G□EAT WESTE□N HOSPITALS NHS FOUNDATION T□UST

TRUST BOA RD

Thursday 11 □anuary 2024 , 9.30 am to 12 noon
□y Teams

AGE NDA

□urpose			
Approve	**Receive**	**Note**	**□ssurance**
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

		PAPE R	BY	□CTI□N	TI□□
□□□NIN□ □USIN□SS					
1.	**□pologies for Absence and Chair's Welcome**	□erbal	LC	-	9.30
2.	**□eclarations 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	□erbal	LC	-	-
3.	**□inutes of the previous meeting □public)** Liam Coleman, Chair • 7 December 2023	1 – 11	LC	Approve	-
□.	**□utstanding actions of the □oard □public)**	12	LC	Note	-
□.	**□uestions from the public to the □oard relating to the work of the Trust**	None	CC	-	-
6.	**Care Reflection □Staff Story) – The Finance Team Improving Together □ourney So Far**	13 – 40	SW	Note	9.45
7.	**Chair's Report** Liam Coleman, Chair	41 – 43	LC	Note	10.15
8.	**Chief Executive's Report** Jon Westbrook, Acting Chief Executive	44 – 49	JW	Note	10.25
9.	**Integrated □erformance Report**	50 – 101	All	□eceive	10.45
BREAK (10 minutes) at 11.20am					
1□.	**□WH CNST □ear 5 Submission – □WH Compliance Report** Lisa Cheek, Chief Nurse Lisa Marshall, Director of Midwifery & Neonatal Services □at Simpson, Head of Midwifery & Neonatal Services	102 – 131	LCh/ LM/□S	Approve	11.30
1□.	**Safe Staffing 6□month review for Nursing, □idwives and AHP** Lisa Cheek, Chief Nurse (received at Quality & Safety Committee 23 November 2023)	132 – 156	LCh	Assurance	11.□0

C□NS□NT IT□□S

These are items that are provided for consideration. □embers 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.

□□.	**Ratification of □ecisions made via □oard Circular** Caroline Coles, Company Secretary	□erbal	CC	Note	11.□0
□□.	**Urgent □ublic □usiness □if any□** To consider any business which the Chair has agreed should be considered as an item of urgent business	□erbal	LC	-	-
□□.	**□ate and Time of ne□t meeting** Thursday 1 February 202□ at □.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN□ □U□	□erbal	LC	Note	-
□□.	**□□clusion of the □ublic and □ress** The Board is asked to resolve□ *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	12.00

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC IN TRUST HQ BOARDROOMS, GREAT WESTERN HOSPITAL, SWINDON, SN3 6BB AND VIA MS TEAMS 7 DECEMBER 2023 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)*	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)*	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Peter Hill (PH)*	Non-Executive Director
Paul Lewis (PL)	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
Naginder Dhanoa (ND)	Chief Digital Officer
Tim Edmonds (TE)*	Associate Director of Communications & Engagement
Steve Haig (SH)*	Deputy Chief Medical Officer
Caroline Holmes (CH)*	BSW Deputy Place Director
Claire Lehman (CL)*	Associate Non-Executive Director
Rommel Ravanan (RR)*	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Tania Currie (TC)*	Head of Patient Experience & Engagement (agenda item 183/23 only)
Jenny Kear (JK)*	Head of PALS (agenda item 183/23 only)

Apologies

Julian Duxfield (JD)	Non-Executive Director

Number of members of the Public: There were 2 members of public (including 1 governor, Chris Shepherd)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
178/23	**Apologies for Absence and Chair's Welcome** The Chair welcomed Board members and attendees to the Great Western Hospitals NHS Foundation Trust Board meeting held in public.	

Minute	Description	Action

The Board acknowledged that this was the last Board meeting for Kevin McNamara as Chief Executive and he was thanked for his leadership and considerable contribution to the Trust and was wished well in his new role.

Apologies were received as above.

179/23 **Declarations of Interest**
There were no declarations of interest.

180/23 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 2 November 2023 were adopted and agreed as a correct record.

181/23 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list. The following was noted:

158/23 : Health & Safety Annual Report – It was confirmed that "uncooperative/stubborn patient" was a national definition.

182/23 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

183/23 **Care Reflection (Patient Story) – Support for patients with hearing impairment**
Tania Currie, Head of Patient Experience & Engagement and Jenny Kear, Head of PALS joined the meeting to present this item.

The Board received a care reflection story on the experience of Derek who is profoundly deaf and regularly used services at GWH and how improvements had been made to enhance the patient experience. Derek had raised a number of concerns in regard to being able to communicate effectively with staff whilst attending appointments, understanding his care and being able to contact the hospital with queries.

The PALS Team had worked closely with the Gloucester Deaf Association to support Derek and to ensure that his needs were being met. A strong relationship had been built with Derek to ensure that he would have good channels of communication and be able to raise any queries and have concerns addressed promptly and effectively.

The Board reflected on the good work being undertaken by PALS and the continued improvements to address inequality and access to care for people affected in this way. Tania Currie added that proactive work around processes for people to identify their needs ahead of time was being reinvigorated to improve accessibility and the patient experience and that implementation of these initiatives would be monitored by the Performance, Population & Place Committee.

The Board **noted** the care reflection patient story.

Minute	Description	Action

184/23 **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 following were highlighted:-

Non-Executive Directors

Two Non-Executive Directors, Helen Spice and Faried Chopdat, had been reappointed for a second term of office at the Council of Governors on 8 November 2023.

Liam Coleman had been appointed for a third term of office as Trust Chair and the Board congratulated all on their reappointments.

The following was also noted:-

Integrated Front Door (IFD)

The significant progress of the IFD project was noted which reflected how well the Trust could run large projects in terms of spending well, on time and on budget.

The Board **noted** the report.

185/23 **Chief Executive's Report**

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

Addressing financial and performance challenges

The actions being taken by the Trust to address the financial and performance challenges caused by industrial action was outlined and how the impact would be funded, alongside a set of national priorities for the remainder of the year specifically to protect patient safety and prioritise emergency performance and capacity. It was also noted that along with other providers in BSW, stringent workforce controls were to be implemented to ensure grip and control on workforce growth. Posts that directly impacted patient safety would be prioritised and options were being explored to help support the financial challenges.

The Board noted the good work that was being done in the Trust to tackle medical and nursing agency spend and was assured by the level of scrutiny on workforce controls. This would continue to be monitored through the People & Culture Committee.

Ambulance handover delays

To address the Trust's deteriorating performance nationally for delays caused to ambulance handovers, additional national support was being accessed as all organisations were being asked to recalibrate risk and, particularly, for acute organisations to take more of that risk within the confines of the acute footprint to reduce the risk to patients waiting out in the community for an ambulance.

The actions being taken were noted by the Board and that quality and safety for patients would continue to be monitored and scrutinised by the Quality & Safety Committee.

Minute	Description	Action

Felicity Taylor-Drewe, Chief Operating Officer added that the period of significant decline in performance could be correlated to multifactorial reasons which included the loss of 24 beds at the Princess Margaret Lodge from the Trust's control at the beginning of September and the loss of eight trolley spaces within the Emergency Department. Data gathered from mid-November also showed a 33.3% increase in conveyances since January 2023. The use of the coordination centre navigation hub at the source of the call was being promoted further to help drive improvement. However, it was accepted that a system-wide approach was also needed.

Industrial action update

The Board noted that further industrial action by junior doctors had been announced for periods during December and January with no derogations. It was noted that whilst the Trust had managed previous periods of industrial action reasonably effectively, and notwithstanding the significant loss of elective activity, this would be a significantly challenging period for the organisation.

Community services

Interest to tender for the provision of Adult and Children's Community Services had now been submitted in collaboration with the Royal United Hospitals Bath NHS Foundation Trust, Salisbury NHS Foundation Trust and Wiltshire Health & Care. An outcome was not expected before September 2024, ahead of the new contract beginning from 1 April 2023. The key threat and opportunities for the Trust and the wider-system were noted.

Staff Survey

It was noted that 69% of staff had completed the staff survey and this was the highest response recorded. This very high response rate had made the Trust to be one of the top performing trusts nationally.

Peter Hill, Non-Executive Director commented the report stated that since Improving Together methodology had been introduced in 2021, more than half of staff said they felt able to make improvements at work and this related to one of the breakthrough objectives. However, Peter Hill reflected that the number of people saying that they felt able to make improvements at work was actually slightly higher before Improving Together than it was now and he asked for further clarification. Claire Thompson, Chief Officer of Improvement & Partnerships agreed that a deteriorating position had been evidenced since Improving Together had been introduced, however correlation was not the causation. The breakthrough objective had been reviewed and would remain to drive sustained improvement.

In response to a question raised by Rommel Ravanan, Associate Non-Executive Director in relation to the impact of the new immigration rules on the care sector, Lisa Cheek, Chief Nurse outlined the good work being undertaken at the Trust in relation to equality, diversity and inclusion and the challenges being faced.

The Board **noted** the report.

186/23 **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 October 2023.

Minute	Description	Action

Quarterly Pillar Metric deep dive

Our Care

Lisa Cheek, Chief Nurse reported that there were two strategic pillars for Our Care. The first one 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 for 2023/24 with the aim to reduce overall numbers by 20% this year in both acute and community settings and have zero Category 3 and 4 reported harms. Improving Together methodology was being applied both in divisional and clinical areas and that a reduction in numbers could be evidenced through increased awareness and reporting, including identified high contributory areas.

There had been an increase of reported harm in ED, MEU and SAU areas which was a direct correlation to delayed ambulance handovers and longer waits within the Emergency Department. Increased focus in these areas, and particularly with support from external colleagues, had resulted in no harm being reported by the Emergency Department during October.

Actions were also being taken to increase early assessment, intervention and treatment within the community setting, particularly in relation to care being delivered by external care agencies to patients on an end-of-life pathway, and that this was being addressed through the delivery of training to those agencies.

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, and also proactive actions to address identified areas of pressure harm.

Helen Spice, Non-Executive Director confrmed that richer conversations were being held at the Quality & Safety Committee and that positive engagement by ward areas could be evidenced by Board Safety Walkarounds.

The second strategic pillar related to the Patient Experience (Friends and Family Test) to achieve consistent positive response rates in excess of 86%. A consistent overall positive score of above 86% could be evidenced, although a consistent score within the Emergency Department and Inpatients had yet to be achieved. Improvements in these two areas continued to be made and would remain an area of increased focus.

Our Performance

Felicity Taylor-Drewe, Chief Operating Officer reported that there were two strategic pillars for Our Performance, which related to Referral to Treatment (RTT) and the number of patients waiting over 65 weeks and Cancer 62 Day. Emergency attendances – Clinically Ready to Proceed (Admitted) (CRTP) had been chosen as a 2023/24 breakthrough objective.

It was reported that performance for RTT 65 Week Waiters continued to improve and that Non-Criteria To Reside (NCTR) remained stable up until October.

Minute	Description	Action

Actions being taken within the Emergency Department to drive improvements for ambulance handover times working with system partners were outlined and that extra bed spaces which had been introduced would be in place until January 2024. This would continue to be risk assessed and monitored by the Performance, Population & Place Committee.

In relation to the 2023/24 breakthrough objective for Emergency Attendances – Clinically Ready to Proceed (CRTP) (Admitted), it was reported that the mean time in ED from arrival to CRTP had slightly increased above mean levels (301 in October from 289 in September) showing patients waited more time to be triaged, seen and diagnosed. The increase in ambulance handover delays had impacted this metric. Mean time in ED from CRTP to admission had decreased from 504 to 449 in October which indicated that patients spent less time in ED waiting admission.

Felicity Taylor-Drewe, Chief Operating Officer reported on the current issues which related to capacity in Majors' chairs and outlined the actions being taken to address them as a priority. Concern was expressed that the graphs presented were too snapshot and that future reports should include cause and impact on the Trust's performance.

All three cancer metrics had shown signs of deterioration and were outside of control limits, although there had been some improvement in October. It was noted that Cancer 62 day waiting times had seen an increase in demand resulting in capacity challenges, with breaches attributed to Urology, Colorectal and Skin pathways. An external provider had now been secured for Skin and that 300 patients would be treated over four weekends and it was hoped that the backlog would be completed by the end of January. A plan was then in place to undertake a patient reprofiling exercise to continue to manage patients waiting 62 days. Full oversight on this issue would continue to be monitored by the Performance, Population & Place Committee.

Felicity Taylor-Drewe, Chief Operating Officer added that there was an AHA strategy in place to consider a different collaborative approach to the delivery of dermatology services in the BSW. External funding had also been secured to support the provision of mock clinics in a GP surgery in Swindon.

Our People

Jude Gray, Chief People Officer provided an update on the actions against the strategic pillars which related to Personal Experience of Discrimination at Work, Voluntary Staff Turnover (rate) and Staff Recommendation as a Place to Work. The results of the Staff Survey were awaited which would inform the breakthrough objectives for 2024/25.

A survey commissioned by the Just and Learning Working Group which focused on discrimination experienced at work alongside turnover rates had been undertaken and that the triangulation of datasets would be reviewed by the People & Culture Committee.

Action: Chief People Officer

Minute	Description	Action

In relation to the 2023/24 breakthrough objective *'I am able to make improvements happen in my area of work'*, it was reported that there had been a 2.6% improvement and commitment to continue with this objective had been reaffirmed until the results of the staff survey were known. Progress against this breakthrough objective would be monitored through monthly staff survey working group meetings with divisional input using local counter measures.

Use of Resources

Simon Wade, Chief Financial Officer reported on the breakthrough objective for productivity. It was noted that productivity in total had improved to an overall total -17% for Month 7, which was a 1% improvement from the -18% at the end of 2022/23. This reflected an improvement in the overall Trust financial position and that there had been improvements in income and corporate accruals. However, the position did not reflect being off track with our activity and financial plan due to higher pay pressures such as industrial action impact and behind plan with CIP delivery.

Further work was being undertaken using the Civica Aurum productivity tool to identify further opportunities to be included in the planning inputs for divisions to review and to seek clinical engagement on.

The Board **noted** the report.

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meeting on 29 November 2023 and the following was highlighted:

Cancer Services – Mitigating actions were received which would support recovery including external support for Dermatology outsourcing and the review work internally for Urology and Lower GI pathways.

Hospital at Home – The position had improved but remained behind the target of 45. This would continue to be monitored by PPPC.

Diagnostics Deep Dive (DM01) – The delivery of ultrasound services remained a problem and that use of an external provider was being explored, together with further maximising the use of the mobile endoscopy unit.

Sunflower Closure – This has been recognised as a positive service change and it had been recommended that lessons learnt be included in future changes to continue to develop best practice.

Emergency Preparedness Resilience & Response Assurance Report (EPRR) – This had received a substantial rating from the ICB and was an improvement on last year's partial rating.

Discussion took place on access to step up care through primary care channels and the wider context of the system with emergency and primary care colleagues.

Minute	Description	Action

Felicity Taylor-Drewe, Chief Operating Officer outlined a care coordination model that was being trialled in the BSW and that the outcome of that trial was awaited. The work being undertaken by GWH to provide support to care homes across the South West together with support for ambulance colleagues and out-of-hours provider to provide a coordinated care approach. Outcomes would be provided in future reports to PPPC.

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 23 November 2023 and the following was highlighted:

Pressure Harms – Numbers remained high but progress could be demonstrated around awareness and proactive responsiveness by matrons and teams with earlier identification and action.

Total Harm – Gram negative infections continued to be above trajectory but the focused water safety pseudomonas work undertaken by Estates had shown impact and infection rates were now in line with planned trajectory.

Safe Allergy Management – Focused work following a deep dive had resulted in a reduction of drug allergy instances by 84% and now the likelihood risk associated with that had decreased.

Serious Incidents – A rise in the number of serious incidents reported were currently being scrutinised. The transition of PSIRF methodology to support SI reporting had been delayed to ensure balanced patient safety, coroner and CQC needs.

Claudia Paoloni, Non-Executive Director reported that to enable progress of metrics to be monitored more effectively, Q&SC had requested that focused timelines be added to enable sight of stepwise progress over periods of time.

Claudia Paoloni, Non-Executive Director added that Q&SC was also concerned about staffing through industrial action and the potential impact on patient safety and quality, together with the impact of winter pressures on accessibility and the Emergency Department.

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 27 November 2023 and the following was highlighted:

BSW Financial Update – An Extraordinary FIDC had been held in November to review the forecast financial position following several national announcements

Minute	Description	Action

around the treatment of industrial action costs and elective activity. The delivery of the recalibrated financial plan would continue to be monitored closely by FIDC.

EPR Programme Update – The Committee was assured of the EPR Programme, however the risk remained that the Full Business Case had yet to be approved by NHSE and the funding received to proceed with the implementation. The Board requested that a "Plan B" scenario be provided if funding was not secured.
Action: Chief Financial Officer

Efficiency Programme – In the month, £1.07m of savings had been delivered against a plan of £1.34m, a shortfall of £0.28m. The key driver was Medicine schemes, delivering £0.03m against a plan of £0.47m. Undelivered savings remain a significant risk to the Trust's inability to hit a breakeven position at year-end. The Financial Recovery Board would continue to monitor progress and accountability by divisions and corporate functions for their efficiency plans.

The Board **noted** the report.

187/23 **Audit, Risk & Assurance Committee Board Assurance Report**
The Board received an overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meeting on 16 November 2023 and highlighted the following:

Appointment of External Audit Services – The Committee supported the recommendation to appoint Deloitte as the Trust's External Auditors to the Council of Governors for approval.

Internal Audit Progress Report – The Internal Audit Plan 2023/24 continued to progress well and was on track.

Local Counter Fraud – Mandate Fraud Review – A review had been undertaken by the Local Counter Fraud Specialist on mandates, which had not raised any significant concerns but that some data cleanse was required on suppliers to improve the Trust's ability to manage its fraud risk.

The Board **noted** the report.

188/23 **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 8 November 2023 and highlighted the following:

Financial Reporting – The General Fund currently stood at £43,730 which was below the agreed minimum threshold of £57k. This had restricted the Committee from approving and releasing funds immediately for the latest cases of need requests. Further legacies were expected in the near future which would allow for charitable funds to be released and that fundraising activities were planned.

Charitable Funds – The new process and approach for Divisions and Fund Managers was working well with a significant increase in funding opportunities being identified and supported.

Minute	Description	Action

The Board **noted** the report.

189/23 **Emergency Preparedness Resilience Response Annual Statement**

The Board received and considered the Emergency Preparedness, Resilience and Response (EPRR) Assurance Report 2023 which outlined the continued progress of the EPRR agenda and provided detail on continued progress and maintained standards whilst embedding learning from the Trust's incident response processes.

It was noted that the Trust had been assessed as fully compliant and had received a substantial rating from the ICB.

In response to a request raised by Will Smart, Non-Executive Director on controls and processes around potential cyber-attacks on the Trust, it was agreed that further assurance would be sought to ensure that controls would be included as part of EPRR and integrated in the EPR project moving forward.

The Board acknowledged the substantial work that had been undertaken within the Trust to reach full compliance.

The Board **noted** the report.

190/23 **Amendments to Standing Financial Instructions (SFIs) Financial Limits**

The Board received and considered a paper which detailed the proposed amendments to the Standing Financial Instructions (SFIs) financial limits.

Lizzie Abderrahim, Non-Executive Director asked for further understanding if the Board of Directors was considered to also be corporate trustees, particularly in relation to financial limits for charitable funds. It was agreed that clarification would be sought and provided prior to approval of the amendments.
Action: Company Secretary

The Board **agreed** to approve the amendments to the Standing Financial Instructions (SFIs) financial limits subject to clarification around the corporate trustees.

191/23 **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.

192/23 **Ratification of Decisions made via Board Circular**

None.

193/23 **Urgent Public Business (if any)**

None.

Minute	Description	Action
194/23	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 11 January 2024 at the DoubleTree by Hilton Hotel, Swindon.	
195/23	**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 11.50hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – January 2024				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
7 December 2023	186/23	**IPR – Pillar Metric deep dive and refresh – Our People** Results of survey to triangulate datasets of discrimination experienced at work alongside turnover rates to be reviewed by the People & Culture Committee.	Chief People Officer	For P&CC
7 December 2023	186/23	**IPR – Pillar Metric deep dive and refresh – Use of Resources** Opportunities identified from Aurum insight tool to be further reviewed by the Finance, Infrastructure & Digital Committee.	Chief Financial Officer	For FIDC
7 December 2023	186/23	**Finance, Infrastructure & Digital Committee Chair Overview** "Plan B" scenario for EPR to be provided if funding was not secured.	Chief Financial Officer	For FIDC
7 December 2023	190/23	**Amendments to Standing Financial Instructions (SFIs) Financial Limits** Clarification to be provided if the Board of Directors was considered to also be corporate trustees.	Company Secretary	The Trust's SFIs state that:- *the Trust is the sole corporate Trustee of the Great Western Hospitals Charitable Funds, and is responsible for the management of funds it holds on trust….and these are administered by the Trust Board acting as Trustees for the Trust.* The Trust's Powers Reserved to the Board states:- *approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust, such as charitable funds, is in.*

Future Actions				

Report Title	**The Finance Team Improving Together Journey so far**				
Meeting	**Trust Board**				
Date	**11 January 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Johanna Bogle, Deputy Chief Financial Officer				
Appendices	A – Towards Excellence Accreditation B – Example team newsletter				

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		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 GWH finance team has undergone a transformation in personnel over the last 18 months, with a turnover of c. 45% (18 of 40 posts).

New team members have brought new ideas from other organisations, and have been able to harness the energy of the incumbent staff to challenge what was a culture of always doing what had always been done. We now reflect a culture of check and challenge towards continuous improvement. This is an ongoing process and we recognise that we still have areas to develop.

Our team presentation today will showcase the way we have used our improving together working groups to formalise our progress. Alongside the cultural changes, we used the Healthcare Financial Management Association's One NHS Finance Towards Excellence Accreditation process to demonstrate improvements made. We are very proud of becoming

Level 1 accredited in December 2023, and are now looking to continue this process through to Level 2 over the next year.

One of the wonderful enhancements we have made within our team has been to embrace diversity of thought through leadership at all levels. Your presentation today will be led by a mix of our finance colleagues, both across sub-teams and levels of pay grades. We look forward to sharing our journey with you, and answering any questions you may have.

Appendix A shows our likely presentation slides. Appendix B is our most recent staff newsletter.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps	Continue to Level 2 FFF Accreditation				

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the improvements made to date, and plans to go further over the coming year.

Accountable Lead Signature	
Date	04/01/2024

Great Western Hospitals
NHS Foundation Trust

Future Focused Finance Towards □□cellence Level

The □ourney so far

□WH Finance Team

Towards □□cellence □ccreditation

NHS
Great Western Hospitals
NHS Foundation Trust

□n overview

ONE NHS FINANCE

□ecognising the best in culture, skills and processes in NHS Finance.

One NHS Finance Towards Excellence Accreditation **shows that your finance team's processes and procedures are working.**

It proves you've developed a culture where staff feel appreciated and successes are celebrated.

Each level has a set of criteria to work through and they focus on these areas□

- ✓ **Infrastructure**
- ✓ **□ersonal □evelopment**
- ✓ **□rofessional □evelopment**
- ✓ **Finance Workforce □ Career □lanning**
- ✓ **Corporate Financial □overnance**
- ✓ **□usiness Controls □ □olicy**

Finance Director Declaration: commitment to continuous improvement

Our CFO Simon Wade signed the One NHS Finance FD Declaration at our recent Finance Improving Together Steering Group, featuring members of the finance team.

Signing the declaration demonstrates his commitment to continuous improvement across the department.

This is a key step in our Accreditation Towards Excellence journey and we're on track to submit our Level 1 document by 31st August national deadline!

A huge well done to everyone in the department for contributing to the accreditation process.


ONE NHS FINANCE

FINANCE DIRECTOR DECLARATION

I DECLARE THAT I WILL:

ONF Towards Excellence Accreditation level 1!

Congratulations

...and thankyou to the whole team on all your efforts, hard work and initiative in working together to achieve Level 1 NHS Finance Towards Excellence Accreditation shows that our team's processes and procedures are working. It proves we have began to develop a culture where staff feel appreciated and successes are celebrated.


ONE NHS FINANCE
TOWARDS EXCELLENCE ACCREDITATION

skills development network

ONE NHS FINANCE

1

LEVEL 1
ACCREDITED

This certificate is awarded by the

The Finance Leadership Council
& NHS Skills Development Network

in recognition that

Great Western Hospitals NHS Foundation Trust

have been accredited at

Level 1

for achieving consistent good practice in Finance Skills Development

September 2023

Julian Kelly,
Chief Financial Officer, NHS England
and Chair of the Finance Leadership Council

Expiry Date:
September 2026

How did we approach this□

- Established a small working group initially
- Level 1 □ □□ criteria, reviewed line by line□what had already been achieved and what are the gaps.
- We rated each criteria as: “Achieved”, “Easy to achieve”, “Requires some effort to achieve” and “Difficult to achieve” to help focus our efforts.
- Allocated 1 criteria each to the department working groups…

TEAM WORKING

There are written procedure notes available to staff for all financial systems and all procured systems are supported by detailed system manuals.

STAFF DEVELOPMENT

Evidence of resources being made available for staff development (e.g. Training Policy, use of local SDN programme, HFMA etc.)

SERVICE PROVISION

A perception / opinion survey of the services provided by the finance function is undertaken at least annually.

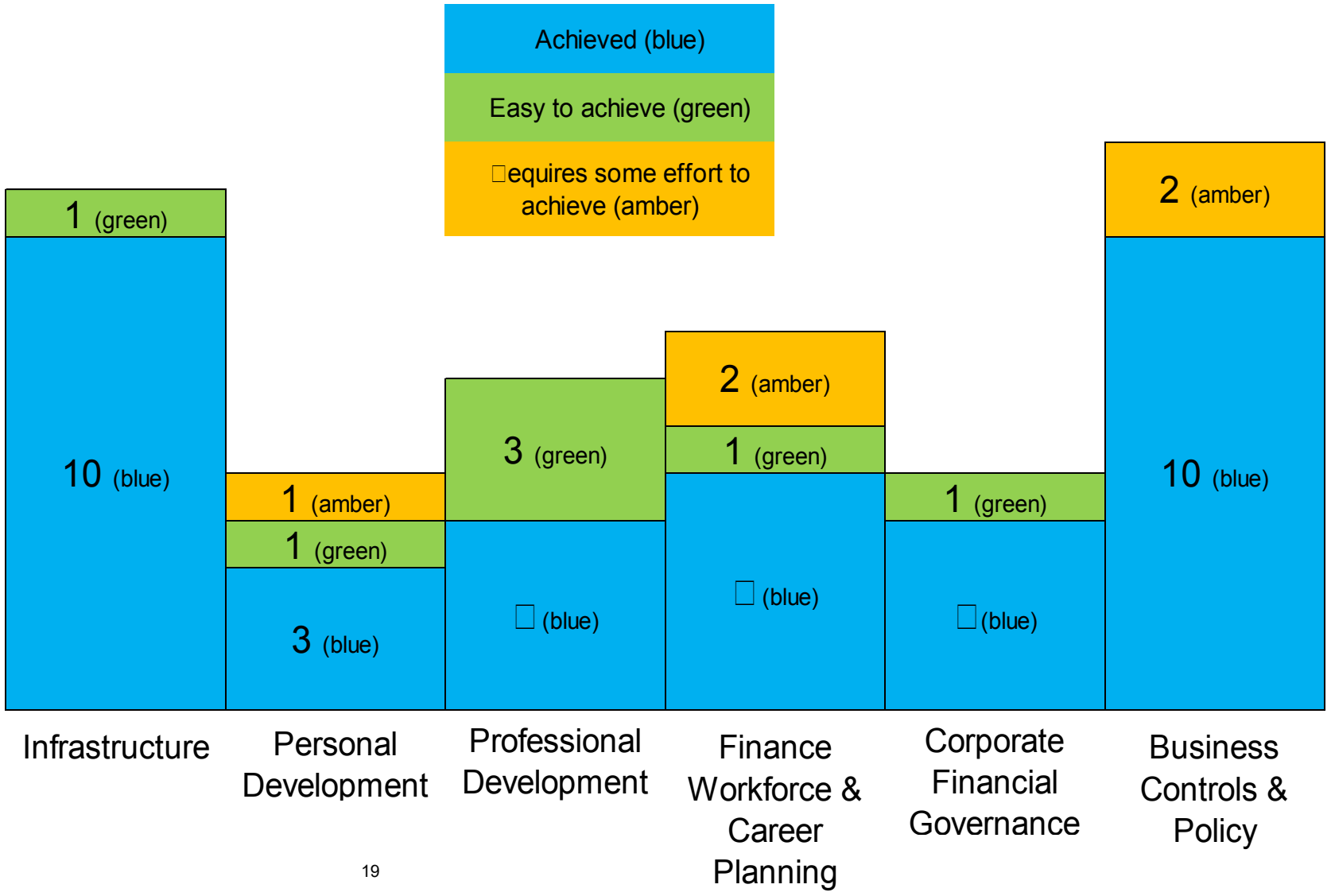
Towards □□cellence □ccreditation Level □

Great Western Hospitals NHS Foundation Trust

Progress tracker…

ACHIEVING LEVEL 1 ACCREDITATION

We're on track!



Some criteria that we worked on

ACHIEVING LEVEL 1 ACCREDITATION

1.3. The organisation is registered with all the relevant professional bodies for both Continuing Professional Development (CPD) and Training purposes.

1.2 A perception / opinion survey of the services provided by the finance function is undertaken at least annually.

1. A business continuity plan is in place for the finance function.

The evidence

ACHIEVING LEVEL 1 ACCREDITATION

- ✓ □rogress remaining criteria and add the re□uired evidence for the Level □ form.
- ✓ Final sign off by CF□, □eputy CF□ □ Senior Team

ONE NHS FINANCE

skills development network

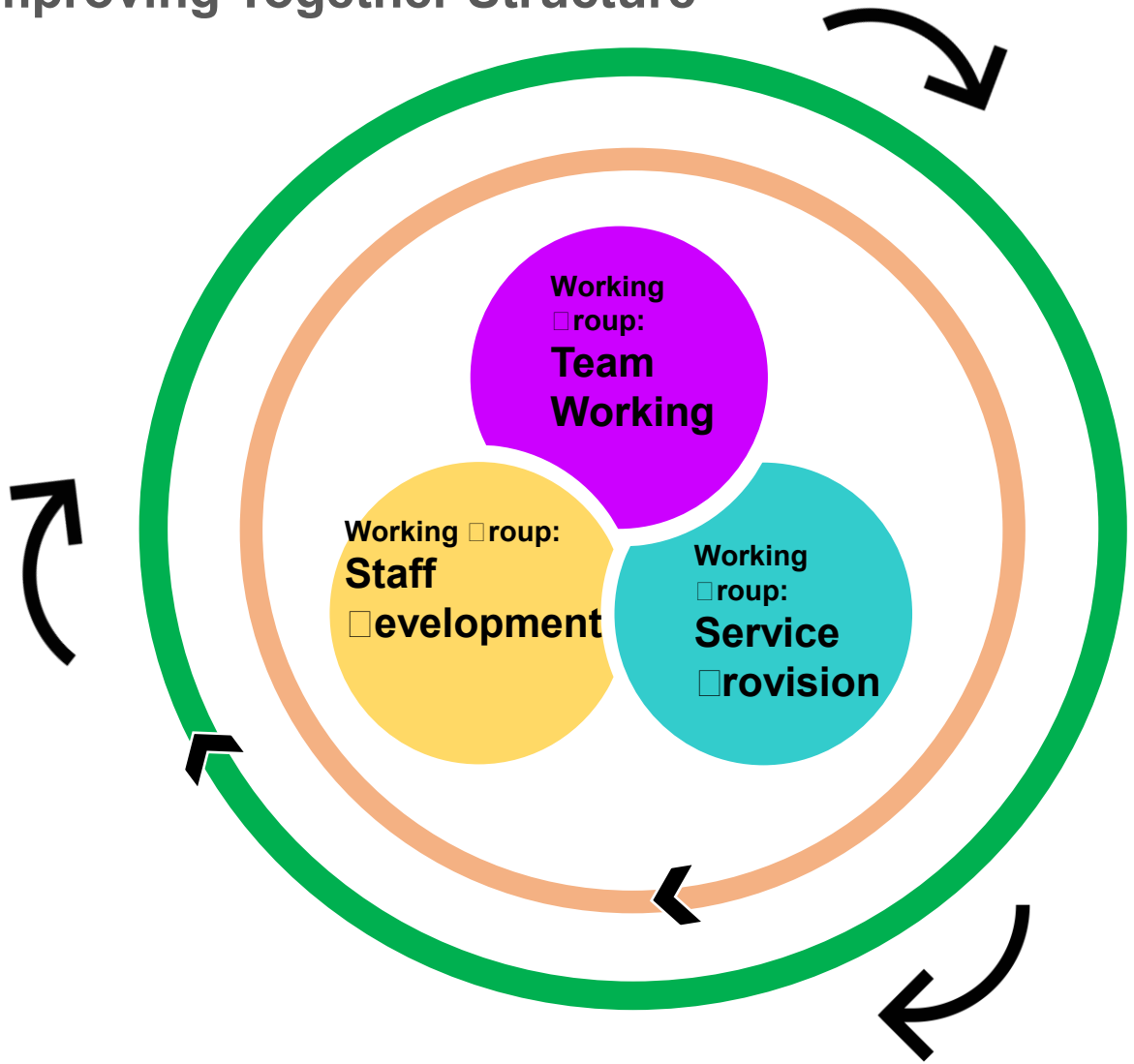
One NHS Finance Towards Excellence Accreditation

Level One Evidence Schedule - 2022

STANDARD	LEVEL 1		EVIDENCE
1. Infrastructure	1.1.1	The Director of Finance / Chief Finance Officer's job description clearly describes professional leadership responsibilities.	Professional leadership responsibilities are clearly described within the CFO's job description and reflected in personal objectives.
	1.1.2	A Finance Skills Development (FSD) Lead and Student Skills Development (SSD) Lead (where applicable) are in place (or there is a shared role where appropriate), with recognition of role in annual objectives or job description.	We have a training and development (FSD) lead. This role is not formally in their job description as it may rotate within the department but will form part of the individual's personal objectives and documented as part of their appraisal. We are seeking an additional person/s from the wider finance team to share this FSD Lead role, almost to act as a FSD Deputy.
	1.1.3	Skills Development Network (SDN) involvement is recorded (e.g., attendance at Leads meetings,	We ensure staff participate in SDN and HFMA courses as well as system and regional sessions such as the Value Maker network for South

□WH Finance Improving Together

□ur Finance Improving Together Structure

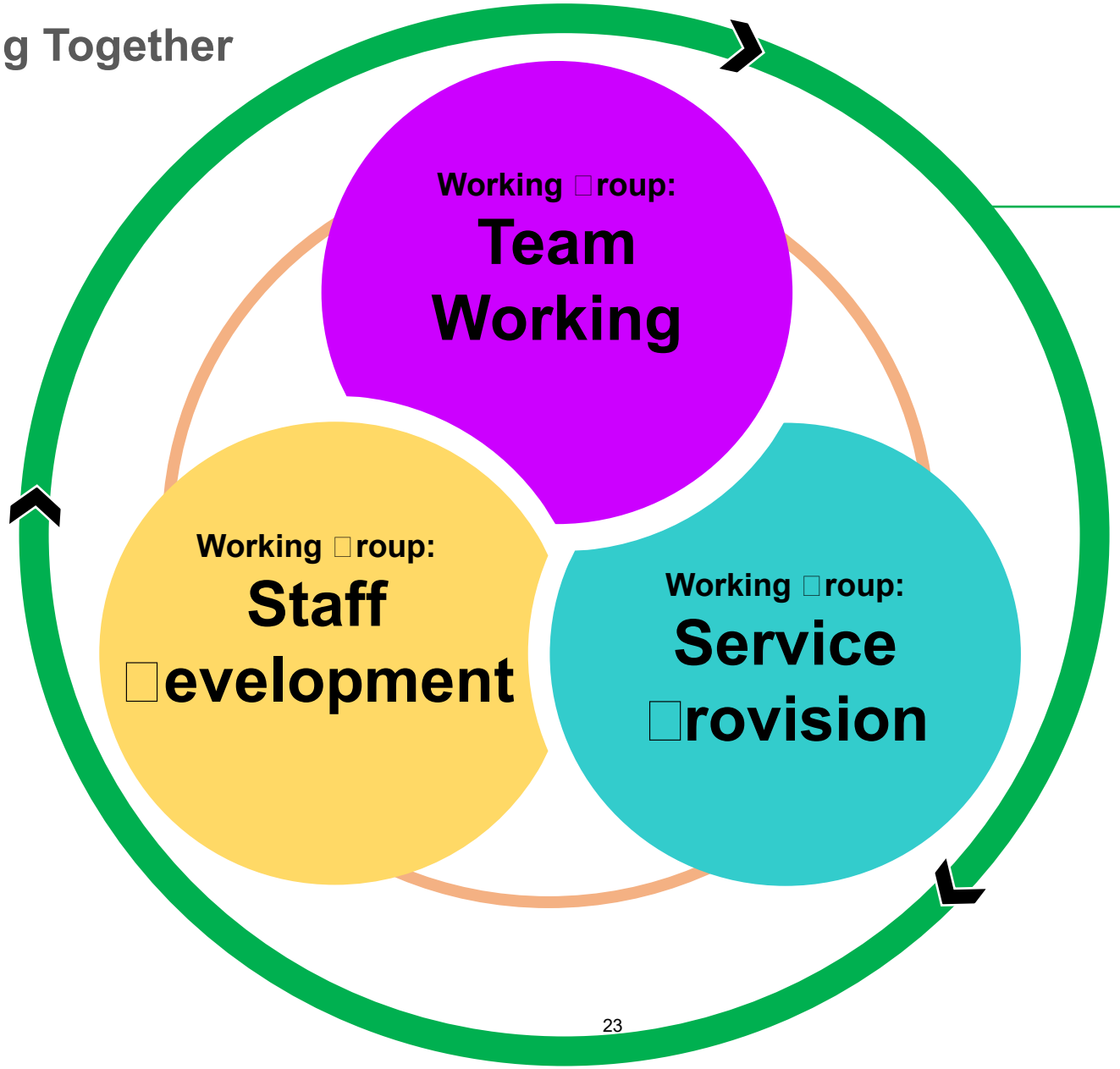


□mbeds a culture of continuous improvement across the department

□WH Finance Improving Together

Great Western Hospitals NHS Foundation Trust

Finance Improving Together Steering □roup



Supported by:

- Finance Improving Together Steering Group
- Weekly department briefings
- Senior Finance Team
- Finance quarterly meetings
- Individual team meetings
- 1:1's
- GWH Improving Together
- Internal department newsletter

□WH Finance Improving Together Steering □roup

Great Western Hospitals NHS Foundation Trust

Team Working e□ample □from Summer □□□□

□ur group priorities:

Short term □in the ne□t □ months□:

1. SOPs – 'finesse' it and ensure that all SOPs are there in correct folders
2. Personality test – complete meet the team document with result & send to people that didn't do the test

Long term □□ months□□:

1. Shadowing team members – Different month for each team (□ teams)

Future Focused Finance Level □ Criteria:
Ref □.□.□□There are written procedure notes available to staff for all financial systems and all procured systems are supported by detailed system manuals.

What has the group worked on since the last Steering □roup meeting:

- Getting SOPs together, saving them in file and getting them in order.
- Preparing the personality test and presentation for the Away day at the end of June.
- Planning meetings between HC & JW as well as meeting with our sponsor Andy Pullin.
- Meet the team document – completed.

Shout about your successes / wins by listing them below, no matter how small □every win counts□

- Personality test went well, it was a success, and everyone was on board□Good results & definitely an ice breaker, good feedback from everyone.
- Having successful meetings of everyone coming together and being on board.
- Moving forward with the shadowing and getting some good ideas for implementation.

Has the group e□perienced any difficulties so far□ What has the group tried to resolve this□

- Having to chase people for SOPs and to complete meet the team document.
- Holidays/people being off as well as having day to day workload pressures.

If still unresolved, what does the group suggest to address this:

- Planning meetings around annual leave/other meetings.

□rief outline of group ne□t steps / actions between now and the ne□t Steering □roup □□uly tbc□:

- Arranging shadowing amongst the teams, send out dates.
- Complete profiles for personality mapping test, collect the tests from people that missed out.
- Checking SOPs to ensure they are complete, in a central folder/no duplicated or missing procedures.

ther successes

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Well done to all those involved with the Finance Drop In Sessions!!!

FINANCE DROP-IN SESSIONS

Do you have questions for, or need help from your finance colleagues?

Come and meet the finance team for advice, guidance, and information.

There will be representation to discuss:

- Access to Oracle and BI (SBS)
- Reading and understanding your budget statement
- Drilling down to your cost transactions on BI
- Devolved income
- SLA's
- CQUIN Reporting
- Overseas visitors
- Travel costs for patients
- Charitable funds and petty cash advice

For more information, please contact Louisa Bux l.bux@nhs.net

Raising requisitions and workflow notifications

Budget reporting and non-PO approval

Setting up or amending SLA's

Benefits of devolved income

STRATEGY DEPLOYMENT ROOM
2nd Floor (near Trust HQ) GWH

Friday 21st July
Friday 18th August
10 am – 3 pm

The sessions are proving to be a big hit with staff across GWH who are able to drop in to meet members of the finance team on hospital site to talk through their queries.

The most recent session, held Friday 21 July, had 13 staff members drop by and staff feedback has been very positive! See below.

Next session:
Friday 18 August 10am – 3pm

It was so informative and I took a lot away from the session even though it was only for an hour. Henriett was patient when I asked lots of questions and I felt she took an active interest in what I had to say.

First of all, thank you so much for organising this session. It was really useful as lots of my queries were resolved that day and also I have been shown some hints and tips to use SBS more cleverly. I'm really pleased that I have manage to come down to see you all.

I intend on coming up next month to get some support with budget management as I am completely new to it. I have also recommended to a few of my colleagues as being really useful.

Just having the opportunity to talk to someone about what I was trying to see in my return and have someone explain what the various labels mean was really useful.

A crib sheet on the intranet explaining what the various terms mean on the Business Intelligence Provider would be useful

I thought the drop-in session worked well for me. I had quite a complicated query which I had part resolved before arriving and the team gave me a quick tour of how to receipt and correct a receipt and solved my problem in about 5 mins.

The crib sheet suggestion has been actioned, uploaded to our intranet and shared with him.

Finance Improving Together | Working group: Service Provision

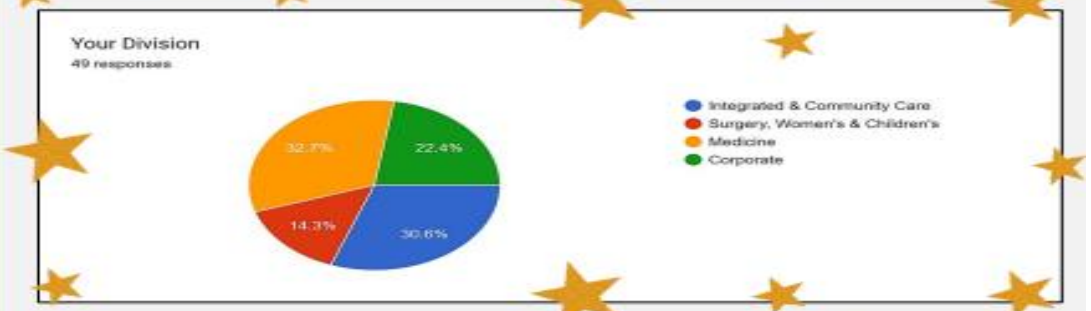
A shout out to our department service provision working group who have sent out a perception survey to our budget holders.

As at Friday 21 July, the survey has received a brilliant 49 responses, with Medicine division leading the way!

The deadline for budget holders to complete their survey is set for **31st July**.

Anything you can do to help nudge your divisional colleagues to complete this will be hugely appreciated!

As an added incentive the group has offered the 1st, 25th and 50th person to complete the survey a box of chocolates!



This survey forms an important part of our Level 1 Accreditation Towards Excellence. Once the survey closes, results will be analysed and key themes will be shared with the wider team in order to celebrate the positives and what we're doing well and also identify where we can improve and how to go about actioning this.

Level 1 criteria: 1.5.2: A perception / opinion survey of the services provided by the finance function is undertaken at least annually.

Finance □way □ays

Great Western Hospitals NHS Foundation Trust

We'd never had them before..*but over the last 18 months they have changed from Senior-team led, to our working groups leading on relevant agenda items*

□urpose and □chievements

- Patients – focusing on why we are here
- Team Working – Cohesive approach – one team
- Improving Together – Working through challenges and implementing process to resolve
- Future Focused Finance Accreditation – Implementing better practice as a team. Achieving Level 1 accreditation as a result

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Future Focused Finance Towards □□cellence Level

What ne□t□

□WH Finance Team

LEVEL 2

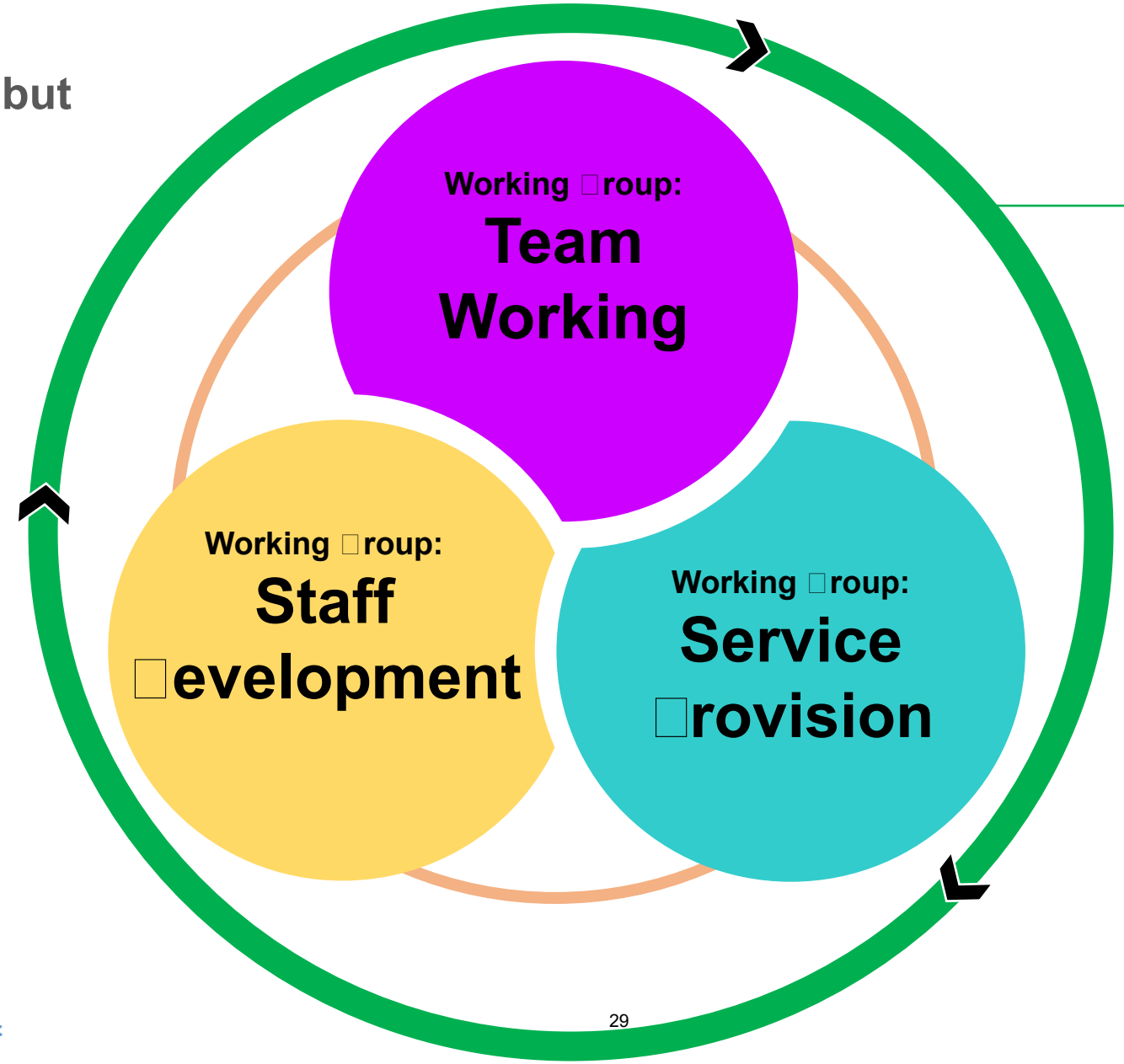
High Level of Performance: The emphasis at this level is on sustained performance. Organisations must demonstrate an overall culture that is innovative and consistently supportive of the development of the finance capability throughout the organisation.

Moving from Level 1 to Level 2 – it is expected that newly accredited organisations allow a 12 month 'grow' period before applying for Level 2, thus allowing a sufficient timeframe for systems and processes to be fully embedded.

Accreditation applications at Level 2 and 3 must be assessed by peers. This process provides an additional level of assurance over and above a self-assessment process.

Looking ahead

Continuation of working groups, but new outputs



- □Improving business acumen across the Trust
- □Training, training, training on how to ensure smooth purchasing e□periences □improved use of □urchase orders□
- □Team shadowing
- □□mbedding finance into divisions □getting on site more□
- □□ood internal staff management to address training needs as soon as identified
- □Trainees – New College work e□perience students start in Feb

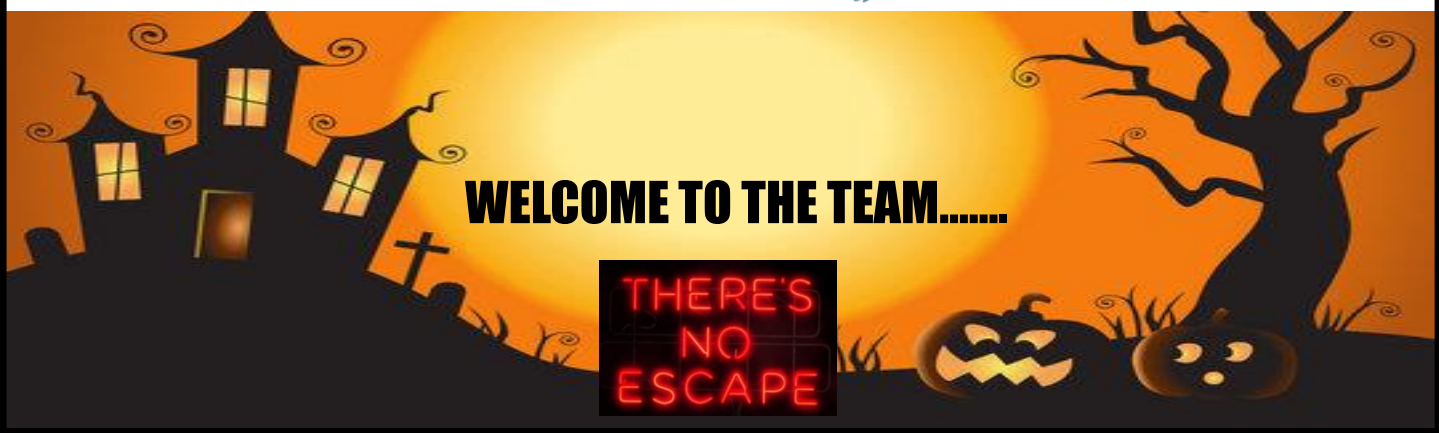
□□ □ll of these feed into L□, but are embedded, not a tick□bo□ e□ercise

GWH FINANCE TEAM

Department Newsletter
September/ October 2023

NHS
Great Western Hospitals
NHS Foundation Trust

This edition:



warm welcome to our newest team members:

ictor auket:
Assistant Management Accountant

Hello everyone,

I am from Swansea Bay University Health Board and I have been working there for the past 4 years as a Finance officer in the Finance operational team before moving to the Great Western Hospital as Assistant Management Accountant.

So far everything has been going well. I have met with most of my Management Accounting colleagues and had a good welcome from everyone as well. I look forward to getting to know everyone in the team as time goes on, Victor

Welcome ack:

- **mma Hanselman**
  Finance Business Partner ICC
- **Ruth Haynes**
  Temporary Finance Business Partner ICC

Both uth and Emma will deliver the ICC FBP role collaboratively from October until the end of December.

ur previous team newsletters can be viewed here

Lets Celebrate

H NN IL S HI HL C N T HF C NFR NC

During the HF South West awards ceremony our some of our very own team members were highly commended.

These are fabulous awards of recognition and what a fantastic way to bring visibility of the reat Western Finance team to the region ery well deserved, ery well done to ohanna and iles

ohanna ogle Highly Commended for eputy irector of Finance.

The HF nnual South West Conference took place the th September, which included full days of networking, keynote speakers, south west updates, motivational speakers, awards and lots of networking

ohanna and ohn attended along with an oshua, inny, Christyn and ippa.

The regional update gave an indication of a re uirement for encouragement of uality and iversity.

iles Fortune, who was Highly Commended for rofessional evelopment ward.

ne of the most well received otivational speakers was onna Fraser, a lympian and former m sprinter for reat ritain, with a successful athletics career which spanned over years. n top of this onna has beat breast Cancer and is now a C who is driving for organisational success to ‘believe and achieve’

Donna Fraser’s key points to be the most successful version of yourself :

- sk Why
- Have a ision and wn it
- Lead by ample
- Challenge yourself push yourself past your comfort one
- Collaborate
- mbrace Change control the controllable
- llyship l Help others in marginalised groups.
- ost importantly Look after yourself

Lets Celebrate

FIN NC T ST RS

Congratulations to Hannah Culley, who was nominated for Star of the onth award September by Tamara Turchet, Senior Research facilitator.

This recognition shows that you are living the Trust values of Service, Teamwork, Ambition and Respect (STAR) in everything you do!
Congratulations - Great work Hannah!

SERVICE

Putting patients first Not necessarily with respect to patients but certainly with regard to colleagues. Hannah is fantastic at coming back to me really promptly whenever I send her a query, no matter how big or small, and with keeping me informed of progress when she cannot immediately resolve my query. She goes above and beyond to help, even answering emails at the very end of the day when she should already have finished her day

TEAMWORK

Working together Hannah is amazingly supportive and patient with me - I email her at least once a week with fairly random finance queries which I have come across. We now have a little running joke to see how far through the week I can get before I need to ask her for help I am very new to finance and invoicing and SBS and O ACLE and I don t find it terribly intuitive or straightforward. Hannah she has helped me navigate the system and understand how it works and who does what. She has sent info, over and above what I ve asked her for and rather than just doing it for me or telling me where to find things has taken the time to teach me how to do those things I can do, expanding my skills and knowledge base and hopefully helping me to avoid asking her the same thing over and again She is always really cheerful and encouraging and even my most silly requests are never too much trouble for her. Her emails are always really clear and positive.

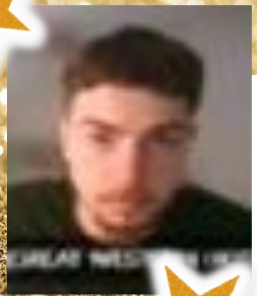
AMBITION

Aspiring to provide the best service Super fast to reply - usually within the morning/afternoon and often within the hour. when Hannah can t resolve something immediately, she will explain what the issue is, what she has done about it and when she hopes to be able to respond with an answer. Great at updates when waiting for a response. I imagine Hannah is massively busy in her role but she is never too busy to help me and others. Hannah is super helpful and friendly and just really lovely to deal with. Her emails always make me smile, even when I m having a real nightmare with Oracle/SBS and invoicing is driving me nuts, she puts everything back in place for me

RESPECT

Acting with integrity All of the above and more Hannah just gets the job done, efficiently and with a friendly, polite and positive approach. She genuinely seems to care about the person behind the email (I ve never met Hannah) and supporting me to do my job. She is a brilliant member of the finance team and a star in every way and thoroughly deserves the STA of the month award

Congratulations Team – as of week commencing th ctober we were the most engaged in entire trust at response rate to staff survey. t th ctober we are only responses away from Well done all



Congratulations to obe on istinction

Jobe Cowling, Management Accounts Assistant recently received a distinction on his first of his AAT Level Diploma in Professional Accounting exam. Jobe received 0 on the “Drafting and Interpreting Financial Statements” exam. Jobe’s next exam will take place at the end of October. Good luck

Lets Celebrate□

□NF Towards □□cellence □ccreditation level □□

Congratulations

…and thankyou to the whole team on all your efforts, hard work and initiative in working together to achieve Level 1 NHS Finance Towards Excellence Accreditation shows that our team's processes and procedures are working. It proves we have began to develop a culture where staff feel appreciated and successes are celebrated.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September 2023

Julian Kelly,
Chief Financial Officer, NHS England
and Chair of the Finance Leadership Council

Expiry Date:
September 2026

There are three levels, and only the very best finance teams achieve full accreditation, so lets keep up the good work and momentum entering level 2, and make this the best NHS Finance team in the U□□

What□s ne□t, □ steering group update from □ohanna □ogle.

The most steering group was full of energy and enthusiasm for the next steps on our journey to becoming Future Focused Finance Level 2, through working on improvement themes that we are passionate about. What was clear from the meeting is that our team is engaged with making things better and that this is now a really natural process – doing the projects we feel we need and want to do will lead to meeting FFF L2 criteria, rather than the process being a tick box exercise.

The steering group agreed that to ensure working groups felt they had the capacity to move their improvements forward, they should book time together that is protected, and that if they felt pressure from other requirements after this was booked, they should feel that they would be supported to hold the protected time by the senior team, and to escalate if there are any issues.

Our next steering group will be in November.

SPOTLIGHT: **FSD LEAD**

Great Western Hospitals NHS Foundation Trust

□n interview with □ohn Ridler, □ssociate □irector of Finance

What is FS□□

Finance Skills Development (FSD) is a collaborative network for the NHS of Finance Skills Development, dedicated to improving the finance skills of all NHS staff.

FSD provides both personal and technical skills training, together with support in all aspects of personal development. These training and development opportunities can be available to all NHS finance staff and non-finance budget holders, along with supporting documentation and information.

What makes a good FS□ lead□

The commitment to developing others is key, as well as making the time necessary to work on FSD. I would also say that listening to others is really important so we can signpost to the right areas or take feedback to change some of the FSD planning going forward.

What are the main responsibilities of an FS□ lead and why is it important to the team□

There is a need for commitment and passion to be supporting the development of all finance staff. We recognise that developing new skills alongside your day job can be a challenge. It's really about giving others the full opportunity and chance to learn, and embrace new situations. This can help our teams gain the confidence to move forward in careers too. It's a rewarding role being an FSD lead as we can work across BSW system to support people□s goals and aspirations together

How do we currently share FS□ opportunities in the system□

The FSD leads meeting comes together to organise and agree on FSD events and strategy. Within our own organisations we share lots of things on Events, tailored webinars and training.

These can include technical areas but also self-development and opportunities such as coaching and mentoring. There is so much to access that there should be something for everyone□

SPOTLIGHT: **FSD LEAD**

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Have you had to do any additional training or learn any new skills

To be honest a lot of it came through getting involved in HFMA and FSD and also through experience of managing and developing teams. Being involved with HFMA is a great platform to take on opportunities like FSD lead and everyone is encourage to get involved where they are interested including helping lead on FSD activities We now have so many things through HFMA and One NHS Finance where you can have that involvement and that has obvious benefits such as building new networks that can stay with you

How do you get incorporate your FS lead role into your daily role

There are planned diary event and commitments as well as preparing briefings. It is also about championing FSD in all conversations and interactions as needed so we can always be there to support people with FSD. This should not just sit with the nominated FSD lead but should be something that everyone is aware of and helps to champion so we embed the benefits through everyone.

What are your best achievements since taking on this responsibility

The best achievement has been when positive feedback comes from our teams or it has helped to develop someone s aspirations. This can open new doors for them or increase confidence.

The FSD events that have taken place in our system have also involved a lot of planning so it s a real achievement when they happen and are well participated in

SPOTLIGHT: **FSD LEAD**

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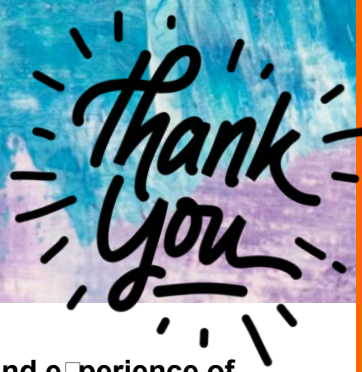
What are the biggest challenges you□ve faced as FS□ lead for finance□

In GWH Often it will be our teams capacity to be involved with FSD and to really set aside that protected time. Our Level 1 accreditation and improving together work as a team has helped to steer us in a exciting direction on this now so we must keep the momentum but continue to appreciate how busy everyone is. It has been really recognised how everyone has played a part in this success so far as we strive for the Level 2 achievement next.

What are you most looking forward to as part of this role in the near future□

We have a BSW system away day coming up on 22nd November to bring all teams together again and celebrate some of our achievements. Our FSD leads are shaping that programme to be an energising day so looking forward to that□

I□m also looking forward to hearing further progress on our GWH improving together working groups where much work is happening to improve our staff development. As we progress some of that further, there will be some areas where the FSD network can help to share best practice across our BSW system so it benefits beyond our own teams. I□m really looking forward to GWH being able to showcase some more great work□



□ very big thankyou for □ohn for taking the time to share his knowledge and e□perience of being our Finance Successful □evelopment Lead.

□re you passionate about development and looking to add to your skills□ □ur team needs at least one □eputy FS□ lead □if you think this could be you please contact □ohn for more info□

Finance Improving Together □Shadowing Sessions

Team Working
Helen Asprey, Sam Cope, □ennedy Mudzi, Debbie Palmer, Jan Williams, Trudie Worner, Emma Moore.
Led By Hannah Culley, Jill White and supported by Andy Pullin.



Group Facilitators□ Hannah & Jill


Sponsor/ Coach□ Andy

As part of Improving Together, the Teamworking group have organised shadowing sessions across various departments across the wider team,

Having full clarity of functions, process and responsibilities of the wider team unites us and builds our strength as an outstanding Finance team. Having this knowledge enhances skills and helps recognise areas for improvement. This gives us the opportunity to develop to working collectively, learn new skills and share ideas to use with within our own roles.

Please try to make at least one of these sessions we hope to make the interactive sessions as interesting and enjoyable as possible. To book onto a session click here to fill in the booking sheet, for any questions please contact Hannah Culley or Jill White.

Upcoming Sessions.....

Financial Management (Helen, Sam, Heni & Jan)	Thursday 16th November 9.30-11am, room tbc
	Tuesday 21st November 9.30-11am, room tbc
Contracts & Income (Kennedy, Trudi)	Thursday 7th December 9.30-11am, room tbc
	Tuesday 12th December 9.30-11am room tbc
Financial Services (Jill, Debbie)	Tuesday 9th January 2024 9.30-11am Witchelstowe meeting room, Vygon
	Thursday 25th January 2024 9.30-11am Witchelstowe meeting room, Vygon

Finance Improving Together □Shadowing

Finance Business Partner, Joshua Ngesera recently spent some time shadowing on Clinical Coding. Joshua gave us a little insight into his experience,…

What was the Reason for shadowing Clinical coding□
I recently completed a course on PLICS and clinical coding was a key feature in it. I wanted to understand the coding process right from when the files leave the wards to when the data is coded into the system.

It was also an opportunity to meet the clinical coding team. Data and Engagement are factors in any successful PLICS process.

Was it worthwile□
Absolutely yes, I have a clear idea of what clinical codes do, any challenges the function might face and how finance can support.

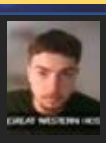
What's next?
Following this coding process to the BI level, so my next one will be with the business intelligence team. Also considering shadowing once of the finance functions such as contracts and Income.

□ny last comments□
Shadowing is a great way to learn, and I support it. Great that it's part of our improving together process.

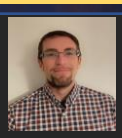
Thanks for Sharing Joshua, if you are interested in particular areas please reach out to leads who will be happy to organise directly□

Finance Improving Together □Working group: Staff □evelopment

Staff □evelopment
Mark Bryant, Miles Fortune, Laxmi Giri, □iv Hume, Chrisyn Iboko, Aggie Juskiewicz.
Led By Jeremy Twala, Jobe Cowling and Lucie Westwood. Supported by John □idler




Group Facilitators□ Jeremy, Jobe & Lucie



Sponsor/ Coach□ John

Update from group facilitator Lucie Westwood:

In the Staff Development Group, we have started looking at designing an induction pack for new starters. This will sit alongside the current Finance Team welcome pack. We are going to work first on drafting an induction pack for management accounts. This will then become our template design for other teams. We have representatives from most teams in our Staff Development group, but we may well need to get input from other members of the finance department. We will certainly be asking for feedback when we have some detailed drafts. We have looked at the FFF Innovation Forum and will use the innovation we found there for information on how another Trust has approached the exercise.

Our other task is to draw up a skills matrix, based on each individual's appraisal. We have our key skills as our headings for the matrix. The next step will be to circulate to team leads for completion.

Finance Improving Together □□rop In Sessions

The sessions are continuing to be a big hit with staff across □WH who are able to drop in to meet members of the finance team on hospital site to talk through their □ueries.

We had great feedback on the most recent session, held Tuesday □□th □ctober. We had □staff members drop by, with □i□of levels and □ivision and staff
Ne□t session:
Thursday □□rd Nov□□am – □pm

□ducational □ngagement

To encourage recruitment and retention it is crucial that we begin to interact with local schools and colleges, so we can attract young enthusiastic students consider NHS Finance as a career. **So what's in the pipeline…..**

GETTING OUT THERE….
We are preparing to tackle the world of school and college fairs and careers events. The medical workforce within GWH is well presented at these local events, as to be expected but there is little to no representation from corporate.

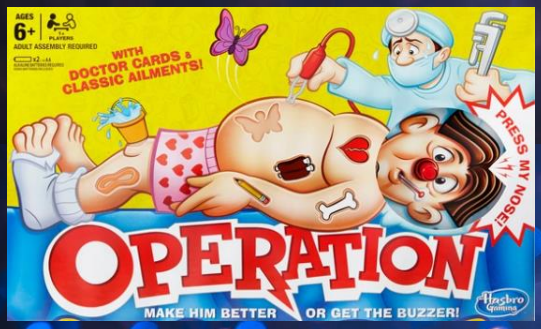
This is why is important that we remind people that there□s so much more going on behind the scenes within the Trust and our team which is growing in success, has many opportunities for those at the start of their careers to learn and grow.

Emma Moore and Debbie Palmer are currently working with our Early Careers advisor Jackie Fawcett putting together materials and making plans for careers events and fairs.

We are looking at how we can tailor our educational engagement to provide opportunities in NHS finance for young people who may not come through a typical degree route. This is important for us as we aim for our team to represent our local population and, therefore, improve our diversity of thought and improve our services to the rest of the organisation.

LETS THINK…

- CAREERS FAIRES
- WORK EXPERIENCE
- LESSON TALKS
- WORK PLACEMENTS



A NEW OPPORTUNITY…
We have just submitted a vacancy post to New College, Swindon for the opportunity to give a placement to a T-Level Accounting student,

They will need to complete □□ days of employment with us as part of their accreditation. We will shortly be putting together a plan with line managers of how this placement will look ensuring a rotation across all departments within the wider team.

This is a first time for us and a very exciting move forwards in terms of community engagement□

ENGAGING…
On the 11th July both Emma Hanselman and Emma Moore attended a NHS One Finance event- Engaging with Schools showcase.

The Session was very interactive and engaging. It focused on how we are engaging with schools and young people and encouraging careers in NHS Finance. A lot of younger people don't consider only medical roles within the NHS so this is an opportunity to get ourselves out there.

There were great tips on how to engage with students at events and suggestions of games incorporating medicine and finance such as using the game Operation, and then talking about the costs of the operation etc.

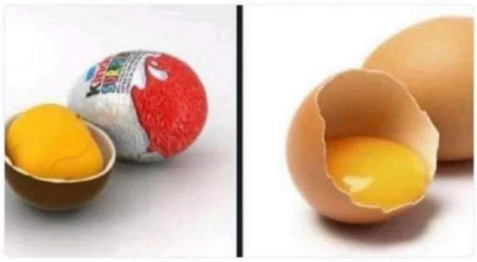
It was interesting to hear that one of the Trusts had set up a stall at a parents evening and had actually snapped up a parent who was looking for a career change, and that parent had now complete their apprentice course and been promoted withing their team□

Check out NHS ONE Finance page to for any courses that you'd be interested, there are tons of fantastic free courses to help you with your progression, and also great for networking and sharing ideas with other Trusts.
Events (onenhsfinance.nhs.uk)

If you would like to get involved with this, please let us know. Maybe you are keen to attend events, engage with students, are you confident speaker, perhaps you would be interested in giving a inspirational or career talk? Possibly you prefer to be behind the scenes but would like to participate in planning and bring ideas forward? Either way your input is just what we need, please contact Emma Moore for more info.

For laughs...

I was today years old when I realised...



Send Help! I've Been Put In Charge of The Company Newsletter

What do you call a fish without eyes?

Fsh.

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**11 January 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

Purpose

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

Assurance Level

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

Process

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

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

Report

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

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

The report provides information in respect of:-

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

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

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	-
Next Steps	-

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	27 December 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 December 2023.

1. Council of Governors

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

Date	Event	Purpose
6 Dec	Engagement & Membership Working Group	To advise and support the Trust in increasing Trust membership and improving membership engagement
7 Dec	Trust Board Meeting – Observers	Holding the Non-Executive to account
14 Dec	Monthly meeting with Chair & Lead Governors	Regular meeting to update and discuss any topical issues

1.2 New Governor – The Trust welcomes a new governor, Councillor Ray Ballman representing Swindon Borough Council.

2. Strengthening Board Oversight & Development

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

Date	Area	Board Member
14 December 2023	General Surgery – Outpatients	Lisa Cheek, Chief Nurse Lizzie Abderrahim, Non-Executive Director Claire Lehman, Associate Non-Executive Director
18 December 2023		Jude Gray, Chief People Officer Claudia Paoloni, Non-Executive Director

3. Trust Chair Key Meetings during December 2023

Meeting	Purpose
Monthly meeting with Non-Executive Directors & Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
AHA Committees in Common	Regular system meeting
Wiltshire Health & Care Members' Board	To attend as a member
BSW Chairs' Catch Up	Regular meeting to update and discuss any topical issues
EPR Update	Monthly meeting

Report Title	**Chief Executive's Report**				
Meeting	Trust Board				
Date	11 January 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jon Westbrook, Acting Chief Executive				
Report Author	Jon Westbrook, Acting Chief Executive				
Appendices	N/A				

Purpose

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

Assurance Level

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

Board members are asked to note the report

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

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

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

Report

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

The report includes updates on:

- Industrial action
- Operational demand
- Financial recovery
- Improving sustainability
- Senior appointments
- Success of WAY Beacons project

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 Score**

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

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

Explanation of above analysis:

The report includes an update on the success of the WAY Beacons project. This is a project which seeks to match vulnerable young people who present to the Emergency Department with a mentor to support them. There is a particular focus on individuals who are involved in petty crime, substance misuse or other social issues, but who aren't necessarily known already to social services.

Recommendation / Action Required The Board/Committee/Group is requested to:	
To note the report	
Accountable Lead Signature	Jon Westbrook, Acting Chief Executive
Date	5 January 2024

1. Operational updates

1.1. Industrial action

Since the Board last met, we have managed two periods of industrial action by junior doctor members of the British Medical Association.

Strikes took place from 20-23 December and 3-9 January.

Hospital Consultants and Specialists Association Junior Doctors also staged a full walkout from 6.59am on 20 December to 6.59am on 23 December.

This action, which marked a full year of industrial action affecting the NHS, represented the longest strike in the NHS' history.

This was a particularly challenging period of industrial action to manage given that there were such a small number of working days between Christmas Day and 3 January for us to safely discharge as many patients as possible to ensure our bed occupancy was as low as possible. The 20-day period between the start of these two strikes and the end included only 4 normal working days with the holiday period as well leaving limited opportunities for the rescheduling of postponed appointments and for this reason we took the decision to apply to the region and BMA for derogations in some services.

During the first strike period (between 20-23 December), unfortunately 694 appointments, procedures and treatments had to be cancelled, while 64 percent of shifts due to be undertaken by junior doctors were not filled.

My thanks go to all staff who prepared the Trust for the industrial action and worked through this period to help us deliver as much patient care as possible, with many staff working additional hours and in different roles.

Separately, Consultant members of the BMA will be consulted on a pay offer following negotiations between the union and Government and we hope for a positive outcome which will reduce the ongoing impact of strikes on our patients.

1.2. Operational demand

A Reset Fortnight is being held from 2-15 January to help us manage the heavy demand we always experience at this time of year.

We have asked staff to ensure they take all necessary steps to help facilitate safe and timely discharges and to also consider using the NHS@Home virtual ward.

Reducing ambulance handover delays remains a key area of focus for us. We have a clinically-led delivery plan in place, agreed with system partners who also have a role to play in addressing our collective performance in this area.

We have seen particularly high numbers of paediatric attendances over recent weeks and declared a business continuity incident to help us manage the demand upon us as best we could. This included working with partners to bring in additional measures such as extra GP support in the Urgent Treatment Centre, extra children's clinics in the community, and closer working with mental health services.

1.3. Supporting our staff

NHS England, the Care Quality Commission, the Nursing and Midwifery Council, and the General Medical Council published a joint letter last month aimed at addressing the impact of operational pressures due to winter and industrial action.

We are confident all clinicians will continue to respond and carry out their duties professionally, but we also understand there will be concerns about working under pressure, and that clinical staff may need to depart from established procedures on occasion to provide the best care.

Professional codes and principles of practice are in place to guide staff and support their
judgments and decision-making in all circumstances.

This includes taking into account local realities and the need to adapt practice at times of significantly increased pressure.

2. Quality

2.1. Improving Together

We recently celebrated our latest group of staff from across the Trust to complete Improving Together training.

Colleagues in Outpatients, Trauma Unit, Emergency Department, Urgent Treatment Centre, Shalbourne and acute medicine will now continue this way of working in their own areas and use it to solve problems, explore ideas and make improvements to benefit staff and patients.

One of the key features is a daily huddle which brings all staff together - doctors, nursing staff, therapists, receptionists, housekeepers and others - helping with teamwork, communication and morale.

Following their training, the team on the Trauma Unit has seen a reduction in pressure ulcers, increased mobility of patients and a boost to staff morale, which were the three areas for improvement they chose to focus on.

Across the Trust, more than 480 staff have taken part in multiple training options, with the next round of training opportunities planned for February.

This month, the Improving Together team will be attending a Matrons Away Day, supporting this important group of leaders to prioritise their quality drivers for the year.

Across our Acute Hospital Alliance, all three trusts are using this new way of working to collectively improve patient outcomes, efficiency and resilience. Recent examples of collaborative improvement work include the introduction of a single procurement function, clinical teams working together to tackle waiting lists and work to build a shared electronic patient record system.

2.2 Developing our next Trust strategy

We have been working with key stakeholders to develop the next Trust strategy which will take us from 2024 and beyond.

The new strategy will help us to build on our successes to date and set the future direction for the organisation.

This work involves engaging with staff, patients, families, carers and residents through a range of surveys, workshops, focus groups and a Staff Steering Group. We are also collecting the views of members, governors, local schools and colleges and partner organisations such as the Integrated Care Board, Prospect Hospice and Healthwatch.

3. Systems and Strategy

3.1. Financial recovery

To help us manage the financial pressure upon us, we have set up an internal recovery board which has identified a number of different workstreams, looking at areas such as clinical recording and coding, better buying and our vacancy control process, among others.

We have introduced tighter processes for recruiting staff which are designed to ensure that we make the most of the money available to us.

We know that we will need to work in different ways to meet the challenges we face in the future and we will be working with our staff on raising awareness of the need to identify waste in the things we do and then work to eliminate it.

By waste we mean the extra steps in the processes that are unnecessary and take too much time and effort for little or no benefit. This will be a key focus for our engagement with staff on the financial challenges we face as we move forward.

3.2. Working to improve sustainability

Our work to improve our carbon footprint and become a more environmentally friendly organisation continues, with a number of projects currently underway.

NHS England has selected our Trust as an exemplar site for the work being done with Sustainability and Infection Prevention Control teams. This is really positive recognition for the Trust and these teams who are working hard to embed practices such as reduced glove use and cannulation. This also means the Trust has a small amount of funding to become a model of best practice to be shared with other organisations, to help drive progress nationally.

The Trust was recently visited by Greener NHS and the NHS England team for net zero and sustainability. This visit was to benchmark our performance and to discuss any tools and resources required to meet these targets.

The feedback from the team was very positive and we were identified as leading the way for waste management, having already met key targets. In fact, we are the first Trust in the country to have established clinical waste training which is available to all staff.

4. Workforce, wellbeing and recognition

4.1. Senior appointments

Following Kevin McNamara leaving the Trust to become CEO at Gloucestershire Hospitals NHS Foundation Trust, interim arrangements for the Acting CEO and Acting Deputy CEO role are now in place.

Ms Anushka Chaudhry has been appointed to the role of Acting Deputy Chief Medical Officer, covering for Dr Steve Haig as he acts up in to the Chief Medical Officer position. Anushka has been a Consultant Breast Surgeon at GWH for the last 10 years and has been the Associate Medical Director for the Acute Hospital Alliance for the last two years.

To cover a period of absence, Deputy Chief Nurse Rayna McDonald has temporarily stepped into the role of Divisional Director of Surgery, Women’s and Children’s.

Interim arrangements for the Joint Chief Digital Officer role will be announced in due course, following Naginder Dhanoa’s decision to leave this position last month.

4.2. Flu and Covid vaccination programme

Our Covid vaccination programme finished shortly before Christmas, with 52 per cent

of staff having the jab and a further 15 per cent of staff letting us know they had the vaccine somewhere other than work, or declining the offer.

Our flu vaccination programme will continue for a few more weeks. So far 67 per cent of staff have had the vaccine, with a further 12 per cent having declined the offer or having the jab somewhere else.

4.3. Way Beacons

WAY Beacons, a collaborative project between Swindon Borough Council and staff in the Emergency Department and Children's Unit, won the 'Connecting People' award at the South West Personalised Care Awards last month.

The project seeks to match vulnerable young people who present to the Emergency Department with a mentor to support them. There is a particular focus on individuals who are involved in petty crime, substance misuse or other social issues, but who aren't necessarily known already to social services.

4.5 Inclusion Recruitment Champions

The Trust's first interview panel to include an Inclusion Recruitment Champion took place at the end of last year and was a great success.

This is part of several initiatives designed to make our recruitment practices more inclusive, providing an additional level of assurance that interviews are free from any form of bias, whether conscious or unconscious.

To date, six staff have received training to become Inclusion Recruitment Champions and more training is taking place this month.

Anyone can become an Inclusion Recruitment Champion, regardless of role, band, or prior interview experience.

Initially Inclusion Recruitment Champions are being included in interview panels for roles at band 8a and above, with a view to including them in more recruitment processes in the long-term.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**11th January 2024**	Part 1 (Public)		Part 2 (Private)]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Lisa Cheek, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Felicity Taylor-Drewe, Chief Operating Officer Rayna McDonald – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer John Ridler – Associate Director of Finance				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

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

Assurance Level

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

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

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

Report

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

Our Performance

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

OPERATIONAL PILLAR METRICS

Of the 6 Operational Pillar Metrics, Cancer deteriorated for the third month in a row. There was improvement in RTT activity especially for patients waiting >52 &65 weeks. Emergency Care Mean stay across Emergency Department (ED) and the Urgent Treatment Centre (UTC) saw marginal change with a slight improvement for patients waiting more than 4 hours in ED and a stabilization in the number of patients spending more than 12 hours in ED. There has been minimal change to the number of patients presenting overall. Ambulance conveyances continue to increase. The number of patients with non-criteria to reside (NCTR) remains within the SPC control limits.

- Cancer 62-day October performance saw further deterioration. a reduction to 48.5% from the previous month of 59.5%
- RTT (Referral to Treatment) 65 Week Waiters – November performance shows the total number of patients waiting over 65 weeks at 417, a decrease compared to October 2023. 4 patients above 78 weeks was reported in November.
- Emergency Care, Emergency Department Mean Stay – There has been no significant change to the time patients spend in the Emergency Department covering both the ED and UTC.
- Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. saw a slight decrease in the total 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 a significant decrease in November 2023.

OPERATIONAL BREAKTHROUGH OBJECTIVE

Clinically Ready to Proceed (CRTP). Type 1 attendances increased slightly in November, from arrival to being CRTP. CRTP for admitted patients shows a reduction in the month, indicating patients are spending less time in the ED awaiting admission.

ALERTING WATCH METRICS

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

RTT shows fewer patients over 18, 52 and 65 weeks. The number of patients over 52 weeks shows a reduction for the 6th month.

DMO1 – The number of patients on a DMO1 waiting list saw an increase in September 2023. Overall performance saw a slight worsening in October by 1.1%

Cancer – of the 4 cancer standards, there is improvement in our 62 day performance, 31 day performance and stabilisation in our Faster Day diagnosis (28 day) standard (this is showing a slight decrease. Validated data awaited for November but as anticipated shows a slight improvement. Letter in relation to poor performance received by Trust from regional team and improvement plan in place.

ED watch metrics show no significant changes. There has been an increase in patients waiting to be handed over from an Ambulance over 30mins but a decrease in over 60 min waiting times. This is linked to the handover improvement plan. The handover improvement plan showed demonstrable improvements in the last 30 days rolling position.

Flow measures show a static position, there has been a decrease in the number of patients waiting >14 & >21 days.

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 decrease in the total number of harms down to 194 from 220 last month. The decrease is linked to a reduction in pressure harms in the community a reduction in falls and a reduction in infections harms (C. difficile and Pseudomonas).
The number of Family and Friends (FFT) positive responses for November is 87.8%, a similar position from last month, and remains above the internal target.

Breakthrough Objectives

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

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

November has seen a further decrease in the number of community pressure related harms, with the third consecutive fall to 34 in month compared to 43 in October and 74 in September. The number of acute related pressure harms has increased in month to 39 compared to 28 in October.

Alerting Watch Metrics

The complaint response rate has decreased in November and is mainly driven by capacity to investigate and respond. Work has continued with an increased level of support by Pals with response writing and additional training for new complaint investigators.

The Trust remains above trajectory for all three gram-negative bloodstream infections (E. coli, Klebsiella and P. aeruginosa) and for C. difficile, however monthly rates for all but Klebsiella have reduced over time.

The rate of Pseudomonas infection has reduced markedly since the summer, when interventions on water hygiene were implemented. Although not acquired at GWH, half of cases since July have related to one patient with a persistent infection, yet these are attributed to the organisation due to UK Health Security Agency's classification criteria.

There has been an increase in the Family and Friends (FFT) Day case response rate and positive response rate, but both remain just below the internal target. The Maternity response rate is the same as the previous two months at 16% and just below the internal target of 18%.

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

- Safer staffing fill rates have improved for the third consecutive month and are well above the National target of 85%.
- Five Serious Incidents have been declared in month, with one attributed as a never event. All will be investigated under the Serious Incident Framework
- There has been an increase in both the number of concerns and complaints in month, but the number of complaints reopened has decreased.
- There have been no reported Methicillin-resistant Staphylococcus Aureus (MRSA) infections for the fourth consecutive month.
- There has been a further decrease in the number of falls in month to 80, 98 for October.
- FFT overall response rate has decreased slightly to 27% and is now just below the internal target of 29%.

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:
Staff and Volunteers feeling valued and involved in helping improve quality of care for patients.

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

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

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

Breakthrough Objectives
The Trust Breakthrough objective is to achieve a 5% improvement from the 2022 Staff Survey in the question "I am able to make improvements happen in my area of work". There is no Q3 survey result during the annual Staff Survey period, and so the next update to this metric will be in January 2024.

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

Initial staff survey results (embargoed) will be shared W/C 11th December and planned briefing will be undertaken in January for management teams.

The Staff Survey working will review the A3 once detailed date is available and agree breakthrough question and counter measures for next year.

Alerting Watch Metrics
In-month sickness absence for September has increased marginally from 4.0% to 4.7% and remains above the Trust KPI of 3.5% which aligned to winter trends. This remains below last year's sickness rate of 5.3%. The Trust has moved from the bottom quartile to the second quartile in the national data (July data).

LTS is currently 2.15% and STS is 2.59% the majority of the increase in month has been STS.

The Trust Absence working group in 2023 will focus on implementing the national tool for "role of the line manager" to enhance the skills of managers to support staff wellbeing and improve capability of managers to proactively manage sickness absence.

The Flu and COVID vaccine roll out is underway and current performance is 65% for Flu and 51% for COVID. This is 4% lower than last year, however national vaccine rates have declined, and the Trust remains the highest uptake in the BSW.

Non-Alerting Watch Metrics
Voluntary turnover continues its downward trajectory, with a further reduction seen in September reducing from 9.5% to 9.2%, below the Trust KPI target of 11%.
Leavers within their first year of employment has changed to a rolling 12 months metric – current performance is 14.1% against a target of 14.8% (average over the last 12 months).

HR Scorecard

Vacancy Rate:
In November our vacancy rate has further improved to 3.9% (211WTE), in line with continued improvement to our turnover rates and a stabilisation in recruitment activity (41 days time-to-hire and 61 starters in October).

The new Vacancy Control Panel may impact current performance of both vacancy rates and time to hire.

Worked Against Budget:
The Budget in WTE for M8 5,383wte compared to a worked 5,582WTE this is 203WTE (3.8%) above budget. This was 70WTE more than last month.

In M8 the workforce costs are a £634K overspend against budget, £4.2m overspend YTD. This is broken down as followed:

- Nursing +£3.32M YTD
- AHP/STT +£0.06M YTD
- Medical +£4.84M YTD
- Admin and Clerical -£3.96M YTD

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

Agency Spend against Plan
In M8 we saw a decrease to our total in-month agency spend with reductions seen for Nursing, Admin, and Medical staff. Total agency spend for November was £0.89M against an in-month target of £0.91M, and reporting as 3.6% as a percentage of total workforce spend. YTD agency spend at November is £7.66M which is £0.49M below target and £2.52M below last year.

Increase in Workforce Controls
As part of an AHA response to the WTE growth across the system and associated workforce costs the Trust has implemented an enhanced workforce control process to all roles, and only roles that have a direct impact on patient care and flow/activity will be approved. A new Executive Level approval process is now required for:

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

Use of Resources
As at M8 the Trust is in a breakeven position which represents a £0.3m adverse variance to plan.

In M8 the Trust received £3.9m to fund industrial action costs incurred as well as £1.1m representing a 2% change from variable to fixed income, also for industrial action. This income, plus other non-recurrent benefits of £1.3m relating to prior year, have offset a number of in-year pressures. These are: undelivered efficiency savings (£1.6m), a shortfall on ERF related income (£2.9m), additional medical pay award costs (£0.6m) and temporary staffing pressures (£1.5m).

The Trust's forecast position is a most likely £2.6m deficit with a working towards best case scenario of £0.1m which we are focusing all of our efforts on delivering over the last quarter of the year.

Efficiency savings were £0.5m ahead of target in-month and are £1.6m behind plan on a YTD basis. The in-month over delivery was due to Medicine division recording non-recurrent savings against staffing. However, Medicine remain the key driver of the YTD under delivery, being £2.2m under plan.

Although the Trust is breaking even at M8, many of the drivers of the position are non-recurrent. Therefore focussing on run rate savings i.e. reducing our monthly spend, particularly on temporary staffing, has to be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum through strong grip & control measures, and that savings delivery is maximised to enable us to deliver as close to breakeven as we can, while retaining safe delivery of patient care.

Breakthrough Objectives
Implied Productivity for the Trust in total is recovering and has improved to an overall total –15% for Month 8 (this is a 3% improvement from the 18% at the end of 2022/23 - March 2023).

The further 2% improvement from last month (M7) reflects further improvement in the overall Trust financial position in Month 8 due mostly to funding received for industrial action and ERF activity (£5m total) but this is largely not within divisions but instead held centrally. The position does still reflect being off track with some of our activity and financial plan due to higher pay pressures such as pay awards, temporary staffing and behind plan CIP Delivery. The measure continues to be against 2019/20 cost change as it is measuring the increased cost from 2019/20 levels.

The activity positions were previously re-forecasted for the remainder of the year and there is recovery in some of these forecasts for Months 8-12 that recovers towards the scenario 3b activity plans.

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

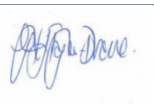
Explanation of above analysis:

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:	
The Board/Committee/Group is requested to: ▪ ***Review and support the continued development of the IPR*** ▪ ***Review and support the ongoing plans to maintain and improve performance***	
Accountable Lead Signature	
Date	04.01.2024

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

December 2023

October 2023 & November 2023 data period

Improving together

Content introduction

Great Western Hospitals NHS Foundation Trust

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

ey Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

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

ey Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection	0 (Nat)	100.0%	200.0%	300.0%	300.0%	300.0%	300.0%	300.0%	400.0%	400.0%	400.0%	Reported two month behind	Reported two month behind
Clostridium difficile infection	100% (Nat)	85.4%	81.3%	87.5%	102.1%	106.5%	123.9%	139.1%	152.2%	156.5%	154.4%	Reported two month behind	Reported two month behind
E. coli bloodstream infection	100% (Nat)	123.2%	129.0%	143.5%	156.5%	157.6%	169.7%	163.6%	168.2%	162.1%	165.2%	Reported two month behind	Reported two month behind
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Leaver rate	11.0% (Nat)	11.8%	11.6%	11.3%	11.2%	10.5%	10.5%	10.2%	9.7%	9.6%	9.5%	9.2%	Reported one month behind
Sickness absence rate	3.5% (Nat)	5.8%	4.9%	4.5%	4.6%	3.8%	3.7%	3.8%	4.4%	4.0%	4.2%	4.7%	Reported one month behind
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	6.8%	6.8%	6.6%	6.6%	6.3%	5.2%	6.7%	5.3%	5.3%	5.3%	5.3%	Reported one month behind
Proportion of staff in senior leadership roles who are women	64% (Nat)	54.0%	56.8%	54.9%	54.3%	55.7%	54.0%	56.0%	56.1%	56.1%	56.1%	56.1%	Reported one month behind
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	0.0%	0.0%	0.0%	0.0%	1.8%	1.7%	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%
Financial efficiency - variance from efficiency plan (£'000)	+/-	-338	-400	-238	281	-377	-384	334	-641	-338	-504	-39	478
Financial stability - variance from break-even (£'000)	+/-	-1502	-1579	-1469	-1482	-2157	-2591	-144	-659	330	-1352	1996	5043
Financial stability - variance from PLAN (£'000)	+/-	164	106	214	-18	-893	-2132	-223	-733	-528	-1646	1334	4489

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

□□ecutive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

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

- Pressure 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.

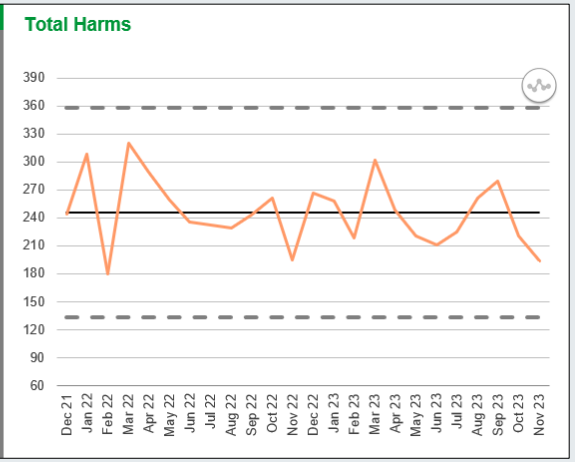
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

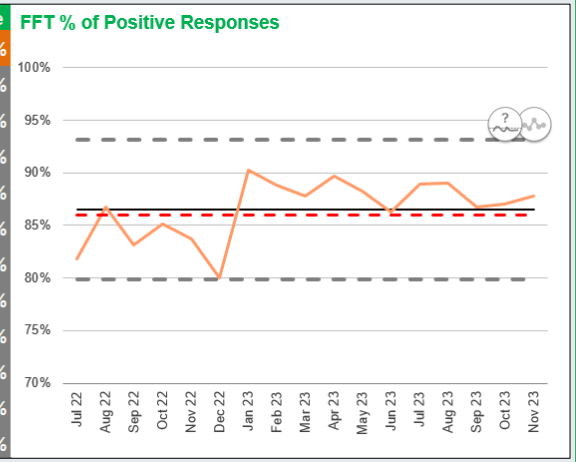
Timescale	Value
Dec 22	267
Jan 23	258
Feb 23	218
Mar 23	302
Apr 23	248
May 23	221
Jun 23	211
Jul 23	225
Aug 23	261
Sep 23	279
Oct 23	220
Nov 23	194



Patient Experience (Friends & Family Test)

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

Timescale	Value
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%
Oct 23	87.1%
Nov 23	87.8%



Counter Measures

The number of harms has reduced in November (194), primarily driven by a reduction in pressure harms in the community, falls and a reduction in *C. difficile (2)* and *Pseudomonas (1)* infection harms.

Whilst the Trust remains over trajectory for *C. diff, E. coli* and *Pseudomonas aeruginosa*, monthly numbers have fallen. Work on improving catheter care and mouth care continues, and we continue to work with external partners including UK Health Security Agency (UKHSA) on water hygiene. Methicillin Sensitive Staphylococcus Aureus (MSSA) rates remain well below last year and below our internally-set trajectory. The Infection Prevention Control team (IPC) will begin a three-month focus on skincare in the new year (including wound and cannula care) to support the maintenance of this improvement.

For November, the Trust wide positive score is 87%, a similar position from the previous month, and still above the internal target of 85%.

The Equality, Diversity, and Inclusion (EDI) lead in PALs is focussing on support with patients with additional needs.

Patient experience surveys have been conducted in the Emergency Department to aid learning and to understand the impact of actions taken to address communication and waiting time concerns.

Pillar Metrics

□□ecutive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

Cancer 62day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In October, there were 60.0 breaches in total, with 44.0 of these attributed to the Urology, Colorectal and Skin pathways. Skin and Colorectal have seen increased demand resulting in capacity challenges. We continue to see greater than normal breaches in Urology where number of breaches relate to patients needing time to consider which choice of treatment they would prefer and pathways requiring additional treatment following an incomplete procedure.

RTT: Number of patients waiting over 65 weeks

The number of patients waiting over 65 weeks decreased in month by 71 patients, to 417. This is the second consecutive month of improvement. The reduction was driven by Gastroenterology (-33), Respiratory (-23) and General Surgery (-22).

Focussed monitoring and support via a weekly improvement plan is being provided to specialities that are currently predicted not to achieve the stretched target of eliminating 65 weeks waits by December 2023. Based on the number of patients waiting over 40 weeks and the current clock stop rate Gastroenterology, General Surgery, Gynaecology and Respiratory Medicine are not on track to meet the March 2024 target. Improvement trajectories and action plans are in place for these services.

3x 78-week breach was reported at the end of November 2023 (1 x Gastroenterology, 1 x GS to Gastro and 1 x Oral) Breaches are due to diagnostic and treatment capacity.

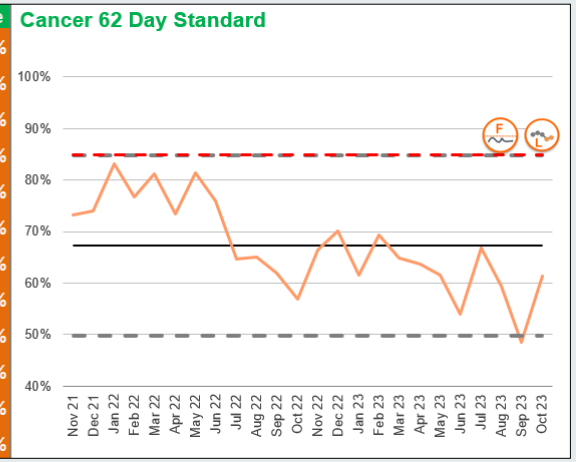
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

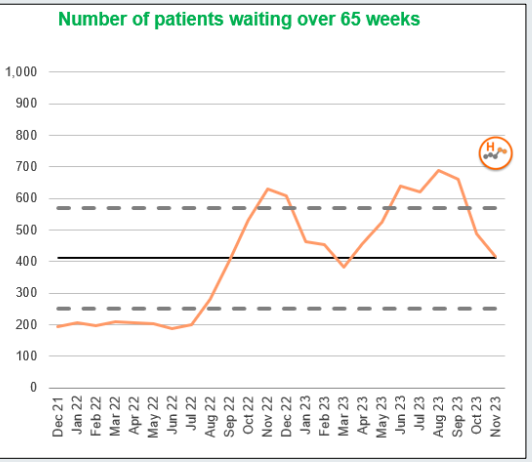
Timescale	Value
Nov 22	66.4%
Dec 22	70.2%
Jan 23	61.6%
Feb 23	69.3%
Mar 23	64.8%
Apr 23	63.8%
May 23	61.5%
Jun 23	54.0%
Jul 23	66.9%
Aug 23	59.5%
Sep 23	48.5%
Oct 23	61.3%



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
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
Oct 23	488
Nov 23	417



Counter Measures

Risk •Dermatology capacity had been impacted by vacancies and increase in referrals.
-Recruitment of substantive Consultant continues. Performance shortfalls are expected through the winter as a result of expected leave. Due to the number of referrals received this will have an impact on the overall Trust performance.
-Additional locum recruited to cover first appointments and minor ops clinics until end of December 23
-External Derm team to provide 600 additional slots over 3 weeks to clear ASI wait lists. Provision to include see and treat where possible. Planning to commence January/February 2024
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 have undergone LATP biopsy training with a view to reducing the demand on TRUS biopsies.

Risk: Insufficient capacity to recover 65 week + breach position by March 2024
Mitigation:
- Patient level details/plans updated on weekly basis in line with recovery trajectory.
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Additional clinical capacity being provided across services for patients at risk of breaching the 65 week standard.
- Booking to DNA rates has commenced in key specialties.
- Validation of waiting lists (Project Verify) being embedded, along with cohorts of patients waiting over 40 weeks being offered alternative health care providers.

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

Pillar Metrics

□□ecutive Summary

Great Western Hospitals NHS Foundation Trust

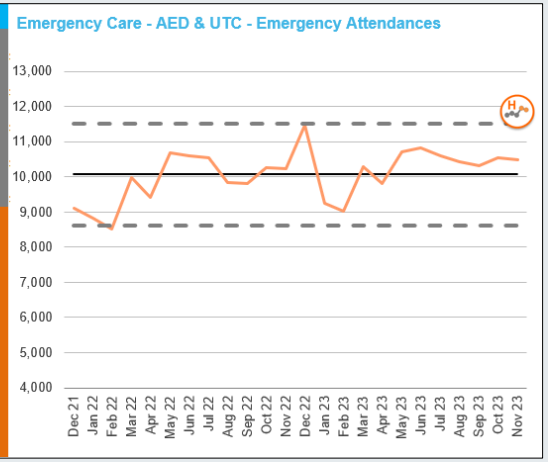
Emergency Department & Urgent Treatment Centre - Emergency Attendances

Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). November has seen a slight reduction in attendances to both ED & UTC from 10,548 to 10,491 in month (ED and UTC).

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

To ensure patients are cared for in the appropriate setting

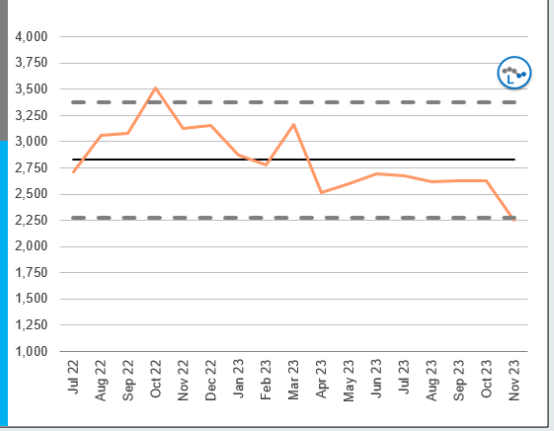
Timescale	Value
Dec 22	11,474
Jan 23	9,252
Feb 23	9,018
Mar 23	10,302
Apr 23	9,801
May 23	10,715
Jun 23	10,833
Jul 23	10,599
Aug 23	10,435
Sep 23	10,325
Oct 23	10,548
Nov 23	10,491



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
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
Oct 23	2,625
Nov 23	2,251



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

November saw a significant decrease in NCTR to 75 which was a decrease of October's 87. Medical outliers decreased slightly to an average of 40 patients (threshold target is <30). There was marginal increase in discharges for November 2.81K. Swindon discharges was the highest on record reaching **246**, with home first equating to 125.

Counter Measures

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

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

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

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

- 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.**
- **<u>RESET week 4th December to focus on the following:</u>**
  Discharge Communication and Patient information to be launched
  ICB Care Co reset 'call before you convey'
  GWH extended hours & Senior Cover
  Site Team supporting discharge flow overnight
  Optimising discharge lounge use
  Optimising care to medical patients on non-medical wards (outliers)
  Satellite SAFER on Assessment Wards
  NHS@HOME
- Discharge to Assess Bed base under review at system level to maximise the utilisation of Fessey House and Princess Lodge winter beds.
- Internal escalation process in place for social care delays

Felicity Taylor-Drewe
Chief Operating Officer

□□ecutive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime in Nov '23 was 471 minutes against the national standard of 240 minutes. This is above mean levels (460mins) but below Nov 22 levels of 500 minutes.

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

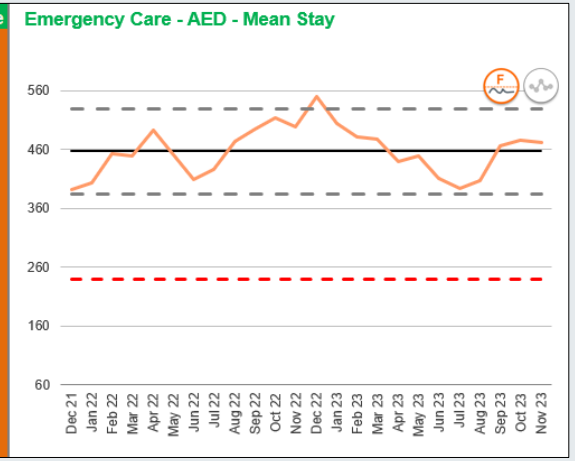
The total meantime wait for a patient in November 2023 was 165 minutes against the national standard of 240 minutes, demonstrating good flow through the service despite an increase in paeds attendances experienced at the end of November.

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.

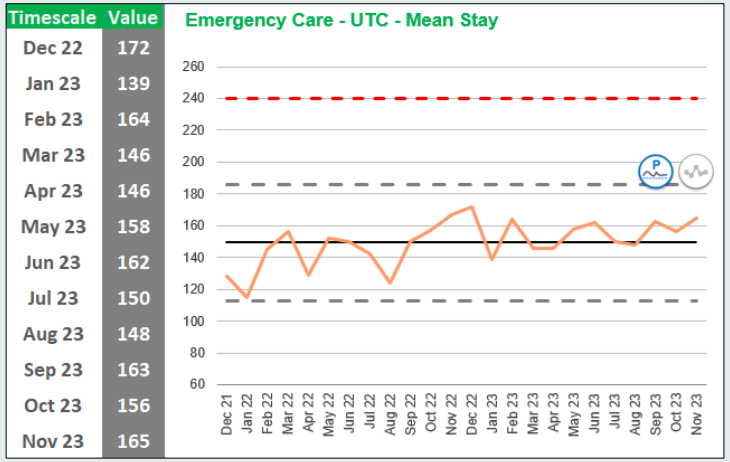
Timescale	Value
Dec 22	550
Jan 23	503
Feb 23	482
Mar 23	477
Apr 23	440
May 23	448
Jun 23	410
Jul 23	393
Aug 23	407
Sep 23	466
Oct 23	475
Nov 23	471



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
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
Oct 23	156
Nov 23	165



Counter Measures

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

- 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.

□□ecutive 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 October, decreasing from 9.5% to 9.2%, and showing sustained performance below the Trust target (11%) for seven months. Performance continues to be maintained through the Trust Retention Working Group, with countermeasures being refined to focus on leavers within the first year of employment.

Staff Recommendation as a Place to Work

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

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

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

The 2023 Annual National Staff Survey closed on 24th November. The Trust achieved a 69% response rate against an internal target of 65%. Initial embargoed results are expected on 11th December with a full analysis available in January.

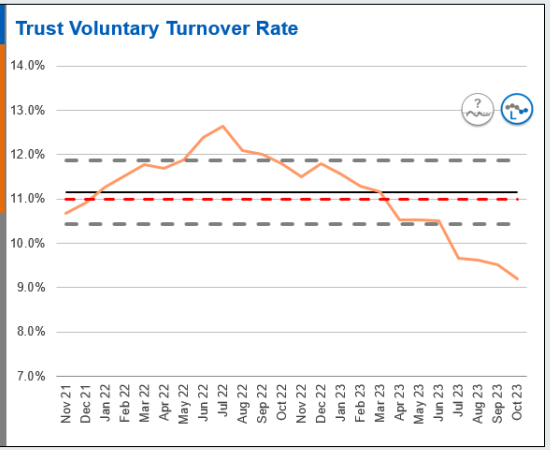
Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

Trust Voluntary Turnover Rate

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

Timescale	Value
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%
Sep 23	9.5%
Oct 23	9.2%



Staff % recommend the organisation as a place to work

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

Counter Measures

- Voluntary turnover has improved to 9.2% in October, remaining below target for the seventh consecutive month and highlighting the long-lasting impact of current countermeasures.
- Accepted on the national Retention Exemplar programme with associated funding for a People Promise Manager.
- The retention working group next meets on 12th December and will be refining the current problem statement to ensure further improvement in this metric, conducting an in-depth review of turnover and retention data.
- To support richer data around employee exits, the retention working group will be reviewing opportunities to enhance and automate the current process to ensure higher completion rates are achieved and more meaningful analysis can be drawn from feedback.

- There has been no change in this metric as it measured quarterly, however the 2023 annual survey result is expected in December.
- Overall the Trust achieved a 69% response rate, 10% above last year and 4% above our internal target of 65%. 3,925 of our colleagues participated in the survey, an additional 776 staff compared to last year.
- The Trust continues to promote Health & Wellbeing initiatives during the winter period:
  - Happiness event held at start of November
  - Launch of Wagestream financial wellbeing app
  - Flu and Covid Booster vaccination programme
  - Seasonal discount for workforce in staff restaurant/food deliveries for community colleagues

Pillar Metrics

□□ecutive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

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

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

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

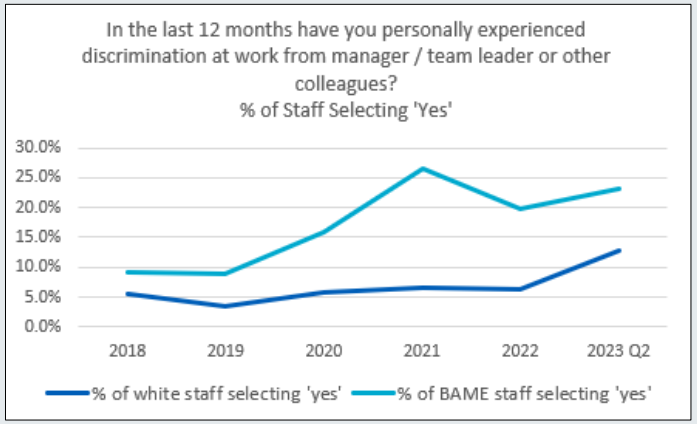
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 8.3% in line with the national average and be below the national average for all staff.

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

Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

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



Counter Measures

- The Race Equality Network hosted a successful Black History Month event in October, including a presentation from an informative guest speaker who promoted the need to understand the importance of hair care, particularly for patients from African, African-Caribbean and mixed heritage backgrounds, the talk helped staff to understand one aspect of the emotional and psychological impact of long term stays in hospital linked to hair damage and hair loss.
- The Trust has been granted an EDI Improvement Award to address unprofessional behaviours, including bullying and harassment and discrimination. The funding will be used to develop EDI Champions as part of the allyship programme and to develop a CPD-level workshop which will be rolled out across the system. Although the award is intended to support disability inclusion, champions will be recruited from across demographics and their work will benefit all staff, particularly marginalised groups.
- The first group of Inclusion Recruitment Champions have been trained and IRCs are now available to sit on interview panels for Band 8B and above roles. The second cohort will be trained in January 2024.
- Following the Equity Data Walk which was undertaken between February and May 2023, an accompanying survey highlighted staff wanted the Trust to prioritise raising awareness; providing pastoral support to staff who experience discrimination; and undertaking more engagement. In response, the Trust is hosting a series workshops and drop-in sessions (Inclusion Cafe) to educate staff and provide further opportunities for staff to share their experience and to continue to inform the EDI work. This included two guest speaker events, one with John Higgins, author of Speak Up, to explore power dynamics and identify the conditions that are necessary to enable staff in junior and middle grades to speak up and the second workshop was with Rumina Morris which focussed on anti-racism and anti-oppression. The second workshop was recorded and will be promoted across the Trust to help set a baseline of understanding, including the impact of bias and discrimination.

□□ecutive 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 M8 the Trust is in a breakeven position which represents a £0.3m adverse variance to plan.

In M8 the Trust received £3.9m to fund industrial action costs incurred as well as £1.1m representing a 2% change from variable to fixed income, also for industrial action. This income, plus other non-recurrent benefits of £1.3m relating to prior year, have offset a number of in-year pressures. These are: undelivered efficiency savings (£1.6m), a shortfall on ERF related income (£2.9m), additional medical pay award costs (£0.6m) and temporary staffing pressures (£1.5m).

The Trust's forecast position is a most likely £2.6m deficit with a working towards best case scenario of £0.1m which we are focusing all of our efforts on delivering over the last quarter of the year.

Efficiency savings were £0.5m ahead of target in-month and are £1.6m behind plan on a YTD basis. The in month over delivery was due to Medicine division recording non-recurrent savings against staffing. However, Medicine remain the key driver of the YTD under delivery, being £2.2m under plan.

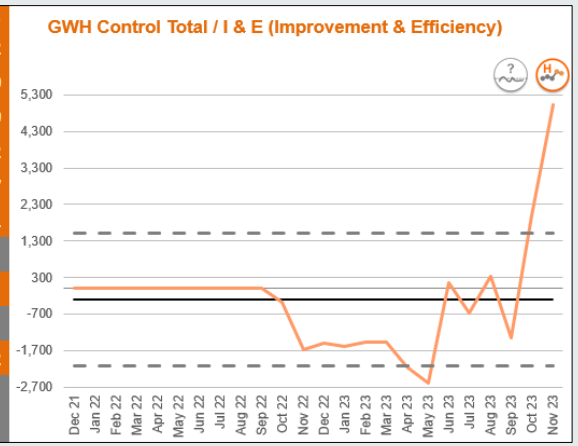
Although the Trust is breaking even at M8, many of the drivers of the position are non-recurrent. Therefore focussing on run rate savings i.e. reducing our monthly spend, particularly on temporary staffing, has to be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum through strong grip & control measures, and that savings delivery is maximised to enable us to deliver as close to breakeven as we can, while retaining safe delivery of patient care.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
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
Oct 23	1996
Nov 23	5043



Counter Measures

- Efficiency savings were □0.□m ahead of target in month and are □1.□m behind plan on a □TD basis. There are □1□.□m of identified schemes but only □□.□m (□1□) of this total is fully developed.
- Countermeasures continue through the efficiency programme, including□
  - Focus on actions to reduce run rate – additional sub committees focusing on green, amber and red actions
  - Cross-divisional schemes such as Better Buying and Medicines Optimisation
  - Financial □ecovery workstreams including workforce controls (incl. Agency reduction), outpatients, clinical coding and elective recovery

□□ecutive Summary

Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

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

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

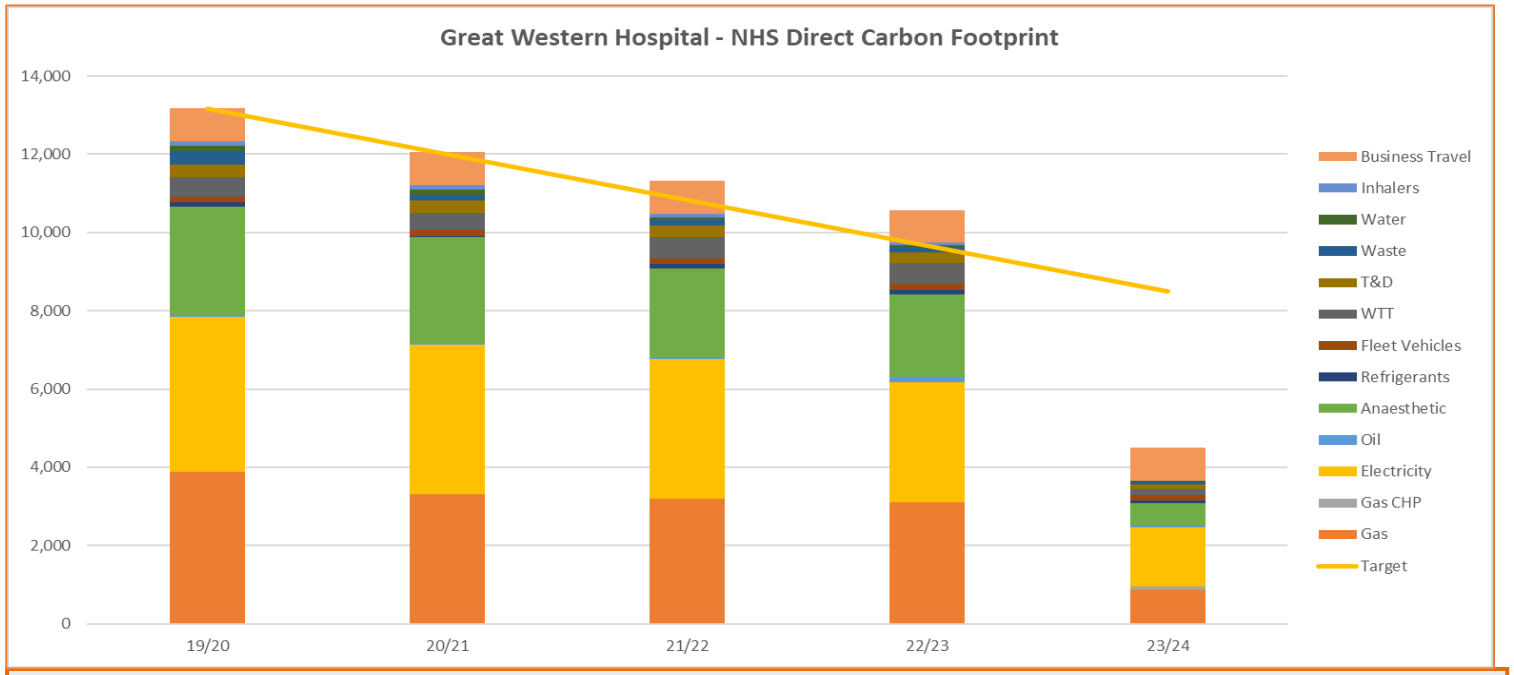
In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032 as shown with the target line on the graph from our 19/20 baseline year.

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

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

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

Simon Wade
Chief Financial Officer



Counter Measures

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

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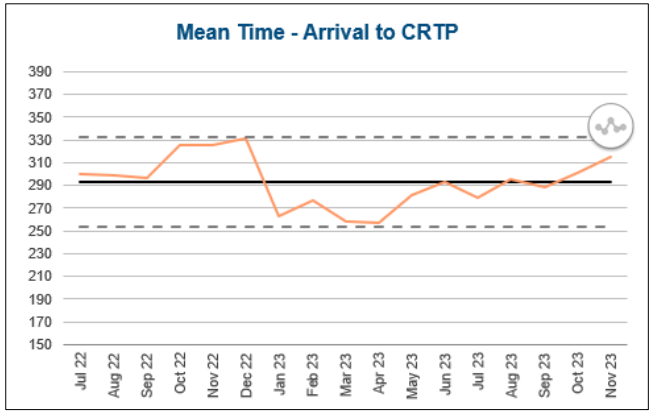
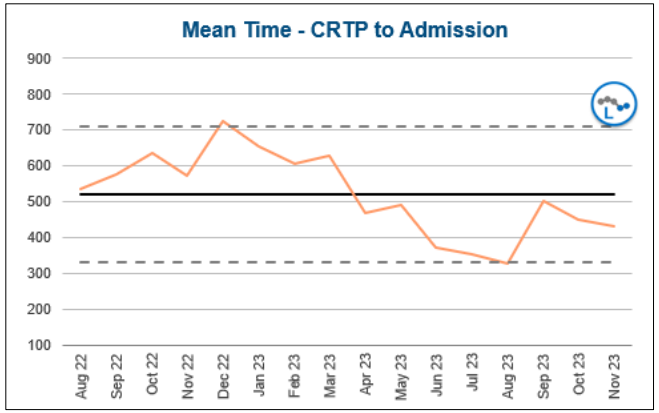
Emergency Attendances - Clinically Ready to Proceed (Admitted)

Great Western Hospitals NHS Foundation Trust

Mean time in ED (Minutes)

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Pre CRTP	332	263	277	259	258	281	293	280	295	289	301	315
Post CRTP	725	654	608	629	467	492	373	352	326	504	449	433





Common cause – no significant change

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

Understanding the Data

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

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

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 slightly increased above mean levels (315 in November from 301 in October) showing patients waited more time to be triaged, seen and diagnosed. The increase in ambulance handover delays has undoubtedly impacted this metric.
- Mean time in ED from CRTP to admission has decreased from 449 to 433 in November indicating patients spending less time in ED awaiting admission.

Risks

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

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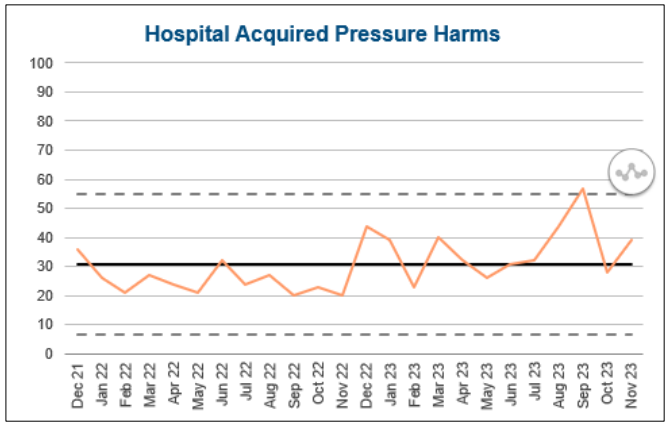
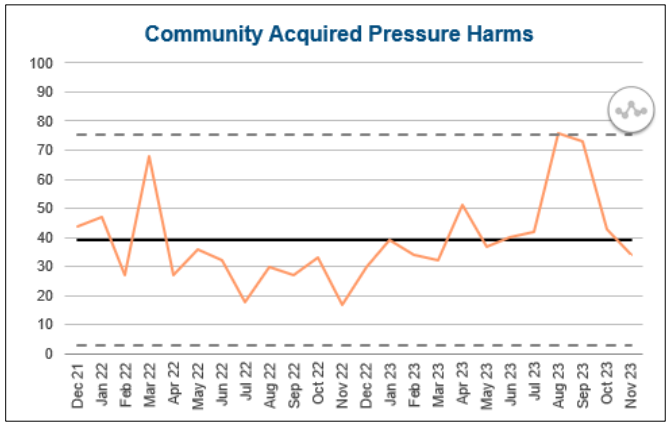
Reduction of Pressure Harms

Great Western Hospitals NHS Foundation Trust

Total Pressure Harms

Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
74	78	57	72	83	63	71	74	120	131	71	73





Common cause – no significant change

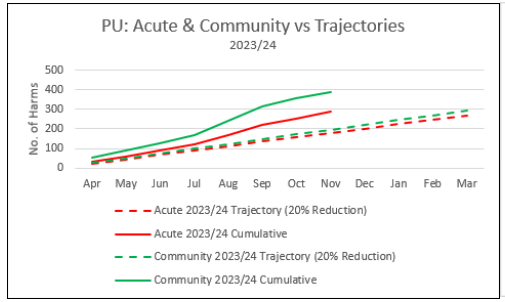
Understanding the Data

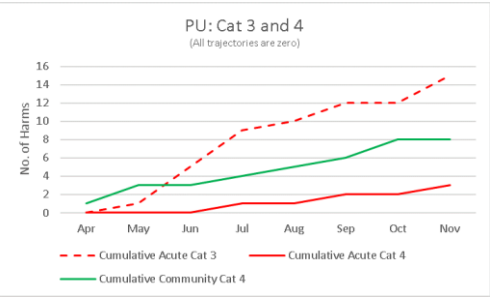
The number in the charts above represents the number of pressure harms that patients have developed whilst in hospital or under the care of a community nursing team. The number reflects the total number of harms not total number of patients i.e., one patient may have two or more pressure harms.

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.

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





Performance

There has been a decrease in the number of pressure harms reported in month, across the community settings, but an increase in the acute setting.

There were 39 (28 in October) hospital-acquired pressure harms during November. This increase follows the reduction seen last month.

- Twenty-two harms occurred over three wards, none of which was previously a top contributor. These three wards will be the focus for extra support.
- Previous top contributing wards have maintained their improved performance.
- An increase was seen in the number of category 1 cases reported. This is seen as best practice, as detecting harm early allows intervention to prevent more severe damage developing. Two were reported in October and nine in November (these are not included in the 39 cases).
- There were six device-related harms, five of which were caused by oxygen nasal tubing. Following successful trials of a product with pressure-relief built in, this will now be rolled out across the hospital.
- A tissue viability nurse masterclass scheduled for January was booked up within three days of being publicised, reflecting ongoing high engagement from ward teams. Additional dates are being planned.

In the community setting there were 34 (43 in October) pressure harms acquired during November. This is a further decrease from the previous month and involved 30 patients in total.

Four patients resided in residential homes and account for a total of six harms. Thirteen patient were receiving complex care packages.

- The new Pressure Ulcer Risk Assessment Tool – 'Purpose T' with newly developed pathways has been successfully implemented with 32 sessions delivered to over 200 clinicians.
- The equipment board has agreed addition core stock lines (e.g. specific air beds) to support rapid implementation of pressure relieving equipment at End of Life.

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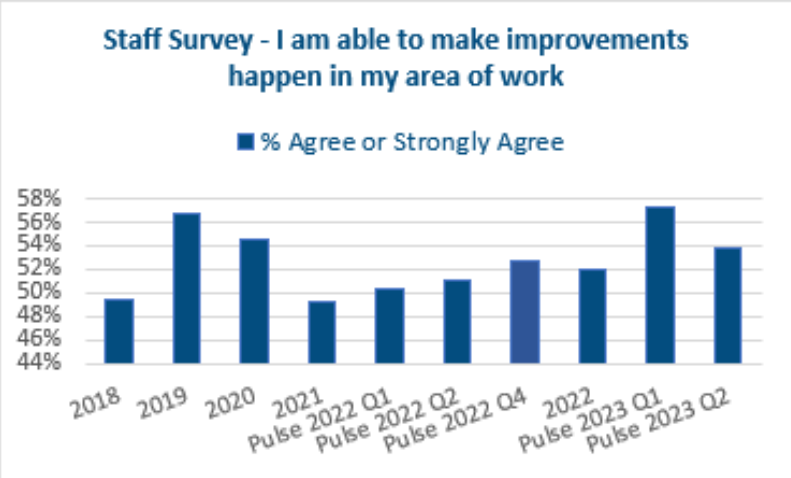
Great Western Hospitals NHS Foundation Trust

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 took place in November.
- Staff Survey initial data available and analysis is underway.
- Divisional data for results will be available shortly, this will be shared with Divisions to review their A3's. Some departments have recently changed their breakthrough questions, these are as followed
  - ICC – EDI question
  - Medicine – Recommend a place to work
  - SW&C – I can make improvements in my area of work
  - Corporate – I can make improvements in my area of work
- Staff Survey working group to review progress and support refresh A3, develop and implement countermeasures.

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.

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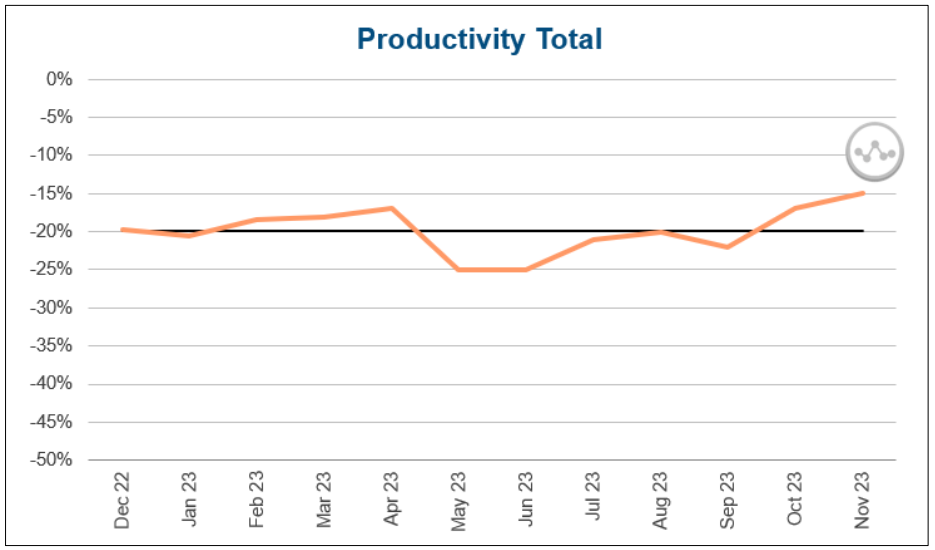
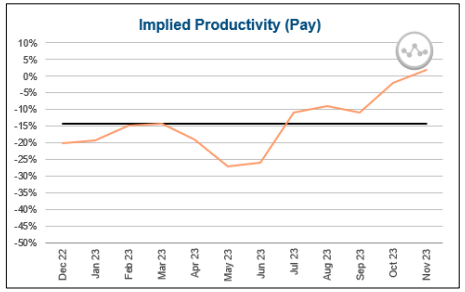
Great Western Hospitals NHS Foundation Trust

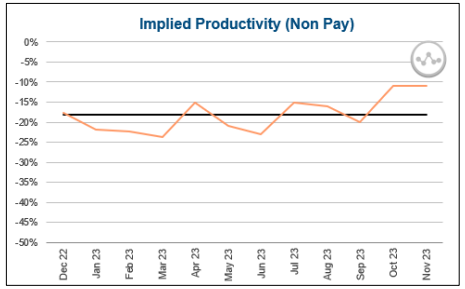
Productivity

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



Common cause – no significant change





Understanding the Data

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

We are driving this measure because…

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

Risks

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

Performance & Countermeasure

Implied Productivity for the Trust in total is recovering and has improved to an overall total **–15%** for Month 8 (this is a 3% improvement from the 18% at the end of 2022/23 - March 2023).

The further 2% improvement from last month (M7) reflects further improvement in the overall Trust financial position in Month 8 due mostly to funding received for industrial action and ERF activity (£5m total) but this is largely not within divisions but instead held centrally. The position does still reflect being off track with some of our activity and financial plan due to higher pay pressures such as pay awards, temporary staffing and behind plan CIP Delivery. The measure continues to be against 2019/20 cost change as it is measuring the increased cost from 2019/20 levels.

The activity positions were previously re-forecasted for the remainder of the year and there is recovery in some of these forecasts for Months 8-12 that recovers towards the scenario 3b activity plans.

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

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

□ur Care

□lerting Watch □etrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		68%	46%	69%	54%	
IP & C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		1	1	1	1	
	Clostridium difficile (C. diff) infections (cumulative)	30.67 (Nat)		38	44	54	56	
	Escherichia coli (E. coli) infections (cumulative)	44 (Nat)		45	53	61	65	
	Pseudomonas infections (cumulative)	9.33 (Nat)		18	20	22	24	
	Klebsiella infections (cumulative)	14.67 (Nat)		16	21	28	34	
FFT	Daycases Response Rate	25% (Int)		22%	22%	23%	24%	
	Daycases Positive Responses	98% (Int)		94%	95%	95%	96%	
	Maternity Response Rate	18% (Int)		17%	16%	16%	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 decreased in November with the main driver capacity to deliver. Pals continue to support Division's with response writing to expedite cases were possible. The Pals team have delivered two days of complaint writing training to upskill staff new to the responsibility of investigating manager.

The Trust remains above trajectory for all three gram-negative bloodstream infections (*E. coli, Klebsiella and P. aeruginosa*) and for *C. difficile,* however monthly rates for all but *Klebsiella* have reduced over time.

The IPC team's focus on mouthcare – important in the prevention of hospital-acquired pneumonia which is a common cause of *Klebsiella* BSI – continues, with teaching on all wards, at handovers and via resources such as posters. This has been a multi-disciplinary project with support from dental specialists, teaching of junior doctors, and a grand round scheduled for the Spring. There has also been an increase in community-onset *Klebsiella* cases which we have highlighted to the Integrated Care Board, the reasons for which are not understood.

The Division of Medicine continue to work to an A3 on *E. coli* reduction, primarily focused on catheter care, which is being supported by the IPC team and appears to be driving improvements in practice and in the timely removal of catheters.

The rate of *Pseudomonas* infection has reduced markedly since the summer, when interventions on water hygiene were implemented. Although not acquired at GWH, half of cases since July have related to one patient with a persistent infection, yet these are attributed to the organisation due to UKHSA's classification criteria.

There has been a slight increase in both the day case response rate and day case positive response rate. The maternity response rate is the same as the previous two month. All remain just below the internal target.

□ur Care

Non□□lerting Watch □etrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23
Harm	No. of serious incidents reported in month	SPC		3	2	8	5
	Falls rate per 1000 bed days	SPC		4.8	5.4	5	4.2
	No. of Falls in month	SPC		90	105	98	80
	No. falls with moderate harm or above	SPC		2	3	2	2
	Medication incidents with moderate harm	SPC		1	3	5	4
Concerns and Complaints	No. of concerns received	SPC		127	158	140	166
	No. of complaints received	SPC		67	59	46	62
	Number of reopened complaints	SPC		4	3	3	1
IP&C	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative)	28 (Int)		15	15	17	20
	Covid – no. of hospital acquired	SPC		21	20	10	15

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

Performance & Counter Measure

There are 29 ongoing Serious Incidents (SI) , with a further five reported in month. Three Serious incidents are reported under the Maternity/Neonatal Care, but no common theme was identified in these SIs. One incident was reported as a Never Event on STEIS under the wrong side nerve block and one is related to a retained guidewire fragment following a Cath lab procedure, this incident has since been designated a Never Event.

The PSIRF plan and policy have been approved by the Integrated Care Board. An internal decision is now to be agreed regarding ceasing to declared SI's and move fully to the new framework. Initial meeting scheduled end of January 2024 to agree timeframes.

There has been an increase in both the number of complaints and concerns in month, but the number of complaints reopened has decreased. Themes remain unchanged related to waiting times, communication, environment and staff attitude and behaviour.

Data from the lying and standing blood pressure audit has shown a further improvement in November. Any assessments noted as outstanding in the monthly audit are shared back to the ward managers to address.

The enhanced care project commenced in November, with the early stages involving; developing and testing the assessment cycle, developing consistent standards, training and identifying barriers.

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

Risks

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

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	90%	92%	93%	94%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	100%	108%	107%	106%
FFT	Overall response rate (%)	29% (Int)	?	33%	31%	29%	27%
	Positive response (%)	86% (Int)	?	89%	87%	87%	88%
	ED & UTC Response Rate	21% (Int)	?	20%	21%	19%	19%
	ED & UTC Positive Responses	81% (Int)	?	80%	77%	78%	78%
	Inpatients Response Rate	27% (Int)	?	27%	24%	25%	25%
	Inpatients Positive Responses	86% (Int)	?	83%	80%	80%	83%
	Outpatients Positive Responses	98% (Int)	?	97%	96%	97%	98%
	Maternity Positive Responses	94% (Int)	?	95%	86%	95%	92%

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

Performance & Counter Measures

Safe Staffing fill rates have improved further in month and for the third consecutive month and are within safe parameters.

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

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

- The Trust has received an official presentation of Gold Employee Recognition Scheme award as part of our Armed Forces Covenant commitment
- An engagement and codesign workshop has been held with patients with Learning Disabilities and Autism to inform our new Emergency Department design and pathways
- The spinal cord injury coproduction group is progressing with development of a new passport to support care and meet requirements following national patient safety alert
- The next leadership behaviour master class planned (December) with patient first as topic including patient experience and engagement
- Carers Awareness Day – many events supported including; attendance at local Carers event to promote GWH support for carers, a stand held at 'Stop the pressure' day offering support to staff and collaboration with Alzheimer's UK and Admiral nurses attending carers café.
- A Schwartz round has been held with carers hearing from staff with personal experience of caring and managing work life balance.

□ur □erformance

□lerting Watch □etrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23	Trend
RTT	No. of >=18 weeks waiters		H	18285	19161	19028	17809	
	No. of >=52 weeks waiters		H	2418	2307	2238	2031	
DM01	No. of patients on DM01 waitlist		H	12989	13843	15095	One month behind	
	DM01 performance %	99% (Nat)	F	44.5%	46.1%	45.0%	One month behind	
	DM01 6 week wait breaches		H	7208	7462	8301	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	59.5%	49.0%	61.1%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	84.9%	81.0%	83.6%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	54.0%	54.0%	39.0%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	62.6%	62.0%	58.2%	One month behind	
	No. of referrals received		H	1828	1934	1983	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

November's DM01 validated performance is showing an increase in performance variance from the 45.01% performance in October to 49.48%. The number of patients on the waiting list has increased to 15380 but the number of 6-week breach has decreased to 7770 driven by Ultrasound, ECHO and DEXA. The 3 Pads in Radiology continue to be fully utilised with all supporting the CDC (CT, MRI and Endoscopy), and activity numbers continue to remain high for the imaging vans with Endoscopy usage improving. The teams continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Ultrasound still remains the largest issue with 7407 on the waiting list and 5121 over 6 weeks. Sleeps studies have recruited with a December start date to help recover the numbers. Endoscopy continue to work with InHealth to improve the performance of the mobile Endoscopy unit.

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathway with 45% of the breaches being accounted for by this service. WLI activity is being used to help manage demand. A locum has been employed to cover the regular locum's extended leave until December. Additional capacity in Plastics is being sourced through private partner (CSP in Wootton Bassett) and through any available mutual aid from OUH.

73.3% 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 44.4% of all of the breaches. Breast pathways accounted for 22.2% of total breaches

In October, 82% (561) 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.

External Derm team to provide 600 additional slots over 3 weeks to clear ASI wait lists. Provision to include see and treat where possible. Planning to commence January/February 2024.

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

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

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

□ur □erformance

□lerting Watch □etrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	74.2%	74.7%	71.5%	71.4%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	6.9%	8.3%	8.5%	8.9%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	52.5%	54.7%	48.5%	48.7%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	13.9%	16.9%	17.1%	17.8%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	95.8%	93.8%	94.2%	94.1%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	1340.62	2862.13	2555.40	2708.18	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1478	1384	1506	1447	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	78%	85%	90%	88%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	907	989	1110	1018	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	48.0%	61.1%	66.1%	62.2%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	470	685	695	646	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	24.9%	42.3%	41.4%	39.5%	
Flow	Average hours lost to ambulance handover delays per day	SPC	H	43	95	82	90	
	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	295	307	334	325	
	Number of Stranded Patients (over 14 days)	SPC	H	119	136	129	129	
	Number of Super Stranded Patients (over 21 days)	SPC	H	67	83	77	78	

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 sable at to 71.4% from 71.5% with type 1 4 hours performance stable at 48.7% from 48.5%.

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

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 slightly from 17.1% to 17.8%.
- Number of ambulance handovers over 30 minutes have seen a rise from 1110 to 1118.
- Number of ambulance handovers over 60 minutes have decreased from 695 to 646.

Winter pressures has arrived in November with several trusts including GWH coming under pressure especially with Paeds attendances. Trust wide Ambulance Handover improvement plan initiated at the end of November.

Counter measures remain in place within the Breakthrough objective slides.

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

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

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23
RTT	No. of >=78 weeks waiters	SPC	L	3	1	1	2
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.1%	0.1%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5207	5236	5054	5236
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	70.9%	73.6%	73.1%	72.1%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		52.9%	48.0%	48.9%	45.2%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		42.3%	51.2%	39.6%	40.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	187	195	202	211
	Emergency Care - AED - Median Stay	240 (Int)		240	238	292	300
	Emergency Care - UTC - Median Stay	240 (Int)	P	139	158	151	164
	Total Number of Ambulance Handovers	SPC	L	1888	1619	1680	1637

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

Number of conveyances dropped from previous month (1680 to 1637) which could indicate work to encourage SWAST crews to call before conveying has helped. XCAD to be delivered in December.

Triage performance by ambulance has remained static but should improve next month as the 2nd pitstop has been opened improving flow for the ambulatory pathway.

Triage performance in UTC has improved from 39.6% to 40.6%. ED triage performance has decreased to 45.2 from 48.9%.

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23
Flow	Admitted - Average Length of Stay in Department (mins)	SPC	H	621	793	749	746
	Elective Patients Average Length of Stay (Days)	SPC	L	2	3	3	2
	Non-Elective Patients Average Length of Stay (Days)	SPC		5	6	6	6
	Community Average Length of Stay (Days)	SPC		20	16	17	14
	GWH Discharges by Noon (%)	SPC		17.7%	16.1%	16.4%	16.0%
	Adult general and acute type 1 bed occupancy	SPC		98.4%	98.7%	94.9%	94.7%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC		20.4%	19.6%	19.3%	17.1%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.2%	95.2%	95.0%	95.2%

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

Performance & Counter Measure

Community average LOS continues to decrease with is within target and continue to report on NCTR within the community to ensure robust monitoring.

Reduced change in discharges before noon, Utilising Discharge Lounge for warranting earlier flow within division, highlighting 'golden' patients the day before whilst highlighting discharges for 'tomorrow' on Nerve Centre.

A slight reduction in the NCTR Bed Days (%), after the Discharge Hub meetings taking place with locality leads 3 times a day (5 days a week) and twice over the weekend.

Risks

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non □lerting Watch □etrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23
Use of Resources	Capital Expenditure (£'000)	SPC		3861	733	2606	2187
	Pay (£'000)	SPC		25776	25468	25350	25419
	Non Pay (£'000)	SPC		15729	15038	14750	16097

Performance & Counter Measure

Capital spend in M8 was £2.2m, which is £0.9m ahead of plan in month. The overerspend is driven by estates replacement schemes and integrated front door costs. 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 £0.1m higher than M7 driven by backdated consultant costs relating to prior years.

Non-Pay is £1.3m higher than M7 due to accrued costs relating to CDC (offset by accrued income).

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

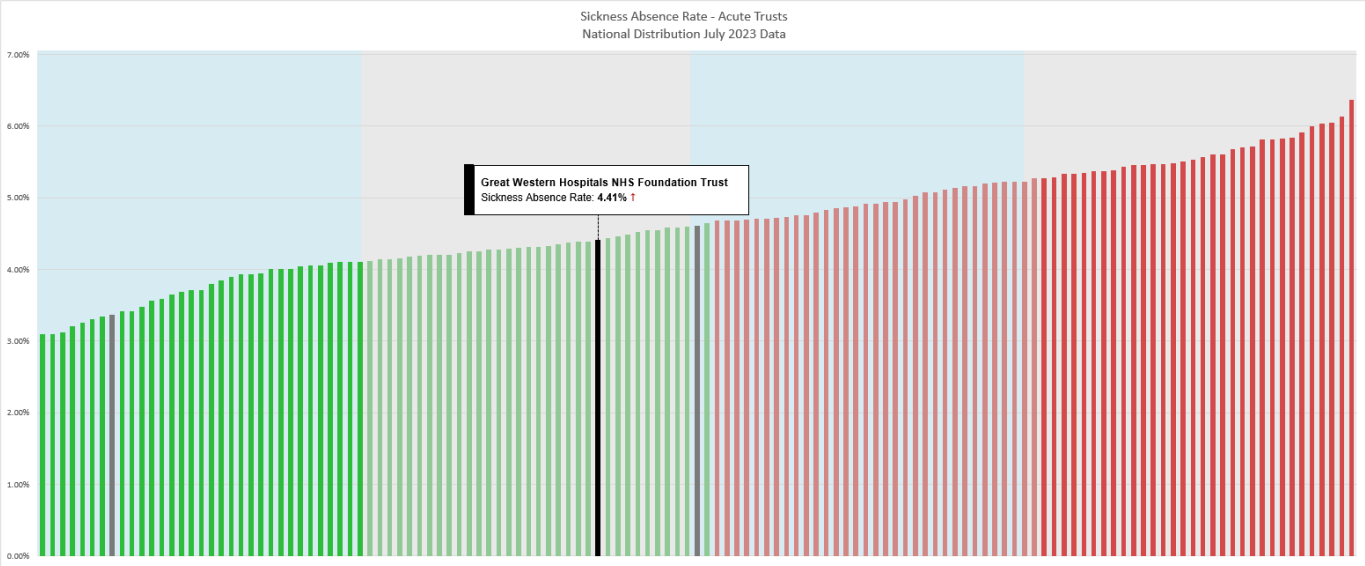
The Trust started the year with a £16.67m cash releasing efficiency plan, which includes a £2.98m carry over from 22/23. As at Month 8, the programme is £1.6m under plan, an improvement of £0.5m from M7 due to additional savings recorded in Medicine division.

Out of the £16.67m target, £6.9m is fully developed, in line with M7. 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	Aug-23	Sep-23	Oct-23	Nov-23	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.0%	4.2%	4.7%	One month behind	



Performance & Counter Measure

- In-month sickness absence has increased again in October from 4.2% to 4.7%, alerting above the Trust KPI of 3.5%. Long term sickness has increased to 2.2% in October, and a larger increase has been seen with short term sickness rising to 2.6%. Whilst this is a higher position than recent months, it remains below last year's sickness rate of 5.3%.
- The Trust Absence Working Group is encouraging managers to engage in HR support with audits of their sickness management practice with a view to ensure full utilisation of return to work meetings, early identification of trends and themes, and timely progression to appropriate management with policy and Health & Wellbeing support.
- Current national benchmarking data (July 2023 - NHS Digital) shows a further increase to the national sickness rate, increasing from 4.51% in May to 4.76% in July. For the South West Region absence also increased in this period from 4.34% to 4.69% with deterioration in the absence rate also present at system level, moving from 4.24% to 4.61%. The absence rate for GWH increased from 3.74% to 4.41% in July, which remains below both the national and regional position.

Risks

- Increased 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. The HR team is currently fully established with new recruits being trained on Trust/local policy and procedures.

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

Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-23	Sep-23	Oct-23	Nov-23
Workforce	% of leavers within 1st year of employment	14.8% (Int)		14.0%	14.3%	14.1%	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

- Leavers within the 1st year of employment has been changed to a rolling 12-month metric to better understand the trend of these leavers over time. The target for this metric has been set using the average figure over the last 12 months (14.8%).
- Staff survey response rates for the 2023 Annual Staff Survey was 69% which is 10% above last year and the highest response rates with the provider Picker..
- We await the annual staff survey results for comparisons on two key questions on well-being and EDI during promotions and career development.

Risks

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

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

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Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Trend Vs	
	Vacancy																	
W	Vacancy Rate	%	7.00%	5.97%	6.23%	7.43%	6.40%	5.30%	7.52%	8.06%	7.94%	7.80%	5.95%	4.87%	4.33%	3.93%	↓	↓
W	Vacancy Rate	WTE	-	313.11	329.52	392.94	335.02	276.66	401.58	437.89	431.29	423.68	320.44	262.33	232.95	211.39		
W	All Nursing Vacancy	%	7.00%	5.27%	5.62%	6.51%	5.20%	3.65%	4.50%	4.95%	5.38%	5.00%	2.73%	1.96%	1.30%	1.94%	↑	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	135.61	146.64	170.25	135.53	94.47	117.71	132.11	143.74	133.58	71.58	51.43	34.17	51.03		
W	All Registered Nursing Vacancy	WTE	-	87.51	91.41	92.65	77.18	43.38	84.20	97.00	107.48	103.62	74.83	47.47	18.62	26.55		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	43.73	54.94	47.18	36.73	27.43	27.90	44.94	53.47	59.84	42.58	23.20	3.60	8.44		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	48.10	55.23	77.60	58.35	51.09	33.51	35.11	36.26	29.96	-3.25	3.96	15.55	24.48		
W	Medical Vacancy	%	7.00%	5.80%	5.43%	5.61%	8.49%	6.86%	9.35%	10.14%	9.93%	10.34%	7.28%	5.22%	5.66%	5.26%	↓	↓
W	Medical Vacancy	WTE	-	40.74	38.33	39.16	59.19	47.86	67.29	74.56	73.05	76.03	53.43	38.22	41.48	38.61		
W	STT/AHP Vacancy	%	7.00%	6.09%	6.54%	6.97%	6.29%	7.66%	11.10%	12.48%	12.69%	13.04%	13.04%	10.41%	9.20%	6.88%	↓	↑
W	STT/AHP Vacancy	WTE	-	50.49	54.28	57.85	51.64	63.84	94.86	107.82	110.17	113.09	112.95	90.28	79.85	58.89		
W	SMA Vacancy	%	7.00%	7.55%	7.88%	10.97%	7.96%	6.37%	10.62%	10.60%	9.01%	8.71%	7.13%	7.12%	6.70%	5.44%	↓	↓
W	SMA Vacancy	WTE	-	86.27	90.27	125.68	88.66	70.50	121.73	123.41	104.33	100.98	82.48	82.40	77.45	62.86		
W	Recruitment Time to Hire - Trust Sub	Days	46.00	74.30	72.30	91.30	50.90	54.50	52.90	50.60	47.60	49.10	45.00	41.70	42.70	41.80	↓	↓
W	Recruitment Time to Hire - Trust Bank	Days	46.00	0.00	0.00	0.00	117.90	127.80	118.00	58.50	26.90	50.40	46.00	43.50	37.00	39.90	↑	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	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	5,379.33	5,382.66		
W	Budgeted vs Worked WTE Variance	WTE	-	184.20	87.52	51.09	109.88	237.86	31.62	45.85	51.23	4.21	131.68	70.68	132.30	203.43		
W	Actual Worked vs Budgeted %	%	-	3.51%	1.65%	0.97%	2.10%	4.55%	0.59%	0.84%	0.94%	0.08%	2.45%	1.31%	2.46%	3.78%		
W	Total Workforce Cost £	£	-	£24.05M	£23.64M	£22.93M	£24.66M	£23.73M	£23.85M	£23.98M	£25.73M	£24.82M	£24.44M	£26.42M	£25.68M	£24.85M		
W	Agency Spend as % of Total Spend	%	4.50%	6.17%	5.97%	5.60%	4.98%	5.35%	3.41%	5.55%	3.41%	4.18%	2.62%	3.11%	4.32%	3.73%	↓	↓
W	Agency Spend £	£	-	£1.48M	£1.41M	£1.28M	£1.23M	£1.27M	£0.81M	£1.33M	£0.88M	£1.04M	£0.64M	£0.82M	£1.11M	£0.93M		
W	Agency Target £	£		-	-	-	-	-	£1.21M	£1.04M	£0.88M	£0.76M	£1.06M	£1.17M	£1.07M	£0.91M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-	-	-	-	-	-£0.40M	£0.29M	£0.00M	£0.28M	-£0.42M	-£0.35M	£0.04M	£0.01M	↓	↓
W	Agency WTE	WTE	-	113.12	109.26	102.88	90.00	106.82	90.76	105.02	96.40	94.71	78.85	74.91	59.88	57.41		
W	Bank WTE	WTE	-	354.47	278.67	310.93	323.25	377.11	303.84	351.68	355.36	303.23	347.55	235.16	278.50	332.80		
W	Registered Nursing Bank Fill	%	45.00%	53.80%	43.60%	52.86%	55.30%	54.71%	57.70%	57.91%	54.99%	54.47%	53.30%	54.80%	62.68%	66.38%	↑	↑
W	Unregistered Nursing Bank Fill	%	70.00%	70.85%	62.98%	74.32%	71.78%	77.63%	83.58%	81.52%	80.82%	79.98%	77.52%	81.35%	79.95%	84.45%	↑	↑

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Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Trend Vs	
	Retention																	
W	All Turnover %	%	13.00%	14.52%	14.90%	14.84%	14.42%	14.48%	13.79%	13.88%	13.27%	12.74%	12.69%	12.56%	12.20%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	11.54%	11.84%	11.57%	11.25%	11.16%	10.54%	10.52%	10.17%	9.67%	9.62%	9.52%	9.20%	-	↓	↓
W	Number of Leavers	Headcount	-	54	69	74	43	79	33	62	52	53	48	63	39	-		
W	Number of RN Leavers	Headcount	-	6.00	14.00	16.00	8.00	17.00	7.00	15.00	16.00	12.00	14.00	18.00	10.00	-		
W	Registered Nursing Vol Turnover	%	-	8.92%	8.79%	8.58%	7.99%	7.83%	7.05%	6.82%	6.82%	6.59%	6.66%	6.55%	6.62%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	17.00	19.00	15.00	12.00	12.00	8.00	12.00	10.00	7.00	13.00	21.00	10.00	-		
W	Unregistered Nursing Vol Turnover	%	-	15.62%	16.37%	16.73%	16.57%	15.95%	15.46%	15.17%	13.99%	13.02%	12.83%	13.35%	12.65%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	14.45%	16.15%	15.51%	15.81%	15.23%	14.56%	14.29%	13.60%	15.53%	13.95%	14.33%	14.05%	-		
W	Number of starters	Headcount	-	85	56	107	72	77	75	66	64	108	61	114	61	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	5.11%	5.34%	5.23%	5.10%	5.02%	4.85%	4.70%	4.60%	4.58%	4.53%	4.50%	4.45%	-	↓	↓
D	Sickness Absence %	%	3.50%	4.87%	5.79%	4.90%	4.53%	4.63%	3.85%	3.68%	3.77%	4.42%	4.03%	4.23%	4.74%	-	↑	↓
W	Long Term Sickness %	%	2.00%	2.36%	2.50%	2.52%	2.24%	2.27%	2.13%	2.06%	2.16%	2.61%	2.20%	2.12%	2.15%	-	↑	↓
W	Short Term Sickness %	%	1.50%	2.51%	3.29%	2.38%	2.29%	2.36%	1.72%	1.61%	1.61%	1.81%	1.84%	2.12%	2.59%	-	↑	↑
W	Sickness Absence Cost £	£	-	£650.4k	£749.9k	£687.4k	£575.4k	£675.3k	£546.9k	£574.4k	£550.4k	£664.8k	£626.3k	£614.8k	£738.9k	-		
W	WTE Days Lost	WTE	-	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	6,401.2	7,487.3	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	86.39%	86.40%	86.61%	86.79%	87.69%	89.20%	90.27%	89.81%	89.90%	90.10%	90.36%	90.75%	91.38%	↑	↑
W	Role Essential MT %	%	85.00%	88.75%	88.94%	89.06%	89.03%	89.66%	90.92%	91.59%	91.37%	91.40%	91.64%	91.93%	92.20%	92.77%	↑	↑
W	CQC Safe MT %	%	85.00%	84.10%	83.93%	84.18%	84.54%	85.71%	87.48%	88.95%	88.25%	88.38%	88.56%	88.78%	89.32%	90.01%	↑	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	-	-	-	-	-	59.32%	64.39%	73.18%	76.28%	79.91%	82.14%	83.26%	83.85%	↑	↓
W	Appraisal Compliance %	%	85.00%	79.31%	81.43%	81.16%	83.33%	82.25%	83.11%	82.18%	83.86%	83.94%	84.29%	84.88%	84.92%	83.62%	↓	↑
W	Non Medical Appraisal Compliance %	%	85.00%	79.18%	81.33%	80.99%	83.02%	81.77%	82.91%	81.80%	83.53%	83.74%	84.27%	84.88%	84.92%	83.68%	↓	↑
W	Medical Appraisal Compliance %	%	85.00%	82.84%	84.13%	85.44%	91.07%	93.90%	87.90%	88.00%	91.81%	88.64%	84.64%	84.84%	85.04%	82.25%	↓	↓

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Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Trend Vs	
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.22%	4.18%	4.17%	4.21%	4.19%	4.14%	4.12%	4.12%	4.13%	4.17%	4.18%	4.12%	4.21%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	255.00	254.00	250.00	253.00	253.00	249.00	251.00	251.00	252.00	257.00	260.00	258.00	265.00		
W	% of Leadership Roles who are Female (B8a+)	%	-	71.37%	71.26%	71.20%	71.54%	70.75%	70.68%	70.92%	70.52%	70.24%	70.82%	71.15%	70.93%	71.32%		
W	% of Leadership Roles who from BME (B8a+)	%	-	5.10%	5.12%	5.20%	5.14%	5.14%	5.22%	5.58%	5.58%	5.95%	6.61%	6.54%	6.20%	6.79%		
W	Staff in Leadership Roles % (B8c+)	%	-	0.98%	0.97%	0.92%	0.93%	0.91%	0.95%	0.95%	0.95%	0.93%	0.93%	0.92%	0.91%	0.92%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	59.00	59.00	55.00	56.00	55.00	57.00	58.00	58.00	57.00	57.00	57.00	57.00	58.00		
W	% of Leadership Roles who are Female (B8c+)	%	-	57.63%	57.63%	60.00%	60.71%	58.18%	57.89%	58.62%	56.90%	56.14%	56.14%	56.14%	56.14%	56.90%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.08%	5.08%	5.45%	5.36%	5.45%	5.26%	5.17%	5.17%	5.26%	5.26%	5.26%	5.26%	5.17%		
W	% of Leadership Roles who are disabled (B8c+)	%	-	0.00%	0.00%	0.00%	0.00%	0.00%	1.75%	1.72%	1.72%	1.75%	1.75%	1.75%	1.75%	1.72%		
W	Male % of Workforce	%	-	17.36%	17.38%	17.55%	17.50%	17.71%	17.63%	17.75%	17.83%	17.90%	18.10%	18.16%	18.36%	18.40%		
W	Female % of Workforce	%	-	82.64%	82.62%	82.45%	82.50%	82.29%	82.37%	82.25%	82.17%	82.10%	81.90%	81.84%	81.64%	81.60%		
W	BME % of Workforce	%	-	21.83%	21.94%	22.54%	22.75%	23.24%	23.60%	24.22%	24.19%	24.49%	25.06%	25.18%	25.47%	25.68%		
W	White % of Workforce	%	-	69.33%	69.16%	68.74%	68.71%	68.25%	68.07%	67.43%	67.29%	67.08%	67.03%	66.86%	66.58%	66.32%		
W	ER Cases Closed	Number	-	39	44	48	57	65	43	56	54	59	20	32	25	23		

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Great Western Hospitals NHS Foundation Trust

Workforce Scorecard □Workforce □lanning

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

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

Performance & Counter Measure

- In M8 there has been a slight increase to our establishment of 3WTE cost neutral changes within Corporate Services and movement of Locum budget in Medicine to substantive WTE. Our establishment WTE remains below plan by 9WTE and within the control total of 5,4414WTE. (ED right sizing has yet to be included in establishment).
- 5,561WTE was utilised in M8 to deliver our services, above our establishment by 179WTE. Further growth to our contracted position in-month means we have continued above our planned position for substantive WTE however still within our establishment. Additional temporary staffing usage in-month (390WTE) has moved us into an over-utilised position.
- Establishment control processes introduced in May have maintained their positive effect, with our establishment remaining in line with plan. Workforce controls are now focussing on further managing our substantive and temporary staff WTE position, alongside continuation of divisional Bank/Agency reduction workstreams.

Risks & Mitigations

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

Our People

Workforce Costs by Staff Group

Staff Group	Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD
Registered Nursing	RGN Sub £	£6,816,804	£6,873,404	£7,587,096	£7,009,523	£7,148,967	£7,089,588	£7,267,579	£7,310,423	**£57,103,385**
	RGN Bank £	£874,747	£687,407	£704,551	£651,544	£700,835	£610,086	£593,390	£553,739	**£5,376,298**
	RGN Agency £	£362,659	£385,349	£393,332	£388,506	£369,005	£387,236	£288,554	£249,411	**£2,824,052**
	Budget £	£7,726,976	£7,377,583	£8,423,594	£7,811,044	£7,772,173	£7,955,310	£8,609,071	£8,077,545	**£63,753,296**
	Actual Cost £	£8,054,210	£7,946,160	£8,684,979	£8,049,574	£8,218,807	£8,086,909	£8,149,523	£8,113,573	**£65,303,735**
	Variance to Budget £	£327,234	£568,577	£261,385	£238,530	£446,634	£131,599	-£459,548	£36,028	**£1,550,439**
Unregistered Nursing	UR Sub £	£2,248,955	£2,401,458	£2,600,592	£2,396,310	£2,465,217	£2,395,713	£2,356,200	£2,376,329	**£19,240,773**
	UR Bank £	£383,425	£405,741	£369,631	£400,036	£367,052	£315,117	£310,343	£283,167	**£2,834,512**
	UR Agency £	£510	£0	£177	£2,721	-£1,925	£168	£2,401	-£2,220	**£1,831**
	Budget £	£2,416,017	£2,401,136	£2,718,394	£2,514,957	£2,515,316	£2,555,614	£3,109,488	£2,080,592	**£20,311,514**
	Actual Cost £	£2,632,891	£2,807,199	£2,970,400	£2,799,066	£2,830,343	£2,710,997	£2,668,944	£2,657,275	**£22,077,116**
	Variance to Budget £	£216,874	£406,063	£252,006	£284,109	£315,027	£155,383	-£440,544	£576,683	**£1,765,602**
Medical and Dental	M & D Sub £	£5,494,571	£5,302,186	£5,549,823	£5,640,491	£5,444,620	£7,513,085	£6,277,312	£6,036,910	**£47,258,998**
	M & D Bank £	£863,619	£609,769	£773,185	£1,090,997	£1,036,278	£1,019,057	£711,536	£516,663	**£6,621,104**
	M & D Agency £	£470,541	£786,209	£370,137	£552,112	£181,897	£474,049	£665,596	£674,770	**£4,175,311**
	Budget £	£6,259,166	£6,777,818	£6,490,677	£6,524,764	£6,560,711	£8,659,913	£5,739,540	£6,204,031	**£53,216,620**
	Actual Cost £	£6,828,731	£6,698,164	£6,693,145	£7,283,600	£6,662,795	£9,006,191	£7,654,444	£7,228,343	**£58,055,413**
	Variance to Budget £	£569,565	-£79,654	£202,468	£758,836	£102,084	£346,278	£1,914,904	£1,024,312	**£4,838,793**
AHP and STT	AHP/STT Sub £	£2,805,608	£2,756,981	£3,176,461	£2,886,789	£2,889,128	£2,915,441	£3,207,907	£3,014,536	**£23,652,851**
	AHP/STT Bank £	£68,831	£60,187	£69,503	£87,766	£79,123	£67,747	£88,723	£81,834	**£603,715**
	AHP/STT Agency £	£43,181	£91,764	£63,015	£38,272	£51,346	£12,680	£42,488	£42,523	**£385,269**
	Budget £	£2,956,319	£3,025,499	£3,421,800	£3,108,596	£3,098,061	£3,165,340	£2,685,033	£3,117,452	**£24,578,100**
	Actual Cost £	£2,917,619	£2,908,932	£3,308,979	£3,012,827	£3,019,597	£2,995,867	£3,339,118	£3,138,894	**£24,641,834**
	Variance to Budget £	-£38,700	-£116,567	-£112,821	-£95,769	-£78,464	-£169,473	£654,085	£21,442	**£63,734**
Admin & Clerical	Admin Sub £	£3,351,090	£3,394,774	£3,878,898	£3,482,592	£3,515,274	£3,557,858	£3,624,369	£3,616,728	**£28,421,582**
	Admin Bank £	£131,134	£160,120	£137,290	£133,670	£154,871	£112,014	£130,320	£135,177	**£1,094,596**
	Admin Agency £	-£63,795	£68,232	£51,429	£56,454	£41,207	-£53,401	£110,323	-£36,898	**£173,551**
	Budget £	£3,352,314	£3,476,831	£3,969,533	£3,691,028	£3,670,144	£3,574,755	£7,177,614	£4,739,527	**£33,651,746**
	Actual Cost £	£3,418,429	£3,623,125	£4,067,616	£3,672,716	£3,711,352	£3,616,471	£3,865,012	£3,715,008	**£29,689,729**
	Variance to Budget £	£66,115	£146,294	£98,083	-£18,312	£41,208	£41,716	-£3,312,602	-£1,024,519	**-£3,962,017**
Total	Total Sub £	£20,717,029	£20,728,802	£22,792,870	£21,415,704	£21,463,206	£23,471,685	£22,733,367	£22,354,926	**£175,677,589**
	Total Bank £	£2,321,756	£1,923,225	£2,054,160	£2,364,014	£2,338,158	£2,124,020	£1,834,312	£1,570,580	**£16,530,225**
	Total Agency £	£813,095	£1,331,554	£878,090	£1,038,065	£641,530	£820,731	£1,109,362	£927,586	**£7,560,013**
	Budget £	£22,710,792	£23,058,867	£25,023,998	£23,650,389	£23,616,405	£25,910,932	£27,320,746	£24,219,147	**£195,511,276**
	Actual Cost £	£23,851,880	£23,983,581	£25,725,120	£24,817,783	£24,442,894	£26,416,436	£25,677,041	£24,853,093	**£199,767,827**
	Variance to Budget £	£1,141,088	£924,714	£701,122	£1,167,394	£826,489	£505,504	-£1,643,705	£633,946	**£4,256,551**

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

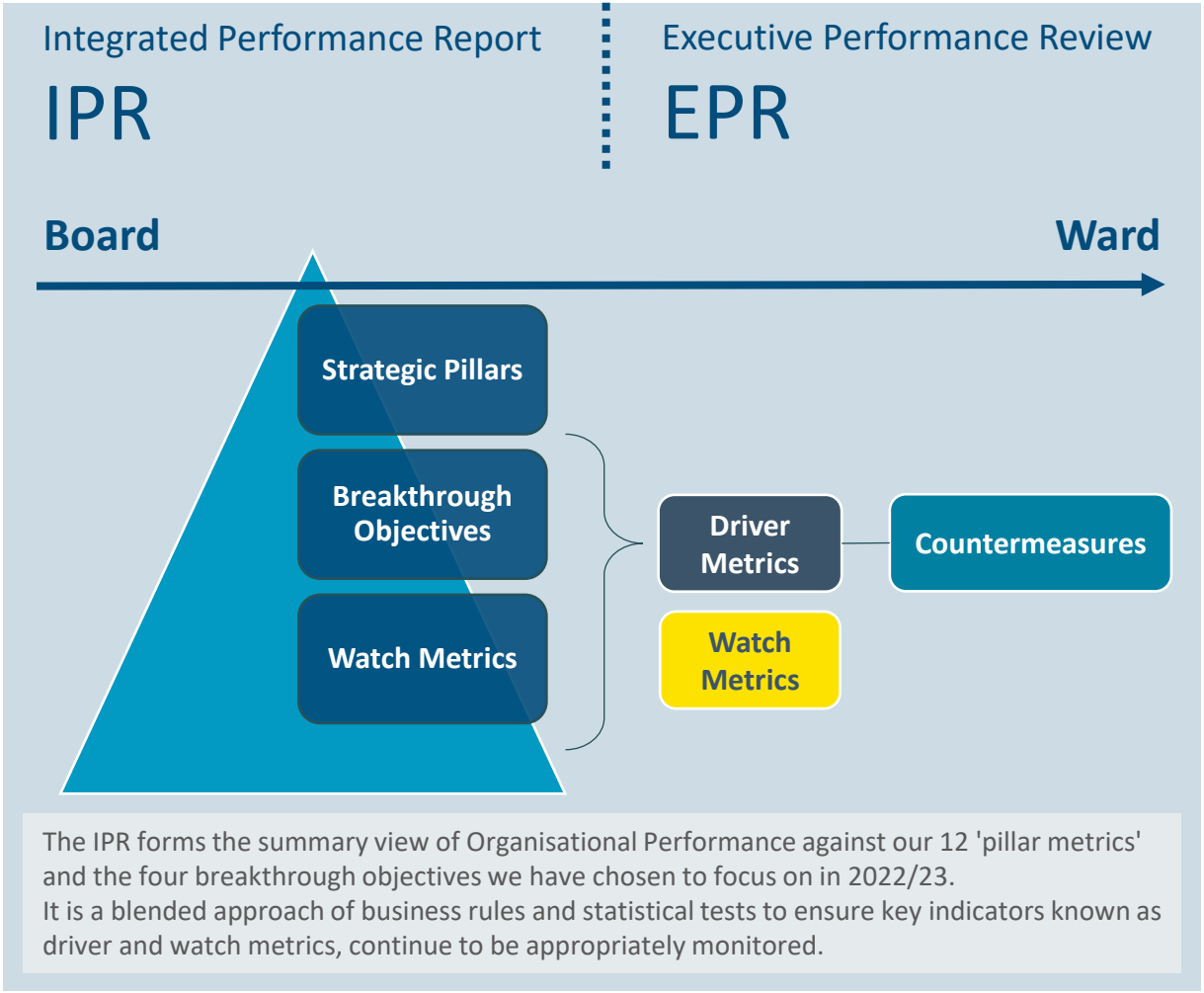
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- 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.

□ur vision □ strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

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

□ur 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 □lanning Framework

Great Western Hospitals NHS Foundation Trust

Our Vision

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

1 Our four strategic pillars

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

1 Leadership & Management Capability

2 The Way Forward Programme

3 Digital First

4 System & Place

5 Improving Together

4 Overlap

Corporate Projects

e.g. Electronic Patient Record

e.g. The Great Care Campaign

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

BTO Productivity

BTO Staff Survey = % improvements

BTO Time to Clinically Ready to Proceed

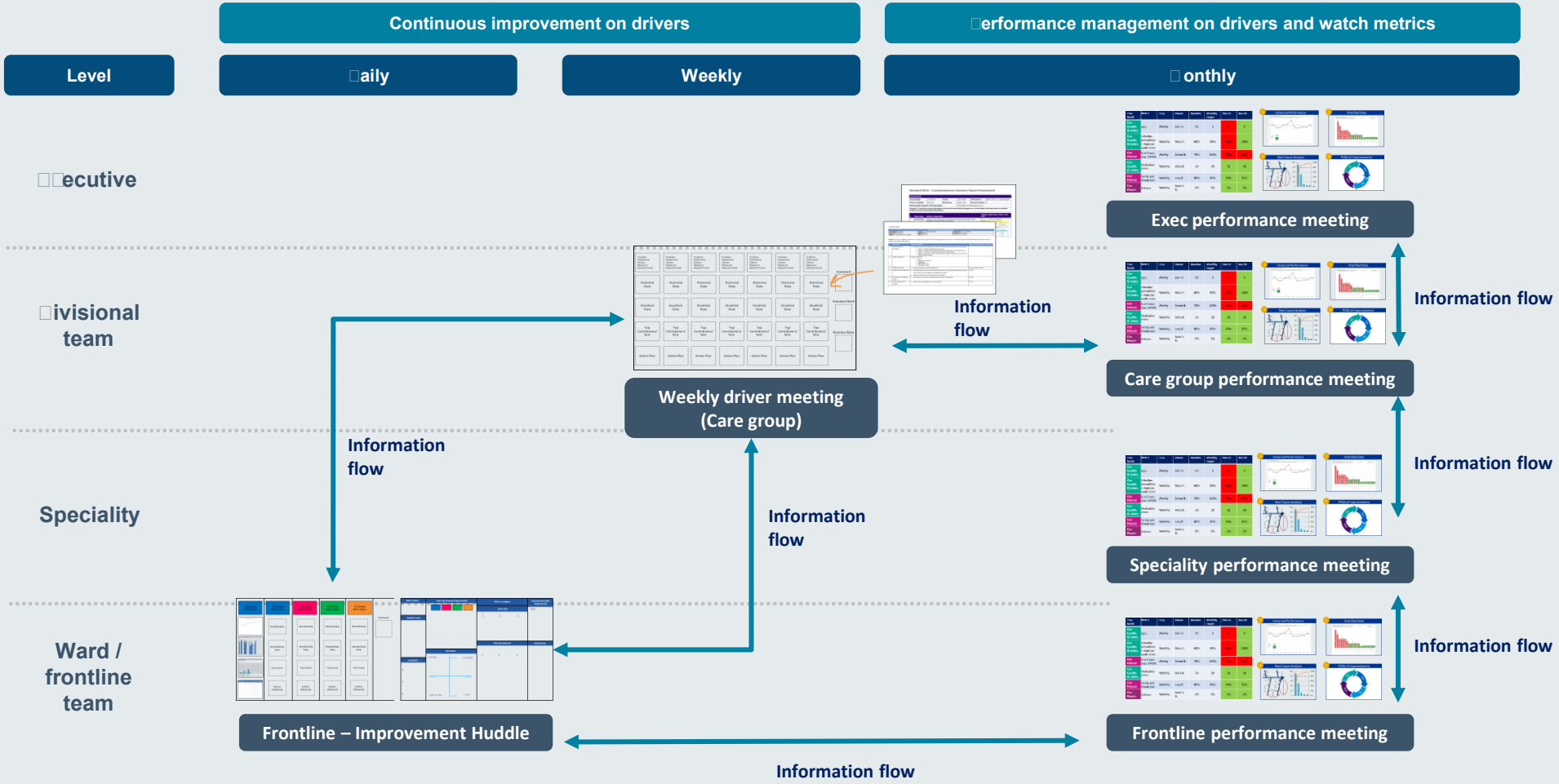
BTO Pressure Harms

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



□uilding a culture of continuous improvement

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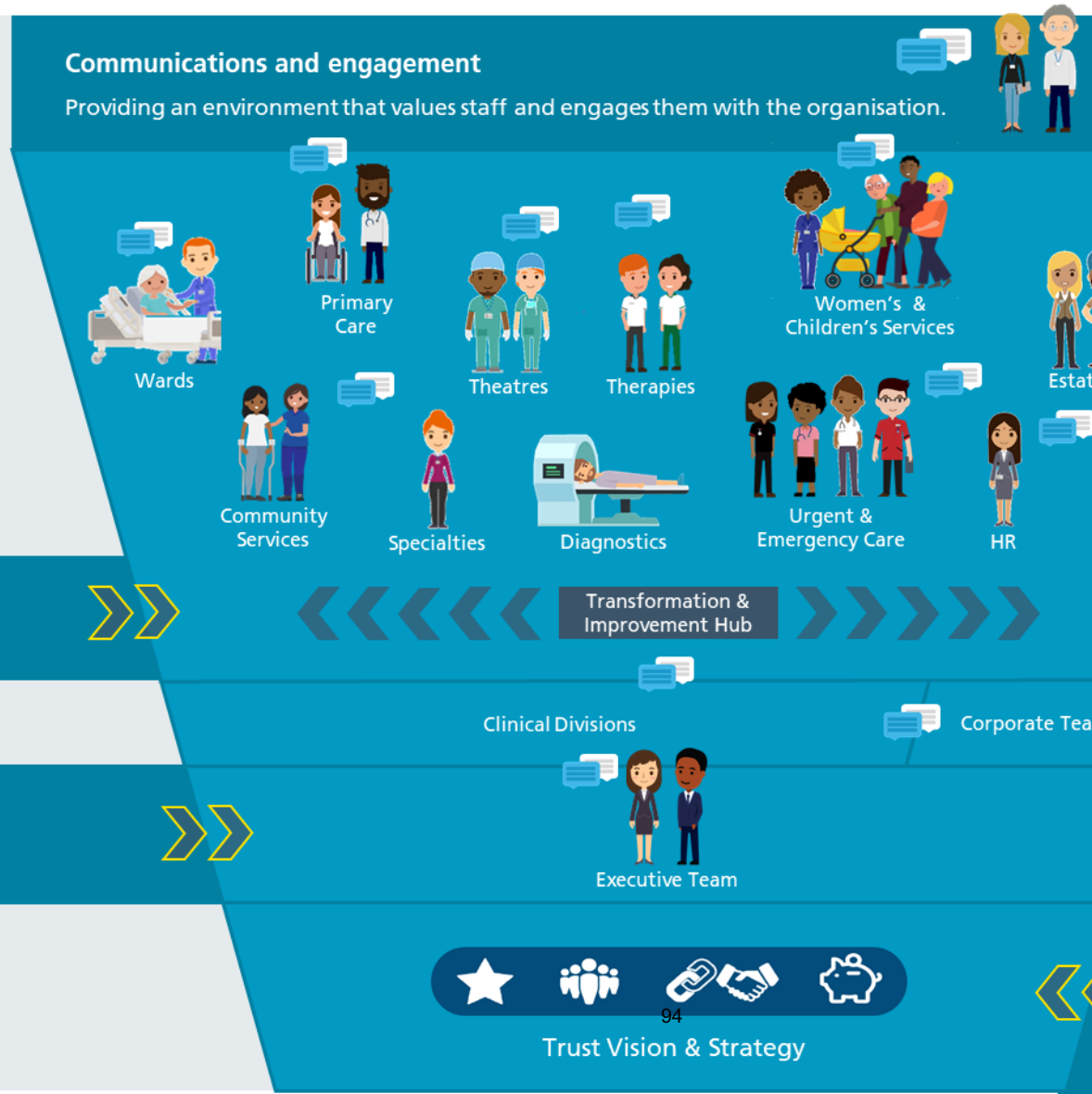


Transformational projects
Using improvement methodology to create step-change improvement.

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

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

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

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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

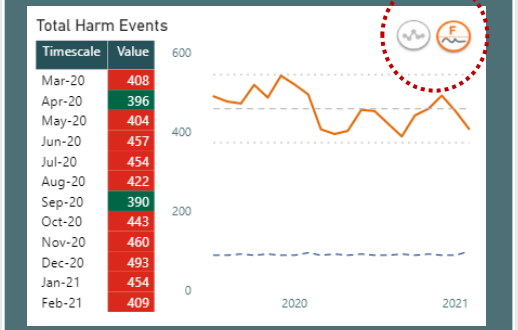
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

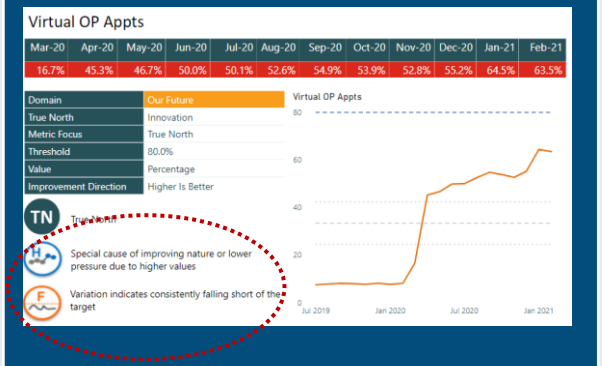
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

Great Western Hospitals NHS Foundation Trust

		□lignment with □aking data count	Rule	□ctions
1		N/A	Driver is □lue 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	●	□range 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
□	●	□range dot	Metric is negatively outside SPC control limits for 2 consecutive reporting periods (e.g. 2 months)	Produce Countermeasure summary performance report
□	●	□range dot	Watch is □range for 3 of the last □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
□	●	□rey dots	Metric is within control limits	Continue to maintain this performance

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

greed Terms

NHS
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NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Report Title	**GWH CNST Year 5 Submission – GWH Compliance Report**				
Meeting	**Trust Board**				
Date	**11th January 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek (Chief Nurse)				
Report Author	Lisa Marshall (Director of Midwifery and Neonatal Services) Kat Simpson (Head of Midwifery and Neonatal Services) Laura Little (Project Coordinator for Midwifery & Neonatal Services)				
(Appendices	GWH CNST Year 5 Summary of Compliance Briefing Paper • Transitional Care Paper & Action Plan • Saving Babies Lives v3 – December LMNS Validated Review • CNST Year 5 Supporting Safety Action Plans				

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 purpose is to notify Trust Board that NHS Resolution (NHSR) is operating a fifth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

This presentation and supporting briefing paper provide a final compliance position update to the Board to demonstrate the achievement of seven out of the ten safety actions. A position of non-compliance has been declared against three safety actions with supporting action plans and a proposal for applying for discretionary payments outlined.

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
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:

CNST safety action seven demonstrates the co-production of a maternity service which has an emphasis on prioritising hearing the voices of families from minority ethnic groups and areas of deprivation alongside our Maternity & Neonatal Voice Partnership.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Approve the final CNST compliance position for GWH in preparation for the NHSR Declaration form to be submitted on 1st February 2024.

Accountable Lead Signature	Lisa Theobald
Date	3 January 2024

Great Western Hospital Trust – Maternity Incentive Scheme (MIS)
Clinical Negligence Scheme for Trusts (CNST) Year 5 Summary of Compliance

Executive Summary

This paper outlines the Trust position on Year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). A position of non-compliance has been declared against 3 of the 10 safety actions. Throughout the Year 5 reporting period there has been a strong focus on embedding a visible and consistent strategy for safety in Maternity & Neonatal care. The implementation of consistent monitoring, guidance and visibility from ward to board through Quality and Safety Committee has enabled a robust governance framework and reporting to the wider system.

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity and neonatal care. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved.

The NHSR declaration process allows safety actions to be categorised as:

- Fully Compliant (able to declare as compliant on NHSR declaration form)
- Compliant with supporting action plan (able to declare as compliant on NHSR declaration form)
- Non-compliant (the Trust must declare as Non-Compliant on NHSR declaration form and submit bid for proportion of incentive funding for reinvestment in service)

The Trust will be declaring compliance with seven out of the ten Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Safety Actions in Year 5 of the scheme. Each safety action is summarised in the paper with the Trust position and associated actions. Where non-compliance is declared the proposal for discretionary payments is outlined. Ongoing improvements and detailed actions continue to be monitored via the Quality and Safety Committee for full discussion and oversight.

Great Western Hospitals maternity and neonatal services continues to be on a journey of improvement through every CNST reporting cycle to reinvest funding to meet targets that are stretched annually to implement national learning and extend ambition for Maternity services.

Safety Action One – Utilising National PMRT to Review Perinatal Deaths

Safety action one provides the requirements for Trusts to use the National Perinatal Mortality Review Tool (PMRT) to review all perinatal deaths within specific timeframes. The Trust have declared non-compliance with this safety action due to one of the eight elements of the safety action not being met within the required timescale. Following recognition of this oversight in

quarter 1, immediate action was taken to mitigate the risk of recurrence. All timescales have been met in the remainder of the reporting period. The risk associated with non-compliance is reputational and no patient risk has been identified.

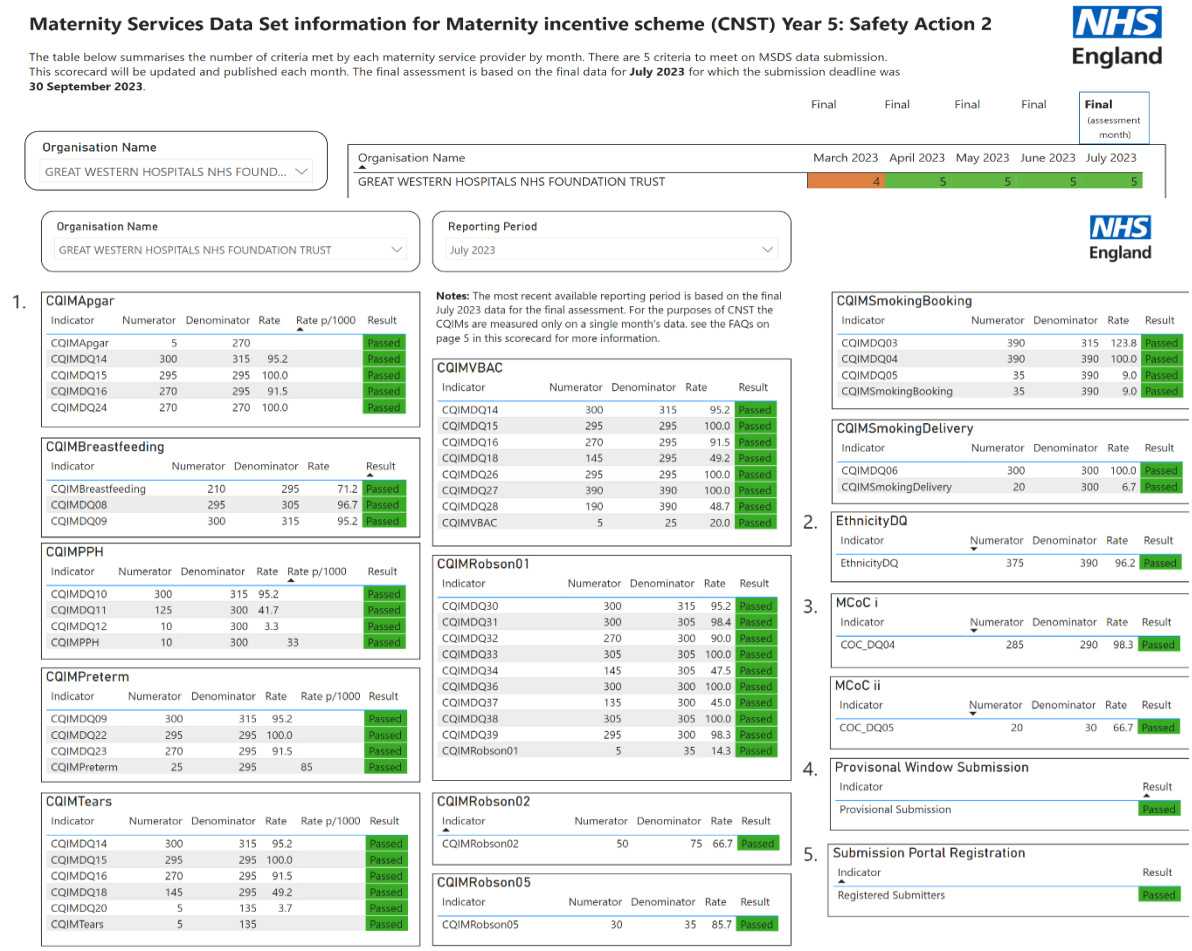
The use of the PMRT tool is embedded in the governance processes with a quarterly update provided to the Quality and Safety Committee.

Safety Action Two – Data Submission to Maternity Services Data Set

Safety action 2 provides assurance that the Trust is submitting data to the Maternity Services Data Set to the required standard. All elements of this safety action have been met by the Trust in year 5. The submission was based on data activity in July 2023 with results published by NHS England in October 2023 (see figure 1). The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for Clinical Quality Improvement Metrics (CQIMs) and other metrics specified above after data submission.

This summary tool also provides an assurance that ethnic category is being recorded in care records and that at the time of reporting, the Trust provision for women under a Continuity of Carer pathway was meeting the needs of the most vulnerable women with timely personalised care planning.

Figure 1.



Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 5: Safety Action 2

NHS England

The table below summarises the number of criteria met by each maternity service provider by month. There are 5 criteria to meet on MSDS data submission. This scorecard will be updated and published each month. The final assessment is based on the final data for **July 2023** for which the submission deadline was **30 September 2023**.

Organisation Name	March 2023 (Final)	April 2023 (Final)	May 2023 (Final)	June 2023 (Final)	July 2023 (Final (assessment month))
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	4	5	5	5	5

Organisation Name: GREAT WESTERN HOSPITALS NHS FOUND...

Organisation Name: GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

Reporting Period: July 2023

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	270			Passed
CQIMDQ14	300	315	95.2		Passed
CQIMDQ15	295	295	100.0		Passed
CQIMDQ16	270	295	91.5		Passed
CQIMDQ24	270	270	100.0		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	210	295	71.2	Passed
CQIMDQ08	295	305	96.7	Passed
CQIMDQ09	300	315	95.2	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	300	315	95.2		Passed
CQIMDQ11	125	300	41.7		Passed
CQIMDQ12	10	300	3.3		Passed
CQIMPPH	10	300		33	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	300	315	95.2		Passed
CQIMDQ22	295	295	100.0		Passed
CQIMDQ23	270	295	91.5		Passed
CQIMPreterm	25	295		85	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	300	315	95.2		Passed
CQIMDQ15	295	295	100.0		Passed
CQIMDQ16	270	295	91.5		Passed
CQIMDQ18	145	295	49.2		Passed
CQIMDQ20	5	135	3.7		Passed
CQIMTears	5	135			Passed

Notes: The most recent available reporting period is based on the final July 2023 data for the final assessment. For the purposes of CNST the CQIMs are measured only on a single month's data. see the FAQs on page 5 in this scorecard for more information.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	300	315	95.2	Passed
CQIMDQ15	295	295	100.0	Passed
CQIMDQ16	270	295	91.5	Passed
CQIMDQ18	145	295	49.2	Passed
CQIMDQ26	295	295	100.0	Passed
CQIMDQ27	390	390	100.0	Passed
CQIMDQ28	190	390	48.7	Passed
CQIMVBAC	5	25	20.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	300	315	95.2	Passed
CQIMDQ31	300	305	98.4	Passed
CQIMDQ32	270	300	90.0	Passed
CQIMDQ33	305	305	100.0	Passed
CQIMDQ34	145	305	47.5	Passed
CQIMDQ36	300	300	100.0	Passed
CQIMDQ37	135	300	45.0	Passed
CQIMDQ38	305	305	100.0	Passed
CQIMDQ39	295	300	98.3	Passed
CQIMRobson01	5	35	14.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	50	75	66.7	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	30	35	85.7	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	390	315	123.8	Passed
CQIMDQ04	390	390	100.0	Passed
CQIMDQ05	35	390	9.0	Passed
CQIMSmokingBooking	35	390	9.0	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	300	300	100.0	Passed
CQIMSmokingDelivery	20	300	6.7	Passed

2. **EthnicityDQ**

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	375	390	96.2	Passed

3. **MCoC i**

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	285	290	98.3	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	20	30	66.7	Passed

4. **Provisonal Window Submission**

Indicator	Result
Provisional Submission	Passed

5. **Submission Portal Registration**

Indicator	Result
Registered Submitters	Passed

Safety Action Three – Use of Transitional Care to Minimise Separation of Mothers and Babies

The Trust have declared compliance with this safety action which requires demonstration of transitional care services that minimise separation of mothers and their babies. One of the seven elements is compliant with a supporting action plan detailing the associated timescales to implement a pathway to reduce separation of mothers and babies from 34 weeks gestation by expanding the transitional care provision at Great Western Hospitals aligned with the BAPM Transitional Care Framework for Practice for both late preterm and term babies.

The local pathways for transitional care in place have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies and ensure that neonatal teams are involved in decision making and planning care for all babies in transitional care. An established audit is in place with identified improvement actions relating to data collection and digital electronic patient records.

Establishing an Advanced Neonatal Nurse Practitioner service at the Trust in 2023 has provided the opportunity to identify further areas for improvement to the transitional care service which support ongoing full compliance. A revised action plan is in place to fully embed a sustainable model of transitional care supported by a dedicated workforce for babies who are born from 34 weeks gestation from April 2025 (Appendix 1). This timescale reflects the need for business planning to aim for a cost neutral reallocation of funding.

The risk associated with one safety element being compliant with a supporting action plan is the unnecessary separation of mothers and babies due to a lack of established transitional care for babies born from 34 weeks gestation which may impact on the mother-baby relationship. There is no risk to the provision of appropriate care as this can be provided on the local neonatal unit.

Safety Action Four – Demonstrating Effective Systems of Clinical Workforce Planning

This safety action requires Trusts to demonstrate an effective system of clinical workforce planning to the required standards. The Trust have declared non-compliance with this safety action due non-compliance with the requirement for a split rota for neonatal and paediatric services.

Business planning has been required to demonstrate progress against the previous Trust position from CNST year 4. This has been challenging within the CNST reporting timeframes, with the business case anticipated to be considered at the Trust Investment Group in January 2024. Achievement of the split medical rota will be supported by funding from the Operational Delivery Network for Neonatal Services. It is proposed that the opportunity to apply for further funding associated with non-compliance with this safety action is utilised to support the year 1 implementation of the proposal. This would enable funding of 1 WTE consultant post for 1 year. The risk for the Trust with non-compliance is the inability to meet the BAPM standards for neonatal consultant workforce which may result in a lack of skilled neonatal consultants to provide specialised care to most vulnerable babies.

Funded establishment for the neonatal nursing workforce to meet the BAPM standards according to activity and the development of the Advance Neonatal Nurse Practitioner workforce is in place.

Clear guidance is in place to support locum doctors and with actions established to ensure that compensatory rest is protected for the obstetric team on call, which is further supported by identified learning from case reviews requiring attendance out of hours in line with guidance published by the Royal College of Obstetricians and Gynaecologists (RCOG).

Positive progress has been demonstrated with the required anaesthetic workforce now in place.

A clear action plan with associated timescales is in place which outlines the improvements required for continued progress towards full compliance (see Appendix 3).

Safety Action Five – Demonstrating Effective Systems of Midwifery Workforce Planning

The Trust have declared compliance with this safety action which requires demonstration of an effective system of midwifery workforce planning to the required standard. One of the six elements is compliant with a supporting action plan detailing prioritisation of the care provision for one-to-one care in labour via robust escalation processes. Monthly compliance with this element is monitored through maternity governance with cases reviewed to identify improvement actions, and oversight through Quality and Safety Committee.

The risk of non-compliance with this element is that one to one care in labour is not achieved. The incidence of this risk occurring is considered low with one family being impacted during the last quarter. Mitigation of this risk is supported by the action plan (see appendix 3).

Safety Action Six – Implementation of Saving Babies Lives v3 (SBLv3) Care Bundle

This safety action requires Trusts to demonstrate the position on compliance with all elements of the Saving Babies' Lives Care Bundle Version Three, which was published on 30th May 2023. An associated implementation tool was released on 5th July 2023 with a requirement for Trusts to submit data to the Local Maternity and Neonatal System (LMNS) using the tool for validated scoring on a quarterly basis. To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.

The Trust have declared non-compliance with this safety action due to the validated scores not meeting the required targets based on the data submitted at the end on Quarter 3, although progress on implementation of the care bundle has been made. A quarterly update is presented to Board with an in-depth review of the full report discussed quarterly in the Safety Champions meetings.

GWH SBLv3 Assessment Board Report Summary

		October 2023				December 2023			
Intervention Elements	Description	Element Progress Status (Self Assessment)	% of Interventions Fully Implemented (Self Assessment)	Element Progress Status (LMNS Validated)	% of interventions Fully implements (LMNS Assessment)	Element Progress Status (Self Assessment)	% of interventions Fully implements (Self Assessment)	Element Progress Status (LMNS Validated)	% of interventions Fully implements (LMNS Assessment)
Element 1	Smoking in Pregnancy	Partially Implemented	30%	Partially Implemented	10%	Partially Implemented	40%	Partially Implemented	10%
Element 2	Fetal Growth Restriction	Partially Implemented	65%	Partially Implemented	10%	Partially Implemented	10%	Partially Implemented	10%
Element 3	Reduced Fetal Movement	Partially Implemented	50%	Partially Implemented	50%	Partially Implemented	50%	Partially Implemented	50%
Element 4	Fetal Monitoring in Labour	Fully Implemented	100%	Partially Implemented	60%	Partially Implemented	80%	Partially Implemented	80%
Element 5	Preterm Birth	Partially Implemented	81%	Partially Implemented	56%	Partially Implemented	56%	Partially Implemented	56%
Element 6	Diabetes	Partially Implemented	67%	Partially Implemented	33%	Partially Implemented	67%	Partially Implemented	50%
All Elements	TOTAL	Partially Implemented	69%	Partially Implemented	34%	Partially Implemented	43%	Partially Implemented	37%

A baseline assessment was completed, and the evidence validated by the LMNS in October 2023. A further submission to demonstrate progress was made in December 2023 by the Trust. Due to time pressures within the LMNS team and the shortened reporting period, responses from the LMNS were received too late for the Trust to respond and provide updated assurance about the improvements that have been implemented. The Trust will continue to submit evidence for LMNS validation and have requested tighter timeframes for LMNS response going forward.

The position of non-compliance provides the opportunity to bid for a proportion of non-recurrent funding. This will be focussed on additional equipment to support delivery of the ultrasound requirements for the care bundle and training opportunities for staff.

The risk associated with this safety action is non-compliance with the revised care bundle which may result in failure to meet the national ambition to halve the number of stillbirths, brain injuries and preterm births by 2025.

Safety Action Seven – Collaborative Working with our Maternity & Neonatal Voice Partnership (MNVP)

This action provides assurance of an effective partnership with a sustainable Maternity and Neonatal Voices Partnership. All elements of the safety action have been met which has been agreed by the local lead. Supporting evidence includes a work plan for the MNVP, demonstration of co-production with an emphasis on prioritising hearing the voices of families from minority ethnic groups and areas of deprivation, and co-production of the action plan to support the CQC Maternity Survey in January 2023 and preparation for the updated action plan to be finalised in January 2024. The local MNVP lead plays an active role in the governance structure by attending key service meetings, obtaining service user feedback, and consistently working collaboratively with the Trust to develop and co-produce the service.

Safety Action Eight – Implementation of Local Training Plans & Multi Professional Training

Safety action eight provides a clear framework to be met with a local training plan in place for implementation of Version 2 of the Core Competency Framework 2, and a target of 90% compliance for all staff groups. Revised guidance was released to reflect the industrial action during the reporting period, resulting in the compliance target being reduced to 80% with a supporting action plan in place for 90% compliance by 23rd February 2024.

Training compliance with all elements for most staff groups met the 90% target with 2 staff groups falling between 80-90% compliance (midwives 87% and anaesthetists 88.6%). The supporting action plan (Appendix 3) was implemented on 30th November 2023 to ensure full compliance for the reporting period. The risk associated with the interim non-compliance is low due to the small numbers of staff impacted.

The local strategy for the delivery of the Core Competency Framework version 2 has been approved through the Quality and Safety Committee and the LMNS/ICB to ensure the ongoing provision of education in maternity services meets the national standards.

Safety Action Nine – Robust Assurance Processes on Maternity & Neonatal Safety and Quality Issues

All elements of this safety action have been met which supports the robust, established Board reporting processes to provide assurance to the Board on maternity and neonatal safety and quality issues. This has been evidenced by further embedding the Maternity and Neonatal Safety Champions model supported by established meetings and Board visibility. An established safety intelligence reporting process from ward to Board is underpinned by improved triangulation of staff and service user feedback. Local progress in implementing the Patient Safety Incident Response Framework (PSIRF) framework and attendance of the perinatal quadrumvirate at the NHS England Perinatal Culture and Leadership further supports achievement of this safety action.

Safety Action Ten – Reporting of Qualifying Cases to External Organisations

Full compliance has been met which provides assurance of reporting 100% of qualifying cases to the Healthcare Safety Investigation Branch (HSIB) (now known as Maternity and Neonatal Safety Investigations Special Health Authority (MNSI)) and to NHS Resolution Early Notification Scheme between 6th December 2022 and 7th December 2023. Evidence supporting this achievement includes established internal databases that monitor qualifying cases and associated actions including Duty of Candour and family information, embedded processes between the governance and legal team and an additional audit process to ensure all qualifying cases are identified.

Final Submission Declaration Position

Great Western Hospital Trust will be declaring compliance with seven out of the ten CNST safety actions in year 5, as demonstrated in Figure 2.

Figure 2.

Section A : Maternity safety actions - Great Western Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	No
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

Conclusion

Great Western Hospitals maternity and neonatal services continues to fully engage with the Maternity Incentive Scheme with the aim to ensure reinvestment of funding supports ongoing compliance as the scheme progresses. Whilst stretch targets have challenged the previous position of full compliance, year on year progress has been made against each safety action which has strengthened the safety and quality of maternity and neonatal services.

Appendices

- Appendix 1 : SA3 - Transitional Care Paper & Action Plan
- Appendix 2 : SA6 - Saving Babies Lives v3 – December LMNS Validated Review
- Appendix 3 : CNST Year 5 Supporting Safety Action Plans

APPENDIX 1

Neonatal Transitional Care (NTC):
Working towards BAPM recommendations in GWH.

July 2023

Executive Summary

GWH have successfully implemented the first stages of NTC, however the current system does not allow for inclusion of all BAPM framework NTC infants. In order to meet the BAPM guidance and be compliant with the CNST actions NTC admission criteria needs to include infants >34 weeks gestation and those requiring nasogastric tube feeds. There are other NTCs within the South West Neonatal Network who are successfully achieving this and by looking at the models they have used to create and staff their units a plan has been designed and proposed for use here at GWH. Following the Plymouth model of staffing the NTC with upskilled Band 4 MSWs or Associate practitioners from the neonatal unit will ensure that the service is appropriately supported, by dedicated TC staff. Parent feedback on TC services shows this consistency in advice and support from a core group of staff is vital for effective TC. Using Band 4 staff would also offer a cost saving compared with recruiting further Band 5 registered nurses. Creating an additional two transitional care cots will allow the unit to be staffed with appropriate and recommended ratios and also meet the increased demand on this service, which is already frequently at over 100% capacity.

Background

In 2017, BAPM published *"Neonatal Transitional Care: a Framework for Practice*" which recognised that keeping mothers and their babies together should be the cornerstone of neonatal care. With the correct support resident mothers can remain the primary care providers for their babies who have care requirements in excess of postnatal ward care, but who do not need to be admitted to the neonatal unit. Within this BAPM framework there are clear criteria for the patients who should be offered a Neonatal Transitional Care (NTC) service and at GWH we are not currently meeting these criteria.

In 2018 GWH started to develop an NTC, initially as a virtual ward and then in 2019 as a dedicated area within the Hazel ward. The BAPM (2010) *"Service Standards for Hospitals Providing Neonatal Care"* was used to look at nursing and midwifery staffing requirements for the NTC. Since 2019 the NTC team has been providing excellent and high-quality care to babies and their mothers within Hazel, which has been staffed by a midwife in charge and midwifery support worker (MSW) with outreach support from the neonatal nursing team. Currently this support is offered by means of a satellite service contactable via DECT phone.

In order to meet the BAPM (2017) framework for NTC, which is now part of Maternity Incentive Scheme Year 5 requirements, the admission criteria need to extend to include infants >34 weeks gestation, and those requiring nasogastric tube feeding and potentially low flow oxygen. With the current staffing model, the unit is not suitable for these patients as the staff are not adequately trained to care for these patients. The GIRFT deep dive also found that GWH was in the top decile for special care or normal care days for late preterm infants, keeping them separated from their parents for longer.

A staffing model that would support this inclusion criteria is that used in Plymouth transitional care unit. Their NTC is staffed by Band 4 MSWs who have completed competency training and assessment

to meet the needs of the more complex NTC patients. This includes nasogastric tube feeding, blood sampling, assessment and care of the late preterm and checking of oral medications.
In 2010, BAPM published the "*NHS England Service Specification for Neonatal Critical Care Services",* which states the **minimum** nurse to patient staffing ratios based on an average unit occupancy of 80% for neonatal services should be:

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

These care levels are defined in specific detail by nationally set criteria. The staffing ratios would meet these criteria ensuring a ratio of 1:4 using a Band 4 MSW supported by the midwife in charge staffing of 1:5-8 and outreach support and formal ward round with a senior neonatal nurse. A senior neonatal nurse would also be appointed as Lead for NTC, working with the team to embed and develop practices.
At GWH we currently have 24 Neonatal cots: (18 cots on the Neonatal Unit and 6 Transitional Care cots on Hazel Ward) which are allocated as:

- 2 Intensive Care
- 4 High Dependency
- 12 Special Care
- 6 Transitional Care

Between August-20 and July-21 the neonatal unit saw an average occupancy rate of 68%, whilst transitional care beds were on average occupied at greater than 100% capacity.

Occupancy Rates	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Avg. Rate
Intensive Care	56%	50%	48%	52%	32%	39%	32%	40%	45%	55%	43%	61%	46%
High Dependency	44%	58%	38%	86%	62%	38%	69%	63%	36%	32%	30%	69%	52%
Special Care	91%	98%	86%	59%	89%	77%	73%	57%	52%	74%	83%	81%	77%
Total Neonatal Unit	**77%**	**84%**	**71%**	**64%**	**77%**	**64%**	**67%**	**56%**	**48%**	**63%**	**67%**	**76%**	**68%**
Transitional Care	94%	104%	134%	111%	122%	91%	115%	118%	97%	86%	101%	89%	105%

It is evident from the activity levels above that whilst the neonatal unit does not always run at full capacity the transitional care ward is often over capacity. If the admission criteria were to be expanded, then there would be further admissions to transitional care and less admissions to the neonatal unit (or shortened stays on the neonatal unit). Research has shown that separation of baby and family can have negative psychological consequences for parents, babies and their siblings. Increasing the number of transitional care cots available will also help to reduce this. Therefore, it is recommended that we move to 8 transitional care cots. This will also enable us to use staff effectively. Looking at our current staffing models on NTC and LNU it is proposed to move to a model where 1 Band 5 Neonatal Nurse and 1 Band 3/4 MSW will be allocated per shift to care for 8 NTC cots rather than 6, meeting the BAPM ratio recommendations.
Using Band 4 MSWs will provide a substantial cost saving versus staffing NTC fully with Band 5 neonatal nurses. It will upskill current staff where career progression is desired and deliver the increased job satisfaction that is observed when employees are offered training opportunities and remuneration. The CNST Maternity Incentive Scheme standards include a specific reference to "**Neonatal transitional care services"**: Failure to meet CNST standards comes with financial penalties for the trust and so there needs to be evidence that GWH is working towards a BAPM model for NTC.

GWH needs to be able to provide a full NTC service, but to do this changes need to be made to the current staffing model, bed allocation and skill set of the staff who will be providing the care. These are all achievable by utilising and up-skilling current staff and increasing the number of transitional care beds to 8. This will improve the maternity and neonatal experience for the mother, her baby and her partner as well as the extended family, resulting in greater parental confidence, improved breast-feeding rates and earlier discharge home for babies with moderate additional care needs. The NTC should also reduce term and late preterm admissions to the LNU and help to prevent blocking of cots.

Timeline

31st July 2023	Proposed timeline and plan taken to safety champions meeting for discussion
October 2023	Meeting with Network team to discuss neonatal nursing staffing model, current budget and vacancies. TC staffing and budget to be discussed at this meeting.
November 2023	AF to spend 2-3 weeks working clinically within TC to understand current ward management, day to day running and current risks.
End November 2023	Immediate and longer-term action plans to be written by AF and CW to address current risks.
March 2024	Formal timeline and business case written and ready for presentation
April 2024	Take to Trust Investment Group Meeting
May 2024	Divisional Planning Meeting for decision Write job descriptions and training package.
June 2024	Through Trust processes by June and job descriptions agreed and planning for competency training complete.
End June 2024	Start recruitment process
September 2024	Have Band 5 Neonatal Nurses in post to cover NTC. Start competency training for newly appointed Band 4 MSWs, if identified. Keep NTC entry criteria the same but increase to 8 cots once 2 members of staff per shift.
April 2025	Once all MSWs/nurse associates signed off and staffing model is sustainable and in place widen admission criteria for NTC to meet BAPM framework.

APPENDIX 2

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

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.

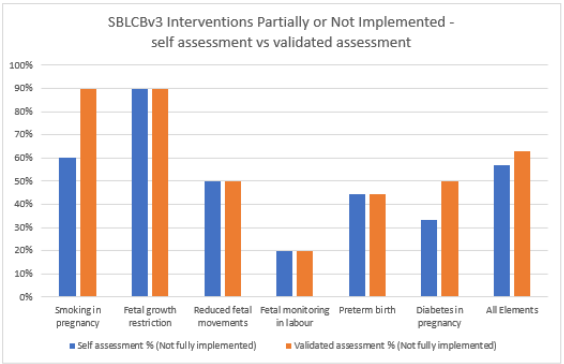
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

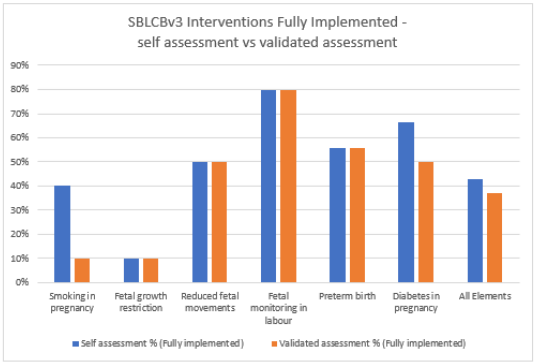
Implementation Grading

Limited Assurance - Activities and control are not suitably designed, or not operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

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)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	40%	Partially implemented	10%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	10%	Partially implemented	10%	CNST Not Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	56%	Partially implemented	56%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	43%	Partially implemented	37%	CNST Not Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Stop smoking strategy/guideline required
1.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence and clear action plan
1.3	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Policy/SOP needs to include processes for communication between Smoke free pregnancy team and named midwife and data collection relating to CO readings.
1.4	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data to include denominator details.
1.5	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Stop smoking strategy/guideline required
1.6	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Audit evidence and improvement plan. SOP ratification date
1.7	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Audit evidence and clear action plan and ratification of SOP
1.8	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Training compliance in line with trajectory- please confirm re Obstetricians training?
1.9	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training compliance in line with trajectory for Obstetricians
1.10	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence of full traininng to NSCST standards for individuals delivering TTD interventions

Element 2

INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Snapshot audit of data from within last 6 months expected at next quarterly assessment.
2.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data
2.3	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Amend AN guidance to include need to record smoking status at booking, 36 weeks and all antenatal appointments
2.4	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Update guideline in line with SBLV3 before next quarterly assessment. Updated audit evidence from within last 6 months
2.5	Not implemented	Not implemented	Focus required on quality improvement intiatives to meet recommended standard.	Implementation of technology platform for recording and assement of risk
2.6	Not implemented	Not implemented	Focus required on quality improvement intiatives to meet recommended standard.	Produce a plan to replace analogue /aneroid BP monitors
2.7	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Update guideline to Appendix D of SBLCB V3. Audit evidence from last 6 months
2.8	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Present MBRRACE report Nov 2023 at LMNS Safety Board . Update Fetal Surveillance SOP in line with SBL V3 guidance
2.9	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Update guideline as per 2.7
2.10	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data from the last 6 months
2.11	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data and evidence of SFH updates included in training plan
2.12	Fully implemented	Fully implemented	0	0
2.13	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Update Guideline in line with SBLV3 as per 2.7
2.14	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Update guidelines to include guidance on use of PlGF and management of suspected FGR in line with SBLV3
2.15	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Update guidance in line with SBLV3
2.16	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Update guidance in line with SBLV3
2.17	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit reviewing implementaton of guidance and standards
2.18	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence from snapshot audit last 6 months. Audit data to include data on all babies identified as being below 3rd centile
2.19	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	MSDS data or audit to support compliance with guidance
2.20	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Review Appendix D SBLV3 declining growth velocity to ensure guideline reflects updated advice

Element 3					
	INTERVENTIONS				
	3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Tommy's leaflet in different languages for local populations - evidence that this is made available for GWH service users (available on line)
	3.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Update guideline in line with SBLV3 Regional guidance required regarding non compliance with next workiing day scan provision

Element 4					
	INTERVENTIONS				
	4.1	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Continued monitoring of staff training compliance
	4.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Risk assessment tool - add frequency of review in labour guidance and where assessments should be documented. Audit compliance less than 80% - regular snapshot audit
	4.3	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence on maternal assessment to be added as part of next audits
	4.4	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Fresh eyes guideline
	4.5	Fully implemented	Fully implemented	0	0

Element 5					
	INTERVENTIONS				
	5.1	Partially implemented	Partially implemented	Evidence not in place - improvement required.	Job descriptions that outline roles
	5.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Guideline stating that assessment for risk of pre-term bith undertaken at booking. PMRT report (or MBRRACE report) to include Column G 5.2
	5.3	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit demoonstrating assessment of risk of pre-term birth (within last 6 months)
	5.4	Fully implemented	Fully implemented	0	0
	5.5	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	LMNS and Regional Agreement re QUIPP
	5.6	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Reaudit data
	5.7	Fully implemented	Fully implemented	0	Links to 1.1 which requires Stop Smoking Strategy
	5.8	Fully implemented	Fully implemented	0	0
	5.9	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data to support evidence against trajectory
	5.10	Fully implemented	Fully implemented	0	0
	5.11	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit of MSU for women at intermediate or high Risk (as per Appendix F SBLV£)
	5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

5.15	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Leaflet details please add along with details of where this is documented when given
5.16	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit required
5.17	Fully implemented	Fully implemented	0	0
5.18	Fully implemented	Fully implemented	0	0
5.19	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Please supply data assurance for 2023 regarding place of birth for births included in Ref 5.19B
5.20	Fully implemented	Fully implemented	0	0
5.21	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	0
5.22	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit to demonstrate compliance
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Continued audit and any improvement activities to reach stretch ambition
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Improvement plan
5.25	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Improvement plan
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	0	0
6.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence
6.3	Fully implemented	Fully implemented	0	0
6.4	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence unclear what percentage of women have had HbA1C between 24 and 30 weeks as audit just states
6.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
6.6	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Add link to ED policy .

APPENDIX 3

ACTION PLAN							
Safety Action 1: Are you using the National PMRT to review perinatal deaths to the required standard?							
Number	**Detail**	**Safety Standard**	**Action**	**Action Lead**	**Completion Date**	**Update/Comments**	**Status**
1a	PMRT	a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	Review reporting process to understand any single points of failure	Patient Safety Lead for Maternity & Neonatal Services	4th August 2023	04.08.2023 - Review of all outstanding information and process completed	Completed
1b			Implement and embed monitoring process to cross-check completion dates for surveillance information	Patient Safety Lead for Maternity & Neonatal Services	11th August 2023	11.08.2023 - Revised monitoring processes implemented	Completed
1c			Monitor throughout Q2 to ensure processes have been embedded	Patient Safety & Governance Midwife for Maternity & Neonates	30th September 2023	30.09.2023 - PMRT report confirmed no further breaches had occurred	Completed
1d			Monitor throughout Q3 to ensure processes have been embedded	Patient Safety & Governance Midwife for Maternity & Neonates	31st December 2023	31.12.2023 0 PMRT report confirmed no further breaches had occurred	Completed
1e			Review potential for CNST Safety Action funding through Declaration Form	Head of Midwifery & Neonatal Services	1st February 2024		Underway
2a	PMRT	b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	No actions required - safety standard compliant				Complete
2b							
2c							
2d							
3a	PMRT	c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months NOTE: Guidance updated in October 2023 (see below) Where MDT PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this impact on the MIS reporting compliance time scales, this will be accepted provided there is an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	No actions required - safety standard compliant				Complete
3b							
3c							
3d							
3e							
3f							
3g							
4a	PMRT	d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	No actions required - safety standard compliant				Complete
4b							
4c							

Version:	2
Date:	28.12.2023

ACTION PLAN

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Number	Detail	Safety Standard	Action	Action Lead	Completion Date	Update/Comments	Status
1a	TC	a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional carehttps://www.rcog.org.uk/en/careers training/workplace-workforce-issues/roles responsibilities-consultant-report/	No actions required - safety standard compliant				Complete
1b							
1c							
1d							
2a	TC	b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB	No actions required - safety standard compliant				Complete
2b							
2c							
2d							
3a	TC	c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.	All improvement actions to be monitored via the wider Transitional Care Service action plan - link found in the update/comments column	Lead ANNP	31st March 2025	T:\Planned_Care\Maternity\Compliance\33.0 Transitional Care	Underway
3b			Initial proposed timeline and plan taken to safety champions meeting for discussion	Lead ANNP	31st July 2023		Complete
3c			Meeting with Network team to discuss neonatal nursing staffing model, current budget and vacancies. TC staffing and budget to be discussed at this meeting	Lead ANNP	31st October 2023		Complete
3d			AF to spend 2-3 weeks working clinically within TC to understand current ward management, day to day running and current risks	Lead ANNP	31st November 2023		Complete
3e			Immediate and longer-term action plans to be written by AF and CW to address current risks	Lead ANNP	31st November 2023		Complete
3f			Away Day to be held with wider Transitional Care team to understand barriers and identify sustainable improvement actions with associated timeframes	Lead ANNP	5th December 2023		Complete
3g			Data collection, data reporting processes and paperwork procedures to be reviewed and improvement actions identified	Lead ANNP	31st March 2024		Underway
3h			Formal action plan to be considered during the business planning process	Lead ANNP	31st March 2024		To be started
3i			Confirmation of staffing model post business planning and associated training required	Lead ANNP	1st May 2024		To be started
3j			Ongoing recruitment process, training and education of existing staff members	Lead ANNP	1st June 2024		To be started
3k			Have Band 5 Neonatal Nurses in post to cover NTC. Start competency training for newly appointed Band 4 MSWs, if identified. Keep NTC entry criteria the same but increase to 8 cots once 2 members of staff per shift	Lead ANNP	30th September 2024		To be started
3l			Once all MSWs/nurse associates signed off and staffing model is sustainable and in place widen admission criteria for NTC to meet BAPM framework	Lead ANNP	1st April 2025		To be started
3m							

Version:	2
Date:	28.12.2023

ACTION PLAN							
Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?							
Number	**Staffing Group**	**Safety Standard**	**Action**	**Action Lead**	**Completion Date**	**Update/Comments**	**Status**
1a	Obstetric Medical Workforce	**Obstetric medical workforce** 1. NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums	Undertake data deep dive to gather information regarding the use of locums in Maternity services throughout the reporting period	HR	31st October 2023	31.10.2023 - Information received from HR and reviewed with Consultant Obstetrician	Complete
1b			Draft Standard Operating Procedure for Management of Middle Grade Locums at GWH	Consultant Obstetrician	31st October 2023		Complete
1c			Ratification of SOP via Maternity Governance	Consultant Obstetrician	21st November 2023		Complete
1d			Establish ongoing management of locum checklists	Consultant Obstetrician HR	31st May 2024		Underway
1e							
2a	Obstetric Medical Workforce	**Obstetric medical workforce** 2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term locums-in-mate.pdf	Undertake data deep dive to gather information regarding the use of locums in Maternity services throughout the reporting period	HR	31st October 2023	31.10.2023 - Information received from HR and reviewed with Consultant Obstetrician	Complete
2b			Draft Standard Operating Procedure for Management of Middle Grade Locums at GWH	Consultant Obstetrician	31st October 2023		Complete
2c			Ratification of SOP via Maternity Governance	Consultant Obstetrician	21st November 2023		Complete
2d			Establish ongoing management of locum checklists	Consultant Obstetrician HR	31st May 2024		Underway
2e							
3a	Obstetric Medical Workforce	**Obstetric medical workforce** 3. Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf	Review of overall Safety Action 4 with actions assigned	Clinical Lead for Obstetrics & Gynae	6th June 2023		Complete
3b			Discussion at Consultant meeting "Workforce planning strategy for perinatal services"	Labour Ward & Fetal Surveillance Lead Clinical Lead for Obstetrics & Gynae	14th September 2023		Complete
3c			Addition to Handover and Ward Rounds in Maternity SOP to detail expectations for consultant compensatory rest as per RCOG and BMA.	Labour Ward & Fetal Surveillance Lead	31st October 2023		Complete
3d			Review and ratification of updated SOP at Maternity Governance (October 2023)	Maternity & Neonatal Services Team	17th October 2023		Complete
3e			Review of consultant job plans to support expectations for consultant compensatory rest as per RCOG and BMA as much as possible	Clinical Lead for Obstetrics & Gynae	1st March 2024		Underway
3f			Discuss and confirm escalation process where clinical activity needs to be covered/cancelled at short notice.	Clinical Lead for Obstetrics & Gynae	1st March 2024		Underway
3g			Update Handover and Ward Round in Maternity SOP to detail confirmed escalation process (as above)	Clinical Lead for Obstetrics & Gynae	1st April 2024		To be started
3h							

4a	Obstetric Medical Workforce	**Obstetric medical workforce** 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers training/workplace-workforce-issues/roles responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non attendance. Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.	**Continued action from the Year 4 action plan:** Collect data using the Handover Form	Delivery Suite Team	31st January 2023	**06.12.2022** - Data collection underway	**Complete**
4b			**Continued action from the Year 4 action plan:** Review the data collected and perform snapshot audit to review learning themes and trends	Labour Ward & Fetal Surveillance Lead	20th February 2023	**06.12.2022** - Data collection underway	**Complete**
4c			**Continued action from the Year 4 action plan:** Bring snapshot audit to next Maternity Governance meeting after full review	Labour Ward & Fetal Surveillance Lead	21st February 2023		**Complete**
4d			**Continued action from the Year 4 action plan:** Develop action plan to address themes and trends identified in the audit	Labour Ward & Fetal Surveillance Lead	28th February 2023		**Complete**
4e			**Continued action from the Year 4 action plan:** Monitor progress of action plan and review opportunities for departmental learning at a monthly Maternity Governance meeting	Labour Ward & Fetal Surveillance Lead	31st May 2023		**Complete**
4f			**Continued action from the Year 4 action plan:** (IF REQUIRED) Use of a task and finish group to establish and implement change & improvements	Labour Ward & Fetal Surveillance Lead	31st May 2023		**Complete**
4g			Undertake audit of consultant attendances to review opportunities for learning	Labour Ward & Fetal Surveillance Lead	31st March 2023	26.11.2023 - Audit published after discussion at November Maternity Governance meeting	**Complete**
4h			Added mandatory question to Datix to gather data on consultant attendance at incidents being reported	Labour Ward & Fetal Surveillance Lead	6th December 2023		**Complete**
4i			Included Consultant Attendance checklist on Labour Ward Coordinator Handover sheet to capture attendance at mandatory situations	Labour Ward & Fetal Surveillance Lead	6th December 2023		**Complete**
4j			Included question on the daily SITREP report (Situation Report) which is completed daily at Senior Team Huddle	Labour Ward & Fetal Surveillance Lead	6th December 2023		**Complete**
4k			Establish ongoing management of opportunities for learning from the data gathered	Labour Ward & Fetal Surveillance Lead	1st March 2024		**Underway**
5a	Anaesthetic medical workforce	**Anaesthetic Medical Workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	No actions carried over from the Y4 CNST action plan				**Complete**
5b			**No actions required - safety standard compliant**				**Complete**
5c							
6a			**Continued action from the Year 3 and Year 4 action plan:** Annual job plan review with Paediatricians	Deputy Divisional Director for SWC	1st April 2023	07.12.2022 - Job plans now on SARD. Awaiting sign off from Divisional Tri. 31.05.2023 - Job planning in embedded as an annual cycle. Action to be marked as complete	**Complete**

6b	Neonatal Medical Workforce	**Neonatal Medical:** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	**Continued action from the Year 3 and Year 4 action plan:** Review service specification to understand if costs are included within the Spec Comm block funding. Align potential funding source with staffing business case.	Deputy Divisional Director for SWC	1st May 2023	07.12.2022 - Contract to be reviewed as part of 2023/24 business planning cycle. 31.03.2023 - Confirmation action was complete	Complete
6c			**Continued action from the Year 4 action plan:** Recruitment for ANNP pathway (as below)	Inpatients Matron	31st March 2023	NOTE: Supports Neonatal Medical as established ANNP pathway able to deliver Junior Medical level work 01.12.2023 - Confirmation of ANNP lead positions and trainees recruited and in post	Complete
6d			**Continued action from the Year 4 action plan:** Continue scoping of potential split rota review - staffing, actuity, activity & capactity review	Deputy Divisional Director for SWC	1st April 2023	07.12.2022 - Split rota being reviewed as part of 2023/24 business planning cycle and budget setting. 31.05.2023 - Action superseded by Year 5 CNST action plan - to be closed	Complete
6e			Draft and complete business case outlining the proposal for splitting the Medical Workforce in Neonatal Services and Paediatrics	Clinical Lead for Neonatal Services	30th November 2023	05.12.2023 - Business case complete 15.12.2023 - Business case discussed and presented at extraordinary SWC Divisional Board	Complete
6f			Present business case to Trust Investment Group for review and comment	Clinical Lead for Neonatal Services	17th January 2024		Underway
6g			Review potential for CNST Safety Action funding through Declaration Form	Head of Midwifery and Neonatal Services	1st February 2024		Underway
6h							
7a	Neonatal Nursing Workforce	**Neonatal Nursing:** The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	**Continued action from the Year 4 action plan:** Recruitment process of Neonatal nurses (ongoing)	Inpatients Matron Ward Manager for Neonatal Services	30th April 2023	**23.11.2022** - Rolling advert to be utilised with trajectory to be fully recruited by April 2023 **01.12.2023** - Confirmation neonatal nursing meeting BAPM nursing standards	Complete
7b			**Continued action from the Year 4 action plan:** ANNP recruitment pathways for trainees and lead positions	Inpatients Matron	31st March 2023	**17.11.2022** - Job Description for Lead ANNP 8b amended and sent to job evaluation for next steps **01.12.2023** - Confirmation of ANNP lead positions and trainees recruited and in post	Complete
7c			**Continued action from the Year 4 action plan:** RUH ANNP Supervisor role (ad hoc Bank position)	Inpatients Matron	31st March 2023	**23.11.2022** - Now in progress through bank application **31.03.2023** - Action complete	Complete
7d			**Continued action from the Year 4 action plan:** Additional funding for ANNP pathway for increased roles	Inpatients Matron	31st March 2023	**23.11.2022** - To be included in business planning process **01.12.2023** - Confirmation of ANNP lead positions and trainees recruited and in post	Complete
7e			**Continued action from the Year 4 action plan:** Engagement with Transisitonal Care Phase 2 Implementation to support Hazel ward midwives	Ward Manager for Neonatal Services Ward Manager for Hazel Ward	28th February 2023	**01.11.2022** - Continued engagment with Hazel Ward midwives to scope and implement Phase 2 of Transitional Care	Complete
7f			No actions required - safety standard compliant				Complete

Version:	2
Date:	28.12.2023

ACTION PLAN
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Number	Detail	Saftey Standard	Action	Action Lead	Completion Date	Update/Comments	Status
1a		a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	No actions required - safety standard compliant				Complete
1b							
1c							
2a		b) Trust Board should evidence midwifery staffing budget reflects establishment as calculated in A (above)	No actions required - safety standard compliant				Complete
2b							
2c							
3a	Supernumerary Status	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service	No actions required - safety standard compliant				Complete
3b							
3c							
4a	One to One Midwifery Care	d) All women in active labour receive one-to-one midwifery care	Ongoing monthly data review by Audit Midwife with multi disciplinary discussion at Maternity Governance meeting. Monthly statistics available on Maternity Dashboard to all staff groups.	Audit & Guidelines Midwife	31st March 2024	26.10.2023 - Ongoing embedded process that takes place monthly 28.12.2023 - Confirmation of continued process throughout Q3 of reporting period	Underway
4b			If data is under 100% compliance rate then full review undertaken to identify themes and issues. Discussion takes place at Maternity Governance meeting and then feedback loop to staff groups completed.	Intrapartum Matron	31st March 2024	26.10.2023 - Ongoing embedded process that takes place monthly 28.12.2023 - Confirmation of continued process throughout Q3 of reporting period	Underway
4c			Data included in Intergrated Performance Report (IPR) monthly which is submitted and discussed at Trust Board sub committee. IPR slides are sent to LMNS Programme Board for review and discussion.	Patient Safety Lead for Maternity & Neonatal Services	31st March 2024	26.10.2023 - Ongoing embedded process that takes place monthly 28.12.2023 - Confirmation of continued process throughout Q3 of reporting period	Underway
5a		e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period	No actions required - safety standard compliant				Complete
5b							
5c							

Version:	2
Date:	28.12.2023

ACTION PLAN							
Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?							
Number	**Detail**	**Safety Standard**	**Action**	**Action Lead**	**Completion Date**	**Update/Comments**	**Status**
1a	Saving Babies Lives V3	a) Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	All improvement actions to be monitored via the national implementation tool - link found in the update/comments column	Head of Midwifery and Neonatal Services	31st March 2024	T:\Planned_Care\Maternity\Compliance\4.0 Saving Babies Lives v3 (SBLv3)	Underway
1b			Continue to engage in national forums to understand what "fully implement" looks like for Trusts	Head of Midwifery and Neonatal Services	31st March 2024		Underway
1c			Continue LMNS assessment and evidence evalution process post CNST reporting period	Head of Midwifery & Neonatal Services Project Coordinator for Maternity & Neonates	31st March 2024		Underway
1d			Provide Trust board with bi-monthly updates (or timeframe as stated by LMNS) of our implementation compliance via the implementation board reporting tool	Head of Midwifery & Neonatal Services Project Coordinator for Maternity & Neonates	31st March 2024		Underway
1e			Review potential for CNST Safety Action funding through Declaration Form	Head of Midwifery and Neonatal Services	1st February 2024		Underway
2a		b) Do you hold quarterly quality improvement discussions with the ICB, uising the new national implementation tool?	No actions required - safety standard compliant				Complete
2b							
2c							
3a		c) Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across all 6 elements overall?	All improvement actions to be monitored via the national implementation tool - link found in the update/comments column	Head of Midwifery and Neonatal Services	31st March 2024	T:\Planned_Care\Maternity\Compliance\4.0 Saving Babies Lives v3 (SBLv3)	Underway
3b							
3c							
4a		d) Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within each of the 6 elements overall?	All improvement actions to be monitored via the national implementation tool - link found in the update/comments column	Head of Midwifery and Neonatal Services	31st March 2024	T:\Planned_Care\Maternity\Compliance\4.0 Saving Babies Lives v3 (SBLv3)	Underway
4b							
4c							

Version:	2
Date:	28.12.2023

ACTION PLAN

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Number	Detail	Safety Standard	Action	Action Lead	Completion Date	Update/Comments	Status
1a	MDT training	a) A local training plan is in place for implementation of Version 2 of the Core Competency Framework. NOTE: Guidance updated in October 2023 (see below) 80% compliance at the end of the previously specific 12-month MIS reported period (December 2022 - December 2023) will be accepted, provided there is an action plan by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted	No actions required - safety standard compliant	N/A	N/A		Complete
1b							
1c							
1d							
1e							
1f							
2a		b) The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB	No actions required - safety standard compliant	N/A	N/A		Complete
3a		c) The plan is developed based on the "How to" Guide developed by NHS England	No actions required - safety standard compliant	N/A	N/A		Complete
4a		d) 80% compliance at the end of the previously specific 12-month MIS reported period (December 2022 - December 2023) will be accepted, provided there is an action plan by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.	Review staffing lists to identify staff who are non compliant with PROMPT training	Education & Workforce Development Lead for Maternity & Neonatal Services	23rd February 2024	NOTE: This is an ongoing monthly process to review and book staff prior to them becoming non-compliant	Complete
4b			All staff are continually booked onto attend PROMPT training within 10 months of their previous attendance date to mitigate lapsing compliance	Education & Workforce Development Lead for Maternity & Neonatal Services	23rd February 2024		Complete
4c			Booking details for PROMPT training sent to staff. Course details and invitations are sent out one month in advance	Education & Workforce Development Lead for Maternity & Neonatal Services	23rd February 2024		Complete
4d			All non-attendees are (and will continue to be) escalated to the appropriate clinical leads, senior maternity and neonates management team, and the medical director	Education & Workforce Development Lead for Maternity & Neonatal Services	23rd February 2024		Underway
4e			Those who do not attend in January 2024 will be re-booked onto the next session as mandatory in February. This is a rolling process for non-attendees throughout the year	Education & Workforce Development Lead for Maternity & Neonatal Services	23rd February 2024		Underway
4f			The national mandated training compliance rate for all staff groups is 90%, as stated in Clinical Negligence Scheme for Trusts (CNST). A GWH monthly reporting process has been established to ensure updated data is input into a rolling trajectory graph to monitor training compliance rates. A monthly trajectory review allows for immediate escalation of risk of non-compliance by any of the identified staffing groups	Education & Workforce Development Lead for Maternity & Neonatal Services	23rd February 2024		Underway
4g			The trajectory slides are included as a standing item on the Integrated Performance Report (IPR) which is presented and discussed monthly at the Quality and Safety Committee, in line with the NHSE Perinatal Quality Surveillance Tool guidance	Education & Workforce Development Lead for Maternity & Neonatal Services	23rd February 2024		Underway

Version:	2
Date:	28.12.2023

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CNST Year 5 Submission – GWH Compliance Report

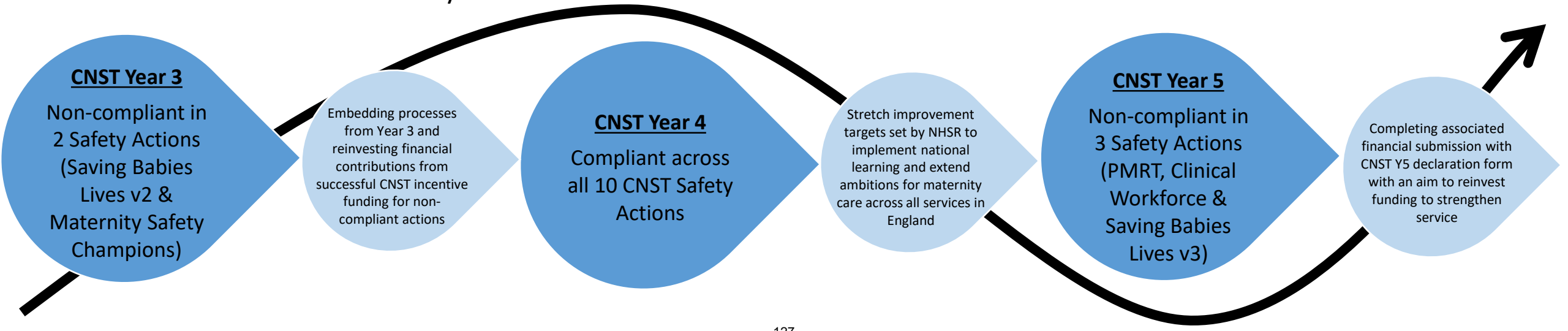
Lisa Marshall — Director of Midwifery and Neonatal Services

Kat Simpson — Head of Midwifery and Neonatal Services

GWH MIS CNST Year 5 Declaration of Compliance Position

Great Western Hospitals NHS Foundation Trust

- Trust will be declaring compliance with seven out of the ten Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Safety Actions in Year 5 of the scheme.
- The NHSR declaration process allows safety actions to be categorised as:
  - Fully Compliant (able to declare as compliant on NHSR declaration form)
  - Compliant with supporting action plan (able to declare as compliant on NHSR declaration form)
  - Non-compliant (Trusts declare as Non-Compliant on NHSR declaration form and submit bid for proportion of incentive funding for reinvestment in service)
- GWH maternity and neonatal services continues to be on a journey of improvement throughout every CNST reporting cycle to reinvest funding to meet targets that are stretched annually to implement national learning and extend ambitions for Maternity services



Assurance of Governance Process for Compliance Against NHSR Safety Actions

Great Western Hospitals NHS Foundation Trust

- Throughout the Year 5 reporting period there has been a strong focus on embedding a visible and consistent strategy for safety in Maternity & Neonatal care.
- The implementation of consistent monitoring, guidance and visibility from ward to board has shaped our local governance framework and reporting to the wider system

1. **Maternity Governance meetings** (monthly)
2. **SWC Divisional Board**
3. **Monthly Perinatal Quality Slides** (reviewed & discussed at Maternity Governance, Quality & Safety, SWC Division Board & Patient Quality Group)
4. **Quarterly Maternity & Neonatal Safety Report** (reviewed & discussed at Quality & Safety Committee)
5. **Maternity & Neonatal Safety Champions meeting** (bi-monthly)
6. **Local Maternity & Neonatal System** (LMNS) & **Integrated Care System** (ICS) meeting

Scheduled Plan For Chief Executive Sign Off	
20th December 2023	CNST Evidence check & challenge meeting with Lisa Cheek *(Chief Nurse & Board Level Maternity & Neonatal Safety Champion)*, Paul Lewis *(Non-Exec Director & Board Level Maternity & Neonatal Safety Champion)* & Gill May *(ICS Accountable Officer)*
11th January 2024	Presentation to Trust Board
23rd January 2024	Formal sign off meeting by Jon Westbrook *(Acting Chief Exec.)* & Gill May *(Accountable Officer)*
1st February 2024 (Noon)	Final deadline for completed Declaration Form (signed by Chief Exec. and Accountable Officer) to be submitted to NHS Resolution

Year 5 GWH CNST Compliance Across NHSR 10 Safety Actions

Great Western Hospitals NHS Foundation Trust

	Criteria	Initial Self Assessment RAG (June 2023)	Submission RAG (Jan 2024)	Key Commentary
1.	Are you using the National PMRT to review perinatal deaths to the required standard?			• Non-compliance with this safety action due to one of the eight elements of the safety action not being met within the required timescale. • Following recognition of this oversight in quarter 1, immediate action was taken to mitigate the risk of recurrence. All timescales have been met in the remainder of the reporting period. • Risk associated with non-compliance is reputational and no patient risk has been identified
2.	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			• All elements compliant based on data activity in July 2023 with results published by NHS England in October 2023 • The summary tool provides assurance that ethnic category is being recorded in care records and the Trust provision for women under a Continuity of Carer pathway was meeting the needs of the most vulnerable women at the time of reporting, with timely personalised care planning
3.	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?		Compliant with supporting action plan	• One element of safety action is compliant with a supporting action plan, all other elements have been met by the Trust • Local pathways have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies • Neonatal teams are involved in decision making and planning care for all babies in transitional care. • Established audit is in place with identified improvement actions • Action plan in place to fully embed a sustainable model of transitional care supported by a dedicated workforce for babies who are born from 34 weeks gestation from 2025
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?			• Non-compliance with this safety action due to the requirement for a split rota for neonatal and paediatric services • Positive progress has been demonstrated with the other workforce groups including anaesthetic, neonatal nursing workforce and the Advance Neonatal Nurse Practitioner workforce. • Guidance is in place to support locum doctors, compensatory rest for the obstetric team on call, and attendance out of hours in line with guidance published by the Royal College of Obstetricians and Gynaecologists (RCOG). • Business planning has been required to demonstrate progress against the previous Trust position from CNST year 4 with the business case anticipated to be considered at the Trust Investment Group in January 2024 • It is proposed that the opportunity to apply for further funding associated with non-compliance with this safety action is utilised to support the year 1 implementation of the proposal. This would enable funding of 1 WTE consultant post for 1 year.
5.	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Compliant with supporting action plan	• One element of safety action is compliant with a supporting action plan, all other elements have been met by the Trust • The action plan details prioritisation of the care provision for one-to-one care in labour and compliance is monitored through maternity governance with cases reviewed to identify improvement actions, and oversight through Quality and Safety Committee. • The risk of non-compliance is considered low with one family being impacted during the last quarter

Year 5 GWH CNST Compliance Across NHSR 10 Safety Actions (cont'd)

Great Western Hospitals NHS Foundation Trust

	Criteria	Initial Self Assessment RAG (June 2023)	Submission RAG (Jan 2024)	Key Commentary
6.	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			• Non-compliance with this safety action due to the validated scores not meeting the required targets • Progress on implementation of the care bundle has been made. • A quarterly update is presented to Board with an in-depth review of the full report discussed quarterly in the Safety Champions meetings • The proposal for non-recurrent funding will be focussed on additional equipment to support ultrasound requirements for the care bundle and training opportunities for staff • The risk associated with this safety action is non-compliance with the revised care bundle which may result in failure to meet the national ambition to halve the number of stillbirths, brain injuries and preterm births by 2025.
7.	Listen to women, parents and families using maternity and neonatal services and coproduce services with users			• All elements of this safety action have been met by the Trust. • Supporting evidence includes an MNVP work plan, demonstration of co-production with an emphasis on prioritising hearing the voices of families from minority ethnic groups and areas of deprivation, and co-production of the action plan to support the CQC Maternity Survey in January 2023 and preparation for the updated action plan to be finalised in January 2024
8.	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		Compliant with supporting action plan	• One element of safety action is compliant with a supporting action plan, all other elements have been met by the Trust • Training compliance with all elements for most staff groups met the 90% target with 2 staff groups falling between 80-90% compliance (midwives 87% and anaesthetists 88.6%). • A supporting action plan is underway to ensure full compliance is achieved within the allowed timeframe. • The risk associated with the interim non-compliance is low due to the small numbers of staff impacted. • The local strategy for the delivery of the Core Competency Framework version 2 has been approved through the Quality and Safety Committee and the LMNS/ICB to ensure the ongoing provision of education in maternity services meets the national standards
9.	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			• All elements of this safety action have been met by the Trust. • Evidenced by further embedding the Maternity and Neonatal Safety Champions model supported by established meetings and Board visibility. • An established safety intelligence reporting process from ward to Board is underpinned by improved triangulation of staff and service user feedback • Local progress in implementing the Patient Safety Incident Response Framework (PSIRF) framework and attendance of the perinatal quadrumvirate at the NHS England Perinatal Culture and Leadership further supports achievement of this safety action
10.	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6th December 2022 to 7 December 2023?			• All elements of this safety action have been met by the Trust. • Evidence supporting this achievement includes established internal databases that monitor qualifying cases and associated actions including Duty of Candour and family information, embedded processes between the governance and legal team and an additional audit process to ensure all qualifying cases are identified

CNST □ear □ Compliance Report

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□nabling safer maternity care

Great Western Hospitals NHS Foundation Trust

Report Title	**Safe Staffing 6-month review for Nursing, Midwifery and AHP**				
Meeting	**Trust Board**				
Date	**11th January 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek Chief Nurse				
Report Author	Luisa Goddard Deputy Chief Nurse, Ana Gardete Divisional Director of Nursing, Lisa Marshall, Director of Midwifery				
Appendices					

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

Assurance Level

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

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

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

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

Report

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

The purpose of this report is to provide the Trust Board with assurance that wards and departments have been safely staffed in line with national and regulatory guidance (National Quality Board guidance (2014), Developing Workforce standards (2018) and CQC standards).

The report covers the following areas relating to safe staffing:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations
- Safe staffing related to AHP
- Community Nursing
- Acute Wards compliance with national guidance and outputs of the Chief Nurse's estblishment reviews

This report details assurance around our key risks and governance of safe staffing and reports on Nursing, Midwifery and AHP workforce.

Governance of Safe Staffing
The report describes how the Trust's safe staffing process is monitored through daily, weekly, monthly and annual actions. The implementation of the Safer Nursing Care Tool will help to inform nursing establishments against patient needs in terms of acuity and dependency.

Nursing report
Highlights the themes from the estblishment reviews with the Chief Nurse Establishment Reviews including:

- There has been a positive impact of the safe staffing investment in relation to patient care and staff satisfaction.
- All wards except for those in SWICC (Forest and Orchard) are now working to a 1 to 8 nurse to patient ratio for registered and unregistered nurses. National guidance is to have ratios of 1:8 or less, ratios above this are recognised as increasing the potential for harm.
- The Division of Medicine is still not compliant with all the guidance set out in the 3-year safer staffing investment plan due to lack of supernumerary coordinator on the night shift. This is currently being reviewed and further work is ongoing.
- Wards with high acuity such as Saturn, Neptune and Meldon need further review and analysis as the establishments are not set in compliance with guidance relating to patients requiring Level 2 care.
- Good progress with Emergency Department compliance with national benchmarking continues. However, the Assessment units (medical and surgical) remain under significant demand and close ongoing review of staffing establishment is required.
- Further work on the role of Registered Nurse Associate is required.

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

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

Community Nursing
Community Nursing is presented in detail highlight the excellent work using the community safer nursing care tool which will inform the estblishment requirements using a recognised methodology for the first time. It also updates on the work to produce a fair and manageable workload and the good progress with vacancies and other workforce metrics.

AHP
The development of the AHP workforce and leadership are described along with the workforce metrics and improvements seen in recruitment.

Conclusion

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

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

The report makes the following recommendations:

- Repeat the SNCT in the new year and then compare the results against funded establishment to inform areas of risk and benchmarking establishments nationally.
- Continue to ensure good recruitment and retention programmes with bespoke plans in high risk areas. The Trust should continue to invest in International Recruitment for all disciplines.
- Ensure the recommendations from the estblishment reviews are considered fully in business planning.
- Continue to develop the Nurse Associate role and the pathway for unregistered nurses into registered nursing.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	Risk 500 There is a risk of poor quality metrics and reduced staff morale/high turnover due to inpatient wards working at a ratio of 1:10 for registered and unregistered staff. This is against the national guidance of 1:8 or below.				12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Nursing, Midwifery and AHP workforce group / Trust Management Committee / 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 paper describes the governance of safe staffing across the Trust.			

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is asked to note the recommendations of the report.	
Accountable Lead Signature	Lisa Deakin
Date	16th November 2023

1. Introduction

The purpose of this report is to provide the Trust Board with assurance that wards and departments have been safely staffed in line with the National Quality Board guidance (2014) and Developing Workforce standards (2018). The report also gives detail on the safe staffing estblishment reviews with the Chief Nurse in September and October 2023 and the Safer Nursing Care tool acuity data.

The report gives in depth focus to Maternity staffing, to ensure compliance with CNST and Ockenden recommendations, and an update on safe staffing within the AHP workforce and Community Nursing.

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

These include:

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

This report serves as the six-monthly safe staffing review at Great Western NHS Foundation Trust. The Trust Management Committee last received a Safe Staffing Paper in April 2023.

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) supports Trusts to use best practice in effective staff deployment and workforce planning utilising evidence-based tools and professional judgement to ensure the right staff, with the right skills are in the right place at the right time. The Board of Directors is expected to confirm their staffing governance processes are safe and sustainable.

In 2021 The Royal College of Nursing published 'Nursing Workforce Standards; supporting a safe and effective nursing workforce' which were designed to support safe staffing. A benchmarking exercise against these standards were previously presented and found to be compliant.

The report covers:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations,
- Safe staffing related to AHP
- Community Nursing safe staffing
- Acute Wards compliance with national guidance and outputs of estblishment reviews

2. Governance of safe staffing

Nursing and Midwifery staffing is monitored through daily, weekly, monthly, and annual actions in compliance with the guidance described above.

Daily
The Trust continues to have a Trust wide three times a day safe staffing meetings which are now always chaired by a Divisional Director of Nursing (DDONS) and a 'duty matron' role providing support out of hours til 20:00 pm and at weekends. After 20:00 pm responsibilities fall to the Clinical Site Managers who have recently received additional training and guidance on safe staffing and esclation controls.

There is a planning meeting on Thursday with the DDON to ensure safe staffing across the weekend.

Weekly
In areas of high risk due to vacancies / turnover or other challenges such as operational pressure there are weekly staffing meetings to 'plan ahead' and ensure any gaps are sufficiently mitigated.

Monthly
The Nursing, Midwifery and AHP Workforce group meets monthly reviewing the Nursing, Midwifery and AHP financial position, divisional staffing reports, including vacancies, turnover, and roster KPIs are presented along with areas of risk. There is also a focus on strategic developments and updates including workforce transformation and education / training updates. Staffing risks are presented at the monthly workforce group and within the divisions.

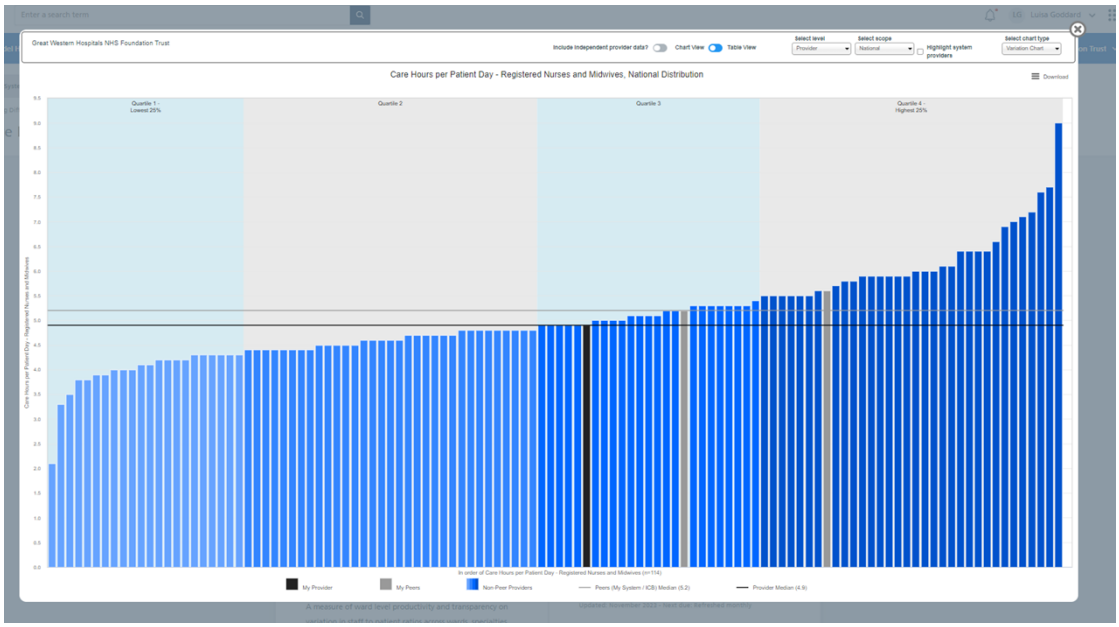
There is a monthly staffing report that is presented to Quality and Safety Committee reviewing actual against expected fill rates and highlighting staffing challenges.

Grip and Control on temporary staffing
To ensure an affordable sustainable workforce, there continues to be fortnightly Improving Together huddles chaired by the Chief Nurse to ensure Nursing and Midwifery agency / temporary staffing costs are reduced. This work currently has A3 improvement plans on the reduction of agency / bank, enhanced care and RMNs. This work has helped drive less reliance on temporary staffing and driving up the oversight of safe staffing.

3. Benchmarking

Model Hospital is the national benchmarking tool which uses Care Hours per Patient Day rather than funded establishments to compare staffing levels. Prior to the investment in safer staffing and improvements in recruitment the Trust sat in the bottom quartile for safe staffing nationally. In August 2023 the Trust moved to the second quartile for the first time, although still below the 2 other acute Trusts in BSW.

Table 1 Care Hours per Patient Day for Registered Nurses – national distribution August 2023 (black line is GWH, grey lines are SFT and RUH).



4. Summary of the Safer Staffing Establishment reviews

One of the recommendations from the Francis report (2013) was to improve the ward to board visibility of safe staffing and at least yearly estblishment reviews by the Chief Nurse. The purpose of these reviews is to allow the Ward/ Unit Managers an opportunity to discuss staffing and any concerns with the Chief Nurse. The reviews cover registered nurse / unregistered nurse to patient ratio, care hours per patient day, model hospital comparators, national or royal college guidance as well as current vacancies, roster metrics and quality metrics / nurse sensitive indicators. A summary is included below, a detailed report will be presented to the Nursing, Midwifery and AHP workforce group.

4.1 Overall themes

There has been a positive impact of the safe staffing investment in relation to patient care and staff satisfaction, with the Ward Leaders all articulating the difference to patient care the investment has made.

All wards except for those in SWICC (Forest and Orchard) are now working to a 1 to 8 nurse to patient ratio for registered and unregistered nurses. National guidance is to have ratios of 1:8 or less, ratios above this are recognised as increasing the potential for harm. The SWICC wards are funded to work at a 1:10 ratio.

The Division of Medicine is still not compliant with all the guidance set out in the 3 year safer staffing investment plan due to lack of supernumerary coordinator on the night shift. This is currently being reviewed and further work is ongoing.

Wards with high acuity such as Saturn, Neptune and Meldon need further review and analysis as the establishments are not set in compliance with guidance relating to patients requiring Level 2 care. For example, Meldon cares for patients post complex surgery or with newly formed tracheostomy requiring high care. These patients are defined as Level 2 patients requiring 1 nurse to 2 patients, but the current ratios only allow for 1 to 8 patient ratios. The triangulation with nurse sensitive quality indictors would support that the staffing levels require further review. A further data collection period using the SNCT will also support the analysis.

Good progress with Emergency Department compliance with national benchmarking continues. However the Assessment units (medical and surgical) remain under significant demand and close ongoing review of staffing establishment is required.

Further work on the role of Registered Nurse Associate is required. Some areas are using this role very effectively such as Teal and the SWICC wards, where it is evident that the role is supporting staff to progress to registered nurses without having to opt for the traditional 3 year university course.

The quality dashboard and roster metrics were reviewed in detail in the establishment reviews. The Ward Managers had good oversight of their data and were taking actions to drive improvement. Roster metrics were well managed with oversight from the Matrons.

Concerns were discussed over the budget alignment with roster templates and establishment worked and a further piece of work is ongoing to drive this improvement.

4.2 Areas of note from the Establishment reviews

4.2.1 Theatres

Theatres staffing has significantly improved since the last review with a robust recruitment plan and reduction in turnover. The theatres safe staffing SOP continues to manage risk very effectively and has been shared across the other acute hospitals.

The main challenge is the recruitment and retention of anaesthetic nurses due to lack of progression and development opportunities in this role. Innovative solutions are being explored by the Matron. The historic use of Band 3 theatre support workers who had received inhouse training to perform an assistant surgical role has now ceased and replaced with a fully trained 'First Assistant' role which is a registered role at Band 6 with a funded and recognised training programme.

4.2.2 Children's Ward

The Children's Ward follows the Royal College of Nursing guidance for registered Children's Nursing of a 1:4 ratio for age 2 or over and a 1:3 ratio for under 2 years old. Children requiring high dependency should be nursed on a ratio no higher than 1:2.

The current funded establishment is set on a 1:4 ratio and does not accommodate the ratio needed to manage children under the age of 2 or those children requiring high dependency care (a 1:2 ratio). This risk is managed on daily basis with escalation for additional staff to meet acuity when required.

Senior staff have received training on the national Safer Nurse Care Tool for children's wards and data collection is ongoing in November with the results expected to inform the next review.

4.2.3 Outpatients

Safe staffing was reviewed in detail for the first time, The Matron and Unit Manager had good oversight and a good use of skill mix based on the type of activity / clinics. They were able to clearly articulate the model and risk assessment process they used to enusre a safe delivery of care.

4.2.4 Forest and Orchard

Forest and Orchard continue to work to a higher than 1 to 8 nurse to patient ratio, they are funded to work at a 1:10 ratio with no coordinator at night. The wards are post acute and

accept patients on the stroke or fracture neck of femur pathway or those requiring complex discharge planning. However, the patient mix has become much more acute due to the operational pressure on the acute wards as well as a high dependency and requirement for enhanced care. It is recommended that the ratios are reviewed in more detail to meet the national standard of 1 to 8.

5.0 Safer Nursing Care tool

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

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

The tool should be used in conjunction with Nurse Sensitive Indicators such as patient falls and pressure ulcer incidence, which can be linked to staffing. It is endorsed by National Institute of Clinical Excellence.

Senior staff from each division were trained by the National team in August 2023 and data was collected for September. The data collection was validated by Matrons or Deputy Divisional Directors of Nursing as well as peer reviewed. This is the first year in GWH that this exercise has been carried out with this level of oversight and governance.

Once collected the data was collated in average for each ward was worked out. This daily average was then applied to the multipliers used in the national tool to determine staffing numbers in whole time equivalents. This number will then be compared to the funded establishments to ensure that they are within then nationally recommended standards.

The recommendation is that this exercise is repeated twice a year to develop a truly reflective picture of the acuity and dependency of our patients and help inform safe staffing. The next report will detail the comparison against funded establishment with the 2 data collection points in more detail.

6.0 Vacancies and turnover for nurses

There has continued to be good progress against the Registered Nursing and Health Care support worker vacancy position. Nationally there continues to be significant vacancy challenge for registered nurses with a figure of 50,000 in the NHS in March 2023 (NHSE). In October 2023 there were 3.6wte band 5 registered nurse vacancies and Health Care Support Workers continue to be in a near 0 vacancy position.

It is recognised that the vacancy figure includes those staff who have started but are supernumerary whilst being inducted. Currently the average Internationally Educated Nurse is supernumerary for 5-6 months whilst completing the training required for NMC registration. Work is ongoing to reduce this and other supernumerary time, including ward based practice educators funded through NHSE education monies.

The successful recruitment plan for registered nursing includes:

- International recruitment

The Trust has recruited 500 Internationally Educated Nurses (IENS) since 2017. With funding support from NHSE, 81 IENS have started since April 23 with another 40 due to start by January 2024.

- Newly qualified registered nurses

59 newly qualified nurses have started between September and October 2023. The Trust has a successful recruitment process for newly qualified nurses from Oxford Brookes university and other local universities. Interviews are currently under way for next years graduates with 91 applicants so far.

- Band 2 -5 Pathway

The pathway for staff to progress to a registered nurse via an apprenticeship or nurse associate route is developing and growing in strength.

The current vacancy position is described below.

Table 4 Registered Nurse vacancies Oct 22 – Oct 23

Metric	Unit/Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Vacancy		2022 10	2022 11	2022 12	2023 01	2023 02	2023 03	2023 04	2023 05	2023 06	2023 07	2023 08	2023 09	2023 10
Vacancy Rate	%	6.56%	5.97%	6.23%	7.43%	6.40%	5.30%	7.52%	8.06%	7.94%	7.80%	5.95%	4.87%	4.33%
Vacancy Rate	WTE	343.04	313.11	329.52	392.94	335.02	276.66	401.58	437.89	431.29	423.68	320.44	262.33	232.95
All Nursing Vacancy	%	5.95%	5.27%	5.62%	6.51%	5.20%	3.65%	4.50%	4.95%	5.38%	5.00%	2.73%	1.96%	1.30%
All Nursing Vacancy (Reg & Unreg)	WTE	151.92	135.61	146.64	170.25	135.53	94.47	117.71	132.11	143.74	133.58	71.58	51.43	34.17
All Registered Nursing Vacancy	WTE	102.85	87.51	91.41	92.65	77.18	43.38	84.20	97.00	107.48	103.62	74.83	47.47	18.62
B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	51.28	43.73	54.94	47.18	36.73	27.43	27.90	44.94	53.47	59.84	42.58	23.20	3.60
B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	49.07	48.10	55.23	77.60	58.35	51.09	33.51	35.11	36.26	29.96	-3.25	3.96	15.55

Health care support workers leavers and starters is described below, the reduction in turnover has continued which has allowed for further retention initiatives such as the ‘Training Ward’ to support the development of this vital workforce.

Table 5 Health Care Support Worker leavers and starters by month Sept 22 – Sept 23

	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
Leavers WTE	9.89	10.93	13.31	10.69	5.19	9.29	2.30	2.96	4.00	2.28	4.31	0.00	4.88
Starters WTE	27.71	27.71	29.44	28.48	11.00	11.00	19.20	25.44	14.64	8.40	18.49	1.96	10.64

7.0 Community Nursing

7.1 Context

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

7.2 Community Nursing Safer Staffing Tool (CNSST)

The QNI (2022) and Royal College of Nursing (2021) set out workforce standards based on modelling and activity. These outline the need for Community Nursing Services to deliver the required nursing care for a defined community population, through safe staffing establishments and skill mix that are reflective of the demand placed upon them by their local population needs.

To support safe workforce planning and delivery, GWH Community Nursing Services participated in cohort one of the NHSE CNSST. Data collection was undertaken the week commencing 24th April 2023, for a period of seven consecutive days during the core working hours. To ensure a national standardised approach, it did not include work performed by the twilight (until 22:00) or night service, as a number of Community providers do not offer this component. Using a decision matrix tool, nurses assigned patient dependencies (1-4) based on the care provided during the visit, and any Community Nursing unmet needs were identified.

Findings demonstrated that the registered nurse (B4-7) to unregistered nurse (B3) establishment ratio was in line with CNSST recommendation (70% registered:30% unregistered). The staffing numbers across all four localities were also reported in line with CNSST recommendations, however, the data collection process was found not to have captured a significant amount of unmet care needs. These were important aspects of care that were perceived less time critical, such as dopplers, and were therefore not routinely assigned care plans until identified capacity was available to deliver them.

During the first CNSST data collection, call outs for the 2-48 hrs response with the Urgent Community Response (UCR) service, for patients known to community nursing, were not included. Historically, this was CNS work but in more recent times has been delivered by UCR, likely due to capacity challenges. This 2-48 hrs work is currently in the process of being realigned back to Clinical Nurse Specialists (CNS) and the data will hopefully be reflected in the second wave of data collection taking place in October 2023. Additionally, CNS work undertaken during the twilight shift is also planned to being captured in October to allow for a true reflection of core community work.

Our data highlights, in line with other South West region providers, that 61% of CNS work delivered is categorised as the lowest level of dependency (category 1). New and sustainable ways of working, using where possible technology and an agile system wide workforce, must be considered during the community contract commissioning.

The second data collection began 30th October 2023, and in line with NHSE recommendation, at least 2 data sets are required before review of permanent establishment changes based on demand. This will be triangulated with professional judgment, quality metrics and benchmarking, and will align with the Trust's business planning cycle.

7.3 Fair and Manageable Workload

Using the Improving Together methodology, a go/see was undertaken with the Divisional HR Business Partner and the Head of Service for planned Community Services, which observed that Community and District Nurses identified that overburdened workloads were a significant barrier to safe holistic care. It was also recognised that there was a paucity in robust risk stratification delivering daily patient care.

The QNI (2022) outlined red flags for safety concerns, including deferring high priority work (for example end of life care, blocked catheters) or high numbers of deferrals on a regular basis. Currently, there are still no identified standards for a maximum caseload size or number of visits per day, however it was noted that evidence suggests that caseloads bigger than 150 patients and more than 10 visits per nurse per day, were tipping points for deterioration of quality indicators and increase in patient harm.

Using prototype tools of CNSST shared by other high performing community nursing services, a prioritisation and triage tool was developed and implemented within Swindon CNS. This tool provides a framework to be used alongside professional judgement that enables nurses to safely defer visits based on a triage and a risk stratified prioritisation of work. The process was implemented using a Quality Improvement approach (PDSA) in order to address any expected or unexpected outcomes. Prior to implementation, the tool was reviewed by specialists in urology, pharmacy, tissue viability, medicine and continence, and continues to follow an iterative process. Version 5 of the tool and the associated escalation process is being presented at Community governance in November for ratification.

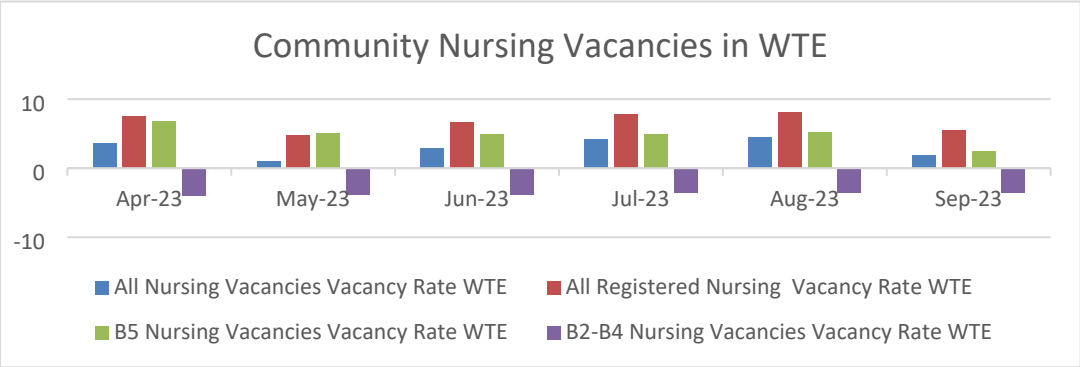
Initial findings have identified that visit assignment is undertaken using a risk stratified approach, which means there is now clearer visibility on unmet need and greater shared working across localities. A survey of staff identified greater work life balance, improved wellbeing and less omissions in care where it had been implemented. Three times per day huddles review unmet need, share work and form part of the divisional escalation process. Metrics, including patient harms (medicines, pressure harms), caseload sizes, deferred visits and deferred visits >7 days, are monitored at the monthly quality and performance meeting to ensure overview. In addition, the service has also planned to implement patient reported experience measures (PREM) and patient reported outcome measures (PROM) over the next 3-6 months.

7.4 Vacancies, turnover and sickness absence

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

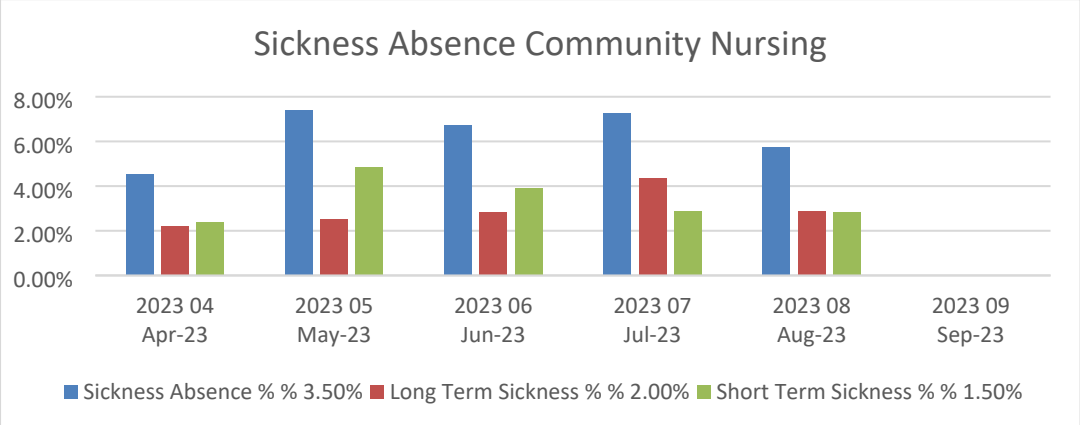
The current vacancies for band 5 registered nurses are 2.49 wte (Sep 23) and the average turnover is 11.76%. The service is slightly over recruited with HealthCare Support workers and the turnover for this group is usually low, with 0% in August 2023.

Table 6 Community Nursing vacancies



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

Table 7 Community nursing sickness absence



8.0 Maternity staffing

8.1 National / regional context

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

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

Trusts are expected to commission a BR+ report every 2-3 years, and a revised report was received by GWH's report in May 2022, which was funded by the Local Maternity and Neonatal System (LMNS). This report identified a registered midwife gap of 3.33wte. The BR+ report is reflective of a 20% uplift in maternity services. Following the Ockenden report there is a requirement to reflect a workforce that can accommodate increased levels of training. This requires a 28% uplift (including maternity leave) to achieve this training requirement. A temporary uplift of 24% has been approved utilising the CNST rebate from year 4 of the maternity incentive scheme. Further analysis of the workforce across the LMNS is in progress to develop a system wide approach to a sustainable headroom uplift.
It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has improved over the last six months by identifying different staffing models, recruitment locally and through engagement with the NHS England international recruitment program.

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

The recruitment plan will continue as a rolling planned model of recruitment to ensure that there is a constant pipeline of new starters.

The inpatient services have been successful with recruitment with the current vacancy sitting within the community midwifery workforce. This is anticipated to be significantly reduced over the next 3 months with newly recruited midwives to the Trust, internal staff moves to the community services and staff returning from parental leave.

There is now a plan to further focus on retention of staff, utilising the health education England funding for the retention lead midwife to continue in post for a further 12 months, April 2023-March 2024.

The below table illustrates the level of staff turnover across departments, monthly between February 2023 and August 2023. Whilst the turnover rate in the Community teams remains high, there has been a decrease in all other areas. The recruitment and retention plan has an increased focus on community services.

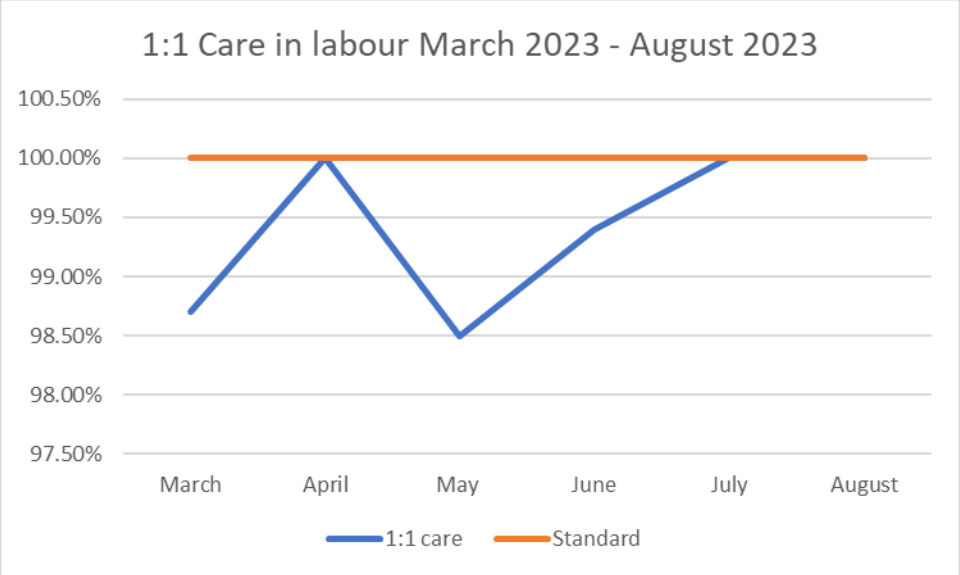
Division	Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Surgery, Women's & Children's Division	Ante-Natal Screening - J65919	5	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Birthing Centre - J65921	15	1	6.90%	1	6.90%
Surgery, Women's & Children's Division	Community Midwifery - J65918	47	8	17.02%	5	10.64%
Surgery, Women's & Children's Division	Continuity of Carer - Midwives - J65922	11	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Day Assessment Unit - J65910	23	0	0.00%	0	0.00%
Surgery, Women's & Children's Division	Hazel & Delivery Staff - J65914	140	25	17.92%	20	14.34%
Surgery, Women's & Children's Division	Specialist Midwives - J65920	22	3	13.95%	2	9.30%

Alongside the reduced turnover rate, there has been a reduction in sickness in most staff group, with a reduction from 10.51% to 4.21% in the Hazel and Delivery Suite staff groups. This has been supported by a focus on supportive 'Welcome Back to Work' meetings and HR guidance.

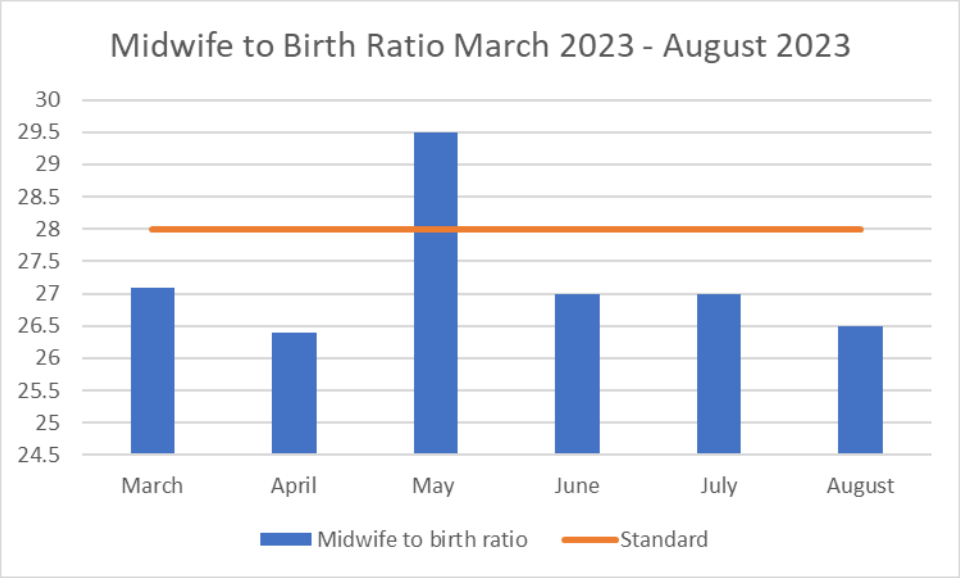
Sickness Rates as of August 2023				
Department	Staff Group	Short Term	Long Term	Absence %
Ante-Natal Screening - J65919	Registered Nursing and Midwifery	0.00%	0.00%	0.00%
Birthing Centre - J65921	Registered Nursing and Midwifery	4.65%	0.00%	4.65%
Community Midwifery - J65918	Registered Nursing and Midwifery	3.30%	2.81%	6.11%
Continuity of Carer - Midwives - J65922	Registered Nursing and Midwifery	0.37%	0.00%	0.37%
Day Assessment Unit - J65910	Registered Nursing and Midwifery	1.18%	4.04%	5.21%
Hazel & Delivery Staff - J65914	Registered Nursing and Midwifery	2.67%	1.54%	4.21%
Specialist Midwives - J65920	Registered Nursing and Midwifery	9.20%	3.20%	12.40%

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

The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the graph below demonstrates that it fluctuates between 98.5 % and 100% compliance over the 6-month period. Each case where 1:1 care is not fully achieved is reviewed to ensure that escalation processes have been utilised to minimise the impact on the family, and to provide opportunities to develop escalation pathways to prioritise labour care in line with the Maternity Incentive Scheme (CNST) safety action 5. A local action plan supports this ambition.

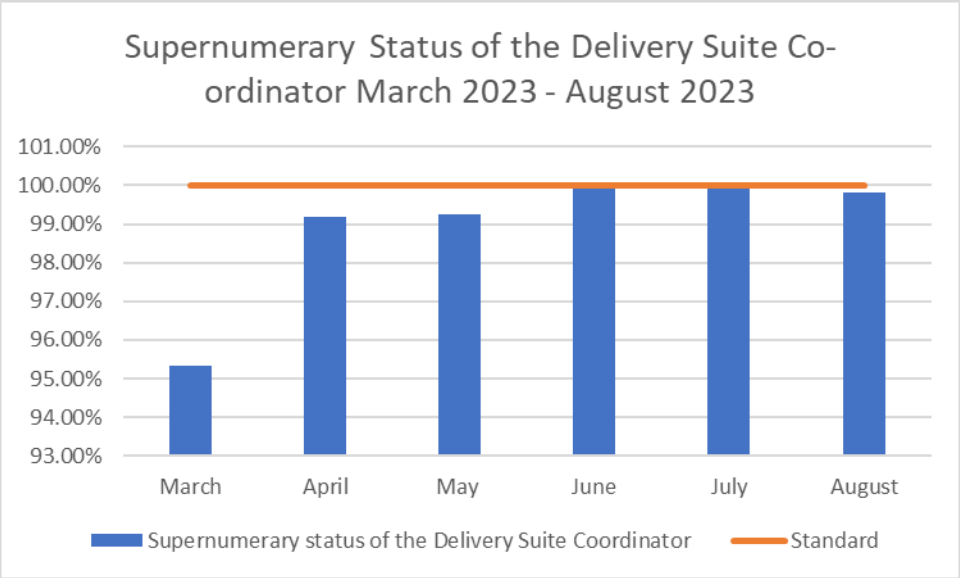


The Maternity Service monitors and reports the Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer Childbirth (2007). The midwife to birth ratio is calculated using the funded establishment rather than the actual staffing numbers in line with national guidance. The table below demonstrates a fluctuation in the midwife to birth ratio which is impacted by variable birth numbers month on month and the vacancy factor in the community midwifery team.



8.4 Supernumerary status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status to ensure there is an oversight of all birth activity within the service. This is defined as having no caseload of their own during their shift. Over the period September 2022 – February 2023 a mean compliance rate of 98.93 % was achieved. The focus is now on achieving 100% compliance and identifying measures to achieve this within the current staffing model. Where compliance is below expected each episode of care is reviewed by the governance team.



8.4 Red Flags

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

The 10 red flags are as follows:

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

Analysis of the data shows that there was an increase in consistent data entry into the tool. There was a reduction in the percentage of data entry occasions that recognised a red flag event from 7% (01/09/2022- 28/02/2023) to 3% (01/03/2023- 31/08/2023). There was also a reduction in the number of occasions where management actions were required to escalate staffing concerns.

In April 2023 an Acute Unit Midwifery on call system was introduced which is now embedded in the Maternity escalation policy. This has been utilised on 6 occasions since introduction, demonstrating a low frequency of use with a high impact where the on-call system been triggered via escalation processes.

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

8.6 Recruitment and retention

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

- Introduction of the Midwifery Degree Apprenticeship Program being introduced in collaboration with Winchester University. The first midwifery apprentices are currently being recruited from the existing maternity support worker workforce
- Retention lead midwife and senior leaders engaging with students from day one as future employees
- An extended supernumerary period for newly qualified midwives, utilising nationally available funding
- Scheduled meet and greets with divisional staff, new starters and students
- Review and refresh of preceptorship package
- Blended learning programme with University of West England
- Working with Universities to increase student midwife places
- Return to practice programme
- Successful International recruitment of Midwives bid (collaborative bid across BSW)
- Band 5 Nurse role within maternity
- Health Education England funding for nurses to undertake 2-year Midwifery course
- Close working with Swindon College, supporting T level student placements
- Health and well-being programme
- Apprenticeship and Nurse Associate model to ‘grow our own’.

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

8.7 Continuity of carer

The model to provide a named midwife for a woman through the perinatal pathway has been a key National deliverable, in 2022 all national targets for full implementation were reviewed. This followed the Ockenden report published on March 30th, 2022, advising a review was undertaken by all provider Trusts of the local implementation of Continuity of Carer model to ensure safe staffing was prioritised across the maternity service.

The Trust continue to provide one Continuity of Carer team, who focus service provision for the geographical area where vulnerable populations are. The team have recognised

challenges with the model of working and have adapted this model to accommodate staff members where possible. The turnover rate has been low for the team to date. Attracting staff to work within the model of care has been challenging due to the high on call requirement, which may be a risk to recruitment to further teams. Focus is on retention of the current team by exploring alternate models of working which may reduce burnout and create a more predictable working pattern.

9.0 Neonatal staffing

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

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

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

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

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

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

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

Staffing requirements will fluctuate with acuity and therefore staffing to an average cot occupancy result in staffing being set at 7.0 wte per shift.

The requirement is for 1 registered nurse that is qualified in speciality (QIS) to 4 intensive care babies. Data for quarter 1 2023/24 shows the Trust was compliant for 84% on days and 83% on nights. This is an increase from 71% at night in the previous reporting period due to staff attaining the QIS qualification.

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

Turnover Rates			
Department	Average Head Count	All leavers	All Turnover
Neonatal Unit - J65931	42	7	16.87%

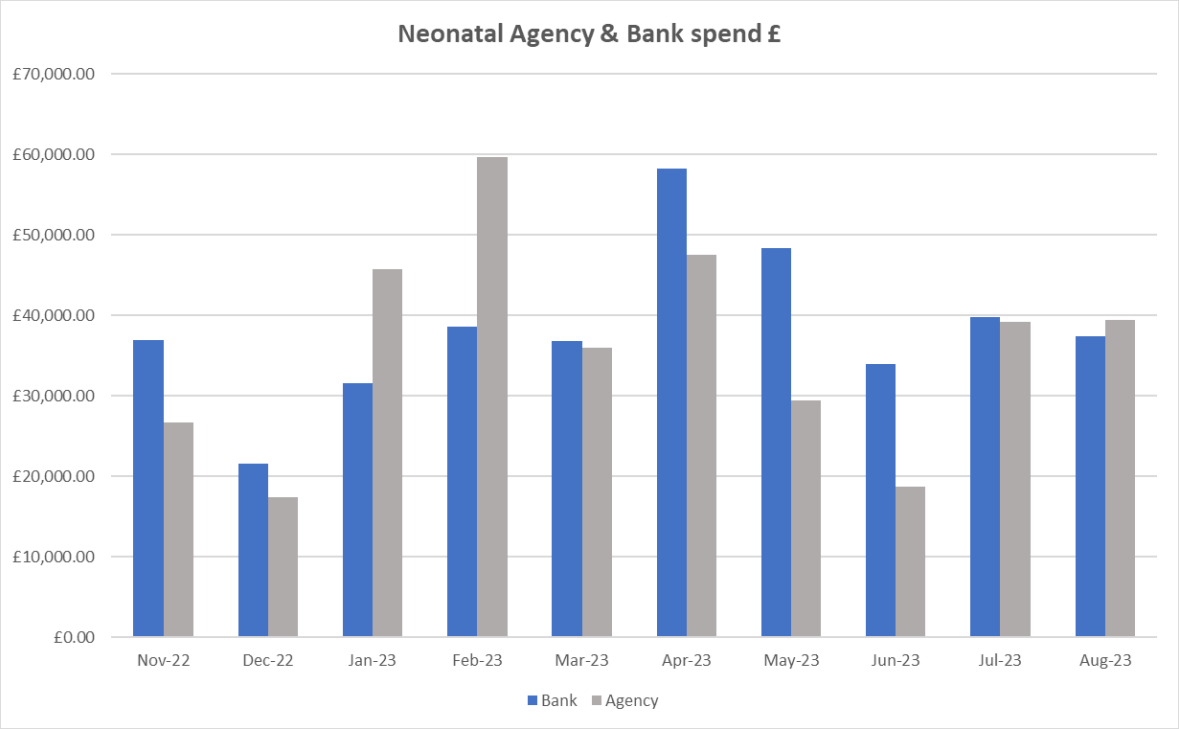
Sickness Rates			
Department	Short Term Sickness	Long term Sickness	Total % Sickness
Neonatal Unit - J65931	3.91%	3.10%	7.01%

There has been an increase in turnover rate within the clinical team due to some staff members geographical relocation and several internal promotions. The sickness has reduced from 15.99% in the previous reporting period to 7.01% in the current period. A refreshed approach to the 'Welcome Back to Work' introduced by the new ward managers process has positively impacted on sickness.

Recruitment of nursing staff continues, with the aim of staffing the neonatal unit to BAPM safe staffing standards following the operational delivery network (ODN) review of staffing against acuity. Recruiting Qualified in Speciality (QIS) nurses has been challenging with no suitable applicants over the reporting period. Recruitment into Band 5 posts for nurses who are not yest QIS has been successful, with the recruitment and retention focus on supporting those nurses through a preceptorship program and with educational support to increase the annual intake of nurses onto the QIS education pathway.

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

There is a current focus on reducing agency use at times of high acuity and there appears to be an improved bank fill compared to agency during 3 of the months in the reporting period. The improved pipeline of new staff, increasing ANNP support and further staff completing the QIS training during the next 4 months is anticipated to reduce the agency use.



10. AHP report

10.1 Introduction

AHP is an umbrella term for a range of professions and includes registered Health and Care Professions Council (HCPC) practitioners and support staff. AHPs are a diverse group of professionals supporting people of all ages to live healthy, active and independent lives. This paper supports provides the six-month workforce review.

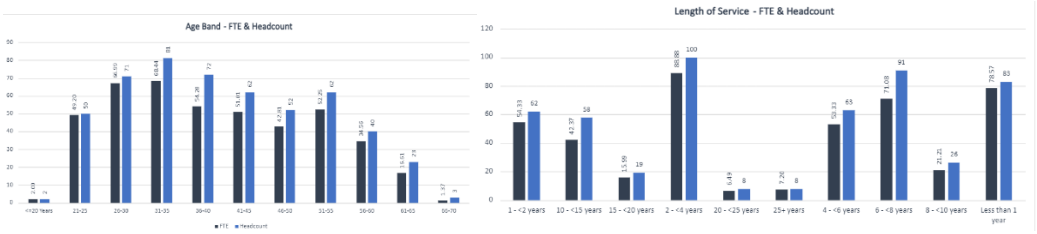
The Trust's AHPs are a distinct group of practitioners who apply their expertise to diagnose, treat and rehabilitate people of all ages across all our divisions. The combined AHP workforce is made up from registered and un-registered colleagues has a headcount of 518 staff or approx. 8.5% of the GWH workforce.

The registered AHPs make up 74% of our AHP staffing and AHP Support workers is around 26%. Within Great Western Hospital there are nine AHP professional staff groups that include Dietitians, Diagnostic Radiography, Occupational Therapy (OT), Operating Department Practitioner (ODP) Orthoptists, Paramedics, Physiotherapy (PT), Podiatrists and Speech and Language Therapists (SLT). The AHPs are essential for delivering Great Care for our patients.

The Trust's AHP workforce metrics demonstrate challenge on presenting an ED&I workforce; as an AHP community, most of the workforce is female, and there is underrepresented from those of a global majority heritage. This is a similar picture nationally for AHPs.

This has changed over the previous six months November 22 - April 23 staff from a Global Majority heritage was around 18.6% and for this period is around 22%.

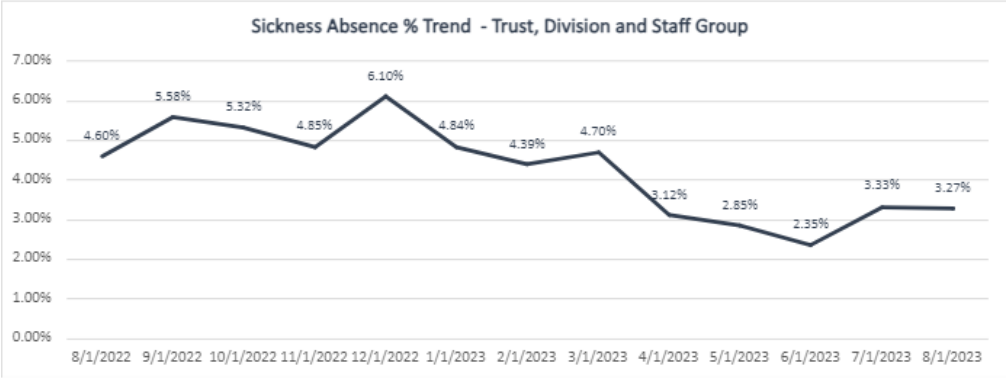
The age profile and the length of service of the AHP workforce is as follows:



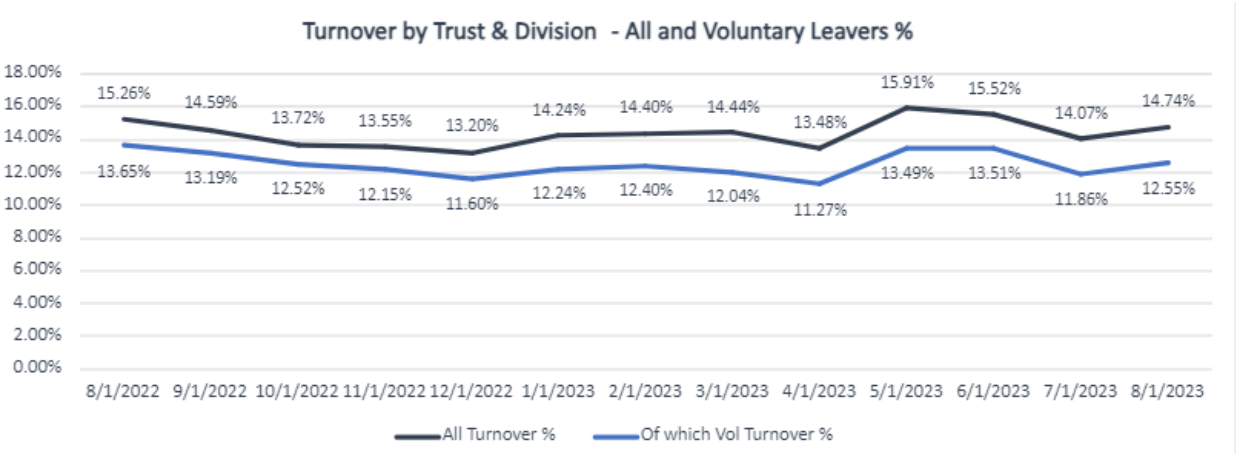
Around 5.5% have declared a disability, again improved recording from the previous report which indicated 22.8% not declared and this is now around 18.8%.
Around 3% of the workforce identify as LGBT+ as classified within ESR, Bisexual, Gay, Lesbian or Other.

10.2 Sickness

Sickness absence is monitored within professions and individual teams and AHP teams are supported by our HR business partners. The Sickness absence is improving and has consistently reduced over the last six months from 4.85% to 3.27%.



Mandatory training is generally very positive and has continued to improve over the last six months. Staff turnover is around 14%,



Of the staff that leave GWH, there is no significant themes across the AHP professions, with the highest reasons being retirement, promotion and to undertake further education (this would include AHP Support workers leaving to start degree programmes).

10.3 AHP workforce planning

This work has begun with the AHP professional leads, linked to strategic work force planning and the NHS long Term Plan. AHP Professional groups, facilitated by the AHP Education and Development lead are working through A3 methodology which will be used to progress an overarching AHP workforce plan. The workforce plan will work through train, retain and reform headings.

10.4 Safer staffing and elective recovery

Job planning for AHP is in its infancy, limited use within some team but this is not centrally managed and will be an area of focus for the Associate Director of AHP. This will link to a wider initiative around values-based health care and AHP productivity and reference costs. This work is reporting to the Trust recovery subcommittee but will also report to the Senior Nurse and AHP workforce committee as it progresses.

Radiology, Physiotherapy and Dietetic are working hard to support the elective recovery plan, with driver metrics to drive recovery and to improve productivity. These are monitored and progressed through the improving together performance framework within their divisions.

10.5 AHP workforce

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

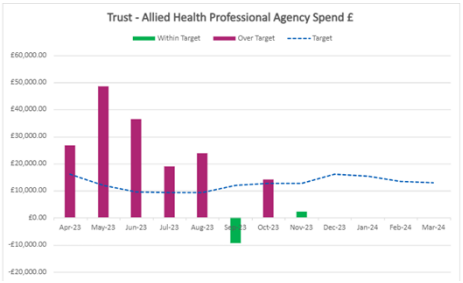
10.6 AHP Leadership

Over the past 18 months, GWH have invested in AHP leadership, with the establishment of the AHP education and development role and this will be reinforced with the appointment of the first dedicated Associate Director for AHP. These roles will continue to support the development of the AHP workforce strategy to secure a progressive AHP workforce for the future.

In addition, there is the appointment to the vacant Head of Acute Therapies (OT and Physiotherapy) and professional lead for Physiotherapy due to commence in January 2024.
There remain gaps in professional leadership within Radiography, they have Clinical leadership of specialities (Diagnostic Radiology, Ultrasound and Mammography) but as yet no professional lead of their service. In addition, orthoptists, ODPs and paramedics are also without professional leadership roles.

10.7 AHP Agency and Bank Spend

AHP have been working hard to address the cost pressures within the various professional teams in the past six months. The most significant AHP agency spend now sits within radiology and specifically relates to a shortage of sonographers.



There is an action plan in place to support the reduction in waiting times for Ultrasound. This is being supported through third party engagement and a plan until March 2024. Radiology do not have a professional lead, but they are supported by a general manger (GM) who is a HCPC registered Radiographer and so the Associate Director for AHPS (AD AHP) will work collaboratively with the GM and service to review workforce models and strategies to improve recruitment and retention.

10.8 Workforce themes

10.8.1 Train

The AHP workforce is vital for providing the best care to our patients, and are working to establish and grow the workforce for the future, building capacity and capability across the professions to secure the future workforce within GWH. AHPS are working closely with the early years team, encouraging our local student population to think about AHP as a future career. AHP workforce plans include the development of clinical apprenticeship roles. The current AHP apprentice workforce has risen to 27 AHP from the previous year of 22; these are from level 3 AHP support workers to level 7 tACP.

The AHP E&D lead and the AHP student placement team within the academy has been vital in improving the offer to AHP student learners and engagement with the early years team. The AHP student placement team have been funded through AHP student tariff and their role is to support student learners across the Trust, support the AHP student supervisors, support and improve relationships with Health Education Institutes and develop the quality and number of student placements. Their focus over the next 12 months is to maximise student placement capacity, enhance student placement experience and support our AHP staff who are clinical educators within the professions.

International Recruitment

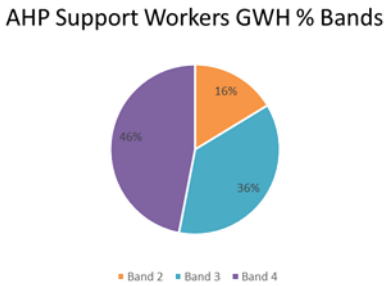
Targeted international recruitment (IR) supported the appointment of two mammographers, one podiatrist and one occupational therapist. There has been additional internationally educated colleagues who have joined our AHP teams through the Trac application process.

IR AHPs are now involved in the extended induction programme and receive additional information, such as the welcome booklet and the “this is me” document that is shared with line managers.

On boarding remains a challenge to those who have not had previous NHS experience and the AHP Education and Development Lead will continue to support teams. It is hoped the launch of the preceptorship programme will help with the additional support required not only for Internationally educated staff but for all our new to roles and newly qualified staff.

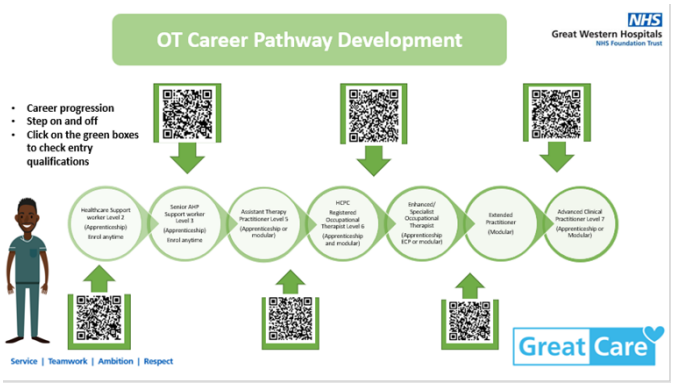
Skill mix

In GWH there are 138 AHP support workers, the approximate break down across the clinical banding is as follows.



The national AHP Support worker framework is used to access high-quality learning and career progression.

There has also been work on mapping the clinical career development route, the example below is for the Occupational Therapy career pathway.



10.8.2 Reform

We are seeing increasing numbers of AHP colleagues practicing as ACP's or who are working towards MSc Advanced Practice (or equivalent).

Examples of AHP reforms

- There are a small AHP team working within the cancer team with a focus to supporting patients to be as well as they can prior to cancer treatment and supporting rehabilitation. Working to reduce length or stay and reduction in readmissions.
- There is an established multidisciplinary AHP team that supports patients on ICU introducing rehabilitation at the earliest part of their clinical recovery. Shortening the recovery journey.
- The acute therapy teams have been working to support the Get Up Get Dressed campaign, supporting the Active Wards initiative, and preventing deconditioning.
- AHP at the front door, facilitating discharge and early intervention, including an ACP and paramedic handover supporting admission avoidance.
- Podiatry and podiatrist surgical teams preventing and avoiding admissions for those with complex foot disease, reducing surgical intervention, decreasing length of stay and admission avoidance.

Key Risk and work in progress

- AHP senior leadership within Divisional senior teams is inconsistent and will be a priority for the Associate Director for AHP to address with Divisional Triumvirates.

- AHP supporting the ED & I programme, including the Allyship programme and cultural ambassadors and cultural competency training.

- Recruitment and retention challenges for specific AHP staff groups remains an issue, for example Orthoptics have been out to advert three times for a band 6 post.
- Roll out of BSW In Place Student placement allocation across AHP's.
- The mapping and development of 7-day services across GWH AHP's

11. Trust Risk Register

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

12. Conclusion

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

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

13. Recommendations

The report makes the following recommendations:

- Repeat the SNCT in the new year and then compare the results against funded establishment to inform areas of risk and benchmarking establishments nationally.
- Continue to ensure good recruitment and retention programmes with bespoke plans in high risk areas. The Trust should continue to invest in International Recruitment for all disciplines.
- Ensure the recommendations from the estblishment reviews are considered fully in business planning.
- Continue to develop the Nurse Associate role and the pathway for unregistered nurses into registered nursing.