GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

# TRUST BOARD

## Thursday 7 December 2023, 9.00am to 12.15pm
## Trust HQ Boardrooms, Great Western Hospital, Swindon / MS Teams (hybrid meeting)

## AGENDA

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

| | | PAPER | BY | ACTION | TIME |
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| **OPENING BUSINESS** | | | | | |
| **1.** | **Apologies for Absence and Chair's Welcome**<br>Julian Duxfield | Verbal | LC | - | 9.00 |
| **2.** | **Declarations of Interest**<br>Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust | Verbal | LC | - | - |
| **3.** | **Minutes of the previous meeting (public)**<br>Liam Coleman, Chair<br>• 2 November 2023 | 1 – 14 | LC | Approve | - |
| **4.** | **Outstanding actions of the Board (public)** | 15 | LC | Note | - |
| **5.** | **Questions from the public to the Board relating to the work of the Trust** | None | CC | - | 9.15 |
| **6.** | **Care Reflection (Patient Story) – Support for patients with hearing impairment**<br>Tania Currie, Head of Patient Experience & Engagement<br>Jenny Kear, Head of PALS | 16 – 21 | TC/JK | Assurance | 9.20 |
| **7.** | **Chair's Report**<br>Liam Coleman, Chair | 22 – 24 | LC | Note | 9.45 |
| **8.** | **Chief Executive's Report**<br>Kevin McNamara, Chief Executive | 25 – 35 | KM | Note | 9.55 |
| **9.** | **Integrated Performance Report**<br>• Integrated Performance Report – Pillar Metric deep dive and refresh | 36 – 85 | LC/ Executive Directors | Assurance | 10.15 |
| ***BREAK (10 minutes) at 10.45am*** | | | | | |
| | • Performance, Population & Place Committee Board Assurance Report (November) – Bernie Morley, Non-Executive Director & Committee Chair | 86 – 87 | BM | Assurance | 10.55 |

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| | • Quality & Safety Committee Board Assurance Report (November) – Claudia Paoloni, Non-Executive Director & Committee Chair | 88 – 89 | CP | Assurance | - |
| | • Finance, Infrastructure & Digital Committee Board Assurance Report (November) – Faried Chopdat, Non-Executive Director & Committee Chair | 90 – 91 | FC | Assurance | - |
| **10.** | **Audit, Risk & Assurance Committee Board Assurance Report**<br>Helen Spice, Non-Executive Director & Committee Chair | 92 | HS | Assurance | 11.25 |
| **11.** | **Charitable Funds Committee Board Assurance Report**<br>Paul Lewis, Non-Executive Director & Committee Chair | 93 – 94 | EKA | Assurance | 11.35 |
| **12.** | **Emergency Preparedness Resilience Response Annual Statement**<br>Felicity Taylor-Drewe, Chief Operating Officer | 95 – 105 | FTD | Assurance | 11.45 |
| **13.** | **Amendments to Standing Financial Instructions (SFIs) Financial Limits**<br>Simon Wade, Chief Financial Officer | 106 – 107 | SW | Approve | 11.55 |
| | **CONSENT ITEMS**<br>**These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.** | | | | |
| **14.** | **Ratification of Decisions made via Board Circular**<br>Caroline Coles, Company Secretary | Verbal | CC | Note | 12.00 |
| **15.** | **Urgent Public Business (if any)**<br>To consider any business which the Chair has agreed should be considered as an item of urgent business | Verbal | LC | - | - |
| **16.** | **Date and Time of next meeting**<br>Thursday 11 January 2024 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ | Verbal | LC | Note | - |
| **17.** | **Exclusion of the Public and Press**<br>The Board is asked to resolve:-<br>*"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"* | - | - | - | 12.15 |

**Board Meeting Timetable**

| 2024 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec |
| Board | Board | Board | Seminar | Board | Board | Seminar | Board | Board | Seminar | Board | Board |
| | | | Culture & Learning | | | Use of Resources | | | Population & Health | | |

Great Western Hospitals NHS Foundation Trust

# MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ AND VIA MS TEAMS 2 NOVEMBER 2023 AT 9.30AM

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**Present:**

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| 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 |
| 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:**

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|---|---|
| Caroline Coles (CC) | Company Secretary |
| Naginder Dhanoa (ND) | Chief Digital Officer |
| Julian Duxfield (JD) | Non-Executive Director |
| Claire Lehman (CL)* | Associate Non-Executive Director |
| Rommel Ravanan (RR)* | Associate Non-Executive Director |
| Deborah Rawlings (DR) | Board Secretary |
| Emily Beardshall | Deputy Director, – Improvement & Partnership (agenda item 147/23 only) |
| Hayley Payne | Nutrition Assistant, Trauma Ward (agenda item 147/23 only) |
| Louise Bent | Clinical Lead, Orthopaedic Therapy (agenda item 147/23 only) |
| Karen Jones | Acute Physiotherapy Team Lead (agenda item 147/23 only) |
| Kat Simpson | Head of Midwifery & Neonatal Services (agenda items 153/23 & 154/23 only) |
| Laura Little | Project Coordinator for Maternity & Neonatal Services (agenda items 153/23 & 154/23 only) |
| Sharon Woma | Lead for Equality, Diversity & Inclusion (agenda item 1155//23 only) |

**Apologies**

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| Will Smart (WS) | Non-Executive Director |

**Number of members of the Public**: There were 4 members of public (including 2 governors Chris Shepherd and Vivien Gibbs).

*Indicates those members attending virtually by MS Teams

## Matters Open to the Public and Press

| Minute | Description | Action |
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| 142/23 | **Apologies for Absence and Chair's Welcome** | |

| Minute | Description | Action |
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The Chair welcomed Board members and attendees to the Great Western Hospitals NHS Foundation Trust Board meeting held in public.

Apologies were received as above.

143/23 **Declarations of Interest**
There were no declarations of interest.

144/23 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 7 September 2023 were adopted and agreed as a correct record, subject to the following amendments:

Minute No. 121/23 – IPR – Quarterly Pillar Metric deep dive – Our Performance
2nd paragraph add "*delays*" at the end of the paragraph.

Minute No. 121/23 – IPR – Our Care
In the 1st paragraph change Lisa Cheek, Chief Nurse to Luisa Goddard, Deputy Chief Nurse.

Minute No. 124/23 – Workforce Disability Equality Standard (WDES) Annual Report 2022-2023 and Workforce Race Equality Standard (WRES) Annual Report 2022-2023
2nd paragraph amend 1st sentence to "The key areas of change and/or progress were noted by the Board, together *with developing an approach* to those areas that required improvement."

145/23 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

146/23 **Questions from the public to the Board relating to the work of the Trust**
There was one question for the Board from a Member of the Trust which was on clinical research for drug treatment of long-term Covid. In response from the Chief Medical Officer, it was noted that treatment was provided in the community by the BSW Long Covid Rehabilitation Assessment Clinic and that any patient who had attended the hospital would be referred to the long Covid clinics.

The Board **noted** the question.

147/23 **Care Reflection (Staff Story) – Improving Together**
*Emily Beardshall, Deputy Director – Improvement & Partnerships, Hayley Payne, Nutrition Assistant, Trauma Ward, Louise Bent, Clinical Lead, Orthopaedic Therapy, and Karen Jones, Acute Physiotherapy Team Lead, joined the meeting to present this item.*

The Board received a reflection from Hayley Payne and Louise Bent on being part of Cohort 4 of the Improving Together training. Improving Together methodology had been applied in the Trauma Ward to drive improvement against its three driver metrics, which related to reducing pressure harms, increasing the number of patients who were mobilised on the day of surgery following a hip fracture and improving staff morale. The challenges faced were noted and that early benefits had been celebrated on the improvements that had since been implemented. The

| Minute | Description | Action |
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approach had been positively received by the multi-disciplinary team and that there had been increased awareness of data and improved ability to take collective action on problems. Hayley added that actions were being taken to continue with the momentum across all disciplines in the Trauma Unit with the aim to encourage change and empower team members to raise ideas.

A further reflection was received from Karen Jones on being part of Cohort 2 of the Improving Together training. Improving Together knowledge had been applied with the Acute Physio team and that a prioritisation board had been implemented. The challenges faced were noted and that early benefits had included the whole team now being engaged in agreeing projects, the prioritisation board helped to show and share progress, and that there was streamlined focus on ideas to create better momentum and encouraged celebration.

Emily Beardshall outlined steps being taken within the organisation to capture benefits realisation and to allow teams to prioritise against methodology and to see alignment through the organisation. Informal support networks for cohorts were being introduced to enable shared opportunities within the organisation to be adapted to individual teams. The ability to have protected time for huddles and dedicated time for off-site Improving Together training had been recognised.

The Chair thanked Emily, Hayley, Louise and Karen for sharing this improvement approach to embed improvement using the Improving Together methodology.

The Board **noted** the Improving Together staff story.

148/23 **Chair's Report**

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

The Board noted the resignation from Mufid Sukkar as governor representing Wiltshire Northern constituency in September 2023. The Board formally thanked Mufid for his support and commitment during his time as governor.

The Board **noted** the report.

149/23 **Chief Executive's Report**

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

Seasonal Plan – The direction of the Seasonal Plan had now been agreed and scaled back to make it more achievable and that the system process for identified funding had been completed. Performance comparison within the system would mean continued scrutiny and active conversations were underway to gain support from system partners during the Winter period.

Care Quality Commission update – The recent engagement visit with the new local CQC team had gone well. The report from the CQC Maternity Inspection held in September 2023 was still awaited.

| Minute | Description | Action |
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Financial position – The integrated care system as a whole was required to achieve financial balance and the Integrated Care Board had established an oversight group to understand our collective performance against the NHS oversight framework. Tighter restrictions were being imposed on revenue investments being made by trusts along with a requirement for more assurance of progress on the delivery of savings. An internal committee had been set up, with a number of Executive-led workstreams to review how spending could be reduced.

Staff survey – Positive engagement with the staff survey had exceeded the previous year's target and currently stood at 61%.

Black history month – A celebration event had been held in the Academy in October which included a number of guest speakers and support networks to share information and answer questions. It was noted that a recent communication from the Health Secretary had instructed the NHS to stop recruiting roles solely focussed on diversity and inclusion. Kevin McNamara, Chief Executive gave reassurance of both the Trust Board and Chief Executive's continued commitment to the EDI agenda and also support for Sharon Woma as the Trust's EDI Lead.

Lizzie Abderrahim, Non-Executive Director commented that she was encouraged by the commitment made by the Chief Executive and the Board to continue to support EDI. Lizzie Abderrahim also encouraged all Board members to sign up to the Allyship Programme as this was a visible way to show commitment as a board and as individuals.

Faried Chopdat, Non-Executive Director asked about the structures and mechanisms in place for Freedom to Speak Up (FTSU) within the organisation and what measures were in place to demonstrate whether people felt safe enough to speak up. Jude Gray, Chief People Officer responded that qualitative feedback would be received from the staff survey, exit interviews and other avenues available to staff to raise concerns. However, acknowledged there was more work required to strengthen the mechanisms and processes in place.

Claire Lehman, Associate Non-Executive Director also commented that the majority of FTSU concerns raised were pertaining to HR issues rather than patient safety concerns and that some safety issues potentially interlinked with HR issues and that it would be useful for the Board to understand this data in more detail. Lisa Cheek, Chief Nurse responded that there were HR policies and processes in place to enable HR issues to be raised and that further consideration would be given to strengthen all processes to ensure that other mechanisms were utilised to allow staff to raise concerns.

It was noted that Speaking Up and Listening would form part of a development session for the Board to be undertaken in April 2024 and in the meantime the Board were requested to complete the FTSU on-line training to raise the Board's capability in this area and a link would be circulated.

**Action: Chief People Officer** **JG**

The Board **noted** the report.

| Minute | Description | Action |
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150/23 **Board Assurance Reports**

**Our Performance**

**Performance, Population and Place Committee Chair Overview**

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meetings on 27 September 2023 and 25 October 2023 and the following was highlighted:

Emergency Access – Ambulance waiting times had increased and non-criteria to reside (NCTR) was stable but had not decreased. A reset week was planned in early December with the South Western Ambulance Service NHS Trust in line with the Care Coordination Hub in Chippenham to take any lessons learnt to improve the situation.

Cancer – 3 cancer metrics were deteriorating, particularly in relation to performance against the 62-day standard especially in terms of dermatology and urology. A dermatology locum consultant for 3 days a week had now been recruited and that funding had been secured from NHSE to outsource treatment. A further deep dive into cancer metrics would be undertaken in November 2023 at the PPPC.

Felicity Taylor-Drewe, Chief Operating Officer added that the 2-week wait pathway had also impacted on routine dermatology appointments and an external provider was due to come online in early December but the impact of this would not be seen until 4 weeks after that date.

A dermatology task and finish group had also been established which involved all stakeholders and that this group would be considering options for new and innovative opportunities working with AHA colleagues. In the meantime, work continued with primary care colleagues, commissioning colleagues and local procurement to drive further improvement.

RTT – There had been one breach over 78 weeks and the number of patients waiting over 65 weeks had decreased in month by 28 patients and this appeared to be a downward trend. Deep dives had been undertaken into the seven specialties and that extensive work undertaken as a result of this had resulted in a significant decrease in the waiting lists.

Theatre Performance - A positive presentation had been received on Theatre utilisation and that steps had been taken to address gaps in usage. Two Theatres were closed due to estates work until the end of March 2024. The number of DNAs had significantly decreased due to an initiative to make changes in the way that patients were contacted prior to booked appointments to ensure that this was still correct.

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 meetings on 21 September 2023 and 19 October 2023 and the following was highlighted:

| Minute | Description | Action |
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Total Harms – Performance for pressure harms and hospital acquired infections had yet to show improvement. However, Q&SC was satisfied that considerable actions were underway to drive improvement and that there was a better understanding of the causes and the actions required in response to that.

Water Management and Pseudomonas and Action Plan – Assurance was provided that actions developed around the mitigation of infection rates had resulted in a reduction in the number of Pseudomonas levels reported over the last three months. The Trust had been working closely with the UKHSA and NHSE to support and challenge this detailed action plan and that the output of those actions could be evidenced to provide a degree of confidence that appropriate steps were being taken.

The Board **noted** the report.

**Use of Resources**

**Finance, Infrastructure & Digital Committee Chair Overview**

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meetings on 25 September 2023 and 23 October 2023 and the following was highlighted:

Month 6 Revenue – As at Month 6, the Trust was in a £6.9m deficit position, representing a £6.0m adverse variance to the plan. The key drivers of the £6.0m unfavourable variance were industrial action direct costs (£1.7m), undelivered efficiency savings (£1.9m), a shortfall on ERF related income (£3.7m), additional medical pay award costs (£0.4m) and temporary staffing pressures (£1.4m). The Committee was assured that improved governance and controls on the finance run rate and productivity, efficiency programme, capital spending, and the EPR programme were in place.

Efficiency Programme – Efficiency savings were £0.5m behind target in-month and were £1.9m behind plan on a YTD basis, specifically the non-delivery of nursing and medical agency savings. An internal Financial Recovery Board had been established to increase focus on delivery through Executive led workstreams. The Committee would continue to monitor the position closely.

In response to a question from Lizzie Abderrahim, Non-Executive Director on the target for agency spend and whether this needed to be changed, Faried Chopdat, Non-Executive Director replied that there had been extensive debate on this at FIDC and although it was acknowledged that good progress had been made in relation to nursing and medical agency spend, this would be reviewed more collectively in relation to locum and bank staff and there would be more focus to reduce the headcount rather than isolated to agency spend.

Simon Wade, Chief Financial Officer updated the Board on work around the risk which related to elective recovery fund income and in response to the industrial action.

| Minute | Description | Action |
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Electronic Patient Record (EPR) – A decision was still awaited from the NHSE in response to the submission of the EPR business case and that any raised queries were being addressed and progressed.

Clinical Coding Update – This longstanding risk continued to be monitored as clinical coding remained a concern and that more effort was required to address this risk to an acceptable position and that further work was being undertaken by Data Warehouse on coding issues.

Data Protection and Cyber Update – Although the Trust had intended activities for 2023/24, concern remained around the heightened risk of cyber-attacks and the Committee requested more insightful reporting on all attacks, whether unsuccessful or not, and the need for greater control and a more robust incident management response approach.

Reinforced Autoclaved Aerated Concrete (RAAC) – It had been confirmed that the Trust did not own or occupy (leased) any properties that contained RAAC.

The Board **noted** the report.

**Our People**

**People & Culture Committee Chair Overview**

The Board received a verbal, due to timing of the meeting, overview of the discussions held at the People & Culture Committee (P&CC) at its meeting on 31 August 2023 and the following was highlighted:

Staff Survey – Integrated Care & Community – Good progress had been made by the Integrated Care & Community Division and that the latest survey response rates were very encouraging.

EDI – There was a lot of proactive work in this area, however one challenge was attracting Network Chairs. It was noted that there was an outstanding action for the Board to provide feedback on their reflections following the previous board development session in April 2023 to the Chief People Office to agree next steps for individual and collective commitments.

**Action: Board members** **ALL**

Annual Retention Report and Annual People Report – These reports had provided good levels of assurance, systems and processes were effective and plans for future improvement had owners and deadlines for oversight by P&CC.

Staff Turnover/Retention Rates – Staff turnover rates continued to improve and has been on an onward trajectory since 2022 and that this Trust compared favourably to national figures.

Sickness absence rates – The trend continued to improve and reflected the significant actions taken at Trust level to drive improvement.

The Board **noted** the report.

| Minute | Description | Action |
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**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 August and September 2023.

The Board **noted** the report.

151/23 **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 14 September 2023 and highlighted the following:

Division of Medicine Risk Report – Extensive work had been undertaken and there were improved processes, however more actions were required to achieve further improvement and maintain control particularly around the extreme risks.

Cyber Security Annual Report – There had been no cyber-attacks and the Trust's systems had not been penetrated. However, ARAC was not assured that there was an appropriate response framework in place to respond to an incident if it arose and that this remained a risk for the Trust. An external review was also to take place to provide additional reassurance.

Internal Audit Progress Report and Action Tracking – Outstanding actions were now closed and that processes to ensure an improved timely sign off of actions was in place.

Internal Audit Plan 2023/24 – The internal audit plan for 2023/24 was approved subject to ensuring that there was flexibility in the plan if alternative reviews were required.

Counter Fraud Progress Report – Communication within the organisation had been undertaken by the new Counter Fraud team and that there had been extensive engagement with several areas of the Trust. This had resulted in 11 cases being notified so far this year, none of which were of concern.

National Cost Collection 2022/23 – The Committee approved the process and timetable for completion of the national cost collection for 2022/23. It was noted that a detailed independent review by NHSE of the Trust's national cost collection submission had not been undertaken for some time and therefore the Committee requested assurance that the comparatives were correct and relevant.

NHSCFA Procurement Report Actions – Good progress had been made in response to findings from the national review on Purchase Order versus Non Purchase Order spend. ARAC would continue to monitor the actions to roll-out the final policy within the organisation and asked for a progress report at its January 2024 meeting.

The Board **noted** the report.

| Minute | Description | Action |
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152/23 **Mental Health Governance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Mental Health Governance Committee at its meeting on 20 October 2023 and highlighted the following:

- There was increased assurance that the Trust was appropriately managing the challenge that was associated with caring for people with mental ill health whilst in our care and that there were much improved reporting processes now in place. Good engagement with partner organisations including regional partners as well as child and adolescent mental health specialist providers.

- Increased agency costs for RMN support were highlighted for both adult and children's services and an example was provided of a young person that continued to be detained under the Mental Health Act.

- An update on the national framework of Right Care, Right Person which sets out how the Police and health services respond to individuals with mental health needs. Lisa Cheek, Chief Nurse commented that the risk continued to increase for the Trust however the true impact of this framework was yet to be known and further engagement was required to address concerns. A Children and Young People's Summit had been convened for 14 November 2023 with the aim to develop and deliver a new model of care for them and their carers.

The Board **noted** the report.

153/23 **Saving Babies Lives v3 – GWH First Assessment (Oct 2023)**

*Kat Simpson, Head of Midwifery & Neonatal Services and Laura Little, Project Coordinator for Maternity & Neonatal Services joined the meeting to present this agenda item.*

The Board received an overview of the improvement plan for all six elements of the Saving Babies' Lives Care Bundle. CNST Year 5 required two Local Maternity & Neonatal System (LMNS) assessment reviews to have taken place within the reporting period by January 2024, which provide a structured analysis of the Trust evidence using the national implementation tool.

It was noted that this was the first data submission to the LMNS and that data had been validated and feedback provided from the LMNS which had defined next steps for improvement. An in-depth review of identified improvement actions and associated timeframes would be reviewed at the November Maternity & Neonatal Safety Champions meeting for discussion.

It was noted that the Trust was at risk of non-compliance with CNST Year 5 Safety Action 6. Validation was still awaited from NHSE via the three year plan as to whether a proportionate response was allowed to be considered as fully compliant. The Board was assured that the Trust would be able to demonstrate implementation of 70% of interventions across all six elements overall and implementation of at least 50% in each individual element.

| Minute | Description | Action |
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The Board noted the overview of the improvement action plan and was assured that the Quality & Safety Committee would continue to monitor progress of the plan to reach compliance.

The Board **noted** the report.

154/23 **Ockenden Report – GWH Update**

*Kat Simpson, Head of Midwifery & Neonatal Services and Laura Little, Project Coordinator for Maternity & Neonatal Services joined the meeting to present this agenda item.*

The Board received a paper which provided an update on the Immediate & Essential Actions (IEAs) outlined in the full Ockenden Report including key highlights for celebration and key risks.

Kat Simpson outlined the actions being undertaken to mitigate against the conversion of the 'amber' actions to 'green' and the next steps for progression. The Board was pleased to note that there were no remaining 'red' actions and it was acknowledged that this was as a result of engagement from the teams in multi-disciplinary training activities and accessing educational opportunities, together with the succession planning strategy across maternity services and implementation of the preceptorship.

Paul Lewis, Non-Executive Director/Maternity Board Safety Champion added that he was assured by the level of ownership and insight that was now in place within maternity and neonatal services and expressed his gratitude for the considerable work undertaken by the team to facilitate this achievement.

The Board **noted** the report.

155/23 **Equality Diversity Inclusion Annual Report 2022-23**

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

The Board received and considered the Equality Diversity Inclusion Annual Report 2022-2023 which provided evidence of progress and achievements during the period for our workforce and patients. A presentation to accompany the report was given by Sharon Woma, Lead for Equality, Diversity & Inclusion and covered progress against objectives, action plan in response to frameworks, and priority actions.

Helen Spice, Non-Executive Director commented that she felt the report was slightly unbalanced between patients and our people in terms of priorities and if future reports could include narrative on equity of access to appointments and treatments. In response, Sharon Woma explained that steps were being taken to improve our staff's ability to be inclusion practitioners to transform patient care and engagement with patients. Claire Thompson, Chief Officer of Improvement & Partnerships added that the health inequalities work being undertaken at the Trust was now considering bringing the groups together and that this would be explored further through the Performance, Population & Place Committee

| Minute | Description | Action |
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Lizzie Abderrahim, Non-Executive Director commented that there was a mixture of 2022/23 and 2023/24 actions contained within the report and there should be a clear distinction, also a key Board decision was excluded around the continuation of the Continuity Care Maternity pathway.

Rommel Ravanan, Associate Non-Executive Director asked for assurance that the Trust was meeting the needs of people in the bottom 20% of deprived areas and how this could be analysed for future annual reports. In response, Sharon Woma explained that this data could be explored further by the Trust's Inclusion & Health Inequalities Sub-Committee to drive further improvement on this data.

It was agreed that the report would be further reviewed to ensure that the points raised had been captured and reflected appropriately within the report prior to publication.
**Action: Chief People Officer** **JG**

**RESOLVED**

The Board **approved** the report subject to the changes reflected in the meeting prior to publication on the Trust's website.

156/23 **Freedom to Speak Up Annual Report 2022-23**

The Board received the Freedom to Speak Up Annual Report 2022-23 which provided an overview of the work of the FTSU Guardians, updates from the National Guardian's Office including the FTSU Guardian Survey, and the activity over the 12-month period related to this report.

It was noted that a new lead Guardian had been appointed in January 2023 and was a dedicated substantive post for two days per week. Due to the change of Lead Guardian and the role being vacant for a number of months prior to this appointment, there had been a decline in some of the activity required to support the FTSU service and this had been reflected in the reduced number of referrals seen this year.

The Quality & Safety Committee had now reviewed the FTSU action plan which focussed on raising awareness and developing a more resilient and robust service. A good communication and meeting structure had now been established with regular oversight meetings, support for the FTSU Guardians from the Deputy Chief Nurse and resource to ensure timely data submission to the National Guardian's Office.

Lizzie Abderrahim, Non-Executive Director asked for a better understanding of the rationale behind the partial assurance level provided as the assurance felt very limited due to the significant gaps and that there was no evidence identified as yet from the impact of the action plan. Kevin McNamara, Chief Executive accepted this challenge in light of the reported issues around the FTSU service and commented that the FTSU service had also been included as part of the Well Led Review of which the outcome was awaited.

The Board **noted** the report.

| Minute | Description | Action |
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157/23 **Patient Safety Incident Response Framework Implementation Plan and Policy**

The Board received a report which outlined the new governance arrangements for responding to patient safety events that might occur at this Trust. The policy has been aligned to the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework and would replace the Incident Management Policy currently used. The policy would be supported by the Patient Safety Response Plan.

It was noted that the plan and policy had been robustly considered by the Quality & Safety Committee, who had recommended it to the Board for approval.

The Board noted that there were five key priorities for the Trust to focus on which related to:

- Reducing pressure harm in our patients
- Reducing falls with harm in our patients
- Medicines safety optimisation
- Optimising care pathways and transfers of care
- Optimising communication

For the five key priorities identified, Trust-wide improvement plans would be developed to increase learning and reduce the risks to patient safety that these areas posed or themes identified. Action plans would then be monitored through an oversight process. The Board welcomed the compassionate engagement of all those involved in the overview of incidents, in relation to the support for families in particular and also support for staff members throughout the process.

In response to a question by Peter Hill, Non-Executive Director on how learning could be cascaded from situations that had been identified as being handled appropriately, Lisa Cheek, Chief Nurse commented that the paper only currently focussed on those areas that did not do well and that the cascade of learning from areas of success had yet to be worked through for inclusion in the implementation plan. The Board welcomed the inclusion of this approach and that oversight through the Quality & Safety Committee would provide ongoing assurance to the Board.

Helen Spice, Non-Executive Director asked how the Board would receive assurance in the future on this new process. Lisa Cheek, Chief Nurse replied that Board would continue to receive the right oversight, however the format was still being developed and would evolve over time as the new process is fully implemented and embedded.

**RESOLVED**

The Board **approved** the policy and plan.

158/23 **GWH Health & Safety Annual Report 2022-23**

The Board received the Annual Health & Safety Report which provided an overview of events and performance of the health and safety, fire and security disciplines for 2022/23. The Annual Health & Safety Statement of Commitment was also noted.

| Minute | Description | Action |
|---|---|---|

It was highlighted that the Trust had received two Health & Safety Executive Improvement Notices in November 2022 which related to the Microbiology Department following their pre-planned inspection. Both Improvement Notices had been remedied within the required compliance dates and learning had been embedded.

The Board acknowledged that although the report was generally positive, there were several areas that still required further work to evidence improvement. The challenges around the resource within the H&S Team were acknowledged by the Board and that active recruitment continued to bring the team up to full establishment.

The Board also discussed inequality data within reported incidents and that the H&S Team needed to review all incidents through an inequality lens to capture learning.

Lizzie Abderrahim, Non-Executive Director asked for further clarification on the definition used for "uncooperative/stubborn patient" and a perception of behaviour may reflect a cultural issue and could affect how data was collected. It was agreed that verification would be sought on whether the definition was a self-generated definition or a definition generated from an external source. **SW**
**Action: Chief Financial Officer**

**RESOLVED**

The Board **approved** the Annual Report and the Health & Safety Statement of Commitment for inclusion in the Health & Safety policy.

159/23 **IT Cyber Security – Annual Summary Report**

The Board received a summary of the annual activity for IT Cyber Security and sought to provide assurance on the key activities being undertaken to bolster the Trust's cyber defences and to maintain the integrity of GWH's computer network and systems from cyber-attacks.

The Board noted that over the reporting period, there had been no successful cyber-attacks on GWH's computer systems and that the network had not been compromised, which was as a result of the implementation of improved toolsets and a focussed team.

Implemented initiatives had continued to deliver cyber security objectives and drive improvements. Collaborative work continued with BSW ICB partners, the South West Region and NHS England to continue to improve cyber defences through joint implementation of security solutions and to adopt the "Stronger Together" and "Defend As One" approach.

It was noted that the Finance, Infrastructure & Digital Committee would continue to monitor the impact and outcome of these implemented initiatives going forward.

The Board **noted** the report.

| Minute | Description | Action |
|---|---|---|
| | **Consent Items**<br>*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.* | |
| 160/23 | **Ratification of Decisions made via Board Circular**<br>None. | |
| 161/23 | **Risk Management Policy**<br>The Board received the Risk Management Policy which had been reviewed in line with the 3-year review period and the changes made were noted.<br><br>**RESOLVED**<br><br>The Board **approved** the Risk Management Policy. | |
| 162/23 | **Urgent Public Business (if any)**<br>None. | |
| 163/23 | **Date and Time of next meeting**<br>It was noted that the next meeting of the Board would be held on 7 December 2023 at 9.30 am, in the Trust Management Boardroom, Great Western Hospital, Swindon, SN3 6BB. | |
| 164/23 | **Exclusion of the Public and Press**<br>The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest. | |

The meeting finished at 13.30hrs

| ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – December 2023 | | | | |
|---|---|---|---|---|
| PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee | | | | |
| **Date Raised** | **Ref** | **Action** | **Lead** | **Comments/Progress** |
| 2 November 2023 | 159/23 | **Chief Executive Report / Freedom to Speak Up**<br>Link/guidance to be circulated to Board members to complete FTSU training. | Chief People Officer | Guidance circulated. |
| 2 November 2023 | 150/23 | **IPR / Our People / ED&I**<br>Board members to provide feedback on their reflections following the previous board development session in April 2023 to the Chief People Office to agree next steps for individual and collective commitments. | ALL | Agenda item on Board private session for discussion on ED&I objectives. |
| 2 November 2023 | 157/223 | **Equality Diversity & Inclusion Annual Report**<br>To amend the annual report to reflect Board member comments before publication. | Chief People Officer | The report has been amended to reflect changes with final sign off by the Chair and Chief Executive before publication. |
| 2 November 2023 | 158/23 | **Health & Safety Annual Report**<br>Verification to be sought on whether the definition used for “uncooperative/stubborn patient” was a self-generated definition or a definition generated from an external source. | Chief Financial Officer | Update at the meeting. |

| **Future Actions** | | | | |
|---|---|---|---|---|
| | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Care Reflection** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **7th December 2023** | Part 1 (Public) | x | Part 2 (Private)] | |
| **Accountable Lead** | Lisa Cheek, Chief Nurse | | | | |
| **Report Author** | Tania Currie, Head of Patient Experience and Engagement | | | | |
| **Appendices** | Powerpoint presentation with film | | | | |

**Purpose**

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

**Assurance Level**

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

| 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:

The Care Reflection identifies actions that have been implemented in order to address areas of concern related to inequality of access to care and services.

**Report**

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

The Care Reflection shares the experience of Derek who is profoundly deaf. Derek has regularly used services at GWH and 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 Patient Advice and Liaison Team have worked closely with the Gloucester Deaf Association to support Derek and to ensure that his needs are met. The team have built a very strong relationship with Derek to ensure that he has good channels of communication and is able to raise any queries and have concerns addressed promptly and effectively.

The film explains some of his personal experience and how the team have worked to improve this.

| | | | | | |
|---|---|---|---|---|---|
| **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** | For noting at Equality, Diversity and Inclusion group | | | | |
| **Next Steps** | The Care Reflection will be shared widely with staff and is available on the trust intranet for future learning | | | | |

| **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 Care Reflection identifies actions that have been implemented in order to address areas of concern related to inequality of access to care and services. | | | |

| **Recommendation / Action Required**<br>The Board/Committee/Group is requested to: | |
|---|---|
| To receive the presentation as assurance of the developments and improvements in patient pathways of care identified in the Care Reflection film. | |
| **Accountable Lead Signature** | Lisa Heath |
| **Date** | 22 November 2023 |

Great Western Hospitals
NHS Foundation Trust

# Care Reflection

Trust Board

December 2023

Tania Currie, Head of Patient Experience and Engagement

Jenny Kear, Head of Patient Advice and Liaison Service

# Care Reflection

Great Western Hospitals NHS Foundation Trust

## Support for Patients with Hearing impairment

- This care reflection explains the experience of Derek who is profoundly deaf
- Derricks first language is British Sign Language (BSL) and he is non verbal
- Many deaf patients also have challenges with understanding written communication
- Derek attends the hospital regularly and had raised a number of concerns in relation to being able to communicate effectively with our staff
- The PALS team have worked collaboratively with Derek and the Gloucester Deaf Association to make improvements to support him

**Film link:** (2) Sign Live: Derek's story - YouTube

# Care Reflection

NHS
Great Western Hospitals
NHS Foundation Trust

## Improvements implemented

- Clearer specific needs alert added to Careflow to highlight need for face to face interpreter
- Education for booking/OPD teams to ensure alert reviewed and implemented
- New role within PALS with EDI focus – direct contact for patients with specific needs
- New Deaf Awareness cards introduced
- Improvements made to hearing loop systems and associated signage
- First cohort of staff undertaking basic BSL interpreting course

# Care Reflection

Great Western Hospitals NHS Foundation Trust

## Improvements implemented

- Sign Live systems upgraded
- Specific device located within ED/UTC
- Additional functionality added to Sign Live System to enable direct communication via Signlive app with the PALS team and BSL interpreter

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Chair's Board Report** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **7 December 2023** | Part 1 (Public) | x | Part 2 (Private)] | |
| **Accountable Lead** | Liam Coleman, Chair | | | | |
| **Report Author** | Caroline Coles, Company Secretary | | | | |
| **Appendices** | n/a | | | | |

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

**Assurance Level**

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

Process

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

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

**Report**

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

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

The report provides information in respect of:-

- Council of Governors – Key Meeting Dates
- Non-Executive Directors
- 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**<br>The Board/Committee/Group is requested to: | |
|---|---|
| **The Board is requested to note the contents.** | |
| **Accountable Lead Signature** | Liam Coleman, Chair |
| **Date** | 28 November 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 November 2023.

## 1. Council of Governors

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

| Date | Event | Purpose |
|---|---|---|
| 8-Nov | Monthly Chair and Lead Governors Meeting | Regular meeting to update and discuss any topical issues |
| 8-Nov | Council of Governors Meeting | To gain assurance, on behalf of the membership and the public, on the organisation's performance, with a particular focus on service quality. |
| 14-Nov | People's Experience & Quality Working Group | To identify key issues in relation to service users and staff experience and the quality of the work of the Trust. The Group received updates on staff survey, quality accounts, patient experience and staff wellbeing. This meeting is aligned to the Board Committees Quality & Safety and People & Culture. |
| 28-Nov | Business & Planning Working Group | To identify key issues in relation to address in relation to Trust finances and business planning. This meeting is aligned to the Board Committees Finance, Digital & Infrastructure and People, Population & Place. |
| Various | Swindon Library Membership Engagement | To promote Trust membership. |

## 2. Non-Executive Directors

2.1 Two Non-Executive Directors, Helen Spice and Faried Chopdat were re-appointed for a second term of office at the Council of Governors on 8 November 2023.

2.2 Also approved for re-appointment at the Council of Governors meeting was my position as Trust Chair for a third term of office. The Council not only considered the balance of the Board in terms of my experience, skills and past performance but also in the context of the departure of the Chief Executive in order to facilitate stability on the Board, retain corporate memory and provide support for the new Chief Executive, as well as the Interim Chief Executive.

## 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 |
|---|---|---|
| 16 November 2023 | Dove Ward | Jon Westbrook, Chief Medical Officer<br>Claudia Paoloni, Non-Executive Director<br>Helen Spice, Non-Executive Director |
| 27 November 2023 | Day Surgery | Claire Thompson, Chief Officer of Improvement & Partnerships<br>Faried Chopdat, Non-Executive Director<br>Claire Lehman, Associate Non-Executive Director |

## 3. Trust Chair Key Meetings during November 2023

| Meeting | Purpose |
|---|---|
| Monthly meeting with Non-Executive Directors & Associate Non-Executive Directors | Regular meeting to update and discuss any topical issues |
| 1-2-1 meeting with Chief Executive | Regular meeting |
| Monthly Chair/Lead Governors' Meeting | Regular meeting to update and discuss any topical issues |
| AHA Committees in Common | Regular system meeting |
| Finance, Infrastructure & Digital Committee | To attend as an observer |
| Performance, Population & Place Committee | To attend as an observer |
| HWB Champions' Forum | To attend as a member |
| Council of Governors | Meeting with Governors |
| Wiltshire Health & Care Members' Board | To attend as a member |
| Trust visit from Ron Kerr, Chair of NHS Providers | Information gathering visit on challenges, priorities and good practice |

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Chief Executive's Report** | | | | |
| **Meeting** | Trust Board | | | | |
| **Date** | 7 December 2023 | Part 1 (Public) | x | Part 2 (Private)] | |
| **Accountable Lead** | Kevin McNamara, Chief Executive | | | | |
| **Report Author** | Kevin McNamara, 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:

- Financial and performance challenges
- Ambulance handover delays
- Maternity Care Quality Commission inspection
- Community services
- Integrated Front Door
- Staff survey
- EDI Inclusive and Safe Workplace Award
- 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**<br>– risk number & description (Link to BAF / Risk Register) | | | | **Risk Score** |
| | N/A | | | |
| **Consultation / Other Committee Review / Scrutiny / Public & Patient involvement** | N/A | | | |
| **Next Steps** | none | | | |

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

Explanation of above analysis:

The report includes a number of updates related to equality, diversity and inclusion, in particular:

- Recognition of our internationally-educated nurses.
- The Trust winning the Inclusive and Safe Workplace Award, meaning we will become an exemplar workplace with our work shared nationally to inform best practice, and funding provided to train a team of EDI champions.
- Disability History Month, which included a focus on encouraging staff to share their disability to help us build a more inclusive workplace.
- WAY Beacons – a collaboration between the Trust and local authority, which matches vulnerable young people with a mentor to support them. Many of these individuals wouldn't have been previously known to social services.

| **Recommendation / Action Required**<br>The Board/Committee/Group is requested to: | |
|---|---|
| **To note the report** | |
| **Accountable Lead Signature** | Kevin McNamara, Chief Executive Officer |
| **Date** | 30 November 2023 |

## 1. Operational updates

### 1.1. Addressing financial and performance challenges

Last month we received a letter from NHS England addressing the financial and performance challenges caused by industrial action and how the impact of industrial action will be funded.

Set alongside the financial arrangements was a set of national priorities for the remainder of the year, specifically to protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care at the same time as achieving financial balance.

Systems have been asked to agree the actions required to deliver these priorities for the remainder of the financial year.

Nationally, the impact of industrial action this financial year has led to costs in the region of £1 billion, and a loss of elective activity.

The Department of Health will allocate £800 million to systems through reprioritising national budgets (such as the digital programme which may have a bearing on our shared Electronic Patient Record full business case) and some new funding resulting in £4m of funding for the Trust proportionate to our workforce headcount. The elective activity target for 2023/24 has been reduced to a national average of 103%.

Board members will be well-versed on our financial performance year to date and the actions that have been taken, and that we continue to take, to reach our year end forecast. Year to date our Trust is £4.7m worse than our plan, with the key drivers for this including industrial action costs, undelivered savings, a shortfall on Elective Recovery Fund-related income, extra medical pay award costs, and temporary staffing pressures. Our focus is to finish the financial year in a breakeven position. The national funding for industrial action to cover the costs we have incurred has helped close the gap but there remains more to do, which is not without risk. However, it remains a goal for the Trust and we are currently the only Trust locally putting forward that forecast for year end.

In addition, we have been asked, along with other providers in BSW, to institute stringent workforce controls to ensure grip and control is maintained on workforce growth. We are working on these controls with the system and it will include a representative from the Integrated Care Board joining our internal vacancy control panel.

Overall our workforce has seen the lowest growth amongst peers in the system since March 2020: our Trust stands at 12.7%, compared to 20.7% at the RUH and 19.2% at SFT. We have also seen the lowest growth in WTEs compared to March 2023.

We must recognise that we were also starting in a challenging position due to lower staffing ratios and care hours per day remains lower in some areas in comparison to our partners.

Notwithstanding the above, these additional controls aim to ensure that posts directly impacting patient safety are prioritised and that we also explore alternatives such as skill mix to help support the financial challenges.

**1.2. Ambulance handover delays**

We know that delayed ambulance handovers create a real risk of patient harm – it can increase mortality for patients waiting to be handed over, and also increase risks for those patients waiting for an ambulance to become free to respond.

Our performance over the past three months places us in the bottom eight Trusts nationally for delays caused to ambulance crews handing their patients over to us and we are accessing additional national support following a national meeting in early November. At that meeting all organisations were asked to recalibrate risk and for acute

organisations to take more of that risk within the confines of the acute footprint to reduce the risk to patients waiting in ambulances or waiting out in the community for an ambulance.

We know from our own experience that there are a set of actions we must take as a Trust to help improve the situation and reduce risk for our community, we have also made a handful of asks of partners to help support their element of the pathway – for example pushing to maximise the use of the Coordination Centre to provide a means for all non-life threatening ambulances to call the Coordination Centre to consider an alternative pathway before a patient is conveyed to hospital.

In the past few weeks we have taken the following actions:

- Initiated daily hospital handover delay meetings to oversee the actions we have agreed and allow a more agile and targeted response when issues arise.
- Established two cohort spaces (around 9 spaces in total) at the front door as additional escalation at peak times to support ambulances to get back on the road
- Three additional spaces have been put into the wards as part of the escalation process. These were deemed to be unsuitable for patients and given the risks we are managing we have agreed to put them back in place.

This capacity is in addition to a range of interventions already in place as part of our escalation including but not limited to an internal queue in the Emergency Department (within a defined area) and pre-empting onto wards. We also continue to use the 23 spaces on wards that do not have full bedded amenities. All of this is part of our escalation process and not without impact on the risk profile in terms of quality, safety, experience, finance and workforce.

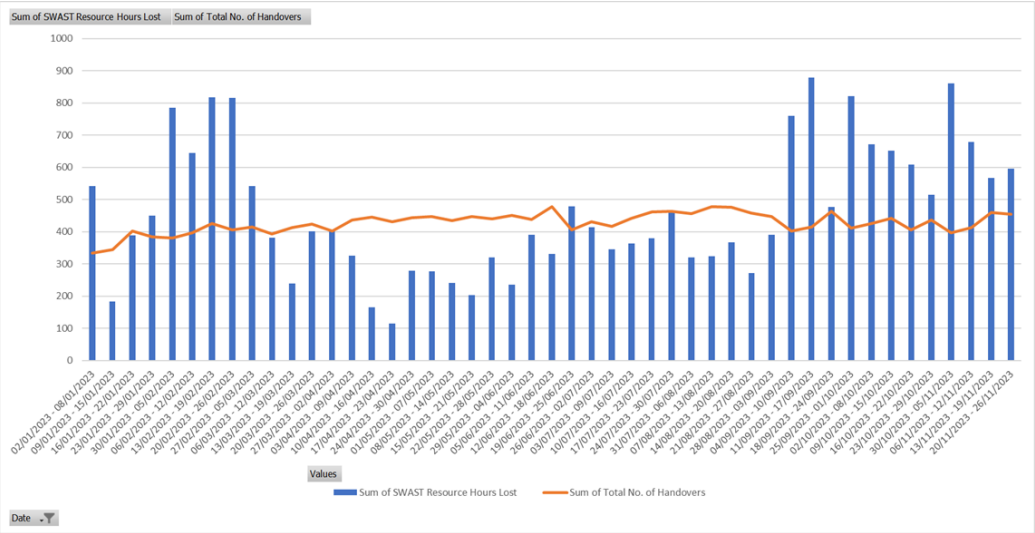
We agreed at the Quality and Safety Committee last month that additional oversight through that committee will be monitored.

We have also worked with system partners to agree new stretch targets for weekday/weekend discharges and length of stay for Non Criteria to Reside patients, in addition some capacity is coming back on stream beginning in December to replace the lost capacity through the Sunflower beds where funding was no longer available.

Internally we continue to push improvements in utilisation of our virtual ward (Hospital@Home) capacity. We have seen positive progress through October and November, after a period of static performance, achieving its highest level of occupancy in the last week of November. More work is required to continue to maximise use of this capacity in the context of the system pressures and patient risk.

In early December we have a planned Reset Week which coincides with BSW Care Coordination week – we hope to capitalise on the level of interest to create a step change across the system.

Ambulance hours lost: January - November 2023




### 1.3. Respiratory illnesses

In recent weeks we have seen an increase in numbers of children with respiratory illness coming to hospital.

In one week in mid-November nearly 700 children required urgent care, an increase of more than a third when compared to the first week of September, with a notable increase in children attending with difficulty breathing.

The high dependency and resus bays in the Emergency Department (ED) have often been full, and there has been a significant increase in attendances to the Urgent Treatment Centre, Emergency Department and in primary care.

In addition, a large number of these children are also requiring ongoing inpatient care, and at times when both the Children's Unit and Paediatric Assessment Unit were full, this has meant some older children being cared for in converted adult beds, with paediatric staff monitoring.

We stood up an incident response, enabling special arrangements to be put in place. This included additional GP support in the Urgent Treatment Centre, children's clinics being stood up in the community run by primary care, and closer working with Child and Adolescent Mental Health Services (CAHMS) to support children with mental health conditions who need follow-up community care after discharge from hospital.

We issued guidance to the public on when to visit the Emergency Department with their children, and worked with local media to raise awareness of this issue.

We asked parents to familiarise themselves with the symptoms of respiratory syncytial virus (RSV), a common winter virus that causes similar symptoms to a cold, including coughs, rapid or laboured breathing and drowsiness.

### 1.4. Industrial Action update

Last week the Government announced that it had made a new pay offer to NHS consultants which could end industrial action. Members of the British Medical Association and Hospital Consultants and Specialists Association will now consider the offer through a ballot. There remains a risk regarding other staff groups during this period.

### 1.5. Project Verify

We have secured funding for a project to help us validate our waiting list through a digital questionnaire.

These questionnaires will confirm whether patients will take up their appointments, gather responses to indicate if a patient's clinical urgency has changed, and help assess whether the patient is suitable for a surgical procedure.

Covering patients on both admitted and non-admitted pathways across 35 specialties, we anticipate this work will involve us contacting around 100,000 patients.

We will be working closely with our digital communication partners at DrDoctor to help share this message, with patients receiving the questionnaire and being asked to respond digitally via text message. This will help us to identify where patients are waiting unnecessarily or receiving appointments that are no longer required, along with confirming that they still need our care.

A better understanding of the patients on our waiting lists helps us to maximise activity by reducing missed appointments while also encouraging patient-initiated follow-ups, which is a key priority for the Trust.

## 2. Quality

### 2.1. Maternity

The Care Quality Commission carried out an inspection of our maternity service in September, as part of a national programme of inspections of maternity units.

At the time of writing, we had received a draft report of the inspection which we were in the process of fact-checking before the report is published.

The feedback received from the CQC indicates the following areas of focus in the report:

- Progress on 'should do' actions previously identified
- Acting on risks
- Triage
- Safeguarding training
- Risks of paper and electronic documentation
- Oversight of incidents

### 2.2. Inpatient survey

Some patients who had a stay in hospital last month will be asked for their views on their experience early in the new year as part of the National Inpatient Survey.

Patients will be asked to share feedback on their inpatient experience, including waiting times, communication, nutrition and information about their care.

Areas identified in the 2022 Inpatient Survey included how long patients wait in urgent and emergency care for admission to a bed and the wider process around discharge. Communication was also recognised as an area for improvement – this includes communication surrounding appointments, but also how staff communicate with patients about their care.

Areas where we saw improvement included a reduction in noise at night and other general areas related to sleeping, the offer of additional food outside of set meal times and discussion between clinical staff and patients or their families about equipment needs at the point of discharge.

### 2.3. Cancer – Targeted Lung Health Checks

Our cancer team has helped the Thames Valley Cancer Alliance to achieve an uptake rate of 76 per cent on their invites for Targeted Lung Health Checks.

We know that Swindon is a significant contributor to this success, and this performance was singled out by NHS Chief Executive Officer Amanda Pritchard in one of her bulletins to leaders across the healthcare system last month.

### 2.4. Improving Together

We held a special week last month to celebrate the work we have done on Improving Together, with a number of learning events and a focus on encouraging staff to share examples of improvements they have made in their area.

Since we introduced this new way of working in 2021, more than half of staff said they feel able to make improvements at work.

### 2.5. NHS Providers visit

Last month we were visited by a team from NHS Providers led by Chair Sir Ron Kerr. They visited our neonatal unit to hear about PERIPrem, Workspace to hear about Improving Together, the Integrated Care Alliance Coordination Centre, and they saw progress on the construction of our Integrated Front Door.

## 3. Systems and Strategy

### 3.1. Integrated Front Door

Last month we held a ceremonial topping out ceremony to mark the latest stage of the Integrated Front Door construction.

Staff, contractors and supporters came together on the roof of the new Emergency Department to celebrate the pace at which the construction work is taking place, with the building now water tight, interior walls in place and individual clinical areas starting to take shape.

I joined Julian Auckland-Lewis, Way Forward Programme Director and Natalie Lawrence, Lead Nurse for the Integrated Front Door, in printing our handprints in wet cement, and local resident Royston Cartwright also showed his support for the project by raking the remaining gravel into position on the roof. Along with other donors, Royston was invited to the topping out ceremony as a thank you for a generous donation he made to the charitable Way Forward Appeal after his life was saved by staff following a cardiac arrest.

### 3.2. Community services

The Integrated Care Board's procurement process for the provision of Adult and Children's Community Services in Bath and North East Somerset, Swindon and Wiltshire has begun.

Our Trust has provided community healthcare to patients in Swindon since 2016, and this contract is due to come to an end on 31 March 2025, in line with other community healthcare contracts across the integrated care system.

We're keen to help shape how community care is provided across the system by working collaboratively with partners in primary care, the local authority, mental health and voluntary sector; together with the Royal United Hospitals Bath NHS Foundation Trust, Salisbury NHS Foundation Trust, and Wiltshire Health and Care.

This is a complex process and an outcome is not expected before September 2024, ahead of the new contract beginning from 1 April 2025.

## 4. Workforce, wellbeing and recognition

### 4.1. Staff survey

The national staff survey has now closed and the Trust had its best ever response rate, with 69 per cent of our staff completing the survey, far exceeding last year's response rate of 59 per cent and our own internal target of 65 per cent.

This very high response rate makes us one of the top performing trusts nationally.

All divisions saw an uplift in their response rates from last year. Corporate teams had the highest response rate (77 per cent), followed by Integrated Care and Community (75 per cent).

A total of 3,925 staff participated in the survey, an increase of 776 on last year.

The findings will be published next year and the high response rate means that we will have a really rich pool of data from staff about what is good about working for the Trust and where we need to focus our efforts to improve.

### 4.2. Flu and Covid vaccination programme

At the time of writing 64 per cent of substantive staff have been vaccinated against flu or got their jab booked in, with the corresponding figure for Covid vaccinations standing at about 51%.

The Covid vaccination programme will finish on 15 December with flu vaccinations continuing to be offered for a few more weeks.

### 4.3. Appointment of Acting Chief Medical Officer

Following a national recruitment process, Deputy Chief Medical Officer Steve Haig has been appointed as Acting Chief Medical Officer when Jon Westbrook steps up as Acting CEO in January.

### 4.4. Inclusive and Safe Workplace Award

We were proud to win the Inclusive and Safe Workplace Award in NHS England's EDI Improvement Awards.

Fifteen trusts from across the country are being celebrated as winners across six award categories, with the NHS England panel noting the remarkable standard of projects submitted as NHS trusts work to create cultures of compassion and inclusion.

This award means we will become an exemplar workplace, with our work shared nationally to inspire and inform best practice. The award also comes with a small amount of funding to train a team of EDI champions across the Trust who will become ambassadors for equality, diversity and inclusion.

### 4.5. Internationally-educated nurses

Equality Lead Nurse Alicia Messiah and Midwifery Clinical Practice Educator Antonella Iarrobino represented the Trust at a reception hosted by King Charles at Buckingham Palace last month to celebrate the contribution of internationally-educated nurses and midwives.

We recently recruited our 500th internationally-educated nurses to our organisation, a significant milestone.

### 4.6. Disability History Month

We marked Disability History Month by calling on staff to share their disability to help us build a more inclusive workplace.

Our latest Workforce Disability Equality Standard (WDES) report shows just 169 (2.98%) of staff recorded a disability on their NHS Electronic Staff Record this year (as at 31 March 2023), however there are likely to be many more staff across the Trust who are yet to share information about their disability.

Staff sharing details of their disability helps us to better understand the needs of our staff, making adjustments to accommodate them as necessary.

### 4.7. WAY Beacons

Our WAY Beacons project has been shortlisted for a South West Personalised Care Award.

This is a collaborative project between Swindon Borough Council and staff in the Emergency Department and Children's Unit that seeks to match vulnerable young people who present to the Emergency Department with a mentor to support them. This is with 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.

A number of our staff have volunteered an hour of their week to be a WAY Mentor, and some have already been matched up with young people.

### 4.8. Armistice Day

We held a short service of remembrance outside the front of Great Western Hospital to mark Armistice Day.

The service was well-attended by staff and volunteers. Our GWH Harmony Choir sang, staff did readings, and Head of Nursing (Integrated Care and Community) Tracey Moss performed a moving rendition of The Last Post.

### 4.9. Support for staff this winter

In partnership with catering company Aramark, we are offering a discount on food and drink for all staff and volunteers this winter.

Throughout December and January, staff will receive a 50% off discount in Café Blue, Bookends and the main Refresh restaurant.

For staff working out in the community, the Trust will be organising weekly food and drink deliveries for sites across Swindon and Wiltshire.

This offer is a thank you from the Trust for staff working hard through what we know will be a challenging few months.

During the Christmas period, we will also be running a mince pie tea trolley across the hospital, with similar deliveries to the community sites, and there will be visits from our therapy dogs and ponies for staff and patients.

We will also be stepping up additional Executive walkabouts, on top of the 24/7 health and wellbeing package that is already available to all staff.

### 4.10. Café conversations

As part of our staff health and wellbeing package, we have launched new Café Conversations.

These are informal sessions taking place in Bookends at the Great Western Hospital, with guest speakers covering a different health topic over the coming months. The first session focussed on the menopause with the next, in January, covering pelvic pain.

### 4.11. STAR of the Month award

Specialist Respiratory Physiologist Colleen Wells is the latest winner of our STAR of the Month award.

Colleen delivers a lung function service to both urgent and routine patients. She runs this clinic on her own, delivering a full weekday service and also seeing patients in the evenings if they are very urgent and has also been delivering weekend clinics too.

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Integrated Performance Report (IPR)** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **7th December 2023** | Part 1 (Public) | x | Part 2 (Private)] | |
| **Accountable Lead** | Felicity Taylor-Drewe, Chief Operating Officer<br>Lisa Cheek, Chief Nurse<br>Jude Gray, Chief People Officer<br>Simon Wade, Chief Financial Officer | | | | |
| **Report Author** | Al Sheward – Deputy Chief Operating Officer<br>Rayna McDonald – Deputy Chief Nurse<br>Claire Warner – Deputy Chief People Officer<br>John Ridler – Associate Director of Finance | | | | |
| **Appendices** | Use of Resources:<br>• Statement of Financial Position<br>• Working Capital<br>• Income & Expenditure – Variance Run Rate<br>• SPC (Statistical Process Control) Chart – Pay | | | | |

**Purpose**

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

**Assurance Level**

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

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

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

**Report**

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

## Our Performance

Key highlights from 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 reduction 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 September performance saw further deterioration. a reduction to 48.5% from the previous month of 59.5%
- RTT (Referral to Treatment) 65 Week Waiters – October performance shows the total number of patients waiting over 65 weeks at 488, a decrease compared to September 2023. 1 patient above 78 weeks was reported in October.
- 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. An increase in the time spent in ED for Type 1 patients with a reduction in time spent in ED for Type 3 patients.
- Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. September saw a slight increase in the number of patients attending the ED.
- Number of non-criteria to reside (NCTR) days. The number of patients who remain in an Acute Hospital bed without a Criteria to Reside (NC2R) saw little movement in October 2023. There has been no significant change since April 2023.

## OPERATIONAL BREAKTHROUGH OBJECTIVE

Clinically Ready to Proceed (CRTP). Type 1 attendances experienced no significant change in October from arrival to being CRTP. CRTP for admitted patients shows a reduction in month.

## 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 5th month.

DMO1 – The number of patients on a DMO1 waiting list saw an increase in September 2023. Overall performance saw a reduction in September.

Cancer – All 3-cancer metrics show signs of deterioration and are outside of control limits. There has been some improvement in October. Validated data awaited.

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

Flow measures show some small improvement. 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 220 from 279 last month. The decrease is linked to a reduction in pressure harms in both the community and acute settings and a slight reduction in falls.

The number of Family and Friends (FFT) positive responses for October is 87.1%, 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.

October has seen a decrease in the number of acute pressure related harms, with 28 in month compared to 57 in September and 43 in month in the community setting compared to 74 in September.

**Alerting Watch Metrics**

The complaint response rate has increased significantly in October, work has continued with Divisional Directors of Nursing to have a focused approach on complaint responses, which is being supported by the PALs team

The rate of C. difficile infection continues to be above that of 2022/23. Each case is reviewed by the Infection Prevention & Control team, an Antimicrobial Pharmacist and a Consultant Microbiologist, and all samples are sent for ribotyping and there have been no links between cases detected. A Banes, Swindon, Wiltshire (BSW) review of all cases has found a strong link with antimicrobial prescribing in primary care, with BSW General Practices prescribing more broad-spectrum antibiotics than those in other systems. Work is ongoing to address this.

Rates of all three reportable gram-negative bloodstream infections (E. coli, Klebsiella and Pseudomonas aeruginosa) remain higher than trajectory, though Pseudomonas numbers have reduced since the combined Estates/Serco/Infection Prevention Control (IPC)/clinical focus on this began in July. A significant theme in the Klebsiella cases has been hospital-acquired pneumonia and work is ongoing as part of the IPC Improvement Plan to reduce the incidence of this, particularly focusing on mouthcare and keeping patients active.

**Non-alerting Watch Metrics**

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

- Safer staffing fill rates are on a par with previous months and remain within safe parameters.
- Eight Serious Incidents have been declared in month, all will be investigated under the Serious Incident Framework.
- There has been a decrease in both the number of concerns and complaints in month.
- There have been no reported Methicillin-resistant Staphylococcus Aureus (MSRA) infections for the third consecutive month.
- FFT overall response rate has decreased slightly but still remains in line with the internal target of 29%.
- The number of hospital acquired COVID cases has decreased by 50% in month (10) when compared to September (20).

**Our People**

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

**Strategic Pillar Target from A3 goals:**
To aim to be in the top 20% of Trusts for staff survey results and in the lower quartile for turnover within Model Hospital.
The Trust aims to improve our Staff Survey response rates year on year and increase the number of staff "recommending the Trust as a place to work"

**Breakthrough Objectives**
The Trust Breakthrough objective is to achieve a 5% improvement 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 active promotion of the survey continues across the Trust. As at week 9 of the campaign, the Trust has exceeded the 65% target, achieving a response rate of 67% compared to 59% last year. There are two further weeks of the campaign remaining in which we are hoping to achieve a stretch target of 70%.

**Alerting Watch Metrics**
In-month sickness absence for September has increased marginally from 4.0% to 4.2%, and remains above the Trust KPI of 3.5%. Long-term absence has decreased in month from 2.2% to 1.8% however has not offset a sharp increase in short-term absence rates (1.8% to 2.5% in September). The current short-term absence rate is in line with usual seasonal variation.

Countermeasures continue with the annual Covid booster and Flu vaccination campaign and intense support for Departments with high short-term sickness.

We have seen an encouraging uptake of 57% for Flu vaccinations, and 48% for Covid boosters. The Occupational Health & Wellbeing team are working hard to continue promotion of the importance of immunisation.

**Non-Alerting Watch Metrics**

Voluntary turnover continues it's downward trajectory, with a further reduction seen in September reducing from 9.6% to 9.5%, below the Trust KPI target of 11%. Whilst this turnover in reduction shows stabilisation in our workforce, its important to also recognise the link to staff engagement. This will be explored in the Trust Retention Working Group to examine tangible initiatives to further reduce turnover by increasing engagement metrics aligned to the NHSE high impact actions.

Leavers within their first year of employment has remained at 28% in September, continuing below the average rate of 31%.

**HR Scorecard**

In October our vacancy rate has further improved to 4.33% (232wte), in line with continued improvement to our turnover rates and a stabilisation in recruitment activity (43 days time-to-hire and 114 starters in September).

In-month Establishment WTE has decreased in October by 2 WTE as a result of planned changes to Band 2 and Band 3 HCSW budgets. Control on Workforce levels is being further reinforced with the introduction of Divisional Vacancy Review panels where departments are being encouraged to assess whether roles are still essential and are being encouraged to consider different ways of working.

In M07 we saw an increase to our in-month agency spend driven by an increase to Medical Locums, resulting in a total spend for October of £1.1M (+£0.4M to target) however still within our KPI target of 4.5% agency spend as a percentage of total spend (4.3% achieved in month). The YTD picture is still promising with a £2.2M reduction compared to last year, and £0.5M position below target.

The Trust continues to utilise more staff than its establishment to deliver services (+93WTE in October). Reduction of this over-utilisation remains a priority, with Medical and Nursing workstreams linked to reducing temporary staffing usage reporting progress into the Financial Recovery Sub-Committee.

**Use of Resources**

As at M7 the Trust is in a £4.9m deficit position which represents a £4.7m adverse variance to plan.

The key drivers of the £4.7m adverse variance are: industrial action direct costs (£1.9m), undelivered efficiency savings (£2.1m), a shortfall on ERF related income (£2.9m), additional medical pay award costs (£0.5m) and temporary staffing pressures (£1.4m). Mitigating a proportion of these adverse variances is non-recurrent benefit totalling £4.1m relating to prior year income.

The focus is to finish the 23/24 financial year in a breakeven position. Work on a revised forecast is underway with the aim of reducing the c.£10.7m most likely deficit previously submitted. We are under pressure to achieve our best case forecast of c.£5.8m deficit.

Efficiency savings were £0.3m behind target in month and are £2.1m behind plan on a YTD basis. 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.

| | | | | | |
|---|---|---|---|---|---|
| **Link to CQC Domain** – select one or more | **Safe** | **Caring** | **Effective** | **Responsive** | **Well Led** |
| | | | | | |
| **Links to Strategic Pillars & Strategic Risks** – select one or more | ★ | | | | |
| | **x** | | **x** | **x** | **x** |
| **Key Risks** – risk number & description (Link to BAF / Risk Register) | | | | | **Risk Score** |
| | | | | | |
| **Consultation / Other Committee Review / Scrutiny / Public & Patient involvement** | PPPC (Performance, Population & Place Committee) & Trust 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**<br>The Board/Committee/Group is requested to: | |
|---|---|
| ***The Board/Committee/Group is requested to:***<br>▪ ***Review and support the continued development of the IPR***<br>▪ ***Review and support the ongoing plans to maintain and improve performance*** | |
| **Accountable Lead Signature** |  <br>**Felicity Taylor-Drewe** |
| **Date** | 15th November 2023 |

NHS
Great Western Hospitals
NHS Foundation Trust

# Integrated Performance Report

November 2023

September 2023 & October 2023 data period

Improving together

# Content & introduction

Great Western Hospitals NHS Foundation Trust

| Section & purpose | Slides |
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| **Executive summary**<br>This provides an overview of the targets, performance and countermeasures (remedial actions) for each of our pillar metrics | 5-12 |
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| **Our Care**<br>This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee | 17-19 |
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| **Use of Resources**<br>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**<br>This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee | 25-30 |
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# Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

| Measure Name | Mean/Thres. | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total patients waiting more than 65 weeks | 0 | 631 | 610 | 463 | 455 | 384 | 458 | 525 | 640 | 621 | 689 | 661 | 488 |
| Percentage of patients who receive a diagnostic test within six weeks of referral | 99% (Nat) | 52.3% | 48.0% | 48.5% | 54.2% | 56.1% | 50.4% | 52.3% | 52.2% | 49.4% | 44.5% | 46.1% | Reported one month behind |
| Cancer - percentage of patients on the waiting list who have been waiting more than 62 days | 2% (Nat) | 8.4% | 11.6% | 10.0% | 6.3% | 5.6% | 10.2% | 9.5% | 9.0% | 8.9% | 10.0% | 10.0% | Reported one month behind |
| Proportion of patients meeting the faster cancer diagnosis standard | 75% (Nat) | 73.2% | 78.2% | 70.8% | 77.8% | 76.5% | 73.6% | 71.3% | 65.0% | 67.2% | 62.6% | 62.0% | Reported one month behind |
| Proportion of patients seen within four hours | 95% (Nat) | 73.1% | 72.3% | 75.8% | 74.3% | 77.2% | 75.7% | 74.8% | 73.8% | 75.5% | 74.2% | 74.6% | 71.5% |
| Ambulance average Category Two response time | 00:18:00 (Nat) | 01:09:25 | 03:05:12 | 00:44:55 | 00:46:13 | 00:53:23 | 00:37:25 | 00:40:02 | 00:51:09 | 00:46:15 | 00:56:36 | 01:48:08 | Waiting for data |
| Percentage of beds occupied by patients who no longer meet the criteria to reside | 13.3% (Nat) | 20.5% | 18.9% | 17.3% | 19.0% | 19.5% | 16.4% | 16.4% | 17.8% | 17.2% | 14.3% | 15.8% | 17.4% |
| Summary Hospital-level Mortality Indicator | | 2 - as expected | 2 - as expected | 2 - as expected | 2 - as expected | 2 - as expected | 2 - as expected | 2 - as expected | Reported five months behind | Reported five months behind | Reported five months behind | Reported five months behind | Reported five months behind |
| National Patient Safety Alerts not completed by deadline | 0 (Nat) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Overall CQC rating | | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection | 0 (Nat) | 1 | 1 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 | 4 |
| Clostridium difficile infection | 100% (Nat) | 97.9% | 85.4% | 81.3% | 87.5% | 102.1% | 106.5% | 123.9% | 117.4% | 130.4% | 130.4% | 132.6% | 147.8% |
| E. coli bloodstream infection | 100% (Nat) | 114.5% | 123.2% | 129.0% | 143.5% | 156.5% | 157.6% | 169.7% | 142.4% | 147.0% | 142.4% | 147.0% | 156.1% |
| CQC well-led rating | | Good | Good | Good | Good | Good | Good | Good | Good | Good | Good | Good | Good |
| Leaver rate | 11.0% (Nat) | 11.5% | 11.8% | 11.6% | 11.3% | 11.2% | 10.5% | 10.5% | 10.2% | 9.7% | 9.6% | 9.5% | Reported one month behind |
| Sickness absence rate | 3.5% (Nat) | 4.9% | 5.8% | 4.9% | 4.5% | 4.6% | 3.8% | 3.7% | 3.8% | 4.4% | 4.0% | 4.2% | Reported one month behind |
| Proportion of staff in senior leadership roles who are from BME background | 16% (Nat) | 6.8% | 6.8% | 6.8% | 6.6% | 6.6% | 6.3% | 5.2% | 6.7% | 5.3% | 5.3% | 5.3% | Reported one month behind |
| Proportion of staff in senior leadership roles who are women | 64% (Nat) | 54.9% | 54.0% | 56.8% | 54.9% | 54.3% | 55.7% | 54.0% | 56.0% | 56.1% | 56.1% | 56.1% | Reported one month behind |
| Financial efficiency - variance from efficiency plan (£'000) | +/- | -378 | -338 | -400 | -238 | 281 | -377 | -384 | 334 | -641 | -338 | -504 | -39 |
| Financial stability - variance from break-even (£'000) | +/- | -1672 | -1502 | -1579 | -1469 | -1482 | -2157 | -2591 | -144 | -659 | 330 | -1352 | 1996 |
| Financial stability - variance from PLAN (£'000) | +/- | 389 | 164 | 106 | 214 | -18 | -893 | -2132 | -223 | -733 | -528 | -1646 | 1334 |

# Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

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

# Executive Summary

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.

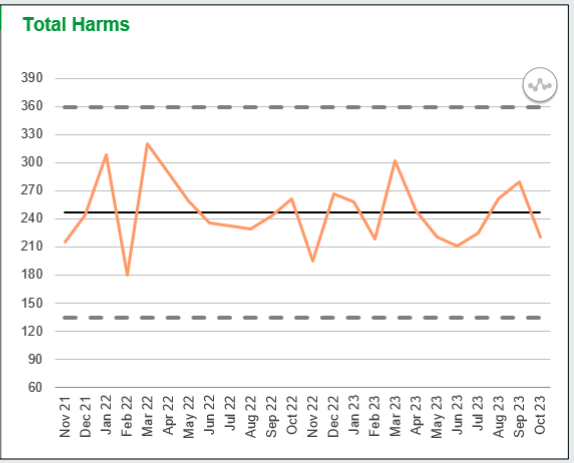
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

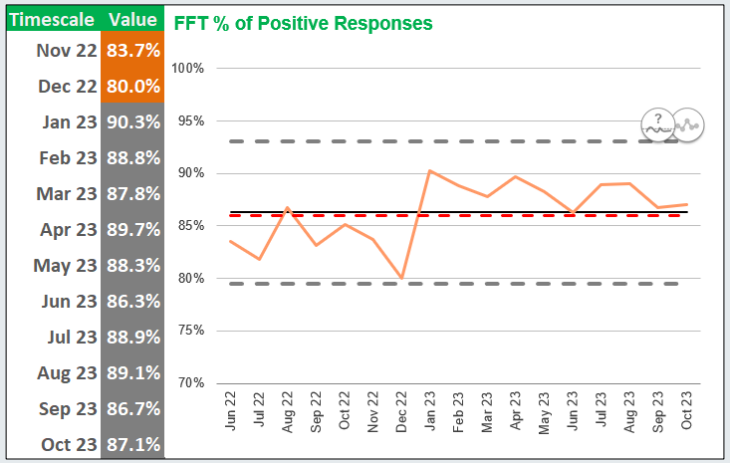
| Timescale | Value |
|---|---|
| Nov 22 | 195 |
| Dec 22 | 267 |
| Jan 23 | 258 |
| Feb 23 | 218 |
| Mar 23 | 302 |
| Apr 23 | 248 |
| May 23 | 221 |
| Jun 23 | 211 |
| Jul 23 | 225 |
| Aug 23 | 261 |
| Sep 23 | 279 |
| Oct 23 | 220 |




## Patient Experience (Friends & Family Test)

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

| Timescale | Value |
|---|---|
| Nov 22 | 83.7% |
| Dec 22 | 80.0% |
| Jan 23 | 90.3% |
| Feb 23 | 88.8% |
| Mar 23 | 87.8% |
| Apr 23 | 89.7% |
| May 23 | 88.3% |
| Jun 23 | 86.3% |
| Jul 23 | 88.9% |
| Aug 23 | 89.1% |
| Sep 23 | 86.7% |
| Oct 23 | 87.1% |




## Counter Measures

The number of harms has reduced in October, primarily driven by a reduction in pressure harms and in cases of nosocomial COVID-19.

The number of healthcare-associated infections has remained high for *C. difficile* and for the gram-negative bloodstream infections, although *Pseudomonas aeruginosa* numbers have, since July, been consistently lower – potentially reflecting the enhanced focus and effort on water hygiene. Rates of Methicillin-susceptible Staphylococcus aureus (MSSA) remain low.

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

Actions have been implemented following direct carer feedback about the discharge process. The matron for operations and flow is using the feedback to influence discharge processes moving forward, particularly in relation to the use of terminology by ensuring clear and simpler language is used to make it easier for patients and families to understand.

# Executive Summary

NHS
Great Western Hospitals
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**Trust Access Standards - Referral to Treatment (RTT) & Cancer Standards**

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

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

**Cancer 62 Day**

In September, there were 51.0 breaches in total, with 38.0 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 173 patients, to 448. The reduction was driven by Gastroenterology (-49), Paediatrics (-25) and General Surgery (-20). Ears, Nose and Throat (ENT) was the only service reporting an increase (+8).

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 Cardiology, Gastroenterology, General Surgery, Gynaecology and Respiratory Medicine are not on track to meet the stretched target. Dermatology, Geriatric Medicine, Neurology, Ophthalmology, Physiotherapy, Podiatry and Rheumatology of on track to meet the stretched target.

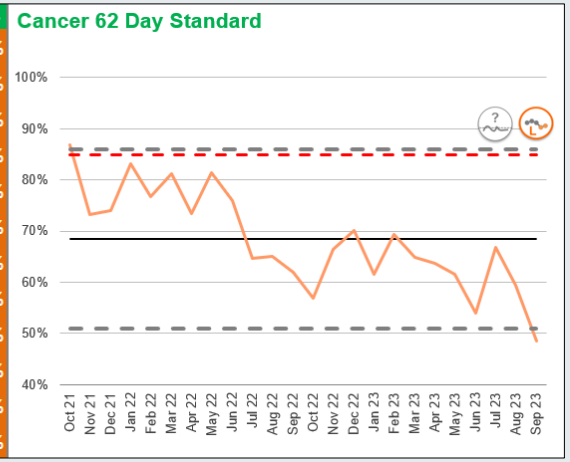
1 x 78-week breach was reported at the end of October 2023. This was a delayed referral to Gastroenterology from General Surgery, which resulted in Gastroenterology being able to offer an appointment with reasonable notice.

**Felicity Taylor-Drewe**
Chief Operating Officer

## Cancer 62 Day

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

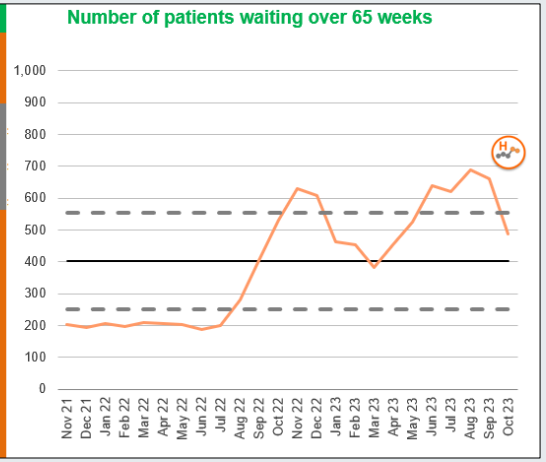
| Timescale | Value |
|---|---|
| Oct 22 | 56.9% |
| Nov 22 | 66.4% |
| Dec 22 | 70.2% |
| Jan 23 | 61.6% |
| Feb 23 | 69.3% |
| Mar 23 | 64.8% |
| Apr 23 | 63.8% |
| May 23 | 61.5% |
| Jun 23 | 54.0% |
| Jul 23 | 66.9% |
| Aug 23 | 59.5% |
| Sep 23 | 48.5% |




## RTT: Number of patients waiting over 65 weeks

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

| Timescale | Value |
|---|---|
| Nov 22 | 631 |
| Dec 22 | 610 |
| Jan 23 | 463 |
| Feb 23 | 455 |
| Mar 23 | 384 |
| Apr 23 | 458 |
| May 23 | 525 |
| Jun 23 | 640 |
| Jul 23 | 621 |
| Aug 23 | 689 |
| Sep 23 | 661 |
| Oct 23 | 488 |




## 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 late Nov/early Dec.*

**Risk:** Capacity in Plastics is insufficient to see and treat patients.
**Mitigation**: Some Plastic patients are being sent to Wootton Bassett to help free up surgical space at GWH. The Pathway has been mapped with the milestones assessed, potential improvements in both pathway and processes are being implemented. Concerns with capacity and operational processes have been raised and discussed with the divisional management team.
**Risk:** Urology Pathway are often complex requiring multiple diagnostics, with multiple treatment options needing to be discussed at Tertiary centres before treatments can be planned. Patients requiring additional treatment following an incomplete TURBT procedure will breach due to recovery and planning time.
**Mitigation:** Pathway improvement manager is working with service to implement the best practice timed pathway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team are undertaking LATP biopsy training with a view to reducing the demand on TRUS biopsies, this will start to have an impact from Q2.

**Risk**: Insufficient capacity to recover 65 week + breach position by March 2024
**Mitigation**:
- Patient level details/plans updated on weekly basis in line with recovery trajectory.
- 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.

# Executive Summary

Great Western Hospitals NHS Foundation Trust

**Emergency Care – Emergency Department - Mean Stay**

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

The total meantime in Oct '23 was 475 minutes against the national standard of 240 minutes. This is still below Oct 22 levels of 515 minutes.

October showed an increase in the mean time in ED from 466 minutes in September.

**Emergency Care – Urgent Treatment Centre - Mean Stay**

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

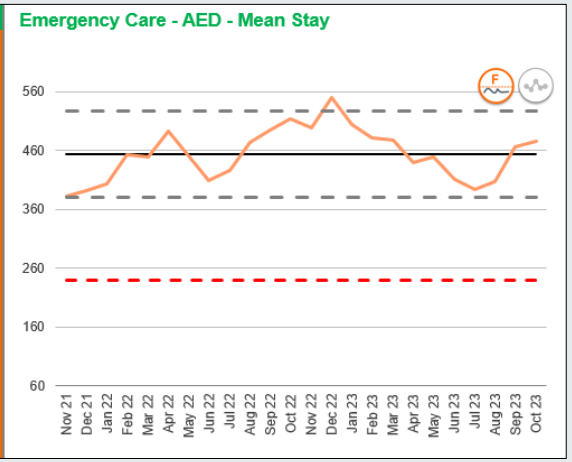
The total meantime wait for a patient in September 2023 was 163 minutes against the national standard of 240 minutes, demonstrating good flow through the service.

**Felicity Taylor-Drewe**
Chief Operating Officer

## Emergency Care – Emergency Department - Mean Stay

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

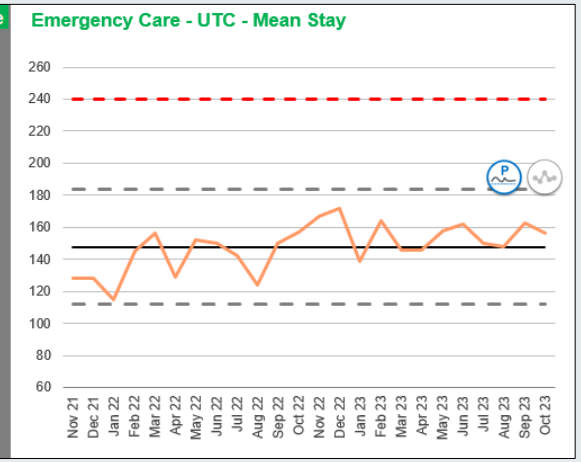
| Timescale | Value |
|---|---|
| Nov 22 | 499 |
| Dec 22 | 550 |
| Jan 23 | 503 |
| Feb 23 | 482 |
| Mar 23 | 477 |
| Apr 23 | 440 |
| May 23 | 448 |
| Jun 23 | 410 |
| Jul 23 | 393 |
| Aug 23 | 407 |
| Sep 23 | 466 |
| Oct 23 | 475 |




## Emergency Care – Urgent Treatment Centre - Mean Stay

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

| Timescale | Value |
|---|---|
| Nov 22 | 167 |
| Dec 22 | 172 |
| Jan 23 | 139 |
| Feb 23 | 164 |
| Mar 23 | 146 |
| Apr 23 | 146 |
| May 23 | 158 |
| Jun 23 | 162 |
| Jul 23 | 150 |
| Aug 23 | 148 |
| Sep 23 | 163 |
| Oct 23 | 156 |




## Counter Measures

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

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

# 1. Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

### Emergency Department & Urgent Treatment Centre - Emergency Attendances

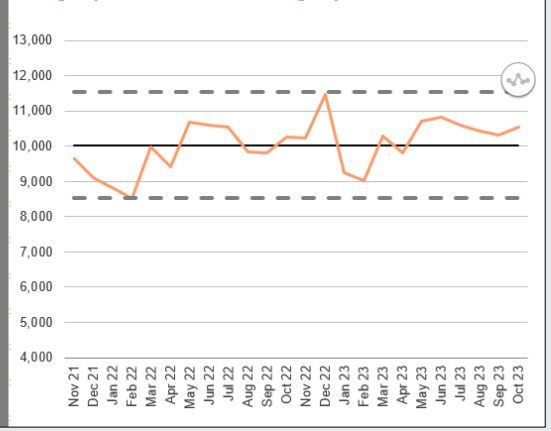
Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). August has seen a slight reduction in attendances to both ED & UTC.

Attendance figures increased in October from 10051 to 10,290 in month (ED and UTC). The increase predominantly coming from ED activity.

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

To ensure patients are cared for in the appropriate setting

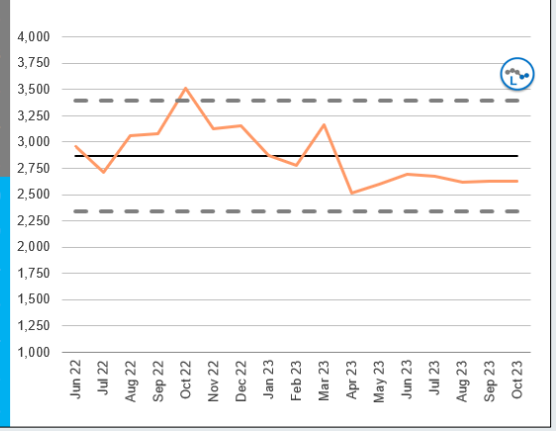
| Timescale | Value |
|---|---|
| Nov 22 | 10,240 |
| Dec 22 | 11,474 |
| Jan 23 | 9,252 |
| Feb 23 | 9,018 |
| Mar 23 | 10,302 |
| Apr 23 | 9,801 |
| May 23 | 10,715 |
| Jun 23 | 10,833 |
| Jul 23 | 10,599 |
| Aug 23 | 10,435 |
| Sep 23 | 10,325 |
| Oct 23 | 10,548 |




### 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 |
|---|---|
| Nov 22 | 3,125 |
| Dec 22 | 3,158 |
| Jan 23 | 2,873 |
| Feb 23 | 2,774 |
| Mar 23 | 3,162 |
| Apr 23 | 2,510 |
| May 23 | 2,599 |
| Jun 23 | 2,694 |
| Jul 23 | 2,675 |
| Aug 23 | 2,614 |
| Sep 23 | 2,631 |
| Oct 23 | 2,625 |




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

October NCTR remained at 87, medical outliers increased to an average of 41 patients. Contributing factors associated with strikes and pressure within the Trust (threshold target is <30) There was a slight increase in discharges for the month of October at 2.69K which was 2.66K in September. There was a significant increase OOA patient discharges for 2023 being at the highest achieving 60 for October – this is a direct result of the continued work within DST. Swindon Home first continued for the second month to be above 100 discharges.

**Felicity Taylor-Drewe**
Chief Operating Officer

### Counter Measures

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

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

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

- SBC senior flow lead charring on Wilts discharge hub, to bring in line the successful model of SBC, offers check and challenge – **this is continuing.**
- Front Door Team therapy involvement at Nav Hub Huddle being scoped in addition to Social work presence within the FDT and DST.
- Readmission Round Table undertaken for Swindon Home First patients to seek opportunities for learning across the system and areas for improvement - (to be reported UCF sub board November)
- **'Walk at Midnight' took place** on 11th Oct with COO – outcomes of this were shared directly with Divisions.
- Discharge to Assess Bed base under review at system level to maximise the utilisation of Fessey House and Sunflower winter beds.

# Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

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

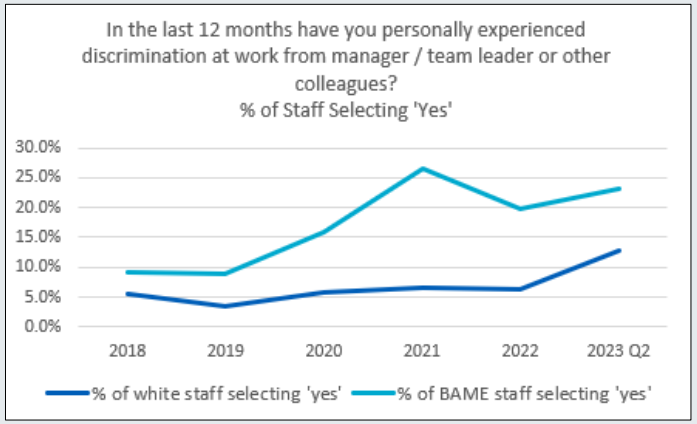
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 8.3% in line with the national average and be below the national average for all staff.

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

**Jude Gray**
Director of Human Resources (HR)

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 Trust's Inclusion Recruitment Champions (IRC) programme began in June 2023 with 19 staff volunteering to become champions. Training was delayed to September but resumed on November 9th for some IRCs, with the rest scheduled for December. IRC support for interviews begins mid-November.
- Following the Equity Data Walk, November will feature workshops including 'Speak Up, Listen Up' with John Higgins on 16th November and an anti-racism masterclass in healthcare with Rumina Morris on 30th November, open to BSW ICS partners. The program in 2023-24 and 2024-25 will mix in-house and external workshops to address discrimination and drive performance on our pillar metric.
- In-house cultural competence training is planned for the New Year. An initial cohort of line managers have attended the training, and our Equality Nurse Lead has attended the train-the-trainer workshop ready for further rollout across the Trust. The EDI lead is working alongside to adapt and redesign this training to meet local needs ready for rollout to our Band 6 and 7 nurses.
- EDI Annual Report is currently in draft and will be published late November following the implementation of recommendations from the November Trust Board meeting. The report highlights the work that has taken place across 2022/23 and demonstrates how the Trust has met the Public Sector Equality Duty (Equality Act 2010).

# Executive Summary

Great Western Hospitals NHS Foundation Trust

**Voluntary Staff Turnover (rate)**

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

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

The Trust has seen a continued improvement in the trend since July 2022. Further reduction to our voluntary turnover rate has been seen in September, decreasing from 9.6% to 9.5%, and below the Trust target for six consecutive months. Performance continues to be maintained through the Trust Retention Working Group, with countermeasures being refined to focus on leavers within the first year of employment.

**Staff Recommendation as a Place to Work**

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

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

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

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

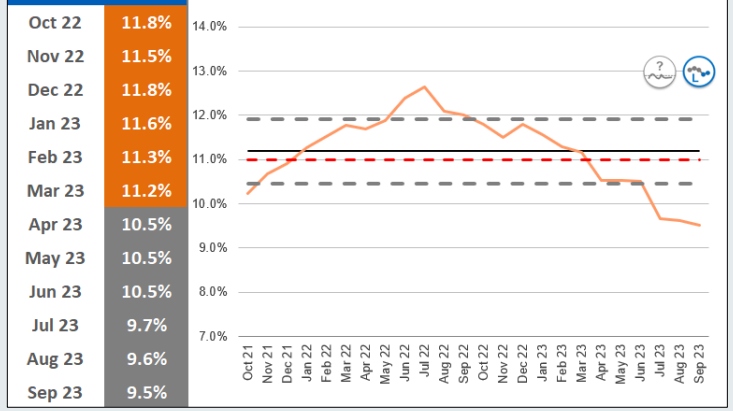
**Jude Gray**
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

## Trust Voluntary Turnover Rate

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

| Timescale | Value |
|---|---|
| Oct 22 | 11.8% |
| Nov 22 | 11.5% |
| Dec 22 | 11.8% |
| Jan 23 | 11.6% |
| Feb 23 | 11.3% |
| Mar 23 | 11.2% |
| Apr 23 | 10.5% |
| May 23 | 10.5% |
| Jun 23 | 10.5% |
| Jul 23 | 9.7% |
| Aug 23 | 9.6% |
| Sep 23 | 9.5% |




## 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 9.5% in September, showing clear stabilisation in this metric.
- The retention working group met on 31st October with refreshed membership from a broader range of staff better placed to represent the feedback from divisional teams. Key progress from the meeting:
  - Agreed Terms of Reference
  - Review of Trust Retention Plan
  - Discussed continuous improvement in retention rates and shared team experience regarding challenges with turnover
  - A3 session conducted to identify themes for problem statement
  - Future session scheduled for December to explore root cause with a fishbone

- There has been no change in this metric as it measured quarterly. Current focus is on the annual staff survey campaign.
- The Trust is aiming for a 65% response rate for the Annual Staff Survey, and the following initiatives are in place to help promote uptake:
  - Weekly review of Trust and divisional performance
  - Targeting of departments with lower response rates or higher volumes of staff
  - Visits to Community sites with iPad and vouchers
  - Evenings visits to departments to engage night staff
- Following the above initiatives, the current Trust completion rate at week 9 of 11 is 67% (3,700 staff), which is a 7% improvement on this period last year and 24% above the national average.

# Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

As at M7 the Trust is in a £4.9m deficit position which represents a £4.7m adverse variance to plan.

The key drivers of the £4.7m adverse variance are: industrial action direct costs (£1.9m), undelivered efficiency savings (£2.1m), a shortfall on ERF related income (£2.9m), additional medical pay award costs (£0.5m) and temporary staffing pressures (£1.4m). Mitigating a proportion of these adverse variances is non-recurrent benefit totalling £4.1m relating to prior year income.

The focus is to finish the 23/24 financial year in a breakeven position. The previously submitted forecast was a c.£10.7m deficit to plan due to a shortfall in efficiency delivery and continued overspends on temporary staffing and industrial action. It also assumed no further loss of ERF income for the remainder of the year. Work on a revised forecast is underway with the aim of reducing the c.£10.7m deficit previously submitted.

Efficiency savings were £0.3m behind target in month and are £2.1m behind plan on a YTD basis. The key driver of the Trust's deficit position is Medicine (£5.1m adverse YTD), and specifically non-delivery of both nursing and medical agency savings.

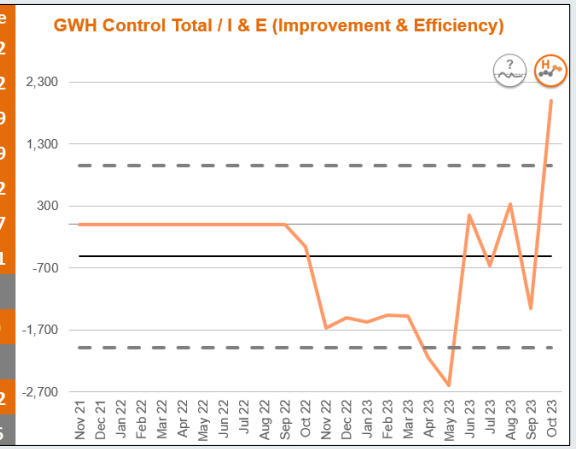
Focussing on run rate savings i.e. reducing our monthly spend, particularly on temporary staffing, has to be the priority for operational colleagues for the remainder of the year. Likewise, we need to ensure that discretionary spending is kept at a minimum through strong grip & control measures, and 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 |
|---|---|
| Nov 22 | -1672 |
| Dec 22 | -1502 |
| Jan 23 | -1579 |
| Feb 23 | -1469 |
| Mar 23 | -1482 |
| Apr 23 | -2157 |
| May 23 | -2591 |
| Jun 23 | 144 |
| Jul 23 | -659 |
| Aug 23 | 330 |
| Sep 23 | -1352 |
| Oct 23 | 1996 |




## Counter Measures

- Efficiency savings were £0.3m behind target in month and are £2.1m behind plan on a YTD basis. There are £16.9m of identified schemes but only £6.9m (41%) 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 Recovery workstreams including workforce controls (incl. Agency reduction), outpatients, clinical coding and elective recovery

# Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

**Carbon Footprint / Sustainability**

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

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

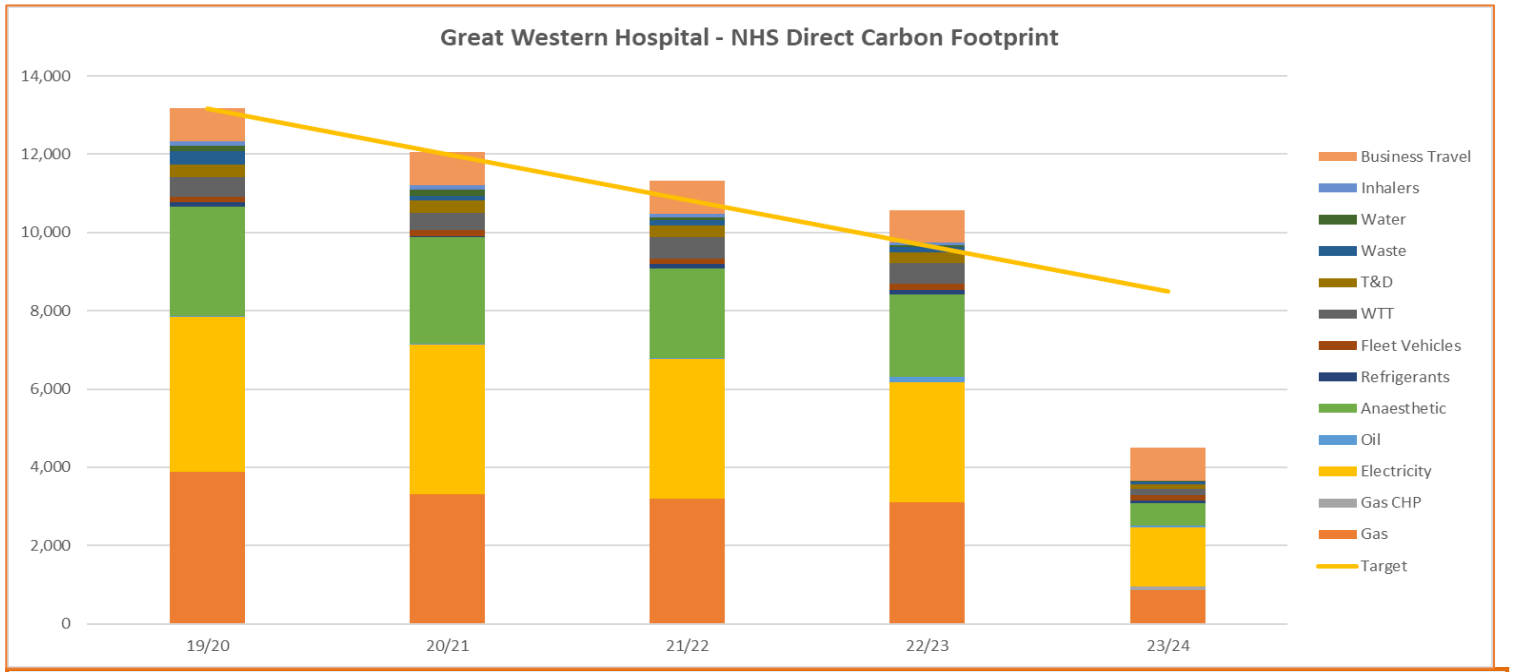
In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032 as shown with the target line on the graph from our 19/20 baseline year.

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

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

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

**Simon Wade**
Chief Financial Officer




## Counter Measures

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

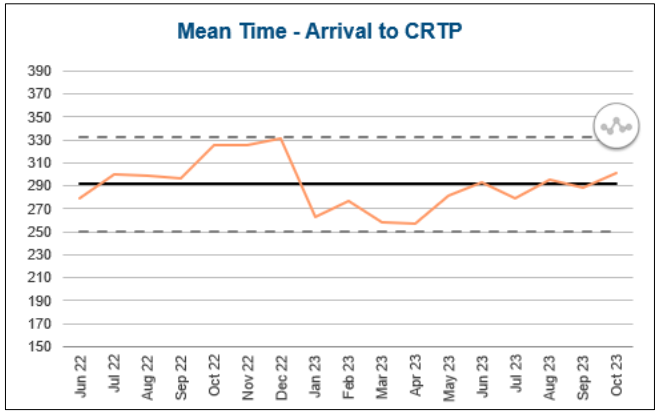
# 2023/24 Breakthrough Objectives

## Emergency Attendances - Clinically Ready to Proceed (Admitted)

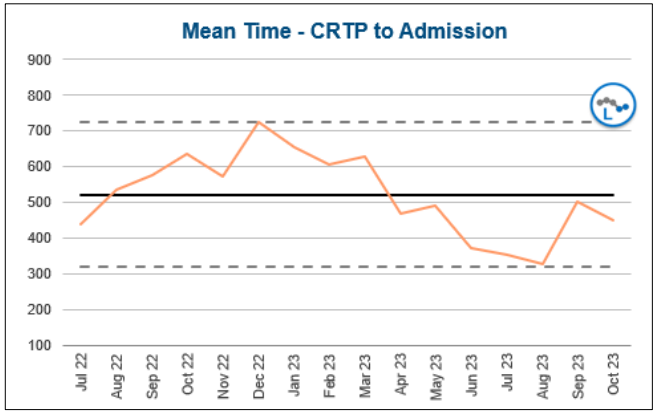
NHS Great Western Hospitals NHS Foundation Trust

### Mean time in ED (Minutes)

| | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pre CRTP | 326 | 332 | 263 | 277 | 259 | 258 | 281 | 293 | 280 | 295 | 289 | 301 |
| Post CRTP | 572 | 725 | 654 | 608 | 629 | 467 | 492 | 373 | 352 | 326 | 504 | 449 |




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 (301 in October from 289 in September) 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 504 to 449 in October 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.

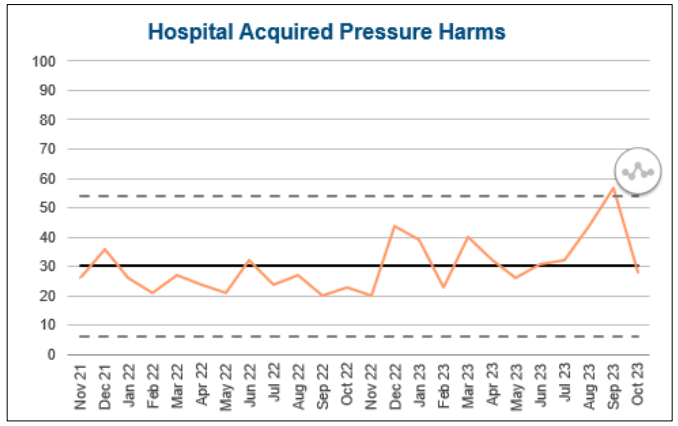
# 2023/24 Breakthrough Objectives

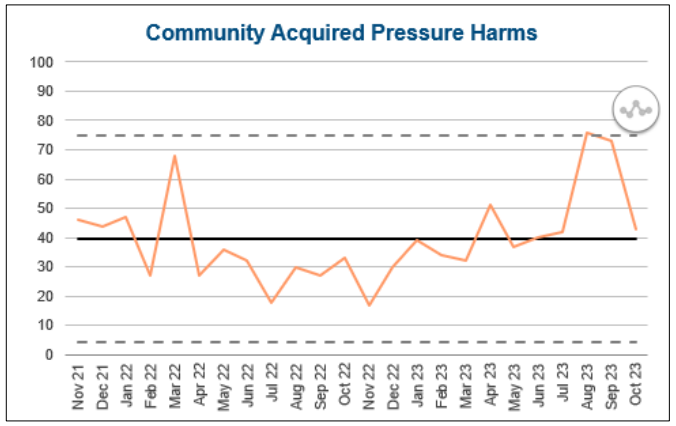
## Reduction of Pressure Harms

Great Western Hospitals NHS Foundation Trust

### Total Pressure Harms

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




Common cause – no significant change

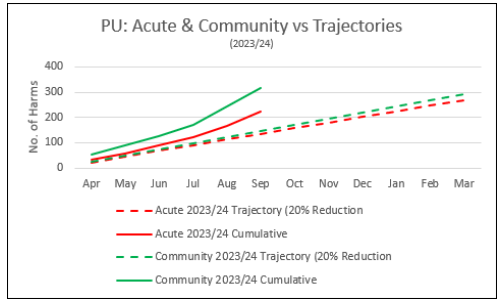
### Understanding the Data

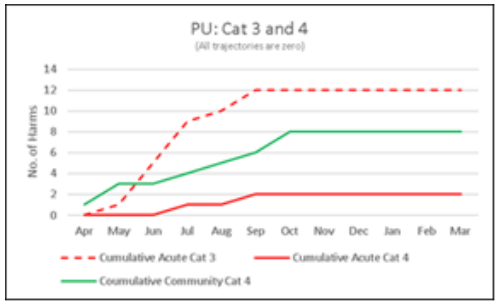
The number in the charts above represents the number of pressure harms that patients have developed whilst in hospital or under the care of a community nursing team. The number reflects the total number of harms not total number of patients i.e., one patient may have two or more pressure harms.

### 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 both acute and community settings.

There were 28 (57 in September) hospital-acquired pressure harms during October. This has been a significant reduction following last month, the focus is now on sustaining this and continuing to reduce further.

- Three harms were device-related; all related to ears from oxygen tubing in areas not trialing the new tubing. The plan is to roll out trust wide.
- The Trust will mark international Stop the Pressure day on Thursday 16th November. The Tissue Viability (TV) Team will be holding a drop-in session all day with a drive to increase awareness of skin inspection and identifying patients at risk of harm.
- Continued pressure ulcers awareness and prevention training sessions will be delivered throughout November by the acute TVN team.
- Pressure ulcer weekly panel meetings are now in place. At these, all harms reported since the previous meeting are discussed by TVN, divisional leads and governance facilitators. This enables timely identification of learning which is then shared through quality huddles and within departments. October has been the first month with these meetings in place.

In the community setting there were 43 (74 in September) pressure harms acquired during October. This is a significant decrease from the previous month and involved 31 patients in total.

Twenty-one harms occurred in patients receiving End of Life Care, equating to 49% of the harms.

- Introduction to new Risk Assessment (RA) training delivered at locality team meetings.
- End of Life (EOL) clinical decision-making tool ratified to support discharge and prevent delays in obtaining pressure relieving equipment.
- Patient Safety Incident Response Framework (PSIRF)/methodology applied to investigations/ Multidisciplinary team (MDT) round table techniques - collaborating with other service providers to understand contributing factors.

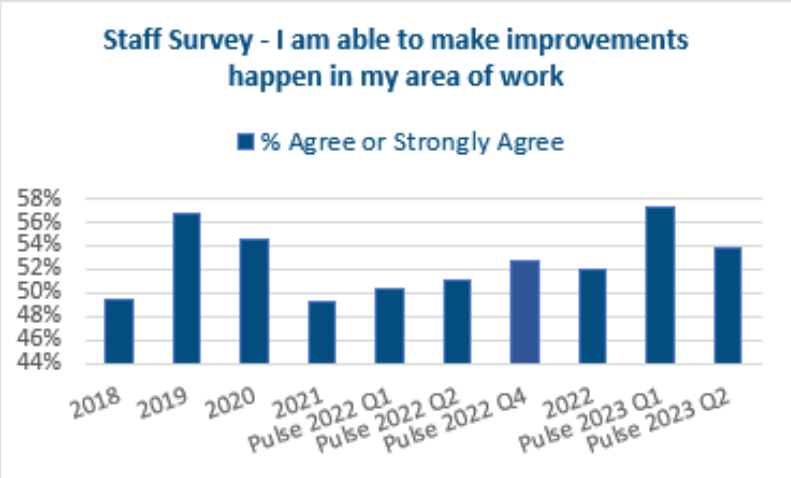
# 2023/24 Breakthrough Objectives

NHS Great Western Hospitals NHS Foundation Trust

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

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

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




### Understanding the Data

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

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

### We are driving this measure because...

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

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

### Performance

- Improving Together week is taking place week commencing 13th November, with various events planned across GWH and The Orbital to showcase our continuous improvement methodology and promote how staff can make improvements happen in their area of work.
- Divisional countermeasures relating to Q3F are being tabled at the monthly Staff Survey Working Group meeting to support with sharing regular communications to staff on improvement work and actions taking place relating to making improvements happen.
- Divisional stratification of the data for Q3F shows the opportunity for highest improvement is sat within Surgery, Women's & Children's. Divisional listening sessions have taken place in October, supported by the Head of OD, to understand drivers of lower performance and enable a robust action plan to drive improvement.

### Risks

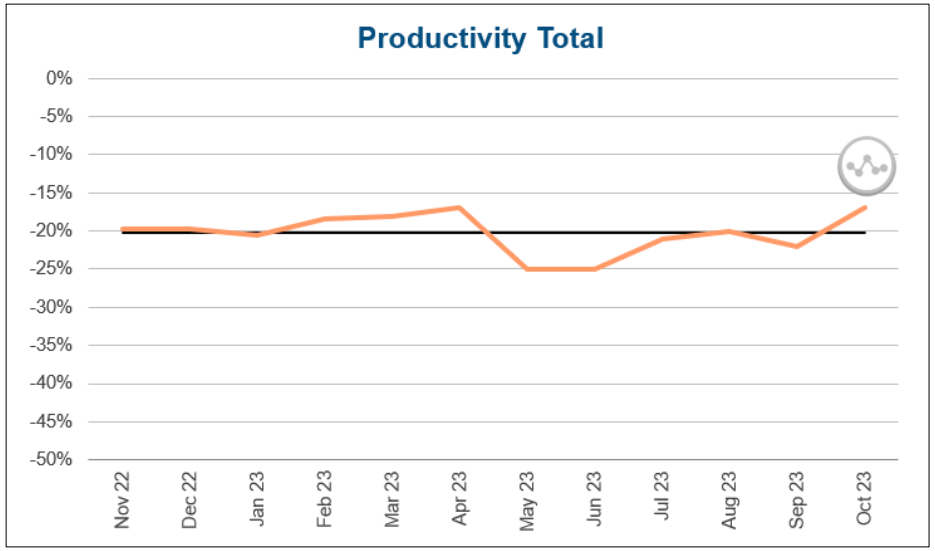
- Whilst continuing the 'inch wide, mile deep' focus on question 3F, there are broader opportunities for improvement which are outlined in the divisional Staff Survey presentations which require focus.
- Not all divisions currently have question 3F as a driver metric, and are reviewing which areas of the staff survey will continue as their priority. There is a risk of this metric declining in line with reduced focus.

# 2023/24 Breakthrough Objectives

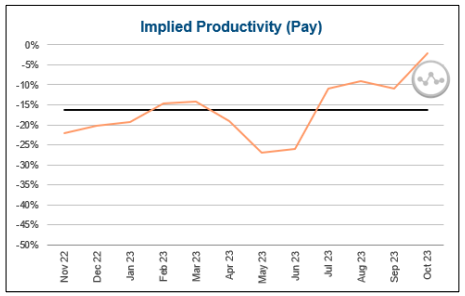
Great Western Hospitals NHS Foundation Trust

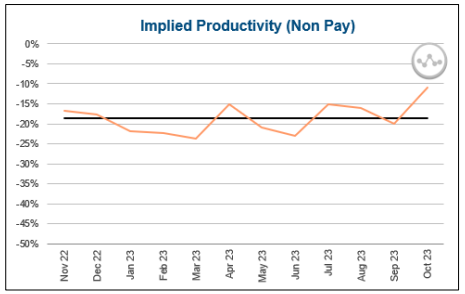
## Productivity

| | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | -20% | -20% | -21% | -18% | -18% | -17% | -25% | -25% | -21% | -20% | -22% | -17% |
| Pay | -22% | -20% | -19% | -15% | -14% | -19% | -27% | -26% | -11% | -9% | -11% | -2% |
| Non Pay | -16% | -19% | -23% | -24% | -24% | -15% | -21% | -23% | -15% | -16% | -20% | -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 has improved to an overall total **–17%** for Month 7 (this is a 1% improvement from the 18% at the end of 2022/23 - March 2023).

This 5% improvement from last month (M6) reflects improvement in the overall Trust financial position in Month 7 but this is largely not within divisions. We have seen improvements in Income and in some of our corporate accruals. The position does still reflect being off track with our activity and financial plan due to higher pay pressures such as industrial action impact 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 have been 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 to seek clinical engagement on. 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.

# Our Care

## Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

| Plan Area | Measure Name | Target | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Trend |
|---|---|---|---|---|---|---|---|---|
| Concerns and Complaints | Trust overall complaint response rate | 80% (Int) | | 78% | 68% | 46% | 69% | |
| IP & C | Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative) | 0 (Nat) | | 1 | 1 | 1 | 1 | |
| | Clostridium difficile (C. diff) infections (cumulative) | 23 (Nat) | | 33 | 38 | 44 | 54 | |
| | Escherichia coli (E. coli) infections (cumulative) | 33 (Nat) | | 36 | 45 | 53 | 61 | |
| | Pseudomonas infections (cumulative) | 7 (Nat) | | 16 | 18 | 20 | 22 | |
| | Klebsiella infections (cumulative) | 11 (Nat) | | 9 | 16 | 21 | 28 | |
| FFT | Daycases Response Rate | 25% (Int) | | 24% | 22% | 22% | 23% | |
| | Daycases Positive Responses | 98% (Int) | | 98% | 94% | 95% | 95% | |
| | Maternity Response Rate | 18% (Int) | | 18% | 17% | 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 increased significantly in October, work has continued with Divisional Directors of Nursing to have a focused approach on complaint responses, which is being supported by the Pals team.

The rate of *C. difficile* infection continues to be above that of 2022/23. Each case is reviewed for learning by the IPC team, an Antimicrobial Pharmacist and a Consultant Microbiologist. All samples are sent for ribotyping and there have been no links between cases detected. The overwhelming majority of cases are not found to have been preventable by GWH. BANES, Swindon, Wiltshire (BSW)'s review of all cases has found a strong link with antimicrobial prescribing in primary care, with BSW GP practices prescribing more broad-spectrum antibiotics than those in other systems. The BSW IPC and Antimicrobial Stewardship teams are working to address this. We continue to see high rates of *C. difficile* in uninfected patients, suggesting that an increased prevalence of the bacteria in the community is ongoing. Reasons for this are unclear but may come from the BSW review.

Rates of all three reportable gram-negative bloodstream infections (*E. coli, Klebsiella* and *Pseudomonas aeruginosa*) remain higher than trajectory, though *Pseudomonas* numbers have reduced since Estates, Serco and IPC have been working intensively on this issue in July.

E.Coli infections are predominately driven by urinary catheters and CAUTI (catheter associated urinary tract infections) working group continues to drive improvements such as the implementation of the catheter passport, catheter care bundle and ensuring challenge to remove catheters as soon as possible.

A significant theme in the *Klebsiella* cases has been hospital-acquired pneumonia and work is ongoing as part of the IPC Improvement Plan to reduce the incidence of this, particularly focusing on mouthcare and keeping patients active.

There has been no change in the family and friend response rates overall.

# Our Care

## Non-Alerting Watch Metrics

| Plan Area | Measure Name | Target | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|
| Harm | No. of serious incidents reported in month | SPC | | 3 | 3 | 2 | 8 |
| | Falls rate per 1000 bed days | SPC | | 4.6 | 4.8 | 5.4 | 5 |
| | No. of Falls in month | SPC | | 90 | 90 | 105 | 98 |
| | No. falls with moderate harm or above | SPC | | 2 | 2 | 3 | 2 |
| | Medication incidents with moderate harm | SPC | | 4 | 1 | 3 | 5 |
| Concerns and Complaints | No. of concerns received | SPC | | 120 | 127 | 158 | 140 |
| | No. of complaints received | SPC | | 59 | 67 | 59 | 46 |
| | Number of reopened complaints | SPC | | 5 | 4 | 3 | 3 |
| IP&C | Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative) | 21 (Int) | | 11 | 15 | 15 | 17 |
| | Covid – no. of hospital acquired | SPC | | 22 | 21 | 20 | 10 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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. | |

60

### Performance & Counter Measure

There are 25 ongoing Serious Incidents (SI) , with a further eight reported in month. The two main areas of concern are related to the death of a patient following an in-patient fall and failure to act on investigations which result in delayed follow-up.

The PSIRF plan and policy were approved at Patient Quality sub-committee in October, with Board approval granted in November 2023.

The number of concerns and complaints have both decreased in month.

Data from the lying and standing blood pressure audit has shown an increase in assessment. All areas where assessment was not completed are informed were informed and additional training put in place as required.

The baseline data collection for the Enhanced Care project was completed during October 2023. The project commences on Teal, Trauma and Orchard wards during November 2023. The aim of the project is to establish whether nursing staff are recommending and implementing an appropriate level of observation to maintain patient safety, in comparison to the clinical judgement of the auditing team.

MSSA rates remain below last year's figures and below our internally-set threshold. The COVID wave which began in late July began to recede in mid-October and a corresponding drop in nosocomial cases was seen. Air scrubber installation continues and there have been no bed or ward closures due to COVID.

### Risks

There have been patient & staff concerns regarding lack of disability access within GWH. Discussions are ongoing with estates and facilities teams to make amendments to some doors once funding agreed.

# Our Care

## Non-Alerting Watch Metrics

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

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

### Performance & Counter Measures

Safe Staffing fill rates remain in line with previous months and within safe parameters.

There has been a slight decrease in the overall FFT response rate, but no change in the positive response rate, and both remain in line with the internal targets.

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

- Our annual Patient Led Assessment of the Care Environment (PLACE) audit is underway with involvement of public members
- Actions have been implemented following direct carer feedback about the discharge process. The matron for operations and flow is using the feedback to influence discharge processes moving forward, particularly in relation to the use of terminology that patients and families understand.
- A survey of young carers has been undertaken. The results demonstrate the need for more involvement of young carers when their cared for person is admitted.
- The results of first national Stroke Patient Reported Experience Measures (PREMs) report has been received and demonstrates some positive findings. A full report will be presented to Patient Quality Sub-Committee
- Improvement work is underway with drug and alcohol support service providers (Grow, Change, Live CGL) to improve discharge process and communication with community teams.

# Our Performance

## Alerting Watch Metrics

| Plan Area | Measure Name | Target /SPC Target Icon | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Trend |
|---|---|---|---|---|---|---|---|---|
| RTT | No. of >=18 weeks waiters | | H | 17685 | 18285 | 19161 | 19028 | |
| | No. of >=52 weeks waiters | | H | 2448 | 2418 | 2307 | 2238 | |
| DM01 | No. of patients on DM01 waitlist | | H | 13075 | 12989 | 13843 | One month behind | |
| | DM01 performance % | 99% (Nat) | F | 49.4% | 44.5% | 46.1% | One month behind | |
| | DM01 6 week wait breaches | | H | 6621 | 7208 | 7462 | One month behind | |
| Cancer | % Cancer 62 day performance | 85% (Nat) | ? | 67.0% | 59.5% | 49.0% | One month behind | |
| | % Cancer 31 day performance | 96% (Nat) | ? | 85.0% | 84.9% | 81.0% | One month behind | |
| | % Cancer 2 week wait | 93% (Nat) | F | 60.0% | 54.0% | 54.0% | One month behind | |
| | % 28 day faster diagnosis | 75% (Nat) | ? | 67.0% | 62.6% | 62.0% | One month behind | |

| | | | | | | |
|---|---|---|---|---|---|---|
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## Performance & Counter Measure

Octobers DM01 validated performance is showing a slight decline in performance variance from the 46.10% performance in September to 45.01%. The number of patients on the waiting list has increased to 15095 and the number of 6-week breach has increased to 8301 driven by Ultrasound, ECHO and Cystoscopy. 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. The teams continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory.
Ultrasound still remains the largest issue, but a recovery plan started in October.. Sleeps studies have recruited with a Dec start date targeted and also a colleague returning from Mat leave in November to help recover the numbers. Endoscopy continue to work with InHealth to improve the performance of the mobile Endoscopy unit although this still remains challenging

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathway with 64% 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.

74.5% 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 53.3% of all of the breaches. Colorectal pathways accounted for 19.7% of total breaches

In September, 80% (511) 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 late Nov/early Dec.

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.

## Risks

# Our Performance

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Target /SPC Target Icon | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|
| RTT | No. of >=78 weeks waiters | SPC | L | 0 | 3 | 1 | 1 |
| Cancer | No. of referrals received | SPC | P | 1819 | 1828 | 1934 | One month behind |
| ED | UTC (Type 03) - Percentage Arrival to Departure within 4 Hours | 95% (Nat) | ? | 95.6% | 95.8% | 94.2% | 93.8% |
| | UTC (Type 03) - Percentage Arrival to Departure over 12 Hours | 2% (Nat) | P | 0.0% | 0.0% | 0.0% | 0.1% |
| | Total ED Type 1 Attendances (all arrival methods) | SPC | | 5347 | 5207 | 5236 | 5054 |
| | A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance | SPC | H | 70.0% | 70.9% | 73.6% | 73.1% |
| | Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival) | SPC | | 50.7% | 52.9% | 48.0% | 48.9% |
| | Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival) | SPC | | 47.3% | 42.3% | 51.2% | 39.6% |
| | A&E (ED & UTC) Median Arrival to Departure in Minutes | 240 (Int) | P | 187 | 187 | 195 | 202 |
| | Emergency Care - AED - Median Stay | 240 (Int) | ? | 238 | 240 | 238 | 292 |
| | Emergency Care - UTC - Median Stay | 240 (Int) | P | 145 | 139 | 158 | 151 |

### Performance & Counter Measure

UTC Type 3 performance has not hit the 4 hour performance metric for Oct 23. The department missed out by 0.2% which will initiate a validation of the data.

Triage performance for both ED and UTC has dropped especially in UTC. This has been impacted due to staffing issues and demand over usual levels. Review of triage performance to be conducted across both settings wc 27th November to formulate improvement actions.

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

In September , 80% (511) 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

| | | | | | | | |
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# Our Performance

## Alerting Watch Metrics

| Plan Area | Measure Name | Target /SPC Target Icon | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Trend |
|---|---|---|---|---|---|---|---|---|
| ED | A&E (ED & UTC) Emergency Care 4 Hour Performance % | 95% (Nat) | F | 75.5% | 74.2% | 71.5% | 74.7% | |
| | A&E (ED & UTC) Emergency Care 12 Hour Performance % | 2% (Nat) | F | 6.9% | 6.9% | 8.5% | 8.3% | |
| | AED (Type 01) - Percentage Arrival to Departure within 4 Hours | 95% (Nat) | F | 55.6% | 52.5% | 48.5% | 54.7% | |
| | AED (Type 01) - Percentage Arrival to Departure over 12 Hours | 2% (Nat) | F | 13.6% | 13.9% | 17.1% | 16.9% | |
| | Number of Ambulance Handover Over 15 Minute Waits | SPC | H | 1244 | 1478 | 1384 | 1506 | |
| | Percentage of Ambulance Handover Over 15 Minute Waits | SPC | H | 73% | 78% | 85% | 90% | |
| | Number of Ambulance Handover 30 Minute Waits | SPC | H | 778 | 907 | 989 | 1110 | |
| | Percentage of Ambulance Handover s Over 30 Minutes | SPC | H | 45.6% | 48.0% | 61.1% | 66.1% | |
| | Number of Ambulance Handover Over 60 Minutes Waits | SPC | H | 474 | 470 | 685 | 695 | |
| | Percentage of Ambulance Handovers Over 60 Minutes | SPC | H | 27.8% | 24.9% | 42.3% | 41.4% | |
| Flow | Average hours lost to ambulance handover delays per day | SPC | H | 49 | 43 | 95 | 82 | |
| | Non - Admitted - Average Length of Stay in Department (mins) | SPC | H | 274 | 295 | 307 | 334 | |
| | Number of Stranded Patients (over 14 days) | SPC | H | 116 | 119 | 136 | 129 | |
| | Number of Super Stranded Patients (over 21 days) | SPC | H | 68 | 67 | 83 | 77 | |

### Performance & Counter Measure

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

ED performance has remained relatively static across most areas compared to previous months. 4 hour performance increased to 74.7% from 71.5% with a rise also seen in type 1 4 hours performance from 48.5% to 54.7%.

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

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

- Total % over 12 hours has decreased slightly from 17.1% to 16.9%.
- Number of ambulance handovers over 30 minutes have seen a rise from 989 to 1110.
- Number of ambulance handovers over 60 minutes have seen a rise from 685 to 695.

Counter measures remain in place within the Breakthrough objective slides.

### Risks

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

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

| | | | | | | | |
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# Use of Resources

Great Western Hospitals NHS Foundation Trust

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Target | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|
| Use of Resources | Capital Expenditure (£'000) | SPC | | 2184 | 3861 | Waiting for data | Waiting for data |
| | Pay (£'000) | SPC | | 25024 | 25776 | 25468 | 25350 |
| | Non Pay (£'000) | SPC | | 15127 | 15729 | 15038 | 14750 |

### Performance & Counter Measure

Capital spend in M7 was £2.6m, which is £0.9m behind plan in month. The underspend is mainly due to lower spend on the way forward programme and Aseptics. All capital project leads are forecasting to spend their allocations by year end, which means that no new capital projects can be approved as we have no additional funding.

Pay costs are £0.1m lower than M6; this is driven by lower medical agency/locum costs.

Non-Pay is £0.3m lower than M6 due to accrued costs relating to prior year which have not materialised.

| | | | | | | |
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### 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 7, the programme is £2.1m under plan, a deterioration of £0.3m from M6.

Out of the £16.67m target, £6.9m is fully developed, in line with M6. Divisions and supporting services must work to turn the remaining schemes flagged as opportunities into deliverable savings.

# Our Performance

Great Western Hospitals NHS Foundation Trust

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Target /SPC Target Icon | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|
| ED | Total Number of Ambulance Handovers | SPC | | 1705 | 1888 | 1619 | 1680 |
| | Total Hours Ambulance Handover Waits (over 15mins) | SPC | | 1521.06 | 1340.62 | 2862.13 | 2555.40 |
| Flow | Admitted - Average Length of Stay in Department (mins) | SPC | | 632 | 621 | 793 | 749 |
| | Elective Patients Average Length of Stay (Days) | SPC | | 2 | 2 | 3 | 3 |
| | Non-Elective Patients Average Length of Stay (Days) | SPC | | 5 | 5 | 5 | 5 |
| | Community Average Length of Stay (Days) | SPC | | 17 | 20 | 16 | 17 |
| | GWH Discharges by Noon (%) | SPC | | 16.0% | 17.7% | 16.1% | 16.4% |
| | Adult general and acute type 1 bed occupancy | SPC | | 97.9% | 98.4% | 98.7% | 94.9% |
| | GWH - Percent Non-Criteria to Reside (NCtR) Bed Days | SPC | | 22.5% | 20.4% | 19.6% | 19.3% |
| | Proportion of patients discharged from hospital to their usual place of residence | SPC | | 94.8% | 95.2% | 95.2% | 95.0% |

### Performance & Counter Measure

Community average LOS 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.

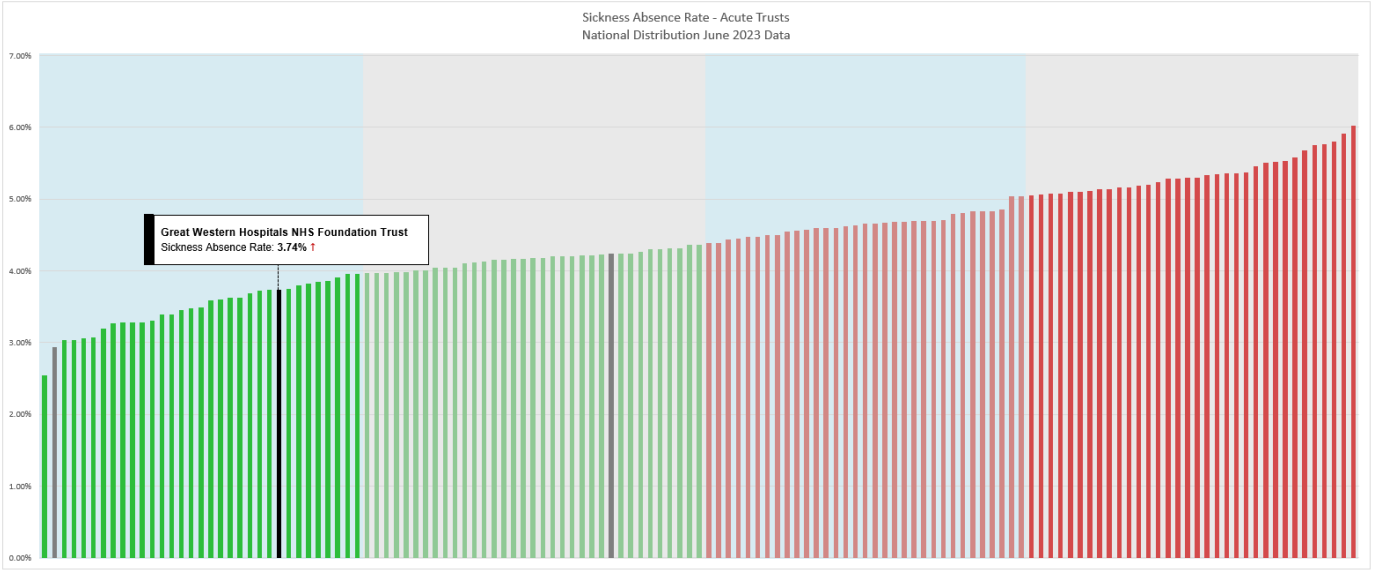
A slight reduction in the NCTR Bed Days (%), after the Discharge Hub meetings taking place with locality leads 3 times a day (5 days a week) and twice over the weekend.

### Risks

# Our People

## Alerting Watch Metrics

| Plan Area | Measure Name | Target /SPC Target Icon | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Trend |
|---|---|---|---|---|---|---|---|---|
| Workforce | Trust sickness absence rate | 3.5% (Int) | F | 4.4% | 4.0% | 4.2% | One month behind | |




### Performance & Counter Measure

- In-month sickness absence has increased marginally in September from 4.0% to 4.2%, and continues to alert above the Trust KPI of 3.5%. Long-term absence has decreased in month from 2.2% to 1.8% however has not offset a sharp increase in short-term absence rates (1.8% to 2.5% in September). The current short-term absence rate is in line with usual seasonal variation.
- Current national benchmarking data (June 2023 - NHS Digital) shows a marginal increase to the national sickness rate, increasing from 4.46% in May to 4.51% in June. For the South West Region, absence decreased in this period from 4.36% to 4.34% and as a system our absence rate remained static at 3.96%. The absence rate for GWH increased from 3.63% to 3.74% in June, which remains below both the national and regional position. GWH remains in the first lowest quartile and the top 20% nationally for Acute Trusts.

### 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.

| | | | | | | | |
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# Our People

Great Western Hospitals NHS Foundation Trust

## Non Alerting Watch Metrics

| Plan Area | Measure Name | Target /SPC Target Icon | SPC Improv. Icon | Jul-23 | Aug-23 | Sep-23 | Oct-23 |
|---|---|---|---|---|---|---|---|
| Workforce | % of leavers within 1st year of employment | 31.2% (Int) | | 34.6% | 27.7% | 27.9% | One month behind |

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

### Performance & Counter Measure

- The % of leavers within 1st year of employment remained static in September 2023 at 28%, below the average of 31%. The Trust Retention Working Group continues to meet and are developing a fishbone to better understand root cause for this cohort of leavers.
- Staff survey response rates for the 2023 Annual Staff Survey continue to be measured weekly during the survey period, with competitions and prizes being used to drive responses across the survey window. The Trust has currently achieved a 66% response rate as at week 9 of the campaign, and therefore above the national average for last year.
- We await the annual staff survey results for comparisons on two key questions on well-being and EDI during promotions and career development.

### Risks

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

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# Our People

## Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

| Type | Metric | Unit/Measure | Target | 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 | Trend Vs Last Month | Trend Vs Oct-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Vacancy | | | | | | | | | | | | | | | | | |
| W | Vacancy Rate | % | 7.00% | 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% | ↓ | ↓ |
| W | 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 | | |
| W | All Nursing Vacancy | % | 7.00% | 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% | ↓ | ↓ |
| W | 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 | | |
| W | 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 | | |
| W | 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 | | |
| W | 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 | | |
| W | Medical Vacancy | % | 7.00% | 5.73% | 5.80% | 5.43% | 5.61% | 8.49% | 6.86% | 9.35% | 10.14% | 9.93% | 10.34% | 7.28% | 5.22% | 5.66% | ↑ | ↓ |
| W | Medical Vacancy | WTE | - | 40.26 | 40.74 | 38.33 | 39.16 | 59.19 | 47.86 | 67.29 | 74.56 | 73.05 | 76.03 | 53.43 | 38.22 | 41.48 | | |
| W | STT/AHP Vacancy | % | 7.00% | 6.89% | 6.09% | 6.54% | 6.97% | 6.29% | 7.66% | 11.10% | 12.48% | 12.69% | 13.04% | 13.04% | 10.41% | 9.20% | ↓ | ↑ |
| W | STT/AHP Vacancy | WTE | - | 57.10 | 50.49 | 54.28 | 57.85 | 51.64 | 63.84 | 94.86 | 107.82 | 110.17 | 113.09 | 112.95 | 90.28 | 79.85 | | |
| W | SMA Vacancy | % | 7.00% | 8.21% | 7.55% | 7.88% | 10.97% | 7.96% | 6.37% | 10.62% | 10.60% | 9.01% | 8.71% | 7.13% | 7.12% | 6.70% | ↓ | ↓ |
| W | SMA Vacancy | WTE | - | 93.76 | 86.27 | 90.27 | 125.68 | 88.66 | 70.50 | 121.73 | 123.41 | 104.33 | 100.98 | 82.48 | 82.40 | 77.45 | | |
| W | Recruitment Time to Hire - Trust Sub | Days | 46.00 | 63.70 | 74.30 | 72.30 | 91.30 | 50.90 | 54.50 | 52.90 | 50.60 | 47.60 | 49.10 | 45.00 | 41.70 | 42.70 | ↑ | ↓ |
| W | Recruitment Time to Hire - Trust Bank | Days | 46.00 | 0.00 | 0.00 | 0.00 | 0.00 | 117.90 | 127.80 | 118.00 | 58.50 | 26.90 | 50.40 | 46.00 | 43.50 | 37.00 | ↓ | ↑ |
| | Workforce Utilisation | | | | | | | | | | | | | | | | | |
| W | Establishment WTE | WTE | - | 5,226.19 | 5,248.35 | 5,289.43 | 5,289.16 | 5,236.02 | 5,224.47 | 5,337.41 | 5,434.85 | 5,433.60 | 5,433.60 | 5,382.13 | 5,381.76 | 5,379.33 | | |
| W | Budgeted vs Worked WTE Variance | WTE | - | 71.71 | 184.20 | 87.52 | 51.09 | 109.88 | 237.86 | 31.62 | 45.85 | 51.23 | 4.21 | 131.68 | 70.68 | 132.30 | | |
| W | Actual Worked vs Budgeted % | % | - | 1.37% | 3.51% | 1.65% | 0.97% | 2.10% | 4.55% | 0.59% | 0.84% | 0.94% | 0.08% | 2.45% | 1.31% | 2.46% | | |
| W | Total Workforce Cost £ | £ | - | £23.43M | £24.05M | £23.64M | £22.93M | £24.66M | £23.73M | £23.85M | £23.98M | £25.73M | £24.82M | £24.44M | £26.42M | £25.68M | | |
| W | Agency Spend as % of Total Spend | % | 4.50% | 6.53% | 6.17% | 5.97% | 5.60% | 4.98% | 5.35% | 3.41% | 5.55% | 3.41% | 4.18% | 2.62% | 3.11% | 4.32% | ↑ | ↓ |
| W | Agency Spend £ | £ | - | £1.53M | £1.48M | £1.41M | £1.28M | £1.23M | £1.27M | £0.81M | £1.33M | £0.88M | £1.04M | £0.64M | £0.82M | £1.11M | | |
| W | Agency Target £ | £ | | - | - | - | - | - | - | £1.21M | £1.04M | £0.88M | £0.76M | £1.06M | £1.17M | £1.07M | | |
| W | Agency Spend vs Target £ | £ Diff | £0.00M | - | - | - | - | - | - | -£0.40M | £0.29M | £0.00M | £0.28M | -£0.42M | -£0.35M | £0.04M | ↑ | ↓ |
| W | Agency WTE | WTE | - | 127.69 | 113.12 | 109.26 | 102.88 | 90.00 | 106.82 | 90.76 | 105.02 | 96.40 | 94.71 | 78.85 | 74.91 | 59.88 | | |
| W | Bank WTE | WTE | - | 258.31 | 354.47 | 278.67 | 310.93 | 323.25 | 377.11 | 303.84 | 351.68 | 355.36 | 303.23 | 347.55 | 235.16 | 278.50 | | |
| W | Registered Nursing Bank Fill | % | 45.00% | 48.32% | 53.80% | 43.60% | 52.86% | 55.30% | 54.71% | 57.70% | 57.91% | 54.99% | 54.47% | 53.30% | 54.80% | 62.68% | ↑ | ↑ |
| W | Unregistered Nursing Bank Fill | % | 70.00% | 66.26% | 70.85% | 62.98% | 74.32% | 71.78% | 77.63% | 83.58% | 81.52% | 80.82% | 79.98% | 77.52% | 81.35% | 79.95% | ↓ | ↑ |

# Our People

## Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

| Type | Metric | Unit/Measure | Target | 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 | Trend Vs | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | Last Month | Oct-22 |
| | Retention | | | | | | | | | | | | | | | | | |
| W | All Turnover % | % | 13.00% | 14.69% | 14.52% | 14.90% | 14.84% | 14.42% | 14.48% | 13.79% | 13.88% | 13.27% | 12.74% | 12.69% | 12.56% | - | ↓ | ↓ |
| W | Voluntary Turnover % | % | 11.00% | 11.78% | 11.54% | 11.84% | 11.57% | 11.25% | 11.16% | 10.54% | 10.52% | 10.17% | 9.67% | 9.62% | 9.52% | - | ↓ | ↓ |
| W | Number of Leavers | Headcount | - | 57 | 54 | 69 | 74 | 43 | 79 | 33 | 62 | 52 | 53 | 47 | 61 | - | | |
| W | Number of RN Leavers | Headcount | - | 8.00 | 6.00 | 14.00 | 16.00 | 8.00 | 17.00 | 7.00 | 15.00 | 16.00 | 12.00 | 14.00 | 18.00 | - | | |
| W | Registered Nursing Vol Turnover | % | - | 9.61% | 8.92% | 8.79% | 8.58% | 7.99% | 7.83% | 7.05% | 6.82% | 6.82% | 6.59% | 6.66% | 6.55% | - | | |
| W | Number of Unreg Nursing Leavers | Headcount | - | 17.00 | 17.00 | 19.00 | 15.00 | 12.00 | 12.00 | 8.00 | 12.00 | 10.00 | 7.00 | 12.00 | 21.00 | - | | |
| W | Unregistered Nursing Vol Turnover | % | - | 15.72% | 15.62% | 16.37% | 16.73% | 16.57% | 15.95% | 15.46% | 15.17% | 13.99% | 13.02% | 12.83% | 13.35% | - | | |
| W | Leavers within 1st Year of Employment | % | - | 28.07% | 29.63% | 21.74% | 24.32% | 30.23% | 24.05% | 36.36% | 29.03% | 25.00% | 33.96% | 27.66% | 27.87% | - | | |
| W | Number of starters | Headcount | - | 103 | 85 | 56 | 106 | 72 | 77 | 75 | 66 | 64 | 128 | 61 | 114 | - | | |
| | Absence | | | | | | | | | | | | | | | | | |
| D | Sickness Absence % Rolling 12 Month | % | 3.50% | 5.06% | 5.00% | 5.20% | 5.14% | 5.04% | 4.98% | 4.84% | 4.71% | 4.61% | 4.60% | 4.55% | 4.50% | - | ↓ | ↓ |
| D | Sickness Absence % | % | 3.50% | 5.34% | 4.87% | 5.79% | 4.90% | 4.53% | 4.63% | 3.85% | 3.68% | 3.77% | 4.42% | 4.04% | 4.21% | - | ↑ | ↓ |
| W | Long Term Sickness % | % | 2.00% | 2.36% | 2.36% | 2.50% | 2.52% | 2.24% | 2.27% | 2.13% | 2.06% | 2.16% | 2.61% | 2.21% | 1.75% | - | ↓ | ↓ |
| W | Short Term Sickness % | % | 1.50% | 2.99% | 2.51% | 3.29% | 2.38% | 2.29% | 2.36% | 1.72% | 1.61% | 1.61% | 1.81% | 1.83% | 2.47% | - | ↑ | ↓ |
| W | Sickness Absence Cost £ | £ | - | £767.6k | £650.4k | £749.9k | £687.4k | £575.4k | £675.3k | £546.9k | £574.4k | £550.4k | £664.8k | £626.3k | £614.8k | - | | |
| W | WTE Days Lost | WTE | - | 7,952.9 | 7,096.4 | 8,768.5 | 7,364.2 | 6,109.2 | 6,960.2 | 5,648.5 | 5,612.7 | 5,568.9 | 6,781.2 | 6,256.4 | 6,401.2 | - | | |
| | Learning & Development | | | | | | | | | | | | | | | | | |
| W | Mandatory Training Compliance % | % | 85.00% | 85.79% | 86.39% | 86.40% | 86.61% | 86.79% | 87.69% | 89.20% | 90.27% | 89.81% | 89.90% | 90.10% | 90.36% | 90.75% | ↑ | ↑ |
| W | Role Essential MT % | % | 85.00% | 87.99% | 88.75% | 88.94% | 89.06% | 89.03% | 89.66% | 90.92% | 91.59% | 91.37% | 91.40% | 91.64% | 91.93% | 92.20% | ↑ | ↑ |
| W | CQC Safe MT % | % | 85.00% | 83.65% | 84.10% | 83.93% | 84.18% | 84.54% | 85.71% | 87.48% | 88.95% | 88.25% | 88.38% | 88.56% | 88.78% | 89.32% | ↑ | ↑ |
| W | Bank-Only Mandatory Training Compliance % | % | 85.00% | - | - | - | - | - | - | 59.32% | 64.39% | 73.18% | 76.28% | 79.91% | 82.14% | 83.26% | ↑ | ↓ |
| W | Appraisal Compliance % | % | 85.00% | 76.32% | 79.31% | 81.43% | 81.16% | 83.33% | 82.25% | 83.11% | 82.18% | 83.86% | 83.94% | 84.29% | 84.88% | 84.92% | ↑ | ↑ |
| W | Non Medical Appraisal Compliance % | % | 85.00% | 76.81% | 79.18% | 81.33% | 80.99% | 83.02% | 81.77% | 82.91% | 81.80% | 83.53% | 83.74% | 84.27% | 84.88% | 84.92% | ↑ | ↑ |
| W | Medical Appraisal Compliance % | % | 85.00% | 64.63% | 82.84% | 84.13% | 85.44% | 91.07% | 93.90% | 87.90% | 88.00% | 91.81% | 88.64% | 84.64% | 84.84% | 85.04% | ↑ | ↑ |

# Our People

## Workforce Scorecard

Great Western Hospitals NHS Foundation Trust

| Type | Metric | Unit/Measure | Target | 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 | Trend Vs | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | Last Month | Oct-22 |
| | Demographics | | | | | | | | | | | | | | | | | |
| W | Staff in Leadership Roles % (B8a+) | % | - | 4.24% | 4.22% | 4.18% | 4.17% | 4.21% | 4.19% | 4.14% | 4.12% | 4.12% | 4.13% | 4.17% | 4.18% | 4.12% | | |
| W | Staff in Leadership Roles WTE (B8a+) | WTE | - | 254.00 | 255.00 | 254.00 | 250.00 | 253.00 | 253.00 | 249.00 | 251.00 | 251.00 | 252.00 | 257.00 | 260.00 | 258.00 | | |
| W | % of Leadership Roles who are Female (B8a+) | % | - | 70.87% | 71.37% | 71.26% | 71.20% | 71.54% | 70.75% | 70.68% | 70.92% | 70.52% | 70.24% | 70.82% | 71.15% | 70.93% | | |
| W | % of Leadership Roles who from BME (B8a+) | % | - | 5.91% | 5.10% | 5.12% | 5.20% | 5.14% | 5.14% | 5.22% | 5.58% | 5.58% | 5.95% | 6.61% | 6.54% | 6.20% | | |
| W | Staff in Leadership Roles % (B8c+) | % | - | 0.93% | 0.98% | 0.97% | 0.92% | 0.93% | 0.91% | 0.95% | 0.95% | 0.95% | 0.93% | 0.93% | 0.92% | 0.91% | | |
| W | Staff in Leadership Roles WTE (B8c+) | WTE | - | 56.00 | 59.00 | 59.00 | 55.00 | 56.00 | 55.00 | 57.00 | 58.00 | 58.00 | 57.00 | 57.00 | 57.00 | 57.00 | | |
| W | % of Leadership Roles who are Female (B8c+) | % | - | 57.14% | 57.63% | 57.63% | 60.00% | 60.71% | 58.18% | 57.89% | 58.62% | 56.90% | 56.14% | 56.14% | 56.14% | 56.14% | | |
| W | % of Leadership Roles who from BME (B8c+) | % | - | 5.36% | 5.08% | 5.08% | 5.45% | 5.36% | 5.45% | 5.26% | 5.17% | 5.17% | 5.26% | 5.26% | 5.26% | 5.26% | | |
| W | Male % of Workforce | % | - | 17.45% | 17.36% | 17.38% | 17.55% | 17.50% | 17.71% | 17.63% | 17.75% | 17.83% | 17.90% | 18.10% | 18.16% | 18.36% | | |
| W | Female % of Workforce | % | - | 82.55% | 82.64% | 82.62% | 82.45% | 82.50% | 82.29% | 82.37% | 82.25% | 82.17% | 82.10% | 81.90% | 81.84% | 81.64% | | |
| W | BME % of Workforce | % | - | 21.48% | 21.83% | 21.94% | 22.54% | 22.75% | 23.24% | 23.60% | 24.22% | 24.19% | 24.49% | 25.06% | 25.18% | 25.47% | | |
| W | White % of Workforce | % | - | 69.60% | 69.33% | 69.16% | 68.74% | 68.71% | 68.25% | 68.07% | 67.43% | 67.29% | 67.08% | 67.03% | 66.86% | 66.58% | | |
| W | ER Cases Closed | Number | - | 41 | 39 | 44 | 48 | 57 | 65 | 43 | 56 | 54 | 58 | 20 | 32 | 23 | | |

# Our People

NHS Great Western Hospitals NHS Foundation Trust

## Workforce Scorecard - Workforce Planning

| | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Establishment | *Plan* | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 |
| | **Actual** | **5337.41** | **5434.85** | **5433.60** | **5433.60** | **5382.13** | **5381.76** | **5379.33** | | | | | |
| | Variance | -54.05 | 43.39 | 42.14 | 42.14 | -9.33 | -9.70 | -12.13 | | | | | |
| Contract | *Plan* | 4917.66 | 4942.06 | 4958.27 | 4973.06 | 4996.74 | 5018.76 | 5041.25 | 5057.46 | 5066.09 | 5064.08 | 5064.98 | 5067.30 |
| | **Actual** | **4935.83** | **4996.96** | **5002.31** | **5009.92** | **5061.69** | **5119.43** | **5146.38** | | | | | |
| | Variance | 18.17 | 54.90 | 44.04 | 36.86 | 64.95 | 100.68 | 105.13 | | | | | |
| Bank | *Plan* | 271.91 | 322.50 | 262.43 | 246.62 | 240.30 | 300.37 | 303.53 | 262.43 | 278.24 | 208.68 | 227.65 | 237.13 |
| | **Actual** | **303.84** | **351.68** | **355.36** | **303.23** | **347.55** | **235.16** | **278.50** | | | | | |
| | Variance | 31.93 | 29.18 | 92.93 | 56.61 | 107.25 | -65.21 | -25.03 | | | | | |
| Agency | *Plan* | 104.12 | 123.49 | 100.49 | 94.43 | 92.01 | 115.01 | 116.23 | 100.49 | 106.54 | 79.90 | 87.17 | 90.80 |
| | **Actual** | **90.76** | **105.02** | **96.40** | **94.71** | **78.85** | **74.91** | **59.88** | | | | | |
| | Variance | -13.36 | -18.47 | -4.09 | 0.28 | -13.16 | -40.10 | -56.35 | | | | | |
| Actual vs Establishment | *Establishment* | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 | 5391.46 |
| | **Actual** | **5330.43** | **5453.66** | **5454.07** | **5407.86** | **5488.09** | **5429.50** | **5484.76** | | | | | |
| | Variance | -61.03 | 62.20 | 62.61 | 16.40 | 96.63 | 38.04 | 93.30 | | | | | |

Key

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

### Performance & Counter Measure

- In M7 there has been a further decrease to our establishment of 2WTE following realignment of pay budgets for unregistered nursing staff moving from band 2 to 3. Our position remains below plan by -12WTE, and within the control total of 5,4414WTE.
- We utilised 5,485WTE to deliver our services in M7 against an establishment of 5,379WTE (+93WTE). Our contracted position is ahead of plan in M7, and has lowered our vacancy rate to 233WTE. Despite this, temporary staff utilisation still remains above our vacancy position with 338WTE used in-month.
- Additional utilisation above establishment continues to be scrutinised, with reduction workstreams currently underway for Nursing and Medical usage. Agency nursing has seen a positive reduction in October, however there is still opportunity for improvement for bank nursing and for Medical & Dental.

### Risks & Mitigations

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

# Appendices

*Explaining the IPR*

Improving
together

# Explaining the IPR

Great Western Hospitals NHS Foundation Trust

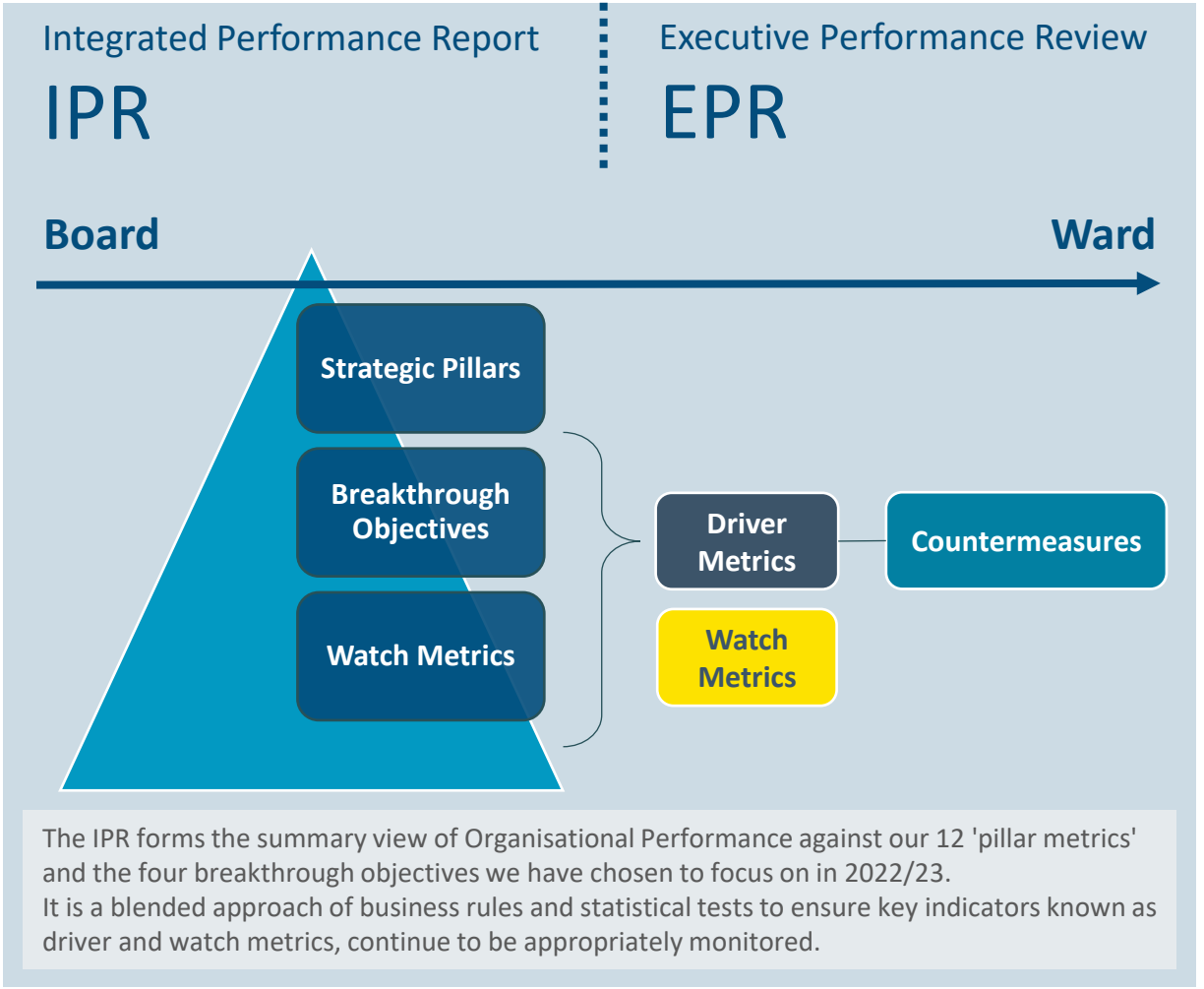
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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




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

# Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

**Our Vision**

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

## Our four strategic pillars

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

# Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

**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

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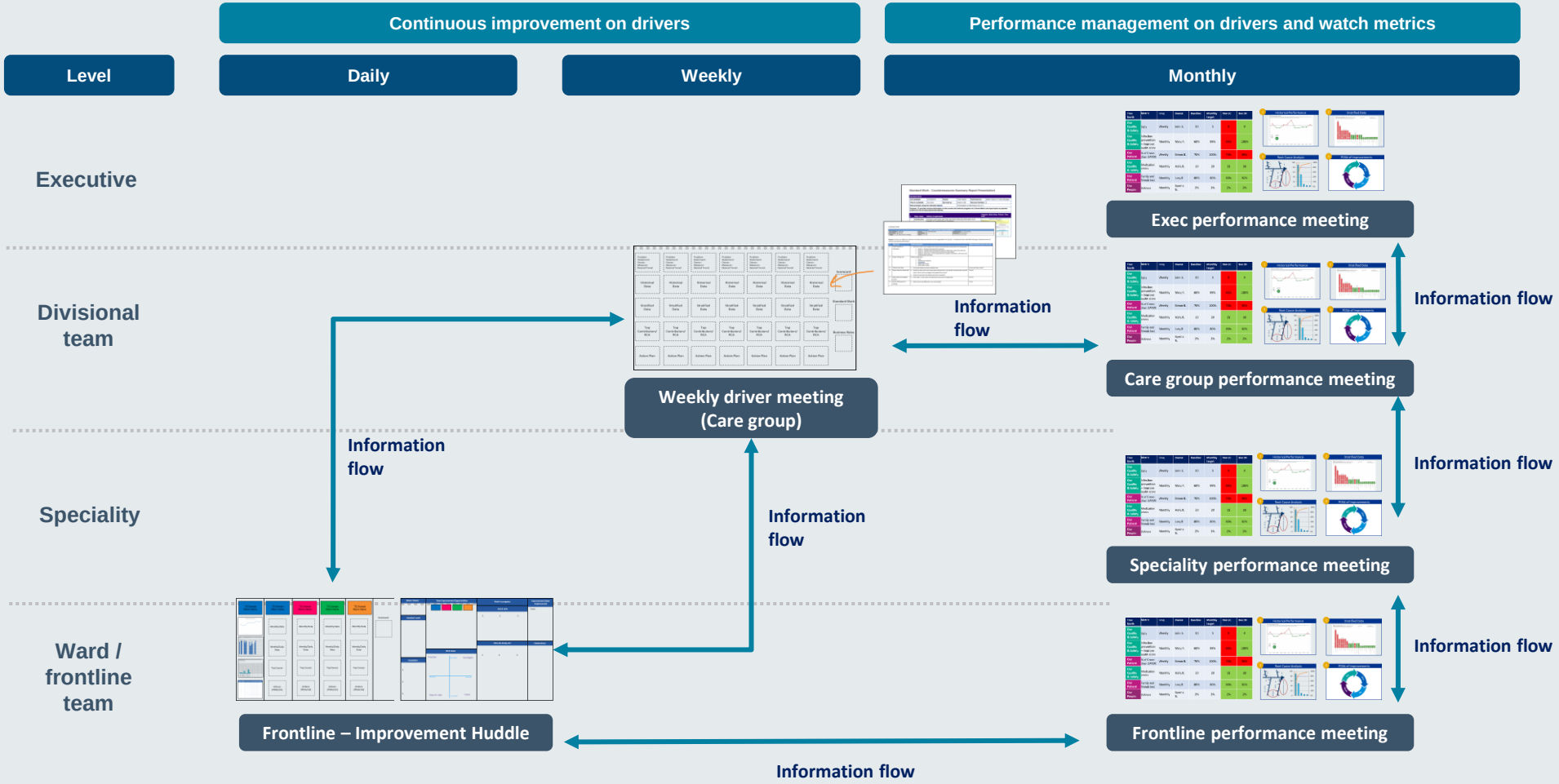

# Building a culture of continuous improvement

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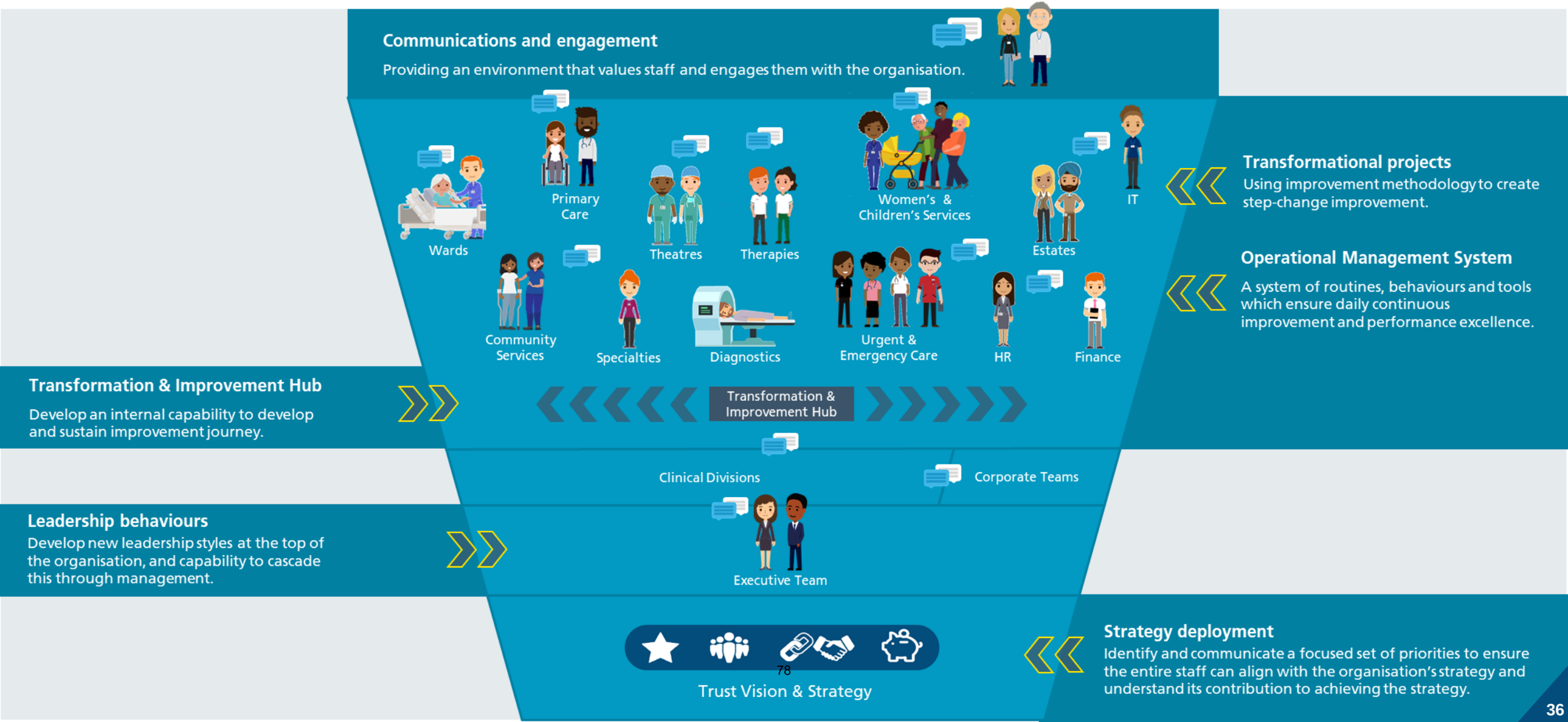


# SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

### What is statistical process control (SPC)?

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

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

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

### Key Facts about an SPC Chart

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

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

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

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

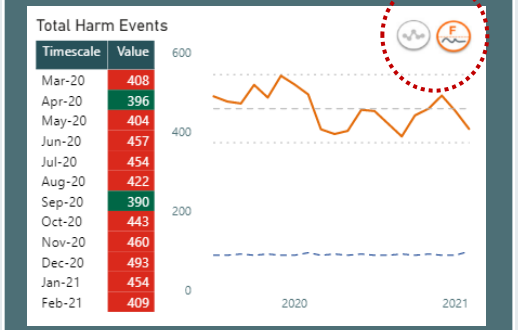
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

### NHS Improvement SPC icons:

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

### Where to find them:

**Strategic Pillars**




**Breakthrough Objectives**

# Performance business rules

Great Western Hospitals NHS Foundation Trust

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

# Agreed Terms

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| Term | Description |
|---|---|
| **A3** | A methodology used as part of Improving Together to ensure that problems, ideas, and areas for improvement are all approached in the same way.<br>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.<br>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.<br>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.<br>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.<br>It is presented at monthly Performance Review Meetings. |

# Agreed Terms

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| Term | Description |
|---|---|
| **Driver Lane** | A visual management tool displayed on a team's Performance Board, containing driver metric information taken from A3 workings (e.g., problem statement, data, contributing factors, 3 C's or Action Plan).<br>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.<br>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.<br>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.<br>It can be used to structure a brainstorming session to identify the potential causes of a problem. |
| **Go and See** | A visit to observe a specific problem or area for improvement and gain a better understanding of the process, engage with staff, and explore opportunities for improvement. While observing, visitors should ask open ended questions, lead with curiosity, and try to see the problem from different perspectives. |
| **Important Project** | A project that supports the four Pillars but is less of a priority than a Mission Critical Project. |
| **Improvement Board** | A visual tool to track daily improvement and operational activities. 1) Improvement activities will be identified when discussing the driver metric on the Performance Board. 2) Daily operational activities can be identified in the morning handovers/ward rounds. |

# Agreed Terms

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| Term | Description |
|---|---|
| **Improvement Huddle Boards** | A visual display used by teams to work through areas for improvement, track improvement work and daily operational activities.<br>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.<br>They aim to encourage conversation, involvement and team working.<br>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.<br>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.<br>This new way of working will help us to achieve our vision and the four pillars we want to be known for.<br>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.<br>Key elements of the system are:<br>- To cascade the organisational priorities to Divisions and then frontline teams, ensuring everyone understands their contribution<br>- Embedding a new performance framework<br>- A focus on problem-solving at Divisions and team level, rather than waiting for solutions to be imposed from above<br>- 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:<br>- A focus on problem-solving at a team, ward, or department level, rather than waiting for solutions to be imposed from above<br>- Concentration on the Four Pillars and vision and ensuring everyone understands their contribution<br>- 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.<br>The PDSA cycle is a series of steps for gaining learning and knowledge for the improvement of a product or process.<br>A PDSA Ticket is a proposed change which needs to be trialed. They are discussed at Improvement Huddles and can take 3-4 weeks to implement after planning, trying it out, observing the results, and acting on what is learnt. |

# Agreed Terms

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| Term | Description |
|---|---|
| **Process Observation** | Observing how a process or procedure is performing compared to the agreed standard. Benefits include creating stability and reducing the risk of deviation from the agreed standard.<br>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).<br>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.<br>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.<br>The purposes of a Scorecard is to:<br>- Make strategy a continual process that involves everyone<br>- Promote key measurements<br>- Make clear the team's goals in relation to the Trust's four pillars<br>- 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.<br>The aim being to:<br>- Understand how each Division contributes to achieving the organisational priorities<br>- 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.<br>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.<br>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.<br>It's important that every member of staff understands what our vision is, what the four pillars are, and how they can make improvements in their area to support these pillars. |

# Agreed Terms

Great Western Hospitals NHS Foundation Trust

| Term | Description |
|---|---|
| **Strategy Deployment** | A planning process which gives long-term direction to a complex organisation.<br>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.<br>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.<br>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.<br>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.<br>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.<br>They can help teams to identify their vision for change, whether it be through problem solving, process mapping or developing plans. They will then support through a mixture of full day training sessions, bite sized coaching and work placed support. |
| **Vision** | Vision captures the few selected organisation wide priorities and goals or the strategic aims that guide all improvement work in an organisation. It can be developed by the Trust's executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation. |
| **Watch Metrics** | Measures that are monitored for adverse trends. |

# Board Committee Assurance Report

| | | |
|---|---|---|
| Committee | **Performance, Population & Place Committee** | |
| Meeting Date | 29th November 2023 | |
| Committee Chair | Bernie Morley, Non Executive Director | |
| Link to Strategic Objective | Pillar 3 : Joining up acute and community services in Swindon | |
| Link to Board Assurance Framework | BAF 3 : SR 5 – Performance and SR6 - Partnerships | |
| Improving Together Pillar Metrics | Emergency Attendance | Waiting List – over 65 week waiters |
| | No Criteria to Reside | Cancer Waiting Times |
| Improving Together Breakthrough Objective | Time in ED – Clinically Ready to Proceed | |

| Items received by the Committee | Level of Assurance | Board Action Required? Yes ✓ or No x |
|---|---|---|
| 1. Operational Highlights Report | See below | |
| 2. Integrated Performance Report | See below | |
| 3. Board Assurance Framework | Partial | |
| 4. Emergency Preparedness Resilience and Response Assurance Report | Substantial | |
| 5. Cancer Services Assurance Report | Limited | ✓ |
| 6. Emergency Access | Partial | ✓ |
| 7. Referral to treatment | Partial | |
| 8. Hospital at Home | Partial | |
| 9. Sunflower Closure | Substantial | |
| 10. Diagnostics Deep Dive (DM01) | Partial | |
| 11. Outpatients Performance Update | Partial | |
| 12. Partnership Report | Substantial | |

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|---|---|
| POINTS OF ESCALATION | • Cancer Services – 1 stabilising (long waiting patient numbers reducing), 2 deteriorating, the Committee received detail of mitigating actions which would support recovery including external support for Dermatology outsourcing and the review work internally for Urology and Lower GI pathways.<br>• Hospital at Home – improving position but behind target of 45. |
| KEY AREAS TO NOTE | • Hospital handover delays concerned the Committee, this follows recognition of our worsening position. Committee received details of mitigating actions and work with system partners on NCTR (which whilst positive this has remained static since April).<br>• Record / Knowledge library of good practice / lessons learnt.<br>• Progress on outpatients was noted including a reduction in DNA rates and clinic utilisation. Future direction for increased video consultation to be included in future reports. |
| BOARD ASSURANCE FRAMEWORK & RISKS | • For Quarter 3, Committee requested that SR5 and SR6 were reviewed jointly to ensure that full partnership effects are recorded. |
| CELEBRATING OUTSTANDING PRACTICE AND INNOVATION | • Sunflower closure was recognised as a positive service change, it was recommended that this was included in future changes to learn the lessons and develop best practice.<br>• EPPR received a substantial rating from the ICB this was an improvement on last year's partial rating. |
| REFERRALS TO OTHER BOARD COMMITTEES | • None. |

| **Key to lead committee assurance ratings**<br>Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know? | |
|---|---|
| SUBSTANTIAL | **Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas. |
| GOOD | **Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas. |
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# Board Committee Assurance Report

| Committee | **Quality & Safety Committee** |
|---|---|
| Meeting Date | 23.11.23 |
| Committee Chair | Claudia Paoloni, Non-Executive Director |
| Link to Strategic Objective | Pillar 1 : Outstanding Patient Care |
| Link to Board Assurance Framework | BAF 1 : SR 1 : Quality |
| Improving Together Pillar Metrics | Reducing Harms |
| | Friends & Family Test |
| Improving Together Breakthrough Objective | Pressure Harms |

| **Items received by the Committee** | **Level of Assurance** | **Board Action Required? Yes ✓ or No x** |
|---|---|---|
| 1. Board assurance Report BAF1 outstanding Patient care | **partial** | |
| 2. Pressure Harms (IPR breakthrough objective) | **partial** | x |
| 3. IP&C (IPR breakthrough objective) | **partial** | x |
| 4. Maternity | **good** | x |
| 5. Q2 2023/34 Maternity and Neonatal Quality and Safety Report | **good** | x |
| 6. CQC Section 29a Improvement Notice for Maternity Services at GWH | | |
| 7. Safe Allergy management Update | **good** | **x** |
| 8. Electronic Discharge Summaries update | **limited** | **x** |
| 9. Quality Account Progress Report | **good** | **x** |
| 10. Safe Staffing 6 month review for Nursing, Midwives and AHP | | |
| 11. Safe staffing Monthly report | **good** | **x** |

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|---|---|
| POINTS OF ESCALATION | |
| KEY AREAS TO NOTE | **BAF 1** Robust conversation around persistent metrics despite focussed work and clear understanding of issues, in addition, the deterioration in risk score since Q3 it was agreed that clearer anticipated time lines around actions required to ensure continued assurance that risks are being appropriately managed. |
| | **IPR** Gram negative infections continue to be above trajectory but the focussed water safety pseudomonas work has been showing impact and infection rates are now in line with planned trajectory |
| | **Pressure Harms** in total remain stubbornly high but Quality Account progress report clearly demonstrated excellent progress has been made over the past year around awareness and proactive responsiveness by matrons and teams. Earlier identification and action is reducing incidence high category harms |
| | **Serious Incidents** There has been an unusual uptick of 8 serious incidents which are currently being scrutinised incluiing a fall with harm. Introduction of PSIRF methodology for SI reporting is slightly delayed as try to ensure balance patient safety, coroner and CQC needs |
| | **Maternity PROMPT** obstetric medical training compliance rates have been negatively impacted by industrial action which is being targeted for improvement. |
| | **Saving Babies Lives** risk of non compliance with both the Maternity Incentive Scheme (CNST) year 5 and the three year Maternity and Neonatal Single Delivery Plan remains due to restricted ultrasound capacity |
| | **Maternity Improving Together for Triage** senior leadership continue to be actively engaged and are focussing on maternity triage within 15 mins and are working to an extensive improvement plan in place |
| | **CQC Improvement notice maternity** discussion around the report and subsequent representations from the Trust back to the CQC which demonstrate the marked mismatch between details and conclusions within the warning notice issued to the actual actions being undertaken by maternity services, whilst acknowledging some areas for improvement. |
| | **Electronic Discharge Summaries** delivery performance remains poor and with limited assurance of resolution, complicated by the hybrid use of paper and multiple electronic systems being used. Paperlite working group continue to work on an improvement plan |
| | **Safer Staffing** positive impact of safer staffing investment in relation to staffing establishment ratios and patient satisfaction. Good governance, improving sickness rates and staff retention rates reflect the extensive work and programmes achieved around this. Issues now arise however with establishment ratios vs acuity of patient needs which impacts staffing distributions and this is being considered for our future staffing level needs. |
| | **Winter Pressures** With the anticipated pressures throughout the winter months, Quality and safety committee will be monitoring the quality and safety impact of accessibility delays and flow issues encountered. |
| BOARD ASSURANCE FRAMEWORK & RISKS | BAF 1. Robust conversation around persistent metrics despite focussed work and clear understanding of issues, in addition, the deterioration in risk score since Q3 it was agreed that clearer anticipated timelines around actions required to ensure continued assurance that risks are being appropriately managed. |

| | |
|---|---|
| CELEBRATING OUTSTANDING PRACTICE AND INNOVATION | **Safe Allergy Management** Following a period of increasing allergy related incidents across the organisation and the combined efforts of senior leadership across a range of services with improvement action plan implementation, allergy related incidents have now dramatically reduced by 84% and the likelihood risk is now low. |
| REFERRALS TO OTHER BOARD COMMITTEES | |

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

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| Committee | **Finance, Infrastructure & Digital Committee** |
| Meeting Date | 27 November 2023 |
| Committee Chair | Faried Chopdat |
| Link to Strategic Objective | Pillar 4: Use of Resources |
| Link to Board Assurance Framework | BAF 4 S6 & S7 |
| Improving Together Pillar Metrics | GWH Control Total / I&E |
| | Sustainability / Carbon Footprint |
| Improving Together Breakthrough Objective | Productivity |

| Items received by the Committee | Level of Assurance | Board Action Required? Yes ✓ or No x |
|---|---|---|
| 1. BAF Strategic Risks | Substantial | x |
| 2. Finance (including the Way Forward Programme Board) Risk Register | Good | x |
| 3. BSW Financial Update | Noted | x |
| 4. Month 7 – Finance Position | Good | x |
| 5. Month 7 – Cash Update | Partial | x |
| 6. Efficiency Program | Partial | x |
| 7. 2024/25 Planning Update | Good | x |
| 8. Update of introduction of IFRS 16 and impact on PFI | Note | x |
| 9. ERIC data comparison | Note | x |
| 10. Update on Department of Health & Social Care PFI Best Practice Conditions Survey | Good | x |
| 11. Letter of Indemnity – Cardiac CT Capital Project | Approve | x |
| 12. Shared EPR Program Update | Limited | x |
| 13. IT Infrastructure Resilience Update | Good | x |
| 14. Financial Recovery Sub-Committee TOR | Approve | x |
| 15. Ratification of the Commercial Research Policy | Approve | x |
| 16. BAF Strategic Risks – Review of Emerging Risks | Note | x |

| | |
|---|---|
| POINTS OF ESCALATION | **BSW Financial Update** – An Extraordinary FIDC was held on 21 November to review the forecast financial position following several national announcements around the treatment of Industrial Action costs and Elective activity. The Trust faces several challenges in delivering its financial plans, and whilst the proposed actions present a constructive way forward, the pace of delivery of Elective activity is critical to gaining greater assurance. Key challenges relating to the plan include further reductions in projected efficiency delivery, unauthorised pay escalation due to winter pressures, capacity restrictions impacting the delivery of Elective work, Bed reconfiguration impact, and movement in Capital charges arising from over-delivery of the Capital plan. A verbal update was provided at the FIDC on 27 November, indicating further changes and savings may be required, and the Committee will monitor this closely. |
| | **Efficiency Programme** - In the month, £1.07m of savings have 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. The Committee was assured that other divisions are aligned with their strategy but must continue to focus on delivering their targets, minimising spending wherever possible, and ensuring controls are in place to restrict unnecessary spending, specifically around temporary staffing/recruitment. From a divisional perspective, the critical risk remains Medicine (agency savings), which accounts for the Trust's year-to-date variance to plan. Undelivered savings remain a significant risk to the Trust's inability to hit a breakeven position at year-end. The Committee is assured that enhanced governance through the Financial Recovery Board will monitor this progress to hold divisions and corporate functions accountable for their efficiency plans. |
| | **EPR Programme Update** – The FBC is in review with NHSE, and management is addressing clarification questions promptly. We were due to receive an update from NHSE on 6 December; however, this is rescheduled to 13 December. The Committee acknowledges the excellent progress the Programme has made to ensure an effective governance model to address the requirements of all three trusts. It has set up the program adequately to deploy EPR. Overall, the Committee is assured of the EPR programme; however, the Committee continues to reiterate the risk that the FBC is yet to be approved by NHSE and the funding received to proceed with the implementation. |
| KEY AREAS TO NOTE | **Month 7 Finance Position** – Whilst the Committee acknowledges that the finance risk remains high (red) and continues to escalate, we are assured of the management actions taken to stabilise the finance position with an ever-greater focus on the run rate and productivity gains. As at M7, the Trust is in a £4.9m deficit position, which represents a £4.7m adverse variance to the plan. The key drivers of the £4.7m adverse variance are industrial action direct costs (£1.9m), undelivered efficiency savings (£2.1m), a shortfall on ERF-related income (£2.9m), additional medical pay award costs (£0.5m) and temporary staffing pressures (£1.4m). Mitigating a proportion of these adverse variances is a non-recurrent benefit totalling £4.1m relating to prior year income. The focus is to finish the 23/24 financial year in a breakeven position. The previously expected most likely forecast was a c.£10.7m deficit to plan due to a shortfall in efficiency delivery and continued overspending on temporary staffing and industrial action. |
| | **Cash Update** - Trusts must maintain a detailed monthly cash flow for the current accounting year and a summary cash flow to support the future five-year plan. With changes in the funding regime and updates based on current expenditure levels, the current position indicates the Trust needs to take active measures or face cash issues in the new 2024-25 financial year. Due to the number of problems raised and assumptions made around the cash position, the Committee requested management to provide greater assurance around its management actions; hence, it has rated this as partial assurance. |
| BOARD ASSURANCE FRAMEWORK & RISKS | **Finance (incl. Way Forward Programme) Quarterly Risk Report**: The Committee noted that the risk management process and reporting are adequate and effective; however, it requested management to focus on ensuring that divisions capture the relevant finance risks appropriately and address them. **The BAF Strategic Risks** were reviewed, and the Committee gained substantial assurance around the process of identifying and reporting these risks. |

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| CELEBRATING OUTSTANDING PRACTICE AND INNOVATION | **Improved Governance** – A Financial Recovery Board has been established following the recognition to broaden the efficiency savings approach to a multi-year financial recovery plan, which addresses underlying deficit and run rate rather than efficiency schemes in isolation. The fortnightly Financial Recovery sub-committee will oversee these schemes and will report to TMC & FIDC monthly. Workstreams are executive sponsored with clear workstream leads and will incorporate or replace the current efficiency schemes to reduce duplication. |
| REFERRALS TO OTHER BOARD COMMITTEES | **None noted.** |

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

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|---|---|
| Committee | **Audit, Risk & Assurance Committee** |
| Meeting Date | 16 November 2023 |
| Committee Chair | Helen Spice, Non-Executive Director |

| Items received by the Committee | Level of Assurance | Board Action Required? Yes ✓ or No x |
|---|---|---|
| 1. Divisional Risk Review – Surgery, Women's & Children | Partial Assurance | |
| 2. Risk Register Report | Not rated | |
| 3. Data Security and Protection Toolkit | Noted | |
| 4. External Audit Progress Report | Noted | |
| 5. Internal Audit Progress Report and Action Tracking | Noted | |
| 6. Internal Audit – Risk Management Report | Good Assurance | |
| 7. Local Counter Fraud Progress Report | Noted | |
| 8. Local Counter Fraud – Mandate Fraud Review | Partial Assurance | |
| 9. Losses & Compensation Q2 2023/24 | Noted | |
| 10. Appointment of External Audit Services | Recommendation Approved to Council of Governors | |

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| POINTS OF ESCALATION | The Committee approved the recommendation to appoint Deloitte as our External Auditors for the coming five financial years onto the Council of Governors (contract three years plus two one-year extensions). |
| KEY AREAS TO NOTE | The KPMG Internal Audit team has now fully transitioned the work from the previous internal auditors. Although their work started late in the year they provided assurance that all reviews are now planned and will be completed by the end of the year in order for annual assurance to be provided.<br><br>The Local Counter Fraud team review on Mandate Fraud raised some concerns about underlying controls on information maintained on suppliers. The agreed actions will address these concerns and this needs to be monitored to enable the Committee to obtain a higher level of assurance. |
| BOARD ASSURANCE FRAMEWORK & RISKS | |
| CELEBRATING OUTSTANDING PRACTICE AND INNOVATION | The Committee recognised the progress made by the Surgery, Women's and Children's team on managing their risks and the ongoing actions that are taking place. |
| REFERRALS TO OTHER BOARD COMMITTEES | Risks identified by Surgery, Women's and Children's Division – assurance to be obtained that risks referred to FIDC are being appropriately monitored by FIDC and risks on Theatres and legionella appropriately referred to Quality and Safety.<br><br>Cyber Security Annual Report – a number of actions came out of the review of this report in September 2023 that have also been raised in FIDC and it was agreed to co-ordinate the approach for resolution with FIDC. |

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

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|---|---|
| Committee | **Charitable Funds Committee** |
| Meeting Date | 8th November 2023 |
| Committee Chair | Paul Lewis, Non-Executive Director |

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

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|---|---|
| POINTS OF ESCALATION | • None |
| KEY AREAS TO NOTE | • The General Fund currently stands at £43,730 which is below the agreed minimum threshold of £57k. This has restricted the Committee from approving and releasing funds immediately for the latest cases of need requests.<br>• The proposal for Staff Recognition Awards was delayed again and will be presented at the February Meeting. The Committee expressed the importance of this being presented at the next meeting in February 2023 so there is clarity and agreement about how some elements of staff recognition may be funded by Charitable Funds in the future (subject to meeting Charity Commission Guidelines).<br>• The Committee received an update for the benefits realisation from the Research & Innovation Team which was well received. The report covered how Charitable Funds have been used in an effective way to cover the cost of a subject matter expert (on a short-term basis) to establish best practice for identifying, scrutinising and approving research proposals that will maximise the likelihood of impact and benefits. A new, transparent and fair process has now been implemented, initial applications have been reviewed (with 2 out of the 8 proposals being approved) which will have financial management support from Finance partners and progress will be closely monitored by the Committee going forward. |
| BOARD ASSURANCE FRAMEWORK & RISKS | • Fundraising – the continued risks and uncertainty with cost-of-living implications are still having an impact. The Committee received the Charity Giving trends Report which provided further insight and detail about the external environment and challenges. The Fundraising events and plans are very encouraging and give reason for more optimism over the coming months.<br>• Financial Reporting – the Statements of Financial Activities, Fund Balances & Commitments, Expenditure over £2k and Changes to Authorised Signatories & Fund Managers were reviewed with no concerns or issues being identified.<br>• Cases of Need – the new process and documentation is now clearly understood and is being followed in an effective way. As stated above, the General Fund Balance is currently below the agreed threshold which has restricted the release of funds at this time to support case of need requests.<br>• Charitable Funds – the new process and approach for Divisions and Fund Managers is working well with a significant increase in funding opportunities being identified and supported. The update from the Surgery, Women & Children's' Spending Plan was well received and provided a high level of assurance.<br>• External review Action Plan – good progress is being made with the implementation of the action plan and no actions are overdue at this time, however there are some significant actions still to be completed and so the Committee noted the potential risks associated with this. |
| CELEBRATING OUTSTANDING PRACTICE AND INNOVATION | • It was noted that significant progress has been made in recent months with improving the governance, structure and processes for Charitable Funds and Cat Weaver and the Finance Team were recognised and acknowledged for the contributions they have made, particularly with Cases of Need, Divisional Spending Plans, agreement of a Minimum Threshold for the General Fund, an initial proposal for the Investment Strategy, Research & Innovation benefit realisation and the production of the Charitable Funds Policy 2023. |

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| REFERRALS TO OTHER BOARD COMMITTEES | • The Committee received the draft Investment Strategy Proposal and requested the addition of Fund Management Fees to be added to the formal proposal which will be presented to the Committee in February 2024. The strategy will then be presented to the Finance Committee and to the Board for approval.<br>• The Committee received a verbal update about the Rationalisation of Funds. A formal proposal will be presented at the next meeting, which will then require referral to the Board for approval.<br>• The Annual Accounts & Trustee Report was approved by the Committee, which will be referred to the Board for sign-off. |

| **Key to lead committee assurance ratings**<br>Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know? | |
|---|---|
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|---|---|---|---|---|---|
| **Report Title** | **Emergency Preparedness, Resilience and Response (EPRR) Update** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **7th December 2023** | Part 1 (Public) | x | Part 2 (Private)] | |
| **Accountable Lead** | Felicity Taylor-Drewe, Chief Operating Officer | | | | |
| **Report Author** | Sarah Orr, Head of Emergency Planning | | | | |
| **Appendices** | EPRR Annual Report | | | | |

**Purpose**

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

**Assurance Level**

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

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

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

**Report**

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

## EPRR Core Standards Assurance

The confirm and challenge process with the ICB to review the trust against the EPRR Core Standards is now complete. It does still need to be ratified in the system report to NHSE, but from the confirm and challenge, the trust has been assessed as fully compliant. This is the first time that EPRR has received this rating, but there is always areas to improve and exceed the minimum standard.

### Last year's areas for improvement:

**CBRN Training** – fully compliant
**Fire** – delivered against improved plans and training.
**Lockdown** – improved plans and process to speed up lockdown.

**Achievements:**

- Comprehensive training needs analysis and training packages to support
- Development of separate EPRR and Business Continuity Policies
- EPRR Steering Group agenda refocused around EPRR Core Standards and Domains
- Significant examples of collaborative working with a key engagement at RIAT, supporting Prospect Hospice with business continuity planning and working with Dorset and Wiltshire Fire and Swindon Borough Council for shelter and evacuation planning.

**Key focuses for next year:**

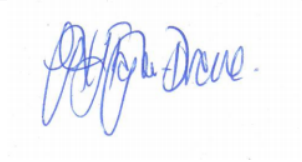
- Fully adopting the new business impact analysis process across the organisation
- Delivering against the training needs analysis so that staff at all levels of response have had training in incident response.
- Plan and deliver a mass casualty exercise in 2024.

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

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

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

**The Board are requested to note the annual report.**

| | |
|---|---|
| **Accountable Lead Signature** |  F Taylor-Drewe |
| **Date** | 20/11/23 |

Bath and North East Somerset,
Swindon and Wiltshire Together

# Emergency Preparedness, Resilience & Response – Assurance Report 2023

## Prepared for BSW ICB
## By: Great Western Hospital NHS Foundation Trust (GWH)
## Dated: September 2023

## Written by: Sarah Orr
## Role: Head of EPRR
## Date: September 2023

## Approved By AEO: Felicity Taylor-Drewe
## Date: 18/09/2023

# Table of Contents

## 1. Executive Summary

The following paper outlines the continued progress of the EPRR agenda at September 2023 and provides detail as to how we have continued to progress and maintain standards whilst embedding learning from our incident response.

## 2. Background Assurance Process

The table below details the assurance compliance for Great Western Hospital NHS Foundation Trust (GWH) since 2020 to date.

| Organisation | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Great Western NHS Foundation Trust | Substantial | Substantial | Substantial | Full |

## 3. EPRR 2022/23

Since the EPRR assurance process in August 2022 there have been further developments and key changes at Great Western Hospital NHS Foundation Trust the detail of which can be seen below:

### 3.1 Staffing

- Felicity Taylor-Drewe - Chief Operating Officer & Accountable Emergency Officer
- Al Sheward – Deputy Chief Operating Officer
- Sarah Orr – Head of EPRR
- Phil Ralls – EPRR Manager
- Michelle Maddison – EPRR Support Officer

### 3.2 General

- Development of separate EPRR and Business Continuity Policies
- EPRR Steering Group agenda refocused around EPRR Core Standards and Domains
- Significant examples of collaborative working with a key engagement at RIAT, supporting Prospect Hospice with business continuity planning and working with Dorset and Wiltshire Fire and Swindon Borough Council for shelter and evacuation planning.
- Key focus areas for next year:
    - Fully adopting the new business impact analysis process across the organisation
    - Delivering against the training needs analysis so that staff at all levels of response have had training in incident response.
    - Plan and deliver a mass casualty exercise in 2024.

### 3.3 Training September 2022 – present

| Training Title | Training Provider | Date & Timings | Participants |
|---|---|---|---|
| Bucket decontamination training | GWH | 25/01/2023 | 25 |
| CBRN Train the Trainer | SWAST | 03/02/2023 | 8 |
| Multi Agency Operational Training (MAOT) | W&S LRF | 20/04/2023 | GWH (1) |
| Mass Casualty Major Incident Training for ED/UTC | GWH | 04/04/2023 | 15 |
| Mass Casualty Major Incident Training for ED/UTC | GWH | 03/05/2023 | 17 |
| Bucket decontamination training | GWH | 28/06/2023 | 14 |
| HAZMAT suit Training | GWH | 28/06/2023 | 14 |
| CBRN Tent Training | GWH | 28/06/2023 | 23 |
| Mass Casualty Major Incident Training for ED/UTC | GWH | 06/07/2023 | 15 |
| Mass Casualty Major Incident Training for ED/UTC | GWH | 07/09/2023 | Session cancelled |

### 3.4 Exercising September 2022 – present

| Name of Exercise | Type of Exercise | Date & Timings | Exercise Lead | Participants |
|---|---|---|---|---|
| Exercise Mustang | Mass casualty TBX | 04/10/2022 | BSW ICB | GWH x3 |
| Exercise Artic Willow | National Exercise | 15 - 17th November 2022 | BSW ICB | GWH x7 |
| Exercise Bounty Oak | Protracted Power Outage Tabletop | 02/02/2023 Face to Face & Virtual 10.00 – 15.00 | BSW ICB – Louise Cadle<br>W&S LRF – Camella Town | GWH |
| SWASFT/NHSE Mass Casualty Exercise of the Casualty Distribution Model | Mass Casualty Distribution | 09/03/2023 Via Microsoft teams 10.00 – 14.00 | NHSE – Douglas Lisle<br>SWAST - | GWH |
| Exercise Mighty Oak | National Power Outage (NPO) | 28/03/2023 – 03/03/2023 full day | W&S LRF as part of National Exercise | GWH |

| | | | | |
|---|---|---|---|---|
| W&S LRF | Walk through of communicable disease plan | 07/03/2023 | W&S LRF (Lite) Hybrid | GWH |
| W&S LRF | CBRNe agency capabilities | 02/05/2023 | W&S LRF (Lite) Hybrid | GWH |
| CBRN Exercise | Live ex | 15/05/23 | Sarah Orr | |

### 3.5 Training Scheduled

| Training Title | Training Provider | Date & Timings | Participants |
|---|---|---|---|
| Mass Casualty Major Incident Training for ED/UTC | GWH | 01/11/2023 | 11 staff booked to date |
| CBRN Tent Training | GWH | TBC – awaiting replacement ground sheet | |
| Fire training | GWH | Quarter 4 | TBC |

### 3.6 Exercising Scheduled

| Name of Exercise | Type of Exercise | Date & Timings | Exercise Lead | Participants |
|---|---|---|---|---|
| Exercise Inundation | Evacuation/Flooding | 04/10/2023 | LRF Led - Evacuation | |
| EPMA Exercise | | 11/10/2023 | Sarah Orr & Paul Devenish | |
| Baby abduction exercise | Live exercise | Nov 2023 | Led by H&S with support from Phil Ralls | |
| Comms Exercise | Communication | 08/11/2023 | Phil Ralls | |
| 6 monthly full alert cascade test | GWH | 31/12/2023 | Sarah Orr | |
| Fire Evacuation Exercise | Evacuation with DWF | 01/03/24 | Sarah Orr & Nick Harvey | |
| CBRN Exercise | Live ex | 19/06/23 | Sarah Orr | |
| 6 monthly full alert cascade test | GWH | 02/07/2024 | Sarah Orr | |

| | | | | |
|---|---|---|---|---|
| TBC | CBRN Exercise | 2024 TBC | | |
| CCU Evacuation Exercise | Evacuation | Tbc | Phil Ralls | |

## 4. COVID-19 Response updates

Level 3 incident response to COVID-19 stood down by NHSE on 18th May 2023

## 5. Incident Responses

### 5.1 Critical Incident Responses from September 2022 to date

| Date of Incident | Type of Incident | Impacting | Incident Declaration | Key Learning |
|---|---|---|---|---|
| 03/01/2023 – 05.01/2023 | Pressures of the long weekend post-Christmas compounded by IPC issues | Trust wide | Critical Incident | • Changes to OPEL action cards |
| 13/01/2023 | Ambulance Handover Delays - Exceeding ICS Trajectory (UEC Performance Trigger) | Flow / Capacity | Critical Incident | • Changes to OPEL action cards |
| 12/06/2023 | Operational Pressures (incl. surge activation) | Trust wide | Critical Incident | • Changes to Escalation Policy |
| 22/06/2023 | UEC Daily Performance Trigger | Trust wide | Critical Incident | • Changes to Escalation Policy |

### 5.1 Major Incident Responses / Business Continuity Incidents from September 2022 to date

| Date of Incident | Type of Incident | Impacting | Incident Declaration | Key Learning |
|---|---|---|---|---|
| 14/06/2023 | GWH current operating status is Opel 3 however are faced with additional pressures of the scheduled 72- | Trust-wide | Business Continuity | • Learning incorporated into future strike planning sessions. |

| | | | | |
|---|---|---|---|---|
| | hour Junior Doctors (BMA) Industrial Strike Action | | | |
| 23/06/2023 | Power Outage | Trust wide | Business Continuity | • More robust process needed for updates from utility provider; single point of contact number failed.<br>• Support from ICB / system on wider implications due to power loss across the Swindon area<br>• Further training needed re EPMA downtime response process – ex planned in Oct 23.<br>• Training needed for wider teams regarding briefing tools as messaging was not always clear. |
| 13/07/2023 | Junior Doctors on Strike for 5 days, followed by a 2-day strike for consultants. | Trust-wide | Business Continuity | • Lessons learned into future strike actions |
| 20/07/2023 | Consultants strikes 20th and 21st July | Trust-wide | Business Continuity | • More robust process around Dr handover created |
| 25/07/2023 | Radiographer strikes 25-27th July | Trust-wide | Business Continuity | • Greater support required for sole radiographer and clearer comms to medics as demands for non-urgent scans was still high |
| 11/08/2023 | Junior Dr Strikes 11-14th Aug. | Trust-wide | Business Continuity | • Lessons learned record in future strike action reports |
| 24/08/2023 | Opel 3 however, are faced with additional pressures of the scheduled 48-hour Consultants Strike | Trust-wide | Business Continuity | |

**5.2 Incidents not declared and managed internally without declaration.**

| Date of Incident | Type of Incident | Impacting | Incident Declaration | Key Learning |
|---|---|---|---|---|
| 08/09/2022 | Instigation of Operation London Bridge | Trust-wide | No declaration | • Awaiting updates to national protocol for Op. Bridge declarations |
| 11/01/2023 | Industrial Action Response | SWAST (GMB) impacting GWH | No declaration | • National Situational reporting – SWAST only |
| 18/01/2023 – 19/01/2023 | Industrial Action Response | RCN IA | No declaration | • Derogations in place<br>• Additional system calls established.<br>• National Situational reporting |
| 23/01/2023 | Industrial Action Response | SWAST IA – impacting GWH | No declaration | • National Situational reporting – SWAST only |
| 06/02/2023 – 07/02/2023 | Industrial Action Response | RCN IA & SWAST IA (GMB & UNITE) | No declaration | • Derogations in place<br>• Additional system calls established.<br>• National Situational reporting |
| 20/02/2023 | Industrial Action Response | SWAST (GMB) impacting GWH | No declaration | • National Situational reporting – SWAST only |
| 13/03/2023 – 15/03/2023 | Industrial Action Response | BMA IA | No declaration | • National Situational reporting |
| 11/04/2023 – 15/04/2023 | Industrial Action Response | BMA IA | No declaration | • National Situational reporting |

**5.4 Debriefs from September 2022 to date.**

| Date of debrief | Date of Incident | Type of incident | Partners attended | Key Learning |
|---|---|---|---|---|
| 27/06/23 | 23/06/23 | Power Outage & IT Outage | Trust partners, ICB and SWAST | • More robust process needed for updates from utility provider; single point of contact number failed<br>• Further training needed re EPMA downtime response process – ex planned in Oct 23.<br>• Training needed for wider teams regarding briefing tools as messaging was not always clear |

| | | | | |
|---|---|---|---|---|
| 19/06/23 | Response Plan for SWAST Mass Casualty Ex Debrief | Ex- March 2023 | Response to debrief completed by Sarah Orr | Review of hospital process to clear ambulances and ED needed. More robust rapid discharge plan needed. |
| 10/05/2023 | Exercise Mighty Oak – Health Debrief | Exercise – March 2023 | Debrief led by NHSE Douglas Lisle | Report cascaded via LHRP |
| 12/05/2023 | Exercise Mighty Oak – Multi-agency debrief | Exercise – March 2023 | | Report cascaded via LHRP |

## 6. Developments to consider for 2023/24

- Continued development of full lockdown procedures to ensure a rapid response.
- Live Fire Exercise to test new processes in place.

## 7. Recommendations

Our self -assessment for 2023/24 continues to build on our EPRR Foundations and we continue to manage a our workplan to continue to develop the foundations and build on best practice, we believe we can demonstrate our compliance status is improving and recommend we are fully compliant with the conversations which have taken place to date with the ICB. We always strive for a best practice approach and plan to enhance the plans that we have improved this year, including lockdown and shelter and evacuation.

| | | | | | |
|---|---|---|---|---|---|
| **Report Title** | **Amendments to the Standing Financial Instructions (SFIs) Financial Limits** | | | | |
| **Meeting** | **Trust Board** | | | | |
| **Date** | **7 December 2023** | Part 1 (Public) | X | Part 2 (Private)] | |
| **Accountable Lead** | Simon Wade, Chief Financial Officer | | | | |
| **Report Author** | Caroline Coles, Company Secretary | | | | |
| **Appendices** | n/a | | | | |

**Purpose**

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

**Assurance Level**

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

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

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

**Report**

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

The purpose of this paper is to detail the proposed amendments to the Standing Financial instructions (SFI) financial limits as follows:-

| Authority | Current Limit | Proposed Limit |
|---|---|---|
| Charitable Funds Committee | £5k | Over £25k |
| *Due to timing issues, if it is not practical to defer a decision until the next meeting of the Charitable Funds Committee, approval can be given by one of the authorised signatories and then reported retrospectively to the Charitable Funds Committee.* | | |
| Deputy Chief Financial Officer | £5k | £5k |
| Chief Financial Officer | - | £5k - £10k |
| Chief Financial Officer & Chief Executive Officer | - | £10k - £25k |
| Trust Board | £500k+ | £500k+ |

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

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

**Recommendation / Action Required**

The Board/Committee/Group is requested to:

**The Board is requested to approve the amendments to the Standing Financial Instructions (SFIs) financial limits.**

| | |
|---|---|
| **Accountable Lead Signature** | Simon Wade, Chief Financial Officer |
| **Date** | 29 November 2023 |