GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD

Thursday 1 August 2024, 9.30am to 12.30pm
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** Claudia Paoloni, Claire Thompson	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 • 6 June 2024 (draft)	7 – 17	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	18	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Care Reflection (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 Helen Casey, Ward Manager, Neonatal Unit	19 – 20	TC/KS/ HC	Note	9.35
7.	**Chair's Report** Liam Coleman, Chair	21 – 24	LC	Note	10.05
8.	**Chief Executive's Report** Jon Westbrook, Acting Chief Executive	25 – 31	JW	Note	10.15
9.	**Integrated Performance Report** • Performance, Population & Place Committee Board Assurance Report (June & July) – Bernie Morley, Non-Executive Director & Committee Chair • Quality & Safety Committee Board Assurance Report (June & July) – Lizzie Abderrahim, Non-Executive Director & Deputy Committee Chair	32 – 35 36 – 41	BM EKA	Assurance Assurance	10.40

	• Finance, Infrastructure & Digital Committee Board Assurance Report (June & July) – Faried Chopdat, Non-Executive Director & Committee Chair	42 – 45	FC	Assurance	
	• People & Culture Committee Board Assurance Report (June) – Julian Duxfield, Non-Executive Director & Committee Chair	46 – 48	JD	Assurance	
	• Integrated Performance Report	49 – 99	All	Assurance	
BREAK (10 minutes) at 11.30 to 11.40am					
10.	**Audit, Risk & Assurance Committee Board Assurance Report (June)** Helen Spice, Non-Executive Director & Committee Chair	100 – 101	HS	Assurance	11.40
11.	**Improving Together Year 2 Review** Emily Beardshall, Deputy Director – Improvement & Partnership	102 – 143	EB	Receive	11.50
12.	**Committee Effectiveness Review 2023/24 – Audit, Risk & Assurance Committee** Caroline Coles, Company Secretary	144 – 155	CC	Approve	12.10
13.	**Fit & Proper Persons Regulation (FPPR) Annual Assurance Report 2023/24** Caroline Coles, Company Secretary	156 – 159	CC	Assurance	12.15
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.**					
14.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	-	CC	Approve	12.25
15.	**Responsible Officer Annual Report** Steve Haig, Acting Chief Medical Officer (approved by Quality & Safety Committee 18 July 2024)	160 – 179	SH	Note	-
16.	**Use of Mental Health Act Annual Report 2023/24** Lizzie Abderrahim, Non-Executive Director (approved by Mental Health Governance Committee 19 July 2024)	180 – 186	EKA	Note	-
17.	**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	-	-
18.	**Date and Time of next meeting** Thursday 5 September 2024 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
19.	**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"*	-	-	-	12.30

Board Meeting Timetable

2024											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Board	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
			Risk Management & Way Forward Plan			GWH Strategy Risk Appetite & Tolerance			Population & Health Cyber Security		

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 6 JUNE 2024 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Faried Chopdat (FC)	Non-Executive Director
Julian Duxfield (JD)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)	Non-Executive Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Acting Chief Executive

In attendance:

Caroline Coles (CC)	Company Secretary
Luisa Goddard (LG)	Deputy Chief Nurse
Claire Lehman (CL)	Associate Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director
Tim Edmonds (TE)*	Associate Director of Communications & Engagement
Deborah Rawlings (DR)	Board Secretary
Carrie Thomas	Breast Clinical Nurse Specialist (agenda item 037/24)

Apologies

Jon Burwell (JB)	Acting Chief Digital Officer
Lisa Cheek (LCh)	Chief Nurse

*Indicates those members attending virtually by MS Teams

Number of members of the Public: There was 1 member of public (Chris Shepherd, Governor)

Matters Open to the Public and Press

Minute	Description	Action
032/24	**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.	
033/24	**Declarations of Interest** There were no declarations of interest.	
034/24	**Minutes of the previous meeting (public)** The minutes of the Board meeting held in public on 2 May 2024 were adopted and agreed as a correct record.	
035/24	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list.	
036/24	**Questions from the public to the Board relating to the work of the Trust**	

Minute	Description	Action

There were no questions from the public to the Board.

037/24 **Care Reflection (Staff Story) – The introduction of endocrine support clinic to improve compliance post breast cancer**
Carrie Thomas, Breast Clinical Nurse Specialist joined the meeting to present this item

The Board received a presentation from Carrie Thompson, Breast Clinical Nurse Specialist on a service which had been set up to improve the quality of life of breast cancer patients on endocrine therapy. A series of virtual workshops had been introduced with the objective to support patients to manage the side effects of treatment for the duration of their course and to provide knowledge and expertise via a dedicated service. Carrie Thomas also outlined the delivery methods chosen, how the service had already evolved and development initiatives to further develop the service.

Other trusts had now shown interest in learning from this service and there was an aim to develop this Trust as a centre of excellence. Encouragement was made for Carrie to connect with the Trust's Research & Innovation Team or the Health Innovation Partnership to help develop the service further. It was also suggested that a bid for funding through the Thames Valley Cancer Alliance could be explored to help with future community physical space to hold workshops in person.

The Board thanked Carrie for their inspirational presentation and the exceptional work being undertaken to support breast cancer patients on endocrine therapy within the local community.

The Board **noted** the patient story.

038/24 **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.

It was noted that Councillor Ray Ballman had been reappointed as Swindon Borough Council governor representative.

The Board **noted** the report.

039/24 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report, and the following was highlighted:

Industrial action
The British Medical Association (BMA) junior doctors had announced further strike dates on 27 June to 2 July 2024. The BMA Speciality and Specialist (SAS) Doctors had rejected the Government's pay offer but had not yet announced any dates for industrial action.

Preparing for the Bank Holiday weekend
In preparation for the Bank Holiday weekend, a number of multi-disciplinary events were being held to prepare the organisation ahead of an anticipated increase in the number of patients. Community teams had also undertaken 'Community Reset Two' week with the aim of taking forward the learning from the first reset week.

Care Quality Commission inspection
An unannounced inspection had been received by the Care Quality Commission in May 2024 and inspectors had visited a number of wards and departments within the Medicine Division. A draft report from the CQC was awaited.

Ward accreditation

Minute	Description	Action

Falcon, Beech and Teal wards had been presented with certificates to recognise the staff's commitment to reaching 'good' as part of the Trust's ward accreditation programme. This programme drives forward patient safety work and wards are assessed across nine standards aligned to fundamental regulations from the Care Quality Commission's Key Lines of Enquiry.

Flexible visiting
Visiting hours at GWH had now been extended from 8am to 8pm on most wards. Changes were in line with the CQC standard, John's Campaign and NHS England plans for the implementation of Care Partners.

Open Gym
A new rehabilitation concept, the Open Gym, had been launched to help improve the recovery of patients who have had a stroke. Patients can attend the gym in the Swindon Intermediate Care Centre at any time of the day and this initiative had helped to increase the amount of time received by patients from therapists.

Infected Blood Inquiry
An inquiry report that reviewed the circumstances in which infected blood products were given was published last month. Blood is now distributed to NHS hospitals by NHS Blood and Transplant with all blood products undergoing extremely rigorous testing prior to being administered. It was confirmed that this organisation was not named in the Inquiry and has never acted as a haemophilia centre.

The Board **noted** the report.

040/23 **CQC Unannounced Inspection of Medical Care**

The Board received a report on the recent unannounced assessment of medical care by the Care Quality Commission in May 2024. The inspection was under the CQC's new single assessment framework and included four key questions; safe, effective, caring and responsive. Well led was not assessed although one quality statement was included under the well led domain. High level findings were fed back at the end of the day and a feedback letter which detailed the initial findings was subsequently received.

An overview of the CQC initial feedback related to proud, dedicated staff who spoke of supportive systems and teams within the hospital; good practice of record keeping around safeguarding, mental capacity assessments and recording and review of pain management; positive feedback provided to the CQC by patients; and good end of life care.

Areas for improvement related to infection control principles, particularly around hand hygiene and PPE; limited staff knowledge of tools, skills and resources to support patients with communication needs; access to medical overview for discharge planning by staff on surgical wards; and patient records on some wards were not always stored securely. Luisa Goddard, Deputy Chief Nurse outlined some of the immediate actions that had been undertaken to address these highlighted areas.

The CQC action plan would be taken through the divisional governance and the Patient Quality Sub-Committee for monitoring and oversight and that work would continue on CQC preparedness ahead of further assessments. The final report, following a factual accuracy review, was expected later in the summer.

Bernie Morley, Non-Executive Director expressed concern on some of the issues that continued to be raised by the CQC particularly in relation to hand hygiene and the ongoing work to improve infection control within the organisation. Luisa Goddard, Deputy Chief Nurse responded that further observational audits were to be undertaken together with additional training to drive cultural change around infection control.

Minute	Description	Action

Faried Chopdat, Non-Executive Director raised concern around the storage of patient records on wards and data confidentiality and the internal mechanisms in place for information security at the Trust. Jon Westbrook, Chief Executive responded that a Medical Records & Security Group headed up by the Trust's Chief Clinical Information Officer continued to explore processes to drive improvement around both paper and digital security and the implementation of an electronic solution to patient records security.

Luisa Goddard, Acting Chief Nurse added that staff were continuously reminded of the need to ensure patient record security at all times as part of the CQC preparedness and that overall storage solutions across the Trust continued to be explored, which also included the storage of cleaning chemicals and locked drug cupboards. Option appraisals would also be undertaken on the cost and requirement implications of increased storage solutions to understand the risk appetite of the organisation further.

The Board **noted** the report.

041/23 **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 April 2024.

Quarterly Pillar Metric deep dive

The quarterly deep dive of breakthrough objectives and pillar metrics were presented, with a particular focus on the past 12 months trends.

Our Care

Luisa Goddard, Deputy Chief Nurse reported that there were two strategic pillar targets for Our Care. These were to achieve zero avoidable harm within 5-10 years and to achieve consistent positive response rates in excess of 86% from patient Family and Friends Test.

The Breakthrough Objective for 2024/25 had changed from reducing harm associated with pressure ulcers to reducing harm from inpatient falls. This was to make improvements in the number of patients that had experienced moderate harm and above related to falls whilst in our care, especially those that had more than one fall. The A3 and countermeasures were being developed through a meeting with key stakeholders as well as a review of falls data and thematic insights from previous investigations. Work was also ongoing to ensure that all clinical areas were aware of their data and improvement trajectories. Assurance was provided through the Quality & Safety Committee which would maintain robust oversight of this breakthrough objective.

In relation to total harm, April had seen a further decrease in the number of pressure related harms for the third consecutive month. There had also been a reduction in hospital acquired pressure ulcers and small reductions in *E.coli* and *C.diff*.

The number of Family and Friends (FFT) positive responses for April had shown an increase from February and remained above the internal target. The target for 2024/25 had been increased to 90%. Assurance was provided to the Board on the work being undertaken within the organisation to improve the patient experience, particularly the Emergency Department and inpatient wards, and that there would also be increased focus to gain feedback from the care of elderly wards and carers to ensure that all feedback was being gathered. Emerging themes would continue to receive attention. Actions were also in place with divisions to improve the overdue complaints response rate. This would continue to receive oversight by the Quality & Safety Committee and to ensure that the right metrics were in place to be measured.

Our Performance

Felicity Taylor-Drewe, Chief Operating Officer reported that there were two strategic pillar targets for Our Performance, which related to Referral to Treatment (RTT) and the number

Minute	Description	Action

of patients waiting over 65 weeks and Cancer 62 Day. Ambulance Handover Delays had been chosen as a 2024/25 breakthrough objective.

April performance data had shown the total number of patients waiting over 52 weeks had reduced from the previous month. Focus for the operating plan was to reduce the size of the waiting list tail by eliminating 65 week wait breaches by the end of September and that validation of the current waiting list was to be undertaken by 'Project Verify' at the Trust.

The Cancer 62 Day performance dropped to 66.7% and therefore remained well below the national standard of 85%. The Trust was to remain in Tier 2 for cancer as part of the performance management regime and the potential impact on Single Oversight Framework (SOF) rating, however this rating was to be reassessed in July for Q1. Initiatives being undertaken to target lung health checks continued to be funded through the Thames Valley Cancer Alliance.

The mean stay in the UTC was at 170 minutes in April, which remained elevated above the mean despite a 5% reduction in attendances compared to March. The mean stay in ED remained broadly in line with the mean, with attendances close to plan for the month.

The 4-hour performance was 75.9% against the operating plan target of 78% and was an improvement of 1.5 percentage points from the previous month. Work continued with a whole hospital focus on 4-hour performance to improve patient experience and mitigations to stream patients away from the UTC and that further work was underway to review UTC demand with primary care support for further streaming and redirection.

April performance data for handover delays showed that 3,613 hours were lost due to ambulance handover delays which was the highest weekly reported delay in the last 12 months. A deep dive of April flow metrics was underway to understand the root cause of special cause variation in ambulance handover delays and that this was being included within the new ambulance handover breakthrough objective A3.

It was noted that the Trust average length of stay for non-elective inpatients increased by an additional day to 5 days in April, with bed occupancy remaining high at 98.3%. April was also the first month of operating with a combined total of 13 less majors cubicle spaces in ED. This planned closure of majors step down was to allow building works to commence for the new ED opening in July 2024. Improvement actions were to continue to focus on internal improvement work to reduce bed occupancy and process delays via the UEC transformation programme and new ways of working collaboratively with system partners.

Our People

Jude Gray, Chief People Officer provided an update on the actions against the strategic pillar targets which related to Staff Survey – Recommend a Place to Work, Staff Voluntary Turnover and EDI disparity. A marked improvement to the score for "Recommend as a Place to Work" had been seen in the 2023 Annual Survey results; however the recent Pulse Survey had shown a decline in this question.

The Trust continued to report a downward trend for its voluntary turnover rate and in March this had reduced to 8.4%. Performance below the 11% target had been sustained for 12 months and performance would continue to be maintained through the Trust Retention Working Group, with counter-measures being refined to focus on leavers within the first year of employment. A People Promise Manager was now in place to drive further improvement.

Feedback arising from the Annual Survey in relation to EDI disparity was being addressed by work being undertaken by the divisions. Fairness was now being reported and the number of Trust-wide projects to support improvement were noted.

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A project plan had been developed to support the Workforce Recovery programme which included a focus on overtime controls and the review of fixed term contracts. It was noted that there was a significant risk to staff morale and engagement due to current financial challenges and the requirements to maintain an affordable and sustainable workforce. A communications workstream was now in place to inform staff on the objectives and mitigating actions to meet these challenges.

The Breakthrough Objective for 2024/25 had been changed to the Staff Survey question "I receive the respect I deserve from my colleagues at work" to drive further improvement in 2024/25. The Trust's current performance against this was at 70% and that national average is 71%. The stretched target for the Trust had been set at 73%. It was noted that the Trust had achieved a small improvement in the question for the Pulse Survey Q1 (70.70%).

Use of Resources

Simon Wade, Chief Financial Officer reported on the breakthrough objective for productivity. The overall A3 was being reworked and the refreshed BTO was to be described as "To remain within our overall deficit plan by month for 2024/25, having improved the underlying financial deficit position by the financial year end through delivery of recurrent CIP". This would mean that the Trust needed to meet its overall planned deficit of c.£7.1m (PFI UK GAAP adjusted deficit £13.4m) and deliver as much of its £21.9m efficiency target as possible on a recurrent basis.

The efficiency target for 2024/25 was £21.9m and all divisions and services were expected to increase overall savings to hit this target, and more specifically to ensure the savings were recurrent to reduce the underlying deficit. Key to the delivery of savings was to become more productive by maximising activity and related ERF income. Divisions and services were expected to focus on the pay spend reduction throughout 2024/25.

Good governance remained in place through monthly monitoring on performance and wider system initiatives through the Financial Recovery Sub-Committee. System planning and delivery executive meetings continued to focus on target areas for improvement and monitoring of measures for delivery.

In response to a question asked by Lizzie Abderrahim, Non-Executive Director on the carbon footprint/sustainability targets for the Trust, Simon Wade, Chief Financial Officer outlined initiatives and the good work being undertaken at the Trust to influence the Green agenda. However, challenges remained with access to capital investment to support delivery of further initiatives and that there was a drive to have bid cases prepared for any larger initiatives to draw on any funding that may become available. Simon Wade also replied that good national and regional feedback had been received on sustainability work underway by the Trust and that learning had been shared with peers.

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meeting on 29 May 2024 and the following was highlighted:

- Ambulance handovers remained of significant concern, with 46 conveyances waiting more than 6 hours. Demand was noted as static in majors and improvement plan across four key internal workstreams was underway to address flow within the hospital.

Minute	Description	Action

- Cancer performance standards remained within the tolerance set. The Trust was to remain in Tier 2 for cancer as part of the performance management regime and the potential impact on Single Oversight Framework (SOF) rating. Sustainability remained around the cancer management of skin, colorectal and urology. Helen Spice, Non-Executive Director asked if PPPC could further reflect on available benchmarking data for cancer performance.
  Action: Chief Operating Officer

- Referral to Treatment (RTT) and diagnostic performance (DM01) performance had decreased and sustainability remained a challenge.

- The EPRR assurance quarterly report continued to report and an outline of the work to support a substantial rating was outlined and noted.

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 meeting on 23 May 2024 and the following was highlighted:

- To reduce harm with falls had been chosen as the breakthrough objective for 2024/25 and April's performance had shown a notable increase to 6 cases. A discussion was held around the metrics being used and presented to enable QSC to have assurance around improvements and status of care around fall prevention and it was noted that A3 methodology and countermeasures were still in development.

- On the back of the CQC visit in September 2023 to the Maternity Unit, the NHSR had requested the division to review all submission provided over the last year for accuracy. This had been completed and confirmed and no amendments were required.

- The Maternity Incentive Scheme (CNST) Year 6 now indicated 9 'green' out of the 10 safety action details, with the 10th as 'amber'.

- The proportion overdue clinical audit items were above average at the end of Q1 2024/25 despite an end of year push, with some delays around the local departmental governance sign off processes, and would be an area of focus for improvement.

- It was reported that 120 NICE guidelines appeared to remain outstanding for assessment against. The Clinical Audit Team continued to drive implementation for progress by divisions.

The Board **noted** the report.

Use of Resources
Finance, Infrastructure & Digital Committee Chair Overview
The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meeting on 28 May 2024 and the following was highlighted:

- The Committee had received a verbal update outlining the System's challenges in the delivery of its financial plan, particularly given the scale of the deficit and the ever-increasing pressure to drive greater efficiency, productivity, and the focus on

Minute	Description	Action

WTE at all levels. It was noted that in-month this Trust fared worse off than the other two trusts due to different phasing assumptions and approaches to delivering efficiency savings, productivity and other financial requirements. There was a requirement for more mature governance processes, greater transparency and consistent criteria and measures at the ICS level to gain greater assurance and sight of comparable data points.

In response to a question raised by Rommel Ravanan, Associate Non-Executive Director on the recent cyber attacks experienced by London hospitals, assurance was provided that cyber security would remain a key focus for the Trust and that this would receive continued robust oversight by FIDC.

The Board **noted** the report.

042/24 **Mental Health Governance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Mental Health Governance Committee (MHGC) at its meeting on 19 April 2024 and highlighted the following:

- There had been increased demand on agency spend in the reporting period and that this was a reflection of the need to provide RMN cover for patients whose mental health acuity was high and for whom there was no acute mental health bed available. MHGC was assured that there were robust actions in place to address the pressures working with service partners and system-wide risks.

- MHGC was assured that there was clear evidence of processes and procedures to address the legal requirements of both the Mental Capacity Act and Deprivation of Liberty Safeguards but that audits demonstrated that further work needed to be done to ensure that these were applied and implemented effectively across GWH.

- Good collaborate work could be evidenced across the system, supported by the cooperative approach taken by Wiltshire Constabulary on the Right Care Right Person initiative which was not reflected in other parts of the country.

The Board **noted** the report.

043/24 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 8 May 2024 and highlighted the following:

- Future fundraising plans were to be further refined. The cost of living issues provide continued risk and uncertainty.

- No major concerns were identified around the financial reporting to CFC.

- Case of need documentation continued to be improved to show the impact of the proposed cases and how they would support the least advantaged patients and those from protected groups.

- Progress was still required to ensure that clear plans existed to use the funds available and that each division would be invited to present at future CFC meetings on their individual plans.

- Good progress continued to be made with the implementation of the external review action plan and that a key outstanding action related to the rationalisation of funds.

Minute	Description	Action

In response to a question asked by Helen Spice, Non-Executive Director on the staff lottery scheme ran at GWH, Julian Duxfield, Non-Executive Director responded that CFC were assured on how the funds raised by the staff lottery were being used by staff within the organisation. The Board requested that further assurance be being sought by CFC on the governance processes around the staff lottery to ensure that robust processes in place.
Action: Claire Thompson, Chief Officer of Improvement & Partnerships

The Board **noted** the report.

044/24 **Safe Staffing 6-month review for Nursing, Midwifery and AHP**

The Board received and considered a report which provided assurance that staffing had been managed over the past six months in line with national recommendations.

The report provided assurance around the Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations; safe staffing related to AHP; Community Nursing safe staffing; and Acute Wards compliance with national guidance and the Emergency Department Safer Nursing care Tool review.

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

The Board noted the Trust's position against national benchmarking using Care Hours per Patient Day, shift fill rates and the Safer Nursing Care Tool. It was highlighted that the majority of wards were now funded to be compliant with the 1 nurse to 8 patient ratios with the exception of the SWICC wards. Good progress on recruitment and retention and the work to maximise efficiency and safe working through the daily staffing meetings and the success of the temporary staffing reduction plan was noted.

The Community safer nursing tool to inform the establishment requirements using a recognised methodology had now been applied, which also provided progress with vacancies and other workforce metrics.

The Trust's midwifery staffing had continued to improve over the last six months by the identification of different staffing models both with local and international recruitment, alongside the recruitment of band 5 nurses to work in specific areas within maternity.

Improvements in the recruitment and reduction in turnover of the AHP workforce was noted and that there was a proactive approach to understanding workforce capacity and delivery, clinical education and workforce reform to formulate a robust longer term workforce strategy.

Assurance was provided to the Board that the risk which related to poor quality metrics and reduced staff morale/high turnover due to inpatient wards working at a ratio of 1:10 for registered and unregistered staff was continuously reviewed and that the risk score of 12 was reasonable and reflected the priorities for staffing during periods of operational pressure.

The Board noted that the Trust had made good progress in the delivery of safe staffing across acute, community and midwifery. Significant improvements had been seen in areas with safer staffing investment and that work on recruitment and retention had continued to improve the staff experience and to support the drive to improve patient care.

The Board **noted** the report.

045/24 **Equality, Diversity & Inclusion Pillar Metric Review**

Minute	Description	Action

Sharon Woma, Alicia Messiah, Kayley Payne, Sarah King, Howard Chitty, and Katie Banks joined the meeting for this item.

Jude Gray, Chief People Officer reminded the Board of its commitment action to invite GWH staff networks to participate in a deep dive into the staff survey questions related to inclusion and discrimination.

The presentation also reflected on the Trust's EDI Pillar Metric of Question 16B of the staff survey "In the last 12 months have you personally experienced discrimination at work form a manager/team leader or other colleagues". Data was highlighted which included the groups (protected characteristics) who disproportionately experienced this behaviour.

The Board members and staff network representatives present were divided into groups for focused dialogue supported by the Discrimination A3 information and to discuss potential counter measures (actions). The feedback and recommendations from these discussions were then shared from each group to help inform the 2024/25 EDI Action Plan.

The Board **received** the report.

046/24 **Committee Effectiveness Review 2023/24**

The Board received a paper to consider the annual review for the Board Committee effectiveness and the terms of reference for Board Committees – Quality & Safety Committee, Finance, Infrastructure & Digital Committee, Mental Health Governance Committee, People & Culture Committee, Performance, Population & Place Committee, Charitable Funds Committee and Remuneration Committee. The following was noted:-

- Each Board Committee had undertaken an open discussion to consider their effectiveness, including terms of reference.
- There were no issues or concerns to draw to the attention of the Board.
- The terms of reference of the Committees were circulated showing minor amendments.

Lizzie Abderrahim, Non-Executive Director asked for clarification on the rationale behind why chairs of some committees were unable to chair other committees. Caroline Coles, Company Secretary agreed to check on the national guidance behind this.
Action: Company Secretary

The Board:

(a) **agreed** that there are no changes proposed to the Board Committee structure; and,
(b) **approved** the Terms of Reference for each Committee as circulated within the Board papers.

047/24 **Delegation of authority for approval of Annual Accounts 2023/24**

The Board was requested to delegate authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2023/24 in order to meet the deadline of 28 June 2024.

The Board to **resolved to delegate authority** to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2023/24 before the deadline of 28 June 2024.

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

Minute	Description	Action

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.

048/24 **Ratification of Decisions made via Board Circular**
None.

049/24 **Annual Self Certification – CoS7**
The Board received a self-certification for Board approval prior to publication. The self-certifications was:

- Condition CoS7 (3) – Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services.

The Board **approved** the annual self-certification for CoS7 (3).

050/24 **Final Annual Quality Account 2023/24**
The Board was requested to ratify the Quality Account 2023/24 for publication on the Trust's website in order to meet the deadline of 30 June 2024, noting that it had been reviewed and approved by the Quality & Safety Committee at its meeting on 23 May 2024.

The Board **resolved to ratify** the Quality Account 2023/24 for publication on the Trust's website before the deadline of 30 June 2024.

051/24 **Urgent Public Business (if any)**
None.

052/24 **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.

053/24 **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 13.15hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – August 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	041/24	**Performance, Population & Place Committee Chair Overview** PPPC to further reflect on available benchmarking data for cancer performance.	Chief Operating Officer	Further benchmarking information is provided in the quarterly updates to PPPC as standard.
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.
6 June 2024	046/24	**Committee Effectiveness Review 2023/24** National guidance to be checked on the rationale behind why chairs of some board sub-committees are unable to chair other board sub-committees.	Company Secretary	There are no restrictions on who should Chair Board committees except for Audit Committee. The terms of reference will be amended accordingly.

Future Actions				

Report Title	**Care Reflection**				
Meeting	**Board of Directors**				
Date	**1st August 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek, Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement Georgia Cotton, Videographer				
Appendices					

Purpose

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

Assurance Level

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

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:

This is an extremely positive story of care received within our neonatal unit.

Report

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

This Care Reflection shares the story of Hazel and her mums Kelly and Janna who experienced care on our Neonatal Unit.

Hazel was born prematurely at 27 weeks at a system network unit. She was transferred to the GWH Neonatal unit just before Christmas in 2023 and spent 3 months with us. Due to her prematurity she required complex clinical interventions and support in order for her to develop and thrive.

Her mums wanted to share their experience of the excellent care they received and send thanks to the team.

Members of the team explain the function and ethos of the Neonatal unit and the importance of good engagement and involvement with families.

This is a positive reflection of care experience but has also identified some areas where care could be further improved.

The film can be viewed at: Care Reflections - Hazel (youtube.com)

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps	The positive experience and learning from this care reflection will be shared widely via the departmental and divisional governance structures and more widely across the trust.				

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: Not formally assessed			

Recommendation / Action Required The Board/Committee/Group is requested to:	
To receive the presentation as assurance of patient and family experience along with the developments and improvements identified from this Care Reflection.	
Accountable Lead Signature	Lisa Shaw
Date	12th July 2024

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

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

Assurance Level

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

Process

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

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

Report

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

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

The report provides information in respect of:-

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

To Note : Throughout June the Trust followed the rules of purdah

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

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	24 July 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 June & July 2024.

1. Council of Governors

1.1 I am delighted to announce that we have recently appointed a new Associate Young Person, Olu Onukun to join the Council of Governors. Olu will present the younger members of our community and their work will ensure that the views of those younger members are heard at the highest levels at the Trust.

1.2 We also welcome our new Wiltshire County Council governor representative, Cllr Sam Pearce-Kearney.

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

June 2024		
Date	**Event**	**Purpose**
6 June	Trust Board Meeting – Observers	Holding the Non-Executive Directors to account
10 June	Public Health Lecture – Dementia	Governors host to promote membership
18 June	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
24 June	Governor Informal Session	Opportunity for governors to get to know Non-Executive Directors – Julian Duxfield attended this session.

25 June	Improving Together Session	Introductory session for governors of Improving Together approach to change, innovation and continuous improvement.

July 204		
Date	**Event**	**Purpose**
9 July	NHS Providers Governor Focus Conference	Event dedicated to NHS governors to share knowledge and best practice
10 July	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues

1.4 The governor election process for 2024 will commence in August and run through the summer, with declarations of result on 1 November 2024. The constituencies and vacancies for election are public elections for Wiltshire Northern and staff elections for Allied Health Professional. Further details will be published on our website.

2. Strengthening Board Oversight & Development

2.1 Safety Visits - There were 3 Board safety visits during the period covered by this report as follows:-

Date	Area	Board Member
24 June 2024	Critical Care Unit	Steve Haig, Acting Chief Medical Officer Will Smart, Non-Executive Director
8 July 2024	Teal Ward	Lisa Cheek, Chief Nurse Julian Duxfield, Non-Executive Director
24 July 2024	Paediatrics	Lisa Cheek, Chief Nurse Lizzie Abderrahim, Non-Executive Director

3. Trust Chair Key Meetings during June and July 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
Extraordinary Council of Governors' Meeting	BSW AHA Briefing
Finance, Infrastructure & Digital Committee	To attend as an observer
Performance, People & Place Committee	Board sub-committee meeting
Mental Health Governance Committee	Board sub-committee meeting
Audit, Risk & Assurance Committee	Board sub-committee meeting – to approve Annual Report & Accounts
AHA Committees in Common	Regular system meeting
AHA Transition Planning	System meeting
BSW Chairs' meeting	Regular meeting to update and discuss any topical issues
EPR Joint Committee	System meeting

Meeting	Purpose
MOU for Chairs Development Workshop	System meeting
WHC Members' Board Meeting	System meeting
Health & Wellbeing Champions Celebration Event	To attend as HWB Champion
Non-Executive Director Appraisals	Annual performance reviews

Report Title	Chief Executive's Report				
Meeting	Trust Board				
Date	1 August 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:

- An electrical outage at the Great Western Hospital
- Industrial action
- Improving Together
- Freedom to Speak Up
- Integrated Front Door development
- Our financial situation
- Appointment of Chief Nurse
- Staff Excellence Awards
- Big Green Week

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 references the Staff Excellence Awards, which includes a specific category focussed on championing equality, diversity and inclusion.

The report also features the Slice of Life sessions we are running as part of our work to build a more inclusive, welcoming and supportive workplace for everyone.

All staff are welcome, with some of the sessions themed around our LGBTQ+, differently abled, race equality, and women's staff networks, and other sessions open to discussions about any experiences staff would like to share

Our support for Pride Month is also mentioned.

Recommendation / Action Required The Board/Committee/Group is requested to:	
To note the report	
Accountable Lead Signature	Jon Westbrook, Acting Chief Executive Officer
Date	25 July 2024

1. Operational updates

1.1. Electrical outage

We declared a major incident on 9 July following a power outage which caused significant disruption to our services and impacted on patients, visitors, staff and volunteers.

Many parts of the hospital were without electricity, lighting, and water for several hours.

Staff worked extremely hard to respond to the incident and deliver patient care in very challenging circumstances.

We were able to reconnect the electrical supply to the main electrical system and plan to install a fifth generator to the hospital site, alongside the existing four generators, for even further resilience.

A full debrief in to how we responded to the incident is being carried out, along with an investigation to better understand how this happened and how we can prevent anything similar occurring.

1.2. Industrial action

British Medical Association (BMA) junior doctors went on strike for five days from 27 June to 2 July.

We declared a business continuity incident to enable us to manage the situation and operational teams worked to mitigate the impact as much as possible. However, more than 580 patients had their outpatient appointment or surgery cancelled due to the action with many more appointments not booked during this period.

The BMA still has a mandate for strike action and action short of strikes until 19 September, but no further dates have been announced and reports indicate the union is in talks with the new government.

General Practitioners are currently being balloted by the BMA regarding potential collective action. Ballot closes 29th July 2024. This has the potential to be very disruptive to patients and other health services including acute trusts. Preparation work will be led by the ICB.

2. Quality

2.1. Improving Together

Our Improving Together way of working has been shortlisted in the Quality Improvement Initiative of the Year category of the Health Service Journal Patient Safety Awards 2024. The awards ceremony takes place on Monday 16 September in Manchester.

We've also just marked the two year anniversary of the launch of the approach in our Trust.

More than 800 staff from across the organisation have received Improving Together training so far.

We have found that adapting the frequency and timing of the huddles has supported teams to find them more manageable with many of the teams huddling between two and three times a week.

Many teams have reported being more proactive and having a better understanding of each other and how colleagues interact with each other.

Among other areas, using this approach has enabled us to reduce total avoidable harms, along with falls in the medicine division, and waiting times for patients to be declared clinically ready to proceed. We have also been able to improve voluntary turnover, and staff feeling able to make improvements in their areas of work.

We will now focus on the sustainability of our work, increasing the patient voice in what we do, and looking at how we develop Improving Together within the wider system.

2.2. Cardiology

Our Cardiology team has been rated as the best team in the UK for teaching by specialist registrars in district and general hospitals.

They were recognised in a survey undertaken by the British Junior Cardiovascular Society, which seeks the views of trainees across the country.

2.3. Freedom to Speak Up

We have appointed three new Freedom to Speak Up Guardians – members of staff who have volunteered to join our existing team of Guardians to help create a safe space for their colleagues to raise concerns.

They are: Candace Wood, Deputy Head of Insights and Learning; Jenny Kear, Head of the Patient Advice and Liaison Service; and Leahann Bonehill, Matron.

Freedom to Speak Up is key to protecting the safety of patients, identifying learning and encouraging improvement.

We have also now introduced mandatory training to support Freedom to Speak up.

The training courses available are:

Speak Up: Core training for all workers, including volunteers, students and those in training, regardless of their contract terms. This covers what speaking up is and why it matters. It will help learners understand how to speak up and what to expect when they do.

Listen Up: This training is for all line and middle managers and is focused more on listening up and the barriers that can get in the way of speaking up.

Follow Up: This training is aimed at all senior leaders, including executive board members (and equivalents), Non-Executive Directors, and Governors, to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement

We also encourage staff to speak up using a number of different channels, including via their line manager, senior managers, the HR team, the health and wellbeing team, the Chaplaincy, staff networks, and professional nurse and midwifery advocates.

3. Systems and Strategy

3.1. Integrated Front Door development

The construction of our £33.5m Integrated Front Door is now nearing completion, after months of preparation and building work following the money for the programme being awarded in January 2023.

A ribbon-cutting event took place last month to celebrate the progress made with local stakeholders attending alongside current and former staff who have worked on the project.

The ribbon was cut by patient Louise Hunt, a wheelchair user who has had input into the overall design.

The new department will have a 60 per cent bigger footprint, with more majors cubicles, four more resuscitation bays, two relatives rooms and a new patient health and wellbeing space.

Teams have worked with communities including those with dementia, a learning disability, young people, mental health services, wheelchair users and more to ensure that the department is inclusive and accessible for all.

With more floor-space, better facilities, and new pathways of care in place, the new facility will enable staff to deliver even better care for our patients.

Final work is currently taking place ahead of the new department opening for its first patients. There have been some imposed delays whilst Fire protection works are rectified and a revised date for opening will be announced shortly.

3.2. Financial situation

The system's financial situation remains very challenging and at our Trust in month three of the year, June, we were in a £4.9m deficit position, which is £2.1m worse than plan.

Our savings target this year is £21.9m. So far we have delivered £2.5m of this, with 47 per cent of these savings recurrent.

All divisions and services have been asked to further increase their overall savings to enable us to reach the savings target, and to specifically ensure the savings they identify are recurrent to help reduce our underlying deficit.

Along with identifying areas for savings, continuing to maximise operational activity and reducing pay spend remain key to the delivery of our financial plan.

3.3. Shared Electronic Patient Record

We are working closely with the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust to introduce a shared Electronic Patient Record to help standardise care and provide a better experience for both patients and staff.

As part of our preparation for the implementation of this single digital solution, we have completed a process to map our current operational and clinical working practices.

This has helped us to better understand the processes which will be affected once the new system is deployed.

Separately, we have been recruiting colleagues to join the programme team and help us deliver this huge piece of work.

4. Workforce, wellbeing and recognition

4.1. Appointment of Chief Nurse

Congratulations to Luisa Goddard, one of our Deputy Chief Nurses, who has been appointed as our next Chief Nurse. Luisa will succeed Lisa Cheek, who has chosen to take early retirement, later on in the year. The recruitment process for the Deputy Chief Nurse position is now underway.

4.2. Staff Excellence Awards

Our annual Staff Excellence Awards took place at the MECA in Swindon in June.

380 staff attended and celebrated the great work of colleagues from right across our organisation.

Our winners were as follows:

- Improving Together Award – Teal
- Rising Star Award – Sophie Reid
- Hero Award: Beyond the Call of Duty – Gemma Turnbull
- Improving Patient Experience Award – Tracey Carr
- Kindness Award – Elizabeth-Anne Mallon
- Leading the GWH Way Award – Jon Freeman
- Championing EDI Award – Charlotte Hunt
- Patient Choice Award – Saturn
- Lifetime Achievement Award – Sally Charlton and Andy Beale
- Team of the Year Award – Department of Older Persons ACPs
- Star of the Year – Kirsty Nelson-Smith

4.3. STAR of the month

Our latest STAR of the Month winner is the Community Services team, who stepped in to help a member of staff when she had a bad fall. The team offered expertise, efficiency and incredible care whilst coordinating the situation. They also demonstrated calm and positive leadership to ensure their colleague was kept safe and well, as well as organising transport to hospital.

Kim Johns, Cancer Multi-disciplinary Team Coordinator, and Shannon Henson, Cancer Administrator, also won a STAR of the Month Award recently. Kim and Shannon supported a woman who was giving birth in the hospital car park. Despite working in non-clinical roles, the pair offered reassurance to the parents and helped deliver the baby before handing the care over to our maternity team.

4.4. Great West Fest

Great West Fest, our free family festival, is returning for its fourth year 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.

4.5. Slice of Life

All staff have been invited to attend a series of new Slice of Life sessions designed to encourage courageous conversations with Trust Board members about the true experiences of staff working across the Trust.

This is part of our work to build a more inclusive, welcoming and supportive workplace for everyone.

All staff are welcome, with some of the sessions themed around our LGBTQ+, differently abled, race equality, and women's staff networks, and other sessions open to discussions about any experiences staff would like to share

The sessions began in July and continue through to November.

4.6. Pride Month

We marked Pride Month in June with a range of events including a bake off and encouraging staff to demonstrate their commitment to LGBTQ+ colleagues by becoming an Ally or an Equality, Diversity and Inclusion Champion.

4.7. Military challenge

Eight staff members recently completed 'Exercise Medical Endeavour', the South West Military Challenge which gives staff the chance to get a taste of the work 243 Multi-Role Medical Regiment does, and participate in leadership and team-working activities in friendly competition with other South West NHS Trusts.

4.8. Big Green Week

We marked Great Big Green Week at the Trust for the first time in June.

The national awareness week is the country's biggest celebration of community action to tackle climate change and protect nature and we joined in to show the work underway to support our organisation to be Net Zero Carbon by 2040.

During the week:

- We had 126 responses to a travel survey to help the Trust identify where we can encourage more sustainable commuting
- Many donations to the clothes 'shwop' were received with all spare items donated to a local charity shop
- 74 staff signed up to become Sustainability Champions, to support colleagues in making greener choices in the workplace
- Individuals from local companies joined staff for a litter pick on the expansion land and collected over eight bags of waste
- Bug hotels were created by the children at Little Pioneers Nursery.

4.9. BBC Make a Difference Awards

Two teams have been shortlisted in the BBC Make a Difference Awards, celebrating local individuals and groups around Swindon and Wiltshire.

The Trust's sustainability team are shortlisted in the 'Green Award' category for their work to support the NHS' pledge to be Carbon Net Zero by 2040. Local voluntary group, Brighter Futures Blanketeers, are shortlisted in the 'Carer Award' category for their incredible work in crocheting and knitting blankets for patients receiving end of life care.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	26th June 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	Deferred	X
2. Operational Highlight Report	N/A	X
3. IPR - DM01	Partial	X
4. IPR - RTT	Partial	X
5. IPR - Cancer	Partial	X
6. IPR – ED / 4 hours	Partial	X
7. IPR – Ambulance Handover	Limited	X
8. Theatre Programme Update	Good	X
9. Improving Together Year 2 Review	Received	X
10. Care Coordination and Navigation Hub	To note	X
11. Quarterly 15+ Risk Report	Deferred	X

POINTS OF ESCALATION	No points of escalation
KEY AREAS TO NOTE	There were 256 x65 ww, an increase of 75 from the previous month; 78 ww remains unchanged. Challenging plan to meet September target of zero, mitigations in place. Waiting list rises due to supporting validation of the 'tail' of the waiting list. DMO1 on plan for activity and for performance at May 66.9% and on trajectory for June. Record ED demand, across Majors and Minors, 11,840 attendances in May 2024, despite this, strong triage time and average 4-hour performance when compared to peers at 75.3%. Handover Delays 12hr (zero) and 8hr waits for ambulances decreased, though an increase in 6hr waits. Total waiting times lost decreased across the month. Focus on addressing the long ambulance waits with an improvement programme was highlighted. Virtual ward was noted as a positive improvement. Committee noted the update in relation to the navigation hub part of care co-ordination and requested a future agenda item on the "hub" provided by Medvivo and our local "spoke". Progress report on year 2 Improving Together was presented and the work to date was commended. Key metrics were described as the feedback from the improvement from the staff survey question "making improvements in work".
BOARD ASSURANCE FRAMEWORK & RISKS	Risk report deferred to July 2024.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Improvement in triage times and majors performance, increased to 60.2% and mean stay has improved in majors down to 371 and UTC mean stay remains consistent at 170. Best DM01 performance since September 2021. Theatre improvements where GWH was quartile one for theatre utilisation was demonstrated, this was recognised as a significant improvement from 2 years ago. We noted we have undertaken over 100 + operations using the surgical robot.
REFERRALS TO OTHER BOARD COMMITTEES	None.

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	**Performance, Population & Place Committee**	
Meeting Date	24th July 2024	
Committee Chair	Julian Duxfield, 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	Received	X
2. NHS Oversight Framework	Received	X
3. BSW Plan 2024/25	Received	X
4. BSW Communities Together	To note	X
5. Operational Highlight Report	To note- see below	X
6. IPR - DM01	Partial	X
7. IPR - RTT	Partial	X
8. IPR - Cancer	Partial	X
9. IPR – ED / 4 hours	Partial	X
10. IPR – Ambulance Handover	Limited	X
11. Quarterly 15+ Risk Report	Received	X

POINTS OF ESCALATION	No points of escalation
KEY AREAS TO NOTE	• Briefing received in relation to the 2024/25 NHS oversight framework (OF) and the relevant committee mapping to the key performance indicators. • Briefing received in relation to GWH OF position in Q4 23/24 as level 2 with potential to move into level 3. Discussion around further assurance metrics that would be used should our OF rating deteriorate. Assurance given we are already learning from other trusts in relation to exit criteria and what we need to focus on. • Noted that further productivity metric information would be provided to the Trust Board which would illustrate GWH position comparative in BSW. • Partnership update provided including the proposed arrangements for the governance structures for delivery of the 2024/25 plan. • Briefing update on community procurement received by committee, noting bid submission 25th July and further update to Trust Board. • Performance metric assurance remains the same as last month across the key domains, noting GWH remains in the tiering regime for Cancer and Diagnostics.
BOARD ASSURANCE FRAMEWORK & RISKS	Risk report was reviewed, committee noted process was good. Further reflections from committee on balance of risks across committee and the target risk score were made and support for the work from the company secretary following Trust Board seminar.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Good progress to be on plan (performance and activity) for DM01 (diagnostics).
REFERRALS TO OTHER BOARD COMMITTEES	None made Notes to take forward further work on risk process – already planned following the Board seminar.

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

Committee	**Quality & Safety Committee**
Meeting Date	20.6.24
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	Reducing harm from falls

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Falls (IPR breakthrough objective)	partial	x
2. IP&C (IPR breakthrough objective)	good	x
3. IPR concerns and complaints(Non-Alerting Metric)	partial	x
4. IPR Maternity	good	x
5. Estates & Facilities Water Pseudomonas Update Report	substantial	x
6. Research and Innovation Annual Report	substantial	x
7. Update on CQC preparedness	good	x
8. Electronic Discharge summaries	note	x
9. Safe staffing Monthly report	note	X

POINTS OF ESCALATION	• **Electronic Discharge summaries** Distribution of electronic discharge within 24hours remains an area of non compliance at GWH with no improvement over the year. Limited assurance from the committee has been regularly raised on Board Assurance reports around this. • Whilst a purchase order has been raised and the Trust are awaiting confirmation of when the integrative work needed by Careflow EPA can be started, this is an essential prerequisite which is delaying progress. • A testing product is available and a team of testers being assembled but rollout requires third party involvement for which time frame is unknown. • Current EDS system is being used with a 72%completiion rate. • Recent CQC visit highlighted EDS completion rates as an area of concern.
	• **Falls** there has been an Increase in falls rate in April and May, but less with harm. • SWICC and Trauma being higher impacted areas. • A discussion was had around the negative impact of all falls irrespective of moderate/severe harm. • The committee sought further assurance around how the information could be presented that would enable them to have assurance around monitoring progress around the set Breakthrough objectives: 1. To reduce the number of patients that have more than 1 inpatient fall by 30% 2. To reduce total number of inpatient falls by 30% • A3 collated around falls improvement work, including policy review, starting monthly enhanced care audit, enhanced care training completion, pharmacy support around medication reviews where medication can contribute to falls, new post falls huddle and Consultant lead.
	• **IPC** There has been significant progress since the robust actions around infection prevention and control. • Pseudomonas has seen zero rates in May. • *E.Coli* rates showed a large increase in May but noted a national uptick. • *Klebsiella* rates remain third worst in BSW which appears to be related to patient deconditioning and issues around sampling, acting on results and catheter care Focussed work is ongoing to address this. • C Diff rates remain some of lowest in region.
	• **Complaints and Concerns**. The committee noted a substantial increase in the months concerns received rate and continued elevated complaints rates, with slow complaints response rates. • Themes appear to be around waiting times/delays in emergency and elective care and communication around this. • Committee requested further detail around the complaints and concerns be presented at a future committee meeting.
	• **Maternity IPR** birth rate increased in May • 99.38% received 1:1 care. coordinator midwife was supernumerary 100% time. • Maternity triage times continues to improve with 73.3% women being seen within 15 minutes of arrival to the hospital.

	• Whilst level 3 specialist adults Safeguarding training rates are not yet compliant, remedy training remains on track and marked improvement noted. Staff turnover rates do impact this rate. • Actions are being undertaken to increase percentage of staff holding Qualified in Specialty (QIS) on LNU due to be achieved by September 2024. • Actions are being taken to address GWH currently being an outlier as baseline surgical infection rates as identified through PreciSSion project, where patients self report infection following surgery once discharged, with now an MDT approach and defined plan including changes to surgical practice and type of surgical dressing use. Our population relatively higher BMI may be a contributor to these outlying results.
	• **Estates and Facilities Pseudomonas Update report** continued good progress. • Remedial work around flexible hose replacements, wash basins and automated taps due to be completed by end of summer. • Continued reduction in water positive counts. • 4 new augmented care areas have been identified and risk assessed, report being reviewed by IP&C. • IP&C confidence in actions and results have resulted in return to 6 monthly sampling. • Good oversight retained Through Water safety Group which reports to Infection Control. • Noted, GWH still remains an outlier in current benchmarking table for *P.aeroginosa* rates, but as results are cumulative assurance was received to anticipate a visible improvement in next 6 months.
	• **Update on CQC preparedness**. The committee received substantial assurance that following the recent CQC publishing of the new guidance for assessment of Organisations and a follow up internal review of our Must do/Should do actions following the 2020 Inspection, where out of 14 Actions, 12 could be closed as complete with 2 (related to waiting times and environment) having ongoing work with new front door and build work etc. • Trust is still awaiting formal report of the CQC visit to medicine in May 2024, but actions have been initiated on the basis of the verbal report and learnings received at the time around sepsis and infection prevention and control.
	• **Research & Innovation Annual Report** Substantial Assurance received around impact and effectiveness of progress in last year around enrolment, management and grant acquisition of research projects. • 43 studies actively recruited to, and 987 participants recruited, exceeding the internal set target. • First in the world to recruit to, and top recruiting global site for CSPOT trial (Cardiac Resynchronisation Therapy Trial). • Now 65 active Principal Investigators. • GWH first Clinical Research Practitioner successfully received their accreditation and received the NIHR Clinical Research Network Regional "Rising Star Award". • Financially breaking near even, good scope to win further wards and research grants and attract more commercial contracts as a research site facility.
	• **Safer Staffing** Overall staffing fill rates were above 90% target. • Hazel, Delivery and WHBC remain areas, with a low fill rate (< 85%). • Work is under way in AMU and areas of concern around recruitment and retention. • We are working to amber shift levels which means safe but at a staffing ratio higher than that funded, i.e 1:10 or more.in some areas.
	• **Electronic Discharge summaries** Distribution of electronic discharge. within 24hours remains an area of non compliance and has been raised.
BOARD ASSURANCE FRAMEWORK & RISKS	Response to Reference from ARAC around Lines of assurance around our internal processes around action plans in response to CQC reports. This was following ARAC identifying a missed action off the action plan from the 2020 CQC report, where assurance was sought in our committee confidence in having adequate oversight. This committee feels confident that following a new methodology and more robust processes we have improved oversight and ability to gain assurance around response to CQC reports.
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?	
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Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	18.7.24
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	Reducing harm from falls

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 5. Perinatal Mortality Review Tool Report Quarter 1 6. Maternity and Neonatal Quality and safety report Quarter 1	**Good** **Good** **Good**	
7. Infection And Prevention Annual Report 23/24	**substantial**	
8. Freedom to speak Up annual report 23/24	**substantial**	
9. Quality Oversight of the integrated Front Door: Emergency Department, Urgent treatment centre and medical expected Unit	**partial**	
10. Responsible Officer Annual Report 11. Patient Safety Incident Response Framework (PSIRF) governance process	**Substantial** **Substantial**	
12. Electronic Discharge summaries	**Limited**	**YES**
13. Risk Report 14. Board safety visits 15. Quarterly CQC Action Plan progress report	**Note** **Note** **note**	

POINTS OF ESCALATION	**Electronic Discharge summaries** • The Committee wish to raise an alert to the Board around the current lack of progress being made around Distribution of electronic discharge within 24hours. • This remains an area of non compliance at GWH with no improvement over the year. The current stagnant position around the electronic delivery of discharge summaries has arisen due to a third party dependency for integrative work. Limited assurance from the committee has been regularly raised on Board Assurance reports around this but no progress made. • Whilst a purchase order has been raised and the Trust are awaiting confirmation of when the integrative work needed by Careflow EPA can be started, this is an essential pre requisite which is delaying progress. • A testing product is available and a team of testers being assembled but rollout requires third party involvement for which time frame is unknown. • Current EDS system is being used with a 72% completion rate and this has patient safety implications for all patients and a potential increased impact with respect to minority groups who already experience health inequality through multiple cause. • Recent CQC visit highlighted EDS completion rates as an area of concern. • A manual system would require huge financial investment in additional staffing hours at a time where there are strict financial restrictions.
	IPR: Breakthrough Objective: • Falls in June there have been 2 falls with moderate harm or above, one of which with catastrophic outcome. Falls being the top cause of inpatient moderate and above harm which is why it has been chosen to be Breakthrough Objective. • The committee sought further assurance around how the information could be presented that would enable them to have assurance around monitoring progress around the set Breakthrough objectives: 1. To reduce the number of patients that have more than 1 inpatient fall by 30% 2. To reduce total number of inpatient falls by 30% • Where inconsistency around initial falls assessments has been found to be a contributor to harm through falls, the committee requested a way of seeing improvements around the initial assessment as a potential interim assurance metric whilst acknowledging this to be only aspect of a multifactorial problem that will take time to see a shift for the breakthrough objective metric. • A3 collated around falls improvement work, including policy review, starting monthly enhanced care audit, enhanced care training completion, pharmacy support around medication reviews where medication can

	contribute to falls, new post falls huddle and Consultant lead have been introduced with policies and A3 work streams divided into Trustwide general measures and Divisional with more local measures.
	IPC • There has been significant progress since the robust actions around infection prevention and control and annual report was received in meeting. • Pseudomonas rates remain low with only one case in June. • *Klebsiella* rates remain third worst in BSW but slight decline in month as with *E.Coli.* •
	Complaints and Concerns • The committee noted a substantial increase in the month of concerns received rate and continued elevated complaints rates, with slow complaints response rates. • Themes appear to be around waiting times/delays in emergency and elective care and communication around this, with a new theme around car parking. • A report with more detail is to be presented next month.
	Perinatal Mortality Review Tool Report Quarter 1 • Report was received assuring the committee that the mandatory requirements for mortality reporting have been achieved for the Trust for Quarter 1. • No themes have emerged have.
	Maternity and Neonatal Quality and safety report Quarter 1 • Themes around complaints and feedback have been around delayed discharges and post delivery analgesia delays. • CNST standards has only one outstanding area around saving babies lives, whilst determining the metric to determine compliance completion. • 3 serious incidents all with completed learnings. • Whilst level 3 specialist adults Safeguarding a training rates and anaesthetic doctor PROMPT compliance rates are anticipated to achieve full compliance by September 2024. • Actions are being undertaken to increase percentage of staff holding Qualified in Specialty (QIS) on LNU also due to be achieved by September 2024. • Training: A local training strategy has been developed to achieve all elements of the Core Competency framework. Fv2 by end of training year 2025/26. • The committee received an in depth review of ethnicity data in reported incidents in maternity and neonatal services during quarter 4 of 2023/2024, an impressive amount of detailed information was achieved which will be used to enable focussed areas of work to address health inequalities in these services resulted in increased. Incidents such as post-partum haemorrhage, pregnancy loss and tears, and additional observational data with associated characteristics to additional medical risks such as gestational diabetes. • UNICEF team report following. Review is expected soon with initial feedback indicating our service meeting 75/86 standards and an overall positive feedback. The outstanding standards are deemed achievable and work in progress towards this.
	Quality Oversight of the Integrated Front Door: Emergency Department, Urgent Treatment Centre and Medical Expected Unit • The committee received an in depth report that highlighted areas of stress that are directly related to the increasing attendance to winter pressure levels and higher than equivalent period one year ago and difficulties with offloading into and exiting out of these areas due to external factors and consequential risks to patients. • Working hard on triage times and length of stay. • Highest harm area is within the chairs area which remains a 'Risk area'. • SHINE data also demonstrates a deterioration in areas of the checklist including NEWS scoring. • ICB and SWAST have been invited to review the front door or any additional recommendations. • Patient experience still identifies noise as a problem, which will hopefully be improved through moving to side rooms rather than cubicles. • Feedback is very positive around staff. • With the relocation of the Navigation Hub to Chippenham with "CareCo" this has impacted communication and efficiencies. • Whilst the committee has only given this a partial assurance rating due to deteriorating SHINE data and LOS and triage times, this does not reflect the good assurance that the committee had around the good processes and work in place.
	Infection Prevention control Annual Report 2023/2024 • An in depth report was received which highlighted the progress made following the focussed work by IPC and collaborative working. • IPC lead assured the committee that improvement has been achieved but there is still work to be done. • Marked improvements in hospital acquired pneumonia, MSSA and gram negative bacteraemias has been achieved through focussed work around water management and catheter care, mouth care and get up and moving and the introduction or air-scrubbers. • *E.Coli* remains an outlying area and an external audit of practice has been requested and a specific workstream created. • There has been improvement in infection prevention methodologies including a reduction in the general use of gloves , which had also been highlighted by the CQC.

	• Our rankings for many of the metrics have improved against national and peer statistics.
	Freedom to Speak Up Annual Report 2023/2024 • A report was received which demonstrated the extensive improvements that have been made to this service. • Despite challenges to recruitment to guardian roles and increased training commitment, there is clear commitment by the Trust to fully support this service by the roll out of the guardian and manager pledge, which supports the guardian and manager to mutually agree the level of time commitment to FTSU. • Additional commitment to the FTSU service has been demonstrated introducing freedom to speak up training for all staff as mandatory but also additional levels of training through Listen up and Follow up for managers and Leaders. • A focus and robust action plan for staff communication and increasing awareness of the new initiatives is starting to show impact as the numbers of concerns being raised have increased bringing us more in line with national levels. • 4 new guardians have been appointed across a range of backgrounds. • The external review by 'Clever Together" is still awaited and falls outside this reporting period.
	Responsible Officer Annual report • This report demonstrated a well embedded system with good compliance. In annual appraisal and easy access and integration to the national database. • There is clear good oversight of all medical staff. • There is a low deferral rate and a robust process around ensuring compliance. • The committee were assured to be able to recommend signing of the report. • Whilst there is recognition that nationally referral to GMC has an EDI association this is not recognised at Great Western Hospital.
	Patient safety Incident. Response Framework (PSIRF) • The trust has now switched to PSIRF for incident management and the committee received a report which demonstrated the extensive work that has gone into this conversion with the move away from the old style of investigation reporting to one with more local responsibility to identify gaps and learnings to then embed into future care. • There is a significant change to the way incidents will be managed going forwards and this will take a period of time to ensure all managers and personnel understand the new process. • A Patient Safety Investigator has been appointed to assist and support the process with future leads. • It is anticipated to take 18 months to fully embed. • The committee sought assurance that a safety net would be in place during this implementation period and were assured that specialty teams would concurrently be involved and the improvement Group oversight element will be reported to Q&S. • Key to the success is the appropriate upskilling of staff to the new process. • The committee has given the processes and planning a substantial assurance rating but will not be able to assess the effectiveness until embedded.
BOARD ASSURANCE FRAMEWORK & RISKS	
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?	
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Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	24 June 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. National Financial Regime Update & BSW Month 2	Limited	x
2. Month 2 Finance Position	Good	x
3. Improvement & Efficiency Plan	Partial	x
4. 2024/25 Capital Plan	Approve	x
5. Update on Procurement	Good	x
6. Scheme of Delegation	Approve	x
7. Review of Emerging Risks: BAF	Approve	x

POINTS OF ESCALATION	**National Financial Regime:** In early June, the national NHSE finance team introduced a revised funding regime to address some gaps in the revenue plans submitted by Providers and ICBs as part of the 2024/25 planning round. The updated regime aims to address those Trusts and Systems that are a significant distance away from their target "fair share" allocation and provide them with transitional revenue funding support to address the financial gap. The updated regime is based on the following critical financial framework principles: (1) Systems have a statutory duty to break even yearly, and the NHS must live within its government-mandated spending limits. (2) Revenue underspends or overspends from a given year are added to the brought forward position and carried forward to the following year. (3) Allocation funding objectives are to reflect a population's relative health needs. (4) Appropriate incentives and consequences through the recovery from the impact of COVID-19 and to enable the plotting of a path to financial and performance sustainability. **BSW Financial Position**: The Trust's financial position and the broader BSW system remain challenging in 2024/24. If financial targets are not met, the revised financial regime could significantly impact the ability of BSW partners to deliver operational performance objectives. Consistent with previous months, the Committee notes that the requirement for more mature governance processes, greater transparency and consistent criteria and measures at the ICS level is ever more critical to gaining greater assurance and better viewing comparable data points.
KEY AREAS TO NOTE	**Month 2 Finance Position:** As of M02 of 2024/25, the Trust is in a £6.6m deficit position, representing a £4.1m adverse variance to plan. The Committee was assured that frequent and consistent meetings, specifically Workforce and Financial Recovery Committees and relevant workstreams, are held to monitor spend and associated savings. Good grip and control exercised over temporary staffing costs. **Improvement and Efficiency Plan:** The efficiency target for 2024/25 is £21.9m. As of M02, the actual delivery was £1.4m, which is £1.2m under the plan. 51% of the £1.4m 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. The key to delivering savings is to become more productive by maximising activity and related ERF income. The Trust already falls short of its ERF target by £1.7m at M02. Divisions and services must also focus on reducing pay spend throughout 2024/25. The target is to reduce the headcount working in the Trust by 263 compared to March 2022 by the end of the year. Tighter controls around approving bank shifts, overtime, and WLIs will contribute to this while continuing with the excellent work already in place, resulting in run rate reductions in temporary staffing, specifically in Nursing.
BOARD ASSURANCE FRAMEWORK & RISKS	Nothing specific to note.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Nothing specific to note.
REFERRALS TO OTHER BOARD COMMITTEES	None noted.

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Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	22 July 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. Divisional Financial Updates: Medicine, Integrated Community Care, and Surgery, Women's & Children	Partial	x
2. BSW Financial Update	Partial	x
3. Month 3 Finance Position	Good	x
4. Improvement & Efficiency Program	Partial	x
5. Risks – Estates & Facilities	Good	x
6. Electrical Incident Update (9 July) – Update	Note	x
7. Health & Safety Annual Report	Approve	x
8. Risks – Digital & IT	Good	x
9. Update: Data Protection, IT Resilience & Cyber Security	Good	x
10. Update: Digital Strategic Plan	Good	x
11. Procurement Recommendation Reports: (1) CDC Endoscopy Unit, and (2) Commercial Developer Partner	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 deficit and the ever-increasing pressure to drive greater efficiency and productivity. The System received a letter from NHSE raising their concern that it was off plan and requested assurance of achieving the key milestones based on the Financial Recovery Plan. The Committee notes that the requirement for more mature governance processes, greater transparency and consistent criteria and measures at the System level is ever more critical to gaining greater assurance and better viewing comparable data points; however, it was assured by Trust leadership that regular meetings are taking place at the System level to address this. Based on these management representations, we agreed to a partial assurance rating.
KEY AREAS TO NOTE	**Divisional Financial Updates: Medicine, Integrated Community Care, and Surgery, Women's & Children**: The Committee received detailed updates from each of the divisional heads that focused on the ERF position and plans to improve it. Each division is required to deliver a stretching level of CIP with the support of the corporate departments. The divisional updates illustrated the risks to the ERF position, including CIP delivery and mitigation plans to address this. The Committee was assured that systems are in place (corporate and divisionally) that provide a range of governance functions and identify and mitigate any gaps in controls. This operates alongside the requirements to provide safe and effective services and is held at both Divisional Board level and through workforce recovery (WTE plans), Elective Delivery (Elective sub-committee), Urgent Care escalation (Elective Subcommittee), and transformation plans (through subgroups) and to Financial Recovery Sub-Committee.
	Month 3 Financial Position: The Trust's adjusted deficit position is £4.9m, representing a £2.1m adverse variance from the plan. ERF income increased by £1.8m in M03 due to work completed on capture and income estimate for all activity to the end of June, including a catch-up for April and May. ERF is now £0.1m above target year to date. NHSE-commissioned drugs are overperforming by £0.7m, and other fixed-income items are £0.2m favourable. We note high levels of temporary staffing in the ED and General Medicine areas, and this month's position includes c.£0.3m of junior doctor industrial action costs for the three days of strikes that occurred in June. Pay is in a good position due to centrally held reserves (e.g., maternity/paternity leave). Non-pay key overspends are noted in clinical supplies, which are £2.9m adverse, particularly within Medicine and Surgery, Women's and Children's. The Committee is assured of regular meetings, specifically Workforce and Financial Recovery Committees, along with relevant workstreams, to monitor spend and associated savings. Good grip and control exercised over temporary staffing costs.
	Improvement and Efficiency Plan: The efficiency target for 2024/25 is £21.9m. As of M03, the actual delivery was £2.5m, which is £1.5m under the plan. 47% of the £2.5m 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 M03, continuing to maximise activity will be crucial to delivering future savings. Tighter controls around approving bank shifts, overtime, and WLIs 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 (63% against year-to-date target) means there can only be partial assurance.
	Health & Safety Annual Report: The Trust prepares an annual Health & Safety report, which provides an overview of events & performance of the Health & Safety, Fire & Security disciplines. The Committee approved the report for 2023/24. We are assured that a corporate Health & Safety team is in place to monitor H&S compliance through policies and procedures, managers' self-assessment audit reports and accident and incident data. Departments are supported with health, safety, fire and security advice and training. A three-year strategy is being developed in 2024/25, along with reportable Key Performance Indicators (KPIs).
	Update on Data Protection, IT Resilience & Cyber Security: The report provided a summary of the key activities and controls the Trust has around Information Governance/Data Protection and Cyber Security. The Trust is reporting strong performance for the Data Security and Protection Toolkit (DSPT), with strong evidence provided. Cyber is regarded as a key priority for the Trust with investment in a range of controls and risk mitigations. Risk is well understood and routinely reviewed.

BOARD ASSURANCE FRAMEWORK & RISKS	**Estates and Facilities Risk Report, and Digital & IT Risk Report**: 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.
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	**People & Culture Committee**	
Date of Meeting	Tuesday 25th June 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**
1. Allied Health Professionals - reason for leaving concerns	Good	No
2. Annual flu report	Substantial	No
3. Annual Resourcing Report	Good	No
4. Annual Employee Relations Case Report	Good	No
5. Corporate Staff Survey Progress Report	Partial	No
6. GWH Retention Self-Assessment Tool and People Promise Actions	Good	No

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	Quality & Safety Committee referred their concern about the recruitment and retention challenge with respect to Allied Health Professional staff. There was a concern that turnover may be being driven up by work-related reasons. Although overall turnover had reduced by 4% for Allied Health Professional workforce group over the last 12 months, the Associate Director of Allied Health Professionals referenced hotspot services. People & Culture Committee reviewed the report presented by the Associate Director of Allied Health Professionals and were provided with good assurance about the action plan to address this issue. This issue will be re-presented to the committee in the autumn and People & Culture Committee will report back their assurance to Quality & Safety Committee. IPR: The committee noted the risk to the workforce recovery plan which is presented by the additional resources which will be required by the EPR and CDC work. It was agreed to identify some suitable comparator data for some metrics which do not currently have these. The committee noted the forthcoming review by Clever Together which will help identify how the Trust can best use the different behavioural frameworks which have been deployed to achieve the greatest impact on our culture.

	The annual flu report outlined the good progress made with Staff flu and COVID vaccinations over the last year. The planning for this year has incorporated the learning points from last year and the committee noted the risk to funding for COVID vaccines. The review of the resourcing plan showed the good progress made in the last 12 months to updating and streamlining resourcing activity and identified a clear plan for the forthcoming year. The Annual Employee Relations Case Report provided the committee with the first annual review of the recently implemented 'just and learning' process and associated four-step model. This showed that the early evidence is that casework is being managed more appropriately and managers are welcoming this approach. However, the committee asked for a broader evidence base to be presented next year to fully evidence the shift that is taking place. A report summarising the staff survey improvement priorities identified across the corporate functions was presented. Due to the heterogeneous nature of these functions, it is hard to identify with real granularity how appropriate these priorities and actions are. Heads of the corporate functions need to ensure that focus is being maintained in this area. The committee noted the risk in performance for staff survey and currently challenging environment and changes senior leadership team. Following from a discussion at a previous P&C cttee meeting a presentation to highlight the results of the 2023 staff survey for the Nursing and Midwifery workforce and the actions being taken as a result was made. The committee received substantial assurance about the actions taken with this group and the further actions being planned. The project to use the NHS people promise framework and diagnostic process was presented. Eight specific actions have been identified which will be delivered by the end of 2024/25 and the framework provided a useful way of summarising the other initiatives and actions in progress to improve staff retention.
BOARD ASSURANCE FRAMEWORK & RISKS	The two 15+ risks outstanding relate to the replacement of Defibrillators and the ongoing industrial action. Both risks have good controls in place

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.

Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**1st August 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

It should be noted that the impact of 5 days of Junior Doctor's strike resulted in the cancellation of 562 outpatient appointments (57 cancer related) and 25 elective cases (2 cancer related). Patients continue to be rebooked in July, and there were no reported Priority 2 elective cancellations (<1 month).

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

STRATEGIC Pillar Metrics

- **RTT (Referral to Treatment) 52 Week Waiters**

June performance shows the total number of patients waiting over 52 weeks at 1,885, a 1.3% decrease from the previous month, but 217 patients worse than operating plan trajectory for June.

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, despite 5 days of junior doctor strikes taking place between 27th June and 2nd July.

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 282 x 65 week wait breaches against an operating plan trajectory of 190, with high-risk areas in Gastroenterology, General Surgery, Cardiology and Respiratory. The Trust also reported 3 x 78 week wait breaches (all due to complexity), with one TCI confirmed for July and two awaiting the outcome of MDT.

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.

In June the revised Trust Access policy was approved and a training package will be launched to ensure RTT rules are being applied consistently and in line with national best practice. A clinically led review of long waiting routine patients is also expected to be completed for patients who may be appropriate to be seen through NHS commissioned activity via the independent sector or by other system partners where waiting times are better.

- **Cancer waiting times**

At the end of May there were 131 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 and whilst validated May performance for 62-day cancer increased to 65.1%, it remains well below the national standard of 85%. Urology, Breast and Colorectal were the top breaching tumour sites in May. A full cancer recovery plan remains in place as part of regional tiering arrangements and a further £325k of non-recurrent funding has been secured from the regional team in year to support recovery. This is in addition to the Thames Valley Cancer Alliance non-recurrent funding. The impact of this additional funding on our operational recovery trajectory is currently being reviewed.

Validated May performance against the 28-day Faster Diagnosis standard (FDS) increased to 66.7% from 59% in April. Colorectal, Urology and Breast remained the most challenged tumour sites. Improvement has been evidenced from the recovery actions in place but skin remains particularly challenged over the summer period with referral demand increasing as anticipated. Weekend insourcing is now in place to provide 1,800 more appointments and 900 additional minor operational procedures over the course of the year, and a nurse led triage model is being developed between now and October. Sustainability of our FDS performance remains a significant risk going into 24/25, predominantly due to outpatient capacity and diagnostic constraints against a backdrop of referrals continuing to run above pre-pandemic levels. 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.

Validated February performance against the 31-day decision to treatment standard remains below the 96% national standard, currently at 87.6%. However, performance is improving for decision to treatment and illustrates the importance of recovering the diagnostic stage of our cancer pathways.

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

ED and UTC attendances reduced by 6% in June following a record number of patients attending in May. Demand continues to remain high with activity reported at 6.9% above operating plan. Mean stay in ED remained stable and mean stay in the UTC improved by 22 minutes compared to the previous month.

4-hour performance was 75.0% against the operating plan target of 78%, with improvements in Type 3 UTC 4 hour performance offset by a deterioration in Type 1 in ED.

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 Medicine Division continue to review staffing levels for the UTC to match peaks in demand, with work ongoing to embed senior decision making in ED majors chairs, offer next day appointments in SDEC (Same Day Emergency Care) and ensure specialty support for patients in ED that are clinically ready to proceed.

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

The number of bed days lost for patients with no criteria to reside (NCTR) remains within control limits with June averaging 82 patients per day. There were 18.2% of beds occupied against the national standard of 13.3% and operating plan target of 10% by March 2025.

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.

OPERATIONAL BREAKTHROUGH OBJECTIVE

- **Ambulance handover delays**

Urgent & Emergency Care (UEC) services remained under significant pressure during the month of June and 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.

The average hours lost per day to ambulance delays increased to 118 hours in June from 94 in May. There were no delays over 10 hours reported in June and work is ongoing to eliminate 6 hour breaches.

From the 10th-13th June the Trust declared a business continuity event due to operational pressures following surge and high bed occupancy. A further declaration was made for the Junior Doctor's strike from 27th June to 2nd July.

In response the Trust has initiated a SAFER Summer rapid improvement event that commenced on 24th June with support across the Trust and system partners. This includes a perfect Ambulance handover week commencing on 8th July, and three multi-agency discharge events scheduled throughout July to support improvement in flow.

ALERTING WATCH METRICS

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

- Diagnostics – June performance against the 6 weeks wait standard improved to 70.55% from 66.90% in May (validated), which was the best performance in three years. 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.

- Virtual ward occupancy – was at 74% in May for Swindon, above the mean threshold of 64.1%. Pathways continue to be reconfigured across the Bath, Swindon and Wiltshire footprint to standardise processes and increase primary care utilisation and interviews for a clinical lead expected to take place in August.

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.

There are some variations within the harm metrics but little overall change to the total number of harms in June (198) when compared to May (199). The main shifts in month are an increase in pressure harms in the acute setting, but a reduction in the community, and changes in the prevalence of infections.

The number of Family and Friends (FFT) positive responses for June was 86.9%, a decrease from the previous month and below the 90% target.

Breakthrough Objectives

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

The aim for 2024/2025

- Reduce the number of patients that have more than 1 inpatient fall by 10%
- Reduce the total number of inpatient falls by 30%

Improvement activity is focused on reducing the number of patients that fall and sustain moderate harm and above due to their fall whilst in our care, specifically by increasing compliance rates of falls assessment and individualised risk reduction actions.

In June two patients had moderate harm or above following an inpatient fall. This included one patient experiencing a fractured hip and the second patient sustaining a catastrophic sub dural haematoma.

Alerting Watch Metrics

The complaint response rate for June has dropped from 68% in May to 62% in June. Additional complaints handling support has been facilitated within the Division of Medicine.

The themes continue to be related to waiting times/delays in emergency and elective care, and communication. There has also been a high number of concerns related to car parking.

NHS England have yet to set trajectories for infections in 2024/25, so the targets given are those for last year and are subject to change. E. coli and Klebsiella numbers remain high compared to our peers, with urinary infections being the main contributor. A new Continence Group has been setup to address this, with cross-divisional representation across acute, community and partner organisations.

Pseudomonas cases are significantly down compared to this period last year and the Trust no longer has the highest rate in the region. There was one case of *Pseudomonas* infection in June (zero in May).

Numbers of C. difficile infections have increased this month following three months of being below the average rates. Analysis has not identified any links between cases.

In June two cases of *Klebsiella* infections were reported compared to five May. The number of E. Coli cases has decreased slightly in June to nine from 12 in May.

Non-alerting Watch Metrics
The number of hospital-acquired pressure ulcers has increased slightly in month (35 in June compared to 23 May). All cases are discussed weekly at a tri-divisional meeting to identify and share learning in a timely way.

The number of Community acquired pressure harms has decreased in month (16 in June compared to 21 in May). This is lowest number of reported harms in the 12-month rolling period.

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

- Safer staffing fill rates remain above the National target of 85%.
- Four Patient Safety Incident Investigations (previous Serious Incident or SI) have been declared in June. There are 12 ongoing Patient Safety Incident Investigations with seven now being reviewed under the new patient safety framework.
- There has been one Methicillin Sensitive Staphylococcus Aureus (MSSA) infection reported in month.

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

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

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

- **Staff Survey – Recommend a Place to Work**
  Target 55% achieving 59.6% (2023 Annual Survey) and 55.9% Q4 Pulse Survey, 56.7% Q1 Pulse Survey.
- **Staff Voluntary Turnover**
  Target 11% achieving 8.6% (April data)
- **EDI disparity (reducing discrimination disparity)**
  Target 9.4% achieving 12.7% (2023 Annual Survey) and 15.9% Q4 Pulse Survey), and 13% Q1 Pulse Survey

A marked improvement to our score for "Recommend as a Place to Work" has been seen in the 2023 Annual Survey results however recently pulse survey has shown a decline in this question. The Q2 Pulse Survey launched on 1st July and results will be available in August.

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

The Trust current performance is 70% (2023 staff survey results) and the national average is 71%. The stretched target the Trust has set itself of 73%.

An update to this metric will be available in August with the results of the Q2 Pulse Survey, including a qualitative analysis of staff's relationship with the theme of 'respect'.

Alerting Watch Metrics
In-month sickness absence decreased slightly in May from 4.19% to 4.16%, although remains above the KPI of 3.5%. Short term sickness has increased slightly to 2.2% and long-term sickness has decreased to 1.9%.

The most recent national benchmarking data (February 2024) shows further reduction to both National and South-West, a trend replicated at both ICS and GWH level. In this period we moved to the first lowest quartile for Acute trusts at 27th out of 133 Trusts.

HR Scorecard

Vacancy Rate
Our vacancy position improved in month 3 decreasing to 216WTE (3.98%). This was driven by a 3WTE reduction to our establishment following admin budget realignments within ICC, and a static contract WTE position.

Workforce Recovery
In month 3, we utilised 5,592WTE to deliver our services against a planned figure of 5,627WTE, representing a favourable position of 35WTE under plan. Overall usage in June has increased compared to May by 23WTE, driven by an increase to Bank WTE across Nursing and Medical staff.

Whilst Bank usage has increased in June, overall temporary staffing utilisation remains under plan by 33WTE for Bank and 18WTE for Agency, showing sustained benefits from heightened controls on temporary staff.

Our Substantive WTE reported above plan by 16WTE in June. Whilst our contracted position remained static, overtime WTE increased marginally compared to May (although still within the planned reduction amounts) and the level of reduction within the Workforce plan was not realised. The overall position against plan remains favourable and the threshold for triggering a non-clinical vacancy freeze has not been reached, although this will be monitored closely through the Workforce Recovery Meetings.

Staff Excellence Awards
The Annual Staff Excellence Awards were held on Friday 14th June at The Meca in Swindon. 400 colleagues came together in an 80s-themed party to recognise the achievements and successes of the past 12 months.

Use of Resources

As at M03 of 24/25 the Trust is in a year-to-date (YTD) £4.9m deficit position, which represents a £2.1m adverse variance to plan.

Income is £1.2m favourable to plan. ERF income increased by £1.8m in M03 due to work completed on activity capture and income estimates for all activity to the end of June, including a catch up for April and May. ERF is now £0.1m above target year to date. NHSE-commissioned drugs are overperforming by £0.7m, and other fixed income items are £0.2m favourable. Education & Training and other miscellaneous income account for a further £0.2m favourable variance to plan. This is partially offset by undelivered savings of £1.5m. In addition, medical & dental pay costs are £1.7m overspent, which includes c.£0.3m of junior doctor industrial action costs. The remainder is driven by the ongoing use of temporary staffing in the ED and General Medicine areas. Clinical supplies are £2.9m adverse, driven by 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 in process to analyse the drivers of clinical supply spend with a view to achieving savings. Drug costs are £0.4m overspent, driven by passthrough drugs. This is offset with the favourable variance on drug income. Net interest costs are £0.6m adverse due to additional PFI lease liability costs. There are £3.8m of pay underspends, mostly on nursing lines, holding some centrally held reserves (e.g. maternity / paternity leave), which will be used to support divisional pay positions throughout the year.

The efficiency target for 2024/25 is £21.9m. As at M03, actual delivery was £2.5m, which is £1.5m under plan. 47% of the £2.5m delivered 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 has increased in M03, continuing to maximise activity will be key to delivery of future savings. Divisions and services must also focus on reducing 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 which has resulted in run rate reductions on 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.

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.

While improved since Month 2, we remain c.£2.1m off plan in Month 3. Our performance behind plan on the efficiency programme of £1.5m 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?

Over the last month, data has been collected and shared with regard to the number of requisitioners listed for each Division, so that they can be revised and rationalised. A training needs assessment has been completed for all staff in relation to finance knowledge, and the team has started to review the requisitioning training available through the procurement team, in order to provide assurance as to its usefulness and efficacy that it is being followed when orders are placed. This work will continue through July.

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	11/07/24

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

July 2024

June 2024 & May 2024 data period

Improving together

Service Teamwork Ambition Respect

Content & introduction

Great Western Hospitals NHS Foundation Trust

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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

NHS
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Measure Name	Mean/Thres.	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Total 104 week waits	0	0	0	0	0	0	0	0	0	0	0	0	0
Total 78 week waits	0	0	3	1	1	2	4	5	10	4	3	4	3
Total patients waiting more than 65 weeks	0	621	689	661	488	417	343	330	267	82	175	250	282
65 weeks wait performance vs plan (size adjusted)	97.4%	356.9%	475.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	70.0%	117.9%	148.4%
Proportion of PTL over 65 week waits (size adjusted)	0.0%	1.6%	1.7%	1.6%	1.2%	1.1%	0.9%	0.9%	0.7%	0.2%	0.4%	0.6%	0
Percentage of patients who receive a diagnostic test within six weeks of referral	99% (Nat)	49.4%	44.5%	46.1%	45.0%	49.5%	46.8%	49.3%	59.8%	66.4%	60.7%	66.9%	Reported one month behind
62 day backlog (As % of allocated "Fair shares" position)	9.53% (Nat)	156.0%	180.3%	200.4%	178.6%	181.1%	145.9%	109.8%	120.7%	90.6%	88.0%	107.3%	Reported one month behind
Faster diagnosis rate	75% (Nat)	67.2%	62.6%	62.0%	58.2%	59.7%	60.4%	60.2%	70.5%	71.3%	59.2%	66.7%	Reported one month behind
62-day performance	85% (Nat)	67.0%	59.5%	49.0%	61.1%	67.2%	65.0%	62.2%	68.6%	66.7%	63.1%	64.3%	Reported one month behind
Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	0	8.9%	10.0%	10.0%	8.9%	7.4%	9.1%	7.7%	7.7%	4.4%	5.5%	5.2%	5.6%
Proportion of patients seen within 4 hours	95% (Nat)	75.5%	74.2%	74.7%	71.5%	71.4%	74.7%	73.5%	71.1%	74.4%	75.9%	75.3%	75.0%
Ambulance average Category Two response time	00:18:00 (Nat)	00:47:12	00:28:22	00:57:11	01:03:52	00:52:16	00:49:02	00:49:39	00:51:11	Waiting for data	Waiting for data	Waiting for data	Waiting for data
Percentage of beds occupied by patients who no longer meet the criteria to reside	13.3% (Nat)	17.2%	14.3%	15.8%	17.4%	18.1%	17.8%	17.8%	17.6%	18.6%	18.1%	17.8%	17.3%
Adult general and acute type 1 bed occupancy (adjusted for void beds)	94.5% (Nat)	97.6%	98.2%	98.7%	98.8%	98.5%	96.3%	98.6%	98.8%	97.7%	98.3%	98.8%	99.0%
Virtual ward - percentage capacity occupied	1	53.7%	44.4%	53.8%	65.1%	70.8%	78.4%	84.8%	78.0%	61.0%	78.0%	74.0%	84.0%
Number of mental health patients spending >12 hours in an emergency dept	9	16	10	7	10	9	5	12	5	5	14	9	6
Readmission rate	16.5%	17.2%	16.2%	15.7%	17.2%	15.9%	16.4%	15.8%	17.1%	16.7%	15.7%	17.6%	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 behind	Reported five months behind	Reported five months behind	Reported five months behind	Reported five months behind
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
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
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Sickness rate	3.5% (Int)	4.4%	4.0%	4.2%	4.7%	4.7%	5.0%	4.9%	4.4%	4.1%	4.2%	4.2%	Reported one month behind
Leaver rate	11.0% (Int)	9.7%	9.6%	9.5%	9.2%	9.2%	8.9%	8.6%	8.6%	8.4%	8.6%	9.7%	Reported one month behind
Implied productivity	0	-21%	-20%	-22%	-17%	-15%	-14%	-16%	-13%	-12%	-0.13	-0.17	Waiting for data
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	5.3%	5.3%	5.3%	5.3%	5.4%	5.4%	3.5%	3.5%	3.5%	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%	56.1%	56.9%	57.1%	56.1%	56.1%	56.1%	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%	1.8%	1.7%	1.8%	1.8%	1.8%	1.8%	1.7%	Waiting for data	Reported one month behind
National Patient Safety Alerts not completed by deadline	0 (Nat)	0	0	0	0	0	0	0	0	0	0	0	0
C.Diff (Cumulative)	11.5 (Nat)	33	38	44	54	56	64	70	78	82	3	7	14
Staph Aureus BSI (Cumulative)	5.5 (Nat)	12	16	16	18	21	22	25	26	27	1	2	3
Gram Negative BSI (Cumulative)	25.5 (Nat)	61	78	94	112	123	136	144	163	175	15	32	45
Financial efficiency - variance from efficiency plan (£'000)	+/-	-641	-338	-504	-39	478	-224	183	-415	-286	-793	-566	Waiting for data
Financial stability - variance from break-even (£'000)	+/-	-659	330	-1352	1996	5043	-1877	-1911	4028	150	-3390	-3320	Waiting for data
Financial stability - variance from PLAN (£'000)	+/-	-733	-528	-1646	1334	4489	-1204	-2417	3907	150	-2346	-2392	Waiting for data

Measure Name	Mean	2017	2018	2019	2020	2021	2022	2023
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	6.7	6.9
Staff survey engagement theme score	6.9	6.9	6.9	7.0	7.0	6.7	6.7	6.9
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.9%	-	-	60.4%	57.1%	56.1%	56.4%	56.5%
Stillbirths per 1,000 total births	2.3	-	2.4	1.9	2.1	2.8	Waiting for data	Waiting for data
Neonatal deaths per 1,000 total live births	1.2	-	1.4	1.0	1.0	60 1.3	Waiting for data	Waiting for data

Executive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

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

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

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

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

Patient Experience (FFT)

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

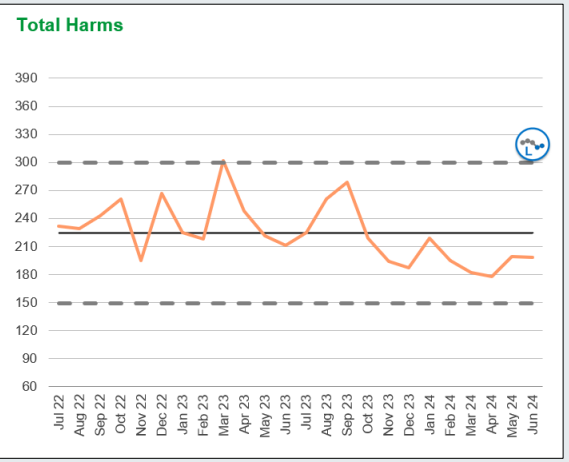
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

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

Total Harms

To achieve and sustain zero avoidable harm.

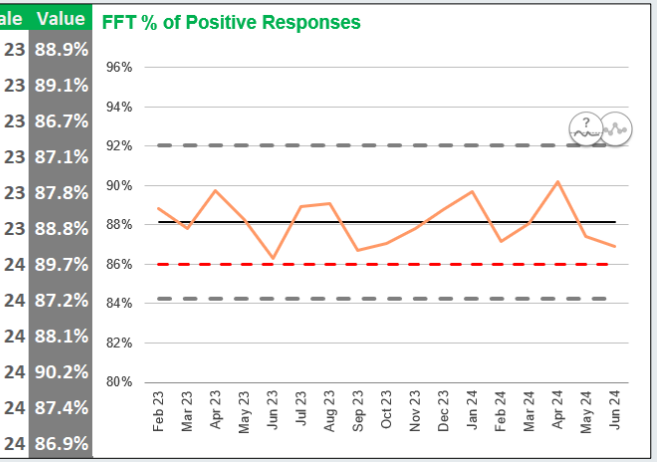
Timescale	Value
Jul 23	225
Aug 23	261
Sep 23	279
Oct 23	219
Nov 23	194
Dec 23	187
Jan 24	219
Feb 24	195
Mar 24	182
Apr 24	178
May 24	199
Jun 24	198



Patient Experience (Friends & Family Test)

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

Timescale	Value
Jul 23	88.9%
Aug 23	89.1%
Sep 23	86.7%
Oct 23	87.1%
Nov 23	87.8%
Dec 23	88.8%
Jan 24	89.7%
Feb 24	87.2%
Mar 24	88.1%
Apr 24	90.2%
May 24	87.4%
Jun 24	86.9%



Counter Measures

There has been no change in the total number of harms in June (198) from those recorded in May (199). There have been slight variations within the harm profiles, seeing a slight increase in some infection harms (C. Difficile and COVID) and a decrease in Klebsiella and E. Coli.

There has been a decrease in pressure harms in the community but an increase in the acute service.

The number of falls resulting in moderate harm or above has decreased in month to two.

For June, the Trust wide positive Family and Friends (FFT) score was 86.9% (a decrease from 87.4% in May). The target for 2024 /25 has been reviewed to 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. These are also now being used as part of Improving Together project plans so that improvements are based on what patients are telling us.

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.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance
Cancer 62-day treatments are now combined for national reporting, with urgent suspected, upgrade and screening pathways being reported as one. In May, there were 61.5 breaches in total, with 53.0 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 is due to replace 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

June performance shows the total number of patients waiting over 52 weeks at 1,885, a 1.3% decrease from the previous month. Patients waiting over 65 weeks was at 282, an increase of 32 from the previous month. On 30th of June our cohort size for the September target was **1,916** patients, 31% below trajectory of 2,7812.

3 x 78 weeks breaches were reported in June 2024.
- 2 x Non-admitted Gastroenterology (2 x complex)
- 1 x Admitted General Surgery (complex)

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

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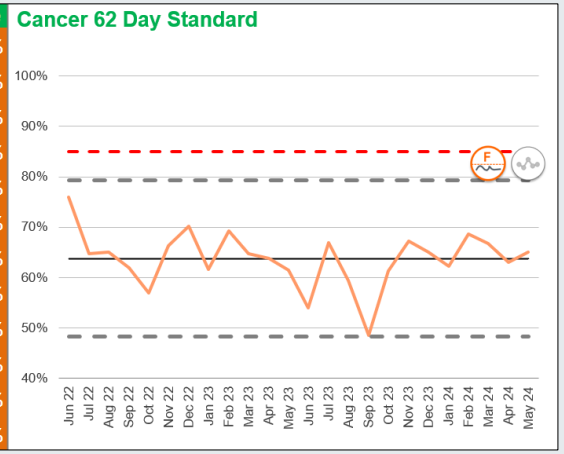
Cancer 62 Day

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

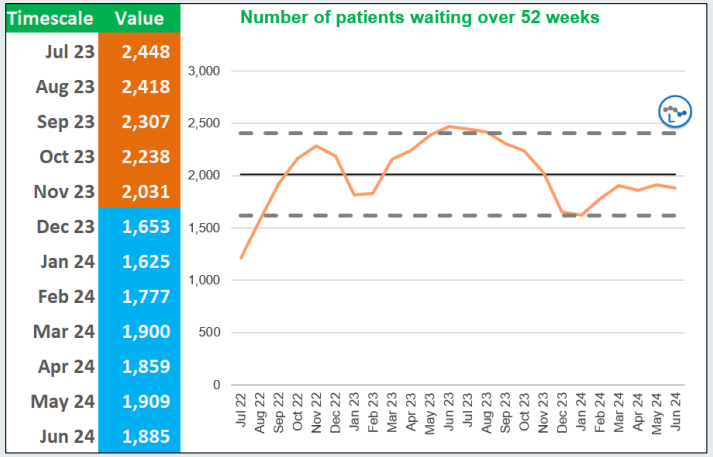
Timescale	Value
Jun 23	54.0%
Jul 23	66.9%
Aug 23	59.5%
Sep 23	48.5%
Oct 23	61.3%
Nov 23	67.2%
Dec 23	65.0%
Jan 24	62.2%
Feb 24	68.6%
Mar 24	66.7%
Apr 24	63.1%
May 24	65.1%



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
Jul 23	2,448
Aug 23	2,418
Sep 23	2,307
Oct 23	2,238
Nov 23	2,031
Dec 23	1,653
Jan 24	1,625
Feb 24	1,777
Mar 24	1,900
Apr 24	1,859
May 24	1,909
Jun 24	1,885



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 from 15 July
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.
-Funding approved for consultant radiologist for 6 months

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

NHS
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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 June 24 was 378 minutes against the national standard of 240 minutes. This is a continuing the downward trend, down from April 24 -398 mins and well below mean levels (460mins). The mean stay is now around lower control limits but still off the national standard.

Emergency Care – Urgent Treatment Centre - Mean Stay

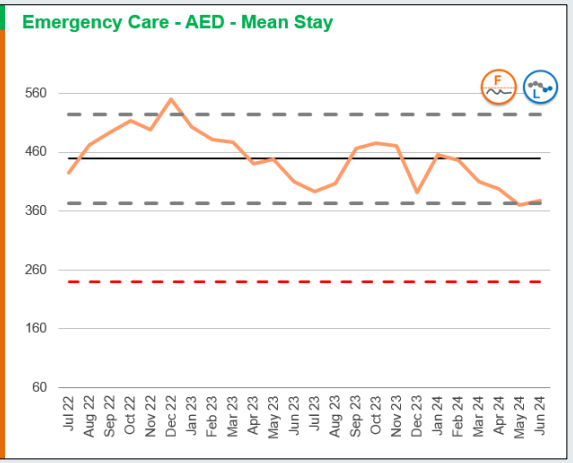
The total meantime wait for a patient in June 24 was 148 minutes against the national standard of 240 minutes. The drop in mean stay could be attributed to a small decrease in attendance levels from the peak seen in May 24.

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.

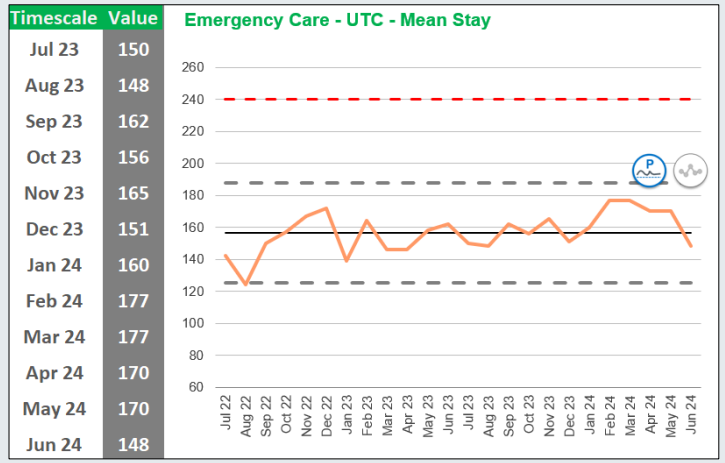
Timescale	Value
Jul 23	393
Aug 23	407
Sep 23	466
Oct 23	475
Nov 23	471
Dec 23	391
Jan 24	455
Feb 24	447
Mar 24	410
Apr 24	398
May 24	371
Jun 24	378



Emergency Care – Urgent Treatment Centre - Mean Stay

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

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



Counter Measures

- Recruitment drive initiated via Medical Control Weekly Meeting to reduce agency and increase substantive body. This will improve the financial sustainability of department but also improve quality of care across the 24/7 running of the department.
- 4 hour Improvement Plan – focusing on breach chasing,
- 2 EPIC trial prior to IFD implementation giving great senior decision making cover across Chairs – noticeable improvement in type 1 4 hour performance.

- 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

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 11,136 patients seen in ED/UTC in June down from a record 11,840 in May. This comprises a 6% reduction in attendances following a busy May but still at very high levels (UTC - 9% ED –3%)

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

June saw a slight increase in **NCTR from 81 to 82** running average on the day compared to May. Discharges were 25% over predicted discharges.
Over 21 days LoS was an average of 31 patients, which is a significant decrease on May which was 39.

Discharges before midday reached 18% which is the highest on record - direct result from messaging for use of discharge lounge and work streams. 63% of patients were discharged prior to 17:00.

To support the IFD opening there has been MADE's scheduled for July to maximise activity at the front door and the back door – working closely with system partners. Summer SAFER has also be launched towards the end of June – which will continue throughout July – linking with Hospital Flow workstreams.

Felicity Taylor-Drewe
Chief Operating Officer

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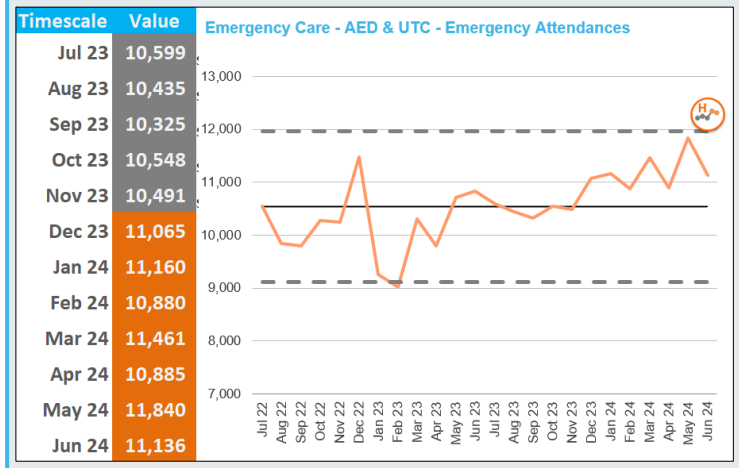
Emergency Care – Emergency Department & Urgent Treatment Centre - Emergency Attendances

To ensure patients are cared for in the appropriate setting

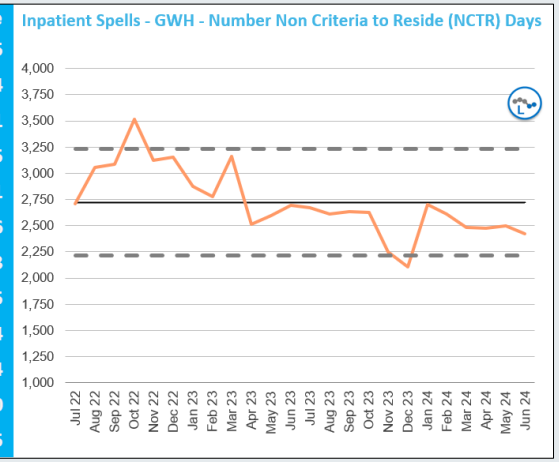
Timescale	Value
Jul 23	10,599
Aug 23	10,435
Sep 23	10,325
Oct 23	10,548
Nov 23	10,491
Dec 23	11,065
Jan 24	11,160
Feb 24	10,880
Mar 24	11,461
Apr 24	10,885
May 24	11,840
Jun 24	11,136



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
Jul 23	2,675
Aug 23	2,614
Sep 23	2,631
Oct 23	2,625
Nov 23	2,251
Dec 23	2,106
Jan 24	2,703
Feb 24	2,615
Mar 24	2,484
Apr 24	2,474
May 24	2,500
Jun 24	2,425



Counter Measures

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

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

Opportunities:

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

Reflections:

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

- **** Summer SAFER to be launched end of June and to continue in July, Perfect Ambulance Handover week commencing 8th 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. Performance continues to be maintained through the Trust Retention Working Group, with countermeasures being refined to focus on leavers within the first year of employment.

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

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

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

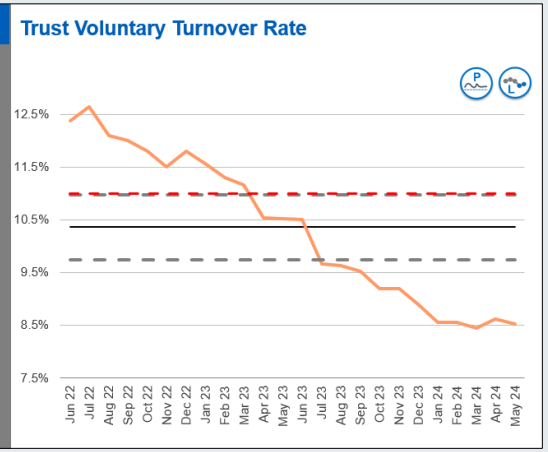
The number of staff who would recommend the organisation as a place to work increase from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey. Pulse survey result has shown a slight decline in results in Q4 and Q1 on recommending a place to work to 55.8% compared to Q4 which was 55.9% Q2 Pulse Survey results are expected in August.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

Timescale	Value
Jun 23	10.5%
Jul 23	9.7%
Aug 23	9.6%
Sep 23	9.5%
Oct 23	9.2%
Nov 23	9.2%
Dec 23	8.9%
Jan 24	8.6%
Feb 24	8.6%
Mar 24	8.4%
Apr 24	8.6%
May 24	8.5%



Staff % recommend the organisation as a place to work

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

Counter Measures

- Voluntary Turnover has decreased in May to 8.5%, maintaining performance below the Trust KPI of 11% and showing a clear stabilisation in this metric.
- Leavers within their 1st year of employment is showing further improvement in May, reducing to 9.7%. The Onboarding & Induction working group, lead by the People Promise Manager, will focus on improvement to staff's onboarding journey to help with further improvement to this cohort of leavers.
- The Retention Working Group is meeting on 9th July to review current retention data and seek further input and engagement on the high-impact actions being lead by the People Promise Manager.

- The Q2 Pulse Survey launched on 1st July, and results will be available in August showing performance of this metric.
- To help ensure our Health & Wellbeing offering continues to meet the needs of our staff, a series of drop-in consultation sessions with the Trust's Clinical Lead for H&WB are scheduled in July and August, seeking feedback on the future shape of Health & Wellbeing services at The Trust.
- Upskilling and education to support managers continues throughout July with Compassion Courses, Mental Health Skills Training, Smoking Cessation, Suicide First Aid, and Mental Health First Aid sessions available for staff to attend.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

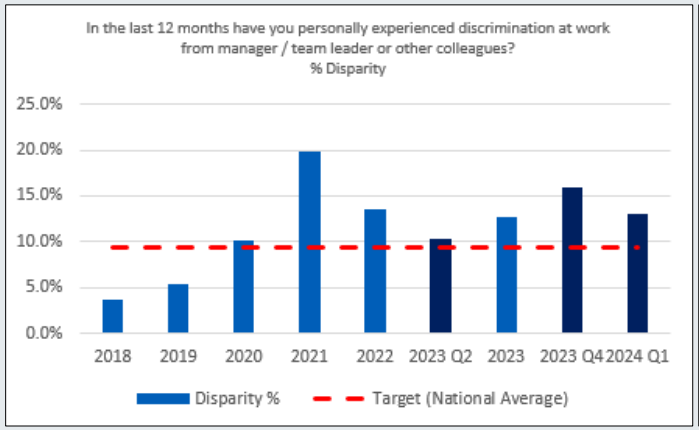
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

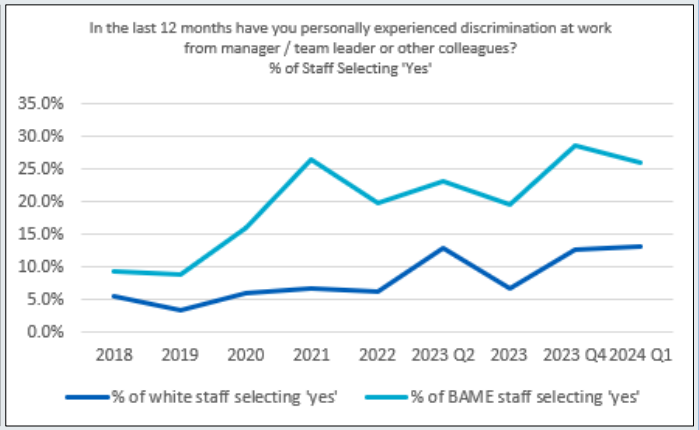
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 8.3% in line with the national average and be below the national average for all staff.

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

Jude Gray
Director of Human Resources (HR)

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





Counter Measures

- 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. This engagement will help the Board to understand the working life experiences of our diverse workforce and provide opportunities for staff to shape the EDI 'change agenda' together.
- EDI related training continues to be offered in July – Inclusion Recruitment Champion training, EDI Champion Bite-Size workshops and Cultural Competence training is on offer.
- To round up the EDI Improvement Award project work, the Trust will host a train-the-trainer session for the workshop 'Addressing Unprofessional Behaviours' that was designed in collaboration with staff. The process to have this workshop CPD accredited has commenced.
- The EDI Lead is currently in the process of writing the EDI Annual Report 2023-24, the combined report will include WRES, WDES, EDS and GPG updates.
- The EDI & Health Inequalities Strategic Subcommittee that oversees the EDI agenda will meet on the 31.07.24, the group will help to shape the EDI Plan for 2024-2028 – this will be aligned with the Trust's new strategy.

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 M03 of 24/25 the Trust is in a year-to-date (YTD) £4.9m deficit position, which represents a £2.1m adverse variance to plan.

Income is £1.2m favourable to plan. ERF income increased by £1.8m in M03 due to work completed on capture and income estimate for all activity to the end of June, including a catch up for April and May. ERF is now £0.1m above target year to date. NHSE-commissioned drugs are overperforming by £0.7m and other fixed income items are £0.2m favourable. Education & Training and other miscellaneous income account for a further £0.2m favourable variance to plan. This is offset by undelivered savings of £1.5m. In addition, medical & dental pay costs are £1.7m overspent, which includes c.£0.3m of junior doctor industrial action costs. The remainder is driven by the ongoing use of temporary staffing in the ED and General Medicine areas. Clinical supplies are £2.9m adverse, driven by Medicine and Surgery, Womens' 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 in process to analyse the drivers of clinical supply spend with a view to achieving savings. Drug costs are £0.4m overspent, driven by passthrough drugs. This is offset with the favourable variance on drug income. Net interest costs are £0.6m adverse due to additional PFI lease liability costs. There are £3.8m of pay underspends, mostly on nursing lines, holding some centrally-held reserves (e.g. maternity / paternity leave), which will be used to support divisional pay positions throughout the year.

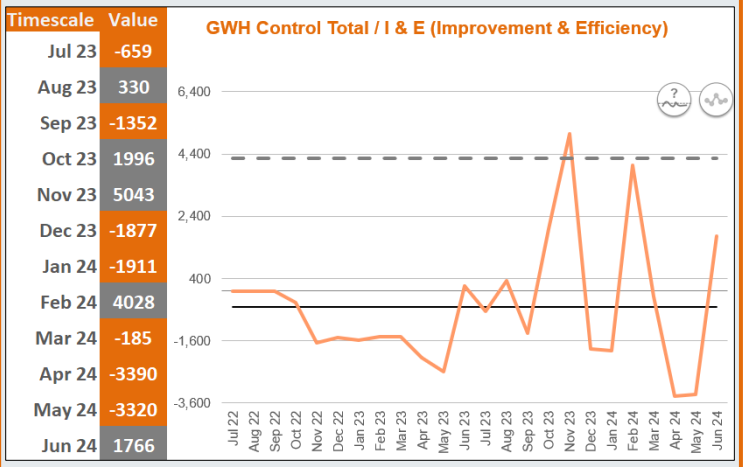
The efficiency target for 2024/25 is £21.9m. As at M03, actual delivery was £2.5m, which is £1.5m under plan. 47% of the £2.5m delivered is recurrent. All divisions and services must further increase overall savings to hit the £21.9m target, and specifically ensure the savings are recurrent to reduce the underlying deficit. While ERF activity and associated income has increased in M03, continuing to maximise activity will be key to delivery of future savings. Divisions and services must also focus on reducing 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 which has resulted in run rate reductions on 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.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Jul 23	-659
Aug 23	330
Sep 23	-1352
Oct 23	1996
Nov 23	5043
Dec 23	-1877
Jan 24	-1911
Feb 24	4028
Mar 24	-185
Apr 24	-3390
May 24	-3320
Jun 24	1766



Counter Measures

- Efficiency savings were £0.3m behind target in month with pay schemes accounting for all of the under delivery. Year-to-date the efficiency programme is £1.5m behind plan with pay accounting for £1.0m, income £0.4m and non-pay £0.1m. Of the £2.5m of savings delivered year-to-date, 47% 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

Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

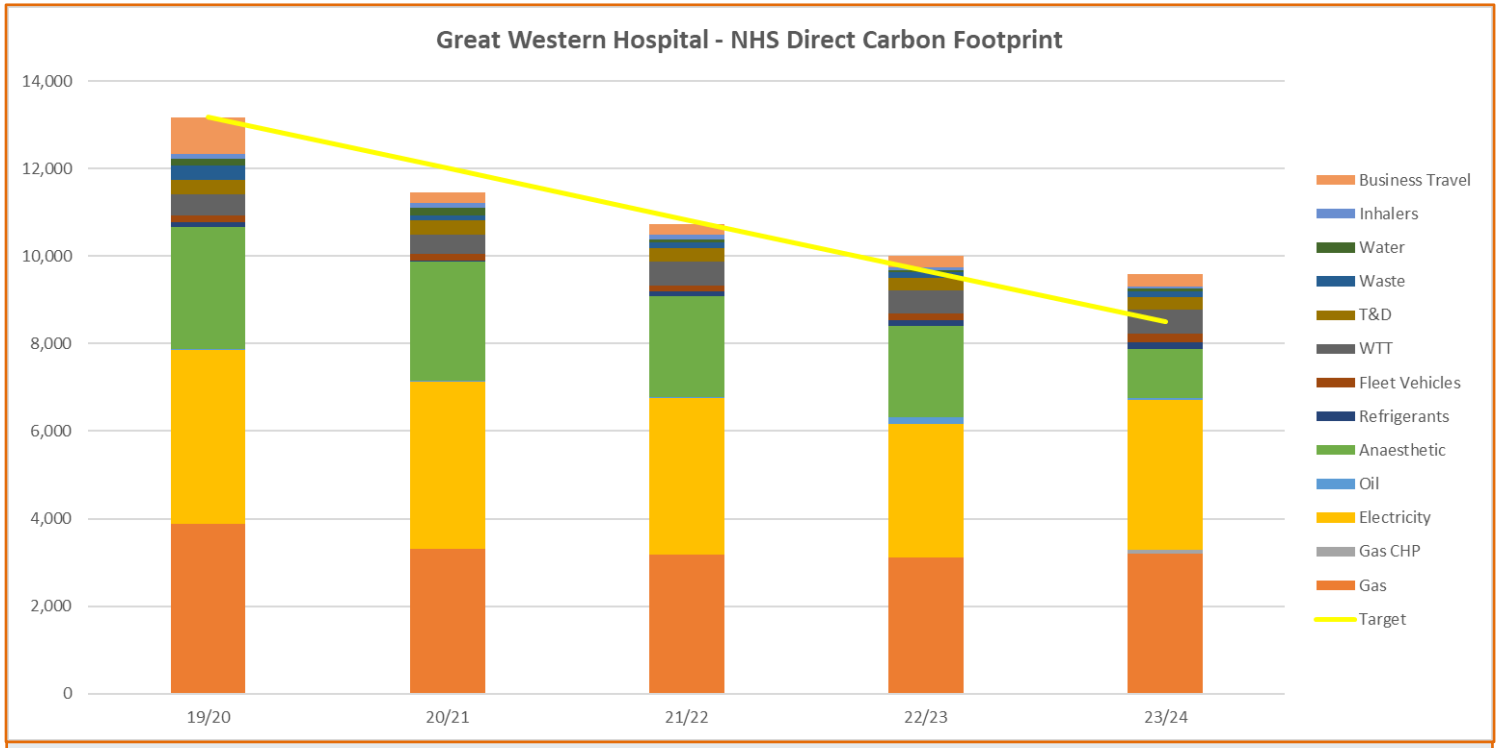
Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations.

The graph shows the year-to-date performance up until **Q4 of financial year 23/24.**

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

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

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



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.

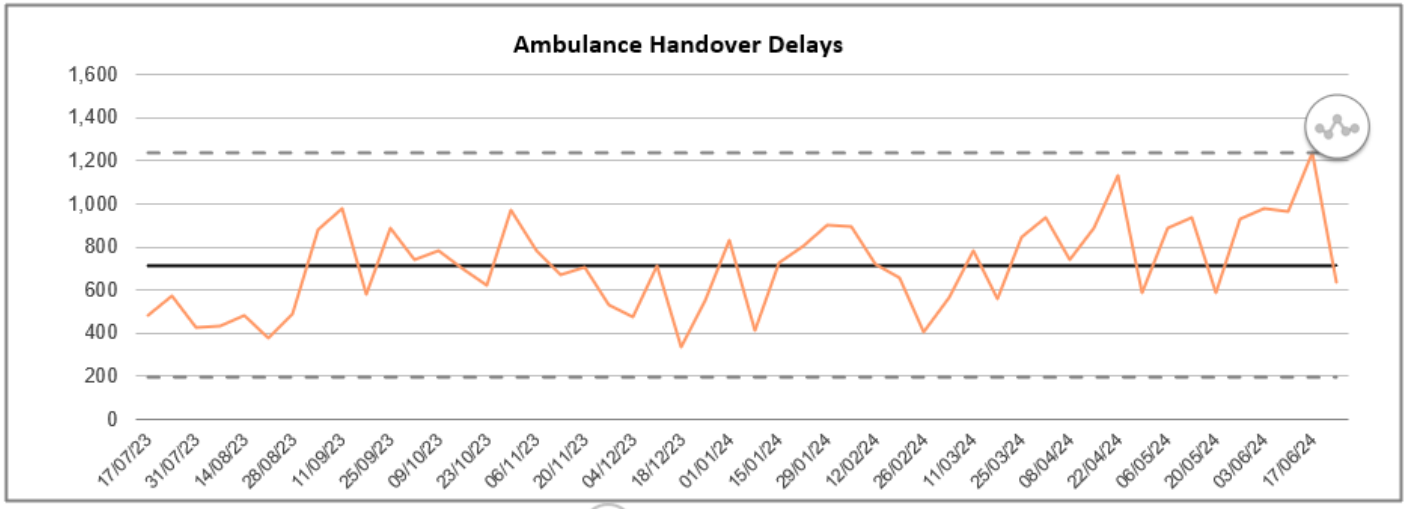
Simon Wade
Chief Financial Officer

2024/25 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Ambulance Handover Delays

08/04/24	15/04/24	22/04/24	29/04/24	06/05/24	13/05/24	20/05/24	27/05/24	03/06/24	10/06/24	17/06/24	24/06/24
741.3	887.0	1132.9	586.0	890.0	934.0	584.0	927.0	977.0	968.0	1239.0	633.0



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 increased to 118 hours in June from 94 in May. Performance continues to remain challenged and the Trust breakthrough objective is to sustain under 70 hours of hours lost per day. 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, 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)

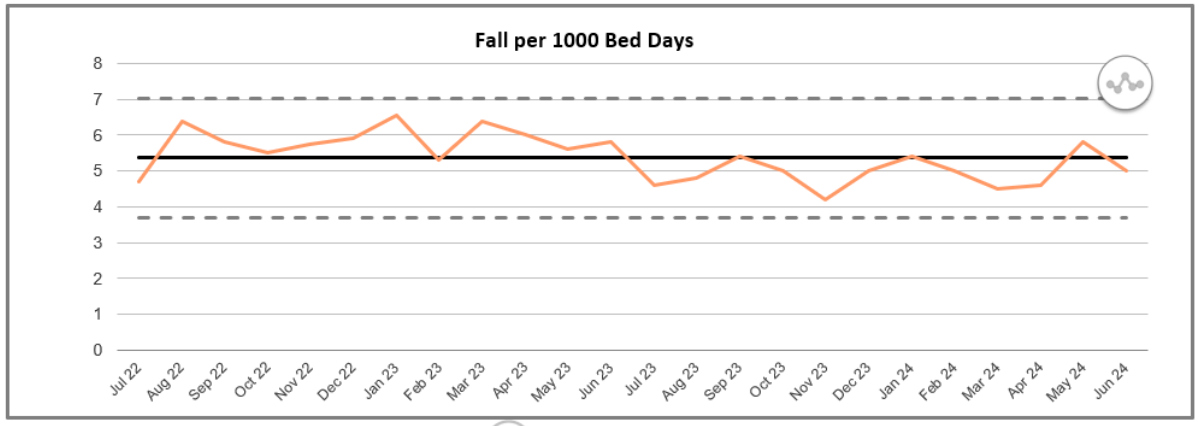
From the 10th-13th June the Trust declared a business continuity event due to operational pressures following surge and high bed occupancy. A further declaration was made for the Junior Doctor's strike from 27th June to 2nd July.

In response the Trust has initiated a SAFER Summer rapid improvement event that commenced on 24th June with support across the Trust and system partners. This includes a perfect Ambulance handover week commencing on 8th July, and three multi-agency discharge events scheduled throughout July to support improvement in flow.

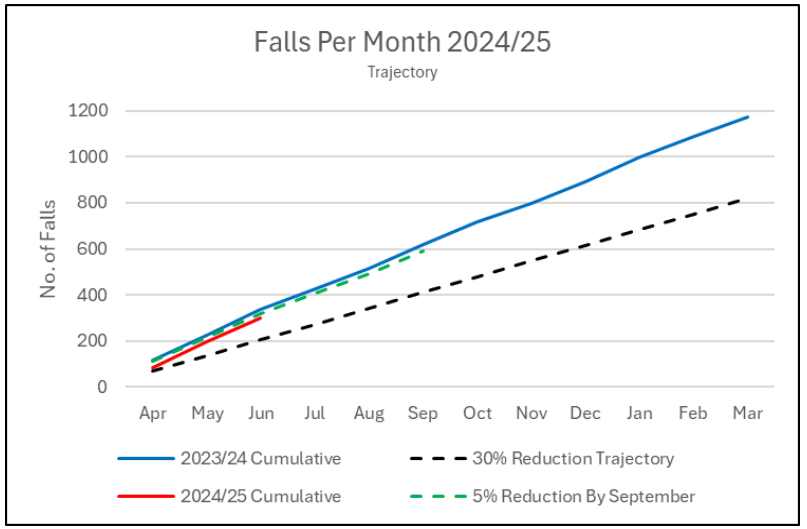
2024/25 Breakthrough Objectives

Reducing Falls & Falls With Harm

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



Common cause - no significant change



Understanding the Data

The number of falls per 1000 bed days has gradually reduced over the last 2 years with a further decrease for June to 5.48.

The number of patients with multiple falls per month is on course to meet the 10% trajectory for September (30% by April 25).

The number of falls with moderate harm or above has remained the same for June as the previous month (three).

Aim for 2024/25

- Reduce the number of patients that have more than 1 inpatient fall by 10%
- Reduce the total number of inpatient falls by 30%

When compared to the 2023/24 data.

We are driving this measure because…

Analysis shows that inpatient falls are a top cause of moderate and above harm in the Trust. Between Jan 23-Dec 23, 1274, were reported, 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

There have been two moderate harms or above in June (three in May). One patient experienced moderate harm (hip fracture) and one patient suffered a catastrophic sub dural haematoma.

A second falls Improving Together meeting has been completed. The areas of focus have been agreed and include enhanced care, falls debrief, lying and standing Blood Pressure and postural hypotension management, and footwear.

The A3 has been updated to reflect these changes.

The current focus for improvement work includes:

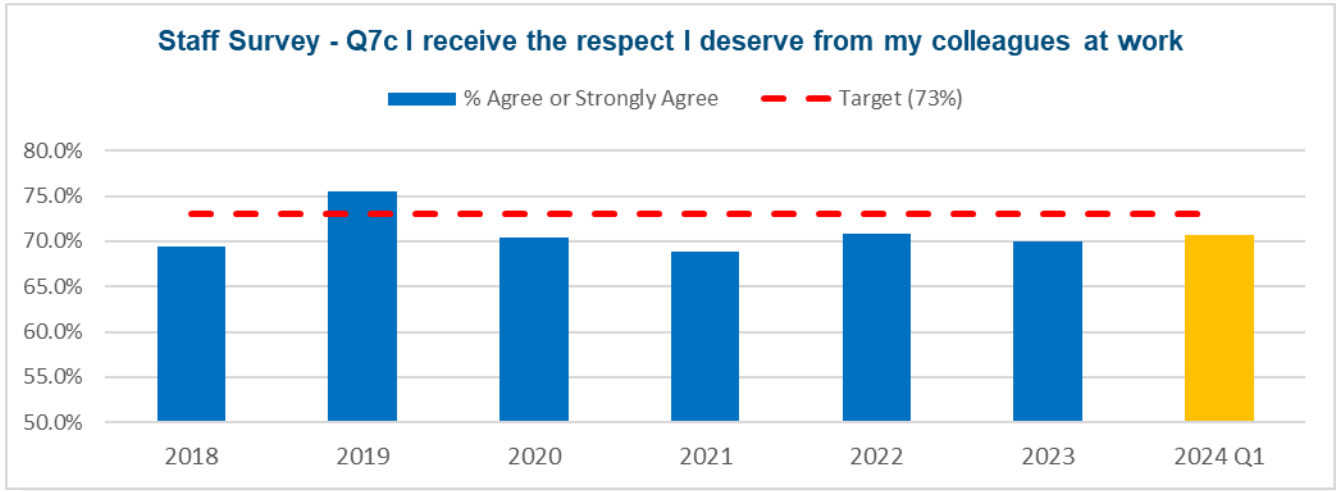
- Bedrail policy approved
- New training module uploaded to staff electronic record.
- Application for consideration of certain aspect of falls training to be included in mandatory training.

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%				



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

- Results from the Q2 Pulse Survey, which launched on 1st July 2024, will be available in August including free-text analysis of staff's feelings around 'respect'.
- Our Estates & Ancillary staff were identified as an area of opportunity due to smaller response rates in the Annual Staff Survey and lower performance in Q7c. The Senior Estates Leads celebrated National Healthcare Estates & Facilities Day in June with staff across all Community sites, ensuring that all Estates colleagues regardless of shift or location received a cream-tea in a box to thank them for their contribution.
- To continue momentum against this survey question, the following Trust-wide projects continue:
  - Implementation of the national toolkit "role of the line manager"
  - Our compassionate way
  - Leaderships behaviours
  - Improved staff recognition and opportunities to thank staff

Risks

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Mar-24	Apr-24	May-24	Jun-24	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		65%	70%	68%	62%	
	No. of complaints received	SPC		70	79	78	54	
	Number of reopened complaints	SPC		4	3	1	2	
IP & C	C.Diff	3.83		4	3	4	7	
	E.coli	5.5		10	7	12	9	
	Klebsiella	1.83		0	4	5	2	
	Pseudomonas	1.17		2	4	0	1	
FFT	Overall response rate (%)	28% (Int)		27%	33%	27%	24%	
	ED & UTC Response Rate	17% (Int)		14%	14%	14%	15%	
	ED & UTC Positive Responses	79% (Int)		77%	81%	77%	79%	
	Inpatients Response Rate	23% (Int)		21%	22%	21%	19%	
	Daycases Response Rate	22% (Int)		20%	22%	22%	19%	

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 for June dropped further in June to 62%. Additional supported has been 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. Pals are working with Divisions to create a more streamlined/standard approach to provide patients with information about expected wait times

The overall number of complaints received in month is lower 54 when compared to May. The number of re-opened complaints remains low (two in month).

NHS England have yet to set trajectories for infections in 2024/25, so the targets given are those for last year and are subject to change. *E. coli* and *Klebsiella* numbers remain high compared to our peers, with urinary infections being the main contributor. A new Continence Group has been setup to address this, with cross-divisional representation across acute, community and partner organisations. An external audit of catheter practice is planned for the summer which will feed into the new group's action plan. *Pseudomonas* cases are significantly down compared to this period last year and the Trust no longer has the highest rate in the region.

C. diff numbers have increased again after three months where they were lower than the recent average. No links between cases have been identified.

The FFT response rates remain below target in June in all alerting watch metrics, although the Emergency Department (ED) and Urgent Treatment Centre (UTC) response has increased slightly in month.

Risks

- Long term sickness and 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 meet response times is negatively impacting PALS team as managing frustrated and upset complainants daily.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Mar-24	Apr-24	May-24	Jun-24
Harm	Patient safety incident investigation	SPC		6	1	4	4
	Falls rate per 1000 bed days	SPC	L	4.5	4.6	5.8	5
	No. of Falls in month	SPC	L	88	86	113	98
	No. falls with moderate harm or above	SPC		1	6	3	3
	Medication incidents with moderate harm	SPC		1	3	3	5
	Pressure Ulcer (Hospital Acquired)	SPC		41	21	23	35
	Pressure Ulcer (Community Acquired)	SPC		25	32	21	16
Concerns and Complaints	No. of concerns received	SPC		237	203	371	334
IP & C	MRSA	0		0	0	0	0
	MSSA	3.67		1	1	1	1
	COVID (hospital acquired)	SPC		7	14	12	15

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

Performance & Counter Measure

There were four Patient Safety Incident Investigation reported in June. There are 12 ongoing Serious Incident (SI) Investigations being reviewed under the SI framework. There is a trajectory to close all SI's in the coming two months.
The Trust has appointed a new patient safety incident investigator who will start at the end of September.

The number of falls has decreased in month to 103 (113 in May). There has been two falls with moderate harm or above this month, at slight decrease from May.

There was a rise in hospital-acquired category 2-4 pressure ulcers from 23 in May to 35 in June. All but three were category 2 and there were zero category 4 ulcers. There has also been an increase in reported pressure harms present on admission, with a total of 135 patients admitted with existing pressure damage, reflecting the vulnerability of many of our patients.

Community harms have decreased by five in month to 16 (21 in May) affecting 13 patients. Five patient were receiving End of Lifecare, attributing to 50% of the harms.

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.

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	Mar-24	Apr-24	May-24	Jun-24
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	94%	94%	93%	94%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	105%	104%	108%	108%
FFT	Positive response (%)	86% (Int)	?	88%	90%	87%	87%
	ED & UTC Positive Responses	79% (Int)	?	77%	81%	77%	79%
	Inpatients Positive Responses	86% (Int)	?	86%	90%	89%	90%
	Daycases Positive Responses	95% (Int)	?	96%	95%	95%	95%
	Outpatients Positive Responses	97% (Int)	?	97%	98%	97%	98%
	Maternity Response Rate	18% (Int)	?	13%	21%	25%	26%
	Maternity Positive Responses	92% (Int)	?	92%	90%	93%	92%

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

Performance & Counter Measures

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

The FFT overall response rate is 24% this month, a reduction from last month (27%). The positive response rate has also remained the same at 87%.

There has been an increase in the non-alerting watch metrics for FFT, across ED and UTC, Inpatient positive responses, Out-patient positive responses, and Maternity response rates.

Day case positive responses and Overall positive responses have remained the same in month.

Maternity has seen a slight decrease in positive response rates to 92% in month (93% in May) but remains on target.

Work underway to embed the patient voice/feedback and involvement into Improving Together training and in all A3 project scopes and improvement plans.

Actions underway in response to Healthwatch community midwifery enter and view visit – most in relation to estates and lack of appropriate clinical space.

Improvement work with community rehab team has significantly reduced wait times for patients and total number of patients waiting.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-24	Apr-24	May-24	Jun-24	Trend
RTT	No. of >=18 weeks waiters		H	18254	18451	18637	19892	
	No. of >=52 weeks waiters		H	1900	1859	1909	1885	
DM01	No. of patients on DM01 waitlist		H	9601	9961	9335	One month behind	
	DM01 performance %	99% (Nat)	F	66.4%	60.7%	66.9%	One month behind	
	DM01 6 week wait breaches		H	3229	3912	3090	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	66.7%	63.1%	65.1%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	89.0%	83.4%	87.6%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	59.4%	40.8%	42.2%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	71.3%	59.2%	66.7%	One month behind	

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Performance & Counter Measure

Diagnostics

June's DM01 performance is showing an increase in performance variance from the 66.90% performance in May to 70.55% - this is the highest DM01 since July 2021. The number of patients on the waiting list has decreased by 271 to 9,064 Driven by the by the continued work to improve NOUS.

Counter measures: Radiology are looking to procure 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 80% utilisation for MRI and CT following the plan to deliver contrast scans at the site which commenced on 10th June. Endoscopy usage remains lower than planned but work with RUH and will hopefully 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.

Cancer

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin & Breast pathways with 92% of the breaches being accounted for by these two services.

86.2% 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 57.8% of all breaches. Capacity for outpatients were the main factors in these breaches.

In May, 61% (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 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 from 15 July
-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, 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	Mar-24	Apr-24	May-24	Jun-24	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	74.4%	75.9%	75.3%	75.0%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	7.1%	7.5%	6.6%	6.9%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	56.1%	56.2%	56.5%	54.2%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	14.8%	15.7%	13.6%	14.2%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	91.2%	94.0%	91.8%	94.7%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2350.19	3272.00	3013.78	3667.81	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1525	1472	1702	1647	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	88%	92%	91%	91%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1050	1117	1231	1260	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	60.8%	69.6%	66.1%	70.0%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	699	824	839	916	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	40.5%	51.4%	45.1%	50.9%	
Flow	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	286	274	371	378	
	Community Average Length of Stay (Days)	SPC	H	24	22	23	21	

Performance & Counter Measure

Plans renewed around improving performance across ED metrics through weekly Medicine Emergency flow meetings

4 hour performance (type 1 and 3) slightly decreased from 75.3% to 75%. Type 3 performance showed significant improvement from 91.8% to 94.7% showing correlation to lower attendances in June. Type 1 4 hours performance reduced from 56.5% to 54.2% showing the impact of the department being overcrowded at times through June.

Total % over 12 hours decreased from 13.6% to 14.2% showing a increase in number of patients experiencing extended waits and times where the department is over crowded.

Number of ambulance handovers over 30 minutes has increased from 1231 to 1260.

Number of ambulance handovers over 60 minutes have decreased from 45.1 to 50.9%

Counter measures remain in place within the Breakthrough objective slides.

Risks

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

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

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-24	Apr-24	May-24	Jun-24
RTT	No. of >=78 weeks waiters	SPC	L	4	3	4	3
Cancer	No. of referrals received	SPC		1879	1831	1967	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.1%	0.0%	0.0%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5498	5212	5587	5415
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	77.4%	78.6%	80.1%	80.0%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		56.3%	59.3%	60.2%	60.6%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		31.4%	38.0%	36.8%	55.2%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	206	199	199	189
	Emergency Care - AED - Median Stay	240 (Int)	?	238	238	238	239
	Emergency Care - UTC - Median Stay	240 (Int)	P	178	170	169	145
	Total Number of Ambulance Handovers	SPC	L	1728	1604	1861	1801
	Average hours lost to ambulance handover delays per day	SPC		76	109	94	118

Performance & Counter Measure

ED

Number of ambulance conveyances idecreased from previous month from 1861 to 1801, albeit at still high levels. Average hours lost increased in June from 94 hours to 118.

Triage performance for ED has improved again rising from 60.2% to 60.6%. Significant improvement in Type 3 triage performance now that additional capacity is in place.

Median stay has stabilised at 239 mins in ED and a big decrease in median stay seen in UTC (145mins down from 169)

Risks

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-24	Apr-24	May-24	Jun-24
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		651	656	Waiting for data	Waiting for data
	Elective Patients Average Length of Stay (Days)	SPC	L	3	3	3	3
	Non-Elective Patients Average Length of Stay (Days)	SPC	L	4	5	4	5
	GWH Discharges by Noon (%)	SPC		18.5%	15.6%	16.8%	16.8%
	Number of Stranded Patients (over 14 days)	SPC		113	121	112	122
	Number of Super Stranded Patients (over 21 days)	SPC		61	69	63	67
	Adult general and acute type 1 bed occupancy	SPC		94.2%	94.9%	95.2%	95.7%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	L	18.6%	18.6%	18.2%	18.2%
	Proportion of patients discharged from hospital to their usual place of residence	SPC	H	95.9%	95.7%	95.2%	95.4%

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Performance & Counter Measure

Patient Flow

- Discharges prior to Midday at 18% not the recorded 16.8% 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.**

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	Mar-24	Apr-24	May-24	Jun-24
Use of Resources	Capital Expenditure (£'000)	SPC		Waiting for data	Waiting for data	2576	1793
	Pay (£'000)	SPC		37412	25246	25849	24562
	Non Pay (£'000)	SPC		19462	17366	18098	17264

Performance & Counter Measure

Year-to-date capital spend at M3 is £4.4m against a plan of £7.4m, giving an underspend against plan of £3m. Key drivers are EPR and CDC.

Pay costs are £1.3m lower than M2 due to accrual releases associated with the consultant pay award in M2 being lower than anticipated.

Non-Pay is £0.8m lower than M2 driven by clinical supplies (£0.6m) following higher stock costs in M2 and drugs (£0.2m).

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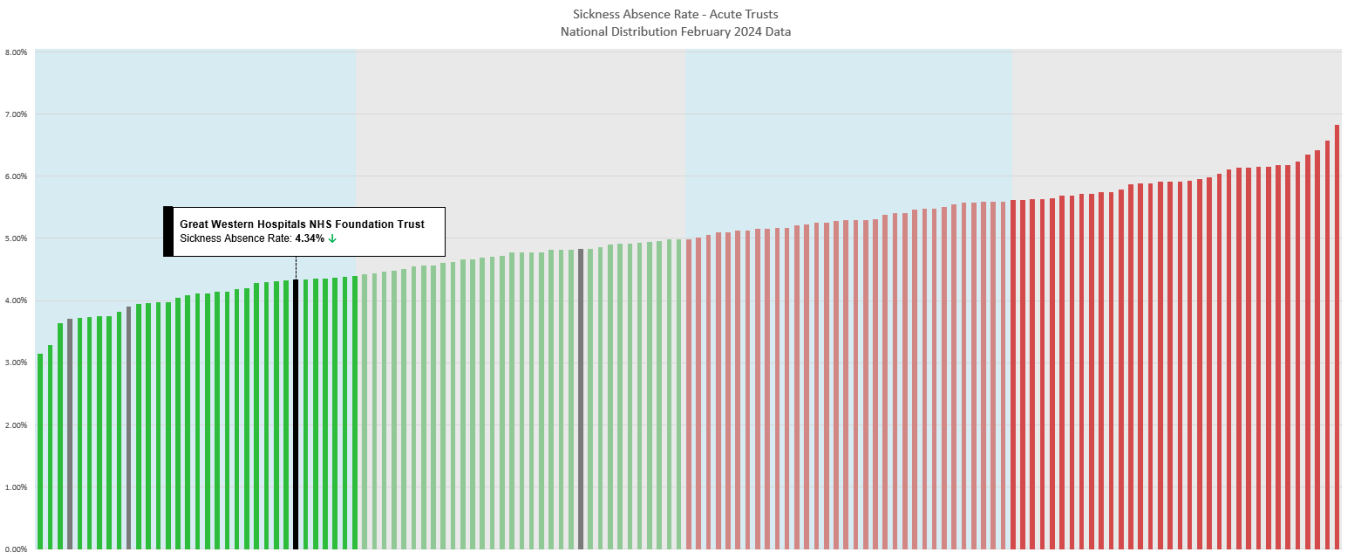
Risks

The Trust started the year with a £21.9m cash releasing efficiency plan. As at M3 delivery is £1.5m behind plan with 47% of the £2.5m 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	Mar-24	Apr-24	May-24	Jun-24	Trend
	Trust sickness absence rate	3.5% (Int)	F	4.1%	4.2%	4.2%	One month behind	



Performance & Counter Measure

- There was a slight decrease to sickness absence in May, reducing from 4.19% to 4.16%. Short term sickness has increased slightly to 2.2% and long-term sickness has decreased to 1.9%.
  - Stress/Anxiety/Depression remained the top reason for absence in May, accounting for 19% of all sickness absence (reduction from 21% in April). 'Other known causes' was the second most prevalent reason (11%) followed by Gastrointestinal issues (10%).
  - Regional benchmarking has been undertaken by the HR Project Lead for Absence, which will be incorporated into the refreshed A3 for sickness absence. A presentation is planned for August People & Culture detailing refreshed countermeasures and next steps.
- Current National benchmarking data (February 2024 - NHS Digital) shows a further reduction in the National absence rate in February, decreasing from 5.48% to 5.10%. A similar level of reduction was seen Regionally with South-West absence decreasing from 5.31% to 4.99% and sickness within our ICB moving from 4.93% to 4.56%. Our absence rate in this period reduced to 4.34%, with this improvement moving us to the 1st-lowest quartile for Acute Trusts (27th 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

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Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-24	Apr-24	May-24	Jun-24
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	11.5%	10.7%	9.7%	One month behind

Performance & Counter Measure

- There has been a further decrease to the number of leavers within their 1st year of employment, reducing to 9.7% in May.

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%

Risks

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

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Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend Vs Last Month	Trend Vs Jun-23
	Vacancy																	
W	Vacancy Rate	%	7.00%	7.96%	7.82%	5.95%	4.87%	4.33%	3.93%	3.74%	4.12%	4.11%	3.93%	4.19%	4.04%	3.98%	↓	↓
W	Vacancy Rate	WTE	-	432.29	424.68	320.44	262.33	232.95	211.39	201.47	223.67	223.82	213.76	227.43	219.66	216.12		
W	All Nursing Vacancy	%	7.00%	5.38%	5.00%	2.73%	1.96%	1.30%	1.94%	1.43%	2.75%	2.39%	2.21%	2.20%	1.73%	1.73%	↓	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	143.74	133.58	71.58	51.43	34.17	51.03	37.87	73.60	63.97	59.14	58.90	46.13	46.07		
W	All Registered Nursing Vacancy	WTE	-	107.48	103.62	74.83	47.47	18.62	26.55	9.50	28.02	14.37	9.70	4.67	4.75	14.57		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	53.47	59.84	42.58	23.20	3.60	8.44	-3.79	5.29	-3.91	-7.35	-19.60	-12.95	-3.59		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	36.26	29.96	-3.25	3.96	15.55	24.48	28.37	45.58	49.60	49.44	54.23	41.38	31.50		
W	Medical Vacancy	%	7.00%	9.93%	10.34%	7.28%	5.22%	5.66%	5.26%	5.89%	7.07%	7.96%	7.47%	8.30%	6.78%	6.67%	↓	↓
W	Medical Vacancy	WTE	-	73.05	76.03	53.43	38.22	41.48	38.61	43.30	53.08	59.82	56.06	62.23	50.71	49.94		
W	STT/AHP Vacancy	%	7.00%	12.69%	13.04%	13.04%	10.41%	9.20%	6.88%	6.44%	4.87%	4.78%	3.74%	3.39%	3.67%	3.63%	↓	↓
W	STT/AHP Vacancy	WTE	-	110.17	113.09	112.95	90.28	79.85	58.89	54.92	41.53	40.83	31.72	28.78	31.27	30.91		
W	SMA Vacancy	%	7.00%	9.09%	8.80%	7.13%	7.12%	6.70%	5.44%	5.66%	4.80%	5.09%	5.76%	6.68%	7.77%	7.58%	↓	↓
W	SMA Vacancy	WTE	-	105.33	101.98	82.48	82.40	77.45	62.86	65.38	55.46	59.20	66.84	77.52	91.55	89.20		
W	Recruitment Time to Hire - AFC	Days	46.00	47.60	49.10	45.00	41.70	42.70	41.80	43.50	44.40	42.70	38.40	39.50	39.40	46.10	↑	↓
W	Recruitment Time to Hire - Bank	Days	46.00	26.90	50.40	46.00	43.50	37.00	39.90	45.20	42.00	50.30	39.30	43.30	33.30	44.00	↑	↑
W	Recruitment Time to Hire - Medical	Days	46.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	64.30	66.10	32.60	39.00	39.44	35.30	↓	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,433.60	5,433.60	5,382.13	5,381.76	5,379.33	5,382.66	5,382.34	5,431.15	5,446.50	5,433.90	5,433.90	5,437.81	5,434.79		
W	Substantive WTE	WTE	-	5,001.31	5,008.92	5,061.69	5,119.43	5,146.38	5,171.27	5,180.87	5,207.48	5,222.68	5,220.14	5,206.47	5,218.15	5,218.67		
W	Additional Substantive WTE	WTE	-	30.79	29.97	25.73	22.95	26.89	24.63	25.22	21.90	22.51	24.78	20.17	5.53	8.24		
W	Bank WTE	WTE	-	296.31	315.54	298.46	277.29	280.45	260.02	246.43	295.57	294.32	380.50	286.32	301.97	326.11		
W	Agency WTE	WTE	-	97.65	98.88	86.02	80.48	66.71	60.65	55.12	61.82	69.47	60.09	49.52	43.70	38.63		
W	Budgeted vs Worked WTE Variance	WTE	-	-7.54	19.71	89.77	118.39	141.10	133.91	125.30	155.62	162.48	251.61	128.59	131.54	156.87		
W	Actual Worked vs Budgeted %	%	-	99.86%	100.36%	101.67%	102.20%	102.62%	102.49%	102.33%	102.87%	102.98%	104.63%	102.37%	102.42%	102.89%		
W	Total Workforce Cost £	£	-	£25.72M	£24.82M	£24.44M	£26.42M	£25.47M	£24.85M	£25.09M	£25.67M	£25.39M	£25.92M	£25.13M	£25.50M	£25.21M		
W	Agency Spend as % of Total Spend	%	4.50%	3.39%	4.15%	2.62%	3.11%	4.56%	3.56%	1.22%	2.83%	2.83%	2.04%	1.83%	1.30%	2.01%	↑	↓
W	Agency Spend £	£	-	£0.87M	£1.03M	£0.64M	£0.82M	£1.16M	£0.89M	£0.30M	£0.73M	£0.72M	£0.53M	£0.46M	£0.33M	£0.51M		
W	Agency Target £	£		£0.88M	£0.76M	£1.06M	£1.17M	£1.07M	£0.91M	£1.10M	£0.91M	£0.86M	£0.96M	£0.54M	£0.52M	£0.51M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-£0.01M	£0.27M	-£0.42M	-£0.35M	£0.09M	-£0.03M	-£0.79M	-£0.18M	-£0.14M	-£0.44M	-£0.08M	-£0.19M	£0.00M	↑	↑
W	Bank Spend £	£	-	£2.05M	£2.37M	£2.34M	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	£1.89M	£2.02M	£2.23M		
W	Bank Target £	£		£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£0.00M	£2.19M	£2.12M	£2.04M		
W	Bank Spend vs Target £	£ Diff	£0.00M	£2.05M	£2.37M	£2.34M	£2.12M	£1.78M	£1.62M	£2.01M	£2.21M	£2.12M	£2.55M	-£0.31M	-£0.10M	£0.19M	↑	↓
W	Registered Nursing Bank Fill	%	45.00%	81.03%	82.92%	81.78%	81.62%	84.87%	86.80%	87.74%	90.73%	90.69%	90.40%	90.86%	94.13%	90.81%	↓	↑
W	Unregistered Nursing Bank Fill	%	70.00%	80.86%	79.98%	77.52%	81.35%	79.99%	84.45%	81.80%	80.12%	79.46%	78.92%	81.89%	87.18%	86.23%	↓	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend Vs Last Month	Trend Vs Jun-23
	Retention																	
W	All Turnover %	%	13.00%	13.27%	12.74%	12.69%	12.56%	12.20%	12.00%	11.49%	10.98%	10.90%	10.72%	10.85%	10.57%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	10.17%	9.67%	9.62%	9.52%	9.20%	9.19%	8.89%	8.55%	8.56%	8.45%	8.62%	8.53%	-	↓	↓
W	Number of Leavers	Headcount	-	51	53	46	63	41	44	42	44	40	62	44	45	-		
W	Number of RN Leavers	Headcount	-	16	12	14	18	11	14	11	21	10	15	12	17	-		
W	Registered Nursing Vol Turnover	%	-	6.72%	6.48%	6.61%	6.50%	6.57%	6.95%	6.99%	7.07%	7.16%	7.19%	7.33%	7.52%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	11	7	13	21	10	8	15	7	11	13	11	10	-		
W	Unregistered Nursing Vol Turnover	%	-	13.90%	12.93%	12.73%	13.35%	12.65%	12.34%	11.86%	12.01%	11.21%	10.87%	11.16%	11.00%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	14.04%	16.02%	14.39%	14.74%	14.44%	13.35%	13.96%	12.14%	11.86%	11.72%	10.68%	9.74%	-		
W	Number of starters	Headcount	-	56	90	56	103	60	67	36	82	38	48	58	44	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	3.72%	3.96%	3.98%	4.03%	4.15%	4.23%	4.33%	4.39%	4.39%	4.36%	4.35%	4.39%	-	↑	↑
D	Sickness Absence %	%	3.50%	3.77%	4.43%	4.03%	4.21%	4.74%	4.70%	4.98%	4.90%	4.34%	4.15%	4.19%	4.16%	-	↓	↑
W	Long Term Sickness %	%	2.00%	2.16%	2.61%	2.20%	2.10%	2.41%	2.40%	2.65%	2.62%	2.38%	2.23%	2.21%	1.92%	-	↓	↓
W	Short Term Sickness %	%	1.50%	1.61%	1.82%	1.83%	2.11%	2.33%	2.31%	2.33%	2.28%	1.96%	1.92%	1.98%	2.24%	-	↑	↑
W	Sickness Absence Cost £	£	-	£550.4k	£664.8k	£626.3k	£614.8k	£738.9k	£726.5k	£794.0k	£777.2k	£647.1k	£669.2k	£675.4k	£708.3k	-		
W	WTE Days Lost	WTE	-	5,568.9	6,781.2	6,256.4	6,401.2	7,487.3	7,187.9	7,922.9	7,774.7	6,566.1	6,618.1	6,482.7	6,662.1	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	89.81%	89.90%	90.10%	90.36%	90.75%	91.38%	91.88%	91.49%	91.72%	92.31%	92.46%	91.37%	91.60%	↑	↑
W	Role Essential MT %	%	85.00%	91.37%	91.40%	91.64%	91.93%	92.20%	92.77%	93.14%	92.92%	93.28%	93.79%	94.03%	91.84%	92.30%	↑	↑
W	CQC Safe MT %	%	85.00%	88.25%	88.38%	88.56%	88.78%	89.32%	90.01%	90.64%	90.07%	90.16%	90.85%	90.90%	90.86%	90.84%	↓	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	73.18%	76.28%	79.91%	81.75%	83.26%	83.85%	85.24%	86.22%	85.23%	86.51%	84.26%	83.54%	82.60%	↓	↑
W	Appraisal Compliance %	%	85.00%	83.86%	83.94%	84.29%	84.88%	84.92%	83.62%	85.63%	84.32%	84.85%	85.26%	84.18%	84.39%	84.74%	↑	↑
W	Non Medical Appraisal Compliance %	%	85.00%	82.76%	83.29%	84.24%	84.89%	84.91%	83.81%	85.37%	84.06%	84.37%	84.59%	84.40%	83.99%	84.87%	↑	↑
W	Medical Appraisal Compliance %	%	85.00%	91.81%	88.64%	84.64%	84.84%	85.04%	82.25%	87.59%	86.32%	88.38%	90.10%	82.58%	87.32%	83.81%	↓	↓

Our People

Workforce Scorecard

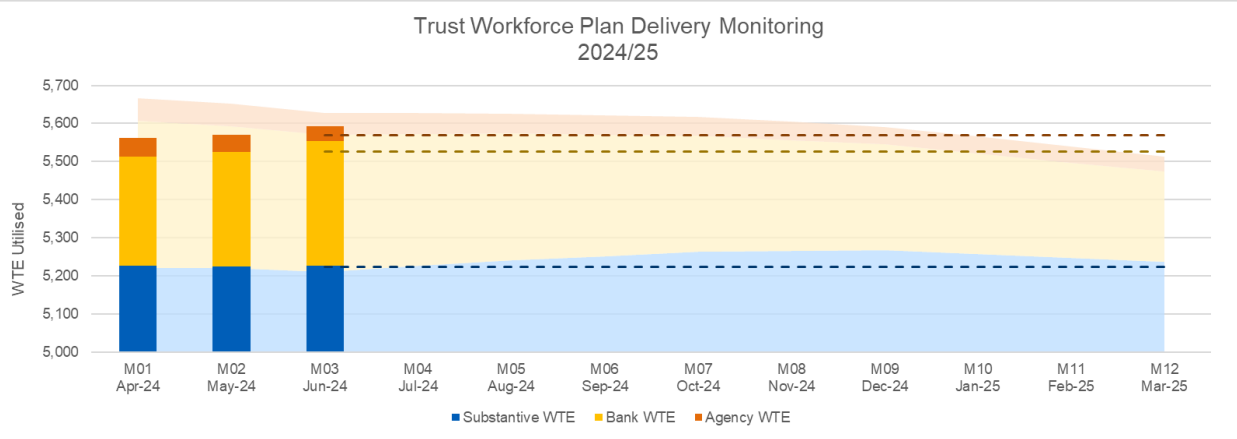
Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Trend Vs	
																	Last Month	May-23
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.12%	4.12%	4.13%	4.17%	4.18%	4.12%	4.21%	4.19%	4.23%	4.26%	4.28%	4.28%	4.23%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	251.00	251.00	252.00	257.00	260.00	258.00	265.00	264.00	268.00	271.00	272.00	272.00	269.00		
W	% of Leadership Roles who are Female (B8a+)	%	-	70.92%	70.52%	70.24%	70.82%	71.15%	70.93%	71.32%	71.59%	71.27%	71.22%	70.59%	70.59%	69.89%		
W	% of Leadership Roles who from BME (B8a+)	%	-	5.58%	5.58%	5.95%	6.61%	6.54%	6.20%	6.79%	6.82%	6.34%	6.64%	6.25%	6.25%	6.32%		
W	Staff in Leadership Roles % (B8c+)	%	-	0.95%	0.95%	0.93%	0.93%	0.92%	0.91%	0.92%	0.89%	0.90%	0.90%	0.90%	0.94%	0.94%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	58.00	58.00	57.00	57.00	57.00	57.00	58.00	56.00	57.00	57.00	57.00	60.00	60.00		
W	% of Leadership Roles who are Female (B8c+)	%	-	58.62%	56.90%	56.14%	56.14%	56.14%	56.14%	56.90%	57.14%	56.14%	56.14%	56.14%	56.67%	56.67%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.17%	5.17%	5.26%	5.26%	5.26%	5.26%	5.17%	5.36%	3.51%	3.51%	3.51%	3.33%	3.33%		
W	% of Leadership Roles who are disabled (B8c+)	%	-	1.72%	1.72%	1.75%	1.75%	1.75%	1.75%	1.72%	1.79%	1.75%	1.75%	1.75%	1.67%	1.67%		
W	Male % of Workforce	%	-	17.75%	17.83%	17.90%	18.10%	18.16%	18.36%	18.40%	18.29%	18.33%	18.32%	18.36%	18.39%	18.54%		
W	Female % of Workforce	%	-	82.25%	82.17%	82.10%	81.90%	81.84%	81.64%	81.60%	81.71%	81.67%	81.68%	81.64%	81.61%	81.46%		
W	BME % of Workforce	%	-	24.22%	24.19%	24.49%	25.06%	25.18%	25.47%	25.68%	25.98%	26.08%	26.12%	26.36%	26.56%	26.78%		
W	White % of Workforce	%	-	67.43%	67.29%	67.08%	67.03%	66.86%	66.58%	66.32%	66.19%	65.84%	65.76%	65.61%	65.36%	65.08%		
W	ER Cases Closed	Number	-	56	55	60	22	35	29	28	36	35	41	16	13	35		

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**	0	0	0	0	0	0	0	0	0
	Variance	-104	-82	-35	-	-	-	-	-	-	-	-	-
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**	0	0	0	0	0	0	0	0	0
	of which Overtime	**20**	**6**	**8**	0	0	0	0	0	0	0	0	0
	Variance	6	4	16	-	-	-	-	-	-	-	-	-
Bank	Plan	387	373	359	346	332	318	305	291	277	264	250	237
	Actual	**286**	**302**	**326**	0	0	0	0	0	0	0	0	0
	Variance	-100	-71	-33	-	-	-	-	-	-	-	-	-
Agency	Plan	60	58	56	55	53	51	49	47	45	44	42	40
	Actual	**50**	**44**	**39**	0	0	0	0	0	0	0	0	0
	Variance	-10	-14	-18	-	-	-	-	-	-	-	-	-
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%**										
	Variance	-0.05%	-0.33%	-	-	-	-	-	-	-	-	-	-
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	**4.35%**	**4.39%**										
	Variance	0.00%	0.06%	-	-	-	-	-	-	-	-	-	-

Performance & Counter Measure

- In M3, 5,592WTE was used to deliver our services against a planned figure of 5,627WTE. Whilst usage has increased month on month, overall workforce levels remain under plan by 35WTE.
- Substantive WTE reported above plan by 16WTE in June. Overtime increased marginally by 2WTE although still in line with planned reductions, and the variance to plan was driven by our contracted position which whilst static compared to M3 did not reflect the planned levels of reduction.
- Temporary staffing WTE continues to report below plan, with Bank usage 33WTE less than plan in June and Agency at 18WTE less than plan. Usage in June did increase compared to May driven by Nursing and Medical & Dental bank usage, attributable in part to industrial action cover.

Impact on Workforce

- The positive impact of heightened overtime controls implemented from 1st May continue in June with usage levels now approximately 27WTE less than in March, although some of this usage has transferred into bank WTE.
- The next planned intervention within the project plan for Workforce Controls is a freeze on non-clinical vacancies. The initial trigger point for this was our workforce levels exceeding the planned amount of 5,627WTE in M3, which has not been implemented due to our positive position against plan in June. This position will be monitored throughout July.

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	£0	£0	£0	£0	£0	£0	£0	£0	£0	£22,379,254
	RGN Bank £	£500,934	£498,227	£505,752	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1,504,914
	RGN Agency £	£134,966	£83,833	£125,905	£0	£0	£0	£0	£0	£0	£0	£0	£0	£344,704
	Budget £	£8,339,881	£8,280,339	£7,502,736	£0	£0	£0	£0	£0	£0	£0	£0	£0	£24,122,956
	Actual Cost £	£8,141,528	£8,101,748	£7,985,596	£0	£0	£0	£0	£0	£0	£0	£0	£0	£24,228,872
	Variance to Budget £	-£198,353	-£178,591	£482,860	£0	£0	£0	£0	£0	£0	£0	£0	£0	£105,916
Unregistered Nursing	UR Sub £	£2,378,175	£2,371,809	£2,353,585	£0	£0	£0	£0	£0	£0	£0	£0	£0	£7,103,569
	UR Bank £	£267,490	£248,476	£295,353	£0	£0	£0	£0	£0	£0	£0	£0	£0	£811,319
	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	£0	£0	£0	£0	£0	£0	£0	£0	£0	£8,020,012
	Actual Cost £	£2,645,665	£2,620,285	£2,648,937	£0	£0	£0	£0	£0	£0	£0	£0	£0	£7,914,887
	Variance to Budget £	-£66,838	-£104,977	£66,690	£0	£0	£0	£0	£0	£0	£0	£0	£0	-£105,125
Medical and Dental	M & D Sub £	£6,211,821	£6,707,627	£5,942,244	£0	£0	£0	£0	£0	£0	£0	£0	£0	£18,861,692
	M & D Bank £	£885,343	£1,027,432	£1,204,978	£0	£0	£0	£0	£0	£0	£0	£0	£0	£3,117,753
	M & D Agency £	£295,354	£154,539	£326,588	£0	£0	£0	£0	£0	£0	£0	£0	£0	£776,481
	Budget £	£6,725,770	£6,526,600	£6,748,637	£0	£0	£0	£0	£0	£0	£0	£0	£0	£20,001,007
	Actual Cost £	£7,392,518	£7,889,598	£7,473,811	£0	£0	£0	£0	£0	£0	£0	£0	£0	£22,755,926
	Variance to Budget £	£666,748	£1,362,998	£725,174	£0	£0	£0	£0	£0	£0	£0	£0	£0	£2,754,919
AHP and STT	AHP/STT Sub £	£3,109,394	£3,128,363	£3,064,414	£0	£0	£0	£0	£0	£0	£0	£0	£0	£9,302,172
	AHP/STT Bank £	£127,201	£119,799	£120,651	£0	£0	£0	£0	£0	£0	£0	£0	£0	£367,651
	AHP/STT Agency £	-£17,442	£108,810	£53,778	£0	£0	£0	£0	£0	£0	£0	£0	£0	£145,146
	Budget £	£3,168,989	£3,182,676	£3,117,077	£0	£0	£0	£0	£0	£0	£0	£0	£0	£9,468,742
	Actual Cost £	£3,219,154	£3,356,972	£3,238,844	£0	£0	£0	£0	£0	£0	£0	£0	£0	£9,814,969
	Variance to Budget £	£50,165	£174,296	£121,767	£0	£0	£0	£0	£0	£0	£0	£0	£0	£346,227
Admin & Clerical	Admin Sub £	£3,581,995	£3,421,806	£3,761,946	£0	£0	£0	£0	£0	£0	£0	£0	£0	£10,765,746
	Admin Bank £	£106,641	£123,368	£99,734	£0	£0	£0	£0	£0	£0	£0	£0	£0	£329,742
	Admin Agency £	£46,781	-£16,117	£169	£0	£0	£0	£0	£0	£0	£0	£0	£0	£30,833
	Budget £	£2,830,472	£3,069,719	£3,087,241	£0	£0	£0	£0	£0	£0	£0	£0	£0	£8,987,432
	Actual Cost £	£3,735,417	£3,529,056	£3,861,848	£0	£0	£0	£0	£0	£0	£0	£0	£0	£11,126,321
	Variance to Budget £	£904,945	£459,337	£774,607	£0	£0	£0	£0	£0	£0	£0	£0	£0	£2,138,889
Total	Total Sub £	£22,787,013	£23,149,293	£22,476,127	£0	£0	£0	£0	£0	£0	£0	£0	£0	£68,412,433
	Total Bank £	£1,887,609	£2,017,302	£2,226,468	£0	£0	£0	£0	£0	£0	£0	£0	£0	£6,131,379
	Total Agency £	£459,659	£331,064	£506,441	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1,297,164
	Budget £	£23,777,615	£23,784,596	£23,037,938	£0	£0	£0	£0	£0	£0	£0	£0	£0	£70,600,149
	Actual Cost £	£25,134,281	£25,497,659	£25,209,036	£0	£0	£0	£0	£0	£0	£0	£0	£0	£75,840,976
	Variance to Budget £	£1,356,666	£1,713,063	£2,171,098	£0	£0	£0	£0	£0	£0	£0	£0	£0	£5,240,827

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

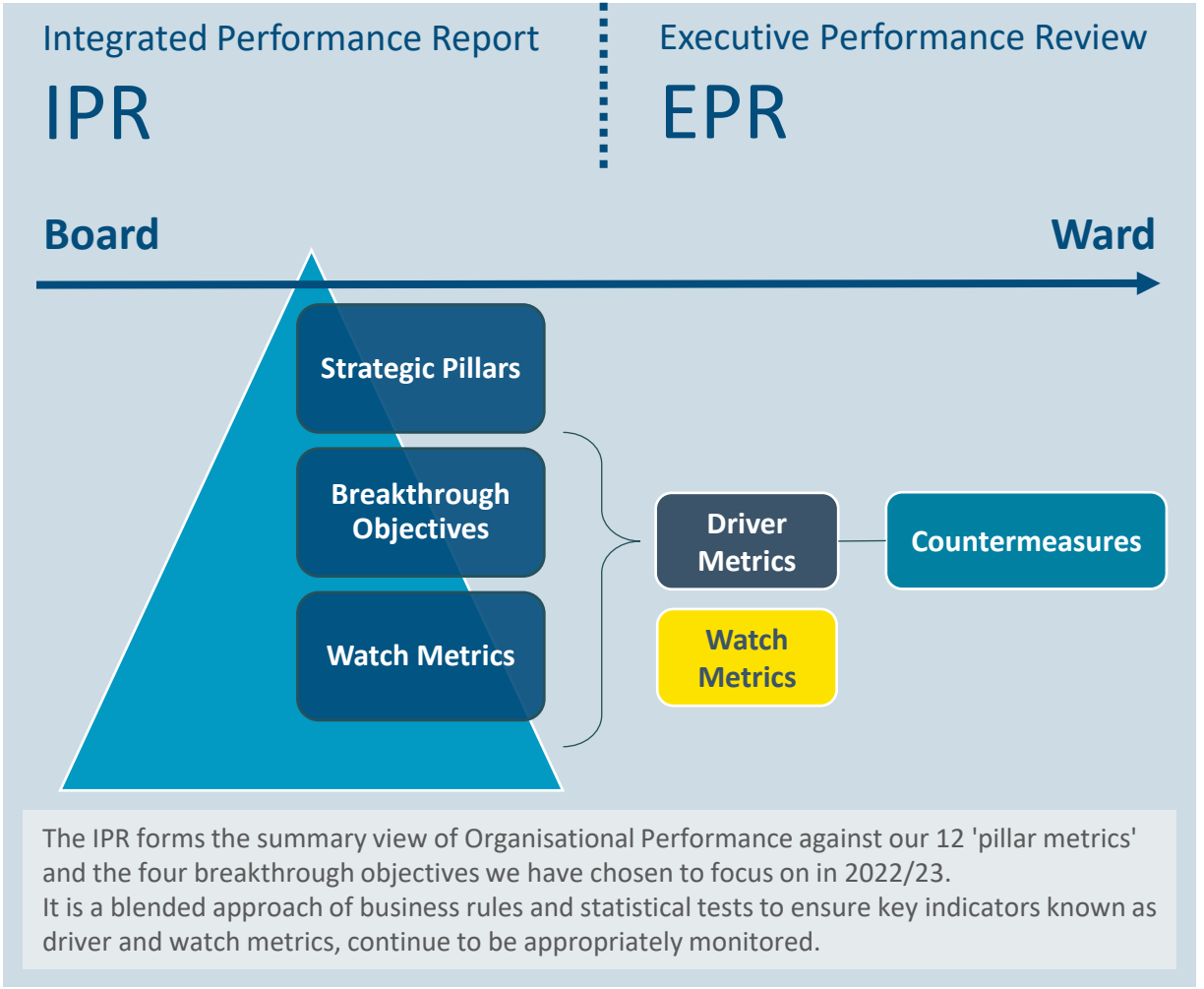
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

NHS
Great Western Hospitals
NHS Foundation Trust

Our Vision

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

Our four strategic pillars

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

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

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

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

24/25 Strategic Planning Framework

NHS Great Western Hospitals NHS Foundation Trust

Our Vision

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

1 Our four strategic pillars

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

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

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust

Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

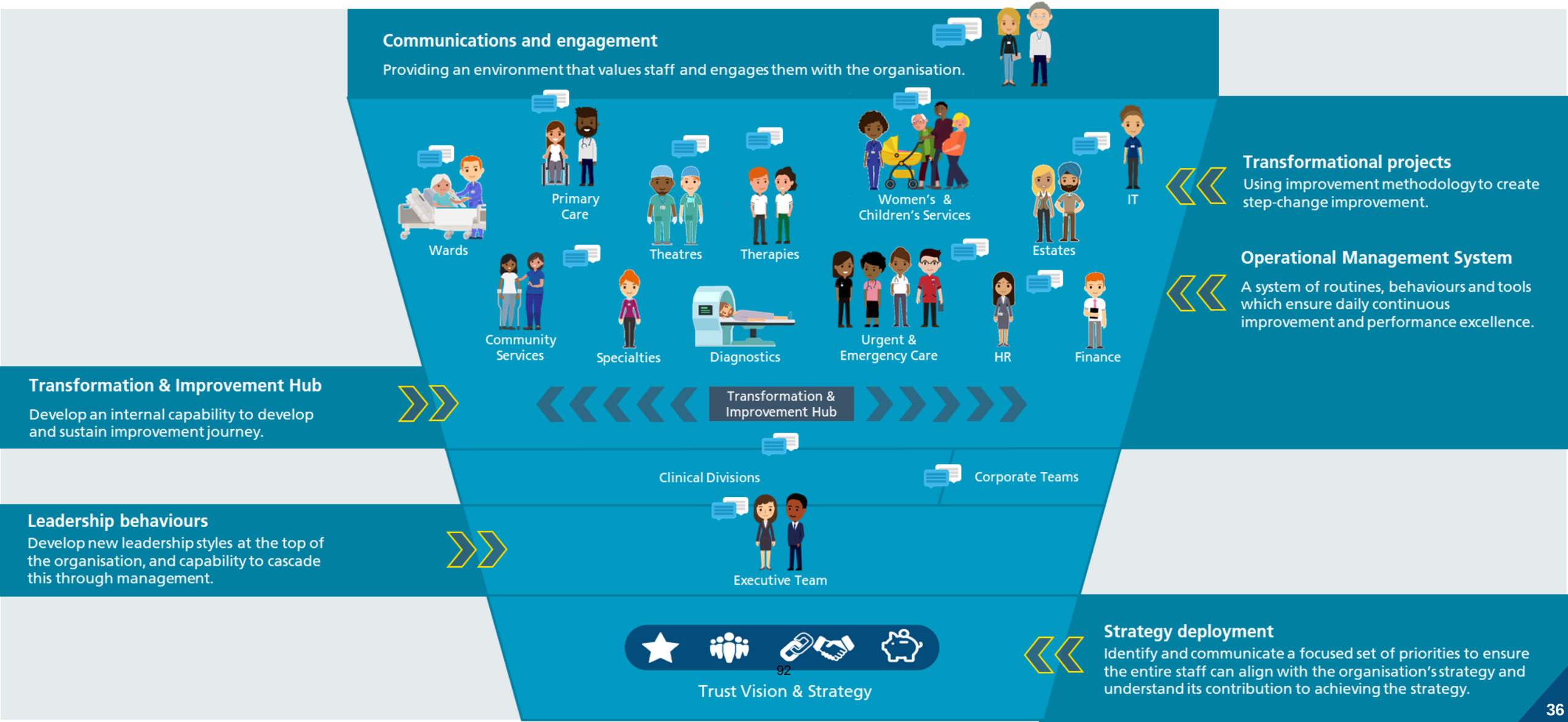
Level	Daily	Weekly	Monthly
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



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.

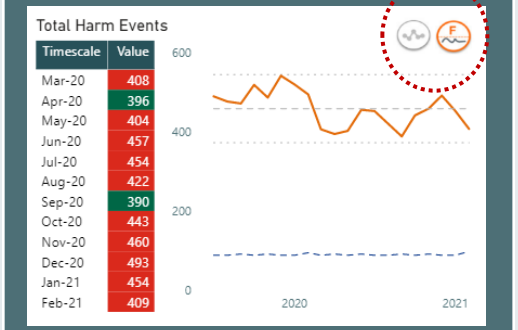
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

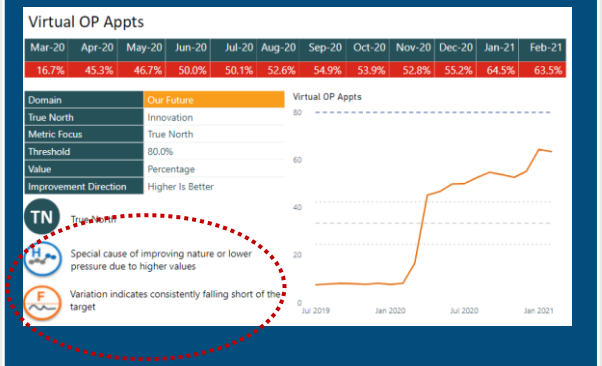
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling 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
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Term	Description
A3	A methodology used as part of Improving Together to ensure that problems, ideas, and areas for improvement are all approached in the same way. A3 provides a template for thinking through a problem, so that teams gain a good understanding of the problem and causes, before reaching a solution. Coined 'A3' after the A3 sized paper used to map the process, it consists of eight steps, with questions to work through. This visual tool provides a complete picture of the problem, contributions, and solution, on one page which should be displayed for all involved to see.
Breakthrough Objectives	The few significant changes we need to meet in order to achieve our vision. Objectives should be achieved within a 12-month period and through teamwork across the organisation.
Business Rules	A set of rules used to determine how metrics are discussed in Performance Review Meetings.
Corporate Projects	Large complex projects identified as a priority by the Executive Team which require the involvement of more than one team, and/or significant capital investment.
Countermeasure	An action to prevent a problem from continuing. It's not a solution so further action may be needed in the future if performance does not improve.
Countermeasure Summary	A document that summaries the A3 information used to explore a problem or area for improvement. It is presented at monthly Performance Review Meetings.

Agreed Terms

NHS
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Term	Description
Driver Lane	A visual management tool displayed on a team's Performance Board, containing driver metric information taken from A3 workings (e.g., problem statement, data, contributing factors, 3 C's or Action Plan). 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	**Audit, Risk & Assurance Committee**
Meeting Date	19 June 2024
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Annual Report and Accounts 2023/24	Approved	
2. ISA 260 Report 2023/24	Good Assurance	
3. Internal Audit Annual Report and Head of Internal Audit Opinion 2023/24	Good Assurance	
4. Internal Audit 2024/25 Progress Report and Action Tracking	Substantial Assurance	
5. Internal Audit – HFMA Final Report	Good Assurance	
6. Internal Audit – Consultant Job Planning Final Report	Good Assurance	
7. Internal Audit - Data Security and Protection Toolkit Final Report	Good Assurance	
8. Internal Audit – Capital Planning Final Report	Good Assurance	
9. Local Counter Fraud Annual Report 2023/24	Noted	
10. Local Counter Fraud Progress Report	Good Assurance	
11. National Cost Collection 2023/24 pre-submission assurance	Good Assurance	
12. Losses and Compensation Report Q4 2023/24	Noted	
13. Annual Committee Effectiveness Review	Approved	

POINTS OF ESCALATION	The Committee approved and recommended approval to the Board of the amended Terms of Reference for the Audit Risk and Assurance Committee.
KEY AREAS TO NOTE	The Committee received the ISA 260 Report from Deloitte for 2023/24 following the completion of their annual audit work and their Value for Money Review. The Committee approved the Annual Report and Accounts for 2023/24 and the letter of representation on behalf of the Board. The Committee received the KPMG Internal Audit Annual Report for 2023/24 which 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 the year end no actions were overdue. KPMG provided four final internal audit reports to complete the internal audits for 2023/24. These reports were a re-review of Consultant Job Planning, the Data Security and Protection Toolkit, follow up from the HFMA checklist review and Capital Planning. All the reviews were rated Significant Assurance with minor improvement opportunities. The Committee ask FIDC to consider the cultural and accountability aspects arising from the HFMA checklist review.
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The Committee recognised the extensive work that goes into the preparation of the Annual Report and the progress that had been made by the Finance Team in the completion of the annual audit for this year.
REFERRALS TO OTHER BOARD COMMITTEES	

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

Report Title	**Improving Together Year 2 Review**				
Meeting	**Trust Board**				
Date	**1 August 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Claire Thompson, Chief Officer – Improvement & Partnership				
Report Author	Emily Beardshall, Deputy Director – Improvement & Partnership				
Appendices	Improving Together Year 2 Review with appendices included Appendix 1 – Training Roll-out Appendix 2 – Strategic Planning Frameworks across the AHA Appendix 3 – Divisional Level Benefits				

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):

The purpose of this paper is to outline progress with our 'Improving Together' approach, to provide assurance that the resources are being deployed effectively and that there is a long-term sustainability plan.

The paper reviews the benefits framework for the roll out of the Improving Together approach; the paper lays out expected improvements in: process measures, output measures and outcome measures. This is based on the framework used for the year 1 review in June 2023. Progress across the Operational Management System (OMS) is detailed alongside assessment of the benefits seen, reflections and learning from year 2 of the implementation of Improving Together.

Overall the paper concludes that

- The current level and nature of benefits are on track against the framework set out in year 1. We are on track with process measures and seeing an increasing number of outcome measure benefits; these benefits are becoming more consistent across the OMS. Some outcome measures are emerging more quickly than expected including in organisational language and wider system and AHA working.

- However, sustainability with teams remains a concern and assessment against the evaluation model shows that some adaptation to our approach to maturity and embedding of huddles and routines may be needed. Ensuring strategic alignment across the organisation is key and this will require commitment and action from everyone across TMC and Board.

Priorities for year 3 are proposed as

1. Focus on sustainability:

- Simplifying the approach where it makes sense making sure our intelligence drives an Improving Together approach
- Increased focus on the performance review cascade & support for frontline teams; increasing the dialogue with specialties about their interaction with frontline teams
- Take an A3 approach to sustainability and maturity
- Recommit to the leadership behaviours, Executive Go & See to focus on waste walks

2. Increasing the patient/public voice

- Increasing the patient/public voice across our improvement work from training to ideas generation to joint problem solving
- Support the role of Governors and NEDs within the Operational Management System to ensure it delivers accountability
- Increase medical inclusivity

3. Design for the future

- Development of Improving Together in the AHA and System space
- Draw on momentum from NHS Impact to support our growing maturity
- Develop our training needs assessment for key roles and review how training will evolve as implementation proceeds

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 BAF S1 – Outstanding Patient Care				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Improving Together Steering Group – May				
Next Steps	Enact year 3 priorities with support of the Board				

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		X	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?		X	
Explanation of above analysis: The subject of this paper is the roll out of an operational management system that places quality improvement at the heart of the work of the Trust. As such it has no directly positive or negative impact on protected groups, but there is an opportunity through the recommendation to increase patient and public voice to consider traditionally under-represented groups			

Recommendation / Action Required The Board/Committee/Group is requested to:	
Trust Board are asked • to receive the reflections and learning to support the refinement of our practice • to discuss the suggested priorities for year 3 and consider the role of Board members in moving these forwards. This may include reflecting on further learning or support Executives and Non-Executives may need to undertake these roles.	
Accountable Lead Signature	
Date	25th July 2024

Great Western Hospitals
NHS Foundation Trust

Improving Together Year 2 Review

Trust Board 2nd August 24

Improving
together

Year 2 Review

Great Western Hospitals NHS Foundation Trust

Purpose

May 2024 marked the end of the second year of deployment of the Improving Together approach to continuous quality improvement across the organisation.

The purpose of this paper is to outline progress with our Improving Together approach, to provide assurance that the resources are being deployed effectively and that there is a long-term sustainability plan.

It reviews the benefits framework for the roll out of the Improving Together approach building on the model used in the year 1 review (June 2023) that shows the expected improvements in: process measures, output measures and outcome measures.

Progress across the Operational Management System (OMS) is detailed alongside reflections and learning.

The Operational Management System

Great Western Hospitals NHS Foundation Trust

Refresh of the OMS for 2024/25

- 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. Improving Together is not a project but 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.
- This is not a 'bolt on' to existing work but provides the operating system for our organisation, through a structure of processes and routines that link 'board to ward' (the Operational Management System, or OMS). We have been using this approach since 2022 to deliver our vision and the 4 pillars we want to be known for. It has become the golden thread that runs through all that we do to make Great Western Hospitals a safer place to receive care and a better place to work.
- Key to the Improving Together approach is that by aligning around a smaller number of priorities and enabling teams through standard systems and tools, improvement is delivered in the processes and outcomes of the organisation. Improving Together relies on a set of behaviours that encourages coaching to enable front line teams, who can best see what needs to change, to find and deliver the improvements required. Importantly it also emphasises that by focussing on a smaller number of priorities, leaders are more respectful of individuals' and teams' time, and can have higher expectations of the delivery of improvement.
- The table below outlines the way in which Improving Together allows us to map our overall strategic intent to specific measurables (pillar metrics) which will help us understand if we are 'winning or losing'; this is known as our Strategic Planning Framework and has recently been updated for 2024/25. The pillar metrics are then cascaded through the organisation through the operational management system, based around a set of improvement routines (including huddles, scorecard agreements and performance reviews) and lean tools and techniques.

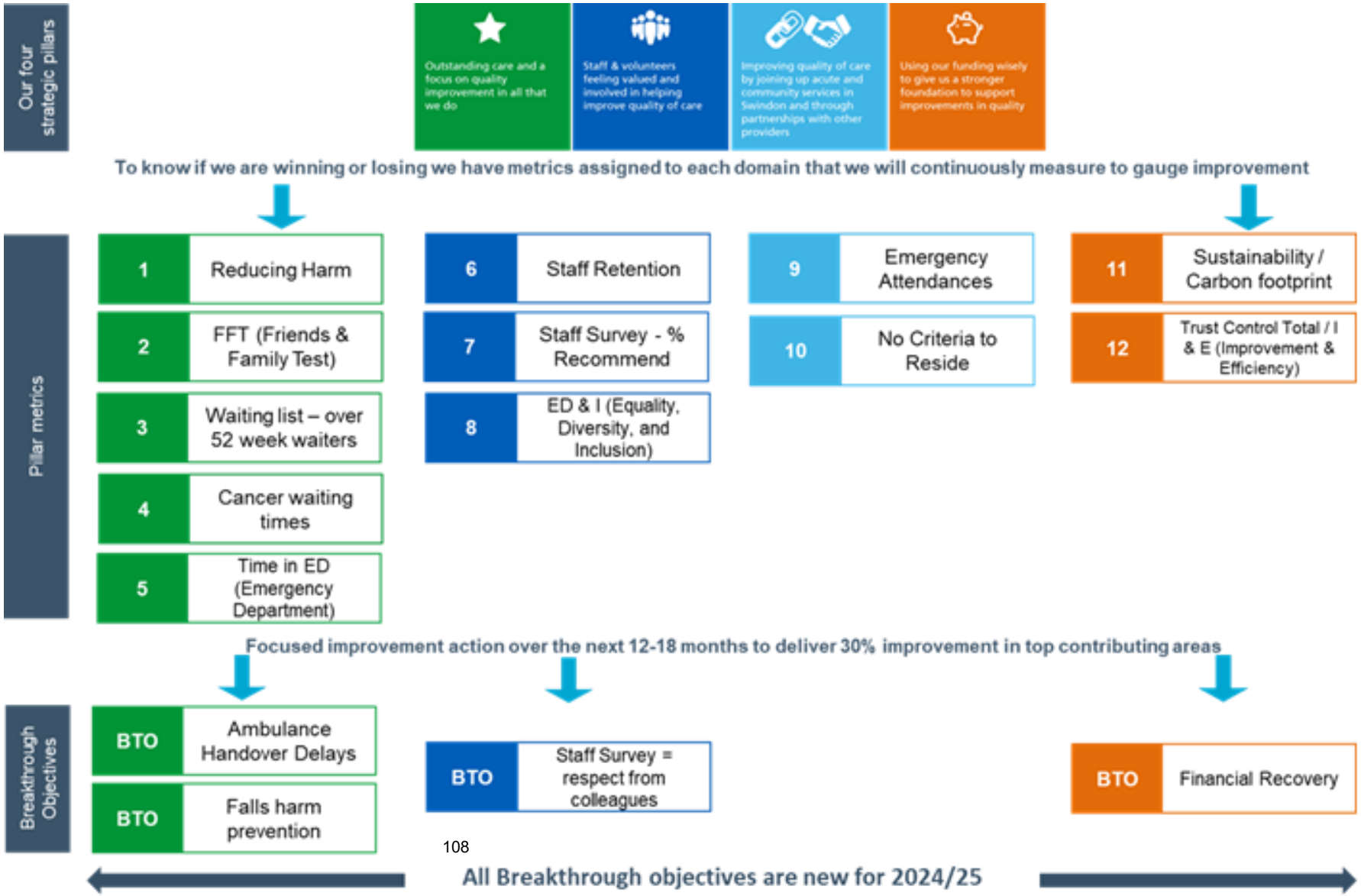
The Operational Management System

Refresh of the OMS for 2024/25

Great Western Hospitals NHS Foundation Trust

Breakthrough objectives have been refreshed for 2024/25 as existing ones had been in place for up to 18 months.

The OMS will be reviewed during 2024/25 as we put into action our refreshed strategy



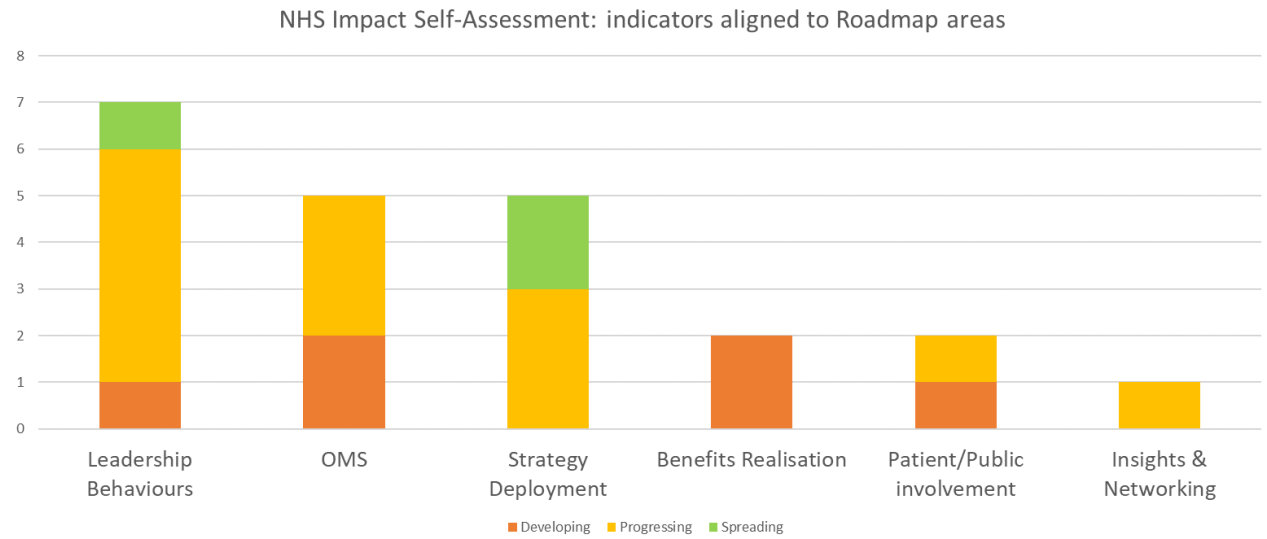
Context of NHS Impact

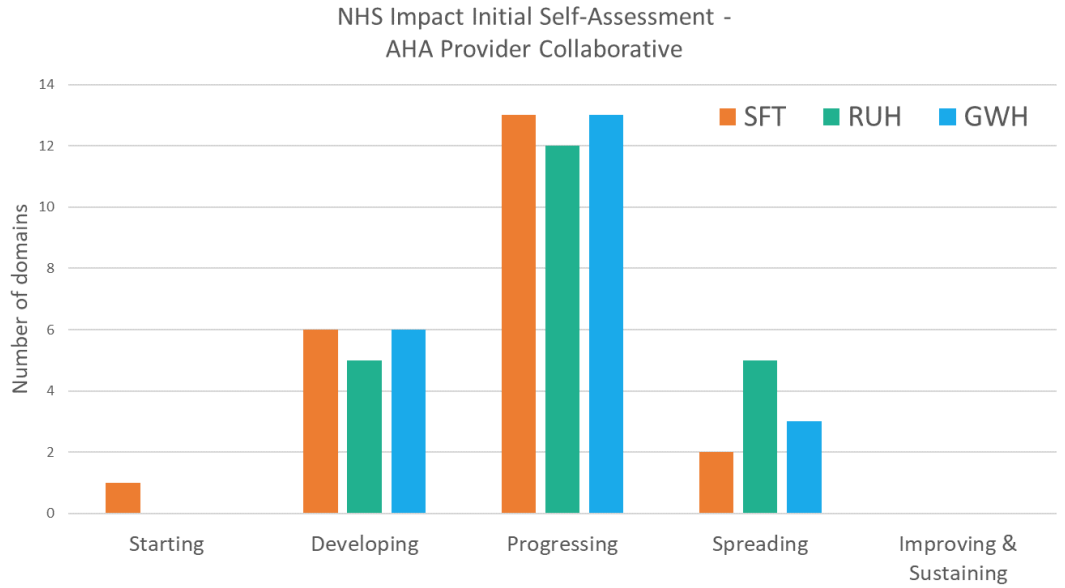
Great Western Hospitals NHS Foundation Trust

NHS Impact 2023

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

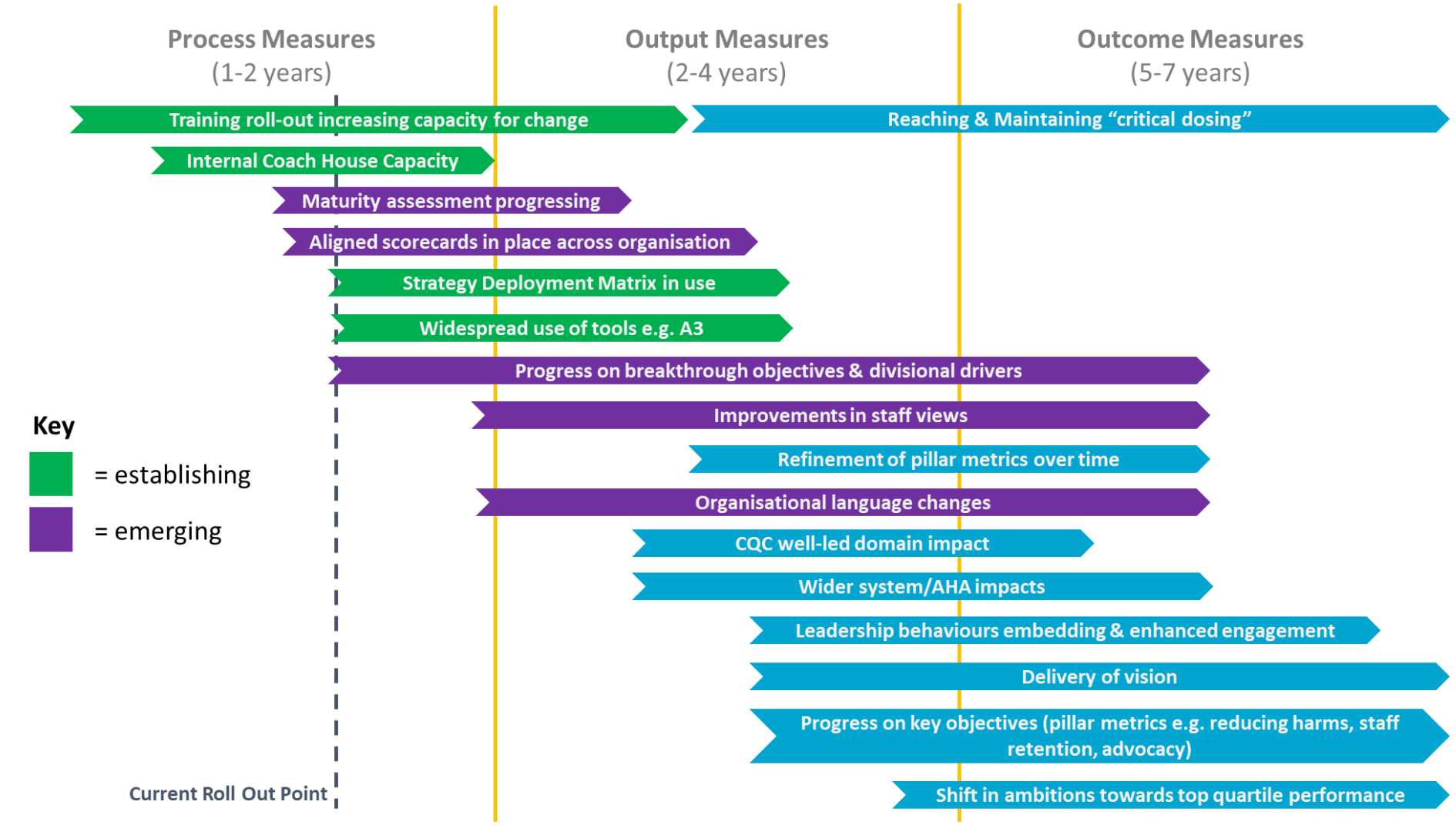
The 5 key components align extremely well with the Improving Together approach and this was born out by our initial self-assessment against the NHS IMPACT tool in October 2023 where we show particular strengths against the NHS IMPACT indicators that align to leadership behaviours and strategy deployment.





Year 2 review

The Framework – from year 1

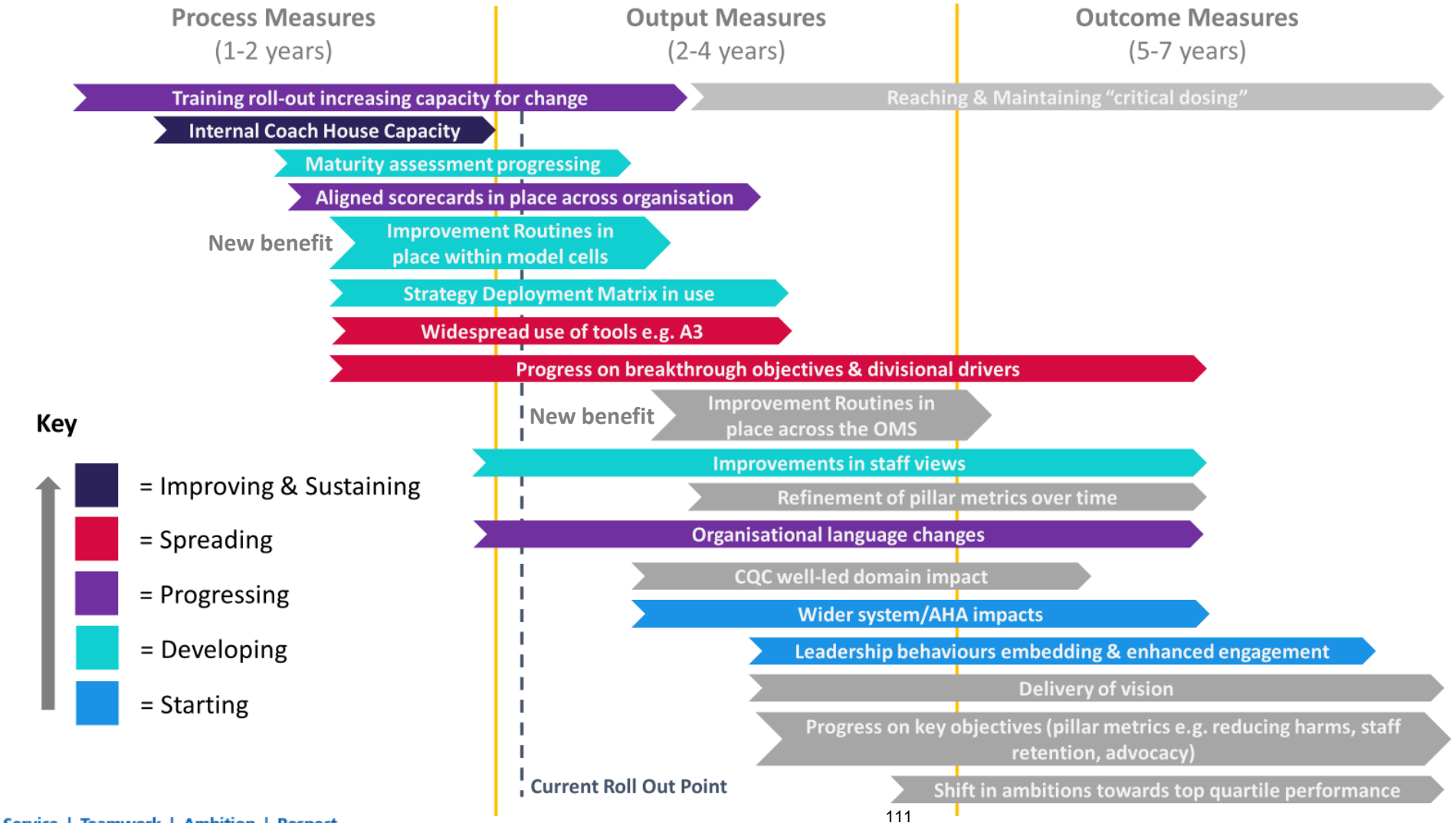


The benefits framework from the June 2023 review showed how we expected to move from process measures, towards outputs and then improving outcomes.

We have used this framework again for year 2 (next page) but have used the NHS Impact criteria for assessment of maturity

Year 2 review

Updated for year 2



Two new anticipated benefits added around routines being in place within the organisation

Good progress is being made with some elements starting earlier than expected.

Routines and maturity assessment perhaps slightly behind where we would expect

Year 2 review – the plan

Great Western Hospitals NHS Foundation Trust

Maturity & Sustainability

- During year 2 there has been an increased focus on the sustainability of the management system particularly looking at the interface between the frontline, specialty, division and executive layers. The strategic deployment down through these layers is essential to creating respect, focus and alignment and is felt to be a top contributor towards sustainability.
- An A3 on sustainability is in place and there is regular dialogue with the Executive and divisional teams on progress and areas for escalation.
- We are actively reviewing our approach to staff training and its effectiveness. We have taken a similar approach to the year 1 review and we aim to draw on the Kirkpatrick model[1] and alignment to NHS Impact over time
    - Level 1: training feedback & dosing of organisation
    - Level 2: learning understanding and confidence (not currently recorded)
    - Level 3: adoption of tools and sustainability
    - Level 4: benefits realised, outcomes improved
- We are actively developing a training needs assessment for the organisation which reflects the current and planned training “dosing” of the organisation.

[1]Internationally recognised model to evaluate effectiveness of training programmes

Roll-out of training

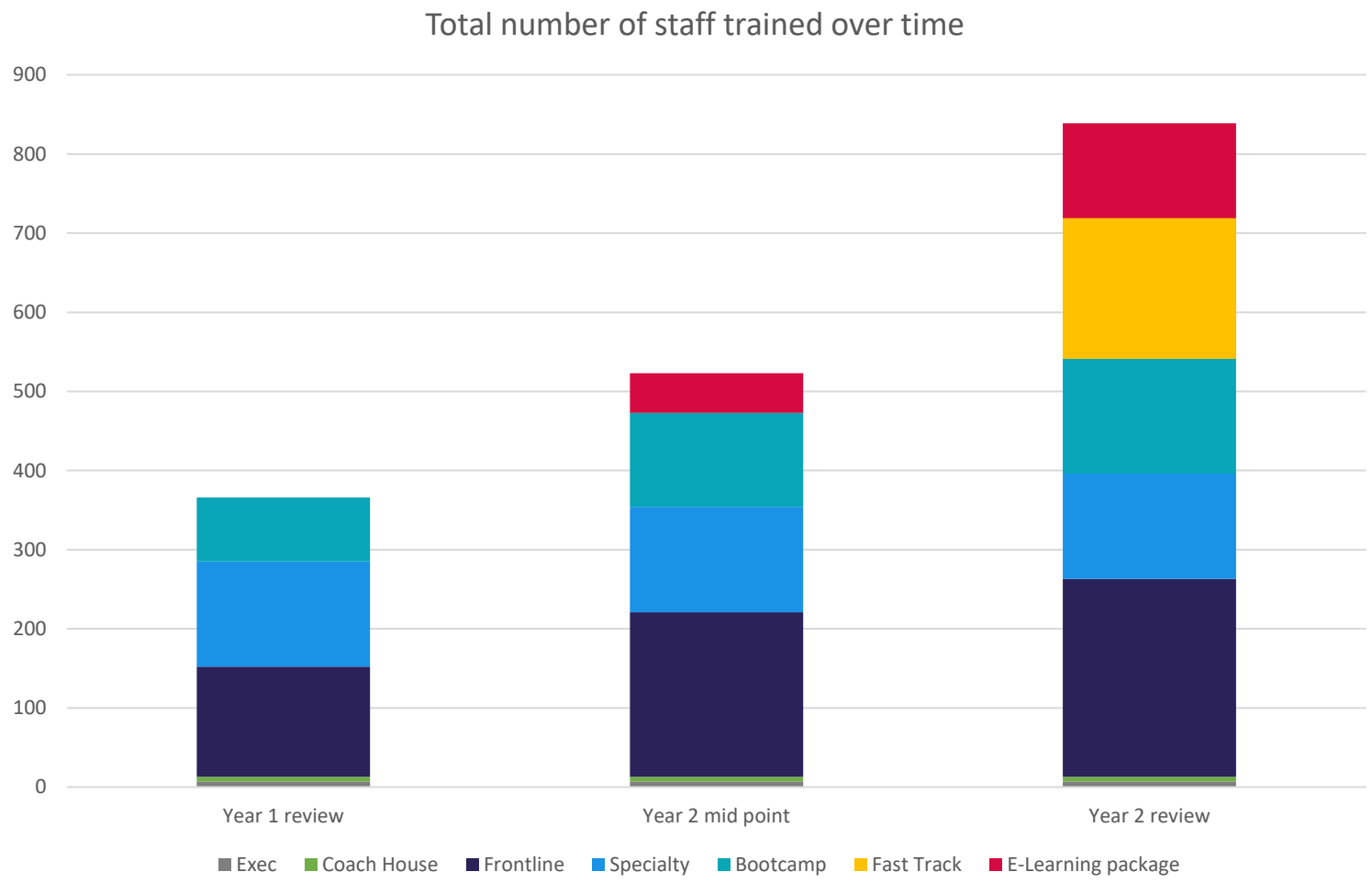
Great Western Hospitals NHS Foundation Trust

- Training has evolved this year
- **Fast Track** training has been introduced alongside other modes
  - Self-selecting – tend to be smaller frontline teams and corporate teams
  - Tailored to meet the need of teams
  - Delivered at a time and pace that works for the team
- **Frontline** training has continued
  - We have updated our training formats to support the operational context reducing from five to four modules.
  - Increased involvement from divisional and specialty teams has made a big difference
  - Coaching sessions have been changed to “working session” delivered at durations and times that suite the teams
  - Content has been simplified to be directed at what the teams need at the start of their journey
- **Induction:** We have introduced training into corporate induction

Fast Track Training	Frontline Training	Boot Camp
(Lighter Touch bespoke training)	*(6 teams per cohort)*	*(Intense Overview)*
Technical training on specific tools and routines relevant to the team.	Technical training and coaching to develop skills, tools and routines	Technical training to give an overview of the Improving Together tools and methodology
1-2 hour sessions every 2 weeks	1 Full Day & 6 hour working group sessions per month	3 Full Days
(Over 2 months)	*(Over 5 months)*	*(Over 3 weeks)*
Time Commitment : 12 Hours	Time Commitment : 64 Hours	Time Commitment: 22.5 Hours
Provided one to one with a team as Coach House capacity allows	2 cohorts per year Each cohort has 6 teams of 10 – 15 people from the team	3 courses per year Each course has up to 60 places

Training Roll-Out

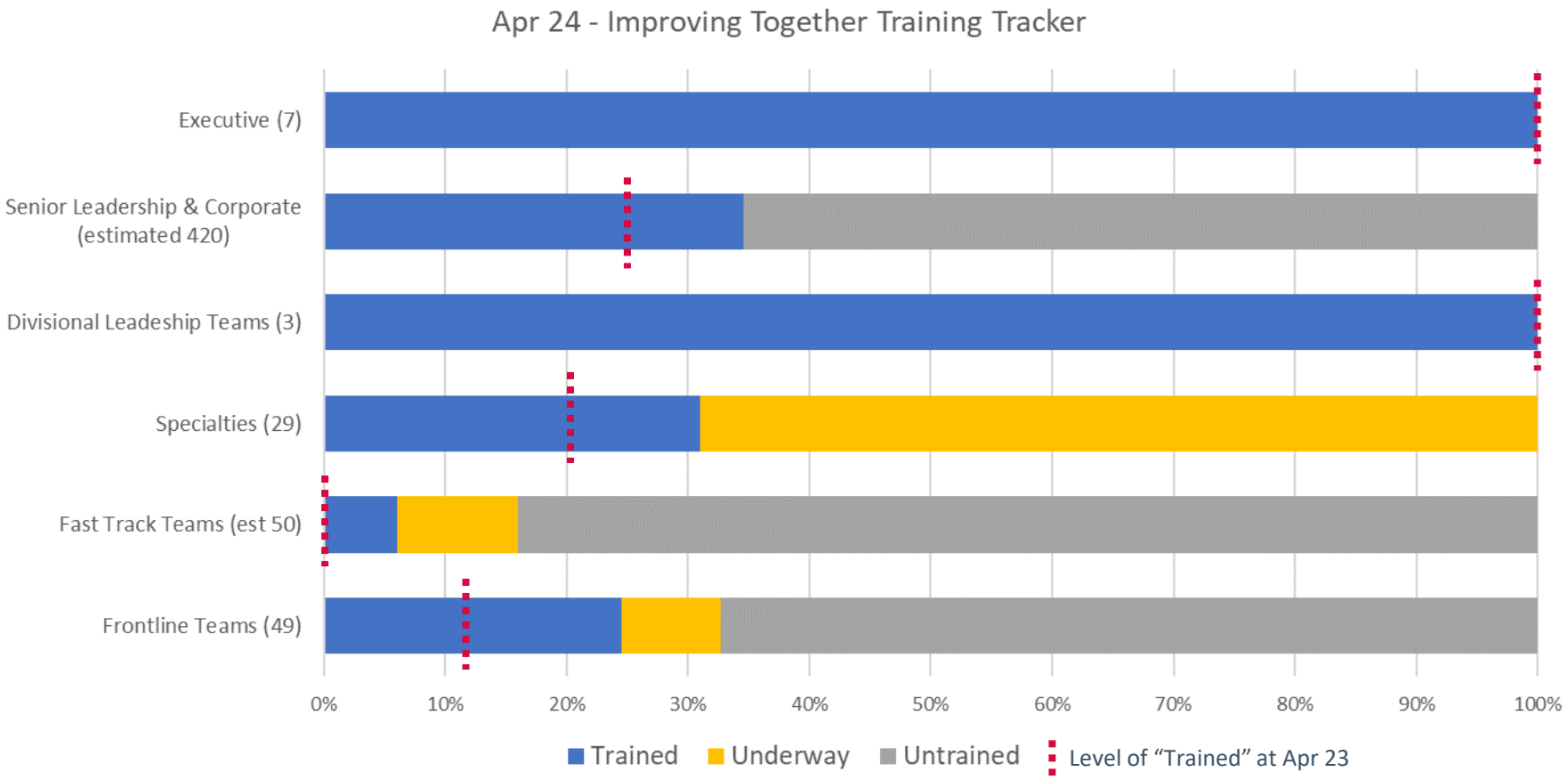
Individuals trained



- Training is progressing at a good rate, with the second half of 2023/24 accelerating due to fast-track training development. Approximately 15% of staff have now received targeted Improving Together training.
- Improving Together material is present in all “in house” leadership development training including Network & Navigate
- Increased alignment with junior doctor QI training and New Consultant programme
- Teams who have received frontline and fast track training are shown in appendix 1
- Fast Track training appears to be a better mode of delivery for community teams and this is being further trialled and refined.

Training Roll-Out

Teams Training

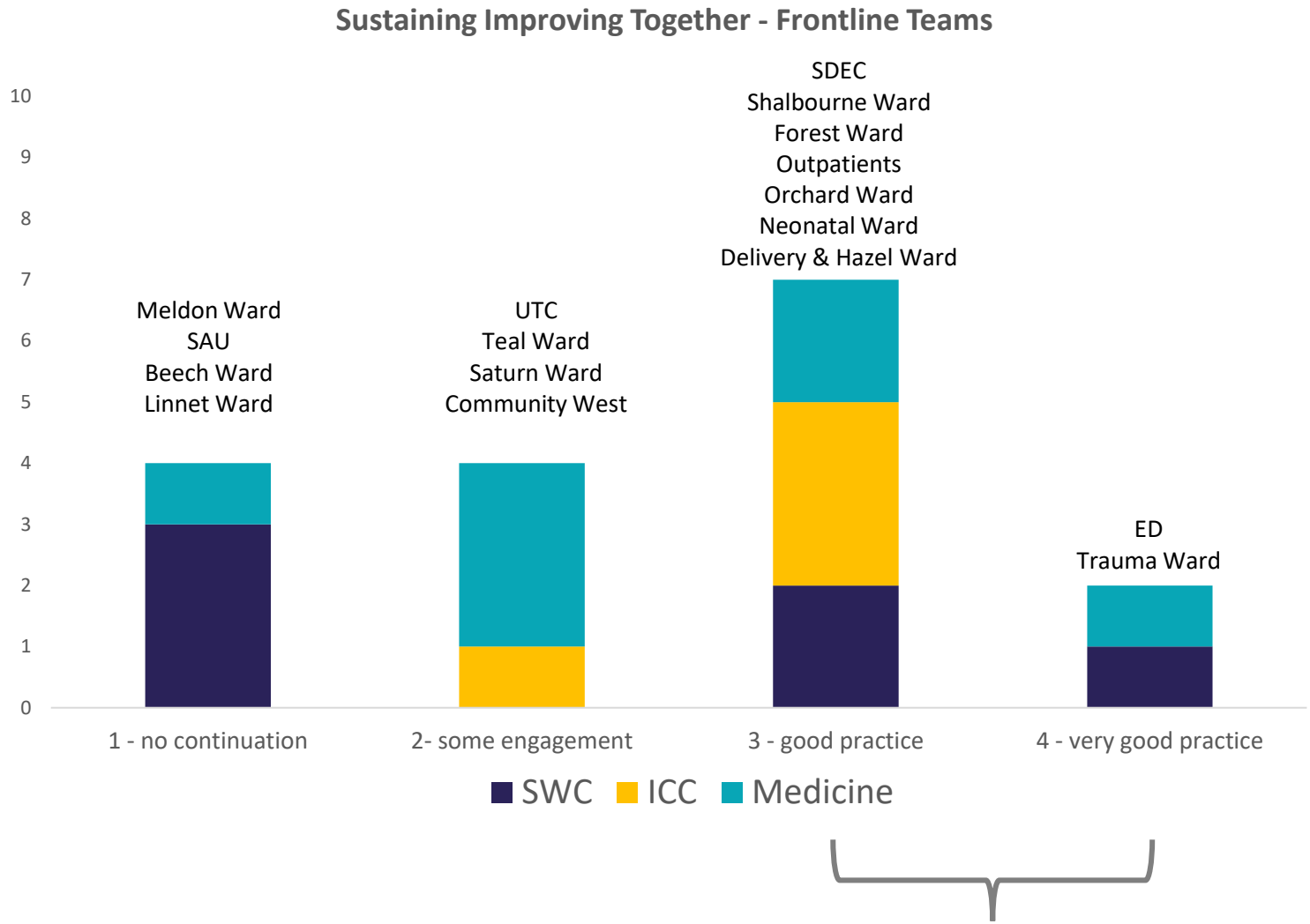


- Roll-out is expected to take 5-7 years
- Organisational "dosing" moving at expected rate.
- Expect around 50 teams to move through fast-track training
- Training will need to continue to evolve as we progress further into the roll out
- Turnover of staff out of the organisation and between teams has created some sustainability issues

Year 2 review – the plan

Great Western Hospitals NHS Foundation Trust

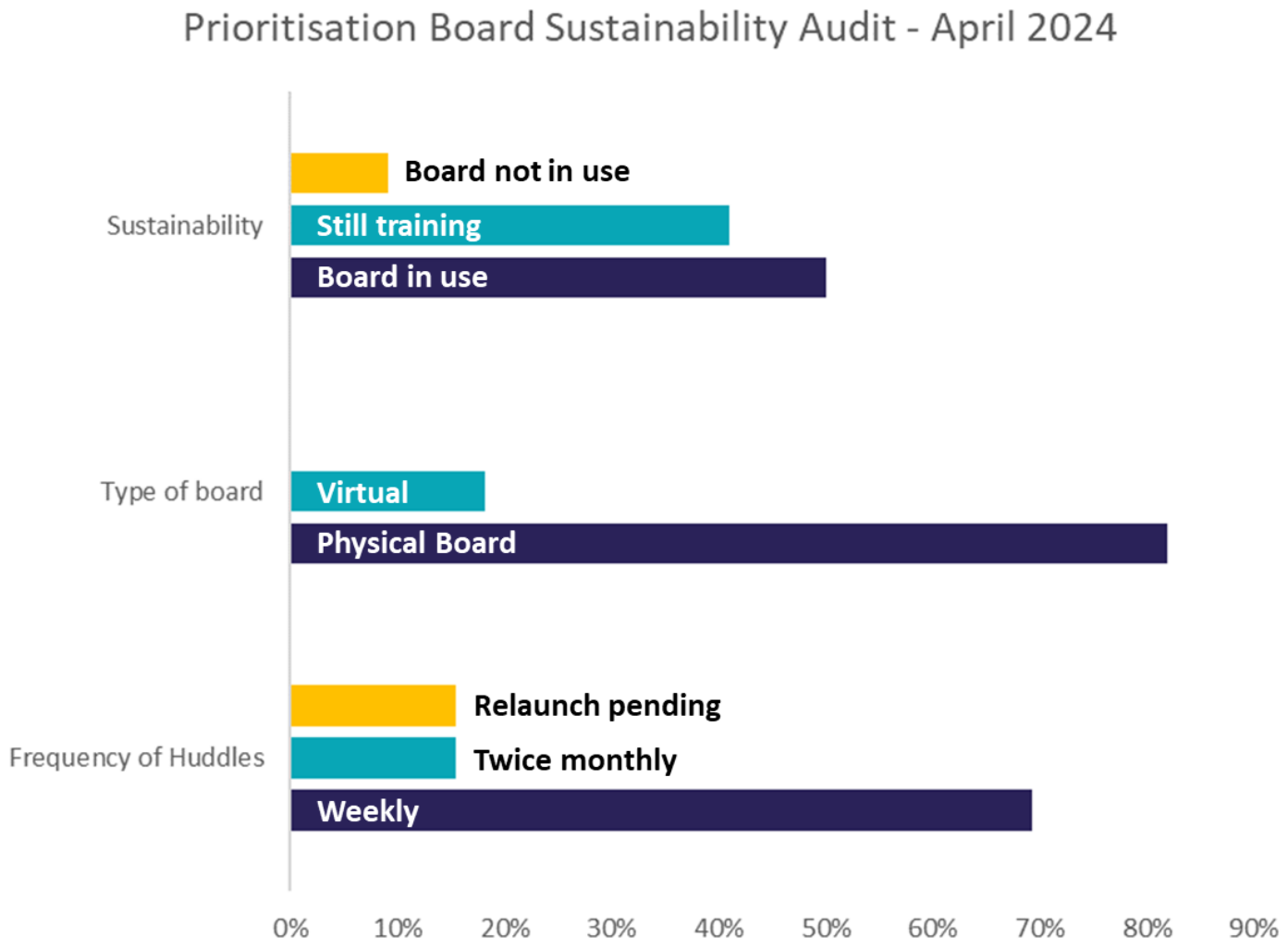
Maturity & Sustainability – Frontline Teams



- 16 frontline teams have undertaken our frontline training, Meldon ward did not complete the training due to changes that were taking place on the ward.
- The training supports teams to begin regular improvement huddles in their areas to support conversations across the team on generating and developing improvements.
- We have found that adapting the frequency and timing of the huddles has supported teams to find them more manageable with many of the teams huddling between 2 and 3 times a week.
- Sustainability is varied across the teams with around half of the teams finding that they are able to maintain the routine. A number of teams have received support to relaunch huddles and this remains an option.
- Main causes of huddles stopping are
  - Changes/turnover in team members
  - Not building huddles into the daily flow of work so that it feels “on top of” other jobs
  - Lack of accountability to the rest of the OMS (lack of Go & See, performance review meetings etc)
  - Lack of “status exchange” across the organisation
- The Coach House are developing a sustainability A3 to review how we might simplify the approach further and work with specialties and divisions on the top contributors around sustainability.

Prioritisation Board

Smaller Teams/Fast-Track Teams



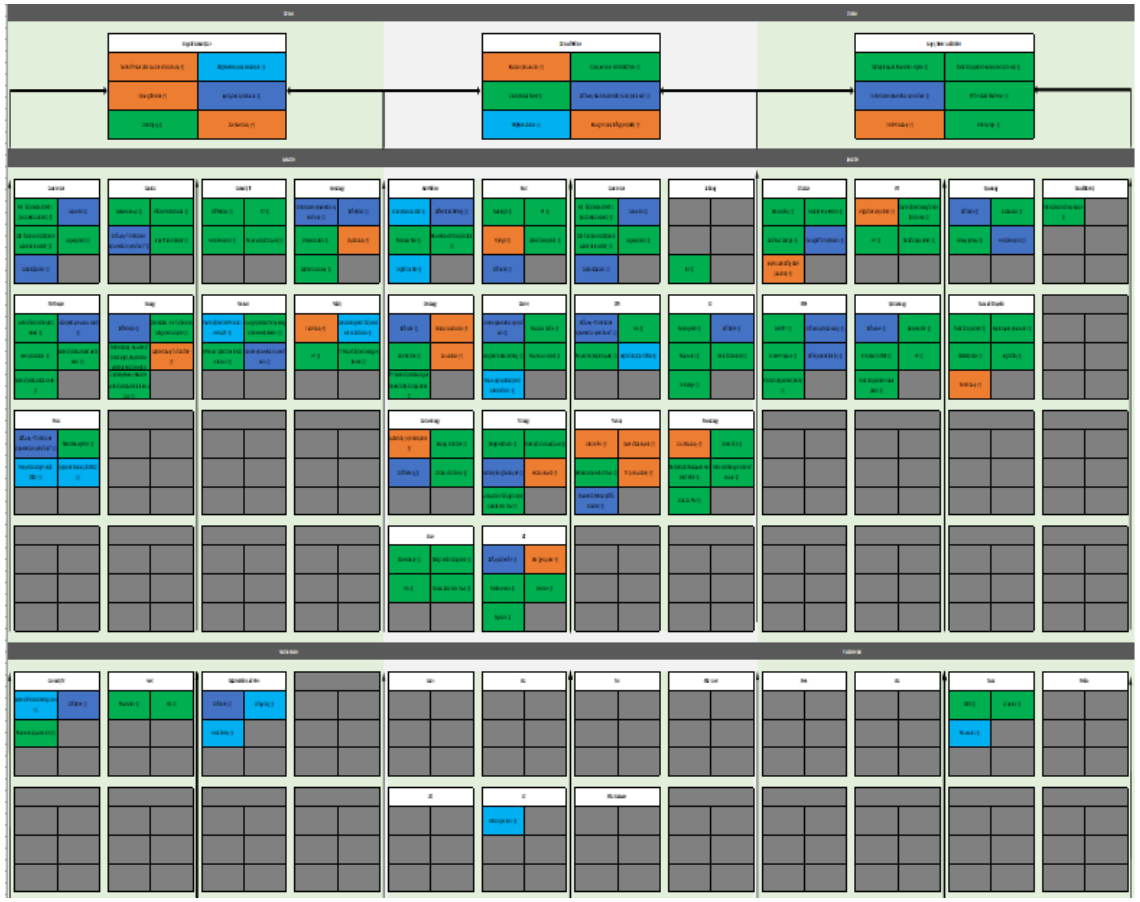
- Prioritisation boards are used for smaller teams often alongside fast-track training.
- Teams are self-selecting
- Training is tailored to teams and delivered at times and durations that work for the team
- Huddles are being sustained at a very high rate with the majority being held weekly
- The learning from prioritisation boards will be drawn into the sustainability A3

Strategic Alignment

Great Western Hospitals NHS Foundation Trust

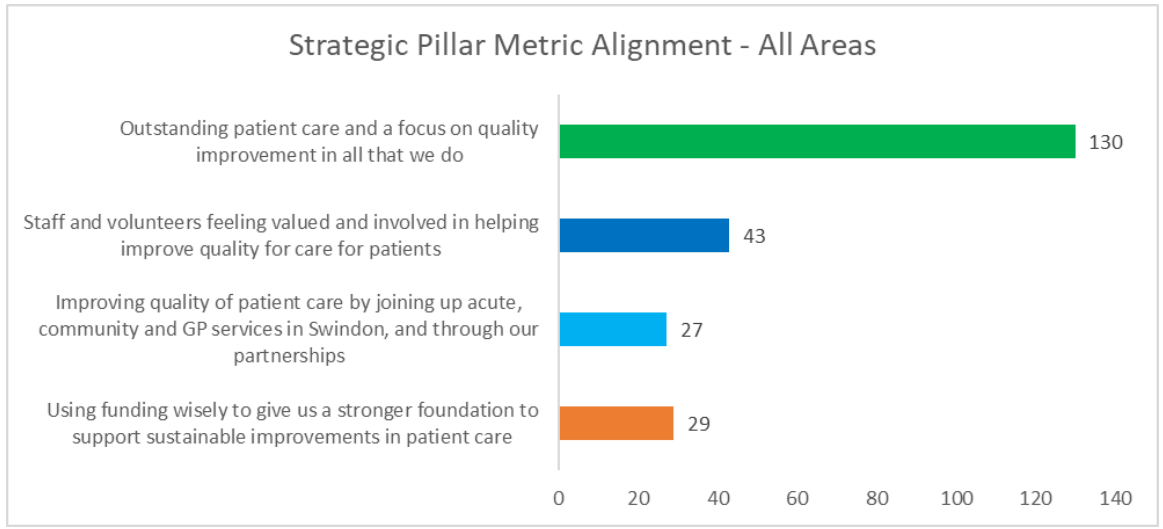
Metric Alignment

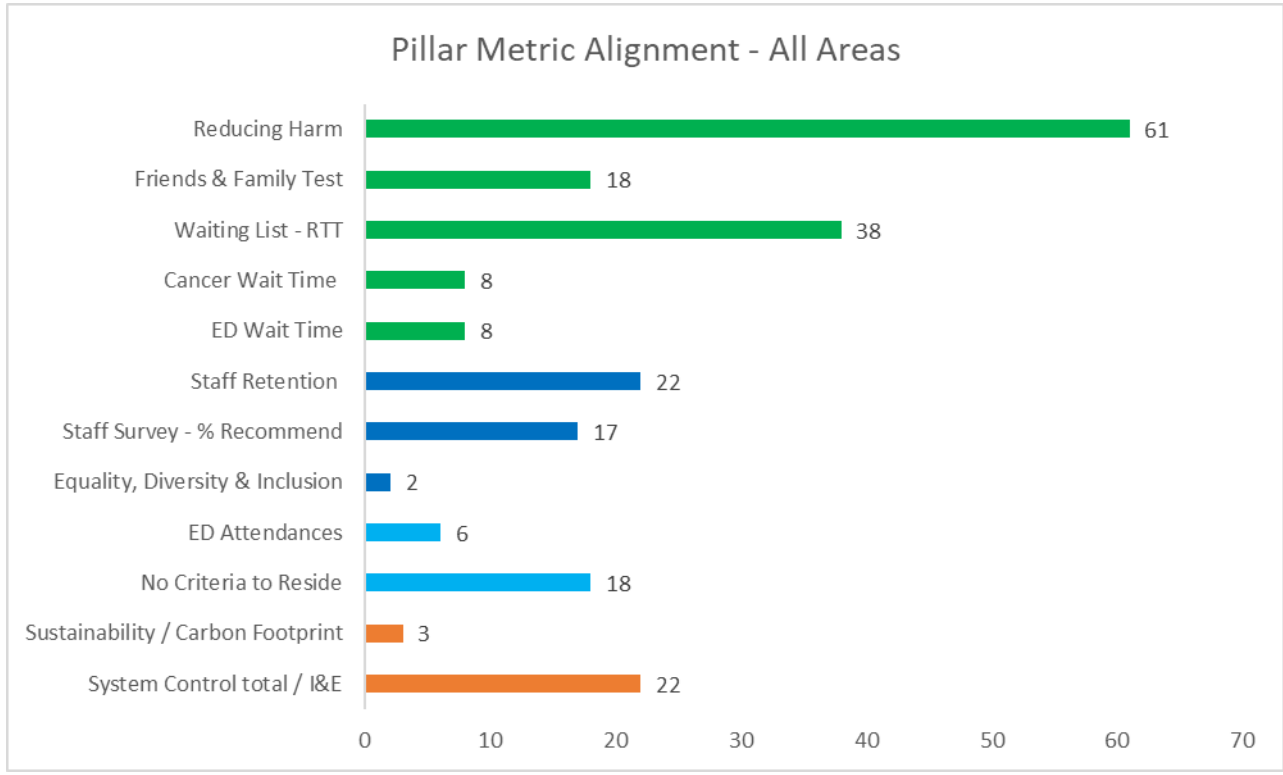
- 6 monthly audit of driver metrics across the organisation (last completed in April 24)
- Gives an assessment of which driver and breakthrough objectives have improvement energies aligned across our Trust
- Good visibility of divisions and frontline teams
- It has been difficult to obtain consistent information from specialties and scorecard maturity much lower across specialties



Strategic Alignment

Metric Alignment





A review of driver metrics across the organisation takes place twice per year. The audit in April 2024 shows that there are 229 drivers across the OMS. Of these 97% align to one of our pillar metrics; the alignment of the drivers to our pillar metrics is shown above. We have also produced maps that show alignment across the organisation. There is very strong alignment to our outstanding patient care pillar with 31% of our drivers being aligned to this pillar. Lower alignment is seen for the following pillars

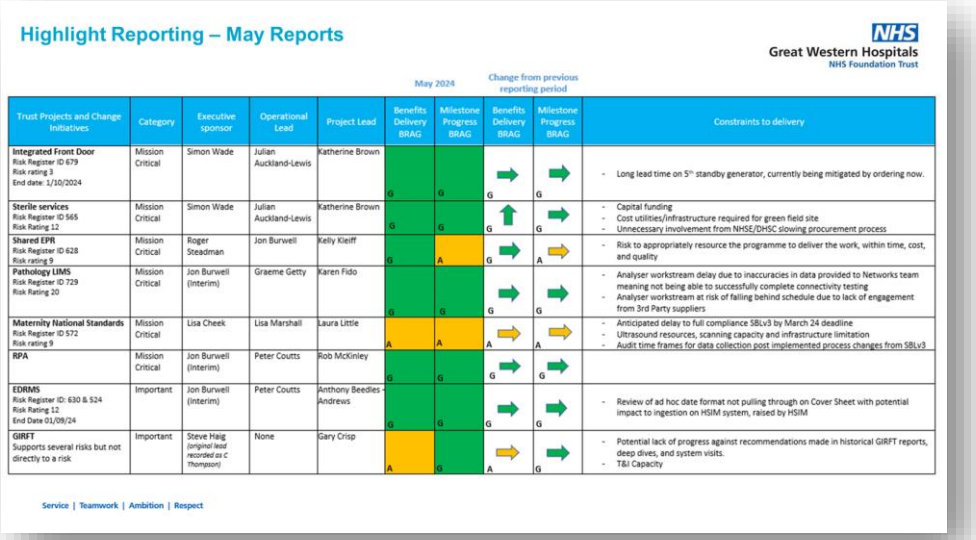
- Equality Diversity & Inclusion
- Sustainability
- Trust financial control total/financial recovery – the audit was taken before financial recovery became a breakthrough objective and therefore alignment is expected to increase in the coming months.

Corporate Projects & SDM

Metric Alignment

During 2023/24 the corporate project routine fully embedded with Trust Investment Group performing review and reporting into TMC. There is improved visibility of the resource requirements and relative prioritisation of projects. Highlight reports are intended to give an overview of the portfolio of work and show where work is off track leading to good discussions about resourcing and intended outcome. A full review of the impact/implementation prioritisation grid is scheduled for TIG in July. Financial recovery workstreams have been added to the strategy deployment matrix as they aim to support the Trust breakthrough objective.

We have 5 Strategic Initiatives that are our “must do, can’t fail” programmes of work needed for organisational health and delivery of strategy over the next 3-5 years. Whilst progress is being made in our Strategic Initiative areas our engine room routines for review are not well developed. The plan for year 2 was that these would report A3 summaries on a bi-monthly basis with a deep dive at TMC Away Day once a year. One deep dive has taken place for The Way Forward Programme.

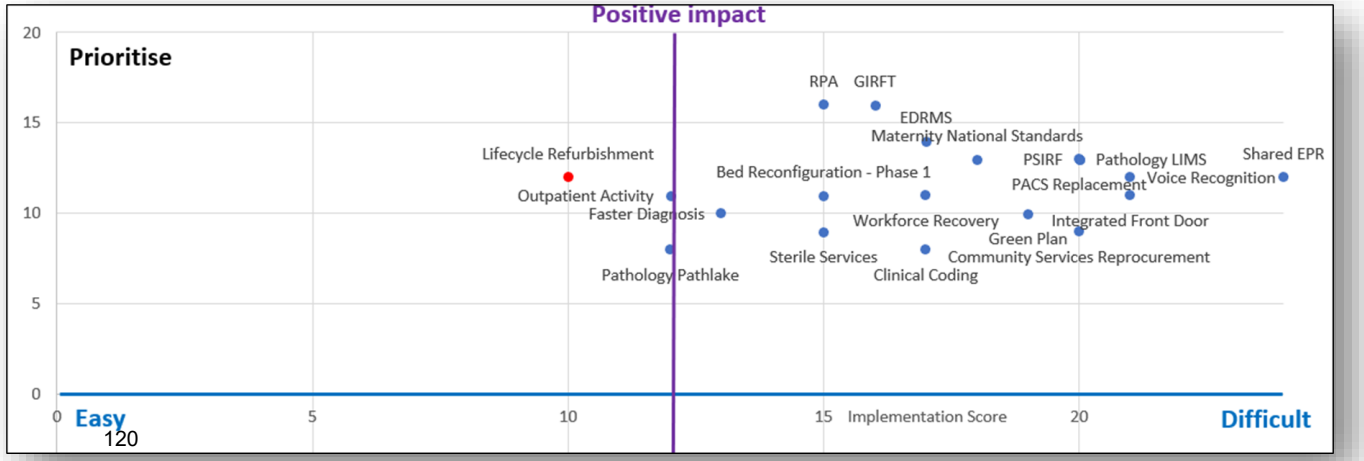


Highlight Reporting – May Reports

Great Western Hospitals NHS Foundation Trust

Trust Projects and Change Initiatives	Category	Executive sponsor	Operational Lead	Project Lead	May 2024: Benefits Delivery BRAG	May 2024: Milestone Progress BRAG	Change from previous reporting period: Benefits Delivery BRAG	Change from previous reporting period: Milestone Progress BRAG	Constraints to delivery
Integrated Front Door Risk Register ID 679 Risk rating 3 End date: 1/10/2024	Mission Critical	Simon Wade	Julian Auckland-Lewis	Katherine Brown	G	G	→	→	- Long lead time on 5th standby generator, currently being mitigated by ordering now.
Sterile services Risk Register ID 565 Risk Rating 12	Mission Critical	Simon Wade	Julian Auckland-Lewis	Katherine Brown	G	G	↑	→	- Capital funding - Cost utilities/infrastructure required for green field site - Unnecessary involvement from NHSE/DHSC slowing procurement process
Shared EPR Risk Register ID 628 Risk rating 9	Mission Critical	Roger Steadman	Jon Burwell	Kelly Kleiff	G	A	→	→	- Risk to appropriately resource the programme to deliver the work, within time, cost, and quality
Pathology LIMS Risk Register ID 729 Risk Rating 20	Mission Critical	Jon Burwell (Interim)	Graeme Getty	Karen Fido	G	G	→	→	- Analyser workstream delay due to inaccuracies in data provided to Networks team meaning not being able to successfully complete connectivity testing - Analyser workstream at risk of falling behind schedule due to lack of engagement from 3rd Party suppliers
Maternity National Standards Risk Register ID 572 Risk rating 9	Mission Critical	Lisa Cheek	Lisa Marshall	Laura Little	A	A	→	→	- Anticipated delay to full compliance SBLv3 by March 24 deadline - Ultrasound resources, scanning capacity and infrastructure limitation - Audit time frames for data collection post implemented process changes from SBLv3
RPA	Mission Critical	Jon Burwell (Interim)	Peter Coutts	Rob McKinley	G	G	→	→	
EDRMS Risk Register ID: 630 & 524 Risk Rating 12 End Date 01/09/24	Important	Jon Burwell (Interim)	Peter Coutts	Anthony Beedles - Andrews	G	G	→	→	- Review of ad hoc date format not pulling through on Cover Sheet with potential impact to ingestion on HSIM system, raised by HSIM
GIRFT Supports several risks but not directly to a risk	Important	Steve Haig *(original lead recorded as C Thompson)*	None	Gary Crisp	A	G	→	→	- Potential lack of progress against recommendations made in historical GIRFT reports, deep dives, and system visits. - T&I Capacity

Service | Teamwork | Ambition | Respect



Board & Governance

Great Western Hospitals NHS Foundation Trust

Well-led review

Our recent CQC Well-led review acknowledges the contribution that Improving Together is making as a key enabler to our well-led approach noting that it is positively supporting changes to cultural indicators. The review also highlighted areas for further attention including

- A consistent focus on trajectories for improvement, action plans and tracking of impact supporting the holding to account.
- The need for key emphasis on embedding learning and assuring full implementation across the organisation
- Opportunity for clearer links between risks and improvement trajectories
- During 2023/24 we have introduced new Executive and Non-executive colleagues to the leadership behaviours and the OMS; taking new NEDs through revised induction process

"A collective approach with cultural, experiential and care impact data is likely to be of interest nationally as ICBs develop quality strategies and improvement hubs"

Leadership Behaviours

Great Western Hospitals NHS Foundation Trust

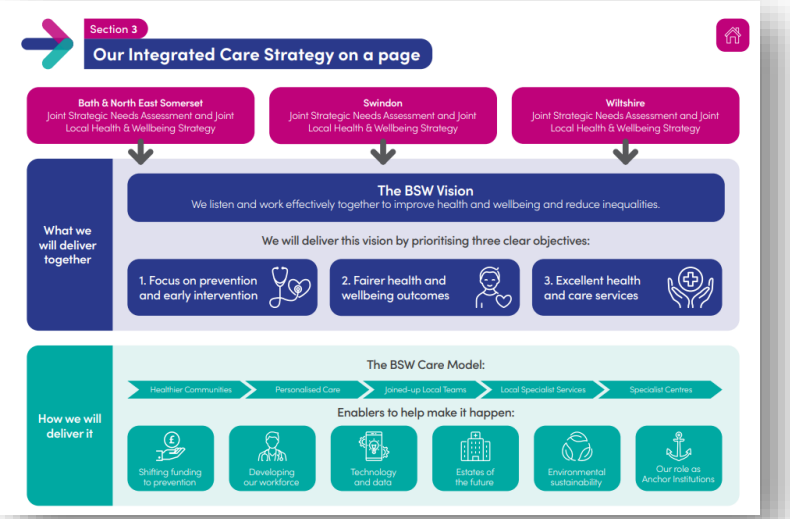
- During 2023/24 the organisation launched the Leadership Behaviours Framework and there continues to be good join-up between the Learning & Development team and the Transformation & Improvement Hub. A review of training between the two teams has ensured that all our core leadership and development training contains appropriate and consistent references and exposure to Improving Together; this includes preceptorship. Monthly masterclasses for leadership behaviours have begun over the last six months.

- Feedback from staff involved in Improving Together training are often keen to emphasise how much of a difference the training makes to the team's communication, respect and understanding. Content of the coaching sessions has been tailored to respond to this. Together we have developed a flow chart that helps to direct teams to the most appropriate training for them discerning between Organisational Development support and Improving Together. Links into the Just & Learning Culture work are important.

- The Academy are currently undertaking Fast Track training across all teams within the department and this is deepening understanding of the approach. We have worked with the Academy to support the registration of junior doctor (and other professional groups) Quality Improvement projects and also linked into junior doctor Quality Improvement training and the Network & Navigate programme.

System Working

Strategic Alignment with ICP strategy



Improving Together is a common approach across our Acute Hospital Alliance which has given us a great opportunity to collaborate across the provider collaborative.

Following an Executive workshop in March 2024 we are actively developing a Strategic Planning Framework across the AHA, focusing on strategic alignment with the BSW Integrated Care Strategy and areas where there is benefit in collaborating across the AHA to bring about faster or more resilient improvement.

We are developing a proposal for a shared SPF and routines that would support this approach being trialled in 2024/25. This work gives us an opportunity to influence how we define our contribution to the BSW vision and measure successes. Appendix 2 shows the 3 organisation level SPFs across the AHA.

Emerging Vision

Bath and North East Somerset, Swindon and Wiltshire Together

Vision: We listen and work effectively together to improve health and wellbeing and reduce inequalities

What "catch ball" conversation do we need?

- Does delivery on the AHA vision contribute to delivery of ICP vision?
- Are we clear how we would measure our contribution?

- Do we understand the work going on at system level that we need to influence and work with?
- Agreeing the approach to "excellent care" will be important

Acute Hospital Alliance

Vision: Working together to provide excellent care

Seeing the Benefits

Improving
together

Pillar Metrics

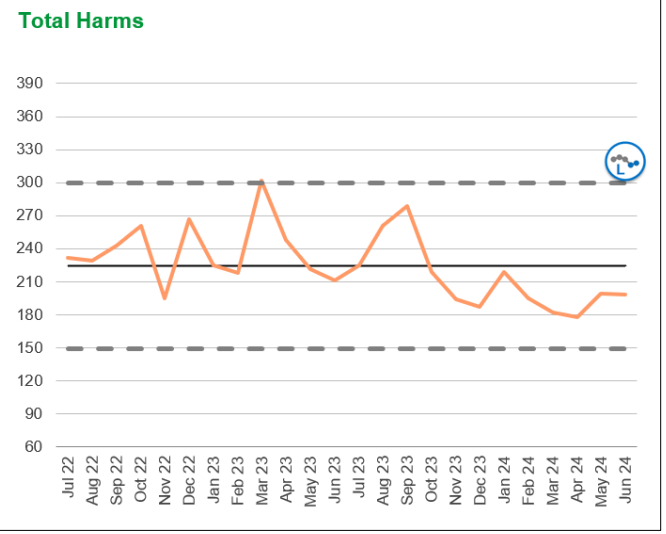
Great Western Hospitals NHS Foundation Trust

2023/24 Progress

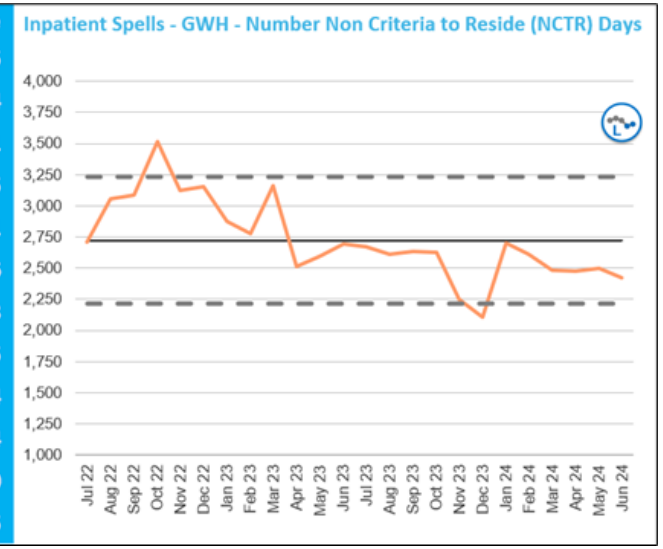
Our pillar metrics show how well we are delivering on our strategic pillars over the lifetime of our strategy. Ongoing measurement against our 12 pillar metrics have shown

- a 27% reduction in total avoidable harms across the Trust in the past two years, from 308 recorded in January 2022, to 198 in June 2024.
- a 70% reduction in pressure harms in our community patients in the past year, with 76 in August 2023, compared to an average of 24 per month over the six months of Jan – June 2024. This steady positive trend follows pressure harm being chosen as a breakthrough objective to focus on across the Trust, with many teams choosing this as a driver metric.
- a reduction in falls in the medicine division with the driver metric of less than 65 falls per month being consistently met for more than one year (since February 2023).
- a sustained reduction in the total number of days that patients are do not meet the criteria to reside (see graph)
- A reduction in the voluntary turnover rate of staff, with the Trust's rate sitting at 8.5% in May 2024 and below the national average of 11% for the past fourteen months.
- Improvement in positive responses in the Friends and Family test score which reached 90% in April 2024, an increase from 87% in January 2021 and above the Trust's internal target of 85%.
- A focus on increasing outpatient productivity including increasing in-session clinic utilisation from an average of 87.5% in 2022 to above 91% for the last 3 months.

Timescale	Value
Jul 23	225
Aug 23	261
Sep 23	279
Oct 23	219
Nov 23	194
Dec 23	187
Jan 24	219
Feb 24	195
Mar 24	182
Apr 24	178
May 24	199
Jun 24	198



Timescale	Value
Jul 23	2,675
Aug 23	2,614
Sep 23	2,631
Oct 23	2,625
Nov 23	2,251
Dec 23	2,106
Jan 24	2,703
Feb 24	2,615
Mar 24	2,484
Apr 24	2,474
May 24	2,500
Jun 24	2,425



Breakthrough Objective Refresh

Great Western Hospitals NHS Foundation Trust

2023/24 Progress

- Breakthrough objectives set between summer 2022 and March 2023
- Aim is for rapid improvement (of around 20-30%) over a 12-18 month period
- A breakthrough objective is derived from our understanding of where the biggest opportunity exists for improvement in our pillar metrics
- A breakthrough objective should be operational in nature and can be supported by frontline continuous improvement and corporate project resource
- Level of improvement seen for 23/24 breakthrough objectives (January 24 data)
- Breakthrough objectives have been refreshed for 2024/25

Breakthrough Objectives

		Aim	Progress
BTO	Clinicallyy ready to proceed	Reduce mean time from arrival to CRTP and from CRTP to admission	Pre CRTP remained static Post CRTP improved below mean position
BTO	Pressure Harms	30% reduction in harms	No significant change
BTO	Staff Survey = % improvements	Achieve 55% in staff survey (5.7% improvement)	5.8% improvement over 2 years Met expectation
BTO	Productivity	30% improvement in top cause	Early signed of improvement in pay productivity

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Pre CRTP	277	259	258	281	293	280	295	289	301	315	284	296
Post CRTP	608	629	467	492	373	352	326	504	449	433	254	414

Total Pressure Harms

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
95	51	57	64	42	57	47	56	37	74	78	57

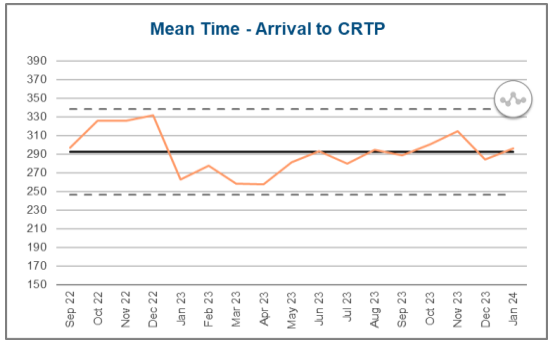
2019	2020	2021	2022	2023
56.70%	54.50%	49.30%	51.90%	55.10%

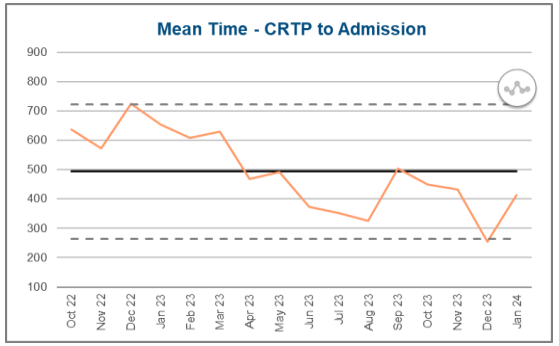
	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total	-18%	-18%	-17%	-25%	-25%	-21%	-20%	-22%	-17%	-15%	-14%	-16%
Pay	-15%	-14%	-19%	-27%	-26%	-11%	-9%	-11%	-2%	2%	6%	0%
Non Pay	-24%	-24%	-15%	-21%	-23%	-15%	-16%	-20%	-11%	-11%	-12%	-18%

Breakthrough Objectives

BTO Clinicallyy ready to proceed

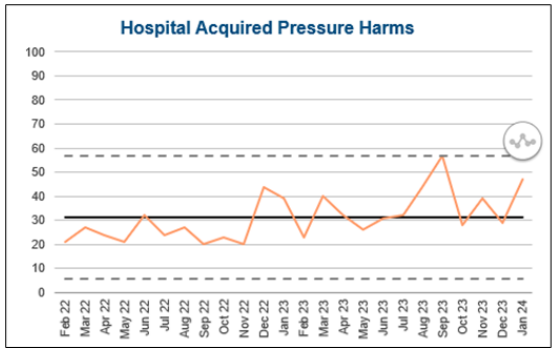
Set March 2023

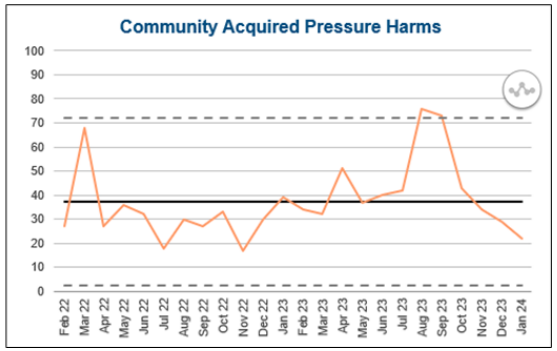




BTO Pressure Harms

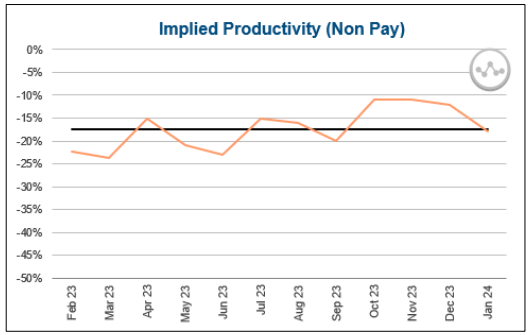
Set Summer 2022

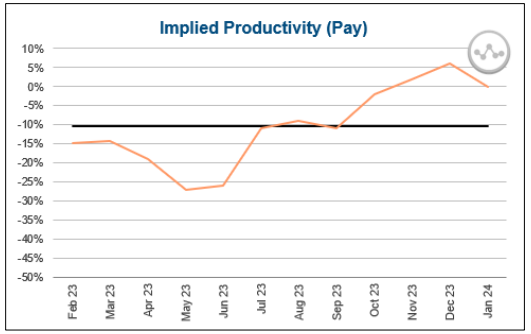




BTO Productivity

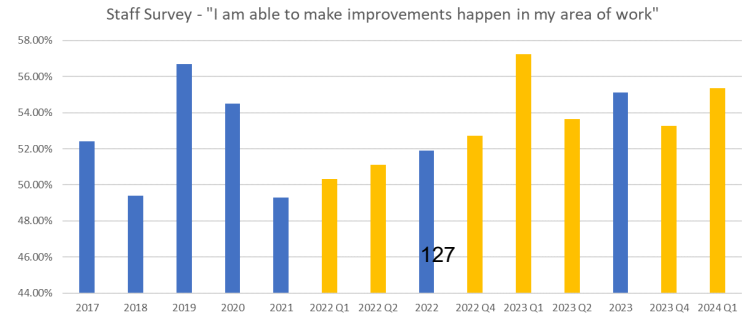
Set March 2023





BTO Staff Survey = % improvements

Set Summer 2022



Great Western Hospitals NHS Foundation Trust

Learning from 23/24

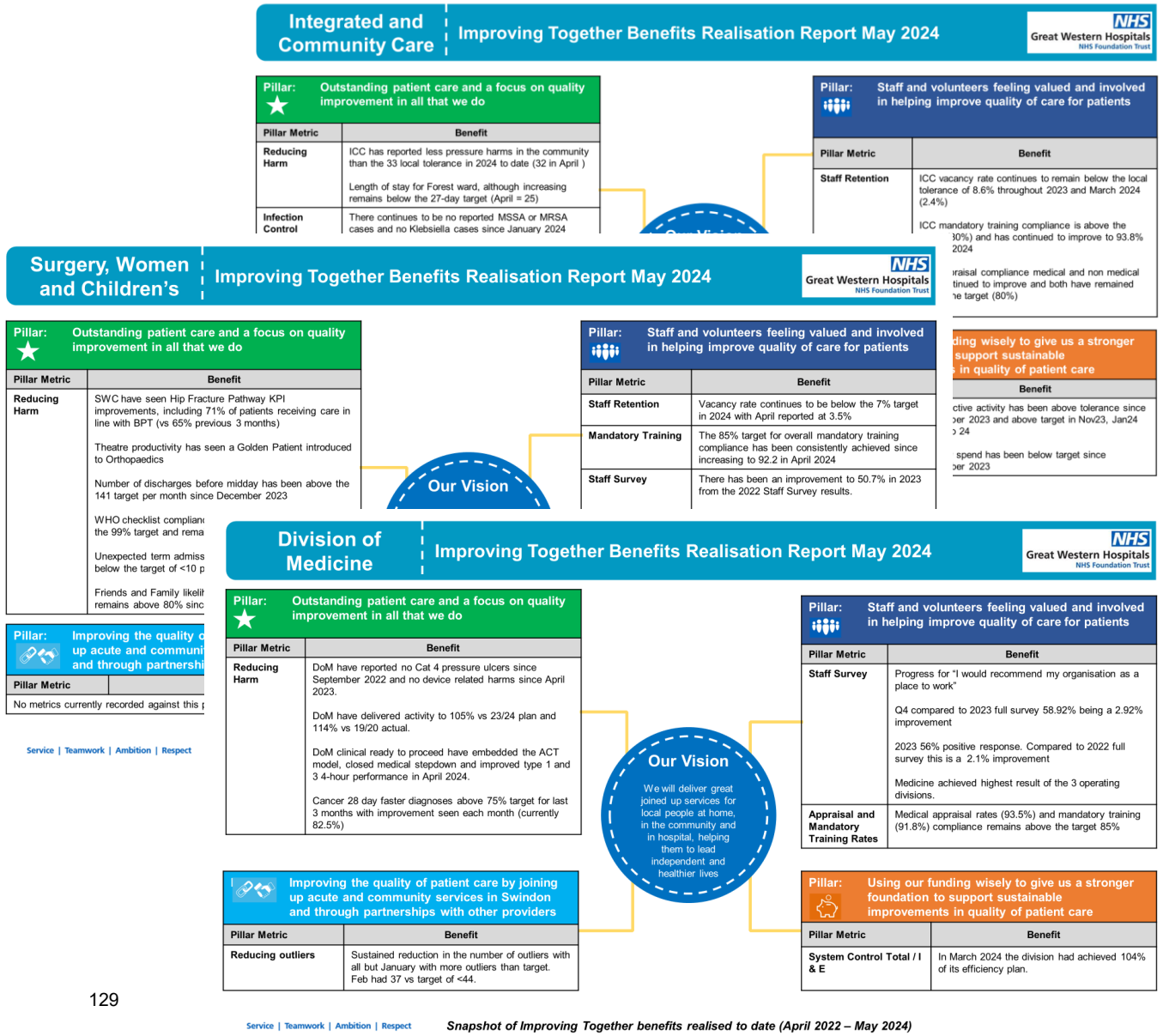
Breakthrough objective review

- Increasing use of A3 approach across the organisation is supporting self-improving systems. Drawing on ad hoc coach house support is helpful to guide and remind people of how move through the improvement cycle.
- Particular benefit is seen when we challenge the relationship between regular stratified data, top causes and countermeasures in place, follow up support/training is available in this area. This learning is common with Salisbury
- There is a need for constancy of purpose to support improvements on multifactorial problems which span across the organisation e.g. pressure harms.
- Embracing learning from failure and celebrating success
- Success may be slowed by the lack of “join up” of improvement action across the layers of the organisation – breakthrough, division, speciality & frontline? Fast track training and a “model cell” approach may support us to accelerate coordination across the organisation.
- Including visual management cues in the business intelligence our teams receive supports A3 thinking e.g. SPC charts that highlight statistically valid improvements and BI reports for routinely stratify data by cause as well as by location
- Recommend refocusing on our support to breakthrough objectives during 24/25 to ensure we are supporting progress across the organisation and that there is sharing between teams working on each of our breakthrough objectives around what works well

Benefits Realisation

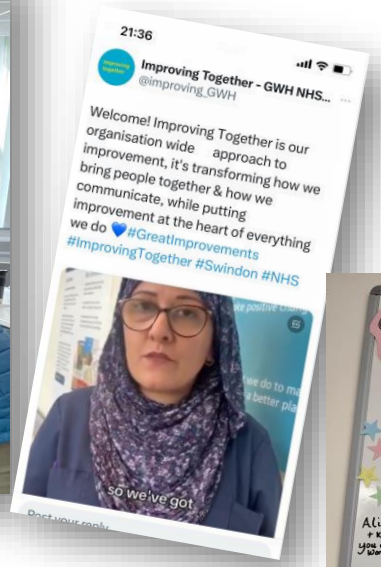
Divisions

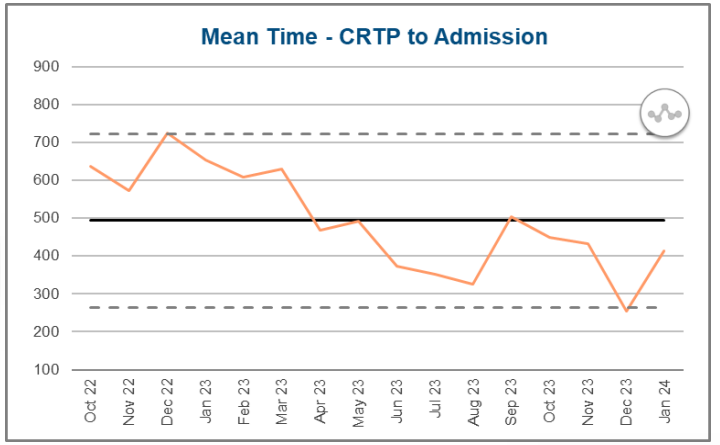
- Divisional benefits realisation is undertaken quarterly and progress on Divisional driver metrics is reviewed via the monthly executive review meetings.
- Divisions have reviewed and updated their divisional driver metrics in response to the refresh of the organisation's breakthrough objectives
- Appendix 3 gives further update on divisional level benefits.



Snapshot of Improving Together benefits realised to date (April 2022 – May 2024)

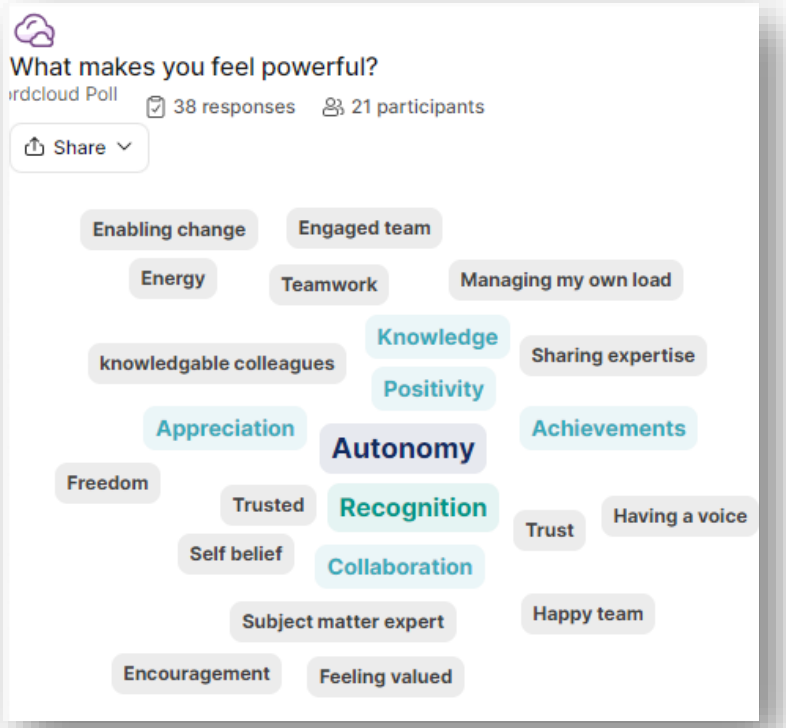
Celebrations



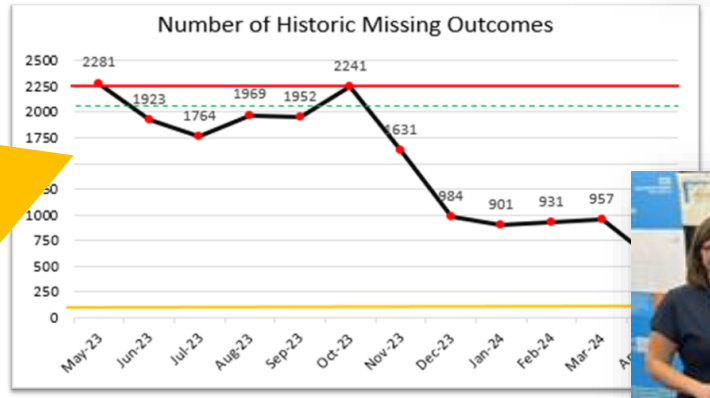


NHS
Great Western Hospitals
NHS Foundation Trust

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



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



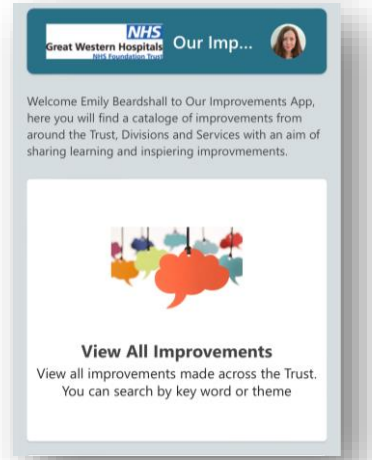
Improving Together hasn't just taught us how to make improvements, it has meant we understand each other better and changed how we talk to each other across the team

We have developed Process Standard Work in the EPU which has engaged staff

Staff Reported benefits

Cohort 5 Celebration Event

- There has been a sustained improvement in the positive staff survey response to “I am able to make improvements happen in my area of work”
- Teams frequently report the team development benefits of attending training, this was really clear at the recent Cohort 5 celebration event.



I wish I had not underestimated how positive people are in response to change….I didn’t realise how much benefit it would be…it is doable!

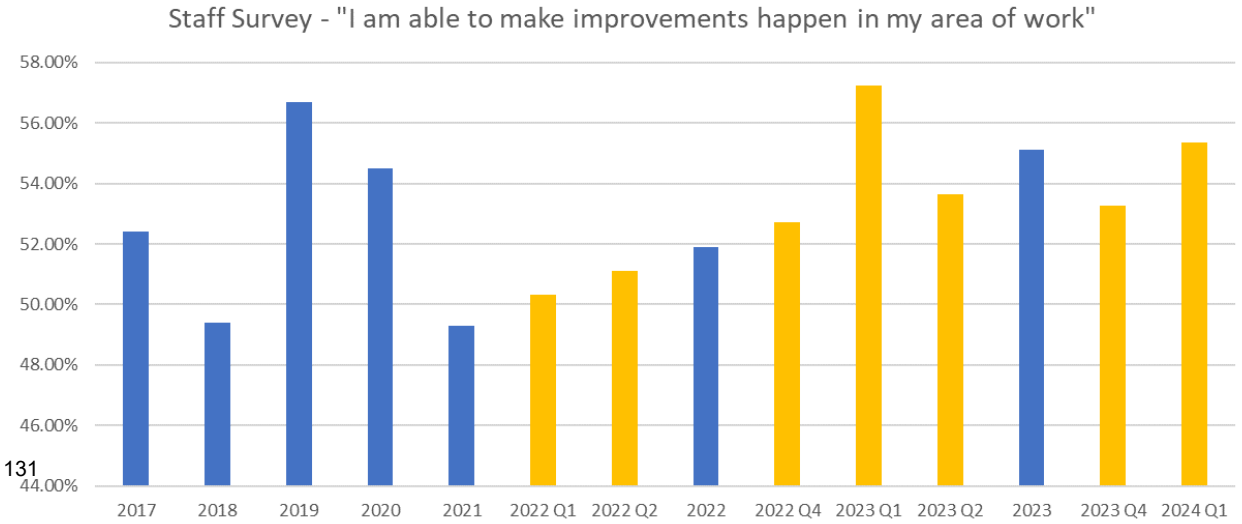
Having a doctor on the team was invaluable to getting medics on board and having a fully representative team

Examples of frontline line team improvements

- Reducing patient reported pain in ED chairs
- Process for wheelchair services referrals
- Increasing the capture of cancer diagnoses
- Stratify community rehab referrals to reduce waiting times for the most urgent
- “Baby in a bag” – neonatal PSW for neonatal observations
- EDI passport work
- Maternity 5s work
- My Improvement App

At the beginning I was reluctant to attend and had a negative view of this training. I thought it was a fad that would fall by the wayside. However, as the modules unfolded, I could see the benefits of implementing this.

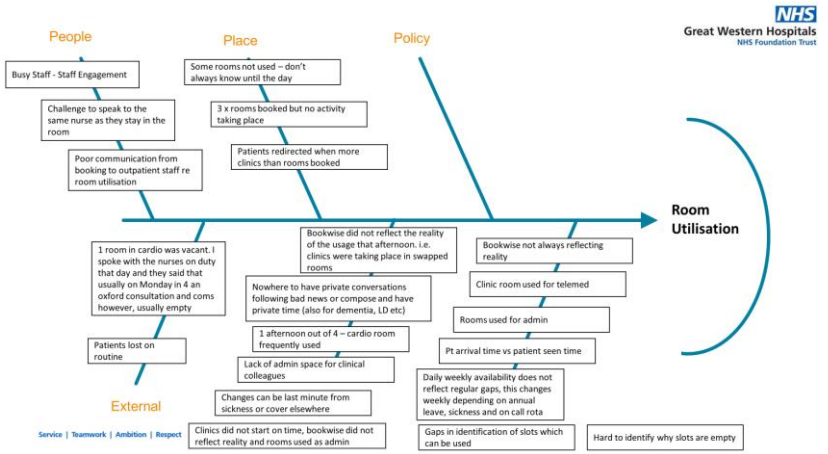
In practice, all staff feel able to share ideas and lead on improvements. Improving Together has had a positive impact on maternity

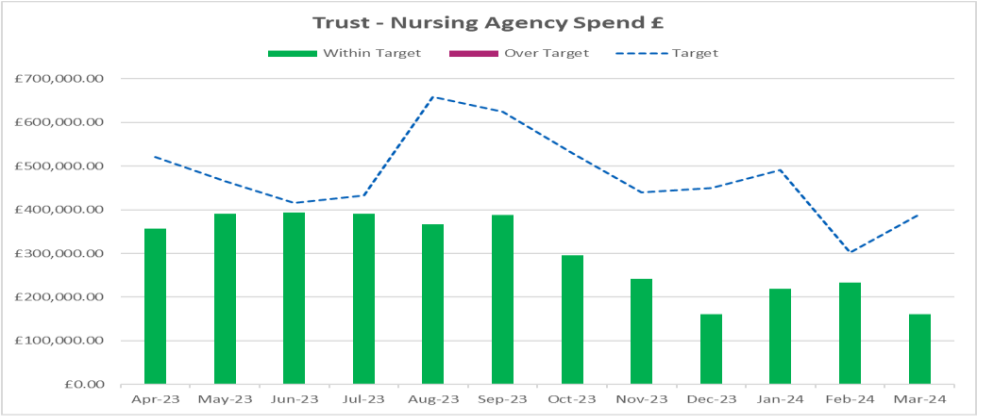


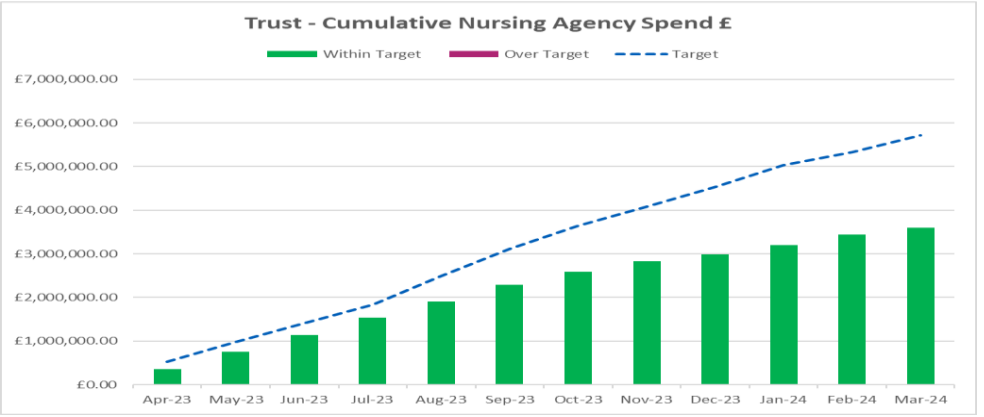
Larger Scale Transformation

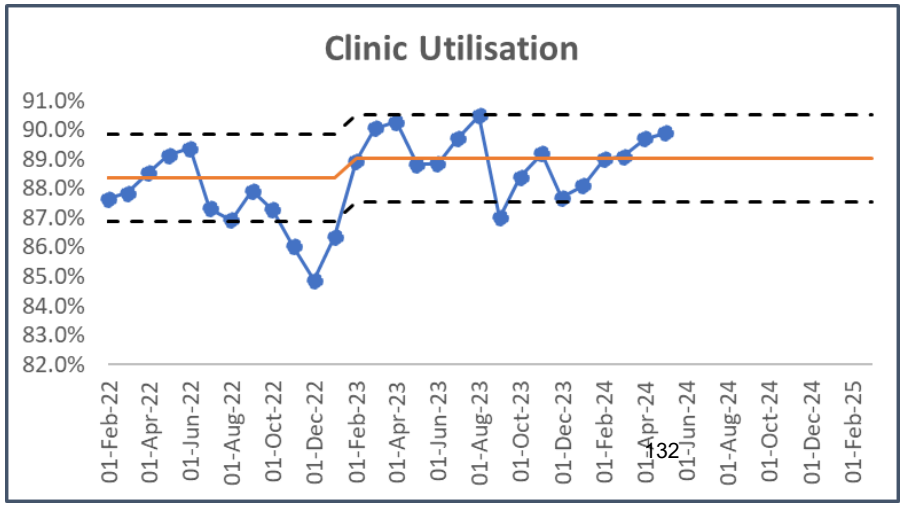
Rapid improvement events & programme delivery

- Increasingly we are applying the approach to larger scale transformation, this has been particularly successful in
  - Workforce recovery – significant reduction in agency and bank spend
  - Outpatient transformation – utilising Rapid Improvement events to drive emphasis and pace. There have been clear benefits in reducing DNAs and improving clinic room utilisation. Involving the experience of patients made a real difference to the direction of the work
  - Being applied in Urgent & Emergency Care Transformation
  - Financial Recovery as a breakthrough objective
- We are developing and reviewing our application to larger scale change and the process standard work for rapid improvement events





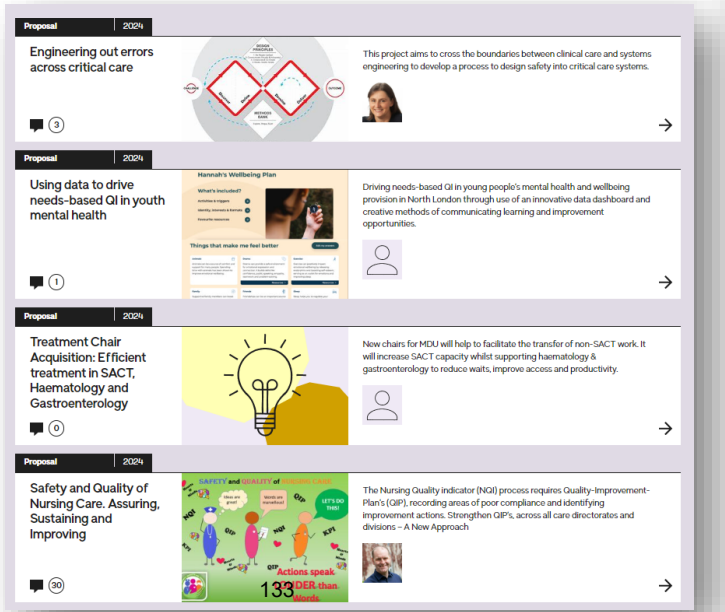


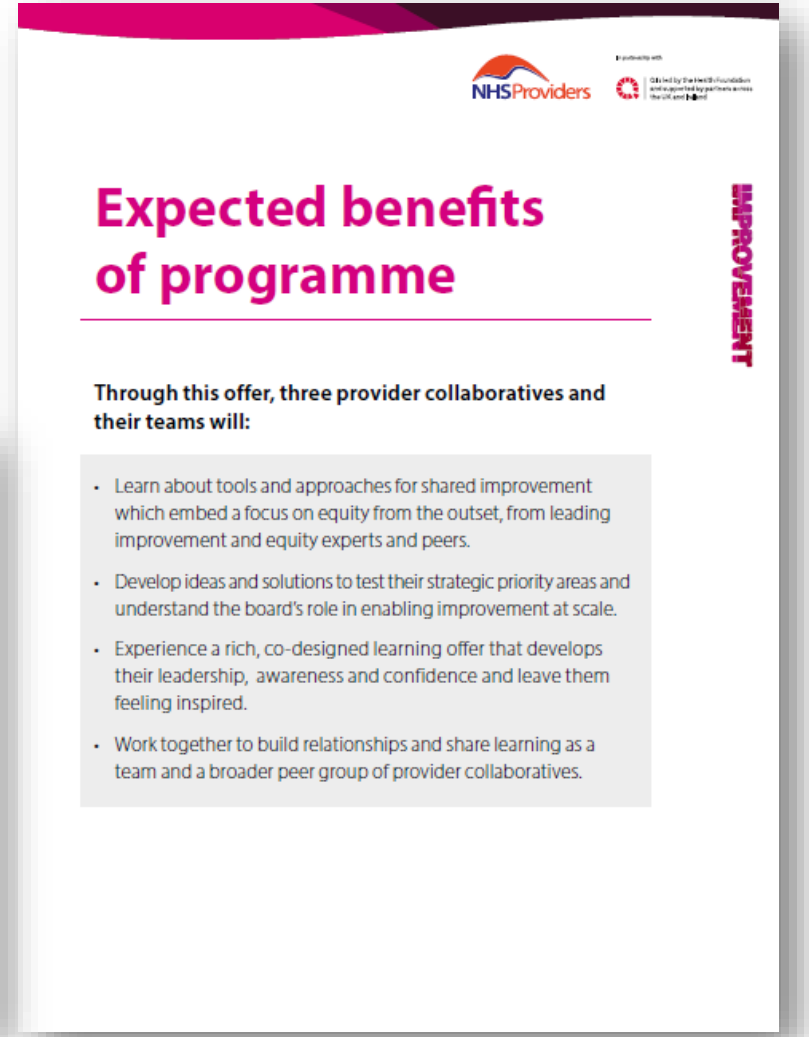


System Working

Wider Networks

- We are increasingly tapping into wider networks
  - Utilising Catalysis Executive Suite
  - NHS Providers: improving equitably programme
  - KPMG Improvement Directors Network & site visits
  - BSW Q Approach
  - The Health Foundation Q Exchange: ICC bid was shortlisted
  - HSJ Patient Safety Award – Finalist Empowering Staff to Lead Change
  - Catalysis CEO Summit to be hosted by AHA at SFT (October 24)



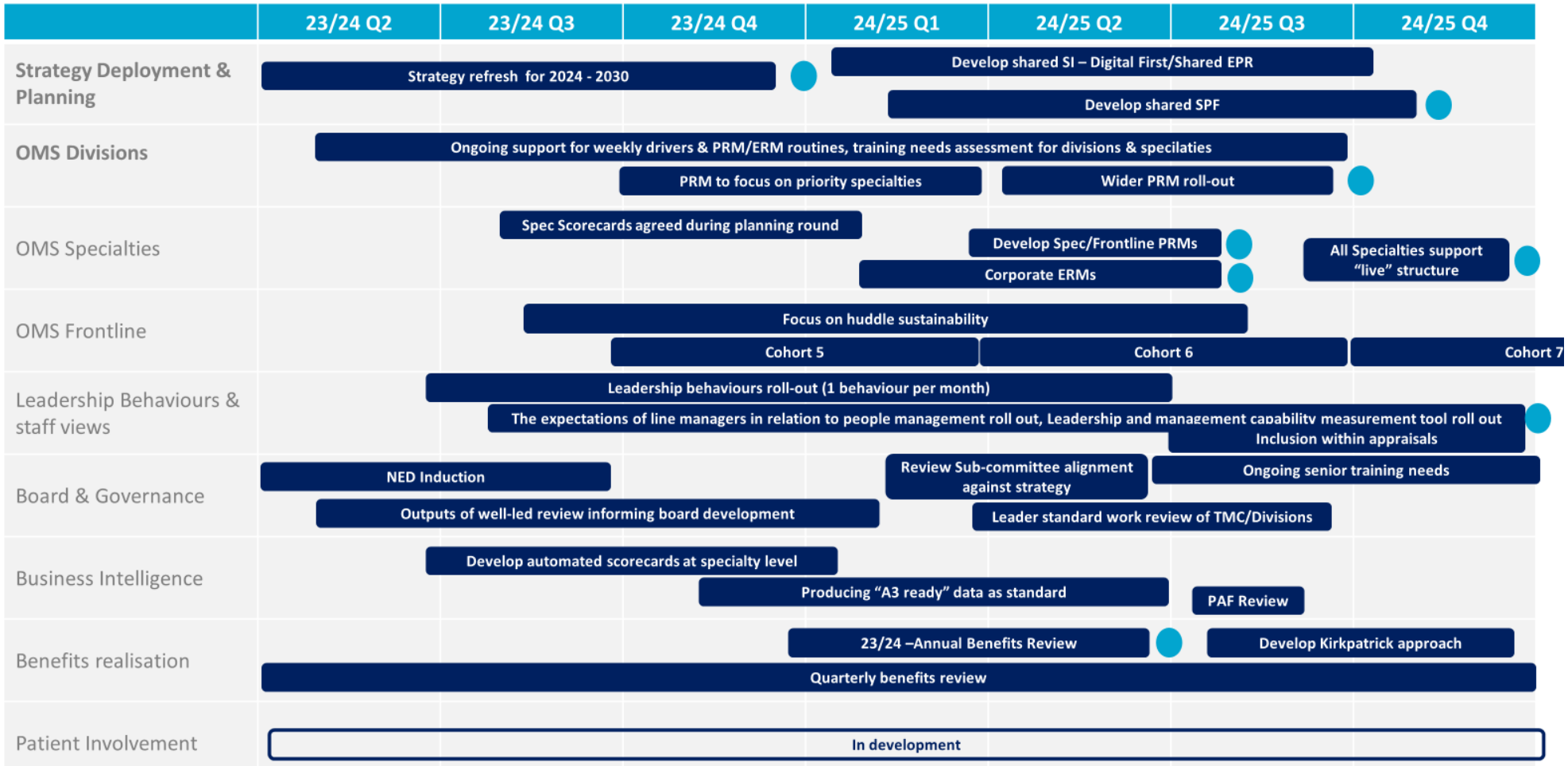


Future Focus

Improving
together

Roadmap

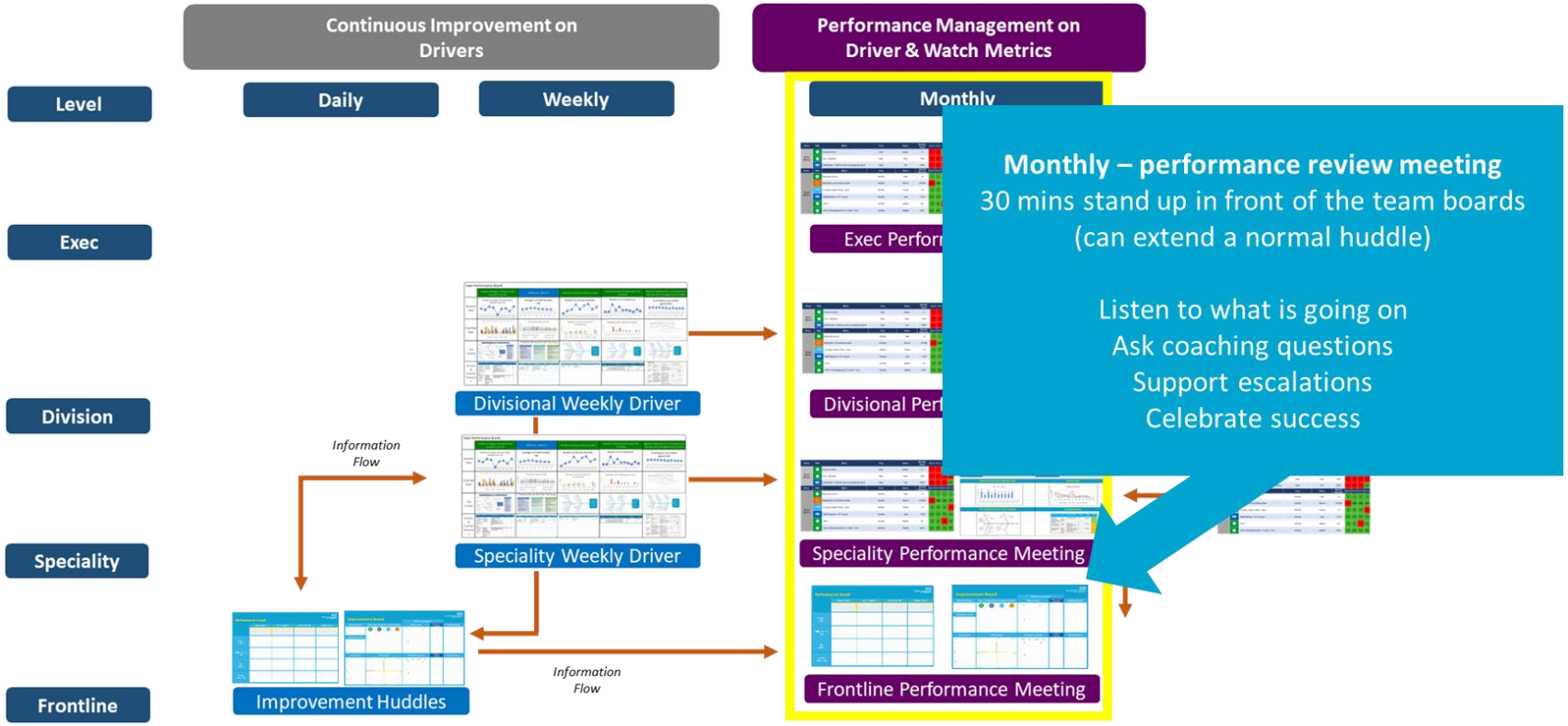
Great Western Hospitals NHS Foundation Trust



- The Improving Together deployment roadmap was refreshed in October 2024.
- The Improving Together Steering Group lead the roadmap delivery
- Continuing to develop at pace is crucial recognising progress needed across the entire OMS.

Connecting with the Teams

Performance Review Meetings



- Simplification of the performance review meetings approach for frontline teams – recommending monthly, 30 minute stand up meeting in front of huddle boards to reduce administration and maximise dialogue
- Involvement of divisional and specialty teams in “drop-in” sessions as part of the frontline cohort training to allow frontline teams to build rapport and agree drivers and huddle approach with speciality and divisional colleagues as well as sharing and celebrating successes.
- Good continuation of Executive Review Meetings with divisional teams will good adherence to the process standard work.
- Working with divisions to agree “model cells” within divisions to relaunch specialty scorecards and performance review meetings

Year 3 focus

Great Western Hospitals NHS Foundation Trust

Conclusions & Next Steps

Improving Together implementation is making good progress and we are learning from what is working well and what we might refine. Assessment against the evaluation model shows that some adaptation to our approach to maturity and embedding of huddles and routines may be needed. Measurable benefits are being to increase and be seen more widely across the organisation and this will need to continue into year 3. The outcome of the review has informed the following priorities for year 3.

1. Focus on sustainability:

- Simplifying the approach where it makes sense making sure our intelligence drives an Improving Together approach
- Increased focus on the performance review cascade & support for frontline teams; increasing the dialogue with specialties about their interaction with frontline teams
- Take an A3 approach to sustainability and maturity
- Recommit to the leadership behaviours, Executive Go & See to focus on waste walks

2. Increasing the patient/public voice

- Increasing the patient/public voice across our improvement work from training to ideas generation to joint problem solving
- Support the role of Governors and NEDs within the Operational Management System to ensure it delivers accountability
- Increase medical inclusivity

3. Design for the future

- Development of Improving Together in the AHA and System space
- Draw on momentum from NHS Impact to support our growing maturity
- Develop our training needs assessment for key roles and review how training will evolve as implementation proceeds

Appendices

Improving
together

Appendix 1 - Training Roll-Out

NHS
Great Western Hospitals
NHS Foundation Trust

Frontline Teams & Departments

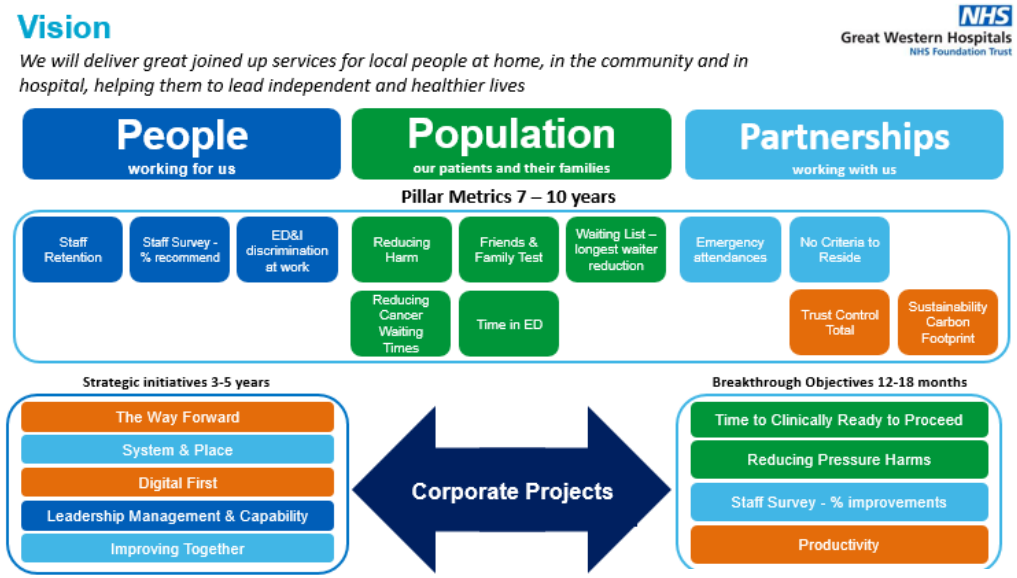
- Teams who have received training

SWC		Medicine		ICC	
Cohort	Fast-track	Cohort	Fast-track	Cohort	Fast-track
SAU Beech Ward Meldon Ward Trauma Ward Hazel Ward & Delivery Neonatal Ward		UTC ED SDEC Saturn Ward Linnet Ward Shalbourne Ward	Pharmacy Gastro Radiology Superintendents	Forest Ward Orchard Ward Community West Outpatients	Wheelchair services Acute OT Acute Physio Community Therapies Anticoagulation Front door team

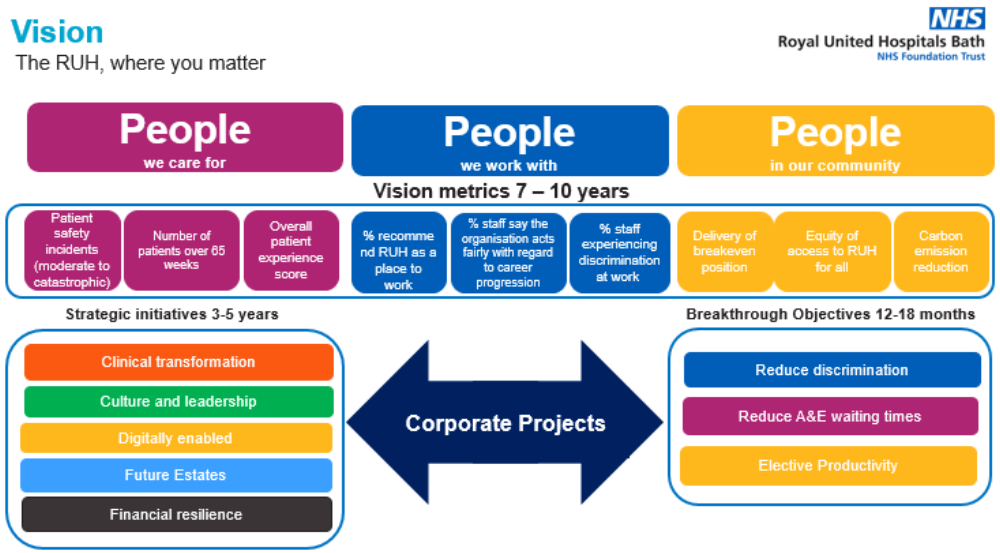
- Sustainability varies across the areas listed

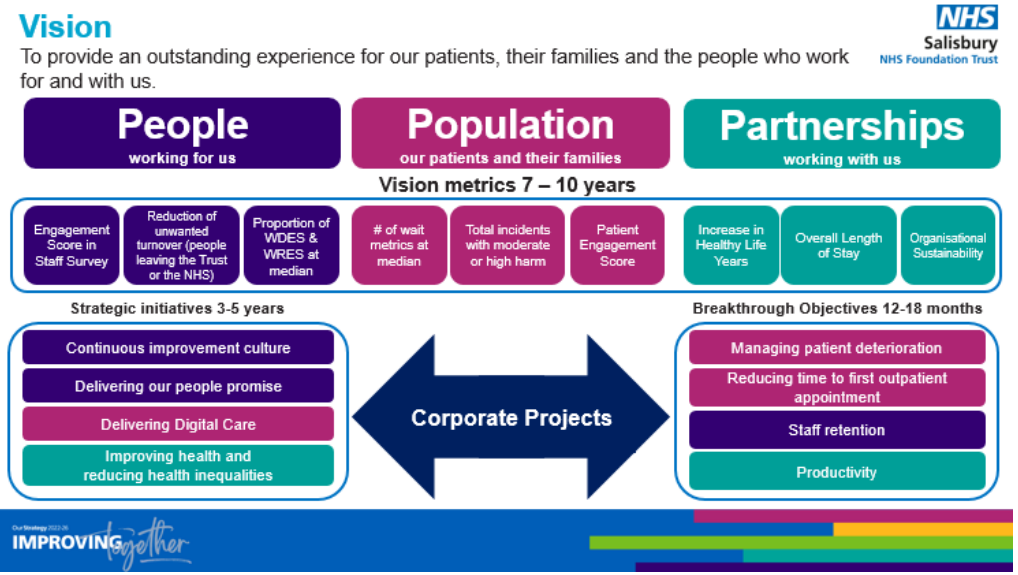
Appendix 2 - AHA Provider Collaborative

Level 4 SPFs



There is good alignment between the 3 organisational level SPFs with strong correlation between domains of “people, population and partnership”. There are emerging “fixed points” within a AHA SPF including shared EPR, community services provisions and implementation of Improving Together

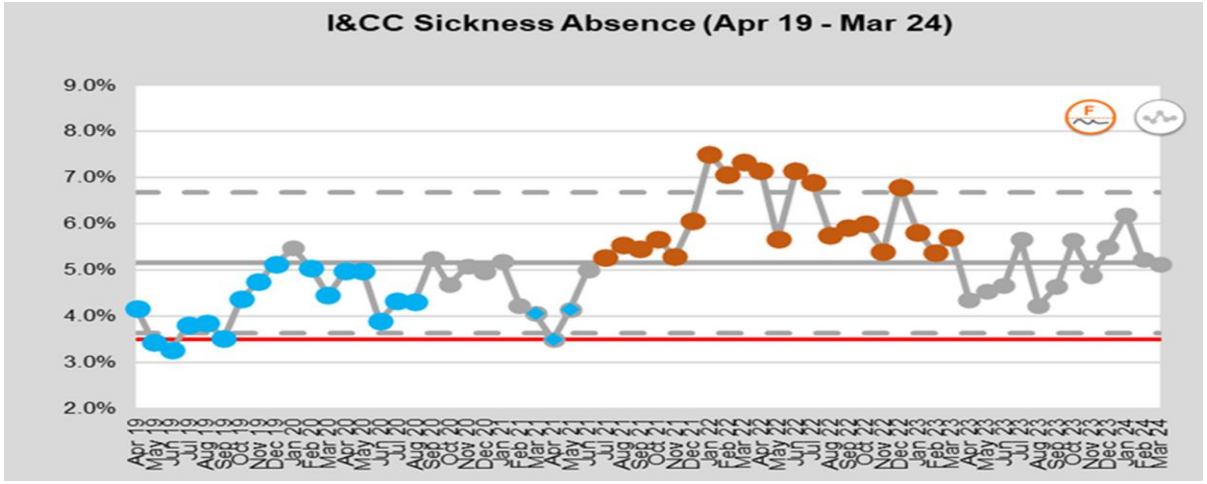




Appendix 3 Benefits Realisation

Divisions - ICC

- The division achieved good success in reducing community pressure harms and this has now moved to a watch metric.
- Really good application of the methodology at divisional level, however, achieving a specialty level approach has been slower to make progress.
- Good progress has been made with
  - NHS@Home capacity
  - Improving attendance
- Newer drivers are developing
  - reducing discrimination between staff,
  - improving cancer staging
  - Financial recovery and achieving elective activity plans



Integrated and Community Care | **Improving Together Benefits Realisation Report May 2024** | NHS Great Western Hospitals NHS Foundation Trust

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

Pillar Metric	Benefit
Reducing Harm	ICC has reported less pressure harms in the community than the 33 local tolerance in 2024 to date (32 in April) Length of stay for Forest ward, although increasing remains below the 27-day target (April = 25)
Infection Control	There continues to be no reported MSSA or MRSA cases and no Klebsiella cases since January 2024
Haematology	31 day Decision to treat to treatment and 2 week wait has been achieving 100% compliance in 2024
Outpatients	ICC DNA rate remains significantly below the target of 5% with April 2024 performance reported as 3.0%

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

Pillar Metric	Benefit
NHS@Home Bed Capacity	Length of stay for Forest ward, although increasing remains below the 27-day target (April = 25) Length of stay for Orchard ward remains below the 25-day target (April = 20)

Service | Teamwork | Ambition | Respect

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

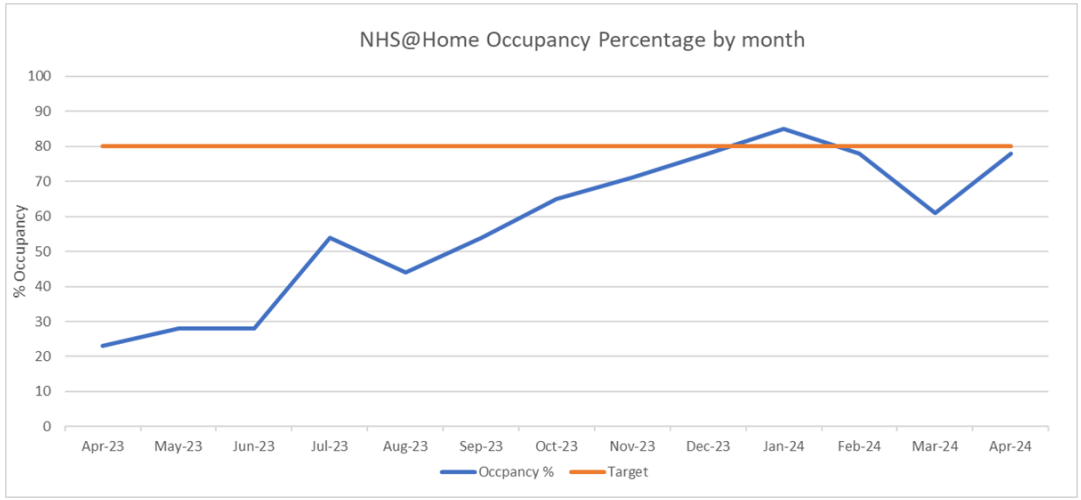
Pillar: Staff and volunteers feeling valued and involved in helping improve quality of care for patients

Pillar Metric	Benefit
Staff Retention	ICC vacancy rate continues to remain below the local tolerance of 8.6% throughout 2023 and March 2024 (2.4%) ICC mandatory training compliance is above the target (80%) and has continued to improve to 93.8% in April 2024 ICC appraisal compliance medical and non medical has continued to improve and both have remained above the target (80%)

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

Pillar Metric	Benefit
System Control Total / I & E	ICC elective activity has been above tolerance since November 2023 and above target in Nov23, Jan24 and Feb 24 Agency spend has been below target since December 2023

Snapshot of Improving Together benefits realised to date (April 2022 – May 2024)



Benefits Realisation

Divisions - Medicine

- The division achieved good success in reducing pressure harms with no Cat 4 pressure harms since September 2022 and reduction in device related harms throughout 2023/24.
- Good progress has been made with
  - Supporting increased utilisation of NHS@Home
  - Improvements in time to clinically ready to proceed
  - Reducing temporary staffing spend
- Further development or progress needed on
  - Staff recommending as a place to work
  - Increasing activity levels in line with 24/25 plan

Division of Medicine | **Improving Together Benefits Realisation Report May 2024** | NHS Great Western Hospitals NHS Foundation Trust

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

Pillar Metric	Benefit
Reducing Harm	DoM have reported no Cat 4 pressure ulcers since September 2022 and no device related harms since April 2023. DoM have delivered activity to 105% vs 23/24 plan and 114% vs 19/20 actual. DoM clinical ready to proceed have embedded the ACT model, closed medical stepdown and improved type 1 and 3 4-hour performance in April 2024. Cancer 28 day faster diagnoses above 75% target for last 3 months with improvement seen each month (currently 82.5%)

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

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

Pillar Metric	Benefit
Staff Survey	Progress for "I would recommend my organisation as a place to work" Q4 compared to 2023 full survey 58.92% being a 2.92% improvement 2023 56% positive response. Compared to 2022 full survey this is a 2.1% improvement Medicine achieved highest result of the 3 operating divisions.
Appraisal and Mandatory Training Rates	Medical appraisal rates (93.5%) and mandatory training (91.8%) compliance remains above the target 85%

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

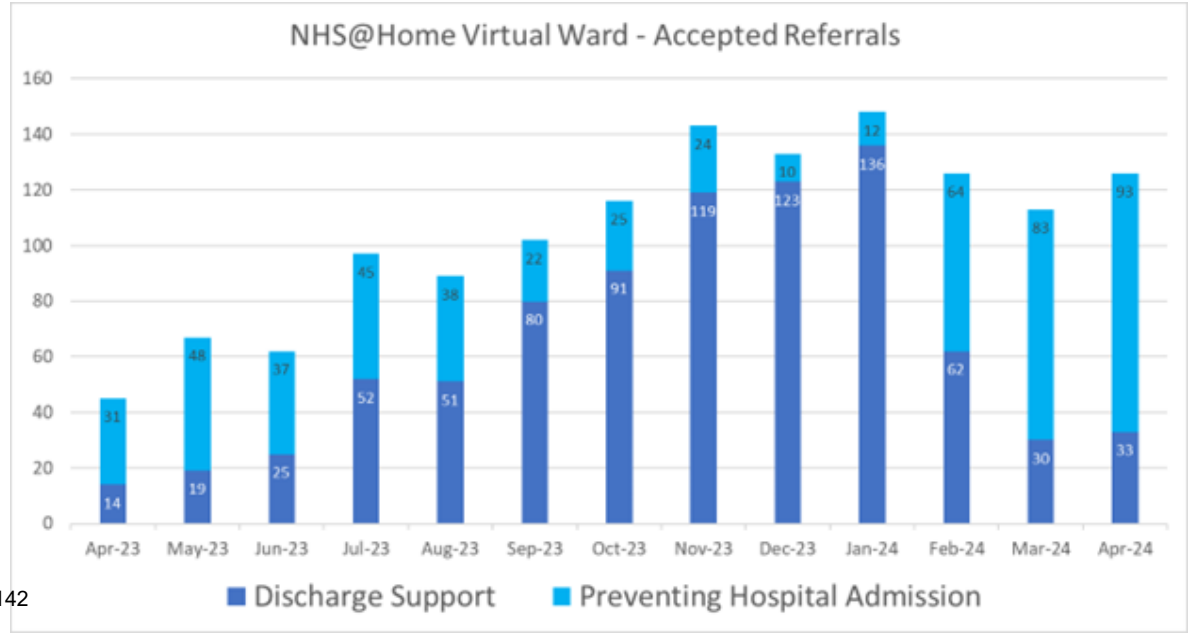
Pillar Metric	Benefit
Reducing outliers	Sustained reduction in the number of outliers with all but January with more outliers than target. Feb had 37 vs target of <44.

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

Pillar Metric	Benefit
System Control Total / I & E	In March 2024 the division had achieved 104% of its efficiency plan.

Service | Teamwork | Ambition | Respect

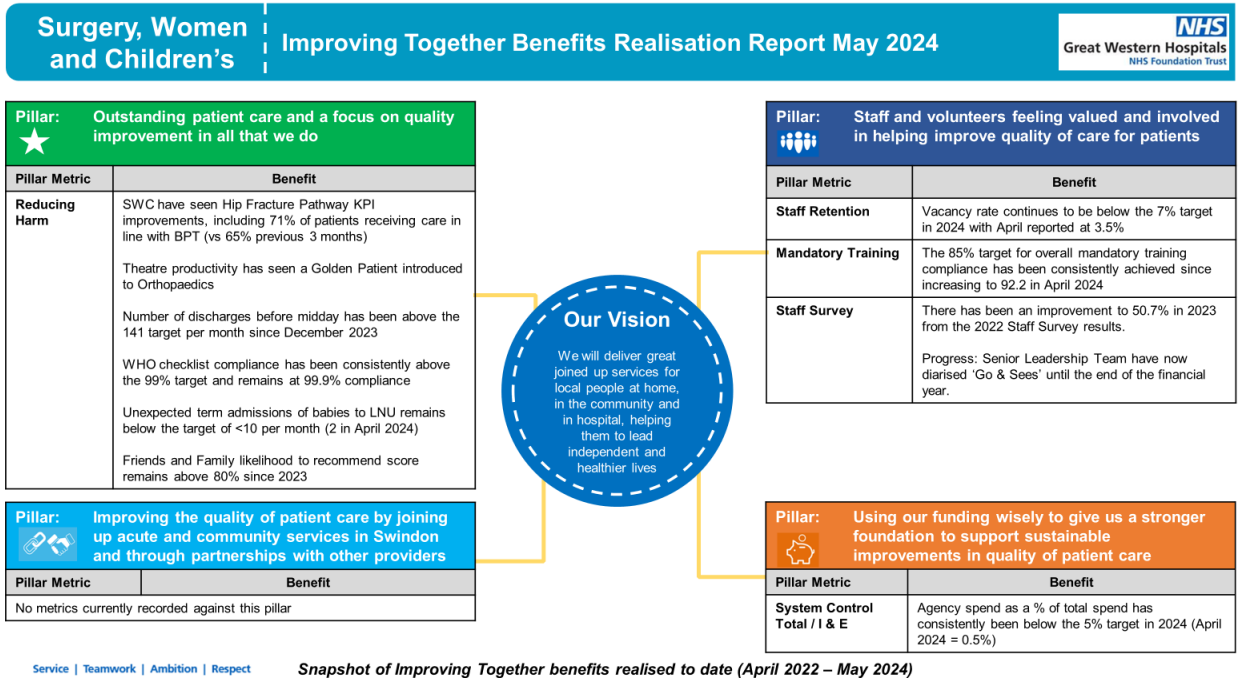
Snapshot of Improving Together benefits realised to date (April 2022 – May 2024)



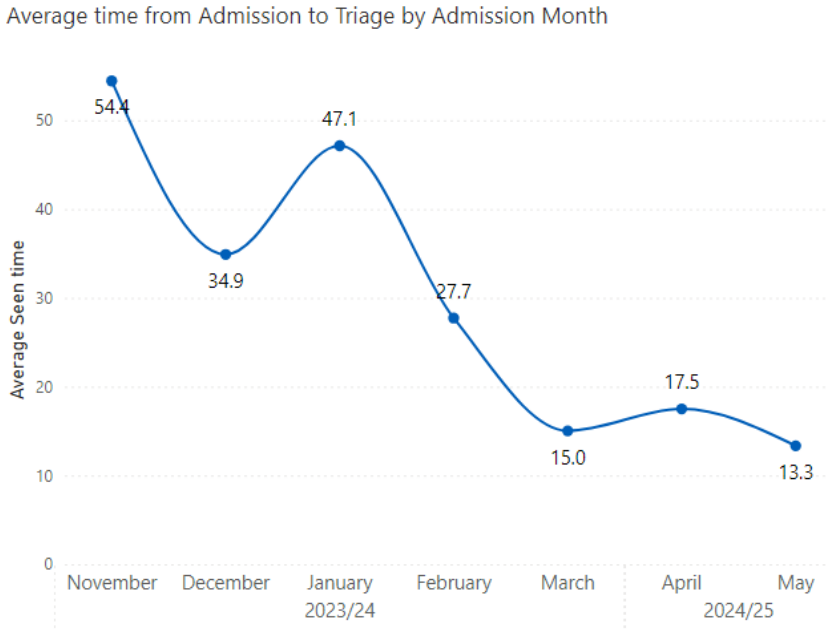
Benefits Realisation

Divisions - SWC

- Hip Fracture KPI has improved with 71% of patients receiving care in line with the best practice tariff
- Maternity triage times have reduced significantly between Nov 23 and May 24
- Good progress has been made with
  - Friends & Family Test
  - Theatre productivity
  - Controlling agency spend
- Further development or progress needed on
  - Staff able to make improvements in their area of work
  - Increasing activity levels in line with 24/25 plan
  - Urology Cancer performance



Snapshot of Improving Together benefits realised to date (April 2022 – May 2024)



Report Title	**Committee Effectiveness Review 2023/24 – Audit, Risk & Assurance Committee**				
Meeting	**Trust Board**				
Date	**1 August 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Audit, Risk & Assurance Committee Terms of Reference				

Purpose

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

Assurance Level

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

Significant	x	Acceptable		Partial		No Assurance	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

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

Report

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

The Audit, Risk & Assurance Committee has completed an annual review and self-assessment of performance using a standardised approach.

The Audit, Risk & Assurance Committee produced an Annual Report and has reviewed their Terms of Reference as appropriate as well as an annual cycle of business.

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

This report invites the Board to note a committee effectives review has been undertaken and to consider the terms of reference of the Audit, Risk & Assurance Committee as attached.

Amendments have been proposed which reflect feedback from committee members, and also the recently published NHS Audit Committee Handbook (March 2024), these are highlighted in yellow.

There were no issues or concerns to draw to the attention of the Board about the effectiveness of the committee.

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

– risk number & description (Link to BAF / Risk Register)		
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Audit, Risk & Assurance Committee	
Next Steps	To align annual work plans to the terms of reference	

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to approve the terms of reference for Audit, Risk & Assurance Committee

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	2 July 2024

AUDIT, RISK & ASSURANCE COMMITTEE
TERMS OF REFERENCE
2024/25

Purpose
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

1. AUTHORITY

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

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

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

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

1.5 The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

1.6 Members will demonstrably consider the equality and diversity implications of decisions they make.

ROLE

2.1 This Committee shall provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

2.2 In addition this Committee shall

- provide assurance of independence for external and internal audits;
- ensure that appropriate standards are set and compliance with them monitored, in non-financial, non-clinical areas that fall within the remit of this Committee; and

- monitor corporate governance (e.g. compliance with terms of authorisation, Constitution, Codes of Conduct, Standing Orders, Standing Financial Instructions, maintenance of registers of interest).

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

3. MEMBERSHIP

3.1 The membership of the Audit, Risk & Assurance Committee shall consist of:

- ~~Three~~ Four Non-Executive Directors (not including the Trust Chair) – at least one of whom will have financial background and one member with be Chair of Quality & Safety Committee

The Chair of the Trust and Chief Executive shall **not** be a member of the Committee.

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

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

4. ATTENDANCE

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

4.2 *Compulsory attendance* - The Chief Financial Officer (or in their absence their deputy and another Executive Director) is expected to attend regularly. The External and Internal Auditors shall normally attend as agreed by the Chair of the Committee. The Counter Fraud Specialist shall attend at least 2 meetings each year as agreed by the Chair of the Committee.

The Chief Executive, as Accounting Officer, shall be invited to attend meetings and should discuss at least annually with the Committee, the process for assurance that supports the annual governance statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

Other Executive Directors and Non-Voting Board Directors shall be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. The Committee may call other officers of the Trust to attend as appropriate.

The company secretary may attend meetings.

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

4.4 The work of this Committee will be supported by the Executive Director Lead, the Chief Financial Officer who will normally attend and ensure appropriate attendance from other directors and officers.

4.5 *Voting* - Only the Non-Executive Directors who are members of the Committee or in their absence their substitute may vote.

4.6 *Additional meetings* – The External Auditor, the Head of Internal Audit and Counter Fraud Specialist have a right of direct access to the Chair. The Accounting Officer, external auditors, or Head of Internal Audit may request a meeting of the Committee if they consider that this is necessary. At least once each year the Committee will meet privately with the internal and external auditors.

5. QUORUM

5.1 The quorum shall be two of the ~~3~~ 4 Non-Executive members.

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet as a minimum five times per year with additional meetings being called where necessary.

7. DUTIES

7.1 Internal Control, Risk Management and Governance

The Committee will review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the Trust's principal objectives. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements (including the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board.
- The structures, processes and responsibilities for identifying and managing key risks facing the organisation and controlling the same. This includes the underlying assurance processes.
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Annual Governance Statement and other relevant guidance.
- Any significant audit adjustments and changes in accounting policies and practices.
- The operational effectiveness of policies and procedures.

- Systems and processes for ensuring effective compliance with health & safety legislation and Standards for Better Health.
- Systems and processes for ensuring compliance with NHS England, CQC and other relevant regulators.
- Arrangements for ensuring compliance with Local Security Management Directions.
- Arrangements for ensuring compliance with counter fraud standards and requirements.
- Keep under review the systems and processes of governance, assurance and their operational effectiveness and impact for the Trust.
- Oversight of systems, processes, controls and governance (compliance with Regulations, Single Oversight Framework, GIRFT & Model Hospital)
- Receive the 15+ Risk Register and Board Assurance Framework at least 2 times a year to take assurance that the processes for managing risks are effective.

7.2 Internal Audit

The Committee will ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit, Risk & Assurance Committee, Chief Executive and Trust Board, by the:

- Consideration of the provision of the internal audit service and associated costs, ensuring it has adequate resource and appropriate standing.
- Review and approval of the internal audit plan, ensuring that there is consistency with the audit needs of the organisation as identified in the Assurance Framework and co-ordination with the work of external audit.
- Consideration of the major findings of internal audit work and management responses and ensuring the co-ordination between internal and external audit to optimise use of audit resources.
- Monitor and review of the effectiveness of the internal audit function

7.3 External Audit

Review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by the following:

- The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process, including the review of the work, findings and management responses to the work. This will be achieved by:
- Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external auditor.

- Reporting to the Trust Board and the Council of Governors identifying any matters where action or improvement is needed and making recommendations for action.
- Reviewing and monitoring of the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.
- Discussing and agreeing with external auditors before the audit commences, the nature and scope of the audit for the Annual Audit. This includes the evaluation of audit risk, assessment of the organisation and impact on the audit work and fee.
- Approving the remuneration and terms of engagement of the external auditor, supplying information as necessary to support statutory function of the Board of Governors to appoint, or remove, the auditor.
- Reviewing all external audit reports, including those charged with governance, before submission to the Board, together with the appropriateness of management responses.

The Committee will:

- Develop and agree with the Council of Governors, the criteria for the appointment, re-appointment and removal of the external auditors.
- Make recommendations to the Council of Governors in relation to the above.

7.4 Financial Reporting

Monitor the integrity of the financial statements of the Trust, including its operating and financial review and significant financial returns to regulators, before clearance by the auditors and before submission to and approval by the Board, and shall review significant financial reporting issues and judgements which they contain. Additionally, the Audit Committee will review the Annual Report and Accounts before submission to the Board, focusing particularly on:

- Wording in the annual governance statement and other disclosures relevant to these terms of reference
- Changes in, and compliance with, accounting policies, practice and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

The Audit, Risk & Assurance Committee will also:-

- Monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing any significant financial reporting judgements.

- Ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

7.5 System Working, Managing Change & Transformation

Oversight of system working, managing change and transformation, notably our role in the Integrated Care System (ICS), partnership working (Wiltshire Health & Care LLP), new projects and transformation schemes.

7.6 Other Assurance Functions

The Audit Committee will refer to the work of other committees within the organisation, whose work can provide relevant assurance to the Audit, Risk & Assurance Committee's own scope of work. In particular, the Audit, Risk & Assurance Committee will refer to the work of the People & Culture Committee, Quality & Safety Committee, Performance, Population & Place Committee and Finance, Infrastructure & Digital Committee.

The People & Culture Committee provides assurance that the relevant legal and regulatory requirements relating to the workforce are met. The Quality & Safety Committee coordinates and implements all the responsive actions being taken by the organisation in relation to quality and provides assurance to the Board of Directors that the quality agenda is being embedded in line with the Quality Strategy, and the Performance, Population & Place Committee provides assurance that performance is measured and monitored, tackling health inequalities and the development of an Anchor organisation. The Financial, Infrastructure & Digital Committee provides an objective view of the financial performance, and financial strategy of the Trust, together with an understanding of the risks and assumptions within the Trust financial plans and projections, together with oversight of the infrastructure of IT and estates.

8. REPORTING RESPONSIBILITIES

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

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

8.3 The Chair of the Committee reports to the Council of Governors through the statutory annual report and accounts process, and in relation to the performance of the external auditor to enable the Council of Governors to consider whether or not to re-appoint the external audit firm. In addition, the Chair of the Committee will report any other significant issues to the Council of Governors.

8.4 The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements
- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

9. MEETING ADMINISTRATION

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

9.2. Meetings of the Committee may be called by the Chair at the request of any of its members or where necessary.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

9.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

10. REPORTING/PROVIDING ASSURANCE

10.1 A forward planner of agenda items shall be determined by the Chair.

11. REVIEW

11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

11.2. The terms of reference of the Committee shall be reviewed annually and approved Board of Directors.

Document Control

Version Control				
Version	Status	Date	Meeting/Persons	Summary of Change
V1.0	For annual review	July 2022	Audit, Risk & Assurance Committee	• 2.3 added • EPRR paragraph deleted as moved to PPPC • FTSU paragraph deleted as moved to Q&SC • 8.3 amended reporting process to CofG • Information Governance deleted as moved to FIDC • 3.1 added 'Trust' before Chair
V2.0	Annual Review	Mar-23	Company Secretary	• Job title changes • Change to NHS England from NHS Improvement due to legislative change • Added areas of assurance to summary box
V2.0	Approved	May-23	Board	As above

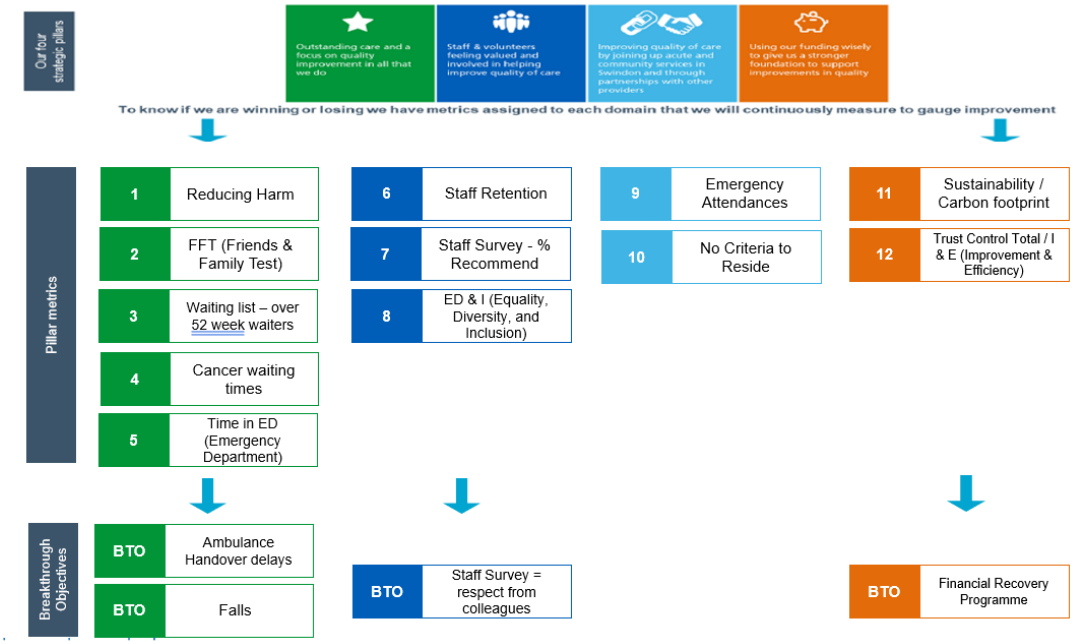
V3.0	Annual Review	Jun-24	Company Secretary	• 1.5 added following review of NHS Audit Committee Handbook (2024) • 1.6 added – added to all tofr in line with Board commitment to ED&I • Company Secretary added as regular attendee following review of NHS Audit Committee Handbook (2024) • 8.4 added – following review of NHS Audit Committee Handbook (2024) • Appendix 1 updated • Appendix 2 updated • Amended membership to 4 NEDs

Appendix 1 - Summary

Committee	**Audit, Risk & Assurance Committee**
Chair Lead EDs	Helen Spice, Non-Executive Director Simon Wade, Chief Financial Officer
Frequency	A minimum five times per year
Membership	4 x NEDs
Quorum	2 x NEDs
Remit	Overseeing the probity and internal financial control of the Trust, working closely with external and internal auditors. Ensuring effective internal and external audit function Ensuring effective governance, risk management and internal controls Ensure effective counter fraud provision Review of annual report accounts and associated documentation before they are submitted to the Board.

Areas of Assurance	Governance and internal control Assurance on financial & operational systems Risk Management Internal Audit Plan Oversight of internal audit recommendations External Audit Plan Counter Fraud Financial Reporting (SFIs & SofD) Assurance Framework Accounting Policies Annual Report and Financial Statements Compliance with the NHS Provider Licence and NHS Code of Governance

Appendix 2 – Improving Together Strategic Pillars



Report Title	**Fit and Proper Persons Regulation (FPPR) Annual Assurance Report 2023/24**				
Meeting	**Trust Board**				
Date	**1 August 2024**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Trust Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

Purpose

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

Assurance Level

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

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 September 2023, NHS England launched new national Fit and Proper Person Test (FPPT) Framework guidance. The Framework sits in the wider context of good governance, leadership and Board development, and is intended to strengthen individual accountability for Board members, thus enhancing the quality of leadership within the NHS.

Overall accountability for adherence to the framework remains with the Chair, which applies to all voting and non-voting Executive and Non-Executive Board members. In addition to the new framework requiring all new Board members to demonstrate that they have met all the required criteria prior to appointment, there is also an ongoing requirement for individual assessments to be completed on currently serving Board members each year.

This report therefore provides confirmation to the Board that all necessary individual annual checks have been completed, and the evidence reviewed confirms that all serving members of the Board are fit and proper.

The requirements for the annual 2023/24 FPPT assessment have therefore been fully satisfied, and an overall summary submitted to the regional NHSE team confirming compliance with the framework within the required deadline of 28 June 2024.

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Trust Board is asked to:

(a) note the content of this paper; and,

(b) record that the FPPT has been conducted for the period 2023/24 and that all current Board members satisfy the requirements.

Accountable Lead Signature	Trust Chair
Date	2 July 2024

1. Introduction

The Fit and Proper Person Regulation (FPPR) came into force for all NHS Trusts in November 2014 and requires all organisations to seek assurance that all directors are fit to undertake the responsibilities of their role.

In August 2023, NHS England (NHSE) developed a Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by the Kark Review in 2019. This was commissioned to establish why the FPPT was not being applied effectively and consistently and built upon the Francis Report which called for better regulation of NHS Board level directors.

2. CQC Regulation 5

The Care Quality Commission (CQC) holds NHS Foundation Trusts to account in relation to FPPR through Regulation 5. This is about ensuring that individuals are fit and proper to carry out the important role of director and ensure healthcare providers meet the requirements of the Health and Social Care Act.

The regulation applies to Executive and Non-Executive Directors who are responsible and accountable for delivering care including associate directors and any other Board members, irrespective of their voting rights.

The CQC expect providers to be able to demonstrate robust recruitment, management, appraisal, disciplinary and dismissal processes in place supported by relevant policies. Whilst it is the Trust's duty to ensure fit and proper directors are in post, CQC has the power to take enforcement action against the Trust if it considers that requirements of FPPR have not been complied with.

3. FPPT Framework

The purpose of the framework is to strengthen individual accountability and transparency for board members, enhancing the quality of leadership within the NHS and ultimately impacting on patient safety.

It introduced the following:

- a means of retaining information relating to testing the requirements of the FPPT for individual directors
- a set of standard competencies for all board directors
- a new way of completing references with additional content whenever a director leaves an NHS board.

The framework was effective from 30 September 2023. NHS organisations are not expected to use the framework retrospectively but to use it for all new board level appointments and for annual assessments going forwards.

The first annual submission was required by 28 June 2024. The framework applies to all Executive and Non-Executive Directors regardless of voting rights or whether an individual is permanent or interim. Some organisations may wish to extend this to other key roles but this is not compulsory.

3.1 Personal Data

A key change is that personal data relating to the FPPT assessment will be retained within local record systems including specific data fields in the NHS Electronic Staff Record (ESR). However, the information contained in these records will not routinely be accessible beyond the individual's own organisation and access will be restricted appropriately within that organisation.

4. Annual Process

Every board member will need to complete an annual self-attestation to confirm that they comply with the full FPPT requirements. The Chair will be accountable for ensuring the FPPT process (both annually and for new appointments) is effective and that the desired culture of their NHS organisation is maintained to support an effective regime.

5. Compliance

To ensure compliance with the FPPR, the Trust must be able to demonstrate that robust processes are in place to determine whether all new and existing directors are, and continue to be, fit. These include:

- A process to ensure all new director-level appointments are fit and proper as part of the recruitment process (as outlined within Regulation 19 and determined by the NHS Employment Standards).
- An annual process for regularly monitoring and reviewing the ongoing fitness of existing directors to ensure that they remain fit for their role, including consideration of serious mismanagement.
- Principles for conducting investigations into concerns about the fitness of a director.

- A process for the right of appeal for directors.

Processes related to FPPR at the Trust are aligned with NHS England recommendations as well as broader HR processes. They are well documented and completed on an annual basis. The Trust now has a process in place to ensure references are completed for leavers.

6. Annual Submission 2023/24

The Chair is supported by the Chief People Officer and the Company Secretary to ensure appropriate processes are followed.

- Ahead of this, the changes to the process were outlined including the need to retain data within ESR. All directors gave their consent for this to occur.
- For the year 2023/24, each individual director completed their annual self-attestation
- The Chair reviewed the signed declarations and determined that the Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.
- In addition, during the year 2023/24, the Chief People Officer has overseen the completion of pre-employment checks for new appointments and leavers and confirms that all checks meet the FPPT Framework.
- The outcome of the FPPT's have been saved on each personal file and uploaded onto ESR.
- All necessary individual annual checks have been completed, and the evidence reviewed confirms that all serving members of the Board are fit and proper.
- Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of either the Company Secretary, Chief People Officer or the Trust Chair.

The requirements for the annual 2023/24 FPPT assessment have therefore been fully satisfied, and an overall summary submitted to the regional NHSE team confirming compliance with the framework within the required deadline of 28 June 2024.

7. Next Steps

It is recommended that, every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The Trust will ensure FPPT is included within the internal audit plan for 2025/26.

In February 2024, the NHS Leadership Competency Framework for Board members was published. This document lists six leadership domains and is designed to support appointments and appraisals of board members, this have been incorporated into the 2023/24 annual appraisal process. The Board Member Appraisal Framework is due to be published later in the year. The Trust will consider these documents as part of the annual appraisal process.

8. Recommendation

The Trust Board is asked to:

(a) note the content of this paper; and,

(b) record that the FPPT has been conducted for the period 2023/24 and that all current Board members satisfy the requirements.

Report Title	**Responsible Officer Annual Report**				
Meeting	**Board of Directors**				
Date	**1st August 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Dr Stephen Haig – Acting Chief Medical Officer				
Report Author	Amy Smith, Medical Revalidation & Job Planning Specialist & Dr Stephen Haig, Acting Chief Medical Officer				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

The purpose of the Responsible Officer annual board report is to monitor compliance, review requirements and demonstrate continuous improvements. Oversight of the appraisal, revalidation process and compliance is monitored monthly at the Medical Staff Support Group (Professional Standards) where any need for support, intervention, concerns or failure to engage are identified and escalated.

Revalidation, Appraisal, and Job Planning are both now implemented utilising SARD and operating as business as usual with a full cycle of job planning covering 2023/24 complete with 2024/25 well underway. Processes are more robust and improved with strengthened oversight for the organisation and support for doctors with a small, dedicated team and intuitive system in place. This is evidenced by consistent appraisal compliance and much-improved compliance of job plans.

With the (ASPAT) tool now underway in the system, feedback reports have been shared to appraisers where they can reflect as part of a development process. This will inform future in house training as part of study days which is already underway with the Trust's Appraisal Lead and the Medical Revalidation & Job Planning Team to improve the process and quality of appraisals.

We will continue to build positive working relationships with SARD whereby we create autonomy in being able to develop and improve a system that is fit for purpose, having wider visibility with a holistic approach and ensure we utilise the system in the best possible way.

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	Appraisals and revalidations are reviewed monthly at the Medical Staff Support Group (Professional Standards).				
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: No issues identified with our processes for medical regulation.			

Recommendation / Action Required

The Board/Committee/Group is requested to:

- The Board is asked to note and accept this summary.

Accountable Lead Signature	
Date	01/07/2024

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Great Western Hospitals NHS Foundation Trust executive management team can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Required. Comments: Acting Chief Medical Officer (Dr Stephen Haig) completed Responsible Officer Training and is now the responsible officer. Action for next year: To ensure both Deputy Chief Medical Officers complete appropriate training for the role, so they can act as delegates.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Continue to embed and deliver a high-level service with a focus on quality and outcomes. Comments: Revalidation, Appraisal, and Job Planning are both now implemented and operating as business as usual with the Revalidation and Job Planning team continually developing the much strengthened and robust revalidation, appraisal and job planning processes. This is evidenced by consistent appraisal compliance and much-improved compliance of job plans. Action for next year: Continue to embed and deliver a high-level service with a focus on quality outcomes.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to maintain up to date records and support medical staff.

Comments: The trust's SARD system continues to link directly to GMC Connect and updates daily, providing an accurate and up to date record of revalidation status for all doctors for whom GWH is the designated body. Automatic emails are sent to the revalidation inbox when a doctor adds or removes their connection to GWH. GMC connect is also updated manually by administrators, when necessary, by keeping track of monthly new starters and leavers and working alongside the recruitment team.

Action for next year: Continue to maintain up to date records and support medical staff.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Continue to embed policy and processes and plan for review in January 2024.

Comments: Policy has been reviewed, updated, and ratified by necessary committees and uploaded to the trust's T-drive and easily accessible via the SARD dashboard for doctors. The process is monitored at monthly Medical Staff Support Group (professional standards) meeting. The policy is next due to be reviewed in January 2027.

Action for next year: Continue to embed policy and processes and plan for review in January 2027.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year Continue with facilitating an external peer review for 2023/24

Comments: A newly formed National Revalidation and Appraisal Managers Network was set up in 2023 whereby managers and specialists can come together as a forum to share approaches, processes, ideas, information and learning within medical revalidation and appraisal. These are currently held by a neighbouring trust online with a view to rotate the chair of the network meetings.

Action for next year: Continue with attendance and support with facilitating future meetings.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue to support locum and short-term placement doctors while they are working at GWH

Comments: There has always been an induction for all locum staff when they start with the Trust. The Medical Revalidation & Job Planning team work closely with Recruitment and Temporary Staffing Teams at the trust to ensure locum doctors are supported and follow the trust appraisal process where necessary, or Transfer of Information Forms are completed if required by the trust or by other organisations that the doctor works at.

Action for next year: Continue to support locum and short-term placement doctors while they are working at GWH.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for

work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: Continue to monitor and quality assure the information that is included on 'other practice forms and quality of appraisals on newly launched template to ensure that there is robust information.

Comments: The SARD appraisal module at the trust is reflective of the medical appraisal template (2022) which included the additional wellbeing questions and education/clinical supervisors appraisal statements. The Good Medical Practice (GMC) domains are included with the post appraisal forms. Doctors that work in other organisations are required to complete an 'Other Practice Form'. This allows for evidence of any complaints or incidents to be shared with GWH. Monthly quality assurance checks take place with SARD with support from CMO office. Please see Appendix A reflecting consistent compliance.

Action for next year: Continue to monitor and quality assure the information that is included on 'other practice forms and quality of appraisals on newly launched template to ensure that there is robust information. to keep up to date with GMC good medical practice updates to guidance and standards.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue monitoring the appraisal process.

Comments: Monthly quality assurance checks take place with support from the trust Appraisal Lead. Any missing relevant information relating to the doctor's fitness to practice is requested with the appraisal re, opened to allow for amendments. Any concerns are discussed and or escalated with the CMO Office. If there are mitigating reasons these are documented and plans can be put in place to support the doctor to achieve their appraisal. If there is continuing non-engagement with the appraisal process the doctor is discussed with the GMC ELA and if appropriate a Non-Engagement Referral is made.

Action for next year: Continue to monitor the appraisal process.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Continue to embed policy and processes and plan for review in January 2024.

Comments: Policy has been reviewed, updated, and ratified by necessary committees and uploaded to the trust's T-drive and easily accessible via the SARD dashboard for doctors. The process is monitored at monthly Medical Staff Support Group (professional standards) meeting. The policy is next due to be reviewed in January 2027.

Action for next year: Continue to embed policy and processes and plan for the next review to be undertaken in January 2027.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Work with SARD and appraisal lead to develop in house refresher training package to provide ongoing support to appraisers.

Comments: The trust currently has an appropriate number of trained appraiser's vs appraisees as per trust policy. The trust appraiser allocation process has been embedded since January 2023 to support with the completion of timely appraisals which is evident through consistent appraisal compliance.

Action for next year: To continue to embed and maintain the trust appraiser allocation process.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Utilise Appraisal Summary and PDP Audit Tool (ASPAT) within the system to support and identify areas where additional training/support may be required. Appraiser development/refresher day being planned for 23/24.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Comments: Appraisee's provide appraiser feedback, which is collated into a report in SARD and is shared with the appraiser yearly and uploaded to their own appraisal for reflection. The use of the ASPAT is now in place which helps to provide feedback to appraisers on summary outputs which can be reflected upon in their own appraisal and as part of a development. 82% of appraisers scored 75% and above (Good). A successful Inhouse Refresher Appraiser Education Event was held on 12th April with further ones booked for the remainder of 2024. New Appraiser Training has been arranged for the summer of 2024.

Action for next year: Continue to embed the ASPAT across the trust to all appraisers and support and identify areas where additional training/support may be required.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Continue to monitor via Medical Staff Support Group (MSSG)

Comments: Quality assurance is maintained by monthly MSSG meetings. These are attended by the Chief Medical Officer, Appraisal Lead, Medical Job Planning and Revalidation Specialist and the Medical Job Planning and Revalidation Administrator and the Deputy CMO for Medical Workforce. The committee regularly review quality assurance and create actions on an ad hoc basis as required.

Action for next year: Continue to monitor via MSSG

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2024	470
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	538

Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	**98**
Total number of agreed exceptions	**91**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: CMO and Deputy CMO will continue to attend all regional RO development days to facilitate shared learning on appraisal across SW Region

Comments: The RO has monthly meetings with the GMC Employer Liaison Advisor (ELA) to discuss all investigations that are on-going and any concerns about engagement in the appraisal process. The GMC ELA is involved in any conversations about deferrals or Failures to Engage and this has helped to avoid the need to reach formal process.

Action for next year: Continue to engage with the GMC ELA.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue with the current policy and monitor impact of SARD.

Comments: The Medical Revalidation & Job Planning Team support with revalidation compliance with CMO office and this is monitored at MSSG. Where a deferral has been made, the RO will write to the doctor involved to explain the reasoning behind the decision. If appropriate the Clinical Lead and HR Business Partner are included so that they are able to support the doctor. The most common reason remains the lack of evidence of colleague or patient feedback.

Action for next year: Continue with the current policy and monitor impact of SARD.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

> Action from last year: Continue with progress towards full job plan compliance, monitoring and reporting to Trust Board.
>
> Comments: Quality assurance and governance of the appraisal and revalidation process is maintained by monthly MSSG meetings. These are attended by the Chief Medical Officer, Appraisal Lead, Medical Job Planning and Revalidation Specialist and the Medical Job Planning and Revalidation Administrator and the Deputy CMO for Medical Workforce. The committee regularly review quality assurance and create actions on an ad hoc basis as required. Medical Job Planning is now business as usual and all job plans are reviewed, monitored and agreed monthly via Medical Working, Consistency and Advisory Group. A recent audit undertaken by KPMG reported that the trust has good and effective governance and controls in place.
>
> Action for next year: Continue with embedding and delivering effective clinical governance for doctors across the trust.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> Action from last year: Continue training and feedback for the new cohort of Case Investigators and Case Managers. 2 additional clinicians, 1 Clinical Lead and 9 People Operations representatives were Maintaining Higher Professional Standards (MHPS) Case Investigator trained in May 2024.
>
> Comments: The MSSG is set up to better triangulate disparate areas of medical performance so that concerns around performance, conduct, health complaints etc can be seen as one offering the opportunity to better support doctors in difficulty and for earlier intervention if concerns are evolving.
>
> Action for next year: To embed the skills gained during the recent Case Investigator training and continuing to ensure individuals are treated consistently and fairly and in a Just and Learning approach.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved

responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue to review investigations upon completion, ensuring the correct process has been followed.

Comments: This is covered in the Medical and Dental Revalidation and Appraisal Policy, reviewing investigations to ensure that the investigation followed policy and if there is any learning for change.

Action for next year: Where appropriate ensure de-brief sessions take place following case investigations to allow for any learning to be identified.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Senior People Partner continues to report to the MSSG on progress with any on-going investigation. The reporting of this information is strictly confidential, and reporting stored in a secure folder.

Comments: The Chief Medical Officer and Senior People Partner meet regularly to discuss any on-going investigations or concerns. The Chief Medical Officer meets as required with the nominated Non-Executive Director to discuss on-going investigations to ensure that the correct process is being followed. A monthly report is presented to Board with anonymous data on current investigations and exclusions or restrictions in practice.

Action for next year: To continue triangulating data sources e.g. complaints, feedback and identified capability and conduct issues to allow for appropriate actions to be taken.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: Continue to build a clear structure for notifying NHS England of concerns about GPs, if issues arise.

Comments: The RO continues to communicate with any other RO relevant to the practice of an individual doctor. The GPs working in the GWH Primary Care Network are not connected to GWH but to NHS England. This relationship has strengthened over the past 12 months with a more robust system for raising and discussing concerns. The RO is in direct communication with the counterpart at the local private hospital to ensure concerns are shared between the two organisations should these arise.

Action for next year: Continuation of the established process between RO's and other appropriate counterparts.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue to develop the MSSG meeting to ensure robust oversight. Staff and Associate Specialist (SAS) representative now included in the membership.

Comments: The MSSG is diverse and includes the Trust lead for Inclusion and Diversity to minimise the risk of unconscious bias impacting on case management and decision making. All members of MSSG are up to date with Equality and Diversity training.

Action for next year: Continue to develop the MSSG meeting to ensure robust oversight.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue to monitor the pre-employment checks.

Comments: The trust has the TRAC recruitment system, and all processes and checks are monitored throughout the year in conjunction with the general recruitment team to standardise processes. Pre-employment checks include GMC check, national insurance number, right to work checks

(Passport/Visa), DBS check, an occupational health check, forms including Confidentiality, Data Protection & Caldicott Statement and Self Declaration

Action for next year: Continue to monitor the pre-employment checks.

Section 6 – Summary of comments, and overall conclusion

Revalidation, Appraisal, and Job Planning are both now implemented utilising SARD and operating as business as usual with a full cycle of job planning covering 2023/24 complete with 2024/25 well underway. Processes are more robust and improved with strengthened oversight for the organisation and support for doctors with a small, dedicated team and intuitive system in place. This is evidenced by consistent appraisal compliance and much-improved compliance of job plans.

With the ASPAT tool now underway in the system, feedback reports have been shared to appraisers where they can reflect as part of a development process. This will inform future in house training as part of study days which is already underway with the Trust's Appraisal Lead and the Medical Revalidation & Job Planning Team to improve the process and quality of appraisals.

We will continue to build positive working relationships with SARD whereby we create autonomy in being able to develop and improve a system that is fit for purpose, having wider visibility with a holistic approach and ensure we utilise the system in the best possible way.

Section 7 – Statement of Compliance:

The board of Great Western Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

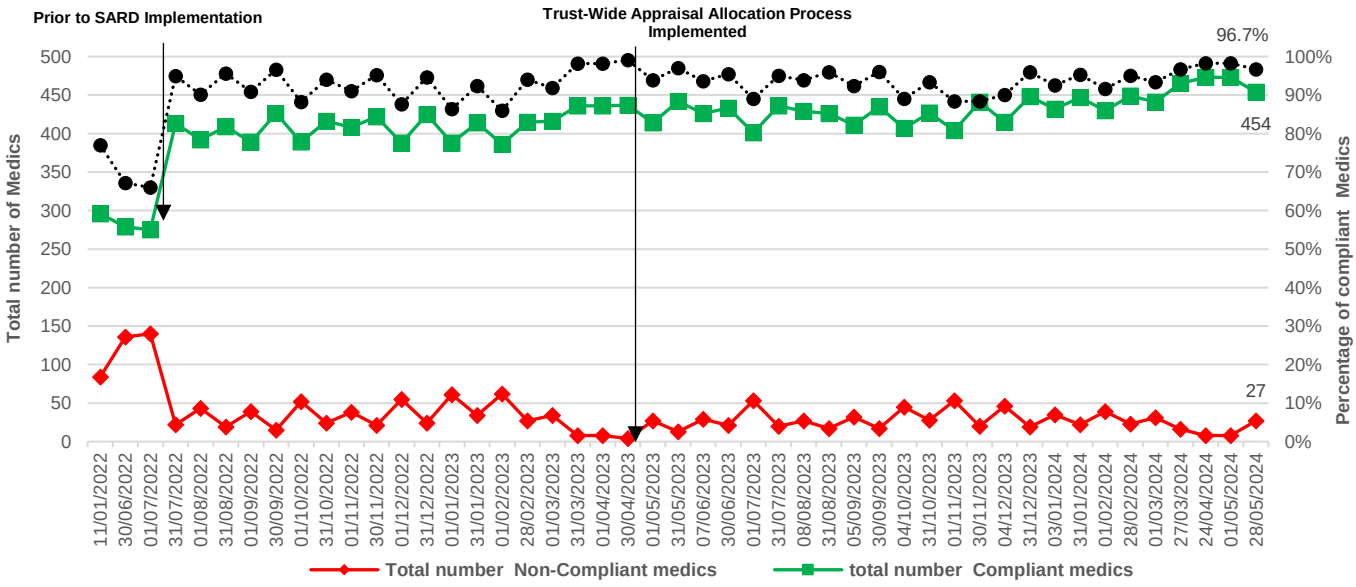
Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: PR1844

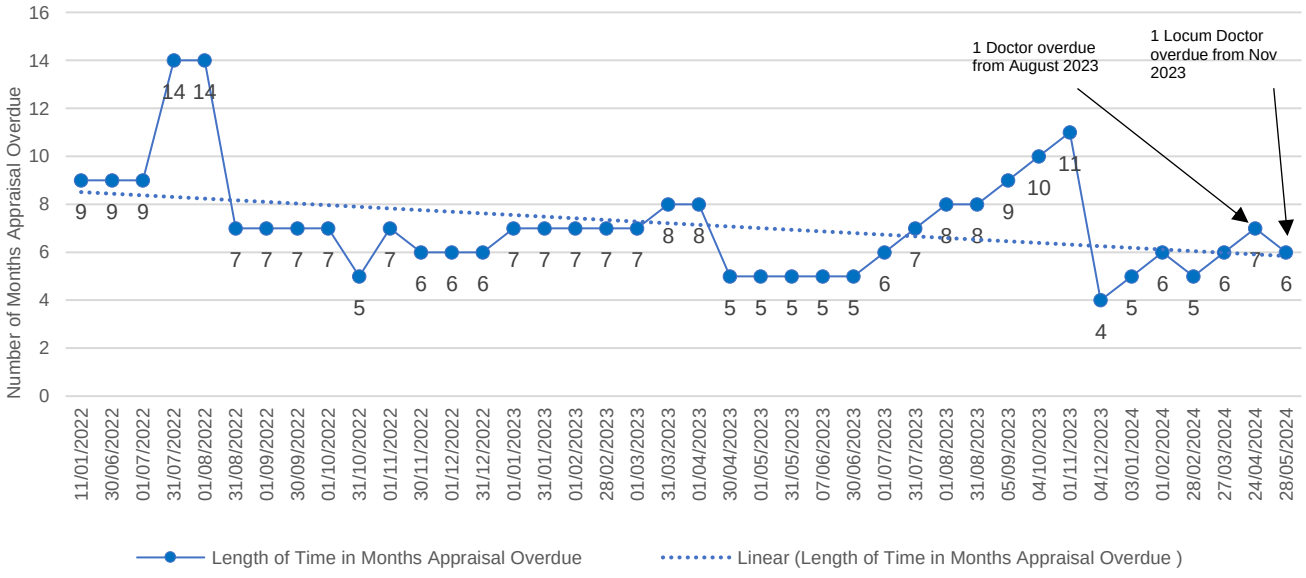
Trust-wide Medical Appraisal Compliance Month on Month



The chart above demonstrates the improved appraisal compliance since SARD was implemented: with the lowest compliance at 66% on 1st July 2022 and the highest since implementation at 99% in April 2023 and most recently 98% in April 2024. Compliance has also remained relatively static since implementation.

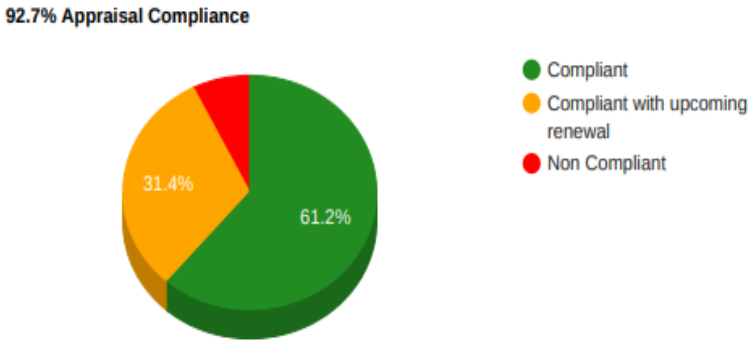
The length of time an appraisal is overdue has also reduced with the longest at fourteen months and the most recent being six months overdue demonstrated in the chart below.

Length of Time Medical Appraisal Overdue



Appraisal Compliance Chart SARD as of June 2024

PRIVATE AND CONFIDENTIAL:
Great Western Hospitals NHS Foundation Trust - Appraisal Compliance



The chart above is a snapshot of live trust compliance within SARD available to the trust. As of 7th June 2024, the trust is currently at 92.7%. The SARD system operates in real time allowing us as a trust to provide insight on the most up to date information to support our medics as well as monitoring job plans against trust policy and guidance and identifying discrepancies to effectively plan to meet the needs across the organisation.

Report Title	**Use of the Mental Health Act GWH NHSFT Annual Report**				
Meeting	**Trust Board**				
Date	**01 August 2024**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Lisa Cheek				
Report Author	Joy Gobey Trust MHA Administrator/Wendy Johnson Associate Director for Safeguarding, Trust Lead for Mental Health				
Appendices	None				

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):

Assurance that patients detained under the Mental Health Act to the Great Western Hospitals NHS Foundation Trust rights are protected under the Act and that the person is treated with compassion, dignity and respect.

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 report informs the Trust Board of the use of the Mental Health Act (MHA, 1983) April 2023 – March 2024

The use of MHA section powers was used in the Trust 148 times in 2023 – 2024.

Section 5(2) had the highest use over the reporting period (44 times), this remains consistent with previous reporting periods.

There were no legal breaches of the MHA and no appeals against detention for a Managers Hearing or appeal to the Mental Health Tribunal Service 2023 – 2024

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

		Risk Score
Key Risks **Risk Number 1125**	Patients with mental health conditions requiring treatment in specialist Mental Health in-patient services may not have their mental needs fully met whilst at the acute Trust and awaiting transfer to the relevant specialist service due to the Trust being primarily an acute physical health care provider.	12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Relevant content data provided by Avon and Wiltshire NHS Partnership Trust (AWP) Relevant content provided by Wiltshire Police	
Next Steps	None	

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		X	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	X		
Explanation of above analysis: The Trust has systems and processes in place to ensure patients who attend the Trust, of any age, and in mental health distress are treated equitably with patient who present with physical health needs			

Recommendation / Action Required The Board/Committee/Group is requested to:	
Note the contents of the report	
Accountable Lead Signature	lisa s check
Date	22.07.2024

Report title: Use of the Mental Health Act (MHA) report 1 April 2023 – 31 March 2024

1 Introduction

The report overviews the annual Mental Health Act activity at the Trust 2023 - 2024. The data in this report is taken from the central Mental Health Act database collated by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Mental Health Administration team and the Trust MHA Administrator. Training data is retrieved from the Electronic Staff Record (ESR).

2 Use of the Mental Health Act (MHA) 2023 – 2024

Mental Health Act	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
Section 5(2)	2	1	2	7	7	2	1	9	2	2	5 (1 child)	4	**44**
Section 2	0	1	1	3	3	3	2	2	1	1	2	1 (child)	**20**
Section 3	0	0	1	1	0	0	1 (child)	0	0	0	1	0	**4**
Section 17	1	0	0	1	0	0	1	0	0	2	4 (2 x children)	0	**9**
Section 19	0	1	1	4	1	2	3	1	2	1	3	1	**20**

Section 23	2	0	1	0	1	0	0	0	0	1 x 5(2)	0	2 x 5(2)	**7**
Section 136	2	7	6	3	1	4	0	3	2	4	7	5	**44**
Appeal for Hospital Managers Hearing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Appeal to Mental Health Tribunal Hearing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number use of the Act	**7**	**10**	**12**	**19**	**13**	**11**	**8**	**15**	**7**	**7**	**22**	**13**	**148**
Number of patients	**2**	**2**	**4**	**9**	**10**	**5**	**4**	**14**	**5**	**5**	**10**	**45**	**115**

Fig.1

2.1 Narrative

The use of MHA section powers was used 148 times in 2023 – 2024

Section 5(2) had the highest use over the reporting period (44 times), this remains consistent with previous reporting periods. Use of the MHA within the Trust is overseen by the Lead for Mental Health. Administration and Medical Scrutiny on use of the MHA is undertaken within the Trust and AWP SLA.

There were no legal breaches of the MHA and no appeals against detention for a Managers Hearing or appeal to the Mental Health Tribunal Service 2023 – 2024

Section 2 to GWH when no mental health bed available

Application of Section 2 of the MHA to the Trust is undertaken on a case-by-case review, when in the best interests and safety of the patient, Trust staff and others. Discussions are held between the AMHP as the detaining professional, the Trust Medical staff and the Mental Health Liaison Team Consultant. If detained, the Mental Health Liaison Team Consultant would become the Responsible Clinician for the patients mental health care.

2.2 Section 17 Granted Leave of Absence (attending GWH for medical assessment/treatment)

Q1	None for Q1
Q2	Section 3 to Sandalwood Court
Q3	Section 3 to Sandalwood Court.
Q4	Section 3 to Victoria Centre. Section 2 to Green Lane Hospital. Section 3 to Green Lane Hospital. Section 3 MHA to Victoria Centre. Section 3 to Marlborough House Adolescent Unit - Child Section 3 to Marlborough House Adolescent Unit - Child

2.3 Section 19 Authority transfer from one hospital to another under different managers

Q1	Patient transferred to Transferred to Sycamore, Hillview Lodge under Section 2
Q2	Patient transferred to Sandalwood Court Patient transferred to Hillview Lodge Patient transferred to Ellern Mede Hospital Derby Patient transferred to Charlton Lane Hospital Patient transferred to Marlborough House, Swindon Patient transferred to Fountain Way – under Section 2 Patient transferred to Thornford Park – under Section 2
Q3	Patient transferred to Hillview Lodge, Bath - under Section 2 Patient transferred to Schoen Clinic Newbridge –under Section 3 Patient transferred to Irwell Unit, Fairfield General Hospital, Bury, Lancashire –under Section 2 Patient transferred to Fountain Way - under Section 2 Patient transferred to Hillview Lodge, Bath - under Section 2 Patient transferred to Fountain Way - under Section 2
Q4	Patient transferred to New Horizon – under Section 2 Patient transferred to Fountain Way - under Section 2 Patient transferred to Fountain Way– under Section 2 Patient transferred to Cygnet Hospital Kewstoke – under Section 3 Patient transferred to Marlborough House, Swindon -–Under Section 2

2.4 Section 136

The Wiltshire Police Mental Health Lead provides Section 136 data to the Trust Mental Health Act Administrator on a quarterly basis of cases where the Trust has been used as the First line 'Place of Safety' (PoS) when Bluebell Unit and Mason Unit PoS are full. This data is included in the reports. The report also overviews activity in relation to attendance to ED for those under Section 136 requiring medical assessment.

Fig5	**2023**									**2024**		
	Apr	**May**	**June**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Attendance to ED due to no space at the Place of Safety Units	2	7	6	2	0	4	0	1	0	3	6	5
Attendance to ED for medical assessment	Included in the above data	Included in the above data	Included in the above data	1	1	0	0	2	2	1	1	0
Total	**2**	**7**	**6**	**3**	**1**	**4**	**0**	**3**	**2**	**4**	**7**	**5**
Annual Toal	**Q1 - 15**			**Q2 - 8**			**Q3 - 5**			**Q4 - 16**		

One of the main patient experience consequences of presentation to the Trust under Section 136 without the need for physical health care is that the AWP Mental Health Liaison service is not commissioned to provide services for patients under Section 136. This can mean patients can be in ED for several hours without the benefit of input from specialist mental health practitioners.

To address this gap the Trust MHA Administrator has developed and is proposing, a mental health presentation assessment proforma is completed by the relevant Mental Health specialist team when an adult, child or young person attends ED under Section 136. The completion of this proforma will support

early intervention and reduction in the patient distress and support Trust staff and the Police, in the management of the patient.

The proposed proforma is being taken through the AWP, Trust, Swindon AMHP, Wiltshire AMHP, Swindon EDS Task and Finish Group for discussion under the Section 136 agenda item. CAMHS and Manager of the Wiltshire Place of Safety will be invited to this agenda item meeting. The AWP service is represented at this meeting.

3 Legal clarification of Section 136 practice

The Trust were concerned around legal practice when a person detained by the police under a Section 136 presents to ED without a physical health need in circumstances where the designated 'Place of Safety' (PoS) is full. Following legal advice obtained from Bevan Brittan the Trust has agreed to accept all Section 136 presentations to ED, when there is no space at the Place of Safety Units as well as when attending for medical assessment. This information provides assurance to the Board that under these circumstances the Trust is acting in the person's best interest and within legal practice.

4 Re-reading of Patient's Rights under the Mental Health Act (MHA)

There have been no adults or children and young people inpatients with a longer stay than 7 days at the Trust detained under the Mental Health Act who would have required re-read of their Rights under the Mental Health Act**.**

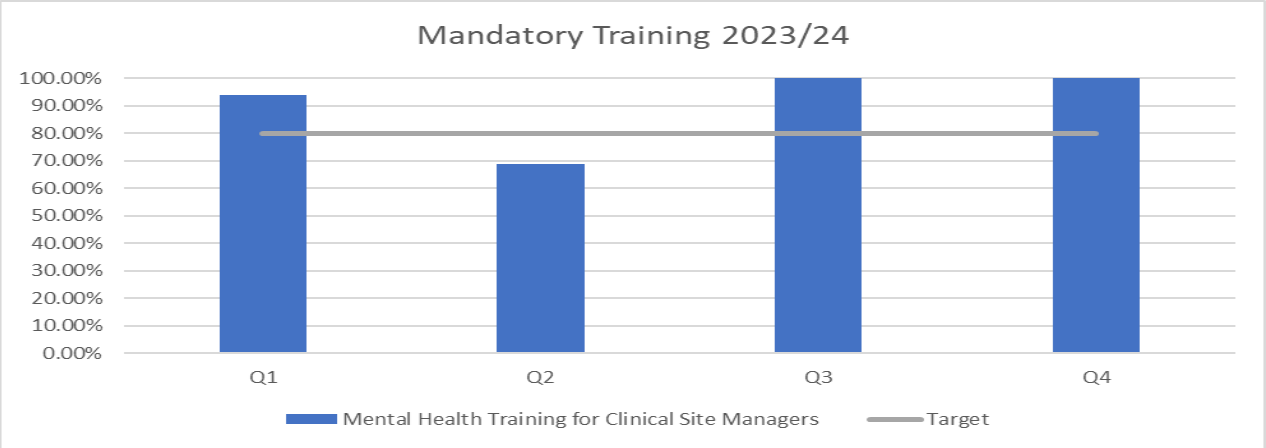
5 Mental Health Act Policy & Procedures

The MHA Policy and Procedures is due for review in April 2026. The current iteration remains fit for purpose.

6 Bespoke Enhanced Mental Health Act ESR module for the Clinical Site Managers

The bespoke ESR module is completed by the Clinical Site Managers in their role as designated, by the Hospital Managers as per Mental Health Act 1983 (as amended 2007) to receive Mental Health Act detention papers for those detained to, on transfer to other another Hospital and on leave to the Great Western Hospital NHS Foundation Trust.

Compliance is 100%. There is a competency assigned to this module. The Clinical Site Managers will automatically receive a reminder from ESR at 3 months and 1 month prior to expiry to complete the module.



7 GWH and CAMHS Service Line Agreement (SLA)

The current SLA is funded by the Integrated Care Board (ICB) under the contract with the ICB and Oxford Health NHS Foundation Trust.

The following SLAs between Oxford Health NHS Foundation Trust - CAMHS Marlborough House Inpatient Unit, CAMHS Community CAMHS Team and the Great Western Hospital NHS Foundation Trust contracts have now been ratified. The contract includes the Responsible Clinician role for the CAMHS patients under the Act and GWH service.

1. **Marlborough House Inpatient Unit** – Mental Health Act, Section 17 Leave to the Great Western Hospital for physical health care
2. **Marlborough House Inpatient Unit** – Informal patient admitted to Great Western Hospital for physical health care.
3. **Community CAMHS Team** – patient detained to the Great Western Hospital under the Mental Health Act, receiving physical health care. (Patients detained under the MHA to GWH come under the care of the Community CAMHS Team).
4. **Community CAMHS Team** (under the care of the Community CAMHS Team) – inpatient on the Children's Unit at the Great Western Hospital, receiving physical health care.

The SLAs are zero cost as the work is included in the SLA between Oxford Health NHS Foundation Trust and the ICB. This work was to formalise processes.

8 Mental Health Act assessment out of hours

8.1 Out of hours Mental Health Act (MHA) assessment request

The Trust has experienced delays in MHA assessment being undertaken out of hours when they have submitted a Section 5(2) application to the Swindon Emergency Duty Service (EDS).

The Swindon EDS team provide a service for Safeguarding Children out of hours and also cover the Wiltshire EDS team out of hours service to GWH. The Swindon EDS team priority is Safeguarding Children, so the MHA assessment very rarely takes place during the out of hours period. The Trust is monitoring the impact of this especially during the three- or four-day bank holiday weekends.

The process if the MHA assessment has not taken place out of hours is for Section 5(2) application to be handed over to the relevant AMHP team, Swindon AMHP day team or the Wiltshire AMHP day team.

The Trust Associate Director for Safeguarding and Lead for Mental Health raised this concern with the Swindon Director of Social Care who is overall manager of social workers including the AMHP team. The EDS Service has been depleted of AMHP team members however, recruitment has been successful with a new AMHP, but the team are still reduced in resources available.

The Manager of the EDS Service is now a member of the AWP/GWH/SBC Task & Finish Group and will pick up concerns regarding the service.

9 Task and Finish Group

A Task and Finish Group has been set up with GWH, AWP, EDS team and the AMHP teams to look at workstreams under the Mental Health umbrella at GWH and to formulate an SLA or Memorandum of Understanding for this work, similar to the work undertaken with GWH and CAMHS – Oxford Health.

Work included in the group is:

1. Mental Capacity Act v Section 5(2)
2. Duty of Candour
3. Section 136 – attendance to GWH
4. Complex Emotional Needs Management (Previously 'Emotionally Unstable Personality Disorder')
5. Emergency Duty Service (out of hours AMHP Service)

An agenda is set for each meeting and relevant multi-agency colleagues will be invited to the meeting pending agenda discussion.

10 Police and Emergency Department Handover Document

The Trust and the Wiltshire Police Mental Health Sergent produced the current dual-agency Section 136 proforma; this proforma has been used to develop another dual agency proforma known as the 'Mental Health Voluntary Attender to ED' form.

This form reflects the learning from a legal case where an NHS Trust was found to be negligent (Section 2 Mental Health Act 1983; duty of care; burden of proof) when a patient with a head injury absconded from an Emergency Department (ED) and suffered harm as a result (Webley v St George's Hospital NHS Trust and anr [2014] EWHC)).

This form is being developed through the 'Right Care Right Person' (RCRP) multi-agency workstream with a view to being used across the system in Acute Trusts. The RCRP is an operational model adopted by the Wiltshire Police which changes the way the emergency services respond to calls involving concerns about mental health. It is aimed at making sure the right agency deals with mental health calls, instead of the Police being the default first responder.

11 Inpatients at GWH under the care of the Community Mental Health Team under a Community Treatment Order (CTO)

The Trust have recently become more aware of patients attending/inpatient at the Trust whilst under a Community Treatment Order (CTO). When the person is an inpatient, the CTO is not valid but is activated on discharge. The Trust have experienced delays in discharge for some of these patients when the plan was felt the person required call back to a mental health inpatient unit rather than discharge back into the Community. The Associate Director for Safeguarding and Mental Health Lead, and the Trust's Mental Health Act Administrator is monitoring this.

10. Key actions 2024/2025

I. Upload refreshed Mental Health Awareness Level 1 E-learning platform module. Deadline 01 September 2024.

II. Progress and ratify the multi-agency task and finish group work regarding the use of the MHA Memorandums of Understanding (MoU's)