TRUST BOARD

Thursday 13 February 2025, 9.30am to 12.45pm

By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Jude Gray	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 9 January 2025 (draft)	8 – 15	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	16	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	CC	-	-
6.	**Staff Story – The role of the Clinical Practice Educator** Amy Fielding, Lead Clinical Practice Educator for Surgery and Hayley Moore, Ward Manager for Meldon	17 – 26	AF/HM	Receive	9.35
7.	**Chair's Report** Liam Coleman, Chair	27 – 30	LC	Note	10.05
8.	**Chief Executive's Report** Cara Charles-Barks, Chief Executive Simon Wade, Deputy Managing Director	31 – 37	CCB/ SW	Note	10.15
9.	**Integrated Performance Report**				10.35
	• Performance, Population & Place Committee Board Assurance Report (January) – Bernie Morley, Non-Executive Director & Committee Chair	38 – 39	BM	Assurance	
	• Quality & Safety Committee Board Assurance Report (January) – Claudia Paoloni, Non-Executive Director & Deputy Committee Chair	40 – 43	CP	Assurance	

		PAGES	BY	ACTION	TIME
	• Finance, Infrastructure & Digital Committee Board Assurance Report (January) – Faried Chopdat, Non-Executive Director & Committee Chair	44 – 45	FC	Assurance	
	• Integrated Performance Report	46 – 96	All	Assurance	
BREAK (10 minutes) at 11.05 to 11.15am					
10.	**Audit, Risk & Assurance Committee Board Assurance Report (January)** Helen Spice, Non-Executive Director & Committee Chair	97 – 98	HS	Assurance	11.15
11.	**Mental Health Governance Committee Board Assurance Report (January)** Lizzie Abderrahim, Non-Executive Director & Committee Chair	99 – 100	EKA	Assurance	11.25
12.	**CNST Year 6 Submission – GWH Compliance Report** Luisa Goddard, Chief Nurse and Dr Alex Van Der Meer, Consultant Obstetrician, Deputy Clinical Lead O&G *(received at Quality & Safety Committee 20 January 2025)*	101 – 108	LG	Approve	11.35
13.	**Learning from Deaths Annual Report 2023/24** Steve Haig, Chief Medical Officer *(received at Quality & Safety Committee 20 January 2025)*	109 – 132	SH	Assurance	11.50
14.	**EDI Board Commitments / Board engagement debrief session** Liam Coleman, Chair and Sharon Woma, Head of EDI & Health Inequalities	133 – 136	LC/SW	Approve	12.05
15.	**Our local strategic direction 2025-28** Claire Thompson, Chief Officer of Improvement & Partnerships and Chris Trow, Associate Director of Strategy	137 – 160	CT/CT	Approve	12.25
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.**					
16.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	-	CC	Approve	12.40
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 13 March 2025 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”*	-	-	-	12.45

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC AT THE DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ AND VIA MS TEAMS 9 JANUARY 2025 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Cara Charles-Barks (CCB)	Chief Executive
Faried Chopdat (FC)*	Deputy Chair/Non-Executive Director
Jon Burwell (JB)	Acting Chief Digital Officer
Julian Duxfield (JD)*	Non-Executive Director
Luisa Goddard (LG)	Chief Nurse
Benny Goodman (BG)	Chief Operating Officer
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
Rommel Ravanan (RR)	Associate Non-Executive Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)*	Non-Executive Director
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer

In attendance:

Caroline Coles (CC)	Company Secretary
Deborah Rawlings (DR)	Board Secretary
Tania Currie	Head of Patient Experience & Engagement (agenda item 198/24)
Stevie Fields	Tissue Viability Nurse (agenda item 198/24)
Sharon Woma	Head of EDI & Health Inequalities (agenda item 202/24)

Apologies

Lizzie Abderrahim (EKA)	Non-Executive Director
Claire Lehman (CL)	Associate Non-Executive Director
Jon Westbrook (JW)	Interim Managing Director

Number of members of the Public: There were 2 members of public in attendance (Chris Shepherd, Governor; Stephen Baldwin, Governor)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
193/24	**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.	
194/24	**Declarations of Interest** There were no declarations of interest.	
195/24	**Minutes of the previous meeting (public)** The minutes of the Board meeting held in public on 5 December 2024 were adopted and agreed as a correct record.	

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Minute	Description	Action
196/24	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list. It was noted that one action was omitted as follows:- 173/24 : Charitable Funds Committee Board Assurance Report : Wiltshire Health & Care An interim proposal on the charitable funds position should be made available for consideration ahead of the next CFC meeting in February 2025.	
197/24	**Questions from the public to the Board relating to the work of the Trust** There were two questions for the Board from members of the Trust. The first question related to the number of beds available at GWH for renal patients. In response from the Acting Chief Medical Officer, it was noted that a strategic approach and long-term plan was being explored with stakeholders to improve the service being provided at different sites. The second question sought assurance that re-admission data was discussed at Board level. The response from the Deputy Chief Operating Officer outlined the governance processes for the appropriate oversight of readmission rates by various committees which included through the integrated performance report to the Board. It was noted that a deep dive into readmission was also currently underway following an internal audit. The Board **noted** the questions.	
198/24	**Care Reflection – Areas for improvement in care, staff awareness and training** *Tania Currie, Head of Patient Experience & Engagement, and Stevie Fields, Tissue Viability Nurse joined the meeting to present this item.* The Board received a care reflection story of John as a member of staff as a patient. John had a long-standing spinal cord injury and had raised concerns during a more recent acute admission about the lack of care regarding his safety and personal care requirements whilst in hospital. The story offered the perspective from both a patient and member of staff viewpoint and described the barriers experienced during his care due to existing relationships with staff. The importance of specialist skin and bowel care were highlighted, along with ongoing messages to staff when caring for a patient with a spinal cord injury. It was noted that a coproduction group were jointly leading improvements, patient and staff awareness and staff training. The Board reflected on how to manage patients which staff may be acquainted with or were a staff member to ensure that all basic care needs were met. Luisa Goddard, Chief Nurse, responded that nursing groups would be asked to share the message from this story and to start a discussion around looking after our own staff to ensure that personal relationships did not interfere with the provision of appropriate care. Further awareness would also be raised with both staff and patients on specialist care passports which would provide details on particular needs ahead of hospital admissions. Patients who were also staff members would be encouraged to speak up about any concerns during their stay in hospital. The Board further reflected on the learning around quality and safety issues from a privacy and dignity perspective. There should also be consistent standards of care across the three hospitals in the Group, together with shared learning from patients to drive improvements. Wider improved experience should also be created for spinal injury patients in all three hospitals and the availability of a direct link to spinal injury specialists at Salisbury. The Board thanked Tania and Stevie for their presentation and for highlighting the issues raised by John in the film.	

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Minute	Description	Action
	The Board **noted** the care reflection story.	
199/24	**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, together with key meetings, training and events during December 2024 in which the Governors participated. The Board Members noted the proposed board meeting cadence to enable a standardised approach within the BSW Group Hospitals and the Board members were reminded to provide their agreement or comments on this approach. The Board noted there would be an increase in the number of meetings as the group structure evolved together with the sequencing of board development sessions over the next few months and that efforts would be taken to maximise board member input without the addition of increased burden. A plan would be provided on the sequence of events over the coming months. Liam Coleman, Chair also reported on a recent introductory meeting with Stephen Collier, Chair of HCRG Care Group, and was encouraged that HCRG seemed well sighted on the scale of the task around the handover of community services. The Board **noted** the report.	
200/24	**Chief Executive's Report** The Board received and considered the Chief Executive's Report, and the following was highlighted: Pressure on our services Cara Charles-Barks, Chief Executive thanked the staff at the Great Western Hospital during a recent period of unprecedented demand on services and the ongoing commitment to keep patients safe and maintain quality of care under difficult circumstances. The significant pressure could be linked to an increase in the flu and other winter viruses. NHS Planning Guidance The NHS Planning Guidance 2025/26 was still awaited. It was expected that this guidance would focus on the four key priorities of reducing waits for elective care; improving A&E and ambulance times; improving access to primary care and dental; and mental healthcare. It was noted that the publication of the plan to reform elective care for patients had now been received and was being reviewed for the implications of expectations around productivity and delivery against performance targets. Group Development Browne Jacobson, a law firm with comprehensive experience of working with healthcare organisations, would be undertaking developmental work with all of the Non-Executive Directors and Governors across the Group to support the development of the Group. This would also include support to establish a joint committee for the Group to facilitate collaboration and governance across the three organisations and that a workshop had been scheduled with a number of NED representatives to progress this. It was noted that a fortnightly briefing document was to be developed which would inform the Board members of the three organisations within the Group on the change management plans.	

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Minute	Description	Action

Improving Together
Improving Together, our Group-wide approach to continuous improvement and way of working, had been chosen as a finalist in the HSJ Partnership Awards in the Best Contribution to Improving the Efficiency of NHS services category.

Finance
The Trust's year-to-date financial deficit position was £8.4m, which was £3.1m worse than the position planned for. This position was mainly due to undelivered savings, clinical supplies being overspent, and medical and dental temporary staffing costs. Actions were being taken to close the deficit to reach the year-end breakeven position.

Shared Electronic Patient Record
The implementation of a shared electronic patient record across the three organisations was progressing and assurance would continue to be sought to ensure that the timetable for implementation would be met and remained close to budget as possible.

Community services
Work continued with the transfer of community services to HCRG Care Group from April 2025 to understand how individual services would be affected by the change and to develop a good partnership. Key priority was to ensure that staff remained informed and supported through the change. Cara Charles-Barks, Chief Executive, thanked Claire Thompson, Chief Officer of Improvement & Partnerships, and her team for the considerable work undertaken to date to navigate the changes.

Benny Goodman, Chief Operating Officer, provided an overview to the Board on recent extreme pressure on services at the Great Western Hospital and the impact on ambulance handovers and increased length of stay. New processes to improve patient pathways continued to be embedded for sustainability, together with continued actions around bed reconfiguration to align resources in the right place. Quality metrics continued to be measured around harm and assurance was provided that mitigations were in place to address pressure harm and deconditioning. Additional clinical support was also being deployed to support an increase in medical patients to ensure that patients were being reviewed rapidly. The Board acknowledged the current operational pressures and were assured by the actions working with system partners around the dynamic risk assessment.

Cara Charles-Barks, Chief Executive, added that discussions were underway with the ICB to develop an urgent care strategy within the system, including the South Western Ambulance Service NHS Foundation Trust, which would require a cultural shift in behavioural change in practice and dynamic conveyancing. Cara Charles-Barks also reported on a piece of work that was underway with the ICB and the national Getting It Right First Time (GIRFT) team around urgent care which had reviewed the data for all three hospitals and that further triangulation of datasets had been requested to deliver excellent urgent care. This data would be shared with the Board once finalised.

A robust discussion was held around the ongoing pressures on services and the wider strategic element around urgent care and partnership working to drive improvement.

The Board **noted** the report.

201/24 **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 November 2024.

Our Performance
Benny Goodman, Chief Operating Officer reported that the performance for RTT (Referral to Treatment) 52 Week Waiters showed a slight decline in November from the previous month. With regards to the 65 week wait cohort, some specialty risks remained which had

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impacted on the aspiration to reduce the end of month breaches in that cohort. The Trust continued to attend weekly "shadow tiering" calls with both ICB and NHSE colleagues to improve its position with system and regional support.

Cancer waiting times
Cancer performance had steadily improved month on month since April 2024, across both the 28-day faster diagnosis standard for cancer (FDS) and 62 Day performance. Great Western Hospital was now officially out of tiering for cancer services and that rigour around performance would need to be embedded to maintain this position and provide system assurance.

Emergency Department (ED) and Urgent Treatment Centre (UTC) Mean Stay and Attendances
ED and UTC attendances had reduced by 3% in November compared to the previous month. Work continued with support from the Emergency Care Intensive Support Team (ECIST) to improve processes within the new emergency department and newly co-located MAU and SDEC, and that recommendations for areas of focus were to be explored to help drive improvement.

Inpatient spells – No Criteria to Reside Bed Days (NCTR)
There was a significant increase in November for NCTR averaging 90, which was 27 patients higher than the operating plan trajectory. A breakdown of the split for this group was noted and that challenges and opportunities to resolve the different periods of time was to be explored further with partners.

Ambulance handover delays
It was noted that an average of 84 hours had been lost per day from ambulance handover delays in November, which was an increase from the previous month. This was the second consecutive month the breakthrough objective of 70 hours had not been met.

The Board noted that interviews were to be held in January for a clinical lead for hospital flow, to add to the nursing and operational leadership already in place.

There was also to be increased focus on driving improvements and development of short-term priorities around the discharge lounge in line with MAU and SAU trauma pathways.

Our Care
Luisa Goddard, Chief Nurse reported that total harms for this period and over the year had shown a slight increase in overall total harms and that this was mainly in relation to the reduction in harms from falls and pressure ulcers in the acute.

It was noted that November had been a challenging month in relation to falls which had shown an increase in the numbers reported. There had been a rise in falls with harm during November and that a review had identified specific themes for further investigation. Staffing challenges during critical incident periods at GWH had now been addressed. Improvement actions around enhanced care and raising awareness of counter measures to reduce the number of patients who had fallen more than once were outlined and noted, with continued oversight by the Falls Improvement Group to ensure that practices were embedded and sustained.

The number of hospital-acquired pressure ulcers had continued to reduce and reflected a sustained improvement over the previous three months with greater ownership and awareness in clinical teams around pressure harm and measures which continued to have a good impact on the levels of reported harm.

C. diff numbers for the Trust have continued to remain below its target trajectory and it was noted that GWH were better than the South West reported average, despite a rise in

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reported cases nationally. *E.coli* was now on trajectory and improvement actions were in place for *Klebsiella* and MSSA. The work to improve better catheter care and training was now starting to have an impact on reported numbers. Hospital-acquired pneumonia remained an area of focus to drive sustained improvement. Pseudomonas rates continued to significantly improve driven by the ongoing estates and infection control work.

The hierarchy of control around flu continued to have impact and an outline of the actions being taken were noted, which included appropriate mask wearing and good infection control precautions.

It was reported that the Trust's complaints response rate remained an area of concern and Luisa Goddard, Chief Nurse outlined actions that were being taken to improve performance, which included regular weekly and monthly meetings to monitor the complaints response rate using Improving Together methodology.

Our People
Jude Gray, Chief People Officer provided an update on the actions against the strategic pillar target which related to that *"Staff and Volunteers feeling valued and involved in helping improve quality of care for patients."*

It was noted that voluntary turnover had increased slightly in October and whilst this was still within control limits, it was an early indication that increased turnover was expected over the coming months. This could be impacted by current workforce controls introduced to reduce the worked WTE. Work being undertaken by the People Promise Manager on actions to reduce turnover and drive improvement in retention rates was to reach its conclusion and that this would be received by the People & Culture Committee. A key part of the work was the launch of the Sexual Safety Toolkit across the Trust.

The 2024 staff survey had achieved a 71% completion rate; initial embargoed results had been received. Discrimination disparity had continued to increase this month due to an increase of Speaking Up in staff reporting discrimination from manager/team leader or colleague. The new Trust initiative 'Count Me In' had been launched in December, which was an internal 'grant' that would be used to enable teams to deliver EDI and health inequalities related projects.

In Q2, the Pulse Survey results had seen a small improvement in the breakthrough objective in question 7c *"I receive the respect I deserve from my colleagues at work"* since the annual survey in 2023.

In-month sickness had increased in month which had been driven by short-term sickness. The Board noted the actions outlined by Jude Gray, Chief People Officer to drive improvement and to support robust control measures already in place.

Jude Gray, Chief People Officer also reflected on the recent Non-Executive/Associate Non-Executive Directors session with Peter Thomond, Clever Together, which provided an update on the project to drive improvement around speaking up within the organisation. The results of this project would continue to receive oversight by the People & Culture Committee. Jude Gray added that a new Lead Guardian had been appointed to continue to raise the profile of Freedom To Speak Up and it was suggested that learning around global majority background data be shared within the system. Caroline Coles, Company Secretary added that data gathered from a recent Membership survey had shown some issues being raised by staff members through that medium, as opposed to raising issues through normal routes, and that this data would be shared with the Chief People Officer.

Use of Resources
Simon Wade, Chief Financial Officer reported that at Month 8, the Trust had a year-to-date adjusted deficit position of £8.4m, which represented a £3.1m adverse variance to plan.

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Income was £7.1m favourable to plan driven by Elective Recovery Fund (ERF) (£4.8m), an overperformance on NHSE commissioned drugs (£2.8m), and industrial action funding (£0.5m) and the drivers for this position were outlined and noted.

Pay was £3m over plan and the position included c.£0.5m of junior doctor industrial action costs offset by income and a £1.6m under delivery of pay efficiencies. Ongoing temporary staffing pressures in front door, specifically in medical and dental, accounted for the rest of the pay variance, partially offset by centrally-held reserves. Simon Wade, Chief Financial Officer, added that temporary nursing agency spend had decreased significantly in comparison to the previous two years. Simon Wade added that although problems remained with medical recruitment, a large amount of the agency had shifted to locum which had delivered additional savings.

Operational non-pay spend was £9.1m over plan, which included £5.4m of overspends in clinical supplies and outsourcing within some divisions. Actions being taken by procurement were outlined and that a number of savings had been identified to drive improvement.

The efficiency plan was £2.8m under target at Month 8 with total savings delivered to date of £10.1m, which would enable access to potential support funding if that target was met. System recovery plans agreed in Month 7 included a delivery of year-end efficiencies of £17.5m and it was noted that other savings continued to be explored to impact the overall position moving forward. Simon Wade, Chief Financial Officer added that the Trust's latest productivity position was a 4.5% improvement on the previous year and was above both regional and national averages.

The forecast was to deliver £16.3m of savings, which would represent a £5.6m under delivery against the £21.9m target. Of the £8.6m savings delivered to date, 52% was recurrent, which was in line with Month 6. The focus of divisions must remain on the increasing the 52% delivery of savings on a recurrent basis to reduce the underlying deficit.

Faried Chopdat, Non-Executive Director added that the Finance, Infrastructure & Digital Committee had reviewed the annual planning for 2025/26 and that robust assurance had been gained around the process. The NHSE planning guidance was still awaited. Faried Chopdat requested that planning guidance be consistent and coherent across the three trusts in the Group to enable a better opportunity to start evaluating the financial position for 2025/26.

202/24 **EDI Board Commitments / Board engagement debrief session**

Sharon Woma, Head of EDI & Health Inequalities joined the meeting to present this item.

The Board received and considered a presentation which outlined the Trust Board's commitment to setting and fulfilling measurable EDI objectives and its key benefits.

Sharon Woma updated the Board on the objectives and key actions taken to date against the three Board EDI commitments for 2024/25 which related to staff and patient listening events, staff networks engagement and support, and Board meetings (ED&I data and reporting). The presentation also provided headlines around Slice of Life and Change the Narrative Event highlights and engagement themes, Board evaluation, and the staff perception survey.

The Board members which attended some of the Slice of Life sessions provided feedback on their perceptions on the effectiveness and output from those sessions but agreed that these sessions should continue in an agreed format building on the momentum already created.

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Minute	Description	Action
	The Board held a robust discussion on different methods to obtain more effective staff insight on EDI issues and how to improve the structure of sessions. The Board agreed that other opportunities should be explored to engage in conversations with patients and that Board members could join existing patient engagement events. It was noted that draft key actions for 2025/26 on the identified themes would be developed for review at the February 2025 Board meeting to reflect Board discussion. **Action: Chief People Officer** The Board **received** the report. **Consent Items** *Consent Items Note – these items are provided for consideration by the Board. Members were asked to read the papers prior to the meeting and, unless the Chair / Company Secretary received notification before the meeting that a member wished to debate the item or seek clarification on an issue, the items and recommendations would be approved without debate at the meeting in line with the process for Consent Items. The recommendations would then be recorded in the minutes of the meeting.*	
203/24	**Ratification of Decisions made via Board Circular** None.	
204/24	**Urgent Public Business (if any)** None.	
205/24	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 9 January 2025 at the DoubleTree by Hilton Hotel, Swindon.	
206/24	**Exclusion of the Public and Press** The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.	

The meeting finished at 12.53hrs

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<table>
<tr><th colspan="5">ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – February 2025</th></tr>
<tr><td colspan="5">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</td></tr>
<tr><th>Date Raised</th><th>Ref</th><th>Action</th><th>Lead</th><th>Comments/Progress</th></tr>
<tr><td>5 December 2024</td><td>173/24</td><td>Charitable Funds Committee Board Assurance Report
PPPC to consider an interim proposal on the charitable funds currently held by Wiltshire Health & Care following the transfer of community services to HCRG ahead of the CFC meeting in February 2025.</td><td>Chief Officer of Improvement & Partnerships</td><td>Verbal update given at PPPC on 29 January 2025. Request received from HCRG Care Group for GWH Charitable Funds to continue to host funds. Legal advice being sought. Outcome would be subject to the approval of the Corporate Trustees.</td></tr>
<tr><td>9 January 2025</td><td>202/24</td><td>EDI Board Commitments / Board engagement debrief session
Draft key actions for 2025/26 on identified themes to be developed for review at the February 2025 Board meeting.</td><td>Chief People Officer</td><td>On the February 2025 Board agenda.</td></tr>
</table>

<table>
<tr><th colspan="5">Future Actions</th></tr>
<tr><td>5 December 2024</td><td>172/24</td><td>Quarterly Pillar Metric deep dive – Our Performance
Further briefing on the detail around the risk of not achieving the national deadline for RTT, particularly for those board members that are not members of PPPC.</td><td>Chief Operating Officer</td><td>Full detailed report to be presented to Board in March 2025 following an external review.</td></tr>
</table>

Report Title	Staff Story – The role of the Clinical Practice Educator				
Meeting	Trust Board				
Date	13th February 2025	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Sue Day				
Report Author	Hayley Moore, Ward Manager for Meldon Amy Fielding, Lead Clinical Practice Educator for Surgery				
Appendices	PowerPoint presentation				

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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, 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):

This presentation highlights how Clinical Practice Educators (CPE) enhance staff development and patient safety through targeted support. Using the case of Song, a Band 5 Staff Nurse struggling with her transition to Meldon Ward, it showcases the CPE team's impact in collaboration with the Ward Manager and Legacy Mentor.

Key Messages:
Effective Support: CPE intervention helped Song achieve her performance goals through tailored planning, regular progress reviews, and mentorship.
Improved Outcomes: The support led to better patient safety, positive team morale, and higher staff retention.
Proof of Concept: The intervention demonstrates the potential for trust-wide benefits when CPE teams are effectively integrated.

This report confirms that the strategic deployment of CPEs can improve staff performance, patient safety, and organisational efficiency.					
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	N/A				

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:	
To note the staff story and the impact of the CPEs in the nursing workforce	
Accountable Lead Signature	Luisa Goddard.
Date	4th February 2025

Staff Story - The role of the Clinical Practice Educator

Amy Fielding – Lead Clinical Practice Educator
Hayley Moore – Meldon Ward Manager

A Case Presentation | November 2024

Introduction

The aim of this session is to highlight the value of the Clinical Practice Educator (CPE) role

We will present a case study of a band 5 Staff Nurse

We will show the impact the CPE team can have Trust wide

Song’s story

Song joined GWH from another Trust and this was her first band 5 position in this country

Setting – Meldon Ward

Expected to be immediately operational but found transition challenging

Unsettled management structure before Hayley who – met with staff and identified Song needed support

Ward based CPE Team introduced…

CPE intervention

Performance

Regular meetings to check progress

Planning phase – Needs analysis

Intervention – Supported by Ward Manager, CPE, Legacy Mentor

Success

SONG ACHIEVED HER AIMS

IMPACT ON PATIENT SAFETY AND EXPERIENCE

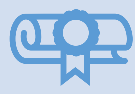
POSITIVE FEEDBACK

SONG'S WELLBEING

Feedback from Song

"I found it a great support, it was very helpful, I'm grateful that I got to use the process."

"I wish there had been a CPE team when I started my role, I would have struggled less"



"I learned a lot from being able to shadow someone with more experience."

Impact for the Trust

Improved patient safety

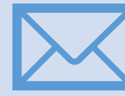
Positive impact on team morale

Better staff retention

Proof of concept

Any Questions?

Thank you for your time and attention, if you have any questions in the future, then please contact us on:

 Hayley.Moore4@nhs.net

Amy.Fielding1@nhs.net

Report Title	Chair's Board Report				
Meeting	Trust Board				
Date	13 February 2025	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

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

Assurance Level Assurance ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).							
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 identified assurance rating (whether substantial, good, partial or limited). *If 'Partial' or 'Limited' assurance has been indicated, 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):

This report outlines a summary of the Chair's activity and key areas of focus since the previous Board of Directors meeting, including:

- Council of Governors – Key Meeting Dates
- Strengthening Board Oversight
- Trust Chair - Key Meeting Dates.
- Board Meeting Dates 25/26 – for approval

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:-

(a) note the contents; and,

(b) approve the changes to the Board meeting dates and structure for 2025/26.

Accountable Lead Signature	Liam Coleman, Chair
Date	4 February 2025

Chair's Board Report

This report outlines a summary of the Chair's activity and key areas of focus since the previous Board of Directors meeting during January 2025.

1. Council of Governors

1.1 The following table outlines the key meetings, training and events during January 2025 which governors participated:-

January 2025		
Date	**Event**	**Purpose**
14 Jan	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
20 Jan	Governor Briefing on 'Role of Governor in system/group'	First of three meetings set for governors to receive a briefing from legal experts on the role of the Council of Governors in a system/group model
21 Jan	Official opening of the Integrated Front Door by Her Majesty The Queen	Lead Governor attended official opening of the Integrated Front Door
21 Jan	Engagement & Membership Working Group	To advise and support the Trust in increasing Trust membership and improving membership engagement
22 Jan	Trust Strategy drop-in session	Provide input and update for governors on the Trust strategy.
22 Jan	Health Talk on ADHD	Governors host to promote membership. Dr Sharman delivered a talk to over 160 attendees, taking questions and offering information on ADHD

27 Jan	Outpatient Visit	Governors host to promote membership. Members were recruited digitally with Trust membership being explained in person.
27 Jan	Member Coffee afternoon face-to-face	Governors host to promote membership. In person informal event to introduce governors to members and vice versa. Governors had the opportunity to listen to member views and talk about their role in the Trust.
29 Jan	Governwell Induction for	Induction for new governors facilitated by external provider.
5 Feb	Business & Finance Working Group	To identify key issues to address in relation to Trust finances and business planning. The working group received reports on finance, digital, estates and performance.

2. Strengthening Board Oversight & Development

2.1 Safety Visits - There was one Board safety visit during the period covered by this report as follows:-

Date	Area	Board Member
29 January 2025	Kingfisher Ward	Benny Goodman, Chief Operating Officer Bernie Morley, Non-Executive Director

3. Trust Chair Key Meetings during January 2025

Meeting	Purpose
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
1-2-1 meeting with Managing Director	Regular meeting
NEDs' Meeting & Improving Together Session	Monthly meeting
Mental Health Governance Committee	To attend as a member
Finance, Infrastructure & Digital Committee	To attend as an observer
Performance, Population & Place Committee	To attend as an observer
Remuneration Committee	Board sub-committee meeting
HWB Oversight Committee	To attend as a member
HWB Champions Forum	Network meeting
Weekly Chairs & Group CEO Meeting	Network meeting
BSW Chairs' meeting	Regular meeting
BSW Hospital Group Chairs' Meeting	Network meeting in person
Committees in Common	Regular system meeting
EPR Joint Committee	System meeting
GWH, RUH & SFT Joint Board to Board Development Day	Network meeting
Meeting with HCRG Chair	Introductory meeting to discuss mobilisation of community services
Managing Director recruitment process	
Integrated Front Door Official Opening	

4. Board Meeting Dates 2025/26

4.1 Following the approval of the change in meeting dates in 2025 to move to the 2nd Thursday of each month a consultation with Board members on further proposed changes to Board cadence was completed post the January Board meeting. There were no objections to the proposals. Therefore, the Board are requested to approve the following Board cadence. This has also been agreed with the other BSW acute trusts and will go to their respective Board meetings for approval.

4.2 With effect from 1 April 2025, to hold 6 full public and private meetings held on alternate months and in the intervening months a Board seminar (x 6) with the opportunity of a small private Board as required.

4.3 For the six seminars a year it is proposed that half of these are local, and half are shared so that all Board members across the three hospitals meet as one. The three 'all Board' seminars per year will require all Trusts to identify a shared date.

Board Cadence for 2025/26

GWH Board Dates 25/26	Apr 10th	May 8th	Jun tbc	Jul 10th	Aug 14th	Sept 11th	Oct tbc	Nov 13th	Dec 11th	Jan 15th	Feb tbc	Mar 12th
	Sem	Bd	Sem	Bd	Sem	Bd	Sem	Bd	Sem	Bd	Sem	Bd
	Local	-	All	-	Local	-	All	-	Local	-	All	-

4.4 The dates of the Board seminars allocated as joint BSW Hospitals Group (all) will be identified by the BSW Company Secretary team and will follow the pattern of one seminar date to be allocated to each trust on their set date (this means that each trust will be required to change two Board dates in 25/26) and will be hosted by that trust.

4.5 The Board is requested to approve the above changes to Board meeting dates and structure in 2025/26.

Report Title	Chief Executive's Report				
Meeting	Trust Board				
Date	13 February 2025	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, 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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, 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 Chief Executive's report covers:

1. National and system updates
2. BSW Hospitals Group development
3. Official opening of Integrated Front Door
4. Current pressures at Great Western Hospital
5. Implementation of new digital maternity record
6. Update on our financial position
7. Transfer of community services

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led

Links to Strategic Pillars & Strategic Risks – select one or more				

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

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

Explanation of above analysis:
The report mentions the Innovation for Healthcare Inequalities Programme which is working to improve patient access in underserved populations.

The report also details some of the work to create Great Western Hospital's sensory room, which has been designed with input from local school children and young adults, to provide a safe and comfortable space where younger patients with additional or complex needs, such as autism or a learning disability, can wait and be treated.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	6.2.25

1. National/system

1.1 Devolution White Paper.

On 15 December 2024, the Government published the Devolution White Paper: https://www.gov.uk/government/publications/english-devolution-white-paper-power-and-partnership-foundations-for-growth/english-devolution-white-paper

We are currently reviewing this important paper, and looking forward to working with partners and colleagues on this interesting work.

1.2 Elective Care Reform

On 6 January 2025, the Government published Reforming Elective Care for Patients https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/

This plan sets out an approach to delivering the NHS Constitution access standard for elective care by March 2029, as well as continuing progress on cancer diagnosis and treatment. It seeks to improve both the timeliness and experience of care for patients – making full use of the capacity, technology and good practice available to offer greater choice and convenience.

The plan sets out the streams of work which will enable delivery over the coming months. This will include agreeing revenue and capital allocations for April 2026 to March 2029, as part of the Spending Review.

1.3 Spring Covid-19 vaccination programme

NHS England's letter about planning for a spring COVID-19 vaccination programme confirms that the Government has accepted Joint Committee on Vaccination and Immunisation guidance to plan for a seasonal Covid-19 vaccination programme from Tuesday 1 April to Tuesday 17 June.

The letter sets out the confirmed cohorts and procurement process and provides advice on addressing inequality and the supply and delivery process.

1.4 NHS Planning Guidance

The NHS Planning Guidance 2025/26 was published on 30 January 2025, following the laying of the Government's Mandate in Parliament. The challenge for 2025/26 is to go further and faster on improvement while continuing to build momentum towards long term solutions. The Government has prioritised more funding for the NHS, but there are also more costs next year. That means we collectively need a continued strong focus on financial rigour and productivity.

The guidance asks systems to focus on:

- reducing the time people wait for elective care
- improving A&E waiting times and ambulance response times
- improving patients' experience and access to general practice and urgent dental care
- improving patient flow through mental health crisis and acute pathways and improving access to children and young people's mental health services.

We are presently reviewing the guidance in detail, developing our local plans. Plans will have Board sign-off.

1.5 Tackling healthcare inequalities through innovation

Find out how the Innovation for Healthcare Inequalities Programme has supported teams across the country to tackle healthcare inequalities by improving patient access to proven innovations in underserved populations across the Core20PLUS5 clinical areas of priority.

2. Group Development

January has seen us taking steps to strengthen the understanding and structures of the BSW Hospitals Group. This has included a Board-to-Board Development Day on 24 January 2025, as well as development sessions with the Councils of Governors from Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust.

In February 2025 we hope to recruit the Managing Directors for each of the three hospitals in the Group, with interviews scheduled for later in the month.

We now have a steady rhythm of weekly meetings between the CEO and Managing Directors and are developing our systems to provide regular information sharing across the three Boards.

Great Western Hospitals NHS Foundation Trust update

3. Official opening of Integrated Front Door

Her Majesty The Queen visited Great Western Hospital on 21 January, to officially open the Integrated Front Door and to meet with staff from right across the organisation.

Her Majesty was greeted by local dignitaries including the Lord-Lieutenant, the High Sheriff and the Mayor, before Chair Liam Coleman and Chief Executive Cara Charles-Barks took her on a tour of the Integrated Front Door, accompanied by Emergency Department Consultant Dr Elizabeth Barneby.

The tour started in the Medical Assessment Unit, moved through the new Emergency Department and in to the Children’s Emergency Department, where Her Majesty met a patient.

In the main Atrium Queen Camilla met a group of staff, patients, and donors before unveiling a plaque to commemorate the occasion with a pupil from Badbury Park Primary School.

Her Majesty met more than 100 staff on her visit, which was a significant day in our organisation’s history, with the last visit from a member of the Royal family taking place when HRH The Princess Royal opened the Brunel Treatment Centre in 2006.

4. Operational update

4.1 Current pressures

We have seen very high numbers of patients using our urgent and emergency services over the last few weeks.

Thanks go to our staff who have worked exceptionally hard in challenging circumstances over a prolonged period of time.

Maintaining a good flow of patients through the hospital is really important to the smooth running of our services, however we have faced difficulties with high numbers of patients occupying beds who do not need to be here, due to issues discharging them quickly enough. This makes it more difficult for new patients to be admitted to hospital beds.

We have also had to close a number of wards to new admissions due to having many patients who are symptomatic of norovirus, and have also seen high numbers of beds occupied by patients with flu.

We have reminded staff of the importance of following strict infection prevention and control guidance to try to stop the virus spreading further, and have discouraged visitors from coming to the hospital when they are symptomatic.

We have also seen challenges with ambulance crews being delayed handing over their patients due to high demand in our Emergency Department. We continue to work closely with the ambulance service to care for patients in a timely way.

5. Quality

5.1 Digital maternity record

We have transitioned to a new digital maternity record, called BadgerNet and BadgerNotes.

This single digital record allows women to access their maternity records in real time on any digital device via an app or website.

The information will be updated by midwives and other healthcare professionals, whether in the hospital, the community or at home.

Benefits of the new system include:

- Information can be shared with women directly from the maternity system, including appointment dates and test results.
- Records can be easily updated at each maternity visit or appointment and can be viewed at any point during or after the woman's maternity journey.
- Real time access to Trust and national information and advice throughout pregnancy.

5.2 Sensory room

Our first ever sensory room, located on the Children's Emergency Unit, is now complete and open.

Designed with input from local school children and young adults, the sensory room is a safe and comfortable space where younger patients with additional or complex needs, such as autism or a learning disability, can wait and be treated away from the bustle of the main department.

The sensory room has padded walls and seating, visual sensory toys and equipment and calming tones which depict nature - with the final designs chosen, in part, by the young adults who attend the Stratton St Margaret Youth Club.

6. Systems and strategy

6.1 Finance

Our year-to-date financial deficit is £9.1m. This is £2.1m worse than plan.

The overspend is predominantly due to:

1. Undelivered savings
2. Clinical supplies being overspent
3. Medical and dental temporary staffing (including industrial action costs)

Divisions have been asked to focus on delivering their identified savings and reducing pay spend throughout 24/25.

Tighter controls around the approval of bank shifts, overtime and waiting list initiatives will contribute to this, while continuing with the good work already in place which has resulted in spending reductions on temporary staffing, specifically in nursing.

As a system we need to work together to reduce our overall deficit – delivering recurrent savings will be a key area of focus in next few years.

6.2 Transfer of community services

We continue to plan for the transfer of community services to HCRG Care Group from 1 April.

The majority of staff have been told if their role will be transferring to HCRG or staying within the Trust, however a small number of staff are working in roles which are still under review. Some of our services are integrated across different areas of the Trust, so reviewing each service is complex.

Staff have now received a ‘Measures Letter’, outlining changes or adjustments HCRG plan to make, and been offered a one-to-one consultation meeting as an opportunity to raise any concerns or ask questions.

HCRG have held face-to-face touch point sessions for staff, talking about who they are and the TUPE process, before answering questions.

Separately, the Community Equipment Service will be led by Swindon Borough Council from 1 April 2025.

The decision, made in partnership with the Integrated Care Board and council, follows a comprehensive review of this service and the growing needs of local people.

Staff directly affected have been informed and there will be opportunities to ask questions and raise any concerns in the coming weeks as part of a formal consultation process.

7. Workforce, wellbeing and recognition

7.1 Flu

With a few weeks left to go until the conclusion of our annual flu vaccination campaign, we currently rank among the top ten NHS Foundation Trusts for vaccination of staff.

Latest UKHSA data shows we are the highest ranked NHS Foundation Trust in our region and the seventh highest nationally for staff flu vaccinations.

To date, we have vaccinated 58 per cent of our staff (around 4,000 individuals).

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	29th January 2025	
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**
References from other committes:		
1. Admissions Audit	Noted	
2. NHS@Home	Good	✓
Operational Highlight Report (see below)		
3. IPR - DM01	Good	
4. IPR - RTT	Limited	
5. IPR - Cancer	Good	
6. IPR – ED / 4 hours	Partial	
7. IPR – Ambulance Handover	Limited	✓
8. Outpatients 6 Monthly Performance Review	Substantial	
9. ECIST Report	Noted	
10. Quarterly 15+ Risk Report	Good	
11. Partnership Report	Noted	
12. Community Services Transfer	Noted	
13. NHS Planning 25/26	Noted	

POINTS OF ESCALATION	Future consistency regarding hospital at home raised at Board level, and assured to PPPC due to change in senior clinical workforce since August and demonstrated effectiveness. The imminent transfer of services to HCRG was not felt to be a risk to service reliability. Ambulance handover delays increased to 103 hours lost per day. In addition ED 12 hour trolley waits increased to 292 in December.
KEY AREAS TO NOTE	Cancer: 28 day FDS is 78.9% versus 75% target. 56.5 breaches for 62 day target predominantly Urology and Plastics. Issue with Oxford SLA for Plastics remains, with escalation to ICB and OUH for support. DM01: Slight drop in performance but still strong with overall waiting list falling by 292 in month. Only 848 waits greater than 6 weeks which is 90% drop since Oct 2023. ED and UTC: Attendances up 5.2% versus same period last year. 153 minute mean time in UTC. 398 minute mean time in ED, versus 240 minute national standard. Currently circa 100 beds closed due to infection on wards. Recommendations in ECIST report and admissions internal audit report will be closely considered to determine which would have the most incremental benefit; due to return to PPPC in 2 months time.

	NCTR patient numbers at 81 on average for December. RTT performance: improved versus 65 week-wait December forecast, which is down 14 from October. Aim remains to remove all 65 week-wait breaches by March 2025. 52 week-waiters have dropped from 234 to 1,423 in Dec (target of 679) and therefore will not meet end of year elimination challenge. National/regional context of delayed planning guidance, imminent NHS 10 year plan, consolidation and implications of pathology and imaging networks discussed. Local work to set ICA priorities for 2025/26 and consideration of the roles of ICA and Health & Wellbeing Board updated. Planning position presented noting delayed guidance, constraints of settlement and expectations/implications of truncated submission timeline for system level plan. Community contract mobilisation has started, programme board established, and issues / risks have been identified and are under discussion with HCRG and ICB.
BOARD ASSURANCE FRAMEWORK & RISKS	Historic management of risk 602 regarding plastics was questioned, but current risk remains. New corporate risk relating to the transfer of community services to HCRG noted.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Hospital At Home improvement in both capacity and utilisation. Outpatient performance in top quartile nationally for Activity, PIFU, Follow up ratio and DNA rates.
REFERRALS TO OTHER BOARD COMMITTEES	Impact on patient safety due to 12-hour trolley waits in ED – to Quality & Safety Committee.

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 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 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 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 Assurance: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	Quality & Safety Committee
Meeting Date	20.1.25
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 Falls with Harm

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Falls (IPR breakthrough objective)	Partial	
2. IP&C (IPR breakthrough objective)	Good	
3. IPR concerns and complaints (Non-Alerting Metric)	Limited	
4. IPR Maternity	Good	
5. Maternity and Neonatal Quality and Safety Report Q3 2024/25	Good	
6. Perinatal Mortality Review Report Q3 2024/25		
7. GWH CNST Yr 6 Submission-GWH Compliance Report		
8. Saving Babies Lives V3 (Q2 Assessment)		
9. National Maternity Survey CQC Report 2024	Good	
10. National Urgent and Emergency Care Survey 2024	Good	
11. Learning from Deaths Report	Good	
12. Risk Register Report January 2025	Good	
13. Safe staffing monthly Report		
14. Electronic Discharge Summaries January 2025 Update		
15. Freedom to Speak Up report Q2 2024-25	Partial	

POINTS OF ESCALATION

Integrated Performance Report

- **IPR: Reduction Total Harms:** little change in the overall harms in month. Patient Safety Incidents investigation numbers now removed from total numbers as captured elsewhere.
- **IPR: continued monitoring Pressure Harms:** December continues to show a reduction in hospital acquired harms and no categories 3 or 4 and stable community acquired numbers. The Committee was assured by the consistently good results, Teal ward has been pressure harm free now for 3 months consecutively.
- **IPR: Infection Control:** GWH remains below target trajectory for *C.Difficile* infection numbers despite a slight further rise in month whilst there has been a decrease in Methicillin-Sensitive Staphylococcus (MSSA) numbers to one and Methicillin Resistant Staphylococcus Aureus (MRSA) remains zero for 10th consecutive month.
  Klebsiella and *E.coli* numbers have also decreased as a result of focused work.
  Work on community acquired gram negative infections is now a focus for action.
  Following the intensive response to pseudomonas aeruginosa infections last year, our infection rates are significantly below trajectory compared to last year.
- **IPR: Breakthrough Objective – Falls:** Whilst falls with moderate harm or above was limited to one, incidents of patients falling more than once had increased slightly. The falls incidence rates are drifting away from trajectory.
  A review of the A3 work and countermeasures towards this Breakthrough Objective is now being undertaken as outcomes have not improved and the Committee do not yet feel assured that the methodology is sufficiently effective.

Complaints and Concerns

- The complaint response rate is still below the expected target. Last month the Committee reduced its assurance rating in this area as there is no improvement despite the focussed work being done around this.

	Maternity Integrated Performance Report • Significant progress against the CQC Action plan, including increasing compliance with Safeguarding level 3 training, 24 hr triage provision and digital move to `Badgernet'. • Emerging themes include increasing post partum haemorrhage (PPH) and safety concerns around the overrunning of the elective caesarean section list. • One perinatal death from November is being investigated. • Immediate and Essential Actions from the Ockendon Report were presented and on track. • As the end of the reporting period for the Maternity Incentive Scheme (CNST) Year 6 approaches, compliance on all 10 standards are expected. • Sustained improvement in staffing levels and more effective use of escalation. • Training metrics met for CNST. • Service user feedback very positive but the number of complaints had increased in November, although many were increasingly de-escalated by the time of the meeting. • Identified areas of improvement are delays to induction of labour and noisy wards.
	Perinatal Mortality Review Report Q3 2024/25 • All perinatal deaths reported using PMRT, 3 cases in December. • Sadly also a maternal death who died on postnatal day 17 at a tertiary referral centre. • No improvement actions were identified from December as no PMRT reports were published due to quoracy issues of the reviewing group. The meeting rescheduled to January 2025. A strategy to minimise the impact of quoracy on reporting has now been put in place. • Themes identified from staff and user feedback includes access to prompt analgesia pre and post partum and the Induction of labour process.
	Quarter 3 2024/25 Maternity and Neonatal Quality and Safety report • 2 serious incidents closed and learnings gained learning plan put in place with tasks allocated. • Pockets of higher staff vacancy rates in maternity triage and community provision. • Workforce review to support 'critical care' trained senior midwife on each shift. • During Q3 the Screening Quality Assurance Service (SQAS) undertook a Quality Assurance review of GWH NHS screening of newborn. 3 urgent recommendations were made resulting in an immediate action plan, of which 2 of 3 actions were completed before the end of Q3. • Saving Babies Lives-demonstrates improved compliance in elements 1, 2 and 5 and maintenance of compliance in elements 3, 4 and 6. • Confirmation was received from the LMNS that the Trust have met the requirements outlined in the Maternity Incentive Scheme CNST yr 6, with action plans in place for 3 of the 10 Maternity Incentive scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Safety actions. • Following maternity inspection in September 2023, a rating of 'requires Improvement' was given with five Must Do and 2 Should Do actions given. • All actions are underpinned by detailed improvement action plans. There has been consistent progress.
	National Maternity Survey CQC Report 2024 • 305 GWH patients were invited to take part in this survey of 30 Trusts nationally, with 62 questions related to all stages of pregnancy, delivery and postnatal care. • 46.4% response rate, slightly lower than national average 49%. • The report demonstrated improvements since 2023 survey with 83.7% mean rating score and our services scoring in top 20% of Trusts for 14 questions. • We remained in the bottom 20% for 9 questions as in 2023, related to feeding, discharge and recovery. • But direct correlation difficult as questions had changed. • Detailed action plan now in place around:- – communications around choice of birth location – postnatal discharge process – infant feeding sessions – postnatal mental health – postnatal training and education
	National Urgent and Emergency Care Survey 2024 • Survey results received from patients over age of 16 treated in our Emergency Department and Urgent Treatment Centre during February 2024, this survey is being undertaken every 2 years.

	• The response rate was 29% ED (previous 28%) and 25% UTC (previous 20%). • For ED we scored 'about the same' as most other Trusts in the majority of questions with just one question scoring better than most around information on ambulance wait times. 13 questions showed improvement and the top scoring questions related to the environment, information and facilities. The worst scores related to privacy, involvement in care, discussing anxieties around test results. • For UTC we scored 'about the same' as most other trusts in the majority of questions with one question scoring worse than expected around help with condition or symptom whilst waiting. • Improvement in the overall patient experience. • Top scoring questions related to the environment, information and facilities. • The Committee reviewed the departmental action plan and felt it to be thorough and focussed.
	Learning from deaths report January 2025 • Standardised Hospital Mortality indices (SHMI) are within expected range, meaning our actual death rate is in line with expected death rate for GWH. • There was a spike in mortalities in November which triggered a deeper review by the medical officers but no cause for concern identified. January and December are showing variable results. • SJR completion has improved this last quarter, but will be more selective going forwards in which cases should go through an SJR to reduce duplication where cases are already undergoing investigation. • The impression given to the Committee was there was distinct improvement in the actions and processes now in place and good engagement in the sub group committee whilst more engagement is still required across the wider Trust and this will now be more likely as the new measures and processes embed.
	Freedom to Speak Up Report Q2 2024/25 • Much improvement achieved. • Freedom to Speak Up training is now mandatory for all, as 'listening up' is for managers. • Promotional work is ongoing for the role of Freedom to Speak Up guardians and there is a plan to expand these numbers. • Further investment has allowed expansion of the lead role which is now 4 days a week role. • There has been an appointment in November 2024 of a new Lead Guardian. • Extensive collaboration in conjunction with ward and line managers is allowing enhanced triangulation around issues raised. • The profile and effectiveness of the Freedom to Speak Up service has significantly increased over the past 12 months. • Self assessment of the service is currently happening every 2 years.
	Electronic Discharge Summaries November 2024 Update • The benchmark to complete EDS within 24 hours of discharge sits at 80%. The current status is 72.1% • Since the last report there has been an interruption of the EDS platform which impacted EDS production and problems with the testing phase. • A coronial inquest where handover discharge was identified as a learning point was undertaken related to an incident involving GWH. • The Chief Digital Officer has committed to a new go live date for the electronic EDS of February 2025. • The Committee remained with limited assurance but acknowledged that in the interim all measures that can be taken cost effectively and with current capacity is being undertaken.
BOARD ASSURANCE FRAMEWORK & RISKS	**Risk Register Report January 2025** • Assurance was received around the trust management processes of the top risks falling under the responsibility of this Committee. • There are 5 risks scoring 15+each with robust understanding and mitigation action plans in place. • Some of these risks come as a result of environment change as the new ED areas have been installed and some related to liaison with community services needs.
CELEBRATING OUTSTANDING	

PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

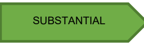
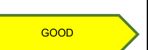
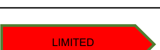
Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	27 January 2025	
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. BSW Financial & Recovery Workstreams Update	Limited	x
2. Month 9 Finance Position	Good	x
3. Improvement & Efficiency Programme	Good	x
4. 2025/26 Planning Update	Limited	x
5. PFI Financial Update	Substantial	x
6. National Cost Collection – 2023/24 results	Good	x
7. Costing Engagement & Service Line Reporting	Good	x
8. Site Utility & Resilience – 6 monthly update	Partial	x
9. ERIC Report update	Note	x
10. Health & Safety – Quarterly Report	Good	x
11. Green Plan – extension request	Approve	x
12. Digital (including shared EPR risks) Risk Register	Good	x
13. Data Protection, IT Resilience & Cyber Security – Quarterly update	Good	x
14. Digital Strategic Plan – Quarterly update	Good	x
15. Procurement update	Good	x
16. Procurement Recommendation Report – Enteral Feeds	Approve	x
17. Expansion Land Private Healthcare (direction of travel approval)	Approve	x
18. GWH/Prime – Draft Partnering Agreement	Note	x
19. BAF Strategic Risks – review of emerging risks	Approve	x

POINTS OF ESCALATION	**BSW Financial Update:** The finance position at M9 is a YTD adverse variance of £12.9m. This position is after recognising the pro-rata share of £30m deficit funding. The individual positions by organisation are as follows: GWH £2.1m off plan; RUH £6.7m off plan; SFT £10.7m off plan; and ICB is £6.6m ahead of plan. These positions are deteriorating at RUH and SFT, with GWH reducing its deficit and the ICB improving. For all providers, issues remain with the delivery of efficiency and improvement programmes, leading to run rates exceeding the required levels. Mitigating actions have been identified to address some of these challenges, but the outlook for 2024/25 remains exceptionally challenging, and delivery of the £30m deficit plan is at risk. The Committee notes that the financial risk for the system is escalating and is high, with the outlook for 2025/26 forecasted as extremely challenging, notwithstanding the actions agreed at the System Financial Recovery Board.
POINTS TO NOTE	**Month 9 Financial Position:** The Trust's adjusted deficit position is £9.1m, representing a £2.2m adverse variance from the plan. Income is £9.3m favourable to the plan, driven by ERF (£4.8m); an overperformance on NHSE Commissioned Drugs (£3.3m) and industrial action funding (£0.5m). Overall, pay is £5.2m over the plan, which includes £0.5m of junior doctor's industrial action costs offset by income and a £0.6 m under delivery of pay efficiencies. Non-Pay is £8.5m over the plan, including a £6.1m variance in clinical supplies and outsourcing, particularly in Medicine and Surgery, Women's & Children's. The Committee is assured that grip and controls are in place including regular meetings, specifically workforce and financial recovery committees, to monitor spending and associated savings.
	Improvement and Efficiency Plan: The Trust started the year with a £21.90m cash-releasing efficiency target with no carry forward of undelivered/non-recurrently delivered efficiency from 2023/24. As of Month 9, the programme has delivered £12.8m year to date, with 49% of this being delivered recurrently. The partial assurance rating relates to the risk of delivering the efficiency programme for 2024/25. Although systems and controls identifying and tracking savings provide good/substantial assurance, the challenge of the scale of efficiencies and current delivery means there can only be partial assurance. 2025/26 preparation: We have been assured that all divisions are working at the cost centre level to establish efficiency plans for 2025/26. This is alongside divisional and workstream level opportunity analysis, however, progress in efficiency identification has been slow due to operational pressures.
	2025/2026 Planning: The Committee was presented with the approach to develop the 2025/26 Plan, which focuses on creating an optimal system plan that will require all organisations within the Group to work together with a consistent set of assumptions, using the same methodology and a template that can be aggregated to form one Plan. Due to the high ambiguity of requirements from a national level and the challenging timelines to develop the Plan, including the concern of meeting our system financial plan and our obligations under the provision of the system deficit funding, the Committee assessed 2025/26 Planning as 'Limited' Assurance.
	Site Utility Resilience: This was historically recorded as 'Good' level of assurance, however considering the electrical incident that occurred on 9 July 2024, the Committee agreed that it was appropriate to reduce the level of assurance to partial until management have fully investigated all events, systems and controls associated with the electrical incident.
BOARD ASSURANCE FRAMEWORK & RISKS	**Digital Risk Register, including Shared EPR Risks:** The Committee 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. All risks rated 15+ were presented with appropriate mitigation actions.

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.

Report Title	Integrated Performance Report (IPR)				
Meeting	Trust Board				
Date	13th February 2025	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Benny Goodman, Chief Operating Officer Luisa Goddard, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Rob Presland, Deputy Chief Operating Officer Ana Gardete, 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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Report

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

Our Performance

Key highlights from our operational performance for December (November for Cancer) are as follows:

Strategic Pillar Metrics

RTT (Referral to Treatment) 52 Week Waiters

December's performance shows the total number of patients waiting over 52 weeks at 1,423. This was a 14% reduction from the previous month, but there remains a significant variance in performance to the operating plan trajectory for December that was set at 77 patients.

The operating plan objective to clear 52 week waits by the end of March will therefore not be met and will be reprofiled as part of operating planning for 2025/26. The 2025/26 operating plan will also require a minimum of a 5% point increase in the RTT incomplete waiting list managed within 18 weeks. At the end of December Trust performance was 54.18%, with the total wait list size 4.8% higher than a year ago in December 2023.

Overall recovery of the RTT waiting list position therefore remains extremely challenged in the context of additional growth in demand, with increases in elective activity achieved in the year to date not yet sufficient enough to reduce the overall wait list size. The NHS England plan[1] for reform of elective patients sets out a number of initiatives to support recovery and the Trust will continue to look at opportunities to reduce the waiting list for "reasons other than treatment" including a review of clinical triage, better management of access policy application in booking and scheduling processes and RTT validation.

The number of patients waiting over 78 weeks reduced to 1 patient in December (complex patient booked in January) and patients waiting over 65 weeks have reduced to 62 against a revised forecast of 68 patients. The Trust continues to attend weekly "shadow tiering" calls with both ICB and NHSE colleagues to improve our position with system and regional support. We have identified specialties at risk who require support with mutual aid and / or utilisation of the independent sector with a revised plan that all specialties will eliminate 65 week wait breaches by the end of March 2025.

The main risks to delivery of the revised plan for zero 65 week waits by the end of March across the clinical divisions of Medicine and Surgery, Women and Children are: Neurology, General Surgery, Trauma and Orthopaedics and Gastroenterology. Ophthalmology remains an outlier due to the volume of patients awaiting a corneal graft as a result of a national shortage of tissue supply.

- **Cancer waiting times**

Cancer performance for the 28-day faster diagnosis standard was better than the operating plan trajectory in the most recent reporting period (78.9% against 75% trajectory). Work is ongoing at system level to improve access across tumor sites, with specific pathways such as Lower GI being selected for review to improve standards across the acute hospitals and based on the application of best practice timed pathways. Lower GI remains the top contributor of 28 day diagnosis breaches.

At the end of November there were 6% of patients waiting over 62 days on the PTL, which has remained below the national target of 6.8% since July 2024. The PTL continues to be managed within nationally set thresholds.

62 day performance for urgent suspected cancer referral to treatment dropped from 78.5% to 70.4% in November and missed the operating plan trajectory target of 72.5%. In November there were 66 combined cancer referral breaches across 10 Tumour sites resulting in 56.5 allocated breaches. Urology made up 31.0%, Plastics 30.1%, with Colorectal 18.6%, and Breast 7.1% of the allocated breaches.

The under-delivery of the Plastics service provided at GWH via an SLA with Oxford continues to remain a significant risk with breaches due to this issue (that affects outpatients and minor ops) accounting for 9% performance deterioration this period. Suitable patients are being transferred to a private third party provider (CSP) where necessary. The revised SLA with Oxford has been approved, but there remains insufficient consultant availability until recruitment has been completed. The Trust has escalated our intentions to serve notice on GWH service provision via the ICB, but this is likely to require a minimum notice period of up to 12 months.

Unvalidated November performance shows cancer 31 day improvement at 93.9% with 14 breaches in the month. Performance is expected to recover to the 96% target in January.

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

ED and UTC attendances increased by 1.2% in December compared to the previous month, with 11,067 patients seen. Growth for the rolling 12 months compared to the previous year was 8.75% for Type 1 and Type 3 attendances.

Reported acuity was also notably higher in December associated with an increase in flu admissions that peaked at over 70 patients during the Christmas and New year period.

The total mean wait time for a patient in December was 153 minutes in UTC, which is within the national standard of 240 minutes. The mean wait type in ED increased for the fourth consecutive month to 398 minutes and is therefore currently 2.6 hours above the national 4 hour target.

Combined 4- hour performance was 74.7%, an improvement on November's figure of 74%, but 2.1% below the operating plan trajectory of 76.1%.

Work has concluded from the national Emergency Care Intensive Support Team (ECIST) to improve processes within the new Emergency department and newly co-located MAU and SDEC with a focus on clinical criteria to admit and alternative admission pathways in ED. The recommendations are currently being reviewed and will be prioritised as part of the flow transformation programme reset for 2025/2026.

- **Inpatient spells - No Criteria to Reside Bed Days (NCTR)**

Bed days lost in December due to no criteria to reside showed an average of 81 patients per day occupying the bed base. Stranded and super stranded patients with length of stay over 14 days and 21 days respectively increased during December and daily discharge planning meetings are in place with partners across the health and care system to progress next steps and expedite discharges. Pathway 2 patients requiring inpatient rehab represent the highest cohort of patient delays and bed days lost. Additional support is being provided to create flow out of community beds to support flow from the acute hospital, including use of out of area capacity where available and appropriate.

Operational Breakthrough Objective

- **Ambulance handover delays**

An average of 103 hours were lost per day from ambulance handover delays in December, up from 84 hours in November. This is the third consecutive month during which the breakthrough objective of 70 hours was not met. There were 77 six hour breaches reported in December, 18 of which breached 8 hours and 4 over 10 hours. Time in the ED department has increased for both admitted and non admitted pathways, with admitted pathway delays associated with ongoing high bed occupancy at 97% in December and 17% of the bed base occupied with patients not meeting criteria to reside.

As a result, 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).

The Trust has been receiving support from Emergency Care Intensive Support Team (ECIST) since October with a work plan to support the realisation of benefits from front door reconfiguration that concludes in January 2025. The recommendations are being reviewed and prioritised as part of the resource plan for the Greater Flow programme in 2025/25.

Until this review is completed the priorities for January include releasing planned care activity from medical same day emergency care (SDEC) by developing the Medical Day Unit service. This will facilitate increased capacity for undifferentiated patients and flow for medically referred patients from ED, therefore supporting ambulance offload plans. This will be part of a wider review of the Medical Assessment Unit pathway to improve flow for medically referred patients and reduce 12 hour trolley waits in ED.

Other improvements include: A relaunch of the Discharge Lounge improvement plan to consistently achieve 12 patients transferred from specialty wards by 12pm; a review of benefit realisation plans

from recent bed reconfiguration changes; and ongoing implementation and evaluation of timely hospital handover processes with partners.

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

Diagnostics – December validated DM01 performance is showing a slight decrease in performance from the 88.45% performance in November to 84.63%. The number of patients on the waiting list has decreased by 292 to 5,519 driven by the by the continued work to improve CT and MRI. There are now only 848 patients waiting over 6 weeks, which is a 90% reduction from the peak of the backlog in October 2023. Further sub modalities are now sustaining compliance with constitutional standards including MRI and Dexa and other modalities remain on track with recovery actions to deliver the Trust wide operating plan target for March 2025.

Our Care

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

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

There has been little change in the total overall harms in month (166 in December compared to 167 in December). Patient Safety Incident Investigation numbers have been removed from the total number of harms from December 2024 onwards.

The has been a slight increase in the number of falls (117 in December from 111 in November) however the number of falls with harm have reduced. There has been a decrease in E. coli, Klebsiella and Methicillin-sensitive Staphylococcus aureus (MSSA).

The number of Family and Friends (FFT) positive responses for December has decreased slightly to 90% but is meeting the stretch target.

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

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

In December there was one patient who experienced moderate harm or above following an inpatient fall, a decrease compared to November (seven).

The numbers of patients with two or more falls were 14 in month, compared to 10 in November.

Alerting Watch Metrics
The number of complaints received in month has decreased to 49 compared to 61 in November. There has been a slight decrease in the overall complaint response rate.

C.difficile numbers have increased this month to seven (three in November), with the Trust remaining below its target trajectory.

Non-alerting Watch Metrics
The overall Family and Friends positive response rate target was reviewed and increased in April to 90% and as a result now sits within an alerting watch metric. The overall positive response rate for December is 90% and meets the new stretch target.

MSSA numbers have decreased to one and are now in-keeping with the numbers seen through the most of 2024.

Methicillin-resistant Staphylococcus aureus (MRSA) remained zero for the tenth consecutive month.

The numbers of E. coli infections fell slightly for the third month in succession, and there are fewer cases associated with catheters following the improvement work on this area of practice, which may also have impacted on our Klebsiella rate.

Of note, only one of the nine gram-negative infections in December was hospital-onset – the others are only deemed healthcare-associated because the patients had been discharged in the previous 28 days. COVID numbers remain at low levels not seen since the start of the pandemic.

The number of hospital-acquired pressure ulcers has decreased in month to 11 (18 in November). There were no category 2 or 3 pressure harms in Dember n the acute setting.

The number of Community acquired pressure harms has remained stable in month at 13. The majority of harms were reported at Category 2 (12), one patient experienced a category three pressure harm, there were no category four harms reported in month.

Further points to note relating to non-alerting watch metrics include:
- Safer staffing fill rates remain above the National target of 85%.
- Six Patient Safety Incident Investigations have been declared in December and will be investigated under the Patient Safety Framework.

Our People

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

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

The Trust Pillar metrics to ensure performance against the Strategic Pillar are:
- **Staff Survey – Recommend a Place to Work**
  Stretched Target 63%: achieving 59.6% (2023 Annual Survey), 55.9% Q1 Pulse Survey, and 55.5% Q2 Pulse Survey (steady decline since the annual survey) - Annual survey embargoed verbal update at the meeting.
- **Staff Voluntary Turnover**
  Target 11% achieving 8.7% (November data)
- **EDI disparity (reducing discrimination disparity**)
  Target 9.4% achieving 12.7% (2023 Annual Survey), and 13.1% Q1 Pulse Survey and 17.5% Q2 Pulse Survey – Annual survey embargoed verbal update at the meeting.

The annual Staff Survey launched on 9th September 2024 and closed on the 29th November. The Trust achieved a 69% response last year ranking second nationally, this year the Trust has achieved 71% response rate (4,228 responses from a sample size of 5,962).

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

The national average for this question is 71% in the 2023 Staff Survey, against which a stretch target of 73% has been set. Currently, The Trust performance is 70% (2023 Staff Survey results) and 71.1% in the Q2 Pulse Survey. Annual survey is currently embargoed and initial results suggest there has not been any improvement in the question since the annual survey in 2023.

Staff Survey results
All Divisions have received their staff survey data and are in the process of undertaking a detailed analysis using the improving together methodology and these will be presented in April 2025 via TMC.

Alerting Watch Metrics
In-month sickness absence reduced slightly in November from 4.9% to 4.8%. High levels of short time absence continue to drive the above-KPI position. As part of the annual review of Pillar Metric the Trust will replace retention with sickness absence to ensure absence is a key focus for 25/26 for the organisation.

HR Scorecard

Vacancy Rate
Our vacancy rate in December reduced from 192WTE to 188WTE which is 3.4% and remains within target. It is anticipated with the increase in vacancy control (without budget removal) this vacancy rate will increase and slow down substantive recruitment to achieve our worked WTE plan.

Workforce Recovery
5,668WTE was used to deliver our services in December which was +77WTE above planned levels (+7WTE from the previous month). The above-plan position is predominantly driven a spike in agency in December, with 61WTE used compared to 43WTE the previous month and failure to reduce the bank worked WTE which is currently 48WTE over plan at 325WTE. This Trust vacancy figure is currently 188WTE however we are using 386WTE temporary workforce to cover this gap (172% more than budgeted establishment allows).

The end of year WTE target is 5,514WTE compared to current usage of 5,668WTE, therefore if we continue at the current run rate, the Trust will be 154WTE above plan by the end of the financial year.

Increased controls have been introduced both locally and by the ICB which will mitigate growing contract WTE levels, however if the Trust continues the trend of increasing Temporary Staffing usage this will continue to negatively impact the overall position against plan.

Use of Resources

As at M09 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £9.1m, which represents a £2.1m adverse variance to plan.

Income is £9.3m favourable to plan, predominantly driven by overperformances on ERF (£4.8m), NHSE commissioned drugs (£3.3m) and industrial action funding (£0.5m). The position includes an additional £0.5m of education income to account for pay award increases, and a further £0.2m of private patient and miscellaneous income. ERF performance remains above the 112% stretch target at 115.5%.

The pay position of £5.2m adverse to plan includes c.£0.5m of junior doctor industrial action costs offset by income and a £0.6m under delivery of pay efficiencies. Ongoing temporary staffing pressures relating to vacancies, escalation and mental health provision account for the rest of the pay variance, partially offset by centrally-held reserves (e.g. maternity / paternity leave).

Operational non-pay spend is £8.4m over plan, which includes £6.1m of overspends in clinical supplies and outsourcing, particularly within Medicine and Surgery, Women's and Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. The non-pay variance also includes £1.1m of undelivered efficiencies, while drug spend is £2.4m over plan, all of which is passthrough-related and offset by income. Estates and PFI-related costs account for the remaining variance.

The efficiency plan is £1.8m under target at M09 with total savings delivered year to date of £12.8m. Forecast delivery has increased by £0.4m from prior month and now stands at £17.9m, which represents a £4m deficit to plan. The in-month increase is due to additional pacer alert income recorded, however this is still to be confirmed by NHSE as being payable. Of the £10.1m savings delivered year-to-date, 49% is recurrent, which is down from M08 (50%). The focus of divisions and directorates remains on increasing recurrent savings to reduce the underlying deficit as we approach 25/26. Analysis of the margin achieved on ERF related activity is being undertaken with a view to recording additional efficiency savings in 25/26, noting that this is dependent on the central ERF rules to be determined in planning.

Pay remains a key area for savings with a target 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 are contributing to this, as is ongoing work in reducing temporary staffing and scrutinising fixed term contracts and vacancy recruitment requests. Non-pay, and specifically clinical supplies spend, is the focus of detailed work between Finance, Procurement and divisional teams to understand the key drivers. Further meetings are booked with Theatres (SWC) and Cardiology (Medicine) to action initial issues raised around stock management practices and clinical choice.

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 end of the financial year through delivery of recurrent CIP.

We remain c.£2.1m off plan in Month 9. Our performance behind plan on the efficiency programme of £1.8m demonstrates that our run-rate reductions are not going far enough to impact our financial position to the extent that it is needed to meet our full-year plan. There are various recovery workstreams in progress, particularly around pay run rates. Activity is being scrutinised for where we are not delivering volume, or value of the relevant volume, against plan.

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

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

Actions continue to be progressed in relation to improving requisitioning controls and developing the training offer. An Improving Together working group has been set up in Finance to focus on financial training throughout the Trust, including a mandatory training course on ESR and staff group specific training. Task & finish groups including Finance, Procurement and Specialty leads have been set up to focus on the drivers of non-pay spend. The first of these meetings have taken place with Theatres (SWC) and Cardiology (Medicine). The analysis has already highlighted some areas where immediate action can be taken to reduce spend, while benchmarking against other system Trusts has flagged further areas for investigation. Work is also ongoing around requisitioning controls. Divisions have submitted a list of users for revocation which is being checked by SBS. Focused training for the remaining requisitioners around best practice is a key next step.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led

Links to Strategic Pillars & Strategic Risks – select one or more	★	(teamwork icon)	(partnership icon)	(finance icon)
	x	x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)				Risk Score
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	PPPC (Performance, Population & Place Committee) & Trust Board			
Next Steps				

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

Explanation of above analysis:

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 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	Benny Goodman
Date	15th January 2025

Integrated Performance Report

January 2025

December 2024 & November 2024 data period

Improving together

Service Teamwork Ambition Respect

Content & introduction

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

Key Indicators

Measure Name	Mean/Thres.	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Total 104 week waits	0	0	0	0	0	0	0	1	1	0	0	0	0
Total 78 week waits	0	5	10	4	3	4	3	3	12	6	5	3	1
65 weeks wait performance vs plan (size adjusted)	100.0%	0.0%	0.0%	0.0%	70.0%	117.9%	148.4%	154.6%	200.7%	0.0%	0.0%	0.0%	0.0%
Proportion of PTL over 65 week waits (size adjusted)	0.0%	0.9%	0.7%	0.2%	0.4%	0.6%	0.7%	0.6%	0.7%	0.2%	0.2%	0.2%	0.2%
Under 18 elective activity rate vs baseline	100%	122.5%	128.8%	119.1%	123.9%	119.0%	114.4%	117.0%	131.8%	124.8%	221.8%	153.8%	Reported one month behind
Faster diagnosis rate	75% (Nat)	60.2%	70.5%	71.3%	59.2%	66.7%	70.2%	75.2%	81.8%	78.8%	79.5%	78.9%	Reported one month behind
62-day performance	85% (Nat)	62.2%	68.6%	66.7%	63.1%	64.3%	69.4%	68.1%	70.3%	70.8%	78.1%	70.4%	Reported one month behind
Proportion of patients seen within 4 hours	95% (Nat)	73.5%	71.1%	74.4%	75.9%	75.3%	75.0%	77.1%	79.5%	77.4%	72.6%	74.0%	74.7%
Number of mental health patients spending >12 hours in an emergency dept	7	12	5	5	14	9	6	6	7	3	9	1	8
Readmission rate	14.6%	11.2%	16.1%	15.7%	14.0%	15.9%	15.1%	14.7%	16.0%	14.8%	13.7%	14.0%	14.5%
Summary Hospital-level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
CQC safe rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Sickness rate	3.5% (Int)	4.9%	4.4%	4.1%	4.2%	4.2%	4.6%	5.2%	4.5%	4.3%	4.9%	4.9%	Reported one month behind
Leaver rate	11.0% (Int)	8.6%	8.6%	8.4%	8.6%	9.7%	11.0%	9.6%	11.0%	10.6%	11.0%	9.7%	Reported one month behind
Implied productivity	0	-16%	-13%	-12%	-13%	-17%	-15%	-17%	-15%	-13%	-11%	-14%	-15%
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	3.5%	3.5%	3.5%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.4%	5.0%	5.0%
Proportion of staff in senior leadership roles who are women	64% (Nat)	56.1%	56.1%	56.1%	56.7%	56.7%	56.7%	57.4%	58.3%	56.7%	56.9%	55.0%	55.0%
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	1.8%	1.8%	1.8%	1.7%	1.7%	1.7%	1.6%	1.7%	1.7%	3.5%	3.3%	3.3%

Key Indicators

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

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

Executive Summary

Total Harms

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

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

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

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

Patient Experience (FFT)

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

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

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

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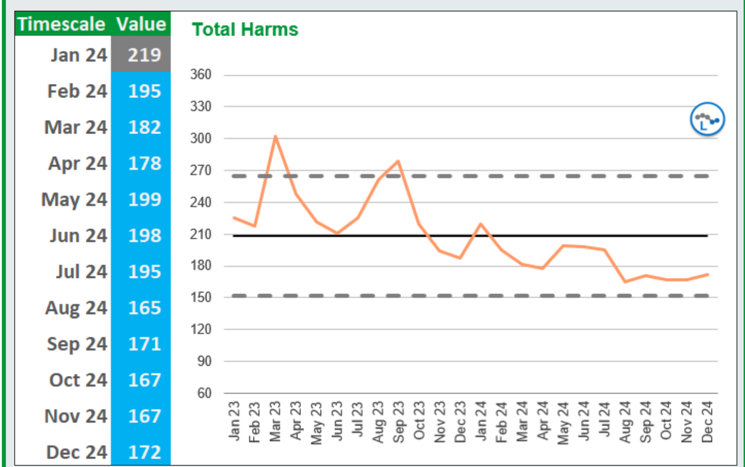
Total Harms

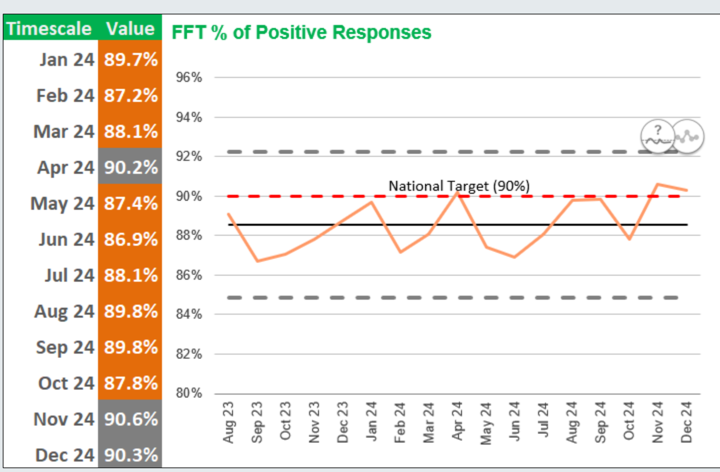
To achieve and sustain zero avoidable harm.



Timescale	Value
Jan 24	219
Feb 24	195
Mar 24	182
Apr 24	178
May 24	199
Jun 24	198
Jul 24	195
Aug 24	165
Sep 24	171
Oct 24	167
Nov 24	167
Dec 24	172

Patient Experience (Friends & Family Test)

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



Timescale	Value
Jan 24	89.7%
Feb 24	87.2%
Mar 24	88.1%
Apr 24	90.2%
May 24	87.4%
Jun 24	86.9%
Jul 24	88.1%
Aug 24	89.8%
Sep 24	89.8%
Oct 24	87.8%
Nov 24	90.6%
Dec 24	90.3%

Counter Measures

The total number of harms has remained similar in month, 166 compared to 167 in November. The numbers of Patient Safety Incident Investigations have been removed from the overall harm total count from December as the harm has already been counted in the respective incident category.

The number of MSSA, *E. coli* and *Klebsiella* infections has fallen. There was a rise in *C. diff* cases however numbers remain below target. There has been a rise in the number of falls in month from to 117 from 111 in November. However, the number of falls with moderate or above harm has reduced to one in month.

There is little change in the December Trust wide positive Family and Friends (FFT) score at 90.3% , just above the increased target of 90% set in 2024/25 to ensure there is stretch.

The volume of discharged patients surveyed by text in some areas, has been reduced from November onwards, to provide a more targeted response and in-line with system partners along-side cost efficiency measures.

Executive Summary

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
In November, there were 56.5 breaches in total, with 45.0 of these attributed to the Urology, Plastic, Colorectal pathways. These pathways are seeing issues with capacity for appointments and diagnostics.

We continue to see greater than normal breaches in Urology (31.0% of all breaches) where number of breaches relate to patients requiring a biopsy after their initial MRI. Template biopsy in Theatres has replaced TRUS biopsy in Radiology, capacity for which had been insufficient to meet demand. This has now been addressed, and it is expected that we will see fewer breaches in the New Year once delayed pathways are completed. The Plastics service is provided at GWH via an SLA with Oxford. Oxford have been unable to meet this SLA resulting in cancer pathway breaches. In November Plastics was responsible for 30.1% of breaches, without these performance would have been 79.4%

RTT: Number of patients waiting over 52 weeks

December performance shows the total number of patients waiting over 52 weeks at 1,423 a reduction of 234 this month. Patients reported waiting over 65 weeks at the end of December was 62, a decrease of 14 from last month. The PTL size at the end of the month was 40,198, an increase of 0.2%.

1 x 78-week breach reported in December 2024 – Urology patient, complex case, requiring extensive work up

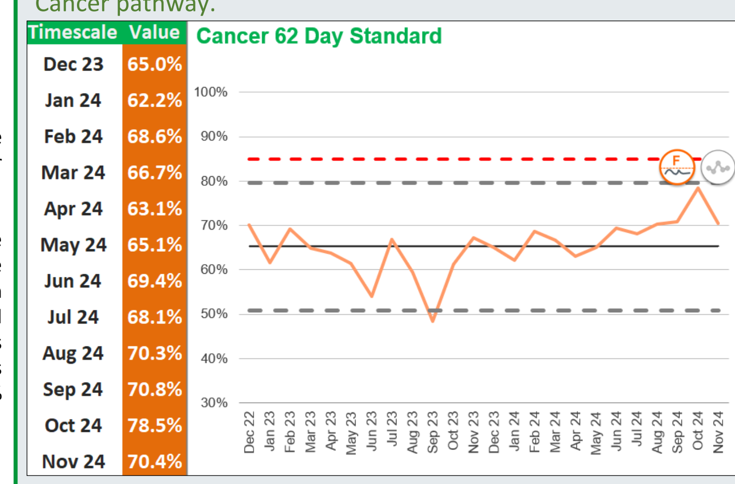
Ambitions to clear our 65-week cohort has been a weekly focus for clinical divisions, with assurance and actions required to bring our backlog down into the new year. Mutual aid has been sought for specialties who are challenged with their cohort, with an aspiration to clear this cohort and maintain by end of March 2025. These specialities include:

- Gastroenterology
- Trauma and Orthopaedic
- Neurology
- General Surgery
- Plastics

Benny Goodman | Chief Operating Officer

Cancer 62 Day

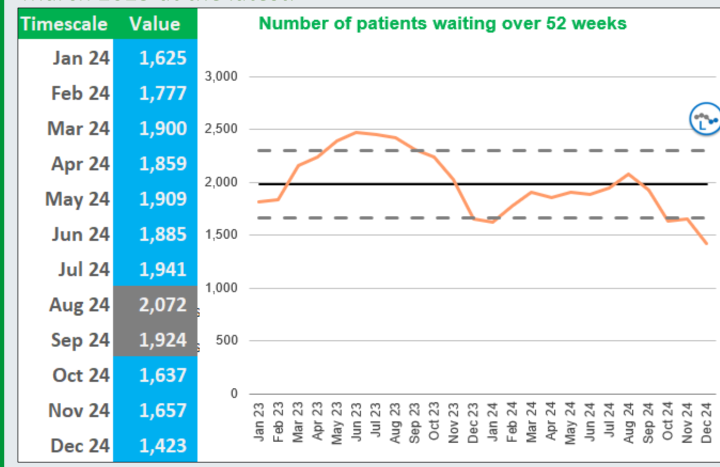
To achieve and sustain 85% performance for patients on a Cancer pathway.



Timescale	Value
Dec 23	65.0%
Jan 24	62.2%
Feb 24	68.6%
Mar 24	66.7%
Apr 24	63.1%
May 24	65.1%
Jun 24	69.4%
Jul 24	68.1%
Aug 24	70.3%
Sep 24	70.8%
Oct 24	78.5%
Nov 24	70.4%

RTT: Number of patients waiting over 52 weeks

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



Timescale	Value
Jan 24	1,625
Feb 24	1,777
Mar 24	1,900
Apr 24	1,859
May 24	1,909
Jun 24	1,885
Jul 24	1,941
Aug 24	2,072
Sep 24	1,924
Oct 24	1,637
Nov 24	1,657
Dec 24	1,423

Counter Measures

Risk: Urology Pathways are impacted by delays in Radiology & Theatres (capacity & vacancies)
Mitigation:
-Funding approved for mobile LATP by TVCA. This went live on 7 September with weekend clinics to clear backlog and provide the necessary additional capacity. Improvements in the 62D performance are expected from New Year onwards
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 **Plastics** for appointments and minor op clinics impacting pathway
Mitigation
-Suitable patients are sent to a private third party provider (CSP) where necessary
-Revised SLA with Oxford approved, though insufficient support from Oxford being provided due to consultant availability. Additional consultant approved and under recruitment at Oxford.

Risk: Insufficient capacity to eliminate waits over 65 weeks as soon as possible and by March 2025 by 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 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/critical incident.
Mitigation:
- All elective activity on strike/major incident 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

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 Dec 24 was 398 minutes against the national standard of 240 minutes. This is the fourth month where mean time in ED has increased following a downward trend throughout 2024.

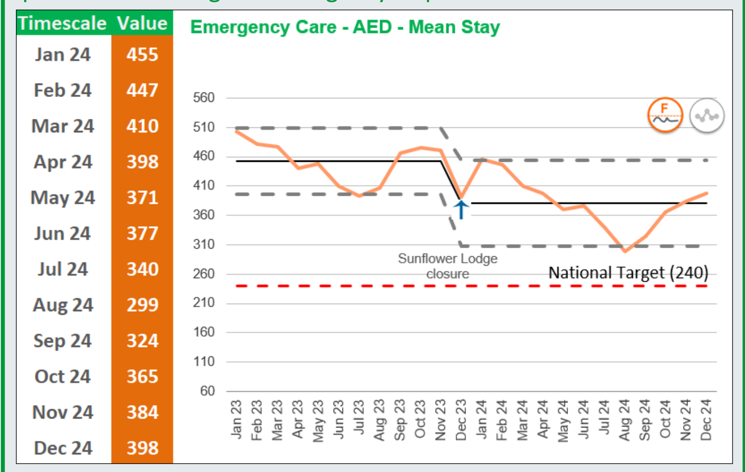
Emergency Care – Urgent Treatment Centre - Mean Stay

The total meantime wait for a patient in December 24 was 153 minutes against the national standard of 240 minutes. This has increased from 149 mins in September where the department experienced a drop in demand.

Benny Goodman | Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

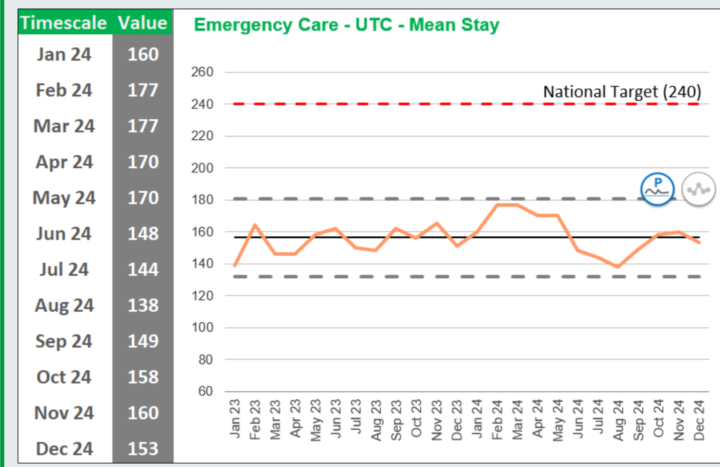
To achieve and sustain a mean time in department for all patients attending the Emergency Department.



Timescale	Value
Jan 24	455
Feb 24	447
Mar 24	410
Apr 24	398
May 24	371
Jun 24	377
Jul 24	340
Aug 24	299
Sep 24	324
Oct 24	365
Nov 24	384
Dec 24	398

Emergency Care – Urgent Treatment Centre - Mean Stay

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



Timescale	Value
Jan 24	160
Feb 24	177
Mar 24	177
Apr 24	170
May 24	170
Jun 24	148
Jul 24	144
Aug 24	138
Sep 24	149
Oct 24	158
Nov 24	160
Dec 24	153

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.
- New ED performance dashboard
- Medicine Emergency flow programme
- National support offer from Emergency Care Intensive Support team.

- 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 since June.

Pillar Metrics

Executive Summary

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 11,067 patients seen in ED/UTC in December, which is a 1.2% increase from November

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

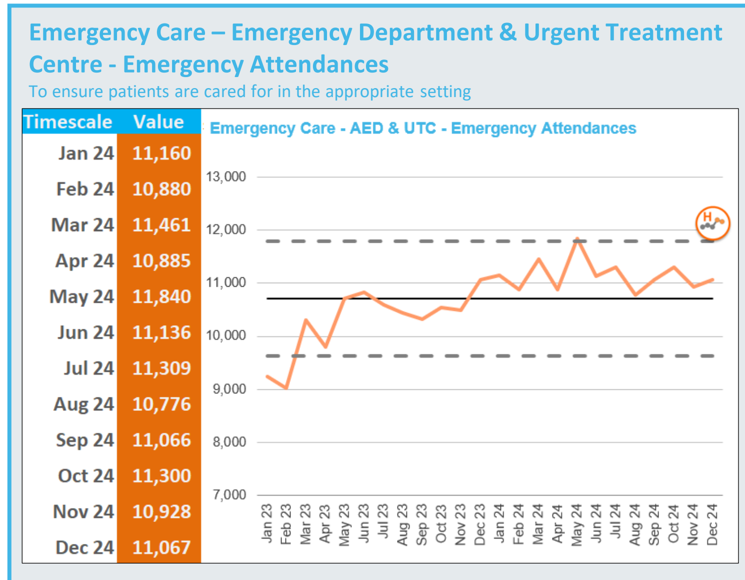
Bed days lost in December due to no criteria to reside showed an average of 81 patients per day occupying the bed base. Stranded and super stranded patients with length of stay over 14 days and 21 days respectively increased during December and daily discharge planning meetings are in place with partners across the health and care system to progress next steps and escalate discharge. Pathway 2 patients requiring inpatient rehab represent the highest cohort of patient delays and bed days lost and additional support is being provided to create flow out of community beds to support the acute hospital position.

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

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

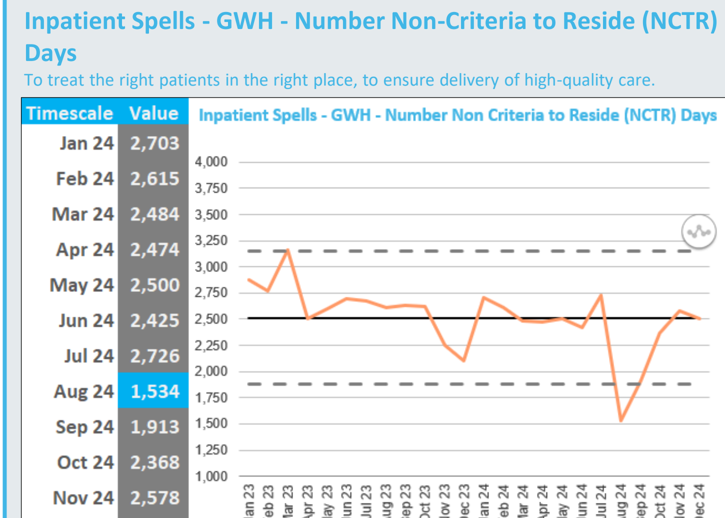
To ensure patients are cared for in the appropriate setting



Timescale	Value
Jan 24	11,160
Feb 24	10,880
Mar 24	11,461
Apr 24	10,885
May 24	11,840
Jun 24	11,136
Jul 24	11,309
Aug 24	10,776
Sep 24	11,066
Oct 24	11,300
Nov 24	10,928
Dec 24	11,067

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
Jan 24	2,703
Feb 24	2,615
Mar 24	2,484
Apr 24	2,474
May 24	2,500
Jun 24	2,425
Jul 24	2,726
Aug 24	1,534
Sep 24	1,913
Oct 24	2,368
Nov 24	2,578
Dec 24	2,500

Counter Measures

- Transfer team introduced towards the end of October – being monitored – objectives to increase before midday discharges and impact on decrease in Ambulance hand over delays.
- Assessment and pathway changes to support direct access from ED & UTC to most appropriate admission areas.
- Specialist Direct to the right bed initiative ongoing since end of August with plans to develop at scale to support new Medical Assessment Unit and Same Day Emergency care function at the front door from mid November. ECIST present to support
- Hospital at Home – towards the end of November has been at 100% occupancy.

Actions within the Hospital Flow/Admitted Flow work streams for Urgent and Emergency Care transformation include:

Opportunities:

- Review of escalation approach for patients with no criteria to reside including out of area patients – this is showing improvement and twice weekly calls in place.
- To review the approach to criteria led discharge for patients and maximise opportunities for earlier in the day discharge including to discharge lounge. - continuing with positive outcomes
- Review wards that have opportunities for higher discharges prior to midday and over weekends – ongoing.
- 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.
- Reserve Boarding needs to be investigated as a continuous flow and enacted daily to proactively manage ambulance surges and prevent bed surges.

Pillar Metrics

Executive Summary

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 18 months. Voluntary turnover decreased in November to 8.7% and remains under the Trust target of 11%.

Staff Recommendation as a Place to Work

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

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

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

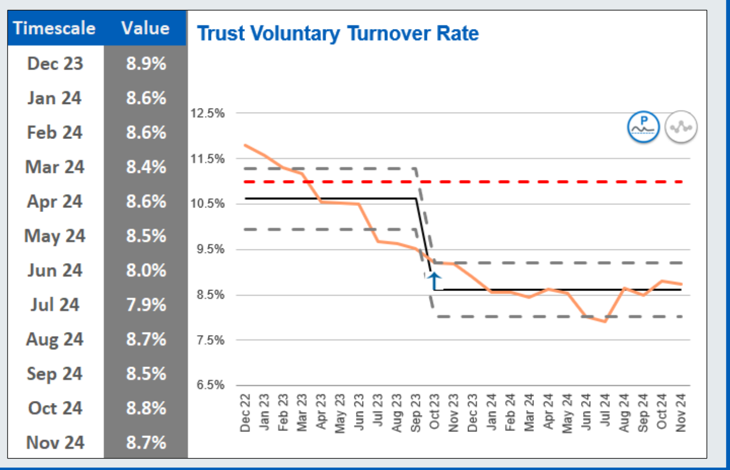
The number of staff who would recommend the organisation as a place to work increased from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey. Whilst a small decline was seen in this metric throughout the year, the 2024 Annual Staff Survey results show a sustained result.

Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

Trust Voluntary Turnover Rate

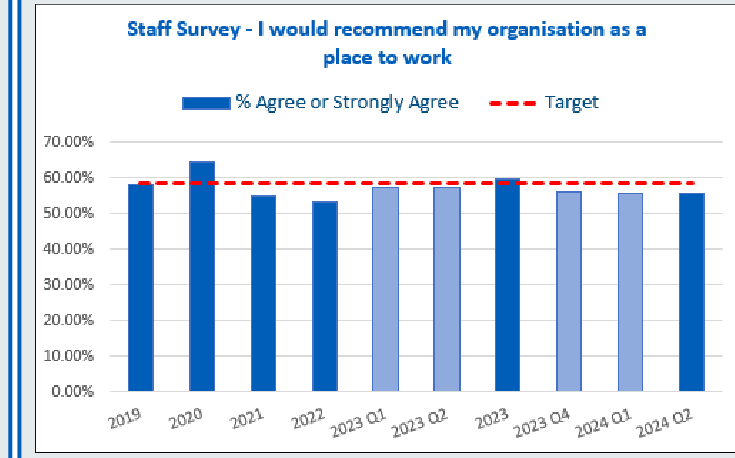
To achieve and maintain a maximum voluntary turnover rate of 11%.



Timescale	Value
Dec 23	8.9%
Jan 24	8.6%
Feb 24	8.6%
Mar 24	8.4%
Apr 24	8.6%
May 24	8.5%
Jun 24	8.0%
Jul 24	7.9%
Aug 24	8.7%
Sep 24	8.5%
Oct 24	8.8%
Nov 24	8.7%

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 slightly in November to 8.7% (8.8% in October).
- The People Promise Manager role is due to cease in March 2025. As part of closure of the role, key deliverables are being handed into a ‘business as usual’ remit across teams.
    - The Trust Induction booklet is in the final stages of delivery to launch at March induction, and includes a guide for employee, manager, and induction ‘buddy’.
    - The Sexual Misconduct Policy and Sexual Safety Toolkit have been approved and a communications campaign to promote ‘NO to sexual harassment in the workplace’ is ready to launch in February.
    - Flexible working within ESR is ready to launch in February, supported by guidance for employees and managers.

- The number of staff who would recommend the organisation as a place to work has been sustained in the 2024 Staff Survey. Results from the survey are currently under embargo, however Divisions have received summary information to help with early identification of themes for improvement and deterioration. Full Trust results will be reported in April 2025.
- The full staff survey results have been shared with Divisions to start undertaking top contributing factors, complete root cause analysis and develop local countermeasure for the next 12 months.
- The Trust Flu campaign is underway and currently compliance is 57% which is 2nd performing Trust in the South-West.
- Series of pension seminars scheduled with Retirement and Financial Wellbeing specialists ‘Affinity Connect’, taking place virtually for staff throughout 2025.

Pillar Metrics

Executive Summary

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

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

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

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

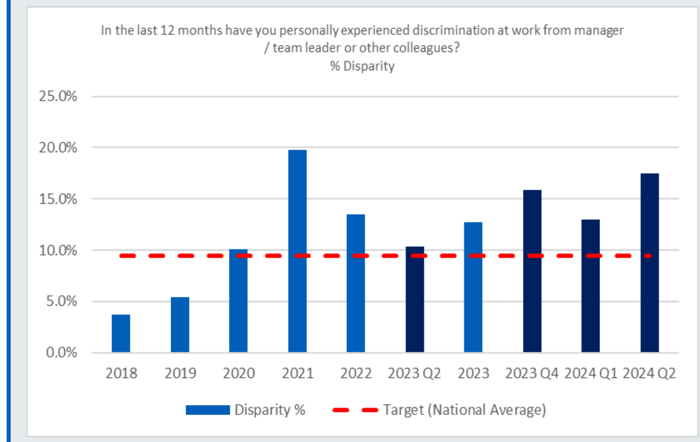
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

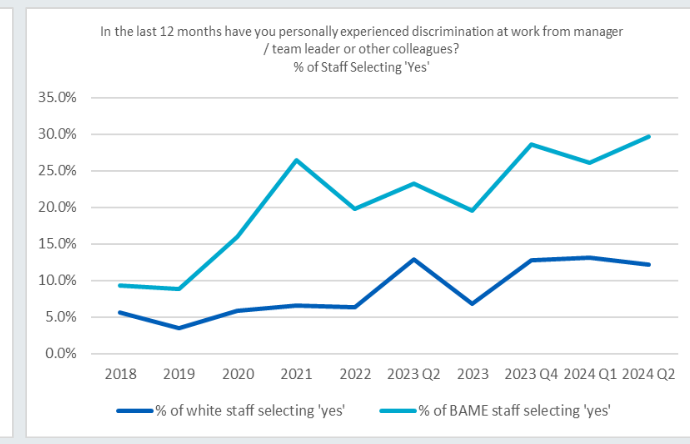
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

Disparity has improved in the 2024 staff survey results. Results are currently embargoed until March 2025.

Jude Gray
Director of Human Resources (HR)

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





Counter Measures

- The Joint Staff Network held its inaugural meeting on 9th January 2025. The network will meet quarterly to manage their joint projects and provide a route for staff or committees across the Trust to seek advice and guidance.
- The Trust Board met on 9th January 2025 and reviewed their EDI commitments, which form part of the Trust's response to NHSE EDI Improvement Plan (six high impact actions). Board representatives have engaged with members of staff and the public over a four-month period to learn more about their lived experience and to identify potential actions. The board also committed to engage and support staff networks and to ensure that good quality equalities information is included in board papers. 2025/26 priorities were also set.
- The design of the 2024/25 Equality Delivery System review continues. Scoring will take place in March 2025.
- Following The Big Coffee Break Roundtable Discussion: Speak Up, Listen Up event in October, GWH hosted a follow-up session on 14th January for attendees from across the NHS to share good practice and explore potential actions that will improve speaking up. The Trust is also due to undertake further work in 2025/26 with Clever Together to streamline and improve speaking up processes.
- The EDI Lead will continue to deliver training for EDI Champions and Inclusion Recruitment Champions (IRC), Quarter 4 2024/25 workshops are scheduled for 21st January (IRC) and 4th February (EDI Champions). The EDI Lead is also working with divisional representatives to deliver training in the three divisions (EDI Improving Together Metric).

Pillar Metrics

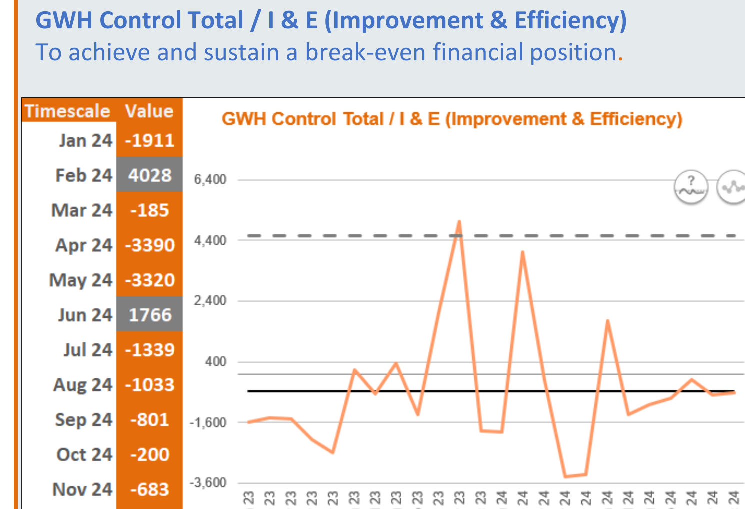
Executive Summary

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

As at M09 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £9.1m, which represents a £2.1m adverse variance to plan. Income is £9.3m favourable to plan, predominantly driven by overperformances on ERF (£4.8m), NHSE commissioned drugs (£3.3m) and industrial action funding (£0.5m). The position includes an additional £0.5m of education income to account for pay award increases, and a further £0.2m of private patient and miscellaneous income. ERF performance remains above the 112% stretch target at 115.5%. The pay position of £5.2m adverse to plan includes c.£0.5m of junior doctor industrial action costs offset by income and a £0.6m under delivery of pay efficiencies. Ongoing temporary staffing pressures relating to vacancies, escalation and mental health provision account for the rest of the pay variance, partially offset by centrally-held reserves (e.g. maternity / paternity leave). Operational non-pay spend is £8.4m over plan, which includes £6.1m of overspends in clinical supplies and outsourcing, particularly within Medicine and Surgery, Women's and Children's. A proportion of the cost relates to delivering additional ERF activity and will, therefore, be partially offset by income. The non-pay variance also includes £1.1m of undelivered efficiencies, while drug spend is £2.4m over plan, all of which is passthrough-related and offset by income. Estates and PFI-related costs account for the remaining variance.

The efficiency plan is £1.8m under target at M09 with total savings delivered year to date of £12.8m. Forecast delivery has increased by £0.4m from prior month and now stands at £17.9m, which represents a £4m deficit to plan. The in-month increase is due to additional pacer alert income recorded, however this is still to be confirmed by NHSE as being payable. Of the £10.1m savings delivered year-to-date, 49% is recurrent, which is down from M08 (50%). The focus of divisions and directorates remains on increasing recurrent savings to reduce the underlying deficit as we approach 25/26. Analysis of the margin achieved on ERF related activity is being undertaken with a view to recording additional efficiency savings in 25/26, noting that this is dependent on the central ERF rules to be determined in planning. Pay remains a key area for savings with a target 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 are contributing to this, as is ongoing work in reducing temporary staffing and scrutinising fixed term contracts and vacancy recruitment requests. Non-pay, and specifically clinical supplies spend, is the focus of detailed work between Finance, Procurement and divisional teams to understand the key drivers. Further meetings are booked with Theatres (SWC) and Cardiology (Medicine) to action initial issues raised around stock management practices and clinical choice.

Simon Wade
Chief Financial Officer



GWH Control Total / I & E (Improvement & Efficiency)
To achieve and sustain a break-even financial position.

Timescale	Value
Jan 24	-1911
Feb 24	4028
Mar 24	-185
Apr 24	-3390
May 24	-3320
Jun 24	1766
Jul 24	-1339
Aug 24	-1033
Sep 24	-801
Oct 24	-200
Nov 24	-683
Dec 24	-610

Counter Measures

- Efficiency savings were £1.0m ahead of target in month. Year-to-date the efficiency programme is £1.8m behind plan with pay accounting for £0.6m, income £0.1m and non-pay £1.1m. Of the £10.1m of savings delivered year-to-date, 49% 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

Pillar Metrics

Executive Summary

Carbon Footprint / Sustainability

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

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

Note: Data for the current financial year is for half-way through the year heading into the winter months. Some utility billing and reading issues therefore utilities have been estimated for the purpose of reporting.

Great Western Hospital - NHS Direct Carbon Footprint

14,000
12,000
10,000
8,000
6,000
4,000
2,000
0

19/20 20/21 21/22 22/23 23/24 24/25

Business Travel
Inhalers
Water
Waste
T&D
WTT
Fleet Vehicles
Refrigerants
Anaesthetic
Oil
Electricity
Gas CHP
Gas
Target

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. A heat decarbonisation plan has been completed following a successful Salix funding bid. Unfortunately our bid for phase 5 funding was not reviewed in the lottery style assessment so no funding has been awarded to further this plan.
3. Sustainability Champions launched in GWH and an expansion of sustainability working groups in departments who have larger carbon footprints e.g. Theaters, ED, Endoscopy and a group for Pharmacy is proposed.

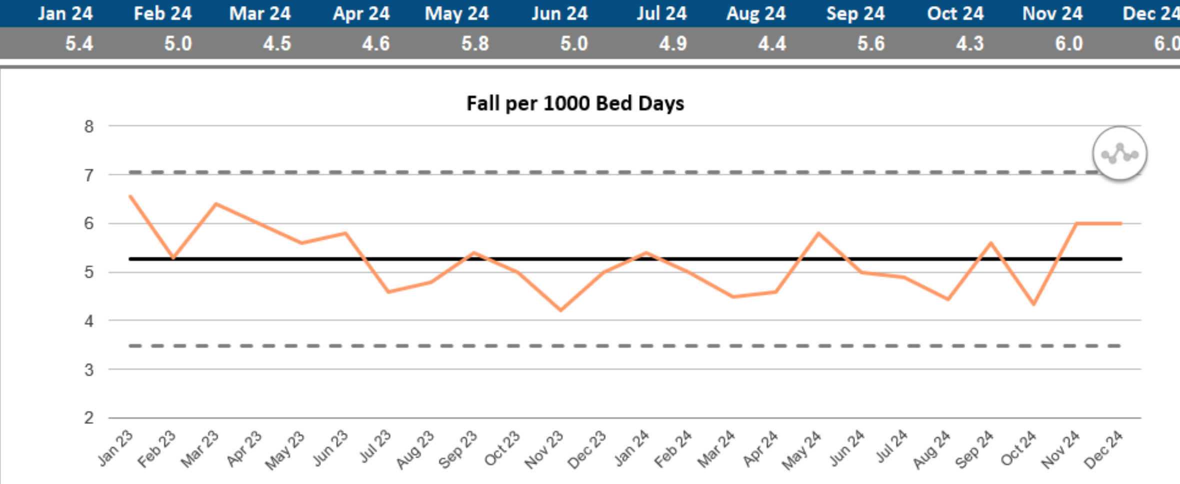
Simon Wade
Chief Financial Officer

2024/25 Breakthrough Objectives

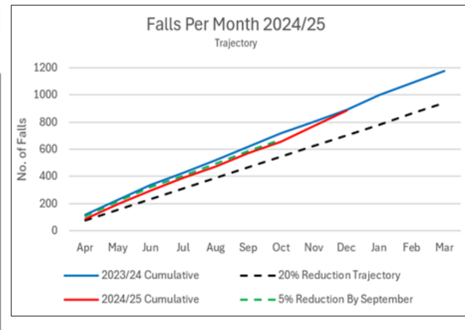
Reducing Falls & Falls With Harm

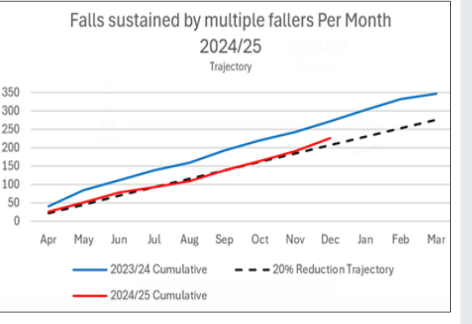
NHS Great Western Hospitals NHS Foundation Trust

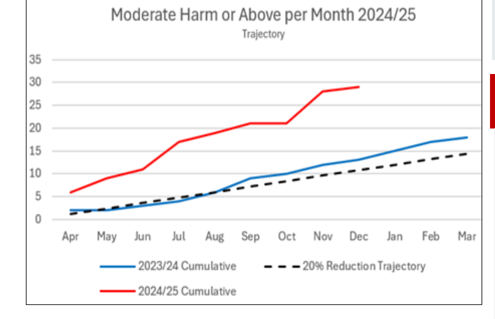
Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
5.4	5.0	4.5	4.6	5.8	5.0	4.9	4.4	5.6	4.3	6.0	6.0



Common cause - no significant change







Understanding the Data

Falls per 1000 bed days will be monitored quarterly to provide benchmarking data. There has been no change in the rate from the previous month.

Aim for 2024/25

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

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

Inpatient falls have increased in month to 117 in December when compared to 111 in November. The number of falls with moderate harm is one, there have been no falls that have resulted in severe harm or death. A significant improvement from November.

The falls policy is under review and out for consultation throughout January.

A new Postural Hypotension Guideline has been developed by Clinical Fellows working with Clinical Lead for Falls. The guideline is currently out for consultation, once ratified this document will be made available on EOLAS (previously microguide).

Falls sustained in patients who have fallen more than once has increased to 14 in month (10 in November) and is a focus for ongoing improvement.

Risks

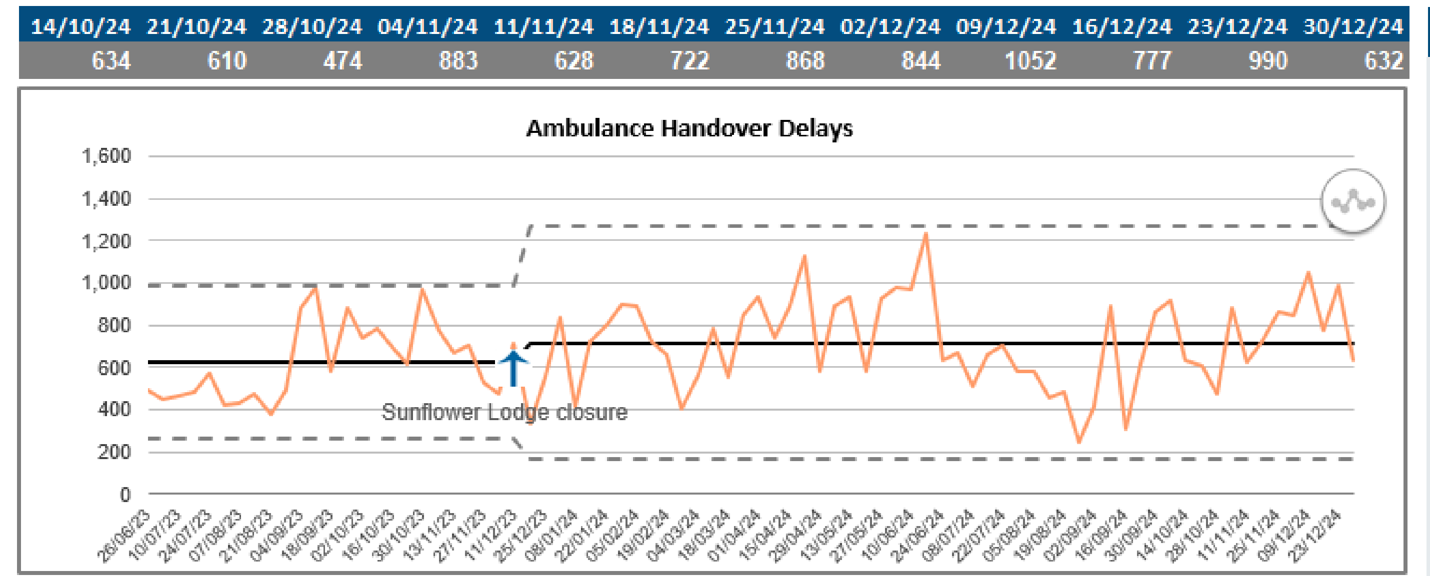
Community services remain non-compliant with Medicines and Healthcare products Regulatory Agency Alert - Bedrails/Medical Beds/Grabhandles due to lack of resources to achieve requirement for ongoing review of all bedrails prescribed for people in the community. This has been entered onto risk register, the alert remains open for the Trust

2024/25 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Ambulance Handover Delays

14/10/24	21/10/24	28/10/24	04/11/24	11/11/24	18/11/24	25/11/24	02/12/24	09/12/24	16/12/24	23/12/24	30/12/24
634	610	474	883	628	722	868	844	1052	777	990	632



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. September 2024 audits have showed potential discrepancies in SWAST handover data and GWH which is also being reviewed as part of counter-measure actions.

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

An average of 103 hours were lost per day from ambulance handover delays in December, up from 84 hours in November. This is the third consecutive month during which the breakthrough objective of 70 hours was not met. There were 77 six hour breaches reported in December, 18 of which breached 8 hours and 4 over 10 hours. Time in the ED department has increased for both admitted and non admitted pathways, with admitted pathway delays associated with ongoing high bed occupancy at 97% in December and 17% of the bed base occupied with patients not meeting criteria to reside.

As a result, 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).

The Trust has been receiving support from Emergency Care Intensive Support Team (ECIST) since October with a work plan to support the realisation of benefits from front door reconfiguration that concludes in January 2025. The recommendations are being reviewed and prioritised as part of the resource plan for the Greater Flow programme in 2025/25. Until this review is completed the priorities for January include releasing planned care activity from medical same day emergency care (SDEC) by developing the Medical Day Unit service. This will facilitate increased capacity for undifferentiated patients and flow for medically referred patients from ED, therefore supporting ambulance offload plans. This will be part of a wider review of the Medical Assessment Unit pathway to improve flow for medically referred patients and reduce 12 hour trolley waits in ED.

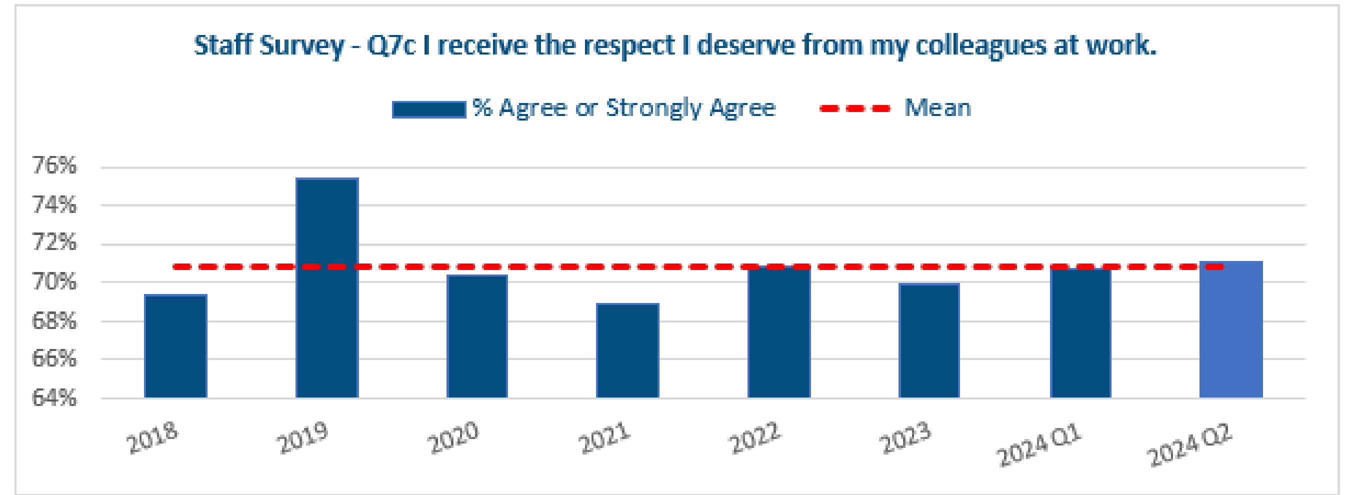
Other improvements include: A relaunch of the Discharge Lounge improvement plan to consistently achieve 12 patients transferred from specialty wards by 12pm; a review of benefit realisation plans from recent bed reconfiguration changes; and ongoing implementation and evaluation of timely hospital handover processes with partners.

2024/25 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

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

2018	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024 Q3	2024 Q4	2024
69.40%	75.44%	70.37%	68.85%	70.80%	69.96%	70.70%	71.10%			



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- "I receive the respect I deserve from my colleagues at work" has seen a small improvement since the annual survey in 2023. There has been a small improvement across the Pulse Surveys in Q1 and Q2, however the 2024 annual survey shows no change in performance.
- The annual staff survey results are currently under embargo however local analysis is underway to identify performance key trends and top contributing areas in line with the improving together methodology.
- Countermeasures will be developed based on the 2024 survey results once analysis has been completed. Given the limited progress in 2024 performance, TMC will be asked to consider how to approach driving improvement during 2025/26.

Risks

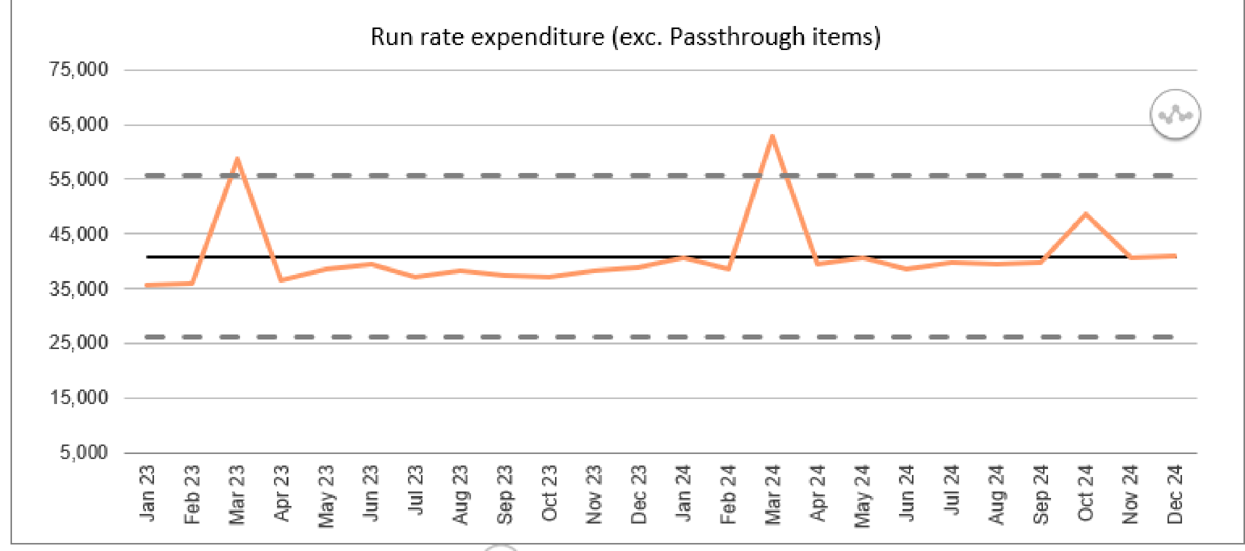
- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change.
- Clinical division's breakthrough objectives whilst aligned to our strategic pillar are not the same as the Trust breakthrough objective, therefore strategic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

2024/25 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Financial Recovery

Expenditure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Total expenditure (excl. passthrough items)	40,519	38,664	62,891	39,339	40,664	38,705	39,705	39,538	39,904	48,729	40,649	40,834
Medicine	13,454	12,028	13,002	12,248	12,820	12,457	12,931	11,862	12,206	16,193	13,250	12,909
SWC	10,498	10,513	11,111	10,484	10,848	10,666	10,633	10,818	10,628	15,049	10,865	11,573
ICC	5,715	5,447	5,805	5,397	5,420	5,057	5,578	5,685	5,620	7,188	5,962	6,181
Corp	7,391	7,484	8,361	7,947	8,022	8,014	8,169	8,348	7,971	8,915	8,008	8,262



Common cause – no significant change

Understanding the Data

The data shows that, if we continue at the current run rate of income and expenditure, we are likely to be c.£15m deficit by year end, compared to a c£10.2m planned deficit. We are also likely to fall short of our CIP target, with a material amount of non-recurrent CIP needing to be found recurrently again next year.

We are driving this measure because...

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

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

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

Performance

- As at M08 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £8.4m, which represents a £3.1m adverse variance to plan.
- We are currently £2.8m behind our YTD efficiency plan.
- Non-pay spend analysis at specialty level is taking place with Theatres (SWC) and Cardiology (Medicine) the first areas of focus, highlighting some points around stock management and clinical choice for further investigation.
- Actions focussing on the Countermeasures include:
  - Training offer to be developed for the whole Trust for general financial acumen, using combination of methods of delivery.
  - Financial Data accessible through SBS Business Intelligence System may not be as user-friendly as needed, so we are developing Power BI dashboards.
  - Agreeing the ideal number of requisitioners with Div Tri's and reducing current requisitioners, as appropriate.
  - Validating training offered by SFT Procurement Team and enhancing where needed.
  - Ensuring financial position updates are shared consistently throughout Div Board / specialty boards / team meetings etc.

Risks

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)	?	72%	58%	66%	61%	
	No. of complaints received	SPC	H	64	56	61	49	
	Number of reopened complaints	SPC	H	1	5	4	3	
IP & C	C.Diff	6.42	?	8	10	3	7	
FFT	ED & UTC Positive Responses	78.9% (Int)	?	78.0%	76%	78.8%	79.0%	

	H	L	H	L	?	P	F
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 December complaint response rate has decreased in month and remains below the internal target of 80%. There is additional support in place to help address this. There is also a decrease in the number of new complaint cases opened in the reporting month. The number of reopened complaints has also reduced, with only three active enquiries with the Parliamentary and Health Service Ombudsman (PHSO), which indicates the quality of response approvals is good. The Deputy Chief Nurse is working with the divisions on improvement work to address the response rate.

Work with Divisions to ensure better oversight of learning actions and their completion has been ongoing for some months and has seen a 55% improvement in closure of actions across a 12-month period. Further work will be led through an A3 process to ensure clear learning points are initially agreed, themes identified, and actions closed promptly.

Department workload has remained high, despite a reduction in complaint cases as PALS contacts for concerns were sustained at over 300 in month.

PALS training in month included First Impressions Customer Service training aimed at bands 2-4. The PALS team continue to work with Divisions to keep the number of open cases less than 100 although currently around 119.

Development of the triangulation of complaints and caseload data with the Royal United Hospitals Bath, and Salisbury Foundation Trust continues to better align and gain insight from our measured performance indicators.

The Trust remains below the NHSE threshold trajectory for *C. diff* and has one of the lowest rates in the Southwest region despite some recent months with higher numbers.

Risks

A backlog of overdue complaint responses remains, and additional resource is being provided to Division of Medicine until the end of the current financial year.

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24
Harm	Patient safety incident investigation	SPC		2	4	3	6
	Falls rate per 1000 bed days	SPC		5.6	4.3	6	6
	No. of Falls in month	SPC		102	83	111	117
	No. falls with moderate harm or above	SPC		2	0	7	2
	Medication incidents with moderate harm	SPC		2	1	3	7
	Pressure Ulcer (Hospital Acquired)	SPC		14	11	18	11
	Pressure Ulcer (Community Acquired)	SPC		17	25	13	13
Concerns and Complaints	No. of concerns received	SPC		294	316	313	306
IP & C	MRSA	0		0	0	0	0
	MSSA	2.00		1	2	6	1
	E.coli	8.33		7	9	7	6
	Klebsiella	2.92		1	4	4	2
	Pseudomonas	2.50		2	1	1	1
	COVID (hospital acquired)	SPC		16	15	0	1

Performance & Counter Measure

There were six Safety Incident Investigations (PSII) reported in the month of December, and zero Never Events. There are 16 PSII's in progress. All PSII's will be investigated using the Patient Safety Incident Review Framework.

The number of concerns received remains high at 306, a further decrease from November.

The number of falls has increased in month to 117 from 111 in November. There has been one fall with moderate harm and no severe harm or death associated with falls this month.

Hospital-acquired category 2-4 pressure ulcers fell back to 11 and remain low compared to historical numbers. A reduction in harm severity was also seen, with zero category 3 or 4 ulcers. Maintaining low levels of harm despite operational pressures hopefully indicates the extent to which good preventative care is now embedded in practice.

The previous SPC chart data has reflected all pressure harms in the community, from November it was amended to only reflect the category 2-4 pressure harms in line with the Acute data. There were 13 category 2-4 pressure ulcer harms in the Community setting in December, unchanged from the previous month.

The Trust remains in a good position for Methicillin-sensitive Staphylococcus aureus (MSSA) infections, having rates well below the regional average and better than all recent previous years. There have been no Methicillin-resistant Staphylococcus aureus (MRSA) infections so far this year. Numbers of *E. coli* infections fell slightly for the third month in succession, and we continue to see fewer cases associated with catheters following the improvement work on this area of practice, which may also have impacted on our *Klebsiella* rate. Of note, only one of the nine gram-negative infections in December was hospital-onset – the others are only deemed healthcare-associated because the patients had been discharged in the previous 28 days. COVID numbers remain at low levels not seen since the start of the pandemic.

Risks

There continues to be a risk associated with lack of accessible information in line with the requirement of the Accessible Information Standard and Equality Act. A plan is in place to add a field to record the information on Nervecentre and also a contact form via the website to go directly to PALS as an interim measures. Deputy Chief Nurse is leading this work.

There are ongoing concerns about the lack of accessibility across the site due to heavy doors. The Inclusion & Health Inequalities Sub Committee have requested a confirmed work plan from Estates

Our Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	93.1%	95.6%	97.2%	98.0%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	102.9%	101.6%	103.1%	101.7%
FFT	Overall response rate (%)	28.3% (Int)	?	32%	26%	31%	29%
	Positive response (%)	90.0% (Int)	?	90%	88%	91%	90%
	ED & UTC Response Rate	15.1% (Int)	?	15.3%	14.2%	18.2%	17.2%
	Inpatients Response Rate	22.1% (Int)	?	23.7%	20.8%	27.4%	26.9%
	Inpatients Positive Responses	89.6% (Int)	?	92.3%	91.0%	90.6%	90.7%
	Daycases Response Rate	22.1% (Int)	?	24.5%	20.9%	25.7%	25.5%
	Daycases Positive Responses	95.0% (Int)	?	96.6%	95.2%	93.9%	94.6%
	Outpatients Positive Responses	97.0% (Int)	?	97.9%	97.7%	97.1%	97.2%
	Maternity Response Rate	22.7% (Int)	?	21.8%	25.9%	24.9%	24.0%
	Maternity Positive Responses	91.9% (Int)	?	91.4%	92.7%	93.2%	91.7%

Performance & Counter Measures

Safe Staffing fill rates have increased to 98.0% and remain above the National target and are within safe parameters.

The December inpatient positive response rate has remained unchanged from November and remains above the target of 90%.

The maternity response rates has decreased slightly but remains above the internal target. The maternity positive response rate has decreased slightly and is just below the internal target.

The sample size for Family and Friends test (FFT) in some areas (ED, Inpatients, Day Cases) was reduced from November 24, this is to provide a more focussed approach and bring us in line with system partners, whilst reducing spend. Maternity remains at 100% collection.

New hearing magnifiers are now in place within the PALS department for loan to wards and departments for patient use to improve communication.

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

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24	Trend
RTT	No. of >=18 weeks waiters		H	20968	19986	18807	18418	
	No. of >=52 weeks waiters		H	1924	1637	1657	1423	
DM01	No. of patients on DM01 waitlist			6907	6639	5811	One month behind	
	DM01 performance %	99% (Nat)	F	80.3%	88.4%	88.6%	One month behind	
	DM01 6 week wait breaches		H	1362	767	663	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	70.8%	78.1%	70.4%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	87.8%	94.6%	93.9%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	87.2%	88.3%	87.3%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	78.8%	79.5%	78.9%	One month behind	

	H	L	H	L	?	P	F
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Performance & Counter Measure

Diagnostics

December validated DM01 performance is showing a slight decrease in performance variance from the 88.45% performance in November to 84.63%. The number of patients on the waiting list has decreased by 292 to 5,519 driven by the by the continued work to improve CT and MRI. There are now only 848 patients waiting over 6 weeks Vs 8301 in October 2023

Counter measures: Radiology now have a specialist CT outsourcing provider to support on the mobile pads with complex scans which make up the majority of the long waiters (Cardiacs and Colons). Activity for the imaging vans on the CDC site is now achieving 90% utilisation for MRI and CT. Ultrasound still remains the largest issue with 1,699 on the waiting list but now only 219 over 6 week. Medicare continue to support US activity. A locum sonographer is also being sourced to help with the more complex long waiters. WLI are now in place to support Endoscopy.

Cancer

79.6% of the 62-day breaches were with the Plastics, Colorectal & Urology pathways.

31D performance fell short in November due to outpatient capacity in the Skin pathways, accounting for 50% of the 14 pathway breaches. Elective capacity in Breast (5), Colorectal & ENT accounted for the other half.

Cancer waiting times for first appointment remain below standard. Upper GI is the largest contributors with 23.9% of all breaches. Patient choice was the main reason for breaches, being responsible for 31.9% of breaches.

Our Performance

Alerting Watch Metrics

NHS Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	77.4%	72.6%	74.0%	74.7%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	3.7%	5.7%	7.4%	7.8%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	57.7%	52.9%	56.0%	53.1%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	7.5%	11.1%	14.6%	15.1%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2000.45	2583.35	2775.00	3391.50	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1740	1742	1483	1745	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	86%	91%	91%	93%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1118	1257	1191	1392	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	55.5%	65.7%	73.1%	74.1%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	664	837	835	1016	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	33.0%	43.8%	51.2%	54.1%	
Flow	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	324	365	384	398	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4 hour performance (type 1 and 3) increased from 74% to 74.7%. This is 1.3% below the 23/24 national target. The reduction in performance relates to type 3 performance reducing and impacting our overall position.

Total % over 12 hours has risen from 14.6% to 15.1% indicating an increase in overcrowding of the department.

Ambulance handover delays over 15 minutes increased from 2775 hours to 3391 hours (phase 1 breakthrough objective = 2100 hours) showing growing pressure on the Emergency Department.

Number of ambulance handovers over 30 minutes has increased from 1191 to 1392.

Number of ambulance handovers over 60 minutes increased from 51.2% to 54%

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

	H / L	H / L	?	P	F
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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24
RTT	No. of >=78 weeks waiters	SPC	L	6	5	3	1
Cancer	No. of referrals received	SPC		1831	1987	1761	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	97.1%	92.9%	92.6%	92.7%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.0%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5531	5742	5499	5735
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	80.9%	84.7%	81.9%	85.4%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		61.6%	60.9%	57.4%	60.7%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		58.6%	55.8%	57.4%	56.8%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	196	208	204	199
	Emergency Care - AED - Median Stay	240 (Int)	?	238	240	239	240
	Emergency Care - UTC - Median Stay	240 (Int)	P	153	156	155	142
	Total Number of Ambulance Handovers	SPC	L	2014	1912	1630	1879
	Average hours lost to ambulance handover delays per day	SPC		65	81	84	103

Performance & Counter Measure

ED

Number of ambulance conveyances have increased from 1630 to 1883. Average hours lost increased in December from 84 to 103.

Triage performance for ED has increased from 57.4% to 60.7%. Type 3 triage performance remaining static following additional triage capacity is in place (56.8%).

Median stay in ED increased slightly from 239 to 240 minutes. Median stay seen in UTC reduced to 142 mins from 155 mins.

Risks

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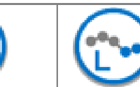
Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		444	530	602	633
	Elective Patients Average Length of Stay (Days)	SPC		3	2	2	3
	Non-Elective Patients Average Length of Stay (Days)	SPC		5	4	7	5
	Community Average Length of Stay (Days)	SPC		18	15	23	23
	GWH Discharges by Noon (%)	SPC		15.6%	16.8%	15.2%	17.6%
	Number of Stranded Patients (over 14 days)	SPC		94	104	109	126
	Number of Super Stranded Patients (over 21 days)	SPC		49	54	61	66
	Adult general and acute type 1 bed occupancy	SPC		95.8%	97.3%	96.3%	97.0%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC		13.4%	15.7%	17.4%	17.0%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.6%	95.8%	95.7%	95.1%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Performance & Counter Measure

Patient Flow

- Bed occupancy increased in month and Trust wide no criteria to reside also correlating with deterioration in ambulance handover delays and 4 hour performance.
- NHS England emergency care intensive support in place with focus on clinical criteria for admission, ED handover processes and benefits realisation for Medical Assessment Unit and Same Day Emergency Care Flow in November and December.
- Trust wide UEC Flow and Transformation programme phase 2 being scoped for Spring.
- Rapid Ambulance Handover Standard Operating procedure being enacted – still discussions being held at system level.

Risks

There is a risk of ongoing ambulance handover delays if overall bed occupancy and no criteria to reside does not reduce further, system calls are in place to monitor trajectory. 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 positivity impact on NCTR reduction.

Use of Resources

Watch Metrics

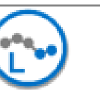
Plan Area	Measure Name	Target	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24
Use of Resources	Capital Expenditure (£'000)	SPC		1474	2971	2862	Waiting for data
	Pay (£'000)	SPC		25648	34801	26444	28225
	Non Pay (£'000)	SPC		17727	17381	17799	15918

Performance & Counter Measure

Year-to-date capital spend at M9 is £18.2m against a plan of £27.5m, giving an underspend against plan of £8.3m. Key drivers are EPR, CDC and Way Forward Programme.

Pay costs are £1.8m higher than M8 driven by gains on pay award accruals released in prior month, additional EPR recharges and higher RMN/escalation costs.

Non-Pay is £1.9m lower than M8 driven by actual PFI costs being lower than estimates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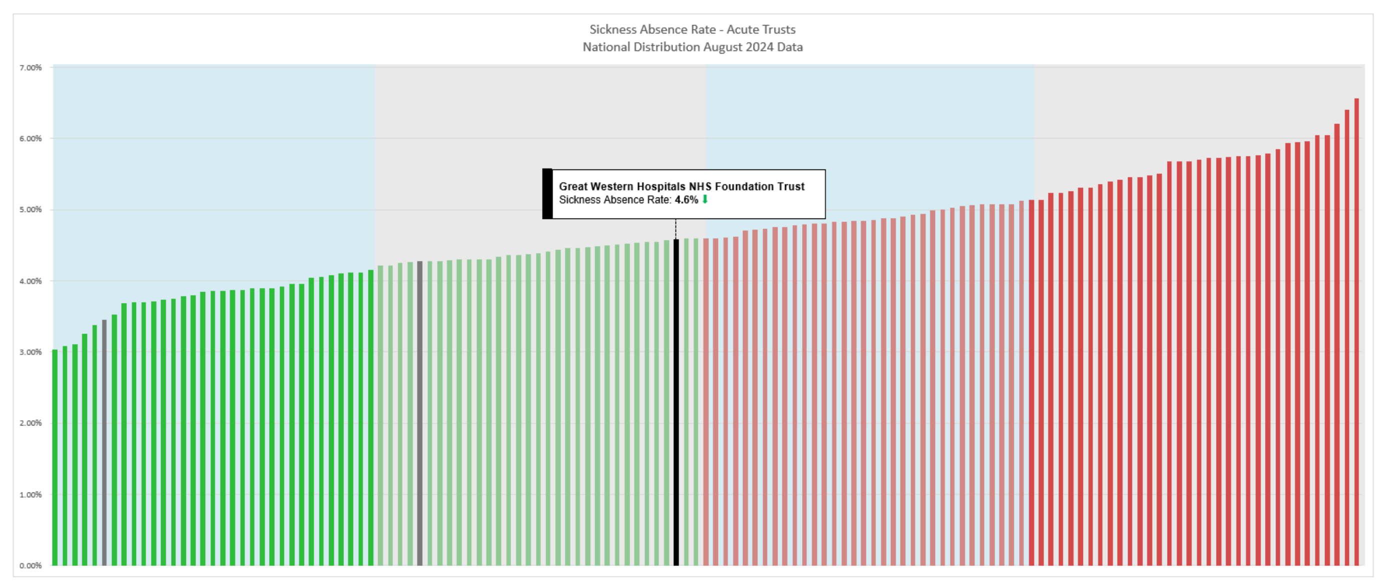
Risks

The Trust started the year with a £21.9m cash releasing efficiency plan. As at M9 delivery is £1.8m behind plan with 49% of the £12.8m 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	Sep-24	Oct-24	Nov-24	Dec-24	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.3%	4.9%	4.9%	One month behind	



Performance & Counter Measure

- Sickness absence remained the same November from 4.9% of which 2.6%. Short term absence and 2.3%. Is long term sickness.
- The Absence Management Policy has been updated to include benchmarked best practice from organisations across the South-West. The refreshed policy proposes a streamlined formal process and clarified support for line manager decision making. Further to key stakeholder feedback, the policy will be reviewed at Employee Partnership Forum sub-group in February.
- It is proposed that in April we replace the retention Pillar Metric with sickness absence to provide Trust focus on reducing sickness absence.
- The Trust working group invites top department with highest sickness rates to attend and undertake A3 approach to reducing sickness, these were presented in December.
- Absence audit for departments with high sickness to be completed by the end of January

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.

	H	L	H	L	?	P	F
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Our People

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Sep-24	Oct-24	Nov-24	Dec-24
Workforce	% of leavers within 1st year of employment	14.8% (Int)		10.6%	11.0%	9.7%	One month behind

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

Performance & Counter Measure

- Leavers within their 1st year of employment decreased in November to 9.7%, below the Trust KPI.

Risks

- Leavers within the 1st year of employment has remained consistently below the target over the last 12 months. There is a risk that changes at senior level and the impact of financial recovery workstreams may impact Trust-wide turnover rates and staff survey results.

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Our People

Workforce Scorecard

Pillar	Type	Metric	Unit/Measure	Target	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend Vs Last Month	Trend Vs Dec-23
		Vacancy																	
	W	Vacancy Rate	%	7.00%	3.74%	4.12%	4.11%	3.93%	4.19%	4.04%	3.98%	3.44%	3.82%	3.53%	3.31%	3.53%	3.44%	↓	↓
	W	Vacancy Rate	WTE	-	201.47	223.67	223.82	213.76	227.43	219.66	216.12	186.71	207.11	191.29	179.89	192.27	187.54		
	W	All Nursing Vacancy	%	7.00%	1.43%	2.75%	2.39%	2.21%	2.20%	1.73%	1.73%	0.96%	1.30%	0.64%	0.72%	1.49%	1.99%	↑	↑
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	37.87	73.60	63.97	59.14	58.90	46.13	46.07	25.61	34.47	17.00	19.26	39.90	53.22		
	W	All Registered Nursing Vacancy	WTE	-	9.50	28.02	14.37	9.70	4.67	4.75	14.57	5.24	0.02	-27.25	-36.48	-28.09	-24.47		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg	WTE	-	-3.79	5.29	-3.91	-7.35	-19.60	-12.95	-3.59	-11.35	-23.55	-47.80	-49.08	-41.52	-42.81		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	28.37	45.58	49.60	49.44	54.23	41.38	31.50	20.37	34.45	44.25	55.74	67.99	77.69		
	W	Medical Vacancy	%	7.00%	5.89%	7.07%	7.96%	7.47%	8.30%	6.78%	6.67%	7.82%	10.39%	8.99%	7.84%	6.37%	7.36%	↑	↑
	W	Medical Vacancy	WTE	-	43.30	53.08	59.82	56.06	62.23	50.71	49.94	58.44	77.65	67.20	58.64	47.53	54.93		
	W	STT/AHP Vacancy	%	7.00%	6.44%	4.87%	4.78%	3.74%	3.39%	3.67%	3.63%	3.00%	2.30%	3.92%	4.31%	3.71%	2.28%	↓	↓
	W	STT/AHP Vacancy	WTE	-	54.92	41.53	40.83	31.72	28.78	31.27	30.91	25.62	19.64	33.48	37.01	31.82	19.62		
	W	SMA Vacancy	%	7.00%	5.66%	4.80%	5.09%	5.76%	6.68%	7.77%	7.58%	6.57%	6.44%	6.30%	5.55%	6.24%	5.10%	↓	↓
	W	SMA Vacancy	WTE	-	65.38	55.46	59.20	66.84	77.52	91.55	89.20	77.04	75.35	73.61	64.98	73.02	59.76		
	W	Recruitment Time to Hire - AFC	Days	46.00	43.50	44.40	42.70	38.40	39.50	39.40	43.20	40.40	43.80	44.10	42.80	41.40	39.50	↓	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	45.20	42.00	50.30	39.30	43.30	33.30	44.00	22.90	-	30.30	26.70	42.90	37.50	↓	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	-	64.30	66.10	32.60	39.00	39.44	35.30	44.20	57.40	37.25	38.40	44.50	36.80	↓	↓
		Workforce Utilisation																	
	W	Establishment WTE	WTE	-	5,382.34	5,431.15	5,446.50	5,433.90	5,433.90	5,437.81	5,434.79	5,430.70	5,427.80	5,424.66	5,442.77	5,448.21	5,457.86		
	W	Substantive WTE	WTE	-	5,180.87	5,207.48	5,222.68	5,220.14	5,206.47	5,218.15	5,218.67	5,243.99	5,220.69	5,233.37	5,262.88	5,255.94	5,270.32		
	W	Additional Substantive WTE	WTE	-	25.22	21.90	22.51	24.78	20.17	5.53	8.24	9.23	6.30	7.64	9.62	13.99	11.26		
	W	Bank WTE	WTE	-	246.43	295.57	294.32	380.50	286.32	301.97	326.11	333.04	333.94	318.99	325.94	348.20	325.04		
	W	Agency WTE	WTE	-	55.12	61.82	69.47	60.09	49.52	43.70	38.63	45.95	44.39	30.74	39.41	43.36	61.07		
	W	Budgeted vs Worked WTE Variance	WTE	-	125.30	155.62	162.48	251.61	128.59	131.54	156.87	201.51	177.52	166.07	195.08	213.27	209.84		
	W	Actual Worked vs Budgeted %	%	-	102.33%	102.87%	102.98%	104.63%	102.37%	102.42%	102.89%	103.71%	103.27%	103.06%	103.58%	103.91%	103.84%		
	W	Total Workforce Cost £	£	-	£25.09M	£25.67M	£25.39M	£25.92M	£25.13M	£25.50M	£25.21M	£25.57M	£25.87M	£25.27M	£36.50M	£26.75M	£28.12M		
	W	Agency Spend as % of Total Spend	%	4.50%	1.22%	2.83%	2.83%	2.04%	1.83%	1.30%	2.01%	1.94%	1.58%	1.01%	1.23%	1.64%	1.60%	↓	↑
	W	Agency Spend £	£	-	£0.30M	£0.73M	£0.72M	£0.53M	£0.46M	£0.33M	£0.51M	£0.50M	£0.41M	£0.26M	£0.45M	£0.44M	£0.45M		
	W	Agency Target £	£		£1.10M	£0.91M	£0.86M	£0.96M	£0.54M	£0.52M	£0.51M	£0.49M	£0.47M	£0.46M	£0.44M	£0.42M	£0.41M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	-£0.79M	-£0.18M	-£0.14M	-£0.44M	-£0.08M	-£0.19M	£0.00M	£0.01M	-£0.06M	-£0.20M	£0.01M	£0.01M	£0.04M	↑	↑
	W	Bank Spend £	£	-	£2.01M	£2.21M	£2.12M	£2.55M	£1.89M	£2.02M	£2.23M	£2.32M	£2.04M	£1.88M	£2.29M	£2.15M	£2.21M		
	W	Bank Target £	£		£0.00M	£0.00M	£0.00M	£0.00M	£2.19M	£2.12M	£2.04M	£1.96M	£1.88M	£1.81M	£1.73M	£1.65M	£1.57M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£2.01M	£2.21M	£2.12M	£2.55M	-£0.31M	-£0.10M	£0.19M	£0.36M	£0.15M	£0.07M	£0.56M	£0.50M	£0.64M	↑	↓
	W	Registered Nursing Bank Fill	%	45.00%	87.74%	90.73%	90.69%	90.40%	90.86%	94.13%	90.81%	85.23%	82.25%	85.50%	83.28%	84.19%	77.28%	↓	↓
	W	Unregistered Nursing Bank Fill	%	70.00%	81.80%	80.12%	79.46%	78.92%	81.89%	87.18%	86.23%	79.50%	77.63%	78.67%	71.95%	71.89%	65.05%	↓	↓

WS

Workforce Scorecard

Our People

Workforce Scorecard

Pillar	Type	Metric	Unit/Measure	Target	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend Vs Last Month	Trend Vs Dec-23
		Retention																	
	W	All Turnover %	%	13.00%	11.49%	10.98%	10.90%	10.72%	10.85%	10.57%	10.24%	10.47%	10.91%	10.70%	11.08%	11.14%	-	↑	↓
	W	Voluntary Turnover %	%	11.00%	8.89%	8.55%	8.56%	8.45%	8.62%	8.53%	8.02%	7.90%	8.66%	8.50%	8.80%	8.75%	-	↓	↓
	W	Number of Leavers	Headcount	-	42	44	40	62	44	46	58	46	72	58	60	48	-		
	W	Number of RN Leavers	Headcount	-	11	21	10	15	12	17	20	14	15	10	14	17	-		
	W	Registered Nursing Vol Turnover	%	-	6.99%	7.07%	7.16%	7.19%	7.33%	7.52%	7.17%	7.36%	7.70%	7.30%	7.39%	7.32%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	15	7	11	13	11	10	13	6	12	14	14	10	-		
	W	Unregistered Nursing Vol Turnover	%	-	11.86%	12.01%	11.21%	10.87%	11.16%	11.00%	10.91%	10.69%	11.10%	10.34%	10.87%	10.98%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	13.96%	12.14%	11.86%	11.72%	10.68%	9.74%	10.98%	9.57%	11.00%	10.62%	11.04%	9.68%	-		
	W	Number of starters	Headcount	-	39	86	38	52	62	44	64	61	69	102	67	50	-		
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.86%	4.88%	4.76%	4.64%	4.57%	4.51%	4.52%	4.60%	4.60%	4.57%	4.60%	4.61%	-	↑	↓
	D	Sickness Absence %	%	3.50%	5.00%	4.92%	4.37%	4.16%	4.21%	4.20%	4.61%	5.20%	4.59%	4.28%	4.89%	4.88%	-	↓	↓
	W	Long Term Sickness %	%	2.00%	2.67%	2.64%	2.41%	2.24%	2.24%	2.32%	2.45%	2.92%	2.82%	2.46%	2.69%	2.26%	-	↓	↓
	W	Short Term Sickness %	%	1.50%	2.33%	2.28%	1.96%	1.92%	1.97%	1.87%	2.17%	2.29%	1.77%	1.82%	2.20%	2.62%	-	↑	↑
	W	Sickness Absence Cost £	£	-	£794.0k	£777.2k	£647.1k	£669.2k	£675.4k	£708.3k	£748.9k	£850.4k	£755.3k	£727.5k	£873.5k	£860.3k	-		
	W	WTE Days Lost	WTE	-	7,922.9	7,774.7	6,566.1	6,618.1	6,482.7	6,662.1	7,157.7	8,351.6	7,372.3	6,700.5	7,958.5	7,725.1	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	91.88%	91.49%	91.72%	92.31%	92.46%	91.37%	91.59%	92.42%	89.84%	89.85%	90.58%	89.79%	90.06%	↑	↓
	W	Role Essential MT %	%	85.00%	93.14%	92.92%	93.28%	93.79%	94.03%	91.84%	92.30%	94.14%	89.00%	89.52%	90.57%	88.86%	89.37%	↑	↓
	W	CQC Safe MT %	%	85.00%	90.64%	90.07%	90.16%	90.85%	90.90%	90.86%	90.84%	90.71%	90.88%	90.25%	90.58%	90.97%	90.95%	↓	↑
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	85.24%	86.22%	85.23%	86.51%	84.26%	83.54%	82.60%	84.77%	86.96%	82.88%	82.42%	84.73%	85.86%	↑	↑
	W	Appraisal Compliance %	%	85.00%	85.63%	84.32%	84.85%	85.26%	84.18%	84.39%	84.74%	84.88%	84.67%	84.09%	84.90%	84.29%	83.46%	↓	↓
	W	Non Medical Appraisal Compliance %	%	85.00%	85.37%	84.06%	84.37%	84.59%	84.40%	83.99%	84.87%	84.95%	84.71%	84.37%	84.94%	84.60%	83.81%	↓	↓
	W	Medical Appraisal Compliance %	%	85.00%	87.59%	86.32%	88.38%	90.10%	82.58%	87.32%	83.81%	84.40%	84.38%	82.07%	84.58%	82.09%	80.94%	↓	↓

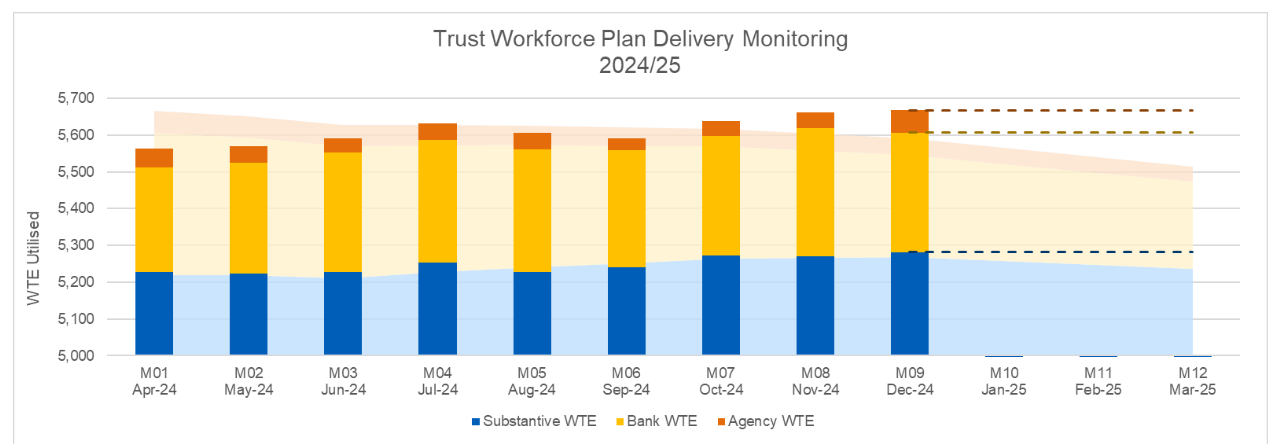
Our People

Workforce Scorecard

Pillar	Type	Metric	Unit/Measure	Target	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend Vs	
																		Last Month	Dec-23
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.19%	4.23%	4.26%	4.28%	4.28%	4.23%	4.26%	4.29%	4.25%	4.21%	4.28%	4.30%	4.26%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	264.00	268.00	271.00	272.00	272.00	269.00	271.00	273.00	273.00	271.00	276.00	277.00	275.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	71.59%	71.27%	71.22%	70.59%	70.59%	69.89%	70.11%	70.33%	70.70%	70.11%	70.29%	70.40%	70.18%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.82%	6.34%	6.64%	6.25%	6.25%	6.32%	6.64%	6.59%	6.23%	6.27%	6.16%	6.50%	6.55%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.89%	0.90%	0.90%	0.90%	0.94%	0.94%	0.94%	0.96%	0.93%	0.93%	0.90%	0.93%	0.93%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	56.00	57.00	57.00	57.00	60.00	60.00	60.00	61.00	60.00	60.00	58.00	60.00	60.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	57.14%	56.14%	56.14%	56.14%	56.67%	56.67%	56.67%	57.38%	58.33%	56.67%	56.90%	55.00%	55.00%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	5.36%	3.51%	3.51%	3.51%	3.33%	3.33%	3.33%	3.28%	3.33%	3.33%	3.45%	5.00%	5.00%		
	W	% of Leadership Roles who are disabled (B8c+)	%	-	1.79%	1.75%	1.75%	1.75%	1.67%	1.67%	1.67%	1.64%	1.67%	1.67%	3.45%	3.33%	3.33%		
	W	Male % of Workforce	%	-	18.29%	18.33%	18.32%	18.36%	18.39%	18.52%	18.51%	18.56%	18.48%	18.32%	18.40%	18.46%	18.51%		
	W	Female % of Workforce	%	-	81.71%	81.67%	81.68%	81.64%	81.61%	81.48%	81.49%	81.44%	81.52%	81.68%	81.60%	81.54%	81.49%		
	W	BME % of Workforce	%	-	25.98%	26.08%	26.12%	26.36%	26.56%	26.76%	27.05%	27.31%	27.53%	27.99%	28.30%	28.40%	28.46%		
	W	White % of Workforce	%	-	66.19%	65.84%	65.76%	65.61%	65.36%	65.09%	64.99%	64.84%	65.00%	64.54%	64.41%	64.30%	64.17%		
	W	ER Cases Closed	Number	-	42	44	45	25	19	60	46	59	48	43	52	43	37		

Our People

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 (OPP)	Plan	5,667	5,651	5,627	5,627	5,626	5,621	5,618	5,604	5,591	5,565	5,539	5,514
	Actual	**5,562**	**5,569**	**5,592**	**5,632**	**5,605**	**5,591**	**5,638**	**5,661**	**5,668**	0	0	0
	Variance	-104	-82	-35	5	-21	-30	20	57	77	-	-	-
Substantive	Plan	5,220	5,220	5,211	5,227	5,241	5,252	5,264	5,266	5,268	5,258	5,247	5,237
	Actual	**5,227**	**5,224**	**5,227**	**5,253**	**5,227**	**5,241**	**5,272**	**5,270**	**5,282**	0	0	0
	of which Overtime	**20**	**6**	**8**	**9**	**6**	**8**	**10**	**14**	**11**	0	0	0
	Variance	6	4	16	26	-14	-11	8	4	14	-	-	-
Bank	Plan	387	373	359	346	332	318	305	291	277	264	250	237
	Actual	**286**	**302**	**326**	**333**	**334**	**319**	**326**	**348**	**325**	0	0	0
	Variance	-100	-71	-33	-13	2	1	21	57	48	-	-	-
Agency	Plan	60	58	56	55	53	51	49	47	45	44	42	40
	Actual	**50**	**44**	**39**	**46**	**44**	**31**	**39**	**43**	**61**	0	0	0
	Variance	-10	-14	-18	-9	-8	-20	-10	-4	16	-	-	-
Trust All Turnover	Plan	10.90%	10.90%	11.19%	11.19%	11.19%	11.19%	11.68%	11.68%	11.68%	12.26%	12.45%	12.65%
	Actual	**10.85%**	**10.57%**	**10.24%**	**10.47%**	**10.91%**	**10.70%**	**11.08%**	**11.14%**				
	Variance	-0.05%	-0.33%	-0.95%	-0.72%	-0.28%	-0.49%	-0.60%	-0.55%	-	-	-	-
Trust 12-Month Sickness	Plan	4.35%	4.33%	4.31%	4.29%	4.29%	4.29%	4.22%	4.22%	4.22%	4.16%	4.14%	4.12%
	Actual	**4.57%**	**4.51%**	**4.52%**	**4.60%**	**4.60%**	**4.57%**	**4.60%**	**4.61%**				
	Variance	0.22%	0.18%	0.22%	0.32%	0.31%	0.29%	0.38%	0.39%	-	-	-	-

Performance & Counter Measure

- 5,668WTE was used to deliver our services in December which was +77WTE above planned levels (+7WTE from the previous month). The above-plan position is predominantly driven a spike in agency in December, with 61WTE used compared to 43WTE the previous month and failure to reduce the bank worked WTE which is currently 48WTE over plan at 325WTE. This Trust vacancy figure is currently 188WTE however we are using 386WTE temporary workforce to cover this gap (172% more than budgeted establishment allows).
- The end of year WTE target is 5,514WTE compared to current usage of 5,668WTE, therefore if we continue at the current run rate, the Trust will be 154WTE above plan by the end of the financial year.

Impact on Workforce

- Introduction of EVRP and ICB VRP process in November. All roles now require Executive approval and all roles band 7 and above require ICB approval. R&R, fixed-term contract extensions, banding increases, and increases in hours also require EVRP and ICB EVRP approval.
- Our current WTE run rate suggests a year-end position of 147 WTE above plan. The Trust has resubmitted an updated forecast to the ICB following increased controls for bank and agency which provided an end of year forecast position of 22WTE above plan, however given the M8 position it is clear this will be a challenge.
- To achieve M12 position the Trust must reduce the worked WTE run rate by 147WTE by March. The Trust does not have robust plans on how this can be achieved and with current pressures on flow, patient acuity this is an increasing risk.

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.

Appendices

Explaining the IPR

Improving together

Explaining the IPR

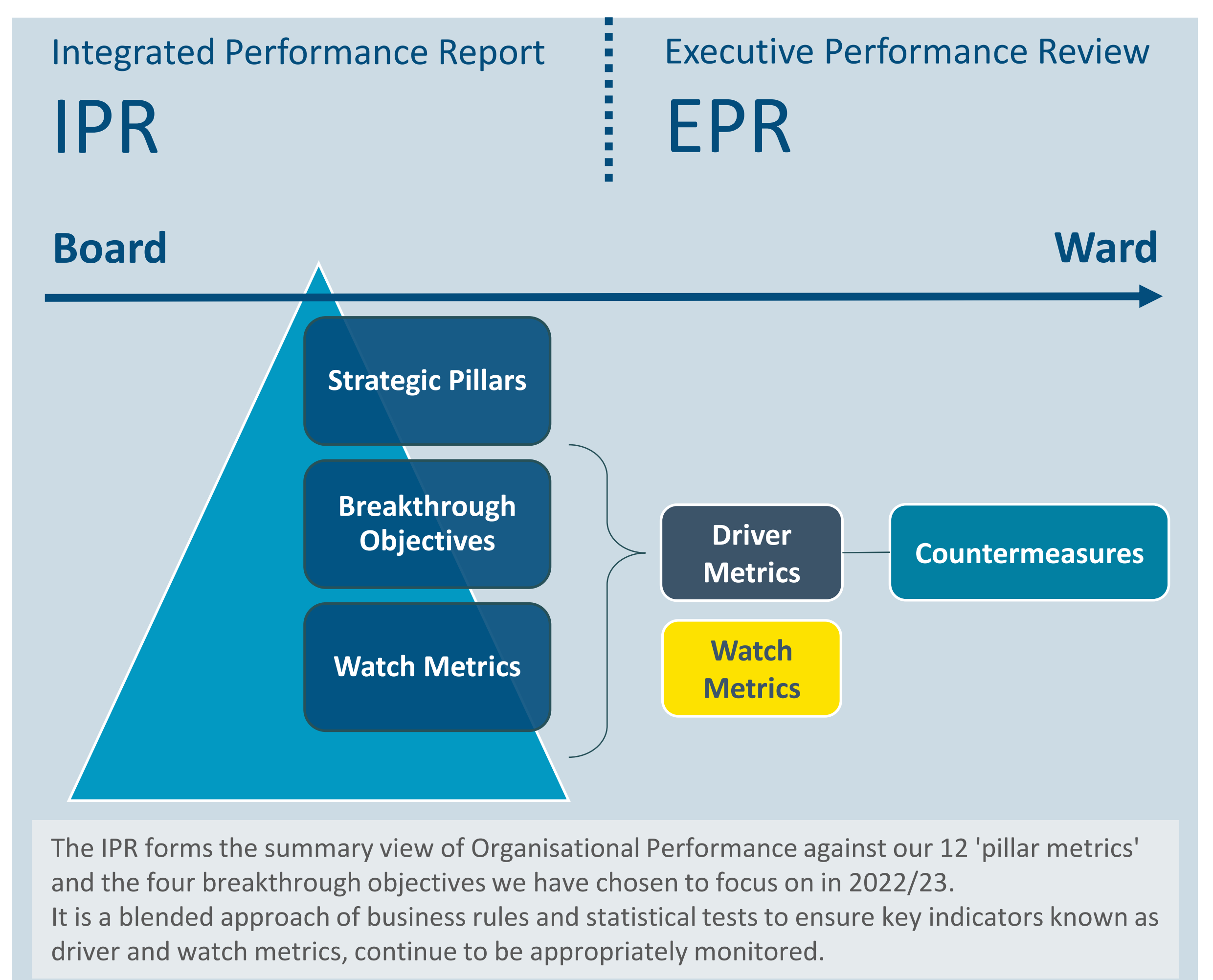
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- 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

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

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

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

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

No.	Initiative
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

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

Information Flow

Speciality Weekly Driver

Speciality Performance Meeting

Frontline

Improvement Huddles

Information Flow

Frontline Performance Meeting

Building a culture of continuous improvement

Communications and engagement

Providing an environment that values staff and engages them with the organisation.

Wards | Primary Care | Theatres | Therapies | Women's & Children's Services | Estates | IT

Community Services | Specialties | Diagnostics | Urgent & Emergency Care | HR | Finance

Transformational projects

Using improvement methodology to create step-change improvement.

Operational Management System

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

Transformation & Improvement Hub

Develop an internal capability to develop and sustain improvement journey.

Transformation & Improvement Hub

Clinical Divisions | Corporate Teams

Leadership behaviours

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

Executive Team

Trust Vision & Strategy

Strategy deployment

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

SPC supporting business rules

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.

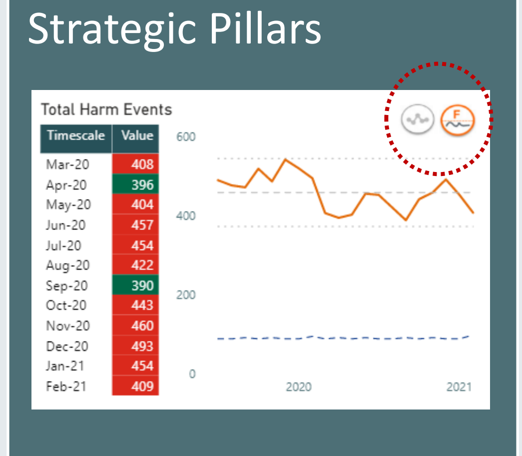
Note:
The Business rules are highlighting deviation from National standards (where these exist), rather than current planning targets.

- 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.

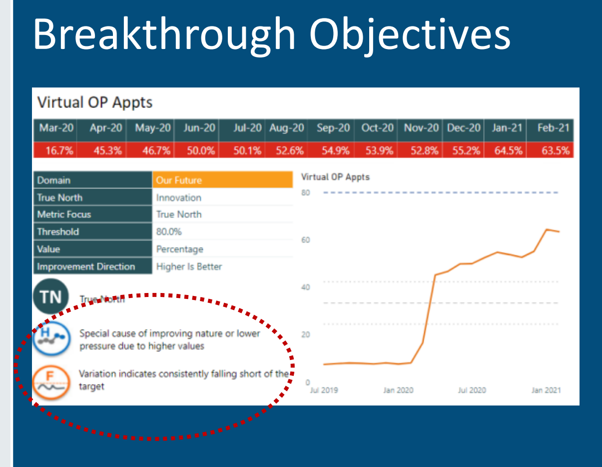
NHS Improvement SPC icons:

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:



Timescale	Value
Mar-20	408
Apr-20	396
May-20	404
Jun-20	457
Jul-20	454
Aug-20	422
Sep-20	390
Oct-20	443
Nov-20	460
Dec-20	493
Jan-21	454
Feb-21	409



Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
16.7%	45.3%	46.7%	50.0%	50.1%	52.6%	54.9%	53.9%	52.8%	55.2%	64.5%	63.5%

Domain	Our Future
True North	Innovation
Metric Focus	True North
Threshold	80.0%
Value	Percentage
Improvement Direction	Higher Is Better

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

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

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

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

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

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	16 January 2025
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Divisional Risk Review - Corporate	Partial Assurance	x
2. Electrical Incident Risk Management Processes	Good Assurance (but see notes below)	x
3. Clinical Coding Internal Audit	Good Assurance	x
4. External Audit Plan	Approved	
5. Internal Audit - Progress Report and Action Tracking	Good Assurance	x
6. Internal Audit – Divisional Risk Management Final Report	Good Assurance	x
7. Local Counter Fraud Progress Report	Noted	
8. Single Tender Actions	Good Assurance	x
9. Code of Governance Compliance Update	Substantial Assurance	x
10. Losses and Compensation Report Q3 2024/25	Noted	

POINTS OF ESCALATION	
KEY AREAS TO NOTE	The Committee received the External Audit plan for 2024/25 from Deloitte. The timetable for completion of the audit is similar to prior years. Deloitte are going to conduct some of the more detailed work during the interim audit in February to ensure that these items are addressed well in advance of the final work. It was also noted that the Finance Team are well prepared for the audit work that will be required. Deloitte noted that they will consider the Value for Money aspects of their work early in the process to ensure adequate time to discuss fully with the Committee. The internal audit programme for the year is progressing well. The Committee gained assurance on the timely completion of actions and the process for review and sign-off of completed actions as well as the internal escalation on overdue items. The Committee received the internal audit report on Divisional Risk Management which was rated as Significant Assurance with minor improvement opportunities. The Committee were pleased to note that risk reporting and oversight is actively discussed by the Divisions and good processes are in place and well embedded in the divisions. Four medium and two low actions were raised and are all due to be completed by March 2025. The Committee noted a few minor concerns around Datix and requested for this to be followed up by Management.
BOARD ASSURANCE FRAMEWORK & RISKS	The Committee was updated on the Corporate Departments Risk Register and the processes in place to identify and manage risks and the actions taken to control and mitigate those risks. This is the first time that this combined report across all Corporate areas has been brought to the Committee who welcomed the oversight. It is recognised that work is being undertaken to ensure all departments are appropriately trained in the processes. Work is being undertaken to review overdue risks and aged risks. It was recognised that the majority of the areas covered by the Corporate Departments are well managed through individual Committees, eg Finance, Digital and Estates through FIDC. However the Committee asked that a review is undertaken of all risks under the Corporate heading to ensure that the governance is complete across all areas and that there are no gaps. The Committee also asked for a view on oversight by management across the total Corporate Department Risks similar to the divisional reviews that are undertaken. An update was provided to the Committee on the processes and governance in place to identify and manage the risks related to the Electrical Incident. The Committee was assured on the processes in place to manage and mitigate the identified risks and thus rated this item as Good Assurance. However it was recognised from an operational perspective that the actions required to resolve all the issues that have been identified is still ongoing and is going to take some months to complete – and from this perspective then the ultimate risk is only partial assurance. These aspects are being overseen by FIDC. The Committee received an update on the independent audit that had been undertaken on Clinical Coding. The actions that arose from the audit have all been completed and the appropriate controls are in place. However the backlog on coding remains an issue and will be monitored and reviewed as appropriate by FIDC and the Quality and Safety Committee.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The Committee reviewed the progress that had been made on the development actions that had been identified to improve the Trust's compliance with NHS England's Code of Governance for NHS Provider Trust. The Committee commended the work that had been undertaken to complete the majority of actions and the detailed report that was provided.
REFERRALS TO OTHER BOARD COMMITTEES	The Committee noted that the coding backlog will continue to be reviewed and monitored by FIDC and the impacts on the mortality statistics by Q&S. The Committee noted that the completion of the actions related to the Electrical Incident are being overseen by FIDC.

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

Board Committee Assurance Report

Committee	Mental Health Governance Committee
Meeting Date	17January 2025
Committee Chair	Lizzie Abderrahim, Non-Executive Director
Link to Strategic Objective	Pillar 1- Outstanding Patient Care & Pillar 3 – Joining Up Acute and Community Services in Swindon
Link to Board Assurance Framework	BAF 1: SR 1 – Quality / SR6 – Partnership Working

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Use of the Mental Health Act Q3 Report		x
2. Mental Capacity Act Q3 Report		✓
3. Use of Deprivation of Liberty Safeguards Q3 Report		x
4. Dementia Strategy Update		x
5. BSW ICB Mental Health Plans	For Noting	x
6. Division of Medicine – Quarterly Report		x
7. Right Care Right Person Update		x
8. Surgery, Women's and Children's Service Quarterly Report		x

POINTS OF ESCALATION	The impact that complex Mental Capacity Act [MCA] cases have on the time and resources available – see *The use of the Mental Capacity Act [MCA] and of Deprivation of Liberty Safeguards [DoLS]* below.
KEY AREAS TO NOTE	*Use of the Mental Health Act [MHA]* Two legal breaches of the MHA had occurred during the reporting period. Whilst these were identified promptly and the effected patients notified quickly and provided with information as to the options open to them, the committee agreed that, rather than maintaining the substantial rating, these breaches justified a good assurance rating. In agreeing that rating it was noted that breaches of the MHA were exceptional and not the norm and that the committee in previous meetings had been satisfied that GWH employed proactive steps to ensure there was a robust approach to the application of the legal framework provided under the MHA and it was acknowledged that the evidence that these breaches had been identified promptly demonstrated that robust approach.
	The use of the Mental Capacity Act [MCA] and of Deprivation of Liberty Safeguards [DoLS] Good assurance ratings were maintained on the basis that there was clear evidence that training continued to be delivered that addressed the legal requirements of both the MCA and DoLS. However, it was noted in relation to the MCA that a number of complex cases involving the Court of Protection had been resource intensive and impacted significantly on professional time. This meant that no MCA audits had been completed during the reporting period. The committee noted that audits are the mechanism by which GWH is able to evidence the extent to which the MCA is applied and implemented effectively across the Trust and to identify what further work needs to be done, it was of concern therefore that resource constraints meant that no audits had been carried out.
	Dementia Strategy Update The committee noted the activities undertaken during 2023/24 to address the 6 priorities of the Dementia Strategy. These included the delivery of training and education, the implementation of a Dementia Care Pathway, work to ensure the provision of dementia friendly environments and experiences, and the involvement of Admiral Nurses in collaborative work with partner organisations. It was evident that there were examples of outstanding care but the committee recognised the challenge was now to ensure that such care was provided consistently across the Trust. The committee was also conscious that the Strategy was at the end of its stated period and that a new Strategy was in the process of development and, for these reasons, agreed that a good assurance rating was appropriate.
	BSW ICB Mental Health Plans The committee noted a presentation from the ICB Interim Director All Age Mental Health on the ICB's plans to address mental health provision, this included the draft Mental Health Strategy [2025-2030] that is in the process of submission to the ICB Board and the medium-term plans to support initiatives designed to impact on the volume and frequency of mental health presentations and admissions to acute hospitals. These initiatives were designed to support the objective of achieving financial stability by reducing mental health presentations to emergency departments [ED], improving early access to primary mental health services, reducing NCTR in acute mental health settings, reducing pathway waiting times and improving access to earlier intervention. Whilst acknowledging the benefit that these initiatives could bring the committee did express some concern that the current presentation rate to ED at GWH was considerably greater [6-8 daily presentations rather than 3.5] and that the challenge might therefore be greater than anticipated.

	Division of Medicine Quarterly Report A good assurance rating was maintained and reflects the work done, in partnership with AWP to ensure that the mental health needs of patients are met. However, the committee noted that longer stays associated with up to 8 daily mental health presentations meant that it was not always possible for patients to be cared for within the observation unit and that this increased the risk of absconding. It was further noted that the location of ED now meant that, for absconding patients, there was a direct route to the A419. Also of note was the necessary RMN spend to address the significant complexity of patients with mental health needs who needed to be cared for within an acute setting and who did so for longer than the optimum period. In relation to these patients the committee acknowledged the information provided during the meeting that during Q3 31.97% of AWP beds were occupied by patients who were clinically ready for discharge and how this demonstrated the significant pressure the system was under.
	Right Care Right Person Update GWH continues to contribute both operationally and strategically in the collaborative work across the system and continues to monitor concerns and incidents with nothing of significance identified. The committee noted that the approach had now been extended to include children and that the impact of this change would be monitored.
	Division of Surgery, Women's and Children's Services Quarterly Report This was the first Divisional report and included, in addition to information in relation to Children's Services [which has been the focus of previous quarterly reporting], information in relation to adult wards and maternity services. In relation to Children's Services the committee noted that work was expected to begin imminently on the creation of a safe room to address the significant risks associated with caring for children and young people exhibiting high risk behaviours on a paediatric ward. There continued to be close collaborative working between GWH and CAMHS although the admission of young people detained under the MHA and awaiting a specialist Tier 4 bed meant that there had been an increase in RMN spend during the reporting period. In relation to adult wards the committee noted the RMN spend that had been incurred and on which wards and the processes in place to ensure that this was managed effectively. In relation to maternity services, it was noted that the imminent implementation of Badgernet would support the collection of perinatal mental health data and this would be reported on in future quarterly reports.
BOARD ASSURANCE FRAMEWORK & RISKS	*15+ Risk Report* There continue to be no 15+ risk to report. Whilst acknowledging that a robust risk management process was in place, including the discussion of mental health related risks in the appropriate divisional governance meetings, oversight from the Risk Group and review at the Mental Health Operational Group, the committee requested a review of the risk score allocated to risk 557. This risk was associated with the potential for harm on the Children's Ward in the absence of a safe room and the committee's concern as to the scoring of this risk related to the increase in the number of incidents that had been reported in the quarterly report from the Division of Surgery, Women's and Children's Services.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

Report Title	GWH CNST Year 6 Submission – GWH Compliance Report				
Meeting	Trust Board				
Date	13th February 2025	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Luisa Goddard (Chief Nurse)				
Report Author	Lisa Marshall (Director of Midwifery and Neonatal Services) Kat Simpson (Head of Midwifery and Neonatal Services) Laura Little (Project Coordinator for Midwifery & Neonatal Services)				
Appendices					

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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Established governance review process and detailed evidence base to provide assurance of Trust compliance across ten safety actions

Report

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

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

This presentation provides a final compliance position update to the Board to demonstrate the achievement of all ten safety actions. Three safety actions are compliant with supporting action plans which have been approved by the Quality and Safety Committee (20th January 2025).

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	X		X		X
Key Risks – risk number & description (Link to BAF / Risk Register)					Risk Score
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Quality & Safety Committee				
Next Steps					

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

Explanation of above analysis:

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

Approve the final CNST compliance position for GWH in preparation for the NHSR Declaration form to be submitted on 3rd March 2025.

Accountable Lead Signature	Luisa Goddard.
Date	5 February 2025

CNST Year 6 Submission – GWH Compliance Report

Lisa Marshall — Director of Midwifery and Neonatal Services

Kat Simpson — Head of Midwifery and Neonatal Services

GWH MIS CNST Year 6 Declaration of Compliance Position

- Trust will be declaring compliance with all ten Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Safety Actions in Year 6 of the scheme.

- The NHSR declaration process allows safety actions to be categorised as:
  - Fully Compliant (able to declare as compliant on NHSR declaration form)
  - Compliant with supporting action plan (able to declare as compliant on NHSR declaration form)
  - Non-compliant (Trusts declare as Non-Compliant on NHSR declaration form and submit bid for proportion of incentive funding for reinvestment in service)

- GWH maternity and neonatal services continues to be on a journey of improvement throughout every CNST reporting cycle to reinvest funding to meet targets that are stretched annually to implement national learning and extend ambitions for Maternity services

CNST Year 4

Compliant across all 10 CNST Safety Actions

Stretch improvement targets set by NHSR to implement national learning and extend ambitions for maternity care across all services in England

CNST Year 5

Non-compliant in 3 Safety Actions (PMRT, Clinical Workforce & Saving Babies Lives v3)

Completing associated financial submission with CNST Y5 declaration form with an aim to reinvest funding to strengthen service

CNST Year 6

Compliant across all 10 CNST Safety Actions

Reinvestment of the rebate will focus on optimising the flow through services. This will be further guided by the Year 7 Maternity Incentive Scheme.

Year 6 GWH CNST Compliance Across NHSR Ten Safety Actions

	Criteria	Initial Self Assessment RAG (April 2024)	Submission RAG (Jan 2025)	Key Commentary
1.	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?			• All elements of this safety action have been met by the Trust, all cases have been reported and reviewed within the required timescales. This data set is externally verified. • There has been a change in the guidance during the reporting period which caused a data anomaly within the nationally reported data. Following verification by the National Perinatal Epidemiology Unit, who lead the PMRT process, this anomaly was excluded from the data set. • The use of the PMRT tool is embedded in the governance processes with a quarterly update provided to the Quality and Safety Committee.
2.	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			• All elements compliant based on data activity in July 2024 with results published by NHS England in October 2024. • The summary tool provides assurance that the Trust is compliant with data quality submissions for all 11 of the monitored CQIMs and that 97.1% of women booked had their ethnic category recorded (target 90%).
3.	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		Compliant with supporting action plan	• One element of safety action is compliant with a supporting action plan, all other elements have been met by the Trust. • This compliance status is supported by a robust action plan which details the final implementation of the pathway to reduce separation of mothers and babies from 34 weeks gestation, by expanding the transitional care provision at Great Western Hospitals. This is aligned with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice for both late preterm and term babies. • A transitional care lead has been appointed deliver service level leadership in establishing this critical area of the service. The action plan will enable a sustainable model of transitional care supported by a dedicated workforce for babies who are born from 34 weeks gestation from April 2025 . • A Quality Improvement project has been launched by the Lead Advanced Neonatal Nurse Practitioner, introducing a new identification tool designed using a traffic light system to ensure all infants are correctly identified at birth for care criteria and commenced on the appropriate pathway
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?		Compliant with supporting action plan	• Two workforce elements of safety action are compliant with supporting action plans, all other elements have been met by the Trust. • Guidance is in place to support locum doctors, compensatory rest for the obstetric team on call, and attendance out of hours in line with guidance published by the Royal College of Obstetricians and Gynaecologists (RCOG). • Oversight of these actions is achieved by noting through the Quarterly Safety Report at Quality and Safety Committee. • Continued compliance has been demonstrated with the required anaesthetic workforce in place. • Significant progress can be demonstrated against action plans for Neonatal medical workforce recruitment and neonatal nursing meeting BAPM standards. • All action plans have received Operational Delivery Network (ODN) and LMNS approval.
5.	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Compliant with supporting action plan	• One element of safety action is compliant with a supporting action plan, all other elements have been met by the Trust. • The action plan details prioritisation of the care provision for one-to-one care in labour and compliance is monitored through maternity governance with cases reviewed to identify improvement actions, and oversight through Quality and Safety Committee. • The risk of non-compliance is considered low with one family being impacted during the last quarter. Mitigation of this risk is supported by the action plan

Year 6 GWH CNST Compliance Across NHSR Ten Safety Actions (cont'd)

	Criteria	Initial Self Assessment RAG (April 2024)	Submission RAG (Jan 2025)	Key Commentary
6.	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			• All elements of this safety action have been met by the Trust. • The Trust position of 94% of actions implemented has been confirmed as meeting this requirement by the LMNS and ICS. • A quarterly update is presented to Board with an in-depth review of the full report discussed quarterly in the Safety Champions meetings. • Themes and trends are monitored in line with PSIRF to identified further targeted actions to support the care bundle and reducing perinatal morbidity and mortality.
7.	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.			• All elements of this safety action have been met by the Trust. • Supporting evidence includes an Maternity and Neonatal Voices Partnership (MNVP) work plan, demonstration of co-production with an emphasis on prioritising hearing the voices of families from minority ethnic groups and areas of deprivation, and co-production of the action plan to support the Care Quality Commission (CQC) Maternity Survey throughout 2024. • The local MNVP lead plays an active role in the governance structure by attending key service meetings, obtaining service user feedback, and consistently working collaboratively with the Trust to develop and co-produce the service.
8.	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?			• All elements of this safety action have been met by the Trust. • Training compliance for all staff groups meets the 90% target across all elements of the Core Competency Framework in fetal surveillance, maternity emergencies and Neonatal Basic Life Support training.
9.	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?			• All elements of this safety action have been met which supports the robust, established Board reporting processes to provide assurance to the Board on maternity and neonatal safety and quality issues. • There is an embedded Maternity and Neonatal Safety Champions model supported by established meetings and Board visibility. • An established safety intelligence reporting process from ward to Board is underpinned by improved triangulation of staff and service user feedback. • The Patient Safety Incident Response Framework (PSIRF) framework is fully embedded and establishment of the perinatal quadrumvirate using the NHS England Perinatal Culture and Leadership framework further supports achievement of this safety action.
10.	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?			• All elements of this safety action have been met by the Trust. • Evidence supporting this achievement includes established internal databases that monitor qualifying cases and associated actions including Duty of Candour and family information, embedded processes between the governance and legal team and an additional audit process to ensure all qualifying cases are identified.

Assurance of Governance Process for Compliance Against NHSR Safety Actions

Great Western Hospitals
NHS Foundation Trust

- Throughout the Year 6 reporting period there has been a strong focus on embedding a visible and consistent strategy for safety in Maternity & Neonatal care.
- The implementation of consistent monitoring, guidance and visibility from ward to board has shaped our local governance framework and reporting to the wider system

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

Timeline For GWH Chief Executive Sign Off	
13th December 2024	CNST Year 6 final compliance report presented at Local Maternity and Neonatal System Programme Board
14th January 2025	CNST Year 6 final compliance report presented at Patient and Safety Quality Committee
15th January 2025	CNST Evidence check & challenge meeting with Luisa Goddard *(Chief Nurse & Board Level Maternity & Neonatal Safety Champion)*, Lizzie Abderrahim *(Non-Exec Director & Board Level Maternity & Neonatal Safety Champion)* & Gill May *(ICS Accountable Officer)*
20th January 2025	CNST Year 6 final compliance report presented at Quality & Safety Committee
13th February 2025	Presentation of final compliance position to Trust Board
27th February 2025	Formal declaration form sign off meeting by Cara Charles-Barks *(Chief Exec.)* & Gill May *(Accountable Officer)*
3rd March 2025 (Noon)	Final deadline for completed Declaration Form (signed by Chief Exec. and Accountable Officer) to be submitted to NHS Resolution

Report Title	Learning from Deaths Annual Report 2023/24			
Meeting	Trust Board			
Date	13 February 2025	Part 1 (Public)	x	Part 2 (Private)]
Accountable Lead	Dr Steve Haig			
Report Author	Dr Laurie Powell			
Appendices	The Annual Learning from Deaths Report 2023/2024			

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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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

Justification for the identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Progress is being made on learning from deaths; still developing divisional oversight, SJR's and mortality.

Report

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

- SHMI and HSMR are within expected range
- Mortality for 2023/2024 was below average and demonstrated a reduction compared with 2022/2023
- SJR completion remains below target, however plans to focus on mandatory categories and utilise the Mortality Review Programme aim to improve this
- Meeting structure has changed with a focus on small group review of data and using trust-wide meetings to share learning
- Support sought from divisional management to facilitate and improve engagement in Learning from Deaths activity

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		

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:	
To receive this report.	
Accountable Lead Signature	[signature]
Date	5/2/2025

Learning from Deaths

2023-24

Project Lead name and job title:	**Dr Laurie Powell** **Trust Mortality Lead**
Contact Details:	laurie.powell1@nhs.net
Specialty / Department:	Mortality
Division:	Corporate
Executive Lead	Dr Steve Haig, Chief Medical Officer
Draft Report Prepared by:	Dr Laurie Powell
Report Finalised by:	Dr Laurie Powell
Report Completion Date:	October 2024

Background / Rationale

The *'Learning from Deaths'* framework was published by the National Quality Board in April 2017 and expects acute trusts and other health care organisations to incorporate the national guidance; aligning mortality and morbidity reviews with their governance systems in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

This report is a summary of Mortality and Morbidity activity and adherence with operational processes across the Trust during 2022-2023.

Audit Priority: Priority 2 – Internal Priority – Implementation of National Guidance

Strategic Driver: Learning from Deaths National Guidance[1]

CQC Domains: **Effective: E2** - How are people's care and treatment outcomes monitored and how do they compare with other services?

Well-Led: W2 - Does the governance framework ensures that responsibilities are clear, and that quality, performance and risks are understood and managed?

Data Period: Deaths during 1st April 2023 – 31st March 2024

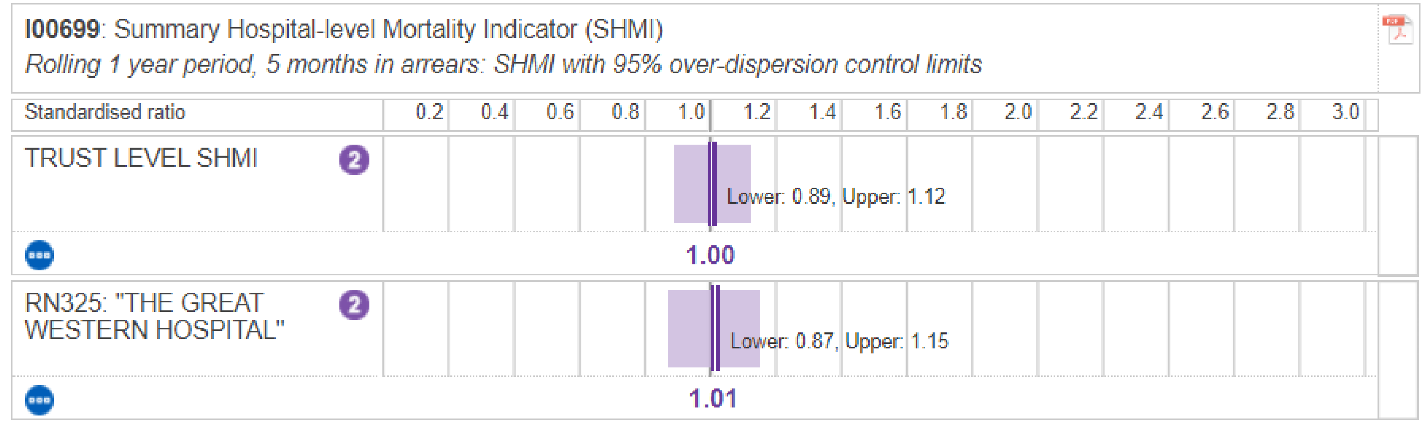
SHMI

(Standardised Hospital Mortality Index)
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It is produced by NHS England and published monthly It covers all deaths reported of patients admitted to non-specialists acute trusts in England and either die while in hospital or within 30 days of discharge. If observed deaths equalled expected deaths at a given trust, the SHMI would be 1.0.

As this report is being submitted in November, we are able to include a SHMI that reflects the year this report relates to (there is always a lag applied to SHMI due to the process of “cleansing” the data by NHSE, meaning that SHMI is published several months after the dates it refers to). The most recent Trust Level SHMI for the period April 2023 to March 2024 is 1.00 (as expected, reduction from 1.06 for April 2022-March 2023), with a Great Western Hospital SHMI of 1.01 (as expected, reduction from 1.03 for April 2022-March 2023).

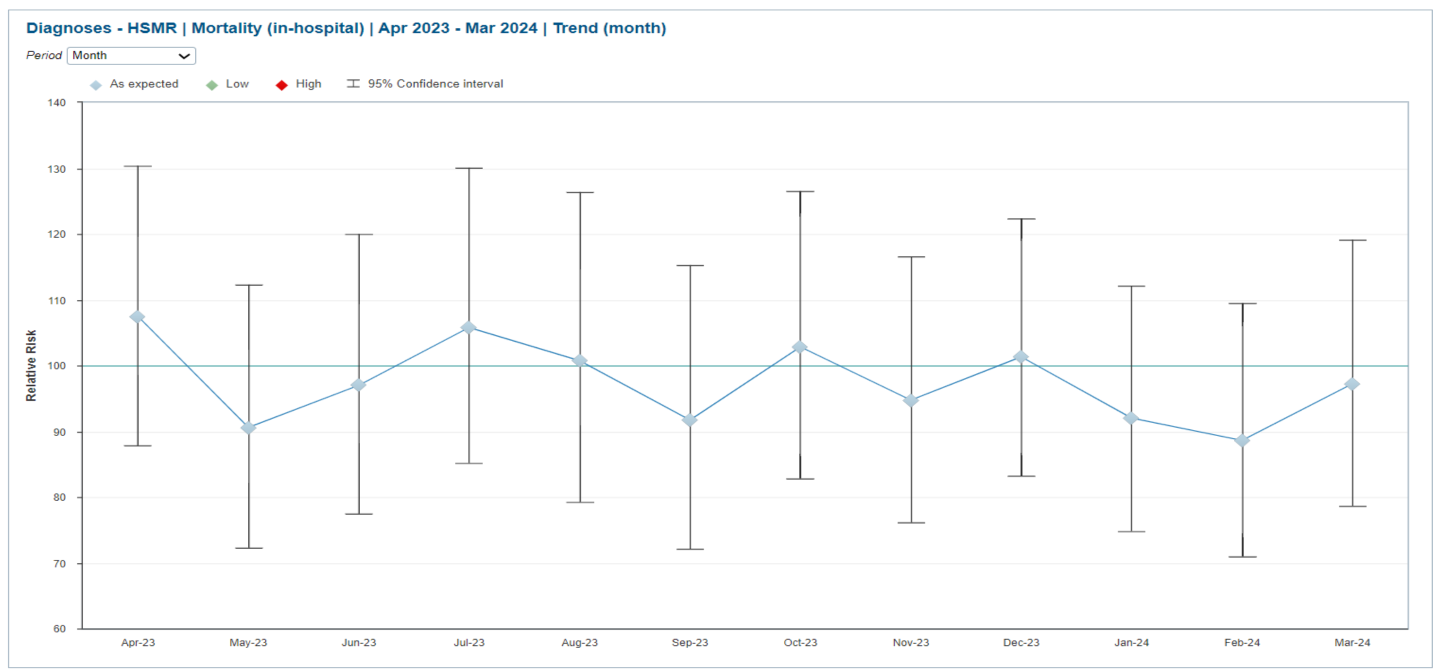
It should also be noted that NHSE have stopped reporting unit-level SHMI for SWICC, instead now being presented as “Trust Level” which includes SWICC, and “The Great Western Hospital”.

Considerable work was undertaken to review coding of non-elective activity for patients in SWICC after identifying that the unit-level SHMI was high and likely to be affected by inaccurate coding of patients being admitted to SWICC (a high SHMI was seen for SWICC due to the fact that most admissions to SWICC were following “emergency” admissions, however the admission to SWICC was being coded as an “elective” admission, and patients admitted “electively” are not usually expected to die). As a result of this work, admissions to SWICC have been coded differently since June 2024, and any changes in SHMI as a result will be reported on in the 2024/2025 annual report.

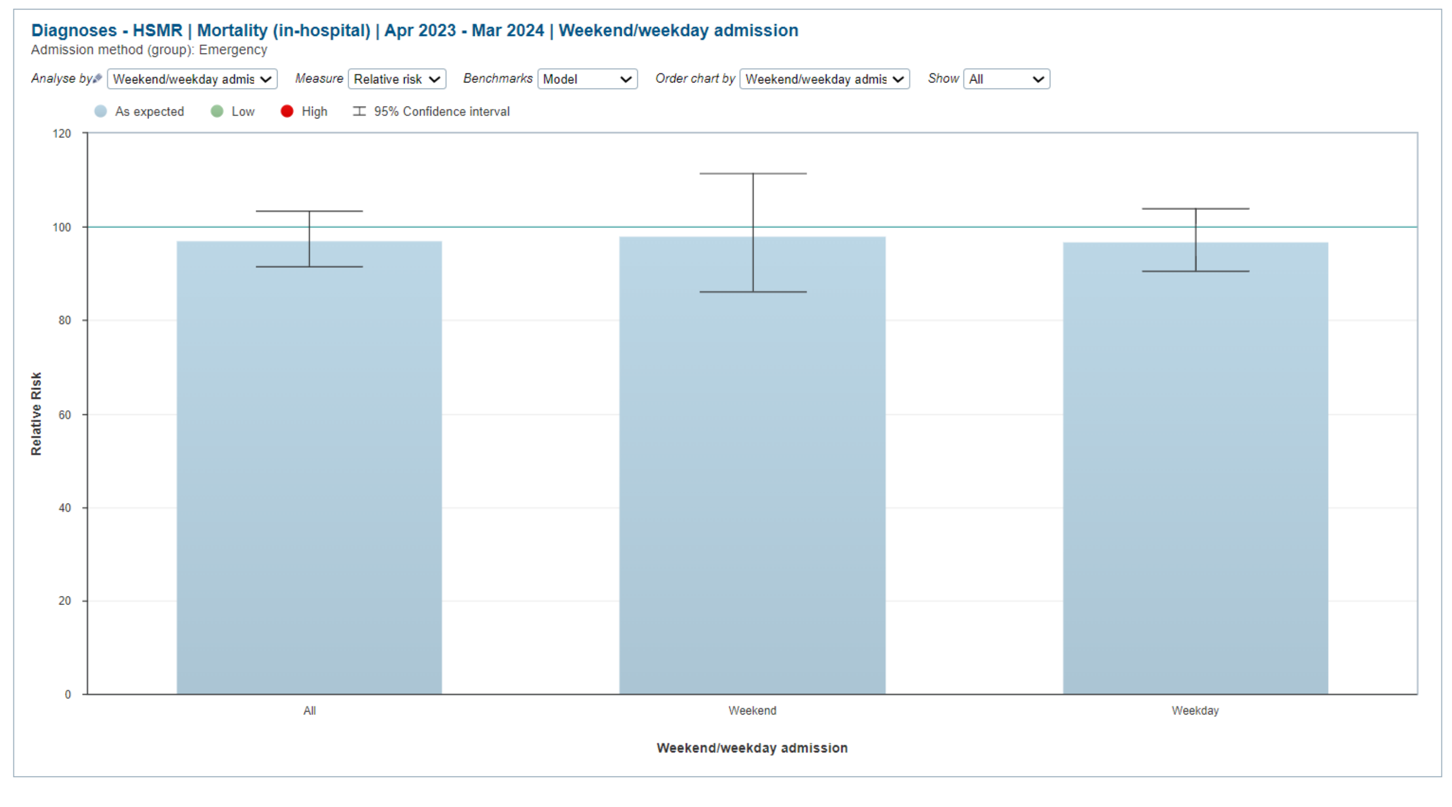


Telstra Health

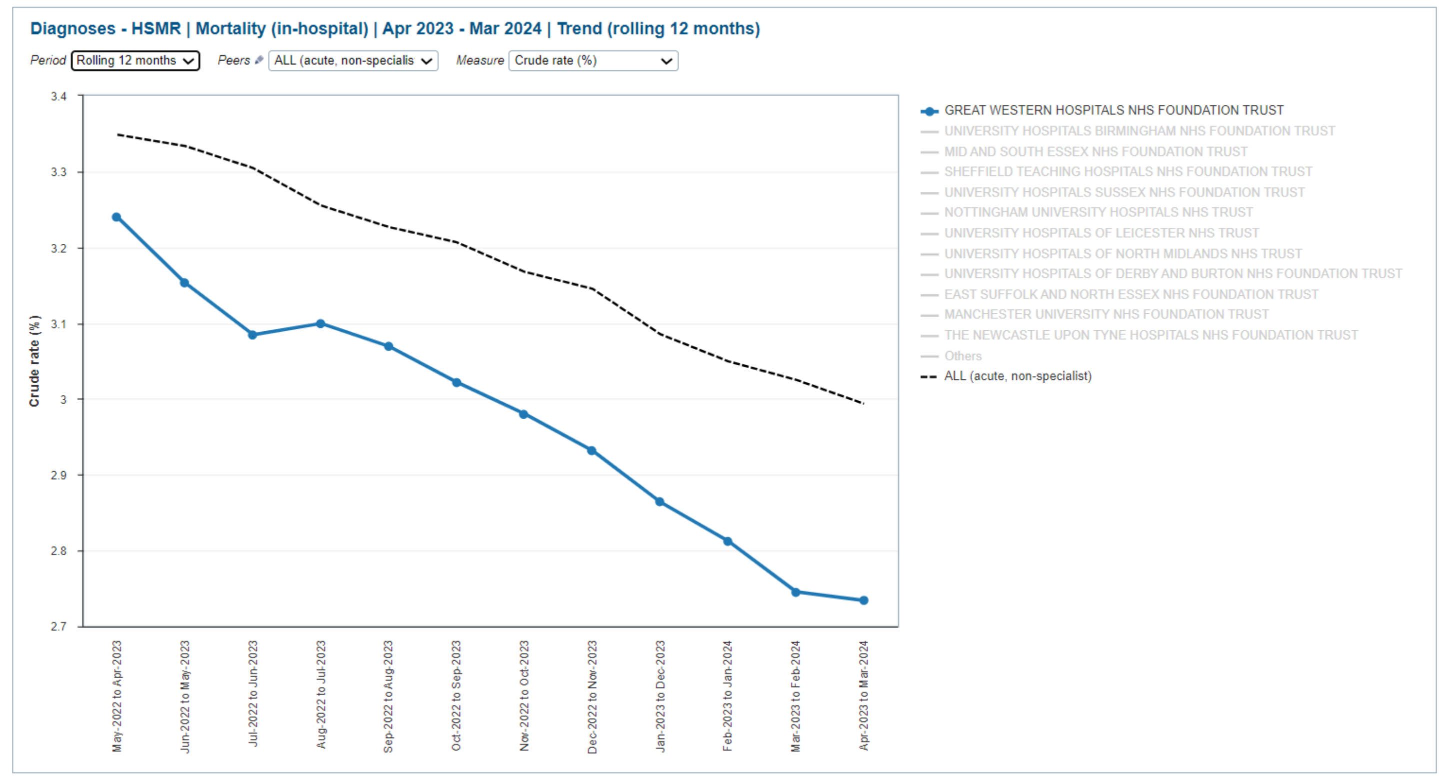
External data provided and analysed by Telstra Health from NHS HES data.
HSMR (Hospital Standardised Mortality Ratio) is another ratio of observed to expected deaths in hospital, adjusted for case-mix factors, and is the ratio reported and analysed by Telstra Health.
It also shows that the current ratio for the period April 2023-March 2024 is 97.4 ("as expected") and has reduced over the year since the last report. It is not clear what has led to this reduction, but the keeping is in line with the reduction in SHMI over the same time period (as with SHMI, we are able to include the HSMR for the year April 2023 – March 2024 which was published in July 2024).



Telstra Health also report on weekday/weekend mortality, which are also reported to be within the expected range and do not raise any concerns.



Crude mortality is also reported by Telstra Health. The graph demonstrates the Trust's rolling 12-month trend in crude mortality and national acute non-specialist peers and has demonstrated a stable decrease in the crude mortality rate over the last year, consistently reporting lower than national peers. The Trust's most recent rolling 12-month crude rate has plateaued slightly. The scale on the chart should be noted, and this change represents a decrease in crude mortality of 0.5% over the year.



Telstra send alerts (CUSUM alerts) when a specific diagnosis group has demonstrated above-expected mortality for 2 consecutive months. Over the year, CUSUM alerts for the following have been identified:

August 23 (M2) Telstra report - *(with 2-month data lag applied)*

- Aspiration pneumonitis, food/vomitus
- Cancer of other urinary organs
- Cancer of prostate
- Malignant neoplasm without specification of site
- Other acquired deformities
- Residual codes, unclassified
- Diagnostic imaging (except heart)
- Excision of vulva
- Rest of ear (diagnostic/minor)
- Rest of urinary

October 23 (M3) Telstra report – *(with 2-month data lag applied due to higher than usual volumes of uncoded activity for May and June '23)*

- Pathological fracture
- Septicaemia (except in labour)

November 23 (M4) Telstra report – *not able to be produced –*
M04 HES data for 23/24 included discharges up to July 2023; a two-month lag was going to be applied and a focus on data to May 2023, but this showed the volume of uncoded data (R69 diagnosis code) for May, June and July 2023 to be heavily affected – therefore M4 report was not produced as it showed nothing new from M3.

November 23 (M5) Telstra report – *not able to be produced –*

Month 5 HES data to August 23 is heavily affected by the backlog in coding and unreliable.

January 24 (M6) Telstra report – *(with 1 month data lag applied lag)*

- Genitourinary congenital anomalies
- Septicaemia (except in labour) – 2nd alert
- Diagnostic imaging (except heart)

January 24 (M7) Telstra report – *(with 1 month data lag applied)*

- Residual codes, unclassified – 2nd alert
- Diagnostic imaging (except heart) – 2nd alert

March 24 (M8) Telstra report – *(with 1 month data lag applied lag)*

- Pathological fracture – 2nd alert

April 24 (M9) Telstra report – *(with 2-month data lag applied lag)*

- No Alerts

July 24 (M13) Telstra report -

- Cancer of rectum and anus (Mar-24)
- Pathological fracture (Oct-23)
- Septicaemia (except in labour) (Apr-23 & Jun-23)

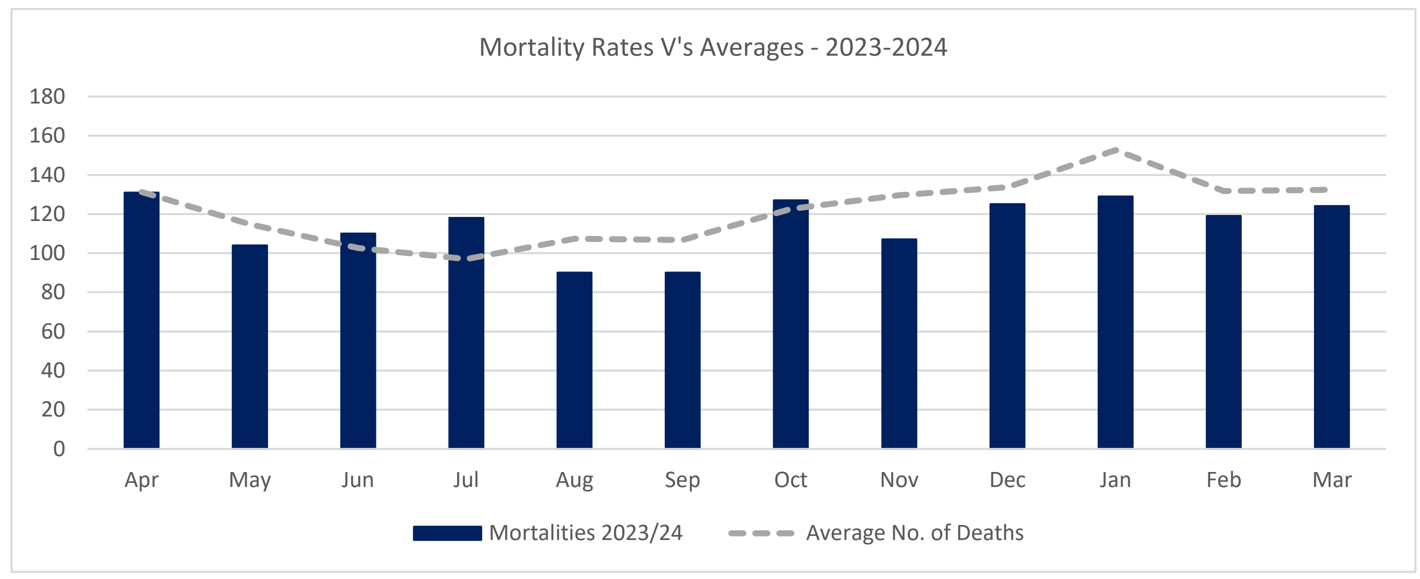
Due to the data lags and high levels of uncoded data, CUSUM alerts could not reliably inform any local reviews, however internal data continued to be monitored for local mortality indicators and diagnoses groups.

Mortality Data

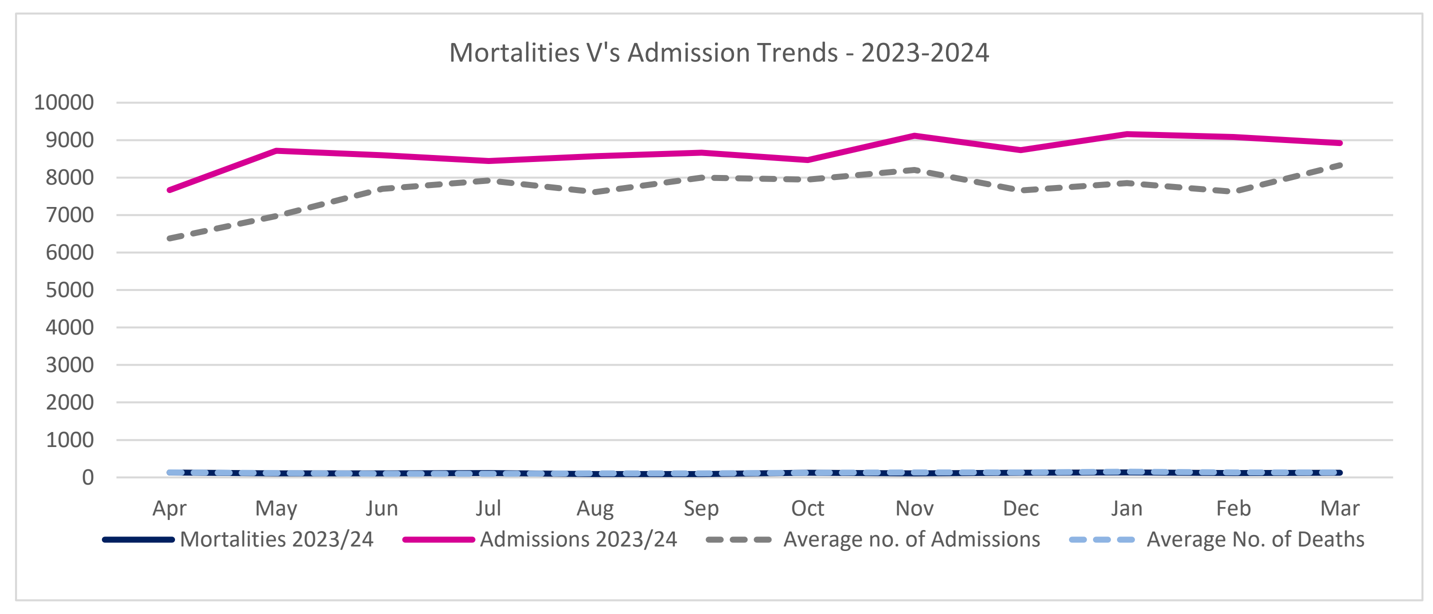
Patient level mortality data is generated by the Trust's Information team and received daily into the Clinical Audit Department; data contains inpatient deaths on a 7-day rolling basis which is uploaded daily onto the Trust's Mortality Database by members of the Clinical Audit team.

The number of deaths recorded during 1st April 2023 – 30th March 2024 was 1374 which was less than the previous year. This represents 14% less deaths and accounted for an average 114.5 deaths per month.

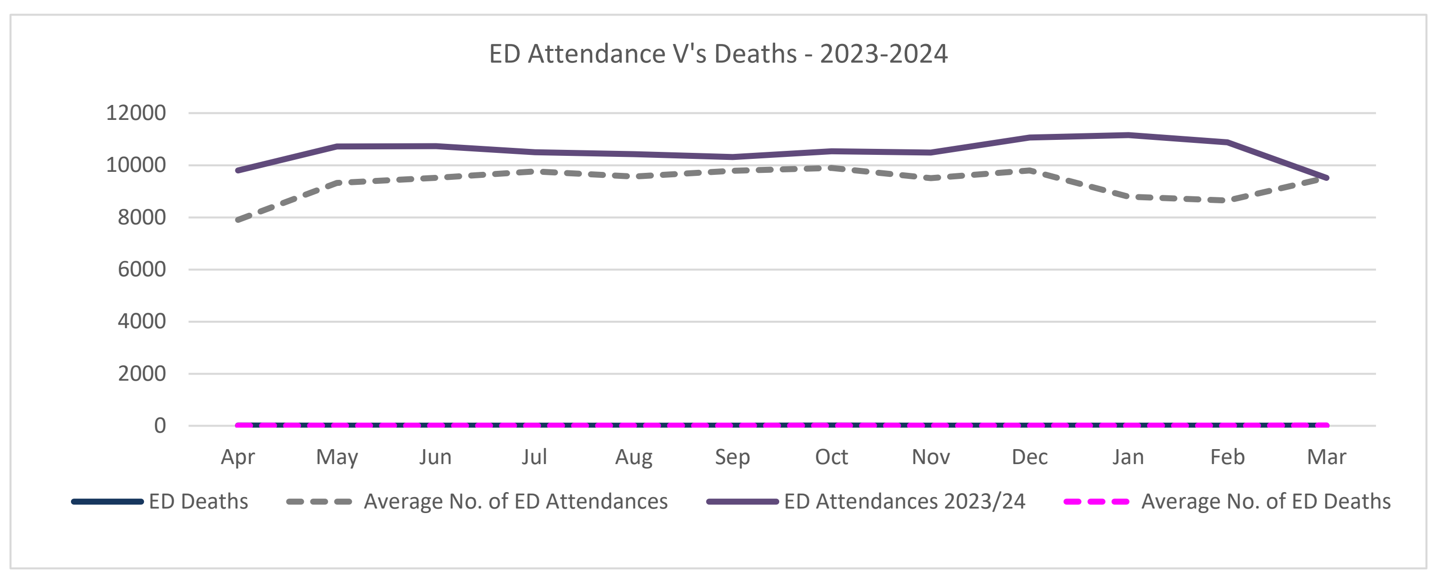
Apart from June, July and October, the number of deaths overall remained less than average, and were in line with previous seasonal trends. The average number of deaths reported per month was 114.5.



Additional mortality data is now received and prepared by the Clinical Audit, Effectiveness & Mortality Team. This allows for internal monitoring of local data including rates of deaths alongside inpatient activity. As shown in the graph below, admission activity throughout the year remained above average levels. The proportion of inpatient deaths ranged between 1.0% to 1.7% with the average proportion of deaths overall reported to be 1.3% of admissions.



Furthermore, internal monitoring of data in relation to attendances to the Emergency Department (ED) also showed higher than average levels of activity, of which the proportion of deaths within ED ranged between 0%-0.2%. The average proportion of ED deaths were recorded at 0.1% of overall attendances. This represents an average of 9.9 deaths per month and is less than previous year which saw an average of 12 deaths per month.

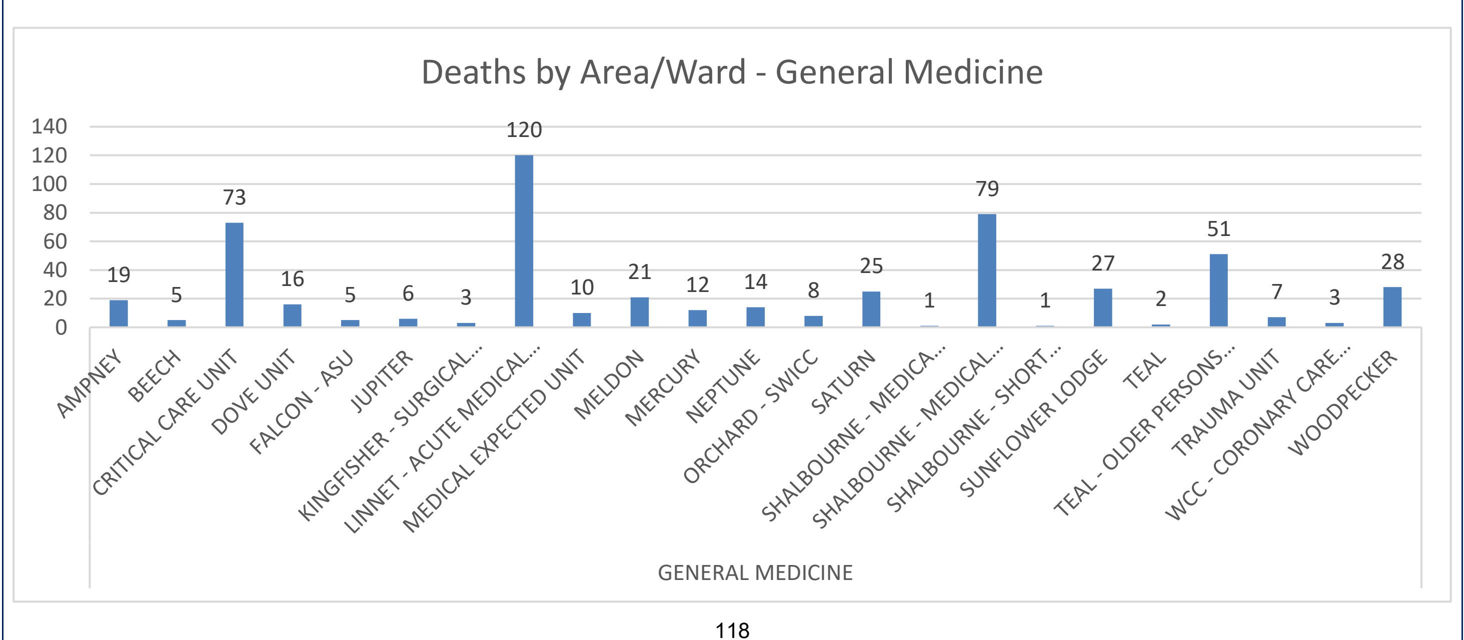


Deaths by Speciality

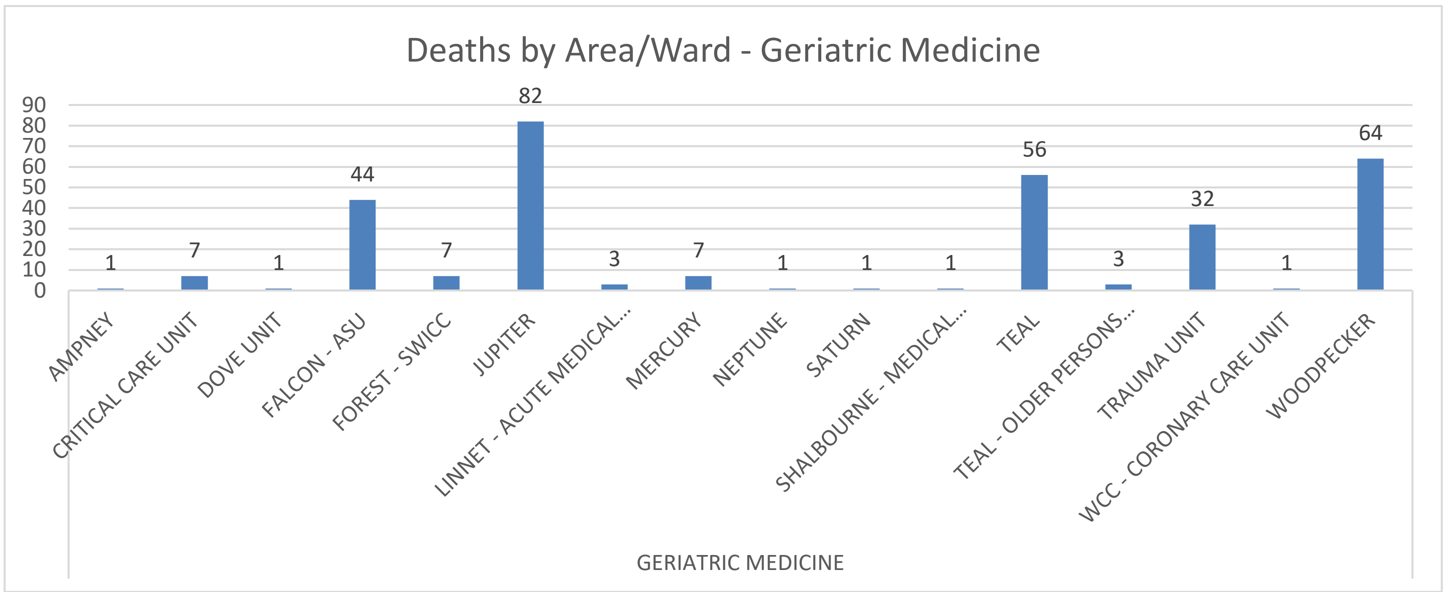
General Medicine, Geriatric Medicine and Accident & Emergency continue to have the greatest number of deaths, accounting for 71% of deaths during the year:

Speciality at time of death	Number of deaths recorded
GENERAL MEDICINE	536 (↓241)
GERIATRIC MEDICINE	311 (↑65)
Accident & Emergency	123 (↓25)

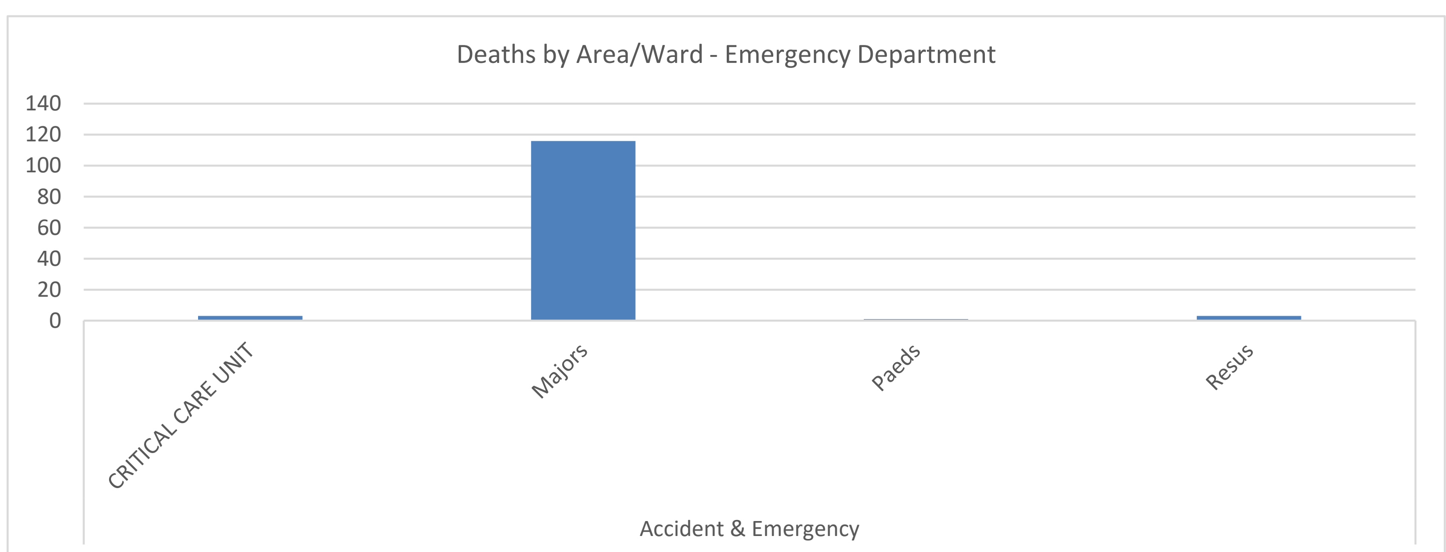
Deaths by area/ward recorded under General Medicine occurred primarily on Linnet Acute Medical Unit (LAMU), Shalbourne Medical Admissions Unit and on the Critical Care Unit.



Deaths observed by the Department for Older People (DOPS) which includes Geriatric Medicine occurred predominantly on the following wards, Jupiter, Woodpecker, Teal, Falcon and the Trauma Unit.



The majority of deaths observed in the Emergency Department occurred primarily in Majors.

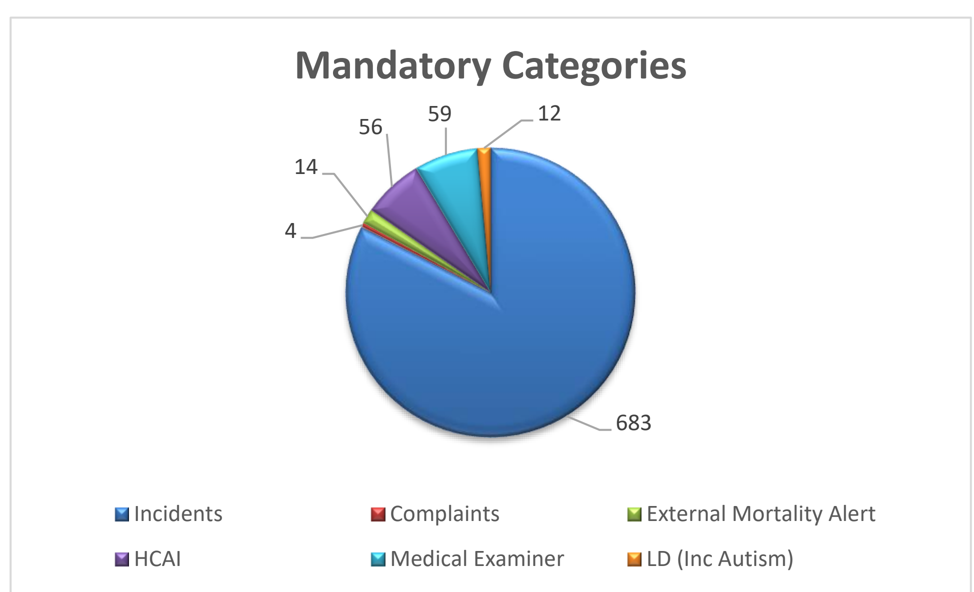


Mandatory Categories

In line with national requirements (National Guidance on Learning from Deaths), it is recommended that all in-patient deaths are reviewed to identify whether further analysis of the patient's care is required in order to identify any problems in care, or examples of excellent care, and emerging themes and trends for improvement are identified. Specific groups of patients have been identified as a mandatory requirement for a mortality review and include the following –

- Deaths following elective surgery
- Patients identified with learning disabilities
- Deaths identified by a speciality/diagnosis/ procedural alert via external monitoring bodies – i.e., CQC, Telstra Health, national audits
- A death where the family have raised concerns
- A death where an incident has occurred
- Deaths identified within local safety initiatives
- Other patient groups identified locally by specialities

The total number of patients identified for a mandatory category Structured Judgement Review (SJR) was 722. This is a 23% increase in comparison to the previous year. It should be noted that patients can be identified in more than one mandatory category, therefore when analysed cumulatively, there was a reported total of 828 alerts. A breakdown of the alerts by category is shown below:



Incidents are received into the Clinical Audit, Effectiveness & Mortality Team as a notification and are screened and uploaded to the mortality database on a daily basis. This enables the identification of SJRs to initiate for a priority review; it should be noted that this includes all incidents that were raised during the patient's final in-patient stay even if it was not a direct cause of the patient death.

A total of 683 patients were identified with raised incidents which is a 69.5% increase compared to the previous year.

There has been a reduction in the number of patients referred for SJR from the Medical Examiner from 79 to 59, and the number of report patients with Healthcare Associated Infections has significantly dropped from 134 to 56. The number of patients identified with Learning Disabilities has increased, however, this may be due to increased data management and identification of this patient group. Overall, 45% (321) SJRs were completed in relation to a mandatory category review, compared to 37% (205) last year.

Structured Judgement Reviews

A Structured Judgement Review (SJR) is systematic exercise using nationally accepted methodology to review a series of individual case records in order to identify any problems in care or examples of excellent care. This allows opportunities to draw learning or conclusions that may inform further actions needed to improve care within a setting or for a particular group of patients.

The procedure for the period that this report relates to (April 2023-March 2024) is as follows:

- SJR is requested by the Clinical Audit, Effectiveness and Mortality Team for the specialties to complete and return to the team within a specified timescale. SJRs can be used within departments for learning and presentation at departmental Mortality and Morbidity meetings.
- The Mortality Review Programme encourages clinicians who wish to take part in completing SJRs (and who may not have a high number of deaths within their own department) to sign up for a specified time period and complete SJRs not completed by the specialty teams. During the year 2023/2024, there was low participation in the MRP (this is a focus for the year 2024/2025 and will be reported on in the corresponding report).

The proportion of mortality reviews entered onto the Trust Mortality Database was 715 which represents 52% of all deaths. This is also a 27% increase of completed reviews compared to previous year. Analysis of the data identified that overall:

- 22.5% of patients were considered to have received good or excellent care, which is a reduction from 51% previously reported.
  This was supported by evidence of appropriate senior reviews, excellent communication between the teams and family members, early recognition of deterioration and timely escalation of care. There was good involvement from the Palliative Care Team.

- 9% of patients were considered to have received adequate care, which is a reduction from 13% compared to last year.
  Care delivered was impacted by the evidence of poor quality of documentation in relation to record keeping, gaps in medical notes in relation to standard forms for example, ReSPECT form, there was also evidence of missing information on electronic systems in relation to the patient admission episode. There were some evidence of gaps in care around medication reviews, management of inpatient falls, and the length of time to plan and execute safe discharges.

- 4% of patients were considered to have received poor or very poor care which has remained the same in comparison to previous year.
  There was evidence of significantly poor levels of the quality of documentation, which also made it difficult to determine if specific elements of care had been delivered for example, in some cases there was no evidence of senior or consultant reviews, and ReSPECT forms not completed. Overall, care in general was considered to be sub-optimal for this group of patients and examples of this include poor use of prescribed meds (or no meds prescribed), delays in investigations and diagnosis, incomplete assessments or investigations, management of patient falls, poor supervision of Junior Doctors and lack of Multidisciplinary Team approach to care.
- Of the 4% (26) of reviews, it was considered that –
  - 11/26 felt that death was more than 50% avoidable however, -
    - 7 cases commented without adequate documentation and access to records to determine all care delivery, it was difficult to determine if death was actually >50% avoidable
    - 2 cases commented failures in specific elements of care or in systems that were considered to have contributed to the patient's delivery of care and possibly death
    - 2 cases commented where death was >50% avoidable, DATIX had been raised.

63% (451) of the reviews did not have a score recorded for the patient's overall care. This is a significant increase from 32% reported last year.

Trust Mortality Meetings and Reporting

The Trust Mortality Team has a new Trust Mortality Lead in place since September 2023 and new Chief Medical Officer oversight since December 2023/January 2024. The structure of work undertaken by the Trust Mortality Team has undergone reshaping during that time period, with the aim of being able to identify and triangulate changes in data trends and alerts on a monthly basis within a small team of people with knowledge and experience in analysing the data from a number of sources, and sharing learning with the wider trust mortality leads on a quarterly basis at the Learning from Deaths (previously Trust Mortality) meeting. The structure during the year 2023/2024 was as follows:

- Weekly meetings between the Trust Mortality Lead and the CAEMT. Responsibilities include arranging mortality reviews and writing of subsequent reports, writing quarterly mortality reports for Quality and Safety committee and Patient Quality sub-committee, writing annual Learning from Deaths report, reviewing internal (dashboard) and external (Telstra) data.
- Monthly mortality meetings – during the year it was agreed that the frequency of meetings would change to quarterly in an attempt to improve engagement and for the meetings to be an opportunity to share learning from the CAEMT (including a brief summary of the internal/external data reviewed at the weekly meetings) and from specialties.

In the year April 2023-March 2024 we held 6 Trust Mortality Meetings, however 4 of these did not meet quoracy and therefore did not proceed.

The weekly meetings between the Trust Mortality Lead and the CAEMT occurred every week unless either person was on lead. Oversight was provided by the Deputy CMO.

Minutes for the Trust Mortality meetings are attached for information. Minutes are not taken for the weekly meetings, however an action tracker is used to monitor work undertaken.

Quarterly reports are prepared for the Patient Quality Sub-committee and the Quality and Safety Committee, reporting on SHMI, weekday/weekend HSMR, SJRs, trust mortality and trust activity (admissions). These are also attached.

Key Assurances

There is evidence of internal mortality monitoring via the mortality dashboard, and review of external data (SHMI, Telstra Health, national audits), both of which are reviewed regularly by the Trust Mortality Team during their weekly meetings. Reports are available from Telstra Health, though there were periods of time during the year which reports were not available due to an issue regarding data accuracy affecting the HES data used by Telstra Health, and during which time we used internal data to monitor trends in mortality. Data provided by Telstra Health is always likely to remain 3 months behind due to cleansing of the patient-level data before it reaches Telstra health for analysis, therefore internal monitoring must always be used in addition to identify real-time trends or concerns, however it is preferable to use both in tandem to provide assurance of reliability.

Quarterly Trust wide Mortality reports are attached and provide assurance regarding the improvement work undertaken over the previous year.

Key Areas for development

During the year 2023/2024 a new process was agreed to enable monthly review of internal and external data alongside information from the ME service, the Patient Safety Team and national mortality audits. As of April 2024, this was yet to commence.

It was agreed that the Mortality Review Programme should continue and would aim to demonstrate improvement in SJR completion.

Externally monitored data remains impacted by the timeliness of scanning patient records and the subsequent impact this has on the ability to apply clinical coding. Whilst there remains a delay in scanning and coding, it is acknowledged that there was a risk of unidentified themes in uncoded notes

Learning from Death meetings are effective when there are good levels of multidisciplinary attendance, however the reason for poor attendance/non-quorum should be explored to understand barriers, and other ways of disseminating learning and facilitating improvement should be considered.

Engagement with Learning from Death activity overall requires improvement at Speciality, Divisional and Trustwide level; this includes actively engaging in specialty and trust-wide meetings, completing SJR's and participating in both the Mortality Review Programme and mortality reviews for alerts or areas of concern. Improvement of existing accountability structures is required in order to enable engagement, needing support from divisional management to allow time and resources for this.

Actions and Improvements

The summary below outlines the actions and improvements made since April 2023:

- Consolidation of mortality meeting process:
  - Weekly meetings of Mortality Team to review data, themes and collate learning to share at Trust wide Learning from Deaths meetings (previously Trust Mortality Meetings)
  - Quarterly Learning from Deaths meetings
- Engagement in System Mortality Group meetings with BSW – these meetings commenced in January 2024 and enable collaborative work between mortality teams at RUH, SFT and GWH, supported by the ICB Chief Medical Officer and other staff.
- Strengthening internal mortality database.
- Creation of the SJR training module – due to be piloted summer 2024
- Implementation of internal timeline for SJR completion; for all patients to undergo all relevant mortality reviews/SJR's within 30 days of death and mandatory category SJRs to be completed within 7 days. This supports meeting key points in other parallel processes.
- Improved awareness of national audits relating to 30-day mortality and reporting structures to enable oversight by Mortality Team:

Clinical Audit, Effectiveness & Mortality Team
Team Structure

Clinical Audit, Effectiveness & Mortality Manager
B7 - 1 x wte

Clinical Audit, Effectiveness & Mortality Facilitator
B5 - 1 x wte (USC & ICC)

Clinical Audit, Effectiveness & Mortality Facilitator
B5 - 1 x wte (SWC & CORP)

Clinical Audit, Effectiveness & Mortality Assistant
B4 - 1 x wte

Clinical Audit, Effectiveness & Mortality Assistant
B4 - 1 x wte

Clinical Audit, Effectiveness & Mortality Assistant
B3 – 0.58 x wte

Clinical Audit, Effectiveness & Mortality Assistant
B3 – 1 x wte

Clinical Audit, Effectiveness & Mortality Assistant
B2 – 0.80 x wte

Actions and Improvements still in progress

- Review and update of LfD policy (due October 2024)
- Establishing Mortality Review Programme to facilitate timely completion of mandatory-category SJRs
- Development of meeting structure (including terms of reference, frequency and agenda) to enable triangulation across multiple data sources and alignment of processes feeding into the mortality picture
- Clarification regarding accountability and oversight for Learning from Deaths at specialty and divisional level.
- Falls mortality review (due May 2024)
- Hip fracture mortality review (identification of GWH as outlier for 30-day mortality following hip fracture)

Summary of Assurance
Overall, what level of Assurance do the local results demonstrate?

- No Assurance – Practice does not meet any standards ☐
- Limited Assurance – Practice meets some standards ☐
- Reasonable Assurance – Practice meets the majority of the standards ✓
- Substantial Assurance – Practice fully meets or exceeds standards ☐

Summary of Risk
Using the Risk Scoring Matrix, what level of Risk does the local results demonstrate overall?

- Low Risk ✓
- Moderate Risk ☐
- High Risk ☐
- Extreme Risk ☐

Executive Sign-Off
This report has been assessed and approved at: Patient Quality Com. ☐ Date:
Governance and Safety Com. ☐ Date:

References
1. NHS England » Learning from deaths in the NHS
2. Telstra Health UK

TRUST MORTALITY GROUP MEETING

A meeting of the Trust Mortality Group

took place on 17/05/2023, 12:00pm to 1:30 pm, in the trust board room GWH.

MINUTES

1. Apologies & Attendees

Apologies received
T Onyirioha, Deputy Medical Director
W Johnson, Associate Director of Safeguarding & Lead for Mental Health
S Carty Consultant Rheumatologist

Attendees
G Baigel, Anaesthetic Consultant (Chair)
T Hyde, Consultant Cardiologist (part of meeting)
N Manzoor, GM for Pathology & Blood Transfusion Services
V Butcher, Senior Consultant, Telstra
S Thomas, Head of Clinical Coding
L Daniels, Specialist Doctor in Emergency Medicine
D Hiller, ED Consultant & Lead Medical Examiner
J Prior, Community Stroke Coordinator
L Powell, Locum Consultant in Palliative Medicine

Attendees
D Marciniak, Specialist Doctor in Oncology
J Lim, Consultant Colorectal Surgeon (part of meeting)
S Edwards, Clinical Audit, Effectiveness& Mortality Manager
S Dad, Clinical Audit, Effectiveness & Mortality Facilitator
J Sysum, Clinical Audit, Effectiveness & Mortality Facilitator
S Newman, Clinical Audit, Effectiveness & Mortality Assistant (minutes)
C Ray, Clinical Audit, Effectiveness & Mortality Assistant (technical facilitator)

2. Minutes & Action Tracker Review

There were no minutes or action tracker from the previous meeting.

3. GWH Mortality Report	Lead	Deadline
HSMR update from VB – ***Please note all figures are unreliable as a result of data quality issues caused by a delay in fully coding discharges.*** HSMR – 115.1, statistically higher than expected. Weekend/Weekday HSMR for Emergency Admissions - Weekday – 117.1, statistically significantly higher than expected Weekend – 106.4, within the expected range SMR - 117.0, statistically significantly higher than expected Progress in coding means that within the near future there will be greater data quality and insights • DH raised there seems to be an increase in the number of aspiration pneumonia, and asked if it is possible that this is due to misdiagnosis. • VB replied that sometimes similar issues have occurred as a result of changes in coding standards.	VB	
• SHMI update – (December 2021 to November 2022) 110.91, within the expected range using NHS England's 95% control limits adjusted for over dispersion	VB	
New Mortality Alerts – There are new alerts but the backlog in coding means they cannot be relied on to be accurate. • Aspiration pneumonitis, food/vomitus – CUSUM • Other acquired deformities – CUSUM • Other disorders of stomach and duodenum - relative risk	Telstra Health Report	

• Pneumonia - CUSUM • Diagnostic imaging (except heart) - CUSUM & relative risk • Rest of respiratory (diagnostic/minor) - relative risk		
4. Current Mortality Alerts – Action Tracker – *Chair*		
• Excision of Labia Alert (1pt) Update GB provided detail of the case: • Elderly lady with a number of comorbidities, had a vulval lump. She was given anaesthetic then died, but in GB's opinion she would not have survived any treatment for the vulval lump regardless of what it turned out to be. This has now been raised as an Incident through Datix.		
5. M&M Reviews / Updates *(Mortality activity and SJR outcome's summary)*		
SE presented her report: • 1593 deaths during 2022-23 • There were higher than average number of deaths per month • Proportion of deaths continue to follow seasonal trends • April 2022 recorded the highest number of deaths undergoing a mortality review (SJR). • 90% (440 SJR's) of all reviews completed on average 4 months after the patient has died • 34% (151 SJR's) of all reviews were completed between 6-12 months after the patient had died. • Incidents recorded have increased following the rollout of the Datix system in July 2022. • Of the mandatory categories, 37% (205) reviews were undertaken. • Trust M&M Database and SJR Proforma updated; encouraged use of Screening tool • The quality of completed SJR's needs to be addressed. • The aim of the learning from deaths framework was initially for every trust to SJR review all deaths, but this is not achievable anywhere in England. • The aim is to make the process work for GWH. LD summarised recent trends in mortality in ED: • ED saw an increase in deaths in March, but anecdotally march was a very difficult and busy period in ED. It settled somewhat in April and LD expects this to be reflected in the data. • Monitoring of patient's glucose levels continues to be an issue. • ED have conducted a joint meeting with the clinicians from the acute medical unit, and this was very helpful. • There was some discussion around the management of cranial haemorrhages. • A lady on NIV was placed in the wrong room, and may have died with NIV ongoing, which is not correct practice.		
6. Mandatory Categories – *Updates / Shared Learning*		
LeDeR – WJ was not present at the meeting. SE provided a brief update: • There were no areas of concern identified in learning disability cases. • WJ would like to supplement the SJR process to better capture and scrutinise aspects of care that specific to LD care. LeDeR – JL provided an update concerning an LD death under general surgery: • There was one case in General Surgery, and there have been extensive discussions regarding this patient and there is no further action required.	WJ	
No attendance/representation.	Clinical Risk	
▪ JP presented her report findings regarding "Mouth Care Matters". It was identified by CQC in 2019 that GWH did not complete oral hygiene assessments on patients or have a process for assessing patients on admission. A trust wide roll out of Oral hygiene awareness was carried out This work was supported by the clinical lead trainer for Mouth Care Matters for the Southwest of England from Health Education England. An Audit was carried out to establish current practices around the mouth care of inpatients at GWH and the effectiveness and the completion of the Oral	JP	

hygiene assessment tool being used. Recommendations from this audit included; Staff training, documentation and to improve stock management of mouth care products. Mouthcare Assessment is going onto Nervecentre but there are some IT issues.		
Medical Examiner – DH reported: • Significant number of Summary of Death Forms (SODF's) not being completed • Have introduced electronic system that can be completed on mobile from the bedside • DH would like to discuss how deaths are managed in patients belonging to different faith communities, and how mortality processes may be altered to better accommodate different communities in future meetings – GB did not think this was the correct platform for this • Statutory medical examiner system has been delayed until April 2024. • Ongoing issues re. contacting junior doctors/completion of paperwork. • February to April 2023: ○ 403 deaths scrutinised, 54 of which sent to the coroner, 13 referred for SJR. • GB asked if the medical examiners could record the dates of issues in care on their referrals.	DH	
7. End of Life (EOL) - *Updates / Shared Learning*		
EOL update – LP gave update: • Sharing data between wards/teams would be helpful in ensuring personalised care plans are followed where patients move between departments/specialities. • When reviewing deaths, there is often no documentation of the hours in the leadup to the patient's death, making review processes harder. • Families are also complaining that deaths were extremely difficult, and a lack of notes around the final hours of life is impeding palliative care in seeking to address this. • Digital respect form has launched. • Digital respect forms should be printed and placed in the notes, but the most up to date version will be on Graphnet. • Palliative Care are also planning a process to better identify and plan for patients that may or may not die during their admission.	LP	
8. Specialty Dashboards - *(Specialty feedback / Themes and Shared Learning)*		
LD gave update from ED – March deaths had increased and was a tough month in ED. April seemed to settle. There are recurrent themes around Glucose monitoring and Hypoglycaemia. Ambulance waits do not appear to be an issue currently.		
9. AOB		
SE explained there has been an increase in the number of specialities pointing out incorrect patients recorded under their respective specialities; the mortality data is derived from what is entered at ward level, so if Clinician/speciality transfers etc are not recorded correctly this is what will be generated and provided by informatics. Data is unable to be correct by the audit department so it is important that the information on Careflow is accurate. DH reported that there have recently been 3 deaths of young people with PE's. DH, LD & SE to meet to discuss.		

These minutes provide an account of items scheduled for discussion at the Trust Mortality meeting in order to provide assurances around effective governance. This includes the monitoring systems and processes, performance, identification of appropriate actions and ascertainment of issues or concerns that may impact on service delivery for escalation.

DATE & TIME OF NEXT MEETING: 15th June 2023 – 12:00pm – 13:30pm
Trust Boardroom

Signed: …………G Baigel………………………………………………..(Chair)
Date:……23/05/2023………………………………..

TRUST MORTALITY GROUP MEETING

A meeting of the Trust Mortality Group took place on 13/09/2023, 2pm to 3:30 pm, via TEAMS

MINUTES

6. Apologies & Attendees

Apologies received - None

Attendees
L Powell, Locum Consultant in Palliative Medicine (Chair)
T Hyde, Consultant Cardiologist
V Butcher, Senior Consultant, Telstra
L Daniels, Specialist Doctor in Emergency Medicine
D Hiller, ED Consultant & Lead Medical Examiner
W Johnson, Associate Director of Safeguarding & Lead for Mental Health
T Onyirioha, Deputy Medical Director
R Prout, Consultant Intensivist and Anaesthetist

Attendees
D Marciniak, Specialist Doctor in Oncology
J Lim, Consultant Colorectal Surgeon
S Edwards, Clinical Audit, Effectiveness& Mortality Manager
S Dad, Clinical Audit, Effectiveness & Mortality Facilitator
J Sysum, Clinical Audit, Effectiveness & Mortality Facilitator
H Boyle-Bowles, Clinical Audit, Effectiveness & Mortality Assistant
S Newman, Clinical Audit, Effectiveness & Mortality Assistant (minutes)

7. Minutes & Action Tracker Review

There were no minutes or action tracker from the previous meeting to discuss. No-one raised any issues relating to the previous meeting. LP introduced herself as the new Mortality Lead for the Trust.

8. GWH Mortality Report	Lead	Deadline
HSMR a more detailed update was given by VB – The HSMR for the latest 12-month period is 109.6 (103.0 – 116.5), this is statistically significantly higher than expected compared to hospital trusts nationally. No individual months have a statistically significantly higher than expected relative risk. The most recent two months of data show an increase in HSMR and have a lower than usual volume of superspells and deaths, this is likely to be due to a delay in fully coding activity from these months and therefore the figures are likely to change when we have more complete data. The emergency weekday HSMR is statistically significantly higher than expected whilst the emergency weekend HSMR is within the expected range. No individual days of admission have a statistically significantly higher than expected relative risk. • Weekday –107.3, statistically significantly higher than expected • Weekend –101.4, within the expected range	VB	
SHMI update given by VB – The SMR for April 2022 to March 2023 is 107.1 (101.7 – 112.7), this is statistically significantly higher than expected compared to hospital trusts nationally. No individual months have a statistically significantly higher than expected relative risk.	VB	
• **New Mortality Alerts** – There are a number of new CUSUM alerts:	Telstra Health Report	

Of the alerting groups, it was suggested the Trust focus on the groups with the largest number of observed deaths as a starting point, these are likely to have the biggest impact on overall SMR/HSMR: • Aspiration pneumonitis, 74 observed deaths vs. 56.2 expected. • Pneumonia, 244 observed deaths vs. 212.0 expected. • Septicaemia, 132 observed deaths vs. 104.2 expected. It was agreed that the alerts with the highest patient numbers would be prioritised to be investigated first by identifying the patients and obtain further information for these. ST to take a sample of these patients to check the coding and if the coding appears accurate, we will proceed to a clinical review of the notes. For the groups with a very small number of deaths, it would be worth reviewing the coding as a starting point to see if the alerts are due to data quality errors. The data for the 22/23 year is now fixed and even if coding is amended at the Trust, this wouldn't be reflected through the HES data, however it can still be useful to identify if there were any data quality errors before deciding whether to review the deaths from a clinical perspective. The groups with small numbers of deaths are below: • Cancer of other urinary organs • Headache, including migraine • Other acquired deformities • Excision of vulva • Rest of ear (diagnostic/minor) • Rest of urinary		
9. Current Mortality Alerts – Action Tracker – *Chair*		
There were no previous alerts to discuss.		
10. M&M Reviews / Updates *(Mortality activity and SJR outcome's summary)*		
Sharon was unavailable to present due to a medical emergency within her team during this Meeting.	SE	
6. Mandatory Categories – *Updates / Shared Learning*		
LeDeR – WJ gave an update from the Learning Disability Mortality (LeDeR) report Quarter 1 2023 - 2024. There was one death in Q1 2023 - 2024 related to in-patients at the Trust coded as having a Learning Disability (LD) or on the autistic spectrum and reported through the monthly informatics report. No cases involved a child under 18 years of age. The Trust does not currently fully meet the NHSI Learning Disability and AS Standards (2018) and because of not being fully compliant with the standards risks not fully meeting the needs of people with LD and as there is no funding stream aligned to support Trusts to meet the standards. There is a LeDeR learning project underway regarding the standardisation and use of the hospital passport. The Trust has representation at this meeting.	WJ	

It was acknowledged that there was no-one attending to represent Clinical Risk, and WJ (later in the meeting) asked whether this would be useful. LP explained that this was something discussed this morning at the Reporting meeting, and that she would explore for future meetings. TO suggested that we could, in future, review deaths that had gone through the Incident Review Meeting. TO reported some learning from the PSIRF – 5 deaths from PEs resulting in cardiac arrests – a trend identified and raised by DH (Medical Examiner), in which the patient was identified as "at risk" but then the risk was downgraded and then they were not treated, or otherwise were not recognised as being "at risk". He has done a review of these, and liaised with DH with regards to learning – a SWIFT was released recently to reflect this.	Clinical Risk – no one attended	
Medical Examiner – DH reported: Ongoing problems with Drs not completing the Summary of Death forms – 60% being completed, they are continuing to look at ways to improve engagement, including easily accessible forms, tea-trolley teaching. • July to August 2023: ○ 243 deaths scrutinised, 23 of which sent to the coroner, 11 referred for SJR. **SJR Themes**: • Latrogenic pleural infection. Lack of requested follow up with GP/ follow up imaging not arranged • Family concerns re. discharge shortly before final illness • Fall on ward – delay in x-raying ?hip injury • Confusion between teams as to who was responsible for MCA assessment • Delayed discharge – died from hospital acquired COVID • **Poor management of hyperkalaemia x 2** • Lack of documentation/concern re. possible ischaemic leg • Lack of provision of Parkinson's medications • Delayed discharge – died from Hospital Associated Pneumonia • Delay in 999 transfer from Orchard to GWH Medical Examiner process being rolled out across community. • Currently around 2/3 GP surgeries actively engaging • Community hospitals/Psychiatric units working well • Currently engaging with hospice Statutory system has been delayed until April 2024 • With this may come changes in MCCD (electronic) and end of cremation forms Ongoing issues re. contacting junior doctors/completion of paperwork • Further investigate use of Nervecentre for Verification and SODF • Tea trolley teaching and Trust Comms	DH	
10. End of Life (EOL) - *Updates / Shared Learning*		
EOL update – LP gave update: Numbers on active caseload have increased over last 2 weeks. Still working on business case for 7 day service, which has not been agreed at present.	LP	
11. Specialty Dashboards - *(Specialty feedback / Themes and Shared Learning)*		
ED (LD gave update) – average 10 deaths per month, which is stable (and had decreased in August) despite increased activity. They continue to perceive a benefit from the palliative care team attendance in ED during the week, however, concerns regarding access to palliative care advice and prescribing support over the weekend.		

There are ongoing concerns about patients not being optimised for NIV prior to commencing. **ICU** (RP gave update) – currently no M&M lead, RP is trying to identify someone to take on the role. She asked whether we would be interested in receiving the ICNARC report they produce in lieu of a representative until they get someone to take on the role? They have noticed an increase in surgical complications causing ITU admissions, e.g bowel leakage following stoma formation. They are discussing with the surgeons regarding further analysis/investigation. DH made aware in case trends are identified via ME service. **Oncology** (DM) – nothing to discuss.		
12. AOB		
JS raised the issue of falls being reviewed via Structured Judgement Review (SJR) screening and asked that if the screening identifies a full SJR is not required (e.g. because the patient fell after recognition of dying, and the fall was not felt to contribute to the morbidity or death of the patient), it is highlighted within the free text of the screening tool so the team can close loop. **LD** raised that the current SJR form does not have the agreed Cause of Death on it, which is helpful when discussing patients at the M&M meetings. JS explained that this is something he is talking to SE about and will hopefully be able to send this information out via the weekly departmental deaths report. Post meeting note: RP emailed and advised us the new M&M Lead for ICU is Elizabeth Mooney who has been added to the distribution list for correspondence going forward.		

These minutes provide an account of items scheduled for discussion at the Trust Mortality meeting in order to provide assurances around effective governance. This includes the monitoring systems and processes, performance, identification of appropriate actions and ascertainment of issues or concerns that may impact on service delivery for escalation.

DATE & TIME OF NEXT MEETING: To be confirmed.

Signed: …… ………………………………………………..(Chair) **Date:…… ………………………………**

Report Title	EDI Board Commitments / Board engagement debrief session				
Meeting	Trust Board				
Date	13 February 2025	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Sharon Woma, Head of EDI & Health Inequalities				
Appendices	Board Commitments template				

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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).							
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 identified assurance rating (whether substantial, good, partial or limited). *If 'Partial' or 'Limited' assurance has been indicated, 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):

This paper presents the proposed **EDI Board Commitments for 2025-2026**. The commitments align with High Impact Action 1 of the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan, ensuring Board members demonstrate compassionate and inclusive leadership while focusing on measurable improvements in EDI outcomes.

The commitments respond directly to three key actions NHS Boards must undertake:

1. Setting **SMART EDI objectives** for all Board and executive members
2. Demonstrating how **organisational data and lived experience** have been used to improve culture, and
3. Ensuring **regular review and prioritisation** of EDI concerns through data-driven decision-making.

The Board will continue to focus on the three strategic themes from the 2024-2025 commitments: Staff & Patient Listening Events, Staff Networks Engagement & Support, and

Board Meetings (EDI Data & Reporting). Key actions include Go & See visits, piloting hybrid listening sessions, deepening Board participation in staff networks, and improving EDI data integration in Board reporting. These actions will ensure sustained progress and accountability at Board level.

Board approval of these commitments will enable the Trust to meet its regulatory obligations while driving meaningful cultural and systemic change.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	X		X		
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps	Board representative to work with EDI Lead to devise schedule.				

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

Explanation of above analysis: The GWH NHS Staff Survey results for 23/24 highlight disparities in the working life experience of staff based on their protected characteristic. Marginalised groups of staff are more likely to experience discrimination, harassment, bullying and abuse and are less likely to feel they have equal opportunities. The Trust measure progress across several metrics (WRES, WDES, EDS, GPG), which indicate incremental progress is being made in these areas of challenge (see EDI Annual Report for 23/24 for details).

By setting objectives at board level, the Board can contribute to the strategic direction across this agenda.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Board to approve paper.

Accountable Lead Signature	Jude Gray, Chief People Officer
Date	03/02/25

Board Commitments 2025-2026

Theme	Objectives	Key Actions	Dates	Update	Status
1. Staff & Patient Listening Events	Strengthen engagement with staff and patients to gather meaningful insights.	• Engage in discussions to improve Board awareness, by understanding the lived experience of staff and to identify opportunities to address inequalities (to focus on Discrimination - EDI Pillar Metric, Q16B Staff Survey): ○ Shift to 'Go & See' approach for staff engagement. ○ Board representatives will volunteer in an allocated area of work. ○ Pilot four hybrid/virtual listening sessions for staff who cannot leave work areas. ○ Host quarterly face-to-face Slice of Life events. ○ Attend leadership conference workshop 26.06.25– Board rep on each table. • Work with Patient Engagement & Involvement Lead to identify existing community events hosted by partner organisations to improve Board awareness and foster good relationships. • Champion culture work (Clever Together) using sphere of influence to improve leadership engagement and commitment. • Review learning and agree any improvements for 2025 Timeframe: Quarterly sessions + ongoing feedback channels			

2. Staff Networks Engagement & Support	Deepen Board engagement with staff networks and enhance their influence on decision-making.	• % of Board to participate in Trust-wide 'Mentoring' programme. • Exec Sponsors to attend the AGM of the Joint Network late 25/early 26. Dates will be provided and receive the Joint Network annual report on network impact. • Host joint workshop with Board and Staff Network representatives to review EDI data and inform the 2025/26 EDI/HI action plan. • Review learning and agree any improvements for 2025 Timeframe: Ongoing + Annual review			
3. Board Meetings (EDI Data and Reporting)	Improve how EDI data and progress are reported at Board meetings.	• Agree the EDI documentation for Board Meetings • Review how EDI is referenced in Board Papers and agree improvements • Ensure the agreed EDI documentation is included in each Board Meeting pack • Review learning and agree any further improvements for 2025 • Review EDS outcomes to improve awareness of inequalities in selected services Timeframe: August/September 2025			

Report Title	Our local strategic direction, 2025-28				
Meeting	Trust Board				
Date	13 February 2025	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Claire Thompson, Chief Officer for Improvement + Partnerships				
Report Author	Chris Trow, Associate Director of Strategy				
Appendices	Our local strategic direction, 2025-28				

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 ratings are based on the 'overall assurance over effectiveness of controls (the measures in place to control risks and reduce the impact or likelihood of them occurring).

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 identified assurance rating (whether substantial, good, partial or limited).
If 'Partial' or 'Limited' assurance has been indicated, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

The development of our local strategic direction has included a significant engagement journey to ensure that our Trust Board have been able to make informed decisions over our future priorities. We have used checkpoints within the process to pause and reflect, discuss progress and consider all the feedback we have received. Our future direction has also been set by taking note of existing reports, strategies and national direction – but we note that this is a challenging period for the NHS across the UK and that the task ahead will be difficult. And while the NHS continues to provide universal access to healthcare, the reality is that getting the right care and living a healthy life is not easy for everyone.

Report

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

We are pleased to present our future strategic direction over the next three years to deliver against our priorities.

In getting to this point, Trust Board started with an initial workshop in May 2023, there followed a period of engagement which we called 'our Big Conversation'. We targeted three core groups:

- our teams of staff and volunteers
- our local communities
- and our partners.

Having gathered feedback, we then considered a range of existing reports, strategies and groups to form our next set of priorities and future direction, see diagram on next page.

Our strategy inputs

What has informed our next strategy

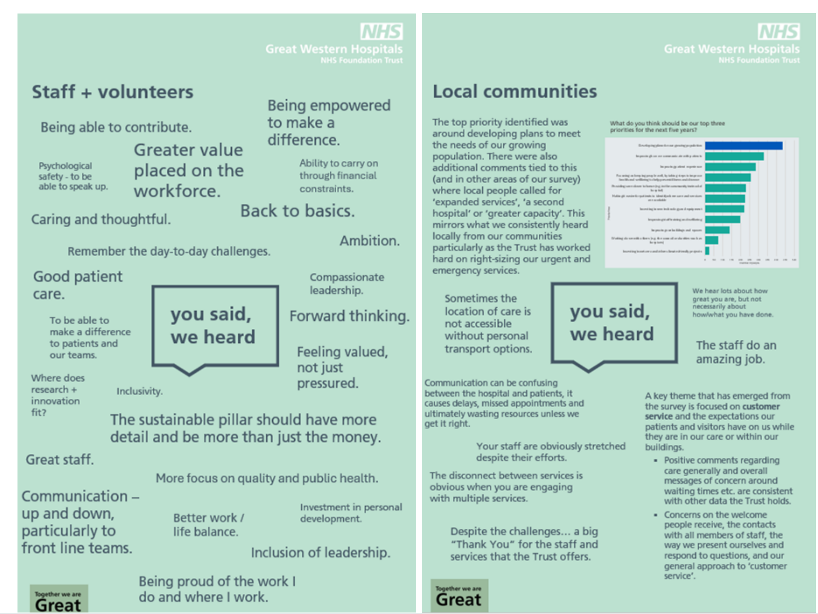
- Our Big Conversation – Surveys
  - Staff and volunteers
  - Local communities
  - Our partners
  - Our internal Strategy Development Steering Group
- Strategies
  - BSW strategy + Case for change
  - Partner strategies – NHS + local authorities
  - National strategy examples
- National documents
  - NHS Long Term Plan
  - Various sources / documents – e.g. The King's Fund
- Local documents + groups
  - HealthWatch reports
  - Voluntary sector representatives
  - Swindon Borough Council Residents Survey (2023)
  - BSW procurement documentation (Adult + Children's Community Services)
  - BSW Primary + Community Care Delivery Plan (2023)
- Internal documents
  - Inpatients survey
  - Feedback from our Patient + Local Communities Engagement Lead
  - Staff survey results
- Independent reports
  - BSW collaboration review / report
- Networks
  - Cross system discussions with neighbouring ICS'
  - Learning from systems across England
- Our Communications Channels
  - Social media feedback

We have developed our strategic direction with simple takeaway messages in a short digestible document.

We are committed to being a values-led organisation, believing that our core principles define who we are and shape the outstanding care we provide. As such, our values are the golden thread running through.

Delivering our priorities will be underpinned by our established Improving Together methodology.

Update since December Trust Board:
We have used January to undertake final testing with our teams of staff and volunteers, local communities and our governors. We paid particular attention to testing our vision and our four strategic priorities / pillars; outstanding care, valued teams, better together and sustainable future. We also played back key feedback themes to check that what we had heard was correct, see below.



These sessions provided an important checkpoint and the feedback supported the messages that were shared with no requirement to make any material changes to what had been developed. Further feedback gained from these sessions will be used to inform our deployment and our performance metrics.

Document changes since the last Trust Board review point:

- Following review some sections and diagrams have been simplified.
- Further narrative has been added to better describe what our values mean to us and why they are important.
- The document has been finalised, this has included a language review and proof reading.
- Formatting changes to improve presentation and document flow.
- Updated narrative to better describe how BSW Hospitals Group will operate and deliver change.
- QR code links have been added to allow people to link to digital versions and specific information on areas such as Core20Plus5, our digital plan and our green plan.

Launch format:
The document will be launched in digital and hard copy.
The digital copy will be placed on our website and made available in three versions;

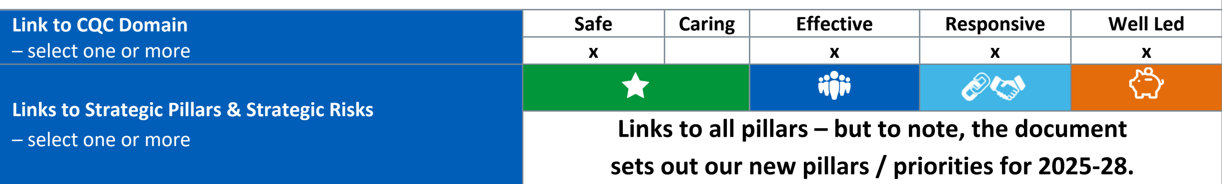
1. the original version (as per the appendix).
    - We have chosen a green and black format for this document. This identity is reserved for this document and limited external facing use. It provides us with an opportunity to create something different, away from the standard 'blue and white' but within the NHS colour spectrum, that will draw attention and lead people, including our teams of staff and volunteers, to pick it up and take the time to read it.

2. a 'clear view' version – this will be a simplified version with an enlarged font in a standard report style format. Images will be removed and diagrams will be made full page. Pages will be white with black text. This version will allow an easy and clear read and will be compatible with electronic screen readers.

3. an 'easy read' version – this version will be created inhouse with the support of our Patient Advice and Liaison Service. It will feature simple key messages supported by images.

On our website we will offer the ability to provide the document in other languages and formats on request, in-line with our NHS organisations.

Launch timeline:
We plan to launch mid-March 2025 internally to our teams of staff and volunteers and externally from April 2025. This approach will allow us to begin deployment just ahead of the new financial year and for our Strategic Planning Framework (which sets out our Improving Together strategy deployment, including monthly reporting) to begin by early summer 2025.



Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
	x		x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	**Links to all pillars – but to note, the document sets out our new pillars / priorities for 2025-28.**				

Key Risks – risk number & description (Link to BAF / Risk Register)		Risk Score
	/	/
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Council of Governors + Governor's review of priorities and measures Final testing with staff + local communities Jan 2025 Trust Board Dec 2024 Trust Board Nov 2024 Trust Board Seminar Oct 2024 Previous Trust Board Workshops Engagement with staff + volunteers, local communities + patients and our partners.	
Next Steps	Finalise Strategic Planning Framework metrics. Launch internally from mid-March 2025. Launch externally from April 2025.	

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 report relates to the future delivery of healthcare services, which we know currently do not take due account of protected characteristics or do enough to address health inequalities. Although our 'local strategic direction' sets out our intent and ambition to reduce inequality this report does not provide assurance of the improvement, such assurances will form part of the process which will follow as part of the strategy deployment.

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board are requested to:

- **note** the updates to the document since the last review point and the final stages of testing.
- **note** the formats that the document will be made available.
- **approve** 'our local strategic direction', including the launch internally from mid-March 2025 and externally from April 2025.

Accountable Lead Signature	[signature]
Date	06 February 2025

our local strategic direction | 2025 - 2028

setting our future direction over the next three years to deliver against our priorities

our future

Scan for digital version

Together we are Great

hello

Since we last set our strategic direction, back in 2019, our staff have risen to the challenge of the Covid-19 pandemic, increasing numbers of urgent and emergency attendances, and the impact of industrial action on our services.

Despite these challenges, we've made huge steps forward, investing in our infrastructure including a new Emergency Department, Urgent Treatment Centre and surgical robot, which have enabled us to improve our environment and the care we deliver.

We are in the process of embedding continuous improvement in everything we do through our Improving Together methodology and way of working.

As we look to the future, we have taken the time to speak to our teams of staff and volunteers, patients, public and partners to better understand what our priority areas should be and how these address the needs of our local communities.

We've considered the kind of organisation we want to be, how we can work more closely with our partners, the conditions we need to thrive and how everyone can contribute.

This work has given us a better understanding of what's important to us and our local communities. It has helped us to create a refreshed vision and set priorities, which will enable us to contribute to delivering the Integrated Care System's strategy (covering Bath and North East Somerset, Swindon and Wiltshire - BSW).

Our vision is to provide great services for local people at home, in the community and in hospital, enabling independent and healthier lives.

We have four strategic pillars, which are our priorities that we want to be known for.

- Outstanding care – continuous quality improvement and co-creation of services with local communities, with a focus on prevention and early intervention.
- Valued teams – our teams of staff and volunteers feeling valued and knowing their contribution to our future success, enabling them to deliver high quality care.
- Better together – collaborative and integrated working to improve quality of care and address health inequalities in our local communities.
- Sustainable future – maximise research and innovation opportunities to support quality improvement, spend wisely, and deliver on carbon net zero.

We believe our vision and pillars give us a clear direction and ambition for our organisation as we go forward.

We know that we can't do this on our own and our staff, volunteers, partners, and communities will be integral to everything we do.

As we work to develop our group model with colleagues at hospitals in Bath and Salisbury, we look forward to seeing the benefits of greater collaboration on the care we are able to provide to our patients.

Liam Coleman
Chair
Great Western Hospitals NHS Foundation Trust

Cara Charles-Barks
Chief Executive
Great Western Hospitals NHS Foundation Trust + BSW Hospitals Group

Jon Westbrook
Interim Managing Director
Great Western Hospitals NHS Foundation Trust

We are a collaborative NHS Foundation Trust

What this means and why it's important

As a provider of NHS healthcare we seek to deliver outstanding patient care to our local communities.

Being a collaborative organisation is important to us, it allows us to work together with teams across our organisation and to recognise the importance of working with local partners to deliver the best possible care. We hold a responsibility to consider and respond to the needs of our local communities, not just through the services under our direct control.

This means that we view our local communities' needs first and that we, internally and with our partners, arrange ourselves to meet this in the most caring and efficient way.

This will increasingly mean that across all providers we will need to deliver care in new ways, moving away from 'community' care and 'hospital' care based services towards models that are more integrated. Our teams will work together and we need to recognise that some care may be better delivered closer to home.

We will support this approach through a joined-up local infrastructure plan and carefully consider how digital technology will enable positive transformation.

It's important for us to describe ourselves as a collaborative NHS Foundation Trust as it demonstrates our committment to all areas of care and shows that we value the vital benefits of prevention and early intervention.

It's also important that all of our teams are valued equally, we all play a part in our future success and the future improvements that we can make to the health outcomes of local people and commmunites.

To do this effectively we'll need to live our values every day, they make us who we are and will ensure that we go about delivering our future in the best possible way.

The role of local people and our communities is central to our strategy, supporting them with prevention, early intervention and timely treatment and care when they need it.

To inform our decision making and the development of our future services, engagement and co-creation will be part of our everyday transformation, helping us ensure that we meet the needs of those we serve.

We are collaborative, because we know that Together we are Great.

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3 steps to success

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working together

We stand ready to build on our foundations and look to the future

It was back in 1871 that the blueprint for the National Health Service was founded by staff from the Great Western Railway (GWR), following on from early developments by the workers of the Mechanics' Institution. By 1892, having merged with GWR welfare services, workers were also getting access to the very first medical centre in the country.

It was this new healthcare service, in the heart of Swindon, that was to become the model for the new National Health Service, and by 1948 the NHS, as we know it, was up and running.

Today, Great Western Hospitals NHS Foundation Trust is one of the biggest healthcare providers and employers in the South West, with over 2.5 million patient contacts a year.

Swindon is a diverse and vibrant town, rich in heritage, but one also focusing on growth and significant development, with a population estimated to grow by 5% between 2020 and 2030 and a further 4% by 2040.

We know that doing more of the same, expanding services and building more units is not affordable or sustainable. Our future needs to be set on getting the foundations right and integrating care, so that it is focused on prevention and early intervention to allow people to live better for longer. This approach will help reduce future growth in demand and ensure that we are fit for the future.

But, we know that we cannot do this alone. We need the full support of our teams of staff and volunteers, and local communities - to make wise health choices, and the support of all of our local partners to help us achieve our priorities.

Collaborative partners

It is often assumed that the NHS is a single entity. In reality, the landscape is a complex network of organisations. Each working with common goals, but sometimes with competing priorities and all too often working in isolation, without sharing vital data or seeking to integrate across organisational boundaries.

We will work openly and collaboratively with all partners and seek out opportunities to integrate where there is clear benefit to our local communities.

We have worked hard in recent years to develop relationships with our partners and we want to also help them by being open to sharing our knowedge, scale advantages and infrastructure.

Locally we will need to support the wider determinants of health by working closely with Swindon Borough Council, as well as Wiltshire Council, and their long-term strategic plans. We will ensure that we not only share data and knowledge but that we look at ways of joining up health and care to drive the pace of change and achieve improvements to the quality of life for people right across our communities. We will do this while recognising that there will be disadvantaged or vulnerable groups that may need additional help or support.

Our group + system

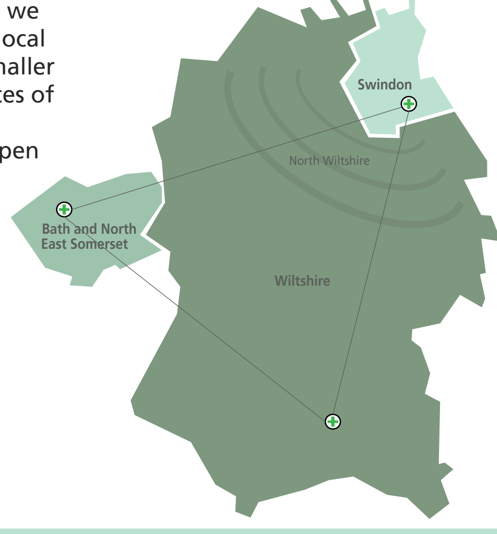
While the NHS provides universal access to healthcare, the reality is that getting the right care and living a healthy life is not easy for everyone.

BSW Hospitals Group is made up of three NHS foundation trusts, each rooted in their local communities. We actively work together in our leadership, clinical and improvement approach, sharing key enabling support functions to drive efficient working. We are proud to serve the people of Bath and North East Somerset, Swindon and Wiltshire, this area is what we call our 'system', and we work closely with the local authorities in each area.

Working as a Group means we are better placed to deliver change, helping to create the next generation health service, which is digital and focused on both prevention and ensuring patients receive great care in the right place when they need it.

Our ambition is to set a standard of exceptional care across our system, eliminating unwarranted variation and consistently achieving outstanding results.

As large organisations, anchored in local communities, we reach out, make connections and work together with local health, social and voluntary organisations as well as smaller community groups. We want to improve the experiences of some of the most disadvantaged members of our communities, ensure access to consistent healthcare, open up career opportunities and improve life chances.



BSW Hospitals Group - three NHS foundation trusts working collaboratively together across our health 'system'.

Working Together. Learning Together. Improving Together.

Great Western Hospitals NHS Foundation Trust

Swindon

We support local communities to stay well and out of hospital, to manage major conditions and provide care in local community facilities, close to home, across Swindon and the surrounding area.

Our hospital has around 480 beds, numerous oupatient clinics, maternity services, CT and MRI scanners, robotic surgery, an intensive care unit and a new 24/7 urgent care centre and emergency department.

Our reach extends beyond Swindon, due to our close proximity to the M4. Our easy accessibility is particularly reflected in the number of people we see using our urgent and emergency services. We work closely with communities within North Wiltshire too as their nearest and most accessible

Royal United Hospitals Bath NHS Foundation Trust

Bath and North East Somerset

Providing a wide range of services including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services.

Specialist services are provided for rheumatology, chronic pain and chronic fatigue syndrome / ME via the Royal National Hospital for Rheumatic Diseases.

In 2021, Sulis Hospital Bath was acquired, an independent hospital that provides care for both private and NHS patients. This has enabled more care for NHS patients, as well as continuing to provide private care to those who choose it.

New in 2024, The Dyson Cancer Centre brings together many of the hospital's cancer services under one roof in a nurturing and therapeutic environment.

Salisbury NHS Foundation Trust

Wiltshire

Salisbury NHS Foundation Trust is a district general hospital in South Wiltshire which delivers a range of clinical care to people in Wiltshire, Dorset and Hampshire including medicine and surgery, services for women and children, emergency services as well as diagnostic and therapeutic services.

Specialist services include burns and plastic surgery, cleft lip and palate, and rehabilitation - these are provided to a wider population footprint across southern England.

Salisbury District Hospital is also a provider of supra-regional spinal cord injury services.

one team

We want to work collaboratively together as one team, delivering high quality care to our local communities, driven by living and breathing our values at every step.

engagement

From the outset, our intent was to listen and reflect on our existing strategic direction. We know that much has changed and that hearing, first hand, from those who are impacted by the way we work and the services we deliver would allow us to ensure that we consider all of these voices in our future.

We used our 'Big Conversation' to drive this and engaged with three key groups; our local communities, our teams of staff and volunteers and our partners.

The conversation doesn't stop here.

Central to our future is co-creation, developing future services with those who deliver them and those who receive them. This goes beyond engagement and discussion and allows for true development, design and continous improvement.

The inputs into our thinking and direction

872
surveys completed by people in our local communities

364
local people have told us that they would like to get involved in our future

832
face-to-face conversations with staff and volunteers

179
staff surveys completed

20
members of staff representing internal groups + networks

12
surveys completed by the partner organisations we work with

Developing our local strategic view

The steps we've taken in developing our local strategic direction.

Trust Board workshops

- overall direction
- vision setting
- values
- priorities
- review

Our Big Conversation

Engaging with our three key groups:

- our local communities
- our staff teams and volunteers
- our partners

Feedback + review

- workshops
- surveys
- testing our thinking
- review and reflection workshops

Live + day-to-day feedback

- our social media channels
- our patient liaison service
- our community engagement leads
- wider surveys and feedback

Strategic direction

- national guidance
- regional and local reports and strategies
- demographic data and trends
- internal data and patient trends

Our network

- health and care networks
- learning from others
- NHS England
- existing informing strategies
- national policy and guidance from the Department of Health and Social Care

our vision +values

Our vision is our guiding beacon, which sets out who we are and what we are here to achieve.

Great services for local people at home, in the community and in hospital, enabling independent and healthier lives.

Our values make us who we are and support us in achieving our vision.

service

teamwork

ambition

respect

We are committed to being a values-led organisation, we believe that our core principles define who we are and shape the outstanding care we provide. Our values - service, teamwork, ambition, and respect - guide every interaction, every decision, and every effort we make to improve the lives of our patients and communities. We take pride in fostering a compassionate and inclusive environment where every individual feels heard, valued, and supported. By embedding these values into everything we do, we will deliver the highest standards of care, adapt to challenges with resilience, and inspire trust in those we serve.

Service is at the heart of our care. We communicate effectively, listen attentively, and act with professionalism and accountability. Every patient deserves to be treated with dignity and receive care that prioritises their safety and well-being. Through teamwork, we build strong partnerships, embrace diversity, and support each other to achieve common goals. Our ambition drives us to strive for excellence, innovate, and uplift those around us, ensuring continuous improvement. And at the core of it all, respect forms the foundation of our relationships, valuing every person’s voice, demonstrating empathy, and fostering a culture of openness and integrity. Together, these values empower us to make a meaningful difference every day.

our priorities

Our priorities are set out through our four strategic pillars. These pillars are what we want to be known for.

Outstanding care

Valued teams

Better together

Sustainable future

Outstanding care

Continuous quality improvement and co-creation of services with local communities, with a focus on prevention and early intervention.

Why we're focused on this + our current position

We are here to deliver safe and effective care to our local communities, centred on their needs in a kind and caring way.

We face a significant challenge with public confidence in the NHS at a national level. Concerns with response times, waiting lists and increasing demand are shared by providers across the country. But, we still have much to celebrate and welcome many positive care experiences from our local communities.

Our everyday patient and visitor contacts can be significantly improved to further enhance the care we provide and give a better all-round experience. We want to embrace our integrated and collaborative approach to develop our services, hand-in-hand with local people.

Using our established improvement methodology we must shift our focus to prevention and early intervention, to lessen the impact of major and multiple health conditions on our communities and address inequalities.

These changes will take time to show benefits, but they are essential for achieving improvements in health over the long term.

Feedback shows that while we provide good levels of individual patient care, there are many opportunities for us to improve the way we present and communicate to our patients, carers, visitors and local communities generally. This will include face-to-face contacts, letters and appointment notifications, information provision and service signposting, as well as our more formalised communications and social media channels.

What we will do + how we'll measure success

- We will aim for Outstanding in all assessed areas of our next Care Quality Commission (CQC) inspection, achieving a rating of at least Good overall.
- Our patients and local communities will receive care provided by one of the safest trusts in the country.
- We are determined to deliver, or go beyond, all nationally set performance standards. These standards are generally reviewed annually but we will also be working closely with NHS England on performance and reform requirements following reviews underway from mid-2024 and the new 10 year NHS plan.
- Excellent patient and visitor experience will be demonstrated through our quality of care, compassion and professional approach. We will have equality, diversity and inclusion at the centre of our service delivery and design.

Equality
We value and respect every individual, including our patients, their families and carers, local community groups, and our dedicated teams of staff and volunteers.

We recognise that everyone is different and we will provide appropriate resources and opportunities to recognise and address inequality.

Diversity
We acknowledge the unique lived experiences of every individual, we are committed to listening, learning, and taking meaningful action to celebrate and embrace diversity.

Inclusion
We take targeted steps to ensure that we work for all the local communities that we serve. We also take action to deliver effective services that address the issues faced by inclusion health groups.

Valued teams

Our teams of staff and volunteers feeling valued and knowing their contribution to our future success, enabling them to deliver high quality care.

Why we're focused on this + our current position

Our teams of staff and volunteers have been under intense pressure in recent years. We have countless examples of how they have gone above and beyond to provide the best possible care. It's their dedication and belief in the NHS and our own organisation that allows us to continue our improvement journey.

The challenges we face are significant and we need the input of all of our teams to help us build on our successes and ensure that we can sustain a future that continues to provide the best possible health outcomes for our local communities.

Being an organisation of almost 5,000 problem solvers, we really will be making a difference - big and small - each and every day, continually improving together. Beyond this, we want to ensure that we are working with all local partners together as a wider team with shared goals and an open and collaborative mindset.

What we will do + how we'll measure success

- Our people will feel recognised and valued for their efforts and achievements.
- Our teams will understand their contribution to our future success and our services will be prepared for the future.
- We will have rolled out our Improving Together methodology to our entire workforce and this will also show high levels of engagement and daily practice of our toolkits.
- Our people will have the opportunity to be involved in the development and shaping of future services.

Improvements made here will be seen in the quality of care we provide, positively impacting on our performance and external / independent inspections.

Better together

Collaborative and integrated working to improve quality of care and address health inequalities in our local communities.

Why we're focused on this + our current position

Growing pressures across the NHS and the pandemic have stalled opportunities to embrace positive steps to better collaborate and integrate services for better health outcomes. This will be a priority area for us, we are better together.

Our local health landscape faces a number of challenges. There is a sharp contrast in health quality and life expectancy depending on where you live in the town. Studies suggest, for example, that men living in more affluent areas could be living up to nine years longer than those in the most deprived. Recognising the wider determinants of health is key to making good decisions on healthcare for the future.

Scan for more information on Core20Plus5

We will develop our approach targeted on equity of access, experience and outcome for Core20Plus5[1] groups.

[1]Core20Plus5 is an NHS England initiative aimed at tackling health inequalities by focusing on the most deprived 20% of the population (Core 20) alongside additional identified groups (Plus) across five specific clinical areas of focus (5) where inequalities are particularly prevalent. Essentially, Core20Plus5 is a strategy to target the most disadvantaged populations with specific healthcare interventions across key clinical areas to reduce health disparities.

What we will do + how we'll measure success

Research shows that there are many wider determinants of health, such as poor housing, access to education and employment opportunities. Our input and support in tackling such issues will be helpful and respectful of the abilities of other partners who have these core issues at the heart of their own agenda. We will also recognise the capacity that we hold and the areas where we need to prioritise our effort and resources.

- Our patients and local communities are our experts by lived experience and will have the opportunity to co-create future services and pathways. Their voice will need to represent all the communities we deliver care to.
- We will be taking an active lead role in working collaboratively. We will shine a light on local health inequalities to ensure they are prioritised within our own delivery plans and work closely with all our partners to help shift focus towards tackling root causes.
- The volunteer sector will feel supported and are partners in the future development of services. They will also have an active and heard voice in local decision making.
- We will be actively empowering our local communities to make good health and care choices, with an emphasis on prevention and early intervention. We will do this collaboratively, recognising the strengths of all our health and care partners.

Sustainable future

Maximise research, innovation and digital opportunities to support quality improvement, spend wisely, and deliver on carbon net zero.

Why we're focused on this + our current position

We have a thriving research and innovation team, who have taken a lead on many projects in recent years, including making us the first trust in the world to trial a new method of pacemakers to improve the lives of patients with a heart condition. We have an opportunity to raise the profile of this team and work collaboratively with partner orgnaisations.

We know that we need to move much more rapidly towards becoming an organisation that uses digital solutions for the benefit of our patients and consider how these solutions are accessible.

Our funding and resources are finite and we need to continue to provide good value for money and plan to invest wisely in our future. We will need to focus on doing more for less but also rethink the way we spend, focusing more on prevention and early intervention to avoid high cost hospital care after conditions have deteriorated or become more complex.

We have a number of initiatives underway to support our journey to carbon net zero by 2040. We have already been awarded the Silver Stars Certificate for our work on sustainable travel planning, achieved a Silver 'Green' Emergency Department accreditation for our efforts to reduce carbon in urgent and emergency care and have invested in many new carbon lowering energy solutions. But this is just the start of our programme.

Scan for more information on our digital roadmap

Scan for more information on our green plan and our journey to carbon net zero

What we will do + how we'll measure success

- All research and innovation projects are linked to at least one of our strategic priorities / pillars to ensure that we focus on best supporting patients' needs. We will be able to demonstrate that, as a Trust, we have raised the profile nationally of our capability and successes and that we are working collaboratively with partner organisations.
- We will be on track with our plans to implement our shared Electronic Patient Record.
- We will have a clear shift in funding towards prevention and early intervention, and / or out of hospital alternatives.
- Our patients, communities and valued teams will be served by a trust that is financially stable, spending well to ensure value for money and is focused on continued productivity and efficiency in all day-to-day operations.
- We will generate income from a variety of sources so that any profits can be reinvested into NHS care.
- We will be on track with our programme to become carbon net zero by 2040.

improving together

our vision

Great services for local people at home, in the community and in hospital, enabling independent and healthier lives.

our strategic priorities / pillars

Outstanding care | **Valued teams** | **Better together** | **Sustainable future**

our strategic framework in action

our strategic initiatives

These significant programmes of work are already established and will continue through to 2028.

- **Way Forward Programme**
  - Focused on setting and delivering our estates and infrastructure strategic plan and planning for the completion of the Great Western Hospital PFI (Public Finance Initiative) in 2029.
- **Digital First**
  - Delivering our shared Electronic Patient Record system across our three group NHS foundation trusts and developing our strategic approach to make the switch from analogue to digital, in a sustainable way, fit for the future.
- **Leadership + Management Capability**
  - Building and developing our leadership and management capability across the organisation.
- **System + Place**
  - Developing and delivering integration across our health system and 'place' (for us that means Swindon).
- **Improving Together**
  - Delivering our improvement methodology across our organisation and embedding it into our everyday work.

your contribution

local communities

care access

What you can do to support us:

Register with a GP practice and know your local pharmacies and the services they offer.
Think prevention and seek help early.

Access your care in the most appropriate way, make use of your GP and local pharmacy. Use 111 online and on the phone for advice and guidance or support when you're not sure of your next health care steps. Look into available services provided by the NHS, such as local community based options, the Urgent Care Centre, protecting the Emergency Department for life-threatening health issues or injuries. In an emergency call 999.

life choices

People in the UK are living longer but are facing more complex needs, often dealing with multiple major conditions. In Swindon and the surrounding area we face our own set of health needs and inequalities, some of which place us behind average trends in England.

45% of people in Swindon have a major condition

at least 1 in 10 have two or more major conditions

High blood pressure*ˆ, depressionˆ, diabetes*ˆ, asthma*, and obesity* are the most common conditions

* Identified conditions are higher than the England average, ˆ identifies a deteriorating position.

What you can do to support us:

Take care of yourself, access care and advice early - be empowered to live well and steer your own health needs. Consider your choices - such as exercise or healthy eating. What can you do to stay well?

Particpate in health programmes, such as vaccinations, and cancer screening, and consider blood and organ donation.

If you are aged 40 to 74 and do not have any known pre-existing conditions, why not access a free NHS check-up of your overall health. It can identify if you're at a higher risk of getting certain health problems and if you could benefit from changes in your lifestyle or early care intervetion to prevent future health complications.

Consider how we can inspire children and young people to make healthy choices as they grow and develop so that they lead their best possible lives.

get involved

What you can do to support us:

We want to develop our future services together so they best meet your needs - through co-creation.

Represent. We need to hear the voices of our entire community so that we can make good decisons about the future of our services that we provide across the community and in hospital.

Give feedback, both positive and negative - join the discussion and help us improve.

We are committed to developing a range of ways where you can get involved, from workshops, to surveys, to community-based group discussions or social media feedback. If you'd like to know more email us at gwh.strategy@nhs.net or speak to a member of staff.

your contribution

our teams + volunteers

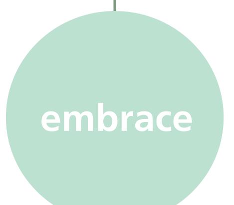
We want to provide the best possible care for our local communities. We need to deliver against our day-to-day committments and also deliver a significant and transformational improvement plan. We can only achieve this with the full support of our teams of staff and volunteers. Every contribution made is important but we all need to pull in the same direction towards the same priorities and goals to make the biggest and most positive impact.

You are our champions

We ask you to take the time to understand our priorities, what's important to us an organisation and how we want to be seen by our local communities and peers.

We are proud of the care we deliver and that we are a collaborative organisation - working as one team, providing high quality services in the community and in hospital. It provides us with the ability to work together to provide the best possible health outcomes.

Let's celebrate our success and share our good work.



Embrace our improvement journey

We need you to get involved and be a part of our improvement journey. Your day-to-day contributions all add up to our future success, be that delivering against our plans to deliver high quality care or by contributing to an improvement in the way we work.

We need to work together on our long-term goals, with every improvement bringing us closer to achieving them.

Use our Improving Together methodology and toolkits to support your improvements. Work with other teams both inside and outside of the organisation and consider prevention and early intervention as your default start position.

Live our values

Our values make us who we are, you can contribute by living them every day. Speak up about anything which gets in the way of doing your job.

Proudly display our values in how you approach your day-to-day work and any improvement contributions that you can make.

We also call on all our valued teams, at all levels, to fully live our leadership behaviours. Good leadership starts with you and how we behave sets the scene for how people feel. When people feel valued and respected it goes a long way in terms of them being the best that they can be at work.

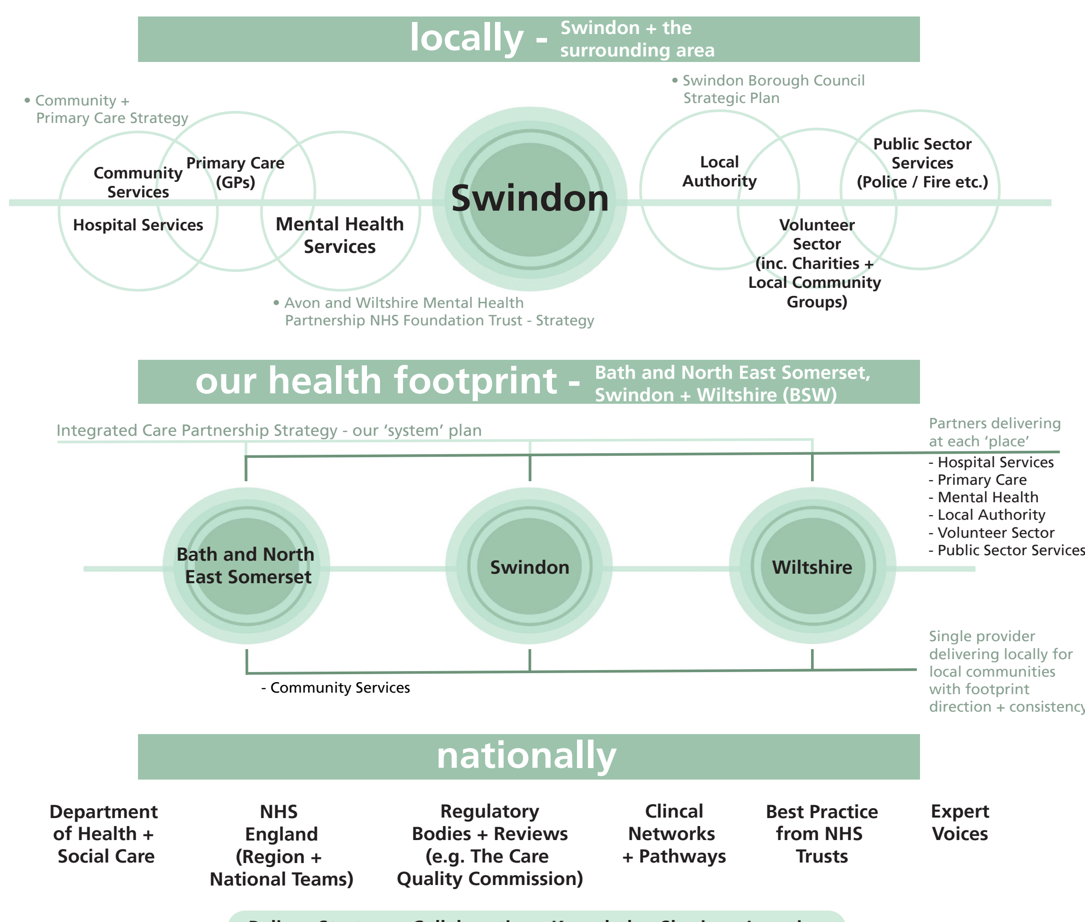
your contribution

our partners

We send a call to action to all of our partners, be they local, across our health footprint or nationally. We want to work with you in an open, transparent, helpful and collaborative way, with shared goals.

We want you to hold us to account when we say we are going to take action. We also ask that you join us with the same spirit, enthusiasm and pace to deliver the change that we need to improve health and care services, taking advantage of integration opportunities where we can to make our services efficent and a better experience for our local communities.

Partners at each level



harnessing our ability to work together

Our experiences + looking ahead

The last few years have seen the NHS tested like never before, with the Covid-19 pandemic bringing disruption to our everyday lives in a way which was unprecedented in modern times.

The challenge we now face is in many ways more complex than the early days of the pandemic. How do we recover our services in a challenged financial environment, with more people needing urgent and emergency care, more acutely ill patients, an older population, and many people living with more than one health condition?

The incredible way our valued teams of staff and volunteers have responded gives us faith that we can help to meet current and future challenges head on, and shape the NHS for the future.

We have now embedded a joined-up approach in our health and social care system locally, with hospital, community and primary care teams working together to do the best for our patients.

As we move forward, we do so together, looking for ways to shift the care people receive from hospital to the community, to move technology from analogue to digital, and away from treating sickness to preventing it from happening in the first place.

We must work together to harness our collective ability to drive innovation and positive change through the power of collaboration.

As we look to the future, we can do so with hope for how we can maximise the opportunities that being part of a group of trusts gives us.

By working together, learning together and improving together we can make things better for our local communities.

Implementing our shared Electronic Patient Record and proactively supporting the delivery of integrated care in the community, give us new opportunities to truly make a difference for our population.

We must now learn from each other and lift each other up, sharing in our successes.

Together, we can connect our ambition with the way we work through Improving Together and the way we behave with a common set of leadership behaviours.

We know that things won't always go as planned, but by living our values and truly embedding a just and learning culture where people feel able to speak up, we can learn from those times and continually improve.

Our work to date has enabled us to establish foundations which we must now build upon, paving the way for a different type of healthcare that embraces opportunities to bring providers closer together with a resolute focus on why we are all here – to provide the best care possible to our patients.

best lives

We want to support our local communities by delivering outstanding care and by reducing inequalities so that everyone can live a healthier life.

Together we are
Great

100% Recycled Paper

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