TE)	Associate Director of Communications & Engagement
Luisa Goddard (LG)	Deputy Chief Nurse
Deborah Rawlings (DR)	Board Secretary
Claire Warner (CW)	Deputy Chief People Officer
Katy Barrett (KB)	NHS Management Trainee Graduate (observing)
Cath Hill (CH)	Director, Aqua (observing as part of Well-Led Review)
Peter Thomas (PT)	Father of patient (agenda item 118/23 only)
Rayna McDonald (RM)	Deputy Chief Nurse (agenda item 118/23 only)
Tania Currie (TC)	Head of Patient Experience & Engagement (agenda item 118/23 only)
Sharon Woma (SW)	Lead for Equality, Diversity & Inclusion (agenda item 125/23 only)
Amanda Wylie (AW)	Associate Director of Organisational Development (agenda item 125/23 only)

Apologies

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
Paul Lewis (PL)	Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director

Number of members of the Public: None

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
113/23	**Apologies for Absence and Chair's Welcome**	

Minute	Description	Action

The Chair welcomed Board members and attendees to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. It was noted that Cath Hill from Aqua was also in attendance observing the meeting as part of the Trust's Well Led Development review.

Apologies were received as above.

114/23 **Declarations of Interest**
There were no declarations of interest.

115/23 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 3 August 2023 were adopted and agreed as a correct record, subject to the following amendments:

Minute No. 96/23 – Finance, Infrastructure & Digital Committee Chair Overview
3rd paragraph – Financial Position – to be amended to read "The Trust was clearly in deficit mode, which was challenging due to a number of factors *partly* outside of the Trust's control."

Minute No. 95/23 – Chief Executive's Report – Sulis Facility Bath
2nd paragraph, 2nd sentence to be amended to read: "Felicity Taylor-Drewe, Chief Operating Officer responded that the operational detail had not been worked through yet, however the principle was that there would not be any additional costs and would be a *site for elective surgery only*."

116/23 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

117/23 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

118/23 **Care Reflection (Patient Story) – Supporting patient with complex needs to receive dental treatment**
Peter Thomas, Father of Alec (patient), Rayna McDonald, Deputy Chief Nurse, and Tania Currie, Head of Patient Experience & Engagement, joined the meeting to present this item.

The Board received a presentation from Peter Thomas on his personal experience of dental treatment and care received by his severely autistic son, Alec, who also had complex learning difficulties. The action plan undertaken by the Trust to dedicate resources to the family to ensure successful treatment.

Rayna McDonald, Deputy Chief Nurse also outlined the leadership and coordination actions taken together with the multi-disciplinary approach that had enabled a successful outcome to be attained. The learning from this case had already been shared widely across the Trust and key themes identified that could be replicated if a similar case occurred.

Kevin McNamara, Chief Executive also reflected on the need to understand others on the Trust's waiting list for treatment with similar cases, with particular focus on those patients with certain characteristics that may require a more coordinated approach and the need to ensure that their pathway for treatment was correct and

Minute	Description	Action

appropriate for their specific personal needs. Kevin McNamara also commented on the learning from complaints raised by similar cases to drive improvement.

Jon Westbrook, Chief Medical Officer reflected on the difficulties of this case and the length of time taken to reach a solution and commended the Anaesthetic staff on the actions taken to move this case forward.

Luisa Goddard, Deputy Chief Nurse commented on the Oliver McGowan mandatory training for all clinicians which focused on learning disabilities and autism based on factual experiences and was being rolled-out across the Trust, also with the aim to raise awareness and the need to ensure that reasonable adjustments were put in place for individual needs.

Claire Lehman, Associate Non-Executive Director highlighted that links to datasets were now available from primary care that would enable a more systematic approach.

Felicity Taylor-Drewe, Chief Operating Officer outlined some of the actions being undertaken at the Trust to highlight those patients on waiting lists with certain characteristics together with children and young people to close the gap on waiting times and to prioritise waiting lists in a different way.

The Board **noted** the reflections and thanked Peter for sharing such a personal and challenging story for Alex and his parents.

119/23 **Chair's Report**

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

The Board noted the briefing on the Fit & Proper Person Test (FPPT) Framework and the key changes being made to the framework following recommendations made by Tom Kark KC in his 2019 review. The new Leadership Competency Framework was also noted which would include a new appraisal framework for Board members for implementation from 1 April 2024.

The Board **noted** the report.

120/23 **Chief Executive's Report**

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

Reflections following the Lucy Lethby trial

The Board reflected on the outcome of the Lucy Lethby trial and what it meant for our patients and the Trust as a whole. The actions taken by the Trust in response to the outcome of the trial and clear learning for everyone working in the NHS was noted. This included the support provided to staff on our Neonatal Unit and the information available to parents of babies in the unit to address any concerns or worries that this case could generate.

The Board noted that the NHS had strengthened oversight of deaths through the introduction of the Medical Examiner (ME) role across all parts of the country and

Minute	Description	Action

it was noted that in this Trust, structured judgement reviews were being routinely undertaken to provide review and challenge of deaths.

Kevin McNamara, Chief Executive, added that an external piece of work was to be undertaken to gain a fresh, objective view of the Trust's speaking up and listening culture and that this would be brought back to the Board once completed for further discussion and reflection.

In response to a question asked by Bernie Morley, Non-Executive Director on whether people felt listened to if they spoke up on a matter, Kevin McNamara, Chief Executive replied that there were policies and processes in place that enable staff to raise concerns however the Trust would facilitate learning from the Lucy Letby case and adopt recommendations from the external review to improve our speaking up and listening culture.

A discussion was held on the review of both local and national data to gain comparison with similar organisations to help understand and drive improvement in listening and speaking up practices. Will Smart, Non-Executive Director agreed to share a short brief on the Federated Data Platform with the board to provide guidance.

The Board noted that a Board Workshop was planned in the future on the Trust's speaking up and listening culture and to review the outcome of the external review.
Action: Chief People Officer **JG**

Industrial action
The Board noted the planned industrial action to be held by BMA consultants and junior doctors during September and October. Staff were expected to provide Christmas Day-level cover to ensure that emergency care would continue to be provided.

Felicity Taylor-Drewe, Chief Operating Officer added that elective work planned for the forthcoming strike days would be affected and wished to record thanks to the administrative colleagues who were having to rebook appointments especially when capacity was already limited in the first instance. The strike days planned for September would be used to undertake a validation exercise.

Visit of NHS Chief Executive Officer, Amanda Pritchard
An outline of the visit by the NHS CEO Amanda Pritchard to the Trust in August was noted and that the visit had received good engagement by staff and that positive feedback had been received.

Staff Survey
It was reported that the results of the latest National Quarterly Pulse survey had shown a slight dip in answers to questions which related to *'I am able to make improvements happen in my area of work'* and *'I would recommend my organisation as a place to work'* but the overall trend for both questions had increased. Positive aspects about working for the Trust had been received which reflected the ongoing work to support staff to make improvements. The Annual Staff Survey was to be launched on 11 September and would run until November.

The Board **noted** the report.

Minute	Description	Action

121/23 **Integrated Performance Report**

The Board received the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in July/August 2023.

Quarterly Pillar Metric deep dive

Our Care

Lisa Cheek, Chief Nurse reported that the strategic pillar for Our Care was to reduce avoidable harm within 5 to 10 years and that the main drivers for harm were healthcare associated infection and pressure damage. Pressure harm had been chosen as a breakthrough objective with the aim to reduce overall numbers by 20% this year and have zero Category 3 and 4 reported harms. This was currently over trajectory and that Improving Together methodology was being applied both in divisional and clinical areas. A review had been undertaken to ensure that counter measures were correct and for support to be provided in identified high contributory areas. The Board noted the actions that were being undertaken to drive improvement in pressure harms and that evidence could be gained on the change in culture in relation to leadership roles and responsibilities. It was also confirmed that a trajectory graph would be added to the IPR going forward and that the Quality & Safety Committee would monitor any trends.

Our Performance

Felicity Taylor-Drewe, Chief Operating Officer explained that there was a new operational breakthrough objective which related to Clinically Ready to Proceed (CRTP) and that this had been developed through liaison with external colleagues in the urgent and emergency care. It was noted that a proxy indicator measure using care flow offered better scrutiny rather than the 12-hour Decision to Admit waits in ED. This would provide focus on the total patient cohort and a better indication of patients in ED and flow.

Felicity Taylor-Drewe reported that alongside the breakthrough objective, all four measures in relation to patients coming to harm whilst waiting for urgent care, had shown some improvements for the third month, however this had not translated into Ambulance Handovers.

It was noted that the July 2023 performance for RTT (Referral to Treatment) 65 Week Waiters showed a small reduction in the number of patients waiting with no patients above 78 weeks or 104 weeks.

It was noted that Cancer 62 day waiting times remained below standard, which reflected a deterioration in performance for the fourth month and that this was driven by dermatology, urology, colorectal and some general surgery and Improving Together methodology was to be applied to seek improvements in performance and a deep dive was to be undertaken.

The Board discussion on IPR noted an inconsistency between the proportion of patients waiting over 12 hours in ED in the narrative and the tables. The Chief Operating Officer explained that this was because the key indicator combined UTC and ED (types 1 & 3) performance whereas the narrative for the watch metric related to ED (type 1) only.

Minute	Description	Action

Use of Resources

Simon Wade, Chief Financial Officer reported on the breakthrough objective for productivity. It was noted that productivity in total had maintained at an overall total -25% for Month 4, however this was a 7% deterioration at the end of 2022/23. This reflected the Trust's activity and financial plan being off track due to higher pay pressures such as industrial action impact and behind plan with CIP delivery. It was noted that this was measuring the increased cost from 2019/20 levels. The pay productivity would return to +10% at the end of the 2023/24 plan if planned cost and efficiency levels were also delivered.

Simon Wade, Chief Financial Officer added that a new tool had been implemented, Aurum, which would produce productivity data, trends and information that could enable intelligence and action plans across divisions in areas such as variation in treatment cost.

It was noted that the Finance, Infrastructure & Digital Committee would continue to monitor and challenge targeted areas and to refine productivity data to make it meaningful to the Board to encourage discussion.

Our People

Claire Warner, Deputy Chief People Officer provided an update on the strategic pillar '*Staff Recommendation as a Place to Work'* and that this had been maintained for a second year with the aim to reach the target response rate of 55% through the Staff Survey. It was noted that the 2023/24 breakthrough objective had been agreed from the Staff Survey question in relation *to 'I am able to make improvements happen in my area of work'*. Progress against this breakthrough objective would be monitored through monthly staff survey working group meetings with divisional input using local counter measures. This would then feed into the People & Culture Committee for monitoring and scrutiny.

The Board **noted** the report.

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 meeting on 30 August 2023 and the following was highlighted:-

Emergency Access – The Trust now had fewer non criteria to reside (NCTR) patients (circa 80) which had enabled an improvement of patient flow from ED.

Elective Access – RTT – The Trust continued to perform well against the 78-week standard with no patients breaching at the end of July. However, 2 to 6 patients would breach in August. Gastro remained the most challenging specialty. Improving Together methodology was being applied along with a large scale valuation exercise that was yielding positive results. With nearly 1,000 outpatient cancellations and 33 cancelled operations, July became the hardest hit month in terms of the impact of industrial action.

Cancer Performance – The Trust's performance continued to deteriorate against the key performance indicators and was now starting to benchmark poorly against the regional and national benchmark. Improving Together methodology was to be applied to seek improvements in performance and a deep dive was to be

Minute	Description	Action

undertaken. The results of the deep dive would be received at the November 2023 PPPC.

Action: Chief Operating Officer **FTD**

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 (Q&SC) at its meeting on 17 August 2023 and the following was highlighted:

Hospital Acquired Infections – Infection rates of gram negative bacteraemia had continued to increase and that the spike in reported cases correlated with a change in cleaning practices in April 2023 by Serco. A report was received by the Contract Director of Serco and Matron in Neurology & Stroke on the impact of this change in cleaning practices and that an action plan had been implemented with immediate effect.

Water Management and Pseudomonas and Action Plan – Assurance was provided that issues around mitigation of infection rates had been recognised and were being reviewed and managed through the Water Safety Group, which reports into infection control.

Maternity Performance Report – The Committee had changed the risk ratings around the maternity performance report to reflect that the Trust would not be compliant for CNST Year 5 (Maternity Incentive Scheme) criteria due to three safety factors around staffing rotas, ultrasound scanning capacity and non-compliance with the Saving Babies Lives Care Bundle (Version 3). The Board noted that this had been impacted by the new changes to the criteria which had been recently imposed. A working group had been established to look at ways to manage the new requirements to include potential collaboration working in the System.

Maternity IUD Case Reviews Report – A report had been received on the cluster of unanticipated stillbirths. It was confirmed that reviews had been undertaken and that no link had been established between each case. Learning from themes had been taken forward and that practice changes around triage and processes in women presenting with multiple attendances had been implemented with immediate effect.

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 meeting on 29 August 2023 and the following was highlighted:

Month 4 Finance Position/Efficiency Programme – At Month 4 the Trust was in a £5.3m deficit position, representing a £3.9m variance to plan. An internal Financial Recovery Board was being put in place to increase focus on delivery through Executive led workstreams. The Committee would continue to monitor closely.

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Seasonal Plan – Although funding for the seasonal plan had been included in the budget for this year as the Trust was currently in a deficit position it would need to go through the BSW Recovery Board and consideration would need to be taken by the Board in due course to balance the quality and safety issues and the required financing to ensure that the appropriate decisions were made for implementation.

EPR – The EPR business case had been submitted to NHSE in August and that engagement with the NHSE was progressing.

IT infrastructure and resilience – Further assurance would be sought by the Committee on next steps on strengthening the resilience of the Trust's IT infrastructure.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received an overview of the detailed discussions held at the People & Culture Committee (P&CC) at its meeting on 31 August 2023 and the following was highlighted:

Staff Survey (Recommend Place to Work and I am able to make improvements happen in my area of work) – The Q2 Pulse Survey results had shown a decrease against both questions and that Divisional plans would be implemented and monitored. The Committee would continue to monitor progress.

Voluntary Staff Turnover Rate – A continued improvement since July 2022 had been reported. A deep dive into the Trust's staff turnover rates with leavers within the first year of employment was reviewed by the Committee and actions were noted against identified issues which had contributed to the turnover of staff.

The Board **noted** the report.

122/23 **Mental Health Governance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Mental Health Governance Committee at its meeting on 21 July 2023 and highlighted the following:

Emergency Department / Mental Health Liaison Team Update – The ongoing challenge in relation to the lack of acute mental health beds in the system remained. The Committee was confident in the level of oversight by agencies and evidence that actions were being taken to address the issues effectively.

The Board noted a report which informed on the use of the Mental Health Act (MHA, 1983) Annual Report 2022/23. The level of capability to address pressures around capacity for mental health services and the financial risks being carried by our organisation remained and it was noted that a system level risk summit was going to be held.

The Board **noted** the report.

Minute	Description	Action

123/23 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee at its meeting on 10 August 2023 and highlighted the following:

Fundraising – Risk remained on the uncertainty of fundraising capability with cost-of-living implications and it was noted that a series of actions were in place.

The Board **noted** the report.

124/23 **Workforce Disability Equality Standard (WDES) Annual Report 2022-2023 and Workforce Race Equality Standard (WRES) Annual Report 2022-2023**

Sharon Woma, Lead for Equality, Diversity & Inclusion and Amanda Wylie, Associate Director of Organisational Development joined the meeting to present this agenda item.

The Board received and considered a paper which contained a summary of the Trust's results for this year's Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reporting.

The key areas of change and/or progress were noted by the Board, together with those areas that required improvement. The Trust's action plans for WDES and WRES 2023/24 to drive improvement were also noted which aimed to address health and wellbeing, equal opportunities to address protected characteristics, ability to recognise discrimination, empower staff to address issues within their own areas, and leadership development for a more inclusive workplace.

This report had already been reviewed by the People & Culture Committee and that the requested changes had been incorporated prior to submission to the Board.

The Board agreed that it was comfortable that both reports could be published and accepted that the reports would be discussed further at the People & Culture Committee. Liam Coleman, Chair added that as of March 2024, the Board would own an EDI objective and that the Non-Executive/Associate Non-Executive Directors would need to work through this process through a Board Workshop in the near future.

Bernie Morley, Non-Executive Director commented on the format of the nationally driven percentages for the disability survey and noted the positive trajectory. Bernie Morley asked Sharon Woma if she considered if the Trust had fundamental concerns on the issues faced in terms of disability or did the survey reflect nationally mandated data. Sharon Woma responded that the Trust was close to the national average and that further work was required to engage with disabled staff to identify any areas of discrimination and added that blockages also exist for equal opportunities and the management of reasonable adjustments. Amanda Wylie provided an outline of the Access to Work scheme which could provide Government funding for reasonable adjustments and join up actions to meet the requirements of long term workforce planning in terms of training and retention.

In response to a question raised by Bernie Morley, Non-Executive Director which related to the availability of questions prior to interviews to aid for differentiable people, Sharon Woma replied that this would be down to the discretion of the individual interviewing manager however could create the risk of inconsistency.

Minute	Description	Action

The Board **approved** the reports for publication on the Trust's website.

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.

125/23 **Ratification of Decisions made via Board Circular**
None.

126/23 **Urgent Public Business (if any)**
None.

127/23 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 2 November 2023 at 9.30 am, at the Double Tree by Hilton, Swindon.

128/23 **Exclusion of the Public and Press**
The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.

The meeting finished at 13.23hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – November 2023				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
7 Sept 2023	120/23	Board Workshop on the Trust's speaking up and listening culture and to review the outcome of the external review.	Chief People Officer	Board Seminar/Development session proposals on agenda in private session.to be finalised.
7 Sept 2023	121/23	Results of the deep dive into Cancer performance to be received at the November 2023 PPPC meeting.	Chief Operating Officer	For PPPC

Future Actions				

Report Title	**Question for the Board**				
Meeting	**Trust Board Meeting**				
Date	**2 November 2023**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

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

Assurance Level

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

Process & outcome

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 'Acceptable' assurance or above, and the timeframe for achieving this:

Assurance in respect of the process of obtaining and gaining response to questions to the Board.

Report

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

This paper reports the question and response asked of the Board by a member on 25 September 2023.

The Board is invited to consider the question raised, the response given and agree if any further action is required.

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	
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					

Next Steps	To be considered by the Council of Governors at the next meeting.

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 consider the question and response and to consider if further action is required.

Accountable Lead Signature	Caroline Coles
Date	25 October 2023

Question to the Board				
Topic	**Questioner**	**Question**	**Responder**	**Response**
Clinical Research for drug treatment of long-term Covid	Greg Iddon, Member	There are numerous drug treatments that clinical research indicate may help such as SSRIs, beta blockers, anti-coagulants, anti-platelets, etc yet these are not yet offered to patients still suffering from the long-term effects of Post-COVID syndrome. (1) What are the Trust's plans regarding Long COVID treatment beyond management and therapies like meditation, diet, managing stress etc? (2) Does the Trust plan to start offering these well-studied drugs in these scenarios and monitor their efficacy with patients suffering from Post-COVID syndrome?	Jon Westbrook, Chief Medical Officer	Long covid treatment is provided in the community by the Bath and North East Somerset, Swindon and Wiltshire (BSW) Long Covid Rehabilitation Assessment Clinic. Any patient attending the hospital would be referred to the long covid clinics. For any further information please contact ask.wiltshirehealthandcare@nhs.net

Great Western Hospitals
NHS Foundation Trust

Improving Together Staff Stories

Trust Board 2nd November 2023

Improving
together

Staff Stories

Hayley

Cohort: 4

Frontline team: Trauma Ward

Role: Nutrition Assistant

Hayley is part of the Trauma Ward team and has attended training between June 23 and November 23. She has been key to driving the work forwards on the ward.

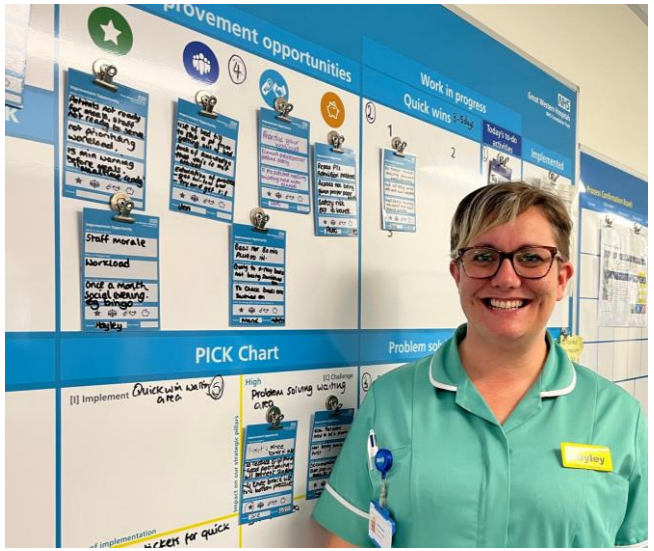
The trauma ward have 3 driver metrics – reducing pressure harms, increasing the number of patients who are mobilised on the day of surgery following a hip fracture and improving staff morale.

Some challenges included

- The team were unsure what to expect and the training days were quite overwhelming to start with but the Coach House improvement facilitator was helpful and things started to come together
- Finding the right time for the daily huddle has involved experimenting with different times and finding a rhythm that works for the ward.

Early benefits

- Lots to celebrate; the team have put in place lots of improvements including
  - Changes to reduce device related pressure harms
  - Better regime for weighing patients using visual management
  - Staff shoutout board supporting staff morale
- Increased awareness of our data and improved ability to take collective action on problems



NHS
Great Western Hospitals
NHS Foundation Trust

We are improving patient experience through improved communication and care. We are more proactive as a team now

Improving Together has helped us acknowledge some barriers to good communication and has helped us take steps to address them.

"The staff shoutout board was Hayley's idea and she has really brought it to life, I am so proud of her" (Matron, Trauma & Orthopaedics)

The training was really inclusive of everyone from across the team giving all roles a voice.

Staff Stories

Karen

Cohort: 2

Frontline team: Teal & DOPS

Role: Acute Physiotherapy Team Lead

Karen participated in cohort 2 as part of the Teal & DOPS frontline teams and she is now applying her Improving Together knowledge with the Acute Physio team, they have been one of the first teams to use our prioritisation border.

The prioritisation board is designed for smaller frontline or corporate teams.

Some challenges included

- The original cohort was ward focused and AHPS are not aligned with specific wards; this led to training for senior staff in June 2022 followed by bite size training to the whole team.
- It has taken time to build the team's confidence to a point where a range of people will lead a huddle.
- Some ideas were "kiboshed" early on due concerns around adding to workload.

Early benefits

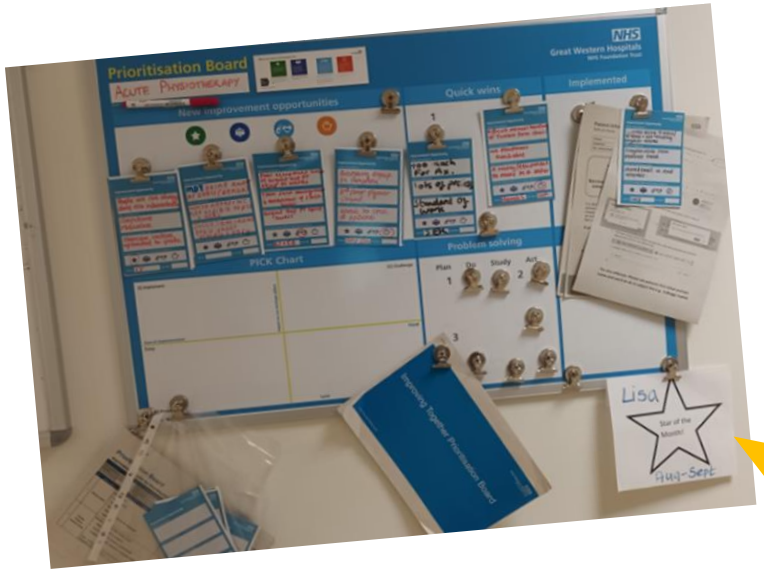
- The whole team are engaged in agreeing projects
- Stops duplication and creates transparency within the team, the board helps show and share progress
- Streamlined focus on ideas creating better momentum and encourages celebration.

3 sub-team areas share 1 board. Some ideas are team specific and some are relevant to the whole service so we use different colour text. Individual teams huddle once a week and the whole service huddle once a week.

NHS Great Western Hospitals NHS Foundation Trust

The prioritisation board came from requests from the team to have our own visual management board so that we could see our improvement work laid out.

All staff feel empowered to put ideas forward.



Generates discussion on ideas early on; this has helped set realistic expectations within the team

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**2 November 2023**	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
- Strengthening Board Oversight
- 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	25 October 2023

Chair's Board Report

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

1. Council of Governors

1.1 Key meetings, training and events during September and October 2023 which governors participated:-

Date	Event	Purpose
5 Sept-23	Engagement & Membership Working Group	Regular governor working group to develop and review the implementation of the Membership Strategy
16-Sept-23	Governor Tic-Tok video uploaded	Promoting to the public becoming a member of our Trust. https://www.facebook.com/watch/?v=3553904641565606
19 Sept-23	Public Health Talk on Wellbeing & Psychology talk by Jon Freeman, GWH Clinical Psychologist	Hosted by a governor to promote membership.
22 Sept-23	Finance Training	In-house Finance Training Development to gain better understanding of NHS finance
25 Sept-23	Annual Members Meeting	To receive the Trust's Annual Report & Accounts 2022/23
28 Sept-23	Freshers Fair New College / Student Board	To support promoting recruitment of new, younger members to GWH Trust.

4-Oct-23	Hospital Radio	To promote membership
10-Oct-23	Chair/Lead Governors meeting	Regular meeting between Chair and Lead Governors to discuss topical items.
13-Oct-23	Governor stand in Atrium	To promote membership and receive feedback
16-Oct-23	Informal Governor Meeting	Regular informal meeting for governors to meet the Non-Executive Directors – attending this meeting was Claudia Paoloni, Julian Duxfield and Bernie Morley.
24-Oct-23	Members Trust Strategy Focus Group	Engagement on the Trust's strategy development

1.2 Governor Resignation : It is with regret that I announce that Mufid Sukkar resigned as governor representing Wiltshire Northern constituency in September 2023. On behalf of the Board, I would formally record my thanks to Mufid for his support and commitment during his time as governor and wish him well for the future.

2. Strengthening Board Oversight & Development

2.1 Board Seminar - A Board workshop was held on 5 October 2023 which focussed on the Trust's Strategy review to help shape 2024+ strategic direction of the organisation.

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

Date	Area	Board Member
23 October 2023	Children's Unit	Bernie Morley, Non-Executive Director Jon Westbrook, Chief Medical Officer
25 October 2023	Medical Day Unit	Lizzie Abderrahim, Non-Executive Director Jude Gray, Chief People Officer

3. Key Meetings during September and October 2023

Meeting	Purpose
Bi-monthly meeting with Chair/Deputy Chair/ Senior Independent Director	Regular meeting to update and discuss any topical issues
Monthly meeting with Non-Executive Directors & Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
Chairs' monthly meeting	Monthly meeting to discuss any issues
Acute Chairs and CEOs catch up	System meeting to discuss any issues

Meeting	Purpose
Extraordinary Wiltshire Health & Care Meetings	To discuss issues
NHS Chairs' Event in London	To receive presentation on topical issues
Annual GWH NHS FT Members' Meeting	Yearly meeting to present the Annual Report and Accounts 2022/23
South West Wellbeing Guardian Network	Bi-monthly meeting
Health & Wellbeing Oversight Committee	To attendee as a member
AHA Committees in Common	Regular system meeting
ICP Board Meeting	Networking meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Mental Health Governance Committee	To attend as a member
Performance, Population & Place Committee	To attend as an observer
Remuneration Committee	To review appraisals of Executive Directors
Nominations & Remuneration Committee	To report on the outcome of the annual performance review of NEDs

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

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

Assurance Level

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

Board members are asked to note the report

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):

This report includes updates on:

- Our seasonal plan
- Freedom to Speak Up Month
- Patient Safety Incident Response Framework
- Progress on our Integrated Front Door
- Financial position
- Project Search
- NHS Cadets
- Project Search
- Staff survey
- Black History Month
- Our allyship programme
- Internal and external awards

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		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	x		

The report details work on our Integrated Front Door and the steps we have taken to proactively engage with both staff and specific patient public groups to ensure the construction meets their needs. This includes people with learning disabilities and autism, and our safeguarding, mental health, and dementia leads.

The Trust's support for the Swindon Tobacco Control launch is featured - smoking remains the biggest cause of avoidable death and health inequalities with continued high levels of smoking seen across disadvantaged groups.

Our support for Project Search is also featured. This is a programme which aims to support young adults with learning disabilities to develop their employability skills, obtain hands-on experience in the workplace, and receive support with securing paid employment after the programme.

The report includes an update on the Staff Survey. This survey is designed to highlight a range of issues, and recent surveys have highlighted issues from staff who are from protected groups and how they feel about working for the Trust. We will use this information to continue to try to make improvements.

Celebrations to mark Black History Month are covered in the report, highlighting in particular the work that black women have done through history.

Our work on allyship is detailed, with a new programme encouraging staff to consider the actions they can take to support marginalised colleagues.

External recognition for our SHarED programme is highlighted in this update – this supports people who use our urgent and emergency care services a lot, and frequently have other health and social needs which require a multi-agency response to help meet.

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **To note the report**

Accountable Lead Signature	Kevin McNamara, Chief Executive Officer
Date	26 October 2023

1. Operational updates

1.1. Seasonal plan

In recent years we have worked on a four-month winter plan to take us from October to March but, this year, we've worked more closely with our clinical divisions to produce a Seasonal Plan which highlights the increased demand on services which are now felt around the year.

There are five core principles to the plan, which are:

1. The seasonal plan must be a system plan with bespoke work for each organisation, overseen by the Integrated Care Alliance leadership teams
2. The plan must support our most vulnerable, during their time of need
3. We should focus on maintaining elective practice
4. We should focus on reducing demanding and increasing capacity
5. The plan must continue to embed recovery into all elements of operational and clinical care.

Each of these five principles allow us to strengthen our resources, using the acute and community capacity available to us and targeting our efforts on maintaining flow through the organisation.

Working more closely with our partners, we'll also be putting stronger focus on NHS@Home, our virtual ward, and other discharge pathways such as Home First, so we can support people to continue their recovery outside of a hospital environment.

We'll be ensuring discharges can happen every day, including weekends, in numbers that mean more urgent and emergency care patients can then be admitted to a ward, and we'll be working with Swindon Borough Council to use the care home beds that are available to us.

We know that the first few weeks of January are often the most challenging, so we will be holding a dedicated fortnight at the start of year to focus on improving the flow of patients through the hospital.

We will continue to offer our staff a comprehensive around-the-clock health and wellbeing package, continually looking for opportunities to add to and improve this.

The Trust and Swindon Borough Council have taken a collaborative public-facing approach to our public-facing winter campaign this year, called 'Stay well Swindon'.

The focus is on promotion of community-based support services to prevent health deterioration resulting in a hospital stay. This includes council-run Welcome Spaces where people can go for cost-of-living advice, a cost-of-living roadshow and other self-care tips for our local communities.

1.2. Industrial action

We are now approaching the one-year anniversary of strike action impacting on the NHS.

In September a 96-hour strike by British Medical Association (BMA) junior doctors and consultants saw more than 700 outpatient appointments and surgical procedures postponed. More than 600 appointments were affected by a 72-hour strike in October by BMA junior doctors/consultants, with this action also coinciding with a 24-hour period of action by the Society of Radiographers.

The Hospital Consultants and Specialists Association (covering some consultants and specialty and specialist doctors) has been balloting its members about taking industrial action.

At the time of writing, we understand that there are talks ongoing between the Government and British Medical Association consultants, junior doctors, and specialty and specialist doctors, and we hope for a resolution as quickly as possible.

2. Quality

2.1. Speaking up

October was Freedom to Speak Up Month and we used this as an opportunity to continue to speak with staff about the many different routes to raise a concern.

Safe Spaces at both Great Western Hospital and the Orbital were set up for staff to drop-in and raise any concerns they might have had.

There was a Safe Space open one day a week at each of these locations, and during these times a Freedom to Speak Up Guardian was present, and staff or volunteers were able to drop-in at any time within the hour slot to speak about anything on their mind in a confidential and safe space.

2.2. Care Quality Commission update

We were pleased to welcome the Care Quality Commission (CQC) to the Trust as part of our programme of regular engagement meetings.

The local CQC team has recently changed so this was a good opportunity to talk through some of our successes, challenges, and areas of focus.

We showed the CQC around our site, with a tour of Teal Ward, the Urgent Treatment Centre, Co-ordination Centre and Workspace.

The CQC's approach to inspections is being revised, but will have a greater focus on system-level assurance on quality and safety.

2.3. Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) has gone live. It replaces the Serious Incident Response Framework and represents a significant shift in the way the NHS responds to patient safety incidents, with a greater focus on learning from incidents.

The framework is focussed on:

- compassion and involving those affected
- system-based approaches to learning and improvement
- considered and proportionate responses
- supportive oversight.

2.4. World Patient Safety Day

To mark World Patient Safety Day, a series of interactive virtual seminars were held across three days. These sessions allowed colleagues to gather to learn and share ideas when it comes to patient safety.

The focus of this year's event was 'engaging patients', and as part of this staff shared their experiences of being relatives to patients affected by safety events. Staff also heard from speakers from partner organisations and our own teams, including pharmacy and the community.

2.5. National Neonatal Audit Programme

Our Neonatal Unit received a positive outlier status in the National Neonatal Audit Programme.

We are a significantly positive outlier at delivering the life-saving intervention of delayed cord clamping for babies born at 34 weeks or under. This is an intervention which is associated with a near 30% reduction in mortality.

We had the sixth highest rates out of nearly 200 units across the UK.

2.6. Haemotology accreditation

Our Haemotology team has been accredited with the Clinical Service Excellence Programme award from Myeloma UK. This recognises best practice in delivering patient-focussed treatment and care.

The assessment team were particularly impressed by the level of holistic support the team provides for myeloma patients in their care and their commitment to service improvement.

3. Systems and Strategy

3.1. Integrated Front Door

Construction work on our Integrated Front Door is progressing well.

The roof has been installed, along with interior walls so individual rooms are now visible. Outer walls are being built to seal the building.

We continue to engage with staff and a range of specific patient and public groups to ensure that the final interiors of the building meet their needs. This includes people with learning disabilities and autism, and our safeguarding, mental health, and dementia leads.

Our 3D fly-through video showing what the interior of the building will look like in the future was shared with staff and shown on ITV West Country and ITV Meridian, with images also used in the Swindon Advertiser.

The new Emergency Department and Children's Emergency Department is expected to open in summer 2024.

3.2. Financial position

The integrated care system as a whole is required to achieve financial balance, however this currently appears very challenging.

The Integrated Care Board has established an oversight group to understand our collective performance against the NHS oversight framework, which outlines how NHS England monitors Integrated Care Boards and trusts in line with its ambition for system-led delivery of integrated care.

As part of this there are now tighter restrictions on revenue investments being made by trusts along with a requirement for more assurance of progress being made on delivery of savings.

The financial and operational impact of industrial action, spending on temporary staffing, and under-delivery of planned savings are all issues we are managing this year, and an internal committee has been set up, with a number of Executive-led workstreams looking at how we can reduce spending.

3.3. Smokefree Swindon

In September I attended the Swindon tobacco control launch and re-signed the NHS Smoke Free pledge. The six priorities for tobacco control action across Swindon are:

Smoking remains the biggest cause of avoidable death and health inequalities with continued high levels of smoking seen across disadvantaged groups. It is estimated that 12.5% of Swindon's adult population smoke, which is 22,743 adults. Each year, 233 people die from smoking in Swindon, which is around four deaths each week. National data suggests that for every death, there are another 20 people living with a smoking-related illness.

We plan to contribute to a consultation on the proposed actions the UK Government and devolved administrations will take to tackle smoking and youth vaping. This consultation asks questions on proposed action to protect future generations from the harms of smoking, by creating the first smokefree generation.

3.4. Improving health and life chances

We continue to work to work with a wide group of people to provide opportunities for people to improve their health and life chances.

NHS Cadets is one of the initiatives we have been involved with – this is a new programme, aimed at young people aged 14 to 18, to provide opportunities for them to explore roles in healthcare. Cadets are able to learn about life in healthcare through first-hand experience and hearing from inspiring professional speakers. They are also taught first aid skills, such as resuscitation.

We are proud to be supporting NHS Cadets, including through offering facilities on the Great Western Hospital site for training sessions and inviting staff from across the organisation to share information about their roles.

Another initiative is Project Search, a programme which aims to support young adults with learning disabilities to develop their employability skills, obtain hands-on experience in the workplace, and receive support with securing paid employment after the programme.

I was really pleased to recently welcome the newest cohort of students from New College Swindon who will be gaining work experience at our Trust by undertaking rotational placements with Serco.

4. Workforce, wellbeing and recognition

4.1. Staff survey

At the time of writing, more than half of our staff had given their views on working for the Trust in the annual NHS staff survey.

The survey is completely confidential and the views given by our staff enable us to gain a good understanding of what it is like to work for our organisation and the areas where we need to improve.

Staff have until 24 November to complete the survey and we hope to exceed last year's 59 per cent response rate to give us a really good database of staff feedback.

4.2. Flu and Covid vaccination programme

Our annual vaccination programme is well underway, with a combined flu and Covid vaccine on offer to all staff, along with separate vaccinations.

We have encouraged staff to get vaccinated to protect themselves and their patients, along with their friends and loved ones.

At the time of writing, around 47 per cent of substantive staff had either been vaccinated against flu, or had their jab booked, with 41 per cent for the Covid vaccination.

4.3. Wagestream app

We've partnered with Wagestream to bring staff a new, free financial wellbeing app with a suite of budgeting, savings, education, coaching and flexible pay features. It connects with existing current accounts so staff can set up alerts or payment reminders and this is linked directly to other systems staff use such as Allocate and ESR.

It also allows staff to track individual shifts, both substantive and bank, so staff can see how much they will earn each month.

4.4. Black history month

This year to mark Black History Month, we asked staff to join us in 'Saluting Our Sisters' showcasing pioneering black women who have made remarkable contributions to literature, music, fashion, sport, business, politics, academia, social and health care, and more.

We produced a video which shares the importance of recognising the work that black women have done through history, and held a celebration in the Academy, with a great

line-up of guest speakers who shared their experiences including former patient Natalie Amber who talked about caring for curly and afro hair.

Our Race Equality Network, Swindon Community Support, Brighter Futures, Freedom to Speak Up Guardians, Staff Health and Wellbeing and nursing teams, were at the event sharing information and answering questions.

4.5. Allyship

During National Inclusion Week we launched our new allyship programme, which is a call to action for all staff to think about what actions they can take to support marginalised colleagues.

An ally is someone who is not a member of a marginalised group, but who wants to support and take action to help others.

By better understanding the struggle, discrimination, and oppression that others face, staff have the opportunity to learn more and actively attempt to make a change.

Staff are invited to be an ally to different racial, ethnic or religious groups, LGBTQ+ identities, people with disabilities, or anyone who faces barriers to equality and inclusion.

Our Allyship Programme offers full training, workshops, networking, and an opportunity to connect with projects that will improve the experience of staff and patients, while also driving forward change in their area.

4.6. STAR of the Month awards

Our Undergraduate Administration team were among the recent winners of our STAR of the Month award, in recognition of their collaborative work with universities and other organisations to deliver successful Objective Structured Clinical Examination training to internationally recruited staff training to work for the NHS. The team supported the students' wellbeing and went above and beyond to ensure the exams ran smoothly.

The Ear, Nose and Throat medical team were also named as STAR of the Month winners, for always putting the patient first, providing patient-centred care to a really high standard. This was recently recognised in national data which placed the team in the top 5% in the country for their multi-disciplinary approach to patient care.

4.7. External awards

We have been successful in a number of external awards recently, and these include:

The Way Forward Programme team, and our contractors and partners, were recognised nationally for their planning and construction of the Urgent Treatment Centre, which won 'Project of the Year' at the **Institute of Healthcare Engineering and Estates Managers Awards** last month.

The HomeFirst and SHarED programme were both finalists at the **Health Service Journal awards**. HomeFirst in the 'Best use of integrated care and partnership working' category and the SHarED programme, which supports high impact users and involves several trusts, in the 'Urgent and Emergency Care Safety Initiative of the Year' category Research

Donna Noonan, Head of Service for Research and Innovation, won the continuous improvement category and Laura McCafferty, Clinical Research Practitioner, won the Rising Star Award at the **Clinical Research Networks regional awards** ceremony. We were also recognised for our contribution to the HARMONIE study, in the collaboration in research category, which is looking at new medicines which protect against RSV.

Our Wellbeing Garden on the hospital site was recognised as part of a joint regional nomination for South Swindon in Bloom, which won the Tesco Cup at the **Britain in Bloom Awards**. The award highlighted the work that Brighter Futures, supported by hundreds of generous donations from local people, did in creating a welcoming and sustainable green space in Swindon.

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		27th September 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access	R	A	No significant change since the last report. The service remains under pressure with Opel 4 regularly triggered over recent weeks. Continued progress against the breakthrough objective to improve the clinically ready to proceed times especially from the decision to admit.	Monitor Actions	October 2023
Integrated Performance Report – Elective Access - RTT	R	A	Three 78+ week waiters were confirmed for August. The Trust saw a further increase in the number of 65+ week waiters with it now reaching 689 (from 384 in March 23). This was largely driven by Gastroenterology – a successful validation exercise undertaken in month which will be reported at the next PPPC.	Monitor Actions	October 2023

Integrated Performance Report – Elective Access – DM01	R	A	The overall DM01 performance dipped to 44.5% in July, however, the COO remains confident in terms of achieving the end of year target. The recovery plan was noted including the additional contracting out of Ultrasound and the ongoing negotiations with Cardiology to reach an acceptable sessional rate. An NHSE diagnostic support visit is scheduled for October with feedback at the next PPPC.	Monitor Actions	October 2023
Integrated Performance Report – Cancer	R	R	The Trust's performance against KPIs remains a concern with Dermatology referrals accounting for 78% of the 31-day breaches. An additional locum Dermatology consultant has been appointed to focus on the 2-week waits. Improved performance against the 62 day standard (54% June, 67% July). A deep dive is scheduled for November and will include feedback on the division's Improving Together work and progress in Urology with the switch from TRUS (Trans Rectal Ultra Sound) to LATP (Local Anaesthetic Transperineal Prostate Biopsy).	Monitor Actions	October 2023
NHS @ Home (Virtual Ward)	R	A	The Committee noted the significant development over the last two months to establish a cross-divisional group to help drive occupancy of the service forward. Highlighted risks to the achievement of objectives for the service include the number of referrals being received and clinician engagement internally and externally. The model's length of stay position was extremely positive. Remote monitoring is due to start in November with no possibility of bringing forward due to procurement processes. The Committee looked forward to the further update in November.	Monitor Actions	October 2023

Issues Referred to another Committee –	
Topic:	**Committee:**

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	25th October 2023	
Committee Chair	Peter Hill	
Link to Strategic Objective	Pillar 3 : Joining up acute and community services in Swindon	
Link to Board Assurance Framework	BAF 3 : SR 5 – Performance and SR6 - Partnerships	
Improving Together Pillar Metrics	Emergency Attendance	Waiting List – over 65 week waiters
	Non-Criteria to Reside	Cancer Waiting Times
Improving Together Breakthrough Objective	Time in ED – Clinically Ready to Proceed	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Integrated Performance Report - Emergency Access	Partial	No x
2. Integrated Performance Report – Elective Access - RTT	Partial	No x
3. Integrated Performance Report – Elective Access – DM01	Partial	No x
4. Integrated Performance Report – Cancer	Limited	No x
5. Theatres Assurance Report	Good	No x

POINTS OF ESCALATION	WHC contract performance notice has been received from the ICB and there is an intensive support team from GWH, RUH & SFT supporting the response and recovery plan.
	3 Cancer metrics are deteriorating, the committee received detail of mitigating actions which should support recovery but until there is an improvement this remains.
KEY AREAS TO NOTE	Likelihood Trust will be in SOF 3 for Q2 due to triggering further metrics, confirmation will be upon receipt of the NHSE and ICB decision.
	Significant number of appointments lost due to strike action (7,362). £2.4m estimated loss of income.
BOARD ASSURANCE FRAMEWORK & RISKS	November update to be provided.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Deputy Divisional Director (SWC) gave a positive presentation on Theatre utilisation and steps taken to address gaps in usage. 2 Theatres are closed due to estates work until the end of March which has been dealt with positively. 211 sessions lost due to Industrial Action.
REFERRALS TO OTHER BOARD COMMITTEES	To Mental Health Governance Committee: pick up the outputs of ICA Mental Health workshops & developments of BSW Mental Health Delivery Plan.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
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Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Claudia Paoloni	Dr Claudia Paoloni		21 September 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR Pillar Metric: Total Harms	A	A	There has been a further increase in the total number of harms from 225 to 249 in month, but no change in the number of falls for the fifth consecutive month. The top contributors to harms remain pressure harms and our gram negative infection rates, *E.Coli* and Klebsiella.		
IPR Pillar Metric: Friends & Family Test	A	A	Overall response rate is up at 33% and the positive response rate remains over the internal target of 86% at 89%. The negative responses have also slightly decreased.		
IPR Breakthrough Objective: Pressure Harms	R	A	July has seen an increase in both community and acquired pressure ulcers. In community this may in part be due to increased reporting, however the hospital acquired rates have shown a disappointing increase in total numbers despite the strong action plan and A3 methodology. This may in part be due to an increased senior leadership absence over the summer		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			period with leave, this is being reviewed and plans for mitigation put in place. In view of the deterioration in rates, we have changed the risk status to red but remain assured that the team are fully cognisant of the problem and managing the rates with a clear methodology and action plan that should result in improved results in the longer term. The team are also being reactive to change in presentation of the harms to enable correct mitigations. It is clear in areas where there is focused work, improvements are seen but the challenge remains around the sustainability of improvements which is impacted by safer staffing levels, senior leadership presence, continuous recruitment and training needs. We are continuing to benchmark ourselves with peer organisations.		
IPR Alerting Watch Metric: Hospital Acquired Infections	R	A	Infection rates of gram negative bacteraemia have continued to increase for *E.coli* and Klebsiella despite the focused work with Infection Prevention & Control around catheter care. MSSA rates remain stable likely reflecting the focused work on cannula care. *C.diff* rates are well over trajectory and we are seeing a higher prevalence in asymptomatic patients supporting the view that there is a higher incidence in the general community. Concern remains around Pseudomonas and Legionella infection rates, an update report was received around extensive mitigating activity.		
Maternity Performance Report	R	A	The Committee has positioned the risk ratings around the maternity performance report in view of the fact that we will not be compliant for CNST Year 5 (Maternity Incentive Scheme) criteria due to three safety factors around staffing rotas, ultrasound scanning capacity and non-compliance with all of the elements of Saving Babies Lives Care Bundle (Version 3). This remains the case.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			This has been impacted by new changes to the criteria which have been recently imposed. The Saving Babies Lives Care Bundle criteria also cannot be met due to key risks around scanning capacity and recent modifications to the criteria have also meant further measures will be required around smoking which impact our ability to fulfil this. A working group has been created to look at ways to manage the new requirements to include potential collaborative working in system. The new format of the report is in line with regional peers which now enables easier comparison. Recent MBRACE report recognises a national increase in stillbirths reflected on our own data. We no longer have any red actions outstanding for the Ockenden report and continue to see progress in reducing amber rated actions. Due to the obstetric staff change in February, a number of staff came with no PROMPT training adversely impacting our PROMPT training compliance. This was anticipated with the August rotation of staff and a pre-identification of those without training and focused and prioritised training demonstrates a trajectory to bring training back up to over 90%. Recent CQC visit on maternity unit identified maternity triage (% women seen within 15 minutes) focussed work has shown a vast improvement. The Committee remain assured the senior leadership have tight control and are reactive to any adverse situations that arise. The red risk rating reflects the inability to comply with CNST year 5 and saving babies lives. To correct this position will require investment and support.		
Patient Experience Report 6-monthly	A	A	We received the 6 monthly report which demonstrated that there has been an increase in numbers of concerns, queries, comments and feedback in Q4 with a reduction in Q1.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			Themes from concerns and complaints are consistently relating to communication, waiting times, staff attitude and follow up treatment, with staff attitude also being one of the top positive themes. There has been a marked increase in PALS workload in Q4 with concerns and complaints resulting in focused work to ensure early resolution and reduction in delays to responses. PALS team have delivered increased training around handling complaints, run with an external handler and aimed at Clinical Leads, Heads of Service, Matrons and Ward managers. There has also been a focus on civility and first impressions and extensive successful initiatives delivered around for example: support for carers, SDEC, maternity services, nutrition and hydration. With an increased patient and public engagement there has been more work within the community with EDI and poverty groups. Successes have included winning the Championing Equality, Diversity and Inclusion Award at the June Staff Excellence Awards and achieving recognition as a Gold Employee Recognition Scheme status for armed forces. Future work is planned around triangulation of concerns and complaint themes with other governance systems.		
Water Management and Pseudomonas Action Plan Update	R	A	A further report from was received from Estates & Facilities around a water management action plan which highlighted the many factors that potentially contribute to Pseudomonas and Legionella infections and the intense actions being undertaken to counter the infection rates. Support has also been sought and is being provided by regional IPC leads and UKHSA with a planned walk around to review and offer advice.	Progress to continue to be reported to the Committee on a monthly basis	On-going

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			There has been increased testing of areas including non-augmented areas and where positive results have been found intensive cleaning programmes and waste outlet and drain replacements have resulted in negative results although there are a few resistant areas which are having focussed investigation. The IPC team, SERCO and estates are working together with an extensive programme and action plan and the Committee was assured that we should see an improvement in our infection rates of pseudomonas. Progress will continue to be reported to the committee.		
National Urgent and Emergency Care Patient Survey 2022	R	A	A report was received with data from 2022. The results demonstrated an extremely low response rate of 28% with a deterioration in our results and a decline in average scores overall. This was found across UTC and Emergency Department despite the large capital investment in UTC. Worst themes related to privacy, cleanliness, transport, information for home and medications. It was recognised these results are a year old and there has been much work since on cleanliness and environment infrastructure. A review against the SHINE checklist will also be undertaken to ensure the focus remains correctly targeted. The Committee was reassured that themes are being reviewed and mitigations put in place that we can expect an improvement with the next survey results.		
Safeguarding Maternity, Adults, Children and Young People Annual Report	A	A	A report was received which showed the extensive increase in work that the safeguarding teams have had to accommodate with a 74% increase in safeguarding referrals to Childrens' Social services and 148% increase in mental health referrals. There has been a lot of activity overall with the significant increase in demand most likely linked to the national financial situation and recent Covid pandemic. There has been a noticeable increase in self neglect, substance and alcohol abuse.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			Cases are increasingly complex requiring increased collaborative multiagency work. There has also been an increased need to support staff around similar issues and domestic abuse as staff are also not immune to the financial and social pressures. Safeguarding training compliance remains a concern across divisions and this is being directly acted upon. Compliance with safeguarding supervision in ED/UTC has not been fully achieved due to the increased demand and pressures within these departments. A ward based training programme for mental capacity assessments has been initiated with good take up and there has been an appointment of a Mental Capacity lead allowing us to respond to the increased demand.		
Clinical Audit & Effectiveness Q1 2023/24	A	A	Participation with national audits is recorded at 98%. Less than 10% of audits have overdue activity. 3 National audits are unable to commence due to a lack in appropriate data collection IT support, which requires investment.		
NICE Guidelines (assessment & implementation) Q1 2023/24	R	A	Current data shows timely assessments of our compliance against NICE guidelines is poor with 322 guidelines outstanding for response some dating back to 2017. This reflects a poor understanding amongst staff around the process at Divisional level. The Clinical Effectiveness Team will be supporting divisional leads to achieve timely review and reporting of all nice guidelines and to address relevant barriers.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Freedom to Speak Up Annual Report 2022-23	R	A	A report was received reflecting the difficulties experienced within this service over the past 12 months with no lead in post for 6-month period and a further period of absence. This has resulted in a decline in activity to support this service and there are clear gaps in service, with the report highlighting some concerns and areas of fragility within the service. This has high importance as FTSU is an integral part of the suite of mechanisms with which to raise concerns and one which is used by CQC in their assessment as part of the Well Led Review. The recent Lucy Letby case has highlighted the importance of good effective routes to raise concerns. In view of the interruption to the service and fragility within it, an indepth review of the service has been commenced, including an SLT review of some of the incidents raised, a strong programme of supported meetings with SLT, Lead NED, Lead Guardian and Guardians and the planned commissioning of an external review of our service. The Committee considered 'Listen Up training' for managers be mandatory and welcomed the external review and planned actions.		
Safe Staffing Monthly Report	Not Rated	Not Rated	This is the first month the average reported was below 90% which is likely due to a culmination of Annual and sick leaves. There is a planned review of reduced safer staffing levels against the continued achievement in reduction of agency spend.		
Update on CQC preparedness	Not Rated	Not Rated	The report stated an intention for all Divisional teams to review the 'Must Do' actions and evidence towards these for future inspection. Level 3 Safeguarding training Compliance remans a focussed area for improvement. Maternity services underwent an inspection in September as part of the national Maternity Inspection programme, which highlighted 4 areas for improvement around maternity triage, documentation, equipment PAT testing and stock controls. For which immediate actions have been put in		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			place. The inspection, however, did highlight the staff team morale as being high.		

Issues Referred to another Committee	
Topic	Committee

Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	19 October 2023
Committee Chair	Lizzie Abderrahim Non-Executive Director [in the absence of 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.	Patient Safety Incident Response Framework Implementation Policy and Plan		✓
2.	Pressure Harms [IPR breakthrough objective]	Partial	x
3.	IP&C [IPR breakthrough objective]	Partial	x
4.	Maternity	Good	x
5.	Perinatal Mortality Review Tool – Q2 Report	Good	x
6.	Trust Mortality Report	Partial	x
7.	National Inpatient Survey 2022	Partial	x
8.	Freedom to Speak Up Action Plan	Partial	**x**
9.	Getting it Right First Time Update	Partial	**x**
10.	15+ Risk Report	Partial	**x**
11.	Estates and Facilities Water Pseudomonas Action Plan	Partial	**x**

POINTS OF ESCALATION	
KEY AREAS TO NOTE	**Complaint Response Rate** [alerting watch metric]. There had been a significant reduction in the complaint response rate that resulted from operational pressures across GWH that had impacted on the capacity to investigate and respond to complaints. In response, regular contact was being maintained with complainants to ensure that they were aware of the reasons for any delay.
	Maternity Triage. This had previously been identified by the CQC as a should do action for GWH but had more recently become an area of concern for the CQC and, because GWH had seen a reduction in the percentage of women seen within 15 minutes, a number of actions had been identified to improve performance and it was expected that the impact of those actions would be seen in the next report.
	Saving Babies Lives. Restricted ultrasound capacity was creating a risk that GWH would not be compliant with both the Maternity Incentive Scheme [CNST] Year 5 and the Three-Year Maternity and Neonatal Single Delivery Plan.
	Perinatal Mortality Review Tool. The assurance rating [previously consistently rated as full – delivered and fully embedded] was reduced to good to reflect that that the timescale for entering the surveillance data had not been met in two out of three cases in the period 30 May to 30 June 2023 – this was the result of an administrative oversight.
	Mortality. HSMR and SMR figures were statistically significantly higher than expected although in line with the national trend. Coding issues were continuing to impact on the data and were being addressed but coding was not the only area of focus and a revamp of mortality was being undertaken with action being taken to improve engagement with teams, to refocus on the learning from deaths and to examine how structured judgement reviews were carried out.
	Freedom to Speak Up. Concerns had been raised by the National Guardians Office about the lack of reporting from GWH and what training was being provided for FTSU Guardians. In response, an action plan was in development. It was also the case that FTSU had been an area of focus for the well led review that was being undertaken and the outcomes from that would feed into the action plan.
BOARD ASSURANCE FRAMEWORK & RISKS	One 15+ risk was reported – risk 690. This related to ED patients in Majors Chairs and Paeds who could experience delay as a result of increasing demand and acuity. The target score for this was 12 but had been consistently scored at 20 over the previous four quarters. However, a range of actions and mitigations were in place to address this and the risk was being reviewed on a monthly basis. It was noted that the current level of risk was unlikely to reduce markedly until the successful implementation of the integrated front door when additional space would be created.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	

REFERRALS TO OTHER BOARD COMMITTEES	Patient Safety Incident Response Framework Implementation Policy and Plan - recommended for approval to Trust Board

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	25 September 2023
Committee Chair	Faried Chopdat
Link to Strategic Objective	Pillar 4: Use of Resources
Link to Board Assurance Framework	BAF 4 S6 & S7
Improving Together Pillar Metrics	GWH Control Total / I&E
	Sustainability / Carbon Footprint
Improving Together Breakthrough Objective	Productivity

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Finance Protocol Enactments – verbal update	Partial	x
2. Month 5 Finance position	Partial	x
3. Efficiency Programme	Partial	x
4. Wiltshire Health & Care – Finance Risk	Note	x
5. Estates & Facilities Quarterly Risk Report	Good	x
6. PAM Submission	Partial	x
7. Reinforced Autoclaved Aerated Concrete (RAAC) Report	Note	x
8. EPR Programme Update	Limited	x
9. Digital Communications & Engagement Plan	Note	x
10. IT Infrastructure Resilience	Partial	x
11. Procurement – Annual Review and Lessons Learnt	Note	x
12. Information Governance Steering Group Terms of Reference	Approve	x
13. Diagnostic & Theatre Benefits Realisation	Note	x

POINTS OF ESCALATION	**Month 5 Finance Position** - As at M5, the Trust is in a £5.6m deficit position, representing a £4.4m adverse variance to the plan. The key drivers are industrial action direct costs (£1.4m), under-delivery of the efficiency target (£1.4m) and spending on temporary staffing to cover mental health provision and sickness/vacancies (£1.6m). Expected ERF income also fell by £1.5m due to a shortfall against our planned delivery. However, the £1.5m has been offset by several in-month benefits. Most notably, the Trust billed £0.7m to Swindon Borough Council (5/12ths of a total £1.7m), clinical supply costs have fallen by £0.5m due to overstocking in Medicine in M4, there was additional R&D income of £0.2m and lower education & training costs of £0.1m. Externally, the Trust continues to forecast breakeven, but on the current run rate plus known changes, there is a risk of a 16 m deficit. The primary reason for this potential overspending would be a shortfall in efficiency delivery and continued overspending on temporary staffing and industrial action. It is important to note that this assumes no loss of ERF income for the remainder of the year. Whilst the Committee acknowledges that management has applied greater focus on managing the run rate and productivity, the finance risk continues to escalate.
	Efficiency Programme - Savings were £0.3m behind target in the month and are £1.4m behind plan on a YTD basis. Medicine drives the in-month and YTD deficits, specifically, the non-delivery of nursing and medical agency savings. n month £1.23m of savings has been delivered against a plan of £1.58m, resulting in a shortfall of £0.34m and £1.3m behind plan year to date. This represents a deterioration from M4 reporting, which was £1.1m behind plan year to date. The identified level of 2023/24 efficiencies have improved in M5 to £15.9m against the £16.67m target (an increase of £0.6m from M4), and there has continued to be a shift from amber/red rated schemes to green rated schemes. Establishing the Financial Recovery Board and the associated workstreams will support increased executive-level support for financial recovery, including driving the 2023/24 improvement and efficiency plan and selecting the 2024/25 approach.
	EPR Programme Update - The FBC is in review with NHSE, and clarification questions are being addressed. The Programme has made further progress in managing the recruitment of crucial programme roles. The current 'as-is' mapping of existing processes at all three Trusts has begun. Staff from each Trust are being contacted for initial consultation and are being booked for workshops to take place from November onwards. Data Migration and archiving tender responses have been received, with three suppliers in the running. Staff from the 3 Trusts are involved in evaluation and scoring over September/October. Overall, the Committee is assured of the EPR programme; however, the Committee continues to reiterate the risk that the FBC is yet to be approved by NHSE and the funding received to proceed with the implementation.
KEY AREAS TO NOTE	**The Premises Assurance Model (PAM)** is a mandatory return for all Trusts. PAM is developed to provide a nationally consistent basis for Trust Board assurance on regulatory and statutory requirements relating to their estate and related services. Timescales did not allow for the appropriate consideration to be carried out within the Trust's internal governance arrangements, with EFM Board and FIDC groups meeting after the NHS Improvement submission date. Therefore, the submission has been provided to the online portal, with a retrospective delegated EFM Board and FIDC Committee approvals being sought. The Committee was reassured about the content of the PAM submission but raised concerns about the retrospective approval following the submission and requested a review of the process and future timelines to meet governance deadlines.
	The Procurement Annual Review and Lessons Learnt update highlighted the essential transformational, strategic, and operational delivery during the last financial year, along with visibility of the scope of activity undertaken across the department and our lessons learned. It includes details to show where GWH benchmarks in Procurement Model Hospital data and the current risks across the department. Key achievements include cash-releasing savings of £2.3m for GWH and £5.1M across the ICS; The operational Helpdesk and new ways of working across Ops have been embedded to improve support to finance and stakeholders; The Control Tower has been launched to improve our data management; and the investment to create one dedicated Procurement Service.
	Reinforced Autoclaved Aerated Concrete (RAAC) - Considering the current media interest in RAAC, the Committee was provided with an update that the Trust does not own any properties containing RAAC. In addition, management have confirmed that following its review they can confirm that it does not occupy (lease) any properties containing RAAC.

BOARD ASSURANCE FRAMEWORK & RISKS	**Estates and Facilities (Infrastructure) Quarterly Risk Report**: The Committee noted that the risk management process and reporting is adequate and effective. Whilst we were reassured that the scoring of risks aligned with the Risk Management Policy, that risk was reviewed monthly and mitigation actions, action owners and timelines to close the risk were identified.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Improved Governance** – A Financial Recovery Board has been established following the recognition to broaden the efficiency savings approach to a multi-year financial recovery plan, which addresses underlying deficit and run rate rather than efficiency schemes in isolation. This requires £17-18.5m recurrent savings per annum with a longer-term set of schemes based on top contributors to financial position. A new fortnightly Financial Recovery sub-committee will oversee these schemes, and this approach will mirror that at RUH & SFT so that AHA-wide schemes. The sub-committee will report to TMC & FIDC. Workstreams are executive sponsored with clear workstream leads and will incorporate or replace the current efficiency schemes to reduce duplication.
REFERRALS TO OTHER BOARD COMMITTEES	**None noted.**

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

Committee	**Finance, Infrastructure & Digital Committee**
Meeting Date	23 October 2023
Committee Chair	Faried Chopdat
Link to Strategic Objective	Pillar 4: Use of Resources
Link to Board Assurance Framework	BAF 4 S6 & S7
Improving Together Pillar Metrics	GWH Control Total / I&E
	Sustainability / Carbon Footprint
Improving Together Breakthrough Objective	Productivity

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Medium Term Financial Plan	Note	x
2. Month 6 Revenue and Capital Position	Limited	x
3. Efficiency Programme	Limited	x
4. 2024/25 Business Planning Update	Substantial	x
5. Community Diagnostic Centre	Approve	x
6. Debtors	Good	x
7. Health & Safety Annual Report	Approve	✓
8. IT & Digital Risk Register (including EPR Risks)	Good	x
9. EPR Programme Update	Limited	x
10. Digital Communications and Engagement Plan	Good	x
11. Quarterly Update – IT/Infrastructure and Resilience	Partial	x
12. Quarterly Update – Cyber Security	Limited	x
13. Clinical Coding Update	Limited	x
14. Procurement Recommendation Report – Pharmaceutical Wholesaler Services	Approve	✓
15. West of England Imaging Network Image Sharing OBC	Approve	x
16. Information Governance Annual Report	Note	x

POINTS OF ESCALATION	**Month 6 Revenue and Capital Position** - As at M6, the Trust is in a £6.9m deficit position, representing a £6.0m adverse variance to the plan. The key drivers of the £6.0m unfavourable variance are industrial action direct costs (£1.7m), undelivered efficiency savings (£1.9m), a shortfall on ERF-related income (£3.7m), additional medical pay award costs (£0.4m) and temporary staffing pressures (£1.4m). Capital expenditure is behind plan due to delays in the aseptic unit (there is a dependency on completing estates-related work) and lower spending on the way forward programme. All capital project leads are forecasting to spend their allocations by year-end. Overall, management has enhanced governance and control to mitigate risks; however, much more work is required to better the Trust's financial position.
	Efficiency Programme - Efficiency savings were £0.5m behind target in the month and are £1.9m behind plan on a YTD basis. Medicine drives the in-month and YTD deficits, specifically the non-delivery of nursing and medical agency savings. Focussing on run rate savings, i.e., reducing our monthly spending, particularly on temporary staffing, must be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum and that savings delivery is maximised to enable us to deliver as close to breakeven as possible while retaining safe patient care delivery. Overall, the committee is delighted that more excellent progress is being made to identify schemes, and better governance and controls are in place to track the delivery of savings.
	Clinical Coding Update - Coding performance was 98% completion for the August activity coded in September 2023, an improvement on the previous month but still impacted by several periods of sickness within the team that prevented 100% completion. In addition, the impact of having to support a sizable contingent of Trainee Coders due to the scarcity of experienced coders in the local market is also impacting the coding capacity of the team. The issues in August persisted into the first week of September, leading to a further rise in the total coding backlog. However, this did reduce and stabilise to an end-of-September position of 18,421; this continues to improve, and as of 13 October, the total backlog has reduced to 17,891. The Committee highlighted that the coding risk has been longstanding, and tremendous effort is required to address this risk to an acceptable position.
KEY AREAS TO NOTE	The **BSW Medium Term Financial Report** was presented for noting. The Integrated Care System (BSW ICS) is facing several challenges, which can broadly be categorised as follows: productivity of 20% under 2019/20 levels; underperformance against essential performance standards; headcount growth and various workforce issues; financial deficit – in-year; and underlying Inflationary headwinds. The recovery programme seeks to convert these challenges into opportunities, identifying systemic root-cause issues and minimisation/mitigation actions. The BSW Medium Term Financial Plan (MTFP), developed in collaboration with the system partners, details the 'road to recovery', highlighting the operating context, system maturity, critical challenges and the next steps in reaching the desired objective of outstanding high-quality care within an affordable financial envelope by 2025/26.
	EPR Programme Update – The Committee received a positive update on the activities of the Programme, with good progress made on identifying external partners to support data migration and archiving activities, recruitment for crucial roles, and addressing queries raised by the NHSE on the FBC. The Committee also had insight into the proposed new Governance Structure for the Programme that will now be submitted to the EPR Programme Board for final approval at the end of October. Whilst the Programme makes good progress, we reiterate the risk that the FBC is still subject to approval and, consequently, the approval and receipt of funds to progress with the EPR implementation.
	Data Protection and Cyber Update - Data Protection and Cyber Update - The report outlined the critical areas of focus on data protection and cyber, with insights into what is happening at a national and ICS level. The cyber awareness plan for 2023/24 highlighted intended activities, many of which have already commenced. The Committee reiterated its concerns about the heightened risk of Cyber-attacks and requested more insightful reporting on all attacks, whether unsuccessful or not, and the need for greater control and a more robust incident management response approach.

BOARD ASSURANCE FRAMEWORK & RISKS	**Digital & IT Quarterly Risk Report** - The Committee noted that a new approach to risk management for digital risks is now in place with 12 risk themes and associated oversight governance for each theme. However, this report's structure remains the same to ensure it is in line with broader risk reports. Overall, 64 risks will be overseen by digital governance, recognising that there is now visibility of risks not directly assigned to the digital team (46 risks of the 64 have the risk type of "IT Infrastructure"). The Committee is reassured that the risk management process and related governance are operating as intended.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Improved Governance & Control** - The Committee noted that management had instituted better governance and controls on the finance run rate and productivity, Efficiency Programme, Capital spending, IT Infrastructure, and the EPR Programme - representing an uplift in governance from the previous year.
REFERRALS TO OTHER BOARD COMMITTEES	**None noted.**

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

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

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

Assurance Level

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

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

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

Report

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

Our Performance

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

OPERATIONAL PILLAR METRICS

Of the 6 Operational Pillar Metrics, Cancer deteriorated in September. Little change was seen to the overall performance of Referral to Treatment (RTT) in September. However, patients at risk of breaching 65 weeks saw improvement. Emergency Care Mean stay

across Emergency Department (ED) and the Urgent Treatment Centre (UTC) saw increases in September. ED attendances saw a small reduction. The number of patients with non-criteria to reside (NCTR) remains within tolerance.

- Cancer 62-day August performance saw a reduction to 59% from the previous month of 66%
- RTT (Referral to Treatment) 65 Week Waiters – September performance shows the total number of patients waiting over 65 weeks at 661 a slight decrease on the previous month. 1 patients above 78 weeks was reported in September.
- Emergency Care, Emergency Department Mean Stay – There has been an increase in both Type 1 and Type 3 delays during September 2023.
- Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. September saw a small reduction in the number of patients attending the ED.
- Number of Non-Criteria to reside (NCTR) days. The number of patients who remain in an Acute Hospital bed without a Criteria to Reside (NC2R) saw little movement in September 2023.

OPERATIONAL BREAKTHROUGH OBJECTIVE
Clinically Ready to Proceed (CRTP). Type 1 attendances experienced a decrease in the time from arrival to being CRTP. Mean time from ED to CRTP reduced in September. CRTP for admitted patients shows an increase in month following 3 months of improvement.

ALERTING WATCH METRICS
Key alerting measures include, RTT, DM01, Cancer, ED and Flow.

RTT shows an increasing number of patients over 18 weeks. The number of patients over 52 weeks shows a reduction for the fourth month.

DMO1 – The number of patients on a DMO1 waiting list saw a slight reduction in August. Overall performance saw a reduction in August.

Cancer – All 3-cancer metrics show signs of deterioration and are outside of control limits.

ED watch metrics show no significant changes. There has been an increase in patients waiting to be handed over from an Ambulance and patients spending more than 12hours in the Emergency Department.

Flow measures show no significant change. A noticeable increase has been seen in Ambulance Handover Delays and Patients spending more than 21 days in the Trust.

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

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

There has been a slight increase in the total number of harms up to 286 from 261 last month. The slight increase is linked to an increase in pressure related harms (acute) and falls.

There has been no change in the number of pressure related harms for the community and the number of infections has remained static from the previous month.

The number of Family and Friends (FFT) positive responses for August is 87%, a slight decrease on the previous month.

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

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

September has seen an increase in the number of acute pressure related harms, with 57 in month compared to 44 in August. There has been 74 pressure related harms in the community setting in month, a reduction of one harm.

Alerting Watch Metrics
The Trust complaint response rate has reduced significantly in month to 46% this reflects the on-going operational pressures which are impacting on clinical and operational capacity to investigate and respond to complaints within the expected time frames. Patients and their families are regularly contacted to ensure they are aware of the progress of their complaint investigation and the reasons for the delay in receiving a final response.

The rate of C. difficile infection continues to be above that of 2022/23. Each case is reviewed by the Infection Prevention & Control team, an Antimicrobial Pharmacist and a Consultant Microbiologist, the majority of cases are not found to have been preventable. BSW's review of all cases has found a strong link with antimicrobial prescribing in primary care, with BSW GP practices prescribing more broad-spectrum antibiotics than those in other regions. The BSW IPC and Antimicrobial Stewardship teams are working to address this.

Rates of all three reportable gram-negative bloodstream infections (E. coli, Klebsiella and Pseudomonas aeruginosa) remain higher than trajectory. A significant proportion of cases deemed preventable on investigation are associated with catheterised patients. Increasing evidence suggests that basin drains are an important reservoir of gram-negative bacteria in hospitals, so it is also likely that the focus on drain hygiene as part of the work to tackle Pseudomonas will have a positive impact on all three infections.

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

- Safer staffing fill rates are on a par with previous months and remain within safe parameters.
- Two Serious Incidents have been declared in month, all will be investigated under the Serious Incident Framework
- There has been an increase in the number of concerns in month, but a decrease in the number of complaints

- There have been no reported Methicillin-resistant Staphylococcus Aureus (MSRA) infections in month
- FFT overall response rate has decreased slightly but still remains above the internal target of 29%.
- The number of hospital acquired COVID cases has remain stable in month (20) when compared to August (21).

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

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

Breakthrough Objectives
The Trust Breakthrough objective is to achieve a 5% improvement in the question "I am able to make improvements happen in my area of work" in the Staff Survey. The survey is quarterly and therefore this month there has been no change to the result. The most result performance is Q2 survey represented a small decline in this question currently tracking at 52.6% against a target of 55%.

The 2023 Annual National Staff Survey launched on 11th September and active promotion of the survey continues across the Trust with a view to achieving a total response rate of 65%. Currently the response rate is at 46% which is above the response rate from this time last year (+5%) and above the national average (+26%).

Alerting Watch Metrics
In-month sickness absence for August has reduced from 4.4% to 4.0%, however slightly remains above the Trust KPI of 3.5%. Long term absences have decreased in month but a continued increase in short term absence, in line with usual seasonal increases, is driving this measure above the KPI. Countermeasures are being explored within the absence working group to drive improvement for this metric, and the annual flu campaign which launched in September continues with 29% of our workforce having received an influenza vaccine.

Non-Alerting Watch Metrics
Voluntary turnover has further reduced in August, reducing from 9.7% to 9.6% and below the Trust KPI target of 11%.

Leavers within their first year of employment has reduced in August to 28%, below the average rate of 31%. To better track this group of leavers the measure is being reviewed with consideration for moving to a 12-month rolling figure.

HR Scorecard

The continued positive trend in our turnover rates, along with further improvement to our recruitment time-to-hire (42 days) and a +58WTE growth to our contracted position from increased recruitment activity has reduced our vacancy rate further in September to 4.8%.

Our Establishment WTE control process has resulted in a positive impact and WTE establishment has remained static and within the Trust control total. There has been a nominal decrease of 0.4WTE in September following skill-mix changes across Medicine and Surgery.

A continued focus on agency usage has sustained our YTD performance, with agency spend reporting £0.35M under plan for September, £0.54M under plan YTD, and £1.95M below last year. In-month agency spend as a percentage of the total paybill has risen marginally in September to 3.1%, however remains under the KPI target of 4.5%. Overall workforce usage compared to our establishment has decreased to +1.3% in September. Additional usage is being driven by temporary staff, and divisional Medical/Nursing teams are reviewing countermeasures to reduce this usage.

Use of Resources

As at M6 the Trust is in a deficit position of £6.9m and is £6.1m behind its submitted plan. The key drivers of the £6.1m adverse variance are: industrial action direct costs (£1.7m), undelivered efficiency savings (£1.9m), a shortfall on ERF related income (£3.7m), additional medical pay award costs (£0.4m) and temporary staffing pressures (£1.7m). Mitigating a proportion of these adverse variances is non-recurrent benefit totalling £3.1m relating to prior year income.

Externally we continue to forecast breakeven, but the latest forecast shows that, on current run rate plus known changes, we will record a c.£10.7m deficit to plan. The primary reasons for this potential overspend would be a shortfall in efficiency delivery and continued overspends on temporary staffing and industrial action. It is important to note that this assumes no loss of ERF income for the remainder of the year.

Focussing on run rate savings i.e. reducing our monthly spend, especially on temporary staffing, has to be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum, and that saving delivery is maximised to enable us to deliver as close to breakeven as we can, while retaining safe delivery of patient care.

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	Performance, Population & Place Committee and Trust Board				
Next Steps					

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

Workforce

The IPR report identifies issues where minoritized protected groups experience is less favourable than other groups. This is specifically around the staff survey question 16B and experience of discrimination from colleague or manager. The staff survey provides this data by ethnicity, and it is likely that other groups both protected and non-protected have reported discrimination. The report identifies a number of countermeasures and actions are underway and planned to reduce discrimination for all staff and specifically those in protected groups.

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

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
Accountable Lead Signature	 **Felicity Taylor-Drewe**
Date	26th October 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

October 2023

September 2023 & August 2023 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: Patients Developing Pressure Ulcers; Emergency Department - Clinically Ready to Proceed; Implied Productivity and Staff Survey Results	13-16
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	17-19
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	20-23
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Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Total patients waiting more than 65 weeks	0	531	631	610	463	455	384	458	525	640	621	689	661
Percentage of patients who receive a diagnostic test within six weeks of referral	99% (Nat)	50.4%	52.3%	48.0%	48.5%	54.2%	56.1%	50.4%	52.3%	52.2%	49.4%	44.5%	Reported one month behind
Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	2% (Nat)	11.5%	8.4%	11.6%	10.0%	6.3%	5.6%	10.2%	9.5%	9.0%	8.9%	10.0%	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	64.7%	73.2%	78.2%	70.8%	77.8%	76.5%	73.6%	71.3%	65.0%	67.2%	62.6%	Reported one month behind
Proportion of patients seen within four hours	95% (Nat)	72.5%	73.1%	72.3%	75.8%	74.3%	77.2%	75.7%	74.8%	73.8%	75.5%	74.2%	74.6%
Ambulance average Category Two response time	00:18:00 (Nat)	01:08:36	01:09:25	03:05:12	00:44:55	00:46:13	00:53:23	00:37:25	00:40:02	00:51:09	00:46:15	00:56:36	Waiting for data
Percentage of beds occupied by patients who no longer meet the criteria to reside	13.3% (Nat)	21.6%	20.5%	18.9%	17.3%	19.0%	19.5%	16.4%	16.4%	17.8%	17.2%	15.9%	17.3%
Summary Hospital-level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months behind	Reported five months behind	Reported five months behind	Reported five months behind	Reported five months behind
National Patient Safety Alerts not completed by deadline	0 (Nat)	0	0	0	0	0	0	0	0	0	0	0	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection	0 (Nat)	1	1	1	2	3	3	3	3	3	3	4	4
Clostridium difficile infection	100% (Nat)	91.7%	97.9%	85.4%	81.3%	87.5%	102.1%	106.5%	123.9%	117.4%	130.4%	130.4%	132.6%
E. coli bloodstream infection	100% (Nat)	110.1%	114.5%	123.2%	129.0%	143.5%	156.5%	157.6%	169.7%	142.4%	147.0%	142.4%	147.0%
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Leaver rate	11.0% (Nat)	11.8%	11.5%	11.8%	11.6%	11.3%	11.2%	10.5%	10.5%	10.2%	9.7%	9.6%	Reported one month behind
Sickness absence rate	3.5% (Nat)	5.3%	4.9%	5.8%	4.9%	4.5%	4.6%	3.8%	3.7%	3.8%	4.4%	4.0%	Reported one month behind
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	6.5%	6.8%	6.8%	6.8%	6.6%	6.6%	6.3%	5.2%	6.7%	5.3%	5.3%	Reported one month behind
Proportion of staff in senior leadership roles who are women	64% (Nat)	54.5%	54.9%	54.0%	56.8%	54.9%	54.3%	55.7%	54.0%	56.0%	56.1%	56.1%	Reported one month behind
Financial efficiency - variance from efficiency plan (£'000)	+/-	190	-378	-338	-400	-238	281	-377	-384	334	-641	-338	-504
Financial stability - variance from break-even (£'000)	+/-	-363	-1672	-1502	-1579	-1469	-1482	-2157	-2591	-144	-659	330	-1352
Financial stability - variance from PLAN (£'000)	+/-	1154	389	164	106	214	-18	-893	-2132	-223	-733	-528	-1646

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean	2017	2018	2019	2020	2021	2022
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	6.7
Staff survey engagement theme score	6.9	6.9	6.9	7	7	6.7	6.7
Stillbirths per 1,000 total births	2.3	-	2.4	1.9	2.1	2.8	Waiting for data
Neonatal deaths per 1,000 total live births	1.2	-	1.4	1.0	1.0	1.3	Waiting for data

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Total Harms

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

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

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

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

Patient Experience (FFT)

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

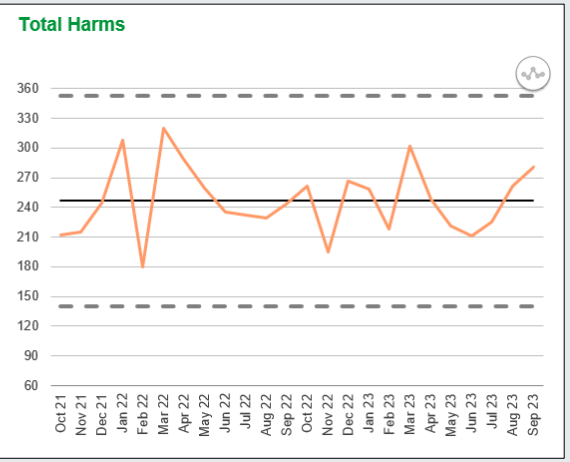
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

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

Total Harms

To achieve and sustain zero avoidable harm.

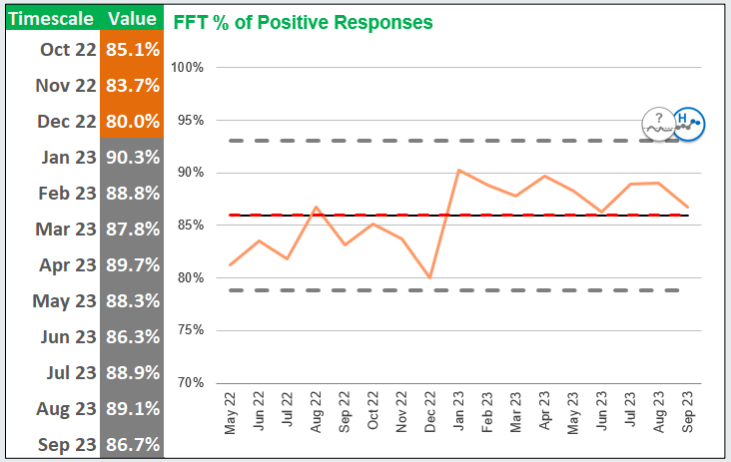
Timescale	Value
Oct 22	261
Nov 22	195
Dec 22	267
Jan 23	258
Feb 23	218
Mar 23	302
Apr 23	248
May 23	221
Jun 23	211
Jul 23	225
Aug 23	261
Sep 23	281



Patient Experience (Friends & Family Test)

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

Timescale	Value
Oct 22	85.1%
Nov 22	83.7%
Dec 22	80.0%
Jan 23	90.3%
Feb 23	88.8%
Mar 23	87.8%
Apr 23	89.7%
May 23	88.3%
Jun 23	86.3%
Jul 23	88.9%
Aug 23	89.1%
Sep 23	86.7%



Counter Measures

The number of harms has increased in September and is in main due to high numbers of pressure damage harms and falls.

The number of healthcare-associated infections has remained high for *C. difficile* and for the gram-negative bloodstream infections. Rates of Methicillin-susceptible Staphylococcus aureus (MSSA) remain low. Cleaning standards continue to improve, as evidenced by audit and by feedback from clinical teams. High *Pseudomonas aeruginosa* numbers continue to drive a focus on water-testing and the disinfection or replacement of affected pipework. This work is being monitored at Executive level.

For September, Trust wide the positive score is 87%, a slight decrease from the previous month, but this still remains above the internal target of 85%.

Public and patient members recruited to take part in next PLACE assessment during October.

There is an ongoing focus on improving nutrition and hydration following feedback from various sources. This includes additional training, monitoring and awareness raising across the wards.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

Cancer 62 Day

In August, there were 41.5 breaches in total, with 31.0 of these attributed to the Urology, Colorectal and Skin pathways. Skin and Colorectal have seen increased demand resulting in capacity challenges. We continue to see greater than normal breaches in Urology where number of breaches in Urology relate to patients needing time to consider which choice of treatment they would prefer and pathways requiring additional treatment following an incomplete procedure..

RTT: Number of patients waiting over 65 weeks

The number of patients waiting over 65 weeks decreased in month by 28 patients, to 661. The reduction was driven by General Surgery (-13), Paediatrics (-13), Urology (-10) and Neurology (-10). Some of the reductions were offset by an increase in Gastroenterology (+19)

Focussed support via a weekly improvement plan is being provided to Gastroenterology, General Surgery, Urology, Orthopaedics and Paediatrics as these services are not on track to achieve the stretched trajectory. Ears, Nose and Throat (ENT), Ophthalmology, Neurology, Endocrinology, Rheumatology, Podiatry and Physiotherapy still remain on target to deliver the stretched trajectory.

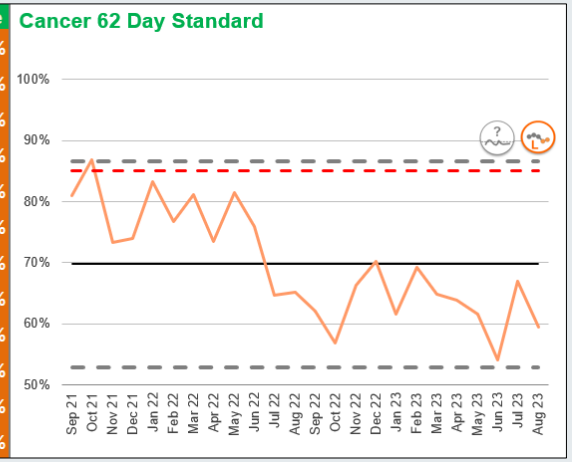
1 x 78-week breach was reported at the end of September 2023. This is the same Urology patient reported in August 2023. Patient was cancelled on the day due to prioritisation of emergencies cases in theatre and unable to rebook in September due to patient choice. Surgery confirmed in October 2023.

Felicity Taylor-Drewe
Chief Operating Officer

Cancer 62 Day

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

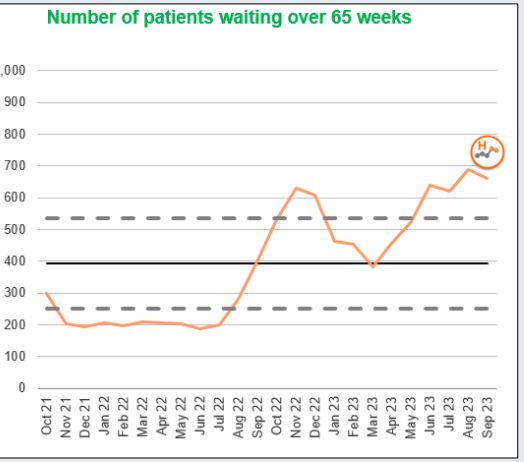
Timescale	Value
Sep 22	62.0%
Oct 22	56.9%
Nov 22	66.4%
Dec 22	70.2%
Jan 23	61.6%
Feb 23	69.3%
Mar 23	64.8%
Apr 23	63.8%
May 23	61.5%
Jun 23	54.0%
Jul 23	66.9%
Aug 23	59.5%



RTT: Number of patients waiting over 65 weeks

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

Timescale	Value
Oct 22	531
Nov 22	631
Dec 22	610
Jan 23	463
Feb 23	455
Mar 23	384
Apr 23	458
May 23	525
Jun 23	640
Jul 23	621
Aug 23	689
Sep 23	661



Counter Measures

Risk •Dermatology capacity had been impacted by vacancies and increase in referrals.
-Recruitment of substantive Consultant continues. Performance shortfalls are expected through the summer as a result of expected leave and seasonal increases in demand. Due to the number of referrals received this will have an impact on the overall Trust performance.
-Additional locum recruited to cover first appointments and minor ops clinics
-Working with the ICB on the use of dermatascopes and advice and guidance (Cinapsis) to aide the reduction of referrals into the service.

Risk: Capacity in Plastics is insufficient to see and treat patients.
Mitigation: Some Plastic patients are being sent to Wootton Bassett to help free up surgical space at GWH. The Pathway has been mapped with the milestones assessed, potential improvements in both pathway and processes are being implemented. Concerns with capacity and operational processes have been raised and discussed with the divisional management team.

Risk: Urology Pathway are often complex requiring multiple diagnostics, with multiple treatment options needing to be discussed at Tertiary centres before treatments can be planned. Patients requiring additional treatment following an incomplete TURBT procedure will breach due to recovery and planning time.
Mitigation: Pathway improvement manager is working with service to implement the best practice timed pathway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team are undertaking LATP biopsy training with a view to reducing the demand on TRUS biopsies, this will start to have an impact from Q2..

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

- Patient level details/plans updated on weekly basis in line with recovery trajectory. For specialities adverse to their 65-week trajectory, deep dives are in place to understand top contributing reasons for the position to then identify rapid improvement actions.
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Additional clinical capacity being provided across services for patients at risk of breaching the 65 week standard.
- Booking to DNA rates has commenced in key specialities.

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

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime in Sept ’23 was 466 minutes against the national standard of 240 minutes.

September showed an increase in the mean time in ED from 407 minutes in August.

Emergency Care – Urgent Treatment Centre - Mean Stay

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

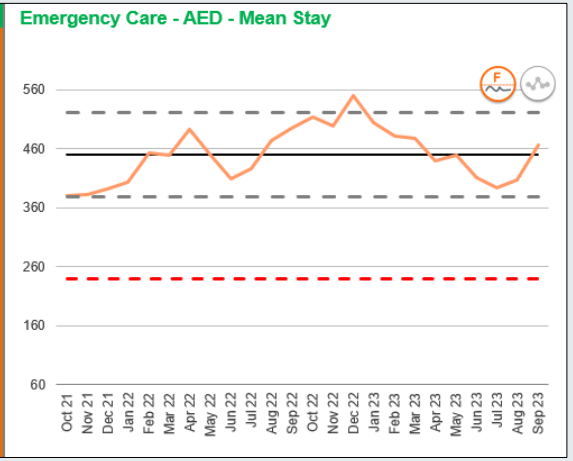
The total meantime wait for a patient in September 2023 was 163 minutes against the national standard of 240 minutes, demonstrating good flow through the service.

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

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

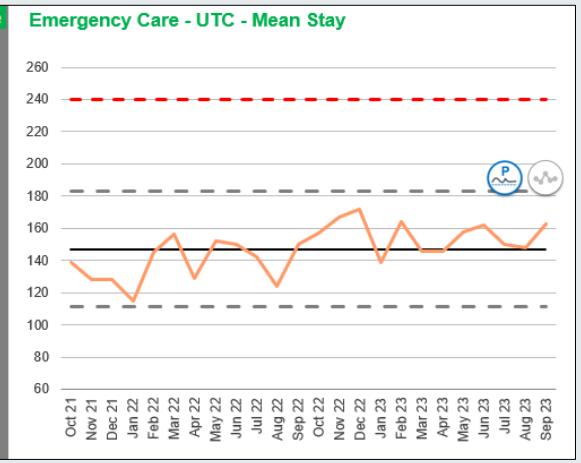
Timescale	Value
Oct 22	514
Nov 22	499
Dec 22	550
Jan 23	503
Feb 23	482
Mar 23	477
Apr 23	440
May 23	448
Jun 23	410
Jul 23	393
Aug 23	407
Sep 23	466



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Oct 22	157
Nov 22	167
Dec 22	172
Jan 23	139
Feb 23	164
Mar 23	146
Apr 23	146
May 23	158
Jun 23	162
Jul 23	150
Aug 23	148
Sep 23	163



Counter Measures

- Weekend ED Paeds Consultant to be maintained with vacancy monies; improve quality of care and waiting times for children, whilst also supporting main ED staffing
- Pit-stop nursing maintained (challenging as now within 'normal' staffing numbers); provides clinical oversight of queue, starts assessments early & potential for simple treatments
- Support services input for admission avoidance & improved discharge - Co-ordination Centre, Flow and Community Teams
- Increased capacity for Triage of self-presenting patients (Triage cubicles x2), assessment of 'ED Majors' patients (6 bays) and provision for early ambulance assessment (Pitstop x1)

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

1. Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Department & Urgent Treatment Centre - Emergency Attendances

Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). August has seen a slight reduction in attendances to both ED & UTC.

ED & UTC combined saw 10,325 patients in September this is a slight decrease on August numbers.

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

September has seen a marginal improvement in NCTR, medical outliers remained within the threshold set internally of <30 this continues to be closely monitored on a daily basis via site calls. There was a slight increase in average discharges per week which averaged 621.8 per week. Swindon Home first was it highest on record 121 with 0 readmissions.

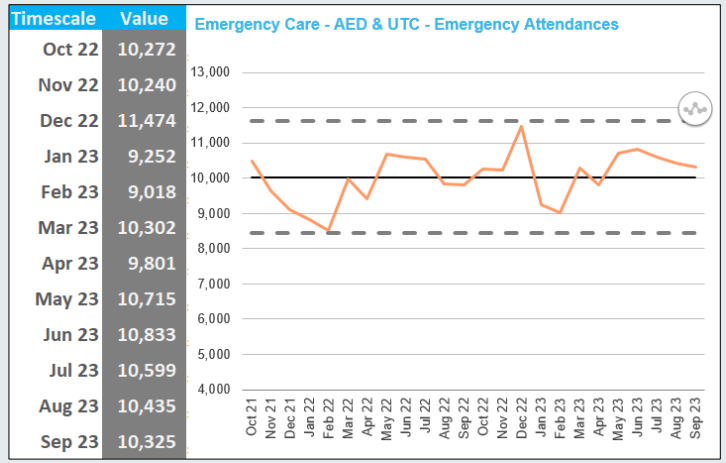
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

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

To ensure patients are cared for in the appropriate setting

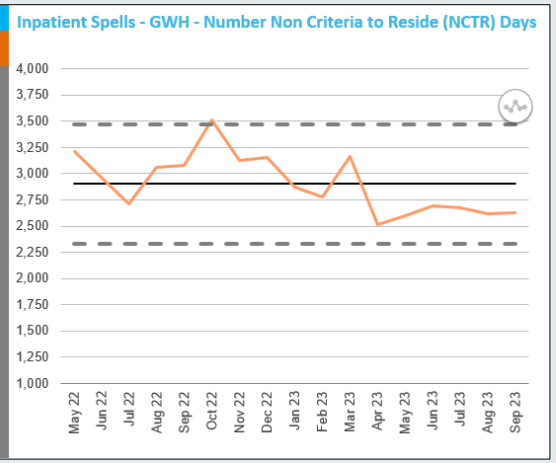
Timescale	Value
Oct 22	10,272
Nov 22	10,240
Dec 22	11,474
Jan 23	9,252
Feb 23	9,018
Mar 23	10,302
Apr 23	9,801
May 23	10,715
Jun 23	10,833
Jul 23	10,599
Aug 23	10,435
Sep 23	10,325



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

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

Timescale	Value
Oct 22	3,514
Nov 22	3,125
Dec 22	3,158
Jan 23	2,873
Feb 23	2,774
Mar 23	3,162
Apr 23	2,510
May 23	2,599
Jun 23	2,694
Jul 23	2,675
Aug 23	2,614
Sep 23	2,631



Counter Measures

Co-ordination Centre and Navigation Hub processing referrals from community teams and ambulance service.

SWAST reviewing processes and conveyance requirements. HALO support in ED.

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

- SBC senior flow lead charring on Wilts discharge hub, to bring in line the successful model of SBC, offers check and challenge – **this is continuing.**
- Front Door Team therapy membership in the Discharge Hub – to escalate patients on point of admission for an MDT focus to facilitate discharge at point of Medical Fitness.
- Readmission Round Table undertaken for Swindon Home First patients to seek opportunities for learning across the system and areas for improvement - (to be reported UCF sub board November)
- **'Walk at Midnight'** planned for 11th Oct with COO – one of the objectives is to review Discharge Pathways/Maybe discharges/tomorrow discharges
- Discharge to Assess Bed base process is under review across the system as currently there is a potential delay in the system attributed to acceptance & completion of paperwork.

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.

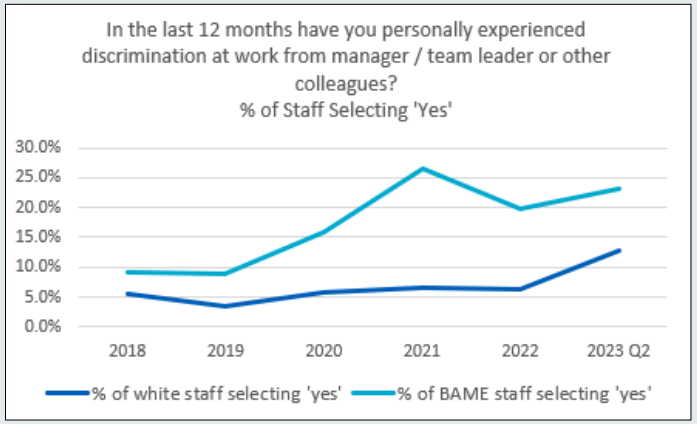
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing 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.

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

Jude Gray
Director of Human Resources (HR)

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



Counter Measures

- This metric is measured quarterly and therefore there has been no change in the performance this month. Actions underway to improve staff experience are outlined below.
- October is Black History Month and the Race Equality Network is hosting an event in the Academy on 12 October and the Trust will take part in a system-wide event on 31 October, celebrating successful black women.
- The Discrimination staff survey that accompanied the Equity Data Walks closed in September. As a result of feedback, the EDI Lead did further engagement with Internationally Educated Staff to understand if their experience mirrors that of BME staff who are from the UK and the findings have been incorporated into the draft report that will be presented to the EDI Group in November. Initiatives are being developed to address issues like 'speaking up' and 'microaggressions' and the Trust launched the Allyship Programme during National Inclusion Week (25 September to 1 October) to get more staff engaged in this agenda. This first session linked to this programme 'Speak Up, Listen Up' will take place in November, followed by the launch of the Inclusion Café which will be a safe space for staff to discuss speaking up. This will support the Trust's wider ambition to encourage Freedom To Speak Up.
- The EDI Annual report will be presented at TMC, PCC, the EDI Group and the Board. The report highlights the work that has taken place across the year (2022-23) and demonstrates how the Trust has met the Public Sector Equality Duty (Equality Act 2010).
- The EDI Lead attended Divisional Board meetings in spring to present discrimination data and encourage divisions to adopt the discrimination pillar metric. This has led to some increase in ad-hoc EDI-related training. The EDI Lead will revisit Divisional Board meeting to present the findings of the Equity Data Walk and seek further commitment.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Voluntary Staff Turnover (rate)

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

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

The Trust has seen a continued improvement in the trend since July 2022. Further reduction to our voluntary turnover rate has been seen in August, decreasing from 9.7% to 9.6%, and below the Trust target for five consecutive months. Performance continues to be maintained through the Trust Retention Working Group, with countermeasures being refined to focus on leavers within the first year of employment.

Staff Recommendation as a Place to Work

The 2023 Annual National Staff Survey launches on 11th September. We are aiming for a 65% response rate from the full sample invited to take part in this year's 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.

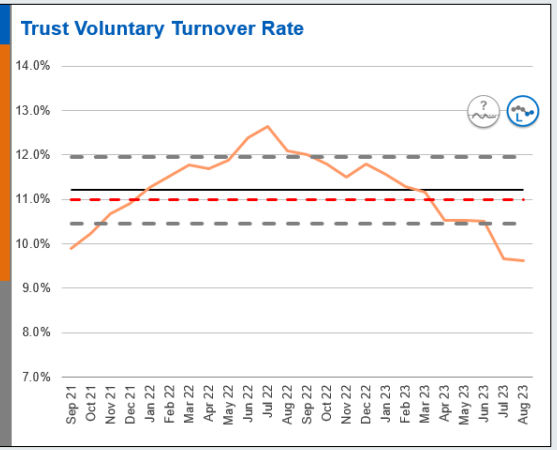
The staff engagement score is seen as a key priority for the Trust. The Kings Fund reports there is now overwhelming evidence to show that engaged staff really do deliver better health care and higher levels of staff engagement (measured through the staff survey) have lower levels of patient mortality, make better use of resources and deliver better financial performance.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

Timescale	Value
Sep 22	12.0%
Oct 22	11.8%
Nov 22	11.5%
Dec 22	11.8%
Jan 23	11.6%
Feb 23	11.3%
Mar 23	11.2%
Apr 23	10.5%
May 23	10.5%
Jun 23	10.5%
Jul 23	9.7%
Aug 23	9.6%



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 improved to 9.6% in August.
- Retention plan six-monthly progress report is on the agenda for TMC and People & Culture. Key highlights include:
  - Continuous improvement in overall retention rates.
  - Consistently below national average for Acute Trusts.
  - Positive improvements in Nursing and Unregistered Nursing
- The retention plan focuses on the following key actions:
  - Embed our 'Just & Learning Culture'
  - Implementation of Trust Recognition Plan for 2024/25.
  - Continue the roll-out of leadership behaviours
  - Refresh the Trust People Strategy
  - Develop material for the role of the line manager as part of the masterclass leadership programme.

- There has been no change in this metric as it measured quarterly. Current focus is on the annual staff survey campaign.
- Improving together roll-out and staff survey working group continues during the annual staff survey campaign to support showcasing of initiatives during the survey period.
- The 2023 Annual Staff Survey launched on 11th September. A Trust-wide promotional campaign has been planned to help drive our target response rate of 65% across the full staff sample included this year.
- Following an impressive campaign launch, the current Trust completion rate at week 4 of 11 is 46% (2,650 staff), which is a 5% improvement on this period last year and 26% above the national average.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

As at M6 the Trust is in a £6.9m deficit position which is £6.1m adverse variance to plan. Pay and non-pay pressures are driving this.

The key drivers of the £6.1m adverse variance are: industrial action direct costs (£1.7m), undelivered efficiency savings (£1.9m), a shortfall on ERF related income (£3.7m), additional medical pay award costs (£0.4m) and temporary staffing pressures (£1.7m). Mitigating a proportion of these adverse variances is non-recurrent benefit totalling £3.1m relating to prior year income.

We are including ERF income in line with activity delivered. This is £3.7m less than our planned income to date. Of this, we believe £2.4m has been lost due to industrial action. This leaves a net under-delivery of £1.2m of ERF income, excluding the impact of industrial action.

Externally we continue to forecast breakeven, but the latest forecast shows that, on current run rate plus known changes, we will record a c.£10.7m deficit to plan. The primary reasons for this potential overspend would be a shortfall in efficiency delivery and continued overspends on temporary staffing and industrial action. It is important to note that this assumes no loss of ERF income for the remainder of the year.

Focussing on run rate savings i.e. reducing our monthly spend, especially on temporary staffing, has to be the priority for operational colleagues for the remainder of the year.

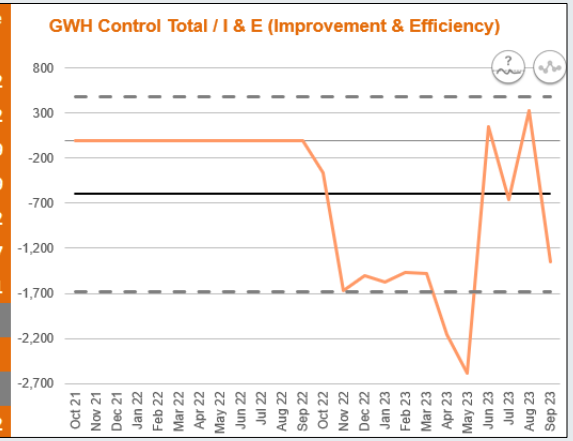
Likewise, we need to ensure that discretionary spending is kept at a minimum, and that savings delivery is maximised to enable us to deliver as close to breakeven as we can, while retaining safe delivery of patient care.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Oct 22	-363
Nov 22	-1672
Dec 22	-1502
Jan 23	-1579
Feb 23	-1469
Mar 23	-1482
Apr 23	-2157
May 23	-2591
Jun 23	144
Jul 23	-659
Aug 23	330
Sep 23	-1352



Counter Measures

- Efficiency savings were £0.5m behind target in month and are £1.9m behind plan on a YTD basis. There are £16.7m of identified schemes but only £6.7m (40%) of this total is fully developed.
- Countermeasures continue through the efficiency programme, including:
  - Focus on actions to reduce run rate – additional sub committees focusing on green, amber and red actions
  - Cross-divisional schemes such as Better Buying and Medicines Optimisation
  - Enhanced workforce and agency controls

Executive Summary

Great Western Hospitals NHS Foundation Trust

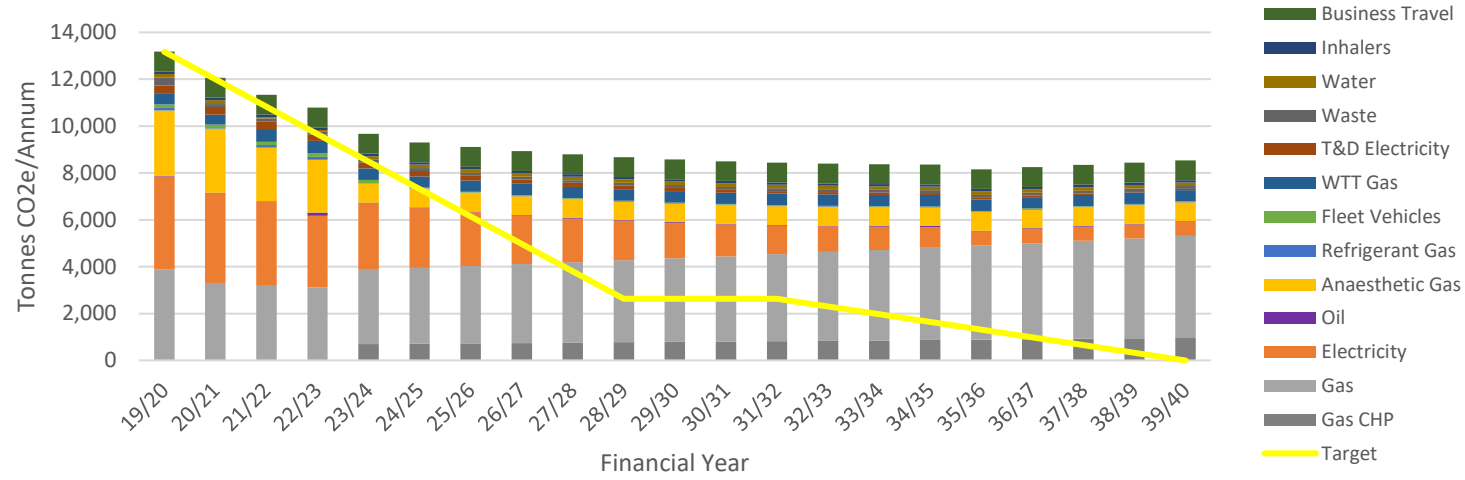
Carbon Footprint / Sustainability

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

This graph shows the current carbon emissions and our net zero interim and long-term targets with no intervention or approved decarbonisation projects in place.

The following carbon footprint updates from the Sustainability Team will show our quarterly carbon footprint for the current financial year benchmarked against previous years and the wider decarbonisation graph (shown currently) will be provided annually.

Simon Wade
Chief Financial Officer



Counter Measures

1. The board approved Green Plan has been published with targets and action plan agreed.
2. The Sustainability Team have won Salix funding for a heat decarbonisation plan which will be completed March 2024 which will impact this graph
3. Capital projects for reducing emissions from medical gasses have taken place.
4. Current capital projects includes the electrification of fleet vehicles

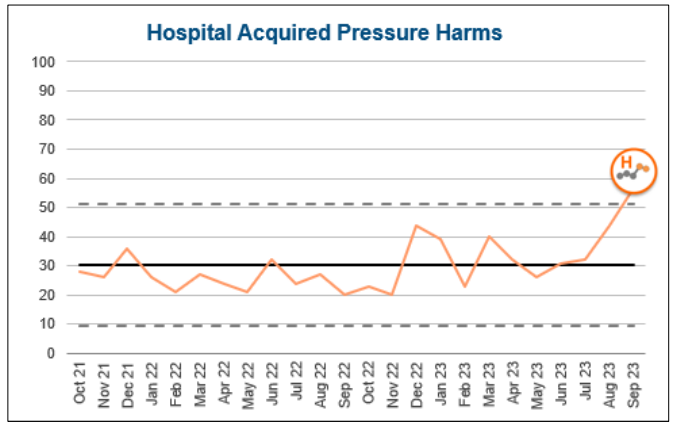
2023/24 Breakthrough Objectives

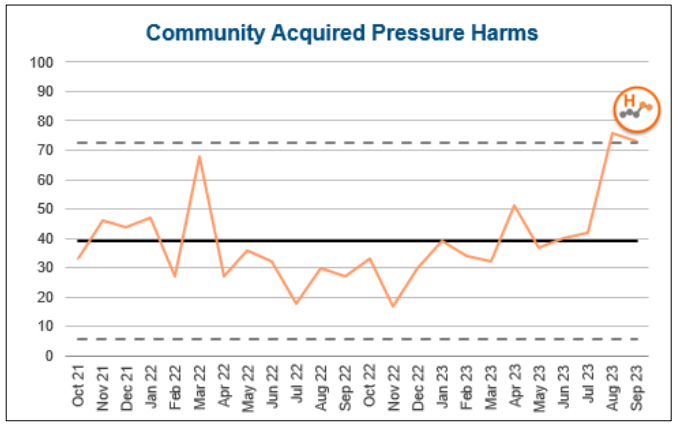
Reduction of Pressure Harms

Great Western Hospitals NHS Foundation Trust

Total Pressure Harms

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
56	37	74	78	57	72	83	63	71	74	120	131





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

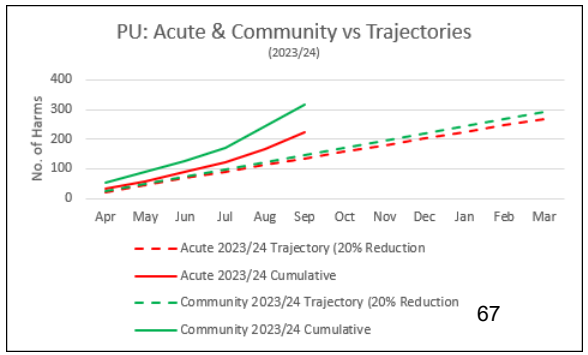
Understanding the Data

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

The graph shows the cumulative number of pressure harms in both the acute and community settings and the trajectory based on the target of 20% reduction on the previous year's performance.

We are driving this measure because...

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



Performance

Overall, there has been an increase in the number of pressure harms reported in month. This is driven by an increase in those in the acute setting. The number of harms in the community setting have decreased slightly in month.

There were 57 (44 in August) hospital-acquired pressure harms during September., Trauma unit and Neptune ward are the areas with highest levels of harm. Additional actions put in place include

- Relocation of Trauma Matron to be based on the unit for a month
- Matron to attend to Daily Improving huddle to ensure TVN is the top metric being discussed
- Spot checks and visible presence of Matron and Ward Manger on Neptune ward.
- ED to adopt same documentation as wards
- Meeting with ambulance service to ensure all pressure harm reduction measures in place.
- Two harms were device-related (both ears on one patient) which is a significant reduction on last month, potentially reflecting the focus given to this on Neptune, Trauma and Critical Care.

In the community setting there were 74 (76 in August) pressure harms acquired during September. This is a small decrease from the previous month and involved 45 patients in total.

There were no new emerging themes, so all previous workstreams related to previous themes identified have continued which include mucosal harms, contractures and Integrated End of Life Care. In addition

- Tissue viability team will support case load reviews conducted by caseload holders.
- Risk assessment training delivered across therapy and UCR teams to raise awareness and improve reporting and documentation.
- PU information Board in Orbital lobby – raising awareness of mucosal / device related harm.

Risks

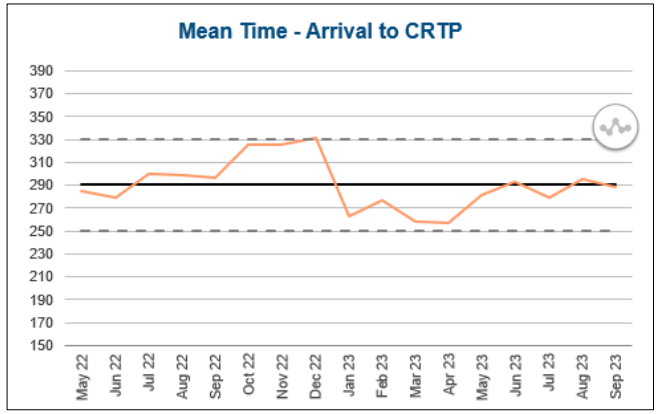
2023/24 Breakthrough Objectives

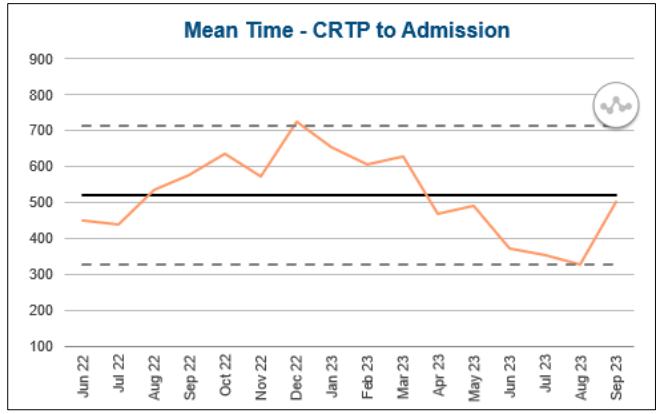
Emergency Attendances - Clinically Ready to Proceed (Admitted)

Great Western Hospitals NHS Foundation Trust

Mean time in ED (Minutes)

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Pre CRTP	326	326	332	263	277	259	258	281	293	280	295	289
Post CRTP	636	572	725	654	608	629	467	492	373	352	326	504





Common cause – no significant change

Understanding the Data

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

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

August data highlights that on average patients are waiting more time in for a bed in ED

We are driving this measure because...

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

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

Performance

- Mean time in ED from arrival to clinically ready to proceed (CRTP) has continued to stabilise at mean levels (289 in September from 295 in August) showing patients waited slightly less time to be triaged, seen and diagnosed.
- Mean time in ED from CRTP to admission has risen from 326 to 504 in September indicating patients spending more time in ED awaiting admission.

Risks

Physical and pathway reconfiguration required for WFP programme will see slightly reduced bed numbers across the ED footprint.

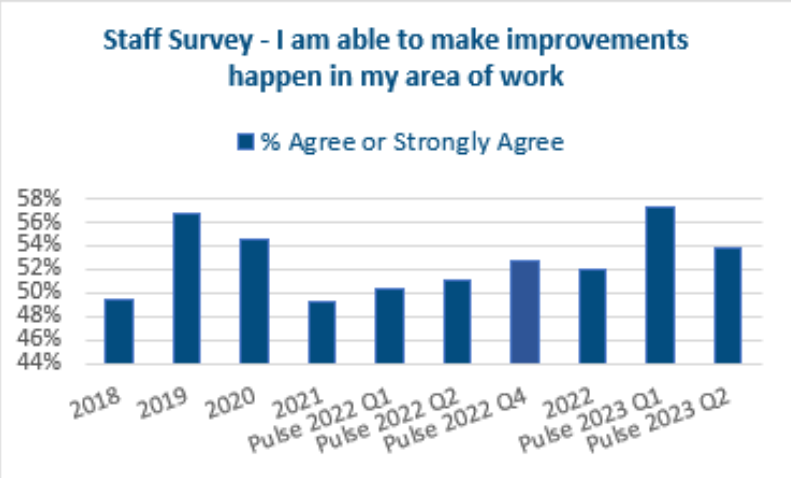
2023/24 Breakthrough Objectives

NHS Great Western Hospitals NHS Foundation Trust

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

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

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



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- Improving Together week has been rescheduled November. This will encompass:
  - Trolley dashes
  - Improvement clinics
  - Trust-wide comms
- The 'Great Place to Work' campaign continues both internally and externally, which showcases multiple employee testimonial stories, and Trust achievements e.g. Staff Excellence Awards, Health and Wellbeing, Way Forward Programme, current vacancies.
- The Transformation & Improvement team are launching a Twitter page to help with visibility of staff making improvements across the organisation.
- Initiatives for this year's annual staff survey campaign include free lunch vouchers, prize draws for gift-vouchers and an iPad, and the use of Computers on Wheels to maximise engagement and uptake.

Risks

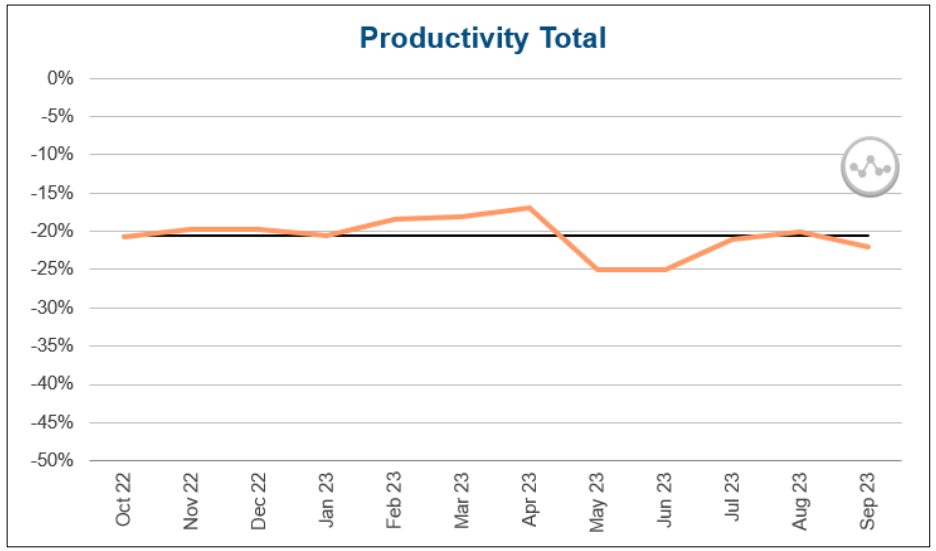
- Whilst continuing the 'inch wide, mile deep' focus on question 3F, there are broader opportunities for improvement which are outlined in the divisional Staff Survey presentations which require focus.
- Divisional teams continue improving together training in different timescales, therefore the risk is that less improvement actions could be made in areas who are yet to go through training.
- Changes in the leadership team may have an impact on progress during a period of change.

2023/24 Breakthrough Objectives

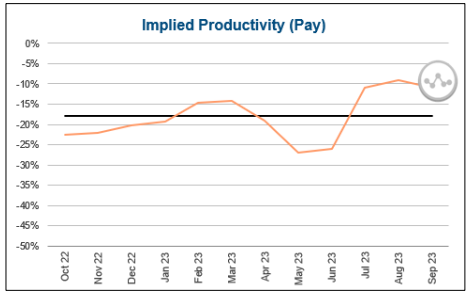
Great Western Hospitals NHS Foundation Trust

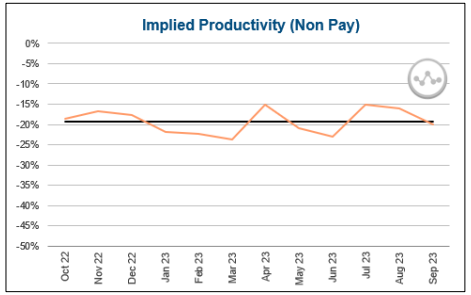
Productivity

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



Common cause – no significant change





Understanding the Data

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

We are driving this measure because…

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

Risks

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

Performance & Countermeasure

Implied Productivity in total has improved to an overall total **–22%** for Month 6 (this is a 4% deterioration from the 18% at the end of 2022/23).

This 2% improvement from last month reflects baseline adjustments made to the 19/20 change for Primary Care Network and Community costs. The position still reflects being off track with our activity and financial plan due to higher pay pressures such as industrial action impact and behind plan CIP Delivery. As this measure continues to be against 2019/20 cost change this is measuring the increased cost from 2019/20 levels. The pay productivity would return to +12% at the end of the 2023/24 plan if planned cost and efficiency levels this year are also delivered.

The CIVICA Aurum insight opportunities are again presented this month at divisional/specialty level. Data quality tolerance needs to be reviewed for areas such as coding and information breakdown.

The outputs will allow more key divisional stratified data to also be presented and for key questions to be asked around business planning for 2024/25. This is being worked into 2024/25 planning inputs for use by divisions along with other sources of support data such as reference cost benchmarking.

The aim is to produce productivity data, trends and information that can enable intelligence and action plans across divisions in areas such as variation in treatment and procedure cost. A clear Division engagement and integration plan for these opportunities and moving them into other forums to achieve outcomes is required. This is being progressed currently.

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		74%	78%	68%	46%	
IP & C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		0	1	1	1	
	Clostridium difficile (C. diff) infections (cumulative)	23 (Nat)		25	33	38	44	
	Escherichia coli (E. coli) infections (cumulative)	33 (Nat)		24	36	45	52	
	Pseudomonas infections (cumulative)	7 (Nat)		11	16	18	20	
	Klebsiella infections (cumulative)	11 (Nat)		8	9	16	20	
FFT	Daycases Response Rate	25% (Int)		23%	24%	22%	22%	
	Daycases Positive Responses	98% (Int)		96%	98%	94%	95%	
	Maternity Response Rate	18% (Int)		17%	18%	17%	16%	

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

Performance & Counter Measure

The complaint response rate has reduced significantly in September and is the result of operational pressures impacting on clinical and operational capacity to investigate and respond to complaints within expected timeframes. Strike action in August and September by medical staff has had a significant impact on the capacity of medical staff to investigate complaints. Patients and their families are regularly contacted to ensure they are aware of the progress of their complaint investigation and the reasons for delay in response.

The rate of *C. difficile* infection continues to be above that of 2022/23. Each case is reviewed for learning by the IPC team, an Antimicrobial Pharmacist and a Consultant Microbiologist. The overwhelming majority of cases are not found to have been preventable. BSW's review of all cases has found a strong link with antimicrobial prescribing in primary care, with BSW GP practices prescribing more broad-spectrum antibiotics than those in other regions. The BSW IPC and Antimicrobial Stewardship teams are working to address this.

We continue to see high rates of *C. difficile* in asymptomatic patients, suggesting that an increased prevalence of the bacteria in the community may also be a factor.

Rates of all three reportable gram-negative bloodstream infections (E. coli, Klebsiella and Pseudomonas aeruginosa) remain higher than trajectory. Increasing research evidence suggests that hand basin drains/plug holes are often a reservoir of gram-negative bacteria in hospitals, it is likely that the focus on cleaning techniques and replacement of drains and pipework as part of work to tackle Pseudomonas will have a positive impact on all three infections. Work continues on improving catheter care, particularly in the Division of Medicine who now have an A3 on this. A significant theme in the Klebsiella cases has been hospital-acquired pneumonia and work is ongoing as part of the IPC Improvement Plan to reduce the incidence of this.

MRSA is alerting because we had one case in July, however this case was an unavoidable deterioration of a community-acquired infection. Excellent care was noted in the post-infection review.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	96%	93%	90%	92%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	106%	107%	100%	108%
FFT	Overall response rate (%)	29% (Int)	?	27%	25%	33%	31%
	Positive response (%)	86% (Int)	?	86%	89%	89%	87%
	ED & UTC Response Rate	21% (Int)	?	20%	20%	20%	21%
	ED & UTC Positive Responses	80% (Int)	?	76%	81%	80%	77%
	Inpatients Response Rate	27% (Int)	?	26%	25%	27%	24%
	Inpatients Positive Responses	86% (Int)	?	85%	87%	83%	80%
	Outpatients Positive Responses	98% (Int)	?	98%	97%	97%	96%
	Maternity Positive Responses	94% (Int)	?	93%	94%	95%	86%

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

Performance & Counter Measures

Safe Staffing fill rates remain in line with previous months and within safe parameters. The data includes RMN and enhanced care, areas with less than 90% are reviewed by the DDONS include neonates, maternity and Neptune.

There has been a slight decrease in both the overall response rate and the positive response rate, although both remain above internal targets.

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

- First spinal injury coproduction event held this month – actions agreed to address areas of concern including development of a spinal injury passport, roll out of training, bowel care policy and awareness raising of Autonomic dysreflexia.
- Following TMC away day focus for improvements from National inpatient survey agreed. 'Go and see' approach to be used with focus on waiting times (elective and emergency) and communication – 'what is happening to me'.
- Research working group has commenced to engage with local minoritised communities and encourage their involvement in research projects.
- There is an ongoing focus on improving nutrition and hydration following feedback from various sources. This includes additional training, monitoring and awareness raising across the wards.
- Meeting held with Swindon Coeliac organisation to support with improvements to meal provision – will be key to training of new ward hostesses.
- Questionnaire developed to share with young carers across Swindon regarding what is important to them when their cared for person is admitted to hospital. Results will form the basis of a planned new children's and young people's carers passport.
- We have seen an improvement in the matron's audit around the sleep environment.
- A workshop with ward managers and matrons was held to develop action and improvement plans in response to the In-patient survey results, the main areas being addressed are nutrition, communication and personalised care.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23
Harm	No. of serious incidents reported in month	SPC		3	3	3	2
	Falls rate per 1000 bed days	SPC		5.8	4.6	4.8	5.4
	No. of Falls in month	SPC		110	90	90	105
	No. falls with moderate harm or above	SPC		1	2	2	3
	Medication incidents with moderate harm	SPC		2	4	1	3
Concerns and Complaints	No. of concerns received	SPC		139	120	127	158
	No. of complaints received	SPC		47	59	67	59
	Number of reopened complaints	SPC		2	5	4	3
IP&C	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative)	21 (Int)		6	11	15	15
	Covid – no. of hospital acquired	SPC		4	22	21	20

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

Performance & Counter Measure

There are 26 ongoing Serious Incidents (SI) , with a further two reported in month. There has been no themes identified within the new SI's declared.

Use of the new learning responses have commenced as part of the PSIRF approach to learning. For incidents that require escalation due to the potential for learning and improvement, a Patient Safety Review (PSR) will be convened at the earliest opportunity.

The number of concerns have increased in month, but the number of complaints has decreased. The number of re-opened complaints has also decreased in month.

A Falls Champions Forum has been set up to run monthly to share resources and promote new learning for the champions to disseminate to their clinical areas.

Monthly lying and standing BP data collection continues, with results and training materials feedback directly to the ward managers. Results have improved from 64% in May 2023 to 87% in September 2023.

MSSA rates have remained below last year's figures and below our internally-set threshold. The COVID wave which began in late July has persisted into autumn. Air scrubber installation continues and there have been no bed or ward closures due to COVID.

Risks

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23	Trend
RTT	No. of >=18 weeks waiters		H	16891	17685	18285	19161	
	No. of >=52 weeks waiters		H	2469	2448	2418	2307	
DM01	No. of patients on DM01 waitlist		H	12491	13075	12989	One month behind	
	DM01 performance %	99% (Nat)	F	52.2%	49.4%	44.5%	One month behind	
	DM01 6 week wait breaches		H	5969	6621	7208	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	54.0%	67.0%	59.5%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	88.0%	85.0%	84.9%	One month behind	
	% Cancer 2 week wait	93% (Nat)	?	67.0%	60.0%	54.0%	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

September's DM01 validated performance is showing an improvement in performance variance from the 44.51% performance in August to 46.10%. The number of patients on the waiting list has increased slightly to 13,843 and the number of 6-week breach has increased to 7,462 driven by Ultrasound and ECHO. The 2 Pads in Radiology continue to be fully utilised with three supporting the CDC (CT, MRI and Endoscopy), and activity numbers continue to remain high. The teams continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Ultrasound still remains the largest issue, but a recovery plan started in October. CT 3 days a week for 6 months until the end of February will be funded by the TVCA. Sleeps studies have recruited with a Dec start date targeted and also a colleague returning from Mat leave in November to help recover the numbers.

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathway with 83% of the breaches being accounted for by this service. WLI activity is being used to help manage demand. A locum returns in October, providing additional capacity. Additional capacity in Plastics is being sourced through private partner (CSP in Wootton Bassett) and through any available mutual aid from OUH.

60.2% of the 62-day breaches were with the Skin, Colorectal & Urology Pathway.

Cancer waiting times for first appointment remain below standard with an increase in demand and the impact on clinic cancelations as a result of the industrial action. The Skin Pathway is having the greatest impact on all of the 2ww standard with 51.5% of all of the breaches. Colorectal pathways accounted for 23.5% of total breaches

In August, 79% (438) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, Skin & Gynae)

Counter Measure - Work is underway with the TVCA to implement the Best Practice Timed Pathways across all 4 (Lower GI, Urology, Gynae & Skin) of these Pathways. Socialisation events with TVCA discussing pathways and next steps have been arranged through September

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

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.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	73.8%	75.5%	74.2%	74.6%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	7.4%	6.9%	6.9%	8.3%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	54.2%	55.6%	52.5%	54.7%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	14.8%	13.6%	13.9%	16.9%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	736	778	907	989	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	462	474	470	685	
Flow	Average hours lost to ambulance handover delays per day	SPC	H	54	49	43	95	
	Number of Super Stranded Patients (over 21 days)	SPC	H	77	68	67	83	
	Adult general and acute type 1 bed occupancy	SPC	H	98.2%	97.9%	98.4%	98.7%	

Performance & Counter Measure

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

ED performance has remained relatively static across most areas compared to previous months. 4 hour performance increased to 74.6% from 74.2% with a rise also seen in type 1 4 hours performance from 52.5% and 54.7%.

Relevant teams are looking at improvement measures across the 'Front Door' , pre-hospital and post discharge with measures to improve flow & discharge rates. This includes liaison with Co-ordination Centre, key stakeholders in & out of hospital, and utilising 'Improving Together' methodology.

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

- Total % over 12 hours has increased from 13.6% to 16.9%.
- Number of ambulance handovers over 30 minutes have seen a rise from 907 to 989.
- Number of ambulance handovers over 60 minutes have seen a rise from 470 to 685.

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	Jun-23	Jul-23	Aug-23	Sep-23
RTT	No. of >=78 weeks waiters	SPC	L	0	0	3	1
Cancer	% 28 day faster diagnosis	75% (Nat)	P	65%	67%	63%	One month behind
	No. of referrals received	SPC		1883	1819	1828	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	93.6%	95.6%	95.8%	93.7%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.0%	0.1%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5433	5347	5207	5054
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	69.0%	70.0%	70.9%	73.1%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		47.0%	50.7%	52.9%	48.9%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		42.6%	47.3%	42.3%	39.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	198	187	187	195
	Emergency Care - AED - Median Stay	240 (Int)	?	239	238	240	238
	Emergency Care - UTC - Median Stay	240 (Int)	P	158	145	139	158

Performance & Counter Measure

ED Type 3 performance has not hit the 4 hour performance metric for Sept 23. This is due to a combination of internal staffing issues in UTC and higher demand that could be associated with staffing issues and MIIU closures in neighbouring areas.

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.

In August, 79% (438) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, Skin & Gynae)

Counter Measure - Work is underway with the TVCA to implement the Best Practice Timed Pathways across all 4 (Lower GI, Urology, Gynae & Skin) of these Pathways. Socialisation events with TVCA discussing pathways and next steps have been arranged through September

Risks

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

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23
ED	Total Number of Ambulance Handovers	SPC	L	1598	1705	1888	1619
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		1628.78	1521.06	1340.62	2862.13
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1152	1244	1478	1384
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		72.1%	73.0%	78.3%	85.5%
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	46.1%	45.6%	48.0%	61.1%
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		29%	28%	25%	42%
Flow	Admitted - Average Length of Stay in Department (mins)	SPC	L	666	632	621	793
	Non - Admitted - Average Length of Stay in Department (mins)	SPC	L	284	274	295	307
	Elective Patients Average Length of Stay (Days)	SPC	L	3	2	2	3
	Non-Elective Patients Average Length of Stay (Days)	SPC		5	5	5	5
	Community Average Length of Stay (Days)	SPC		20	17	20	16
	GWH Discharges by Noon (%)	SPC		0	0	0	0
	Number of Stranded Patients (over 14 days)	SPC		127	116	119	136
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC		23.4%	22.5%	20.4%	19.6%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		94.6%	94.8%	95.2%	95.2%

Performance & Counter Measure

Risks

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23
Use of Resources	Capital Expenditure (£'000)	SPC		2386	2184	3861	Waiting for data
	Pay (£'000)	SPC		25830	25024	25776	25468
	Non Pay	SPC		16488	15127	15729	15038

Performance & Counter Measure

Capital spend has decreased significantly in month at £0.7m, this is £2.9m behind plan in month. The underspend is mainly due to lower spend on the way forward programme and Aseptics. All capital project leads are forecasting to spend their allocations by year end, which means that no new capital projects can be approved as we have no additional funding.

Pay costs are £0.3m lower than M5; this is driven by lower Nursing costs across substantive and temporary staffing.

Non-Pay is £0.7m lower than M5; there has been reduced medicine usage and additional VAT recovery has also been achieved in 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.

Risks

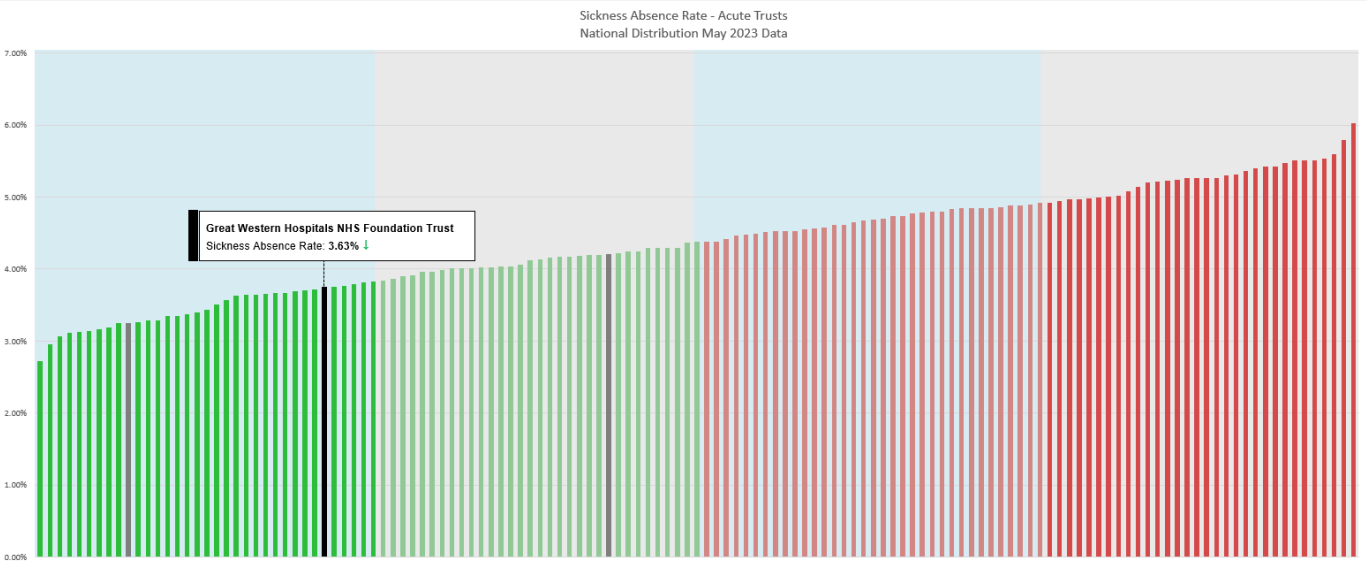
The Trust started the year with a £16.67m cash releasing efficiency plan, which includes a £2.98m carry over from 22/23. As at Month 6, the programme is £1.9m under plan, a deterioration of £0.5m from M5.

Out of the £16.67m target £16.7m is identified, an increase of £0.8m from M5. £6.1m is fully developed, up by £0.6m from M5. Divisions and supporting services must work to turn the remaining schemes flagged as opportunities into deliverable savings.

Our People

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	3.8%	4.4%	4.0%	One month behind	



Performance & Counter Measure

- In-month sickness absence has reduced in August from 4.4% to 4.0%, although remains alerting and above the Trust KPI of 3.5%. The decrease in-month has been driven by a reduction in long-term sickness absence from 2.61% in July to 1.91% in August. Short-term absence has increased in-month from 1.81% to 2.12%.
- Current national benchmarking data (May 2023 - NHS Digital) shows a slight decrease to the national sickness level in May, reducing from 4.51% to 4.46%. In the South West Region, absence increased marginally in this period from 4.33% to 4.36%, and for GWH the absence rate decreased from 3.82% to 3.63% with the Trust holdings its position in the first lowest quartile and the top 20% nationally.

Risks

- Increase sickness rate as per national trend during winter.
- 70% movement in the HR team due to Maternity, Resignation, and Long-Term Sickness could impact level of support for absence management.

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

Our People

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jun-23	Jul-23	Aug-23	Sep-23
Workforce	% of leavers within 1st year of employment	31.2% (Int)		23.5%	34.6%	27.7%	One month behind

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

Performance & Counter Measure

- The % of leavers within 1st year of employment decreased in August 2023 to 28%, below the average of 31%. Actions in the retention plan have been developed to sustain and improve this measure. In order to gain a better understanding of this metric's performance over time we will review the measure and consider moving to a rolling 12-month reference period.
- Staff survey response rates for the 2023 Annual Staff Survey will be measured weekly during the survey period, with competitions and prizes being used to drive responses across the survey window. The Trust has currently achieved a 47% response rate as at week 4 of the campaign, and therefore above the national average for last year.
- We await the annual staff survey results for comparisons on two key questions on well-being and EDI during promotions and career development.

Risks

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

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

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Trend Vs Last Month	Trend Vs Sep-22
	Vacancy																	
W	Vacancy Rate	%	7.00%	6.31%	6.56%	5.97%	6.23%	7.43%	6.40%	5.30%	7.52%	8.06%	7.94%	7.80%	5.95%	4.87%	↓	↓
W	Vacancy Rate	WTE	-	328.65	343.04	313.11	329.52	392.94	335.02	276.66	401.58	437.89	431.29	423.68	320.44	262.33		
W	All Nursing Vacancy	%	7.00%	5.58%	5.95%	5.27%	5.62%	6.51%	5.20%	3.65%	4.50%	4.95%	5.38%	5.00%	2.73%	1.96%	↓	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	141.28	151.92	135.61	146.64	170.25	135.53	94.47	117.71	132.11	143.74	133.58	71.58	51.43		
W	All Registered Nursing Vacancy	WTE	-	113.32	102.85	87.51	91.41	92.65	77.18	43.38	84.20	97.00	107.48	103.62	74.83	47.47		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	50.49	51.28	43.73	54.94	47.18	36.73	27.43	27.90	44.94	53.47	59.84	42.58	23.20		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	27.96	49.07	48.10	55.23	77.60	58.35	51.09	33.51	35.11	36.26	29.96	-3.25	3.96		
W	Medical Vacancy	%	7.00%	3.64%	5.73%	5.80%	5.43%	5.61%	8.49%	6.86%	9.35%	10.14%	9.93%	10.34%	7.28%	5.22%	↓	↑
W	Medical Vacancy	WTE	-	25.59	40.26	40.74	38.33	39.16	59.19	47.86	67.29	74.56	73.05	76.03	53.43	38.22		
W	STT/AHP Vacancy	%	7.00%	7.57%	6.89%	6.09%	6.54%	6.97%	6.29%	7.66%	11.10%	12.48%	12.69%	13.04%	13.04%	10.41%	↓	↑
W	STT/AHP Vacancy	WTE	-	62.72	57.10	50.49	54.28	57.85	51.64	63.84	94.86	107.82	110.17	113.09	112.95	90.28		
W	SMA Vacancy	%	7.00%	8.68%	8.21%	7.55%	7.88%	10.97%	7.96%	6.37%	10.62%	10.60%	9.01%	8.71%	7.13%	7.12%	↓	↓
W	SMA Vacancy	WTE	-	99.06	93.76	86.27	90.27	125.68	88.66	70.50	121.73	123.41	104.33	100.98	82.48	82.40		
W	Recruitment Time to Hire - Trust Sub	Days	46.00	74.70	63.70	74.30	72.30	91.30	50.90	54.50	52.90	50.60	47.60	49.10	45.00	41.70	↓	↓
W	Recruitment Time to Hire - Trust Bank	Days	46.00	0.00	0.00	0.00	0.00	0.00	117.90	127.80	118.00	58.50	26.90	50.40	46.00	43.50	↓	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,204.80	5,226.19	5,248.35	5,289.43	5,289.16	5,236.02	5,224.47	5,337.41	5,434.85	5,433.60	5,433.60	5,382.13	5,381.76		
W	Budgeted vs Worked WTE Variance	WTE	-	121.30	71.71	184.20	87.52	51.09	109.88	237.86	31.62	45.85	51.23	4.21	131.68	70.68		
W	Actual Worked vs Budgeted %	%	-	2.33%	1.37%	3.51%	1.65%	0.97%	2.10%	4.55%	0.59%	0.84%	0.94%	0.08%	2.45%	1.31%		
W	Total Workforce Cost £	£	-	£27.41M	£23.43M	£24.05M	£23.64M	£22.93M	£24.66M	£23.73M	£23.85M	£23.98M	£25.73M	£24.82M	£24.44M	£26.42M		
W	Agency Spend as % of Total Spend	%	4.50%	5.65%	6.53%	6.17%	5.97%	5.60%	4.98%	5.35%	3.41%	5.55%	3.41%	4.18%	2.62%	3.11%	↑	↓
W	Agency Spend £	£	-	£1.55M	£1.53M	£1.48M	£1.41M	£1.28M	£1.23M	£1.27M	£0.81M	£1.33M	£0.88M	£1.04M	£0.64M	£0.82M		
W	Agency Target £	£		-	-	-	-	-	-	-	£1.21M	£1.04M	£0.88M	£0.76M	£1.06M	£1.17M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-	-	-	-	-	-	-	-£0.40M	£0.29M	£0.00M	£0.28M	-£0.42M	-£0.35M	↑	↓
W	Agency WTE	WTE	-	137.51	127.69	113.12	109.26	102.88	90.00	106.82	90.76	105.02	96.40	94.71	78.85	74.91		
W	Bank WTE	WTE	-	285.71	258.31	354.47	278.67	310.93	323.25	377.11	303.84	351.68	355.36	303.23	347.55	235.16		
W	Registered Nursing Bank Fill	%	45.00%	46.59%	48.32%	53.80%	43.60%	52.86%	55.30%	54.71%	57.70%	57.91%	54.99%	54.47%	53.30%	54.80%	↑	↑
W	Unregistered Nursing Bank Fill	%	70.00%	72.94%	66.26%	70.85%	62.98%	74.32%	71.78%	77.63%	83.58%	81.52%	80.82%	79.98%	77.52%	81.35%	↑	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Trend Vs Last Month	Trend Vs Sep-22
	Retention																	
W	All Turnover %	%	13.00%	14.87%	14.69%	14.52%	14.90%	14.84%	14.42%	14.48%	13.79%	13.88%	13.27%	12.74%	12.69%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	12.00%	11.78%	11.54%	11.84%	11.57%	11.25%	11.16%	10.54%	10.52%	10.17%	9.67%	9.62%	-	↓	↓
W	Number of Leavers	Headcount	-	65	57	54	69	74	43	79	33	62	52	53	47	-		
W	Number of RN Leavers	Headcount	-	15.00	8.00	6.00	14.00	16.00	8.00	17.00	7.00	15.00	16.00	12.00	14.00	-		
W	Registered Nursing Vol Turnover	%	-	10.02%	9.61%	8.92%	8.79%	8.58%	7.99%	7.83%	7.05%	6.82%	6.82%	6.59%	6.66%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	16.00	17.00	17.00	19.00	15.00	12.00	12.00	8.00	12.00	10.00	7.00	12.00	-		
W	Unregistered Nursing Vol Turnover	%	-	15.29%	15.72%	15.62%	16.37%	16.73%	16.57%	15.95%	15.46%	15.17%	13.99%	13.02%	12.83%	-		
W	Leavers within 1st Year of Employment	%	-	20.00%	28.07%	29.63%	21.74%	24.32%	30.23%	24.05%	36.36%	29.03%	25.00%	33.96%	27.66%	-		
W	Number of starters	Headcount	-	103	103	84	56	107	72	77	75	66	64	107	59	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	4.75%	4.95%	4.93%	5.11%	5.07%	5.00%	4.95%	4.83%	4.71%	4.62%	4.61%	4.55%	-	↓	↓
D	Sickness Absence %	%	3.50%	4.77%	5.34%	4.87%	5.79%	4.90%	4.53%	4.63%	3.85%	3.68%	3.77%	4.42%	4.03%	-	↓	↓
W	Long Term Sickness %	%	2.00%	2.52%	2.36%	2.36%	2.50%	2.52%	2.24%	2.27%	2.13%	2.06%	2.15%	2.61%	1.91%	-	↓	↓
W	Short Term Sickness %	%	1.50%	2.24%	2.99%	2.51%	3.29%	2.38%	2.29%	2.36%	1.72%	1.61%	1.61%	1.81%	2.12%	-	↑	↓
W	Sickness Absence Cost £	£	-	£638.9k	£767.6k	£650.4k	£749.9k	£687.4k	£575.4k	£675.3k	£546.9k	£574.4k	£550.4k	£664.8k	£626.3k	-		
W	WTE Days Lost	WTE	-	6,780.7	7,952.9	7,096.4	8,768.5	7,364.2	6,109.2	6,960.2	5,648.5	5,612.7	5,568.9	6,781.2	6,256.4	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	87.22%	85.79%	86.39%	86.40%	86.61%	86.79%	87.69%	89.20%	90.27%	89.81%	89.90%	90.10%	90.36%	↑	↑
W	Role Essential MT %	%	85.00%	89.28%	87.99%	88.75%	88.94%	89.06%	89.03%	89.66%	90.92%	91.59%	91.37%	91.40%	91.64%	91.93%	↑	↑
W	CQC Safe MT %	%	85.00%	85.22%	83.65%	84.10%	83.93%	84.18%	84.54%	85.71%	87.48%	88.95%	88.25%	88.38%	88.56%	88.78%	↑	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	-	-	-	-	-	-	-	59.32%	64.39%	73.18%	76.28%	79.91%	-		
W	Appraisal Compliance %	%	85.00%	75.04%	76.32%	79.31%	81.43%	81.16%	83.33%	82.25%	83.11%	82.18%	83.86%	83.94%	84.29%	84.88%	↑	↑
W	Non Medical Appraisal Compliance %	%	85.00%	78.03%	77.94%	78.88%	81.08%	80.60%	82.33%	80.68%	82.46%	81.38%	82.76%	83.29%	84.24%	84.89%	↑	↑
W	Medical Appraisal Compliance %	%	85.00%	53.44%	64.63%	82.84%	84.13%	85.44%	91.07%	93.90%	87.90%	88.00%	91.81%	88.64%	84.64%	84.84%	↑	↑
	Demographics																	
W	Staff in Leadership Roles %	%	-	3.24%	3.32%	3.21%	3.17%	3.20%	3.26%	3.26%	3.44%	3.45%	3.43%	0.93%	0.93%	0.92%		
W	Staff in Leadership Roles WTE	WTE	-	194.00	199.00	194.00	193.00	192.00	196.00	197.00	207.00	210.00	209.00	57.00	57.00	57.00		
W	% of Leadership Roles who are Female	%	-	66.49%	67.34%	68.04%	67.88%	68.23%	68.37%	67.51%	68.12%	68.57%	67.46%	56.14%	56.14%	56.14%		
W	% of Leadership Roles who from BME	%	-	6.19%	6.53%	5.67%	5.70%	6.77%	6.63%	6.60%	6.28%	6.67%	6.70%	5.26%	5.26%	5.26%		
W	Male % of Workforce	%	-	17.62%	17.45%	17.36%	17.38%	17.55%	17.50%	17.71%	17.63%	17.75%	17.83%	17.90%	18.10%	18.16%		
W	Female % of Workforce	%	-	82.38%	82.55%	82.64%	82.62%	82.45%	82.50%	82.29%	82.37%	82.25%	82.17%	82.10%	81.90%	81.84%		
W	BME % of Workforce	%	-	21.24%	21.48%	21.83%	21.94%	22.54%	22.75%	23.24%	23.60%	24.22%	24.19%	24.49%	25.06%	25.18%		
W	White % of Workforce	%	-	69.71%	69.60%	69.33%	69.16%	68.74%	68.71%	68.25%	68.07%	67.43%	67.29%	67.08%	67.03%	66.86%		

Our People

NHS Great Western Hospitals NHS Foundation Trust

Workforce Scorecard - Workforce Planning

		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Establishment	*Plan*	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46
	Actual	**5337.41**	**5434.85**	**5433.60**	**5433.60**	**5382.13**	**5381.76**						
	Variance	-54.05	43.39	42.14	42.14	-9.33	-9.70						
Contract	*Plan*	4917.66	4942.06	4958.27	4973.06	4996.74	5018.76	5041.25	5057.46	5066.09	5064.08	5064.98	5067.30
	Actual	**4935.83**	**4996.96**	**5002.31**	**5009.92**	**5061.69**	**5119.43**						
	Variance	18.17	54.90	44.04	36.86	64.95	100.68						
Bank	*Plan*	271.91	322.50	262.43	246.62	240.30	300.37	303.53	262.43	278.24	208.68	227.65	237.13
	Actual	**303.84**	**351.68**	**355.36**	**303.23**	**347.55**	**235.16**						
	Variance	31.93	29.18	92.93	56.61	107.25	-65.21						
Agency	*Plan*	104.12	123.49	100.49	94.43	92.01	115.01	116.23	100.49	106.54	79.90	87.17	90.80
	Actual	**90.76**	**105.02**	**96.40**	**94.71**	**78.85**	**74.91**						
	Variance	-13.36	-18.47	-4.09	0.28	-13.16	-40.10						
Actual vs Establishment	*Establishment*	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46
	Actual	**5330.43**	**5453.66**	**5454.07**	**5407.86**	**5488.09**	**5429.50**						
	Variance	-61.03	62.20	62.61	16.40	96.63	38.04						

Key

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

Performance & Counter Measure

- Establishment WTE has reduced marginally in M06 by 0.4TE following skill-mix reviews across Medicine and budget realignment in Anaesthetics, and remains below our control total (5,441WTE) and in line with our 2023/24 operational planning submission.
- Further improvement to our contracted WTE position (+58WTE) has been seen in M06, however a corresponding decrease in temporary staff has not been achieved in-month. As a result, total workforce usage remains above our establishment WTE by +38WTE in September.
- In-month bank and agency usage has reduced again in September, with agency reporting -40WTE under planned usage levels and bank -65WTE. Whilst this is a promising reduction, overall temporary staffing usage remains out of sync with the improved contractual position and is therefore driving usage above establishment and our YTD overspend.

Risks & Mitigations

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

Appendices

Explaining the IPR

Improving together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

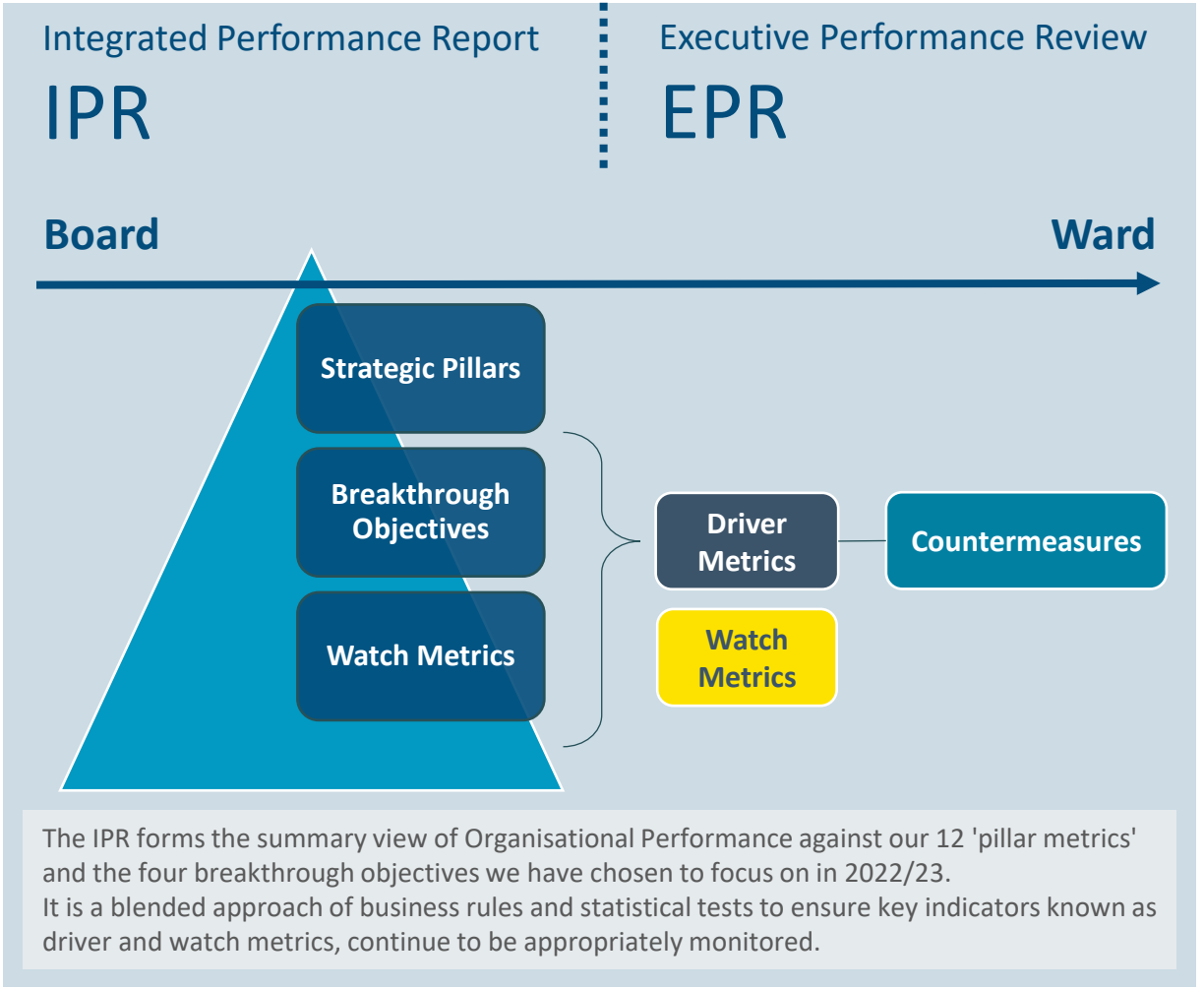
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

NHS
Great Western Hospitals
NHS Foundation Trust

Our Vision

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

Our four strategic pillars

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

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

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

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

Strategic Planning Framework

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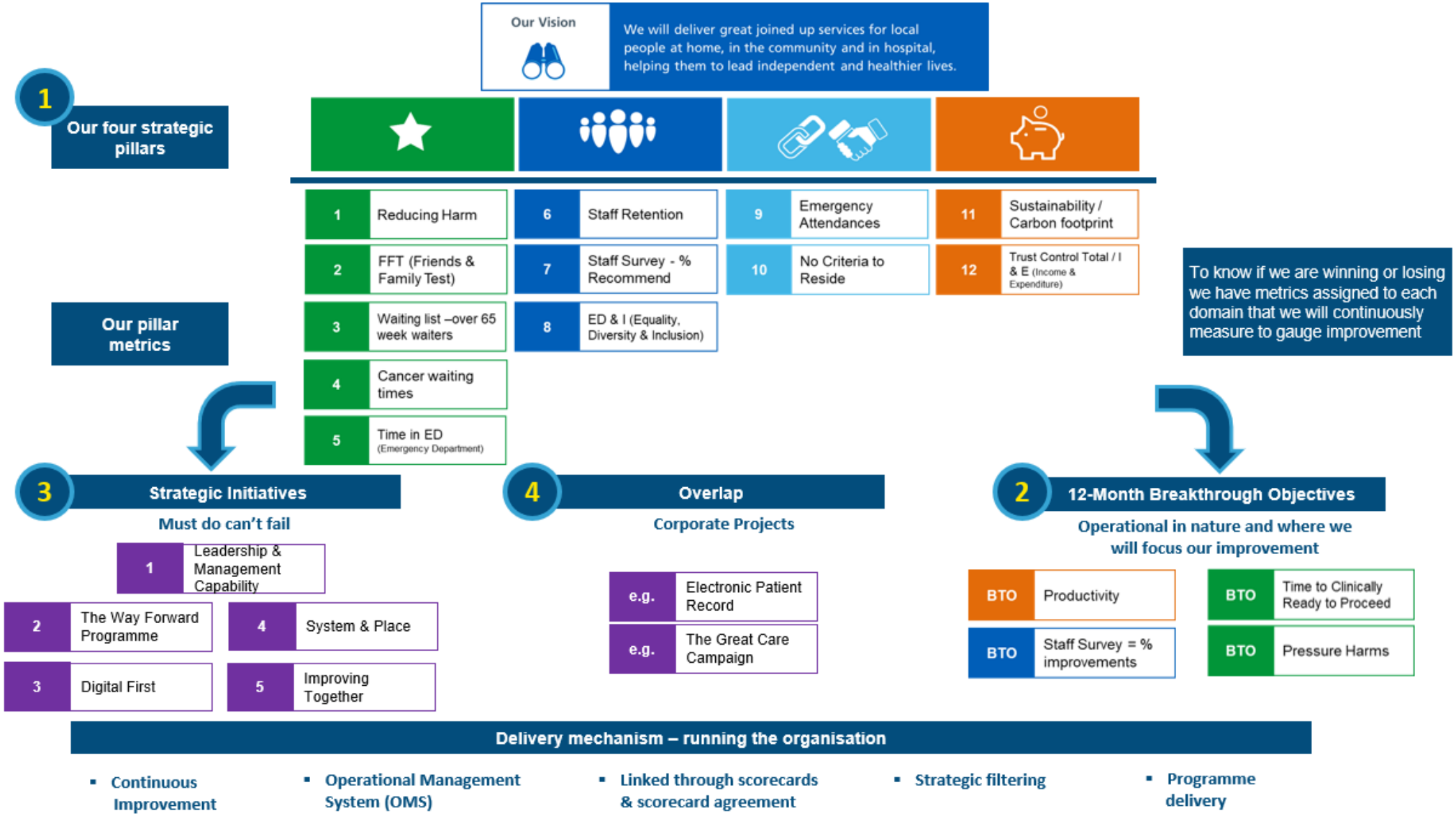
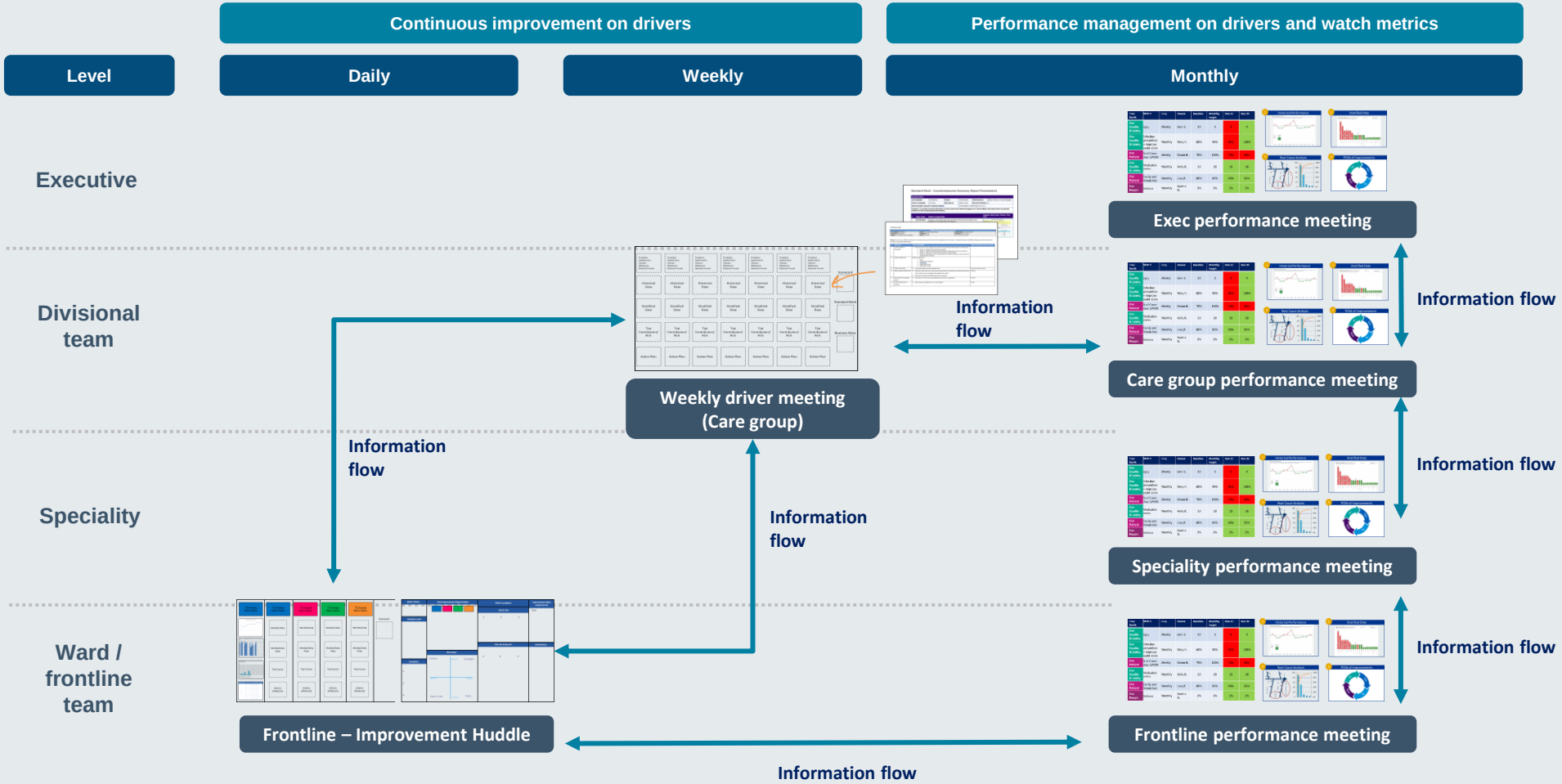


Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Building a culture of continuous improvement

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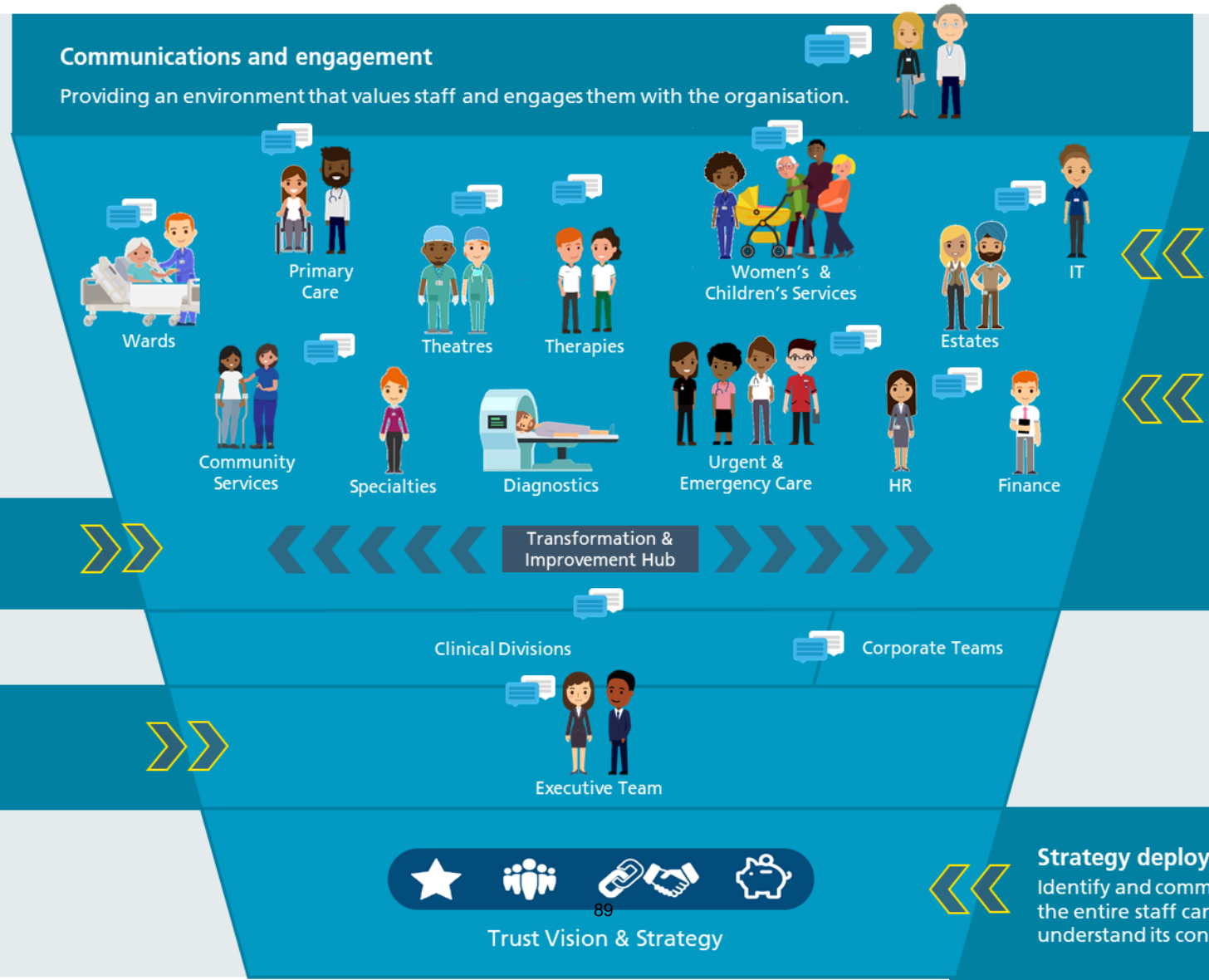


Transformation & Improvement Hub
Develop an internal capability to develop and sustain improvement journey.

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

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

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

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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

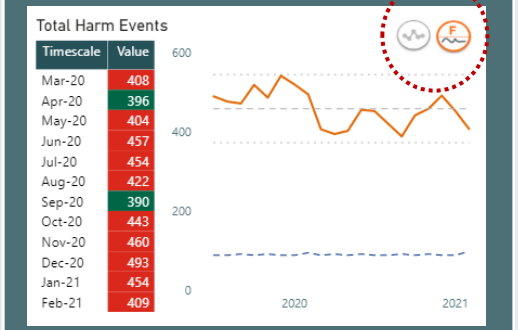
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

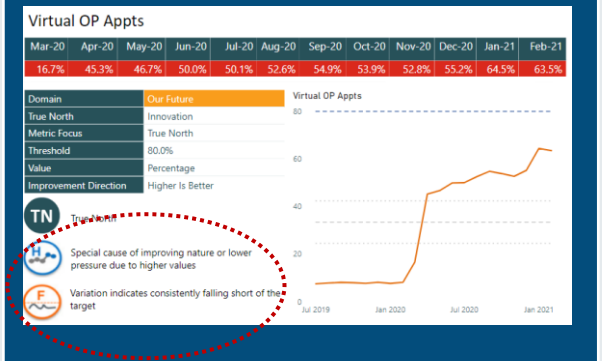
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

		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

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Board Committee Assurance Report

Audit, Risk and Assurance Committee – 14 September 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Helen Spice	Helen Spice		14 September 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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

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

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Divisional Risk Review – Division of Medicine	**A**	**A**	The Division of Medicine updated the Committee on their processes to manage risk and their actions to mitigate the risks. The Committee recognised the extensive work that has been undertaken and the improvements in processes. It was also noted that as at the date of the meeting there were no overdue actions or risk reviews. However there are some extreme risks in the division and there are still more actions required to achieve further improvement and maintain control		Nex review
Board Assurance Framework	**N/A**	**G**	The Committee received an update on the Board Assurance Framework and process that has been followed by Committees. The Committee recognised that this is now a well-established process, that is operating effectively as defined. The sub committees value the process and the introduction of the end of meeting reflection has increased its effectiveness. It was also noted that the BAF will be reviewed as part of the Aqua review and the internal audit later in the year.		January 2024

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Risk Register Report	**A**	**A**	The Committee received a report on the trust risk management process, high risks and performance against the risk indicators. The Committee continues to be assured that the processes for managing risk in the trust are effective. However, there has been an increase in the number of risks, so the Committee requested an overview of the full governance map for the next meeting to continue to get assurance that the process is effectively managed overall at Executive level. In addition, the Committee requested consideration of considering interim steps of movement towards the target score and expected date of risk reduction.		November 2023
Cyber Security Annual Report	**R**	**A**	The Committee received the Cyber Security Annual Report. The Committee were pleased to note that in the period there has been no cyber-attacks and the Trusts systems have not been penetrated. External review also place the Trust as medium rated for security. However, the Committee were not assured that there is an appropriate response framework in place to respond to an incident if it arises and thus the red rating for risk.		November 2023
Audit Action Update – Data Warehouse & Data Quality	**N/A**	**N/A**	The Data Quality lead was asked to attend the Committee to report back on the reasons for the delays to close the actions from the internal audit undertaken in 2020. The main issues are now resolved, and the Committee were assured that the importance of resolving issues in a timely manner was recognised.		
External Audit Progress Report	**N/A**	**N/A**	The Committee were advised that all the submissions have now been completed for the external audit for 2022/23. The audit for the charity is about to commence.		
Internal Audit Progress Report and Action Tracking	**A**	**G**	The Committee were assured that there has been good progress in completing outstanding actions and the report to the Committee – subject to the comments on Data Warehouse and Data Quality. The Committee were assured on the progress to date and that reviews are being scheduled to ensure that all will be completed by year end. The internal auditors were comfortable that they will be able to provide annual assurance despite the reviews starting later in the year.		
Internal Audit Plan 2023/24	**N/A**	**N/A**	The Committee approved the internal audit plan for 2023/24 subject to ensuring that there is flexibility in the plan if alternative reviews are required. On that basis the Committee asked management to consider a potential future internal review of incident response, specifically including cyber security for the future based on the comments on cyber above.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			The Committee valued the one-page overview of the five-year plan for internal audit and requested that management review all the identified risks to provide assurance that each item is covered by the appropriate management processes as a first line of defence.		
Counter Fraud Progress Report	**A**	**G**	The Committee received a report on the current work being undertaken by counter fraud. There have been 11 cases notified so far this year, of which 8 are closed. This is higher than for the whole of last year, but it is recognised that there has been extensive engagement with a number of areas of the trust in the introduction of the new counter fraud team. The LCFS recognised the responsiveness of the trust in dealing with matters as they arise.		
Counter Fraud Plan 2023/24	**N/A**	**N/A**	The Committee approved the counter fraud plan for 2023/24. As per the comment above on internal audit the Committee requested confirmation that management processes are in place for each element of the counter fraud plan as a first line of defence.		
National Cost Collection 2022/23	**N/A**	**N/A**	The Committee approved the process and timetable for completion of the national cost collection for 2022/23. It was noted that there has not been a detailed independent review by NHSE of our submission for some time. The Committee felt that this would be helpful to ensure that when we use the data from NHSE for all trusts that we can be assured that the comparatives are correct and relevant.		
Single Tender Actions	**A**	**G**	The Committee received a report on the number of waivers carried out between 1 December 2022 and 31 May 2023. The Committee recognised that there is a good process in place with appropriate escalations to Executive. The Committee accepts that there are likely to be waivers around the Trust year end but felt that the number of waivers outside this period are still too high.		
NHSCFA Procurement Report Actions	**A**	**A**	The Committee received an update on the actions being taken on the Trust's progress with responding to the findings from the national review on Purchase Order versus non Purchase Order spend. The Committee were pleased with the progress being made. However, there was some concern on the timeline as the final policy is not yet approved and rolled out and the actions are not yet complete so the committee asked for a report back in January 2024. The Committee noted that the process for roll-out will build on the lessons learned from the recent RUH process.		January 2024

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Losses and Compensations Q4 2022/23	**N/A**	**N/A**	The committee noted the Losses and Compensations report for Q1 2023/24.		
NHS England Code of Governance	**N/A**	**N/A**	The Committee received an interim review of the Trust's compliance with the governance requirements as set out in new NHS England's Code of Governance for NHS Provider, in place from 1 April 2023. The Committee were assured on the process that is being followed ahead of the formal review later in the year and requested an assessment at that stage of the strength of our compliance and how it could be improved.		
Documents Signed under Trust Seal	**N/A**	**N/A**	The Committee noted the documents signed under trust seal in the last quarter.		

Issues Referred to another Committee	
Topic	**Committee**
Management of High Risks	ARAC has oversight for risk management process but would like assurance to ensure that each individual risk is being overseen by the appropriate and relevant committee/committees.

Board Committee Assurance Report

Committee	**Mental Health Governance Committee**
Meeting Date	20 October 2023
Committee Chair	Lizzie Abderrahim, Non-Executive Director
Link to Strategic Objective	Pillar 1- Outstanding Patient Care & Pillar 3 – Joining Up Acute and Community Services in Swindon
Link to Board Assurance Framework	BAF 1: SR 1 – Quality / SR6 – Partnership Working

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Use of the Mental Health Act	Substantial	x
2. Mental Capacity Act Practice	Good	x
3. Use of the Deprivation of Liberty Safeguards	Good	x
4. Mental Health Governance Workplan	Substantial	x
5. Risk Report	Substantial	x
6. Emergency Department - Quarterly Report	Good	**x**
7. Right Care, Right Time – National Partnership Agreement	Limited	**x**
8. Children's Services – Quarterly Report	Good	**x**

POINTS OF ESCALATION	
KEY AREAS TO NOTE	**Mental Capacity Act [MCA] Practice:** Work on the development of the MCA / BI process for SystemOne was noted. This had involved a review and revision of MCA documentation to ensure that it aligned with case law and was further progress addressing CQC concerns about documentation.
	Deprivation of Liberty Safeguards: Ongoing work to ensure that the right processes were in place in relation to locked ward doors was noted. This would ensure that those whose liberty was not restricted were not restrained by the operation of a locked door.
	Mental Health Governance Workplan: There was ongoing concern that the Change Grow Live [CGL] Substance Misuse Service would not be fully functioning until such time as CGL was able to recruit an onsite Coordinator. Mitigations were put in place in April 2023, when CGL took over the service from Avon and Wiltshire Partnership Trust [AWP], and these continue.
	Emergency Department: Robust monitoring of all mental health stays in ED observation had been established and, whilst the position in relation to these stays was not worsening, in Q1 there had been three patients with long stays [one of five days and two of four days]. In relation to these patients delays were associated with the lack of acute mental health beds, in AWP being able to provide a mental health assessment and a mental health plan within the PLAN V7 timescales. Throughout their stay these patients were supported by RMNs with associated agency costs of these needing to be met.
	Right Care, Right Person [RCRP]: RCRP is a national framework that will set out how the police and health services will respond to individuals with mental health needs. The impact of the police response to these individuals on BSW health services in general and on GWH in particular was unclear at this stage although it was understood that the police would be adopting a phased approach to implementation and it was clear that partnership working would be an imperative. GWH had therefore taken action to ensure that GWH is appropriately represented at regional implementation groups and a review of GWH's approach to missing ["absconding"] patients was to take place.
	Children's Services - HSIB report: This recognised the significant risks to the safety and wellbeing of children and young people exhibiting high risk behaviours whilst being cared for on paediatric wards and that such high-risk behaviours created a further risk to other patients and to staff. At GWH, to address those risks, a range of mitigating actions were being deployed and the development of a "safe room" was being actively pursued using an investment of £280k [during 2024/25] that had been identified to improve the environments for children admitted to the children's emergency unit and the children's ward.
	Children's Services – Mental Health Admissions and Length of Stay: Robust monitoring of admissions and length of stay was taking place and long stays awaiting specialist Tier 4 beds continued to be reported with the longest stay being 59 days [and continuing] and involved detention under s3 of the Mental Health Act.
BOARD ASSURANCE FRAMEWORK & RISKS	No 15+ risks were reported. A review of mental health risks had been undertaken and the committee was assured that a robust approach was being taken, that the risk register accurately represented current mental health risks and that these risks were being managed in line with the risk management process.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	

REFERRALS TO OTHER BOARD COMMITTEES	

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

Report Title	**Saving Babies Lives v3 – GWH First Assessment (Oct 2023)**				
Meeting	**Trust Board**				
Date	2 November 2023	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek (Chief Nurse)				
Report Author	Lisa Marshall, Kat Simpson & Laura Little				
Appendices	None				

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

Assurance Level

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

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

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

Report

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

The Saving Babies' Lives Care Bundle' (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. Implementation of all six elements of the care bundle will reduce unwarranted variation of care across NHS England. CNST Year 5 requires two Local Maternity & Neonatal System (LMNS) assessment reviews to have taken place within the reporting period by January 2024. These assessment reviews provide a structured analysis of the Trust evidence using the national implementation tool.

Presentation of the first LMNS assessment of GWH evidence and current compliance percentages across all six elements of SBLv3. GWH are at risk of non-compliance with CNST Year 5 Safety Action 6.

An overview of improvement action plan for all six elements. An in-depth review of identified improvement actions and associated timeframes will be reviewed at the November Maternity & Neonatal Safety Champions meeting for discussion.

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)	ID: 610 & ID: 612				**Risk Score**
	There is a risk of fetal growth abnormalities not being diagnosed because of the inability to fully implement Saving Babies Lives Care Bundle Version 2 as mandated by the Maternity Incentive Scheme. Resulting in possible still born or poor outcome at birth				6
	There is a risk that GWH will fail to identify babies at risk in pregnancy because of inadequate ultrasound infrastructure in the Antenatal Clinic and Delivery Suite, resulting in poor patient outcomes and patient experience				6
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps					

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

Explanation of above analysis:

None of the six elements focus on historically under-represented groups and therefore is not directly referenced in the content. The perinatal team ensure that all improvement workstreams prioritise equality, diversity, and inclusion for all service users.

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **To note the GWH first assessment compliance rates and overview of identified improvement actions for Saving Babies Lives v3**

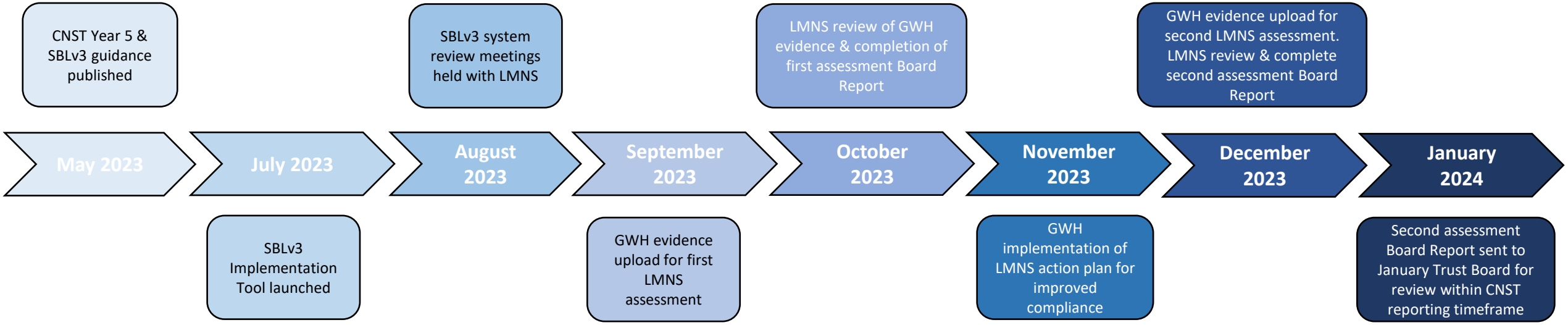
Accountable Lead Signature	
Date	26 October 2023

Saving Babies Lives version 3 (SBLv3)
GWH First Assessment (October 2023)

Lisa Marshall — Director of Midwifery and Neonatal Services
Kat Simpson — Head of Midwifery and Neonatal Services
Laura Little — Project Co-Ordinator for Maternity and Neonatal Services

Timeline & background of Saving Babies Lives v3 (SBLv3)

Great Western Hospitals NHS Foundation Trust



- The Saving Babies' Lives Care Bundle' (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality
- Implementation of all six elements of the care bundle will reduce unwarranted variation of care across NHS England
- The three year delivery plan for Maternity & Neonatal services requires full compliance with SBLv3 by March 2024
- CNST Year 5 requires two Local Maternity & Neonatal System (LMNS) assessment reviews to have taken place within the reporting period by January 2024
- These assessment reviews provide a structured analysis of the Trust evidence using the national implementation tool
- LMNS system data will be reported to Regional teams providing the opportunity for benchmarking at local and national level

Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Great Western Hospitals NHS Foundation Trust

Implementation Report

Trust	Great Western Hospitals NHS Foundation Trust
Date of Report	23 10 2023
ICB Accountable Officer	Gill May
Trust Accountable Officer	Lisa Marshall
LMNS Peer Assessor Names	Sandra Richards

Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

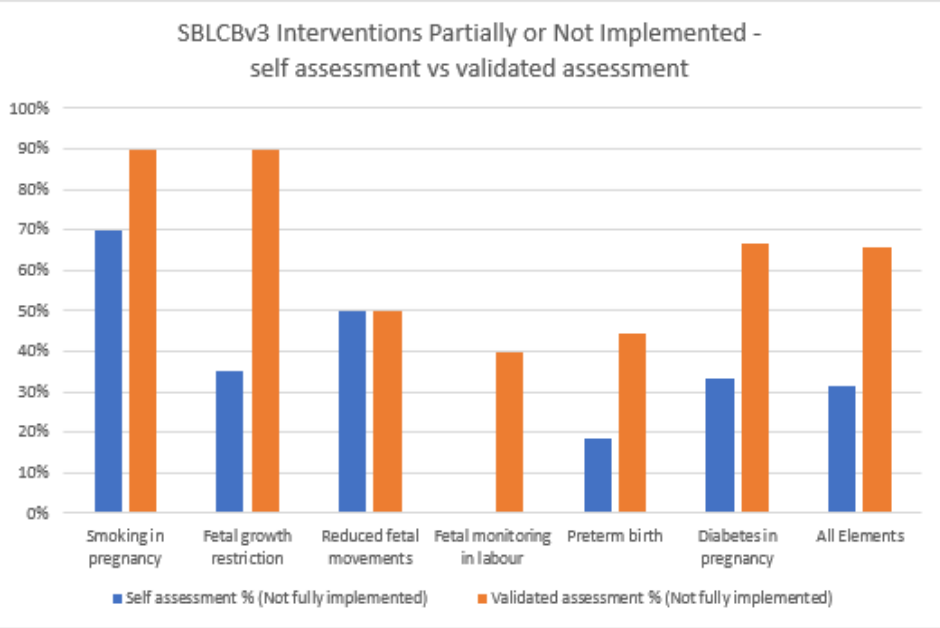
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

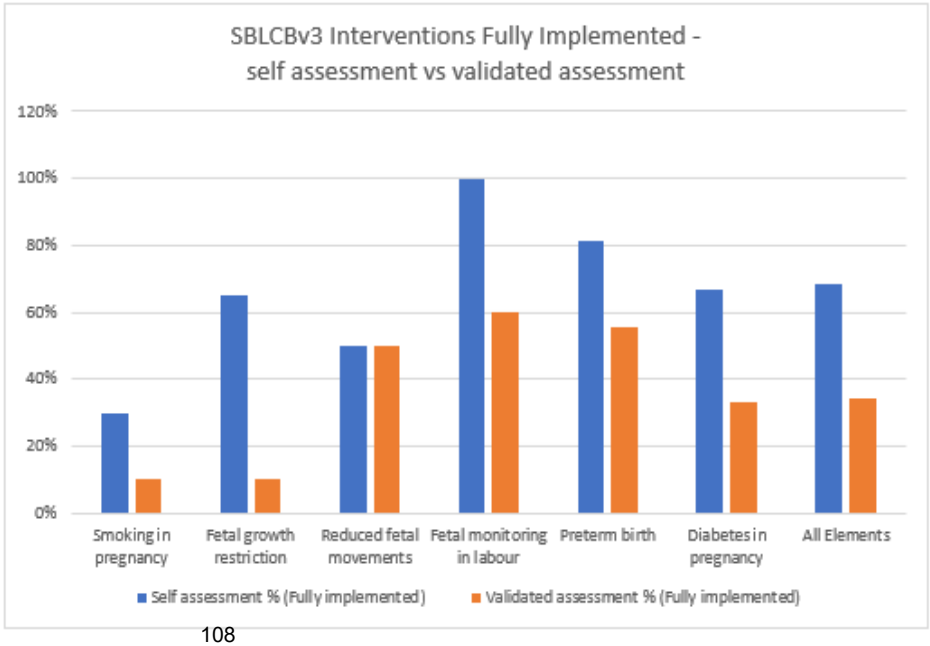
Board report template is automatically generated from national Implementation tool. Evidence is assessed by LMNS peer assessor.

A system wide approach has been adopted across BSW to ensure shared learning, a consistent approach to reporting and opportunities for collaborative working

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	30%	Partially implemented	10%
Element 2	Fetal growth restriction	Partially implemented	65%	Partially implemented	10%
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	60%
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	56%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	33%
All Elements	TOTAL	Partially implemented	69%	Partially implemented	34%





Great Western Hospitals NHS Foundation Trust

For compliance with CNST Safety Action 6 providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% in each individual element.

GWH are at risk of non-compliance with CNST Year 5 Safety Action 6

An in-depth review of identified improvement actions and associated timeframes will be reviewed at the November Maternity & Neonatal Safety Champions meeting for discussion

Overview of Improvement Action Plan

Great Western Hospitals NHS Foundation Trust

Element	Summary of Improvement Actions
Element One. Reducing Smoking in Pregnancy	• Development of a local Smoking Cessation Standing Operation Procedure (SOP) to encompass all ongoing practices & Public Health strategies • Utilising Public Health reporting databases to inform compliance audit and identify any specific areas of improvement
Element Two. Fetal Growth Restriction	• Redefining the local guidance in line with national pathways and assessing impact on supporting infrastructure • Implementation of full audit programme to support compliance with amended local SOP • Review financial impact of updating available equipment for digital blood pressure monitoring in line with evidence based practice • Implementation of improved digital risk assessment tool in line with Maternity digital strategy
Element Three. Reduced Fetal Movement	• Redefining the local guidance in line with national pathways and assessing impact on supporting infrastructure • Implementation of full audit programme to support compliance with amended local SOP
Element Four. Effective Fetal Monitoring	• Redefining the local guidance in line with national pathways and assessing impact on supporting infrastructure • Implementation of full audit programme to support compliance with amended local SOP
Element Five. Reducing Preterm Birth	• Review of specific job descriptions through the workforce planning process to include details of Pre-term Birth lead roles • Redefining the local guidance in line with national pathways • Implementation of full audit programme to support compliance with amended local SOP • LMNS & Regional agreement to be evidenced of local pathway for digital tool evaluation of women presenting in pre-term labour
Element Six. Management of Diabetes	• Redefining the local guidance in line with national pathways • Implementation of full audit programme to support compliance with amended local SOP

Saving Babies Lives v3 (2023)

NHS
Great Western Hospitals
NHS Foundation Trust

Driving quality improvement to reduce perinatal mortality

Report Title	**Ockenden Report – GWH Update**				
Meeting	**Trust Board**				
Date	2 November 2023	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek (Chief Nurse)				
Report Author	Kat Simpson & Laura Little				
Appendices	None				

Purpose

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

Assurance Level

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

Substantial		**Good**	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 progress update on the Immediate & Essential Actions (IEAs) outlined in the full Ockenden Report including key highlights for celebration and ongoing improvement 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)	ID: 572 There is a risk that mothers and babies are at risk of potential harm in the event of not achieving all 15 immediate and essential actions as outlined in the full Ockenden Report (published March 2022) Risk has been reviewed and is in date.				**Risk Score** 9
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					

Next Steps	

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

Explanation of above analysis:

None of the Immediate and Essential Actions (IEAs) focus on historically under-represented groups and therefore is not directly referenced in the content. The perinatal team ensure that all improvement workstreams prioritise equality, diversity, and inclusion for all service users.

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **Understand the progress against the Immediate and Essential Actions and their impact on the development of the perinatal strategy for access to safe maternity care**

Accountable Lead Signature	
Date	26 October 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Ockenden Report – GWH Update (November 2023)

Lisa Marshall	Director of Midwifery and Neonatal Services
Kat Simpson	Head of Midwifery and Neonatal Services
Laura Little	Project Co-Ordinator for Maternity and Neonatal Services

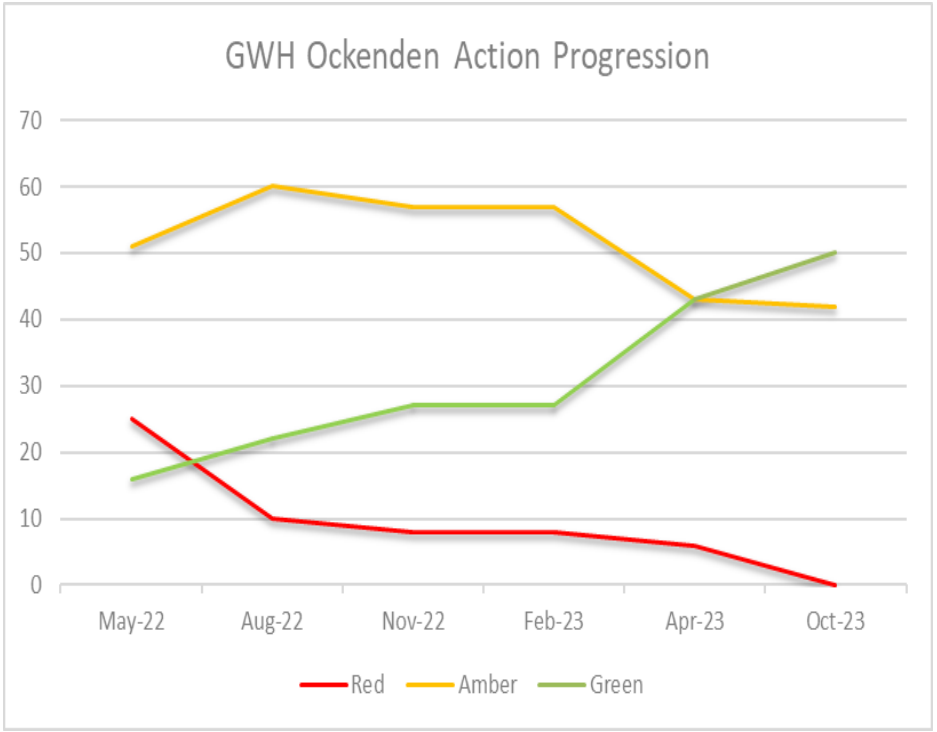
Ockenden Report & GWH Progress Summary

Great Western Hospitals NHS Foundation Trust

Key Highlights for Celebration:

- Remaining 'red' actions converted to amber with improvement action plans identified
- Significant increase in 'green' Immediate and Essential actions following a deep dive into the 'amber' actions
- Improved access to education opportunities with GWH attending MOMUS training in clinical human factors with HEE funding
- Maternity succession planning strategy underway
- Reliable processes implemented to successfully react to national funding opportunities
- Robust preceptorship programme for newly qualified midwives implemented
- Risk assessment and escalation protocol reviewed for periods of competing workloads
- Ockenden funding secured for additional PA assigned to Obstetrics Audit & Guidelines lead.
- Mandatory input for both Midwifery & Obstetrics team for audits
- Monthly pre-conception clinic established with supporting Standing Operating Procedure
- Continued focus on informed decision making & risk assessment of women
- Well established anaesthetic documentation implemented that records all appropriate patient data which has been rigorously reviewed regionally and nationally
- Consistent neonatal presence at all NET calls and established process of Neonatal Team Coordinator accessing DECT phone.

	RED	AMBER	GREEN
May 2022	25	51	16
Nov 2022	8	57	27
April 2023	6	43	43
Oct 2023	0 ↓	42 ↓	50 ↑



GWH Ockenden Report Ongoing Improvement Actions

Great Western Hospitals NHS Foundation Trust

IEA				Ongoing Improvement Actions
1	0	7	4	• Continued engagement with national bodies for acuity tool review • Engagement with workforce planning across Local Maternity & Neonatal System (LMNS) • Development of in-house training provision for High Dependency maternity care • Publish Maternity Succession Planning strategy
2	0	6	4	• Continued review of Obstetric and Gynaecology workforce in line with RCOG guidance • Bi-directional pathways to be formally audited to provide assurance of communication between community and hospital based settings
3	0	2	3	• Review and improvement planning for Obstetric and Gynaecology workforce with consideration of Ockenden requirements
4	0	2	5	• Embedding PSIRF framework into Maternity with supporting education provision • Comprehensive review of ongoing improvement actions against the Self Assessment criteria for National Patient Safety tool
5	0	3	4	• Implementation of quarterly triangulation of complaints, incidents and Trust Claims scorecard process • Continued engagement with Maternity & Neonatal Voice Partnership (MNVP) to ensure complaint responses meet the Ockenden criteria • Embedding assurance process for local action plans from serious incidents meet Ockenden criteria for completion within six months
6	0	0	3	• No continued improvement actions identified
7	0	1	6	• Continued roll-out of multi disciplinary training as per the updated requirements of Core Competency Framework v2

IEA				Ongoing Improvement Actions
8	0	3	2	• Ratification of local audit program with associated improvement plans where indicated • Engagement with national agencies to understand the requirements for a specialist midwifery team for multifetal pregnancies
9	0	0	4	• No continued improvement actions identified
10	0	3	3	• Audit of newly introduced pathway for women birthing in the community to ensure practice and documentation embedded • Operational review of escalation policy for Induction of Labour pathway in progress
11	0	5	3	• Continued engagement with anaesthetic national bodies to understand next steps with implementation of Ockenden recommendations
12	0	3	1	• Implementation of improvement actions identified for consultant review of post-natal readmissions
13	0	1	3	• Enhanced training and education for midwives undertaking post-mortem consent supported by an Ockenden funded bereavement role
14	0	3	5	• Continued engagement with out Operation Delivery Network for Neonatal Care (ODN) to promote access to shared learning and experiences. • Development of a model for rotation with the ODN • Business planning cycle for Paediatric & Neonatal workforce
15	0	3	0	• Embedding practice of the OCEANS psychological support service • Delivery of specialist training sessions throughout the three year education programme

Ockenden Report (2022)

NHS
Great Western Hospitals
NHS Foundation Trust

Enabling safer maternity care

Report Title	**Equality Diversity Inclusion Annual Report 2022-2023**				
Meeting	**Trust Board**				
Date	**2 November 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jude Gray – Chief People Officer, GWH				
Report Author	Sharon Woma, EDI Lead				
Appendices	EDI Annual Report 2022-23				

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

Assurance Level

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

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

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

N/A

Report

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

The EDI annual report highlights a range of initiatives we have undertaken to improve access to services and patient experience; diversify our listening to local communities and our workforce; develop an inclusive leadership mindset and create an inclusive working environment for our staff.

These initiatives align with the Trust's EDI strategic objectives: -

- Inclusive and compassionate leadership
- Representative and supported workforce
- Support our patients and communities to achieve better life outcomes
- Let every voice be heard

The report also includes a demographic profile of our patients and workforce, and an outline of our performance against key EDI frameworks (WRES, WDES, GPG, EDS).

Notably, the Improving Together methodology has been implemented in the EDI work and the Restorative Just & Learning Culture and the recently published Leadership Behaviours

will provide further opportunities to support the EDI agenda by influencing organisational behaviour.

By publishing our EDI-related reports each year, the Trust is able to demonstrate how it meets the Public Sector Equality Duty (Equality Act 2010) and provide assurance to our stakeholders that we are taking positive action to drive change.

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	Trust Management Committee People & Culture Committee EDI-HI Steering Group				
Next Steps	Report design and publish to Trust website				

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

There are two important legislations that provide a legal framework for the Trust, the Equality Act 2010 (Public Sector Equality Duty) General Duties that sets out a legal duty to have due regard to eliminate unlawful discrimination, advance equality for groups who do not fully participate in 'public life' and foster good relationships between people who hold one protected characteristic and another; the Specific Duty to publish equalities information and set objectives; and the Health & Social Care Act 2012, which directs us to take steps to reduce health inequalities. This report helps the Trust to demonstrate how we have met our statutory obligations.

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board to review and approve the report	
Accountable Lead Signature	Jude Gray, Chief People Officer
Date	27 October 2023

DRAFT

[The report layout will be designed following its first review]

Report Title: Equality Diversity Inclusion Annual Report: Improving Together

2022 – 2023

Accessibility Statement

If you require this document in an alternative language or format please contact the Trust's Equality Diversity Inclusion (EDI) Lead by telephone or email:

- Telephone: 01793 604020
- Email: sharon.woma@nhs.net [CHANGE TO INCLUSION]

If you have any comments, suggestions or feedback about this document, please contact the EDI Lead, using the above telephone number or email address.

Legal Statement

This document sets out how we have met the legal duties set out in the Equality Act 2010 and the Health & Social Care Act 2022 and our obligations set out in the NHS Standard Contract 22/23 Service Condition 13 (SC13) – Equity of Access, Equality and Non-Discrimination. The report outlines the work undertaken to meet our commitment to improve healthcare and health and wellbeing for all and reduce health inequalities for our patients, local population and workforce. We have also highlighted some of our broader equality, diversity and inclusion work that supports our objectives set out in the Trust's Equality, Diversity & Inclusion (EDI) Strategy 2020-24. The EDI strategy will be refreshed in 2023/24, taking into account NHS E EDI Improvement plan (6 High impact actions) and will be aligned with the aims of the new Trust strategy which will be published in the New Year.

We have fulfilled our statutory and mandatory reporting requirements (see section two) of this report including Equality Delivery System (EDS2022), the Gender Pay Gap 2021/22, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports 2022/23 and Accessible Information Standards.

Report Contributors

Kat Bailey, Training Systems and Compliance Manager
Tania Currie, Head Of Patient Experience and Engagement
Jacqueline Fawcett, Early Years Careers Advisor
Jon Freeman, Clinical Psychologist - Clinical Lead for Occupational Health & Wellbeing
Nicola Green, Head of Leadership, Succession Planning & Talent Management
Wendy Johnson, Associate Director of Safeguarding and Lead for Mental Health
Christopher Mattock, Chaplaincy Team Leader & FTSU Lead Guardian
Jade Pearce, Learning Disability Liaison Nurse
Katherine Simpson, Risk and Governance Lead Midwife
Claire Thompson, Director of Improvement and Partnership
Helen Winter, Head of Insights and Learning
Claire Warner, Deputy Chief People Officer
Candice Wood, Head of PALS and Complaints
Sharon Woma, Equality Diversity Inclusion (EDI) Lead

Contents

Message from Kevin McNamara, Chief Executive

This report sets out some of the progress we have made on equality, diversity and inclusion as an organisation this year.

There's lots we can be proud of, and one of my highlights of the year was in January when we welcomed our 400th internationally educated nurse to the organisation.

We also launched our Women's Network in March, strengthening our staff networks further, and more recently were awarded the Gold Award in the Ministry of Defence's Employer Recognition Scheme.

This is the highest standard in the scheme, and was given in recognition of our commitment and work to support staff and patients who are reservists and veterans, forces families and other local people who have links to the Armed Forces. It reflects our commitment to being a forces-friendly organisation.

We have seen the percentage of our workforce identifying as being from black minority ethnic backgrounds increase to 25%. While our Staff Survey results show that we are moving in the right direction, with improvements in many of the questions related to EDI, it is also clear that we still have work to do.

I was pleased to welcome Sharon Woma to the organisation as our EDI lead in January and under her leadership and guidance we will continue to implement our Equality, Diversity and Inclusion strategy in to our organisation and keep celebrating and championing diversity.

At Board level we are starting to be more representative of the communities we serve.

Our Board is committed to continuing to challenge all forms of discrimination, to act as allies, and to support our staff networks to develop as strong a voice as possible and we held a Board-level workshop looking at EDI this year to develop our capability and thinking in this space.

In Swindon we continue to work to fulfil our responsibilities as an anchor organisation, looking to work with others to provide opportunities for people to improve their health and life chances.

NHS Cadets is one of the initiatives we have been involved with – this is a new programme, aimed at young people aged 14 to 18, to provide opportunities for them to explore roles in healthcare. Cadets are able to learn about life in healthcare through first-hand experience and hearing from inspiring professional speakers. They are also taught first aid skills, such as resuscitation. We are proud to be supporting NHS Cadets, including through offering facilities on the Great Western Hospital site for training sessions and inviting staff from across the organisation to share information about their roles.

Another initiative is Project Search, a programme which aims to support young adults with learning disabilities to develop their employability skills, obtain hands-on experience in the workplace, and receive support with securing paid employment after the programme. I was really pleased to welcome the newest cohort of students from New College Swindon who will be gaining work experience by undertaking rotational placements with Serco.

Along with openness, wellbeing and leadership, inclusion is one of the fundamental strands of our journey to create a Just and Learning Culture.

Our leaders are integral to helping us do this, and this year we launched our 12 Leadership Behaviours, one of which is EDI. We ask our leaders to:

- promote and encourage a culture which supports equality, diversity and inclusion and an environment where everyone can thrive
- challenge discrimination whenever they see it and support others to do the same
- recognise their role in reducing health inequalities by making their contribution to the Trust as an anchor institution
- advocate for the provision of health services for all where nobody is marginalised, excluded or left behind.

There is much we can be proud of in this report but the challenge we face is a large one, with every step forward serving as a reminder of how much further we have to go.

Finally, this year, we celebrated the NHS' 75th birthday, and also the 75th anniversary of Windrush, and we saw the diversity of the NHS workforce really highlighted. This is something we should all be proud of.

EDI Annual Report Summary

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

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

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

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

The EDI Strategy sets our four objectives which has directed our work over the past four years. The objectives are:

Our EDI strategy will be refreshed in 2024 and we look forward to working with our staff and stakeholders to create an EDI strategy that responds to the needs of the population and workforce and one that aligns with the Trust's new organisation-wide strategy that will be published next year.

This report highlights a range of initiatives undertaken throughout the year April 2022 to March 2023 which responds to the EDI objectives, a few of these are highlighted in the table below and in the body of this report:

Objective	Initiative
Inclusive & Compassionate Leadership	• Launched the 'Our Great Way' working group to embed Restorative Just & Learning Culture in our hire and retention processes. • The Trust expanded access to the Scope for Growth Career Conversations to include Internationally Educated Nurses. Scope for Growth is an inclusive framework for supporting and developing talent across our organisation. • Board workshop in March 2023 on Leading for Inclusion and Restorative Just and Learning Culture. • Cultural Maturity Audit - The Trust was externally audited to evaluate its EDI performance. This has helped us to identify further opportunities to drive systemic change.
Represented & Supported Workforce	• Improvements made to the recruitment process to attract a more diverse pool of candidates. • Robust health and wellbeing programme made available for staff including support from Mental Health First Aiders and Wellbeing Champions. • Stay & Thrive conversations take place to support retention of our internationally educated nursing staff. • Appointment of International Medical Graduate Lead • Appointment of SAS advocate
Support our Patients and Communities to achieve better life outcomes	• Following last year's EDI First Impressions Challenge, several improvements have been made to address issues raised including improvements to signage and upgrade of hearing loops. There is an ongoing estates programme to improve accessibility. • The Trust has launched a supporting trans patients guide to guide staff in making informed decisions and hold sensitive conversations with our trans patients and staff training has been delivered in-house. • Trust is part of Harbour Project for refugees – this includes the provision of sexual health guidance, advice and support. • Launch of a Trust-wide Mental Capacity Act (MCA)competency programme for base wards • Completion of a 'Changing Places' adaptable bathroom in the Urgent Care Centre and the paediatric ward in July 2022.

	• Our volunteers have supported:
	  • Patients with 179 Outpatient Welcome Liaison Services (OWLS) appointments
	  • Pets as Therapy programme, which has 14 dogs and 6 miniature ponies who have visited 65 areas at the Trust
	  • Active Responder Programme – 130 volunteers, have attended 3241 shifts across the Hospital
	  • Tea trolley and book trolley services

Let every Voice be heard	• Staff Networks have engaged with staff across the year to raise awareness about the groups they represent and celebrated key calendar dates including Women's International Day and Black History Month, staff also launched a Women's Network in May 2023. Network chairs sit on the EDI strategic group and can influence the EDI agenda. • Increased engagement with seldom heard and minority communities. • Launched Carers Passport in May 2023 which is designed to support staff to recognise carers more quickly, allowing them to be involved in discussions about the patient's care where appropriate. • Launch of Oliver McGowan Training

These initiatives support the Trust to meet its Public Sector Equality Duty, set out in the Equality Act 2010 – to eliminate discrimination, advance equality and foster relationships between different groups of people.

The report also highlights some of the work that will be undertaken in 2023-2024 and the action plan in the appendix responds to the EDI performance frameworks that we use to measure how inclusive our organisation is and the impact of our initiatives over time. The EDI work will benefit from new ways of working, including Improving Together, a change management approach which is being rolled out across the Trust and implemented in our EDI work. We are delighted to align our work with national plans to improved diversity and inclusion and to address inequalities in our workforce, the NHS EDI Improvement plan alongside other frameworks like Core20 Plus5 will also influence our work over the coming years. These plans will strengthen our work across the system and provide further opportunities to collaborate with our partners in this region. We also acknowledge the changing profile of our local population and workforce and our plans must be supportive of this. We recognise, as our workforce and patient population age and we see some communities with increasing levels of co-morbidity, we will also see a rise in demand for services and greater need for health and wellbeing support for our staff.

We have made progress across the Workforce Disability Equality Standard, the Equality Delivery System 2022 and the Gender Pay Gap Reporting, and there is marked improvement in the Workforce Race Equality Standard, we believe a national and local drive to address racial inequity has supported this improvement and a similar focus could result in improvements in our metrics that measure disability inclusion.

We recognise progress is impossible without the support of our staff including our staff networks who play a vital role in influencing and engaging staff by raising awareness, challenging systems, policy, practice and behaviour and acting as a voice for the staff groups they represent. Staff involvement is critical to our success; therefore, we are also introducing new initiatives to empower our staff to get more involved in the EDI agenda and to develop a greater sense of agency and influence.

Finally, we hope our readers find this report informative and engaging and we extend an invitation to all stakeholders to engage with this agenda.

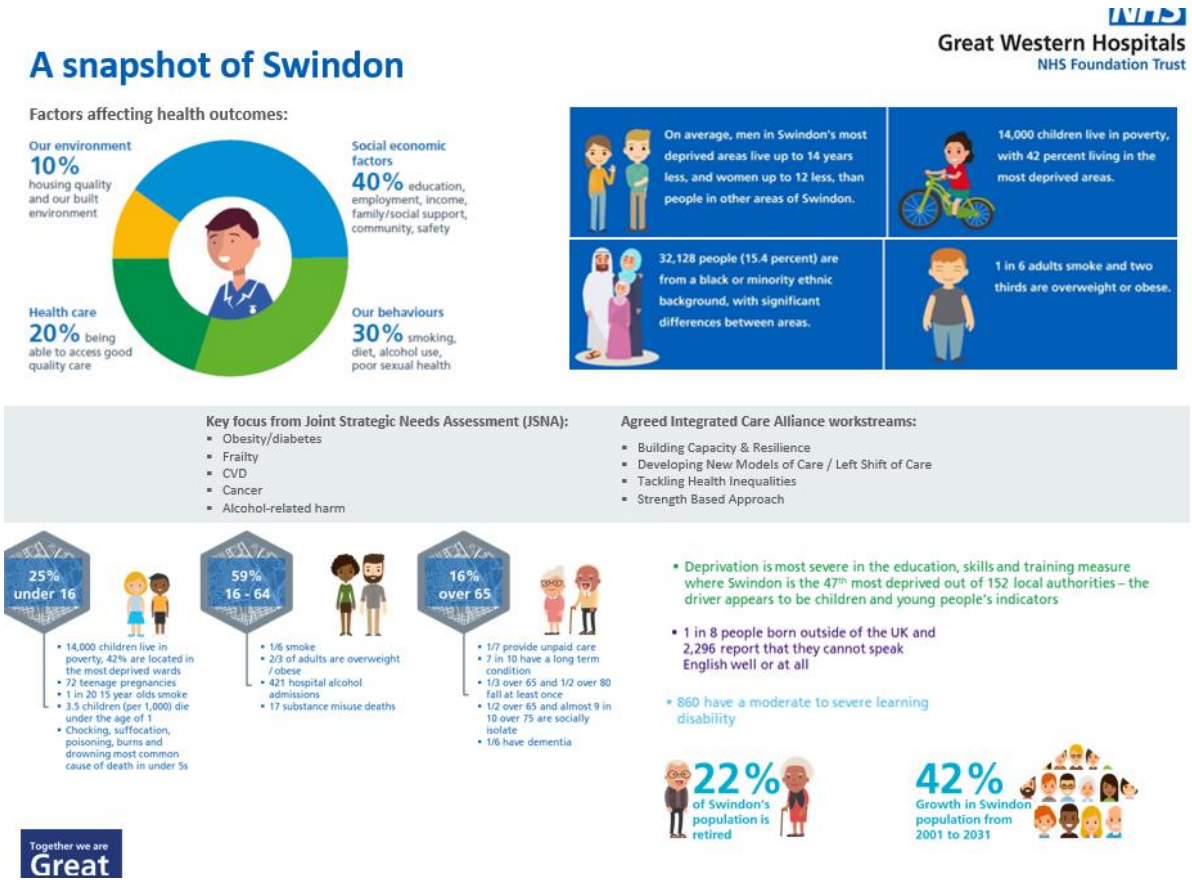
Our Star Values

We are guided by clear values that our staff have helped to develop. The Star Values are at the heart of everything we do and underpin the way we work, treat each other, deliver care and make use of our resources. They underpin our organisational culture. Our values make us who we are and are integral to achieving our vision. Our values are:
Service – We will put our customers first
Teamwork – We will work together
Ambition – We will aspire to provide the best service
Respect – We will act with integrity.

Service Teamwork Ambition Respect

Our Population

A snapshot of Swindon



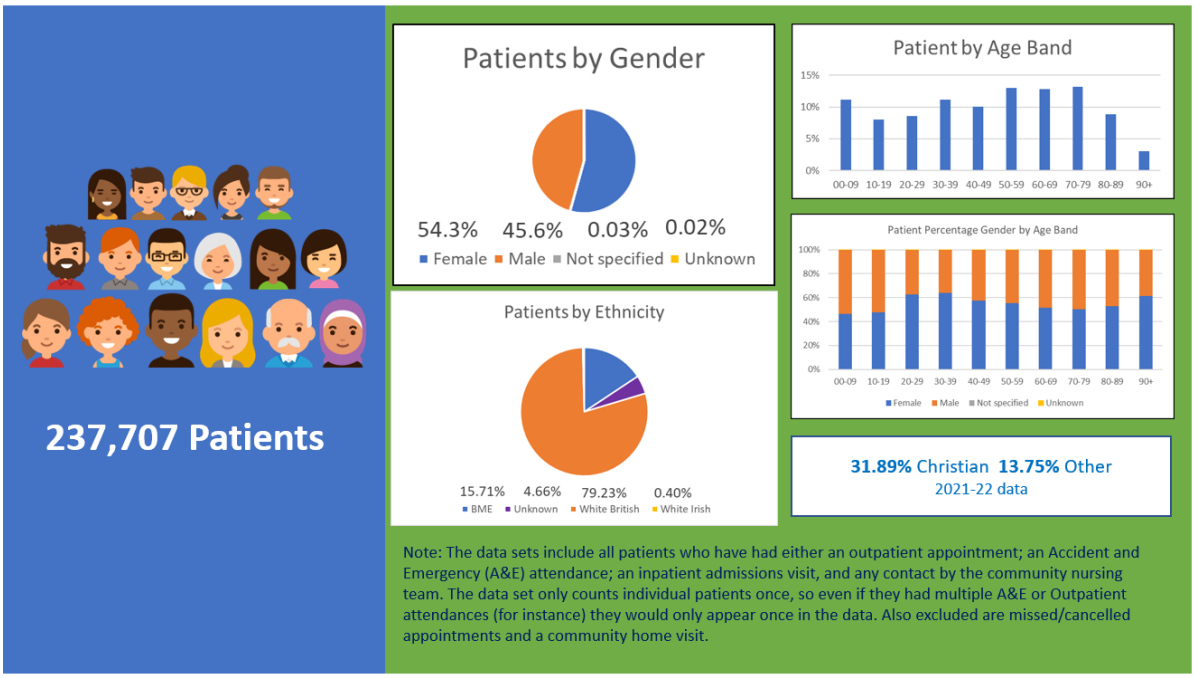
Our Patients

During the year 1 April 2022 to 31 March 2023 Great Western Hospital cared for 237,707 patients, from new-born babies to people aged 90 and over. Demographic information about these patients can be seen in the infographic below. The data represents all individuals who had contact with the Trust during the year. 129,093 (54.3%) of patients were female and 108,488 (45.6%) male; 188,340 (79.2%) of patients were White and 37,345 (15.7%) were from an ethnic minority background. The largest group of patients were in the age bands 70-79 years – 31,307 (13.2%) and 50-59 years – 31,035 (13.1%).

We know that the demographic profile of our region, Bath and Northeast Somerset, Swindon and Wiltshire (BSW) population is changing. According to the Office of National Statistics (ONS), this will grow from 947k to 1.1m over the next 15 years. An overall growth of around 6% - the number of people over 60 will grow by 35%, however our population numbers under 60 will remain unchanged. In addition, our data modelling also shows that in 10 years BSW will have 25,000 more people with frailty

than we do today. An aging population and increase in frailty and people with multiple health conditions is likely to put increasing pressure on services in BSW over the coming decade.

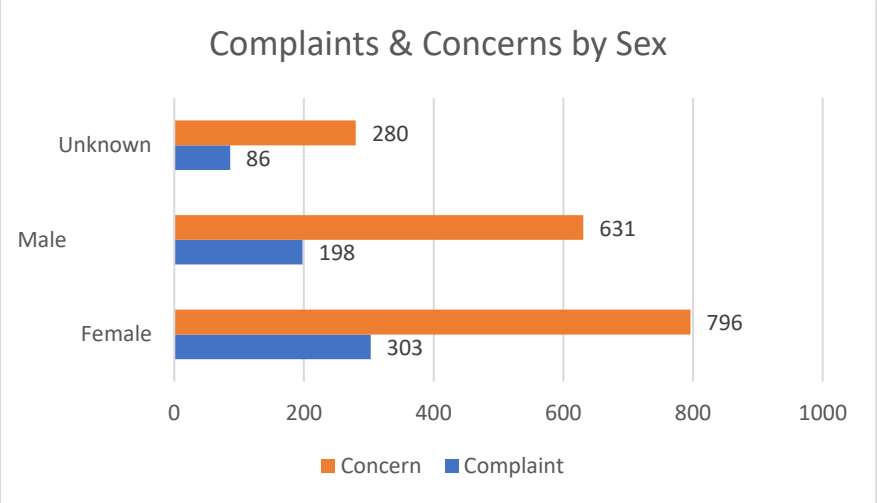
Our Patient Demographic Profile

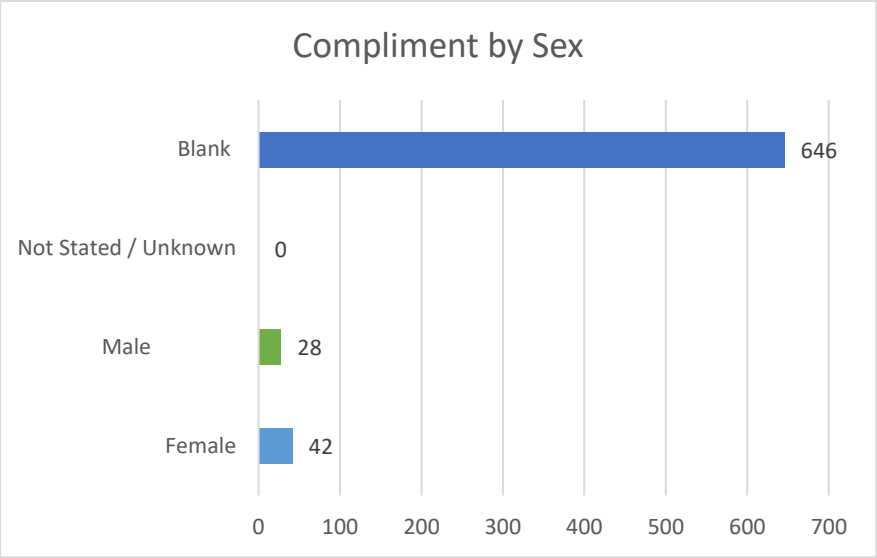


Note, at present we do not have access to the level of data that would indicate sexual orientation or disability. However, ethnicity, religion, gender and age range are recorded. The Trust has a commitment to improve data capture across all protected characteristics over time.

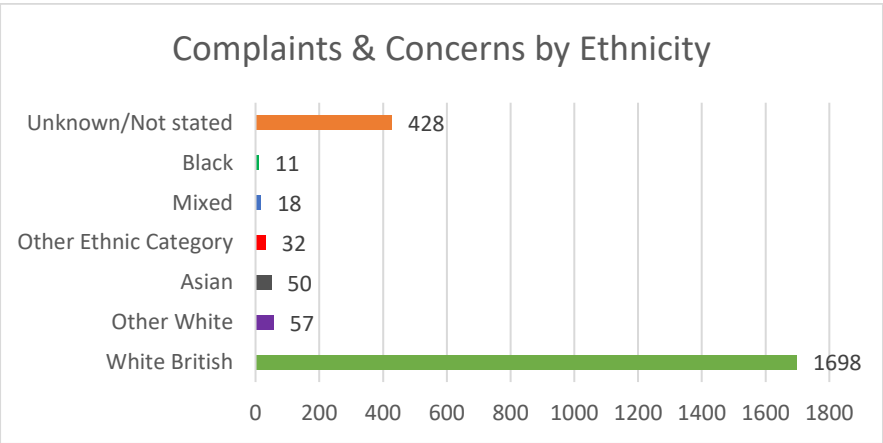
Complaints, Concerns & Compliments

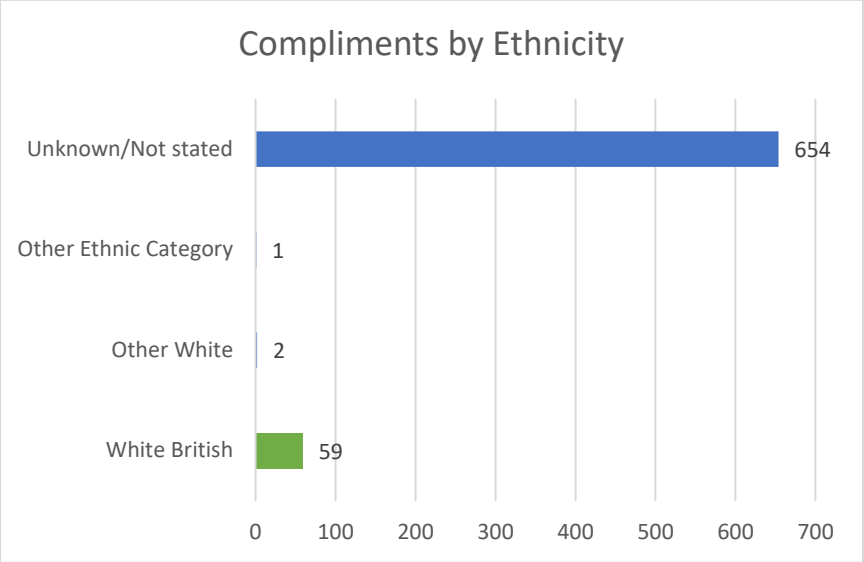
Data on complaints and concerns by Sex (male and female) is aggregated, data on compliments appears below. All data is for the period April 2022 to March 2023. The unknown category includes ‘not stated’ and ‘blank’ fields.





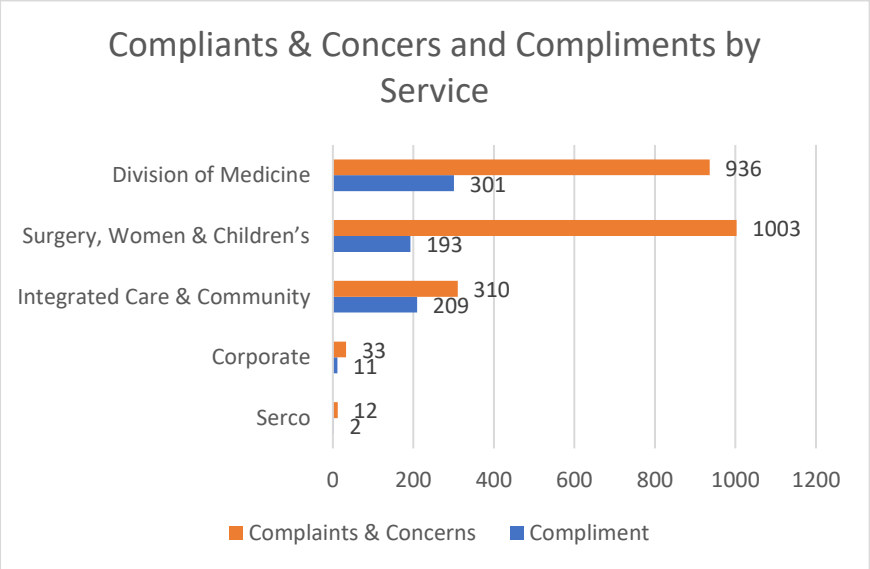
Data on complaints and concerns by Ethnicity is aggregated, data on compliments appears below. All data is for the period April 2022 to March 2023.





We stated last year that our new data system has enabled the Trust to gather more detailed information on protected characteristics including ethnicity and gender including being able to record complaints, concerns, and compliments from transgender patients (no patients have declared they are transgender this year).

Our records show that the Division of Medicine and Surgery, Women & Children received the most complaints and concerns (936/ 40.8% and 1,003/ 43.7% respectively); and Division of Medicine and Integrated Care & Community received the most compliments (301/42.0% and 209/29.2% respectively). Note, the Division of Medicine and Surgery Women & Children will have more patient episodes or clinical interactions per year and as a result are more likely to have a larger share of complaints, concerns, or compliments than other divisions.



Delivering Patient-Centred Care

Our Head of Patient Experience and Engagement, along with other colleagues across the organisation, are continuing to make improvements to patient care and to ensure that the voice of patients, families, carers, and the wider public are involved including those from seldom heard and minority groups.

Over the last year there has been significant progress made in terms of networking with a variety of diverse local communities by attending various community groups, venues, and events. We have focussed on building relationships and trust to facilitate further engagement and involvement in specific work as we move forward.

We continue to work closely with system and community partners including – Healthwatch, Voluntary Action Swindon, Livewell Swindon, Swindon Equality Coalition, Maternity Voices Partnership, Learning Disability Partnership Board, Disability Experts, Swindon Children's and Young People's Participation network, Swindon Special Educational Needs and Disabilities, New College Swindon, the Borough Council, local charities, and faith groups.

Involving patients, families, and carers in our work

We have encouraged public members to become involved in the work of the Trust and to increase the voice of patients in all aspects of our improvement work. This has included recruitment of Patient Safety Partners, the codesign of new projects, document review and writing and attendance at various committees across the Trust.

Examples of improvements include:

- Development of a guide for staff to support care of trans patients which involved service users input into the content of the document.
- Feedback from a local children's disability action group led to the installation of a Changing Places facility in our new Urgent Treatment Centre and within the Children's ward. These are fully accessible toilets and changing rooms and meet strict national accreditation standards.
- Following concerns and complaints, additional facilities have been implemented around the Trust to support the deaf community with the changes being agreed and supported by a deaf patient.
- Raising awareness of the importance of hydration in conjunction with a patient (patient partner).

Carers

Over the last year, we have made significant progress in our work to support carers who access our services. In July 2022 we launched our Carers Charter which articulates our commitment to carers and our aim to increase identification, work in partnership with and support and listen to their needs.

Following the launch, we have successfully reopened our Carers Café, which was halted due to COVID, and have recruited new volunteers to support information giving in wards and departments. In May 2023, following extensive consultation and involvement of carers, external partners, and carer organisations, we launched our new Carer Support Passport, which is available in other languages and formats. The passport has been designed to support staff to recognise carers more quickly, allowing them to be involved in discussions about the patient's care where appropriate. It also provides an opportunity to document the agreed involvement in the care that will continue to be provided by the carer during the patient's hospital stay and makes it clear the support and benefits available to unpaid carers. This may include flexible visiting, being able to stay overnight, concessions on parking, food, and beverages.

During Autumn 2022 we submitted a large volume of evidence to Carers Support Wiltshire in order to be assessed against their Carers Accreditation Standard for our Wren outpatient department. We were delighted to have been awarded gold accreditation, which demonstrates the commitment and work of the teams to make improvements in recognising, supporting and signposting carers and patients.

Our Carers Lead is currently working with Swindon Carers Centre and a new group set up to support young carers specifically. The engagement work will focus on understanding what is important to young carers when their cared for person is admitted to hospital, how we can better support them and will include coproduction (with children and young people) of a children's carers support passport.

There are also plans to launch new Carers ID cards to assist with identification and recognition of carers in ward areas. These will be available in each ward to issue along with the Carer Support Passport.

We have worked with Swindon Carers Centre to introduce new Carers information leaflets in languages other than English and are now reviewing options to add these to our internal patient information portal.

EDI First Impressions Challenge

Following a review of our EDI First Impression Challenge last year, several improvements were made to address the issues raised**.**

These have included:

- Improvements in signage
- A focus on decluttering our corridors
- Review and upgrade of all hearing loop systems
- Installation of new hearing loop signage
- A new checking process of public accessible toilet call bells
- Removal of old COVID signage

An ongoing review of heavy doors is continuing with involvement of our fire experts, Health and Safety team, the hospital company and SERCO. A further fire assessment is required in order to agree which routes could have additional electronic mechanisms added to the doors in order to improve access for people using wheelchairs or who have mobility challenges.

Armed Forces

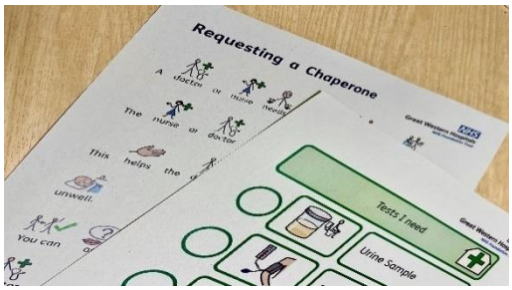
As a Veteran Aware organisation, we have continued to make improvements to ensure that our patients and staff with military connections are appropriately supported and do not face disadvantage**.** Joint external and Trust funding was obtained to implement a new Defence Medical Welfare Service with an on-site Welfare Officer to review patients with military connections and to facilitate support and signposting to additional services. Over a 4-month period this resulted in 88 contacts and 45 patients being supported with aspects such as mental health, suicide prevention, financial support, housing, chronic pain and new or ongoing disability. Data is being gathered to demonstrate the benefits of the service in terms of patient experience but also in relation to bed days saved, potential admission avoidance and financial savings.

We have recently signed up to the Pride in Veterans Standard (PIVS) which has been introduced by the military charity, Fighting with Pride, and aims to support LGBTQ+ Veterans, serving personnel and their families. As Armed Forces lead the Head of Patient Experience and Engagement is working to ensure we can achieve the standard and make improvements in care and raise staff awareness where necessary.

Supporting Trans patients

Following significant consultation and involvement a Staff Guide to Support Care of Trans Patients was ratified and is now available across the organisation. The guide has been successfully used as a resource to guide staff in making informed decisions and hold sensitive conversations with our patients. Awareness training has also taken place and we are continuing to work with BSW Academy to facilitate ongoing training, awareness raising and access to support resources for staff.

Easy Read



The PALS team have implemented new software to be able to create a variety of documents in easy read format. These have included assessment flash cards which have been particularly useful in our front door services.

Meaningful Activity

As part of Learning Disability awareness raising, the Emergency Department implemented new 'Little Bags of Calm', which provide distraction resources for patients attending the department who have a Learning Disability or any cognitive impairment or sensory challenges. The bags contain an eye mask, ear plugs, fidget tools and a mindfulness colouring book.

New resources have also been purchased by Brighter Futures to support meaningful activity. Specially recruited volunteers are taking the new resource trollies around our wards to support patients. The trollies are laden with lots of items to stimulate patients, facilitate communication, and support physical and mental health.

Next Steps

The Head of Patient Experience and Engagement will be continuing to develop networks with seldom heard groups, particularly with communities that we have not yet built clear connections with and to progress involvement of these communities in specific improvement work. The aim will be for us to continue:

- demonstrating our commitment to the EDI agenda and explaining the work that we are doing at the Trust.
- understanding what is important to that particular community from a patient experience point of view and what considerations or adjustments that may be appropriate.
- understanding any health inequalities for the community, why they may not access health care and explaining how outcomes could be improved.

- make tangible improvements to our care and services because of the feedback and involvement.

Spotlight on our Services

Interpreting and Translation Services

Our Interpreting and Translation Services have continued to develop and improve the provision. Within our Patient Advice and Liaison Service (PALS) we have introduced a new position with a focus on equality and diversity and this role will lead our interpreting and translating services along with other aspects of EDI work.

We continue to offer face-to-face, telephone, skype and Sign Live (British Sign Language -BSL) services to service users to ensure that they can be communicated with effectively. Our Patient Information Leaflets are available in all languages, formats, and easy read. We are currently reviewing options to implement new software to enable all leaflets to be available via portal linked to our Trust webpage.

We have implemented new language prompt posters to support patients and staff to easily identify if the person is unable to speak English and may require an interpreter.

We have been working with our digital provider for patient outpatient communications to ensure that letters are automatically generated in alternate formats such as Braille when requested. This has been a challenging project, but we are committed to ensuring patients are able to receive information in the required format.

During 2022 we implemented a new functionality to our Sign Live system to enable deaf patients to contact the PALS team directly via an app with immediate connection to a BSL interpreter. This facility can aid them to resolve any general queries or gain the information they need but are unable to obtain by telephone. The PALS team have been working with our partners at The Gloucester Deaf Association to create a patient video to promote available services and they have also implemented Deaf Awareness cards, which were developed in conjunction with a deaf patient; the cards signal to staff that the carrier has hearing loss.

Deaf Awareness cards:

Sexual Health Services

The Consultant Sexual Health and HIV, and the sexual health team see the highest percentage of non-white and LGBTQ+ patients in the Trust, they are always striving to be as welcoming as possible to all patient groups.

This year they will be attending Swindon Pride, providing free sexual health screening kits, condoms, incentives, and advice.

The team have also arranged for a disability group to visit them to provide advice on improving access and the patient experience in the clinic, the results of which will be presented at their clinical governance meeting.

The Trust has supported refugees at the Harbour Project. A team provides women with advice about the menstrual cycle, contraception, sexual health and improving access to mainstream services. The clinic arranged a huge collection of sanitary products, which were provided to this group of female refugees living temporarily in Swindon hotels who are unable to afford the items.

The team also work with the Nelson Trust for vulnerable women and have a van that goes out every Thursday night to the street sex workers and women with addiction problems to provide food, clothing, contraception and STI screening and treatment and the sexual health outreach nurses work with some of the most vulnerable adolescents at risk of sexual exploitation and teenage pregnancy providing contraception in their homes and at school.

The Learning Disability (LD) Service

For a long time, people with learning disabilities and their advocates have been fighting for equality with the rest of the population. While progress has been made, there is still some way to go. People with learning disabilities are still affected by inequality of treatment in healthcare settings and can face barriers to accessing healthcare that people without learning disabilities do not. The Covid-19 Pandemic accentuated these difficulties. The LD agenda remains a priority for the Trust, and there is a wide range of activities to support people with learning disabilities in our locality. Principal among these is the Learning Disability Forum, which:

- Delivers an annual work and audit plan, to reduce inequality of access to healthcare.
- The Trust has an established patient feedback programme with a local day service provider (OK4U) to ensure the patient is at the heart of all our service delivery and planning.
- The forum includes those with lived experience of, and those who care for people with LD
- Is chaired by the Associate Director for Safeguarding and has a collaborative working model with multi-professional engagement from the acute site, community, service users, carers, community care providers, mental health providers and advocacy groups.

Key Achievements 2022 -2023

- Delivery of the annual workplan reflecting learning from National Report recommendations (Learning Disabilities Mortality Review, or LeDeR), local need (Swindon JNSA) and local intelligence data.
- Employment of a Mental Capacity Act (MCA) and Liberty Protection Safeguards (LPS) lead and the launch of a Trust-wide MCA competency programme for base wards to ensure consent and mental capacity processes are legally robust.

- System/partner agency collaboration: Trust attendance and contribution at the following Boards and meetings: Learning Disability Board, Partnership Board (LDPB), Autism Partnership Board, Suicide Prevention Group and Domestic Abuse Forum (DA and WAGV) and regional (LeDeR) mortality learning programme meetings.
- The Trust lead for LD practice supported ED with a month-long focus in March 2023 on LD practice. ED focussed on staff education and introduced a series of measures that will support patients with LD to have a positive patient experience, and as a consequence, will increase concordance with care plans and reduce the risk of diagnostic overshadowing. The work was showcased in March at 'Grand Round' (Consultant governance meeting).

The team will deliver Learning Disability and Autism awareness training for newly recruited international staff from the summer of 2023.

Note, staff will be asked to complete Oliver McGowan Training as a mandatory requirement, this is being developed collaboratively across the system. All staff will complete Tier 1 and patient facing staff Tier 2. The training is named after a young man whose death shone a light on the need for health and social care staff to have better skills, knowledge and understanding of the needs for autistic people and people with a learning disability.

Maternity & Neonatal Services

Our Maternity and Neonatal Services are taking steps to improve equity in access, experience and outcomes for marginalised and minoritized groups of our population and workforce. Equity means that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes. In line with this, work is underway to develop an action plan that responds to internal reviews and national policy. Our commitment has included working across the region with system partners including the voluntary sector to identify what we are doing well and where improvements can be made (see Section Two: Equality Delivery System).

To date this has included:

- Monthly meetings with Maternity and Neonatal Voice Partnership (MNVP) team to monitor progress on our inclusion focused improvement plans and to ensure collaborative approaches to service provision adaptations are effectively implemented.
- Continuing work with the PALS team to review patient documentation and improve accessibility of information for our pregnant population via the Trust webpage and to improve access to translation services.
- Shared learning, for example, attendance at an education webinar on Refugees and Asylum Seekers in Pregnancy, hosted by Royal College of Midwives (RCM), and ensuring what we learn informs improvement initiatives for refugee families. Resources are shared widely across maternity services and other stakeholders, including Maternity and Neonatal Voice Partnership (MNVP).
- The maternity team are leading EDI discussions regarding education and training plans, development of cultural awareness clinical simulations and opportunities for continuous learning from incidents. This will include training that incorporates the voice of people with lived experience. In addition, the Local Maternity and Neonatal System has reported that funding will be available for Anti-Racism training for midwives, which will be rolled out in conjunction with Black Maternity Matters.

GWH Chaplaincy Service

GWH Chaplaincy Service is religion-non-specific and denominationally neutral and offers generic spiritual and pastoral care to all patients and their carers, family and friends, staff and volunteers to help deal with the experiences of illness and injury, life and death and to process issues of personal meaning and purpose. Chaplains are trained and experienced in listening to and supporting people in difficult situations and offer a sensitive and discreet support. The team can also help with cultural and religious routines and rites of passage.

We have one whole time Lead, one whole time Team Chaplain and two part time Chaplains supported by four Honorary Chaplains and six chaplaincy volunteers from a range of social and religious backgrounds including an Imam, from Broad Street Mosque, a Roman Catholic Extraordinary Minister of Holy Communion, and a Pagan Priest of the Pagan Federation Hospital Ministry. Within the next 12 months we aim to recruit honorary chaplains from the Sikh and Hindu religions.

Our department is accredited by the Spiritual Healthcare Academy of Guy's and Thomas' Hospital Department of Spiritual Healthcare as a training placement and our MSc student chaplain for 2023/4 is Rev Francis Offeh who is an Assemblies of God Minister.

Our Roman Catholic Chaplaincy is provided by two Extraordinary Ministers of Holy Communion, one of whom is an Honorary Chaplain, and the Swindon RC Deanery which allocates a Priest to be on call 24/7. The Roman Catholic Diocese have provided prayer booklets for staff and families to use with end-of-life patients.

The Chaplaincy Centre and Sanctuary is on the First Floor of the hospital, near Main Theatres and the Daisy Unit. Our sanctuary provides a place of peace in the midst of the busy daily life of the hospital. It is open 24/7 for reflection, quiet and if appropriate prayer.

Local religious communities and faith groups supply the chaplaincy with a range of religious texts from the major world religions which is available for staff and patients. Within the Sanctuary room are artefacts from the Christian, Muslim, Sikh, Hindu, Buddhist and Jewish religions kept in bespoke cabinets which can be opened, or closed, as appropriate. In 2020 we were early adopters of virtual visiting technology using iPads and mobiles phones to assist families of patients unable to visit the hospital, and we have continued to use this technology to facilitate communication between patients, relatives and their religious leaders.

The emergency religious contacts list has again been approved by Swindon Interfaith Group and is available to all staff on the Chaplaincy intranet page. Our lead Chaplain is a member of the organising committee of the Swindon Interfaith Group

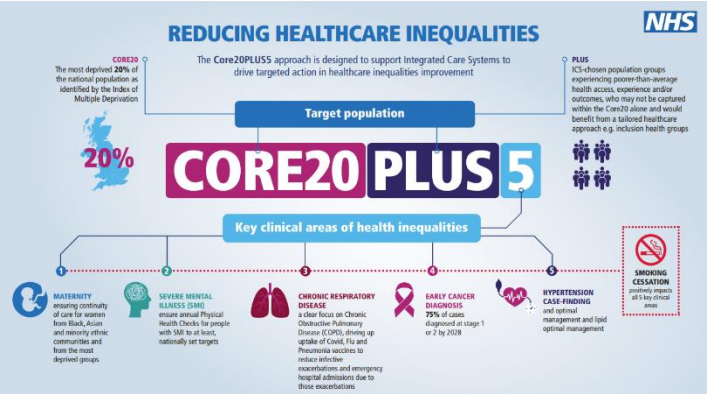
Bibles and New Testaments and Psalms for patients and staff are provided by 'Good News for Everyone', the organisation that took over from Gideons International.

Accessible Information Standards

The Accessible Information Standard (AIS) applies to all NHS organisations; by applying the Standard, the Trust ensures that public information and communication with its staff and population is accessible. We are committed to following the principles of the AIS which requires a specific and consistent approach to identifying, recording, flagging and meeting people's information and communication support needs, where those needs relate to a disability or sensory loss. Our publications and reports can be made available in a number of formats upon request. Page 20-22 of this reports highlight several initiatives that have improved access to information for disabled patients.

The Trust partners with its disabled staff network, the Differently Abled Network, to help raise awareness around accessibility issues. In May 2022, the Trust launched an Access Information Standards e-learning course which all staff can access. The training module takes staff through steps on how to communicate effectively with patients whilst being inclusive, to ensure that patients feel involved and empowered to make informed decisions about their care. In 2022 a working group met to review AIS and identify opportunities to make improvements, although the group disbanded the Trust is keen to establish a new working group in 2024.

Health Inequalities



The NHS has adopted a national approach to tackling inequalities in healthcare - inequalities are unfair differences relating to where we are born, live, work and age. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. Trust has a local and system plan to tackle inequalities. The Trust is working with Swindon Borough Council and different community groups to better understand the barriers to accessing healthcare and learn how we can ensure our services reach and benefit everyone and we formed a Health Inequalities Steering Group to have oversight of this work. The Health Inequalities Steering Group will merge with the Equality Diversity Inclusion strategic group in October 2023 and the combined groups will drive the inclusion and health inequalities agenda. This new group will be called the Inclusion and Health Inequalities Group.

We are committed to deliver against the following phases set out in the system plan:

Phase 1: To make inequality everyone's business through awareness raising, training and engagement.

Phase 2: To tackle healthcare related inequalities.

Phase 3: To focus on prevention, social, economic and environmental factors (known as 'wider determinants').

Our local plans will need to take account of the changing face of our BSW population where some groups of people or local areas might experience a higher prevalence of co-morbidities or health conditions like cancer.

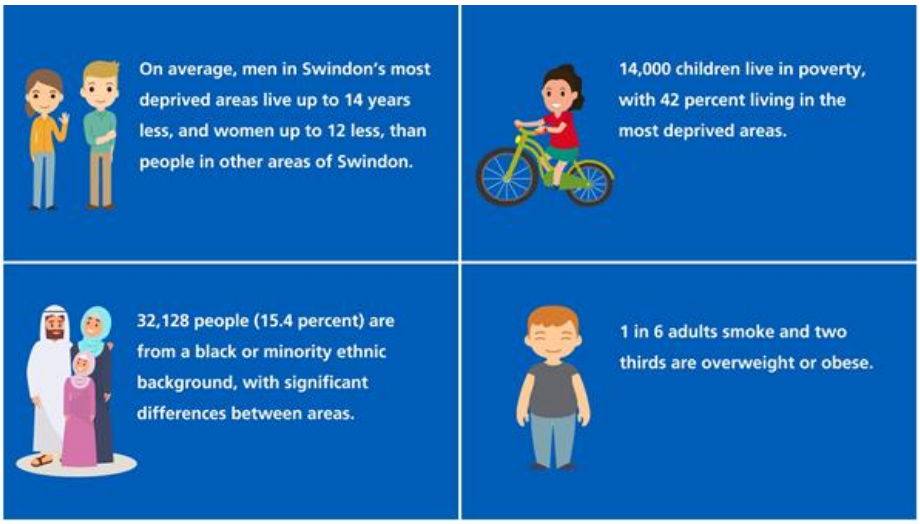
Initiatives underway include:

Changing Suits	The project is raising awareness of mental health within the South Asian community (SAC) and increases SAC engagement with local service providers. This is being done through SAC based events and support groups, which highlight the causes and impacts, diagnosis and treatment of mental health problems.

Kennet Furniture Refurbishment	Local support organisation to alleviate furniture poverty (including beds) for the most vulnerable households in Swindon.
Citizens Advice Swindon cost of living support & Live Well	Citizens Advice Lead will is based in Sanford House reception alongside the Live Well team supporting them to identify and provide debt, benefits, energy, or housing advice. The aim is to increase knowledge and shared expertise in identifying and providing solutions in relation to practical advice issues.
Public Health Inequalities Specialist Health	An Inequalities Projects co-ordination role is hosted in Swindon Borough, to provide support and lead on monitoring and evaluation of the eight inequalities projects.
Central Swindon North Parish Council - multiagency project	This is a 12-month pilot partnership project addressing food poverty provision in the Central Swindon North Parish area, supported by the Feeding Swindon Partnership Project officer (SBC) between Central Swindon North Parish, the Salvation Army, Nightshelter, Renew CIC, Stepping Stones (Gorsehill Baptist Church), Penhill Community Café and FoodCycle.

As a large organisation, deeply rooted in the local community, we have an opportunity to maximise our impact on the health and wellbeing of local people, reducing health inequalities and improving the life chances of the most disadvantaged people in Swindon. Our health inequalities initiatives extend beyond meeting patient needs and we recognise our role as an employer (see anchor institution section below), procurer and our impact on the environment.

Kevin's video [Our commitment to tackling health inequalities#]



Our People

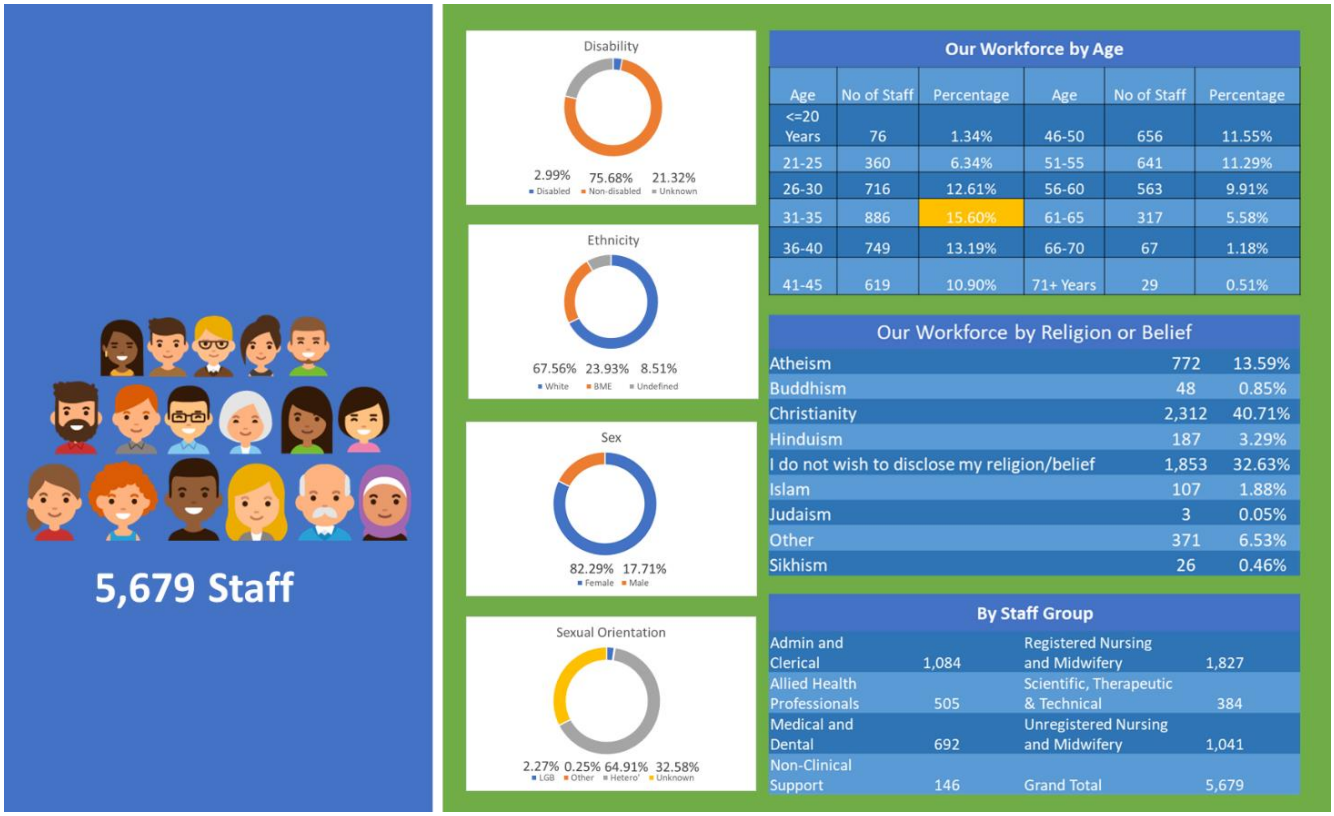
The Trust is proud of its staff, they work extremely hard to care for our patients in challenging circumstances. External awards like the 2022 NHS Parliamentary Award (Midwifery Category) and our own Staff Excellence Awards are a testament to the hard work, dedication, commitment and pride we witness every day from our staff. Our People continue to face work pressures as we seek to recover services post-pandemic and tackle increased service demand and we are thankful for their sacrifice and contribution to achieving our vision: to deliver joined up services for local people at home, in the community and in the hospital helping them to lead independent and healthier lives.

The Trust employed 5,679 staff as at 31 March 2023.

- Most of our staff are female (female 4,673 (82.29%) and male 1,006 (17.71%)).
- 4,298 staff (75.68%) are non-disabled and 170 (2.99%) are disabled. We know not all disabled staff have shared this information and the number of disabled staff, including those with living long-term health conditions is much larger.
- 3,837 staff (67.56%) are White and 1,359 (25.94%) Ethnic Minority and 'Other'.
- 50 staff (0.88%) are Bisexual, 3,686 (64.91%) are heterosexual and 79 (1.39%) Gay or Lesbian.
- 2,312 staff (40.71%) are Christian, 742 (13.07%) are other faiths/beliefs and 772 (13.59%) have no religion or belief.
- The largest age bracket is 31-35 years old, 886 staff (15.6%) are in this age group; 436 staff (7.68%) are under 25 and 96 staff (1.69%) are over 65.
- 1,084 staff (19.09%) are employed in admin and clerical roles, 2,868 (50.50%) in nursing roles (including unregistered nurses) and 692 staff (12.19%) in medical and dental roles. The infographic below highlights the diversity in our workforce.

Our People Demographic Profile

Full time staff: 3,216 (57%)
Part time staff: 2,463 (43%)



Our Workforce by Age

Age	No of Staff	Percentage	Age	No of Staff	Percentage
<=20 Years	76	1.34%	46-50	656	11.55%
21-25	360	6.34%	51-55	641	11.29%
26-30	716	12.61%	56-60	563	9.91%
31-35	886	15.60%	61-65	317	5.58%
36-40	749	13.19%	66-70	67	1.18%
41-45	619	10.90%	71+ Years	29	0.51%

Our Workforce by Religion or Belief

Atheism	772	13.59%
Buddhism	48	0.85%
Christianity	2,312	40.71%
Hinduism	187	3.29%
I do not wish to disclose my religion/belief	1,853	32.63%
Islam	107	1.88%
Judaism	3	0.05%
Other	371	6.53%
Sikhism	26	0.46%

By Staff Group

Admin and Clerical	1,084	Registered Nursing and Midwifery	1,827
Allied Health Professionals	505	Scientific, Therapeutic & Technical	384
Medical and Dental	692	Unregistered Nursing and Midwifery	1,041
Non-Clinical Support	146	Grand Total	5,679

We are an Equal Opportunities Employer, and a Disability Confident Leader, the highest award in the Disability Confident certification which we achieved in May 2023 and our commitment to armed services personnel, veterans and their families also extends to providing employment.

Volunteers

Volunteers make a real difference to the experience of our patients and visitors by helping in some of the following ways:

- Supporting patients with practical tasks, such as making mealtimes more sociable, helping patients to keep moving, listening to experiences, helping people to speak up or by providing social interaction.

- Helping visitors by providing a warm welcome, giving directions and assistance with finding their way around the hospital and by providing or signposting to further information.

- Supporting our staff by helping with occasional administrative tasks or making sure information for patients is readily available.

The Trust had 395 Volunteers as at 31 March 2023 and we have over 100 potential volunteers in the recruitment process. Like our paid workforce, our volunteers are also diverse. The infographics below show the demographic make-up of our volunteers.

395 Volunteers

Age			
<=20 Years	137	46-50	15
21-25	72	51-55	20
26-30	14	56-60	20
31-35	10	61-65	33
36-40	15	66-70	33
41-45	14	70+	15

Sex	
291 (74%) Female	
104 (26%) Male	

Ethnicity	
BME	98
Unknown	44
White	253

Disability	
Yes	31
No	321
Unknown	43

Sexual Orientation	
Bisexual	5
Gay or Lesbian	5
Heterosexual or Straight	236
Other (not listed)	2
Undecided	3
Not Stated	144

Religion & Belief	
Atheism	40
Christianity	130
Other religion/belief	58
Unknown	167

The largest group of volunteers is in the 'under 20 years' age range, this represents 35% of the volunteers (137 people), followed by the 21-25 age group, 18% (72 people).

291 (74%) of volunteers are female, and 104 (26%) male, the percentage of male volunteers is larger when compared to the make-up of paid staff (82% female and 18% male).

236 (60%) of volunteers are heterosexual, 22 (5%) Lesbian and Gay and 26 (6%) Bisexual.

253 (64%) of our volunteers are White and 98 (25%) BME.

321 (81%) of our volunteers are non-disabled and 31 (8%) have a disability or are living with a long-term health condition.

130 volunteers (33%) are Christian, 58 (15%) practice other religions or beliefs and 40 (10%) practice no religion or belief.

Volunteer achievements

- This year 10 of our volunteers were employed by the Trust
- Completed 328 pharmacy runs and 155 patient mobility requests
- Supported patients with 179 OWLS appointments
- Visited wards with the Mobile Book Trolley and the Staff tea Trolley when needed
- Pets as Therapy programme has 14 dogs and 6 miniature ponies who have visited 65 areas at the Trust
- Over 7000 hours volunteered across

We are keen to continue to diversify our workforce and our action plan (see appendix) will support our ambition to have a diverse representative workforce at every level of the organisation and to

ensure that we attract the best talent when we recruit staff. We have launched a pilot in June 2023 to train and deploy Inclusion Recruitment Champions, they are individuals who will sit on interview panels for senior roles (Band 8a and above) and support the recruiting team to implement inclusion best practice and to recognise when bias might be at play. We will also continue to find new routes to promote job adverts so that we can attract candidates from every walk of life.

Attracting & Retaining Talent

Our Recruitment department has improved our marketing to help us to increase the candidate pool. This has helped the Trust to attract more talent from minoritized backgrounds. Enhancements have included more use of social media to promote roles and we use diverse images of staff, rather than stock photos in our adverts. The Trust has implemented a Fresh Eyes survey, which provides valuable insights into the recruitment process from new starters and this information is used to improve the process. Improvements are also informed by data we collect from staff that highlight their experience. In 2023/24 the Trust will audit the end-to-end recruitment life cycle and equality, diversity and inclusion will be taken into account during this process.

Retention is just as important as recruitment. We are working with line managers to help them to provide a great candidate and new starter experience and we have improved our induction day. We are also taking steps to increase the uptake of our offer of health and wellbeing services and we will support our line managers to effectively manage talent through training, provide resources and advice and guidance and we are improving talent development related programmes to ensure our staff who want to progress can access development and coaching opportunities to help them move towards their career goals.

The Trust also has a Stay & Thrive programme of work to support our internationally educated nursing staff. This includes support to find initial accommodation, settle into life in Swindon, onboarding and pastoral care (including ward mentors, buddies and drop-in sessions) and professional development; and we offer a range of learning opportunities for all staff including functional maths and English skills training before and after office hours for staff who do not hold a maths qualification, which may help some staff apply for apprenticeships where they currently cannot.

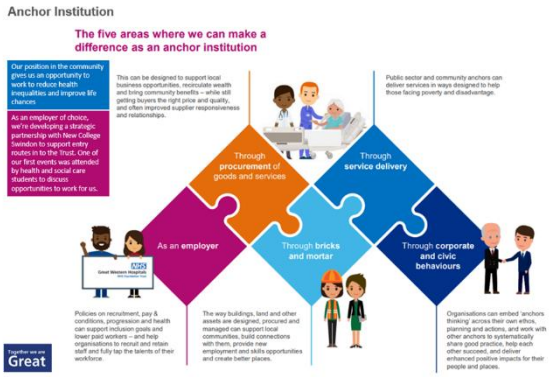
In June 2023, NHS England published the Long-Term Workforce Plan which sets out how the NHS will address existing and future workforce challenges. There will be three areas of focus: Train, Retain; Reform which includes training new doctors, nurses, allied health professionals and support staff to help us grow our workforce; a renewed focus on retention with better opportunities for career development and flexible working; and reforming how we work. The Trust will take account of the national approach as part of its ongoing workforce planning arrangements.

Inclusive Leadership

The Trust supports its leaders and managers at all levels of the organisation to understand the importance and role of equality, diversity and inclusion in delivering equitable healthcare and creating a positive culture, this includes equipping them to be able to hold culturally sensitive and empathetic conversations with staff, enabling them to recognise bias and to make decisions that lead to equitable access to services for our patients. EDI has been embedded in the leadership programmes delivered

by the Trust and you can read more about this in the Equality Diversity Inclusion training section of this report. Staff will have the opportunity to get more involved in this work through the Allyship programme that will be launched in September 2023.

We are an Anchor Institution



The impact the NHS has on people's health extends well beyond its role as a provider of treatment and care. As large employers, purchasers, and capital asset holders, health care organisations are well positioned to use their spending power and resources to address the adverse social, economic and environmental factors that widen inequalities and contribute to poor health.

We have worked with local partners in several ways to address the social determinants of health, these are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Our Early Years Career Advisor has more to say about widening participation below.

Widening Participation

Figure 1 Jaqueline Fawcett, Early Years Career Advisor

As an anchor institution (one whose long-term sustainability is tied to the wellbeing of our local community), we seek to improve and increase entry routes for staff from diverse backgrounds, to facilitate better access to development and career opportunities. Current projects include:

Scoping and creating opportunities to raise the aspirations of children and young people through work experience, informed presentations, and outreach activities by creating a strong network within schools, colleges, and other providers within our local community.

Supporting Local Authorities in their role as corporate guardians, to secure the best outcomes for looked after and young people.

Supporting and exploring projects that examine routes into employment and training, making a positive impact on local communities. For example, the NHS Cadet Scheme, supporting schools with ASDAN students' programmes, and colleges with T-Level placements. 10% of young people included in our outreach programme are from our local BAME communities. We also work closely with our local SEND providers.

The Early Years Careers Service (EYCS) aims to attract diverse students through multiple routes, such as the school careers advisory service, local council careers hubs and social media outlets. Our data

shows that 30% of our virtual work experience programme intake identify as Black, Asian, and Minority Ethnic (BAME), and our programmes are tailored more widely to meet diverse student interests, needs and academic abilities.

Jackie Fawcett (pictured, above) is our Early Years Careers Advisor, Early Years Career Service.

Staff Networks

The Trust has five staff networks who represent minoritized groups of staff. These include the:

- Differently Abled Network who represent the interest of disabled staff.
- LGBTQ+ Network who represent the interest of our lesbian, gay, bisexual, transgender and queer plus staff.
- Race Equality Network who represent the interest of ethnic minority staff.
- And a Women's Network.
- Armed Forces Network, although armed services personnel and veterans are not a protected characteristic, the Trust recognises the unique challenges they face.

Staff networks play an important role in the life of the Trust. Our staff networks are part of the Equality Diversity Inclusion Group, which is a strategic group that oversees the EDI agenda and the progress we are making. The networks also act as supportive spaces for their members and they welcome allies (who might not share the same protected characteristics as the beneficiaries of the network) who help to deliver various initiatives including engagement and workshops. During the course of the year they lead on a range of events to mark key EDI calendar dates including International Women's Day, Pride, Disability Awareness Month and Black History Month.

Other staff groups include Mental Health First Aiders, Health & Wellbeing Champions, the Employee Partnership Forum, and social committees or groups who organise events like the Great West Fest and Staff Awards.

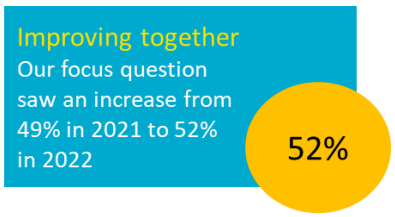
Staff Engagement

Improving Together

Improving Together is an evidence-based way of working which can be used by any team, creating an open and collaborative culture, giving everyone a voice and empowering everyone to be more proactive. Improving Together recognises the need to identify the critical few initiatives that will have the biggest impact, by taking an 'inch wide, mile deep' approach we are able to identify a single area of work and address it systemically.

The Trust is rolling out the Improving Together methodology across the organisation, during 2022-2023 our focus question 'I am able to make improvements happen in my area of work' has given staff across the organisation more agency to influence change. The Trust

has seen an improvement in this staff survey question which has increased from 49% to 52% of staff stating they feel able to make improvements to their area of work.



The change methodology has also provided opportunities for equality, diversity and inclusion. In response to our NHS Staff Survey results (see section two) we will have an organisation-wide focus (a Pillar Metric) on discrimination. Between March and July we undertook engagement with staff including hosting workshops and visiting Wards to understand their experiences and to provide an opportunity for staff to inform the initiatives that are developed to address discrimination. The Trust will launch an Allyship programme late September 2023 which will give staff an opportunity to become EDI change agents in their area of work.

As staff engage with the Improving Together training and build skills around using the tools, we anticipate more teams and departments will use the methodology to improve inclusion in their area of work. The Academy, the Trust's education centre, is one such department and they will implement an Improving Together initiative to increase accessibility for disabled staff, including staff who are neuro atypical. The Trust is keen to improve inclusion for our disabled staff (see WDES update in section two) and patients, we recognise the social model of disability and understand that our systems, processes, policy, physical spaces and behaviours can act as a barrier for disabled people to fully participate, the Academy project will be a positive step in the right direction and provide learning for the rest of the Trust.

You can learn more about Improving Together by watching this short video.

Let every voice be heard

Employee listening is instrumental in creating an inclusive working environment for staff and to reducing health inequalities for our population. Our staff are experts by experience (professional experience and personal or lived experience as patients and community members) and bring rich insights to the table which the Trust can harness to transform how we care for patients and how we work together. Employee listening can be described as gaining a solid understanding of how our staff feel and what they encounter in their daily interactions in the workplace with staff and patients. We provide a range of mechanisms to enable our staff voices to be heard.

Equity Data Walk

An equity data walk is designed to enable stakeholders to learn about and discuss data around a given topic. We launched an Equity Data Walk in February 2023 in response to our NHS Staff Survey findings, 6.3% or White staff and 19.8% of Ethnic Minority staff stated they have experienced discrimination from another colleague. To reduce the likelihood of staff experiencing discrimination the Trust engaged with staff over several weeks, this included workshops and visiting several wards to hear about their lived experience and to enable staff to influence the initiatives that the Trust

will roll out to tackle poor behaviour. The Trust is also committed to addressing discrimination from patients and the public.

Change the Narrative

In July 2023 the Trust launched Change the Narrative, which provides an opportunity for staff to share their stories. Our first event in celebration of Windrush and the NHS's 75th birthday highlighted stories from internationally educated colleagues from across the region who work for the NHS or who have retired. Storytelling is an impactful way to raise awareness, address stereotypical beliefs and bridge cultural barriers. These events help us to foster good relationships between different groups which is a legal requirement (The Equality Act 2010 Public Sector Equality Duty).

Restorative Just and Learning Culture

To support our efforts to address workforce inequalities, the Trust has adopted the Restorative Just and Learning Culture (RJLC) approach, which moves away from punitive behaviour. RJLC recognises when harm is done and seeks to address this, learn from the experience and move towards reconciliation. This philosophy and way of working is being piloted in three areas of the Trust before further roll out. A programme of engagement and training will help to socialise RJLC and embed its practice in the organisation over time and we are planning to deliver the national RJLC tool across the organisation at the end November 2023.

Strategy Engagement

The Trust is currently undertaking a large engagement project to work with staff, patients, families and partners to develop the new Trust Strategy, which will take us from 2024 and onwards. Our staff have several opportunities to attend focus group sessions and can share feedback via a survey. This will ensure the strategy has been informed by diverse perspectives.

Celebrating diversity

The Trust's communications team are pivotal to EDI engagement. They help to deliver key messages and influence behavioural change. Throughout the year Communications promote celebrations, raise awareness across a range of issues and highlight the importance of creating accessible services, this included marking Deaf Awareness Week, Gypsy Roma Traveller History Month and celebrating International Nurses Day in May 2023. Our first podcast of the new season featured two of our international nurses. You can listen to it here: https://www.gwh.nhs.uk/about-us/who-we-are-and-what-we-do/great-to-talk-our-podcast/.

The Trust podcast Great to Talk celebrates the work of our staff and provides a space for staff to tell their stories. You can find links to the podcast using this link.

https://www.gwh.nhs.uk/about-us/who-we-are-and-what-we-do/great-to-talk-our-podcast/

The Big Coffee Break

Working collaboratively and sharing good practice is one way the Trust is improving our EDI performance. We work with partners in the BSW system to deliver joint programmes of work and our staff also network with EDI practitioners across the UK to identify best practice, share learning and resources. Since January 2023 the Trust has played host to the Big Coffee Break which was founded by our EDI Lead. The national network meets 3-4 times a year and has a focus on addressing inequalities.

Equality Diversity Inclusion Training

Mandatory EDI Training

Statutory mandatory EDI-related training is delivered through our e-learning platform. The training introduces staff to key terminology and helps them to understand our collective and individual responsibility to advance inclusion and to eliminate discrimination. The training will be updated to help staff to under our requirements under the Human Rights Act and the Armed Forces Act. 2,151 staff completed the training between Apr 22 and Mar 23.

In addition to mandatory EDI training, the Trust's EDI Lead and EDI Lead Nurse hosts a range of workshops to help staff to develop their cultural competence. This has included delivering sessions on the Trust's leadership development programmes, workshops for our Internationally Educated Nurses and the EDI Lead introduced LEGO© Serious Play to the Trust in August 2023, where LEGO© is used as a creative tool to foster inclusive discussions and to generate ideas.

In the New Year the Trust's learning centre, the Academy, will deliver a suite of masterclasses including cultural awareness and we will deliver discrimination and EDI workshops in response to our staff feedback during the Equity Data Walk.

In addition to EDI-related training we provide opportunities for all our staff to develop, specifically targeting staff from minoritized groups where participation has previously been low. This includes:

- **Career conversation (Scope for Growth) –** Scope for Growth is an inclusive framework for supporting and developing talent across our organisation. Training has been offered to Internationally Educated Nurses and Black, Asian and Minority Ethnic colleagues with several conversations now taking place. We have recently recruited two new Scope for Growth facilitators to represent Black, Asian and Minority Ethnic colleagues to further improve engagement and empower staff to feel valued.

- **Individual career coaching conversations –** We offer internal and external coaching for staff. Coaching can often help to improve an individual's performance and may be instrumental in them applying for a future role. This may help them to apply for a role that enables them to move to a higher grade.

- **Internal Leadership Programmes –** In 22/23 the Trust continued to provide internal leadership opportunities for Bands 4-8a which includes awareness sessions relating to EDI, delivered by

experts from across the Trust. In addition, we have supported ten individuals from a Black, Asian and Minority Ethnic background and Internationally Educated Nurses and Allied Health Professional programme to complete the Aspiring Leaders Programme.

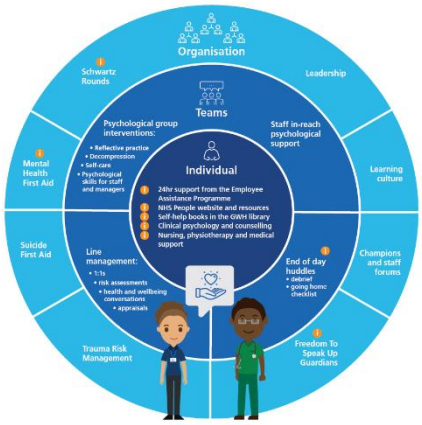
- **External Leadership programmes –** The Trust supports individuals to release their potential and develop their knowledge, skills and behaviours in leadership and management through the signposting and promotion of external opportunities including programmes at Masters level.

Leadership behaviours

The Trust launched our new GWH Leadership Behaviours in June 2023. One leadership behaviour will be promoted each month from September 2023 and this will feature videos, case studies and other resources.

The leadership behaviours were produced by working with people from across the organisation to provide a breadth of perspectives. These 12 leadership behaviours set the standards of expectation we aspire to in our everyday work. We consider everyone to be a leader. This framework will be integrated within all elements of our staff journey, from workforce planning to recruitment and selection, induction and ongoing development and performance review, to ensure we are as effective and consistent as possible.

Health & Wellbeing



Our staff are our most valuable asset and their health and wellbeing are essential to them being able to deliver a great service. We provide a range of opportunities for our staff to access services to support their physical and mental health. We provide several routes to access health and wellbeing support and staff can receive external support. You can read more about our approach to health and wellbeing in the Trust's Health & Wellbeing Plan 2021-25.

Key achievements are highlighted below.

Top performer in the Southwest and 8th nationally for flu vaccination compliance	416 individual physical health checks attended
4,119 occupational health appointments attended	115 staff trained in Mental Health First Aid
1,328 psychological group-based clinical contacts made	51 staff trained to be Suicide First Aiders
761 individual counselling and psychology appointments attended	73 staff trained in Health and Wellbeing Conversations

Freedom to Speak Up

We aim to ensure everyone working within the Trust feels safe and confident to speak up. When a concern feels serious because it might affect patients, people receiving care, colleagues or the whole organisation, it can be difficult to know what to do, therefore having someone to turn is important to our staff and leadership.

The Trust has seven Freedom to Speak Up Guardians (FTSU). The Guardians listen to staff concerns, support them and agree the best way forward for their concerns. The role is an important one, when staff feel unable to speak up, it can lead to high levels of risk for patient safety and can damage the culture and reputation of the organisation.

We recognise that it is also important that we learn from other organisations and the Trust will facilitate learning from the Lucy Letby case and adopt recommendations from any subsequent enquiries.

Looking Ahead 2023 - 2024

The Equality Diversity Inclusion Annual report 2022-2023 highlights numerous initiatives and provisions that support the Trust to provide inclusive services and to foster a culture that is welcoming to a diverse workforce and volunteers, including our internationally educated staff. We value and strive to have a workforce that is representative of our patients and local population and we continue to develop recruitment initiatives to make progress in this area, the increase in ethnic minority staff, internationally educated staff and disabled staff is a testament to improvements in this area. We value our staff and their wellbeing and we are proud of our health and wellbeing offer and the work of our staff networks, Freedom to Speak Up Guardians, Union Representatives and other support groups who help us to create a healthy working environment. We have also showcased numerous projects that have led to better patient care and improved access to our services. We know there is room for improvement and this is highlighted in our EDI performance reports in the following section.

We have a robust and ambitious EDI strategy that takes us up to 2024, the strategy sets out our four EDI objectives which have governed the work we have undertaken over the past year and continues to provide cohesive direction across the Trust for the coming year. Over the next few months, the Trust is engaging with staff to inform the new Trust strategy and our refreshed EDI strategy will align with the Trust priorities and objectives.

There is a strong business case for equality, diversity and inclusion and we want to capitalise on this. A diverse and inclusive organisation is known to improve performance, staff health and wellbeing, recruitment and retention and ultimately leads to better patient outcomes. We are excited about the transformative potential of opportunities like the Improving Together methodology and Restorative Just and Learning Culture approaches will provide to improve staff experience and reduce health inequalities in the workforce and for our patients.

Our action plan for 2023-2024 is ambitious and recognises the need to respond to national priorities like the NHS EDI Improvement Plan as we continue to address inequalities and we are confident that this plan will have a positive impact for the organisation. We are also keen to see cultural transformation take place and we believe we are more likely to achieve this if we prioritise a few initiatives in the action plan that will have the greatest impact, these are:

Priority One: Building an allyship programme. We recognise if we are to make significant progress in any area of this work, we must call on our staff across the Trust to actively work with their teams to address inequities and discrimination. Inclusion must be everyone's business. We will empower our staff to become change agents through initiatives like the Allyship programme that will include Inclusion Recruitment Champions and Cultural Ambassadors and we will widen our offer of development and support over the winter period by offering training, creating psychologically space spaces for staff to meet to talk about their experience and to shape ideas.

Priority Two: Addressing discrimination. The Trust has an organisation-wide focus on addressing discrimination in all its forms, when we engaged with staff they told us they are more likely to experience covert forms of discrimination like microaggressions or experience incivility. By addressing

unprofessional behaviours in all its forms we will improve the working life experience of our ethnic minority and disabled staff who disproportionately experience these behaviours, alongside improving the experience of all staff.

Priority Three: Equal Opportunities: Taking Action on the Gender Pay Gap – We will engage with female staff to understand perceptions and experience of equal opportunities in the Trust, particularly for medical and dental staff. This will help us to target any specific issues.

Improving Together is about all of us, and we invite our staff, leadership, governors, volunteers, and stakeholders to partner with the Trust to deliver this work successfully. If you would like to know how you can get involved contact our EDI Lead sharon.woma@nhs.net.

Part Two

Graphics/Image

Equality Diversity Inclusion Performance

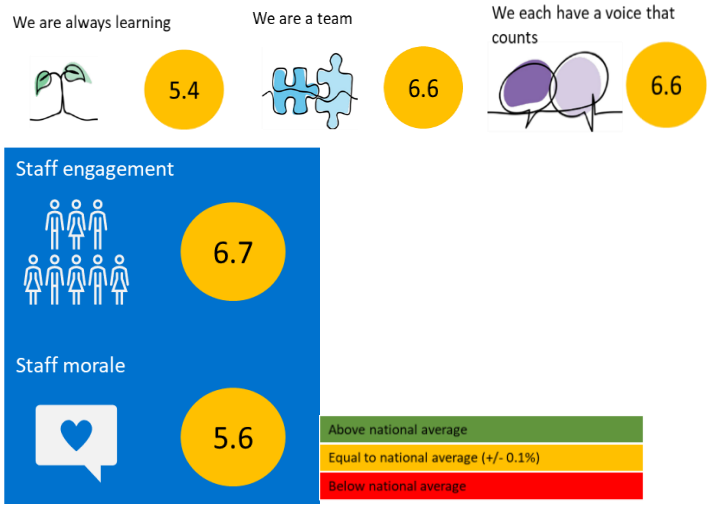
The Trust is committed to improving the experience and outcomes of its staff and population and we monitor EDI performance to ensure that we are making progress against our action plans and that initiatives have a positive impact. We are also able to benchmark ourselves against other organisations and be transparent about our progress. The Trust uses a combination of quantitative and qualitative data to measure progress towards embedding equality, diversity and inclusion which are highlighted below.

NHS Staff Survey

The Trust undertakes an annual survey every year and we invite all staff to take part. We are proud to say that we have seen improvements in 33 questions this year, compared to zero in 2021, and we scored above the sector benchmark on 16 questions, compared with just five in 2021. Our core strengths include supporting flexible working and the positive action we are taking on health and wellbeing, staff also felt respected at work and enjoy working with colleagues. Our areas for improvement include managing work pressures and advocacy. The NHS Staff Survey publication can be accessed here.

The 2022 NHS Staff Survey is in line with the People Promise, which is the NHS's commitment to its workforce. The staff survey tracks progress towards the seven elements of the People Promise, as well as measuring morale and staff engagement.

Here is a snapshot of our results:



Mandatory & Statutory Report Summaries

Equality Delivery System 2022

The Trust completed the Equality Delivery System (EDS2022) review in May 2023. The EDS2022 is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The tool measures equality diversity inclusion performance in three Domains:

- Commissioned and Provider Services – the group of organisations that make up the BSW system reviewed maternity services across the region, this work was led by the BSW Integrated Care Board. The remaining two Domains were reviewed internally by staff and senior leaders.
- Workforce Health & Wellbeing.
- Inclusive Leadership.

And there are four potential scores – Undeveloped Activity (score of 0-7); Developing Activity (score of 8-21); Achieving Activity (score of 22-32) and Excelling Activity (score of 33). The Trust achieved a score of **Developing Activity**, which indicates we have met the basic requirements.

A full report has been produced following the EDS2022 exercise, which highlights varied initiatives included in the scoring process. This will be published along with an action plan on the Trust website by 31 January 2024.

The next Equality Delivery System review will be done collaboratively with our system partners and we are currently exploring which services will be evaluated, this is likely to include one or more of the following areas – Learning Disability (focus on Annual health checks), Stroke Service and End of life pathway.

Gender Pay Gap (GPG) Reporting

The 2021-2022 Gender Pay Gap report was published on 31 March 2023. The Gender Pay Gap is the difference between the average (mean or median) earnings of men and women across a workforce. The report also looks at the difference between the (mean and median) bonus payments for men and women. The gender pay gap audit obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. As an organisation that employs more than 250 people and listed in Schedule 2 to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 we must publish and report specific information about our gender pay gap.

Our latest report indicates that the Trust has a mean pay gap of £7.56 (30.32%), which had increased by 1.22% since the previous year's figure of £6.89 (29.10%). When medical staff are removed from calculations, the mean pay gap significantly decreases to £1.24 (7.07%), an increase of 0.62% from the previous year's figure of £1.09 (6.45%). We have made some progress in reducing the pay gap between males and females across a number of our Bands (Band 4, 8A, 8C, 8D, 9, Medical Consultant, Medical Junior and Non-Exec) however they are still in favour of male staff. The report also pinpoints the cause of the pay gap which included an increase in male staff in more senior roles.

The following table highlights the main report results:

Gender pay gap standard measures (difference)		2020-21	2021-22	Comparison of male and female average earnings: Direction of travel	
1	The mean gender pay gap	29.10% £6.89	30.32% £7.56	Similar	⇐⇒
2	The median gender pay gap	19.81% £3.84	19.19% £3.83	Similar	⇐⇒
3	The mean bonus gender pay gap	79.37%	83.65%	Up / Negative	↓
4	The median bonus gender pay gap	79.76%	93.98%	Up / Negative	↓
5	The proportions of males and females receiving a bonus payment	21.44% M 28.97% F	20.76% M 22.49% F	Down / Positive (closer to parity for both)	↑
6	The Gender Pay Gap excluding medical and dental staff				
	The mean gender pay gap	6.47% £1.09	7.07% £1.24	Similar	⇐⇒
	The median gender pay gap	3.05% £0.47	6.26% £1.01	Up / Negative	↓
	The mean gender bonus gap	-2.41% -£17.09	-11.78% -£52.47	Up / Negative *(favours females)*	↓
	The median gender bonus gap	-20.00% -£80.00	0.00% £0	Down / Positive *(parity)*	↑

The Trust has undertaken several initiatives to close the pay gap including improvements to our recruitment processes and we have reviewed and revised criteria for our local Clinical Excellence Awards, we also acknowledge more work needs to be done to close the gap. The full Gender Pay Gap report can be found on the Trust's website. The Gender Pay Gap report for 2022-2023 will be published in January 2024 with an updated action plan. Actions from the current GPG report have been included in the appendix of this report.

NHS Equality Standards

The NHS has two mandatory reporting frameworks that measure the experience of our disabled and ethnic minority staff, when compared to our non-disabled and White staff. The reports help NHS commissioners and NHS healthcare providers (including independent organisations) to achieve workplace parity between the above-mentioned staff groups. It aims to achieve this by reviewing data against a number of key performance indicators, and obliges organisations to produce action plans to close identified gaps in career and workplace experiences.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

WDES improvement has been slow, and this is reflective of national challenges. The Trust has made progress in three metrics and there has been a slight decline across 5 metrics. The following metrics depict where there has been positive movement and the three metrics with the greatest decline:

- Percentage of staff who experienced bullying and harassment from managers improved ↑ 1.7%, from 16.9% to 15.2% (national avg. 17.1%)
- Percentage of staff who felt the Trust has provided reasonable adjustments improved ↑ 1.8%, from 70.5% to 72.3% (national avg. 71.8%)
- Increased the number of disabled staff in the organisation from ↑ from 2.42% to 2.98%
- Percentage of staff who experienced bullying and harassment from colleagues worsened ↓ 1.3%, from 27.5% to 28.8% (national avg. 26.9%)
- Percentage of staff who felt the Trust valued their work worsened↓ 3.3%, from 31.3% to
- 28% (national avg. 32.5%
- Relative likelihood of Disabled staff entering the formal capability process (performance management rather than ill health) compared to non-disabled staff worsened, from 1.94 to 3.63. However, due to the small number of staff involved any small change will result in a significant increase in the percentages. In 2021-22, the two-year average was zero, in contrast in 2022-23 this reporting year, the two-year average of staff entering the formal capability process was 0.5 for disabled staff – number of staff involved included one disabled staff, 7 non-disabled staff and one staff who does not have their status recorded (unknown).

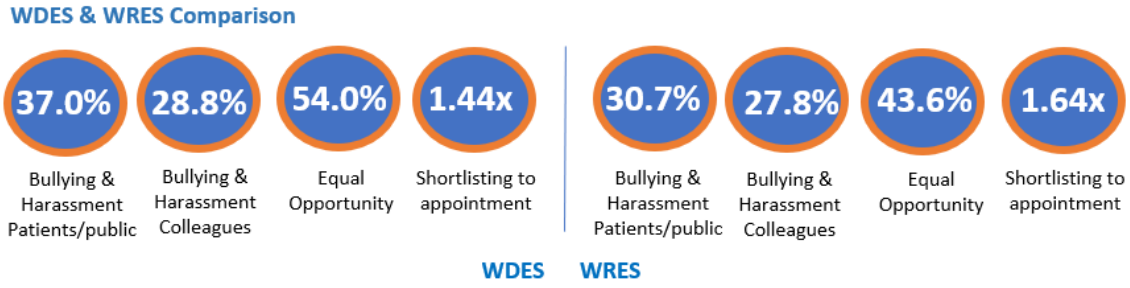
Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) is a set of nine specific measures (indicators) which enables NHS organisations to compare the workplace and career experiences of ethnic minority staff and white staff.

The Trust is delighted to report positive movement in 6 of the 9 WRES metrics, however, there is still work to be done, especially where the numbers still lag behind the national average and my ambition is to be above average within 3-5 years. Significant movement has been made across the following metrics:

- Bullying and harassment from staff improved ↑ by 4.9%, from 32.7% to 27.8% (national BME avg. 28.8%)
- Experiencing discrimination from colleague/team lead/manager improved ↑ by 6.6%, from 26.4% to 19.8% (but still above national BME avg. 17.3%)
- Bullying and harassment from patients improved ↑ by 4.1%, from 34.8% to 30.7% (BME national avg. 30.8%)
- Equal opportunities improved ↑ by 4.7%, from 38.9% to 43.6% (BME national avg. 47%)

The infographic below highlights key comparisons between WRES and WDES:



The Trust Board approved the WDES and WRES for publication at the recent Board meeting on 7 September 2023, the full reports can be found on the Trust website. The Trust uses WDES and WRES reporting to inform action plans which have been incorporated into this report (see appendix).

Part Three

Action Plan 2023 - 2024

Priority Actions have been highlighted in the table below:-

- Action 1: Launch of allyship programme to enable initiatives to be supported across the Trust.
- Action 2: Programme of work to address discrimination and other unprofessional behaviours.
- Action 3: Equal Opportunities: Taking action on the Gender Pay Gap – understand workforce perception and experience.

They represent the actions that are likely to have the greatest impact across the organisation. The remaining actions reflect our broader ambition to make improvements across all aspects of our Inclusion work.

This Action Plan pulls together plans from the various EDI frameworks utilised by the Trust including - Equality Diversity System (EDS2022), Gender Pay Gap (GPG) Reporting, Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), the externally led BDO Audit and are supportive of our commitment to deliver against the NHS England EDI Improvement Plan and the Trust's four-year EDI strategy.

Category	Key Action	Steps to achieve action	Due by	Action Owner	Desired outcome
Health & Wellbeing	Reduce discrimination, bullying, harassment and abuse in the workforce	Equity data walk – engage with staff to explore their lived experience and take action to support positive change based on findings. Including promotion of the NMC 'Combatting Racial Discrimination' toolkit.	Ongoing	EDI Lead	• Improved WRES Indicator 8: Experiencing discrimination at work from staff • Improved WDES Indicator 4: harassment, bullying or abuse from managers and colleagues
		Priority Action 1: **Launch Allyship programme - Promote everyday allyship and build a programme for volunteers to encourage staff to advocate for others and to challenge behaviour that is not in line with Trust values. Including re-launch of Reciprocal Mentoring programme.**	**Sep 2023**	**EDI Lead**	• **Improved WDES Indicator 4 and WRES Indicator 6: harassment, bullying or abuse from managers and colleagues** • **Improved WRES Indicator 8: Experiencing discrimination at work from staff**
		EDI Masterclass Series to be developed in-house to improve cultural competence and raise awareness around key issues including 'making adequate adjustments'.	Nov 2023	EDI Lead	• Improved WDES Indicator 4 and WRES Indicator 6: harassment, bullying or abuse from managers and colleagues • Improved WDES Indicator 6: Presenteeism • Improved WRES Indicator 8: Experiencing discrimination at work from staff

	Reduce discrimination, bullying, harassment and abuse from patients, relatives or the public	**Priority Action 2: Programme to address Unprofessional Behaviours (promote the reduction of bullying and harassment, incivility, disrespect, discrimination) – utilising varied communications, bite-size learning, allies, system shared resources**	**Oct 2023**	**EDI Lead**	• **Improved WDES Indicator 4 and WRES Indicator 5: harassment, bullying or abuse from patients, their family or the public**
	Increase Health & Wellbeing services	Deliver a new 4-hour training package for line managers - 'Mental Health Skills for Managers'.	Jan 2024	Clinical Lead for Staff Health & Wellbeing	• EDS2022 workforce health and wellbeing • Improved WDES Indicator 6: Presenteeism
		Health & Wellbeing (HWB) conversations to be added to the Electronic Staff Record system to improve the recording of this data and to facilitate HWB conversations.	Oct 2023	Clinical Lead for Staff Health & Wellbeing	• EDS2022 workforce health and wellbeing • Improved WDES Indicator 6: Presenteeism
		Provide in-reach physical health checks available for all staff – to include cholesterol, blood sugar levels and provide general advice	Aug 2023	Clinical Lead for Staff Health & Wellbeing	• EDS2022 workforce health and wellbeing • Improved WDES Indicator 6: Presenteeism
	Improved provision of Reasonable Adjustments	Apply for WDES funding in 2024 (funding might not be open for 2023/24)	TBC	EDI Lead	• EDS2022 workforce health and wellbeing • Improved WDES Indicator 6: Presenteeism • And WDES 8: Employer has made adequate adjustments
Equal Opportunities	Pilot Cultural Ambassadors	Train and support a small group of Cultural Ambassadors to act as an independent voice in the disciplinary process and to share good practice across the Trust, reducing likelihood of 'no case to answer' incidences which cause harm to staff and organisation.	Oct 2023	Equality Lead Nurse	• Improved WRES Indicator 3: Relative likelihood of staff entering the formal disciplinary process
	Reduce shortlisting to appointment disparity	Launch Inclusion Recruitment Champions programme in June 2023. Volunteer champions will be trained in August and will be available to support interviews for Band 8A above roles.	Jun 2023	Head of Resourcing	• Improved WDES and WRES Indicator 1: Workforce representation • Improved WDES and WRES Indicator 2: Relative likelihood of being appointed from shortlisting
	Expand Scope for Growth Conversations	Promote Scope for Growth (Career) Conversations to ethnic minority staff including Internationally Educated Nurses.	Nov 2023	Head of Leadership, Succession Planning & Talent Management	• Improved WRES Indicator 1: Workforce representation
	Work experience placements	Provide work experience placements for young people with special education needs and those not in education and employment.	Aug 2023	Early Years Careers Advisor	• Improved WDES Indicator 1: Workforce representation
	Promote apprenticeships	Promote apprenticeship opportunities to students from deprived areas.	Ongoing	Early Years Careers Advisor	• Improved WDES and WRES Indicator 1: Workforce representation

	NHS Cadets scheme	Working with NHS Cadets, a new scheme designed to provide 14-16-year-olds from under-represented communities with opportunities to explore voluntary work and careers with the NHS, providing one year of vital hands-on work experience in a wide range of roles. There are both clinical and non-clinical opportunities.	Ongoing	Early Years Careers Advisor	• Improved WDES and WRES Indicator 1: Workforce representation
	New College Swindon partnership	Trust to commence programme with New College Swindon and Swindon Borough Council in Oct 23, supporting young adults from disadvantaged areas of Swindon, looked after children and young carers. This would be an additional development programme supporting them into an apprenticeship	Oct 2023	Early Years Careers Advisor	• Improved WDES and WRES Indicator 1: Workforce representation • Improved WRES and WDES Indicator 2: Relative likelihood of being appointed from shortlisting
	Project Search scheme	Trust to initiate Project Search – national programme providing work experience opportunities for young adults within the SEND community.	Sept 2023	Early Years Careers Advisor	• Improved WDES and WRES Indicator 1: Workforce representation • Improved WDES Indicator 2: Relative likelihood of being appointed from shortlisting
	Better promotion of our senior vacancies to women and organisations that support women, including medical and dental vacancies	**Priority Action 3:** **Equal opportunities review – review of quantitative and qualitative evidence (focus group study) to assess female staff experience and perceptions around equal opportunities.**	**Revised date Feb 2024**	**EDI Lead**	• **Reduction of the Gender Pay Gap** • **Improved WDES and WRES Indicator 1: Workforce representation** • **Improved WRES Indicator 7: improve perceptions around 'equal opportunities'**
	Identify other areas of good practice across the system in order to reduce the Gender Pay Gap	Identify good practice across the system to reduce gender pay gap and inform future action plans.	Revised date April 2024	EDI Lead	• Reduction of the Gender Pay Gap • Indicator 1: Workforce representation • Improved WRES Indicator 7: improve perceptions around 'equal opportunities'
	Expand pay gap review to include other protected characteristics	Undertake pay gap reporting based on ethnicity, disability and sexual orientation	Revised date Jun 2024	EDI Lead	• Reduction of the Gender Pay Gap • BDO external audit action plan
	Improve parity in Clinical Excellence Awards	Review local Clinical Excellence Awards and extend criteria for 2023-24 awards.	Nov 2023	HR Business Partner with remit	• Reduction of the Gender Pay Gap
Inclusive Leadership	Inclusive Leadership training	GWH managers and leaders to participate in system-wide leadership training, training opportunity actively promoted to minoritized staff	Ongoing (cohort 2)	BSW ICB	• Improved WDES Indicator 7: Staff feel valued by the Trust • Improved WRES Indicator 7: improve perceptions around 'equal opportunities'
	Host Equality Diversity Inclusion conference	EDI conference to be hosted by Trust to support leaders to understand how	Mar 2024	EDI Lead	• EDS2022 Inclusive Leadership

		to lead 'Inclusion' in their work areas, to manage cultural change and support an increasingly diverse workforce			
	EDI to be embedded in all in-house leadership training	Review and revise internal leadership training offers to ensure they include key EDI messages	Sept 2023	Head of Learning & Development	• EDS2022 Inclusive Leadership
	Set Board objectives	Board to develop collective and individual EDI objectives linked to their appraisal. This will align with the national High Impact Action 1.	Mar 2024	Board Chairperson	• EDS2022 Inclusive Leadership
Workforce Engagement	Deliver a series of Workforce Listening Events	Host a series of 'Change the Narrative' Storytelling events throughout the year to help to raise awareness and to challenge stereotypes.	Ongoing	EDI Lead	• Support overall improvement across all aspects of EDI • Improved WDES Indicator 4 and WRES Indicator 6: harassment, bullying or abuse from managers and colleagues
	Provide access to regular EDI support across workforce	Launch 'Inclusion Café' to provide an opportunity for staff to regularly engage with EDI Lead, the café will be a forum for bite-size learning and provide an opportunity for staff to share their views and seek support.	Oct 2023	EDI Lead	• Support overall improvement across all aspects of EDI
	Promote Restorative Just & Learning Culture	Understand further the national tool and pilot in three areas with a view to using this across the whole organisation. Communications, training and support to embed RJLC.	Ongoing	Associate Director of Organisational Development & Learning	• Support overall improvement across all aspects of EDI • Improved WRES Indicator 6: harassment, bullying or abuse from managers and colleagues • Improved WRES Indicator 8: Experiencing discrimination at work from staff
	Support staff networks to deliver a range of initiatives	EDI function to support staff networks across a range of initiatives including events and learning opportunities	March 24	EDI Lead	• Support overall improvement across all aspects of EDI
Access to Equitable Health and Care for Patients	Meet accessible information standards across the whole organisation to ensure there is a consistent approach	EDS2022 evaluation that will take place in 2023-24 will include a review of complaints and concerns in relation to EDI	April 2024	BSW ICB	EDS Domain 1: Commissioned & Provider Services
	Improve patient access, experience and outcomes	Monitor and report complaint, concerns, and incident themes in relation to patient access concerns and implement actions to address. Implement new software to enable all leaflets to be available via digital portal linked to Trust website, enabling translation at source. Use service user feedback from diverse groups to support improvements in physical accessibility across the organisation.	Ongoing February 2024 April 2024	Head of Patient Experience and Engagement	The number of EDI access complaints, concerns and incidents will be reduced

		Work with local carers organisations to develop a specific young carer passport to improve patient and carer experience. Continue to promote the Carer Support Passport and support to improve patient and carer experience. Implement Carer information leaflets in languages and formats other than English. Evaluate use and effectiveness of new on-site Defence Medical Welfare Service, which supports patients with military connections.	February 2024 Ongoing February 2024 January 2024		
	Use patient equality and diversity data throughout the organisation to ensure that future improvement plans evolve to meet the needs of our local population	Improvement to data systems to enable automatic flow of data and enable links between data sets to support additional patient profiling.	March 2024	Associate Director of Business Intelligence	
	Increase working collaboratively with patients, families, and carers, from diverse communities in the design of services and pathways	Further expand engagement with seldom heard communities by identifying and networking with new groups. Develop more opportunities for engagement, involvement and for co-production to learn what is important to specific groups.	Ongoing	Head of Patient Experience and Engagement	Evidence that there is an opportunity for all patients voices to be heard.

NHS
Great Western Hospitals
NHS Foundation Trust

Equality Diversity Inclusion Annual Report

2022-2023

Together we are Great

Public Sector Equality Duty

Great Western Hospitals NHS Foundation Trust

EA210 S.149 - Public Sector Equality Duty

General Duties

- (1) A public authority must, in the exercise of its functions, have due regard to the need to—
- (a) eliminate discrimination, harassment, victimisation…
- (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Specific Duties

- Public bodies must publish:

  Gender pay gap information

  Equality information – service users and workforce

  Equality objectives

Progress against Objectives

Great Western Hospitals NHS Foundation Trust

One

- Launched the 'Our Great Way' working group – RJLC
- Expanded Scope for Growth
- Board EDI education
- Positive external BDO EDI Audit

Inclusive & Compassionate Leadership

Two

- Inclusive recruitment practice leading to diversity hires
- Robust health and wellbeing offer
- Stay & Thrive conversations for IENs

Represented & Supported Workforce

Three

- Improvements to signage and doors
- Published trans patient guidance
- Launch Patient Passport
- Anchor Institution projects to address health inequalities

Support our Patients & Communities

Four

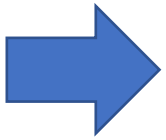
- Engagement across workforce, including staff network led initiatives
- Launched Carers Passport
- Improving Together in EDI

Let every voice be heard

Action Plan that responds to frameworks

Great Western Hospitals NHS Foundation Trust

1	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3	Develop and implement an improvement plan to eliminate pay gaps.
4	Develop and implement an improvement plan to address health inequalities within the workforce.
5	Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.
6	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.



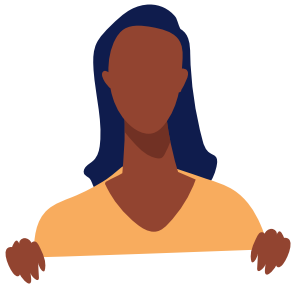
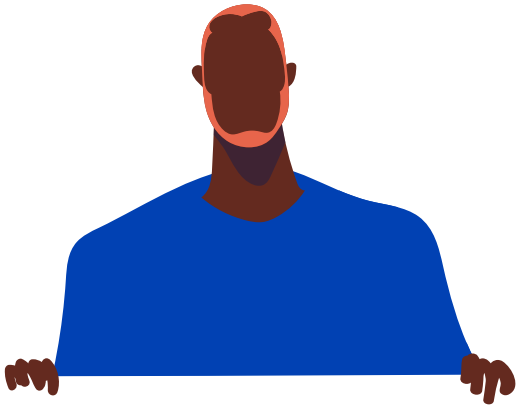
- National policy – Workforce Plan
- System Plans
- Equality Delivery System
- Gender Pay Gap
- Race Equality Std
- Disability Equality Std

Priority Actions

Great Western Hospitals NHS Foundation Trust

1	Developing the Allyship programme to create local support and taking action ‘in the moment’
2	Address discrimination (Improving Together EDI Metric) and other Unprofessional Behaviours in all its forms
3	Action of the Agenda Pay Gap: Exploring Equal Opportunities perceptions and experience

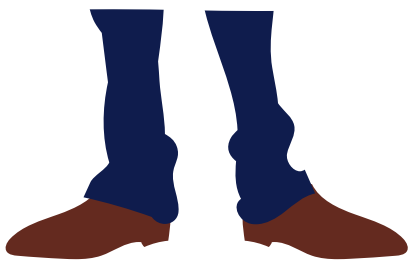
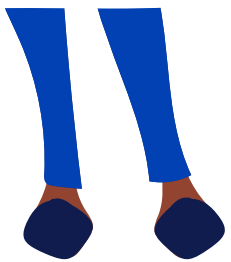
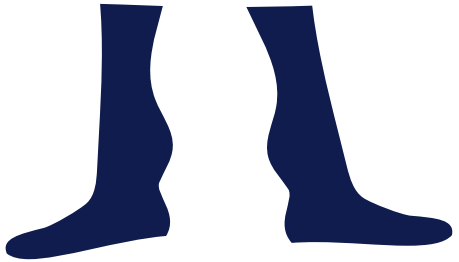
Discussion


Is the report balanced (patient and workforce inclusion and overall content)?

What is your overall reaction to the report?

Given the scale of work (including need to respond to national, system and local needs) how do we Improve Together and make Inclusion everyone's business? And what is your commitment to help to facilitate this shift in practice?


Mark the dates in your diary

Great Western Hospitals NHS Foundation Trust

GWH internal events:
Addressing Discrimination: A workshop for Managers & Leaders (working title)
Join Rumina Morris, founder of Rumina Morris (ruminamorris.com) and former Director of Anti-racism and Anti-oppression at the City of London Canada (local authority) for an informative and solution-focussed workshop to address discrimination.
30 November 2023, 1pm to 3pm. Microsoft Teams

Inclusion Cafe Launch: Speak Up Listen Up (a safe space to explore advocacy and inclusion at GWH): Following the John Higgins (author of Speak Up, Listen Up) session with staff (B7 and under) on 16 November, where staff will explore building confidence and finding their voice, staff and leaders are invited to an Improving Together themed session to consider how we can build advocacy and inclusion at GWH.
Tuesday28 November, 11.30 to 12.30pm, Seminar Room 4, The Academy

The Big Coffee Break:
Equality Human Rights Commission: Is Britain Fairer? The EHRC will share key themes from this year's statutory report, soon to be published. This is a report that informs the work of many EDI professionals, by joining us at this event, you will learn key data and insights relating to health and social care through the lens of equity and human rights. The EHRC team will also share highlights from their ongoing audit of ICBs (meeting the Public Sector Equality Duty). Tuesday 14 November, 11am to 12.30pm, Microsoft Teams

Addressing Unprofessional Behaviours: Join the Big Coffee Break for an informative webinar with Dr Jane Ferguson Assistant Professor & Programme Director of Health and Care System Leadership and Justin Aunger PhD, Research Fellow from the Midlands Patient Safety Research Collaboration at the University of Birmingham, who will share recent findings from research on unprofessional behaviours (discrimination, bullying, incivility) in the NHS and in healthcare. The team will share good practice from around the world, and insights into developing evidence-based EDI practice.
Tuesday 23 January 2024, 10am to 11.30am, Microsoft Teams

Speak Up, Listen Up with John Higgins, January/February date TBC. This will be a round table discussion exploring speaking up.

GWH plays host to The Big Coffee Break, a national peer-led network established by Sharon Woma in January 2022 to strategically influence and support systemic EDI practice.

Great Western Hospitals NHS Foundation Trust

Report Title	**Freedom to speak up Annual Report 2022-23**				
Meeting	**Trust Board**				
Date	2 November 2023	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Rayna McDonald, Deputy Chief Nurse				
Appendices					

Purpose

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

Assurance Level

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

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

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

The report describes a service that has not been able to meet its objectives over the year due to lack of continuity of a Lead Guardian. This has led to a decline in referrals and reduced activity to promote the service during the time frame of this report.

Report

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

The purpose of this paper is to provide an overview of the work of the FSTU Guardians, updates from the National Guardian office including the FTSU Guardian Survey, and the activity over the twelve-month period related to this report.

This report has been discussed at the Trust Management Committee and the Quality and Safety Committee, as a follow up action the Quality and Safety Committee have also reviewed the action plan which has a focus on raising awareness and developing a more resilient and robust service.

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		

		Risk Score
Key Risks – risk number & description (Link to BAF / Risk Register)	**Risk 332**- Risk that staff feel unable to speak up and therefore the opportunity for learning and improvement is missed	6
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Trust Management Committee Quality & Safety Committee	
Next Steps		

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

Explanation of above analysis:

The subject matter of this report is likely to disproportionately affect those with protected characteristics. The report does not explore this or describe initiatives for improvements to specifically reduce inequality.

Recommendation / Action Required

The Board/Committee/Group is requested to:

- To note the contents of this annual report.

Accountable Lead Signature	
Date	25 October 2023

Introduction

This paper provides an Annual Report from the Freedom to Speak Up (FTSU) Guardians for 2022/23. It covers the period June 2022 to June 2023. The report describes the FTSU service and its performance over the year.

The Trust's approach to developing and supporting a 'speaking up' culture is an important component of the CQC's well-led framework. If staff feel empowered to raise concerns and that their concerns are addressed, then this will positively impact patient safety and allow the trust to learn lessons from incidents and promote good practice. Leadership and support are provided by the Trust Board and Senior Leadership team to ensure an open and transparent culture.

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

Freedom To Speak Up Service 2022-23

The FTSU service is led by a Lead Guardian who is supported by Guardians who take on the role in addition to their substantive roles, this often creates difficulties with having the time and capacity to respond effectively to the needs of the service. In July 2022 with the Lead Guardian stepping down and one other Guardian resigning this meant the total number of Guardian has reduced from seven to five.

Following the resignation of the Lead Guardian in July 2022, there was a period of time where the service did not have a Lead Guardian in place. A new lead was appointed and commenced in role in January 2023. This new post was established as a dedicated substantive post for two days per week. Due to the change of Lead Guardian and the role being vacant for a number of months there was a decline in some of the activity required to support the FTSU service and this may be reflected in the reduced referrals seen this year.

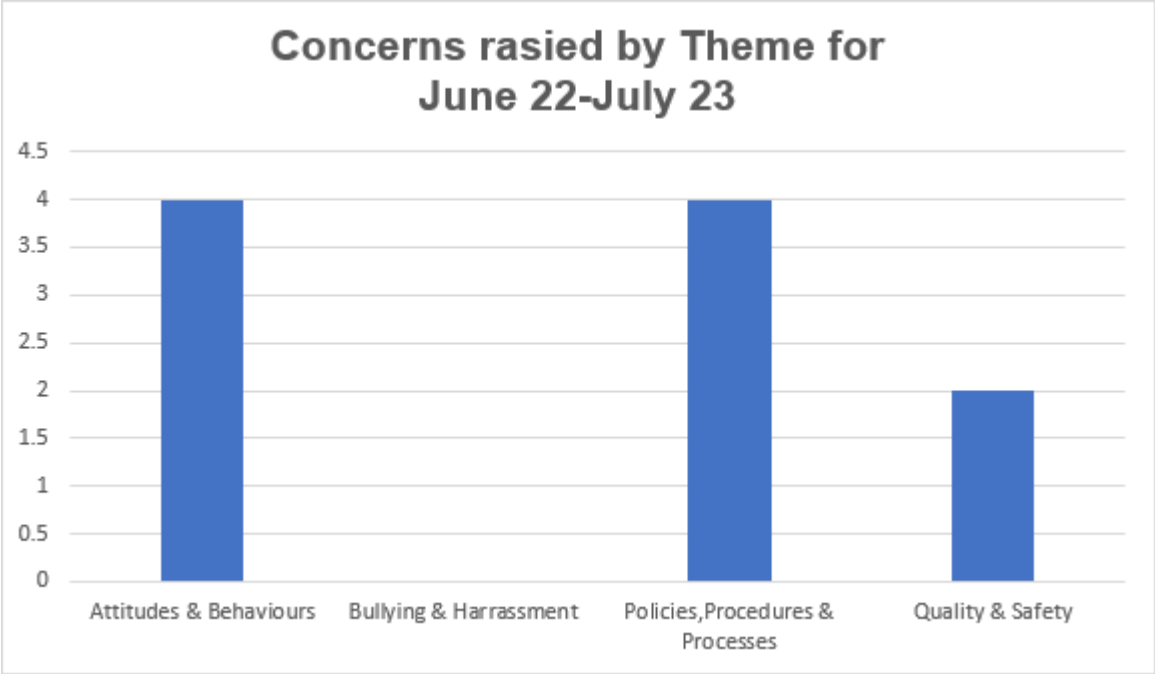
Staff who have used the FTSU service report they find the FTSU role valuable as they are able to access independent and confidential advice, and support.

The Guardians and users of the service have reported that the FTSU process often gives people a voice that they did not feel that they had, and they note that relatively minor incidents can have a huge impact on staff. A key part of the service is ensuring that emotional and wellbeing support is available to all staff who are involved in speaking up processes.

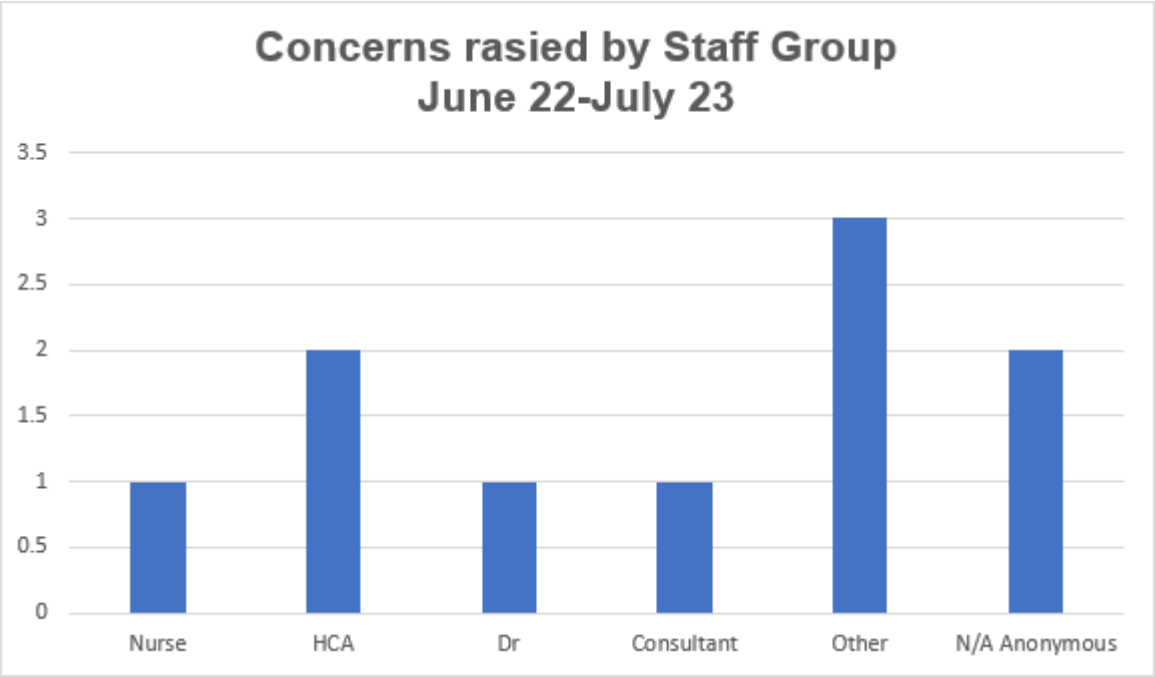
Freedom To Speak Up Cases
There were 10 concerns raised to the Freedom to speak up Guardians between June 22 and June 23 compared to 22 in the previous year. There were a total of two cases where staff wanted to remain anonymous compared to 14 in the previous year.

We have a low number of concerns being raised, which may be indicative of not having an active Lead Guardian for several months. All ten concerns were responded to within the agreed timeframe by the appropriate lead.

Theme of concerns



Concerns by staff group



FTSU Training
All Staff can access Freedom to Speak Up training via ESR. In line with National Guardians Office standards, currently there remains little uptake for the training and it is not mandated, this may be an option to consider. It is planned for the Lead Guardian to increase awareness of the various training options that are available. Trust and Junior Doctor induction includes an introduction to the FTSU service.

The training on offer includes.

- **Speak Up:** Core training, for all workers, covers what speaking up is and why it matters. It will help learners understand how to speak up and what to expect when they do.
- **Listen Up:** This training for all line and middle managers and is focussed more on listening up and the barriers that can get in the way of speaking up.
- **Follow Up:** This training is aimed at all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.

FTSU Self-Assessment
NHS improvement (NHSI) and the National Guardian Office (NGO) published 'Guidance for Boards on Freedom to Speak Up in the NHS Trusts and Foundation Trusts in July 2019. The guide supports Boards to create a culture where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high-quality care or affects their experience in the workplace.

Next Steps
The service recognises that there is work to do in the coming year in raising awareness of the service, building the capability and capacity of the service and ensuring that the FTSU service is embedded as a key component in supporting a culture that supports speaking up.

An action plan has been developed that includes.

- Communication plan, including a suite of events in October FTSU month.
- Establish a regular meetings for the Guardians to share experiences and learning.
- Review training delivery options and how to increase participation.
- Develop plans to develop how learning can be shared more widely for example develop a short report that helps managers reflect on the learning from a case and how they assure themselves that the learning prompts sustainable improvement.
- Seek permission from the person that spoke up and the manager involved to tell their stories about the learning from their case.
- Develop external links with other Guardians and engage with Southwest Regional Network of Guardians and sharing learning.
- Continue discussions at a system level to look at a more sustainable model for the longer term.
- Review internally resources dedicated to FTSU to ensure the service is robust and resilient.
- Complete the FTSU self-assessment tool to assess compliance against the National Guardian's Office requirements and use the findings to inform the improvement actions.

Conclusion

After a difficult year the service now has some dedicated if limited resource to support increasing awareness and developing a more robust service in terms of capacity to provide support. Progress will be reported in the six-monthly report in March 2024.

The implementation of new national patient safety strategy, which encourages developing a learning environment and the Trust explicitly implementing the framework to support a Just and learning culture all resonates strongly with FTSU and will support and work alongside the service moving forward.

Great Western Hospitals NHS Foundation Trust

Report Title	**Patient Safety Incident Response Framework Implementation plan and policy**				
Meeting	**Trust Board**				
Date	2nd November 2023	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek - Chief Nurse				
Report Author	Helen Winter – Head of Patient Safety and Quality				
Appendices	Nil				

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):

There is confidence that the development of both the plan and policy have been robust with wide consultation and engagement. Thus, supporting the facilitation of the objective to implement a robust plan and policy that meets the National Patient Safety Strategy and supports patient safety across the organisation.

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):

This document outlines the governance arrangements for responding to Patient Safety Events that occur at Great Western Hospital or through any service provision that the Great Western Hospital NHS Foundation Trust (the Trust) Provides through the policy.

This policy is aligned to the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework and replaces the Incident Management Policy used by the Trust under the Serious Incident Framework 2014. The policy is supported by the Patient Safety Response Plan. The plan provides the granular detail of how the organisation will review a patient safety event(s), this includes the types of learning responses available and the requirement for a response that is proportionate.

The plan sets out the organisational vision to derive learning, share learning and a move to a Safety II profile (Safety II is a move to ensuring as many things as possible go right and learn from things that go right, rather than investigating where things go wrong (Safety I). Organisations will use both safety I and II approaches. The plan sets out the links to the STAR values and the collaborative approach to system wide learning and sharing.

To establish both the policy and the plan a full consultation process with the development of a series of engagement meetings was completed. The organisational safety profile has been established and priorities agreed based on the data available.

The policy will be reviewed as required but at a minimum every three years. The patient safety response plan will be reviewed formally at 12-18 months but will be a live document reviewed every three months in line with any changes to the organisation's safety profile, and any system or national directives.

The patient safety response plan also details the patient safety responses and the need for any learning responses to be conducted proportionately following any patient safety event. To support this response templates are available and have been socialised over the past few months.

Once the patient safety response plan and policy are fully approved the organisation will formally move to the new framework. However, declaration of a Serious Incident is still a national requirement but locally the type of investigation/review will follow the new framework and utilise the new documentation, this is in agreement with the Integrated Care Board.

The organisation has developed this policy and plan in accordance with the national guidance, using the nationally provided templates. The request for formal approval at board level is in line with national requirements, the Plan and the Policy have been reviewed by the Patient Quality Sub- Committee and by the Quality and Safety Sub Committee who recommend the Trust Board approves Patient Safety Incident Response Framework Implementation Policy and Plan.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	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	The information contained within the report is a summary of the work undertaken by the PSIRF Implementation Group and subgroups. The plan and policy have been presented and discussed at the Patient Quality Sub Committee and the Quality and Safety Committee. The Quality and Safety Committee approved recommendation to the board for final approval on 19th October 2023				
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 are requested to provide final approval based on the recommendation from the Quality and Safety Committee on 19th October 2023.	
Accountable Lead Signature	Lisa Hall
Date	26 October 2023

Great Western Hospitals NHS Foundation Trust

Patient safety incident response plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Tom Blowers**	**Deputy Head of Insights and Learning.**	**Tom Blowers**	**August 2023**
Reviewer	**Helen Winter**	**Head of Insights and Learning.**	**Helen Winter**	**August 2023**
Authoriser	**Trust Board**	**NA**	**NA**	

Consultation

The development of this plan has been through a very wide consultation process, and it is not possible to list all those consulted in the below table. Each Division has been able to input into the document development at various meetings, including the Implementation group and the Oversight group. In addition to this the Divisional Quality Governance Facilitators have had direct input to the plan development.

Contents

Introduction to the Great Western Hospital NHS Foundation Trust Patient Safety Incident Response Plan

The Patient Safety Incident Response Framework (PSIRF) was released in August 2022 and is one of the deliverables outlined in the NHS Patient Safety Strategy (PSS) released in July 2019.

The Framework was released following a period of consultation with earlier adopters, replacing the Serious Incident Framework. PSIRF outlines how providers should respond to patient safety incidents for the purpose of learning and improvement, prioritising compassion and involving those affected by patient safety incidents. PSIRF outlines the requirement for a system-based approach to learning and improving from patient safety incidents, ensuring that a considered and proportionate response occurs and there is robust oversight of how the Trust learns from incidents.

The Trust will transition from the Serious Incident Framework to PSIRF from September 2023. Preparation for this transition has included, understanding the existing patient safety processes and culture, developing a robust oversight and governance structure, considering the four main aims in PSIRF.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them.

The principles of PSIRF also include using different learning responses to respond to patient safety incidents and this patient safety incident response plan will outline the array of learning responses that should be used proportionately when a patient safety incident occurs. The Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Our Vision

This patient safety incident response plan sets out how Great Western Hospitals NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

We will aim to ensure that whatever approach we take to learning from an incident, that there is a key focus on meaningful actions and improvement. A priority for us is to learn from patient safety events and approach that learning in a way that does not apportion blame, treats all those involved in a just and fair way and promotes system wide learning and improvement.

There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. This plan explains the scope for a systems-based approach to learning from Patient Safety Incidents (PSIs). We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

	Service	Teamwork	Ambition	Respect
Our Values	• Effective communication • Prioritise customer care and safety • Flexibility and meeting patient need • Be professional • Take personal responsibility for the service we provide • Take pride in our work	• Treat Everyone as equal • Work effectively in partnership with others • Appreciate Different levels of responsibility • Recognise diversity • Be friendly and supportive • Be reliable • Be open to change • Use resources effectively	• Strive for excellence • Act as a good role model • Be creative and proactive • Have a positive attitude • Encourage others • Recognise and Celebrate achievement • Reflect and improve from feedback	• Be open and honest whilst maintaining confidentiality • Be an advocate for the Trust • Demonstrate compassion and empathy • Treat others with dignity • Value everyone's contribution
PSIRF Aims	Compassionate engagement and involvement of those affected by patient safety incidents	Considered and proportionate responses to patient safety incidents	Application of a range of system-based approaches to learning from patient safety incidents	Supportive oversight focused on strengthening response system functioning and improvement

Our services

We reviewed the services we provide focussing on what we could learn and what we could improve. This was achieved through mapping of current services and the direction or input of patient safety concerns to the organisation. It has been identified that there are many different routes for a patient safety incident to be identified and many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

Responses covered in this plan include:

- Patient Safety Incident Investigations (PSIIs)
- After Action Reviews
- Multidisciplinary Team Reviews
- Patient Safety Reviews
- Other types of response may be considered and used if it is agreed that these will be best in deriving optimal learning and improvement. An example of this may be a case study.
- Immediate learning reviews (Timeline mapping, Risk assessment, Debrief)
- Systematic learning reviews: (Case record/note review)
- Specialised reviews (e.g., Falls, pressure ulcers, IPC reviews)
- Appreciative inquiry
- Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests or criminal investigations. The principal aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- Human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators
- Legal teams for clinical negligence claims
- Medical examiners and, if appropriate, local coroners for issues related to the cause of a death
- The police for concerns about criminal activity

Defining our patient safety incident profile

A review of the data and activity (associated with patient safety incident investigation) has been completed. This has included a review of:

- Risks on the Trust wide risk register
- Complaints, concerns and queries
- Patient Safety incidents raised on Datix

Risk Register

A review of the risk themes under the 'Safe' category on the risk register has identified the following themes:

- Staffing (safe staffing levels and staff competencies)
- Infection, prevent and Control (Infection rates)
- Medicines (Medicines Safety)
- Environment (Space)
- Medical devices/equipment (maintenance)

Complaints Concerns, Queries

A review of 12 months of complaints, concerns and queries that have been managed via the Patient Advice and Liaison Service (Pals) has identified the following themes:

- Access and waiting
- Better information, communication, and choice
- Behaviour and attitude
- Clean comfortable place to be
- Safe, high quality co-ordinated care

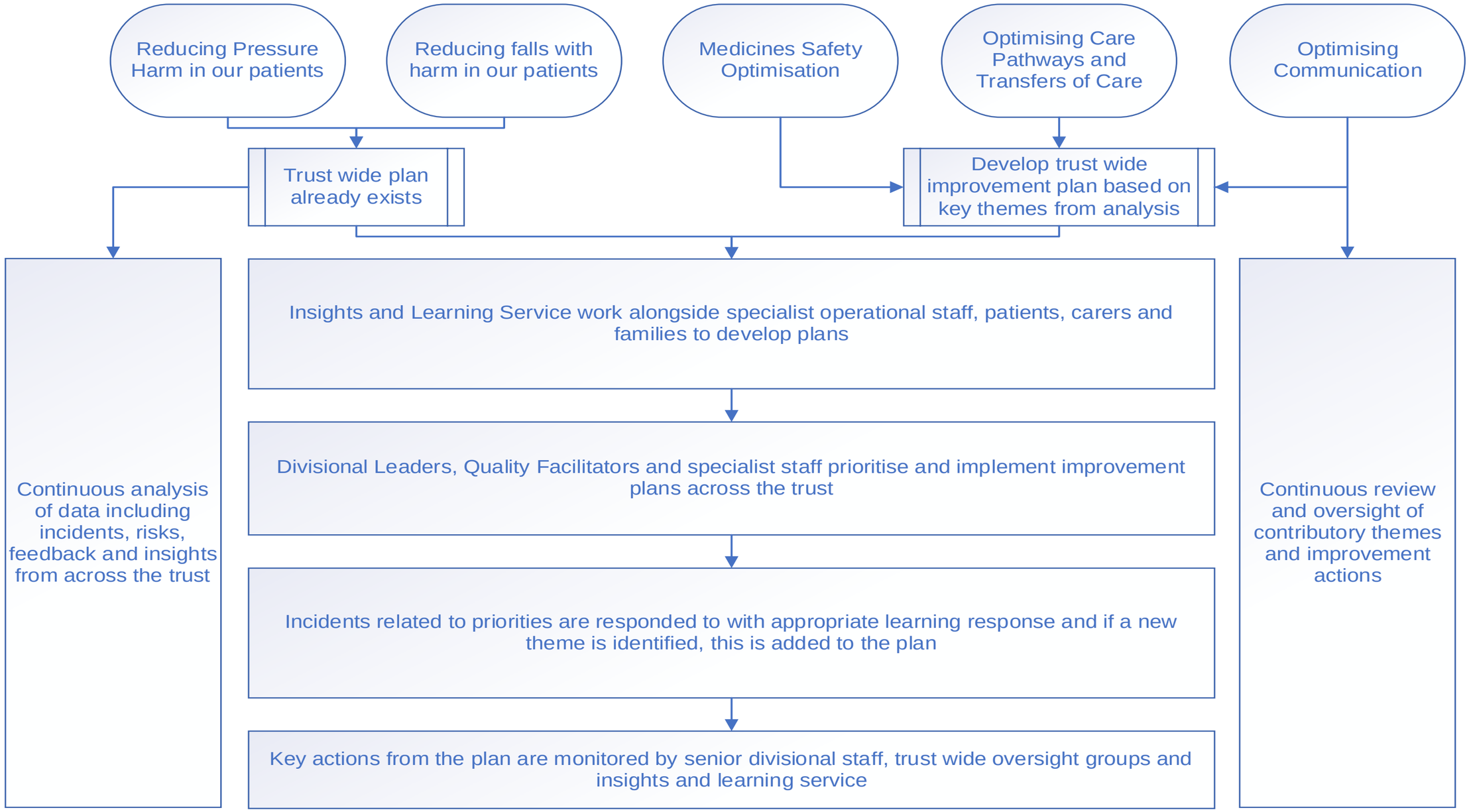
Patient Safety Incidents

A review of the patient safety management system (Datix) since July 2022 has identified the top three categories (graph one) as:

- Tissue Viability
- Patient accident/falls
- Medication

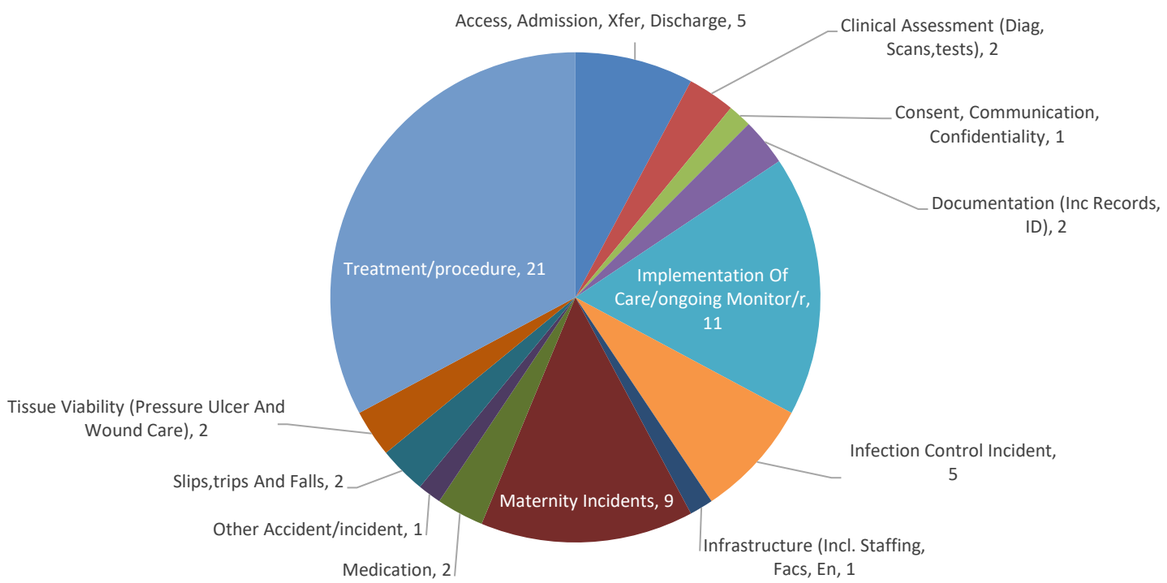
Defining our patient safety improvement profile

Review of the incidents, risks and complaints that support us to identify patient safety issues has helped us understand five key priorities which we as a Trust would like to focus on. This does not mean that other incidents will not have adequate focus. It means that for the five key priorities we have identified, we will develop Trust wide improvement plans to increase learning and reduce the risks to patient safety that these areas pose. Where there is already a Trust wide improvement plan, these will be reviewed and enhanced ensuring they are optimised, reflective of PSIRF values and understood across the Trust. Where new themes are identified, consideration will be given to developing a new improvement plan. Where improvement plans reach the desired patient safety targets, they may be stepped down and monitored.



How we agreed our patient safety learning responses

Figure 1 serious incidents by cause reported 06/21 - 06/23



The chart to left (figure 1) shows Serious Incidents that were reported from June 2021 to June 2023 from Great Western Hospital. Whilst this has provided us with some valuable information around what caused some of these incidents, we also thematically analysed each serious incident report to show us more about the common themes that arose. These included:

- Communication issues
- Missed opportunities
- Documentation issues
- Training
- Delays

We also reviewed complaints, concerns and queries into the rust and found that the top themes of these were:

- Access and waiting
- Information, communication and choice
- Behaviour and attitude
- Clean and comfortable place to be
- Safe, high quality coordinated care

Figure 2, top 10 reported incidents July 2022 - June 2023

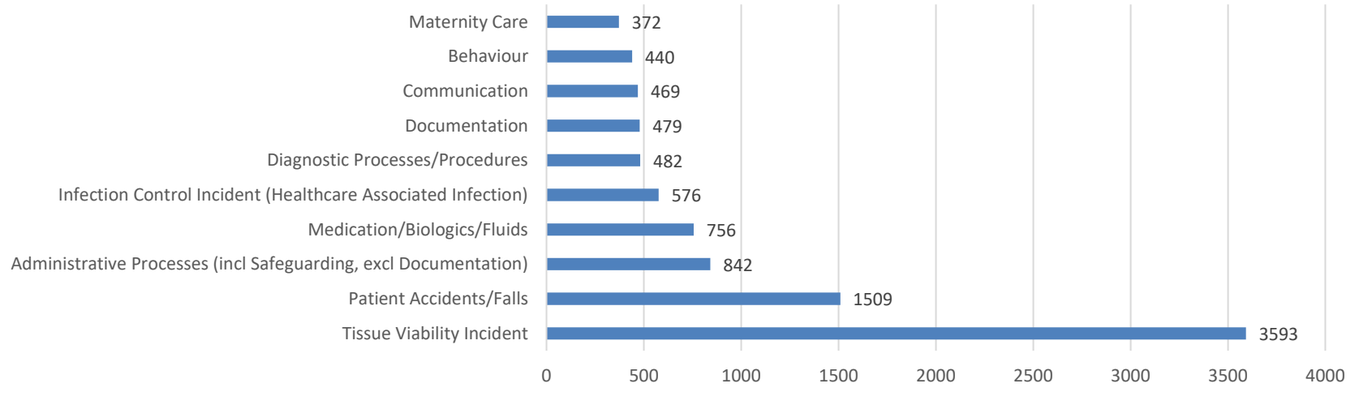


Figure 2 shows the top 10 incidents reported from July 2022 to June 2023. The top five reported themes are known safety challenges. The theme administrative processes often included issues around discharging patients and therefore a robust learning response is required to improve this area of care.

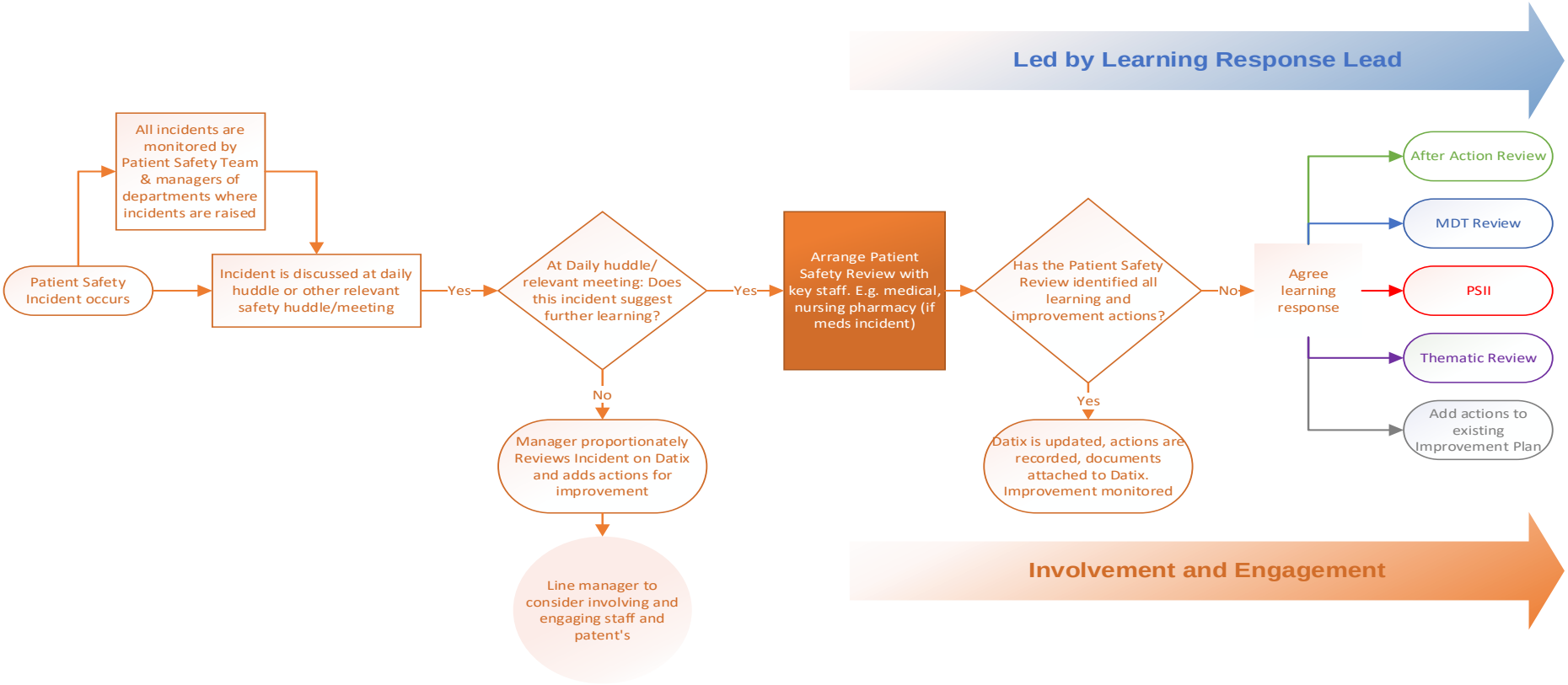
Colleagues in our Safeguarding department also undertook some analysis of safeguarding enquiries that had been raised the key themes that led to safeguarding enquiries were around Tissue Viability care and concerns in patients and issues with discharging patients from the hospital.

Our patient safety incident response plan: national requirements

	Patient Safety Event	Learning Response		Improvement
National Priorities	Mental Health Related Homicide	Recorded on Clinical Risk Management system and referral made to:	Relevant NHS England and NHS regional improvement investigation team	Recommendations are implemented and responded to, and improvement monitored through Trust wide learning and improvement governance meetings
	Maternity and Neonatal meeting HSIB criteria		Patient safety Event referred to Health care Investigation Branch	
	Deaths of Persons with Learning Disabilities		Reported and reviewed by Learning Disabilities Mortality Review	
	Safeguarding where various plans are in place for the patients		Learning response agreed with GWH Safeguarding lead	
	NHS screening Program Incidents		Reported to Public Health England	
	Domestic Homicide (including domestic suicide)		Relevant National and Local bodies	
	Death of Patients in Custody/prison/probation		Reported to Prison and Probation Ombudsman	
Locally Led Patient Safety Incident Investigations	Deaths thought more likely than not due to problems in care	Round table/Huddle occurs with appropriate professionals - nursing staff/medical staff/pharmacy and Quality professionals to determine Terms of Reference (ToR) and focus and any immediate learning	Patient Safety Incident Investigation	Recommendations are implemented and responded to, and improvement monitored through Trust wide learning and improvement governance meetings
	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Mental Health Act (1983) or where the Mental Capacity Act (2005) applies			
	Incidents meeting Never Event Criteria 2018 or its replacement			
	Incidents where there may be significant new learning that is not being addressed through any other learning response			
Trust wide priorities	Reducing Pressure Harm in our patients	Improvement plans are developed and implemented to address Trust wide priorities. Where there are linked incidents, an appropriate learning response is utilised and if a new issue identified then added to improvement Plan. Plans are monitored through appropriate Trust wide learning and improvement governance meetings.	Trust wide improvement plans focussed on key issues identified through thematic review. Continuous Thematic Review to monitor improvement and flex improvement plans.	Improvement plans are monitored and reviewed through relevant specialist groups & Trust wide learning and improvement governance meetings
	Reducing falls with harm in our patients			
	Medicines safety optimisation			
	Optimising care pathways and transfers of care			
	Optimising communication			
Other incidents resulting or that could have resulted in harm to patients	Incidents that have not been managed through the above processes	Round table/Huddle occurs with correct professionals - nursing staff/medical staff/pharmacy and Quality professionals to determine appropriate learning response	Utilise suite of learning responses most appropriate and proportionate for deriving optimal learning. E.g., After action review, MDT Review, locally defined learning response.	Learning responses are saved/recorded on Clinical Risk Management Database and actions are completed and monitored through governance dashboards & reviews.

Our patient safety incident response plan: local focus

All patient safety incidents that occur are discussed daily across the Trust in divisional huddle meetings. It is imperative that these daily meetings are attended staff who understand PSIRF principles and are trained and equipped to lead brief discussions regarding the next steps to learning and improvement from the incidents discussed. It is at these daily huddles that patient safety incidents will be briefly reviewed, discussed and further escalation agreed. Where further escalation is agreed due to the potential for learning and improvement, a Patient Safety Review will be convened at the earliest opportunity. The Patient Safety Review will be led by a trained facilitator with a view to deriving maximum learning and actions for improvement. On occasion the Patient Safety Review itself may provide enough learning to enable closure of the incident and monitoring of agreed actions. However, at the end of the Patient Safety Review, further agreement will be reached regarding the next stage of learning response.



Patient safety incident type or issue	Planned response	Anticipated improvement route
Any patient safety incident that occurs	Discussed at Daily Huddle	Discussion and agreement for escalation if required. If no escalation is required, then incident manager proportionately investigates the incident and sets appropriate local actions if required.
Patient safety incident escalated from Daily Huddle	A Patient Safety Review (see appendix 1) is convened as soon as possible after the incident to discuss the incident on the agreed template and agree any learning and actions for improvement. If necessary, further learning responses will be discussed these include: 	If the Patient Safety Review is confident that all learning has been derived, then actions will be assigned accordingly, and progress will be monitored through team/divisional and Trust wide clinical governance groups.
Incident escalated from Patient Safety Review	After Action review (see appendix 2)	Actions for improvement are agreed. Where they are already being managed through an improvement plan, the relevant plan is updated. Actions are monitored through departmental/divisional and Trust wide oversight groups. Where new emerging themes are identified, consideration is given as to whether this theme becomes a priority with an associated improvement plan.
	MDT Review (see appendix 3)	
	Patient Safety Incident Investigation (see appendix 4). **Undertaken when there is significant learning to be gained from an in-depth investigation, or when this type of investigation is mandated due to meeting criteria**	
	Further analysis/thematic review	Some learning responses may prompt the requirement for deeper analysis of data to understand whether there are key themes occurring that are contributing to patient safety issues.

How we will oversee learning actions and improvement

Discussion and agreement will be reached through the stages of learning response as described in our local focus plan.

The Datix database will be used to record the types of learning responses that are utilised to respond to patient safety events that occur.

At the transition stage (September 1st, 2023) the existing groups that discuss, monitor and make some decisions regarding patient safety investigations will continue, but transition into oversight groups will occur between September 2023 and January 2024. Primarily this will shift from any decision making to being informed of and having oversight of actions that have been agreed and their progress in improving safety for patients.

Meeting title	Current	Transition to
Incident Review Meeting	Reviews 72-hour reports & internal comprehensive investigations that have been drafted following an incident escalated for further investigation. Supports in decision making regarding whether the incident is a serious incident.	Is informed of learning and improvement actions that have been agreed from learning responses that are not PSII and provides challenge and support where appropriate - Patient Safety Review - After Action Review - MDT Review - Other proportionate learning responses
Serious Incident Review & Learning Group	Reviews Serious Incident reports and their actions and agrees closure or further amendments	Is informed of learning and improvement actions that have been agreed from PSII and provides challenge and support where appropriate. Receives presentations on PSII action progress and escalated to Executive
Patient Safety Learning Group	Receives reports on Serious Incidents and other incidents of concern with a focus on the learning that has been identified	Oversees Trust wide priority improvement plans, providing advice and support to ensure that plans are SMART meaningful and making a difference
Patient Safety & Quality Sub Committee	Receives reports on Serious Incidents and other incidents of concern	Receives information and reports on learning and improvements made from the array of learning responses, including metrics, case studies and feedback.

How patients, families and carers will be involved in learning responses

We Understand that patient safety incidents can have an impact on the people who are involved in them. Therefore, whenever there is a patient safety incident, we want to be open and honest with the person(s) who are affected by it. Where we escalate an incident for further learning as defined in, local focus plan we will always endeavour to work with the person(s) affected to understand what level of involvement they feel they require and what questions they would like answered in that learning response.

This is regardless of the level of harm that is recorded for that reported patient safety incident. For example, if a low harm incident is escalated for further learning, we will approach the person(s) affected as outlined above. Involvement and engagement with patients, families and carers will be coordinated by involvement and engagement leads who have been appropriately trained across the Trust.

Patient safety incident type or issue	Planned response	Patient, Family, and carer involvement
Any patient safety incident that occurs	Discussed at Daily Huddle	We will apologise and explain what may happen because of the incident occurring
Patient safety incident escalated from Daily Huddle	A Patient Safety Review (see appendix 1) is convened as soon as possible after the incident to discuss the incident on the agreed template and agree any learning and actions for improvement.	We will be open and honest regarding the incident and the next steps; we will let the person(s) affected know that we have escalated the incident and will consider how involved they want to be in the learning response and which questions they would like answered from the response.
		
Incident escalated from Patient Safety Review	After Action review (see appendix 2)	
	MDT Review (see appendix 3)	
	Patient Safety Incident Investigation (see appendix 4).	

Duty of Candour

Duty of Candour legislation still applies to patient Safety incidents and therefore where a patient safety incident is recorded and assessed as having caused moderate or above harm to a patient then the Trusts duty of candour policy and process will be followed alongside and supplementary to our involvement and engagement processes.

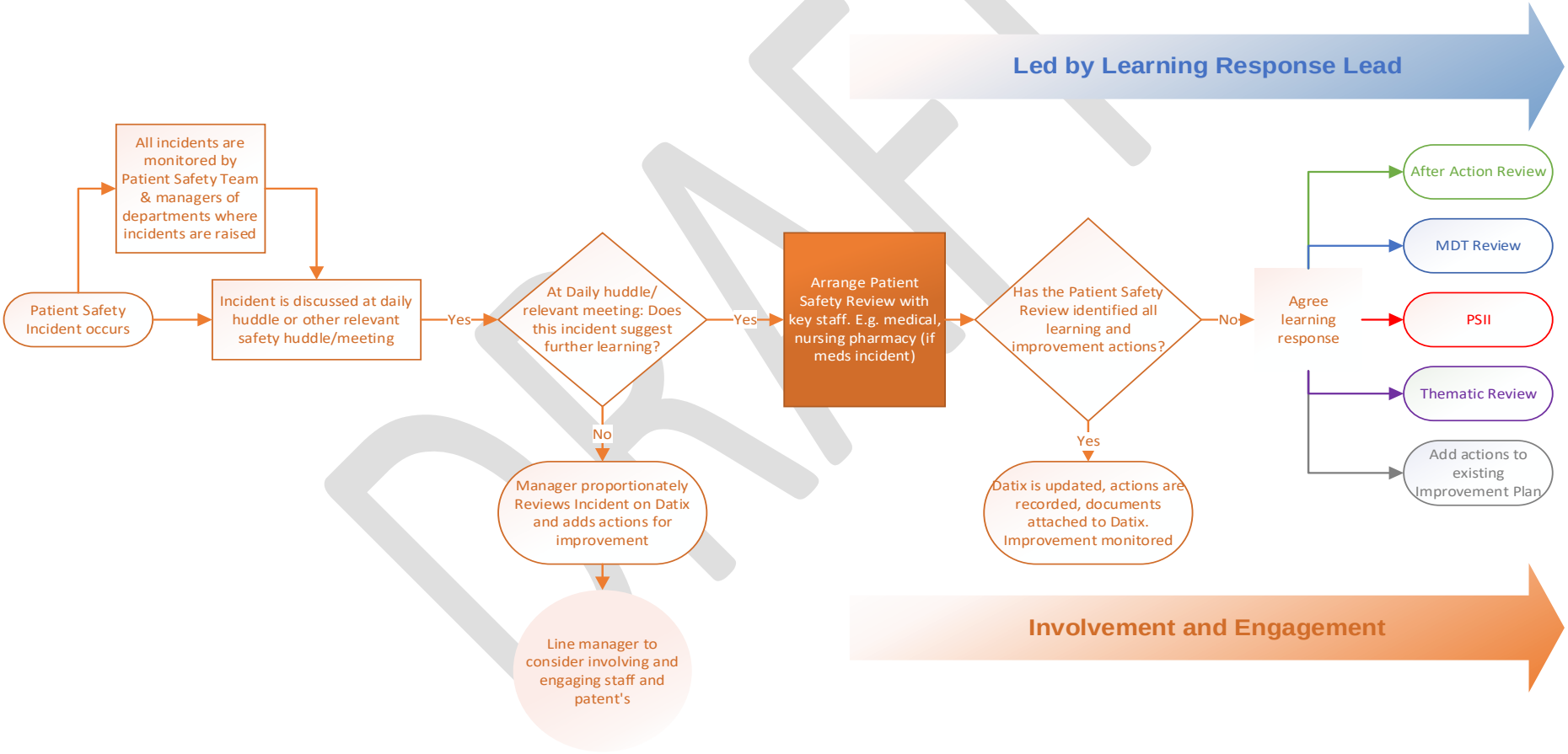
Supporting staff following patient safety incidents

We know that staff can sometimes be affected by incidents that occur (second victim), this can be due to the emotional impact that the incident itself has had on them to feelings of guilt and shame that an incident occurred that they were involved in. There is no place in Great Western Hospitals incident responses for blame, liability, or focussing on individuals' actions without a wider view of the whole system factors that contributed to the incident.

All learning responses will be undertaken by a trained senior member of staff and facilitated by the Trusts central Patient Safety Team. The standards that are required for each Trust are outlined in the Patient safety incident response standards, 2022. The Trust has developed a training analysis and has been working in collaboration with other member Trust across the Integrated Care Board to procure suitable training to ensure these standards are achieved.

Appendix one – Patient Safety Review

Key information: Incident occurring to Patient Safety Review



Patient Safety Review for Learning and Improvement

For further guidance click here B1465-Patient Safety Review-v1-FINAL.pdf (england.nhs.uk)

Type of incident:	
Date & time of incident:	
Date & time of Patient Safety Review:	
Patient Safety Review learning response Lead:	
Engagement & Involvement Lead:	
Incident Number:	
Attendees (name and job role):	

1. What did the patient (1st Victim) say happened (patients' narrative)? **Consider:** *What led up to the incident? What is their understanding of the incident/patient safety event? How would they like to be involved in learning and improvement?* Wellness check: *How are they feeling about the incident, and do they need further support?*
2. Narrative of incident/patient safety event, from those involved (2nd victims)?
3. What immediate actions have been taken? Consider: Review multifactorial risk assessment and interventions that were in place
4. Discussion – what factors were involved in the incident? Click here for guidance

Tools and Technology:	
Tasks:	
External Environment:	
Organisation:	
Person:	

Internal Environment:	

5. Just and learning culture discussion

6. What is the learning from this incident?

7. What are the improvement actions needed (consider where else this could happen in the Trust)

	Action description:	Action assigned to:	Due date:
Improvement Action 1:			
Improvement Action 2:			
Improvement Action 3:			
Improvement Action 4:			
Improvement Action 5:			
Improvement Action 6:			

8. Following this Patient Safety Review meeting, is a further Learning Response Required (Y/N)

Learning Response	Agreed ToR for learning response
Patient safety Incident Investigation	
After Action Review	
MDT Review	
Thematic Review	
Priority Improvement Plan	
Other proportionate learning response	

SEIPs model – System Factors Prompts

Tools & Technology
- Describe the equipment/tools you use
- Describe the equipment design
- Share your insights into equipment availability and appropriateness
- Share your insights into equipment reliability
- Describe how information is presented (eg records/IT systems)
- Describe alarms and alerts
- Are any tasks automated?
- Describe where equipment is positioned. Is this optimal?
- Are tools/technology maintained and updated?
- Are manuals, procedures and supports accessible?

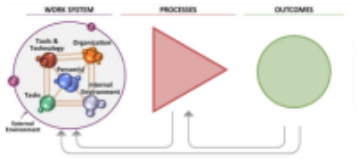
Organisation
- Tell me about how the patient pathways work
- Describe the information flow (how information is communicated)
- What is the communications workload like?
- Tell me how new information is flagged
- Where is new information held?
- Describe the leadership and supervision arrangements
- Describe how works is scheduled/allocated
- Describe staffing levels and resourcing
- Describe the safety/organisational culture
- Describe how change management works

Tasks
- Tell me about the task demands you face
- Describe the tasks which are complex or challenging to carry out
- Talk me through your experiences of the workload
- Are there time pressures? If yes please tell me more
- Does task repetition/monotony occur in this work system?
- Do you have to re-prioritise/reorganise?

Person
- Tell me about the patient mix
- Describe the team who deliver patient care
- Who else is part of the team (eg admin, domestic)?
- How familiar are team members with care processes/pathways?
- Are roles/responsibilities clearly defined?
- Describe how training is organised to support safe care
- Describe the team dynamics
- Describe the impact of personal factors (eg stress, morale, tiredness)

Internal environment
- Does the workspace support safe patient care/task performance?
- Share your thoughts on the layout of the environment
- Is the workspace appropriate for the task?
- Where are tasks completed?
- Describe any distractions you experience regularly
- Do interruptions impact patient care/task performance? If yes, how?
- Describe the impact of the ambient environment (eg lighting, noise, air quality)

External environment
- Describe any relevant national targets
- Tell me how the following impacts (if at all):
  - Policy and regulatory demands
  - Accreditation standards
  - Political decision making
  - Global events



Desired Outcomes

System Performance:

Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

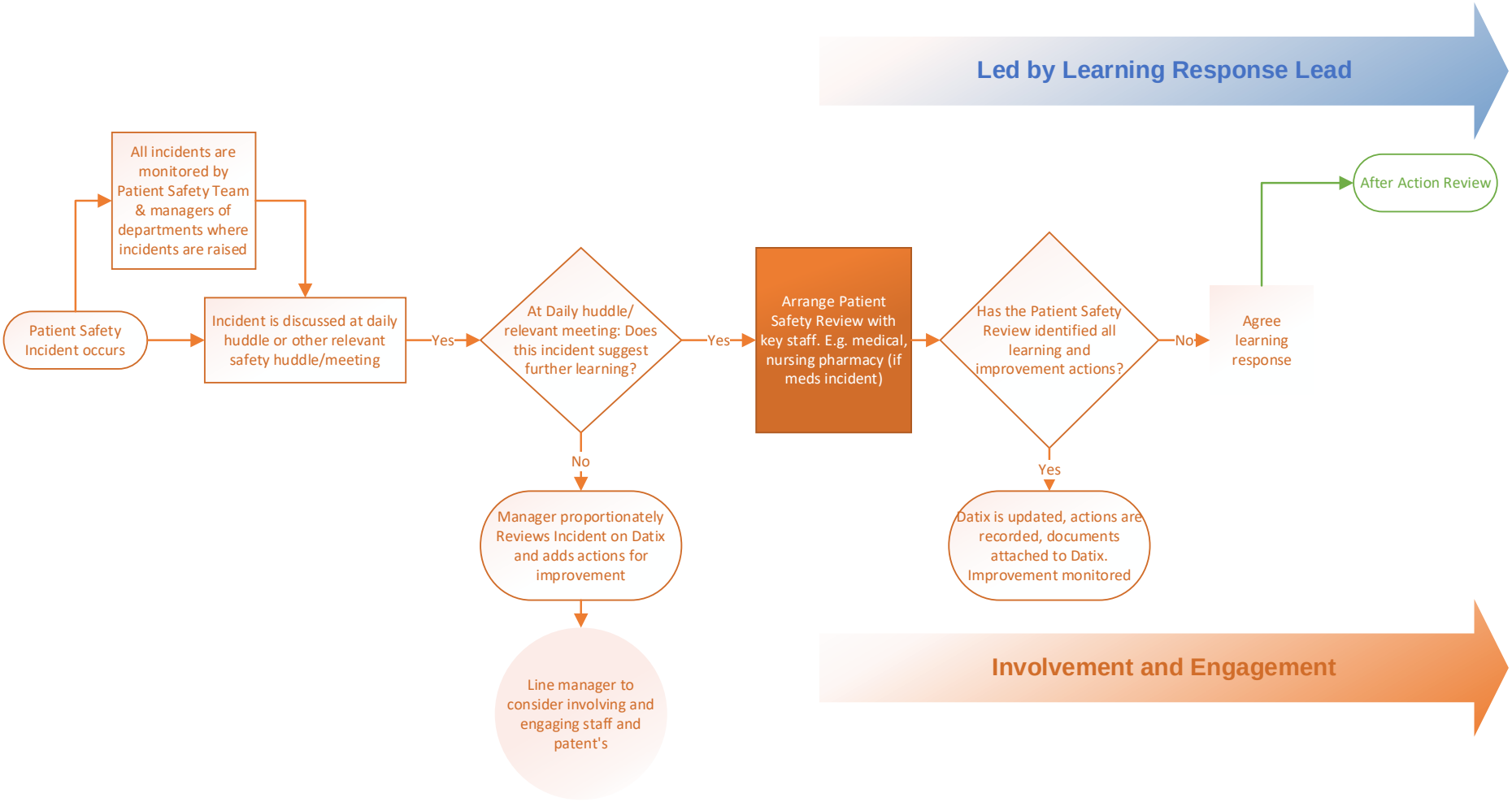
Incidents that need internal/external PSII

	Patient Safety Event		Learning Response
National Priorities	Mental Health Related Homicide	Recorded on Clinical Risk Management system and referral made to:	Relevant NHS England and NHS regional improvement investigation team
	Maternity and Neonatal meeting HSIB criteria		Patient safety Event referred to Health care Investigation Branch
	Deaths of Persons with Learning Disabilities		Reported and reviewed by Learning Disabilities Mortality Review
	Safeguarding where various plans are in place for the patients		Learning response agreed with GWH Safeguarding lead
	NHS screening Program Incidents		Reported to Public Health England
	Domestic Homicide		Relevant National and Local bodies
	Death of Patients in Custody/prison/probation		Reported to Prison and Probation Ombudsman

Locally Led Patient Safety Incident Investigations	Deaths though more likely than not due to problems in care	Patient Safety Review occurs with correct professionals - nursing staff/medical staff/pharmacy and Quality professionals to determine ToR and focus and any immediate learning	Patient Safety Incident Investigation
	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Mental Health Act (1983) or where the Mental Capacity Act (2005) applies		
	Incidents meeting Never Event Criteria 2018 or its replacement		
	Incidents where there may be significant new learning that is not being addressed through any other learning response		

Appendix two – After Action review

After Action Review



Patient Safety Review agenda and guidance

Great Western Hospitals
NHS Foundation Trust

After Action Review for Learning and Improvement

For further guidance regarding After Action Reviews click here Layout 1 (england.nhs.uk)

Type of incident:	
Date & time of incident:	
Date & time of After-Action Review:	
After Action Review learning response Lead:	
Engagement & Involvement Lead:	
Incident Number:	
Attendees (name and job role:	

1. **What happened that we want to learn from?** **Consider:** AARs can be used after any activity or event that has been particularly successful or unsuccessful. It is also often used at the end of a project to help populate a lessons learnt log. It is important to disseminate learning widely so that good practice can be shared, and others can learn from mistakes
2. Narrative of incident from those involved?
3. What was it we set out to do?
4. What actually happened?
5. Why were there differences?
6. What went well and why?

7. What could have gone better?
8. What would we do differently next time? *(what is the learning?)*
9. What are the actions that need to be taken including how we will share the learning more widely?

	Action Description:	Action Assigned to:	Due Date:
Improvement Action 1:			
Improvement Action 2:			
Improvement Action 3:			
Improvement Action 4:			
Improvement Action 5:			
Improvement Action 6:			

10. Following this After Action Review is a further Learning Response Required (Y/N)	
Patient safety Incident Investigation	
After Action Review	
MDT Review	
Thematic Review	
Priority Improvement Plan	
Other proportionate learning response	

Incidents that need internal/external PSII

Patient Safety Event			Learning Response
National Priorities	Mental Health Related Homicide	Recorded on Clinical Risk Management system and referral made to:	Relevant NHS England and NHS regional improvement investigation team
	Maternity and Neonatal meeting HSIB criteria		Patient safety Event referred to Health care Investigation Branch
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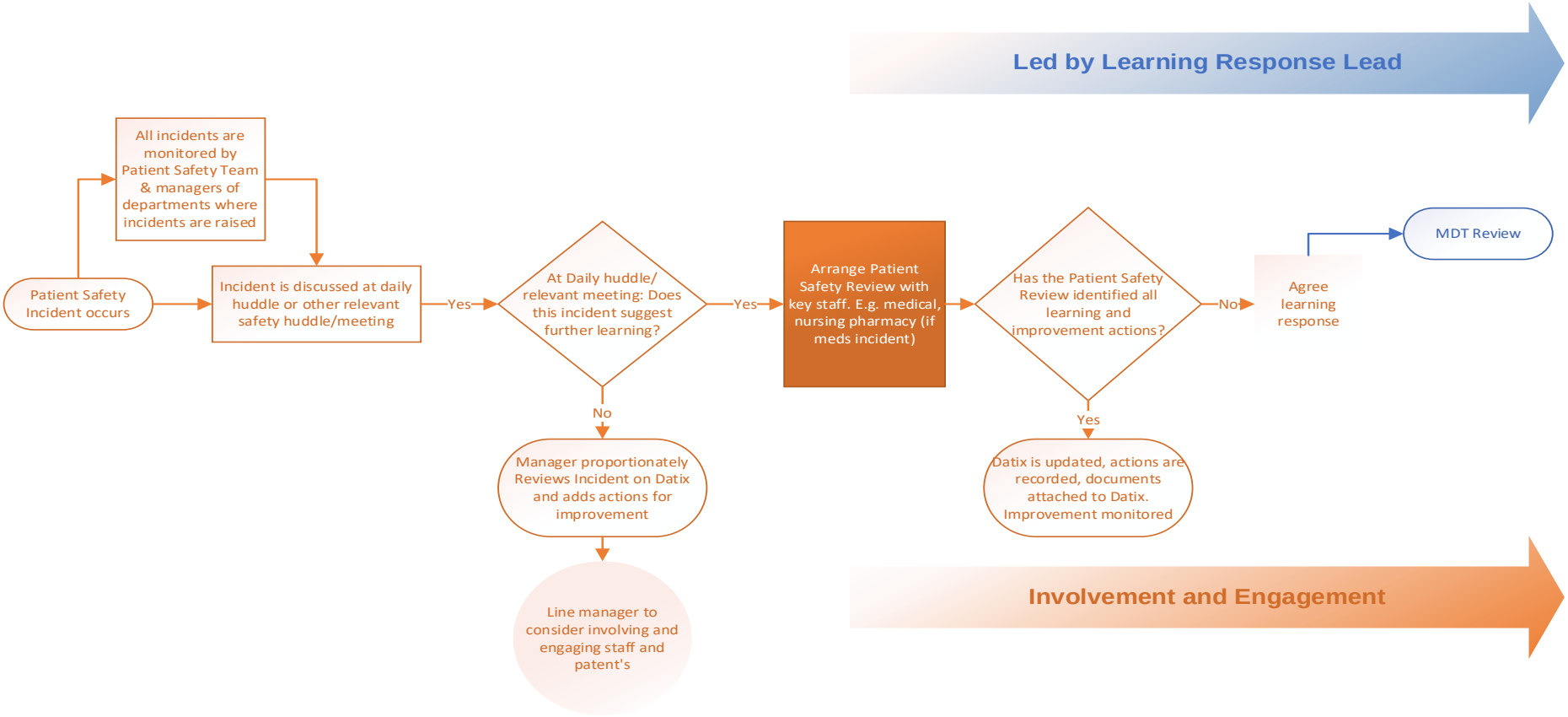
Locally Led Patient Safety Incident Investigations	Deaths though more likely than not due to problems in care	Patient Safety Review occurs with correct professionals - nursing staff/medical staff/pharmacy and Quality professionals to determine ToR and focus and any immediate learning	Patient Safety Incident Investigation
	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Mental Health Act (1983) or where the Mental Capacity Act (2005) applies		
	Incidents meeting Never Event Criteria 2018 or its replacement		
	Incidents where there may be significant new learning that is not being addressed through any other learning response		

Appendix three MDT Review

Multi-Disciplinary Team Review



After Action Review agenda and guidance

Great Western Hospitals
NHS Foundation Trust

MDT Review for Learning and Improvement

For further guidance regarding MDT Reviews click here B1465-MDT-review-v1_FINAL.pdf (england.nhs.uk)

Type of incident:	
Date & time of incident:	
Date & time of MDT Review:	
MDT learning response Lead:	
Involvement and Engagement lead	
Incident Number:	
Attendees (name and job role:	

1. Narrative of incident from those involved

Task Matrix

	Who Performs	Goal(s) of task	Frequency	How performed	When performed	Notes
Task 1						
Task 2						
Task 3						

Tools Matrix

	Users	Purpose of use	Frequency of use	Ease of access	Usability	Notes
Task 1						
Task 2						
Task 3						

2. What gaps and issues have you identified through the walkthrough processes?

1.
2.
3.
4.
5.

3. Which factors contributed to the gaps and issues you have identified? You can refer to the SEIPS model:

Tools and technology	Organisational	Tasks	Person	Internal Environment	External Environment

4. What are the next steps? (e.g., further information and analysis if required)

5. Which stakeholders will the information gathered in this review be shared with?

6. What are the actions that need to be taken including how we will share the learning more widely?

	Action Description:	Action Assigned to:	Due Date:
Improvement Action 1:			
Improvement Action 2:			
Improvement Action 3:			
Improvement Action 4:			
Improvement Action 5:			
Improvement Action 6:			

7. Following this meeting is a further Learning Response Required (Y/N)

Patient safety Incident Investigation	
After Action Review	
MDT Review	
Thematic Review	
Priority Improvement Plan	
Other proportionate learning response	

SEIPs model – System Factors Prompts

Tools & Technology
- Describe the equipment/tools you use
- Describe the equipment design
- Share your insights into equipment availability and appropriateness
- Share your insights into equipment reliability
- Describe how information is presented (eg records/IT systems)
- Describe alarms and alerts
- Are any tasks automated?
- Describe where equipment is positioned. Is this optimal?
- Are tools/technology maintained and updated?
- Are manuals, procedures and supports accessible?

Organisation
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- Tell me how new information is flagged
- Where is new information held?
- Describe the leadership and supervision arrangements
- Describe how works is scheduled/allocated
- Describe staffing levels and resourcing
- Describe the safety/organisational culture
- Describe how change management works

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- Describe the tasks which are complex or challenging to carry out
- Talk me through your experiences of the workload
- Are there time pressures? If yes please tell me more
- Does task repetition/monotony occur in this work system?
- Do you have to re-prioritise/reorganise?

Person
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- Are roles/responsibilities clearly defined?
- Describe how training is organised to support safe care
- Describe the team dynamics
- Describe the impact of personal factors (eg stress, morale, tiredness)

Internal environment
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- Is the workspace appropriate for the task?
- Where are tasks completed?
- Describe any distractions you experience regularly
- Do interruptions impact patient care/task performance? If yes, how?
- Describe the impact of the ambient environment (eg lighting, noise, air quality)

External environment
- Describe any relevant national targets
- Tell me how the following impacts (if at all):
  - Policy and regulatory demands
  - Accreditation standards
  - Political decision making
  - Global events

Desired Outcomes

System Performance:

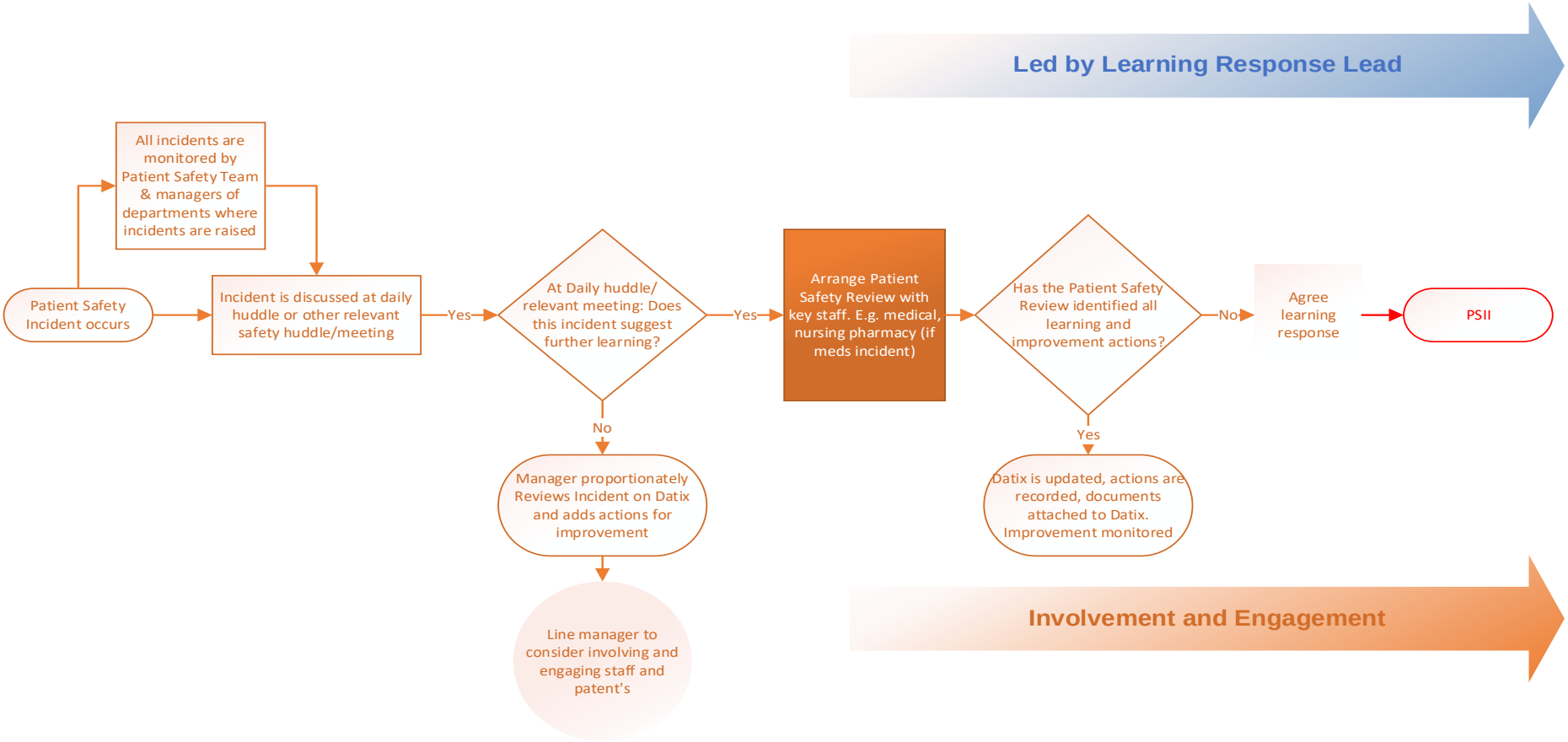
Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

Appendix four Patient Safety Incident Investigation

Patient safety incident investigation (PSII) report



Patient safety incident investigation (PSII) report

Distribution list

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

List who will receive the final draft and the final report (e.g. patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	Position

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement to the people involved in the investigation. Including Patient(s), Family, Carers and staff

Executive summary (complete this after the main report has been written)

Incident overview (A brief description of what happened)

Summary of key findings (bullet point the key findings here after the investigation is complete)

Summary of areas for improvement and safety actions use bullet points to list areas for improvement and whether these will be addressed by a safety improvement plan or if they are already being addressed in an existing safety improvement plan Refer to the Safety action development guide for further details on how to write safety actions.

Contents

Background and context provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

Description of the patient safety incident Think about how best to structure the information – e.g. by day or by contact with different services on the care pathway. It should be written in neutral language, e.g. 'XX asked YY' not 'YY did not listen to XX'. Avoid language such as 'failure,' 'delay' and 'lapse' that can prompt blame. If the patient or family/carer has agreed, you could personalise the title of this section to '[NAME]'s story/experience.'

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:			
Engagement & Involvement Lead:			

Summary of investigation process include a short paragraph outlining the investigation process

Terms or reference

- What are the aspects of care to be covered by the investigation
- What are questions raised by the those affected that will be addressed by the investigation

Information gathering provide a brief overview of your investigation approach, including interviews, reflections, prior learning responses

Findings summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis

Summary of findings, areas for improvement and safety actions bring together the main findings of the investigation

Safety action summary table

Area for improvement: [e.g. r*eview of test results*]								
	Safety action description *(SMART)*	**Safety action owner *(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency *(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight *(e.g. specific group/ individual, etc)***	**Planned review date *(e.g. annually)***
1.								
2.								
…								

Area for Improvement: [e.g. *nurse-to-nurse handover*]								
	Safety action description *(SMART)*	**Safety action owner *(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency *(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight *(e.g. specific group/ individual, etc)***	**Planned review date *(e.g. annually)***
1.								
…								

Appendices

References Include references to national and local policy/procedure/guidance, and other data sources as required.

Patient safety incident response policy

Policy Number:	
Scope of this Document:	**All Staff**
Ratifying Committee:	**Trust Public Board**
Date Ratified:	
Next Review Date (by):	
Date implemented (made live for use):	
Accountable Lead:	*Deputy Head of Insights and learning*
Division or Department	*Corporate*
Lead Author(s):	*Deputy Head of Insights and Learning*

Great Western Hospitals
NHS Foundation Trust

TRUST-WIDE POLICY DOCUMENT

Patient safety incident response policy

Further information about this document:

Document summary	This document outlines the governance arrangements for responding to Patient Safety Events that occur at Great Western Hospital or through any service provision that the Great Western Hospital NHS Foundation Trust (the Trust) Provides. This policy is aligned to the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework and replaces the Incident Management Policy used by the Trust under the Serious Incident Framework 2014.
Author(s)	Head of Insights and Learning Deputy Head of Insights and Learning Insights and Learning Matron
Published by	**Corporate Governance Team** **Trust HQ** **Great Western Hospitals NHS FT** **Marlborough Road** **Swindon**
To be read in conjunction with	This policy is aligned to the NHS Patient Safety Strategy and Patient Safety Incident Response Framework. It should be read in conjunction with the Trusts: - Duty of Candour Policy (Ref 1) - Quality Governance Framework (Ref 2) - Risk Management Policy (Ref 3) - Complaints Policy (Ref 4) **Stage 2 Full Equality Impact Assessment**
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.	

Version Control:

	Version History:

Patient safety incident response policy
Effective date:
Estimated refresh date:

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) 2020 (Ref 5) and sets out **Great Western Hospital NHS Foundation Trust'** approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

This is an overarching policy detailing all aspects of incident management within the Trust, including patient safety incident reporting and safety improvement monitoring. The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust. It does not outline responses to:

- Complaints
- Human Resources Investigations
- Professional Standards Investigations
- Coronial Inquests
- Criminal Investigations
- Claims
- Safeguarding investigations
- Information Governance concerns
- Financial investigations and audits

However, when applying learning responses to incidents, a triangulation process will occur to better understand causal factors and associations to that incident. This may include (for example) analysing claims, complaints and other types of investigations that may provide insights to why the incident occurred. An example of this may be:

- An incident is raised on a ward regarding a medication error. It is considered that there is learning to be derived from this incident. Therefore, in preparation to responding to this incident, analysis will occur to investigate whether there have been complaints, claims, risks, safeguarding issues raised that are linked to the theme of the incident. This will support in providing oversight into whether there is a wider issue and learning response that needs to be explored.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident. Learning responses will follow SEIPS questioning (System Engineering Initiative for Patient Safety), seeking to understand system factors that caused the event.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

The Trust is committed to creating the right foundations that fosters a just culture to improve safety and learning. This is achieved by providing training to those that communicate with and involve those that have been affected by a patient safety incident in a learning response. This may also include completing Duty of Candour (DoC) process. Leadership training must focus on compassionate leadership and engagement in a way that prioritises and respects the needs of people who have been affected by a patient safety incident:

Those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible as part of our duty of care.

Engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in the future. Engaging and involving those affected in incidents fosters a culture of openness and transparency thereby resulting in the increase of reporting of incidents.

The patient safety team in conjunction with the organisational development team (Human Resources) must work together to ensure delivery of a Restorative Just & Learning Culture (RJLC) practice to support open and transparent reporting. Review of incidents must focus on the systems in which people work in rather than blaming individuals. RJLC training might include masterclasses and workshops that will include ways of managing dissatisfaction, ensuring inclusivity and processes for seeking and acting on feedback. Regular patient safety culture surveys must be triangulated with staff surveys to understand the patient safety culture, identify learning opportunities and improvement.

Patient safety partners will be utilised across the Trust and must be incorporated to key patient safety meetings to ensure patient's voice is heard and understood regarding processes in place to learn and improve from patient safety events/incidents.

Other activities such as board safety visits and Schwartz rounds must be scheduled regularly to ensure involvement of staff. Ways of ensuring regular feedback to staff and patients must be developed and shared with staff.

Patient safety partners

In July 2019, the NHS Patient Safety Strategy (Ref 6) was released with a framework for Patient Safety Partners (PSPs) involvement in healthcare organisational safety. PSPs are patients, carers and other lay people who can play a part in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. The Trust has recruited PSPs that have been gradually introduced into different governance and patient safety implementation teams. PSPs feedback on work that they have been supporting with and amplify patient voice to support in defining clinical governance and learning and improvement from patient safety processes. They have influence over safety cultural issues and development of patient safety initiatives.

Roles for PSPs can include:

- Membership of divisional and Trust wide safety and quality committees whose responsibilities include the review and analysis of safety data.
- Involvement in divisional and Trust wide patient safety improvement projects.
- Working with organisation and divisional boards to consider how to improve safety (e.g. policy writing, be part of interview panels).
- Involvement in staff patient safety training.
- Participation of investigation oversight groups.

The PSP's role is to provide objectivity; challenge us on our actions and evidence and 'bring us back to reality' of what it's like to be a patient or family member. PSPs remind us that following up when things go wrong is not just about incident reviews and report writing, but understanding that patients, families and carers are involved and impacted by patients' safety evets/incident that occur. They help us close the gap between patients and staff and build the interaction between patients, staff and patient and staff safety, bridging the gap between patients and clinicians responsible for them. PSPs provide real time listening rather than delayed Duty of Candour and are a useful resource for providing opportunities of speaking up and the consequences of not wanting to.

Addressing Health inequalities

Insights, intelligent use of data and proactivity are core to our patient safety incident response processes. The incident reporting database and key questions asked when a patient safety incident response is required are central to understanding any health inequalities related to patient safety within the Trust. Therefore, the modules used within the patient safety database will have questions related to health inequalities built into its reporting and review forms so that this information can be analysed in relation to patient safety events that occur.

For example, the incident reporting form will enquire about protected characteristics regarding the patient(s) who have been involved in the patient safety event and will also ask for narrative as to why those protected characteristics may have been impacted. Alongside this, key demographic information will also be requested regarding patient age, ethnicity, sexual orientation, disabilities and gender to allow analysis in regard to whether patient safety events occur more frequently or have different impacts on patients with certain demographics. Where it is potentially evident that patient safety events are occurring or impacting patients due to demographic identity or protected characteristics, then this should form part of the Terms of Reference for that patient safety response. Additionally, triangulation and analysis should occur to support that learning response, ensuring that health inequalities are understood and addressed, with key actions for improvement established.

Key to understanding how a person is affected by a patient safety event will be inclusion from the outset in the learning response. This ethos extends to families and carers impacted by the event. This involvement and engagement will ensure that the learning response is tailored to the individual, understands their feelings regarding what occurred and addresses the issues they have identified.

As well as patients, families, and carers, it is equally important that staff involved in patient safety events are confident that the processes used are transparent and based on a system factors approach. Too often conclusions of ‘human error’ are stated in learning responses, ‘staff failed to,’ or, ‘the member of staff has reflected on their practice as a result of this incident.’ Whilst individual accounts and reflections are important to understanding events, they should be approached from the viewpoint of understanding what systems, tools and processes around the individual were in use at the time and contributed to the event occurring. For staff involved in patient safety events the prospect of being involved in an investigation can be daunting and it is imperative that throughout the process they are supported, reassured, and given clear understanding that the process is aimed at system wide learning and improvement. These approaches will ensure that there is not disparity for staff involved in incidents, regardless of their identity demographic or protected characteristics.

Engaging and involving patients, families and staff following a patient safety incident

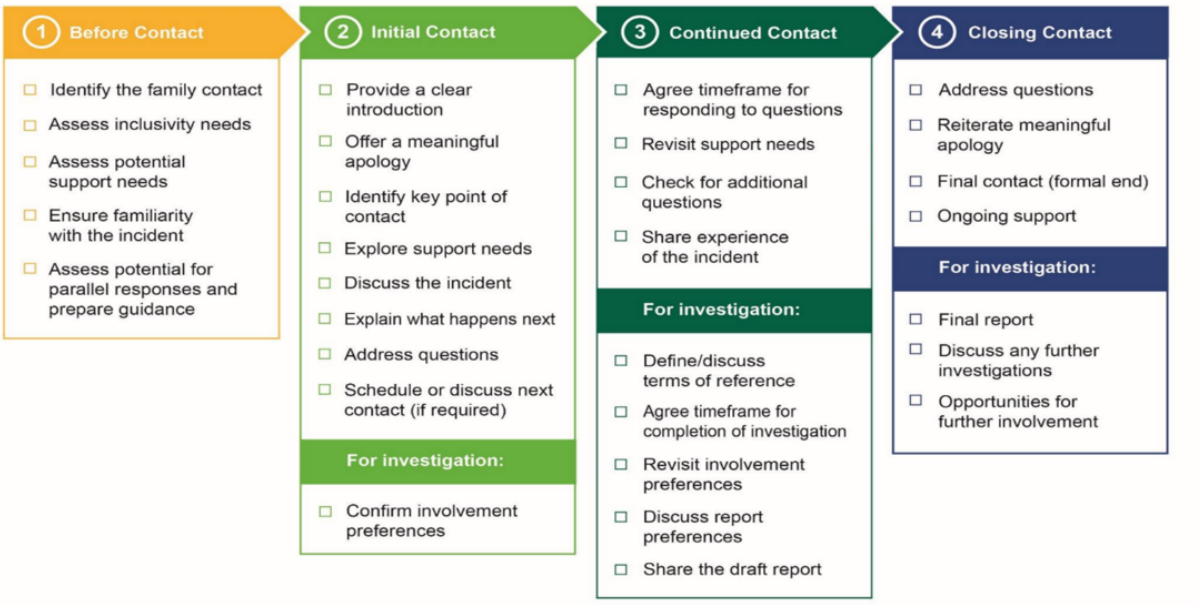
PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

We are pledged to deliver outstanding patient care and focus on quality improvement in all that we do. We want to learn from any incident where care does not go as planned or expected by our patients, their families and carers to prevent recurrence. We understand and acknowledge that being involved in a patient safety incident can cause significant impact on those affected. Involving and engaging with those individuals not only helps alleviate the harm experienced, but also helps avoid compounding that harm. While we cannot change the fact that an incident has happened, it is always within our gift to compassionately engage with those affected, listen to them and answer their questions and try to meet their needs that may result from the incident.

Engaging with those affected by a patient safety incident substantially improves our understanding of what happened and potentially how to prevent a similar incident in future. Patients, their family members, and carers may be the only people with insight into what occurred at every stage of a person's journey through the healthcare system. Not including those insights could mean an incomplete picture of what happened is created. Similarly, staff have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account.

The following four step process must be followed to ensure that a meaningful compassionate engagement and DoC (Ref 1) process is followed. With all efforts undertaken to ensure that staff/patients/family/cares are included within the reviewing process.

Table 1 Engagement and Involvement Process



This must be done in an open and transparent manner ensuring that the first victim (patient's and their families involved in incidents) and second victim (staff involved in incidents and those that are supporting them) needs are met. Duty of Candour remains a statutory requirement and discussions must be recorded on the incident management database, and copies shared with the patients/person(s) affected, where agreed.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions stated below.

Previous harm grades (National Reporting &Learning System (NLRS))	New physical harm grades (Learning From Patient Safety Events (LFPSE))	New psychological harm grades (LFPSE)
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm
Death	Fatal	n/a

The threshold for DoC is any incident where patients have suspected or come to moderate harm or above including death. If the patient cannot be involved in this process due to various reasons, the next of kin must be contacted. The patients and staff must be provided with leaflets detailing the next steps of the incident review process.

It is important to remember that whilst we use these levels of harm to determine whether the DoC legislation applies, it is not a governing factor into whether we should investigate and learn from an incident. This marks a change from the previous Serious Incident (SI)

Framework where often, decisions to investigate incidents were based on the harms caused as opposed to the opportunity for learning. The key theme of the new Patient Safety Strategy is that learning responses should be utilised when a patient safety event/incident indicates there is learning to be gained – regardless of whether it was a near miss/no harm/or harm.

Alongside this it is important to remember that whilst the DoC legislation applies for incidents that have caused Moderate physical or psychological harm (and above) we should always aim to engage and involve patient(s) and other person(s) affected in any learning response.

Patient safety incident response planning

Patient safety incident responses should be proportionate and undertaken using an approach that will maximise learning and opportunities for improvement. This approach does not base the learning response required on the level of harm that was caused, but on the potential for learning and improvement at both local and system wide levels.

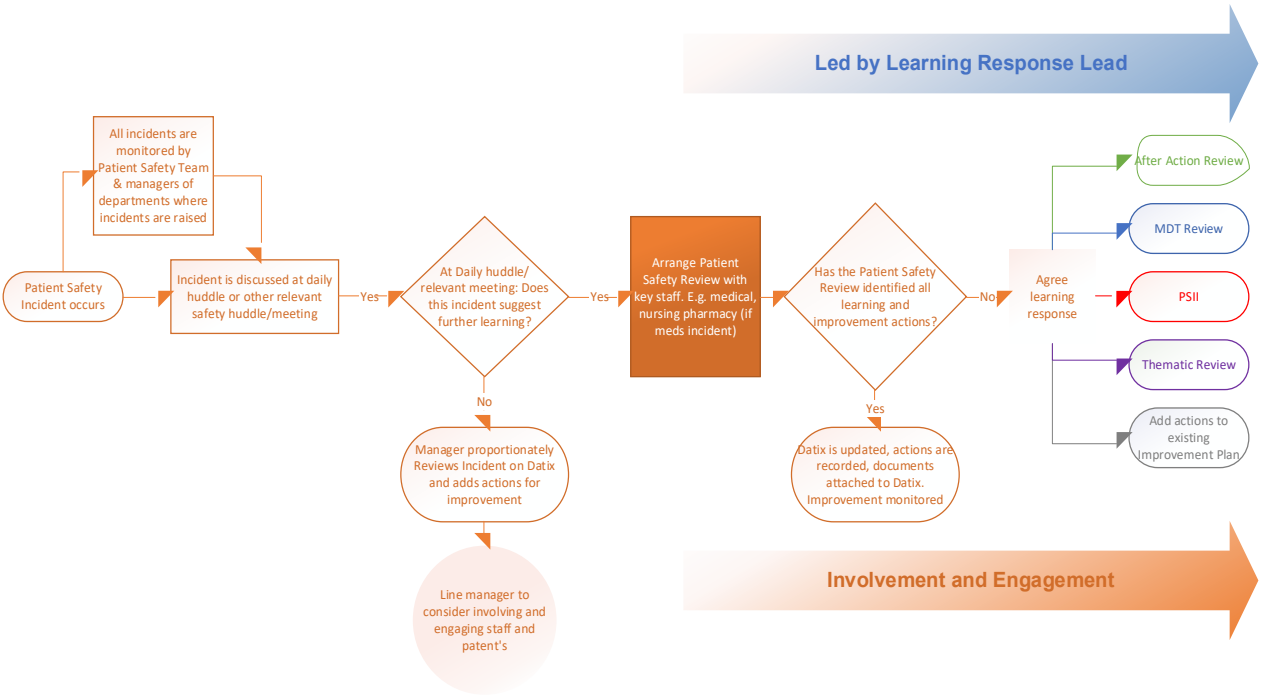
The Great Western Hospital NHS Foundation Trusts Patient Safety Incident Response Plan (ref 7) (PSIRP) outlines the processes and approaches required to ensure that patient safety incidents are responded to using a range of appropriate tools and methodologies. The foundation for ensuring meaningful learning responses is a systems-based approach that focusses on learning from an event that has occurred. This means that incidents that have had no or minimal harm may present opportunities for learning to prevent future harm. It also means that incidents that have caused harm may not always require a detailed linear investigation, provided that the system issues that contributed to the incident are identified and addressed through appropriate learning and improvement. Part of the Trusts PSIRP identifies key safety priorities that require improvement and monitoring across the organisation, these are:

- Reducing Pressure Harm in our patients
- Reducing falls with harm in our patients
- Medicines safety optimisation
- Optimising care pathways and transfers of care
- Optimising communication

Comprehensive improvement plans will be developed and monitored to address the issues stated. A result of this might mean that if a fall has occurred that resulted in severe harm to a patient, it may not be a good use of time and resource to undertake a traditional incident investigation. Instead, a meaningful review should occur as soon as possible after the event to understand; what happened, what the learning is, and what do we need to do to prevent it happening again. Sometimes, this review process may identify causal factors that have been identified in other similar incidents and therefore these should be added to or addressed in the improvement plan.

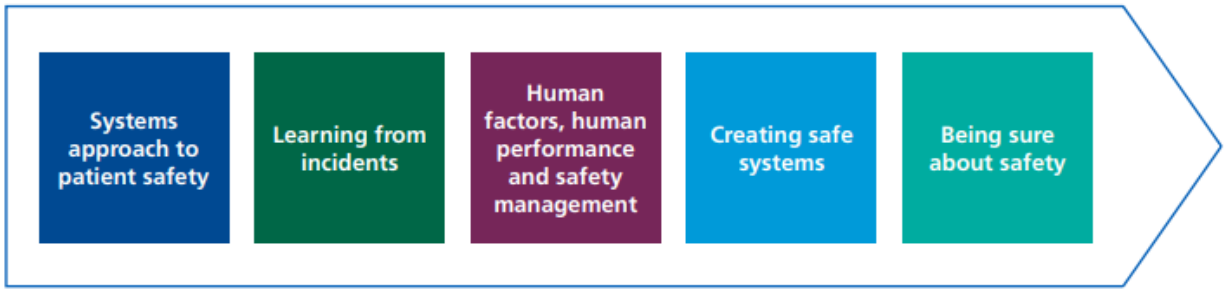
The PSIRP also outlines learning responses for other patient safety events that are not related to the Trust wide priorities. Following any patient safety event that occurs, the initial step will be a Patient Safety Review with the right people present to discuss the event and record findings from a system factors approach.

Table 2 Learning Response Process



Resources and training to support patient safety incident responses

Training for PSIRF is prescribed by the National Patient Safety Strategy (NHS, 2019) (Ref 6). The strategy developed different levels of staff training under the National Patient Safety Syllabus which comprises five patient safety themed domains reflected in Figure 1 below:
Figure 1. National Patient Safety Syllabus domains.



The structure of the syllabus focuses on knowledge, action, and consolidation. Each of the five domains contains subsections, which describe key elements and capabilities to be attained and these are presented with essential learning outcomes, which encompass basic training for all NHS staff and higher training for specific groups of staff.
Training delivery is structured as levels from 1 - 5:

- Level 1 must be completed by both clinical and non-clinical staff as a once only training session
- Level 2 must be completed by all those within patient safety roles.

- Levels 3 – 5 are educational modules that include training material from training providers approved by National Health Service England/Improvement (NHS E/I). There will be overlap of roles such that key staff may need to attend some or all the training. This level of training is for staff who have defined patient safety roles under PSIRF such as:
    - PSIRF learning response leads
    - PSIRF engagement leads
    - PSIRF oversight roles

To deliver the required training a Training Needs Analysis (TNA) has been developed.

The three mandated training packages are:

- Learning Response leads (Band 8a and above) - Systems approach to learning from patient safety incidents
- Engagement & Involvement leads (band 6 and above including senior nurse, doctors & Allied Health Professional (AHP)) - Involving those affected by patient safety incidents in the learning process.
- Oversight leads (Divisional Triumvirates, Medical Director & Associate Medical Directors, Chief Nurse & Divisional Directors of Nursing, AHP leads) - Oversight of Learning from Patient Safety Incidents.

Our training numbers below have not changed. Appropriate staff from the Insights and Learning Team will provide support to investigational leads, ensuring that learning events meet the required standards. This does not negate the need for a separate investigation lead and engagement lead.

Learning Response Leads	Engagement & Involvement Leads	Oversight Leads
All must be 8A HSIB (Healthcare Safety Investigation Branch) online Training.	Must be band 6 and above-hybrid training.	Oversight leads train for all 3 roles in above headings.

Our Patient Safety Incident Response Plan

Our Patient Safety Incident Response Plan (Ref 7) (PSIRP) sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. In following the plan we will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected.

The Trust wide Patient Safety Incident Response Plan can be accessed via our internet page (for public) or in our Trust wide documents for staff.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months or when it is indicated that a review of approaches and focus needs to occur to ensure our plan remains current - with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our Integrated Care Board (ICB)) to adequate resource and planning is given to learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

When an incident is discovered, all employees have a responsibility to ensure immediate action is taken to reduce further risk, maintain safety and ensure that their own safety is not compromised. The safety of employees, patients, and visitors are paramount. Line managers should be informed immediately if there are ongoing concerns and further risks to safety that require management and escalation.

Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incidents/events on the Trusts' incident reporting system. Divisions and specialities across the trust will have daily or frequent review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. It is at these Patient Safety Huddles that all patient safety events will be briefly reviewed, discussed and further escalation agreed. Examples of these will be:

- Daily Divisional Patient Safety Huddles
- Frequent Specialist Patient Safety Huddles (e.g., Pressure Ulcer Screening Panel/Falls huddles)
- Weekly corporate Patient Safety Huddle

Where further escalation is agreed due to the potential for learning and improvement, a Patient Safety Review (PSR) will be convened at the earliest opportunity. On occasion, the PSR itself may provide enough learning to enable closure of the incident and monitoring of agreed actions. However, at the end of the PSR, further agreement will be reached regarding the next stage of learning responses that may be required, which can include:

- After Action Review
- MDT (Multi-Disciplinary Team) Review
- PSII (Patient Safety Incident Investigation)
- Thematic Review
- Inclusion of actions to existing improvement plan to be monitored through and established group
- Other agreed proportionate learning response

During the daily huddle, consideration of Duty of Candour and/or Engagement and involvement process should begin.

Divisions/specialities will identify and escalate to the Patient Safety Team any incident which appears to meet the requirement for reporting to the third party. This will be to allow the Trust to work in a transparent and collaborative way with our ICB (Integrated Care Board) or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

Patient safety incident response decision-making

At Divisional level there are established governance processes for reviewing patient safety incidents daily (excluding weekends and bank holidays) and agreeing the next step required for capturing immediate learning and agreeing if escalation to a Patient Safety Review is required. In addition to the Divisional daily safety huddles, there are additional governance processes established that capture insights from services not normally represented at the huddle. An example of this is the Pressure Ulcer Screening Panel, which discusses and agrees further actions/learning responses for patient incidents related to skin integrity issues. The same process will be adopted for these speciality patient safety huddles, in that incidents will be escalated based on the potential learning that can be derived, as opposed to the harm that has been caused. Involvement and engagement processes and DoC processes will ensure where relevant as outlines in this policy (Ref 1).

All incidents that are escalated to a Patient Safety Review will be tabled for discussion at the trust wide incident review meeting ensuring that there is appropriate oversight of patient safety events and monitoring of the associated actions to improve patient safety. Incidents that automatically meet the threshold for a Patient Safety Incident Investigation will initially have a Patient Safety Review which will be discussed at the trust wide incident review meeting. Following this, when completed, the more detailed Patient Safety Incident Investigation Report will be tabled for the Trust wide Serious Incident and Learning Group. It is here that the report will be discussed, and a check and challenge will occur to ensure that appropriate learning and improvement actions have been established through the investigation.

The Trusts Patient Safety Incident Response Plan sets out the proposals for oversight and monitoring of Patient Safety Events/incidents that have been escalate for further review.

Table 3 route for patient safety Incidents as defined in GWH PSIRP

Patient safety incident type or issue	Planned response	Anticipated improvement route
Any patient safety incident that occurs	Discussed at Daily Huddle	Discussion and agreement for escalation if required. If no escalation is required, then incident manager proportionately investigates the incident and sets appropriate local actions if required.
Patient safety incident escalated from Daily Huddle	A Patient Safety Review is convened as soon as possible after the incident to discuss the incident on the agreed template and agree any learning and actions for improvement. If necessary, further learning responses will be discussed these include:	If the Patient Safety Review is confident that all learning has been derived, then actions will be assigned accordingly, and progress will be monitored through team/divisional and Trust wide clinical governance groups.
Incident escalated from Patient Safety Review	After Action review	Actions for improvement are agreed. Where they are already being managed through an improvement plan, the relevant plan is updated. Actions are monitored through departmental/divisional and Trust wide oversight groups. Where new emerging themes are identified, consideration is given as to whether this theme becomes a priority with an associated improvement plan.
	MDT Review	
	Patient Safety Incident Investigation **Undertaken when there is significant learning to be gained from an in-depth investigation, or when this type of investigation is mandated due to meeting criteria**	
	Further analysis/thematic review	Some learning responses may prompt the requirement for deeper analysis of data to understand whether there are key themes occurring that are contributing to patient safety issues.

Table 4 Oversight of escalated patient safety events/incidents taken from GWH PSIRP

Meeting title	Current	Transition to
Incident Review Meeting	Reviews 72-hour reports & internal comprehensive investigations that have been drafted following an incident escalated for further investigation. Supports in decision making regarding whether the incident is a serious incident.	Is informed of learning and improvement actions that have been agreed from learning responses that are not PSII and provides challenge and support where appropriate - Patient Safety Review - After Action Review - MDT Review - Other proportionate learning responses
Serious Incident Review & Learning Group	Reviews Serious Incident reports and their actions and agrees closure or further amendments	Is informed of learning and improvement actions that have been agreed from PSII and provides challenge and support where appropriate. Receives presentations on PSII action progress and escalated to Executive
Patient Safety Learning Group	Receives reports on Serious Incidents and other incidents of concern with a focus on the learning that has been identified	Oversees Trust wide priority improvement plans, providing advice and support to ensure that plans are SMART (Specific, Measurable, Achievable, Realistic, Timebound) meaningful and making a difference
Patient Safety & Quality Sub Committee	Receives reports on Serious Incidents and other incidents of concern	Receives information and reports on learning and improvements made from the array of learning responses, including metrics, case studies and feedback.

Responding to cross-system incidents/issues

The need to further develop and adopt cross-system learning from patient safety events is a significant drive in the National Patient Safety Strategy. The Trust are committed to supporting cross-system working and learning.

Oversight Roles and Responsibilities

BANES, Swindon and Wiltshire (BSW) system will be recognised as a thriving and empowering patient safety learning system. All system partners will commit to working collectively to ensure the appropriate oversight is in place to maximise the opportunities of sharing insight, participating in collaborative improvement, and learning, to continuously improve patient safety for everybody living in BANES, Swindon, and Wiltshire. A collective approach will be achieved through already existing improvement networks and Community of Practices, for example, Patient Safety Specialists and BSW Local Maternity and Neonatal System, and if required, through the development of new improvement networks to align to

shared improvement priorities. The Academic Health Science Networks (AHSN) will be an important partner to help BSW system adopt and optimise continuous improvement and learning. The integral relationship with BSW System Quality Group (SQG) will also offer further opportunity to share learning and ensure further opportunities for:

- Positive assurance that statutory duties are being met, concerns and risks are addressed, and improvement plans are having the desired effect
- Confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight, and learning. This includes confidence that inequalities and unwarranted variation are being addressed.

SQGs are not statutory bodies and will NOT serve as the ICB's formal assurance committee for quality. This will be undertaken by the ICB board itself or by a committee of the board to which it designates responsibility and where senior executives from providers have recognised governance roles. However, SQG discussions and scheduled reports will inform the process of assurance for the ICB.

Active demonstration of Quality Improvement within organisations, alongside engagement, information sharing and participation in system learning and improvement, through the established system boards and networks will be recognised through provider quality schedules, as part of the contracting process.

Information governance agreements will be in place to ensure sharing within and between system partners to support effective communication during both an incident response and improvement endeavours.

Providers will defer to BSW ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. The ICB will give support with identifying a suitable reviewer in such circumstances and will agree with all relevant partners how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement. Providers will ensure they have robust processes and resource in place to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.

Timeframes for learning responses

Each learning response will be assessed against the national priorities to establish if there is an expected timeframe for completion. If this is the case the timeframe will be discussed at the patient safety review and documented within the terms of reference.

If there is no overarching timeframe required by a governing body, then the attendees at the patient safety review will put forward an agreed timeframe for the patient safety response completion based on the level of review required, and complexity of the event, which is agreed by all involved including the patient or their family.

The Trust will monitor completion of learning responses and where learning responses are not completed within the agreed timeframe detailed in the terms of reference, will work to support the learning response lead and others involved in the review to ensure that it is completed. Barriers to completing within the agreed timeframes will be documented and explored to support learning for future responses, ensuring that those future responses meet expectations of patients, families and carers as well as the Trust.

Safety action development and monitoring improvement

The Trust has adopted Improving Together methodology as the agreed approach to continuous improvement. There are five principles of Improving Together:

- A clear vision
- A consistent approach to improvement
- Involving everyone
- Celebrate success
- Speak to the experts

By utilising the Improving Together methodology and the principles it endorses, the Trust can make improvements Trust wide, supporting achievement of the Trust vision in making a real difference to patient care.

Embedding the learning from patient safety events and monitoring the improvements will be achieved through use of the Improving Together methodology. Improvement or oversight groups will be established to monitor the agreed Trust patient safety priorities, building sustainable changes using the A3 methodology in the clinical areas.

Trust wide monitoring, oversight and sharing will be achieved through the Patient Safety Learning Group (PSLG) for improvement groups. Immediate learning and oversight will be achieved through the Incident Review meeting (IRM) for all other patient safety learning responses that do not directly feed into an established improvement group. The Serious Incident Review Learning Group (SIRLG) will provide a forum for discussion and learning related to patient safety events that require a PSII, with an onward summary provide through the governance structure to board level every quarter.

Safety improvement plans

PSLG will monitor actions and improvement plans for all patient safety priorities as well as other patient safety improvement work that has not been assessed as a local patient safety priority for the Trust.

An annual planner will be developed and established for PSLG that will pull together a structure that will enable oversight of all agreed priority workstreams, as well as those other patient safety workstreams and groups not assessed as a priority based on the data analysis at the time of developing the PSIRP. PSLG will also make recommendations for any changes to the PSIRP based on emergent themes from patient safety events.

The work plans, where possible, will align to the Trust Strategic Initiatives, therefore supporting a streamlined approach to patient safety.

- Leadership & Management Capability
- Way Forward Programme
- Digital First
- System & Place
- Improving Together

Through ensuring this link is achieved through everything we do, a golden thread for patient safety will be established.

Oversight roles and responsibilities

The Trust has established patient safety groups that provide a basis for oversight of patient safety events, and a platform for understanding and sharing learning. To ensure the ethos of PSIRF is captured existing decision-making meetings will be removed and replaced with oversight meetings. The terms of reference have been reviewed to capture the aim of learning form patient safety events and exploring if further learning can be achieved through additional learning responses.

We work in partnership with our commissioners at Banes Swindon and Wiltshire Integrated Care Board (BSWICB) to ensure that there is robust oversight of escalated incidents. Representatives attend our Serious Incident Review and Learning Group, Patient Safety Learning Group and the Patient Safety and Quality Sub Committee.

Regular engagement meetings also occur with the Care Quality Commission (CQC) to provide assurance regarding learning that has been achieved or is in progress from Patient Safety Events.

Table 5 Details of Patient Safety Oversight Meetings

Meeting title	Meeting Purpose
Incident Review Meeting	Is informed of learning and improvement actions that have been agreed from learning responses that are not PSII and provides challenge and support where appropriate - Patient Safety Review - After Action Review - MDT Review - Other proportionate learning responses
Serious Incident Review & Learning Group	Is informed of learning and improvement actions that have been agreed from PSII and provides challenge and support where appropriate. Receives presentations on PSII action progress and escalated to Executive
Patient Safety Learning Group	Oversees Trust wide priority improvement plans, providing advice and support to ensure that plans are SMART meaningful and making a difference
Patient Safety & Quality Sub Committee	Receives information and reports on learning and improvements made from the array of learning responses, including metrics, case studies and feedback.

Complaints and appeals

Throughout a learning response process, there will be a designated engagement and involvement lead who will be the continuous point of contact for patients, families and carers regarding information about the event and learning response. In the first instance, if there are concerns following a learning response these should be highlighted to the designated engagement and involvement lead who will provide appropriate support and escalation if required. Additionally, we will share details and information regarding our complaints process, if the patient, family/carers request this.

Glossary

Acronym	Meaning
AHP	Allied Health Professional
BSWICB	Banes Swindon and Wiltshire Integrated Care Board
CQC	Care Quality Commission
DoC	Duty of Candour
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board
IRM	Incident Review Meeting
SI	Serious Incident
LFPSE	Learning From Patient Safety Events
NHSEI	National Health Service England Improvement
NRLS	National Reporting and Learning System
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSII	Patient Safety Incident Investigation
PSLG	Patient Safety Learning Group
PSP	Patient Safety Partners
PSR	Patient Safety Review
RJLC	Restorative Just and Learning Culture
SEIPS	System Engineering Initiative for Patient Safety
SIRLG	Serious Incident Review & learning Group
SMART	Specific Measurable Achievable Realistic Timebound
SQG	System Quality Group

Acronym	Meaning
TNA	Training Needs Analysis

Consultation

The following is a list of consultees in formulating this document and the date that they approved the document:
The development of this policy has been through a very wide consultation process, and it is not possible to list all those consulted in the below table. Each Division has been able to input into the document development at various meetings, including the Implementation group and the Oversight group. In addition to this the Divisional Quality Governance Facilitators have had direct input to the policy development.

Job Title / Department	Date Consultee Agreed Document Contents
PSIRF Implementation Group	10/08/2023
Divisional Governance Facilitator – Surgery, Women's, and Children's	14/08/2023
Divisional Governance Facilitator – Integrated Care and Community	14/08/2023
Divisional Governance Facilitator – Division of Medicine	14/08/2023
Head of Insights and Learning – Corporate	18/08/2023
Deputy head of Insights and Learning - Corporate	18/08/2023
PSIRF Oversight Group	23/08/2023
Patient Quality Sub Committee	05/09/2023
Quality and Safety Sub Committee	Tabled for 19th Oct 2023

Supporting Documents

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

Ref. No.	Document Title	Document Location
1	Duty of Candour Policy	Trust wide Documents
2	Quality Governance Framework	Trust wide Documents
3	Risk Management Policy	Trust wide Documents
4	Complaints Policy	Trust wide Documents

Ref. No.	Document Title	Document Location
5	NHSE Patient Safety Incident Response Framework (2020)	NHS England » Patient Safety Incident Response Framework
6	National Patient Safety Strategy 2019 (updated 2021)	NHS England » NHS Patient Safety Strategy: 2021 update
7	Great Western Hospital NHS Trust Patient Safety Incident Response Plan	Trust wide Documents/GWH Website

Report Title	**GWH Health & Safety Annual Report 2022/23**				
Meeting	**Trust Board**				
Date	**2nd November 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Barry Slade, Interim Head of Health, Safety, Fire & Security				
Appendices	Appendix A – Health & Safety Annual Report 2022/23 Appendix B – Health & Safety Statement of Commitment				

Purpose

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

Assurance Level

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

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

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

Report

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

The Trust prepares an annual Health & Safety report, which provides an overview of events & performance of the Health & Safety, Fire & Security disciplines. The report for 2022/23 is included below.

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

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
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Full report approved by TMC 21 Sep23				

	Full report approved by FIDC 23Oct23 Report will be shared with all staff via Trust Intranet once Trust Board approved.
Next Steps	

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

- approve the content of the report.
- approve the H&S Statement of Commitment for inclusion in the Trust Health & Safety policy.

Accountable Lead Signature	Simon Wade
Date	27th October 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Health & Safety, Fire and Security

Annual Report 2022-23

Together we are Great

Contents

1. Purpose

This annual report has been prepared to inform the Trust of the current status of Health, Safety, Fire and Security management across the Trust during the period 1st April 2022 to 31st March 2023. The report summarises progress and issues identified over the past year in the key areas.

2. Executive Summary

Health & Safety

The Trust received two Health & Safety Executive (HSE) Improvement Notices on the 11th November 2022 relating to the Microbiology Department, following their pre-planned inspection of the Microbiology Department on the 2nd November 2022.

The first Improvement notice related to the Control of Substances Hazardous to Health Regulations 2002 and required formal confirmation as follows - 'Please provide a copy of the certificate/report of examination by the agreed compliance date of the 16th December 2022.'

The second Improvement notice related to the Management of Health and Safety at Work Regulations 1999 and required formal confirmation as follows – 'A compliance visit will be arranged in due course; this to take place at an agreed convenient time in advance of the agreed compliance date of the 24th February 2023.'

Both Improvement Notices were remedied within the required compliance dates.

There were no prosecutions or improvement notices from the CQC or Dorset & Wiltshire Fire & Rescue Service during 2022/2023, This status has now been maintained for many years and is a direct result of the 'good Safety Culture' and the high standards throughout the Trust with health & safety compliance.

The Trust has seen a slight decrease in the number of incidents reported compared with the previous year. This may be explained by the change in the Trust's incident reporting system for staff (from Safeguard to Datix), alongside the fact that the Primary Care Services (GP Surgeries) no longer report incidents through the Trust's incident reporting system (following their transfer to another provider). The Trust will continue to monitor this situation to ensure we do not miss any trends requiring further attention.

During the year there were only five RIDDOR reportable accidents reported to the HSE, compared with ten in 2021/22.

Root cause analysis investigations have been completed for each incident to ensure continued learning, but the overall 50% decrease is seen as a very positive improvement in our RIDDOR incident reporting.

The main reporting categories consisted of three fractures, one strain / sprain and one physical assault. Three of the RIDDORS were reported to the HSE late (i.e. >7-day) and to avoid this going forward there have been repeated reminders to managers about meeting the timescales.

During the year 2022/23 there were several building projects across the site, along with internal departmental moves to utilise space efficiently where Heath, Safety, Fire and Security input was required. These also included involvement with the new Urgent Treatment Centre (UTC) build and the Integrated Front Door (IFD) projects.

The H&S 2-day bespoke training for Safety Reps with our external provider, has seen an increase in participants in 2022/23 and feedback has been excellent from staff regarding this course as it has been specifically designed around health care and the hospital rather than as a general health and safety course.

This course has now been opened up to all managers in the Trust to support them with a better understanding of the health and safety culture within the organisation.

The Annual Health & Safety audit of all departments with 10 or more employees took place in June 2022. There were 104 departments identified and we had 103 returned. Three departments achieved 100% and they were presented with certificates to acknowledge their achievements. There were seven departments that scored <70% and these departments were contacted by H&S officers who provided them with support & guidance moving forward.

In July 2022 we carried out workplace air monitoring in our high-risk areas. The report came back with some actions that needed to be followed up with some departments. There were 17 actions / recommendations across eight departments, of which ten were closed during 2022/23, with seven carried through into 2023/24. The remaining open actions are regularly followed to understand the current status.

Fire

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

The Trust Fire Safety Officer has been heavily involved within the planning of the fire strategy across Trust wide projects with the introduction of UTC Decant and the new UTC planning. And the Fire Advisor has designed and carried out a detailed survey of the spaces designed within the hospital to be safe refuges for evacuation purposes.

The Trust's ability to keep our main hospital streets free of equipment remains a challenge. A small working group was tasked with addressing this issue. Funding was also secured for the purchase evacuation equipment in the form of 55 ski sheets to safely assist with the vertical evacuation of patients in an emergency within the GWH building.

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

Since 2020 we have been unable to comply with HTM05_01 where it is stated that all patient facing employees must have face to face training in relation to fire awareness and providing this training within departments. We are looking to come into line with legislation & recommendations during 2022/2023 and add this to the 2023/24 business plan.

Security

The Trust's Security Management Specialist [SMS] remains committed to reducing acts of violence and aggression against our staff and is always there to support managers and staff when required. Despite long-term sickness within the SMS Team, they have still provided the Trust with an excellent service throughout the year.

During May 2022, in accordance with the Trust's contractual obligations, our Accredited Security Management Specialist completed the NHS self-review tool (SRT) on our behalf. The SRT has been reviewed against the new Violence Prevention and Reduction indicators.

The Trust reported 904 security related incidents via the Incident Reporting System [IR1] during the year 2022/23. This shows an increase of 5% from the previous year. This is due to the change over from Safeguard to Datix, however this still shows a very robust reporting across the organisation and it also shows there is no decrease in the reports being raised.

There has been a slight increase in incidents reported during the 2022/23 financial year compared to 2021-22 which was 862. This can be seen as a positive safety culture that staff are raising Datix forms for security issues.

There have been a number of catalytic convertor thefts on the GWH site. Additional countermeasures (such as boulders) have been located in car park areas to help prevent unwanted activity and prevent vehicles access and egress into car parks.

The SMS Team has also started a review of the access control & CCTV systems to ensure full compliance and to ensure the systems are suitable for our future needs.

The team are working with SAFE on how lockdown can be achieved on the GWH site should the trust need to use this method to ensure areas can be controlled and measures due to a threat to site. There is now a lockdown policy in draft format. This continues to be an ongoing project and will be part of the business plan 2023/24.

3. Risk Register review process

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

Risk Number	Description	Risk Value	Status
	Fire		
736	There is a risk that the Health, Safety, Fire & Security team cannot fulfil all its duties due to long term sickness gaps within the team which could lead to delays in, or failure to, carry out some of its duties (or chartered accreditation).	9	Open
763	There is a risk that equipment, furniture, supplies stored within the GWH streets could create an obstruction in a fire / emergency situation preventing a timely evacuation.	12	Open
764	There is a risk that a timely fire evacuation might be compromised due to gaps in up-to-date Fire Plans within some department areas.	12	Open
846	There is a risk due to lack of correct fire compartmentation in risk room (Laundry), because when the space had a change of use no fire consultation was carried out resulting in fire safety non-compliance and unsafe working area for staff.	9	Open
848	Hazard waste store lack of Fire Safety Provision and management. Insufficient Fire safety signage, no floor markings to highlight escape routes, staff that use the area not aware or trained on fire safety as fire doors and escape routes are continually blocked with trolleys.	9	Open
	Safety		
256	Entonox gas extraction systems and processes are not ensuring staff exposure to Nitrous Oxide is below workplace exposure limit	12	Open
260	GWH Smoke dampers potentially not operating effectively against the threat of cold smoke permeation outside of fire compartmentation boundaries.	12	Open

4. Incident reporting

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

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

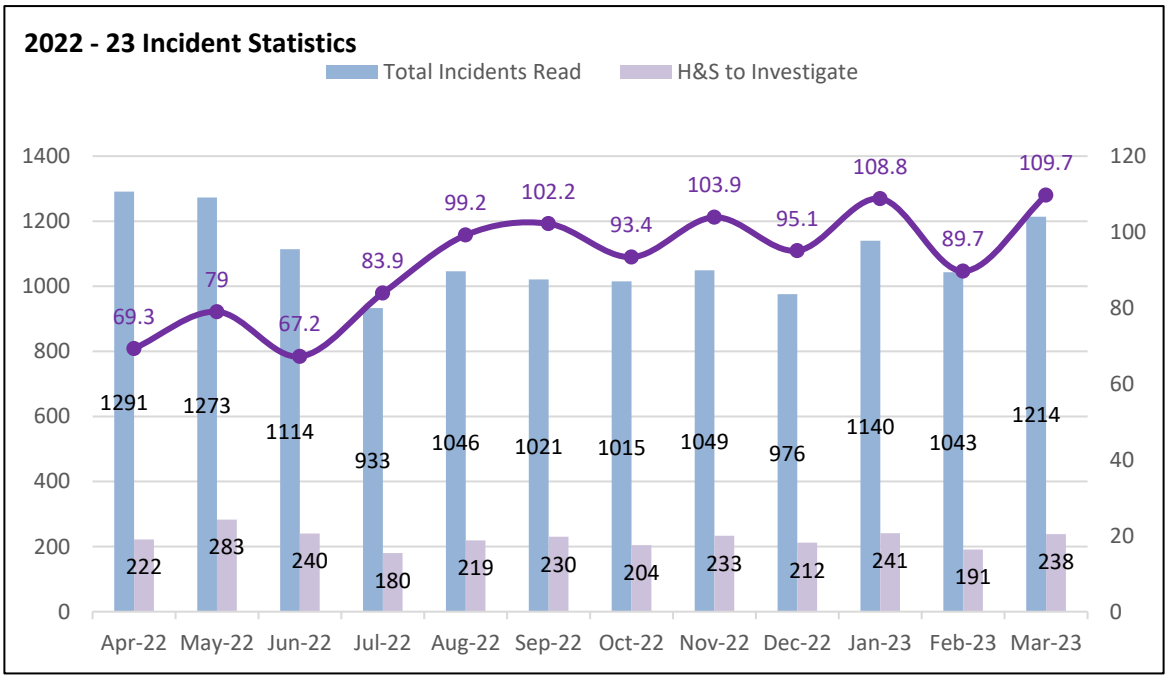
The team also review all patient falls to ensure there are no Health & Safety environmental hazards that contributed towards the fall and whether they are RIDDOR reportable. This is done through the checking of Careflow results for fractures / injuries and falls questionnaires being scrutinised. Each incident is managed appropriately through correspondence with managers and staff, ensuring the correct areas have been notified and manager outcomes show incidents have been fully investigated.

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

Incidents reported during the year constitute an 8% decrease on the figures from the previous year.

This may be explained by the change in the Trust's incident reporting system for staff (from Safeguard to Datix), alongside the fact that the Primary Care Services (GP Surgeries) no longer report incidents through the Trust's incident reporting system (following their transfer to another provider). The Trust will continue to monitor this situation to ensure we do not miss any trends requiring further attention.

2693 of the incidents reported required further action / follow-up from the Health & Safety team. All incidents submitted are read to ensure we have not missed any that may have been incorrectly categorised.

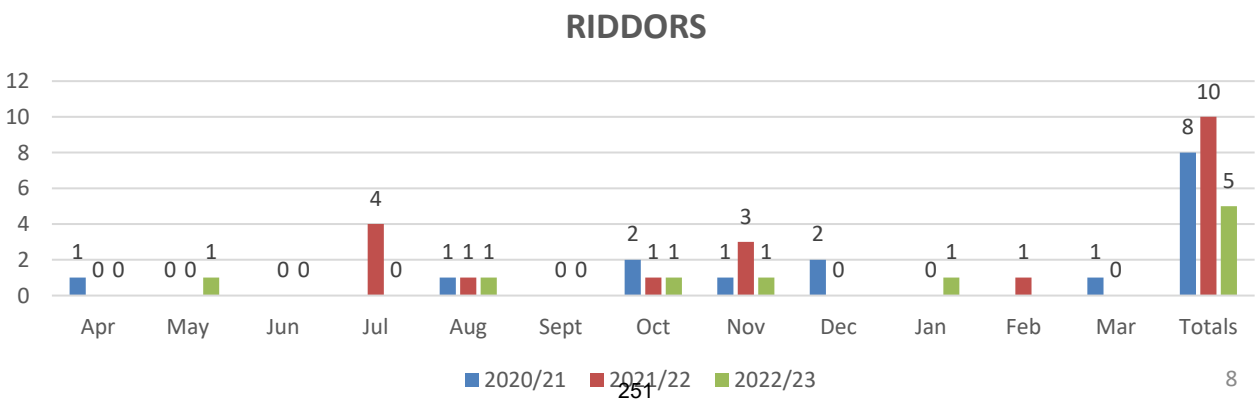


5. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

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

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

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



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

2022/2023 Summary of RIDDORs				
(5) May	28/05/2022	ICU	Staff	>7 days Strains/Sprain - back injury
(8) August	15/08/2022	Endoscopy	Staff	STF - Fracture foot
(10) October	31/10/2022	Theatre 3	Staff	>7 days STF - Fracture - finger or fingers
(11) November	06/11/2022	Surgical Assessment Unit	Staff	STF - Fracture Lower Limb
(1) January	19/01/2023	Paediatrics	Staff	>7 days - Physical assault

Using national data (ERIC) from 2021/22 of 212 Trusts, the average annual Estates and Facilities specific RIDDOR count is 5, with zero being the lowest and 268 being the highest (Mental Health and Learning Disability Trust). The highest score for a Medium Acute Trust was 16. None of the reported incident above were specific to Estates and Facilities.

Our robust reporting & learning regimes along with our strong safety culture mean that are RIDDOR numbers are encouragingly lower than other Trusts.

The main reporting categories consisted of three fractures, one strain / sprain and one physical assault. Three of the RIDDORS were reported to the HSE late (i.e. >7-day) and to avoid this going forward there have been repeated reminders to managers about meeting the timescales.

There are no specific trends to these RIDDOR incidents, but across the board it seems individuals are not paying attention to their surroundings whilst undertaking an activity.

Lost time accidents that were not reported as RIDDOR's

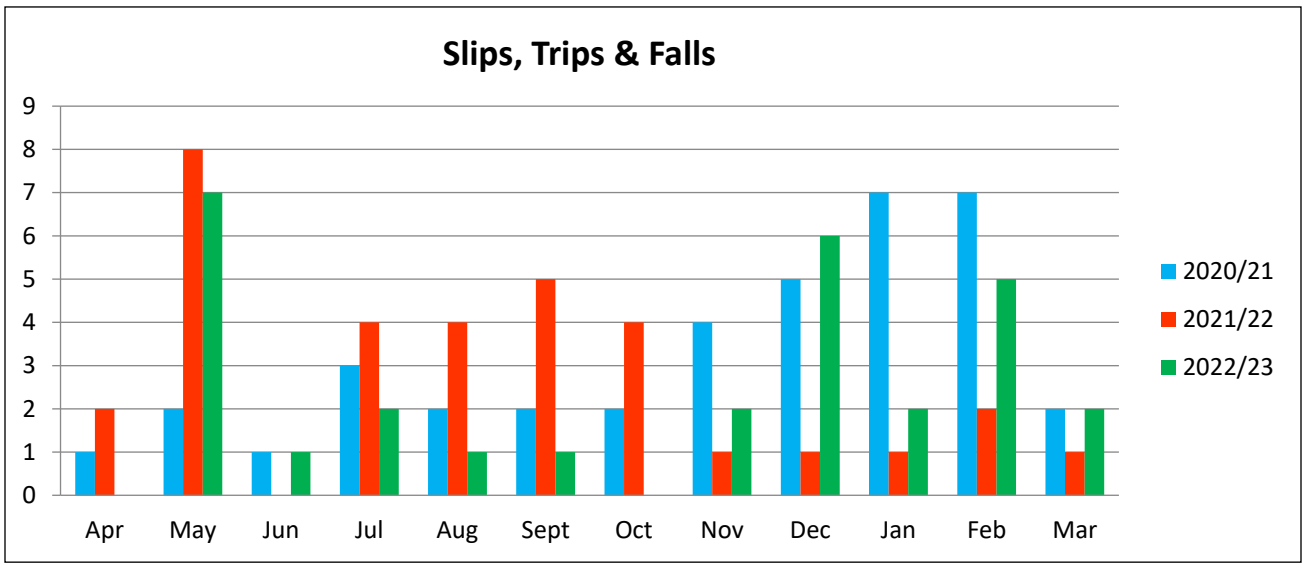
Year	Days
April 2020 to March 2021	53
April 2021 to March 2022	51
April 2022 to March 2023	52

The Health & Safety team also continue to monitor all lost time due to accidents which are less than the threshold for RIDDOR reporting of seven lost workdays or more.

The RIDDOR regulations continue to require that incidents of over three-day incapacitation must be recorded but not reported to the HSE. These 'Lost Time' incident days are equally as important in understanding the root causes after a thorough investigation and help reinforce our safety culture to reduce all accidental loss or injury.

6. Slips, trips and falls

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



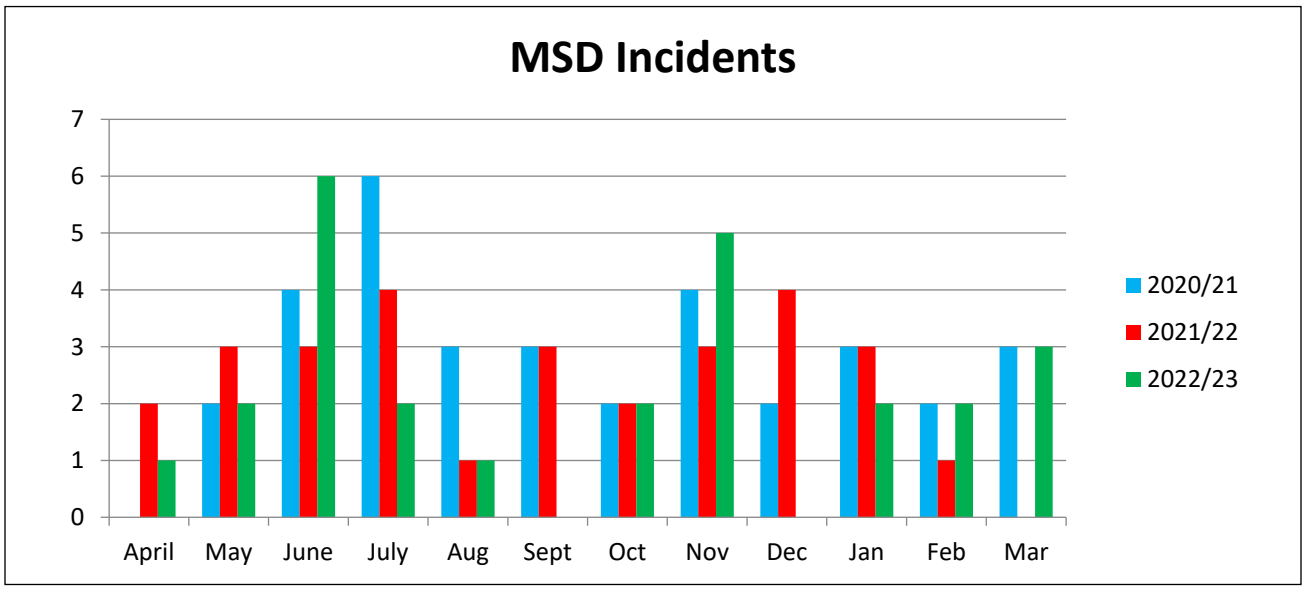
Year	Number of Slips / Trips
2020/21	38
2021/22	33
2022/23	29

There were 29 slip, trip and fall incidents reported during 2022/23, a decrease of four incidents or 12% from the previous year.

There were no particular trends identified regarding the Trust slip, trip, fall incidents reported and investigated.

7. Manual handling

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



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

Work-related Manual Handling incidents, resulting in a staff injury, remain very low in comparison to the total Musculoskeletal Disorder [MSD] cases reported. There was a decrease of four incidents or 10% from the previous year. Each of these incidents was investigated for learning and to prevent recurrence by the Manual Handling team.

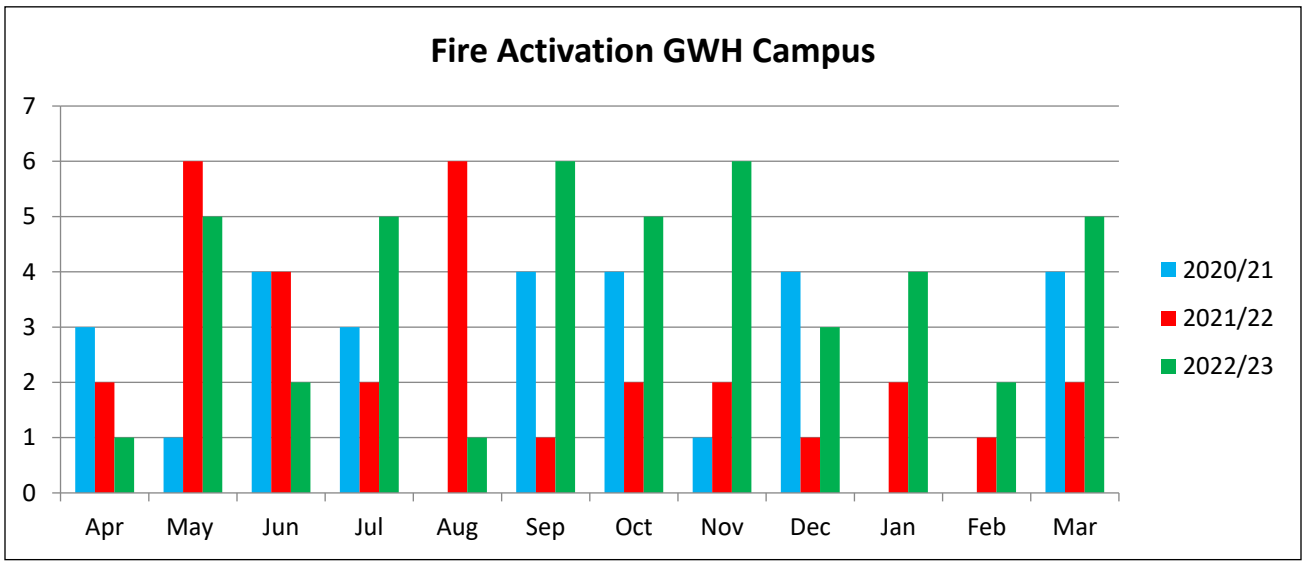
The continued decrease year on year provides a positive trend and highlights improvement of MSD activities across the Trust and a good safety culture.

8. Training

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

9. Fire

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



Year	Number of Fire Activations
2020/21	28
2021/22	31
2022/23	45

The five-minute protocol, during 'in hours' (0800hrs to 1630hrs) Monday to Sunday (Inc. Bank Holidays), continues to reduce unnecessary calls to the Fire & Rescue Service (FRS). During 'in hours' the fire response teams have five minutes to investigate the cause of fire alarms before deciding upon calling the FRS. The protocol also controls the automatic response by the Alarm Receiving Centre from summoning the FRS. Beyond the five minutes the default position is to phone the FRS regardless of the cause of the alarm.

Total Activations for 2022/23 GWH Campus so far = 45 inclusive of March. (In the same time period 2021/22 there were 31 activations)

Of the 45 activations there were 26 FRS attendance, 19 No FRS attendance.

Of the 26 activations where the fire brigade was called 11 of them were reported within core hours, when the 5-minute protocol should be in use. 5 off these were due to switchboard not receiving a call from the fire team within the required timeframe.

In 2021/22 and 2022/23 the top reason for fire alarm activations was due to a break glass being operated, whether deliberate or accidental.

2021/22 – 8
2022/23 – 15

There was a marked increase in reported toaster activations from two in 2021/22 to ten in 2022/23. Two departments each saw three activations (ED & Teal Ward).

Using national data (ERIC) from 2021/22 of 212 Trusts, the average annual number of fire alarm activations was 68 (no FRS attendance) and 28 (resulting in FRS attendance) with zero being the lowest and 500 (no
FRS attendance) & 512 (FRS attendance) being the highest. The highest score for a Medium Acute Trust was 273 (no FRS attendance) & 94 (FRS attendance).

Mandatory Fire Awareness training this year has continued to be conducted on-line. Staff have been advised to complete the on-line training module to maintain their fire safety awareness; this has been a necessary derogation from the Department of Health's guidance HTM05-01. The Trust will be looking to return to face-to-face training in accordance with the Department of Health guidance document Fire code - the year-end compliance figure is 79% (inclusive of clinical & non-clinical).

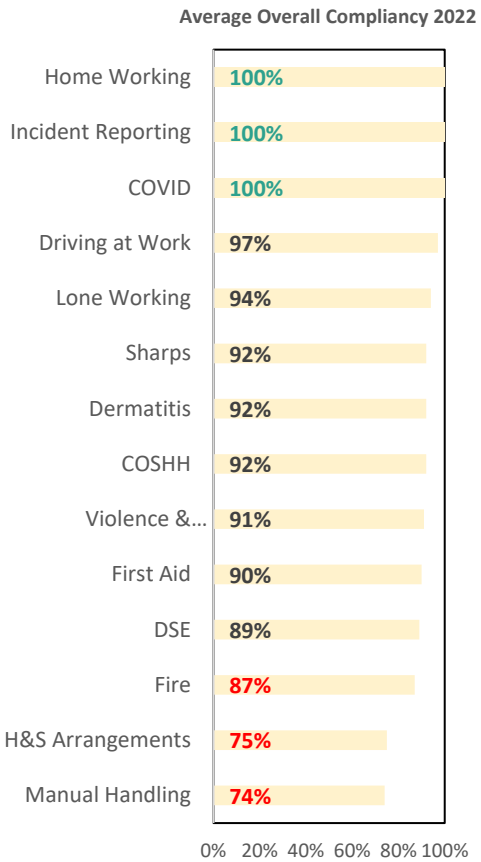
10. H&S Audit programme

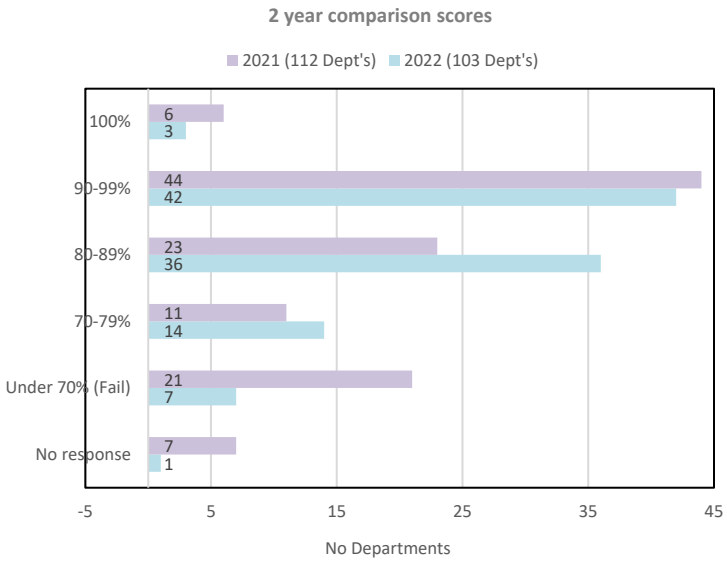
The annual Health & Safety audit programme is a fundamental part of our safety management programme and helps confirm compliance with Trust Standards and Legislation. This was completed across all acute Trust departments, community and the newly merged Primary Care sites that had ten or more staff.

104 Audits were sent out and 103 were returned. The graph below shows the number of departments achieving each scoring range, i.e., three departments [3%] of departments that submitted an audit, scored the full 100%.

100% SCORE

- Clinical Quality
- Community Dental Services Management
- Research & Innovation





All departments that either provided no response or scored under 70% were contacted and / or visited to provide support and guidance.

11. Security

The Trust reported 904 security related incidents via the Incident Reporting System [Datix] during the year 2022/23. This shows an increase of 5% from the previous year.

The Trust remains confident that reporting accuracy of all incidents involving Serco Security are reported well utilising the Trust Incident Reporting system [IR1].

Total Incidents Reported

Number of incidents 01/04/2021 to 31/03/2022	Number of incidents 01/04/2022 to 31/03/2023	Increase / Decrease
862	904	Increase of 5%

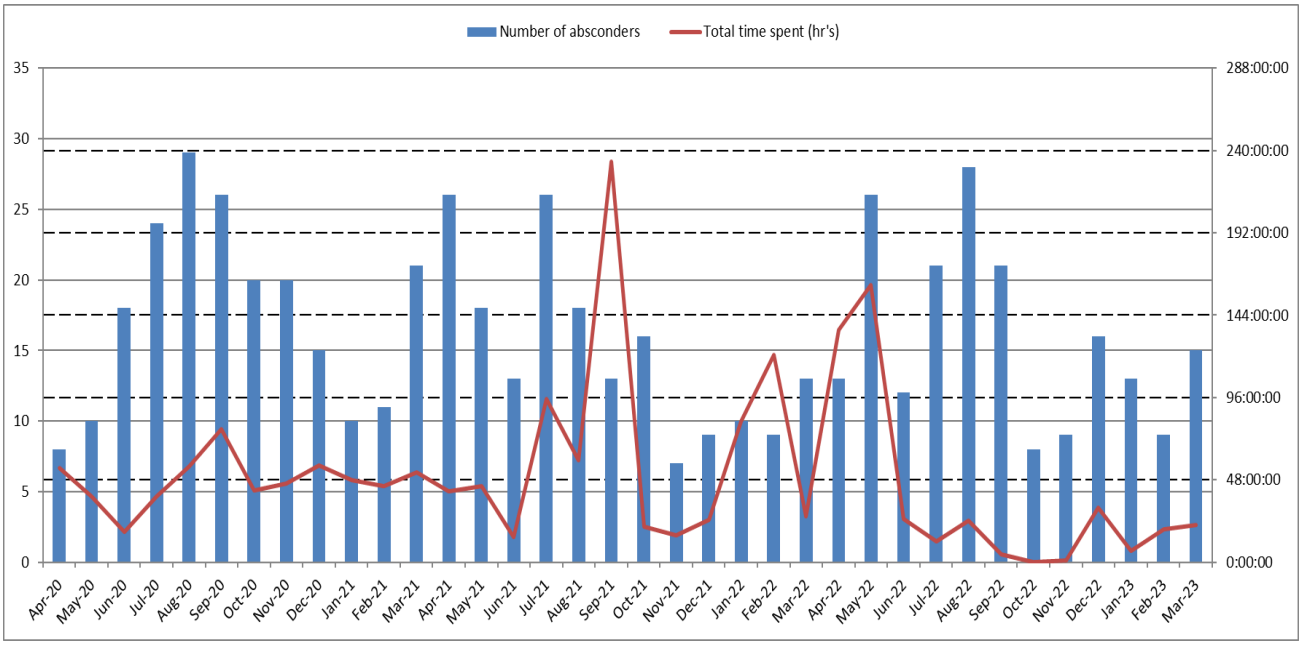
There has been a slight increase in incidents reported during the 2022/23 financial year compared to 2021-22.

Absconder / Missing Patient

Number of incidents 01/04/2021 to 31/03/2022	Number of incidents 01/04/2022 to 31/03/2023	Increase/Decrease
178	177	Decrease of < 1%

Summary: Absconding/Missing patients numbers remain static between the year-on-year dates.

Absconder Man Hours



The reduction in absconder man hours is mainly due to the incident description not providing Security stand down time which is where we collect our data from.

Physical Abuse (injury) Patient on Staff

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Increase/Decrease
44	98	Increase of 55%
Summary: The number of incidents raised has increased significantly. Data has shown there has been increased reporting across Teal, Jupiter, ED & Woodpecker. There is also the possibility that the change in the categories associated with the new reporting system have had an impact on the figures. This will continue to be monitored.		

Physical Abuse (no injury) Patient on Staff

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Increase/Decrease
36	30	Decrease of 17%
Summary: The decrease in incidents reported highlights a continued trend. There is also the possibility that the change in the categories associated with the new reporting system have had an impact on the figures. This will continue to be monitored.		

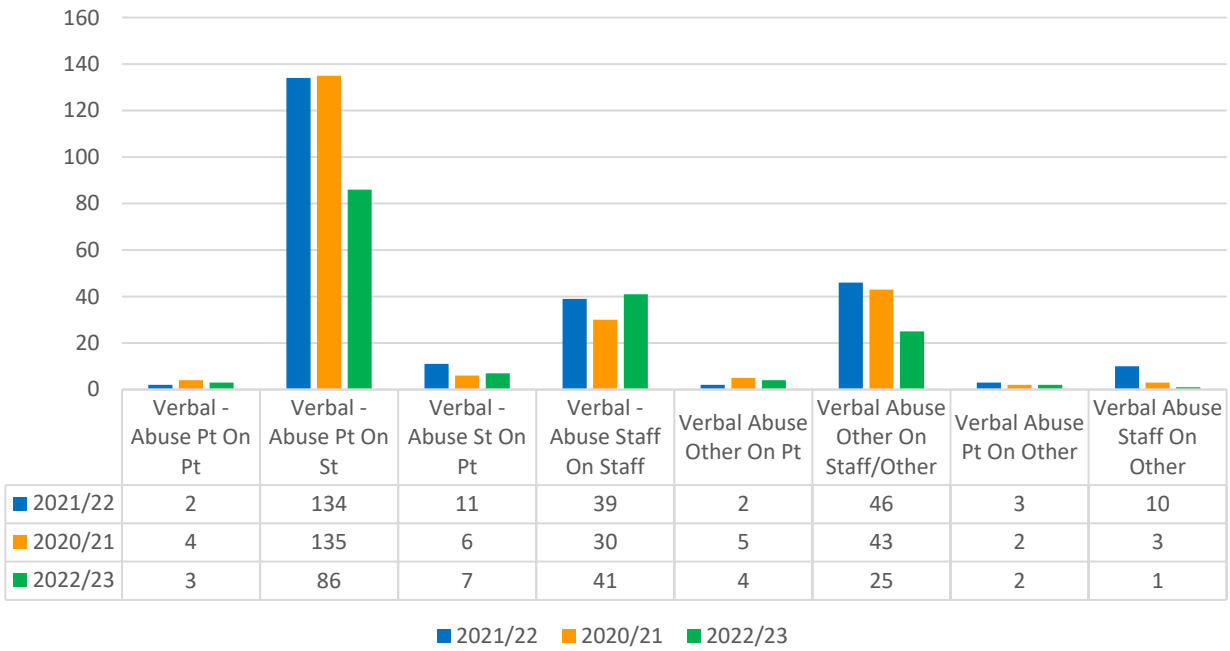
Verbal Abuse Staff on Staff (includes Agency Staff on Staff)

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Increase/Decrease
39	41	Increase of 5%
This shows a slight increase of 5% in incidents reported for staff-on-staff verbal abuse. It was noted there was reduced reporting in Q3 (Oct 22 – Dec 22). The incidents were generalised throughout the year with a spike in reported incidents during July & September 2022. There was no one month where an incident was not reported. Of the total incidents reported the three top reporting departments were ED – 4, Serco – 4 and Theatre – 3. This equates to 27% of the 41 incidents reported. This highlights there is no one area that shows any trends. The incidents comment on how staff are talking to each other -miscommunication, misinterpretation, the way it is said (i.e., abruptly, angrily, rude, tone).		

Verbal Abuse Pt on St & Verbal Abuse other on staff/other

Number of incidents 01.04.2021 to 31.03.2022	Number of incidents 01.04.2022 to 31.03.2023	Increase/Decrease
134	86	Decrease of 36%
46	25	Decrease of 46%
Summary: The marked decrease in incidents reported could be solely due to the change in the categories associated with the new reporting system having an impact on the figures. As no trends were identified we will continue to monitor as we obtain more data.		

Verbal Abuse Incidents



	Verbal - Abuse Pt On Pt	Verbal - Abuse Pt On St	Verbal - Abuse St On Pt	Verbal - Abuse Staff On Staff	Verbal Abuse Other On Pt	Verbal Abuse Other On Staff/Other	Verbal Abuse Pt On Other	Verbal Abuse Staff On Other
2021/22	2	134	11	39	2	46	3	10
2020/21	4	135	6	30	5	43	2	3
2022/23	3	86	7	41	4	25	2	1

Uncooperative/Stubborn patient – Physical behaviour

Number of incidents 01.07.2022 to 31.03.2023
29
Summary: Please note this category is being reported for the first time with data starting from 01/07/2022.

Uncooperative/Stubborn patient – Verbal behaviour

Number of incidents 01.07.2022 to 31.03.2023
37
Summary: Please note this category is being reported for the first time with data starting from 01/07/2022.

In previous years we have reported on categories Security Breach & Security Unsafe Environment. As outlined on previous annual reports the incidents reported under these categories were not always best placed. Due to the change to the incident reporting system from July 2022, we are unable to provide accurate data for year-on-year analysis.

Please note above we are now reporting on two categories that we feel will be beneficial moving forward.

Sanctions issued 2022/2023

- 25 x Verbal warnings
- 3 x UBLs issued
- 1 x Acceptable Behaviour Agreement
- 0 x Final Warnings
- 0 x Joint Wilts Police/GWH warning letter ABA – GWH/Wilts Police – Completed but requires Exec level sign off
- 3 x Community Protection Warnings
- 0 x Community Protection Notice
- 9 x Successful prosecutions Including a custodial sentence
- 1 x Civil Injunction Working with the Anti-Social Behaviour Investigator from Swindon Borough Council

This year we have seen a number of successful prosecutions, with one resulting in a custodial sentence. The SMS Client Engagement Lead continues to work with numerous partner agencies to hold perpetrators to account for their actions on Trust. Our SMS has developed an extremely good working relationship with the Wiltshire Police SPOC (single point of contact). This continues to be mutually beneficial and has been instrumental in helping to secure these prosecutions over this reporting period.

Police Involvement by department

Although reported in previous annual reports this year we are unable to do so. After discussing with the team that manage Datix we have been advised that it seems the 'Police Involved' section on the incident reporting form has been hidden so would not have been utilised by users. This means that any data pulled would not be a true reflection. We will be discussing with relevant parties to ensure this is rectified for future reporting.

12. Statement of Commitment for Health & Safety

The following statement of commitment is signed by the Trust Chief Executive and Chairman each year and continues to form the first page of the Trust Health & Safety Policy. The statement is also audited to ensure that it is adhered to departmental Health & Safety noticeboards across the Trust.

Health & Safety Policy

Statement of Commitment

The health, safety and security of everyone who may be affected by the Great Western Hospitals NHS Foundation Trust's activities including staff, patients, visitors and carers is of paramount importance to us all.

The Chief Executive and Board are committed to providing and maintaining a safe and healthy working environment providing and maintaining safe plant and equipment and ensuring safe manual handling practices as well as safe use of hazardous substances so far as is reasonably practicable.

The Trust will strive for continual improvement in all aspects of risk management and aim to prevent accidents and cases of work-related ill health whilst recognising its requirements to comply with all relevant health and safety legislation as a minimum requirement. In pursuing these aims, Trust employees are empowered to take all reasonable steps to ensure the highest standards of health, safety and welfare for staff, patients, visitors and any other persons that may be affected by the Trust's activities.

The Trust will provide adequate control of the occupational health and safety risks arising from our work activities and will provide the necessary information, instruction, training and supervision for our staff in order to ensure they are competent to conduct their tasks.

The Trust recognises that good risk management awareness and use of risk assessment practice at all levels is a critical success factor for our organisation.

Policies will be reviewed regularly in line with changes in legislation, approved codes of practice or official guidance as recommended by recognised national bodies as advised by the Health and Safety Department.

The Trust encourages staff at all levels of the organisation to give consideration to and take a responsible approach to the assessment and management of all risks when planning and organising work activities or changes to the workplace. In order to promote active participation and consultation at all levels within the organisation, the Trust encourages staff to take on health and safety responsibilities particularly as accredited Safety Representatives.

Full co-operation on the part of staff is vital to the successful delivery of this Policy and in achieving the safety aims of the Trust. The Trust expects all staff to fully comply with all matters of health and safety and in return offers full commitment to the well-being of employees. Each employee shall recognise their personal involvement and responsibility for observing all Trust policies and procedures.

Liam Coleman
Chairman ..... Date 14/11/22.

Kevin McNamara
Chief Executive KMcN..... Date 14/11/22

Appendices

Appendix A – Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

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

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

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

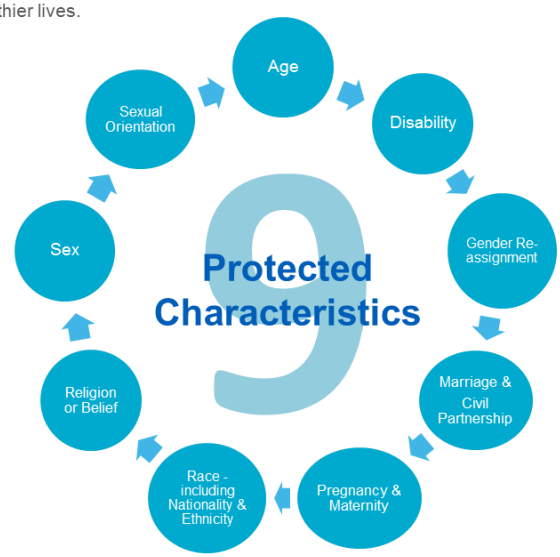
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

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

Our Vision

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



Appendix B

Statement of Commitment for Health & Safety

The following statement of commitment is signed by the Trust Chief Executive and Chairman each year and continues to form the first page of the Trust Health & Safety Policy. The statement is also audited to ensure that it is adhered to departmental Health & Safety noticeboards across the Trust.

NHS
Great Western Hospitals
NHS Foundation Trust

Health & Safety Policy

Statement of Commitment

The health, safety and security of everyone who may be affected by the Great Western Hospitals NHS Foundation Trust's activities including staff, patients, visitors and carers is of paramount importance to us all.

The Chief Executive and Board are committed to providing and maintaining a safe and healthy working environment providing and maintaining safe plant and equipment and ensuring safe manual handling practices as well as safe use of hazardous substances so far as is reasonably practicable.

The Trust will strive for continual improvement in all aspects of risk management and aim to prevent accidents and cases of work-related ill health whilst recognising its requirements to comply with all relevant health and safety legislation as a minimum requirement. In pursuing these aims, Trust employees are empowered to take all reasonable steps to ensure the highest standards of health, safety and welfare for staff, patients, visitors and any other persons that may be affected by the Trust's activities.

The Trust will provide adequate control of the occupational health and safety risks arising from our work activities and will provide the necessary information, instruction, training and supervision for our staff in order to ensure they are competent to conduct their tasks.

The Trust recognises that good risk management awareness and use of risk assessment practice at all levels is a critical success factor for our organisation.

Policies will be reviewed regularly in line with changes in legislation, approved codes of practice or official guidance as recommended by recognised national bodies as advised by the Health and Safety Department.

The Trust encourages staff at all levels of the organisation to give consideration to and take a responsible approach to the assessment and management of all risks when planning and organising work activities or changes to the workplace. In order to promote active participation and consultation at all levels within the organisation, the Trust encourages staff to take on health and safety responsibilities particularly as accredited Safety Representatives.

Full co-operation on the part of staff is vital to the successful delivery of this Policy and in achieving the safety aims of the Trust. The Trust expects all staff to fully comply with all matters of health and safety and in return offers full commitment to the well-being of employees. Each employee shall recognise their personal involvement and responsibility for observing all Trust policies and procedures.

Liam Coleman
Chairman
..... Date 14/11/22.

Kevin McNamara
Chief Executive
KMcN Date 14/11/22

Report Title	**IT Cyber Security – Annual Summary Report**				
Meeting	**Trust Board**				
Date	2 November 2023	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Naginder Dhanoa, Chief Digital Officer				
Report Author	Glyn Rowe, Head of IT Security and Configuration				
Appendices	GWH - Cyber Security Annual Update 2023				

Purpose

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

Assurance Level

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

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

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

Whilst there are good technical controls, awareness activities and engagement with regional and national expertise/activities in place, recent discussions at Finance, Investment and Digital Committee highlighted the need for further assurance on preparedness for a cyber event before assurance would be marked as acceptable/good.

Report

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

The purpose of this paper is to share the cyber annual report summary. In so doing, the report seeks to assure the committee regarding the key activities being undertaken to bolster our cyber defences and continue to maintain the integrity of GWH's computer network and systems from cyber-attacks. This paper was presented at Trust Management Committee in June 2023, to Audit and Risk Assurance Committee in September 2023 and now subsequently to Trust Board.

It is important to emphasise that over the reporting period, there has been no successful cyber-attacks on GWH's computer systems and our network has not been compromised. This situation owes much to the implementation of improved toolsets and the setup of a focused team that have enhanced the steps that we have taken throughout the last 12 months, including:

1. Improving device security by replacing obsolete devices and software
    a. Migrating to Office 365
    b. Migrating to applications off IE11 to use modern supported browsers

c. Minimising Legacy Operating System software with additional protections applied

2. Enhancing and Securing GWH's network perimeter through Firewall IPS, IDS and Anti Malware
3. Enhancing automation through the use of IT inventory and Patch management tools
4. Compliance with the NHS England CareCert process both in response and remediation
5. Enhancing Computer and Server protections through increased IPS, IDS and Anti Malware
6. Improving our Speed of response Phishing Blocking using Proxy and Firewall Toolsets
7. NHS Mail have implemented Safer Links protection to improved email protections
8. Enhancing the use and reporting from the Security, Information and Events Management (SIEM) system through active alerting against privileged users and groups.
9. Improving network resilience and segmentation by deploying a Software Defined Network to control device and user access through policy and profiles helping to minimise risk to medical devices
10. Enhancing use and reporting from the Microsoft Defender (NHS Digital provided) toolset
11. Enhancing disaster recovery preparedness through further modernisation of GWH's data backup systems to ensure fast recovery of critical data in the event of a cyber-attack.
12. Staff training and information dissemination through providing staff regular and targeted cyber and information security awareness training appropriate to their job role, etc.
13. Senior IT attendance at NHSE Events plus Cyber & Resilience exercises conducted across the ICB.
14. Implementation and Enhancement of the Privileged Access Management solution
15. Embracing NHS England funded security audit reviews – Active Directory
16. Enhancing the use of Pentera cyber security software to show penetration techniques to shine a light of device / network weak points through cyber simulations that help target remediation activities
17. Improving the use of the Risk Register to identify key cyber security risks that require focus
18. Creation of a focused internal IT Configuration and Security (ICaS) Team
19. The Trust participates in the NHS Cyber Associates Network (CAN) for Advanced warning and sharing
20. The Trust participates in the NCSC Advanced warning programme

Together, these initiatives enable us to continue to deliver the cybersecurity objectives and keep our computer systems safe. We continue to work collaboratively with ICS partners and NHS England, both at a South West regional and national level, to improve our cyber defences through joint implementation of security solutions and looking to adopt the "Stronger Together" and "Defend As One" approaches. Examples of the collaboration includes:

1. GWH IT are active members of the steering and user groups in the South-West.
2. GWH IT are active membres of the BSW ICB TDA (Technical Design Authority) group that works to ensure sharing of information, awarness toolsets etc are all adopted.
3. Improved communication within the ICB and regular engagement with ICB colleagues provides the Trust with additional intelligence and experiences.
4. Partnership working with NHS England has meant real-time access to CareCert notifications and advisory actions, and security patches and hotfixes that are now applied routinely to our systems.
5. We are signed up to an actively use the external assesment service Bitsight that lists GWH between Intermeidate and Advanced for our perimeter protections.

By way of conclusion, our local cybersecurity is being improved continually, we are working much closer together with our BSW ICB partners, the South-West region and NHS England to continue to make our defences stronger, use reporting / alerting information to enhance our ability to "seek and secure" areas of risk. During 2023/24 there will be increased focus on developing the "defend as one" within the Trust and ICB. We completed the final Annual DSPT submission in June 2023 and GWH retained our Compliance Met for this submission. Specific focus on Windows 2012 server migration will be a key item for 2023/24. We will enhance the existing relationship with SFT colleagues to look at ways to harmonise policies, share experiences and opportunities. In addition, we will be looking to work with technology / security partners to enhance the need to continuously maintain and enhance the protections required for safe systems.

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

– risk number & description (Link to BAF / Risk Register)	Risk 485 - Cyber Security Attack	8
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:	
Trust Board to note content of this report	
Accountable Lead Signature	
Date	26 October 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Cyber Security

Annual Report 2023

Glyn Rowe
Head of IT Security and Configuration

Cyber Security – Perimeter Protection

Great Western Hospitals NHS Foundation Trust

GWH IT adopts a **layered approach** to perimeter security

- **Firewalls** - **Closed Door Policy – "If your not on the list you can't come in"**
  - Rules based access allows approved inbound and outbound access only - Layer 1
  - Intrusion protection service enabled and blocks unwanted traffic - Layer 2
  - Anti-malware protection scans all traffic and blocks unwanted traffic - Layer 3

- **PROXY** - **Checks access is appropriate / allowed – "If this isn't approved - proxy blocks access"**
  - All requests to the Internet go through the proxy server
  - The proxy server checks that the access requested is allowed
  - If the access is not authorised the request is blocked
  - We use the proxy server rules to help stop users clicking on malicious links

- **Microsoft Defender 365 (MDE)** **- Alert mechanism reporting "security check" actions on devices**
  - MDE provides alerts to NHS Digital and GWH IT Security staff
  - GWH IT Security will "respond and remediate" issues
  - GWH IT Security have the ability "quarantine" individual or multiple devices
  - NHS Digital have the ability "quarantine" individual devices, multiple devices or the entire site

  (Note – this is a capability of the system – not something that NHS Digital would use without notification and critical need)

Cyber Security - External View

Great Western Hospitals NHS Foundation Trust

NHS Digital

Windows Defender 365 (MDE) Server / Device Security Posture

GWH devices are connected to the central NHS Digital security solution. The CSOC (Cyber Security Operations Centre) monitors security related issues and alerts, informing GWH IT security of issues to assess / remediate.

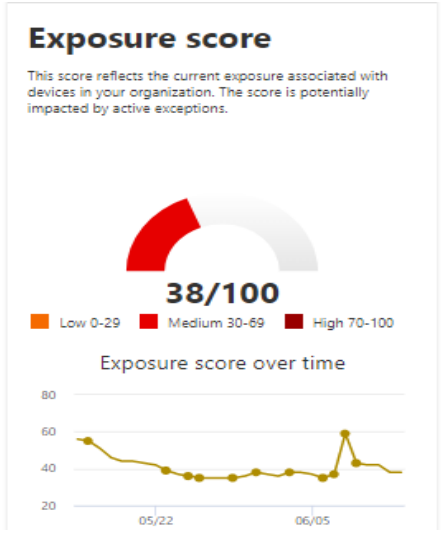
GWH IT Security use this tool alongside others tools to aid our security improvement activities.

Key Activity to Improve Rating

Current score similar to SFT and RUH.

The lower the score the better

- Upgrade legacy systems
- Keep systems up to date
- Windows 2012 upgrades



BitSight

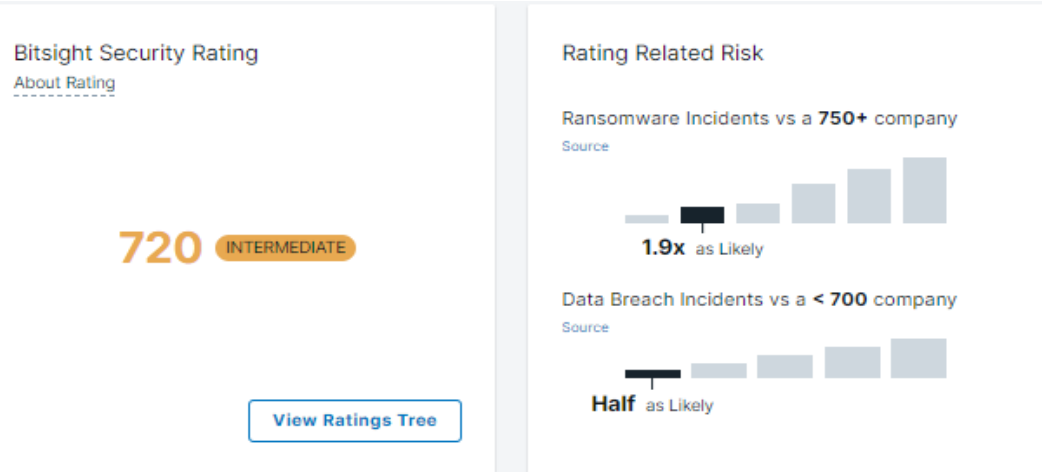
Internet Facing Security Posture

The score below assesses how secure our "perimeter security" is from the "outside".

We currently rate as **Intermediate.**

We regularly assess ways of improving our protection and score to move to an advanced rating during 2023/24.

The HIGHER the score the better



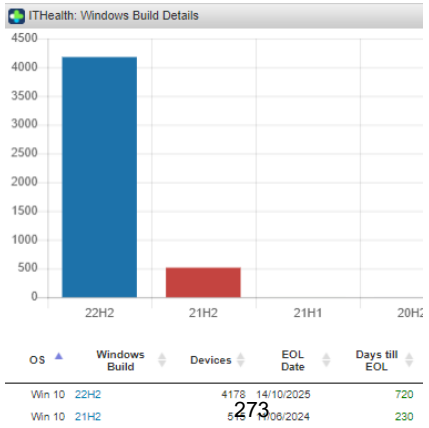
Cyber Security – Internal Protection

Great Western Hospitals NHS Foundation Trust

GWH IT adopts a **layered approach** to Internal security – “Check and Protect”

- **Anti-Malware Protection – Trend**
  - Computers are automatically updated
  - Computers are set to scan files on access – including USB and portable media
  - When issues are found an alert is sent to the user and GWH IT who will further assess the remediation action required
  - Outbreak manager can be used to “quarantine” devices of concern - individual devices, multiple area or the entire site
- **Intrusion Protection Service (IPS) – Trend**
  - Provides a “shield” against known issues ahead of patches being deployed – helps with zero day attacks when no patch is available
  - Computers are automatically updated with new rules - without a reboot required
  - System alerts GWH IT if “probing attacks” happening – proven as part of the penetration test
  - GWH IT can lockdown individual devices or areas
- **Security Patching**
  - Desktops and servers are updated regularly (at least monthly) with security patches
  - ITHealth helps GWH IT track “devices of concern” and aids our “seek and secure” activities
  - ITHealth provides an ability to push patches out quickly
- **Desktop Upgrade Activity**

  Windows 10 - Adopting Supported Versions
  - 99.8% of GWH devices (4600+) on supported versions
  - Windows 10 22H2 is our default and remains in support until May 2025.
  - Remaining 21H2 devices are in support, but are being automatically updated.
  - Windows 11 planning underway, with build, test and migration planning in 2024.



- **Server Upgrade Activity**

  Windows 2008 / 2012 – Upgrades
  - Remaining 2008 Servers that can be upgraded to be completed.
  - Windows 2012 Server upgrades in flight and a primary focus for 2023/24. Where possible all servers will move to Windows Server 2019 versions that remain in support until 2029.
  - Trend Deep Security is used to protect these systems.

Cyber Security – Multi Factor Authentication (MFA)

Great Western Hospitals NHS Foundation Trust

GWH IT is adopting a controlled approach to MFA enablement

MFA is an additional security measure to ensure the person using the account

- **IT Security System Access**
  - The majority of our security systems are now MFA enabled
    - Internal Sites – PAM360, LOG360, Trend Deep Security, Trend Apex One, Penterra, NCSC
    - External Sites – NCSC, BitSight, Microsoft Defender Endpoint

- **Privileged Access Management (PAM)**
  - The solution has been implemented and uses MFA to access the system
  - IT staff are using this service to access and administer resources
  - Additional “resources” are being added to provide support staff with controlled access to support services

- **NHS Mail / Office 365 (National System – Central Tenant)**
  - From October 2023 all new NHS Mail accounts will require MFA enabled on their accounts
  - MFA will be needed to access NHS Mail and Office 365 services
  - Microsoft Authenticator App will be the default MFA option of choice
  - Staff enrolment is in progress and being project managed
  - Training and support information is being shared
  - By 31st March 2024 ALL user accounts need to be MFA enabled

- **VPN Access with MFA**
  - We are currently testing improved VPN security and MFA facilities.
  - The solution is based on the Microsoft Authenticator App to provide a common App platform with NHS Mail / Office 365

Cyber Security – NHS High Severity Alerts (HSA)

NHS Great Western Hospitals NHS Foundation Trust

The following summarises the High Severity Alerts received by NHS England over the last 12 months and GWH IT performance response to these.

Alert ID	Alert Title	Alert issued date/time	Status	48 hour acknowledgement deadline met	14-day closed-response deadline met	Comments	Final Status
CC-4140	Critical Update for VMware Products	03/08/2022 14:15	Not applicable	Yes	Yes		Complete
CC-4165	Microsoft Windows TCP/IP Remote Code Execution Vulnerability	14/09/2022 15:52	Complete	Yes	No	Large number of devices not powered on so took longer to updated devices	Complete
CC-4169	Critical RCE Vulnerability in Microsoft Windows Internet Key Exchange (IKE) Protocol Extensions	16/09/2022 13:03	Complete	Yes	No	Large number of devices not powered on so took longer to updated devices	Complete
CC-4178	Zero-day Vulnerabilities in Microsoft Exchange Server	30/09/2022 11:57	Not applicable	Yes	Yes		Complete
CC-4192	Fortinet FortiOS, FortiProxy, and FortiSwitch Manager Authentication Bypass Vulnerability under Active Exploitation	17/10/2022 14:33	Not applicable	Yes	Yes		Complete
CC-4210	Remediation Released for Zero-day Vulnerabilities in Microsoft Exchange Server	09/11/2022 12:33	Not applicable	Yes	Yes		Complete
CC-4225	Fortinet FortiOS Heap-based Buffer Overflow in SSL-VPN Vulnerability under Active Exploitation	13/12/2022 11:14	Not applicable	Yes	Yes		Complete
CC-4226	Citrix Releases Security Updates in Citrix Gateway and Citrix ADC for CVE-2022-27518	13/12/2022 15:52	Not applicable	Yes	Yes		Complete
CC-4245	Zoho ManageEngine RCE Vulnerability CVE-2022-47966	19/01/2023 11:22	Complete	Yes	Yes		Complete
CC-4282	Critical Privilege Escalation Vulnerability in Microsoft Outlook for Windows	15/03/2023 09:00	Complete	Yes	No	Large number of devices not powered on so took longer to updated devices	Complete
CC-4291	Active Intrusion Campaign Targeting 3CX DesktopApp	30/03/2023 13:05	Not applicable	Yes	Yes		Complete
CC-4306	Active Exploitation of a Critical RCE Vulnerability in PaperCut MF/NG Servers	20/04/2023 13:54	Complete	Yes	No	Large number of devices not powered on so took longer to updated devices	Complete
CC-4334	Critical FortiOS & FortiProxy pre-authentication heap-based buffer overflow vulnerability in SSL-VPN	13/06/2023 09:07	Not applicable	Yes	Yes		Complete
CC-4359	Citrix Releases Critical Security Updates for NetScaler ADC and NetScaler Gateway	18/07/2023 17:22	Not applicable	Yes	Yes		Complete
CC-4362	Remote Unauthenticated API Access Vulnerability in Ivanti Endpoint Manager Mobile	25/07/2023 13:43	Not applicable	Yes	Yes		Complete
CC-4385	Progress Issues Security Update for Critical Vulnerabilities in WS_FTP Server	29/09/2023 12:08	Not applicable	Yes	Yes		Complete
CC-4395	Cisco Releases Security Advisory for Actively Exploited Vulnerability CVE-2023-20198	17/10/2023 16:50	Complete	Yes	Yes		Complete

Cyber Security – BIA / BCP / Testing

Great Western Hospitals NHS Foundation Trust

Business Impact Assessments - BIA

IT are working with Resilience colleagues to update and enhance current BIA documentation.
This close working relationship allows IT and Resilience to share information.

Business Continuity Plans - BCP

We are conducting a full desk based BCP exercise on the 23rd November 2023, facilitated by SFT EPRR and digital peers.
This event will engage a number of staff from IT, Resilience, Operational and Clinical areas.
The output and learning from this event will be shared in the next quarterly reporting to FIDC.
Rolling BCP events will be scheduled in for 2024

Testing

We keep an annual diary of the planned system recoveries completed.
The annual DSPT submission requires documented evidence of data and system recovery tests.
Increased focus is being placed in this area to improve both the level of testing and evidence.

Cyber ICS Event

On the 9th November an ICS wide Cyber event is being conducted.
This brings together colleagues from a range of services across BSW.
The output and learning from this event will be shared at the subsequent ICS Digital Board.

Cyber Security – Summary

NHS Great Western Hospitals NHS Foundation Trust

NHS England, NHS Digital and NCSC are all issuing very similar guidance. The key areas of focus are:

Area	Activity	Further Work
Check your system patching	Checked and confirmed as functioning as intended	Constant need to patch and improve systems
Verify Access Controls	NHSD Active Directory Review completed	Final recommendations to be applied Continual Review and Improvement
Ensure Defences are working	Firewalls, Anti Malware and Intrusion Protection systems have been checked and operating as intended	New Network improves user and device policy controls and increased device segmentation
Review your backups	NHSD Backup Review – Completed Planned restores are completed on a regular basis	Continual Review and Improvement
Incident Plan / Testing	NHSD Cyber Exercises attended during 2022/2023 EPRR update activity underway to bring plans up to date	Continual Review and Improvement
Check your Internet Footprint	Bitsight currently score GWH as Intermediate	Continual Review and Improvement
Phishing Response	Trend Proxy and Apex One provide toolset protection IT send out advice comms around Email, Spam etc	Improved staff awareness Add to Mandatory Training requirements
NSCS / NHS Digital Services	NCSC – Early Warning and Web Check = GWH Active User NHSD – Vulnerability Management Service = GWH Active User	Continual Review and Improvement
Brief Your wider organisation	IT send out guidance on Passwords, SPAM, IT Security and Confidentiality. Cyber Profile is higher on the agenda.	Improved staff awareness Add to Mandatory Training requirements

Cyber Incident Response capability - In the event of a cyber attack, NHS organisations are expected to inform NHS Digital's Cyber Security Operations Centre immediately on **telephone 0300 303 5222**.
NHS Digital holds a call-off contract for specialist cyber incident response capability which will be deployed to local organisations if required.

Report Title	**Risk Management Policy**				
Meeting	**Trust Board**				
Date	2 November 2023	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Rayna McDonald, Deputy Chief Nurse				
Report Author	Megan Fernandes – Risk & Legal Facilitator				
Appendices	Risk Management Policy				

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

Assurance Level

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

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

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

Report

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

The risk policy has been reviewed in line with the 3-year review period. Changes have been made to the policy including:

- The risk management framework has been split into four sections, including determining priorities and horizon scanning, risk identification, risk assessment and risk response.
- The management of 15+ risks is explained via flowchart, as well as escalation and de-escalation of risks throughout the Trust.
- Risk categorisation including strategic risks, divisional and corporate departments organisational risks and project risks are explained, with the appropriate governance controls outlined to provide assurance throughout the Trust.

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

Key Risks – risk number & description (Link to BAF / Risk Register)		**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Trust Management Committee Audit Risk and Assurance 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:			

Recommendation / Action Required The Board/Committee/Group is requested to:	
It is recommended that the Trust Board approve this policy.	
Accountable Lead Signature	
Date	26 October 2023

TRUST-WIDE POLICY DOCUMENT

RISK MANAGEMENT POLICY

Policy Number:	Corp - 00003
Scope of this Document:	**All Staff**
Ratifying Committee:	**Trust Board**
Date Ratified:	
Next Review Date (by):	
Date implemented (made live for use):	
Accountable Lead:	Chief Nurse
Division or Department	Corporate – Quality
Lead Author(s):	Risk & Legal Facilitator

Version

*Content in blue italics are for guidance when using this template, and should be **deleted**.*
Fields in red are completed by the Corporate Governance Assistant. Authors are not to complete these
*Text in green should be either **deleted or amended** as necessary but is included as a helpful guide.*

TRUST-WIDE POLICY DOCUMENT

RISK MANAGEMENT POLICY

Further information about this document:

Document summary	The aim of this policy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities.
Author(s)	Risk & Legal Facilitator Head of Patient Safety and Quality
Published by	**Corporate Governance Team** **Trust HQ** **Great Western Hospitals NHS FT** **Marlborough Road** **Swindon**
To be read in conjunction with	*This section should identify the legislation which applies in relation to the requirements of the document, i.e. is there a law or Act that dictates this document must exist. Or it should identify if there are any agencies that regulate the healthcare providers set out such as CQC.* **Stage 2 Full Equality Impact Assessment**
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.	

Version Control:

	Version History:

Contents

1 PURPOSE AND RATIONALE

Purpose –

Risk is an inherent part of the delivery of healthcare. This risk management policy outlines the Trust's approach to risk management throughout the organisation.

Risks provide us with threats and opportunities, which can impact the achievement of objectives. Risk is defined events that 'might happen' as the effect or result of uncertainty on objectives. Risk management includes identifying, assessing, and responding to risks. Good risk management awareness and practice at all levels is a critical factor for success.

The aim of this policy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The policy seeks to ensure that:

- the Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected
- the implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk based upon the support and leadership offered by the Trust Board

Staff at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

The aim of this Risk Management Policy is to provide a supportive risk management framework that ensures:

- Integration of risk management into activities throughout the Trust
- Chances of adverse incidents, risks and complaints are minimised by effective risk identification, treatment and management
- A risk management framework is maintained, which provides assurance to the Board that strategic and operational risks are being managed
- Risk management is an integral part of GWH culture and encourages learning from incidents
- Informs prioritisation of investment and is aligned to business planning

This is the predominant risk management policy in the Trust. The Maternity Services Risk Management Strategy (Ref 1) has been developed to supplement the Trust Risk Management Policy; however, this remains subservient to the Trust-wide Risk Management Policy.

3 SCOPE

This document applies to all staff employed by Great Western Hospitals NHS Foundation Trust (whether on a permanent, temporary or honorary contract) who are involved in writing, reviewing or the management of Policy documents.

4 DEFINITIONS

The following terms and acronyms are used within the document:

CQC	Care Quality Commission

EIA	Equality Impact Assessment
GWH	Great Western Hospital
ID	Identification
NHS	National Health Service
NPSA	National Patient Safety Agency

5 DUTIES

5.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

5.2 Executive Leads

Executive Leads are directly accountable to the Board for effective risk management within their areas of responsibility. They are required to ensure that risks are identified promptly and managed effectively in accordance with this Strategy and any associated documents, policies and procedures.

5.3 Divisional Triumvirate and Corporate Department Leads

Divisional Triumvirates and Corporate Departments will:

- Scrutinise risks scoring 12+ within their Division at least monthly (the review, together with any action taken, must be minuted);
- Holds departmental managers to account for managing their risks;
- Reports areas of concern to the Trust Management Committee .
- Ensure that appropriate and effective risk management processes are in place within designated areas and scope of responsibility and that all employees are made aware of the risks within their work environment and of their personal responsibilities;
- Implement and monitor any identified risk management control measures within their designated area and scope of responsibility ensuring that they are appropriate and adequate;
- Ensure that risks are captured onto division/specific-area risk ; and
- Ensure that a local group (usually the monthly division/specific-area meetings) review the Division/specific-area risks

Executive Directors are responsible for ensuring the Risk Owner reviews the risk regularly and has effective controls and mitigations in place. They are also responsible for ensuring the risk is scored appropriately and are responsible for approving or rejecting them onto the Corporate Risk Register.

5.4 Service Leads

The Service Lead has responsibility to ensure risks are being managed within their services. They will be responsible for management of risks scoring 1 – 10 within their services and responsible for the escalation of risks scoring 12+ to the Divisional Risk Registers.
The Company Secretary is responsible for the coordination of the Trust Board's Board Assurance Framework to ensure proactive management and to ensure the Board remains sighted on the key risks facing the Trust.

5.5 Departments and Teams

Departments and Teams will review their risks to ensure their management and will report any areas of concern to the Service Leads.

5.6 Risk Owners

The risk owner is the responsible point of contact for an identified risk, who co-ordinates efforts to mitigate and manage the risk with various individuals who may also own parts of the risk. The responsibilities of the risk owner are to ensure that:

- Risks are identified, assessed, managed and monitored
- Risks are clearly articulated within the Risk Management Tool
- Controls and actions are in place to mitigate the risk in line with the risk appetite

5.7 All Employees

All employees are required to comply with all relevant legislation and regulation, attend training where appropriate and maintain their own professional competencies, ensuring they are familiar with, and comply with, Trust policies, procedures, and other documents.

All employees have a responsibility to ensure any risks that they identify are flagged to their line manager in the first instance. Employees must be aware of risk management procedures and be willing to report incidents and risk management issues.

5.8 Risk and Compliance Team

The Risk and Compliance Team are responsible for:

- Supporting Divisions in compiling division risk dashboards.
- Providing support and training on the Risk Management Tool.
- Producing Divisional Risk Dashboards using data from the Risk Management Tool system on a monthly basis to support the review of risk at Divisional Governance Meetings.
- Supporting the Deputy Chief Nurse with compiling a 15+ Risk Dashboard and report; and
- Providing administrative support and training on the Risk Management Tool.
- Provide support to department in the monthly production of the template which enables them to produce and report on their area risks.
- Weekly oversight huddle to monitor quality of risk.

5.9 Company Secretary

The Company Secretary is responsible for the coordination of the Board Assurance Framework to ensure proactive management and to ensure the Board remains sighted on the principal risks facing the Trust.

5.10 Trust Board

The Trust Board is responsible for risk management throughout the Trust. It delegates some responsibility to the Trust Management Committee and the Audit, Risk and Assurance Committee and receives assurance from those committees on the effectiveness of the risk management strategy. To discharge its responsibilities it will:

- Ratify the Trust's Risk Management Policy every three years;
- Review the 15+ Risks at least quarterly;

- Review the Board Assurance Framework on a quarterly basis;
- Delegate responsibility for taking assurance on the management of 15+ risks in relation to the relevant Board sub-committees.
- Delegate responsibility for taking assurance on the risk management processes to the Audit, Risk and Assurance Committee.

5.11 Board Committees

Th Board Committees have responsibility for seeking assurance relating to work within their remit.

The Quality & Safety Committee is particularly concerned with quality and safety matters and ensuring risk mitigation in these areas, whereas the Finance Investment & Digital Committee is engaged in regular reviews of risk outcomes of financial performance and the estates and digital infrastructure. The Performance, Population & Place Committee is concerned with operational performance and partnership working risks and the People & Culture Committee focusing on workforce risk. The Mental Health Governance Committee is concerned with areas relating to mental health, safeguarding and learning disabilities.

Each of these committees has delegated oversight and scrutiny of those relevant strategic risks on the Board Assurance Framework and the relevant risks on the Corporate Risk Register which have been assigned to them by the Board. The committees will undertake the following roles in relation to the Board Assurance Framework;

- Seek assurance on a quarterly basis that the strategic risks under the Strategic Objective(s) aligned to the remit of the Committee are effectively managed and mitigated.
- .
- Consider the scoring of those strategic risks based upon the assurance received.
- Report any gaps in assurances or deterioration on strategic risks scores to the Board by exception.

5.12 Audit, Risk & Assurance Committee

The role of the Audit, Risk and Assurance Committee is to oversee the implementation of the Risk Management Policy and to take assurances that the processes supporting the Risk Management Policy are effective in mitigating risk. It does not have operational responsibility for individual risks, but will take assurances from the Trust Management Committee that risks are being managed. Its specific responsibilities are:

- To review the management of 15+ Risks at least twice a year;
- To review Divisional Risk management and governance processes at least once a year;
- To review the Board Assurance Framework quarterly.

The Audit, Risk and Assurance Committee will also receive assurances from the Board Committees to supplement the overall assessment of risk and the effectiveness of the risk management process within the Trust.

5.13 Trust Management Committee

The Trust Management Committee has operational responsibility to ensure risks are being managed. It has specific responsibility to:

- Scrutinise and challenge the 15+ Risks on a quarterly basis;

- Consider risks for escalation to the Board Assurance Framework and where identified recommend these for inclusion to the Board;
- Scrutinise and challenge the Board Assurance Framework on a quarterly basis year;
- Scrutinise and challenge each Divisions Risks once a year;
- Hold Associate Medical Directors and Divisional Directors to account using the Risk Report on how risks are managed within their Division, directing action where appropriate.

5.14 Risk Group

The Risk Group has responsibility to provide oversight, challenge and scrutiny to the management of risks on the Trust's risk register reporting to the Trust Management Committee and Audit, Risk & Assurance Committee.

6 PROCESS

6.1 Risk Management Framework

Stage 1 – Determine priorities and horizon scanning
The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change. This is part of the annual Business Planning Process.

By undertaking a continuous, systematic and participatory approach to horizon scanning the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Divisions and Corporate services will highlight any issues on the horizon through the risk register and when presenting their risk reports to the Risk Group (as per the Risk Group programme); the Board will undertake at least one formal horizon scanning session per year when undertaking the annual Board Assurance Framework refresh. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Stage 2 – Risk identification
Risk is identified in many ways; we identify risk proactively by assessing corporate objectives, work related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation by the Trust. (2.1.2)

Stage 3 – Risk assessment
Risk assessment involves the analysis of individual risks, including any plausible risk aggregation (the combined effect of different risks) where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure (2.1.3)

Stage 4 – Risk response (risk treatment)
For each risk, controls are established, documented and understood. Controls are implemented to avoid, modify, transfer or accept risk; or to seek risk (take opportunity). Gaps in control are subject to action plans which are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk, and expressed its appetite in the form of 'tolerable'

risk ratings in the Board Assurance Framework. So as to prevent inconsistencies from being introduced which may destabilise and reduce the effectiveness of the risk management framework, any fundamental changes to the way in which risks are described will require the approval of the Risk Group. (2.1.4)

6.2 Risk Management Process

Risk management is a systematic and cyclical process, in which risks are identified, assessed, managed, monitored and reviewed. It is applicable at all level throughout the Trust – Board, Divisional, Department, team and individual.

This process enables the Trust to monitor and address the strategic risks that would prevent the organisational achieving its strategic objectives. It sets out controls (or ways the risk is being mitigated), and the sources of assurance that those controls are effective, as well as setting out action plans for those risks that require action to bring them within the risk appetite where possible.

6.2.1 Risk Management Process

The Trust should strive to identify, evaluate and manage changes in the risk environment, preferably before they manifest as a risk or become a threat to the organisation. Proactive risk identification can also identify positive areas for the Trust to develop its business and services, taking opportunities when they arise. The risks identified and managed throughout the Trust can be grouped by either:

- Strategic Risks
- Corporate Risks
- Operational Risks
- Programme and Project Risk Log
- Organisational Risks

Strategic risks are the Principal Risks that populate the Board Assurance Framework (BAF). These are defined by the Board of Directors and managed through the work of Lead Committees and Lead Directors.

Corporate Risks consist of those risks that score 15 and above and cover both clinical and corporate services. These risks can affect multiple areas (rather than being confined to a single division). These risks will be assigned to an appropriate lead, who will co-ordinate the risk response for the Trust. They are recorded and maintained on Datix as part of the Corporate risk register.

Operational risks are defined at service level and vary dependent upon the specific activities that take place within each service. They are also recorded and maintained on Datix as part of the organisational risk register.

Programme and Project risk logs are risks that are identified at project management level, and are defines as those which impact directly on the success or failure of a particular project being undertaken.

Organisational risks are risks that affect GWH fulfilling its contractual, statutory, and regulatory objectives to provide safe and effective care. Risks falling into this category are those that have an organisation-level impact. The risk themes for these risks align to the Risk Appetite and are as follows:

- Quality Outcomes
- Legal, regulatory, compliance
- Workforce
- Continuous Quality Improvement/Innovation
- Operational
- Commercial
- Reputation
- System Working
- Finance
- Estates
- Digital Technology / Data

All Organisational risks are owned by the department or service that has operational responsibility.

6.2.2 Identify – Risk Identification

When identifying a risk, consideration should be given to what could pose a potential threat, or opportunity to the organisation.

It is important to understand the difference between risks, incidents, and issues.

- Risks are things that **might happen** and would stop the Trust achieving their objectives, or otherwise impact the success of the organisation.

- Incidents/issues are things that **have already happened,** which were not planned and require management action, must be reported as appropriate and where required in line with the Trust Incident Management including Serious Incidents Policy (Ref 3).

Once identified, the risk needs to be described clearly to ensure that the risk is understood. Once understood, the risk should be added to the Risk Management Tool (Datix). Guidance on how to access Datix and complete the Risk Form can be found on the Intranet (Ref 4).

A risk description should be described explaining the three following points:

1. **The Risk** (There is a risk that…) Think about what / who is at risk.
2. **The Root Cause** (Because of…) Why could this risk happen?
3. **The Impact** (Resulting in…) What would happen if the risk materialised?

6.2.3 Assess and Evaluate - Risk assessment and evaluation

A risk assessment is an evaluation of the nature and magnitude of the risk. The assessment is completed by scoring the likelihood of the risk occurring and the impact should it occur. Appendix B sets out the Trust's scoring matrix in accordance with the National Patient Safety Agency (NPSA), which has been adapted to our organisation. The table below shows the overall risk ratings that a risk could have.

The overall residual risk rating
Low Risk (1 – 3)
Moderate Risk (4 – 6)
High Risk (8 – 12)
Extreme Risk (15 - 25)

Once a risk score has been determined, the risk evaluation involves making a decision about what should be done with the risk. It includes determining appropriate controls and or treatments for the risk, and what level of risk can be tolerated within the Trust as per the Risk Appetite.

- A **control** is an **existing** process or strategy in place, such as policies, systems, procedures and practices.

- An **action** is an **additional** strategy/activity that the Trust needs to develop, and implement should the risk level be unacceptable after controls are applied.

Where there is an immediate risk to the health and wellbeing of patients, employees or visitors, this must be escalated immediately. If outside of normal working hours, the risk must be reported to the on-call manager for assistance.

Not all risks can be dealt with in the same way, and some require different responses to others. The table below provides an explanation of the different risk responses that the Trust can take.

Risk Response	
Terminate	Where an activity or system gives risk to significant risk to the Trust, an informed decision to not become involves in the risk situation takes place, e.g., terminate the activity.
Tolerate (Accept)	Where it is considered that nothing more can be done at a reasonable cost to reduce the risk, the likelihood and consequence of a particular risk happening is accepted. See below for accepted risk criteria.
Treat	Actions are carried out to reduce the likelihood or consequences of the risk (this is the most common response).
Transfer	Shifting the responsibility or burden for loss to another third party. E.g., the risk is insured against or subcontracted to another company.

The Trust recognises that it is not possible to eliminate all risks, either because of the high costs of elimination in comparison with the potential severity of the risk, other priorities or other external factors.

When all reasonable control measures have been put in place some residual risk might remain and this level of risk can be accepted if the risk:

(i) is minor in nature, with minimal potential for financial loss or damage to structure, persons, equipment or property; or
(ii) will occur rarely and might cause serious harm, damage or loss but which would take disproportionate resources to eliminate or reduce.
(iii) the target risk score has been reached, and that target risk score is within the organisation's risk tolerance (See risk appetite Ref 2)

Where risks are deemed tolerable (accepted) with no further action to be taken, they should still be reviewed in case circumstances have changed. The frequency of the review will depend on the level of risk. The minimum review frequency for accepted risks is set out below.

All accepted risks will have an action added to them to review them at quarterly intervals as a minimum. Any risks scoring 15+ which are accepted will be required to be reviewed monthly. The action will be added by the Risk & Legal Facilitator and will be assigned to the risk owner. The description will state 'Accepted risk action - Review controls in place and ensure they are still appropriate and effective. The risk is to be reviewed as a minimum every quarter to ensure that the risk is still relevant. Details of the review need to be recorded.'

Risk score	Level of risk	Review frequency
1 - 3	Low risk	Quarterly
4 - 6	Moderate risk	
8 - 12	High risk	
15 - 25	Extreme risk	Monthly†

†All risks that score 15 or above can only be deemed 'accepted' by Trust Board. All risks which score 15 or above must be reviewed at least monthly, irrespective of whether they are deemed 'accepted'.

100% of all risks that have been accepted on the Risk Management Tool must have evidence attached to the risk in the form of documentation that records the decision to accept the risk. Each division's compliance with evidencing acceptance is reported to The Audit Risk and Assurance Committee on a quarterly basis.

6.2.4 Plan – Action Plan

The risk will require action to reduce the likelihood and/or impact of a threat, or maximise the likelihood or opportunities, a risk action plan should be devised and documented on the Risk Management System.

The actions must have individual owners and should be specific to the risk and SMART (specific, measurable, achievable, relevant and time bound) to evidence how the risk score can be reduced.

When agreeing actions to control the risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

If a risk has already occurred and cannot be prevented or is a risk is rated high or extreme, then a contingency plan should be in place should the risk materialise. These plans should be recorded under the 'Controls' section on the Risk Management Tool. Good risk management is

about being risk aware and able to handle the risk, not being risk adverse.

6.2.5 Monitor and Review

The implementation of actions must be kept under review along with the risk score to measure their effectiveness. If the actions are not reducing the risk, other actions need to be considered.

Once an action has been implemented the risk will be re-assessed and rescored and that action will become a control.

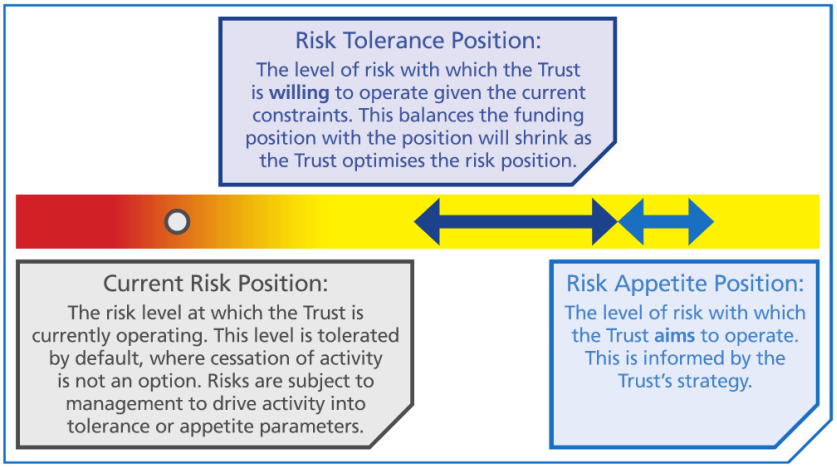
The risk will be reviewed periodically depending on the risk score. The minimum review frequencies are below:

Risk score	Level of risk	Minimum review frequency
1 - 3	Low risk	Annually
4 - 6	Moderate risk	Bi - annually
8 - 12	High risk	Quarterly
15 - 25	Extreme risk	Monthly

6.3 Risk Appetite & Risk Tolerance

Risk appetite is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time to deliver the Trust strategy, whilst ensuring we provide safe and effective patient outcomes.

Risk Appetite is defined as 'the level of risk at which the Trust **accepts** to achieve its objectives'
Risk Tolerance is defined as 'the level of risk at which the Trust is **willing** deviate from the risk appetite'



On an annual basis the Trust will publish its Risk Appetite Statement (Ref 2) as a separate document covering the overarching areas of:

- Quality Outcomes
- Legal, regulatory, compliance
- Workforce
- Continuous Quality Improvement/Innovation
- Operational

- Commercial
- Reputation
- Finance
- Estates
- Digital Technology / Data Information

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

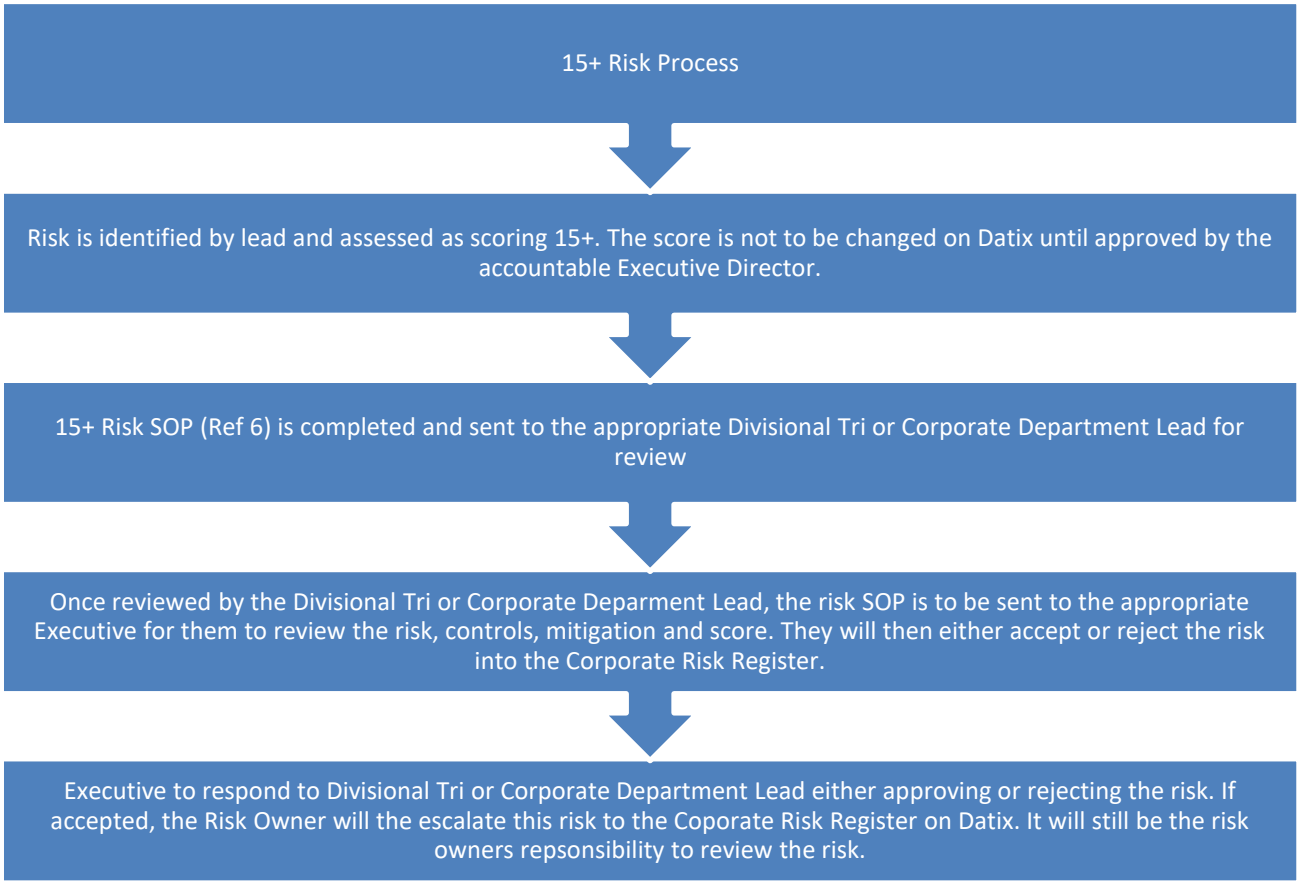
Risk Appetite Scale	Appetite	Tolerance
Averse Avoidance of risk and uncertainty is key objective	1-3	4-6
Minimal Preference for very safe business delivery options that have a low degree of inherent risk and only for limited reward potential	4-5	6-10
Cautious Preference for safe options that have low degree of inherent risk and only limited potential for benefit and may only have Limited potential for reward	6-8	9-15
Open Willing to consider all options and choose one that is most likely to result in successful delivery while also providing an acceptable level of reward (and VFM)	8-10	12-20
Eager Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	12-15	16-25

Risk Tolerance is the level of risk the organisation is willing to take in order to achieve strategic goals given the current constraints.

6.4 Risk Management Assurance

6.4.1 15+ Risk Process

When a risk scoring 15+ is identified, please follow the flowchart below.



6.4.2 Escalation and De-escalation (Appendix C)

Depending on the score of the risk, it will need to be escalated and de-escalated throughout the Trust. Appendix C sets out the process for how risks can be escalated for inclusion on the Divisional and GWH Corporate Risk Registers.

A How to Guide on escalation and de-escalation via Datix is available on the Intranet (Ref 5).

6.5 Risk Management Tool

The purpose of the Risk Management Tool (Datix) is to enable oversight and scrutiny of risks and support the reduction of risk by identifying mitigating actions. The centralised system allows for oversight of all enterprise risks, identification of risk themes and monitor risk management across the Trust.

The Trust requires the following minimum content on the Risk Management Tool:

- Risk Identification (ID)
- Risk Title

- Risk Description
- Risk Owner
- Status of Risk (Open / Accepted / Closed)
- Target Date for closure
- Category
- Risk Register
- Risk Opened Date
- Next Review Date
- Reports to (Meeting or Committee)
- Risk Score and target score
- Controls in Place
- Actions to mitigate risks with due dates and action lead

6.6 Accountability for Risk

6.6.1 What are Strategic Risks?

The Trust set out its strategic objectives in the Great Western Hospitals NHS Foundation Trust 5 Year Plan for 2019-24 (Ref 16).

Strategic risks represent major threats to achieving the Trust's strategic objectives, or to its Continued existence. Strategic risks can include key operational failures which would be very damaging to the achievement of the strategic objectives if they materialised. Being clear about strategic risk enables the Board to be sure that the information it receives is relevant to the achievement of these objectives.

6.6.2 Documenting Strategic Risks

The Board Assurance Framework enables the Board to: identify and understand the strategic (principal) risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks and where improvements are needed, action plans are in place and are being delivered; provide an assessment of the risk to achieving the objectives based on the strength of the controls and assurances in place (risk rating).

6.6.3 Strategic Risk Oversight

All Strategic Risks

All strategic risks will be presented to the Trust Board and Trust Management Committee at least four times a year. Discussions should be had to determine if the risk score is accurate and if there are appropriate actions in place to mitigate the risk to an acceptable level.

Annual Board Assurance Schedule

Action	Executive Lead	Management Lead	Date
Strategic **Objective setting** to be undertaken as part of the annual business planning cycle	Trust Chair/Chief Executive	Associate Director of Strategy	Quarters 3 & 4 October to March each year
Review of **Risk Appetite and Tolerance** Statement	Chief Executive	Company Secretary	Quarter 4 Jan to March each year
Strategic and **significant risk** review and identification to be undertaken as part of business planning process	Trust Chair/Chief Executive	Company Secretary	Quarter 1 April each year
Approval of Strategic Risks	Chief Executive	Company Secretary	April each year
Population of Board Assurance Framework	Chief Executive	Company Secretary	Quarter 1 April each year
Board Assurance Framework **updated** every quarter		Company Secretary	End of quarter Sept / Jan / Apr /June
Executive Lead Review prior to Board Committee/Trust Management Committee review	Relevant Executive Lead	Company Secretary	End of each quarter Oct / Jan / Apr / July
Sections of the Board Assurance Framework to be **monitored** by relevant **Board committee and Trust Management Committee** to ensure risk management and delivery of the strategic objective	Relevant Lead Director/Company Secretary	Company Secretary Timetable scheduled by Company Secretary	End of each quarter – Trust Management Committee - Oct / Jan / Apr/July Board Committees – Nov / Feb / May / Aug
Presentation to **Audit, Risk**	Chief Executive	Company	ARAC – Nov / May

& Assurance Committee		Secretary	
Presentation to **Trust Board**	Chief Executive	Company Secretary	Trust Board* – Jan / Apr / July / Oct *month later due to scheduled Board Seminar sessions (Dec / Mar / June / Sept)

6.6.4 Scrutiny and Challenge Including Frequency

The relevant sections of the Board Assurance Framework (BAF) are presented to the Board Committees quarterly to enable the Committee to review the assurances and controls in place to mitigate the strategic risks. The Committees will use the BAF to inform their Committee Forward Plans and their discussion and challenge of agenda items and will draw to the attention of the Board to any issues or concerns through their Chair Board Assurance Reports.

The Trust Management Committee will review the BAF quarterly to scrutinise and challenge the assurances and controls and instruct any actions as necessary. The Audit, Risk and Assurance Committee has a key role in overseeing this process as part of its responsibility in overseeing the overall system of risk management for the Trust. This takes place at least twice a year.

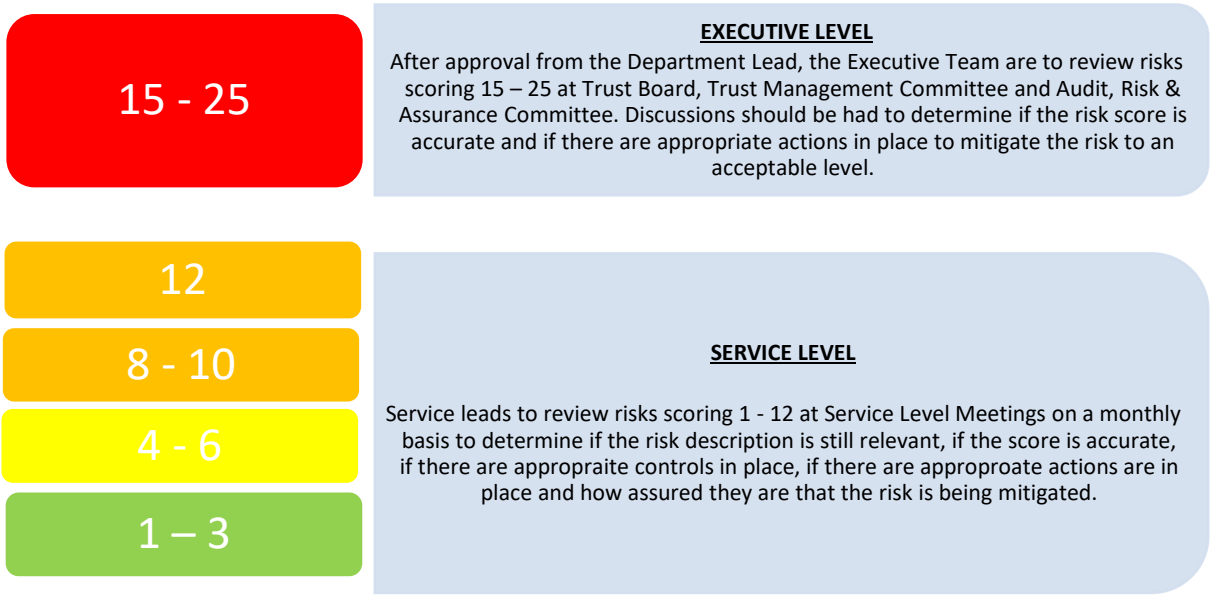
6.6.5 Divisional Organisational Risk Oversight

The structure below shows the oversight for risks within the Divisions of Surgery, Women's and Children's, Unscheduled Care and Integrated and Community Care

15 - 25	**EXECUTIVE LEVEL** After approval from the Divisional Tri, the Executive Team are to review risks scoring 15 – 25 at Trust Board, Trust Management Committee and Audit, Risk & Assurance Committee. Discussions should be had to determine if the risk score is accurate and if there are appropriate actions in place to mitigate the risk to an acceptable level.
12	**DIVISIONAL LEVEL** Divisional Tri to review risks scoring 12 at Divisional Governance meetings to determine if the risk description is still relevant, if the score is accurate, if there are appropriate controls in place, if there are appropriate actions are in place and how assured they are that the risk is being mitigated.
8 - 10	**SERVICE LEVEL** Service leads to review risks scoring 8 – 10 at specialist service meetings to determine if the risk description is still relevant, if the score is accurate, if there are appropriate controls in place, if there are appropriate actions are in place and how assured they are that the risk is being mitigated.
4 - 6 1 – 3	**DEPARTMENT LEVEL** Departments to review risks scoring 1-6 at team meetings to determine if the risk description is still relevant, if the score is accurate, if there are appropriate controls in place, if there are appropriate actions are in place and how assured they are that the risk is being mitigated.

6.6.6 Corporate Departments Organisational Risk Oversight

The structure below shows the oversight for risks within the Corporate Departments.



6.7 Continuity and Transferring Risk / Existing Staff Members

To ensure that risk management continuity is maintained, it will be a requirement of all line managers to ensure that as part of the process of overseeing the exit of a staff member, the line manager checks whether the “exiting staff member” is a risk owner. Where the exiting staff member is a risk owner, the line manager will be responsible for reallocating the risk into the name of an alternative risk owner prior to the departure of the staff member.

6.8 Triangulation to inform Patient Safety Incident Investigations

Work will be completed on a bi-monthly basis to take a specific department/service risk and triangulate with incident data and complaints. This information will be presented at the Risk Group for documented discussion to ensure themes from incidents and complaints are accurately reflected on the Risk Management Tool.

6.9 Risk Management Process – Project Risks

Project risks are managed within the project management process throughout the life of a project, and are not placed on GWH Risk Management Tool.

Where the success or failure of a project poses a risk to GWH achieving one of its strategic aims, this will be recorded on GWH’s Board Assurance Framework.

Where the implementation of a project poses a risk to the day to day running of the business of GWH, this should be added to the organisational risk register, and managed as an organisational risk. Such risks will usually have been considered prior to the initiation of a

project, and a decision made by the Trust Management Committee that the benefits of implementing the project outweighed the risks caused by implementing the project. The effectiveness of the controls to mitigate the risks of implementing the project will have been considered as part of this exercise.

Where project risks are ranked highly after mitigation (i.e. project risks actively scoring 16+), these will be reported to the Trust Management Committee at a frequency agreed by the Trust Management Committee (which may vary from project to project). It will be the responsibility of the Executive Lead overseeing the project to ensure that significant Project risks are escalated to the Trust Management Committee.

Where project risks are escalated to the Trust Management Committee, they will consider the actions being taken to mitigate those risks and may direct that additional/alternative actions are taken.

Project risks may be reported to the Local Project Board in a manner and at a frequency deemed appropriate by the Trust Management Committee.

15 - 25	**EXECUTIVE LEVEL** All risks scoring 15+ to be reported to the Trust Management Commmittee on a quarterly basis
12 8 - 10 4 - 6 1 – 3	**SERVICE LEVEL** Project managers to review risks monthly and report to the Local Project Board for oversight.

7 CONSULTATION

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department .	Date Consultee Agreed Document Contents
Deputy Chief Nurse	01/02/2023
Company Secretary (for risk management in particular the Board Assurance Framework)	12/01/2023
Head of Patient Safety & Quality	20/01/2022
Lead Clinical Risk & Patient Safety Manager, Deputy Head of Patient Safety & Quality	12/01/2023
Quality & Compliance Manager	13/12/2022
Divisional Director – Surgery, Women & Children's	10/01/2023
Chief Nurse	11/01/2023
Patient Safety & Risk Matron	06/10/2022
Director of Pharmacy	05/12/2022
Trust Management Committee	TBC
Audit, Assurance and Risk committee	TBC

8 TRAINING AND SUPPPORT

Any employee adding or managing risks via the Risk Management Tool requires training which is provided by the Risk & Legal Facilitator. This training will provide information on how to use the system effectively.

A user guide will be provided at the end of the session to aid employees when they are adding, reviewing and closing risks.

9 MONITORING, Compliance and Effectiveness of Implementation

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

Element to be monitored	Lead	Frequency	Reporting Arrangements
Development and maintenance of a Board Assurance Framework	Company Secretary	As per internal audit plan	Audit, Risk and Assurance Committee

15+ Risks review and scrutiny	Trust Management Committee Audit, Risk and Assurance Committee Risk Group	Monthly At least 3 times a year Bi-monthly	Trust Board
Division risk review and scrutiny	Division meetings Trust management Committee	Monthly At least once per year	Trust management Committee Audit, Risk and Assurance Committee

10 SUPPORTING DOCUMENTS

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

Ref. No.	Document Title	Document Location
1	Maternity Services Risk Management Strategy	*T:\Trust-wide Documents*
2	Risk Appetite Statement	Available from the Company Secretary
3	Incident Management including Serious Incidents Policy	T:\Trust-wide Documents
4	Datix User Guide	Quality, Compliance & Risk
5	Datix Escalation and De-Escalation How to Guide	Quality, Compliance & Risk
6	15+ Risk SOP	Quality, Compliance & Risk

APPENDIX H – Initial Screening for Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? Risk Management Policy		
2.	Briefly describe the aim of the policy, strategy, project. What needs or duty is it designed to meet? The aim of this policy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Megan Fernandes
Date completed	01/02/2023
Job Title	Risk & Legal Facilitator

<u>On completion of Stage 1</u>: A full impact assessment will normally be required if you have answered YES to one or more of questions 3, 4 and 5 above

Appendix A -Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

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

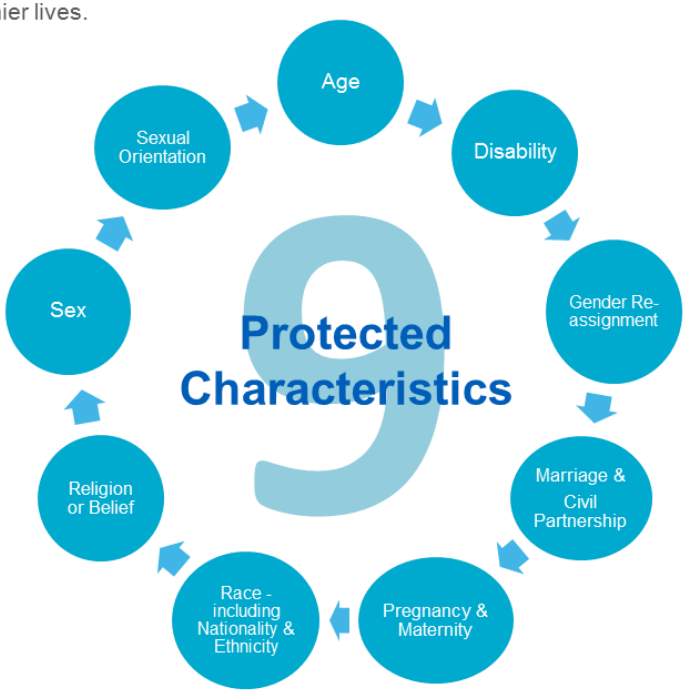
Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey,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

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

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

Our Vision

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



Trust Equality and Diversity Objectives

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

Appendix B – NSPA Risk Scoring Matrix

	Consequence score and examples of descriptors				
Description	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Objectives / Projects	Insignificant cost increase/schedule slippage. Barely noticeable reduction in scope or quality.	<5% over budget/schedule slippage. Minor/reduction in quality/scope.	5-10% over budget / schedule slippage. Reduction in scope or quality.	10-25% over budget / schedule slippage. Does not meet secondary objectives.	>25% over budget / schedule slippage. Does not met primary objectives.
Patient / Staff Safety	Minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	RIDDOR / Agency reportable.	Major injuries, or long term incapacity / disability (loss of limb).	Death or major permanent incapacity.
Patient Experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience.
Complaints / Claims	Locally solved complaint	Potential claim. Justified complaint peripheral to clinical care.	Potential claim. Justified complaint involving lack of appropriate care.	Likely claim. Multiple justified complaints.	Multiple claims or single major claim.
Clinical Service / Business Interruption	Local interruption with back up.	Local interruption.	Loss / interruption >1 hr.	Loss / interruption >8 hrs.	Loss / interruption >24 hrs.
Staffing & Competence	Short term low staff level temporarily reduces service quality (<1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objectives / service due to lack of staff. Minor error due to poor training. Ongoing unsafe staffing level.	Uncertain delivery of key objectives / service due to lack of staff. Serious error due to poor staffing	Non-delivery of key objectives / service due to lack of staff. Critical error due to insufficient training.
Financial	Small loss	Loss of >0.5% of budget.	Loss of >1% of budget	Loss of >3% of budget	Loss of >5% of budget
Inspection / Audit	Minor recommendations. Minor non-compliance with standards.	Recommendations given. Non-compliance with standards.	Reduce rating. Challenging recommendations. Non-compliance with core standards.	Enforcement action. Low rating. Critical report. Major non-compliance with core standards.	Prosecution. Zero rating. Severely critical report.
Adverse publicity/ reputation	Rumours	Local media coverage – short-term. Minor effect on staff morale.	Local media - long-term. Significant effect on staff morale.	National media coverage with <3 days.	National media coverage with >3 days. MP concerned (questions in the House)

	Consequence score and examples of descriptors				
Description	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Information Governance	Damage to individual reputation, possible media interest. Potentially serious breach, less than 5 people affected of risk assess as low.	Damage to a team's reputation. Some local media interest may not go public. Serious potential breach and risk assessed high. Up to 20 people affected.	Damage to a services reputation / low key media coverage. Serious breach of confidentiality, ie. Up to 100 people affected.	Damage to organisation's reputation/local media coverage. Serious breach with either particular sensitively or up to 1,000 people affected.	Damage to NHS reputation, national media coverage. Serious breach with potential for ID theft or over 1,000 people affected.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	Will occur in exceptional standards	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

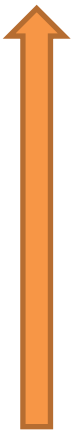
The overall risk rating reflects both the likelihood that harm or loss will occur and the severity of its outcome: **(i.e., risk = likelihood x consequence).**

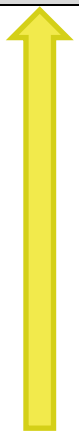
	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5 – Catastrophic	5	10	15	20	25
4 – Major	4	8	12	16	20
3 – Moderate	3	6	9	12	15
2 – Minor	2	4	6	8	10
1 – Negligible	1	2	3	4	5

In grading risk, the scores obtained from the risk matrix are assigned grades as follows:

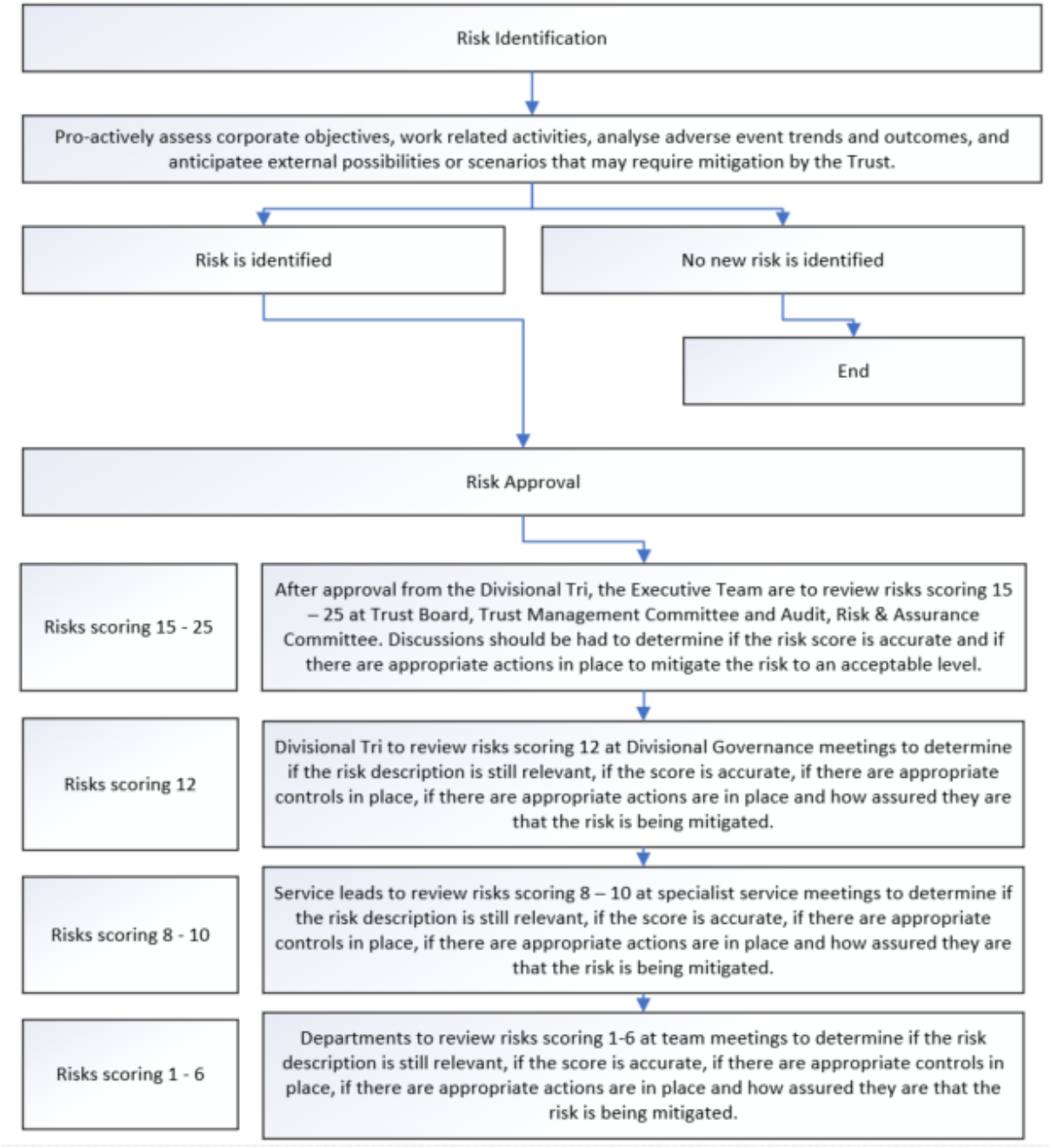
The overall residual risk rating	
Low Risk (1 – 3)	Quick easy measures implemented immediately, and further action planned for when resources permit
Moderate Risk (4 – 6)	Actions implemented as soon as possible, but not later than a year
High Risk (8 – 12)	Actions implemented as soon as possible and no later than six months
Extreme Risk (15 - 25)	Requires urgent action. Trust Board is made aware and implements corrective action

Appendix C – Risk Escalation and Responsibility

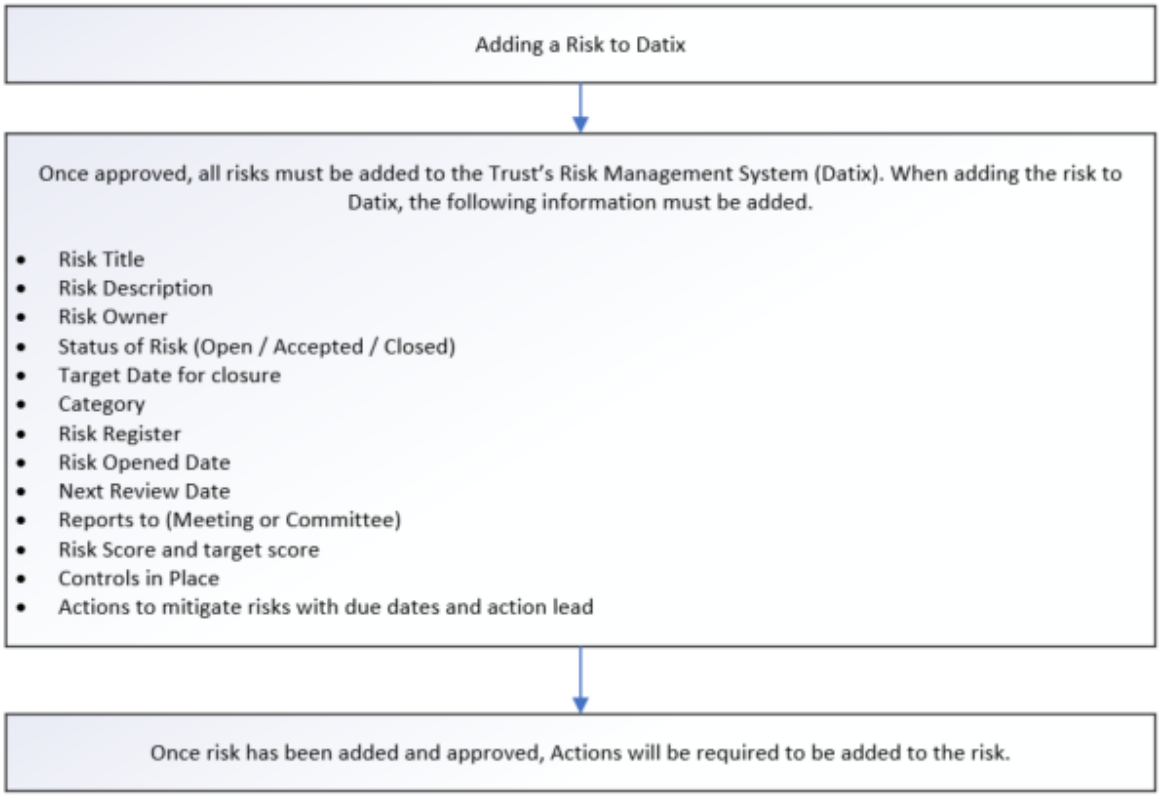
Risk Score	Risk Response	Action	By Whom	Escalation
Extreme Risk	Treat / Transfer / Terminate			
15 - 25	Risks deemed as extreme require a systems approach to identify the root causes of the risk and thereby help choose an appropriate risk response. Where it is not possible to terminate or transfer the risk a treatment (action) plan will be put in place.	• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risk to be reviewed by the Divisional Tri for score approval. • Once approved by the Divisional Tri, the risk will be escalated to the appropriate Executive for risk score approval. • Once approved, the risk will be escalated to the GWH Corporate Risk Register within Datix. • Risk will be reported to the Trust Board Trust Management Committee and the Audit, Risk & Assurance Committee.	Executive Lead	
High Risk	Treat			
12	Risks deemed as high will require a treatment (action) plan in line with the risk appetite. Those risk where it is deemed there is no further action that can reduce the score will be reviewed regularly to assess their impact on the organisation.	• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risks identified scoring 12 are reviewed by the **Divisional Management** and discussed monthly at Governance Meetings. • It is expected that the Divisions 12 + risk will be reported to the Trust Management Committee on an annual basis.	Divisional Management	
8 - 10		• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risks identified scoring 8 – 10 are reported to the Divisional Management	Service Leads	

		and discussed monthly at Governance Meetings.		
Moderate Risk	Treat / Tolerate			
4 - 6 Low Risk 1 – 3	Risks scored as 1 – 6 can be managed through local action or by an appropriate person or department.	• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risks discussed at departmental meetings	Departmental Lead	

Appendix D – Risk Identification Flowchart



Appendix E – Adding a Risk to Datix Flowchart



Appendix F – Risk Review Flowchart