Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 5 September 2024, 9.30am to 1.00pm
By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Jude Gray	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 22 July 2024 (draft) • 1 August 2024 (draft)	 7 – 9 10 – 19	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	20 – 21	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Improving Together Staff Stories (plus film)** Emily Beardshall, Deputy Director – Improvement & Partnership Hannah Langford-Wood, Paediatric Consultant with special interest in Neonatology Shelly Knight, Student Placement Manager	22 – 29	EB/ HLW/ SK	Note	9.35
7.	**Chair's Report** Liam Coleman, Chair	30 – 34	LC	Note	10.05
8.	**Chief Executive's Report** Jon Westbrook, Acting Chief Executive	35 – 40	JW	Note	10.15
9.	**Integrated Performance Report** • Integrated Performance Report – Breakthrough Objective and Pillar Metric deep dive	41 – 92	LC/ Executive Directors	Assurance	10.35
BREAK (10 minutes) at 11.20 to 11.30am					
	• Performance, Population & Place Committee Board Assurance Report (August) – Bernie Morley, Non-Executive Director & Committee Chair	93 – 94	BM	Assurance	11.30

		PAGES	BY	ACTION	TIME
	• Quality & Safety Committee Board Assurance Report (August) – Claudia Paoloni, Non-Executive Director & Deputy Committee Chair	95 – 97	CP	Assurance	
	• People & Culture Committee Board Assurance Report (August) – Julian Duxfield, Non-Executive Director & Committee Chair	98 – 99	JD	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (August) – Faried Chopdat, Non-Executive Director & Committee Chair	100 – 101	FC	Assurance	
10.	**Mental Health Governance Committee Board Assurance Report (July)** Lizzie Abderrahim, Non-Executive Director & Committee Chair	102 – 103	EKA	Assurance	12.00
11.	**Charitable Funds Committee Board Assurance Report (August)** Julian Duxfield, Non-Executive Director & Committee Chair	104 – 105	JD	Assurance	12.10
12.	**Inclusion & Health Inequalities Annual Report 2023/24** (including Workforce Disability Equality Standard, Workforce Race Equality Standard and Gender Pay Gap reporting) Claire Warner, Deputy Chief People Officer Sharon Woma, Lead for Equality, Diversity & Inclusion	106 – 170	CW/SW	Approve	12.20
	CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**				
13.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	-	CC	Approve	12.50
14.	**Annual Review of Scheme of Delegation (including Powers Reserved to the Board)** Caroline Coles, Company Secretary	171 – 203	CC	Approve	-
15.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
16.	**Date and Time of next meeting** Thursday 7 November 2024 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
17.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	13.00

Great Western Hospitals NHS Foundation Trust

Board Meeting Timetable

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

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC
VIA MS TEAMS
22 JULY 2024 AT 2.30PM

Present:

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

In attendance:

Caroline Coles (CC)	Company Secretary
Tim Edmonds (TE)	Associate Director of Communications & Engagement
Claire Lehman (CL)	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Claire Warner (CW)	Deputy Chief People Officer

Apologies

Julian Duxfield (JD)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Bernie Morley (BM)	Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director

Number of members of the Public: There were 3 members of public (Chris Callow, Lead Governor and Chris Shepherd and Pauline Cooke, Governors)

Matters Open to the Public and Press

Minute	Description	Action
069/24	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
070/24	**Declarations of Interest** There were no declarations of interest.	
071/24	**Development of a group model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust** The Board received and considered a paper which outlined the development of a group model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust, the case for collaboration and the draft Joint Committee Terms of Reference. Jon Westbrook, Acting Chief Executive outlined the proposal which would offer significant opportunities to improve the health of the wider population, but to also meet the particular	

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Minute	Description	Action

performance and financial challenges, building on the achievements already made through the Acute Hospital Alliance (AHA). The AHA in collaboration with the ICS and the wider region had commissioned a review of the case for collaboration which had made a strong case for more effective joint working between the three organisations and transformational delivery, supported by the Improving Together programme, which was used across all three organisations to deliver sustainable and excellent care. It was noted that the work around equality impact assessments continued and confirmation would be provided to the Board when this had been completed.
Action: Acting Chief Executive

The proposed new leadership group model outlined eight recommendations for Board approval. It was emphasised that this was not a formal merger or legal change and all three sovereign boards would continue to exist, but it created a clear roadmap to develop a joint model.

Liam Coleman, Chair also provided assurance that the collective proposal across the three trusts was supported by the ICS, ICB and NHSE regional leadership team.

Claire Thompson, Chief Officer of Improvement & Partnerships commented that the draft Joint Committee terms of reference still required some additional work in relation to expectations around role modelling, collaboration, acting in a unitary fashion in service of the wider population, and taking a population based approach. Will Smart, Non-Executive Director added that the membership of the Joint Committee was executive led and there should be greater non-executive director presence. Board members were encouraged to provide any further comments on the terms of reference and that a further draft would be recirculated for Board approval in due course.

Liam Coleman, Chair highlighted that the Trust's Governors had been involved in discussions to date and would come together over the next coming months to scope the role of the shared chair.

In relation to the recommendations the following was noted:-

- Recommendation 5 & 8 - the wording should change from non-executive directors to board.
- Recommendation 8 - the Board recognised that Organisational Development support needed to facilitate the collective recommendations of the process would require resourcing.

RESOLUTION

The Board approved the following:-

- **Recommendation 1 : Shared leadership.** To identify a Joint Chief Executive and Joint Chair but retaining its own board and sovereignty with each site having a Deputy Chief Executive to support the single CEO.
- **Recommendation 2 : Memorandum of Understanding (MOU).** To develop a MOU for how the Chairs will support the Joint Chief Executive during the transition to a Joint Chair.
- **Recommendation 3 : Joint Committee.** To create a Joint Committee, with terms of reference to be agreed at a later Board meeting.
- **Recommendation 4 : Priorities for 2024-25**. To identify priorities for 2024-25 which would include EPR Implementation, BSW Communities Together, stabilisation of the services and financial position.
- **Recommendation 5 : Group Operating Model.** To develop a Group Operating Model for approval by boards and mobilise in 2025/26, supported by a Group

Minute	Description	Action

Development Team, local leaders, boards *(note change of wording from non-executive directors)* and governors.

- **Recommendation 6 : Strategic Planning Framework**. To create a Strategic Planning Framework, using Improving Together approach.
- **Recommendation 7 : BSW Integrated Care Partnership Strategy**. To deliver, working with our partners in health, local government, and the voluntary sector the BSW Integrated Care Partnership Strategy.
- **Recommendation 8 : Organisational Development.** Organisational Development support for coming years will be secured to support leaders, teams, board *(note change of wording from non-executive directors)*, and governors to help shape the future together.

072/24 **Urgent Public Business (if any)**
None.

073/24 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 1 August 2024 at the DoubleTree by Hilton Hotel, Swindon.

The meeting finished at 1452hrs

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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 1 AUGUST 2024 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)*	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)*	Non-Executive Director
Julian Duxfield (JD)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Bernie Morley (BM)	Non-Executive Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Acting Chief Executive

In attendance:

Emily Beardshall (EB)	Deputy Director – Improvement & Partnership (deputising for Claire Thompson)
Jon Burwell (JB)	Acting Chief Digital Officer
Caroline Coles (CC)	Company Secretary
Claire Lehman (CL)	Associate Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Tania Currie	Head of Patient Experience & Engagement (agenda item 079/24)
Kat Simpson	Head of Midwifery & Neonatal Services (agenda item 079/24)
Helen Casey	Ward Manager, Neonatal Unit (agenda item 079/24)

Apologies

Claudia Paoloni (CP)	Non-Executive Director
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships

*Indicates those members attending virtually by MS Teams

Number of members of the Public: There were 3 members of public (Pauline Cooke, Governor, Chris Shepherd, Governor and Deborah Pook, COO candidate)

Matters Open to the Public and Press

Minute	Description	Action
074/24	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
075/24	**Declarations of Interest** There were no declarations of interest.	
076/24	**Minutes of the previous meeting (public)** The minutes of the Board meeting held in public on 6 June 2024 were adopted and agreed as a correct record, subject to the following amendment: Minute No. 041/23 – Integrated Performance Report – Our People	

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Minute	Description	Action
	Third paragraph, deletion of the second sentence *"Fairness was now being reported and the number of Trust-wide projects to support improvement were noted."* Minute No. 041/23 – Our Care – Quality & Safety Committee Chair Overview First bullet point to be amended to read *"Reducing falls with harm had been chosen as the breakthrough objective…"*	
077/24	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list.	
078/24	**Questions from the public to the Board relating to the work of the Trust** The Board was verbally informed of a question asked by Pauline Cooke, Governor on the EPR system and a BBC article on 'NHS computer issues linked to patient harm' and if the Governors could be assured that the issues raised in the article were being considered and that there would be sufficient testing prior to launch to minimise risk to patients. The Acting Chief Digital Officer gave a verbal response and the Board noted that the Trust was aware of the press report and had learnt from other systems and providers, and aware of the risks presented particularly by resource limitations and that actions were being taken to ensure risks were managed. A full response had been sent to Pauline prior to the meeting and a copy would be circulated to the Board members following the meeting. **Action: Company Secretary**	**CC**
079/24	**Care Reflection (Patient Story and film) – Positive reflection of care experience in Neonatal Unit** *Tania Currie, Head of Patient Experience & Engagement, Kat Simpson, Head of Midwifery & Neonatal Services, and Helen Casey, Ward Manager, Neonatal Unit joined the meeting to present this item* The Board received a story and film of a family's experience of their care journey received on the Neonatal Unit for complex clinical interventions following a premature birth. The function and ethos of the unit was explained and the importance of good engagement and involvement with families. Some areas had been identified where care could be further improved and Kat Simpson confirmed that the team was working proactively to drive improvement building on the patient experience feedback received, particularly in relation to access to the unit by both patient and visitors, and a space utilisation review to allow for a more private space to be made available. The Board thanked Kat and Helen for their presentation and also to the family for sharing their story. The Board **noted** the patient story.	
080/24	**Chair's Report** The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally. The following was highlighted: • A new Associate Young Person had joined the Council of Governors who will present the younger members of our community. • A new Wiltshire County Council governor representative had been appointed to the Council of Governors. • The Board Safety Visits particularly noting that all future visits would be announced, rather than unannounced, to allow for a more constructive visit.	

Minute	Description	Action

The Board **noted** the report.

081/24 **Chief Executive's Report**

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

Electrical outage

A major incident had been declared on 9 July 2024 following a power outage that had caused significant disruption. Plans were now in place to install a fifth generator to the hospital site for even further resilience. A full debrief on the response to the incident was to be undertaken along with future preventative measures. Jon Westbrook, Chief Executive recorded his formal thanks to the staff who had worked extremely hard to respond to the incident and deliver patient care in very challenging circumstances.

Industrial action

General Practitioners were currently being balloted by the BMA regarding potential collective action. This would potentially be very disruptive and NHSE had written to all ICBs to prepare contingency plans in the event of any announced action.

Improving Together

The Trust's Improving Together way of working had been shortlisted in the Quality Improvement Initiative of the Year category of the Health Service Journal Patient Safety Awards 2024, which was to take place on 16 September.

The two-year anniversary of the launch of the Improving Together approach within the Trust had just been marked and an increase in quality improvement work could be evidenced. Work was now underway to focus on sustainability and to develop Improving Together within the wider system.

Cardiology

The GWH Cardiology Team had been rated as the best team in the UK for teaching by specialist registrars in district and general hospitals. This recognition was the outcome from a survey undertaken by the British Junior Cardiovascular Society which sought the view of trainees across the country.

Freedom to Speak Up (FTSU)

Three new Freedom to Speak Up Guardians have been appointed to join the existing team of Guardians. Mandatory training had also been introduced to support FTSU.

Integrated Front Door development

The construction of the Integrated Front Door was now nearing completion and a ribbon cutting event took place last month to celebrate the progress made with local stakeholders attending alongside current and former staff who had worked on the project. It was reported that the move into the new Emergency Department had been delayed due to an identification that there was a mismatch between the evacuation spaces and the alarm system for Fire Protection in the unit. Work to rectify the situation had been undertaken and a revised date would be set following the completion of this work.

Financial situation

The system's financial situation remained challenging. The Trust was in a £4.9m deficit position in June, which was £2.1m worse than plan. This was a significant improvement since the Month 2 position due to the completion of work around coding and recording of activity which had resulted in a £1.8m improvement in the Trust's position. Further opportunities for improvement had been identified for future months, with divisions working hard on developing further cost improvement plans.

Shared Electronic Patient Record

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Minute	Description	Action

Work progressed on the introduction of a shared Electronic Patient Record with the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust to help standardise care and provide a better experience for both patients and staff. Recruitment was underway for the programme team to help deliver this significant piece of work.

An EPR Joint Committee had also been established to help drive the implementation and that a review of lessons learned from other organisations who had already implemented the system was also being undertaken.

Appointment of Chief Nurse
Luisa Goddard (one of the Deputy Chief Nurses) had been appointed as the Trust's next Chief Nurse. The recruitment process for the Deputy Chief Nurse position was now underway.

Great West Fest
The Great West Fest is due to take place on Saturday 14 September and all Board members were encouraged to attend.

Pride Month
Pride Month in June was marked with a range of events.

Big Green Week
Great Big Green Week was marked for the first time in June at the Trust. The national awareness week was the country's biggest celebration of community action to tackle climate change and protect nature and work underway by this Trust was shown to support the organisation's drive to be Net Zero Carbon by 2040.

BBC Make a Difference Awards
Two teams have been shortlisted in the BBC Make a Difference Awards, which celebrated local individuals and groups around Swindon and Wiltshire. The Trust's Sustainability Team are shortlisted in the 'Green Award' category and local voluntary group, Brighter Future Blanketeers, are in the 'Carer Award' category.

It was noted that the Slice for Life sessions which had been planned for July had been postponed due to low numbers of attendance. There followed a discussion on the approach to these meetings and how the Trust were going to build confidence and cultivate a better relationship with staff. Jude Gray, Chief People Officer explained that there were plans in place to encourage a wider staff representation at future sessions.

The Board **noted** the report.

082/23 **Integrated Performance Report**

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

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

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

- DM01 remained on trajectory for June at 66.9% and was at the highest position since 2021.
- Good triage time and 4-hour performance at 75% was still achieved despite the pressure and increased attendances at ED.

Minute	Description	Action

- Briefing received in relation to the 2024/25 NHS Oversight Framework and the relevant committee mapping to the key performance indicators and learning gained from other trusts.
- Update received on community procurement ahead of bid submission on 25 July.
- The final BSW system plan for 2024/25 was received which contained stretch targets for performance, workforce and finance and the risk of under-delivery against this which was being actively mitigated against. This also included a comparison of previous years and other trusts.

In response to a question raised by Helen Spice, Non-Executive Director on the transfer of services to Medvivo and how the process was working, Felicity Taylor-Drewe, Chief Operating Officer responded that this would be followed up at Performance, Population & Place Committee as an agenda item.
Action: Chief Operating Officer

Liam Coleman, Chair asked when the next Single Oversight Framework (SOF) ratings were due. Felicity Taylor-Drewe, Chief Operating Officer confirmed that this would be in October 2024.

In response to an observation raised by Liam Coleman, Chair on equipment being stored in corridors, Simon Wade, Chief Financial Officer confirmed that a review of current storage options within GWH was underway to drive improvement, which also included the possible use of the expansion land. A 'Clean The Streets' Group had also been set up to help tidy up the corridors and explore other storage solutions.

The Board **noted** the report.

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

- Electronic Discharge Summaries remained an intractable issue and that the current position around the electronic delivery of discharge summaries had arisen due to a third-party dependency for integrative work. This had been escalated to Board for consideration.
- The Freedom To Speak Up Annual Report 2023/24 was received which demonstrated the improvements that had been made to this service. Four new guardians had been appointed across a range of backgrounds. The outcome of the external review by 'Clever Together' was still awaited and that this would receive a slot at the October 2024 Board Workshop.
- The Trust had now switched to the Patient Safety Incident Response Framework (PSIRF) for incident management and a report was received on the extensive work that had been undertaken for this conversion. QSC was assured by the approach taken to implement new processes.

The Board requested that a further review be undertaken to ensure that all options had been explored to expedite the work to improve EDS including escalation to the highest point.
Action: Chief Medical Officer and Chief Digital Officer **SH & JB**

The Board **noted** the report.

Use of Resources
Finance, Infrastructure & Digital Committee Chair Overview

Minute	Description	Action

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

- A revised national financial funding regime had been introduced in early June to address some gaps in the revenue plans submitted by providers and ICBs as part of the 2024/25 planning round. The updated regime aimed to address those trusts and systems that were a significant distance away from the target 'fair share' allocation and provide transitional revenue funding support to address the financial gap within critical financial framework principles.
- The Trust's financial position and the broader BSW system remained a challenge in 2024/25. The system had received a letter from NHSE which raised concern on the delivery of its financial recovery plan and requested assurance to achieve the key milestones based on the plan. There was a requirement for more mature governance processes, greater transparency and consistent criteria and measures at system level to gain greater assurance and better viewing comparable data points. However, FIDC was assured that regular meetings were taking place at system level to address this.
- The efficiency target for 2024/25 was £21.9m. As of Month 3, the actual delivery was £2.5m which was £1.5m under the plan. It was noted that 47% of the £2.5m delivered was recurrent. All divisions and services would be expected to increase overall savings to hit the £21.9m target and ensure that savings were recurrent to reduce the underlying deficit. The actions and tighter controls to deliver future savings was noted.
- Divisional updates were received on the risks to the ERF position, including CIP delivery and mitigation plans to address this. FIDC were assured that systems were in place (corporate and divisionally) that provided a range of governance functions and identified and mitigated any gaps in controls.
- An update on Data Protection, IT Resilience and Cyber Security was received which summarised key activities and controls the Trust had in place. Cyber security remained a key priority for the Trust with investment in a range of controls and risk mitigations, together with business continuity planning around incident management response.
- Risk management processes around Estates & Facilities, Digital and IT were received and FIDC was assured that risks were identified and mitigation actions were in place.
- The Health & Safety Annual Report was received and approved by FIDC which provided an overview of events and performance of the Health & Safety, Fire and Security disciplines.

Simon Wade, Chief Financial Officer added that revised national productivity data had been published and that GWH had gone down from 17.7% to -10% and that this was a considerable move compared to other organisations in the system and in line with the national position.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

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

- A report summarising the staff survey improvement priorities identified across the corporate functions was received. Feedback was received from the finance function but due to the variation across different functions, a higher level of

Minute	Description	Action

assurance against the issues could not be provided. Focus by heads of the corporate functions was required on priorities to ensure that action plans to improve staff survey results and the experience for staff would be maintained.

- The annual flu report outlined the good progress made with staff flu and Covid vaccinations over the last year and that learning points would be incorporated into planning for this year. Risk remained around funding for Covid vaccines.
- Referral from QSC on the recruitment and retention challenge with respect to Allied Health Professional staff and concern was expressed that turnover may be driven up by work-related reasons. Good assurance around the action plan to address the issue was received and was to be re-presented to PCC in the Autumn to review longer term results before reporting back to QSC on findings.
- Early data from the Just and Learning process and culture showed that casework was being managed more appropriately using a more traditional framework. This would be reviewed further once more data was received.

Liam Coleman, Chair requested that the 15+ risk which related to ongoing industrial action should be revisited in view of the consequence of the primary care vote for industrial action and possible future action by other staff groups following the agreed pay deal for junior doctors.

The Board **noted** the report.

083/24 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meeting on 19 June 2024 and highlighted the following:

- The Annual Report and Accounts 2023/24 and letter of representation on behalf of the Board was approved. The audit process had significantly improved from the previous year. The considerable work undertaken by the Finance Team and Company Secretary was formally acknowledged by the Board.
- The KPMG Internal Audit Annual Report 2023/24 had rated The Head of Internal Audit opinion as one of 'significant assurance with minor improvement opportunities'. The full plan for the year was completed and as at year end no actions were overdue.
- Four final KPMG internal audit reports for 2023/24 were received in relation to are-review of Consultant Job Planning, Data Security and Protection Toolkit, follow up from the HFMA checklist review and Capital Planning. The Consultant Job Planning review had evidenced that considerable progress had been made since the review in the previous year. FIDC would be asked to consider the cultural and accountability aspects arising from the HFMA checklist review to ensure that it was embedded through the organisation from a finance perspective.

Caroline Coles, Company Secretary alerted the Board that the Annual Members' Meeting scheduled for 25 September 2024 may have to be moved if the Annual Report & Accounts could not be laid before Parliament due to the election process and timing of parliament recess.

The Board **noted** the report.

084/24 **Improving Together Year 2 Review**

The Board received a paper which outlined the progress with the Trust's 'Improving Together' approach, provided assurance that the resources were being deployed effectively and that there was a long-term sustainability plan in place.

The paper reviewed the benefits framework for the roll out of the Improving Together approach, with expected improvements in process measures, output measures and outcome measures. It was reported that this was based on the framework used for the year

Minute	Description	Action

1 review in June 2023. Progress across the Operational Management System (OMS) was detailed alongside assessment of the benefits seen, reflections and learning from year 2 of the implementation of Improving Together.

The Board noted that the Year 3 priorities were proposed to focus on sustainability, increase the patient/public voice, and design development for the future.

It was also noted that the model had also been adopted by both Royal United Hospitals Bath NHSFT and Salisbury NHSFT and that a single improvement methodology for the group model work. Collaborative working across all three trusts was embedded and an outline of an example of the deployment of transformation resources in relation to outpatient transformations was provided. This consistent approach would become more important as the group model develops.

Will Smart, Non-Executive Director raised a question around alignment to the national Impact Framework, and where the Trust was in terms of maturity within Improving Together. Emily Beardshall, Deputy Director – Improvement & Partnership agreed to share offline more of the work around the alignment between the NHS initiative and the maturity assessment and evaluation matrix to provide more background on this.

Will Smart, Non-Executive Director also reflected on the Operational Management System within the context of the strategy for a Group Model. Emily Beardshall, Deputy Director – Improvement & Partnership responded that the strategic planning framework and pillar metrics in the context of the group model would be part of the strategy refresh.

Emily Beardshall outlined the ongoing work to provide Improving Together training to all teams and the continued support for an improvement journey. Fast track training had evolved to reach those smaller teams and that at the end of Cohort 8 or 9, all significant frontline teams would have received training within the next 18 months. Networking was also available to all teams to provide further support and sharing. Improving Together had also been incorporated into the Trust Induction. It was noted that there had also been good engagement from senior clinical staff with the training and actions would be taken at the beginning of each cohort to ensure that there was good representation by the teams to ensure diversity and inclusivity. This data would be monitored.

Liam Coleman, Chair requested that further training on Improving Together and a better understanding of A3 methodology be provided to the Non-Executive Directors. It was noted that a further session had been arranged for the NEDs in November 2024.

The Board **noted** the report.

085/24 **Committee Effectiveness Review 2023/24 – Audit, Risk & Assurance Committee**

The Board received a paper to consider the annual review for the committee effectiveness for the Audit, Risk & Assurance Committee (ARAC), which included its terms of reference. The amendments to the terms of reference had been undertaken following a review of the new HFMA NHS Audit Committee Handbook published in March 2024. It was noted that:

- ARAC had undertaken an open discussion to consider its effectiveness, including terms of reference.
- There were no issues or concerns to draw to the attention of the Board.

A discussion also took place on the even number of Non-Executive Directors at the Board sub-committees and that the chair of the committee would have the casting vote in a split decision situation. It was agreed that this would be added to the terms of reference for all Board sub-committees.

RESOLVED

Minute	Description	Action

The Board:

(a) **approved** the Terms of Reference for the Audit, Risk & Assurance Committee; and,

(b) **agreed** that reference to the chair of the committee to have the casting vote in a split decision would be added to all Board committee terms of references.

086/24 **Fit & Proper Persons Regulation (FPPR) Annual Assurance Report 2023/24**

The Board received a report that provided assurance to the Board that all necessary individual annual checks had been completed in line with the new national Fit and Proper Person Test (FPPT) Framework guidance published by NHS England in September 2023 and that the evidence reviewed confirmed all serving members of the Board were fit and proper.

The Board **noted** the report.

Consent Items

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

087/24 **Ratification of Decisions made via Board Circular**

None.

088/24 **Responsible Officer Annual Report**

The Board received and noted the Responsible Officer Annual Report. This report had been reviewed in detail by the Quality & Safety Committee (QSC) at its meeting on 18 July 2024 and recommended approval by the Board for publication.

A discussion took place around the assurance level of 'good' and that QSC had agreed that the assurance given by the report was 'substantial', noting that processes around revalidation, appraisal and job planning were now more robust and improved with strengthened oversight for the organisation and support for doctors and could be evidenced by consistent appraisal compliance and much improved compliance of job plans. It was agreed that the assurance level from the report to the Board could be raised from 'good' to 'substantial' in the context of the confidence and assurance level that QSC had taken from the report as presented.

RESOLUTION

The Board **approved** the Responsible Officer Annual Report for publication.

089/24 **Use of Mental Health Act Annual Report 2023/24**

The Board received and noted a report which informed the Board on the use of the Mental Health Act (MHA, 1983) during April 2023 to March 2024 as a statutory requirement. This report had been approved and recommended by the Mental Health Governance Committee at its meeting on 19 July 2024.

The Board **noted** the report.

090/24 **Urgent Public Business (if any)**

None.

091/24 **Date and Time of next meeting**

DRAFT

Minute	Description	Action
	It was noted that the next meeting of the Board would be held on 5 September 2024 at the DoubleTree by Hilton Hotel, Swindon.	
092/24	**Exclusion of the Public and Press** The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.	

The meeting finished at 12:24hrs

DRAFT

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – September 2024				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
6 June 2024	043/24	**Charitable Funds Committee Board Assurance Report** Further assurance to be sought by the Charitable Funds Committee on the governance processes around the staff lottery to ensure that robust processes are in place.	Chief Officer of Improvement & Partnerships	Charitable Funds Committee received a report on the staff lottery arrangements and assured members that this had been established and was appropriately registered with the local authority. However, for trust governance purposes it does not form part of the charitable funds portfolio, over which different rules apply. The management oversight of the staff lottery therefore remains outstanding and is being resolved as a matter of urgency with the relevant directors. **August update:** Action to remain open until completed.
1 August 2024	078/24	**Questions from the public to the Board relating to the work of the Trust** A copy of the full reply on the EPR system and BBC article on computer issues linked to patient harm to be circulated to the Board members following the August Board meeting.	Company Secretary	Completed. **Closed**
1 August 2024	082/24	**Quality & Safety Committee Board Assurance Report – Electronic Discharge Summaries (EDS)** Further review to be undertaken to ensure that all options had been explored to expedite the work to improve EDS and that this be escalated to NHS England with full Board support to put further pressure on the third-party supplier.	Chief Medical Officer & Chief Digital Officer	Further escalation and discussion with the supplier to expedite activities has happened through August. Still awaiting a timeframe from System C as at 28 August 2024.

Future Actions				
None				

Report Title	**Improving Together Staff Stories**				
Meeting	**Trust Board**				
Date	**5th September 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Claire Thompson, Chief Officer for Improvement & Partnerships				
Report Author	Emily Beardshall, Deputy Director of Improvement & Partnership				
Appendices	Improving Together Staff Story Summaries				

Purpose

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

Assurance Level

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

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

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

Report

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

Two staff will attend Trust Board to share their reflections on being part of recent Improving Together training.

The staff members are

- Hannah Langford-Wood, Paediatric Consultant with special interest in Neonatology
- Shelly Knight, Student Placement Manager

The attached slides give a short overview of the Improving Together deployment and an overview of reflections from staff on recent Improving Together training. Hannah was part of the most recent cohort of teams to complete training (training and support was from February to June 2024). Shelly has recently been part of a team receiving Fast Track training in the Academy. Both teams continue to meet in Improvement Huddles.

We are keen to build on reflections of staff to improve and refine our approach, understanding how it feels for staff to implement Improving Together in different environments is important and supports us maximising sustainability and benefits whilst also

learning about the areas we need to adapt or increase support. Over time we aim for the staff stories to provide perspectives from a range of professions and roles.

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**
	Improving Together is a key part of mitigation to BAFSR1 – Outstanding Patient Care				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps					

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		x	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	x		
Explanation of above analysis: The focus of Improving Together pillar metric 8 provides some assurance on the promotion of EDI within the trust.			

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

The Board are asked to listen to the staff stories presented and reflect on our learning within the deployment of Improving Together.

Accountable Lead Signature	
Date	29/08/24

Great Western Hospitals
NHS Foundation Trust

Improving Together Staff Stories

Trust Board 5th September 2024

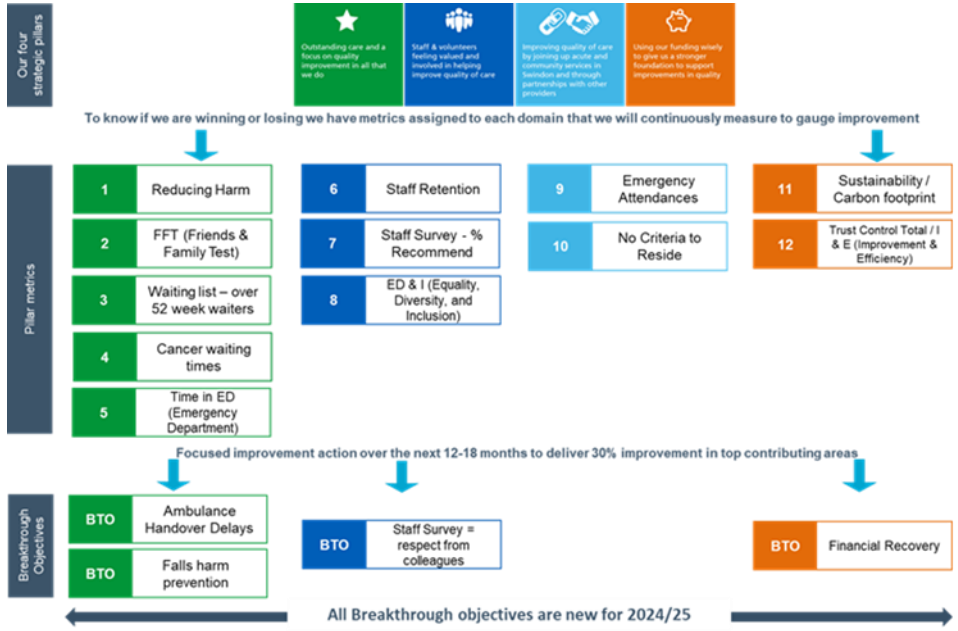
Improving together

What is Improving Together?

NHS
Great Western Hospitals
NHS Foundation Trust

Our Improvement Approach

- Improving Together is our Trust-wide approach to change, innovation and continuous improvement which introduces a consistent methodology across the organisation so that 'improving' becomes something we all do in the same way. It is a way of creating a culture of continuous improvement, developing and empowering our workforce so all staff feel able to contribute to making improvements as part of their day job, every day.
- Improving Together is how we go about delivering our vision and strategic pillars, becoming the 'golden thread' that runs through all that we do to make this a safer place to receive care and a better place to work.
- Improving Together is not only an improvement approach but provides a strategic framework and operational management system for the organisation that embeds improvement in everything we do, with a clear focus on supporting frontline teams to deliver improvements in their own areas of work.
- It fulfils all the 5 components of the recommendation of the *NHS delivery and continuous improvement review* (published April 2023).



Can you say….

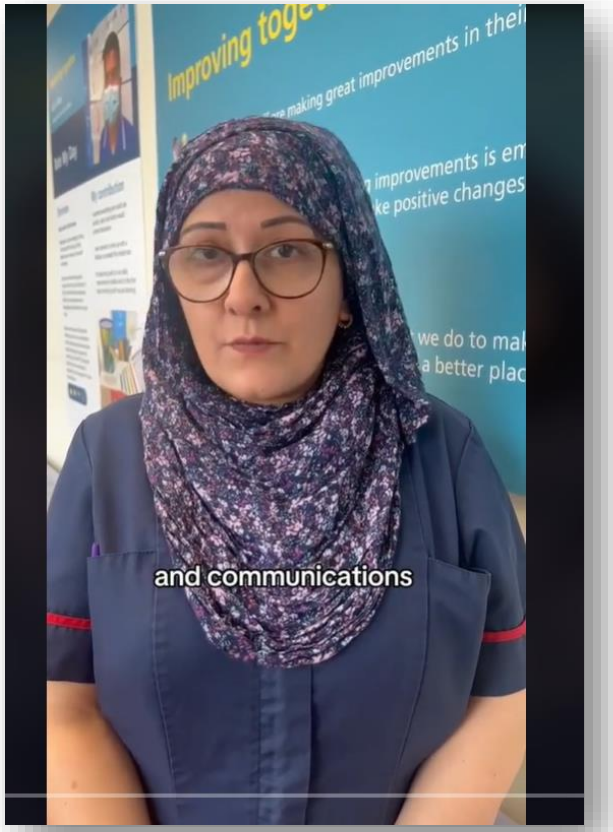
1. I understand our strategy and how we are performing against our goals
2. I understand what my team and I need to do to contribution towards the strategy
3. I am able to deliver both great work ***and*** improve how I do it as part of my *"day job"*

Empowering Staff to Lead

Cohort 5

Great Western Hospitals NHS Foundation Trust

Video https://www.tiktok.com/@gwhnhs/video/7304319310317522209?_t=8nsNaDHZt5s&_r=1



Staff Stories

Hannah

Cohort: 5

Frontline team: Neonatology Ward

Role: Paediatric Consultant with special interest in Neonatology

"The junior doctors can find it difficult to complete a meaningful improvement project in 3-4 months but with Improving Together they can be part of a team and build on ideas and projects that are ongoing"

Some challenges included

- Freeing time up from a consultant schedule to attend the training was tricky, Hannah was not able to attend all the sessions but was able to manage with attending some and supporting other medical staff to become engaged on the ward.
- Maintaining huddles can be difficult and sticking to daily huddles can help with the routine.
- It would be good to have people from within the specialty and division more engaged with the changes we are making and escalations we might have

It's great to see people making it happen

We worked hard to get a wide group of staff involved and increase confidence in running huddles which has made a difference to the sustainability of huddles.

Early benefits

- The team have implemented a process standard work focused on supporting on maintaining neonatal babies at an ideal temperature, the standard work is called "baby in a bag" and helps babies maintain a constant temperature even whilst having observations taken.
- One of the team's drivers has been improving feeding in the first 3 days of a babies life and they have improved early feeding compliance with the national standard from 30 – 88% in around 3 months.
- Huddles are a great place to spread the word on daily tasks, safety updates and things we need people to try and feedback on bringing the whole multidisciplinary team together

The huddles give us space for the whole team to think about why things happen and to problem solve together

Staff Stories

Shelly

Training: The Academy Fast Track

Role: Student Placement Manager

Some challenges included

- Staff availability to attend the fast track sessions; there are plans to overcome this in phase 2 of delivery with access for staff to any session being offered, this also allows cross team working and engagement to attend any sessions missed
- The existing culture of improving together within the academy needed to embed to enhance the buy-in from teams. Fast track training enabled staff to see the value and how they can influence and make changes however big or small the idea is (and impact this has on the patient experience).
- Space to deliver wasn't as inclusive due to noise levels from medical records in same vicinity (could it be delivered in a blended approach online but this also provides its own challenges; you need the energy from being together).

Early benefits

- Foundations and momentum – need to get foundation right (attending boot camp allowed us as managers to achieve this and apply theory to practice).
- Bitesize sessions allowed team to implement as we went along and then share ideas and reflect at the next session ready to continue the journey.
- Following the fast track programme – kept us focused on priority workstreams and kept us accountable to progress with it.

As a team accessing 'fast track' allowed us to put the 'theory into practice' with the experts from coachouse supporting our implementation within our teams

NHS Great Western Hospitals NHS Foundation Trust

The first time we completed our performance huddle – we had someone observe us which was really valuable to reassure us we were doing it right!

Fast track allowed us to share the improving together methodology with the wider team in bite sized chunks

It allowed reduced duplication between services and allowed teams to work together effectively

Staff Stories

Chris

Cohort: 5

Frontline team: Same Day Emergency Care

Role: Trainee Advanced Clinical Practitioner

We really want to maintain momentum when the unit moves and working together with the MEU team will be important in making this happen.

The training made us really think and start to move away from “the way we have always done things”

Some challenges included

- Rotational staff on the unit made creating an improvement team challenging, during the training the staff group became more fixed which opened up opportunities.
- At the beginning of training people were worried about time commitment and saw the training as a tick box exercise. Creating protected time for staff to work on improvements is challenging.
- Attendance of the specialty team at training was great and follow up interaction with the huddle board would help maintain momentum.

“It is so important that we celebrate our successes and this has helped – we never did that enough”

Early benefits

- There have been lots of changes which have helped reduce duplication and time for patients in the department. The team have developed standard pathways of care including a direct to scan pathway for patients with a suspected pulmonary embolism and standard care sets for common procedures. Exploring increased autonomy for patients in the blood pressure pathway.
- GP trainees have really engaged with the work and the timing of the huddle was moved so that more doctors can attend and contribute to the meetings sharing their knowledge.
- A static staff group has meant that more improved roles could be developed[29] reducing induction time and workload for staff

“It has made me really think about my own practice and how I am the most effective I can be at work and in my team.”

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**5 September 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Summary of Board Safety Visits				

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

Assurance Level

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

Process

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

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

Report

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

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

The report provides information in respect of:-

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

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

– risk number & description (Link to BAF / Risk Register)	-	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	-	
Next Steps	-	

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	28 August 2024

Chair's Board Report

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

1. Council of Governors

1.1 Governor elections commenced on 2 August 2024 and will conclude by 31 October 2024. Elections are being held for the following positions:-

- Wiltshire Northern (public) 2 seats
- Wiltshire Central (public) 2 seats
- West Berkshire & Oxfordshire (public) 1 seat
- Allied Health Professionals (staff) 1 seat

1.2 Cllr Sam Pearce-Kearney, our new Wiltshire County Council governor representative attended an induction with the Chair, Company Secretary and Lead Governor.

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

August 2024		
Date	**Event**	**Purpose**
1 Aug	Trust Board Meeting – Observers	Holding the Non-Executive Directors to account
7 Aug	People's Experience & Quality Working Group	To identify key issues in relation to service users and staff experience and the quality of the work of the Trust. The Group received updates on the new CQC approach and patient experience, as well as the relevant Board Assurance Committee reports. This meeting is

		aligned to the Board Committees Quality & Safety and People & Culture.
13 Aug	Business & Planning Working Group	To identify key issues in relation to address in relation to Trust finances and business planning. The Group received updates on the mth 11 financial position and financial risks, as well as the relevant Board Assurance Committee reports. This meeting is aligned to the Board Committees Finance, Infrastructure & Digital and People, Population & Place.
16 Aug	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
16 Aug	Visit to Neonatal Ward	To observe a 'Huddle'.

2. Strengthening Board Oversight & Development

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

Date	Area	Board Member
14 August 2024	Surgical Assessment Unit	Lisa Cheek, Chief Nurse Liam Coleman, Chair
28 August 2024	SCBU and Neonatal Unit	Jude Gray, Chief People Officer Lizzie Abderrahim, Non-Executive Director

2.2 A summary of the Board safety visits from January to May 2024 is outlined in appendix 1.

3. Trust Chair Key Meetings during August 2024

Meeting	Purpose
Monthly meeting with Non-Executive Directors & Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Performance, Population & Place Committee	To attend as an observer
Remuneration Committee	Board sub-committee meeting
Non-Executive Director appraisals	Annual performance reviews
Chairs' Catch Up	Regular system meeting
AHA Transition Planning	System meeting
Chairs' MOU Development meeting	System meeting

Appendix 1 - Board Safety Walk Arounds Summary Report for January to May 2024

1. Introduction

The National Health Service Patient Safety Strategy 'Safer culture, safer systems, safer patients' (2019), sets out how the NHS will address the challenges required to achieve its vision to continuously improve patient safety. There are three strategic aims: Insight, Involvement, and Improvement.

The Board Safety visits are an opportunity for engagement with front line staff in respect to implementation of this vision. Providing a dedicated opportunity for staff across the Trust to engage with Board members, participate in conversations about safety, and for those board members to listen and learn about the challenges being faced regarding safety. The board safety walks provide an opportunity to embrace the National Patient Safety Strategy foundations, supporting to build a patient safety culture and a patient safety system that will continuously improve patient safety across the Trust.

Table one provides a summary of the wards/departments where visits have taken place from January to May 2024. This includes announced and unannounced visits.

Table one – visit summary

Name of site	Date of Walk Around	Type of visit
Emergency Department	24th January 2024	Unannounced
Linnett Ward	29th January 2024	Announced
Theatres	26th February 2024	Announced
Therapy Teams	28th February 2024	Unannounced
Forrest Ward	6th March 2024	Announced
Physiotherapy Acute Respiratory	25th March 2024	Announced
Maternity	22nd April 2024	Announced
Mercury Ward	24th April 2024	Unannounced
Emergency Department	29th May 2024	Announced

2. Summary of feedback

The themes identified through visits were space, transfer of care and pathways of care.

Safety points raised on the visit:

Safety points raised were lack of clinical space, access through the keri card system, recruitment and delays in internal transfer.

Positive points raised on the visit:

Communication was highlighted as the main positive theme, this included usage of Improving Together, MDTs, volunteer service, teamwork, relationships with other trusts and improved working facilities for medics.

Learning points raised on the visit:

There was no overall theme identified across all visits. The learning points raised were around use of Improving Together to improve slot utilisation, reviewing the effectiveness of group therapy, some of the challenges of temporary accommodation and using learning from one area to make improvement in another.

Triangulation with PSIRF priorities
The information obtained at the safety visits has been triangulated against the Trusts five PSIRF priorities. This has highlighted ‘Optimising Care Pathways and Transfers of Care’ and ‘Optimising Communication’ as the main themes.

This data will be used to guide the development of the oversight groups for these priorities as they are very broad.

3. Outcomes
Following each Board safety visit notes are made available to all those that attended the visit with an action tracker to monitor actions taken forward to completion.

4. Future Planned Visits
Future planed visits will follow the same format for the remainder of the year. Providing an opportunity for individuals and teams to guide the conversation and raise any points related to patient safety (positive or negative) with the visiting team. The current list of areas visited this year will be reviewed to develop a forward planner for 2025/26.

5. Future unannounced visits
Following a discussion at Quality & Safety Committee it has been agreed that future unannounced visits will cease as these visits offer limited opportunity for interaction of staff that are not readily available at the time of the visit. Some team members may choose to attend the ward at the time of the visit to be involved in the planned visits. The interactions at unannounced visits are often limited and staff do not have the opportunity to consider the points that they wish to share, show case what is good or raise areas of concern.

6. Governance and review
The visits have now been running well for several years, using an agreed Standard Operating Procedure (SOP) to ensure consistency of approach and guide each visit. The governance of the visits is well established, including the pre visit organisation, visit ethos and after visit action(s). To help the teams use the data gathered from each visit the visits notes are now shared along with the individual ward/department themes.

7. Summary
The feedback from the board safety visits continues to remain very positive, with excellent staff engagement before, during and after the visits. Clear actions have been agreed on the day and followed through afterwards to ensure completion. Actions are agreed during each visit and monitored until completion.

Triangulation is enabling conversation in other key areas like patient engagement to ensure that all aspects of patient safety and engagement are a trend throughout.

Report Title	**Chief Executive's Report**				
Meeting	Trust Board				
Date	5 September 2024	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jon Westbrook, Acting Chief Executive				
Report Author	Jon Westbrook, Acting Chief Executive				
Appendices	N/A				

Purpose

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

Assurance Level

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

Board members are asked to note the report

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

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

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

Report

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

The report includes updates on:

- National disorder
- Integrated Front Door development
- Industrial action
- Adult Inpatient Survey
- Financial situation
- Veteran aware re-accreditation
- Senior appointments

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

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

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

Explanation of above analysis:

The report mentions our re-accreditation as a Veteran Aware organisation, which recognises our work in demonstrating the NHS' pledge to the Armed Forces Covenant, by sharing best practice as an exemplar of the high standards of care for the Armed Forces community.

It also references our work to mark South Asian Heritage Month, celebrating the stories that make up our diverse and vibrant community.

There is also mention of our support for the Swindon and Wiltshire Pride festival, with staff joining in the celebrations and also offering healthcare advice.

Recommendation / Action Required The Board/Committee/Group is requested to:	
To note the report	
Accountable Lead Signature	Jon Westbrook, Acting Chief Executive Officer
Date	29 August 2024

1. National disorder

There was understandable concern among our staff and the local community following the violence and disorder seen in other parts of the country last month.

Fortunately, this was not replicated in Swindon and Wiltshire.

NHS Chief Executive, Amanda Pritchard, published a message saying racism towards NHS staff would not be tolerated, and I echoed this sentiment in a message to our Trust staff.

We will stand up for and support any staff who face prejudice, violence or abuse.

Any staff who engage in racist or violent demonstrations or the sharing of discriminatory material, either in person or on social media, will be dealt with promptly.

2. Operational updates

2.1. Integrated Front Door development

We officially took ownership of our new Emergency Department (ED) building from the construction company, IHP, on 19 August.

The new ED is expected to open later this month, and follows an official ceremony taking place to mark the progress made on the building.

A plan is in place to safely care for patients during the transition from the old department to the new department.

All of our operational partners, including the ambulance service, have been involved in simulations and have had tours of the new ED.

There is no change to how we would expect patients to access our services – walk-in patients have been arriving via the Urgent Treatment Centre and been triaged at the door since July 2022.

2.2. Industrial action

Junior Doctors have been offered a 22.3 per cent pay rise over two years by the Government. The British Medical Association has put this offer to its members and we hope that this will being an end to the industrial action which has impacted patient care.

We are aware that a number of GPs are taking collective action after the British Medical Association rejected changes to the 2024/25 General Medical Service contract.

Collective action means GPs taking action that, in this initial phase, may stop or reduce certain work. This means staff would still be working and practices would still be open to see patients.

GPs should advise members of the public about changes to their services at practices.

Patients have been advised not to change the way they would normally access health services as a result of this action, so should continue to attend appointments with their GP practice as normal.

We are aware that UNISON members who work for Serco at Great Western Hospital have voted to go on strike. This primarily affects housekeeping and portering staff.

We've been in close contact with Serco, who have advised that the impact on our services should be minimal.

The action is being taken due to a pay dispute between UNISON members and Serco as their employer.

3. Quality

3.1. Adult Inpatient Survey

Results of the 2023 Adult Inpatient Survey, run by the Care Quality Commission, were published last month. Our Trust had a 42.4 per cent response rate from over 16s who had spent at least one night in hospital in November 2023.

We were pleased to see improvement in 20 questions throughout the survey, for areas including good staffing levels and attention from staff when needed, privacy and dignity and the overall patient experience.

These encouraging scores recognised the work underway to ensure patients have a more positive experience in hospital, such as through initiatives to make menus and food choices more accessible (available food and drink scored well in the survey), investment in staffing and opportunities for patients to provide feedback.

Seven of the questions showed a decline relating to the discharge process. Some patients said they were not always clear what their discharge plan was, did not always get medication in a timely way and were not clear who to contact with any concerns once they had returned home.

This year, the survey also introduced two new questions relating to virtual wards and, with the Trust scoring lower than average in relation to patient information, we know there is more we can be doing in this area.

We have reviewed the findings of the survey and have agreed a number of actions to take, including:

- Improving the patient's experience of discharge by communicating clearly what they are waiting for and when they are likely to go home
- Continuing to focus on ensuring patients have enough support to eat and drink by introducing additional drink rounds, protected mealtimes, more meal-time companions and working with Serco to implement a ward host role
- Looking at how we can be more responsive to patients and answer call bells more promptly
- Ensuring patients receive the same standard of care at night as they do during the day time.

4. Systems and Strategy

4.1. Financial situation

As at month 4, July, we are in a £6.2m deficit position, which is £3.3m worse than plan.

Our savings target this year is £21.9m. So far we have delivered £3.9m of this, with 59% of these savings recurrent.

All divisions and services must further increase overall savings to hit the £21.9m target, and specifically ensure the savings are recurrent to reduce the underlying deficit.

Continuing to work to reduce pay spend is key to delivery of our future savings so tight controls on approval of bank shifts, overtime, and waiting list initiative payments will continue.

4.2. Veteran aware

We are proud to have been re-accredited as a Veteran Aware organisation.

This shows our support to veterans, reservists, families and other members of the Armed Forces. It demonstrates our commitment to ensuring members of the Armed Forces are never disadvantaged, staff are trained in support and signposting and we remain a 'forces friendly' employer.

It also recognises our work in demonstrating the NHS' pledge to the Armed Forces Covenant, by sharing best practice as an exemplar of the high standards of care for the Armed Forces community.

5. Workforce, wellbeing and recognition

5.1. Senior appointments

Benny Goodman has been appointed as our new Chief Operating Officer. He is currently Director of Operations, Networked Care Group, at the Royal Berkshire Hospital NHS Foundation Trust. He will succeed Felicity Taylor-Drewe when she leaves the Trust later this year.

Ana Gardete has been appointed Deputy Chief Nurse following Luisa Goddard’s promotion to the role of Chief Nurse.

5.2. STAR of the month

Our latest STAR of the Month winner is Joe Stevens, Clinical Research Assistant, who was recognised for the support he gave his team during a power outage at the Great Western Hospital by acting as a fire warden to keep patients and staff safe. Joe also acted as a runner so that multiple teams were kept well informed and showed great leadership qualities in a challenging environment.

5.3. Great West Fest

Great West Fest, our free family festival, will take place for the fourth time on Saturday 14 September.

This year there are 4,500 tickets available for staff, volunteers and families, making this our biggest event yet.

Taking place at Town Gardens in Old Town, Swindon, Great West Fest will feature a great line-up of artists, bands and performers; including headline act Rorkes Drift as a Queen tribute. There will also be funfair rides, a circus skills area, food vendors, face painting and more.

5.4. Launch of e-cards staff recognition scheme

In response to feedback from last year's staff survey, we have launched a peer-to-peer e-card system to help make it easier for staff to recognise and celebrate their colleagues' hard work.

The e-cards will enable staff to send a personalised message to anyone in the organisation, and is part of our work to continue to build a more compassionate and respectful culture.

There are a variety of designs to choose from, including messages for multi-cultural holidays, awareness months, and other notable events, and they can be linked to our 12 leadership behaviours.

5.5. South Asian Heritage Month

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

5.6. Pride

Some of our staff joined local people from across Swindon and Wiltshire for the Swindon and Wiltshire Pride festival last month. The team shared some of the great work happening across the Trust to ensure we are an inclusive and equal organisation, including some of the initiatives underway to develop our diverse workforce. Colleagues from our Sexual Health team also volunteered at the event, offering healthcare advice.

Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**5th September 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Lisa Cheek, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Robert Presland – Deputy Chief Operating Officer Luisa Goddard – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

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

Assurance Level

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

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

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

Report

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

Our Performance

Key highlights from our operational performance for July (June for Cancer) are as follows:

Strategic Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

July performance shows the total number of patients waiting over 52 weeks at 1,941, a 3% increase from the previous month, but 371 patients worse than operating plan trajectory for July.

To achieve the end of year target of zero breaches the Trust operating plan is targeting the booking of all first outpatient appointments for potential 52 week breaches by the end of September. This is to allow enough headroom to schedule and complete the next stage of treatment, where required, to stop the clock before the end of March. The Trust remains ahead of trajectory in this area across all specialties, with the largest volume of unbooked patients in General Surgery, Gastroenterology and Gynecology.

The Trust also remains committed to reducing the size of the waiting list tail by eliminating 65 week wait breaches by the end of September. At the end of June, there were 259 x 65 week wait breaches against an operating plan trajectory of 174. The Trust also reported 3 x 78 week wait breaches (1 x capacity and 2 x complexity), with one TCI confirmed for August, one awaiting outcome from MDT and one patient transferred to another Trust for surgery.

Performance trajectories and delivery plans with mitigations for clock stops to meet the desired run rate continue to be reviewed at fortnightly Divisional escalation meetings and specialty level trajectories have been developed by Divisions to support the risk assessment against the September target for zero breaches.

Main risks to delivery in Medicine are Gastroenterology (mitigated by predicted uptake of waiting list initiatives and outsourcing arrangements to independent sector for suitable patients), Neurology (mitigated by increased capacity for new consultant starting and waiting list initiatives) and Respiratory Medicine (implementing change to one stop model for diagnostics).

In Surgery, Women's and Children's the main risks are within General Surgery (mitigated by some pooling of lists for backlog and waiting list initiatives). General Surgery also has a 27% conversion rate from outpatient appointment to requiring surgery, which may result in challenges to booking patients into available theatre capacity in September. This will be monitored closely during August and September between booking teams and the Trust Access team.

- **Cancer waiting times**

At the end of June there were 125 patients waiting >62 days on the PTL, which was 5.6% of the overall PTL size and therefore remaining below the national target of 6.8%. The PTL continues to be managed within nationally set thresholds.

The Trust exceeded the operating plan trajectory for both the 28-day Faster Diagnosis (FDS) standard and 62 day referral to treatment standard in June at 70.2% and 69.4% respectively. In July we forecast that we will meet the 28-day FDS trajectory but miss the 62-day trajectory due to the continuing issue with Urology pathways impacted by waits for LATP biopsy and capacity issues in Plastics. We are not expecting to see improvement through August due to ongoing issues within the Urology, Dermatology, Plastics & Colorectal.

Validated June performance against the 31-day decision to treatment standard remains below the 96% national standard, currently at 89.5%. However, performance is improving for decision to treatment and illustrates the importance of recovering the diagnostic stage of our cancer pathways.

GWH remains in tiering for cancer performance and any decision by the national and regional teams to exit GWH from tiering support for cancer recovery will require robust evidence of sustaining an improved position on cancer performance.

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

ED and UTC attendances increased by 1.6% in July although remains below the record number of attendances experienced during May. Demand continues to remain high with year to date activity reported at 2.6% above operating plan, and 15.6% above the 2019/20 baseline. Mean stay in ED and the UTC continues to improve despite the growth in activity. Improvements in UTC have been

supported by changes to streaming of patients and reconfiguration of triage capacity to meet demand at peak periods.

Combined 4 hour performance was 77.1% and above operating plan trajectory of 76.1%, with improvements in both Type 3 UTC and Type 1 ED 4 hour performance compared to the previous month, as a result of specific improvement initiative.

Increases in Type 3 UTC demand continue to threaten delivery of the 78% 4 hour target. Work continues with a whole hospital focus on 4-hour performance to improve patient experience and mitigations to stream patients away from the UTC include joint working with Primary Care to reduce inappropriate attendances including those for blood tests and scans. The opening of the Integrated Front Door in the Autumn will also facilitate improvements to accessing same day emergency care pathways.

- **Inpatient spells - No Criteria to Reside Bed Days**

The number of bed days lost for patients with no criteria to reside (NCTR) remains within control limits with July averaging 88 patients per day. There were 20.1% of beds occupied against the operating plan trajectory of 13.9%.

Current priorities for improvement with partners remain in terms of reviewing processes through the Transfer of Care Hub (with a focus on Pathway 1 home first), enhancing escalation processes for out of area referrals, improving the timeliness and completeness of recording and daily touchpoint calls with partners to review discharge plans for complex and stranded patients. Nationally mandated changes to recording of no criteria to reside are also in the process of being implemented by August.

A place based Care Transfer Hub steering group will also be set up in September as part of the Trust winter planning approach. This group will be tasked with reviewing recovery trajectories and associated activities to ensure the required bed day equivalent savings are realised between now and March 2025 through reductions in no criteria to reside.

Operational Breakthrough Objective

- **Ambulance handover delays**

  The average hours lost per day to ambulance delays reduced by 40% from 118 hours in June to 71 in July. This was just above the breakthrough target of under 70 hours of hours lost per day. Whilst improved there remains a significant risk to patient safety and care for patients who require emergency treatment due to the inability to offload ambulances at the point of arrival. This is due to critical capacity of the Trust, Emergency Department, and MAU, & flow throughout the Hospital and to system partners (including out of area patients).

  The Trust initiated a SAFER Summer rapid improvement event throughout July with support across the Trust and system partners. This included a perfect Ambulance handover week commencing on 8th July, and three multi-agency discharge events scheduled throughout July to support improvements in flow. The learning from this event will be carried forward into the Urgent and Emergency Care transformation programme.

Alerting Watch Metrics

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

- **Diagnostics** – July performance against the 6 weeks wait standard improved to 70.72% from 70.55% in June (validated), in line with plan. Recovery towards the 99% constitutional standard (above our operating plan) remains dependent on reducing the size of the NOUS backlog and also a sustainable improvement plan for endoscopy which remains below plan.

Our Care

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

Strategic Pillar Targets

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

The total number of harms remains fairly static in July (200) compared to June (198) and May (199). Pressure harms in the acute setting have reduced slightly this month to 25 (35 in June) and a slight increase in the community from 16 in June to 25 in July.

The number of Family and Friends (FFT) positive responses for July was 88.1%, a decrease from the previous month and below the 90% target.

Breakthrough Objectives

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

Aim for 2024/25

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

The Countermeasures include:

- Patients to be encouraged to bring in own foot wear or use the Trust slipper bank.
- All patients to have postural blood pressure checked on admission and wards to implement an oversight process of this.
- The new enhanced care policy and training to be embedded with a daily process to audit and 'check and challenge' the enhanced levels of supervision are correct.
- To prevent deconditioning Wards are identifying champions to support patients sitting out of bed for meals and work to improve handover of mobility status Is ongoing.

In July there were 5 patients with moderate harm or above from inpatient falls. This included one patient sustaining a catastrophic sub dural haematoma.

Alerting Watch Metrics

The complaint response rate remained at 62% with no change from last month.

Additional support continues to be provided to the Division of Medicine to facilitate the management and closure of complaints. Allocation of complaints to facilitate a better process and prevent any further delays is being supported by the PALS team. Agreement has now been made on wider distribution of complaints across all divisional leadership roles.

The overall number of complaints received in month has increased to 70 (from 54 in June). The number of re-opened complaints is zero in month.

E. coli and *Klebsiella* numbers remain high compared to our peers, with urinary infections being the main contributor. An external audit of catheter practice is currently taking place and will feed into the Continence Group's action plan. *Pseudomonas* cases rose in July and we are investigating a cluster of three possibly related cases on one ward. *C. diff* numbers returned to normal after a spike in June and the Trust remains close to trajectory.

Non-alerting Watch Metrics

Pressure harms in the acute setting have reduced slightly this month to 25 (35 in June) and a slight increase in the community from 16 in June to 25 in July. Four were category 3 pressure ulcers. 2 wards, Forest and Trauma, remain as top contributors and are receiving additional support and strengthened improvement plans.

There was a slight increase in community pressure ulcer harms in July (25) involving 17 patients (16 in June). 11 of these harms were associated with patients on an end of life pathway. The majority of harms were reported at Category 2 (16) with 3 category 3 harms identified. Improvement actions

include working with the surgical division on the end of Life pathway to reduce harms and fortnightly training on the pressure ulcer risk assessment tool.

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

- Safer staffing fill rates remain above the National target of 85%.
- There are a total of 8 Serious Incident Investigations and 7 Patient Safety Incident Investigations (PSII) in progress. There were no PSII's reported in month of July. There is a trajectory to close all investigations on the old SI framework and eliminate any overdue investigations by September.

Our People

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

Strategic Pillar Target from A3 goals:

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

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

- **Staff Survey – Recommend a Place to Work**
  Stretched Target 63%: achieving 59.6% (2023 Annual Survey), 55.9% Q1 Pulse Survey, and 55.5% Q2 Pulse Survey (steady decline since the annual survey)
- **Staff Voluntary Turnover**
  Target 11% achieving 8.0% (June data)
- **EDI disparity (reducing discrimination disparity)**
  Target 9.4% achieving 12.7% (2023 Annual Survey), and 13.1% Q1 Pulse Survey and 17.5% Q2 Pulse Survey

A marked improvement to our score for "Recommend as a Place to Work" has been seen in the 2023 Annual Survey results however recently pulse survey has shown a decline in this question. In Q2 there has been a slight decline to the number of staff who would recommend the organisation as a place to work, driven by a noticeable decrease in the number of Healthcare Support Workers who agree with this statement.

Breakthrough Objectives

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

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

The Q2 Pulse Survey also included free text questions allowing staff to share their expectations around respect in the workplace. Key themes have been identified relating to 'communication', 'listening', 'equality & fairness', 'understanding & empathy', and 'support & teamwork'. This culminates in a view that respect relates to 'belonging to a team and culture where staff are valued, heard, and all voices matter'.

Alerting Watch Metrics

In-month sickness absence increased in June from 4.2% to 4.6%, driven by an increase to short-term absence and remaining above the KPI of 3.5%. Short term sickness has increased to 2.5% and long-term sickness has increased to 2.1%.

The Trust is performing in the second-lowest quartile reporting at 37th out of 133 Trusts (March 2024).

HR Scorecard

Vacancy Rate
Our vacancies decreased further in month 4, reducing to 187WTE (3.44%) and achieving our goal of reducing vacancy levels to under 200WTE. This has resulted in clinical vacancies being at their lowest level in the 12 month reporting period.

Nursing Vacancy
Band 5 Nursing vacancy continues to hold its over-established position (-11WTE), and all nursing vacancy levels are down to just 25WTE in July compared to 133WTE 12 months ago. We've seen further reduction to our Unregistered Nursing vacancy position, decreasing by 11WTE in month to 20WTE vacancy.

AHP Vacancy
AHP vacancy has reduced to 26WTE compared to 113WTE 12 months ago.

Medical Vacancy
Whilst Medical vacancy has increased from 49WTE in June to 58WTE, it still remains lower than the vacancy level of 76WTE this time last year.

Our establishment WTE decreased marginally in-month, with the reduction to vacancies largely attributed to an increase in starters in July and improvement in our time-to-hire metric (40.4 days).

Workforce Utilisation
Agency spend as a percentage of total pay was 1.94%, within the KPI of 4.5%. In-month spend decreased by £0.1M in July, however alerted above target due to levels of spend reduction not being met in month 4 (£100k above plan in July). Bank spend remained static in July at £2.32M, and above target by £0.36M.

Learning & Development
The Trust appraisal compliance rate continues to alert in month 4 at 84.9%, marginally below the KPI of 85%. Electronic management of appraisals through the ESR system is set to launch in October.
Medical appraisal compliance is also alerting in July, however has seen an improvement month on month. Escalation meetings for overdue medical appraisals took place throughout July.

Workforce Recovery
In month 4 we utilised 5,632WTE to deliver our services against a planned figure of 5,627WTE. This was 5WTE above planned levels in July and represents further growth to our workforce of 41WTE compared to June.

Bank and Agency usage increased in July, with bank rising by 7WTE and agency by 7WTE. Overall temporary staffing levels remain under plan by 22WTE at month 4 and underspent £110K YTD, however this position is no longer offsetting our over-plan position on contract WTE.

Growth in our substantive WTE continued with an additional 26WTE in July. This was due to growth within Cancer, SWICC, and Community Inter Care teams. Whilst our total workforce level against plan is now alerting, (due to increasing substantive workforce without a subsequent reduction in temporary staffing), our overall financial position remains within tolerable levels meaning the decision to initiate the next planned intervention (non-clinical vacancy freeze) was held. This position continues to be monitored at the fortnightly Workforce Recovery Meetings.

Use of Resources
As at M04 of 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £6.2m, which represents a £3.3m adverse variance to plan.

Income is £1.3m favourable to plan driven by ERF (£0.4m) and an overperformance on NHSE-commissioned drugs (£0.9m).

The pay position includes c.£0.5m of junior doctor industrial action incurred over June/July. Overall, pay remains £0.5m under plan due to centrally-held reserves (e.g. maternity / paternity leave), which will be used to support divisional pay positions throughout the year.

Non-Pay is £5.8m over plan which includes a £3.8m variance in clinical supplies, particularly within Medicine and Surgery, Women's and Children's'. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. A working group, including Procurement, is analysing the drivers of clinical supply spend with a view to achieving savings.

An internally-generated forecast aligned to current run rate and known changes suggests a gap to plan of £8.3m, however the Trust has a recovery plan agreed with the ICB to improve this back to plan. Factors that play into this improvement include but are not limited to: further ERF stretch through additional activity and coding; improved CIP delivery; no further industrial action costs (and an assumption that costs to date will be reimbursed nationally); and a reduction in non-pay run rate costs.

The £3.3m adverse variance to plan includes a £1.8m underperformance against the efficiency target, which is £5.7m as at M04 and £21.9m for the full year. 59% of the £3.9m delivered year-to-date is recurrent. All divisions and services must further increase overall savings to hit the £21.9m target, and specifically ensure the savings are recurrent to reduce the underlying deficit. While ERF activity and associated income is currently above the plan, continuing to maximise activity will be key to delivery of future savings. Divisions and services must also focus on reducing pay and non-pay spend throughout 2024/25. The target is to reduce the number of headcount working in the Trust by 263 compared to March 2022 by the end of the year. Tighter controls around the approval of bank shifts, overtime and WLIs will contribute to this, while continuing with the good work already in place that has resulted in run rate reductions on temporary staffing. Clinical supplies spend should be scrutinised at the point of order, to ensure that we are practicing good governance with the choice and amount of stock being purchased.

Breakthrough Objectives

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

We remain c.£3.3m off plan in Month 4. Our performance behind plan on the efficiency programme of £1.8m demonstrates that our run-rate reductions are not going far enough to impact our financial position to the extent that it is needed to meet our full-year plan. There are various recovery workstreams in progress, particularly around pay run rates. Activity is being scrutinised for where we are not delivering volume, or value of the relevant volume, against plan.

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

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

Actions continue to be progressed in relation to improving requisitioning controls and developing the training offer. This work is continuing through August at a limited pace, due to annual leave and vacancies that are not being backfilled.

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

Key Risks – risk number & description (Link to BAF / Risk Register)		**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	PPPC (Performance, Population & Place Committee) & Trust Management Committee	
Next Steps		

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

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

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

- ***Review and support the continued development of the IPR***
- ***Review and support the ongoing plans to maintain and improve performance***

Accountable Lead Signature	
Date	13.08.2024

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

August 2024

July 2024 & June 2024 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Total 104 week waits	0	0	0	0	0	0	0	0	0	0	0	0	1
Total 78 week waits	0	3	1	1	2	4	5	10	4	3	4	3	3
65 weeks wait performance vs plan (size adjusted)	80.5%	475.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	70.0%	117.9%	148.4%	154.6%
Proportion of PTL over 65 week waits (size adjusted)	0.0%	1.7%	1.6%	1.2%	1.1%	0.9%	0.9%	0.7%	0.2%	0.4%	0.6%	0.7%	0.6%
Under 18 elective activity rate vs baseline	100%	123.3%	116.2%	115.7%	117.5%	116.3%	122.5%	128.8%	119.1%	123.9%	119.0%	114.4%	117.5%
Faster diagnosis rate	75% (Nat)	62.6%	62.0%	58.2%	59.7%	60.4%	60.2%	70.5%	71.3%	59.2%	66.7%	70.2%	Reported one month behind
62-day performance	85% (Nat)	59.5%	49.0%	61.1%	67.2%	65.0%	62.2%	68.6%	66.7%	63.1%	64.3%	69.4%	Reported one month behind
Proportion of patients seen within 4 hours	95% (Nat)	74.2%	74.7%	71.5%	71.4%	74.7%	73.5%	71.1%	74.4%	75.9%	75.3%	75.0%	77.1%
Number of mental health patients spending >12 hours in an emergency dept	8	10	7	10	9	5	12	5	5	14	9	6	6
Readmission rate	16.5%	16.2%	15.7%	17.2%	15.9%	16.4%	15.8%	17.1%	16.7%	15.7%	17.6%	16.9%	16.9%
Summary Hospital-level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
CQC safe rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Sickness rate	3.5% (Int)	4.0%	4.2%	4.7%	4.7%	5.0%	4.9%	4.4%	4.1%	4.2%	4.2%	4.6%	Reported one month behind
Leaver rate	11.0% (Int)	9.6%	9.5%	9.2%	9.2%	8.9%	8.6%	8.6%	8.4%	8.6%	9.7%	11.0%	Reported one month behind
Implied productivity	0	-20%	-22%	-17%	-15%	-14%	-16%	-13%	-12%	-13%	-17%	-15%	Waiting for data
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	5.3%	5.3%	5.3%	5.4%	5.4%	3.5%	3.5%	3.5%	3.3%	3.3%	3.3%	Reported one month behind
Proportion of staff in senior leadership roles who are women	64% (Nat)	56.1%	56.1%	56.1%	56.9%	57.1%	56.1%	56.1%	56.1%	56.7%	56.7%	56.7%	Reported one month behind
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	1.8%	1.8%	1.8%	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%	1.7%	0.0%	Reported one month behind

Key Indicators

Great Western Hospitals NHS Foundation Trust

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

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

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

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

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

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

Patient Experience (FFT)

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

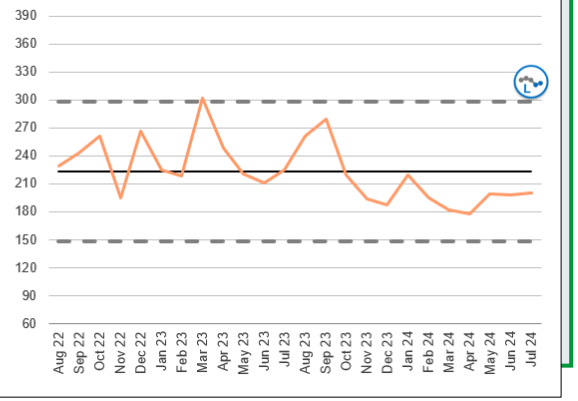
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

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

Total Harms

To achieve and sustain zero avoidable harm.

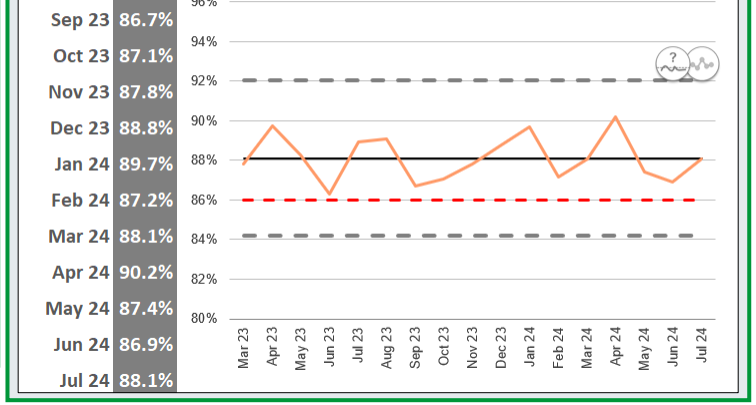
Timescale	Value
Aug 23	261
Sep 23	279
Oct 23	219
Nov 23	194
Dec 23	187
Jan 24	219
Feb 24	195
Mar 24	182
Apr 24	178
May 24	199
Jun 24	198
Jul 24	200



Patient Experience (Friends & Family Test)

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

Timescale	Value
Aug 23	89.1%
Sep 23	86.7%
Oct 23	87.1%
Nov 23	87.8%
Dec 23	88.8%
Jan 24	89.7%
Feb 24	87.2%
Mar 24	88.1%
Apr 24	90.2%
May 24	87.4%
Jun 24	86.9%
Jul 24	88.1%



Counter Measures

The total number of harms remains fairly static in July (200) compared to June (198) and May (199).
There have been slight variations within the harm profiles, with an increase in health care acquired Covid, 29 in July (15 in June) and an increase in pseudomonas (5 in July, 1 in June).
There has been a decrease in pressure harms in the acute this month (25 from 35 in June), although level of harm has increased slightly. Community has seen an overall increase this month to 25 (16 in June).
The number of falls resulting in moderate harm or above has increased to 5, although the overall number of falls has reduced.

For July, the Trust wide positive Family and Friends (FFT) score has remained relatively static. The target for 2024 /25 is 90% to ensure there is a stretch target. The PALS team are ensuing that divisions are fully sighted on their FFT results and are providing additional reports to highlight key themes. All Improving Together training now includes FFT data in order to inform improvement project plans and to ensure the patients voice is heard in these workstreams. The Just and Learning Culture and Compassionate Leadership work continues with an aim of addressing one of the top negative FFT themes of staff attitude and behaviour and there has been a slight improvements reflected in the FFT data.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance
Cancer 62-day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In June, there were 60.5 breaches in total, with 49.5 of these attributed to the Urology, Breast, Colorectal and Skin pathways. There are capacity issues within a number of sites including Colorectal, Skin and Urology.

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

RTT: Number of patients waiting over 52 weeks

July performance shows the total number of patients waiting over 52 weeks at 1,941, an increase of 56 in month. Patients waiting over 65 weeks was at 259, a decrease of 13 in month. As of 28th July, our cohort size for the September target was **1,200** patients, 36 % below trajectory of 1,877. There is cohort size of 21,137 pathways, which are in scope to turn 52 weeks by end of March 25.

3 x 78 weeks breaches were reported in July 2024.
- 1 x Non-admitted Gastroenterology
- 1 x Non-admitted Cardiology
- 1 x Admitted General Surgery

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

High risk areas where capacity breaches are possible include Gastroenterology, General Surgery, Cardiology and Respiratory. Risks and mitigations are being reviewed weekly in Division and fortnightly alongside corporate colleagues.

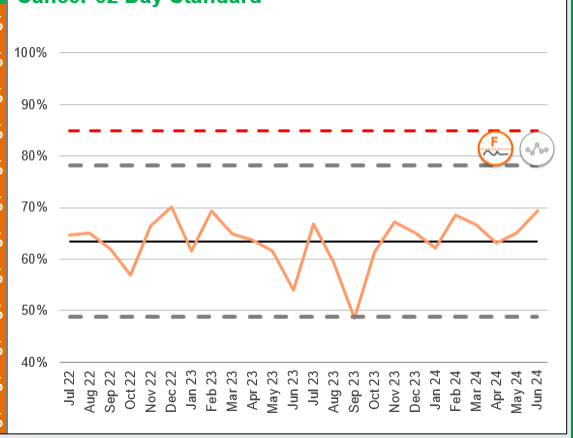
Felicity Taylor-Drewe | Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

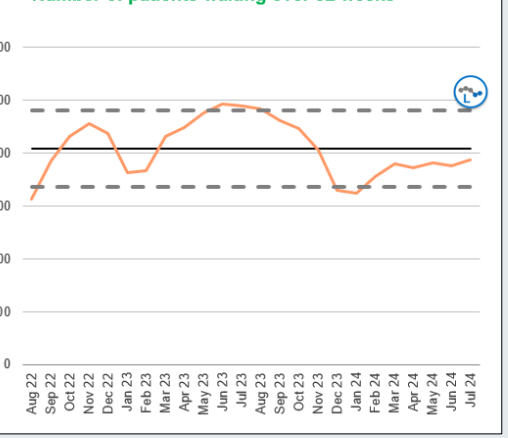
Timescale	Value
Jul 23	66.9%
Aug 23	59.5%
Sep 23	48.5%
Oct 23	61.3%
Nov 23	67.2%
Dec 23	65.0%
Jan 24	62.2%
Feb 24	68.6%
Mar 24	66.7%
Apr 24	63.1%
May 24	65.1%
Jun 24	69.4%



RTT: Number of patients waiting over 52 weeks

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

Timescale	Value
Aug 23	2,418
Sep 23	2,307
Oct 23	2,238
Nov 23	2,031
Dec 23	1,653
Jan 24	1,625
Feb 24	1,777
Mar 24	1,900
Apr 24	1,859
May 24	1,909
Jun 24	1,885
Jul 24	1,941



Counter Measures

Risk: Capacity in **Plastics** is insufficient to see and treat patients (OUH unable to meet 9.5 PA clinics since Nov/Dec 23)
Mitigation:
-Eligible Plastic patients are being sent to Wootton Bassett
-OUH locum providing 3 PAs per week started on 17 May & Increase in SLA with OUH from 9.5 to 16.5 PAs per week approved
Risk: Urology Pathways are impacted by delays in Radiology & Theatres (capacity & vacancies)
Mitigation:
-Funding approved for mobile LATP by TVCA, funds to be used to assist with flexible cystoscopy capacity too. This is due to go live late Augsut
Risk: Capacity issues for **Colorectal** 2ww triage, post diagnostic reviews and appointments after MDT are an issue.
Mitigation:
-Close management of Registrar rota's with Consultant input to allow triage to happen. Registrar clinics in place to aid outpatient capacity for first appointment and MDT slots are allocated to clinics
Risk: Capacity issues in **Breast** for first one stop clinic coupled with surgical capacity impacts pathway
Mitigation
-Funding from TVCA to support additional WLI one stop clinics approved and being utilised
-Funding approved for consultant radiologist for 6 months and being utilised

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

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

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 July 24 was 340 minutes against the national standard of 240 minutes. This is a continuing the downward trend where mean levels have dropped from above 500 mins to just 340 mins.

Emergency Care – Urgent Treatment Centre - Mean Stay

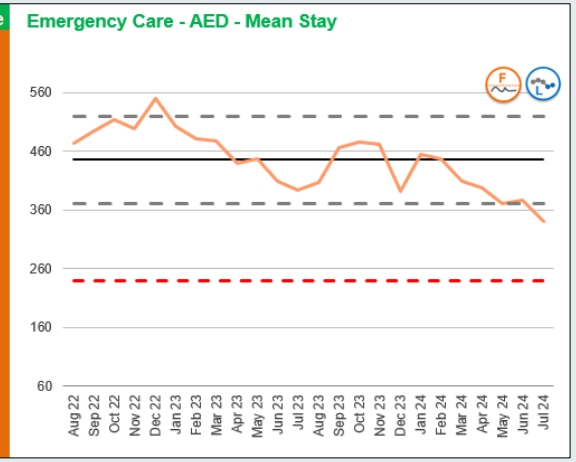
The total meantime wait for a patient in July 24 was 144 minutes against the national standard of 240 minutes. Continued drop in mean stay associated with improvements made in streaming, additional triage capacity and a slight reduction in attendances compared to the record volumes of patients seen in May.

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.

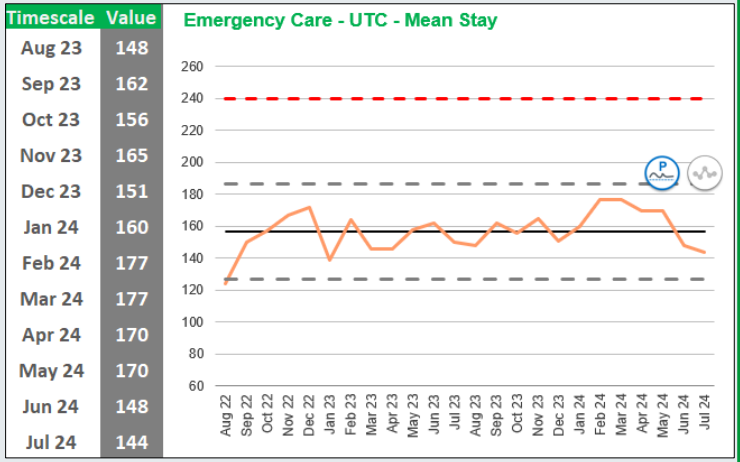
Timescale	Value
Aug 23	407
Sep 23	466
Oct 23	475
Nov 23	471
Dec 23	391
Jan 24	455
Feb 24	447
Mar 24	410
Apr 24	398
May 24	371
Jun 24	377
Jul 24	340



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Aug 23	148
Sep 23	162
Oct 23	156
Nov 23	165
Dec 23	151
Jan 24	160
Feb 24	177
Mar 24	177
Apr 24	170
May 24	170
Jun 24	148
Jul 24	144



Counter Measures

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

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

Executive Summary

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).

There were 11,309 patients seen in ED/UTC in July, which is a 1.6% increase from June, but lower than the record number of attendances seen in May. Month on month growth was 2% ED and 1% from the UTC.

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

July saw a slight increase in **NCTR from 88 to 82** running average on the day compared to June. Discharges showed a 5% increase on June with two days where we did not hit target (90 per weekday/60 Saturday/45 Sunday).
Over 21 days LoS was an average of 33 patients, which is a significant increase on 31 last month.

Discharges before midday reached 18% which remained the same as last month.- direct result from messaging for use of discharge lounge and work streams. 64% of patients were discharged prior to 17:00.

July was a good preforming month in relation to discharges, NCTR was slightly up. 119 patients were discharged via Home fist pathway. Discharge Lounge escalation for housing patients was used on 4 occasions and use of extra bed spaces significantly reduced.

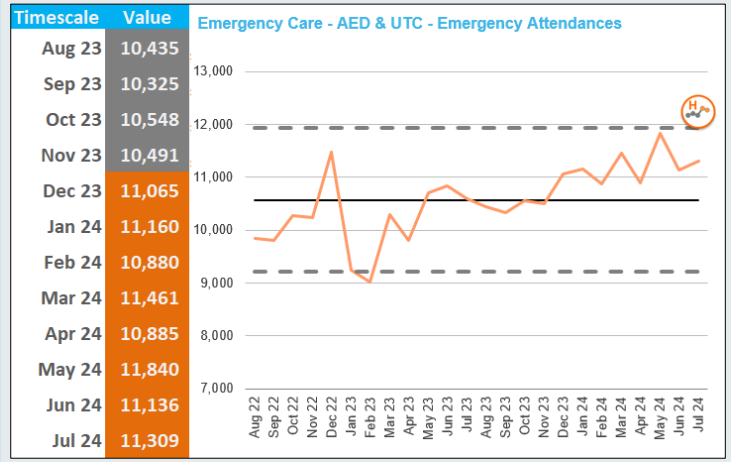
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

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

To ensure patients are cared for in the appropriate setting

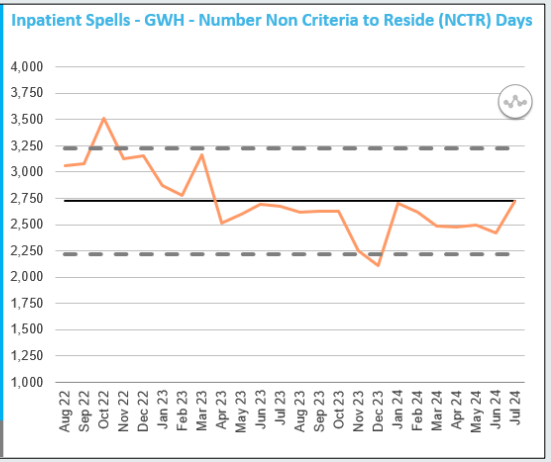
Timescale	Value
Aug 23	10,435
Sep 23	10,325
Oct 23	10,548
Nov 23	10,491
Dec 23	11,065
Jan 24	11,160
Feb 24	10,880
Mar 24	11,461
Apr 24	10,885
May 24	11,840
Jun 24	11,136
Jul 24	11,309



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
Aug 23	2,614
Sep 23	2,631
Oct 23	2,625
Nov 23	2,251
Dec 23	2,106
Jan 24	2,703
Feb 24	2,615
Mar 24	2,484
Apr 24	2,474
May 24	2,500
Jun 24	2,425
Jul 24	2,726



Counter Measures

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

Actions within the Admitted Flow work stream for Urgent and Emergency Care transformation include:

Opportunities:

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

Reflections:

- Standardising discharge processes including discharge summaries and medicine to take away.
- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.

SAFER Summer flow improvement event also completed in July.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

The Trust has seen a downward trend seen in its voluntary turnover rate from July 2022, with performance below the 11% target being sustained for over 12 months. Voluntary turnover in June dropped to 8.0%, reaching its lowest levels since April 2020. Our People Promise Manager continues to drive high-impact actions to further reduce our turnover rate through our Trust Retention Working Group.

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

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

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

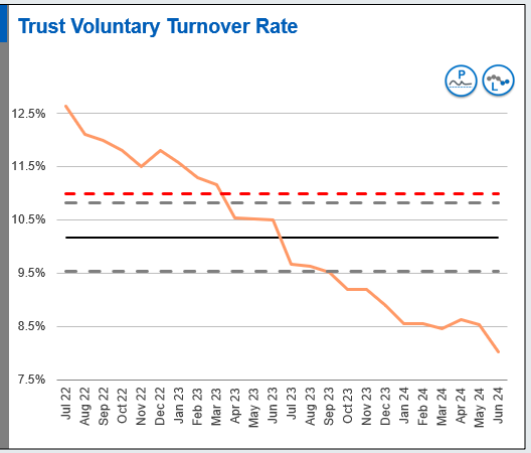
The number of staff who would recommend the organisation as a place to work increase from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey. Pulse survey result has shown a slight decline in results since the annual survey, deteriorating to 55.9% in Q1 and to 55.5% in the latest Q2 survey.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

Timescale	Value
Jul 23	9.7%
Aug 23	9.6%
Sep 23	9.5%
Oct 23	9.2%
Nov 23	9.2%
Dec 23	8.9%
Jan 24	8.6%
Feb 24	8.6%
Mar 24	8.4%
Apr 24	8.6%
May 24	8.5%
Jun 24	8.0%



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 in June has decreased further to 8.0%, reaching its lowest point since April 2020. A reduction in the number of leavers in-month and growth to headcount has put all professional groups under the KPI target of 11%.
- Rolling 12-month leavers within their 1st year of employment has seen a small increase in June to 11%, although still within the KPI target. Admin & Clerical and Unregistered Nursing leavers have driven the in-month increase and remain over-represented in this cohort of leavers.
- The People Promise Manager is progressing high impact actions:
  - Incorporating 'Stay Conversations' into regular 1-2-1 template.
  - Creation of a 90-day induction booklet based off benchmarking and best-practice.
  - Implementation of flexible working and exit interviews within ESR.

- Q2 Pulse Survey results show a small decline in the number of staff who recommend GWH as a place to work, dropping to 55.5%. Registered Nursing and Scientific Staff have shown an increase in this question in Q2 whilst the most noticeable decline is within Unregistered Nursing Staff (7.4% decrease).
- The Health & Wellbeing team are holding a Trust-wide wellbeing event in August offering massage, arts & crafts, and visits from therapy dogs to allow staff an opportunity to unwind and focus on wellness.
- Our wellbeing offering continues in August with the following planned:
  - Physiotherapy in-reach sessions
  - Reflexology session for Orbital staff
  - Mental Health & Suicide First Aid training

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

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

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

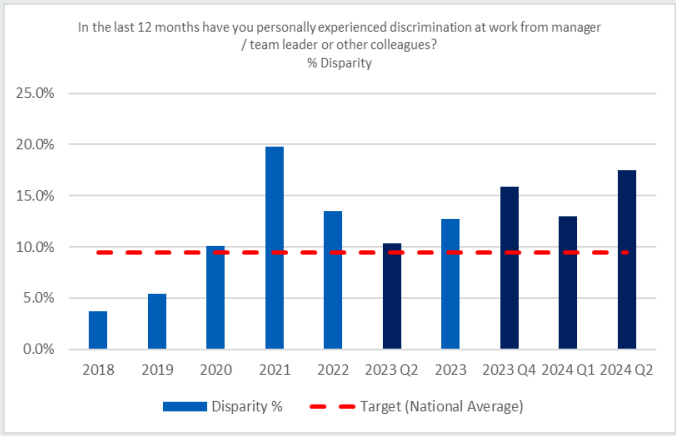
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

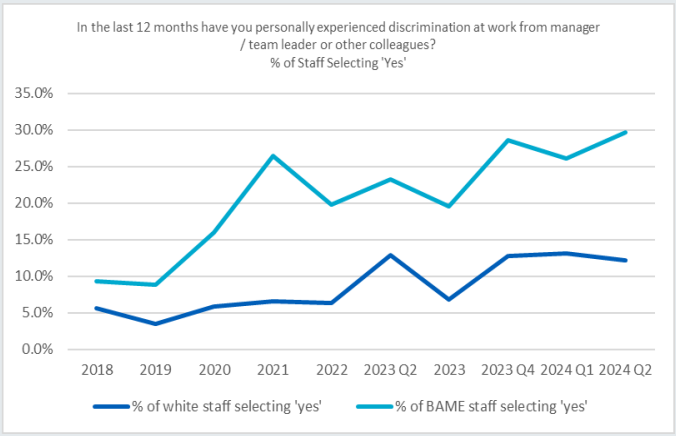
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

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

Jude Gray
Director of Human Resources (HR)

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





Counter Measures

- The Q2 Pulse survey indicates an increase in discrimination disparity. Since the Q1 survey the number of total staff reporting discrimination has slightly risen from 15.4% to 15.9%, however, this is a significant increase from the 2023 annual survey when the measure was 10.2%. In addition, the disparity in experience between black staff and white staff has worsened from 13.0% in Q1 to 17.5% in Q2. 26.1% of ethnic minority staff reported experiencing discrimination in Q1, compared to 29.7% in Q2. To address this negative experience the EDI Lead will continue to recruit, train and deploy EDI Champions, offer Cultural Competence and Addressing Unprofessional Behaviours workshops, work with staff network leads to determine a network response and continue to support the divisional representatives who are delivering local action plans.

- Communications have been issued to promote the Board engagement sessions 'A Slice of Life'. The Trust Board will meet with staff represented by the four staff networks and there are two events open to all staff. Unfortunately, due to low engagement for the LGBTQ+ the first session was cancelled. The next scheduled event is 9th September understanding experience of women and staff from an ethnic minority. A communication plan and direct engagement with networks to ensure engagement at the September event.

- The Trust hosted the 'Addressing Unprofessional Behaviours' train-the-trainer session on 31st July. The workshop was attended by 18 staff including system representatives from AWP, RUH Bath, Salisbury, the local authorities and voluntary sector. System partners will be able to adapt the workshop for internal use. The workshop will be rolled out in GWH from October, the resource is currently going through a CPD accreditation process, alongside the Cultural Competence workshop which will encourage more staff to attend and be able to evidence professional development.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

As at M04 of 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £6.2m, which represents a £3.3m adverse variance to plan. Income is £1.3m favourable to plan driven by ERF (£0.4m) and an overperformance on NHSE-commissioned drugs (£0.9m). The pay position includes c.£0.5m of junior doctor industrial action incurred over June/July. Overall, pay remains £0.5m under plan due to centrally-held reserves (e.g. maternity / paternity leave), which will be used to support divisional pay positions throughout the year. Non-Pay is £5.8m over plan which includes a £3.8m variance in clinical supplies, particularly within Medicine and Surgery, Women's and Childrens'. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. A working group, including Procurement, is analysing the drivers of clinical supply spend with a view to achieving savings.

An internally-generated forecast aligned to current run rate and known changes suggests a gap to plan of £8.3m, however the Trust has a recovery plan agreed with the ICB to improve this back to plan. Factors that play into this improvement include but are not limited to: further ERF stretch through additional activity and coding; improved CIP delivery; no further industrial action costs (and an assumption that costs to date will be reimbursed nationally); and a reduction in non-pay run rate costs.

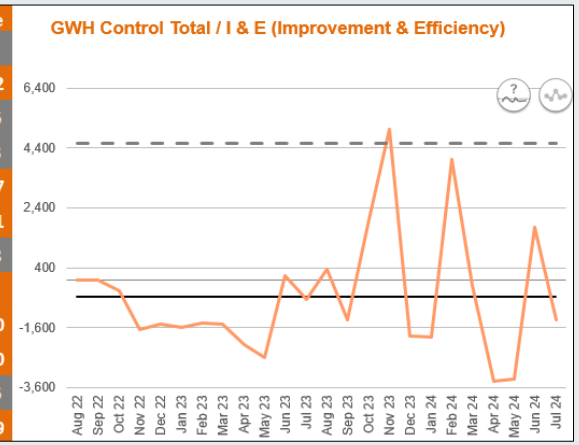
The £3.3m adverse variance to plan includes a £1.8m underperformance against the efficiency target, which is £5.7m as at M04 and £21.9m for the full year. 59% of the £3.9m delivered year-to-date is recurrent. All divisions and services must further increase overall savings to hit the £21.9m target, and specifically ensure the savings are recurrent to reduce the underlying deficit. While ERF activity and associated income is currently above the plan, continuing to maximise activity will be key to delivery of future savings. Divisions and services must also focus on reducing pay and non-pay spend throughout 2024/25. The target is to reduce the number of headcount working in the Trust by 263 compared to March 2022 by the end of the year. Tighter controls around the approval of bank shifts, overtime and WLIs will contribute to this, while continuing with the good work already in place that has resulted in run rate reductions on temporary staffing. Clinical supplies spend should be scrutinised at the point of order, to ensure that we are practicing good governance with the choice and amount of stock being purchased.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Aug 23	330
Sep 23	-1352
Oct 23	1996
Nov 23	5043
Dec 23	-1877
Jan 24	-1911
Feb 24	4028
Mar 24	-185
Apr 24	-3390
May 24	-3320
Jun 24	1766
Jul 24	-1339



Counter Measures

- Efficiency savings were £0.3m behind target in month with pay and non-pay schemes accounting for all of the under delivery. Year-to-date the efficiency programme is £1.8m behind plan with pay accounting for £1.3m, income £0.2m and non-pay £0.3m. Of the £3.9m of savings delivered year-to-date, 54% is recurrent.
- The Trust has a £21.9m target for 24/25 with a heavy focus on workforce related reduction schemes (£12m) and specifically reducing the number of funded posts. As mentioned, divisions and services will need to undertake a thorough review of their resources and processes to identify schemes for recurrent delivery. Increasing productivity by meeting the Trust's activity targets and associated ERF income is also a key objective in 24/25

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

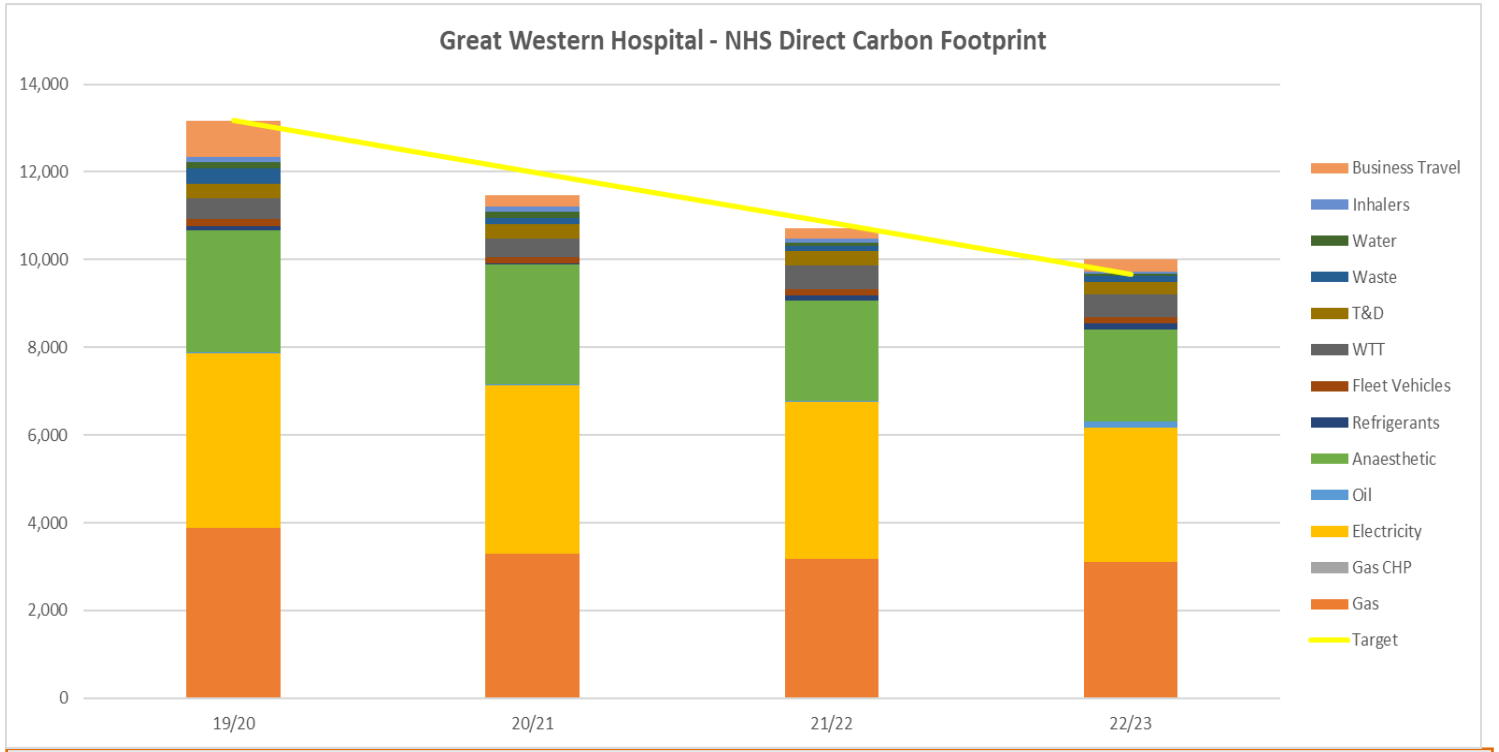
Carbon Footprint / Sustainability

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

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

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

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



Counter Measures

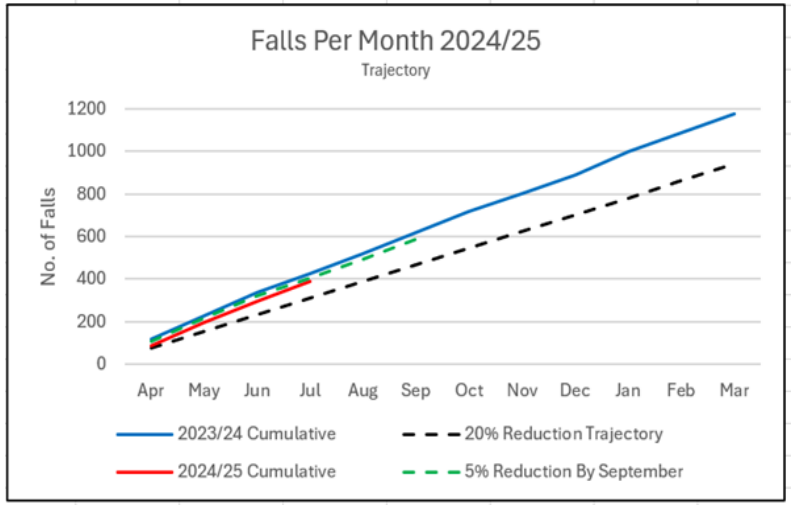
1. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and for indirect emissions by 2045.
2. The Sustainability Team have a full detail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

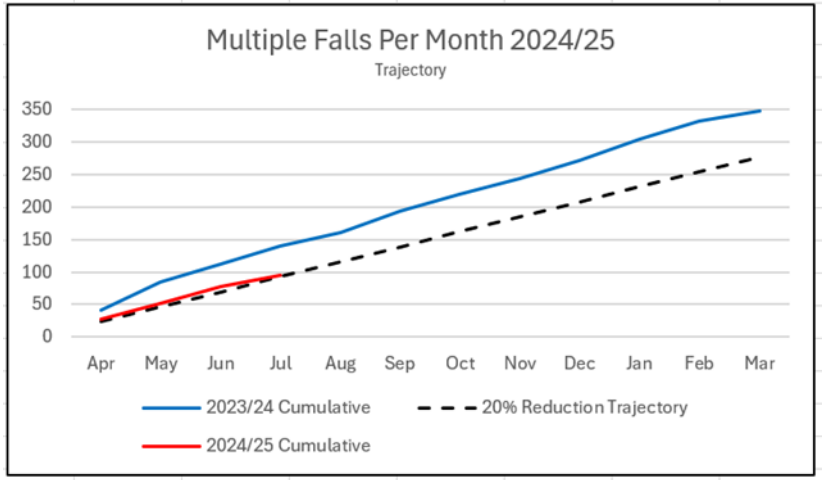
Simon Wade
Chief Financial Officer

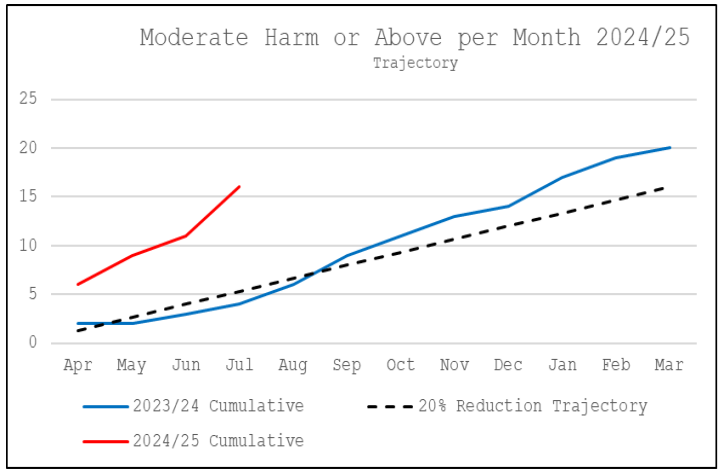
2024/25 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust







Falls per 1000 bed days will be monitored quarterly to provide benchmarking data.
In July the rate was slightly down to 4.9 (5.0 in June).
The number of falls with moderate harm or above has risen slightly with 5 patients experiencing moderate harm or above in July (3 in June).

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

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

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

Performance

The Countermeasures include:
Patients to be encouraged to bring in own foot wear or use of Trust slipper bank.
All patients to have postural blood pressures checked on admission and wards to implement an oversight process of this.
The new enhanced care policy and training to be embedded with a daily process to audit and 'check and challenge' the enhanced levels of supervision are correct.
To prevent deconditioning Wards are identifying champions to support patients sitting out of bed for meals and work to improve handover of mobility status Is ongoing.

Current projects include:
A new project has commenced on Woodpecker, Trauma, Orchard, Jupiter and Mercury. The project aims to introduce a new Bedside Mobility Assessment Tool (BMAT), alongside new manual handling equipment, which combined aims to increase the number of patients getting up and out of bed during the day.

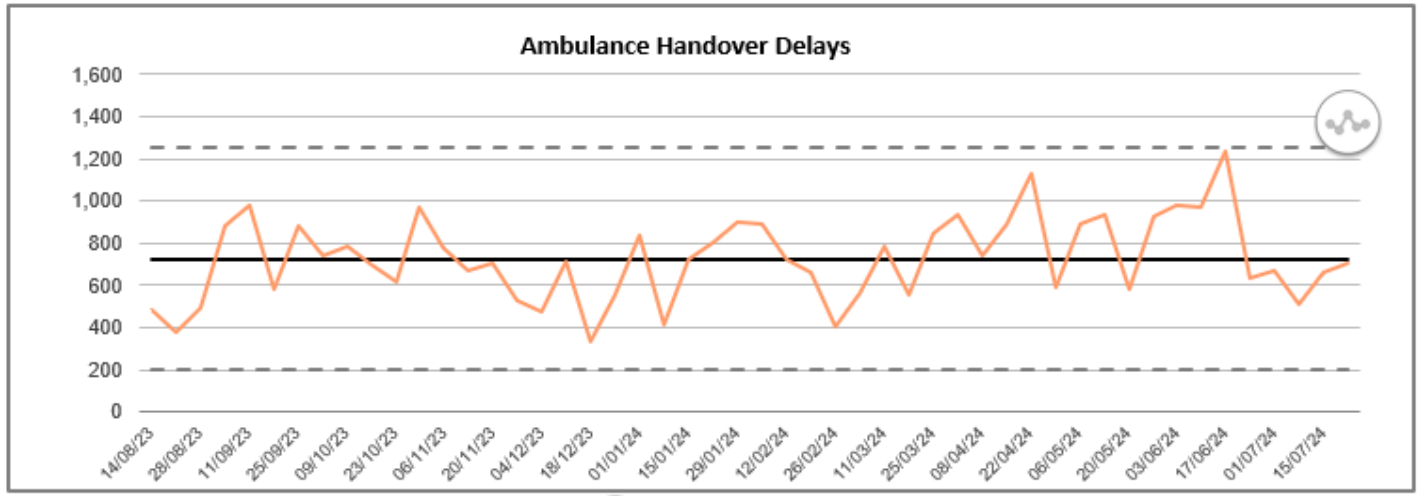
A deconditioning video has been recorded with the support of the Comms Team and Head of Patient Experience and Engagement.

2024/25 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Ambulance Handover Delays

06/05/24	13/05/24	20/05/24	27/05/24	03/06/24	10/06/24	17/06/24	24/06/24	01/07/24	08/07/24	15/07/24	22/07/24
890.0	934.0	584.0	927.0	977.0	968.0	1239.0	633.0	672.0	514.0	658.0	708.0



Common cause - no significant change

Understanding the Data

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

The data is provided daily by the South Western ambulance service. Work is ongoing to improve data quality and data completeness, as some Ambulance providers may not be included in reporting. The SPC control limits also need to be reset to August 2023. This was the point at which 24 Sunflower beds were decommissioned by the Integrated Care Board which were part of the GWH community bed base. Future test of change will therefore review the period August 2023 onwards by resetting the SPC parameters.

We are driving this measure because...

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

Performance

The average hours lost per day to ambulance delays reduced by 40% from 118 hours in June to 71 in July. This was just above the Breakthrough target of under 70 hours of hours lost per day. Whilst improved there remains a significant risk to patient safety and care for patients who require emergency treatment due to the inability to offload ambulances at the point of arrival. This is due to critical capacity of the Trust, Emergency Department, and MAU, & flow throughout the Hospital and to system partners (including out of area patients) (Risk ID 731 and 1085).

An Urgent and Emergency Care transformation programme has been launched to support delivery of the breakthrough objective. These include:

- ED ambulance handover process review, 4 hour RCA process, full ED protocols and non-admitted 4 hour performance focus (Emergency Flow)
- Early identification of medical and surgical patients to move to discharge lounge (12 by 12pm) to create early flow from ED to Assessment Units and actions to increase overall usage (Hospital flow)
- Focus on Ward processes in Medicine and Surgery with lowest discharges before 12pm and understanding current usage of criteria led discharge. Quantification of impact and timing from system supported interventions to reduce no criteria to reside. (Admitted Patient Flow)
- Development of NHS@Home pathways and pilot with Saturn ward to increase referrals (Out of Hospital Flow)

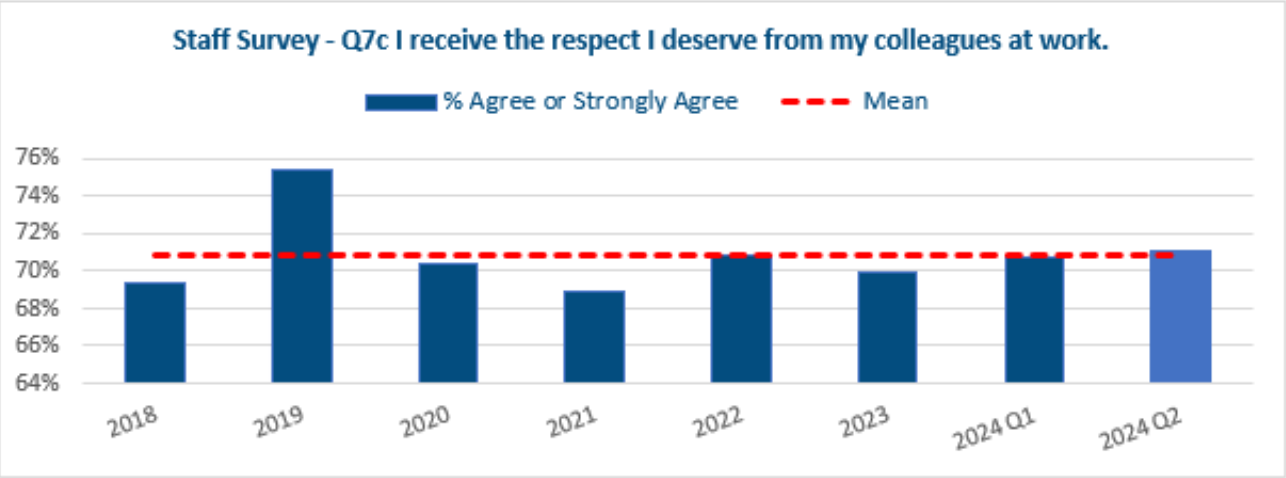
Current performance in ED is showing improved metrics across the board especially in 4 hour performance where the Trust has regularly been in the top 25 nationally for type 1 and 3 performance in July.

2024/25 Breakthrough Objectives

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

Great Western Hospitals NHS Foundation Trust

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



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- The Q2 Pulse Survey results show a small increase in the number of staff who agree/strongly agree that they receive the respect they deserve from colleagues at work, increasing to 71.1%.
- Staff were able to provide free-text comments on what respect feels like to them at work and how they demonstrate this. Analysis of these comments show the prevalent themes relate to 'communication', 'listening', 'equality & fairness', 'understanding & empathy', and 'support & teamwork'. This culminates in a view that respect relates to 'belonging to a team and culture where staff are valued, heard, and all voices matter'.
- Countermeasures lead by the Trust Staff Survey Working Group continue, focusing on :
  - Launch of Trust-wide recognition scheme (e-cards) w/c 12th August
  - Expectations of Line Managers toolkit/training in November 2024
  - Creation of an infographic to communicate staff's expectations around respect aligned to the STAR values from colleagues based off Q2 Pulse Survey feedback
  - Launch of the great place to work campaign at the end of August

Risks

- Significant risk to staff morale and engagement due to current financial challenges and requirement to reduce our workforce.
- Clinical division's breakthrough objectives whilst aligned to our strategic pillar are not the same as the Trust breakthrough objective, therefore strategic focus is not aligned.
- Competing demands on reduced workforce in People Services.

2024/25 Breakthrough Objectives

Financial Recovery

Great Western Hospitals NHS Foundation Trust

Understanding the Data

The data shows that, if we continue at the current run rate of income and expenditure, we are likely to be c.£18m deficit by year end, compared to a c£10.2m planned deficit. We are also likely to fall short of our CIP target, with a material amount of non-recurrent CIP needing to be found recurrently again next year.

We are driving this measure because…

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

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

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

Performance

- We had a slight improvement on the year-to date average monthly deficit at Month 4, which led us to a c.£6.6m YTD deficit (c£3.3m adverse to plan). This position includes c£0.5m industrial action costs, as well as c.£1.8m behind plan on CIP delivery. The remainder of the overspend is due to various ups and downs, but a key area of focus is the non pay spend on clinical supplies, which remain high compared to last year.

- Actions focussing on the Countermeasures include:
  - Training needs analysis on whole Trust for general financial acumen.
  - Financial Data accessible through SBS Business Intelligence System may not be as user-friendly as needed.
  - Agree ideal number of requisitioners with Div Tri and reduce down as appropriate.
  - Validate training offered by SFT Procurement Team and enhance where needed.
  - Ensure TMC message shared consistently throughout Div Board / specialty boards / team meetings etc.

Risks

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

- Competing demands on reduced workforce in Finance

Our Care

Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		70%	68%	62%	62%	
	No. of complaints received	SPC		79	78	54	70	
	Number of reopened complaints	SPC		3	1	2	0	
IP & C	C.Diff	3.75		3	4	7	4	
	E.coli	5.9		7	12	10	10	
	Klebsiella	2		4	5	2	4	
	Pseudomonas	1.08		4	0	1	5	
FFT	Overall response rate (%)	28% (Int)		33%	27%	24%	26%	
	ED & UTC Response Rate	17% (Int)		14%	14%	15%	15%	
	Inpatients Response Rate	23% (Int)		22%	21%	19%	21%	
	Daycases Response Rate	22% (Int)		22%	22%	19%	21%	

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

Performance & Counter Measure

The complaint response rate remained at 62% with no change from June. Additional support continues to be provided to the Division of Medicine to facilitate the management and closure of complaints. An improved process for allocation of investigators has been developed to help ensure capacity for a timely response.

The overall number of complaints received in month has increased to 70 when compared to June. The number of re-opened complaints is zero in month.

NHS England have yet to set trajectories for infections in 2024/25, so the targets given are estimates based on previous NHSE methodology and are subject to change. *E. coli* and *Klebsiella* numbers remain high compared to our peers, with urinary infections being the main contributor. An external audit of catheter practice is currently taking place and will feed into the Continence Group's action plan. *Pseudomonas* cases rose in July and we are investigating a cluster of three possibly related cases on one ward. *C. diff* numbers returned to normal after a spike in June and the Trust remains close to trajectory.

The FFT overall response rate has risen but remains below target in July. Emergency Department (ED) and Urgent Treatment Centre (UTC) response has increased slightly in month.

We have seen increase in response rates across all areas with the ED positive response rate remaining on target. We are currently investigating procurement options for our FFT provider to increase our response rates.

Risks

- Vacancies within PALS (Patient Advice and Liaison Service) team currently covered with bank. This is significantly impacting on the PALS workload, particularly at a time of continued staff shortage.
- Rise in backlog of complaints and failure to response in a timely manner is negatively impacting on patient experience.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24
Harm	Patient safety incident investigation	SPC		1	4	4	0
	Falls rate per 1000 bed days	SPC	L	4.6	5.8	5	4.9
	No. of Falls in month	SPC	L	86	113	98	93
	No. falls with moderate harm or above	SPC		6	3	2	5
	Medication incidents with moderate harm	SPC		3	3	5	6
	Pressure Ulcer (Hospital Acquired)	SPC		21	23	35	25
	Pressure Ulcer (Community Acquired)	SPC		32	21	16	25
Concerns and Complaints	No. of concerns received	SPC		203	371	334	441
IP & C	MRSA	0		0	0	0	0
	MSSA	1.83		1	1	1	2
	COVID (hospital acquired)	SPC		14	12	15	29

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

Performance & Counter Measure

There are a total of 8 Serious Incident Investigations and 7 Patient Safety Incident Investigations (PSII) in progress. There were no PSII's reported in month of July. There is a trajectory to close all investigations on the old SI framework and eliminate any overdue investigations by September.

The number of falls has decreased in month to 93 in July (98 in June). There has been 5 falls with moderate harm or above this month.

There was a fall in hospital-acquired category 2-4 pressure ulcers from 35 in June to 25 in July. Four were category 3 and there were zero category 4 ulcers. Forest and Trauma Wards continue to be top contributors to pressure harm numbers, with four on each ward. Trauma Ward remain in a period of enhanced support and Forest Ward staff have been brought together in a meeting to discuss the need for improvements.

There was a slight increase in community pressure ulcer harms in July (25) involving 17 patients (16 in June). 11 of these harms were associated with patients on an end of life pathway. The majority of harms were reported at Category 2 (16) with 3 category 3 harms identified. Improvement actions include working with the surgical division on the end of Life pathway to reduce harms and fortnightly training on the pressure ulcer risk assessment tool.

Methicillin-Susceptible Staphylococcus Aureus (MSSA) and COVID numbers remain low compared to previous years and there have been zero Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections so far in 2024/5.

We have seen a significant rise in the number of concern cases handled by the PALS team with a key theme of waiting times. Divisional reporting has commenced to target improvement work on this issue.

Risks

- Patient concerns raised about lack of accessible information in line with the requirement of the Accessible Information Standard and Equality Act. Deputy Chief Nurse leading on new implementation group.
- Patient and staff concerns regarding lack of disability access within GWH in line with Equality Act requirements. This includes heavy doors, lack of blue badge spaces close to building, lack of lighting, blue lights in toilets. Estates team leading on plan and await capital funding.

Our Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	94%	93%	94%	95%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	104%	108%	108%	108%
FFT	Positive response (%)	86% (Int)	?	90%	87%	87%	88%
	ED & UTC Positive Responses	79% (Int)	?	81%	77%	79%	79%
	Inpatients Positive Responses	86% (Int)	?	90%	89%	90%	91%
	Daycases Positive Responses	95% (Int)	?	95%	95%	95%	95%
	Outpatients Positive Responses	97% (Int)	?	98%	97%	98%	98%
	Maternity Response Rate	19% (Int)	?	21%	25%	26%	25%
	Maternity Positive Responses	92% (Int)	?	90%	93%	92%	93%

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

Performance & Counter Measures

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

The FFT overall response rate is 25.8% this month, an improvement of 2.1% from June (23.7%). The positive response rate remains similar to last month at 88.1% in July, (87% in June and below the internal target of 90%.

The inpatient positive response rate has increased by 1.6% with an increased response rate of 2.1%. Maternity has seen a small increase in positive response rate of 0.4%.
A Patient engagement event held (July 24th) to discuss digitalisation of appointment letters. Very successful with generation of ideas and areas for further investigation and improvement.
The latest cohort of Improving Together trainees now using patient feedback data to base improvement ideas on and the Head of Patient Experience and Engagement attending Improving Together sessions to support with involvement of patients and request that all cohorts add an improvement target to support patient discharge process.

Engagement event held with carers to gain feedback and explain GWH processes. We have added a new carer referral email so that wards and departments can contact the carer support service for advice and visit any carers. This is prompted via a mandatory carer assessment on Nervecentre.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24	Trend
RTT	No. of >=18 weeks waiters		H	18451	18637	19892	20650	
	No. of >=52 weeks waiters		H	1859	1909	1885	1941	
DM01	No. of patients on DM01 waitlist			9961	9335	9064	One month behind	
	DM01 performance %	99% (Nat)	F	60.7%	66.9%	70.6%	One month behind	
	DM01 6 week wait breaches		H	3912	3090	2669	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	63.1%	65.1%	69.4%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	83.4%	87.6%	89.5%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	40.8%	42.2%	40.7%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	59.2%	66.7%	70.2%	One month behind	

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

Performance & Counter Measure

Diagnostics

July's DM01 performance is showing an increase in performance variance from the 755% performance in June to 70.72% - this is the highest DM01 since July 2021. The number of patients on the waiting list has decreased by 245 to 8,819 driven by the by the continued work to improve NOUS.

Counter measures: Radiology have procured a specialist CT outsourcing provider to support on the mobile pads with complex scans which make up the majority of the long waiters (Cardiacs and Colons). Activity for the imaging vans on the CDC site is now achieving 90% utilisation for MRI and CT.. Endoscopy usage remains lower than planned but work with RUH undertaken to close the gap. Ultrasound still remains the largest issue with 3,223 on the waiting list and 1,382 over 6 week. Medicare continue to support US activity on site with levels increasing as they increase support to the team. A locum sonographer is also being sourced to help with the more complex long waiters.

Cancer

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin & Breast pathways with 96% of the breaches being accounted for by these two services.

81.8% of the 62-day breaches were with the Skin, Breast, Colorectal & Urology pathways.

Cancer waiting times for first appointment remain below standard. Breast and Dermatology are the largest contributors with 73.7% of all breaches. Capacity for outpatients were the main factors in these breaches.

In June, 65.7% (314) of the 28-day breaches were for across 3 tumour sites (Colorectal & Urology, Breast)
Counter Measures
- Work is underway with the TVCA to implement the Best Practice Timed Pathways across 3 (Lower GI & Urology) of these Pathways.
-OUH unable to meet Plastic Surgery SLA agreement to provide 9.5 PA/week since Nov/Dec 23. Provision in OUH SLA for additional clinic PAs in Plastics has been approved, now with OUH to assess. External provision of MOP clinics in Wootton Bassett for eligible patients ongoing. Locum from OUH to provide 3 PAs to commence May.
-External Derm team has been retained to assist with capacity through 24/25 providing 1800 new patient appointment slots
-Funding secured and in use to assist with additional one stop clinics in Breast pathway
-Funding for external provision of LATP biopsies in Prostate pathway approved. Funds will also be used to support cystoscopy capacity in the Bladder pathway. This is due to commence late August.
-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. Additional targeted PTL reviews in main challenged sites are now also in place to focus on patients at day 48 and beyond. This will ensure patients will have next steps planned at the earliest available time.

Cancer referrals remain above pre covid levels (28%), resulting in capacity issues in a number of sites. The services are providing WLI activity to support where possible, though cancer performance is adversely affected where this is insufficient.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	75.9%	75.3%	75.0%	77.1%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	7.5%	6.6%	6.9%	5.2%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	56.2%	56.5%	54.2%	58.2%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	15.7%	13.6%	14.2%	10.7%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	94.0%	91.8%	94.7%	95.1%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	3272.00	3013.78	3667.81	2296.43	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1472	1702	1647	1691	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	92%	91%	91%	89%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1117	1231	1260	1213	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	69.6%	66.1%	70.0%	64.1%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	824	839	916	781	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	51.4%	45.1%	50.9%	41.3%	
Flow	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	274	371	378	340	
	Community Average Length of Stay (Days)	SPC	H	22	23	21	22	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4 hour performance (type 1 and 3) slightly increased from 75% to 77%. Throughout July the Trust was in the top 25 in the country. This is due to Type 3 performance continuing to significantly improve from 94.7% to 95.1%. Type 1 4 hours performance improved by 4% from 54.2% to 58.2%.

Total % over 12 hours decreased significantly from 14.2% to 10.7% showing the improvements made across the whole ED pathway.

Number of ambulance handovers over 30 minutes has decreased from 1260 to 1213.

Number of ambulance handovers over 60 minutes significantly decreased from 50.9% to 41.3%

Counter measures remain in place within the Breakthrough objective slides.

Risks

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

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

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

Our Performance

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24
RTT	No. of >=78 weeks waiters	SPC	L	3	4	3	3
Cancer	No. of referrals received	SPC		1831	1967	1858	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.0%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5212	5587	5415	5525
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	78.6%	80.1%	80.0%	82.6%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		59.3%	60.2%	60.6%	60.8%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		38.0%	36.8%	55.2%	52.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	199	199	189	183
	Emergency Care - AED - Median Stay	240 (Int)	?	238	238	239	237
	Emergency Care - UTC - Median Stay	240 (Int)	P	170	169	145	140
	Total Number of Ambulance Handovers	SPC	L	1604	1861	1801	1891
	Average hours lost to ambulance handover delays per day	SPC		109	94	118	71

Performance & Counter Measure

ED

Number of ambulance conveyances increased from previous month from 1801 to 1891. Average hours lost decreased in June from 118 to 71.

Triage performance for ED has improved again rising from 60.6% to 60.8%. Significant improvement in Type 3 triage performance now that additional capacity is in place.

Median stay has decreased to 237 mins in ED and a big decrease in median stay seen in UTC (140mins down from 145)

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		656	598	594	524
	Elective Patients Average Length of Stay (Days)	SPC	L	3	3	3	3
	Non-Elective Patients Average Length of Stay (Days)	SPC	L	5	4	5	5
	GWH Discharges by Noon (%)	SPC		15.6%	16.8%	16.8%	17.2%
	Number of Stranded Patients (over 14 days)	SPC		121	112	122	130
	Number of Super Stranded Patients (over 21 days)	SPC		69	63	67	78
	Adult general and acute type 1 bed occupancy	SPC		94.9%	95.2%	95.7%	94.5%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	L	18.6%	18.2%	18.2%	20.1%
	Proportion of patients discharged from hospital to their usual place of residence	SPC	H	95.7%	95.2%	95.4%	95.7%

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Performance & Counter Measure

Patient Flow

- Discharges prior to Midday at 18% not the recorded 17.2% on data set.
- Data set reports increase in stranded patients over 14 days - mitigations in place: NCTR daily calls, BSW senior flow calls daily, MADE's and Summer SAFER.

Changes in National NCTR guidance Jan 24 - will impact within different pathways (PW). These are further changing with guidance released on the 30th April. **This work is underway at system level to implement the changes in coding - this will be introduced 14th August. This is on track to be rolled out – comms was shared the start of August Trust wide**

PW0's – will now be inclusive of restarts and return to care homes – these were in PW3 and PW1's.
PW1 – will be any temporary/short term care provision or intermediate care
PW2 – Bed based rehab or intermediate care
PW3 – Permanent placements
This has further developed with coding changes for sitrep reports - Informatics are supporting with this and reporting progress at system level. GWH leading for BSW.

Risks

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

Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24
Use of Resources	Capital Expenditure (£'000)	SPC		42	2576	1793	2325
	Pay (£'000)	SPC		25246	25849	24562	25158
	Non Pay (£'000)	SPC		17366	18098	17264	17712

Performance & Counter Measure

Year-to-date capital spend at M4 is £6.7m against a plan of £13.0m, giving an underspend against plan of £6.3m. Key drivers are EPR, CDC and PFI lifecycle.

Pay costs are £0.6m higher than M3 due to accrued pay award and additional nursing temporary staffing spend as a result of increased RMN/escalation coverage

Non-Pay is £0.4m higher than M3 driven by clinical/non-clinical supplies (£0.3m) and drugs (£0.1m)

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

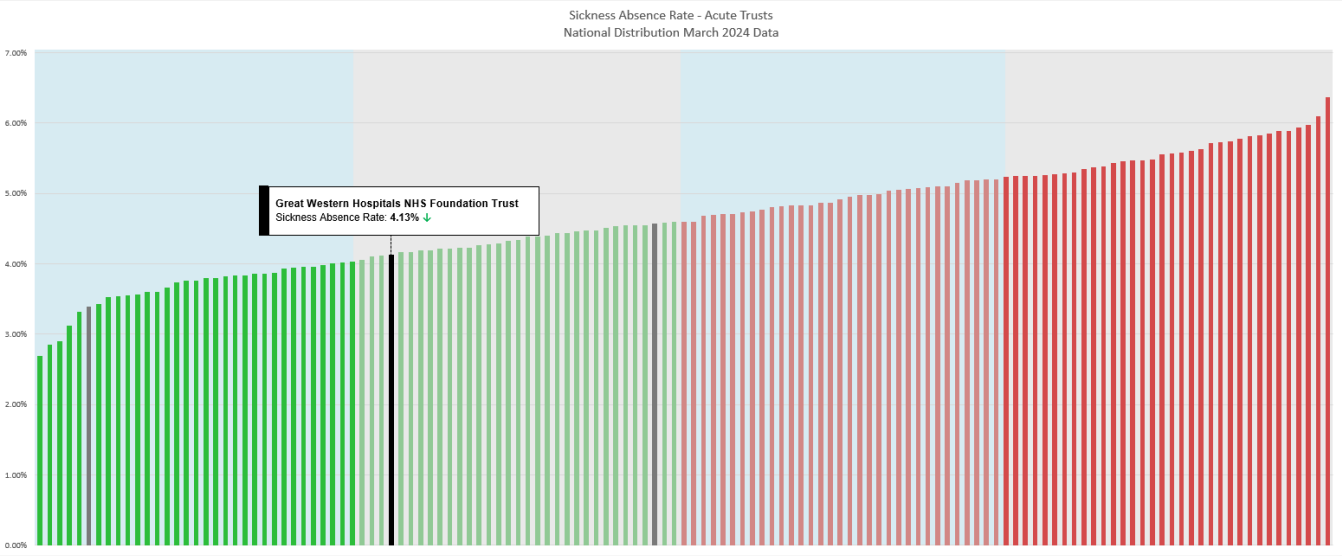
Risks

The Trust started the year with a £21.9m cash releasing efficiency plan. As at M4 delivery is £1.8m behind plan with 54% of the £3.9m delivered being recurrent. The risk is that any unmet or non-recurrent delivery adds to the underlying deficit of the Trust. Divisions and services must work to develop recurrent cash releasing schemes. There is a key focus on workforce savings in 24/25, with pay schemes accounting for £12m of the £21.9m plan.

Our People

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24	Trend
	Trust sickness absence rate	3.5% (Int)	F	4.2%	4.2%	4.6%	One month behind	



Performance & Counter Measure

- Sickness absence has increased from 4.21% in May to 4.61% in June, driven by an increase in short-term absence which rose from 1.88% to 2.49%.
  - Whilst Stress/Anxiety/Depression continues as our top reason for absence in June (20% of all sickness), Cold/Cough/Flu has increased in June and now accounting for 9.6% of absence as our second most prevalent reason.
  - Following a review by the Trust Sickness Absence Lead, managers of hot-spot areas for sickness absence will receive support from the People Operations team to analyse their data, manage short-term sickness within policy, and receive extended training across the department on sickness absence management.
- Benchmarking data (March 2024 - NHS Digital) shows a drop in national absence levels of 0.36% in March, decreasing from 5.10% to 4.74%. This trend was replicated regionally with South West absence dropping from 4.99% to 4.63%, and within the ICB dropping from 4.56% to 4.28%. Our absence rate in this period reduced further to 4.13%, remaining below the South-West and BSW position. A larger reduction was seen across other Acute's putting us in the second lowest quartile for Acute Trusts (37th out of 133).

Risks

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

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

Our People

NHS Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-24	May-24	Jun-24	Jul-24
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	10.7%	9.7%	11.0%	One month behind

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

Performance & Counter Measure

- Leavers within their 1st year of employment has increased in June to 11%, although under the target of 14.8%. Initial analysis of this cohort of leavers shows Unregistered Nursing and Admin & Clerical staff are over-represented compared to their proportion of the total workforce.
- Response rates for the Q2 Pulse Survey increased to 24% (compared to 23% in Q1).

Risks

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

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

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Trend Vs Last Month	Trend Vs Jul-23
		Vacancy																	
	W	Vacancy Rate	%	7.00%	7.82%	5.95%	4.87%	4.33%	3.93%	3.74%	4.12%	4.11%	3.93%	4.19%	4.04%	3.98%	3.44%	↓	↓
	W	Vacancy Rate	WTE	-	424.68	320.44	262.33	232.95	211.39	201.47	223.67	223.82	213.76	227.43	219.66	216.12	186.71		
	W	All Nursing Vacancy	%	7.00%	5.00%	2.73%	1.96%	1.30%	1.94%	1.43%	2.75%	2.39%	2.21%	2.20%	1.73%	1.73%	0.96%	↓	↓
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	133.58	71.58	51.43	34.17	51.03	37.87	73.60	63.97	59.14	58.90	46.13	46.07	25.61		
	W	All Registered Nursing Vacancy	WTE	-	103.62	74.83	47.47	18.62	26.55	9.50	28.02	14.37	9.70	4.67	4.75	14.57	5.24		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	59.84	42.58	23.20	3.60	8.44	-3.79	5.29	-3.91	-7.35	-19.60	-12.95	-3.59	-11.35		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	29.96	-3.25	3.96	15.55	24.48	28.37	45.58	49.60	49.44	54.23	41.38	31.50	20.37		
	W	Medical Vacancy	%	7.00%	10.34%	7.28%	5.22%	5.66%	5.26%	5.89%	7.07%	7.96%	7.47%	8.30%	6.78%	6.67%	7.82%	↑	↓
	W	Medical Vacancy	WTE	-	76.03	53.43	38.22	41.48	38.61	43.30	53.08	59.82	56.06	62.23	50.71	49.94	58.44		
	W	STT/AHP Vacancy	%	7.00%	13.04%	13.04%	10.41%	9.20%	6.88%	6.44%	4.87%	4.78%	3.74%	3.39%	3.67%	3.63%	3.00%	↓	↓
	W	STT/AHP Vacancy	WTE	-	113.09	112.95	90.28	79.85	58.89	54.92	41.53	40.83	31.72	28.78	31.27	30.91	25.62		
	W	SMA Vacancy	%	7.00%	8.80%	7.13%	7.12%	6.70%	5.44%	5.66%	4.80%	5.09%	5.76%	6.68%	7.77%	7.58%	6.57%	↓	↓
	W	SMA Vacancy	WTE	-	101.98	82.48	82.40	77.45	62.86	65.38	55.46	59.20	66.84	77.52	91.55	89.20	77.04		
	W	Recruitment Time to Hire - AFC	Days	46.00	49.10	45.00	41.70	42.70	41.80	43.50	44.40	42.70	38.40	39.50	39.40	43.20	40.40	↓	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	50.40	46.00	43.50	37.00	39.90	45.20	42.00	50.30	39.30	43.30	33.30	44.00	22.90	↓	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	0.00	0.00	0.00	0.00	0.00	0.00	64.30	66.10	32.60	39.00	39.44	35.30	44.20	↑	↑
		Workforce Utilisation																	
	W	Establishment WTE	WTE	-	5,433.60	5,382.13	5,381.76	5,379.33	5,382.66	5,382.34	5,431.15	5,446.50	5,433.90	5,433.90	5,437.81	5,434.79	5,430.70		
	W	Substantive WTE	WTE	-	5,008.92	5,061.69	5,119.43	5,146.38	5,171.27	5,180.87	5,207.48	5,222.68	5,220.14	5,206.47	5,218.15	5,218.67	5,243.99		
	W	Additional Substantive WTE	WTE	-	29.97	25.73	22.95	26.89	24.63	25.22	21.90	22.51	24.78	20.17	5.53	8.24	9.23		
	W	Bank WTE	WTE	-	315.54	298.46	277.29	280.45	260.02	246.43	295.57	294.32	380.50	286.32	301.97	326.11	333.04		
	W	Agency WTE	WTE	-	98.88	86.02	80.48	66.71	60.65	55.12	61.82	69.47	60.09	49.52	43.70	38.63	45.95		
	W	Budgeted vs Worked WTE Variance	WTE	-	19.71	89.77	118.39	141.10	133.91	125.30	155.62	162.48	251.61	128.59	131.54	156.87	201.51		
	W	Actual Worked vs Budgeted %	%	-	100.36%	101.67%	102.20%	102.62%	102.49%	102.33%	102.87%	102.98%	104.63%	102.37%	102.42%	102.89%	103.71%		
	W	Total Workforce Cost £	£	-	£24.82M	£24.44M	£26.42M	£25.47M	£24.85M	£25.09M	£25.67M	£25.39M	£25.92M	£25.13M	£25.50M	£25.21M	£25.57M		
	W	Agency Spend as % of Total Spend	%	4.50%	4.15%	2.62%	3.11%	4.56%	3.56%	1.22%	2.83%	2.83%	2.04%	1.83%	1.30%	2.01%	1.94%	↓	↓
	W	Agency Spend £	£	-	£1.03M	£0.64M	£0.82M	£1.16M	£0.89M	£0.30M	£0.73M	£0.72M	£0.53M	£0.46M	£0.33M	£0.51M	£0.50M		
	W	Agency Target £	£		£0.76M	£1.06M	£1.17M	£1.07M	£0.91M	£1.10M	£0.91M	£0.86M	£0.96M	£0.54M	£0.52M	£0.51M	£0.49M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	£0.27M	-£0.42M	-£0.35M	£0.09M	-£0.03M	-£0.79M	-£0.18M	-£0.14M	-£0.44M	-£0.08M	-£0.19M	£0.00M	£0.01M	↑	↓
	W	Bank Spend £	£	-	£2.37M	£2.34M	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	£1.89M	£2.02M	£2.23M	£2.32M		
	W	Bank Target £	£		£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£2.19M	£2.12M	£2.04M	£1.96M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£2.37M	£2.34M	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	-£0.31M	-£0.10M	£0.19M	£0.36M	↑	↓
	W	Registered Nursing Bank Fill	%	45.00%	82.92%	81.78%	81.62%	84.87%	86.80%	87.74%	90.73%	90.69%	90.40%	90.86%	94.13%	90.81%	85.23%	↓	↑
	W	Unregistered Nursing Bank Fill	%	70.00%	79.98%	77.52%	81.35%	79.99%	84.45%	81.80%	80.12%	79.46%	78.92%	81.89%	87.18%	86.23%	79.50%	↓	↓

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Trend Vs	
																		Last Month	Jul-23
		Retention																	
	W	All Turnover %	%	13.00%	12.74%	12.69%	12.56%	12.20%	12.00%	11.49%	10.98%	10.90%	10.72%	10.85%	10.57%	10.24%	-	↓	↓
	W	Voluntary Turnover %	%	11.00%	9.67%	9.62%	9.52%	9.20%	9.19%	8.89%	8.55%	8.56%	8.45%	8.62%	8.53%	8.02%	-	↓	↓
	W	Number of Leavers	Headcount	-	53	46	63	41	44	42	44	40	62	44	46	58	-		
	W	Number of RN Leavers	Headcount	-	12	14	18	11	14	11	21	10	15	12	17	20	-		
	W	Registered Nursing Vol Turnover	%	-	6.48%	6.61%	6.50%	6.57%	6.95%	6.99%	7.07%	7.16%	7.19%	7.33%	7.52%	7.17%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	7	13	21	10	8	15	7	11	13	11	10	13	-		
	W	Unregistered Nursing Vol Turnover	%	-	12.93%	12.73%	13.35%	12.65%	12.34%	11.86%	12.01%	11.21%	10.87%	11.16%	11.00%	10.91%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	16.02%	14.39%	14.74%	14.44%	13.35%	13.96%	12.14%	11.86%	11.72%	10.68%	9.74%	10.98%	-		
	W	Number of starters	Headcount	-	89	56	103	58	65	35	78	35	46	57	44	55	-		
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.11%	4.08%	4.11%	4.24%	4.32%	4.42%	4.48%	4.47%	4.44%	4.41%	4.40%	4.46%	-	↑	↑
	D	Sickness Absence %	%	3.50%	4.43%	4.03%	4.21%	4.74%	4.70%	4.98%	4.91%	4.36%	4.16%	4.21%	4.21%	4.61%	-	↑	↑
	W	Long Term Sickness %	%	2.00%	2.61%	2.20%	2.10%	2.41%	2.40%	2.65%	2.63%	2.40%	2.24%	2.24%	2.34%	2.12%	-	↓	↓
	W	Short Term Sickness %	%	1.50%	1.82%	1.83%	2.11%	2.33%	2.31%	2.33%	2.28%	1.96%	1.92%	1.97%	1.88%	2.49%	-	↑	↑
	W	Sickness Absence Cost £	£	-	£664.8k	£626.3k	£614.8k	£738.9k	£726.5k	£794.0k	£777.2k	£647.1k	£669.2k	£675.4k	£708.3k	£748.9k	-		
	W	WTE Days Lost	WTE	-	6,781.2	6,256.4	6,401.2	7,487.3	7,187.9	7,922.9	7,774.7	6,566.1	6,618.1	6,482.7	6,662.1	7,157.7	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	89.90%	90.10%	90.36%	90.75%	91.38%	91.88%	91.49%	91.72%	92.31%	92.46%	91.37%	91.59%	92.42%	↑	↑
	W	Role Essential MT %	%	85.00%	91.40%	91.64%	91.93%	92.20%	92.77%	93.14%	92.92%	93.28%	93.79%	94.03%	91.84%	92.30%	94.14%	↑	↑
	W	CQC Safe MT %	%	85.00%	88.38%	88.56%	88.78%	89.32%	90.01%	90.64%	90.07%	90.16%	90.85%	90.90%	90.86%	90.84%	90.71%	↓	↑
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	76.28%	79.91%	68.93%	83.26%	83.85%	85.24%	86.22%	85.23%	86.51%	84.26%	83.54%	82.60%	84.77%	↑	↑
	W	Appraisal Compliance %	%	85.00%	83.94%	84.29%	84.88%	84.92%	83.62%	85.63%	84.32%	84.85%	85.26%	84.18%	84.39%	84.74%	84.88%	↑	↑
	W	Non Medical Appraisal Compliance %	%	85.00%	83.29%	84.24%	84.89%	84.91%	83.81%	85.37%	84.06%	84.37%	84.59%	84.40%	83.99%	84.87%	84.95%	↑	↑
	W	Medical Appraisal Compliance %	%	85.00%	88.64%	84.64%	84.84%	85.04%	82.25%	87.59%	86.32%	88.38%	90.10%	82.58%	87.32%	83.81%	84.40%	↑	↓

Our People

Workforce Scorecard

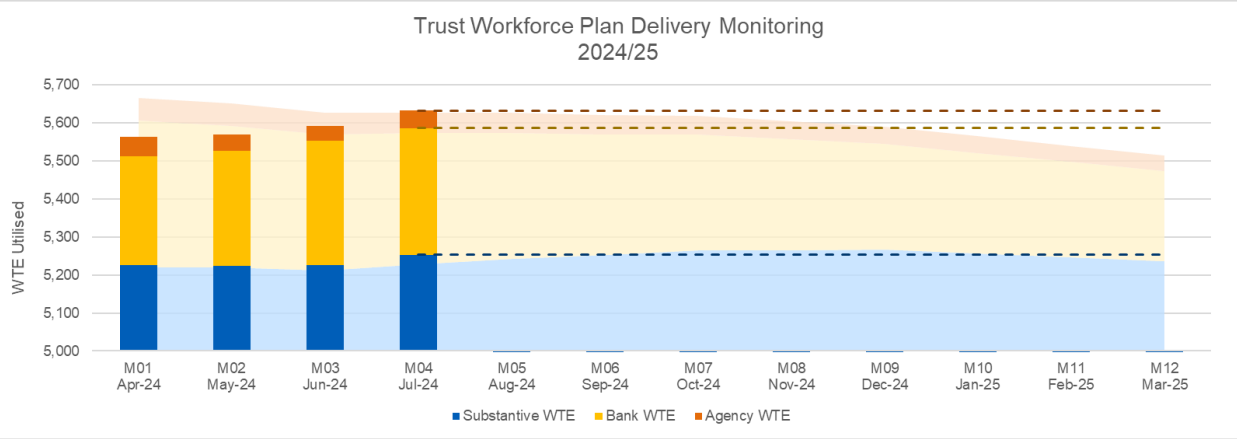
NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Trend Vs	
																		Last Month	Jul-23
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.13%	4.17%	4.18%	4.12%	4.21%	4.19%	4.23%	4.26%	4.28%	4.28%	4.23%	4.26%	4.29%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	252.00	257.00	260.00	258.00	265.00	264.00	268.00	271.00	272.00	272.00	269.00	271.00	273.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	70.24%	70.82%	71.15%	70.93%	71.32%	71.59%	71.27%	71.22%	70.59%	70.59%	69.89%	70.11%	70.33%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	5.95%	6.61%	6.54%	6.20%	6.79%	6.82%	6.34%	6.64%	6.25%	6.25%	6.32%	6.64%	6.59%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.93%	0.93%	0.92%	0.91%	0.92%	0.89%	0.90%	0.90%	0.90%	0.94%	0.94%	0.94%	0.96%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	57.00	57.00	57.00	57.00	58.00	56.00	57.00	57.00	57.00	60.00	60.00	60.00	61.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	56.14%	56.14%	56.14%	56.14%	56.90%	57.14%	56.14%	56.14%	56.14%	56.67%	56.67%	56.67%	57.38%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	5.26%	5.26%	5.26%	5.26%	5.17%	5.36%	3.51%	3.51%	3.51%	3.33%	3.33%	3.33%	3.28%		
	W	% of Leadership Roles who are disabled (B8c+)	%	-	1.75%	1.75%	1.75%	1.75%	1.72%	1.79%	1.75%	1.75%	1.75%	1.67%	1.67%	1.67%	1.64%		
	W	Male % of Workforce	%	-	17.90%	18.10%	18.16%	18.36%	18.40%	18.29%	18.33%	18.32%	18.36%	18.39%	18.54%	18.56%	18.59%		
	W	Female % of Workforce	%	-	82.10%	81.90%	81.84%	81.64%	81.60%	81.71%	81.67%	81.68%	81.64%	81.61%	81.46%	81.44%	81.41%		
	W	BME % of Workforce	%	-	24.49%	25.06%	25.18%	25.47%	25.68%	25.98%	26.08%	26.12%	26.36%	26.56%	26.78%	27.08%	27.33%		
	W	White % of Workforce	%	-	67.08%	67.03%	66.86%	66.58%	66.32%	66.19%	65.84%	65.76%	65.61%	65.36%	65.08%	64.94%	64.81%		
	W	ER Cases Closed	Number	-	60	24	35	30	28	40	42	44	24	19	56	43	42		

Our People

Great Western Hospitals NHS Foundation Trust

Workforce Scorecard - Workforce Planning



		M01 Apr-24	M02 May-24	M03 Jun-24	M04 Jul-24	M05 Aug-24	M06 Sep-24	M07 Oct-24	M08 Nov-24	M09 Dec-24	M10 Jan-25	M11 Feb-25	M12 Mar-25
Total Workforce	Plan	5,667	5,651	5,627	*5,627*	5,626	5,621	5,618	5,604	5,591	5,565	5,539	5,514
	Actual	**5,562**	**5,569**	**5,592**	***5,632***	0	0	0	0	0	0	0	0
	Variance	-104	-82	-35	*5*	-	-	-	-	-	-	-	-
Substantive	Plan	5,220	5,220	5,211	*5,227*	5,241	5,252	5,264	5,266	5,268	5,258	5,247	5,237
	Actual	**5,227**	**5,224**	**5,227**	***5,253***	0	0	0	0	0	0	0	0
	of which Overtime	**20**	**6**	**8**	***9***	0	0	0	0	0	0	0	0
	Variance	6	4	16	*26*	-	-	-	-	-	-	-	-
Bank	Plan	387	373	359	*346*	332	318	305	291	277	264	250	237
	Actual	**286**	**302**	**326**	***333***	0	0	0	0	0	0	0	0
	Variance	-100	-71	-33	*-13*	-	-	-	-	-	-	-	-
Agency	Plan	60	58	56	*55*	53	51	49	47	45	44	42	40
	Actual	**50**	**44**	**39**	***46***	0	0	0	0	0	0	0	0
	Variance	-10	-14	-18	*-9*	-	-	-	-	-	-	-	-
Trust All Turnover	Plan	10.90%	10.90%	11.19%	11.19%	11.36%	11.52%	11.68%	11.88%	12.07%	12.26%	12.45%	12.65%
	Actual	**10.85%**	**10.57%**	**10.24%**									
	Variance	-0.05%	-0.33%	-0.95%	-	-	-	-	-	-	-	-	-
Trust 12-Month Sickness	Plan	4.35%	4.33%	4.31%	4.29%	4.27%	4.25%	4.22%	4.20%	4.18%	4.16%	4.14%	4.12%
	Actual	**4.41%**	**4.40%**	**4.46%**									
	Variance	0.06%	0.07%	0.15%	-	-	-	-	-	-	-	-	-

Performance & Counter Measure

- 5,632WTE was used to deliver our services in July, an increase of 41WTE compared to June and 5WTE against a planned figure of 5,627WTE.
- Our substantive WTE continued above plan in month 4 by 26WTE, driven by a marginal increase in overtime and further growth to our contracted WTE within Cancer, SWICC, and Community Inter Care teams.
- Temporary staffing WTE remains below plan in month 4, with Agency usage 9WTE less than plan in July and Bank 13WTE less. Whilst still within planned levels, temporary staffing utilisation did increase in month 4. Analysis of request reasons for temporary staff shows an increase to enhanced care and additional demand/activity as top contributing factors.
- Whilst total workforce vs plan is alerting in July, our overall pay position remains within tolerable levels and so escalation to planned interventions has not been instigated.

Impact on Workforce

- Whilst increasing marginally in July overtime reduction still represents a 26WTE reduction compared to March levels, although it should be noted there has been transference of this usage to bank.
- A freeze on non-clinical vacancies has not yet been initiated as financial tolerances do not yet warrant intervention. The position will continue to be closely monitored throughout August to ensure a timely response if needed, with regular review continuing at the fortnightly Workforce Recovery Meeting.

Risks & Mitigations

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

Our People

Workforce Costs by Staff Group

Great Western Hospitals NHS Foundation Trust

Staff Group	Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Registered Nursing	RGN Sub £	£7,505,628	£7,519,688	£7,353,938	£7,538,260	£0	£0	£0	£0	£0	£0	£0	£0	£29,917,515
	RGN Bank £	£500,934	£498,227	£505,752	£524,782	£0	£0	£0	£0	£0	£0	£0	£0	£2,029,696
	RGN Agency £	£134,966	£83,833	£125,905	£199,065	£0	£0	£0	£0	£0	£0	£0	£0	£543,769
	Budget £	£8,339,881	£8,280,339	£7,502,736	£8,252,454	£0	£0	£0	£0	£0	£0	£0	£0	£32,375,410
	Actual Cost £	£8,141,528	£8,101,748	£7,985,596	£8,262,107	£0	£0	£0	£0	£0	£0	£0	£0	£32,490,979
	Variance to Budget £	-£198,353	-£178,591	£482,860	£9,653	£0	£0	£0	£0	£0	£0	£0	£0	£115,569
Unregistered Nursing	UR Sub £	£2,378,175	£2,371,809	£2,353,585	£2,400,003	£0	£0	£0	£0	£0	£0	£0	£0	£9,503,571
	UR Bank £	£267,490	£248,476	£295,353	£320,470	£0	£0	£0	£0	£0	£0	£0	£0	£1,131,789
	UR Agency £	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Budget £	£2,712,503	£2,725,262	£2,582,247	£2,667,898	£0	£0	£0	£0	£0	£0	£0	£0	£10,687,910
	Actual Cost £	£2,645,665	£2,620,285	£2,648,937	£2,720,473	£0	£0	£0	£0	£0	£0	£0	£0	£10,635,360
	Variance to Budget £	-£66,838	-£104,977	£66,690	£52,575	£0	£0	£0	£0	£0	£0	£0	£0	-£52,550
Medical and Dental	M & D Sub £	£6,211,821	£6,707,627	£5,942,244	£6,116,758	£0	£0	£0	£0	£0	£0	£0	£0	£24,978,450
	M & D Bank £	£885,343	£1,027,432	£1,204,978	£1,226,806	£0	£0	£0	£0	£0	£0	£0	£0	£4,344,559
	M & D Agency £	£295,354	£154,539	£326,588	£271,514	£0	£0	£0	£0	£0	£0	£0	£0	£1,047,995
	Budget £	£6,725,770	£6,526,600	£6,748,637	£6,658,436	£0	£0	£0	£0	£0	£0	£0	£0	£26,659,443
	Actual Cost £	£7,392,518	£7,889,598	£7,473,811	£7,615,079	£0	£0	£0	£0	£0	£0	£0	£0	£30,371,005
	Variance to Budget £	£666,748	£1,362,998	£725,174	£956,643	£0	£0	£0	£0	£0	£0	£0	£0	£3,711,562
AHP and STT	AHP/STT Sub £	£3,109,394	£3,128,363	£3,064,414	£3,158,393	£0	£0	£0	£0	£0	£0	£0	£0	£12,460,564
	AHP/STT Bank £	£127,201	£119,799	£120,651	£123,232	£0	£0	£0	£0	£0	£0	£0	£0	£490,883
	AHP/STT Agency £	-£17,442	£108,810	£53,778	£27,125	£0	£0	£0	£0	£0	£0	£0	£0	£172,271
	Budget £	£3,168,989	£3,182,676	£3,117,077	£3,161,193	£0	£0	£0	£0	£0	£0	£0	£0	£12,629,935
	Actual Cost £	£3,219,154	£3,356,972	£3,238,844	£3,308,750	£0	£0	£0	£0	£0	£0	£0	£0	£13,123,719
	Variance to Budget £	£50,165	£174,296	£121,767	£147,557	£0	£0	£0	£0	£0	£0	£0	£0	£493,784
Admin & Clerical	Admin Sub £	£3,581,995	£3,421,806	£3,761,946	£3,543,384	£0	£0	£0	£0	£0	£0	£0	£0	£14,309,130
	Admin Bank £	£106,641	£123,368	£99,734	£123,793	£0	£0	£0	£0	£0	£0	£0	£0	£453,536
	Admin Agency £	£46,781	-£16,117	£169	-£1,722	£0	£0	£0	£0	£0	£0	£0	£0	£29,111
	Budget £	£2,830,472	£3,069,719	£3,087,241	£3,980,453	£0	£0	£0	£0	£0	£0	£0	£0	£12,967,886
	Actual Cost £	£3,735,417	£3,529,056	£3,861,848	£3,665,455	£0	£0	£0	£0	£0	£0	£0	£0	£14,791,777
	Variance to Budget £	£904,945	£459,337	£774,607	-£314,998	£0	£0	£0	£0	£0	£0	£0	£0	£1,823,891
Total	Total Sub £	£22,787,013	£23,149,293	£22,476,127	£22,756,799	£0	£0	£0	£0	£0	£0	£0	£0	£91,169,231
	Total Bank £	£1,887,609	£2,017,302	£2,226,468	£2,319,083	£0	£0	£0	£0	£0	£0	£0	£0	£8,450,462
	Total Agency £	£459,659	£331,064	£506,441	£495,982	£0	£0	£0	£0	£0	£0	£0	£0	£1,793,146
	Budget £	£23,777,615	£23,784,596	£23,037,938	£24,720,434	£0	£0	£0	£0	£0	£0	£0	£0	£95,320,584
	Actual Cost £	£25,134,281	£25,497,659	£25,209,036	£25,571,863	£0	£0	£0	£0	£0	£0	£0	£0	£101,412,839
	Variance to Budget £	£1,356,666	£1,713,063	£2,171,098	£851,429	£0	£0	£0	£0	£0	£0	£0	£0	£6,092,256

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

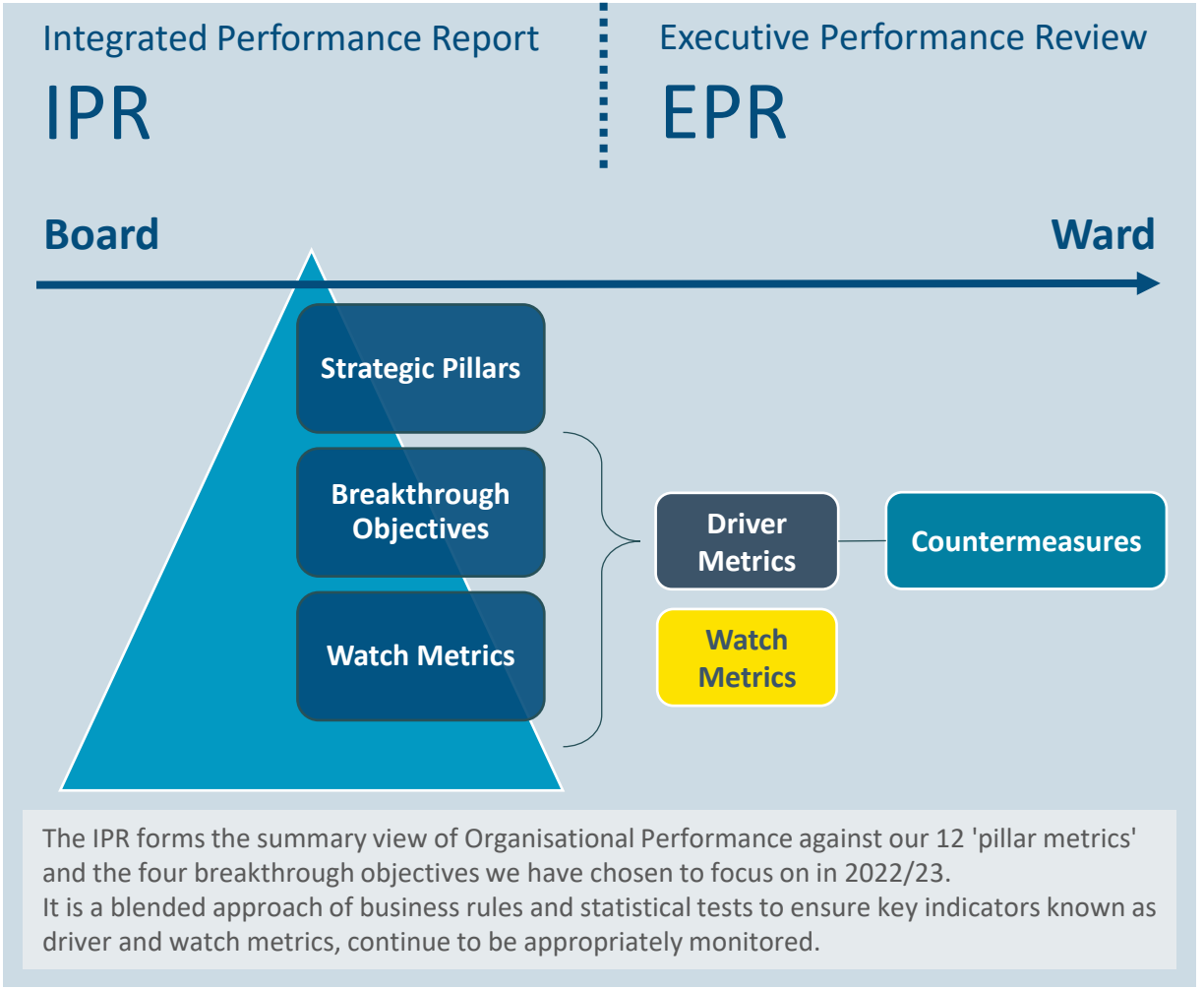
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

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

Our four strategic pillars

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

24/25 Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

Our Vision

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

1 Our four strategic pillars

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

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

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

NHS Great Western Hospitals NHS Foundation Trust

Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

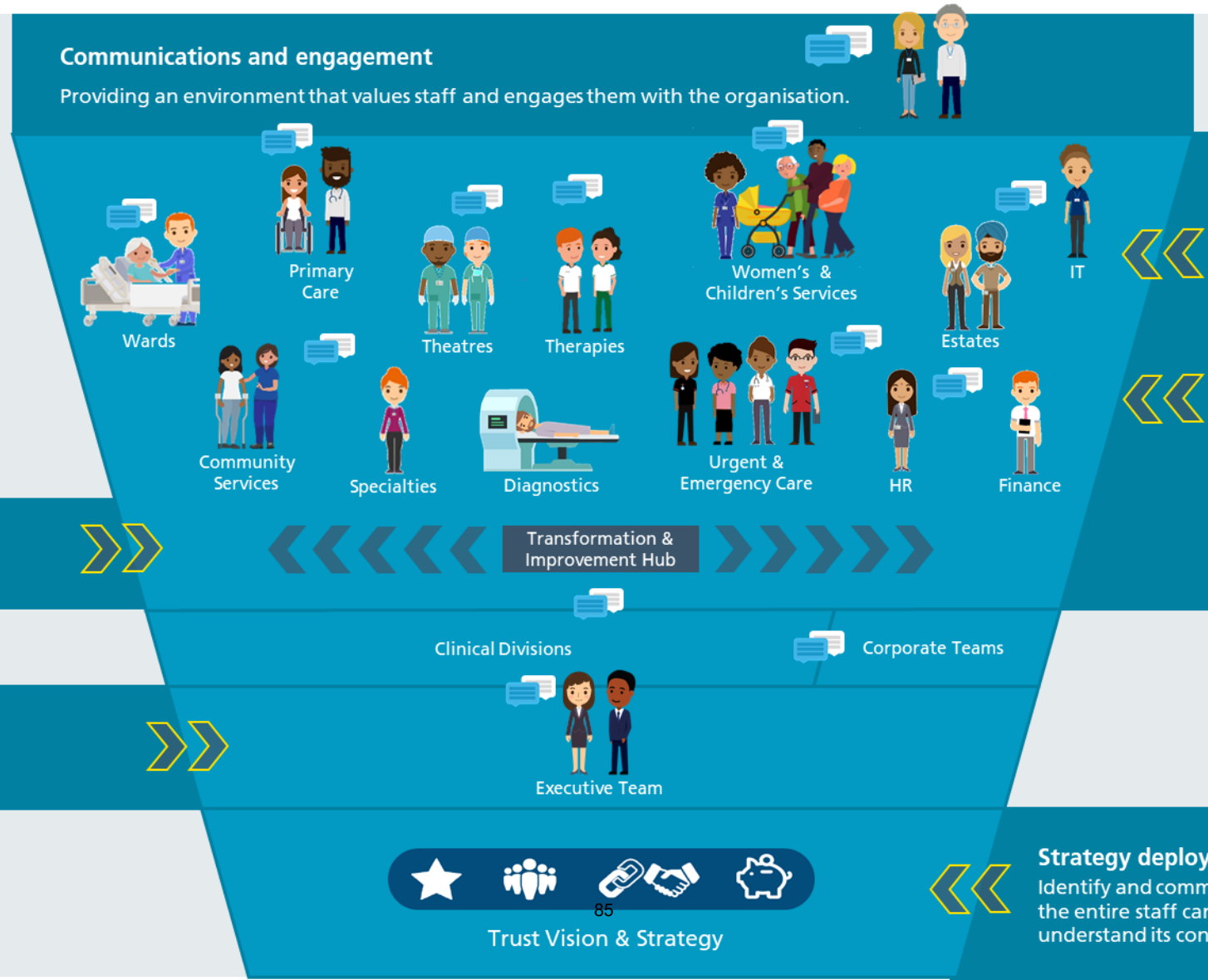
Level	Daily	Weekly	Monthly
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



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

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

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

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

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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

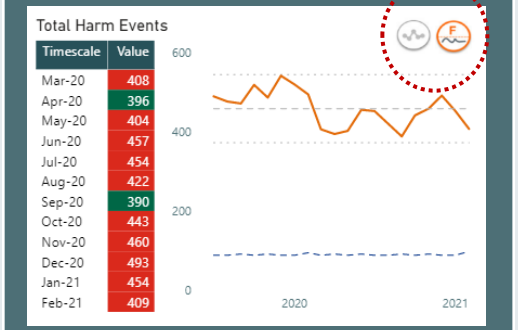
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

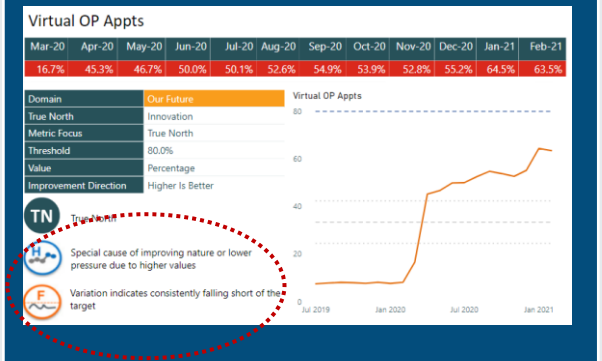
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	28th August 2024	
Committee Chair	Bernie Morley Non-Executive Director	
Link to Strategic Objective	Pillar 3: Joining up acute and community services in Swindon	
Link to Board Assurance Framework	BAF 3: SR 5 – Performance and SR6 - Partnerships	
Improving Together Pillar Metrics	Emergency Attendances	Waiting List – over 65-week waiters
	Diagnostic Waiting Times	Cancer Waiting Times
Improving Together Breakthrough Objective	Reduction in ambulance handover delays	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Partnership Update	N/A	X
2. Health Inequalities Quarterly Report	N/A	X
3. Operational Highlight Report	N/A	X
4. IPR - DM01	Partial	X
5. IPR - RTT	Partial	X
6. IPR - Cancer	Partial	X
7. IPR – ED / 4 hours	Good	X
8. IPR – Ambulance Handover	Limited	X
9. Cancer Services Quarterly Assurance Report	Partial	X
10. Theatre Update	Substantial	X
11. Emergency Preparedness Resilience & Response Assurance Quarterly Report	Substantial	X
12. Board Assurance Framework	Substantial	X

POINTS OF ESCALATION	No items to escalate to Trust Board.
KEY AREAS TO NOTE	• Diagnostic performance continues to deliver above plan for activity and for performance at 70.72% for July 2024, which is the best performance since July 2021. Work continues to ensure all modalities are supported to achieve their performance recovery. Of note, good recovery in NOUS and CT modalities. • 4-hour performance above plan at 77.1%, which is in the top quartile of trust performance, this represents performance improvement in both type 3 and type 1 performance following an improvement programme. • Ambulance handover delays are reduced by 40% and now just above breakthrough target (71 hours) – however this remains a challenge and a concern for the committee to ensure that recent improvements can be maintained. • RTT focused work to limit the number of 65-week wait breaches to meet the September deadline continues. Some risk to this position was noted. Total waiting list continues to increase as the focus is on the tail of the waiting list. • Cancer performance showing improvement, with good mitigations in place. • Committee noted that GWH remains in tiering for Cancer and Diagnostics and UEC as a system. • Formal ICS partnership structures continue to mature through the BSW Recovery Board supported by the Planning and Delivery Executive, working together on a joint planning process for 2025/26, based on a 3 year plan (set of assumptions) currently being developed.

	• The Committee was updated on the work of the Swindon Integrated Care Alliance, the Borough Council / Health & Wellbeing Board, and the Acute Hospital Alliance work to strengthen collaboration across our 3 Trusts. • The quarterly update on health inequalities was received with recognition of the work underway and the long term nature of the interventions. The balance of capacity and action in relation to staff EDI and population health inequality was noted and discussed.
BOARD ASSURANCE FRAMEWORK & RISKS	BAF reviewed and substantial assurance reached. Discussion around how the committee balances the assurance for the population and place aspects of its brief.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Successful receipt of funding to support cancer services in targeted areas to improve performance. Theatres programme and productivity measures illustrating continued good performance. Innovative pilot with SBC public health around use of a Population Health Management approach for GWH staff, to target health promoting interventions (vaccine uptake initially).
REFERRALS TO OTHER BOARD COMMITTEES	None, but would note agreement to change the receiving committee for 2 risks (711 & 293) as identified last month have been confirmed to change to Q&S.

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

Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	22.8.24
Committee Chair	Claudia Paoloni, Non-Executive Director
Link to Strategic Objective	Pillar 1 : Outstanding Patient Care
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality
Improving Together Pillar Metrics	Reducing Harms
	Friends & Family Test
Improving Together Breakthrough Objective	Falls Reduction

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Falls (IPR breakthrough objective). Falls	Partial	
2. IP&C (IPR breakthrough objective)	Good	
3. IPR concerns and complaints (Non-Alerting Metric)	Partial	
4. IPR Maternity	Good	
5. Complaints Report	Partial	
6. Trust Mortality Report	Limited	
7. Clinical Audit and Effectiveness Report Q1 2024/25	Partial	
8. Nice Guidelines Q1 2024-25	Substantial	
9. GWH Electrical Incident	Substantial	
10. Electronic Discharge summaries	Limited	YES
11. Safe Staffing report	Note	
12. Patient Quality Subcommittee Review of Terms of reference	Note	

POINTS OF ESCALATION

IPR: Breakthrough Objective: AIM 2024/25

- **Falls:** Reduction in number of Total inpatient falls by 20%
  Reduction in the number of patients experiencing moderate harm or above by 20%
  Reduction in the number of patients that fall more than once by 20%
- In July there have been 5 falls with moderate harm or above, one of which sustained catastrophic harm with sub dural haematoma.
- The committee were assured that data being collected and presented was now meeting the objective aims and would allow progress to be more easily assessed.
- Countermeasures including adequate footwear, more vigorous assessment of risk through postural Blood pressure and need for enhanced care assessment, and increased staff training has been trialled in SWICC and noted a 50% reduction in falls with harm, these are now being implemented throughout.
- Work around preventing deconditioning has also begun working closely with therapy colleagues.

IPR: IPC

- There was a significant increase in Covid in July impacting total harms.
- *E.Coli* and *Klebsiella* rates remain higher than peers and this appears to be related to urinary catheter care. An improvement group has been set up for this and around line care.
- % pseudomonas cases were recorded, 3 of which were from a single ward resulting in an immediate deep dive response including additional water testing.
- *Clostridium Difficile* rates are back in line with expected and may be related to improved antibiotic prescribing practice in the community.
- The committee were assured that there is good oversight and immediate response to infection status changes.

Pressure Ulcers

- There have been a reduction in the acute setting pressure ulcers but despite no longer being a breakthrough measure, the committee was reassured by the controls of oversight put in place which identified a slight increase in Grade 3 and Grade 4 Pressure harms which has resulted in an immediate active response to ensure care standards maintained.

Complaints and Concerns Report

- The committee noted a substantial increase in the first quarter concerns received rate and continued elevated complaints rates.

	• Whilst acknowledging problems remain with delayed response rates the committee was cognisant of the fact that response rates remain static despite a doubling of complaints and concerns. • The report was useful for the committee to understand the work being undertaken. • Themes appear to be around waiting times/delays in emergency and elective care and discharge communication and clinical care, often relating to language and communication around care plan and care received. • Work streams have been established and improvements around ensuring increased Divisional Oversight and responsiveness. • It is to be noted that this is a situation that is being experienced in our neighbouring Trusts.
	IPR: Maternity report • Significant progress against the CQC action Plan. • Sustained achievement of maternity triage times within 15 mins in more than 70%. • Surgical Site Infections prevention now has routine use of more appropriate dressings for higher BMI ladies, which was found to be an increased risk. • Immediate and essential actions from the Ockendon report, CNST year 6 and 3 year maternity and neonatal delivery plan are on track with anticipated optimal conversion of RAG ratings against agreed timelines. • Safeguarding training level 3 compliance is improving and problematic areas being addressed directly.
	Trust Mortality Report July 2024 • The committee noted the extensive work being undertaken by the new Mortality Lead Clinician and team in attempting to improve mortality reviews, learning from reviews, completion of SJRs. • However, the limited assurance rating by the committee relates to wider issues of engagement by clinicians in the process and this will now be more directly addressed through the Medical Director Team. • It was also noted that GWH is an outlier for 30 day hip fracture mortality which is being investigated, but delays in coding and reviews will impact ability to respond appropriately, this is being further investigated. • The committee has also requested a review of data presentation to enable progress to be reviewed.
	Clinical Effectiveness and Audit Report Q1 2024/25 • All National Audits have been commenced except for 2 that have been delayed by national delays which will require revision of submission dates. • No delays in national audit data submission but this required additional resource around coding. • 5 completed reports provided limited assurance, of note around stroke care, paediatric diabetic monitoring and paediatric epilepsy service. These are being reviewed and methodology on how to monitor progress being determined, • Actions from completed reports are submitted through Divisional Governance to enable action plans and monitoring to be established.
	NICE Guidelines Q1 2024-25 • A team have been established to review the Trust status in implementation of current NICE guidelines. • The data gathering stage has identified areas of duplication, omission and historic versions. • A new database has been created to be mapped against the national NICE database. • Data cleansing is still ongoing. • The new database will enable Divisional Quality teams to have accurate data to be able to make improvements to ensure all correct Nice Guidelines are being implemented.
	GWH Electrical Incident 9 July 2024 • Reports and summaries around this have been presented at various meetings but the committee received a report on the quality and safety impact of the electrical outage problem. • 216 separate incidents have been logged to date from patient/organisational and equipment impact. • Incident reports have also been requested from local partners including SWAST. • 18 theatre procedures were cancelled, 3 patients woken up from anaesthesia, 6 patients already underway were completed and all have come to no harm. • 188 cancelled outpatient appointments, all rebooked. • 134 diagnostic appointments cancelled and now rebooked. • No harm has been identified but learnings will be gained to inform managing any future incidents. • One patient safety incident is being investigated, but may not be directly related to the power outage as the patient had already attended the emergency department on 2 recently previous occasions.
	Electronic discharge Summaries • Following the escalation to August Board meeting of the lack of progress around electronic discharge summary provision and the current option to await an electronic solution, a robust discussion was had around the lack of assurance around interim measures being implemented through careflow integration adjustments, with no control around the third party activity. • The committee also required further options to be provided around non electronic interim. Measures and costings around this and expected effectiveness if chosen to invest additional resource towards this.

BOARD ASSURANCE FRAMEWORK & RISKS	Q1 2024/25 OUTSTANDING PATIENT CARE: **SR1 There is a risk that our patients do not receive safe and effective care that meets their needs due to a failure to build and embed a culture of quality improvement and learning across the organisation** • No changes to risk scores or assurance levels • Two new controls added • Six committee assurance reports deleted • One new gap in controls around sepsis oversight added.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
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PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
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BOARD COMMITTEE ASSURANCE REPORT

Committee	**People & Culture Committee**	
Date of Meeting	Tuesday 20th August 2024	
Committee Chair	Julian Duxfield, Non-Executive Director	
Link to Strategic Objective	Pillar 2: Workforce	
Link to Board Assurance Framework	BAF: SR 2 (Culture), SR 3 (Health & Wellbeing), SR 4 (Workforce Plan)	
Improving Together Pillar Metrics	Voluntary Turnover	Staff Recommendation as a place to work
	Equality, Diversity & Inclusion (EDI)	
Improving Together Breakthrough Objective	Improving Staff Survey – Q7c I receive the respect I deserve from my colleagues at work	

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
Guardian of Safe Working Hours Report	Good	No
ICC Staff Survey update	Partial	No
Six Monthly Leadership Development Update Report	Good	No
Career Development Update	Partial	No

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	It was noted from the integrated performance report that the two key current 'threats' were levels of discrimination reported by staff via the pulse survey including the disparity between white staff and BAME staff reporting discrimination from a colleague and WTE above workforce plan this month potentially impacting workforce recovery. The committee noted significant progress had been made on the Trust vacancy position (under 200wte) with significant reduction in nursing and a reduction in all staff groups. The Committee reported good assurance of the report from the Guardian of Safe Working Hours. There are currently limited additional hours being worked by junior doctors and issues are being addressed in the areas affected. The Integrated and Community Care Division reported on their plans and progress with addressing feedback from the staff survey. It was noted that the pulse survey results had not reported an improvement in the breakthrough question (staff reporting discrimination by colleague or team leader). It was recognised that several improvement initiatives had only recently been rolled-out and therefore impact had not been measured.

	Sickness levels, particularly short-term absence, across the Trust have increased over the last 12 months, with current level being 4.6% against a target of 3.5%, although we have lower levels than the NHS nationally (5%). A proposed 4.2% target was discussed (in line with Pre COVID sickness level and the NHS People Plan, however was agreed to leave our target unchanged and continue with the actions required at a local level and in line with the Trust absence management policy. The committee received an update on the leadership development work across the Trust. A range of good initiatives are being deployed, but we need to ensure that our approach continues to be simplified and that evidence of impact is tracked in the future. The emerging work on career development plans and the implementation of the 'scope for growth' model for career conversations with staff was presented. The intention is to hold our first Succession Planning Moderation Boards (Talent Review Boards) in October & November for all Executives using the outcome from these Scope for Growth careers conversations. A single report, the Inclusion & Health Inequalities Annual Report for 2023/4, was presented which summarised all the Trust's work and progress in this area. This is a welcome simplification of our reporting.
BOARD ASSURANCE FRAMEWORK & RISKS	Minor changes to the current BAF were noted. The intention is that strategic risk 3 (health and wellbeing) will be incorporated into strategic risk 2 (culture) for Q2 and that workforce appetite and tolerance statements will be available for review at the October's P&CC meeting, together with any changes to the risk descriptions.

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Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	27 August 2024	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BAF Strategic Risks	Substantial	x
2. Finance Risk Register (incl. Way Forward Program)	Substantial	x
3. BSW Financial & Recovery Workstreams Update	Partial	x
4. Month 4 Finance Position	Good	x
5. Improvement & Efficiency Program	Partial	x
6. Seasonal Plan – spend approval	Good/Approve	x
7. National Cost Collection 2022/23 – national results	Note	x
8. Site Utility & Resilience Update	Partial	x
9. PFI – 6 monthly Update	Good	x
10. ERIC report – Annual Update	Good	x
11. Primary Care Premises Hand Back	Good/Approve	x
12. Sundry Spend Review	Good/Approve	X
13. 2023/24 PAM Submission	Good/Approve	X
14. Quarterly Coding & Mortality Status Report	Partial	X
15. Cyber Framework	Partial	x
16. Procurement Recommendation Reports: (1) CDC Endoscopy Equipment	Partial /Approve	✓

POINTS OF ESCALATION	**BSW Financial Update** – The Committee received a verbal update outlining the System's challenges in delivering its financial plan, particularly given the scale of the collective deficit. The deficit position currently stands at £21.1m at Month 4 with a projected year-end deficit of £30m in line with the plan, but with significant risk attached. As mentioned in previous months, the Committee notes that the requirement for more mature governance processes, greater transparency and consistent criteria and a uniform forecasting methodology at the System level is ever more critical to gaining greater assurance and better viewing comparable data points. The Committee remains unsure about the alignment of the Trust governance processes to that of the System and the actions to be taken. However, Trust leadership assured us that regular meetings are taking place at the system level to address this and move plans into the delivery phase. Based on these management representations, we agreed to a partial assurance rating.
	Month 4 Financial Position: The Trust's adjusted deficit position is £6.2m, representing a £3.3m adverse variance from the plan. Income increased by £1.3m in M04 driven by ERF (£0.4m) and an overperformance on NHSE Commissioned Drugs (£0.9m). The Pay position includes c.£0.5m of Junior Doctor industrial action incurred over June/July. Overall, Pay remains £0.5m under the plan due to centrally held reserves (e.g. maternity / paternity leave), which will be used to support divisional pay positions throughout the year. Non-Pay is £5.8m over the plan, including a £3.8m variance in clinical supplies, particularly in Medicine, Surgery, Women's & Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. A working group, including Procurement, is analysing the drivers of clinical supply spending to better understand the position and achieve savings. An internally generated forecast aligned to current run rate and known changes suggests a potential gap to plan of £8.3m, however the Trust has a recovery plan agreed with the ICB to improve this back to plan. The Trust is taking proactive steps to improve its financial position, including further ERF stretch through additional activity and coding, improved CIP delivery, no further industrial action costs, and reduced non-pay run-rate costs.
	Improvement and Efficiency Plan: The efficiency target for 2024/25 is £21.9m. As of M03, the actual delivery was £3.9m, which is £1.8m under the plan. 59% of the £3.9m delivered is recurrent. All divisions and services must increase overall savings to hit the £21.9m target and ensure the savings are recurrent to reduce the underlying deficit. While ERF activity and associated income have increased in M04, continuing to maximise activity will be crucial to delivering future savings. Tighter controls around approving bank shifts, overtime, and Waiting List Initiative Payments will contribute to this while continuing with the excellent work already in place, resulting in run rate reductions in temporary staffing, specifically in Nursing. Non-pay, most notably clinical supplies, will be the focus of cross-team/divisional support to maximise savings opportunities in this area. The partial assurance rating relates to the risk of delivering the efficiency programme for 2024/25. Although systems and controls identifying and tracking savings provide good/substantial assurance, the challenge of the scale of efficiencies and current delivery means there can only be partial assurance.
	Seasonal Planning – Winter 2024/25: The Seasonal Plan for Winter 2024-25 follows the formal lessons learned completed in May 2024. The plan outlines priorities for 2024/25 and ensures early opportunity for achieving organisational readiness ahead of Winter so that our statutory duties for emergency preparedness, resilience and response are met. The Committee was requested to note and endorse the Winter Plan for 2024-25 and approve the Winter Plan priority 1 scheme so that mobilisation can commence ahead of winter at an estimated cost of **£530,226**, funded by the COO budget.
	Quarterly Coding & Mortality Status Report: Coding performance is improving slowly, but there are still several risks; these include a significant rise in the volumes of Inpatient episodes that require coding compared to prior years (11,084 average in 24/25, 10,301 average in 23/24) and the loss of 3rd Party Coding Support from CEC in May and June due to lack of available funding leading to a drop of 3,500 episodes of Coding capacity. Further recruitment activity has progressed to fill the remaining vacancies within the Clinical Coding Team with the successful candidates starting in post in June and July 2024. However, due to the difficulties in recruiting experienced staff, there remains a significant number of Trainee Coders within the Clinical Coding Team due to the need for more skilled coders in the local market, which continues to impact overall coding capacity. Governance is in place to oversee coding improvement, but further action

	needs to be taken on risk mitigation, particularly the approval of the investment in the business case. An independent audit was conducted and highlighted some areas for improvement, but overall, it was a favourable report.
	Cyber Security Framework: The Trust is reporting strong performance for the Data Security and Protection Toolkit (DSPT), with solid evidence provided. Cybersecurity is a crucial priority for the Trust, requiring investment in various controls and risk mitigations. Risk is well understood and routinely reviewed. Improvements have been identified throughout the report, which will be undertaken through 2024/25. The assurance is noted as partial, given that this is the first report and the range of improvement actions to improve the controls in place.
BOARD ASSURANCE FRAMEWORK & RISKS	**Finance Risk Register (incl. Way Forward Program)**: The Committee received both reports and noted that the risk management process and reporting are adequate and effective and is assured that risks are identified, appropriately rated, and mitigation actions are in place. The Committee is assured that the review process for risk oversight by the senior finance team is embedded, with monthly meetings and mitigation actions allocated to risk owners.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	None noted.
REFERRALS TO OTHER BOARD COMMITTEES	None noted.

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

Board Committee Assurance Report

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

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Use of the Mental Health Act Q1 Report		x
2. Use of the Mental Health Act 2023/24 Annual Report	For Board Approval	✓
3. Mental Capacity Act Q1 Report		x
4. Use of Deprivation of Liberty Safeguards Q1 Report		x
5. Division of Medicine – Quarterly Report		**x**
6. Right Care Right Person Update		**x**
7. Children's Service Quarterly Report		**x**

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	*Use of the Mental Health Act [MHA]* Evidence of the proactive steps taken to ensure that the Trust maintains a robust approach to the application of the legal framework provided under the MHA continues to provide substantial assurance.
	Use of the Mental Health Act 2023/24 Annual Report The Committee reviewed the Annual Report and agreed it was an accurate reflection of the year's activity and should be submitted to the Trust Board for approval.
	The use of the Mental Capacity Act [MC] and of Deprivation of Liberty Safeguards [DoLS] Good assurance ratings are maintained on the basis that there is clear evidence of processes and procedures to address the legal requirements of both the MCA and DoLS but audits continue to demonstrate that further work needs to be done to ensure that these are applied and implemented effectively across GWH
	Division of Medicine / Children's Services – Quarterly Reports Good assurance ratings reflect the work done, in partnership with AWP and CAMHS, to ensure that the mental health needs of patients are met. Of note in relation to ED were the steps being taken to support the safe management of patients presenting to ED with mental health issues given the reduction in the bed base associated with the development of the integrated front door. In relation to Children's Services the development of Mental Health Champions and the introduction of the Barnardo's Youth Workers were of particular note.
	Right Care Right Person Update GWH continues to contribute both operationally and strategically in the collaborative work across the system and, in relation to the implementation of phase 2, has conducted a review of internal missing persons procedures which demonstrated that these were fit for phase 2 implementation.
BOARD ASSURANCE FRAMEWORK & RISKS	*15+ Risk Report* There continue to be no 15+ risk to report. However, the committee was assured that a robust risk management process was in place with mental health related risks discussed in the appropriate divisional governance meetings, there was oversight from the Risk Group and review at the Mental Health Operational Group
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	A Youth Worker pilot service provided in partnership with Barnardo's is being provided on the Children's Ward. The service is designed to support to children and young people aged 11-25 years who are displaying low/medium mental health concerns and those living with long term conditions
REFERRALS TO OTHER BOARD COMMITTEES	

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

Committee	**Charitable Funds Committee**
Meeting Date	14 August 2024
Committee Chair	Julian Duxfield, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Fundraising	Partial	No
2. Financial reporting	Good	No
3. Cases of need	Good	No
4. Charitable funds	Good	No
5. External review action plan	Partial	No

POINTS OF ESCALATION	Consultation with the Trust Board on the Investment Strategy for the Trust's charitable funds, using an external Fund Manager, will be delayed due to personnel changes in the Finance team.
KEY AREAS TO NOTE	Immediately prior to this meeting the General Fund's uncommitted balance stood at £232,512, above our agreed minimum threshold of £57,000. The meeting reviewed the 'cases of need' and it was agreed to fund staff recognition events, including the Great West Fest event in September, replacement chairs for carers and a spare Paediatric flexible rhino-laryngoscope. It was agreed in principle to fund the prescription collection lockers pending full funds being available at the time of the November meeting. Further consideration for future funding will be given to a penicillin de-labelling service. The Medicine Division Charitable Funds Spending Plan was presented as part of the Committee's process of inviting each Division to present, on an annual basis. These plans are becoming better co-ordinated and the main priorities are to move the spending plans for Radiology and Cardiology through to fruition. The Division is also reviewing a 5-year Capital Plan alongside the remaining balance of charitable funds so there is clearer visibility about how the charitable funds can be spent on strategic schemes for the Division. The November meeting will review the revised Charity strategy to follow the revised Trust strategy. A modest spending proposal from Wiltshire Health & Care's charitable fund was approved and the Committee noted that WH&C have significant funds available (ca. £240k) and they were encouraged to develop clear plans for these funds. A revised proforma for submission of cases of need was agreed. This includes new questions seeking to confirm numbers of patients, staff and/or volunteers that will benefit, how the project will deliver against the Trust's strategic pillar metrics, and how the project might address health inequalities. The Committee agreed a new Charitable Funds Impact Report which will offer us a way of analysing and measuring the impact of charitable funding. This will enable communication of the benefits of efforts to different stakeholders, donors, external funders and people in the community. It will allow us to give our donors confidence that we use their money wisely by highlighting some of the Charity's key achievements through the inclusion of case studies from beneficiaries.
BOARD ASSURANCE FRAMEWORK & RISKS	Fundraising – Partial assurance given, no change from previous rating. Financial Reporting – No major concerns were identified. However, it was noted that the methodology agreed in 2021 to apportion all charges to charitable funds based on all income, including legacies had not been followed. The Committee will review the apportionment methodology in November, considering benchmarking with our neighbouring Trusts as we move towards a group model. Cases of Need – The process and documentation is currently good, and will be improved by the revised process.

	Charitable Funds – Some good progress was reported on the dialogue with Divisions about ensuring that clear plans exist to use the funds available. The assurance on this issue was increased to 'Good'. Each Division will be continuing to attend a meeting of the Committee each year to present a further 'deep-dive' into these plans. External Review Action Plan – Good progress is being made with the implementation of the action plan. A key outstanding action is the rationalisation of funds.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	It was noted that this quarter's fundraising performance has exceeded expectations against the same period this time last year, even with the staffing pressures the Brighter Futures team have faced during April to June. We experienced two pre-election periods during this quarter, which restricted the fundraising content shared across social media platforms, but despite this we received £110,066 (not including legacies) in income across all funds.
REFERRALS TO OTHER BOARD COMMITTEES	The Committee will refer the issue of the Staff Lottery sitting outside the charitable funds structure back to the Trust Board in order to agree the correct Executive lead within the Trust (HR or Finance) for oversight.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
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Report Title	**Inclusion & Health Inequalities Annual Report 2023-2024**				
Meeting	**Trust Board**				
Date	**5 September 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Sharon Woma, EDI Lead				
Appendices	PowerPoint slides and Annual Report				

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

Assurance Level

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

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

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

Report

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

The EDI Lead, with the support of key stakeholders has prepared the Trust's 2023-2024 Inclusion & Health Inequalities Annual Report. As agreed by the Board, we have reduced the amount of reporting to enable a greater focus on delivery, and we are presenting a single report that showcases our achievements.

The report highlights the breath of policy, process and initiatives that support us to continue to build an inclusive, safe and just culture that responds to the needs of our diverse stakeholders, including the patients who use our services and their carers; and responds to various frameworks that we use to measure and monitor progress - namely the Workforce Disability Equality and Workforce Race Equality Standards, the Gender Pay Gap reporting, Equality Delivery System and the NHS EDI Improvement Plan which the Trust implemented this year.

By publishing our equalities information annually, we are able to demonstrate due regard for the Public Sector Equality Duty (section 149 of the Equality Act 2010) - to eliminate unlawful

discrimination; advance equality and foster good relationships between communities who share different protected characteristics.

The EDI strategy 2020-2024 is currently being refreshed, a new Strategic EDI Plan will be published towards the end of 2025 which will provide direction for the next four years; the EDI plan published in this year's annual report for the year ahead, represents the foundation work that is currently taking place to support the 2024-2028 Strategic Plan. The plan will be dynamic in nature to reflect the need for change including adapting to meet the emerging system needs from our partnership arrangements.

SP&C, TMC and The Board are invited to note the positive work that has taken place, the impact this has made when viewed through the lens of our performance reports (EDS etc) and to approve this report for publication.

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	Inclusion & Health Inequalities Sub-Committee – review and co-production of action plan Strategic People & Culture Sub Committee and Trust Management Committee review and approval				
Next Steps	Trust Board review and approval				

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:

This report responds to our duty to publish annual information, which is set out in the Specific Aims of the Public Sector Equality Duty (Equality Act 2010). The report high lights work done across the year and incorporates the Trust's mandatory and statutory reports (WRES, WDES, GPG), improvements have been made across 6 of the 10 WDES metrics, 3 metrics have worsened; and improvements have been made across 5 of the 9 WRES metrics, 2 have worsened. The Gender Pay Gap has also worsened slightly (by £0.92 from £6.88 to £7.80), a rationale is shared in the report.

Recommendation / Action Required The Board/Committee/Group is requested to:	
Trust Board to receive and approve the report for publication.	
Accountable Lead Signature	Jude Gray
Date	22/08/2024

Great Western Hospitals NHS Foundation Trust

Equality, Diversity & Inclusion (EDI) and Health Inequalities (HI) Annual Report 2023-2024

Contents

Accessibility Statement

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

- Telephone: 01793 604020
- Email: gwh.inclusion@nhs.net

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

Legal Statement

This document sets out how we have met the legal duties set out in the Equality Act 2010 – the Public Sector Equality Duty and the Health & Social Care Act 2022 and our obligations set out in the NHS Standard Contract 23/24 Service Condition 13 (SC13) – Equity of Access, Equality and Non-Discrimination. The report outlines the work undertaken to meet our commitment to improve healthcare and health and wellbeing for all and reduce health inequalities for our patients, local population and workforce. We have also highlighted some of our broader equality, diversity and inclusion work that supports our objectives set out in the Trust's Equality, Diversity & Inclusion (EDI) Strategy 2020-24. The EDI strategy will be refreshed during the summer of 2024, taking into account NHS England's EDI Improvement plan (6 High impact actions) and will be aligned with the aims of the new Trust strategy which will be published in the winter of 2024/25.

Report Contributors

Kat Bailey, Training Systems and Compliance Manager
Tania Currie, Head of Patient Experience and Engagement
Tim Edmonds, Associate Director of Communications & Engagement
Jon Freeman, Clinical Psychologist - Clinical Lead for Occupational Health & Wellbeing
Nicola Green, Head of Leadership, Succession Planning & Talent Management
Jude Gray, Chief People Officer
Wendy Johnson, Associate Director of Safeguarding and Lead for Mental Health
Christopher Mattock, Chaplaincy Team Leader & FTSU Lead Guardian
Katherine Simpson, Head of Midwifery and Neonatal Services
Claire Thompson, Director of Improvement and Partnership
Claire Warner, Deputy Chief People Officer
Jon Westbrook, Acting Chief Executive Officer
Helen Winter, Head of Insights and Learning
Candice Wood, Head of PALS and Complaints
Sharon Woma, Equality Diversity Inclusion (EDI) Lead
Amanda Wylie, Associate Director of OD & LD

Foreword by the Acting Chief Executive

I am pleased to present our annual report on Equality, Diversity and Inclusion (EDI) and Health Inequalities (HI) for 2023-24.

This report highlights our progress in building a welcoming, respectful and inclusive workplace, where staff feel valued and diversity is celebrated.

It also shares our ambition to become an anchor of inclusion for local communities, as we aspire to make healthcare equally accessible to everyone and tackle the unfair inequalities which we know exist in our local population.

A large proportion of our workforce are also members of our local communities and so our success as both an employer and healthcare provider are deeply connected. This is why I am so pleased to see many staff volunteering as EDI Champions in their own area. It's a great sign of the appetite for change and passion for inclusion which I see growing across the Trust.

I have enjoyed the fantastic events we have held throughout the year to raise awareness of the strength in diversity, particularly our first Neurodiversity Celebration which brought staff and local partners together for a fascinating day of learning, sharing and connection.

Our work extends beyond the Trust and into the communities we serve, and I can see the impact this is having. Our partnership with New College Swindon and Project Search is just one of the ways we are giving work experience to young people with learning disabilities or autism who may otherwise not have had the opportunity.

While our Staff Survey results show that we are moving in the right direction, with improvements in many areas related to EDI, it is also clear that we still have work to do.

As a Board we are leading by example by embodying our Leadership Behaviours which are integral to creating the Just and Learning Culture we are working towards.

In our daily activities, meetings and conversations we are committed to challenging all forms of discrimination, to being active allies, and to elevating the voices of staff through our collective of staff networks.

There is much to celebrate in this report and our progress is testament to the dedication of staff, but we must also recognise the scale and complexity of the challenge we face, with every step forward serving as a reminder for how far we have to go.

Jon Westbrook
Acting Chief Executive Officer
Great Western Hospitals NHS Foundation Trust

Foreword from the Equality, Diversity Inclusion Lead

I am delighted to present the 2023-2024 Equality Diversity & Inclusion and Health Inequalities Annual Report. Since joining the Trust eighteen months ago, I have had the honour of working with staff who are committed to addressing inequity wherever it occurs.

I have also teamed up with the equality staff in other organisations across the BSW system, and we have worked together to deliver several projects including the Equality Delivery System and engagement with staff over the year. I was invited to co-chair the system EDI group and this role will enable the Trust to help shape the inclusion and health inequalities agenda beyond the organisation walls.

This year, we were successful in winning an award, the EDI Improvement Award which has supported some ground-breaking work to recruit EDI Champions across the Trust. I continue to champion making inclusion ‘everyone’s business’, this is the only way we can bring about transformational change which has organisation wide benefits.

Over the year we have increased engagement with staff, increased EDI-related training and partnered with our staff networks to raise awareness of inequalities and issues that affect different groups of staff.

We hope that our readers find this report informative and engaging and invite you to share your views with us. There are a number of ways to engage with the Trust about patient/public experience during the year and you can contact gwh.inclusion@nhs.net if you would like to get involved

Sharon Woma

EDI Lead

1 | Introduction

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

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

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

EDI Strategic Objectives

The EDI Strategy 2020-2024 sets our four objectives which has directed our work over the past four years and three priorities which we set in 2023-24, this report focuses on our progress in 2023-2024. The objectives and priorities are:

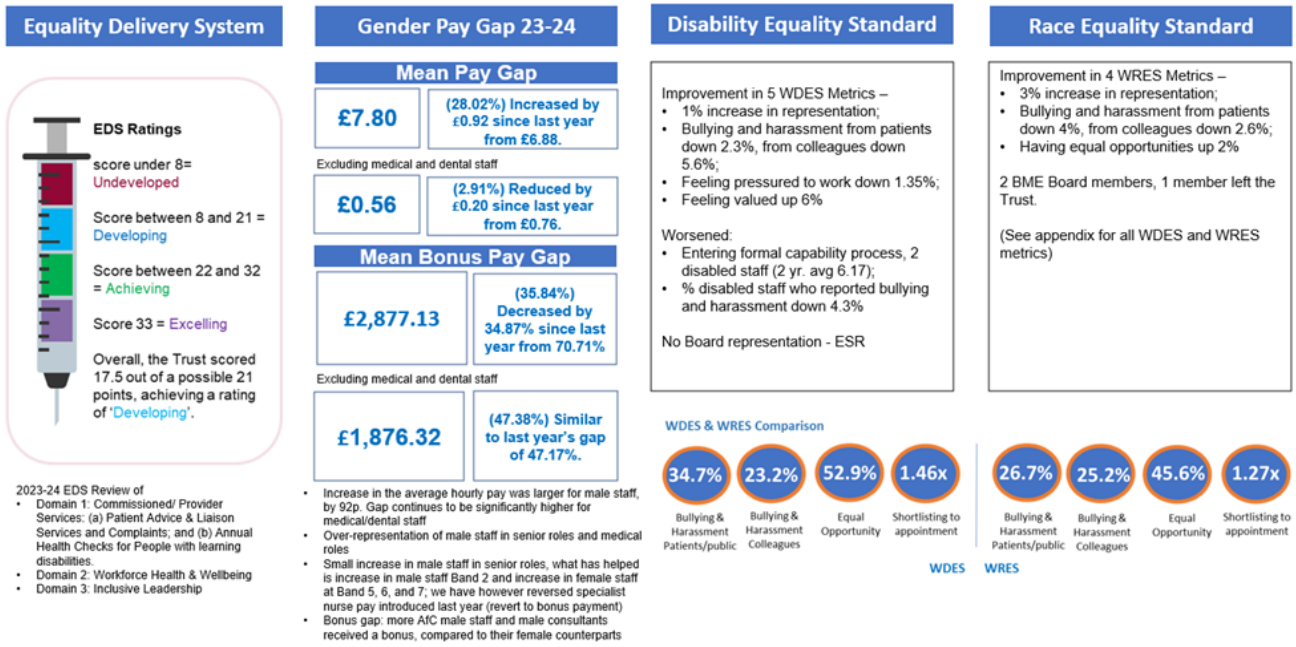
In addition, the Trust is an Anchor Institution. This term refers to organisations whose long-term sustainability is tied into the wellbeing of the populations they serve. We are therefore committed to providing employment for groups of people or communities who face more barriers to accessing work; and we are taking steps to reduce our carbon footprint and support local suppliers.

Achievements during 2023-2024 include:

Impact of our actions on our key performance metrics:

We have seen improvements in our two key performance frameworks – Workforce Disability Equality Standard and Workforce Race Equality Standard. Bullying and harassment has reduced, and staff feel more valued. Our staff survey indicates that discrimination remains relatively the same as last year and we will continue our Trust-wide effort to address this over the coming months.

Our staff and staff networks continue to play an instrumental role in delivering the reported actions and in shaping a culture that is responsive to the need for an inclusive, equitable and accessible NHS.



Workforce Disability Equality Standard Report – this report measures the extent to which our disabled staff have equal access to career opportunities and receive fair treatment at work, when compared to non-disabled staff.

No	Metric	2022-23	2023-24	Movement
1	Percentage of staff in each of the AfC Bands 1-9 and VSM	2.98%	4.14%	Improved
2	Relative likelihood of staff being appointed from shortlisting across all posts	1.44	1.46	Similar
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal capability investigation (average rolling two-year period)	3.63 (1 disabled staff)	6.17 (2 disabled staff)	Worsened
4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, managers and colleagues			
	Patients	37.0%	34.7%	Improved
	Managers	15.2%	12.8%	Improved
	Colleagues	28.8%	23.2%	Improved
	b) Percentage of staff who reported bullying and harassment	50.1%	45.7%	Worsened

5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	54.0%	52.9%	Worsened
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	30.7%	27.2%	Improved
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	28.0%	34.0%	Improved
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	72.3%	73.2%	Similar
9	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	6.3	6.4	Similar
	b) Initiatives that support the voice of disabled staff: Staff networks represent staff at strategic meetings and provide a safe space for staff to meet; Executive Sponsor appointed to support network and champion their work; Differently Abled Staff Network input into key policy development and initiatives to improve patient equity – this year they toured the hospital site with Estates to review door accessibility; staff engage directly with the CEO at monthly open forums; line managers receive training to support health and wellbeing conversations.			
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	0	0	Similar

Workforce Race Equality Standard Report – this report measures the extent to which our ethnic minority staff have equal access to career opportunities and receive fair treatment at work, when compared to white staff.

No	Metric	2022-23	2023-24	Movement
1	Percentage and number of staff in the Trust by ethnicity (AfC Bands 1-9 and VSM)	24%	27%	Improved
2	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants	1.64	1.27	Improved
3	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff	1.09	0.44	Worsened for white staff
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff	1.04	1.02	Similar
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	30.7%	26.8%	Improved
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	27.8%	25.2%	Improved
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	43.6%	45.6%	Improved

8	Percentage of staff experiencing discrimination at work from other staff in the last 12 months	19.5%	19.5%	Similar
9	The representation of BME people amongst board members	2	2	Similar

2 | Insights

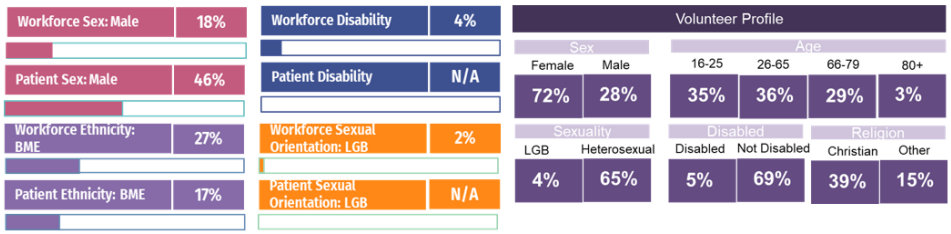
A snapshot of our region

We know that the demographic profile of our region, Bath and Northeast Somerset, Swindon and Wiltshire (BSW) population is changing. According to the Office of National Statistics (ONS), this will grow from 947k to 1.1m over the next 15 years. An overall growth of around 6% - the number of people over 60 will grow by 35%, however our population numbers under 60 will remain unchanged. In addition, our data modelling also shows that in 10 years BSW will have 25,000 more people with frailty than we do today. An aging population and increase in frailty and people with multiple health conditions is likely to put increasing pressure on services in BSW over the coming decade. This will have implications for how we work together as an Acute Hospital Alliance – made up of GWH, RUH Bath and Salisbury NHS Foundation Trust and the wider healthcare system. In the coming year we will consider how we build on this partnership working.

Patient & Workforce Profile

Year	Female	Male	BME	White	Ethnicity Unknown	Disabled	Not Disabled	Disability Unknown	LGB	Hetero-sexual	Orientation Unknown
2022	82%	18%	24%	68%	8%	3%	76%	21%	2%	65%	33%
2023	82%	18%	27%	65%	8%	4%	77%	19%	2%	67%	30%

More ethnically diverse, a growth of 3%, and 1% increase in disabled staff. Unknown status improving.



Patient data less robust but does indicate male staff are under-represented compared to patient profile.

Patients by age band

Age Band	Patients by Age Band	% Patients by Age Band	Age Band	Patients by Age Band	% Patients by Age Band
00-09	21124	11.2%	50-59	24892	13.2%
10-19	16424	8.7%	60-69	24198	12.9%
20-29	16660	8.9%	70-79	23031	12.2%
30-39	22641	12.0%	80-89	14908	7.9%
40-49	20007	10.6%	90+	4175	2.2%

Overall	188060	100%

Workforce by age band

Age Band	Head Count (HC)	HC %	Age Band	Head Count (HC)	HC %
<=20 Years	62	1.04%	46-50	649	10.87%
21-25	367	6.15%	51-55	657	11.01%
26-30	773	12.95%	56-60	569	9.53%
31-35	941	15.76%	61-65	348	5.83%
36-40	849	14.22%	66-70	73	1.22%
41-45	649	10.87%	71+ Years	32	0.54%
Grand Total				5,969	100.00%

Patient Profile

The Trust delivered care to 188,060 patients during 2023-2024 with 1,076,043 total patient contacts across A&E, Outpatients, Inpatients and Community. We do not hold data relating to sexual orientation or disability status.

The age profile of our patients is highlighted in the table above, the largest group of patients are in the 50-59 age band (13.2%), 60-69 (12.9%) and 70-79 (12.2%). The smallest age bands are 80-89 (7.9%) and 90+ (2.2%).

Workforce Profile

*The Trust employs **5962 staff** as at 31.03.2024, the gender split (sex) remains the same, 82% female and 18% male. We are supported by **410 Volunteers** and a further 109 currently in the recruitment process. 72% are women and 28% men. **3,407 (57%)** are **full-time staff** and **2,562 part-time (43%)**.*

In order to meet the unique needs of the different communities that use our services, we need a diverse workforce with lived experience who can inform our practice and policies. We are under-represented in some areas, when compared to our patients, 82% of our staff are female and 18% male, in contrast the split in the patient group is 54:46. Note, at present we do not have access to the level of data that would indicate sexual orientation or disability. However, ethnicity, religion, gender and age range are recorded. Note data on our transgender or other gendered staff and patients is not available due to the small population size. In the 2021 Census 0.24% of people had a gender identify that was different from sex registered at birth – 0.2% of responders identified as transgender, 0.06% identified as non-binary. This might give some indication of the make-up of our local population.

The age profile of the Trust is relatively young, the largest age group being 31-35 years old (16%). 20% of our workforce is under 20 to 30 years old; 41% between 31 and 45; 31% between 46 and 60 years old and 8% between 61 and over 70 years old.

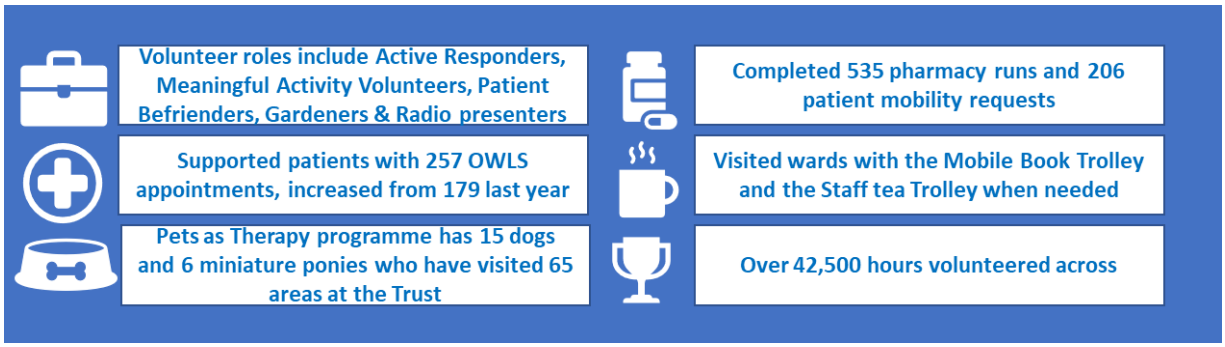
Volunteering at GWH

Volunteers are critical to the future of our NHS. They make a huge contribution to the health and wellbeing of the nation by giving their time, skills, and expertise freely to support people most in need. Volunteers are an integral part of the NHS's vision for the future of health and social care, as partners with, not substitutes for, skilled staff.

Great Western Hospitals NHS Foundation Trust currently has a total of **410** Volunteers and a further **109** currently in the recruitment process. The Trust is fortunate to retain a fantastic team of volunteers who commit to giving their time to help support staff, patients, and visitors across the hospital. **72%** are women and **28%** men.

The longest serving volunteer has been with us for 20 years. Our oldest consistent volunteer is 87 years old and the youngest is 16 years old; 33% of our volunteers are students. In 2023/24 **14 volunteers** became paid staff.

Highlights from 2023-2024 include:



3 | Inclusive Leadership

We believe inclusive leadership is a critical driver for organisational success. Therefore, we are committed to promoting the principles and practices of inclusive leadership, which can help us to foster an environment where every member of staff feels valued, respected, and empowered to contribute their best. This will enable us to unlock the full potential of our workforce, drive innovation, and enhance overall performance. This may also contribute to retention.

At the heart of this ethos is delivering great patient care, research evidence indicates that where inclusion is practiced, it is known to lead to better experience and outcomes for our patients.

4 | Culture

Building an inclusive culture is crucial to harness the full potential of our diverse workforce. Our ambition is to foster an environment where every staff member feels supported and valued and feels a sense of belonging, which in turn will boost morale and productivity and enables the Trust to deliver high-quality patient care.

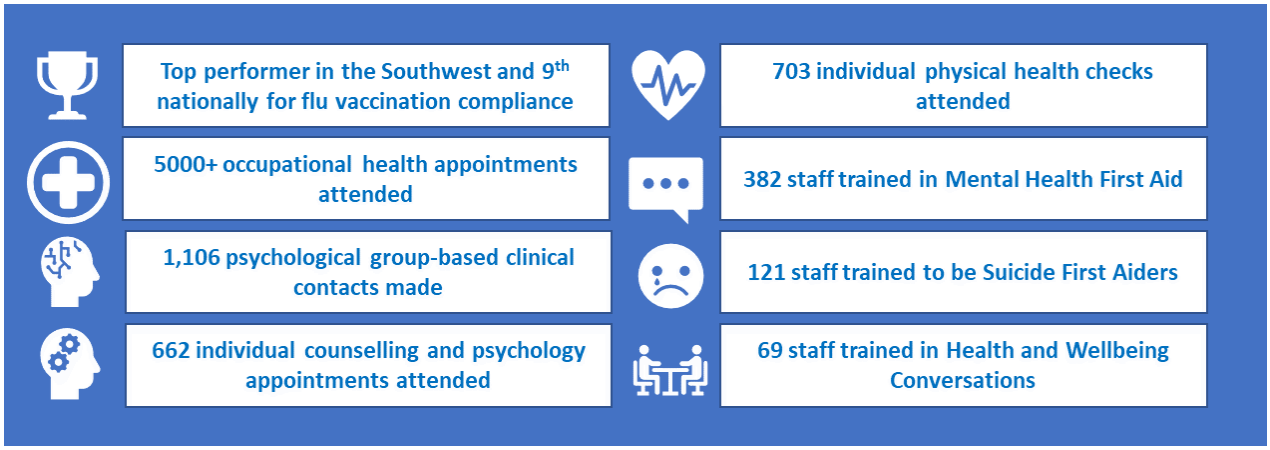
We achieved our highest ever response rate of 69%, in the 2023 NHS Staff Survey (59% in 2022).

Staff have indicated we have made improvements across all metrics that measure performance against our NHS People Promise goals. The table below shows where we have made the most improvements, including 'we are recognised and rewarded', 'we are safe and healthy', 'we are always learning' and morale.

PEOPLE PROMISE ELEMENTS	23-24 INITIATIVES INCLUDE	2022-2023 SCORE	2023-2024 SCORE	INCREASE
We are recognised and rewarded	2023 Annual Staff Excellence Awards at STEAM Swindon	5.65	5.91	0.26
We are safe and healthy	Health & Wellbeing days and action on Discrimination	5.84	6.12	0.28
We are always learning	Access to leadership development and role-specific training	5.37	5.69	0.32
Morale	Engagement with staff – input into the Trust Strategic Plan 2025-28	5.65	5.91	0.26

Health & Wellbeing

The health and wellbeing of our workforce remains paramount, we want our staff to be healthy and well; to support this we deliver a range of initiatives informed by our Health & Wellbeing Strategy. This includes helping them look after their physical and mental health.



The Voice of our Staff

Employee listening is crucial for fostering an inclusive work environment and reducing health inequalities within our community. Our staff are also patients and community members who have both professional expertise and personal experiences and provide valuable insights that the Trust can leverage to enhance patient care and improve our collaborative efforts. By actively seeking to understand our employees' feelings and experiences in their daily interactions with colleagues and patients, we gain a comprehensive view of our workplace dynamics. We offer various platforms to ensure that all staff voices can be heard.

Improving Together

We are embedding the Improving Together methodology across the Trust, with over 800 staff accessing training and implementing the ‘continuous improvement’ approach in their areas of work, in fact 55% of staff feel they are able to make improvements in their area of work. Improvements in 2023 include interventions in perinatal care, where we are seeking to optimise care for our most vulnerable babies and mothers, staff have implemented evidence-based interventions, parent held passports and coaching teams; ‘Think Hydration’ is a campaign to remind staff and patients of the importance of hydration for recovery, healing and wellbeing; and one ward introduced ‘Rate my Day’, a daily check of staff morale to help measure how staff are feeling – the tool is used to prompt health and wellbeing discussions.

We selected Discrimination as our ‘Improving Together’ Pillar Metric this year – which has raised the profile of this negative experience and prompted Trust-wide initiatives. Our Staff Survey data (see Workforce Race Equality Standard) highlights that staff from ethnic minority backgrounds disproportionately have this experience (57%, compared to 16% for gender-based discrimination and 9% on the grounds of disability), and we are keen to both reduce the level of discrimination for all staff and address the disparities in the experience between different demographic groups.

EDI Improvement Award

In November 2023, the Trust won the EDI Improvement Award, under the category of ‘Inclusive and Safe Workplace’. The award supported a programme of work to recruit, train and deploy EDI Champions across the Trust. Champions are staff volunteers who support colleagues in their area of work, when they experience unprofessional behaviours; they also play a role in supporting the networks and wider EDI agenda. During this period, staff took part in shaping the programme, and designing the output which is a workshop to address unprofessional behaviours. We value the support and work of all our Champions who have given over 80 hours of their time so far to promote inclusion and support their colleagues.

Our Staff Networks

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

- Differently Abled Network who represent the interest of disabled staff.
- LGBTQ+ Network who represent the interest of our lesbian, gay, bisexual, transgender and queer plus staff.
- Race Equality Network who represent the interest of ethnic minority staff.
- The Women's Network.
- Armed Forces Network, although armed services personnel and veterans are not a protected characteristic, the Trust recognises the unique challenges they face.
- A Carer's Network to provide support and information for staff who may be caring for a family member, relative or friend whilst balancing working life.

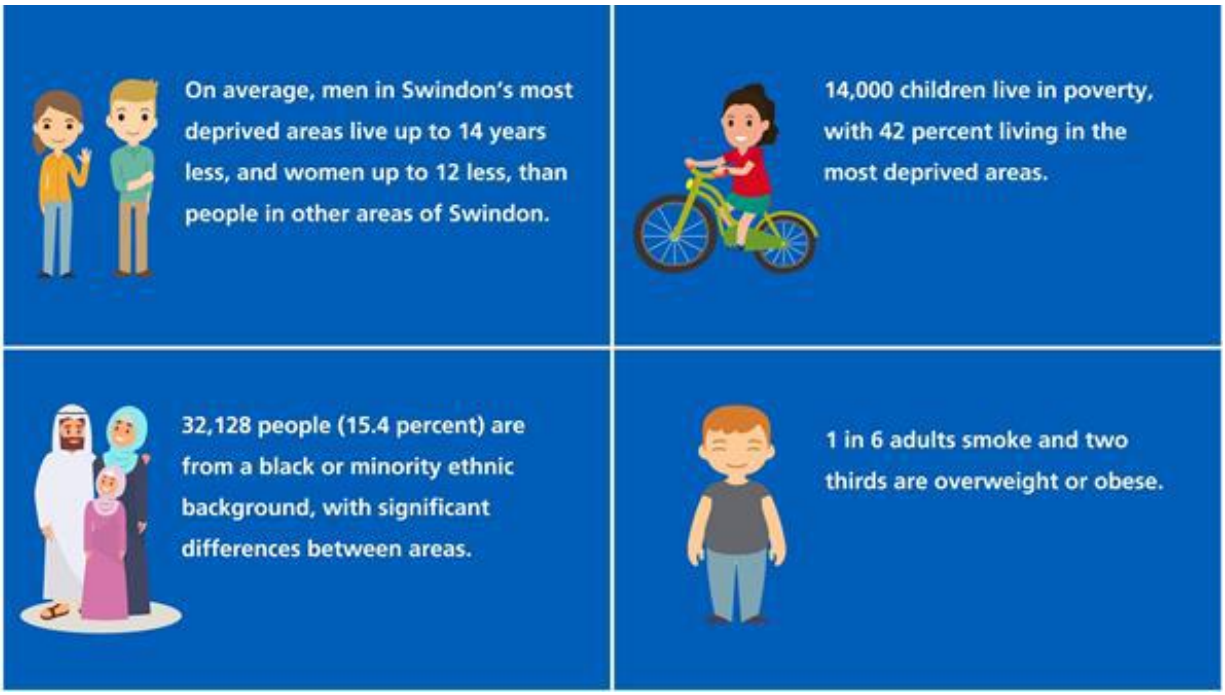
Staff networks play an important role in the life of the Trust. Our staff networks are part of the Inclusion & Health Inequalities Subcommittee, which is a strategic group that oversees the EDI agenda and the progress we are making. The networks also act as supportive spaces for their members and they welcome allies (who might not share the same protected characteristics as the beneficiaries of the network) who help to deliver various initiatives including engagement and workshops. During the course of the year, they lead on a range of events to mark key EDI calendar dates including International Women's Day, Pride, Disability Awareness Month and Black History Month. In January 2024 we hosted our first Neurodiversity Celebration event which was a day-long event including workshops, internal and external guest speakers and our special guest speaker, the Rt Honourable Robert Buckland KC closed the event.

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

We also reviewed evidence to help us to measure our EDI performance by undertaking a self-evaluation using the Equality Delivery System (EDS) framework. EDS is a comprehensive evaluation of both patient and workforce inclusion. Between July 2024 and March 2024, we scored the Trust against three Domains – Commissioned & Provider Services; Workforce Health & Wellbeing and Inclusive Leadership. The Trust scored a total of 17.5 out of 22 marks during this process. Two services were evaluated, Patient Advice & Liaison Services (PALS) & Complaints and Annual Health Checks (for patients on the learning disability register). Our services were reviewed as a system with partner organisations, which has helped us to identify areas that we can focus on collectively and provide each organisation with external scrutiny and challenge. We scored health and wellbeing and leadership internally and will take steps to involve other stakeholders in the future.

We believe fostering an inclusive culture is everyone's business, our data indicates where we have made progress across several metrics, and we are keen to see transformative change in the areas we are still lagging. This can only happen when inclusion is everyone's business.

5 | Tackling Health Inequalities



We continue to make improvements to patient care and to ensure that the voice of patients, families, carers, and the wider public are involved including those from seldom heard and minority groups.

Over the last year we have focussed on building relationships and trust to facilitate further engagement with our patients and carers, including people from seldom-heard communities. This has included working with carers, people with spinal cord injuries, people with learning disabilities and mental health disorders. We have undertaken co-production initiatives and worked with our patients and staff to improve access to physical spaces and made improvements to support our Deaf patients, as highlighted in the table below.

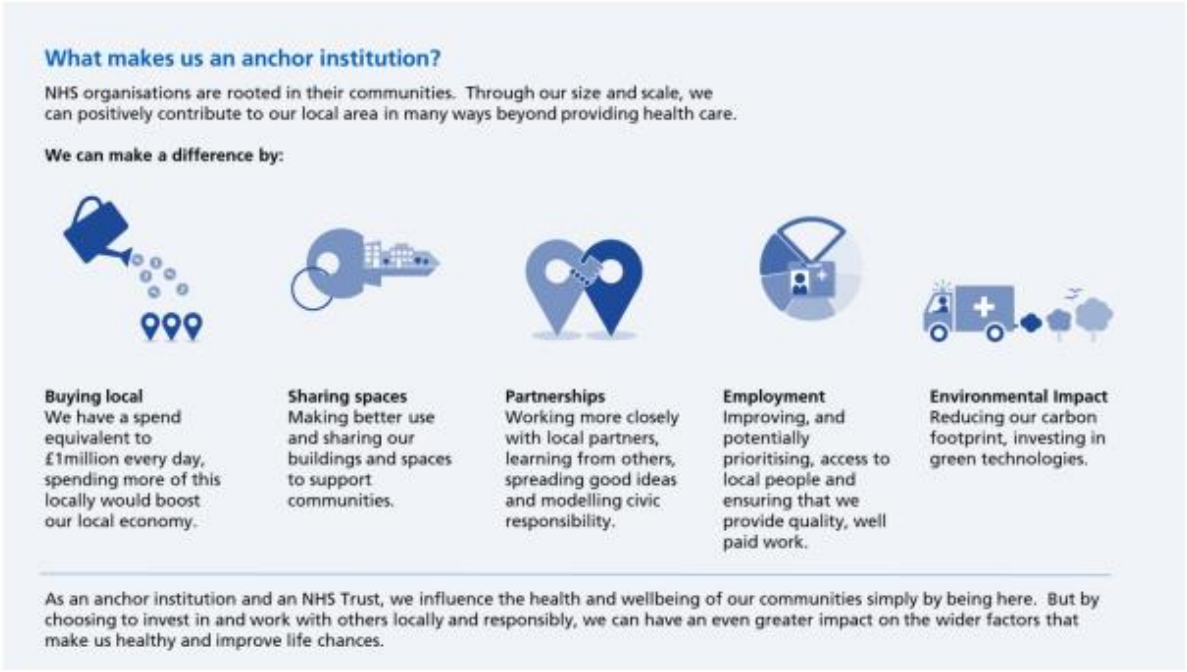
Voice	Spinal Cord Injury Coproduction group formed in September 2023 - staff and patients in collaboration.	Worked in collaboration with Deaf patients to improve access including BSL training for staff.
	Two sessions held in community to understand views of people with learning disabilities and autism.	Patients with mental health disorders completed a survey to help us improve access.
Access	Staff training include patients with lived experience, e.g. of Spinal Cord Injury and Learning Disability.	Two services reviewed (see EDS reporting*) to improve access, experience and outcomes.
	Met with patients with physical and sensory impairtments to discuss new Integrated Front Door.	Engaged with disabled staff to review door accessibility to inform planned improvements.
Support	Carers Support Passport launched in May 2023 which assists staff to recognise carers.	Outpatient Welcome Liaison Service (OWLS) volunteers escort carers and patients when needed.
	PALS feedback, alternative language and multi-language welcome posters now available.	'Supporting Trans Patients Guide' was developed to help direct staff when caring for trans patients.

* Equality Delivery System (EDS) is a self-assessment undertaken in the NHS to measure and monitor access, experience and outcomes across all patient and workforce groups.

We work closely with system and community partners including – Healthwatch, Voluntary Action Swindon, Livewell Swindon, Swindon Equality Coalition, Maternity Voices Partnership, Learning Disability Partnership Board, Disability Experts, Swindon Children's and Young People's Participation network, Swindon Special Educational Needs and Disabilities, New College Swindon, the Borough Council, local charities, and faith groups to support our ambition to make GWH services inclusive and accessible for everyone we serve.

Evolving as an Anchor Institution

We are developing our role as an Anchor Institution. As a large employer, purchaser, and capital asset holder, we are well positioned to use our spending power and resources to address the adverse social, economic and environmental factors that widen inequalities and contribute to poor health.



In July 2023 the Trust adopted the BSW Integrated Care System's Suppliers & Representatives Code of Conduct Policy. The policy supports the ICS's Equality and Diversity Policies and introduces the BSW ICS Supplier Charter which establishes the system's ambition to work with suppliers who have values and behaviours that endorses our mission. The charter also sets out expectations including 'generating social value'.

We have also worked with local partners in several ways to address the social determinants of health, these are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. This has included providing work experience placements for young people from poorer socio-economic backgrounds, we have hosted students who attended the Dare to Doctor programme in July 2023 which gives aspiring young people an opportunity to get hands-on experience whilst they explore the field of medicine and healthcare science as a career – new programmes, Dare to AHP, Dare to Nurse and Dare to Care will be introduced in the summer of 2024. During the year we also hosted Project Search, which helps young adults with learning disabilities and autism gain experience and find employment and from February 2023 we offered 20 T-Level healthcare placements to local college students; T-Levels are vocational qualifications, equivalent to three A-Levels. The programme inspires many young people to pursue a career in healthcare.

During our engagement with local communities and our staff and volunteers in 2023 and 2024, they told us that they wanted the Trust to broaden our sustainability focus, beyond the financial challenge and to include the long-term sustainability of our services and to deliver against our commitments on carbon net zero. These areas have been priorities for the Trust for some time, but we recognise that we can do more to showcase the work we do to ensure our sustainable future.

6 | Looking Ahead

This report highlights numerous initiatives and provisions which have supported the Trust to provide inclusive services and to create a climate that is more welcoming and diverse. We value our staff, and the Trust's wellbeing and support offer is a testament to our commitment to keep our workforce safe and healthy, more can be done across all of the areas we monitor, but our efforts have led to some positive improvement in our EDI performance in 2023-24.

We will continue to review and improve our recruitment processes to ensure all candidates have a great interview experience and we will build on the work we have delivered to support retention, including strengthening our talent management programme, building on our Trust-wide approach to tackling unprofessional behaviours, facilitating the voice of staff by creating a platform for them to engage with Board Members and undertaking an independent review of our Speaking Up processes. Our action plan will take into account all six EDI High Improvement Actions

set out in the national NHSE EDI Improvement Plan, in addition to responding the different frameworks, and regional and local People (workforce) and EDI strategies.

Our robust EDI Strategy 2020-24 that provided a cohesive direction for the Trust over the past four years is due to be renewed, going forward we will have one Trust strategy, and an EDI Strategic Plan which aligns with this key document and our partnership model with Salisbury NHS Foundation Trust and RUH Bath.

We believe these plans will help us to transform tomorrow's NHS and we invite our stakeholders, including staff, leadership, governors, volunteers, patients and local population, to partner with us to deliver this work successfully. If you would like to know how you can get involved contact us at gwh.inclusion@nhs.net.

7 | Appendix

Performance Reports

Accessible Information Standards

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

The Trust partners with its disabled staff network, the Differently Abled Network, to help raise awareness around accessibility issues. The Trust offers an Access Information Standards e-learning course which all staff can access. The training module takes staff through steps on how to communicate effectively with patients whilst being inclusive, to ensure that patients feel involved and empowered to make informed decisions about their care. In November 2023 Differently Abled Staff Network members were part of a go-and-see group including Estates and the Head of Patient Experience and Engagement, who toured various parts of the hospital to assess door accessibility, this has informed a schedule of work to make improvements. In the next reporting year, April 2024-March 2025, the Trust will complete the implementation of the new Reasonable Adjustments Digital Flag which will improve flagging across the NHS. This will improve access for all relevant patients who require adjustments to care, in line with the disability (protected characteristic) requirements of the Equality Act (2010).

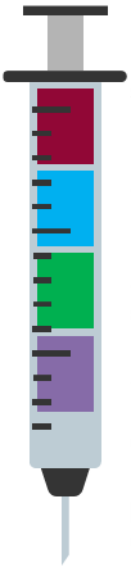
Equality Delivery System 2023-2024

The NHS Equality Delivery System (EDS 2022) is a self-assessment framework designed to help NHS organizations review and improve our performance in promoting equality and diversity and ensuring fair and inclusive healthcare services. It provides a set of objectives and outcomes we use to measure our progress in delivering equality across all aspects of our operations, from patient care to workforce management. EDS 2022 consists of three Domains:

- **Commissioned and Provided Services:**
    - **Better Health Outcomes**: Ensuring equitable health outcomes for all patients, regardless of their background.

    - **Improved Patient Access and Experience**: Making sure that all patients have equal access to services and receive respectful and responsive care.
- **A Representative and Supported Workforce**: Ensuring that the NHS workforce is diverse and that staff from all backgrounds feel supported and valued.
- **Inclusive Leadership**: Promoting leadership that is diverse and inclusive at all levels of the NHS.

There are 18 specific and measurable outcomes across the three domains including reducing health inequalities in the population and workforce; improving patient feedback mechanisms and leadership engagement and governance in relation to the inclusion and health inequalities agenda. Stakeholders are invited to come along and score a range of evidence under each Domain, and all group scores are totalled to give an overall score. Currently, Commissioned and Provided Services are scored at system level alongside partner organisations in the BSW Integrated Care System. Workforce and Leadership Domains are scored internally. The Trust will continue to widen participation in this process annually.



EDS Ratings

score under 8= Undeveloped

Score between 8 and 21 = Developing

Score between 22 and 32 = Achieving

Score 33 = Excelling

Overall, the Trust scored 17.5 out of a possible 21 points, achieving a rating of 'Developing'.

This year, between July 2023 and March 2024 two services were reviewed – Annual Health checks for patients with learning disabilities (score of 12) and Patient Advice & Liaison Services and Complaints (score of 5), resulting in an average score of 8.5. Domain 2 Workforce Health & Wellbeing scored 5, the score was impacted by the constraints of our current data by demographic information. To significantly increase Domain 2 score, in the NHS Staff Survey results over 70% of staff would have to 'recommend the organisation as a place to work' and over 70% of staff 'would be happy with the standard of care provided if a friend or family member used the services'. The Trust's score for 2023 is 59.57% and 60.61% respectively, this score has improved since last year. Inclusive Leadership which focusses on evidence of Board engagement and awareness, scored lower than the other two Domains, achieving a score of 4. Although progress has been evidenced, with increased Board engagement with workforce, and Board education, scoring can only be improved with an evidence of additional data across protected characteristics and year-on-year improvements across the different monitoring/measurement frameworks, like the Workforce Disability Equality and Workforce Race Equality Standards reported below; and we are confident the emerging trend will help improve future scoring.

Actions from the EDS report, which could improve the Trust score are included in the EDI & HI Action Plan in this appendix.

NHS Staff Survey 2023

The NHS Staff Survey is an annual survey conducted among employees of the NHS in England. It aims to collect feedback on various aspects of working within the NHS, including work conditions, job satisfaction, management, well-being, and other factors that influence the staff experience. The Trust invites staff to take part in the survey every year and we use the results to inform and improve policies and practices; to gather feedback; to measure staff engagement and to benchmark ourselves against other NHS organisations of a similar size and against national performance.

68.9% of our staff completed the NHS Staff Survey in November 2023, this has risen from 58.6% last year. The Trust ranks in the top 5 for the number of staff who have completed the survey.

Key questions in this survey are used to inform the Equality, Diversity & Inclusion strategy and annual plans – there are specific questions related to diversity and inclusion that are reported in the Workforce Disability Equality Standard and Workforce Race Equality Standard in the following section of this report and the Equality Delivery System Review; and we have shared improvements made in our 'People Promise' overleaf.

Our People Promise

The NHS People Promise is an initiative aimed at fostering a supportive and inclusive work environment for all NHS staff. It is part of the broader NHS People Plan and focuses on making the NHS a better place to work. The promise outlines a set of commitments designed to ensure that every member of the NHS workforce feels respected, valued, and supported. The key components of the People Promise are:

- We are compassionate and inclusive: Promoting a culture where everyone feels respected and included, ensuring equality and diversity are upheld.
- We are recognized and rewarded: Ensuring that staff contributions are acknowledged and that they receive fair rewards for their hard work.
- We each have a voice that counts: Encouraging open communication and ensuring that all staff feel their opinions and concerns are heard and valued.
- We are safe and healthy: Prioritizing the physical and mental well-being of staff, providing support and a safe working environment.
- We are always learning: Offering opportunities for continuous professional development and lifelong learning.
- We work flexibly: Supporting flexible working arrangements to help staff balance their work and personal lives.

PEOPLE PROMISE ELEMENTS	2022-2023 SCORE	2023-2024 SCORE
We are compassionate and inclusive	7.16	7.25
We are recognised and rewarded	5.65	5.91
We each have a voice that counts	6.64	6.71
We are safe and healthy	5.84	6.12
We are always learning	5.37	5.69
We work flexibly	6.25	6.41
We are a team	6.64	6.79
Themes		
Staff Engagement	6.70	6.85
Morale	5.65	5.91

Colour Code: Statistically significant change since 2022

Significantly higher	Not Significant	Significantly lower

- We are a team: Fostering teamwork and collaboration, ensuring everyone works together towards common goals.

Since we last reported (2022-2023), we have significantly improved on the majority of the People Promise elements, notably, the metric 'we are recognised and rewarded' has increased by 0.26, from 5.65 last year to 5.91 this year (2023-2024); 'we are safe and healthy' increased by 0.28, from 5.84 to 6.12; 'we are always learning' increased by 0.32, from 5.37 to 5.69; and morale has increased by 0.26, from 5.65 to 5.91. We are currently developing a robust action plan to improve this area, and we have recently appointed a People Promise Manager to oversee delivery.

Gender Pay Gap Report 2023-2024

What is our Gender Pay Gap Report

Under the provisions of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which relate to public sector employers in England and Wales, the Trust is required by law to publish an annual gender pay gap report.

We published our Gender Pay Gap each year based on a snapshot date of 31 March.

The Trust has been required to report and publish specific details about its gender pay since 2018, including:

- Mean and median gender pay gaps
- Mean and median gender pay gap for bonus payments
- The proportion of males and females who received bonus payments
- The proportion of males and females in each pay quartile.

The gender pay gap measures the difference between the pay rates of all male and female staff across the Trust, irrespective of their role and seniority.

Our Gender Pay Gap data at the snapshot date of 31.03.2024 is: -

All Staff – Female staff earn £0.72 for every £1 a male staff earns when comparing the mean pay:

Mean Gender Pay Gap – all staff	£7.80	(28.02%) increased by £0.92 since last year from £6.88

The Trust mean gender pay gap for all staff is £7.80 (28.02%), a small increase of £0.92 (76%). The average hourly pay for female staff has increased by £1.67, in comparison the hourly pay for male staff has increased by £2.59.

The median gender pay gap is £2.62 (12.76%), this has improved by £1.30 (6.12%) since last year.

Excluding medical and dental staff – female staff earn £0.97 for every £1 a male staff earn when comparing the mean pay:

Mean Gender Pay Gap - non medical and dental staff	£0.56	(2.91%) decreased by 1.27% since last year from £0.76

When medical and dental staff are excluded from the equation, the mean and median gender pay gap is significantly reduced. **The mean gender pay gap is £0.56 (2.91%)** this has improved by £0.20 (1.27%) since last year; **the median gender pay gap is -£0.52 (-3.03%)** in favour of female staff, the gap was in favour of male staff last year when it was £0.21 (1.25%).

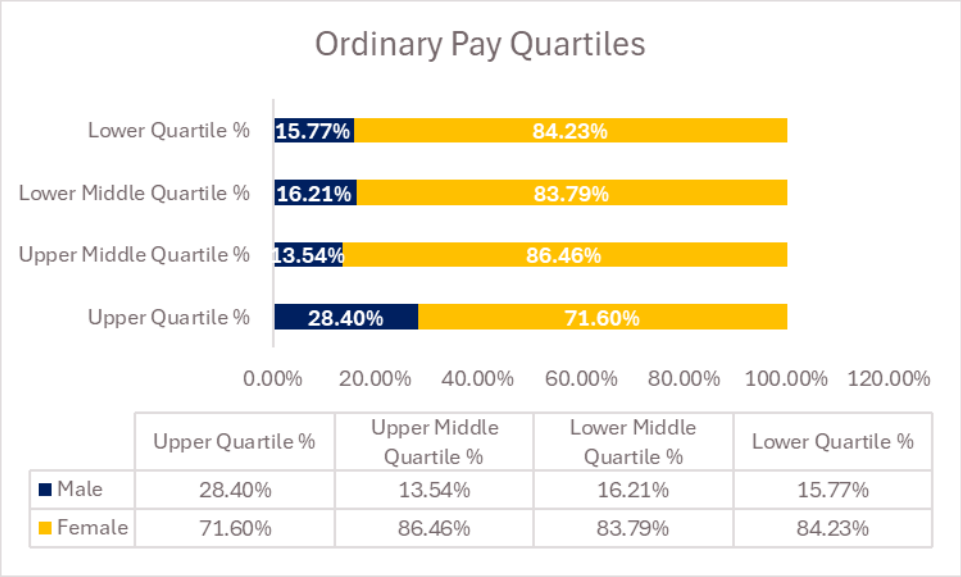
Medical only staff – female staff earn £0.86 for every £1 male staff earn when comparing the mean pay:

Mean Gender Pay Gap - medical and dental staff only	£6.61	(13.85%) decreased by 5.20% since last year from £7.52

Our gender pay gap is driven by our medical and dental staff group. When this group are analysed in isolation, **the mean gender pay gap is £6.61 (13.85%)** and **the median gender pay gap is £12.15 (26.79%)**. The mean gender pay gap has improved by £0.91 (5.20%). The percentage median gender pay gap has improved slightly this year, from 27.65% in 2022-23 to 26.79%.

Why do we have a Mean Gender Pay Gap?

The Trust had a mean gender pay gap of £7.80 (28.02%). The gap is mainly driven by the higher proportion of male staff who are employed in senior roles and male staff in medical roles and therefore earn a higher hourly rate of pay on average – distribution of male staff across pay quartiles, 28% in the highest pay quartile compared to 16% in the lower quartile (lowest paid), 16% in the lower middle quartile and 13% in the upper middle quartile; whereas female staff are more evenly distributed across the lower, lower middle and upper middle quartiles (84%, 84% and 86% respectively) but are under-represented in the upper quartile, at 72%.



	Upper Quartile %	Upper Middle Quartile %	Lower Middle Quartile %	Lower Quartile %
Male	28.40%	13.54%	16.21%	15.77%
Female	71.60%	86.46%	83.79%	84.23%

Our mean gender pay gap for all staff has slightly worsened since last year, which is driven by the impact of medical staff, if medical staff are excluded the mean improves significantly to £0.56 (2.91%). When we analyse our data by pay band, we have slightly increased the number of male staff in senior roles, for example, non-execs males have increased by two and VSMs have increased by two males since last year, in contrast female VSMs have decreased by 1; and male medical staff have increased by 30, compared to an increase of 18 female staff in this group. What has helped is we have increased the number of female staff in the upper-lower and middle bands (Band 5, Band 6 and Band 7) and increased the number of male staff in the lower band (significantly in Band 2).

Bonus Pay Gap 2023-24

The gender pay gap for bonus payments shows how bonus/incentive payments were distributed between male and female employees who received bonuses in the 12 months leading up to 31st March 2024.

Bonus Payments consist of:

- Recruitment & Retention Premiums including relocation payments
- Local and national Clinical Excellence Awards for Medical & Dental Staff
- Incentive payments for hard to fill shifts

"Specialist" bank rates are included in bonus payments this year (reported in ordinary pay in 2023) owing to a change in payment type within ESR linked to pension contributions. This has resulted in the bonus pay levels for Agenda for Change staff increasing year on year.

All Staff – Female staff earn £0.64 for every £1 that male staff earn when comparing the Mean Bonus Pay.

Mean Bonus Pay Gap – all staff	£2877.13	(35.84%) decreased by 34.87% since last year from 70.71%

The mean bonus pay gap for all staff is £2877.13 (35.84%), the mean bonus paid has significantly reduced by £10,601.54 and the gap has decreased by 34.87%, a significant improvement. **There is no median bonus pay gap.**

Mean Bonus Pay Gap – non medical and dental staff	£1876.32	(47.38%) increased by 0.21% since last year from 47.17%
Mean Bonus Pay Gap - medical and dental staff only	£1508.61	(18.02%) increased by 4.80% since last year from 13.22%

However, when we analyse data for non-medical staff the mean bonus pay is £1876.32 (47.38%) and median is £840.00 (43.75%), significantly higher than the mean and median for medical staff (18.02%/£1508.61 and 0% respectively).

Who received Bonus Pay

1017 male staff and 4493 female staff were eligible for a bonus. 115 male staff received a bonus (92% of this group were medical and dental staff) and 106 female staff received a bonus payment (64% of this group were medical and dental staff). Medical and dental staff receive larger bonuses than non-medical staff.

Why do we have a Gender Pay Gap in Bonus Pay for non-medical staff?

The bonus pay gap exists in non-medical roles because male staff have received significantly higher payments.

Although fewer male staff received a bonus, 9 male staff compared to 38 female; male staff received a higher bonus payment, a difference of £1876.32 on average. This is as a result of an increase in Waiting List Initiative (WLI) rates for Agenda for Change Staff and more male staff receive this payment than female; we also reversed the pay treatment of specialist nurse roles because of the impact on pensions, the pay increase awarded last year, has been reverted to a bonus payment. The median, or mid-point, is also higher, a difference of £840, indicating the higher payments are not an outlier, non-medical male staff tend to occupy higher paid roles (see pay quartiles chart).

Why do we have a Gender Pay Gap in Bonus Pay for medical staff?

The bonus pay gap exists because male medical and dental staff receive a larger share of the bonus payments; in addition, there are more male consultants than female (m 158, 64% vs f 90, 36%), and consultant bonuses attract a higher payment.

Although bonus payments were relatively similar for both groups (115 bonus payments for male staff and 106 bonus payments for female staff), there were more male staff in the medical/dental sub-group (61% of the group) and medical and dental staff earn a

higher bonus, compared to non-medical/dental staff. In addition, consultants who are also mainly male staff (m 151, f 91), receive two potential awards (see LCEA below), again, these awards attract a higher payment further widening the gap.

2023 Local Clinical Excellence Awards (LCEA)

There were 166 consultant applications for this award, 161 consultants met the criteria. 96 (60%) were male and 65 (40%) were female.

Pre-2018 Local Clinical Excellence Awards (LCEA)

Consultants were eligible for 48 awards (38 male and 10 female), out of which 43 made an application. 35 awards were given to male staff and 8 to female. Note, a consultant can receive more than one payment.

2024-2025 Changes

National consultant contract changes will be implemented on the 1st April 2024, as a result all consultants currently receiving a pre-2018 LCEA will continue to do so at the existing value until they retire or leave the NHS. The Trust will not undertake any future reviews of this award.

Note, the median pay and bonus pay value represents the man or woman who is in the middle of a list of hourly pay rates and bonus payments ordered from highest to lowest paid; the median is a useful number because it represents a ‘typical’ situation and is not distorted by high or low values (outliers). However, by reviewing the mean (average) pay, we are more likely to be able to identify issues because it gives an overall picture of our gender pay gap, but very high or very low figures can distort the data.

Gender Pay Gap Actions

We recognise that improving the gender pay gap will take considerable time, this is impacted by historic contractual arrangements in the medical and dental workforce and gender inequalities across society. Women pay a higher penalty because they disproportionately have unpaid caring responsibilities which can lead to career breaks, work part-time and can experience occupational segregation, with men tending to dominate certain roles and this work is valued differently.

However, we continue to strive for change by making improvements to our job advertising to ensure that we attract a diverse candidate pool, and this is evidenced in our recruitment data, we have increased representation in disabled staff and ethnic minority staff. We are also diversifying where we advertise our roles, and now utilise specialist job platforms like Black Leadership Jobs Boards for some roles and LinkedIn which has helped. We introduced the ‘Inclusion Recruitment Champions (IRC)’ in 2023, they are volunteer staff who sit on interview panels for Band 8B and above roles. Our IRCs participate equally in the interview process; and they provide an additional level of assurance that our interview panels are free from any form of bias, whether conscious or unconscious. We will evaluate this programme in 2025 to gauge its effectiveness.

The Trust offers leadership programmes to help develop our future talent and provide recruitment and interview skills training to help recruiting managers apply best practice. We are also supporting our nursing staff, who are mainly female, to progress through training and development; our legacy mentors support staff across a range of topics from career progression to issues they experience on the job and we provide sessions to improve job applications for our internationally educated nurses. Further training will be launched in September 2024 to support newly qualified nurses in practice and internationally educated nurse who want to attain their NMC pin and progress.

A panel continues to meet annually to oversee the bonus awards and take steps to raise awareness of the awards and encourage female consultants to apply.

In 2024-2025 we will look at pay gap data for other groups.

Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is an initiative designed to improve the workplace experience and career opportunities for NHS staff with disabilities. It requires NHS organizations to measure and understand the experiences of disabled employees through a set of specific metrics. These metrics include aspects such as representation in the workforce, career development opportunities, and levels of bullying or harassment. By analysing this data and implementing targeted actions, the WDES aims to create a more inclusive and supportive environment for disabled staff, ensuring they have equal opportunities to thrive within the NHS.

The 2023-2024 WDES Report is based on a snapshot of our workforce data as at 31 March 2024. National data, used for comparison, is based on 2022-23 NHS Staff Survey data and 2023 Electronic Staff Record data from across the NHS.

Section three and four of this annual report highlights a number of initiatives we have undertaken during the year to improve these metrics and an action plan has been included at the end of this report to reflect the initiatives that will be undertaken in the year ahead (2024-2025) to drive further progress.

The WDES contains ten metrics highlighted in the table below: -

No	Metric
1	Percentage of staff in each of the AfC Bands 1-9 and VSM
2	Relative likelihood of staff being appointed from shortlisting across all posts
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal capability investigation

4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse
	b) Percentage of staff who reported bullying and harassment
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
9	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation
	b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce

Metric 1 Percentage of staff in each of the AfC Bands 1-9 and VSM

247 (4.14%) with a disability or long-term health condition. National benchmark 4.9%.

The Trust has increased its number of disabled staff to 247, which represents 4.14% of the workforce, compared to 169 (2.98%) last year. The number of staff who have not shared their disability status has improved, from 1206 last year to 1140 this year.

The trend remains positive and the number of Disabled staff has increased incrementally over the past five years (see table). Our data confirms there has been an increase in applications from disabled people, this will be influenced by an increase in people feeling more confident about self-disclosure at the interview stage and our recruitment efforts to promote jobs to different communities to attract a more diverse candidate pool.

						Percentage of total workforce		
Year	Disabled Staff	Growth since previous year	Non-Disabled Staff	Unknown Status	Total	% Disabled	% Non-Disabled	% Unknown

2019	64		3298	1366	4728	1.35%	69.75%	28.89%
2020	73	14.06%	3720	1418	5211	1.40%	71.39%	27.21%
2021	83	13.70%	3999	1421	5503	1.51%	72.67%	25.82%
2022	133	60.24%	4133	1239	5505	2.42%	75.08%	22.51%
2023	169	27.07%	4300	1206	5675	2.98%	75.77%	21.25%
2024	247	46.15%	4575	1140	5962	4.14%	76.74%	19.12%

247 of the Trust's 5962 staff are disabled, who are employed across clinical roles (175 staff) and non-clinical roles (72 staff). One disabled member of staff is in a band 8+ clinical role, five are in non-clinical roles and eight are in medical roles, including two consultants. This has improved since last year when there was one disabled member of staff in Band 8A and above non-clinical roles, three in clinical roles and three in medical roles including one consultant. 1.8% of medical and dental staff are disabled, 85.83% are non-disabled and 13.09% unknown.

2024	Non-Clinical						Clinical, Medical & Dental					
	Disabled	Non-Disabled	Not Known	Total	Disabled %	Non-Disabled %	Disabled	Non-Disabled	Not Known	Total	Disabled %	Non-Disabled %
Under Band 1	1	6	0	7	1.4%	0.6%	1	6	0	7	0.6%	0.2%
Band 1	0	1	0	1	0.0%	0.1%	1	1	0	2	0.6%	0.0%
Band 2	15	261	56	332	20.8%	26.3%	18	212	50	280	10.3%	5.9%
Band 3	27	319	64	410	37.5%	32.2%	38	596	123	757	21.7%	16.6%
Band 4	5	100	37	142	6.9%	10.1%	12	186	85	283	6.9%	5.2%
Band 5	8	85	14	107	11.1%	8.6%	34	750	279	1063	19.4%	20.9%
Band 6	5	62	14	81	6.9%	6.3%	40	694	168	902	22.9%	19.4%
Band 7	6	61	10	77	8.3%	6.1%	22	366	97	485	12.6%	10.2%
Band 8A	3	40	8	51	4.2%	4.0%	1	97	22	120	0.6%	2.7%
Band 8B	1	30	2	33	1.4%	3.0%	0	20	5	25	0.0%	0.6%
Band 8C	1	10	4	15	1.4%	1.0%	0	9	1	10	0.0%	0.3%
Band 8D	0	4	2	6	0.0%	0.4%	0	7	0	7	0.0%	0.2%
Band 9	0	8	1	9	0.0%	0.8%	0	2	0	2	0.0%	0.1%
VSM	0	5	0	5	0.0%	0.5%	0	1	1	2	0.0%	50.0%

Consultant							2	199	41	242	1.1%	5.6%
Non-consultants Career Grade							3	92	16	111	1.7%	2.6%
Trainee Grades							3	345	40	388	1.7%	9.6%
Other												
Total	72	992	212	1276	5.6%	77.7%	175	3583	928	4686	3.7%	76.5%

When medical and dental staff are excluded, disabled staff are well represented in Bands 1-5 compared to non-disabled staff; reducing the significant number of staff with an 'unknown' disability status will help us to build a more accurate picture. When looking at our Electronic Staff Record (ESR) data, disabled staff are under-represented across the workforce at 4%, compared to the local Swindon population of 6.9% (ONS). When we look at alternative data from our staff survey questions, 22% of staff are disabled. The staff survey figure accounts for staff who might not identify as disabled but have a long-term health condition.

Distribution of staff - Band 1 to VSM (excluding medical/dental)	Disabled	Non-Disabled	Unknown
Lower Bands (1-5)	66.95%	64.05%	67.88%
Middle Bands (6-7)	30.54%	30.03%	27.71%
Upper Bands (8a and above)	2.51%	5.92%	4.41%

Metric 2 Relative likelihood of staff being appointed from shortlisting across all posts

Non-Disabled candidates are 1.46 times more likely to be appointed from shortlisting, than disabled candidates. National benchmark 0.99.

Year	Relative Likelihood of appointment
2018/19	1.66
2019/20	1.52
2020/21	1.12
2021/22	0.98
2022/23	1.44
2024/24	1.46

During the year 360 staff were shortlisted following a job application, and 30 (8.33%) have been appointed. During the same period 4404 non-disabled candidates applied for roles and 536 non-disabled candidates (12.17%) from this group have been appointed. 465 candidates did not share their disability status, from this group 288 (61.94%) were appointment. Improving the number of candidates who share their status will help to build a more accurate picture.

The shortlisting to appointment ratio is similar to last year when it was 1.44 (384 disabled candidates were shortlisted and 24 (6.25%) appointed).

The reader is advised to note the small sample size of disabled candidates, when making any statistical comparisons between both groups

Metric 3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal capability investigation

Disabled staff are six times more likely to enter a formal capability process (number compounded by non-disclosure). National benchmark 2.17x.

Year	Relative Likelihood
2018/19	2.62
2019/20	2.83
2020/21	0.00
2021/22	0.00
2022/23	3.63
2023/24	6.17

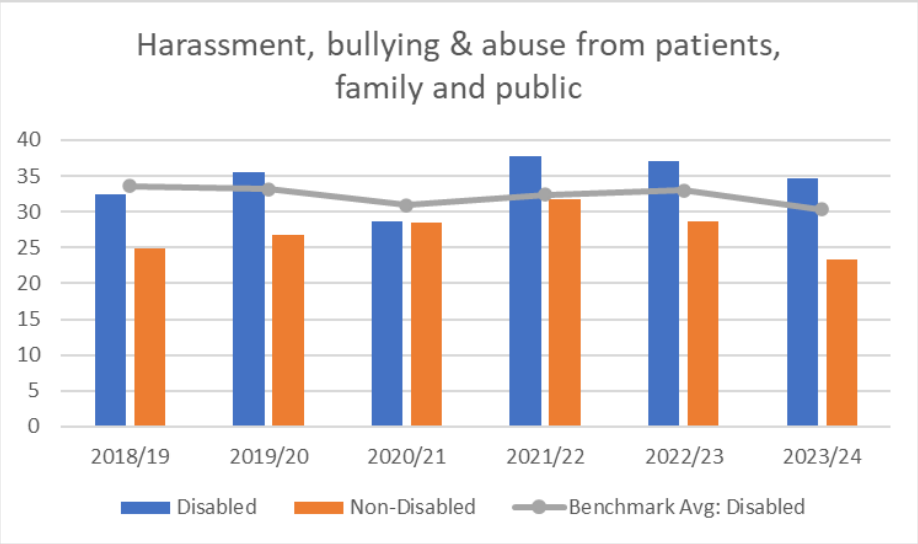
The 2023/24 relative likelihood is 6.17, indicating Disabled staff are more than six times as likely to enter the capability* process as their Non-Disabled colleagues. This data is skewed by the number of staff whose disability status is unknown – three staff with unknown status entered a capability process over the two-year period; two were disabled, six non-disabled and three had an unknown status. In last year's report, one disabled person entered the formal capability process during the two-year rolling period.

A figure above 1 indicates that Disabled staff are more likely than Non-Disabled staff to enter the

**By capability, we mean capability on the basis of performance, not ill health. This Metric is based on data from a two-year rolling average of the current year and the previous year (April 2022 to March 2023 and April 2023 to March 2024).*

Metric 4 a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse

34.7% of disabled staff have experienced harassment, bullying and abuse from patients, family and the public. National benchmark 33.2%.

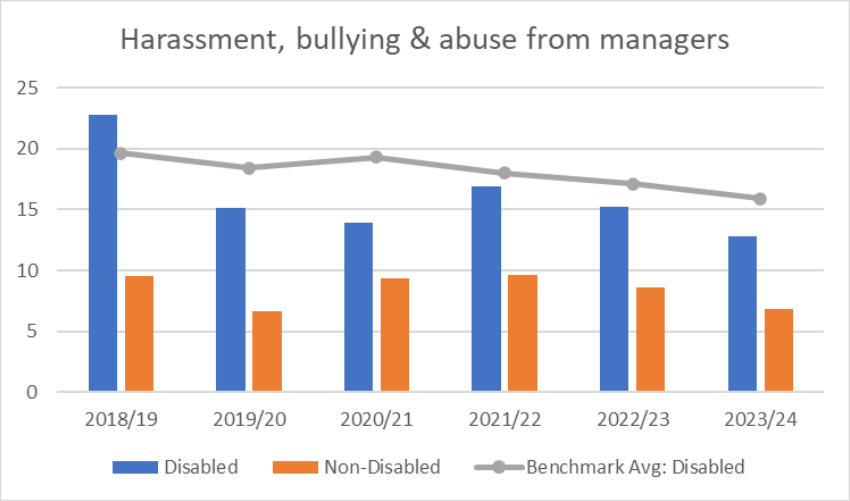


34.7% of disabled staff have experienced harassment, bullying and abuse from patients, family and the public. The benchmark* average is 30.3%. This has improved since last year when 37.03% of disabled staff had the same experience.

In comparison, 23.3% of non-disabled staff experienced harassment, bullying and abuse from patients, family and the public – similar to the benchmark average of 23.8%; this metric has also improved for non-disabled staff, last year 28.7% had this experience.

**The Trust is benchmarked against NHS organisations of a similar size. The grey line in the chart represents this benchmark average. This average differs from the national picture which reflects all participating NHS organisations (the national average is provided*

12.8% of disabled staff experienced harassment, bullying and abuse from managers. National benchmark 16.1%.

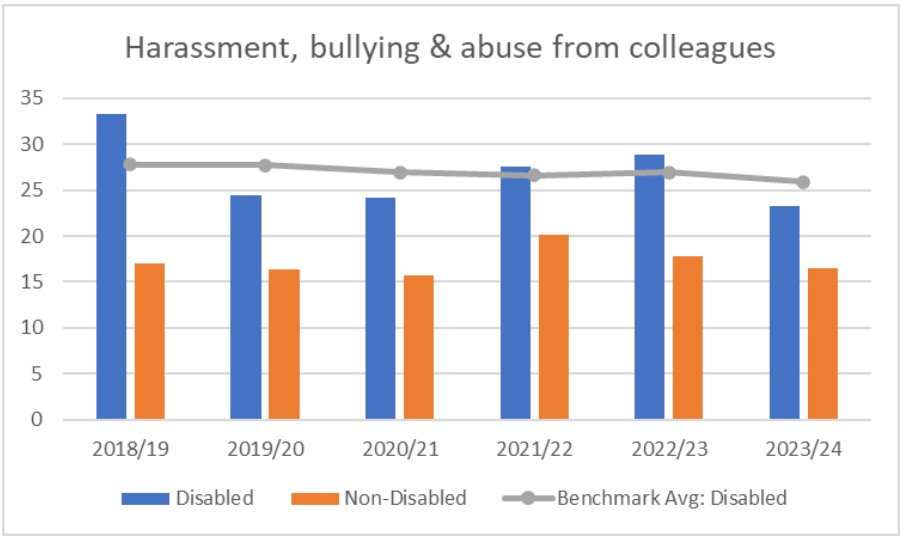


12.8% of disabled staff have experienced harassment, bullying and abuse from a manager. The Trust is performing better than the national average of 15.9%. This metric has improved since last year when 15.2% of disabled staff had the same experience.

In comparison, 6.8% of non-disabled staff experienced harassment, bullying and abuse from managers, which is also better than the benchmark of 8.7%. This metric has also improved for non-disabled staff, last year 8.8% had this experience.

**The Trust is benchmarked against NHS organisations of a similar size. The grey line in the chart represents this benchmark average. This average differs from the national picture which reflects all participating NHS organisations (the national average is provided in the summary text).*

23.2% of disabled staff experienced harassment, bullying and abuse from other colleagues. National benchmark 24.8%.



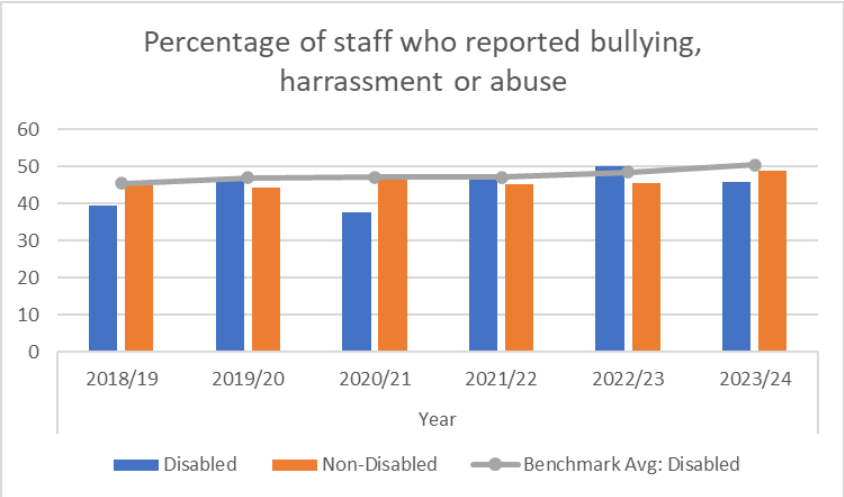
23.2% of disabled staff have experienced harassment, bullying and abuse from another colleague. GWH is performing better than the benchmark average of 25.7%. This has improved since last year when 28.8% of disabled staff had the same experience.

In comparison, 16.5% of non-disabled staff experienced harassment, bullying and abuse from colleagues – similar to the benchmark average of 16.6%. This metric has also improved for non-disabled staff, last year 17.8% had this experience.

The Trust is benchmarked against NHS organisations of a similar size. The grey line in the chart represents this benchmark average. This average differs from the national picture which reflects all participating NHS organisations (the national average is provided in the summary text).

Metric 4 b) Percentage of staff who reported bullying and harassment

45.7% of disabled staff who experienced harassment, bullying and abuse reported it. National benchmark 51.3%.



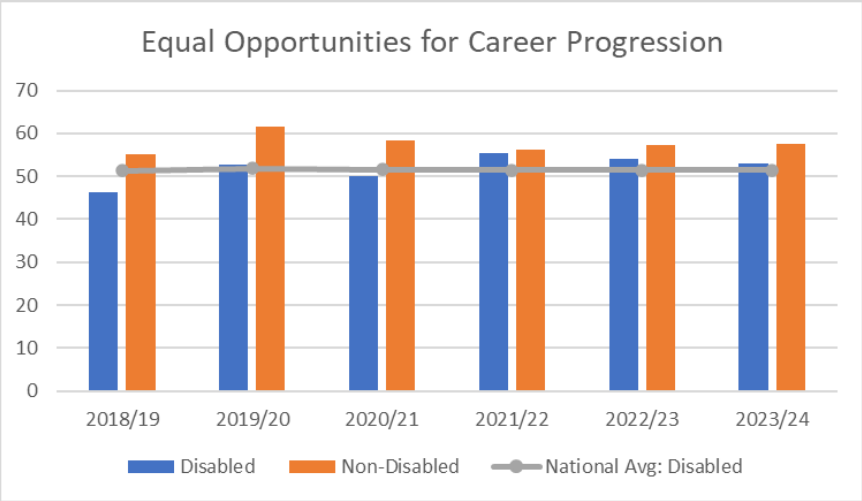
45.7% of disabled staff who experienced harassment, bullying and abuse stated they or a colleague reported it. The benchmark* average for this year is 50.4%. This has worsened since last year when 50.1% of disabled staff said they or a colleague reported the incident.

In comparison, 48.4% of non-disabled staff who experienced harassment, bullying and abuse reported it; similar to the benchmark average of 49.3%. This metric has improved for non-disabled staff, last year 45.5% said they or a colleague reported the incident.

**The Trust is benchmarked against NHS organisations of a similar size. The grey line in the chart represents this benchmark average. This average differs from the national picture which reflects all participating NHS organisations (the national average is provided in the summary text).*

Metric 5 Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

52.9% of disabled staff believe the Trust provides equal opportunities for career progression or promotion. National benchmark 52.1%.



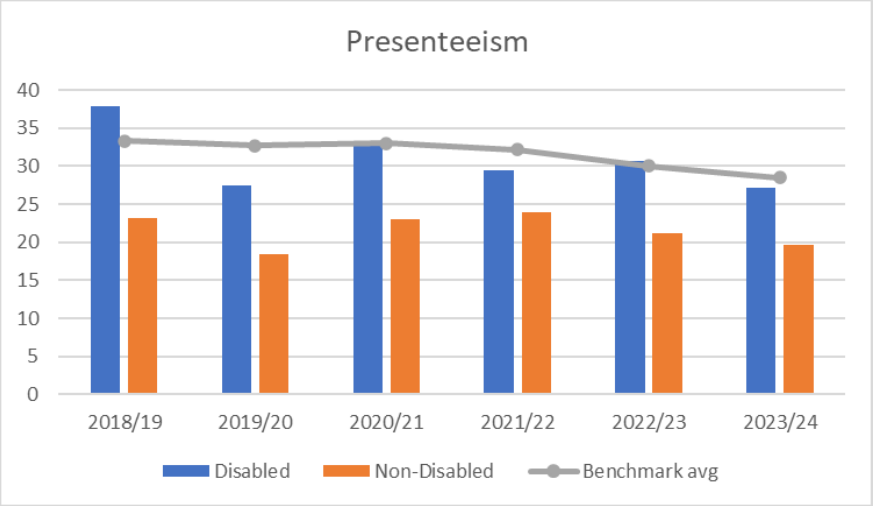
52.9% of disabled staff feel they have equal opportunities. This has worsened since last year when 54.0% of disabled staff felt they had equal opportunities. The benchmark average is 51.5%.

In comparison, 57.5% of non-disabled staff feel they have equal opportunities; this metric is similar to last year when 57.3% of non-disabled staff felt they had equal opportunities. The benchmark average is 57.5%.

The Trust is benchmarked against NHS organisations of a similar size. The grey line in the chart represents this benchmark average. This average differs from the national picture which reflects all participating NHS organisations (the national average is provided in the summary text).

Metric 6 Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

27.2% of disabled staff felt pressure from their line manager to work despite not feeling well enough to perform their duties. National benchmark 27.7%.



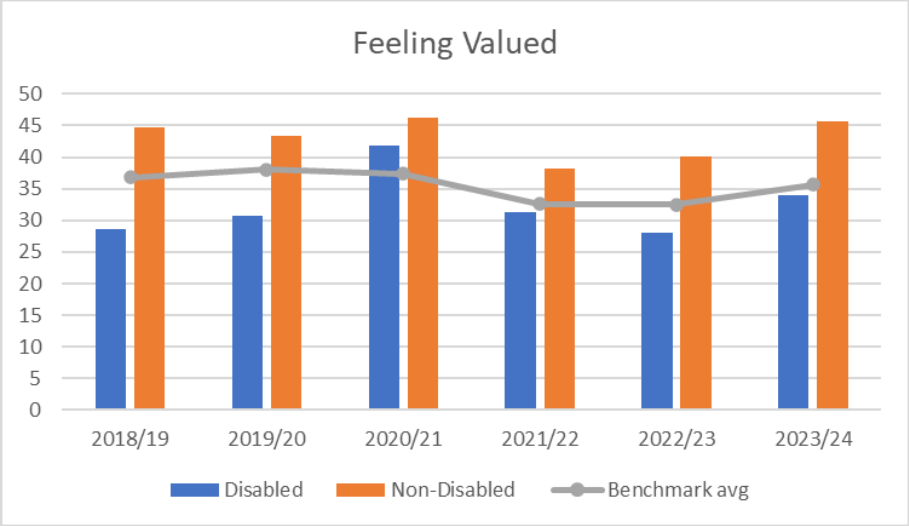
Less than a third of Disabled staff (27.2%) reported that they felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. This is slightly lower than the benchmark average of 28.55%*. This has improved by 3.46 percentage points since last year, when 30.67% of disabled staff felt pressure to work.

In contrast, 19.6% of Non-Disabled staff reported the same; which is reflective of the benchmark average of 19.5%.

**The Trust is benchmarked against NHS organisations of a similar size. The grey line in the chart represents this benchmark average. This average differs from the national picture which reflects all participating NHS organisations (the national average is provided in the summary text).*

Metric 7 Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

34% of disabled staff were satisfied with the extent to which the Trust valued their work. National benchmark 35.2%.



34.0% of staff feel satisfied with the extent to which the Trust values their work. This has markedly improved since last year when 28.0% of disabled staff felt satisfied. In contrast, 45.6% of non-disabled staff felt the Trust valued their work, this metric has also markedly improved since last year when 40.0% of non-disabled staff felt their work was valued. The benchmark* average is 35.7% for disabled staff and 47.2% for non-disabled staff.

**The Trust is benchmarked against NHS organisations of a similar size. The grey line in the chart represents this benchmark average. This average differs from the national picture which reflects all participating NHS organisations (the national average is provided in the summary text).*

Metric 8 Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

73.2% of disabled staff have adequate workplace adjustments. National benchmark 73.4%.

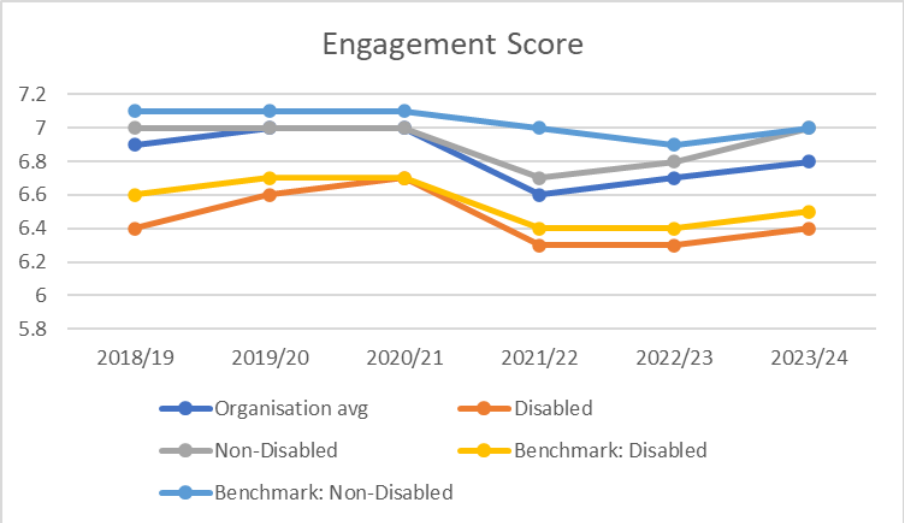
Year	Relative Likelihood
2018/19	75.0%
2019/20	82.4%
2020/21	81.4%
2021/22	70.5%
2022/23	72.3%
2023/24	73.2%

73.2% of staff with a disability or long-lasting health condition or illness feel the Trust has made reasonable adjustments to enable them to carry out their work. This is reflective of the benchmark* average of 73.38%. This metric has improved slightly since last year, from 72.3%.

**The Trust is benchmarked against NHS organisations of a similar size.*

Metric 9 a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

Disabled staff Engagement Score of 6.4 (range 0-10). National benchmark 6.4.



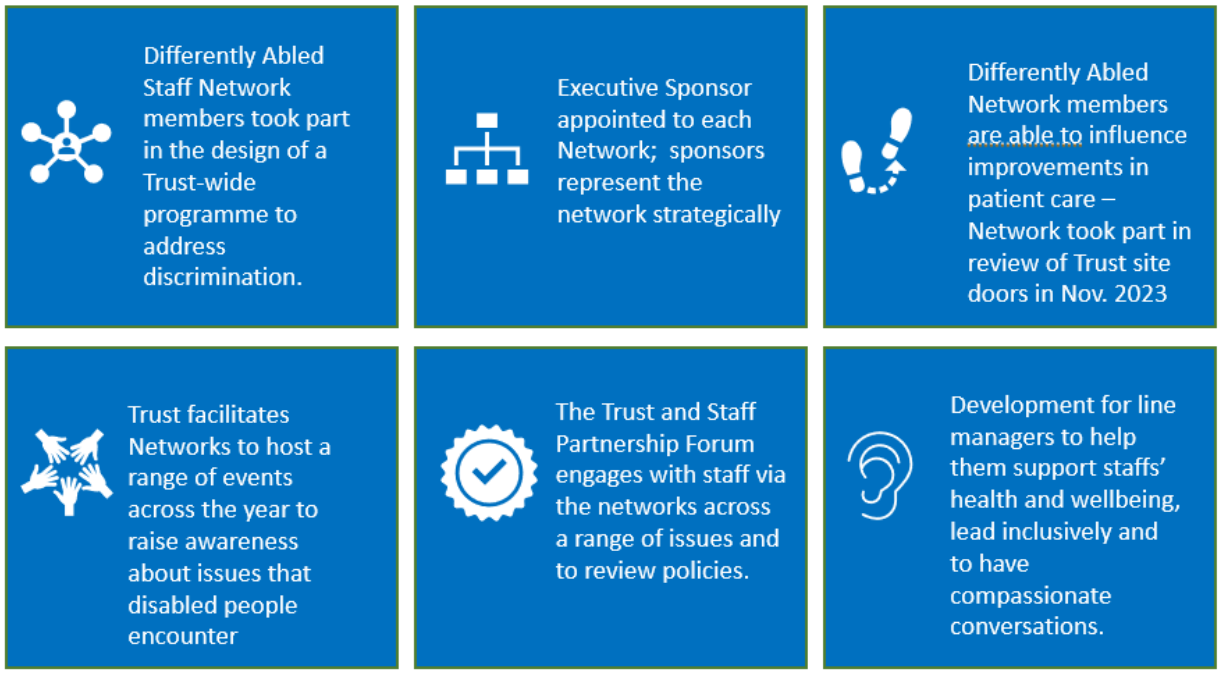
Disabled staff feel slightly less engaged than non-disabled staff, with an engagement score of 6.4, compared to a score of 7.0 for non-disabled staff. This is similar to last year's score for disabled staff which was 6.33. The Trust is performing in line with it's benchmark average of 6.5 for disabled staff and 7.0 for non-disabled staff.

The Trust's overall engagement score is 6.8, which is similar to last year's 6.7.

**The Trust is benchmarked against NHS organisations of a similar size.*

Metric 9 b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

The Trust provides several routes for staff to speak up, which are highlighted in the 'Culture' section of this report, including monthly staff forum meetings with the CEO and access to Speak Up Guardians, union representatives, leadership and staff networks. Our networks play a vital role in representing the voice of disabled staff. Members sit on our strategic EDI and Health Inequalities committee, review policies and help the Trust to improve access to the hospital and the network works closely with the EDI Lead to champion inclusion.



Metric 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce

The Trust Board has no disabled board members and twelve non-disabled board members. Seven have not shared their status. National benchmark 5.7%.

	2023 BOARD MEMBERSHIP					OVERALL WORKFORCE	RATE OF DISABILITY/ LTC* FROM STAFF SURVEY
	Voting	Non-Voting	Executive	Non-Executive	Total		
Disabled	0	0	0	0	0	4%	22%
Non-Disabled	12	0	6	6	12	77%	78%
Unknown	4	3	1	6	7	19%	

Our Electronic Staff Records (ESR) does not indicate that the Trust has any disabled Board Members, this data remains the same as 2022-2023. Only 4% of staff have shared their disability status via ESR, in contrast 846 staff (22%) who completed the survey have stated they have a disability or long-term health condition. Staff are encouraged to share this information; however, some staff do not identify as being disabled or would prefer not to say. Twelve of our Board Members are Non-Disabled, all 12 are voting members; seven have not shared their disability status, one of which is a voting member and six non-voting. Non-voting members include two Associate Non-Executive Directors (NEDs). The NHS Associate NED programme has been developed to support people with senior level experience, who are currently under-represented on NHS Boards into non-executive roles.

Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) is an initiative aimed at addressing racial inequalities within the NHS workforce. It focuses on ensuring that employees from ethnic minority background have equal access to career opportunities and receive fair treatment in the workplace. The WRES requires NHS organizations to collect, analyse, and publish data on race equality indicators such as recruitment, career progression, and disciplinary actions. By highlighting disparities and holding organizations accountable, the WRES seeks to create a more inclusive and equitable working environment for all NHS staff.

The 2023-2024 WRES Report is based on a snapshot of our workforce data as at 31 March 2024. National data, used for comparison, is based on staff survey results for 2022-23 and Electronic Staff Records data as at March 2023 from across the NHS.

Section three and four of this annual report highlights a number of initiatives we have undertaken during the year to improve these metrics and an action plan has been included at the end of this report to reflect the initiatives that will be undertaken in the year ahead (2024-2025) to drive further progress.

The WRES contains nine metrics highlighted in the table below: -

No	Metric
1	Percentage and number of staff in the Trust by ethnicity (AfC Bands 1-9 and VSM)
2	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants
3	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion
8	Percentage of staff experiencing discrimination at work from other staff in the last 12 months

9	The representation of BME people amongst board members

Metric 1 Percentage and number of staff in the Trust by ethnicity (AfC Bands 1-9 and VSM)

1624 (27.24%) of staff are from an ethnic minority background. National benchmark 26.4%.

The Trust employs 5962 staff, 3859 (65%) of these staff are white and 1624 (27%) are from an ethnic minority background (including 418 international staff), in 2022-2023, the percentage of ethnic minority staff was 24%.

						Percentage of total workforce		
Year	BME Staff	Growth since previous year	White Staff	Unknown Status	Total	% BME	% White	% Unknown
2018	564		4509	539	5612	10.05%	80.35%	9.60%
2019	556	↓ -1.42%	3613	586	4755	11.69%	75.98%	12.32%
2020	753	↑ 35.43%	3846	612	5211	14.45%	73.81%	11.74%
2021	938	↑ 24.57%	3943	581	5462	17.17%	72.19%	10.64%
2022	1131	↑ 20.58%	3863	511	5505	20.54%	70.17%	9.28%
2023	1369	↑ 21.04%	3829	477	5675	24.12%	67.47%	8.41%
2024	1624	↑ 15.71%	3859	479	5962	27.24%	64.73%	8.03%

Our ethnic minority staff are well represented in clinical roles, 32%; this group is over-representative of the local ethnic minority population, which is currently around 15%; non-clinical roles are less diverse, 9% of these staff are from an ethnic minority background. The largest growth in staff numbers has been in Band 5 roles, which has increased by 114 staff since last year. This is due to a growth in the number of staff in clinical roles (from 479 to 591). Ethnic minority staff are well-represented in consultancy grade roles (22%), non-consultant career grade roles (35%) and trainee grades (36%).

2024	Non-Clinical						Clinical, Medical & Dental					
	White	BME	Not Known	Total	White %	BME %	White	BME	Not Known	Total	White %	BME %
Under Band 1	7	0	0	7	100.0%	0.0%	6	1	0	7	85.7%	14.3%
Band 1	1	0	0	1	100.0%	0.0%	2	0	0	2	100.0%	0.0%
Band 2	279	33	20	332	84.0%	9.9%	147	113	20	280	52.5%	40.4%
Band 3	353	36	21	410	86.1%	8.8%	466	241	50	757	61.6%	31.8%
Band 4	125	7	10	142	88.0%	4.9%	197	65	21	283	69.6%	23.0%
Band 5	89	12	6	107	83.2%	11.2%	354	591	118	1063	33.3%	55.6%
Band 6	65	12	4	81	80.2%	14.8%	640	204	58	902	71.0%	22.6%
Band 7	68	8	1	77	88.3%	10.4%	406	47	32	485	83.7%	9.7%
Band 8A	44	6	1	51	86.3%	11.8%	106	7	7	120	88.3%	5.8%
Band 8B	29	1	3	33	87.9%	3.0%	18	3	4	25	72.0%	12.0%
Band 8C	14	0	1	15	93.3%	0.0%	8	1	1	10	80.0%	10.0%
Band 8D	5	0	1	6	83.3%	0.0%	7	0	0	7	100.0%	0.0%
Band 9	9	0	0	9	100.0%	0.0%	1	1	0	2	50.0%	50.0%
VSM	5	0	0	5	100.0%	0.0%	2	0	0	2	100.0%	0.0%
Consultant							153	54	35	242	63.2%	22.3%
Non-consultants Career Grade							56	39	16	111	50.5%	35.1%
Trainee Grades							197	142	49	388	50.8%	36.6%
Other							0	0	0	0	0	0
Total	1093	115	68	1276	85.7%	9.0%	2766	1509	411	4686	59.0%	32.2%

When medical and dental staff are excluded, ethnic minority staff are over-represented in the lower bands one to five; the Trust's Disparity Ratio as at 31.03.24 is 7.16; which indicates that white staff are 7 times more likely to progress from the lower bands into senior roles, Band 8A and above.

	Disparity Ratio	
Banding	Mar-23	Mar-24
Lower (B1-5) to Middle Bands (B6-7)	2.34	2.37
Middle (B6-7) to Upper Bands (B8a-9)	3.1	3.02

Lower to Upper Bands	7.27	7.16

Representation in Lower- Upper Banding	BME staff	White Staff	Unknown
Lower Bands (1-5)	79.12%	58.67%	70.18%
Middle Bands (6-7)	19.51%	34.14%	25.07%
Upper Bands (8a and above)	1.37%	7.18%	4.75%

Metric 2 The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

White candidates are 1.27 times more likely to be appointed from shortlisting, than candidates from an ethnic minority background. National benchmark not provided – NHSE report at 76% of NHS Trusts, white applicants are significantly more likely to be appointed than ethnic minority candidates.

Year	Relative Likelihood of appointment
2018/19	**1.46**
2019/20	**1.59**
2020/21	**1.13**
2021/22	**1.37**
2022/23	**1.64**
2023/24	**1.27**

During the year 5229 applicants were shortlisted, 2431 were white and 330 (13.5%) from this group were appointed, 2344 ethnic minority, with 251 (10%) from this group appointed and 454 were of unknown ethnicity, and 273 appointed from the unknown group. The shortlisting to appointment ratio has improved since last year, reducing from 1.64 to 1.27. Last year 2278 ethnic minority candidates were shortlisted and 155 (6.8%) appointed. During this period, we have also increased our numbers of internationally educated staff.

**The Trust is benchmarked against NHS organisations of a similar size.*

Metric 3 The relative likelihood of BME staff entering the formal disciplinary process compared to white staff

The relatively likelihood of BME staff entering the formal disciplinary process is 0.44. National benchmark – at 46% of NHS Trusts ethnic minority staff are 1.25X more likely than white staff to enter a formal disciplinary process.

Year	Relative Likelihood
2018/19	0.57
2019/20	0.83
2020/21	0.72
2021/22	0.81
2022/23	1.09
2023/24	0.44

The relatively likelihood of ethnic minority staff entering the formal disciplinary process is 0.44, indicating this group is less likely to enter a formal disciplinary process than white staff; a figure of one would equate to parity, i.e. neither white nor ethnic minority staff are disproportionately affected. The Trust seeks to have parity for both groups of staff.

Metric 4 The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff

The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff is 1.02. National benchmark 1.25.

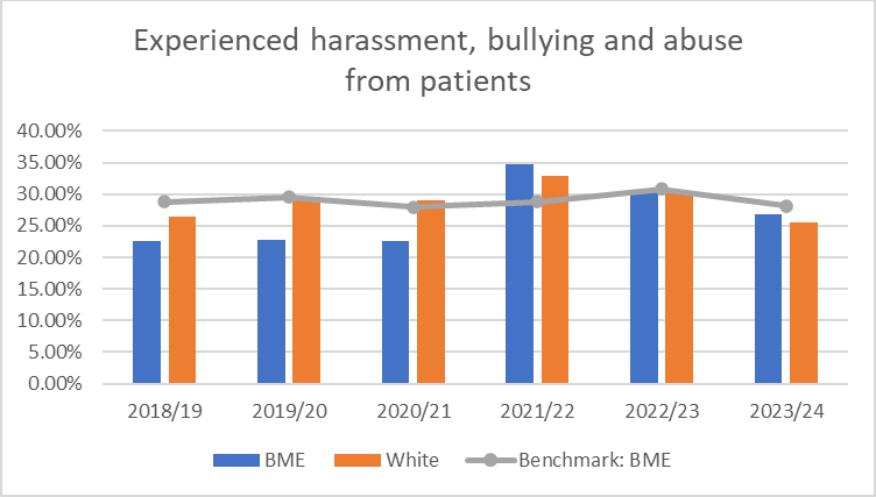
Year	Relative Likelihood
2018/19	0.97
2019/20	0.91
2020/21	0.92
2021/22	1.01
2022/23	1.04
2023/24	1.02

Our records indicate that there is no disparity when accessing non-mandatory training based on ethnicity, a figure of one is equal to parity.

The Trust continues to perform well in this metric, last year the relative likelihood was 1.04.

Metric 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

26.8% of ethnic minority staff experience harassment, bullying or abuse from patients, relatives or the public. National benchmark 30.4%.



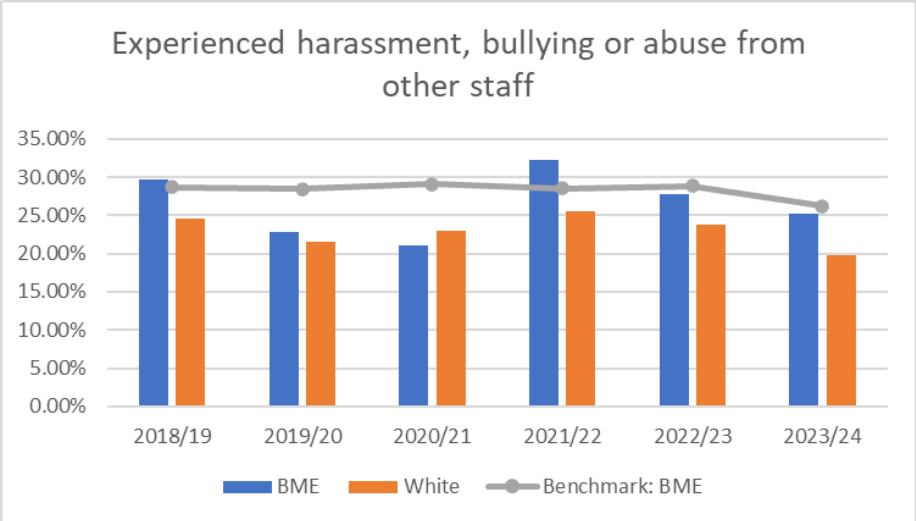
26.8% of our staff from ethnic minority backgrounds experience harassment, bullying or abuse from patients, their relatives or the public, similarly, 25.5% of white staff have this negative experience. The Trust is performing better than its benchmark* of 28.11% for ethnic minority staff.

This metric has significantly improved for both groups, reducing by 3.93% (from 30.7%) for ethnic minority staff and 4.89% (from 30.4%) for white staff.

*The Trust is benchmarked against NHS organisations of a similar size.

Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

25.2% of ethnic minority staff have experienced harassment, bullying or abuse from another member of staff in the last 12 months. National benchmark 27.7%.



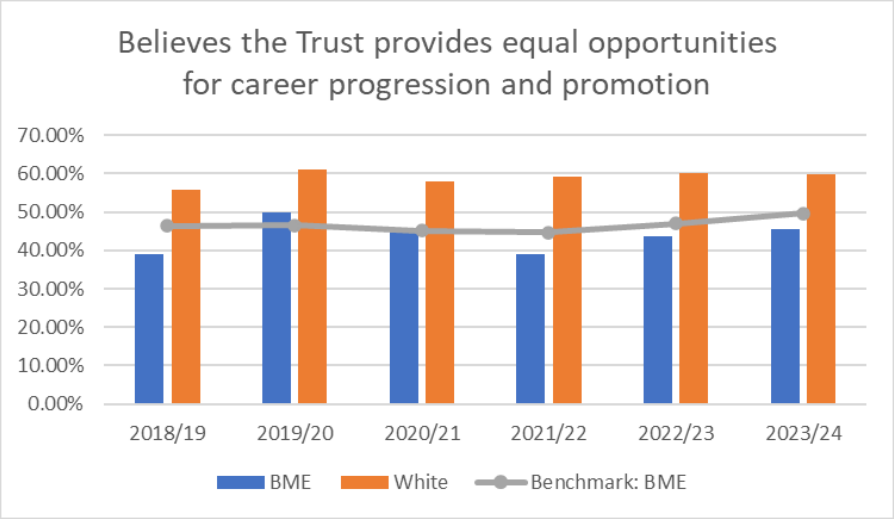
25.2% of our staff from ethnic minority backgrounds experience harassment, bullying or abuse from other colleagues, in comparison, 19.8% of white staff have this negative experience. The Trust is performing better than its benchmark* of 26.2% for ethnic minority staff.

This metric has improved for both groups, reducing by 2.56% (from 27.8%) for ethnic minority staff and 3.86% (from 23.7%) for white staff.

*The Trust is benchmarked against NHS organisations of a similar size.

Metric 7 Percentage of staff believing that their trust provides equal opportunities for career progression or promotion

45.6% of ethnic minority staff believe the Trust provides equal opportunities for career progression and promotion. National benchmark 46.6%.



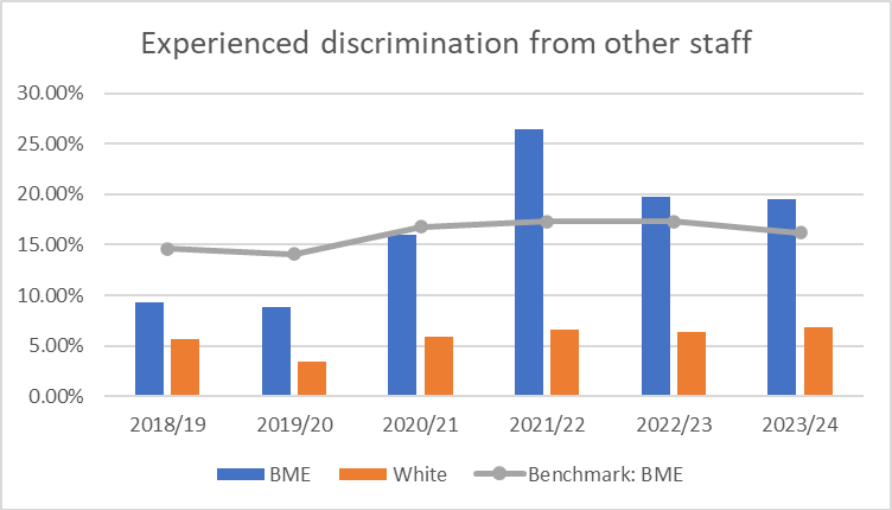
45.6% of our staff from ethnic minority backgrounds believe the Trust provides equal opportunities for career progression and promotion, in comparison, 59.9% of white staff believe this. The Trust is performing worse than its benchmark* of 49.6% for ethnic minority staff.

This metric has improved for ethnic minority since last year, increasing by 2% (from 43.6%); and remains similar for white staff, where we reported a figure of 60%.

*The Trust is benchmarked against NHS organisations of a similar size.

Metric 8 Percentage of staff experiencing discrimination at work from other staff in the last 12 months

19.5% of ethnic minority staff have experienced discrimination at work from other staff in the past 12 months. National benchmark 16.6%.



19.5% of our staff from an ethnic minority background have experienced discrimination from a colleague, in comparison, 6.84%% of white staff have had this negative experience. The Trust is performing worse than its benchmark* of 16.2% for ethnic minority staff.

This metric is similar to last year's figures of 19.55% for ethnic minority staff and 6.84% for white staff. Notably, the number of staff who respond to the survey has increased, and confidence in reporting may have improved.

*The Trust is benchmarked against NHS organisations of a similar size.

Metric 9 The representation of BME people amongst board members

The Trust Board has two ethnic minority board member and seventeen white board members – 10.5% BME. National benchmark 15.6%.

	2023 BOARD MEMBERSHIP					OVERALL WORKFORCE	RATE OF ETHNICITY FROM STAFF SURVEY
	Voting	Non-Voting	Executive	Non-Executive	Total		
Ethnic Minority	1	1	0	2	2	27%	27%
White	15	2	7	10	17	65%	73%
Unknown	0	0	0	0	0	8%	

The Trust has two ethnic minority Board Members, neither are Executives; one ethnic minority Board Member (Executive) has left the Trust in-year. Seventeen of our Board Members are White, fifteen voting and two non-voting. The NHS Associate NED programme has been developed to support people with senior level experience, who are currently under-represented on NHS Boards into non-executive roles.

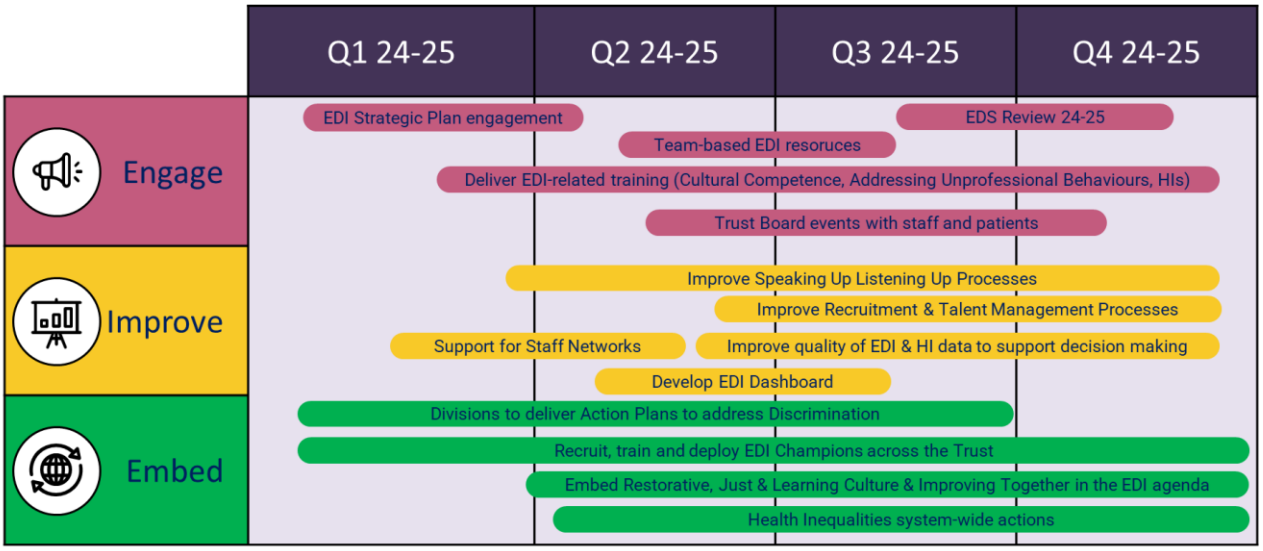
Equality, Diversity & Inclusion (EDI) and Health Inequalities (HI) Action Plan

Over the past four years, our Trust has diligently advanced its Equality, Diversity, and Inclusion (EDI) initiatives. This year's action plan, encapsulated within our "Improving Together" continuous improvement methodology, represents a collaborative effort by professionals across the Trust to address workforce and patient health inequalities. It is designed to align with our performance frameworks, including the Workforce Disability Equality Standard, Workforce Race Equality Standard, Gender Pay Gap, Equality Delivery System, and the NHS EDI Improvement Plan. Central to our approach is the 'inch wide, mile deep' philosophy, which focuses on a few critical priorities to maximize impact. These priorities are organized into three themes:

- Engaging with staff and patients
- Making key improvements in our data and programmes of work that we will carry forward into 24-25, and
- Embedding Inclusion and Health Inequalities into our everyday practices.

The following diagram illustrates the specific actions and initiatives we will undertake in these areas to drive meaningful and sustainable change.

The Inclusion & Health Inequalities strategic group (I-HISC), which includes our staff network reps and professionals from across the Trust have supported development of this action plan.



Key: EDI = Equality, Diversity & Inclusion; EDS = Equality Delivery System self-evaluation process; HI – Health Inequalities

NHS
Great Western Hospitals
NHS Foundation Trust

(Draft) EDI & HI Annual Report 2023-2024

31 July 2024

Sharon Woma, EDI Lead

Together we are Great

Great Western Hospitals
NHS Foundation Trust

Public Sector Equality Duty

Meeting our Duty

General Aims:

1. Eliminate discrimination
2. Advance Equality
3. Foster Good Relationships

Specific Duties:

1. Publish Equalities Information to demonstrate compliance with the Duty – due regard to the 3 aims (above), at least annually
2. Publish Objectives, at least every 4 years

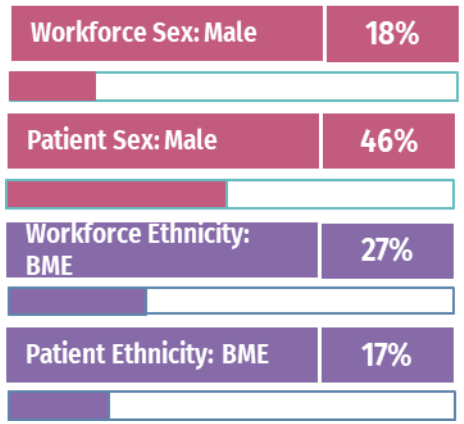
Diversity in the Trust

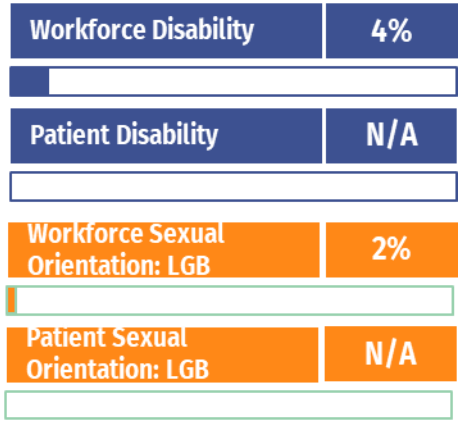
Great Western Hospitals NHS Foundation Trust

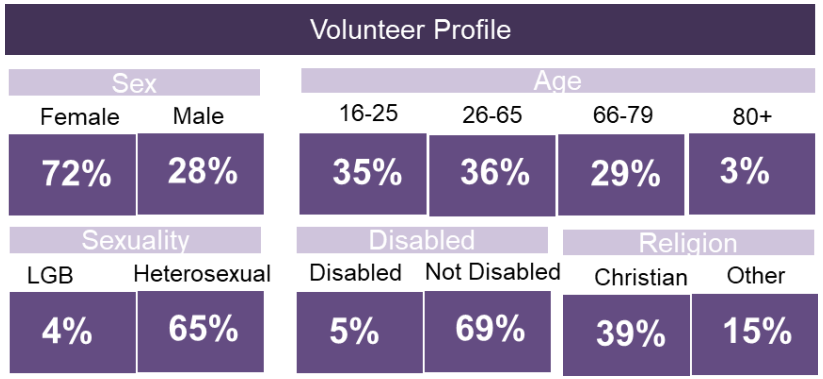
The Trust employs **5962 staff** as at 31.03.2024, the gender split (sex) remains the same, 82% female and 18% male.
We are supported by **410 Volunteers** and a further 109 currently in the recruitment process. 72% are women and 28% men.

Year	Female	Male	BME	White	Ethnicity Unknown	Disabled	Not Disabled	Disability Unknown	LGB	Hetero-sexual	Orientation Unknown
2022	82%	18%	24%	68%	8%	3%	76%	21%	2%	65%	33%
2023	82%	18%	27%	65%	8%	4%	77%	19%	2%	67%	30%

More ethnically diverse, a growth of 3%, and 1% increase in disabled staff. Unknown status improving.







Patient data less robust but does indicate male staff are under-represented compared to patient profile.

Equality, Diversity & Inclusion Achievements 2023-2024

NHS Great Western Hospitals NHS Foundation Trust

Inclusive & Compassionate Leadership

- Leadership conference June 23
- Launch of Leadership Behaviours
- EDI embedded in leadership courses and EDI Masterclass
- Trust and Board engage in EDI workshops
- Trust Board oversight and approval of EDI papers
- Trust Board set objectives for year ahead
- Divisional Boards review EDI pillar metric data and Divisional Reps leading on action plans

Represented & Supported Workforce

- Disability Confident and Equal Opportunities Employer
- EDI events led by networks and supported by leadership
- Robust HWB offer: HWB events throughout year; tea trolley visits, MHFA/HWB Champions, In-reach physical health checks; training for line managers to facilitate health and wellbeing conversations with staff
- Swartz Rounds provide a safe space for staff to talk about emotional and social aspects of work
- Flu and Covid Vaccine campaign
- EDI Improvement Award to address unprofessional behaviours
- Anchor Institution Programme
- Support for staff during doctor's strikes in 2023

Supporting Patients & Communities

- Launch of Oliver McGowan training
- Week-long event 'Improving Outpatient Services', followed by 'A perfect week' later in year
- DAN network part of site visit to assess doors to improve patient access
- Maternity & Neonatal Services delivery 3-year action plan to address inequalities and Divisional Reps leading EDI projects (EDI Pillar Metric)
- Patient engagement throughout the year, attending community events; and patients involved in co-production

Let Every Voice Be Heard

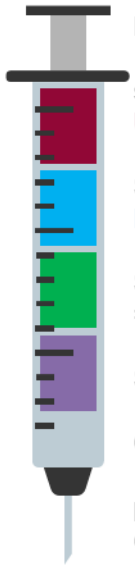
- Monthly Staff Forum with CEO
- Listening events internally and at system level provide an opportunity for staff to share their lived experience
- Staff networks represent the voice of staff at key strategic meetings.
- Several routes to speaking up including networks, Freedom to Speak Up Guardians, Mental Health First Aiders, Union Reps, EDI Champions and managers
- Over 50 staff trained to become EDI champions
- Staff engaged in sustainability
- 800 staff have attended Improving Together training to enable them to lead change in their areas of work

Impact of Initiatives: Performance Metrics

Great Western Hospitals NHS Foundation Trust

EDS, GPG, WRES, WDES

Equality Delivery System



EDS Ratings

score under 8= Undeveloped

Score between 8 and 21 = Developing

Score between 22 and 32 = Achieving

Score 33 = Excelling

Overall, the Trust scored 17.5 out of a possible 21 points, achieving a rating of 'Developing'.

2023-24 EDS Review of
- Domain 1: Commissioned/ Provider Services: (a) Patient Advice & Liaison Services and Complaints; and (b) Annual Health Checks for People with learning disabilities.
- Domain 2: Workforce Health & Wellbeing
- Domain 3: Inclusive Leadership

Gender Pay Gap 23-24

Mean Pay Gap

£7.80	(28.02%) Increased by £0.92 since last year from £6.88.

Excluding medical and dental staff

£0.56	(2.91%) Reduced by £0.20 since last year from £0.76.

Mean Bonus Pay Gap

£2,877.13	(35.84%) Decreased by 34.87% since last year from 70.71%

Excluding medical and dental staff

£1,876.32	(47.38%) Similar to last year's gap of 47.17%.

- Increase in the average hourly pay was larger for male staff, by 92p. Gap continues to be significantly higher for medical/dental staff
- Over-representation of male staff in senior roles and medical roles
- Small increase in male staff in senior roles, what has helped is increase in male staff Band 2 and increase in female staff at Band 5, 6, and 7; we have however reversed specialist nurse pay introduced last year (revert to bonus payment)
- Bonus gap: more AfC male staff and male consultants received a bonus, compared to their female counterparts

Disability Equality Standard

Improvement in 5 WDES Metrics –
- 1% increase in representation;
- Bullying and harassment from patients down 2.3%, from colleagues down 5.6%;
- Feeling pressured to work down 1.35%;
- Feeling valued up 6%

Worsened:
- Entering formal capability process, 2 disabled staff (2 yr. avg 6.17);
- % disabled staff who reported bullying and harassment down 4.3%

No Board representation - ESR

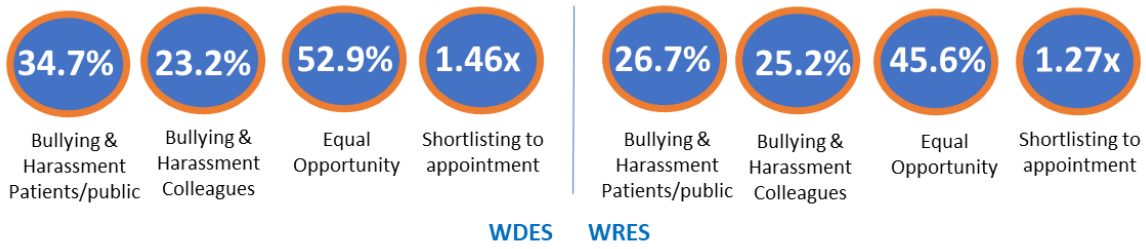
Race Equality Standard

Improvement in 4 WRES Metrics –
- 3% increase in representation;
- Bullying and harassment from patients down 4%, from colleagues down 2.6%;
- Having equal opportunities up 2%

2 BME Board members, 1 member left the Trust.

(See appendix for all WDES and WRES metrics)

WDES & WRES Comparison



Informing our plans: Themes from Committee & Board Engagement

I-HISC Themes	Potential Action
Data	Building data insights •Analysis of data currently held to identify trends – workforce and patient health inequalities
Engagement (education, learning and raising awareness)	Patients •Engage with patient population to understand their experience at a granular level, working with partner organisations •Engagement around accessible communications Workforce •Raise profile of health inequalities to indicate its equal importance to EDI agenda •Supporting a mindset shift, achieving EDI objectives is everyone's responsibility and not a choice •Education, bite size events, space for staff to discuss and share their experiences and improve awareness
Evidence based practice	Support the building of evidence-based practice •Work with Improving Together team to identify a mechanism to share EDI/HI work that emerges from Huddles and Improving Together conversations/working groups

Trust Board Themes	Potential Action
Embedding change	• Make the red lines more visible – zero tolerance; clarity on expected behaviours; holding people accountable • Create space for brave conversations • Making Inclusion everyone's business – collectivism approach – networks, wider workforce, include staff stories • Gender Pay Gap/Adjust compensation conversations
Development	• Support team level discussions to enable open honest conversations • Equip managers to deal with issues in their team • Build confidence to act and promote routes for reporting behaviours
Health & Wellbeing (HWB)	• Use of data – overlay workforce data with Health Inequalities data • Improve disclosure rates on ESR • Screening programme for HWB • Workplace (Reasonable) Adjustments policy to support staff and managers
Evidence based practice	• Intersectional approach to Inclusion • Engage with staff to understand experience and needs (soft intelligence to support data)

Setting our Priorities

The report highlights numerous initiatives and provisions which have supported the Trust to provide inclusive services and to create a climate that is more welcoming and diverse.

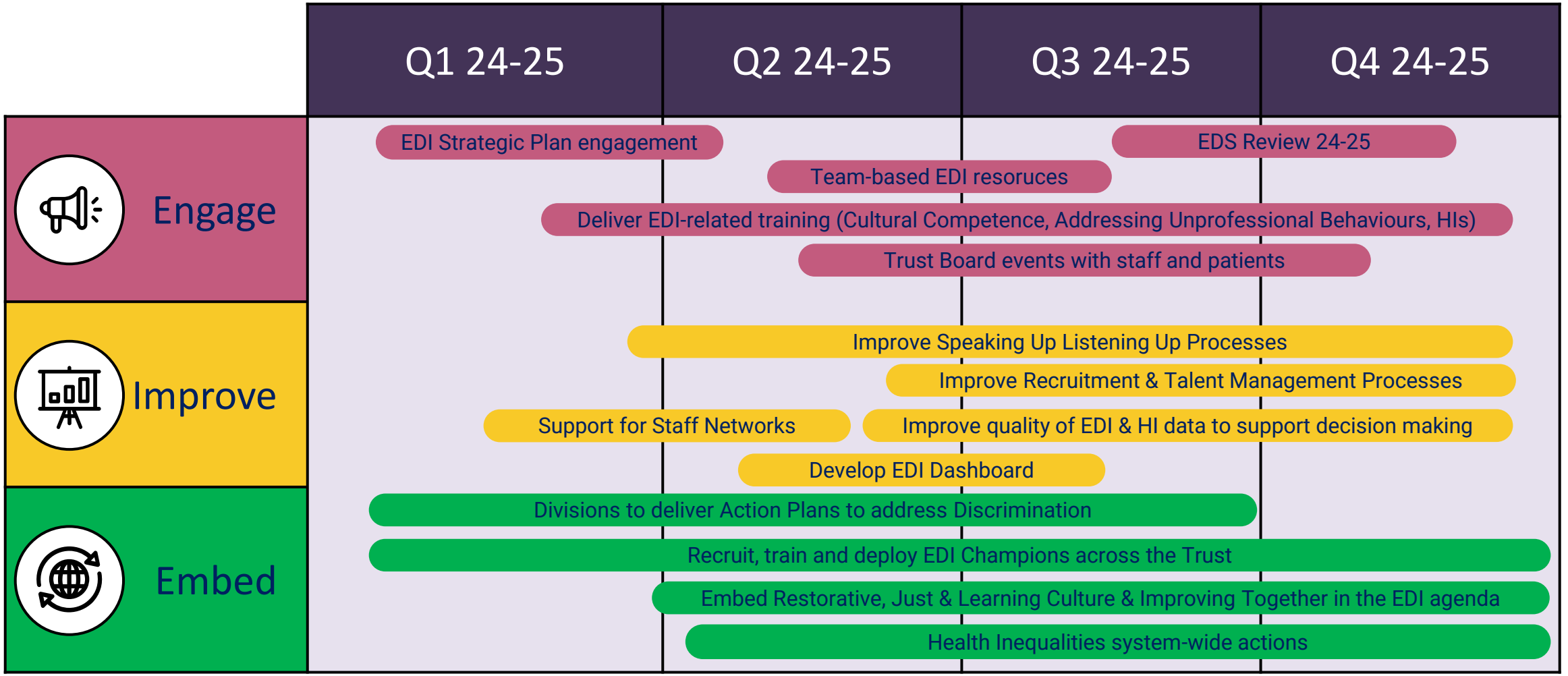
We want to build on the great work delivered under our 2020-2024 EDI Strategy, which has provided a cohesive direction for the past few years. The action plan for 2024-25 reflects work underway since April 2024 and our plans for the rest of the year, and we will continue to embody the 'Improving Together' philosophy (our continuous improvement approach), which invites us to identify the few priorities that will make the biggest difference, which are highlighted in the table opposite and the action plan overleaf. These priorities are informed from the engagement with our Inclusion-Health Inequalities Sub Committee and the Trust Board.

I-HISC & Board Feedback translated into priorities

Engage Engage with stakeholders to understand their experience Workforce training and raising awareness to foster inclusion and reduce inequalities	**01**
Improve Improve quality of EDI Data; build an evidence-based approach to demonstrating the value of EDI and a more robust approach to gathering evidence to support evaluating our performance	**02**
Embed Addressing unprofessional behaviours across the Trust Phase II of implementing the Just & Learning Culture philosophy Response to system Health Inequalities plan	**03**

EDI Action Plan Summary

Great Western Hospitals NHS Foundation Trust



Key: EDI = Equality, Diversity & Inclusion; EDS = Equality Delivery System self-evaluation process; HI – Health Inequalities

Appendix – WDES & WRES Metrics Tables

Workforce Disability Equality Standard Report – this report measures the extent in which our disabled staff have equal access to career opportunities and receive fair treatment at work, when compared to non-disabled staff.

No	Metric	2022-23	2023-24	Movement
1	Percentage of staff in each of the AfC Bands 1-9 and VSM	2.98%	4.14%	Improved
2	Relative likelihood of staff being appointed from shortlisting across all posts	1.44	1.46	Similar
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal capability investigation (average rolling two-year period)	3.63 (1 disabled staff)	6.17 (2 disabled staff)	Worsened
4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, managers and colleagues			
	Patients	37.0%	34.7%	Improved
	Managers	15.2%	12.8%	Improved
	Colleagues	28.8%	23.2%	Improved
	b) Percentage of staff who reported bullying and harassment	50.1%	45.7%	Worsened
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	54.0%	52.9%	Worsened
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	30.7%	27.2%	Improved
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	28.0%	34.0%	Improved

Appendix – WDES & WRES Metrics Tables

Workforce Disability Equality Standard Report – this report measures the extent in which our disabled staff have equal access to career opportunities and receive fair treatment at work, when compared to non-disabled staff.

No	Metric	2022-23	2023-24	Movement
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	72.3%	73.2%	Similar
9	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	6.3	6.4	Similar
	b) Initiatives that support the voice of disabled staff: Staff networks represent staff at strategic meetings and provide a safe space for staff to meet; Executive Sponsor appointed to support network and champion their work; Differently Abled Staff Network input into key policy development and initiatives to improve patient equity – this year they toured the hospital site with Estates to review door accessibility; staff engage directly with the CEO at monthly open forums; line managers receive training to support health and wellbeing conversations.			
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	0	0	Similar

Appendix – WDES & WRES Metrics Tables

Workforce Race Equality Standard Report – this report measures the extent in which our ethnic minority staff have equal access to career opportunities and receive fair treatment at work, when compared to white staff.

No	Metric	2022-23	2023-24	Movement
1	Percentage and number of staff in the Trust by ethnicity (AfC Bands 1-9 and VSM)	24%	27%	Improved
2	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants	1.64	1.27	Improved
3	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff	1.09	0.44	Worsened for white staff
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff	1.04	1.02	Similar
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	30.7%	26.8%	Improved
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	27.8%	25.2%	Improved
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	43.6%	45.6%	Improved
8	Percentage of staff experiencing discrimination at work from other staff in the last 12 months	19.5%	19.5%	Similar
9	The representation of BME people amongst board members	2 (plus 1 assoc.)	1	Worsened

Initiatives that support improving the working life experience of ethnic minority staff: The Trust has four staff networks, including the Race Equality Network; we are recruiting, training and deploying EDI Champions who can support staff who experience discrimination, bullying and harassment; and Inclusion Recruitment Champions sit on interview panels for senior roles to support inclusive practices and help address any potential bias; the Trust has a range of management and leadership training to help all staff prepare for senior roles, including targeted programmes to improve inclusive leadership and develop ethnic minority staff, and we monitor our non-mandatory training data to ensure it is accessed equitably.

Report Title	**Annual Review of Scheme of Delegation (including Powers Reserved to the Board)**				
Meeting	**Trust Board**				
Date	**5 September 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Jon, Westbrook Chief Executive				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Scheme of Delegation				

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):

In 2023 the Scheme of Delegation undertook a complete refresh, along with the Standing Financial Instructions (SFIs), which were approved by the Board in August 2023.

There was an amendment to the SFIs in December 2023 which the Board approved.

Following an annual review of the Scheme of Deletion, there are two amendments proposed as indicated below and highlighted in yellow in the attached document, both contained within the Powers Reserved to the Board.

Proposed changes to the Scheme of Delegation

Reference	Current	Proposal	Rationale for change
Powers Reserved to the Board			
Council of Governors	To represent the interests of the	To represent the members of the trust	In alignment with wording from the

	members of the NHS Foundation Trust and the public.	as a whole and the public **at large**.	Code of Governance for NHS Providers
Trust Board	Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.	To delete	The "*Patients' Property (including valuable) and Lost Property (including valuables) Policy*" approval sits with Patient Quality Sub Committee (Chaired by Chief Nurse & Chief Medical Officer)

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

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 Trust Board is requested to approve the amendments to the Scheme of Delegation.

Accountable Lead Signature	Jon Westbrook, Chief Executive
Date	Caroline Coles, Company Secretary

Great Western Hospitals
NHS Foundation Trust

Scheme of Delegation

This appendix sets out the powers of the Trust ("the Powers") that are reserved to the Board of Directors ("the Board") and the Scheme of Delegation.

All Powers which have not been retained by the Board or delegated to a committee of the Board shall be exercised on behalf of the Board by the Chief Executive. All powers delegated by the Chief Executive can be reassumed by them should the need arise. If the Chief Executive is absent powers delegated to them may be exercised by a nominated Officer after taking appropriate advice from the Chief Financial Officer.

The Board remains accountable for all of its functions, including those which have been delegated. The Board may request at any time information about the exercise of delegated functions to enable it to maintain its monitoring role. In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director's or Officer's superior.

The tables below show the scheme of reservation and delegation.

Section 1- Scheme of Reservation (Council of Governors)

Ref	The council of governors ("the council")	Decisions reserved to the council
NA	The Council	The specific statutory powers and duties of the Council of Governors are to:

		• appoint and, if appropriate, remove the Chair of the Board; • appoint the Deputy Chair of the Board; • appoint and, if appropriate, remove the other Non-Executive Directors; • decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors; • approve the appointment of the Chief Executive; • appoint and, if appropriate, remove the external auditor; and • receive the annual accounts, any report of the auditor on them and the annual report; • hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; • approve significant transactions, mergers and acquisitions and applications for separation and dissolution; • decide, where the Trust intends to carry our activity which is not providing goods and services for the purposes of the health service in England, whether that work would significantly interfere with the Trust's principal purpose i.e. the provision of goods and services for the Health Service in England or the performance of other functions; • approve any proposed increases in private patient income of 5% or more in any financial year. • approve amendments to the Trust's Constitution (this function is shared with the Trust Board). • to represent the ~~interests of the members~~ members of the trust as a whole and the public at large.
NA	Council of governors' nominations and remuneration committee	The Council of Governors shall establish the Council of Governors' Nominations and Remuneration Committee to: • Periodically review the structure, size and composition (including the skills, knowledge and experience and diversity) required of the Non-Executive Directors and make recommendations to the Council with regard to any changes; • Give consideration to succession planning for Non-Executive Directors, taking into account the challenges and opportunities facing the Foundation Trust and the skills and expertise needed on

		the Board of Directors in the future and; make recommendations to the Council of Governors concerning plans for succession; • Agree with the Council of Governors a clear process for the nomination of a Non-Executive Director; • For each appointment of a Non-Executive Director, agree a description of the role, capabilities and, expected time commitment required; • Make recommendations for suitable Non-Executive Director / Chair candidates to fill vacant posts within the Committee's remit, for appointment by the Council of Governors; • Make recommendations to the Council of Governors in respect of the re-appointment of any Non-Executive Director. Any term beyond six years must be subject to a particularly rigorous review; • Make recommendations to the Council of Governors in regard to any matters relating to the removal of office of a Non-Executive Director; • To be consulted by the Board of Directors on the appointment of the Senior Independent Director and to report on this consultation to the Council of Governors ; • To consider the Non-Executive Director appraisal process; • To receive reports on the appraisal of the Chair and Non-Executive Directors from the Senior Independent Director and the Chair of the Trust respectively; • To recommend to the Council of Governors the remuneration, allowances and other terms and conditions for Non-Executive Directors; taking into account the views of the Chair (except in respect of his/her own remuneration, allowances and other terms and conditions), the Chief Executive Officer and any external advisers.

Section 2- Scheme of Reservation (Trust Board)

Ref	The trust Board ('the Board')	Decisions reserved to the Board
NA	The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	The Board	**Regulations and Control** (a) Approval of the Constitution (in accordance with approval framework), a schedule of matters reserved to the Board, Standing Orders and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business. (b) Approval of a scheme of delegation of powers from the Board to employees. (c) Requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration. (d) Requiring and receiving the declaration of interests from employees which may conflict with those of the Trust via the Audit, Risk & Assurance Committee. (e) Considering instances of failure to comply with the Authorisation, Provider Licence, Constitution and Standing Financial Instructions and taking action where appropriate.

		(f) Approval of significant changes to organisation structures that require formal consultation under relevant legislation or any changes within a previously approved strategy. (g) To receive reports from committees including those which the Trust is required by the Secretary of State, the Constitution, Standing Financial Instructions or other regulations to establish and to take appropriate action thereon. (h) To approve the recommendations of the Trust's committees where the committees do not have Executive powers. To establish terms of reference and reporting arrangements of all Board committees (and other committees if required). (i) Ratification of any urgent decisions taken by the Chair or Chief Executive in accordance with the Constitution, Scheme of Delegation or Standing Financial Instructions and Standing Orders. (j) Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust, such as charitable funds. ~~(k) Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.~~
NA	The Board	**Appointments** (a) The establishment, approval of terms of reference, approval of membership including Chairs, reporting arrangements and disbanding of all committees of the Board. (b) The appointment of members to any committee of the Trust and the appointment of representatives on outside bodies. (c) Approval of the Senior Independent Director (having regard to the views of the Council of Governors) from amongst the Non-Executive Directors of the Trust.

NA	The Board	**Strategy and Plans** (a) Development and approval of the strategic aims, objectives and priorities of the Trust. (b) Approval of the Integrated Business Plan, Operational Plan and Annual Budget (including capital budget) and 5 Year Plan. (c) To approve any joint venture or merger with external organisations and acquisitions, subject to requirements set out in the Constitution. (d) Approval of strategy for ensuring quality and clinical governance in services provided by the Trust. (e) Approval of strategy for ensuring equality, diversity and inclusivity in both employment and the delivery of services.
NA	The Board	**Policy Determination** (a) Approval of strategy and policy in accordance with the provisions of the Scheme of Delegation. (b) Approval and monitoring of the Trust's policies and procedures for the management of risk. (c) Approval of the Trust's Health & Safety Policy.
NA	The Board	**Financial and Performance** (a) Approval of plans in respect of the application of available financial resources. (b) Approval of the opening or closing of any bank or investment account. (c) Approval of any borrowing.

		(d) Acquisition, disposal or significant change of use of land and/or buildings (including leases and licences) and approval of the associated financial limits. The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £5m, over the contract period, £1m in the case of capital spend. (e) Approval of expenditure in excess of £15m with NHS England approval. (f) Approval of individual compensation payments (patients, former patients, carers and other non-staff) non NHS Resolution above the limits of delegation to the Chief Executive and Chief Financial Officer (for losses and special payments) as referred to in the Scheme of Delegation. (g) To approve proposals for action on litigation against or on behalf of the Trust which are over £50,000 except where these are made in accordance with NHS Resolution instructions. (h) Approval of any applications for public dividend capital.
NA	The Board	**Reporting Arrangements** (a) Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and employees of the Trust. (b) All monitoring returns and submissions required by NHS England, the Care Quality Commission, the Charity Commission and any others will be approved by the Board via the Finance, Infrastructure & Digital Committee. (c) Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive. (d) Consideration and approval of the Trust's Annual Report including the Annual Accounts and the Quality Accounts. The Board of Directors may choose to delegate authority to approve the Annual

		Report & Accounts to the Audit, Risk & Assurance Committee to meet NHSE's deadline for submission of the Annual Report & Accounts. (e) Receipt and approval of the Annual Report(s) for funds held on trust (e.g. charitable funds).
NA	The Board	**Investment Policy** (a) To approve the investment policy for exchequer funds and discharge of trustee responsibilities in relation to non-exchequer funds. (b) To approve Private Finance Initiative (PFI) proposals. (c) To approve any purchase of shareholding. (d) To review and approve alternatives to NHS Resolution risk pooling schemes. (e) To approve any substantive changes to the Trust's insurance or indemnity arrangements in relation to Directors and staff liability.
NA	The Board	**Audit Arrangements** (a) The receipt of the annual management letter from the external auditor and agreement of action on the recommendation where appropriate of the Audit, Risk and Assurance Committee. (b) The receipt of the annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit, Risk and Assurance Committee

Delegation of powers to committees and sub-committees

The Board may determine that some of its powers can be exercised by Committees. The Board has delegated some functions to a number of committees, details of which are set out in their respective Terms of Reference.

The Board will determine the reporting requirements in respect of those committees. In turn those committees may delegate functions to a number of sub-committees or groups, details of which are set out in their respective Terms of Reference, but the delegate of powers to sub-committees must be expressly authorised by the Board.

Staff are authorised to act in accordance with their terms of appointment and in accordance with Trust policies and procedures.

The Constitution also specifies delegated authority to directors and the Company Secretary.

Section 3 - Decisions/duties delegated by the Board to Committees within the SFI

Ref	Committee	Decisions/duties delegated by the board to committees
For full duties and responsibilities see terms of reference for each Board Committee		
SFI pg 10	Audit, risk and assurance committee	The Committee will advise and support the Board through: (a) overseeing Internal and External Audit services; (b) reviewing financial and information systems, monitoring the integrity of the financial

		statements and any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgments; (c) reviewing the establishment and maintenance of an effective system of corporate governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives; (d) monitoring compliance with Standing Orders and SFIs and the scheme of delegation; (e) reviewing schedules of losses and compensations and making recommendations to the Board; (f) Reviewing schedules of debtors/creditors balances over 6 months old and over a *de minimus* limit as defined by the Audit, Risk and Assurance Committee and related explanations/action plans; (g) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly. (h) Monitoring and reviewing the effectiveness of the Trust's internal audit function and ensuring that it meets any mandatory standards set by NHS England and any relevant UK professional and regulatory requirements; (i) Monitoring the independence and objectivity of the External Auditor; **(j)** Receiving reports from the Local Counter Fraud Service (LCFS) and monitor the work of the LCFS service.
SFI pg 39	Board of directors remuneration committee	The Committee shall determine the appropriate remuneration and terms of service for the Chief Executive, Executive Directors posts that will enable the Trust to attract and retain the best candidates.
SFIs pg 66	Charitable funds committee	In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Board of Directors will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission. This paragraph must be read in conjunction with the Standing Financial Instructions.

Section 4 – Duties from the NHS Foundation Trust Accounting Officer Memorandum (IRG 24/15 5 August 2015)

Ref	Delegated to	Duties delegated
7	Accounting Officer	The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The Accounting Officer must ensure that: • there is a high standard of financial management in the NHS foundation trust as a whole; • financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS foundation trust; • financial considerations are fully taken into account in decisions on NHS foundation trust policy proposals.
8	Accounting Officer	The essence of the accounting Officer's role is a personal responsibility for: • the propriety and regularity of the public finances for which he or she is answerable • the keeping of proper accounts; • prudent and economical administration in line with the principles set out in Managing public money[1]; • the avoidance of waste and extravagance; • the efficient and effective use of all the resources in their charge. [1] www.gov.uk/government/publications/managing-public-money

9	Accounting Officer	The Accounting Officer must: • personally sign the accounts and, in doing, so accept personal responsibility for ensuring • their proper form and content as prescribed by NHS England in accordance with the Act: • comply with the financial requirements of the NHS provider licence; • ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust); • ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official; • ensure that assets for which they are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate; • ensure that any protected property (or interest in) is not disposed of without the consent of NHS England; • ensure that conflicts of interest are avoided, whether in the proceedings of the Board of directors, council of governors or in the actions or advice of the NHS Foundation Trust's staff, including themselves; • ensure that, in the consideration of policy proposals relating to the expenditure for which they are responsible as accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of directors.

10	Accounting Officer	Ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels: • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives; • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS Foundation Trust), including a critical scrutiny of output and value for money; • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
11	Accounting Officer	Must make sure that the arrangements he/she puts in place for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standard and practices set out in the *Public Sector Internal Audit Standards*[2] [2]www.gov.uk/government/publications/public-sector-internal-audit

12	Accounting Officer	See that appropriate advice is tendered to the Board of Executives and the council of governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. The Accounting Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as accounting Officer to justify, to the Public Accounts Committee (PAC), transactions for which they are accountable.
13	Accounting Officer	Set out in writing their objection to any proposal or course of action of the Council of Governors or the Board of Directors which may infringe the requirements of propriety or regularity, and the reasons for this objection. Inform NHS England should any decision to proceed be taken which infringes the requirements of propriety or regularity despite his/her objection. Inform the Trust's External Auditors and NHS England if the decision is taken and the Accounting Officers objections are overruled.
14	Accounting Officer	Inform the Board of Directors and Council of Governors, of any issue relating to the wider responsibilities for economy, efficiency and effectiveness, and provide advice to the Board of Directors and Council of Governors on a recommended course of action. If the Accounting Officer's advice is not taken, they should seek an instruction to proceed in writing from the Board or Council before proceeding.
16-20	Accounting Officer	The Accounting Officer may be required to appear before the Public Accounts Committee and will furnish the information and evidence required by the Committee.

22	Board of directors	Appoint an acting Accounting Officer (normally the Chief Financial Officer) if an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more.

Section 5 – Authorities/duties delegated from Standing Orders

So ref	Delegated to	Authorities/duties delegated
1A.1	Chair	Final authority in interpretation of Standing Orders (SOs) as set out in the Constitution
3.2.2	Chair	Call meetings.
3.8	Chair	Give final ruling in questions of order, relevancy and regularity of any matters.
3.13.1	Chair	Having a second or casting vote
3.15	Board	Suspension of Standing Orders
3.15.5	Audit, risk and assurance committee	Audit, Risk and Assurance Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
5.1	Board	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Board.)
4.2	Chair & Chief Executive	The powers which the Board has retained to itself within the Standing Orders and this scheme of reservation and delegation may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive Director members.

4.4.1	Chief Executive	Functions of the Trust which have not been retained as reserved by the Board or delegated to a committee of the Board, shall be exercised by the Chief Executive on behalf of the Board.
4.4.2	Chief Executive	The Chief Executive shall prepare a scheme of delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
4.4.4	All	Disclosure of non-compliance with Standing Orders and this scheme of reservation and delegation to the Company Secretary as soon as possible.
7.1	The board	Declare relevant and material interests.
7.15.2	Company Secretary	Maintain Register(s) of Interests of members of the Board upon receipt of new or amended information.
8.1.1	Directors	Comply with the Directors' Code of Conduct and any guidance and best practice advice issued by NHS England.
8.2.2	Directors	Disclose relationship between self and candidate for staff appointment. (Company Secretary to report the disclosure to the Board.)
9.1	Company Secretary/ nominated officer	Keep common seal of the Trust in safe place and maintain a register of sealing.
9.2.3	Chief Executive	Sign all documents which will be necessary in legal proceedings.

Section 6 – Authorities/duties delegated from Standing Financial Instructions

Sfi ref	Delegated to	Authorities/duties delegated
SFI 2.4	All members of the board and employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.
SFI 3.5	Chief Executive	Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
SFI 3.4	Chief Executive & chief Financial Officer	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
SFI 3.6	Chief Executive	To ensure all Board members, Officers and employees, present and future, are notified of and understand Standing Financial Instructions.
SFI 3.7	Chief Financial Officer	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared, documented and maintained; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and Officers; e) Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
SFI 3.9	All members of the Board and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

SFI 3.10	Chief Executive	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
SFI 4.1	Audit, risk and assurance committee	Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control.
SFI 4.1 (i)	Chair of audit, risk and assurance committee	Raise the matter at the Board meeting where Audit, Risk and Assurance Committee considers there is evidence of ultra vires transactions or improper acts.
SFI 4.3	Chief Financial Officer	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit, Risk and Assurance Committee in the selection process when/if an internal audit service provider is changed.)
SFI 4.6	Head of internal audit	Review, appraise and report in accordance with guidance within the Government Internal Audit Standards.
SFI 4.18	Chief Executive & Chief Financial Officer	Monitor and ensure compliance with any relevant guidance issued by NHS England or NHS Counter Fraud Authority.
SFI 4.20	Chief Financial Officer	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
SFI 5.1	Chief Executive	Compile and submit to the Board a Plan which takes into account financial targets and forecast limits of available resources.
SFI 5.4	Chief Financial Officer	Submit budgets to the Board for approval
SFI 5.11	Chief Financial Officer	Ensure adequate training is delivered on an ongoing basis to budget holders.
SFI 5.15	Chief Executive	Delegate budget to budget holders.
SFI 5.16	Chief Executive & budget holders	Must not exceed the budgetary total or virement limits set by the Board.

SFI 3.7 (b)	Chief financial officer	Devise and maintain systems of budgetary control.
SFI 5.12 – 5.14	Budget holders	Ensure that: • they deliver their budgets as agreed in the Annual Plan • any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board • the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement • no permanent employees are appointed without the approval of the Chief Financial Officer other than those provided for in the budgeted establishment as approved by the Board • identifying and implementing cost improvements, cost savings and income generation initiatives to achieve a return that meets the requirements of Monitor; and • effective systems exist within the directorate to ensure that all expenditure is authorised in advance of commitment and that the individuals incurring expenditure fully understand their budgetary control responsibilities.
SFI 5.14	Chief Executive	Identify and implement cost improvements and income generation initiatives with budget holders in line with the Annual Plan and a balanced budget.
SFI 5.20	Chief Financial Officer	Submit financial monitoring returns.
SFI 5.20	Executives	Submit governance returns.
SFI 6.1	Chief Financial Officer	Preparation of annual accounts
SFI 6.2	Company Secretary	Preparation of the annual report
SFI 6.5	Company Secretary	Submit to Annual Report and Accounts to NHS England and put forward to be laid before Parliament each year.
SFI 7.1 &	Chief Financial Officer	Managing banking arrangements, including provision of banking services, operation of

7.2		accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
SFI 7.10	Chief Financial Officer	Advise the Board on the Trust's ability to pay interest on and repay capital debt and new borrowing.
SFI 7.10	Chief Financial Officer	Report periodically on current debt, loans and overdrafts.
SFI 7.11	Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust.
SFI 7.16	Chief Financial Officer	Will advise the Board on investments and report, periodically, on performance of same.
SFI 7.17	Chief Financial Officer	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
SFI 8.1	Chief Financial Officer	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
SFI 8.5	All employees	Duty to inform the Chief Financial Officer of money due from transactions which they initiate/deal with.
SFI 9.2	Chief Executive	Must ensure the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services.
SFI 10.66	Chief Financial Officer	Report waivers of tendering procedures to the Audit, Risk and Assurance Committee.
SFI 5.7.4	Chief Executive	The Chief Executive or his nominated Officer should evaluate the quotation and select the quote which gives the best value for money.
SFI 5.7.4	Chief Executive or Chief Financial Officer	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or the Chief Financial Officer.
SFI 5.7.5	Chief Executive or nominated representative	Responsible for the receipt and safe custody of tenders received.
SFI 5.7.5	Chief Executive	Shall maintain a register to show each set of competitive tender invitations despatched.

SFI 5.7.9	Chief Executive & Chief Financial Officer	Where one tender is received will assess for value for money and fair price.
SFI 5.7.9	Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
SFI 5.7.9	Chief Financial Officer	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
SFI 5.7.15	Chief Executive	The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.
SFI 10.19	Chief Executive	The Chief Executive shall nominate Officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
SFI 5.7.18	Chief Executive	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
SFI	Chief Executive	The Chief Executive shall nominate an Officer to oversee and manage the contract on behalf of the Trust
SFI 11.1	Board of directors	Establish a Board of Directors Remuneration Committee.
SFI 11.3	Board of directors remuneration committee	Report in writing to the Board its decisions and its bases about remuneration and terms of service of Executives
SFI 11.7	Chief Financial Officer	Approval of variation to funded establishment of any department.
SFI 11.20	Chief Financial Officer	Payroll: (a) specifying timetables for submission of properly authorised time records and other notifications; (b) final determination of pay and allowances; (c) making payments on agreed dates; (d) agreeing method of payment;

SFI 11.21	Chief Financial Officer	Issue instructions listed in the SFI.
SFI 11.22	NOMINATED MANAGERS*	(a) Submit time records and other notifications in accordance with agreed timetables. (b) Complete time records and other notifications in required form. (c) Submitting termination forms in prescribed form and on time.
SFI 11.23	Chief Financial Officer	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
SFI 11.19	Board	(a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and (b) Deal with variations to, or termination of, contracts of employment.
SFI 12.1	Chief Financial Officer	Determine the level of delegation of non-pay expenditure to budget managers.
SFI 12.4	Chief Financial Officer	(a) Set out the list of managers who are authorised to place requisitions/ orders for the supply of goods and services. (b) Set out the maximum financial level for each requisition/ order and the system for authorisation above that level.
SFI 12.4 (c)	Chief Financial Officer	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
SFI 12.7	Chief Financial Officer	Shall be responsible for the prompt payment of accounts and claims in accordance with contract terms or national guidance.
SFI 12.8	Chief Financial Officer	(a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; (b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods,

		works and services incorporating the thresholds; (c) Be responsible for the prompt payment of all properly authorised accounts and claims; (d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; (e) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; (f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; (g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
SFI 12.9 (b)	Appropriate Executive Director	Make a written case to support the need for a prepayment.
SFI 12.9 (d)	Chief Financial Officer	Approve proposed prepayment arrangements.
SFI 12.10	Budget holder	Ensure that all items due under a prepayment contract are received and immediately inform the appropriate Director or Chief Executive if problems are encountered.
SFI 5.9.2.7	Chief Executive	Authorise who may use and be issued with official orders.
SFI 12.11	Officers	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer.
SFI 5.12	Chief Executive	Capital investment programme: (a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans (b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost;

		(c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences;
SFI 15.1	Capital prioritisation and management group	Ensure that a business case is produced for every significant capital expenditure proposal.
SFI 15.2 (f)	Chief Financial Officer	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
SFI 15.7	Chief Financial Officer	Issue procedures for management of contracts involving stage payments.
SFI 15.4	Chief Financial Officer	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
SFI 15.5	Chief Financial Officer	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender.
SFI 15.6	Chief Executive	Issue a Scheme of Delegation for capital investment management.
SFI 15.7	Chief Financial Officer	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
SFI 15.10	Chief Financial Officer	Maintenance of asset registers and arranging for a physical check of assets against the asset register.
SFI 15.15	Chief Financial Officer	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
SFI 15.17	Chief Executive	Overall responsibility for fixed assets.
SFI 15.18	Chief Financial Officer	Approval of fixed asset control procedures.
SFI 15.19	Board, Executive members and staff	All significant discrepancies revealed by verification of physical assets to fixed asset registers to be notified to the Chief Financial Officer.

SFI 15.20	Board, Executive members and staff	Responsibility for security of Trust property.
SFI 15.20	Executives and senior officers	Apply such appropriate routine security practices in relation to Trust property.
SFI 15.20	Board, Executive members and staff	Report any damage to the Trust's premises, vehicles and equipment or any losses in accordance with Trust procedure.
SFI 17.3	Chief Executive	Delegate overall responsibility for control of stores (subject to the Chief Financial Officer's responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
SFI 17.3	Designated pharmaceutical Officer	Responsible for controls of pharmaceutical stocks.
SFI 17.3	Designated estates Manager	Responsible for control of stocks of fuel oil and coal.
SFI 17.4	Designated manager / pharmaceutical Officer	Security arrangements and custody of keys.
SFI 17.5	Chief Financial Officer	Set out procedures and systems to regulate the stores.
SFI 17.6	Chief Financial Officer	Agree stocktaking arrangements.
SFI 17.8	Chief Financial Officer	Approve alternative arrangements where a complete system of stores control is not justified.
SFI 17.9	Chief Financial Officer	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.

SFI 17.9	Designated pharmaceutical Officer	Operate system for slow moving and obsolete stock, and report to the Chief Financial Officer evidence of significant overstocking.
SFI 17.11	Chief Financial Officer	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
SFI 19.1	Chief Financial Officer	Responsible for accuracy and security of computerised data.
SFI 19.3	Chief Financial Officer	Satisfy themselves that new computer systems (including finance systems) and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
SFI 19.5	Chief Financial Officer	Shall publish and maintain a Freedom of Information Scheme or adopt a model Publication Scheme approved by the information Commissioner.
SFI 19.4	Relevant officers	Send proposals for general computer systems to the Chief Financial Officer.
SFI 19.6	Chief Financial Officer	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.
SFI 19.7	Chief Financial Officer	Seek periodic assurances from the provider that adequate controls are in operation.
SFI 19.9	Chief Financial Officer	Ensure that risks to the Trust from use of IT are identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans

SFI 19.10	Chief Financial Officer	Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that: (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy; (b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists; (c) Finance staff have access to such data; Have adequate controls in place; and (d) such computer audit reviews as are considered necessary are being carried out
SFI 20.2	Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission and that the Trust will not accept responsibility or liability for patient's property unless the procedures are followed.
SFI 20.3	Chief Financial Officer	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
SFI 20.6	Departmental Managers	Inform staff of their responsibilities and duties for the administration of the property of patients.
SFI 23.1	Chief Executive	Retention of document procedures in accordance with Department of Health Guidance.
SFI 24.1	Chief Executive	Develop a risk management programme in line with NHS assurance framework requirements, which must be approved and monitored by the Board.
SFI 24.1	Board of Directors	Approve and monitor risk management programme.
SFI 24.5	Board of Directors	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self- insure should be reviewed annually.
SFI 24.6	Chief Financial Officer	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme.

SFI 24.7	Chief Financial Officer	Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
SFI 25.1	Chief Financial Officer	Establish procedures for the management of expense claims.
SFI 26.1	Chief Financial Officer	Approve the contract or transaction in relation to credit finance commitments
SFI 26.2	Chief Financial Officer	Approve leasing agreements and hire purchase undertakings.
SFI 27.9	Chief Financial Officer	Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds.
SFI 27.10	Chief Financial Officer	Arrange for the administration of all existing charitable Funds held on Trust
SFI 27.11	Chief Financial Officer	Ensure that all charitable Funds held on Trust are currently registered with the Charities Commission in accordance with the Charities Act 2011 or subsequent legislation.
SFI 27.12	Chief Financial Officer	The Chief Financial Officer shall recommend the creation of a new charitable fund where funds and/or other assets, received in accordance with the Trust's policies cannot adequately be managed as part of an existing fund
SFI 27.15	All officers	Immediately hand over all gifts, donations and proceeds of fund-raising activities, which are intended for the Trust's use to the Chief Financial Officer.
SFI 27.16	Chief Financial Officer	Produce guidelines to Officers as to how to proceed when offered funds.
SFI 27.16	Chief Financial Officer	Ensure that in respect of legacies and bequests, • all correspondence concerning a legacy is dealt with on behalf of the Trust; • where necessary, grant of probate is obtained or apply for a grant of letters of administration, where the Trust is the beneficiary; and

(B)		• that arrangements regarding the administration of a will are negotiated with executors and to discharge them from their duty
SFI 27.17	The Board	Give final approval for major appeals, defined as events raising in excess of £100,000.
SFI 27.17	Charitable funds committee	Give final approval for smaller appeals, defined as events anticipating to raise less than £100,000
SFI 27.18	Charitable funds committee	Be responsible for all aspects of the management of the investment of Funds held on Trust.
SFI 27.18	Chief financial officer	Be responsible for the appropriate treatment of all investment income.
SFI 27.20	Charitable funds committee	Exercise of expenditure discretion (can be delegated to the Chief Financial Officer).
SFI 27.22	Chief Financial Officer	Advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee
SFI 27.23	Chief Financial Officer	• Appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; • appropriate measures are taken to protect and/or to replace assets; • donated assets received on trust shall be accounted for appropriately; and • all assets acquired from charitable Funds held on Trust which are intended to be retained within the trust funds are appropriately accounted for.
SFI 27.24	Chief Financial Officer	Ensure that regular reports are made to the Charities Committee and the Board with regard to, inter alia, the receipt of Funds held on Trust, investments of these trust funds and the disposition of resources
SFI 27.25	Chief Financial Officer	Prepare the Annual Accounts

SFI 27.26	Chief Financial Officer	In relation to the non-charitable trust funds prepare any required returns to NHS England.
SFI 27.26	Chief Financial Officer	Prepare an annual trustees report regarding charitable trust funds and make the required return to the Charities Commission
SFI 27.27	Chief Financial Officer	Maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.
SFI 27.28	Chief Financial Officer	Determine a basis for the distribution of investment income to the charitable Funds held on Trust and the recovery of administration costs.
SFI 27.29	Chief Financial Officer	Ensure that the records, accounts and returns receive adequate scrutiny by the Trust's Internal Audit during the year
SFI 27.30	Chief Financial Officer	Advise the Board of the outcome of the annual audit.
SFI 27.31	Chief Financial Officer	Identify all costs directly incurred in the administration of all Funds held on Trust and charge such costs to the appropriate trust accounts
SFI 27.33	Chief Financial Officer	Ensure that the Trust's liability to taxation and excise duty is managed appropriately
SFI 28.1	Chief Executive	Ensure that all intellectual property is identified, protected and used for the benefit of the Trust, the NHS and service users.
SFI 28.2	Chief Executive	Ensure that all intellectual property is identified and properly recorded in the Trust's Intellectual Property register.
SFI 28.3	Chief Executive	Ensure all third party intellectual property, upon which the Trust's intellectual property relies is properly licensed and confers rights to sub-license as part of the Trust's intellectual property.
SFI 28.4	All staff	Required to identify and protect the intellectual property of the Trust and ensure that is properly recorded in the Trust's Intellectual Property register.

SFI 28	Chief Executive	Responsible for compliance with the SFIs as they relate to the identification, protection, use and licensing of Trust and third party intellectual property.